

See discussions, stats, and author profiles for this publication at: <https://www.researchgate.net/publication/343425507>

# Connecting cash with care for better child well-being A nine-month post intervention follow-up evaluation of a Family and Community Strengthening Programme for beneficiaries of the...

Technical Report · July 2020

DOI: 10.13140/RG.2.2.23531.98087

CITATIONS

0

READS

43

4 authors, including:



**Eleanor Ross**

University of Johannesburg

138 PUBLICATIONS 980 CITATIONS

[SEE PROFILE](#)



**Leila Patel**

University of Johannesburg

68 PUBLICATIONS 600 CITATIONS

[SEE PROFILE](#)



**Khuliso Matidza**

University of Witwatersrand

1 PUBLICATION 0 CITATIONS

[SEE PROFILE](#)

Some of the authors of this publication are also working on these related projects:



Reflecting on Professionalism: An Analysis of Bachelor of Clinical Medical Practice (BCMP) Students' Portfolios During Clinical Rotations [View project](#)



Families, the Child Support Grant, and Child Well-Being Outcomes [View project](#)



**sihleng'imizi**  
we care for families

## Connecting cash with care for better child well-being

**A nine-month post intervention  
follow-up evaluation of a Family  
and Community Strengthening  
Programme for beneficiaries of  
the Child Support Grant**

**Eleanor Ross, Leila Patel, Madoda Sitshange and Khuliso Matidza**  
July 2020

**CSDA**  
CENTRE FOR  
SOCIAL DEVELOPMENT  
IN AFRICA



*Sihleng'imizi* is a South African adaption of the SAFE Children Family Programme, developed by the Families and Communities Research Group, School of Social Service Administration, University of Chicago, USA. The programme is a community-based family strengthening intervention for Child Support Grant (CSG) beneficiaries and their families to improve child well-being. The research was led by Leila Patel, Department of Science and Technology and National Research Foundation funded South African Research Chair in Welfare and Social Development, who is located at the Centre for Social Development in Africa, and the late Tessa Hochfeld, who was also from the Centre for Social Development in Africa.

Copyright © The Centre for Social Development in Africa (CSDA), University of Johannesburg. This document can be reproduced in part or whole as long as due acknowledgement of the authors and the CSDA is made.

**CSDA**  
CENTRE FOR  
SOCIAL DEVELOPMENT  
IN AFRICA



a world class African city



**science  
& technology**

Department:  
Science and Technology  
**REPUBLIC OF SOUTH AFRICA**



## ***Dedication***

*This research report is dedicated to the memory of the late Tessa Hochfeld who was one of the key drivers of the Sihleng'imizi Family Strengthening programme.*

## ACKNOWLEDGEMENTS

This intervention research study was funded by the National Research Foundation (NRF), through the DST/NRF South African Research Chair in Welfare and Social Development; the University of Johannesburg; the City of Johannesburg; and UNICEF South Africa. Opinions expressed and conclusions arrived at, are those of the authors and are not necessarily to be attributed to any of the funders.

The data collection for the nine-month follow-up study was conducted by Madoda Sitshange and supervised by Prof Tessa Hochfeld and Prof Leila Patel. Data analysis was conducted by Prof Eleanor Ross, Madoda Sitshange and Prof Leila Patel. The writing and research was carried out by the authors.

Prof Trudie Knijn from Utrecht University was our collaborating partner in the first phase of the study. Following the initial piloting of the programme and based on evidence generated, the programme was subject to further adaption. The City of Johannesburg, UNICEF South Africa and the CSDA collaborated in the advanced testing and evaluation of the programme in ten of the poorest wards in Johannesburg.

The nutrition module was developed by Dr Hema Kesa, a nutrition specialist at the School of Tourism and Hospitality, University of Johannesburg in collaboration with the CSDA team.

The original SAFE Children material was developed by Professor Deborah Gorman-Smith of the School of Social Service Administration, University of Chicago. It was adapted to the South African context by Tessa Hochfeld and Jenita Chiba from the CSDA and Molly Coeling and Franklin Cosey-Gay from the University of Chicago. Programme content, such as the hand-drawn graphic stories, was drawn from the Sinovuyo Caring Families manual and the Sinovuyo Caring Families Teen manual, open source material. This contribution is gratefully acknowledged.

The authors wishes to thank all the other colleagues who assisted with the adaption of the SAFE Children programme: Innocentia Kgaphola, Senzelwe Mthembu, Keletso Sello, Lauren Graham, Kgomotso Mangolela, Ruth Chauke and Sibusiso Mcanyana for their inputs in the early stages of the development of this programme. Jenita Chiba provided valuable research, practice-based knowledge, and training, supervision of social workers and supervisors in the piloting of the programme and in the advanced testing and evaluation of the programme in the City of Johannesburg. Kgomotso Mangolela assisted with the training, supervision and roll-out of the implementation of the programme in the City of Johannesburg and in overseeing the collection of the data.

Thank you to the social workers, the childcare workers and managers from the City of Johannesburg (CoJ) who delivered the programme. They are Aletta Mzimela, Rosina Masoa, Faith Sibiya, Dikeledi Monareng, Refilwe Goeieman, Patience Selemela, Leandi Mac Maneveldt, Dudu Bojosi, Tshepo Sekgala, Mandla Phahlake, Mapitsi Matlawa, Rose Ndhlovu, Anele Gxothelwa, Buhle Simelane, Lucky Mookamedi, Dimakatso Vena, Tsakani Ntshangule and Dimakatso Mahlatsi.

We are indebted to the families and children who participated actively in the group sessions and answered all our research questions. A special thank you to the teachers from the schools in the communities who helped us with the selection of the children for the study and for collaborating with us in this study. The schools involved are: Bernaard Isaacs Primary School, Malvern Primary School, Stretford Primary School, Thembalihle Primary School, Lejoeleputsoa Primary School, Masakhane Tswelopele Farm School, Muzomuhle Primary School, Mikateka Primary School, Malboro Combined School, Ekukhanyisweni Primary School, and Mayibuye Primary School.

We also wish to thank the field workers who conducted interviews in the first and second waves of the study with the families. They are: Nosi Wright, Selby Khoza, Thembela Manyathi, Sydney Radebe, Thembisa Zulu, Zinhle Nkosi, Thembalani Adonis and Pinky Nkete.

# CONTENTS

<b>EXECUTIVE SUMMARY .....</b>	<b>4</b>
<b>1. INTRODUCTION .....</b>	<b>9</b>
<b>2. LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK .....</b>	<b>10</b>
2.1 THE FAMILY, SOCIAL CONTEXT AND CHILD WELL-BEING .....	10
2.2 THE CASH AND CARE NEXUS .....	12
2.3 THEORY OF CHANGE OF THE SIHLENG'IMIZI PROGRAMME.....	13
<b>3. SUMMARY OF THE ORIGINAL SIHLENG'IMIZI STUDY CONDUCTED IN 2018 .....</b>	<b>17</b>
3.1 METHODOLOGY UNDERPINNING THE ORIGINAL SIHLENG'IMIZI STUDY.....	17
3.2 FINDINGS .....	17
3.3 CONCLUSIONS.....	19
<b>4. THE NINE-MONTH POST INTERVENTION FOLLOW-UP STUDY .....</b>	<b>21</b>
4.1 METHODOLOGY EMPLOYED IN THE FOLLOW-UP STUDY .....	21
4.1.1 Research design .....	21
4.1.2 Research sites.....	21
4.1.3 Sampling .....	23
4.1.4 Data collection .....	24
4.1.5 Data analysis .....	24
4.1.6 Trustworthiness .....	26
4.1.7 Limitations .....	26
4.1.8 Ethics .....	26
<b>5. FINDINGS FROM THE FOLLOW-UP INTERVENTION .....</b>	<b>27</b>
5.1 PROFILE OF THE INTERVENTION FAMILIES AT FOLLOW-UP .....	27
5.2 FINDINGS FROM CAREGIVERS IN THE INTERVENTION GROUP AT FOLLOW-UP REGARDING THE FIVE DIMENSIONS OF THE STUDY .....	28
5.3 SUMMARY OF FINDINGS FROM CAREGIVERS IN THE INTERVENTION GROUP IN RESPECT OF THE FIVE DIMENSIONS OF THE STUDY .....	42
5.3.1 Family and caregiver relations .....	42
5.3.2 Caregiver involvement in child's education .....	42
5.3.3 Social and community connectedness .....	43
5.3.4 Financial capabilities .....	43
5.3.5 Nutritional knowledge .....	43
5.4 FINDINGS FROM THE FOLLOW-UP CONTROL GROUP.....	43
5.4.1 Profile of the control families at follow-up .....	43
5.5 SUMMARY OF FINDINGS FROM CAREGIVERS IN THE CONTROL GROUP IN RESPECT OF THE FIVE DIMENSIONS OF THE STUDY .....	53
5.5.1 Family and caregiver relations .....	53
5.5.2 Caregiver involvement in child's education .....	54
5.5.3 Financial capabilities .....	54

5.5.4 Knowledge of nutrition .....	54
5.6 DEPRESSION SYMPTOMOLOGY OF CAREGIVERS IN THE INTERVENTION AND CONTROL GROUPS.....	55
5.7 WHAT DO THE CHILDREN SAY? .....	55
5.7.1 Themes that emerged from the intervention children's drawings at follow-up .....	55
5.7.2 Themes that emerged from the control children's drawings at follow-up .....	59
<b>6. DISCUSSION OF FINDINGS</b> .....	62
6.1 HOUSEHOLD CHANGES.....	62
6.2 PERCEPTIONS OF CAREGIVING SKILLS .....	62
6.3 DEPRESSIVE SYMPTOMATOLOGY .....	62
6.4 KNOWLEDGE OF NUTRITION .....	63
6.5 LIMITATIONS OF THE STUDY .....	63
<b>7. CONCLUSIONS AND RECOMMENDATIONS</b> .....	64
<b>8. REFERENCES</b> .....	65

#### TABLES

Table 1: Brief descriptions of research sites (City regions and wards) .....	22
Table 2: Follow-up Intervention and control group samples for qualitative analysis, according to wards and regions.....	24
Table 3: Research tools used at follow-up .....	24

#### FIGURES

Figure 1: Development Ecological Model source: <a href="http://www.wcsap.org">http://www.wcsap.org</a> .....	14
Figure 2: Approximate locations of each ward in the Regions of the City of Johannesburg .....	23
Figure 3: Changes in caregiver and household status of intervention group at follow-up (n=27).....	27
Figure 4: How do you feel now compared to how you felt before Sihleng'imizi? (n=24) .....	34
Figure 5: Changes in caregiver and household of control group at follow-up (n=15).....	44
Figure 6: How important are your food choices according to: healthy lifestyle, time/ convenience, type/taste, brand, nutritional value and cost (intervention group n=27) .....	41
Figure 7: How important are your food choices according to: healthy lifestyle, time/ convenience, Type/taste, Brand, Nutritional value and cost (control group n=15) .....	53
Figure 8: Depression index for intervention and control groups at follow-up .....	55
Figure 9: Happy drawing from intervention group at follow-up .....	57
Figure 10: Happy drawing from intervention group at follow-up .....	57
Figure 11: Happy drawing from control group at follow-up .....	60
Figure 12: Happy drawing from control group at follow-up .....	61

## EXECUTIVE SUMMARY

The Sihleng'imizi (meaning 'we care for families') Family Programme is designed to complement and scale up the positive benefits of the Child Support Grant (CSG) in South Africa and strengthen disadvantaged families to improve child well-being outcomes. The main purpose of the follow-up evaluation was to assess first, whether participants in the Sihleng'imizi Family Strengthening programmes had retained what they had learned and were able to implement these learnings nine months following termination of the intervention; second, to compare these findings with the control group that had not been exposed to the programme; and finally, to consider the policy implications of combining cash transfers with family care programmes. Accordingly, 25 families were randomly selected from the sample of families who participated in the intervention and 15 families who were similarly selected from the control group that did not receive the intervention. Over a 12-month period, data were collected for a total of 145 families composed of 71 families at baseline and 65 at end point with an attrition of 9 families.

## FINDINGS FROM CAREGIVERS IN THE INTERVENTION GROUP

Interviews with the caregivers in the intervention group at nine-months' follow-up were analysed in terms of the five dimensions of the study, namely child-caregiver relations; involvement of caregivers in child's education; social and community connectedness; financial capabilities and nutritional knowledge, as well as depression symptoms among caregivers. The following findings suggested that the Sihleng'imizi programme was sustainable as participants had been able to recall and implement what they had learned from attending the programme nine months earlier:

### *Family and caregiver relations*

When caregivers were asked about their dreams for themselves and their children's future, it seemed that they retained the same dreams that they had articulated at the time of the Sihleng'imizi programme. The most frequent theme articulated by nine caregivers was for their children to do well at school in order to be able to study further at university. The second most frequent theme articulated by seven participants was a wish for employment for the caregiver and a place of their own. Three participants expressed the wish that when their children were grown-up they should obtain employment and assist their mother. There was awareness of the need for themselves and their children to work hard to achieve their dreams.

The majority i.e. 22 of the caregivers emphasized the increase in positive communication with children following attendance at the Sihleng'imizi programme. They were now able to listen and talk to their children, encourage two-way communication and engage in problem solving. They were able to set aside quality time to spend with the children. When children had done something wrong, they were able to reprimand them without shouting at them or hitting them. Caregivers reported a reduction in the use of uncouth language and swearing. Caregivers felt that there had been an improvement in family communication. They were also able to teach their children to delay gratification of their needs.

Caregivers reported using positive parenting in the form of praising children for doing something good. They showed love and encouragement. Rewards were given as a form of positive reinforcement. Caregivers found it easier to discipline children through talking rather than shouting. Since attending Sihleng'imizi, caregivers were better able to make children aware of wrongdoing. They were now able to talk to their

children, explain how to do something, control their anger and avoid shouting. Caregivers reported that they had learnt about “the naughty corner” from attending the Sihleng'imizi programme and found this approach to disciplining children very useful. They withheld rewards for negative behaviour. Caregivers had either stopped or reduced the use of corporal punishment. Caregivers explained that they were now able to control their anger and not resort to shouting. Some caregivers reported that they continued to maintain rules and routines that existed even prior to Sihleng'imizi. Others described how they had implemented rules and routines since attending the Sihleng'imizi programme. At follow-up it was easier to communicate with children when they had broken a rule or done something wrong. They indicated that they monitored their children at home and were aware of their children's whereabouts. Caregivers had developed positive attitudes toward being a parent. When asked what they do well as a parent, they explained that they show love to their children, make sure that they have everything they need for school, motivate them with their schoolwork, are able to take care of them and are interested in their daily lives.

### *Caregiver involvement in child's education*

Caregivers reported that their children enjoyed going to school, children were actively engaged in schoolwork and there had been an improvement in schoolwork. Children's behaviour at school had also improved, although one child presented with emotional problems. Caregivers indicated that since Sihleng'imizi they were more engaged with their children's school. They checked their children's books on a daily basis to see whether there was homework that needed to be done or a message from the teacher. One caregiver encouraged his children to read books. Others arranged for their children to receive assistance with school subjects. Caregivers helped their children with homework and when they were unable to assist their children with homework, they asked others for help. Following on what they had learned at Sihleng'imizi, they asked about the child's day at school. Since attending Sihleng'imizi, the caregivers had also developed confidence to speak to the child's teacher.

### *Social and community connectedness*

Since Sihleng'imizi, they had maintained contact with other group members on a WhatsApp group. They also kept contact with group members through phone calls or met when fetching their children from school. Involvement in Sihleng'imizi had expanded their networks and strengthened bonds with other participants. The buddy system had helped participants to communicate with and assist one another, particularly with regard to parenting their children.

### *Financial capabilities*

Since attending Sihleng'imizi participants had learnt the value of budgeting and were able to implement this practice in their lives. They were also now able to save despite having meagre sources of income. Others had tried to save money by joining a stokvel. As a result of attending the Sihleng'imizi programme, they were able to distinguish between wants, needs and obligations and were thereby able to delay gratification of things that were not necessary. Caregivers reported that as a result of attending Sihleng'imizi, they had learned to spend money wisely and had become aware of the negative consequences of borrowing money.

### *Nutritional knowledge*

Participants recognized the importance of breakfast. They believed that nutritional value, a healthy lifestyle, type/taste and cost were important considerations in making food choices, but attached somewhat less importance to time/convenience. They also gave the impression of having a good understanding of what constitutes a balanced meal. When participants were asked to rate the importance of their food choices in terms of six dimensions, it seemed that healthy lifestyle, type/taste, nutritional value and cost were regarded as the most important considerations with brand and time/convenience being considered less important.

### *Depression*

Within the intervention group 11 or 40.74% were depressed at follow-up according to the CESDR-10 scale scores. This represents an increase of 3.94% from 36.8% who were depressed at endpoint i.e. termination of the Sihleng'imizi programme compared to 52.5% of all the participants at baseline. The increase in depressive symptoms nine months after the programme ended may be due to the lack of support received by the families.

## FINDINGS FROM CAREGIVERS IN THE CONTROL GROUP

### *Family and caregiver relations*

When asked about their dreams for their children's futures, the caregivers articulated their desire for their children to live a good life. They wanted their children to finish school, receive an education, work for themselves and become independent. They also aspired to be good parents for their children. In terms of their own dreams, one parent wanted to further her own studies. Others saw employment as the answer to their dreams. One caregiver dreamt of having a home of her own, while another participant articulated the feeling of having lost hope at ever finding a job.

Caregivers reported that since their last contact with the interviewer, communication with children continued to be satisfactory. They gave examples of positive communication including actively listening to their children. Caregivers reprimanded children for wrongdoing through speaking or shouting at them. They were able to engage in problem-solving. However, with others there was no discernible change or improvement in communication.

Caregivers explained that they had family rules and routines for different activities such as the time for children to be back home, when to do homework and when they needed to go to sleep. They also had duties and chores as a family such as polishing shoes, tidying up their toys and so forth. Caregivers maintained an awareness of their children's whereabouts and children were taught to be wary of strangers.

In terms of positive parenting, caregivers mentioned the use of rewards for positive behaviour. Caregivers also used praise and appreciation for good behaviour. They provided encouragement through demonstrating affection. Caregivers reported disciplining children through talking to them and helping them to understand the difference between acceptable and unacceptable behavior. One participant described how she no longer shouted at her child. One caregiver mentioned the use of the 'naughty corner' to discipline her child. There was also withholding of rewards for negative behavior. In addition, caregivers endeavored to spend quality time with their children. When participants were asked what aspects of their parenting they were proud of, they described being able to communicate, being patient and not taking out one's anger on the child. There was pride in the fact that the child was coping at school. Caregivers experienced pride in their ability to discipline their children. Some caregivers felt proud of their ability to be independent. They experienced pride in their ability to care for and raise their children. Caregivers also felt proud of being able to help their children's schoolwork.

These findings suggest that although members of the control group did not have exposure to the intervention, most nevertheless had some knowledge and skills of positive communication. These are strengths that families have regardless of whether they participated in the Sihleng'imizi programme or not. The fact that one of the caregivers indicated that she no longer shouted at her children and used the 'naughty corner' may suggest some contamination between the treatment and control groups. It might also be that they were exposed to sources of knowledge and information other than the family intervention. However, significant changes were noted in the treatment group in positive communication and these may be confidently attributed to the intervention.

### *Caregiver involvement in child's education*

When caregivers were asked how their children were functioning at school, they mentioned that their children enjoyed school. Others reported that their children were performing well at school. Some

caregivers reported an improvement in their children's schoolwork. When participants were asked about their engagement in their children's education, they reported that they checked their children's books. They provided encouragement with schoolwork. Caregivers also assisted their children with homework/schoolwork. When they were unable to assist their child with homework, they sought help from another child. Participants attended school meetings and made a concerted effort to provide additional stimulation for their children. They switched off the television to avoid distractions. Caregivers also talked to the teacher when they were concerned about their child or were simply wondering how he or she was doing at school.

### *Financial capabilities*

Some caregivers indicated that they endeavoured to budget. They also reported improved ability to save. They no longer borrowed money due to awareness of consequences of borrowing. However, others reported that they were not able to budget or save from their limited incomes.

### *Nutritional knowledge*

Participants acknowledged that breakfast was the most important meal of the day. They believed that nutritional value, a healthy lifestyle, type/taste and cost were important considerations in making food choice. However, not all participants had a satisfactory understanding of what constitutes a balanced meal.

### *Depression*

Within the control group, 9 or 60% were depressed at follow-up, representing an increase of 18.5% on 41.5% who were depressed at endpoint i.e. termination of the Sihleng'imizi programme. This finding suggests that depression increased possibly because they were not exposed to the buddy system which was the case in the intervention group where depression increased by 3.9%. Overall, the intervention group had significantly lower depression levels at follow up compared to the control group.

## COMPARING FINDINGS FROM THE INTERVENTION AND CONTROL GROUPS

Findings from the intervention group indicated that the goal of strengthening disadvantaged families had been achieved and that participants were able to retain and implement what they had learned nine months post intervention, particularly with regard to enhanced communication, greater involvement in children's education, use of positive parenting and less harsh forms of discipline, increased social networks and improved financial capabilities. A surprising finding that emerged from comparing results from the intervention and control groups, was that they were very similar except for the fact that more persons in the control group used shouting to discipline their children rather than talking calmly, and more persons in the control group reported difficulty in being able to budget and save from their limited incomes. Similarities may have been attributable to a degree of contamination between both groups as participants in the control group may have had contact with those in the intervention group and in this way had learned alternate forms of disciplining children such as the use of the 'naughty corner'. In addition, some of the changes may have been due to the 'Hawthorne effect' whereby questions posed by the interviewers may have made participants aware of certain needs e.g. the need to communicate and to use alternate forms of discipline.

When the results for nutrition were examined at follow-up, they appeared to be very similar to those obtained for both intervention and control groups at the termination of the Sihleng'imizi programme, nine months earlier. In comparing the responses from the intervention and control groups, the impression gained was that both groups recognised the importance of breakfast. Both groups believed that nutritional value, a healthy lifestyle, type/taste and cost were important considerations in making food choices, although the intervention group attached somewhat less importance to time/convenience. However, more persons in the intervention group had a better understanding of what constitutes a balanced meal,

which could be attributed to their exposure to a module on nutrition presented during the Sihleng'imizi programme. In contrast, the control group did not have access to this information.

Within the intervention group 11 or 40.74% were depressed at follow-up, which represents an increase of 3.94% from 36.8% according to the CESDR-10 scale scores at endpoint. The higher number of persons presenting with depressive symptomology at follow-up may possibly be attributable to the discontinuation of the Sihleng'imizi programme, which presumably provided support for participants while it was being run. Within the control group, 9 or 60% were depressed at follow-up, representing an increase of 18.5% on 41.5% at endpoint. This increase may have been due to lack of support as well as high rates of poverty and unemployment prevalent at the time of the follow-up study.

The findings from the follow-up study show that caregivers continued to apply the knowledge and skills nine months later in the key domains tested and provide support for combining cash transfers with family care programmes to enhance the well-being of CSG beneficiaries (Patel et al., 2017).

## IMPLICATIONS FOR COMBINING CASH TRANSFERS AND CARE POLICIES

While South Africa's expansive social grants system improves material well-being and has many other positive benefits for children and families, on its own, it is not able to address the other multi-dimensional needs of children and their families. Cash plus family care interventions have the potential to accelerate child well-being through improving their physical, educational and social and emotional development. Additionally, they have the potential to improve caregiver and overall family well-being through reducing caregiver depression and improving care-giver knowledge and skills such as the use of alternative forms of discipline and positive behaviour management of children, strengthen family relations and bonding, and increase financial capabilities and knowledge of good nutrition and hygiene practices.

These findings are relevant for redesigning social assistance policies to be complemented with child and family welfare services to address the broader care needs of CSG families with children. A comprehensive preventative family and community-based intervention such as Sihleng'imizi, could be scaled up in urban areas using existing social service and development infrastructure. Further research is needed to test the efficacy of the programme in rural areas. Dedicated financial and human resources including training and mentoring of front-line social workers and auxiliary social workers are needed to achieve this goal. The research also confirmed the importance of obtaining beneficiary feedback and input on social interventions and how they experience it and use it in executing their care roles. While the necessary policies are in place to promote cash and care policies and programmes, political will and the commitment of administrators to give effect to innovation of this kind are required. How to translate evidence into workable social welfare and development programmes remains a key challenge and is crucial to improving child well-being outcomes in the long-run. There is need for further experimentation through designing, implementing and testing programmes that link social assistance policies with child and family welfare programmes. Limited evidence exists of the range and types of programmes that could best complement cash transfers and which programmes are most suited for particular target groups. Notwithstanding these challenges, this intervention research study demonstrates what contribution a preventative family strengthening intervention such as Sihleng'imizi could make to promoting child well-being by empowering caregivers with knowledge and skills that could enhance their capabilities and social support systems.

# INTRODUCTION

Over 12 million children, or 63% of all children in South Africa received a Child Support Grant (CSG) in 2018. The CSG is a cash transfer that has had a positive impact on child nutrition and school attendance and in reducing income poverty in poor families with children. However, despite the significant poverty-alleviation benefits of the CSG, the provision of cash alone falls short in meeting the multi-dimensional needs of children and their families.

Recognising the limitations of cash transfers as a stand-alone intervention, and in order to enhance child well-being in a holistic fashion as well as accelerate the positive benefits of the CSG, complementary family and community-centred care and support services are now widely advocated (Patel et al, 2017). Watson and Palermo (2016) refer to 'cash plus' or 'cash and care' programmes that combine cash transfers with other sorts of social and development support. Family strengthening interventions to support CSG beneficiaries in their caregiving responsibilities and to promote child well-being is one such complementary intervention. Research studies locally and internationally show that family strengthening interventions have the potential to mitigate psychosocial, systemic and structural risks associated with compromised child well-being (Cluver et al, 2016; Richter & Naicker, 2013; Gorman-Smith et al, 2007). Finding evidence-based innovative social development interventions to promote positive parenting and enhance caregiver knowledge and skills is particularly important in South Africa and in developing country contexts, to offer structurally disadvantaged children as much support as possible to enhance their well-being.

Evidence-based social interventions to combine cash with care interventions are being tested in different countries to enhance child well-being. The Sihleng'imizi (meaning 'we care for families') Family Programme is an example of such an evidence based preventative social-educational intervention. It was specifically designed to complement and scale up the positive benefits of the CSG in South Africa. The goal is to strengthen disadvantaged families living in a growing and changing African city to improve child well-being outcomes. The theory of change was informed by the social development model and social-educational intervention principles. The design of the programme builds on the existing strengths of families and proposed that improved knowledge and skills in the following five areas could improve overall family and child well-being outcomes.

- (i) Child-caregiver relations: improve communication, family cohesion, behavioural management, and caregiving capabilities;
- (ii) Involvement of caregivers in the child's education;
- (iii) Social and community connectedness: improve social networks and social supports;
- (iv) Financial capabilities: enhancing basic budgeting and savings knowledge and skills, and
- (v) Nutritional knowledge such as basic nutrition and hygiene in food preparation.

The purpose of this report was to assess whether the gains made from participation in the original Sihleng'imizi programme were sustained by participants nine months post intervention.

## 2

# LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

## 2.1 THE FAMILY, SOCIAL CONTEXT AND CHILD WELL-BEING

In South Africa, the high rates of child and household poverty and inequality, HIV/AIDS prevalence rates, physical and sexual violence perpetrated against children, coupled with unequal access to basic services are known risk factors that compromise overall child well-being. In this research we understand well-being as a multi-dimensional construct, made up of different dimensions (Pollard & Lee, 2002), including material, physical, cognitive, social and emotional well-being (Savahl, Adams, Isaacs, September, Hendricks & Noordien, 2015). We explain this conception further in Patel et al (2017).

Risk factors include low or inadequate levels of income, as this is associated with nutritional deficits in early childhood (Vorster 2010) and lower levels of school performance, leading to lower levels of employment and earning capacity in adulthood (Haile, Nigatu, Gashaw & Demelash, 2016). Moreover, hunger and malnutrition are linked to increases in behavioural problems of children, attention deficits and maternal depression (Black, 2012). Income poverty was also found to be directly linked to stunted growth and micronutrient deficiencies in children in a school nutrition study in Gauteng and the Eastern Cape (Hochfeld, Graham, Patel, Moodley & Ross, 2016).

Research findings show that the CSG goes a long way towards mitigating these risks. For instance, the benefits of the CSG in improving child well-being is now well established, including child nutrition (Agüero, Carter & Woolard, 2007; Coetzee, 2013); improvements in school attendance (Case, Hosegood & Lund, 2005); positive effects on learning outcomes (DSD, SASSA & UNICEF, 2012); and increased caregiver engagement in children's well-being (Patel, Knijn & van Wel, 2015). More recent research using quantitative data from the 2008 wave of the National Income Dynamics Survey (NIDS) identified the outcomes and factors associated with child well-being based on over 3 000 CSG beneficiaries (Patel et al, 2017). Key findings were that the CSG had positive impacts on food security, nutrition, subjective perceptions of child health, and school enrolment of children aged 6-7 years. While the CSG raised household income for all the beneficiaries, the grant was insufficient to lift them above the upper bounds of the poverty line. Moreover, four out of 10 households in which children lived experienced food shortages. In rural areas, higher levels of caregiver age and health and having a two-parent household were associated with positive perceptions of child health. Within urban contexts, it emerged that having more individuals in a household was associated with poorer perceptions of child health due to lower levels of food security. Caregiver depression featured in both rural and urban contexts, but was higher in urban areas. Qualitative data revealed that caregivers identified a need for knowledge and skills in parenting such as appropriate management of children's behaviour, monitoring and supervision of children to enhance child safety; in improving communication with children; and for assuming financial responsibility for their children.

The design of family strengthening interventions also needs to take account of the changing nature and structure of families in South Africa. While these changes are occurring globally, South Africa is somewhat of an outlier (Hall & Richter, 2018). Children generally live with one parent only and the two-parent family is less likely to be the norm than in other countries surveyed in a global study (Child Trends, 2014). Significantly, compared to other countries, larger numbers of children are cared for apart from their parents by relatives. Moreover, biological father absence is the norm for many children who are cared for by their mothers, grandmother and female relatives (Khan, 2019; Van den Berg & Makusha, 2018).

South Africa's history of apartheid and separation of families due to migrant labour and influx control policies, among other forms of institutionalised separation of families, resulted in severe disruption of family life and changing family structures. Posel and Grapsa (2017) point out that one of the legacies of apartheid is that it left black (African) parents without the resources to create a favourable home environment for their children. African children are less likely to live in households with both their parents, and parents are usually less educated. African children who attend poorer schools are more likely to reside in households with limited physical space, where there is no running water and electricity, and where there is limited access to books and computers (Spaull, 2013). African children also spend significantly more time on household chores than children of other race groups (Posel & Grapsa, 2017).

The resulting family structures can influence child well-being beyond income and socio-economic circumstances. As in South Africa the marriage rate is particularly low, and fathers commonly do not reside with their children (Makiwane, Gumede & Molefi, 2016) many children are raised in 'lone parent' households. While mothers and grandmothers tend to live with other relatives who can assist in caring for their children/grandchildren (Patel et al, 2017), being a lone parent can be particularly tough (Ntshongwana, Wright, Barnes, & Noble, 2015). Even when living with other relatives, lone parents are more likely to have fewer household resources and a lower income than their married counterparts (Ntshongwana et al, 2015), making their households more vulnerable. This can translate into more time away from home looking for work, stress, and fatigue. When caregivers are under financial stress or have other pressing concerns, they often become anxious and emotionally unavailable to their children (Roman, 2011).

Regardless of family structure, what takes place within families is critical to child well-being. Family functioning is the mechanism through which children are socialised, including learning appropriate and inappropriate behaviour, decision-making skills, understanding roles and norms of a society, and influencing psychological well-being (Roman, Davids, Moyo, Schilder, Lacante & Lens, 2015). In addition to material, health and educational needs, families provide the environment in which the basic emotional and psychological needs of children are met (Roman et al, 2015).

Specifically, the caregiver's relationship with a child has an enormous influence on well-being. Caregiving that is characterised by warmth, emotional engagement, responsiveness, flexibility, but with limits, offers a child emotional security, belonging, and psychological well-being, while unavailable, unresponsive, rejecting, hostile or punitive caregiving has poor outcomes for children (Rose, Roman, Mwaba, & Ismail, 2018). Berry and Malek (2013) highlight the protective role of strong caregiver relationships and demonstrations of warmth for children. These factors are important for child mental health (Cedarbaum et al, 2017) and have been shown to reduce the risk of child abuse (Meinck et al, 2015), as well as behavioural problems in childhood (Gardner, Sonuga-Barke & Sayal, 1999) and can reduce negative social and community influences (Holte et al, 2014). In families where parents are involved with their children's schooling, children tend to achieve higher grades, have better attendance records, drop out less often, have higher career aspirations and have more positive attitudes towards school and homework – particularly in disadvantaged, highly stressed families (Bogenschneider et al, 2012).

Families represent a fundamental component of a strong and vital society (Bogenschneider et al, 2012). The family and community contexts in which children are raised are critical in the social reproduction of children and future generations. The Sihleng'imizi family programme was designed to support families, to mitigate some of these systemic risk factors, and to support caregivers in their care responsibilities with the view to enhancing child well-being. The intervention is a micro and mezzo level family and community intervention that is limited in responding to policy and economic factors that underlie poverty and inequality in South Africa. However, the intervention is intended to support children to "grow up in households that allow them to develop to their full potential" (Bradshaw, Martonrano, Natali, & de Neubourg, 2013:8).

## 2.2 THE CASH AND CARE NEXUS

While it is widely recognised that cash transfers are an effective poverty-alleviation mechanism, on its own a cash transfer cannot address the multi-dimensional and inter-connected needs of social grant-receiving children and their families. For this reason, combining cash transfers with various other complementary and supportive services (referred to as 'cash plus programming' or 'cash and care') may potentially improve people's lives (Banerjee, Duflo, Glennerster & Kinnan, 2015).

Family strengthening interventions represent one kind of service that could provide substantial benefits for disadvantaged children and families. Richter and Naicker (2013) reviewed more than 600 relevant peer-reviewed papers between 2000 and 2012, including 83 systematic reviews on publications that focused on programmes of parent support and strengthening of child-caregiver relationships. The purpose was to extract general principles to guide parenting programmes in contexts affected by HIV and AIDS and poverty. Key findings that emerged included the notion that families comprise the most important response to children affected by AIDS and poverty.

Many of the parenting programmes reviewed are culture-bound and labour intensive and would be costly and inappropriate for low- and middle-income countries such as South Africa. Nevertheless, the theoretical framework for parenting programmes, including attachment theory, language acquisition, and social learning are universal mechanisms. Moreover, the goals of parenting programmes in high-income countries such as enhancing parental facilitation of children's health and development, reducing parental stress, improving family well-being, and managing difficult child behaviour, resonate with caregivers and children living in countries ravaged by AIDS and poverty. The studies that were reviewed, highlight the value of parent support programmes, especially for those responsible for caregiving under particularly stressful conditions, such as young mothers, aged caregivers, socially isolated caregivers and caregivers of children with a disability. Circumstances that lead to caregiver vulnerability can trigger or exacerbate harmful parenting, such as caregivers who are punitive, hostile, withdrawn, controlling or emotionally disengaged. Caregivers of children affected by HIV and poverty raise concerns about children experiencing bereavement, dislocation, disadvantage and stigmatization. Emotional/behavioural problems include anxiety, depression and aggression. Efforts to promote improved child and home safety and to reduce harsh punishment through training in verbal and behavioural limit setting have yielded evidence of success. Among the lessons learned has been the need to understand what parents need and want from parent support programmes, making culturally-appropriate local adaptations, using easy-to-read materials, employing peer trainers, including men and children in the programmes making use of practice and feedback and incorporating buddy supports. Other lessons include the need to share knowledge about children's development, and the importance of talking and reading to children. However, parenting programmes are only effective if they acknowledge and address the socio-economic and other challenges likely to be experienced by parents (Richter & Naicker, 2013).

More recently, Özdemir (2015) scrutinized the methodological rigour of research evaluations of the effects of parenting programmes. He concluded that prevention researchers have made significant advances in developing and evaluating evidence-based parenting programmes designed to prevent child problem behaviours and enhance parenting skills and well-being. Several meta-analyses suggest that they can be cost-effective and can achieve significant improvements in respect of child and parent outcomes in the short-term. However, the evidence for long-term effects is limited.

Finally, Rose et al (2018) identify in a systematic review that caregivers are able to positively change the nature of their attachments to their children if they are willing to undergo self-reflection and social education, which reduces their child's risk of poor outcomes. In addition, it is far more successful to support improvements in positive parenting rather than reductions in negative parenting (Rose et al, 2018; Gardner, Hutchings, Bywater & Whitaker, 2010).

The provision of complementary family and community-based preventative developmental interventions that combine social and economic interventions such as cash transfers and family strengthening programmes is critical if we are to break the inter-generational cycle of poverty and inequality in South

Africa. Such an approach is consistent with the developmental approach to social welfare and the White Paper on Families in South Africa (DSD, 2012).

## 2.3 THEORY OF CHANGE OF THE SIHLENG'IMIZI PROGRAMME

The theory of change is based on the notion that child well-being is multi-dimensional, and these different dimensions of well-being are interrelated (Pollard & Lee, 2003). The dimensions include material (or economic), physical, cognitive, social and emotional well-being (Patel et al, 2017). Sihleng'imizi is broadly a social development intervention that aims to promote child well-being in the long term by supporting caregivers and families to provide the best possible environment for children to develop in all these dimensions. In this way, it has primary, secondary, and tertiary prevention goals, which are to reduce harsh parenting in the short term, to promote positive parenting, social, financial, and nutritional skills in the medium term, and to lead to better well-being outcomes in all these dimensions for children in the long term.

The intervention is embedded in a social development approach to child and family well-being (Patel et al, 2017). It builds on the principles of developmental social welfare.

The programme is aligned with the developmental welfare model (Patel, 2015), and has at its foundation the following:

- The right to a CSG for all disadvantaged children is acknowledged.
- Voluntary participation of CSG beneficiary families in the intervention.
- Co-creation of learning between facilitators and group members.
- Acknowledgement of the agency of participants as change agents.
- Empowerment of the family group by strengthening their knowledge and skills.
- Delivery of a programme that is holistic to promote child well-being. Programme content includes all aspects relevant to child well-being e.g. social, emotional, material, physical and educational.
- Working in a partnership with families, schools, local authorities, NGOs, and higher education institutions.
- Interventions that have the potential to scale up social impact through the delivery of integrated family and community-based information, education and preventative programmes.

The social development model draws on various theories, which influenced the theoretical development of the programme, specifically, the Developmental-Ecological Risk theory, systems thinking and the psycho-educational approach to family intervention, which are described briefly below.

First, the intervention focuses on specific risk factors that may compromise child well-being and that may require strengthening in specific domains. The concept of 'Developmental-Ecological Risk' provides a useful schema of identifying risks at the individual, relationship, community and societal levels. Individual development is thought to exist within different circles of social structures. Individuals live in families, which exist in extended family and friendship systems, and they in turn exist within larger social contexts, such as schools and neighbourhoods. Neighbourhoods are affected by the wider community and society as a whole. Each of these social settings affects human development not only directly but also indirectly (Bronfenbrenner, 1979; Tolan, Guerra & Kendall, 1995). The families in the intervention could be considered at risk due to the social, environmental and developmental context (ecology) in which they live (Tolan et al, 1995).

With reference to Sihleng'imizi, all the families participating in the programme are receiving one or more CSGs, which are means-tested and go only to poor children. While many of the families display real strength and resilience, we consider them to be at risk due to poverty, a lack of resources and opportunities in employment and education, and other challenges that come from their difficult social environment. Complementary family interventions that address these risks specifically could promote optimal family functioning. In addition, positive parenting/caregiving is strongly associated with positive

child well-being outcomes. By minimising risks, we are able to prevent future behavioural problems and promote positive social behaviours (Ward, Dawes & Van Der Merwe, 2012; Ward & Wessels, 2013; Tolan, Gorman-Smith, Huesmann & Zelli, 1997; Webster-Stratton, Reid & Hammond, 2001). As women take on the vast majority of caregiving in South Africa, they bear the greater share of burdens that caregiving under disadvantaged conditions brings. It is also true that they are often perceived to be solely responsible for protecting their children from risk. Investing in the development and support of caregivers contributes to empowering caregivers.

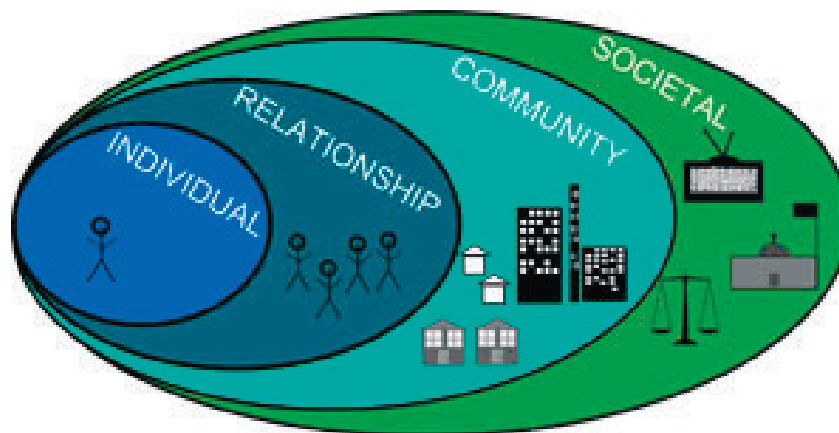


Figure 1: Development Ecological Model source: <http://www.wcsap.org>

Second, a systemic ecological approach to understanding families is widely used in social work with families. A family is made up of a network of interdependent relationships that need to work synergistically to achieve optimal social outcomes. Effecting systemic changes in family relationships and how the family connects with the wider community (see figure 1) could have positive benefits for the way in which the family is functioning. The term family is broadly defined. The intervention takes the diversity of family forms and economic and social realities they face as its starting point, building on their strengths, assets, capabilities and agency to make choices and decisions to achieve their goals (Giddens, 1991).

Third, the psycho-educational approach to increase access to information and knowledge and skills in parenting/caregiving could promote and prevent social and behaviour difficulties in the short, medium and longer term. These findings emerged from longitudinal research of the SAFE Children project (Tolan et al, 2004). Further, in the South African context, many families lack information about where and how to access resources and services such as social grants, private maintenance for children, housing subsidies, access to public works programmes and applications for identity documents, to mention a few. Information failures and knowledge gaps are widely recognised to be major obstacles to improved well-being and the empowerment of at-risk groups (Patel, Hochfeld & Chiba, 2018). Addressing these knowledge and information gaps through a family intervention is assumed to have beneficial child well-being effects.

Fourth, the interventions in the Sihleng'imizi project combine components of psychoeducational, functional, and structural strategic approaches to family intervention. They are grounded in 'developmental-ecological' theory (Tolan et al, 1995) and take account of the constraints and opportunities of their social contexts. It is a preventive programme designed to assist families to manage the stresses and challenges of everyday life in poor or difficult circumstances. The family relational components of the programme in particular work by first helping families to develop a daily organisational structure that promotes their children's social and academic success. Second, improving or maintaining positive family relations that have been shown to give children support, improve family connectedness, and decrease risk for antisocial or problem behaviour. Third, helping families understand and use their inner strengths to protect them from stressful environmental influences and meet developmental and social-ecological challenges. Finally, helping families to ask for and use help when necessary.

To do this, the programme helps families to identify strengths and goals and to define and resolve concrete problems that are of concern to them. In addition, it also helps them rebuild or strengthen their networks of support and to develop skills in behaviour management, financial education and nutrition.

Therefore, based on both the material needs of families and the theories described above, it is assumed that having access to financial resources including employment, livelihood strategies, access to social assistance and to basic services such as water, sanitation, shelter and energy are key determinants of material and child health and well-being. Additionally, the availability of good quality food and health services to monitor and promote child health outcomes is also contingent on material well-being, as well as parental knowledge and skills. While positive educational outcomes depend on regular school attendance and quality education, parental and/or caregiver engagement with children's schooling also matters in enhancing school performance. Equally, the social and emotional well-being of children depends on warm, loving, nurturing and cohesive family and home environments. Positive child-caregiver relations are also influenced by effective communication, behaviour management and monitoring and supervision of children. From the perspective of caregivers, having a social support system, enjoying good mental health and psychosocial well-being, and access to material and non-material resources to care for children, are other factors associated with better well-being outcomes for children. The majority of caregivers are women, and caring for children under challenging financial and social circumstances is difficult. Gender inequalities in care disadvantage both women and children, and Sihleng'imizi is designed to support women in their caregiving without reinforcing gender disparities.

In summary, Sihleng'imizi was designed to bring about change in five domains of child well-being, the primary aims of this intervention. The intervention is founded on theory-based assumptions about factors that are associated with child well-being (Patel et al, 2017) and uses psycho-educational family intervention models to effect change in the domains below (Tolan et al, 2004). It is assumed that benefits to children will also have positive effects on the family and specific benefits for caregivers as well.

- **Family/child-caregiver relations:** the quality of relations, communication, social cohesion, behavioural management and caregiving capabilities are critical ways of improving family functioning and contribute to the social and emotional development of the child (emotional, psychological and social well-being).
- **Educational development:** helping children succeed at school, especially in the early years, is likely to yield long-term educational outcomes. One of the key factors in enhancing success at school is through parental/caregiver involvement in the child's education (educational well-being).
- **Physical development (nutrition):** improved knowledge and skills of caregivers about nutrition is associated with positive child health and educational benefits (health and educational well-being).
- **Financial capabilities to enhance material well-being:** besides the financial support provided via the CSG, enhanced knowledge and skills of family financial matters could improve social and economic well-being (material well-being).
- **Social well-being and community connectedness:** knowledge and skills to access and sustain family support systems, social and basic services and connectedness to community support systems are known to moderate life stress and improve family functioning (social well-being).

By increasing the knowledge and skills of parents/caregivers and the family group as a whole, we assume that the programme will lead to the tangible changes in child well-being outlined above. We assume that the programme will be beneficial not only to the children, but also to the caregivers in that it could result in lower caregiver stress levels and depression, and improved self-esteem, confidence and social support. Individual level changes of this nature could also enhance the ability of caregivers to navigate their way around the structural barriers to well-being.

It is further assumed that individual level benefits derived from Sihleng'imizi could enhance the ability of caregivers' to navigate their way through various structural barriers to well-being. Sihleng'imizi intends that the micro skills families gain could have longer-term effects. Examples are, firstly, that psycho-social benefits can strengthen families to be resilient to economic and social shocks, maintain supportive relations over the life cycle and model strong and caring relationships that can positively shape children's future. A second example is that positive parenting skills can be very empowering for caregivers who struggled to

manage behaviour previously, and can promote self-confidence and encourage goal setting and a future orientation. Thirdly, developing advocacy skills in the school environment empowers caregivers to be engaged in children's education, help children develop good educational habits, and promote long-term educational performance. In addition, caregiver involvement in schools is an investment in strong schools and caring communities despite disadvantage. Fourth, increasing knowledge about existing community services improves skills in accessing these services and in claiming rights. This could in turn reduce care burdens particularly on women who provide most of the caregiving. A fifth example is that financial capabilities are not just in order for people to use their money more effectively, but also giving them the confidence to use financial opportunities to reduce financial exclusion. Finally, nutritional knowledge is another human capital investment, which can improve the health status of families in the longer-term.

The combination of cash and care interventions (such as the CSG and Sihleng'imizi) that empower families and that tackle the structural barriers that poor families with children face could go a long way towards breaking the intergenerational cycle of poverty, inequality and social disadvantage in South Africa.



# SUMMARY OF THE ORIGINAL SIHLENG'IMIZI STUDY CONDUCTED IN 2018

## 3.1 METHODOLOGY UNDERPINNING THE ORIGINAL SIHLENG'IMIZI STUDY

The original programme was structured as a weekly group meeting with five families that included all family members, over 14 sessions in the second half of 2017. It was facilitated by a qualified social worker and supported by a qualified childcare worker. One group was run in each of the 10 most deprived wards of the City of Johannesburg (CoJ). The groups were facilitated by CoJ social workers and childcare staff who were trained and supervised throughout.

The research design was quasi-experimental, with pre- and post-intervention data collection for the intervention group, and a comparative control group for whom data was also collected at pre- and post-intervention stages. Families were randomly selected via school class lists of children in Grade R and Grade 1 at the identified school in each ward. The data were mainly qualitative in nature, with interviews conducted with the primary caregiver, the sampled child, and the child's educator at baseline (before the intervention) and endpoint (after the intervention) for the intervention and the control group.

The study sample consisted of 135 families, with a total of 740 individuals, at baseline. There was an average of 5.7 members per family, and a range of 2 to 14 members. The majority of children in the families (83%) were in primary school or younger, and 75% of children had their biological mother as their primary caregiver, followed by their grandmother (13%). A large number of adult family members were unemployed (45%), whereas only 19% were employed full-time (the others were self-employed or on a casual or part-time basis). The majority of households received between one and three CSGs for children in their care.

This report presents the findings of this intervention study evaluating the short-term outcomes of Sihleng'imizi. The qualitative data were drawn from interviews with the 40 families that completed the programme and 20 control group families.

## 3.2 FINDINGS

The outcomes of the programme were assessed in relation to changes that were evident in the five areas outlined above.

### *Child-caregiver relations*

One of the objectives of the Sihleng'imizi programme was to reduce the prevalence of harsh parenting in this group of caregivers by teaching alternative forms of discipline. The changes reported by respondents show that corporal punishment, anger and shouting had been reduced and most caregivers had successfully implemented the 'calm down corner' strategy. These findings suggest that the programme was successful in empowering families by developing their skills in communication, caregiving and behaviour management. These are critical ways of improving family functioning and contribute to the social and emotional development of the child.

Caregivers identified shifts in communication practices following attendance at the Sihleng'imizi programme. The most frequently cited change was in terms of increased positive communication (such as praising children), followed by more problem-solving behaviour and more active listening. A smaller number of respondents mentioned a reduction in the use of uncouth language and improvements in caregivers' own behaviour, particularly in terms of keeping calm, talking to solve problems, and a reduction in shouting. The most frequent changes were noted in positive parenting and took the form of praising the child, teaching him/her the consequences of negative behaviour, and rewarding and encouraging good behaviour.

Regarding knowledge of risks, there was an increase in awareness of the child's whereabouts, stranger danger, safety within the home, and monitoring of the child at home and after school. However, with 18 caregivers (47%) it was not clear whether there had been any improvement in monitoring and supervision of children. This finding suggests that at baseline respondents were already aware of dangers and risks within their environment and were actively engaged in monitoring their children's safety, possibly related to media exposure of increasing crimes perpetrated against children.

It was apparent that the majority of caregivers had made significant changes to family rules, chores and routines following exposure to the Sihleng'imizi programme (such as initiating clear bed-times, shared meal times and rules about homework). In this way, families were helped to develop a daily organisational structure that can potentially promote their children's social and academic success, and emotional well-being.

When asked whether caregivers' perceptions of their own caregiving had changed following attendance at the Sihleng'imizi programme, half (10 out of the 20 who responded to this question) felt that there had been a definite improvement. They self-reported changes such as: more positive attitudes among caregivers, the use of less harsh forms of discipline, enhanced communication with the child, increased quality time spent with the child and greater pride experienced in their own caregiving. In this way, the programme seems to have played a key role in enhancing caregivers' confidence and self-esteem (according to their self-reporting).

These findings suggest that the first objective of the Sihleng'imizi programme was achieved, namely, the programme helped to strengthen child-caregiver and family relations. This objective was achieved through increasing opportunities for bonding between child and caregiver, increased use of positive parenting skills, especially in relation to discipline, and in relation to family strengthening: via building family cohesion and improving family communication.

### *Caregiver involvement in child's education*

The improvements in caregiver involvement in the child's education that were cited most frequently were increased help with homework followed by increased confidence in speaking to teachers, checking the child's books, and turning off the TV to avoid distraction during time spent on homework. These results are important if one considers that one of the key factors in enhancing success at school is through parental/caregiver involvement in the child's education (Fan & Chen, 2001). Even in cases where caregivers already engaged in such behaviour prior to the intervention, the involvement of the caregivers increased.

In evaluating these results, the impression gained was that the second objective of the programme was largely achieved, namely, to increase caregiver involvement in the child's education via active support for school work, active addressing of school attendance barriers, and improved advocacy for the child's needs at school. Where these behaviours were not markedly increased (as they already existed), it is assumed (but not proven) that they were reinforced via the programme exercises related to this dimension.

### *Social and community connectedness*

Caregivers were asked if there had been any change in their social networks following their attendance at the Sihleng'imizi group. The improvements mentioned most frequently were plans to keep in contact with their buddy (families were matched in buddy pairs)/the group, while some were already actively keeping in touch, for example through WhatsApp groups. Social networks were experienced as valuable,

and communication with the extended family had improved. Among the values of the social relationships developed in the group were that caregivers identified, were learning from others, experiencing love and care, enhancing relationships with people, learning other languages, gaining understanding, improving communication, and knowing where to seek help with a problem. Caregivers were also able to share new knowledge from the group for the benefit of their community. These findings suggest that the third objective of the programme were achieved, namely, to promote social and community connectedness and positive engagement with community networks. There was minimal evidence of changes in engagement with community services.

### *Financial capabilities*

The most important changes in this area since attendance at the Sihleng'imizi programme were in terms of improved saving and budgeting behaviour, the ability to differentiate between wants, needs and obligations, and awareness of the consequences of loans. In terms of the theory of change underpinning the study, it is recognised that besides the financial support provided by the CSG, enhanced knowledge and skills in handling family financial matters could improve social and economic well-being.

With respect to these findings, there is evidence that the fourth objective of the programme was achieved, namely, to strengthen the financial capabilities of the caregiver and family via basic financial literacy skills and family budgeting and saving.

### *Caregiver and family knowledge of nutrition*

While 69% of caregivers regarded breakfast as the most important meal of the day prior to the intervention, this increased slightly post-intervention (74%). Increases in the number of caregivers who rated 'healthy lifestyle' as very important in choosing food was also noted. However, overall, there seemed to be minimal improvement in nutritional knowledge and skills.

### *Symptoms of caregiver depression*

In addition to the above dimensions, the study also investigated changes in symptoms of depression among the caregivers, using a validated tool (CESDR-10). Findings show that there was a decrease in the number of caregivers presenting with symptoms of depression (from 53% at baseline to 37% at endpoint). This result is particularly positive, as research does indicate that mental health difficulties have a negative effect on caregiving (Davies, Schneider, Nyatsanza, & Lund, 2016). At the same time the control group also experienced a reduction in depressive symptomology; therefore we are cautious in attributing these changes specifically to the Sihleng'imizi intervention.

### *Findings from interviews with children and educators*

Owing to a lack of direct observational data and the limitations of 5 – 8 year olds verbalising change, the interviews with the sampled children used quantitative questions about their school experience and focused on the child's perception of their family via a drawing and interview. The majority of the sampled children appeared to be happy and well-adjusted. There were however 23 cases where information from the caregiver, educator or the child him/herself indicated possible educational and/ or child well-being concerns. These were referred on for assessment and intervention.

All the intervention group children reported enjoying participating in the group.

## 3.3 CONCLUSIONS

The Sihleng'imizi programme served to considerably enhance child and family well-being in terms of four of the five programme objectives, namely strengthening (1) family relations; (2) educational development; (3) financial capabilities; and (4) social well-being and community connectedness. In relation to (5) nutritional and food preparation, hygiene knowledge was increased to a modest degree.

Some changes were noted in the control group in relation to improved communication within families. This change may be due to the 'Hawthorne effect' (Rosenburg et al, 2018), whereby questions posed by the researchers made respondents more aware of this need. Increased financial stress was also observed in the control group, which was attributed to environmental factors external to the programme – e.g. the threat of being evicted from one's home.

The findings reveal short-term positive outcomes from the intervention. The theory of change assumes that these outcomes may minimise some of the risks for future behavioural or other problems, thereby fulfilling a preventive function. Nevertheless, some of the child participants presented with some learning, social and emotional difficulties that the programme was not designed to address.

The Sihleng'imizi programme has been shown to have the potential to scale up the impact of social grants through its holistic content, which is relevant to the social, emotional, material, physical and educational well-being of children and families, particularly those that are socially and economically disadvantaged. The majority of caregivers are women, and they care for children under challenging financial and social circumstances. Gender inequalities in care disadvantage both women and children, and Sihleng'imizi is designed to support women in their caregiving without reinforcing gender disparities. While the programme is designed to have micro-effects on individuals and families, it is also intended that these changes can over time support the more effective navigation of systemic and structural barriers that block the development and well-being of poor and disadvantaged communities.

This study had some limitations, for example, there is the possibility that some participants may have furnished socially desirable responses. Also, the study design was appropriate for the real-life conditions experienced by the families, but some changes cannot be definitively attributed to the Sihleng'imizi programme, but rather to other factors such as better family situations, child maturation, or other influences that could not be controlled for.

Overall, the Sihleng'imizi family strengthening intervention was found to be beneficial. It has the potential to scale up the positive effects of the CSG. Future social policy for families with children needs to move beyond the provision of cash transfers only and incorporate the concept of care in its widest sense. Complementary social interventions that combine cash transfers with a range of care services and strategies are needed to fast track improved social outcomes for children and families. Cash and care interventions that tackle the structural barriers that poor families with children face, could go a long way towards breaking the intergenerational cycle of poverty, inequality and social disadvantage in South Africa.



## THE NINE-MONTH POST INTERVENTION FOLLOW-UP STUDY

The purpose of the follow-up study was to ascertain whether the gains made immediately following the Sihleng'imizi family and community strengthening programme were sustained in the long-term i.e. nine-months post intervention in September 2019. The methodology employed and the findings that emerged are presented and discussed in the following sections of this report.

### 4.1 METHODOLOGY EMPLOYED IN THE FOLLOW-UP STUDY

#### 4.1.1 Research design

The research took the form of a predominantly qualitative, post-intervention design with a small quantitative component.

The population targeted by the programme were recipients of the CSG who had children in Grade R or Grade 1 and who resided in the 10 poorest wards identified by CoJ. However, for the follow-up study a random sample of 25 caregivers from the original intervention group of 135 persons were compared with 15 caregivers who were also randomly selected from the original control group of 20 persons who had not been exposed to the programme.

Prior to data collection, a two-day training programme was conducted with the field workers who were all qualified social workers who had been involved with the original data collection at baseline and endpoint. Data were collected via individual face-to-face interviews with caregivers. Quantitative data were analysed using descriptive statistics while qualitative data were analysed via Atlas ti.

#### 4.1.2 Research sites

The CoJ identified 10 of their most deprived wards for this study. The wards are spread over the Johannesburg metro and are different in look and characteristics, but all of them are socio-economically disadvantaged and families living there are poor.

Table 1 identifies the wards in which the research was done and a description of the area to give a sense of the research sites.



Table 1: Brief descriptions of research sites (City regions and wards)

Region of the CoJ	Ward and Area name	Area description
A	Ivory Park: 77	The population of this ward in Ivory Park is approximately 38,546 with nearly 30% of these under the age of 18 years. The rate of employment is about 45%, indicating a high number of out-of-work residents. Most people in Ivory Park have access to piped water (97%) and sanitation (93%), although 22% of households live in informal dwellings (shacks).
	Diepsloot: 95	With an average population of 46,238 about a fifth are under 18 years old in Diepsloot. Shack living is common in ward 95, and informal housing makes up about 77% of the homes. Ninety percent of all residents have access to piped water but only 84% have access to sanitation. The average household income is only R2, 500 per month. Diepsloot is located in the far north of the CoJ.
B	Westbury: 69	Approximately, 26,360 people call Westbury home. Housing is formal, with a large number of apartment buildings compared to other areas in Johannesburg. Children 5-17 years old are largely in school (87%), with 76% of the out-of-school population having on average completed grade 9 or higher. Gang violence occurs frequently in Westbury, and there is significant drug use and sales.
C	Doornkop: 50	Doornkop, commonly known as Snake Park, is a formally laid out area, but 36% of households live in backyard shacks or informal housing. Of the 23,255 residents there, 97% have piped water access and 90% have access to sanitation services. Thirty-six percent of the population are unemployed. Here, the average household income is R1, 200 per month.
	Zandspruit: 114	Zandspruit is home to approximately 34,978 residents. It is a township located to the West of Johannesburg. About 22% of the population is under 18, with an average residential age of 27 years. About half of the population is employed. Only 47% of residents have access to flush toilets, with 43% living in informal dwellings.
D	Meadowlands: 42	Ward 42 in Meadowlands, commonly known as Ndofoya, has an average population of 23,974, with about 6,686 under 18. Three percent of children 14 and under have no surviving biological parents. The average monthly household income is R2, 500, with a 40% employment rate. Eighty-five percent of residents live in formal housing. Meadowlands is located in Soweto.
	Orlando East: 31	Orlando East, also in Soweto, is known in the township as London. Although the area is a formal one, 27% of residents live in informal housing. Despite this, residents have piped water and sanitation access (98% and 99% respectively). Sixty percent of the population is unemployed and average household incomes are low.
E	Alexandra: 109	Commonly known as Alex, and located very near to the financial centre of Sandton, this is a high-density part of Johannesburg. Informal housing make up 28% of the homes, and 71% of the population has access to sanitation. Water provision reaches 96% of the ward. Over half the population are employed (61%), and 1% of children 14 years and under have no surviving biological parents.
F	Malvern: 65	Malvern, with a population of 26,529, is an area of largely formal housing. It is a diverse population, with many foreigners calling this home. Fifty-two percent of working-age residents are employed, and most people have access to piped water and sanitation.
G	Orange Farm: 1	A large number of people in Orange Farm are under eighteen, 36% of the total population of 41,767. Only 33% are employed and the household average monthly income is R2, 500. Here 34% live in informal housing and 46% have access to sanitation. Orange Farm is located in the very south of the City, with high transport costs to travel to the City centre.

Source: Municipal Elections 2016: Electoral Commission of South Africa (IEC), Municipal election results [file:///C:/Users/madodas/Documents/City%20of%20Johannesburg%20Ward%2031%20\(79800031\)%20-%20Profile%20data%20-%20Wazimap.htm](file:///C:/Users/madodas/Documents/City%20of%20Johannesburg%20Ward%2031%20(79800031)%20-%20Profile%20data%20-%20Wazimap.htm)

Census 2011: Statistics South Africa (2011) South African Population Census 2011. Indicators derived from the full population Census [file:///C:/Users/madodas/Documents/City%20of%20Johannesburg%20Ward%2031%20\(79800031\)%20-%20Profile%20data%20-%20Wazimap.htm](file:///C:/Users/madodas/Documents/City%20of%20Johannesburg%20Ward%2031%20(79800031)%20-%20Profile%20data%20-%20Wazimap.htm)

Figure 2 shows the regions of the City of Johannesburg, with approximate locations of each ward.

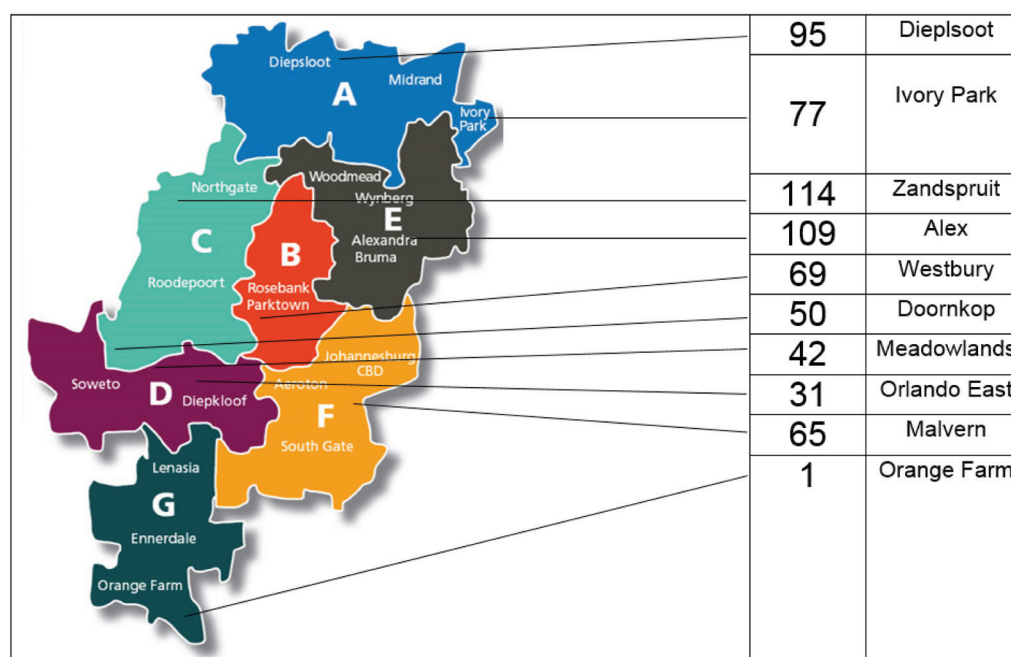


Figure 2: Approximate locations of each ward in the Regions of the City of Johannesburg

### 4.1.3 Sampling

In order to comply with quasi-experimental design principles, the intervention and control groups were randomly selected from the same populations to ensure comparability.

One primary school was identified in each ward (in most wards there was only one primary school; in two wards the school selected was the one that gave permission for the study). All these schools were 'no-fee' schools, which means the children are exempted from paying school fees as they live in deprived areas. The study participants were recruited via these primary schools. Both the control and the intervention group were selected randomly from the same schools. The selection criteria were that there was an identified child who (a) was attending Grade R or Grade 1 in 2017; (b) that this child was a recipient of a Child Support Grant; (c) that the family lived locally, so access to the group venue would be uncomplicated; and (d) that the caregiver and the child agreed to the process.

The class-lists of all the Grade R and Grade 1 classes in that school were provided by the schools. Each child was assigned a number, and numbers were selected randomly from the class lists (using the randomising feature on MS Excel). Seven numbers and seven substitute numbers were randomly selected for the intervention group, and similarly seven numbers and seven substitute numbers were randomly selected for the control group. Field workers contacted the families by phone, checked the family met the above criteria, then explained the intervention and study to the intervention group and invited their participation, and explained just the study to the control group and invited their participation.

Data were collected from 25 intervention group families and 15 control families at follow-up.

Table 2: Follow-up Intervention and control group samples for qualitative analysis, according to wards and regions

Region of the CoJ	Area name	Wards	Number of families: Intervention group	Number of families: Control group
A	Ivory Park Diepsloot	77 95	2 2	1 0
B	Westbury	69	2	1
C	Doornkop Zandspruit	50 114	2 3	3 0
D	Meadowlands Orlando East	42 31	2 2	2 2
E	Alexandra Alexandra	109 75	1 3	1 1
F	Malvern	65	4	1
G	Orange Farm	1	2	3
<b>TOTAL</b>		<b>11</b>	<b>25</b>	<b>15</b>

#### 4.1.4 Data collection

While the original study triangulated data from children, caregivers and educators, in the follow-up study data were only collected from caregivers and children. Interviews were conducted with 25 primary caregivers and children from the intervention group and 15 caregivers from the control group.

Table 3: Research tools used at follow-up

	Caregiver	Child
<b>Intervention group</b>	<ul style="list-style-type: none"> <li>Qualitative questions relating to the 5 dimensions under investigation</li> <li>Survey nutrition questions</li> <li>Depression index (CESD-R-10*)</li> </ul>	<ul style="list-style-type: none"> <li>Draw your family' exercise</li> <li>Simple closed ended questions about family and school</li> </ul>
<b>Control group</b>	Same as above	Same as above

\* Centre for Epidemiologic Studies Depression Scale Revised (CESD –R-10) scale, developed by Radloff (1977) and validated for the South African population (Baron, Davies & Lund, 2017).

#### 4.1.5 Data analysis

##### **Analysis of demographic and household data and interviews with caregivers and children**

The demographic and household profile information were collected via a short survey. They are presented using descriptive statistics illustrated with various tables and figures. No quantitative analysis was conducted on these data as they were only collected for descriptive purposes as background information to make sense of some of the qualitative analysis.

Qualitative data from the interviews with caregivers and children were analysed using a combination of closed and open coding and thematic analysis. The closed coding used a coding tree developed from the five dimensions indicated in section 1 that formed the core of the intervention programme and therefore the key areas for evaluation in this study. The coding was undertaken using Atlas-ti, qualitative data management software.

Some of the findings are presented in tabular or figure format with percentages, even though the sample for this study is small (25 intervention and 15 control families). The intention is not to imply that the

findings can be generalised beyond this small sample. It rather offers some clarity about the number of participants who expressed a particular opinion, so that readers can be clear how extensive the opinion or experience was among the sampled participants. Please take note of the 'n' (number of participants who responded to a particular question / set of questions), which will assist in identifying how widely the results were spread.

### ***Analysis of children's drawings***

The children's drawings were analysed using the following theoretical approach:

Children's drawings are usually so natural and spontaneous that they are believed to provide us with 'a mirror to their minds' (Baluch, Duffy, Badami & Pereira, 2017; Hamama & Ronen, 2008) through access to their inner world of thought, feelings and emotions which they may be unable or unwilling to verbalise (Gerhardt, Keller & Rübeling, 2016). Particular interest has been focused on children's drawings that are assumed to reveal children's representations of themselves as well as relational experiences within their families (Cherney, Seiwert, Dickey & Flichtbeil, 2006). For this reason, in this study, the children in the intervention group were asked to draw a picture of themselves and their families at follow-up. In analysing the drawings, we took into consideration the following factors:

### ***Maturation***

Universal stages in human figure drawing that have been noted in all cultures demonstrate a developmental progression through the phases identified by Koppitz (1968) and Lowenfeld and Britain (1970). These stages include: the *kinaesthetic phase* (scribbling) at approximately 18 months to two years of age; followed by the *representational phase* (commonly referred to as 'tadpole man', with a large circular head and projecting arms and legs) observed at age 3 to 5 years. The *schematic phase* tends to occur at ages 5 to 7 years; and finally, the *visual realism phase* at about 10 years. Boys tend to lag behind girls in drawing skill (Crawford, Gross & Patterson, 2012). Crawford et al (2012) found that there was no relation between children's colour choices and their depiction of positive and negative events.

### ***Emotional indicators***

Koppitz (1968) emphasised that one should not rely on any *one* emotional indicator but rather on the total number, and that emotionally poorly adjusted children tend to exhibit more indicators in their human figure drawings than 'normal' children. Children's self-concept can be analysed in terms of the *size of the figures* drawn (large versus small); their *location* (in the centre or the periphery of the page); and the *strength of the mark* left by the writing implement. However, the size of the figures in drawings is contested by some authors in terms of predictive power, so relying on one indicator is inadvisable (Dunn, O'Connor & Levy, 2002). A drawing with few *erasures* is considered to indicate confidence, whereas one replete with many erasures usually shows anxiety. Figures with facial expressions provide information about the child's feelings and emotions.

Certain characteristics of human figure drawings tend to occur more frequently in drawings of children manifesting emotional problems than in children not displaying such problems, including exaggerated *size of the head or body*, and *shading* (Koppitz, 1968), as well as *short arms*, *slanting figures*, *missing body parts* (Ryan-Wenger, 1998). Other indicators of emotional problems include *objects such as a knife, gun or blood* (suggestive of aggression), *deleting important components of the body* (e.g. a hand or leg), *simplifying the head or body*, *distortion or lack of proportion* (e.g. inappropriate arm size). Further signs include *shading*, and emphasis on the *eyes and mouth*. Rates of impulsivity and emotional problem indices in children with Attention Deficit Hyperactivity Disorder (ADHD) are significantly more common than in those of the typically developing children (Haghighi, Khaterizadeh, Chalbani, Toobaei & Ghanizadeh, 2014).

### ***Exclusion of family members***

Leaving out of family members was found to be associated with adjustment problems reported by teachers and parents, especially in step-families or families where significant structural change had occurred (Dunn, O'Connor & Levy, 2002). Inclusion and proximity of figures may also be related to children's quality of attachment to these persons (Gerhardt, Keller & Rübeling, 2016).

### ***Cultural factors***

Although universal stages in the development of children's drawings have been observed across cultures (Betts, 2013), there has been acknowledgement that cultural differences could influence children's drawings. For example, children tend to *shade the faces* of persons drawn if they themselves have darker skin colours (Baluch et al, 2017), and this is clearly not a sign of emotional disturbance.

### ***Conclusion***

While children's drawings enable them to express their inner world of thoughts, feelings and relationships, they cannot be relied upon as sole indicators of their emotional and cognitive state. Moreover, one cannot rely on only one emotional indicator but rather on the total number. Age, maturation and culture also influence children's drawings. For these reasons, we considered all the aforementioned factors and triangulated children's drawings with child interviews and caregiver interviews for holistic evaluations.

#### ***4.1.6 Trustworthiness***

The research tools were pre-tested and then used in the 2016 pilot intervention programme. Some minor changes were made before data collection in this study. The depression index used, CESD-R-10, has been validated for the South African population (Baron, Davies & Lund, 2017).

Quality control took place in-field during data collection (by the field supervisor), at the transcription stage (by CSDA staff), and at the analysis stage (by the researcher analysing the data). If there was a quality concern in-field there was data-checking and re-collecting data where necessary. Transcription and translation checks led to corrections as needed. After this point, any quality concerns were discussed with the team and in a small number of cases, data were discarded where necessary.

Trustworthiness of the qualitative data analysis was enhanced through moderation of the codes assigned using correspondence checking. Townsend and De la Rey (2008) define correspondence checking as the use of additional researchers/colleagues to analyse the data. The different sets of analyses are compared to check for similarities and differences, thereby enhancing the confirmability of the data. In the present study, three individual researchers coded the data and categorised the themes that emerged. One person moderated the coding for consistency, and then all three cross-checked the themes with one another to achieve correspondence. This procedure was managed using Atlas-ti software.

A sample of quotations accompany the findings in order to give evidence for the conclusions arrived at.

#### ***4.1.7 Limitations***

The strengths of the research design lay in the use of a mixed methods approach, randomly selected participants and a control group. The weaknesses of the research centred on attrition where data went missing or it was not possible to find participants because they had re-located their shacks to another area or had changed cell phone numbers. We were also confronted with the 'attribution paradox' (Hewitt, Sims & Harris, 2012) where it was not possible to establish cause-effect relationships between the Sihleng'imizi programme and outcome measures. For example, we were not able to rule out the effects of maturation on the part of the child, or history effects i.e. events occurring at the same time as the intervention such as departure of a family member from the household. Moreover, some caregivers may have furnished socially desirable responses. In order to obviate this limitation, interviewers endeavoured to establish rapport with respondents and assure them that there were no right or wrong answers. Nevertheless, the findings provide a good indication of the trends of the changes.

#### ***4.1.8 Ethics***

This research was approved by the University of Johannesburg's Faculty of Humanities Research Ethics Committee, by the Gauteng Department of Education District Directors (Johannesburg North District and Johannesburg South District), and by each school principal. At recruitment caregivers were explicitly told that participating in the research was voluntary and would attract no negative consequences. The intervention participants were offered the air-time as an incentive to participate in the follow-up, but nothing was offered to the control group participants. Participants in both the intervention and control groups were made aware of the availability of social work services in their wards and were given contact details.

## FINDINGS FROM THE FOLLOW-UP INTERVENTION

### 5.1 PROFILE OF THE INTERVENTION FAMILIES AT FOLLOW-UP

At the time when the follow up research was conducted, nine months after the endpoint, the sample size consisted of 42 caregivers. Of the 42 participants, 27 were part of the intervention group and the remaining 15 were part of the control group. The decrease in sample size from 85 at endpoint to 42 at the point of follow up was because a smaller sample was targeted at follow-up. Most caregivers in the intervention group indicated that they were still the main caregiver of the child  $n=25$  and only 2 indicated that they were no longer the main caregiver. A noticeable change from the intervention data is that at endpoint there was no one who started receiving a grant and at least 3 people were reported to have started receiving a grant during follow up. A positive finding was that 6 people reported that someone within the family had found employment since endpoint. However, of concern was that 6 caregivers reported that something had happened to make it more difficult to cope.

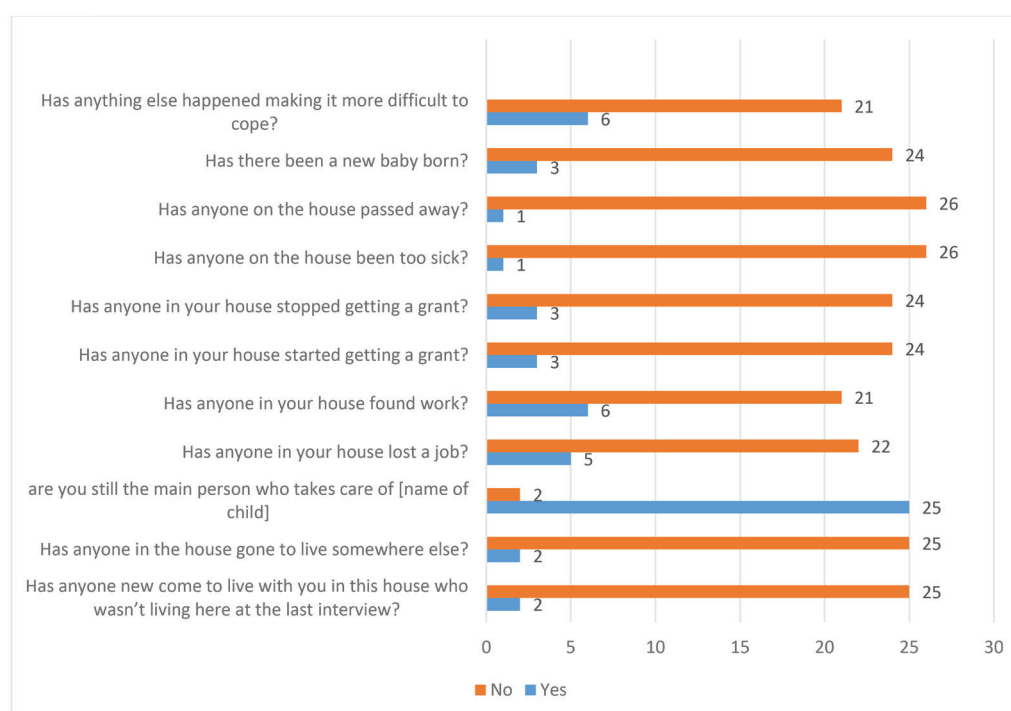


Figure 3: Changes in caregiver and household status of intervention group at follow-up (n=27)

## 5.2 FINDINGS FROM CAREGIVERS IN THE INTERVENTION GROUP AT FOLLOW-UP REGARDING THE FIVE DIMENSIONS OF THE STUDY

Findings are discussed in terms of the five dimensions underpinning the study.

### **FAMILY AND CAREGIVER RELATIONS**

#### ***Dreams for carer's/children's future***

When caregivers were asked about their dreams for themselves and their children's future, it seemed that they retained the same dreams that they had articulated at the time of the Sihleng'imizi programme. The most frequent theme articulated by nine caregivers was for their children to do well at school in order to be able to study further at university.

*"The hopes I have is that she should study and pass the level I got to, she should continue and not get stuck where I did... The dreams is that she could get to University, as I did not get to University but only went to College but I wish she can continue and not get stuck where I did".*

*"For me, firstly she should do well at school so that she can have a good future. Because I think if she doesn't do well at school there is no way she would be fine in life, so every day I wish she can do well at school so that even when we can't get involved as parents but when the child is doing well it becomes easy to get bursaries and stuff*

The second most frequent theme articulated by seven participants was a wish for employment for the caregiver and a place of their own.

*"I wish that one day I can also have..., right now for us to get our own place, and for me to find a job so that I can be able to raise the children well and be able to reach for their needs then they can be able to go to school".*

*"The dreams I have is especially a house, I want a house and if I can get an open space. The dreams I have is to be successful in life".*

*"I want to get a job so I will be able build a good future for my children. Take them to school so they will be educated, be able to go out there and be successful person"*

Three participants expressed the wish that when their children were grown up they should get employment and assist their mother.

*"I am thinking that when the child is alone, and he can see that he is grown up he should go and look for a job so that he can assist me".*

There was awareness of the need for themselves and their children to work hard to achieve their dreams.

*"As a parent I have to push my kids, you understand that they have to work hard so that their dreams can come true, even me as a parent I have to work hard for them".*

Another caregiver wanted her children to be able to talk to her if they have a problem.

*"My dream is for me and my children to; when they have a problem, they must know that I am a mother, I am a sister, I am a friend to them, do you understand?"*

#### **Communication**

The majority i.e. 22 of the caregivers emphasized the increase in positive communication with children following attendance at the Sihleng'imizi programme. They were now able to listen and talk to their children, encourage two-way communication and engage in problem solving.

*"I can listen especially when the child comes crying, I listen. If I find that it is a case that will cause a disagreement, I just encourage them, that's where it ends".*

*"It has changed a lot because at that time we didn't have it that we want to spend time together, we couldn't see who is weak where and who is strong where. But now we know that if there is a problem we can sit down, talk and solve that problem".*

*"Another change I have seen is communication with children, the thing that I am a parent and the child would come and talk to you, and wish to play with you and I am busy with pots. So, now I make sure that I do my pots early so that when he wants to play we would play during that time, then I tell him that 'baby, now mom is cooking because you have to eat'."*

*"Now I am able to talk with my children, at that time I couldn't talk with the children".*

*"It is different because we are able to talk, before some would keep quiet because they are little and not want to say anything; scared that they would be told they are disrespectful. But now they are able to say "I don't like such and such a thing," "This is wrong," things like that".*

*"We do talk a lot and he would tell me. Even when his teacher was not at school he would tell me that 'mom, we were at Ms so and so's class today; mom today we were doing 1, 2, 3; I wrote with whoever, mom I got a wrong in some but a right in others, so and so got more than me' you see, those kind of things".*

They were able to set aside quality time to spend with the children.

*"There has been a change (since Sihleng'imizi) because most of the time we didn't make time to sit down and help the children with their homework. A lot of the time I was busy, a lot of the time, but I try now to make time for the homework and if there is no homework we try to communicate and ask each other".*

*"What I think is good and what I am proud of (as a parent) is that I am able to listen to them, I am able to give them that time. Sitting them down wasn't something easy to do, I would just think that 'these ones don't listen' but I can see that they can hear and they do feel pain. So it's important to sit them down and tell them that 'life is like this' without shouting".*

*"So far what I am doing well is spending time with S".*

*"What has worked a lot for me (since the group) it's the children's things that you have to give yourself time with the children and you shouldn't always be harsh on the children. That has helped me".*

*"We do sit a lot and someone might even think that there is an older person I am sitting with, while I'm only sitting with them in here".*

When children had done something wrong, they were able to reprimand them without shouting at them or hitting them.

*(Previously I would shout) "But now I am able to sit down and talk to them well. When he did something wrong, I would give him 5 minutes to calm down, give him his corner to sit there"*

*(These changes) "They are positive. Because you don't need to hit the child, when you are able to talk to them so that they can be fine then there is no need to hit him.*

*"We are able to sit down and talk when we have problems, yeah. And then..., yeah and disciplining children, and reminding myself that 'let me not hit him, let me speak to him'... I am able to lower my voice when I talk to her because I used to be very loud, yes there are some days when I am loud but I can be able to lower my voice when I talk to her... They taught me to lower my tone when I talk to the child so that she can understand more because when you always shout at her, that's when she would do even more bad things."*

*"I used to beat them a lot. So, I was taught that corporal punishment is illegal and it makes them to be very stubborn. Now I just communicate with them, I try to be calm even if I am angry with them because sometimes, they can push you to the edge. And then I control myself".*

Caregivers reported a reduction in the use of vulgar language and swearing.

*"It has changed because I no longer use the tough words for children. I use proper words that are respectful".*

*"In the beginning..., when you are reprimanding the child you can't say 'hey you, sies...' and things like that, you talk to him well. Because if you say 'hey you Voetsek' and things like that, the following day he*

*would say the same and you would say 'where do you get those words?' he would be taking them from you when you are shouting at him".*

*"The vulgarity I had is not there anymore, it's not there".*

Caregivers felt that there had been an improvement in family communication.

*"As a family it's positive for us that on this time we have to do this and that, and we communicate and there isn't that one is older and the other is younger. When something is wrong, it's just wrong and we are able to communicate there. We are able to spend quality time as a family".*

*"Since the group ended, as a group of buddies and as a family we are able to share and there are no secrets. We are able to share information with each other.*

They were also able to teach their children to delay gratification of their needs.

*"I would talk to him, the older one maybe sometimes he would say 'I want this and that tekkie' and maybe he would say by month end. So I once sat down with them and explained to the older one the situation, I that this and that. That you shouldn't see other children wearing that tekkie, their parents are working well. They work in the mines and they get about 15 to 18 000 per month. Then I would say maybe month end we should lay-bye it, maybe it's a R1000 and maybe we should lay-bye it for 3 months and pay for it bit by bit. Then in 3 months' time he can get it, and he understands. Or sometimes he would say 'no I don't want it now, I want it in December'. Then I would say show me the tekkie you are looking for or maybe take a picture for me and I would see what to do, but at this time I promise that you would have it. They know that they won't just get it now, they would only get it) when I have buying powers in my account, and not for no reasons".*

### **Family rules**

Some caregivers reported that they continued to maintain rules and routines that existed even prior to Sihleng'imizi.

*"Home rules since I met you, there is nothing I have changed. I have realised that the way we have spoken..., I am still continuing with it, I don't let the child go without me knowing where he is. When the sun sets all children should be in the yard. When we eat supper we are together, not that we eat while one is not here and we don't know where he is".*

*"I tell them that they should go and play, but by 05:30 or 6 o'clock because they usually play inside the flat. They know that they would come back home, they would eat and maybe watch that 1 story we would be watching on TV, then she would go sleep because tomorrow it's a school day".*

*"They (the rules) were already there. They know that we take turns with cleaning, whoever has not cooked must wash the dishes, things like that. And then whoever has done the washing, they will not do the ironing; the person who has not done the washing will iron. It has been like this for a long time".*

*"There are those rules we have always had, such as that they should not use the knives, they don't prepare food for themselves until a certain age, yeah. And what else? The way one talks to the other".*

Other caregivers described how they had implemented rules and routines since attending the Sihleng'imizi programme.

*"Since the group has come to an end they would wash the dishes, when they come back from school they would do their home works, one would go to the library and study, when she comes back from the library she would change her uniform. When there is food, because they come back from school hungry, they would make some bread when there is bread and eat with a juice.*

*"The changes that are there is that she also knows when she comes back from school that she has to change uniform and where to put it. And when she has a homework she is able to take it out and say 'mom I have a homework' and I help her there and there; even in the evening before she sleeps she would say 'mom help me polish my shoes' and things like that".*

*"It's a huge change because now the children know that if it's time to come back home they have to be home. And we also get home during that time, as older people we know that if we said it's 6 we also know that at 6 we have to be home".*

*"Before the group the children would go and come back at night, they would go out and play at 7 and even when we didn't know where they are we didn't have a problem because we would just think that they are just around. But now since we attended the group we know that at 6 the child has to be home, the child shouldn't be outside at night and before we sleep the child should know that dishes are washed. We would sometimes sleep without having washed the dishes; there has been a huge change with the children and myself".*

At follow-up it was easier to communicate with children when they had broken a rule or done something wrong.

*"I would tell them that 'I wanted to buy you something, I wanted to take you out but I won't take you out anymore because it seems like you don't listen'".*

*"I am more encouraged as a parent and sometimes when I was angry I would take out my anger on the children, I would hit her. But now I don't hit the child anymore, I would just talk to her and when I see that maybe I am angry, I would rather deny her something and say 'I know that you won't get this'".*

### **Monitoring child behaviour**

Caregivers were aware of their children's whereabouts.

*"They play inside the yard with other children, so they are not children who go out. Unless because there is another child who lives over here, and when they want to go and play over there the old man in there would say 'can they please come and play with him because he is lonely'. Then he would open the gate for them, and he would say that 'I will look after them when they are here so that you won't say they would be stolen'. Then they would go out to the other child over there... For me even the one who is at crèche, when I am not here I would tell his brother, 'can you please fetch him at 5' because when he comes back from school he has to eat, wash his shirt, he would go out with A to his soccer because I told him not to leave him alone".*

*"I want to know where he is. I don't just leave him without knowing where he is".*

*"She is safe there. There is a child who is her age, a girl. And the mother, there are two women living there and the father if he didn't go to work, but she is safe there. We know that there are some doors where we don't want the children to go, and they don't go there".*

Caregivers indicated that they monitored their children at home.

*"When they come back from school he would get home first and there is this other lady outside here then she would stay with him, then until his brother who is at high school comes back and makes some food for him then they eat".*

*"They play next to home".*

*"They don't always go and play outside. Yesterday we were playing with them here; we were playing soccer and stuff. Sometimes they would go out to play and come back, but the latest is 05:30 to 6.*

*"Like after school when I go there, the time I used to walk her the child wouldn't walk out of the school alone. Last time I found that she went out and didn't even know where she was, and I found her far. So I think it would be better if the children's safety should come first".*

### **Parenting and discipline**

Caregivers reported using positive parenting in the form of praising children for doing something good.

*"When he did something good I would thank him, and my children also love their cultural praises and being called with their cultural praises, when you say 'thank you' they become happy... It's easy (to praise children) and it makes them motivated. Even when you say 'polish your school shoes' then you say 'yeah, good boy' then he becomes happy, he has that thing".*

They showed love and encouragement.

*"If he is struggling, I think even showing the child some love. That's one of the main things that encourages him at school".*

*"I can listen especially when the child comes crying, I listen. If I find that it is a case that will cause a disagreement, I just encourage them, that's where it ends".*

*"Just being a parent who loves her children, I think that's important, to show love to your children. You can have something or have nothing but when you love your children, I think that's one important thing. I think love comes first, as a parent you shouldn't take the problems you have to the children because the children would end up not feeling loved at home".*

Rewards were given as a form of positive reinforcement.

*"Sometimes you would say 'when I have money' or maybe when I see that I have some money, because I am someone who would buy them something and hide it to them.*

*"She would come back and say 'Mom, you see I am in the top 10 again, what will I get?' So I think it's encouraging her that 'you will get this' and I think it has helped her a lot".*

Caregivers found it easier to discipline children through talking rather than shouting.

*"It's easier (to talk to the child), it's easier than shouting because when you are always shouting the child would always be scared and not even know whether they are doing something right or wrong".*

Since attending Sihleng'imizi, caregivers were better able to make children aware of wrongdoing. They were now able to talk to their children, explain how to do something, control their anger and avoid shouting.

*"I tell him immediately that 'I don't like what you did' before he forgets because children forget".*

*"When they do something I am able to talk to them on how to do this and that, and when they make a mistake I am able to talk to them. When I also make a mistake, they can also talk to me that 'mom, I don't like what you did'."*

*"Sometimes I get stressed, since I started going there, they have shown me how, when my children have wronged me, to communicate to them so that I don't get angry; how to be able to control my anger, so now I can talk with them politely*

*"What I can say I am doing well with is that I am a good parent, but I have learned to talk to her. We were not talking that much".*

*(If a child does something wrong)" I tell him immediately that 'I don't like what you did' before he forgets because children forget"*

### **Harsh parenting reduced**

Caregivers reported that they had learnt about "the naughty corner" from attending the Sihleng'imizi programme and found this approach to disciplining children very useful.

*"That has helped me a lot, even when the child does something wrong you always raised your voice because the child would always be scared. So, that's one thing they were telling us that you should give him the corner so that he can stay there as a punishment, so that he can know that I did this".*

*"I would use the punishment from Sihleng'imizi that they should sit on the chair, they should stand on one foot, they would sit on the chair and sleep on the chair".*

*"I would shout, but now I am able to sit down and talk to them well. When he did something wrong I would give him 5 minutes to calm down, give him his corner to sit there".*

They withheld rewards for negative behaviour.

*"I punish him and say 'you won't get this', so when someone says 'mom can I please have a juice' then I say 'no you can't have a juice because you did 1, 2, 3'"*

*"They like money, so I will say, "I will not give you so much, I won't give you money." They can see then, that they have made a mistake2.*

Caregivers had either stopped or reduced the use of corporal punishment.

*"I would shout and sometimes you would find that I am swearing at them, but now I don't care. When there is something they know that I punish them, I would say 'I will punish you' and they would become afraid of that. But a way of talking has changed, even beating them is only once in a while where I would beat them, but after that I would feel that you know what..., I don't beat them as before.*

*"I used to hit them but not anymore, no"*

*"I don't hit them physically anymore. I just speak verbally".*

(The biggest change since the group) *"It's that you should not be physical with the child and hit them. That when the child has done something wrong you should just punish him or talk to him".*

*"Before Sihleng'imizi we didn't know how to discipline the child, we would just leave him or beat him if you are someone who beats a child. So, since we attended Sihleng'imizi you are able to discipline the child without being physical".*

*"I am more encouraged as a parent and sometimes when I was angry I would take out my anger on the children, I would hit her. But now I don't hit the child anymore, I would just talk to her and when I see that maybe I am angry, I would rather deny her something and say 'I know that you won't get this'... It's a good change, it's a good change and it helped us that we should be patient with the children. We shouldn't take out our anger to the children, it was a good change. Because I used to hit the children a lot, and they know that".*

*"I used to beat them a lot. So I was taught that corporal punishment is illegal and it makes them to be very stubborn. Now I just communicate with them, I try to be calm even if I am angry with them because sometimes they can push you to the edge. And then I control myself".*

*"... It's better because last year, I was a person who was short tempered. I would always use physical (punishment) with the child, when they were being naughty, I would give them a hiding. But now I'm better and my family here at home, they are much better, they come in on time.*

Caregivers explained that they were now able to control their anger and not resort to shouting.

*"You see me, I am someone who shouts, I shout. But now I would just be quiet and not say anything, and he would even come back and say 'mom, I am sorry, are you angry?' and I say 'no, I am angry'. Or maybe when one of them see me quiet they would ask for something and I would keep quiet, because I want to give them that punishment".*

*"The changes is that when I talk to him before, when he was naughty I would shout at him, I never liked beating him because he is the only boy and I love him more than the others; not that I am talking behind them. But for him, I made sure that I shout at him but after I have attended this, I don't do that. I just talk to him well and he understands".*

*"Now when I talk, I don't shout anymore, I speak well to her so that she can hear what I am saying".*

*"Sometimes I get stressed, since I started going there, they have shown me how, when my children have wronged me, to communicate to them so that I don't get angry; how to be able to control my anger, so now I can talk with them politely".*

*"I am able to lower my voice when I talk to her because I used to be very loud, yes there are some days when I am loud but I can be able to lower my voice when I talk to her".*

*"They taught me to lower my tone when I talk to the child so that she can understand more because when you always shout at her, that's when she would do even more bad things".*

*"Like I said before, I used to shout and be harsh, but now I am able to sit down with her and talk to her well, without fighting.*

### Perceptions of own caregiving

Caregivers had developed positive attitudes toward being a parent.

*"I am happy about being a parent and being able to raise my own children, as I said that as I am with them I wish that they can have that mother's love from me as a parent. I should not take my children and dump them at some place and they get to see me sometimes, so I should share what I have with them".*

*"I cannot say I find it difficult because for me, being a parent I think it's out of choice because I have planned my kids, you understand? I am the one who brought them to this world, so I cannot say my kids are giving me some difficulty, no. Even though kids are just kids and they would make you exhausted sometimes but it's nothing that would make me feel like 'yoh, I am tired and I don't want to deal with these kids' you see".*

When asked what they do well as a parent, they explained that they show love to their children, make sure that they have everything they need for school, motivate them with their schoolwork, are able to take care of them and are interested in their daily lives.

*"Just being a parent who loves her children, I think that's important, to show love to your children. You can have something or have nothing but when you love your children, I think that's one important thing. I think love comes first a parent, you shouldn't take the problems you have to the children because the children would end up not feeling loved at home".*

*"It's for me to motivate them at school, they shouldn't skip school and they should do their home works the way they are supposed to".*

*"I can be there for them... I am a good parent to my children, I am able to take care of them".*

*"I think it's giving the child attention a lot, I think that one..., knowing that I spend time with her, checking that her school work is fine every day, asking her what they did at school, what they said and all that".*

Participants were asked to reflect on their caregiving relations with their children.

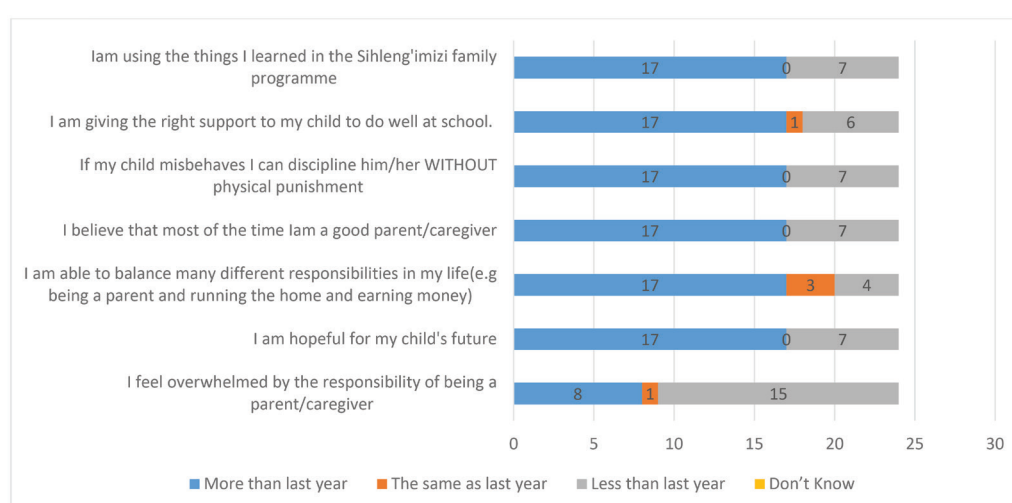


Figure 4: How do you feel now compared to how you felt before Sihleng'imizi? (n=24)

Figure 4 presents data on how participants in the intervention group felt during follow-up as compared to how they felt at endpoint. Of the entire sample who answered these questions (n=24), the majority of the caregivers (n=17) reported that they had been using what they had learned in the Sihleng'imizi programme. They were more able to discipline their child without resorting to physical punishment. They felt more confident about their parenting abilities; they were better able to balance the different responsibilities in their life; and were more hopeful of their child's future. The fact that 7 caregivers felt less hopeful of their child's future may be attributable to the fact that despite the programme, they were still living in

deprived conditions. Of concern was that 7 caregivers felt less able than at endpoint to discipline their children without physical punishment. This finding suggests that for these caregivers the use of physical punishment remains deeply rooted in their socialization processes. In addition although a majority (n=15) felt less overwhelmed by the responsibility of being a parent/caregiver than at endpoint, a sizeable number of caregivers (n=8) felt more overwhelmed. This finding needs to be viewed in conjunction with the findings from the Depression Index, which showed an increase in the number of persons identified as depressed at follow-up and could again be related to their deprived living conditions.

## CAREGIVER INVOLVEMENT IN CHILD'S EDUCATION

### Child functioning at school

Caregivers reported that their children enjoyed going to school.

*"He does enjoy and the way I see that is because he also knows the date, which is something I don't even notice... He has a Calendar in his bag and he said 'the 18th is on a Tuesday and my social workers would come'; he is performing well".*

*"He didn't like school but now he has improved, he likes school and he cries even when he is sick and say 'Mom I am going to fail, can I please go to school'.*

*"Yeah, he does enjoy now he's not the same as last year".*

*"In the beginning he would cry in the morning when he had to go to school, but now he is the one waking up first. Even in the afternoon he would say 'I am bathing now, I don't want to struggle bathing tomorrow. I just want to wake-up and dress-up then go to school'."*

Children were actively engaged in schoolwork.

*"Even with his studies, he is more active in doing home works. Even when they say he should do something at school, he has the energy for that because last time there were some donations they needed at school and he kept on asking that 'mom, I need some donation'. And luckily because he is someone who is loved by people".*

*"So far, she is not a child that I can be worried about because she learns, even when you check her books, you can see that she is learning".*

There had been an improvement in schoolwork.

*"What I have seen is that when I check him books, they are better than before. Even the teacher is saying that he's not the same as last year, he is repeating a grade".*

*"There are changes, he has improved a lot".*

*"What I have seen is that when I check him books, they are better than before. Even the teacher is saying that he's not the same as last year, he is repeating a grade".*

Children's behaviour at school had improved.

*"My child was naughty and I was called to school every now and then, even when I go to the school. Now, when there is a meeting and I talk to his teacher he is praising him in things he does" (Nonhlanhla Mhlongo caregiver child Andiswa)*

One child presented with emotional problems.

*"The teacher I spoke to last time and her previous teacher said that she thinks he has depression or there is something he is missing, so she said we should focus on her and there should be someone to talk to her on the side".*

### Caregiver engagement in education

Caregivers indicated that since Sihleng'imizi they were more engaged with their children's school.

*"Before I used to go when they would tell us to come and see the children's books, but now I go and see them, especially N's teacher, because he is still young. I don't understand if there may be some things*

*that he doesn't understand, so I do go to find out, because even the pencils we take to school. I go to ask if he is still alright, does he have all his things.*

They checked their children's books on a daily basis to see whether there was homework that needed to be done or a message from the teacher.

*"When the teacher wants to say something she would write on it, and I would write on it as well. Sometimes when they have an event coming up at school, so now their teacher said they are also teaching them to write on the diary that 'on this day' than having to always issue letters. So, you check on the diary that 'on this day', just like when there are some services they are doing at school, they are writing".*

*"When he has written the homework I would sign when he has done writing, then I would check if what he has written is correct or not".*

*"In the homework book there is where they say 'parent sign' but sometimes they don't write the one that says 'parent sign' and I would just help him with the homework without signing. Sometimes he would come with a book and say his teacher said they should do '4 pages' and find that there is nowhere it says I must sign, but I also have his teacher's number and I would sometimes call her or contact her on WhatsApp and things like that".*

*"What I do is that I make sure that I check her books and I make sure that I know what topics they are doing for this term or this week so that I can help her wherever I can".*

One caregiver encouraged her children to read books.

*"I give them a book every day, sometimes I buy them books so that I know that he can read. So, if he can't then I would show him that 'this is this, this is this, this is not this'"*

Others arranged for the child to receive assistance with school subjects.

*"Sometimes when it comes to Mathematics because my child loves Mathematics, especially T. ...And I even bought them the Mathematics chart so that they can practice every day".*

*"Like last time when they were writing the school, I asked if they are done writing and if he can go back or not, then she would say 'no we are doing practicals, he can come to me'. And I would ask her 'which ones are practicals, can I help him?' and she said 'yes you can help him, I will give this and that book and he will bring it'. Then he would tell me that 'it's this and that page', he would tell me".*

*"I registered him at a Saturday school and they are teaching them Maths and English, and it's reasonable for me. I can see that I will afford it, it's R100".*

*"I spoke with the teacher and she told me that he has to practice. He has joined English reading classes after school, so he told me that 'Mom today I went to a reading class' and that's good because he also improves his English. Even though it's a local school but they are also trying at school to improve English, even myself I talk to him. I would give him a magazine or a book then he would read, then if he doesn't understand a word from the Magazine or a book he would ask me and I would tell him".*

Caregivers helped their children with homework.

*"What I help him with his homework".*

*(Before Sihleng'imizi) "I was not able to go to the teacher and talk to the child about his problems, even the home works sometimes I would say 'hay, I am tired' but now I am able to assist him in reading and also ask 'what were you doing at school today? Like last night he was reading, he said 'Mom we are writing exams, please help me read'. I was tired but I had the time to do it".*

*"There has been a change (since Sihleng'imizi) because most of the time we didn't make time to sit down and help the children with their homework. A lot of the time I was busy, but I try now to make time for the homework and if there is no homework we try to communicate and ask each other"*

*"I help her with homework every day, I ask her and we have some charts we would use to count because she would come with some papers. She would tell me and count for me, and write for me".*

*"When she comes back to school we have to do the homework together, and I also open her books because sometimes they would say they don't have a homework while they have it".*

When caregivers were unable to assist their children with homework, they asked others for help.

*"I have tried that he attends on weekends, but the eldest one, N, but only to find that he's very lazy, I tried to get few of his class mates and I managed get them to help him during the homework time and even over the weekends, they work together".*

*"Because I don't know seSotho, I have found them someone to help them with their Sotho. They help them with their homework, as well...A lot of the time I am at the pots, I ask my sister, "There is such and such a homework, may you please help them," and she helps them. And the person who helps them with seSotho, they help them with everything... yes. When I have money, I give them a little, and when I don't have money, it is still okay they understand... because they do it with love... We found a school that she attends after school, because sometimes what children are like; you can teach them as a parent and nothing will stick, the child better understands a person on the street".*

*"I would say 'my baby, please sit down with your sister because she is ahead with school as she is doing Grade 7'. She would sit with him then she would teach him and help him study, writing and things like that.*

*"We read, and in some parts his sisters know more than me, so I would ask them to assist him".*

Following on what they had learned at Sihleng'imizi, they asked about child's day at school.

*"At Sihleng'imizi they taught us about one-on-one every day. That it's very important to know what happened during the course of the day while the child was at school, by so doing you get to understand more regarding the performance at school and the duties".*

*"Every time when she comes back from school I would ask her 'what did you do today?' and she would say 'we wrote this and that' if they have written or they have read something".*

*"I ask were you good at school? Sometimes he would say, "no". Or, he would come back and say, "they beaten me", or he would say, "I feel pains. Some other days he would say, "I am right".*

*"I think it's giving the child attention a lot...I spend time with her, checking that her school work is fine every day, asking her what they did at school, what they said and all that".*

Since attending Sihleng'imizi, the caregivers had developed confidence to speak to the child's teacher.

*"I am also able to ask his teacher 'why is the child dropping here? We can work together (with the teacher) for me to also encourage the child, so that when there are problems I can also be able to encourage the child and ask 'O what happened' or I can also go to the teacher and ask 'teacher, what's happening here because here O is performing bad but here he is performing well, what's the problem?' maybe it's spelling, writing or reading, you see?"*

*"We have a good relationship because she is able to explain to me about the child at school and I am able to explain about the child at home, when I see that I have problems at home with the child I am able to go and tell her that 'teacher, he is doing this at home, what's happening with him at school?'...I was afraid (to go to the teacher last year) because sometimes the teachers like said words that are not good, so now I am able to go to her".*

*"Before I loved that I be part of what my child is doing, but it was added more to that, as a parent, not that when you send a child to school, only the teacher must see. I used to look first oh my child, now that he is in grade two, is he able to read and those kinds of things. So now after Sihleng'imizi, we learnt that you should not wait until maybe you see the child passes well, you should meet with the teacher and discuss".*

*"Before I used to go once a quarter, so now I go sometimes when I see there may be somewhere where he is lacking. I don't understand if there may be some things that he doesn't understand, so I do go to find out, because even the pencils we take to school. I go to ask if he is still alright, does he have all his things... I do ask that when a child is this age, what is it that they have to know, or in their syllabus as a child who is*

*in grade two. What is it that they should know by now? So the teacher is able to explain to us, like now the way that they are learning it is no longer the same as when we were taught. I find that I ask, "So now that you say the child must do this, and they can't read, what must we then do, because obviously they can't." And she said, "You have to read for him," so things like that. Because things are no longer the same".*

*"(Before Sihleng'imizi) I never saw the importance of it (going to see the teacher); I thought they were going to tell us when there was a problem. I was waiting for them to call me".*

*"At the group (I learned) that as a parent sometimes you have to go and ask the teacher how your child is doing".*

## **SOCIAL AND COMMUNITY CONNECTEDNESS**

### **Social networks sustained and strengthened**

Since Sihleng'imizi, they had maintained contact with other group members on a WhatsApp group.

*"One of them, we do contact each other on WhatsApp".*

*"We have a WhatsApp group we are able to communicate using the WhatsApp group. Maybe twice a week".*

They also kept contact with group members through phone calls or met when fetching their children from school.

*"Most of the time (we contact) through the phone, someone I would meet H's mom as we would mostly meet when I fetch my child and when she also fetches her child".*

*"Most of the time we meet because in the morning we would have accompanied".*

Involvement in Sihleng'imizi had expanded their networks and strengthened bonds with other participants.

*"I have known them for a while, but we became close at the group".*

*"You are now communicating with a lot of people... and its people I didn't know before".*

*"Since the group ended, as a group of buddies and as a family we are able to share and there are no secrets. We are able to share information with each other".*

*"I think it's friendship (that the group added to my life) because it was people I didn't know, we started meeting there but I think even the fact that always when we meet we talk about children that 'mine is fine, she has picked up' and you would tell the other that 'I did this and that with mine, try it' because what we have learned is that children are not the same, so maybe the way you will discipline them won't be the same".*

The buddy system had helped participants to communicate with and assist one another, particularly with regard to parenting their children.

*"What (the buddies have added to my life) is for me to have a communication with them so that we can be able to help the children because as parents we are not the same. One would say 'I do this with mine' and the other on would say 'I do this with mine'... An example I can say sometimes as I come back late from school, if they are writing N's mom is able to go to the class and because S is also used to them they can also be able to assist her with the homework if they are busy writing. They are able to spend time with her as I won't be there".*

*"We used to play games because even at the group there were some neighbours, people who live near to me. So now it's better because we can talk to each other, which we didn't do before... Yes, we were playing some games which taught us to talk to those people".*

*"We were helping each other, you would find that when they gave us the home works then somewhere somehow I don't understand then I would send her a WhatsApp, the one I have her contacts so that they can explain to me in my language so that I can understand".*

*"Now we talk and advise each other, one would say that 'so and so doesn't want to write' and we would advise each other that 'with mine I do this and that so that she can write her home works'".*

*"Since the group ended, as a group of buddies and as a family we are able to share and there are no secrets. We are able to share information with each other."*

## **FINANCIAL CAPABILITIES**

### **Budgeting and saving behaviour**

Since attending Sihleng'imizi, participants had learnt the value of budgeting and were able to implement this practice in their lives.

*"There are changes because now we have a lot of information we didn't have about how to budget and things like that. So, we are able to sit down now and on how things are going this month, and this thing made the family to be close because we are also able to talk".*

*"I budget now (since Sihleng'imizi), you understand? And I want to invest for my kids because from this year until last year I have seen that I have been playing with money".*

*"It (Sihleng'imizi) has assisted a lot because when you know that you have this much money this month, then you have to know that I will use this money on this and that, I will save that".*

They were also now able to save despite having meagre sources of income.

*"I am saving in the tin, even when I came back from selling I put it there".*

*"I am saving, for instance now the older one is doing Matric. We were supposed to save for Matric Dance and we have started saving...These younger ones now are able to save, now there will be Heritage and they are able to save R2 and R1 for Heritage...It (Sihleng'imizi) helped me not to overspend unnecessarily, spending on things that I really need".*

*"I opened some accounts, so I do save, even if it is not every month, because I do jump now, but a lot of it I have used and we each had a can... where they would throw in. So the little ones still carry on and you find me, it becomes hard because I have to give them as well, with mine it has been a while since I have thrown anything in it...It (Sihleng'imizi) has helped us a lot, it helped me in actual fact because you are able to buy something that is; I used to buy something when it was already finished, now I am able to buy things in big quantities and not small quantities that will not last the whole month. I now buy big things, things like sugar and mealie meal".*

*"They gave us light with that (the talk on budgeting), things we didn't know. Because we were used to when the money comes, we use all of it at once, you even forget that there might be something big coming and which you have to do it, like it or not. We learned that you save money and I found that with my children, when they have money, they are able to take a two litre bottle save and say, "This I am putting away".*

*"So, now because I am not working I can see that money has been a little bit uptight. So, I am trying to save every little cent and I am no longer playing with money like before (Sihleng'imizi)".*

*"There is a lot I have learned from you, that when I am saving money I must not keep it here at home because when it happens that the house burns then the money will also burn but it will be safe at the bank".*

*"There is a lot. (that has changed since Sihleng'imizi) ...I used to buy Blue Ribbon bread, but with the one I buy now when I have R10 there would be a change. So I would take that change and put it inside a money box, and when I am very broke I would open there and you would find that I have over R60 with the 60 cents".*

Others had tried to save money by joining a stokvel.

*"We have decided to join there and become the stokvel women".*

*"I have a burial society and I have another society we used to buy grocery and split in December but now we are saving money which we will split in December".*

### ***Differentiating between wants, needs and obligations***

As a result of attending the Sihleng'imizi programme, they were now able to distinguish between wants, needs and obligations and were thereby able to delay gratification of things that were not necessary.

*"There are some things you can see that you don't have money but you wish for, but when you look at it at the end of the day you can see that it doesn't have that much work, it's not as important. So, now I make sure that in all what I am thinking of doing, I should first look at the needs and I will see the rest when I have some money left".*

*"You know, when I know that it's month end I should write down things that I know that we need at home. Things we really need at home, I should write a list that I should do 1, 2, and 3. Even if I can leave out this one, but I would do it later when I have some money left".*

*"(The programme has helped) so that you can know the difference in things you need and just things. So that you know that 'I need these and I must have them' and these other ones..., maybe just being used that every Friday we do this, not that it's a must but it's just being used to it...knowing that 'this one I need it and this one is just want...'...I believe that when you don't have something then you don't have it, you have to wait".*

### ***Spending money wisely and being aware of the consequences of borrowing money***

Caregivers reported that as a result of attending Sihleng'imizi, they had learned to spend money wisely and had become aware of the negative consequences of borrowing money.

*"The only thing I can see that has helped, what I have added is that at least when you buy things you should go when there are specials. It doesn't matter whether you will enter up to five shops but as long as you will buy things when they are less, you can't just buy because you see the things you need. Even if maybe you buy two items in Pick'n Pay then continue to buy three more at Checkers".*

*"Yes, now I am able to take care of money. I was someone who loved nice things, you see? But after I went for this session she taught me and I also realised that it's important to do thing you need, don't do because you see money or you see the food. Do enough and in a good way, and now I am able to".*

*"I think through balancing my finances and be well balanced with them... not be envious of big things and then be able to manage my money well and then I think I will be able to manage a good future".*

*"I don't borrow money now I don't want to lie. I don't mean I have it but I don't borrow, as I said that I have planned with the father that 'when you do 1, I will do 2 with what I get'. So, when I know that there is money to be able to go to work during that day when they have called me then I would know that I have that spare R50, waiting for anyone who might call me and say 'come to work on this day'. I can't go out to my neighbours to borrow money, and money for bread for the children. I make sure that there is money for bread for the children".*

## **CAREGIVER AND FAMILY KNOWLEDGE OF NUTRITION**

### ***The most important meal of the day***

Caregivers seemed to have a basic understanding of the importance of breakfast as reflected in the following quotes:

*"Because it give you power and energy throughout the day".*

*"Because it gives you energy and power to start a day because without breakfast your day will be a complete mess"*

*"So that you can start your day with a full stomach"*

*"If they don't eat breakfast they won't concentrate at school"*

### Elements of a balanced meal

The majority of caregivers understood the main elements of a balanced meal. For example:

*"It consists of vitamins, carbohydrates and proteins".*

*"Vegetables, starch and meat".*

*"Nutritious proteins and fruits and vegetables. It also consist of dairy products"*

*"Proteins with vegetables and starch".*

*"Vegetables, proteins, dairy products and starches".*

*"Vitamins, proteins, fibre".*

*"Food with protein, vitamin C, carbohydrates, starch and iron".*

*"It consists vegetables, meat, porridge and fruits".*

Others did not seem to understand the elements of a balanced meal as illustrated in the following responses:

*"A balanced meal consists of fruits and cereal or mealie pap".*

*"Maize meal and samp as well as mageu".*

*"Is supposed to be mixed and consist of fruits and vegetables"*

When asked about the main method of cooking, the most frequent response was boiling food.

### Food choices

When participants were asked to rate the importance of their food choices in terms of six dimensions, it seemed that healthy lifestyle, type/taste, nutritional value and cost were regarded as the most important considerations with brand and time/convenience being considered less important.

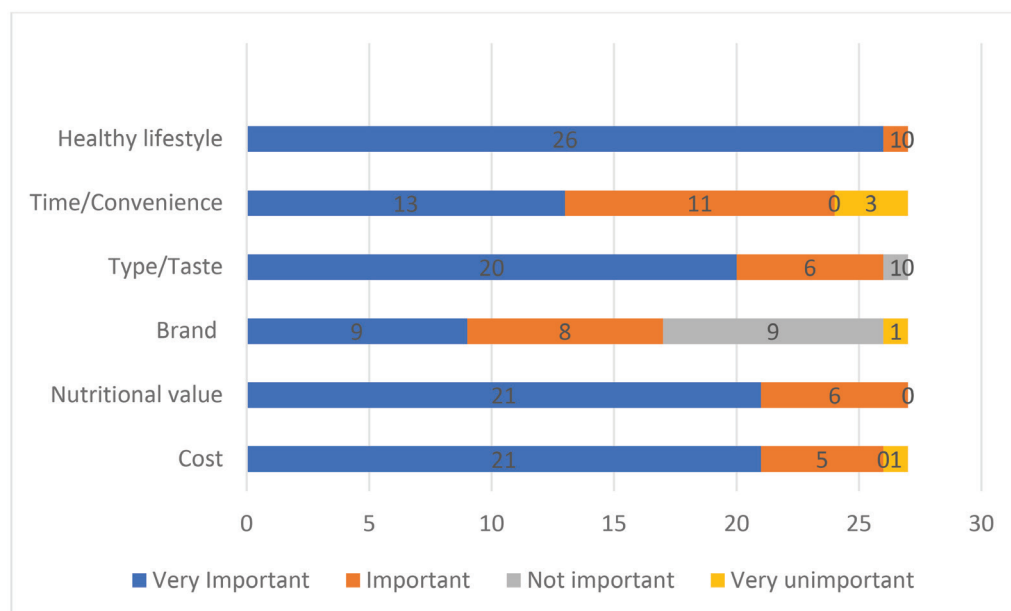


Figure 6: How important are your food choices according to: healthy lifestyle, time/convenience, type/taste, brand, nutritional value and cost (Intervention group n=27)

## 5.3 SUMMARY OF FINDINGS FROM CAREGIVERS IN THE INTERVENTION GROUP IN RESPECT OF THE FIVE DIMENSIONS OF THE STUDY

### 5.3.1 *Family and caregiver relations*

When caregivers were asked about their dreams for themselves and their children's future, it seemed that they retained the same dreams that they had articulated at the time of the Sihleng'imizi programme. The most frequent theme articulated by nine caregivers was for their children to do well at school in order to be able to study further at university. The second most frequent theme articulated by seven participants was a wish for employment for the caregiver and a place of their own. Three participants expressed the wish that when their children were grown-up they should get employment and assist their mother. There was awareness of the need for themselves and their children to work hard to achieve their dreams. Another caregiver wanted her children to be able to talk to her if they have a problem. The majority i.e. 22 of the caregivers emphasized the increase in positive communication with children following attendance at the Sihleng'imizi programme. They were now able to listen and talk to their children, encourage two-way communication and engage in problem solving. They were able to set aside quality time to spend with the children. When children had done something wrong, they were able to reprimand them without shouting at them or hitting them. Caregivers reported a reduction in the use of vulgar language and swearing. Caregivers felt that there had been an improvement in family communication. They were also able to teach their children to delay gratification of their needs.

Caregivers reported using positive parenting in the form of praising children for doing something good. They showed love and encouragement. Rewards were given as a form of positive reinforcement. Caregivers found it easier to discipline children through talking rather than shouting. Since attending Sihleng'imizi, caregivers were better able to make children aware of wrongdoing. They were now able to talk to their children, explain how to do something, control their anger and avoid shouting. Caregivers reported that they had learnt about "the naughty corner" from attending the Sihleng'imizi programme and found this approach to disciplining children very useful. They withheld rewards for negative behaviour. Caregivers had either stopped or reduced the use of corporal punishment. Caregivers explained that they were now able to control their anger and not resort to shouting. Some caregivers reported that they continued to maintain rules and routines that existed even prior to Sihleng'imizi. Other caregivers described how they had implemented rules and routines since attending the Sihleng'imizi programme. At follow-up it was easier to communicate with children when they had broken a rule or done something wrong. Caregivers indicated that they monitored their children at home and were aware of their children's whereabouts. Caregivers had developed positive attitudes toward being a parent. When asked what they do well as a parent, they explained that they show love to their children, make sure that they have everything they need for school, motivate them with their schoolwork, are able to take care of them and are interested in their daily lives.

### 5.3.2 *Caregiver involvement in child's education*

Caregivers reported that their children enjoyed going to school. Children were actively engaged in schoolwork. There had been an improvement in schoolwork. Children's behaviour at school had improved. One child presented with emotional problems. Caregivers indicated that since Sihleng'imizi they were more engaged with their children's school. They checked their children's books on a daily basis to see whether there was homework that needed to be done or a message from the teacher. One caregiver encouraged his children to read books. Others arranged for the child to receive assistance with school subjects. Caregivers helped their children with homework. When caregivers were unable to assist their children with homework, they asked others for help. Following on what they had learned at Sihleng'imizi, they asked about child's day at school. Since attending Sihleng'imizi, the caregivers had developed confidence to speak to the child's teacher.

### 5.3.3 Social and community connectedness

Since Sihleng'imizi, they had maintained contact with other group members on a WhatsApp group. They also kept contact with group members through phone calls or met when fetching their children from school. Involvement in Sihleng'imizi had expanded their networks and strengthened bonds with other participants. The buddy system had helped participants to communicate with and assist one another, particularly with regard to parenting their children.

### 5.3.4 Financial capabilities

Since attending Sihleng'imizi, participants had learnt the value of budgeting and were able to implement this practice in their lives. They were also now able to save despite having meagre sources of income. Others had tried to save money by joining a stokvel. As a result of attending the Sihleng'imizi programme, they were now able to distinguish between wants, needs and obligations and were thereby able to delay gratification of things that were not necessary. Caregivers reported that as a result of attending Sihleng'imizi, they had learned to spend money wisely and had become aware of the negative consequences of borrowing money.

### 5.3.5 Nutritional knowledge

Caregivers seemed to have a basic understanding of the importance of breakfast. While the majority of caregivers understood the main elements of a balanced meal, others did not seem to have this knowledge. When asked about the main method of cooking, the most frequent response was boiling food. When participants were asked to rate the importance of their food choices in terms of six dimensions, it seemed that healthy lifestyle, type/taste, nutritional value and cost were regarded as the most important considerations with brand and time/convenience being considered less important.

## 5.4 FINDINGS FROM THE FOLLOW-UP CONTROL GROUP

### 5.4.1 Profile of the control families at follow-up

At follow-up the control group was limited to 15 caregivers. Almost all the control group caregivers indicated that they were still the main caregiver of the child (n=14). Only one control group participant was no longer the main caregiver at the time of the follow up interview. A positive finding was that 5 persons had found employment since endpoint. However, of concern was that 4 caregivers reported that something had happened to make it more difficult for them to cope.



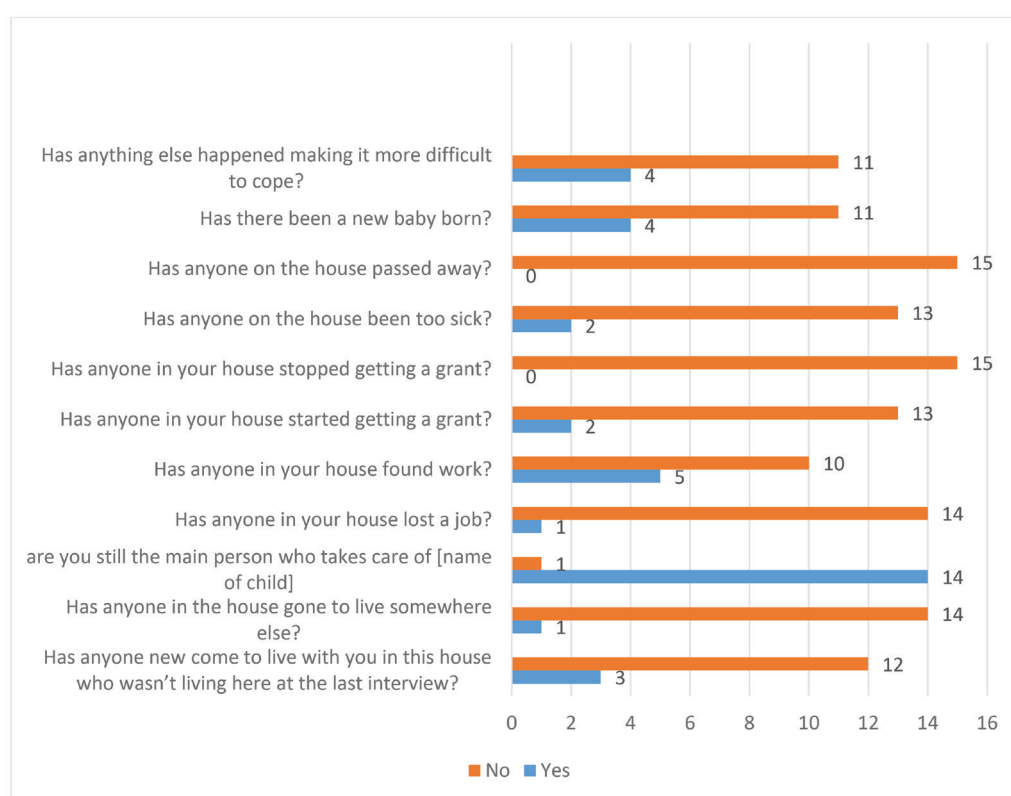


Figure 5: Changes in caregiver and household of control group at follow-up (n=15)

Profile of the children in the control group (n=15)

Variable	No.	Missing data
<b>Gender</b>		1
Male	8	
Female	6	
<b>Race</b>		1
Black	13	
Coloured	1	
<b>Age in years</b>		3
5	2	
6	1	
7	4	
8	4	
9	1	

## FAMILY AND CHILD-CAREGIVER RELATIONS

### Carer/children's future

When asked about their dreams for themselves and their children, the caregivers articulated their desire for their children to live a good life.

*"The dreams that I have is for me to be able to do everything, for him to live a good life and all that... we should always be happy, those are my dreams".*

*"I want my child to have a good life".*

They wanted their children to finish school, receive an education, work for themselves and become independent.

*"I wish he can finish school, be able to work for himself and be independent".*

*"I would really love to see them finishing school, and supporting them a lot, because I; okay, now they are getting my support as a mother and I may not be supporting them properly financially. It would be having their savings set up so that when they have finished school they will be able to flow and not get stuck as I did, as my brothers did. So just saving up for them to carry on with school and finish."*

*"Be a good child, finish school and if the Lord has kept me, have money to take him to university and all the other children".*

*"That she should study, continue and I should be able to do everything she wants. She should feel free, and we should have that bond, it should not end. That's what I wish".*

They also aspired to be good parents for their children.

*"I want to help my child and know where he ends".*

*"By working hard as a parent, you understand? I cannot say 'oh it's free education' ...and then I just sit down and relax, you understand? As a parent I have to push my kids, you understand that they have to work hard so that their dreams can come true, even me as a parent I have to work hard for them"*

*"And for me as a parent, creating a better future for my kids"*

In terms of their own dreams, one parent wanted to further her own studies.

*"I still want to further my studies, do the best in giving my children a better future, you see?"*

Others saw employment as the answer to their dreams.

*"I wish I could find a job, so that I can be able to save money for my child for here education, so that she can have a tertiary education after she finishes primary and high school"*

*"Like now, I see that a job is hard to find because that is the thing that is lacking here at home. I thought about having a business of my own, that's what I'm thinking of doing, because I used to volunteer at Tsosolotso, there's an NGO at the school".*

One caregiver dreamt of having a home of her own.

*"What I wish is to get a good stable place, because last time you met me there and I am here now. I wish I can get a house because I would end up dying while renting around and leaving children renting".*

Another participant articulated the feeling of having lost hope at ever finding a job.

*"As I have said, I am hopeless. It's been a long time trying to find a job. What I am looking at is her, if she can only finish school... I have given up. (Caregiver N Nxumalo)*

### **Communication**

Caregivers reported that since their last contact with the interviewer, communication with children continued to be satisfactory. They gave examples of positive communication.

*"Just chatting so that there can be communication".*

*"Every day when he comes from school I would ask him about what they have learned and he would tell me that 'we are learning about time, that when the longer horn is at 12 and the smaller one is at 6 then it's 6 o'clock'. He is learning things like that".*

*"He tells me what the teacher has been teaching them at school, they have been drawing or whatever they have been writing".*

*"It's still the same (the way I talk to the child). With respect and humbleness, yeah. We should use proper words, we shouldn't have any vulgar words or attitude and things like that... We were talking about fetching her sister so that they can spend holidays together as schools are about to close, that they have things. I have to take them to the Zoo, Gold reef City".*

*"It's easy (to talk to him because he is still a child, he still listens... T talks when he gets back from school, if ever there is something wrong he say, "They did this and that to me."*

*"We do talk because usually we have our moments when we close ourselves in the bedroom and just relax and the person talks what about what they want".*

They actively listened to their children.

*"Every day. I always listen, even though sometimes it's tiring because 'mommy, today we were doing this', 'no give me a chance, give me a chance'. So, I don't know which to listen to, so sometimes I have to end up saying 'no T give your sister P a chance to talk', so I always listen to them and there is no other way that I would stay without listening to them".*

Caregivers reprimanded children for wrongdoing through speaking or shouting at them.

*"I sit them down and tell them that 'I don't like this and that'.*

*"I speak to her well, but when she is wrong, I shout at her well as a parent, not that I hit her".*

*"At times I shout at her, a lot... that is what has changed... I said she is sometimes stubborn, you will have to shout at her first".*

They were able to engage in problem-solving.

*"So the teacher can pick up that one problem which I was not aware that he has, so it's important because it tells you that..., because I didn't know that P likes an eraser, for instance. So when the teacher told me that 'P likes erasing, I wish you can help him' then I came up with the plan that I should let him write on a scribble book first then he would copy to the book to avoid erasing.*

However, with others there was no discernible change or improvement in communication.

*"He doesn't talk about school. Except when you ask him and he would say 'we were drawing or doing this and that'.*

*"I talk to him, I talk... he would say 'yes mom' but because he is a child he would do the same thing again the following day...If you say 'you heard that kids are being stolen' he would just say 'mh' but the following day, there he would be again".*

*"So far I would say it's the same, but the last time I went to the school to see her teacher I told her about things that I don't like and what S would complain about. But she looked into that, and that she would lose some things at school; but her teacher is not paying attention to that".*

### **Family rules**

Caregivers explained that they had family rules and routines for different activities.

*"At this time I am supposed to be cooking and when it is time for Skeem Saam (TV soap opera). When Skeem Saam is playing that means that they have to clear the table of their books and then that's when I can dish up for them. And then the ones who do the dishes do them. L by the time it's eight o'clock he is already fast asleep, yeah he is sleeping".*

*"There's time for home works. When they have homework he would tell me immediately when he gets home that 'Mommy I have home works today' and I would say 'before you watch cartoons, let's first start with home works my baby'".*

*"She has to bath before she sleeps and I have to cook, so our time is six, she comes back in the house from playing around half past five".*

*"There are no rules that I have added or halved, since the last time. They are the ones that she knows, coming home before the sun sets and bath before going to bed. Those are the only ones, they have not changed that much, she knows what she has to do"*

*"Obviously my kids cannot be playing around until 6 o'clock. Even if they are playing here but they must enter the house, it's late. Around 5 they should be in the house*

*"The rules haven't changed, they are still the same. He knows that he is not supposed to be late home, he must be here at 6 and even if he is not inside the house but he should play inside the yard with other children where we would see him because now there is a lot of children now. Even in the house there are children who have come, so there is nothing that might keep him in the streets at night. It hasn't changed, even that they have to bath before they sleep".*

They also had duties and chores as a family.

*"As a family we all have duties that we do, we have a schedule; with the children, its washing the dishes, making sure that there are no dishes with the elder ones. And then L has to make sure that there is no dog poop outside and then polishing his shoes, but that I stopped him because he applies too much polish... so I polish them myself now. But he doesn't have a lot of responsibilities; it's only his shoes and the dogs, yeah".*

*"When they come back from school they have to polish their school shoes and wash their socks, there is one who fetches water. I clean the toilet myself because I am renting here, I can't let them clean the toilet. They are also exchanging amongst themselves washing dishes, the washing and stuff I do that myself".*

*"At home we have rules and number one, they must keep the house clean. Like now they are kids, I am teaching that 'after eating, you must wash the dishes', you understand? That's part of growing, I am teaching that 'after playing with your toys you must tidy up' because I don't have time to do that anymore, I am busy focusing on the little one. When you are messing up the house and someone comes in and they find the house upside down, you understand? Then when you come back from school you must fold your school uniform nicely, you polish your shoes and put everything in order".*

### **Monitoring child behaviour**

Caregivers maintained an awareness of their children's whereabouts.

*"I am always looking for her; she can go out; yes there is a place where I know that when she is there she is safe".*

*"He doesn't go out of the yard; I don't have a child who plays in the street. Even if I send you to the shop, I stand by the gate, watch you go to the shop and come back. If I haven't allowed him to go out with the dog, then I have to look out for him, that's how I do things...They ask for permission and usually I don't allow them to go out alone. If he; like the other day he wanted to go play with his cousin, I had to send his sister and the two of them went".*

*"She always plays in another yard and there is always a granny there...They don't play in the street, they play inside the yard".*

*"I will check on him from time to time and other times I will call out for him, 'Ti! After ten minutes, 'Mama I am here'. He plays here at home... he doesn't go out because there are a lot of children here, and they don't play outside, they play here in the yard".*

*"Even when I am not here I always call. If maybe she is with her sister, I would ask her and always remind her before 01:30 to fetch her at school because their school-out is 01:30. I would ask her if she has fetched her, where she is and what they are doing".*

Children were taught to be wary of strangers.

*"I told him that children are being stolen, 'you should know that they would steal you' I feel that I should tell him, I should not shield him as if nothing is happening".*

*"I always tell my kids that 'you must watch, even when someone say come, let's go and you don't know them, then you should not go with them. It's either you go with your father, with me, -with uncle or with H or with their grandmother'.*

## Parenting and discipline

In terms of positive parenting, children were rewarded for positive behaviour.

*"We go for lunch or I would pamper her, or I would buy her clothes when I have money...I have to thank her so that she knows that there isn't always money, even when you just told her that 'my baby, what you did is good' so that she doesn't always expect to get something".*

*"I am able to buy her like; things like ice-cream, we go to the gate and buy ice-cream. I compliment her and show her and tell her she has done a good thing".*

*"I have stars here at home, it's just that I don't know where I have put them. I use those to encourage them that 'you did well baby, here's your star'." "I go to the shop and buy him something, then I show him".*

Caregivers also used praise and appreciation for good behaviour.

*"I tell him that 'good boy, Mommy's baby' I just say that and he likes it".*

(If she has done something good), I congratulate her"

*"I let him know that I am impressed. It's always heartfelt, I don't give him treats most of the time, but when he deserves it, then I do give it to him. But usually it is heartfelt conversations, "You know, thank you my child you have done the right thing this time."*

They provided encouragement through demonstrating affection.

*"I give him a hug and a kiss and I show him a smile on my face. (She avoids giving presents). The thing is, children will get used to something like 'when I have done something good I get a present,' only to find that at that time I don't have money, so they will be expecting to get that thing you always get them."*

Caregivers reported disciplining children through talking to them and helping them to understand the difference between acceptable and unacceptable behavior.

*"Here at home we don't hit them, we reprimand him that he is wrong and he should know that he is wrong. So, it's just that we are reprimanding".*

*"I sit down with him and talk to him that 'Mommy doesn't like this, it's wrong and I hope you won't do it again'...He understands and say 'sorry Mom'."*

*"I sit him down and say "I don't want this and that" and he says "Sorry mama," and then I tell him "If you do it again, we will have a problem."*

*"I sit her down and become serious and tell her that what she has done I don't like and she can also see that I am serious; she understands that she has done wrong". (She doesn't spank the child because) I grew up being spanked too much, and I ended up in hospital from being spanked".*

One participant described how she no longer shouted at her child.

*"Talking to them, I am someone who liked shouting but then I realised that K was not coping well at school and I thought 'let me reduce the..., maybe when I am making too much noise for the child that's why they can't even do well at school'*

One caregiver mentioned the use of the 'naughty corner' to discipline her child.

*"When she did a mistake, or she has been naughty or things like that. There is a naughty corner. They say 'apologize, sit down' or the TV 'you won't watch these cartoons until you accept your mistake'."*

There was also withholding of rewards for negative behavior.

*"I talk to him, I tell him "You see this;" you see now he has a bad habit, every time he comes back from school, he has torn something. And like you can see that this was done intentionally, this person has torn it. So I told him, "You see this week you were supposed to get pocket money, so you will not get it this week, I will be putting money together to be able to patch those pants." So that's how we talk".*

In addition, caregivers endeavoured to spend quality time with their children.

*"I should always be with him and he should have less time to go and play, we should spend more times on the books".*

*(If child is behaving well) "I take them out".*

### **Positive perceptions of own caregiving**

When participants were asked what aspects of their parenting they were proud of, they described being able to communicate, being patient and not taking out one's anger on the child.

*"Teaching myself that even when I get angry, to have patience for my child, I must take my anger down and not take my frustrations out on the child... There is communication between my child and I, and we understand each other, that's why it is easy (to parent)."*

*"Even if I don't have anything, I am always happy. When I have stress, I don't show my children, I don't want that this thing will cause me to have anger and that anger I will take out on the children. They will be talking to me and when that thing hits me, I will snap at them and at the time my children will not know anything, it is within me. I have to get control over it and be alright".*

There was pride in the fact that the child was coping at school.

*"When I spoke to the teacher and she tells me how he is coping in class".*

Caregivers experienced pride in their ability to discipline their children.

*"I am really proud because my child is well disciplined, she listens and she does whatever you tell her".*

Some caregivers felt proud of their ability to be independent.

*"I am proud of myself because I am able to independently do things by myself without depending on someone else, and when I can't do something I accept that I can't do it and I don't have it. And I am proud that I don't ask anything from anyone".*

They experienced pride in their ability to care for and raise their children.

*"I am proud because I have been able to raise my children, I have need able to raise my grandchildren. So, I can feel that I am a mother to my children".*

*"I am pulling weight, it's hard but I going to stand firm as a mother. I owe it to them; it's my responsibility to support them through everything. It hurts when I disappoint them, so that is why I try by all means to give them what they need, like I can go out of my way when they ask, "Mama there is a day when it has to be like this and this and that." I will make it a point that I make it possible for them, even though I don't have much, but I will make it a point that it happens."*

*"I give him love and respect".*

*"I feel that I am still that same mother who takes care of them, makes sure that they eat, makes sure that they are clean, and makes sure that they go to school every day. I am still that mother and hoping to be more".*

*"I wash for them, I cook for them, you see? That's one thing I am proud of myself about. They are up to date; they are not struggling with anything".*

Caregivers also felt proud of being able to help their children with schoolwork.

*"I am always watching him, and I would ask if he has a home work, if the teacher hasn't given them a home work. He would tell me what they were doing at school...I can be able to do what they need at school for him".*

## **CAREGIVER INVOLVEMENT IN CHILD'S EDUCATION**

### **Functioning of child at school**

When caregivers were asked how their children were functioning at school, they mentioned that their children enjoyed school.

*"She is a happy child and at school she is alright".*

Others reported that their children were performing well at school.

*"She is performing well.*

*"He is still fine, I don't want to lie, I'm actually very impressed with school because he is pushing a lot".*

*"He is doing very well, I will show you his report. He is doing very well, even last year he got an award during December because they give them awards at school, so even now he passed well".*

*"At school, oh well; the last time I checked with the teacher, he was doing well, she was impressed as well and I am also impressed. He is fine".*

*"He is a good listener, he catches on very fast; okay and even though he may be bullied here and there, he will have some complaint and all that, yeah he is holding up, he is performing well at school".*

Some caregivers reported an improvement in their children's schoolwork.

*"The difference I see is with the child...He can write at school and even his reports come looking good".*

*"Before you came K was not concentrating at school, the teacher said he was not doing well at school and he was also stubborn. When you taught him he would tell you, when you told him he would also tell you and write wrong things. So, now there is progress and it's much better... You would see that he has energy and when he came back from school he would show me that 'mom, look how I am now writing' and his work is neat. Last year's books were dirty and he was also erasing with saliva, but now he doesn't erase anymore".*

*"Bokang has a huge improvement now because he repeated Grade 1. The teacher who was teaching him Grade 1 also called his teacher and said that Bokang has improved, and I also confirmed that I can see from his reports".*

### **Caregiver engagement in education**

When participants were asked about their engagement in their children's education, they reported that they checked their children's books.

*"I also check his books and he is fine... he is able to tell me that 'Mom, they said you should sign here' and I would sign".*

*"I don't wait for the teachers to give them a home work, I have to take their books and check".*

*"It's something that's in my blood to ask them 'what did you do today, what did the teacher do? Give me your book, let me see what happened, didn't they give you a paper for parents...' you see. Then he would tell me 'yes' or 'no', then I would say 'let me see your book, and I would sign'"*

*"When she comes back from school we would check her books, do homework. When I am off and free, or when I am the one who picked her up from school then we would check the books before she plays and do other things".*

*"When she gets back from school, I check her school bag, check for homework and help her with the homework" (Caregiver interview N Nxumalo)*

They provided encouragement with schoolwork.

*"I used to encourage him and help him practice writing his name, and sometimes a child would cry when he doesn't know something and I would tell him that 'no K, you have to be patient..."*

Caregivers also assisted their children with homework/schoolwork.

*(In order to help him to learn better at school) "I sit him down when he is from school and teach him... where he is struggling".*

*"The steps I have taken is to help him every day with his home works when he has a homework, when he is out playing because they like playing I would check his books then I would call him and say 'K, you have to do 1, 2, 3' because he didn't even know the A, B, C well".*

*"There's time for home works. When they have home work he would tell me immediately when he gets home that 'Mommy I have home works today' and I would say 'before you watch cartoons, let's first start with home works my baby'. I give him a chance first to see if he can do it, then where he can't do it he would ask me and I would say 'no, this one is right, this one is wrong'. I would correct him then he would watch whatever he wants to watch, cartoons or whatever".*

*"It's helping her with home works, discussing about them for me to see if she can grasp some of the things, doing corrections with some things she has failed or got wrong at school".*

*"We sit down the two of us and read the homework and then I tell her how to do and she understands it and then she writes it down in her book".*

*"Sit him down when he is from school and teach him... where he is struggling".*

When they were unable to assist their child with homework, they sought help from another child.

*"When he comes back with homework, a lot of the times, there is a child here at home who is in the same class as him, they do homework together, and where they are struggling, they help each other out. They do it as a group".*

*"When it comes to homework, I don't want to lie, I don't help him, he has his two siblings, one is in grade 4, not I'm lying grade 5 and then the other one is in grade 7. So they sit around the table; it is only today because he did not go to school, they sit around, do the homework and tutor him. I just come by with checking and sign if it is alright, that's it".*

*"A lot of the time, when he has a problem at school, I bring him back home, and they get together with the others and when they are together it gets a bit better. Because you can't put the entire load on the teacher, you also have to play your part".*

Participants attended school meetings.

*"There is a specific day that they say 'Come and see your child's books,' if your child has a problem, we speak to the teacher".*

*"Like when they have called us for meetings, his teacher is the one in Grade 1 because he is in Grade 1. So, we go there most of the time to see where he is lacking".*

Caregivers made a concerted effort to provide additional stimulation for their children.

*"I give them a book every day, sometimes I buy them books so that I know that he can read".*

*"There are some education programmes she likes watching on DSTV, she would watch them then we talk about those things".*

*"I spoke with the teacher and she told me that he has to practice. He has joined English reading classes after school, so he told me that 'Mom today I went to a reading class' and that's good because he also improves his English. Even though it's a local school but they are also trying at school to improve English, even myself I talk to him. I would give him a magazine or a book then he would read, then if he doesn't understand a word from the Magazine or a book he would ask me and I would tell him".*

They switched off the television to avoid distractions.

*"The TV is switched off".*

*"We don't watch TV when she is doing her homework because she will never be able to concentrate, and she will never know what she is talking about and what she will be reading".*

Caregivers also talked to the teacher when they were concerned about their child or were simply wondering how he or she was doing.

*"I should go to his teacher and talk to her, if she also can't assist then I should talk to her and see how we can help each other".*

*"I go to the school and ask the teachers how it's going with him".*

*"I sit down with him and ask him what's happening. When I don't understand I go to the teacher and understand what's happening".*

*"I once went to school because there was a bully who was eating his lunch, he cut his school bag and all that. I spoke to the teacher and told her that B says there is P and E, they are two and they are bothering him here at school. I spoke to the teacher and she said she would deal with them, and I asked B if it's still continuing, 'are they still bothering you?' and he said 'no'. But now they have started again and bothering him because he spoke about it today".*

*"So, when school goes out, because we are allowed to enter the school at 01:30, then I would go in and ask the teacher 'how was B behaving in the class today, what's been happening?' and she would tell me. She would tell me that 'B is like this and that at school".*

## **FINANCIAL CAPABILITIES**

### **Budgeting and saving behaviour**

Caregivers indicated that they endeavoured to budget.

*"I budget now, you understand? And I want to invest for my kids because from this year until last year I have seen that I have been playing with money*

They also reported improved ability to save.

*"Now I am able to save money. I save in my card, it remains in my card.*

*"When I get Bokang's grant I am able to take R50 and make it R1 and R2, and I save it as his money to carry to school".*

They no longer borrowed money due to awareness of consequences of borrowing.

*"I am very relieved that I am no longer borrowing money. That was a big challenge for me. Yeah like now I don't borrow money. If I know that this is the amount I am getting for the month, I know this will be enough for food; this will be enough for day-care and then the other patches for our needs here and there. So if there is a debt, then it has to be something important.*

Others reported that they were not able to budget or save from their limited incomes.

*"I am not saving money, I can't do it.*

*"I haven't "(been able to save).*

*"There is no money I can be able to save".*

*"It's the same as before, it hasn't changed (savings behaviour). I think it's still the same because things have changed, rent and food has gone up but the salary hasn't gone up. So, I think it's still the same and there hasn't been any difference... There is some I am saving but it's not that much because there are always needs, there is this and that".*

## **FAMILY AND CAREGIVERS' KNOWLEDGE OF NUTRITION**

### **The importance of breakfast**

They recognised the importance of breakfast.

*"Keeps people energised, especially those that attend school".*

*"You cannot start your day with an empty stomach".*

It gives you strength for the day and energy"

*"It gives energy to start a day. Also for concentration at school for my child".*

*"Because it's an important meal of the day. Without breakfast you will collapse".*

Some participants felt that dinner was the most important meal of the day, for the following reason:

*"Because we eat together as a family".*

### The elements of a balanced meal

Some participants understood the basics of what a balanced meal should consist of:

*"Healthy foods like vitamins, carbohydrates and proteins".*

*"Fruits and vegetables and meat and starch".*

*"Food with energy, mineral, carbohydrates and proteins".*

*"It consists of vegetable, mealie meal, iron and vitamins".*

Others indicated that they did not understand the elements of a balanced meal. They either did not complete this section of the questionnaire or provided the following types of answers:

*"Rice, pap and macaroni".*

*"Vegetables, cereal and fruit".*

### Food choices

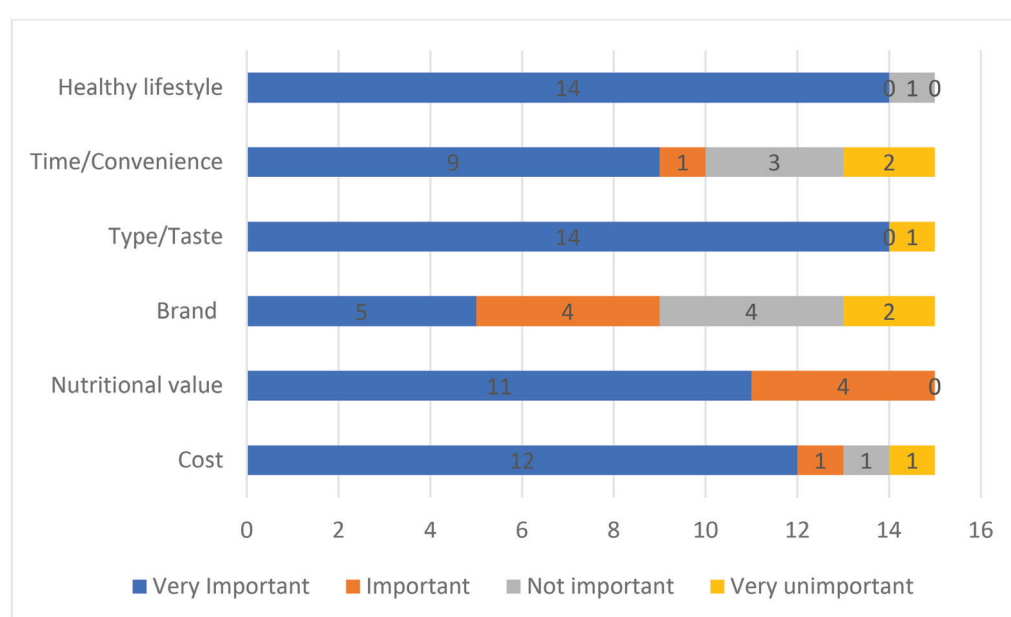


Figure 7: How important are your food choices according to: healthy lifestyle, time/convenience, Type/taste, Brand, Nutritional value and cost (control group n=15)

When participants were asked how they rated food choices in terms of six dimensions, it seemed that they considered healthy lifestyle, type and taste, nutritional value and cost as the most important factors. Brand and time/convenience were regarded as less important.

## 5.5 SUMMARY OF FINDINGS FROM CAREGIVERS IN THE CONTROL GROUP IN RESPECT OF THE FIVE DIMENSIONS OF THE STUDY

### 5.5.1 Family and caregiver relations

When asked about their dreams for themselves and their children, the caregivers articulated their desire for their children to live a good life. They wanted their children to finish school, receive an education, work for themselves and become independent. They also aspired to be good parents for their children. In terms of their own dreams, one parent wanted to further her own studies. Others saw employment as the answer to their dreams. One caregiver dreamt of having a home of her own. Another participant articulated the feeling of having lost hope at ever finding a job.

Caregivers reported that since their last contact with the interviewer, communication with children continued to be satisfactory. They gave examples of positive communication. They engaged in actively listening to their children. Caregivers reprimanded children for wrongdoing through speaking or shouting at them. They were able to engage in problem-solving. However, with others there was no discernible change or improvement in communication.

Caregivers explained that they had family rules and routines for different activities such as the time to be back home, when to do homework and when they needed to go to sleep. They also had duties and chores as a family such as polishing shoes, tidying up their toys and so forth. Caregivers maintained an awareness of their children's whereabouts. Children were taught to be wary of strangers.

In terms of positive parenting, children were rewarded for positive behaviour. Caregivers also used praise and appreciation for good behaviour. They provided encouragement through demonstrating affection. Caregivers reported disciplining children through talking to them and helping them to understand the difference between acceptable and unacceptable behavior. One participant described how she no longer shouted at her child. One caregiver mentioned the use of the 'naughty corner' to discipline her child. There was also withholding of rewards for negative behavior. In addition, caregivers endeavored to spend quality time with their children. When participants were asked what aspects of their parenting they were proud of, they described being able to communicate, being patient and not taking out one's anger on the child. There was pride in the fact that the child was coping at school. Caregivers experienced pride in their ability to discipline their children. Some caregivers felt proud of their ability to be independent. They experienced pride in their ability to care for and raise their children. Caregivers also felt proud of being able to help their children with schoolwork.

### **5.5.2 Caregiver involvement in child's education**

When caregivers were asked how their children were functioning at school, they mentioned that their children enjoyed school. Others reported that their children were performing well at school. Some caregivers reported an improvement in their children's schoolwork. When participants were asked about their engagement in their children's education, they reported that they checked their children's books. They provided encouragement with schoolwork. Caregivers also assisted their children with homework/schoolwork. When they were unable to assist their child with homework, they sought help from another child. Participants attended school meetings. Caregivers made a concerted effort to provide additional stimulation for their children. They switched off the television to avoid distractions. Caregivers also talked to the teacher when they were concerned about their child or were simply wondering how he or she was doing.

### **5.5.3 Financial capabilities**

Caregivers indicated that they endeavoured to budget. They also reported improved ability to save. They no longer borrowed money due to awareness of consequences of borrowing. Others reported that they were not able to budget or save from their limited incomes.

### **5.5.4 Knowledge of nutrition**

Participants recognized the importance of breakfast. They believed that nutritional value, a healthy lifestyle, type/taste and cost were important considerations in making food choices, but attached somewhat less importance to time/convenience. While some participants gave the impression of having a good understanding of what constitutes a balanced meal, others did not seem to have this knowledge. When participants were asked to rate the importance of their food choices in terms of six dimensions, it seemed that healthy lifestyle, type/taste, nutritional value and cost were regarded as the most important considerations with brand and time/convenience being considered less important.

## 5.6 DEPRESSION SYMPTOMOLOGY OF CAREGIVERS IN THE INTERVENTION AND CONTROL GROUPS

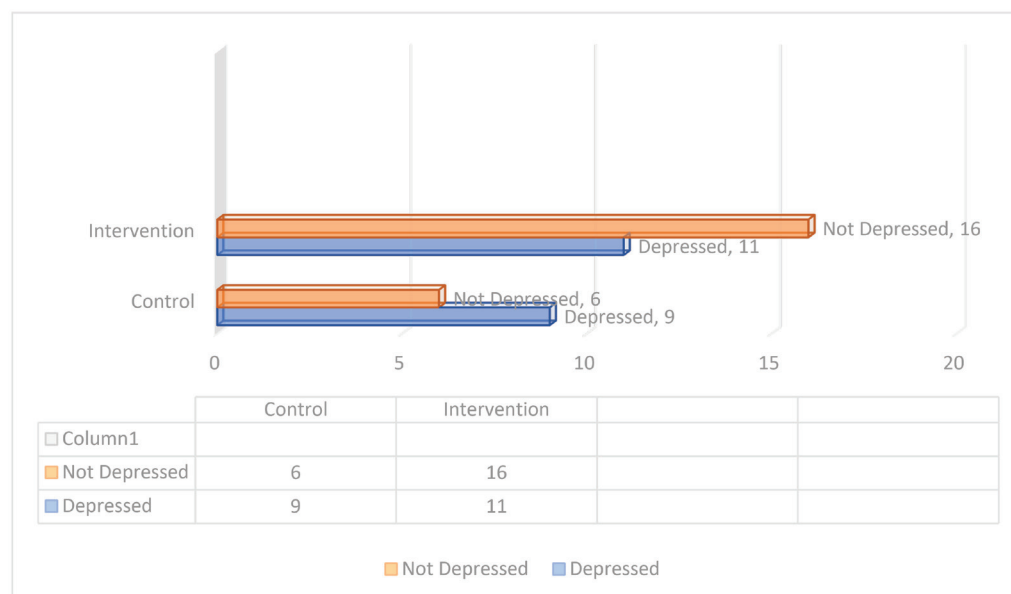


Figure 8: Depression index for intervention and control groups at follow-up

Figure 8 shows that within the intervention group 16 or 59.26% were not depressed while 11 or 40.74% were depressed at follow-up, which represents an increase of 3.94% from 36.8% according to the CESDR-10 scale at endpoint. Within the control group, 6 or 40% were not depressed while 9 or 60% were depressed at follow-up, representing an increase of 18.5% on 41.5% at endpoint.

## 5.7 WHAT DO THE CHILDREN SAY?

### Profile of the intervention children at follow-up

Due to missing data in terms of gender and ethnicity, it is difficult to provide a completely accurate profile of children in the intervention group at follow-up. However, of the 25 children, 10 were male and 11 were female; 20 were black and 3 were coloured and all the children were in the age range 6 to 8 years.

#### 5.7.1 Themes that emerged from the intervention children's drawings at follow-up

The children were asked to draw a picture of themselves and their families engaged in some sort of activity and were encouraged to describe their pictures. The interviewers also asked about the various family members and the child's teacher. When the drawings and interviews were analysed, the following themes emerged:

#### Theme 1: Drawings indicating happy children and families

The majority of children i.e. 19 of the 25 children drew pictures depicting happy children and families.

*"It's my mother. It's me. It's my brother. We were going to Jet (A clothing chain)...after my mother said we should climb on the taxi and go to Jet in Dobsonville. We bought clothes for me and my brother...and then my mother said we should go to KFC (Kentucky Fried Chicken) and then we went there and ate. And then my mother said, 'It's late now, you know, let's go to the other shops...We bought a pink dress... We bought this t-shirt...we bought a pair of grey shorts...and shoes...and...apples and we left. Here is my home. Here is my next door. It is trees. It was very hot. It's a bag. ...It is my family home".*

*"This is me. It's K and grandmother and my mother. These are cars. They are passing by. My grandmother, she is cooking. I am playing with a ball. My brother is playing with the ball. We all are at the grounds".*

*"My mom is going to buy food. My mom loves buying clothes. My dad was going to buy his clothes. My mom bought food for the baby to eat at home. This one is me. I am smiling because my family is interesting. I like my family because they bought me new clothes. This one is my mom. We were going to Jabulani Mall. Dad is smiling because he will buy me a new bicycle. My brother is laughing because my dad will buy him toys. Baby is happy that mom will buy her nice food. Mom and dad like talking well. I look after my sister. I don't make her cry. My brother and I we treat each other well. Mom gets upset when we run out of water in the house. Dad is unhappy when there is no electricity. He doesn't like children who are disrespectful. I am unhappy when my friends don't play with me. Baby cries when there is no food for her to eat at home. My family makes me happy. They love me. When I go to school they give me lunch to eat".*

*"We are sitting. It's my father. It's my mother. It's me and my younger brother. Me and my younger brother we write a homework. Mom and dad, they are eating. It's a kitchen up here, and here is downstairs where we wash. And here we put clothes and our sponges. We are going to church. I go with my father alone and my mother stays with my younger brother. Father, he has a smiling face. He is happy. Mother, she has a smiling face. She is happy when she comes back from work she brings us some toys and when we get home we say 'thank you'. I am happy. I am learning at school and I listen to what the teacher is saying. My brother is sad. He likes fighting with other children. Father is happy when he is relaxing. They are getting paid and they get a lot of money...We like church. I like going downstairs to watch TV...I am happy because I love school".*

*"This is granny, this is S, this is T. Granny is dancing to a church song. I am dancing. He is going to school. He is flying, he is jumping, skipping. I am holding a bag. He is smoking. It's a house, my home. Granny is happy when dad is around. S is happy. It was his birthday. He was angry when they took his phone".*

*"I have drawn my family. It's my sister A. She is standing and laughing at this other person. I am smiling because I am taking a selfie. My sister S is happy because she is going with her friends. My brother is playing soccer. He is angry because they are robbing him. They said he didn't score but he scored. My mom is laughing with her friend. She is standing with her friend and they are talking. She is happy. My grandmother is busy with WhatsApp and laughing. She is contacting her friends. It's a house, its clouds, it's the sun. My grandmother is sad when she says my sister should wash dishes and she would just leave. We love going to Eastgate. We take toys and play. My grandmother would remain talking. We would play and come back. We would say 'granny we are done' and granny would buy us ice cream. My grandmother and my mom would eat KFC but me, my sister and my brother, we eat Pizza. Mom becomes happy because she got a job and we go out. I am happy at the swimming pool. We swim and pour water on each other and it becomes nice".*

*"We came from a shopping place by Pick n Pay (supermarket chain). It's the sun, my grandfather, my mommy, my sister, my cousin. Grandfather is happy because he just went to spend his last money. Mommy is happy because she came with me. My sister is happy because she got sweets. My brother is happy because he went to his favourite place – Pick n Pay. I am having fun with my family...its clouds".*

*"It's M, it's me, it's my grandmother, and it's my mother. My grandmother, she is hanging the laundry. My brother is playing with a ball. We are playing tag. It is like a ball. You pass to another person and then the other person tried to tag another one out. This one lives there. We are in the house. We are just sitting. It's K, he is a boy. A is my brother".*

*"I want to score here and this one wants to defend me here. This one is blowing a horn. I am here. I want to hit the ball. This is a frame. It's the thing that we are playing soccer. It's my father. It's me. It's my sister and it's my mother. This is grass. We are playing soccer. We wash together and we also clean the house together. This one wants to trip me. He wants to take the ball. They are happy that they are going to win. We become happy when we are sitting together in the house and watching TV. It's always going out together".*

*"This is my mother. This is me. This is my father. This is S. It's our car. I write at school and listen to the teacher. It's our house. We are sitting in this house. My mom and my dad make me happy all the time, and my aunt, my grandmother and my brother. They are happy that I have passed. I write at school and I listen to the teacher. When the teacher is teaching I keep quiet".*

Figure 9 and Figure 10 are examples of "happy drawings" from the intervention group at follow-up.



Figure 9: Happy drawing from intervention group at follow-up



Figure 10: Happy drawing from intervention group at follow-up

## **Theme 2: Use of corporal punishment**

Four children spoke about physical punishment for wrongdoing.

*"The teacher hits us when we have been naughty".*

*"When we are naughty, they (family) have to send us to the naughty corner. And when we are naughty, they must shout at us or when we are naughty they must give us a hiding".*

*"Every morning they call A to come and eat and he doesn't want to. He stays in bed. Sometimes my older brother who is in college makes food for us and we would wake up and bath. He likes waking up and when they make food for us he goes back to bed. When they say he should come he doesn't want to... Sometimes it happens that he comes because my father would come and beat him....I call my friends to go to the park and play. Then we come back, but we don't come back late because our parents are going to beat us".*

When asked what makes her sister sad or angry, she replied, 'When my grandfather hits her. When she comes late... Father hits K and shouts at him'.

*"Mother and father – they are beating us".*

## **Theme 3: Memories of the Sihleng'imizi group**

Fourteen children recalled happy memories of Sihleng'imizi.

*"We used to pray there, after we would sing, and then they would tell us to go play a bit, go to the toilet, and draw pictures while the parents finish talking... And then we go to take food and eat. The mothers go to a meeting...Sihleng'imizi makes me happy. They are teaching us how to draw and about talking. They told us how to talk to our parents. I told my mother, 'Mama, I am happy', and she would also say, 'Yes, I am also happy'. And then they would tell us to sit down and we would sit and this other mother would talk. They would say as we were all sitting down, we should stand up, hold each other's hands and say a prayer, so that God can be with us".*

*"At Sihleng'imizi they were giving us food. I was very happy. I was playing with other children. We were playing at the swing".*

*"It's fun. It makes me happy".*

*"I remember that we used to sing there. After that they would make us write and draw. After that we would paste it. After that we would make containers and after that we would eat".*

*"We were playing with toys. We were sitting down. They were teaching us about our mothers. They must not beat us".*

*"We were singing Hayo Mathata and Khololwami, and Um'uJehova evula Iminyango. Then they would give us crayons to write, or we would write houses and ourselves, or your friend... Those people who brought food would bring food and put it there. Then they would give it to us. When we leave they would give us food...It's nice. We are playing. They are also talking to our mothers and they say we should go outside and play".*

*"We were drawing, we were making money boxes. That's what I remember. It was nice, and we were also singing: 'Oh yes the blood of Jesus, The blood was shed, was shed for you and me, Shall never lose its power".*

*"I like it (Sihleng'imizi). Because they taught us that we should listen to our parents and teachers".*

*"We would play. It was nice. We were laughing and playing on the swing and I ended up getting a white friend. We always play. They make me happy. (He would go back) because it's nice. We were writing and getting on the swing, from up there until here".*

*"We were talking. They were asking us some questions and we were answering them. They give us food and juice. After talking we would leave".*

## **Theme 4: Bullying or normal fighting among children?**

Three children mentioned fighting but it was not clear whether they were referring to normal squabbles between children or bullying.

*"My brother he is afraid of me. He knows that...they also know at home that he is afraid of me. They know that whoever starts with me, I will beat them".*

*"I feel angry when I fight with my friend. We fight and hit each other with stones. Then I become angry".*

*"I get angry when they beat me. It's my sister. She beats me when I am also bothering her while she is playing with a ball".*

### 5.7.2 Themes that emerged from the control children's drawings at follow-up

Thirteen out of 15 of the children in the control group drew pictures depicting happy children and families.

#### Theme 1: Drawings indicating happy children and families

*"It is my mother, my father and me. We are standing. They are happy. We are going to the mall. We go to buy food and my birthday cake. Child points to clouds, the sun and the street in the picture. Child is happy when playing with other children. "My mother and father love me...They buy me nice things... Pizza...KFC, anything that I want they buy for me".*

*"This is my mother, this is my father, this is me, this is my brother, and this is our house. Mother is going into the house. Father is going to work, I am going to play. My brother is sleeping in the house...My mother gets angry when my father shouts at her. She gets happy when we have passed. My father is happy when he is working. I get angry when my mother and father shout at each other. I am happy when they are not shouting at each other. At the mall they buy me pizza and cool drink".*

*"This is my granny, this is M, this is E, this is B, this is my mother. They are smiling. B is cooking, E is playing. M likes to play in the bedroom. My granny – she is watching TV. Her walking stick is in her hand. I am picking up the dog's poo. There are two dogs. Mother is cooking pap. E loves going to granny and she laughs. I haven't drawn M because I ran out of space. I didn't draw the dogs because they are always tied up".*

*"I am wiping the floor and my mother is cooking and my sister is sitting down. Here is the dining room. The TV. Generations is playing (A TV soap opera). I watch Generations with my mother, my father and my sister. (The ones outside the house) they are my friends. We play with the skipping rope. This one doesn't live here... I go to school with T and M only. (Father is not in the picture) I forgot about him. He was at work. I like wiping the floor. My sister likes watching cartoons. Mother is cooking for me, my sister, herself and my father. My sister was happy. She is sitting on the couch".*

*"It's K, me and s and Y. We were watching TV cartoons. We went to play. My mother said I must cut my hair. My friend, they have plaits. K's dress is pink. S is wearing blue. Y is wearing pink and blue. I am wearing a t-shirt and pants. We play in the yard".*

*"This is M, This is A, This is mother. They are my family. M has a cat. I am having a dog. I like a dog. This is the sun, this is a dog. It's a flower. It's a house. It's a balloon. God makes them happy. They like playing with these ones and chasing them around. What makes granny happy is going to church and praying only. Church and work make mother happy. A dog and cat make me happy".*

*"It was my birthday. It's my mom, my dad, my sister, my younger sister and me. Its balloons. They are for a birthday. This is a table. It's a cake and a cup. It's a Coke for my younger sister. They are looking at the cake. They are happy because of the cake. My mom, my dad, my brother, my younger sister and my sister. They all make me happy. They play with me with the ball".*

*"It's my sister, it's my mother and me. It's a street. It's just open land. My sister is happy when they buy her clothes and when she's playing. Mother is happy when she's cooking and when she bought herself shoes. It's my father, my grandmother and my uncle. We go to church and we go and buy clothes".*

*"Here they are playing skipping. This one is playing skipping alone. This is a street. Here is the sun, here it's clouds, and here it's the white things up there. It's my friends. Its girls playing skipping outside. At the mall I like to buy burger and pizza and KFC".*

*"We are in hospital visiting my grandmother. This is my mother. This is my baby brother. This is my grandfather. This is my sister. This is my uncle. These are clouds, the sun. When my father promised me my tablet I was excited".*

*"It's a light. It's a house. I sat with my mom, N and my grandmother, M and N. I am standing. This is my brother. He is playing soccer. My grandmother is watching TV with my mom. They are laughing. They are helping each other".*

*"It's my father. It's my mom. It's my sister. It's me. We are in the rural areas. We were taking photos. It's my uncle. We were happy that we were home because in Alexandria it's boring and it's nice in the rural areas. When I grow up I want to check cars. You check them, then you drive them and feel if they are fine. Then you come back with them. Then the person would take them".*

*"We like going to Alex Mall and we are going to Eastgate. It's me. It's my mom. It's my brother. It's my uncle. It's my grandmother. It's my father. It's my grandfather. It's her in Alex Mall. We were buying things and taking them home. We go there to buy grocery. They are happy because they said, 'I am going to buy this one.' Then they say, 'no, no'. They are laughing that a couch will come home. It's my father's car. It's parked outside Alex Mall... I want to study to be a fire extinguisher because when the fire is burning I would put out the fire".*

Figures 11 and 12 are examples of "happy drawings" completed by children from the control group at follow-up.



Figure 11: Happy drawing from control group at follow-up

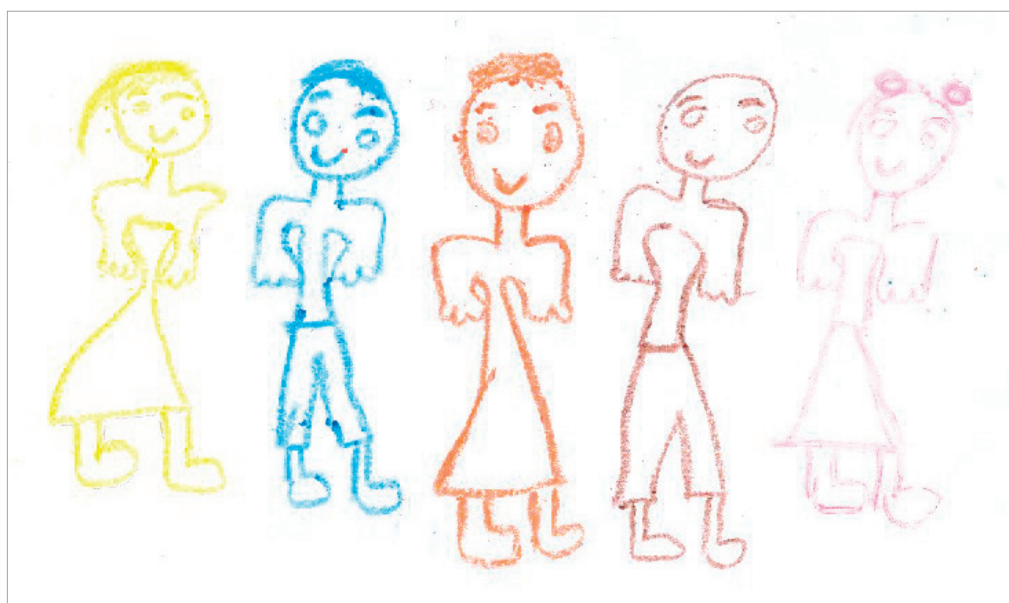


Figure 12: Happy drawing from control group at follow-up

### **Theme 2: Use of corporal punishment**

Four children mentioned the experience of corporal punishment.

When asked what makes him angry, one child responded: *"When they (parents) give me a hiding".*

*"M is rude to them (the teacher), goes under the tables and hides ma'am's stick. When ma'am hits her with the stick, she holds it".*

*"The teacher gets angry because we are naughty, when we are being a nuisance. They give us hidings".*

When asked what the teacher does, the child responded, *"She beats us".*

### **Theme 3: Poverty**

Poverty and shortage or lack of income was also revealed in the responses of two children:

When asked why he was not at school that day, the child responded: *"There was a trip but my mother did not have money".* When asked about school, he said: *"I always don't have lunch".*

When asked why he was not at school that day, he responded: *"There is a trip and I didn't pay".*

### **Theme 4: Bullying or normal fighting among children?**

In the case of three children it was not clear whether they were referring to normal fighting among children or bullying.

*"I am angry when M hits me. I didn't hit him. He hit me first. He was starting with me"*

*"My friends make me angry when they hit me...They just start with me".*

*"This one they call B beats others, and K and boy... They beat me".*

## 6

## DISCUSSION OF FINDINGS

### 6.1 HOUSEHOLD CHANGES

When we compare the caregiver's household changes for both intervention and control groups (Figure 1 and 2), the results suggest that both sets of households had remained more or less the same at follow up as compared to endpoint., with the data reflecting the normal changes in family life such as births, deaths, illness and acquiring or losing employment.

### 6.2 PERCEPTIONS OF CAREGIVING SKILLS

Participants in the intervention group were asked during follow-up how they felt about their child caregiving skills as compared to how they felt at endpoint. Of the entire sample (n=24), the majority of the caregivers (n=17) reported that they had been using what they had learned in the Sihleng'imizi programme. They were more able to discipline their child without resorting to physical punishment. They felt more confident about their parenting abilities; they were better able to balance the different responsibilities in their life; and were more hopeful of their child's future. The fact that 7 caregivers felt less hopeful of their child's future may be attributable to the fact that despite the programme, they were still living in deprived conditions. Of concern was that 7 caregivers felt less able than at endpoint to discipline their children without physical punishment. This finding suggests that for these caregivers the use of physical punishment remains deeply rooted in their socialization processes. In addition although a majority (n=15) felt less overwhelmed by the responsibility of being a parent/caregiver than at endpoint, a sizeable number of caregivers (n=8) felt more overwhelmed. This finding needs to be viewed in conjunction with the findings from the Depression Index, which showed an increase in the number of persons identified as depressed at follow-up and could again be related to their deprived living conditions.

### 6.3 DEPRESSIVE SYMPTOMATOLOGY

The higher number of persons in the intervention group presenting with depressive symptomatology at follow-up may possibly be attributable to the discontinuation of the Sihleng'imizi programme, which presumably provided support for participants while it was being run. It is not clear why more persons in the control group were depressed at follow-up. However, it is possible that the higher rates of depression in the control group may have been due to the fact that they had not been exposed to the buddy system and therefore had less support to draw upon than the intervention group. We can also speculate that the relatively high rates of depression in both groups may have been related to history effects in the form of poor economic conditions prevailing in South Africa at the time and the high rate of unemployment (29%). Both the intervention and control groups were recruited from 11 of the poorest wards in Joburg and we know that poverty has been associated with depression. According to the social causation hypothesis, conditions of poverty increase the risk of mental illness through heightened stress, social exclusion, decreased social capital, malnutrition, and increased obstetric risks, violence, and trauma (Flisher, Lund & Funk, 2007; Lund, Breen, Flisher et al., 2010). It is of interest that Moodley (2014) also found many instances of depression among her sample of women drawn from a poverty-stricken, disadvantaged community in Doornkop, South Africa with high rates of unemployment. More recently, Kruger and Lourens (2016) found that mothers from low income groups who struggled to feed their children developed signs

of major depressive disorder and manifested feelings ranging from sadness, guilt and shame to anger, frustration and resentment. These findings provide support for cash and care programmes with their emphasis on combining cash transfers with support for grant beneficiaries (Patel et al., 2017).

## 6.4 KNOWLEDGE OF NUTRITION

When the results for nutrition were examined at follow-up, they appeared to be very similar to those obtained for both intervention and control groups at the termination of the Sihleng'imizi programme, nine months earlier. In comparing the responses from the intervention and control groups, the impression gained was that both groups recognised the importance of breakfast. Both groups believed that nutritional value, a healthy lifestyle, type/taste and cost were important considerations in making food choices, although the intervention group attached somewhat less importance to time/convenience. However, while there were participants in both the intervention and control groups who did not understand the elements of a balanced meal, a larger proportion of persons in the intervention group had a better understanding of what constitutes a balanced meal, which could be attributed to their exposure to a module on nutrition presented during the Sihleng'imizi programme. In contrast, the control group did not have access to this information. However, a noticeable difference in terms of time/convenience when making food choices existed between the intervention and the control group, with the more participants (89%) in the intervention group valuing the time/convenience compared to the control group (67%). This finding may possibly be attributed to the fact that participants in the intervention group had been taught to spend much of their time with the children and therefore may have felt that it was not as important to spend time in purchasing or preparing food.

## 6.5 LIMITATIONS OF THE STUDY

Missing data in terms of gender and ethnicity of some of the children represents a limitation of the study.



## 7

## CONCLUSIONS AND RECOMMENDATIONS

While South Africa's expansive social grants system improves material well-being and has many other positive benefits for children and families, on its own, it is not able to address the other multi-dimensional needs of children and their families (Patel et al. 2017). The findings demonstrate how 'Cash plus' family care interventions have the potential to accelerate child well-being through improving their physical, educational and social and emotional development. Additionally, they have the potential to improve caregiver and overall family well-being through reducing caregiver depression and improving care-giver knowledge and skills such as the use of alternative forms of discipline and positive behaviour management of children, strengthen family relations and bonding, and increase financial capabilities and knowledge of good nutrition and hygiene practices.

These findings are relevant for redesigning social assistance policies to be complemented with child and family welfare services to address the broader care needs of CSG families with children. A comprehensive preventative family and community-based intervention such as Sihleng'imizi, could be scaled up in urban areas using existing social service and development infrastructure. The programme was tested in an urban context and in a local authority setting delivered by social workers and auxiliary social workers. It is recommended that the programme be scaled up in other urban local authorities in the country. Further research is needed to test the efficacy of the programme in rural areas. However, to secure a positive outcome, dedicated financial and human resources including training and mentoring of front-line social workers and auxiliary social workers are needed. The research also confirmed the importance of obtaining beneficiary feedback and input on social interventions and how they experience it and use it in executing their care roles. While the necessary policies are in place locally and nationally in South Africa to implement cash and care policies and programmes, political will from politicians and the commitment of administrators to give effect to innovation of this kind are required. How to translate evidence into workable social welfare and development programmes remains a key challenge. Getting it right is crucial to improving child well-being outcomes in the long-run.

There is need for further experimentation through designing, implementing and testing programmes that are deliberately designed to link social assistance policies with child and family welfare programmes. Limited evidence exists of the range and types of programmes that could best complement cash transfers and which programmes are most suited for particular target groups and for children and families with different risk profiles. Notwithstanding these challenges, this intervention research study demonstrates what contribution a preventative family strengthening intervention such as Sihleng'imizi could make to promoting child well-being by empowering caregivers with knowledge and skills that could enhance their capabilities and social support systems. It also provides an evidence-based exemplar of the developmental approach to social welfare and social work services drawing on the main principles and features of the approach (Patel, 2015). More particularly, it shows how cash transfers as an economic intervention may be combined with family and care services (social work interventions) to accelerate child, caregiver and overall family well-being.

## REFERENCES

- Agüero, J.M., Carter, M.R., & Woolard, I. (2007). *The impact of the unconditional cash transfers on nutrition: The South African Child Support Grant: Working Paper 39*. Brazil: International Poverty centre, United Nations Development Programme.
- Baluch, B., Duffy, L.J., Badami, R., & Pereira, E.C. (2017). A Cross-Continental Study on Children's Drawings of Football Players: Implications for Understanding Key Issues and Controversies in Human Figure Drawings. *Europe's Journal of Psychology*, 13(3): 455-471. Doi: 10.5964/ejop.v13i3.1237. (Accessed 8 August 2018).
- Banerjee, A., Duflo, E., Glennerster, R. & Kinnan, C. (2015). The Miracle of Microfinance? Evidence from a Randomized Evaluation. *American Economic Journal: Applied Economics*, 7 (1): 22-53.
- Baron, E. C., Davies, T., & Lund, C. (2017). Validation of the 10-item Centre for Epidemiological Studies Depression Scale (CES-D-10) in Zulu, Xhosa and Afrikaans populations in South Africa. *BMC Psychiatry* 17(1):6. DOI 10.1186/s12888-016-1178-x.
- Berry, L., & Malek, E. (2013). Caring for children: Relationships matter. In L. Jamieson, L. Berry & L. Lake (Eds.). *The South African Child Gauge 2017*. Cape Town, South Africa: The children's Institute, University of Cape Town.
- Betts, D. (2013). A review of the principles for culturally appropriate art therapy assessment tools. *Art Therapy*, 30(3): 98-106.
- Black, M. (2012). Household food insecurities: Threats to children's well-being. *SES Indicator 10(1)* Online. Retrieved from <http://www.apa.org/pi/ses/resources/indicator/2012/0/household-food-insecurities.aspx>.
- Bogensneider, K., Little, O.M., Ooms, T., Benning, S., Cadigan, K., & Corbett, T. (2012). The family impact lens: A family-focused, evidence-informed approach to policy and practice. *Family Relations*, 61: 514-531. DOI: 10.1111/j.1741-3729.2012.00704.x.
- Bradshaw, J., Martonrano, B., Natali, L. and de Neubourg, C. (2013). *Children's Subjective Well-being in Rich Countries*. Working Paper 2013-03. Florence: UNICEF Office of Research.
- Bronfenbrenner, (1979). *The ecology of human development*. Cambridge, MA: Harvard University.
- Case, A., Hosegood, V., & Lund, F. (2005). The reach and impact of Child Support Grants: Evidence from Kwa-Zulu-Natal. *Development Southern Africa*, 22 (4): 467-482.
- Cedarbaum, J.A., He, A.S., Fulginiti, A., Sullivan, K., Krauss, M.D., Amutah, N., & Pohle, C. (2017). Caregiver qualities, family closeness, and the well-being of adolescents engaged in the child welfare system. *Children and Youth Services Review*, 73, 113-120.
- Cherney, I.D., Seiwert, C.S., Dickey, T.M., & Flichtbeil, J.D. (2006). Children's drawings: A mirror to their minds. *Educational Psychology*, 26, 127-142. Doi: 10.1080/01443410500344167. (Accessed 8 August 2018).
- Child Trends (2014). *Mapping Family Change and Child Well-Being Outcomes*. World Child Map 2014. <http://www.childtrends.org>.
- Cluver, L.D., Meinck, F., Shenderovich, Y., Ward, K.L., Romero, R.H., Redfern, A., Lombard, C., Doubt, J., Steinert, J., Catanho, R., Wittesaele, C., De Stone, S., Salah, N., Mpimpilashe, P., Lachman, J., Loening, H., Gardner, F., Blanc, D., Nocuza, M., & Lechowicz, M. (2016). A parenting programme to prevent abuse of adolescents in South Africa: Study protocol for randomised controlled trials. *Trials*, 17, 1-10.
- Coetzee M. (2013). Finding the benefits: Estimating the impact of the South African child support grant. *South African Journal of Economics*, 81(3):427-450.
- Crawford, E., Gross, J., Patterson, T., & Hayne, H. (2012). *Infant and Child Development*, 21: 198-215. Doi: 10.1002/icd.742 (accessed 8 august, 2018).

- Davies, T., Schneider, M., Nyatsanza, M., and Lund, C. (2016). "The Sun Has Set Even Though it is Morning": Experiences and Explanations of Perinatal Depression in an Urban Township, Cape Town. *Transcultural Psychiatry*, 53(3):286-312. Doi: 10.1177/1363461516632389.
- DSD. (2012). *White Paper on Families in South Africa*. Pretoria, Department of Social Development. Retrieved from [http://www.dsd.gov.za/index.php?option=com\\_docman&task=doc\\_download&gid=370&Itemid=39](http://www.dsd.gov.za/index.php?option=com_docman&task=doc_download&gid=370&Itemid=39).
- DSD, SASSA & UNICEF, (2012). The South African Child Support Grant impact assessment: Evidence from a survey of children. *Adolescents and their Households*. Pretoria, South Africa: UNICEF.
- Dunn, J., O'Connor, TG., & Levy, I. (2002). Out of the picture: A study of family drawings by children from step, single-parent, and non-step families. *Journal of Clinical and Adolescent Psychology*, 31 (4): 505-512.
- Fan, X. T., & Chen, M. (2001). Parental involvement and students' academic achievement: A meta-analysis. *Educational Psychology Review*, 13, 1-22.
- Flisher, A.J., Lund, C., & Funk, M. (2007) Mental Health Policy Development and Implementation in Four African Countries, *Journal of Health Psychology*, 12 (3): 505-516. <https://doi.org/10.1177/1359105307076237>. (Accessed 29/09/2019).
- Gardner, F.E., Sonuga-Barke, E.J., & Sayal, K. (1999). Parents anticipating misbehaviour: An observational study of strategies parents use to prevent conflict with behaviour problem children. *The Journal of Child Psychology and Psychiatry and Allied disciplines*, 40 (8): 1185-1196.
- Gardner, F., Hutchings, J., Bywater, T., & Whitaker, C. (2010). Who benefits and how does it work? Moderators and Mediators of Outcome in an Effectiveness Trial of a Parenting Intervention. *Clinical Child and Adolescent Psychology*, 39, 568-580.
- Gerhardt, A., Keller, H., & Rübeling, H. (2016). Children's family drawings as expressions of attachment representations across cultures: Possibilities and limitation. *Child Development*, 87(4): 1069-1078. Doi: 10.1111/cdev.12516. (Accessed 8 August 2018).
- Giddens, Anthony (1991) *Modernity and Self-Identity. Self and Society in the Late Modern Age*. Cambridge: Polity Press.
- Gorman-Smith, D., Tolan, P., Henry, D. B., Quintana, E., Lutovsky, K., & Leventhal, A. (2007). Schools and Families Educating Children: A Preventive Intervention for Early Elementary School Children. In P. Tolan, J. Szapocznik, & S. Sambrano (Eds.), *Preventing youth substance abuse: Science-based programs for children and adolescents*. Washington, DC, US: American Psychological Association. 113-135.
- Haghighi, M., Khaterizadeh, M., Chalbani, G., Toobaie, S., & Ghanizadeh, A. (2014). Comparing the drawings of children with Attention Deficit Hyperactivity Disorder with normal children. *Iran Journal of Psychiatry*, 9 (4): 222-227.
- Haile, D., Nigatu, D., Gashaw, K., & Demelash, H. (2016). Height for age z score and cognitive function are associated with academic performance among school children aged 8-11 years old. *Archives of Public Health*, 74 (17):1-7.
- Hall, K. & Richter, L. (2018). Introduction: Children, families and the state. In Hall K, Richter L, Mokomane Z & Lake L (eds.) (2018) *South African Child Gauge 2018*. Cape Town: Children's Institute, University of Cape Town.
- Hamama, L., & Ronen, T. (2008). Children's drawings as a self-report measurement. *Child & Family Social Work*, 14: 90-102. Doi: 10.1111/j.1365-2206.2008.00585.x (accessed 8 August 2018).
- Hewitt, G., Sims, S., & Harris, R. (2012). The realist approach to evaluation research: An introduction. *International Journal of Therapy and Rehabilitation*, 19 (5): 250-260.
- Hochfeld, T., Graham, L., Patel, L., Moodley, J., & Ross, E. (2016). Does school breakfast make a difference? An evaluation of an in-school breakfast programme in South Africa. *International Journal of Educational Development*, 51: 1-9.
- Holte, A., Barry, M.M., Bekkhus, M., Inger, A., Borge, H., Bowes, L., Casas, F., Friberg, O., Grinde, B., Headey, B., Jozefiak, T., Lekhal, R., Marks, M., Muffels, R. Bang Nes, R., Roysamb, E., Thimm, J.C., Torgersen, S., Trommsdorff, G., Veenhoven, R., Vitterso, J., Waaktaar, Wagner, G.G., Arfwidson Wang, CE., Wold, B., & Zachrisson, H.D. (2014). Psychology of well-being. In A. Ben-Arieh, F. Casas, I Frones & J.E. Korbin (Eds.). *The Handbook of Child Well-Being: Theories, Methods and Policies in Global Perspective*. Pp.555-632), New York, NY: Springer.
- Khan, Z. (2019). *Men and the Child Support Grant: Gender, care and child wellbeing* (doctoral thesis). Johannesburg: University of Johannesburg.

- Koppitz, EM. (1968). *Psychological evaluation of human figure drawings*. New York: Grune & Stratton.
- Kruger, L-M., & Lourens, M. (2016). Motherhood and the "Madness of Hunger": "...Want Almal Vra vir My vir 'n Stukkie Brood" ("...Because Everyone Asks Me for a Little Piece of Bread") Culture, Medicine, and Psychiatry, 40 (1): 124–143.
- Lowenfeld, V. & Britain, WL. (1970). *Creative and mental growth*. (5<sup>th</sup> Ed.). New York: Macmillan.
- Lund, C., Breen, A., Flisher, A.J., Kakuma, R., Corrigall, J., et al. (2010) Poverty and common mental disorders in low and middle income countries: A systematic review. *Social Science & Medicine*, 71, 517-528. Doi:10.1016/j.socscimed.2010.04.027 (accessed 29/09/2019).
- Makiwane, M., Gumede, N. A. & Molefi, S. (2016). Continuity and Change: Relationships, Childbearing and Children's Living Arrangements. In M. Makiwane, M. Nduna & N. E. Khalema (eds.) *Children in South African Families: Lives and Times*. Newcastle upon Tyne: Cambridge Scholars Publishing.
- Moodley, J. (2014). Women's mental health: Coping mechanisms in the context of poverty. *Journal of Psychology in Africa*, 24(3):264-271. <https://doi.org/10.1080/14330237.2014.906078>.
- Meinck, F., Cluver, L.D., Boyes, M.E., & Mhlomo, E.L. (2015). Risk and protective factors for physical and sexual abuse of children and adolescents in Africa: A review and implications for practice. *Trauma, Violence & Abuse*, 16 (1): 81-107.
- Ntshongwana, P., Wright, G., Barnes, H., & Noble, M. (2015) Lone motherhood in South Africa: Some methodological challenges and policy imperatives. *South African Review of Sociology*, 46 (4): 80-99. <https://doi.org/10.1080/21528586.2015.1100096>
- Özdemir, M. (2015). How much do we know about the long-term effectiveness of parenting programmes? Advances, shortcomings, and future directions. *Journal of Children's services*, 10 (2): 120-132.
- Patel, L. (2015). *Social welfare and social development*. 2<sup>nd</sup> ed. Cape Town, South Africa: Oxford University Press.
- Patel, L., Hochfeld, T. and Chiba, J. (2018). Perspectives of South African Caregivers in receipt of Child Support Grants: Implications for Family Strengthening Interventions. *International Journal of Social Welfare*. DOI: 10.1111/ijsw.12364.
- Patel, L., Knijn, T., & van Wel, F. (2015). Child support grants in South Africa: A pathway to women's empowerment and child well-being? *Journal of social Policy*, 44(2):377-397.
- Patel, L., Knijn, T., Gorman-Smith, D, Hochfeld, T., Isserow, M., Garthe, R., Chiba, J., Moodley J., & Kgaphola, I. (2017). *Family contexts, child support grants and child well-being in South Africa*. Johannesburg, Centre for Social Development in Africa, University of Johannesburg.
- Pollard, E.L., & Lee, P.D. (2003). Child well-being: A systematic review of the literature. *Social Indicators Research*, 61 (1): 59-78.
- Posel, D., & Grapsa, E. (2017). Time to learn? Time allocations among children in South Africa. *International Journal of Educational Development*, 56, 1-10.
- Radloff, L. S. (1977). CES-D scale: A self-report depression scale for research in the general populations. *Applied Psychological Measurement*. 1:385-401.
- Richter, L.M. & Naicker, S. (2013). *A review of published literature on supporting and strengthening child caregiver relationships (Parenting)*. Arlington, VA: USAID'S AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.
- Roman, N. V. (2011). Maternal Parenting in Single and Two-Parent Families in South Africa from a Child's Perspective. *Social Behaviour and Personality*, 39(5), 577-586. DOI 10.2224/sbp.2011.39.5.577
- Roman, N. V., Davids, E. L., Moyo, A., Schilder, L., Lacante, M. & Lens, W. (2015) Parenting Styles and Psychological Needs Influences on Adolescent Life Goals and Aspirations in a South African Setting, *Journal of Psychology in Africa*, 25:4, 305-312, DOI: 10.1080/14330237.2015.1078087
- Rose, J., Roman, N., Mwaba, K. & Ismail, K. (2018) The Relationship Between Parenting and Internalizing Behaviours of Children: A Systematic Review. *Early Child Development and Care*, 188:10, 1468-1486, DOI: 10.1080/03004430.2016.1269762
- Rosenberg, M., Pettifor, A., Twine, R., Hughes, J. P., Gomez-Olive, X., Wagner, R. G., Sulaimon, A., Tollman, S., Selin, A., MacPhail, C. & Kahn, K. (2018) Evidence for sample selection effect and Hawthorne effect in behavioural HIV prevention trial among young women in a rural South African community. *BMJ Open*. 8:e019167. Doi: 10.1136/bmjopen-2017-019167.
- Ryan-Wenger, NA. (1998). Children's drawings: An invaluable source of information for nurses. *Journal of Paediatric Health Care*, 12, 109-110.

- Savahl, S., Adams, S., Isaacs, S., September, R., Hendricks, G. & Noordien, Z. (2015). Subjective Well-Being amongst a Sample of South African Children: A Descriptive Study. *Child Indicator Research*, 8, 211–226.
- Spaull, N. (2013). Poverty & privilege: Primary school inequality in South Africa. *International Journal of Educational Development*, 33, 436–447.
- Tolan, P., Gorman-Smith, D., & Henry, D. (2004). Supporting families in a high-risk setting: Proximal effects of the SAFE Children Preventive Intervention. *Journal of Consulting and Clinical Psychology*, 72 (5), 855–869.
- Tolan, P.H., Gorman-Smith, D., Huesmann, L.R., & Zelli, A. (1997). Assessment of family relationship characteristics: A measure to explain risk for antisocial behaviour and depression among urban youth. *Psychological Assessment*, 9 (3): 212–223. <http://dx.doi.org/10.1037/1040-3590.9.3.212>
- Tolan, P.H., Guerra, N.G., & Kendall, P.C. (1995). A development ecological perspective in anti-social behaviour in children and adolescents: Towards a unified risk and intervention framework. *Journal of Consulting and Clinical Psychology*, 63 (4): 579–584.
- Townsend, L., & De la Rey, C. (2008). Research methods in psychology. In L. Swartz, C De la Rey, N. Duncan, & L. Townsend (Eds.). *Psychology: An Introduction*. (2nd ed., pp19–42). Cape Town, South Africa: Oxford University Press Southern Africa.
- Van den Berg, W. & Makusha, T., (2018). *State of South African Fathers' Report*. Cape Town: Sonke Gender Justice and Human Sciences Research Council. <http://genderjustice.org.za/publication/state-of-south-africas-fathers-2018/>.
- Vorster, H. (2010). The link between poverty and malnutrition: A South African perspective. *Health SA Gesondheid*, 15(1), 1–6.
- Ward, C.L., Dawes, A., & van der Merwe, A. (2012). *Youth violence: Sources and solutions in South Africa*. Cape town, South Africa: UCT Press.
- Ward, C.L., & Wessels, I. (2013). Rising to the challenge: Towards effective parenting programmes. In: L.Berry, L. Biersteker, A. Dawes., L. Lake & C. Smith (Eds.). *South African Child Gauge*. Cape Town, South Africa: Children's Institute, University of Cape Town.
- Watson, C., & Palermo, T. (2016). *Options for a 'Cash Plus' Intervention to enhance Adolescent Well-being in Tanzania: An Introduction and review of Evidence from different Programme Models in Eastern and Southern Africa*. Florence: UNICEF Office of Research -Innocenti.
- Webster-Stratton, C., Reid, J., & Hammond, M. (2001). Social skills and problem-solving training for children with early-onset conduct problems, who benefits? *Journal of Child Psychology and Psychiatry*, 42 (7): 943–952.



#### CONTACT DETAILS

**Phone:** +27 (0) 11 559 1904 | **Fax:** +27 (0) 11 559 1575  
**Email:** csdainfo@uj.ac.za | **Website:** [www.uj.ac.za/csda](http://www.uj.ac.za/csda)

#### PHYSICAL ADDRESS

Centre for Social Development in Africa  
House 9, Humanities Research Village  
University of Johannesburg  
Bunting Road  
Auckland Park

#### POSTAL ADDRESS

Centre for Social Development in Africa  
University of Johannesburg  
P.O. Box 524, Auckland Park  
Johannesburg, 2006



**CSDA**  
CENTRE FOR  
SOCIAL DEVELOPMENT  
IN AFRICA

