Exploring factors that could potentially have affected the first thousand days of absent learners in the Foundation Phase

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DECLARATION OF RESEARCHER

I, Carien van Zyl, hereby declare that the thesis entitled *Exploring factors that could potentially have affected the first thousand days of absent learners in the Foundation Phase* is my own, original work. All the resources that were used and quoted from, have been acknowledged by means of references in the text and in a comprehensive reference list. I further declare that I have not in the past, whether in part or in its entirety, submitted this dissertation to any university to obtain any other qualification.

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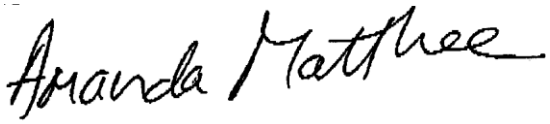

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PREFACE

This dissertation is presented in a full format for a master's degree as stipulated in the North-West University postgraduate faculty manual (2016).

This dissertation consists of four chapters:

- Chapter 1: Introduction and orientation to the research study
- Chapter 2: Literature study divided into two parts. Part 1 presents the first thousand days, Foundation Phase of schooling and school absenteeism. Part 2 provides a comprehensive literature study on child development.
- Chapter 3: Research findings
- Chapter 4: Summary, conclusions and recommendations of the research study.

These chapters are followed by a complete reference list and annexures. North-West University's Harvard referencing style (2012) is used in this document. Any reference made to 'researcher' within this dissertation will refer to the student, Carien van Zyl.

ABSTRACT

The first thousand days in the life of a child, that is from conception to the age of two, is considered the most critical development phase because children's physical, cognitive and socio-emotional development during this time can have lifelong consequences for their health and well-being. Literature explains the rapid development of the brain structure which forms more than one million neural connections per second during this time, thus shaping the building blocks for the child's future. The brain structure formed during pregnancy and the first two years of the child's life can either result in a weak or strong foundation for the child's future health, behaviour and learning. Research has confirmed that children need nurturing care during the first thousand days to ensure that they develop favourably and reach their full potential. This care includes good health, proper nutrition, responsive care, safety, security and early learning.

Recognising the importance of the first thousand days of a child's life, the Western Cape Government launched its First 1000 Days initiative called 'Right start, Bright future' in 2016. This initiative, aimed at providing services during the first thousand days to help ensure that children reach their full potential, has three key areas that could potentially impact the first thousand days of a child's life: (1) health and nutrition, (2) love and attention, and (3) play and stimulation. These key areas focus on factors such as nutritional deficiency, the physical and mental health of the mother and child, the mother's substance use/abuse during pregnancy, support to mother and child, nurturing care, attachment, stimulation and learning.

The aim of this study was to qualitatively explore and describe factors that could potentially have affected the first thousand days of absent learners during the Foundation Phase within the Paarl East area in the Western Cape. The rationale for focusing specifically on 'absent learners' was motivated by the researcher's work context where she is employed by a Non-Profit Organisation (NPO) rendering services to absent learners and their families.

A qualitative approach and qualitative descriptive design were utilised in this study. Data collection consisted of semi-structured interviews with 18 biological mothers, using an interview schedule and timeline tool. The interview schedule was developed with 12 questions relating to the three key areas of the Western Cape Government's First 1000 Days initiative. These interviews were voice recorded, transcribed and analysed using thematic data analysis. This research revealed the following six themes: (1) the health of the mother during the first thousand days of the child's life, (2) the health of the child during the first thousand days of life, (3) the availability of support to the mother and the child during the first thousand days of the child's life, (4) the circumstances of the mother and the child during the first thousand days of the child's life, (5) the attachment

and relationship between the mother and the child during the first thousand days of the child's life, and (6) the development and care of the child during the first thousand days of life. The themes, sub-themes and categories that emerged in this study relate to the various factors that could potentially have affected the first thousand days of absent learners in the Foundation Phase.

Based on the data collected, the researcher concluded that a wide range of factors are playing a role during the first thousand days of a child's life, thus support and nurturing care for both the mother and the child are crucial. Due to the enormous amount of support needed, the researcher recommended stronger collaboration and multi-sector partnerships between government departments, NPOs, professionals, the private sector and people who are passionate about children in order to help ensure that all South African children reach their full potential.

Keywords: absent learner, biological mother, first thousand days, Foundation Phase

OPSOMMING

Die eerste duisend dae in die lewe van 'n kind, dit wil sê vanaf bevrugting tot op ouderdom twee jaar, word as die heel belangrikste ontwikkelingsfase beskou want kinders se fisieke, kognitiewe en sosio-emosionele ontwikkeling in hierdie tyd kan lewenslange gevolge vir hul gesondheid en welstand inhou. Die literatuur verduidelik hoe vinnig die brein in hierdie tyd groei en hoe die breinstruktuur ontwikkel deur meer as een miljoen neuroverbindings per sekonde te vorm om só die boublokke vir die kind se toekoms te skep. Die breinstruktuur wat tydens swangerskap en die eerste twee jaar gevorm word, kan dus 'n swak of sterk grondslag vorm wat die kind se toekomstige gesondheid, gedrag en leer beïnvloed. Navorsing bevestig dat kinders koesterende sorg tydens die eerste duisend dae benodig sodat hulle gunstig kan ontwikkel en hul volle potensiaal kan bereik. Hierdie sorg sluit in goeie gesondheid, behoorlike voeding, toegewyde sorg, veiligheid, sekuriteit en vroeë leer.

Die Wes-Kaapse regering erken die belangrikheid van die eerste duisend dae van 'n kind se lewe. Daarom het die provinsiale regering in 2016 die *Eerste 1000 dae* initiatief genoem ‘Right start, Bright future’ bekend gestel. Hierdie initiatief, wat ten doel het om dienste tydens die eerste duisend dae te lewer om te verseker dat kinders hul volle potensiaal kan bereik, is op drie kernareas gerig, naamlik (1) gesondheid en voeding, (2) liefde en aandag, en (3) spel en stimulasie. Hierdie kernareas fokus op faktore soos voedingstekorte, die fisieke en geestesgesondheid van die moeder en kind, die moeder se middelgebruik/-misbruik tydens swangerskap, ondersteuning aan die moeder en kind, koesterende sorg, binding, stimulasie en leer.

Die doel van hierdie studie was 'n kwalitatiewe verkenning en beskrywing van die faktore wat moontlik die eerste duisend dae van afwesige leerders in die Grondslagfase in die Paarl-Oos-gebied in die Wes-Kaap kon beïnvloed. Die spesifieke klem op ‘afwesige leerders’ in hierdie studie is gemotiveer deur die navorser se werkkonteks waar sy vir 'n nie-winsgewende organisasie werk wat dienste aan afwesige leerders en hul gesinne lewer.

'n Kwalitatiewe benadering en kwalitatiewe beskrywende ontwerp vorm die onderbou van hierdie studie. Data-insameling het bestaan uit semi-gestruktureerde onderhoude met 18 biologiese moeders. Die onderhoude is met behulp van 'n onderhoudskedule en tydlyn-hulpmiddel gevoer. Die onderhoudskedule is ontwikkel met 12 vrae wat verband hou met die drie kernareas van die Wes-Kaapse regering se *Eerste 1000 dae* initiatief. Die onderhoude is opgeneem, getranskribeer en ontleed deur middel van tematiese data-ontleding. Hierdie navorsingstudie het die volgende ses temas onthul: (1) die gesondheid van die moeder tydens die eerste duisend dae van die kind

se lewe, (2) die gesondheid van die kind tydens die eerste duisend dae van lewe, (3) die beskikbaarheid van ondersteuning aan die moeder en kind tydens die eerste duisend dae van die kind se lewe, (4) die omstandighede van die moeder en die kind tydens die eerste duisend dae van die kind se lewe, (5) die binding en verhouding tussen die moeder en die kind tydens die eerste duisend dae van die kind se lewe, en (6) die ontwikkeling en sorg van die kind tydens die eerste duisend dae van lewe. Die temas, sub-temas en kategorieë wat in hierdie studie na vore gekom het, hou verband met die talle faktore wat moontlik die eerste duisend dae van afwesige leerders in die Grondslagfase kon beïnvloed.

Die navorser het, gegrond op die data wat ingesamel is, tot die gevolgtrekking gekom dat daar 'n groot verskeidenheid faktore is wat 'n rol kan speel tydens die eerste duisend dae van 'n kind se lewe. Ondersteuning en koesterende sorg vir die moeder sowel as die kind op verskeie vlakke is dus noodsaaklik. As gevolg van die enorme behoefte aan ondersteuning, beveel die navorser groter samewerking en multi-sektor-vennootskappe aan tussen regeringsdepartemente, nie-winsgewende organisasies, die privaat sektor en mense wat passievol is oor kinders ten einde te help verseker dat alle Suid-Afrikaanse kinders hul volle potensiaal kan bereik.

Sleutelwoorde: afwesige leerder, biologiese moeder, eerste duisend dae, Grondslagfase

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ABBREVIATIONS

ADHD	Attention Deficit Hyperactivity Disorder
AIDS	Acquired Immune Deficiency Syndrome
ARND	Alcohol-Related Neurodevelopmental Disorder
CAQDAS	Computer-Aided Qualitative Data Analysis Software
DCPO	Designated Child Protection Organisation
DSD	Department of Social Development
ECD	Early Childhood Development
ECDAN	Early Childhood Development Action Network
ELDA	Early Learning and Development Area
FAE	Fetal Alcohol Effects
FAS	Fetal Alcohol Syndrome
FASD	Fetal Alcohol Spectrum Disorder
HIV	Human Immune-deficiency Virus
HREC	Health Research Ethics Committee
NCF	Nurturing Care Framework
NPO	Non-Profit Organisation
PCBs	Polychlorinated biphenyls
p-FAS	Partial Fetal Alcohol Syndrome
PICH	Parent Infant and Child Health
POPI	Protection of Personal Information
PPCT	Process-Person-Context-Time

REM	Rapid Eye Movement
SAICA	South African Institute of Chartered Accountants
SGB	School Governing Body
SIDS	Sudden Infant Death Syndrome
SUN	Scaling Up Nutrition
TB	Tuberculosis
UIF	Unemployment Insurance Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

CHAPTER 1: INTRODUCTION AND ORIENTATION TO THE RESEARCH STUDY

1.1 INTRODUCTION

The first thousand days in the life of a child, that is from conception to the age of two, is considered the most important development phase because children's physical, cognitive and socio-emotional development during this time could have lifelong consequences for their health and well-being (Pem, 2015:1). Various factors could potentially have affected the first thousand days of absent learners in the Foundation Phase, since this period establishes the foundation of a child's life. If these factors are explored, valuable information could be obtained to motivate professionals and others to educate and support pregnant mothers or mothers with children under two years of age regarding the importance of establishing a good foundation during the first thousand days.

In the section that follows, the problem statement for this study is presented to highlight the identified gap in current research, thereby emphasising the need to explore the factors that could potentially have impacted the first thousand days of absent learners in the Foundation Phase. This chapter also provides an in-depth discussion of the research process that was followed, as well as other relevant aspects such as ethical considerations and the trustworthiness of this study.

1.2 RATIONALE AND PROBLEM STATEMENT

The United Nations Children's Fund (UNICEF) (2017) said the following about child development:

The first 1000 days of life – between a woman's pregnancy and her child's second birthday – is a unique period of opportunity when the foundations for optimum health and development across the lifespan are established. The right nutrition and care during the 1000 day window influences not only whether the child will survive, but also, his or her ability to grow, learn and rise out of poverty. As such, it contributes to society's long-term health, stability and prosperity.

The importance of the first thousand days is widely proclaimed, being the focus of an initiative launched by Global Wellness Institute (2016). Children from birth to two years need nurturing care that includes good health care, nutrition, security, safety, responsive caregiving, and early learning in order to reach their full potential (Bhardwaj *et al.,* 2017:22, 34). The brain architecture that is formed before birth and early in life could either establish a sturdy or weak foundation for all future health, learning and behaviour (Center on the Developing Child of Harvard University, 2016:7).

According to an evidence paper from the Centre for Community Child Health, a research group of the Murdoch Children's Research Institute and Department of the Royal Children's Hospital in Melbourne, the first thousand days period could have lifelong consequences on a child's health and well-being (Moore *et al.*, 2017:1, 68, 70). According to these researchers, the fetus and infant are at their most vulnerable to external exposures and experiences during the first thousand days. They also stated that a poor start to life during the first thousand days may influence the neurological and biological adaptations in a child's life. At the same time, the first thousand days are the period of greatest developmental plasticity with the ability to adapt to the particular environment. Plasticity, as described by Cook and Cook (2010:127), refers to the brain's ability to remain flexible until synaptogenesis is complete. Although this ability to adapt to adverse experiences may help in the short term, it will have negative biological and developmental implications in the long term (Moore *et al.*, 2017:70). A recent study entitled 'Nurturing care during the first 1000 days of life: A systematic review', conducted by Mputle (2019), confirms the importance of health care, proper nutrition, responsive care, safety and security, as well early learning during the first thousand days to ensure the favourable development of children. She emphasised how the absence of these factors during this crucial time could lead to physical, emotional and social challenges later in these children's lives.

The Western Cape Government also recognised the importance of the first thousand days at the 2016 Provincial Health Research Day with the 'First thousand days' as theme (Malek, 2016:2). On 17 February 2016, the Western Cape Government launched the First 1000 Days initiative entitled 'Right start, Bright future' in the province to help ensure that children reach their full potential. This initiative focuses on three key areas, namely: (1) health and nutrition, (2) love and attention, and (3) play and stimulation. During the first thousand days, these three key areas play a vital role in the child's physical, social, emotional and cognitive development (Western Cape Government, 2017). The first key area, namely health and nutrition, is related to factors such as nutritional deficiency, malnourishment, and the physical and mental health of both the mother and child, as well as the mother's substance abuse during pregnancy. The second key area, namely love and attention, include factors such as support, toxic stress, care and attachment. The third key area, namely play and stimulation, refers to the stimulation and protection of the child (Western Cape Government, 2019a).

All children have the right to thrive, not only survive, and to reach their full potential which includes their physical, mental, moral, spiritual and social development. It is therefore important to identify risks factors that impact a child's development (Mezmur, 2017:7). As described above, the first thousand days already start during the pre-natal phase and, as explained by Bhardwaj *et al.* (2017:22, 34), the developing brain of a baby sets up the basic architecture of human potential.

According to Donald and Wilmshurst (2016:17), human brain development during the prenatal period is particularly vulnerable to prenatal influences. Neuroscience, as described by Berg (2016a:iii) and Lake (2017), revealed the explosive growth of brain structure during infancy with the forming of a thousand neural connections every second, thus shaping the building blocks for a child's future. The Center on the Developing Child of Harvard University (2019a) now believes that more than one million new neural connections per second are formed during the first few years, instead of their earlier estimated 700 to 1 000 connections per second.

The first thousand days is considered the most important development phase of a child's life because the physical, cognitive, socio-emotional development of a child during this period has immense impact on the child later in life (Pem, 2015:1). Infancy, the period between birth and approximately two years, is described by Bornstein *et al.* (2014:1, 16, 80) as the period of rapid development of the physical and nervous systems, often influencing development in other spheres of the child's life. They further explained how fundamental the characteristics are that an infant develops and acquires during this phase. The three domains of child development, namely physical, cognitive and socio-emotional development, interact with each other with development in one domain often impacting development in other domains (Levine & Munch 2014:7-8).

The rationale for selecting absent learners as a topic for this study was motivated by the researcher's work context and personal passion to make a difference in the lives of absent learners and their families. The researcher currently works at Khula Development Group, a registered NPO in Paarl in the Western Cape. It is the mission of the Khula Development Group to reintegrate primary school children in disadvantaged communities, at risk of dropping out, back into the school system (Khula Development Group, n.d.). The researcher is appointed as principal social worker within the organisation to render indirect services to absent learners by supervising the other social workers and assist with strategic planning and programme development. This organisation offers various programmes to support absent learners and their families, including support to the primary caregivers. Although Khula Development Group focuses on absent learners as target group, their services include support to these learners' primary caregivers who often are pregnant or have other children younger than two years of age.

The researcher has been working for Khula Development Group since 2014. During this time, she has seen the number of referrals regarding absent learners almost tripling, which was a cause of a great concern for her professionally. The increase of absenteeism among primary school children encouraged the researcher to develop preventative programmes within her work context.

School absenteeism is a great concern in South Africa with an alarming statistic of 615 327 learners being absent in the Cape Winelands District in the Western Cape province during 2017 (Western Cape Education Department, 2017). School absenteeism has consequences on multiple levels, leading to, among others, poor academic performance and increased school dropout rates in the short term with long-term consequences such as inadequate education, unemployment, financial instability and health-related problems, thus creating an unfortunate cycle of poverty and poor health outcomes (Ogburn, 2017:1). The researcher's interest in the proposed topic originated from her attendance of the First 1000 Days roadshow at Paarl Hospital in November 2017, as well as her work at Khula Development Group focusing on learner absenteeism. Personal context, as confirmed by Salkind (2012:42), could often be a motivator for starting research, as seen in the researcher's journey pertaining to this research study.

The researcher was particularly interested in the Foundation Phase as this is the first phase of formal schooling in South Africa. This phase establishes the basis for learners' growth (Embury Institute for Higher Education, 2019). Grades 1 to 3, as described by Hoadley (2013:74), focus on the learning of formal curriculum content including reading, writing, counting and calculating. Success in school is determined by a variety of the child's behaviours and abilities such as working well with other children, engaging in learning, the ability to follow directions, as well as literacy and numeracy skills. These behaviours and abilities are interconnected with the child's physical, motor, social, emotional, moral and spiritual development (UNICEF, 2012a:4). As explained by Janse van Rensburg (2015:107), learners should achieve certain assessment standards by the end of Grade R as well as linguistic and cognitive readiness in order to understand the concepts used in the teaching of the Foundation Phase. For example, if learners do not acquire basic reading skills during the Foundation Phase, they will be excluded from learning and struggle to engage with the curriculum in higher grades (Pretorius *et al.*, 2016:4). According to Daniel *et al*., (2010:173), children's anxiety about their inability to do academic work is one of the main reasons for school refusal. Mitchell *et al.* (2016:185) explained the importance of success in the early years of schooling and highlighted that children who repeat Grade 1 are particularly at risk of future dropout. Therefore, children's development in the early years needs to be stimulated in order to reach the required stage of school readiness when they enter formal schooling, as this will influence their school performance during formal education (Van Zyl, 2011:83).

The researcher acknowledged the existence of many variables, besides the first thousand days, that could influence a child's schooling. However, she was specifically interested in the potential impact of certain aspects of the first thousand days relating to schooling. According to literature,

the following factors of the Western Cape Government's First 1000 Days initiative can potentially affect a child's schooling:

(i) **Nutritional deficiencies:** Iron deficiency during the first two years of life may lead to reduced cognitive abilities and deficits in school achievement later in life (Maalouf-Manasseh *et al*., 2016:1,4). They also emphasised the long-term consequences of malnourishment during the first thousand days such as repeating of school grades, decreased learning, school absenteeism and school dropout.

(ii) **Mother's substance abuse during pregnancy:** This could include the biological mother's use of licit or illicit drugs such as tobacco, alcohol, marijuana and other drugs (Finnegan, 2013:2). Due to the high prevalence of Fetal Alcohol Spectrum Disorder (FASD) in the Western Cape of nearly one in four school entry aged children, FASD relating to schooling will be emphasised (Adnams, 2016:12). FASD, as defined by Berk (2013:98-99), is a collection of physical and neurobehavioural disabilities caused by prenatal exposure to excessive amounts of alcohol during pregnancy. FASD, according to Adnams (2016:12) and Kellerman (2003), comes to the fore when the child enters formal schooling and manifests in the form of learning and behaviour problems such as hyperactivity, memory difficulties, problem solving, social problems, reading, lack of attention, disruptive behaviour in class, disobeying school rules, absenteeism, suspension and school dropout.

(iii) **Toxic stress:** The architecture of the developing brain is weakened by toxic stress which could lead to lifelong problems in learning (Center on the Developing Child of Harvard University, 2017a). Considerable evidence shows the sensitivity of the fetus to hormonal and physiological indicators of maternal stress, confirming that heightened exposure to stress in the womb could cause long-term emotional and cognitive problems. Stressful experiences that are prevalent to families living in poverty can alter children's neurobiology, undermining their ability to succeed in school (Thompson, 2014:41, 43).

(iv) **Attachment:** There is a strong link between secure attachment in infancy and children's positive relationship with their teachers, higher self-esteem and greater resilience later in life (Berg, 2016b:16). Disorganised attachment in infancy is associated with a range of developmental problems in the school years such as aggressive behaviour, poor peer relations and cognitive immaturity (Newman *et al*., 2015:4).

(v) **Stimulation:** Children who had received stimulation during infancy performed better in cognitive and educational aspects later in life (Jamieson & Richter, 2017:36). According to Lake (2016:12), stimulation of young children's minds through playing, talking and reading

will enhance brain development and foster their ability to learn. Ebrahim *et al*. (2013:69) explained that children's learning at school is impacted by the lack of learning and stimulation in the early years.

A significant amount of international literature and research regarding the first thousand days of children's development could be located (Arabena *et al*., 2016; Arabena *et al.*, 2015; Berg, 2016a; De Angulo & Losada, 2016; Kattula *et al.*, 2014; Maalouf-Manasseh, 2016; Moore *et al.*, 2017; Ritte *et al.*, 2016; Wave Trust, 2013, Wopereis *et al*., 2014). However, only a limited amount of literature and research pertaining to the first thousand days of children in South Africa could be found (Malek, 2016; Mputle, 2019; Lundie *et al*. 2018; UNICEF, 2017). Within the Western Cape context, only one study was found (Pentecost, 2015). This study, conducted in Khayelitsha, focused on the link between the first thousand days of life and obesity. Since the first thousand days of life is a fairly new topic in South Africa, and with the launch of the First 1000 Days initiative in the Western Cape only three years ago in 2016, the gap for more research in this field, especially within the Western Cape, was identified.

This study purposes to make a contribution by adding to literature with specific reference to understanding the first thousand days of absent learners in the Foundation Phase. These insights may give Khula Development Group and other professionals in this field, especially those working with young children and mothers, new information and understanding that could guide the way they plan interventions. This research study will provide Khula Development Group with guidelines and recommendations in order to inform programmes for the future. Deeper insight into this phenomenon might furthermore influence the employees of Khula Development Group – namely fieldworkers, social auxiliary workers, programme facilitators and social workers – to educate pregnant mothers or mothers with children younger than two years regarding the importance of the first thousand days. Thus, the researcher intends to provide Khula Development Group with the findings of this study, and to use this information during strategic planning and programme development, which forms part of her formal job description. In addition, the researcher plans to provide this study to the First 1000 Days workgroup in order to strengthen their work. It is thus envisioned that the key findings and recommendations of this study can guide organisations in their approach to incorporate more preventative strategies focusing on the first thousand days into their service delivery programmes.

The researcher acknowledges the many variables regarding learner absenteeism. Hence, this study does not aim to determine a correlation between the first thousand days and absenteeism. The aim of the study was solely to explore factors that could potentially have affected the first

thousand days of absent learners in the Foundation Phase by conducting semi-structured interviews with these learners' mothers.

In the light of this, the research question for this study was formulated. As stated by Tracy (2013:15-17), the research question is important to navigate the research and provide a sense of purpose. The research question guiding this study has therefore been formulated as:

What themes will emerge regarding the factors that could potentially have affected the first thousand days of absent learners in the Foundation Phase?

1.3 KEY CONCEPT DEFINITIONS

1.3.1 First thousand days

The first thousand days is the time period from conception to the end of the child's second year (Malek, 2016:2; Moore *et al.*, 2017:1). It is furthered described as the earliest period of human life which includes the pregnancy phase, birth, neonatal phase, as well as infancy phase up to the first two years of childhood (Lundie *et al.*, 2018:2).

1.3.2 Absent learner

In terms of the Department of Basic Education's Policy on Learner Attendance, a learner is absent from school when the learner is not present in class or participating in a school activity when the register is marked (Department of Basic Education, 2010:10). This policy also defines a learner as any person receiving education or obliged to receive education in terms of the South African School Act.

1.3.3 Foundation Phase

In South Africa, the Foundation Phase refers to the phase of schooling from Grade R to Grade 3 (Mitchell *et al.*, 2016:186-187; Western Cape Government, 2015).

1.3.4 Biological mother

Collins English Dictionary (2018) defines biological mother as "the mother who gave birth to a child".

1.4 AIM AND OBJECTIVES

According to Sarantakos (2013:11), a social research study usually refers to the immediate outcomes of the research. Joubert *et al*. (2016:27) emphasised the importance of the research

aim being realistic and feasible based on the available resources and time. The aim of this study was formulated in order to understand the primary purpose of this research, as noted by Tracy (2013:98).

The aim of this study was to qualitatively explore and describe factors that could potentially have affected the first thousand days of absent learners in the Foundation Phase within the Paarl East area in the Western Cape.

Fouché and De Vos (2011:94) highlighted the importance of deliberately defining the goal and objectives of a research study, indicating that a study may include multiple objectives. They further explained how the action of the research will lead to the type of objectives, stating that the verb "explore" is usually associated with exploratory research.

The two objectives of this study were to:

(i) Conduct a literature study on the first thousand days, Foundation Phase of schooling, school absenteeism, as well as child development from pregnancy to two years in order to develop a conceptual framework for this study.

(ii) Explore and describe factors that could potentially have affected the first thousand days of absent learners in the Foundation Phase by conducting semi-structured interviews.

1.5 LITERATURE STUDY

During the literature study, the researcher identified literature relevant to this study, as suggested by Fouché and Delport (2011:109), and selected data that was most relevant to this particular study, as noted by Brynard *et al.* (2014:33). According to Tracy (2013:99), the literature study forms the conceptual framework, outlining the primary concepts and theories for a study. The literature study, according to Delport *et al.* (2011:302), should be included from the beginning of the research process to assist the researcher to formulate the problem statement and to build a logical framework for the study in the context of related studies.

The researcher conducted a literature study as a starting point, as noted by Joubert *et al.* (2016:32), in order to gain an understanding of the research problem and to familiarise herself with the available literature on child development during the first thousand days, school absenteeism and the Foundation Phase. The researcher accessed various search engines and databases, for example EbscoHost, Google Scholar, SAePublications and ScienceDirect, as well as the services of the libraries of North-West University and Stellenbosch University for books and scientific or journal articles. The researcher conducted interdisciplinary searches using the

following keywords for searches: first thousand days, school absenteeism, Foundation Phase and child development.

1.6 RESEARCH METHODOLOGY

Methodology, as defined by Hesse-Biber (2017:7-8, 10), is the strategy used to describe the rational for the choice of a specific research method in the study and to execute the research. The methodology of a study thus guides the researcher's choice of methods and how it will be utilised. She also explained how the methodology serves as a bridge between the philosophical level and research design level of a study. In addition, she said that the research method should be compatible with the purpose and research questions of the study. According to Brynard *et al.* (2014:38), the research methodology includes various questions such as which data collection methods should be selected, which factors play a role in the research design and research process, and how the research purpose influences the selection of methods.

1.6.1 Research approach and design

The research approach for this study was qualitative research. Qualitative research, according to Hesse-Biber (2017:4), provides insight into the social world of people to obtain an understanding of a social issue. Brynard *et al.* (2014:39) explained how qualitative research produces descriptive data which in general includes the participant's own words regarding the context. The qualitative approached enabled the researcher to collect information about the phenomenon by using individual interviews (Ivankova *et al.*, 2016:309; Marshall & Rossman, 2016:147; Patton, 2015:14). This approach was suitable for the research study as it enabled the researcher to become acquainted with the participants, in this case the biological mothers, allowing them the opportunity to share information about the phenomenon, namely the first thousand days of their children's lives (Brynard *et al.*, 2014:39). Quantitative research, which uses techniques to produce numerical information, as stated by Neuman (2014:204), was not suitable for this study since rich information was needed to explore this phenomenon.

The research design refers to the plan or blueprint that outlines how the researcher intends to conduct the study (Babbie & Mouton, 2011:74). A qualitative descriptive design was utilised in this study to provide factual responses regarding a specific area (Colorafi & Evans, 2016:17). According to Lambert and Lambert (2012:255) and Sandelowski (2000:334), the qualitative descriptive design offers a comprehensive summary of everyday events and allows the researcher to stay close to the data. The qualitative descriptive design was applicable for this study as it allowed the biological mothers to share rich information regarding the first thousand

days of absent learners in the Foundation Phase by providing comprehensive information on their children's first thousand days.

This researcher utilised inductive reasoning as described by Tracy (2013:36) to begin with particular observations and then moved to broader, comprehensive generalisations. The qualitative descriptive design allowed the researcher to create an inductive process by following the data as concepts emerged and staying close to what the data said (Bradshaw *et al.*, 2017:5). Inductive reasoning is therefore closely linked to the methodology of qualitative descriptive research, which enabled the researcher to allow the research findings to guide the process without including any pre-existing theoretical underpinnings (Neergaard *et al*., 2009:2; Sandelowski, 2010:79).

1.6.2 Research context

The study was conducted within the context of Khula Development Group, the only organisation rendering intensive services to absent learners and their families in Paarl. Furthermore, the researcher selected Paarl East as focus area due to her involvement with the First 1000 Days workgroup in Paarl, which focused on the Paarl East community in particular.

The referral criteria for Khula Development Group includes either continuous absenteeism of three or more consecutive days or chronic absenteeism of ten or more days per term. Thus, the learners included in this study involved both types of absenteeism. Furthermore, could the context of Paarl-East be described as a community characterised by a low income population, since only 41% residents received an income from formal employment and 38,4 % residents were depended on social grants in 2016. In addition, were this community prioritised as a Safe Node Area in order to receive more resources from the Western Cape Government with the aim to increase wellness, safety and reduction of social ills (Western Cape Government Community Safety, 2017:8).

1.6.3 Population

In the research context, a population is the larger group of members, usually people from which a smaller number of members are selected (Babbie & Mouton, 2011:100; Neuman, 2014:40).

The population for this study comprised of biological mothers of Foundation Phase learners from Grades R to 3 recorded as active cases on Khula Development Group's database. The Khula Development Group database contains comprehensive information regarding absent primary school learners who have been referred by the schools to Khula Development Group, according to the organisation's referral criteria for absenteeism.

The rationale for focusing on Foundation Phase learners is the importance of this phase in establishing the foundation for learners to grow during formal schooling to guide their future learning (Embury Institute for Higher Education, 2019; University of Johannesburg, 2014:ii). Another reason for limiting learners to the Foundation Phase is the smaller gap between younger learners in this phase of schooling and their first thousand days, compared to older learners in the intermediate and senior phases of schooling. Thus, this smaller gap in the timeframe from conception to the Foundation Phase will help the biological mothers to better recall details about their children's first thousand days.

1.6.4 Sample

1.6.4.1 Sample method

Sampling is defined by Brynard *et al.* (2014:56) as a technique to select a smaller group or sample from the larger population. For this study, the random purposive sampling method was utilised to select potential participants.

Neuman (2014:255) described random sampling as a mathematical method to ensure that each element of the population has an equal chance to be selected in the sample. Purposive sampling, as defined by Maree and Pietersen (2016:198), was used to select participants with a specific purpose in mind. Random purposive sampling, as noted by Marshall and Rossman (2016:115), could add credibility to the sample if the potential purposeful sample is too large.

The process and steps that were followed to select the sample of this research study were the following:

- Compile a list of potential participants according to specific inclusion and exclusion criteria.
- Assign a number to each potential participant on the list.
- Write all the numbers down by wide-spreading it on a large piece of paper.
- Select numbers randomly by pointing a pen to any number without looking.

Where selected participants were unwilling to participate, steps three and four, as described above, were repeated to ensure the proposed sample size of 18 biological mothers were reached.

1.6.4.2 Sample size

A purposive sampling method, as described by Ivankova *et al.* (2016:331), uses a small number of participants to gain a deep understanding of the phenomenon being explored. Homogeneous populations, as in the case of this study, may sufficiently be represented by smaller samples (Maree & Pietersen, 2016:199). According to Brynard *et al.* (2014:58), there is no specific pre-set number of participants. Marshall *et al.* (2013:12) confirmed that qualitative methodologists are unlikely to agree on exact sample sizes. However, a study by Guest *et al.* (2006:66) regarding data saturation and the number of interviews conducted found that data saturation occurred by 12 interviews. Harreveld *et al.* (2016:35) referred to the acceptability of a small sample size in a qualitative study and the importance of the quality rather than the volume of data. Additionally, Salkind (2012:106) explained that it is unnecessary to generate samples larger than needed. Marshall *et al.* (2013:12-12) suggested the recommendations of other scholars as well as the citing of sample sizes used in studies with similar research designs as methods to justify a sample size in qualitative research.

The proposed sample size for this research study was 18 biological mothers, or until data saturation was achieved. This sample size was only concluded once data saturation was reached. Data saturation, as defined by Marshall and Rossman (2016:229), refers to the impression that any added data collection will result in similar findings. If data saturation was not reached, more participants would have been included. However, the researcher believes that data saturation occured, since similar themes repeatedly emerged. Therefore, more participants were not included, since the 18 biological mothers provided adequate data for this study.

1.6.4.3 Sample inclusion and exclusion criteria

The following inclusion criteria were utilised to select participants:

(i) **Biological mothers of absent learners in the Foundation Phase:** These learners had to be in Grade R to 3 and recorded as active cases on Khula Development Group's database. The Foundation Phase was selected because this phase establishes the foundation for schooling and because there is a smaller gap between Grade R to 3 learners and their first thousand days compared to the intermediate and senior phases. This enhanced biological mothers' chances to better recall the details regarding their children's first thousand days. Learners who were referred to Khula Development Group and are still absent to various degrees are recorded on the database as active cases.

(ii) **Residing in Paarl-East:** This community was selected as the researcher attended the First 1000 Days workgroup meetings in Paarl which focused on services in the Paarl East community.

(iii) **Lived with their child during their child's first thousand days:** The mothers had to live with their children from conception up to two years of age. The rationale for this was to enable the biological mothers to give an account of their children's full first thousand days.

(iv) **Currently lives with their child:** The biological mothers and their whereabouts will only be indicated on Khula Development Group's database if they currently reside with the learners.

(v) **Were factually capable of giving consent and to participate in this research study:** Many of the biological mothers that Khula Development Group works with are not factually capable due to the high prevalence of their own substance abuse. Factual capability was determined from information given by the Khula Development Group's social workers, social auxiliary workers and fieldworkers working directly with the biological mothers on the compiled list.

The criteria for the exclusion of participants were the following:

(i) **Biological mothers of Grade R to 3 learners that were not absent:** This included learners recorded on Khula Development Group's database where the children were referred to Khula Development Group for other reasons besides absenteeism. Although Khula Development Group's referral criteria specify that only absent learners can be referred, the schools on occasion still refer learners for other reasons such as social, emotional or behavioural problems.

1.6.5 Process of recruitment

For the purpose of this study, a gatekeeper, mediator and independent persons were involved in the recruitment of suitable participants. The gatekeeper referred to the Chief Operational Officer at Khula Development Group while the mediator referred to the branch manager of Khula Development Group. The independent persons referred to two employees from Khula Development Group appointed by the mediator to act as independent persons. The researcher had an informal conversation with the Chief Operational Officer and branch manager prior to the study, and they verbally agreed to fulfil these respective roles. The specific roles of the gatekeeper, mediator, independent persons and researcher will be discussed next.

1.6.5.1 Role of the gatekeeper

The researcher approached the Chief Operational Officer at Khula Development Group after approval was granted from the Health Research Ethics Committee (HREC) of North-West University to formally request that she acts as gatekeeper in order to facilitate access to Khula Development Group's database and participants. The researcher also scheduled a meeting with the Chief Operational Officer at Khula Development Group to provide a comprehensive description of the study and obtained the necessary written permission (see Annexure B) to conduct the study at Khula Development Group. This permission included using the organisation's offices and using employees from Khula Development Group as the mediator and independent persons. Permission was also obtained for the independent persons to utilise the organisation's vehicle to conduct the home visits in order to recruit participants. Permission was also obtained for the mediator to use the organisation's database in order to compile a list of potential participants according to the inclusion and exclusion criteria, and to contact prospective participants in order to obtain their permission to provide their information according to the Protection of Personal Information (POPI) Act (No. 4 of 2013) (South African Institute of Chartered Accountants, 2019).

1.6.5.2 Role of the mediator

The researcher approached the branch manager of Khula Development Group to act as the mediator and scheduled a meeting with her. During this meeting, the researcher discussed the planned study with her and provided the informed consent form (see Annexure C) describing the study, as well as detailed information regarding the population and sampling size, inclusion and exclusion criteria and sampling method. The mediator received training on her role as mediator, as well as all the information discussed during the meeting mentioned above. The mediator also signed a confidentiality agreement during this training session.

After the mediator had selected the sample, she first contacted the individuals on the list and obtained their consent to provide their names to the independent persons in order to comply with the POPI act. If the individuals on the list could not be contacted telephonically, the mediator conducted a home visit to obtain their consent for providing their names to the independent persons. The mediator then provided the researcher with a list of contact details of the 18 prospective participants.

The mediator was requested to appoint two employees from Khula Development Group to act as independent persons to conduct home visits to prospective participants in order to explain the informed consent forms. These two persons had to adhere to the following criteria: (1) They are

in a role where they do not have a prior relationship with the prospective participants and are not in a potentially hierarchical relationship, (2) have a valid driver's licence and are able to drive to the prospective participants' homes, (3) know the Paarl East area and will be able to find the homes easily, (4) are comfortable in conducting home visits in this area, (5) have adequate knowledge regarding the specific community known to them which will enable them to approach the biological mothers in the correct manner with the necessary understanding, (6) are Afrikaans speaking, which is the common home language of the prospective participants, and (7) could speak English as a second language in case some of the mothers were not Afrikaans speaking.

Khula Development Group's guidelines state that employees should always conduct home visits with a team of two people for safety reasons – hence the reason for appointing two independent persons instead of just one independent person. Therefore, according to the above-mentioned criteria, there were no potential influence and the two appointed persons were truly independent.

1.6.5.3 Role of the independent persons

After the mediator appointed two employees as the two independent persons, an appointment was scheduled with them to provide all the necessary information and training. The independent persons were trained by the researcher on the research study, the recruitment of participants and the research process. They were provided with the Afrikaans informed consent forms (see Annexure D), extra English informed consent forms, as well as a list of prospective participants. The independent persons were furthermore trained on their role as independent persons. Both of them signed a confidentiality agreement.

The independent persons conducted home visits at the biological mothers' homes with the Afrikaans informed consent forms to explain in Afrikaans the research study, consent and expectations of the participants, and to provide them with the information and consent documents. The independent persons were also provided with English informed consent forms in case of non-Afrikaans speaking participants. The informed consent forms included information about the aim of the research, confidentiality, the audio-recording of the interviews, risks to the participants, remuneration and other relevant information, as well as the contact details of the independent persons and the HREC contact person. The explanation of consent included the use of a witness as an option in the case of illiteracy. All prospective participants were informed that their participation was voluntary and that they could withdraw from the research study without explanation at any time for whatever reason without any negative consequences. The right of the participants to discontinue participation if they felt uneasy or distressed was respected. The

independent persons also provided the prospective participants with the contact number of the researcher should they have further enquiries.

Once this was done, the researcher was available to the prospective participants to explain the study further and to answer questions where needed. After the prospective participants received a copy of the informed consent form, they were told that they are allowed three working days to go through the information, to consult with a person of their choice whom they trusted, and to consider participating in the research. Illiterate persons were encouraged to ask the assistance of a literate person of their choice to read the information to them. It was explained to prospective participants that the independent persons will contact them after the three working days have passed to enquire regarding their decisions about participating in the study. Thus, the principle of respect was followed by providing all the relevant information to prospective participants in order to allow an informed choice.

After three working days, the independent persons followed up telephonically with the biological mothers, asking them whether they were interested in participating in this study. If participants could not be contacted telephonically, the independent persons conducted another home visit to give them an opportunity to indicate whether they were interested to participate. The rationale for the independent persons contacting the participants was the consideration of context where participants might not have the means to make telephonic or personal contact due to the lack of cell phones, airtime or transport. Should the participants decide to participate, they had to sign the consent document in the presence of at least one of the independent persons as well as a witness where applicable. All participants were provided with a copy of the signed informed consent form. The transport indemnity form was explained by the independent persons and participants were requested to sign the transport indemnity forms.

The independent persons then provided the researcher with a list and contact details of all the biological mothers who indicated that they were willing to participate in the study. The independent persons also provided the researcher will all the signed informed consent forms and signed transport indemnity forms.

1.6.5.4 Role of the researcher

The researcher contacted the participants telephonically to schedule the date and time for the semi-structured interviews, as suggested by Brynard *et al.* (2014:43). If participants could not be contacted telephonically, the researcher conducted a home visit to make arrangements for the interviews.

1.6.6 Data collection

Data collection methods refer to the tools that are utilised by the researcher to collect data for learning about a social reality (Hesse-Biber, 2017:9). The researcher used primary data in this study, as described by Brynard *et al.* (2014:38), since she collected the data herself and did not use other researchers' data. For the purpose of this research study, semi-structured interviews were conducted, as described by Nieuwenhuis (2016a:93), to enable the researcher to ask specific open-ended questions, which were followed by probing questions. Semi-structured interviews were used to gain a detailed portrayal of a certain topic and provide more flexibility to the researcher and participants (Greeff, 2011:351). For this research study, semi-structured interviews seemed appropriate as it allowed the researcher to add questions according to the participants' responses while providing the participants with the freedom to add anything they felt comfortable with.

An interview schedule (see Annexure F), developed by the researcher, was used for the semi-structured interviews. The interview schedule included 12 open-ended questions, as referred to by Babbie and Mouton (2011:233), allowing participants to provide their own answers to the questions. The researcher used literature regarding the first thousand days, focusing specifically on the Western Cape Government's First 1000 Days initiative to develop relevant questions for the interview schedule accordingly to this information. These questions were specifically formulated to explore factors pertaining to the three key areas of the Western Cape Government's First 1000 Days initiative. The questions were translated into Afrikaans, as this is the home language of most people living in this specific community. These questions were reviewed by two social workers from Khula Development Group to ensure that the questions would be understood correctly by the biological mothers and also to provide recommendations regarding the type and formulation of questions. The researcher adjusted the interview schedule after receiving feedback from the two social workers. The first two semi-structured interviews were used to pilot these questions in order to assess whether the questions were clearly understood by the participants and to correct any misunderstandings, should they occur. The researcher consulted with her research supervisor during the pilot phase, and they concluded that no changes to the research questions were necessary. The data obtained from these interviews was included in the data analysis.

The semi-structured interviews were conducted individually with each biological mother. The interviews were conducted at Khula Development Group's offices in Paarl and lasted for approximately one hour. The interviews were conducted by the researcher personally, and since her work at Khula Development Group does not require direct services to absent learners and

their families, no power balance between the researcher and the biological mothers occurred. On the day of the interviews, the researcher orientated the participants, as suggested by Welman *et al.* (2011:168), by doing the following: thanking the biological mothers for participating in the study, referring to the informed consent form, emphasising confidentiality, informing them that they could alert the researcher if they experienced fatigue or emotional distress, explaining the time-line tool and providing an opportunity for questions. This was followed by the actual interview. Good interviewing skills, including active listening and probing, were applied to ensure that participants continued talking and elaborating on their answers during the interviews (Hesse-Biber, 2017:119-120). Probing as defined by Sarantakos (2013:289) involves questions or neutral statements to encourage participants to extend their responses.

The researcher incorporated a timeline tool as a creative medium to visually demonstrate the logical sequence of the questions during the interviews. A timeline, as described by Adriansen (2012:43), provided a visual representation of the pregnancy phase, as well as the period after the child's birth up to two years. This timeline tool enabled the participants to construct their story regarding the first thousand days of their children's lives. The timeline tool, as shown in Figure 1.1, was prepared in advance on a large cardboard with a drawn timeline indicating the two phases that form part of the first thousand days, namely (1) the pregnancy phase and (2) birth up to two years. Various coloured papers with headings and pictures, including the colours and pictures of the First 1000 Days logo, with the questions were pasted on the timeline. In accordance with the timeline tool, the interview schedule included two sections, namely (1) questions relating the pregnancy phase and (2) questions relating to the phase from birth to two years. The interview schedule included 12 questions relating to the three key areas of the Western Cape's First 1000 Days initiative. These questions were divided in the following manner: Questions 1 and 6 referred to the pregnancy phase and did not relate to any of the specific key areas of the First 1000 Days campaign. Questions 2 and 3 related to health and nutrition, while Questions 4 and 5 related to love and attention. Questions 7 and 12 were general questions while Questions 8 and 9 related to health and nutrition, Question 10 related to love and attention, and Question 11 related to stimulation and play. Figure 1.1 below illustrates the construction of the timeline tool. A photo of the timeline poster that was used during the interviews can be seen in Annexure E.

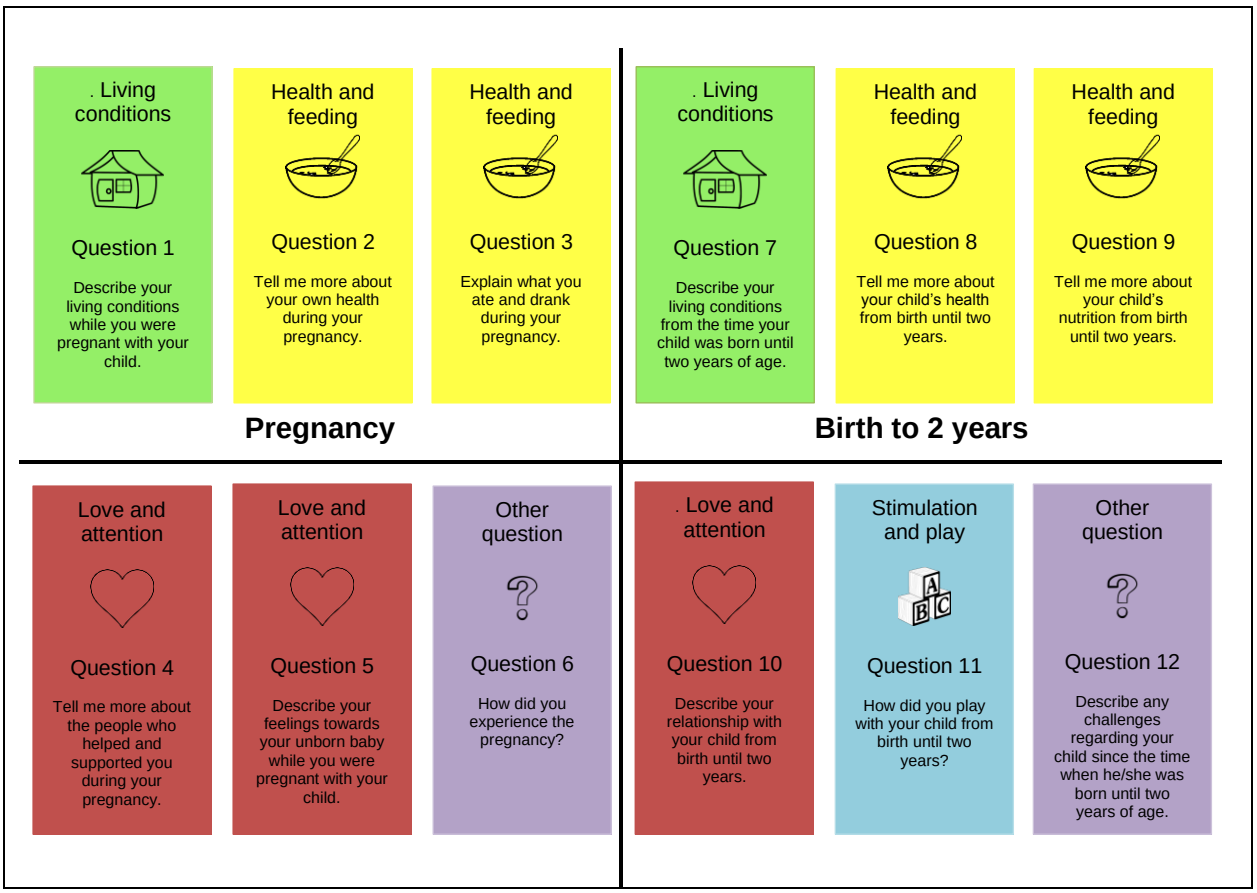

Figure 1-1: Construction of the timeline tool

The researcher initially planned to construct a timeline for each participant and to write down key words on the timeline during the interview. However, she revised this plan after the first interview, since she experienced that it made Participant 1 nervous when she wrote things down. The researcher felt that it was more important to help participants feel at ease by keeping eye contact with the participants and to use her active listening skills, as suggested by Hesse-Biber (2017:117), than to make notes on the timeline. After consultation with her research supervisor, it was decided that the researcher will not make notes on the timeline, but rather use the timeline as a tool to visually demonstrate the sequence of the questions. This strategy worked extremely well, and the succeeding participants seemed more relaxed and engaging during the interviews. Thus, the researcher used the same timeline tool with the rest of the participants as it did not contain any personal information.

Another challenge, which occurred during data collection, was some of the recruited participants not showing up on the day of their interview. The researcher realised that this was due to transport problems or feelings of uncertainty to visit an unfamiliar place on their own. An amendment was sent to HREC, requesting that the researcher could transport participants to the research site. Once the amendment was approved, the data collection phase progressed rapidly.

All the interviews were audio-recorded on two devices to ensure that no recordings were lost due to technical problems. The audio-recorded data was transferred as soon as possible to the researcher's personal laptop after the interview took place in order to safeguard this data. Next, the recorded data was transcribed. The researcher initially began to transcribe the interviews herself. However, due to time constraints, she obtained the services of a professional transcribing company who transcribed the interviews intelligent verbatim, thus without the fillers.

1.6.7 Data analysis

Data in qualitative research is represented by human acts, their statements, as well as documents (Sarantakos, 2013:365). According to Wagner *et al.* (2012:231), thematic analysis is a typical approach used to analyse qualitative data, involving the identification of themes or patterns. Braun and Clarke (2006:77; 2013:120) described thematic analysis as a useful and flexible qualitative analytic method used to search for themes and patterns. Sarantakos (2013:15) defined themes as a group of categories that share the same meanings and explained how themes are formed during an inductive analytic process. A theme, as noted by Braun and Clarke (2006:82), relates to a response or meaning that formed a pattern in a data set.

In this study, the six phases of thematic analysis proposed by Braun and Clarke (2006:87-93; 2013:121) were utilised. These six phases are summarised in Figure 1.2 below.

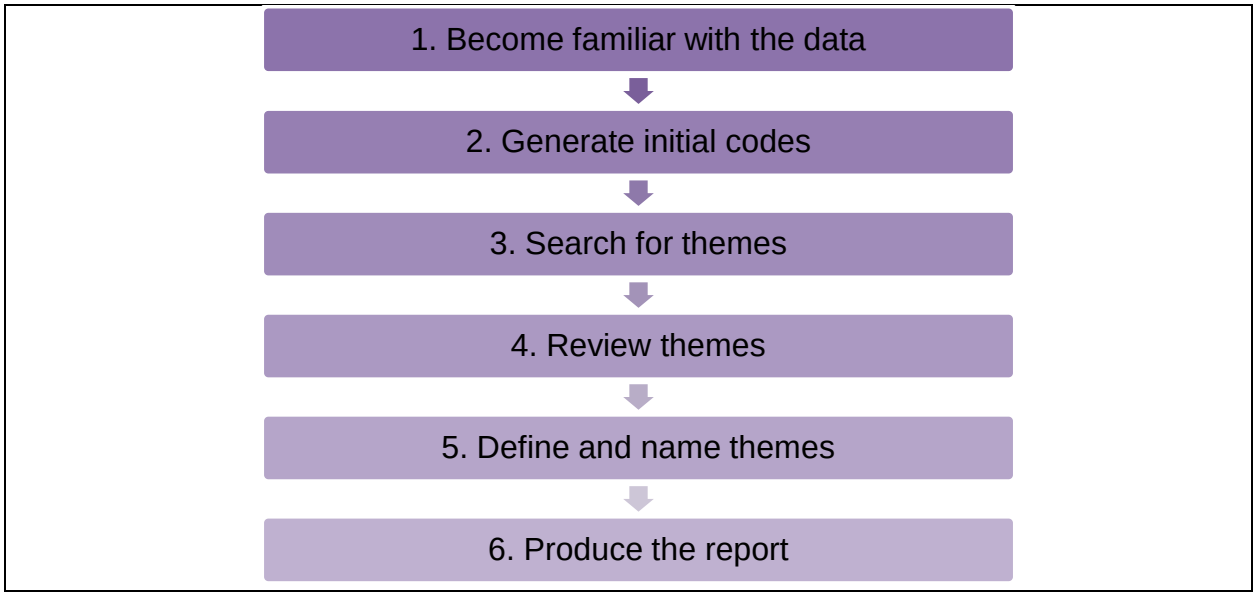

Figure 1-2: Phases of thematic analysis

The six phases, as outlined by Braun and Clarke (2006:16-23; 2013:121), were undertaken by the researcher in the following manner.

(i) **Phase 1 – Becoming familiar with the data:** Since the researcher collected the data herself by conducting the interviews, she was already familiar with the data to some extent, as explained by Braun and Clark (2006:87). The data was transcribed intelligent verbatim. The researcher immersed herself in the data by reading through the data while listening to the recorded interviews. This was followed by reading the data repeatedly in an active way in order to search for meanings and patterns.

(ii) **Phase 2 – Generating initial codes:** The researcher identified an initial list of codes which could be linked to the main objectives of the research (Braun & Clark, 2006:88).

(iii) **Phase 3 – Searching for themes:** During this phase, the researcher identified themes and sub-themes within the codes. The researcher used Computer-Aided Qualitative Data Analysis Software (CAQDAS), as noted by Babbie and Mouton (2011:503-504), to assist with the analysis of the qualitative data. As stated by these authors, this software is not designed to do the analysis but only to organise the data in a proper manner. The use of CAQDAS assisted the researcher to store the documents, codes and quotations in one place. Additionally, Sarantakos (2013:396-397) confirmed that the use of CAQDAS could be more beneficial for researchers than manual processing, mentioning that the advantages of using this software included time efficiency, accuracy, reliability, flexibility and easier access to texts and codes. The researcher utilised QDA Miner Lite, a free version of assisted qualitative analysis software. The process involved importing the transcribed data into the program and capturing the initial names of the themes, sub-themes and categories into the software. The researcher read through the data thoroughly, highlighted it and linked the data with the codes. The QDA Miner Lite software then sorted the data under the various categories, sub-themes and themes, which enabled the researcher to continue with the next phase.

(iv) **Phase 4 – Reviewing the themes:** The themes were reviewed to identify which themes were most important, which ones could be grouped together, and which themes should be divided. The researcher created a thematic map to check if the themes work together in relation to the coded extracts of the data. Additionally, the researcher used a co-coder with a master's degree who reviewed and confirmed the themes.

(v) **Phase 5 – Defining the themes:** During this phase the themes were defined and appropriate names were allocated to each theme. With the assistance of the research supervisor, the themes were revised and refined.

(vi) **Phase 6 – Writing the report:** Once all the themes had been identified, the researcher began to write the report to produce the story of the data collected. Extracts from the data, including direct quotes, were utilised to support the identified themes. Literature was also used to support the data collected.

1.7 ETHICAL CONSIDERATIONS

According to Babbie and Mouton (2011:520), researchers have the right to collect data, but not at the expense of the rights of people, and to explain how ethical issues arise from the interaction between people. Sarantakos (2013:15) believed that ethical standards form an essential part of a research study. Conducting research activities in scientific research, as explained by Brynard *et al.* (2014:94), should be morally acceptable. They further defined research ethics as the right or wrong way of conducting scientific research.

The research proposal for this study was submitted to HREC of North-West University for ethical clearance. An ethics committee assesses all ethical issues to ensure the rights and interest of human subjects are protected (Babbie & Mouton, 2011:528). This research study was approved, ensuring that the research complied with the university's ethical standards and code of conduct, as emphasised by Brynard *et al.* (2014:94). The approval letter from HREC with the ethics number NWU-00008-19-A1 is attached as Annexure A. Regular monitoring reports were additionally submitted to HREC for the duration of the study.

The following ethical considerations will be discussed in the next section: informed consent, experience of participants, risks and benefits, vulnerable participants, incentive/reimbursement, legal authorisation, goodwill permission/consent, role players, expertise of the researcher, facilities, dissemination of results, and storage and archiving of data.

1.7.1 Informed consent

Sarantakos (2013:19) explained how researchers should provide respondents with adequate information pertaining to the nature of the research, as well as the possible consequences for the respondents. He emphasised the respondents' rights to agree or disagree to partake in research and referred to the signing of consent forms as an indication that a respondent agrees to take part.

The informed consent form was written in a simple and easy-to-read format. Since Afrikaans was the common home language of the prospective participants in this community, the final informed consent form was translated into Afrikaans after it had been approved by HREC. An English informed consent form was also available in case of non-Afrikaans speaking participants. However, the English informed consent form was not used.

The informed consent forms included information about the aim of the research, confidentiality, the audio-recording of the interview, risks to the participants, remuneration and other relevant information, as well as the contact details of the independent persons and the HREC contact person. The explanation of consent additionally included the use of a witness as an option in the case of illiteracy. All prospective participants were informed that their participation is voluntary and that they could withdraw from the research study without explanation at any time for whatever reason without any negative consequences. A few participants who were recruited and indicated that they would like to participate by signing the informed consent form, did not show up for their interviews, which was regarded as withdrawal from the study. The right of the participants to discontinue participation if they felt uneasy or distressed was respected.

1.7.2 Goodwill permission/consent

Prior to the study, the researcher obtained verbal permission from the Chief Operational Officer at Khula Development Group to conduct the study at the organisation. The COO assured the researcher of her full support. Once the research proposal and ethical application had been approved, the researcher scheduled a meeting with the Chief Operational Officer at Khula Development Group. During this meeting, the researcher provided a comprehensive description of the study and obtained the necessary written permission, including a signed permission letter.

1.7.3 Experience of participants

The biological mothers were required to partake in a 60-minute to 90-minute audio-recorded semi-structured interview, which might have caused some physical discomfort or fatigue due to the duration of the interview. Participants were informed prior to the interview that they may alert the researcher when they experienced physical discomfort or fatigue in order to stop for a short break. Where the researcher observed that participants showed signs of physical discomfort or fatigue, but refrained from requesting a break, the researcher suggested a short break after approximately 45 minutes into the interview. The researcher also provided water and biscuits to all participants during the interviews.

The researcher was sensitive to any harm to participants, especially psychological harm due to the sensitive topic and/or stressful experiences such as single motherhood or unemployment that occurred during pregnancy or after the child was born up to two years of age. Therefore, all possible precautions were considered and implemented, as recommended by Neuman (2014:150). The risks associated with participation, as well as the precautions, are discussed in Table 1.1.

If necessary, a referral would have been offered to Good Hope Psychological Service for free counselling. None of the participants needed a referral for psychological counselling due to emotional distress experienced during the interview. However, one participant was referred to the Department of Social Development on her request due to her substance abuse problem. The participants were not required to participate in a high-risk study with the risk of causing severe harm. Therefore, participants in this research study were not exposed to an experience greater than ordinary encounters in daily life in a stable society.

1.7.4 Risks and benefits

Participation in the study held no direct benefits for the participants. However, some participants experienced a sense of increased self-worth as they felt that they were participating in a research study which could contribute to improved service delivery programmes in the future, as confirmed by participants before or after the interviews. After the interviews, a number of participants mentioned that they had enjoyed this opportunity and felt a sense of emotional well-being after sharing some of their experiences during that time of their lives. The indirect benefits of this research study will result from the recommendations aimed at contributing to the improvement of intervention programmes for Foundation Phase absent learners and their families, and even programmes relating to the first thousand days. Hence, this will potentially benefit the NPO sector, Khula Development Group, other professionals, the Paarl East community and even society at large.

According to Sarantakos (2013:18), participants could experience physical, mental or legal harm during research. Hence, it is important for researchers to attempt to prevent any harm or end the research where serious harm to participants occur. The following table (Table 1.1) stipulates the researcher's analysis of anticipated risks, as well as recommended precautions to mitigate or reduce the risks.

Table 1-1: Risks associated with participation as well as precautions

Risks	Precautions
• Participants could have experienced fatigue during the 60-minute to 90-minute semi-structured interviews.	• The researcher informed each participant prior to the interview that they may alert the researcher when they felt fatigue in order to stop for a short break. • Where the researcher observed that participants showed signs of fatigue, but refrained from requesting a break, she suggested a short break after approximately 45 minutes into the interview. Some participants took a break by going to the bathroom or drinking water, but many of them did not feel they needed a break. • The researcher made water and biscuits available to all participants. Some of the participants enjoyed their water and biscuits during the interview, but most of them took the refreshments home.
• There was potential emotional harm where biological mothers could have experienced emotional stress and feelings such as guilt, sadness, embarrassment, and anger due to the sensitive topic and questions relating to their care and relationship with their child in the first thousand days.	• Where a biological mother experienced any emotional distress during the interview process, the researcher stopped the recording and the interview, debriefed the participant and only continued the interview if the participant was emotionally able and willing to continue. This occurred a few times, causing the researcher to stop the recording. However, all the participants were willing and able to continue. • If the participant was emotionally unable or unwilling to continue, the interview process would have been terminated and the participant would no longer have been considered for the study. This did not occur. • The researcher would provide the participant with the option to be referred to Good Hope Psychological Service in Paarl for free counselling if needed.
• There was potential financial harm where biological mothers who were working might have lost a day's income in order to participate in the interviews.	• The researcher accommodated participants and arranged interviews on days that suited them. • The researcher provided transport for participants from their homes to the research site, as well as travel money for transport from the research site back to their homes.

1.7.5 Vulnerable participants

The participants in this research study were likely to be vulnerable as a result of the rural community in which they are living and the high rates of poverty characterising this community (Drakenstein Municipality, n.d.). Based on the researcher's previous working experience in this community where she rendered direct services to clients, it was possible that many of the participants were illiterate. As a result of this vulnerability and the sensitivity of the research study, the researcher took the following steps to minimise vulnerability: She obtained permission from the Chief Operation Officer at Khula Development Group who served as gatekeeper of the interview process, encouraged the use of a witness during the consent process in the case of illiterate participants, enhanced participants' understanding during the interviews by using pictures on the timeline tool, and protected the participants' identity by using pseudonyms to ensure anonymity. All the participants were able to read and write, as none of them made use of a witness. Most of them read the consent forms themselves and all of them were able to sign the consent forms.

The inclusion of this vulnerable population in the research study was justified by the importance of this research in terms of the first thousand days of absent learners in Paarl East, a rural community characterised by high rates of poverty. Additionally, the inclusion of a vulnerable population allowed the researcher to make recommendations aimed at enhancing intervention programmes for absent learners and their biological mothers. Furthermore, the risk-benefit ratio was appropriate to this vulnerable population, since the overall benefits will outweigh the risks.

1.7.6 Incentive/reimbursement

The South African Health Products Regulatory Authority indicates how participants should be compensated for their time (T), inconvenience (I) and expenses (E). All the participants in this study received a token of appreciation to recognise their time and any inconvenience according to the TIE principle (South African Health Products Regulatory Authority, 2018:3). Tokens of appreciation in the form of Shoprite stamps to the value of R50 per participant were provided to all the participants to compensate them for their time and any inconvenience. The researcher also provided transport for the participants from their homes to the research site, as well as travel money for transport from the research site back to their homes in order to compensate them for these expenses. The informed consent form contained all the information about the token of appreciation and the transport money. The Shoprite stamps and travel money were given to the participants directly after the conclusion of the interviews.

1.7.7 Legal authorisation

This research study was not conducted with school learners and therefore did not require authorisation from the Western Cape Department of Education. Therefore, no legal authorisation was required.

1.7.8 Confidentiality, anonymity and privacy

Confidentiality, anonymity and privacy, as described by Neuman (2014:154-155), were ensured as follows:

(i) **Confidentiality**: This entails that research data is kept confidential and secret from the public, not releasing information that could link individuals to specific responses. The researcher discussed confidentiality with all the participants and reassured them that all information would be kept confidential. The mediator and independent persons involved with the selection and recruitment of participants were informed about their ethical responsibility regarding confidentiality (Babbie & Mouton, 2011:523) and they signed confidentiality agreements to ensure confidentiality during the recruitment of participants. The researcher ensured that the transcriber and co-coder also signed confidentiality agreements.

(ii) **Anonymity**: The term anonymity describes the protection of participants' identity in order to remain unknown. The researcher ensured anonymity by allocating a pseudonym to each participant before the interviews were transcribed. Therefore, only the researcher was aware of the true identity of the participants. The researcher took care that the final report did not reveal the identity of any individuals. Furthermore, no identification information of participants was included when the researcher provided feedback on the findings to Khula Development Group. In addition, the researcher ensured that the final report did not reveal any demographic data, as suggested by Sarantakos (2013:20).

(iii) **Privacy**: This refers to the invasion of a person's privacy by probing into beliefs, backgrounds and behaviours in such a way that it reveals intimate private details of their lives. Therefore, interviews were conducted at the Khula Development Group's offices in Paarl behind closed doors to ensure the necessary privacy. During the interviews, a notice was put on the door indicating that a private interview was in progress.

1.7.9 Facilities

An appropriate facility for interviews, according to Tracy (2013:160), is characterised by access, quiet space, safety, privacy, comfort and the availability of electricity. Therefore, the interviews were conducted at the Khula Development Group's offices in Paarl, which complied with the above-mentioned characteristics. These offices are situated in central Paarl, outside the borders of the Paarl East community, helping to prevent stigmatisation and interruptions from other community members. The offices were easily accessible by public transport and within a very short walking distance of a taxi rank. The use of these facilities provided privacy and a comfortable environment, which made participants feel at ease. The offices also provided the necessary space for the utilisation of the timeline tool. Furthermore, the facility was quiet, safe, had electricity available if required for the audio-recorder, as well as adequate light and ventilation.

1.7.10 Conflict of interest and bias

The researcher conducted the research on absent learners in her work context. As she was personally very passionate about this population group, she acknowledged the occurrence of possible bias. Bias in research, as described by Neuman (2014:101,170.323), can be countered by researchers applying rational thinking, bracketing their own views, as well as avoiding emotional language and prestige bias in the structuring of the interviewing questions. Additional ways to combat bias are to utilise a random approach in selecting participants, frequent sessions between the researcher and his or her research supervisor, self-reflection and the avoidance of interviewer bias (Salkind 2012:203; Tracy, 2013:48). The researcher thus countered bias in this study by excluding emotional language or prestige bias in the interview schedule, bracketing her own views and preconceptions regarding the first thousand days or absenteeism, applying rational thinking during the research process, especially while analysing the data, self-reflected by keeping a reflective journal, avoided interviewer bias during the semi-structured interviews by not influencing the participants to respond in a certain way. Additionally, the researcher used a co-coder with a master's degree to assist with the coding process and generation of themes. The researcher regularly met with her research supervisor to provide a sounding board for her developing ideas and interpretations, and to help her recognise any bias ideas or preferences.

1.7.11 Dissemination of results

The researcher will arrange a function with refreshments for the participating biological mothers to provide a summary of the findings after completion of the study. This function will only be held in 2020. An electronic copy of the final report will be emailed to the Chief Operational Officer and the rest of the executive committee at Khula Development Group after the completion of the study.

The researcher will additionally offer the option of a feedback session to all the employees at Khula Development Group.

1.7.12 Storage and archiving of data

All electronic data, including the transcribed and audio-recordings, was stored on the researcher's personal laptop in a password-protected folder to which only the researcher had access. Once the researcher had safely stored the recordings on her personal laptop and checked that it was done successfully, the recordings were deleted from the audio-recorder. As backup, the electronic data was also stored in a password-protected folder on an external hard drive. For the duration of the research, the external hard drive and hard copies of the data was stored in a secure space at the researcher's home.

After completion of the research, the raw research data will be stored for five years in a locked safe at the offices of the Centre for Child, Youth and Family Studies in Wellington. The researcher deleted all electronic data in the password-protected folders from her personal data once it was successfully transferred to a flash drive. The researcher will hand all data, hard and soft copies pertaining to this research, including the flash drive, timeline tools and transcriptions of the interviews to her research supervisor no later than ten days prior to graduation. The research supervisor will take it to the appointed line manager at the Centre for Child, Youth and Family Studies in Wellington. The line manager will be the only person with access to the safe and will take responsibility for destroying the data after the prescribed five years. The line manager has a recordkeeping system with a reminder of when the data should be destroyed. All hard and soft copies of the data will be destroyed via shredding, and electronic data will be deleted from the flash drive.

1.8 TRUSTWORTHINESS

Accuracy in qualitative research, according to Prion and Adamson (2014:1), can be described as the standards for trustworthiness. The researcher demonstrated rigour in this study by applying the four criteria of trustworthiness. Lincoln and Guba (cited by Marshall & Rossman, 2016:46) identified the four criteria in the quest for trustworthiness in a qualitative research study as credibility, transferability, dependability and confirmability.

1.8.1 Credibility

Credibility refers to how convincing the findings are in terms of reality (Nieuwenhuis, 2016b:123) and to establish if the results are believable (Farrelly, 2013:149). The credibility of this research was ensured by applying the following strategies: reputable research methods and a research

design suitable for the research question, as stated by Nieuwenhuis (2016b:123). Furthermore, credibility was enhanced in this study by including clear purposive sampling, thorough data collection, regular debriefing sessions between the researcher and research supervisor, notes of reflection from the researcher, and in-depth description of the phenomenon (Nieuwenhuis, 2016b:123).

1.8.2 Transferability

According to Farrelly (2013:150), transferability refers to the degree to which the qualitative research results can be transferred to other contexts. Marshall and Rossman (2016:261) described transferability as the ways the findings will be helpful to others in comparable situations or with related research questions. The same authors explained that the responsibility to determine if the research findings apply to another context do not rest with the original researcher, but with the researcher who makes that transfer.

To ensure transferability in this research study, the researcher provided a comprehensive description of sampling, data collection, data analysis and the course of the whole research process in order to enable other researchers and readers of the research report to judge whether the research could be applied to another context. To further promote the transferability of this research, the researcher included purposeful sampling which was utilised by the mediator to carefully create the list of possible participants in terms of the phenomenon being investigated.

1.8.3 Dependability

Dependability is similar to reliability in quantitative research and refers to the stability of the conditions depending on the nature of the study (Connelly, 2016:435). According to Nieuwenhuis (2016b:124), the research design and its implementation, operational detail of data collection and reflective appraisal of the project demonstrate dependability. Nieuwenhuis further explained that the research design may change, and new data sources and data-gathering techniques may be added, but suggested the researcher keep a journal of these changes to assist others to follow the researcher's reasoning. In this study, the researcher ensured dependability by documenting her reflections regarding the research process in the form of a journal. She also provided reflections and a thorough description of the research design and data collection in the final report. The researcher ensured that the research process was coherent, documented and well-reviewed by her research supervisor.

1.8.4 Confirmability

Farrelly (2016:150), Marshall and Rossman (2016:262) defined confirmability as the degree to which the results could be confirmed by others. In addition, Marshall and Rossman (2016:263) explained that qualitative research does not claim to be replicable but concentrates on the recording of the complexity of the situational context within a flexible research design. Confirmability in this study was established by keeping an 'audit trail' and purposefully selecting quotes for the final report, as described by Nieuwenhuis (2016b:125). Thus, the researcher documented the research process step by step. Also, the data will be stored at the Centre for Child, Youth and Families Studies, Wellington, for five years after which it will be destroyed according to their relevant policies.

1.9 CONCLUSION

Chapter 1 provided insight into the motivation for this study, the problem statement, the aim and objectives, as well as other relevant aspects like key concepts and the research context. This chapter further discussed the research methodology, as well as aspects relating to ethics and trustworthiness. The next chapter will present the literature study on the first thousand days, the Foundation Phase of schooling, school absenteeism, as well as child development from pregnancy to two years in order to provide the conceptual framework for this study

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CHAPTER 2: LITERATURE STUDY

2.1 INTRODUCTION

As a result of the wide range of aspects relating to the research topic, this chapter is divided into the following two parts:

- **Part 1:** The significance of the first thousand days, Foundation Phase and school absenteeism: This part focuses on various aspects of the first thousand days of life, the Foundation Phase of schooling and information pertaining to school absenteeism.
- **Part 2:** Child development from pregnancy to two years and related theories: This part gives attention to child development during pregnancy, as well as the phases from birth to two years. In addition, Part 2 will include theories on child development and other related theories.

PART 1: THE SIGNIFICANCE OF THE FIRST THOUSAND DAYS, FOUNDATION PHASE AND SCHOOL ABSENTEEISM

In this part, literature on the following will be explored: the importance of the first thousand days, the Western Cape Government's First 1000 Days initiative, background information on the Foundation Phase of schooling, the importance of reading and writing in the Foundation Phase, early learning before entering the Foundation Phase, definitions of school absenteeism, the importance of school attendance, reasons for school absenteeism, the consequences of school absenteeism and school absenteeism in the South African context.

2.2 THE FIRST THOUSAND DAYS

The following section will look more closely at the importance of the first thousand days, as well as the First 1000 Days initiative in the Western Cape which includes the history and related three key areas.

2.2.1 The importance of the first thousand days

The first thousand days of life, from conception to the child's second birthday, is a crucial time in life as it determines much of the child's future (Malek, 2016:2; Save the Children, 2012:3; UNICEF, 2017). In the United States of America, the NPO called the 1,000 Days confirms the importance of the first thousand days as a window of opportunity to improve children's health and their future (1,000 Days, 2016:3).

Lindland *et al.* (2016:9-10) highlighted the following areas as central to the importance of the first thousand days:

(i) **Brain development:** Childhood development experts believe that the development of the brain is at the heart of the child's development during the first thousand days, since brain connections grow and strengthen rapidly. At first, simple neural circuits are developed, followed by more complex ones, with plasticity at its peak during this critical time period. Plasticity refers to the brain's capacity to change over time if developmental circumstances provide these opportunities for change. Since brain plasticity decreases over time, the first thousand days are viewed as a once-in-a-lifetime phase of brain development. Therefore, creating positive brain development during this time helps to set up foundational skills and produces good health, education and social outcomes for children. A study conducted by De Angulo and Losada (2016:113) confirmed the importance of brain development during the first thousand days. They believed that infants' health and development is based on

their brain architecture and capacity to self-regulate their biological, emotional, cognitive and interactional processes with their environment.

(ii) **Setting up of foundational skills:** During the first thousand days, the child's emotional and communicative abilities are activated in order to develop higher order skills, namely 'executive function' and 'self-regulation' which depends on the quality of the child's early relationships. These two skills include the ability to focus, switch attention to something else where needed, resist distractions, remember a number of things at the same time and regulate one's own emotions, which are crucial for 'setting up' a variety of skills, competencies and behaviour.

(iii) **Genes and environment:** Development includes a transactional process between children's genetic makeup and their environment, which includes their experiences and relationships.

(iv) **Quality of relationships:** Children's emotional and psychological development is fundamentally shaped by the quality of their relationships. Children need supportive and interactive relationships that are both stimulating and responding to their needs and interests in order to establish good physical and mental health, as well as resilience.

(v) **Early childhood development:** Children's development and growth during pregnancy and the first two post-natal years are seen as critical for creating their foundations for life.

The importance of the first thousand days is also emphasised by the Global Wellness Institute (2016) and it is recognised as a specific focus in various countries worldwide. A report compiled for South Island in New Zealand emphasised the importance of the first thousand days as a period during which a child's environment has significant and long-term impact. This report described the first thousand days of life as a time of rapid and complex development impacting a child's health, educational and social outcomes. For this reason, South Island has a range of initiatives pertaining to the first thousand days including national-level universal health care services and other community-based initiatives (Community and Public Health, 2018:10, 31-33). The Government of Zambia also recognised the first thousand days as critical by prioritising multi-sectoral activities to strengthen interventions related to the first thousand days in order to prevent stunting in children younger than two years (National Food and Nutrition Commission of Zambia, 2012:ii).

Friedman and Wolfheim (2019:5) outlined a range of global initiatives that emerged in recent years, including interventions pertaining to the first thousand days of life. They summarised the following initiatives:

(i) **UN Secretary-General's Global Strategy for Women's, Children's and Adolescents' Health (2016-2030):** This strategy focuses on the 'survive, thrive and transform' framework to help children to thrive and health systems to transform. Relating to the first thousand days, this global strategy promotes breastfeeding, nutrition for infants and young children, responsive caregiving, as well as early stimulation.

(ii) **Scaling Up Nutrition (SUN) Movement initiated in 2010:** This initiative focuses on the first thousand days to work collaboratively in order to end malnutrition in its 61 member countries.

(iii) **Child Health Redesign:** A series of stakeholder meetings across the World Health Organization (WHO) regions were held in 2018 to discuss the 'redesign' of child health programmes aimed at achieving the best possible health, growth and well-being for all children and adolescents. For young children, the focus includes aspects such as nutrition, child development and risk prevention. A global meeting between UNICEF and the WHO in January 2019 generated the consensus that a paradigm shift and public health response are needed to ensure that newborns, children and adolescents survive, are healthy and develop to their full potential.

(iv) **Nurturing Care Framework (NCF):** This framework, published in 2018, was developed by UNICEF, the WHO, the World Bank Group, the Partnership for Maternal, Newborn and Child Health, and the Early Childhood Development Action Network (ECDAN) to provide strategic direction for the holistic development of children during pregnancy up to three years. The NCF focuses on the improvement of survive and thrive interventions that could lead to transformation and includes the following five components of nurturing care: (1) good health, (2) adequate nutrition, (3) responsive caregiving, (4) early learning, and (5) security and safety.

(v) **Lancet Commission on Child Health and Wellbeing:** The WHO and UNICEF initiated this commission which frames an agenda for all children from birth to 18 years to thrive in the Sustainable Development Goals (SDG) era. The commission included different regions and disciplines like maternal and child health, nursing, nutrition, education, social science and environmental science, and established five working groups. Its goal is to identify the best ways to optimise, reposition and redesign child health in order to meet the Sustainable

Development Goals 2030 (Coll-Seck, 2019:110). Figure 2.1 provides a summary of the Sustainable Development Goals 2030. For the purpose of the study, these goals will not be discussed in detail.

Figure 2-1: Sustainable Development Goals 2030

Source: Adapted from United Nations (n.d.)

According to Berry and Malek (2017:56), the significance of the first thousand days has been recognised in South Africa, especially in the Western Cape province, by launching the First 1000 Days initiative in 2016. This initiative enables children to thrive and reach their full potential by promoting the health and wellness of pregnant mothers and infants. The next section will provide more information on the First 1000 Days initiative in the Western Cape, as well as on the factors impacting the first thousand days of a child's life.

2.2.2 First 1000 Days initiative in the Western Cape

2.2.2.1 History of the First 1000 Days initiative

A prominent scholar, Daniel Stern, made a call for action on behalf of infants at the World Association for Infant Mental Health's eleventh conference in 2008. Five years later, the UK Government issued a manifesto entitled "The 1001 Critical Days" to work together to help ensure that all babies in their county had the best possible start in life. In South Africa, information on the first thousand days was shared by a senior dietician from Stellenbosch University at the Parent

Infant and Child Health (PICH) provincial meeting in May 2013. The chairperson from PICH tapped into this growing international focus on the first thousand days by attending a conference in Edinburgh and distributing this information to the PICH committee afterwards. This led to the establishment of a multi-disciplinary working group, the Parent Infant Child Health and Wellness Working Group in 2013 to drive the agenda for the Western Cape's First 1000 Days initiative. This initiative formed part of the Provincial Strategic Plan for 2014-2019. This working group was mandated to achieve two aims: (1) raise awareness of the importance of the first thousand days within government departments such as Health, Social Development, Education, Arts and Culture, as well as in the non-profit sector, and (2) supply scientific evidence regarding the economic benefits of investing in the early life span phase. The Western Cape Minister of Health, Dr Nomafrench Mbombo, and Minister of Social Development, Adv. Albert Fritz, subsequently launched an official First 1000 Days campaign on 17 February 2016 in response to this awareness (Thanjan, 2017:4, Western Cape Government, 2017).

According to Western Cape Government (2017), this campaign was intended to be an inter-sectoral campaign as explained by the Western Cape Minister of Health at the official launch: "We realise that health and wellness requires a wider response than any one department can deliver, and that's why the Department of Health and Department of Social Development (DSD) have joined together on the First 1000 Days initiative."

Various meetings were facilitated by the Director of Health Programmes in the Western Cape Department of Health to strategise on the development of a First 1000 Days campaign. Although Department of Health took the lead on this initiative, the value of an inter-sectoral approach with the Department of Social Development and Education was recognised. A team of five people from the Western Cape Department of Health and the City of Cape Town led the development of a structured workshop. It was decided to use videos and documentaries to communicate a more passionate message of the first thousand days. Initially, six workshops in the form of roadshows were held in the Metro district in the Western Cape during May and July 2016. After requests for more roadshows, the initial small planning team was enlarged to include more trainers and a second series of workshops were conducted, including in the Drakenstein area (Berg, 2016a:iii; Puura *et al.*, 2018; Thanjan, 2017:4-5).

2.2.2.2 Three key areas of the First 1000 Days initiative

This initiative focuses on three key areas, namely health and nutrition, love and attention, and play and stimulation. These key areas are represented in the initiative's logo (see Figure 2.2) and

are explained below (Malek, 2016; Western Cape Government 2017; Western Cape Government 2019a):

- Health and nutrition are indicated by the yellow bowl (also referred to as Nutrition and health)
- Love and attention are indicated by the red heart (also referred to as Nurture, care and support)
- Play and stimulation are indicated by the blue building blocks (also referred to as Safety, protection and stimulation).

Figure 2-2: The logo of the First 1000 days initiative

Source: Adapted from the Western Cape Government (2019b)

(i) Health and nutrition

Health is defined by the WHO (2006:1) as *"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"*. The first key area, namely health and nutrition, refers to the health and nutrition aspects of the pregnant mother and her unborn baby, as well as the health and nutrition of the infant after birth and the growing baby up to two years of age. This key area is related to factors such as the physical health of the child and mother, the mental health of the mother, nutritional deficiency and malnourishment, stunting, breastfeeding, the mother's substance use/abuse during pregnancy, and immunisations (Western Cape Government, 2019a). The following factors – the health of the child, nutrition, stunting, breastfeeding, the mental health of the mother and the substance use/abuse of the mother – will be discussed in more detail.

Health of the child

The Center on the Developing Child of Harvard University (2010:2, 4) explained that children's health begins with their future mother's health even before pregnancy, which lays the foundations for their lifelong health and well-being. The development of a strong brain architecture and a wide

range of skills and learning capabilities depends on good health of the child during the earliest years. Hence, they stated the following: “The biology of health is defined by advances in science that explain how experiences and environmental influences ‘get under the skin’ and interact with genetic predispositions, which then result in various combinations of physiological adaptation and disruption that affect lifelong outcomes in learning, behaviour, and both physical and mental well-being.” According to them, the child’s physical and mental well-being is therefore influenced by the following three areas: (1) secure and nurturing relationships, (2) a safe and supportive environment, free of toxins and fear, and (3) proper nutrition.

Nutrition

According to Save the Children (2012:2,5), nutrition is one of the main components influencing a child’s first thousand days of life. Good nutrition during the first thousand days window period is vital for children’s cognitive and physical development as it will assist them to perform better in school one day. The quality of nutrition during the first thousand days establishes the foundation for a child’s healthy and productive future, which also determines a nation’s future. The child’s brain and body develop rapidly during this crucial time, and a lack of healthy nutrition has damaging effects which are often irreversible. Investment in nutrition solutions for mothers and children during the first thousand days could make a huge difference for both mother and child, as well as for communities and society as a whole. Prado and Dewey (2014:267) explained that normal brain development requires adequate nutrition, especially during pregnancy and infancy. These crucial periods of brain development lay the foundation for cognitive, motor and socio-emotional skills throughout childhood and adulthood. They further believed that nutritional deficiencies during pregnancy and infancy can affect a person’s cognition, behaviour and productivity throughout the school years and adult life.

The Academy of Nutrition and Dietetics (2019), Paramor (2016:26-28) and the WHO (2017:4-5) identified folic acid, iron, vitamin A, B2, B6, B12, C, iodine, magnesium, zinc and calcium as vitally important nutrients during pregnancy. Folic acid reduces the risk of birth defects, iron prevents maternal iron deficiency and calcium promotes the healthy development of the baby’s teeth, bones, heart, nerves and muscles. They also cautioned that when a pregnant mother does not consume adequate calcium it is taken from the baby’s bones. The American College of Obstetricians and Gynecologists (2018a) and Paramor (2016:26-27) recommended the inclusion of the following food into a pregnant woman’s diet: (1) grains and legumes, including pasta, brown rice, oatmeal, cereal, peas, lentils and chickpeas, (2) fruits, (3) vegetables, (4) protein foods such as meat, poultry, seafood, beans, eggs, nuts and seeds, (5) dairy products like milk, cheese and

yoghurt, and (6) healthy fats. The inclusion of sufficient amounts of macronutrients and micronutrients during pregnancy is emphasised by Paramor (2016:26-27).

Schwarzenberg and Georgieff (2018:1) agreed that maternal prenatal nutrition and nutrition in the child's first thousand days are critical for neurodevelopment and lifelong health. They explained how failure to provide key nutrients – such as protein, zinc, iron, choline, folate, iodine, vitamins A, D, B6 and B12, and polyunsaturated fatty acids – required for brain growth during this period may result in a lifelong deficit in brain function. The importance of adequate nutrition for the healthy growth and development of children is confirmed by Cook and Cook (2010:117), who described the function of key nutrients as follows:

- **Protein:** Protein provides the body with amino acids, the essential 'building blocks' for growth, and are especially needed during periods of rapid growth (such as the third trimester of pregnancy) and infancy.

- **Carbohydrates:** These provide energy for muscle activity to generate body heat, and for the brain and nervous system.

- **Fats:** Fats provide energy and insulate the body from variations in environmental temperatures.

- **Minerals and vitamins:** These help to sustain the body's growth and normal functions.

Stunting

Chronic undernutrition may lead to stunting which can hamper the development of human capital and result in substantial long-term health costs. During the first two years of live, stunting is especially harmful and may be irreversible. The mother's nutritional status before and during pregnancy is a further risk factor for low birth weight and stunting (Sanders & Reynolds, 2017:68). According to Prendergast and Humphrey (2014:251), women who were stunted as children are more likely to have stunted children, creating an intergenerational cycle of poverty. These authors emphasised the importance of environmental factors such as maternal nutritional status, feeding practices, hygiene, frequency of infections and access to health care as major determining factors of growth in the first thousand days of life. UNICEF (2017) confirmed that stunting occurs in approximately a third of children under three years of age as a result of chronic malnutrition, with long lasting effects like impaired brain development, lower IQ and weaker immune systems. According to the Barker hypothesis, currently known as the DOHaD hypothesis, "fetal programming" caused by the fetus adapting to a limited supply of nutrients could cause permanent

change to their physiology and metabolism, which may be the origin of various diseases later in life, including stroke, diabetes and hypertension (Barker, 1997:96; Georgieff *et al.*, 2018:1063).

Breastfeeding

Various organisations promote the benefits of breastmilk and its positive impact on the child's health and development. According to Every Woman Every Child (2015:19), promoting breastfeeding during the first two years could prevent undernutrition and ensure a good start for every child. The WHO (2019f) said that breast milk contains all the nutrients an infant needs, with long-term health benefits for the mother and the child. Therefore, they recommend exclusive breastfeeding for the first six months. Continued breastfeeding from six months up to two years or even longer can improve the child's cognitive ability, resulting in improved school performance and increased productivity (UNICEF, 2016a:8).

Faure *et al*. (2016:156) explained the value of colostrum, the first breastmilk for three to four days after birth, which is rich in nutrients and antibodies that line the gut of newborns, thus protecting them from infection. They added that the colostrum acts as a laxative to assist the baby to pass the meconium stool. Additionally, various entities highlighted the benefits of breastfeeding which include improved brain maturation, a stronger immune system due to antibodies in breastmilk which help the baby to fight viruses and bacteria, reduced risk for asthma or allergies, better teeth and jaw development, fewer colds and respiratory illnesses, fewer ear infections, lower risk of bacterial meningitis, fewer childhood cancers, fewer digestive problems and better vision (Cleveland Clinic, 2019a.; UNICEF, 2005; Western Cape Government, 2019c.; WHO, 2019a). Breastfeeding also holds physical and emotional benefits for mothers, such as faster weight gain, fewer urinary tract infections, lower risk for certain cancers and type 2 diabetes, and reduced stress due to the production of oxytocin and prolactin (Cleveland Clinic, 2019a.; Office on Women's Health, 2019). An article entitled 'Committing to Breastfeeding in Social Work' affirmed the importance of breastfeeding and indicated that social workers could help to reduce health inequities for at-risk populations by empowering women to breastfeed (Hurst *et al.*, 2018:252,258).

The Department of Health (n.d.b) in South Africa also recognises breast milk as a unique nutritional source that holds benefits for both the mother and the child. The Western Cape Government (2019c) supported World Breastfeeding Week from 1 to 7 August 2019 with the aim to promote the importance of breastfeeding. The World Alliance for Breastfeeding Action (WABA) has been coordinating World Breastfeeding Week since 2016, which is aligned with the United Nation's Sustainable Development Goals (World Alliance for Breastfeeding Action, 2019).

UNICEF and the WHO identified seven actions needed in countries to enable women to breastfeed. These seven actions include: (1) the funding of breastfeeding programmes, (2) the regulation of the marketing of breast milk substitutes, (3) maternity protection in the workplace, (4) compliance with the Baby-Friendly Hospital Initiative, (5) access to breastfeeding counselling and training, (6) the availability of community support programmes, and (7) consistent monitoring. The Global Breastfeeding Scorecard reviews the implementation of these seven actions to encourage progress and policy changes (Global Breastfeeding Scorecard, 2018).

Mental health of the mother

The study conducted by Nierenberg (2017) emphasises the important role of a mother's well-being and mental outlook during pregnancy. The baby's well-being depends on the mother's well-being, as described by Murkoff and Mazel (2016:18). According the Perinatal Mental Health Project (2019), an independent initiative based at the University of Cape Town, women are more vulnerable to mental illnesses around pregnancy due to life changes. A pregnant mother's mental illness could directly affect the fetus with long-lasting physical, cognitive and emotional outcomes for the child. Maternal depression and anxiety are strongly linked with children's lower educational levels. Statistics for South Africa showed that one in three women suffers from common mental disorders such as depression or anxiety during and after pregnancy. Maternal mental illnesses are very common in low-income and informal settings, with most of South African women experiencing a maternal mental illness coming from disadvantaged communities.

Substance use/abuse during pregnancy

Substance abuse during pregnancy can have several harmful outcomes for the mother and the baby. These harmful effects are influenced by the type of substance, the amount, as well as the point of exposure during pregnancy (Forray, 2016:4; Passey *et al.*, 2014:44-50). The WHO (2019b) warned against the harmful effects of substance use during pregnancy, as quoted:

Use of alcohol, illicit drugs and other psychoactive substances during pregnancy can lead to multiple health and social problems for both mother and child, including miscarriage, stillbirth, low birthweight, prematurity, physical malformations and neurological damage.

Faure *et al.* (2016:23) described the devastating consequences of prenatal alcohol use, since alcohol is a teratogen, affecting the development and migration of brain cells. Moderate use of alcohol could cause Fetal Alcohol Effects (FAE), resulting in learning problems, Attention Deficit Hyperactive Disorder (ADHD) and other conduct disorders. Excessive alcohol abuse during pregnancy leads to FASD, which involves cognitive as well as other developmental abnormalities. The harmful effects of a mother using alcohol during pregnancy include the risk of FASD, as

confirmed by the Addiction Center (2019a). They further referred to the range of lifelong physical, behavioural and intellectual disabilities associated with FASD, including the following: abnormal small head and brains, abnormal facial features, heart and spine defects, shorter height, low body weight, vision and hearing problems, delayed physical development, heart, kidney and skeletal problems, hyperactive disorder, speech and language delays, intellectual disability and poor memory. A study on the prevalence rates on FASD in South Africa found that this country has the highest reported rates of this disorder (Olivier *et al.*, 2016:105).

The damaging effects of maternal smoking during pregnancy have been highlighted by the American College of Obstetricians and Gynecologists (2019a). They explained how smoking cigarettes during pregnancy exposes the developing fetus to 4 000 toxic chemicals passing from the mother to her fetus. One of these toxic chemicals, nicotine, narrows blood vessels, causing less oxygen and nutrients to reach the baby while also causing permanent damage to the brain and lungs. Other risks like preterm births, Sudden Infant Death Syndrome (SIDS), childhood asthma and obesity are all associated with maternal smoking during pregnancy.

The use of illicit drugs during pregnancy could lead to a miscarriage, low birth weight, premature labour, placental abruption, fetal death and even maternal death. Dagga or marijuana reduces the oxygen supply to the baby by increasing the carbon monoxide and carbon dioxide in the blood, which could cause developmental delays, as well as behavioural and learning problems in the child. Methamphetamine increases both the pregnant mother and baby's heart rate, causing the baby to obtain less oxygen. This increases the chances of premature labour, miscarriage and placental abruption. Furthermore, babies born from mothers who used methamphetamine during pregnancy could be born addicted to this drug, consequently suffering from withdrawal symptoms after birth (American Pregnancy Association, 2019a). The use of dagga during pregnancy, according to the American College of Obstetricians and Gynecologists (2019a), could increase the risk of lower birth weight or stillbirth, as well as attention and behavioural problems in the child later in life.

(ii) Love and attention

The second key area, namely love and attention, refers to the child's caregiving and nurturing, attachment and toxic stress experienced by the mother and the child (Western Cape Government, 2019a). This will be described next.

The child's caregiving and nurturing

Jamieson and Richter (2017:33) mentioned that babies need nurturing care, a supportive environment and an enabling context to survive and thrive. They indicated that a specific kind of environment – one that provides good nutrition and protection from toxins, trauma and disease – is critical to ensure that the developing embryo and fetus grow and develop optimally in order to survive and thrive. If faced with a hostile environment, as indicated above, some babies will not survive while others might survive these threats but will not thrive. Therefore, a child needs an environment that is not only free from harm, but is also enriched with experiences that promote the development and growth of the brain (Jamieson & Richter, 2017:33). The study conducted by Mputle (2019) included a systematic review of the WHO's nurturing framework which includes the following five areas: (1) nutrition, (2) health, (3) early learning, (4) responsive care, and (5) security and safety. Mputle concluded that all of these areas are crucial for child development during the first thousand days of life. In addition, she identified supportive interventions as an extra area playing a role during this time period in her study.

In addition to the WHO's nurturing framework, as indicated above, the organisation Ilifa Labantwana (2013:8) considers the following five components as essential for care towards vulnerable children in order to promote their health and development: (1) nutritional support, (2) primary level maternal and child health interventions, (3) social services, (4) support for primary caregivers, and (5) stimulation for early learning.

Attachment

According to the National Scientific Council on the Developing Child (2004:1), the quality and stability of children's relationships in the early years affects all aspects of their development. This will also impact their developmental outcomes later, such as their mental health, school progress, motivation to learn, conflict resolution skills and moral discernment. Berry and Malek (2017:51) explained that emotional attachment between parents and the infant during the first thousand days is vital for survival and lifelong healthy development. They emphasised that poor maternal care can cause emotional stress in infants, which impacts the brain function and reduces children's ability to thrive. The importance of a secure attachment during infancy is confirmed by Berg (2016b:16), indicating that a positive relationship between parents and children influences their future relationships, self-esteem and resilience. She believes that the attachment between children and their caregivers is the most important during the early phase of life, namely the first thousand days. The Center on the Developing Child of Harvard University (2017b:2) further emphasised how a responsive relationship could help to protect children from the potential harm

of excessive stress. A study conducted by Benoit (2004:541-542) indicated how attachment between the child and the parent could lead to the child feeling safe, secure and protected.

Toxic stress experienced by the mother and the child

The aspect of toxic stress refers to both the mother's and child's experience of toxic stress and the impact thereof. The biology of stress – caused by significant stressors like abuse, neglect or poverty – could lead to physiological and behavioural disruptions in a person's life. Toxic stress could negatively affect the architecture of the child's brain, as well the adult's ability to engage in work and family life (Center on the Developing Child of Harvard University, 2017a:2). According to the University of Zurich (2017), the concentration of stress hormones in amniotic fluid rises if the mother is stressed over a long period of time during pregnancy. When pregnant mothers experience stress over a long period of time, the risk of the unborn child developing a mental or physical illness later in life – such as attention ADHD or cardiovascular disease – increases.

In South Africa, the high prevalence of poverty is often associated with stressors like poor housing, unemployment, poor education and social challenges like domestic violence, crime, substance abuse and child abuse that could threaten the well-being of a child's development (Morgan, 2013:1-4). Morgan explained that stress during the first thousand days could be particularly damaging to the child as a result of the release of adrenalin and cortisol, causing physiological and psychological changes to two systems, namely the sympathetic nervous system (SNS), and the hypothalamus-adrenal (HA) axis (Morgan, 2013:1-4). According to Moodley *et al*. (2019:30), infants are not able to regulate their own biological stress response due to the immature brain cortex. Hence, they strongly rely on comfort and reassurance during times of stress.

(iii) Play and stimulation

The third key area, namely play and stimulation, refers to the stimulation of the child, as well as providing a safe space for the child during the first thousand days (Western Cape Government, 2019a).

The areas of a child's brain responsible for learning develops rapidly from pregnancy up to 24 months, thus the first thousand days of life. However, children's capacity to learn depends on their brain's health and functioning. Early learning is described as a complex process comprising of the interactions between the children's experiences and their brain. Ebrahim *et al.* emphasised the importance of age-appropriate stimulation during the early years and referred to factors like self-regulation, motivation and socio-emotional development which could influence a child's ability

to learn (Ebrahim *et al.*, 2013:66). Playing opportunities, as described by Haughton and Ellis (2013:76, 84), can assist children in their own learning, social interactions and negotiating skills. According to them, enjoyment obtained from play, promotes the child's psychological and physiological development.

Cook and Cook (2010:429-431) emphasised the importance of play where children learn more about themselves and their world which enhances their cognitive, physical and social development. Play provides opportunities for children to be creative, learn problem solving skills and language skills, solve conflict and make friends. These authors indicated Mildred Parten's (1932) six levels of play:

- **Unoccupied behaviour:** This is where children are simply sitting or standing, apparently not playing or watching others play.
- **Onlooking:** This is where children are watching others play without engaging in the play themselves.
- **Solitary play:** This is where children are playing by themselves without making connections with others.
- **Parallel play:** This occurs where children play beside others, but not with them.
- **Associative play:** This refers to children associating with others playing and playing among them but without coordinating their play activities.
- **Cooperative play:** This type of play refers to children playing with each other in an integrated and coordinated manner.

2.3 FOUNDATION PHASE OF SCHOOLING

This section provides an overview of the Foundation Phase by discussing the following aspects: background information on the Foundation Phase, the importance of reading and writing in the Foundation Phase, and early learning before entering the Foundation Phase.

2.3.1 Background information on the Foundation Phase

One of the main events in a child's life is entering formal schooling. Children's readiness for formal learning forms the basis of their involvement with the learning context, thus influencing their future learning (De Witt, 2009:169). In South Africa, Grade R forms part of the Department of Basic Education's national Foundation Phase curriculum. However, until now, Grade R has not been

compulsory although the Department of Basic Education is committed to making Grade R compulsory (Department of Basic Education, 2019). According to Notice 2433 on the age requirements for admission to an ordinary public school, it is compulsory for learners to be admitted to Grade 1 if they turn seven during the course of that year. This notice also stated that learners may attend Grade R in the year that they turn six, although it is not compulsory to enrol for Grade R (Department of Basic Education, 1998). The Western Cape Government (2015) referred to the Foundation Phase of schooling as the inclusion of Grade R to Grade 3. For this study, the Foundation Phase will include learners from Grades R to 3, although it is acknowledged that Grade R is not yet compulsory.

2.3.2 The importance of reading and writing in the Foundation Phase

The learning process for reading and writing begins in Grade 1 of the Foundation Phase and includes the use of the alphabet and natural numbers (National Education Evaluation & Development Unit, 2012:24). Grades 1 to 3 in the Foundation Phase represent the period during which children 'learn to read', whereas from Grade 4 onwards they are supposed to 'read to learn'. The child should therefore use the reading skills acquired in Grades 1 to 3 to obtain new information in the following phases of schooling. Therefore, reading for meaning is one of the most important skills a child must learn during the Foundation Phase as all future learning will depend on this. Reading for meaning is also a primary indicator of school efficacy. Children need to be able to read with meaning in order the access the curriculum. Unfortunately, most children in South Africa do not possess this reading skill by the end of Grade 3, causing them to fall behind even further in the next grades (Spaull & Zenex Foundation, 2016:2).

Since reading and writing form the basis of learning, learners who do not acquire these basic skills during the Foundation Phase experience further restrictions in their schooling in the higher grades. If learners are not able to decode text in their home language, they cannot 'survive' and 'thrive' at school. Therefore, it is of utmost importance for learners to learn how to read fluently with comprehension during their early years of schooling in order for them to reach their full potential later in life (Spaull & Hoadley, 2017:77).

The cognitive processing that occurs during reading is complex and includes three main components, namely (1) decoding, (2) comprehension and (3) response. Decoding refers to the brain processing the printed symbols taken in by the eyes and translating these into language. Learners will find it difficult to understand what they are reading if they struggle with decoding. Language comprehension includes the ability to construct and understand the overall meaning of text on three different levels, namely the literal level (identifying information that is explicitly

stated), inferential level (determining the implicit meaning) and evaluative level (analysing the text). Children can respond either positively or negatively to reading. If they do not comprehend the meaning of the words they are reading, they can have a negative response to reading which could have a lifelong effect on them (Pretorius *et al*., 2016:9, 10, 14, 15, 17).

2.3.3 Early learning before entering the Foundation Phase

The ability to read is influenced by children's interaction with their family and environment in their earliest years. Their language and vocabulary development during these early years build the foundation for oral language which is crucial for fluent reading and understanding during their school years (Spaull & Hoadley, 2017:78). According the Department of Education and UNICEF (2015:4), the process of early literacy begins at birth. In addition, the literacy process and development of children need to be supported by families and early childhood development (ECD) practitioners to establish the foundation needed to enter Grade 1. De Witt said that children need to be physically, linguistically, socially and cognitive ready when they enter formal schooling (De Witt, 2009:172). She also emphasised the importance of a loving and supportive relationship between children and their mothers in order for children to be prepared for formal schooling. In addition, Brown (2016:78) believed in the importance of school readiness, stating that children lacking school readiness are at risk of falling behind from the start in the Foundation Phase of schooling.

Healthy brain development in children's first few years of life form the building blocks of their later life by determining their cognitive, emotional and social development. Children's brain development during these crucial years will influence their capacity to learn and their future success. Their experiences and condition before they enter formal schooling affect the formation of critical brain connections. The construction of these neural connections and children's ability to learn are facilitated by stimulation, proper nutrition, as well as protection from abuse, violence and toxic stress (Bernard van Leer Foundation 2016:12). A systematic review by Tanner *et al.* (2015) showed that interventions during early childhood development could affect a child's schooling in a number of possible ways. They have found that increased cognitive development could lead to improved scholastic achievement and that healthier children are able to attend school better. In addition, they have concluded that children experience a vocabulary explosion between 12 and 24 months, and that their linguistic development during this time plays a vital role in their ability to read when they attend school later on.

The South African National Curriculum Framework for children from birth to age four recognises the importance of the early years as a crucial time in a child's life and has incorporated six Early

Learning and Development Areas (ELDAs) into this framework to enhance children's development and learning. These six areas include (1) well-being, (2) identity and belonging, (3) communication, (4) exploring mathematics, (5) creativity, and (6) knowledge and understanding of the world. The well-being of children encompasses physical, emotional and social aspects of their development which will impact their motivation for learning. Children's identity and belonging relate to their personal and social development, as well as secure relationships which will influence their resilience and attitude towards learning. Communication begins at birth, and it is essential for children to explore their environment, gain knowledge and understanding of the world, and learn language skills. Children's early mathematical skill development includes problem solving, reasoning, designing things and investigating mathematical concepts like numbers, counting, shapes, space and measures. Creativity is strongly associated with children's mathematical and scientific thinking, and could include various art forms like visual and performing arts. Visual arts develop children's sensory-motor skills, as well as their fine and gross motor skills, whereas performing arts promote memory, self-confidence and self-discipline. Knowledge and understanding of the world improve children's learning when they obtain accurate information about their environment, other people and living creatures (Department of Basic Education; 2010; Department of Education & UNICEF, 2015:8, 16, 31, 40, 50, 57, 65).

Based on the information provided in this section, it appears that holistic development during the first thousand days could influence children's readiness for schooling, as well as their ability to learn at school. It was established that a good start during the Foundation Phase, which includes efficient reading and writing abilities, is critical for children's success in schooling. However, school absenteeism could have a negative effect on children's academic progress. This will be discussed next.

2.4 SCHOOL ABSENTEEISM

The following section will look at the importance of school attendance, the definition of school absenteeism, the reasons for and consequences of school absenteeism, as well as absenteeism in South Africa.

2.4.1 Definition of school absenteeism

Learner absenteeism, according to Coetzee and Venter (2016:2), refers to an umbrella of concepts. According to Attendance Works (2011:1) and Henderson *et al.* (2014:5), in the United States of America, chronic absenteeism refers to learners who miss school for 10% of the school days in year (approximately one month of schooling for that year), for whatever excused or unexcused reasons. Henderson *et al.* (2014:5) stated that chronic absenteeism measures all

forms of absence, despite being excused or unexcused, since this relates to learners' overall attendance. However, Attendance Works (2011:1) differentiated between chronic absenteeism and truancy, where truancy is associated with being wilfully absent. McCray (2006:31) described truancy as the act of missing school without permission.

The South African Policy for Learner Attendance 2010 (Department of Basic Education, 2010:10) provides definitions for various terms relating to absenteeism. The term *absent* is used for any learner that is not in class or participating in school activities when the class register is marked. *Continuous absenteeism* is used where a learner is absent from school for ten consecutive days without a valid reason. *Learner absentee day* refers to the school day when a learner is marked absent in the class register (Department of Basic Education, 2010:3-5). According to Coetzee and Venter (2016:7), the concept of absence is too narrowly defined in the South African Policy on Learner Attendance. Hence, they suggested that this policy should make a clear distinction between chronic absenteeism and continuous absenteeism.

In this study, the term *absenteeism* or *absent learner* will be used to indicate any form of absence from school, whether continuous or irregular.

2.4.2 The importance of school attendance

Henderson *et al.* (2014:5) highlighted the importance of school attendance and believed that regular school attendance influences academic success. The school setting provides children with a language-rich environment for academic and social development, as well as the opportunity to develop other skills such as problem-solving skills. Regular school attendance is vital for a child's development and success later in life. Yet, school absenteeism is a common and serious problem (Kearny & Graczyk, 2014:1-2). According to Attendance Works (2011:3), regular school attendance, especially during the first few grades, is crucial for setting learners on a successful academic path to ensure sufficient reading skills by Grade 3. In South Africa, the Department of Basic Education (2010:9) proclaimed the importance of regular school attendance for an educated nation. The department regards education as every child's fundamental right and believes that regular school attendance could break the cycles of teenage pregnancies and Human Immune-deficiency Virus (HIV) infection. Mitchell *et al*. (2016:158) emphasised the importance of education for children living in poverty to ensure they reach their full potential.

2.4.3 Reasons for school absenteeism

Attendance Works (2011:1, 3) noted the strong focus on chronic absenteeism in high schools, while neglecting absenteeism during the early years of schooling. The organisation believes that

absenteeism in the early years of schooling could lead to an entrenched habit of poor attendance during the higher grades of schooling. They further explained the impact of poverty on chronic absenteeism. For learners from families living in poverty, factors such as inadequate transport, housing challenges, lack of health care, a higher occurrence of chronic diseases, poor nutrition and safety risks could contribute to chronic absenteeism. In addition, Attendance Works (2011:1, 3) stated that schools in poor communities are often less engaging educationally, which can also influence learners' attendance.

According to Coetzee and Venter (2016:1), social and financial circumstances often lead to involuntarily learner absenteeism. Henderson *et al*. (2014:13) highlighted the following reasons for school absenteeism: lack of transport, chronic health problems (for example asthma), children's lack of interest in the curriculum, bullying, disabilities and the lack of support from family to promote regular school attendance.

In addition, a study conducted by Sahin *et al*. (2016:197-198) identified the following five themes as reasons for school absenteeism:

- **Family-child relationship:** This included various aspects such as lack of care, the parent not establishing relations with the school, poor communication between the family and child, working conditions of the parents and failure to provide positive role modelling.
- **The family's view of absenteeism:** Families may prefer to keep their children out of school for reasons like shopping, weddings or funerals.
- **Family problems:** Problems such as divorce, domestic violence, death of a parent and having someone at home in need of care could have a negative effect on a child's school attendance.
- **View of education:** Parents' lack of understanding regarding the importance of education, as well as their own lack of education can lead to a disregard for their child's education, which appears to be an important cause of school absenteeism.
- **Poor financial circumstances:** Aspects like financial difficulties, children working at home or taking care of siblings, the parents' inability to provide school supplies and an unsuitable home environment play a significant role in absenteeism.

In South Africa, the Department of Basic Education (2010:8-9) highlighted poverty as one of the key reasons for school absenteeism in the country. They view poverty as the root cause of irregular school attendance due to reasons like parents' inability to afford a school uniform or school fees, lack of transport, poor nutrition, child labour, dysfunctional families and gang

violence, as well as the chronic illnesses (including HIV/Aids and tuberculosis) of parents and/or children. A research study conducted by the Community Agency For Social Enquiry & Joint Education Trust (2007:25-26) found that illnesses, gender, age, learning disabilities and psychological problems relating to learners played a role in their absenteeism.

Although there are various reasons for school absenteeism, the following valid reasons are indicated in the South African Policy for Learner Attendance 2010 (Department of Basic Education, 2010:10):

- Study leave taken by Grade 12 learners
- Physical or psychological illness
- Giving birth to a child
- Religious or cultural activities approved by the School Governing Body (SGB)
- Death of a family member
- An appointment at court, Social Services or another official agency
- Suspension by the School Governing Body
- Natural disasters, outside human control
- Exceptional circumstances where the principal believes it is unavoidable or in the learner's best interest to be absent from school.

2.4.4 Consequences of school absenteeism

Absenteeism during the early years of schooling affects learners' chances to learn and their academic performance while hindering their reading ability, which widens achievement gaps. Chronic absenteeism by Grade 6 is one of the main early-warning indicators that a learner will eventually drop out in high school (Attendance Works, 2011:1,3). According to Tanner-Smith and Wilson (2013:469), children who are absent have less instructional time at school, resulting in them falling behind with their schoolwork. McCray (2006:32-33) believed that chronic absenteeism is an obstacle for learners' academic success and could potentially limit the possibilities for them. According to her, chronic absenteeism is not just an individual problem but a societal one which requires families, schools and communities to work together in order for children to attend school regularly.

School absenteeism in the early grades of schooling, as noted by Cook *et al*. (2017:262), could cause school disengagement, academic failure and eventually school dropout. Tanner-Smith and Wilson (2013:469) referred to the risk of school absenteeism leading to dropping out of school permanently, which will further deprive learners of financial and social opportunities, with adverse personal and social consequences. As indicated by Ogburn (2017:1), school absenteeism could have short-term and long-term consequences, including inadequate education, unemployment, financial instability and health-related problems, thus creating an unfortunate cycle of poverty and poor health outcomes.

2.4.5 School absenteeism in the South African context

In terms of the South African Policy for Learner Attendance 2010, it is the class teacher's responsibility to report to the principal those learners who are absent without an explanation for three consecutive days. The principal must then follow the steps outlined in the policy (Department of Basic Education, 2010:10):

- Inform the learner's parents of the importance of regular school attendance
- Emphasise the learner's duty to attend school regularly according the school's code of conduct
- Explain the legal implications of absenteeism to the parents if the learner is under the compulsory school-going age
- Inform the parents of the risk of the learner being deregistered after ten consecutive days of absenteeism
- Request that the learner returns to school
- Obtain the assistance of the District Office and/or government or non-government entities, where necessary.

The South African Policy for Learner Attendance 2010 (Department of Basic Education, 2010:18) says that where a learner's absenteeism without a valid reason persists despite the intervention outlined above, the principal must charge this learner with breaching the school's code of conduct or cancel the learner's record in the class register if absenteeism of more than ten consecutive school days has occurred. According to paragraph 56 of this policy, the principal must cancel a learner's record in the class register on the grounds of continuous absenteeism of ten consecutive school days without a valid reason. When the principal cancels a learner's record, he or she must

inform the parents and class teacher in writing regarding the date and reason for this cancellation as well as the District Office if the learner is of a compulsory school-going age. In terms of the South African School Act, No. 84 of 1996, paragraph 3, learners are of school-going age from the first day of school in the year they turn seven until the last school day in the year they turn 15, or Grade 9, whichever occurs first (Department of Basic Education, 1996:6).

A study conducted by Coetzee and Venter (2016:1, 3, 5, 6, 7) analysed South Africa's legislation and policies, with a strong focus on the South African Policy for Learner Attendance 2010, to determine whether these legislations and policies support an exosystemic approach. They argued that the reasons for absenteeism should not be examined in isolation. Instead, all the influences in an individual's environment should be taken into consideration when probing their absenteeism. They found that some sections of the Policy on Learner Attendance support an exosystemic approach by examining individual factors interrelating with the learner's context that could affect school attendance. For example, valid reasons for absenteeism could include lack of transport, psychological or physical illnesses, poverty or teenage pregnancy. They concluded that the section regarding the principal's legal responsibility to cancel the learner's record in the class register for being absent for ten consecutive days does not support an exosystemic approach in managing learner absenteeism. Their contention was that these procedures are punitive and do not provide the learners with an opportunity to make amends and restore relationships within their school context. Also, fairness and the learner's best interest were not promoted by this legal instruction. Hence, they provided the following recommendations: arranging a consultation between the teacher and the learner where a pattern of absenteeism has been detected, changing the policy to make provision for School Based Support Teams to address absenteeism, and revising the Policy of Learner Attendance to include that any punitive action will only follow after a fair disciplinary action. They also provided the following guidelines to enhance an exosystemic approach toward managing learner absenteeism: (1) Understanding that the multitude of risk factors in an absent learner's environment demands a rehabilitative approach, (2) defining learner absenteeism in a manner that will not brand or alienate the absent learners, (3) examining the impact of the micro-, meso-, macro-, exo- and chronosystems on the learner's absent behaviour, and (4) understanding that the effective management of absenteeism requires a collaborative effort from the school's management, educators and support teams.

School absenteeism in South Africa is a huge challenge with a total of 615 327 learners indicated as being absent from school in the Cape Winelands District during 2017 (Western Cape Education Department, 2017). It is therefore critical to revise South African laws and policies on school attendance and to incorporate an exosystemic approach towards managing school absenteeism, as recommended in the above-mentioned study.

PART 2: CHILD DEVELOPMENT FROM PREGNANCY TO TWO YEARS AND RELATED THEORIES

The researcher acknowledged the extent of literature in the field of childhood development. However, the amount of theory in this literature study had to be limited in order to focus on the most important aspects relating to the child development phases from pregnancy to two years of age. As Louw and Louw (2014) are well-known authors of literature on child and human development in South Africa, their literature will be one of the key resources used in this discussion.

The following section will cover the development of a child during the three stages of the prenatal phase (germinal stage, embryonic stage and fetal stage) and the two phases after birth up to two years (neonatal phase and infancy phase), as well as theories relating to child development.

2.5 CHILD DEVELOPMENT FROM PREGNANCY TO TWO YEARS

Humans start a process of change at conception and continue with this throughout their lives. Developmentalists refer to this lifelong process of human development as life-span development (Papalia & Feldman, 2012:4-6). The three main domains of human development are (1) physical development, (2) cognitive development, and (3) psychosocial development. Physical development refers to the growth and development of the body, brain and sensory motor skills. Cognitive development consists of learning, memory, thinking, reasoning, attention and creativity, while psychosocial development relates to a person's emotions, personality and social relationships. These domains are interrelated and affect each other. Physical, cognitive and psychosocial development can therefore be seen as a unified process.

According to Louw and Louw (2014:8), the developmental stages of children include the following:

- **Prenatal period:** This period ranges from conception to birth, and is divided into three stages (germinal, embryonic and fetal stages).
- **Neonatal period and infancy period:** This refers to the time from birth to two years.
- **Early childhood period:** This stage is from two to approximately six years.
- **Middle childhood period:** The stage is from six years to about twelve years.
- **Adolescence period:** This stage runs from the beginning of puberty, usually at age twelve, to adulthood.

According to the stages indicated above, the first thousand days of a child's life include the prenatal, neonatal and infancy periods. The neonatal and infancy phases will determine the development in the three main domains of development (physical, cognitive and psychosocial development), as indicated above.

The first thousand days of children's lives, from conception to two years, is a critical time period to ensure their optimal development (Malek, 2016:2). The three developmental phases pertaining to the first thousand days of a child will now be discussed to provide a better understanding of the comprehensive development that occurs during this time period.

2.5.1 Phases of child development from pregnancy to two years

The three phases of child development from pregnancy to two years are the (1) prenatal phase, (2) neonatal phase, and (3) infancy phase.

2.5.1.1 Prenatal phase

Prenatal development, according to Cook and Cook (2010:74), refers to the phase where humans develop before (pre) their birth (natal). This phase signifies the period from conception to birth and lasts for approximately nine months. Visser and Mulder (2016:v) believed that the prenatal phase is probably the most important period of a person's structural and functional growth because the foundations for short-term and long term outcomes are laid during this stage.

(i) Stages of the prenatal phase

The prenatal phase can typically be divided into three stages, namely the (1) germinal stage, (2) embryonic stage and (3) fetal stage (Cook & Cook, 2010:75; Louw & Louw, 2014:67). Figure 2.3 illustrates the three stages of prenatal development. Due to the vast amount of information available on each stage, it will not be possible to describe every stage in detail. Therefore, only the most important aspects were selected.

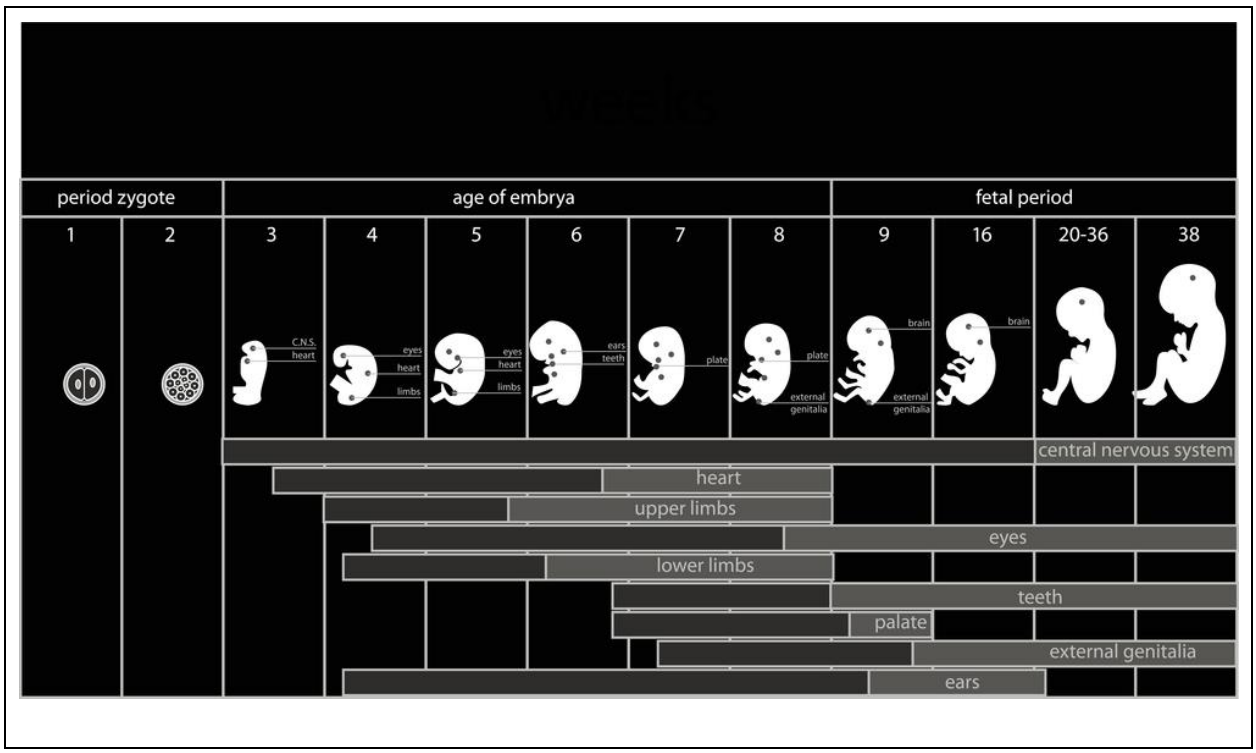

Figure 2-3: Three stages of prenatal development

Source: American Pregnancy Association (2019b).

Germinal stage

Every human life begins as a single fertilised ovum or zygote which reproduces itself through the process of cell division, called mitosis (Davidson *et al.*, 2014:243). The germinal stage, also known as the zygote period, commences from conception and lasts for one to two weeks. During this stage, the zygote grows rapidly through cell division (Berk, 2013:89, Louw & Louw, 2014:67). The process where the zygote attaches itself to the uterus is called implantation and indicates the end of the germinal stage. The physiologically dependent relationship between the zygote and the support system of the mother begins during this stage (Louw & Louw, 2014:67).

Embryonic stage

Once the zygote has been implanted into the uterine lining, the organism is referred to as an embryo. From this stage onwards, the embryo is very vulnerable to toxins in the mother's bloodstream. Therefore, the mother's blood needs to be enriched with healthy nutrients and oxygen, and needs to be free from damaging substances like alcohol, nicotine and drugs in order for the healthy development of the embryo to proceed (Cook & Cook, 2010:77). According to Berk (2013:91), the embryonic stage lasts from implantation until approximately eight weeks after conception and lays the foundation for all bodily structures and organs.

During this stage, as explained by Davidson *et al*. (2014:249) and Stoppard (2008:73), the cells of the embryo become more specialised, forming three primary germ layers, namely the (1) ectoderm, (2) mesoderm, and (3) endoderm. From these three layers all tissue, organs and organ systems will develop. Louw and Louw (2014:68-69) referred to the rapid growth or the developing organism, also called the embryo, where cell and organ differentiation takes place. The placenta and umbilical cord develop during this stage. The umbilical cord is referred to as the 'lifeline' connecting the embryo to the placenta. The placenta forms the structure that supplies oxygen and nutrients to the embryo, and also removes embryonic waste. According to Cook and Cook (2010:77, 121), the most complicated organ, namely the brain, is one of the first organs to develop during tissue differentiation in the embryo. The brain and nervous system are the vital structures that enable thinking, emotions and behaviours. They further explained the forming of the neural tube, spinal cord and brain during this time, causing the brain cells to be extremely vulnerable to any toxins in the uterine environment. Thus, any damage to these first brain cells could endanger normal brain development. The blood vessels and stomach develop during the third week. The brain expands from the fifth week, generating around 250 000 neurons per minute. The complete chest and abdomen are also formed by the fifth week. The heart undergoes vital structural and functional changes where the four heart chambers develop between the fifth and sixth week. By the eight week the face, mouth, eyes, ears, arms, legs, hands, feet, sexual organs, muscles and cartilage have started to develop. Internal organs such as the liver, pancreas, lungs and kidneys begin to fulfil part of their function (Louw & Louw, 2014:69). According to Zastrow and Kirst-Ashman (2013:55), the first trimester of a pregnancy is considered the most critical period due to the rapid differentiation and development of the embryo, making the embryo extremely vulnerable to aspects of the mother's health and her intake of harmful substances. Stoppard (2008:73) explained how a baby is known as the embryo until the eighth week of pregnancy, whereafter it is called the fetus, a Latin word meaning 'young one', thus entering the last stage, namely the fetal stage.

Fetal stage

The fetal stage, from the ninth week to birth, is the longest stage. During this stage, the fetus rapidly increases in size. The organs and systems develop further during this growth and finishing phase to function more effectively. During the third month, the connection between the nervous system, organs and muscles become more organised (Berk, 2013:92). By the seventh month the nervous, circulatory, respiratory and other body systems are relatively well developed (Louw & Louw, 2014:71-72). Louw and Louw also explained that learning already begins in the womb, especially during the last three months where the fetus responds to sounds filtered through the

amniotic fluid (2014:71-72). Table 2.1 below summarises the development during the fetal stage according to weeks.

Table 2-1: Fetal development according to specific weeks

Developmental age	***Description***
8-12 weeks	• Fetal heart tones could be heard using a Doppler device.
16 weeks	• The fetus looks like a baby. • The gender can be seen.
20 weeks	• Heartbeat could be heard using a fetoscope. • The baby's movements can be felt by the mother. • Regular schedule of sleeping, sucking and kicking. • Grasping of hands. • Baby develops a favourite position in the utero. • The lanolin protective layer, vernix, form to protect the skin. • Hair on the head, eyelashes and eyebrows are formed.
24 weeks	• Activity of the baby is increasing. • Fetal respiratory movements start.
28 weeks	• Opening and closing of the eyes. • Baby can breathe in the womb and the surfactant needed for breathing after birth is formed. • Fetus is two-thirds of its final size.
32 weeks	• Finger and toenails are present. • Central nervous system has matured. • Subcutaneous fat is being formed.
38+ weeks	• The baby fills the total uterus. • The baby obtains antibodies from the mother

Source: Adapted from Davidson *et al.* (2014:264).

(ii) Influences during the prenatal phase

The previous section referred to normal development during the prenatal phase. However, according to Louw and Louw (2014:73-74), certain factors may disturb normal development, affecting the child's physical and mental health. Environmental agents that cause damage during the prenatal period are referred to teratogens. The harm caused by these teratogens depends on various factors, as described by Berk (2013:95-96):

- **Dose:** A larger dose of teratogens over a longer period usually causes more harm.
- **Heredity:** This refers to the genetic construction of the mother and developing fetus, since some individuals can better withstand negative environments.
- **Other negative influences:** The impact is worsened if there are several negative influences during the same time period.

- **Time of exposure:** Each developing organ and structure has a sensitive period during which development may be disturbed if exposed to teratogens.

Berk (2013:96) explained that exposure to teratogens during the germinal stage rarely has an impact since the zygote has not yet attached itself to the mother's uterine lining. However, the embryonic stage has the greatest risk of serious defects since this stage lays the foundation for all body parts and organs. Damage during the fetal stage is less compared to the previous stage. However, organs like the brain, eyes, ears, teeth and genitals can still be impacted. In addition to the immediate physical damage, exposure to teratogens could also delay health outcomes and cause psychological consequences in the future.

The influence of the following teratogens are subsequently described:

(i) **Alcohol:** Prenatal exposure to alcohol causes a range of physical, mental and behavioural damages referred to as Fetal Alcohol Spectrum Disorder (FASD). This spectrum disorder refers to three diagnoses: Fetal Alcohol Syndrome (FAS), Partial Fetal Alcohol Syndrome (p-FAS) and Alcohol-Related Neurodevelopmental Disorder (ARND). FAS is characterised by (1) poor physical growth, (2) at least three of the following facial abnormalities: short eyelid openings, thin upper lip, flattened philtrum, and indent from the bottom of the nose to the upper lip, and (3) brain injury and impairments in at least three of the following functioning areas: memory, language and communication, attention span, planning and reasoning, motor coordination or social skills. p-FAS occurs where the mother consumed alcohol in smaller quantities and the child's defects vary. Children with p-FAS are distinguished by two or three of the facial abnormalities mentioned above, as well as brain injury and impairments in at least three areas. Children with ARND have at least three areas of mental disfunctioning, regardless of typical physical growth and the absence of facial abnormalities present in children with FAS. The mental impairment that occurs in all three FASD diagnoses is permanent. Babies with FAS struggle to catch up in terms of their physical size during infancy and childhood, even when provided with enriched diets after birth (Berk, 2013:98-99).

(ii) **Nicotine:** Nicotine in tobacco can cause poor fetal growth and impact children's cognitive performance, as noted by Louw and Louw (2014:77). According to Holbrook (2016:181), nicotine is extremely harmful to the fetus and could create long-term health problems, poor academic performance and behavioural problems including ADHD.

(iii) **Illicit drugs:** The use of illicit drugs during pregnancy can cause complications and birth defects such as preterm birth, low birth weight, growth retardation, brain abnormalities,

respiratory distress and intestine problems, depending on the specific type of drug used (Cook & Cook, 2010:81).

(iv) **Diseases during pregnancy:** Certain illnesses with small agents that can enter the placenta – such as Aids, rubella, syphilis and genital herpes – can affect the unborn baby (Louw & Louw, 2014:76).

(v) **Use of medication:** Medicine such as aspirin, antihistamines, certain antidepressants, antibiotics and sedatives could have dangerous effects on the unborn baby (Louw & Louw, 2014:77).

(vi) **Environmental pollution:** Exposure to certain pollutants and toxic compounds can cause severe prenatal damage in the developing baby. Lead present in paint and industrial material can result in cognitive impairment, growth retardation, low birth weight and miscarriage. Mercury found in industrial settings and contaminated fish can cause brain damage, abnormal speech, uncoordinated movements, blindness, physical deformities and cerebral palsy. Polychlorinated biphenyls (PCBs) come from industrial settings and certain materials such as electric isolators and can lead to preterm birth, low birth weight, microcephaly, visual problems and short-term memory problems (Berk, 2013:101; Cook & Cook, 2010:81).

Other maternal factors besides exposure to teratogens can also affect the embryo and fetus. The following factors have been identified by Louw and Louw (2014:73-74):

(i) **Age of the parents:** Mothers younger than 20 years and older than 35 years have a greater risk of giving birth to a baby with physical and psychological defects. Teenage mothers are particularly vulnerable to premature births, stillbirths and birth problems, while older women tend to have more difficult birth processes or are more at risk of giving birth to a child with Down's syndrome. However, the age of the mother does not necessarily have to be a negative factor if the mother is physically and emotionally healthy.

(ii) **Nutrition of the mother:** Unborn babies obtain all their nutrition from the mother's bloodstream and are directly dependent on the mother for all their nutritional needs. There is a link between a pregnant mother's insufficient diet and abnormalities such as still births, low birth weight, delayed growth, deformities and death in the first year.

(iii) **Emotional state of the mother:** The mother's emotional state influences the unborn baby due to the release of hormones such as adrenaline and noradrenaline. These hormones affect fetal activity, which lasts much longer than the mother's emotions. It has been found

that certain occurrences – such as spontaneous abortions, premature births, low birth weight and difficult deliveries – may be linked to a mother's emotional stress.

As seen above, the development of human life from conception to birth is divided into three stages with each stage characterised by distinct developments. The two phases after birth will be discussed in the following section.

2.5.1.2 Neonatal phase

The neonatal phase runs from birth to four weeks. Until the 1960s, researchers believed that a baby in the neonatal phase only ate, slept, cried and breathed. Now new research has shown that development during this phase is more advanced than initially thought (Louw & Louw, 2014:87). As this short phase only consists of four weeks and often overlaps with the next phase, the development in all the areas are not as distinct as during the infancy phase. The physical development will be discussed more comprehensively than the cognitive and psychosocial development of the baby.

(i) Physical development

The neonate's nervous system is relatively immature, since most of the sensory systems still need to be formed, as described by Cook and Cook (2010:129). Their behaviour mostly displays various reflexes during this period. A reflex refers to the natural, automatic response to a particular stimulation. Some reflexes like the sucking reflex has survival value, whereas other reflexes such as the palmar grasp reflex assist with the interaction between parents and the baby. These reflexes are important, as some of them form the foundation for the development of complex motor skills at a later stage. The assessment of reflexes at birth can reveal certain aspects of the baby's nervous system, especially where birth trauma occurred. In addition, abnormal reflexes may indicate brain damage (Berk, 2013:130-131).

The neonate has the following perceptual abilities, as described by Louw and Louw (2014:92-93):

(i) **Vision:** Neonates have a complete and functional visual system. However, it is not yet fully developed. For example, newborns are able to follow a moving light or blink their eyes but are not able to distinguish well between colours since their cells for colour perception have not reached full maturity yet. The muscles controlling the eye lenses are still underdeveloped, thus the neonate's eyes are not able to focus on objects at differing distances and they view the world as a blur.

(ii) **Hearing:** The auditory canal is still filled with amniotic fluid during the first few days after birth with the result of sound being relatively soft. A major aural adjustment takes place after birth where sound is now steered through air and not through water as during the prenatal phase. Evidence shows that neonates can distinguish between various sounds within a few hours after birth and can recognise their mother's voice. During the first few days after birth, sound localisation is present and newborns can distinguish between different pitches.

(iii) **Smell:** Neonates are able to perceive smells and distinguish between them. For instance, a newborn can distinguish between their mother's breast and another women's breast.

(iv) **Taste:** A neonate's sense of taste is not very sensitive, but they are able to distinguish between various strong flavours. A neonate's sucking movements can be influenced by changes in the sweetness of food.

(v) **Pain:** It is generally acknowledged today that neonates can experience pain compared to the historical belief that neonates have insufficient neurological development to experience pain.

According to Louw and Louw (2014:89-91), the neonate must make a number of drastic adjustments regarding basic life processes in order to transition from the prenatal dependent existence to an independent individual. These adjustments include the following:

(i) **Blood circulation:** At the baby's birth, the change-over from fetal to prenatal blood circulation begins. Hence, the baby is now responsible for the purification of its own blood.

(ii) **Respiration:** Newborns must obtain oxygen for themselves. Breathing begins after birth as soon as the baby makes contact with air containing oxygen.

(iii) **Digestion:** After birth, when the umbilical cord is cut, the neonate has to take over the task of feeding and digestion themselves.

(iv) **Body temperature:** The baby's skin has to make major adjustments after birth to act as an insulator against external temperatures.

(v) **Nervous system:** The neonate's nervous system is similar to that of older children and adults, with some differences. These differences include such the weight of the brain that is approximately only 25% of an adult's brain, with the cerebral cortex not yet fully developed. Reflexes play an essential role in the functioning and survival of the neonate with an estimated 20 to 100 reflexes described in literature.

(vi) **Immunity:** After birth, the baby gradually loses the antibodies received from the mother's blood during the prenatal phase and must build up its own immune system, which may take several years. Therefore, an immunisation programme is necessary for babies and in South Africa. At birth, babies must be immunised against polio and TB.

During the neonatal phase, babies sleep between 17 and 20 hours during a 24-hour cycle. Research has found that neonates spend half their sleeping time in the Rapid Eye Movement (REM) phase, the phase associated with dreaming. The REM phase helps to mature the baby's central nervous system while preparing the neonate to cope with the outside world's stimulation (Louw & Louw, 2014:93-94). In addition, neonates spend a large proportion of their time when they are awake on feeding, with between eight and 14 feeding times per day.

(ii) Cognitive development

The child's intelligence is not fixed at birth as it is influenced by both inheritance and experience. The importance of early brain stimulation for cognitive development is emphasised by Papalia and Feldman (2012:142). The brain is already more than half the size of the adult brain at birth, but continues to develop and grow, gaining glial cells. Glial cells are specialised cells that provide structural support and hold the neurons together (Cook & Cook, 2010:121, 125). Babies have a 'built-in learning capacity' that allows them to immediately learn from experiences. Babies learn in two basic ways, namely (1) classical conditioning and (2) operant conditioning. Classical conditioning occurs where a specific stimulus activates a certain response. The various reflexes present in neonates enable classical conditioning after birth. In the beginning, the stimulus leads to a reflexive response. Later on, the baby's nervous system will enable it to make the connection between the two, thus producing behaviour by itself. Operant conditioning occurs where the baby's behaviour is followed by a stimulus from the environment, which increases the possibility of the baby repeating this specific behaviour. A stimulus that increases the chances of the reoccurrence of certain behaviours is called a reinforcer, while a punishment presents a stimulus that will decrease the occurrence of a specific behaviour. At birth, the neonate's brain is structured to be attracted by any new element in the environment to ensure that they build their knowledge base of information. Habituation takes place where the strength of the response gradually declines due to the stimulus being repeated. Once a loss of interest has occurred, a new stimulus and a change in the environment are needed to cause the habituated response to return, which is referred to as the concept of recovery. These two concepts ensure more efficient learning by focusing the baby's attention on new aspects in the environment (Berk, 2013:139-142).

(iii) Psychosocial development

Factors like bonding, responsiveness, sensitivity and temperament influence the neonate's emotional state. In addition, touch plays a vital role in emotional development as it connects the newborn with its parent(s) and shows responsiveness to the baby (Charlesworth, 2014:140,143-144). Newborn babies display signals like crying, smiling and laughing to indicate their emotions. Crying is the most powerful way in which newborn babies communicate their needs. The first spontaneous smile after birth is as a result of nervous system activity and could also appear during periods of REM sleep (Papalia & Feldman, 2012:177-178).

2.5.1.3 Infancy phase

The infancy phase lasts from the neonatal phase to the end of the baby's second year of life. This critical phase is characterised by rapid growth and development, and the establishment of the foundation for various behavioural patterns (Louw & Louw, 2014:97). As the infant grows and develops, certain patterns are followed and human development occurs, including physical, cognitive and psychosocial development (Zastrow & Kirst-Ashman 2013:67).

(i) Physical development

The physical development of children includes general physical development, motor development and perceptual development. Children's physical characteristics have implications for their development in other psychological domains. Growth data is therefore vital to provide normative guidelines for human development (Bornstein *et al.*, 2014:110-112). Bornstein and his co-authors identified four principles for physical growth:

- **Directionality:** This refers to development that appears to follow various directions. Firstly, cephalocaudal development takes place, from "head to tail", where the infant's visual system reaches anatomical maturity before the legs. This enables infants to have voluntary visual control before they begin to walk. Secondly, development proceeds from the centre of the body outward where infants gain control over their neck and torso before their fingers. Thirdly, the large muscle's groups develop before the fine muscle groups develop, enabling infants to first move their arms before they can flutter their fingers. Lastly, hierarchical integration development takes place where simple skills develop into more organised and complex skills.

- **Independence of systems:** The three major systems, namely the nervous system, body size and sexual characteristics, grow towards mature status at different growth rates.

- **Canalisation:** This implies that developmental outcomes endure despite non-optimal circumstances, allowing the infant to catch up in the domain of physical development, as well as in other domains of development.

- **Statistically normal:** This refers to the interplay between norms and individual differences. For example, the age at which infants start to walk or talk differs for each individual child.

Rapid skeletal and muscular growth, as well as growth pertaining to the nervous system, takes place. The fontanelle, referring to the soft tissue between the bones and skull, also closes during this period (Louw & Louw, 2014:99). The infant phase reflects remarkable development of the nervous system which involves central and peripheral components. The major central components include the brain and spinal cord, whereas the peripheral components include the nerve fibres connecting the receptors and effectors to the brain (Bornstein *et al.*, 2014:112-113). According to Louw and Louw (2014:99), the infant phase is characterised by rapid brain development and growth where the brain reaches two-thirds of its adult size by the end of two years of age.

The motor development of the infant includes gross-motor development, referring to control over larger actions like crawling and walking, and fine-motor development, referring to smaller movements like reaching and grasping. Various internal and external influences can affect motor development during the first two years of a child's life (Berk, 2013:147). Key motor development and the coordination of physical movement develop dramatically during the infant phase. Motor development and the sequence of coordination depend on physical maturation and experience. The neurological systems that direct motor activity comprises of two systems: the pyramidal system, which controls precise and skilled movements such as walking, and the extrapyramidal system, which controls posture and coordination. The infant is able to move objects as these systems begin to develop. Increasing control over the infant's hands and arms is necessary for them to plan their actions and use objects, for example to learn how to hold and use a spoon (Bornstein *et al.*, 2014:132-133).

Infants must continuously coordinate perceptual information with their motor activities, hence the importance of perceptual development during this phase (Berk, 2013:152). According to Louw and Louw (2014:102), research over the past few decades has revealed that infants' perceptual development and abilities are far more advanced and complex than originally thought. Bornstein *et al*. (2014:144-155) and Louw and Louw (2014:102-104) identified the following abilities relating to perceptual development:

- **Depth perception:** The well-known visual cliff experiment carried out by Gibson and Walk in 1960 showed that most babies between six and 14 months can perceive depth.

- **Visual acuity:** Infants' ability to see fine detail increases rapidly during the infancy phase. By eleven months, this ability is virtually as good as that of adults.

- **Colour perception:** Infants are able to distinguish between most colours at four months. By six months, their colour perception is similar to that of adults.

- **Focusing ability:** Three-month-old infants' focusing ability is nearly as good as the focusing ability of adults.

- **Viewpoint invariance:** This refers to the ability to realise that an object viewed from different angles is still the same object. Infants can see 3D shapes and view the same object at different distances.

- **Auditory perception**: Infants' hearing develops rapidly, and by six months they have auditory perception that is relatively well-developed. By eight months they are able to hear much softer sounds of 34 decibels compared to their ability to only hear louder sounds of 60 decibels during the neonatal phase.

- **Intermodal perception**: This process of integrating perceptual information such as sound, sight, touch and smell is present in the neonatal phase, but only develops significantly by around five to six months.

(ii) Cognitive development

Life is one huge learning experience for the infant during this phase. According to information-processing theorists, the memory system involves the following three multiple components: (1) the sensory memory, (2) short-term memory, and (3) long-term memory. The sensory memory is the component that recognises the information while the short-term memory processes the information and the long-term memory stores the information. The amount of information that an infant can remember increases during the first year after birth. Memory also enhances the learning of words and words in turn promote the encoding of later memories (Louw & Louw, 2014:127-128, 108,110). Children's cognitive development during this phase, according to Piaget's theory on cognitive development, will be discussed in more detail in section 2.5.2.3. Piaget's theory describes the various sub-stages of the sensorimotor stage of children from birth to two years.

According to Louw and Louw (2014:112), the development of language is one of the most significant tasks that a child masters during the infancy phase. They explained that babies understand language before they can speak, since their brains start to process specific aspects of language much earlier. Papalia and Feldman (2012:161) defined language as a communication system established by words and grammar, which is used to represent actions or objects. They also explained how children are able to communicate their needs, feelings and ideas once they know the words, which allows them to have more power over their own lives. Language development includes various phases of vocalisation which occurs during infancy, as described by Louw and Louw (2014:112-113). The phases of vocalisation as discussed are summarised in Table 2.2 below.

Table 2-2: Phases of vocalisation

Phase	***Developmental phase***	***Description of crisis***
Undifferentiated crying	Birth to 1 month	• Babies use crying to signal their needs. Their crying is often undifferentiated during this phase, since it is difficult to distinguish between the various kinds of crying.
Differentiated crying	From about 2 months	• Babies start to use a variety of sound patterns and pitches to form different kinds of crying.
Cooing and babbling	From about 2 to 5 months	• Cooing includes the squealing sound babies make when they feel happy, satisfied and excited. • Babbling refers to the repetition of a consonant or vowel sound.
Lallation	From about 7 to 8 months	• Babies begin to repeat the sounds and words they have heard. • Although it is often incorrect or by accident, this phase is important for communication.
Echolalia	From about 9 to 10 months	• This is the more correct and deliberate repetition of sounds and words.
Single-word sentences	From about 12 months	• They use a single word to communicate a specific idea to other people.
Full sentences	From about 21 months	• This phase includes the use of full sentences and progresses from two-word sentences to more sophisticated structured sentences.

During the first six months, the learning of new words is fairly slow as the baby learns to connect different words with a specific meaning. The learning of new words increases quickly between 16 and 24 months. Although these phases are linked to certain ages, these are only guidelines. Hence, children's individual development must be considered (Louw & Louw, 2014:113).

(iii) Psychosocial development

Louw and Louw (2014:119) explained that personality refers to a person's unique feelings, thoughts and behaviour which occur in a consistent way. Although personality develops throughout a person's life, the infancy phase is important for the development of the child's personality. The basic components of a person's personality are formed by emotions, and are caused by certain situations that are associated with physiological and behavioural reactions. For example, fear is accompanied by an increased heartbeat. Soon after birth, emotions such as contentment and distress appear, mostly due to physiological responses to sensory stimulation. At six months, true emotions that have meaning to the infant appear, such as joy, surprise, sadness, anger and fear. Self-conscious emotions such as embarrassment and jealousy emerge between 15 and 24 months when the child has developed self-awareness. Around two months, the infant's crying is a more deliberate response to certain situations and a vital form of communication of specific emotions. Babies whose mothers reacted quickly and lovingly to their crying will cry less at the end of their first year while mothers who ignored, hit or scolded their babies for crying will have more aggressive or upset babies.

Children's emotional reactions develop during infancy and form the basis of their personality. The child's psychosocial development from birth to 36 months, as explained by Papalia and Feldman (2012:177), involves the following according to these age indicators:

- **Zero to three months:** Infants start to show interest and smile regularly at people.
- **Three to six months:** Babies can anticipate what is going to happen and they experience disappointment or anger when it does not happen as they expected. There is a social awakening, and they smile and laugh often.
- **Six to nine months:** Children show more differentiated emotions such as joy, fear, anger and surprise. They will attempt to get responses from other people and, for example, touch other babies to get a response.
- **Nine to 12 months:** During this time, children are preoccupied with their primary caregiver and may experience fear of strangers. They begin to show clear emotions, moods and ambivalence.
- **12 to 18 months:** If children master their environment during this stage, they become more eager and confident to assert themselves.

- **18 to 36 months:** Children may become more anxious as they realise that they are separating from their caregivers.

Socialisation is defined by Louw and Louw (2014:143) as, "… *the process by which the child learns to conform to the moral standards, role expectations and requirements for acceptable behaviour of his or her particular community and culture*". The primary aim of socialisation during infancy is the learning of desirable behaviour, as well as the elimination of undesirable behaviour. The most important socialisation agents during infancy are the parents or primary caregivers. Another important milestone during the socialisation process is the acquiring of toilet skills. Peer interaction, referring to companions who are approximately the same age, is another vital aspect of socialisation in order to provide the child with feedback regarding academic, social and emotional capabilities. Peer interaction changes significantly, from simple peer interest to peers playing a more crucial part in the child's emotional and social life (Louw & Louw, 2014:143-147). According to Zastrow and Kirst-Ashman (2013:160), the child's family fulfil the role of primary socialisation agents during the child's early years. They explained that the family environment includes the circumstances and social climate for social development, and acknowledged that each family has its own unique structure. In addition, children often learn undesirable behaviour during socialisation with others, hence the importance of behaviour management (Zastrow & Kirst-Ashman, 2013:180).

2.5.2 Theories relating to child development

Various theories and paradigms are used in social work, especially those relating to child development. According to Charlesworth (2014:9), theorists and researchers develop ideas to explain the development of children, which are referred to as theories. He defined a theory in this context as a set of rules or plan to describe or predict the manner in which children develop, grow and learn. Due to the multitude of theories, the researcher will only discuss some of the theories in detail.

2.5.2.1 Overview of various theories

Important child development theories by key scholars and theorists, as described by Beckley (2013:9-15) and Charlesworth (2014:10-14), include the following:

(i) **Locke (1632-1704):** He believed that all children are born with a 'blank slate' and that their interaction with people and the environment affect their development the most, rather than their natural skills and knowledge. He highlighted the importance of early experiences from birth onwards, and believed that negative experiences during the infancy years could have

long-term negative consequences for the child. Positive associations from birth are therefore necessary for the child's successful development. Also, early life experiences are more important than experiences later in life. Locke emphasised three methods to educate children effectively: (1) develop a healthy body by maintaining a healthy diet and sleep patterns, (2) form a virtuous character where children can think rationally, and (3) provide an appropriate educational curriculum that promotes critical thinking and interest in learning. In this way, Locke's beliefs correlate with the first thousand days of life being a critical window of opportunity to lay the foundation for the child's future development (UNICEF, 2017).

(ii) **Rousseau (1712-1778):** His theory suggested the development of a child's character and moral sense as crucial for children to make their own judgement about what is right or wrong. According to him, child development occurs in three stages: (1) infancy to 12 years, during which children are governed by their emotions and impulses, (2) from 12 to 16 years, during which reason develops, and (3) from 16 years onwards, during which children develop into adults. He believed that, during their early stages of development, children learn through their senses and interaction with the environment, thus emphasising the importance of an environment that enables children to explore their world.

(iii) **Freud (1856-1939):** This theory is based on Freud's beliefs that children are both unconsciously and consciously influenced by concepts called the 'id', 'ego' and 'super-ego' which play a role in the development of self-regulation and moral decision making. He proposed that children develop through a series of 'psychosexual stages' and stated that infants are governed by the unconscious 'id' to seek immediate gratification. In addition, Freud indicated that children could become fixated on one of the stages, thus motivating caregivers to meet children's age-appropriate needs in order for children to move through all the stages successfully.

(iv) **Dewey (1859-1952):** According to Dewey, children need social interaction to learn and thrive in an environment where they can interact with their surroundings. He believed that children related new information to past experiences to enhance meaning. Thus, he highlighted the importance of experiential, hands-on learning.

(v) **Skinner (1904-1990):** This theory focused on the role of 'conditioning' in childhood learning, believing that children learn though rewarding or punishing specific behaviours. He suggested that positive reinforcements like providing food, compliments or a smile will strengthen the chance for a behaviour to be repeated, compared to behaviour that will

decrease due to punishment or withdrawal. Thus, children learn how to behave in a certain way based on the consequences of their behaviour.

(vi) **Kohlberg (1927-1987):** He expanded on Piaget's work and focused his theory on the moral development of children. He believed that children must progress through the six stages towards higher reasoning in order to deal with moral dilemmas more effectively. The stages comprise of the following: Stage 1 (pre-conventional stage) suggests that children are driven by the avoidance of punishment; Stage 2 (pre-conventional stage) includes self-interest where children consider what is right in terms of their own best interest; Stages 3 and 4 (conventional stage) refer to adherence to certain social norms and rules; while Stages 5 and 6 (post-conventional stage) are characterised by the development of the individual's moral reasoning and a moral code outside social norms and rules.

(vii) **Vygotsky (1896-1939):** His theory suggested that children learn mainly through their social interaction with others in a variety of contexts. Thus, he emphasised the importance of social interaction to promote a child's development. He believed that there is a difference between children's actual development and potential development. He recommended that children learn the best where they are presented with new information just above their current understanding. Information should therefore not be too advanced, as children will struggle to integrate it with previous information. Neither should new information fall below the level of the child's understanding as this will hinder the development of further knowledge.

(viii) **Brunner (1915):** He proposed that children learn new information and skills through a process called 'scaffolding' and believed that any person is able to learn a new skill, as long as it is structured appropriately. Scaffolding refers to the temporary support provided by parents or others to a child doing a task, until the child is able to accomplish the task alone (Papalia & Feldman, 2012:34). Brunner believed that social interaction plays a key role in language acquisition, especially through parent-child interaction.

Erikson's psychosocial theory, Piaget's theory of cognitive development, attachment theory and Bronfenbrenner's bioecological theory will be discussed in more detail to provide an overview of important aspects pertaining to the child's development during the first thousand days. Although Maslow's hierarchy of needs is not a theory of child development, it was selected to provide valuable information regarding the needs of humans, including the needs of the mothers and children in this study.

2.5.2.2 Erickson psychosocial theory

Erik Erickson, a student of Freud, built on Freud's idea of unconscious conflict, but highlighted the psychosocial and social aspects rather than the biological and sexual aspects of Freud's theory (Louw & Louw, 2014:22). Erickson's psychosocial theory presents human development in a sequence of eight stages, each defined by a unique crisis. He argued that the degree to which humans resolved a crisis in one stage will affect their ability to overcome crises in the later stages (Zastrow & Kirst-Ashman, 2013:303). Thus, Erickson believed that the earlier stages of psychosocial development form the foundation for the later stages, and that the outcomes of a child's development are reflected by the manner which they overcame early obstacles (Louw & Louw, 2014:23). Table 2.3 below provides a summary of Erickson's stages of human development.

Table 2-3: Erickson's stages of development

Stage and developmental/ psychosocial crisis	***Developmental phase***	***Description of crisis***
Stage 1: Basic trust vs. mistrust	Infancy (birth to 1 year)	• To develop trust and a sense that the world is a safe place
Stage 2: Autonomy vs. shame and doubt	Early childhood (1-3 years)	• To accomplish things independently and to learn that they can make their own decisions
Stage 3: Initiative vs. guilt	Pre-school stage (3-6 years)	• To explore and experience the environment and learn to take initiative
Stage 4: Industry vs. inferiority	School age (6-12 years)	• To learn how to be productive and succeed in their activities • This includes the mastering of academic skills in school.
Stage 5: Identity vs. role confusion	Adolescence	• To explore who they are and to develop their own identity
Stage 6: Intimacy vs. isolation	Young adulthood	• To experience intimate relationships with others, which include more than sexual relationships in that it includes sharing and giving of oneself to another person.
Stage 7: Generativity vs. stagnation	Mature adulthood	• To assist, produce and guide the next generation
Stage 8: Ego integrity vs. despair	Old age	• To reflect on their own life and feel content with their accomplishments

Source: Adapted from Louw and Louw (2014:22) and Zastrow & Kirst-Ashman (2013:303-304).

Stage 1 and Stage 2, as described above, play an important role during the child's first thousand days and relate to the period from birth to two years. Parents play an important role during the first year, where children learn to trust if they consistently receive nurturing care. The child will apply this trust to other relationships later in life. During Stage 2, children who accomplish tasks

themselves will experience feelings of self-worth and self-confidence. However, if they are restricted and punished while learning tasks, self-doubt will develop. Stage 4 plays an important role, especially for learners during the Foundation Phase. If children experience failure in school, a sense of inferiority develops. During this stage, comparison with peers becomes extremely important, and can lead to a sense of inferiority if they do not master skills compared to their peers (Zastrow & Kirst-Ashman, 2013:303).

2.5.2.3 Piaget's theory of cognitive development

Piaget, according to Bornstein *et al.* (2014:168), believed that knowledge is acquired by doing rather than passively observing. He therefore believed that individuals can actively build their own development. Piaget emphasised the progression of the infant away from egocentrism, which referred to infants' understanding of their world in terms of their own motor activity (Bornstein *et al.*, 2014:168). Piaget's theory interprets language development as an ability that depends on overall cognitive maturation (Cook & Cook, 2010:269). This theory of cognitive development suggests that children progress through four stages of cognitive development, as described by Louw and Louw (2014:26):

- **Stage 1 – sensorimotor stage:** This occurs from birth to two years, where infants' understanding of their world is developed through their senses.
- **Stage 2 – preoperational stage:** From two to six years, children begin to use language and symbols to represent ideas.
- **Stage 3 – concrete operational stage:** This stage runs from seven to eleven years, and includes the development of logical thinking although it only applies to concrete objects.
- **Stage 4 – formal operational stage:** Children twelve years and older learn to think abstractly and to reason deductively.

The first thousand days of life refer to the first stage of cognitive development. The sensorimotor stage describes how infants gain knowledge and information through sensory input and motor activities. This gradual development of how to coordinate information occurs across six substages, as explained by Louw and Louw (2014:105-106) and summarised in Table 2.4.

Table 2-4: Substages of the sensorimotor stage

Substage	***Age***	***Description***
Substage 1: Reflexes	Birth to 1 month	• Responding to available stimuli and their actions are mostly reflective. It does not seem that they remember events or things or plan.
Substage 2: Primary circular reactions	1-4 months	• This substage indicates the beginning of the coordination of certain activities that infants use to explore their world.
Substage 3: Secondary circular reactions	4-8 months	• Infants begin to repeat actions intentionally to trigger a response from people or their environment.
Substage 4: Coordination of secondary reactions	8-12 months	• This substage includes the beginning of an understanding of cause and effect, and involves purposeful behaviour to modify and coordinate actions.
Substage 5: Tertiary circular reactions	12-18 months	• Infants vary their actions and discover new ways to meet a challenge. • They use trial and error to find the best solution to reach their goal.
Substage 6: Mental representation	18-24 months	• This substage is marked as the beginning of insight and creativity. • They start to use mental planning instead of a trial and error approach. • The infant begins to use symbols such as words, numbers and images to represent objects and actions.

Various cognitive skills across these six substages are developed during the sensorimotor stage. One of the most important aspects that develops is called object permanence where infants develop the understanding that an object continues to exist even when they cannot see it. According to Piaget, object permanence is only fully mastered between 18 and 24 months. Another skill, termed 'imitation', refers to the child's ability to imitate the behaviour of someone else.

As described above, the child develops very specific skills and abilities during this period from birth to two years. An environment that promotes and strengthens these skills during the first thousand days is therefore crucial for the child's optimal cognitive development. Stage 3, the concrete operational stage, relates to children in the Foundation Phase where logical thinking is developed.

2.5.2.4 Attachment theory

Berk (2013:428) defined attachment as a strong tie or bond between one person and other significant people where the person experiences joy as a result of interaction with these significant

people and is comforted by their closeness during times of stress. By six months babies will form attachments with familiar people who respond to their needs. Zastrow and Kirst-Ashman (2013:131) emphasised the significance of the interaction between the parent or primary caregiver and child to form emotional bonding. The basic principles of the attachment theory, as described by Bretherton (1992:759), were originally formulated by John Bowlby and developed by Mary Ainsworth. Bowlby's views on a child's connection with its mother and the disturbance caused by separation and deprivation formed the basis of the attachment theory. Ainsworth tested some of Bowlby's ideas and expanded the theory with the concept that the attachment figure serves as a secure base from which the infant explores their environment. She additionally formulated the development of infant-mother attachment patterns based on the maternal sensitivity to the infant's signals. Louw and Louw (2014:120,132), agreeing with Bowlby and Ainsworth, regarded the child's close relationship with at least one responsive adult as crucial for healthy development. Hence, there was agreement that a child's relationship with an attuned attachment figure is vital for their mental and development progress.

Berk (2013:429) and Louw and Louw (2014:133-134) explained how attachment develops in four phases (Bowlby, 1958, 1973):

(i) **Pre-attachment phase (indiscriminate responsiveness to humans):** From birth to six weeks, babies' responses are determined by reflexes and their reactions towards strangers and familiar persons seem to be similar. Although babies can recognise the mother's smell, voice and face, they are not yet attached to her as they can be left with an unfamiliar person.

(ii) **Attachment-in-the-making phase (focusing on familiar people):** This phase lasts from six weeks to approximately six to eight months and is marked by the infant's different reactions towards familiar and unfamiliar people. During this phase, babies develop a greater degree of attachment to their primary caregiver and a sense of trust if their needs are fulfilled.

(iii) **Clear-cut attachment (active proximity seeking):** This phase lasts from about six to eight months to 18 months or two years. During this phase, attachment with the primary caregiver is evident. The infant uses the primary caregiver as a secure base from where to explore and can display separation anxiety when their trusted primary caregiver leaves.

(iv) **Formation of a reciprocal relationship (partnership behaviour):** This phase lasts from 18 months to two years and beyond. During this phase, attachment becomes more complex as a result of the child's cognitive, social and emotional development. Babies will attempt

to influence their primary caregiver's behaviour by using negotiation and requests to reach their goals.

According to Counselling Buckinghamshire (2019) and Louw and Louw (2014:266), Bowlby (1980) described the forming of children's 'internal working model' during these four phases, which represents a cognitive understanding of the world, themselves and others, and which becomes a vital part of their personality, guiding all future close relationships. Bowlby's internal working model has three main qualities: (1) a model of the other that can be trusted, (2) a model of the person who is valuable, and (3) a model of the self when interacting with others. The primary caregiver, who serves as the attachment figure, is thus key to develop the child's sense of being securely attached.

Ainsworth, Blehar, Waters and Wall, as indicated by Berk (2013:430-431) and Louw and Louw (2014:134), identified three types of attachments, namely secure, avoidant and ambivalent/resistant attachment. Then Main and Solomon (1986) identified disorganised attachment as a fourth attachment type. These four attachment types, as described by Berk (2013:430-431) and Louw and Louw (2014:134-135), are summarised in Table 2.5.

Table 2-5: Categories or types of attachment

Type	***Description***
Secure attachment	• The mother is used as a secure base from where the child explores its environment. • Babies are visibly distressed when they are separated from their mothers. However, when the mother returns, the baby actively seeks contact and is happy.
Avoidant attachment	• The baby does not explore its environment when it is with its mother. • The infant is not upset when the mother leaves and usually avoids the mother when she returns. • The baby will react to strangers in the same way it reacts to the mother.
Ambivalent or resistant attachment	• It is unlikely that these infants will explore their environment. • They become very anxious before the mother leaves. When the mother returns, the baby behaves ambivalently and cannot be comforted easily.
Disorganised attachment	• The infant is very insecurity because the mother is insensitive, intrusive or abusive. • When the mother returns, the child shows confused, contradictory behaviours by, for example, looking away or displaying odd, frozen postures.

The following four factors, according to Berk (2013:433), influence secure attachment: (1) the early availability of a consistent caregiver, (2) the quality of caregiving, (3) the characteristics of the baby, and (4) the parent's own internal working model and attachment experiences. Cook and Cook (2010:313) emphasised the importance of the quality of care that the infant receives, especially during the first year after birth, as this affects the quality of the attachments they form. Newman *et al.* (2015:1) highlighted the crucial developmental period during infancy and the significance of early relationships for the child's psychological and relational functioning. They explained how the structural and functional networks of the infant's brain are shaped by the nature and quality of the interactions between the primary caregiver and child during this time period. Thus, the importance of the development of secure attachment during infancy is critical.

2.5.2.5 Bronfenbrenner's bioecological theory

According to Rosa and Tudge (2013:244), Bronfenbrenner's bioecological theory refers to the interaction between different systems, and views human development as evolving from the interaction between the individual and the context. Tudge *et al.* (2016:428) explained that Bronfenbrenner's bioecological theory incorporates the Process-Person-Context-Time model (PPCT model), involving the synergistic interconnection of four elements: proximal processes, person characteristics, context and time. Ettekal and Mahoney (2017:2, 5, 6) expanded on the terms proximal processes, person characteristics, context and time. The four elements therefore are:

- **Proximal processes:** These are the complex reciprocal exchanges between a person and its immediate external environment.
- **Personal characteristics:** This refers to individual characteristics that interact with the setting to influence development.
- **Context:** This includes the four interrelated systems of Bronfenbrenner's original ecological system – namely the (1) microsystem, (2) mesosystem, (3) exosystem and (4) macrosystem – which interact with the individual and influence development.
- **Time:** This is interpreted at the various levels of the ecological system and includes micro-time (e.g. minute-by-minute exposure), meso-time (over longer intervals like days or weeks) and macro-time (historic changes in society across generations).

Bronfenbrenner (1979, 1986, 1994) and Bronfenbrenner and Moris (1998), as described by Papalia and Feldman (2012:35), identified five levels of environmental influences, fluctuating from

very intimate to vastly broad. According to Louw and Louw (2014:30), the fifth level, the chronosystem, was added by Bronfenbrenner (2005) at the end of his life, thus not receiving as much attention as his previous four-level system. The influences of these five levels provide an understanding of the complexity of human development, as described by Louw and Louw (2014:29-30) and Papalia and Feldman (2012:35-36). These five levels consist of the (1) microsystem, (2) mesosystem, (3) exosystem, (4) macrosystem and (5) chronosystem. The microsystem includes the immediate environment such as the home, family members and school. The mesosystem refers to the interlocking of the various microsystems, for example where children's support from their parent(s) influences their progress at school. Exosystems represent social settings outside the person's immediate environment that influence them indirectly, like the media, health care and social welfare institutions. The macrosystem includes the broadest environmental context, for example the culture, economic system and political system in which the microsystem, mesosystem and exosystem are embedded. Finally, the chronosystem adds to the dimension of time and changes consistency in the person and their environment, for example changes in the family structure or place of residency. Figure 2.4 below offers a diagrammatic representation of the various systems of Bronfenbrenner's bioecological theory.

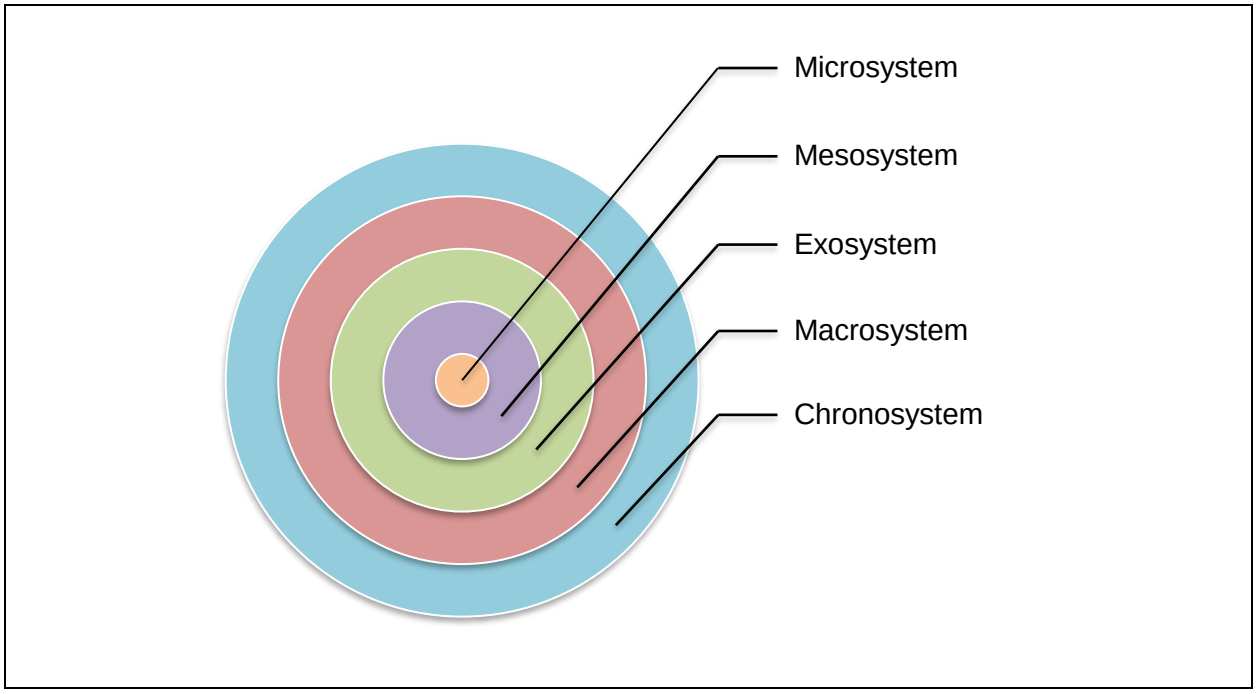

Figure 2-4: Bronfenbrenner's bioecological theory

Source: Adapted from Papalia & Feldman (2012:36).

Bronfenbrenner's ecological theory provides an understanding of the various systems that can influence a child during the first thousand days of life. This theory can provide insight into the various systems that play a role in the mothers' lives during this time period.

2.5.2.6 Maslow's hierarchy of needs

Abraham Maslow (1954, 1968, 1971), as explained by Zastrow and Kirst-Ashman (2013:456), believed that humans have enormous potential for personal development and that it is part of their nature to strive to develop themselves to their full capacity. Although he proposed that human nature includes striving for self-actualisation, he believed that only a few people actually reached a complete state of self-actualisation. He observed how most people are constantly striving to meet their own needs, which led him to identify a hierarchy of needs that motivates human behaviour. Maslow proposed that each stage of the hierarchy of needs must be achieved before an individual can progress to the next level.

Beckley (2013:15) and Zastrow and Kirst-Ashman (2013:456) described the five needs of Maslow's hierarchy as (1) physiological needs, (2) the need for safety, (3) the need for love and belonging, (4) the need for self-esteem, and (5) the need for self-actualisation, thus striving to realise their full potential. Physiological needs include the most basic needs such as food, water, oxygen and rest. Safety needs refer to security, stability, as well as freedom from fear, anxiety, threats and chaos. The need for love and belonging involves intimacy and affection provided by people like family and friends. Self-esteem needs consist of self-respect, respect of others, achievement, attention and the need for appreciation. Lastly, the highest need, namely self-actualisation, relates to people's sense of fulfilling their own potential and results in the need to create and learn. People who have reached self-actualisation portray characteristics such as respect for themselves, others and nature, the ability to seek justice and truth, problem-solving skills, rich emotional responses, satisfying relationships with others, and high moral standards. According to Maslow, individuals experience anxiety and tension when the first four needs (i.e. physiological, safety, love/belonging and self-esteem needs) have not been met (Beckley, 2013:15). Maslow's hierarchy of needs is illustrated in Figure 2.5 below.

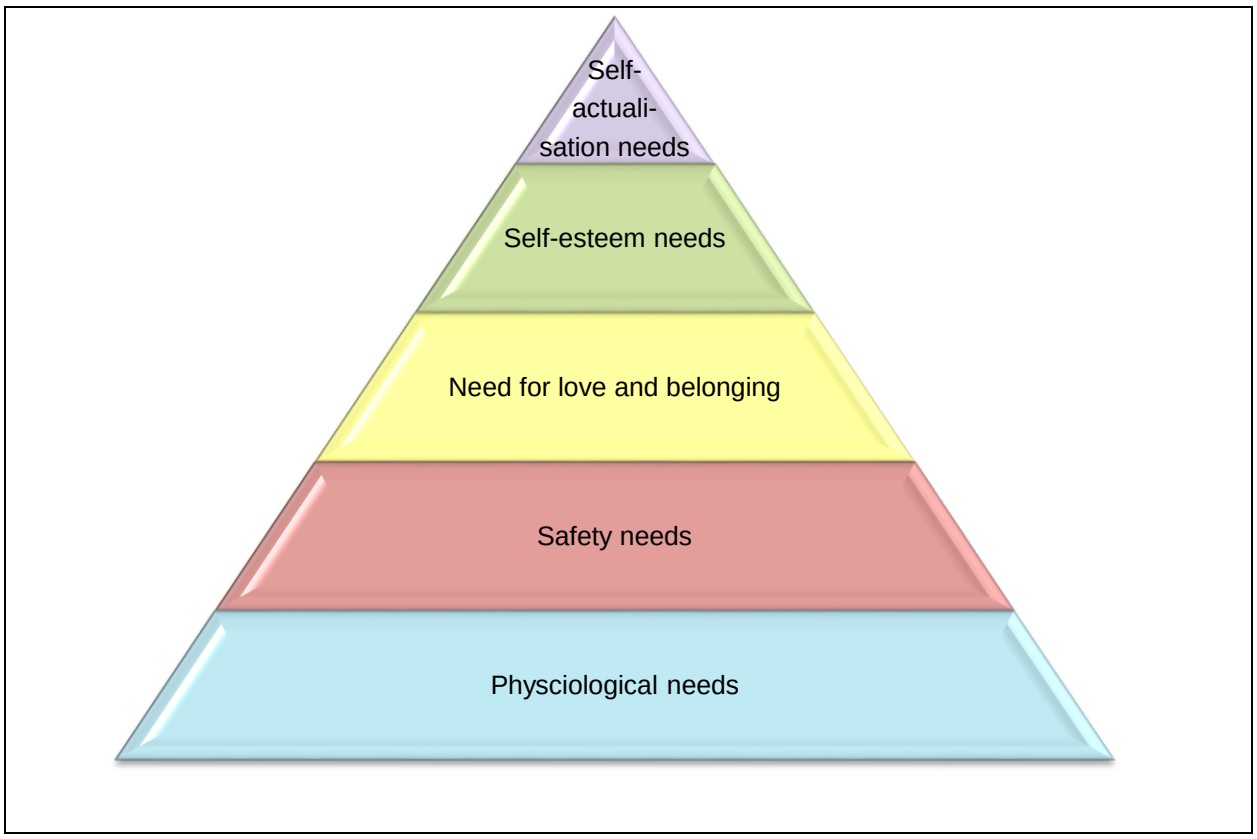

Figure 2-5: Maslow's hierarchy of needs

Source: Adapted from Zastrow & Kirst-Ashman (2013:458).

According to Charlesworth (2014:376), children's physiological and safety needs, which are basic needs for survival, must be met before they will be motivated to learn and seek knowledge. This means that children entering formal schooling will only be motivated to learn once their physiological and safety needs have been met. This has implications for the children in this study.

A study conducted by Noltemeyer *et al.* (2012:1862, 1866) explored the relationship between children's deficiency needs and growth needs according to Maslow's influential theory. Their empirical investigation provided some support for Maslow's claim that improvements in a child's deficiency needs, such as safety and love and belonging, can positively promote the child's growth needs, such as academic progress in school. They also found that access to health care and dental care increased the child's academic and cognitive performance.

In the light of this, Maslow's hierarchy of needs appears to play a vital role during children's first thousand days, as well as in their schooling in the Foundation Phase. These five needs also relate to the three key areas (health and nutrition, love and attention, and play and stimulation) identified in the Western Cape Government's First 1000 Days initiative (discussed in Section 2.2.2.2).

2.6 CONCLUSION

This chapter provided insight into the importance of the first thousand days of a child's life, the value of the Foundation Phase, school absenteeism and, more specifically, the reasons for and consequences of absenteeism in South Africa. This literature study further provided an in-depth understanding of the relevant childhood development phases during the first thousand days, as well as theories on child development. The following chapter will provide an overview of the research process and the mothers who participated, as well as a detailed discussion of the findings of this study.

CHAPTER 3: RESEARCH FINDINGS

3.1 INTRODUCTION

Chapter 2 served as a conceptual framework for this study. This succeeding chapter will focus on the findings of this study. The purpose of this chapter is to provide a detailed discussion of the factors that could potentially have affected the first thousand days of absent learners in the Foundation Phase. This chapter incorporates an overview of the research process, the biographic information of the participants, a comprehensive discussion of the findings that emerged from the data analysis, as well as a summary of the findings.

3.2 OVERVIEW OF THE RESEARCH PROCESS

The research process was comprehensively discussed in Chapter 1. This section will therefore only present an overview of the process.

3.2.1 Research approach and design

The researcher aimed to gain a comprehensive understanding of the factors that could potentially have affected the first thousand days of absent learners in the Foundation Phase. A qualitive approach was utilised to provide the researcher with insight into the social world of the participants in order to acquire an understanding of this phenomenon (Hesse-Biber, 2017:4). This approach enabled the researcher to use individual interviews to collect data (Ivankova *et al.*, 2016:309; Marshall & Rossman, 2016:147; Patton, 2015:14). Furthermore, the qualitative approach allowed the biological mothers the opportunity to share rich information in their own words on the first thousand days of their children's lives (Brynard *et al.*, 2014:39).

A qualitative descriptive design was used to provide factual responses (Colorafi & Evans, 2016:17) regarding the factors that could potentially have affected the first thousand days of absent learners in the Foundation Phase. Importantly, this specific design allowed the researcher to stay close to the data (Lambert & Lambert, 2012:255; Sandelowski, 2000:334).

3.2.2 Population and sampling

The population consisted of all the biological mothers of absent learners from Grade R to 3 recorded as active cases on the Khula Development Group's database. A random purposive sampling method was utilised to randomly select participants with a specific purpose in mind (Maree & Pietersen, 2016:1; Neuman, 2014:255). The mediator selected participants randomly by following a specific process as indicated in Section 1.6.4.1. A sample size of 18 biological

mothers were selected. Each mother had to adhere to the following inclusion criteria: (1) be a biological mother of an absent learner in the Foundation Phase recorded on Khula Development Group's database, (2) reside in Paarl East, (3) must have lived with her child from pregnancy to two years, (4) currently lives with her child, and (5) is capable of giving consent and can participate in the study. Biological mothers of Grade R to 3 learners who were referred to Khula Development Group for another reason besides absenteeism were excluded. Data saturation, as described by Marshall and Rossman (2016:229), occurred after collecting data from 18 mothers. Hence, more participants were not included in this study.

3.2.3 Data collection

The recruitment procedure, as outlined in Section 1.6.5, is summarised below:

- Once ethical clearance had been granted by HREC at North-West University, the researcher obtained written permission from the Chief Operational Officer at Khula Development Group to conduct the study within the organisation.
- A mediator and two independent persons were involved in recruiting 18 mothers for this study.
- After receiving the list of contact details and signed forms (informed consent forms and transport indemnity forms) from the independent persons, the researcher contacted the participants to schedule a suitable date and time for the individual interviews.

The researcher conducted semi-structured interviews with all the mothers to collect the data. An interview schedule with 12 questions, as well as a timeline tool were utilised during the interviews. All the interviews were audio-recorded and transcribed intelligent verbatim to prepare the data for analysis.

3.2.4 Data analysis

Thematic analysis was used to extract themes from the data, as explained by Wagner *et al.* (2012:231). This involved the six phases of thematic analysis, as suggested by Braun and Clarke (2006:87-93; 2013): (1) becoming familiar with the data, (2) generating initial codes, (3) searching for themes, (4) reviewing the themes, (5) defining and naming the themes, and (6) producing the report.

3.3 BIOGRAPHIC INFORMATION OF THE PARTICIPANTS

The participants in this study were all females since they were the biological mothers of the absent learners. All the participants were Afrikaans speaking and resided in the Paarl East community, Western Cape. Each mother's current age, relational status and total number of children, as well as the position of the relevant child in terms of his/her siblings have been captured in Table 3.1.

Table 3-1: Overview of participants in this study

Participant	***Current age during the study***	***Current relational status during the study***	***Total number of children***	***Position of absent learner in relation to other siblings***
Participant 1	31 years	Single	3	Eldest
Participant 2	28 years	Married	3	Eldest
Participant 3	40 years	Married	6	Fourth child
Participant 4	31 years	Single	2	Youngest
Participant 5	26 years	Single	3	Eldest
Participant 6	37 years	Long-term relationship	7	Fifth child
Participant 7	42 years	Married	5	Youngest
Participant 8	39 years	Married	7	Fourth child
Participant 9	31 years	Married	3	Eldest
Participant 10	44 years	Long-term relationship	5	Youngest
Participant 11	37 years	Divorced	4	Third child
Participant 12	29 years	Single	2	Youngest
Participant 13	48 years	Single	4	Youngest
Participant 14	33 years	Married	2	Youngest
Participant 15	28 years	Long-term relationship	2	Eldest
Participant 16	29 years	Long-term relationship	2	Eldest
Participant 17	32 years	Long-term relationship	2	Youngest
Participant 18	34 years	Long-term relationship	3	Middle child

3.4 DISCUSSION OF FINDINGS

The findings of this qualitative study are presented as six themes: (1) the health of the mother during the first thousand days of the child's life, (2) the health of the child during the first thousand days of life, (3) the availability of support to the mother and child during the first thousand days of the child's life, (4) the circumstances of the mother and child during the first thousand days of the child's life, (5) the attachment and relationship between the mother and the child during the first thousand days of the child's life, and (6) the development and care of the child during the first thousand days of life. The researcher will discuss relevant literature in line with the research findings. Figure 3.1 below gives a visual overview of the themes.

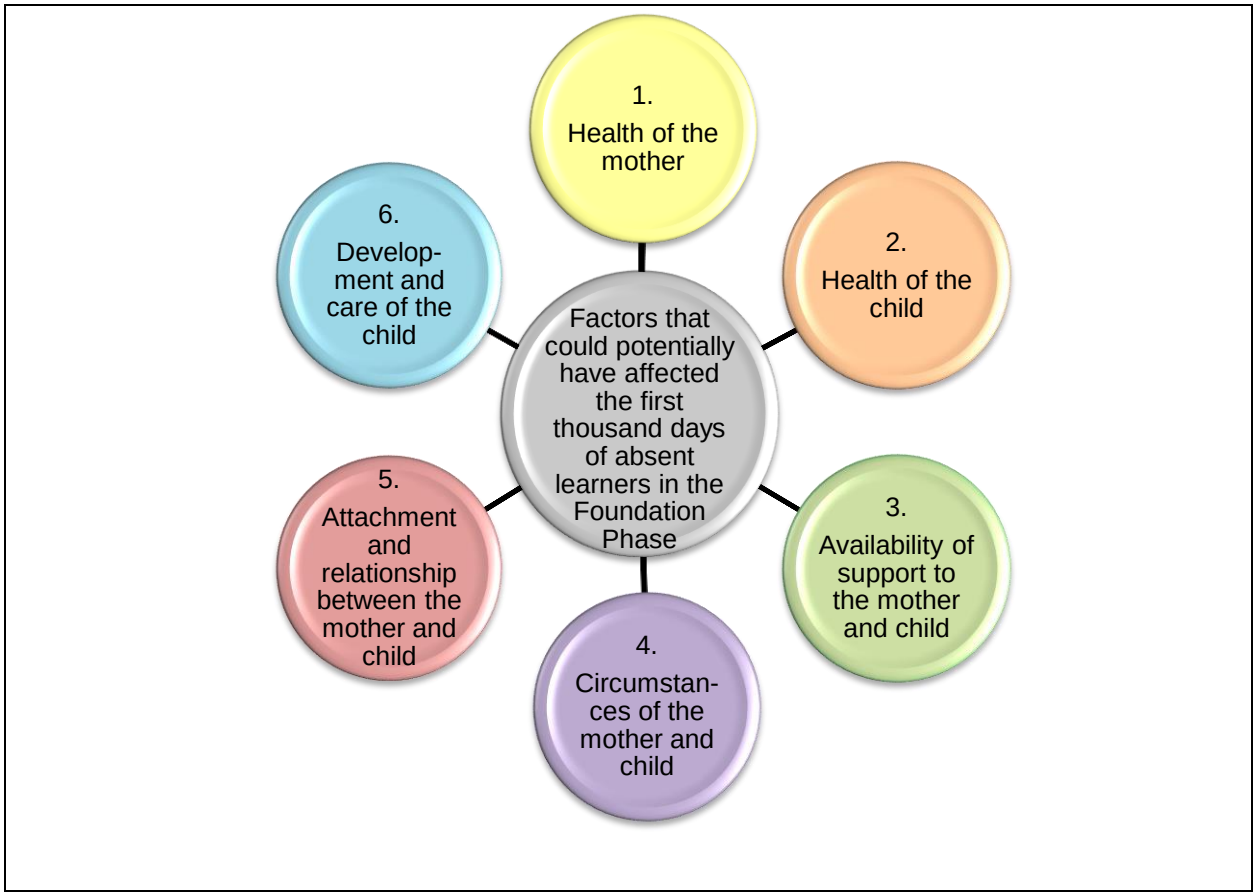

Figure 3-1: A graphical representation of the six main themes (condensed version) that could potentially have affected the first thousand days of absent learners in the Foundation Phase

The six themes above were divided into sub-themes and categories, which are indicated in table format at the beginning of each theme. An overview of the six themes with their sub-themes and categories can be found in Annexure G. These themes, with their sub-themes and categories, will be illustrated with quotations from the interviews. Since all the participants were Afrikaans speaking, the researcher freely translated the quotations into English. The original Afrikaans quotes for theme 1 can be found in Annexure H as an example.

In this study, the sub-themes and categories referred to the main two phases of the child's first thousand days, namely the pregnancy phase and the phase from birth to two years. For the purpose of this discussion, the participants were referred to as mothers. As this study explored the first thousand days of the child, which included various factors pertaining to the child and the mother, reference to both will be denoted. The participants (mothers) were numbered 1 to 18 (e.g. participant 1). Identifying information – like the children's names, the names of places and hospitals – was blocked out. Sometimes, words were added in brackets to help provide clarity.

3.4.1 Theme 1: Health of the mother during the first thousand days of the child's life

The WHO (2006) referred to health as the total physical, mental and social well-being of a person, and not solely as the lack of disease. The latest WHO report, entitled *World Health Statistics Overview 2019* and issued in September 2019, revealed that health in low-income countries is recurrently affected by preventable or treatable diseases and conditions. The report identified the leading causes of death as environmental factors, tobacco use, unhealthy diet, lack of physical activity and unhealthy consumption of alcohol (WHO, 2019c:v).

This theme relates with the above-mentioned information by referring to the physical and mental well-being of the mother, as well as other factors that play a role in the mother's overall health, such as nutrition and substance use/abuse. Theme 1 is summarised in Table 3.2 below and will be discussed referring to the various sub-themes and their categories.

Table 3-2: Theme 1: Health of the mother during the first thousand days of the child's life

Theme 1: Health of the mother during the first thousand days of the child's life	
Sub-theme	***Category***
1.1 Physical health of the mother	(i) General physical health of the mother
	(ii) Complications during pregnancy and birth
1.2 Mental health and emotional well-being of the mother	(i) Mother's own experience of the pregnancy
	(ii) Stressors and related emotions/thoughts of the mother during pregnancy and the birth process
	(iii) Stressors and related emotions/thoughts of the mother from birth to two years
1.3 Nutrition of the mother	(i) General nutrition and type of food intake by the mother
	(ii) Challenges regarding nutrition and food
1.4 Substance use/abuse of the mother during pregnancy	(i) Nature of substance use/abuse during pregnancy
	(ii) Effect of the mother's substance use/abuse during pregnancy

3.4.1.1 Sub-theme 1.1: Physical health of the mother

Table 3.3 below illustrates the two categories, namely the general physical health of the mother and complications during pregnancy and birth occurring in this sub-theme.

Table 3-3: Sub-theme 1.1: Physical health of the mother

Theme 1: Health of the mother during the first thousand days of the child's life	
Sub-theme	***Category***
1.1 Physical health of the mother	(i) General physical health of the mother
	(ii) Complications during pregnancy and birth

Category (i): General physical health of the mother

The findings from this study can be divided into two groups, where approximately half of the mothers recalled having good physical health during their pregnancy while the rest of the mothers indicated some health issues.

The mothers with good health referred to feeling healthy in general, as well as not experiencing any morning sickness, illnesses or complications, as indicated by the following statements:

- Participant 3: "I did not have any illnesses or high blood, sugar, or any other things. Everything was fine. My health was good and every time I went to the hospital, they test your urine and weigh you and look at your blood or your sugar and draw a little bit of blood or so, but everything was just fine."
- Participant 5: "I did not have any morning sickness … I was very healthy. I had a healthy pregnancy, there never were problems."
- Participant 6: "I was healthy for my nine months. No complications."
- Participant 9: "I was very healthy. Strong as a horse … I was not sickly."

The other mothers experienced poor physical health, which varied from minor conditions such as heartburn and morning sickness to more severe illnesses and conditions such as high blood pressure and TB. Participant 1 mentioned heartburn and morning sickness at the end of the pregnancy*: "It was only heartburn that a person have a little bit. If I am near finishing [giving birth] and then I vomit a lot. At eight months, almost nine months, then I throw up every time."* Participant 4 only experienced morning sickness in the beginning of the pregnancy: *"Only throw up. That was not too long. It was only about a month and a half, then the nausea was over."* As noted by Faure *et al*. (2016:20), morning sickness usually occurs within the first three months of pregnancy. It is therefore a common pregnancy symptom, marked by nausea and vomiting during the first trimester.

Some women, like participant 2, could possibly have suffered from a condition called hyperemesis gravidarum, which continues into the second and even third trimester, causing severe nausea, vomiting, weight loss and lack of electrolytes (American Pregnancy Association 2019c). Some of these symptoms were confirmed by Participant 2's statement: *"The morning sickness I had with him [child] … I was very sick with him … up to seven months."*

Four participants suffered from high blood pressure during their pregnancy, which put them at high risk and caused related symptoms such as red eyes, swollen feet, legs and hands, dehydration and shortness of breath. These symptoms were experienced by participant 12 who stated the following: *"It is only my high blood. It is when my feet swell, and my legs and I am short of breath … Then I went to hospital. Then I stayed there until I finished [giving birth]. That was more than a month that I had to stay there in the hospital."* The American Academy of Family Physicians (2016:1) confirmed that high blood pressure during pregnancy could cause severe problems and symptoms such as swelling of the hands. Participant 8 suffered extreme high blood pressure, as quoted: *"… the high blood is so high and my eyes get red, swollen, everything swell up, my hands, everything. Then I had to walk to hospital [going to the hospital] with her [child], because my high blood was high and … five months that I was pregnant, then I got a stroke."* The risk of a stroke caused by high blood pressure during pregnancy is in line with literature indicating that high blood pressure poses high risks such as blood clots, a stroke, preeclampsia, placental abruption, premature birth, low birth weight and even the risk of stillbirth (Biswas & Amato, 2016:140). The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (2017) explained that severe high blood pressure could cause complications for both the mother and the baby, including poor growth of the baby due to low oxygen supply, as well as pre-eclampsia, involving abnormal function in one or more organs of the mother. Participant 10 understood the risks: *"I had high blood pressure during my pregnancy, yes. I am a high risk when I am pregnant."*

Furthermore, two participants got infected with TB. Participant 16 described this as follows: *"I got TB while I was pregnant with [redacted] [child]. I was nine months pregnant … my body started to weaken. They [clinic staff] had to give me a drip, iron pills, vitamin pills…"* As stated by participant 18, she contracted this illness at the beginning of her pregnancy: *"I got TB, then I did not even know [that she was pregnant]. It [TB] was surely in the beginning stage of the pregnancy. Yes, and then they [clinic staff] gave me treatment to prevent the baby from getting TB, because it was another six months. Finish completing, the child is then safe, then it is over."*

According to the WHO (2016a), TB during pregnancy increases the risk of complications like premature birth. TB, according to the Center for Disease Control and Prevention (2016), could be

fatal if not treated properly. In addition, untreated TB during pregnancy could be more dangerous to the mother and unborn child than the treatment itself. The Center for Disease Control and Prevention (2016) also noted that TB treatment does not appear to be harmful to the fetus. In South Africa, pregnant women with TB are recognised as a key and vulnerable population (South African Government, n.d:23).

Category (ii): Complications during pregnancy and birth

Various participants experienced complications during pregnancy or birth. Participant 12 had a pre-term pregnancy and remarked: "*… she was an eight-month child. She was born early now due to the high blood that I had."* Participant 2 verbalised her post-term pregnancy as follows: "*I had to finish [giving birth] the 29th of June, but then finished the 29th of July with* [redacted] *[child]. So, I was very much over, over my time, almost up to 43 weeks.*"

Participants 2 and 12 both recalled receiving medication to induce labour, but had to receive an emergency caesarean as well, as illustrated by the following statements:

- Participant 2: "… then I went in the Monday and on the Tuesday morning they [hospital staff] cut my water and put me on pains [giving medication for induced labour] … When they came to me, they saw that I've never unlocked, then I had to get an emergency caesarean with him [child]."

- Participant 12: "Then they [hospital staff] gave me pills that I now can get pains, but it did not take on me. Then they had to give me a caesarean to take her [child] out, because otherwise the child would not have made it."

Participant 16 described how TB affected her: *"… but I was just long in labour, because the TB exhausted me sometimes, it made me short of breath and that made me tired… To me, they [hospital staff] explained the longer I withhold the pain, the more difficult I make it for myself. Or I must just do like they [hospital staff] tell me or I am going to suffocate the baby and so they've explained to me."* Participant 8 experienced an ectopic pregnancy where the fertilised egg attached to the fallopian tube instead of the uterus, as explained by the American Pregnancy Association (n.d.c) and Mayo Clinic (2018a). She described it as follows: *"… then they [hospital staff] told me the child lay in the tube of the womb, in one of the tubes. But I delivered very difficult with her. I had to go for a caesarean. I laid at* [redacted] *[hospital] for four, five weeks. I had pain but could not deliver her."*

Various types of complications, as confirmed by the Center for Disease Control and Prevention (2018) and Stanford Children's Health (2019a), can occur during pregnancy, including gestational

diabetes, preterm labour, low birth weight, umbilical cord prolapse and ectopic pregnancy. According to the WHO (2019d), 800 women die per day due to childbirth complications. They indicated that pregnant women from developing countries are 36 times more likely to suffer from complications during pregnancy, stating severe bleeding, hypertension, sepsis, unsafe abortions and obstructed labour as leading causes of death.

Other complications experienced by participants 3 and 9 involved the malposition of the baby. Participant 3 explained*: "Then the knees laid there in me [birth canal]. Then he is first out with his knees."* Participant 9 said: *"So, baby come out with her feet first."* These participants experienced a breech birth as described by the American College of Obstetricians and Gynecologists (2019b) and MedlinePlus (2018). According to Cleveland Clinic (2014), the child of participant 18 experienced umbilical cord prolapse, as demonstrated by this mother's statement: *"… but when I went into labour with her, then with the push, then the umbilical cord was stuck around her neck."* Cleveland Clinic (2014) explained that umbilical cord prolapse could occur prior to or during the pregnancy, posing a great danger to the fetus as a result of loss of oxygen. Umbilical cord prolapse may even result in a stillbirth.

Children from participants 3, 9, 10, 17 and 18 showed symptoms of a lack of oxygen, which included abnormal skin colour, as described by Seattle Children's Hospital (1995-2019). Participant 3 recalled*: "… but when he [child] was out, he was white."* Participant 10 mentioned: *"And when they [hospital staff] lifted* [redacted] *[child] up, then* [redacted] *[child] was blue around her mouth and her eyes, because she was busy suffocating."* Oxygen deprivation, also known as asphyxia, means the lack of oxygen and blood flow to the brain and other organs before, during or directly after birth, which can cause disabilities and developmental delays, as well as other long-term effects such as lung, heart and muscle problems, seizures, learning disabilities and behavioural problems (Ankin, 2019; Seattle Children's Hospital Research Foundation, 2019).

Participants 2, 8, 12 and 16 (who were teenage mothers) experienced some form of complication during pregnancy and/or birth. This correlates with Statistics South Africa (2017:10), stating that teenage mothers have a high risk for adverse pregnancies.

3.4.1.2 Sub-theme 1.2: Mental health and emotional well-being of the mother

The sub-theme 'Mental health and emotional well-being of the mother' includes three categories, as shown in Table 3.4 below. This next section, which will look at the mother's maternal mental health during pregnancy and after birth, includes the following three categories: (i) the mother's own experience of the pregnancy, (ii) stressors and related emotions/thoughts of the mother

during pregnancy, and (iii) stressors and related emotions/thoughts of the mother from birth to two years.

Table 4-4: Sub-theme 1.2: Mental health and emotional well-being of the mother

Theme 1: Health of the mother during the first thousand days of the child's life		
Sub-theme	***Category***	
1.2 Mental health and emotional well-being of the mother	(i)	Mother's own experience of the pregnancy
	(ii)	Stressors and related emotions/thoughts of the mother during pregnancy and the birth process
	(iii)	Stressors and related emotions/thoughts of the mother from birth to two years

Category (i): Mother's own experience of the pregnancy

During the interviews, participants reported different experiences regarding their pregnancy. Although various participants described their pregnancy experience in a positive light, some of the participants defined their pregnancy as a negative experience.

Positive pregnancy experiences were described as follows:

- Participant 3: "The pregnancy was … it was exciting."
- Participant 6: "… it was a good experience. There is nothing to complain about that I can think off."
- Participant 7: "With him [child] I had a very comfortable pregnancy."

Participant 5 felt beautiful and enjoyed the experience: *"To me it was a nice experience to walk with the big stomach. And then when I was pregnant with her, I was very pretty, my hair was very pretty, and I liked dressing beautifully. Yes, it was a good experience for me."* Biswas and Amato (2016:18) confirmed participant 5's experience by describing the glowing appearance of pregnant women during the second trimester due to increased blood volume around the body. Other participants experienced the pregnancy as miraculous and a blessing, feeling very positive during their pregnancy, as mentioned by participant 3: *"But I felt great, I felt happy … because it is a blessing that you get, it is a miracle."*

As seen above, a positive pregnancy experience can promote the emotional well-being of the mother. However, the WHO (2017) described a positive pregnancy as much more than just positive emotions. They defined a positive pregnancy as a healthy pregnancy for both the mother and the baby with a good transition into labour, resulting in positive motherhood at the end.

Therefore, it seems that the pregnancy experience plays a vital role in the holistic health of the mother and the baby.

A number of participants in this study did not have a positive pregnancy experience as a result of various reasons. Participant 2 experienced extreme morning sickness, a condition called hyperemesis gravidarum, for seven months and mentioned: *"… could not get anything [food] in and it was not a nice experience."* The findings of this study suggested that symptoms of hyperemesis gravidarum could increase the mother's risk of emotional distress (Kjeldgaard *et al*., 2017:251). Therefore, this study could possibly explain the reason for this participant's negative experience of her pregnancy. This same participant mentioned her trouble to sleep and her swollen feet as challenges. Participant 12 had to be hospitalised for a few weeks due to high blood pressure, which contributed to a negative pregnancy experience, as she recalled: *"I did not experience it well. Why must I be in hospital? That experience was not the nicest."* For participant 9 it was her first pregnancy. She felt: *"For me it was in the first place, was it something unpredictable. I was not used to it. I did not know what to do."* She added, *"My experience was that it was difficult to sleep".*

The participants mentioned morning sickness, swelling, uncertainty, trouble sleeping and high blood pressure as reasons why they found their pregnancy challenging. These reasons were confirmed by Horsager-Boehrer (2017) as common reasons why some women do not enjoy their pregnancy.

Category (ii): Stressors and related emotions/thoughts experienced by the mother during pregnancy and the birth process

Collins English Dictionary (2019) defines a stressor as "an event, experience, etc. that causes stress". According to the *Business Directory* (2019), a stressor is defined as a "Physical, psychological, or social force that puts real or perceived demands on the body, emotions, mind, or spirit of an individual". Stressors, as described by the Mayo Clinic (2019a), can be categorised as external or internal stressors. External stressors include major life changes such as pregnancy, the death of a loved one, environmental stressors and unpredictable events. Internal stressors relate to feelings and thoughts that cause emotional turmoil, like fears, uncertainty, lack of control and certain beliefs, opinions, attitudes and expectations.

During the interviews, various participants mentioned a variety of stressors experienced during pregnancy and the birth process. The participants experienced either external stressors, internal stressors or both. Stressors during this time varied from mild to severe. Participant 3 voiced a mild stressor relating to her other children*: "… the children let you stress just a little bit if you are*

in the home. Maybe they are naughty or the one does not want to do their homework." A more severe external stressor was experienced by participant 8 when she was still a teenager: *"I was in Grade 11. I was still in school and when I found out … that time it was still, if you expect [pregnant], you had to come out of school, because there is not really room for pregnant girls. And then I left the school."* The same stressor was experienced by participant 16 who stated: *"I was still in school … and I did not know what do to with the child."*

Many participants indicated their current circumstances as external stressors, as shown in the following extractions:

- Participant 2: "… if I think about the circumstances that always stressed me out."
- Participant 8: "Back then, everything was, everything was too much in the home. There were too many people in the home. Everyone had their own problems. The one scolded about that and that one scold about this. Sometimes there was no food, then they scolded at each other, or they would fight or stab each other with a knife. So, every day, it went like this in the home … it became too much for me."
- Participant 14: "What was the saddest for me, I told him [child's father], I would have killed the child because of him, his circumstance and things."

Stressors relating to the child's father and the father's relationship with the mother were verbalised by various participants. Participant 5 was involved in a short-term relationship with the child's father. He initially denied fatherhood and requested blood test during the pregnancy. This situation caused severe stress and triggered emotions regarding her relationship with her own father. She stated: *"I had a lot of stress. Very stressful. What was sad for me was that I also grew up without a dad and now I had to put my child, my unborn child, through that. This was very sad for me."* The stress experienced by this participant escalated to the extent of causing panic attacks at the end of her pregnancy. Participant 16 too experienced the lack of involvement from the child's father as a stressor and felt: *"Sometimes I was emotional, because my child was never going to know her dad. Other children walk by with their dads …"*

Participant 17 endured serious physical abuse from the child's father: *"Oh, he hit me that evening. He took the belt. He pulled my hair … He said it was not his child. My stomach was blue from how he hit me. But the child kicked and the child, the child did not die … He wanted to kill me with the child. This is why [redacted] [child] is like this. I had to drink 'wee' [urine] that the child could go down [abort], newspaper water will bring the child down, but I am already six months and the child still sits in my stomach and then the police took me home."* Donovan *et al*. (2016:1289, 1297)

confirmed the harmful effects of intimate partner violence on the mother and child, as experienced by participant 17. They concluded that exposure to this type of violence increases the mother's risk of an adverse birth outcome. A study by McFarlane *et al*. (2014:839) found that the negative effects of abuse on pregnant women could last for at least 24 months after the child was born.

Some participants also experienced internal stressors. These internal stressors were specifically related to the announcement of the pregnancy to family members. Participant 2 internalised the situation, saying: *"I felt like a disappointment, felt like I've disappointed them [family] with the pregnancy."* Keeping the pregnancy a secret caused great distress for participant 9, as expressed: *"I walked and cried to work … but I did not know how to tell my grandmother. Bottled up everything and I did not know what to do … So, I was more a … I was a closed book as one would say…"* Participant 16 felt guilty about adding pressure to her family. Participant 15 experienced fear when thinking about informing her parents, as illustrated by her comment: *"I was very scared to tell my dad and mom, because my dad was a very, he was very strict with us."*

The negative impact of the prenatal stress of the mother on the fetus has been confirmed by various researchers (Coussons-Read, 2013; DeSocio, 2015; DeSocio, 2018; Gross *et al*., 2016). As indicated by Coussons-Read (2013:52), the effect of stress may occur directly through prenatal stress-related physiological changes, or indirectly through the effect of stress on the mother's health or pregnancy. He also explained how mild, moderate and severe stress could negatively influence the pregnancy and consequently the behavioural and psychosocial development of the baby.

From the statements above it is evident that these participants experienced various negative emotions as a result of the particular stressors. The participants mentioned feelings like sadness, anxiety, guilt and worthlessness, which could possibly, according to the American Pregnancy Association (n.d.b), indicate symptoms of depression during pregnancy, referred to antepartum depression. Prenatal exposure to maternal depression could affect the baby as confirmed by a research study conducted by Marroun *et al*. (2018:327) who suggested that a difference in the microstructure of the white matter tracts in the child's brain could be associated with exposure to depression symptoms of the mother during pregnancy.

Various participants experienced the birth process itself as a stressor. Participant 16 was only 17 years old and recalled: *"Because I was now afraid. A little bit nervous, because other people next to me are screaming and making a noise and I am now a stupid seventeen, how do I give birth? I do not know how. Yes, when the pain came, then I held it in because I was afraid. Am I going to die if I give birth? What will happen? Is the baby just going to come out?"* The quote by participant

18 revealed her emotions: *"And then I had to give hundred per cent attention and it is a fear in you, because if you make a mistake here, then it is your fault. Then I panicked…"* Various participants encountered complications during the birth process, which were stressful and triggered negative emotions. Participant 11 expressed her intense experience as follows: *"And I was so afraid the baby can suffocate, because if the baby's head is sitting there [birth canal] it means baby is ready to come out. And I cried also. And I was in that state if your water breaks, you go crazy now. That child can die."* These experiences could potentially be described as birth trauma, as indicated by the Australian Birth Trauma Association (2017), where they refer to birth trauma as physical or psychological damage caused by a stressful childbirth that leads to great distress to the mother. This experience often impacts the mother's physical and mental health, which could affect the mother's ability to bond with the baby. Negative emotions experienced during childbirth can play a role in the development of postnatal anxiety, depression or other stress-related disorders. It became evident from the interviews that some of these mothers have experienced birth trauma as a result of stressful childbirth.

Category (iii): Stressors and related emotions/thoughts experienced by the mother from birth to two years

In this study, some participants mentioned the stressors experienced during the time period from the child's birth up to two years. Compared to the stressors experienced during pregnancy, fewer participants verbalised the stressors experienced after the birth of the baby. Some of the participants mentioned common stressors regarding childcare, as explained by participant 2: *"Every time that he [child] was ill, my nerves were finished. It seemed that I couldn't handle it to see my child in pain."* Stressors varied on a scale from mild and moderate to severe. For participant 13, the stressors were fleeting and more of a mild nature: *"The money that I had for the lay-buy to go and collect the child's clothes, the dad used it. I was so angry."* Participants 1, 8 and 15 experienced a similar stressor by losing a loved one during this time. Participant 15 described her feelings regarding the death of the child's father: *"But when she [child] was eleven months, then they stabbed him [child's father] dead with a knife. I was very sore [sad]."*

Participant 17 experienced a severe stressor and traumatic event as voiced: *"We were sleeping one night. [redacted] [child] was still a newborn baby then. When my boyfriend woke up, the structure was burning already. The candle burnt on the cupboard … the whole cupboard was burning."* The poor mental health of participant 17 was further portrayed by serious indicators of attempts to harm her child. Deep emotions were contained in her statement: *"I cannot anymore. I left the child at the hospital … I walked out without the child. I do not want the child, because I told myself I do not want the child. I am tired of being a mother, because it is hard."* On another occasion, the

same participant tried to kill the baby as indicated by her statement: *I went to the soccer field with the child … Then I told myself, throw the child in the dam of water. Then another man came and said, 'Girl, you must not do this; I said, 'Keep your mouth shut. We are hungry. We don't have food." The man called the police, and the police came*." This participant's feelings of irritability and hopelessness, as well as lack of interest in the baby showed possible symptoms of postpartum depression, as explained by the American College of Obstetricians and Gynecologists (2013) and the American Psychiatric Association (2017). The latter resource explained that women could also suffer from peripartum depression, occurring during pregnancy, which was a strong possibility for this participant based on her account of her mental state during pregnancy. The WHO (2019e) explained that suffering from depression could in some cases result in thoughts about deliberately harming the baby. According to Davidson *et al.* (2014:1203-1204), the National Institute of Mental Health (n.d.) and the WHO (2019e) risk factors such as poverty, unplanned pregnancy, depression symptoms during pregnancy, ambivalence about maintaining the pregnancy, domestic violence, lack of support and drug abuse could increase the probability of postpartum depression or other mental disorders during pregnancy or the first year after delivery. The Addiction Center (2019b) confirmed that women with a substance abuse history are more prone to postpartum depression, which also related to this participant since she had a drug abuse history.

3.4.1.3 Sub-theme 1.3: Nutrition of the mother

The third sub-theme related to the nutrition of the mother and included the following categories: (i) the general nutrition and food intake of the mother, and (ii) challenges experienced regarding nutrition, as indicated in the table below.

Table 3-5: Sub-theme 1.3: Nutrition of the mother

Theme 1: Health of the mother during the first thousand days of the child's life	
Sub-theme	***Category***
1.3 Nutrition of the mother	(i) General nutrition and type of food intake by the mother
	(ii) Challenges regarding nutrition and food

Category (i): General nutrition and type of food intake by the mother

Various participants felt that they ate healthily during their pregnancy, as reflected by participant 11: *"I ate like I must eat, ate more than I should have, and yes, I ate healthily."* Participant 13 also confirmed eating healthily, as indicated by her statement: *"… ate very healthily … At my own home where I stayed, we always ate healthily."* Many participants who indicated healthy eating, specified eating one or more healthy food varieties which included fruit, vegetables, seafood, liver,

eggs and salad. As verbalised participant 7 explained: *"I loved a boiled egg, my bananas, oranges, fruit. And I was very fond of salads."* The American Pregnancy Association (2019d) confirmed the importance of healthy eating during pregnancy for the growth and overall health of the developing baby. A mother requires a healthy diet during pregnancy to meet both her own and the baby's nutritional needs. A healthy diet refers to the adequate intake of energy, protein, vitamins and minerals (WHO, 2016 b:3). Some of the healthy food items – like grains, fruits, vegetables, meat, dairy products and healthy fats – mentioned by the participants are in line with literature and the recommendations of the American College of Obstetricians and Gynecologists (2018a) and Paramor (2016:26-27).

Only participants 1, 9 and 15 specified drinking water, which is vital during pregnancy to stay hydrated, as confirmed by Paramor (2016:24-25). According to Cruz (2017), a pregnant woman requires plenty of water to form amniotic fluid and extra blood, build new tissue, transfer nutrients, promote digestion and remove toxins from her body. In addition, staying hydrated during pregnancy decreases constipation and the risk of urinary tract infections, reduces swelling, increases energy, and lowers the risk of preterm labour and preterm birth (Cruz, 2017).

Some participants understood the significance of proper nutrition during pregnancy and its benefits for the baby, as stated by the following quotes:

- Participant 9: "We [participant and her grandmother] worked out a plan [eating plan], like every morning you eat oats, a glass of water or a glass of milk, and lunch. She will make some food, like toast and maybe an avocado and eggs and such things. And fruit like paw-paws, mangos, strawberries – that I ate. I liked my muesli and rusks. I ate very healthily. Grandmother pressed out juice like oranges, which I did not like. She always made her own juices and things like carrot juice and beetroot juice, all those things. So, that's grandmother, healthy from the farm."

- Participant 11: "I made myself some smoothies. Why I do not know, because it did not taste nice, but just because baby needs it. Then I tell myself, 'Girl, you are going to drink this now, because baby needs it."

- Participant 13: "But then we ate very healthily at that time. That's why she [child] was born so healthy."

The benefits of healthy eating during pregnancy for both the mother and the baby have been confirmed by literature. According to Murkoff and Mazel (2016:84-85), these benefits include a safer pregnancy, increased chances of a healthy birthweight, improved brain development and reduced risk of specific birth defects. They also referred to certain maternal advantages, like better

balanced emotions, fewer physical symptoms such as morning sickness, heartburn, constipation and fatigue, as well as full-term pregnancy and swifter postpartum recovery.

However, contrary to the good nutrition mentioned above, a few participants admitted eating unhealthy food and maintaining poor nutrition during pregnancy. Participant 1 stated: *"I did not eat healthy when I was pregnant. Ate anything."* Participant 4 recalled not concerning herself with healthy nutrition: *"I ate a lot of junk food. Ate very never minded. I did not worry about what I was eating. I only drank coffee."* Nutritional deficiencies during pregnancy could affect a child's cognition, behaviour and productivity later in life, as confirmed by Prado and Dewey (2014:267). The effect of poor nutrition during pregnancy and beyond has also been emphasised by UNICEF (2016a).

Even though participant 9 ate very healthily, as described above, she admitted the following: *"And I liked coffee very much. My grandmother said, '* [redacted] *[participant], you must get off the coffee, too much caffeine.' And she started to give me Rooibos tea …"* According to Murkoff and Maze (2016:63), a small amount of coffee is not harmful to the baby. However, it must be limited since caffeine during pregnancy could prevent the absorption of iron and cause key nutrients to be washed out of the mother's system before proper absorption. They also stated that too much caffeine combined with pregnancy hormones could increase mood swings. The WHO (2017:4) additionally cautioned pregnant women to lower their daily caffeine intake in order to reduce the risk of low birth weight babies.

Two participants mentioned eating unusual items like ice, clay and chalk during their pregnancy. The National Eating Disorders Association (2018) explained that a person eating non-food items with no nutritional value could suffer from an eating disorder called pica. They identified iron deficiency and malnutrition as two common causes of pica. This conclusion was confirmed by participant 14*: "Because my iron … was too little iron. I liked clay more."*

Category (ii): Challenges regarding nutrition and food

Various participants experienced challenges regarding their own nutrition and food during pregnancy or even after the child was born. A few participants explained the impact of morning sickness on their food intake, as described by Participant 2: *"And all that I could force down was water and potato chips. It was the only thing that I could get in my stomach – up to seven months."* Participant 14 explained that she could not eat certain food, while participant 8 was only able to eat after eleven or twelve o'clock for food to stay in her system. Although morning sickness during the first trimester is considered normal, Faure *et al*. (2016:66-67) cautioned mothers suffering from prolonged morning sickness into the second trimester to seek assistance in order to provide

adequate nourishment to the growing baby. According to the American Pregnancy Association (2019c), hyperemesis gravidarum, as possibly experienced by participant 2, could be harmful to the mother and the baby due to the possible lack of vital nutrients.

A lack of food or limited food was mentioned as a major challenge by some of the participants. As a result of this, many participants relied on soup kitchens for food as they were not able to provide food for themselves at home. Some of these soup kitchens were only operating every second day or did not provide enough food to completely satisfy the participants. The following quotes illustrate these challenges:

- Participant 8: "Food was scarce. There were places [soup kitchens] that handed out food and then I would go and fetch some. And so I ate and then she [child] got some feeding. But it was not really … it did not make me full… Not every day [soup kitchen], it was every second day. The Monday and then the Thursday, and then the Sunday they also handed out [food]."

- Participant 10: "But I could not really eat from my home because there was nothing [no food]."

- Participant 18: "So we went to sister [redacted] [name] soup kitchen. If there was no [food], then we went there."

Participant 14 obtained food in the following manner: *"… then we [participant and the child's father] walked around in town to look for food … I maybe went to my mother to ask her if she did not have something for us to eat."* Due to food scarcity, participant 17 experienced the following: *"You do not have solid food that you can eat when you are pregnant. I did not really eat. Now in the evenings, I would go and sleep just like that [without eating]. Tonight, and some mornings there were nothing [food]. So, then I can't anymore. I must eat, because I can feel I do not have energy…"*

It is possible that a few of the participants suffered from iron deficiency or other nutritional deficiencies during their pregnancy. However, the clinic did provide iron and/or vitamin pills, as well as formulated nutritional cereal to some participants. Participant 16 explained: *"During my pregnancy, in the mornings the first thing I had to eat was the clinic cereal before I could drink the three tablets and the iron pill and the vitamin pill."* According to participants 2 and 14, the iron pills prescribed by the clinic made them very nauseous. Therefore, they could not drink it as noted by participant 14: *"… just gave iron pills, but it did not help me. It really made me nauseous and I did not have energy and appetite."*

The mother's nutritional status plays a vital role in the development and growth of the fetus, which makes a healthy, balanced diet essential during pregnancy. Malnourished mothers may not be able to adequately provide for the unborn child's nutritional needs during pregnancy, since the fetus is dependent on the mother's nutrient intake. The mother's diet must sustain herself and the fetus by providing energy and nutrients (Castrogiovanni & Imbesi, 2017:6). According to research on poverty and pregnancy in South Africa by Scorgie *et al.* (2015:1), it is common to have insufficient food during pregnancy when faced with poverty, as seen by some of the mothers in this study.

3.4.1.4 Sub-theme 1.4: Substance use/abuse of the mother during pregnancy

The sub-theme pertaining to substance use/abuse of the mother during pregnancy consisted of two categories, which will be discussed next.

Table 3-6: Sub-theme 1.4: Substance use/abuse of the mother during pregnancy

Theme 1: Health of the mother during the first thousand days of the child's life	
Sub-theme	***Category***
1.4 Substance use/abuse of the mother during pregnancy	(i) Nature of substance use/abuse during pregnancy
	(ii) Effect of the mother's substance use/abuse during pregnancy

Category (i): Nature of substance use/abuse during pregnancy

Some of the participants exposed their unborn babies to the harmful effects of various substances during pregnancy, including alcohol, cigarettes and illicit drugs. However, a small number of participants proclaimed a total lack of any substances during their pregnancy, as cited by participant 9*: "No, nothing. I did not drink. I also did not smoke."* Although some participants specified the lack of certain substances such as alcohol or drugs, at a later stage they indicated the use of other substances like cigarettes. Thus, some of the mothers did use some substances during pregnancy. The following statement by participant 6 highlighted this: *"No drugs, no drinks. I do not use alcohol. Only smoked, because I smoke a lot. I smoke about ten cigarettes a day."*

Most of the participants primarily drank beer, except participant 12 who indicated drinking a stronger type of alcohol as well as beer daily. She proclaimed: *"We mostly drank beer only. If we went out, I maybe ordered stronger wine … Maybe just two whiskeys or a rum or so. We drank beer every day."* Alcohol use varied from drinking occasionally to regularly. Participant 1 stated: *"When my friends came, we would go and drink beer … But I did not make a habit of it."* Participant 7 acknowledged drinking regularly during her whole pregnancy: *"I drank a lot with him [child]. I was only a beer drinker … I finished [giving birth] on the Sunday, the Saturday evening I still had*

alcohol." The quantity of alcohol varied from one to a few bottles of beer, with the extreme amount of five litres, as self-confessed by the following participants:

- Participant 5: "We divided the twelve beers between six people, so we each got two. It was not 'dumpies' [small bottles], it was the large bottles [750 ml]."
- Participant 10: "I drank about six bottles of that beer, because it was small bottles…"
- Participant 13: "… then I will maybe drink one beer with her [friend]."
- Participant 14: "I drank when I was expectant with her, then I drank. It was only beer. Every weekend I drank litres … about five litres … I just drank a lot."

The prenatal use of alcohol by the mothers in this study corresponded with the high prevalence rates of FASD in South Africa (Olivier *et al.*, 2016:105). A systematic review by Irner (2012:521) confirmed the long-term consequences of the mother's use of alcohol during pregnancy on the child's cognitive, behavioural, social and emotional development. She concluded that the extent of these consequences depended on the amount and timing of prenatal exposure to alcohol.

From all the substances mentioned during the interviews, cigarettes were the most prevalent, with more than half of the participants revealing that they smoked cigarettes during their pregnancy. As with the use of alcohol, the extent of smoking varied. Only participants 8 and 13 did not smoke every day, as verbalised by participant 8: *"No, I did not smoke every day when I was pregnant."* Participant 13 said: *"… but I smoked a cigarette now and then … one or two in a day, or three."* The rest of the participants smoked daily, with the number of cigarettes ranging from two to approximately 20 cigarettes per day. Participant 7 said that she smoked less with this particular child: *"I smoked very little with him. With [redacted] [child], I did not smoke a lot. If I had four [cigarettes] … when my husband came home from work in the evening, about one and a half were left."* Two participants, participants 4 and 11, smoked a large number of cigarettes per day, as stated by participant 4: *"In my pregnancy I smoked a lot … it was a packet a day."* Participant 11 also confirmed heavy smoking: *"I smoked a lot of cigarettes. Smoked cigarettes the whole day. If I just thought about smoking, then I smoked. I smoked 20 cigarettes per day."*

The American College of Obstetricians and Gynecologists (2019a) explained that the harmful effects of smoking during pregnancy were as a result of less oxygen and nutrients to the baby. This could lead to permanent damage to the baby's brain and lungs or other risks including preterm birth, SIDS and childhood asthma. The American Pregnancy Association (n.d.b) indicated that the long-term health risks for the baby included lung problems, learning difficulties

and physical growth challenges. They explained that where the mother continued smoking after the birth, the baby could be even more prone to colds, coughs, middle-ear infection, bronchitis and pneumonia.

Participants 12, 16, 17 and 18 confirmed using drugs during pregnancy, which included dagga, rocks, Mandrax and/or methamphetamine (Tik). The following statements of participants describe their drug abuse:

- Participant 12: “And I used drugs during that time. I was on ‘rocks’ … it is not like Tik, but is it also a drug. I smoked dagga, but during that time I smoked the pipes. We mixed the dagga with the cigarettes and then we smoked it.”

- Participant 16: “With my pregnancy with [redacted] [child] I smoked dagga. Green dagga. That is the pure dagga, yes, without cigarettes.”

- Participant 17: “I was on drugs. I am still on drugs, but now I was drugged with [redacted] [child]. Tik and Mandrax. A lot, a lot, a lot. Every day … three, four grams [drugs]. Buttons and Tik and so every day, up to eight months.”

- Participant 18: “The Tik … just smoked Tik, ma’am. Just weekends … then it became almost like regular. You must smoke every weekend.”

The enormous risks associated with the use of illicit drugs during pregnancy – such as miscarriage, low birth weight, stillbirth, developmental delays, and behavioural and learning problems later in life – are confirmed by the American Pregnancy Association (2019a) and the American College of Obstetricians and Gynecologists (2019a). A systematic review and meta-analysis of prenatal exposure to cannabis and maternal and child health outcomes found that cannabis during pregnancy could increase the mother’s odds for anaemia and decrease the birth weight of infants (Gunn *et al*., 2016:1).

Various participants confirmed the severe use of alcohol, cigarettes and/or drugs during pregnancy. Yet, some participants reduced their substance intake or stopped for a few months during their pregnancy. Participant 14 explained: *“… and I started to smoke less. Up to six months, then I did not worry to drink anymore.”* Participant 18 confessed her struggle: *“… but I couldn’t stop it [Tik] immediately. It was not so easy as the people said. I also used it sneakily. Then I would say, ‘No I don’t smoke anymore. I stopped the smoking’, but then I lied, because I was smoking again. So, I went on, less and less. By the end of the pregnancy I could say I completely stopped smoking. No, say at about eight and a half [months], there about.”*

The WHO views pregnancy as an opportunity for women to make positive changes in their lives (2019b). This is what the above-mentioned participants did when they changed their substance abuse patterns during pregnancy. According to the WHO, health workers can provide support and advice to women using substances by helping these women to understand their social, mental and physical problems. Hence, the WHO developed guidelines for the identification and management of substance use in pregnant women with the goal to promote healthy outcomes for both the mother and child (WHO, 2014). The WHO also developed a document on maternal mental health, which includes the recommendation that health care workers should question pregnant women at every antenatal visit about their past and present use of cigarettes, alcohol and other substances (WHO, 2017:5).

Category (ii): Effect of substance use/abuse during pregnancy

A few of the participants acknowledged that they understood the effects of their substance abuse on the child during pregnancy. However, some of the participants showed a lack of understanding or misguided understanding regarding substance abuse and its impact on the child.

Participant 7 believed that she could not stop using alcohol when she found out she was pregnant, as the child was used to this substance and was in need of it. She recalled*: "The point is, if you find out late that you are pregnant, do not stop that alcohol level, because then you will make your child ill, because your child is now used to that alcohol level. He is used to that in his bloodstream. But that child will seek that little bit [alcohol] still, because he is now used to it."* She concluded: *"The alcohol did nothing to* [redacted] *[child] …"* It seemed as if participant 12 contradicted herself as she tried to rationalise the impact of her drug abuse on the child. She stated: *"But he [child] did not have any effects that we … we can't say that he had any effects, because nothing was the matter with our children."* Her next statement showed that she probably believed that drugs during pregnancy could be harmful to a baby: *"I do not encourage anyone to use drugs while she is pregnant … because one out of a thousand children come out healthy from this, with lungs formed properly or so, their inner parts."*

The following quotes showed that participants 16 and 18 had insight into the negative impact of their substance abuse on the baby while they were pregnant:

- Participant 16: "I realised it [drugs] was wrong and I got TB while I was pregnant with [redacted] [child]. And I stopped the dagga, for the sake of [redacted] [child]."

- Participant 18: “I mean, and I thought no … what I take in, the child automatically takes in. But with the Tik I thought, oh, the child will be disabled, because I watched TV and I saw, and I heard what was going on.”

Although participant 17 did not mention her understanding of the impact of her drug abuse while she was pregnant, she verbalised her current understanding of the long-lasting effects of her drug abuse during pregnancy on her child’s health and school performance. Her powerful statement points the effects of drug abuse on her child: *“Tik and Mandrax. That is why [redacted] [child] was so sickly. So, this is why the child, [redacted] [child’s] condition is like this. And at school too. It is almost as if the drugs left something behind … This is why she takes so long, struggle to think. She has two teachers that are teaching her. She was in Grade 1 for two years because she could not write properly like the others. She could not do in class what the others were doing. She can’t focus well like the others. It [drugs] has an effect on her schoolwork, yes, that is why she thinks a bit slower. Because that [drugs] leaves something behind when you are pregnant. So, you may not use it when you are pregnant because it leaves something behind in the child.”*

Some of the participants experienced certain effects on their own health, which they linked directly to a specific substance, especially alcohol and cigarettes. These symptoms included nausea, heartburn, dizzy spells, hot flushes or feeling exhausted. Some of the previously mentioned symptoms were mentioned in the following statement by participant 8: *“It was the cigarettes. It gave me mucus … seemed like something building up and then coming out. And in the mornings when I wake up, then I feel that acid in my stomach, then I vomit. It is now the acid that comes out from the cigarettes and then I get heartburn afterwards.”* Some participants mentioned other effects as a result of their substance abuse. For instance, participant 17 voiced: *“But when I was so drugged, I sometimes did not know what I was doing.”* The effect of Tik on participant 18 hindered a healthy lifestyle, as illustrated by her statement: *“So then I smoked [Tik], then one does not feel hungry and you stay awake.”*

The information given above provided more insight into the four categories of this theme, namely: (1) the physical health of the mother, (2) the mental health of the mother, (3) the nutrition of the mother, and (4) the substance use/abuse of the mother during pregnancy.

3.4.2 Theme 2: Health of the child during the first thousand days of life

The second theme on the child’s health during the first thousand days of life will be covered by a discussion on the two sub-themes illustrated in Table 3.7 below.

Table 3-7: Theme 2: Health of the child during the first thousand days of life

Theme 2: Health of the child during the first thousand days of life	
Sub-theme	***Category***
2.1 Physical health of the child	(i) General physical health of the child
	(ii) Challenges relating to the child's health
2.2 Nutrition of the child	(i) General nutrition and type of food intake by the child
	(ii) Challenges regarding nutrition and food

3.4.2.1 Sub-theme 2.1: Physical health of the child

According to UNICEF (2017), the first thousand days of life is a unique period to establish the foundations for optimal health and development across the child's lifespan. UNICEF (2017) also stated that children in South Africa continue to die from conditions like pneumonia, HIV, TB and diarrhoea, which are all preventable. These conditions are influenced by poor health care, nutrition and hygiene of the pregnant mother and child during the first thousand days of the child's life.

Table 3.8 illustrates the categories under the 'Physical health of the child' that refer to (i) the general health of the child, and (ii) challenges relating to the child's health.

Table 3-8: Sub-theme 2.1: Physical health of the child

Theme 2: Health of the child during the first thousand days of life	
Sub-theme	***Category***
2.1 Physical health of the child	(i) General physical health of the child
	(ii) Challenges relating to the child's health

Category (i): General physical health of the child

Various participants perceived their children to be healthy during the time between birth and two years, as illustrated by participant 6: *"… but she was healthy from being a baby to two years. No, she was strong and healthy."* Participant 9 added: *"And baby was very healthy. They [hospital staff] said the baby was healthy, everything was fine, everything was there that should be there … and she was not a sickly child. She was not on medication, on anything. She was a very healthy child."* Participant 3 was very surprised that her child was so healthy, since she experienced complications during his birth: *"I thought because he now came out like this [with his knees first], he will maybe be a very sickly child or so, but then he never was a sickly child up to two years and until now."* Other participants referenced the absence of illness or lack of visits to medical facilities when they described their children's good health, as mentioned by participant 18: *"There*

were no illnesses, not even chicken pox or anything, nothing." Participant 13 explained: *"I never had to sit with her at the hospitals or at the clinics or so."*

Some of the participants' children suffered from a diversity of illnesses from birth to two years. These illnesses varied from mild and moderate to severe. Participant 2 mentioned that her child had an eye infection and rash, indicating mild conditions that were easily cured. A few of the participants mentioned their children had gastro or fever fits, as noted by participant 6: *"It was just always gastro … Just gastro when she was cutting teeth [teething]."* According to participant 5, her child contracted gastro while hospitalised for fever convulsions when the child was only five months old, resulting in intravenous feeding. As seen with the child of participant 5, hospitalisation often becomes necessary. The Royal Children's Hospital Melbourne (2018) explained that the risk of dehydration caused by gastroenteritis (gastro) for babies under six months frequently requires intravenous therapy.

Participants 7, 8, 15 and 17 indicated their children suffered from various types of respiratory problems. Participant 8 said: *"But the chest, I must just keep coming so that they [clinic staff] can see if there is any mucus on the chest. Because if she sleeps, she makes 'ggg'. If she snores, then there is a wheezing in her chest."* Participant 17 explained: *"Then it is the child's chest. The child had asthma. Then they [clinic staff] gave her an asthma inhaler."* It is interesting to note that all four these participants smoked cigarettes while pregnant. McEvoy and Spindel (2017:31) concluded in their research that tobacco products could alter the developing lungs of the fetus with long-lasting effects on the lungs after birth. The damaging effects of smoking during pregnancy on the child's health, especially on the lungs, have also been confirmed by the Center for Disease Control and Prevention (2019), Cleveland Clinic (2019b) and the State of Victoria (2018). A study by Zacharasiewicz (2016) confirmed the influence of maternal smoking during pregnancy on childhood asthma, which was mentioned by participant 17.

Two of the participants' children contracted TB before the age of two. In this regard, participant 14 indicated: *"Three months, yes, then I noticed the child has TB. It [TB treatment] was for six months."* The child of participant 16 was born with a kidney disease and was hospitalised for three weeks after birth. Participant 17 mentioned that her child's poor health included colon problems, difficulty to walk and asthma, which she had already noted. This participant admitted her feelings and thoughts pertaining to her child's functioning: *"Now I tell myself, there are many things about her that do not work. She is not so well, not normal, if I can say."* Apart from smoking cigarettes, this participant used Metamphetamine (Tik) and Mandrax while pregnant. Nel and Geraghty (2017:554) confirmed the health consequences of Metamphetamine use in pregnancy, resulting

in complications for the mother and the neonate, as visible in the health status of participant 17's child.

Information about medical check-ups and immunisations also surfaced during the interviews. A few participants confirmed taking their children for their regular medical check-ups and immunisations, as highlighted by participant 3: *"I attended every date of the clinic, because it is injections that they must get and sometimes they get weighed."* Only one participant did not adhere to the child's clinic dates, as verbalised by participant 17: *"If it was her date [clinic check-up], then I tell myself 'I don't feel like going to the hospital today' … At a year and six months, then she got all the injections that she should have gotten."* The South African Government (2019a) emphasised the importance of immunisations to protect children against diseases such as polio, measles, hepatitis B and meningitis. According to the vaccine schedule used in South Africa (Department of Health, 2009), the child of participant 17 missed vital vaccinations at six weeks, ten weeks, 14 weeks and nine months as her mother only took her to the clinic at 18 months.

Category (ii): Challenges relating to the child's health

Various participants experienced challenges as a result of their children's illnesses or medical conditions. Some of the participants' challenges did not last long, as in the case of participant 1: *"She had jaundice … And I did not really get out with her."* Other challenges included transport to medical facilities, as recalled by participant 2: *"It was the whole time, and we could not get transport. And we called the ambulance, but they did not come out."* A small number of participants felt uninformed about their children's illnesses due to a lack of communication by the medical staff, as described by participant 4: *"I really wanted to know what the matter was with my child, but they [hospital staff] never told me … I don't know why he got ill. I still don't know."*

Several participants experienced challenges due to their children being hospitalised, as illustrated by the following quotes:

- Participant 5: "Yes, she was very ill and I was very tired, because I had to sit alone during the nights at the hospital."
- Participant 10: "And I was in and out [the hospital] every day … On some days I had to walk from [redacted] [town where the hospital is] back to [redacted] [town of residence] just to see if my other two children were okay, if they were in good care and if they had something to eat. Then in the evenings I had to hike from [redacted] [town of residence] to the hospital to be with [redacted] [child] again."

- Participant 16: “I was not with her at the hospital every day. Sometimes my mother and I rotated. I could come and sleep at home while my mother stayed with her. In the evenings, my mother was at home. Then I again slept with her [in the hospital] …”

Challenges such as mothers trying to cope while their children were in hospital, and the emotional impact of this, have been confirmed by literature. Doupnik *et al*. (2017) confirmed the psychological stress experienced by parents when their children are hospitalised. In a study on parenting a sick child focused on the challenges of parents caring for sick children along with balancing other caregiving roles (Carter, 2014). Also, enhanced stress to the caregiver caused by infant illnesses can impact attachment and lead to insecure attachment (Berk, 2013:435).

Participant 16 described losing the SASSA care dependency grant as she could not afford the transport money to take the child to the hospital out of town for the doctors to complete the necessary documentation. The South African Government (2019b) requires a medical assessment report as part of the application process for a care dependency grant. Participant 12 had to walk with her child to the clinic every day for two months, even in the rain, in order to receive her TB medication directly from the clinic staff. Participant 17 expressed her challenges regarding the child’s colon problems as she had to go for daily check-ups at the local clinic.

3.4.2.2 Sub-theme 2.2: Nutrition of the child

The quality of nutrition during the child’s first thousand days can have a lifelong impact on the health of the child. Proper nutrition can form the foundation for future health and development, while the consequences of malnutrition can last until adulthood (UNICEF, 2016a). Table 3.9 below illustrates the two categories indicated under the nutrition of the child.

Table 3-9: Sub-theme 2.2: Nutrition of the child

Theme 2: Health of the child during the first thousand days of life	
Sub-theme	***Category***
2.2 Nutrition of the child	(i) General nutrition and type of food intake by the child
	(ii) Challenges regarding nutrition and food

Category (i): General nutrition and type of food intake by the child

Prado and Dewey (2014:267,280) stated the importance of sufficient nutrition for normal brain development, especially during pregnancy and infancy. Adequate nutrition from conception through infancy provides the necessary energy, protein, fatty acids and micronutrients needed for healthy brain development, thus establishing the foundation for the child’s lifelong brain function. Children who are well nourished can better interact with others and their environment, which is

required for healthy brain development. However, inadequate nourishment and nutritional deficiencies during this crucial time can affect the child's cognitive functioning throughout the child's life, including the school years.

The following aspects regarding the child's nutrition and food intake surfaced during the interviews: the nature of milk feeding, the age at which children can consume solid foods and type of foods that children can consume. In this regard, various participants felt that their children ate healthily, as expressed by participant 3: *"He ate healthily and he still eats healthily*." Participant 7 also said: *"* [redacted] *[child] ate very well."*

Approximately half of the participants breastfed their children from birth. Only a few participants fed their babies formula milk, while others used mixed feeding, consisting of breastmilk and formula milk. The duration of the breastfeeding varied from a few days to over a year. The following statements from participants describe the duration differences:

- Participant 4: "Yes, I breastfed her up to six months."
- Participant 9: "Breastfeeding up to a year and a half, then she took herself off the breast."
- Participant 10: "And then [redacted] [child] did not want my breast anymore … and she was only ten days old."
- Participant 11: "[redacted] [child] was two or three months old when I took [redacted] [child] off the breast…"
- Participant 13: "Breast up to four years old."

Participants 7 and 12 both mentioned the health benefits of breastmilk. Participant 7's statement: *"… as the clinic and the doctors told me, breastmilk contains everything"* is confirmed by the Infant Nutrition Council (n.d.) which believes that breastmilk contains all the essential nutrients needed for the baby's growth and development. The council also believed that breastmilk contains immune-beneficial components, digestive enzymes and hormones that play a vital role in promoting the baby's health. Participant 12 added her beliefs regarding breastmilk: *"I've realised that bottle babies are slower than breast babies … breast babies are more clever than bottle children."*

Various institutions have confirmed the benefits of breastfeeding for the child – such as improved brain development, a stronger immune system, improved health and fewer infections – as well as for the mother – such as faster weight gain, fewer infections like urinary tract infections, the

reduced likelihood of certain cancers and stress reduction (Cleveland Clinic, 2019a; Office on Women's Health, 2019; UNICEF, 2005; Western Cape Government, 2019c; WHO, 2019f).

The British Pregnancy Advisory Service (2015) said that breastfeeding is not the only option as other ways of feeding an infant included formula feeding, expressed breastmilk fed through a bottle and mixed feeding, combining breastfeeding and formula feeding. The service stated that some mothers preferred alternative ways of feeding their babies as they experienced discomfort or inconvenience during breastfeeding, or they desired to share feedings with their partners. The participants agreed with this. However, only a very few participants gave their children a combination of breastmilk and formula milk, or only formula milk. Participant 1 mentioned: *"Actually she drank breast. Now and then, I made a bottle. So, she had breastmilk and bottle milk."* Participant 6 explained: *"… had to put her on Nan milk [formula]. Yes, bottle milk."* A few participants adhered to recommendations from the Association for Dietetics in South Africa (n.d) and the WHO (2003:7-8) by exclusively breastfeeding their babies for the first six months. Participant 3 noted: *"When* [redacted] *[child] was born, he first drank breastmilk. I gave him breastmilk up to six months."* The WHO's recommendations on breastfeeding have also been adopted in South Africa (Association for Dietetics in South Africa, n.d.). In addition, three participants mentioned giving their children a herb mixture called a "medicine bottle" which they believed assisted with acid reduction and digestion, as described by participant 15: *"When she was a baby, she got her medicine bottle on time … a herb bottle. We make it from African Wormwood ['wilde als'], to take with her food."* However, in the Department of Health's *Road to Health* booklet, launched in 2018, mothers are cautioned not to give any home remedies or traditional medicines to their babies during the first six months (Department of Health, 2018:4).

According to the participants, their children started to eat solid foods from as young as one month to approximately a year. Participant 1 shared: *"The child was not even a month. Then my aunt came … and she fed her cereal. Rice cereal."* Participant 10 commented: *"At two months I began giving* [redacted] *[child] her first cereal, her rice cereal and Purity."* The age from which babies are ready to consume solid foods, according to the Mayo Clinic (2019b), ranges from four to six months when the tongue can move food to the back of their mouth. However, the Department of Health (2016:10) recommends six months as the age at which to start a child on solid foods. This recommendation corresponds with the recommendations from a study titled 'Age at introduction of solid foods and feeding difficulties in childhood: Findings from the Southampton Women Survey' which showed that children introduced to solid foods at or after six months had fewer general feeding difficulties (Hollis *et al.*, 2016:749). A few participants adhered to the latter recommendations, as illustrated by participant 2: *"For the first six months he only had the milk and water that I gave him … And after six months he began eating cereal*." Participant 6

mentioned: *"… because at six months she started to eat the potato and pumpkin and squash that we cooked."* Other participants mentioned starting their children on solid foods later than six months – ranging from seven months to a year, as verbalised by participant 15: "*From a year she started to eat, yes*."

The participants showed an understanding of the type, texture and amount of food they had to give to their babies when they started on solid foods. Participant 9 explained: *"Like I always cooked carrots and a potato and sweet potato, and then I mashed it and give it to her."* The appropriate texture according to age is seen as important in the Infant Feeding Guidelines for Australia (Australian Government, 2013:10). UNICEF (n.d.) recommended small portions. Participant 3 gave small portions at a time: "*So, in the mornings it was just four spoons of cereal. In the afternoons I give him a vegetable, and in the evenings the food we ate. I mash it and then give him some of it, but not a lot, about two, three spoons*."

During the interviews, various participants referred to healthy food for their children, mentioning items such as yoghurt, fruit, vegetables, meat, rice, peanut butter and eggs. According to participant 1, her child ate the following: *"She liked a yoghurt. What I ate, I gave to her. Meat, fish."* Most of these food items are also specified in the Infant Feeding Guidelines for Australia as good food choices to ensure healthy nutrition (Australian Government, 2013:10, 12). Participant 7 explained her child's food intake: *"The squashes, butternut, potatoes, mashed. And if I gave him an egg, I made an egg sandwich."* Participant 17 received specific food from the clinic as the child was underweight: *"… because they [clinic staff] gave her that food to pick up weight [gain weight]. Every month, six packets of milk, six packets of cereal and six containers of peanut butter. I had to give it to her every day."*

A few participants mentioned giving their children commercialised baby food, as verbalised by participant 8: "*Yes, she ate cereal, baby cereal and Purity*." Interestingly, participant 11 and the child's paternal grandmother did not believe in commercialised baby food, as quoted: *"They talked about baby cereal and Purities. No, I did not believe in things like that. Grandmother herself also did not believe in things like that. When the baby started to eat, grandmother cooked food. Pumpkin food and those kinds of food. It was mashed so that baby could eat."*

A few of the participants listed some unhealthy food items consumed by their children during the infancy phase. Participant 4 declared: *"Sweets, very much so. He cried a lot over a lollipop when he was a baby. He was crazy about a lollipop."* Two participants made a type of cereal consisting of biscuits and water, as mentioned by participant 7: *"From one month onwards, I gave him some*

of those biscuits with the pictures, with the elephants, that I soaked in boiling water. Those glucose biscuits. I made it for him and then he ate it."

Several participants referred to their children's weight as healthy and normal, as voiced by participant 1: *"Her weight was fine. Everyone at the hospital then tell you your baby's weight is right."* Participants 14, 16 and 17 commented on their children being underweight, as explained by participant 17: *"She was smaller than the other children … because the child was small, smaller than a shoebox. The child's weight was not right. She was almost underweight, very, very underweight."* The Boston Children's Hospital (2019) listed various reasons for babies being underweight at birth such as premature birth, teenage pregnancy, multiple births, inadequate prenatal care, pregnancy complications, poor nutrition of the mother and prenatal substance abuse. Participants 14, 16 and 17 used substances such as alcohol or drugs during their pregnancy, which could possibly explain their children's low birth weight – as stated the Boston Children's Hospital (2019). A link was found between the intrauterine growth retardation of the child and prenatal exposure to Methamphetamine (Dahshan, 2009:88), as in the case of participant 17. According to the Boston Children's Hospital (2019) and Stanford Children's Health (2019b), the following factors, in addition to premature birth, could increase the risk for a low birth weight baby: infection during pregnancy, the mother's age, multiple births, substance abuse during pregnancy, poor nutrition, inadequate prenatal care, and birth complications. According to Mezmur (2017:7), risk factors such as birth weight, caregiving towards the child, family history, poverty and violence can play a role in the child's health, consequently affecting their development.

According to participants 8, 9 and 11, their children were overweight during this time period, as quoted by participant 11: *"She was a little bit overweight. The clinic said, 'Mommy, you must not give the child so much food'. The child's legs started to rub against each other."* A study by Ojha *et al.* (2013:821) showed that excessive feeding during pregnancy and infancy could be linked to the increased risk of obesity in adulthood. They associated this with metabolic health problems and referred to metabolic programming of the offspring due to extreme nutrient supply.

Category (ii): Challenges regarding the child's nutrition and feeding

Various challenges regarding the children's feeding were revealed during the interviews. These challenges played a role in the children's nutrition during this crucial time period.

Some of the participants could not breastfeed from the child's birth or for at least the first six months due to various challenges, as illustrated by the following quotes:

- Participant 2: “From birth he did not want to take my breasts.”
- Participant 6: “Because I did not have milk in my breast … I only had milk for two, three days, must put her on Nan milk.”
- Participant 10: “And [redacted] [child] did not want my breast … she was only ten days old.”
- Participant 11: “[redacted] [child] was two or three months when [redacted] [child] was off my breast because I had to go back to work. Not permanently – in the evenings she still got breastmilk.”

There were other challenges with breastfeeding as well, as stated by participant 5: *“The day she was born, we had to breastfeed. Then she did not want to drink from my breast. Then she was born past nine. She only drank on my breast by around three o’clock. The doctors worry that the baby must drink so that the oxygen can go to the brain … the oxygen to the brain was too little, because she did not breastfeed immediately.”* The WHO (2019f) emphasises the importance of breastfeeding within one hour after birth to ensure that the infant consumes the colostrum, called ‘first milk’, which is rich in protective factors. It seemed as if participant 8 experienced latching difficulties as described by Faure and Richardson (2016:40), because she said: *“No, she drank breast, but she only sucks, then she starts to cry. If I give her the bottle, then she drinks the bottle. My breasts were full, but she only drank a little bit, then left it, then she pulls herself up, then started to cry, and then I must give her the bottle.”* Participant 9 expressed her milk daily at work in order to give it to her baby in the evenings. According to participant 16, she had to receive additional TB treatment to prevent the baby from contracting TB through breastfeeding. Although the American Pregnancy Association (2019e) promotes breastfeeding, they acknowledge that it is not always possible for the mother to breastfeed as a result of, among others, medical illnesses or the mother producing insufficient amounts of breastmilk. Faure and Richardson (2016:41-42) regarded some of these challenges as normal, saying that breastfeeding is a skill that must be learnt by both the mother and the baby, and that mothers should be encouraged to overcome some of these challenges.

When some of the children in this study were introduced to solid foods, they encountered various challenges. Participant 2 experienced many challenges regarding her child’s feeding when he started to eat solid foods. There was a time when he refused to eat any food, except sweets and olives. She struggled to feed him and had to mix cereal with milk to form a drink, just to get something into his body. It is likely that this child suffered from pica, as described by his mother: *“And he loved sand. If he sees the sand … I went to the clinic to hear if he had an iron deficiency or what, as he just wanted the sand in his mouth …”* McNaughten *et al*. (2017:226) described pica

as the consumption of non-nutritive substances and confirmed that it is common in children, persons with learning disabilities and pregnant women.

Several participants recalled financial difficulty and often a lack of food as challenges that impacted their children's feeding. Participant 14 described this challenge: *"There was little food. There was not much. I had to walk with her [child], looking where we could eat. Come back and then I first ask her if her stomach was full … Then she said, no, it's okay, she is a little bit full now."* Participant 16 explained her challenge in this regard: *"We could not put her on formula milk, because there was no money. We bought her tea, added milk and so we started to teach her to drink bottle."* Participant 17 also referred to their financial challenges: *"If there was no cereal for the child and the child was hungry, I had to go and ask people so that she could eat."*

Nutritional deficiencies possibly occurred during this time due to lack of proper food intake. Poor nutrition during the child's first thousand days can cause stunted growth, leading to impaired cognitive development, as well as decreased school and work performance later in a child's life (UNICEF, 2019:10-11). According to Prado and Dewey (2014:267), nutritional deficiency experienced during pregnancy and infancy can have long-term effects, impacting these children's cognition and behaviour throughout their schooling and adult years. UNICEF, the WHO and World Bank Group (2018:2) explained that children could suffer from 'wasting' as a result of poor nutrient intake and/or disease. This can weaken the immunity and increase their risk of developmental delays and even death for nearly 51 million children under five years. They also explained how poor nutrition during pregnancy and early childhood can lead to stunting in children. Stunted children's brain development is affected, which means they will never reach their full cognitive potential, often resulting in learning difficulties at school. The Global Nutrition Report 2017 indicated that 155 million children worldwide are stunted due to chronic and acute malnutrition during the early years (Global Nutrition Report Stakeholder Group, 2017).

Although this theme only consisted of two sub-themes, the sub-themes and categories covered various aspects from birth to two years. The child's nutrition during pregnancy was not discussed in this section, since it was influenced by the mother's nutrition during pregnancy, which was referred to in Theme 1.

3.4.3 Theme 3: Availability of support to the mother and child during the first thousand days of the child's life

The following table (see Table 3.10) provides a summary of the mother's experience regarding support, as well as the type of support that was provided to the mother and child during pregnancy and after the birth of the child.

Table 3-10: Theme 3: Availability of support to the mother and the child during the first thousand days of the child's life

Sub-theme	*Category*	
3.1 Mother's experience regarding support	(i)	Other people's response to the announcement of the pregnancy
	(ii)	Mother's emotions and thoughts regarding support
3.2 Support from the child's biological father	(i)	Support from the biological father during pregnancy
	(ii)	Support from the biological father from birth to two years
	(iii)	Challenges in the relationship between the mother and the biological father
	(iv)	Relationship between the child and the biological father
3.3 Support from family and others	(i)	Support from family/others during pregnancy
	(ii)	Support from family/others from birth to two years
	(iii)	Relationship between the child and family/others

3.4.3.1 Sub-theme 3.1: Mother's experience regarding support

This sub-theme comprises of two categories: (i) other people's response to the announcement of the pregnancy and (ii) the mother's emotions and thoughts regarding support during pregnancy, birth and up to two years.

Table 3-11: Sub-theme 3.1: The mother's experience regarding support

Theme 3: Availability of support to the mother and the child during the first thousand days of the child's life		
Sub-theme	***Category***	
3.1 Mother's experience regarding support	(i)	Other people's response to the announcement of the pregnancy
	(ii)	Mother's emotions and thoughts regarding support

Category (i): Other people's response to the announcement of the pregnancy

According to the participants, the announcement of the pregnancy caused both positive and negative responses. Several participants were unmarried at the time and were still living with their families. This caused them to experience anxiety or fear before announcing their pregnancy. Some of the negative reactions from family members when they found out about the pregnancy are illustrated by the following quotes:

- Participant 2: "At the beginning of the pregnancy nobody in the home wanted to talk to me because they were very disappointed in me and that hurt me a lot."

- Participant 4: “She [participant’s mother] did not want me to fetch another child [fall pregnant], because it was the second one. Then my mom was very hard and strict with me. She did not really accept the pregnancy.”

- Participant 9: “Grandmother responded a bit differently. She was very shocked. She did not expect it from me.”

- Participant 16: “He [participant’s father] was very strict. He wanted to put me out [out of the home] …”

Although participant 3 was living with the child’s father during that time, her parents, as well as the parents of the child’s father, were not excited about the announcement of the pregnancy, as indicated by her quote: *“My parents and his [child’s father] parents kicked a bit against the cars [they were against the situation] because they said, ‘No, you cannot, life is already so difficult, you can’t have more children’…”* According to Fernández and Newby (2010:29), the rejection from family members due to the pregnancy, as seen above, can have a negative impact on the mother, including that they are least likely to seek prenatal care, eat healthier or look forward to their baby’s birth.

Participants 2, 5 and 16 were not married to the child’s father and their pregnancies were not planned, which caused various negative responses from these fathers. The mothers verbalised some of the responses when they told the child’s father that they were pregnant, as voiced by participant 2: *“He [child’s father] told me it was not his child. All those types of things – he degraded me.”* A similar response was also experienced by participant 5: *“Then he [child’ father] argued and said it was not his child and he wanted me to go for blood tests while I was pregnant.”* According to the American Pregnancy Association (2019f) it is quite normal for fathers to respond with shock in case of an unplanned pregnancy, especially when they are not married to the mother. They recommend that fathers consider the following together with the child’s mother during this time: decisions regarding the pregnancy, their relationship, as well as the future. Only participants 3 and 8 said that the child’s father had a positive reaction to the news of fatherhood, as articulated by participant 8: *“He [child’s father] was happy …”* Participant 3 said that the child’s father had a premonition about the pregnancy: *“He [child’s father] was always the one that picked up on things before the time. Maybe a month ago he said, ‘You are going to have another baby’. And he felt it was a boy and I felt it was a girl.”*

Category (ii): Mother's emotions and thoughts regarding support

During the semi-structured interviews, many emotions and thoughts regarding support from others were expressed by the participants. Many mothers felt supported during their pregnancy, as indicated by participant 1: *"There are people who helped and supported me."* Participant 9 said: *"So, help comes from all sides. But everyone supported me when I was pregnant."* The support received from others resulted in positive feelings, as illustrated by the following quotes:

- Participant 2: "And it [support] made me feel very happy."
- Participant 15: "But the support made me very much … I appreciated it a lot."
- Participant 16: "He [friend] made me feel that there was hope. At least there are people who care."

As confirmed by Zastrow and Kirst-Ashman (2013:31), each individual is interdependent on other people; we cannot exist without others. This interdependence and the reliance of these mothers on other people are evident from their statements. Nurullah (2012:184) explained how the nature and quality of support received from others could influence a person's health and well-being – as witness in this study. In addition, Mputle (2019:63) confirmed that good support to mothers from their partners, families and professionals during the child's first thousand days can promote healthy behaviour for both the mother and the infant.

Some of the participants indicated a lack of support during their pregnancy. The following quotes illustrate the negative emotions and thoughts regarding support from others:

- Participant 2: "It felt that everyone turned their backs on me, and I thought it was going to be like that for the rest of the pregnancy."
- Participant 4: "But I take it like this, my mother was not going to support me with the child and I must now sit it out alone – all those problems."
- Participant 12: "It is difficult if you are pregnant and you don't have good support."
- Participant 13: "And then for me it was a battle, it was sad. I had nobody."
- Participant 17: "And there was no help."

From the comments above it is clear that these participants experienced a lack of support and a sense of loneliness during the pregnancy. According to Perinatal Anxiety and Depression

Australia (2017), lack of support has been identified as a risk factor that could cause pregnant women to be more vulnerable to depression and anxiety.

Participant 11 had people who could support her, but she was very independent and chose not to rely on others: *"Now I feel I don't want to bother people with my stuff. I am equipped to stand on my own feet [be independent], and if I saddled up the horse, then I must ride the horse [taking responsibility for her own actions]. I can't expect other people to help me. I don't want to be a burden to other people. Maybe there were people who could have helped, but I maybe didn't see that they wanted to help because I didn't seek others' help."* This participant expected the child's father to support her: *"… but the help that the father gave, is the help what he must give. It is the maintenance that he must give. He must now take responsibility … it is not that he [child's father] very much wanted to do it, it is because he must. It is his responsibility. He must provide, he must provide for the baby's things."*

According to Rosa and Tudge (2013:244), the Bronfenbrenner's bioecological theory of human development views human development as evolving from the interaction of the individual and context. Tudge *et al.* (2016:428) explained that Bronfenbrenner's bioecological theory incorporates the PPTC model, involving the synergistic interconnection of four elements, namely proximal processes, person characteristics, time and context. In view of this, the impact of proximal processes, thus the interactions and relationships of the mother and others, as well as the child and others in this study is very prevalent.

3.4.3.2 Sub-theme 3.2: Support from the child's biological father

Fathers can have a major influence on their child's mental health from pregnancy to adolescence and help them to build positive relationships. Additionally, they could create a co-parenting alliance with the child's mother even if they do not live with them (Khan, 2017:9). This sub-theme, as outlined in Table 3.12, consist of four categories relevant to support from the biological father to the mother and the child, as well as relational aspects between these parties.

Table 3-12: Sub-theme 3.2: Support from the child's biological father

Theme 3: Availability of support to the mother and the child during the first thousand days of the child's life		
Sub-theme	***Category***	
3.2 Support from the child's biological father	(i)	Support from the biological father during pregnancy
	(ii)	Support from the biological father from birth to two years
	(iii)	Challenges in the relationship between the mother and the biological father
	(iv)	Relationship between the child and the biological father

Category (i): Support from the biological father during pregnancy

The following participants experienced good support from the child's father. The statement of participant 3 illustrates emotional and practical support: *"And when the man come home, then we talked, and he would always ask me how I felt, if I was okay, if the child was okay or if the baby kicked … And if maybe I did not make any food, he would say, 'No, you can sit down'. Then he kept himself busy with the food and I could just dish up."* Participants 8, 9 and 12 were accompanied by the father to the hospital or clinic for their medical visits, as stated by participant 9: *"If I had to go to the hospital, he [child's father] was there. If I had appointments, he came through."* Even though participant 8 and the child's father were both still teenagers, he provided excellent support to her, as she described: *"Oh, if my feet were swollen, he massaged it. He was there … If I had my date at the hospital, he came along. He wanted to know what the doctor said, and he gave his opinion also. He was always there. I never had to go to the hospital on my own. He was always there."* Participants 1 and 18 both felt that the child's father supported them, even though these fathers were unemployed at that stage, as voiced by participant 1: *"The boy … her dad was there although he did not work."* Participant 7 summarised her feelings regarding the support from the father in this statement: *"Honestly, I must say, my husband was my best supporter."* Participant 15 added: *"… and her dad assisted me with the pregnancy."* The C.S. Mott Children's Hospital (2018) highlighted the importance of the biological father's support to the mother, which comprises of physical and emotional support. The hospital provided practical recommendations to the fathers to promote feelings of support to the mother. These recommendations included attending the medical visits with the mother, encouraging her and showing affection, assisting with the cooking and cleaning, and giving her a back or foot massage to relieve stress. Good support during pregnancy can result in the mother feeling happier and less stressed, which is good for the baby too. A study conducted by Tanner-Stapleton *et al*. (2012) concluded that high-quality support from the mother's partner during pregnancy can improve maternal and infant well-being.

However, not all the participants felt supported by the child's father. Although the father of the child was present at the hospital during labour, participant 2 expressed a lack of support from him during the pregnancy: *"And he was not someone I could rely on because I endured it [the pregnancy] alone. It is because the father could not help me."* Participant 13 also felt unsupported: *"He did not help me. He was only there because he had to, but he never helped me like other dads helped their wives or girlfriends. The dad did not assist me fully and he did not have a permanent job."* The impact of the lack of support from fathers, as seen above, has been confirmed by the National Fatherhood Initiative (2016). According to this initiative, mothers who lack support from the child's father are more likely to have complications during pregnancy.

Category (ii): Support from the biological father from birth to two years

The support or lack of support from the fathers were mentioned during the data collection. A few of the participants mentioned the father's presence at the hospital during the delivery, as confirmed by participant 2: *"Then his dad was also there the day I went into labour. His dad was also there."* Participant 3 was well supported during the delivery, as described: *"And he was with me and we went to the hospital. When I got the pains and pushed, I held his hand, I held on tightly."* The biological father of participant 8's baby became very emotional during the delivery of the child, as revealed by participant 8: *"The father also cried, because they [hospital staff] said they don't know if she had moved to the uterus … he thought she was going to die. [After birth] He said she looks just like me."* Participant 9 explained the following: *"Sunday morning, I gave birth and he [child's father] came during visiting hours that afternoon."* The American College of Obstetricians and Gynecologists (2016) stated that mothers may be less anxious during pregnancy and labour when they are well supported by the father, and they provided practical guidelines for fathers to support the mother during labour. Davidson et al. (2014:1102) confirmed the importance of father's presence during the birth process, describing how he could influence the mother's perceptions in a positive way and enhance her feelings of control.

Participants 1 and 7 referred to the father's practical support after the child's birth, as noted by participant 1: *"He helped me with her a lot. When I was washing her [child] clothes, he carried her, took her to his mother's."* Participant 7 elaborated: *"Then he cleans up, and he puts on the rice and peels the potatoes. He was my best supporter. He helped me with everything. He supported me. He was my best helper."* For participant 5 the support from the father was mostly financial: *"… but he paid my money every month."* Participant 9 experienced more than financial support: *"And when [redacted] [child] was born, then he [child's father] … he maintained her … He came to visit and then he went home."*

The White Paper for Families in South Africa (Department of Social Development, 2013:40) highlighted the importance of the role and support of the father by encouraging father involvement as part of its strategic priority to promote healthy family life. The National Fatherhood Initiative (2018:9) also emphasised the important role that fathers can play in transforming their children and family's lives by being a responsible father.

However, participants 2, 5, 13, 14 and 16 did not feel supported by the child's father. Participant 2 felt: *"And then his dad came again. Then he works, then he leaves his jobs. It just felt to me that the child was not important to him and that he feels there is someone he must maintain."* Although participant 5 received financial support from the father, he was not involved: *"… but he was never*

there for her." Participant 13 still felt unsupported, even though the father was present as mentioned: *"… but he never contributed. The father was there, but he did not worry."* Participants 14 and 16 also experienced a lack of support, as mentioned by participant 16: *"We did not receive any fatherly stuff [financial support] from the father, nothing. [redacted] [child's] father did not provide any earthly possessions … no support. … He never supported [redacted] [child] financially."* It is thus clear that these mothers lacked emotional and physical support from the child's father. In this regard, Khan (2017:9) noted that fathers do not always receive guidance and support to be the best fathers, and that their own mental health was often neglected. Due to certain stressors and their own circumstances, many fathers struggled to support their families as they should, and ended up distancing themselves from the child and mother.

Category (iii): Challenges in the relationship between the mother and the biological father

Several participants expressed challenges in their relationship with the child's father. Interestingly, these participants were not married to the child's father, which contributed to aspects such as an unstable relationship and maintenance issues. Participant 5 only had a once-off sexual encounter with the father, resulting in the pregnancy. Due to the absence of a relationship, their personal contact was limited to about two times after she had told him that she was pregnant. Participant 9 explained the ending of their relationship: "*When he found out I was pregnant things were a little bit … were not well. So, he … we broke up when I was two months pregnant."* Participant 2 described her unstable relationship with the child's father until they broke up permanently when the child was two years old: *"He hurt me very much emotionally when he said the child was not his. All those types of things, he degraded me. There was a time that I left him. Then I gave him another chance for the child's sake. During the pregnancy, we went out twice. It was very difficult for me, but I've accepted it. Then he was drunk and we always argued … I could not do things with him anymore, like the times we went out … And that made that our relationship was not going so well."* She also expressed her feelings about him being the father: *"I was very regretful. Sometimes I felt I regretted it that I've met him … sometimes there were regretful thoughts that he was the father of the child."* Participant 17 was living with the father, but their relationship was very hostile and characterised by problems such as his psychiatric disorder, physical abuse, substance abuse, criminal activities and adultery, as summarised: *"I have an interdict against him… He is stealing and doing drugs. Said to him, 'I will never be able to trust you again because your betrayed me with my sister'. I will always have a grudge against him for what he did to me."*

Participant 14 described her adverse relationship with the father as follows: *"The father, because he made me stress more, because why … often, there was nothing to eat. Then there were times when we scolded each other and we fought with each other. And there is stuff that he uses, it is*

drugs … Then he lied to me. He told me the people paid him short …" Participant 16 struggled with maintenance issues, as voiced: *"If I report him for maintenance in* [redacted] *[one town] and then he runs to* [redacted] *[another town] … so I could never get a fixed address to give to the court."*

The Hall Health Center at the University of Washington (2016) outlined various characteristics of an unhealthy relationship, many of which correspond with some of the challenges the above-mentioned participants experienced in their relationships. These included arguments not settled fairly, yelling, physical abuse, a lack of fairness and unequal control of resources.

Category (iv): Relationship between the child and the biological father

Quite a number of participants made no mention of the relationship between the child and the father.

Only five participants said that their children had a good relationship with their biological fathers. Participant 1 stated: *"He was very, is very mad about her [fond of the child]."* Participant 6 voiced: *"When her dad arrived [home from work], then she was dad's child."* Participant 8 described the father as being very protective and close to his daughter. Although participant 9 and the child's father were not in a romantic relationship anymore, he continued to build a relationship with this daughter, as explained: *"And* [redacted] *[child's] dad came … they are so close."* Participant 15 shared that the child's father unfortunately died before the child turned one, and her statement illustrated his involvement in his child's life: *"He was looking forward to her [first birthday], because he told his friends and he wanted to give her a nice birthday … party."* The positive impact of father involvement is confirmed by literature. A summary of the research evidence on the effect of father involvement shows that father involvement has significant implications for their children's social, emotional and cognitive development (Allen & Daly, 2007:1). According to Child Crisis Arizona (2017), fathers can impact their children's development in the following five ways:

- Increase their emotional intelligence and problem-solving skills
- Boost their confidence and improve their self-esteem
- Reinforce good behaviour by positive role modelling
- Provide a different perspective to life's questions
- Promote emotional well-being through love and encouragement.

However, some of the participants talked about the poor or absent relationship between the child and the biological father. Participant 5 specified: *"But he was still with her at three months and then he did not come again … When she was two years old, he came again, but then she did not want anything to do with him …"* Participant 13 verbalised: *"Their dad never played with them like I played with them. When her dad came there at times, then she did not worry about him."* Participant 16 recounted: *"… did not give her maybe the fatherly love. That's where she became somewhat confused. The one week she saw a man that said he was her dad and the other week he was just missing and gone."* Absent fathers or poor involvement, as seen in this study, is a worrying trend in South Africa, where only 28% of children were living with both parents in 2016 (Department of Health, Statistics South Africa, South African Medical Research Council and ICF, 2019:16). McLanahan *et al*. (2013) reviewed 47 research articles on the effect of father absence and found strong evidence that father absence negatively impacts a child's social-emotional development. This impact continues into adolescence and can increase risky behaviour like smoking or teenage pregnancy. They further discovered that the psychological harmful effects throughout a child's life affected their mental health as adults. Additionally, they said that these effects may be more pronounced if the absence of the father occurred during the child's early childhood years.

3.4.3.3 Sub-theme 3.3: Support from family and others

Table 3.13 provides a summary of the three categories indicated under this sub-theme on support from family and others. These categories are: (i) support from family/other during pregnancy, (ii) support from family/others from birth to two years, and (iii) the relationship between the child and family/others.

Table 3-13: Sub-theme 3.3: Support from family and others

Theme 3: Availability of support to the mother and the child during the first thousand days of the child's life	
Sub-theme	***Category***
3.3 Support from family and others	(i) Support from family/others during pregnancy
	(ii) Support from family/others from birth to two years
	(iii) Relationship between the child and family/others

Category (i): Support from family/others during pregnancy

In total, 14 of the 18 participants indicated specific family members who supported them well during their pregnancy. This support included advice, practical assistance, emotional support and financial support. Participants 2, 3, 5, 7, 14, 15, 16 and 18 named their own mothers as supporters. The support of participant 2's mother influenced her thoughts on considering an

abortion, as she described: *"One day I just said to my mom that I had gone to the clinic to find out [about the pregnancy] and they [clinic staff] asked me about the option for abortion. Then my mom said, 'No, abortion is not an option'. She would help me."* Her mother also accompanied her to the hospital visits when she [the mother] was not working. Participant 16 had a similar story: *"And my mom had my dad understand, if I go for an abortion, then it is murder and then she is just as guilty as me."* Participant 5 highlighted her mother's support: *"My mom supported me. I always told her I craved bacon, then she always brought me bacon … She always made the vegetable dish, because I loved it. She supported me a lot during the pregnancy."* Support in the form of food or baby goods were provided by the mothers of participants 2, 5, 14 and 18, as illustrated by participant 18: *"My mother also helped us, maybe buy Kimbies [disposable nappies] and so. My mother used money from her pay to buy Kimbies and what the baby needed. So, it was only my mom … who contributed financially or who bought clothes and stuff."*

Participant 9 grew up with her grandmother as she was placed in her foster care after her mother was murdered by the participant's father when she was very young. When participant 9 fell pregnant, she was staying with her grandmother, brother, aunt and her cousins. She felt very supported by them, especially her grandmother, as quoted: *"But grandmother supported me in everything I needed. She support me, because my mom was not there … my grandmother always did things, like putting my feet in a foot spa. She would make me tea. Grandmother supported me in everything. Like if I sat up in the evenings with pain, she was there. Grandmother spoiled me the most. Every day, grandmother bought me fruit and chips and such things, popcorn."* She also referred to support from her aunt and the rest of the family staying in the home: *"If my aunt was at home, she would say I must come sit with her and talk. Then she would sit with me and rub my back or massage my feet. So, everyone who lived in the home supported me."* It is clear that participant 9 received ample support in the form of practical, emotional and material support.

The participants also mentioned the support from family members like their own fathers, aunts, cousins, older adult children, younger children in the home and, in some instances, the family of the child's father. Participant 2 had little contact with her own biological father since the age of six when her parents separated, but the pregnancy caused her father to make contact again, as she recalled: *"Before the child was born, then he [participant's father] started to make more contact. He phoned, he regularly visited to see what I did. My dad came to support me a lot with* [redacted] *[child], the last part of the pregnancy."* The father of participant 12 also supported her, but mainly financially. Participant 3 felt supported by her other children who were in primary school during her pregnancy, as quoted: *"They were very helpful towards me. They would always get up … and make us a cup of tea."* Participant 4 became emotional during the interview when she described the impact of the support from her three cousins: *"In the first place I wanted to have an abortion,*

but then my cousins told me it was not necessary. My cousins love me. They actually did a lot for me. Like they walked with me to the hospital. They bought baby goods …"

A study by East *et al*. (2019) emphasised the importance of support to pregnant women from caring family members, friends and health professionals. This study assessed the impact of programmes offering additional social support to women at increased risk of low birth weight babies and concluded that women who received such support may be less likely to have a low birth weight baby and may also feel less depressed. The Victoria State Government (2018) stressed the importance of support to pregnant women during this life-changing time. Hence, they provided guidelines for support – such as practical assistance, conducting certain household chores, emotional support, attending medical visits with the mother, encouraging her to eat healthily, and helping her to prepare for the baby's arrival.

Various participants mentioned other people supporting them, such as neighbours, friends, colleagues and staff at the local clinic. This support included practical support, emotional support or both. Participants 1 and 4 felt supported by neighbours, as noted by participant 4: *"And neighbours, yes, they cared a lot."* Support provided to participant 2 was described in the following way: *"It was a friend of mine, she went with me to the clinic when I found out [about the pregnancy] and she was the only one who knew in the beginning. And I trusted her with everything, how I felt at that moment, and she would cheer me up."* Participant 18 also felt supported by her friends: *"Your friends understand … because you have TB, you must eat. And if I went to them, they would give me a sandwich and so."* Participant 9 was a waitress and described the support from colleagues in the following way: "*And at work, they [colleagues] did not want me to carry things, even plates. They said, 'You take orders, then we take the food out. You can take coffees, but do not carry heavy things or move things …' So, it was nice at work because people, they wanted to do everything."* Participants 3, 16 and 17 singled out the support from clinic staff, as voiced by participant 3: *"They [clinic staff] would ask, 'How are you? Where are the other children? And are you okay? Is the husband still there?' And that is the support that they gave me, like hugs or so."* Participant 16 added: *"Say I couldn't talk to my mother or I couldn't talk to my sisters, I couldn't confide in them, then I could talk to the clinic sisters."*

The Department of Health (n.d.a) in South Africa recognises the importance of support during pregnancy to the benefit of a healthy mother and baby. From 1 April 2017, to help ensure proper support for a healthy pregnancy, the antenatal visits in South Africa have been increased from four to eight during pregnancy. These visits include discussions about the mother's mental health and offer emotional support. The mother is also encouraged to choose people like the father, family or friends to form a support system and to accompany her to the antenatal visits. The

significance of support was also emphasised by a study on the impact of social support on pregnancy anxiety, which highlighted the correlation between pregnant women's anxiety levels and support. The researchers indicated that pregnant women's anxiety levels decreased when support from other people increased (Duman & Kocak, 2013:1161).

Some participants experienced a lack of support from certain family members. A few participants either experienced a total lack of support from the family or only from specific family members. Participants 2 and 18 did not receive any support from the family of the child's father. Although participant 18 was living with the child's father in his mother's home, she felt: *"There was no assistance from them."* The following quotes also describe the participants' lack of support from family members:

- Participant 11: "Okay, I have parents, but my mom and dad are divorced. My mother lives her own life and my sister, she is also married, she also has her own life."

- Participant 12: "So back then, there was no … like family that could help us and maybe say, 'Here, let's help you'."

- Participant 13: "Although my mom was there, her cousins, aunts … they did not help me. I went through everything on my own."

Fernández and Newby (2010:28-29) found that the lack of support from family, particularly from the pregnant woman's mother, appears to have the most impact on the pregnant woman's attitude and behaviour. A recent study found that pregnant women lacking family care and social support have a higher risk of depression, prenatal stress and anxiety (Xian *et al.*, 2019:299).

Category (ii): Support from family/others from birth to two years

A few participants mentioned family members who were present at the hospital during the baby's delivery. Participant 7 referred to her mother's support: *"I went to the hospital and I thought, but that is my mom's voice, saying, 'My child, does the child have clothes? Does the child have a nappy?' … She was there for me."* For participant 16, her brother's support made a big impact to her: *"My brother came down [to the hospital] and brought me stuff. My brother said, 'Brother's child' [speaking to the child] and I knew that he would help me."*

During the interviews, many participants recalled receiving support from family or others during the period from birth up to two years, as shown by the following quotes:

- Participant 1: “There were people who helped me, my aunt and uncle. She [participant’s aunt] helped me. Yes, she was like a mother to me.”
- Participant 2: “My grandmother and them were there for me and for [redacted] [child] all the way.”
- Participant 16: “Yes, my mom supported me a lot.”

A few participants described how their own family supported them financially by providing for their or the baby’s needs. Participant 1 recalled: *“If there was no Kimbi [disposable nappy], then she [participant’s aunt] always scratched in her purse to go and buy some.”* Participant 12 felt supported by her sister: *“When she [participant’s sister] came, she came with a bottle, massage stuff, or powder or toiletries for me. She gave me pocket money and bought cooldrink or fruit.”* Participants 11, 12, 14 and 15 received baby goods from the family of the child’s father. Participant 11 voiced*: “The baby was, like they say, spoiled. And grandmother and grandfather were buying all the time.”* Participant 12 said: *“And his [child’s father] mother and them and his sisters, brothers also bought clothes. Supported well. Even his cousins too.”* Participant 15 also confirmed support from the family of the child’s father: *“Her [child] father’s people have always been supporting me, even today still. Yes, they bought her Kimbies [disposable nappies] and clothes.”*

Various participants explained how their family provided advice or practical assistance with the baby. Participant 2 said: *“Then I always came to my mom to help me or so. Because sometimes my mom saw, my mom could see that I was tired. Maybe he [child] did not sleep at night and when the teething started. Then my mom always helped. Then I rested a bit if she was at home, then she took him. So, she helped me with him a lot.”* Participant 9 had support from her grandmother, cousin, brother and aunt who helped her in the following ways: *“My brother always played with her. Then he would say, ‘Go and rest for a while, then I will play with her’. My grandmother liked to tell me what I must do and what I must not do.”* Participant 12 commented: *“She [participant’s aunt] supported me to care for her [child]. She helped to bath, to massage her, did her washing, even did all our washing. She bought clothes too. If she still had money left, then she would buy clothes.”* Participant 17 explained how her mother helped her: *“My mother wrapped her [child] in a blanket. Then my mom said, ‘You must cover the child like this’.”* Additionally, participants 4 and 11 indicated that the child’s grandparents looked after the child while they were at work.

The national campaign Side-by-Side, which was launched in South Africa during November 2017, assists mothers with their child-rearing journey. They promote the importance of support to the mother from significant others, proclaiming the message that it takes a village to raise a child. Their message – ‘Together, we can ensure that South Africa’s youngest children receive the care

they need to survive and thrive' – portrays the significance of support to young children and their mothers (Side-by-Side, n.d.).

The participants also mentioned other people who supported them during this time period. Participants 2 and 16 met new male friends who accepted their children and helped them with their children, as voiced by participant 2: *"Then I met him [friend] and grew up with him and then he turned into the one who helped me with* [redacted] *[child] … I could I always rely on him."* Participant 16 added: *"* [redacted] *[child] was six months old when I met* [redacted] *[friend]. He took me and accepted her [child] as his own … He made sure that the child had everything …* [redacted] *[friend] was the one who supported her, raised her. When I worked … then he preferred to look after her rather than ask somebody else."*

Participants 12 and 13 received support from their friends, as participant 12 remarked: *"Even my friends – they supported me by maybe holding her when I was busy at the home or so. They also bought clothes, massage things. This is what a person's friends must do when you are in need."* Participant 13 had a good friend who looked after the child during the day when she was working. Participant 9 experienced the crèche staff as very supportive*: "So, they [crèche staff] were actually very nice. That was very nice of them, because you don't actually get people who will wait for you to come and fetch your child."* According to participant 11, her manager and colleagues supported her in the following way: *"Then they [colleagues] would ask, 'Where is baby?', and I would say, 'Baby will come'. One day I asked my manager if it was possible to have my child with me on certain days when I didn't have so much work … just for ten minutes, twenty minutes or so when the shop was quiet. Then he said it was fine."*

Davidson *et al*. (2014:1056) mentioned the mother's increased need for support during the postpartum period, emphasising the importance of a support network to improve the psychological outcomes of the mother. They noted that women without friends and family to support them are at a higher risk of isolation and postpartum depression.

Some of the participants felt they received no support from family such as their siblings, the family of the child's father and their own mother. Participant 4 noted: *"Our sister and brothers talk to each other, but we do not worry about each other."* Participant 8 stayed with the family of the child's father and expressed: *"I asked nothing of them, and they asked nothing of me. And we did not talk together like family … not at all."* She also referred to her own mother: *"She [participant's mother] worked for herself and I did not even put in the effort … to go to her, even though she lives close by. I am not going to tell her my children need bread, or the children need this."* Participants 16, 17 and 18 did not get along with the family of the child's father. As participant 17

mentioned: *"Because the grandmother [mother of the child's father] did not worry about what happens next door. If I needed something, I had to go and get it myself."*

Category (iii): Relationship between the child and family/others

Participants 2, 4, 5, 8, 11, 13, 15 and 16 stayed with the child's maternal or paternal grandparent(s) in the same home where the grandparent(s) played an integral role in the child's life. Participant 4 described her child's relationship with his grandparents: *"… and stepdad and my mother were very fond of him … he crawled deep into my stepdad and my mother's heart. So, he was with them most of the time when I was at work."* This participant also said: *"He [child] was closer to them [grandparents] than to me."* This indicated that the child had formed an attachment with his grandparents instead of with the mother, which was understandable as the mother was working long hours and only saw her child once a week. Participant 5 said: *"When I brought her home [from the hospital], they took over the child. I never really had her for myself at birth, because it was grandmother's child."* The following statement from participant 11 described the child's close relationship with her paternal grandparents*: "And from that time [when the participant started working], [redacted] [child] slept with grandmother and grandfather. [redacted] [child] never slept with me again. Grandmother and grandfather's baby. Like I said, it was their child in the home. Everything was about the baby."* Participant 16 felt her mother had a special love for her child due the child's kidney disease: "*My mother loved [redacted] [child] very much because she was the sick baby."*

Participant 9 lived with her grandmother, and it was clear that the child and her great grandmother had a close relationship: *"She [child] loved grandmother very much … She [participant's grandmother] loved [redacted] [child] very much. [redacted] [child] looked like grandmother."* Although participant 7 lived with her husband and children, her mother and father would come to visit the child: *"When she [participant's mother] came to see her grandchildren, especially the two [youngest two children], then she was there for all my children. Or he [participant's father] would come to see what the boy was doing … He would look at [redacted] [child] and stroke his head."* Participant 14 also did not stay with her mother but felt: *"And my mother and them are so fond of her. They give her whatever they can give her …"*

The participants also mentioned other family members with whom the child had a good relationship. Participant 1 revealed: *"Because she [participant's aunt] took it … so now, it is her grandchild. She is very fond of her."* Participant 2 felt that the child's paternal grandmother was not really fulfilling this role, but that the aunt of the child's father was more of a grandmother to her child, as explained: *"That aunt loved him [child]. She is no longer here today. But she made*

as if [redacted] *[child] was her own grandchild. … She was virtually his grandmother … That role, that bond between them … He called her grandmother … because she made him feel that she was his grandmother. She always sent the children to fetch him. She made time to be part of his life."* Even though participant 5 had a poor relationship with her brother and sister, they we very fond of the child, as noted: *"Yes, he [participant's brother] loved her very much and my sister was also fond of her."* This participant further explained her child's relationship with them: *"As she [child] then knew who was who, she was very fond of my mother and my sister."* Participant 7 spoke of the child's relationship with his siblings: *"He was really spoiled by his sisters. They dressed him up … They were crazy about him."*

Referring to the importance of the relationship between the child and others, Lavis (2016) said that humans are social beings and that their capacity to form relationships is a key component for a sense of well-being. She specifically mentioned that other people's interaction with the child during its first thousand days could impact his/her development. The Center on the Developing Child of Harvard University (2019a) noted how crucial relationships are for the development of a child's brain architecture during the early years. The National Scientific Council on the Developing Child (2004:1) confirmed that the relationship with others affected the young child's intellectual, social, emotional, physical, behavioural and moral development. Hence, the quality and stability of the child's relationships with others lay the foundation for later outcomes – such as the motivation to learn and to do well at school.

Participants 2, 5, 9 and 16 spoke about other men fulfilling the role of a father figure in their child's life, as illustrated by the following quotes:

- Participant 2: "… because he [participant's friend] loved [redacted] [child] very much."
- Participant 5: "… because the godfather that raise her, like an own dad up to now … she was very fond of him. There was a stronger bond between them than what she had with her dad. And she calls him 'daddy'."
- Participant 9: "So the husband that I have is actually not [redacted] [child's] dad, but he loves her very much. They get along well."
- Participant 16: "He [participant's friend] took me and her, and accepted her as his own child … because he is the only dad that she has known from her baby time …"

A few participants mentioned family members who either had no relationship or a poor relationship with their child. Participant 1 shared: *"My dad was not there for us. No, he was there somewhere*

… but he still did not know she [child] was my child." Participant 2 explained the paternal grandmother's response to the child: *"His [child's father's] mother and they were very strange towards my child. Like she never picked him up, or like other grandmothers came to fetch him or made time for the child. Then I took him to them, but he always cried when she picked him up. But I never knew why … he must have felt something, a baby can feel if someone is not friendly…"*

The significance and nature of support to the mother and child from various people – like the family and the child's father – was outlined in this theme. The next theme will look at the circumstances of the mother and the child during the first thousand days of the child's life.

3.4.4 Theme 4: Circumstances of the mother and the child during the first thousand days of the child's life

The circumstances, relating to the living and financial circumstances of the mother during pregnancy, as well as the circumstances of the mother and child from birth to two years, are discussed in this theme. Table 3.14 shows the two sub-themes with their categories.

Table 3-14: Theme 4: Circumstances of the mother and the child during the first thousand days of the child's life

Theme 4: Circumstances of the mother and the child during the first thousand days of the child's life	
Sub-theme	***Category***
4.1 Living circumstances	(i) Living circumstances during pregnancy
	(ii) Living circumstances from birth to two years
4.2 Financial circumstances	(i) Financial circumstances during pregnancy
	(ii) Financial circumstances from birth to two years

3.4.4.1 Sub-theme 4.1: Living circumstances

The social environment, according to Zastrow and Kirst-Ashman (2013:29), refers to an individual's conditions, circumstances and interaction with others. The social environment involves the person's physical setting including their type of home and their interaction with other systems such as family, friends and healthcare. Table 3.15 provides a summary of the two categories in the sub-theme pertaining to living conditions. These living conditions or social setting of the mother and child refer to two phases, namely the pregnancy phase and the period from the child's birth to two years.

Table 3-15: Sub-theme 4.1: Living circumstances

Theme 4: Circumstances of the mother and the child during the first thousand days of the child's life	
Sub-theme	***Category***
4.1 Living circumstances	(i) Living circumstances during pregnancy
	(ii) Living circumstances from birth to two years

Category (i): Living circumstances during pregnancy

The participants referred to various aspects of their living circumstances, including the general experience, whether good or poor, the relationship dynamics in the home, and the physical living circumstances. More than half of the participants referred to positive aspects regarding their living circumstances during their pregnancy. These participants described their general circumstances in a positive way, as stated in the following quotes:

- Participant 1: "My living circumstances were good. We got along at home. I stayed with my aunt, where I am still staying. There were no problems."

- Participant 3: "When I was pregnant with [redacted] [child], we already had our own place. We did not stay in a built house but in a bungalow. I was at home and my husband worked. We were married already. There were other children in the house as well. And the circumstances in the house were lovely."

- Participant 6: "There were no problems when I was pregnant. We stayed, me and [redacted] [child]'s father, my fiancé … we stayed in a flat, rented. There were no problems."

- Participant 7: "My circumstances with [redacted] [child] were more secure than with the other children, because I stayed on my own and was married. When we moved to the new side, my husband did not know about alcohol and smoking and such things … I was married, newly married when I found out I was pregnant. To be honest, it was good."

These participants either stayed on their own with the child's father or with family. The physical circumstances included various types of housing such as informal structures, flats and houses. Participant 2 stayed in an informal structure with her mother in her grandmother's yard, but when she fell pregnant the grandmother extended her house so that she could move into the house with the baby. Participant 9 described her favourable circumstances: *"We stayed on the farm, stayed with grandmother. It was very nice. So, it is my grandmother, my aunt and it was me and my two cousins and my bother. We stayed together in one house, so our environment was very nice. We made it nice for ourselves. We always went out. And it was nice to stay on the farm,*

because everything was comfortable … it's just nice. There was electricity. There was water … the house was grandmother's … but had a very pleasant stay with her."

However, many participants shared negative aspects about their living circumstances during this time:

- Participant 5: "I stay in an informal settlement. It was an informal house, wooden house."
- Participant 15: "Circumstances were not so nice … we stayed in a structure … When I was pregnant there was no power in the house. We used candlelight and gas stoves. Yes, there was water, only outside or we had to tap water at other people's places and then those people wanted to be paid for the water."
- Participant 17: "In the structures, where we were staying. The circumstances were not nice … it was difficult, but we stuck it out. No, there was none [water and electricity] at the time."
- Participant 18: "Yes, her father [the child's father] and I stayed at his mother and them in the flat. But because there were too many bugs in the bed, I decided … that we must make ourselves at home in the bathroom, because of the itching … there are no bedbugs there, so we made ourselves at home there."

Participant 8 stayed with the family of the child's father, but the house was overcrowded, creating an unfavourable environment, as illustrated by the following description: *"I stayed with my mother-in-law … I guess twenty [people living in the house], because it was brothers, children, and my father-in-law's sister's children. There were a lot of people in the three rooms. We did not have our own room. We slept in the sitting room … on a mattress and so we got used to it. Not married yet. There were too many people in the house. Everyone had their own problems and the one ranted over this and that one ranted over that. Sometimes, there was no food and they scolded each other or fought or stabbed each other with a knife. So, this is how it went in the house every day."* She added that there was no electricity at the time and that her mother-in-law was mentally and physically ill. Participant 10 had difficult circumstances due to challenges with their landlord: *"We had to pay rent, we must pay the electricity, and the people with whom we stayed in the backyard were not very friendly and I had to dance according to their tune [do as they said]. There are people in that community where I stayed who wanted to become rich. Even though you were poor, they wanted to take every last bit out of you."*

Some participants referred to substance abuse by family members in the home, as indicated by participant 11: *"He [brother of child's father] was on drugs. Now he was ranting all over the place.*

There were times when I worked myself up [got upset] over that, but he did not hurt me or scold at me." Participant 16 added: *"My mom drank. My dad was on Mandrax."* Furthermore, two participants mentioned the caretaking of family members as an additional challenge to their circumstances. Participant 2 had to look after her baby sister while her mother was working. Participant 12 had to take care of her ill grandmother, which was challenging: *"… but at that stage my grandmother was bedridden. So, I had to look after grandmother, because I was the oldest grandchild and the wisest in the home. That was difficult … I had to pick her up. I had to put her on the couch and there was no one that could help me. It was very difficult that time."*

According to a study by Scorgie *et al*. (2015:10-11), pregnancy could potentially further marginalise women and children living in vulnerable households, as measured by socio-economic factors like low income, educational level and access to housing. They further stated that pregnancy for women living in poverty could be associated with disempowerment and a crisis. It is evident that many of the mothers in this study had to cope with difficult living circumstances. Coping, as described by Zatrow and Kirsth-Ashman (2012:30), includes a form of adaptation in order for the individual to overcome problems.

Category (ii): Living circumstances from birth to two years

Some of the participants relocated to another place which improved their circumstances, as demonstrated by the following statements:

- Participant 7: "[redacted] [child] was a year, almost a year that they [municipality] moved us … my place was bigger. I had a two-bedroom house. My own kitchen, living area. There was a lot of space. I had a beautiful flower garden. I had my own vegetable garden."

- Participant 10: "… and I stayed in a Wendy House of my own, which was very big, three by nine Wendy House. Because it was now the three children … each had his own bedroom. [redacted] [child] was with me in the bedroom and a living area and a kitchen."

- Participant 18: "After the birth, we no longer stayed there [previous flat]. We moved to my friend's sister's place. It was a structure that she had in the yard. Then we went to stay there with her. Me and the oldest girl and the father. Yes, water we got inside from them. They also provided for us with power [electricity]. It was nice. The structure was small, but is was warm, comfortable and not leaking or so. It was quite okay."

After birth, Participant 2 moved into her own room in her grandmother's house. The parents of participant 16 also made changes to accommodate her with the baby: *"Then my mom built a*

structure next door. Me and [redacted] *[child] moved into our own room. Stayed alone in the structure, after birth."* The same participant also mentioned change in her parents' substance abuse: *"My mother stopped drinking wine and my dad stopped using his Mandrax. He smoked sneakily on the side, but we were never aware of it. We saw there was a change in the home."* When [redacted] [child] turned one year, the structure was damaged by rain, and she and her child moved in with her friend and his mother.

Many participants experienced difficult living circumstances after the child's birth. Participant 8's circumstances did not improve, and the house was still overcrowded. During this time, she also became more aware of the negative community environment, as she noted: *"The gang fights which went on in our environment, it was not right – the drugs and those things."* The difficult situation with participant 10's landlord worsened after the child's birth, as described: *"When I got* [redacted] *[child], and came home, the people were even more rude. They cut off my power [electricity]. I didn't get power, I didn't get water … So, there were public taps against the railroad where I could get water, and we coped with the candle or lamp and gas pot. It was very difficult that time."* They relocated to other people's yard when the child was only seven months, but encountered different challenges at that location, as described: *"The people with whom I stayed was a grandmother and grandfather who received pension. There was no power in the yard, no water in the yard, but I made the best of the situation … We dug for a main and then I talked to people, talked with my neighbour and he said he will give me power. So, we tried to make life easier for us. All the youngsters came to sit there and gambled, and dagga and buttons [Mandrax], smoking and spitting. The grandmother and grandfather could not talk because the youngsters would hurt them. That was difficult for me during the first year because we did not have decent accommodation, housing."*

As during the pregnancy phase, some of the participants commented about family members using alcohol or drugs during this time. Participant 1 mentioned: *"The people that we were with drank. My aunt drank and my uncle."* Participant 5's brother also used drugs, as well as a family member who stayed with participant 11: *"And the brother that was on drugs, he ranted but not near the baby, also not in front of the baby, also not where baby could hear …"* Furthermore, the findings from this study showed that various challenges, especially increased conflict, appeared after the arrival of the baby in the home, as verbalised by participant 2: *"But there was my uncle's son, who caused trouble because he was older than* [redacted] *[child] and then he bullied* [redacted] *[child]."* At one time, the conflict in the home resulted in the participant being asked to leave the home for a few weeks: *"But they [the family in the home] could not deal with this [the participant's protection and care of the child] … they said I idolised him [the child]. But then I did not care about what they said anymore. Then we stopped talking and I went to stay with the aunt of the child's father, but*

only for two weeks." The parents of participant 4 took care of the child because she was working long hours, causing her sisters to be jealous. The effect of the new baby in the home resulted in a lot of conflict at participant 16's home: *"And in the home, my sisters and I had a lot of fighting. The child cried, they couldn't sleep … and then the other grandchildren felt now they were being neglected and* [redacted] *[child] got more attention … If there was not enough food on the table for everyone that evening, my mom would made sure that* [redacted] *[child] got an extra bite and so the others felt that my mother favoured us above them and made us her responsibility, while the father of* [redacted] *[child] should have taken responsibility. So, we argued a lot in the home."*

As explained in Chapter 2, Bronfenbrenner's bioecological theory involves the interconnection of a person to four elements, namely proximal processes, person characteristics, time and context. (Rosa & Tudge, 2013:244; Tudge *et al.,* 2016:428). Hence, it has been shown that the element of context – namely the environment of the mothers and children in this study – plays a vital role. It seemed that many of these mothers applied the concept of 'adaptation' to adjust to their circumstances in order to function more effectively, as explained by Zastrow and Kirst-Ashman (2013:30).

3.4.4.2 Sub-theme 4.2: Financial circumstances

Financial circumstances are divided into two categories to refer to circumstances during pregnancy, and from birth to two years. Table 3.16 illustrates the content of this sub-theme.

Table 3-16: Sub-theme 4.2: Financial circumstances

Theme 4: Circumstances of the mother and the child during the first thousand days of the child's life	
Sub-theme	***Category***
4.2 Financial circumstances	(i) Financial circumstances during pregnancy
	(ii) Financial circumstances from birth to two years

Category (i): Financial circumstances during pregnancy

In this study, participants indicated employment as the main contributing factor to financial circumstances. From the data collected, it was clear that the nature of employment and the number of people working in the household played a significant role and that this varied among the participants.

A few of the participants described favourable financial circumstances, as illustrated by these quotes:

- Participant 5: “Financially we were … we were well raised.”
- Participant 6: “He [child’s father] worked. He worked full-time. He earned a good salary when we were that side.”
- Participant 7: “He [child’s father] also had a full-time job. Financially, it went well during my pregnancy. His income was enough.”

Participants 4 and 9 continued to work almost through the whole pregnancy, as stated by participant 9: *“I worked up to eight months.”* Some participants mentioned other family members who were employed, like the child’s father, their parents, siblings, grandmother and aunts who contributed to the household income. Participant 4 mentioned: *“I worked, my sister worked, and my brother worked.”* Participant 11 added: *“He [child’s father] worked at that time. He supported us with my pregnancy and with the previous daughter. He provided for us, and for everything the baby was going to need …”* Although the father of [redacted] [child] was unemployed for a while, his permanent job was very positive, as recalled by participant 12: *“Then he [child’s father] started and got a fixed [permanent] job as security. So, things started to go better, because there was support and we started to buy what we needed and so on.”*

Some of the participants experienced financial strain as they themselves or their family members only worked part-time or were unemployed during this time. This is illustrated in the following excerpts from the interviews:

- Participant 1: “I worked up to four, five months, then I did not work anymore … I had to go on at home.”
- Participant 2: “It was difficult. Only my grandmother and mother worked, about two times, three times per week.”
- Participant 8: “It was very difficult. Inside the home, nobody worked. My father-in-law did char jobs. He made brooms for us for evening power [electricity], bread … and my mother-in-law also did char jobs, but only two times a week or once a week …”
- Participant 11: “I did not work at that time. I would not say it [finances] was sufficient, because we had to make do in order to fill every hole because there was a baby on the way.”

- Participant 15: “I struggled a bit, because he [participant’s father] was the only one who worked in the home. My dad was the only one who worked, and he did not always bring money home. When I found out I was pregnant, I did not work.”

- Participant 18: “There was not money or income or so, so I went to soup kitchens to eat every day.”

As indicated above, participant 15’s father was the only person in the household working, which put financial strain on the family. Participant 15 said: *“… and I helped here and there, just so that we could eat. If one of my friends asked me to come and help with the washing … She [participant’s mother] also helped other people with washing or house cleaning and then got us something to eat during the day.”* Additionally, participants 2, 8, 12, 13, 14, 17 and 18 noted the unemployment of the child’s father during their pregnancy, as confirmed by participant 13: *“He did not have a fixed job.”* Participant 14 commented: *“He did not yet work during that time.”* In some cases, both the participant and the child’s father were unemployed with virtually no income, as stated by participant 17: *“Nobody [worked]. There was nothing [no income].”* Participant 18 had a similar situation with her older daughter’s child support grant as their only income. Participants 2, 8, 12 and 16 were teenagers and left school when they became pregnant, thus impacting their financial circumstances, as expressed by participant 12: *“Like me, I do not have experience of work and so. Grade 10 out of the school.”* The father of participant 8’s children was also a teenager, still attending school and not able to work during this time.

Participant 10 felt emotional about the impact of their financial struggles on their family during that time: *“Very little money, financially we had to stick it out [endure] until after the pregnancy. Actually, it was sad for me [emotional during the interview] … the time that I was hungry. Then my children would come and say, ‘Mommy, I am hungry’. Then I can’t do anything because the income that the father brought in was not enough.”* To assist in this desperate situation, the participant went to work, although she was not supposed to, as described: *“I should actually not have worked while I was pregnant with* [redacted] *[child], because I have a heart problem. But then I went against my will. Then there was a time that I worked at* [redacted] *[workplace] for three months to help him [child’s father] work so that we can get things for the child’s birth.”*

As seen above, the impact of financial stress can be detrimental to the mother, as confirmed by literature. According to the Cambridge Credit Counseling Corp. (2019), financial stress can virtually affect every area of a person’s life and have a major impact on their health. They believe that anxiety and depression are two of the most common effects of financial stress. Additionally, they mentioned that the following could be caused or worsened by financial stress: heart disease,

gastrointestinal problems, weight gain or loss, eating disorders, insomnia, cancer, high blood pressure and substance abuse. A study by Palta (2015) concluded that higher financial strain is associated with higher oxidative stress, which is a potential precursor to poor health. Research further confirmed the link between socio-economic factors during pregnancy and birth outcomes (Blumenshine *et al*., 2010:267). According to a study done by Braveman *et al*. (2015), socio-economic factors could play a role in preterm births. The findings of Mitchell and Christian (2017) showed that psychological distress as a result of financial strain during pregnancy could contribute to the lower birth weight of a baby. Additionally, Aftab *et al.* (2012:5) concluded that poverty negatively impacts pregnant women's well-being and could result in malnutrition, anaemia, low birth weight babies or fetal loss.

Category (ii): Financial circumstances from birth to two years

Financial well-being across the income spectrum is affected by the birth of a child (Ansel, 2016). A working paper series on "The dynamics of household economic circumstances around birth" stated that the average household experienced a decline in its financial well-being around the time of the baby's birth (Stanczyk, 2016:32). Therefore, a new baby affects a household's income and financial well-being. In the light of this, various participants commented on positive financial contributors such as income, Unemployment Insurance Fund (UIF) benefits, maintenance from the child's father, as well as the child support grant that enabled them to ensure care for their baby.

The employment that the participants referred to, included their own as well as that of the child's father and/or other family members. Participants 1, 4, 9, 11, 15 and 16 referred to their own employment during the time after the child's birth up to two years, as voiced by participant 4: *"I worked at a catering place. They took me in there*." Participants 15 and 16 mentioned their babies' age when they started to work, as stated by participant 15: *"She was already a year old, then I went to work."* Participant 16 added: *"When [redacted] [child] was seven or eight months old … I went working. And then it started to go better. Then there were two incomes, my dad's in the work he had and the farm money. It was not a lot, but it helped, helped very much."*

A few of the participants discussed the employment of the child's father. Some participants indicated that the father already had employment before the child's birth, while other participants revealed that the father only started working after the child's birth. Participant 3 confirmed: *"Yes, he [child's father] still worked."* Participant 12 noted *"… like he [child's father] worked now and he saved a little bit of money for us too."* For participant 18, the employment of the child's father

made a significant difference: *"Things weren't so bad during that time because the father now, how can I say, had a permanent job which his friend gave him, that paid weekly on Fridays."*

Participant 9 received various forms of income during this time, including monthly maintenance from the child's father, Unemployment Insurance Fund (UIF) benefits, as well as her own income after returning to work, once her maternity leave had passed. A variety income sources – such as financial support from the father or his family, as well as the child support grant – was also mentioned by other participants, as verified by participant 5: *"And then I got the all pay [child support grant] for* [redacted] *[child] and I got the maintenance, her dad sent it every month."*

Some participants, unfortunately, experienced financial strain as a result of various influencing factors. Some of the participants were single mothers who were financially worse off after the birth of the baby (Stanczyk, 2016:32). Ansel (2016), agreeing with Stanczyk, said that the financial burden on single mothers often result in them returning to work far sooner than married mothers, affecting both the mother and the child. This was confirmed by participant 2: *"And there was one time when he [child] was about five months when I got a job at* [redacted] *[workplace] and then I had to work nights, but I could not … I only worked for three weeks, but then, then I could not anymore, because I thought about him all the time during the nights and so."* She felt that she could not rely on the child's father as he often resigned from his employment. Participant 1, a single mother, described her financial stress after the baby's birth before she got employed: *"And if there was no cereal for the child … I did not have money because I did not work … We really struggled. Sometimes there was nothing to eat. Then I took her [child] to my aunt there at the back and asked. Those days were difficult – although my aunt was there for us. We struggled, made debt."* Participant 16 was also a single mother who struggled financially due to the lack of financial support from the child's father. Her child had a kidney disease and required medical visits to a hospital in another town, which caused great distress to the mother as a result of financial pressure. She expressed: *"The child had to visit* [redacted] *[hospital] regularly. And there was no money to get there. The transport had to be paid, all those things."*

Some participants experienced severe financial difficulty and were consequently not able to sufficiently provide for their own and the baby's needs. The following quotes confirm this:

- Participant 8: "And we had to give ironware and tins at [redacted] [name of place] for her milk. Tinned milk and so. Yes, there was not really an income."

- Participant 10: "Then there were those Fridays when we did not even have money for a box of milk for [redacted] [child]. We were not in a financial position to give [redacted] [child] what was due to her."

- Participant 14: "… ask someone next door if they did not have something for us, even if it was just mielie meal that I could give to her [child]. Then I would say, 'I am not worried about myself, as long as she can eat'… There was little of it [money]."

- Participant 17: "That was the most difficult for me because I now had to go look for a Kimbi [disposable nappy] or a piece of soap."

Children growing up in poverty, as evidenced by some of the above-mentioned statements, are deprived of a good start in life. The devastating consequences include insufficient nutrition, lack of early stimulation, and exposure to stress, often leading to stunting and a negative impact on their human potential (UNICEF, 2016a:2).

The two sub-themes, namely the living circumstances and financial circumstances, included the various factors that played an important role during the child's first thousand days, thus impacting the mother and the child.

3.4.5 Theme 5: Attachment and relationship between the mother and the child during the first thousand days of the child's life

This theme indicates the nature of attachment and relationship between the mother and the child during pregnancy, directly after birth and during the time up to the two years. The two sub-themes relating to attachment during these two phases, namely pregnancy and birth up to two years, with their specific categories, are indicated in the Table 3.17.

Table 3-17: Theme 5: Attachment and relationship between the mother and the child during the first thousand days of the child's life

Theme 5: Attachment and relationship between the mother and the child during the first thousand days of the child's life	
Sub-theme	***Category***
5.1 Attachment and relationship between the mother and the child during pregnancy	(i) Mother's initial response to the pregnancy announcement
	(ii) Mother's response to the gender of the child
	(iii) Mother's emotions and thoughts towards the unborn baby
	(iv) Mother's interaction with the unborn child
5.2 Attachment and relationship between the mother and the child from birth to two years	(i) Mother's initial response to the newborn baby
	(ii) Mother's emotions and thoughts towards the child from birth to two years
	(iii) Child's attachment and relationship with the mother

3.4.5.1 Sub-theme 5.1: Attachment and relationship between the mother and the child during pregnancy

Four categories are indicated in this sub-theme, namely (i) the mother's initial response to the pregnancy announcement, (ii) the mother's response to the gender of the child, (iii) the mother's emotions and thoughts towards the unborn child, and (iv) the mother's interaction with the unborn child.

Table 3-18: Sub-theme 5.1: Attachment and relationship between the mother and the child during pregnancy

Theme 5: Attachment and relationship between the mother and the child during the first thousand days of the child's life	
Sub-theme	***Category***
5.1 Attachment and relationship between the mother and the child during pregnancy	(i) Mother's initial response to the pregnancy announcement
	(ii) Mother's response to the gender of the child
	(iii) Mother's emotions and thoughts towards the unborn baby
	(iv) Mother's interaction with the unborn child

Category (i): Mother's initial response to the announcement of the pregnancy

The data collected in this study revealed various initial responses from the mothers when they found out that they were pregnant. Participants 3, 5, 6, 10, 11, 14 and 15 revealed positive emotions regarding the announcement of their pregnancy, as stated by participant 5: *"I was happy, because, in general, I love children. Yes, I was happy that I was expecting."* Participant 6 also expressed her joy: *"I was excited because it was our second child together. Because my desire was for more children and when I got* [redacted] *[child] … it was my, her father's second child that I expected from him, I was excited."* The same happiness was shared by participant 10: *"I was thrilled. I was very glad."*

However, not all the participants initially had positive emotions or thoughts regarding their pregnancy. Participants 1, 2, 4, 7, 9, 12, 13, 16, 17, and 18 experienced various negative emotions including shock, disappointment, anger, sadness and panic. The following responses are filled with heartfelt emotions:

- Participant 1: "And I thought, how I am now going to cope with a baby on my own …"
- Participant 2: "And when I found out I was pregnant with him I did not really want to have him. But I was scared of what is my parents were going to say. I was scared that they would put

me out of the house. In the beginning stage, it was almost a shock, then I thought but I can't bring the child forth. I was 17 when I found out. And besides my family and other people, I just felt it was a mistake and it made me feel so."

- Participant 4: "In the first place, I did not want [redacted] [child] … very … down, disappointed in myself."

- Participant 7: "He [child] was completely unexpected. He caught me unexpectedly. A person feels a bit downcast."

- Participant 9: "Then I said, 'It can't be'."

- Participant 12: "I was very angry about it because … the first time, we made a mistake. So, the second time I was very angry about it. I was actually angry at myself. Point number one, I should have used contraceptives."

- Participant 13: "I felt sad, because I did not really want the child. I was alone. How was I going to care for the child? Who was going to help because she was now the fourth child? … I was on the injection [contraceptive] …Then he [doctor] could see the disappointment on my face, and I told him, 'I can't afford a child now' because I knew what the circumstances were."

- Participant 16: "I was still at school … and I did not know what to do with the child …"

- Participant 17: "I did not want the child. I was like, 'No man, I am going to kill the child or so'. I did not want the child."

- Participant 18: "First, I panicked. Thought … 'I already have a child and circumstances are not favourable. I can't expect another child now because we are really struggling. Then I thought, 'Oh, how am I going to make it? How am I going to tell my mother and them? And how are they going to respond?'"

Based on the negative responses above, it seems that these pregnancies were unexpected and not planned. Higgens (2018) confirmed that intense negative emotions such as shock and confusion are normal when hearing the news of an unplanned pregnancy. The study titled "Unplanned pregnancy and the risk of maternal depression: Secondary data analysis from a prospective pregnancy cohort" demonstrated that unplanned pregnancy could be a risk factor for maternal depression (Faisal-Cury *et al.*, 2017:70).

Category (ii): Mother's response to the gender of the child

This study clearly indicated the strong gender preference of many participants, as well as the effect of their emotions when the child's gender was confirmed. Ten out of the 13 participants who referred to the child's gender experienced positive emotions like relief, happiness and excitement when the gender was made known to them. The participants expressed their feelings as follows:

- Participant 6: "Excited, and the day I found out it was a girl, then I was even more happy."
- Participant 7: "I felt almost … thank you, it's a boy, because I am now tired of girls. So, I can't really tell you how I would have felt if it was a girl again."
- Participant 8: "Oh, when I found out she was a girl, then I said, 'Thank you'. I was very happy when I heard it was a girl. I could not wait to tell my husband it was a girl."

The reasons why the participants preferred a certain gender for their children varied. A few of the participants had a specific preference for their first child, as illustrated by participant 1: *"… because I always said my first baby must be a girl."* Participant 15 said: *"I wanted my first child to be a girl."* Some already had other children from a specific gender and therefore desired this child to be of the opposite gender, as voiced by participant 4: *"… because I have a girl, the oldest one. I now have one of each."* Participant 7 lost a baby boy at a young age and therefore she felt: *"… and it is a son again. The son that I lost the Father gave back to me."* Participants 3 and 14 had no specific preference and were content with any gender, as expressed by participant 14: *"For me, it was not about a boy or a girl. They say the Father gives you [the right one]."* Participant 12 was very unhappy to learn about the gender of her child: *"When I found out it was a girl it was too late already … I was actually very angry … It is not nice to raise a girl in such an atmosphere. But you can't interfere with the Lord's work."* Although the gender coincided with several of the participants' gender preference, the child's gender was not what participant 12 had hoped for. This participant most probably experienced gender disappointment, a complex emotion occurring when the baby's gender does not match the mother's expectation, as described by Faure *et al.* (2016:74).

Based on these narratives, it is evident that the gender preference of most of these mothers was very significant. A study done more than 20 years ago showed the influence of the prenatal gender preference of the parents on the short-term and long-term effects of the parent-child relationship. The researchers found more negative consequences for the parent-child relationship where the child's gender did not coincide with the parent's stated preference (Stattin & Klackenberg-Larsson, 1991:145). According to Gonzalez and Koestner (2005:407), parents unconsciously

divided boys and girls into two separate categories, namely status and attachment, which are related to pride and happiness. Their findings suggested that parents experience more pride with boys and happiness with girls, and that this may influence the perception of parents regarding their child's worth, as well as their investment in their child's development. A study by Cigdem and Derya (2018:499) emphasised the impact of the child's gender and concluded that gender preference in pregnancy could impact prenatal attachment and perceived social support.

Category (iii): Mother's emotions and thoughts towards the unborn child

During the pregnancy, a few participants considered abortion or adoption, but at the end decided to keep their baby. Participant 4 considered: *"In the first place, I wanted an abortion …"* Participant 17 declared: *"I told myself, 'I am going to let the child be adopted by other people'."* The quotes from participant 2 revealed that she was contemplating both options, abortion and adoption: *"Then, when I found out I was almost three months pregnant … Because I now … abortion, they [clinic staff] ask you in the beginning when you get yourself tested, 'Are you going to keep the baby or are you going …?' [silence]. Then they gave me time to go and think. But I … [silence] did not."* She added: *"There was a time that I felt I wanted him [child] to be adopted*."

On the other hand, three participants expressed that they never consideration abortion or adoption, as captured by the statements of participants 1 and 10. Participant 1 explained: *"When I was pregnant, I did not think I was going to bring her down [abortion] or so. I was going to keep my baby for myself."* Participant 10 said: *"… I never thought about giving* [redacted] *[child] away, or for the child to be adopted."*

Most of the participants expressed positive thoughts and emotions towards their unborn babies, especially when they started to feel the baby's movements. Some of these thoughts and emotions are illustrated by the following quotes:

- Participant 4: "I was very happy about the kicks. And to see on the sonar how he was moving and carrying on. It was beautiful. It was nice."
- Participant 8: "Very happy. She feels what I feel … She felt I wanted her to come out and be healthy. I prayed every night that she must just be healthy."
- Participant 9: "I came to love the thing inside me very much. So, I enjoyed the baby that was there."
- Participant 13: "If there is life in you, you get to love it."

- Participant 18: “Then I started to feel, no, I must now protect, protect the baby.”

From the above-mentioned statements, it is apparent that participants experienced various positive emotions, including happiness, excitement, enjoyment, love, acceptance and protection. Participant 3 felt several positive emotions and experienced her baby’s development as miraculous: *“You always feel, you feel excited, because I felt, here he is kicking now, or she is kicking. She or he lives. You feel that feeling inside of you. You feel very happy and lovely, and you just feel that life inside of you. And just to think that he, how can I say, that there is something like that in your stomach. Look, he grows and grows, then he is a baby. So, I often thought, ‘This is just a miracle’.”* This participant also recalled her excitement about the baby’s arrival: *“… could not wait for me to finish. Here at your eight, ninth month it felt that it takes longer to finish … I just wanted to finish so that I can have him or hold him.”* Additionally, the words of participant 6: *“I could not wait when she was coming.”* Participant 14 reflected her anticipation about the baby’s arrival by saying: *“I could not wait for her to come out…”*

Bonding during pregnancy, as highlighted by Wheatly (2019), promotes secure attachment and consequently improves the baby’s social, emotional and cognitive outcomes. Participants 2 and 10 felt that they had bonded with their baby during pregnancy, as indicated below:

- Participant 2: “I started to get a love for my child. I’ve bonded with him while I was pregnant.”
- Participant 10: “… because I’ve bonded with [redacted] [child] at the time … that I was pregnant with her.”

Participant 17 had very conflicting thoughts and emotions towards her unborn baby. This participant was using drugs and was living in very difficult circumstances which could possibly explain some of her responses. On the one hand, she said: *“Then I told myself, ‘The circumstances in what I am in, I can’t … have another child in such circumstances, to raise a baby…’ I did not want the child in such circumstances.”* On the other hand, she felt: *“… but I started to love her [child], when I started to feel her kick in my stomach. Then I started to love her. First time she kicked, yes. You feel happy when you feel here the child is kicking in your stomach.”* The latter response could also be an indication of bonding, as confirmed by Faure *et al*. (2016:74) who said that a baby’s movement could initiate bonding from the mother’s side. The same authors stated that certain mothers experience bonding from conception, which is strengthened in the third trimester, while other mothers only bonded with the baby after delivery. They described attachment as a journey that takes time.

Category (iv): Mother's interaction with the unborn child

Many participants explained how they have interacted with their unborn children, which included talking to their baby, playing music, singing, massaging their stomach or putting an object on top of their stomach. The following statements describe the mothers' interaction with their unborn children:

- Participant 2: "If I was alone with him and he kicked me, then I talked to him. And I listened to music, always with the phone, then I put the phone next to me …"
- Participant 8: "And then I sang, when she was still in my stomach."
- Participant 9: "And I always laid down and talked, and then I felt my stomach and then I pushed it. And I regularly stroked my stomach and talked with baby and so."
- Participant 18: "… rubbed over the stomach and talked with the baby …"

Participant 10, who struggled financially and often lacked food, shared these concerns with her unborn baby, as demonstrated by this heartfelt quote: *"I've always talked to her. When I was sitting still, I would ask her, 'Baby, is baby okay? Mother is hungry, but baby is surely not hungry, hey?' I always communicated with her. That's why she was in such a hurry to come out."* Participant 11 understood the positive effect of her interaction with the baby, as noted: *"… but here is a living being inside me. If you talk, he is going to grow."* She felt that her baby reacted back, as she explained: *"Two months later the baby started to make bumps, surely to say, 'I am here. I am inside of you, so I hear.' And there were times that I talked and then baby made a bump on the one side, almost like you responding to what I say to you."*

According to NHS Health Scotland (2019), babies can hear from at least 16 weeks onwards. Talking and singing to them therefore promotes their development. NHS Health Scotland (2019) also believes that hearing voices will help a baby to feel safe and secure. What's more, prenatal interaction also enhances bonding, which serves as a protective factor after birth (Van der Walt *et al*., 2016:27). The baby bond stimulation programme was developed to positively affect bonding during pregnancy by encouraging expecting mothers to interact with their unborn children. This programme recommends the stimulation of the baby's auditory and tactile senses through activities like talking to the baby, playing music and the mother massaging her stomach (Van der Walt, 2014). A study conducted by Daglar and Nur (2018:439) concluded that prenatal attachment increases the level of postpartum bonding.

3.4.5.2 Sub-theme 5.2: Attachment and relationship between the mother and the child from birth to two years

This sub-theme relates to the attachment and relationship between the mother and the child after the child's birth, and includes three categories, as indicated in the table below.

Table 3-19: Sub-theme 5.2: Attachment and relationship between the mother and the child from birth to two years

Theme 5: Attachment and relationship between the mother and the child during the first thousand days of the child's life		
Sub-theme	***Category***	
5.2 Attachment and relationship between the mother and the child from birth to two years	(i)	Mother's initial response to the newborn baby
	(ii)	Mother's emotions and thoughts towards the child from birth to two years
	(iii)	Child's attachment and relationship with the mother

Category (i): Mother's initial response towards the newborn baby

Various participants described their initial response towards their baby after birth, which in most cases were positive and filled with love, joy and pride. The following statements reflect these responses:

- Participant 2: "I felt happy. It was a feeling I can't describe. I felt happy. My tears sometimes rolled, even if I think about it now… [became emotional]. It was [tears] of joy, because he was my first."

- Participant 7: "I was in love with him [child] from day one. That moment when they put him in my arms, I was in love with [redacted] [child], until now."

- Participant 8: "It is my baby, it is my child … It is my girl. Oh, if I take her home, what will the people say? What is the grandmother going to say? What is the father going to say? It was all those things that went through my head."

Participants 1, 3 and 11 recalled their immediate interactions with their babies. Participant 1 voiced: *"When she was lying there after her birth, I played with her or sang for her."* Participant 3 experienced the following: *"At birth, [redacted] [child] was now a baby. You must now talk to him and touch his cheeks. And talk and smile, and then he smiles back."* According to participant 11, it felt like she already knew her child well, because she communicated regularly with the baby during pregnancy. She depicted this in detail: *"And the day she was born, then I said, she is still such a small baby. Then I said, 'Baby, you and me, we know each other, hey? Although you don't see*

me now, although you don't know where you are, even if you looked wrinkled with you skin, you know my voice, because I know you.' And it did not feel to me like a new baby. I said, I know this child, the baby was inside me, the child laid under my heart. It felt like I've already seen the baby, I knew this baby." This feeling of connectedness, noticeable in the above-mentioned participants' interactions with their babies, was confirmed by Davidson *et al*. (2014:1057) who also noted that some parents experienced feelings of shock or disbelief, like participant 17 in this study. They highlighted the importance of positive interaction between the mother and the infant during this acquaintance phase in order to promote attachment.

For participants 14 and 16, the birth of their child brought a sense of responsibility and motivation to improve themselves, as described by participant 14: *"Then after that [the child's birth], then I thought to myself, 'I must stand out a bit' and I did stand out for her."* This reveals her desire for self-enrichment. Participant 16 explained: *"And when I saw her for the first time, then I told my mom, 'I am going to do everything in my power to give her the life that I did not have and that she must not have."*

Stoppard (2008:316) confirmed the importance of the mother's first moments with her baby as one of the most significant interactions between mother and child. After the child's birth, the mother could experience many new emotions as she realises the baby's total dependence on her. She also explained how parents who are able to show affection and care for their baby immediately after delivery are more inclined to their child's needs later on. According to Davidson *et al.* (2014:1056), various factors can influence a mother's first interaction with her newborn, including her family of origin, her relationships, the home environment, and the degree of nurturing received during her own childhood. They further explained how other personal characteristics of the mother – like trust, self-esteem, emotional state and knowledge of childcare – influence the mother's emotional orientation towards her baby.

All the above-mentioned participants expressed positive emotions, except participant 17 who said: *"I want to know what type of child is it that lies here, because the child does not look like a child. They [hospital staff] said, 'Mommy, it is a kangaroo baby.' I said, 'A kangaroo baby, I don't understand.' 'You must put the baby here [on the chest], mommy.' I said, 'I can't put the child here, all the other children are laying there in their cots. Why must my child lie here while all the others' children are lying next to them?' But the child was so small, I could not understand. I did not understand where I should put the child. I didn't want the child here [on her chest]."* Kangaroo care, as described by Faure *et al*. (2016:148), is usually recommended for premature babies and involves the placement of the baby on the mother's bare chest. They believed that this could be

highly beneficial for the baby. However, it seems that this participant showed a lack of understanding, impacting her willingness to apply this to her baby.

Category (ii): Mother's emotions and thoughts towards the child from birth to two years

During the 24 months from birth up to two years, participants experienced different emotions and thoughts towards their children. The statements below indicate the mothers' positive responses:

- Participant 1: "I loved her very much, I still love her. I always gave her a hug … I cared for her."
- Participant 2: "Because I gave him all my love that I could have given. I love him very much."
- Participant 7: "… he's the apple of my eye. Love very much…"
- Participant 14: "Me and her, our relationship was good … No, it was good, because I liked her … gave her love."

Many participants described their attachment to their children. Participant 2 took her child with her everywhere she went, almost never leaving him with somebody else. Various statements described their close relationship with their children during this time. Participant 7 said, *"… had a very close relationship …"* Participant 8 commented: *"It was all about her. You have that bond with your child."* Participant 9 stated: *"I was very attached to her."* It was also apparent that certain circumstances improved the mother's relationship and bond with the child, as indicated by the following participants. Participant 10 grew closer to her daughter during her illness, as mentioned: *"I never wanted to go away from her … I had more love for* [redacted] *[child] with the illness which she had. A big, close bond."* Participant 16 shared a similar experience: *"… so, I begin to love her after I found out she is sick … The more attention I gave her, the more I loved her, until I realised, to have her is a privilege …"* In addiction, participant 15 described her relationship after the child's father passed away: *"I had a good relationship with the child and loved her very much after she lost her father. She is close to my heart. We have a very good relationship, understandable relationship. I love her very much."* Participant 17 felt a bond when her child was a few months old, as expressed: *"Ten months, eleven months then I feel, no, this is my child. I started to get used to* [redacted] *[child] and loved the child. So, I've started to love her until today, that bond of mother and child …"*

According to participants 2 and 18, their babies sparked positive change in their lives. Participant 2 reflected: *"He [child] turned me into a mother. He taught me to take responsibility. He taught me many things. I can't only think about myself, because there is now somebody above me, his needs*

must now be above mine. Because since his birth, was it often just the two of us alone and nothing else mattered for me and him." Additionally, participant 18 described her positive change: *"They say children change your life … and if it wasn't for her [child], I would still be smoking [use drugs]."*

It appears from the findings of this study that the characteristics of the child influenced the mother's relationship with the child, since various participants specifically described aspects of their children when asked about their relationship. Participant 5 noted: *"Oh, I was very fond of her, because she was a beautiful girl. But she was a very friendly baby. Not naughty. She is still like that, a people person."* The statement of participant 6 revealed the following: *"She was a lovely baby. All that I can say is that she was a lovely child, from birth up to two years …"* Participant 7 added: *"I did not have a problem with* [redacted] *[child]. He was the most well-behaved child."* Participant 13 concluded: *"I love her very much. She is my split image … She's my miracle. O, I loved her very much and she was a sweet child. She was a very calm child, really, I never had a problem with her … We got along well."*

Some participants experienced negative emotions or thoughts at times. Participant 11 mentioned a slight irritation when the baby visited at her work, a furniture store, as portrayed by her statement: *"I don't feel up to baby today, because baby started to write on my desk. Baby is only looking for something to write with on the walls. She writes on anything she sees, and she wants to lie in front of the TVs."* Participant 4 described her lack of attachment with the child as follows: *"I did not really have a relationship because I wanted to be more in my work than anything else. Not attached. Saw him very little, four times a month … I did not have a relationship with him."*

Although participant 17 expressed a bond with her child when the child was about ten or eleven months old, she often experienced negative emotions and thoughts during the first few months, as described: "In the beginning I thought when [redacted] [child] cried, I wanted nothing to do with the child, I didn't want the child." Another time she felt: *"But it is difficult, it is very hard, and I told myself, 'Can't the child die or something, throw the child away?'"* These thoughts and emotions progressed into detrimental actions, as described in category (iii), sub-theme 1.2: 'Mental health and emotional well-being of the mother'.

Looking at the information provided by participant 17, it appears as if she did not form an attachment with her baby until a few months later. She therefore displayed negative thoughts, emotions and risky behaviour towards the child for the first few months until she bonded with the child when the child was about ten or eleven months old. According to Newman (2017:iii), various factors – such as depression, substance abuse, poverty, poor relationship with the child's father, mental illness and violence – could influence a mother's ability to bond with her baby. Many of

these factors were present in participant 17's life during that time, which could help to explain her incapability to form an attachment with her baby from the beginning. Newman (2017:iii) referred to the negative effects on the child due to poor attachment, like poor social coping and problem-solving skills, behavioural issues and long-lasting impact during their developmental years.

Category (iii): Child's attachment and relationship with the mother

Participants 1, 2, 3, 7, 10 and 13 made mention of the fact that their children wanted to be with them constantly, often crying when they were left with someone else. The following quotes show evidence of this:

- Participant 1: "If I am not with her, then she cries. She was very close to me. I could not walk away … she looked for me."

- Participant 2: "He quickly realised if I went somewhere … then he always cried. Then it took a long time before they could quiet him. And there was a stage when he would not go to anyone else. Then he just wanted to be with me."

- Participant 7: "You just walk, then he cries. Nobody wanted to look after [redacted] [child]. This is how our bond became stronger …"

- Participant 10: "She surely found out I am her mother and that her mother loved her very much, because [redacted] [child] almost never wanted to be with other people. [redacted] [child] just wanted to be with her mother."

- Participant 13: "That child was crazy about me. I couldn't go anywhere. I couldn't even go to the toilet. Then she would say, 'Mommy, mommy, open the door'. She was very fond of me."

Additionally, participant 3 recalled her child's attachment to her: *"He was more fond of me than of the father. He was always… when I wanted to go somewhere and he could not come along, he cried. He wanted to be picked up in the house; he wanted to be held."* It appears as if some of these children experienced separation anxiety when their mothers left, resulting in crying which is normal for babies between six and 18 months, as noted by Berk (2013:429). Furthermore, the statement of participant 6 shows her understanding of her child's emotional needs: *"She was a child that sought that warmth. Warmth, just wanted to be against another person. Yes, love. Laid against a person, it is all she did, yes."*

The quotes from participants 8 and 10 describe their children's positive responses to their interaction, as well as the children's attachment to their mothers. Participant 8 remembers: *"…*

one year old and she knew this was my mother. And she always clung, grabbed and said, 'Mommy', then grabbed me and held onto me. She is still attached to me now. I don't know, but it is something that binds the two of us together. If I cry, then she cries." Participant 10 shared her encounters with her child during that specific time: *"I could see when she was a baby, two, three weeks old, when she heard my voice, then she already looked, where is the voice, because it sounds like my mother's voice. She recognised my voice. That's how she bonded herself to me … I can't go anywhere without her. Big, close bond."* Participant 18 captured her experience: *"She just wanted all the attention, all the love. Everything must be about her."* From the preceding information, attachment is visible, but as explained by Benoit (2004:543), the quality of attachment is important, not just the fact that some form of attachment occurred, since the quality of infant-parent attachment strongly predicts the child's social and emotional outcomes later in life.

Contrary to the above-mentioned statements, participant 5 felt: *"But she was not really into me [attached] at birth."* According to Faure *et al*. (2016:157), bonding is a variable process that does not always take place during pregnancy or moments after birth. They believed that bonding is a growth process that occurs over time during the first year, therefore encouraging parents not to feel guilty if it is not love at first sight. However, they described the attachment as a two-way emotional process which is crucial for the development of a meaningful parent-child relationship, as well as for the child's future relationships.

Theme 5, which pertains to the attachment and relationship between the mother and the child during the first thousand days of the child's life, provided insight into the attachment and relationship between the mother and the child during pregnancy, as well as after birth up to two years. The last theme covers the development and care of the child during this critical time.

3.4.6 Theme 6: Development and care of the child during the first thousand days of life

A prior South African Minister of Social Development, Dr Skweyiya, wrote the foreword of *Guidelines for Early Childhood Development Services 2006* that children needed nurturing, protection and a secure family to ensure their development in the early years (Department of Social Development & UNICEF, 2006:1). This theme will provide the findings related to the following three sub-themes: (1) the child's development, (2) the mother's care and protection towards the child, and (3) stimulation and play. Table 3.20 provides an overview of the sub-themes and categories in this theme.

Table 3-20: Theme 6: Development and care of the child during the first thousand days of life

Theme 6: Development and care of the child during the first thousand days of life	
Sub-theme	***Category***
6.1 Child's development	(i) Mother's understanding of the child's developmental needs
	(ii) Child's developmental milestones
6.2 Mother's care and protection towards the child	(i) Caregiving towards the child
	(ii) Protection and discipline
	(iii) Challenges regarding the caregiving of the child
6.3 Stimulation and play	(i) Type of stimulation and play
	(ii) Child's interaction and play with the mother and others

3.4.6.1 Sub-theme 6.1: Child's development

Sub-theme 6.1 covers the child's development from birth up to two years and is divided into two categories. A summary of this sub-theme is provided in Table 3.21 below.

Table 3-21: Sub-theme 6.1: Child's development

Theme 6: Development and care of the child during the first thousand days of life	
Sub-theme	***Category***
6.1 Child's development	(i) Mother's understanding of the child's developmental needs
	(ii) Child's developmental milestones

Category (i): Mother's understanding of the child's developmental needs

More than half of the participants showed an understanding of one or more of their child's developmental needs. The following statements made by participants illustrate their understanding of the child's physical development:

- Participant 2: "It was easy in the beginning, because then I could … he laid still in one place after he was bathed, and he drank on his side … afterwards he started to move and then you had to keep an extra eye on him. Then he started to crawl, and everything went into the mouth."

- Participant 3: "There is where he learned to crawl so quickly, because if he takes the ball, then the ball rolls again. Then he had to go fetch the ball. Then I keep myself busy and then I see, wait there he goes forward."

- Participant 7: “You don’t leave your child alone; you must be alert. When he started to roll and crawl, I used the pillow to protect him. If he maybe fell over and I was busy, he would fall onto the pillow. Later on, I let him crawl on the floor.”

- Participant 9: “We wanted to see if she could hear correctly, if she could listen … Can her eyes move and look in the direction of the music or if someone was talking, or did she look to the side or so? We were very attentive, because grandmother said one must make sure your child can hear, see, notice movements and so on.”

- Participant 11: “I can’t wake her up when I come. She needs that rest.”

- Participant 12: “With her off my arm, she started to develop quickly.”

A few participants referred to their children’s emotional needs, as voiced by participant 13: *“She gets her love and attention on time.”* Participants 2 and 9 understood the security provided by a specific item loved by the child, as explained by participant 2: *“He had a sheep [soft toy]. He could not sleep without the sheep.”* Participant 9 said: *“Then I bought her a cotton blanket, a thin one, not so thick, that she can put over her shoulders and then sleep with it. She had to hold something in her hand. So, when she laid down, maybe with a bottle, she would reach for the blanket, take it and hold onto it.”*

Some of the participants showed insight into the child’s linguistic and cognitive development. Participants 3 and 8 both indicated that they did not speak ‘baby language’ to their children. As explained by participant 3: *“Many parents speak baby language, but I started to talk right. I found out that the way in which you talk to your child is the way he is going to grow up, and then he is also going to talk like that. So, rather talk right from the beginning, then he will also speak properly when he starts to talk.”* The quote from participant 8 also refers to linguistic development: *“Then my mother-in-law always watched and said, ‘You quickly taught the child to talk’. I said, ‘No, it’s not me, it’s because we don’t talk baby language’. We talk like we talk normally, like the way my mother-in-law and I talk, I am going to talk to her in the same way. Then my mother-in law always said, ‘Ai, look how beautifully she speaks. The others can’t talk so beautifully. They still talk baby language.’ Then I said, ‘It is how you communicate with your child’.”* Participant 11 realised her child’s need to learn and explore: *“And curious. She wanted to know about everything. ‘Why? Now why like this? Now how are you going to do that? Now where to? Now why must it look like this?’ She just wanted to know what was going on. And she learnt things. She was at that age where she walked, she experimented with things.”* Participant 7 had four children and she understood that the individual needs of her children differed, as described: *“What works for the one child will not necessarily work for the other child. Every child is unique.”*

Marotz (2009:22) said that time period from birth to two years was exceptional due to the dramatic changes and growth occurring in a relatively short time span. During this phase, the child progresses from being totally dependent and relatively passive, to a stage of exploring the environment and communicating with others. Marotz (2009:22) regarded the child's first year as a time of remarkable growth and development that will never be repeated in the child's life span. Thus, a mother's understanding of this development is vital. As seen above, it seemed that many of the mothers showed insight into their children's development needs.

However, a few participants showed a lack of insight into specific areas of the child's development. Participant 1 did not understand her child's attachment needs, as stated: *"She was a naughty baby. My mother did not want to look after her because she was naughty. She cried a lot. Because if she went to other people, she cried. If she was with me, she was quiet. What is that then, that is a naughty child."* This crying, according to Louw and Louw (2016:142), could occur as a result of separation anxiety, which is normal for babies between eight and 12 months. Whatever the reason for this child's crying when she was not with her mother, it is clear that this participant showed a lack of understanding by regarding her child as naughty.

Participant 2 thought: *"He was the only one, but then he could not walk yet because of laziness."* Participant 4 was unaware of the holistic needs of her child: *"As long as he is healthy, I did not really worry."* Participant 4 was lacking the knowledge to identify and meet her child's needs in a proper way: *"He cried over nothing. I didn't know what he was crying about. Easy, put a rand in his hand, then he was quiet."* Participant 17 did not have insight into her child's developmental impediment, as declared by her: *"Then if the child wanted to walk, I thought to myself … 'What child is she?' But I never knew there was something wrong with her leg."*

Charlesworth (2014:145) indicated the importance of professionals to teach mothers about child development in order for them to better understand their children's developmental needs from birth. This will enable mothers to apply the knowledge to their children and to promote positive interaction between the mother and the child. Mothers also need to be aware of their child's needs according to Maslow's hierarchy of needs, as outlined in Chapter 2, section 2.5.2.6.

Category (ii): Child's developmental milestones

Faure and Richardson (2016:70-72) explained that although there are guidelines for a baby's milestones at specific times, each baby progresses at its own pace. Parents must keep in mind the broad time spans in which their children's milestones are reached. Faure and Richardson (2016:70-72) also believed that babies are individuals and must not be assessed based only on their achievement of milestones, since this is not always a predictor of a delay or giftedness. In

contrast, Dosman *et al*. (2012:561, 567) believed that the failure of milestones could assist to identify developmental disorders in children. Hence, they have developed a framework to assist physicians with developmental surveillance, the process of monitoring child development over time to identify potential problems, which requires an understanding of developmental trajectories and milestones.

Some participants stated that their children reached some milestones early. Participant 3 said in this regard: *"He crawled so early."* Participant 12 was satisfied with her child's physical development: *"She did everything early. Early teething. She was six months then she already had teeth. She developed everything early … She did not crawl for long, then she started to stand up against things and began to walk. She developed quickly."*

Babies usually start walking between nine months and approximately 19 months, as noted by Bhattacharya *et al*. (2013:189). Butcher (2013) indicated 12 months as the average age for walking. The following statements from participants are in line with literature:

- Participant 3: "He was quick. He learned to walk fast. He was eleven and a half months when he started to walk against the things and climb onto things."
- Participant 8: "Not even a year, then she walked."
- Participant 10: "… from a year old, then she started walking."

However, participant 9 revealed that her child only began walking at age two, contrary to the average age as indicated above. Even though Mitchigan State University (2013) considers it as 'late walking' when a child starts walking after the age of 18 months, Martoz (2009:28) felt that two years is still age appropriate for this developmental achievement. Participant 8 mentioned that her child skipped the crawling phase. However, Mitchigan State University (2013) explained the benefits of crawling for the child's brain and future motor skills. As children crawl, their brains make more and more connections. Each connection is a solution to a problem that they have solved by and with crawling. The more they crawl, the more streamlined these connections become and the more automatic the skill becomes. A study conducted by Visser and Franzsen (2010) showed the importance of crawling for a child's development.

Not all the participants referred to their children's milestones. Participant 17 revealed her child's cognitive and physical developmental challenges: *"She does not catch [understand] if I talk to her, she does not listen. She does not catch or understand so well what I say. And the one eye is here while the other eye turns that side."* When the child was two years old, she recalled: *"Then all the*

other children were playing. My heart was sore because she already turned two, but the child just sat like that because there was something wrong with her. I went to the hospital and they told me at the hospital that [redacted] [child] will not be able to walk with her one leg."

3.4.6.2 Sub-theme 6.2: Mother's care and protection towards the child

The Department of Health's new *Road to Health* booklet, which was launched at public health facilities in November 2018, indicates five important areas for children's growth and development. These areas are (1) good nutrition, (2) lots of love, playing and talking, (3) protection from disease and injury, (4) health care when the child is sick, and (5) extra care and support where needed in high-risk circumstances (Department of Health, South Africa, 2018:1).

This sub-theme of the mother's care and protection towards the child has three categories, as illustrated in Table 3.22 below.

Table 3-22: Sub-theme 6.2: Mother's care and protection towards the child

Theme 6: Development and care of the child during the first thousand days of life	
Sub-theme	***Category***
6.2 Mother's care and protection towards the child	(i) Caregiving towards the child
	(ii) Protection and discipline
	(iii) Challenges regarding the caregiving of the child

Category (i): Caregiving towards the child

During the interviews, many participants referred to aspects of caregiving. The following statements are examples of good caregiving provided by the participants:

- Participant 2: "If he was maybe dirty, then I would wash him, go bath him again or wipe him off with the wipes and dress him in clean clothes. Because for me it was, he must just be clean. I always ensured that everything was clean and just right for him, perfect for him. I tried to do everything for the child myself."

- Participant 3: "So, I must make sure that he has everything, because the nanny must be paid, she must be looked after, her food must be ready – what she eats, her milk, clothing, everything. Then he sleeps too nicely and then it is the breastmilk that he drinks. So, I raised him in baby time."

- Participant 9: "So, every morning before work, I made baby ready."

- Participant 16: "… then I give her a little bit of breast and then make her sleep, see if she was dry and so, yes. Five o'clock I washed her, then my mother massaged her."

A few of the participants explained how they or their mothers or other family members massaged the baby regularly, as mentioned by participant 12: "She [participant's aunt] … bathed her [child], massaged …" According to Faure and Richardson (2016:15), physical touch like massage, cuddling or swaddling releases endorphins, which promotes the baby's emotional development.

Participants 2, 7 and 11 explicitly noted that their children had all they needed, referring specifically to their physical needs. Participant 2 planned in advance in order to ensure her child had all the necessary items like formula and nappies, as stated: *"Provision was always made for him … He never lacked anything. He was never hungry or so. When I saw that there was not enough of what he needed [necessary items] … then I would phone my father, or I make provision. He was my first priority."* Participant 7 felt confident in caring for this child, since this was not her first child: *"He never lacked anything. I had experience in how to raise children."* Participant 11 mentioned that the child's paternal grandparents bought many baby goods, thus she believed her child had more than enough: *"* [redacted] *[child] now had everything.* [redacted] *[child] was spoiled. The child had to get a pram and a stroller and a carrier and everything …* [redacted] *[child] must get a set so that she can sit in the car, a seat that she can eat in, a seat that she can sit in to watch TV. So, I can't say that she had a lack."*

Some participants also indicated emotional caregiving as important, as illustrated by participant 14's statement: *"I gave her what I could give her. I gave her love, I gave that all to her, until today, until now."* Participant 9 also met her baby's emotional needs by providing close contact when she was an infant: *"I always put her on my chest and took the blanket or my nightgown and covered her. Then she would lie like that on my chest because she did not want to lie in the bed. Once she was warmer, we would move to the chair and sit and sleep like that."* She further explained: *"… got a carry bag [baby carrier] that I could tie her in front of me …"* This participant was the only one who mentioned her child attending an Early Childhood Development Centre. Participant 8 described how she helped her two-year-old child through the grieving process when the child's grandmother passed away: *"But she saw, she was not going across the road that we walked to my grandmother's. Then she [child] became sick. Then I asked the doctor if it was maybe the teeth. Then they say, 'No, it's longing'. A day did not go by that she did not cry. Then the doctor said show her a photo of my grandmother. Then I showed her the photo …"*

Category (ii): Protection and discipline

Participants 1, 7 and 9 displayed an awareness of risks and the need to protect their children, as portrayed by the following excerpts:

- Participant 1: “She can maybe just be in the yard at the back, then I would look for her. Don’t let her play in the street. Scared the cars will drive over her.”

- Participant 7: “No, they were always where I could keep an eye on them, because at age two they move all the time. But I will do what I can. That’s what every mother does to protect her child.”

- Participant 9: “I did not like it when I had her on my arm, and I worked with hot things. Anything can happen. So, I always waited until she slept to make myself some coffee or something to eat or drink.”

Participant 2 acknowledged being overprotective: *“… overprotective of him. Must not get hurt or someone else must not hurt him.”* Due to challenges in the high-risk community, participant 8 felt*: “Oh, it’s a girl, I must protect her. And in our environment, a girl can’t walk alone, because anything can happen, so we must protect her.”*

Participants 1, 13 and 15 admitted to using smacking as a form of discipline, as explained by participant 1: *“But she’s naughty. If she did something wrong, then I will smack her on her hands.”* Participant 15 added: *“If she knows she is wrong, then I will give her a smack or two.”* Participant 14 also used smacking when verbal reprimanding did not change the child’s behaviour: *“… then I tell her, ‘Don’t do that, don’t do that, leave that thing, take this thing’. Then she did not do it, or she did it the other way around. And then there were a few smacks – not too hard, but a bit soft. After then she would say to me, ‘Mommy, okay, I may not do it anymore’.”*

The participants also mentioned other ways of discipline besides smacking:

- Participant 3: “So, you must know when to be patient and when to raise your voice, so that the child can listen.”

- Participant 6: “She makes a noise, I scold her.”

- Participant 13: “When I am strict with them [participant’s children], and they know I am strict, then they must know how to behave themselves.”

Zastrow and Kirst-Ashman (2013:179) said that spanking and scolding as forms of punishment, as seen above, are often used by parents to change their child's undesirable behaviour. From participant 11's comment it is clear that her child was testing the boundaries: *"… and if you said to her, 'Don't scratch there', she went and scratched there. If you told her, 'Baby, don't' then it just starts again. She scratched and then looked at me. She knew that maybe it was wrong, she must not scratch there. But she wanted to see what my reaction would be. If I now said, 'Jo', she knew it was wrong. But tomorrow she would do it again because she wanted to see what would happen."*

Category (iii): Challenges regarding the caregiving of the child

The following quote by Bhattacharya (2013:168) refers to the challenges of parenthood: *"Parenting is about raising a child to be happy, to thrive, and to succeed. But no one said it was going to be easy."* Based on the data collected, it was evident that the participants experienced a range of challenges regarding the caregiving of their children. These challenges varied from normal challenges for this time period, to more severe challenges. Some of the challenges associated with children between birth and two years included disturbed sleeping patterns, crying, teething and managing an energetic toddler, as experienced by the following participants:

- Participant 2: "Sometimes, yes he was tired, but he always battled to sleep … When he became older, it was always a struggle to get him to sleep."
- Participant 3: "Yes … maybe a bit continuous crying, yes, then you feel, 'Yo, what is wrong with the child?'"
- Participant 7: "What was difficult about [redacted] [child] was the teething. That was difficult for me."

According to Berk (2013:135), all babies have certain times when they will simply cry inconsolably, as indicated by participant 3's statement above. Another challenge, as explained by Davidson *et al*. (2014:1071), is when new mothers lack experience with a newborn baby and feel overwhelmed. They cautioned that new mothers could even become passive due to feelings of inadequacy, thus emphasising the importance of the mother's psychological adjustment with the help of public health nurses. This was experienced by participants 2 and 15 when they were uncertain about how to take care of their children, as they were very young and it was their first child, as voiced by participant 2: *"… but from birth I've struggled … It was my first child, I did not really know how. But my mother and grandmother helped with burping the baby."* Participant 15 shared a similar experience: *"… didn't know what to do, then I asked my mother …"*

Participant 9 had a caesarean which affected her physical well-being, as stated: *"But I was very tired. When I gave birth, I was very thin and they [hospital staff] said that I must get vitamins and things that will uplift me, that will give me energy … But I was very weak after the birth."* Thus, she found the first few months very difficult, taking care of the child on her own while the rest of her family was at work. She openly shared how she felt: *"I think it was the cut that caught me off guard … I had a lot of pain, so I did not have time for her. According to me, I shall say a little bit, because I am supposed to give more attention to her than to myself, but I myself was in pain. So, I neglected her a little bit … while I had pain [after the caesarean] and I could not really bend and so."* Davidson *et al.* (2014:1100-1101) explained that the physical condition of the mother and maternal stress after a caesarean could influence the mother's interaction with her baby. They also said that an unanticipated caesarean, like in the case of participant 9 could impact a mother's emotions, resulting in depression, anger, guilt or grief.

She continued to express her challenges during this time: *"… because she was now a colic baby and they cry a lot … And it was a bit lonely for me, because there was no one at the house at that time to help me."* Participant 16 was still a teenager and recovering from TB, as she shared: *"The TB made my body feel fatigued, almost like I am tired. Now I also sat with a child. What am I going to do with the child? I am also still a child."* She continued to share her journey as a teenage mother: *"I left school after her birth to look after* [redacted] *[child] myself. My other friends went out, I couldn't go out. I must now sit in the night with a baby …"* She also said: *"… mornings I felt so tired and if I am frustrated, then I felt I can shake her to keep her mouth shut … and then I would leave her to cry for ten, fifteen minutes until somebody said the child cries."* This correlates with symptoms of postpartum depression, as described by Davidson *et al.* (2014:1203).

Various participants lacked the necessary baby goods due to financial strain, adding pressure and making it extremely difficult to provide proper caregiving, as noted by participant 8: *"Yes and there was no Kimbies [disposable nappies]. Nappies, I had six nappies. When it rained, I had to make sure that the nappies dried so that she can put it on."* Participant 17 revealed: *"Sometimes, when there was no cereal and I didn't have money, then the child cried the whole day and so. When there were no [nappies], then you must just take a cloth and a plastic bag, then make two holes in the plastic bag and tie it together. I couldn't wash the nappies because there was no soap."* Besides financial struggles, participant 10 shared another challenge where she had to leave her ten-day-old baby in the care of her oldest daughter, due to her other daughter having an operation.

3.4.6.3 Sub-theme 6.3: Stimulation and play

Table 3.23 shows the categories in this sub-theme, including type of stimulation and play and the child's interaction with the mother and others.

Table 3-23: Sub-theme 6.3: Stimulation and play

Theme 6: Development and care of the child during the first thousand days of life	
Sub-theme	***Category***
6.3 Stimulation and play	(i) Type of stimulation and play
	(ii) Child's interaction and play with the mother and others

Category (i): Type of stimulation and play

According to Cook and Cook (2010:126-127), the child needs a stimulating environment to form sophisticated neural connections in the brain. The developing young brain is stimulated when the child has opportunities to interact with their environment in rich and meaningful ways. This interaction includes toys, books, reading, singing, hugs, tickles, and speaking to the child. However, when children are deprived of sufficient stimulation, they lose the opportunity to form new synapses that help them to reach their full cognitive potential.

This study revealed different ways in which the mothers incorporated stimulation and play into the various phases of their child's life. Many participants provided examples of how they played with their children during infancy and the first few months, as seen below:

- Participant 3: "That was every morning, then I had to talk to him and play and say, 'Good morning'. Say I washed him, then I played with him and tickled him on his chest, which made him laugh and giggle … Or I would sing something to him so that he can laugh and be playful, that he can just feel happy."

- Participant 5: "You know, tickling them and then sing for them. Then swing them a little bit."

- Participant 13: "… played hide and seek … then she will hear my voice, then she knows it's me, then she looks, then she laughs, although she knows it's me."

- Participant 18: "Nurtured her and so, 'Yes, mommy's baby' and then the child laughed … and then I tickled her, only the neck … and then I throw the child up in the air. Did everything she liked."

The above-mentioned interactions, referred to 'serve and return' by the Center on the Developing Child of Harvard University (2019b), build a strong foundation in the child's brain architecture for

the child's future learning and development. This type of responsive and attentive contact with two-way interaction between the parent and child supports the development of communication and social skills.

Participant 7 described her initiative: *"Then I maybe make the balloons, I tie about three balloons at the shop. It's how much, ten cents, then I make it so … with a string to just where his hands could touch, then he plays with it."* Participant 13 indicated: *"Yes, and as she grew older, I hanged her toys in the air…"* Participant 8 did the following: *"… five months, I put her in front of the TV. Barney. And so, she learned to count, sing …"*

When the children were older, many participants provided their children with toys, including educational toys like puzzles, blocks and counting frames, as confirmed by participant 14: *'Yes, she had enough toys … It's blocks and counting frames they use to count …"* Shrier (2018) confirmed the advantages of these educational toys mentioned by some participants. She explained how playing with blocks enhances brain development, and noted the benefits of puzzle building by stating: *"As children solve puzzles, they are utilising problem-solving skills, hand-eye coordination, fine-motor skills, shape recognition, memory, spatial-awareness skills and more."*

Participant 11 too understood the importance of educational toys: *"I told people if they give toys to my child, give educational things."* Participant 6 exposed her child to different experiences and stimulating surroundings: *"We go out, like a family goes out, to the beach, to the park…"* This type of stimulation, as seen in the mothers' former statements, is vital for the child's cognitive development, since this phase corresponds with Piaget's sensorimotor phase where children acquire an understanding of their world through their senses and apply sensorimotor thinking (Louw & Louw, 2014:26).

All the participants indicated some form of stimulation or play except participant 17 who said: *"No, there was no play."* According to the Center on the Developing Child of Harvard University (2019c), a lack of stimulation and appropriate input from caring adults could disrupt the developing architecture of the child's brain, subsequently impacting their physical, mental and emotional development. The centre explained how the ongoing absence of 'serve and return' interaction, as described above, deprived the child's brain of positive stimulation while flooding the developing brain with potentially harmful stress hormones.

Category (ii): Child's interaction and play with the mother and others

Although many mothers played with their children, for example tickling them when they were a few months old, as indicated in the previous category, only some of the participants played

together with their children when they were older. Participants 2, 3, 5, 7, 14, 15 and 18 indicated playing together with their children, as demonstrated by the following quotes:

- Participant 2: “I played with him with his cars, with his cars and dolls.”
- Participant 5: “We always played with her with the dolls, sang for her, danced.”
- Participant 14: “… then she runs a bit, then I run to her. Then I catch her a bit, hug each other…”
- Participant 15: “… if she played doll’s house, I always played with her and so. If she wanted a doll, then I give her a doll and then she said, ‘That’s mommy’s, this is mine’.”

A few mothers used certain interactive activities to stimulate and educate their children. Participant 7 mentioned: *“I had my own vegetable garden. [redacted] [child] started to walk. Then I said, ‘ [redacted] [child], these are tomatoes that are growing here’.”* Participant 8 explained: *“If I now maybe sing about Barney, she would correct me. Then she sings, ‘Two, mommy, two’. We helped each other in this way. And colours, I would then say, ‘That’s pink’. Then she says, ‘No, it’s white’. I taught them things.”* Participant 11 taught her child about colours and shapes in the following manner: *“It’s because I talked to her and said, ‘Sit on the blue chair’ or ‘Give the purple brush’… ‘Quickly sit on the rectangular table’.”*

Although some participants played directly with their children, some mothers did not do this, as illustrated by participant 1: *“When she played with her doll she always said, ‘Play with me.’ Then I would say, ‘I can’t play with your doll now’.”* Participants 6 and 10 did not regard it as necessary to play directly with their children. Participant 6 said in this regard: *“No, because most of the time she played with her sisters. So, I did not really play like that, like in play with her…”* Participant 10 mentioned: *“I did not really play with her when she was one year old, when she started to walk and not crawl, because the two sisters were more in control of her.”*

Several participants referred to the social interaction between the child and other people including the biological father, siblings, other family and peers. Participants 3 and 18 referred to the father playing with the child. Participant 18 noted: *“… and then I would go and call the father … and then we [participant, child and father] played together.”* According to participants 3, 6, 7 and 10, the siblings played with the child, as confirmed by the following quotes:

- Participant 3: “If the children came out of school, they would always play with him or walk with him.”

- Participant 7: “But the one dressed him like a girl, then the other one dressed him like a ballerina [laughs].”

- Participant 10: “… they [child’s sisters] would throw a blanket in the front room, put all the toys there, now the three of them sat down and played.”

Participant 3 recalled her child’s interaction with another baby of the same age: *“My friend also had a baby, now maybe eight, nine months, then the two of them played nicely.”* Participant 9 referenced the child’s interaction with her uncle: *“My brother always played with her.”*

As explained by Cook and Cook (2010:420-421, 430), play can occur on various levels, as seen above, which could include children playing on their own, among others or with other people. They also said that social interaction between babies and their peers usually occurred after one year when they started to communicate with each other. According to them, social interaction and playing with others are important for children in order to learn how to form social relationships and make friends. Zastrow and Kirst-Ashmen (2013:160) confirmed the importance of socialisation where children learn to interact with family and others. Through socialisation they acquire knowledge and skills regarding language, values, behaviour and social expectations.

3.5 SUMMARY OF THE FINDINGS

This study highlighted the various factors that can potentially influence the first thousand days of a child’s life. In the context of this study, these factors relate to the three key areas outlined in the First 1000 Days initiative of the Western Cape Government (2017). Table 3.24 below illustrates how these factors relate to the various areas of the First 1000 Days initiate.

Table 3-24: Key areas of the First 1000 Days initiative and related themes

Key area of the First 1000 Days initiative	***Theme***
1. Health and nutrition	Theme 1: Health of the mother during the first thousand days of the child's life
	Theme 2: Health of the child during the first thousand days of life
2. Love and attention (also referred to as nurture, care and support)	Theme 3: Availability of support to the mother and child during during the first thousand days of the child's life
	Theme 4: Circumstances of the mother and the child during the first thousand days of the child's life
	Theme 5: Attachment and relationship between the mother and the child during the first thousand days of the child's life
	Sub-theme 6.2: Mother's care and protection towards the child
3. Play and stimulation (also referred to as safety, protection and stimulation)	Theme 6: Development and care of the child during the first thousand days of life (sub-themes 6.1 and 6.3)

A summary of the findings will be provided based on the three key areas as indicated above, namely (1) health and nutrition, (2) love and attention, and (3) play and stimulation.

Health and nutrition

The health of the mother (Theme 1) and the health of the child (Theme 2) relate to the first key area namely health and nutrition. The physical and mental health of the mother during pregnancy plays a vital role during pregnancy, as well as after the birth of the child. Various biological mothers in this study suffered from severe illnesses and medical conditions like extreme high blood pressure, a stroke, and TB during their pregnancy. These conditions increase the risk of complications for both mother and child (Biswas & Amato, 2016:140; The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2017; WHO, 2016a). These conditions required medication, regular clinic visits and in some cases hospitalisation. Complications during pregnancy, especially during the birth process, were extremely likely and included the following: preterm birth, low birth weight, umbilical cord prolapse, ectopic pregnancy, hypertension and breech births. Four of the participants who suffered from complications were teenagers, which increases the risk for adverse pregnancies (Statistics South Africa, 2017:10). In addition, several children suffered from oxygen deprivation after birth, which could cause disabilities and developmental delays (Ankin, 2019; Birth Injury Guide, 2019; Seattle Children's Hospital Research Foundation, 2019).

The mother's well-being influences the baby's well-being during pregnancy (Murkoff & Mazel, 2016:18), which could have positive and long-lasting physical, cognitive and emotional outcomes for the child (Perinatal Mental Health Project, 2019). The pregnancy itself clearly influenced the

emotional and mental well-being of the mothers in this study, whether positive or negative. Although some participants encountered a positive experience and emotions, others endured severe stress during the pregnancy, especially since it seemed that all of these pregnancies were unplanned. Several participants described the pregnancy experience in a negative light as a result of the morning sickness, swelling, uncertainty, sleeping challenges and high blood pressure caused by the pregnancy.

Stressors related to the mother's current circumstances, for example being teenagers and still attending school, as well as the relationship with the biological father of the child were very prevalent. The severe stress experienced by one participant resulted in panic attacks. Another participant endured an extremely stressful and traumatic event when the child's father attempted to kill both her and the baby. Various participants experienced internal stressors, especially relating to the announcement of the pregnancy to family, which included intense emotions like guilt, disappointment in oneself, fear and anxiety. The findings also indicated that a few of the mothers displayed symptoms of possible depression, which included sadness, anxiety, guilt and feelings of worthlessness (American Pregnancy Association, n.d.a). Prenatal exposure to maternal depression could affect the brain development of the fetus (Marroun *et al.*, 2018:327). In addition, various participants experienced the birth process as stressful, possibly resulting in birth trauma, thus impacting the mothers' physical and mental health (The Australian Birth Trauma Association, 2017).

Fewer mothers indicated stressors during the time from the child's birth to two years. However, the stressors that were mentioned mostly included stressors pertaining to motherhood and losing a loved one. One mother's mental health after the birth of her child showed signs of postpartum depression (American College of Obstetricians and Gynecologists, 2013; American Psychiatric Association, 2017) or even postpartum psychosis (Mayo Clinic, 2018b) since she attempted to kill her baby.

Although many participants ate healthily during the pregnancy, poor nutrition was seen among some participants. Nutritional deficiencies during pregnancy can affect the child's cognition, behaviour and productivity later in life (Prado & Dewey, 2014:267; UNICEF, 2016a). Many of the mothers did not acquire sufficient nutrition during pregnancy as a result of challenges like food scarcity.

The occurrence of substance use/abuse during pregnancy was significantly high, with cigarette smoking the highest, followed by alcohol use and, lastly, drug abuse. Several participants indicated high amounts of substance intake, including a packet of cigarettes per day, a few bottles

of beer or, in one extreme case, nearly five litres of beer at a time. Illicit drugs that were consumed during pregnancy included Methamphetamine (Tik), Dagga and Mandrax. Substance use/abuse during pregnancy posed severe risks to both the mother and the child. These risks included physical and neurological damage to the child (WHO, 2019b). A few participants showed insight into the effect of their substance use/abuse on the child, with one participant linking it to her child's current poor schooling outcomes.

The health of the child (Theme 2) during the first thousand days establishes the foundation for optimal health and development later in life (UNICEF, 2017). A few mothers highlighted their children's good health while many of these children experienced poor health during this crucial time. A few children suffered from oxygen deprivation directly after birth, which can cause disabilities and developmental delays and other long-term effects for the child (Ankin, 2019; Birth Injury Guide, 2019; Seattle Children's Hospital Research Foundation, 2019). The mothers of the four children with respiratory problems smoked cigarettes during their pregnancy, which could possibly be the cause of these health conditions, as explained by McEvoy and Spindel (2017:31). Some children had more severe illnesses and conditions such as TB, kidney disease and colon problems as well as physical disabilities. A few of these children were hospitalised, causing severe psychological stress and other challenges such as a lack of sleep and transport problems to the hospital. Some participants confirmed taking their children for their medical check-ups and immunisation at the scheduled times, which play a vital role in children's health (Department of Health, n.d.a).

The nutritional needs and nature of feeding from birth to two years included various aspects. Most of the mothers breastfed their children during the first few months, as recommended by the WHO (2003:7-8) and various South African authorities in this field. Only a few of the mothers used mixed feeding or only formula. A few mothers provided their children with a herb mixture which they believe assisted with digestive problems, but is not recommended by the Department of Health (2018:4). Only a few mothers complied with the guidelines of the Department of Health (2016:10) on the age for introducing solid foods into a baby's diet – which is only at six months. Some mothers provided solid food as early as one month while others provided solid foods much later, between seven and 12 months. Most of the mothers showed a good understanding of nutrition and provided good food choices like fruit, vegetables, meat and dairy products, as suggested by, among others, the Australian Government (2013:10, 12).

In terms of the child's weight, several mothers indicated that their children had a healthy weight while a few stated that their children were underweight or overweight. It was evident that many mothers experienced challenges regarding their children's feeding and nutrition, with lack or

limited food due to financial strain indicated as the main challenge. Due to poor nutrition and other challenges, nutritional deficiencies occurred, leading to stunting in some of these children, thus affecting brain development and often resulting in learning difficulties at school (UNICEF, WHO & World Bank Group, 2018:2).

Love and attention

Theme 3, Theme 4, Theme 5 and Sub-theme 6.2 relate to the second key area of the First 1000 Days initiative, namely 'Love and attention', which refer to aspects like support, nurturing care and attachment. The mothers' emotions and thoughts regarding support, as well as the announcement of the pregnancy and other people's responses to this news, had an effect on the mothers' experience of support during pregnancy, as well as after birth to two years. Since many of the mothers were unmarried when they fell pregnant, the announcement of the pregnancy caused anxiety and fear. In most cases, the reactions of family members and the biological father in the beginning after the announcement of the pregnancy were not positive and supportive. Some mothers experienced family members not talking to them, threatening to put them out of the house, or the biological father denying fatherhood. Although various mothers felt supported during their pregnancy and after the birth of the child, many participants experienced a lack of support that resulted in a sense of loneliness. The lack of support caused the mothers to be more vulnerable to depression and anxiety (Perinatal Anxiety & Depression Australia, 2017). However, good support led to these mothers feeling happy, grateful and hopeful.

Support from the biological father is of utmost importance (C.S. Mott Children's Hospital, 2018), as experienced by some of these mothers. This support included emotional support, attending medical visits with the mother and practical support. However, several participants experienced a lack of the support from the biological father during pregnancy, as well as the time from birth to two years. Many mothers expressed challenges pertaining to their relationship with the biological father, including an unstable relationship, conflict, drug abuse of the father and lack of financial support. A few fathers engaged with their children and played an active role in their lives, which can have a positive influence on these children's social, emotional and cognitive development (Allen & Daly, 2007:1).

Various mothers experienced good support in the form of advice, practical assistance, emotional support and financial support from family and others like neighbours, colleagues, friends and staff from the local clinic. On the other hand, several mothers felt totally unsupported or only lacked support from specified people, especially the family of the child's father. It was apparent that other people, especially the grandparents and the mother's male friends, played a positive role in the

child's life. In view of Bronfenbrenner's bioecological theory (Rosa & Tudge, 2013:244; Tudge *et al.*, 2016:428), the interactions and relationships between the mother and others, as well as the child and others, involve proximal processes that have an impact on the mother and the child.

Theme 4 referred to the living and financial circumstances during the two phases, pregnancy and birth to two years. More than half of the mothers described their living circumstances as suitable and pleasant, while others experienced adverse living conditions like improper housing, a significant amount of family conflict, as well as substance abuse in the home causing vulnerability for the mother and the child (Scorgie *et al.*, 2015:10-11). The living circumstances remained the same in most cases. However, there were changes and even improvements for some mothers.

Financial circumstances had a significant impact on the mothers during this time and most of the mothers experienced some form of financial strain, with contributing factors like unemployment, limited employment and lack of financial support from the father. Some participants experienced severe financial challenges, often lacking the resources to supply in their child's basic needs. The element of context in Bronfenbrenner's bioecological theory affected the mother's experiences of the environment on micro, meso and macro level (Tudge *et al.*, 2016:428). This theme summarises the mothers' experiences of their environment on micro, meso and macro level.

Theme 5 highlights the process of attachment and relationship between the mothers and their children during pregnancy, directly after birth, as well as during the two-year period after birth. Although quite of few of the mothers were happy and excited when they found out they were pregnant, many of the mothers experienced initial negative emotions such as shock, confusion, disappointment, anger, sadness and panic due to the pregnancy being unplanned (Higgens, 2018), making them susceptible to the risk of maternal depression (Faisal-*Cury et al.*, 2017:70).

The gender of the child impacted the mothers' emotional responses and many of them felt relief, happiness and excitement when the gender coincided with their preferences. Quite a few mothers considered abortion or adoption, especially in the beginning of the pregnancy. The movement of the unborn baby activated a variety of positive emotions like happiness, excitement, enjoyment, love, acceptance and protection, indicating signs of bonding (NHS Health Scotland, 2019; Wheatly, 2019). The mothers interacted with their unborn children in various ways, for example by talking and singing to them.

The mothers' positive response immediately after birth could influence them to be more inclined towards their children's needs later on (Stoppard, 2008:316). Various participants expressed positive initial responses, interaction and emotions directly after the birth of the child while some experienced an internal motivation for self-improvement. It was noticeable that attachment

between the mother and her child formed during the two-year period after the child's birth, since most mothers experienced positive emotions and thoughts towards their children. It was evident that most of the children in this study formed an emotional attachment with their mothers.

The sixth and last theme involves the development and care of the child during the first thousand days. Sub-theme 6.2 on the mother's care and protection towards the child relates to the second key area of the First 1000 Days initiative, 'Love and attention', which includes care of the child. Many mothers mentioned positive caregiving towards their children, including physical care and nurturing. However, various participants experienced challenges relating to the child and their care, like disturbed sleeping patterns, colic, fatigue, feeling overwhelmed, as well as financial challenges resulting in a lack of basic baby goods, which added extreme pressure. A few mothers indicated using smacking as a way to discipline their children while none of the mothers mentioned any form of positive discipline, indicating a lack of knowledge regarding these important techniques.

Play and stimulation

Sub-theme 6.1, 'Child's development', and Sub-theme 6.3, 'Stimulation and play', relate to the third key area, as described above. With regard to the mothers' understanding of their children's developmental needs, it was clear that more than half of the mothers showed an understanding of one or more of the children's needs. Most of the mothers understood their children's physical needs well, but showed less insight into their children's other developmental needs. Only a few participants showed insight into their children's emotional, linguistic and cognitive developmental needs. Several participants lacked an understanding of their children's holistic developmental needs and regarded some of the children's behaviour as naughty or lazy.

Various mothers felt that their children met their developmental milestones, with some mothers highlighting their children's rapid development. A few mothers did not reveal anything about their children's milestones. One specific mother who abused drugs during her pregnancy, pointed out her child's cognitive and physical developmental challenges.

In terms of stimulation and play, many mothers used 'serve and return' to stimulate and play with their children when they were babies, which is very beneficial to build a strong foundation in the child's brain architecture (Center on the Developing Child of Harvard University, 2019c). Several mothers used educational toys or activities to incorporate stimulation and play into their children's lives. Quite a few mothers used toys to play with their children when they were older. However, many other mothers did not regard playing with their children individually as necessary, since they

felt that the child could play with their siblings. In addition, the children's social interaction included playing with others like the father, siblings or other family members.

In summary, it should be noted that although the aim of this study was not to determine a correlation between the first thousand days and absenteeism, the findings of this study clearly indicates that many factors played a vital role during the first thousand days of life. These factors, for instance the health and nutrition of the mother and child, substance abuse/use of the mother during pregnancy, toxic stress, support of the mother and child, living and financial circumstances of the mother and child, attachment and relationship between the mother and child, as well as the stimulation of the child during this critical time period of the first thousand days could affect the child's physical, cognitive, socio-emotional development with long lasting consequences later in life (Pem, 2015:1). Literature further confirms that specific aspects revealed in the findings of this study, such as nutritional deficiency (Maalouf-Manasseh *et al*., 2016:1,4), the mother's substance abuse during pregnancy (Adnams, 2016:12; Kellerman, 2003), toxic stress (Thompson, 2014:41, 43), attachment (Newman *et al*., 2015:4) and stimulation (Ebrahim *et al*., 2013:69) could have negative effects on a child's schooling. Some of these aspects include academic, social and/or emotional problems at school, as well as school absenteeism. Thus, taking the findings of this study and literature regarding schooling into account, it seems that some of these factors could be connected to absent learners.

Finally, reflecting on the findings of this study and various theories relating to child development discussed in Chapter 2, it appears that these theories played a significant role in the following way. The first two stages of Erickson psychosocial theory (Louw and Louw, 2014:22; Zastrow & Kirst-Ashman, 2013:303-304) relates to the ages of birth to two years and referred to the children's development of trust and autonomy. The sensorimotor stage of Piaget's theory of cognitive development were visible in the way these mothers described their children's understanding of their environment though different activities involving their senses. Attachment between the mother and child as indicated by the attachment theory (Berk, 2013:428) were indicated as one of the themes and transpired various times in this study. The four phases of the attachment theory (Berk, 2013:429; Louw & Louw, 2014:133-134) were also displayed during the time from birth to two years as these mothers described the bond between them and their child, as well as the reaction of the child when separation occurred. However, the specific types of attachment (Berk, 2013:430-431; Louw & Louw, 2014:134-135) were not definite. Bronfenbrenner's bioecological theory (Rosa and Tudge, 2013:244) were clearly seen throughout the study where both the mother and child's interaction with various systems played an essential role. Lastly, Maslow's hierarchy of needs (Beckley, 2013:15; Zastrow & Kirst-Ashman, 2013:456), mainly the first three needs namely (1) physiological needs, (2) the need for safety, and (3) the

need for love were strongly evident in the findings. The lack of basic physiological needs for example food and baby goods due to poverty had a huge effect on some of these mothers and were highlighted by many of them.

3.6 CONCLUSION

The findings from the data analysis have been comprehensively discussed in this chapter. The six themes that emerged and that relate to the First 1000 Days initiative of the Western Cape Government provide in-depth insight into the multitude of factors that play a role during this crucial time from pregnancy to two years. As confirmed by the literature indicated in Chapter 2, as well as literature in this chapter, the first thousand days of children's lives could have long-lasting effects on various areas of their development and schooling. As indicated before, this study's aim was not to determine a correlation between the first thousand days and absenteeism, but solely to explore the factors that could potentially have affected the first thousand days of absent learners in the Foundation Phase. Based on the data collected, it is clear that many of the absent learners in this study endured several negative factors that could potentially have affected their first thousand days of life.

The last chapter of this study, Chapter 4, will present a summary of the research question, aim, objectives and trustworthiness. It will also offer a discussion of the conclusions based on the themes, with recommendations for practice. In addition, other recommendations, the contribution, limitations and a personal reflection will be provided.

CHAPTER 4: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS OF THE RESEARCH STUDY

4.1 INTRODUCTION

This chapter provides a summary of the completed study in the context of the research question. An overview is provided of how the research question, aim and objectives were reached, as well as the trustworthiness that underpinned this study. Conclusions and recommendations for practice pertaining to the specific themes will be discussed with the hope to make a contribution to organisations and professionals working with mothers who are pregnant or who have children under two years in order to promote optimal support to these mothers during their children's first thousand days. This section will also include further recommendations for training, research and policy, followed by limitations, contribution of this study, as well as a brief version of the researcher's personal reflection on her experience regarding this research journey.

4.2 SUMMARY OF THE RESEARCH QUESTION, AIM AND OBJECTIVES

This section will explain how the research question, aim and objectives of the study were achieved as these research components guided the direction of this research.

4.2.1 Research question

The primary research question guiding this study was: What themes will emerge regarding the factors that could potentially have affected the first thousand days of absent learners in the Foundation Phase? This question was composed based on the research problem regarding the various factors that could influence a child's first thousand days of life, as well as the researcher's personal interest pertaining to absent learners in the Foundation Phase. The research question was answered by accomplishing the research aim and objectives of this study. Thus, the research question was answered by exploring the six themes as indicated in Table 4.1.

Table 4-1: Summary of the six themes

Theme number	*Theme title*
Theme 1	Health of the mother during the first thousand days of the child's life
Theme 2	Health of the child during the first thousand days of life
Theme 3	Availability of support to the mother and the child during the first thousand days of the child's life
Theme 4	Circumstances of the mother and the child during the first thousand days of the child's life
Theme 5	Attachment and relationship between the mother and the child during the first thousand days of the child's life
Theme 6	Development and care of the child during the first thousand days of life

4.2.2 Aim and objectives

The aim of this study was to qualitatively explore and describe factors that could potentially have affected the first thousand days of absent learners in the Foundation Phase within the Paarl East area in the Western Cape.

The qualitative descriptive design allowed the researcher to explore and describe factors that could potentially have affected the first thousand days of absent learners. Semi-structured interviews were conducted with 18 mothers of absent learners residing in the Paarl East community to explore this phenomenon. The audio-recorded data was transcribed and analysed using thematic analysis. Therefore, the aim of this study was accomplished by revealing the six main themes, sub-themes and categories to describe factors that could potentially have affected the first thousand days of absent learners within the Paarl East area in the Western Cape.

The two objectives of this study were to:

(i) Conduct a literature study on the first thousand days, Foundation Phase of schooling, school absenteeism, as well as child development from pregnancy to two years in order to develop a conceptual framework for this study.

(ii) Explore and describe factors that could potentially have affected the first thousand days of absent learners in the Foundation Phase by conducting semi-structured interviews with the mothers of such learners.

Objective one was achieved by conducting a literature study on the above-mentioned topics, as reported on in Chapter 2. The literature study was divided into the following two parts, namely: (1) The significance of the first thousand days, Foundation Phase and school absenteeism, and (2) Child development from pregnancy to two years and related theories. The aspects included in

Part 1 were the importance of the first thousand days, the Western Cape Government's First 1000 Days initiative, background information regarding the Foundation Phase of schooling, the importance of reading and writing in the Foundation Phase, early learning before entering the Foundation Phase, definitions of school absenteeism, the importance of school attendance, reasons for school absenteeism, consequences of school absenteeism, as well as school absenteeism in the South African context. Part 2 consisted of the three stages of the prenatal phase, the two phases after birth to two years and theories related to child development and other relevant theories.

The second objective was reached by conducting semi-structured interviews with 18 biological mothers of absent learners in the Foundation Phase to explore their children's first thousand days of life. An interview schedule, which correlated with certain key factors of the Western Cape Government's First 1000 Days initiative, as well as a timeline tool were used during the semi-structured interviews. These interviews provided the researcher with insight into the various factors that could potentially have affected the first thousand days of these learners. The research findings describing the factors that could potentially have impacted the first thousand days of absent learners in the Foundation Phase were discussed in detail in Chapter 3.

4.3 TRUSTWORTHINESS

As discussed under section 1.8 in Chapter 1, trustworthiness was demonstrated by applying the four criteria of trustworthiness in this research study, namely (1) credibility, (2) transferability, (3) dependability, and (4) confirmability. Credibility was ensured by conducting this research according to a respectable research process and by utilising sound research methods. In addition, as suggested by Nieuwenhuis (2016b:123), the researcher collected comprehensive data and had regular sessions with her research supervisor to ensure that the research findings were a true reflection of the data collected. The researcher believes that the research findings can be transferred to similar contexts as that of the specific community in which the study was conducted, which means that transferability might be possible in other contexts. Trustworthiness was established by providing a comprehensive description of the sampling, data collection, data analysis and the entire research process, as seen in Chapter 1. Dependability was achieved by keeping a reflective journal, ensuring the research process was logical and clear, as well as providing a comprehensive description of the research design and data collection as indicated under 1.6 in Chapter 1. The researcher accomplished confirmability by providing an 'audit trail' and specifically selecting quotes for this final report. Confirmability is also ensured by storing all the data at the Centre for Child, Youth and Families Studies, Wellington, for five years after the completion of this study.

4.4 CONCLUSIONS AND RECOMMENDATIONS

In this study, the factors that could potentially have affected the first thousand days of absent learners in the Foundation Phase were explored. After analysing the data, six themes emerged in this research study. Conclusions and recommendations will be presented according to the themes that emerged from this study. Each of the six themes will be discussed individually with its own conclusions and recommendations for practice, since this domain offers the opportunity for swift implementation of these recommendations. The recommendations for practice do not only focus on the Social work field, but also include professionals working in the Department of Health, as well as any other relevant service delivery entities such as NPOs, Early Childhood Development Centres and churches. At the end of this section, recommendations on training, future research, legislation and policy, as well as summative recommendations will be made.

4.4.1 Conclusions according to themes with recommendations for practice

Theme 1: Health of the mother during the first thousand days of the child's life

The conclusions for this theme are the following:

(i) The impact of the mother's physical and mental health, nutrition and substance use/abuse during pregnancy, as well as after the birth of the child was very significant and could affect the baby either directly or indirectly.

(ii) The physical health of the mothers in this study revealed severe illnesses and medical conditions like TB, high blood pressure and stroke, and a variety of birth complications. These could increase the risk for both mother and child and even cause developmental delays later in life, especially where oxygen deprivation occurred. Teenage mothers are more prone to birth complications, as confirmed in this study, and need special attention. Illnesses and medical conditions during pregnancy or after giving birth could impact a mother's emotional well-being, which means that mothers with medical conditions need extra emotional support.

(iii) The mothers' mental health and emotional well-being was influenced by their experience of the pregnancy, as well as stressors and related emotions and thoughts from pregnancy up to the child's second birthday. The pregnancy itself affected these mothers' emotional well-being and caused severe stress to many mothers, especially the announcement of the pregnancy to their families.

(iv) All the pregnancies seemed to be unplanned which affected these mothers' emotional well-being and caused severe stress, especially where the mothers were teenagers or unmarried. Pregnancy challenges such as morning sickness, swelling, feelings of uncertainty, sleeping problems and other medical conditions contributed to a negative pregnancy experience. Birth trauma and stressors after the child's birth to two years caused negative emotions and thoughts like fear, anxiety, panic and sadness, which could possibly increase the risk for postpartum depression.

(v) A mother's nutrition during pregnancy could impact both her own and the baby's health. The lack of adequate food and nutrition as a result of unemployment and poverty was one of the main challenges regarding food, which led to poor nutrition of these mothers during pregnancy.

(vi) Many mothers revealed using one or more of the following substances, namely alcohol, cigarettes and illicit drugs, with cigarette smoking being the most prevalent. Although the amount of substances varied, extremely high doses of alcohol, cigarettes and regular drug abuse were indicated, thus presenting a high risk for these children's physical and neurological development. Insight into the negative effects of substance use/abuse on the developing baby caused some mothers to decrease or stop their substance use during pregnancy. However, insight into the harmful effects of substance use/abuse during pregnancy was only indicated by a limited number of mothers.

Recommendations for practice are the following:

(i) Health care professionals should provide basic emotional support during medical visits while treating pregnant mothers' illnesses or medical conditions.

(ii) When working therapeutically with mothers, Social workers and other professional counsellors could empower mothers with stress management tools that include practical ideas like journaling, breathing exercises and selfcare guidelines.

(iii) Support groups for pregnant mothers or mothers with babies up to two years are also recommended in order to provide emotional support during this sensitive time. It is recommended that each group member is connected with another group member to provide each other with continuous support in between group sessions.

(iv) Health care professionals should be provided with a list of soup kitchens and other organisations that could assist mothers with food. These organisations should be made aware by the local clinic of the nutritional needs of pregnant and lactating mothers to

incorporate nutritional food into their meals. Another recommendation is that soup kitchens or organisations provide meals on the premises of local clinics, focusing on pregnant and lactating mothers. Therefore, a strong networking relationship between the local clinic or hospital and these organisations is recommended. Where clinics provide a feeding programme and nutritional packs to pregnant mothers, these mothers should be closely monitored to ensure that they consume the nutritional packs, which must preferably be served daily at the clinic.

(v) Health care professionals in the public sector should follow the WHO's guidelines on the identification and management of substance abuse disorders during pregnancy (WHO, 2014). These guidelines include educating mothers on the risks of substance use/abuse during pregnancy, screening a pregnant mother's past and present substance use/abuse during every antenatal visit, as well as referring them for professional help where needed. Social workers in private practice or working within the non-profit sector could use brief interviewing skills to motivate mothers to decrease or end their substance use/abuse while pregnant. Social workers working for Designated Child Protection Organisations (DCPOs) could include a plan of action regarding pregnant mothers' substance use/abuse in the safety plan after a risk assessment has been done.

Theme 2: Health of the child during the first thousand days of life

The conclusions for this theme are the following:

(i) The findings in this study indicated that many of these children endured illnesses or had a medical condition. All the children who had some form of respiratory problem after birth had mothers who smoked cigarettes during pregnancy, confirming the literature stating that cigarette smoking during pregnancy can cause health problems, especially chest problems, in these children. Several mothers indicated that their children suffered from severe illnesses or medical conditions like TB, kidney disease or colon problems. In some cases, these children were hospitalised, causing various challenges and psychological stress for the mothers. Some of the mothers showed insight into the importance of their children's medical visits and immunisations on the specified times, which plays a vital role in the children's health outcomes.

(ii) More than half of the mothers were breastfeeding their children as recommended by the Department of Health, thus providing their children with the nutritional benefits of breastmilk. The recommended age of six months for introducing a baby to solid food was not adhered to by many mothers, since a few started their babies on solid food much earlier or few

months later. The child's weight according to specified age guidelines is an important indicator of nutrition, which was mentioned by some of the mothers. A few children were underweight, a possible sign of malnutrition or even stunting, which is detrimental to their brain development and could cause learning challenges during their school years. On the other hand, some of these children were overweight, which is also not beneficial to their health. In a similar way that the mothers experienced nutritional challenges, these children were also exposed to poor nutrition and a lack of sufficient food caused by poverty during the critical window of opportunity from birth to two years of age.

Recommendations for practice are the following:

(i) Social workers rendering services to mothers with babies up to two years should include the *Road to Health* booklet in their assessments and assist the health sector by motivating the mothers to adhere to the clinic and immunisation dates.

(ii) Social workers working with mothers with children older than two years should ask the mothers to bring their children's *Road to Health* booklets to their initial assessment when they are requesting services in order to provide valuable information regarding these children's health during the first thousand days. These insights could assist Social workers to develop individual developmental plans or safety plans.

(iii) Although Social workers are not specialised in nutrition, they could provide mothers with basic information about healthy food and nutrition, as well as assistance regarding budgeting and the use of the child support grant to ensure proper nutrition of children during their first thousand days.

(iv) It is suggested that Social workers or other professionals incorporate this basic information on the child's health and nutrition into their sessions for parenting groups or workshops.

Theme 3: Availability of support to the mother and the child during the first thousand days of the child's life

The conclusions for this theme are the following:

(i) The mothers' experience regarding support indicated that the response of family and the children's fathers to the pregnancy news affected their support, especially in the beginning of the pregnancy. Since these pregnancies were not planned, the pregnancy announcement came unexpectedly and as a great shock to family and/or the biological fathers. Most of the mothers experienced support in some way, especially from their family in the home.

However, the lack of support from specific people were explicitly mentioned, for example the family of the child's father. It was evident that the lack of support increased these mothers' stress levels, whereas good support in the form of practical assistance, and emotional and financial support improved the mothers' emotional well-being.

(ii) The support and commitment from the children's biological fathers ranged from poor to good. It looked as if many of the biological fathers who were not in a stable relationship with these mothers showed a lack of support to the mothers. However, it seemed as if the children's fathers provided good support when they were in a committed and healthy relationship with the mothers. Thus, the nature of the relationship between these mothers and the children's fathers seemed to affect the mothers' support. Many mothers experienced the children's fathers as supportive during their pregnancy and after the children's birth, with this supporting including emotional and financial support, as well as practical assistance with house chores or the baby. However, several mothers experienced a lack of support from their child's father causing various emotional reactions from the mothers, including disappointment and anger. Various challenges – such as conflict, physical and/or emotional abuse, substance abuse and unemployment of the father – affected the relationship between the mother and biological father, ultimately impacting the support received from the child's father. On the other hand, the positive effect of good support from the biological fathers was visible in the mothers' reactions and quotes. A poor or absent relationship between the child and the biological father was voiced by many mothers. This apparently caused emotional distress and sadness for the mothers, even during their pregnancy, as they related it back to the relationship with their own biological fathers.

(iii) The majority of mothers highlighted good support from family members including advice and practical help with the baby, emotional support and financial assistance by providing baby essentials. Other support that was appreciated was that from colleagues, friends and medical staff at the local clinic. It also seemed that these children had various family members and other people who cared for them and invested in their lives. However, certain important role players in a child's life, such as the family of the child's father and the maternal or paternal grandparents, were not positively involved in all the cases, as mentioned by some of these mothers. A good support structure during this crucial time is critical for the mother and the child and should therefore not be underestimated.

Recommendations for practice are the following:

(i) During the mother's first medical visit after becoming aware of the pregnancy, health care professionals could prepare her for the announcement of the pregnancy to others if negative reactions are anticipated, especially during unplanned and/or teenage pregnancies. This should include emotional support during this visit or a referral for counselling where needed.

(ii) Once again, professionals can assist by offering support groups to pregnant mothers or mothers with newborn babies up to two years. This will provide an opportunity for mothers to support each other and to experience a place of hope where they could find encouragement and practical advice.

(iii) It can also be of value to present workshops or interactive events for extended family members or friends to provide information on the importance of support during the first thousand days, as well as practical ideas on how these role players can support mothers.

(iv) Since father involvement is already encouraged as part of the Western Cape Government's First 1000 Days initiative, other professionals besides the Department of Health should motivate biological fathers to attend the antenatal visits with the mother, as well as to support her in any way possible. Professionals should also educate fathers on the positive impact they could have on their child and use resource material on fatherhood such as the resource manuals of '*The world needs a father'*.

(v) Professionals should assess a mother's support structure during individual sessions and assist her to strengthen her support systems during the first thousand days of a child's life.

Theme 4: Circumstances of the mother and the child during the first thousand days of the child's life

The conclusions for this theme are the following:

(i) Living conditions during pregnancy as well as after birth to two years played a role in the mothers' sense of security, thus affecting their emotional well-being. Although several participants felt they have experienced pleasant living conditions, many of these mothers endured adverse circumstances. A few mothers relocated during this time which could be very stressful, whereas some experienced severe housing challenges, like living in informal structures or overcrowded housing. These mothers also mentioned family members in the household abusing substances like alcohol and drugs, as well as extreme conflict, even violence, which caused extreme stress for them. Suitable, stable and secure living

circumstances for mothers and children during the first thousand days speak to the first two needs of Maslow's hierarchy and could enhance the mothers' emotional well-being if these needs are met. It seemed that where the physiological and safety needs of these mothers and children have been met, a positive relationship between mother and child occurred, which enabled the mothers to meet their children's third need, namely love and belonging.

(ii) Many mothers associated their financial circumstances with serious financial challenges as a result of their own unemployment or the unemployment of the father or other family members living in the same household. This often led to the basic needs of the mothers and children not being met. The impact of financial security in the form of permanent employment of the biological father was visible. It appeared that permanent employment of the biological father increased emotional well-being, while unemployment of the father contributed to increased stress levels. Other important aspects noted by the mothers relating to finances were whether the biological father paid monthly maintenance or not, as well as assistance in the form of the child support grant which was the only stable income in some cases.

Recommendations for practice are the following:

(i) The government, private sector and even NPOs should promote job creation to relieve poverty, which could support mothers during this crucial time.

(ii) Mothers should be empowered with budgeting skills, even if they have a limited income, in order to assist them with planning and meeting the most important basic needs.

(iii) Professionals could use the strength-based approach to explore the mothers' skills and possible entrepreneurial opportunities, thus empowering them to generate some form of income.

Theme 5: Attachment and relationship between the mother and the child during the first thousand days of the child's life

The conclusions for this theme are the following:

(i) Various factors influenced the forming of attachment and the relationship between the mother and the child during the pregnancy phase, namely (1) the mother's initial response to the pregnancy announcement, (2) the gender of the child, (3) the mother's emotions and thoughts towards the unborn child, and (4) the mother's interaction with the unborn child. These unplanned pregnancies caught many of the mothers off guard, resulting in negative

emotions such as shock, confusion, disappointment, anger, sadness and panic when they initially discovered that they were pregnant. Finding out the child's gender was a significant moment where the mother's gender preference played a strong role in affecting her emotions towards the unborn child. Some of the mothers said that they contemplated an abortion or adoption, mostly due to difficult circumstances. However, at the end they decided to keep the baby. Experiencing the baby's movement in the womb was very meaningful and a turning point for the mothers in this study. These movements sparked a sense of life inside of them, thus enhancing various forms of interaction with the unborn baby. The above-mentioned factors could impact the forming of a positive or negative relationship during pregnancy and should receive special attention.

(ii) The attachment and relationship between the mother and the child from birth to two years covered various aspects. The mothers described their initial response after their baby's birth as a time filled with positive emotions and memories, thus marking an unforgettable moment. Therefore, an effort should be made to create a safe, peaceful and comfortable space for mother and child soon after birth to experience a special time of bonding and getting acquainted. The development of attachment from the mother, as well as from the child's side during this two-year period was evident, but the type of attachment is unclear. Mothers need to be aware of the process of attachment development, as well as the different attachment styles in order to promote the forming of a secure attachment style.

Recommendations for practice are the following:

(i) Health care professionals announcing the pregnancy to the mother should be made aware of the emotional impact of this. They could also offer a short emotional debriefing. It is recommended that mothers are encouraged to keep a journal regarding their emotions and thoughts.

(ii) Since the gender of the baby plays a significant role, it is recommended that the health care professional conducting the sonar to reveal the gender should ask the mother beforehand about her expectations of the gender. When the actual gender differs from the mother's preference, a debriefing of emotions is recommended.

(iii) It is recommended that professionals utilise existing programmes such as the Baby Bond stimulation programme to enhance prenatal bonding in the third trimester of pregnancy.

(iv) Practical resources like photos or videos about child development in the womb could promote excitement regarding the growing baby. These positive emotions and insight into

the development and growth of the fetus can stimulate the mother's need to interact with her baby.

(v) Health care workers should focus on creating a comfortable space for mother and child in the medical facility directly after birth, for example by closing the bed's curtains or switching off bright lights in the hospital room to promote bonding.

(vi) Social workers and other professionals could play a vital role in educating and guiding mothers on the developing of a secure attachment. This could easily be conducted in groups or individually. It is recommended that these sessions for mothers and their babies include practical ways to facilitate this process.

Theme 6: Development and care of the child during the first thousand days of life

The conclusions for this theme are the following:

(i) Most of the mothers showed some insight into their children's development. However, they did not necessarily have a complete understanding of the holistic development of their child in all areas, namely their physical, cognitive, emotional and social development. Since development during the first thousand days is of utmost importance, it is vital that all mothers understand the holistic development of their child. Some mothers showed insight into the developmental milestones of their children, which could serve as an important indicator of healthy growth and development.

(ii) The mother's care and protection towards the child is imperative during this crucial time. Most of these mothers described positive caregiving where possible. However, some mothers experienced a variety of challenges regarding the child's caregiving. These challenges mostly occurred during the first few months after the baby's birth when they themselves were still in a recovering and adjusting phase. The financial circumstances of the mothers again surfaced as one of the main challenges that impacted their caregiving due to a lack of basic baby goods like nappies and formula milk. The first few months after a baby's birth is a very sensitive period where mothers are often sleep deprived and adjusting to changes, especially when they are first-time mothers, like many of the mothers in this study. During this vulnerable time, mothers are prone to postpartum depression and should receive extra support and practical assistance with the baby to provide opportunities for rest and self-care. In addition, it appears that these mothers lacked knowledge of positive discipline methods since none of them indicated these methods and rather used spanking or scolding as forms of discipline.

(iii) Age-appropriate stimulation and play is of utmost importance, as shown in this study. The mothers expressed how they have applied stimulation and play techniques such as 'serve and return' to their infants. This came naturally to them without knowing the impact of this on their child's brain development. Although a few mothers described educational activities, the rest of the mothers had no knowledge of this. It was apparent that these mothers played and interacted with their children as young babies but did not regard this as important when the children were older. In addition, only a few of the fathers played with their children. Yet others, especially the children's siblings, interacted socially and played with the children. Stimulation and play according to the child's developmental phase are important. Therefore, all mothers should be made aware of the value of play and stimulation during this crucial time of development.

Recommendations for practice are the following:

(i) Professionals must educate mothers regarding the holistic developmental needs of children during these specific phases, including the basic aspects of relevant theories.

(ii) Professionals could use Maslow's hierarchy of needs as a tool to assess the current needs of the mother and the child. This information could be used by professionals to develop an action plan in cooperation with the mother to enable her to meet all her child's needs.

(iii) Organisations and churches can facilitate group sessions or workshops on basic childcare. This can even be linked to incentives for attendance in the form of second-hand or donated baby goods to assist mothers experiencing financial strain.

(iv) It is recommended that churches read the report entitled "The church's role in supporting human development in the first thousand days of life", which encourages churches to run first thousand days programmes in their communities (Lundie *et al*., 2018).

(v) Organisations and Early Childhood Development Centres should run interactive workshops for mothers and babies between birth and two years to teach mothers how to provide adequate and age-appropriate stimulation and play activities for their children. These workshops should include the making of toys from recycled materials and free activities to empower all mothers, especially those experiencing financial difficulties to stimulate and play with their children in creative ways. Government funding for these organisations should be increased to enable them to extend their services.

4.4.2 Recommendations for training

Recommendations for training include the following:

(i) It is recommended that Social workers receive training at universities on the importance of the first thousand days of life. This training can be incorporated into their modules on childhood development.

(ii) It is recommended that all Social workers at DCPOs in the Western Cape receive training on the First 1000 Days initiative and their role in strengthening this initiative.

(iii) Further training for Social workers on key factors influencing the first thousand days should include the nutrition and health of the child and mother, the new *Road to Health* booklet, attachment theory and practical ways to develop secure attachment, as well as age-appropriate developmental skills and techniques for proper care, positive discipline and the stimulation of children in the developmental phases. This training should include a variety of techniques and assessment tools such as a timeline tool to enable Social workers to assess these factors as indicated above.

4.4.3 Recommendations for future research

Recommendations for future research include the following:

(i) This study involved 18 participants in total. Although data saturation was achieved, it is recommended that the research is repeated, using a larger sample size.

(ii) This study was conducted in a specific community, Paarl East in the Western Cape, therefore similar studies in other communities are recommended.

(iii) Since the First 1000 Days initiative involves very aspects relating to the three key areas, it is recommended that a quantitative study is conducted to obtain results with numerical value.

(iv) Finally, it is recommended that the impact of the First 1000 Days initiative in the Western Cape province is evaluated through formal research to provide insight and recommendations to other provinces in South Africa.

4.4.4 Recommendations for policy and legislation

Recommendations for policy and legislation include the following:

(i) It is recommended that the First 1000 Days initiative is incorporated into national policies in order for this initiative to be implemented in all the provinces of this country.

(ii) Since nutrition during the first thousand days has already been integrated into the National Developmental Plan 2030 (National Planning Commission, n.d.:379), it is further recommended that more aspects relating to the first thousand days are specifically addressed in the next National Developmental Plan.

(iii) Finally, it is recommended that programmes focusing on the first thousand days are included into the chapter on Early Childhood Development in the Children's Act, No. 38 of 2005, when this act is amended.

4.4.5 Summative conclusions and recommendations

The context of this study was to explore the factors that could potentially have affected the first thousand days of absent learners in the Foundation Phase within the Paarl East area in the Western Cape. It is apparent from the findings in this study that a substantial number of factors – like the health and nutrition of both the mother and the child, substance use/abuse during pregnancy, toxic stress, support to the mother and child, attachment, attentive care, stimulation and play – could have played a role during the first thousand days of the absent learners in this study. Most of these factors relate to the Western Cape Government's First 1000 Days initiative entitled 'Right start, Bright future', as well as other aspects highlighted in this study. It was confirmed by literature that the factors relating to the First 1000 Days initiative could potentially have affected children's development during the first thousand days, with lifelong impact on, among others, their schooling. In addition, it was clear that support for both the mother and the child during this time is vital. In summary, the following is recommended:

(i) Due to the enormous amount of support needed, it is essential that professionals, NGOs, churches and even the private sector are educated regarding the importance of the first thousand days. This will hopefully motivate these entities to take hands with government departments to strengthen support to mothers and children during the first thousand days of the child's life. Greater collaboration and multi-sector partnerships will promote the achievement of some of the above-mentioned recommendations in order to give children in South Africa the right start for a bright future, enabling them to thrive and transform, not just to survive.

(ii) It is recommended that Khula Development Group incorporates some of the recommendations or aspects of the First 1000 Days initiative into its service delivery to absent learners and their families in order to work more preventatively. Since the fieldworkers have daily contact with mothers during home visits, they regularly come across pregnant mothers or those who have children up to two years. This creates a perfect opportunity for them to educate mothers on the various factors that could potentially affect children's first thousand days. The resources of the First 1000 Days initiative or a tailor-made pamphlet for Khula Development Group could be used as a visual tool during these home visits. In addition, it is recommended that some of the recommendations in this study be incorporated into the curriculum and sessions of the Primary Caregiver programme.

4.5 CONTRIBUTION OF THE STUDY

This study may contribute to improving the knowledge and services relating to the first thousand days of life in the following ways:

(i) Since research studies pertaining to the first thousand days of children in South Africa are relatively limited, due to this topic being fairly new in our country, this study contributes by adding to research on this topic.

(ii) Furthermore, no studies on the first thousand days and absent learners could be found. Hence, this study provides insight into the factors that could potentially have affected the first thousand days of absent learners in the Foundation Phase.

(iii) The insights relating to the key findings, as well as the recommendations made in this study could motivate and assist organisations and professionals to expand their services by including components on the first thousand days into their programmes.

4.6 LIMITATIONS OF THE STUDY

While the findings of this study led to an increased understanding of the factors that could potentially have affected the first thousand days of absent learners in the Foundation Phase, the following limitations should be noted:

(i) This study involved participants from the Paarl East area in the Western Cape, a rural community characterised by high rates of poverty. Therefore, the findings may not be representative of all children pertaining to their first thousand days of life.

(ii) Practical aspects included the lack of transport, resulting in some participants not showing up for the interviews. This was addressed by the researcher transporting them to the research site after the approval of an amendment to HREC.

(iii) The researcher did not include questions on all the aspects of the First 1000 Days initiative in the interview schedule. Instead, she grouped the questions together according to the three key areas in order to limit it to 12 questions. This resulted in some areas not covered in detail. For example, the age of the mother during pregnancy or whether the pregnancy was planned were not explicit questions. Another aspect that was not explored was the mothers' substance use/abuse after birth while they were breastfeeding, since this was not a definite question and it was not mentioned by the mothers.

4.7 RESEARCHER'S PERSONAL REFLECTION

This following section includes personal reflections by the researcher regarding the research process and experience. As such, it will be written in the first person.

I have a personal passion to work with children and I am saddened that many of the children in South Africa are not thriving but bombarded with many challenges hindering them to reach their full potential. Since I've been working with vulnerable children and communities in various settings over the last 15 years, I was trying to assess which factors caused challenges later in these children's lives. During these years, gaining experience as a Social worker, I've been allocating two or three factors – such as poverty, attachment and substance abuse – to explain the possible causes for these challenges but was never satisfied that I've discovered the answer. My work at Khula Development Group touched my heart deeply since I saw many primary school learners as early as Grade R and 1 forming a pattern of school absenteeism for various reasons, including not coping academically, emotionally and/or socially. This continuous absenteeism often results in learners permanently dropping out of the school system as young as Grade 3. This heart-breaking trend in my work context spurred me on to find the answer to my aching question, *"Where does it all begin?"* The attendance of the First 1000 Days roadshow at Paarl Hospital in November 2017 was a light bulb moment for me personally where I felt that I've discovered the answer to my question, namely *"It begins in the first thousand days of a child's life".* My interest in the first thousand days of life became the motivator to embark on a research journey, thus conducting this study.

I've soon discovered during the planning phase of this research study that it is not possible to provide a link between the first thousand days and absenteeism, due to the nature of this study and the many variables that could contribute to school absenteeism. However, I am satisfied that

this study could contribute by exploring the factors that could potentially have affected the first thousand days of absent learners in the Foundation Phase. During this research journey, I've learned about all the ethical considerations and that research must do good instead of harm, which correlates with my inner belief and motivation of treating all people with respect and dignity. However, these ethical considerations caused some obstacles which I had to overcome. One example was the use of my colleagues to fulfil the roles of mediator and independent persons which put great pressure on them due to the number of home visits they had to conduct during the recruitment process, since these mothers could not be contacted telephonically. This resulted in approximately 60 home visits all together between these parties, which created feelings of guilt within myself, but I was reassured of their help and support. In the end, I was encouraged to be surrounded by valuable colleagues who were willing to go the extra mile for someone else. I realised that not all researchers would be so privileged.

I've enjoyed conducting the interviews. I found the mothers to be engaging and openly sharing information on their pregnancy and their child's life from birth to two years, indicating struggles, but also the rewards of motherhood. However, during the interviews, some of these mothers became emotional and I had to deliberately restrain myself from stepping into a therapeutic role. The interviews felt very clinical at times. I had to stop the audio-recordings during some of the interviews when mothers began to cry. This provided them with the opportunity to share their emotions. I have realised during these sessions that these mothers yearn for a safe space where they could just share experiences within a confidential setting, since they've expressed that they can't talk to the people in their community. I believed that the comfortable warm office space at Khula Development Group made these mothers feel at ease, enabling them to share freely regarding their child's first thousand days. These mothers showed outstanding strength and resilience despite immense challenges. It was also heart-warming to see their gratitude for the Shoprite stamps that were given to them as a token of appreciation.

During data analysis, where I became more familiar with the data, I became emotional at times due to the tremendous hardships some of these mothers endured during a time which should be marked by joy and excitement. On the other hand, I've also experienced delight and hope to see the initiative, strength and perseverance displayed by the mothers participating in this study. Thus, the research journey was filled with many emotions, and I've been overwhelmed with the amount of rich data provided by these mothers. Therefore, I hope that the findings and recommendations of this study could make a difference in the lives of vulnerable women and children.

4.8 FINAL WORD

The late president Abraham Lincoln said, *"The best way to predict your future is to create it"* (Good reads Inc., 2019).

For the researcher, there is a link between this future-orientated quote and the research topic about the importance of the first thousand days of a child's life as this window of opportunity could have a long-lasting impact on children's future. The literature and research findings from this study confirm the importance of investing in children's health and development during their first thousand days of life in order to build a strong foundation for them. Good health and nutrition, proper care and nurturing, as well as stimulation and play during the first thousand days will provide children the ability to thrive and reach their full potential.

This study also confirmed and highlighted the many factors that could potentially have affected the first thousand days of absent learners in the Foundation Phase. The research findings from this study offer insight to professionals and anyone passionate about making a difference in the lives of children. In addition, the recommendations made in this study can assist professionals and organisations to improve their services to mothers and children during this crucial first thousand days. In the light of this, the study is concluded with the inspiring words of late president Nelson Mandela (Nelson Mandela Children's Fund, 2015):

"Our children are the rock on which our future will be built, our greatest asset as a nation. They will be the leaders of our country, the creators of our national wealth who care for and protect our people."

and

"Each of us as citizens has a role to play in creating a better world for our children."

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ANNEXURE A: ETHICAL CLEARANCE FROM NORTH-WEST UNIVERSITY

Private Bag X1290, Potchefstroom
South Africa 2520

Tel: 018 299-1111/2222
Fax: 018 299-4910
Web: http://www.nwu.ac.za

Research Ethics Regulatory Committee
Tel: 018 299-4849
Email: nkosinathi.machine@nwu.ac.za

17 April 2019

ETHICS APPROVAL LETTER OF STUDY

Based on approval by the North West University Health Research Ethics Committee (NWU-HREC) on 17/04/2019, the NWU Health Research Ethics Committee hereby approves your study as indicated below. This implies that the North-West University Research Ethics Regulatory Committee (NWU-RERC) grants its permission that, provided the special conditions specified below are met and pending any other authorisation that may be necessary, the study may be initiated, using the ethics number below.

Study title: Exploring the first thousand days of absent learners in the foundation phase.
Study Leader/Supervisor (Principal Investigator)/Researcher: Dr C van Wyk
Student: C van Zyl

Ethics number: N W U - 0 0 0 0 8 - 1 9 - A 1
Institution Study Number Year Status
Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation

Application Type: Single Study
Commencement date: 17/04/2019 **Risk:** Medium
Expiry date: 30/04/2020
Approval of the study is initially provided for a year, after which continuation of the study is dependent on receipt and review of the six-monthly (or as otherwise stipulated) monitoring report and the concomitant issuing of a letter of continuation.

Special in process conditions of the research for approval (if applicable):

General conditions:

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, the following general terms and conditions will apply:

- *The study leader/supervisor (principle investigator)/researcher must report in the prescribed format to the NWU-HREC:*
  - *annually (or as otherwise requested) on the monitoring of the study, whereby a letter of continuation will be provided, and upon completion of the study; and*
  - *without any delay in case of any adverse event or incident (or any matter that interrupts sound ethical principles) during the course of the study.*
- *The approval applies strictly to the proposal as stipulated in the application form. Should any amendments to the proposal be deemed necessary during the course of the study, the study leader/researcher must apply for approval of these amendments at the NWU-HREC, prior to implementation. Should there be any deviations from the study proposal without the necessary approval of such amendments, the ethics approval is immediately and automatically forfeited.*
- *Annually a number of studies may be randomly selected for an external audit.*
- *The date of approval indicates the first date that the study may be started.*
- *In the interest of ethical responsibility the NWU-RERC and NWU-HREC reserves the right to:*
  - *request access to any information or data at any time during the course or after completion of the study;*
  - *to ask further questions, seek additional information, require further modification or monitor the conduct of your research or the informed consent process;*
  - *withdraw or postpone approval if:*
    - *any unethical principles or practices of the study are revealed or suspected;*

- *it becomes apparent that any relevant information was withheld from the NWU-HREC or that information has been false or misrepresented;*
- *submission of the annual (or otherwise stipulated) monitoring report, the required amendments, or reporting of adverse events or incidents was not done in a timely manner and accurately; and /or*
- *new institutional rules, national legislation or international conventions deem it necessary.*

- *NWU-HREC can be contacted for further information or any report templates via Ethics-HRECApply@nwu.ac.za or 018 299 1206.*

The NWU-HREC would like to remain at your service as scientist and researcher, and wishes you well with your study. Please do not hesitate to contact the NWU-HREC or the NWU-RERC for any further enquiries or requests for assistance.

Yours sincerely

Prof Wayne Towers
Chairperson NWU Health Research Ethics Committee

Original details: (22351930) C:\Users\22351930\Desktop\ETHICS APPROVAL LETTER OF STUDY.docm
8 November 2018

Current details: (22351930) M:\DSS1\8533\Monitoring and Reporting Cluster\Ethics\Certificates\Templates\Research Ethics Approval Letters\9.1.5.4.1 HREC Ethical Approval Letter.docm
3 December 2018

File reference: 9.1.5.4.2

ANNEXURE B: PERMISSION LETTER FROM KHULA DEVELOPMENT GROUP

NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT
POTCHEFSTROOMKAMPUS

PO Box 1083
WELLINGTON
7654

SCHOOL OF PSYCHOSOCIAL HEALTH
Centre for Child, Youth and Family studies
Tel: 021 864 3593

5 April 2019

Attention: The Chief Operation Officer
Khula Development Group
Suite 139
Private Bag X 3041
Paarl
7620

Dear Mrs Daleen Labuschagne

RE: PERMISSION TO CONDUCT THE RESEARCH STUDY AT KHULA DEVELOPMENT GROUP

I would like to introduce the research that I am currently busy with for my Master's degree in Social work and would like to request permission to conduct this study within Khula Development Group.

Title of my research study

Exploring factors that can potentially affect the first thousand days of absent learners in the foundation phase

Motivation for the study

The first thousand days, from conception to age two is considered the most important development phase of a child's life where their physical, cognitive and socio-emotional development could have lifelong consequences on a child's health and wellbeing later in life. The researcher's interest in the proposed topic originates from her attendance of the 'First 1000 days' roadshow in 2017, as well as her work context focusing on learner absenteeism.

The aim of this study is to qualitatively explore and describe factors that can potentially affect the first thousand days of absent learners within the Paarl-East area in the Western Cape. The two main objectives are: (1) to conduct a literature study on the first thousand days, child development

1

during the prenatal and infancy phase, school absenteeism and the foundation phase in order to develop a conceptual framework for this study and (2) to explore and describe factors that can potentially affect the first thousand days of absent learners in the foundation phase by conducting semi-structured interviews with biological mothers.

This study will utilize a qualitative descriptive design and a random purposive sampling method.

Who can participate in the study?

A random purposive sampling method will be utilized in this study to select biological mothers as potential participants according to the following inclusion criteria:

- Biological mothers of absent foundation phase (Grade R-3) learners recorded as active cases on Khula Development Group's database.
- Residing in Paarl-East.
- Lived with their child during their child's first thousand days, from conception up to two years of age.
- Currently lives with their child.
- Are factually capable of giving consent and to participate in this research study.

What will be expected of the biological mothers who participate?

Semi-structured interviews will be conducted for the purpose of data collection. The biological mothers will be expected to attend an individual interview for approximately 1 hour to 1 ½ hours. The interviews will take place at Development Group's offices and consist of twelve questions. The days of the interviews will be scheduled preferably on a Thursday or Friday between 08h00-16h00 or another time suited for the participant. This study will not inflict any cost on the participants. Participants will receive a token of appreciation in the form of a R50 Shoprite voucher to recognise their time and any inconvenience for participating in this research study, as well as reimbursement for transport costs.

What will be expected from you?

I would like to request the following:

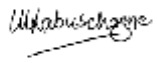
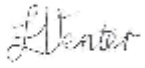
(a) That you provide me permission to conduct the study at Khula Development Group.
(b) That you act as gatekeeper of the study.
(c) That I may utilize an employee from Khula Development Group as mediator to use the organisation's database to compile a list of potential participants.
(d) That the mediator may appoint two other employees from Khula Development Group as independent persons to conduct home visits in order to recruit prospective participants.
(e) That the independent persons may utilize Khula Development Group's vehicle in order to conduct the home visits.
(f) That I may use the facilities at Khula Development Group to conduct the interviews and the feedback function.

I confirm that Khula Development Group has granted Ms Carien van Zyl permission to conduct this research study at this organisation and agree to all the requests mentioned above.

Ms C van Zyl's approval is on the following conditions:

(a) She only collects information which is relevant to her research study.
(b) She maintains strict confidentiality on all information obtained from the organisation.
(c) She shares her findings and recommendation of the research study with the organisation.

SIGNED AT Paarl **ON THIS** 10th **DAY OF** April **2019**

Daleen Labuschagne	
Chief Operational Officer: Name and surname in print	**Chief Operational Officer:** Signature
Lozanne Venter	
Witness: Name and surname in print	**Witness:** Signature

ANNEXURE C: INFORMED CONSENT FORM IN ENGLISH

Private Bag X1290, Potchefstroom
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Tel: +2718 299-1111/2222
Fax: +2718 299-4910
Web: http://www.nwu.ac.za

Health Research Ethics Committee
Faculty of Health Sciences
NORTH-WEST University
(Potchefstroom Campus)
2019 -05- 31
HREC Stamp

INFORMED CONSENT FORM FOR BIOLOGICAL MOTHERS OF ABSENT LEARNERS IN THE FOUNDATION PHASE (GRADE R-3) BEING INTERVIEWED

TITLE OF THE RESEARCH STUDY: Exploring factors that can potentially affect the first thousand days of absent learners in the foundation phase

ETHICS REFERENCE NUMBERS: NWU-00008-19-A1

MAIN RESEARCHER (STUDY LEADER): Dr Carlien van Wyk

POST GRADUATE STUDENT: Carien van Zyl (31440118)

ADDRESS: Centre for Child, Youth and Family Studies, PO Box 1083, Wellington, 7654

CONTACT NUMBER: 021 864 3593

You are being invited to take part in a research study that forms part of a Masters study in Social Work. Please take time to read this information where it explains the details of this research. Please ask any questions about the research that you do not completely understand. You can ask the questions to the researcher or persons explaining the research to you. It is very important that you are completely sure that you understand what this research is about and how you might be involved.

Also, your participation is **completely voluntary (out of free will)** and you are free to **say no** to take part. If you say no, this will not affect you negatively in any way. You are also free to **withdraw** from the research at any time without explanation, even if you do

agree to take part now. There will be no negative consequences for you when you withdraw from the study for any reason.

This study has been approved by the **Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University** (NWU-00008-19-S1) and will be done according to the ethical guidelines and principles of Ethics in Health Research: Principles, Processes and Structures (DoH, 2015) and other international ethical guidelines applicable to this study. It might be necessary for the research ethics committee members or other relevant people to examine the research records. **This part means that there will be a committee (group of people) at the university that will make sure that this research is done in the right way.**

What is this research study all about?

- *To learn more about the first thousand days of absent learners in Paarl-East in the Western Cape. (The first thousand days refer to the time from conception/pregnancy up to two years of age. Absent learners mean children not going to school regularly.)*
- *This research will take place from April to June 2019 at Khula Development Group's office in 6 Loop Street, Paarl.*
- *The research will be done by a social worker.*
- *At least 18 participants will be included in this study.*

Why have you been invited to participate?

- *You have been invited to be part of this research because of the following reasons:*
  - *you are a biological mother of an absent learner in the foundation phase (Grade R-3) who get services from Khula Development Group.*
  - *you now live in Paarl-East;*
  - *you lived with your child during pregnancy until the child was two years old;*
  - *you now live with the child;*
  - *you are able to give information about your child's first thousand days from pregnancy up to two years of age.*
- *You will unfortunately not be able to take part in this research if your child was not absent when he/she was referred to Khula Development Group. This means that your child was referred for another reason, but not for absenteeism.*

What will be expected of you?

- *A home visit will be done to explain the research study to you. You will be given a consent form and someone will explain this form to you.*
- *You will have 3 working days to go through the information and to speak to family or friends of your choice to decide if you want to take part in the research. If you can't read, you will be encouraged to ask the help of a person you trust to read this information to you. After the 3 working days are over, the persons who explained the research to you, will contact you (telephonically or by doing a home visit) to ask about your decision to take part in the study.*

- *If you decide to take part in this research out of free will, you must sign the consent form in the presence of the persons who explained the information to you.*
- *You must sign the transport indemnity form in order for the researcher to pick you up at your home and transport you to Khula Development Group's office in 6 Loop Street, Paarl.*
- *You must take a taxi back home after the interview at Khula Development Group's office. The researcher will give you money for the taxi transport.*
- *You must take part in an interview of 1 hour to 1 ½ hours where the sound (voices) will be recorded. This interview will take place from April to June 2019 where you must answer 12 questions. The interview will be done by the researcher, who is a social worker with 15 years of experience. Before the interview begins, the researcher will explain all the information about the research again and give you an opportunity to ask questions. The interview will be held at Khula Development Group's offices, preferably on a Tuesday or a Friday between 8h00-16h00 at a time arranged with you. If these planned days or times do not suit you, the researcher will arrange another day or time which suits you.*

Will there be any advantages for you for taking part in this research?

- *There will be no direct advantages for you in the study. But you can feel good about yourself for taking part in a research study which could help to improve programmes in the future.*
- *The other advantages of the study are the recommendations that will help to improve programmes for foundation phase learners and their families. The programmes can even be about the first thousand days. These recommendations will help Khula Development Group, other professionals, the Paarl-East community and even the larger society when they work with foundation phase learners and their families.*

Are there risks involved in you taking part in this research and what will be done to prevent them?

- *The risks to you in this study and how it will be limited are indicated in this table below:*

Risks	Precautions (How it will be limited)
• *You could feel tired during the 1 hour to 1 ½ hour interview.*	• *The researcher will tell you before the interview that you may tell her when you feel tired to stop for a short break.* • *If the researcher sees that you look tired, but you do not ask for a break, she will suggest a short break after 45 minutes.* • *The researcher will also make water available to you.*

• *There is possible emotional harm where you could feel emotional stress and feelings such as guilt, sadness, embarrassment, and anger due to the sensitive topic and questions about the care and relationship with your child from pregnancy up to two years of age.*	• *Should you experience any emotional stress during the interview process, the researcher will stop the interview, talk to you and only continue the interview if you are emotionally able and willing to continue.* • *If you are too emotional to go on or do not want to go on with the interview, the interview will be stopped and you will no longer be included in the study.* • *The researcher will also refer you to Good Hope Psychological Service for free counselling if you need it and would like to go.*
• *There is possible financial loss where you come to the interview on a day that you are working and loose a day's pay.*	• *The researcher will arrange the interview on the day which suits you when you are not working.* • *The researcher will pick you up at your home to transport you to Khula's office and give you money for taxi transport to go home after the interview.*

How will we protect your confidentiality and who will see your findings?

- *Your own name will not be used. Your information will be protected by putting another name with your information when writing down the sound recorded information. Only the researcher will know the real names (identity) of the participants. The researcher will make sure that the final report does not show the identity of any individuals. When the researcher gives feedback about the research to Khula Development Group, she will not use identifiable information of the participants.*
- *Your privacy will be respected by doing the interview at the Khula Development Group's offices in Paarl behind a closed door.*
- *Your results will be kept confidential by not sharing any recognisable details of the participants. Confidentiality agreements will also be signed by the persons helping with the selection and recruitment of possible participants. Only the researcher and co-coder (person who help to analyse the information) who will sign a confidentiality agreement will be able to look at your information which you shared.*

What will happen with the information and results?

- *The results of this research will only be used for this study and not for any other study.*
- *Information will be written in a final report and may be included in published articles.*

- *Information will be kept safe by locking the information on paper in locked cupboards at the researcher's home. Other information will be stored in a folder with a password on the researcher's personal laptop. As soon as the information which was recorded has been written down, it will be deleted from the recorder. When the research is fully completed the information will be stored for 5 years in a locked safe at the offices of the University (Centre for Child, Youth and Family Studies) in Wellington. After 5 years, all the information will be destroyed.*

How will you know about the results of this research?

- *When the research is completed, the researcher will arrange a function with refreshments (cake and tea function) for all the participants in January 2020 where she will share a summary of the research.*

Will you be paid to take part in this study and are there any costs for you?

- No you will not be paid to take part in the study.
- *You will receive a R50 Shoprite voucher to thank you for your time when you take part in the study. This voucher will be given to you on the same day, after the interview.*
- *Transport money will be paid to all participants who have to travel to the Khula Development Group's offices. The researcher will give you money for public transport. This transport money will be given to you on the same day after the interview.*
- *Water will be available for you during your interview.*
- *There will therefore be no costs for you if you do take part in this study.*

Are there any sponsors and conflict of interest?

- *The researcher pays for this study and there are no other sponsors.*
- *The researcher works for Khula Development Group and therefore she can have her own ideas and preferences which could influence the research. But she will take some actions to try to prevent this.*

Is there anything else that you should know or do?

- *You can contact the persons explaining the research to you at 021 8711511 (Khula's office number) if you have any further questions about the research.*
- *You can contact the researcher, Carien van Zyl at 021 8711511 if you have any further questions about the research.*
- *You can also contact the Health Research Ethics Committee through Mrs Carolien van Zyl at 018 299 1206 or carolien.vanzyl@nwu.ac.za if you have any concerns that were not answered about the research or if you have complaints about the research.*
- *You will receive a copy of this information and consent form for you to keep.*

Declaration by participant

By signing below, I……(name and surname of participant) agree to take part in the research study titled: Exploring factors that can potentially affect the first thousand days of absent learners in the foundation phase

I declare that:

- I have read this information/it was explained to me by a trusted person in a language with which I fully understand and are comfortable with.
- The research was clearly explained to me.
- I had a chance to ask questions to the persons getting the consent from me, as well as the researcher and all my questions have been answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be handled in a negative way if I do so.
- I may be asked to leave the study before it has finished, if the researcher feels it is in the best interest, or if I do not follow the study plan, as agreed to.

Signed at (*place*) ..... on (*date*) ……..…….. 20....

.....	.....
Signature of participant	**Signature of witness**

Declaration by person(s) obtaining consent

I/we *(name/names)* ..... declare that:

- I/we clearly and in detail explained the information in this document to

  .....
- I/we did/did not use an interpreter.
- I/we encouraged her to ask questions and took adequate time to answer them.
- I/we am/are satisfied that she adequately understands all aspects of the research, as discussed above
- I/we gave her time to discuss it with others if she wished to do so.

Signed at (*place*) ..... on (*date*) ..... 20....

.....

Signature(s) of person(s) obtaining consent

Declaration by researcher

I *(name)* ..... declare that:

- I had the information in this document clearly and in detailed explained by ..... persons whom I trained for this purpose.
- I did/did not use an interpreter.
- I was available should she want to ask any further questions.
- The informed consent was obtained by two independent persons.
- I am satisfied that she adequately understands all aspects of the research, as described above.
- I am satisfied that she had time to discuss it with others if she wished to do so.

Signed at (*place*) ..... on (*date*) ..... 20....

.....

Signature of researcher

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25 April 2018

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ANNEXURE D: INFORMED CONSENT FORM IN AFRIKAANS

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INGELIGTE TOESTEMMINGSVORM VIR BIOLOGIESE MOEDERS VAN AFWESIGE LEERDERS IN DIE GRONDSLAGFASE (GRAAD R-3) WAT ONDERVRA WORD

TITEL VAN DIE STUDIE: Verkenning van faktore wat potensiëel die eerste duisend dae van afwesige leerders in die grondslagfase kan affekteer

ETIESE VERWYSINGSNOMMER: NWU-00008-19-S1

HOOF NAVORSER (STUDIE LEIER): Dr Carlien van Wyk

NAGRAADSE STUDENT: Carien van Zyl (31440118)

ADRES: Sentrum vir Kinder- Jeug en Familiestudies, Posbus 1083, Wellington, 7654

KONTAKNOMMER: 021 864 3593

U word uitgenooi om aan 'n navorsingstudie deel te neem wat deel is van 'n Meestersgraadstudie in Maatskaplike Werk. Neem asseblief tyd om hierdie inligting deur te lees waar dit die besonderhede van die navorsing verduidelik. Vra asseblief enige vrae oor die navorsing wat u nie heeltemal verstaan nie. U kan vir die navorser of die persone wat die navorsing aan u verduidelik, vra. Dit is baie belangrik dat u heeltemal seker is dat u verstaan waaroor hierdie navorsing gaan en hoe u betrokke gaan wees.

U deelname is heeltemal vrywilliglik (uit vrye keuse) en u is vry om **nee** te sê. As u nee sê, sal dit nie u negatief affekteer op enige manier nie. U is ook vry om enige tyd van die

die navorsing te **onttrek** sonder 'n verduideliking, selfs al stem u nou in om deel te neem. Daar sal geen negatiewe gevolge vir u wees wanneer u onttrek nie.

Hierdie studie is deur die **Etiese navorsingskomitee van die Geesteswetenskappe Fakuliteit van Noord-Wes Universiteit** (NWU-00008-19-S1) goedgekeur. Hierdie navorsing sal gedoen word volgens die etiese riglyne en beginsels van Etiek in navorsing: Beginsels, prosesse en strukture (DoH, 2015) en ander internasionale etiese riglyne wat op toepassing van hierdie studie is. Die etiese komitee of ander relevante persone mag hierdie navorsingsrekords ondersoek. **Hierdie beteken dat daar 'n komitee (groep mense) by die universiteit is wat sal seker maak dat hierdie navorsing op die regte manier gedoen word.**

Wat behels hierdie navorsingstudie?

- *Om meer te leer oor die eerste duisend dae van afwesige leerders in Paarl-Oos in die Wes-Kaap. (Die eerste duisend dae verwys na die tydperk van bevrugting/swangerskap tot en met twee jaar. Afwesige leerders beteken kinders wat nie gereeld skool toe gaan nie.)*
- *Die navorsing sal van April tot Junie 2019 by Khula Development Group se kantore in Loopstraat 6, Paarl, plaasvind.*
- *Die navorsing sal deur 'n maatskaplike werker gedoen word.*
- *Ten minste 18 deelnemers sal deel van hierdie studie wees.*

Waarom word u genooi om deel te neem?

- *U word genooi om deel te neem aan hierdie navorsing vir die volgende redes:*
  - u is 'n biologiese ma van 'n afwesige leerder in die grondslagfase (Graad R-3) wat dienste van Khula Development Group kry;
  - u woon nou in Paarl-Oos;
  - u het saam u kind gewoon toe u swanger was totdat die kind twee jaar oud was;
  - u woon nou saam die kind;
  - u is instaat om inligting te gee oor u kind se eerste duisend dae vanaf swangerskap tot en met twee jaar van ouderdom.
- *U sal ongelukkig nie aan hierdie navorsing mag deelneem as u kind nie afwesig wat toe hy/sy na Khula Development Group verwys was nie. Dit beteken dat u kind verwys was vir 'n ander rede, maar nie vir afwesigheid nie.*

Wat sal van u verwag word?

- *'n Tuisbesoek sal gedoen word om hierdie navorsing aan u te verduidelik. U sal 'n ingeligte toestemmingsvorm kry en iemand sal hierdie vorm vir u verduidelik.*
- *U sal 3 werksdae kry om deur die inligting te gaan en met familie of vriende van u keuse te praat om te besluit of u aan hierdie navorsing wil deelneem. As u nie kan lees nie, word u aangemoedig om vir iemand wat u vertrou te vra om hierdie inligting vir u te lees. Nadat die 3 werksdae verby is, sal die persone wat die navorsing vir u verduidelik het, u kontak (telefonies of 'n tuisbesoek) om te vra oor u besluit om deel te neem aan die studie.*

- *As u besluit om deel te neem uit vrye keuse, moet u die toestemmingsvorm in die teenwoordigheid van die persone wat die inligting verduidelik teken.*
- *U moet die vervoer vrywaringsvorm teken, sodat die navorser u by u huis kan oplaai en vervoer tot by Khula Development Group se kantore in Loopstraat 6, Paarl.*
- *U moet self 'n taxi terug neem na u huis toe na die onderhoud by Khula Development Group se kantore. Die navorser sal vir u geld gee vir die taxi vervoer.*
- *U moet aan 'n onderhoud van 1 uur tot 1 ½ ure lank deelneem waar die klank (stemme) opgeneem gaan word. Hierdie onderhoud sal van April to Junie 2019 plaasvind waar u 12 vrae moet beantwoord. Die onderhoud sal deur die navorser, 'n maatskaplike werker met 15 jaar ervaring gedoen word. Voor die onderhoud begin, sal die navorser weer al die inliging oor die navorsing verduidelik en vir u 'n geleentheid gee om vrae te vra. Die onderhoud sal by Khula Development Group se kantore plaasvind, verkieslik op 'n Donderdag of Vrydag tussen 8h00-16h00 op 'n tyd wat met u gereël is. As hierdie beplande dae of tye u nie pas nie, sal die navorser 'n ander dag of tyd met u reël wat u pas.*

Sal daar enige voordele vir u wees as u deelneem aan hierdie navorsing?

- *Daar sal geen direkte voordele vir u wees nie. Maar u kan goed voel oor uself dat u deelneem aan 'n navorsingstudie wat kan help om programme in die toekoms te verbeter.*
- *Die ander voordeel van die studie is die aanbevelings wat kan help om programme vir gronslagfase leerders en hul gesinne te verbeter. Die programme kan selfs oor die eerste duisend dae gaan. Hierdie aanbevelings sal Khula Development Group, ander professionele persone en selfs die groter gemeenskap help wanneer hulle met grondslagfase leerders en hul families werk.*

Is daar risiko's vir deelname aan hierdie navorsing en wat gaan gedoen word om dit te voorkom?

- *Die risiko's vir u in hierdie studie en hoe dit beperk gaan word, word in die tabel hieronder aangedui:*

Risiko's	Voorsorgmaatreëls (Hoe dit beperk gaan word)
• *U kan moeg voel tydens die onderhoud van 1 uur tot 1 ½ uur lank.*	• *Die navorser sal vir u voor die onderhoud noem dat u vir haar kan sê wanneer u moeg voel om te stop vir 'n kort breek.* • *As die navorser sien dat u moeg lyk en nie vra vir 'n breek nie, sal sy na 45 minute 'n kort breek voorstel.* • *Die navorser sal ook water vir u beskikbaar stel.*

• *Daar is moontlike emosionele skade waar u emosionele stres en emosies soos skuldgevoelens, hartseer, skaamte en woede kan ervaar as gevolg van die sensitiewe onderwerp en vrae oor die sorg en verhouding met u kind van swangerskap tot en met twee jaar.*	• *As u emosionele stres tydens die onderhoud ervaar, sal die navorser die onderhoud stop, met u praat en slegs voortgaan as u emosioneel instaat is en bereid is om voort te gaan.* • *As u te emosioneel is om voort te gaan of nie wil voortgaan met die onderhoud nie, sal die onderhoud gestop word en u sal nie meer by die studie ingesluit word nie.* • *Die navorser sal u ook verwys na Goedehoop Sielkundige Diens vir gratis berading as u dit benodig en wil gaan.*
• *Daar is moontlike finansiële verlies as u na die onderhoud kom op 'n dag wat u werk en 'n dag se inkomste verloor.*	• *Die navorser sal die onderhoud reël op 'n dag wat u pas en wanneer u nie werk nie.* • *Die navorser sal u kom optel by u huis en na Khula se kantore vervoer en ook vir u geld vir taxi vervoer om huis toe te gaan na die onderhoud.*

Hoe sal ons vertroulikheid beskerm en wie sal u inligting sien?

- *U eie naam sal nie gebruik word nie. U inligting sal beskerm word deur 'n ander naam by u inligting te sit wanneer u inligting wat opgeneem is, neergeskryf word. Slegs die navorser sal die regte name (identiteit) van die deelnemers weet. Die navorser sal seker maak dat die finale verslag nie die identiteit van enige deelnemers wys nie. Wanneer die navorser terugvoering aan Khula Development Group gee oor die navorsing, sal sy nie enige identifiserende inligting van die deelnemers gebruik nie.*
- *U privaatheid sal gerespekteer word deur die onderhoud by Khula Development Group se kantore in Paarl agter 'n toe deur te hou.*
- *U resultate sal vertroulik gehou word deur nie enige erkenbare besonderhede van deelnemers bekend te maak nie. Vertroulikheidsooreenkomste sal deur die persone wat help om die deelnemers te kry, geteken word. Slegs die navorser en die ko-kodeerder (persoon wat help om die inligting te ontleed) wat 'n vertroulikheidsooreenkoms sal teken, sal na die inligting wat u gedeel het mag kyk.*

Wat sal met die inligting en resultate gebeur?

- *Die resultate van hierdie navorsing sal slegs gebruik word vir hierdie studie en nie enige ander studie nie.*
- *Inligting sal in 'n finale verslag geskryf word en miskien in gepubliseerde artikels.*

- *Inligting sal veilig gehou word deur die inligting op papier in 'n kas by die navorser se huis toe te sluit. Ander inligting sal in 'n afdeling met 'n wagwoord op die navorser se private rekenaar gestoor word. Sodra die inligting wat opgeneem is, neergeskryf is sal dit van die opnemer afgevee word. Wanneer die navorsing heeltemal klaar is, sal al die inligting vir 5 jaar in 'n kluis by die kantoor van die Universiteit (Sentrum vir Kinder- Jeug en Familiestudies) in Wellington toegesluit word. Na 5 jaar, sal al die inligting verwoes word.*

Hoe sal u weet van die resultate van die navorsing?

- *Wanneer die navorsing voltooi is, sal die navorser 'n funksie met verversings (koek en tee funksie) vir al die deelnemers in Januarie 2020 reël waar sy 'n opsomming van die resultate sal deel.*

Sal u betaal word om deel te neem aan die studie en is daar enige kostes vir u?

- *Nee, u sal nie betaal word om deel te neem aan die studie nie.*
- *U sal 'n R50 Shoprite koopbewys ontvang om u te bedank vir u tyd en dat u deelgeneem het aan die studie. Hierdie koopbewys sal vir u gegee word op dieselfde dag na die onderhoud.*
- *Vervoergeld sal vir al die deelnemers betaal word wat na die Khula Development Group se kantoor vervoer word. Die navorser sal vir u geld gee vir publieke vervoer. Hierdie vervoergeld sal vir u gegee word op dieselfde dag na die onderhoud.*
- *Water sal beskikbaar wees vir u tydens die onderhoud.*
- *Daar sal dus geen onkoste vir u wees om deel te neem aan hierdie studie nie.*

Is daar enige borge en 'n konflik van belange?

- *Die navorser betaal self vir hierdie studie en daar is geen ander borge nie.*
- *Die navorser werk vir Khula Development Group en kan daarom haar eie idees en voorkeure hê wat die navorsing mag beïnvloed. Maar sy sal sekere aksies neem om dit te probeer voorkom.*

Is daar enige iets anders wat u moet weet?

- *U kan die persone wat die navorsing aan u verduidelik kontak by 021 8711511 (Khula se kantoornommer) indien u enige verdere vrae oor die navorsing het.*
- *U kan die navorser, Carien van Zyl kontak by 021 8711511 indien u enige verdere vrae oor die navorsing het.*
- *U kan ook die Etiese komitee deur Mev Carolien van Zyl kontak by 018 299 1206 of carolien.vanzyl@nwu.ac.za indien u enige bekommernisse oor die navorsing het wat nie beantwoord was nie of enige klagtes oor die navorsing het.*
- *U sal 'n afskrif van hierdie ingeligte toestemmingsvorms ontvang vir uself om te hou.*

Verklaring deur die deelnemer

Deur hieronder te teken, stem ek.....(naam en van van deelnemer) in om deel te neem aan die navorsing met die titel: Verkenning van faktore wat potensiëel die eerste duisend dae van afwesige leerders in die grondslagfase kan affekteer

Ek verklaar dat:

- Ek hierdie inligting gelees het/dit was aan my verduidelik deur 'n persoon wat ek vertrou in 'n taal wat ek heeltemal verstaan en waarin ek gemaklik is.
- Die navorsing was duidelik aan my verduidelik.
- Ek het 'n kans gehad om vrae te vra vir die persone wat die toestemming van my gekry het, sowel as die navorser en al my vrae was beantwoord.
- Ek verstaan dat deelname aan hierdie studie **vrywilliglik** is en dat ek nie onder druk geplaas was om deel te neem nie.
- Ek verstaan dat ek mag kies om die studie enige tyd te verlaat en dat dit nie negatief op enige manier hanteer sal word nie.
- Ek mag gevra word om die studie te verlaat voordat dit klaar is as die navorser voel dat dit in die beste is of as ek nie die studieplan soos ooreengekom, nakom nie.

Geteken by (*plek*) .....op (*datum*) ..... 20....

.....
Handtekening van deelnemer

.....
Handtekening van getuie

Verklaring van persoon (persone) wat toestemming verkry

Ek/ons *(naam/name)* ..... verklaar dat:

- Ek/ons duidelik in detail al die inligting in hierdie dokument verduidelik het aan

  .....
- Ek/ons het/het nie 'n tolk gebruik nie.
- Ek/ons het haar aangemoedig om vrae te vra en het genoeg tyd geneem om die vrae te beantwoord.
- Ek/ons is tevrede dat sy volkome al die aspekte van die navorsing, soos hierbo bespreek, verstaan.
- Ek/ons het haar tyd gegee om dit met ander te bespreek as sy wou.

Geteken by (*plek*) .....op (*datum*) ..... 20....

.....

Handtekening van persoon/persone wat toestemming verkry

Verklaring deur die navorser

Ek (naam) ..... verklaar dat:

- Ek het die inligting in hierdie dokument duidelik en in detail laat verduidelik deur ..... persone wat ek opgelei het vir hierdie doel.
- Ek het/het nie 'n tolk gebruik nie.
- Ek was beskikbaar as sy verdere vrae wou vra.
- Die ingeligte toestemming is verkry deur twee onafhanklike persone.
- Ek is tevrede dat sy volkome al die aspekte van die navorsing, soos hierbo bespreek, verstaan.
- Ek is tevrede dat sy tyd gehad het om dit met ander te bespreek as sy wou.

Geteken by (*plek*) .....op (*datum*) ..... 20....

.....

Handtekening van navorser

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25 April 2018

File reference: 9.1.5.8

ANNEXURE E: TIMELINE TOOL

ANNEXURE F: INTERVIEW SCHEDULE FOR SEMI-STRUCTURED INTERVIEWS

Title: Exploring factors that could potentially have affected the first thousand days of absent learners in the Foundation Phase

Interview schedule for the biological mothers

These semi-structured interview questions form part of this research study to explore the first thousand days of absent learners in the foundation phase within the Paarl East area in the Western Cape.

Section 1: Question relating to the pregnancy phase

1. Describe your living conditions while you were pregnant with your child.
2. Tell me more about your own health during your pregnancy.
3. Explain what you ate and drank during your pregnancy.
4. Tell me more about the people who helped and supported you during your pregnancy.
5. Describe your feelings towards your unborn baby while you were pregnant with your child.
6. How did you experience the pregnancy?

Section 2: Question relating to the phase from birth to two years

7. Describe your living conditions from the time your child was born until two years of age.
8. Tell me more about your child's health from birth until two years.
9. Tell me more about your child's nutrition from birth until two years.
10. Describe your relationship with your child from birth until two years.
11. How did you play with your child from birth until two years?
12. Describe any challenges regarding your child since the time when he/she was born until two years of age.

Titel: Verkenning van faktore wat potensiëel die eerste duisend dae van afwesige leerders in die Grondslagfase kon beïnvloed het

Onderhoudskedule vir die biologiese moeders

Hierdie semi-gestruktureerde onderhoudsvrae vorm deel van hierdie studie om die eerste duisend dae van afwesige leerders in die grondslagfase in Paarl-Oos area in die Wes-Kaap, te ondersoek.

Afdeling 1: Vrae in verband met die swangerskap

1. Beskryf jou huislike omstandighede terwyl jy swanger was met jou kind.
2. Vertel my meer van jou eie gesondheid tydens jou swangerskap.
3. Verduidelik wat jy geëet en gedrink het tydens jou swangerskap.
4. Vertel my meer van die mense wat jou gehelp en ondersteun het tydens jou swangerskap.
5. Beskryf hoe jy teenoor jou kind gevoel het toe jy nog swanger was met hom/haar?
6. Hoe het jy die swangerskap ervaar?

Afdeling 2: Vrae in verband met die fase vanaf die kind se geboorte tot die ouderdom van twee jaar

7. Beskryf jou huislike omstandighede vanaf jou kind se geboorte tot die ouderdom van twee jaar.
8. Vertel my meer van jou kind se gesondheid vanaf geboorte tot twee jaar.
9. Vertel my meer van jou kind se voeding vanaf geboorte tot twee jaar.
10. Beskryf jou verhouding met jou kind vanaf geboorte tot twee jaar.
11. Hoe het jy met jou kind gespeel vanaf geboorte tot twee jaar?
12. Beskryf enige uitdagings ten opsigte van jou kind vanaf die tyd wat hy/sy gebore was tot die ouderdom van twee jaar.

ANNEXURE G: SUMMARY OF THEMES, SUB-THEMES AND CATEGORIES

Theme 1: Health of the mother during the first thousand days of the child's life	
Sub-theme	***Category***
1.1 Physical health of the mother	(i) General physical health of the mother
	(ii) Complications during pregnancy and birth
1.2 Mental health and emotional well-being of the mother	(i) Mother's own experience of the pregnancy
	(ii) Stressors and related emotions/thoughts of the mother during pregnancy and the birth process
	(iii) Stressors and related emotions/thoughts of the mother from birth to two years
1.3 Nutrition of the mother	(i) General nutrition and type of food intake by the mother
	(ii) Challenges regarding nutrition and food
1.4 Substance use/abuse of the mother during pregnancy	(i) Nature of substance use/abuse during pregnancy
	(ii) Effect of the mother's substance use/abuse during pregnancy
Theme 2: Health of the child during the first thousand days of life	
Sub-theme	***Category***
2.1 Physical health of the child	(i) General physical health of the child
	(ii) Challenges relating to the child's health
2.2 Nutrition of the child	(i) General nutrition and type of food intake by the child
	(ii) Challenges regarding nutrition and food
Theme 3: Availability of support to the mother and the child during the first thousand days of the child's life	
Sub-theme	***Category***
3.1 Mother's experience regarding support	(i) Other people's response to the announcement of the pregnancy
	(ii) Mother's emotions and thoughts regarding support
3.2 Support from the child's biological father	(i) Support from the biological father during pregnancy
	(ii) Support from the biological father from birth to two years
	(iii) Challenges in the relationship between the mother and the biological father
	(iv) Relationship between the child and their biological father
3.3 Support from family and others	(i) Support from family/others during pregnancy
	(ii) Support from family/others from birth to two years
	(iii) Relationship between the child and family/others
Theme 4: Circumstances of the mother and the child during the first thousand days of the child's life	
Sub-theme	***Category***
4.1 Living circumstances	(i) Living circumstances during pregnancy
	(ii) Living circumstances from birth to two years
4.2 Financial circumstances	(i) Financial circumstances during pregnancy
	(ii) Financial circumstances from birth to two years

Theme 5: Attachment and relationship between the mother and the child during the first thousand days of the child's life		
Sub-theme	***Category***	
5.1 Attachment and relationship between the mother and the child during pregnancy	(i)	Mother's initial response to the pregnancy announcement
	(ii)	Mother's response to the gender of the child
	(iii)	Mother's emotions and thoughts towards the unborn baby
	(iv)	Mother's interaction with the unborn child
5.2 Attachment and relationship between the mother and the child from birth to two years	(i)	Mother's initial response to the newborn baby
	(ii)	Mother's emotions and thoughts towards the child from birth to two years
	(iii)	Child's attachment and relationship with the mother
Theme 6: Development and care of the child during the first thousand days of life		
Sub-theme	***Category***	
6.1 Child's development	(i)	Mother's understanding of the child's developmental needs
	(ii)	Child's developmental milestones
6.2 Mother's care and protection towards the child	(i)	Caregiving towards the child
	(ii)	Protection and discipline
	(iii)	Challenges regarding the caregiving or the child
6.3 Stimulation and play	(i)	Type of stimulation and play
	(ii)	Child's interaction and play with the mother and others

ANNEXURE H: ORIGINAL AFRIKAANS QUOTES FOR THEME 1

Theme 1: Health of the mother during the first thousand days of the child's life
Sub-theme 1.1: Physical health of the mother
Category (i): General physical health of the mother
<u>Goeie fisiese gesondheid</u>: "… dit [gesondheid] was oraait gewees. Ek was nie siek nie of so nie." (Deelnemer 1) "Maar verder het ek nie nog ander siektes of hoë bloed, suiker of ander dinge gehad nie. Als was reg gewees. My gesondheid was goed en elke keer as ek miskien nou hospitaal toe gegaan het, dan word jou uriene getoets en hulle weeg jou en kyk na jou bloed of jou suiker, en trek nou bietjie bloedjies of so, maar als was net reg gewees." (Deelnemer 3) "Ek was gesond soos 'n 'horse', soos 'n bees soos hulle sé. Alles was normaal. Niks, sieklik gewees nie, nee. (Deelnemer 4) "Ek het nie 'morning sickness' of ... ek was baie gesond. Ek het 'n gesonde swangerskap gehad, daar was nooit probleme nie." (Deelnemer 5) "Ek was gesond vir my nege maande. Niks komplikasies nie." (Deelnemer 6) "Hy's die enigste kind wat ek nie 'morning sickness' gekry het nie. Hy's die enigste kind waarvoor ek nie ysterpille nodig gehad het nie. My gesondheid was met kind 7 [kind] baie uitstekend. Ek het nie nodig gehad vir pille nie, …" (Deelnemer 7) "Ek was baie gesond. Perdfris … Maar ek was baie gesond. Ek was nie sieklik nie." (Deelnemer 9) "Seker oorgesond [Lag]. Volle nege maande. Niks komplikasies gehad nie." (Deelnemer 11) "Ek is 'n baie sterk vrou, so ek het niks probleme eintlik gehad met my swangerskap nie." (Deelnemer 13) "My gesondheid, ek het baie gekyk na my … maar ek het nooit eintlik kwale en goed nie, gehad nie." (Deelnemer 14) "… ek was nie siek of so nie. My swangerskap was 'orraait' gewees. Als het normaal afgeloop. Ek het niks siektes gehad ook nie. Nee, niks 'morning sickness' nie." (Deelnemer 15) **<u>Swak fisiese gesondheid (Siektes en mediese toestande)</u>:** "Dit was net die sooibrand wat 'n mens bietjie het." (Deelnemer 1) "As ek naby klaar maak en dan braak ek baie. Op agt maande, amper nege maande dan gooi ek elke keer op." (Deelnemer 1) "Die 'morning sickness' het ek gehad met hom [kind]… ek was baie siek [naar] gewees met hom." (Deelnemer 2) "As ek altyd swanger gewees het met elke kind dan het ek 'n bors. Nie heeltemal soos asma nie. 'n Benoude bors, ja. Hulle [hospitaal personeel] noem dit mos benoude ... jy kry 'n benoude bors en 'n asma bors. Twee verskillendes." (Deelnemer 3) "Net opgegooi. Daai was nie so lank nie. Dit was maar net seker 'n maand en 'n half, toe is die naar oor." (Deelnemer 4) "Dit was hier by November toe kry ek daai 'panic attacks' dat my hart net so gaan. Daai dag toe ek dit [paniekaanvalle] gekry het toe wil ek my uittrek, gesweet, moeg gevoel." (Deelnemer 5)

“Ek het net hoë bloed gehad. Ek het baie ontwater … die hoë bloed is net so hoog en my oë raak rooi, swel op, alles swel op, my hande, alles. Toe moet ek hospitaal loop ook met haar [kind], want my hoë bloed was te hoog en … vyf maande wat ek vir haar verwag toe kry ek 'n stroke.” (Deelnemer 8)

“Ek het hoë bloeddruk gehad tydens my swangeskap, ja. Ek is 'n hoë risiko as ek swanger is. Vir die hoë bloeddruk, want ek drink 1 ½ hoë bloeddruk pil soggens en een moet ek saans drink. As ek nie daai deur die dag doen nie [hoë bloeddruk pille drink] dan is ek so slap mevrou, ek kan niks doen omtrent nie. Dan is ek net slap …” (Deelnemer 10)

“Dis net my hoë bloed. Dis wat my voete geswel is en my bene en ek is kort van asem sê sy vir my, en goeters. Toe gaan ek mos hospitaal toe. Toe het ek daar gebly tot wanneer ek klaargemaak het. En daai was meer as 'n maand wat ek daar in die hospitaal gebly het.” (Deelnemer 12)

“Wel ek het hoë bloed. Hoë bloed.” (Deelnemer 14)

“… ek het TB gekry terwyl ek swanger was met [redacted] [kind]. Ek was nege maande swanger gewees … Vir ses maande het ek TB gehet en my liggaam het beginne verswak. Hulle moes vir my 'n drup gee, yster pille, vitamiene pille … En toe het hulle [kliniek personeel] nog vir my pille gegee wat keer dat sy [kind] ook nie die kiem [TB] kan kry nie, terwyl ek vir haar borsvoed.” (Deelnemer 16)

“… ek het TB gekry. Toe het ek nog nie eers geweet nie. Dit [TB] was seker maar in die beginstadium van die swangerskap. Ja en toe gee hulle [kliniek personeel] mos nou behandeling om te keer sodat die baba nou nie kan TB ook kry nie, want dit was nog 'n ses maande, klaar voltooi is, die kind is toe veilig, toe is dit oor.” (Deelnemer 18)

Sub-theme 1.1: Physical health of the mother

Category (ii): Complications during pregnancy and birth

“… ek moes van die nege en twintigste Junie af klaar gemaak het, toe maak ek die nege en twintigste Julie klaar met [redacted] [kind]. So ek het baie oor, oor my tyd geloop, amper tot drie en veertig weke. … toe's ek al die Maandag in en hulle het vir my die Dinsdag oggend het hulle [hospitaal personeel] my water geknip, my op pyne gesit, … Toe hulle by my kom, toe sal hulle sien ek het nog nooit ontsluit nie, toe moes ek 'n nood keisersnit kry met hom [kind].” (Deelnemer 2)

“En toe wys hulle [hospitaal personeel] nou die skerm [sonar] en die pa sien dit ook. Toe sê hulle dat die kind het weer terug geswaai. Toe lê die knieë nou daar by my in die [geboortekanaal]. Toe is hy [kind] eers met sy knieë uit. … maar toe hy nou uit is, toe is hy al spierwit. Maar hulle moes hom nog 'n hou gee. Die vierde hou het hulle hom baie hard geslaan, en toe begin hy te huil.” (Deelnemer 3)

“… toe sê hulle [hospitaal personeel] vir my sy [kind] lê in die buis van die baarmoeder, in een van die buise. Maar ek het baie swaar gekraam met haar. Baie swaar. Ek moes gegaan het vir 'n keisersny. Ek het vier, vyf weke gelê by Paarl Hospitaal. Ek het pyn maar ek kon nie vir haar gekraam het nie.” (Deelnemer 8)

“… so babatjie kom toe met haar voetjies uit, en sy [suster by die hospitaal] kom toe in en sy sê vir my, o jene. … want babatjie se voetjies het nou toe al bietjie blou getrek. En dokter sê vir my hy gaan net so ietsie daar sit laat die voetjies binne bly, want hulle moet nou 'n ‘ceasar’ doen.” (Deelnemer 9)

“En sy [dokter] sê vir my ek moenie druk nie, want my serviks kan skeur. Ek sê vir haar, dokter maar ek voel die kind wil kom. In die tyd wat die dokter by die deur uitstap toe maak ek klaar [kraam]. En [redacted] [kind] moes vir 'n tien minute net so gelê het in daai ... want ek kan myself nie oplig om vir [redacted] [kind] op te tel nie. En toe het ek nou vir die ‘cleaner’ geroep en vir haar gesê, kry vir my 'n dokter of 'n nurse want die kind lê al tien minute ... ek is al tien minute terug klaargemaak [gekraam]. En toe hulle vir [redacted] [kind] oplig, toe is [redacted] [kind] nog blou om haar mondjie en om haar oë, want sy was amper besig om te versmoor.” (Deelnemer 10)

“Maar net ek het moeilik gekraam. Ek was baie lank in ‘labour’. … hulle [hospitaal personeel] het die Donderdag vir my pyne gegee, ek was die Vrydag in kraam. Die baba se kop was nou al daar, maar baba kan net nie kom nie. En nou, hulle het vir my pyne gegee en ek het my eie pyne ook gekry, wat baie moeilik

was. Hulle moes vir my suurstoftenke aansit. En die Saterdagoggend toe kan ek nie meer nie. Toe sê ek vir dokter, dokter, ek kan nie meer nie. Ek kan nie kraam nie, want die kind sit nou al tussen my bene vir hoe lank. Enige iets kon gebeur het, ek kon my kind dood versmoor het, want hulle nou vir my al weggevat al in 'n separate kamertjie. Ek lê nou alleen daar, want baba wil nie uit nie, baba kan mos nou ook nie terug nie. Baba se kop wys al uit, maar baba kan net nie uitkom nie." (Deelnemer 11)

"… sy was 'n agt maande kind. Sy was vroeg gebore mos nou ter wille van die hoë bloed wat ek mos nou gehad het. Van die 14de Desember af tot en met Februarie-maand [opgeneem in die hospitaal tydens swangerskap]. Toe gee hulle [hospitaalpersoneel] mos nou vir my pilletjies dat ek nou moet pyne kry, maar dit het nie op my gevat nie. Toe moet hulle vir my 'n keisersnit gee om vir haar uit te gehaal het, want anderste sou sy [kind] dit nie gemaak het nie." (Deelnemer 12)

"… maar ek was net lank in kraam gewees, omdat die TB my somtyds uitput – dit het my kort van asem gemaak het en dit maak my moeg … Vir my verduidelik hoe langer ek die pyn opbou, hoe moeiliker gaan ek dit vir myself maak, of ek moet net maak soos hulle sê, of ek kan vir baba versmoor en so het hulle my verduidelik." (Deelnemer 16)

"Met hom wil ek nie gedruk het nie. As ek moet druk dan wil ek nie druk nie. As ek nie moet druk nie, dan druk ek. Toe sê hulle "mammie, jy gaan die, jy gaan jou kind doodmaak". Die kind se kop is al uit al, maar hulle sukkel met my want ek … Die kind gaan dood versmoor hier binne, want ek moet druk dat die kind kan uitkom en dit het vir hulle gekos om met my te sukkel om te druk vir die kind om uit te kom en wat die kind uitkom, toe sê ek "maar die kind is spierwit." (Deelnemer 17)

"… maar toe ek gaan kraam met haar, toe dit nou kom by die druk slag toe sit die naelstring om haar nek vas." (Deelnemer 18)

Sub-theme 1.2: Mental health and emotional wellbeing of the mother

Category (i): Mother's own experience of the pregnancy

<u>Positiewe ervaring</u>:
"… my swangerskap was goed gewees." (Deelnemer 1)

"Die swangerskap was ... dit was 'exciting'. Maar ek het lieflik gevoel, ek het gelukkig gevoel, want jy kry nie weer so iets nie. … want dis [kind] mos nou 'n blessing wat ek kry, dis mos nou 'n 'miracle'. So het ek altyd gevoel." (Deelnemer 3)

"Dit was vir my 'n lekker ervaring om te stap met die groot maag en toe ek vir haar mos nou verwag het, was ek baie mooi, my hare was baie mooi, ek het gehou van mooi aantrek. Ja, dit was vir my 'n lekker ervaring." (Deelnemer 5)

"… dit (swangerskap) was 'n goeie ervaring. Daar's niks om oor te kla nie wat ek kan aan dink nie." (Deelnemer 6)

"Met syne [kind] het ek 'n baie gemaklike swangerskap gehad." (Deelnemer 7)

"Nee, dit [swangerskap] was vir my 'n goeie ervaring …" (Deelnemer 10)

"… dit was 'n baie goeie ervaring vir my gewees." (Deelnemer 15)

<u>Negatiewe ervaring</u>:
"… kon niks [kos] inkry nie en dit was nie 'n lekker ervaring gewees nie. (Deelnemer 2)

"Ek kon nie reg geslaap het nie. En toe op die laaste was dit 'n bietjie moeilik, veral vir opstaan. Ek kon nie meer alles doen wat ek kon gedoen het nie. Kon nie meer my wasgoed was, self nie. Ek kon nie meer help in die huis nie. Ek moet nou net gesit het. My voete was altyd geswel en my hande." (Deelnemer 2)

"[Swangerskap] Was baie swaar. Dit was baie swaar." (Deelnemer 8)

“Vir my was dit [swangerskap] in die eerste plek, was dit iets baie onvoorspelbaar. Ek was nie dit gewoond nie. Ek het nie geweet wat om te doen nie.” (Deelnemer 9)

“Ek het dit [swangerskap] nie lekker ervaar nie, hoekom moet ek in die hospitaal is. Daai ervaring was nie die lekkerste van alles nie.” (Deelnemer 12)

“Ek kan nou nie rêrig sê nie, maar vir my was dit amper net so, ek is swanger, hoe kan ek sê, ek is swanger, ek moet dit ‘face’, ek moet daar deur gaan en maak wat ek kan maak daarmee en klaar kry, oor en verby.” (Deelnemer 13)

Sub-theme 1.2: Mental health and emotional well-being of the mother

Category (ii): Stressors and related emotions/thoughts of the mother during pregnancy and the birth process

Negatiewe emosies/gedagtes en stressors tydens swangerskap:

“… baie gestres en so. … omdat die pa ook nie vir my kon help nie en aan die begin van die swangerskap wou niemand in die huis met my gepraat het nie, want hulle [familie] was baie teleurgesteld en dit het my baie ook seergemaak.” (Deelnemer 2)

“… het ek gevoel soos 'n teleurstelling, het gevoel ek het hulle [familie] teleurgestel met die swangerskap.” (Deelnemer 2)

“Dit het, alles was net swaar gewees, dit het net vir my swaar en moeilik gevoel, dit het vir my gelyk ek gaan nie, ek sal dit nie kan maak nie. Want ek het altyd gedink as die kind gaan gebore word, hoe gaan ek maak, want ek myself werk nie en my ouma hulle, ek het baie skuldig gevoel, want ek het nou my verantwoordelikheid, het dit op hulle [familie] gebring. Dat hulle nou vir my moet help sorg vir die kind, ek het nie goed daaroor gevoel nie.” (Deelnemer 2)

“… die kinders laat jou mos net 'n bietjie stres as jy nou in die huis is. Miskien hulle [deelnemer se ander kinders] is gruwelik of die een wil nou nie sy huiswerk doen nie.” (Deelnemer 3)

“Want ek was ‘nervous’. Mos oor my ma wat nou nie die swangerskap aanvaar het nie en dit het my baie laat stres ook. Die stres, ek het 'n bietjie af gevoel … Ek was net bekommerd oor my ma en my stiefpa.” (Deelnemer 4)

“Ek het baie stres. Baie stresvol.” (Deelnemer 5)

“Wat vir my ‘sad’ gewees het, ek het self sonder 'n pa grootgeword, en nou moet ek my kind ook, my ongebore babatjie ook deur daai sit. Dit was vir my baie sad.” (Deelnemer 5)

“Dit [dat die kind se pa sê dis nie sy kind nie] het my hartseer gemaak. Ek het baie sleg gevoel, want as iemand mos nou so vir iemand sê, dan is dit mos die een was sleg of ... Dit het my baie sleg laat voel, want ek weet ek is nie daai tipe vroumens nie. Hy het my baie afgebreek. Die feit dat ek is swanger. 'n Mens sien mos altyd uit daarna as jy swanger is, die pa moet teenwoordig is. Want almal, die mense vra mos altyd vrae, mens sien jy's swanger maar nou waar's die pa? Daai het my baie stres gegee. (Deelnemer 5)

“Ek het baie gehuil saans, dan huil ek, alleen gevoel. Ek het mos ‘panic attacks’ gekry, toe hier naby klaarmaak het ek panic attacks gekry. Is net die pa mos nou en die omstandighede wat my hartseer gemaak het, …” (Deelnemer 5)

“Daai tyd [swangerskap] toe is alles, alles was te veel in die huis. Daar was te veel mense in die huis. Elkeen het sy eie probleme, die een skel daaroor en daai een skel daaroor. Partykeer is daar nie kos nie dan skel hulle onder mekaar, of hulle baklei of hulle steek mes onder mekaar. So het dit elke dag gegaan in die huis. … dit het te veel geraak vir my.” (Deelnemer 8)

“Ek was graad elf. Standerd nege. Ek was in die skool en toe vind ek uit ... daai tyd toe's dit mos nog, as jy verwag moet jy uit die skool uitkom, want daar is nie eintlik plek vir verwagtende meisies nie. En toe het ek die skool gelos.” (Deelnemer 8)

“Ek het geloop en huil werk toe. … maar ek weet nie hoe om vir my ouma te sê nie [van die swangerskap] … alles opkrop en ek weet nie wat om te doen nie, … So ek was meer, ek was 'n toe boek soos 'n mens sal sê …” (Deelnemer 9) “Miskien as hy [pa se broer] nou so aangaan [skel] in die huis, dat ek net gestres het daaroor.” (Deelnemer 11)
“… toe het my ouma nog net daai Januarie-maand nou net uitgelewe toe is sy op die einde van die maand nogals dood.” (Deelnemer 12)
“En hulle [deelnemer se kinders) pa het ook vir my baie stres gegee. Dan kom hy, dan gaan hy. So ek kon dit nie ge-‘handle’ het nie.” (Deelnemer 13)
“… ek het hartseer gevoel, want ek wil nie eintlik die kind gehad het nie.” (Deelnemer 13)
“… toe ek swanger gewees het met haar [kind], toe het ek baie stres en sulke klas van goed gehad.” (Deelnemer 14)
“Wat wat vir my die seerste is gewees, ek het vir hom [kind se pa] gesê .. ek sal nou die kind doodgemaak het “because” of van hom, sy omstandighede en goeters.” (Deelnemer 14)
“Ek was baie bang om vir my pa en ma te sê, want my pa was 'n baie – hy was baie streng met ons gewees, …” (Deelnemer 15)
“Somtye was ek emosioneel gewees, sodat my kind gaan nooit haar pa ken nie. Ander kinders loop met hulle pa's verby en so, maar partykeer het ek my suster gesê hoe ek voel.” (Deelnemer 16)
“Ek was nog op skool gewees by … en ek het nie geweet hoe om met die kind te maak, ...” (Deelnemer 16)
“O, hy [kind se pa] slaan my my daai aand, dit lyk my– ai mevrou, hy vat die belt. Hy trek my hare, … maag is blou soos hy my geslaan het, maar die kind skop en die kind, die kind gaan nie dood nie, dit kind sit net hier. Dis hoekom [redacted] [kind] so is. Ek moet die ‘pee’ drink dat die kind kan af, koerant water gaan die kind mos afbring, maar ek is al ses maande en die kind sit nog in my maag en toe vat die polisie my huis toe.” (Deelnemer 17)
<u>Negatiewe emosies/gedagtes en stressors tydens die geboorte proses:</u> “Ek dink hoekom moet ek dan nou nie meer druk nie. Nou hy [kind se pa] staan nou by my, nou sê ek vir hom,’nee, jy kan nie by my staan nie, jy moet vir hulle gaan dophou want hulle roep nou die dokters en ons weet nou nie wat is fout nou met die kind en so aan nie’, … maar ek sit en ek dink, o, is hier nou iets fout. Nou [tydens die geboorte] is ek ‘geworried’.” (Deelnemer 3)
“En ek is so bang baba kan versmoor, want as baba se kop daar sit beteken dit baba is reg vir uitkom. En ek het gehuil ook. En ek is al in daai toestand as jou water gebreek het, jy raak mal nou al. Daardie kind kan doodgaan.” (Deelnemer 11)
“Want ek was nou [tydens geboorte] bang gewees. Bietjie op my senuwees gewees, want die ander mense langsaan skree en raas en ek is nou 'n dom sewentien, hoe gee ek geboorte? Ek weet nie hoe nie. Ja, as die pyn gekom het dan het ek dit weer opgehou, want ek is bang, gaan ek dood as ek kraam? Wat gaan gebeur? Gaan die baba net uitkom?” (Deelnemer 16)
“En toe moet ek nou honderd persent aandag gee en dis 'n vrees in jou, want jy weet as jy nou 'n ‘mistake’ hier maak dan is dit jou skuld. Toe het ek maar nou so ge-‘panic’… (Deelnemer 18)
Sub-theme 1.2: Mental health and emotional well-being of the mother
Category (iii): Stressors and related emotions/thoughts of the mother from birth to two years
“My ma is maar 'n paar maande daarna [na kind se geboorte] dood.” (Deelnemer 1)

“Ek het hom elke tyd, wat hy [kind] siek gewees het, was my senuwees so op. Dit het gelyk ek, ek kan dit nie hanteer om my kind so in pyn te sien nie.” (Deelnemer 2)

“My ouma was oorlede.” (Deelnemer 8)

“Die geld wat ek gehad het vir die ‘lay-buy’ om die kind se klere te gaan haal, die pa het dit gebruik. En vir my, ek was so kwaad gewees.” (Deelnemer 13)

“Maar toe sy [kind] elf maande is, toe steek hulle mos vir hom (kind se pa) dood. Ek was baie seer gewees.” (Deelnemer 15)

“Om 'n kind so sukkel-sukkel groot te maak was nie lekker nie.” (Deelnemer 15)

“Die TB het my liggaam tam laat voel, amper soos ek is moeg. Nou sit ek nog met 'n kind ook, wat gaan ek met die kind maak? Ek is ook nog 'n kind. Ek gaan nie sewentien-jarige ouderdom nou 'n werk kry nie.” (Deelnemer 16)

“Ons het een nag so geslaap, toe was [redacted] [kind] nog so 'n pap babatjie. My outjie skrik wakker, toe brand die hok al. Die kers het gebrand op die kassie, maar hy het hom nie op die kas gesit nie, toe brand die hele kassie.” (Deelnemer 17)

“Maar dis hard, dis baie hard en ek het al vir myself gesê ‘Here, kan die kind nie maar dood of iets nie, gooi die kind weg’ …” (Deelnemer 17)

Ek kan nie meer nie. Ek los die kind daar by die hospitaal, maar okay, daar is bekende mense. Ek loop sonder die kind, ek wil nie die kind hê nie, want ek sê vir myself “ek wil die kind hê nie, ek, is al moeg van 'n ma te wees, want dis hard.” (Deelnemer 17)

Ek het gesê die kind, ek is sokkerveld toe met die kind daar by ons … dan sê ek vir myself “ek gooi die kind af hier by die dam water.” (Deelnemer 17)

Sub-theme 1.3: Nutrition of the mother

Category (i): General nutrition and type of food intake by the mother

Goeie voeding en gesonde kos:

... ek maak slap ‘chippies’ en 'n eier en ‘n avo, elke dag altyd al drie daai geëet in die bord. Ek maak 'n plan dat ek al drie ... want ek het net lus gekry vir daai soort kosse sê maar elke middag. Dan is dit nou soggens die pap en saans is dit gekookte kos wat ek nou eet en so aan. Tussen is dit miskien nou 'n vruggie of soetding, wat jy nou lus voor kry en baie suurlemoene. (Deelnemer 3)

“… goeie eetlus. Ek het baie groente geëet. Ek was baie lief vir eiers, groente, “bacon”, ja. Ek was baie lief vir groentekos.” (Deelnemer 5)

“Ek was baie lief vir 'n gekookte eier, my piesangs, lemoene, vrugte. En ek was baie lief vir slaaie gewees.” (Deelnemer 7)

“Rooibos tee gegee, en ons [deelnemer en haar ouma] het 'n plan [eetplan] uitgewerk, soos elke oggend eet jy “oats”, 'n glas water of 'n glas melk, en middagete sal sy vir ons middagkos maak, soos sy sal “toast” maak en dan sal sy miskien avo en eiers en sulke goed vir ons voorsit. En vrugte was soos “paw-paws”, mangos, “strawberries”, dit het ek geëet. Ek het gehou van muesli en beskuit. Baie gesond. Sy't [deelnemer se ouma] gesê jy kan nie enige iets eet nie en sy't vir my 'n plan uitgewerk soos wat om te eet. Ek het baie gesond geëet. Ouma het vir ons sap uitgedruk, soos “oranges”, wat ek nie van hou nie. Sy [deelnemer se ouma] het altyd haar eie sappe en goed gemaak soos wortel ‘juice’ en ‘beetroot juice’, …” (Deelnemer 9)

“Ek het geëet soos ek moet, meer geëet as wat ek moes geëet het seker, en ja, ek het gesond geëet. Elke dag van my lewe, sit ek met die boks piesangs. Ek was nogal baie oor gesonde kos gewees. Ek het vir my “smoothies” gemaak. So ek sal sê ek het gesond geëet en gesond gedrink ook.” (Deelnemer 11)

“Ons het baie gesond geëet. Of ons maak vir ons 'n potjie op die vuur, die drie-been pot buite. Nou hulle het mos, daai tjommies van my was van Hawston. Ons het baie perlemoen ook geëet. Kreefsterte. Yo, ons het baie lekker geëet. Groentepot het ons gewoonlik gemaak.” (Deelnemer 12)

“Ons het baie gesond geëet. Ons het altyd gemaak dat ons lekker ook eet, … man, man [elkeen] gooi 'n tien rand, koop ons vir ons sop braaibrood en smeerwors, of ons koop polonies of so. Ja. Maar ons het baie gesond geëet daai tyd. Dis wat sy [kind] so gesond gebore gewees het.” (Deelnemer 13)

“Baie water. Baie gesond geëet. … by my eie huis waar ek bly, het ons geëet gesond altyd. Ek is meer oor ‘stew’, gekookte goed, opgekookte goed is ek baie mal oor, en my vis, ek is lief vir my vis.” (Deelnemer 13)

“… dan het ek nou soos vrugte het ek nou baie geëet.” (Deelnemer 14)

“Genoeg groente en vrugte geëet en net koeldrank en genoeg water gedrink, …” (Deelnemer 15)

Swak voeding en ongesonde kos:
“Ek het maar ook nie gesond geëet nie toe ek swanger was nie. Enige iets geëet.” (Deelnemer 1)

“… was net water tot op sewe maande en aartappelskyfies op sewe maande,…” (Deelnemer 2)

“Ek het baie junk kos geëet. Baie “never mind” geëet. Ek “worry nie” wat ek eet nie. Ek het net koffie gedrink.” (Deelnemer 4)

“Al wat ek nou verkeerd gedrink het was kaffiëne. En ek het baie van koffie gehou. My ouma het gesê, deelnemer 9 [naam van deelnemer], jy moet afskuif van die koffie af, is te veel kaffiëne. En sy het vir my rooibos tee begin gee.” (Deelnemer 9)

“Ek het gewoonlik saans net altyd 'n maaltyd geëet. Nie deur die dag nie.” (Deelnemer 10)

“En ek was lief vir daai ys in die yskas, daai wit ys. En dis ongesond, want dis gas wat daai [yskas] maak.” (Deelnemer 11)

“… omdat my yster mos ... ek was te min yster. Ek het meer gehou van die klei. En dan is dit nou die bord kryt. Met haar het ek eintlik baie min geëet.” (Deelnemer 14)

“Hulle [kliniek personeel] het my yster pille gegee en so, maar aanmekaar as ek kom dan sê hulle “ons gee aanmekaar vir jou yster pille, maar hoekom bly jou bloed dan so?” Partykeer het ek dit [ysterpille] nie gedrink nie, dan gooi ek dit weg, so.” (Deelnemer 17)

Sub-theme 1.3: Nutrition of the mother

Category (ii): Challenges regarding nutrition and food

“Maar toe ek nou die dag gaan uitvind by die kliniek ek is swanger, seker net 'n dag of twee daarna toe kon ek nie niks inkry nie, ek kon nie eet nie. Die pille wat hulle my gegee het, het my ook naar gemaak, dit voel of dit maak my siek, kan dit ook nie inkry nie. En al wat ek vir my ingeforseer het was water en aartappelskyfies het ek nog ge-‘force’, is net daai wat ek kon ingekry het. Tot op sewe maande.” (Deelnemer 2)

“Kos was skaars. Dan kry ons sop, of ons kry miskien macaroni met velletjies wat die sopkombuis nou uitdeel, ons kry lensiekos met beentjies in, die nekkies, of ons kry rys en lensie biriyani kry ons. Dan was daar plekke (sopkombuise) waar hulle kos uitgedeel het en dan gaan ek en haal ek, en so het ek geëet en dan kry sy die voeding en so. Maar dit was, nie eintlik om dit sê dit ... ek maak vir my vol nie, … Nie elke dag [sopkombuise] nie. Dit was al oor die twee dae. Die Maandag en dan is dit die Donderdag en dan Sondagmiddae deel hulle ook uit. Maar daar was nie elke dag nie. En ek het so geloop dat ons, die kos wat hulle uitdeel, daar's 'n klomp skemas, dan loop ek so elke dag om 'n bordjie of 'n pakkie om te ontvang.” (Deelnemer 8)

"… maar sê nie deur die dag geëet nie, want daar was nie [kos] vir my om te eet nie. … en jy moet maar kyk as daar ietsie is of is daar aktiwiteite [sopkombuise] wat daar uitdeel of daar 'n kossie uitdeel, dan gaan ek maar. Maar ek kan nooit van my huis sommer geëet het nie, want daar was [kos] nie." (Deelnemer 10)

"Toe [na kind se geboorte] was daar niks om te eet of om te drink of niks nie, maar my meisiekind het voorsien, by haar skoonmense gaan haal, laat ek net kan melk produseer vir [redacted] [kind], want my borste kan nie, wat ek het niks in my lyf gehad nie." (Deelnemer 10)

"… dan het ons [deelnemer en kind se pa] nou in die dorp in rondgeloop en gekyk vir kos, sulke klas van goed. (Deelnemer 14)

… het ek miskien na my ma toe gegaan en vir haar gaan vra of sy nie iets het vir ons om te eet nie." (Deelnemer 14)

"… net yster pille gegee, maar dit het my nie gehelp nie. Dit het my liewerste naar laat raak en ek het nie meer energie en eetlus nie." (Deelnemer 14)

"… as daar nie [kos] is nie, dan het my ma ook altyd 'n way gemaak ook dat ons kan eet terwyl my pa in die werk is, …" (Deelnemer 15)

"… het die kliniek vir my pap gegee, amper soos 'n voeding skema." (Deelnemer 16)

Tydens my swangerskap. Soggens moes ek eerste die kliniek pap eet voordat ek drie tablette (TB medikasie) gedrink het en die yster pil en die vitamiene pil. (Deelnemer 16)

"… jy het nie vaste kos wat jy kan eet as jy verwag nie. Ek eet nie eintlik nie. Saans dan, jy moet mos eet as jy verwag. Nou saans gaan slaap ek sommer net so [sonder om te eet]." (Deelnemer 17)

"Hulle [kliniek personeel] moet mos nou prik en dan kan die bloed nie uitkom nie, want dis te min yster. Dan wil sy [kliniek personeel] weet hoekom my bloed, dan sê ek, ek het nie geëet nie, dit gaan swaar." (Deelnemer 17)

"Vanaand en party oggende was daar nie [kos] gewees nie, so en dan is daar party oggende dan gee, dan kan ek nou nie meer nie, dan moet ek eet, want ek kan voel ek het nie krag nie, …" (Deelnemer 17)

"So ons het altyd daar by suster Magda [naam] se sopkombuis en as daar nie [kos] is nie, dan gaan ons maar tot daar." (Deelnemer 18)

Sub-theme 1.4: Substance use/abuse of the mother during pregnancy

Category (i): Nature of substance use/abuse during pregnancy

Geen gebruik van sekere middels:

"Nee, ek het nie sigarette gerook nie, ook nie drank gedrink, voorheen voordat ek begin swanger raak met hom het ek nie gedrink nie." (Deelnemer 2)

"… maar deur my swangerskap sorg ek dat ek nie rook of drink nie. Ek sal altyd vir nege maande uithou sonder niks [sigarette en alkohol]. Dan stop ek als [sigarette en alkohol]. Maklik om als [sigarette en alkohol] te los, vir my ja." (Deelnemer 3)

"… maar deur my swangerskap sorg ek dat ek nie rook of drink nie. Ek sal altyd vir nege maande uithou sonder niks." (Deelnemer 3)

"Niks drugs. Niks drank nie. Ek drink nie. Ek gebruik nie alkohol nie." (Deelnemer 6)

"Nee, nee, niks [alkohol of dwelms]. Ek het gedrink, maar nie so ... maar terwyl ek swanger is vir nege maand, nee." (Deelnemer 8)

"Nee, niks. Ek het nie gedrink nie, ek het ook nie gerook nie." (Deelnemer 9)

"… vyf maande of ses maande voor ek swanger geraak het met haar [kind], het ek dit [dwelms] gelos." (Deelnemer 11)

"Maar tydens die swangerskap, niks van dit nie. Niks alkohol nie." (Deelnemer 11)

"Nie dwelms gebruik nie, …" (Deelnemer 13)

"Toe ek swanger gewees het toe het ek glad nie [gerook nie]." (Deelnemer 14)

"… niks alkohol of so nie. … niks dwelms nie." (Deelnemer 15)

"Geen alkohol, …" (Deelnemer 18)

Verminderde gebruik van sekere middels:
"Nee, ek het nie elke dag gerook as ek swanger is nie." (Deelnemer 8)

"Maar agterna toe los ek dit [dwelms] vanself." (Deelnemer 12)

"Tot op ses maande, toe 'worry' ek nie meer om te drink nie." (Deelnemer 14)

"… en ek het minder beginne rook ook." (Deelnemer 14)

"… maar ek kan dit [tik] nie dadelik gelos het nie. Dit was nie so maklik soos wat mense sê nie. Ek het ook skelmpies – dan sê ek "nee, ek rook nie meer nie, ek het die rook gelos", maar dan lieg ek want dan rook ek nog maar. So het ek gegaan al hoe minderer, al hoe minderer." Die laaste van die swangerskap wat ek nou heeltemal kan gesê het ek rook nou nie meer nie [Tik]. Nee, sê maar so agt en 'n half [maande] se kante daar rond." (Deelnemer 18)

"Toe sê ek myself nee, jy kan mos en vir die baba se onthalwe en so het ek minderer en minderer en minderer (tik) gerook tot ek opgehou rook het, maar nou nie met die sigarette nie." (Deelnemer 18)

Alkohol:
"My tjommies mos kom, ons gaan drink 'n bier, … Dan drink ons [deelnemer en vriende]. Maar ek maak nie 'n habit daarvan nie." (Deelnemer 1)

"Ek het 'n bier gedrink ja. So wanneer ek lus het. Wanneer die gier gekom het. … ek nou nie beskryf die hoeveelheid nie, want ek het gedrink tot ek aan die slaap is. Nie (gedrink) die hele swangerskap nie. Wat ek begin swanger word het. En voor ek klaarmaak, [kraam] het ek nog 'n bier gedrink. Miskien al oor 'n naweek [bier gedrink]. Tot ek aan die slaap raak en daai is omtrent heel dag. Seker maar net vier [biere] as ek alleen gedrink het." (Deelnemer 4)

"En om eerlik te wees so nou en dan het ek gedrink. Bier gedrink. Ek het net bier gedrink. Ek het naweke ... baie naweke het ek gedrink. Nie elke naweek nie. Dit was baie [biere]. Ons deel dit nou tussen die twaalf biere tussen ses mense, dan het ons elkeen twee [biere] gekry. Dis nie die dumpies nie, dis die groot bottels [750 ml]." (Deelnemer 5)

"Ek is om die eerlike waarheid te sê, 'n bier drinker. Met [redacted] [kind], ek het ook goed gedrink met hom. Ek was net 'n bier drinker. Ek het nie sterk drank gedrink nie. Nie eens 'n 'cider' het ek gedrink nie. Ek was net 'n bier drinker met al my swangerskappe." (Deelnemer 7)

"… ek het op 'n Sondag klaargemaak [kraam], die Saterdagaand toe staan ek nog met die alkohol. … ek het saans begin met drink... sê nou ek is alleen dan drink ek tot twee biere 'n dag. Saam met ander mense is dit plus minus so ag, tien of tot twaalf [biere]. Ek sal drink sover my limit dit kan vat. As my kop vir my sê jy het genoeg gehad, ek gaan nou vir jou presies sê, as my kop sê jy het nou genoeg gehad, So my limit was plus minus, as ek genoeg gehad het, ek kan nie vir jou sê is ontelbaar nie, maar ek skat hom, sê maar daar's 'n kis bier, daar's twaalf biere in en ons is vier. Tot op waar drie op daai kis nog oor is, dan stop ons, of ek stop. Dit is gewoonlik op 'n Sondag wat dit gebeur het wat 'n mens so oor 'n mens se 'limit' gaan." (Deelnemer 7)

“Altyd net 'n biertjie gedrink, 'n Castle biertjie of so gedrink. Mevrou, ons het klein botteltjies altyd gekoop en dan kan ek maar sê ek het so ses botteltjies van daai bier gedrink, want dis mos nou maar klein botteltjies en ons is mos nou maar ook nou 'n klomp op daai botteltjies. Ons het maar nou so elkeen ses botteltjies gedrink.” (Deelnemer 10)

“Ek het gedrink daai tyd, soos in alkohol het ek gebruik. Ons het net meestal bier gedrink. As ons uitgaan sal ek miskien nou vir my sterk wyn bestel …Ons was mos altyd 'n klomp vriende bymekaar. My tjommie se man het mos gesmokkel. Drugs ... groot gesmokkel. So daar was elke dag biere of ciders gewees om te drink, so ons haal nie geld uit nie. Sy [vriendin] sal miskien nou sê kom help, kom maak ons saam of sy kom roep ons miskien by die huis, kom help huis skoonmaak, dan help ek miskien nog vir haar die huis uit turn. Soos ons uit turn so drink ons mos nou. … maar is nou nie dat ek miskien nou heelnag sterk wyn drink nie. Miskien net so twee wiskeys of 'n rum of so. Ons het elke dag gedrink.” (Deelnemer 12)

“Ek gaan nie nonsens praat nie, maar ek het, as dinge ook vir my te veel geraak het en daar het miskien 'n vriendin gekom wat saam my gewerk het of so, dan sal ek miskien een bier saam met haar drink, …” (Deelnemer 13)

“Ek het gedrink toe ek vir haar [kind] verwag het, toe het ek gedrink. Dis net bier. Elke naweek het ek nou liters [bier] gedrink. Net naweke, maar nie in die week in nie. Dis miskien nou as ek nou sê, as jy die hele dag, miskien van twaalfuur af tot ‘nine-o'-clock’ toe. As ek moet skat hoeveel liters, wat was dit gewees? Kan ek nou sê, dis seker naby vyf liters. … ek het net baie gedrink.” (Deelnemer 14)

Sigarette:

“In my swangerskap het ek baie gerook [sigarette]. Ek weet nie, ek kan nie sê nie, maak dit maar 'n pakkie [sigarette] op 'n dag.” (Deelnemer 4)

“Net gerook [sigatette]. Want ek rook baie. Ek rook seker tien “cigarettes” 'n dag.” (Deelnemer 6)

“Ek het baie min met hom gerook. Met [redacted] [kind] het ek nie baie gerook nogal nie. As ek vier [sigarette] gehad het en my man kom uit die werk uit die aand, dan lê daar nog een en 'n half seker nog oor.” (Deelnemer 7)

“Sigarette, ek rook sigarette. Ek sal miskien in die oggend een, dan rook ek nie deur die dag nie. Dan in die aand voor ek gaan lê wanneer ek klaar geëet het, ek gaan lê nou, dis nou slapenstyd dan rook ons, dan rook ek 'n entjie, … Ons was baie ledig gewees, en partykeer as ons [deelnemer en vriende] by die vuur sit dan rook ek miskien, in die aand dan sit ons by die vuur dan rook ek drie tot vier entjies vir daai kort tydjie.” (Deelnemer 8)

“Ja. Ek het gerook tydens my swangerskap. Dis hoekom ek moet maar ook net saans met [redacted] [kind] gerook gehet. Ja, ek maak net drie sigarette 'n dag.” (Deelnemer 10)

“Net sigarette het ek gerook. Ek is nou dood eerlik. So ek sal nie sê ek het nie gerook nie, ek het gerook. Ek het sommer klomp sigarette gerook. Heeldag sigarette gerook. As ek gedagte kry van rook, dan rook ek. Elke dag. Ek het sommer genoeg sigarette gerook. O, sê maar twintig per dag. Daai's nou 'n pakkie sigarette per dag. So ek is eerlik. Ek het sommer twintig sigarette per dag gerook.” (Deelnemer 11)

“Ja, sigarette het ek gerook, …” (Deelnemer 12)

“… maar ek het so nou en dan 'n sigaretjie gerook. … seker so twee ... een of twee al oor 'n dag of drie, maar nie gerook, rook nie. Ek is darem nie 'n strawwe roker … nie.” (Deelnemer 13)

“Sigarette, net sigarette, … Dan soggens miskien een [sigaret], dan weer smiddags en dan nou saans het ek 'n sigaret geneem. Ek het nie aanmekaar gerook nie. Ja, elke dag gerook. Drie sigarette 'n dag.” (Deelnemer 15)

“Sigarette ook, ja. Baie gerook, baie. Entjie op 'n entjie elke dag. Agt entjies of so, …” (Deelnemer 17)

“Ek het sigarette gerook. En as die sigaretjies op is, dan rook en maar die toppertjies van die sigarette en dan swaai ek nou maar 'n pilletjie as ek verder lus het vir rook en dan rook ek die pilletjie maar. Dis nou die

sigaret stompie. Daai laaste bietjies swaai ek nou half soos 'n pilletjie as dit nou uitgedruk is en daar nie meer 'n sigaretjie oor is nie. Elke dag gerook, ja. Sê so tien ja, plus minus tien 'n dag." (Deelnemer 18)

Dwelms:
"En ek het drugs ook daai tyd gebruik. Toe was ek mos op rocks gewees. Dis [rocks] amper soos ... dis nie soos tik nie, maar is ook 'n drug. Nee, net nou en dan [Rocks]. As ek miskien nou voel ek raak dronk dan rook ons dit [Rocks]." (Deelnemer 12)

"… ek het dagga gerook, maar daai tyd toe rook ek mos pype. Mos die dagga en die sigarette "mix" ons dit mos mee, … dan rook ons dit so." (Deelnemer 12)

"Met my swangerskap met [redacted] [kind]het ek dagga gerook. Groen dagga. Dis mos nou die skoon dagga gewees. Ja, sonder sigarette. Ek het dit net so gerook." (Deelnemer 16)

"Ek was op drugs. Ek is nog altyd op drugs, … maar nou ek was ge-'drug' met [redacted] [kind]. Tik en Mandrax. Ja, al lankal (dwelms gebruik voor swangeskap). Baie, baie, baie [dwelms]. Elke dag. … drie, vier gramme [dwelms] …Elke dag buttons en tik en so, tot op nou agt maande." (Deelnemer 17)

"Die tikkies. … net tik gerook mevrou. Net naweke. O, ek kan nou nie presies sê [hoeveel Tik] nie, … dan raak dit amper soos 'n gereelde – jy moet nou elke naweek rook [Tik]." (Deelnemer 18)

Sub-theme 1.4: Substance use/abuse of the mother during pregnancy

Category (ii): Effect of the mother's substance use/abuse during pregnancy

"… kan nie daai goed [alkohol] inkry as ek swanger is nie met my kinders. Dan braak ek so." (Deelnemer 1)

"... die punt is as jy te laat uitvind jy is swanger, moenie daai alkohol vlak stop nie, want dan maak jy jou kind eintlik siek, want jou kind is nou gewoond aan daai alkohol vlak. Hy's gewoond daai in sy bloedstroom. Maar daai kind gaan daai bietjie (alkohol) soek nog, want hy's mos nou gewoond." (Deelnemer 7)

"Die alkohol het niks aan [redacted] [kind] gedoen nie. …'n probleem gehad met geleerentheid of met hulle liggaamsbou nie of iets soos daai nie." (Deelnemer 7)

"Veral met [redacted] [kind], ek het nogal nie so baie gerook met kind nie, want [redacted] [kind] het vir my sooibrand gegee." (Deelnemer 7)

"Dit was die sigarette. Dit het my daai slyme gegee en ek het daai ... lyk amper iets krop net so op en dan kom dit uit. En in die oggende as ek opstaan dan voel ek daai suur op my maag, dan moet ek "vomit". Ek moet. Dis nou al die suur wat uitkom van die entjies en ek kry sooibrand agterna." (Deelnemer 8)

"Nou dan was dit lyk my te warm, of sy [kind] wil nie gerook gehê het op haar nie. Sodra ek gerook het, dan voel ek net donker voor my en dan moet ek nou sit of ek moet nou lê tot wanneer daai nou verbygaan, amper soos 'n warmgloed wat ek kry. Ek moet my uittrek. Warmte en sweetdruppels tap my ... daai vat nou 'n tydjie tot dit nou weer verdwyn." (Deelnemer 10)

"Want doen ek dit [dwelms] dan wat sal nou met my kindjie gebeur het. En toe wat ek swanger raak toe is ek ook eintlik bly ek doen nie dit [dwelms] nie, want dis my kindjie. En soos jy lees in die boeke wat kan met jou kind gebeur as jy die goed gaan doen, dan gaan jou kind heeltemal 'transform' of jou kind gaan nie lyk soos jou kind moet lyk nie, jou kind se brein gaan nie reg vorm nie." (Deelnemer 11)

"Maar hy [kind] het nie effek dat ons nou ... ons kan nou nie sê hy't nie effek nie, want ons kinders het niks makeer nie." (Deelnemer 12)

"Ek moedig nogals nie iemand aan om drugs te gebruik terwyl sy swanger is nie. …vandag die lewe is nie meer die moeite werd om op drugs te wees nie. Veral as jy swanger is nie. Want dis een uit 'n duisend uit se kinders wat gesond is van die, of wat se longe nou reg gevorm is of so. Hulle binnedele." (Deelnemer 12)

“En die swangerskap het so gemaak dat ek nie eers 'n entjie kan rook nie, want dan bly ek nou mislik daarna.” (Deelnemer 14)

“Kort voor lank het ek besef maar dit [dwelms] was verkeerd en ek het TB gekry terwyl ek swanger was met [redacted] [kind] en ek het die dagga gelos. Ter wille van [redacted] [kind].” (Deelnemer 16)

“En nadat ek die dagga gelos het, my behandeling gebruik het vir die eerste drie maande, was daar vordering [met kind se groei en gewig].” (Deelnemer 16)

“… maar nou na ek was ge-‘drug’ met [redacted] [kind] en [redacted] [kind] was baie klein gewees. Tik en Mandrax. Dit was hoekom [redacted] [kind] so sieklik gewees het. … so, dis hoekom die kind, [redacted] [kind] se toestand so is. En by die skool ook. Dis amper asof daai drugs het iets agter gelos. … dis hoekom sy [sy] so lank vat, swaar te dink. Sy het twee juffrouens wat haar geleer het. Twee jaar was sy in graad een gewees, want sy kan nie lekker skrywe nie soos die ander nie. Sy kan nie in die klas doen soos die ander nie. Sy kan ook nie lekker ‘focus’ soos die ander nie. Dit [dwelms] het effek op haar skoolwerk, ja, dis hoekom sy 'n bietjie stadig dink sien mevrou?” (Deelnemer 17)

“Want daai [dwelms] los iets agter as jy swanger is en jy mag dit nie gebruik as jy swanger is nie, want dit los iets agter by die kind, verstaan mevrou? So daai is amper soos ek het dit agter gelos by [redacted] [kind].” (Deelnemer 17)

“So klein was daai kindjie, dis hoekom sy so sieklik gewees het van die ‘drugs’. (Deelnemer 17)

“… ek het heel tyd die broodgeld gehou. Vanaand wil ek sit en stres, jy [deelnemer] het geld gehet en toe gebruik jy dit nou op ander goed [dwelms], so … dan eet ek nie, dan rook ek net en ek stres, maar ek dink nie aan die kind, want ek moet eet vir die kind wat hier binne my maag is, …” (Deelnemer 17)

“Maar dan sê ek myself weer die “drugs”, as ek “gedrug” is dan skop die kind die heel nag. Die kind moet ophou skop of "hou jou mond of moenie skop nie", so. Dan sê ek vir myself, ‘nee man jy kan nie, jy gaan dit [kind] mos doodmaak of so.’ Maar as ek so gedrug was, party keer weet ek nie wat ek doen nie, dan sê ek Here, help my net.” (Deelnemer 17)

“Ek bedoel ek het nou gedink nee maar die kindwat ek inkry kry die kind outomaties in. … maar by die tik toe dink ek, o die kind sal gestrem word, want ek kyk mos TV en ek sien mos en ek hoor ook wat gaan aan, …” (Deelnemer 18)

“So dan rook ek [Tik] ook maar, dan raak mens nie honger nie en jy bly wakker … as ek aan die slaap gaan bly, sommer in die week, dan “worry” ek nie. Sodra die by Donderdag kom, dan lus, dis amper soos 'n “craving”, dan beginne lus ek nou vir die goedjies [dwelms].” (Deelnemer 18)