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Supporting good outcomes for early childhood home-visiting programmes: Guidelines for practice

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Background: This article emerged from a larger qualitative study, which revealed that children continue to be exposed to a complex range of risk factors with devastating consequences for their well-being. Gaps in services further hinder their development. The study concluded that there is a need for multidisciplinary teams to implement an early childhood home-visiting programme, and that such a programme would hold many potential benefits for the young and vulnerable children.

Aim: This article presents a set of guidelines that can be used to support good outcomes for an early childhood home-visiting programme for vulnerable children aged 0 – 2 years.

Setting: The study is set in the Eastern Cape province of South Africa.

Methods: The guidelines were developed over three phases of the study, which used an intervention research design.

Results: The guidelines emerged as a number of practice principles and include: engagement and advocacy; the recruitment of a multidisciplinary workforce; training of the home-visiting workforce; implementation of the programme; and monitoring and evaluation of the programme.

Conclusion: The article suggests that the guidelines hold promise for both supporting the well-being of vulnerable children and shaping a programme that is preventative, focussed on early intervention, and both multidisciplinary and transdisciplinary in nature.

Contribution: The guidelines are intended as a support to those working in the fields of both early childhood and vulnerable children, and can be used alongside the existing services.

Keywords: vulnerable children; early childhood; home-visiting; transdisciplinary; guidelines.

Introduction

Numerous researchers, globally, and from many different disciplines, such as science, education, social development, and health, agree that early childhood is an extremely important life stage. The development that occurs during this period sets the foundation for future and ongoing development and learning (Dlamini 2015; Morgan & Sotuku 2019; Motshekga 2015; Slemming & Salojee 2013). Early childhood development (ECD) programmes that are offered to young children and their caregivers are delivered in various forms and can be either home-, community-, or centre-based. Despite the value of such programmes, majority of vulnerable children in South Africa do not receive these services (Ilifa Labantwana 2021; Proudlock & Rohrs 2018). If South Africa is to make a full and comprehensive ECD package available to all children, it is problematic that in a province, such as the Eastern Cape, which has the highest rates of child poverty, only 12% of the 0–2-year-olds have access to any ECD programme. The majority of vulnerable children are found at home with their caregivers.

There is, therefore, a need for effective ECD programmes, in particular non-centre-based programmes such as home-visiting programmes that target the most vulnerable children during their first 1000 days in the communities in which they reside. Various studies agree that home-visiting programmes are effective, yet in most studies there is a lack of such programmes in the rural provinces, such as the Eastern Cape, where children are most vulnerable because of high rates of poverty, unemployment, and a lack of adequate resources (Azzi-Lessing & Schmidt 2019; Cooper et al. 2009; Ilifa Labantwana 2018; Le Roux et al. 2010; Van Niekerk, Ashley-Cooper & Atmore 2017). In the light of the scarcity of ECD programmes and the potential benefits of a home-visiting programme, the intention of this article is to present a set of guidelines that can be used

to guide and inform best practice while supporting good outcomes for an early childhood home-visiting programme.

Guidelines essentially provide recommendations for practice and inform users as to what can be done to achieve the best possible outcomes (Davids 2020; World Health Organization [WHO], United Nations International Children's Front [UNICEF] & World Bank Group 2018). The guidelines presented in this article hold promise for practice in education, health, and social work shaping a programme that is preventative, focussed on early intervention, and both multidisciplinary and transdisciplinary in nature. These guidelines are intended as a frame of reference for those already working in the field or for those who are considering the use of a home-visiting programme to support the optimal development of vulnerable children during early childhood. Quality interventions during early childhood become especially important for vulnerable children because of the responsiveness and potential of brain development during this period. Such interventions may be essential in supporting social justice in South Africa so that intergenerational cycles of poverty and poor outcomes can be broken giving each child, at least, an opportunity to achieve their full potential.

The significance of this article lies firstly, in adding to the existing research in the field of early childhood, vulnerable children, and home-visiting programmes. Secondly, it has practical importance as it provides recommendations for a home-visiting programme, which is highlighted in the National Integrated Early Childhood Development Policy 2015 (NIECD) as important. Thirdly, if implemented, these guidelines can support vulnerable children who do not have any access to ECD programmes within their communities. These findings emerged from a larger study that aimed to develop a model of an early childhood home-visiting programme that supports the optimal development of vulnerable children aged 0–2 years in the Eastern Cape province of South Africa.

Literature review

Early childhood is a critical time in life as the brain develops at its most rapid pace then, exhibiting a high capacity for change and growth, and setting the foundation for future development. It encompasses the physical, socio-emotional, cognitive, and motor development that occurs in a child (WHO et al. 2018). According to Azzi-Lessing (2017), when a child is raised in an environment that is adequately resourced and the child is well cared for and protected from harm, optimal brain development is supported. This will then support development in all other areas for the young child right through to adulthood.

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

The responsiveness of the brain to good care and protection during the early years is one of the main reasons that the international community and South Africa is determined to ensure a good quality of ECD services to the youngest children and their caregivers. Even though South Africa is committed to ECD, many children remain negatively impacted by a range of social, health, and economic risk factors. Equitable and quality ECD services remain an unachieved ideal (Atmore 2013; Aubrey 2017).

In a country such as South Africa, where poverty rates are high and often accompanied by high rates of child abuse, neglect, maternal distress, family and community violence and crime, good quality equitable ECD services can act as a buffer against the toxic stress young children are exposed to within their social environments. The term buffering is used to 'describe the nurturing care that an adult gives an infant' (Morgan & Sotuku 2019:31). When such care is not offered within the home or community where children live, it can be offered through a safe and nurturing ECD programme, which can then support optimal development, buffering the toxic stress experienced in the family or social environment. These programmes, which are offered in various forms, then serve as protective factors for the vulnerable child and their caregiver.

Safe and quality learning opportunities can either be offered through non-centre-based ECD programmes or more formal centre-based ECD programmes. Non-centre-based ECD programmes may be more suitable for caregivers who have no formal employment, while centre-based ECD programmes may be more suitable for those caregivers who are in formal employment. Either option can become a protective factor for both the caregiver and the child if the programme is of good quality. Rowlands (2010) outlines four key components for a quality ECD programme that are especially relevant for early childhood home-visiting programmes. Firstly, the programme recognises that the child and caregiver live in a community that shapes learning and parenting. Furthermore, the programme is able to recognise that all children and caregivers have strengths that enable them to survive in the most challenging circumstances. Secondly, the programme works with the family, respects their self-determination and individualisation, listens to their stories, and supports them in making good decisions for themselves. To realise this, a strong relationship should exist between the facilitators of the programme and the child and caregiver. Thirdly, a successful programme reaches out to families in places where

they already spend time and is not dependent on a specific site for rendering services. Lastly, the programme knows and understands what resources exist in the community and can refer families, assisting them to access specialised services as and when they are needed.

Such programmes are critical for vulnerable children, the majority of whom are found at home in the care of their caregivers. Home-visiting programmes take place in the home of the vulnerable child and caregiver. Visits take place once or twice a week, or monthly, depending on the needs of the child and caregiver or the specific programme that is being implemented. The home-visiting programme can be shaped around the specific needs of the family, with a special focus on the overall healthy development of the child, or these programmes can follow a strict predetermined manualised format (Azzi-Lessing 2013; Tomlinson et al. 2020). With many children unable to access centre-based ECD programmes, and with early childhood being the most effective and cost-efficient time to intervene, it thus makes sense that government should invest in home-visiting programmes that support the optimal development of the child and their caregivers (Department of Basic Education [DoBE] 2015). Home-visiting programmes have received attention both internationally and locally with many proving effective in supporting the development of the vulnerable child.

In Africa, some countries have initiated the use of home-visiting programmes to support young children and their caregivers. In Gambia, a small country in West Africa, The Baby Friendly Community Initiative (BFCI) was launched because of high poverty rates, high infant mortality rates, and the high rate of maternal deaths (Marfo et al. 2008). The programme incorporated traditional and cultural knowledge with good health practices, engaging with caregivers of the child, including fathers and male relatives (Marfo et al. 2008). The importance of recognising and respecting the family and culture within which the child exists as being influential in child development is seen in this initiative. This would be an important starting point for any home-visiting programme; engaging with caregivers is essential so that both home visitors and the programme is accepted. Working with local knowledge and engaging with caregivers in the context of their homes was seen as one of the programme strengths and contributed towards making the strategy 'most successful' (Marfo et al. 2008:215). However, despite the overall success of the programme, there were some challenges. The greatest challenge was the sustainability of a voluntary workforce that served the project without any payment (Marfo et al. 2008). Here, the debate around the workforce used to implement home-visiting programmes is raised once more. Trained, unpaid volunteers were used for the programme and while the programme was successful, the greatest challenge was the retention of these volunteers. Indirectly, the challenge regarding funding of ECD programmes is also seen in South Africa as such programmes may be more sustainable when the workforce is employed and remunerated for the important work they do. It may be that a sincere commitment from government to fund ECD programmes is needed for such programmes to be sustainable. Atmore, Ashley-Cooper and Van Niekerk (2021) agree, sharing that in South Africa, the government has not yet allocated sufficient funding for ECD programmes.

Home-visiting programmes, as an important option for advancing ECD services – in particular to vulnerable children – are beginning to receive attention in South Africa (Azzi-Lessing & Schmidt 2019; Tomlinson et al. 2020). Future Families, a home-visiting programme implemented in the formal and informal settlements of Tshwane, has shown significant success in supporting orphans and vulnerable children (OVCs). Their access to human immunodeficiency virus (HIV) counselling and testing (HCT) has been increased and families are provided with an individualised care programme based on their unique needs (Thurman et al. 2016). In this programme, a qualified social worker provides supervision and training to a group of caregivers who have completed their secondary education and who then render home-visiting services to households with vulnerable children (Thurman et al. 2016). The results of the programme support the usefulness of community-based home-visiting programmes in assisting OVCs to access critically important health and social support (Thurman et al. 2016).

While this programme may not have been specifically aimed at OVCs during early childhood, the benefits of such a programme being offered during early childhood are supported through literature. This confirms that timely diagnosis of vulnerabilities, such as HIV, is essential as more than 50% of young children will die within the first 2 years of life if they are HIV positive but do not receive antiretroviral therapy (ART) (Grinsztejn et al. 2014). Furthermore, two South African studies — both in the Western Cape — confirm the success of utilising home-visiting services to offer support to vulnerable children and their caregivers. The first study shows positive outcomes for improving early mother–infant interactions and attachment, and the second shows positive outcomes for children who were malnourished (Cooper et al. 2009; Le Roux et al. 2010). A third programme implemented in various South African provinces, the Family and Community Motivator (FCM) Home Visiting Programme, offers support to vulnerable households with pregnant women or young children (Ilifa Labantwana 2018). The FCM Home Visiting Programme succeeded in promoting protective factors through increasing opportunities for early stimulation, supporting caregivers, improving health practices within the home, and increasing access to essential childhood services. The programme was received positively both by communities and government (Marfo et al. 2008). Here, the usefulness of home-visiting programmes in supporting vulnerable children can be seen. The main challenge, as with other home-visiting programmes, was in securing sustainable funding to pay volunteers, administrative costs, and support. This resulted in some programmes being implemented over 12 months and others over 18 months, before they were suspended (Biersteker 1997; Marfo et al. 2008). These challenges highlight that

although government acknowledges early childhood as a critical period of development through legislation and policy, the acknowledgement is not adequately supported through a sufficient and sustainable allocation of resources. For a country to feel so strongly about children's rights and to acknowledge early childhood as a foundation to good future outcomes, it makes no sense that scarce resources are allocated towards programmes that protect and nurture vulnerable children during the first 1000 days. As such, these programmes deserve more attention within the South African context, especially in the rural areas where many young children reside and where a dearth of ECD services is noticed.

Biopsychosocial model

The biopsychosocial model was used as the theoretical framework for the study. This model has been used in previous studies to understand the factors that influence and work together so that children can develop optimally during early childhood (Horwitz & Neiderhiser 2011; Morgan & Sotuku 2019; Shonkoff et al. 2012). The biopsychosocial model proposes that the different biological, psychological, and social factors work together, influencing one another from the time of conception to impact upon the development and brain development of the child. Factors relating to biology that impact upon the development of the child include genetics, immunity, illness, and disability (Lehman, David & Gruber 2017). The different factors of psychology that have an effect on overall health of the child include personality, mood, behaviour, and trauma (Lehman et al. 2017). The social factors influencing health and well-being can include interpersonal, family, and community support systems, culture, and economic status (Lehman et al. 2017). This model suggests that all of these factors are equally important and are interdependent in influencing development during early childhood. The significance of the biopsychosocial model for this study lies in understanding that for a home-visiting programme to be effective, it needs a workforce that is able to assess and address factors across the areas of biopsychosocial functioning to influence good outcomes for the vulnerable child and caregiver. In addition, it may need to draw together a multidisciplinary team of professionals across the different disciplines of health, psychology, and social work to effectively implement the biopsychosocial model.

Research methods and design

The study worked from an interpretivist paradigm and adopted a qualitative research approach. The qualitative approach is interpretivist in nature and aims to understand the lives and complex social circumstances of the participants rather than bring the researcher's own understanding or hypotheses to the research (Bakkabulindi 2015).

The subjective ontology and epistemology of the qualitative approach, and the flexible stance that it adopts to methodology, have made the qualitative approach a good fit for this study. The theoretical framework for the study proposes that vulnerabilities during early childhood are often complex and shaped by the biological, psychological, and social factors of the individual child and caregiver as well as the community within which they live. This implies that for a home-visiting programme to be developed, a deeper understanding of the needs of vulnerable children as well as the factors that work together to support the overall well-being of children is needed. This deeper, contextualised understanding can only be sought through an interpretivist and qualitative approach and cannot be tested by a hypothesis or the manipulation of variables. For this reason, the study collected data from a relatively small group of participants, which included a variety of professionals who work with vulnerable young children as well as the caregivers of vulnerable children. This small sample allowed the research to seek a deeper understanding of the complexities facing vulnerable children. In addition, these participants were on the 'inside' of early childhood in the Eastern Cape province, either working with or caring for vulnerable young children. They had particular insight into the needs of vulnerable young children, the existing programmes, the role players who should be involved in such a programme, and the guidelines needed for a home-visiting programme. Creswell and Poth (2017) confirm that a qualitative study is conducted for many reasons with the following three being most applicable to this study: firstly, when a topic needs to be explored; secondly, when an in-depth understanding of the topic is needed; and thirdly, when the context from which the participants understand the problem is needed (Creswell & Poth 2017).

In addition to a qualitative approach and interpretivist paradigm, an intervention research design was used in the study. A research design is understood as the broader plan for solving the research problem, thus assisting in meeting the overall aim and objectives of the study (Leedy & Ormond 2013). Intervention research is known to be undertaken by social workers when facilitating a process of change with families or communities to strengthen and maintain well-being (Fraser 2004; Fraser & Galinsky 2010). Intervention research was, therefore, most suited to this study as the goal of the study was to develop a home-visiting programme in partnership with professionals who work with vulnerable children and their caregivers, thus making 'intervention' the focus and overall aim of the study. Intervention research is used when a practical solution is needed to support a particular family or community (De Vos & Strydom 2011; Rothman & Thomas 1994). The different vulnerabilities and the high rates of these vulnerabilities facing children during early childhood in South Africa and, in particular, the Eastern Cape province, highlighted the need for a practical and contextually relevant solution to support optimal development during this critical life stage.

Approval for the study was granted by the University of Fort Hare Research Ethics Committee (UREC) and the Inter Faculty Research Ethics Committee (IFREC). In addition, ethical clearance was sought from research sites before participants were approached to participate in the study. The

research population for the study was identified as professionals working with vulnerable children and their caregivers in the Eastern Cape province. The agreement of each participant to voluntarily participate in the study was sought and then consolidated through signed consent before the interviews commenced.

For the first and second phase of the study, 18 professionals from across the disciplines of social work, health, and education and 9 caregivers of vulnerable children were individually interviewed. The biographical details of the participants are given in Table 1 and Table 2.

Data from these interviews were analysed using thematic analysis. In phase three of the study, the draft guidelines were circulated to all 18 of the professional participants – who essentially constituted a panel of experts – for input. Three of the participants, a medical doctor, an education specialist, and a community-based healthcare worker, submitted input and this was incorporated into the draft guidelines document. Several other participants promised to send input but after 2 weeks, despite follow-up, had not done so. A consensus workshop was then set up and all 18 participants were invited to attend so that a process of agreement could be reached with regard to the guidelines. Six participants, including an educational specialist, an occupational therapist, a community-based healthcare worker, an ECD practitioner and trainer, a child and youth care worker and trainer, and the manager of a place of safety, attended the consensus workshop. Participants added one guideline to the document and recommended some additional detail be added to processes throughout the guidelines document. After 2 h, consensus for each guideline and the related processes was reached, and the workshop was concluded.

TABLE 1: Biographical profile of professionals.

Criteria	Number of professionals (N = 18)
Age of professionals	
20–29 years	1
30–39 years	4
40–49 years	6
50 years and above	7
Gender	
Male	1
Female	17
Qualifications	
Matric	1
Diploma and/or certificate	9
Honours degree	6
Master's degree	2
Place of employment	
Tertiary state hospital	6
University	2
NGO and/or NPO	10
Years of working experience	
0–9 years	5
10–19 years	4
20 years and above	9
Experience working in a home-visiting programme	
Yes	8
No	10

NGO, non-governmental organisation; NPO, non-profit organisation.

Presentation and discussion of findings

The guidelines that were developed during phase two of the study and were refined and agreed on during phase three, are presented and discussed in this article. These guidelines may be followed to develop a model of an early childhood home-visiting programme or may be used alongside services already being rendered to support good outcomes for vulnerable children and their caregivers. Each guideline is presented and discussed in the sections that follow.

Guideline one: Engagement and advocacy

The first guideline was added to the draft guidelines by participants during the consensus workshop. This guideline outlines the processes that should be followed to engage with stakeholders and role players before the programme can be implemented. It aligns well to the biopsychosocial model, which calls for stakeholders and role players to adopt a team-based approach in the services being offered to vulnerable children. Engagement and advocacy with a

TABLE 2: Biographical profile of caregivers.

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

range of existing stakeholders and role players would thus support the initial implementation of the biopsychosocial model as it works towards building a multidisciplinary approach to the support offered to vulnerable children and their caregivers.

Participants agreed that it would be important to reach out to both stakeholders, such as the Department of Social Development (DSD), the Department of Basic Education (DoBE), the Department of Health (DoH) and local municipality, and role players, such as non-governmental organisations (NGOs) and non-profit organisations (NPOs), across the sectors of social work, education, and health, so that the dissemination of relevant and related research findings on the topic of home-visiting programmes can be facilitated. This process of engagement should include sharing local literature and the findings of local and international studies so that support can be harnessed for the implementation of the programme. Participants recommended that this should form part of the advocacy that was needed to harness support before the programme could begin. Participants observed that this practice principle was critically important because of the inconsistencies and poor management within the different systems of health, social development, and education in South Africa. It was felt that, if adequately coordinated, a home-visiting programme had the potential to bring these systems together and effect the necessary change for the vulnerable child.

Once the relevant stakeholders and role players (as identified here) had been engaged, participants felt that the guidelines for the early childhood home-visiting programme should be shared together with a synopsis that outlines a time frame for the implementation of the home-visiting programme. Participants observed that such a process was an important form of advocacy, which was integral if stakeholders and role players were to support the implementation of the home-visiting programme. In addition, it was noticed that such a guideline can assist with the recruitment of a home-visiting workforce from those who were already qualified in related fields and who may be interested in getting involved through the existing stakeholders or role players.

Guideline two: Recruitment and selection of a home-visiting workforce

The second guideline unpacks the processes that can be implemented for the recruitment of a multidisciplinary team to attend training for the home-visiting programme, and the processes that can be followed for the training and selection of home visitors and supervisors. During the consensus workshop, participants felt that more details should be added to the range of disciplines that would be required to participate in the training (and who would then make up the home-visiting workforce). This detail would ensure that the team is representative of professionals who are able to support optimal development across biological, psychological, and social functioning in alignment with the biopsychosocial model.

For a home-visiting programme to be effective, a multidisciplinary workforce needs to be recruited to attend a training programme. Such a workforce should include potential home visitors who are community members who have knowledge of the community and life experience as well as paraprofessionals and professionals who already have advanced training in the fields of healthcare, social work, or education, and are experienced in working with vulnerable children. The partnership between community members and professionals was seen as a potential strength of the home-visiting programme because of the support they could provide to caregivers and each other in the implementation of the programme. It was unanimously agreed that supervisors should be included as part of the workforce and that they would be required to provide regular supervision of the home visitors. It is preferable that supervision is undertaken by trained professionals, such as nurses, social workers, or ECD educators, who have experience in working with vulnerable children, in rendering home visits, and in supervising a workforce.

The findings show that trainers from a range of professional disciplines should be recruited to work together to provide the initial and, at a later stage, regular and ongoing training to the home-visiting and supervisory workforce. It was suggested that a multidisciplinary approach to the training of a home-visiting workforce would facilitate the transfer of knowledge and skill that is transdisciplinary in nature. It was felt that this is essential if the optimal development of vulnerable children is to be supported. Once a multidisciplinary workforce was recruited to attend the training, it was put forward that both the home visitors and supervisors should attend the training programme and that their level of knowledge and skill be assessed at the end of the training.

It was then recommended that the final selection of home visitors and supervisors is made from the group of attendees who participate in both the training and the formal assessment. This would then comprise the home-visiting workforce. The careful selection of paraprofessional and professional home visitors to work in partnership with community members needs to ensure representation from across the disciplines of health, social work, and ECD. This is important as these disciplines represent the biological, psychological, and social spheres of influence for the vulnerable child. Findings indicate that the selection of the home visitors should be guided by the need for a large team of trained home visitors, some of whom should reside in the community where the programme is offered as well as those who have paraprofessional or professional qualifications, and who will work alongside these community members. A training certificate could be given to those who attended the training but were not a part of the final selection to join the programme. This could assist them as they seek alternate employment or enrich the work they may already be doing.

Guideline three: Content of a training programme for a home-visiting workforce

The following guideline provides suggestions for the content of a training programme for a home-visiting workforce. Participants reached consensus around this guideline but added a more detailed description to some of the processes. Participants agreed that such a training programme would need to facilitate a process where the following content is covered: professional values, relationship-building skills, assessment of protective and risk factors, planning for intervention, knowledge of community resources, safety measures, and self-care. Participants also felt that such content would need to extend beyond a particular discipline because of the needs of the vulnerable child. This aligns to the biopsychosocial model, which calls for a multidisciplinary- and team-based approach to health and development. Yet, it also extends beyond what the model calls for. These processes essentially create a platform for a range of professionals from different disciplines to come together and train a home-visiting workforce.

This results in a training programme that is transdisciplinary in nature and a transdisciplinary workforce, thus moving beyond the multidisciplinary approach of the biopsychosocial model.

Findings suggest that the first part of a training programme for a home-visiting workforce should equip home visitors with the professional values and relationship-building skills needed to facilitate effective and quality engagement and a strength-based assessment with caregivers, families, and communities. A strength-based assessment values both the caregiver and the child, and acknowledges that they have potential to develop and grow despite the hardships they may be facing. It was agreed that values, such as respect, individualisation, confidentiality, and self-determination, will need to be taught as these are essential values for the development of strong relationships. In addition, these values form the foundation of a strength-based assessment, and are implemented through relationship-building skills such as listening, attentiveness, questioning, and basic and advanced empathy. The implementation of these values through the use of relationship-building skills will, therefore, need to be taught, practised, and evaluated during the training programme.

Once there is an understanding of the values and skills that are needed to effectively engage with children and caregivers, the content of a home-visiting training programme should begin to build knowledge around the factors that offer protection and build resilience during early childhood. These include responsible caregiving and a nurturing environment. Firstly, careful attention should be given to building a comprehensive understanding of these protective factors within the biological, psychological, and social domains of the child and secondly, of the interrelatedness of these factors. It was suggested that such knowledge can inform a strength-based assessment. The home-visiting workforce will need to be trained to identify context-specific risk factors that prevent children from achieving optimal development and well-being. These may differ according to the geographical area where the child resides.

In the Eastern Cape province, the study found that the most common risk factors vulnerable children were exposed to included: extreme levels of poverty, including poverty of subsistence, unemployment, a lack of legal documentation, and understanding; ongoing and severe maltreatment including neglect, abuse, disrupted caregiving, family violence, and substance abuse; poor physical health, including premature births, low birth weight, malnutrition, illness and disability; and unplanned pregnancies, backstreet abortions, teenage pregnancy, single parents, and a lack of knowledge.

As with protective factors, such risk factors may present across the biological, psychological, and social domains of the child and, if persistent, may hold the child back from achieving optimal development. Findings indicated that the early identification of risk factors can minimise the impact of these risk factors on the development and well-being of the child. Furthermore, it was suggested that early identification may reduce the consequences that long-term exposure to such risk factors have for the future outcomes of the child. This knowledge and understanding will assist the home visitors in conducting a thorough assessment. The protective and most common risk factors guided by the biopsychosocial model, which acknowledges the influence of variables on each of the biological, psychological, and social domains of the child, can be built into an easy-to-use assessment tool or checklist to assist home visitors in completing a thorough assessment.

The content of a training programme must cover the skills and knowledge the home-visiting workforce need to develop and plan an intervention that works towards strengthening the protective factors and minimising the risk factors within the biological, psychological, and social domains of the child. It was agreed that such an intervention plan needs to be uniquely shaped to meet the needs of each child and caregiver. Rather than developing a set intervention tool as part of the guidelines for vulnerable children, who often face a complex array of risk factors, an individual intervention and developmental plan is suggested. This will allow home visitors to work with the child and caregiver in addressing their unique risk factors while building capacity around protective factors. Such an approach may be more effective than a set intervention tool that is unable to accommodate the individual needs of a child and caregiver.

There are a variety of early childhood intervention programmes and resources available online. These focus on different aspects of building protective factors during early childhood. Some, for example, focus on early learning and stimulation while others focus on parenting skills. Rather than reproducing these programmes and resources, it is recommended that a home-visiting workforce works from the existing tools and intervention programmes to develop a

specific set of interventions that will assist in meeting the unique needs of the child and caregiver. The interventions will then be delivered within the home of the child and caregiver. It was felt that this individualised approach, combined with the delivery of services within the home of the child and caregiver, makes this programme significant in its ability to reach the most vulnerable of children, some of whom may simply not have access to any other resources.

It was agreed that the home-visiting workforce will need to be equipped with knowledge relating to community resources so that vulnerable children and their caregivers may be linked to such resources as and when required. This should only be performed in situations where the home-visiting programme is unable to offer such services, where the caregiver is unresponsive to change, or where the safety and well-being of the child is at risk. Findings suggest that these community resources could include informal networks of support, such as community leaders or gatekeepers within the community, or formal networks of support offered by paraprofessionals or professionals in the field of health, social work, and education. Knowledge of community resources, and the manner in which such resources can be accessed, can support the optimal development of vulnerable children and their caregivers.

If the guideline regarding the recruitment of a multidisciplinary team of trainers is followed, then much of the knowledge around current services, as well as how to effectively access such services, can be shared as part of the content of a training programme. Ideally, it was felt that the multidisciplinary team of trainers would represent the various community resources that can be accessed to support vulnerable children. For example, an official from the Department of Home Affairs (DHA) may facilitate some of the training to equip the home-visiting workforce with knowledge about the registration and late registration of births. This will enable the transfer of transdisciplinary knowledge that can empower the home-visiting workforce to support vulnerable children, caregivers, family, and the community to effectively access such community resources. Participants felt that the development of a comprehensive resource list (presently unavailable) for distribution among the home-visiting workforce, stakeholders, and role players would be beneficial in developing a knowledge base of local resources.

It was agreed that an important part of the training programme for home visitors was the inclusion of information relative to safety measures and self-care. The very nature of a home-visiting programme, where home visitors might step from an office into a community where violence and crime is rife and then into the home of a caregiver and a child who is vulnerable, in itself presents various risks to the physical and emotional well-being of the home visitor. At times, these risks may be easily noticeable. For example, the caregiver may refuse to allow the home visitor into the home or threaten the home visitor with violence. However, these risks may be less noticeable at other times. For example, the caregiver may allow the home visit to take place but may conceal the risk factors that the child is exposed to, thereby making intervention challenging and difficult to negotiate.

Findings in this study suggest that creating awareness of the physical dangers and the emotional risks of burnout when working in a home-visiting programme will need to be addressed as part of the training programme. Strategies to manage or prevent them will also need to be included. It was suggested that the organisation that employs the home-visiting workforce have a safety plan, that the workforce receives training in this safety plan, and that supervisors support home visitors in the implementation of such a plan. In addition to a safety plan, findings suggest that the role of the supervisor in providing regular supervision, which is both educational and supportive, is critical to preventing burnout among home visitors.

Guideline four: Implementation of the home-visiting programme

The following guideline presents processes that relate to the implementation of the home-visiting programme. Such processes refer to: programme funding; the setting up of a referral system; the duration and frequency of home visits; programme implementation by the home-visiting workforce; supervisory support; comprehensive and ongoing training; and the development of a forum. These are essentially structural processes within the social domain of society which, if the biopsychosocial model is to be considered, need to be strengthened as they are influential in supporting caregivers and the optimal development of vulnerable children. Participants reached consensus regarding this guideline although they felt that more details needed to be added to some of the processes.

This study found that for the implementation of the home-visiting programme to be effective, sufficient, and sustainable, intersectoral funding should be sourced on both a national and international level. Both national and international policy and legislation within the sectors of health, social development, and education prioritise early childhood programmes and, as such, could be approached to fund an early childhood home-visiting programme. It was suggested that programme funding would need to ensure that the salaries of the multidisciplinary workforce are paid. The payment of salaries will assist with the retention of the workforce needed to implement the programme. There was unanimous agreement that programme funding should ensure that the programme is well resourced with the practical resources required to monitor and support the optimal development of the child. Such practical resources should include nutritional support, material support, transport costs, and early learning materials. A partnership with an academic or research institution could assist such a programme to access sustainable and substantial funding.

Furthermore, this research confirmed that there was a lack of follow-up and intersectoral collaboration even though vulnerabilities or risk factors were identified. For this reason, the home-visiting programme would need to have an

effective and efficient referral system in place. The referral system should ensure that vulnerable children are immediately referred to the programme by a range of stakeholders when risk factors are suspected. This will assist the programme to offer services at a prevention and early intervention level. It was suggested that this is critical if vulnerable children are to be supported towards optimal development before the consequences of exposure to risk factors result in poor outcomes, which are challenging to undo at a later stage. Such a referral system will require that a range of professionals across disciplines that offer services to vulnerable children are informed of the programme and of the process for referral. This will ensure that as many vulnerable children as possible can be assisted through the programme. Participants felt that a strong marketing campaign, with a WhatsApp number for referrals by professionals and self-referrals by caregivers, would assist in ensuring that the referral system is effective and efficient.

The programme should ideally be offered from conception through to when the child turns 2 years of age. Such long-term programmes have shown good outcomes for both the child and caregiver. Once risk factors have been reduced and protective factors have been put in place, caregivers can be referred to other ECD programmes, such as play groups, parenting groups, toy libraries, or an ECD centre, to replace or supplement the home-visiting programme. Findings of this study have indicated that the frequency of home visits will be determined by the complexity of the risk factors identified in either the referral process or during the assessment. As such, home visits may be as often as twice daily or once a week, and should be of sufficient length to engage with the caregiver and child and intervene where necessary. In addition to the frequency of home visits, it was suggested that the duration of the programme should extend over enough time so that progress can be monitored and evaluated.

Essentially, the role of the home visitors would be to implement the home-visiting programme from engagement and assessment through to intervention and evaluation. Each home visitor can work with 20 – 30 referrals, depending on the complexity of the referrals received. The complexity of the referrals will guide the home visitor in their planning for the frequency of home visits. It was agreed that the implementation of the programme would begin through engagement with the community and then the family and caregiver of the child.

Findings also suggested that the role of the home visitor would extend through to conducting a thorough strength-based assessment and developing an intervention plan to support the well-being of the child and caregiver. The home visitor would then continue to monitor the growth and development of the child. If the intervention is successful, then the home-visiting programme can be supplemented with less intensive services such as play groups, toy libraries, parenting groups, or an ECD centre. If the intervention is unsuccessful, and the child remains at risk, it was suggested that the role of the home visitor would then be to work with the supervisor to refer the case for further intervention.

The role of the supervisor is to assist with the implementation of the home-visiting programme through managing the referral system and matching home visitors to vulnerable children and caregivers. The results of this study show that supervisors would be required to provide ongoing educational, administrative, and emotional support to home visitors as they monitor and evaluate the effectiveness of both the programme and the home visitors. It will be important to have a variety of supervisors, ranging from healthcare professionals, social workers, and ECD educators, so that they can support the home visitors with the discipline-specific knowledge that is needed to implement the programme effectively. Each supervisor may be required to take responsibility for 4 – 5 home visitors, ensuring that adequate supervision and case management is possible. It was suggested that supervisors would be required to network among stakeholders to ensure that the home-visiting programme is accessible to all who work with vulnerable children. Where vulnerabilities are identified by professionals in the field, they would then be able to refer the child and caregiver to the programme at an early stage so that prevention and early intervention services are possible.

If the gaps in support being offered to vulnerable children are to be considered, then it is suggested that an additional role of the supervisor would be to advocate for vulnerable children and families on a societal level. For risk factors such as poverty and unemployment to change, society and government will have to accept that it has neglected to support the most vulnerable in society. If changes are to be made, then such changes will have to be effected on a societal, political, and community level, and not only at an individual or family level.

There was agreement in the findings that the role of the trainers in the home-visiting programme would be to provide comprehensive and ongoing training to both the home visitors and supervisors. It was felt that trainers should be recruited from the various fields of practice that offer services to vulnerable children during early childhood. This will ensure that both home visitors and supervisors clearly understand the different variables within the biological, psychological, and social domains of the child that either support or threaten optimal development. Some examples of trainers from the health sector who can be invited to provide training to the home-visiting workforce include doctors, nurses, dieticians, and occupational therapists. Social workers, psychologists, child and youth care workers, and officials from the DHA, the Department of Agriculture, Land Reform and Rural Development (DALRRD) (to assist with poverty alleviation through gardening) as well as ECD educators and practitioners will be included in the training team as they have expert knowledge that supports the psychological and social well-being of the child, family, and community.

If the literature is to be considered, then the training of home visitors and supervisors should be performed through the sharing and application of knowledge so as to ensure optimal learning. The application of knowledge should be facilitated by the trainers and can be performed through the use of case studies, role plays, simulations, and feedback. In addition to this, the trainers – as experts in their field of knowledge – can support supervisors with advocacy on a societal, political, and community level.

Because of the scarcity of resources in the Eastern Cape province as well as the need for a platform that draws professionals together, findings suggest that programme implementation include the development of a forum. Such a forum can facilitate the sharing of knowledge, resources, and support in building a network in the Eastern Cape province that supports vulnerable children as well as the professionals who currently offer services to such children. Findings confirm that no such forum currently exists in the Eastern Cape province, and this may perpetuate a disconnect between the different departments, disciplines, organisations, and individuals that work with vulnerable children and caregivers. Participants felt that such a forum could begin in the local municipal area and then move out to other municipal areas in the Eastern Cape province.

Guideline five: Monitoring and evaluation of the home-visiting programme

The following guideline suggests processes in relation to the monitoring and evaluation of the home-visiting programme. Participants were in agreement that such a guideline was vitally important to the programme, both in terms of securing sustainable funding and for the sustainability of the programme. The guideline should include processes relating to both qualitative and quantitative methods of evaluating the outcome of the programme for both the caregiver and the vulnerable child.

While there are many early childhood programmes offered, very few are able to explain how the rendering of services or outcomes for the programme are evaluated. Evidence of impact and effectiveness is thus lacking. It is suggested that the monitoring and evaluation of the programme, with its associated outcomes for the child and caregiver, will need to be carefully planned, implemented, and documented. Participants in this study felt that such evaluations should include formal and informal feedback from caregivers, home visitors, and community stakeholders in relation to the impact that the programme has on reducing risk factors, building protective factors, and in supporting good future outcomes for the child. Once evaluations are conducted, data should be analysed and shared with stakeholders. This may assist in securing sustainable funding for the programme and may support evidence-based practice.

In addition to the qualitative programme evaluation, some forms of quantitative evaluations that rely on statistics (which may, or may not show reduced risk factors, improved protective factors, and improved outcomes for vulnerable children) are also recommended. Findings suggest that such an evaluation could monitor the number of readmissions to hospitals or cases reported to child protection agencies. In addition, it was suggested that the growth and weight of children and immunisation compliance could also be monitored and recorded at each home visit. Monitoring the access that children in the programme have to ECD centres as they grow, as well as tracking their overall progress until school-going age, could also form part of the long-term quantitative evaluations. Each of these evaluations should be diligently planned, implemented, and documented – possibly through a digital platform – so that a long-term impact evaluation is possible. In essence, such evaluations, as with those mentioned in the previous section, can assist with securing sustainable funding and support evidence-based practice.

Conclusion and recommendations

There is an increased call for the development of quality early childhood programmes that offer comprehensive, preventative, and early intervention support for the optimal development of the young and vulnerable child. In essence, the South African Government is being challenged by social work and the early childhood sectors to take responsibility for the implementation of legislation and policies that prioritise support services to young and vulnerable children before they are exposed to ongoing risk factors that have detrimental consequences for their development.

This article suggests that home-visiting programmes are needed and have many potential benefits for the young child. Such programmes will need to be well resourced in terms of support from stakeholders and role players, a well-trained workforce, and sustainable funding to support a home-visiting workforce as well as to provide practical resources for vulnerable children and their caregivers. Rather than developing a detailed weekly programme or curriculum, the guidelines suggest that a thorough assessment should be conducted with each child and caregiver, followed by an individual intervention plan because of the unique and complex risk factors faced by vulnerable children. Such an intervention plan may include working with the community, extended family, and caregiver to reduce risk factors while simultaneously building protective factors rather than following a specific ECD curriculum or weekly plan.

The guidelines that have been developed for the model of this home-visiting programme have the potential to translate the theory of the biopsychosocial model into practice. These guidelines facilitate both a multidisciplinary approach to the support offered to vulnerable children and a transdisciplinary approach to the training of the home-visiting workforce, through which the effective support of vulnerable children and their caregivers is made possible.

Additionally, the guidelines outline the need for the development of a comprehensive resource list, an effective and efficient referral system, and a local forum. These are

all additional platforms that, if established, support the implementation of the biopsychosocial model, drawing service providers together through the work that they are doing with vulnerable children. The guidelines support the need for the monitoring and evaluation of the programme. There is currently a shortage of impact evaluations in the field of health, child protection, and ECD. This programme model has the potential to contribute to this research and knowledge gap. The contribution of knowledge and research will, in addition, be transdisciplinary because of the nature of the work being done by the home-visiting workforce, which is compelled to stretch across the disciplines of health, social work, and ECD if it is to effectively support vulnerable children towards optimal development.

Recommendations for practice include that there is a need for home-visiting programmes that support responsible caregiving and a nurturing environment for the young child. In addition, it is suggested that the guidelines presented in this article may support such programmes towards successful implementation and in securing good outcomes for the vulnerable child. Recommendations for policy are that government needs to allocate sufficient and sustainable funding for the implementation of policies and legislation that offer protection and support for vulnerable children. While this will be a costly investment to begin with, the return on investment will be worthwhile as quality ECD services promote optimal development, supporting children towards good future educational, health, and social outcomes. These outcomes may result in less expenses for the government in the long run as good future educational, health, and social outcomes translate into citizens who are able to independently contribute to a stable and healthy economy. The challenge of inadequate funding for ECD services, in effect, renders the very legislation and policies that are there to support children, and especially the most vulnerable children, useless. Additional resources are needed if good outcomes for children in South Africa are going to be achieved (Bamford 2019; Masiteng 2019; Van Niekerk et al. 2017). Without funding, the very children meant to be protected by legislation and policy continue to be exposed to risk factors as there may very well not be many protective factors within their families or communities that they are able to access. It remains government's responsibility to adequately fund a range of quality programmes across disciplines so that all vulnerable children can access such support. For some children and their caregivers, this may be in the form of a home-visiting programme.

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Authors' contributions

The first author, K.S., is the PHD student who completed her study in 2023. This article presents a section of the work performed for that study. The second author. P.T.T. was the supervisor of the student and has thus contributed to the study through supervision from the proposal stage through to completion.

Ethical considerations

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Data availability

The data that support the findings of this study are available from the corresponding author, K.S., upon reasonable request.

Disclaimer

The views and opinions expressed in this article are those of the authors and do not necessarily reflect the official policy or position of any affiliated agency of the authors, and the publisher.

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