The Church’s Role in Supporting Human Development in the First Thousand Days

Exploratory research into church-based support for children, from conception to two years

Research conducted in Cape Town, South Africa by common good
The church’s role in supporting human development in the first thousand days of life

Exploratory research into church-based support for children from conception to two years

Suggested Citation


Disclaimer

Whilst the authors and the publisher made every effort to ensure that the information in this report was accurate at time of publication, the authors and publisher do hereby disclaim any liability and responsibility related to this information and the opinions expressed by interviewees.


Enquiries

Common Good
23 Milner Road
Rondebosch
Cape Town
South Africa

Phone: +27 (0)21 686 2970
Email: info@commongood.org.za
Website: www.commongood.org.za

This report is available for download at www.commongood.org.za/earlylife

Copyright © 2018 Common Good
The church’s role in supporting human development in the FIRST THOUSAND DAYS OF LIFE

Exploratory research into church-based support for children, from conception to two years

LEAD RESEARCHERS & AUTHORS
Ruth Lundie, Deborah Hancox, Susan Farrell

SUPPORTING RESEARCHERS
Zoleka Majola, Alicia Swartz

FEBRUARY 2018

common good

This report was commissioned and published by Common Good
Supported by Societas for ECD
ACKNOWLEDGEMENTS

The authors and researchers wish to acknowledge and thank the following people for their contribution to this research:

- All those who were interviewed and surveyed and who attended research workshops
- Nioma Venter and Shantelle Weber who assisted with the theological conceptualisation of the First Thousand Days (FTD)
- Neil Kramm who assisted with the online survey of church leaders
- Common Good leadership for their strategic guidance and support, especially Sarah Binos
- Albert Geldenhuys and Societas for ECD who made this possible through our partnership and relationships
- Common Good team members who supported along the way – Cherilyn Barry, Jessica Kietzmann, Suhail Khan, Coleen Adams, Nomakhaya Mani, Andrea Ressell, Maya Powers and Ryan Jacobs
- Catherine Janse van Rensburg who proofread and edited
- Common Ground Church for financial and spiritual support of Common Good
Deep inside every one of us is our ‘inner child’ – not who we once were, but who we still are. A sense of self that made you, you – even before your earliest memories! The twists and turns of life keep shaping you, but you have an essence-of-being that holds your past, present and future together. You are always you – as an embryo, child, teenager, young adult, older person. Your inner child is genetically primed to be loving, powerful and joyful. It holds the promise of life, no matter how old you are. It is your core identity, and everything about you flows from it.

It is no coincidence that all four Gospels start by defining the identity of Christ, by explaining who He is. John goes right back to the ‘beginning of eternity’ and places ‘The Word’ there. Mark locates Him as the Son of God. Matthew and Luke take us on a journey to Bethlehem, where Christ’s birth in a humble stable upends the common expectation of a powerful liberator, even as it affirms Him as such!

That nativity redefined the meaning of power. It took it out of the hand of Herod and placed it firmly in a human child. It replaced weapons of war with an instrument of peace – namely love – with which to build kin-dom’s of God. The first love that the infant Christ experienced was that of his mother and father. In relationship, through a sense of identity and belonging, Jesus ‘grew in wisdom and in stature and in favour with God and people’. This strong sense, both of self and of being-held in love, nurtured His sense of purpose, and ultimately defined His mission.

Two thousand years later, a vast body of science has asserted the centrality of the first thousand days of life in human and social development. The journey of becoming who you are relies on good health and nutrition, but it also relies on relationship – love, safety (that sense of being-held) and the stimulation that builds physical strength and mental wisdom. Science and faith converge in the power of love.

Love is visceral as much as it is spiritual; fully human, yet wholly divine, because where there is love, there is God (1 John 4). When tested by an expert in the law, who wanted to know what he should do to inherit eternal life, Jesus replied: ‘Love the Lord your God with all your heart and with all your soul and with all your strength and with all your mind – and love your neighbour as yourself’ (Luke 10:27).

It is time to embrace the image of Madonna and Child more firmly – to grasp fully that the love that is required to love your neighbour as yourself stems from the earliest mother-child relationships that shape the circuitry of the brain. Love gets wired into you, and you are called to wire it into others. This is the mission of the Church. It is the reason why it should play a central part in human development in the first thousand days of life, in a society where so many children are outcasts.

Common Good has woven together these challenging ideas, which still elude full explanation, both physiologically and theologically! Nonetheless, the authors present a compelling case, both from the imperatives of Christian faith and science: Share the love, power and joy of your inner child with other children who are still chronologically young – and you will build humanity, for yours is the Kingdom of Heaven.

DAVID HARRISON

David Harrison is a medical doctor and specialist in public policy. He is currently CEO of the DG Murray Trust.
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHRA</td>
<td>Church in High Risk Area</td>
</tr>
<tr>
<td>CLRA</td>
<td>Church in Low Risk Area</td>
</tr>
<tr>
<td>DoH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>DSD</td>
<td>Department of Social Development</td>
</tr>
<tr>
<td>ECD</td>
<td>Early Childhood Development</td>
</tr>
<tr>
<td>EBF</td>
<td>Exclusive Breastfeeding</td>
</tr>
<tr>
<td>FTD</td>
<td>First Thousand Days</td>
</tr>
<tr>
<td>NIECDP</td>
<td>National Integrated Early Childhood Development Policy</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Government Organisation</td>
</tr>
<tr>
<td>NPO</td>
<td>Non-Profit Organisation</td>
</tr>
<tr>
<td>RSA</td>
<td>Republic of South Africa</td>
</tr>
<tr>
<td>Stats SA</td>
<td>Statistics South Africa</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>WBOTs</td>
<td>Ward Based Outreach Teams</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
Whilst there is a growing body of research indicating the life-long significance of the First Thousand Days (FTD) in a person’s life, there is currently limited research regarding the church’s understanding and support of this critical period from conception to two years. Therefore, Common Good (a Cape Town-based Christian NGO working to equip churches and Christians in social justice) took the decision to conduct exploratory, multi-disciplinary research that would provide some preliminary answers to the question: “What is the specific contribution a local church can make in support of the First Thousand Days (conception to 2 years) of a child’s life in Cape Town?”

Mixed methods research was conducted in Cape Town with 194 respondents and included church leaders, church laity, denominational leaders, FTD experts, FTD practitioners and mothers of young children. The research sought to understand knowledge and attitudes of church leaders towards FTD, current church responses, existing FTD models and approaches which may be church suited, the role that respondents see for the church in FTD, and barriers to mothers accessing FTD services. Given the impact of socio-economic conditions on FTD, a key theme in the research was to consider the respective roles of churches in areas where people are at high and low risk during FTD.

Two literature reviews were also undertaken. The first covered the FTD context and summarised extant literature regarding what happens to a person during FTD and risk and mitigation factors. The South African context of FTD was also explored. The second literature review motivated for the church as a social actor in social development (and therefore for FTD) and located church-based responses within a typology of the different types of social development. A religious health assets approach was proposed, one which would work with the existing strengths of a local congregation. A missiological framework was given as the theological motivation for the church as a social actor. Some preliminary thoughts were presented on the intersect between the mission of the church and FTD.

The empirical findings were brought together with the literature reviews to recommend multiple types of church-based support for FTD that would build on the science of FTD, the usual activities of a church and an understanding of realistic approaches for a church as a social actor.

---

1 Refer to chapter 10 for a summary of findings and recommendations.
CONTENTS

Acknowledgements ........................................................................................................................................ iii
Foreword ......................................................................................................................................................... iv
Abbreviations .................................................................................................................................................... v
Abstract ........................................................................................................................................................... vi

1 Introduction .................................................................................................................................................. 1
  1.1 Background to the research ..................................................................................................................... 1
  1.2 Key concepts ............................................................................................................................................ 2
  1.3 Research question ................................................................................................................................... 2
  1.4 Delimitations of the research .................................................................................................................. 3
  1.5 Overview of the research report .............................................................................................................. 4
  1.6 Expected value of the research .............................................................................................................. 4

2 Research Design & Methodology ............................................................................................................... 6
  2.1 Introduction ............................................................................................................................................. 6
  2.2 Research design ..................................................................................................................................... 6
  2.3 Research methodology ............................................................................................................................ 7
  2.4 Locating the researchers within the research ........................................................................................ 19
  2.5 Research ethics ..................................................................................................................................... 19

3 The context of the First Thousand Days .................................................................................................... 20
  3.1 What is FTD? .......................................................................................................................................... 20
  3.2 What is happening in this short, yet critical period? .............................................................................. 20
  3.3 What are the risk factors? ....................................................................................................................... 21
  3.4 What are the protective factors? ........................................................................................................... 27
  3.5 What is the situation in South Africa? .................................................................................................. 28
  3.6 What is South Africa’s legal framework for FTD? ................................................................................. 30
  3.7 What is the opportunity for FTD support? ............................................................................................. 31
  3.8 Closing thoughts ................................................................................................................................... 33

4 The Church, Social Development & FTD .................................................................................................... 34
  4.1 Introduction .......................................................................................................................................... 34
  4.2 The church as an actor in social development ..................................................................................... 34
  4.3 The mission of the church and its implications for FTD ....................................................................... 45
  4.4 In closing ................................................................................................................................................. 56
Every person’s life begins at the moment of conception with the joining of a woman’s ovum and a man’s sperm. This beginning is the same wherever and however a person is conceived and whatever the socioeconomic status\(^2\) of his or her biological parents. However, from the moment of conception, those circumstances impact the trajectory of that person’s life, and his or her ability to survive and to thrive. Research\(^3\) points decisively to the impact of the first thousand days (FTD) (the time from conception to the age of two) in setting the course for a person’s entire life. And the quality of a person’s FTD is strongly impacted by his or her socio-economic circumstances.

Many government and civil society initiatives seek to help people who are negatively impacted by their socio-economic circumstances at various life stages. However, a growing body of evidence supports the thinking that one of the most effective ways to assist human flourishing is to ensure “a good start in life” through the provision of the basic building blocks of love, nutrition, stimulation, health and safety during the phase of conception to two years.

Whilst the importance of the FTD of life is broadly accepted by government, civil society organisations and academia (refer to Chapter 3 for this discussion), the understanding and contribution of the local church to this important life stage is not well understood or researched. Hence the decision to conduct this exploratory research to understand how the church is currently; and can increasingly, promote the wellbeing of people in their FTD of life, especially those at risk during this phase.

**Common Good’s involvement with the FTD**

This research was conducted by Common Good, a Christian development organisation birthed from Common Ground Church in Cape Town. In 2014, Common Good identified early childhood development (ECD) as one of its four focus areas\(^4\). Subsequently, from mid-2014 to mid-2016, the organisation developed and piloted the Champions for Children Programme (CCP) which focused on development during the first thousand days (FTD) of a child’s life – from conception to 2 years. The overarching aim of CCP was to see young children in two communities - Vrygrond and Heideveld - flourish, contributing to better longer-term outcomes for them. The key strategy was to build layers of care and support for the primary caregiver (usually but not always the birth mother) of a child in his or her FTD of life and in so doing to significantly impact the trajectory of the child’s life.

CCP was significantly impactful on multiple levels for both the carer and the connector (and therefore, it is believed, for the child). However, there were a number of challenges which made it hard to create the right environment for the carer to flourish. In reviewing CCP, Common Good recognised the need to answer the

---

\(^2\) “Socioeconomic status (SES) encompasses not just income but also educational attainment, occupational prestige, and subjective perceptions of social status and social class. Socioeconomic status can encompass quality of life attributes as well as the opportunities and privileges afforded to people within society. Poverty, specifically, is not a single factor but rather is characterised by multiple physical and psychosocial stressors. Further, SES is a consistent and reliable predictor of a vast array of outcomes across the life span, including physical and psychological health.” [http://www.apa.org/pi/ses/resources/publications/children-families.aspx](http://www.apa.org/pi/ses/resources/publications/children-families.aspx)

\(^3\) Refer to chapter 3 of this report for a summary of this research.

\(^4\) Along with Employment, Education and Congregational Support.
pivotal question of the local church’s involvement in the programme and thus in FTD generally. Hence their decision to conduct this research to inform their future strategy in FTD, as part of their Early Life Programme.

1.2 KEY CONCEPTS

Two key concepts that are brought together in this research are first thousand days and church. Hence they are given a working definition here, and both will be expanded in their related literature review chapters:

**First thousand days (FTD)**

The first thousand days is the earliest period of human life from conception to the age of two years. This period of early childhood development (ECD) includes pregnancy, birth, infancy and the first two years of childhood, as well as the parenting and caring during this time. It is during this period that foundational development is taking place that enables the child to reach his or her future potential.5

**Church**

The word “church” comes from the Greek word *ekklesia* which is defined as “an assembly” or “the called-out ones.” It is not in the first instance a building or a place, but a fellowship of people who seek to follow Jesus Christ together. More mystically, the church is called the body of Christ, of whom Christ himself is the head. Ephesians 1:22-23 in the Bible says, “And God placed all things under his feet and appointed him to be head over everything for the church, which is his body, the fullness of him who fills everything in every way.” This body of Christ is made up of all believers in Jesus Christ from the day of Pentecost (Acts chapter 2) until Christ’s eventual return.

Through the ages, local groups of believers have met together for teaching, worship, discipleship, pastoring, fellowship and to practice the sacraments such as communion and baptism. These groups of believers (laity) are usually led by trained leaders (clergy) and are often affiliated to larger groupings such as denominations or church movements. Gathering in a specific time and place they are referred to as a local church or a congregation, often also associated with the building where they meet from time to time. It is this local church or congregation (both laity and clergy), located in a particular community, which is our primary focus in this research report and will sometimes be referred to in the plural “churches”. At other times the word church will be used to refer to the one church of Jesus Christ, made up of many local bodies. It is also the church in Cape Town on whom our focus rests, but we draw from an understanding of church and related research that is global.

1.3 RESEARCH QUESTION

The overarching question in this research is:

*What is the specific contribution a local church can make in support of the First Thousand Days (conception to 2 years) of a child’s life in Cape Town?*

In seeking to answer to this question, the following supporting questions were asked:

1. What is FTD and why is it important?
2. Why should the church engage FTD?
3. What is the knowledge and attitude of church leaders in Cape Town to FTD?

---

5 Refer to chapter 3 of this report for more in-depth explanation to FTD.
4. What are the barriers mothers and other carers face in accessing FTD services?
5. How is the church currently responding to FTD in Cape Town?
6. What existing models and approaches (including financial models) are showing signs of successful implementation and impact in Cape Town and beyond?
7. What is the possible role of both churches in areas of low risk and churches in areas of high risk for children in their FTD?

Research methodology

This research is positioned as exploratory research, implying a preliminary investigation into a research area about which there is limited understanding. Exploratory research therefore requires an open and flexible methodology that assists in the search for new insights (Durrheim, 2006, p.44). The empirical research component used a mixed methods approach including both qualitative and quantitative research which engaged a number of different key informants using a variety of tools. In addition, the research was enriched by two literature reviews. The research is also multidisciplinary in nature (Osmer, 2008, p.163-164) as it brings together bodies of knowledge within the disciplines of health, social sciences and theology without any one discipline taking primacy. The details of how the research was conducted are covered in Chapter 2 – Research Design and Methodology.

1.4 DELIMITATIONS OF THE RESEARCH

The research was conducted within certain delimitations that must be understood when reading, evaluating and using the research. These delimitations are not seen as devaluing the research in anyway but rather help the reader to understand the scope and resources with which the researchers worked.

The research is exploratory

As mentioned above, the research is positioned as exploratory and does not aim to provide definitive answers to the research question but rather to open up and demarcate the research area.

The empirical research took place only in Cape Town

For reasons including budget, operational area and timeframe of the researchers, the researchers only worked in one geographic area, being the City of Cape Town in South Africa. Should this research prove to be of value, future research should be done in other areas. However, the researchers believe their report will still be of interest and relevance to people and churches in other parts of South Africa, and beyond.

Specific needs were not researched

Within FTD, there are many situations that require special understanding and focus within the church, such as disability, miscarriage, abortion, stillbirth, inability to conceive, adoption, unwanted pregnancy and so forth. These were not specifically addressed and should form the focus of further FTD and church research.

Limited budget and team

The research was funded by church and business donors and the researchers are most grateful for the funding made available to conduct this research. However, the budget was limited, and the research team comprised two part-time staff, supplemented at key points by two additional part time team members, and two part-time consultants from January to December 2017.
Practitioner not academic research

This research was conducted by a church-based Christian NGO which is positioned as a practitioner organisation and not an academic one. Therefore whilst seeking to adhere to good research practice, the researchers were more action than theory based in their research. In addition, the primary audience in mind is not an academic one but a practitioner one within both social development and church. The hope is that reports such as this can help build bridges between faith-based organisations and other social development organisations as well as with the academy, theological and otherwise.

Timebound

The research was timebound as it is intended to inform the strategy and programmatic development of the 2018 FTD programme of the organisation who conducted the research.

1.5 OVERVIEW OF THE RESEARCH REPORT

Chapter 2 - Research Design and Methodology gives a detailed description of how the empirical research was conducted. This research reports begins with two literature studies namely, Chapter 3 – The Context of FTD gives the reader an introduction to the topic of FTD from extant research; and Chapter 4 - The Church, Social Development and FTD makes the case from both a social development and theological perspective as to why the church has a role to play in FTD. It also suggests some barriers to the church’s involvement in this area. The findings of this empirical research are presented in Chapter 5 through to Chapter 9 – they are reported according to the supporting questions listed in section 3 above. The report ends with the Chapter 10 - Conclusion where the literature studies and empirical findings are brought together and discussed to answer the overarching research question. Finally, the Appendices include, amongst other expected items, recommendations for further reading compiled during the writing of the two literature reviews.

1.6 EXPECTED VALUE OF THE RESEARCH

The researchers have the following expectations of their work:

Provide a basis for FTD and church strategy development

The research is intended to assist anyone seeking to develop strategies for greater inclusion of the church in FTD in Cape Town (and beyond). This was the original motivation for the research.

Initiate dialogue

It is hoped that this research will result in increased dialogue within the church on FTD, as well as providing grounds for greater engagement between FTD practitioners and the church.

Provide sign-posts to immediate action for the church in FTD

This research report, and the more accessible, shorter version that will be drawn from it, are intended to inform, motivate and empower church leaders to take their next steps in making their church a place that nurtures, protects and champions people in their FTD.

Motivate further research

Being exploratory research, this research is broad but not necessarily deep nor generalisable. Several areas for future research were identified and these are listed in Chapter 10 - Conclusion.
Encourage more practitioner research within Christian NGOs

Having sought to conduct rigorous research within the opportunities and limitations of a local Christian NGO, the researchers hope that others in similar organisations in FTD and other fields will be encouraged to contribute to research with their knowledge, insights, experience, networks and grassroots access.

And most of all, it is expected that the lives of the littlest of people, people in their FTD will be positively impacted because of this research, in Cape Town and beyond

If the time and resources that have gone in to this research do not lead to improved conditions for children at risk in their FTD, then it will all have been in vain.
2 RESEARCH DESIGN & METHODOLOGY

2.1 INTRODUCTION

The research included a wide variety of key informants including church leaders, church laity, NGO leaders (practitioners), denominational leaders, and experts in the field of FTD. The research also included two literature reviews, one covering the context of FTD and the other motivating why the church has a role in social development and therefore in FTD.

This chapter describes the various research choices that were made, how the research was conducted and with whom. It starts with a section on research design followed by a section on research methodology which gives details of the research tools and participants. It includes a brief section which locates the researchers within the research and ends with information about the research ethics that were adhered to.

2.2 RESEARCH DESIGN

Research design describes the choices and approaches of the researcher in seeking to answer the research question. It also directs the researcher in his or her choices of research methodology. The following key points summarise the design of this research:

**Multidisciplinary**

The field of FTD is a multidisciplinary field in that it brings together health, sociology and psychology. In this research, FTD within these fields is being brought into dialogue with the discipline of theology and especially that of practical theology, the area of theological discipline that (amongst other things) speaks to the practice of the church. It is a field which seeks “not simply to contemplate or comprehend the world as it is, but to contribute to the world’s becoming what God intends” (Cowan, quoted in Smith, 2008, p. 204). As such, this research is multidisciplinary. However, in terms of research methodology, it is predominantly the research methods of the social sciences that have been used, with some theological methods (for example biblical exegesis) being used within the literature review in Chapter 4. The extended research team consisted of members from social science and theological disciplines.

**Exploratory**

One of the most defining aspects of this research is its exploratory nature, which implies a preliminary investigation into a research area about which there is limited understanding. Certainly, there is a broad body of knowledge in disciplines with an FTD focus (see Chapter 3) but a search of literature as well as anecdotal evidence within the church pointed to a very low level of engagement of this critical life phase within theological and church research. In addition, the research was commissioned to inform strategy and not to inform development of interventions nor as action research seeking change within the informants. Whilst no hypothesis was developed and tested, the research did begin with the belief of the research team that the church has a significant role to play in FTD. As the topic of the role of the church in FTD is a mostly unresearched topic, the research is exploratory rather than conclusive and will hopefully lead to more extensive research on this topic.

---

6 There is a large body of literature on children (to age 18) within practical theology. However, very little that speaks specifically to the stage of conception – 2 years from either a spiritual formation or a church practice perspective.
Scope was tightly delimited

Given the exploratory nature of the research as well as time and funding constraints, the scope of the research was narrowly defined. The research was delimited to key informants within the Cape Town Metropole (the area of interest of the researchers). The only exception to this was interviews with denominational leaders who were national within South Africa. In addition, many specific issues within FTD and the church were not specifically researched, and further research would be beneficial in these areas. They include (amongst others) adoption, loss and grief, abortion, and disability.

Mixed Methods

Mixed methods is an approach to research that uses both qualitative and quantitative methods to gain breadth and depth in research and corroboration of findings. The use of mixed methods and different key informants seeks to ensure some triangulation\(^7\) of the data (cf. Mouton, 1996, p. 156-157). Klaasen et al (2012) give one of the reasons for using mixed methods as being a focus on “research questions that call for real-life contextual understandings, multi-level perspectives, and cultural influences”. Given the exploratory nature of the research, the researchers sought to use mixed methods that would allow probing from several different angles. To this end, in addition to two discreet literature reviews, qualitative methods (interviews and workshops) and quantitative methods (a survey) were used.

Purposive sampling

Sampling of key informants was guided by the knowledge and connections of the research team, and was purposive and therefore also non-probability\(^8\) sampling:

The main objective of a purposive sample is to produce a sample that can be logically assumed to be representative of the population. This is often accomplished by applying expert knowledge of the population to select in a non-random manner a sample of elements that represents a cross-section of the population (Lavrakis, 2008).

Deliberate steps were taken to broaden the sample by bringing into the research team people with connections in both the Khayelitsha and Cape Flats areas, and by seeking referrals to people from various denominations.

Thematic analysis and coding choices

Thematic analysis is a method for identifying and reporting patterns (themes) within data in an attempt to interpret various aspects of the research question (Braun & Clarke, 2006, p.79). Initial coding was open (that is, without a prescribed code list), but a standard list of codes was later compiled according to emerging themes and FTD literature and as far as possible this was used to classify the empirical research findings.

2.3 RESEARCH METHODOLOGY

Research methodology focuses on the tools and procedures used in research (Mouton, 2001, p.56). The methodology used in this research included two literature reviews, a survey, two workshops and 35 interviews with four different types of key informants. Each of these is further explained below with a

---

\(^7\) Triangulation seeks to verify data from more than one source.

\(^8\) Non-probability implies that the selection was not random, and therefore not everyone with the research profile had an equal chance of being selected for the survey.
description of the methods used to collect and analyse the data and sample key informants. There is also a
description of the key informants and the means used to analyse the data.

2.3.1 FTD literature review

The research recognised that church leaders and laity are not necessarily well versed in the current science
and understandings of FTD. This FTD literature review aimed to assist church leaders and laity in increasing
their knowledge base as well as highlighting the imperative of the opportunity to support FTD.

Literature regarding FTD and early childhood development (ECD) (with a specific focus on very current
research reports, reviews and policies within South Africa) was included, as well as current global literature.
This review sought to highlight the current science around FTD and overview the crucial topics that would
assist in building the motivation to be involved in FTD with a good foundational understanding of the current
South African situation.

2.3.2 Theological literature review

The theological literature review sought to locate and motivate for the local church as a social actor within
social development. It was felt that the field of social development was the one in which the church as an
entity was best equipped to engage for the benefit of FTD. To this end, literature on religion and social
development, especially within a South African context, was engaged. In addition, the religious health assets
approach was put forward as an approach that could be used to mobilise the church’s health assets for an
individual and for a community and several pieces of literature covering this approach were referenced. Up
to this point, the approach was primarily from a sociological or sociology of religion approach. After this, the
position of the literature review changed to a theological reflection on mission and the proposal was made
that the role of social actor fitted well within the missional mandate of the church. The review ended with
some suggestions from literature regarding barriers to the churches social engagement that have emerged
through practical theological research.

2.3.3 Survey of church leaders

Overview

A quantitative survey for church leaders was designed to collect data on several of the research objectives.
These included the demographics of church leaders and church members in Cape Town, as well as
knowledge, attitudes and opinions of church leaders regarding social issues and FTD.

Method description

It was decided to make use of an online survey tool and Survey Monkey was selected based on its wide use
in social science research and ease of downloading of data for analysis. The survey was piloted with church
leaders in one church and with members of staff of the organisation conducting the research. This led to a
few adjustments prior to running the survey. To enable the participation of some church leaders who did not
have access to the internet, surveys were manually facilitated with two of the research team members
meeting church leaders, asking them the survey questions and then capturing the responses later into Survey
Monkey.

The survey was opened on 12 June 2017 and closed 31 July 2017. 79 Surveys were submitted.
**Sample selection and why this group was researched**

As mentioned in chapter 2, sampling was purposive. Various methods were used to populate a list of over 150 possible respondents. These included the knowledge and networks of the research team and their organisational colleagues. Two of the research team had contact with churches and church networks in Khayelitsha and Vrygrond respectively. The internet was also used to search for churches in Cape Town. The STATS SA 2001 census’s list of denominations was used to ensure a spread of denominations, and some of these were phoned and asked for church contacts to survey. A WhatsApp link was sent to various contacts to pass on. The team tried to ensure that they covered a range of socio-economic, gender and ethnic profiles.

**Analysis of data**

The data was downloaded from Survey Monkey and imported into an Excel spreadsheet. Of the 79 surveys submitted, 5 surveys were found to be substantially incomplete and were therefore discarded. Where questions allowed for open-ended responses, these were coded to enable the analysis.

Given that this was a purposive sample and not intended to be a representative sample from which generalisations would be inferred, quantitative analysis was done using descriptive statistical methods.

**Description of key informants**

71 survey respondents provided both Gender and Age data – of these, 25% were females and 75% were males. The chart below illustrates the age and gender distribution:
As depicted in the chart below, the home language of most respondents is English, isiXhosa or Afrikaans - this is to be expected as the survey was locally targeted.

Church leaders were asked to describe the composition of ‘most of their congregants’ according to several criteria. These results are depicted in the charts below:
72 out of 74 survey responses were from church leaders in the Cape Town Metropole. Through the networking approach used, two church leaders outside of the Cape Town Metropole completed the survey. In order to better understand and analyse the socio-economic status of the churches represented, use was made of the draft report, “Cape Town Municipal Spatial Development Framework (MSDF) 2017-2022”. This report described areas in terms of a socio-economic index as “Very Needy, Needy, Average, Good or Very Good”. In the MSDF report (page 25) there is a map which shows which areas fall into which socio-economic category. The research team manually mapped the areas in which the churches were located, to the relevant category and used this index as a means of disaggregating responses to some survey questions. In terms of composition of congregations\(^9\), the survey reflects the reality of the spatial divides which are still mostly along racial lines in the Cape Town area.

\(^9\) N=71 as one of the Cape Town churches did not respond to the question on racial profile of most congregants.
The chart below describes the composition of the congregations according to the age and household income of most congregants, so in the sample represented, 54% of the congregations are made up mostly of adults with young families (26-40 yrs), and 37% have congregations of mostly mature adults (41-60 yrs). In 37% of the congregations sampled, most congregants have a household income of R1,600 – R5,000 per month.

In order to understand the size of the congregations represented in the survey, a number of questions were asked regarding numbers of attendees on a typical Sunday, and numbers of staff employed:

63 of the 74 survey respondents were classified as pastors, based on their title, and of these, 61 responded to the question on income - 23% derive all their income from the church, with 46% receiving none of their income from the church. There was no correlation between the size of the church in terms of number (Nr) of employees and pastors’ income from the church e.g. in churches with 4-10 employees (23%), some pastors receive all of their income from the church, some receive part of their income, and some receive none of their income from the church.
2.3.4 Interviews

Overview
As a method of collecting in-depth qualitative data, one-on-one interviews were used. These interviews were semi-structured in nature, as a set of interview questions was designed for each of the interviewee groups (see Appendix C 3.2), but the interviewer used probing techniques to explore the perspectives of different interviewees and to gain deeper understanding.

Method description
Interview methods varied across key informants and informant types:

- **Denominational leaders**: Structured interviews, telephonic except for a few that had offices in Cape Town and preferred to meet face to face. Average interview duration: 30 minutes.
- **Experts in FTD**: Semi-structured interviews, majority were face-to-face, a couple were telephonic. Average interview duration: 40 – 60 minutes.
- **Pastors and the practitioners**: Semi-structured face-to-face interviews. The pastors’ interviews were conducted in their language of choice (isiXhosa, Afrikaans or English). Average interview duration: 40 – 60 minutes.

The interviews were not transcribed but detailed notes were recorded and these were checked and transcribed. As far as possible, interviews were recorded and the recordings used to complete or verify interview notes.

Sample selection and why this group was researched
Once again, sampling was purposive. Methods differed based on the different type of key informant:

- **Denominational leaders**: Using the STATS SA 2001 Censors list of denominations, the researchers contacted the various church offices to request an interview with a key leader within the denomination who has strategic oversight of children and family ministries within the denomination.
- **Experts in FTD**: Informants were selected on their perceived or recognised leadership and influence in the field of FTD. Some for example speak into the Macro dialogue of FTD in South Africa through policy, research or the organisations that they lead.
• Pastors: Pastors were selected from those who had completed the survey and those who had provided richness in their answers to qualitative questions. They were also selected to represent Khayelitsha, Cape Flats and Southern Suburbs and a mix of gender.

• Practitioners: Practitioners were NGOs known to the research team who are active in the field of Early Childhood Development in Cape Town.

Interviewees are not quoted by name in this report, but a list of participant names can be found in Appendix D. It was confirmed with the interviewees that they were happy to have their names included.

**Analysis of data**

The detailed transcribed interview notes were analysed in MS-Excel. Demographic data was analysed using descriptive statistical methods, and the responses to interview questions were then analysed thematically. The researchers worked iteratively through the responses to interview questions, inductively identifying and coding broad themes as they emerged, and highlighting key quotes.

**Description of key informants**

A total of 35 interviews were conducted with 40 participants, of which 60% were female and 40% male:

**TABLE 1: Numbers of Interviewees**

<table>
<thead>
<tr>
<th>INTERVIEWS</th>
<th>NR INTERVIEWS</th>
<th>NR FEMALE INTERVIEWEES</th>
<th>NR MALE INTERVIEWEES</th>
<th>TOTAL INTERVIEWEES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experts in Field</td>
<td>11</td>
<td>10</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Denominational Leaders</td>
<td>12</td>
<td>3</td>
<td>10</td>
<td>13</td>
</tr>
<tr>
<td>Pastors</td>
<td>8</td>
<td>6</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Practitioners</td>
<td>4</td>
<td>5</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>35</strong></td>
<td><strong>24</strong></td>
<td><strong>16</strong></td>
<td><strong>40</strong></td>
</tr>
</tbody>
</table>

60% 40%
The gender split of participants can be graphically depicted as follows:

Expert Interviewees were selected as recognised leaders in various fields related to FTD:

Pastors who were invited for in-depth interviews represented congregations in areas rated according to the socio-economic index as used in the survey analysis.
2.3.5 Workshops with mothers and carers

Overview

The researchers felt it was essential to have the insights and voices of mothers (or primary carers) of young children included in the research, particularly those from areas in the city where children are most at risk in the FTD. To this end, two workshops were held, one in Khayelitsha and the other in Vrygrond.

Method description

Two facilitation teams were established, each with a lead facilitator from the research team and with four table facilitators. The lead facilitators were from Khayelitsha and Vrygrond respectively and they recruited women who they knew from these areas as the table facilitators. One group was Xhosa speaking and the other English and Afrikaans. A morning workshop was held on 11 July to train the facilitators and table facilitators. This training was conducted by two other members of the research team.

After this facilitator training, two three-hour morning workshops were held, on 18 July in Khayelitsha and on 25 July in Vrygrond. Refreshments were served as people arrived and they were invited to choose a table to sit at. The workshop started with an ice-breaker, welcome, explanation of workshop purpose and ethics. Questions were then asked about their recent experiences of pregnancy and motherhood, about the FTD services offered in their community and the uptake of these, and getting their ideas about the sort of services they see as needed to support FTD in their community. (See Appendix C: 3.3.1 for the questions they were asked.) For each question, there was table discussion and note taking by the table facilitator, followed by brief plenary sharing facilitated by the workshop facilitator. The workshop ended with a light meal for all attendees.

Sample selection

In Khayelitsha, the facilitator went to a soup kitchen close to the Community Bible Society in Khayelitsha as well as the nearby shopping centre and gave out invitations to women with young children. In Vrygrond, the facilitator worked through the selected table facilitators who are all active in ECD in Vrygrond. They also gave out invitations to women with young children. Mostly the women were the mothers of the children but in some cases they were carers of the children, for example the grandmother.

Analysis of data

Discussion notes for each question, as recorded by the table facilitators, were transcribed. The Khayelitsha and Vrygrond notes were analysed separately to ensure an understanding of the different contexts. They were analysed by means of open coding, using the software package ATLAS.ti. 66 codes emerged for Vrygrond and 44 for Khayelitsha. From this a thematic analysis led to key findings, with illustrative quotations. At a later stage in the analysis of findings, some of the codes were merged into a list of core codes that were emerging generally in the research.
**Description of Key Informants**

**TABLE 2: Participants of Mothers/Carers Workshop**

<table>
<thead>
<tr>
<th></th>
<th>VRYGROND</th>
<th>KHAYELITSHA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nr Participants:</td>
<td>17</td>
<td>23</td>
</tr>
<tr>
<td>Average Age (in yrs):</td>
<td>29,6</td>
<td>34,2</td>
</tr>
<tr>
<td>Age of Youngest Participant:</td>
<td>17</td>
<td>23</td>
</tr>
<tr>
<td>Age of Oldest Participant:</td>
<td>57</td>
<td>52</td>
</tr>
<tr>
<td>Average Nr of Children:</td>
<td>2,1</td>
<td>2,3</td>
</tr>
<tr>
<td>Most Nr of Children:</td>
<td>7</td>
<td>5</td>
</tr>
</tbody>
</table>

The majority of attendees (70%+) were unemployed. This was not analysed further but it is probable that it is those who are unemployed who were able to attend a workshop on a weekday morning. It is also reflective of high unemployment rates in these areas. The majority receive a SASSA grant, although the type of grant was not specified. Most probably it is the child support grant.

Participants were asked to optionally record a church that they attend. In Khayelitsha, 91% of the participants gave the name of a church, and in Vrygrond 59% gave the name of a church.

### 2.3.6 Workshop with church laity

**Overview**

The researchers sought to gain insights from church laity (i.e. not clergy / pastors / church leaders). Within the laity, they wanted to engage with people who were either vocationally or voluntarily engaged with children and their parents/carers in their FTD. This could be within a local church context, for example in...
children’s ministry, or vocationally, for example as doctors within the public health system, or within a non-profit organisation.

**Method description**

A three-hour workshop was held on 22 August 2017 at Common Ground Church in Rondebosch. Participants were allocated to table groups of about 6 people, each with an external table facilitator. Two members of the research team provided plenary facilitation. They positioned the topic, explained the ethical requirements of the workshop but gave minimal information so as not to influence the group. Their role was to pose the questions for table group discussion and lead brief plenary feedback after each question.

Table facilitators were trained in advance not influence the group in any way but to keep the discussion focused on the question and act as scribes for the group. They also ensured that the ethics forms were understood and signed.

The following three questions were posed:

1. What is the local church doing to promote the wellbeing of children from conception – 2 years of age?
2. It is 2025. The church in Cape Town is responding well to the needs of the First 1000 Days. What is the church doing, and with whom?
3. What could the individual Christ follower do in their everyday life to promote the well-being of children at risk in their first 1000 days?

**Sample selection**

People were invited based on being known by the researchers, and also based on referral from people being interviewed as part of this research. 81 people received personalised email invitations; some were followed up with phone calls or additional emails. 52 people said they would attend, and in the end 40 people attended, with 4 phoning and giving reasons why they were not able to attend.

This was a purposive sample, and researchers actively sought to recruit people from churches across the city, namely in the Inner City, the Southern Suburbs, the Cape Flats, and Khayelitsha.

**Analysis of data**

Discussion notes for each question, taken by the 6 table facilitators, as well as notes taken by one of the lead facilitators during the plenary feedback, were transcribed. They were then analysed by means of open coding, using the software package ATLAS.ti. 48 codes were allocated and from this a thematic analysis led to key findings, with illustrative quotations. Later in the analysis of findings, some of the codes were merged to align with the research’s emergent code list.

**Description of key informants**

A register was taken with attendees’ names and the name of their church. 26 different churches from across the city were represented. Other demographics were not recorded in the register, but it is worth noting that only 3 participants were men.
2.4 LOCATING THE RESEARCHERS WITHIN THE RESEARCH

The core team were either employed part time or contracted by the organisation requesting the research. All profess to be Christians and are regular and involved attendees at churches in Cape Town that may be described as “evangelical/charismatic”. Two team members are from large traditional denominations and the others from newer, independent churches. They share a commitment to the role of the local church in social transformation and are all experienced and involved in various Christian social transformation initiatives in the city and beyond. This implies that they can speak as “insiders” with regards to the local church, and that they carry a personal motivation in finding the connection between FTD and local church, whilst at the same time being able to critique the church’s response from first-hand experience. It is worth noting that the research team had one man (who helped with the online survey) whilst the rest were women, the majority of whom are themselves mothers. Whilst racially and linguistically mixed, the team was predominantly white, English-speaking South Africans.

2.5 RESEARCH ETHICS

The research was conducted by an NGO which had not conducted such research before. Therefore, it was necessary to create the organisational procedures and structures to ensure that the research was carried out in line with world-wide standards for ethical research. The researchers set up their own methods for ensuring factors such as informant anonymity within the report, confidentiality of data, voluntary participation, non-payment of informants, the right of informants to withdraw at any time and a complaints and ethics oversight mechanism. Key informants were required to read and sign (or in the case of the online survey, to accept) informed consent forms regarding their participation and rights. Researchers signed non-disclosure agreements which also covered their responsibilities within the research project.

The Board of the NGO that conducted the research agreed to act as an appeal board in case of any complaints or issues related to the research. The name and contact details of the organisation’s CEO were given to participants in case they felt the need to contact someone outside of the research team with any issues.

It is worth noting that the project was classified as low-risk, as informants were not vulnerable people (except for some of the mothers/carers who because of low socio-economic status could have been considered vulnerable) nor were there likely to be any adverse effects for those involved in the research. In addition, children were not part of the empirical research. All research was conducted in a language understood by the participants (English, Xhosa or Afrikaans) and all data was recorded in English. During the research, no ethical issues arose. Applying an ethical research framework developed the capacity of both the researchers and the research organisation in this important aspect of research.
This chapter reviews current literature on the topic of the first thousand days (FTD), positioned as it is within Early Childhood Development (ECD). The aim of this section is to give context to the topic of FTD; giving descriptions to what the key issues in this topic are, what is currently happening in South Africa and more specifically within the Western Cape and Cape Town. This section gives context to the rest of the report about what is important in FTD and what the opportunities are to make a difference in this critical period of life.

3.1 WHAT IS FTD?

The National Integrated Early Childhood Development Policy (NIECDP) (2015) describes early childhood as “the period in which the foundation is laid for the survival, growth, development and protection of children to their full potential across all domains and competencies” (2015, p. 22).

The period in childhood commonly referred to as the “first thousand days” (FTD) of a human life refers to the earliest time of life, from conception to the age of two. This beginning time is where the foundation for a child to reach his or her full potential is laid (Van Niekerk, Ashley-Cooper, and Atmore, 2017, p. 10; Republic of South Africa, 2015, p. 19). According to the NIECDP, FTD offers 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. 19)

The NIECDP and other experts also point out that these early years are a ‘critically sensitive period’ of rapid growth and change, the rate and shape of which is determined by intrinsic and extrinsic factors. The intrinsic factors include the child’s individual nature and gender and the extrinsic factors include living conditions, family profile, care arrangements, health and education systems, and cultural beliefs (Republic of South Africa, 2015, p. 22). For optimal development to take place, experts emphasize that it depends on the availability of a supportive and nurturing environment in the earliest months and years of a child’s life (Lindland et al., 2016, p. 9; Republic of South Africa, 2015, p. 22).

3.2 WHAT IS HAPPENING IN THIS SHORT, YET CRITICAL PERIOD?

The Developing Brain

Central to the importance of FTD, according to experts globally, is the development of the brain (Lindland et al., 2016, p. 9). In this period of time it is “calculated that connections in the brain are created at a rate of a million per second” (Leadsom, 2016 p. 5). The brain grows up to 80% of its size in FTD (Fourie, 2017, p. 5; Ngobese, 2016). Hence experts state that “ensuring that the brain achieves its optimum development and nurturing during this peak period of growth is vitally important” (Leadsom; 2016, p. 5).

Key to understanding the development taking place in FTD is the concept of brain ‘plasticity’. ‘Plasticity’ is the brain’s capacity to learn from experiences and change over time (Center on the Developing Child Harvard University, 2016, p. 7; Lindland et al., 2016, p. 9). FTD is the period of “enormous change and is characterised by a high degree of ‘plasticity’ in the brain” and “foundational skills are set up early” (Britto et al., 2017, p. 91; Lindland et al. 2016, p. 9). These are the “critical periods” when the brain’s ‘plasticity’ is at its peak (early childhood and in adolescence) (Lindland et al., 2016, p. 9).

After these “critical periods” there is still brain ‘plasticity’, giving opportunity for re-shaping the brain for many years, however, more effort is required from both the individual and society, to try and change
behaviour or build new skills if the brain circuits are not wired to support these changes (Center on the Developing Child at Harvard University, 2016, p. 7). For this reason experts describe these as “once in a lifetime” periods of brain development as ‘plasticity’ decreases with time (Lindland et al., 2016, p. 9).

**Genes and Environment**

There is a ‘transactional’ process that takes place between the genetics (intrinsic) of the child and the environmental (extrinsic) experiences of the child (Lindland et al., 2016, p. 9). The earliest experiences shape an infant’s’ brain development, and have a lifelong impact on the infant’s mental and emotional health (Lindland et al. 2016, p. 9). Significantly an environment of relationships, especially relationships with caregivers is important in the genes manifesting (Lindland et al., 2016, p. 9).

Stated differently, “starting prenatally and continuing through infancy and into childhood and beyond, development is driven by an ongoing, inextricable interaction between biology (as defined by genetic predispositions) and ecology (as defined by the social and physical environment)” (Shonkoff et al., 2012, p. e234).

**Quality of Relationships**

In understanding how the brain develops and the interaction with the genes and environment, what is very important is the quality of the relationships that fundamentally shape the child’s physical, emotional, cognitive, and psychological development as well as their resilience (Lindland et al., 2016, p. 9) It is in these responsive relationships and positive experiences that strong brain architecture is built (Center on the Developing Child at Harvard University, 2016, p5). These “supportive environments and rich learning experiences can generate epigenetic signatures that activate positive genetic potential, such as the capacity for goal-directed behavior or a well-functioning immune system” (Center on the Developing Child Harvard University, 2016, p. 5).

### 3.3 WHAT ARE THE RISK FACTORS?

FTD sets the foundation for future health and wellbeing for children. Unfortunately though, “too many children are conceived, born into and grow in environments which put their survival at high risk, resulting in their death” (Reagon 2017, p. 9). Experts explain these profound differences in outcomes for children are due to being exposed to a “range of protective and risk factors” (Lindland et al., 2016, p. 10). These factors “either support or undermine the child’s developing brain and biological systems” (Lindland et al., 2016, p. 10).

The NIECDP outlined what the risk factors are for FTD and their impact on ECD. Stating that “the sensitivity of the brain in this early period is a double-edged sword in that it makes the structure and functioning of the child’s early brain (and hence, later child) developmentally vulnerable to biological, social and environmental risk factors” (Republic of South Africa, 2015, p. 19).

As stated in the NIECDP, the following risk factors are predictive of poor early childhood development:

1. Poverty;
2. Malnutrition;
3. Stunting;
4. Low birth-weight;
5. Infectious diseases in pregnant women, infants and children;
6. Environmental toxins;
7. Stress;
8. Exposure to violence;
9. Psychosocial risks;
10. Disrupted caregiving – absent parents, ill parents, non-parent caregivers or abandonment;
11. Disabilities

(Republic of South Africa, 2015, p. 19–20)

These risk factors are discussed in more detail below:

**Poverty**

The NIECDP asserts:

*Poverty is widely recognised as ‘a root cause of poor child development’. Low socioeconomic status is a key predictor of poor early childhood development. Persistent, cumulative poverty and exposure to hardship in the first year of life have a detrimental effect on cognitive functioning, with the impact being stronger on verbal, compared to non-verbal, skills*(Republic of South Africa, 2015, p. 19).

The Lancet Series on early childhood development explained that “extreme poverty increases children’s likelihood of exposure to multiple adversities” (Black et al. 2017, p. 5). These multiple adversities are risk factors in and of themselves like “family stress, child abuse or neglect, food insecurity, and exposure to violence, these are then often compounded by living in communities with limited resources” (Black et al., 2017, p. 5). The knock on effect of poverty is that these “accumulated adversities are often more detrimental to children’s development than single adversities” and the hardships affecting families and the broader socioeconomic context can undermine the capacity of families to provide the required nurturing care (Black et al., 2017, p. 5).

In South Africa, 2015 data indicated that 62% of young children live in households that fall below the ‘upper-bound poverty line’ (Hall et al., 2017, p. 9). The ‘upper-bound poverty line’ was R 1 138 for 2017, per person per month, this is the minimum required to afford both the minimum adequate food and basic non-food items (Hall et al. 2017, p. 9; Statistics South Africa, 2017, p. 8). Hall et al. explain that according to 2015 data, 30% of young children fall below the ‘food poverty line’. The ‘food poverty line’ is the most severe, as people living below this level of income are unable to afford sufficient food to provide adequate nutrition. The value of the ‘food poverty line’ was equivalent to R 531 in 2017, per person per month (Statistics South Africa, 2017, p. 8). “This is very serious, as children living in such poverty are likely to be food insecure and may become malnourished” (Hall et al., 2017, p. 9).

**Malnutrition**

Poor nutrition in FTD, maternal, infant and child nutrition, “can cause significant structural damage to the foetus in utero” (Republic of South Africa, 2015, p. 19). Poor nutrition can cause major, often irreversible development stunting, delays and damage, with the increased risk of degenerative diseases later on in life (Ilifa Labantwana, 2013, p. 13; Republic of South Africa, 2015, p. 19). Poor nutrition negatively impacts on cognitive development, learning capacity and physical development (Ilifa Labantwana, 2013, p. 13; Republic of South Africa, 2015, p. 19). This in turn results in lower education and labour market performance and the economic development of society as a whole (Ilifa Labantwana, 2013, p. 13; Republic of South Africa, 2015, p. 19). The impact of improved access to nutrition has shown “direct effects on national rates of school enrolment and even increased adult earnings by up to 40%” (Van Niekerk et al., 2017, p. 12).
Stunting

Stunting is low height-for-age, and is the most prominent form of chronic malnutrition in South Africa (Hall et al., 2017, p. 18; Republic of South Africa, 2015, p. 19). The impact of stunting on brain development in this critical early period will endure. “On average, children who are stunted by age 2 go on to access fewer years of schooling, perform more poorly at school and earn less as adults” (Republic of South Africa, 2015, p. 19). In South Africa, more than 1 in 5 children under the age of 5 suffer from stunting (Hall et al., 2017, p. 18). More specifically, the Human Sciences Research Council did a study in 2012 and found that in the age group 0-3 years, 1 in every 4 children were stunted; 1 in 20 children were wasted; 1 in 10 children were underweight (Department of Health South Africa, 2016, p. 1). In the Western Cape, stunting prevalence is at 20.7%, with underweight and wasting of 5.6% and 1.2% are also a concern (Biersteker and Goeiman, 2017, p. 1).

The life-long implications of stunting include “compromised motor and cognitive functioning and development. Impaired cognitive development has an effect on educational outcomes later in life, with studies showing reading, non-verbal cognitive skills and years of schooling to be affected. The outcomes of stunting further include lower earning potential as adults and less productive contributions to the workforce due to compromised intellect, slighter build and an increased proneness to disease” (Biersteker and Goeiman, 2017, p. 1).

The Department of Social Development subsidises food and nutrition in registered ECD programmes (Biersteker and Goeiman, 2017, p. 7). However, this subsidy “only reaches about 12% of children in the birth to school going age group. The approximately 75% of young children unreached are likely to be the most vulnerable – those either too young to be in an ECD programme or whose parents are too poor to pay the fees and those in informal care arrangements” (Biersteker and Goeiman, 2017, p. 7). “In general, under nutrition is associated with significant loss of GDP, yet return on investment is competitive in relation to other public spending” (Biersteker and Goeiman, 2017, p. 1). The evidence shows that children who were well-nourished in the FTD are “10 times more likely to overcome life threatening childhood diseases, complete 4.6 times more grades in school, earn 21% more wages as adults and are more likely as adults to have healthier families (Biersteker and Goeiman, 2017, p. 1).

Low birth-weight

In South Africa in 2015, 13% of infants born in public facilities had low birth weight (defined as < 2 500 grams) (Hall et al., 2017, p. 19). The risks with low birth-weight are “an increased lifetime risk for cardiovascular disease, diabetes and learning difficulties” (Republic of South Africa, 2015, p. 19). International studies have shown that if an infant’s development falls behind the norm during FTD, it is more likely to fall even further behind in subsequent years, than those who had a better start to life (Leadsom, 2016, p. 5).

Infectious diseases in pregnant women, infants and children

In South Africa, mortality in the first month of life accounts for 30% of all deaths of children under 5 years, with the Western Cape having the lowest rate of mortality in South Africa (Ilifa Labantwana, 2013, p. 17; WC Government, 2016). Maternal mortality and low birth weight in surviving children is associated with poor antenatal care as one of the most significant contributing factors (Ilifa Labantwana, 2013, p. 17). The NIECDP explains that “antenatal infections in pregnant women, such as syphilis and rubella, as well as diseases in infants and young children, such as measles, meningitis, middle ear infection, diarrhoea, parasitic infections and HIV, may negatively affect the young child’s physical and cognitive development” (Republic of South Africa, 2015, p. 19). Therefore, the health sector and primary health services for FTD have a crucial and unique responsibility in the prevention of common illnesses and the promotion of childcare and nutrition (Ilifa Labantwana, 2013, p. 17).
Environmental toxins

The NIECDP acknowledges that “pre- and post-natal exposure to environmental toxins such as alcohol, drugs, chemicals, and pesticides can cause significant irreversible damage to the developing brain and resultant cognitive, physical, emotional, and social development of the embryo (first trimester), foetuses (second and third trimester) and the young child” (Republic of South Africa, 2015, p. 19).

In the Western Cape, substance abuse disorders are extremely high with smoking, alcohol and methamphetamine (tik) being the top three substances used by expecting mothers (WC Government, 2016). Alcohol and tik are the most prevalent amongst mothers who did not attend antenatal care (WC Government, 2016). Mowbray Maternity Hospital reported a threefold increase of incidence of substance use in pregnancy in the last five years (WC Government, 2016).

The use of substances during pregnancy increases the risk of premature birth, birth deformities and stillbirth (WC Government, 2016). Substance use can cause irreversible abnormalities of the infant’s heart, brain, kidneys and digestive system, as well as being born with withdrawal symptoms (WC Government, 2016).

The important messages are that there is no ‘safe’ level of smoking, drinking or drug use during pregnancy. Exposure to drugs and alcohol causes damage to the developing foetus. Then environmental factors can cause further damage to the development of the child, leading to secondary implications such as “compromised education outcomes, criminal behaviour or inpatient treatment for mental health or alcohol and drug abuse” (WC Government, 2016).

Stress

Scientists emphasize that chronic stress (often powerful, unremitting, long-lasting stress) threatens and undermines development in profound ways (Center on the Developing Child at Harvard University, 2016, p. 11; Lindland et al., 2016, p. 10). Literature lists a variety of stress factors that include: poverty; physical and emotional abuse, neglect and maltreatment; domestic violence; mental health problems and severe maternal depression; and parental substance abuse as well as powerful external stressors like racism and living in dangerous communities (Center on the Developing Child at Harvard University, 2016, p. 10–11; Leadsom, 2016, p. 5; Lindland et al., 2016, p. 10; Republic of South Africa, 2015, p. 20). There are three distinct types of stress responses in young children, namely, “positive, tolerable and toxic stress”, the difference is in “their potential to cause enduring physiological disruptions as a result of the intensity and duration of the response” (Shonkoff et al., 2012, p. e235). The NIECDP explain that “in the absence of a supportive caregiver to buffer children against stress ... that which would ordinarily be ‘tolerable stress’ becomes ‘toxic’” (Republic of South Africa, 2015, p. 20).

When these stress factors are “persistent and unbuffered by caregivers’ love and protection,” this can lead to the “continuous over-activation of the body’s stress response system” (Lindland et al., 2016, p. 10). The plasticity of the young brain makes it especially sensitive to the persistently elevated levels of stress hormones (Shonkoff et al., 2012, p. e236). In the process “the developing architecture of the brain can be impaired in numerous ways that create a weak foundation for later learning, behaviour, and health” (Shonkoff et al., 2012, p. e236). This is called ‘toxic stress’, “toxic stress can lead to cognitive damage, health damaging behaviours and harmful adult lifestyles, as well as greater susceptibility throughout childhood and later adult life to physical illnesses, such as cardiovascular diseases, obesity, diabetes and others, as well as mental health problems like depression, anxiety disorders and substance abuse” (Lindland et al., 2016, p. 10; Republic of South Africa, 2015, p. 20). “Chapter 8 of the Children’s Act (No. 38 of 2005) recognises that
families under stress may struggle to provide supportive and affectionate care to children and that this places children at risk of maltreatment” (Ilifa Labantwana, 2013, p. 26).

**Exposure to violence**

The NIECDP states:

The social and emotional development of infants and young children who are exposed to violence in their families and communities (including corporal punishment), and who do not enjoy the protective buffering of strong and supportive caregiving, is compromised. They are at a greater risk of insecure attachments and behaviour problems, reduced levels of pro-social behaviour, increased aggressive behaviour, and an inability to regulate their own emotions (Republic of South Africa, 2015, p. 20).

South African research also shows “that abuse and violence tend to increase during pregnancy” and “abuse during pregnancy contributes to pregnancy complications and miscarriages” (Turner and Honikman, 2016, p. 1165).

South Africa also has shockingly high child murder rates that are double the global rate. “A third of children were killed in their own home” and mostly younger children; 44.6% of child homicides were in the context of child abuse and neglect (Mathews and Martin, 2017, p. 15). Infants are disproportionately vulnerable to abuse and neglect (Leadsom, 2016, p. 5). Investigations have established that the neonatal period is a high risk, particularly for preterm infants. The early neonatal period is the period of heightened risk for abandonment or deaths due to injuries (Mathews and Martin, 2017, p. 16).

**Psychosocial risks**

In all sectors of society, depression is commonly diagnosed, including during pregnancy (Lund, Turner, and Schneider, 2017, p. 13). The most common conditions to coexist with pregnancy are depression and anxiety, affecting 20-40% of South African women in the perinatal period (Britto et al., 2017, p. 93; Turner and Honikman, 2016, p. 1167). These common mental disorders during the FTD pose a risk due to the negative impact on the mother’s ability to function and ability to provide a “responsive and nurturing environment”, as well as the “possible negative physical and developmental effects on the foetus and infant” (Ilifa Labantwana, 2013, p. 28; Turner and Honikman, 2016, p. 1164). Mental disorders and stress during pregnancy can “disrupt maternal programming”, which prepares women to respond to their infants, and can have a negative effect on the foetus (Britto et al., 2017, p. 93; Lachmann, 2017, p. 7).

Maternal depression poses a risk due to the negative outcomes of the cognitive, physical, social and emotional development of the infants and young children (Britto et al., 2017, p. 93; Lachmann, 2017, p. 7; Republic of South Africa, 2015, p. 20). Research has linked maternal depression and child malnutrition; and it is also associated with insecure mother-infant attachment, and exposure to maltreatment (Britto et al., 2017, p. 93; Ilifa Labantwana, 2013, p. 28). “Recent evidence is emerging that paternal mental health during pregnancy can also influence the socioemotional and behavioural development of children” (Britto et al., 2017, p. 93).

It is important to note that the relationship between maternal depression and negative early childhood development outcomes is multilevel and cumulative due to other risk factors for poor child development like poverty, low education, high stress, intimate partner violence, substance use, lack of empowerment and poor social support (including emotional and financial support from partner, friends or community) (Republic of South Africa, 2015, p. 20; Turner and Honikman, 2016, p. 1164). It is also important to take into account the ‘poverty mental illness cycle’- “there is an increased risk of mental illness for those living in poverty, and an
increased likelihood that those suffering from a mental illness will drift into or remain in poverty. The driving forces for this cycle are complex and include factors such as additional stresses of unemployment, poor housing and food insecurity” (Turner and Honikman, 2016, p. 1164).

At the same time though, depression is one of the most common mental health conditions and is treatable (Lund et al., 2017, p. 13). However, research has shown that pregnant women’s depression is poorly managed with a significant treatment gap (Lund et al., 2017, p. 13). Hence it is essential to provide adequate treatment and psychosocial support to caregivers, to promote the wellbeing of the caregiver and to reduce the risk of neglect and malnutrition in young children (Ilifa Labantwana, 2013, p. 28).

**Disrupted caregiving – absent parents, ill parents, non-parent caregivers or abandonment**

It would be the hope for all children to grow up in a loving and caring environment in the presence of both of their biological parents. In South Africa this is not the case for about a quarter of children do not live with any of their biological parents even though 83% of these children still had at least one of their parent’s alive (Van Niekerk et al., 2017, p. 11).

The NIECDP explains:

> Disruptions of parental caregiving through illness or death of the caregiver or abandonment of the child, and the assumption of the caregiving role by a non-parent caregiver, creates a risk of bullying, mental health problems, abuse and emotional and behavioural problems in infants and young children. Infants and young children living without their biological parents are especially at risk of being denied the care necessary for their physical and psychosocial well-being (Republic of South Africa, 2015, p. 20).

Waterworth (2017) notes: “Abandoned or neglected infants are the most vulnerable when it comes to receiving proper love and stimulation.” Child Welfare Durban records between 24 – 40 abandoned babies in a year. Factors that contribute to abandonment are poverty and unemployment; family shame or anger towards the mother; substance abuse and a lack of knowledge or resources. Alternatively, mothers faced with a crisis or unplanned pregnancy often due to teenage pregnancy, rape, incest, poverty and sexual abuse chose to have an abortion for similar reasons that mothers abandon their babies. Lois Law from the Catholic Parliamentary Liaison Office, argues that more needs to be done to support mothers and address the reasons which lead to women seeking abortions and abandonment (Law, 2017).

**Disabilities**

The NIECDP acknowledges:

> Approximately 23 percent of children between the ages of birth to 9 years in low and middle income countries are at risk for disabilities. Whilst this is indicative of their compromised development, children with disabilities are, in addition, at risk of low access to early childhood development services and at an increased risk of poor quality care (Republic of South Africa, 2015, p. 20).

**Inadequate services undermine development**

In the ‘Early means early’ report the experts identified one more risk factor for FTD and early childhood development. They state that there is a “substantial gap between what the science says are the conditions to support early childhood development and the kinds of programs and policies that are actually in place” (Lindland et al., 2016, p. 10). The report says that at a societal level there are inadequate public services like housing, health, education and household financial support as well as inadequate pre- and post-natal care
for health, wellbeing, nutrition, and the prevention of substance abuse and violence. These gaps at a societal level “can impede the subsequent healthy development in the child” (Lindland et al., 2016, p. 10).

The NIECDP states: “This situation is not inevitable: the loss of human capital is avoidable through the provision of timely and appropriate quality early childhood development services targeting the causes and consequences of the known risk factors” (Republic of South Africa, 2015, p. 20).

3.4 WHAT ARE THE PROTECTIVE FACTORS?

During FTD the opportunity of brain ‘plasticity' means that it is very responsive to environmental factors that promote strong brain development. Science has identified a number of protective factors that support and promote strong brain development and positive outcomes (Lindland et al., 2016, p. 10; Republic of South Africa, 2015, p. 19).

The protective factors are aligned with the risk factors discussed earlier. To promote strong brain development the mother, infant and the young child need a “good health and nutritional status”; they require a clean environment free from pollutants like alcohol and drugs (Republic of South Africa, 2015, p. 19). Then starting from birth, until the child enters formal school, the child needs access to safe care and quality early learning opportunities (in centre- and noncentre-based ECD programmes) (Republic of South Africa, 2015, p. 19). Significantly in the FTD the child requires “strong, protective and stimulating relationships with parents and other primary caregivers which involve language-rich, nurturing and responsive caregiving” (Republic of South Africa, 2015, p. 19).

These factors can be summarised into the term ‘nurturing care’ which includes the above-mentioned factors of health, safety, nutrition, stimulation and love. The protective factors of responsive relationship and ‘nurturing care’ are discussed below. Importantly these protective factors are able to build resilience despite the adversity faced (Center on the Developing Child at Harvard University, 2016, p. 7).

**Stable, responsive relationships**

One key protective factor is “at least one stable and responsive relationship with a parent, caregiver or other adult” (Center on the Developing Child at Harvard University, 2016, p. 7). Research has shown that the presence of this stable, responsive relationship has meant that “no matter what form of hardship or threats may have been experienced”, that children who end up doing well are most often those who have had this protective factor (Center on the Developing Child at Harvard University, 2016, p. 7).

There is a double benefit to stable, responsive relationships. Firstly, this type of relationship stimulates brain development and secondly, it provides the “buffering protection that can keep even a very challenging experience from producing toxic stress effects” (Center on the Developing Child at Harvard University, 2016, p. 16).

Many studies have shown that positive early experiences and environment, where there is nurturing and supportive caregiving during FTD, has a positive effect on social, emotional and intellectual development. That these experiences can “counterbalance the consequences of adversity” (Britto et al., 2017, p. 92; Center on the Developing Child at Harvard University, 2016, p. 7; Ilifa Labantwana, 2013, p. 26).

“At least one loving, sensitive and responsive relationship with an adult caregiver teaches the baby to believe that the world is a good place and reduces the risk of them facing disruptive issues in later life” (Leadsom, 2016, p. 5).
**Nurturing care**

The 2016 Lancet Early Childhood Development Series emphasises ‘nurturing care’ as an essential factor, especially for children below three years of age. Defining ‘nurturing care’ as “a stable environment that is sensitive to children’s health and nutritional needs, with protection from threats, opportunities for early learning, and interactions that are responsive, emotionally supportive, and developmentally stimulating” (Britto et al., 2017, p. 91).

The Lancet Series explains that the “single most powerful context for ‘nurturing care’ is the immediate home and care settings of young children often provided by mothers, but also by fathers and other family members, as well as by child-care services” (Britto et al., 2017, p. 91). Early-life multiple adversities such as poverty, nutritional deficiencies, high-crime communities, and low-quality resources come at a cost to life course development. However, “maternal nurturing care during early childhood can attenuate the detrimental effects of low socioeconomic status by protecting early brain development” (Black et al., 2017, p. 4).

Advances in science have shown that the brain is wired to respond to a wide range of early experiences, which support the “acquisition of language, cognitive skills, and socioemotional competencies” (Britto et al., 2017, p. 91). “Nurturing care mediates the development of key brain regions and promotes developmental adaptations” (Britto et al., 2017, p. 91). ‘Nurturing care’ enables these developments that have “lifelong benefits for children, including an increased ability to learn, greater achievement in school and later life, citizenship, involvement in community activities, and overall quality of life” (Britto et al., 2017, p. 91).

The Lancet Series states that improvements are happening in the number of children who are surviving, including in high-income countries, but many are beginning life at a “disadvantage because they do not receive the ‘nurturing care’ necessary for their physical and psychological development” (Richter et al., 2017, p. 104).

**Enabling environment for nurturing care**

Importantly, the Lancet ECD series describes an environment that enables family, caregivers and community to provide ‘nurturing care’. This “enabling environment supports the family and caregivers as proximal providers of ‘nurturing care’. Support for caregivers’ nutrition and mental and physical health, benefits children’s growth and development, and enhances caregivers’ receptiveness to parenting programmes” (Black et al., 2017, p. 11).

Enabling ‘nurturing care’ environments begins with ‘thriving families’ but also involves other adults who play important roles in their lives (Black et al., 2017, p. 5). This can include extended family members, substitute caregivers, providers of early care and education, teachers, nurses, social workers, coaches, and neighbors” (Center on the Developing Child at Harvard University, 2016, p. 5).

### 3.5 WHAT IS THE SITUATION IN SOUTH AFRICA?

It is estimated that 250 million children (43% of children younger than 5 years in low-middle income countries) are at “elevated risk of not achieving their human potential because of stunting or exposure to extreme poverty” (Richter et al., 2017, p. 104). South Africa is a middle-income country with approximately 50% of the population being under the age of 25 and about 5.9 million children under the age of four (Van Niekerk et al., 2017, p. 12; Republic of South Africa, 2015, p. 40).
In South Africa more than a million children are born each year, many born into conditions with high unemployment rates and poor living conditions (Hall et al., 2017, p. 4). Statistics show that “nearly two-thirds of children under 6 in South Africa live in the poorest 40% of households” and more than 1.8 million young children living in households where nobody is working (Hall et al. 2017, p. 6 & 9).

The number of children living in poverty has decreased since 2003 and this is mainly due to the Child Support Grant (CSG), with 11.3 million children being recipients of the CSG, in 2013 (Van Niekerk et al. 2017, p. 14). “Most children live in rural areas (54%) and one in eight children (0 - 2 years) live in informal settlements” (HSRC/DST, 2015, p. vii).

Of major concern is the data on mother and father care, with more than 50% of children living with only a mother and 10% of children in FTD having neither a father nor a mother, this is largely due to HIV which has resulted in many single parents and no parents over time (HSRC/DST, 2015, p. vii).

Health status
The HIV epidemic has been one of South Africa’s main health and socio-economic challenges. Recent results indicated that 30% of pregnant women were HIV-positive. There has been a “decline in HIV-related deaths amongst infants and children below the age of five and this has lowered infant mortality to 34 per 1 000 live births in 2015 in contrast with 51 per 1 000 live births in 2002” (Van Niekerk et al., 2017, p. 14). Alarmingly, South Africa also has the highest documented rates of Foetal Alcohol Syndrome (FAS) in the world, “namely 65 to 74 per 1 000 children in 2005” (Hall et al., 2017, p. 24; Van Niekerk et al., 2017, p. 10). Maternal mental health data indicates that about one in three South African mothers suffer from both pre-natal and post-natal depression (Van Niekerk et al., 2017, p. 10).

Recent positive data indicated that in South Africa, “97% of pregnant women attend at least one antenatal clinic visit; 89% of children are fully immunised at the age of one; 83% of births are registered” (Van Niekerk et al., 2017, p. 15).

Childcare arrangements
According to the 2015 household survey, of the children below the age of 4 in South African, “33% were going to day care, 45.8% stayed home with a parent or a guardian, 5.9% were taken care of by another adult, 14.1% were taken care of by a day mother, and 1% of children were taken care of at someone else’s dwelling. The remaining 0.2% of children were either taken care of by someone younger than 18 years, or classified their care arrangement as ‘other’ (0.1%)” (Van Niekerk et al., 2017, p. 15).

What is the situation in the Western Cape?
It is estimated that 102 000 births were expected in the Western Cape for the financial year 2016/2017 (WC Government, 2016). Between 2002 and 2014, the number of children (under 18 years) living in the Western Cape has increased by 14% (Goeiman, 2017, p. 3; WCGH, 2017, p. 2).

The Western Cape is comparatively seen by many as a “well resourced” province within South Africa. Yet, there are a growing number of vulnerable and at-risk children in the province according to data published (Goeiman, 2017, p. 3). Statistics indicate some of the interrelated challenges that are faced by children in the Western Cape. Children living in poverty in 2014 were reported to be 39.2%; and children living in households where child hunger was reported was at 13.5% (Goeiman, 2017, p. 3; WCGH, 2017, p. 2). Access to Child
Support Grants (CGS) in 2016 indicated that 51.5% (337,168) of children (0-5 years) received a CGS (Goeiman, 2017, p. 3; WCGH, 2017, p. 2).

In the Western Cape it is also not uncommon for children to live in the care of relatives other than their biological parents, with 7% of children having lost at least one parent (Goeiman, 2017, p. 3; WCGH, 2017, p. 2). Research done in Cape Town indicates that 39% of women living in impoverished areas struggle with depression and anxiety disorders throughout their pregnancy (Van Niekerk et al., 2017, p. 10).

The Early Child Review of 2017 states that “all of these children have rights to survival, health, protection and development. These rights are protected in the highest law of our land, the Constitution, and also in international law” (Hall et al., 2017, p. 4). However, “there are striking inequalities in the welfare of young children across the country, and within provinces” (Hall et al., 2017, p. 5).

### 3.6 WHAT IS SOUTH AFRICA’S LEGAL FRAMEWORK FOR FTD?

The South African government has committed itself to respect, protect, promote and fulfil the rights of children as stated in the Children’s Act (Van Niekerk et al., 2017, p. 19). Since 1994, the Government has written a number of policies and acts that are in place within South Africa, looking at the rights and needs of Children and Early Childhood Development (Republic of South Africa, 2015, p. 30–38).

“Huge strides have been made in provisions to benefit young children in South Africa in an attempt to overcome the damage done to children and families by the racially exclusive policies and programmes of Apartheid” (Lindland et al., 2016, p. 4). Even so, the NIECDP recognises that there are still “various policy and programmatic gaps and a range of deficiencies in implementation and systems mean that a number of early childhood development services are not available to all young children” (Republic of South Africa, 2015, p. 40).

**National development plan 2030**

In the ‘National Development Plan 2030: Our future-make it work’ (NDP), the government has prioritised ECD and is “calling for the writing of a new story that places early childhood development at its centre” (Republic of South Africa, 2015, p. 8 & 22). The “goal is that by 2030, a full comprehensive age and developmental stage appropriate package of quality early childhood development services is available and accessible to all infants and young children and their caregivers” (Republic of South Africa, 2015, p. 7). “The NDP further sets quality early childhood development as a top priority for the country to improve quality of education and the long-term prospects of future generations and society as a whole” (Republic of South Africa, 2015, p. 23).

**National integrated early childhood development policy 2015**

In December 2015, Cabinet approved the new National Integrated Early Childhood Development Policy (NIECDP) (Republic of South Africa, 2015, p. 7). The NIECDP introduces guidelines for the implementation of a comprehensive ECD package of services for all South African children (conception - 5 years and includes children with disabilities up to the age of 7 years) (Van Niekerk et al., 2017, p. 20).

The National Integrated ECD Policy “is child-centred and emphasises the important role of parents and primary caregivers in providing care, support and upbringing of their children”, as well as “combining a range of services that contribute to ensuring infants and young children thrive and are healthy” (Republic of South Africa, 2015, p. 7). With a commitment to inclusivity and that “no child must be left behind” (Republic of South Africa, 2015, p. 23).
South Africa, 2015, p. 7), the NIECDP states that “government recognises early childhood development as a fundamental and universal human right to which all young children are equally entitled without discrimination” (Republic of South Africa, 2015, p. 22).

**Economic growth**

There is ever-growing global recognition and evidence that quality early childhood development is a key tool for positive socio-economic change and a nation’s development depends on unlocking the potential human capital (Van Niekerk et al., 2017, p. 19; Republic of South Africa, 2015, p. 18). The NDP states that

“**quality early childhood development services, especially for the most vulnerable, as a sustainable and cost-effective way of ensuring the optimal development of children, their resultant educational success and their improved employment prospects – in short, as a key lever to overcoming the apartheid legacy of poverty and inequality**” (Republic of South Africa, 2015, p. 23).

Central to the NDP is the assertion that the “social returns on increased public investment in early childhood development services will not only benefit the individual but all of society” (Republic of South Africa, 2015, p. 20). The National Integrated Early Childhood Development Policy 2015 asserts:

“The science is conclusive: investments in early childhood development yields lifetime development returns for the child, his or her family and society. Notably, early childhood development has the potential to contribute significantly to the reduction of key development challenges facing South Africa, particularly poverty and inequality” (p. 23).

**Multi-sectoral and whole society approach**

The NIECDP has given direction and requirements for the “development of a comprehensive, multi-sectoral system that recognises the need for Government-led provision of early childhood development services and support” (Republic of South Africa, 2015, p. 120).

Provision of quality ECD is a public good where the benefits spill over from individual parents to society as a whole. The primary responsibility for the care and upbringing of young children belongs to parents and families; however the state has a responsibility to subsidise and assure that quality ECD services are available and the broader community has a responsibility to support and promote the wellbeing of young children and families (Lindland et al., 2016, p. 4).

### 3.7 WHAT IS THE OPPORTUNITY FOR FTD SUPPORT?

There is a collective understanding that with the overwhelming and conclusive scientific evidence there is both a critical challenge and a powerful, unique, and transformational opportunity to improve the well-being and long-term life prospects of the most vulnerable children in society (Center on the Developing Child at Harvard University, 2016, p. 3; Republic of South Africa, 2015, p. 8; Shonkoff et al., 2012, p. e233).

Investing early, in interventions that reduce adversity in order to lay the foundations for optimal health, growth and neurodevelopment in young children will generate even larger returns for the whole of society (Goeiman, 2017, p. 3; Shonkoff et al., 2012, p. e233). It is less costly to invest early in creating positive brain development than it is for both the individual and society to try improve things later (Lindland et al. 2016, p. 9).
The Lancet Series describes how during these “essential first years of life, when the effects of risk, and also plasticity”, are at their greatest, that little is being done globally, and that there is “a crucial gap in interventions to accelerate improvements in children’s early development at scale” (Richter et al., 2017, p. 104).

There is “an urgent need to increase multi-sectoral coverage of quality programming that incorporates health, nutrition, security and safety, responsive caregiving, and early learning” (Black et al., 2017, p. 1). “To redress these challenges to child development, countries worldwide must scale up systemic actions to promote, protect, and support early childhood development, ensuring that the most vulnerable children and families are reached” (Richter et al., 2017, p. 104). The “lack of opportunities and interventions, or poor quality interventions, during early childhood can significantly disadvantage young children and diminish their potential for success” (Republic of South Africa, 2015, p. 8).

“Indeed, every system that touches the lives of children - as well as mothers before and during pregnancy - offers an opportunity to leverage this rapidly growing knowledge base to strengthen the foundations and capacities that make lifelong healthy development possible. Toward this end, explicit investment in the early reduction of significant adversity are particularly likely to generate positive returns” (Shonkoff et al., 2012, p. e240).

The opportunity to influence change in society is possible with focused intervention in the FTD. The NIECDP explains that science has shown that quality ECD services and support for FTD has a positive impact on “the mental and physical health of children and adults; school enrolment, retention and performance; a stronger economy; inequality; poverty; and a safer and more inclusive society” (Republic of South Africa, 2015, p. 21).11

**Priority focus areas of intervention**

With such a significant and unique opportunity in this window of life, the questions is “what can be done to improve early childhood development outcomes?” (Lindland et al., 2016, p. 10).

The process of ECD is continuous, starting at conception and continuing until a child starts his or her first day at school. There is a need to provide unique developmental stage-appropriate services and maximise the protective factors and minimise the risk factors to which the mother and child are exposed at the different stages (Republic of South Africa, 2015, p. 67). Focusing more specifically on FTD there are two stages of early childhood development services, namely, pregnancy and birth to 2 years (Republic of South Africa, 2015, p. 68).

The NIECDP and other experts who have identified the current gaps in the South African system for vulnerable young children, conclude that the following are the priority areas that need significant attention: child nutrition (prevention of stunting); parenting support and education; quality early learning programmes; non-centre based ECD programmes; care arrangements for the youngest children; and advocacy (increase public awareness) (Lindland et al., 2016, p. 4; Republic of South Africa, 2015, p. 45).

The literature recognises other areas that also need transformation. Shonkoff et al. (2012, p. e241) argues that “the prevention of child maltreatment needs to become a public health concern.” The other gap that Shonkoff et al. (2012) recognises is the “striking gap between science and practice in the treatment of depression in women with young children” (p. e241). Shonkoff et al. (2012) explains that research shows that

---

11 Read the NIECDP for more detail of these positive impacts
maternal depression has an impact on the mother-child (dyadic) relationship and that the treatment and support of maternal depression does not take this into account (p. e242).

The ‘Early Means Early’ report identified areas that need attention namely, there is a need to “improve the conditions of families, caregivers and children” through “income support, free health services, family leave, maternal mental health, home visits, family groups, and substance abuse treatment and violence prevention programs” (Lindland et al., 2016, p. 10).

For at-risk population groups, the ‘Early Means Early’ report argues that there is a need “for more strategic and well-integrated efforts to reach at-risk children and families, alongside a broader effort to improve support for children in general” (Lindland et al., 2016, p. 10). This will include “efforts to end discrimination against marginalized populations, and to extend services and supports to populations who have less access to or who are less engaged with the family and child support services that do exist” (Lindland et al. 2016, p. 10).

“We know too that not intervening now will affect not just this generation of children and young people but also the next. Those who suffer multiple adverse childhood events achieve less educationally, earn less, and are less healthy, making it more likely that the cycle of harm is perpetuated, in the following generation” - The UK’s 1001 Critical Days Manifest (Leadsom, 2016, p. 2)

3.8 CLOSING THOUGHTS

This section has explored what the First Thousand Days is and what is happening in this critical period of life. This section has discussed what the risk factors and protective factors are for FTD and detailed what the situation is like in South Africa and more specifically in the Western Cape, for the youngest population group. This section has also investigated what the current South African policies are for ECD and what the opportunities are for strategic intervention, as well as the areas that need the most urgent attention.

“There can be no equality of opportunity without... appropriate stimulation, nurturing, and nutrition for infants and young children. Conditions of poverty, toxic stress and conflict will have produced such damage that they may never be able to make the best of any future opportunities. If your brain won’t let you learn and adapt in a fast changing world, you won’t prosper and, neither will society.” World Bank Group President Jim Yong Kim, Oct 1, 2015 (Richter et al., 2017, p. 104)

As well formulated by the South African government, “the centrality of early childhood development is founded on an ever-growing body of evidence which confirms that a nation’s development depends on the extent to which it can unlock the potential human capital inherent within its very youngest population”. In addition to securing the potential of future generations, promoting universal access to ECD services fundamentally means promoting and protecting children’s rights” (Van Niekerk et al., 2017:12).

It is with this understanding that the report will now look at what the role and opportunity for local churches to support the FTD looks like.
4 THE CHURCH, SOCIAL DEVELOPMENT & FTD

4.1 INTRODUCTION

Exploring the role of the church in support of FTD begs the question of whether in fact the church has a role to play, and if so, why? In this chapter we seek to motivate for the church’s involvement in social development and therefore in FTD. In doing so, we begin by positioning the church as a social actor with a recognised role in social development and consider some barriers to the church playing this role. We then consider the church’s motivation for engaging in social development when we state our belief that the church is called not to its own mission, but to follow God in his mission of redemption, reconciliation and liberation, and we put forward some preliminary thoughts about what God’s mission might look like in FTD.

Much of what is covered in this chapter pertains to the church’s social agency in general, and there are no specific recommendations for the church and FTD. Recommendations for FTD and the church will be put forward in chapter 10 when the literature engaged in this chapter and in chapter 3 will be brought into dialogue with the findings from the empirical research shared in chapters 5 - 9, all pointing towards the church’s possible role in FTD.

4.2 THE CHURCH AS AN ACTOR IN SOCIAL DEVELOPMENT

Before considering the church’s internal and faith motivation for involvement with FTD, we will look at the church as a social actor in social development, one of many social actors seeking the well-being of society and its members. We will define social development and move on to engage some commentators on the role of religion in social development. We will also look at the church as a social actor within the South African context. Leading on from this, one approach is put forward as to how the church may play its role as a social actor, namely a religious health assets approach.

4.2.1 Social development and social actors

Social development is about social actors putting people at the centre of development. It is “a process of planned social change designed to promote the well-being of the population as a whole within the context of a dynamic multifaceted development process” (Midgley, 2014, p. 13). ‘Social’ refers to human interactions and the entities that arise from them. These may include for example families, community groups and organisations (including the church), even whole communities. ‘Development’ refers to a multifaceted process seeking positive societal change that comprises social, cultural, gender, political, environmental as well as economic dimensions (p. 9). Social development actors are any group seeking either directly or indirectly to promote social development, both governmental and non-governmental actors. We see churches as non-governmental social development actors.

Social development may be further defined with reference to David Korten’s (1990) typology of development responses (or generations) which range from short to long term. Actors in social development may be involved in one or all the following response types:

1. Relief - immediate response to a crisis or shortage of things where agents, external to those in crisis lead the response
2. Local development – longer term (over several years) programmatic responses to shortage of skills and inertia in people, assisted by external agents, community based
3. Systems development – even longer term (10 years and more) initiatives that address the failure of societal and cultural systems, involving all relevant public and private institutions

4. People’s movements – of indefinite time frames and seeking to activate mobilising vision within society and involving local and global networks of people and organisations

As many of the world’s most at risk and disadvantaged people are children, it almost goes without saying that children are a key focus in social development. The Unicef *State of World’s Children report* begins as follows: “Every child has the right to a fair chance in life. But around the world, millions of children are trapped in an intergenerational cycle of disadvantage that endangers their futures – and the future of their societies” (UNICEF, 2016). Therefore, to be engaged in social development is to be engaged with children, especially in their most important formative phase from conception to two years.

Social development for FTD would include any activities that address social issues that impact on the wellbeing of parents, carers and infants, for example employment, decent housing and access to health care. More focused FTD activities would comprise of, for example, providing a pregnant woman with a nutritious meal, providing a loving home for an abandoned baby, teaching parenting skills, promoting family planning, facilitating adoption, challenging mindsets about gender roles, advocating for access to good maternity clinics, facilitating family strengthening, improved working conditions for pregnant and breastfeeding women and promoting active fatherhood.

It is with the above understanding of social development and its connection to FTD that this section on the church as an agent of social development is written.

4.2.2 The role of religion in social development

Having established a working definition of social development, the question arises as to the role of religion and religious institutions (and therefore the church) within social development, as social actors. This is a topic about which much has been written, and it is only possible to put forward a few thoughts on the topic in this chapter.

Erasmus (2007, p. 377-378) points to literature regarding the significant role of religion in social change, even at a time of widely accepted secularisation within society. He discusses scholars who show how religion is embedded in change processes – not passive but (due to the diversity within the religious sector) playing a role that may both promote and inhibit change. Erasmus continues that the question is no longer whether religion impacts social change, but in what ways it promotes or inhibits change. He quotes McGuire (1997, p. 240-248) who considers three ways: religious ideas, religious leadership and religious groups.

In support of the pervasiveness of religion in society, Ter Haar and Ellis (2006, p. 351) state that within the development sector “one of the greatest surprises in recent decades has been the resilience of religion”. This has led to a renewed interest in religion in development, supported by a broader definition of development as human development and “creating an environment where people can develop their full potential and live productive and creative lives in accord with their needs and interests” (p. 353). In addition, for human development to be sustainable it needs to build on the assets that people have, including their spiritual assets. Religion, they maintain, provides a powerful motivation for many people in the way they choose to act and therefore the world views of people that social development is seeking to benefit must be engaged (p. 365).

---

12 One would note of course that change is not always positive, and sometimes in resisting negative societal change religion can play a positive role.
In addition to its direct role in social development, religion also has a role in critiquing forms of social development that promote a belief in “redemption through progress”, a view often at odds with a religious (particularly a Christian) understanding of the human condition, including sin, human freedom, the limits of human power, the active agency of God in history and the atoning mercy of God. Steve de Gruchy, in engaging the theologian Reinhold Niebuhr, powerfully states:

An awareness of God’s mercy should not lead to complacency in the life of the believer. Rather, it ushers in an attitude of thankfulness and humility that should characterise our dealings with history. The desire to claim too much for ourselves is gone, and with it a new realism about what we can and cannot achieve. This is the “nonchalance of faith” that enables us to be free agents of history, delivered from the false creed of redemption through history, and thereby more able to contribute to justice (in Haddad (ed) 2015, p.19).

This brief look at the role of religion in social development points to the integral role of religion in initiatives seeking to benefit people in their first thousand days of life.

4.2.3 The church as a social actor in South Africa

South Africa has a long history of the church as a social actor, with both positive and negative influence being exerted by different churches and at various times, for example during the struggle to end (or to maintain) apartheid. Within South Africa, there is considerable support for the idea of the church as a positive social actor. Bowers and August (2004, p. 416-417) point back to the 1980’s and the Second Carnegie Inquiry into Poverty and Development in Southern Africa. This was a time when people were already looking ahead to the rebuilding of a post-apartheid South Africa. The Inquiry report proposed that “organisations outside of the state would best be able to transform power relations – to empower the poor and lay foundations, which will help determine the shape of society in the long run.” The report identified several types of ‘organisations for change’, and among them was the church. Building on Carnegie II, Bowers and August affirm the need for the church as a social actor, more specifically as an “active moral and prophetic agent in South African society” (2004, p. 425). They state that religious organisations such as the church can ‘create space’ for the voices of the poor to be heard and for issues to be addressed in a country struggling with its apartheid legacy and the impact of globalisation which is resulting in “the liberalisation of the economy, fragmented communities and a growing inequality gap between the rich and poor”.

Another compelling reason for looking to the church as a social actor, is that the church and religion is pervasive within South African society and could be considered the strongest and most influential non-government institution in the country (Erasmus, 2007, p. 374). In Census 2001, 79.8% of the population indicated that they are affiliated with the Christian religion, with churches reaching on average 63% of the Christian population weekly (Erasmus & Hendriks, 2003). There are approximately 43 000 Christian faith communities (Froise & Hendriks, 1999, p. 37) reaching every corner of the country. In rating South African social institutions, the Human Science Research Council (2000) found that the public’s view of the church received the highest percentage of trust (74% in 2000) of any institution on the country.

Erasmus (2007, p. 373) notes that “the well-being of communities depends largely on the harnessing of their citizens’ contributions” and as the majority are people of faith, most of the contributions (physical, emotional or other resource) come from people of faith. He states that “No one who wants to mobilise these contributions towards the transformation of the community can ignore the pervasiveness of faith communities”.

---

13 Some sources place this at a lower 33 000 (Bowers & August 2004, p. 421).
Nelson Mandela, whilst president, acknowledged the connection between the social and the spiritual when he said: “In striving for political and economic development, the ANC recognises that social transformation cannot be separated from spiritual transformation.” (The African National Congress’s Statement on the Moral Renewal of the Nation, 1998, p. 1). As Swart explains (2010, p.448), there were moves under the presidency of Thabo Mbeki to forge a stronger religion-state partnership for the delivery of social welfare services by religious bodies. This led to ‘rising expectations’ of the religious sector by the state, which were not always realistic or desirable. Whilst there is no space to cover the debate here, suffice it to say that in South Africa the church is generally positively viewed by the state in terms of social service delivery, especially through church linked NGOs. However, should the church develop a stronger public and prophetic voice on social and political issues, this generally convivial relationship could well change. For now, churches should acknowledge and utilise the freedom they have from the state to be social actors especially in the field of social development.

We will now look at one approach regarding what the church may contribute as a social actor. This leads us into a discussion about religious health assets. Whilst not specifically focused on FTD, it would certainly cover FTD in its scope.

4.2.4 Religious health assets in social development

There are many ways to think about the church as a social actor in social development in South Africa. In this chapter we will look at only one because of space constraints but more importantly because researchers believe that it is an approach which has great resonance with the church’s potential to benefit people in their first thousand days of life, and those caring for them. This section is drawn from the work of James Cochrane, Gary Gunderson and others and their work within IRHAP14. Several of their publications were accessed, including the highly recommended and accessible “Mobilizing Religious Health Assets for Transformation - Barefoot Guide 3”15. We do not claim to do justice to the richness in their work, but rather to introduce it into the conversation of church and FTD.

Positioning religious health assets

Much of the analysis and many of the interventions within social development are based on what is wrong or what is missing. Religious Health Assets (RHA) turns this around and building on an asset-based community development approach, asks the question: What are the assets, those things that are valuable and useful, which are present in a community (in this case the religious or church community) that may be mobilised? As Cochrane (2006, p. 116) states, “an approach via ‘assets’ focuses more strongly on agency in the local context, to identify what is already there to work with, rather than assuming a pathology of deficits that require the need for outside agency in the first place, thus undermining local agency”. RHA are identified from within the community through dialogue and appreciative enquiry. They are positioned wider than disease and health outcomes and within a wider socio-ecological model16 which includes upstream health

14 IRHAP is the International Religious Health Assets Programme, which is inclusive of ARHAP – the African Religious Health Assets Programme. See http://www.irhap.uct.ac.za/

15 This book is published by CDRA and is downloadable for free at www.barefootguide.org

16 This is a “theory-based framework for understanding the multifaceted and interactive effects of personal and environmental factors that determine behaviors, and for identifying behavioral and organizational leverage points and intermediaries for health promotion within organizations” (Unicef: https://www.unicef.org/cbcs/files/Module_1_-_MNCHN_C4D_Guide.docx).
factors and a broader array of determinants of health (Kaiser, Jones and Gunderson, 2006, p. 53) as seen in the following diagram:

![Socio-Ecological Model](image)

(Mason, McKeithen and Mourao, 2018)

**Defining religious health assets**

RHA are defined broadly and are “more complex than are seen at first glance” (Kaiser, Jones and Gunderson, 2006, p. 54). They can be either tangible (something one can touch or see, like a clinic, a healer, a care group, a ritual) or intangible (something you can’t touch or see, like a prayer, motivation, resilience). In addition, they can have a direct or indirect influence on health and wellbeing of individuals and communities. The following matrix gives examples of these diverse types of RHA:

![ARHAP® Matrix](image)

(Kaiser, Jones and Gunderson, 2006, p. 54)
Identifying religious health assets

Whilst it is possible to draw up a generic list of RHA, it is necessary for a church (or better still, a group of churches in one area) to work in a participatory way to identify their RHA. There are various community development tools available to assist in such an exercise, for example the PIRHANA toolset\(^{17}\) developed specifically for RHA. This toolset aims at naming the networks, the assets and finding where the agency (or power to mobilise networks and assets) is. Any tools selected to identify RHA should use an asset-based approach and include appreciative inquiry and dialogical action.

Religious health assets and the leading causes of life

In seeking to understand RHA, Gunderson and Cochrane posit five “leading causes of life” which, rather than focusing on what causes death, look at what brings life. They ask “Where does resilience come from? What increases resilience? Which generative life processes are at work here? What helps people choose life in the face of what threatens it, whether a disease of the body or a sickness of society?” (Gunderson and Cochrane, 2012, p. 49). They suggest the following (p. 50-51):

1. Coherence - The many ways we make sense of life, how life makes sense to us; to see our journey as intelligible and not wholly random or as a victim to inexplicable forces.
2. Connection - As human beings we find life through complex social relationships and connections to one another, building communities of various kinds that enable us to adapt to changing threats and opportunities.
3. Agency - To have the will and the resourcefulness to act, and to act with the full capabilities we have as human beings, is a central ‘cause’ of life.
4. Hope - Hope in the deepest sense is about imagining a different, healthier future and finding the energy to do something to try to bring that future into being. If we can see a positive future this nurtures the life force to enable it to happen.
5. Intergenerativity - When our lives are blessed and nurtured by those who come before and after us, we become encouraged, strengthened, enlivened and more able to shape our own lives, to make vital choices.

It is important to note that they realistically point out that “chaos fights back”, unpredictable and turbulent forces that appear to fight against the underlying order of life. Life does not always win. Therefore, in seeking life we must deal with the interplay between emergent new order and the reality of disorder (p. 62).

Lifeworlds and healthworlds - health beyond the individual in isolation

Within a RHA approach, health is comprehensive and is based on the connections between individuals, their family and community. If one part of this social ecology is not functioning, then all parts suffer in some way. RHA refers to these interconnections as “healthworlds”, seeking to link health, freedom and justice together (p.74). These healthworlds are impacted by religion and must be considered in seeking the health of individuals, families and communities. Cochrane describes this connection as follows, in this case using the health issue of HIV:

We are dealing, therefore, not just with a virus, but with lifeworlds within which religious sensibilities, ideas, rituals and behaviour are deeply rooted. No intervention can or should bypass this fact. The extent to which this is understood, and to which the strategic or instrumental rationalities that guide most current health interventions are united with the communicative rationalities that govern

reception, behaviour, norms and values, to that extent will the success of any intervention be determined (Cochrane, 2006, p. 68).

Working with the church’s strengths

Within the framework of RHA, the aim is to work with the strengths and capacities inherent to a spiritual community such as a church congregation. Below is a list of congregational strengths as developed by Gunderson in his book ‘Deeply Woven Roots’ (1997). It is important to note that these are strengths inherent in the spiritual community, the congregation, and not merely in the church leaders. Here, in Gunderson’s own words (2000, p. 362-363), are the posited eight strengths inherent to a congregation:

1. Accompany: to show up in each other’s lives, personally and physically; to visit, care, be present, attend, and listen, one human with another.
2. Convene: to gather in groups of appropriate size around coffee tables and stadiums to engage opportunities and challenges of finding God’s intentions for people and communities.
3. Connect: to create webs of relationship among the complex lives of members and communities so that resources can be engaged, accessed, and aligned. This is a critical strength for children who cannot be expected to cope with the highly complex institutional systems that create, manage, and control critical resources needed for development.
4. Frame or tell stories: to place in context experience and data so that people can recognize and play their role amid their complex relationships with other humans and God. Congregations have the strength to answer “Who am I?” without dumbing the question down to a set of statistics, labels, and legal obligations. Note that stories are told not only with words, but actions, especially those repeated over time. Again, this is of obvious significance to the health of children.
5. Give sanctuary: to create safe spaces for important programs and services that can be critical for individuals and for important dialogues necessary to align the social and political systems that determine health at community scale.
6. Bless. People, especially children, grow in the direction of that which blesses them and looks like life. Congregations have enormous practical power to bless. Indeed, it might be that this power is what links all the other strengths.
7. Pray: to help people live at the boundary of human and holy with a rich menu of vocabulary, symbol, ritual, and religious practice.
8. Endure. Congregations are built for slow change, long-term mundane discipline, growth and development throughout the cycle of life. This gives them quite different accountability than almost any other social structure; it might even give them patience for the countless unremarkable things a child, or a hundred thousand children, might need in order to grow as God intends.

These strengths can be linked to factors known to promote health and well-being at the individual and community level (especially and including people in their first thousand days) and even prevent excessive disease and premature deaths (Kaiser, Jones and Gunderson, 2006, p. 54).

Boundary leadership

And finally, to mobilise RHA, a particular type of leadership is needed. Named ‘boundary leadership’ this is a type of leadership that leads by learning to participate, one which nurtures innovation and transformation. Boundary leaders can “work for transformation, develop a common vision, align a wide range of assets, rebuild community in the face of disparities, conflicts and inequalities, and help create further boundary leadership” (p. 90).
Closing thoughts

We close this section with the following cautionary words about faith communities and health:

It is deceptively easy to make simple assumptions about the contributions the faith community makes to the health of the public. Such assumptions often limit the recognition and engagement of the faith community’s full strengths. Faith communities are quite complex, as also are determinants of health. Recognition of this, along with the appropriate conceptual models, is necessary for mobilizing all of the [religious health] assets in communities (Kaiser, Jones and Gunderson, 2006, p. 58).

Many of the issues and opportunities facing people in their first thousand days fit into a broad understanding of individual and community health that can be positively impacted by the mobilization of the religious health assets of the church.

4.2.5 Modes of the church as a social actor

Having explored the role of the church as a social actor for social development and having considered the religious health assets of the church, we will now consider what type of social actor the church may be, reflecting on what can be realistically expected of a congregation. A study from the USA (which is probably equally true for South Africa) found that “there is abundant evidence that congregations have difficulty sustaining community development and delivering social welfare services” (Farnsley quoted in Swart, 2010, p. 452). With this caution in mind, and remembering the above discussion on religious health assets, we use Korten’s (1990) four generations (or modes) of intervention in development (mentioned above) to consider ways in which the church may fulfil its role as a social actor. In this we will interact with and build on the thinking of Ignatius Swart (2004, 2006, 2010) who has written extensively on this topic.

First generation: relief and welfare

The first generation includes immediate responses to a crisis or shortage of things where agents external to those in crisis lead the response. Here the church is a ‘doer’. Acting out of love and compassion, the church has always and should continue to provide relief and welfare to those in desperate circumstances, for example when people have lost homes through fires, when people are destitute or when natural disasters hit. The church is well placed as a local community organisation, often with buildings and other infrastructure, to play this role. However, the danger is getting stuck in short term feel-good solutions that do not bring about wider change and develop dependency amongst recipients.

Second generation: community development

The second generation of development responses comprises longer term (over several years) programmatic responses to shortage of skills and inertia in people at a community level, assisted by external agents. Here the church is a mobiliser. Starting with its own church community and building on relationships of trust, respect and commitment, the local church is well placed to motivate its own church members to constructive personal and social change and to impart skills for this within a shared belief system and values framework. These members are then equipped through their own lifestyle to become agents of change within the wider community. The church itself is generally less effective at running such programmes within its wider community unless it does so through an NGO that attracts funding and professional skills for running such programmes. Should the church wish to be part of wider community development initiatives, it would be best done in partnership with and support of a local NGO, particularly with a Christian faith-based one where there may already be alignment of beliefs and values. Such partnership can take place, for example, through
provision of volunteers, spiritual services and community, buildings and other material resources of the church and its members.

Third generation: sustainable systems development

Third generation approaches are even longer term (10 years and more) initiatives that address the failure of societal and cultural systems beyond the local community, involving all relevant public and private institutions. Here the church acts as a catalyst. This requires that the church finds its place in the public square and is able to provide an ethics or value-based critique and contribution to issues such as corruption and violence that are impacting negatively on social and cultural systems. The church is best placed to address these issues within its own congregation through e.g. preaching, prayer, discussion and development of its own members as change agents. In terms of more public impact, this would be best done through collaboration with other churches through the various network and alliance structures within the broader church.

Fourth generation: people’s movements

Fourth generation approaches seek to create national or global movements for change. Here the church is an activist and educator. Development in the fourth generation is values driven and sees social movements take centre stage in promoting a more just global society. Churches are well placed to play a role in the development and national movements for change, provided they are connected by wider leadership beyond the local congregation and motivated by a clear vision of change. (The role of the South African and global church in helping end apartheid is an example of this.) As Swart (2004, p. 24) states:

[The thesis may well be proposed that an institution such as the church is potentially far better suited to make a meaningful contribution to Korten’s fourth generation mode. Contrary to the technical demands that the third generation imposes on them, it is in the fourth generation mode, one can argue, that the churches would be able to do what they do best: to appeal to the attitudes and consciousness of people across boundaries and cultures; to promote the alternative ideas and values of the new social movements and civil society... [in] their role as voluntary and people’s organisations.

In closing, we might well conclude that much of the church’s unique and invaluable contribution to social development (and therefore to FTD) is to be found in encouraging churches to do what they do best – to use their various religious (health) assets to “shape virtuous people, nurturing the voluntary spirit and creating good citizens” (Swart, 2010, p. 453)18. It is not in the first instance the running of community development programmes for which the church is mostly not equipped, and which are often best done by an NGO – faith based or otherwise19. However, this does not preclude the church from running programmes for its own congregants’ well-being and inviting others in the community to join in. In the process it will be equipping (discipling) congregants to ‘love their neighbour’ and be agents of positive change and providers of hands to help within their immediate community. Such help may be informal or formalised by groups of motivated congregants – with or without the involvement of church leaders. This, it would seem, is a more far-reaching, realistic and sustainable approach for the church to adopt as a social actor and one which does not place unrealistic expectation on the church or its leadership. Once this form of “development from within moving outwards” has become normative within the church, it will be ready (and expected and accepted?) to play a

---

18 This is especially an opportunity within South Africa given the large church membership in the country.

19 Churches, especially those that are better financially resourced, may of course start or operate in part as an NGO. Churches may also consider partnering with an NGO that has programmes that are suitable for use within and by congregations.
greater fourth generation role in social movements for good and with “a development praxis that would be more radical, ideologically critical and sophisticated in the light of the complexity of the problems of poverty and underdevelopment” (Swart, 2004, p. 2).

4.2.6 Barriers to the church fulfilling its role as a social actor

A consideration of the church as a social actor for social development would be incomplete without an examination of some of the barriers to the church fulfilling this role. We will now consider three factors internal to the church and one factor external to the church that may inhibit the church as a social actor, including in the field of FTD.

Theological frameworks that mitigate against the church’s engagement in social development

Whilst it may be argued that development itself had its nascence in Christian mission (James, 2011, p. 109), the engagement by the church with development has not been easy or unified. In the second half of the 20th century, engagement with matters of development varied greatly within the church, with a wholistic social liberation agenda at the one end and relief (or charity) accompanied by (or as a means to) evangelism at the other end. Broadly speaking, the former approach was supported by ecumenical movements and the latter by evangelical movements. The South African missiologist David Bosch stated that “the relationship between the evangelistic and societal dimensions of the Christian mission constitutes one of the thorniest areas in the theology and practice of mission” (1994, p. 401). Whilst there has been a growing ‘convergence of convictions’ within the church on how society is engaged, this engagement continues in many churches to be informed by a dualistic spirituality which is able to separate human nature into spirit and matter and thereafter prioritise the former above the latter. This, combined sometimes with a premillennial theology, leads to a purely individualised and personalised view of evangelism and redemption rather than including the transformation of society in the present time (Bowers, 2010, p. 432-435). For the church to fully engage as a social actor, a rediscovery and implementation of a biblically based view of God’s holistic mission is needed.

Inadequate theological conceptualisation of FTD

Although theology and development is a new discipline within theology, there is a growing body of research and literature available on this topic. However, in conducting a theological literature search for literature on FTD, it is quicky apparent that there is very little engagement theologically with FTD. Several theologians (for example Miller Mc-Lemore, 2003; Bunge, 2014; Greener, 2016) have observed that in general, children are in many ways marginalized by theology. Sagberg (2008, p. 358) narrows this concern down to an observation that of all empirical studies on children and their spirituality, only a few have focused on children in early childhood (0-5 years), and even less on those in FTD. Current research also found that theological studies on children specifically during the first thousand days, is almost non-existent. It is as if this phase of human life is not being engaged theologically. Exceptions are writings dealing with human formation, and pastoral material dealing with family and parenting. As most church leaders are trained from curricula based on available theology, this lack of theological reflection on FTD would therefore be carried over into churches.

---

20 Indeed, one would also want to hear from church leaders themselves how they see their role in social development and particularly, in terms of this research, in FTD and Chapter 5 contains some indicators of this from empirical research.

21 A premillennial theology, supported by some more fundamentalist arms of the church, maintains that society will only improve once Jesus Christ returns and therefore efforts to improve society are mostly futile. This is countered by a postmillennial theology which calls on Christians to seek improved societal conditions prior to the return of Jesus Christ.

22 Exceptions to this were on the topic of infant baptism and original sin.
and how they conceive of the church’s role in FTD. For this to change requires increased theological research, reflection and teaching on FTD within theology faculties and church leader training institutions. Biblical narratives offer rich opportunities to broaden our conception of children and strengthen our commitment to them in all areas of the church and its mission.

**Poor engagement with issues of power**

In other research, Bowers du Toit (2016) names an ‘elephant in the room’, namely the notion of power in the church’s role in society. In post-apartheid South Africa, the move was from “resistance to assistance” as regards the church’s relationship with the state and other social actors. However, in view of the various socio-economic and political crises South Africa is now facing, this approach may be considered “‘weak’ in [its] acknowledgement and understanding of power … [t]here is an underlying assumption that poverty can be addressed without confronting the powers, that is, that charity or neighbourly partnering alone can bring about transformation” (Bowers du Toit, 2016, p. 4). For the church to be an effective social actor it must be willing to not only cooperate with other social actors but also prophetically and practically resist those people and powers perpetuating injustice in society and therefore injustice against those in FTD. It is the time, suggests Bowers du Toit, for the church to revisit theologies of resistance in its social engagement (p. 8).

Another aspect of power which is key when considering social development, the church as a social actor and the area of FTD is power in gender relationships. Haddad (2001, p. 8) defines gender as “the socially constructed and culturally defined differences between men and women” and that “gender analysis always defines the relationship between the sexes in terms of power relationships”. The church, like any other institution of society, is not immune to its own particular issues in this regard. Theologians and church leaders have traditionally been men, and although this is changing, much of what is considered important or central is still informed by men and their experience of the world. Therefore, the topics of FTD (like pregnancy, breast-feeding and nurturing care) have not found their way into mainstream church and theological agendas, to the detriment of both men and women (and of course little children too). This is seen, for example, in the striking absence of programmes that strengthen fatherhood. In approaching the topic of FTD within the church one needs to understand the gender power dynamics at play and the shifts currently underway in this regard. There is also much in the church that can be used to overcome societal gender power imbalances and benefit FTD, for example following a God who declares men and women to be equally made in his image (Gen 1:27); the example of Jesus who treated women in an inclusive, equal, redemptive and counter-cultural manner and a recognition and inclusion of the assets and strengths of women in the church, especially “the survival faith of poor and marginalised women, a faith that joins the spiritual and material, [and] is crucial to our theorising and theologising of development practice” (Haddad, 2001, p. 5).

**Church leaders in Cape Town face several challenges in playing their social actor role**

Recent and highly relevant research conducted with church leaders in Cape Town (Bowers du Toit, 2017) points to obstacles preventing the church in the city from playing a more active role as a social actor. Bowers du Toit found that whilst churches were engaging in social development issues, “much of their engagement is characterised by what is termed ‘relief and charity’ approaches” (p. 3). Hindrances to more and sustainable responses included: feeling overwhelmed by issues of poverty and socio-economic challenges; fear of going into socio-economically depressed areas; lacking skills (including skills in cross-cultural and cross-racial

---

23 We acknowledge of course that the church during apartheid was divided and especially many white churches did not resist apartheid nor have they significantly moved to assistance post apartheid.

24 For an overview of gender, development and religion in South Africa, we recommend the article “Theologising Development: A gendered analysis of poverty, survival and faith” by Beverley Haddad.
relationships); partnering with NGOs (esp. faith-based ones) who have skills and resources to lead initiatives and this was at times disempowering; living in suburban cocoons; individualism and lack of time; a culture of entitlement affecting both wealthier and poorer communities in different ways in their engagement with social issues and a lack of church unity, with churches unable to work together for a social purpose. Certainly, these obstacles must be kept in mind in considering social initiatives involving the church and FTD.

**Acceptance of the church as a social actor by secular social development actors is needed**

Despite activities especially in the 2000’s to forge relationships between state and religious bodies for social development, there continues to be a failure by both state and secular social development actors to integrate and work effectively with churches as social actors (Swart, 2010). Whilst Christian-based NGOs are actively engaged and partnered with, the local congregation seems somewhat left out. This despite the acknowledgement of the social capital of the church by the Western Cape government (Swart, 2010). If the assets of the church are to be mobilised for social development and for FTD in particular, increased efforts in collaboration with churches (on equal terms) are to be made by state, secular and non-church faith-based social development actors.

### 4.3 THE MISSION OF THE CHURCH AND ITS IMPLICATIONS FOR FTD

The church is not only an independent civil society organisation, deciding its identity and setting its own agenda. It is “the body of Christ” (Eph 1:22-23) in the world, called into being by Jesus Christ, empowered through Holy Spirit for the purposes of God the Father and seeking to follow the person, teachings and commands of Jesus Christ, within the broader teachings of the Bible. Although diverse in practice, beliefs, biblical interpretation and theology, the Christian church is united across this diversity as it is informed by a shared “God story” as described in the bible, interpreted through the 2000-year history and activity of the church and held within its creeds and confessions. Increasingly, the purpose and formation of the church is being informed by a new understanding that Christian mission – “is not primarily an activity of the church, but an attribute of God” (Bosch, 1991, p. 390). This is the *missio Dei* or mission of God which informs the *missio ecclesiae* – the mission of the church and how it is formed and functions. This missional perspective provides an excellent lens through which to view the role of the church as a social actor in social development including FTD. In this section, we will take a brief look at the *missio Dei*, and the response of the church - the *missio ecclesiae*, closing with some very preliminary thoughts on the intersect of mission and FTD. This discussion is positioned as a theological one as it is theology (academic and otherwise) which informs the practice of the church. But it is hoped that what follows will be helpful to anyone seeking to understand the internal motivation and approach for the church to participate in social development and provide support in FTD.

In this section, it is the work of the internationally renowned South African missiologist David Bosch (1929 – 1992) that is followed and brought into dialogue with other exponents of mission as well as biblical text.

#### 4.3.1 An overview of God’s mission – *missio Dei*

The church’s understanding of mission has, in the past 2000 years, gone through various paradigms or patterns. A view currently broadly held by Christian theologians is that the church entered a new post-enlightenment paradigm of mission in the earlier part of last century (Bosch, 1991) and by the middle of the

---

25 The “God story” told in the Bible and revealing God’s purposes in the world and his purposes for humankind. Beginning with creation and ending with the return of Jesus Christ and the final judgement of humankind, it moves through history.
twentieth century, broad theological consensus regarding mission as the mission of God, the *missio Dei* had been reached (Bosch, 1991, p. 389-391). The theologian Karl Barth was instrumental in promoting this thinking when, in 1932 at the Brandenburg Missionary Conference, he positioned mission within the sending that is to be found in the classical doctrine of *missio Dei* – the Father sent the Son, and the Father and Son sent the Spirit – adding yet another sending, that of Father, Son and Spirit sending the church. This definition of the *missio Dei* shifted the agency of mission away from the church, placing primary agency in mission within the life of the Triune God. Whilst built on an existing understanding of mission, this thinking marked the beginning of a new paradigm in the church’s understanding of mission, as an activity and attribute of God that derives from the nature of God. As such, mission is not situated in either ecclesiology or soteriology but in the Trinity. Mission is not “the apostolic road from church to church” (Karl Graul, quoted in Bosch, 1980, p. 240) but rather the Triune God moving into the world. Mission is never initiated by humans but is always the initiative of God. It is in this mission that God invites the church to participate.

**God’s mission and the kingdom of God**

God’s sending is not the detached sending of a distant, absent monarch sending an envoy, but the present and involved sending of God-self based in God’s love for the entire world (cf. John 3:16). Bosch (1991, p. 10) defines the *missio Dei* as follows: “God’s self-revelation as the one who loves the world, God’s involvement in and with the world, the nature and activity of God, which embraces both the church and the world, and in which the church is privileged to participate. *Missio Dei* enunciates the good news that God is a God-for-people”. The very presence of a self-giving and self-revealing God within creation history should never be forgotten and “Trinitarian processions are understood not only as movements within the mystery of God as such, but as God moving in saving love within the world” (Bevans and Schroeder, 2004, p. 287).

If mission is an attribute and activity of God, one must next ask – to what end? What is the ultimate goal of the *missio Dei*? Johannes Verkuyl (1979, p. 168) answers this question well when he says: “… in both the Old Testament and the New, God by both his words and deeds claims that he is intent on bringing the kingdom of God to expression and restoring his liberating domain of authority”. In short, the kingdom (or reign) of God is the goal of the *missio Dei*, and this is achieved as God, through Christ, reconciles all things to himself (Col 1:19-20; 2 Cor 5:19; Rom 5:10-11). This is a holistic reconciliation coming from God’s loving and missionary heart. As Robert Schreiter says: “The horizontal understanding of reconciliation is clearly grounded in the vertical understanding of God’s saving work. The mission of reconciliation is therefore based in the *missio Dei*” (Schreiter, 2005, p. 80).

In describing the kingdom of God, it is good to remember that Jesus spoke of the kingdom in parables that both reveal and hide its true identity (for example, Matthew 13:36-43). Bosch, commenting on the strong kingdom motif in Matthew’s gospel says: “From Matthew’s perspective, to encounter the kingdom is to encounter Jesus Christ ... In Jesus, the reign of God has drawn near to humankind” (1991, p. 71). He states that the reign of God was central to Jesus’ entire ministry and to his understanding of his own mission (p. 31). He points out how Jesus’ ministry launches an all-out attack on evil, with God’s reign arriving “...wherever Jesus overcomes the power of evil” in its many individual and systemic forms. The all-embracing nature of Jesus’ saving work indicates the all-embracing nature of God’s reign, the non-political yet political nature of the manifestation of God’s reign in Jesus (p. 33). “Faith in the reality and presence of God’s reign” says Bosch “takes the form of a resistance movement against fate and against being manipulated and exploited by others” (p. 34) and “In Jesus’ ministry... God’s reign is interpreted as the expression of God’s caring authority

---

26 Within the Christian belief system, God is mystically one and three at the same time – Father, Son and Holy Spirit - living and moving in perpetual love and oneness. A “perichoretic dance”.

46
over the whole of life” (p. 34). Counter forces remain a reality as Jesus has inaugurated the kingdom but it is not yet consummated. Leonardo Boff, quoted by Bosch, says that “the kingdom is both bestowal and challenge, gift and promise, present and future, celebration and anticipation” (1991, p. 35).

Similarly, Bevans and Schroeder highlight the centrality of the proclamation of the kingdom or reign of God in Jesus’ ministry. They say: “It is of this kingdom that Jesus speaks in his parables, witnesses to in his works of healing and nourishment, and embodies in the very mystery of his person” (2004, p. 305). Jesus, through his ministry, death and resurrection, inaugurated and both showed and made the way to the kingdom (Mark 1:14-15; Luke 4:43). He did so in a manner that redefined King and kingdom as a reversal of the ways of the world. He gave new meaning to power, coming as a servant and taking the way of the cross and reflecting love for the world over love for self (John 3:16; John 13, Phil 2:1-11). It was a “love that challenges the distorted values that have ruled the world, including distorted understanding of power” (Christian, 1999, p. 197). In so doing, Christ “rescued us from the power of darkness and transferred us into the kingdom” (Col 1:13) by confronting the satanic power under which the present world groans (Rom 8:22). In this “upside-down Kingdom” (Kraybill, 1978) that Jesus inaugurated, it is the poor (Math 5:3), the little child (Math 19:4), the rejected woman (John 4:7-42; Luke 7:37-39) and the tax collector (Luke 19:1-10) who understand and enter the kingdom once they have met with Jesus. This emphasis also led Jayakumar Christian to comment: “The kingdom of God is redemptively biased towards the marginalised” (1999, p. 184) whilst the wealthy (Matt 19:24), the hard-hearted and the self-righteous (Luke 10:25-37) struggle to enter it. The way of the cross and the suffering servant taken by Jesus shows the way his followers are to take if they want to find and enter the kingdom. Paul gives an insight into the nature of the kingdom when he says “…the kingdom of God is not food and drink but righteousness and peace and joy in the Holy Spirit” (Romans 14:17 NRSV). Verkuyl gives an inspiring summation, expressing the breadth of God’s kingdom in its vertical and horizontal (or holistic) scope:

The kingdom of God is that new order of affairs begun in Christ which, when finally completed by him, will involve a proper restoration not only of man’s relationship to God but also of those between sexes, generations, races, and even between man and nature. This is the message of the prophets, and this is what John saw in his visions recorded in the book of Revelation. This too is the testimony of the Apostles who join Peter in affirming, ”We await a new heaven and a new earth in which righteousness dwells” (II Pet. 3: 13) (1979, p. 168).

God’s kingdom was inaugurated by Jesus (Mark 1:15) and both exists in the present (“has come near”) and will reach its fulfilment once it has been proclaimed throughout the world (Math 24:14). It is first and foremost God’s theocentric and dynamic kingdom or rule (Ladd, 1974, p. 46), and not something that people can build but rather are invited into through a spiritual birth (John 3:3) or receive as a reward (Matt 24:34). When people have a revelation of the kingdom, they will give their all to have it (Math 13:44-46). God is active in history to bring about the fullness of his kingdom and whilst history itself is not redemptive, God is redemptive in history as God views all people and their history (especially the poor and marginalised) from his perspective of righteousness (Christian, 1999, p. 189). That is why Lesslie Newbigin can write: “The reign of God… is the true secret of universal and cosmic history. It is not a program for private deliverance but is the hidden reality by which the public history of humankind is to be understood” (1995, p. 37).

Newbigin (1995, p. 30) writes that the kingdom of God is concerned with the reign of God who is “creator, upholder and consummator of all that is”. His reign is over all things and shows his intent to bless all nations...
and to “bring about the completion of God’s purposes in the creation of the world and of man within the world” (p. 34) He stresses beautifully the all-encompassing nature of the kingdom:

The reign of God is not a new ‘movement’ in which those interested may enlist. It is not a cause for support, a cause that might succeed or fail according to the amount of support it attracts. It is, to be precise, the reign of God, the fact that God whom Jesus knows as Father is the sovereign ruler of all peoples and all things. …an impending reality (1995, p. 34).

Given the topic of this research as First Thousand Days, it seems appropriate to draw inspiration for our understanding of God’s kingdom and how we enter it from Matthew 18:3 where Jesus said: “Truly I tell you, unless you change and become like little children, you will never enter the kingdom of heaven.” The Child Theology Movement, in their pioneering and insightful book “Toddling into the Kingdom” says, in this regard: “The church, taking the marginalised child and putting [him or her] in its midst embodies the kingdom of God and expresses God’s mission here and now” (Collier ed., 2009, p. 208). This statement, and the words of Jesus, necessitates deep meditation by a church which prays “Thy Kingdom come”.

God’s mission as a mission of reconciliation

It is through reconciliation that God’s kingdom is made manifest. A Lausanne Occasional Paper defines reconciliation as God “restoring a broken world to God’s intentions” (LOP51, p. 11) with restored relationships between people and God, between people and with creation. Reconciliation (like mission) is not something we initiate or do, rather “…we discover it already active in God through Christ” (Schreiter, 1992, p. 43) and we are invited into that work (p. 59). Reconciliation has its source in God’s Trinitarian self and his heart of love. Reconciliation is not something apart from him but is always reconciliation into him and his kingdom. Reconciliation has begun in the death and resurrection of Jesus Christ and will be completed when God has reconciled the whole universe in Christ (Eph. 1:10). At this present time, “Reconciliation is a sign of God’s presence in the world, of the kingdom of God drawing near” (LOP51, p. 15). Reconciliation exhibits as God’s peace, his shalom. This peace is not the peace of the world (John 14:27) but peace that brings fullness of life (John 10:10): “God’s peace encompasses all dimensions of human life, including the spiritual, physical, cognitive, emotional, social, societal and economic. Shalom pursues mercy, truth, justice and peacefulness through both personal conversion in Christ and social transformation” (LOP51, p. 15).

4.3.2 The church’s witness to God’s mission – missio ecclesiae

The church is called to actively witness to God’s mission. It is the church who has been given the ministry of the message of God’s reconciliation (2 Cor 5:20), been called to proclaim the good news of the kingdom of God (Matt 10:7; Luke 9:2) and to witness to the person and work of Jesus Christ (Acts 1:8). As mission is the mission of God and not the mission of the church, what the church does in mission is to witness to the primary agency of God in mission.

The identity of the witnessing church

It is important to note that the church is currently undergoing a radical reorientation in line with missio Dei thinking (Bosch, 1991, p. 467). Guder (1998, p. 4) talks to the source of this reorientation: “The ecclesiocentric understanding of mission has been replaced ... by a profoundly theocentric reconceptualization of Christian mission requiring the conversion of the church to its radically simple missional vocation” (Guder, 2009, p. 24). This shift from a church centred mission to a mission centred church was famously articulated at the Willingen Conference of 1952:
God’s salvific work precedes both church and mission. We should not subordinate mission to the church nor the church to mission; both should, rather, be taken up into the *missio Dei*, which now become the overarching concept. The *missio Dei* institutes the *missio ecclesiae*. The church changes from being the sending one to the one being sent (quoted in Bosch, 1991, p. 370).

Bosch states that the entire life of the church is missionary (1991, p. 472). However, whilst the church is defined in terms of its missionary role, we must remember that God in mission is not confined within the church. Newbigin writes:

> The Spirit who thus bears witness in the life of the Church to the purpose of the Father is not confined within the limits of the Church. It is the clear teaching of the Acts of the Apostles, as it is the experience of missionaries that the Spirit goes, so to speak, ahead of the Church; it is the preparation for the coming of the Church, which means that the Church must be ever ready to follow where the Spirit leads. (1963, p. 49)

It is as the community, the body of Jesus Christ, that the church exists (Col 1:8; 1 Cor 12:27) and as such, he must be central to any thinking about the church. Rene Padilla speaks to the centrality of the person of Jesus in the church’s identity in mission: “The New Testament presents the church as the community of the kingdom of which Jesus is acknowledged as Lord of the universe and through which, in anticipation of the end, the kingdom is concretely manifested in history” (Padilla, 2010, p. 202). The church as the Christian community is the result of the missionary event of Jesus Christ’s own self-declaration (Flett, 2010, p. 248), the community of Jesus Christ’s reconciliation. The whole being and action of the Christian community rests on this single declaration: Jesus Christ is risen, he is risen indeed. The community’s own particular form cannot be any different from the content of this revelation (Flett, 2010, p. 249-251). His community lives as a reconciled and reconciling community; a community that must offer an answer to the question “Who is Jesus Christ?” (Flett, 2010, p. 294-5). As the body of Christ in this world, “The church is a community of mutual participation in God’s own life and the life of the world” (Van Gelder and Zscheile, 2011, p. 107).

We will now look at two characteristics of this missional church that especially pertain to social development, namely the church as a community for the world, and the church as a local community-based witness.

**The church as a community for the world**

The missional church is a community for the world. Jesus Christ speaks to his elected and sent people with the “intention and commission” (as Karl Barth stated it) that they should speak to the world, to be his messenger within it (Matt 28:16-20). The life of the community is to have the character of revelation to the world, “of the word of God demanding expression”. The community, in its movement into the world, is for the whole of humanity because that is the reach of God’s reconciliation (Flett, 2010, p. 249-251). However, as a community for the world, the church must remember that God’s mission in the world is related to the reign or kingdom of God and therefore the work of God in the world is larger than the mission or work of the church in the world (Van Gelder and Zscheile, 2011, p. 4). Bosch (1991, p. 377) states that the church is the bearer of revelation to the world about God’s kingdom and to be credible the church must display to humanity “a glimmer of God’s imminent reign – a kingdom of reconciliation, peace and new life”. This should happen visibly in the church community. But it also happens through Christians active in society “since Christ is Lord of the world as well”. As Bevans and Schroeder (2004, p. 287) elaborate: “The church is then understood as the people that God has chosen not only to participate in the saving life of the divine community ... [but also] to be agent and co-operator in God’s outreach to the whole of creation.” As Jesus Christ himself stated, the church is to be salt and light in the world (Matthew 5:13-16).
Barth (CD IV/3.2., 762 quoted in Flett, 2010, p. 272) makes the point forcefully, regarding the church as a community for the world: “First and supremely it is God who exists for the world. And since the community of Jesus Christ exists first and supremely for God, she has no option but in her own manner and place to exist for the world. How else could she exist for God?” Flett, building on Barth, elaborates: “As God has not associated himself with the world in a manner of ‘idle co-existence,’ so the community cannot engage the world in ‘a sincere but inactive participation’ (CD IV 3.2, 777). Her solidarity with the world means full and active commitment to and engagement with it” (Flett, 2010, p. 272). Jesus Christ’s community is “holy in her openness to the street and even the alley” (CDIV/1, 725 quoted in Flett, 2010, p. 272). For the church to serve God is to live in service to the world, and at the same time “the community cannot exist in the world without calling people out of it, without inviting them to participate in His work” (CD III/4, 504 quoted in Flett, 2010, p. 273). The church that witnesses to the reconciling reign of God is therefore a community for and in the world.

The church as a local community-based witness

The church in its witness and missionary vocation exists primarily as a local community, combining its sociological identity with its theological identity. It is, as Bosch simply states, “an inseparable union of the divine and the dusty” (Bosch, 1991, p. 389). Newbigin points out that in the New Testament, a church was always designated by the place where it was located, for example the church in Rome (Newbigin 1994, p. 51). “Church is always local, in a locale, having a specific physical place. The church is named in the Bible as ekklesia Theous, the assembly of God, and named by the place that they meet. The church of God for that place” (1994, p. 53).

Craig Zscheile (2013, p. 2) says that within the 21st-century globalised and participatory culture, and in light of a “participatory triune God who forms and restores community” we move towards the local “where we reclaim the centrality of local Christian communities and their ordinary disciples as primary missionary organizations and personnel”. For Padilla (2010, p. 127) a local church (or “truly indigenous church” as he calls it) is “one that through death and resurrection with Christ embodies the gospel within its own culture”. The church in its witness is a sign, instrument and foretaste of God’s reign for the particular place in which it is located (Newbigin 1995, p.10). Bosch, referencing Newbigin, continues that in these times, “our witness will only be credible if it flows from a local, worshipping community” and not from institutional church structures (Bosch, 1991, p. 59) and that both theology and mission have no life “unless it is borne by a community” (p. 60). The identity of the witnessing church therefore will primarily be that of the local community, the local church.

This leads us on to a discussion of the mission of the church as both contextual and as liberating action within that context.

The church’s mission as contextual

Reconciliation within the missio Dei, as discussed above, is of and for the world, not out of the world. Therefore, God’s activity in mission is always within a given context, and mission cannot be fully conceived of apart from a context. And as the church witnesses to God’s contextualized mission, it too must be conscious of its context. As Bosch (1991, p. 447) reminds us, we are contextualising a holistic salvation where salvation and liberation may never be divorced from each other, nor should they be confused. Faith and one’s lived, contextual reality are inseparable and “Mission as contextualisation is an affirmation that God has

28 This points us to consider the church in Cape Town as one, made up of many different ‘local’ churches and to consider the effect such a conceptual and instantiated oneness might have in the city.
turned towards the world” (Bosch, 1991, p. 426). Padilla (2010, p. 122) warns against a failure to contextualise when he says: “If the gospel is not contextualized, the Word of God will remain a logos asarkos (unincarnate word), a message that touches our lives only tangentially”. The result of an uncontextualized gospel, for him, is that it will have a foreign sound or no sound at all in relation to the lived reality of people.

Scripture offers much support for this concept of contextualization. The Old Testament is the history of God’s working in and through the people of Israel in their cultural and historical context. Jesus lived his earthly life in Palestine as a first-century Jew and his interactions with people were always in terms of their contexts. Think for example of the tax collector Zacchaeus (Luke 19:1-10), the outspoken Samaritan woman (John 4:1-42) and the rich young ruler (Mark 10:17-27). Jesus identified especially with the context of the oppressed (Luke 4:18). The apostle Paul too in his mission activities always engaged culture and context. In speaking to the Jews he spoke in terms of the law, but in speaking to Gentiles, he addressed them in the language of their culture (1 Cor 9:19-23). At Pentecost, the Spirit was poured out equally on people from different nations and different contexts. Jesus in the great command instructed his followers to go to all nations – that is to all ethne or people groups. It is clear from Scripture that God in his mission works within diverse cultures and contexts.

Being contextual is also about reading the signs and the times. Bosch asks: “Which are the signs in human history that reveal God’s will and God’s presence?” If we are to follow God into the world, which are his footprints? This is a dangerous endeavour, as signs and times are often misread (1991, p. 428). We tend to sacralise current sociological forces of history (p. 429); we must read the signs of times in the light of the gospel. The gospel is to be the “norming norm” (1991, p. 430).

Whilst context in mission may refer to different cultures, it may equally refer to contexts of poverty, exploitation and marginalisation. As these are the contexts in which God is active in mission, the church too needs to be aware of these contexts and avoid an “under-contextualized approach to mission” (Bosch, 1991, p. 426). At the same time, we must acknowledge that “the gospel is foreign in every culture. It will always be a sign of contradiction” (p. 455). Therefore, we must accept as experimental and contingent the nature of all theology and whilst confirming its essentially contextual nature we “also have to affirm the universal and context-transcending dimensions of theology” and avoid relativism. (p. 427). As Gutierrez, a leading contextual theologian states: “any theology is a discourse about a universal message” (Gutierrez quoted in Bosch, 1991, p. 457).

The missiologist Andrew Walls concurs: “No one ever meets universal Christianity in itself: we only ever meet Christianity in a local form and that means a historically, culturally conditioned form. ... There is nothing wrong in having local forms of Christianity - provided that we remember that they are local.” (1996, p. 235). Stephen Bevans writes at length about contextualisation in theology and states: “Contextualization is not a luxury... It is at the heart of what it means to do theology, and the theologian who does not take the process seriously only contextualizes unconsciously” (1985).

The church’s mission as a liberating action

The church, as witness to the reconciling reign of God, lives in solidarity with the world, not as the conqueror of the world. It is (or should be) impossible to think about church without thinking in the same breath about the world to which it is sent (Bosch, 1991). There is an inescapable connection between the church and the world as well as the recognition of God’s activities in the world, outside the church. Bosch says that to participate in mission is to participate in the movement of God’s love towards people, since God is a fountain of sending love (1991, p. 390) and our missionary activities are only authentic insofar as they reflect participation in the mission of God (1991, p. 391). Andrew Kirk, quoted in Bevans and Schroeder (2004, p.
expresses a similar sentiment: “God’s mission is based on the very nature of God as such – a community of love and mutuality that overflows into the world in a presence that calls humanity to equality, mercy, mutuality, compassion and justice.” Indeed, they are expounding on the love of God in Jesus Christ, expressed clearly in the Bible (cf. Jn 3:16).

In recognising that Jesus is God’s Word made flesh, we must accept that the word may never be divorced from the deed, as this is the gospel. Clearly alluding to James 2:14-19 Bosch expands on this thought: “Deed without the word is dumb; the word without the deed is empty. Words interpret deeds and deeds validate words, which does not mean that every deed must have a word attached to it, nor every word a deed” (1991, p. 420). Newbigin concurs and says that words require action and actions require words. “The words without deeds lack authority! The deeds without the words are mute, they lack meaning. The two go together” (1994, p. 62).

God, as loving creator-saviour is “reconciling all things to himself through Christ Jesus” (Col 1:20) and the church is appointed ambassador of this reconciliation (2 Cor 5:20). As discussed above, this reconciliation is not only spiritual and other worldly, but material and of this world. As a Lausanne Occasional Paper states: “Christians participate with God’s mission by being transformed into ambassadors of reconciliation” (LOPS1, p. 11). Newbigin says that the Bible is covered with God’s purpose of blessing for all the nations and the completion of God’s purpose in the creation of the world and of humankind within the world. “It is not ... concerned with offering a way of escape for the redeemed soul out of history, but with the action of God to bring history to its true end” (Newbigin, 1978; 1995, p. 34).

The liberating action of the church takes many forms, including through the charitable, developmental and advocacy actions of individual Christians, or Christians working together seeking urgent or incremental liberation for an individual or oppressed group. It is also through promoting the “leading causes of life” and using its congregational strengths as discussed above. Newbigin also rightly emphasises the importance of liberating action by church members in their everyday life:

> When the Christian congregation is filled with the Spirit and lives the true story, such actions will flow from it. Primarily they will be the actions of the members in their several vocations every day. While there are also actions that a congregation or a wider church body may undertake, these are secondary. The primary action of the Church in the world is the action of its members in their daily work. A congregation may have no social action programme and may yet be acting more effectively in secular society than a congregation with a big program of social action (1994, p. 154).

Hunsberger (Guder, 1998, p. 106) reminds us that this was how Jesus lived his life and far from being a distraction from his preaching, “Jesus’ compassionate responses to human need were signposts raised to public view”.

The church can be an instrument through which God’s will for justice, peace and freedom is done in the world (Newbigin, 1995, p. 39). Mission, suggests Newbigin, is the acting out of the faith that the kingdom of God has drawn near. “It is the acting out of the central prayer that Jesus taught his disciples to use” (p. 39). He says elsewhere that “The prayer ‘Thy will be done’ is in vain if it is not made visible in action for the doing of that will. Consequently, missions have never been able to separate the preaching of the gospel from action for God’s justice” (1985, p. 91). Bosch also connects seeking the kingdom in prayer to action: “As we pray ‘your kingdom come!’ we also commit ourselves to initiate, here and now, approximations and anticipations of God’s reign” (1991, p. 35). As succinctly and popularly summarised by Pope Francis: “You pray for the hungry, then you feed them. That is how prayer works”.

52
We need to remember, however, that as an eschatological community, the church “may not commit itself without reservation to any social, political or economic project” (Bosch, 1991, p. 387). The church is a bearer of liberation, not a crusader of liberation (Newbigin, 1994). “Even if secular history and the history of salvation are inseparable they are not identical, and the building of the world does not directly lead to the reign of God... In its action in the world, the church ‘anticipates God’s reign in the here and now’” (Bosch 1991, p. 387). We also need to remember that God has other instruments for achieving his will in the world, for example government. However, it is only the church, the Christian community, that can be the foretaste of the Kingdom and the church should never forget this special calling upon it (Newbigin, 1994, p. 63). Padilla states emphatically the importance of the church’s liberating action in and for the world: “Through the church and its good works the kingdom becomes historically visible as a present reality. Good works are not, therefore, a mere addendum to mission; rather, they are an integral part of the present manifestation of the kingdom; they point back to the kingdom that has already come and forward to the kingdom that is yet to come” (Padilla, 2010, p. 206).

This concludes our discussion on the church as a witness to God’s mission and to his reconciling reign. At this point, it seems self-evident that the church, within its own missional mandate, has a God-given calling to play a role as a social actor in many different areas and ways, including within social development and FTD.

**4.3.3 First thousand days and the mission of the church**

We end this section by offering some very preliminary thoughts regarding a missional church’s thinking and possible activities related to FTD. Each age group has a contribution to make to the coming of God’s kingdom and to our understanding of kingdom and the ‘life to the full’ that it brings. This is no different with people in their first, formative stage of life. Fundamental to this thinking is the understanding that people in their FTD are created in the image of God, the imago Dei. One is led to ponder the question... at what point did the Son of God become fully human in Jesus? And when shepherds and wise men worshipped him as a newborn and as an infant, was he at that point in his very being the divine-human Christ Jesus, or was he merely waiting for a certain amount of time to pass to become such?

We are therefore in search of a missional practice that affirms the full humanity of a person in his or her FTD. We will use the term ‘little children’ in this section to mean people in their FTD. To this end we will start by highlighting briefly some touchpoints on children, church and theology and then give some very preliminary (and no doubt at times disputed) pointers to mission by, with and for little children. Further theological research and wider consultation is required to develop a fuller missional theology of FTD.

**Children, church and theology**

Bunge (Collier ed., 2009, p. 98-109), writing about children generally and not only those in FTD, summarises six ways in which the Christian tradition and the church has viewed children: gifts of God and sources of joy; sinful creatures and moral agents; developing beings who need instruction and guidance; fully human and made in the image of God; orphans, neighbours and strangers in need of justice and compassion. These six ways give a broad and complex view of children. She warns against a simplistic view in favour of one that acknowledges the complexity and the inter-relatedness of these different views of children.

---

29 A missional theology of FTD is beyond the scope of this research - in time, funds, and the composition of the research team. However, the research would not have been complete without some reflection on this, given that we are looking at the role of the church in FTD and the role of the church is (or should be) formed around mission.

30 Inspiration for these three frames was found in Greener (2017) who writes about the need for a model of integral mission ‘to, for, and with’ children-at-risk.
In a similar vein, Miller McLemore (2003) encourages us to neither commoditise, idolise nor demonise little children. But rather to protect, celebrate, nurture and acknowledge them as agents. We are to seek their resilience, wholeness and fullness of life.

Greener (2016) in her insightful and envisioning article *Children-at-Risk and the Whole Gospel* proposes that the church should “conceive of [children at risk] as whole, complex human beings who actively participate in their own development, who grow in context, and who, although vulnerable, possess the capacity to be agents of God, regardless of age, status or gender” (p. 159). She urges us to consider the whole gospel for the whole child in their whole context. She states that, like any mission undertaking, the church will not be able to respond if it has limited understanding of those it is seeking to engage. She calls for the child to be viewed within his or her specific context of place, caregivers, community, culture and time in history. “When household, community, and cultural contexts are added to our conversation, the implementation of holistic care for children becomes far more complicated” (p. 163). However, this complexity also opens the way to wholistic mission with children and not only a spiritualised one, “particularly in supporting vulnerable, oppressed, and marginalized children as evidence of true religion (James 1:23–27), giving dignity to the downtrodden, and caring for those whose basic needs are unmet (James 2)” (p. 159). Whilst Greener was talking about children in general, her argument holds true for those in their FTD. Her proposal is that instead of starting with the gospel and seeking to insert the child into mission that way, we should rather do as Jesus did by starting with the child, placing him in the centre and then contemplating kingdom realities. “In so doing” she says “a compelling rationale for a whole person, whole gospel understanding of mission ‘to, for, and with’ [children at risk] emerges as a more robust and biblical representation of children as vulnerable agents of God” (p. 160). All that she says can and should be applied specifically to children in their FTD.

From a South African and African perspective, the writings of the African Child Theology group are recommended reading for anyone interested in the dialogue on children and church in South Africa (and beyond). The work of the group is especially necessary given the highly contextual nature of any mission endeavour and that “[M]ost of the academic literature in the field of Theologies of Childhood is from American or British-European origin” (Grobbelaar & Breed, 2016). Two volumes of articles produced by the group - Theologies of Childhood and the African Child (Grobbelaar & Breed, 2016) and Welcoming Africa’s children: Theological and ministry perspectives (Grobbelaar & Breed, 2016) - seek to establish the biblical, church and African context of the child. It will be good to see in future if this group widens the discourse to include a specific focus on FTD and to include voices from the Christian development sector where so much work is being done with children, based on a biblical motivation.

Weber and de Beer (2016) suggest we should be seeking to advance a child-friendly African continent by doing theology with, for, about and through children. They put forward some presuppositions for this theological work by proposing that children should be regarded as “collaborators in doing theology; children should be engaged not merely as objects but as subjects of research and knowledge generation; children articulate their own experiences with God; and the biblical imperatives to listen carefully to and engage with children” (p: 1). Whilst it may be challenging to hold to these propositions for children in their FTD, it is by no means impossible and theological methods need to be strengthened in how this can be done.

Bunge, in writing about the church and child wellbeing states: “Although Christianity’s long history includes foundations for and examples of child nurture and protection, Christians do and must confess they do not consistently live up to Christian teachings and must seek God’s forgiveness and renewal” (2014:584). The researchers believe that one way forward is to bring children in their FTDs more broadly into the ongoing and active conversation about theology, church and children and to develop theological theory and practice for children in their FTD. This, they believe, will contribute greatly to wholistic “thriving” in not only this age
group, but as the foundation for all age groups, and in deed for society as a whole. One framework for a theology of FTD is a missional one, which we will now explore very briefly.

**Mission by little children**

We start by considering how little children (before birth, even before conception) are agents of mission. We see this in the Bible where people such as Isaac, John the Evangelist and of course Jesus himself are spoken of as those who will be born to progress God’s purposes in mission. God certainly must have his mission in mind as new lives begin with the possibility of each one’s place in and contribution to the purposes of God.

Little children also show us the way to enter God’s kingdom. When his disciples were jockeying for positions of honour, Jesus placed a little child in the midst of them and said that in order to enter the kingdom one must become like a little child (Mark 10:13-16). If little children are our model for entering the kingdom, how might we get to know their ways, and follow their example?

Little children also teach us about Christian faith and grace, especially to their parents and close community but more generally too. Nioma Venter (2017) expands this thinking. Little children, she says, in their helpless dependency are “a hermeneutic lens for understanding the gift of faith and grace”. As such, they “give hope in a world where merit and accomplishment mostly determine the value of a person and the grandeur of his or her spiritual standing”. We can therefore declare that “More than ever, we are convinced that early life has much more to offer in getting to know and understand the living God and his compassion for creation”. Bunge (in Collier, 2009) states that “if we truly believe, as Jesus did, that children can teach adults to be moral witnesses, models of faith and sources of revelation, then we will listen more attentively to children and learn from them”. Perhaps in little children and babies, before they can speak, it is about observing them and our response to them, and learning from them in that way.

Little children are the living hope of the next generation and the means through which faith and following of Jesus Christ continues. We are told: “One generation commends your works to another; they tell of your mighty acts” (Psalm 145:4). Without little children in the chain of faith, our Christian faith will come to an end.

As is popularly stated, children are not the church of tomorrow, but the church of today. This includes little children in their first thousand days. As full image bearers of God, as those who show the way to a kingdom entered by faith through grace, and as those who are the carriers of the faith from one generation to the next, let us not forget the intrinsic missional role of little children. Let us also remember 1 Corinthians 12:22: “On the contrary, those parts of the body that seem to be weaker are indispensable”.

**Mission with little children**

Mission with little children considers all the activities of the church that seek to ensure that people in this most important foundational phase are equipped for the ‘life to the full’ that Jesus came to bring when he ushered in his Kingdom. This pertains to spiritual, social, physical and mental formation and the reduction of stunting in any of these areas of human functioning. It is in these early years that attachment and security begin to form a person’s spirituality and their receptiveness to a loving God. Therefore, a missional church should be seeking to enable conditions that put important building blocks in place for little children. Often this will take the form of helping to strengthen a nurturing environment through, for example, marriage guidance, parental training and support, family pastoring, discipleship and support. In extreme cases, churches and the homes of its members can become safe and nurturing places for children deprived of such.
Church practices of welcoming children (baptism, christening) acknowledge the little child as part of the family of faith and are an important time when the church community agrees to provide support to the child and his or her family as needed. Inclusion of little children in various ways during communion is also significant - for example by being brought to the communion table or alter rail, being prayed for and blessed and generally “included” in this church family meal without having to take the bread and wine. Churches can also provide places and practices in their gatherings that accommodate young children, breastfeeding mothers, places for fathers to be with their children. Little children even benefit from the provision of “sacred places” where they can be present and find connection with God (cf. Sagberg, 2008).

Mission for little children

And finally, there are things that the church must do on behalf of little children, things that they cannot do for themselves. The Bible says we should “Speak up for those who cannot speak for themselves, for the rights of all who are destitute. Speak up and judge fairly; defend the rights of the poor and needy (Proverbs 31:8&9). Who, if not little children and especially those in difficult socio-economic conditions, should we have in mind in reading this passage. And what are the things we should speak? It is about a mission for little children that seeks what is essential for the child in this life stage. Survival, family and a loving home, an involved mother and father, care, food, love, unconditional acceptance, safety. Church members should be informed, encouraged and empowered to live a lifestyle that is mindful of what mission for little children looks like and how they can contribute to it whatever their own life circumstances. When children are murdered, abused and neglected, or deprived of what they need to thrive, the church as follower of Jesus Christ should be the first to react. Let us never forget that amongst the harshest words ever spoken by Jesus, were those concerning harm to little children: “If anyone causes one of these little ones - those who believe in me - to stumble, it would be better for them to have a large millstone hung around their neck and to be drowned in the depths of the sea” (Matthew 18:6).

Let us therefore as church and theological community continue, with a sense of urgency and discerning God’s heart, to develop a theology of mission by, with and for little children, those in their first thousand days.

4.4 IN CLOSING

This chapter has been an attempt to locate and motivate, from both social development and theological perspectives, the role of the church as a social actor in social development, keeping in mind our particular interest in the area of FTD and being aware of barriers to the church fulfilling this role.

We end this chapter with these motivating words from the South African theologian and church historian Jerry Pillay (2017, p. 11) – let us read them with children in their first thousand days in mind, and consider what the implications might be, especially for little children at risk:

[T]he Christian church has always been involved in the transformation of society, especially as it took sides with the poor and oppressed. At times it seemed to have lost this focus, but somehow, throughout the ages, it has managed to sustain this mission responsibility. Today, more than ever, given the increasing poverty, violence and injustices in the world, the Christian church is called upon to embrace, engage and continue with its task of being an agent for transformation and change. It has to fulfil the gospel imperative of making the world a better place for all to live with justice, peace and harmony.
5 KNOWLEDGE & ATTITUDES OF CHURCH LEADERS TOWARDS FTD

This research sought to explore the current knowledge and attitude of church leaders both at a denominational level and at a local church leadership level around the topic of First Thousand Days (FTD) and Early Childhood Development (ECD). Two methods were used to answer this question, firstly the interviews with the denominational leaders and secondly the surveys with the local church pastors.

5.1 INTERVIEW FINDINGS

Denominational leaders (n=12) were asked a series of interview questions to ascertain their awareness and understanding of topic of FTD. The data below indicates the answers given:

- Denominational leaders heard of term 'first thousand days' (n=12):
  - Yes: 7
  - Yes-because of research: 2
  - Unsure: 1
  - No: 2

- Denominational leaders understanding of 'first thousand days' (n=12):
  - From Conception: 6
  - From Birth: 3
  - Unsure: 3

- Denominational leaders understanding of when faith begins (n=12):
  - In womb: 4
  - From Birth: 4
  - From Cognition: 2
  - Unsure: 2

- Denominational leaders understanding of when learning begins (n=12):
  - From Cognition: 1
  - In womb: 5
  - From Birth: 6

There is some awareness of FTD amongst the denominational leaders, with about half recognising it starting in the womb. At least 2 of the denominational leaders admitted to hearing and learning about FTD through their participation in this research. More than half of the denominational leaders interviewed are not aware of the development that happens in the womb, and therefore may not fully appreciate the importance of this critical period in a child’s life as foundational for future development.
The survey for pastors included a series of questions to ascertain their own awareness and understanding, as well as that of their congregants around FTD and ECD. The first set of questions centred on pregnancy.

Largely pastors showed positive, supportive feelings toward pregnancy, with the responsibility and desire to help and support. Only five responses indicating that they have neutral or negative feelings toward pregnant congregants. Then depending on the circumstance around the pregnancy, 12 pastors indicated that their feelings can vary.

This question was looking at stigma and judgment within the community around teenage pregnancy and pregnancy outside of marriage. According to the responses from the survey when comparing unmarried
women and teenagers, teenagers are generally less supported and more avoided and rejected by the community than unmarried women. It is noteworthy though that both pregnant teenagers and unmarried women are still ostracised in some communities. This is an area of concern too.

Respondents were asked to choose three out of a series of options for the following questions. In answer to the question below it is gratifying to see that very few respondents selected the generally ‘incorrect’ options. The responses seem to show a good general understanding from the pastor of what the pregnant women should be doing. However, 6 respondents selected the option, “She should take responsibility for her actions and not destroy the future of the father”, which is a view that absolves fathers from their joint responsibility in conception and parenthood.

The option “She should start her paperwork for child grant” has no responses. This could indicate a lack of understanding of the benefits of early access to child support grants on the developmental outcomes of infants living in poverty.
In response to “what the baby needs”, a large majority selected the key positive things that baby does need. This is encouraging.

The responses indicate that fathers have a positive role to play in caring for the baby and supporting the mother, as well as providing material needs. Importantly, indicating largely positive responses around supporting and helping the mother in the caring role as well as emotionally connecting with baby by showing love, affection and responsive interactions. This type of father involvement is important and historic gender
roles may have said that the role of the father is only to provide, however the survey results show the opposite - with only one response indicating that it is not the father’s role to get involved with the baby. It is encouraging that the responses are more on the side of fathers playing a caring, involved role. This is an asset that the church can build on. The role of fathers in the FTD is significant and should be encouraged and should not be overlooked.

There is not the scope in this research report to discuss in depth the important topic of fathers. A reference to literature is, however, helpful at this point to gain a deeper understanding of fathers and fatherhood. It is recommended to read the report published by MenCare in 2015 called “State of the World’s Fathers: A MenCare Advocacy Publication” (Levtov et al., 2015, p. 16–22).

Here are a few key finding from the MenCare report:

1. Involved fatherhood helps children thrive.
2. Involved fatherhood allows women and girls to achieve their full potential – now and in future generations.
3. Involved fatherhood makes men happier and healthier.
4. Men’s involvement in caregiving is increasing in some parts of the world, but nowhere does it equal that of women.
5. Fathers want to spend more time with their children.
6. Men’s participation and support are urgently needed to ensure that all children are wanted children.
7. Engaging men – in ways that women want – early on in prenatal visits, childbirth, and immediately after the birth of a child can bring lasting benefits.
8. Promoting father’s involvement must include efforts to interrupt the cycle of violence.
9. Children, women, and men benefit when fathers take parental leave.
10. Men’s greater involvement in care work also brings economic benefits.

There is much to be said about including men in the caring role starting in FTD. Literature points to the fact that everyone wins when fathers and men are actively involved and engaged in caregiving. Therefore, an essential part of FTD and churches’ response.

“Fathers matter. Father–child relationships, in all communities and at all stages of a child’s life, have profound and wide-ranging impacts on children that last a lifetime, whether these relationships are positive, negative, or lacking. Men’s participation as fathers and as caregivers also matters tremendously for women’s lives. And, it positively affects the lives of men themselves” (Levtov et al., 2015, p. 15).
There was a very positive response to breastfeeding in churches:

![Breastfeeding during church services](chart1)

This would seem to indicate that churches are supportive of breastfeeding and many create a space for mothers to breastfeed.

With regard to the questions of when learning and when faith formation begin, the female respondents seem to have a better understanding of the development that happens within the womb than the male respondents:

![When does learning begin](chart2)

31 The researchers realised when analysing the data that the responses offered for these two questions should have been exactly the same, for better comparison of results.
There is recognition in the responses to the above two questions, that learning (96% male & 100% female) and faith formation (78% male & 87% female) does begin in the FTD. If this is correct then services and activities in churches should align with this recognition of where it begins.

When asked the most important reason to attend an ECD (centre), 12% of respondents did not select a learning outcome as the most important reason for ECD.
FTD is a critical starting point or foundation for preparing children to be ready for school. Attending quality ECD centres or accessing quality early learning programmes is also key in the continued preparation for being school ready. According to the National Integrated Policy of ECD (NIECDP) (2015) (there is a need to increase public awareness of the value of ECD services as well as scaling up quality early learning programmes to reduce the school-readiness gap for children living in poverty and under-serviced areas (Republic of South Africa, 2015, p. 45).

### 5.3 LITERATURE FINDINGS

The ‘Early Means Early: Mapping the Gaps between Expert, Stakeholders, and Public Understandings of Early Childhood Development in South Africa’ (2016) report, “documents how people think” and identifies the gaps between what experts know about early childhood development from science and what public understanding is. The report also shows where there are overlaps in understanding. The aim of the research was to inform communication strategy that could help the public to foster optimal development for children (Lindland et al., 2016, p. 6). The ‘Early Means Early’ report is a good source to use when looking at improving church leaders’ knowledge and understanding around early childhood development in South Africa.

An example of one of the gaps in understanding between experts and the public as identified in the ‘Early Means Early’ report, is the timing of interventions. Experts assert that programmes should start with pregnant mothers and children in FTD as this is where they can have the “greatest and most enduring impacts”, however the public’s attention is more on older, school-aged children in schools and youth clubs, thinking that the most important improvements can and should be made there (Lindland et al., 2016, p. 31).

### 5.4 CONSOLIDATED FINDINGS

In exploring the knowledge and attitudes of church leaders in Cape Town, the findings point to some knowledge and awareness around the topic but leaders are not confident in their understanding. The findings seem to indicate insufficient insight and knowledge into this phase of conception, pregnancy and infancy.

There seems to be a desire to support pregnant women and recognition that fathers do have a caring role to play. Breastfeeding is supported within the church, however this does not necessarily translate into women exclusively breastfeeding. There is also some evidence of stigma and lack of support from the community around pregnant teenagers and women who are pregnant outside of marriage.

In light of the more detailed research from the ‘Early Means Early’ research and the findings highlighted in this research report, one can argue that there is room to improve the understanding around optimal early childhood development for church leaders and their congregants as well as the community. Particularly, around the importance and immense opportunity of starting early with interventions to support early childhood development.

---

32 Recommended reading: ‘Early Means Early’ 2016
One question that the research attempts to answer is “what are the barriers to mothers (and other carers) providing what is needed and accessing services during the First Thousand Days (FTD)?”

One of the motivations for this question came from the pilot intervention that the research organisation had run, where the one constraint in the pilot was the recruitment of participants. Then when working with mothers they became very aware of women not accessing services and/or not providing what was needed in the FTD.

An example of not accessing available services came from listening to women’s stories and hearing that they had not gone to the clinic to book their first antenatal visit and yet they were more than eight months pregnant. The standard in clinics is for expectant mothers to book their first visit at the clinic before 20 weeks. During their first antenatal visit, known as the booking visit, an initial full assessment and counselling are done. Then their pregnancy and health is closely monitored through regular follow-up visits (Western Cape Government, 2017, p. 1). Not accessing this key preventative health service during pregnancy is a serious concern in FTD.

In this section the findings from multiple sources of empirical data are used to understand what the barriers are for women. Firstly, findings from the interviews conducted with experts, pastors and practitioners will be discussed. Then findings from the pastors’ survey will be compared with these findings. Secondly, the findings from the mothers/carers workshop are examined. These workshops were specifically conducted in two communities, Khayelitsha and Vrygrond, where the risk factors in FTD are higher. These workshops aimed to hear the voices and perspectives of the mothers. The findings here speak to what these mothers think the barriers are in their own communities. Finally, the findings from literature are highlighted. All this data is then brought together to speak to the various constraints and barriers in the FTD for mothers and carers to access services and provide what is needed in the FTD.

6.1 INTERVIEW FINDINGS

Experts and pastors were both asked the research question, “What are the barriers to mothers (and other carers) providing what is needed and accessing services during the FTDs?” In the interviews with practitioners, the question was phrased slightly differently, “What are the biggest obstacles to children in this community flourishing in the FTDs?” The interviews were analysed thematically and responses coded. The table below shows the results using a heat map format. Within each group of respondents, the darkest colour is used to indicate the barrier most mentioned, and the lightest colour indicates the barrier least mentioned. The table itself is sorted to show the barriers most frequently mentioned across all respondent groups at the top of the table.
<table>
<thead>
<tr>
<th>BARRIER CODE</th>
<th>COMMENTS</th>
<th>EXPERTS (n=11)</th>
<th>PASTORS (n=8)</th>
<th>PRACTITIONERS (n=4)</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poverty</td>
<td>Unemployment; if employed - mother is absent (returned to work asap); no money for transport to services; food insecurity; no vitamins; no books / toys</td>
<td>6</td>
<td>5</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Knowledge</td>
<td>Lack of, or no access to knowledge about: - when life begins; - available services; - parenting skills; - importance of stimulation, verbalisation, toys (can be improvised). Lack of confidence</td>
<td>6</td>
<td>4</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Services</td>
<td>Not enough, not coordinated; long waits; not accessible; poor referral systems; target the child and not the mother; unfriendly and judgmental; Results in feeling fearful; distrustful; overwhelmed - don't report pregnancies</td>
<td>5</td>
<td>1</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Family Breakdown</td>
<td>No support; grannies caring for children; young girls evicted by parents</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>Addictions</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Nutrition</td>
<td>Malnutrition; hunger; poor distribution of food; lack of nutrition in pregnancy;</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Attitudes</td>
<td>Low morals; lazy; rebellious</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Shame</td>
<td>On drugs; not coping; 'just a mom'</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Violence</td>
<td>In home; in community; prevents access to services; stress</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Isolation</td>
<td>Need social network</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>
This analysis highlights that poverty, lack of knowledge and poor services are the major barriers experienced by parents/caregivers and their children in the FTDs as reported by experts, practitioners and pastors.

In addition to the Comments expanding on each Barrier in the table above, the following quotes from the interviews give additional insight into these barriers:

**Poverty:**

The economic reality of households where everyone needs to be earning is also a huge barrier. Because you’re taking the parents away from the kids. And then they are needing to go to day care or after care, in crowded environments. From a very young age they don’t have the mother and father present all the time. It is a huge obstacle. (Pastor)

**Services & violence:**

It is bloody difficult to get to clinics. Clinics are open at really stupid hours. The booking system sort of works and sort of doesn’t. I was working in Manenberg and often women couldn’t get to where they were going because of the gang lands or they were fearful of doing that. (Expert)

**Services:**

Overused and insufficient services... wait 2 days at the clinic... people won’t do it as it is a waste of time. Clinics are overfull. Rather go to work than go to the clinic.... that way of delivering services is outdated. (Expert)

People working in this space don’t spend time in the community with mother. Not targeting their interventions well. Often stigmatized services on what they ‘think’ is happening. Inadequate support for mothers as they target child. (Practitioner)

**Family breakdown:**

Then there are grannies that have the burden of looking after the children. They are sometimes very angry that they have been dumped with it. (Expert)

**Shame:**

Some mothers might feel ashamed or even afraid that someone will take their children away from them, when they see the condition of the child or find out that they are on drugs. (Pastor)

Stigma around not coping and a child that is crying and a child that is not thriving that is tied to shame.... Guilt – maybe I shouldn’t have been working during pregnancy... (Expert)
6.2 PASTORS’ SURVEY FINDINGS

In the survey there was not a question specifically about barriers to FTD, but respondents were asked to select the 4 social issues most affecting their congregants. The results to this question were further analysed according to the socio-economic index of the area in which the church is located.

Although the survey question was not specific to FTD, the top 5 issues most affecting congregants relate closely with the barriers identified in the previous section:

- High Unemployment, Low wages ≈ Poverty
- Absent Fathers; Poor Parenting, Neglect of Children ≈ Family Breakdown
- Crime & Violence ≈ Violence
- Substance Abuse (named in both sections)

It is also interesting to note that the top 8 social issues are recognised across all socio-economic groupings. These findings show a recognition between what are identified barriers and what are key issues in the communities. This congruency is positive. This is not unknown information to the church leader. The church leaders do understand the concerns of their congregants.
6.3 MOTHERS / CARERS WORKSHOP FINDINGS

The aim of the mothers/carers workshop was to hear the voices of mothers/carers from areas in the city (Khayelitsha & Vrygrond) where children are at risk in the FTD. The intent was to hear from the women what the barriers are, based on their experience and knowledge of their communities. During the mothers/carers workshop a number of questions were asked. The findings that are relevant to this section are discussed below.

Current sources of FTD help

One question asked was “within our community, where is there help during pregnancy and the first 2 years of a child’s life?”

A large response from Vrygrond mothers was that there is no help available and/or people are unaware of the services that are there to help in the FTD, as well as low score for medical facilities. This is an indication of the barrier of poor services and/or the lack of knowledge in their community. In Khayelitsha, more women spoke of medical facilities being available and few local NGO services, which was the opposite of what is available in Vrygrond. This indicates the help that is available in the two communities is different. The findings also indicate that there is more help available in Khayelitsha for FTD than in Vrygrond.

Barriers in communities

The following are the key findings from the mothers/carers workshop regarding why services are, or are not accessed.

Use of available FTD help?

In Vrygrond and Khayelitsha, there were a few that said, “yes, people do use this help”. In Vrygrond they also said that people would use the services “if they knew about services” and “if we had services”. In Khayelitsha, some said that people don’t make use of this help because of “avoidance of issues” and “afraid of stigma”. Barriers identified here to accessing available services are stigma, lack of services and lack of knowledge.
Largely poor service levels at the clinic (including long waits at health facilities) and transport issues were cited as the main barriers. Then lack of safety due to violence, gangsterism and lack of policing are also preventing people from accessing services. In Vrygrond, women need to travel far (by taxi or by foot) to the nearest clinic and Midwife Obstetrics Unit (MOU), hence cost and availability of transport being a barrier as well as lack of safety to access services that are mainly outside of the community.

The ‘Other’ indicates the responses that were not as comprehensive, especially from the Khayelitsha group. ‘Other’ includes comments like “they are busy”; “carelessness (for they drink a lot)”; “negligent”; “abuse”; “lack of attention”; “parent disinterested”; and “lack of education of mothers”. These responses seem to point to the individual mother/carers’ own barriers and behaviours that are stopping them from accessing help.

The following quotes from the mothers give additional insight into these barriers:

**Services**

There is a strong perception of poor service levels from medical facilities, and there are no services in Vrygrond.

> Sometimes they miss one appointment then the next one is difficult because of the behaviour of the health workers. (Khayelitsha Mom)

> No primary health care, only Seawinds clinic (outside of Vrygrond/Capricorn). (Vrygrond Mom)

> Moms sometimes don’t book because of the way they are treated. They wait until the last minute to give birth and turn up at the M.O.U. (Vrygrond Mom)

> The nurses don’t care. Because it’s always full, they don’t always do the correct examinations which results in them give us the wrong medication for our children. (Vrygrond Mom)

> When our children are sick the nurses don’t seem to understand or give us a voice to speak, they always shut us down. (Vrygrond Mom)

---

33 The responses recorded for this question from the participants in Khayelitsha were not as detailed as from the participants in Vrygrond.
They criticize others because of their race e.g. Foreigners who don’t belong here, you have too many kids, don’t know what to do as a mother, they make you feel worthless. (Vrygrond Mom)

The ambulance won’t come into the area because they say they don’t know the area. (Vrygrond Mom)

**Poverty = Transport costs**

- Inability to reach where help is found, due to lack of funds. (Khayelitsha Mom)
- It’s all outside of our area and it’s too far to walk. (Vrygrond Mom)
- Retreat Clinic, is too far and we don’t have travelling fare. (Vrygrond Mom)

More clinics, child and mom friendly clinics, mobile clinics and longer clinic hours were all suggested as solutions.

**Shame and stigma**

- People judge others when they see the carers or social workers visiting their homes, they think they visit because they are HIV positive. (Khayelitsha Mom)
- Some parents are drinking so they don’t work with carers, they will tell or advise them to stop drinking. (Khayelitsha Mom)

**Knowledge**

- Moms are uneducated of what it is to be a mother. (Vrygrond Mom)

**Attitude**

- Parents are neglecting services because they just not interested. (Vrygrond Mom)

6.4 LITERATURE FINDINGS

When reviewing the literature around FTDs, various barriers and constraints where mentioned. These are highlighted below, along with their sources.

**Barriers to and in antenatal services**

**Poor quality of services and transport**

The South African Early Childhood Review 2017 states that the primary barriers to antenatal service are “poor handling of women and girls’ private and confidential information; the need for accurate and readily accessible health information; and the cost and transport implications associated with visiting clinics, particularly for those living in rural areas” (Hall et al., 2017, p. 26). “Health system audits have shown that in general, maternal care services, including postnatal care, lack quality and require strengthening” (Hall et al., 2017, p. 26).
Barriers to participate in playgroup services

Work
Cotlands early learning playgroups (ELPGs) reported that “recruitment of participants to these groups has proved to be a challenge” (Van Niekerk et al., 2017, p. 101). Cotlands found that the reason for women, who were interested in the groups, was that they would need to go out to work and therefore were not able to attend the playgroups with their children.

Culture
Cotlands also found that the cultural context also impacted some areas “there are taboos around physically touching children, and this programme has many elements of baby massage incorporated into it” (Van Niekerk et al., 2017, p. 101).

Barriers to accessing services of child support grant (CSG)

Poor quality of services
The NIECDP explains that access to the CSG has increased, 76% of all eligible children are now receiving the grant. However, “there is a consistent trend amongst caregivers to delay the application for CSG for their infants until after the child is 1 or 2 years old” with grant up-take peaking at around 4 years old (Republic of South Africa, 2015, p. 42–43). “This points to barriers in accessing the grant in the first year of life – the period when children are arguably most in need of nutritional foods, access to health care and other forms of support; it is also the period during which access to the grant has the largest impact on early development” (Republic of South Africa, 2015, p. 42–43). More specifically, there is a known pattern that the lowest uptake rates for the CSG is in the Western Cape and Gauteng (Hall et al., 2017, p. 30). “Possible reasons include that social security officials in wealthier provinces act as gatekeepers, making it more difficult for people to apply, or that greater population density results in long queues that deter applicants” (Hall et al., 2017, p. 30). “This ‘error of exclusion’ is of concern because it tends to be the most vulnerable and needy children who do not access the grant” (Hall et al., 2017, p. 31). “Early registration of births is important because birth certificates are the gateway to other services and benefits, such as the CSG” (Hall et al., 2017, p. 30).

Barriers to accessing services

Maternal mental health
Maternal mental health has an impact on mothers’ ability to access service and results in the “lower uptake of available services” (Turner and Honikman, 2016, p. 1164). Turner and Honikman (2016), explain that “this is the result of several factors, including a compromised ability to plan effectively, together with low levels of energy and motivation and fear of discrimination. Decreased access to care, in turn, leads to adverse maternal and child outcomes, which further add to levels of stress and consequently increase mental health problems. Similar vicious cycles of escalation exist between many risk factors and mental health problems” (p. 1164).

Barriers to exclusive breastfeeding (EBF)
The EBF rates for babies (6 months and younger) is reported to be at 8% in South Africa (du Plessis, 2015, p. 103).
Mothers’ lack of knowledge
Du Plessis (2015) found in literature that the persistent constraints to EBF for mothers “include lack of knowledge, the perceived insufficiency of breastmilk to satisfy an infant’s needs, cultural practices and societal influences” (p. 103).

Poor quality of services
Breastfeeding is seen as a prioritised nutritional intervention however, the implementation seems to be “constrained by poor quality counselling, including nurses’ weak knowledge and skills, the inconsistent training of health workers on breastfeeding, healthcare staff shortages, and suboptimal monitoring and evaluation” (du Plessis, 2015, p. 103).

Workplace limitations
The workplace creates challenges on mothers to EBF, this includes “insufficient maternity leave and facilities at work which are unsupportive of breastfeeding” and then there are other legislative and policy issues that need to be urgently addressed (du Plessis, 2015, p. 104).

Barriers to infant and young child nutrition (IYCN)

Lack of knowledge of practices
Du Plessis (2017), conducted research in the Breede Valley, Western Cape, and found that “stakeholders displayed good understanding of the links between IYCN and the development of the child but they lacked the knowledge around appropriate IYCN practices” (du Plessis, 2017, p. 11). The research also found that the factors influencing feeding practices also came from the issues within the community like poverty as well as poor service delivery from government and poor community response (du Plessis, 2017, p. 11–12).

6.5 CONSOLIDATED FINDINGS
The above findings from multiple sources of data attempt to give an understanding, from different perspectives, as to the complex nature of barriers and constraints to mothers/carers accessing services and providing what is needed in the FTDs. The findings point to the fact that there is not one single barrier. Instead the barriers are complex, with layers of barriers that impact on each other. At an individual level there are barriers like personal poverty (lack of resources to provide, food insecurity, costs of transport) and personal well-being of the mother/carer (maternal mental health, lack of knowledge, feelings of shame and guilt). There is also the economic pressure to return to work which creates a variety of barriers, especially for EBF.

At a community level there are barriers like lack of quality services that are easily accessible. Other community barriers include lack of safety, as well as cultural and social norms in the community. Services differ from one community to another. The picture that emerges from the two very different communities (Vrygrond and Khayelitsha) is that Vrygrond is underserved with services, especially health services; however has a strong NGO presence. This as opposed to Khayelitsha where there are reportedly better government, social and health services but more difficulties with stigma. Therefore one needs to look at a micro or community level to address barriers.

The barriers to and in the health services seem to be well known by experts, practitioners, pastors, mothers and are also shown in the literature. These include poor quality of care; long queues; inadequate treatment of women which includes judgement, shame and stigma; as well as transport costs to access the health
services. Within the health services there also seems to be the lack of adequate training and qualifications of staff on the topic of FTD.

These barriers and constraints can become a vicious circle. For instance, inaccessible poor quality service prevents women from making the extra effort and incurring expenses to move toward accessing the services. If their psychological well-being is low they are less likely to push through the various obstacles to access services that are of poor quality. This is even more so if the mothers'/carers' motivation, knowledge and value around the importance of the particular service is also very low.
7 CURRENT CHURCH RESPONSES TO FTD

Anecdotally, one hears of some activities that churches in Cape Town are engaged in that relate to the First Thousand Days (FTD). In investigating what the role of churches could be, the research sought to use several of the data gathering exercises to explore in more depth what churches are currently doing in FTD – either within their own congregation, or within their wider community. The three main groups of key informants were denominational leaders, church pastors and church laity. Each of these groups has insight at different levels on what is currently happening in their respective churches, and across denominational and socio-economic lines. In the area of early childhood development (ECD) churches in Cape Town are most actively engaging with children 3 to 6 years of age, whereas the current responses in FTD tended to be minimal with a general focus on parenting support and with the notable exception of any meaningful activities that engage specifically with fathers.

7.1 INTERVIEW FINDINGS

Denominational services

Denominational leaders were asked if their denominations offered services to the following target groups:

- Pregnant mothers
- Expectant fathers
- Parents/caregivers
- Babies (0-2 yrs)
- Children (3-6 yrs)

Analyses of their responses are depicted in the chart below:
Areas where denominations have most formal programmes are in services to pregnant mothers and children 3 – 6 years.

**TABLE 4: Formal Programmes offered by Denominations**

<table>
<thead>
<tr>
<th>EXAMPLES OF FORMAL PROGRAMMES OFFERED BY DENOMINATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pregnant Mothers</strong></td>
</tr>
<tr>
<td>Home for single, pregnant women (place of safety)</td>
</tr>
<tr>
<td>Trained community care workers (2 programmes)</td>
</tr>
<tr>
<td>Embrace groups (FTD)</td>
</tr>
<tr>
<td><strong>Expectant Fathers</strong></td>
</tr>
<tr>
<td><strong>Parents / Caregivers</strong></td>
</tr>
<tr>
<td>Badisa (social work institution)</td>
</tr>
<tr>
<td>Own parenting course/workshop (2 programmes)</td>
</tr>
<tr>
<td><strong>Babies (0-2yrs)</strong></td>
</tr>
<tr>
<td>Statutory prog for abandoned babies - 15 places of safety</td>
</tr>
<tr>
<td>Embrace Groups (FTD)</td>
</tr>
<tr>
<td><strong>Children (3-6yrs)</strong></td>
</tr>
<tr>
<td>Orphan/foster care prog, Cluster foster care home</td>
</tr>
<tr>
<td>Statutory prog - 33 CYCCs</td>
</tr>
<tr>
<td>Smart Start (ECD centre)</td>
</tr>
<tr>
<td>Kids Clubs</td>
</tr>
</tbody>
</table>

The table above lists some of the formal programmes that are denominationally led. These formal programmes are generally specialised, professionally run organisations that fall under child protection facilities and then ECD centres for children 3-6 years. In a few of the denominations these are large organisations or NGO’s that have been in existence for a very long time. However, they don’t necessarily directly work into FTD or with a local congregation, with some exceptions. None of the denominations mentioned a formal programme for expectant fathers, though some at a congregational level have men’s groups, and fathers are included in parenting trainings. When asked about the effectiveness of these programmes, there is no hard evidence, though some can provide anecdotal evidence by way of testimonies or stories of positive change.

**Congregational services**

Eight pastors who had completed the survey were interviewed. It is important to note that they were selected based on the quality of answers they provided in the survey and the level of engagement in the topic in comparison to the rest of the survey respondents. From the survey results these churches generally seemed to be more actively involved hence they were selected for the in depth interviews. However, when comparing their services to the chart above it is noticeable that they are no more engaged in FTD than at a denominational level, especially with regards to pregnant mothers and expectant fathers.
The chart below highlights the areas where no services are provided:

![Chart showing areas with no services](chart)

It is interesting to note the corresponding shape of the blue curve on both charts above – this shows that the least services are offered to expectant fathers, and most services are available to children 3-6 years.

The table below provides information on the types of services that are offered by the above eight churches:

**TABLE 5:** Services offered by 8 churches interviewed

<table>
<thead>
<tr>
<th>SERVICES OFFERED (N = 8)</th>
<th>EXAMPLES OF SERVICES OFFERED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant Mothers</td>
<td>2 Parent Capacity Development: Course - Expectant couples, Antenatal Classes</td>
</tr>
<tr>
<td>Expectant Fathers</td>
<td>1 Parent Capacity Development: Course - Expectant couples</td>
</tr>
<tr>
<td>Babies (0-2yrs)</td>
<td>5 Parent Support: Mom's Group Child Education: Play group, Day Care Spiritual: Sunday - crèche, nursing area, parents' room (where sermon can be heard) family-friendly services Material Resources: Baby ministry - washing &amp; feeding babies</td>
</tr>
<tr>
<td>Children (3-6yrs)</td>
<td>8 Spiritual: Sunday School (mentioned by 7/8) Child Education: Educare, Aftercare Material Resources: Transport to / from school</td>
</tr>
</tbody>
</table>
7.2 PASTORS SURVEY FINDINGS

The survey of church pastors from Cape Town asked a number of questions to explore the level of engagement with the topic of FTD and services offered by these churches. In the survey, pastors were asked if they had preached on a number of topics, as listed in the table below:

<table>
<thead>
<tr>
<th>Have you ever preached on the following topics?</th>
<th>% Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family planning (n=65)</td>
<td>44.6%</td>
</tr>
<tr>
<td>Unplanned pregnancies (n=66)</td>
<td>54.5%</td>
</tr>
<tr>
<td>Effective parenting (n=65)</td>
<td>81.5%</td>
</tr>
<tr>
<td>Preached on all 3 (n=69)</td>
<td>26.1%</td>
</tr>
</tbody>
</table>

Only a quarter of pastors surveyed had preached on all three topics and around 50% had never preached on family planning or unplanned pregnancies.

Pastors were also asked to describe any services they provided to the five target groups discussed previously. Most participants did not provide answers to these open-ended questions – it is reasonable to conclude that in most cases this is because their church does not actually provide any services to these groups:

What is common across both the interviews and surveys conducted with pastors is that services to expectant fathers is the least served area, and the target group receiving the most services is children in the age group 3-6 years.

Where pastors did provide detail on the services they offered, these were analysed thematically and the results are depicted using a heat map with darker colours indicating the services most mentioned and lighter colours for those with fewer mentions:
**TABLE 6: Services offered by local churches**

<table>
<thead>
<tr>
<th>SERVICE CATEGORY</th>
<th>COMMENTS</th>
<th>PREGNANT MOTHERS</th>
<th>EXPECTANT FATHERS</th>
<th>PARENTS / CAREGIVERS</th>
<th>BABIES (0-2YRS)</th>
<th>CHILDREN (3-6YRS)</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support</td>
<td>Congregational support, coaching, counselling, social worker, ministry group, baby room/crèche during Sunday services</td>
<td>14</td>
<td>10</td>
<td>13</td>
<td>11</td>
<td>3</td>
<td>51</td>
</tr>
<tr>
<td>Spiritual</td>
<td>Prayers, baptism, Sunday school</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>25</td>
<td>38</td>
</tr>
<tr>
<td>Capacity</td>
<td>Teaching: effective parenting, healthy food, prenatal classes</td>
<td>7</td>
<td>7</td>
<td>13</td>
<td>2</td>
<td>0</td>
<td>29</td>
</tr>
<tr>
<td>Resources</td>
<td>Baby shower, clothing (mother &amp; baby), financial, nappies, blankets, milk &amp; porridge, toys, books, gifts</td>
<td>4</td>
<td>0</td>
<td>5</td>
<td>5</td>
<td>7</td>
<td>21</td>
</tr>
<tr>
<td>Education</td>
<td>Early learning centre, nursery, pre-school, play therapy</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>5</td>
<td>12</td>
<td>19</td>
</tr>
<tr>
<td>Health</td>
<td>Information, nursing sisters/midwives, baby washing, home visits, referrals clinic</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>NGO</td>
<td>Links to NGOs</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
</tbody>
</table>

|                  | 33                           | 21               | 36               | 29                   | 47             | 166               |

The services most offered to pregnant mothers and expectant fathers are of a supportive nature, with some offering capacity development workshops/training. Capacity development initiatives do seem to be mostly targeted at those who are already parents/caregivers, and this group also benefits from formal supportive services like ministry groups and counselling. Many survey respondents also mentioned general congregational support. For children 3-6 years, by far the most frequently mentioned service (and across all target groups) is Sunday school. It would seem this is the service area in which the church is most comfortable.

Survey respondents were also asked who they thought should be providing services to these target groups – they could indicate any one or all of the following as service providers: local churches, government, non-profit organisations, and private businesses. The results to this question are depicted in the chart below:
It is probably reasonable to conclude that government services (especially health services) are needed by pregnant mothers and their babies. That aside, survey participants definitely believe that churches are a major role-player in the provision of services, particularly to parents/caregivers. This is an important finding when considering what the role of the church could be in FTD. Church leaders recognised that the church does have a key role to play.

## 7.3 CHURCH LAITY WORKSHOP FINDINGS

The church laity workshop understanding of current church responses was classified as follows:

<table>
<thead>
<tr>
<th>Current church responses</th>
<th>0</th>
<th>2</th>
<th>4</th>
<th>6</th>
<th>8</th>
<th>10</th>
<th>12</th>
<th>14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parenting Support</td>
<td>14</td>
<td>12</td>
<td>10</td>
<td>8</td>
<td>6</td>
<td>4</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Parenting Capacity</td>
<td>12</td>
<td>10</td>
<td>8</td>
<td>6</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Development</td>
<td>10</td>
<td>8</td>
<td>6</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Child Education</td>
<td>10</td>
<td>8</td>
<td>6</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Material Resources</td>
<td>10</td>
<td>8</td>
<td>6</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Spiritual</td>
<td>6</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Protection</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Health</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Below are more detailed responses and some quotes from the workshop, specifically focusing on what churches are currently doing in the area of FTD.

### Parenting support and capacity development

Most responses by far fell into this category. Parenting support and capacity development can take several forms:

1. **Premarital classes**: Where some parenting information and discussion is included.

   *Our church has premarital classes which include training around expecting parents and the well-being of a child. (Church laity)*
2. **Skills training and transfer**: Often through relationship or informally.

   It’s about being in a relationship where you can be given emotional support and through this relationship skills are also transferred. (Church laity)

3. **Small groups/cell groups**: Where there is a focus on parenting support, including those expecting children.

4. **Parenting and antenatal classes**

5. **Psycho-social support for mothers**: Counselling for drug addicted moms, moms in crisis or trauma.

6. **Moms groups**: Distinct from parenting which seeks to include both parents. This seems to be more prevalent within the wealthier congregations, or those economically mixed.

   We have a mom’s group at our church every second week. When I was pregnant this was a good support system. Within our church we have both economically wealthy and poorer moms. It was hard having both moms in the group especially since we are looking at things from different views and our material needs are different. (Church laity)

**Material Resources**

Some churches are responding to the needs with material support, such as:

1. Soup kitchens, food parcels
2. Care package incl. baby food, nappies etc.
3. Baby clothes

   We have a baby ministry (newborn until 18 months). It happens every Wednesday when we have our soup kitchen. We make a bottle for them and feed them, we then bath them and provide them with a ‘care package’ which includes purity, nappies etc. (Church laity)

**Working with or through an NGO**

One way that some churches are responding is by working with or through a local NGO.

1. Community based development programmes run by church through its NGO arm
   a. Building capacity of local church to respond to community needs
   b. Running a health centre
   c. Running a crèche and pre-school support

   Our church has an NGO arm. We do parenting and awareness workshops in our community. We support preschools as well as connect and network with the children’s parents. (Church laity)

2. Using or volunteering for an NGO programme: e.g. Shine early stimulation training for moms.

**Provision of crèche facilities**

There are two distinct types of care facilities being provided by churches:

1. On Sundays

   Churches have “crèche” which is more like a baby-sitting club. (Church laity)
2. During the week

*In Khayelitsha, churches are used to open up ECDs. Local pastors’ wives take it up free of charge, church members volunteer. (Church laity)*

**Other responses**

Some occasionally mentioned responses did not fit into the categories – below are other mentions:

1. An opportunity for evangelism and discipleship

*Local churches offering support, stimulation, love through moms and tots groups so becomes a tool for evangelism and discipleship. (Church laity)*

2. Churches responding in crisis only

*Churches tend to address these issues when there is a crisis. (Church laity)*

3. Some referrals and connections by and through the church

*We link with a local clinic happening in the church. (Church laity)*

**No (or a negative) response**

In answering what churches are currently doing, some responses focused more on the negative of what the church is doing (or not doing).

1. Several mentions that the church was not doing enough in FTD
2. A mention of a negative response by church to single pregnant teens

*Shaming and chastising of single pregnant teens who then drop out of church, but same is not done to single pregnant adults. We need to do better. Grace? Forgiveness? (Church laity)*

3. Responses by the church not seen as developmental

*What we see in churches: Relief work, cry rooms, nothing developmental. Nothing that follows the science. (Church laity)*

**7.4 CONSOLIDATED FINDINGS**

The findings in this section have highlighted the areas in which various churches are involved but at the same time point to many gaps in churches current services and activities which meaningfully target the critical period of FTD. One of the notable gaps is the intentional engagement with fathers. Traditionally Sunday school programmes have been the main focus area for churches, targeting predominantly children 3-6 years; this is evident in the findings.

In the survey, pastors indicated that churches have a major role to play in FTD. However, this role is not reflected in what the church is currently doing. It seems that various churches do have different responses to this area. However, the activities specifically for FTD seem very scattered and ad hoc and seem to be lacking in intentionality around the science and developmental significance of FTD. The services also do not directly address the barriers outlined in the research.
EXISTING MODELS & APPROACHES IN SUPPORT OF FTD

The research attempted to identify which first thousand day (FTD) models and programmes are showing signs of successful implementation and impact both locally and internationally. In so doing, the intent was to identify models that could be used or adapted by churches and also point to possible partners that exist for church-based FTD work. The research has also attempted to highlight financial models that could be investigated further to sustain and scale FTD work in churches. The two main sources of findings in this section are experts and practitioners as well as what was found in literature.

Early Childhood Development (ECD) services have various ways of being delivered. In South Africa, most children who are currently accessing ECD services are accessing it through ‘non-centre-based programmes’, defined as “any ECD programme, service or intervention provided to children from birth until the year before they enter formal school, with the intention to promote the child’s early emotional, cognitive, sensory, spiritual, moral, physical, social and communication development and early learning” (van Niekerk et al. 2017, p. 16).

These non-centre-based ECD services can also provide support to parents and caregivers and within South Africa “these services are generally provided by trained members of the community through NPOs and/or government departments” (van Niekerk et al. 2017, p. 16).

This research made use of the National Integrated Policy of ECD (NIECDP) (2015) categories to give a framework for understanding the different models and programmes for the various early childhood development services and support. The NIECDP has based these categories on scientific evidence of important, appropriate early childhood development interventions, services and programmes (Republic of South Africa, 2015, p. 25).

The following categories are presented in the NIECDP (Republic of South Africa, 2015, p. 25–28):

1. Parenting support and capacity development
2. Child-centred social security
3. Health care
4. Free birth registration
5. Food and nutrition support
6. Safe and affordable day care for children where parents are absent
7. Early learning support services
8. Protection from abuse, neglect and exploitation
9. Play and recreational facilities
10. Inclusive and specialised services for children with disabilities
11. Early childhood development information

The NIECDP has positioned these categories in terms of what should be provided publicly by the Government. Not all of these categories of services and support are relevant to this research and not all were mentioned in the interviews. The categories that have not been discussed are “Inclusive and specialised services for children with disabilities” (due to being out of the scope of this research); “Free-birth registration” (due to being a unique government service); “Safe and affordable day care for children where parents are absent”; and “Play and recreational facilities”. The order has also been changed in order of most mentioned in the interviews.
In this section, when discussing existing models, it is also important to note that interventions should enable parents, caregivers and family to provide ‘nurturing care’ and protection in order for young children to achieve their developmental potential, as discussed in chapter 3. The Lancet Series emphasises that studies of interventions from around the world (including Jamaica, Pakistan, and Turkey) have shown that including elements of ‘nurturing care’, significantly improves childhood development and even later adult outcomes (Britto et al., 2017, p. 92).

Expert and practitioner interviewees were asked to share their knowledge of existing FTD models/interventions. When the literature was reviewed, models/interventions were identified that were relevant to this research. The models that were identified by the interviews and literature are categorised by intervention type in the tables below.

(Please refer to Appendix E for a brief description of each of the models listed, and links to websites for more information, if available).

## 8.1 PARENTING SUPPORT AND CAPACITY DEVELOPMENT

It is well recognised that the family is the natural environment for the growth and well-being of children. Parents are primarily responsible for promoting their children’s development and well-being (Republic of South Africa, 2015, p. 25). Unfortunately, many caregivers in South Africa are faced with multiple adversities and stressors, they are in need of support and care in order to provide the responsive, nurturing care their children need (Hall et al., 2017, p. 24). The NIECDP asserts that parenting support programmes, are “a proven intervention for building constructive parental-child relationships and effective parenting practices” and that they “are critical for parents who are raising children in the context of high levels of poverty; chronic illness and disability; violence; and other social risk factors” (Republic of South Africa, 2015, p. 43). Parent support programmes are an essential component of the comprehensive package of ECD services (Hall et al., 2017, p. 24).

The aim of parent support programmes is to improve parental knowledge, behaviour, interactions, capacity, beliefs, attitudes and practices to support parents in their role as nurturing, responsive caregivers (Britto et al., 2017, p. 94; Hall et al., 2017, p. 28). The South African government see its role as to “provide support, capacity development, counselling and, where necessary, resources to parents or, in their absence, primary caregivers to strengthen the nurturing parent-/caregiver-child relationships” (Republic of South Africa, 2015, p. 25).

The implementation of supportive parenting programmes varies in frequency of the intervention, setting, and curriculum as well as making use of different settings including community support groups; parent enrichment programmes; regular clinic visits; media; home visiting; and or a combination of these (Britto et al., 2017, p. 94; Hall et al., 2017, p. 24; Ilifa Labantwana, 2013, p. 26; Republic of South Africa, 2015, p. 25).

> The importance of psychosocial support to caregivers and children cannot be overstated (Ilifa Labantwana, 2013, p. 26).

Specialist parental support is especially important and relevant, given the data showing the number of vulnerable caregivers living in poverty and affected by mental health concerns, substance abuse and exposure to violence and abuse among other social problems (Hall et al., 2017, p. 28; Ilifa Labantwana, 2013, p. 26). Well targeted programmes in the FTD are critical and have the opportunity to provide support around issues of adjusting to motherhood and fatherhood; influencing responsive and nurturing care; encouraging
and supporting breastfeeding; and bonding with the infant (Hall et al. 2017, p. 26; Ilifa Labantwana, 2013, p. 26).

Examples of specific models or programmes mentioned in the interviews and in the literature:

<table>
<thead>
<tr>
<th>CATEGORY OF INTERVENTION</th>
<th>MODELS MENTIONED IN INTERVIEWS</th>
<th>MODELS MENTIONED IN LITERATURE</th>
</tr>
</thead>
</table>
| Parenting Capacity Development: | Care for Child Development (CCD)  
Care Up Mobile App  
Family in Focus Programme (FIF) *  
Head Start  
Living Hope Moms & Tots Group  
Parent Centre Teen Pregnancy Programme  
Proud to be Me  
WC First Thousand Days | Care for Child Development (CCD)  
Crece Contigo  
Family in Focus Programme (FIF) *  
Family Outreach Programme *  
Integrated ECD Community Development Programme*  
National Parenting Programme  
Reach Up and Learn*  
Roving Caregivers*  
Sobambisana Initiative *  
Triple P |
| Parenting Support: | Care for Child Development (CCD)  
Cape Town Embrace  
Family and Community Motivator (FCM) *  
Nyamekela 4 Care  
The Step-Programme *  
Philani*  
The Parent-Infant Programme *  
Ububele *  
Zoe Project | Care for Child Development (CCD)  
Colombia Home Visiting Intervention  
Family Outreach Programme *  
Ibhayi Lengane *  
Integrated ECD Community Development Programme*  
Mae Coruja  
MomConnect  
Pastoral del Nino  
Primeira Infancia Melhor *  
Sobambisana Initiative *  
The Parent-Infant Programme * |

(*Programme includes home visiting) Some of the models mentioned in this table are highlighted in the paragraphs that follow. A short description of each model can be found in Appendix E.

**Care for Child Development (CCD)**

One of the models that was mentioned a number of times was Care for Child Development (CCD). CCD was developed by WHO and UNICEF. The Lancet series affirms that it is a tested parenting programme that promotes nurturing care, and is among the most widely implemented in low to middle income countries (Richter et al., 2017, p. 105). The CCD programme can be delivered across various sectors by home visitors and community workers as well as facility-based providers through various health, early learning, family, mental health and social protection services (Richter et al., 2017, p. 105). Findings also suggest that the programme can be incorporated into existing health services at relatively low cost (Richter et al., 2017, p. 105).
Home visiting and Community Health Workers (CHW)

Home-based early childhood development activities (home visiting) are generally implemented by trained community health workers (CHW) or ward-based outreach teams (WBOT) and run by the Department of Health and other government sectors or through NGOs (Black et al., 2017, p. 10; Republic of South Africa, 2015, p. 70). The Lancet Series pointed out that “there is a broad evidence base supporting home-based interventions to build parenting capacity” and improving child outcomes extending into adulthood (Black et al., 2017, p. 10).

The NIECDP indicates that from the Government’s’ side “there is a strong imperative for the provision of early and intensive support by trained home visitors to vulnerable families, beginning antenatally, and continuing through birth and until the age of 2 years” (Republic of South Africa, 2015, p. 25).

Home visiting programmes target all stakeholders in the FTD depending on the targeted outcome. Generally the purpose is to provide information, health and nutritional support, and psychosocial support for parents and caregivers. The support of early learning and development can be given as well as the promoting of referrals and networking to support services (Republic of South Africa, 2015, p. 70). Home visiting is one of the most successful strategies for reaching the most vulnerable in the FTD, especially for caregivers and children who are either far from services, unable to access services or lack the awareness of the importance of services (Biersteker, n.d. p. 6; Republic of South Africa, 2015, p. 70).

Research in South Africa on home visiting programmes in vulnerable communities showed significant changes in parent behaviours, stimulation practices, health and safety as well as linking families to social grants and other services (Biersteker, n.d. p. 5). Biersteker (no date) explains that for pregnant women and infants, home visiting had a positive effect on attachment and stimulation (p. 5). International studies in Jamaica, Brazil and India have shown positive outcomes of home visiting on various outcomes (Biersteker, n.d. p. 5).

Psychosocial support groups for maternal mental health

The Lancet Series found that “psychological interventions delivered by local CHWs, for women with antenatal depression in low and middle income countries showed positive effects on reducing maternal depression” (Britto et al., 2017, p. 94). The benefits for the children include improved mother-infant interaction, and improved health and cognitive development (Britto et al., 2017, p. 94).

In South Africa AFFIRM-SA trialled the task-sharing counselling intervention in two MOUs making use of trained CHW to reduce symptoms of depression among pregnant women (Lund et al., 2017, p. 13). Overall they found that the intervention resulted in significant reduction in depression, however the results also show that there is room for improvement as the results were not as good as similar studies in other countries (Lund et al., 2017, p. 13–14). The conclusion from the trial emphasises that “feasible interventions, using task-shifting can successfully impact positively on maternal depression in the Western Cape” (Lund et al., 2017, p. 14).

Turner and Honikman (2016) emphasise the value of empathic care groups for the maternal mental health of all women during the perinatal period. Turner and Honikman (2016) explain that these spaces need to be safe and caring; where active listening is used to understand women’s problems, and mothers are empowered by being assisted in finding their own solutions. This support can include practical stress reduction strategies as well as referral systems for vulnerable women (Turner and Honikman, 2016, p. 1166). Turner and Honikman (2016) observe that with this kind of intervention, many women do not need specialist care for their mental health, as they respond well to “empathic care provided by general health workers” (p. 86).
The Lancet Series also found that recent trails of group-based parenting programmes improved maternal mental health in community settings, which in turn improved child outcomes (Britto et al., 2017, p. 94). This is a key finding because with increased access to these kinds of psychosocial support groups, more women’s mental health will be cared for without the need of expensive, inaccessible, limited specialised care.

**Evaluations and evidence based data in literature**

In South Africa there is no national data available on the provision and access to parenting support and capacity development programmes across the country; this is an important data gap (Hall et al., 2017, p. 28; Republic of South Africa, 2015, p. 43). The nonprofit sector provides the majority of the available parenting support programmes, however, the quality of the programmes offered and the benefits to early childhood development has not been determined (Republic of South Africa, 2015, p. 43).

More specifically, parent education programmes in South Africa commonly include a wide range of topics (Ilifa Labantwana, 2013, p. 26). The caution here is that ‘holistic’ parenting programmes that include a wide range of topics can suffer from the “limitation of insufficient time spent on each area” and the outcomes can be limited (Ilifa Labantwana, 2013, 26). Ilifa Labantwana (2013), “holds the position that the design and delivery of parenting programmes should be informed by evidence, and the content and outcomes of such programmes should be clearly defined” (p. 26).

Internationally there have been evaluations of various types of programmes and the Lancet ECD Series highlighted the notable ones with the intention of scaling these programmes. A few highlights of what the Lancet series explained:

- Trials show that combined group sessions and home visits produce better outcomes than home visits did on their own (Britto et al., 2017, p. 94).
- “The most effective parenting programmes used several behaviour-change techniques, including media such as posters and cards that illustrate enrichment practices, opportunities for parental practice of play and responsive talk with their child, guidance and support for changing practices, and problem-solving strategies” (Britto et al., 2017, p. 94).
- “Parenting programmes that combine nutrition and stimulation have been effective in improving child cognitive and language development outcomes” (Britto et al., 2017, p. 94).

The Lancet Series points out that “taken together, the results suggest that parenting support programmes that promote nurturing care and protection can substantially augment the positive effects of basic health and nutrition, education, and protection interventions on early child development outcomes” (Britto et al., 2017, p. 94).

Ilifa Labantwana (2013) asserts the importance of trained staff in providing psychosocial support to vulnerable parents and caregivers. However, Ilifa Labantwana (2013) also says that there is “much to be said for warm, supportive companionship” (p. 28). Especially, in South Africa where there is a need to support the large number of families living in poverty and other circumstances that undermine their parenting capacity (Republic of South Africa, 2015, p. 43).

---

34 Suggested further reading: The Lancet ECD Series
The simple provision of opportunities for the caregiver to share her difficulties with an attentive and compassionate support person is enormously helpful, providing relief from what may seem like insurmountable everyday burdens (Ilifa Labantwana, 2013, p. 28).

8.2 CHILD-CENTRED SOCIAL SECURITY

The legacy of South Africa’s past continues to impact negatively on children caught in the cycle of intergenerational poverty marked by striking racial disparities (Van Niekerk et al., 2017, p. 13). Living in poverty as discussed in Chapter 3, is associated with high degrees of stress and negative early childhood outcomes (Britto et al., 2017, p. 94). One of the most effective poverty alleviation interventions are social grants because of their positive impact and wide reach (Hall et al., 2017, p. 30). Social assistance is one way of redistributing resources to the poor through the mechanism of grants (Hall et al., 2017, p. 30). Increasing family income in the first four years of a child’s life, especially those living in poverty, has a greater impact on early childhood development than other determinants of optimal development of infants and young children (Republic of South Africa, 2015, p. 42–43).

In the FTD, protecting households from the stress and insecurity that comes with poverty is “one of the most promising and cost effective investments to secure early childhood and human development” (Republic of South Africa, 2015, p. 25). The earlier the social assistance is accessed, the greater the impact. Social assistance through cash transfer programmes “in the early years improves young children’s health and development, especially their cognitive, emotional, language and fine motor development and has a positive effect on their schooling” (Republic of South Africa, 2015, p. 25).

Examples of specific models or programmes mentioned in the interviews and in the literature:

<table>
<thead>
<tr>
<th>CATEGORY OF INTERVENTION</th>
<th>MODELS MENTIONED IN INTERVIEWS</th>
<th>MODELS MENTIONED IN LITERATURE</th>
</tr>
</thead>
</table>

Some of the models mentioned in this table are highlighted in the paragraphs that follow. A brief description of each model may be found in Appendix E.

Child Support Grants (CSG):

In South Africa the Child Support Grants (CSG) is the main grant for children living in poverty, providing an income support for caregivers (Hall et al., 2017, p. 30). The CSG has proven to be an effective child poverty-alleviation programme within South Africa (Republic of South Africa, 2015, p. 42–43). The CSG is a cash transfer of R380 per month (2017) per child, paid to primary caregivers whose income falls below the means-test income threshold. The CSG forms part of the broader social protection programme in South Africa, which includes free and/or subsidised health care, water, sanitation and education (Republic of South Africa, 2015, p. 42–43).

There is well documented, convincing evidence of the impact of CSG, especially where the grant is accessed early, in the first 12 months of the child’s life. CSGs have significant developmental value and impact on early childhood development, child nutrition, health and educational outcomes (Republic of South Africa, 2015, p. 42–43). The grants improve food security and nutrition, especially in very poor households which in turn
increases child height, especially for girls (Biersteker and Goeiman, 2017, p. 8). Early access to the CSG is very important, yet the uptake for the CSG remains the lowest for infants under a year (Hall et al., 2017, p. 30). The grant is available to all children whose caregivers qualify and have registered the birth, they are able to start receiving the CSG within the first month of the child’s life, however, it is concerning that there is a slow uptake of CSG for infants under a year (Hall et al., 2017, p. 30).

The substantial developmental impact of CSG on children and their families living in poverty is important. However, Hall et al. (2017) also states that “more needs to be done to address income poverty and inequality, especially in light of new trends showing that poverty has increased since 2011” (p. 30).

### 8.3 FOOD AND NUTRITION SUPPORT

Nutrition during the FTD is critical in breaking the cycle of inequality. Adequate nutrition provides the necessary “building blocks for brain development, a healthy body and a good immune system” (du Plessis, 2017, p. 11). The NIECDP states that “poor nutrition in these crucial periods can lead to irreversible stunting and developmental delays, resultant poor cognitive development, and ultimately lower educational and labour market performance” (Republic of South Africa, 2015, p. 26). This in turn contributes to persistent inequality (Hall et al., 2017, p. 18). The NIECDP describes that two direct factors that result in malnutrition are inadequate food intake and illness in young children. The underlying determinants to malnutrition are “food insecurity, inadequate maternal care, insufficient health service, poor hygiene and unhealthy environments” (Republic of South Africa, 2015, p. 42).

Concerning the nutritional situation in South Africa:

- There is a high level of poor nutrition among young children, with vitamin A deficiency being regarded as a significant public health concern, and 27% of children under 3yrs are stunted (Republic of South Africa, 2015, p. 42).
- Malnutrition is a key driver for under-five mortality with severe acute malnutrition in children younger than 12 months increasing, indicating poor feeding practices and inadequate or no breastfeeding (Republic of South Africa, 2015, p. 42).

Du Plessis (2017), explains that in the Western Cape, the specific areas of concern in nutrition in FTD include household food insecurity/hunger; low exclusive breastfeeding (EBF); childhood stunting; childhood overweight and obesity; maternal overweight and obesity as well as poor maternal micronutrient status (p. 11).

Interventions to improve maternal and child nutritional outcomes include micronutrient supplementation, immunisation, education about breastfeeding and child nutrition, and income support through social grants (Hall et al., 2017, p. 18).

Examples of specific models or programmes mentioned in the interviews and in the literature:
Table 9: Models for Food & Nutrition Support mentioned in Interviews & Literature

<table>
<thead>
<tr>
<th>CATEGORY OF INTERVENTION</th>
<th>MODELS MENTIONED IN INTERVIEWS</th>
<th>MODELS MENTIONED IN LITERATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food and nutrition support</td>
<td>Philani* Zero Stunting Programme</td>
<td>Breastfeeding Support Human Milk Banking Micronutrient Supplementation Mother Baby Friendly Initiative (MBFI) / Baby-Friendly Hospital Initiative Nutrition Guidelines for ECD Centres</td>
</tr>
</tbody>
</table>

Some of the models mentioned in this table are highlighted in the paragraphs that follow. A brief description of each model can be found in Appendix E.

**Exclusive Breastfeeding (EBF) and breastfeeding support**

Internationally, breastfeeding is emphasized as the best way to feed an infant. The Lancet Series concluded that the benefits of breastfeeding for child’s health are clear with “reducing mortality and morbidity from infectious diseases, encouraging healthy food preferences, and promoting the establishment of a healthy gut microbiome” (Britto et al., 2017, p. 95). The Lancet series says that recent reviews show “evidence that optimal breastfeeding supports improved performance in intelligence tests in childhood and adolescence” (Britto et al., 2017, p. 95). The Lancet Series also refers to findings from another study showing “a dose-response association between breastfeeding duration and increased child intelligence, educational attainment, and income at the age of 30 years” (Britto et al., 2017, p. 95).

Exclusive breastfeeding (EBF) is breastfeeding until the infant is 6 months old with no other food or drink (Department of Health South Africa, 2016, p. 6). Breast milk contains all the necessary nutrients for the infant’s growth and protects against illness and infection, as well as strengthens the emotional bond between mother and child (Hall et al., 2017, p. 19–20). Unfortunately, in South Africa, infant feeding practices are sub-optimal and the rates of EBF are low, only 8% of infants (6 months and younger) are EBF and 1 in 4 children are not breastfed at all (Hall et al., 2017, p. 19–20; du Plessis, 2015, p. 103; Republic of South Africa, 2015, p. 42). At the same time of great concern in South Africa is the common practice of mixed feeding. Many infants below 6 months are given water, tea or other liquids or even diluted maize meal porridge as infant formula instead of breastmilk for some of their feeds (Department of Health South Africa, 2016, p. 6). The NIECDP explain that “a refocus is required to support women to continue to breastfeed for as long as possible (only 13.4% of children being breastfed at 20 -23 months) (Republic of South Africa, 2015, p. 42).

The Tshwane declaration of support for breastfeeding in South Africa (2011)

The Tshwane declaration noted that “promotion, protection and support of breastfeeding requires commitment and action from all stakeholders, including government and legislators, community leaders, traditional leaders and traditional healers, civil society, healthcare workers and managers, researchers, and the private sector, employers, the women’s sector, the media and every citizen” (Anon, 2011, p. 214). The Tshwane declaration asserts that “we specifically resolve that: South Africa declares itself as a country that actively promotes, protects and supports exclusive breastfeeding, and takes actions to demonstrate this commitment. This includes further mainstreaming of breastfeeding in all relevant policies, legislation, strategies and protocols” (p. 214). The declaration calls on all stakeholders and every citizen to support and strengthen efforts to promote and protect breastfeeding (du Plessis, 2015, p. 104). Du Plessis (2015), argues that the importance of nutrition in eliminating poverty and reducing inequality, is emphasised in the National
Development Plan. This plan requires the adoption of a “whole society approach.” The success of interventions points to a multidimensional approach that draws on all sectors and stakeholders together (du Plessis, 2015, p. 104).

**Micronutrient supplementation**

Malnutrition is a serious challenge in developing countries which undermines survival, growth and development of children (Britto et al., 2017, p. 96). Micronutrient deficiencies are associated with stunting and severe acute malnutrition, and are a matter of national concern in the children with the prevalence of vitamin A deficiency, anaemia and iron deficiency (Britto et al., 2017, p. 96; Republic of South Africa, 2015, p. 42).

- Iron, is needed for new red blood cells, also assists in growth and development as well as help the body fight infections. With insufficient iron children develop anaemia, with 1 in 10 children below 5 years are anaemic (Department of Health South Africa, 2016, p. 1)
- Vitamin A deficiency is a major contributor to childhood illness and death, with 4 in 10 children 0-5 years with a deficiency (Department of Health South Africa, 2016, p. 1)

The Lancet Series states that “given the wide prevalence of multiple micronutrient deficiencies in malnourished children, there is a need to implement interventions that combine micronutrient interventions with appropriate infant and young child feeding” (Britto et al., 2017, p. 96). The Lancet Series discussed various reviews of different types of supplementation interventions including multiple micronutrient supplementation, iron supplementation and then supplementary food given and responsive feeding. Each of them showed different results with varying improvements in psychomotor development and cognitive development (Britto et al., 2017, p. 96).

Part of the intervention in the South African Public Health Sector is growth monitoring and promotion as well as Vitamin A supplementation, provided by the Department of Health, for free, to help prevent deficiencies and malnutrition (Department of Health South Africa, 2016, p. 24).

8.4 HEALTH CARE

The provision of basic primary health care in the FTD is a requirement of the government. The NIECDP recognises the rights of infants and young children to the provision of basic health care. This basic health care should include “access to basic preventative and curative medical care for pregnant women and children, prevent health threats to development and provide early diagnosis and intervention when a problem is discovered” (Republic of South Africa, 2015, p. 26).

There has been an improvement in the public provision of health services since 1994, as well as “significant improvements in the health status of children in South Africa” with infant and child mortality rates decreasing and national immunisation rates at 95% (Republic of South Africa, 2015, p. 40–41). However, the NIECDP also recognises that despite these improvements, the health gains of young children are “muted by the variable levels of access to, and quality of, public health services, especially among historically vulnerable African children living in poverty in provinces with strong rural character and living in under-serviced informal urban areas” (Republic of South Africa, 2015, p. 41).
The concerning health status in SA:

“More than a quarter of African children, and 34 per cent of those living in the poorest 20 percent of households, have to travel far (more than 30 minutes) to their nearest primary health-care facility” (Republic of South Africa, 2015, p. 41).

“While antenatal care coverage is high at over 90 per cent, less than half of women attend before 20 weeks of pregnancy, while those attending do so only for an average of three visits, thereby minimising the opportunity for early identification of and effective intervention in problems in pregnancy” (Republic of South Africa, 2015, p. 41). Other areas of concern have to do with high incidences of diarrhoeal disease, and pneumonia, in children under five years, due to insufficient prevention, poor caregiver response to symptoms, and compromised access to water and sanitation services for vulnerable children (Republic of South Africa, 2015, p. 41). Access to clean drinking water and adequate sanitation remains a concern for many young African children in urban informal and rural areas (only 40% of young African children enjoy flushing toilets) (Republic of South Africa, 2015, p. 41).

It is estimated that one in three mothers are affected by antenatal and postnatal depression and anxiety (Hall et al., 2017, p. 26). Maternal depression is common, yet it “is frequently not identified or treated because maternal mental health services are currently not universally integrated into the primary healthcare system” in South Africa (Hall et al., 2017, p. 28). This is an important issue for both the mother and the child. Child outcomes such as “physical growth, immunisation, HIV testing and treatment adherence, and emotional state can be affected by the mental health of the caregiver” (Hall et al., 2017, p. 26).

The NIECDP admits that “the current health framework is marked by a number of Policy challenges related to young child health, which include limited parenting preparation and support; mental health screening and support; and the provision of support and referrals for maternal domestic violence and substance abuse” (Republic of South Africa, 2015, p. 41).

Examples of health care service models mentioned in the interviews and in literature:

**TABLE 10: Models for Health mentioned in Interviews & Literature**

<table>
<thead>
<tr>
<th>CATEGORY OF INTERVENTION</th>
<th>MODELS MENTIONED IN INTERVIEWS</th>
<th>MODELS MENTIONED IN LITERATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>Care for Children Development (CCD)</td>
<td>Antenatal Care (ANC)</td>
</tr>
<tr>
<td></td>
<td>David Olds – Nurse Family Partnership *</td>
<td>Kangaroo Mother Care</td>
</tr>
<tr>
<td></td>
<td>FARR</td>
<td>Lady Health Workers in Pakistan *</td>
</tr>
<tr>
<td></td>
<td>Hello Doctor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MSF Baby Clinic</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Step-Programme</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Perinatal Mental Health Project (PMHP)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Philani *</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** The home visiting programme mentioned in the above section, often has a health and nutritional component to the programme. See Appendix E (*Includes home visiting*)
Antenatal care (ANC)

Support of mothers begins with antenatal care (ANC), which is a critical preventative intervention for protecting the health of a mother and her child (Hall et al., 2017, p. 12). The intervention is important in reducing poor pregnancy outcomes; for the prevention of stunting and HIV in young children and reducing Foetal Alcohol Syndrome (FAS) (Hall et al., 2017, p. 12). Women are encouraged to attend ANC before 20 weeks in pregnancy, which is important in accessing primary health and nutrition services, for both mother and child, and mental health screening and referrals (Hall et al., 2017, p. 12–13). Unfortunately, around 40% of first antenatal visits happen after 20 weeks into pregnancy (Hall et al., 2017, p. 12). There is room to improve early attendance of antenatal visits with women attending public antenatal care visiting at least four times during pregnancy (Hall et al., 2017, p. 25). One risk of non-attendance, late attendance and infrequent attendance of ANC is perinatal death as well as patient-related maternal mortality, which is avoidable (Hall et al., 2017, p. 25).

8.5 EARLY LEARNING SUPPORT SERVICES

Parents and caregivers are the first and most important teachers in the FTD period of a child (Republic of South Africa, 2015, p. 26). In the FTD the child has the right to the exposure of quality early learning and development.

The NIECDP stipulates that the provision of early learning and stimulation requires:

1. “Supplying parents and other caregivers with information and support to enable them to understand and fulfil their role in children’s early learning” (Republic of South Africa, 2015, p. 27).
2. “Providing community- and centre-based organised play-based early learning programmes that complement the parents’ role and that are developed in partnership with parents and early childhood development professionals” (Republic of South Africa, 2015, p. 27).

In the FTD most children are not in formal programmes but are in the care of their parents or other caregivers in their homes. In the FTD learning starts to take place at birth, through nurturing relationships with caring adults in the child’s life (Hall et al., 2017, p. 34). The NIECDP points out that currently there is “no meaningful funding, training or quality management and improvement plan to ensure that early childhood care is provided to children in the age group birth to 2 years” (Republic of South Africa, 2015, p 44). Hall et al. (2017), highlight that data from the 2015 General Household Survey showed that nationally, 17% of children birth to 2 years were reportedly attending an early learning programme (p. 34). Hall et al. (2017), state that “it is difficult to interpret these data meaningfully because many group learning programmes are inappropriate for children of this age” and therefore “better data are needed on the full range of early learning programmes targeting 0-2 year old children” (p. 34).

Programmes discussed earlier, such as home visiting and parenting support are designed to enrich the caregiver’s engagement with the child and are “extremely important” for a child’s early development (Hall et al., 2017, p. 34). In South Africa, van Niekerk, Ashley-Cooper and Atmore (2017), conclude that the most effective and critical initiatives in reaching the most marginalised children who cannot afford access to formal ECD centres are family outreach programmes and informal playgroup programmes (p. 16).

Examples of specific models or programmes mentioned in the interviews and in the literature:
TABLE 11: Models for Child Education mentioned in Interviews & Literature

<table>
<thead>
<tr>
<th>CATEGORY OF INTERVENTION</th>
<th>MODELS MENTIONED IN INTERVIEWS</th>
<th>MODELS MENTIONED IN LITERATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Education</td>
<td>Book Sharing, Clothing Bank Grow With, Cotlands Toy Library, ELRU 1st 1000 days programme, Nalibali, Smart Start, Ububele</td>
<td>Cotlands Early Learning Playgroups Programme (ELPG), Cotlands Toy Library, Informal Playgroup Programmes</td>
</tr>
</tbody>
</table>

A short description of each model can be found in Appendix E.

8.6 PROTECTION FROM ABUSE, NEGLECT AND EXPLOITATION

The NIECDP affirms that “research has shown that in toxic stress, when the infant or young child is exposed to or experiences abuse, neglect, violence, etc., high levels of the stress hormone (cortisol) is produced that disrupts the process of brain development, which limits proliferation of brain cells and damages the health, learning and behaviour of the infant and young child...this requires that measures be implemented to protect young children from abuse, including corporal punishment” (Republic of South Africa, 2015, p. 27).

Examples of specific models or programmes mentioned in the interviews and in the literature:

TABLE 12: Models for Child Protection mentioned in Interviews & Literature

<table>
<thead>
<tr>
<th>CATEGORY OF INTERVENTION</th>
<th>MODELS MENTIONED IN INTERVIEWS</th>
<th>MODELS MENTIONED IN LITERATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protection</td>
<td>David Olds - Nurse Family Partnership (Home Visiting), Triple P – Positive Parenting Program</td>
<td></td>
</tr>
</tbody>
</table>

A brief description of each model can be found in Appendix E.

Prevention of Child Maltreatment

Violence, especially violence in the home, is a key public concern in South Africa. Maltreatment in childhood is associated with physical changes in the brain structure. The Lancet Series points out that children, especially in the FTD, “who receive inadequate care, are more sensitive to the effects of stress and display more behavioural problems than do children who receive nurturing care (Britto et al., 2017, p. 96).

The Lancet Series explains that interventions that prevent maltreatment, with the best evidence that shows positive results “are selective programmes (e.g., Nurse Family Partnership) characterised by intensive visits by professional home visitors and beginning prenatally... early interventions that occurs before the onset of abusive and neglectful parenting is crucial to preventing maltreatment” (Britto et al., 2017, p. 96). The Lancet Series also states that “there is an urgent need for more rigorously evaluated maltreatment prevention interventions in low to middle income countries, focusing on parenting and child outcomes, and adapted for low resource contexts” (Britto et al., 2017, p. 96).
The NIECDP assert that “while parents, caregivers and children have a right to timely and accessible” information”, “very little is currently available in terms of national communications campaigns relaying pertinent early childhood development messages” (Republic of South Africa, 2015, p. 28 & 45).

According to the NIECDP, communication aimed at parents should enable them to:

- “Understand what they can do to improve their children’s nutrition, health and early learning;
- Protect their children, and engage in positive discipline and refrain from corporal punishment;
- Understand and demand quality early learning and development;
- Understand the importance of play in the early learning and development of their children;
- Foster parent-child interaction;
- Access support and early intervention services for children with disabilities;
- Build understanding of the roles of mothers and fathers in early childhood development” (Republic of South Africa, 2015, p. 45).

This messaging should be evidence based and must be consistent across all communication mediums (Republic of South Africa, 2015, p. 45).

The ‘Early Means Early’ report provides insights into the patterns of public thinking to inform communication with research-based recommendations. The report is positioned to give a plan “for a communication strategy that can be used to help people think more productively about the importance of supporting parents, families, and communities as they seek to foster optimal development for children” (Lindland et al., 2016, p. 6).

Examples of specific models or programmes mentioned in the interviews and in the literature:

**TABLE 13: Models for ECD Information mentioned in Interviews & Literature**

<table>
<thead>
<tr>
<th>CATEGORY OF INTERVENTION</th>
<th>MODELS MENTIONED IN INTERVIEWS</th>
<th>MODELS MENTIONED IN LITERATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Childhood development information</td>
<td>Radio Drama</td>
<td>WC First 1000 Days Campaign</td>
</tr>
<tr>
<td></td>
<td>#LovePlayTalk</td>
<td></td>
</tr>
</tbody>
</table>

A brief description of each model can be found in Appendix E.
8.8 FINANCIAL MODELS

This research sort to explore relevant financial models that could be used in scaling and sustaining FTD work and that could be investigated further. However, the information that was gathered from the interviews did not point to any specific tangible financial models. There was some mention of making use of the South African Expanded Public Works Programme (EPWP) which “aims to provide poverty and income relief through temporary work for the unemployed to carry out socially useful activities at the EPWP” (Western Cape Government, 2017). One sector that EPWP creates work opportunities in is through “the Non-Profit Organisation Programme (NPOP) and Community Work Programme (CWP) under the Non-State sector” (Department Public Works, 2013). This was suggested, by experts, as one avenue of funding for FTD work. However, they also cautioned that this is not an easy avenue of funding for organisations.

The Lancet ECD Series, part three, ‘Investing in the foundation of sustainable development: pathways to scale up for early childhood development’ shows that:

“the burden of poor development is higher than estimated, taking into account additional risk factors. National programmes are needed....Effective and feasible programmes to support early child development are now available. All sectors, particularly education, and social and child protection, must play a role to meet the holistic needs of young children. However, health provides a critical starting point for scaling up, given its reach to pregnant women, families, and young children. Starting at conception, interventions to promote nurturing care can feasibly build on existing health and nutrition services at limited additional cost. Failure to scale up has severe personal and social consequences. Children at elevated risk for compromised development due to stunting and poverty are likely to forgo about a quarter of average adult income per year, and the cost of inaction to gross domestic product can be double what some countries currently spend on health. ...”Abstract (Richter et al., 2017)

The Lancet Series, based on their review of the science and programme evaluations, propose “three illustrative packages” that make use of the principles and the findings in their review. These three packages are namely “Family support and strengthening package”; “Multi-generational nurturing care package”; and “Early Learning and protection package” (Britto et al., 2017, p. 98). (Read the Lancet ECD Series for more information).

The Centre for ECD (CECD) wrote a research report, released in March 2017, ‘Effective early childhood development programme options meeting the needs of young South African children’. This report gives current information about the implementation of twelve best-practice ECD programmes in South Africa. For each of the twelve programmes in the report there is a costing of each programme. The report then gives cost comparisons (p. 285 & 286) and recommendations for ECD funding models (p. 291). One finding from the CECD report is that finding long-term funding for programmes is generally difficult for many organisations, especially smaller organisations that don’t have a proven track record. This has an impact on the roll-out of ECD programmes in South Africa (van Niekerk, Ashley-Cooper and Atmore, 2017, p. 285).

The CECD report’s specific recommendation for FTD programmes is that there needs to be a substantial increase in funding for ECD programmes focusing on FTD. The report explains that in this age group, children are generally at home and most do not have access to centre-based facilities. For this reason, funding is specifically needed to support out-of-centre programmes targeting the youngest children and their
caregivers in order to lay the foundations for the children to reach the full potential (van Niekerk, Ashley-Cooper and Atmore, 2017, p. 291).

Other literature points to studies that suggest that “the cost of parent-focused interventions compares favourably to that of other interventions, such as day-care and preschool, and a cost-benefit analysis showed that, in at least some setting, parent-focused programmes may lead to high returns on investment. Parent-focused programmes are, therefore, likely to be cost-effective” (Biersteker, n.d. p. 3). At the same time “evaluations of parent-focused interventions suggest that parent-alone information-based interventions are less effective than interventions in which the change agent worked with both the parent and the child” (Biersteker, n.d. p. 3).

The South African government recognises the need for investment of resources “to support and promote the optimal child development from conception” (Republic of South Africa, 2015, p. 8). Therefore the NIECDP has listed programmes that the government will develop, fund and implement in order to scale up ECD services, this includes home visiting and parent group programmes that are “offered in homes, clinics and other community centres”. These programmes will “provide information about self-care, health and nutrition, early learning, stimulation, and service referrals, as well as to build social support networks amongst parents” (Republic of South Africa, 2015, p. 70).

Other programmes and services that the NIECDP has listed to develop, fund and implement include childminders caring; playgroups; toy libraries; early learning programmes; mobile early childhood development programmes; and media (Republic of South Africa, 2015, p. 70).

When looking at the literature to understand the financial model, the researchers recognise the need for further investigation into this topic. One helpful resource for further investigation is ‘The Heckman equation’ which has researched and quantified the return on investment of early childhood development programmes (https://heckmanequation.org/).

### 8.9 CONSOLIDATED FINDINGS

The NIECDP explained that in order to effectively reach all children with early childhood development services there is a need to scale up both centre and non-centre based programmes (Republic of South Africa, 2015, p. 69).

The above findings from interviews with experts and practitioners as well as from literature has discussed the range of FTD models and programmes that are showing signs of successful implementation and impact both locally and internationally. The findings also gave insights to some evaluations done on interventions as well as where there are gaps in understanding or available data. The models that are generally found in literature are predominantly from the perspective of what is scalable at a national and international level. This then impacts on what is accessible for local churches to partner with. However, it is important for churches to be aware of what is happening in the FTD space as far as working models that are based on evidence and scientific understanding of early childhood development.

Significantly, the Lancet ECD Series also acknowledged that there is “a notable gap in published reviews on the role of fathers in promoting nurturing care and protection” (Britto et al., 2017, p. 94). This gap in existing models or approaches that engage with fatherhood is a much-needed area to be invested in and researched further.
It is essential to take into account that this research report has not evaluated any of the above-mentioned models/interventions/programmes. This report is not making any evaluative judgements on models discussed. The hope is to give an informative outline of what has come to the fore in the process of researching the topic. It is at the readers’ discretion to decide what is applicable in their context, with the information at hand.

The research also attempted to understand financial models that could be investigated further to sustain and scale FTD work. Considering the findings that came to the fore in the process of this research, there is a need to investigate the topic further. The research did not come across any existing financial models.

The Lancet ECD Series concluded that:

“successful, smart, and sustainable interventions to improve developmental outcomes need to: promote nurturing care and protection; be implemented as packages that target multiple risks; be applied at developmentally appropriate times during the life course; be of high quality; and build on existing delivery platforms to enhance feasibility of scaling up and sustainability ... The nature of these interventions will continue to progress as new understanding of early human development emerges”(Britto et al., 2017, p. 99).
ROLE OF THE CHURCH IN FTD

This research has sought to explore, “What is the role of the church in support of the First Thousand Days?” (FTD). This bigger question was broken down into three sub questions. Firstly, “What is the possible role of a church in a high risk area (CHRA)?” Secondly, “What is the possible role of a church in a low risk area (CLRA)?” Thirdly, “What advocacy role is or could the church be playing in FTD?” Multiple methods were used to explore these questions, namely the survey, interviews and workshops. Firstly, the findings from the pastors’ survey are discussed, then briefly the findings from the mothers/carers and church laity workshops are highlighted. Lastly the large volume of qualitative findings from the experts, denominational leaders, pastors and practitioners’ interviews are brought together with findings from the workshops. These findings are discussed in order of categories of interventions mentioned.

9.1 PASTORS SURVEY FINDINGS

Pastors who participated in the survey were asked, in an open-ended question, to describe the role in FTD of a well-resourced church and a church in a vulnerable area. The responses were analysed thematically and the results are depicted using a ‘heat map’ format where dark colours indicate most frequent responses and lighter colours less frequent responses.

TABLE 14: Role of Church

<table>
<thead>
<tr>
<th>INTERVENTION CATEGORY</th>
<th>COMMENTS</th>
<th>CHURCH IN HIGH RISK AREA</th>
<th>CHURCH IN LOW RISK AREA</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support</td>
<td>Love; congregational support; help each other; support groups; counselling; mentoring; babysitting services; support for single parents, young mothers, grandmothers; encouragement; emotional support; inclusion. Making space available, safe spaces, safe homes.</td>
<td>25</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>Capacity Development</td>
<td>Antenatal classes; parenting skills; how to keep kids safe; health &amp; safety;</td>
<td>13</td>
<td>19</td>
<td>19</td>
</tr>
<tr>
<td>Resources</td>
<td>Food, books, Bibles, toys, clothes, nappies, transport</td>
<td>15</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>Education</td>
<td>For children: stimulation; after care; day care; crèche; playgroup; early learning; free childcare; build centres for games</td>
<td>19</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Spiritual</td>
<td>Sunday school; preaching importance of women &amp; children; family model</td>
<td>8</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Community</td>
<td>Involvement, training community workers, Awareness progs, well-resourced churches to assist / work with community church, work with NPOs, Work with DOH, DSD</td>
<td>7</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Health</td>
<td>Drugs, abuse, home visits, immunisation &amp; feeding, clinic, encourage breastfeeding, report abuse</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Advocacy</td>
<td>Govt red tape</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Job Support</td>
<td>CVs, Interviews, skills</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Adolescent</td>
<td>Programmes for teenagers</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>No more progs</td>
<td>Parents too busy to spend time with children</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
The role of providing support, especially as it pertains to providing a ‘safe space’ in the community for mothers and children (in both a physical and emotional sense) is seen as important for both churches in low risk areas and churches in high risk areas. Capacity building and providing material resources are also seen as important roles for churches. However, in vulnerable areas, the church is seen to have a role in providing educational services for children – this is to be expected, as schools in vulnerable areas are often not providing good educational opportunities (though pockets of excellence in Education do exist in vulnerable areas).

9.2 MOTHERS/CARERS WORKSHOP FINDINGS

The mothers/carers were not asked specifically about the role of the church. However, they were asked what they think would most help the pregnant women and mothers of young children in their community:

The three strongest suggestions across the two communities are: support group; counselling and skills training for (young) mothers; and home visiting. The combination* of three similar suggestions that fall into the category of education and skills training (young mothers, maternal and paternal) has been strongly identified as a service that would most help pregnant women and mothers of young children, as expressed by mothers and carers from the communities, more specifically in the Vrygrond area.

The findings from the mother/carers workshop will be cross-tabulated with other findings in the following sections looking at specific areas of intervention or roles that the church has in FTD according to interview findings.
In terms of the role of the church, this group explored two questions.

**Question 1: It is 2025, the church is responding well to FTD. What do we see the church doing?**

The following open codes were identified:

- Parenting support
- Church: Collaborating & networking
- Parenting capacity building
- Church: Connecting with community
- Church: Using spiritual gifts
- Church: Aligning with what already happening
- Church: Whole church responding
- Church: Wealthier providing funding
- Material resources
- Church: Empowering the community
- Church: Sharing
- Church: Vision
- Church: Welcoming children
- Church: Doing what govt can’t
- Negative treatment during pregnancy
- Health
- Church: Educate church leaders re FTD
- Church: Being flexible

The church laity workshop identified: parenting support; the church collaborating and networking; and parenting capacity building as the top three areas that the church is doing in 2025, amongst a long list of other suggestions.

**Question 2: How can Christians in their everyday lives contribute to FTD?**

The following codes were identified:

- Parenting support
- Church members increase knowledge about FTD
- Church members advocate
- Material resources
- Parenting capacity building
- Church: Educate church leaders re FTD
- Church: Collaborating and networking
- Church: Sharing resources
The overwhelming response to this question from the church laity was parenting support. Here are some quotes from the church laity workshop that help to understand what this parenting support looks like as an everyday response for Christians.

Strengthening of parents, families and teenagers:

1. Support motherhood

   Groups of moms gather in homes (babies under 6 months). Pray for moms and group.
   Mothers who have babies under 6 months invite older moms for gospel and support.
   Open homes particularly for moms. Extend over boundaries. (Church laity)

2. Family strengthening

   I would love to see the average person to get involved and not only expect our NGO arm to do all the work. The whole church should partner even if it’s through personal connections and relationships e.g. A mom can connect with another mom or a family with another family.
   Coming alongside families – can you act as a buffer in a tense “unwanted” pregnancy to come alongside mom. This needs to be driven by the church/pastors attitude to reduce shame.
   Build relationship with the mom and child, then adopt the family unit and invite them in our home for social gatherings. (Church laity)

9.4 INTERVIEW FINDINGS

Experts, denominational leaders, pastors and practitioners were asked to give their opinions on the role of the church in FTD. They were specifically asked to differentiate between the role of a church in a high risk area and a church in low risk area - the two heat maps below show the analysis of these responses.

**TABLE 15: Role of Church in High Risk Area**

<table>
<thead>
<tr>
<th>INTERVENTION CATEGORY</th>
<th>COMMENTS</th>
<th>EXPERTS (n=11)</th>
<th>DENOM LEADERS (n=12)</th>
<th>PASTORS (n=8)</th>
<th>PRACTITIONERS (n=4)</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support</td>
<td>Sharing, listening &amp; relationships alleviates depression, mother-child bonding &amp; attachment, loving baby vs. violence, involve fathers, Groups for pregnant mothers, Moms &amp; Tots groups, mom's groups, mother-to-mother peer support, social networks prevent isolation &amp; depression, available safe spaces, church as place of safety, mentoring, counselling, referral to services, childcare (for working parents), home visits, include divorcees, single parents, children born out of wedlock</td>
<td>8</td>
<td>8</td>
<td>6</td>
<td>3</td>
<td>25</td>
</tr>
</tbody>
</table>
Across all interviewee groups there was consensus that the most important role of the church in a vulnerable area is to provide support to parents. These churches are also seen to have a role in building the capacity of parents – especially around parenting skills, providing resources to vulnerable families, providing educational/stimulation services for children, and then effecting changes within the church – especially around delivering factual information to overcome misconceptions or lack of knowledge.
### TABLE 16: Role of Church in Low Risk Area

<table>
<thead>
<tr>
<th>INTERVENTION CATEGORY</th>
<th>COMMENTS</th>
<th>EXPERTS (n=11)</th>
<th>DENOM LEADERS (n=12)</th>
<th>PASTORS (n=8)</th>
<th>PRACTITIONERS (n=4)</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support</td>
<td>Loneliness, breakdown of families can lead to depression, stress, anxiety, pressure, spend time with kids, support groups for mothers, mentoring fathers, parents working with other parents, home visits, economically comfortable parents still vulnerable emotionally</td>
<td>7</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td>17</td>
</tr>
<tr>
<td>Connect</td>
<td>Create connections with marginalised communities, greater awareness of needs, develop relationships, partner/twin well-resourced church with under-resourced church and financially assist them, share skills (doctors, social workers), train locals, pastors come together, provide volunteers, provide educational material. Create networks support with local service providers, networks of resources &amp; information, connect with government, match moms from 2 communities</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>2</td>
<td>16</td>
</tr>
<tr>
<td>Resources</td>
<td>Channel money, gifts, skills to vulnerable, nutrition packs, vitamins, knitting blankets, making preschool play equipment, food, clothing, transport money to clinics, baby boxes</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Capacity Development</td>
<td>Parenting classes, self-worth, faith formation in children, make info available - DVDs, access to mobile apps</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Education</td>
<td>For children: limit screen stimulation, nursery schools, ECDs (esp. for parents can’t afford fees)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>NGO Support</td>
<td>Support existing organisations, fund project staff, provide skills, collaborate, take to scale, make them more sustainable, don’t reinvent wheel, volunteers from church, financial support, local congregations support children’s homes, refugee care</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Job</td>
<td>Income generating skills, work opportunities</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Advocacy</td>
<td>To employers - keeping mother &amp; child together</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Change within</td>
<td>Fathers involvement</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Health</td>
<td>Harmful effects substance abuse, alcohol abuse, smoking during pregnancy</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Spiritual</td>
<td></td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>
According to interviewees, churches in low risk areas also have a key role in providing support to parents. However, there is a definite expectation that churches in low risk areas need to be connecting and partnering with churches in vulnerable areas in ways that are more intentional and relational, as opposed to merely passing on material resources. Church in low risk areas can also play a role in supporting NGOs.

In addition to the short comments about each intervention in the two previous tables, quotes from the interviewees providing more depth of insight about each intervention are arranged in tabular format on the following pages according to the following areas of intervention:

1. Parenting Support (psychosocial support; church as a safe space; support for fathers)
2. Parenting capacity development
3. Material resources
4. Health care
5. Spiritual support
6. Education (early learning; ECD and aftercare)
7. Advocacy (policy change)
8. Changing attitudes within the church
9. Collaborating and connecting

Findings from the church laity and mothers/cares workshop are integrated into these findings to substantiate what was found in the interviews.

### 1. PARENTING SUPPORT (INCL. PSYCHOSOCIAL SUPPORT)

<table>
<thead>
<tr>
<th>ROLE OF CHURCH GENERALLY</th>
<th>Supportive role models</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>We find that we have a lot of younger mothers, their mothers/parents might also have been younger mothers/parents. It means that no one was there to help them or even show them the way. (Pastor Interviewee)</td>
</tr>
<tr>
<td></td>
<td>Older women who are mothers who can share their experiences and <strong>support</strong>. (Practitioner)</td>
</tr>
</tbody>
</table>

**Safe supportive groups & counselling**

With **empathic support training ‘non’- professionals** can give **mental health support**. Adequate support only needs kindness and empathy – which is research/documentated to work. The church can offer **kindness** and **empathy**. (Expert)

Letting the moms know that the **church is a safe haven**. They can come and speak, share, off load, be counselled, have group sessions etc. That will assist with the self-confidence because it’s lacking. It will help them build up their self-esteem. (Pastor Interviewee)

Biggest roles is one of **supporting** the mother, **educating** the mother and coming alongside the mother. Giving them a **sense of community**. One of the things that I find is that first time moms just feel so alone and hopeless and inadequate. So if a church could address that. I think that would be massive. (Pastor Interviewee)
Small groups of pregnant mothers to come together and be equipped in relationship and community of encouragement. (Denom Leader)

I do know that **Support groups for women** really help. (Expert)

A **support group for mothers**, including mothers that are pregnant. They could learn from one another. It will assist mothers who are struggling, mothers who struggled to give birth. Because the mothers experiences so many challenges (trauma when giving birth) it will also form part of post counselling that is always needed, not only pre counselling. It will also encourage and make them accountable partners. They will then support each other. (Pastor Interviewee)

Churches to give more support not only to its members. (Khayelitsha Mothers)

### SPECIFIC ROLE OF CHURCH IN LOW RISK AREA

**Supportive role models**

*Depression is everywhere*, maternal depression. *Loneliness*. I think the young mother is often very lonely. Extended families have broken down in all communities. And if the mother has a poor relationship with her mother, that does not bode well. So the Church can play the *Grandmother role*, if there isn’t a grandmother. And to identify depression where there is. If it is severe to **refer** to a psychologist or psychiatrist. Sometimes the problems in the wealthier communities can actually be more complicated with more family pathology. That is my experience. (Expert)

**Supportive groups**

I think that well-resourced, economically comfortable young parents are just as vulnerable emotionally and often very thrown by this new circumstance in their life. So I think that the fact that they are economically or financially well-resourced doesn’t take away from the fact that they **need a lot of support and community** around them. And shoulders to cry on and people to come to say what’s wrong with my baby it is not sleeping or whatever. (Pastor Interviewee)

**Grief counselling**

One area that we are desperately bad at is **grief counselling**...only four out of seven tertiary hospitals has a grief counsellor on board. There is hardly anyone who knows anything about **miscarriage** and **stillbirth**. The process through which poor women deliver stillborn babies is horrendous. In the field of grief counselling the need is enormous. Churches can really make a big difference. It is a big gap, it’s really hard, people really **need support**. (Expert)

### SPECIFIC ROLE OF CHURCH IN HIGH RISK AREA

**Supportive role models**

The stronger **mothers and fathers** should **mentor** others and pass on skills and knowledge e.g. start a fatherhood and motherhood structure. (Denom Leader)

Linked to experienced moms, church support (counselling and life skills, truth). (Vrygrond Mothers)

**Meet with other ladies** in the community, so that we can share and give advice even the younger mom’s. (Vrygrond Mothers)
Supportive groups

I think that there is a lot that can be done from the pulpit; in smaller groups; in solidarity; from pregnancy, through the transition, first 6 months of life. That is just such an incredibly vulnerable and psychologically vulnerable time and again which are the children that are failing to thrive; it is the moms who are depressed. And while the church may not be able to do something about depression they can help the mother cope. How can they help mothers cope by creating these circles of support. (Expert)

Church can help in creating social networks – social activation. When people are depressed they withdraw from social settings and nurturing community - which reinforces the mental health problem. They become isolated. Churches can identify and gently bring women into social networks. (Expert)

Alone and stressed during pregnancy: statistic – in WC 1 in 3 moms will go through postnatal depression (PND). Especially in a vulnerable situation, the stress is much higher and impacts your ability to parent and often there isn’t a facility for counselling to take place, nurses don’t often have the time, or women feel intimidated because there is that imbalance of power between nurses and moms. So one thing the church could provide is a counselling service, like a safe space for mothers, especially teenage mothers as there is a lot of shame. Refer to social workers if needed or medication. (Expert)

Make mom’s feel they are not alone in this especially when baby is not planned. (Vrygrond Mothers)

Home visiting

I honestly do think that in the South African context home visiting works best. Because there is a general challenge in getting, particularly the people who need it the most, to actually attend parenting groups. So home visiting works well in rural and urban settings because it comes to you. What we find is that parenting groups work for parents who can get themselves organised to come to the group. (Expert)

The church could put its money into training volunteers or giving them a stipend. To do the home visiting programme for all mothers who have given birth or even late in pregnancy. If parents have a chance to share their worries with somebody, who listens, without judgement... then often can initially look like a depressed mother, the depression actually lifts. You don’t need to run to psychiatry. It is really about relationship and somebody listening. There is a need to start really early, because if you can strengthen the bond between mother and child within the first year, then you can have a buffer against other hardships. We can’t take away poverty or give jobs. But we can help parents to have secure attachments with their children. (Expert)

Home visits to help new moms who struggle with breastfeeding. Home based care training for Mom’s- for income generation. (Vrygrond Mothers)

Meeting in our houses having chats over coffee resolving our issues and problems that we are facing. (Khayelitsha Mothers)
Neighbours, being an eye to your child or your pregnant mother. (Khayelitsha Mothers)

Being community and getting involved in people’s lives. (Practitioner)

Recent research from the Heckman Foundation... – pointing that home visiting has an impact but specifically for very low income families. Poorest quintile. As the family moves up the quintile the benefits declines. The impact is also different for boys than girls. Comprehensive research on home visiting. (Expert)

Heckman curve – if you put in $1 early – get far more return than if you put $1 in at adolescence or adulthood – so it is far more cost effective. (Expert)

Chris Desmond from Unicef – he has decided the home visiting is ‘the best bang for your buck’. (Expert)

### 2. PARENTING SUPPORT – CHURCH AS A SAFE SPACE (PHYSICALLY & EMOTIONALLY)

<table>
<thead>
<tr>
<th>ROLE OF CHURCH GENERALLY</th>
<th>Providing safe spaces</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>There are spaces but they are empty space. Not open at the right time. Only open on Sunday. Making their spaces available. (Practitioner)</td>
</tr>
<tr>
<td></td>
<td>Supportive, loving community. A safe place. Explore what that means... in community. Grounding in Jesus Christ and his love. This provides stickability. Local church needs to be a tenacious, loving, truth speaking community. Provide nutrition, values, love, stick with each other. (Practitioner)</td>
</tr>
<tr>
<td></td>
<td>Making use of venues – opening up facilities to create safe spaces. Have a young mom’s ministry. Make it a priority. Space for moms to come together. (Practitioner)</td>
</tr>
<tr>
<td></td>
<td>Churches can be a safe space. Brilliant safe spaces. (Pastor Interviewee)</td>
</tr>
<tr>
<td></td>
<td>Expert Project story: That was the most valuable thing that there was somewhere outside the house where they felt safe and could come. (Expert)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SPECIFIC ROLE OF CHURCH IN LOW RISK AREA</th>
<th>Providing safe spaces</th>
</tr>
</thead>
<tbody>
<tr>
<td>No findings noted</td>
<td>I would think that for a church in a vulnerable community to provide a safe place for people to come to and to feel welcomed and to feel that they and their child are being cared for would be very important and an age appropriate environment even if it is just a room with a few toys or actually just loving people because sometimes you don’t have the resources for anything else. (Pastor Interviewee)</td>
</tr>
<tr>
<td></td>
<td>A space where people/mothers would feel loved, appreciated and respected. Like a support group to encourage, inform or share knowledge of the importance of being a mother. (Vrygrond Mothers)</td>
</tr>
</tbody>
</table>
### 2. PARENTING SUPPORT – SUPPORT FOR FATHERS

#### ROLE OF CHURCH GENERALLY

**Encourage father involvement**

**Fathers** think that they can only interact once the child starts talking...There I think you can stress that **father involvement** is adding to the child’s overall adjustment and functioning in school. Where fathers have been involved with their infants their children do better all around, later on. Because fathers stimulate children and babies in different ways than mothers do. And it helps with the brain development.... **earlier the better.** (Expert)

> In SA 70% of the mothers are single. The fathers are not around and there is violence involved. So church, if you want the two biggest contributions that churches could make, if in all churches in South Africa if fathers were involved with their children and everyone stopped hitting their children we would have a transformed society. It’s that simple, I think. That would be gigantic. I don’t think religious organisations in Africa use their power in this realm ... its women’s work in the home...private space the church doesn’t intrude. (Expert)

I was encouraged by Malachi 4: 6 “His preaching will turn the hearts of fathers to their children, and the hearts of children to their fathers. Otherwise I will come and strike the land with a curse.” (Church Laity)

Churches should encourage continuous parenting classes along with events that involve the whole family, focusing on fathers as well. Because we know the lack of fatherhood and role models is a huge challenge. It will assist, support and encourage families; it will also prevent a lot of things from happening in the future. It’s good to have resources linked to wealth but to build relationships of trust as well. (Church Laity)

I would like to see more talks on fatherhood, the intimate relationship with not only mothers and children but fathers and children. I feel that is the core of the role of the church. (Church Laity)

#### SPECIFIC ROLE OF CHURCH IN LOW RISK AREA

No findings noted

#### SPECIFIC ROLE OF CHURCH IN HIGH RISK AREA

**Encourage father involvement**

A church could have a very interesting role in mentoring fathers and male kin. There are a lot of really good fatherhood programmes around. (Expert)

Church could be speaking more into the issue of fatherhood from within the church during services. **Promoting fatherhood.** Struggle of fathers. Promoting family life within the church. (Expert)

The church can help get fathers involved. I think that is another big factor. Because mothers are left alone. So if you have fathers that come to church, you have a way
The research shows that babies who have fathers that are involved do much better than those who just have a mother. ... It really adds. If the church can make Fatherhood in or cool. Then that would be an enormous thing. Because that brings support for mother, mother not depressed. It has cascade effect if father involved.

I would actually put that first. Before home visiting. I really think that father involvement is important and I think the church can really have access to men.

(Expert)\(^{35}\)

Workshops for Dads on how best to assist their wives with the children. (Vrygrond Mothers)

### 2. PARENTING CAPACITY DEVELOPMENT

<table>
<thead>
<tr>
<th>ROLE OF CHURCH GENERALLY</th>
<th>Antenatal classes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Can’t a church provide a space for antenatal class – prepare them for what is about to come. That antenatal care is for all, it is free to all, and it is not just for the more affluent. But that there is a community church making it accessible to all. (Practitioner)</td>
</tr>
<tr>
<td></td>
<td>Sessions to empower and inform mothers of the necessities, informing them of what happens and what needs to happen in the first 1000 days of a child’s life. (Pastor Interviewee)</td>
</tr>
<tr>
<td></td>
<td>Educare starts from the minute the mother finds out she is pregnant. Creating support and care, education &amp; information. (Church Laity)</td>
</tr>
<tr>
<td></td>
<td>The church building to offer antenatal classes and counselling for those in need. After or alongside the antenatal classes it should flow into a moms group. This will encourage a mom to have an army of support during that time to assist her with teaching, help and talk through breastfeeding and even bless the moms with toys that will encourage stimulation. (Church Laity)</td>
</tr>
<tr>
<td></td>
<td>Parenting classes</td>
</tr>
<tr>
<td></td>
<td>One thing Churches do a lot of in other countries probably here too they have preparation for parenting course for pregnant people. (Expert)</td>
</tr>
<tr>
<td></td>
<td>The church should have more parenting classes focusing on family strengthening, families gather together over a meal (focusing on a family as a whole). (Church Laity)</td>
</tr>
<tr>
<td></td>
<td>Teaching parenting skills to carers and moms and child minders. (Practitioner)</td>
</tr>
<tr>
<td></td>
<td>Focus groups that teachers how children are raised, how to handle children. (Khayelitsha Mothers)</td>
</tr>
<tr>
<td></td>
<td>What they can expect, what do they need to watch out for, developmental stages of children. (Pastor Interviewee)</td>
</tr>
</tbody>
</table>

\(^{35}\) Refer Sonke Gender Justice - Fatherhood (culturally relevant)
A sanctuary for moms and little ones. Here they can be equipped and empowered. Learn **first aid, lifesaving skills.** (Practitioner)

Seminars with mothers to give awareness and **give love.** (Practitioner)

As a church, to be **intentionally educating moms.** We should have topics such as identity and look at healthy and unhealthy relationships, abortion, that children are a gift from God etc. (Church Laity)

Awareness programmes to make mothers and children aware. Using Clinics as entry points as to the **kinds of food** they should be giving their children and why it’s important and what it actually achieves towards children prospering later. (Expert)

High mention for the church laity group was support motherhood, including skills and support in many topics – antenatal, abortion, sex, relationships, identity and value, hard and soft skills, support for teenage moms, investing in young girls.

### SPECIFIC ROLE OF CHURCH IN LOW RISK AREA

**Access to information**

But a well-resourced church can do very simple things like **making information available** around the first 1000 days - a well-resourced church could get hold of them and distribute them: (Expert)

- Like David Harrison’s PPT that he has done;
- Like - Psychiatrist Astrid Berg has produced a very interesting DVD “Together from the beginning”. A very simple video, in three languages for the SA context. Seeing the world form the foetal perspective and asks what is good for the foetus.
- One thing a church can do is connect moms to ‘MomConnect’ **Mobile SMS.**

### SPECIFIC ROLE OF CHURCH IN HIGH RISK AREA

**Education**

Nurturing and care in **loving** your baby. I think there are a lot of mothers who come from very toxic environments and they don’t actually have **skills** to love their children gently or **how to discipline** their children. So there is a lot of socio-emotional development awareness that is needs to happen. Many parents that are way too **violent**, the teachers are too violent they get angry very quickly, they land up basically manhandling the kids because that’s how they were brought up. So trying to reverse that cycle is a huge thing. (Expert)

### 3. MATERIAL RESOURCES (INCL. FOOD & NUTRITION)

**ROLE OF CHURCH GENERALLY**

**Through relationship and empowerment**

We really believe it is to give/share of yourself first before you give of your resources. (Denom Leader)

Problem with just giving food parcels, people only come when they want a food pack. But meeting people’s physical needs is so important. But **through befriending, not just giving out.** (Practitioner)

Not a hand out but a **hand up.** (Pastor Interviewee)
### SPECIFIC ROLE OF CHURCH IN LOW RISK AREA

**Partnership; Financial & Other Resources**

They could play a role in financing programs/mothers. But if not, they could assist with healthy foods, snacks, nappies, clothing etc. It will ensure that those in the vulnerable communities could assist/help their children in the way they should. (Pastor Interviewee)

Need to support **financially, food, workshops** to teach leaders. (Pastor Interviewee)

I haven’t really thought about it...but perhaps a well-resourced **church to twin** with a under-resourced church.....send people and resources to help them provide for their community (Pastor Interviewee)

Can support with once off resources or ‘**play stuff**’ for mom’s group. Or find **sustainable partnerships** through listening and engaging. (Practitioner)

**Partner** with them and **financially assist** them. And if there are other ways of helping them with **expertise** and come on board to support them and help. (Denom Leader)

A lot of opportunities – it’s because of connections or agencies, networks... helps people... individuals in the church that are matched but I don’t know if it would work to **match moms from two communities** because they are so busy..... stressed and time poor.... to support someone else... but the power imbalance. The important thing is the **approach** of how it is done.... it’s a **relationship, a journey and building trust**. (Expert)

**Fund nutrition**

Lack of finances – take **vitamins**... money is an issue. **Funds to access** the right kind of **nutrition**. You get nutrition packs - like ‘glop’ a range of vitamins– if you just scaled that as a church and got it to every single child every single day – that could tip the scale. (Experts)

A critical area that churches could become involved in, and that has to do with **supporting nutrition goals** for infants (refer ECD Nutrition policy that the Dept Health put out); there is a huge role for the **provision of quality food** through either childcare centres or home visiting networks.

Transfer of skills esp. **income generation**; help with work which **gives dignity** and respect. (Practitioner)

### SPECIFIC ROLE OF CHURCH IN HIGH RISK AREA

**Feeding**

Churches in vulnerable communities should play a role in **feeding** and **clothing mothers and children** who cannot afford it e.g. taking up donated clothing and distributing it. (Pastor Interviewee)

Have a soup kitchen and **feeding schemes**. (Pastor Interviewee)

If you can’t find food you not going to care for your kid. Church has a role to support the process of **access to food**. Not just handing out food. But working partnership with people. (Expert)
### 4. HEALTH CARE

| ROLE OF CHURCH GENERALLY | Sponsoring **food kitchens** that get good nutrition to children and mothers. (Expert)

When women are pregnant they are often able to access some reasonable nutrition and if they are reporting for antenatal care then they are also on folic acid and iron supplements. But in the immediate postpartum period in very poor communities, unless women are properly integrated into family structures then they lose access to food, food goes to babies, and that is critical. So what you see is a **redistribution of food within a household after birth** and new moms lose out big time. What we know about that is that hunger is a major stimulant to **postnatal depression** and we know that we have unbelievably high rates of postnatal depression, really, really high in Western Cape. (Expert)

| SPECIFIC ROLE OF CHURCH IN LOW RISK AREA | Skill on how to **wean your child**. **Breastfeeding** support. Volunteers visiting once a week or so and celebrating with mothers. Helping with latching – if latching is fixed in first 3 days it assist with breastfeeding. Help with confidence in mother around breastfeeding. (Practitioner)

Awareness programmes: **FAS, immunisation**. (Practitioner)

Have a **clinic** where no papers, no id is required, all are welcome. Whatever people need - medical care, crisis pregnancy, they are invited in. (Practitioner)

**Professional skills**

Professionals e.g. doctors, social workers, who can intervene. **Intellectual skills to be shared**. (Practitioner)

**Provide transport**

I think that our resourced churches have an opportunity to step out and move in and assist not paternalistically or in an authoritative manner but **share their resources**. I think that if we do that it will help and facilitate and equip young mothers bring them closer to **access to clinics**....far away... **taxi money**...don’t get the health education they need... so if we move in the church in the less resourced church with programmes.. they will be open to it. I have seen some churches open up to facilitate **health education**. (Denom Leader)

They can get offered all the counselling in the world but if they don’t have the money to get to the clinic..... **taxi fare**. ... why didn’t you get your appointment... because Red cross is two taxis away... they will rather pay for electricity than go to the hospital. (Expert)

A well-resourced church can **assist the Milk Banks** – they need **transport** – at the moment it is being done by one doctor. Milk Matters – Mowbray Maternity.

They could **offer a transport** system to claim their **UIF** or **child care grant**... they don’t have money to get her there or the money to pay for someone to look after their child... so getting women there with transport could really help.

---

| ROLE OF CHURCH GENERALLY | Skill on how to **wean your child**. **Breastfeeding** support. Volunteers visiting once a week or so and celebrating with mothers. Helping with latching – if latching is fixed in first 3 days it assist with breastfeeding. Help with confidence in mother around breastfeeding. (Practitioner)

Awareness programmes: **FAS, immunisation**. (Practitioner)

Have a **clinic** where no papers, no id is required, all are welcome. Whatever people need - medical care, crisis pregnancy, they are invited in. (Practitioner)

**Professional skills**

Professionals e.g. doctors, social workers, who can intervene. **Intellectual skills to be shared**. (Practitioner)

**Provide transport**

I think that our resourced churches have an opportunity to step out and move in and assist not paternalistically or in an authoritative manner but **share their resources**. I think that if we do that it will help and facilitate and equip young mothers bring them closer to **access to clinics**....far away... **taxi money**...don’t get the health education they need... so if we move in the church in the less resourced church with programmes.. they will be open to it. I have seen some churches open up to facilitate **health education**. (Denom Leader)

They can get offered all the counselling in the world but if they don’t have the money to get to the clinic..... **taxi fare**. ... why didn’t you get your appointment... because Red cross is two taxis away... they will rather pay for electricity than go to the hospital. (Expert)

A well-resourced church can **assist the Milk Banks** – they need **transport** – at the moment it is being done by one doctor. Milk Matters – Mowbray Maternity.

They could **offer a transport** system to claim their **UIF** or **child care grant**... they don’t have money to get her there or the money to pay for someone to look after their child... so getting women there with transport could really help.
| SPECIFIC ROLE OF CHURCH IN HIGH RISK AREA | Parent awareness campaigns  
Nutrition messaging, awareness of stunting, why are clinic appointments important.  
Networking  
Provide mothers and their children with medical care, getting them in contact with shelters/orphanages and safe homes when needed. Maybe even get accommodation for those living on the streets. (Pastor Interviewee)  
Building those networks of support at a local level between service providers....  
The church can play a role there. (Expert)  
We mobilise and we train and educate church members as volunteers, and we send out people as home based care workers to pregnant women. Making sure that they taking care of themselves. (Denom Leader) |
| --- | --- |
| 5. SPIRITUAL SUPPORT | Churches should provide spiritual support – wholeness inside and embraced, get people plugged in. To do the best they can.  
- Journey with them. If you journey with the mother then you journey with the whole household. Discipleship - believing that one child can change a nation. Can be a light in the home.  
- Feeling love. What the church can do. Help people to love themselves to love others – sense of worth. Children in Sunday school are seen and shown love.  
- Relational then practical needs. True relationships – true love and trust. Can show people what true relationships are especially when they come from broken relationships. (Pastor Interviewee)  
Are we welcoming babies that are not being welcomed by the world? (Church Laity)  
A lot of healing from past wounds (emotional, spiritual) is needed. (Practitioner) |
| SPECIFIC ROLE OF CHURCH IN LOW RISK AREA | Churches must go around the community to give hope. (Khayelitsha Mothers) |
| SPECIFIC ROLE OF CHURCH IN HIGH RISK AREA | Early learning information  
Teaching preschool stimulation to carers and moms and child minders. (Practitioner) |
<p>| 6. EDUCATION - EARLY LEARNING (Incl. play &amp; stimulation; ECD; and aftercare) | --- |</p>
<table>
<thead>
<tr>
<th>SPECIFIC ROLE OF CHURCH IN LOW RISK AREA</th>
<th>Child care facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>An ECD that would accommodate children whose parents cannot afford to pay. We find that parents don’t send their children to school because of finance and these children then become streetwise at such a young age, these children then don’t reach their milestones and are often under nourished. (Pastor Interviewee)</td>
</tr>
<tr>
<td></td>
<td>Education – aftercare - <strong>fund after school feeding</strong> programme ‘Game changers’ (Expert)</td>
</tr>
<tr>
<td></td>
<td><strong>Early learning information</strong></td>
</tr>
<tr>
<td></td>
<td>Tell them that to calm your child through an ipad or cellphone is not a good idea under the age of two. So <strong>limit the use of screen</strong> for young children. Children need to explore with their bodies. (Expert)</td>
</tr>
<tr>
<td></td>
<td>Lots of Churches have been involved in <strong>making play equipment</strong> to support preschools. Lovely project – doll making project.... that has been very nice. So in some <strong>home visiting programmes</strong> they may show moms how to make toys and may leave them with something... So might find people in the church who can do that. (Expert)</td>
</tr>
<tr>
<td></td>
<td><strong>Early learning groups</strong></td>
</tr>
<tr>
<td></td>
<td>The church could start <strong>day care</strong>/space for mothers and children to come together so that they can be <strong>stimulated</strong> simultaneously (a sense of nurturing), maybe for an hour or so with the help of well-resourced churches. (Pastor Interviewee)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SPECIFIC ROLE OF CHURCH IN HIGH RISK AREA</th>
<th>Child care facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Helping practically, where women don’t have the resources to properly care for the child. Often it is an employment battle as well, I can’t provide economically, seeking work but who’s going to be looking after my child? So <strong>child care facilities</strong>, preschool, crèches, aftercare, all of that. But it is more during working hours. (Denom Leader)</td>
</tr>
<tr>
<td></td>
<td><strong>Early learning information</strong></td>
</tr>
<tr>
<td></td>
<td>Expert anecdote:  Asked nanny if she talked and played with the grandchildren and her nanny just said “Our church said you must actually start as soon as you have them in your tummy” - the moral authority of your church telling you that rather than a teacher or social worker or anyone else is so compelling actually. (Expert)</td>
</tr>
<tr>
<td></td>
<td>Mobilising congregations to offer support and programmes that stimulate and educate on the importance of early childhood development. (Denom Leader)</td>
</tr>
<tr>
<td></td>
<td><strong>Early learning groups</strong></td>
</tr>
<tr>
<td></td>
<td>Moms in vulnerable communities to have classes – like art, music, and tips around how to <strong>stimulate</strong> (brain development) - fun mom’s groups. (Expert)</td>
</tr>
</tbody>
</table>
## 7. ADVOCACY (POLICY CHANGE)

### ROLE OF CHURCH GENERALLY

**Lobbying:**
- for *maternity grants* – for pregnant mothers who are starving
- Extended *paternity leave* – Sonke Gender Justice
- Paid *maternity leave* and *UIF* rights – mothers don’t know

If the church came behind it collectively, their voice is very influential. (Practitioner)

Being a *voice to government* - can moms be given some finances – so she doesn’t go back to work straight away, lobby the government – *maternal grant*. Really want to protect that space; you want that baby to be in that safe home space for as long as possible. (Expert)

**Speak to employers** – what are you doing to keep mother and child together.
Domestic workers, factory workers... helping them to stay with their children...(Practitioner)

The church isn’t doing enough to *keep moms and babies together*. In interventions like adoption, foster care and options with abortion not enough is done to support mothers to keep their children. Need to look seriously at trying to keep mother and child together. (Practitioner)

The churches roles to be the advocate for the child....if we’re not taking this seriously, I think we’re failing our children that God brings into our communities. Protections of *children rights* and beyond. (Expert)

The Catholic Church says NO to abortion and with the introduction of the 1st 1000 days policy there is room to advocate in this area. Christian Action Network – they mainly advocate around abortion and corporal punishment. There used to be more churches speaking into policies in parliament but this does not seem to be the case anymore. Even the SACC has closed their office. There isn’t much happening to advocate for the 1st 1000 days. (Expert)

### SPECIFIC ROLE OF CHURCH IN LOW RISK AREA

**Use its public voice**

Speak into a public space about the opportunity of ensuring that:

- every child is exposed to early childhood development;
- no child is nutritionally stunted in South Africa;
- every child is ready to read by the time they get to school;
- every vulnerable child is part of a network of care and support.

These are basic things but they are most fundamental in transforming South African society, and people need to keep hearing that. (Expert)

### SPECIFIC ROLE OF CHURCH IN HIGH RISK AREA

**Educate on rights**

We don’t have very high rates of *breastfeeding*. Very low, bit higher than 8%. .... lots of women find it very hard; many women don’t know that they qualify for UIF or that they can breastfeed at work. So roles that the church can play is *telling women what*
their rights are. And then lobbying. UIF is big because women don’t know that they are entitled to four months UIF. (Expert)

Engage with community & advocate for community

The local church would almost need to **advocate for people from the community** because sometimes I feel like the church sometimes sits outside of what is happening in community like ... the church is a Sunday thing, they are not engaging the police and the hospitals and holding them in account. It is so terrible in South Africa, especially in poor communities that **services are so bad** and you get treated badly ... first thing in the morning 5am standing in the queue, take the whole day off work just to see doctor... but we don’t **hold them to account.** We don’t communicate with the hospital manager or the principal... I’m sure leadership in churches knows what is happening - people talk about their stress... The church needs to be more responsible and also the head managers and principals they go to church also. It’s like we separate these things. ...the church should be holding people accountable for **service deliverables.** (Expert)

Improvement of the times at the clinic, instead of sending the people back after 1pm, Clinics must accept the patients. (Khayelitsha Mothers)

Children with **disability** in poor community often goes unrecognised especially in the first 1000 days. Mother takes on a lot of blame... they can’t actually access services... have a programme to help advocate for the church could be the body to advocate for these services..... (Expert)

<table>
<thead>
<tr>
<th>ROLE OF CHURCH GENERALLY</th>
<th>Use its public voice for awareness and influence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>You have got the audience – got the ears – advocacy and education plays a big role. (Practitioner)</td>
</tr>
<tr>
<td></td>
<td>The church also has a powerful voice – like into the issue of breastfeeding/ /modesty – shaming practices. View of modesty over breastfeeding. Subconscious messages we take on board. (Practitioner)</td>
</tr>
<tr>
<td></td>
<td>If churches are <strong>aware of the first 1000 days</strong> they will act to the call:</td>
</tr>
<tr>
<td></td>
<td>• It could be <strong>broadcast on CCFM</strong>, interacting with individuals. It will then encourage or give listeners more understanding and knowledge around the topic. Thereafter when people/pastors engage with each other, it won’t be something new for them but will encourage conversation;</td>
</tr>
<tr>
<td></td>
<td>• In <strong>local newspapers</strong> e.g. The Southern Mail;</td>
</tr>
<tr>
<td></td>
<td>• Through <strong>church leadership forums.</strong> (Pastor Interviewee)</td>
</tr>
<tr>
<td></td>
<td>It’s important that the Christ follower know more about the first 1 000 days, it would be encouraging to hear leaders implementing more topics on the first 1 000 days in their sermons, discussions, small groups etc. to raise awareness. (Church Laity)</td>
</tr>
<tr>
<td></td>
<td>Put the topic on the agenda, start a conversation. (Church Laity)</td>
</tr>
</tbody>
</table>
We all have sphere of influence, using our positions and resources to provide from. (Church Laity)

Advocate: share the importance of the first 1000 days. (Church Laity)

**Status and value of motherhood**

Changing the messaging around the value of mothers and motherhood (especially from a traditionally patriarchal church setting). (Practitioner)

If the church values the first 1000 days they would raise the status of women who are ‘just’ at home nurturing the most important gift that they can. (Expert)

Respect the new moms, don’t judge or assume. (Church Laity)

**Stop hitting children**

I think our churches are probably the most untapped resources in Africa..... if there is one thing that churches can do to change child development, for me it is a very easy answer... stop religious people hitting their children that’s it! Because it is profoundly damaging to the child and to the parent child relationship. The only people who can change this are the churches. It would be the single greatest contribution to child development alone. I would say that to anyone. If we stop hitting children a whole lot of other things change. That for me would be a gigantic contribution which I think is incredibly difficult to shift. (Expert)

**Value of marriage**

I think that the church, probably across the world but certainly in South Africa, has lost the battle about sex before marriage and about marriage. .... the kind of normal is that it is okay to sleep together before marriage, it is okay to have children out of wedlock, it is okay to go to work right away and have both parents working. And the Church is almost irrelevant, even in strongly churched communities. .... I think the church has lost the battle both spiritually and morally about this... I would say that is the failure of the church. What can the church do to help? Probably to re-institution right from the start some biblical concepts of what God wanted for a family. Without rebuke, without judgement, try and offer the model as this is the safest model; this is the way it was designed. Even if you are out of it at the moment or vulnerable within it. We can make it work for you. We can see what we can do. if James says that true religion is to look after widows and orphans. Then I think that we need to extrapolate that a little bit and I think that it needs to include divorcees, single parents, children born out of wedlock, kind of modern day orphans. True religion means that the Church got to show some real active role in caring for those. (Denom Leader)

**Disability**

Need to ensure children with disability (physical, emotional, mental) are seen and supported, including parents on this often hard and lonely journey – church has a role here to be inclusive, safe, not shaming. (Church Laity)
| SPECIFIC ROLE OF CHURCH IN LOW RISK AREA | **All parents need support**

There is an assumption that well-resourced families don’t have needs but when you scratch... you find that these families are stress, anxiety, pressure.... The pressures on middle income families are huge. **Huge pressure on parents** to get the best for their kids, which is put more pressure on the family system. Middle income families are over stressing their children with giving them too much to do. There is a lot of education for the church for the importance of this age and supporting mothers in supporting their kids and spending time with their kids. **Helping parents** to network - **mom’s groups, dad’s groups** - to get involved with their kids but they don’t know how. Kids do better with the **involvement of dads**. (Expert) |
| SPECIFIC ROLE OF CHURCH IN HIGH RISK AREA | **Use its public voice for awareness and influence**

I think Churches have far more **clout** than departments and experts by miles, “But our Church has told us to do this.” (Expert)

Behaviour change campaigns – one thing that is very important is ‘**influencers**’ so people that are trusted to spread a message. So church leaders and traditional leaders are usually a **trusted source of information** will have a bigger impact in terms of behaviour changes than let’s say a radio ad or a TV ad..... There are harmful practices that exist in vulnerable communities (like some cultural practices), and good practices. So church leaders could be the information source – like breastfeeding, or access to child support grants, where they can get support or services. (Expert)

**Sex education**

I think that one of the taboos in many of our communities is **sex education**, I think that ns some of our communities it is completely absent. And so the earlier we can engage that and speak to that as a faith community... the better... something we should do more of as the church to make an impact. (Denom Leader)

Teach about the **consequences of sex**. Have church for young people. These days, church is often just like any other place, not an authority anymore. (Practitioner)

The church can also **play a role with adolescence**. To inform them that to have a baby is a **huge responsibility**... They should consider before falling pregnant. Because some of those pregnancies are not not-intended. In a realistic way not because of some morality. (Expert)

**Breastfeeding support**

Some of the key things like perceptions of **breastfeeding** that stem so much from the perception that wealthier women or women with status, bottle feed. So dealing with **issues of womanhood** and who you are. In the context of that locating breastfeeding; locating care for the child; locating early stimulation, is really, really important. Here the challenge for the church is that it is so easy to slip into the informational, the knowledge based or even the moral based standpoint that you must breastfeed your child till six months without understanding what is driving the mother not to breastfeed for six months. The thing that’s driving her not to feed for
six months is the difficulty of it, and she is seeking a job and also these issues of status or statue in community. (Expert)

**Shame, judgement and stigma**

The church should not embarrass or shame mothers or judge or condemn them. But create environments that journey together that are encouraging. (Denom Leader)

This is new to us. We need to start as early as mother is pregnant. Because the problem is starting when mama is pregnant. Because in the churches we normally want to look at the mothers who are married. Many people that are around in our churches they can be pregnant but in the church we are saying ‘why are you pregnant?’ ‘why you not married?’ Sometimes we make a lot of mistakes. (Denom Leader)

From mental health perspective:

- Church can reduce the stigma and increase access
- Mental health needs to be spoken about. It needs to become ordinary. There need to be carefully constructed messages. That remove the blame and the myths
- That it is easy to treat
- Symptoms should be discussed. That women have the right to feel better
- Can ask for care and persist in asking for care (Expert)

### 9. COLLABORATE AND CONNECT

<table>
<thead>
<tr>
<th>ROLE OF CHURCH GENERALLY</th>
<th>Collaborating with churches</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Churches to work together in collaboration. If they have the same mission and heart. (Pastor Interviewee)</td>
</tr>
<tr>
<td></td>
<td>The church doesn’t have unity in being one voice. Due to being competitive or threatened. The church needs to stand together. In one voice. But to do this the church needs to also grow its voice of credibility slowly through faithfulness. (Pastor Interviewee)</td>
</tr>
<tr>
<td></td>
<td>Collaboration between churches in the well-resourced and under-resourced churches, the well-resourced have the funds and the manpower to assist us. Well-resourced churches could have workshops that would empower parents. Giving them informative sessions that could help parents with parenting skills, a space where their skills can be nurtured. They could be empowered on how they could better themselves as well. In those workshops show them their self-worth, so that they are able to be better parents and give their children a better future. Have workshops around job opportunities. (Pastor Interviewee)</td>
</tr>
<tr>
<td></td>
<td>Well-resourced churches can adopt an under researched church or NGO in their area instead of starting something new, and supporting the good work that is already happening. (Church Laity)</td>
</tr>
</tbody>
</table>
I would like to see more collaboration with resourced and under resourced churches. (Church Laity)

We are sponsored by a wealthier church that helps us to sustain the baby ministry in our local church. Without their financial contribution it will be impossible to do what we do. Their financial contribution helps us a lot to contribute to the moms and their babies. We would like to see a more sustainable ministry with the help of other funders and volunteers. The wealthier church doesn’t really have a big need within their community/area and chose to partnered with us. (Church Laity)

So many skills in the church, but we don’t work together. Even from our workplaces we can connect the dots. (Church Laity)

**Collaborate with government**

Churches need to be listening to government. .... Churches mustn’t be cowboys either... they must be listening to government – what are you guys seeing that we can fill the gap...going to private funders is not the answer either... need to integrate into government ...replication... I would encourage churches to connect with government around what they are doing...Find out what the bigger overarching vision... you can also influences those decisions. (Expert)

**Collaborate with NGOs**

Networking with NGOs, government, clinics, MOUs, work as team. (Church Laity)

Adopting daycares, helping them to register their centres. (Church Laity)

Alignment rather than duplicate; consider community agency; research rather than knee jerk reaction. (Church Laity)

Finding people that are already doing good work within the community and partner. (Church Laity)

Co-ordination: the church can network and link. (Church Laity)

Church collaborators and networks – reaches out to those with resources, create connection. (Church Laity)

**Collaborate with community**

Forming relationship with those in surrounding community of the church. Care, pray, include, equip.

We are aware that things are happening but I would like to see more happening from the churches side e.g. like outreaches. Both small and larger churches can do things with the man power they have, connecting with their surrounding communities. People mainly desire the relationship and not necessarily the resources only. A simple greeting will mean a lot to someone out there and make a huge difference, knowing someone cares. (Church Laity)

The church being united within communities for the 1000 days. (Church Laity)
<table>
<thead>
<tr>
<th>SPECIFIC ROLE OF CHURCH IN LOW RISK AREA</th>
<th>Financially support NGOs/churches</th>
</tr>
</thead>
<tbody>
<tr>
<td>I do think that there is a role of churches getting involved in communities and supporting initiatives, especially supporting initiatives that aren’t going to get funding from more conventional funders or government. There are very few foundations that find it easy to speak about love ... so find ways to put relationship at the centre as opposed to programme at the centre. Continue to build and nurture those kinds of programmes. (Expert)</td>
<td></td>
</tr>
<tr>
<td>Look for which existing organisations need funding to deepen and widen their impact. Support existing organisations by funding project staff. Individuals in the church? Depends on their expertise – marketing, IT.... they can support existing organisations with what they are already doing but providing ‘in kind’ support – like website design. (Expert)</td>
<td></td>
</tr>
<tr>
<td>My advice is to look at what is out there, speak to experts and find out from people in the sector and choose what resonates with you. Find out who the big players are; who’s already doing what ... Find out what they need to be more robust.... come alongside an existing ... make them more sustainable... use your skills ... collaboration. There is so much already happening. .. pull resources to work together - there would be more impact. Trick is not to reinvent the wheel but rather look at what is already happening. Look at how you can take high impact interventions to scale by beefing things up. (Expert)</td>
<td></td>
</tr>
<tr>
<td>I think that a number of NGOs have been started by more well-resourced churches so I think pioneering new kind of charities or NGOs. (Denom Leader)</td>
<td></td>
</tr>
<tr>
<td>Well-resourced churches can support churches in the vulnerable communities e.g. offer financial support in their existing ministries/services: (Pastor Interviewee)</td>
<td></td>
</tr>
<tr>
<td>• With education and contacts (networking)</td>
<td></td>
</tr>
<tr>
<td>• Do research to see what other churches are doing</td>
<td></td>
</tr>
<tr>
<td>• And support the course and even offer support where needed</td>
<td></td>
</tr>
<tr>
<td>• Collecting volunteers to assist in the ministry/service</td>
<td></td>
</tr>
<tr>
<td>• Raising awareness of the problems our churches face</td>
<td></td>
</tr>
<tr>
<td>• Fundraising to support the ministry/service</td>
<td></td>
</tr>
<tr>
<td>• Providing educational material for expectant mothers/new mothers to help them accordingly</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SPECIFIC ROLE OF CHURCH IN HIGH RISK AREA</th>
<th>No findings noted</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
9.5 ADDITIONAL FINDINGS

The approach is important

While these research questions were largely looking at the potential role of the church in FTD, an additional factor surfaced which was the importance of the church’s approach. Respondents expressed the desire for churches to be genuine, to be present and to be consistent in approach.

For the youth in Manenberg... “the role models for us are the local teachers that are consistent that we will take advice from because they are real people and they remain in our community. They not in and out. Not like a missionary that comes and leaves” so where churches are authentic in terms of being present, continuous, authentic in terms of being genuine, they are in a great position, they can be involved in any structures, they can support teachers... Social fibre offering... (Expert)

A strong call for churches in low risk areas is to take inequality seriously:

I still absolutely feel that wealthier churches have to take inequality seriously. And have to find ways to create connections that cut across class. I see no other way for this country. If we don’t do that. What is driving so much of the violence, the anger in South Africa, is persistent polarization, persistent marginalization, and a sense of exclusion. If you have a look at what is driving child vulnerability the big things are not that people cannot access health services or that they don’t have access to child support grant, yes, those are some issues. It’s that they are people who are excluded, who feel marginalized and that itself has a very, very negative cycle, just that sense of marginalisation, that sense of exclusion. So finding ways to connect, in genuine ways, that are not simply about charity, or about one way giving. It is not easy but we have to do it. We have to keep at it. For me that is the biggest and the most important. (Expert)

Call to be aware of what the needs are in communities:

One thing is for a greater awareness of needs. One of the products of separate development of Apartheid, we don’t live in homogeneous communities. We live separate lives. So people just aren’t aware of the difficulties. (Denom Leader)

Call for the centrality of love and relationships in FTD:

When you have a look at much of the health service or social development response to the first 1000 days we forget about the centrality of love. Really understanding if we can provide these most basic inputs of love, food, stimulation, safety, security to a child their genes do the rest. Their genes are programmed to deliver....So we mustn’t over design programmes it is about relationship; it is about those inputs, how do you create it, how do you do that. (Expert)
I think that the issues of the First 1000 days are most importantly about relationships. So it has to be in the home. Think about the first 1000 days, a maximum of 20 days are spent interfacing with formal health services, social development. 980 days in the home. So the relationship between the mom and the child or the parents or the caregiver and the child and the relationship between that household and broader society – whether disconnected or linked in - those are the factors that determine child vulnerability. (Expert)

Volunteering has its place if individuals are building genuine relationships:

Let’s not scoff at volunteerism, ... relationship, you don’t need to be paid to be in relationship with others. Coming to the role of faith based organisations that IS going to be their biggest contribution that they can make in the first 1000 days. (Expert)

Call to be empowering in the churches approach:

Rather than coming in from the outside, saying we going to save the day. But rather empowering a local church to do it, is probably a more sustainable model. They can provide for some of the practical needs and do some of the training.... (Pastor Interviewee)

9.6 CONSOLIDATED FINDINGS

When trying to understand the role of local churches in FTD, the findings point to multiple levels of engagement with many different ways that churches can play a role in making a difference in FTD of a child’s life. There is consensus that churches do have an essential role to play in using their untapped resource of influence and trusted voice; as well as creating safe spaces of community with love and genuine relationships.

When considering all the above findings, parenting support and capacity development come out as the strongest response in the pastors’ survey findings; in the mother/cares workshop findings; in the church laity workshop findings; as well as in the interview findings.

Parenting support and capacity development encompasses a large variety of options and suggestions. Importantly this support also needs to include fathers and strengthening the whole family. This is one area of intervention that churches can look at, how they can engage with supporting mothers, fathers, grandparents, carers and children in their context and community. With the aim of creating enabling environments for nurturing care to take place. Supporting parents and increasing their capacity for nurturing care to be evident in households for children and families to thrive, and for communities to be transformed.
10 CONCLUSION

The research report concludes with a summation of the findings and recommendations regarding the specific contribution a local church can make in support of the First Thousand Days (conception to 2 years) of a child’s life in Cape Town. Recommendations focus particularly on children at risk in their First Thousand Days (FTD). However, it was both churches in low risk areas (CLRA) and churches in high risk areas (CHRA) that were being considered in terms of their respective contributions.

A brief recap of the research report content may help the reader at this point. After the preliminaries of the Introduction (Chapter 1) and the Research Design and Methodology (Chapter 2), the two Literature Reviews were presented. Chapter 3 covered the context of FTD. As FTD is a multi-disciplinary area, literature was accessed from fields including health, education, psychology and community development. The researchers sought to summarise a vast body of literature that would both inform the empirical research and inform the recommendations regarding the contribution of the local church. Whilst drawn from global literature, there was a specific focus on literature (including related government documents) and context related to South Africa, with an even narrower focus on the Western Cape and Cape Town where possible. This was followed by a literature review that sought to answer the question as to why the church should even be considered as an actor in FTD (Chapter 4). Two aspects were considered in motivating for the involvement of the church. Firstly, it was posited that the church is an important social actor in social development. Literature considered included secular and theological literature supporting this role but also highlighting certain limitations and barriers. Once again, there was an emphasis on literature from the South African context, whilst including writings on this topic that were not country specific. Secondly, speaking directly to the theological motivations for the church’s involvement, FTD was positioned within a framework of the mission of God – the missio Dei – and the consequent mission of the church – the missio ecclesiae. The research report continued to answer the sub-questions posed in the introduction (page 11) with the presentation of empirical research findings (Chapters 5 – 9). The empirical research had a quantitative element (a survey of 74 church leaders across Cape Town) but was predominantly qualitative and included one-on-one interviews with key informants (local church clergy, denominational leaders, FTD experts and practitioners), a workshop with mothers (and some other primary carers) and a workshop with church laity.

In this concluding chapter we will begin with a brief explanation of our research design and then present some summary findings from Chapters 3 - 9. We will bring these findings together as we propose 3 approaches and two frameworks for church and FTD arising from the research. We will close with some recommendations for future research.

10.1 RESEARCH DESIGN

The research was exploratory, multi-disciplinary, mixed methods research that accessed 194 key informants including church leaders, church laity, denominational leaders, FTD experts, FTD practitioners, mothers. Except for some denominational leaders and some experts, all were Cape Town based and resident in areas with a cross section of socio-economic ratings.

10.2 SUMMARY OF FINDINGS

Information from various literature and empirical sources was used to answer the 6 supporting questions posed in Chapter 1 (see page 2).
10.2.1 What is FTD and why is it important?

FTD is a critically sensitive period of foundational human development. It is a time of rapid brain development and significant brain plasticity that transacts with genetics and environmental experiences. This is recognised across academic research, by experts in the field and national policy.

There are multiple risk factors that can undermine the developing brain - poverty, nutrition, infectious diseases, environmental toxins (drugs & alcohol), stress (toxic stress), exposure to violence, psychosocial risk (mental health), disrupted caregiving and disabilities. Poverty has been revealed to be a crucial risk factor which increases the likelihood of exposure to multiple adversities. Poverty extensively impacts millions of South African children. Poor nutrition has noteworthy lifelong impacts on the developmental outcomes of a person, including brain development, structural damage, a lower adult income and GDP losses for a country. Maternal depression is a common and treatable risk factor that negatively impacts on mother’s ability to provide responsive, nurturing care.

Importantly, protective factors can buffer the risk factor of multiple stressors and can improve resilience despite adversity. Equivalently, un-buffered stress can become toxic stress and is detrimental to the developing infant. The availability of quality, responsive and nurturing relationships and supportive environmental factors are essential. There is a transactional process of development between the relational environment and the genetics of the child. Providing an enabling environment for nurturing care is essential for the lifelong developmental benefits for children and adults.

FTD presents a unique window of opportunity to secure the optimal development of children and in so doing work towards the positive developmental trajectory of the country. Investing earlier, in interventions that reduce adversity, is less costly than trying to improve things later. Interventions specifically focusing on vulnerable communities (where multiple risk factors are present) are especially called for. Ensuring optimal development of the youngest children, especially the most vulnerable, is a key lever to overcoming poverty and inequality and improving socio-economic development in South Africa with benefits for the whole of society. The investment in FTD yields lifetime development returns for both the child and the whole of society.

10.2.2 Why should the church engage FTD?

The question of why the church should engage FTD (and in fact why people in FTD should engage the church) was addressed in Chapter 4 by considering the church as a social actor. Literature showed that the church has a role as a social actor. This is affirmed by secular development and missional literature where aspects of the church’s mission clearly intersect with children in their FTD. However, there are barriers to the church playing this role (see page 53) which should be kept in mind and work needs to be done to overcome these barriers for the church to engage fully as a social actor.

---

36 In support of this finding, when looking at the survey conducted with pastors in Cape Town, they significantly recognise that the church has a role and responsibility in FTD. The findings from the empirical research show that all the participants in the research, experts, church laity and denominational leaders all agree that the church does have a role to play.
Literature showed that the church is more suited to some kinds of social development activity than others. Churches often struggle to implement and sustain social development programmes, unless this is through an NGO which they have formed. Using David Korten’s social development generations typography is helpful in this regard. Churches are better suited to relief and charity (type 1) or to discipling and developing their own congregants as people who then go on formally (through community projects) and informally (through everyday lifestyle choices), to be change agents for good (type 2). The church also has a role as an activist and leader in social movements for wide-scale change (type 4), however this most probably first requires the church to engage in issues internally and within its own community. It also requires that churches work together more effectively around a shared social change agenda, especially within the same community and city.

A local church has assets and strengths that should be identified and used as the church plays her social actor role. Building on the religious health assets approach of Gunderson, Cochrane and others, social initiatives involving churches should access the church’s unique assets and strengths. In defining the role of the church in FTD, these should become central for church, state and civil society actors seeking to engage the church for FTD.

Moving to the emic or internal motivation for the church to engage in supportive FTD activity, a missional framework was presented. Christian mission is God’s mission to which the church is called to bear active witness. God’s mission is one of holistic (both spiritual and material) liberation and restoration as he seeks to bring about his kingdom, his reign. This kingdom is both ‘now and not yet’, inaugurated by Jesus and awaiting its fulfilment with the return of Jesus Christ to earth. However, in looking towards that time – as the foretaste and promise of it and in loving care of people and the world in the present - the church in its mission must seek justice and mercy and life to the full, especially for those at risk. In considering mission, some preliminary thoughts were put forward regarding the intersect of FTD and mission, considering mission by, with and for infants and children in their FTD. It was noted that there is a lack of theological literature regarding FTD.

10.2.3 What is the knowledge and attitude of church leaders in Cape Town to FTD?

The survey of church leaders in Cape Town shed interesting light on clergy understanding of FTD. A key finding is that there is lack of awareness of FTD in the church leadership. Church leaders do not fully understand and appreciate the importance of this critical period in a child’s life. The unique window of opportunity that FTD presents and the need for early interventions is not fully understood by church leaders. There was limited understanding on topics like when human learning and spiritual formation begins.

In terms of attitudes related to pregnancy, church leaders recognise the presence of stigma, judgement and lack of support from the community toward teenage pregnancy and pregnancy outside of marriage. They also recognise the importance of the father in being involved in caregiving in FTD, to both the child and the mother. This is an asset that the church can build on.

10.2.4 What are the barriers to mothers and other carers accessing FTD services?

One of the learning’s from an FTD initiative in which the researchers were involved was that quite frequently mothers and other carers fail to access FTD services. To understand this better, two workshops with mothers and carers in high-risk areas were held. They shared their struggles in accessing services. Experts, church leaders and practitioners were also asked about this in interviews. Four key findings emerged. Firstly, poverty presents multiple barriers for mothers and carers to access services and support in FTD. These include lack
of adequate safe transport to services, food insecurity, unemployment and returning to work as soon as possible. Secondly, lack of knowledge and access to information also present as barriers for mothers and carers. This includes knowledge about FTD, available services, parenting skills, and nurturing care. Thirdly, inadequate services and poor quality of accessible services, especially within the health sector, present as barriers, where mothers report experiencing unfriendly and judgemental services. Finally, maternal mental health, especially depression, is a critical barrier for mothers and carers accessing services and providing the nurturing care that is required in FTD.

10.2.5 How is the church currently responding to FTD in Cape Town?

Clergy, denominational leaders and laity were asked in what ways their church was providing support and services related to FTD. Findings show that whilst the church is currently contributing to a limited extent to FTD, activities are scattered, ad hoc and lacking in intentionality toward the specific FTD needs. However, churches in Cape Town are more actively and intentionally involved with children aged 3 – 6 years. When churches do engage FTD they do so in a very traditional context – pastoring, supporting, parenting training, preaching, and relief. Additionally, expectant fathers and fathers of little children are under served within local churches. Fatherhood matters in FTD and this is a significant gap. In contrast to the local church, denominational level responses tend to focus more on formal programming than on skills building for engaging FTD contextually. Another significant gap is that there seems to be little to no engagement by church leaders with people in their FTD as needing spiritual formation and discipleship. However, it is encouraging to note that church leaders recognise that the church does have a major role to play in providing services in FTD, even though this is not reflected in what churches are currently doing.

10.2.6 What existing models and approaches are showing signs of successful implementation and impact in Cape Town and beyond?

To move the church into a more supportive role in FTD, the researchers sought to identify ways in which ‘good’ (i.e. aligned with literature on what is needed in FTD) support is being offered generally in communities, and for this to be a source of information regarding possible interventions that could be used (adapted or not) by churches. What emerged is that there are a large variety of ways to intervene to attend to the number of risk factors involved in FTD. These models and approaches are discussed in Chapter 8 and are listed in Appendix E. In addition, the health sector is a central entry point for scalable interventions in FTD, with primary health care, antenatal care and postnatal care, and nutritional interventions. Three specific areas of intervention were identified in the existing models and approaches. Firstly, parenting support and capacity development – Care for Child Development and Home Visiting are leading existing evaluated approaches to provide psychosocial support and education. Secondly, promotion of Child Support Grants in South Africa - which aim to increase the income of families living in poverty - is a proven, cost-effective approach to improve child developmental outcomes, especially if accessed very early. Thirdly, exclusive breastfeeding support, promotion and protection is a priority practice with proven benefits in FTD and breastfeeding is everyone’s responsibility.

10.2.7 What do key informants think the role of the church is in FTD?

There is consensus that the church does have a role to play in making a difference in FTD for those at risk during this crucial and formative period of life. Interventions will depend on the needs of the community and context of each local church and whether the church is a CHRA or a CLRA. At the same time though, the role of a CLRA is not too different to the role of the church located in the vulnerable community as all parents need support during their child’s FTD in order to provide the vital nurturing care. Parenting support and
capacity development are seen as the principle intervention areas for churches. Churches are uniquely positioned (see church strengths below) to offer psychosocial and spiritual support that includes the fundamentals of love, kindness, care and empathy. Capacity development of parents through education and skills training is also seen as something that churches can do through initiatives such as antenatal classes, positive parenting programmes, pre-marriage classes and early learning information. Churches can provide and create both emotionally and physically safe spaces to support mothers, fathers and other carers, including support groups and counselling. Home visiting was found to be an indispensable intervention that can address different outcomes depending on the focus of the programme. Homes are where mothers spend most of their time in the early days and are the best places to target vulnerable mothers. Churches can play an influential and crucial role in encouraging father involvement and engagement in FTD as one of the most overlooked areas in FTD interventions, both within and outside of the church in supporting fathers.

Those interviewed and surveyed generally stressed that CLRAs can do more partnering, twinning, financially supporting of NGOs/programmes/churches in communities where there is high risk during FTD. CHRA can be more hands-on relationally with families facing multiple adversities and provide some relief – including feeding and material resources.

The church is recognised as having a trusted voice of influence in society – which people still listen to the church and therefore the church should use its voice and influence to raise awareness and advocate about the importance, risks and potential of FTD. Experts indicate that the church has a voice into broader systemic issues that impact on FTD, for example stigma, judgement, shame, lack of awareness, gender issues, paternalism and patriarchy, violence, intimate partner violence, corporal punishment and inequality.

There is much opportunity for the church’s positive support for FTD and there are multiple levels of engagement and ways for the church to be involved in FTD. In addition, there are programmes and approaches which any church can consider adopting immediately, today!

10.3 PROPOSED ROLE OF THE CHURCH IN FTD

In summarising the proposed role of the church in FTD, three approaches are proposed. These are linked to David Korten’s generations of social development, as discussed in Chapter 4 of this report. In addition, during the research, two existing models resonated with the researchers and seemed to fit well when thinking about church and FTD, firstly church support for FTD within a socio-ecological model (see page 47 -48) and a church strengths-based model, drawn from the religious health assets literature (see pages 47 - 51). We will use the socio-ecological model as our primary model and link recommendations within this to church strengths.

10.3.1 Three suggested approaches

Approach 1: FTD included and normalised across all church activities

In this approach (linked to Korten’s first generation of social development), ways would be sought to encourage and assist a local church (and wider church bodies such as denominational structures, ministers’ fraternals, and training institutions) to include FTD awareness and support across the activities of a local church. This would involve moving FTD people (infants, parents etc.) and topics (conception, pregnancy, fatherhood etc.) from the periphery of church activity into the mainstream activities of a church including preaching, mission outreach, worship, service, discipleship and evangelism. It could also include some relief activity in the wider community but would be predominantly focused on the well-being of FTD people within their own church community. Church based responses should include the everyday activities of church
members, like visiting people in their homes, and not just responses of the organised church body. Churches should start by developing interventions that assist their own members in FTD and then move outwards into the community. In doing so, they should seek to identify, adapt and promote ‘church-suited’ existing initiatives and promote their uptake. Churches should seek to look at their current responses and see if they can be more coordinated, strategic and informed by science to make an even bigger impact. Churches could facilitate a multi-sectoral space for Christians vocationally involved with FTD to form connections built on their common interest and faith.

**Approach 2: Programmatic responses to FTD by and with the church**

In this approach (which falls within Korten’s second generation) churches can run FTD programmes in their church and surrounding (or other) communities. These could be, for example, home visiting programmes, parental training and support programmes, clinic support programmes, fatherhood programmes - to name but a few. Such programmes would be best run in partnership with specialist NGOs, faith-based or secular, and wherever possible in conjunction with other churches in their area.

It would be good to bear in mind three types of programmes: faith-based (including direct linkage to the Christian faith and the Bible); faith-placed (secular programmes which are run by a church) and collaborative (designed and run in partnership between churches and specialist outside groups). Some level of integration between the science of FTD and the beliefs and practices of the church could be obtained through such collaborative approaches. All three programme types are possible within a church context, but the faith-placed would be least likely to succeed, especially if it was an attempt to implement a programme through a church and was not owned or led by that church – be it clergy or laity.

Churches need to adjust their programmatic approaches based on their context and resources. Programmatic responses should consider the respective roles of churches in low risk areas (CLRA) and churches in high risk areas (CHRA) (ref ch8). Programmes that build unity across church denominations and church streams in the same community are also more likely to have wider systemic impact.

**Approach 3: Advocacy and influence through the wider church**

Given the scope of the church in South Africa (ref Chapter 4, page 46), a third suggested approach is for the church (locally and collectively) to be one of the institutions mobilising society (including its own members) to address the failure of political, societal and cultural systems beyond its own community in support of FTD. This could in time lead to the church contributing to a national movement of people who live in an active awareness of this critical phase of life – critical to each child and his or her parents and critical to the wellbeing of the nation. This advocacy and influence approach reflects Korten’s third and fourth generations of social development.

Whatever approach is used, churches need to live in the healthy, humbling tension between God’s model for human development, marriage, family and community as found in the Bible, and the acknowledgement that the entire Bible is premised around God’s redemptive and restoring grace for us when we are in difficult and different life circumstances - both individually and as societies. Churches should seek and be helped to provide non-judgemental, inclusive parental support to all – for example single parents, young mothers, grandmothers, divorcees, children born out of wedlock, those facing unplanned and difficult pregnancies - whilst continuing to hold to what it believes to be God’s best design for family and little children.
10.3.2 A model for church and FTD

A model for church and FTD is now proposed that draws together two concepts presented in this research, namely church strengths and the socio ecological model. Gary Gunderson, in his book “Deeply Woven Roots” (1997) proposes eight strengths of local churches which he says can, should and do shape communities. These strengths were mentioned in Chapter 4 of this research report when motivating for the church as a social actor and are repeated here for ease of reference:

<table>
<thead>
<tr>
<th>CHURCH STRENGTH</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strength to Accompany</strong></td>
<td>To show up in each other’s lives, personally and physically; to visit, care, be present, attend, and listen, one human with another.</td>
</tr>
<tr>
<td><strong>Strength to Convene</strong></td>
<td>To gather in groups of appropriate size around coffee tables and stadiums to engage opportunities and challenges of finding God’s intentions for people and communities.</td>
</tr>
<tr>
<td><strong>Strength to Connect</strong></td>
<td>To create webs of relationship among the complex lives of members and communities so that resources can be engaged, accessed, and aligned.</td>
</tr>
<tr>
<td><strong>Strength to Tell Stories</strong></td>
<td>To place in context experience and data so that people can recognize and play their role amid their complex relationships with other humans and God.</td>
</tr>
<tr>
<td><strong>Strength to Give Sanctuary</strong></td>
<td>To create safe spaces for important programs and services that can be critical for individuals and for important dialogues that determine health at community scale.</td>
</tr>
<tr>
<td><strong>Strength to Bless</strong></td>
<td>People, especially children, grow in the direction of that which blesses them and looks like life. Congregations have enormous practical power to bless. Indeed, it might be that this power is what links all the other strengths.</td>
</tr>
<tr>
<td><strong>Strength to Pray</strong></td>
<td>To help people live at the boundary of human and holy with a rich menu of vocabulary, symbol, ritual, and religious practice</td>
</tr>
<tr>
<td><strong>Strength to Endure</strong></td>
<td>Congregations are built for slow change, long-term discipline, growth and development throughout the cycle of life.</td>
</tr>
</tbody>
</table>

The socio-ecological model (SEM) was also introduced in Chapter 4 when discussing a religious health assets (RHA) approach. SEM is “a theory-based framework for understanding the multifaceted and interactive effects of personal and environmental factors that determine behaviors, and for identifying behavioral and organizational leverage points and intermediaries for health promotion within organizations” (UNICEF). In Chapter 3, it was put forward from literature that FTD interventions need to be addressed from a multi-sectoral and whole society approach and that public good will spill over from individual parents to society as a whole. This thinking fits with the SEM which shows the complex nature of the different levels in society and how they fit together. FTD responses begin at the individual level with the knowledge, attitudes, beliefs and behaviours of individuals who directly or indirectly impact on the child in his or her FTD, and his or her parents. Hence the need for responses that educate and challenge incorrect thinking about this important phase. The primary responsibility for care of young children does belong at the level of parents and families. At the same time though, at the broader community level there is a responsibility and a need to support and promote the wellbeing of young children and families and provide services that nurture young families. Then at a state and government level there is a responsibility to ensure good policy, laws and provision for quality

37 See: Unicef: https://www.unicef.org/cbsc/files/Module_1_-_MNCHN_C4D_Guide.docx
early childhood development services and support are available. The SEM gives a holistic view of society and shows how the health of individuals and communities is impacted by their circumstances and environments.

When examining the many roles that the church can play in support of FTD and looking at the various risk factors and protective factors as well as the barriers to accessing services for carers in FTD, the researchers identified that the SEM gives a helpful framework to bring all of these parts together. The SEM is good for both envisioning and planning church engagement in FTD in an integrated manner, and in a way which would complement secular models and assist in partnership formation. SEM helps us to position the church within society and to consider its role in FTD across the different spheres of the SEM that impact on FTD. SEM gives perspective to the complex nature of the health and flourishing of a child in FTD. The SEM helps to plot the interaction that is taking place between the child’s genetics and the environment at the various levels of the model.

The church as an organisation may be positioned within the third level of the socio-ecological model, that of institution/organisation. The church is also well positioned within the SEM to play a crucial, influential role into all the levels of the SEM. The Christian faith which the church seeks to represent and nurture is present across all levels of the SEM through the presence of individual Christians seeking to live out their faith at these various levels. The opportunity therefore is for the organised church, through its members and its individual and collective organisational forms to support FTD. As stated early in the report, the church is the most trusted institution within South Africa and a significant number of South Africans participate in church activities frequently. Therefore the church has leverage in all of the areas within the SEM. The church can and does have a role at the individual level; the interpersonal level; the institutional/organisational level; the community level; and public policy level.

The table below discusses some of the examples of the role that the church can play at each level, based on finding in this research. It also suggests which strengths the church can utilise. This is not an exhaustive list. The researchers recognise that these are preliminary ideas that can stimulate thinking and more research is required to verify and expand on these ideas and how they fit into SEM and make use of a RHA approach and church strengths.

![Socio-Ecological Model](image-url)

(Mason, McKeithen, and Mourao 2018).

The table below discusses some of the examples of the role that the church can play at each level, based on finding in this research. It also suggests which strengths the church can utilise. This is not an exhaustive list. The researchers recognise that these are preliminary ideas that can stimulate thinking and more research is required to verify and expand on these ideas and how they fit into SEM and make use of a RHA approach and church strengths.
Examples of how the church can interact with FTD at each SEM level, linked to church strengths:

<table>
<thead>
<tr>
<th>SEM LEVEL AND SUGGESTED ACTIVITIES</th>
<th>CHURCH STRENGTH UTILISED</th>
</tr>
</thead>
</table>
| **1. INDIVIDUAL: ‘family’ or primary carer around the child.**  
(Knowledge, attitudes, behaviour, self-efficacy, skills) | |
| At this primary level of the individual the church should strengthen the hand of the individual by supporting the mother, father or other primary carer to provide responsive nurturing care. As well as influencing knowledge, attitudes, behaviour and skills of the individual in FTD. | |
| Educate and **raise awareness and knowledge** around the importance of FTD and available services (including accessing health services and CSG early; registration of birth). | Tell Stories |
| Promote and **support breastfeeding** as a priority feeding practice in FTD | Give Sanctuary |
| Encourage and **support father** involvement in FTD | Give Sanctuary |
| **Assess individual barriers** to support services and empower individuals to overcome these barriers | Tell Stories |
| **Promote services** to mitigate risk factors to FTD and enable nurturing care. | Connect |
| Actualise **spiritual support** and discipleship of a person from as early as in the womb | Pray |
| **2. INTERPERSONAL** (Family, friends, peers, social networks) | |
| At the interpersonal level, churches generally provide ongoing social support and encouragement with various groups through building relationships and community amongst congregants. | |
| **Create safe spaces** (emotional and physical) in the community to enable nurturing care and supportive groups for all parents, especially those facing multiple adversities (these spaces can also be made available to partner with government/NGOs to run antenatal classes for church members and the broader community) | Give Sanctuary |
| Establish targeted **parenting support and capacity development** interventions through home visiting, antenatal classes, parenting skills training and access to information | Convene |
| Prioritise **visiting** new and expecting parents in their homes in pastoral and caring ways, providing essential emotional support (non-professional home visiting) | Accompany |
| Pursue interventions and services to meaningfully engage with and **support fathers and male kin** | Connect |
| Offer **counselling** and **supportive role models** to enable parents to provide nurturing care | Give Sanctuary |
### 3. INSTITUTIONAL / ORGANISATIONAL (Churches, business, community organisations and social institutions)

At level three the organisation of the church itself is located. At this level the church is providing organisational resources, support and promoting services for FTD. As well as addressing any organisational barriers to FTD.

<table>
<thead>
<tr>
<th>Acknowledge and realise that the church does have a role, responsibility and a mission imperative to promote the well-being of children to engage meaningfully and intentionally with FTD to secure optimal development of children and transform the whole of society</th>
<th>Tell Stories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhance and deepen the church’s theology, knowledge and awareness of the crucial opportunity that FTD is to ensure optimal development through a targeted communication campaign to raise conviction and motivation for involvement and action</td>
<td>Endure</td>
</tr>
<tr>
<td>Conduct a Religious Health Assets Assessment to identify the unique strengths and assets of the church community to mobilise them to assert positive change within the congregation and then the surrounding community</td>
<td>Tell Stories Connect</td>
</tr>
<tr>
<td>Identify, adapt and promote ‘church-suited’ existing initiatives that are coordinated, strategic and informed by science and evidence based</td>
<td>Endure</td>
</tr>
<tr>
<td>Educate, promote and support breastfeeding as a priority feeding practice in FTD</td>
<td>Tell Stories</td>
</tr>
<tr>
<td>Champion, promote and popularize the meaningful positive engagement and involvement of fathers and male kin in FTD through utilising the churches’ influential positioning in society</td>
<td>Give Sanctuary Bless</td>
</tr>
<tr>
<td>Educate on rights around maternity &amp; paternity leave, UIF, CSG, living wage and increasing the household income, as an important part of FTD and the significance impact it can have on child development outcomes</td>
<td>Tell Stories Connect</td>
</tr>
<tr>
<td>Arrange for material resources and nutritional interventions for parents and children through relationship, partnership and empowerment (Income and nutritional security)</td>
<td>Bless Connect</td>
</tr>
<tr>
<td>Address system barriers from within the church (including stigma, judgment, and shame)</td>
<td>Give Sanctuary Connect Tell Stories</td>
</tr>
<tr>
<td>Utilise all the activities of the church and the whole life course to intentionally target the specific needs of FTD (include everyday activities of church members and establish a multi-sectoral vocational space for Christians involved with FTD)</td>
<td>Endure Connect Bless</td>
</tr>
</tbody>
</table>

### 4. COMMUNITY (Social networks, country, town, neighbourhood)

At the community level, the church is part of the network of resources and support. At this level the church can advocate, collaborate, connect and partner with organisations (including other churches, NGOs & local government structures).

| Utilise the churches’ trusted and powerful voice to influence, raise awareness and knowledge, change attitudes within community for positive social development within FTD | Tell Stories Convene |

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

134
Mediate for and engage with the community for improved availability, quality and accessibility of FTD services in own community

Investigate and innovate solutions to remove the barriers that prevent people from accessing FTD services from within own community (including cost of transport to services, lack of safety to get to services, poor quality services with long waits, stigma and shame)

Engage with awareness and sensitivity in approach to partnership, relationship and topics that need deeper dialogue (inequality; gender)

Establish working partnerships with government, civil society, community forums and NGOs to strength and enhance the quality and availability of FTD services

Investigate home visiting as a key intervention for churches. Potentially partner with NGO’s/ government to up skill, train, supervise and stipend volunteers/community health workers (CHW) to offer a formalised home visiting programme to encourage specific support for outcomes like nutrition, EBF, psychosocial, education or stimulation and more, to enable nurturing care in the home

5. POLICY & ENABLING ENVIRONMENT (National, State, local laws, and regulations)

At the public policy level the church should be familiar with the laws and regulations that affect FTD and organisation resources and support; government programs; policy barriers; and stakeholders.

Advocate for the rights of UIF, CSG and rights in the workplace (maternity and paternity leave; workplace breastfeeding, living wage) to improve mother/father-child dyad and increased income, decreased stress and increased nutrition in the home

10.4 RECOMMENDATIONS FOR FUTURE RESEARCH

This exploratory research has highlighted topics that require further research and investigation. There are three under researched areas which the researchers feel are foundational to strengthening the church response to FTD.

Firstly, there is a requirement for deeper theological reflection on FTD. Whilst there is quite extensive theological engagement with childhood and youth, there is very limited engagement specifically with FTD. FTD is under-represented across the theological disciplines, in South Africa and globally. Early childhood has received attention when discussing doctrinal issues such as sin and baptism, but the importance of this age group to the wellbeing of people, the church and society generally has not received adequate attention. This probably accounts for its limited and sporadic attention in the local church. Were there to be increased theological research on FTD, this should lead to training of church leaders to be better informed and inclusive of FTD within their church practices, and also create a specialist church practice field of FTD.

Secondly, further research is required into fatherhood and effective initiatives that engage with men and fathers to promote their active, positive involvement in FTD. There is a noticeable gap in programmes and interventions that specifically target men, both within society and churches.
Thirdly, there is scope to do further academic research into the various topics addressed within this exploratory research, specifically around the barriers that prevent access to FTD services and providing the necessary nurturing care within a South African context.

10.5 IN CLOSING

This research shows there is significant consensus amongst clergy, laity, experts and practitioners that the church does have a specific and influential role to play in supporting FTD. However, it also shows that effective engagement with FTD is a gap within the church. Given the unique life-long impact this phase has on the quality of life, it is an area about which no church or Christian should be ignorant or avoidant. Hence there is a need for interventions to increase the awareness, knowledge and skills in churches around FTD and to equip churches to use their unique assets and strengths in this area. Given the extent of the church in South Africa, the potential for the individual and societal impact of an FTD enabled and active church is significant. Jesus Christ, who is the head of the church, desires that all people should know life to the full (John 10:10). The church is well placed to make a significant contribution to this life by engaging more fully with people in their first thousand days, equipping and supporting parents and communities to provide the responsive, nurturing care required for optimal development.
11 BIBLIOGRAPHY

11.1 CHAPTER 3, CONTEXT OF FTD


11.2 CHAPTER 4, THE CHURCH, SOCIAL DEVELOPMENT AND FTD


Bowers Du Toit, N.F., 2016. The elephant in the room: the need to re-discover the intersection between poverty, powerlessness and power in ‘theology and development’ praxis: original research. HTS Teologiese Studies / Theological Studies, 72(4).


APPENDIX A: DEFINITION OF TERMS

The following definitions are applicable in the interpretation of concepts within this specific research. Concepts not defined here are sufficiently explained in the text of the research. The definitions below are mostly as currently defined by the National Integrated ECD Policy (Republic of South Africa, 2015, p. 11).

Child outcomes

Specifically determined achievements for babies and young children against national and international benchmarks for their early emotional, cognitive, sensory, spiritual, moral, physical, social and communication development. (Republic of South Africa, 2015, p. 11)

Early childhood

Refers to the period of human development from birth until the year before a child enters formal school. (Republic of South Africa, 2015, p. 11)

Early Childhood Development (ECD) Centre

A partial care facility that provides an early childhood programme with an early learning and development focus for children from birth until the year before they enter Grade R/formal school. (Republic of South Africa, 2015, p. 11)

ECD partnership

An organisational framework made up of two or more partnering organisations working towards a common objective of ensuring the emotional, cognitive, sensory, spiritual, moral, physical, social and communication development of infants and young children. (Republic of South Africa, 2015, p. 11)

ECD practitioner

A person who provides early childhood development services through formal early childhood development programmes, family services and playgroups and training, as well as those providing management support services to these workers. (Republic of South Africa, 2015, p. 12)

ECD programmes

Programmes that provide one or more forms of daily care, development, early learning opportunities and support to children from birth until the year before they enter formal school. These programmes include, but are not limited to:

- Community-based playgroups operating for specific hours;
- Outreach and support programmes for young children and their families/caregivers, at a household level;
- Parenting support and enrichment programmes;
- Support for the psychosocial needs of young children and their families;
- ECD programmes provided at partial care facilities and at child and youth care facilities, as contemplated in section 93 (5) of the children’s act; and
- Any other programme that focuses on the care, development and early learning of children from birth until the year before they enter formal school. (Republic of South Africa, 2015, p. 12)

ECD services
Services or support provided to infants and young children or to the child’s parent or caregiver by a government department or civil society organisation with the intention to promote the child’s early emotional, cognitive, sensory, spiritual, moral, physical, social and communication development. (Republic of South Africa, 2015, p. 12)

Early intervention

The experiences and opportunities afforded to infants and young children with disabilities or developmental delays, or to those at risk of developmental difficulties (vulnerable children), by primary caregivers and/or professional practitioners that are intended to promote children’s behavioural competencies and enable them to participate meaningfully in their homes and community environments. (Republic of South Africa, 2015, p. 12)

Equitable access to ECD Services

When all children and their caregivers, including those who face barriers to access and early learning, such as poverty, geographic location (i.e. physical distance from services) and developmental difficulties, have the opportunity to access an age-and-development-stage-appropriate early childhood development services. (Republic of South Africa, 2015, p. 12)

Extended Family

A multigenerational family that may or may not share the same household. It includes family members who share blood relations, relations by marriage, cohabitation and/or legal relations. (Republic of South Africa, 2015, p. 12)

Family

A group of persons united by the ties of marriage, blood, adoption or cohabitation, characterised by a common residence or household, interacting and communicating with one another in their respective family roles, maintaining a common culture and governed by family rules. (Republic of South Africa, 2015, p. 12)

Home-based early

Any early childhood development services, including home-visiting, that are provided to pregnant women, infants and young children, and their family in their home by an appropriately qualified and sanctioned early childhood development practitioner or related worker to promote the children’s early emotional, cognitive, sensory, spiritual, moral, physical, social and communication development. (Republic of South Africa, 2015, p. 12)

Home-visiting

Delivery of services at the household level to parents/primary caregivers and young children for the purposes of providing information, supporting early learning and development, and promoting referrals and linkages to support services. (Republic of South Africa, 2015, p. 12)
Non-centre based ECD programmes

Any early childhood development programme, service or intervention provided to children from birth until the year before they enter formal school, with the intention to promote the child’s early emotional, cognitive, sensory, spiritual, moral, physical, social and communication development and early learning. This may include, parent support groups, outreach programmes play groups, childminders, toy-libraries, mobile programmes, amongst others. (Republic of South Africa, 2015, p. 13)

Outreach ECD programme

Programmes that use early childhood development centres as support for programmes where parents are equipped with skills to promote parental involvement in stimulation of their children at their homes. (Republic of South Africa, 2015, p. 13)

Parent

A biological, foster or adoptive mother and/or father responsible for the care and protection of a young child, who is stable in the child’s life and who loves the child and wants to protect the child. (Republic of South Africa, 2015, p. 13)

Parent support

A broad range of programmes and interventions to support one or more aspects of parenting. These are provided to a parent or primary caregiver. (Republic of South Africa, 2015, p. 13)

Playgroup

A group of young children organised for play or play activities for early learning and development (cognitive, language, motor, emotional, social). A playgroup is attended by children from birth until the year before they enter formal school, usually accompanied by their mothers and/or fathers or primary caregivers, and supervised by a voluntary or paid playgroup facilitator. (Republic of South Africa, 2015, p. 13)

Playgroup facilitator

A community-based worker primarily responsible for early learning and development programmes provided to children at least twice a week through a playgroup at a community facility or, in some instances, at the home of one of the participating parents. (Republic of South Africa, 2015, p. 13)

Primary caregiver

A person, whether related to the child or not, who takes primary responsibility for meeting the daily care needs of the child in question, excluding those who take care of children for remuneration or reward. (Republic of South Africa, 2015, p. 13)

Public good

The provision of early childhood development services can be regarded as a public good, based on the recognition that these services not only contribute to the development and outcomes of the
child, but also to the growth and development of society as a whole in the medium and long-term. (Republic of South Africa, 2015, p. 13)

Vulnerable children

Those who experience compromised caregiving and/or compromised access to quality early childhood development services because of one or more structural, social, economic, geographic, physical, mental, psychosocial, racial, familial or any other risk factors associated with poor access to services, and/or poor early childhood outcomes. These may include, but are not limited to:

- Children living in poverty;
- Children experiencing developmental difficulties;
- Children with chronic health conditions, including HIV and AIDS;
- Orphaned children and other children living without their biological parents;
- Children living in child-headed households;
- Children living in under-serviced rural areas;
- Children living in under-serviced urban informal settlements;
- Children whose caregivers suffer from mental health conditions;
- Children whose caregivers abuse substances such as alcohol and drugs;
- Children who are exposed to violence;
- Children living with disabilities; and
- Children from birth to two years accompanying their incarcerated mothers on admission to correctional centres to serve their sentences. (Republic of South Africa 2015, p. 14 and 15)
APPENDIX B: RESEARCH PROPOSAL – CHURCH BASED SUPPORT FOR FTD

1.1 BACKGROUND TO THE RESEARCH

About 75 000 38 babies are born in the metropolitan of Cape Town each year. Half follow a life trajectory that results in the potential to flourish. The other half miss out, some stunted from lack of food, many without opportunity for early learning, a substantial percentage ultimately dropping out of school and falling prey to the various social ills that Cape Town faces. Research points decisively to the impact of the first 1000 days of a person’s life (from conception to the age of two) in setting the trajectory for their entire life. The church, with its social and spiritual assets (social capital) is well placed to have a widespread impact in this important window of opportunity in a person’s life. With that in mind, Common Good and the Woema Welsynsfonds are partnering to conduct research that will inform strategy for development of local church responses to the first 1000 days. Responses which are seen as simple, scalable and sustainable.

1.2 RESEARCH QUESTION AND SUPPORTING QUESTIONS

The overarching research question in this research proposal is:

*What is the specific contribution a local church can make in support of the first 1000 days (conception to 2 years) of a child’s life in Cape Town?*

The research will seek to identify and bring together the purpose and assets of a church with the medical science, social science and current responses related to the first 1000 days, presenting information and pointing to possibilities.

Supporting questions include:

1. Why should the church engage this topic? (Scientific, social and theological motivations to be referenced in answering this question.)
2. How are churches currently responding, if at all, to the need for first 1000 day support? What current church activities fall within this issue? (Reference initiatives that directly or indirectly address this issue, for example crisis pregnancy, women’s and family ministry, relief services, mothering classes and home-based care programmes. Think also about relevant personal lifestyle/discipleship initiatives for church members.)

---

3. What first 1000 day models and programmes (church-based or otherwise) are showing signs of successful implementation and impact, both in Cape Town and in other parts of the country and globally? What possible partners exist for church-based first 1000 day work?

4. What advocacy role is or could the church be playing in first 1000 days? The church as an institution and the church as the body of believers.

5. What is the knowledge and attitude of church leaders from different demographics with regards to the first 1000 days and what do they consider to be the role of the church in this issue?

6. What is the possible role of a financially well-resourced church in the first 1000 days?

7. What is the possible role of a church that is located in a community where children are at high risk during their first 1000 days?

8. What financial models (i.e. those already at use in and through churches) are relevant that could be flagged for further investigation and which would assist in scaling and sustaining first 1000 days work. (See, for example, Smart Start ECD.)

9. What are the barriers to mothers (and other carers) providing what is needed and accessing services during the first 1000 days?

1.3 LITERATURE REVIEW

This research proposal does not contain a literature review, rather this will be one of the research deliverables. The literature review should specifically focus on the research question and supporting questions and only address by way of introduction the broad body of knowledge on the first 1000 days. This research is not about motivating for a first 1000 day focus, the need for which is accepted by those commissioning this research. In addition, various documents on this topic are already known to Common Good’s Early Life team and will be put forward for reference and inclusion, as appropriate.

1.4 RESEARCH SCOPE AND METHODS

The suggested research methods for answering the research question are desk-based secondary research (incl. literature review) and key informant interviews. Researchers may identify other methods - such as site visits, observation of related programmes, focus groups and surveys - to inform their research. Research should reference areas of medical science, social science and theology, but always with the specific research question in mind.

Whilst the research question is particularly framed within the Cape Town context, researchers should make use of literature from within a global context when looking for innovative responses. Key informants will be church leaders, leaders of related ministries such as: church-based health and crisis pregnancy services, leaders of secular and Christian NGOs, academics, parents and carers of children in their first 1000 days.
Research should include possible responses aimed at direct interventions (such as the Champions for Children Programme) and also think through advocacy and Christian lifestyle interventions.

Any recommendations need to:

- Involve church members (volunteers, how the average church member can respond)
- Involve mostly ‘unskilled’ people i.e. not professional social workers, psychologists etc.
- Speak to low literacy groups
- Be replicable and sustainable in multiple contexts

It should be kept in mind that this research is input to future strategy development and not strategy development itself which would involve a different stakeholder group and would be internal to the organisations requesting this research and any other users of the research findings.

1.5 KEYPH INFORMANTS

The list of key informants for this research should be compiled in conjunction with those requesting this research (Common Good and Woema Foundation) and approved prior to any interviews.

1.6 RESEARCH REPORT OUTLINE

The researchers are at liberty to structure the research as they see fit, however the following sections (or similar) would be amongst those expected:

- Literature review as discussed above
- Research methodology and methods followed and list of key informants
- Research findings and recommendations related to the research question and the supporting questions

In addition to the report, all research data needs to be submitted as appendix to the report.

1.7 RESEARCH OVERSIGHT, TIME-FRAME AND BUDGET

The research should be completed by the end of July 2017. Oversight of the research will be by representatives of the partnering organisations, with Ruth Lundie from the Early Life Programme of Common Good being available to work with the researchers within agreed parameters. Budgets for the research will be agreed once proposals have been received from potential.
1.8 PARTIES REQUESTING AND OVERSEEING THE RESEARCH

This research is a joint initiative between the church-based NGO Common Good and Woema Foundation. Both parties are keen to see the local church engaging in support of the first 1000 days.

1.8.1 Common Good

Common Good is a Christian development organisation within the Common Ground group of congregations, based in Cape Town, in 2014, Common Good identified Early Childhood Development (ECD) as one of its four focus areas. Subsequently, from mid-2014 to mid-2016, the organisation developed and piloted the Champions for Children Programme (CCP) which focused on development during the first 1000 days of a child’s life – from conception to 2 years. The overarching aim of CCP was to see young children in two communities - Vrygrond and Heideveld - flourish, contributing to better longer term outcomes for them. The key strategy was to build layers of care and support for the primary caregiver (usually but not always the birth mother) of a child in his or her First 1000 Days of life and in so doing to significantly impact the trajectory of the child’s life. The programme was designed to include the role of a “connector” – a woman from a Common Ground congregation who would volunteer to build a supportive and caring relationship with a carer.

CCP was based on research indicating that the first 1000 days of life is where critical foundations are laid for a person’s future development. ECD therefore does not begin with attending a preschool, or even at birth, but at conception and in the womb. Research further indicates that an involved carer, supported by another caring adult and with moderate access to opportunity, can significantly impact the child’s life for the better in both the short and long term.

CCP was significantly impactful on multiple levels for both the carer and the connector (and therefore, it is believed, for the child). However, there are a number of challenges that make it hard to create the right environment for the carer to flourish and to create an environment where the carer/connector relationship flourishes too. Issues faced by the Programme were the complexity of the ‘problem’ (the challenges facing the carers), requiring a significant journey with the carer to address the many layers to the ‘problem’; and the complexity of CCP design with multiple stakeholders who needed to be aligned in order to implement smoothly. Creating demand with the carers to participate in the programme was an ongoing struggle and creating demand within Common Ground Church for people to volunteer to become connectors was also difficult. How to include the local church in the carer’s community is still a question to be answered. To this end, CCP has been placed on hold pending the outcome of further research to be conducted in quarter one of 2017. The research will focus on how best a local congregation can support the development of a child in

39 Along with Employment, Education and Congregational Support.
his or her first 1000 days. This includes both Common Ground congregations and other churches where Common Good may in future provide church strengthening activities. The research should think afresh about Church and the first 1000 days, whilst exploring ways in which CCP may be revised or re-imagined to overcome the obstacles identified. Common Good remains committed to seeing children flourish through defining and enabling the Church’s role in a child’s earliest life. This research should provide enough information to enable Common Good to begin developing its 5 year ECD vision and mission and a supporting 2-3 year strategy.

1.8.2 Woema Welsynsfonds

Woema Welsynsfonds is the social investment arm of ARCO. They have experience in working with Societas ([http://www.societas.co.za/](http://www.societas.co.za/)) in ECD, specifically with the Smart Start model. They are now seeking to extend their involvement in the wellbeing of young children through this first 1000 day research and strategies that may be forthcoming from it.
First 1000 Days Research

Common Good is researching the involvement of the church in the first 1000 days (conception to 2 years of age) of a child's life. The information you provide will be used to improve programmes offered through churches to primary carers (mothers) and young children.

The survey consists of 38 questions and should take approximately 20 minutes to complete. You are not required to provide your name, and in the research report all responses will be anonymised i.e. no particular church or individual will be identified.

Your participation is voluntary and you may choose to stop the survey at any time. If you need any further clarification, please do not hesitate to contact Ruth Lundie, Early Life Programme Manager, Common Good (ruth.lundie@commongood.org.za).

We value your time and expertise and appreciate your opinions.

1. What is your title as a leader in your church?

2. How old are you?
   - Youth (below 25 yrs)
   - Young Adult (26-40 yrs)
   - Mature Adult (41-60 yrs)
   - Senior (above 60 yrs)

3. What is your gender?
   - Male
   - Female

4. What is your home language?
   - isiXhosa
   - Afrikaans
   - English
   - isiNdebele
   - isiZulu
   - Sesotho sa Leboa
   - Other (please specify)
5. Name of your Church

6. Area where your Church is located

7. Denomination of your Church
   ○ African Independent
   ○ Anglican
   ○ Apostolic
   ○ Apostolic Faith Mission
   ○ Baptist
   ○ Catholic
   ○ Congregational
   ○ Evangelical / Charismatic
   ○ Other (please specify)

8. What is the racial profile of most of your congregation?
   ○ Coloured
   ○ Black African
   ○ White
   ○ Indian or Asian
   ○ Mixed
   ○ Don’t want to specify

9. What is the age group of the most of your congregation?
   ○ Youth (below 25yrs)
   ○ Young Families (25-40 yrs)
   ○ Mature Adults (41-60yrs)
   ○ Seniors (above 60yrs)

10. Number of people attending your church on an average Sunday (all services)
    ○ Less than 35
    ○ 35- 249
    ○ 250 - 499
    ○ 500 - 999
    ○ 1000 - 1999
    ○ More than 2000
11. What is the average monthly household income of your congregation?
- R0 - R1600
- R1,600 - R5,000
- R5,000 - R10,000
- R10,000 - R16,500
- R16,500 - R33,500
- R33,500 - R57,000
- R57,000 +

12. Number of staff employed by your church
- None
- 1 - 3 Employees
- 4 - 10 Employees
- 11 or more Employees

13. How much of your personal monthly income do you receive from your church?
- All my income is from the church
- Part of my income is from the church
- None of my income is from the church

14. The following is a list of social issues. Select the 4 that you feel most affect your congregants
- Poor parenting, neglect of Children
- Absent Fathers
- Gangsterism
- Crime & Violence
- Racism / Xenophobia
- Corruption
- Poor service delivery (water, sanitation, electricity, housing)
- Domestic Violence
- Substance Abuse
- High Unemployment, Low wages
- Poor quality education & healthcare
- Water shortages
- Other (please specify)
15. Which of the following will most reduce poverty and inequality in South Africa? Select 4 options

- Redistribution of land
- Increased social grants
- Moral regeneration
- Prayer
- Improved education & care for 0-6 year olds
- Other (please specify)

16. Which statement most closely resembles your feelings towards any pregnant woman in your congregation

- I have no particular feelings
- I feel excited at the start of a new life
- I feel a responsibility to support
- My feelings vary depending on the circumstances
- I feel compassion but I tend to stay away from them
- I feel anger towards her for falling pregnant
- I feel neutral as it is a private family matter
- I feel it’s a women’s matter
- I feel the desire to help but I don’t know how
- Other (please specify)

17. How is a pregnant unmarried woman treated by people in the community surrounding your church?

- Most people reject her
- Most people are friendly, but avoid her
- The community mostly supports and helps her
- The community are very supportive and embrace her
- Other (please specify)
18. How is a pregnant teenager treated by people in the community surrounding your church?

- Most people reject her
- Most people are friendly, but avoid her
- The community mostly supports and helps her
- The community are very supportive and embrace her
- Other (please specify)

19. In your church, when is pregnancy not celebrated or acknowledged?

- Whilst mother is at school
- Outside of marriage
- As a result of rape
- We celebrate all pregnancies
- Woman's 5th or 6th child
- When the father is not present
- Pregnancy is not celebrated or acknowledged in our church
- When it's a baby girl
- Other (please specify)

20. What things should a pregnant woman do to promote the health of her baby? Select 3

- She should know her HIV status
- She should avoid funerals
- She should access ante-natal care
- She should take iron supplements and Vitamin A
- She should avoid eating yellow food such as oranges
- She should be immunised against tetanus
- She should avoid stressful situations
- She should have enough rest
- She should avoid exercise
- She should stop smoking and avoid alcohol & drugs
- She should take responsibility for her actions and not destroy the future of the father
- She should start working
- She should start her paperwork for a child grant
- Other (please specify)
21. What are the 3 most important things a baby needs?

☐ Reading, playing and talking with baby
☐ Breastfeeding and health food
☐ A loving parent who gives full attention to baby
☐ Good sleep routine
☐ Safe and protective environment
☐ Holding, hugging and comforting the baby
☐ Regular visits to clinic and vaccinations
☐ Cows milk and fruit juice
☐ Discipline
☐ Do not know
☐ Other (please specify)

22. What are the 3 most important things a father can do to help the development of his baby?

☐ Show love and affection to the baby and play with him/her
☐ It’s not the father’s role to get involved with the baby
☐ Talk to the baby, tell stories
☐ Provide for day-to-day necessities such as soap, food, clothes.
☐ Help in caring for the baby (e.g. bathing, nappy changing, getting dressed)
☐ Buy toys
☐ Provide a safe home for the baby
☐ Support the mother
☐ Other (please specify)

23. How do you approach breastfeeding during church services?

☐ Breastfeeding is encouraged anywhere and anytime
☐ We have a special room set aside for breastfeeding moms
☐ We prefer that breastfeeding doesn’t happen at church

☐ Other (please specify)

24. When does ‘learning’ begin?

☐ In the womb
☐ At birth
☐ 3-5 years in playschool
☐ 1-2 years
☐ First 12 months
☐ Primary School from 5-12 years
☐ 12 years +
25. Have you ever heard the term ‘ECD’?

- Yes
- No

26. What does the term ECD mean?

- Early Childhood Disease
- Early Childhood Development
- Emerging Child Development
- Early Clinical Development
- Education, Culture & Democracy
- Education, Care and Discipline

27. What is the most important reason for a child to attend an ECD centre?

- Child-minding so that mother can work
- Place of safety
- Learn social skills
- Provision of food
- Learn to read and write
- Safe place for the child to play
- Preparing the child to be ready for school

28. When does the ‘faith formation’ of a child begin?

- In the womb
- 3-5 years in playschool
- First 12 months
- Primary School from 5-12 years
- 1-2 years
- 12 years +

29. Have you ever preached on the following topics?

<table>
<thead>
<tr>
<th>Topic</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family planning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unplanned pregnancies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effective parenting</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
30. Who do you think should be responsible for providing services to the following:

<table>
<thead>
<tr>
<th></th>
<th>Government</th>
<th>Non-profit Organisations</th>
<th>Local Churches</th>
<th>Private Business</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant mothers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expectant fathers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New parents</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Babies (0-2yrs)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

31. Describe any services your church provides to the following:

- Pregnant mothers
- Expectant fathers
- Parents/caregivers
- Babies (0-2yrs)
- Children (3-6yrs)

32. Describe any effective church programmes that are offered by other churches to the following:

- Pregnant mothers
- Parents/caregivers
- Babies (0-2yrs)
33. What role do you think well-resourced churches should play in the first 1000 days (conception to 2 years of age) of a child's life?

34. What role do you think churches that are located in communities where children are vulnerable in their first 1000 days (conception to 2 years of age) can play?

35. Would you like to hear more about what happens during the first 1000 days of a child's life?
   
   - [ ] Yes
   - [ ] No

36. What would be the most effective way for you, as a church leader, to get more information about the first 1000 days and related services?
   Select 3
   
   - [ ] Newspaper & magazines
   - [ ] Radio
   - [ ] TV
   - [ ] Billboards
   - [ ] Brochures, posters, and other printed material
   - [ ] Health workers
   - [ ] Religious leaders forums
   - [ ] Websites
   - [ ] Training workshops
   - [ ] Social media (Twitter, Facebook etc.)
   - [ ] Other (please specify)

   [ ]
37. Would you like to receive a copy of the final research report about the church and the first 1000 days of a child's life? (available by the end of 2017)

☐ Yes  ☐ No

38. Please provide an e-mail address to which the final report can be sent.

Disclaimer:
1) All information provided in this survey will be kept anonymous in the research.
2) Your contact information will be kept confidential and will only be used to send you the final research report.
THANK YOU

for your participation and for completing this survey.

This research is focusing specifically on 'What is the specific contribution a local church can make in support of the First 1000 days of a child’s life in Cape Town?'

What is the ‘First 1000 Days’? The term ‘First 1000 Days’ refers to the period of life from conception to two years of age.

Pregnancy (270 days) + Year 1 (365 days) + Year 2 (365 days) = 1000 days

Why is the ‘First 1000 Days’ important? Overwhelmingly, scientific evidence points decisively to the tremendous importance of the early years for human development. There is an immense need for investing resources to support and promote optimal child development from conception.

This critical period of a person’s life sets the trajectory of a person’s entire life. Within Cape Town, about 75 000 babies are born each year. About half of these children will follow a life trajectory that results in the potential to flourish. The other half of these children will miss out, some stunted from lack of food, many without opportunity for early learning, a substantial percentage ultimately dropping out of school and falling prey to the various social ills that Cape Town faces. The lack of appropriate support significantly disadvantaging young children and diminishing their potential for success.

What is ‘ECD’? The term ‘ECD’ refers to Early Childhood Development. Early Childhood refers to the period of human development from birth until the year before a child enters grade R/formal school.

‘ECD services’ refers to services or support that is provided to infants and young children or to the child’s parent or caregiver by a government department or civil society organisation with the intention to promote the child’s early emotional, cognitive, sensory, spiritual, moral, physical, social and communication developments.

These definitions are in line with the South African National Integrated Early Childhood Development Policy 2015.
# Semi-Structured Interview of Experts in The First 1000 Days in SA

<table>
<thead>
<tr>
<th>Interviewer Name:</th>
<th>Ruth Lundie</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interviewee Name (+ title):</td>
<td></td>
</tr>
<tr>
<td>Organisation:</td>
<td></td>
</tr>
<tr>
<td>Contact Number:</td>
<td></td>
</tr>
<tr>
<td>Date / Time of Interview:</td>
<td></td>
</tr>
<tr>
<td>End Time / Duration:</td>
<td></td>
</tr>
<tr>
<td>Recording Track Nr:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Greeting &amp; introductions:</th>
<th>*(Greet the person appropriately) *(Introduce yourself by name) <em>(Make sure you have adequate time available for the discussion)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Thanks:</td>
<td><em>Thank you</em> for being available for this discussion and for giving up your time – it is very much appreciated</td>
</tr>
<tr>
<td>Purpose:</td>
<td>I am part of Common Good... This interview forms part of a research project that Common Good is conducting and your opinions and input will help us in answering the big research question ‘what is the specific contribution a local church can make in support of the first 1000 days (conception to 2 years) of a child’s life?’</td>
</tr>
</tbody>
</table>

We would greatly appreciate your insights around successful models and programmes in the first 1000 days as well as what you consider to be the contribution a local church can make. |

| Asking Questions: | I have a number of **questions** I would like to ask you. The questions are about your understanding and insights as someone working in this field. |

| Anonymous | Please note that we will annonymise all the information within the report and will keep all the information provided confidential (Consent form) |
We would like to mention that you were interviewed as a key informant, but no information will be linked to you.

Are you willing to be interviewed?

You will also have access to the final research report.

<table>
<thead>
<tr>
<th>Recording:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before we start, I would like to ask your permission to record our conversation.</td>
</tr>
<tr>
<td>Although I will be taking notes, I cannot write fast enough to make note of everything you say, so the recording will help me to write up my research notes. So is it alright for us to proceed?</td>
</tr>
</tbody>
</table>

**BACKGROUND (Demographics)**

1. What is your title and role within your organisation?

2. How long have you been working in the field of Early Childhood Development and or First 1000 Days? (Brief bio / credentials)

   | years: |
   | months: |

**SUCCESSFUL MODELS OF FIRST 1000 DAYS**

3. What first 1000 day models and programmes that you know about are showing signs of successful implementation and impact, both in Cape Town and in other parts of the country and globally?

   Which models or programmes are you most excited about? They are showing good signs of impact to improving outcomes in the First 1000 days; programmes that are scalable, good return on investment and can be done by a lay person?

   If you could list 3 which ones would they be?
4. Can you speak into the financial models of successful programmes that could assist in scaling or sustaining first 1000 days work? (or could be flagged for further investigation)
   (Specifically - Financial models that are income generating or self sustainable and that don’t depend on donor funding)

### ROLE OF THE CHURCH

5. What role do you think churches located in vulnerable communities, where mother (carer) and child are at risk, should play in the first 1000 days of a child’s life?

6. What role do you think the financially well-resourced church should play in the first 1000 days of a child’s life? – to support children and churches in vulnerable communities

   Have you come across a well-resourced church that is doing this well?

7. What possible partners exist for church-based first 1000 days response (in Cape Town and beyond)?

8. What advocacy role is or could the church be playing in support of the first 1000 days of a child’s life?

9. Lastly, In your experience, what are the barriers to mothers (and other carers) providing what is needed and accessing services during the First 1000 days?

### Closing

Would you like to receive a copy of the final research report about the church and the first 1000 days of a child's life? (available by the end of 2017)

**Yes:**

Please provide your email address:
<table>
<thead>
<tr>
<th><strong>No:</strong></th>
</tr>
</thead>
</table>

**Thank you**

Thank you so much for giving of your time and participating in this research. Your insights and expertises around this topic is valuable and will greatly assist us in this research in understanding more about how to engage the church around the topic of first 1000 days of a child’s life.

**Referral**

Is there anyone who you would like to refer / put us in contact with?

**Recap**

Just to **recap** coming out of this interview:

- You will receive a copy of the report at the end of the year.

In closing, I would just like to thank you again for giving your time to answer our questions – your insights are important and appreciated.
Telephonic Interview of Leaders of Denominations of Churches within South Africa

Before making the call, make sure you have the following in place:

**IF TELEPHONIC INTERVIEW – A VOICE RECORDER AND EARPIECE (WITH BATTERIES THAT ARE CHARGED)**

- If Skype interview – download and test the voice recorder
- Check: Position within Denomination of person being interviewed – are they? (Q1)

<table>
<thead>
<tr>
<th>Interviewer Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interviewee Name (+ title):</td>
<td></td>
</tr>
<tr>
<td>Denomination:</td>
<td></td>
</tr>
<tr>
<td>Contact Number:</td>
<td></td>
</tr>
<tr>
<td>Date / Time of Interview:</td>
<td></td>
</tr>
<tr>
<td>End Time / Duration:</td>
<td></td>
</tr>
</tbody>
</table>

**Greeting & introductions:**

*Greet the person appropriately*

*Introduce yourself by name*

*Make sure they have the adequate time available for the discussion*

**Thanks:**

Thank you for being available for this discussion and for giving up your time – it is very much appreciated.

**Purpose:**

I am part of Common Good …. This interview forms part of a research project that Common Good is conducting and your opinions and input will help us in answering the big research question ‘what is the specific contribution a local church can make in support of the first 1000 days (conception to 2 years) of a child’s life?

We would greatly appreciate your insights to help us understand your denomination /group of churches engagement are around the first 1000 days.

**Asking Questions:**

I have a number of questions I would like to ask you. The questions are about your understanding and insights from within your Denomination.
| Anonymous | Please note that we will anonymise all the information within the report and will keep all the information provided confidential. (Consent form)  

Whilst we will mention that your denomination/church group was interviewed, the information will not be linked.  

Are you willing to be interviewed on behalf of your denomination?  

You will also have access to the final research report |
|---|---|
| Recording: | Before we start, I would like to ask your permission to record our conversation.  

Although I will be taking notes, I cannot write fast enough to make a note of everything you say, so the recording will help me to write up my research notes. So is it alright for us to proceed? |
### BACKGROUND (Demographics)

**10.** What is your title within your denomination?

<table>
<thead>
<tr>
<th>Nr of years:</th>
<th>Nr of months:</th>
</tr>
</thead>
</table>

**11.** How long have you been in this position as 
__________ leader?

<table>
<thead>
<tr>
<th>Nr of years:</th>
<th>Nr of months:</th>
</tr>
</thead>
</table>

**12.** Number of people you represent (number of members, number of attendees on Sunday, or number of people who call themselves ______________) or number of congregations.

### UNDERSTANDING OF FIRST 1000 DAYS

**13.** Have you heard of the term ‘First 1000 days’ of a child’s life? 

<table>
<thead>
<tr>
<th>Yes:</th>
<th>No:</th>
</tr>
</thead>
</table>

**14.** What do you understand by the term ‘First 1000 days’?

**15.** Do you think this is a critical stage of life? Why / Why not? 

<table>
<thead>
<tr>
<th>Yes:</th>
<th>No:</th>
</tr>
</thead>
</table>

**16.** When do you think ‘learning’ begins in a person?

**17.** When does the ‘faith formation’ of a person begins?

### ROLE OF THE CHURCH

**20.** What role do you think churches located in vulnerable communities, should play in the first 1000 days of a child’s life?

“Please tell me more.”

**21.** What role do you think the financially well-resourced church within your denomination should play in the first 1000 days of a child’s life – could support churches and children in vulnerable community?

“Would you explain further?”

### CHURCH ACTIVITIES

**22.** Describe any services that your denomination provides for the following:

1. Pregnant mothers

2. Expectant fathers

3. Parents / caregivers

4. Babies (0-2yrs)
5. Children (3-6yrs)

“Could you give me an example?”

“Can you describe in more detail?”

23. How effective do you think these initiatives are?

24. What advocacy role is or could the church be playing in support of the first 1000 days of a child’s life?

(Thinking about the church as an institution (collective) and the church as the body of believers (individuals))

“Can you tell me more about … ?”

<table>
<thead>
<tr>
<th>Closing</th>
<th>Would you like to receive a copy of the final research report about the church and the first 1000 days of a child’s life? (available by the end of 2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Yes:</strong></td>
</tr>
<tr>
<td></td>
<td>Please provide your email address:</td>
</tr>
<tr>
<td></td>
<td><strong>No:</strong></td>
</tr>
</tbody>
</table>

Thank you

Thank you for your participation and for sharing your insights around this topic. It will be very useful in understanding more about how to engage the church around the topic of first 1000 days of a child’s life.

Referral

Is there anyone who you would like to refer / put us in contact with?

Recap

Just to **recap** coming out of this interview:

- You will receive a copy of the report at the end of the year.

In closing, I would just like to thank you again for giving your time to answer our questions – your insights are important and appreciated.
**In Depth Semi-Structured Interview of Pastors**

<table>
<thead>
<tr>
<th>Interviewer Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interviewee Name (+ title):</td>
<td></td>
</tr>
<tr>
<td>Church:</td>
<td></td>
</tr>
<tr>
<td>Contact Number:</td>
<td></td>
</tr>
<tr>
<td>Date / Time of Interview:</td>
<td></td>
</tr>
<tr>
<td>End Time / Duration:</td>
<td>Recording Track Nr:</td>
</tr>
</tbody>
</table>

**Greeting & introductions:**

(Greet the person appropriately) (Introduce yourself by name) (Make sure you have adequate time available for the discussion)

**Thanks:**

Thank you for being available for this discussion and for giving up your time – it is very much appreciated

**Purpose:**

I am part of Common Good... This interview forms part of a research project that Common Good is conducting and your opinions and input will help us in answering the big research question ‘what is the specific contribution a local church can make in support of the first 1000 days (conception to 2 years) of a child’s life?

We would greatly appreciate your insights around successful models and programmes in the first 1000 days as well as what you consider to be the contribution a local church can make.

**Asking Questions:**

I have a number of questions I would like to ask you. The questions are about your understanding and insights as someone working in this field.

**Anonymous**

Please note that we will anonymise all the information within the report and will keep all the information provided confidential (Consent form)
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>We would like to mention that you were interviewed as a key informant, but no information will be linked to you.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Are you willing to be interviewed?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>You will also have access to the final research report</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Recording:</strong></td>
<td><strong>Before we start, I would like to ask your permission to record our conversation.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Although I will be taking notes, I cannot write fast enough to make note of everything you say, so the recording will help me to write up my research notes. So is it alright for us to proceed?</strong></td>
</tr>
</tbody>
</table>
**BACKGROUND (Demographics)**

1. What is your title and role within your church?

2. Describe any services your church provides to the following: (Ask for details of how the activity is run and by who)
   - Pregnant Mothers
   - Expectant Fathers
   - Parents/Caregivers
   - Babies (0-2yrs)
   - Children (3-6yrs)

**ROLE OF THE CHURCH**

3. What role do you think churches located in vulnerable communities, where mother (carer) and child are at risk, should play in the first 1000 days of a child’s life?

4. What role do you think the financially well-resourced church should play in the first 1000 days of a child’s life? – to support children and churches in vulnerable communities

   Have you come across a well-resourced church that is doing this well?

5. What advocacy role is or could the church be playing in support of the first 1000 days of a child’s life?
6. In your experience, what are the barriers to mothers (and other carers) providing what is needed and accessing services during the First 1000 days?

7. Lastly, as a pastor, can you speak about how you go about pastoring or ministering to children within this age group (0 – 2 years)

<table>
<thead>
<tr>
<th>Closing</th>
<th>Would you like to receive a copy of the final research report about the church and the first 1000 days of a child’s life? (available by the end of 2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes:</td>
<td>Please provide your email address:</td>
</tr>
<tr>
<td>No:</td>
<td></td>
</tr>
</tbody>
</table>

| Thank you | Thank you so much for giving of your time and participating in this research. Your insights and expertises around this topic is valuable and will greatly assist us in this research in understanding more about how to engage the church around the topic of first 1000 days of a child’s life. |
| Referral | Is there anyone who you would like to refer / put us in contact with?                                                    |

<table>
<thead>
<tr>
<th>Recap</th>
<th>Just to <strong>recap</strong> coming out of this interview:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- You will receive a copy of the report at the end of the year.</td>
</tr>
<tr>
<td></td>
<td>In closing, I would just like to thank you again for giving your time to answer our questions – your insights are important and appreciated.</td>
</tr>
</tbody>
</table>
Mothers and carers workshop questions

Recent experiences of mothers (during the pregnancy or while the child was under 2):

1.1. What was good about this time (pregnancy or while the child was under 2)?
1.2. What were a couple of things you found difficult in this time (pregnancy or while the child was under 2)?
1.3. What or who helped you during this time (pregnancy or while the child was under 2)?

2. Current services and uptake:

2.1. Within our community, where is there help during pregnancy and in first 2 years of child’s life?
2.2. Do people use this help? Why?
2.3. What stops people using this help?

3. Get their ideas, seeing what they value and want:

3.1. What do you think would most help the pregnant women and mothers of young children in your community?
3.2. What would need to change, for this to be available?

Church laity questions

1. What is the local church doing for people in this age group, conception - 2?

1.1. Think: · Well-resourced churches ·
1.2. Churches in area where this age group is at risk

2. Vision picture with words. What local church could look like if active in First 1000 Days for children at risk.

3. The church “scattered”, incarnated, missional, vocational, Mon – Fri: what is happening, what potential is there to be harnessed?
### APPENDIX D: INTERVIEW PARTICIPANTS

<table>
<thead>
<tr>
<th>GROUP</th>
<th>INTERVIEWEE NAME</th>
<th>ORGANISATION</th>
<th>TITLE</th>
<th>GENDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experts</td>
<td>Astrid Berg</td>
<td>University Stellenbosch</td>
<td>Emeritus Professor at UCT and Extraordinary associate professorship at Stellenbosch University.</td>
<td>F</td>
</tr>
<tr>
<td>Experts</td>
<td>David Harrison</td>
<td>DGMT</td>
<td>CEO</td>
<td>M</td>
</tr>
<tr>
<td>Experts</td>
<td>Dr Elmarie Malek</td>
<td>Tygerberg Hospital</td>
<td>Head of General Paediatric specialist services for Tygerberg Hospital with Clinical Governance oversight for Metro East.</td>
<td>F</td>
</tr>
<tr>
<td>Experts</td>
<td>Dr Simone Honikman</td>
<td>UCT Perinatal Mental Health Project</td>
<td>Director and Founder of Perinatal Mental Health Project.</td>
<td>F</td>
</tr>
<tr>
<td>Experts</td>
<td>Jacqui Couper</td>
<td>Independent</td>
<td>Occupational Therapist</td>
<td>F</td>
</tr>
<tr>
<td>Experts</td>
<td>Kamesh Flynn</td>
<td>Department of Social Development</td>
<td>Project manager on Early Childhood Development</td>
<td>F</td>
</tr>
<tr>
<td>Experts</td>
<td>Linda Biersteker</td>
<td>Freelancer</td>
<td>ECD policy and programming specialist</td>
<td>F</td>
</tr>
<tr>
<td>Experts</td>
<td>Lois Law</td>
<td>Southern African Catholic Bishops’ Conference. Parliamentary Liaison Office</td>
<td>Researcher</td>
<td>F</td>
</tr>
<tr>
<td>Experts</td>
<td>Prof Fiona Ross</td>
<td>UCT Anthropology Dept</td>
<td>Professor and Head of Anthropology</td>
<td>F</td>
</tr>
<tr>
<td>Experts</td>
<td>Prof Mark Tomlinson</td>
<td>University of Stellenbosch</td>
<td>Professor of Psychology and Public Mental Health</td>
<td>M</td>
</tr>
<tr>
<td>Experts</td>
<td>Sithembile Dube</td>
<td>Ilifa labantwana</td>
<td>Monitoring and Evaluation of programmes</td>
<td>F</td>
</tr>
<tr>
<td>Experts</td>
<td>Svetlana Doneva</td>
<td>Ilifa labantwana</td>
<td>Communications manager</td>
<td>F</td>
</tr>
<tr>
<td>Denomination Leaders</td>
<td>Alan Noble</td>
<td>Reach SA</td>
<td>Pastor of local Church, with oversight responsibilities in the Western Cape Region</td>
<td>M</td>
</tr>
<tr>
<td>Denomination Leaders</td>
<td>Bishop Aaron Makili</td>
<td>The Great Commission Network</td>
<td>Apostle</td>
<td>M</td>
</tr>
<tr>
<td>Denomination Leaders</td>
<td>Bishop Michel Hansrod</td>
<td>Methodist Church</td>
<td>Reverend Bishop of the Cape of Good Hope District</td>
<td>M</td>
</tr>
<tr>
<td>Denomination Leaders</td>
<td>Rev Errol Muller</td>
<td>Baptist Church</td>
<td>Executive Director for the all compassionate ministries</td>
<td>M</td>
</tr>
<tr>
<td>Denomination Leaders</td>
<td>Pastor Gareth Stead</td>
<td>Every Nation N1 City</td>
<td>Lead Elder of the N1 City Congregation</td>
<td>M</td>
</tr>
<tr>
<td>Denomination Leaders</td>
<td>Helena Jackson</td>
<td>AFM Welfare Department</td>
<td>CEO of the Welfare Department of the AFM Church</td>
<td>F</td>
</tr>
<tr>
<td>Denomination Leaders</td>
<td>Captain Juanita Wright</td>
<td>Salvation Army</td>
<td>Director for Children's Ministries and Assistant Territorial Youth Secretary</td>
<td>F</td>
</tr>
<tr>
<td>GROUP</td>
<td>INTERVIEWEE NAME</td>
<td>ORGANISATION</td>
<td>TITLE</td>
<td>GENDER</td>
</tr>
<tr>
<td>---------------------</td>
<td>------------------</td>
<td>------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>Denomination Leaders</td>
<td>Pastor Rod Botsis</td>
<td>Uniting Presbyterian Church (Belville)</td>
<td>Director for Children’s Ministries</td>
<td>M</td>
</tr>
<tr>
<td>Denomination Leaders</td>
<td>Simbarashe Kanenungo</td>
<td>Church of Nazarene</td>
<td>Child Development Coordinator - Nazarene Compassionate Ministries-Africa</td>
<td>M</td>
</tr>
<tr>
<td>Denomination Leaders</td>
<td>Steffan van der Male</td>
<td>Hillsong Africa Foundation</td>
<td>CEO of Hillsong Africa Foundation</td>
<td>M</td>
</tr>
<tr>
<td>Denomination Leaders</td>
<td>Tony Lawrence</td>
<td>Anglican Youth of SA</td>
<td>Director of Children and Youth in Southern Africa</td>
<td>M</td>
</tr>
<tr>
<td>Denomination Leaders</td>
<td>Sean Esterhuizen</td>
<td>NGK &amp; VGK – Diaconia</td>
<td>MSS Diaconia (Minister in Synodical Service) (CEO for Diaconia)</td>
<td>M</td>
</tr>
<tr>
<td>Denomination Leaders</td>
<td>Nioma Venter</td>
<td>NGK &amp; VGK – Diaconia</td>
<td>MSS Diaconia (Minister in Synodical Service) (CEO for Diaconia)</td>
<td>F</td>
</tr>
<tr>
<td>Pastors</td>
<td>Anthea Elliott</td>
<td>Bayview Baptist Church in Houtbay</td>
<td>Pastors Wife</td>
<td>F</td>
</tr>
<tr>
<td>Pastors</td>
<td>Barbara Richardson</td>
<td>Christ Church Kenilworth – Anglican</td>
<td>Children, teen and family ministry coordinator</td>
<td>F</td>
</tr>
<tr>
<td>Pastors</td>
<td>Bishop Derick Mtsolo</td>
<td>Litha Methodist Church</td>
<td>Presiding Bishop, Doctor of the Litha Methodist of South Africa</td>
<td>M</td>
</tr>
<tr>
<td>Pastors</td>
<td>Bradley Anderson</td>
<td>Common Ground Church</td>
<td>Next Generation Pastor.</td>
<td>M</td>
</tr>
<tr>
<td>Pastors</td>
<td>Pastor Desiree November</td>
<td>Lakeview Baptist</td>
<td>Pastor</td>
<td>F</td>
</tr>
<tr>
<td>Pastors</td>
<td>Kelly Adams</td>
<td>Assemblies of God Testimonies M.P</td>
<td>Children ministry leader</td>
<td>F</td>
</tr>
<tr>
<td>Pastors</td>
<td>Pastor Enrico</td>
<td>Assemblies of God Testimonies M.P</td>
<td>Assistant Pastor</td>
<td>M</td>
</tr>
<tr>
<td>Pastors</td>
<td>Sheldon Kidwell</td>
<td>The Bay Community Church</td>
<td>Pastor</td>
<td>M</td>
</tr>
<tr>
<td>Pastors</td>
<td>Suretha v Rooyen</td>
<td>The Bay Community Church</td>
<td>Children’s minister</td>
<td>F</td>
</tr>
<tr>
<td>Pastors</td>
<td>Lou-Mare Denton</td>
<td>Brackenfell NGK</td>
<td>Dominee – NGK Brankefell</td>
<td>F</td>
</tr>
<tr>
<td>Practitioners</td>
<td>Blanche Rezant</td>
<td>Parent Centre</td>
<td>Parent infant programme manager.</td>
<td>F</td>
</tr>
<tr>
<td>Practitioners</td>
<td>Karen Wilson</td>
<td>Jubilee Health Centre</td>
<td>Doctor, Centre Manager</td>
<td>F</td>
</tr>
<tr>
<td>Practitioners</td>
<td>Rachel Lilliot</td>
<td>Jubilee Health Centre</td>
<td>Nurse</td>
<td>F</td>
</tr>
<tr>
<td>Practitioners</td>
<td>Julie Mentor</td>
<td>CT Embrace</td>
<td>Project Leader</td>
<td>F</td>
</tr>
<tr>
<td>Practitioners</td>
<td>Thembi Nexsi</td>
<td>Sikula Sonke</td>
<td>Programme Manager</td>
<td>F</td>
</tr>
</tbody>
</table>
## APPENDIX E: DESCRIPTION OF FTD MODELS

<table>
<thead>
<tr>
<th>MODEL</th>
<th>LOC / INT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>The Book Sharing Project is based in Khayelitsha and has recently broadened its scope of impact to Lesotho. The ultimate goal of this project is to create opportunities for the mother and child to bond in a safe and educative setting that not only enhances the relationship but also develops language and literacy skills. Despite the project being quite resource-based, the outcomes have been extremely positive for dedicated participants that work through the programme.</td>
</tr>
<tr>
<td><strong>Cape Town Embrace</strong></td>
<td>Loc</td>
<td>Website: <a href="http://www.embrace.org.za/">http://www.embrace.org.za/</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cape Town Embrace seeks to reach all of Cape Town’s vulnerable children in a way that enables diverse but passionate groups of people to make a change in their communities. The main aim of the project is to enable all citizens to make a difference in the lives of Cape Town’s children.</td>
</tr>
<tr>
<td><strong>Care for Child Development</strong></td>
<td>Int</td>
<td>Website: <a href="https://www.unicef.org/earlychildhood/index_68195.html">https://www.unicef.org/earlychildhood/index_68195.html</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Care for Child Development (CCD) package developed by UNICEF and WHO. Makes use of multiple strategies to strengthen ‘nurturing care’ by parents. It is being implemented in more than 14 UNICEF countries in three regions. CCD intervention provides information and recommendations for cognitive stimulation and social support to young children, through sensitive and responsive caregiver-child interactions.</td>
</tr>
<tr>
<td><strong>Care UP</strong></td>
<td>Loc</td>
<td>Website: <a href="http://innovationedge.org.za/project/careup/">http://innovationedge.org.za/project/careup/</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Care UP is a mobile application that was funded by Innovation Edge as a means to provide mobile early childhood development programmes to be used for underserviced areas, either as a standalone service or as an additional component of other non-centre-based early childhood development services. The Care Up application is currently only available on the Google Playstore.</td>
</tr>
</tbody>
</table>

40 Model is Local (in South Africa) or International (Loc or Int)
<table>
<thead>
<tr>
<th>Program Name</th>
<th>Type</th>
<th>Website</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clothing Bank Grow With</td>
<td>Loc</td>
<td>Website: <a href="http://www.growecd.co.za/">http://www.growecd.co.za/</a></td>
<td>Grow with Educare Centres was started by the Clothing Bank to create fee-paying Early Childhood Development centres in low-income areas that offer quality education and resources for children between the ages of 2 and 5 years old.</td>
</tr>
<tr>
<td>Conditional Cash Transfers</td>
<td>Int</td>
<td>Website: <a href="https://en.wikipedia.org/wiki/Oportunidades">https://en.wikipedia.org/wiki/Oportunidades</a> Website: <a href="https://en.wikipedia.org/wiki/Bolsa_Fam%C3%ADlia">https://en.wikipedia.org/wiki/Bolsa_Fam%C3%ADlia</a></td>
<td>The Latin American countries have developed branded national programmes for children, for families. They have specific strategic levers that they use. Typically, they use conditional grants, income transfer to families, but that is an incentive to get mothers into clinics, other social spaces around nutrition and early stimulation for children. Mexico – Oportunidades – Cash transfer programme usually giving cash to mothers, conditional cash is provided to a household to encourage compliance with a prespecified action (it also serves as a way to alleviate short-run economic pressure), and unconditional cash is provided to a household with no established, related requirements that are linked to receive the cash. Brazil - Bolsa Familia Programme (Family Allowance Program) - Instituted widespread conditional cash transfers that launched in 2003 to provide cash to poor households. The outcomes of these types of programme is that it has “increased the proportion of people receiving prenatal care, probability of in-facility birth and of having a skilled birth attendant, conditions often associated with improved birth outcomes (ie, decreased neonatal mortality) and later developmental outcomes (Britto et al. 2017, p. 94).</td>
</tr>
</tbody>
</table>
opportunities through scalable models that provides access to early learning opportunities, through playgroups supported by toy libraries.

<table>
<thead>
<tr>
<th>Location</th>
<th>Description</th>
</tr>
</thead>
</table>
Toy library is a high impact, cost effective, non-centre based programme that gives children, their families, early learning facilitators and early childhood development practitioners access to a collection of carefully selected educational play materials, play sessions and training on how to use the toys to encourage development. |
| Crece Contigo | Website: [http://www.crececontigo.gob.cl/acerca-de-chcc/](http://www.crececontigo.gob.cl/acerca-de-chcc/)  
Chile Crece Contigo (Chile Grows with You) - The aim is to articulate, organize, and integrate early childhood care from pregnancy to age 5. This includes providing public services and monitoring the developmental trajectory of young children. (Global and Exploring, 2017, p. 46)  
Website: [http://www.mides.gub.uy/41937/uruguay-crece-contigo-ucc](http://www.mides.gub.uy/41937/uruguay-crece-contigo-ucc)  
Uruguay Crece Contigo (Uruguay Grows with You) - The aim is to meet the needs of highly vulnerable populations, pregnant women and children below the age of 4 by creating a comprehensive programme that guarantees the rights of households with pregnant women and children. (Global and Exploring, 2017, p. 47) |
| David Olds – Nurse Family Partnership | Website: [https://www.nursefamilypartnership.org/about/program-history/](https://www.nursefamilypartnership.org/about/program-history/)  
The David Olds Nurse Family Partnership brings professional assistance into homes, offering both support and assistance to mothers and local health systems. |
| ERLU 1st 1000 days programme | Website: [http://www.elru.co.za/](http://www.elru.co.za/)  
ELRU's primary focus is based on building the foundation of early childhood development. This is done through the provision of support to practitioners, caregivers and children from conception to 6 years. The 1st 1000 days programme has been playing an active role in the North West province for numerous years. |
| Family in Focus Programme (FIF) | Website: [http://www.fcw.co.za](http://www.fcw.co.za)  
Foundation for Community Work (FCW) is an NGO, based in Athlone, Cape Town. One of their programmes is the Family in Focus Programme (FIF) which is a non-centre-based, home-visiting, family outreach, early learning and stimulation programme. They target pre-school aged children (0-6 years) and their caregivers. It is a well-established home-visiting programme that is registered with DSD as an ECD learning programme. In 2016 they had 245 home visitors reaching in excess of 10 000 children and families in urban, peri-urban and rural communities in the WC, making it one of the largest ECD home-visiting programmes in SA. They target from pregnancy through to six years old. (Van Niekerk, Ashley-Cooper, and Atmore, 2017, p. 32–55). (SEE page 32 -55 of the CECD Research Report “Effective
<table>
<thead>
<tr>
<th>Programme</th>
<th>Location</th>
<th>Website</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family Outreach Programme</strong></td>
<td>Loc</td>
<td><a href="http://cecd.org.za/">http://cecd.org.za/</a></td>
<td>Family Outreach Programmes is a mobile programme that aims to provide face-to-face assistance to both parents and caregivers in the stimulation of early learning and the caring of a child. Currently, Family Outreach Programmes are playing an active role in Gugulethu through home visits, parenting sessions and playgroups.</td>
</tr>
<tr>
<td><strong>FARR</strong></td>
<td>Loc</td>
<td><a href="http://www.farrsa.org.za/">http://www.farrsa.org.za/</a></td>
<td>The Foundation for Alcohol Related Research (FARR) is a registered NGO that focuses on researching and providing information about Fetal Alcohol Spectrum Disorders (FASD) and Fetal Alcohol Syndrome (FAS) in South Africa. FARR is actively involved in programmes that stretch across South Africa that primarily provide support to families and caregivers affected by FAS.</td>
</tr>
<tr>
<td><strong>FCM (Mothers 2 Mothers)</strong></td>
<td>Int</td>
<td><a href="https://www.m2m.org/">https://www.m2m.org/</a></td>
<td>Mothers 2 Mothers seeks to empower local mothers in various underprivileged communities through training and employing HIV positive mothers. These 'Mentor Mothers' serve as frontline healthcare workers within under-sourced communities. Through direct support sessions, Mentor Mothers share knowledge with mothers about health education and provide support to women on how they can protect their babies from HIV infection, and keep themselves and their families healthy.</td>
</tr>
<tr>
<td><strong>FCM programme by ELRU</strong></td>
<td>Loc</td>
<td><a href="http://www.elru.co.za/">http://www.elru.co.za/</a></td>
<td>The Family and Community Motivator (FCM) Programme by ELRU is an initiative that provides home visits to pregnant women, caregivers and children 0 – 2 years in Langa, Vredendberg: Saldanah/Louwville.</td>
</tr>
<tr>
<td><strong>Head Start</strong></td>
<td>Int</td>
<td><a href="https://eclkc.ohs.acf.hhs.gov/">https://eclkc.ohs.acf.hhs.gov/</a></td>
<td>Head Start aims to assist low-income families prepare their children for school through programs within the United States. These programs encourage development through initiatives and services in early learning, health and family well-being.</td>
</tr>
<tr>
<td><strong>Hello Doctor</strong></td>
<td>Loc</td>
<td><a href="https://www.helloworld.doctor.co.za/">https://www.helloworld.doctor.co.za/</a></td>
<td>Hello Doctor is a mobile application that assists users with the diagnosis and education of symptoms that are experienced. Users are required to pay a monthly subscription fee in order to receive advice from a qualified medical practitioner.</td>
</tr>
</tbody>
</table>

41 Family and Community Motivators (FCMs)
Hello Doctor also has an application which provides valuable information about pregnancy and what to expect as an expectant mother.

### Human Milk Banking
- **Loc**
- **Website:** [http://www.hmbasa.org.za/](http://www.hmbasa.org.za/)

Human Milk Bank Association of South Africa is an initiative endorsed by the South African Government as a means to provide natural milk for premature babies in neonatal intensive care units in both state and private hospitals.

### Ibhayi Lengane
- **Loc**
- **Website:** [http://ilifalabantwana.co.za/project/ibhayi-lengane/](http://ilifalabantwana.co.za/project/ibhayi-lengane/)

First 1000 Days Relationship Support Tool to help caregivers realise the ‘ordinary magic’ which takes place through loving, responsive care. The tool, called Ibhayi Lengane (meaning 'baby’s blanket'), includes a home-visiting activity guide for home visitors, leave-at-home materials for caregivers and families, and a training manual to train home visitors in implementation.

### Informal Playgroup Programmes
- **Loc**
- **Website:** [http://www.sikhulasonke.org.za/programmes.html](http://www.sikhulasonke.org.za/programmes.html)
- **Website:** [http://www.elru.co.za/content/community-based-ecd](http://www.elru.co.za/content/community-based-ecd)

Playgroups provide learning activities and opportunities for child socialisation and to act as a referral point for other services. These could take the form of mother and child playgroups and include capacity building for caregivers, especially for children from birth until the year before they enter formal school. The content for older children should be more structured, with more frequent sessions, and parents would not attend regularly. These could be hosted through available public community facilities and private homes (Republic of South Africa 2015:70).

### Ilifa Labantwana
- **Loc**
- **Website:** [http://ilifalabantwana.co.za/](http://ilifalabantwana.co.za/)

Ilifa Labantwana (Children’s Heritage) is a South African early childhood development programme founded in 2009. Their goal over the next 5 years is to enable an additional 1 million children, aged zero to five, to access quality ECD through the Early Learning Subsidy. Children should be able to access the subsidy if they are attending an ECD centre, or if they are accessing ECD through a non-centre based programme.

### Integrated ECD Community Development Programme
- **Loc**
- **Website:** [http://www.khululeka.org.za/](http://www.khululeka.org.za/)

Khululeka Community Education Development Centre is an NGO based in rural areas of the Eastern Cape. The Early Childhood Development Community Development Programme that Khululeka offers non-centre-based and seeks to assist with family health, hygiene, safety and nutrition as well as quality ECD practice in the home. (Van Niekerk et al. 2017, p. 76–95)

### Kangaroo Mother Care
- **Int**
- **Website:** [http://kangaroomothercare.com/](http://kangaroomothercare.com/)
Kangaroo Mother Care is a programme that seeks to encourage the bonding between infant and mother. The programme is primarily made up of three parts: skin-to-skin contact, exclusive breastfeeding and supporting the DYAD.

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Location</th>
<th>Website</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lady Health Workers in Pakistan</td>
<td>Int</td>
<td><a href="http://www.who.int/workforcealliance/knowledge/resources/casestudy_pakistan/en/">http://www.who.int/workforcealliance/knowledge/resources/casestudy_pakistan/en/</a></td>
<td>The 100,000 plus workers serve mostly rural regions through the promotion of available service as well as health education. The Lady Health Workers Program seeks to support the public sector in family planning, prenatal care and care referrals. (Global and Exploring, 2017, p. 49)</td>
</tr>
<tr>
<td>Living Hope Moms &amp; Tots Group</td>
<td>Loc</td>
<td><a href="http://www.livinghope.co.za/ministries/living-right/moms-and-tots/">http://www.livinghope.co.za/ministries/living-right/moms-and-tots/</a></td>
<td>Moms &amp; Tots Group provides biblical teaching and mentoring to mothers with children 0-6 months, who attend the group. Teach skills about basic motherhood such as breastfeeding, hygiene, safety, the importance of immunizations, child development and the need for stimulation.</td>
</tr>
<tr>
<td>Mae Coruja (Mother Owl)</td>
<td>Int</td>
<td><a href="http://maecoruja.pe.gov.br/o-programa/">http://maecoruja.pe.gov.br/o-programa/</a></td>
<td>Mãe Coruja (Mother Owl) is one of Brazil’s social programmes. The programme provided care for pregnant women and their children, up to age 5 years. (Global and Exploring, 2017, p. 46)</td>
</tr>
<tr>
<td>MomConnect</td>
<td>Loc</td>
<td><a href="http://www.health.gov.za/index.php/mom-connect">http://www.health.gov.za/index.php/mom-connect</a></td>
<td>The fundamental idea to MomConnect is to offer a universal parent support programme through the use of cellphones. This is to be utilized in under-serviced areas to support both mothers and communities.</td>
</tr>
<tr>
<td>MSF Baby clinic</td>
<td>Int</td>
<td><a href="http://www.msf.org/en">http://www.msf.org/en</a></td>
<td>The MSF Baby Clinic model was implemented by Doctors Without Borders as a means to care for and offer health services to mothers in under-serviced areas across the globe.</td>
</tr>
<tr>
<td>Baby-Friendly Hospital initiative</td>
<td>Int</td>
<td><a href="https://www.unicef.org/nutrition/index_24806.html">https://www.unicef.org/nutrition/index_24806.html</a></td>
<td>The Baby-friendly Hospital Initiative (BFHI) is a global effort launched by WHO and UNICEF to implement practices that protect, promote and support breastfeeding.</td>
</tr>
<tr>
<td>National Parenting Programme</td>
<td>Loc</td>
<td><a href="https://www.unicef.org/southafrica/SAF_resources_parentals.pdf">https://www.unicef.org/southafrica/SAF_resources_parentals.pdf</a></td>
<td>National Parenting Programme: Parental /Primary Caregiver Capacity Building Training Package developed by The Department of Social Development SA and UNICEF for parents and caregivers of young children. The programme seeks to raise caregivers’ awareness of their role in early childhood development through</td>
</tr>
<tr>
<td><strong>Nalibali</strong></td>
<td>Loc</td>
<td>Website: <a href="http://nalibali.org/">http://nalibali.org/</a></td>
<td></td>
</tr>
<tr>
<td><strong>Nyamekela 4 Care</strong></td>
<td>Loc</td>
<td>Website: <a href="https://pmhp.za.org/wp-content/uploads/PMHP_N4C_-outline.pdf">https://pmhp.za.org/wp-content/uploads/PMHP_N4C_-outline.pdf</a></td>
<td></td>
</tr>
<tr>
<td><strong>Pastoral del Nino</strong></td>
<td>Int</td>
<td>Website: <a href="https://www.researchgate.net/publication/234559955_Pastoral_del_Nino_Bringing_the_Abundant_Life_to_Paraguayan_Children">Pastoral del Nino: Bringing the Abundant Life to Paraguayan Children. Available from:</a> [accessed Nov 24 2017].</td>
<td></td>
</tr>
</tbody>
</table>

11 sessions with a wide range of topics focusing on essential skills, knowledge and attitudes important in raising babies and young children up to five years old. It is designed to be holistic and flexible in presentation. (DSD/UNICEF 2008:2–3)

Nal’ibali focuses on creating foundational platforms of reading for both mother and child in home languages. Through various research initiatives by Nal’ibali, they have seen that improved outcomes for children are based on the enjoyment of a child’s reading. In other words, a firm foundation of literacy allows increases a child’s academic success.

The Department of Health put together the ‘Nutrition Guidelines for Early Childhood Development Centres’ (2016) which forms part of the SA ECD Policy commitment to improve Early Childhood Development services. There are shortcomings in the delivery of nutritional support of infants and young children, especially for children under the age of two, those living in poverty and in underserviced areas. These guidelines should improve the total nutritional intake of children of this age. The guidelines are aimed at childcare workers and ECD practitioners as the minimum standard for nutrition and child care in all settings. People who provide childcare to children under the age of 5 years are uniquely positioned to positively influence the food, and hence, nutritional intake of children. They lay the foundations for the children to have accurate knowledge about healthy eating and positive attitudes towards food and a healthy lifestyle. The objective of this guidelines are to provide ECD practitioners and caregivers information on how to plan, prepare and serve appropriate, nutritious, adequate and safe foods to children in their care. (Department of Health South Africa, 2016)

Nyamekela4Care (N4C) is an intervention initiative that provides a structured training, skills development, case sharing and self-care system. N4C was developed as a multi-component intervention to address problems that impact the quality of care among care workers.

Pastoral del Nino is transforming children’s lives in rural Paraguay. Part of Pastoral Social (Catholic Social Services), Pastoral del Nino's primary focus is to bring "vida en abundancia" (the abundant life) to families by ensuring that mothers survive childbirth and children reach their first birthdays. In addition, the organization
promotes child health and development in the context of family and community. Pastoral del Nino began in Paraguay in 1995 and operates almost entirely through the help of local volunteers, who are also called community leaders. Three thousand volunteers strong today, the organization serves nearly four thousand families each year. Services are delivered on the village level by community leaders. Pastoral del Nino programs (1) are financially feasible; (2) encourage community-wide participation; (3) build local capacity; (4) address multiple levels of child development; and (5) strengthen families and communities. Taken together, these five components result in Pastoral's success each year in reaching more than ten thousand rural Paraguayan children whose families are poor. The program strengthens families and communities and promotes solutions that build local capacity for self-help and problem solving.

<table>
<thead>
<tr>
<th>Perinatal Mental Health project (PMHP)</th>
<th>Loc</th>
<th>Website: <a href="https://pmhp.za.org/">https://pmhp.za.org/</a></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Partnering with the Departments of Health and Social Development, PMHP provides mental health services for pregnant and postnatal women, train those who work with mothers to improve the quality of their care, form partnerships to promote the scale up of services and inform global interventions through robust research and advocacy. They support state agencies and partner with non-profit organisations to achieve health and social development objectives and more.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Philani focuses on three key areas, namely: maternal, child health and nutrition. The idea of Philani is to identify mentor mothers who provide support to the mother till the child is about 5 years old. These mentor mothers are predominantly from the same communities and through training, are able to provide advice and education.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primeira Infancia Melhor</th>
<th>Int</th>
<th>Website: <a href="http://www.pim.saude.rs.gov.br/v2/o-pim/o-que-e/">http://www.pim.saude.rs.gov.br/v2/o-pim/o-que-e/</a></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Primeira Infancia Melhor (Improved Early Childhood) in Brazil, helps families understand child development in order to establish strong parent–child bonds through home visiting services. (Global and Exploring, 2017, p. 46)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Proud to be Me</th>
<th>Loc</th>
<th>Website: <a href="http://www.proud2b.org/">http://www.proud2b.org/</a></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Proud to be Me is a parenting programme that seeks to encourage parents to raise children that are proud of who they are and where they are from.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Media to be used to raise awareness and create demand for services and provide supporting messaging/material for use in all programmes. An example is Radio Drama Project with behaviour change communication to support the protection of</td>
</tr>
<tr>
<td>Country</td>
<td>Programme</td>
<td>Type</td>
</tr>
<tr>
<td>---------</td>
<td>------------</td>
<td>------</td>
</tr>
<tr>
<td>Mali, Burkina Faso and Ivory Coast</td>
<td>Reach Up and Learn</td>
<td>Int</td>
</tr>
<tr>
<td>Roving Caregivers Programme</td>
<td>The Rural Family Support Organisation (RuFamSo) Roving Caregivers Programme works with youngsters between the ages of 0 and 3 in targeted communities who do not have access to the formal education system are the primary beneficiaries of the internationally recognized 16-year-old programme. As a result of its success in Jamaica, RCP has since been replicated in Belize, St. Lucia, Grenada, Dominica and St. Vincent in collaboration with the Caribbean Child Support Initiative (CSSI). And, it was bestowed the prestigious UNICEF Maurice Pete Award for protecting and promoting the health, welfare and general well being of children.</td>
<td></td>
</tr>
<tr>
<td>Jamaica</td>
<td>SmartStart</td>
<td>Loc</td>
</tr>
<tr>
<td>South Africa</td>
<td>Sobambisana Initiative</td>
<td>Loc</td>
</tr>
<tr>
<td>Programme</td>
<td>Location</td>
<td>Website</td>
</tr>
<tr>
<td>-----------</td>
<td>----------</td>
<td>---------</td>
</tr>
<tr>
<td>1. home visits to caregivers and children</td>
<td>Loc</td>
<td></td>
</tr>
<tr>
<td>2. community playgroups with parent education components</td>
<td>Loc</td>
<td></td>
</tr>
<tr>
<td>3. community playgroups without parent education components</td>
<td>Loc</td>
<td></td>
</tr>
<tr>
<td>4. centre and school-based interventions</td>
<td>Loc</td>
<td></td>
</tr>
<tr>
<td>5. advocacy for improved and integrated services for children among regional and local government officials and civil society organisations.</td>
<td>Loc</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Loc</td>
<td></td>
</tr>
</tbody>
</table>

The Parent Centre
Website: [http://www.theparentcentre.org.za/](http://www.theparentcentre.org.za/)

The Parent Centre is a Teen pregnancy and Parenting Programme that seeks to ensure that children are able to reach their full potential whilst being protected from the dangers of society.

The Parent-Infant Programme

The Parent Centre has a Parent Infant Home Visiting Project which provides information and support to pregnant women during and after the birth of their baby to encourage positive parent and infant attachment.

The Step-Programme
Website: [https://www.nji.nl/nl/Download-NJi/Publicatie-NJi/Homebased_programmes_in_the_Netherlands.pdf](https://www.nji.nl/nl/Download-NJi/Publicatie-NJi/Homebased_programmes_in_the_Netherlands.pdf)

The Step-Programme in the Netherlands – three parts Instapje (1-2yrs); Opstapje (2-4); Opstap (4-6yrs). Instapje is a home-based programme which provides the first steps in stimulating communication between parents and children. Focused on parent’s behaviour supporting the child in daily interactions.

Triple P
Website: [http://www.triplep.net/glo-en/home/](http://www.triplep.net/glo-en/home/)

The Triple P – Positive Parenting Program is one of the most effective evidence-based parenting programs in the world, backed up by more than 35 years of ongoing research. Triple P gives parents simple and practical strategies to help them build strong, healthy relationships, confidently manage their children’s behavior and prevent problems developing. Triple P is currently used in more than 25 countries and has been shown to work across cultures, socio-economic groups and in many different kinds of family structures.

Ububele
Website: [https://ububele.org/](https://ububele.org/)

Ububele is based in Johannesburg and currently runs two initiatives: the home visitors programme and the baby mat programmes. Both of these initiatives seek to support both the mother and child.
<table>
<thead>
<tr>
<th>Project</th>
<th>Loc</th>
<th>Website</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>WC First Thousand Days Campaign</td>
<td></td>
<td><a href="https://www.westerncape.gov.za/first-1000-days/">https://www.westerncape.gov.za/first-1000-days/</a></td>
<td>The Western Cape First Thousand Days Campaign was launched in February 2016 as a means to create awareness of the importance of the first 1000 days of a child’s life. This programme was initiated by the Western Cape Government.</td>
</tr>
<tr>
<td>Zero Stunting Initiative</td>
<td></td>
<td><a href="https://dgmt.co.za/our-new-zero-stunting-initiative-employment-opportunities/">https://dgmt.co.za/our-new-zero-stunting-initiative-employment-opportunities/</a></td>
<td>The Zero-Stunting Initiative seeks to achieve four objectives: 1) Support and promote behaviour change of mothers through universal access to antenatal and postnatal classes. 2) Catalysing Community Healthcare Workers into ‘Champions for Children’. 3) Change the culture of early child feeding practices (both non-exclusive breastfeeding and poor weaning practices) through disruptive mass media communications. 4) Drive national commitment to Zero-stunting by 2030 through data-driven advocacy. To this end, the Zero-Stunting Initiative is recruiting a high-value, high-performance team to lead this work and achieve the ambitious goal of halving the prevalence of stunting in South Africa within a decade.</td>
</tr>
<tr>
<td>Zoe Project</td>
<td></td>
<td><a href="http://thezoeproject.co.za/">http://thezoeproject.co.za/</a></td>
<td>The Zoe Project is currently based in three communities within the Western Cape, namely: Retreat, Hanover Park and Mowbray. The main idea of the project is to provide assistance and support to mothers as well as provide baby packs for newborns.</td>
</tr>
<tr>
<td>#LovePlayTalk</td>
<td></td>
<td><a href="https://dgmt.co.za/tag/loveplaytalk/">https://dgmt.co.za/tag/loveplaytalk/</a></td>
<td>First national public campaign using multimedia, mass communication public service campaign. Aim to create awareness around the importance of responsive parenting during pregnancy and early years of a child’s life.</td>
</tr>
</tbody>
</table>
APPENDIX F: LIST OF RECOMMENDED READINGS

RECOMMENDED READING FOR FIRST THOUSAND DAYS

The three part Lancet ECD Series:


RECOMMENDED READING ON “CHURCH, SOCIAL DEVELOPMENT AND FTD”


BIBLIOGRAPHY FOR APPENDIX


