



Connecting cash with care for better child well-being

An evaluation of a Family and Community
Strengthening Programme for beneficiaries
of the Child Support Grant

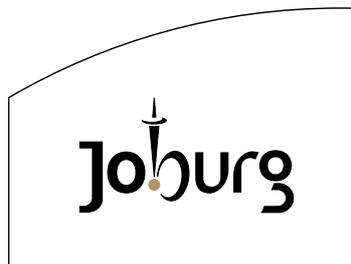
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Sihleng'imizi is a South African adaption of the SAFE Children Family Programme, developed by the Families and Communities Research Group, School of Social Service Administration, University of Chicago, USA. The programme is a community-based family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

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EXECUTIVE SUMMARY

Over 12 million children, or 63% of all children in South Africa, received a Child Support Grant (CSG) in 2018. The CSG is a monthly cash transfer that has had a positive impact on child nutrition and school attendance and reduces income poverty in poor families with children.

Complementary family strengthening interventions are widely advocated to accelerate the positive effects of cash transfers locally and internationally. It is anticipated that these strategies could mitigate psychosocial, systemic and structural risks that compromise child well-being in disadvantaged families (Patel et al, 2017; Cluver et al, 2016; Richter & Naicker, 2013; Gorman-Smith et al, 2007).

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: improving communication, family cohesion, behavioural management, and caregiving capabilities;
- ii. Involvement of caregivers in the child's education;
- iii. Social and community connectedness: improving 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 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 ten of the 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 was 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 was drawn from interviews with the 40 families who completed the programme and 20 control group families.

FINDINGS

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

Family and 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 vulgar 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 & family relations. This was achieved via 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 was 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 slightly increased 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 is particularly positive, as research does indicate that mental health difficulties have a negative effect on caregiving (Davies, Schneider, Nyatsanza, & Lund, 2016). However, 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.

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 and child-caregiver 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 may be due to the 'Hawthorne effect' (Rosenburg et al, 2016), 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 has 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. Other factors such as better family situations, child maturation, or other influences 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.

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.

Drawing on our research at the Centre for Social Development in Africa (CSDA), University of Johannesburg, and its partners, contained in a report titled *Family Contexts, Child Support Grants and Child Well-being in South Africa* (Patel et al, 2017), a family intervention was designed and piloted in 2016. The Sihleng'imizi Family Programme is a preventive social development educational intervention, and is specifically designed to complement and scale up the positive benefits of the CSG in South Africa. The goal is to strengthen families, as a protective measure for children, which is anticipated to lead to better child well-being outcomes. Social investments of this kind, and especially in the early years of life, are associated with positive long-term trajectories for children and with breaking the cycle of poverty (Heckman, 2008; Desmond, Richter & Martin 2016; Richter et al, 2017; Department of Welfare, 1997).

1.1 THE SIHLENG'IMIZI PROGRAMME

Sihleng'imizi is an adaption of the SAFE Children Family Intervention that was designed for poor urban families in Chicago, USA (Tolan, Gorman-Smith, & Henry, 2004). While SAFE Children was created for a different context, it contains some of the key programme components relevant to disadvantaged and poor families living in difficult circumstances in South Africa. These components relate to (a) family functioning, and (b) to enhancing educational success. It was thus chosen as the basis on which to create a new, culturally relevant, and a locally appropriate programme for South African families that receive one or more CSGs. Sihleng'imizi is a Zulu phrase that means: *we care for families*.

The Centre for Social Development in Africa (CSDA), University of Johannesburg, and the Families and Communities Research Group, School of Social Service Administration, University of Chicago, collaborated to adapt SAFE Children for the South African environment. Drawing on the lessons learnt from the SAFE Children programme and CSDA's collaborative research (Patel et al, 2017) as well as local literature (Richter & Naicker, 2013), a 12-week training programme was devised. Teams of practitioners and researchers in

South Africa and Chicago collaborated in the adaptation, which involved a qualitative review of all aspects of the programme, including training of facilitators and supervisors. A pilot programme was implemented in Doornkop, Soweto (an urban site) and in Moutse, in Limpopo (a rural site). The programme was subsequently adapted based on lessons learnt from its implementation in 2016. Advanced testing and evaluation was conducted in 2017 based on the implementation of the programme in 10 poor wards in the City of Johannesburg (CoJ) in partnership with UNICEF South Africa.

While Sihleng'imizi was modelled on SAFE Children, the South African programme is new in that it was specifically developed to complement the positive gains derived from cash transfers and to promote overall child well-being. Aspects of the SAFE children programme such as its preventative and educational goals, the focus on reducing risk factors for child well-being in disadvantaged communities, the methodology, delivery principles and its positive outcomes, inspired the adaptation and design of Sihleng'imizi. The rationale and goals of SAFE Children, its conceptualisation, identification of target groups, programme content and delivery principles and implementation were adapted, and informed the design of a local family intervention that is more closely aligned to South Africa's developmental model of social welfare and priorities.

Sihleng'imizi was specifically devised to reflect local languages, literacy levels of caregivers, and the social relevance of the topics and activities. Accordingly, every session was changed to fit the local context, using new material created by the team, as well as material drawn from the *Sinovuyo Caring Families Programme* and the *Sinovuyo Teen Programme*, parenting and family support programmes developed in South Africa. This material is open source and thus available for use. We would like to gratefully acknowledge the Sinovuyo Programmes, their authors¹ and developers². Modules on Financial Capabilities were adapted from the CSDA's *Siyakha Youth Assets* programme (Graham et al, 2016) and the Nutrition module was developed by Dr Hema Kesa, a specialist in community nutrition and Head of Hospitality Management, School of Tourism and Hospitality Management at the University of Johannesburg.

1.2 AIM AND DESIGN OF THE PROGRAMME

The overall aim of the Sihleng'imizi intervention was to complement cash transfers with a family strengthening intervention to improve child well-being in poor households receiving a CSG. The content was designed to positively affect the social, emotional, physical, educational and material domains of child well-being (September & Savahl 2009; Meinck, Cluver, Boyes, & Mhlongo, 2015; Minkkinen 2013). The programme was aimed at caregivers who were receiving a CSG for children aged 5 to 8 years who were in Grade R and Grade 1. These caregivers were primarily biological mothers and grandmothers, but in some cases other relatives were the primary caregivers. It was delivered by trained social workers and childcare practitioners whose function was to deliver the intervention in selected poor wards in the CoJ.

The curriculum of the programme focused specifically on the following dimensions. First, strengthening child-caregiver and family relations. This was done via promoting opportunities for child and caregiver to bond emotionally, and increasing the use of positive parenting³ skills especially in relation to discipline, which impacts on the child-caregiver relationship, and building family cohesion and improving family communication. A second focus was to increase caregiver involvement in the child's education, via active support for schoolwork, improving caregiver engagement in school-related activities, overcoming school attendance barriers and improved advocacy for the child's needs at school. Thirdly, it aimed to enhance

1 *The Sinovuyo Caring Families Project Facilitator's Handbook* was written by Jamie McLaren Lachman and Judy Hutchings. *The Sinovuyo Caring Families Programme For Parents and Teens Facilitator Manual* was written by Jenny Doubt, Sibongile Tsoanyane, Lucie Cluver, Catherine Ward and Jamie McLaren Lachman.

2 *The Sinovuyo Caring Families Project* is a partnership between the Universities of Cape Town, Oxford and Bangor, Clowns Without Borders South Africa, UNICEF South Africa, UNICEF HQ, UNICEF Office of Research – Innocenti and the World Health Organisation.

3 *When we refer to 'parenting skills' we recognise that not all caregivers are biological parents, but this is an accepted term for the caregiving, relationships, and discipline skills that parents and caregivers use to raise their children.*

the caregiver and family's social and community connectedness, via improved knowledge and use of community level social services and by strengthening their social networks. Fourth, strengthening the financial capabilities of the caregiver and family, via basic financial literacy knowledge and skills and family budgeting and saving, was built into the programme. Lastly, improving caregiver and family knowledge of nutrition, via basic nutritional information, food preparation hygiene skills and home food preparation skills, was intended.

The unique programme design contained the following features:

- Sihleng'imizi is a group programme: Approximately five families with a child in Grade R or Grade 1 receiving a CSG were invited to take part in a shared weekly group meeting, which takes place at a close location, mostly the local primary school.
- The whole family was invited (not just caregivers and the identified child), so that adults and children participated in the group together.
- The programme ran for 14 weekly sessions, each of about two hour's duration.
- Group facilitators were qualified social workers specifically trained to deliver the programme, and they were supported by qualified childcare workers to assist with the children taking part at different stages in the delivery of the programme.
- Sessions were run in the local vernacular, and the family workbook was available in English, Zulu, Sotho and Afrikaans.
- Each session consisted of family exercises involving caregivers and children. Where this was not appropriate, children spent some of the time in a separate group activity that was tailored to address a particular aspect of the programme content.
- The sessions included group activities and a shared meal, and at-home tasks were done between all the sessions.
- The content focused on parenting/caregiving, family relationship characteristics (communication, support, cohesion), caregiver involvement and investment in their child's schooling, financial capabilities, and nutrition education.
- Each family was paired with another family, called their Sihleng'imizi buddy, to support each other between sessions and after the group sessions end.

The group sessions provided the participants with the opportunity to reflect on their existing skills and what they are doing well, as well as to use new skills learnt and to practise positive parenting behaviour. In each session, there were opportunities for families to practise or observe others practising family skills and effective ways of relating. Special attention was paid to helping families recognise their strengths, understand the consequences of negative reinforcement, and learn about 'risk factors' for problem behaviour. By facilitating family group coherence and an atmosphere of mutual interest and concern, the facilitator helped families to be a reciprocal source of social support, to each other within families, but also across families. Lastly, the agency of participants was encouraged by exploration and reflection on their own perspectives on issues, values, beliefs, care practices and in making choices. The session titles appear in Table 1.

In addition to the work completed in sessions, families were given specific tasks to work on and practise at home. Each task was intended to:

- Help families practise what they learned and work toward independent/internal responsibility for addressing family issues.
- Provide a sense of continuity between what happens in the group meetings and what happens at home. This continuity is important if families are to feel that what they learn in session has relevance to their everyday lives.
- Keep the session activities and real-life family needs in the foreground of the thinking and discussions about family functioning.
- Offer the opportunity for the co-creation of knowledge and learning in the group involving adults, children, the facilitator and childcare worker.
- Establish a buddy system to help families develop their own support system in the community by reaching out to a peer to seek help.

Session 1: Identifying Family Strengths
Session 2: On the Home Front: Helping Kids Succeed in School
Session 3: At School: Parents as Teachers and Advocates
Session 4: Nutrition Education
Session 5: Developmental Expectations
Session 6: Communication with Children and Adults
Session 7: Anger and Behaviour Management A
Session 8: Behaviour Management B
Session 9: Consequences and Conflict Resolution
Session 10: Redefining Family Rules and Consequences
Session 11: Making a Budget with our Money
Session 12: Ways to Save Money and Making a Family Savings Plan
Session 13: Social Support and Staying Connected
Session 14: Evaluation and Graduation

Table 1: Session titles.

Between July and December 2017, the Sihleng'imizi programme was implemented by social workers from the CoJ in ten of the City's most deprived wards. The intervention was evaluated using a qualitative research design that included a pre-test and post-test method of study to assess the child, caregiver and family contexts before the intervention was delivered (at baseline) and at the end of the programme. The aim of the intervention study was to assess the effects of the Sihleng'imizi family programme on child well-being by comparing data collected from children, caregivers and educators prior to the onset of the programme (baseline) with data collected after completion of the programme (endpoint) and to compare the intervention group with a randomised control group. Data was collected from caregivers, social workers, childcare workers, children and teachers.

The evaluation study set out to ascertain whether the programme strengthens child-caregiver relations; promotes social and community connectedness; enhances caregiver involvement in the child's education; increases the financial capabilities of the caregiver and family; and improves caregiver and family knowledge of nutrition. It was anticipated that the advanced testing of the programme and evaluation of its effects on caregiver and child well-being could yield valid results about (a) the effectiveness of the family strengthening intervention; (b) the implementation of the programme; and (c) its potential to be scaled up. The method of the intervention study is discussed in further detail in section 3.



2

CONCEPTUAL FRAMEWORK AND LITERATURE REVIEW

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, forthcoming, 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, K. & 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 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) conducted a systematic review and concluded 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, and 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.

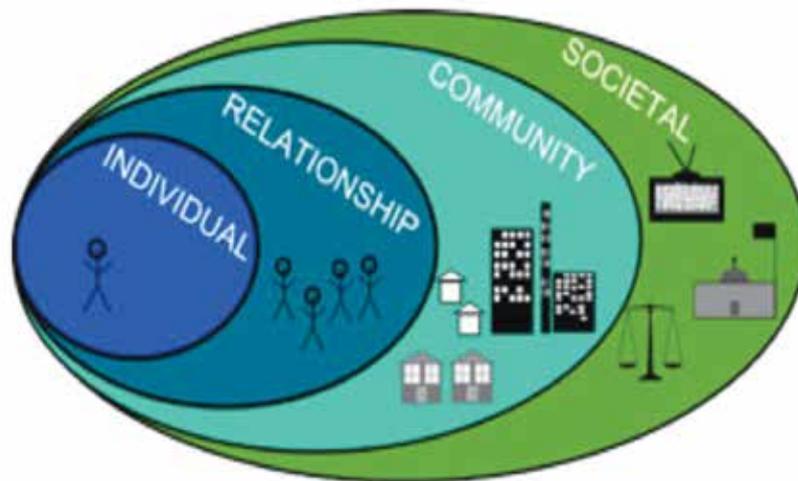


Figure 1: Development Ecological Model source: <http://www.wcsap.org>

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 structuralstrategic 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.



RESEARCH DESIGN AND METHODOLOGY

3.1 RESEARCH DESIGN

Intervention research is designed to facilitate the development of interventions that have the desired effects in a range of real-life contexts, with those who themselves experience the problem or issue (de Vos, 2002). This current research has broadly followed what is known as the 'D&D' (design and development) model, which involves, briefly, developing an innovative prototype programme, pilot testing it, modifying it accordingly, and then undertaking evaluation and advanced development, before refining and disseminating the intervention (de Vos, 2002). Sihleng'imizi has undergone the first stages of this process as follows: the need for a family support programme was identified via a mixed methods study (Patel et al, 2017), a prototype was developed through a collaborative adaption process, incorporating SAFE Children materials and Sinovuyo materials, and a pilot study was undertaken with four groups in 2016.

The pilot Sihleng'imizi programme was implemented in Doornkop, Soweto and Moutse in Limpopo in 2016 by a CSDA team and its partner organisations, *Humana People to People* (Doornkop) and *Ndlovu Care Centre* (Moutse). Four family groups were delivered, two in Doornkop (an urban site) and two in Moutse (a rural site). Compliance and competence fidelity were monitored and a qualitative short-term outcome evaluation was conducted. Results were positive, and provided direction for further refinement and adaption. A three-month qualitative follow-up evaluation was conducted which demonstrated sustained positive outcomes over this period. Further follow-ups will be conducted with this pilot group to establish longer-term benefits. The results of this pilot led to amendments of the programme in relation to content and process of implementation.

This research report is an account of the evaluation and advanced development phase, using a quasi-experimental design to track the relationship between the intervention and the behaviours and related conditions targeted for change (de Vos, 2002). The data used to track these changes is qualitative in nature. The intention is to develop an evidence-based programme that identifies not only the content that should be covered, but also the process and implementation conditions that are most likely to lead to the intended outcomes of improved child well-being, and what works best for whom and why (Fixsen, Naoom, Blase, Friedman & Wallace, 2005; Westhorpe, 2014).

Nine-month post-intervention follow-up data collection has been conducted, the results of which will be presented in a forthcoming report. This forms part of the further testing prior to refinement and dissemination.

The quasi-experimental design of the advanced testing and evaluation reported on here consisted of a control (comparison) group and an intervention (treatment) group, with pre- and post-intervention data collection with both groups. This is a qualitative study, with data gathered through interviews with participants and key informants. Demographic data was collected in the form of a small survey. Further details of this process follow.

3.2 RESEARCH SITES

The CoJ identified 12 of their most deprived wards for this study, which were reduced to 10 wards when establishing groups became difficult in two of the wards. 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.

The following table identifies the wards in which the research was done and a description of the area to give a sense of the research sites.

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 Ndofaya, 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.

Table 2: Brief descriptions of research sites (City regions and wards)

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)

The figure below shows the regions of the City of Johannesburg, with approximate locations of each ward.

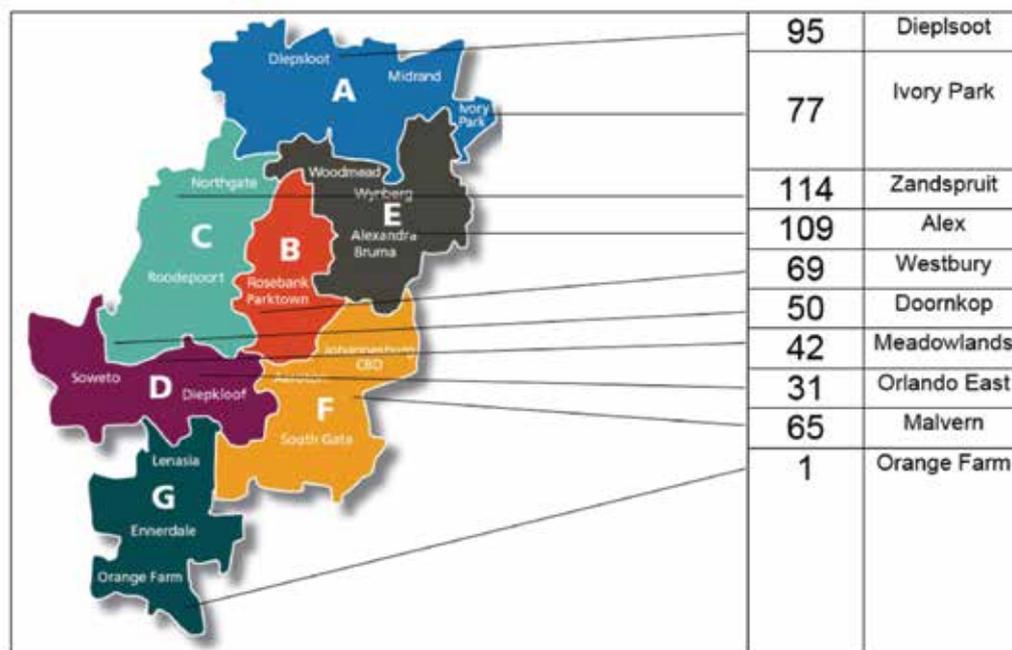


Figure 2: Approximate locations of each ward in the Regions of the City of Johannesburg

3.3 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.

If control group members agreed to take part, they were visited by a field worker for the baseline data collection. If intervention group members agreed to take part, they were visited by a trained social worker to explain the intervention in more detail and to collect baseline data.

The recruitment target for the intervention group was 60 families, the number recruited was 64 families, and the final number which completed the programme was 40 families. Therefore the retention rate of families in the intervention was 62% from start to completion. This is lower than the over 90% retention in Sinovuyo Teens, a comparable family programme (Cluver et al, 2016), but is similar to the average retention in parenting programmes (Smokowski, Corona, Bacallao, Fortson, Marshall & Yaros, 2018).

Data was collected from 71 control group families at baseline, and 65 families at endpoint. The full sample was used to report on basic demographic and other profile data of the population (the *n* is identified in all the reported results).

However, the control group sample was reduced for the purposes of the analysis of the interview data. Although 65 interviews were conducted, the final control group sample was 20 families (selected via cluster random sampling to ensure every ward was represented), which is when data saturation occurred. The table below shows the final numbers at endpoint for the qualitative analysis.

Table 3: 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 (qualitative analysis)
A	Ivory Park Diepsloot	77	5	2
		95	3	1
B	Westbury	69	5	1
C	Doornkop Zandspruit	50	4	3
		114	4	1
D	Meadowlands Orlando East	42	6	3
		31	4	3
E	Alexandra	109	4	1
F	Malvern	65	5	1
G	Orange Farm	1	3	4
TOTAL		10	40	20

3.4 INTERVENTION

The CSDA partnered with the Department of Social Development at the City of Johannesburg. The CoJ committed 11 social workers, 2 supervisors, and their infrastructure and facilities to run Sihleng'imizi as part of the testing process. They also provided funding for direct costs of the intervention such as materials and refreshments.

Each social worker was matched by a childcare worker, who were all either qualified as an Early Childhood Development (ECD) practitioner or a SmartStart facilitator⁴.

The intervention team underwent 14 days of intensive training on the Sihleng'imizi programme, which began in June 2017, and the final training module was run in August 2017. Intervention groups started between September and October. Most of the groups had to run double sessions each week in order to complete the programme by the end of November, which was a limitation, as the programme was designed to be completed weekly. All facilitators ran 14 sessions. All groups successfully terminated at the end of November, to ensure they ended before the close of the school year.

⁴ SmartStart is a specific early learning franchise programme running in the CoJ (<https://www.smartstart.org.za/>).

3.5 DATA COLLECTION

This is a qualitative study, and there was triangulation of data from children, caregivers and educators. Data collection procedures were exactly the same for the intervention and control groups.

At baseline, the identified child, the primary caregiver, and the child's educator was interviewed, and these interviews were repeated at endpoint. Educator interviews were not always easy to secure, as educators were not available for interviews, leading to some missing data. A summary of the number of interviews is reflected in the two tables below. The analysis was done on families where there was both baseline and endpoint data. Owing to attrition in the intervention group the data from a total of 40 families was used, as reflected in Table 4.

	Families	Caregiver interviews	Child interviews	Educator interviews	Total interviews
Baseline	69	69	69	28	166
Endpoint	40	40	36	34	110
TOTAL		109	105	62	276

Table 4: Number of families & interviews completed in intervention group

Seventy-one control group families were interviewed at baseline and 65 of these were interviewed at endpoint. This data was utilised for the population profile (see section 4.1.1).

However, to match the intervention group, only data for a total of 20 families was used for the analysis of the qualitative interview data. The exact number was reached due to data saturation of the control group qualitative data.

	Families	Caregiver interviews	Child interviews	Educator interviews	Total interviews
Baseline	71	71	69	56	196
Endpoint	65	65	59	54	178
TOTAL		136	128	110	374

Table 5: Number of families & interviews in control group conducted and used for population profile.

Research tools consisted of the following. A selection of these tools are reproduced in Appendix A.

	Caregiver	Child	Educator
Research tools: baseline	<ul style="list-style-type: none"> Qualitative questions relating to the 5 dimensions under investigation. Survey nutrition questions Depression index (CESD-R-10⁵). 	<ul style="list-style-type: none"> Simple closed-ended questions about school & mood 'Draw your family' exercise 	<ul style="list-style-type: none"> Short set of qualitative questions about behaviour and performance.
Research tools: endpoint	Same as above, plus for the intervention group a set of closed-ended and open-ended questions about the programme.	Same as above	Same as above

Table 6: Brief description of research tools used

In order to evaluate the programme itself, another set of tools were employed, such as fidelity monitoring checklists and individual session evaluation forms for every family. The findings from this set of tools will be presented in a forthcoming report.

⁵ 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).

3.6 DATA ANALYSIS

3.6.1 Analysis of data

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

Qualitative data from the interviews with caregivers, educators and children was 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 2.3 that forms 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 table or figure form with percentages, even though the sample for this study is small (40 intervention and 20 control families). The intention is not to imply that the findings can be generalised beyond this small sample. It rather offers some clarity about how many of the participants expressed a particular opinion, so that readers can be clear how extensive the opinion or experience is 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 are spread.

3.6.2 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 & Rübelling, 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 were asked to draw a picture of themselves and their families at baseline and endpoint. In analysing the drawings, we took the following factors into consideration:

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 & 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. The size of the figures in drawings is contested in terms of predictive power by others, however, 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 & Rübelling, 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, caregiver interviews, and educator report data for holistic evaluations.

3.7 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 was discarded where necessary.

Trustworthiness of the qualitative data analysis was enhanced through moderation of the codes assigned using correspondence checking. Townsend & 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 was managed using Atlas-ti software.

A sample of quotations accompany the findings in order to give evidence for the conclusions arrived at. In order to ensure transparency of the evidence, and therefore trustworthiness of this study, additional quotations are contained in Appendix B, which can be found at the end of this report.

3.8 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.

3.9 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 programme as an incentive, but nothing was offered to the control group participants. Low-value gifts were given to each family at the end of their interviews at baseline and endpoint (at baseline the children were given the crayons provided by the CSDA for drawing their family, and at endpoint each family was given a bag of fresh vegetables).

During the analysis of the data, researchers identified both educational and child well-being concerns in a number of cases. There were five schools where reports of educators hitting or shouting at children warranted intervention. There were 23 cases where we had worries about a specific child.

There were five cases where educator or caregiver reports indicated possible additional learning needs for specific children, and warranted an educational assessment. There were 11 cases where the child's behaviour indicated potential problems, such as aggressive or withdrawn behaviour, or the child or educator reported corporal punishment, violence, or other social problems at home. There were seven additional cases involving both concerns.

As the whole focus of this intervention programme and research is to promote child well-being, it would have been ethically wrong to ignore these concerns. The CSDA responded as follows: We arranged a school-level intervention for educators to upskill them in non-violent behaviour management, and pro-bono educational assessments for the identified children, both undertaken by qualified educational psychologists, one from within the Gauteng Department of Education. At the time of publication of this report, not all schools had yet received these services, but will do so. The social issues were referred back to the social workers who ran the group that particular family had been in, for individual intervention and onward referral if necessary.

The control group participants were not offered the intervention as there was an additional round of data collection conducted nine months after the endpoint phase and we did not want to compromise these findings. However, they were all made aware of the social work services in their wards (and given contact details). There were a number of cases where the fieldworker was concerned about a family after data was collected, or was confronted by social problems directly; for example one field worker was present when a close relative of the participant family arrived at the house immediately after being raped nearby. In all these cases, field workers assisted with referral to social work and other services (such as calling for medical and police assistance). De-briefing was conducted for this field worker and for others who witnessed other upsetting incidents.

FINDINGS

4.1 CAREGIVER AND FAMILY CONTEXT

This section describes, first, the socio-demographic profile of all families interviewed prior to the commencement of the intervention (at baseline) and whether there were any changes in their profile at endpoint. The data used here refers to all 140 families visited at baseline, a much larger sample than the final group for whom we analysed qualitative data. The purpose of this is to give the reader a sense of the family structures and environments of similar families in these communities (all these families met the inclusion criteria). This will assist the reader in understanding and contextualising the findings.

Second, the 'as-is' (baseline) situation of the families with reference to the five dimensions of the study is described. This sets the scene for how things were prior to the intervention, for the intervention group (40 families) and the control group used for comparative purposes (20 families). In both instances, the similarities and differences between the families in the intervention and control groups are identified and discussed.

Thirdly, the findings from a depression index (CESDR-10, for more information on this index see section 3.5.) are presented. This gives a sense of the depression symptomology of the primary caregivers, at baseline and at endpoint.

4.1.1 Profile of the families in the study

4.1.1.1 Profile at baseline

The total household sample of the 140 families at baseline was composed of 740 individuals, 351 adults (48%) and 389 children (53%). Household size ranged from two to 14 members, with an average of 5.7 persons per household, which is similar to the national household size for CSG children and their families (Patel et al, 2017). The intervention and control groups were very similar in terms of household size and range of the number of family members.

Comparison of the age groups for the intervention (69 families) and control (71 families) groups suggested that they were fairly evenly matched. The majority of children in the households (under 19 years of age) were in primary school (63%) followed by children who were too young to attend school (20%). The children in high school made up 12% of the household population of children, and only 3% were in a post-school education and training facility. These findings are understandable given that the selection criteria for participation in the programme was limited to caregivers with children between the ages of 5 and 8 years (the ages children are in Grade R or Grade 1). With regard to the employment status of the household members who were older than 19 years of age, a large number were unemployed (45%), with 18% in full-time work and 19% in part-time employment. Six percent were pensioners.

Figure 3 shows that most children's primary caregiver was their biological mother (74% of the intervention group, and 76% of the control group), followed by grandmother (16% intervention group; 9% control group), biological father (5% intervention group; 9% control group) and aunt (2% intervention group; 6% control group).

While there were only small variations in who cared for the child between intervention and control groups, Figures 4 and 5 suggest fairly significant differences between the intervention and control groups in regard to the number of maternal orphans. There were more maternal orphans in the intervention

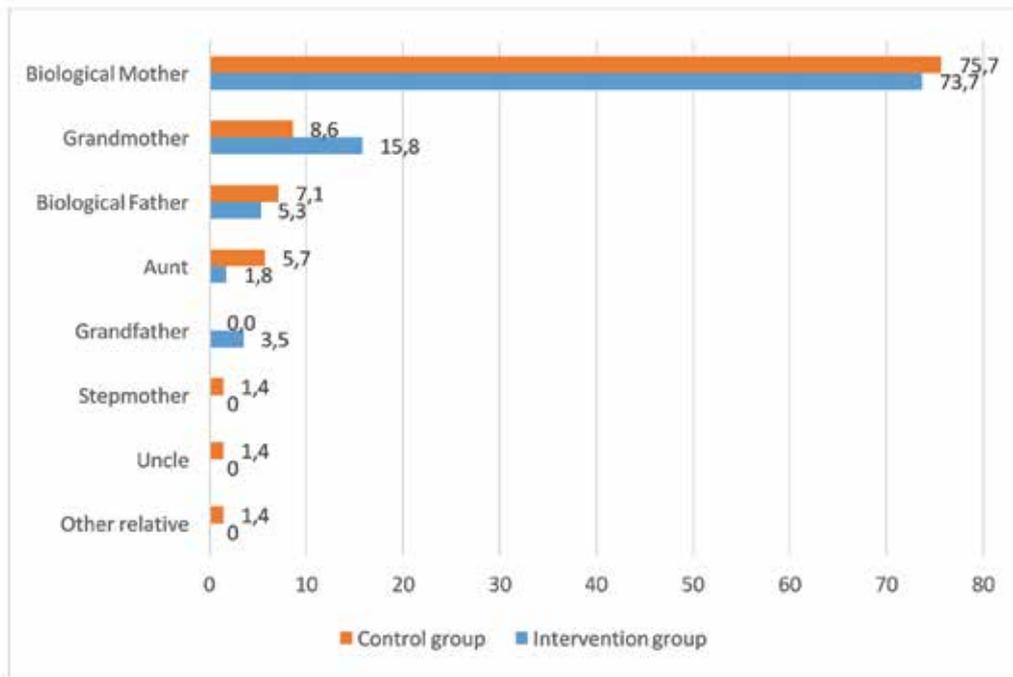


Figure 3: Relationship of caregiver to identified child
 Total n=127; Control n=70; Intervention n=57

group compared to the control group. The control group also had significantly more biological mothers who were alive but not living with the children, although the mother saw the children often (see Figure 4). A fairly large proportion of fathers were co-resident but were not the primary caregivers in the control group compared to the intervention group, where fewer fathers were co-resident (see Figure 5).

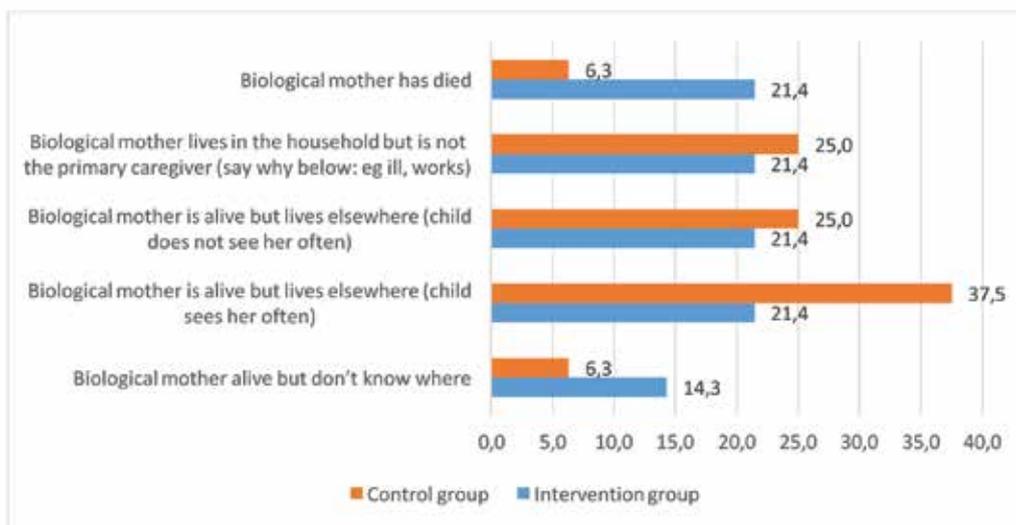


Figure 4: Maternal orphans, co-residence of the biological mother, and her presence in the child's life
 Total N=20; Intervention n=14; Control n=16

Figure 4 indicates that there were some differences between the intervention and control groups. For example, more biological mothers from the intervention group (21.4%) than the control group (6.3%) had passed away, and more mothers from the control group (37.5%) than the intervention group (21.4%) were living elsewhere and did not see their children often.

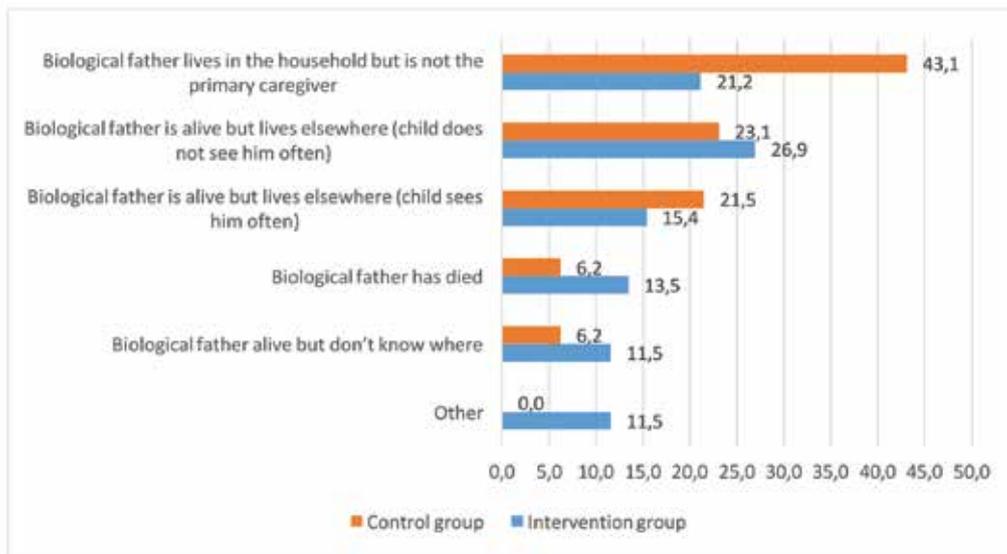


Figure 5: Paternal orphans, co-residence of the biological father and his presence in the child's life
 Total N=117; Intervention group n=52; Control group n=65

When asked "Who else helps you to care for the identified child?" 83% in the intervention group and 87% in the control group mentioned someone else who assisted with caring for the child (largely close female relatives such as a grandmother or adult daughter). Eight percent of the intervention group and 7% of the control group specifically stated they did the caring entirely on their own.

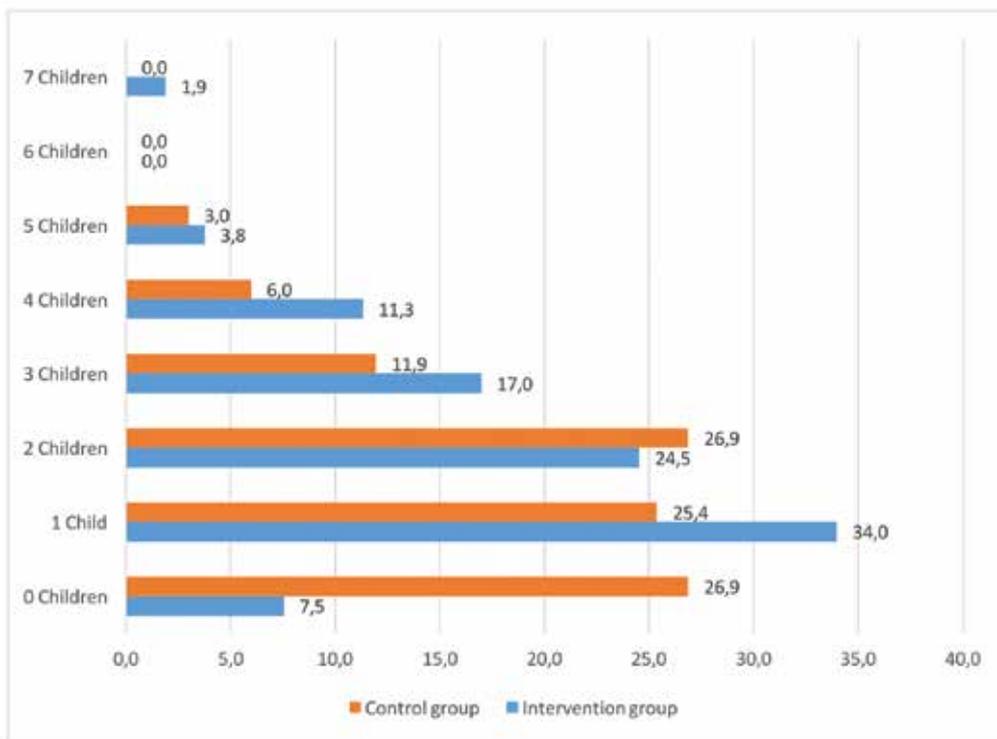


Figure 6: The number of **other** children in the family getting a CSG

As shown in figure 6, the highest number of additional children receiving a CSG in both the intervention and control groups was seven children, but by far most households had only one, two or three children receiving a CSG.

In summary, the demographics for household size, ages of family members, relationship of caregiver to child, location of mother and father if either of them was not the primary caregiver, and number of other children in the family receiving a CSG, suggested that the intervention and control groups were fairly evenly matched.

4.1.1.2 Profile at endpoint

What follows is the results from the survey data collected on the full sample (140 families at baseline). By endpoint the intervention group size was 40 families and the control group size was 65 families, with a total of 105 families. The majority of the original caregivers (89.5%) from the intervention group continued to be the main person who takes care of the child. A small percentage (15.8%) of other household members had gone to live elsewhere, changing the household composition a little. The control group changes were minimal. At endpoint all (100%) of the caregivers had remained the same and household composition had changed only slightly. These findings suggested that caregiver and household status had remained fairly stable for both groups (see Figures 7 and 8).

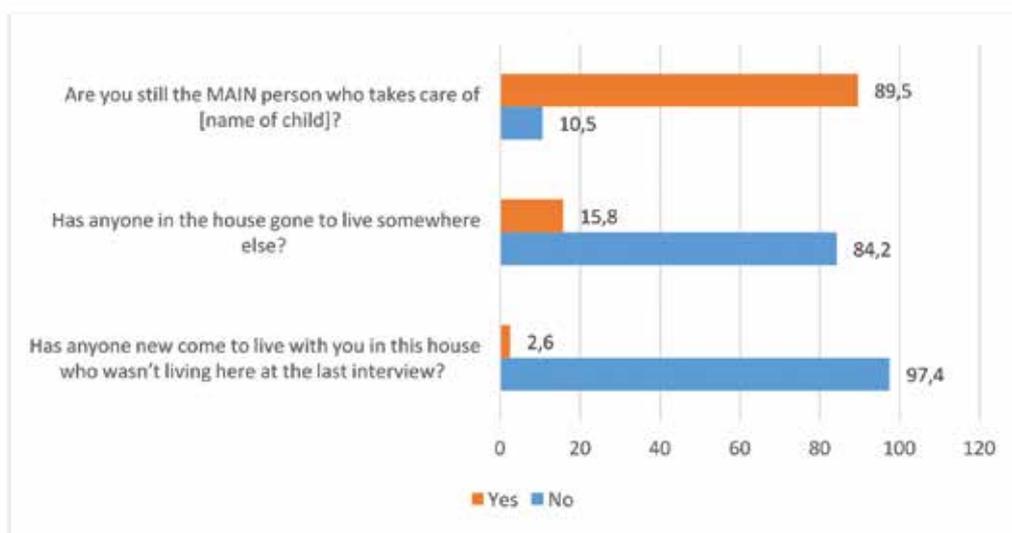


Figure 7: Changes in caregiver and household status of intervention group at endpoint (n=38)

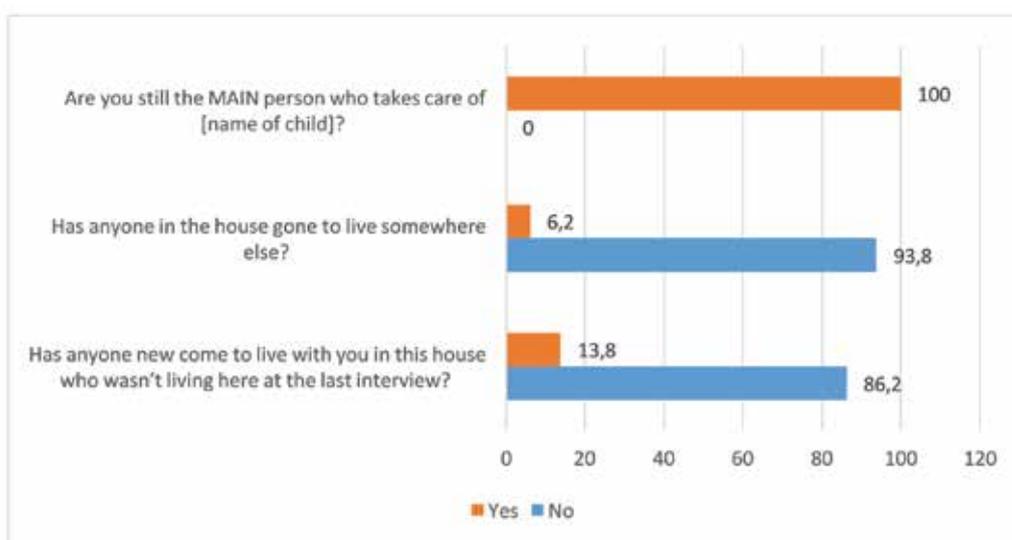


Figure 8: Changes in caregiver and household status of control group at endpoint (n=65)

When we compared the two figures (9 and 10) illustrating additional household changes, it seemed that

the changes in the intervention and control groups were very similar, and reflected normal changes in family life such as births, deaths, illness and acquiring or losing employment.

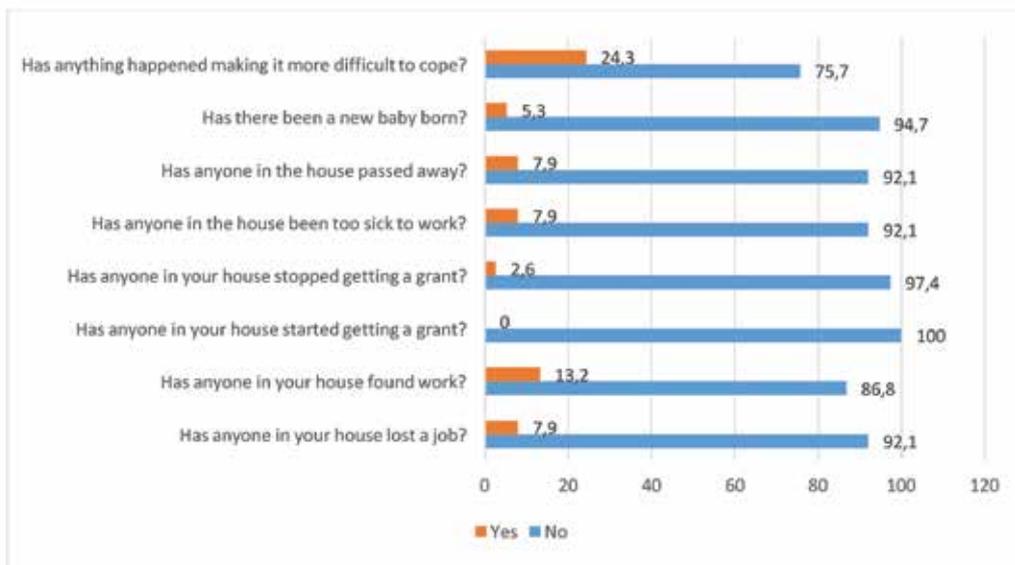


Figure 9: Additional household changes in intervention group at endpoint (n=38)

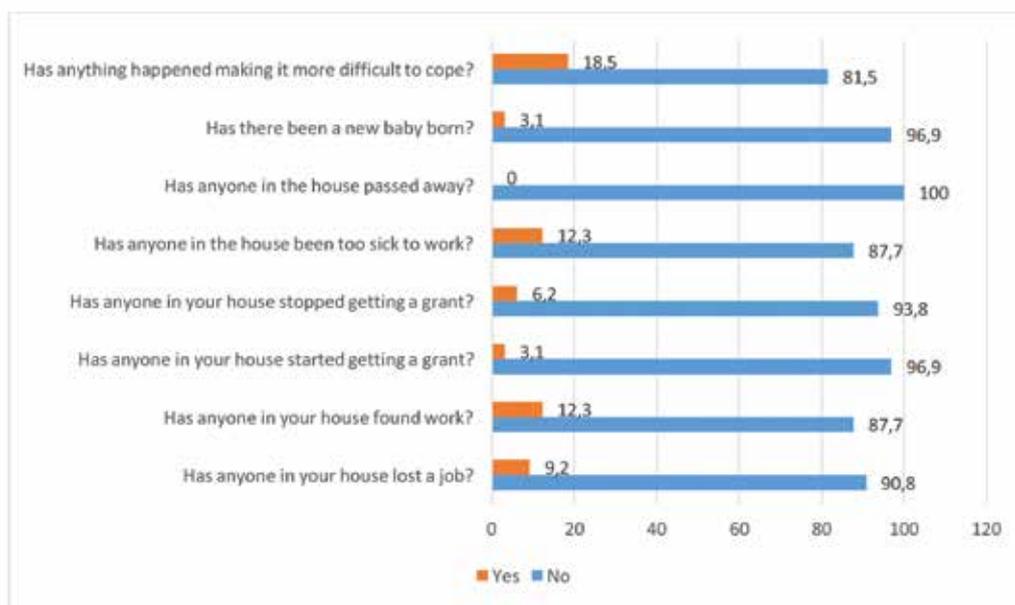


Figure 10: Additional household changes in control group at endpoint (n=65)

It is apparent that the household profiles changed in minor ways over time for both the control and intervention group between the start of the research and at endpoint.

4.1.2 Who are these families? Depiction of caregivers and families at baseline

The themes that emerged from the interviews were grouped according to the five key dimensions targeted by the research. This section presents the baseline analysis from interviews with the 60 families for whom we also analysed endpoint data (the endpoint data results appear in section 4.3). Summarised at the end of this section are the similarities and differences between the intervention (40 families) and control (20 families) groups at baseline. The first dimension was the child-caregiver and family relationships.

4.1.2.1 Family and child-caregiver relations

The first key theme was the broad area of family and child-caregiver relations. This theme incorporated a range of sub-themes, such as those related first to family relations and functioning: family contexts and livelihoods; hopes and dreams for the future; family cohesion; and second, those that relate to child-caregiver relations: such as communication and rules; child monitoring and discipline; parenting skills and perceptions of own caregiving.

Family relations (livelihoods, hopes and dreams for their family, and family cohesion)

Livelihoods: The impression gained was that many of the respondents were unemployed and survived on social grants, which they supplemented with activities such as ironing, running a small spaza shop, selling chickens and so forth.

"I sell chickens and I started in 2005" (Mathapelo, caregiver)⁶.

"I do ironing for someone" (Celiwe, caregiver).

Caregiver challenges: Poverty was pervasive and the biggest challenge seemed to be to provide children with material needs – e.g. uniforms and money for school outings.

"I wish to get a job so that I can work for my children and they should not struggle at school. When they need money for lunch, they should have it. When they need school uniform, they should get them. I should have a house where I stay with my children, provide them with enough food in their lives so that they can eat nutritious food, so that they don't just eat anything" (Mathapelo, caregiver).

Single parents and grandparents also struggled with the burden of raising young children.

"Being alone with the children, it's difficult" (Mathapelo, caregiver).

"I even asked God that 'God, keep these children' because sometimes I have arthritis. I can't go up and down looking for them in this place because I don't know this place. I am still new here ..." (Agnes, caregiver).

Hopes and dreams: Respondents' aspirations seemed to revolve around getting a job and earning an income.

"For me as a man, it would be for me to get a stable job, to get an income on regular basis so that my life is stable and so would be the life of my family" (Dovhani, male caregiver).

With respect to their aspirations for their children, respondents all valued education as a way of exiting poverty.

"I like to see my children living well, being educated so that they can find jobs and their lives to... progress" (Nomsa, Caregiver).

"I wish that my kids can be educated and be successful ... because I did not have that opportunity to get education. I wish they can go to the universities, so that they can work for themselves" (Dovhani, male caregiver).

Family cohesion and bonding activities: Most respondents reported feelings of family belonging.

"We are on good terms, understand each other" (Nomsa, Caregiver).

"Yeah, we do trust each other. We are together most of the time. As far as I know we are happy, we do support each other. Even the children understand our relationship, so for that we are happy and grateful" (Anna, Caregiver).

They engaged in various joint family activities.

"We enjoyed most when we watch favourite things on TV, movies – that we do basically most of the time" (Celiwe, caregiver).

Child-caregiver relations and caregiving

Child-caregiver communication: Caregivers described how they asked their children how their day was and what they had done at school.

"I ask them a lot about school, what they were doing then they would tell me if they were eating, writing or whatever they were doing" (Agnes, caregiver).

⁶ All names have been changed to protect confidentiality. Caregivers are female unless otherwise indicated.

"I listen to them as they tell me of what their day was and stories" (Nosipho, Caregiver).

They tried to instil certain values and behaviour in their children.

"I talk about them getting educated. I tell them that I want them to be educated so that they are successful in life" (Nomsa, Caregiver).

"I talk to her a lot because she loves playing out on the street I tell her you see when you love going on the streets this is what happens to children who love playing in the streets, she watches TV, I would say to her, "did you see what happened to the lost child. I tell her that she must not like being in the streets but rather be in the yard and even safer in the house and she can do many things like taking her books reading and writing or even watch television" (Doris, caregiver).

"I do talk to her, I talk to her. I talk, especially at this stage she is in, you will experience a lot of things physically and spiritually because some things you just think about them especially when you are a teenage girl and feel that you could fall in love, you will feel a change in your body. So, there are things like that but it doesn't mean that you have to experience them or want to test them, maybe what those who are drinking alcohol feel, what those who are smoking feel, if I sleep with a boy what happens? So those things, I tell her that you will feel them but you are able to suppress them until the right time" (Nkateko, Caregiver).

They also discussed how they attempted to resolve problems and conflicts.

"If there is a problem, we try to solve it. We quickly solve it together" (Doris, caregiver).

"What I like with my children is that no one has a secret, we all talk about everything, and we do things together" (Zanele, Caregiver).

Family rules: Most respondents employed some form of family rules and chores.

"Rules are there. Applying mostly to the children. The older one knows that when she has gone to play, she must be back in the house at a certain time. She knows that by five, she must be back in the house at five. That is one thing she knows, even if she is playing with friends, she must ask what time is it and check on the where the sun is so that by the set time she is back home" (Doris, caregiver).

"They know that they don't leave through the gate without having told anyone, they don't come back late, they don't go to the streets where we can't see them. When he leaves, he should say 'I am going to play there' then he should go there and we check if he really is going there" (Zanele, Caregiver).

"The first things when they come back from school they are not supposed to leave their bags where we sit, or just leave their shoes there, or they just sit with the uniform without taking it off; I don't want that. That's the rule, and that we don't go to bed without the dishes washed, we don't go to bed without having done the dishes. And those who go out they don't come back after 6, I want them to come back home early because it's not safe these days, and they are girls. So it's things like that, so there are not strict rules" (Nkateko, Caregiver).

Child monitoring: Caregivers explained how they endeavoured to monitor their children's behaviour and ensure their safety.

"When it comes to the boy we don't always know, sometimes he goes to the soccer fields ... But mostly Mondays we know that he is in a computer class then he comes back, so he doesn't go anywhere" (Anna, Caregiver).

"I don't have anything that uses paraffin here at home, and secondly if it happened that there is no electricity they use phone torch because I don't believe that candles and matches are safe as they are still young. They might light them and burn clothes" (Jabulile, Caregiver).

"I always, every morning accompany him to school. I take him to school ensure that he is in class. Coming back from school, if I do not fetch him, I know there is a school patrol that ensures that they cross the roads safely and that he is always with his friends. They go together most of the time. I know that the school is safe" (Cynthia, Caregiver).

"I would tell him that a lot of people know you here, and these people with cars would call him. I would say 'sometimes they would call you to come get sweets and they would steal you and go with you, don't go to someone you don't know'" (D12).

Parenting and discipline: In terms of discipline, most tended to resort to spanking the child.

"I hit them with a stick" (Agnes, caregiver).

"I use an open hand and give it to her on the legs" (Nosipho, Caregiver).

"With the small tree branch, I give them a little of hits on the legs" (Thokozile, Caregiver).

In addition to physical punishment, they all used reward and positive reinforcement to praise children when they did something well.

"When they have passed well we buy them a cake" (Nomsa, Caregiver).

"I sometimes just tell her without giving her anything that I am happy and proud of what she has done, like doing her homework right. I will clap hands for her praising her. At times when I have some money I will give her to go and get herself some crisps or a lollipop because she wrote well or did something right" (Dovhani, male caregiver).

Perception of own parenting/caregiving: Most caregivers seemed to feel that that they were doing a good job of parenting – particularly in relation to material aspects such as providing food, clothing etc.

"I can say I am a good parent because I can take care of my family. Like when there are no groceries in the house and my husband has not received his pay from the piece jobs he works at, I can buy groceries and we eat as a family ... Even when my children need clothes I buy them, so that they are like other children" (Doris, caregiver).

"I know that I am a mother to my children, that's what satisfies me that even when I leave, I know that I am something. It makes me happy knowing that I am a mother to my children. I wish I can become the role model so that they can look up to me about life" (Celiwe, caregiver).

"I think I am my children's role model – the way I carry myself, the self-respect. All these things they see from me. I have a lot of respect from others as I give to them as well. At times my children ask me, 'Mama, you don't go to parties like other parents, why?' I tell them that I grew up like that and it is working for me" (Thokozile, Caregiver).

These sub-themes reveal a range of strengths in these families, which indicate the resilience of families in the face of financial difficulties or disadvantage. The caregivers have hopes that their children's lives will be better than their own, and they actively care for these children in material, physical, social and emotional ways.

This is not always easy, however, and indications of areas where changes could result in better outcomes are already evident, such as in monitoring and disciplining children. In addition, even where caregivers are already engaging in positive behaviours such as family communication and bonding, these things can be reinforced and supported more.

The next theme is how much and in what way the caregiver is involved in the education of their children.

4.1.2.2 Caregiver involvement in children's education

The baseline interviews revealed in both control and intervention groups that caregivers seemed to value their children's education. They also did at times attend school meetings, and tried to assist with homework. A few quotations illustrate this:

"I would go to the school (meetings) to find out where and in what she is struggling with. I would also help where I can" (Nosipho, Caregiver).

"He does it (homework) himself, then I check if he did it correct. Then I would ask him questions like, 'Why did you do this like this, but didn't do it like that?' Those are the instructions from his teacher" (Jabulile, Caregiver).

4.1.2.3 Social and community connectedness, trust and community safety

This theme is important in relation to family well-being, as the more support caregivers and families have in their communities, the better they fare (Tolan et al, 2004). In addition, the more they know about and utilise community resources, the more likely they are to receive the service and material support that is necessary.

Community resources: When prompted by the researchers, caregivers were able to identify resources such as SASSA, clinics, police and so forth. They highlighted the poor quality of community resources in their area – e.g. sewage running down streets.

“So there is just sewage water flowing there sometimes but sometimes it’s not there, like these days there is water coming out up there by extension 8. There is water coming out there by the main road” (Agnes, caregiver).

“I am looking at the streets, water and when it is raining, eish, it is not a nice place. It doesn’t make me happy” (Nomsa, Caregiver).

“We don’t have it (electricity) and we need it” (Nomsa, Caregiver).

“Ja, but several people are not using these clinics because they are always not having medicines or short of this or that” (Thokozile, Caregiver).

No mention of social work services: None of the respondents mentioned social work services as a source of support.

Community trust and safety: While some caregivers trusted community members, others did not.

“I would say yes, I love people and people in turn respect me. I respect every person in the community and they in turn respect me” (Thokozile, Caregiver).

“We are not safe but especially when you stay here. I believe that when someone housebreaks they know what is in the house. They know when you are not around ... we try to lock the gates. Even though it’s a person like you, you won’t be able to close them out” (Nkateko, Caregiver).

4.1.2.4 Financial capabilities

By financial capabilities we specifically refer to basic financial literacy skills and family budgeting and saving behaviours.

While there was little evidence of budgeting behaviour, caregivers tried to save from their limited incomes with the most common source of saving being through stokvels⁷.

“There is money that I save at the bank” (Thokozile, Caregiver).

“The child’s grant I’m saving at the moment now. I don’t really do much with it now because I’m saving it for December” (Celiwe, caregiver).

“I buy food stamps. I have a funeral cover, I have stokvel for funeral grocery [savings to buy food for a funeral] only” (Zanele, Caregiver).

“We have joined the church stokvels which works when we say one member has problems like death in the family. The money that each family contribute towards the scheme is then given to the family with the problem that needs money to solve” (Nomsa, Caregiver).

4.1.2.5 Caregiver and family knowledge of nutrition

Caregivers appeared to have a basic understanding of nutrition and food preparation hygiene as reflected in the following quotes:

“Breakfast is very important to a child, because a child is supposed to eat three times a day. Healthy foods are vegetables, milk, fruits and fish” (Zanele, Caregiver).

⁷ This is the colloquial name for various types of rotating savings associations in South Africa, commonly known and widespread.

“We should eat food that is balanced. You shouldn’t eat the same thing, pap in the morning, pap during the day, and pap in the afternoon” (Nkateko, Caregiver).

“When it comes to safety I make sure that they don’t put plastic things especially on the stove because sometimes you would find that it hasn’t cooled off, so you would put a cup or a plate then it would burn. But I make sure that I switch it off after using it, and that I clean it because when it’s not clean there would be germs in the kitchen, so we tidy up when we are done. We might just put the dishes without packing them up but they should be washed, another thing that’s important it’s the toilet. It should always stay clean and closed” (Nkateko, Caregiver).

4.1.3 Depression symptomology of caregivers

This section describes the findings from a depression index (CESDR-10), which is not a diagnostic tool but can give a sense of the severity of the symptoms of depression for an individual. The index gives a score; above a certain score (10 and above) the person is considered likely to be depressed and below that score the person is likely not to be depressed. The battery of questions was asked at baseline and at endpoint of all the caregivers taking part. As it was part of the survey data collected, this is reported for the full population of 140 families (baseline) and 105 families (endpoint). The results for the population (intervention and control) are concerning: 53% reported symptoms of depression at baseline.

Findings show that the rate of depressive symptomology dropped between baseline and endpoint in the intervention group, from 53% to 37% (see figure below). This is a 16% change, and a very positive finding, suggesting that the intervention assisted in giving caregivers the support they need to feel less depressed.

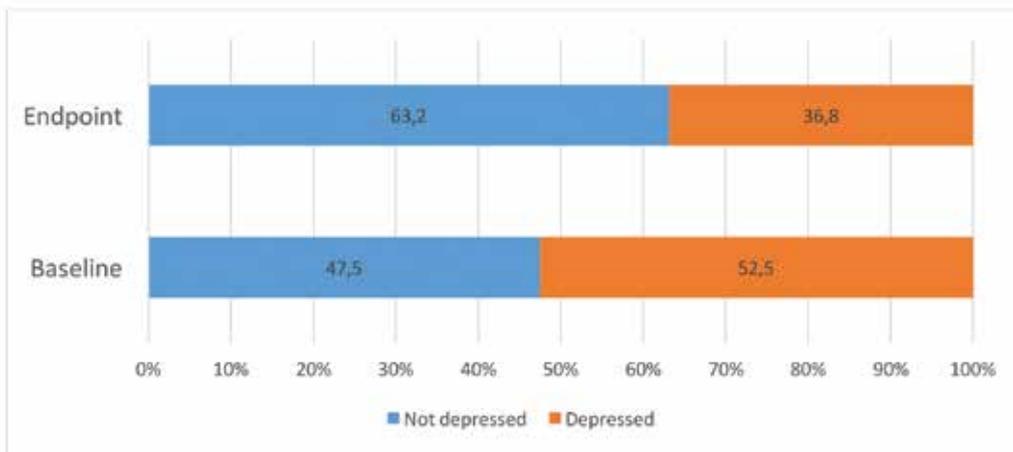


Figure 11: Intervention group depression index (Baseline n = 59; Endpoint n = 38)

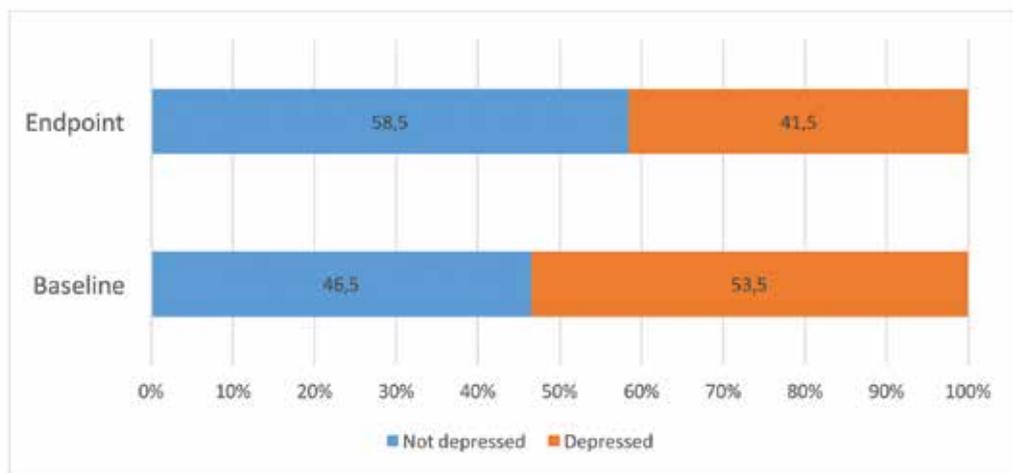


Figure 12: Control group depression index (Baseline n = 71; Endpoint n = 65)

However, it is important to note that the control group findings also showed a reduction in depression over time (from 54% to 42%, see figure below). The cause of this 12% change is unclear, as they did not undergo any intervention. It is possibly attributable to the 'Hawthorne Effect', which has been noted in other South African research (Cluver et al, 2018; Rosenburg et al, 2016). Contamination across the intervention and control groups is very unlikely, as participants were randomly selected and allocated. While control and intervention groups came from the same schools, and in some cases could have known or met each other, this is highly unlikely across all the wards taking part.

4.1.4 Summary of all caregivers at baseline

The impression gained from this baseline depiction of all the caregivers was that the majority were unemployed and survived on social grants, which they supplemented with a range of income-generating activities, such as ironing. Poverty was pervasive and the biggest challenge seemed to be to provide children with material needs – e.g. uniforms and money for school outings. Single parents and grandparents also struggled with the burden of raising young children. Fifty-three percent of all caregivers reported symptoms of depression, a high level. Similar findings emerged from previous research in Doornkop, Soweto (Moodley, 2014).

Respondents' aspirations seemed to revolve around getting a job and earning an income. With respect to their aspirations for their children, respondents all valued education as a way of exiting poverty. Most respondents reported feelings of family belonging. They engaged in various joint family activities such as watching TV together. Caregivers gave examples of family communication by describing how they asked their children how their day was and what they had done at school. They tried to instil certain values and behaviour in their children such as the value of education and not playing on the streets. They also discussed how they attempted to resolve problems and conflicts. Most respondents employed some form of family rules and chores – for example, children needing to tell someone that they were going out to play, being home by a certain time, and washing dishes before going to bed at night. Caregivers explained that they endeavoured to monitor their children's behaviour and ensure their safety by e.g. keeping candles and matches out of children's reach, accompanying them to school, and instructing them to decline lifts from strangers.

In terms of discipline, most tended to resort to spanking their children. In addition to physical punishment, they all sometimes used reward and positive reinforcement to praise children when they did something well. Most caregivers seemed to feel that they were doing a good job of parenting – particularly in relation to material aspects such as providing food, clothing etc. Caregivers seemed to genuinely care about their children, and some attended school meetings, and tried to assist with homework. When prompted by the researchers, caregivers were able to identify resources such as SASSA, clinics, police and so forth. They highlighted the poor quality of community resources in their area – e.g. sewage running down streets. None of the respondents mentioned social work services as a source of support. While some caregivers trusted community members, others did not. Although there was little evidence of budgeting behaviour, caregivers tried to save from their limited incomes, with the most common source of saving being through stokvels. Caregivers appeared to have a basic understanding of nutrition and food hygiene.

The impression gained from the qualitative interviews was that there were no major differences between the intervention and control groups at baseline in relation to the five dimensions underpinning the study. This finding is understandable given the fact that both groups were randomly drawn from socio-economically poor wards in Johannesburg, all caregivers were in receipt of social grants and they had a school-going child in Grade R or Grade 1. In terms of the theory of change underpinning the study, all the families in the intervention and control groups were receiving one or more Child Support Grant, which is means-tested and paid only to poor families. Hence, both groups could be considered at risk for compromised child well-being due to the social, environmental and developmental context (ecology) in which they live (Tolan et al, 1995).

4.2 CAREGIVER FEEDBACK AT BASELINE AND ENDPOINT: CONTROL GROUP

This section provides an overview of the families in the **control group** in relation to the key dimensions of interest. The purpose is to use this information for comparative purposes, so that any changes found in the intervention group can more confidently be linked to the Sihleng'imizi programme. The findings have been somewhat summarised in order to use for comparative purposes.

4.2.1 Profile of control group

As in the case of the intervention group, caregivers in the control group were randomly selected from social grant beneficiaries with children in Grade R or Grade 1 attending primary schools in the 10 wards identified as disadvantaged by CoJ officials. At baseline, in the majority of cases the caregiver was the mother of the child, with a smaller proportion being cared for by grandparents, the biological father or other relatives. In many cases the biological mother and biological father lived in the same household but were not the primary caregivers – e.g. because they worked. In 87% of cases someone else also assisted with caregiving e.g. a grandmother or adult daughter. In terms of other children receiving grants, the most frequent responses were one child, two children or no other child. At endpoint the same caregiver took care of the child. There had been very few major life changes such as a birth, death or illness.

One change noted was the reduction in the symptoms of depression reported by the participants, from 54% at baseline to 42% at endpoint. It is not clear what would have caused this. It is possible that just asking questions about mental health assisted participants to consider their lives and make changes that reduced their depressive symptomology, known as the 'Hawthorn Effect' (Rosenburg et al, 2016).

4.2.2 Themes that emerged from interviews with the control group at baseline and endpoint

Family and child-caregiver relations

All of the 20 respondents in the baseline interviews communicated concerns about the children's/family's futures. Their hopes and dreams were related to ensuring future independence, and financial sustainability. For example: *"I want to see them [my children] doing good at school ... live a better life than what we are offering right now"*. Hopes and dreams were experienced to be undermined and prevented by financial difficulties and shortages. For instance: *"Sometimes it is hard for us to give them [children] those things [asked for by children] and as a result it gets ... trust gets shaken a bit. Then they don't trust that our parents can do 1, 2, and 3"*. Sixteen (80%) of respondents reported no change in terms of their hopes and dreams for the future. Three respondents reported that they either lost their homes or were in the process of being evicted from their homes. In these cases, the family focused their responses on finding somewhere to live, redirecting their responses from their children's education (future hope and dream) to finding a home (immediate).

Family bonding and cohesion mostly remained unchanged – indicating that while strengths were maintained in this area, if there were challenges in family bonding and cohesion, these did not shift either. Specifically now focusing on child-caregiver relations, evidence of aspects of positive parenting for the most part remained unchanged between the baseline and endpoint findings. This means that strengths that were exhibited by the caregivers in relation to positive parenting skills at baseline, were sustained throughout this period. Family rules, mostly related to chores family members were expected to complete daily, also remained unchanged.

One aspect of caregiver relationships did seem to change: communication within families appeared to increase over this time. This is positive for these families, but is not attributable to a specific event or process, as there was no consistent event experienced by all these caregivers over this period. Therefore there does not seem to be a clear explanation for this shift.

There appeared to be an increase in stress relating to financial difficulties, for example: *“So, I’ve heard that my mom wants take us all out of the house and rent it out and I don’t know where we will stay”*. This shift was related to individual family circumstances and not to anything experienced by the group as a whole.

Existence of conflict mostly remained unchanged. Parental aims were reported to be focused on disciplined obedience. There was evidence that caregivers used corporal punishment in a number of cases. For example:

“But it depends, maybe I have told him ... ‘do not ever do that’ and he repeats it, that’s when I see it necessary to beat him.” (Thokozile, caregiver)

Caregiver involvement in children’s education

Some caregivers reported an improvement in the child’s performance at school. These changes appear to be related to individual family changes that occurred such as a parent moving into the house, or grandparents becoming involved. In one case, the caregiver reported becoming more engaged in the children’s homework. For example:

“But now we are three, my grandmother ... and my father would also help me with something ... and my brother would come and help me out as well ... So, there is some fresh air ... it’s there, it has changed everything, and she is picking up her marks again at school” (Nkateko, caregiver).

Where there were concerns about performance, responses did not indicate that the efforts to shift this were related to educational inputs. For example, in one case the caregiver assumed the poor performance was related to the child’s experience of poverty. She commented:

“Like now, she is still in Grade R and not Grade 1 [like she should be]. I have to try everything for her, try and make sure that she is like the other children. Like uniform, so that she does not get disturbed and be like other children” (Cynthia, caregiver).

The majority of respondents reported no change in their own engagement in the child’s education. Any contact caregivers did have with schools appeared to be somewhat superficial. For example, one parent said: *“At school he’s coping alright, he’s good and his teacher hasn’t complained about him”*. This does not mean there was no active support for the educational needs of children, just that these did not appear to change between baseline and endpoint. For example, at baseline one caregiver said that she knew that it was best to:

“Teach the child, make time to teach them and not concentrate on the TV” (Anna, caregiver).

Social and community connectedness, trust and community safety

The majority of caregivers reported that they have very little trust within the community, specifically when it comes to the safety of their family. For example, *“Eish ... you can’t trust anyone with your children”*. *“I don’t feel safe.”* There was little change between baseline and endpoint.

Respondents were aware of basic community services such as clinics, schools, police stations and so on, but were primarily concerned about problems with these institutions in offering comprehensive services, such a queues at the clinic and non-responsive police. There was no mention of alternative resources available in the community.

Financial capabilities

No respondents indicated that they were actively practising budgeting skills, although of course it is probable that many of them do so without realising this. Financial management seems to be largely composed of future wishes and dreams rather than concrete plans. As one caregiver said:

“[I] wish to have a house and for my children to get an education, a good future for my children and have a stable home ... If I could find a better job” At endpoint the same caregiver expressed the desire: “For them to learn and for me to have things in life ... to have things that I want like a house ... And a better job.” (Julia, caregiver).

Six (30%) of respondents who reported that their financial challenges decreased indicated that their living arrangements had changed – i.e. either the family in question moved in with another family member

or vice versa, so that financial burdens were therefore shared. However, in circumstances where financial stress was reduced because of shared space, the relationship between the child and the caregiver was altered, accompanied by difficult behaviour from the child.

All the respondents had knowledge of the loan services and savings programmes. However, their main source of income was derived from social grants and all the available revenue was used for basic subsistence needs and to pay off loans. Caregivers were aware of community savings programmes such as “stokvels”. The conclusion reached was that budgetary and savings behaviour remained largely unchanged.

4.2.3 Discussion of findings for the control group at baseline and endpoint

Analysis of the 20 caregiver interviews in the control group revealed minimal changes between baseline and endpoint in terms of the key dimensions of the study. Where changes were evident, it seems that these were related to events specific to the individual families. This is not surprising, as family contexts do in fact shift over time for all of us, and are not static. Consequently, the changes recorded must take into account the fluidity of people’s lives, such as gaining and losing employment and moving house.

It is also possible that the ‘Hawthorne effect’ may have been operating, as reported by Cluver et al (2018) in their parenting programme for adolescents and their families in South Africa. In other words, the fact that researchers asked caregivers about various aspects of child–family relationships and parenting may have prompted some caregivers to reflect on and improve these aspects in their lives. It is unlikely that there was ‘contamination’ between members of the intervention and control group. While these groups came from the same schools, the control group participants had no knowledge of the programme. Some caregivers probably knew each other across groups, but this was varied across each research site.

4.3 WHAT CHANGES OCCURRED AS A RESULT OF THE INTERVENTION?

This section focuses on the changes that occurred in the intervention group, which appear to be related to the Sihleng’imizi intervention programme. The areas of no change are also identified. The findings reflected in this section are accompanied by a representative few quotations from the qualitative data. However, for the purposes of trustworthiness of the evidence that led to the findings contained here, additional quotations are contained in Appendix B, which can be found at the end of this report.

4.3.1 Changes in accordance with the five key dimensions of the study

Changes that occurred between baseline and endpoint are discussed in terms of the five key dimensions of the study, namely, (i) family and child-caregiver relations in terms of hopes and dreams; family cohesion, communication and rules; child monitoring, discipline and parenting; and perceptions of own caregiving; (ii) caregiver involvement in children’s education; (iii) social and community connectedness, trust and community safety; (iv) financial capabilities in terms of budgeting and saving behaviour; and (v) caregiver and family knowledge of nutrition, food preparation hygiene skills and food preparation skills.

4.3.1.1 Dimension 1: Family and child-caregiver relations

The findings related to family and child-caregiver relations are made up of a number of different sub-themes: (a) hopes and dreams; (b) increased positive communication patterns in families; (c) increased use of positive parenting behaviour; (d) the establishment or maintenance of family rules and consequences; (e) discipline and reduction in harsh parenting; (f) monitoring child safety; and (g) the perception of caregivers’ own parenting capability.

a) Hopes and dreams

In expressing their hopes and dreams, caregivers mentioned more than one aspiration for the future. The most frequently mentioned aspirations were, in decreasing order, a good education for their child/ren, employment for themselves, to increase their own education, and to be good parents in relation to their children. These aspirations remained very similar at baseline and endpoint, and so it is unlikely that any of these were as a direct result of the intervention, but could have been reinforced via Sihleng’imizi.

At endpoint, many caregivers (48%) expressed the view that education for their child was key to realising their hopes and dreams, and having a better future, as articulated in the following verbatim responses:

"I wish that they grow up, and when they are grown up they should go to school and finish. That's what I want, that they should go to school and finish and maybe one day they will also be successful" (Lungisa, caregiver).

"I wish that they study and pass, then move forward" (Grace, Caregiver).

"My wish is for all my children to study more than me, and have a great future, I should raise them and take care of them. They shouldn't struggle while I am still alive" (Aubrey, male caregiver).

Twenty-four percent of the respondents aspired to getting a job so that their lives could improve and their children could be educated. These are indicative comments:

"My wishes are that if I could work, work for my children so that they can get good education, yes. Because during our times, when you got to Matric, when your parents can't take you further, then they can't take you further and there is nothing you can ..., you also know the situation at home. So, for me to try with the little I get and save for my children's lives" (Ayanda, caregiver).

"If I can also find a better and good job that will bring in some money for me to raise them better because everything now needs money" (Aubrey, male caregiver).

A number of caregivers mentioned wanting to improve their own education, as follows:

"For me, for next year is to further my qualification. Upgrade my tertiary results and in the family to encourage my nieces and nephews to focus on their studies" (Muzi, male caregiver).

Other caregivers focused on being a good parent to their children as a primary aspiration. For example:

"My hopes is that we can continue as a family and also continue to respect each other because when there is no union and respect for each other, then nothing will work out. So, I wish we can continue then I become a good parent and support the child all the time, when they call me at school then I can be able to be there for her" (Khanyisile, Caregiver).

An interesting sub-theme that emerged was the desire that children should be able to distinguish right from wrong despite not being punished physically for wrongdoing. Implicit in this idea was the belief held prior to the Sihleng'imizi programme that it was necessary to physically chastise a child in order to teach him or her to know right from wrong.

"My hope is that they must grow and become those people that even if I do not hit them but they still listen to me and also know that ... and not say that we don't hit them at home and they go out of the right path. That they must be educated and progress" (Nomvula, Caregiver).

The theme of being a good parent also extended to other children and teaching them things that the caregiver had learned at Sihleng'imizi. The following comment highlighted the need for more parents and children to have access to the programme:

"I also wish for my life, I know that if it's good in my life it will also be good in the child's life. Maybe the way or the knowledge I have with children should move forward, and then ..., yeah. So that I can know that maybe not only for my child but I should also be a good parent to other children and teach other children good things because I remember some people who were not in the group were asking me 'what are you doing at the school?' and I would show them the book that 'we are doing this and that' and I would see that they also love it, they would say 'hao, why didn't they involve us?' and I said 'I don't know, the social workers just chose for themselves'. So, my dream is that all children should be in this [programme]" (Phindile, Caregiver).

b) Communication patterns

Of the 30 caregivers who responded to questions regarding communication, all (100%) emphasised positive changes in family communication following attendance at Sihleng'imizi. Figure 12 indicates that the most frequent change was towards positive communication skills, followed by increased problem-solving behaviour, and active listening. A smaller number of respondents mentioned a reduction in the

use of vulgar language and improvements in caregivers' own behaviour, particularly in terms of keeping calm, talking and avoiding shouting.

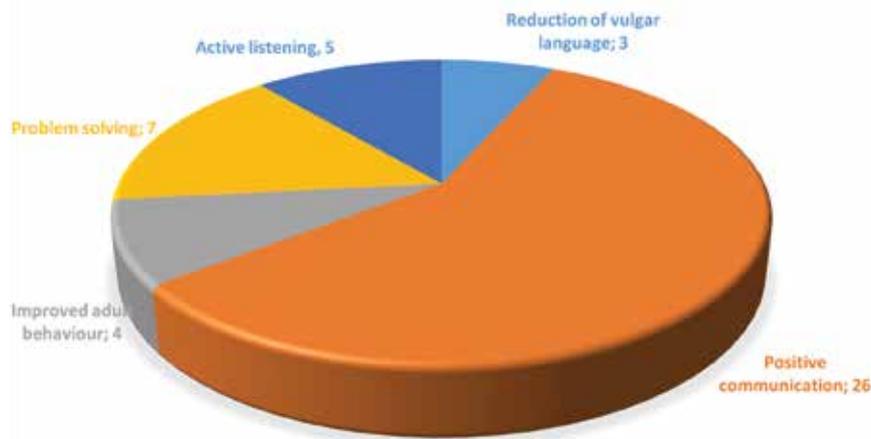


Figure 13: Improvements in communication (n=30)

Note: Numbers do not add up to 30, as caregivers used various forms of communication.

Positive communication skills

As many as 26 out of 30 caregivers highlighted the use of positive communication with their children and family members. Within this theme, two sub-themes emerged.

Sub-theme 1: Ability to talk respectfully to one another, ask about child's welfare, and share experiences

"Since I started there now I can see the changes in them also and ..., yeah we communicate better also now, we are more closer ... She listens now, and she is more comfortable speaking to me now They were always fighting, hitting each other and then, but now they have become close, the way they speak to each other and that" (Mashudu, Caregiver).

"I do see a change, a lot because now she can also tell me things that [she is unhappy about], or when she needs something. Because at first she was afraid to ask me something" (Nobuhle, Caregiver).

"There has been improvement in communication. Myself and T, I think we have learned to say how we feel, instead of reacting before we speak to each other. That has been the biggest highlight of the programme, and implementing what is in the module as well, it's also been very helpful ... I have noticed that he's more confident, and there is more willingness tell me how he feels, so there is a more secured kind of feel and that's a lot important and one of the things I have picked up from T. And he expresses himself and how he is feeling, he is not coming into a shell any longer, you know. So, he's very, very open" (Rose, Caregiver).

Sub-theme 2: No longer needing to resort to shouting and hitting

"I was shouting but now I can talk to them well. That when you do this and that, do you think it's fine? Maybe they would say 'no Mama it's not fine' ... We would sit down and talk 'why did you do this, what did they say on that day there' and then you'll find that they would apologise then" (Thembisa, Caregiver).

Active listening

Five out of 30 caregivers reported that they had learned how to adopt active listening skills. The fact that only five persons mentioned active listening skills did not necessarily mean that none of the others had acquired this skill. It simply meant that these five caregivers highlighted this aspect in response to open-ended questions about changes in communication following exposure to the programme, while others commented on other aspects.

"Yes, I sit down with them because this one said after studying he wants to be a doctor, so I would listen to him telling me about the subjects that are needed" (Oratile, Caregiver).

"I listen to them. Before I wasn't listening" (Siphokazi, Caregiver).

Problem solving

When asked how they resolved conflicts and disagreements, seven caregivers responded to this question, and explained they employed problem-solving behaviour, and in most cases this was different to before.

"What I would say would happen now is that we are communicating things through. Where if one is unhappy, and we make sure that it works out for all of us before it happens" (Mashudu, Caregiver).

"It has changed because when someone hurt me before, I would do things in anger. But now when someone has done a mistake, for us to solve the thing we should talk to each other" (Masego, Caregiver).

Reduction in child's use of vulgar language

Three respondents reported that there had been a reduction in their children's use of swear words and vulgar language.

"There are those (rules) I have added, in terms of time, in terms of supper, in terms of communication. There is no longer vulgar [talk] that works in the house, and corporal punishment is no longer there" (Lindiwe, Caregiver).

"N does no longer swear and she does not do funny stuff anymore. When you talk to her, she listens to you and when we do something here at home, she is no longer scared to talk to me. Let's say she wants us to do something, she is able to say 'mama, let's do this or let's play together'" (Motlalepula, Caregiver).

Improved adult behaviour

Four caregivers informed the researchers that the programme had not only impacted on their children, but had also positively influenced their own behaviour, as they were now better able to control their anger and discuss matters in a calm and rational manner. These are insightful comments, recognising their own limitations and how they have made real progress in managing their own strong emotions.

"You know, sometimes when I have my own stress I would be rude to them. So, since I joined that group I am able to manage my behaviour with them" (Oratile, Caregiver).

"I had anger and took it out on her and that's anger I had towards A's mother because she's the one who made me angry then I would take it out on [the child] ... I would say she's like her mother ... That's what I used to say that you're naughty like your mother, you don't listen! ... Yes and I could see how hard life is and her mother is spending grant money and even at school she doesn't have school uniform but ever since I went there (Sihleng'imizi) we are able to take time to talk ... I'm now able to do that because I was unable [before]. When you find that I'm angry I would pick up a stick and hit them" (Adeleide, Caregiver).

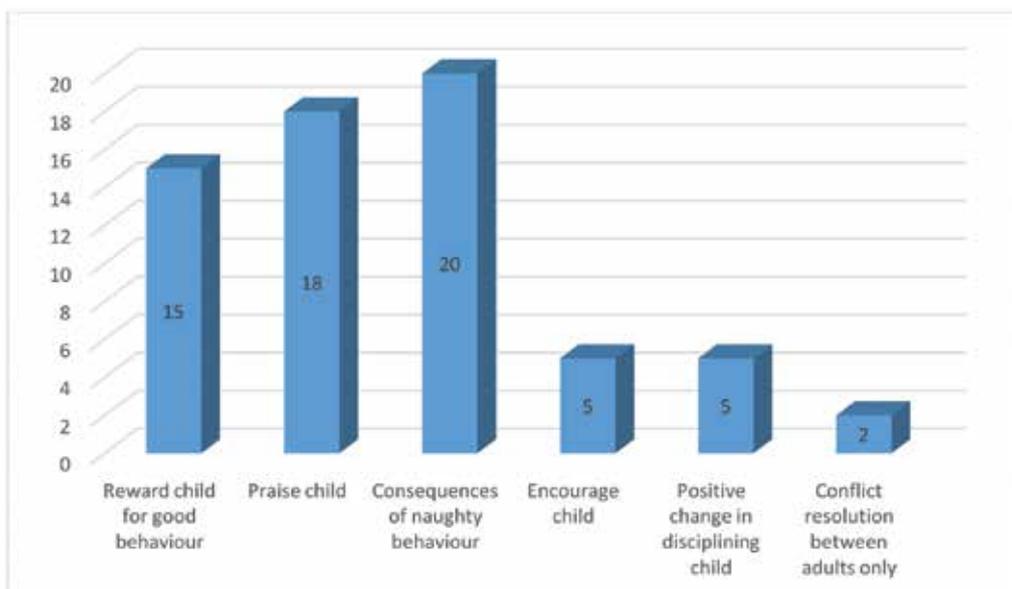


Figure 14: Increase in positive parenting (n=30)

Note: Numbers do not add up to 30, as caregivers employed various forms of positive parenting.

c) Increase in positive parenting behaviour

Figure 14 indicates that the most frequent changes in positive parenting behaviour took the form of praising the child, teaching him/her the consequences of negative behaviour, and rewarding and encouraging good behaviour.

Rewarding child for good behaviour

Fifteen caregivers emphasized that following attendance at Sihleng'imizi, they rewarded their child for good behaviour. Rewards could be either monetary or non-monetary.

"I have adopted the Sihleng'imizi style of charts. So, I also bought stickers and whenever we bring things and we say 'we are not doing anything, let's write'. Daddy has his file, I have my file, N has her own file, T has his own file. So, when we do our assessments it's a sticker. If she decides that 'Mama, because you are doing dishes, let me help you'. Ok, I would say 'you are helping me with cups, and whatever but don't do the glasses and knives' then after that I would buy her a yoghurt or anything she wants for that moment, I would praise her with it" (Lindiwe, Caregiver).

"We have like the everyday chart for rewards, so what we have done is that we bought stickers. So, when he does something that is really outstanding, he gets a sticker for that. And yeah, he doesn't take no for stickers, he actually really wants stickers he worked for" (Rose, Caregiver).

"When she is well behaved I am able to award her with that Chappies (chewing gum), I would say that 'yesterday you did this and that, so I bought you this Chappies for what you did yesterday'; I am able to reward her ... Sometimes when I don't have money I am able to give her a hug and explain to her what the hug is for" (Khanyisile, Caregiver).

Praise

It was difficult to distinguish between reward and praise, as many caregivers employed a combination of both reward and praise for good behaviour. However, 18 caregivers reported using praise as a form of positive reinforcement. While of course praise did occur in some families before the programme, caregivers reported being more intentional with their praise.

"I praise her if for instance she helped me to wash dishes, I would tell her that 'thank you for washing the dishes ... you are getting wise and growing up now.'" (Doris, caregiver).

"There is a change because now I am able to praise them when they have done something good or sometimes I am able to give them rewards ... Even not to shout when I talk to them tell them in a right manner that if you see me doing this that it is because you have done this and that ... that is wrong, without shouting" (Nomvula, Caregiver).

"I tell him that 'my child, continue behaving like that. I like what you did, it's beautiful'" (Grace, Caregiver).

Encouraging child

Five caregivers used encouragement to motivate the child to continue with good behaviour.

"I encourage them because if I don't encourage them then who would encourage them? Even if someone from outside would say 'you are dumb' for example, he should know that his mother is the one who knows him that he's not dumb, he can do something like this" (Oratile, Caregiver).

"Sometimes when she sees L drawing, her brothers can draw and she can't draw like them. Then I would say 'hey, they were also drawing like this and you will also be able to draw like them when you are their age'" (Lesedi, Caregiver).

Consequences for negative behaviour

Twenty caregivers learnt from attending the group that they needed to spell out the consequences of negative behaviour to children so that they learned to avoid such behaviour. Caregivers used these consequences as a means of discipline without resorting to hitting or beating. Consequences included depriving the child of some favourite thing or activity such as switching off the TV or sending the child to

the 'calm down corner'. Verbatim responses highlight these three sub-themes which came out strongly in the findings.

The first sub-theme was making the **child aware that there were consequences for wrongdoing**.

"But in the end you shouldn't leave a child with a question mark. You should make it clear 'what you did is wrong' and why I am saying it's wrong. What you say it's right and correct the child" (Mashudu, Caregiver).

"I used to like to shout at her and when she had done something wrong, I used to beat her up, but now when she has done something wrong, I call her and make her take note that she has done something wrong and I ask her what she is supposed to do when she has done something wrong. And then she knows that she should apologise" (Motlalepula, Caregiver).

The second sub-theme was using the technique of **depriving the child of a favourite thing or activity** as a form of effective discipline.

"When a child did a mistake, I won't say I will punish him next time. Now I have found an alternative that 'you won't get what you wanted, Danone (yoghurt), I will give it to you later, please fix your mistake here'" (Masego, Caregiver).

"I cut off the favouritism, maybe they won't be able to watch the TV for 10 minutes or 15 minutes. I don't give him the dessert after meal ... Switch off the TV ... and if we are supposed to go to the park we postpone the date, if they misbehave" (Gugu, Caregiver).

"If they don't keep up with the sleeping time when I talk to them, I can see they don't want to sleep, I just switch off the TV" (Adeleide, Caregiver).

The third sub-theme was an increase in the use of the technique of a **calm down corner** as a means to manage behaviour.

The Sihleng'imizi programme promoted the use of a five-minute cool-down exercise or using a 'calm down' corner as an alternative to reacting with anger or physical punishments. The following quotations reflect this new skill. In the last quotation, it is clear this caregiver had already been using the concept of a calm down corner in her management of behaviour, so this technique was reinforced and its effectiveness supported.

"I put him for five minutes, after putting him for five minutes he would tell me that 'I won't do what I did again' because you have punished him. I even told people that when you beat the child, he would never listen to you" (Nkhensani, Caregiver).

"At Sihleng'imizi they taught us about cool down corner. That you will put her in the corner [and] you explain to her that, 'you are sitting here because you left [the house without permission] and you came back after a long time'... so punishing them by hitting them NO" (Nomvula, Caregiver).

"I would hear and reprimand, if he continues he goes to the calming corner and I also have my calming corner so that I don't get worked up or he doesn't get worked up. Each and every time he is going to calm down and then come back and say 'you know what mom, sorry' Before the group he was into the naughty corner, if the naughty corner doesn't work he would get spanked. And that was my method ... and the nice thing about it is that I don't have to talk too many times, I talk once or twice and that's it, and he understands" (Rose, Caregiver).

Positive change in disciplining child

Five caregivers described positive changes following attendance at Sihleng'imizi in the way they disciplined their child. At endpoint it became clear that the extent of corporal punishment at home was under-reported in the baseline data collection, as this is a taboo subject. There also had been some families where there had been a lot of shouting during disciplining. The participants were far more able to discuss this after the group ended, and shared quite openly how they previously beat the children, and that certain techniques learned in the group have been very helpful to reduce physical punishment.

Additional discussion of corporal punishment and its reduction will appear further on in this report.

“At first I liked shouting at her when she was doing something wrong. When she doesn’t listen maybe I would beat her, and then now I can talk to her while I am calm ... I don’t fight; I talk to her while I am calm so that she can also talk to me” (Nobuhle, Caregiver).

“The group has taught us also is that we must think before we react. That’s the only reason why we have the calm down corner. We have the calm down boxes and all that. In all those things is to make you think before you react or before you do something that you might regret” (Mashudu, Caregiver).

“Change that has been there is that I am able to bond with her, I am also able to respect her and I am also able to talk to her without beating her” (Khanyisile, Caregiver).

Conflict resolution between adults

Two caregivers explained that they tried to avoid engagement in conflicts with partners when their children were present.

“When my partner and I are fighting, I do not want us to fight in N’s presence. So I tell him that we should wait until N has fallen asleep and we can discuss those issues then” (Motlalepula, Caregiver).

“Our problems as parents they are not problem that we are talking with children ... We are supposed to talk amongst the two of us” (Nomvula, Caregiver).

Positive parenting skills can be very empowering to caregivers, especially if these are new behaviours. In some cases caregivers were using one or more of these skills already, and the emphasis on the effectiveness of this behaviour helped reinforce the basket of positive parenting techniques. Caregivers were asked at endpoint to reflect on their perspective on aspects of caregiving in relation to how they felt before Sihleng’imizi and after the intervention ended. Their responses are reflected in the figure below.

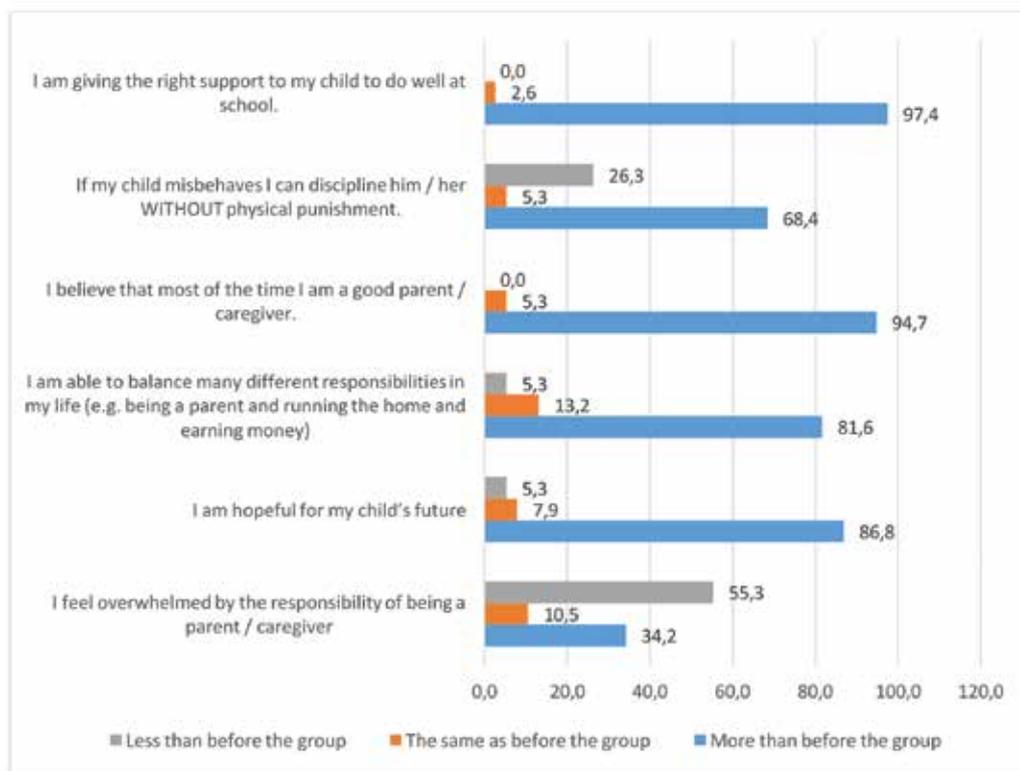


Figure 15: How you feel now compared to how you felt before Sihleng’imizi? (n=38)

Figure 15 shows that following attendance at the Sihleng’imizi programme, the majority of caregivers (68.4%) 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.

It is not clear why 26.3% of the group felt they were less able than before the group to discipline their child without physical punishment. In addition, although the majority (55.3%) felt less overwhelmed by the responsibility of being a parent/caregiver, a sizeable proportion (34.2%) felt more overwhelmed. The programme may have made them more aware of the enormity of their responsibilities towards their children, or they struggled with new child-discipline skills. Alternatively, these findings may have been due to misunderstanding arising from the negative wording of both of these questions.

d) Family rules and consequences

We were interested in ascertaining whether children's lives were safer as well as more structured and contained following the intervention. For this reason, interviewers specifically probed whether changes in family rules and routines had been made as a result of attendance at Sihleng'imizi. While there was a certain amount of overlap, the themes depicted in Figure 16 emerged. 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.

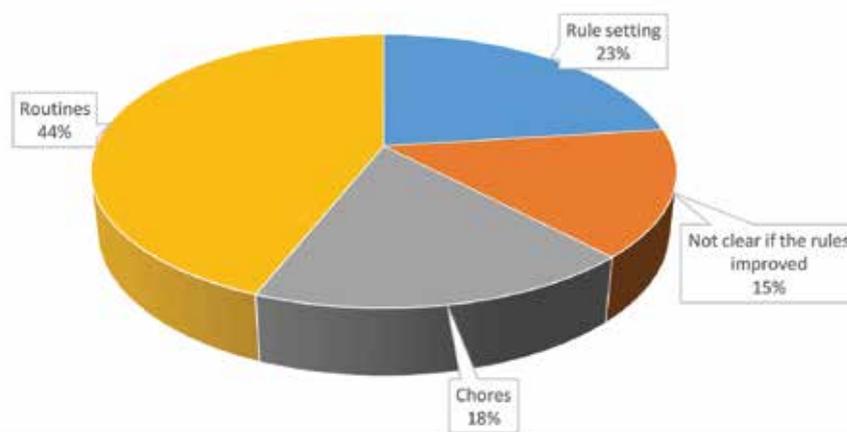


Figure 16: Change/improvement in family rules, n=34

Improvement of rules in relation to chores

Six caregivers stated that their children were allocated chores to complete, which are either new rules or were previously rules but are clearer than before. Examples are as follows:

"Now she comes home early, where they mess they clean, where they break something they clean, yeah. Before they would break and I would clean" (Mashudu, Caregiver).

"(Before) we were unable to assist each other here in the house with chores, like one will do this and the other one will do that. They will just watch me do things on my own" (Siphokazi, Caregiver).

Implementation of routines

The implementation of rules and routines was suggested during Sihleng'imizi as a way of managing behaviour, of encouraging emotional security and safety in expectations and boundaries, of benefitting children in relation to sufficient sleep, safety in the evenings, monitoring child whereabouts, and so on. Although there is slippage between the notions of rules and routines (the one leading to the other), in this section we try and focus on the routines themselves, and later we focus on the rules.

Comments by 15 caregivers highlighted the changed emphasis on routines following the programme. Within this theme, three overlapping sub-themes emerged. The first sub-theme is the **structuring of routine activities and behaviour at home**.

"The behaviour, and we started to re-structure the rules. For instance, to come back home 6 o'clock and their sleeping time is 8 o'clock, the latest is 08:30. The reason why I am emphasising the sleeping time is

because I want them to be as early as possible to school. I don't like it when they are late for school, and now I don't have much challenges than before ... Before we used to eat one by one. After Sihleng'imizi they taught us that it's very important to eat as a family because we can have some talks while we are eating" (Gugu, Caregiver).

"They were used to fighting a lot but now they are able to play together and help each other. And that they are able to encourage themselves to do school work, because we also made a draft which we put on the wall that on Monday we are doing this, Tuesday we are doing this. So they already know that Monday when we come back from school we do this and that ... Yes, as I have explained that they (the rules) are there on the fridge, they shouldn't come back home after 6, so at 6 o'clock we should all be home. Before eating they should know that they have washed their hands, another one is bed time, that the latest is 7:45. And when they go to school they leave at 07:20, and then they should also know where their clothes stay" (Kedi, Caregiver).

Sub-theme two is to do with **coming home from school or from playing outside by a certain time.**

"We've got structured rules, for example no late coming. Remember 'light on, you have to be inside' if you overstep that, of course there is consequences. But rules that actually calm him down, like I said I am not that hard on him, where I would derail him. So, with the rules being flexible ..." (Rose, Caregiver).

"Firstly ... my children were not coming on time at home. So, when we started attending Sihleng'imizi we decided on setting a time to come home. And secondly, they didn't do their homework properly. When you asked them to do their homework, they would sometimes whine and ignore me. But when they came from over there, they came back knowing how important it is to do your homework" (Siphokazi, Caregiver).

The third sub-theme relates to **spending time together as a family.**

"Like spending time together before, it used to happen sometimes. But now that we have the rules, we made the rules and it has become a must that maybe two times or three times a week we should do things together with the children" (Phindile, Caregiver).

"The change that we had is that we were able to have a special time as a family and we had ground rules which we were able to continue with in the family. So we had a special time about how we bond as a family" (Khanyisile, Caregiver).

Rule setting

Eight caregivers reported that they had implemented new rules, as reflected in the following quotes:

"I would tell her that even when you went to play, and then someone comes. Even if you know them, maybe it's my friend saying 'let's go' you should come to me first, when she comes and say 'H let's go' you should run and come to me, and tell me that 'Mama, here's so and so's mother, they are going wherever, can I go there?' so that I can know. Not that when someone comes, when I leave here you would have told me that you are coming here but only to find that you are there" (Phindile, Caregiver).

"What I did before the group came to an end, I wrote on a paper, can you see it on the fridge. Those were the rules and what happens if you don't keep those rules, so we are trying to stick to that. So they haven't done those huge mistakes because they know that if they do something that doesn't go along with the house rules they get the consequences" (Kedi, Caregiver).

"They must not go alone at least when they go somewhere they must be in a group or even when I send them to Pick 'n Pay (supermarket chain) ... I don't send one child, at least one goes with another one and they are two" (Nomvula, Caregiver).

Not clear whether family rules had improved

In the case of five respondents it was not clear whether chores and family rules had changed or improved following the programme or had been part of family life prior to the programme. This result, particularly the sharing of chores, reiterated the finding by Posel and Grapsa (2017) that Black African children spend significantly more time on household work than children of other races in South Africa.

"They [already] know that they have to be home on time, and we eat together. When we eat supper, the children should be there. They know that they do dishes, they iron before they sleep so that tomorrow when they wake up they only bath, eat and go to school" (Lesedi, Caregiver).

"We haven't changed anything, everything that we were taught we implement it at home. When the gate is locked no one is allowed to go out ... We respect each other, the young and the old" (Nolwazi, Caregiver).

e) Discipline and reduction in harsh parenting

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 are reflected in Figure 17, which shows that corporal punishment, anger and shouting had been reduced and caregivers had successfully implemented the 'calm down corner' strategy.

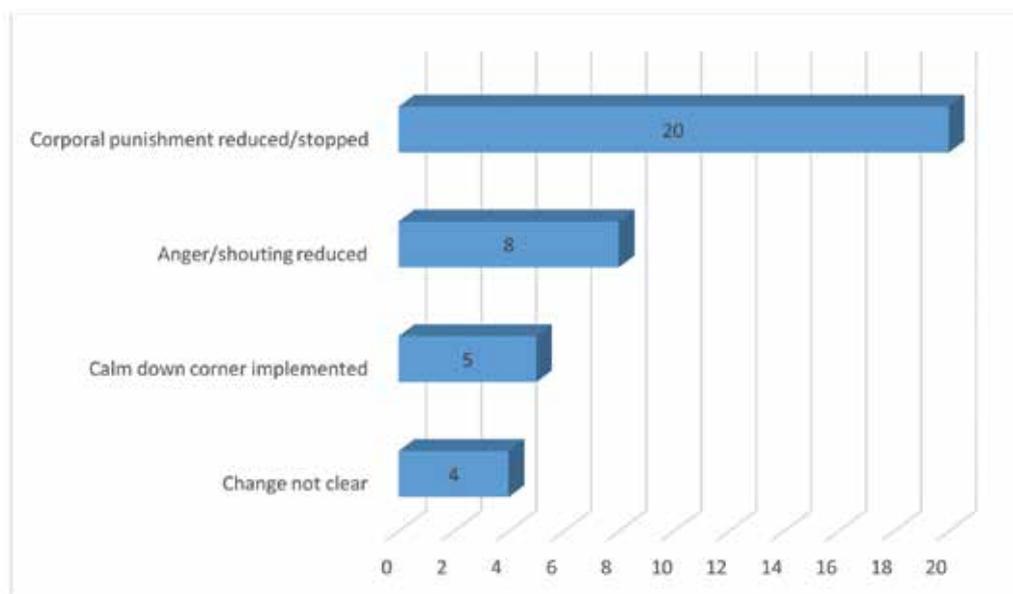


Figure 17: Reduction in harsh parenting (n=24)

Corporal punishment stopped/reduced

When caregivers were asked about any changes that had occurred in the way they disciplined their child following the group, 20 respondents reported that they no longer beat their children. While one cannot rule out the possibility of some respondents having furnished socially desirable responses, the answers suggested heightened awareness of the negative impact of these practices. This finding is important considering recent research by Richter, Mathews, Kagura and Nonterah (2018) in Johannesburg-Soweto that revealed that approximately 50% of pre-school and primary school children had experienced physical punishment by parents.

"What I have discovered while attending Sihleng'imizi is that communication has changed now. They were afraid of me, they were not afraid of their father. Like, he is not someone who beats them and I beat them. But it has changed, I don't beat them anymore. Whenever I punish, I punish in a way that she has her corner. It's either whatever makes her happy, she won't get it anymore ... I become angry and I don't entertain her, instead of using a sjambok [like I did before] ... There is no longer vulgar words in the house, and corporal punishment is no longer there (Lindiwe, Caregiver).

"We [still have] punishment [but now it is different]. Firstly, he will fill up all the buckets with water alone ... He will wash the dishes. That's how I punish them ... I use to hit them before ... I saw that they were right when they say don't hit a child, because when you hit him you're making him worse ... I wasn't using something that could hurt him. I used a wet bath cloth" (Siphokazi, Caregiver).

"Since the group I don't beat her, and I would tell her something now and she wouldn't forget, I would ask her about the spelling we were doing yesterday and she would remember it as it is. So, I think beating her

is something that makes her be afraid. She would catch it but when you ask her she would have forgotten, but since I don't beat her she is fine. So, I have realised that it means that's the good way to work with her. I shouldn't beat her, I shouldn't shout at her. I should put her in the cool down corner until she is fine or punish her by saying 'you are not going to get this if you didn't do that'" (Phindile, Caregiver).

"The major change is that I have managed to become a good parent for N. When she has made mistakes, I no longer beat her up, I use other alternatives of punishing her, instead of beating her. I think that they (the changes) are positive and here at home we are fine [doing better] it's not as it was before and the suffering has subsided a lot" (Motlalepula, Caregiver).

Shouting and anger reduced

Eight caregivers reported that their anger and shouting behaviour had been reduced following attendance at Sihleng'imizi.

"I don't hit them or shout at them [anymore]. Now I see that what I was doing was not right ... I think as a parent what I'm doing right is that they know that I listen to them ... They know that mother can listen to us when we tell her something and she no longer shout at us" (Adeleide, Caregiver).

"Before that I used to shout, I would always scream and shout. And L has the tendency of crying when you shout at her or scream at her, you don't necessarily hit her. You just scream or shout and she starts crying because she doesn't like it ... but now I speak calmly to her" (Mashudu, Caregiver).

"Sometimes I used to shout, and I would be afraid that maybe they would also be a bad example to other children. I would shout that 'hey, don't do this and that' but now I am calm and I also don't shout, I tell them 1, 2, 3 that it's like this" (Aubrey, male caregiver).

'Calm down corner' implemented

Five caregivers emphasised the value they had derived from implementing the 'calm down corner' strategy.

"I am more mindful, like I said. I hear what he said and depending on what it is, like the programme has three different areas, I would hear and reprimand, if he continues he goes to the calming corner and or he doesn't get worked up. Each and every time he is going to calm down and then come back and say 'you know what mom, sorry' ... Before the group he would get spanked. And that was my method ... and the nice thing about it is that I don't have to talk too many times, I talk once or twice and that's it, and he understands" (Rose, Caregiver).

"What we have learned at Sihleng'imizi is that sometimes when the child did something you don't like, give him his corner where you would put him ... That's a good way because even when he thinks of doing the wrong thing he would say 'ah, Mama would put me at the corner'. And I would say 'it's for when you are doing what is not good'" (Ayanda, caregiver).

Not clear if disciplining behaviour changed or same as before

With four of the caregivers it was not clear whether harsh parenting behaviour had decreased or remained the same. For example, in the quotations below from two caregivers it is possible that they did not beat their children before coming on the programme, so their behaviour hasn't changed.

"The children are not to be beaten" (Nkhensani, Caregiver).

"I don't beat them, I just talk" (Grace, Caregiver).

f) Monitoring child safety

Figure 18 shows that there was an increase in awareness of the child's whereabouts, the danger posed by strangers, safety within the home, and monitoring of the child at home and after school. However, in 18 cases (47%) it was not clear whether there had been any improvement. This finding suggests that at baseline respondents were already aware of dangers and risks within their environment and were monitoring their children's safety, possibly due to extensive media coverage of illegal electrical connections, and violence perpetrated against children in South Africa.

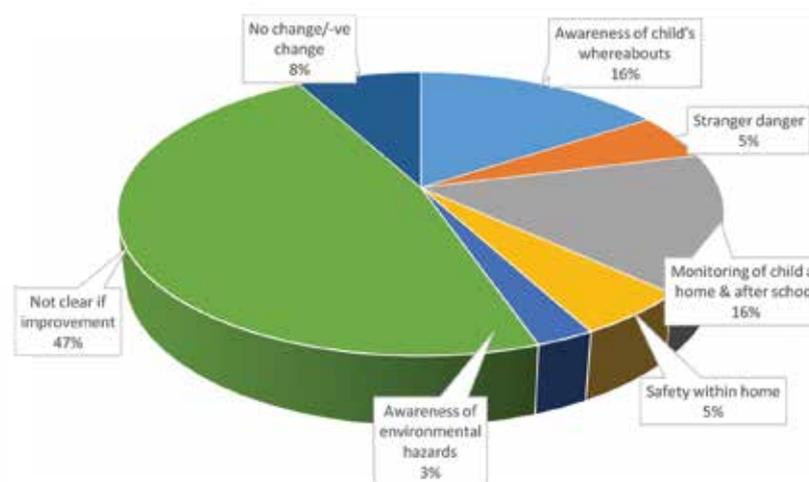


Figure 18: Increase in child monitoring behaviour (n=34)

Monitoring children at home and after school

Twelve caregivers showed a definite improvement in awareness of their child's whereabouts, as reflected in the following quotes:

"I now know where they are because they tell me when they go out of the house "mother we are going to ..." (Adeleide, Caregiver).

"I keep track of T, for example he would be with his friends outside ... me and my mom we are always looking after each other's kids, and if he's with my mom, I know he's with my mom. So, I always check up on them, and now there is never a time where I don't know where he is" (Rose, Caregiver).

"For now the safety reasons are anything for me, gut feeling that something is not right, I have a line of people surrounding, you know. That keep communicating with me that 'you know, your son is here or go find out ...'. So, for me the nice things for me is that now we have parents that look out for each other's children, so that's the good things for me" (Rose, Caregiver).

Safety within the home

Following attendance at Sihleng'imizi, two caregivers emphasised their increased attention to safety in the home.

"[Now] I make sure that she doesn't touch the kettle. I make sure that when the phone is charging, it's charging, she should be busy with the phone because at times she might be dragging the phone but find that there is a plug there then her finger gets in there" (Khanyisile, Caregiver).

Awareness of environmental hazards

One caregiver explained her heightened awareness of environmental hazards as follows:

"It has changed because I am ... teaching them ... that L shouldn't play with rubbish. I teach them, I also teach the boy that he shouldn't smoke drugs (Nyaope)" (Lungisa, caregiver).

Not clear if improvement or as before

In the case of 18 respondents it was not clear whether there had been any improvement or monitoring of child behaviour had remained the same as prior to Sihleng'imizi. These caregivers were largely aware of the safety issues at home and in the immediate environment prior to the intervention. The hazardous conditions under which many families live, make child safety both a priority and a real challenge. Participants mentioned a number of environmental dangers prevalent in informal settlements, such as sewage in the streets, *izinyokanyoka* (illegal electric connections), rat poison, playing on dumps, the danger of abduction or abuse, and dangers in the home such as paraffin, open flames, and so on. Poor

service delivery, from the provision of safe, affordable housing, to issues of water, sanitation, electricity and others, has a direct and negative impact on children, and are an example of how poverty and structural problems create barriers to child well-being.

g) The perception of caregiver's own parenting

We were also interested in finding out whether caregivers' perceptions of their own caregiving had changed following attendance at the Sihleng'imizi programme. Figure 19 indicates that 10 out of the 20 caregivers who responded to this question felt that there had been a definite improvement in terms of more positive attitudes, less harsh discipline, enhanced communication with the child, increased quality time spent with the child and greater pride experienced in their own caregiving.

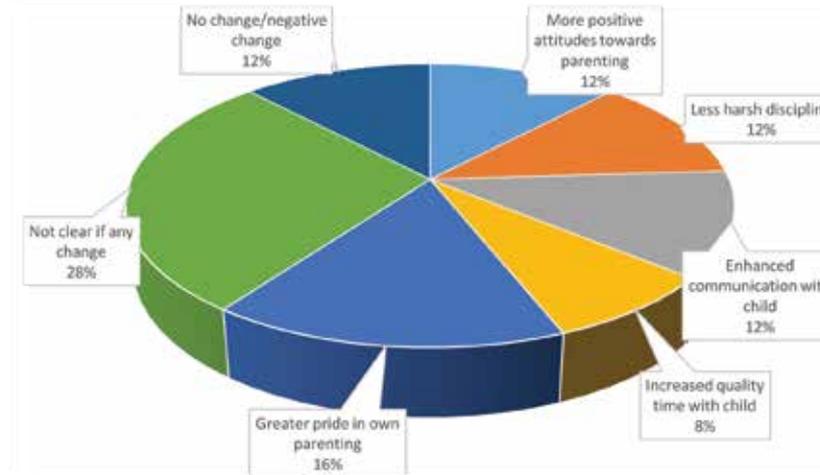


Figure 19: Changes in perceptions of own caregiving (n=20)

Note: The sub-themes do not add up to 20 as individual respondents articulated more than one sub-theme.

Three caregivers (12%) drew attention to their improved attitude towards parenting, such as:

"I am more confident, I am more flexible than before ... It's not a tough game anymore, I don't have to stop myself being aggravated because T is my son, you know. Now I have that if I give him my time, then he's going to be rewarded because he's going to have good behaviour" (Rose, Caregiver).

"I believe as a caregiver I am really taking attention to detail to what he needs and not what he wants. [Its] more rewarding. And I also find that for me it's also beneficial because I also find the inner child in me ... I am also understanding that it's fun to actually be playing with the child" (Rose, Caregiver).

Three caregivers (12%) noted a positive change in disciplining children, including a reduction in harsh parenting.

"I think as a parent what I'm doing right is that they know that I listen to them. They know that mother can listen to us when we tell her something and she no longer shout at us. She no longer hit us" (Adeleide, Caregiver).

"The major change is that I have managed to become a good parent for N. When she has made mistakes, I no longer beat her up. I use other alternatives of punishing her, instead of beating her. It's not as it was before and the suffering has subsided a lot" (Motlalepula, Caregiver).

Three caregivers (12%) emphasised their enhanced ability to talk to and listen to their children as well as spend quality time with them.

"It's talking to her while I am calm because I am a noisy person, yeah. For that I am proud, I talk to her well and she is also able to talk to me about a lot of things because she can see that I am calm" (Nobuhle, Caregiver).

Two caregivers (8%) informed the researcher that they now spent more quality time with their child.

"[The change from before] ... it is [more] time with my children" (Nomvula, Caregiver).

When asked what they felt they did well as a parent, caregivers (18%) noted the physical and emotional care of their children as follows:

"I love them and I care about them and everything they do" (Ayanda, caregiver).

"What makes me proud is that I am an uncle to these children, I am always with them to keep them away from fighting and also to keep them company so that they don't have to feel isolated like the way I felt isolated some other times" (Muzi, male caregiver).

Not all caregivers pointed out change in their caregiving. In some cases (seven, or 28%) it was not clear whether things had remained the same or improved following exposure to the Sihleng'imizi programme, and in some cases (three, or 12%) it appeared there was no change.

4.3.1.2 Dimension 2: Caregiver involvement in children's education

Continuing with the demonstration of changes that occurred in the intervention group between baseline and endpoint, the second of the five key dimensions of this study is caregiver involvement in children's education.

When asked about differences in school-related behaviour that caregivers perceived to have occurred in their children between baseline and endpoint, participants spoke of improvements in behaviour and performance outcomes. The Sihleng'imizi intervention emphasises the importance of a positive and supportive attitude towards learning and school, and suggests ways for caregivers to engage more with and support the learning of their children. It is not an academic or teaching programme and intended outcomes are not performance-related. The following section relates improvements perceived by the caregivers, which are likely to do with improved attitude towards school.

Improvement of child at school

While the programme was not designed to specifically impact children's behaviour at school, caregivers seemed to believe there had been positive changes since the child participated in the group. Figure 20 shows that the changes mentioned most frequently were enjoyment of school, engagement in schoolwork and improvement in subjects.

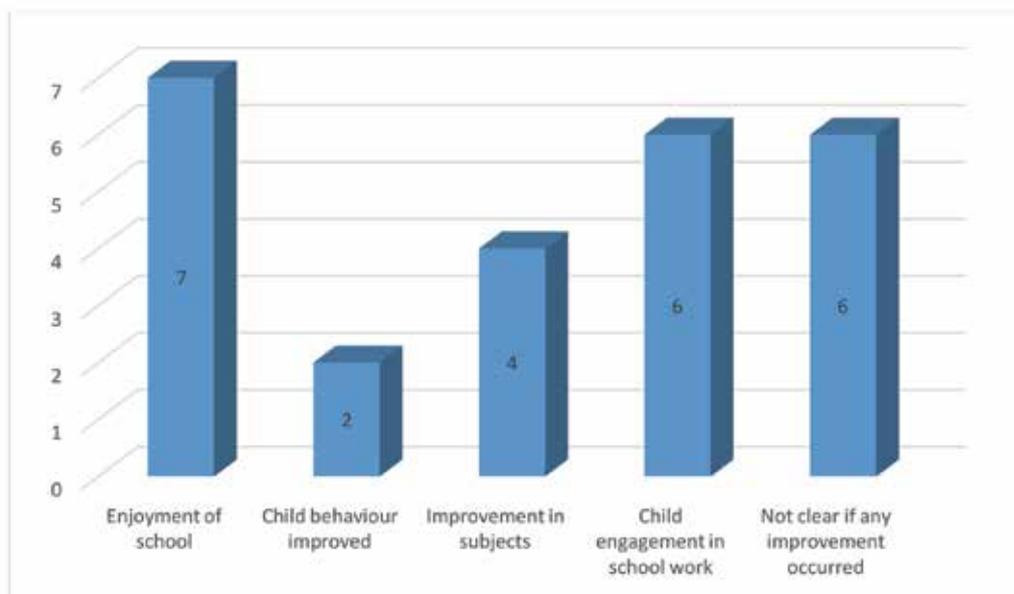


Figure 20: Caregivers' evaluation of child improvement at school (n=21)

Enjoyment of school

Seven caregivers reported that their children enjoyed school following attendance at the Sihleng'imizi group, as reflected in the following quotes:

"There is no doubt about that, he enjoyed school ... This is evident by what he does and how he speak of his teacher and his class mates, so there is always a positivity, there is never a reluctant, for example, he's always excited about school ... I would say it is because of the programme, and why I say that is because there were times where instead there would be tantrums, you know I am feeling sick, I don't want to go to school, whatever, tummy ache, [but since Sihleng'imizi] he's been very excited about school, so I would recommend it" (Rose, Caregiver).

Improvement in subjects

Four caregivers highlighted their children's improvement in various school subjects.

"He's happy since the group, he struggled with counting and he didn't have an interest to do Maths, now he can even count using his hands and also take stickers to count with" (Oratile, Caregiver).

"T has progressed, for the last month he has done really well. He has done exceptionally well, so we are pleased with that" (Rose, Caregiver).

Child engagement in schoolwork

Six respondents emphasised their child's enhanced engagement in schoolwork after having attended the group.

"They taught us to also take books and read for them so you will see a child coming to you with a book asking you to read for her and what is the book saying. You see sometimes he ask that I must also explain even on the Sihleng'imizi book he is the one who is starting by saying 'Mom, let us write homeworks'" (Nomvula, Caregiver).

"After we started the group she had this thing of doing spelling she was doing it every week Wednesdays and Fridays. So, it ended up overlapping to the time of spending time together. She knew on that time that we would talk everyday 'Mama, can you please help me with spelling'" (Phindile, Caregiver).

"Some papers she was not taking out, when she got home and we asked her if she has a homework, she would say she doesn't have a homework while she has it. But now she is able to say 'Dad, here I have a homework, please help me where I don't understand'" (Aubrey, male caregiver).

Child behaviour improved

In the case of two children, respondents had noticed a marked improvement in behaviour between baseline and endpoint. In both cases there was a definite reduction in anger and aggressive behaviour on the part of the children, confirmed by the teachers.

"He is not a child who talks a lot, but he liked hitting with what was next to him ... But I also heard about that from school ... If maybe the child steps on him, he would beat them. But [since we started the group] that's something which was not happening here at home because he knows that when something happened and he comes to report, I would say 'call that child you were playing with so that we can talk to him'. I would say 'apologise to that one' and I would also say to the other one too that 'you apologise too'; and I also have that thing where I would say 'give him a hug, that you have forgiven each other'... The violence has decreased ... Even this thing of being called to school as a parent that he did this and that, since the group started I was never called to go and attend ... Because now there are no [bad] reports [from school] I had to follow" (Ayanda, caregiver).

"L has changed a lot, she now listens, she's progressed well at school and stopped fighting. She used to fight a lot and she was very violent ... she was always angry. I have recently asked how L is doing and she calls me sweetheart, she said, 'Oh my sweetheart, L has changed... and she is now the type of child who takes care of other children'" (Catherine, Caregiver).

From the responses of six caregivers, it was not clear whether there had been any change in the child's functioning at school or if it had remained the same.

Engagement in child's education

One of the objectives of the Sihleng'imizi programme was to enhance caregivers' engagement in their child's education. Figure 21 shows that the improvements cited most frequently were 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 homework. However, in several cases it was not clear from responses whether there had been any changes in this regard.

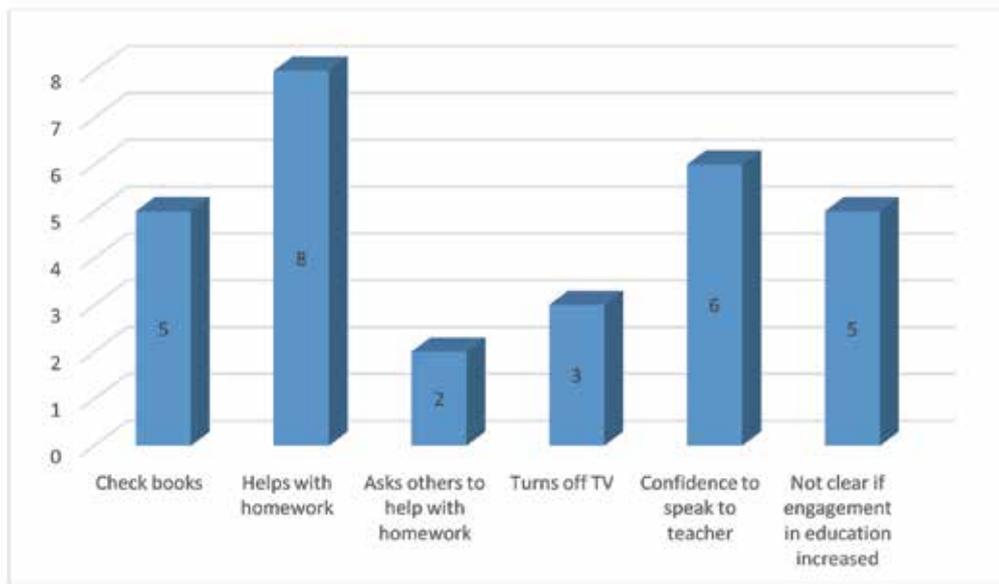


Figure 21: Ways in which caregivers' engagement in child's education increased (n=21)

Checks books

When caregivers were asked whether their engagement in their child's education had increased following exposure to the Sihleng'imizi programme, five persons indicated that they now checked their child's books.

"It's increased a lot now because everything she does I have to look at it, not necessarily only homework. Basically, her schoolwork is alright, I would take a look and ask about it" (Mashudu, Caregiver).

Helps with homework

Eight caregivers described how they assisted their child with homework.

"I am helping them more with their homeworks" (Gugu, Caregiver).

"I assist them more because last time I didn't feel that it was that important, I would tell them to assist each other" (Naledi, Caregiver).

Turns off TV

Three caregivers stated that they now turned off the TV when the child was doing homework as they had learnt at Sihleng'imizi that TV was an unnecessary distraction.

"We switch it off" (Catherine, Caregiver).

Confidence to speak to teacher

It emerged at baseline that some caregivers were reluctant to approach teachers as they felt somewhat intimidated by them. Hence efforts were made during the programme to instil confidence in caregivers to speak to teachers and thereby become more involved in their child's education as well as become their advocates, demonstrating the links between the programme content and the theory of change. Six caregivers informed the researchers about their increased confidence in this regard.

"Previously I was shy yoh, I was afraid... Now I would go and as because even when we go to the groups I would see her at school and ask how she is coping in class" (Lesedi, Caregiver).

"Talking to the teacher, at first it was not easy just to approach the teacher and talk to him. But now I have realised that communication solves problems" (Masego, Caregiver).

"I talked to her asking how he is doing and they said he is doing well ... In the beginning I never went, it was my first time going ... Talking to the teacher or talking to him and asking him what's his problem at school, what [is he not doing] well" (Phunzo, Caregiver).

Asks others for help with homework

Two caregivers explained that they asked someone else to assist with the child's homework as they were unable to do so. For example, some aspects currently taught to their child were not taught when they were at school.

"I help him, I would sign for him and check it, and he would go back to school with it because sometimes there is some hard work. His older brother would help him, and I would also tell him that 'don't do everything for him, show him how he should do some of the things'" (Ayanda, caregiver).

Not clear if engagement in education increased

In the case of five caregivers it was not clear from their responses whether their engagement in their child's education had increased or remained the same.

"You would hear them saying I should help them, but I don't know their things. They are helped by their aunt" (Grace, Caregiver).

4.3.1.3 Dimension 3: Social and community connectedness

The third key dimension of this study is social and community connectedness. We wished to ascertain whether respondents felt connected or alienated from their communities and social networks, whether they trusted neighbours and other persons in the community, and whether these had changed since attending Sihleng'imizi.

Improvement in social networks

Caregivers were asked if there had been any change in their social networks following their attendance at the Sihleng'imizi group. Figure 22 shows that the improvements mentioned most frequently were plans to keep contact with their buddy/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 building social relationships in the group was 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 the community. Comments from six respondents suggested the existence of general trust in the community unrelated to the Sihleng'imizi programme.

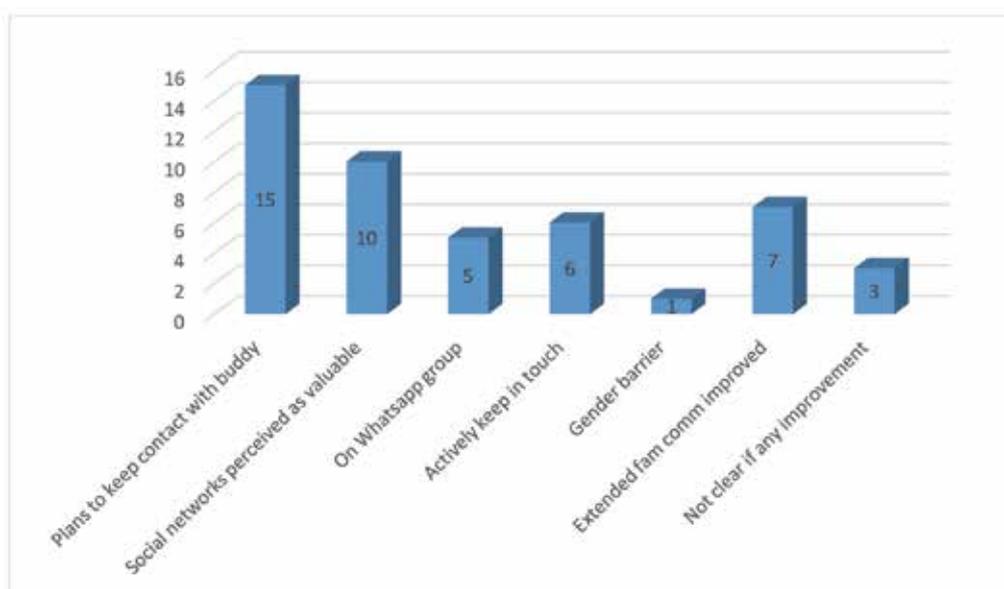


Figure 22: Improvement in social networks (n=32)

Plans to keep in touch with buddy/group

Fifteen caregivers informed the researcher that they intended keeping in touch with their buddy / the group. Follow-up studies are needed to ascertain whether these intentions were translated into ongoing connections or simply remained intentions.

"I know there is one lady ... I see her now and then, she passes here. So, I would see her only on the streets, and another lady I've got the number, I'll phone her ... So, yeah I will keep in touch with them" (Mashudu, Caregiver).

"Yes, because we have decided that we should have a WhatsApp group so that we can help each other. Because in our group when we closed yesterday, we talked that it's important that we communicate because when we checked we realised that these people who are in the group, most of the time they are single parents. So, we can help each other. You'll find that there is a father there, there's only mothers there, so you can get a father figure from that family and they also get a mother figure" (Naledi, Caregiver).

This last quotation reveals that the participants of this group explicitly saw the value in positive role models for caregiving skills and practices. They also believed that gendered norms and roles affect what you should be doing as a caregiver.

On WhatsApp group

Five caregivers explained that they had made actual contact through joining WhatsApp groups, as reflected in the following quote:

"We are in contact, we chat on WhatsApp ... We just chat about 'how is it going with the children, how are your children coping, how are you, are you fine? We haven't seen each other in a while', you see. Sometimes it happens that you come across some at the shops, there is Shoprite this side and you would meet, you see. It's like we are people who have known each other for long, the way it is. Because even over the phone, I can just phone special and greet them 'are you still there, I am still here, when are you going to the rural areas' and things like that" (Ayanda, caregiver).

Social networks perceived as valuable

Ten caregivers described their social networks resulting from the programme as beneficial. Among the values of social networking identified by the caregivers was 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. These aspects would appear to be significant advantages derived from the Sihleng'imizi experience and are likely to enhance the quality of social life of caregivers and their sense of well-being.

"With me being the youngest of them all with two kids, I have learned such a lot from them. We had this one in the group, she was the grandmother of the daughter. I have learned such a lot from her, I even said to her 'no, you must explain to me where you are staying'. She explained to me, but I still don't understand, but I will find out ... you can never stop learning, we always learn from other people" (Mashudu, Caregiver).

When asked about the benefit derived from the group, one caregiver responded as follows:

"The love among each other, the caring about us, yes ... Like to be with other people, and see how other people are working, and seeing the ideas that other people have" (Dinah, Caregiver).

"This thing of Sihleng'imizi buddy, it made me change in my life and be like other people, the way they live and enjoy my life ... It was useful by changing my relationship with the family, we were getting along but not too much" (Nkhensani, Caregiver).

Caregivers were also able to share new knowledge from the group for community benefit. For example:

"I am now able to tell the neighbour that 'no, when we beat the children it's not that we are disciplining them, but the more we beat them is the more we lead them astray' ... someone might take you and say

'you bring your rules to my house, this is my house' but some of them would do it, they would test it and see what will happen if they do that" (Khanyisile, Caregiver).

Gender barrier

One male caregiver mentioned the difficulty associated with exchanging contact details with other females from the group. The majority of caregivers in South Africa are female, and so it is not surprising that the participants in Sihleng'imizi were almost all women.

"There is this lady we used to meet, some are complaining that they won't be able to because I was the only man in the group. So, they have their partners who are crazy, and we can't exchange phones with them. But there is one I used to meet at Shoprite and we would also accompany each other. But we couldn't exchange phone numbers because I also won't agree for my wife to give other people because men are jealous" (Aubrey, male caregiver).

Concerted efforts need to be made to recruit more men in future roll-outs of the programme, and to encourage more male family members to take part. Men taking part in caregiving benefits women in sharing the burdens of care, especially heavy burdens when conditions are difficult and finances are tight. Furthermore, it also benefits children and the men themselves by creating opportunities to build good bonds with each other.

Actively keep in touch

Six caregivers emphasised that they continued to keep actively in contact with buddies and other group members following termination of the programme – not necessarily through WhatsApp.

"We see each other, we contact each other. Even though it can't be something that happens every day but often. For us as a family, if maybe we are going and taking the children somewhere, we would go together. It's not that I would only leave with my child, even if my sister can't go but I would ask her 'bring the children, we are going there and there, we are taking the children for fun and we are going together with the children'" (Phindile, Caregiver).

"We must look after each other, at this point I even phoned my buddy last night but she didn't answer the phone. I think she doesn't know the work number, just to ask how she is" (Dinah, Caregiver).

"We do talk because recently I met N's mother we talked and she told me 'I couldn't come yesterday, I sent her uncle' we were talking, we do talk. Even here ..., what is it? When they were graduating, when they were all going to grade R, we were sitting together as a group from Sihleng'imizi. People thought we were family, we were a family from Sihleng'imizi" (Nobuhle, Caregiver).

Extended family communication improved

When asked if their relationships with their extended family had changed after attending the Sihleng'imizi programme, seven caregivers responded in the affirmative. Responses included reconciling past differences, being able to apologise, forgive others and seek forgiveness, communicate with family members and show compassion.

"It has changed because we can communicate now, they have also been asking me what I am doing with the social workers. You know when you go to the social workers, it means there is a huge problem, we knew that. But I explained to them that it's like this and that, and they are also able to ask how it's going, as I was saying that N is giving me difficulties. He's not like the time when he just got here or when he was still at crèche. He's now a naughty child. So now even the older sister can involve herself in the issue because she was also someone who didn't care" (Kedi, Caregiver).

"I spoke to my mom last week, I used to be quiet and wait for her to call me" (Gugu, Caregiver).

"It has changed for me because there was a family, I can say its family because it's a family that I got here in Johannesburg ... There was a time where we didn't get along with them for many years ... we disagreed on something and we even went to the police. So when I started Sihleng'imizi, I thought it's useless holding grudges for someone. I know that they did get me arrested. But let me go to them and

apologise, even though I know I didn't do anything wrong. I went there to talk to them; I firstly spoke with their father ... And the father welcomed me ... and yesterday I was talking to the mother. And I sat down with her and said as a family there shouldn't be a conflict between us. I know that you've wronged me, but can we have peace you see. We talked and she was happy and she said thank you" (Siphokazi, Caregiver).

Not clear if there was improvement

In the case of three respondents, it was not clear whether there had been any changes to social networks following exposure to the programme or whether there had been pre-existing relations with family and neighbours.

4.3.1.4 Dimension 4: Financial capabilities

When budgeting and saving behaviour were compared at baseline and endpoint, various themes emerged that are reflected in Figure. 23 The most important changes 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.

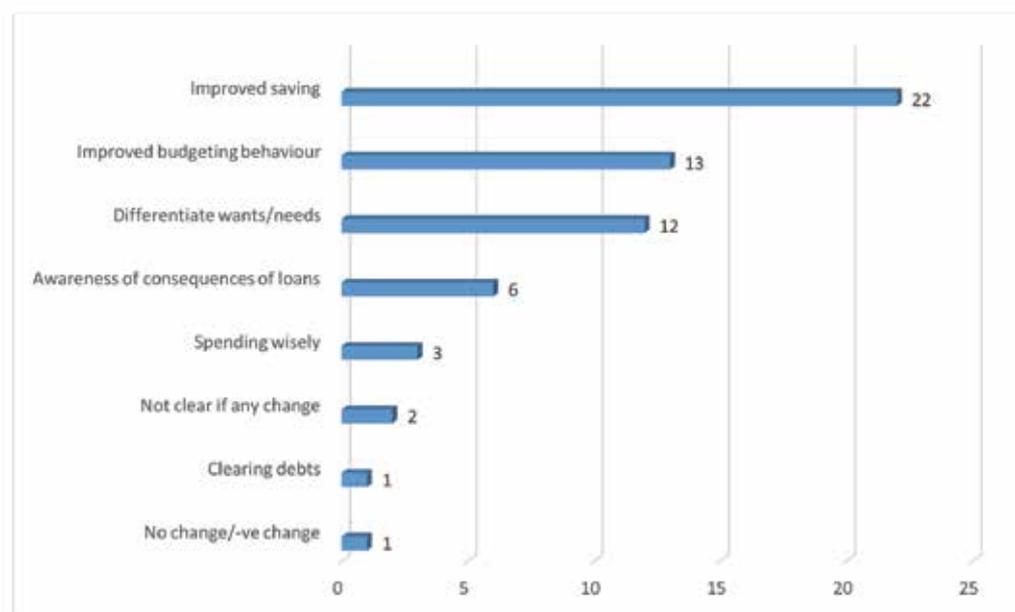


Figure 23: Changes in financial capabilities reflected at endpoint

Improvement in budgeting behaviour

Comments furnished by 13 respondents indicated that there had been a definite improvement in budgeting behaviour following exposure to the Sihleng'imizi programme as encapsulated in the following verbatim responses:

"Yes, it has changed because most of the time I wasn't counting, like when I have money that I will do this with a R1000, I wasn't doing that. I would just have the whole money and buy those things I see without even checking how much they cost and how much is left; I would see when I get home that there is certain money left. But since I have joined I am able to say at least with R1000 I am able to do this and that and write down if those things add up to R1000 and I would know what to do with the remaining money" (Oratile, Caregiver).

"Like being able to write something on the paper, like the grocery list and when I buy bread for R10.00, I know that it will last for three days and cooking oil will last for a month. It has helped me to be able to make a budget on the side like now I must go to fix my phone or do something else. I am able to know that if I have bought enough food in the house, then I can fix my phone with the extra money"

that I have and still be able to leave some money aside in case I need something else in the house” (Motlalepula, Caregiver).

“I didn’t understand what it is to really budget. And when we did the activities, we found ..., we used sticks and stones, and we had to put them ..., we have R500 for example, and we had to use the 500 or the month. We used the strategy of how we are going to pay everyone, how much we are going to save, and how much we are going to have for our needs and our wants. So, it was very, very interesting” (Rose, Caregiver).

A budgeting exercise, which focused on helping the participants differentiate between wants, needs, and obligations, made a big impression on participants. Comments by 12 caregivers referred to this, as illustrated below:

“I have learned about needs, wants, and obligations, there are some things which when you are alone you would think that it’s a need but when you look into it, you would see that ‘this is not a need, it’s just a want’. So, that thing helped a lot and I have also seen that a lot of our money which is spent, we spend it on the obligations, not with the needs. We end up spending little money on the needs and then we spend a lot on obligations and wants rather than needs” (Phindile, Caregiver).

Improvements in savings behaviour

Unlike the control group where there appeared to be no change in savings behaviour, the reflections of 22 caregivers in the intervention group highlighted improvements in this aspect between baseline and endpoint. These changes would appear to be significant considering the participants’ low levels of income.

“It (the group) taught me about saving. As a person, you have to save so that you can be able to do what you want. It helped me not to waste money, I should save it so that I can do other things. I should continue saving so that I can have a future ... It taught me that as a person I should go to bank and I should save money, after saving my money I should keep it safe by putting it at the bank, not in the house. In the house it’s not safe” (Nkhensani, Caregiver).

“We have always had the belief that for someone to save money, they should have a lot of money. So at Sihleng’imizi we have learned that even that 50 cents you are able to save it every day or once a month or once a week, put that R10 aside and have something like a container. But they made an example with the 2 litre bottle, that once a month you can ..., or every month put a R100 in there. Put in the container until in December the 24th or on the 10th you go and open that container and see how much you have. And sometimes you can take the same money to the bank and save for the child since she is growing up” (Khanyisile, Caregiver).

There are certainly limits to saving under circumstances of poverty and disadvantage, and households relying on Child Support Grants are particularly economically vulnerable (FinMark Trust, 2018). While accruing considerable savings are almost impossible under these circumstances, the benefits and sense of empowerment of being able to save small amounts for specific purposes can be very meaningful.

Improvement in spending money wisely & avoiding loans

Comments from three respondents highlighted the wise spending theme as reflected in the following quotes:

“And now we think wisely of spending money also, when we cut off, we cut off. When we are saving, we are saving” (Mashudu, Caregiver).

“It make me very conscious of what I spend my money on, and how I spend it. And this is an investment ... So, instead of buying a dress for R150, I can buy a dress for R50 and take the R100 and put it in the savings for [something]. So, my mindset has changed, my way of thinking has changed” (Rose, Caregiver).

Six respondents revealed a heightened awareness of the consequences of taking loans, as in these comments:

“I borrow, every month I am in the finance debt, but like I said I will try my best not to do it. Not to borrow” (Dinah, Caregiver).

“I used to loan from the bank, you know in my 3-year life I would say. And now I look at all the interest and what we have discussed, and also the pressure that cause because now you owe someone money,

and you owe an X amount. And you don't have an X amount to pay the person you loaned money from, and you've got other needs as well. So, really the programme has really helped me a great deal" (Rose, Caregiver).

One caregiver indicated a definite improvement in ability to clear debts that she had incurred.

"For now I am since I am still working here at crèche and I still don't have a job, what I can do is to invest R200 each month for them. R200 each, and when I see that I have paid all my debts then I make it R300" (Oratile, Caregiver).

Not clear whether things had remained the same or had improved

In two cases it was not clear whether behaviour had remained the same or changed following the programme. Certainly those who save via stokvels did this before the programme. One participant specifically stated that she continues to take loans as she cannot otherwise make ends meet.

3.4.1.5 Dimension 5: Caregiver and family knowledge of nutrition

The questions about nutritional knowledge were asked quantitatively. There were modest changes in the responses of intervention and control group participants between baseline and endpoint.

There was a slight increase in the number of intervention group caregivers identifying breakfast as the most important meal of the day at endpoint (from 69% to 74%), in concert with the nutritional training completed during Sihleng'imizi.

After Sihleng'imizi the intervention group identified nutritional value (98%) as the most important factor in choosing or buying food, rather than cost (73%) which was the primary factor at baseline. The shifts in the control group data were small. Therefore it appears that nutritional knowledge in relation to the factors to take into account when buying food were positive, and there was a modest increase in knowledge of the most important meal of the day.

When asked qualitatively, it appears that this session was enjoyed by most of the participants, and some found it very useful, as reflected below:

"The biggest change has been in spending time with family, and the family rules, and the menu, our menu as a family because sometimes we were not following the menu, we were just cooking. And food diet, yeah it's important because we were just cooking. So, since we joined the group now we know what and how we are supposed to eat and that we should exercise so that we can stay healthy" (Oratile, Caregiver).

4.3.2 Discussion of changes in the intervention group at baseline and endpoint

The Sihleng'imizi family strengthening programme was implemented by trained social workers and child and youth care workers and was found to have a broad range of positive outcomes. These are discussed in terms of the five key objectives or domains targeted by the study, plus mental health.

4.3.2.1 Family and child-caregiver relations

The fact that the majority of families continued to have few family members who were employed and who derived any income other than the social grants that they received, highlights the continuing vulnerability of these families to the social, environmental and developmental risks associated with poverty. In expressing their hopes and dreams, caregivers mentioned more than one aspiration for the future, such as to be able to gain employment for themselves and a good education for their child as well as themselves. They also wanted to be good parents in relation to their children. These aspirations remained the same at baseline and endpoint.

With respect to child-caregiver relations and caregiving practices, 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

helping them to develop skills in communication, caregiving and behaviour management, which are critical ways of improving family functioning and contribute to the social and emotional development of the child. They can also help to prevent future behavioural problems and promote positive social behaviour (Tolan, Gorman-Smith, Huesmann & Zelli, 1997; Ward & Wessels, 2013; Ward, Dawes & Van der Merwe, 2012).

Of the 30 caregivers who responded to questions regarding communication, all emphasized the increase in family communication following attendance at the Sihleng'imizi programme. The most frequent change was in terms of positive communication techniques, followed by problem-solving behaviour and active listening. A smaller number of respondents mentioned a reduction in the use of vulgar 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 in positive parenting took the form of praising the child, teaching him/her the consequences of negative behaviour, and rewarding and encouraging good behaviour. An interesting sub-theme that emerged was the desire that children should be able to distinguish right from wrong despite not being punished physically for wrong-doing. Implicit in this idea was the belief held prior to the Sihleng'imizi programme that it was necessary to physically chastise a child in order to teach him or her to know right from wrong.

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 many 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. For example, figures from Statistics South Africa (2018) highlight the increase in violent crimes against women and children.

We also sought to ascertain whether children's lives were safer as well as more structured and contained following the intervention. For this reason, interviewers specifically probed whether changes in family rules and routines had been made as a result of attendance at Sihleng'imizi. 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. 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 in terms of more positive attitudes, less harsh 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. Moreover, it seems reasonable to assume that the increased quality time spent with children may have enhanced family bonding, described by Enrique, Howk and Huitt (2007) as time spent together between family members during which members of the family enjoy a shared space, a shared experience, and their emotions regarding that experience. Parental bonds with a child also foster the development of skills needed to develop emotional awareness, empathy, respect for diversity and successful relationships with others (Enrique, Howk & Huitt 2007; 11).

These findings suggest that the first objective of the Sihleng'imizi programme had been achieved, namely, the programme helped to strengthen family and child-caregiver relations via building family cohesion, bonding, improving family communication, and use of positive parenting skills, especially in relation to discipline. However, although the programme provided caregivers with parenting skills so that the majority felt less overwhelmed by the responsibility of being a parent/caregiver, a third (34.2%) reported feeling more overwhelmed. This last finding may have been due to misunderstanding arising from the negative wording of the question. Alternately, the programme may have made them more aware of the enormity of their responsibilities towards their children.

4.3.2.2 Caregiver involvement in child's education

When caregivers were asked about their children's engagement in school, the changes mentioned most frequently were enjoyment of school, increased engagement in schoolwork and improvement in subjects.

The improvements in caregiver involvement in the child's education that were cited most frequently were 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. More specifically, Walker, Hoover-Dempsey, Whetsel and Green (2004; 2-3) state that when parents involve themselves in children's homework they interact with the learner's teacher about homework; monitor and supervise the homework process; respond to the child's homework performance; and support learners' understanding of homework. Fan and Chen (2001) state that the potential benefits for children when parents are involved in school include: higher grades and test scores; better attendance and effective homework completion; fewer placements in special education; more positive attitudes and behaviours; higher graduation rates; and greater enrolment in post-secondary education. However, in several cases it was not clear from responses whether there had been any changes in regard to parental involvement in the child's education.

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. However, in several cases it was not clear from responses whether there had been any changes in this regard.

4.3.2.3 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 contact with their buddy/the group, while some were already actively keeping in touch, for example through WhatsApp groups. New social networks were experienced as valuable, and communication with the extended family had improved. Among the values of social relations in the group 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. The benefits from the programme are critical if one considers that 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. The results also highlighted the systemic changes in family relationships and how the family connects with the wider community, as posited in Bronfenbrenner's (1979) ecological theory.

These findings suggest that the third objective of the programme had been achieved, namely, to promote social and community connectedness and positive engagement with community networks – although there was minimal evidence of additional engagement with community services.

4.3.2.4 Financial capabilities in terms of budgeting and saving behaviour

The most important changes 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, it seemed 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.

4.3.2.5 Caregiver and family knowledge of nutrition

Between baseline and endpoint there was a slight increase in the number of respondents who regarded breakfast as the most important meal of the day. There was a substantial increase in the number of caregivers who rated 'healthy lifestyle' as very important in choosing food. However, overall there seemed to be minimal improvement in nutritional knowledge and skills.

4.3.2.6 Symptoms of caregiver depression

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 (see Figure 11, page 37). This is particularly positive, as research does indicate that mental health difficulties have a negative effect on caregiving (Davies, Schneider, Nyatsanza, & Lund, 2016).

4.4 WHAT DO THE CHILDREN SAY? PERCEPTIONS FROM THE CHILDREN SAMPLED

4.4.1 Profile of children

Within the sample of 36 identified children, the majority (33 or 91.7%) were drawn from the Black African group, with three (8.3%) identifying as coloured. Half (18 or 50%) were male, 10 or 40% were female, and due to missing information it was not possible to determine whether the remaining children were male or female. All the children were within the age group 5-8 years and were either in Grade R or Grade 1 at baseline.

4.4.2 Themes that emerged from the children's interviews at baseline and endpoint

In order to facilitate interaction between the children and the researchers and encourage the children to engage in the interviews, they were asked to draw pictures of their families (the research tool can be found in Appendix A). The children's interviews were triangulated with their drawings as well as the educator interviews, and the following themes emerged.

4.4.2.1 Pictures depicting families engaged in various activities

At baseline and endpoint, the children drew pictures depicting families engaged in various activities. For example, at baseline one child drew a picture of nuclear and extended family members. He indicated that the different individuals like to bake, shop, grow plants and wash the car. Another child drew a picture of the family with himself dancing. Other children drew pictures of the family going to KFC (Kentucky Fried Chicken fast food chain) for burgers or shopping at Shoprite. They also discussed other activities that they engaged in. These activities included celebrating the child's birthday, going to town, watching TV, going to the shops and talking to/ playing with friends.

The same pattern emerged at endpoint. One child drew a picture of the family, flowers, a table, children going to school, grandmother going to sell and grandfather going to work. Another child drew a picture of family members going to make spaghetti. Tyrone described his picture as follows:

"My mother, me and my cousin and my aunt, we are outside taking pictures. We went for a picnic and all the stuff. My aunt picked up flowers for my grandmother and we went back home".

Some children drew pictures of the family members at church while others depicted their family, aeroplanes, houses and flowers; siblings playing with toys and friends; watching TV and eat burgers at KFC and pizza; mom washing and a sibling playing. Themba drew a picture of grandfather, father, Ndou and Siphon, and said:

"I am dancing, my grandmother is cooking, my dad went to work and my mom is also cooking. Themba is in the streets, Siphon is in the streets. Themba is dancing".

Andiswa drew a picture of his family. His uncle lost his hand when he was drunk, described as follows:

"At night he was drunk, he was walking with other people and he fell. There was a bottle, then his hand was cut off".

4.4.2.2 Pictures of family members laughing

At baseline a few children drew pictures of family members laughing. Madoda commented: *"They are always laughing"*. Kedi drew a picture of family members sitting and laughing, but mom is *"staring with a bad face"*.

At endpoint one child drew a picture with his sister and father laughing, while another drew a picture of family members smiling and wearing nice dresses. A further child depicted the family with the children playing soccer. He explained that afterwards they go into the house and eat peanut butter and bread. His family make him laugh.

4.4.2.3 Family tensions

At baseline some interviews suggested the presence of family tensions. For example, Madoda informed the interviewer that his grandparents *"are sometimes happy but after that they are not happy"*. *"Mama always goes out at night with aunty. After that they would arrive with beer bottles and they would drink alcohol"* (which makes him feel sad). Child also feels sad *"when grandmother is fighting with grandfather"*. These tensions were not evident at endpoint.

4.4.2.4 Physical punishment by family and teachers

A further theme that surfaced at both baseline and endpoint was that of family members beating the child. Nhlanhla said that he felt angry because:

"My mom beats me ... my mom beats me with a belt".

"They are sad when you don't listen. When you don't listen they talk to you at once". He feels angry "because my mother always hurts me ... she holds my arm like this and she hits me" (Tyrone).

"My grandmother, she beats us with a shoe at night ... Sometimes I come home late (from visiting his friend) and they beat me. They don't want me to go (to his friend), so I go by force" (Nhlanhla).

Nhlanhla drew a picture of the family. He indicated that some family members *"beat him"* and one bites. At endpoint a few children mentioned that various family members such as the mother or an older sibling beat them. Nomi reported that mom is happy when she does the right thing but becomes angry and beats her *"when I trouble her"*.

Similarly, despite legislation prohibiting the use of corporal punishment in schools, at both baseline and endpoint children referred to teachers who beat them at school. For instance, at baseline Thomas reported with regard to teachers:

"When I make noise they beat me".

One child drew a person, a house, an ice cream, a banana, an orange, a watch, a tree, a skirt and a hand. The hand:

"It's beating people ... because they are disrespectful" (Vulani).

"[The teachers] are beating us when we break toys" (Senzi).

Another child mentioned that the class teacher hits the children. Yet another child indicated that the teacher hits the children on their hands with a pipe when they make a noise. Lunga also reported being hit on his hands with a pipe.

Similarly at endpoint several children reported that they had been beaten by teachers. For example, Lunga reported that the *"teacher beats me when I make noise"* and *"Teacher beats me up"* (Lerato).

An issue mentioned by one child at baseline was that of bullying by other children.

"There are two boys that I fear in our class" (Simangele).

4.4.2.5 Activities engaged in at the group

When asked at endpoint what activities they had engaged in at the group, the children reported that they were given juice and food (such as rice, beetroot, samp and chips), they went to the park where the children played on the swings, did homework, drawing and worked on a project, they played soccer and sang songs. *"We were playing nicely, we were eating cakes, we were writing" (Mlungisi).*

Many of the children reported singing various gospel songs at the group. Madoda explained that at the group *"they were calling us with our names ... When they finished they gave us food. We sat down and they took up photos with our things. After that we went outside to take our things. Then we went outside and they took us other photos. After that we left. When we finished eating we left, we went home"*.

Among the activities that children particularly enjoyed at the group were skipping, playing soccer, playing with friends, doing back flips and having fun, singing in the choir and making balloons with dough. They enjoyed the food and juice, eating a burger, getting stickers and being given a present. Andiswa explained that he liked the party where *“we were getting things, chips and hats, dolls for boys and tekkies. They gave us shoes”*. Madoda liked *“the snacks and the stick sweets and Chappies and Coke and biscuits and food”*. Among the educational activities that they enjoyed were playing with the toys, watching TV and writing, playing with a ball and puzzles and playing 123 and A,B,C,D, and answering questions.

The best thing Tyrone liked about the group was: *“I liked speaking about your family, how they are, and what they have been doing for you, and what they provided for you”*.

Nqobile enjoyed talking about special times and asking each other questions. *“We were standing on the line at the group making a train. Everyone was taking their card with a name [and] inside there were sweets. You hold it with the legs or the mouth [to play the game]”*.

When asked what they did not like about the group, individual children did not enjoy skipping, being told to sit down or being told what to do. For example, *“I did not like forcing me (to eat) and I didn't like telling me what to do” (Tyrone)*. Other children did not like it when other children were fighting or when the other boys in the group beat them. One child did not like making circles.

When asked what they learned, Senzi said *“that I shouldn't come [home from friends] at night [when it is already dark]”*. Several children mentioned that they had learned ‘good things’ such as how to write, be respectful, listen to teachers and older persons, share, not swear and not fight. In terms of respect, Ogone learned *“that we shouldn't disregard others”*. They were also taught about food and how to draw a person.

4.4.3 Discussion of child interviews

The themes that emerged at endpoint were similar to those at baseline, except for the comments on the experience of the Sihleng'imizi programme, referred to by the interviewers and children as “the group”. Overall, the children were far more relaxed and verbal at endpoint and seemed to enjoy speaking about the group experience. The increased verbal engagement could have been due to their familiarity with the persons who had interviewed them at baseline. It also seems reasonable to attribute this behaviour to the emphasis in the programme on verbal skills and language development, and discussions between trainers, caregivers and children. In this way, the findings from the children's interviews suggested that the programme may have helped to enhance educational, communicative and social development.

They drew pictures of their families engaged in a wide variety of activities, including shopping at Shoprite, buying burgers from KFC, cooking, dancing, playing, going to church, individual family members going to work and so forth. During the endpoint interviews, the children were quite forthcoming in singing the various gospel songs that they had learnt at the group. They reported that they had learned about respecting and listening to their elders, sharing, how to draw a picture of a person, not coming home at night, and not swearing. They enjoyed the food, juice and sweets that were provided and enjoyed activities such as skipping, soccer and talking about their families. Individual children did not like being told what to do or being told to sit down. They also did not like the fighting that occurred in some groups.

It was not possible to link the themes with categorisation of the children into happy/well-adjusted or those with problems. An interesting finding was that some children who depicted happy, laughing family members also mentioned beatings by teachers and/or family members, suggesting that physical punishment was possibly regarded as a normal mode of disciplining children and did not necessarily detract from their overall sense of happiness or well-being.

4.4.4 Overall results from children's drawings

We analysed the drawings of children before and after exposure to the Sihleng'imizi programme. Interviewers provided each child with a sheet of paper and drawing materials and asked them to draw a picture of his or her family. The drawings were then analysed based on a review of literature on the topic. It was possible to analyse only 36 pictures, as there were five baseline drawings with no endpoints and five endpoints with no baselines.

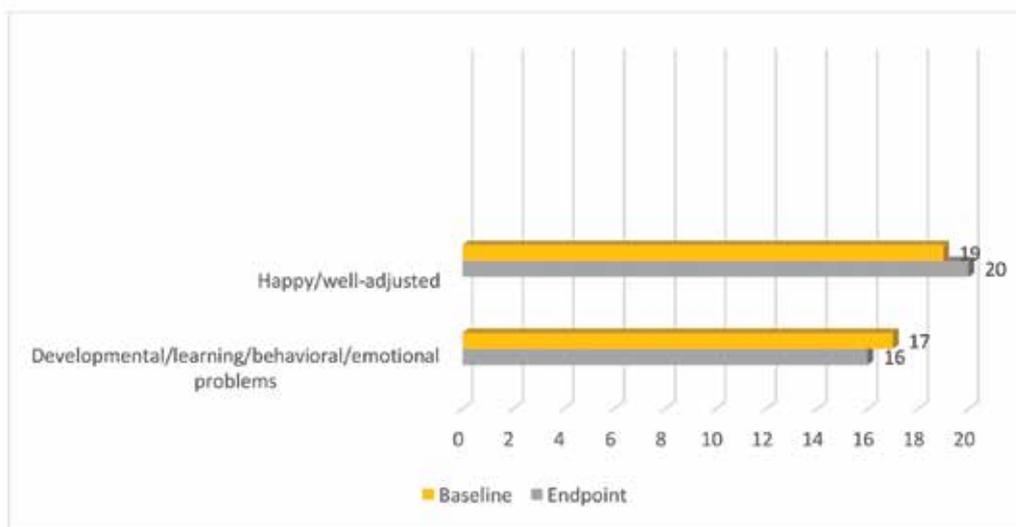


Figure 24: Comparison of 36 sets of drawings at baseline and endpoint

Figure 24 shows the breakdown of drawings suggesting happy, well-adjusted children and those suggesting possible developmental delay, emotional disturbance, learning difficulties and/or behavioural problems. Those suggesting any kind of difficulty or problem were combined into a single group, as individual children presented with more than one difficulty, for example, emotional and behavioural problems or learning and behavioural problems.

4.4.5 Discussion of children's drawings

It was difficult to make definitive assessments based on the drawings alone. Hence, in line with recommendations by Ryan-Wenger (1998) these were combined with information derived from the interviews with caregiver and educators to provide a more holistic assessment. Overall there were few apparent differences between baseline and endpoint drawings. While the assessment of the children's drawings was somewhat subjective, it emerged that 19 (52.8%) of drawings at baseline depicted relatively happy, well-adjusted children, with the figure increasing slightly to 20 (55.5%) at endpoint. The fact that only just over half of the children seemed happy and well-adjusted could possibly be explained in part by the highly vulnerable, poverty-stricken communities that were targeted and their dependence on social grants. At endpoint the number of children whose drawings suggested some type of developmental and/or learning, behavioural, or emotional problem declined slightly from 17 (47.2%) to 16 (44.4%).

Some differences seemed to be a function of the type of writing implement used. For example, at baseline many of the children were provided with either Koki pens or pencil crayons, which allowed them to draw slightly smaller figures with greater clarity and attention to detail; whereas at endpoint they drew with wax crayons, which tended to result in larger figures with less clarity and detail. Figure 25 shows a happy/well-adjusted child at baseline and endpoint. Some children drew in landscape format at one setting and in portrait at another setting, which then allowed them less room to incorporate all figures, as depicted in the two drawings.

Other examples of happy, well-adjusted children are depicted in Figures 26 – 29.

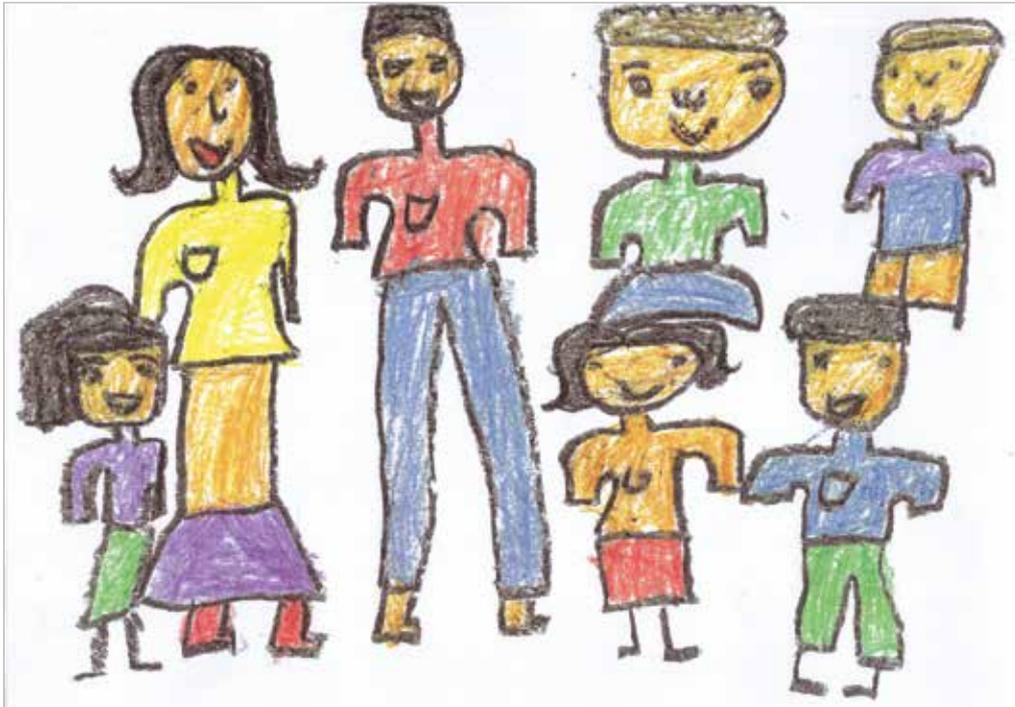


Figure 25: Happy child at baseline and endpoint (A)



Figure 26: Happy child at baseline and endpoint (B)



Figure 27: Happy child at endpoint (C)



Figure 28: Happy child at endpoint (D)

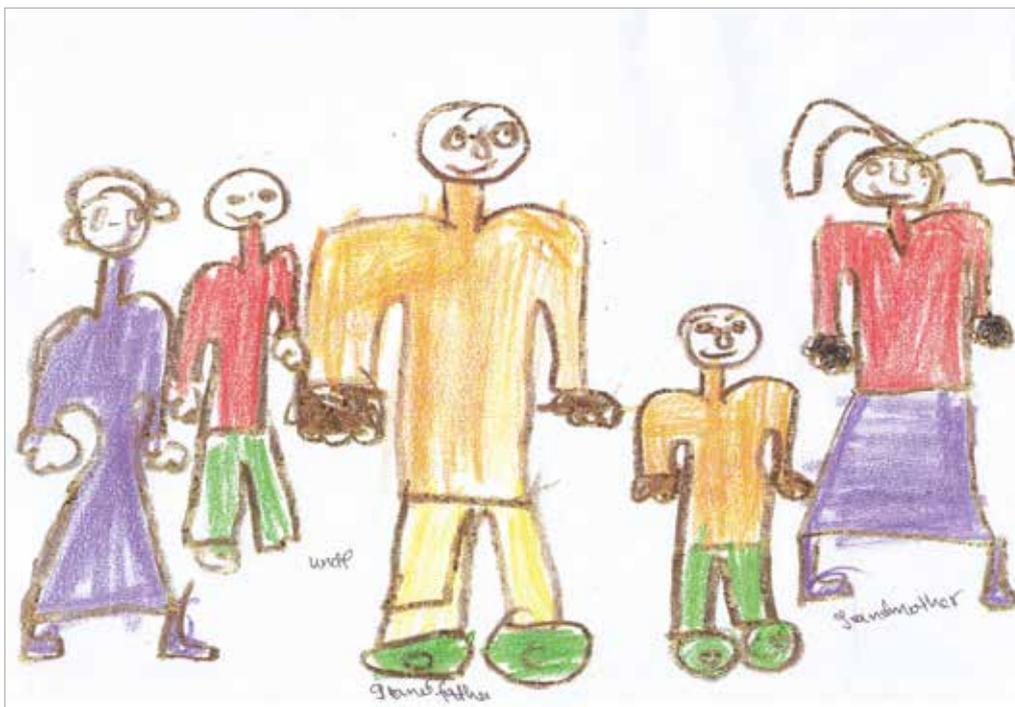


Figure 29: Happy child at endpoint (E)

While the international literature tends to regard shading as a sign of emotional disturbance (Koppitz, 1968; Baluch et al, 2017), in most cases in the current study the use of brown shading for skin colour appeared to be culturally appropriate. However, in some instances the shading together with the downturned mouths and poor writing of name seemed to suggest a possible emotional problem, as highlighted in Figures 30 and 31 below.



Figure 30: Shading used & sad faces: possible concerns (A)



Figure 31: Shading used & sad faces: possible concerns (B)

Some of the signs suggestive of emotional indicators, e.g. missing body parts, could possibly have been related to the child's maturational or developmental level. In other instances, the teachers provided information that informed the researchers' assessment. For example, the child was grieving for a parent who had died or moved away from the home; the child had become withdrawn and prone to sleeping in class; families who had absent fathers who did not provide financial support; the presence of alcohol abuse in the home, conflict among family members and other social issues. This drawing (figure 32) has indications of possible concerns from an emotional and learning perspective, as the picture is disorganised and people have sad faces, and there is evidence of difficulty in writing.



Figure 32: Potential signs of emotional and learning difficulties

Figure 33 shows an example of mirror writing, possibly suggestive of some kind of learning difficulty. Figure 34 reveals the child's attempts at erasure plus difficulty in name writing, which might have revealed a degree of anxiety plus learning problems.



Figure 33: Potential signs of learning difficulties (mirror writing)

Crawford, Gross and Patterson (2012) maintain that it is generally acknowledged that girls develop drawing ability at a faster rate than boys. However, it proved difficult to factor in the issue of gender, as the gender of the child was missing information in some cases, and many of their first names could be applicable to boys or girls. In addition, no information was provided on the chronological and/or mental age of the children, so it was not possible to determine whether a particular child was aged 6 or 7 or 8 years, even if they were in the same class at school. Consequently, in the case of those children who had difficulty writing their names, it was not possible to definitively attribute this factor to the child's developmental age or possible learning problems.

With regard to learning difficulties such as Attention Deficit and Hyperactivity Disorder (ADHD), as well as behavioural and emotional problems, the child-parent programme was only of fourteen weeks duration and was not geared to addressing these issues. The slight increase in the number of happy children at endpoint and the slight decrease in the number of children presenting with developmental, learning, behavioural and/or emotional problems could have been due to various other factors such as child maturation, better family situations, the return of a parental figure to the household and so forth. Moreover, the analysis did not allow us to confirm a diagnosis of emotional, behavioural or cognitive disorder. Instead the drawings only provided descriptive information on this particular group of children. While it is therefore not possible to draw any definitive conclusions, it is clear that some drawings raise concerns about these particular children and therefore warrant further investigation, while other drawings seemed to indicate few concerns. In accordance with professional ethics, the children who seemed to present with problems and were possibly at risk, were referred to appropriate sources for professional assessment and therapy or remediation.



Figure 34: Potential signs of learning difficulties (erasure)

4.5 EDUCATORS' VIEWS OF THE IMPACT OF THE PROGRAMME

4.5.1 Changes in educators' perceptions of children between baseline and endpoint

While 28 interviews were conducted with educators at baseline and 34 were conducted at endpoint, there were only 19 sets of transcripts where both the baseline and the endpoint interviews for the same child were secured. As we wished to compare baseline and endpoint data, we have only used these 19 interviews in the following analysis. Securing interviews with teachers was difficult in a number of cases, which is why there is data missing.

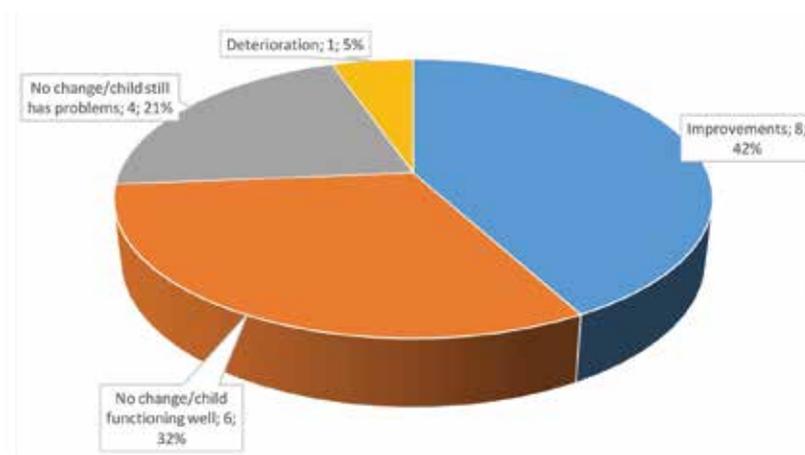


Figure 35: Children's status from perspective of educators at endpoint (n=19)

Figure 35 indicates that eight of the children showed improvements, while one child had deteriorated significantly. For 10 out of the 19 children there was no apparent change, with four still presenting with problems and six continuing to function well. If we combine the improvement category with the group that continued to function well, despite any apparent changes, then the overall results at endpoint suggest that the majority of children (six plus eight), i.e. 14 out of the 19, showed positive functioning. Examples are presented from each of these categories, and illustrated with verbatim comments from teachers.

4.5.1.1 Children showing improvement

In the case of Nqobile, the teacher reported that previously she had a problem with Nqobile's absenteeism. They had a meeting and the child promised that she would never be absent from school without valid reasons.

"Because they were coached and motivated to attend school regularly, she is no longer absenting herself from school ... She has been very excellent from the start. She is very, very intelligent, even though she was always absent from school. She does her homeworks but I don't think that the mother is involved because she is intelligent, she does everything herself and when you ask her, 'where was your mother when you were doing this?' 'She was sleeping'. In terms of her behaviour, she has never had any problems. However, "she is more talkative now, she reports everything. She discusses whatever they are discussing at the meetings".

The teacher reported improvements in Senzi. *"Senzi has also improved a lot, but I see a lot of improvement on the drawings and writing".* As reported at baseline, Senzi continues to be a quiet child. The teacher has no real concerns about her, and her mother continues to be a highly involved parent. *"Senzi behaves well, but she is not a child who talks too much ... Her mother, she is always here at school".*

With Madoda there was a drastic improvement in his functioning at school, which seemed to be related to the return of his mother, who was previously living in a different city, but returned as she missed him and wanted to live with him. The teacher reported drastic changes and improvement in the child since

baseline when he struggled to write his name. The teacher's attitude towards the child also seemed far more positive than at baseline.

"Since the last time we had the interview with you, there is a drastic change from Madoda, especially academically. I am happy about his performance so far ... So far with Madoda I have seen a lot of improvement in his work ..., the mother is still young but she is very supportive. She [now] comes to the school. You know she is taking care of him and he's very clean, very neat".

4.5.1.2 Children continuing to function well

With regard to Queenie, the teacher reported no changes in the child:

"There is no problem with Queenie, she's a very careful child, hard worker ... she's always neat. So she's in a good home, she's taken care of. I never had any problem with her or any situations that are a concern".

In respect of Ayanda, the teacher reported that in comparison with baseline:

"There are no changes. The child is a good child. He's well taken care of ... Socially he's performing well. He tries his best. He's a lovely child".

The teacher reported no changes with Lulu. *"Lulu has been the same academically and behaviour wise".* She hasn't noted any problems. *"She does her schoolwork. She has done what we expected of her and I didn't pick up anything different to that".*

4.5.1.3 Children continuing to present with problems

Some of the problems that continued to manifest at endpoint included developmental delay, learning difficulties, hyperactivity and possible dyslexia; aggressive behaviour; loss and bereavement; and child neglect.

Children described as slow, hyperactive or dyslexic

A few children continued to be described by teachers as slow, hyperactive or dyslexic.

For example, with regard to Andiswa, the teacher commented:

"Since last time I have noticed slight changes, but what I forgot to say in the previous interview, it's that Andiswa writes, academically he writes everything properly. Just that it's almost like his letters are back to front, like backwards. But I don't classify that as he being dyslexic because he knows all the alphabets but when he's writing it it's almost like he's squashing it up, and he's writing it back to front. The N is on the right hand instead of the left side".

However, this child now opens up to the teacher more than previously, and she believes that the child is getting more personal attention at home, which is helping him at school.

With Tyrone, the same problems were reported as at baseline:

"I don't know. I'm not sure if it's hyperactivity or what but he does have the potential. It's not like he has a learning problem. He knows what to do and he is a good reader, he can identify words ... He is all over the place, he doesn't sit still, he is always fidgeting".

She reported that the mother communicates regularly with the teacher and the child appears to be well cared for:

"I think he does get a lot of support at home, but then he's just a very fidgetive child and when you remind and speak to him he will sit around for a short while and then focus again ... I think it's difficult in a big class, you can't always focus on one child". "I know she (mother) is taking him for an ear test or an eye test. Maybe they must check for his hyperactivity ... he is still young ... you know maturity ... we'll see next year".

Concerns with home life

At baseline the teacher reported that Nlhanhla was failing, was easily distracted, was never able to sit still, tended to fight with other children and was difficult to control. At endpoint the teacher reported:

"I cannot say he has changed ... Socially he fights. He beats other children. He swears at them ... I even told his mother and she said 'Ma'am I don't blame him, the situation at home is not well.' So what I can say is that this one really we need to monitor him ... He like to fight. He is very aggressive".

The mother informed her that the granny does not like the children and does not want them in her home and can be verbally abusive and sometimes sends them to bed without food.

Nelson appeared to need help in grieving for his parents, who apparently passed away. The teacher reported that Nelson was still struggling. He is very quiet and does not respond when she talks to him. He only talks to his sister. *"He doesn't participate and prefers to sleep"*. He lives with the grandmother, as his mother passed away. *"Sometimes he would come here not eaten"*. When the father comes the sister cries, as she does not want him to leave.

Kevin seemed to be somewhat neglected, despite improvements in coming late for school. His teacher reported the following:

"He does seem to improve ... especially in his late coming ... But there is still a bit of concerns about him. Sometimes he wears the same clothes for a week ... I actually tell him 'you need to change' ... After I spoke to him he changed [his clothes] ... His language has improved quite a bit ... Some days I have found that he comes to school with no lunch. He said he cooks for himself, he dresses himself, he bathed his brother or sister that's smaller than him and he dresses them. And he walks to school and he walks home. Some days if he doesn't have (lunch) I give him".

Deterioration in academic performance and behaviour

The academic performance of one child, Themba, was reported to have deteriorated significantly to the point where he was now failing and he had become very withdrawn and was possibly depressed. He is staying with his aunt, as his father is a mineworker far from the City. Themba used to be able to write his name and surname, but at endpoint he seemed to have regressed and was unable to do so. The teacher explained:

"I think there is a fight in that the situation at home is not well. So what I can say is that this one we need to monitor him ... I even told the aunt 'this child has dropped' and he has become withdrawn all of a sudden. Thabiso comes to school every day and sits in the corner. "Sometimes you find that he's asleep ... and I would say 'T are you sleeping? I would say 'what is wrong, are you hungry? 'No teacher' Then I would sense that there is something ... I am concerned about him".

4.5.2 Discussion of educator interviews

The verbatim responses from the interviews with educators provided rich qualitative insights into their perspectives regarding individual children. One can also discern the genuine concern they had for the learners in their care. However, it is significant that none of them mentioned referral and follow-up of learners presenting with problems for assessment and/or therapy. In analysing the findings, we were again confronted with the "attribution paradox" (Hewitt Sims & Harris, 2012). For example, in terms of improvements, it was not always clear whether improvements could be attributed to the Sihleng'imizi programme, better family situations, child maturation, or teachers not recalling accurately what they had told the interviewer about a particular child during the baseline interviews. Similarly, in the case of the child whose functioning had deteriorated drastically, this regression was unlikely to be attributed to the Sihleng'imizi programme. In all cases where the educator identified learning or home problems, the CSDA has followed up and referred the family (see section 3.9).

4.6 FEEDBACK FROM CAREGIVERS FOLLOWING ATTENDANCE AT THE SIHLENG'IMIZI PROGRAMME

The caregivers in the intervention group were asked a series of quantitative questions about Sihleng'imizi in order to ascertain their perception of the implementation of the programme. From Figure 36 it is apparent that in only 36.8% of cases did the entire family attend, which is understandable given the time of day and duration of the programme. All the respondents found the family workbook useful and the

majority found it easy to use. The venue was rated as comfortable and easily accessible, and the length and timing of group sessions were convenient. The stickers proved to be a fun-filled incentive. While the food was considered sufficient and of good quality, a significant finding was that all respondents would come to another Sihleng'imizi group even if there was no food provided as an incentive.

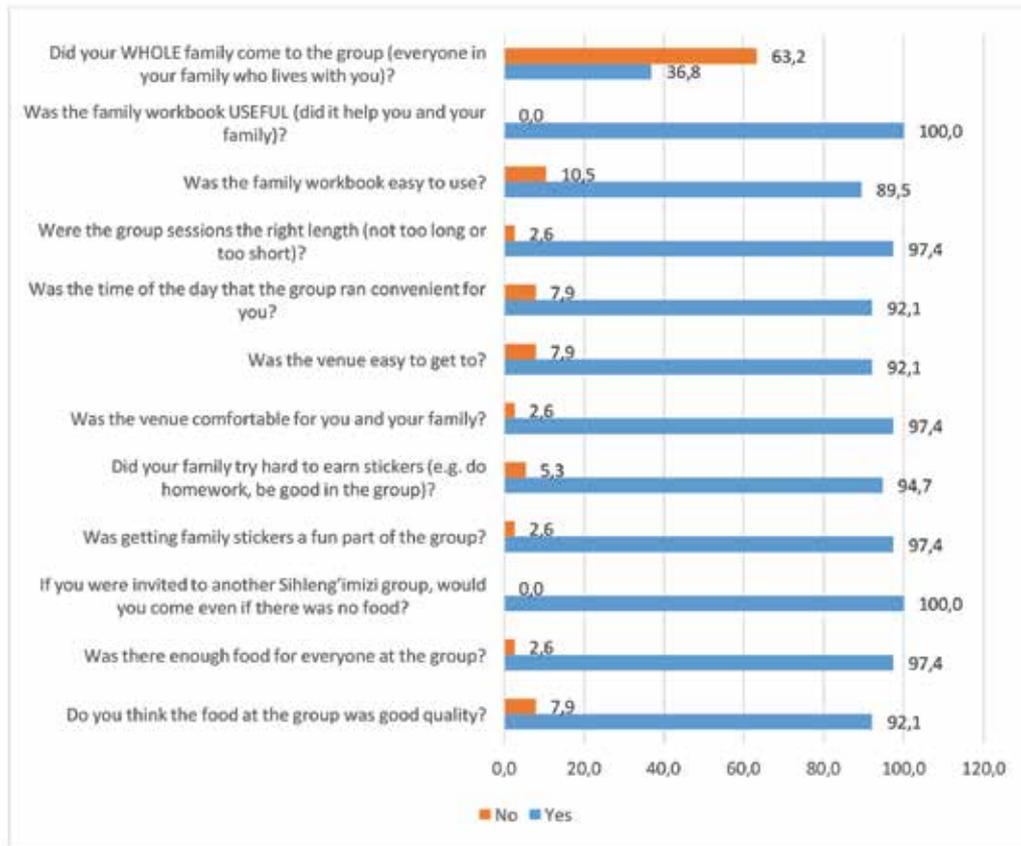


Figure 36: Consumers' views: logistical and operational features of Sihleng'imizi (n=38)

CONCLUSIONS AND RECOMMENDATIONS

5.1 Conclusions

The explanatory theory undergirding the Sihleng'imizi programme is that families and caregivers of children are assumed to want the best for their children, and this is true even if the family is poor or disadvantaged. However, in the context of structural problems such as poverty, inequality, unemployment, a lack of opportunities for education, gender inequalities in giving care to children, and limited formal and informal support, they do not always have the knowledge, skills and attitudes to facilitate better life chances and child well-being.

Based on the theory of change underpinning the programme, it was proposed that (1) with enhanced social support, better access to formal services, and families that demonstrate warmth and care, these children would have better chances of improved outcomes. We also proposed that (2) exposure to the Sihleng'imizi programme would offer new and useful parenting skills to caregivers, give them support and increased self-confidence, reduce harsh parenting, strengthen financial capabilities of caregivers and families, improve knowledge of nutrition and enhance engagement with schools. In addition, our theory of change was that (1) and (2) would work together to help mitigate systemic and structural barriers to child well-being. While changing structural inequalities is the responsibility of society and the state (and not any one individual), building skills and knowledge to navigate barriers assists in child and family well-being outcomes. Although the first proposition can be tested only in long-term follow-up studies, the second proposition was supported by the results of the study.

The main conclusion that can be drawn from the comparison of baseline and endpoint data derived from the intervention group is that the Sihleng'imizi programme served to considerably enhance child and family well-being in terms of the 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. The fifth objective was to enhance nutritional knowledge, and there was evidence of modest positive changes.

More specifically, caregivers reported the following outcomes: positive relationships through Sihleng'imizi buddies; improved discipline and behaviour management of children; improved skills in demonstrating warmth and care; more self-confidence in caregiving; better knowledge of social services; more engaged relationships with schools; improved financial literacy capabilities; and slightly better knowledge of nutrition. In addition, symptoms of depression decreased significantly for the intervention group comparing baseline and endpoint data, implying that the programme could have assisted in caregivers feeling less despondent and more in control of their lives.

When changes in the intervention and control groups were compared it emerged that unlike the intervention group, where there were substantial changes across four of the five dimensions between baseline and endpoint, with the control group the only changes were in terms of increased family communication and increased financial stress. Improved communication within families could possibly have been due to the 'Hawthorne effect' (Rosenburg et al, 2016), which is when changes occur due to the increased awareness of an issue, and this is directly precipitated by the questions posed by researchers. Increased financial stress was attributed to environmental factors external to the programme – e.g. the

threat of being evicted from one's home. There was a decrease in symptoms of depression between baseline and endpoint for the control group. It is difficult to explain this result.

Given the fact that all the families in both intervention and control groups were in receipt of social grants based on their low levels of income, they could be considered at risk due to poverty, lack of resources and opportunities in employment and education, and other challenges that come from a difficult social environment. However, findings from the study suggest that the programme may have minimised some of the risks for future behavioural problems, thereby fulfilling a preventive function. Nevertheless, it needs to be acknowledged that 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.

From a methodological perspective, triangulation of data (drawn from three sources: caregivers, children and educators), random selection of participants, and the use of a control group, enhanced the quality of the research design.

At the same time we need to acknowledge two limitations of the study. Firstly, there is the possibility that some participants may have furnished socially desirable responses. Secondly, the 'attribution paradox' (Hewitt et al, 2012) was evident, where it was not always clear whether improvements could be attributed to the Sihleng'imizi programme, better family situations, child maturation, or teachers not recalling accurately what they had told the interviewer about a particular child during the baseline interviews. With regard to the possibility of socially desirable responding, an interesting finding emerged. Some caregivers at baseline acknowledged using corporal punishment to discipline their children, but there were more caregivers who retrospectively admitted that they had previously hit their children but were now reducing physical punishment.

Despite these limitations, feedback from participants indicates that the programme was well received and that the logistics and operational aspects were considered appropriate. The fact that all respondents indicated that they would attend a future Sihleng'imizi programme if invited, even if no food was provided, suggests that the intervention was highly valued. Interviews with child participants also suggested that the programme activities were suitable for this age group because most of the children reported enjoying the group. In addition, the use of drawings proved to be an effective way of facilitating communication between the interviewers and the children. The drawings also revealed whether children appeared to be happy and well-adjusted or experiencing emotional, learning and/or behavioural problems. While the drawings could not provide definitive diagnoses of problem behaviour, the input from the educators did provide supportive evidence.

The theory of change underpinning the Sihleng'imizi programme, namely, the social development model, underpins social welfare and social work in this country and draws upon developmental-ecological risk theory; systems thinking; and the psycho-educational approach to family strengthening interventions. This proved to be an effective framework for conceptualising and evaluating the programme. The mechanisms of change employed in the programme also proved to be effective, namely sharing of knowledge, group delivery, social education techniques and the linking up two families living in close proximity for social support.

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. 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.

5.2 Recommendations

- 5.2.1 It appears it would be beneficial for the programme to be rolled out to other disadvantaged communities in urban areas in South Africa, particularly targeting children in poor schools.
- 5.2.2 The establishment of Sihleng'imizi within institutions requires careful consideration and planning, as implementation, institutionalisation, and scale-up are complex processes (Fixsen et al, 2005).
- 5.2.3 It is recommended that strategies are found to better engage adult men in the Sihleng'imizi programme. This would bring important benefits to women, men and children. Also, drawing men into care activities is important to ensure that interventions such as this do not unintentionally reinforce gender inequalities by assuming care is a women's domain.
- 5.2.4 Training workshops with educators to help them not only to identify children with potential risks for behavioural, emotional and learning problems, but to be aware of resources to which children can be referred for therapy and remediation, would be valuable.
- 5.2.5 Given the potential of the Sihleng'imizi programme to scale up the effects of social grants, future social policy in South Africa needs to move beyond cash transfers to incorporate the concept of cash and care.
- 5.2.6 While the programme showed immediate positive post-test effects, follow-up studies need to be conducted in order to determine whether the benefits of the programme are sustained in the longer-term.
- 5.2.7 The study was conducted by the programme developers; hence future evaluations of the programme need to be conducted by independent researchers (Cluver et al, 2018).



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APPENDIX A: RESEARCH TOOLS

A full set of baseline and endpoint research tools (English, SeSotho, isiZulu and Afrikaans versions) is available on request. Presented here for illustrative purposes are:

Caregiver endpoint tool (quantitative): English

Caregiver endpoint tool (qualitative): English

Child endpoint tool: English

Educator endpoint tool: English



Sihleng'imizi Caregiver Questionnaire ENDPOINT intervention & control

Name of interviewer	
Name of participant (adult)	
Name of participant (child)	
Date of interview	
Interview research ID number	

Instructions for the interviewer: Greet the caregiver.

Thank you for allowing me to return to talk to you and your child again. We want to find out about any changes that may have happened in your household since me or someone else interviewed you a few months ago. At that time, you agreed we could return for this interview.

Remember that what we discuss today will stay private, and when we write a report of this research we will not be using any person's name, so no-one is going to know who you are in the report. Remember that we want to record the interview to make sure we remember exactly what you said today.

Please sign to say you agree to this interview, and the audio-recording.

Signature

Date

A: HOUSEHOLD

1. Please can you say if any of these things have happened in your household since the last time we came to interview you.

		Yes	No
1.1	Has anyone new come to live with you in this house who wasn't living here at the last interview?	1	2
1.2	Has anyone in the house gone to live somewhere else ?	1	2
1.3.1	Are you still the MAIN person who takes care of [name of child]?	1	2

1.3.2. If the answer to 1.3.1. was NO, please ask for further information: who now takes care of the child, what is their relationship to the child, and why this change.

1.4	Has anyone in your house lost a job (eg retrenched, or piece job ended)?	1	2
1.5	Has anyone in your house found work / started a business?	1	2
1.6	Has anyone in your house started getting a grant since the last interview (eg CSG, pension, disability grant)?	1	2
1.7	Has anyone in your house stopped getting a grant (e.g. child turned 18 years and the grant ended; or a person passed on and the grant was stopped or a temporary disability grant was suspended)?	1	2
1.8	Has anyone on the house been too sick or disabled to work?	1	2
1.9	Has anyone on the house passed away ?	1	2
1.9	Has there been a new baby born?	1	2
1.10.1	Has anything else happened that has made it more difficult to cope at home?	1	2

1.10.2 If the answer to 1.10.1 was YES, please specify what happened and why did it make things more difficult to cope.

Thanks for this information. Now I am going to ask you some questions about food and eating in your home.

B: NUTRITION

1.1. What do you think is the most important meal of the day?

Breakfast	1
Lunch	2
Dinner	3

1.2 Please state why you have indicated which meal is the most important meal of the day:

2.1 Do you know what is meant by a balanced meal?

Yes	1
No	2

2.2. If yes, what does a balanced meal consist off?

3 Which of the following cooking method/s do you think is healthy?

(Mark one or more)

3.1	Deep frying	1
3.2	Baking	2
3.3	Boiling	3
3.4	Grilling	4
3.5	Steaming	5
3.6	Other, please specify	6

4 How important are the below to you in your food choices:

- 1 – Very Important
- 2 – Important
- 3 – Not Important
- 4 – Very Unimportant

		Very important	Important	Not important	Very unimportant
4.1	Cost	1	2	3	4
4.2	Nutritional Value	1	2	3	4
4.3	Brand	1	2	3	4
4.4	Type/Taste	1	2	3	4
4.5	Time/Convenience	1	2	3	4
4.6	Healthy lifestyle	1	2	3	4

5 Please say briefly what you know about safety and hygiene in the kitchen.

C: DEPRESSION INDEX

1. Now I am going to list some of the ways you may have felt or behaved. Please say how often you have felt this way in the last week.

		Rarely or not often (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	All of the time (5-7 days)
1.1.	I was bothered by things that usually don't bother me.	1	2	3	4
1.2	I had trouble keeping my mind on what I was doing.	1	2	3	4
1.3	I felt depressed.	1	2	3	4
1.4	I felt that everything I did was an effort.	1	2	3	4
1.5	I felt hopeful about the future.	1	2	3	4
1.6	I felt fearful.	1	2	3	4
1.7	My sleep was restless.	1	2	3	4
1.8	I was happy.	1	2	3	4
1.9	I felt lonely.	1	2	3	4
1.10	I could not "get going."	1	2	3	4

THE NEXT SECTION IS ONLY FOR THE INTERVENTION GROUP FAMILIES WHO TOOK PART IN THE SIHLENG'IMIZI FAMILY PROGRAMME.

2. I am now going to ask some questions about how you feel **now compared to how you felt before** taking part in the Sihleng'imizi group.

		More than before the group	The same as before the group	Less than before the group	Don't know
2.1	I feel overwhelmed by the responsibility of being a parent / caregiver	1	2	3	4
2.2	I am hopeful for my child's future	1	2	3	4
2.3	I am able to balance many different responsibilities in my life (e.g. being a parent and running the home and earning money)	1	2	3	4
2.4	I believe that most of the time I am a good parent / caregiver.	1	2	3	4
2.5	If my child misbehaves I can discipline him / her WITHOUT physical punishment.	1	2	3	4
2.6	I am giving the right support to my child to do well at school.	1	2	3	4

3. Please answer the following questions about the Sihleng'imizi group.

		Yes	No
3.1	Do you think the food at the group was good quality?	1	2
3.2	Was there enough food for everyone at the group?	1	2
3.3	If you were invited to another Sihleng'imizi group, would you come even if there was no food?	1	2
3.4	Was getting family stickers a fun part of the group?	1	2
3.5	Did your family try hard to earn stickers (e.g. do homework, be good in the group)?	1	2
3.6	Was the venue comfortable for you and your family?	1	2
3.7	Was the venue easy to get to?	1	2
3.8	Was the time of the day that the group ran convenient for you?	1	2
3.9	Were the group sessions the right length (not too long or too short)?	1	2
3.10	Was the family workbook easy to use?	1	2
3.11	Was the family workbook USEFUL (did it help you and your family)?	1	2
3.12.1	Did your WHOLE family come to the group (everyone in your family who lives with you)?	1	2

3.12.2 If the answer to 3.12.1. was NO, please ask for further information: who did not come and why did they not come.

		Yes	No
3.13.1	Do you think the social worker did a good job in running the group?	1	2

3.13.2 If the answer to 3.13.1. was NO, please ask for further information: what did you think they did not do well, and please give examples.

		Yes	No
3.14.1	Do you think the childcare worker did a good job at working with the children?		

3.14.2 If the answer to 3.14.1. was NO, please ask for further information: what did you think they did not do well, and please give examples.



Sihleng'imizi Caregiver Research Tool ENDPOINT intervention

PLEASE FILL IN ACCOMPANYING QUESTIONNAIRE FOR:

Section A: HOUSEHOLD

Section B: NUTRITION

Section C: DEPRESSION INDEX

I want to find out whether there have been any changes in your family since the Sihleng'imizi family group. Please can you help me by answering the following questions.

D: FAMILY QUESTIONS

PART 1: PROGRAMME OUTCOMES

1. What has been the biggest change in your household since the group?

PROMPTS:

- *Can you tell me specifically what has changed?*
- *If nothing has changed could you tell me why do you think this is so?*
- *Explain whether you think these changes are positive or negative.*

2. Have there been any changes that you have noticed in your child since the group?

PROMPTS:

- *Has the change been a good one?*
- *Has your child's behavior become worse?*
- *Why do you think this has happened?*

PART 2: CAREGIVER INVOLVEMENT IN SCHOOL

1. Have you noticed any changes in your child's performance at school?

PROMPT:

- *Do they enjoy going to school?*
- *How are they getting along with other children at school?*
- *How has your child interacted with their teacher?*

2. Do you see their homework or help them with their homework more or less or the same since the group?

PROMPT:

- *Have you managed to assist them?*
- *Have you started looking in their homework book, checking their school books or noting assignment dates?*
- *Have you turned off the TV and given them a quiet space to do homework?*
- *Do you discuss what they are learning at school with them?*
- *Do you sign their homework book?*

3. Since the group started, have you spoken to the child's teacher or gone to school meetings? Please tell me more.

PROMPT:

- *Have you been able to speak to the teacher when before you were too shy or didn't think you should 'interfere'?*
- *What did you do well, or do not so well in speaking to the teacher/school?*
- *Was there anything you think you should have learned in the group that you didn't learn about how to talk to the teacher or school?*

4. If you are worried about your child's progress at school, what have you done?

PROMPT:

- *Have you spoken to the teacher?*
- *Were you able to come up with a joint plan between you and the school?*
- *Did you find out what help the school can give?*
- *Did you find out what other help is available?*

5. In the new school year, what are your plans to be more involved in your child's education?

PART 3: FAMILY FUNCTIONING

1. After taking part in the Sihleng'imizi group, what are some of your hopes and dreams that you have for yourself and for your child/ren?

PROMPTS:

- *What do you hope for your children's future?*
- *Do you think your children's life will be easier /harder than yours?*
- *In what ways?*

2. In which ways do you think these hopes and dreams could be achieved?

3. Is there any change in **how close your family is** since you took part in the Sihleng'imizi group?

PROMPTS:

- *Is there trust?*
- *Do you have a feeling of togetherness as a family?*
- *Are you 'there' for each other when needed?*
- *Do you feel like you belong in your family?*

4. Has anything changed in **the way you talk** to your child/ren since you were in the group?

PROMPT:

- *as an example, think of a conversation that you had with your child/ren yesterday*
- *Do you find it easy to talk to your child/ren?*
- *Are you able to sit down for a few minutes and listen to your child/ren's stories of their day?*
- *When they ask for your attention, do you make them wait ages, or sometimes forget they asked?*

5. Since the group, do you always know where your child is?

PROMPTS

- *When your child goes to a friend's house, do they get permission from you?*
- *Who are they with after school?*
- *Is there adult supervision on the way home from school?*
- *Do they play in the street? If yes, can you see them?*

6. Since the group, what things do you do to keep your child/ren safe?

PROMPTS

- *Ask about physical safety from dangers in the home such as open fire, paraffin stoves, candles, boiling water*
- *Ask about physical safety from dangers outside the home such as traffic / safety in taxis / safe from potential abusers / safe from burglars*
- *Ask about safety at school*
- *Ask about environmental hazards eg. Pit latrines, stagnant water, rubbish dumps*

7. Now that you have finished the group, what happens at home if your child has done / said something they should not have?

- *Do you punish your child? If yes, what do you do? If no, why not?*
- *Do you ever physically punish your child? Please describe.*
- *Are you ever worried about hurting your child? Please explain*

8. If your child is well-behaved what are some of the things that you now do since the group?

PROMPT:

- *Do you find it easy/difficult to praise your child?*
- *Do you reward your child? Consistently or only sometimes? Why or why not?*
- *Do you give encouragement when they find something difficult to do?*

9. Please tell me about any household rules for your family that are different since you took part in the Sihleng'imizi group?

PROMPTS

- *Do you think everyone in the household knows what the rules are?*
- *Give examples*
- *Are the rules very strict?*
- *What happens when the rules are broken?*
- *Are there rules about who children can go out with?*
- *Do they have a certain time to be home by?*
- *Is there a set time for bed time?*

10. Since the end of the group, now what happens in your family when there is conflict or disagreement?

11. What would you say you are doing well as a caregiver/parent since the group?

12. What do you find hard/difficult do as a caregiver/parent?

13. What do you feel could assist you with these challenges?

PART 4: SOCIAL AND COMMUNITY CONNECTEDNESS

1. Do you think your relationship with your neighbours/community has changed since Sihleng'imizi?

PROMPT:

- *Do you trust your neighbours/community?*
- *Do you feel safe in your community?*
- *Do you feel part of your community?*

2. Do you think your relationship with your extended family members (e.g. aunts/cousins, etc.) has changed since Sihleng'imizi?

PROMPT:

- *How often do you visit your family?*
- *Do they come to visit you?*
- *Do they live close to you?*

3. Now that the programme has come to an end, will you still keep in touch with your Sihleng'imizi buddy or other group members? Please explain further.

PROMPT:

- *What has the buddy added to your life?*
- *How useful has this been?*

4. What community resources have you learned about in the Sihleng'imizi group that you think you can or will use if you need to?

PROMPT:

- *What community resources did you learn about in the group?*
- *Would you use them?*
- *Why or why not?*

PART 5: FINANCIAL CAPABILITIES

1. What did you think about the part of the group where you spoke about money, budgeting and savings?

PROMPT:

- Did you learn anything new?
- Was this enjoyable?

2. How has the programme assisted you with decisions about spending money in the household?

PROMPT:

- Do you think the wants, needs and obligations activity will / did assist?
- Can you give any examples of how this has helped?

3. Has anything changed in the way that you save money in your household since the group?

PROMPT:

- Have you joined a stokvel, opened a bank account or putting money aside at home?
- Have you been able to involve other members in your family?

4. Has your view on loaning money changed since the programme?

PROMPT:

- What would use from the programme to assist you with this (e.g. approach a bank)?

PART 6: PARENTAL / CAREGIVER SELF-EFFICACY

1. Do you feel good about yourself? Why or why not? Has this changed since the Sihleng'imizi group?

PROMPTS

- Can you do things as well as most other people else?
- Do you think you have many good qualities?
- Do you respect yourself?

PART 7: PROGRAMME EVALUATION

1. Thinking back to what was covered in the programme, is there anything that you feel should have been included?

2. If there is anything that you would change or add to the Sihleng'imizi programme, what would it be?



Sihleng'imizi Child Research Tool ENDPOINT (intervention)

Name of interviewer	
Name of participant (adult)	
Name of participant (child)	
Date of interview	
Interview research ID number	

Instructions for the interviewer: Greet the child. Remind them that you met them last year to learn about their family, and that you talked and they drew a picture. Explain you are back to ask if they would please answer a few more questions and do another drawing. Ask if you can start.
REMEMBER TO STATE YOUR NAME AND THEIR NAME AND THE DATE AT THE START FOR THE AUDIO RECORDING.

1. "Please draw me a picture of your family on this piece of paper. Please draw you and your family **DOING SOMETHING**. Here are crayons for you to use".

If the child asks 'Doing what?' say: "Doing something together. Anything that you do together as a family." Do not suggest a topic for them. If they still don't know what to draw, then say: "Maybe draw something you together in the house, or you do together in the yard, or when you go out of the house together to do something"

The purpose of this exercise is to understand the family relations, how cohesive the family is, and how the child views him/herself in the family.

Provide the child with a clipboard to press on, coloured crayons, and a piece of A4 blank paper. Allow them to complete the drawing, without commenting or making suggestions on the drawing. Allow them at least 15 minutes for the drawing.

Once the child has completed the drawing, please interview him/her about it, using these prompts (only use prompt that are appropriate and relevant to the picture).

- Please tell me about your picture.
- Which is you?
- Who are these people?
- What is in the background?
- What is s/he doing? Why do you think they are doing this?
- Tell me a bit about the happy / sad look on this person's face.
- Tell me a bit about how these two people get along – do they ever fight? Do they ever have fun together?
- Is this person ever sad? When are they sad?
- What makes this person happy?
- Who is missing from your picture that you would like to have in your family?
- What else can you tell me about your picture?

"I have a few more questions to ask you now. This won't take very long. I am going to start by reading you some sentences that describe how some boys and girls think or feel or act. Listen carefully to each sentence. If you agree with the sentence, answer 'yes'. If you do not agree with the sentence, answer 'no'.

Give the best answer for you for each sentence, even if it is hard to make up your mind. There are no right or wrong answers. Please do your best, tell the truth and answer every sentence."

2. I like going to school

Yes	1
No	2

3. I wish I didn't have to go to school

Yes	1
No	2

4. Most teachers are unfair

Yes	1
No	2

5. Sometimes my teacher makes me feel bad.

Yes	1
No	2

6. I am always bored during school.

Yes	1
No	2

7. I hate school.

Yes	1
No	2

9. Sometimes my teacher makes me feel stupid.

Yes	1
No	2

10. My teacher likes the other children more than me.

Yes	1
No	2

11. School is always boring.

Yes	1
No	2

12. My teacher gets angry with me for nothing.

Yes	1
No	2

13. My teacher gets angry with me too much.

Yes	1
No	2

14. This is how I feel today (show child the feelings card and record the answer here):

Happy	1
Sad	2
Angry	3
Worried	4
Shy	5

Excited	6
Other (please specify)	7

15. Most other days I feel like this (show child the feelings card and record the answer here):

Happy	1
Sad	2
Angry	3
Worried	4
Shy	5
Excited	6
Other (please specify)	7

16. Some days I am not sure if there is anyone who loves me

Yes	1
No	2

17. I feel loved by my family

Yes	1
No	2

18. If I feel sad I have someone who I can talk to.

Yes	1
No	2

19. What do you remember about the Sihleng'imizi group you went to last year?

20. Is there anything different in your family since you did the group together?

21. Would you like to do another group like this one day? Why or why not?





Sihleng'imizi Educator Research Tool ENDPOINT (intervention)

Instructions for the interviewer: Greet the educator. Remind them you are conducting research on the Sihleng'imizi programme, which is a preventive family-based group to support poor families getting a Child Support Grant. Remind them that [child's name] from his/her class was taking part in the group, which is now over /almost over. Request a 15 minute interview with the educator to get a bit of information on [child's name].

The following information must be stated at the start of the interview so the recording can be correctly allocated.

- Name of interviewer
- Name of educator
- Name of participant (adult)
- Name of participant (child)
- Date of interview

Interview questions

1. Are there any **changes** you have noticed in this child since we last spoke to you in August? If yes, what are these changes? (social, academic, homework, behavioural, other changes) Please describe in detail.
2. Have you had any **contact with the caregiver** of this child since August 2017? If yes, please describe who initiated the contact and what occurred.
3. Are there any **changes** you think may have happened at this child's home since August? If yes, please explain why you say this.
4. Are there any **concerns** you have about this child?
5. Is there **anything else** you think we should know about [child's name]?

APPENDIX B: ADDITIONAL DATA

The following data forms a body of additional evidence to support the findings in the main part of the text. It adds to **Section 4.3. What Changes Occurred as a Result of the Intervention?**, specifically **4.3.1. Changes in Accordance with the Five Key Dimensions of the Study**.

Each section below contains just additional data in the form of quotations that form the basis of the evidence for the conclusions of the study. The analysis is contained in the main body of the text.

4.3.1.1 Dimension 1: Family and child-caregiver relations

a) Hopes and dreams

"If I can find a job and have money so that they can be able to go to college, you see?" (Phunzo, Caregiver).

"I want to get a job so that they can study and become successful and continue" (Lungisa, caregiver).

"I wish that I can get some piece jobs so that I am able to help my children so that they do not struggle and they should be like other kids at school" (Mottlalepula, Caregiver).

"The hopes and the dreams is for her just to be a good person and just to be a loving person, that's the hopes for her and she must finish school" (Dinah, Caregiver).

"He should continue taking care of himself, he should finish school and become what he would like to be" (Phunzo, Caregiver).

"After joining this thing, it taught me a lot of things. It taught me about the future of my child, that my child should move forward with his education, my child should study for what he wants when he is done with school so that he will be like other children" (Nkhensani, Caregiver).

"I hope for life, I wish God can keep me to see them grow up. May they get educated and love school" (Catherine, Caregiver).

"I want them to learn and focus on their education and succeed" (Nolwazi, Caregiver).

"For myself is to get MA Education, and to complete my degree in communication, that's 1 in a few things I would like to achieve" (Rose, Caregiver).

"The dreams, yoh it's a lot. I want..., my dreams neh. I want to open my own business, and we want a house, our home and the best education for my daughter and for myself too. And then..., yeah, we should be happy" (Nobuhle, Caregiver).

"They should be independent in life, they should learn to be independent, they should know what is wrong and what is right in life, that when we do this it's wrong and when we do that it's right" (Ayanda, caregiver).

b) Communication patterns

"I think it's better because when she need something she's able to call and ask "grandmother may I please have this...She now knows how to ask that please come and help me" (Adeleide, Caregiver).

"I was a shy person. I was not asking children questions and things like that, I was just living in the house. Now I know that I have to ask 'are you fine?' I have to tell her every day that 'I love you' and things like that, I didn't do that before" (Lesedi, Caregiver).

"Now it seems there is a lot of improvement and they are starting to communicate with me, initially they didn't want to communicate" (Gugu, Caregiver).

"In the beginning we didn't communicate a lot but since the group started, we have good communication and spending time together because we do those rules and now it's like a rule spending time together. Now we spend more time together" (Phindile, Caregiver).

"Change that has been there is that I am able to bond with her, I am also able to respect her and I am also able to talk to her without beating her" (Khanyisile, Caregiver).

"There has been a change in talking to them because there is..., you know, you should give the child a chance to listen to what he is saying to you. I shouldn't say because I am older, then I know everything all the time. I give them that chance to say what they didn't like, what happened, like when the child comes back from school and you ask 'was it nice at school, what did you do?' and he would say. This one would just come, before he even changes and I would say 'change first' and he would tell me that 'at school was like this, at school was like that'. You see, he is becoming open and he is talking" (Ayanda, caregiver).

"We now can sit down and communicate, that's the change I can say is there now. And that we have time for another person, and we also ask each other 'how was your day?' and the other person can be able to explain that 'eish, I felt bad here and there'. And that we can ask how was school, so every person now we can share" (Naledi, Caregiver).

"I have seen a big change in that we are now respectful towards each other with my boy. When one is talking the other one listens, and then it was to train our children in the same way and not have one person pull this way and the other one that way. After our meeting with the social worker, it is much better; we have a common way of handling the children" (Sindi, Caregiver).

"It has changed because when we go there (to Sihleng'imizi) we would talk and everyone would say their problems, and when everyone is saying their problems I also take somethings which I feel that they might help me at home. When I get here, I try to speak to them that 'hey, this and that'. It really helps me, it's not the same as when I didn't go there" (Lungisa, caregiver).

"When I call them so we can talk as a family they're able to sit down and listen to me. I see the biggest change when I look at my children and also in the house I see change...from the children and with A when you ask her to come and write she's able to do so... Now there's a bigger change because I don't hit them anymore. I just sit with them down and talk, explain and advise them yes... I don't shout at them. I don't scold them I tell them nicely, I call them if I see that there's something I don't like. I call them and sit down with them and we talk" (Adeleide, Caregiver)."

"I also know how to care for my children and they listen to me, I also listen to them if they want to tell me something" (Adeleide, Caregiver).

"I tell them to speak at that time if they want to talk because I might forget because most of the time I am always busy... always going out to buy sweets and tomatoes come back and sell so I don't have enough time so I like to listen the moment they want to talk" (Samke, Caregiver).

"Sometimes I used to shout, and I would be afraid that maybe they would also be a bad example to other children. I would shout that 'hey, don't do this and that' but now I am calm and I also don't shout, I tell them 1, 2, 3 that it's like this" (Aubrey, male caregiver).

"When there is a disagreement we sit down and talk it through as a family" (Nolwazi, Caregiver).

"We sit down and talk, they would tell me what they didn't like then we would try and solve that problem" (Oratile, Caregiver).

"If ever maybe someone did something wrong, we would talk to him and ask what the problem is. Then after talking maybe we would find the solution to solve the problem" (Lesedi, Caregiver).

"Since he joined the group he has learned because he doesn't say the rude words he used to say" (Oratile, Caregiver).

"Now I am able to reprimand them because..., I cool down before talking to the child, and they are able to understand when I explain that the problem you did is this and how we are supposed to solve it" (Masego, Caregiver).

"I can now calm down; I am a person who is loud. It has been able to calm me down, even if that thing makes me angry there and there. I am no longer that person who becomes jumpy, shouting" (Lindiwe, Caregiver).

c) Increase in positive parenting behaviour

"When she is well behaved we tell her that 'what you did is good, and we are going to pour a cold drink for you or we are going to buy you a packet of chips or chocolate for you'" (Dinah, Caregiver).

"He doesn't get a reward, but when he behaved well I won't tell him what I would do but he knows that I will give him something" (Oratile, Caregiver).

(When she has behaved well) when I have money I buy her something that I know she likes. Like ice cream. I surprise her by going to the shops and she buys what she wants and she says 'thank you mama.'...Sometimes when I have got money, I go to Pick 'n Pay (large supermarket chain store) or Pep (clothing chain store) and is she says that she wants toys, I buy them for her" (Motlalepula, Caregiver).

"We praise him and there is a reward there that is they behave well and respect, like as you are here they would be making up and down and calling 'mama' and disturbing, so when someone like that is well behaved we have agreed that we reward him at the end of the month" (Lindiwe, Caregiver).

"I praise her, and she would also be happy. Maybe also buy them something to make them happy, a cake from Spar (supermarket)" (Aubrey, male caregiver).

"I praise her, and she would also be happy. Maybe also buy them something to make them happy, a cake from Spar (supermarket)" (Aubrey, male caregiver).

"I praise them or reward them with something. Like telling them that I will take them to MacDonald (fast food chain)" (Nomvula, Caregiver).

"I would praise them and say 'my baby you did well here, you should be doing well all the time. Do you see that you made Mama happy?' and all that" (Thembisa, Caregiver).

"I get happy, praise him, and give him a hug, if I have money I buy sweets you see" (Siphokazi, Caregiver).

"By thanking him I thank him only by mouth not by money because when he is doing a wrong thing he will know that I will shout but when he did something right I will give him money and tell him that he has done good I am doing this for tomorrow that he will not say that I want to make something good so that my mom will give me money and want him to always know that I did wrong I did right my mother never say she will give me money..." (Samke, Caregiver).

"When she did something I like I hug her and tell her that I am happy. I also give her a high 5, she knows that this thing is good" (Nobuhle, Caregiver).

"Where I don't reward her is when I don't have it, but I am able to reward her with words and praise her that 'what you did is good, thank you' (Khanyisile, Caregiver).

"When he is well behaved I praise him, I say 'thank you'" (Lungisa, caregiver).

"You have to praise them, because the children also love when you say 'thank you' they become happy and they would ask 'what else should I do for you' because they want you to say 'thank you again'. Even when they eat, they would eat together. One would eat and finish her food and the other one not finish, I would say 'oh, you are a good girl' there is where the other one would also eat because she also want to be told that she is a good girl" (Phindile, Caregiver).

"I would thank him during that time, thank you that you did this and keep it up, it's a good thing" (Naledi, Caregiver).

"I give them a kiss and a hug to show them that they have done well and for them to be happy" (Faith, Caregiver).

"If you as a parent you are scared to talk to your child no one will give him the proper guidance. It must be you as a parent who must sit down and talk to him. When he did something wrong he must know that he has done something wrong but you must also be thankful when he has done something good so that he know the wrong and right" (Samke, Caregiver).

"When the child is well behaved I would thank him and say 'my child, what you did is good and you should keep it up'" (Nkhensani, Caregiver).

"I ask first what kind of thing she said, is she said a wrong thing then when we meet for example, I would reprimand her that we don't say things like that. Even when she is fighting with someone I tell her not to do things like that... Then all of us, if it's a younger one, we would talk to him and tell him that 'you don't listen, you don't do this. And the consequences of that thing is this'" (Lesedi, Caregiver).

"They also taught that every time when the child did something wrong, you should tell the child in time that there is something wrong he has done and then you should try on how to punish him as his mother. Not by beating him or something, you should punish him with what he likes, maybe what he would need...When the child did something wrong you shouldn't feel pity or something, you should tell him that he did something wrong. Don't change the statement or feel pity that because it's your child, tell them the right thing" (Thembisa, Caregiver).

"I ask them why they are doing this, and I say don't do this because this one is negative. And if they don't hear me there is also punishment which is... for instance 'when you don't do this, tomorrow you won't carry anything when you go to school or you are not going to get this for December'" (Muzi, male caregiver).

"I complement her but now once she behaves badly then I take that away. Then, yeah she'll get a negative with a negative. Not necessarily compliment her, I speak to her a lot" (Mashudu, Caregiver).

"We were taught about calm down corner, that you shouldn't shout him or what. So, if he repeats to do that thing...it could be making noise or what, you can take him there to sit there alone for some time" (Naledi, Caregiver).

"And when you talk to them, when I would tell them to do something they would just say they will do it but not, and now they are able to jump up and do it, because they were scared of the punishment, they now know that there is punishment. I showed them that when they don't listen, they will sit in the corner, the naughty corner. And I was the kind of granny that liked to give hidings, with anger, but the anger has subsided and the hidings have become less" (Catherine, Caregiver).

"What we have learned at Sihleng'imizi is that sometimes when the child did something you don't like, give him his corner where you would put him...That's a good way because even when he thinks of doing the wrong thing he would say 'ah, Mama would put me at the corner' and I would say 'it's for when you are doing what is not good'" (Ayanda, caregiver).

"I no longer shout. It's a bit better. Even though I'm not used to it but step by step" (Nolwazi, Caregiver).

"I sit down and talk to him that I don't like what he's saying" (Grace, Caregiver).

"A person must make up their bed in the morning and tidy after up even if the house has not yet been swept and then they can go to school. I tell them that the dishes must be washed before 20:00. It mustn't reach 20:00 before you fetch water. At 19:00 you must bath and wash dishes" (Adeleide, Caregiver).

"The rule I had here in the house was to teach them that when finish eating we wash dishes and they don't sleep before they bath" (Adeleide, Caregiver).

"Ok, I made it that when my children come back from school they should come and keep their school things. And they should do their things in time so that tomorrow they can wake up early and do their chores" (Masego, Caregiver).

"There is a change because our children are quiet and then when we met with the social worker, they explained to us the times of which the children should go out to play and when they should come back inside the house, you see. So they also now know the time to go play and to be back in the house" (Sindi, Caregiver).

"Not to come back late from playing, they should stay clean, when they wake up in the morning they should brush their teeth, they should take/ keep their routine" (Muzi, male caregiver).

"When she wakes up in the morning she should bath, brush her teeth and wash her face before she can eat breakfast" (Khanyisile, Caregiver).

"And we also learned that..., because we didn't have bed time, the children were just sleeping and sometimes find that he would sleep on that time he wants to sleep. So we have learned that it's important that the child has time to sleep... That they have to sleep early, because that one we didn't have as a rule. So, that's the one we have added" (Naledi, Caregiver).

"When a person is eating must not eat the food and leave leftovers but eat all the food and finished" (Adeleide, Caregiver).

"The household rules we have is that we would tell them that they shouldn't come back late because being on the streets at night, at times they might come across the uncle who would take the child and leave with her. That's where we tell them that they shouldn't come back home at night" (Khanyisile, Caregiver).

"It has changed because in the beginning some of the things we would just do them but they were not in the rules. So, after we left there, we felt that it's not good to just say something, you should put it as a rule and for everyone in the house to know that these are the rules here at home and when you are not doing this, the consequences would be like that... Another thing I can think that happened is that I am the one who made the rule in the house that on Fridays, Saturdays we don't cook, we eat out. So, when we talked there I realised again that I am the one who will stop that thing so that we can save that... because I realised that maybe Friday alone going to eat out, because we are many we would spend R4 – R500. Saturday it's another R4 or R500, so do you understand that within 2 days we have already spent a R1000 of which...of which we can spend R300 in buying what we are going to cook at home at save that R700. I sat down and told them that I know that I am the one who put that rule, but now we leave it" (Phindile, Caregiver).

"There has been that change like if I can make an example with time to eat, that we are eating on this time. When you are late, you will find your food cold and we will not dish up for you. So, you will see how you are going to eat because time to eat is up. We will dish up for people who are there during that time and we eat, so when you are not there..., so that's something that makes it for everyone to know that when it's time to eat they are there, we do everything together, then they can leave" (Phindile, Caregiver).

"Oh, now it has changed because when I speak them they listen. They don't leave and come back at night anymore, they come back early...They come back at 4 because sometimes you would find that they have bad company, previously I was afraid to tell them that 'these friends are not good' but now I am able to tell them that 'don't play like this with other children because you can see how they are, this time you are supposed to be home. Don't play until it's 8 while you are still there, at 5 or 4 o'clock you are supposed to be home' and she knows that at 4 she has to start cooking" (Lungisa, Caregiver).

"The time to go to bed, for the children it is set, eight o'clock in bed...When they get back from school they must wash their socks and polish their shoes, and I must see that they are clean" (Catherine, Caregiver).

"There is a change because they were taught to come back home early. So immediately when you remind them about what did they say at Sihleng'imizi they remember that at Sihleng'imizi sister P taught us that we must not come back home late and we are also following our household rules that were made as a family" (Nomvula, Caregiver)

"I have seen it in the children, especially my grandchildren, they used to come back home late. Like when I tell them that we will be eating at six, and they have to be in the house at 17:45, they will get in the house around 18:30 or something to seven. But ever since we have been attending that place, I saw a change and they would now come back around ten to or five to six" (Catherine, Caregiver).

"They wake-up on time to school and when they come from school they take their books read and do their homeworks... The changes I've seen here at home is that the children can go to play and come

home on time. They don't come home at night and they're able to sleep on time, not at 10 o'clock they used to sleep at 10 but they know how to sleep on time and wake up on time to go to school. That's the change I've seen. And I also know how to care for my children and they listen to me, I also listen to them if they want to tell me something" (Adeleide, Caregiver).

"They should come early, they shouldn't come home late. When they come from school they shouldn't just go and play with other children because other children are doing that, we started with A and tried for her to get home early. You would find that she is on the way coming and I would meet her half way, I would see her and meet here. There is a difference because she does come home early. We tell her that you shouldn't go and play to a certain place while we don't know that, she also knows that. They are able to say 'dad, can we please go to the shop'" (Aubrey, male caregiver).

Discipline and reduction in harsh parenting

"Now there's a bigger change because I don't hit them anymore. I just sit with them down and talk, explain and advise them yes...because I was unable...When you find that I'm angry, I would pick up a stick and hit them" (Adeleide, Caregiver).

"Because I can see I make them happy, they are not afraid of me the way they used to be anymore because they knew that I beat them" (Kedi, Caregiver).

"After putting him for 5 minutes he would tell me that 'I won't do what I did again' because you have punished him. I even told people that when you beat the child, he would never listen to you. You should not beat the child, when you put him for 4 minutes and tell him that because you..., he would tell them that my mom punished me, I am no longer going with you" (Nkhensani, Caregiver).

"They knew back then that I used to beat them, and then I would punish them...It's better now. It's not the same, they are also saying that 'hay, now it looks like we are good'" (Lungisa, caregiver).

"I'm able to talk to my children, I don't hit them" (Nolwazi, Caregiver).

"The child's behaviour is better even though the child won't be perfect but now you are able to discipline them, especially when you tell them what did they say at Sihlengi'imizi? He reprimands himself easily and he is able to say that they taught us this and that and he also knows that we are not supposed to hit him" (Nomvula, Caregiver).

"It's a change that when the child comes back from school I am able to spend time with him, and then I no longer beat him as discipline" (Phunzo, Caregiver).

"M was a cheeky child. Since we came back from there we don't beat him, have you seen in the beginning I used to beat him but now I don't beat him anymore because he understands that when I say it's not there, it's not there. When I say it's there, it's there; but in the beginning when I would say 'it's not there' he would say 'look for it in this place'" (Thembisa, Caregiver).

"I don't hit them. At first I was shouting at them. But now I am no longer shouting - I just say a person must go to his corner" (Samke, Caregiver).

"I also have my calming corner so that I don't get worked up" (Nolwazi, Caregiver).

"Before I always had anger. In everything I do, I was always shouting but now I don't shout... Sometimes I would chase them outside, and do unnecessary Spring-cleaning, trying to calm myself" (Siphokazi, Caregiver).

"It has changed because as I have mentioned that mostly there they were teaching us about children, punishments and all that. We were having the mind-set that you have to hit and shout at the child, so now we have seen there that it's not [what works]. [Instead of] beating them [we can] build them. You can just punish her with small things and say 'you are not going to find this' and such punishments makes her [listen]..., you leave the child without being too strict with her (Phindile, Caregiver).

"I used to be loud, and shout and shout. But now I have seen that shouting makes her worse, so I better be polite and reprimand her while I am calm, then she understands better" (Lindiwe, Caregiver).

"Then in the behaviour I know that when a child is doing this, before I used to beat her, so now I know when she has done something she has to have a calm down corner. We would watch TV and when they are making noise we would tell them that 'no, you are noisy' and we would leave her in the calm down corner. Change that has been there is that I am able to bond with her. I am also able to respect her and I am also able to talk to her without beating her... "The punishment - I beat her with the calm down corner" (Khanyisile, Caregiver).

"At Sihlengi'imizi they taught us about cool down corner. That you will put her in the corner tell her not to move and then after moving you explain to her that, "you are sitting here because you left and you came back after a long time" or else like that you talking to her, she does not listen; you call her, she does not come. There are consequences. They taught us that you can tell her that from now I cut your pocket money. No punishing them by hitting them" (Nomvula, Caregiver).

"And when you talk to them, when I would tell them to do something they would just say they will do it but not now, and now they are able to jump up and do it, because they were scared of the punishment, they now know that there is punishment. I showed them that when they don't listen, they will sit in the corner, the naughty corner. And I was the kind of granny that liked the give hidings, with anger, but the anger has subsided and the hidings have become less" (Catherine, Caregiver).

"She does ask and say 'Mama I am going to play there by M, I would tell her that 'I would call you when I need you, but don't play until sun set'...After school there is my mother here at home, she is around by that time... I make sure that they don't go to the streets. The play and the pavement there, sometimes they are here at the gate" (Khanyisile, Caregiver).

"I would tell her that even when you went to play, and then someone comes. Even if you know them, maybe it's my friend saying 'let's go' you should come to me first, when she comes and say 'H let's go' you should run and come to me, and tell me that 'Mama, here's so and so's mother there going wherever, can I go there' so that I can know. Not that when someone comes, when I leave here you would have told me that you are coming here but only to find that you are there" (Phindile, Caregiver).

"I tell him that children are raped. When there is someone you don't know calling you or giving you something, you should not agree because you don't know this person. If you take what they give you then they will take you with them or they will go and rape you there without us knowing what happened, I also tell this one that children are stolen. When you meet someone on the way and they call you 'come and take a sweet' This older one asks, but the others just disappear. But they would normally be at the neighbours, but we don't like that they just leave without our consent" (Awethu, Caregiver).

"When she's not in the yard she goes to the corner house which is the second or third house from here at home, so she plays there with her friend and there only. When she is here she plays in the yard and at school they are locked in because they are in Grade R" (Nobuhle, Caregiver).

"We talk a lot to T about safety, and he's aware that he doesn't touch, he doesn't play with the lighter, and he doesn't do things like that" (Rose, Caregiver).

4.3.1.2 Dimension 2: Caregiver involvement in children's education

a) Improvement of child at school

"There is a change because the younger one didn't like school but now he enjoys going to school" (Masego, Caregiver).

"She enjoys going to school...Why I say that, because you can even when she stand up in the morning she would ask, 'I am going to school, why am I not going to school?' and you tell her that listen here, the school is closed, there are no children at school. Even on a Sunday you would hear 'I am going to school'" (Dinah, Caregiver).

"He likes going to school" (Nolwazi, Caregiver).

"I would go to school to check my child's books, they called me and said 'come and see our child's books so that you can see how your child is performing' when I checked my child's books I found that he is

impressive. They said I should tell him to keep it up, all that we have taught him, he shouldn't drop when he gets to other classes" (Nkhensani, Caregiver).

"There has been an improvement a lot. The previous report for the third term K got 6 and 7, there is no 5, there is no 4 on the report" (Gugu, Caregiver).

"At school ...she's getting straight 7s... Every time when she goes to school it's like she get a total or something because even at home if someone assist her with her homework, she should get a total. Or else that person would never touch her books, she would tell them that they don't know anything. Imagine she got the awards for spelling and she also came with awards for 'star of the week', star of the week with spelling" (Phindile, Caregiver).

"Most of the times when you teach S he didn't like to learn but now he likes it, he takes his pencil. He likes drawing. He will sit down and draw then he will write names, this is grandmother and this is so and so" (Siphokazi, Caregiver).

"When he's with his teacher and there's something that he doesn't understand, he asks his teacher and the teacher also ask if he is done writing. If he is done, he will say yes but if he is not done he will say I will finish. He is very good now" (Siphokazi, Caregiver).

"When S comes back from school I was checking his homework but sometime I would forget to check the books but now even if I did not check S will come to me and say "Mom they said at school we must do these," and we will take the books and look and write the homework in time" (Samke, Caregiver).

b) Engagement in child's education

"When she comes I check her books every day. Previously I wasn't checking them every day, I was checking them sometimes" (Lesedi, Caregiver).

"It does not happen that he goes to school with homework not done. It does not happen" (Samke, Caregiver).

"Yes, that is one of the disciplines, one of our rules in the house. Even though he's off to after care and he has someone that sits with him, he still comes home and we still go through the homework, so that's the routine" (Rose, Caregiver).

"He would change his uniform and sit down. Then he would take out a book and tell me a page, he would say 'page so and so teacher gave me an assignment, I understand this calculation but there is another one I don't understand' I would take a page and show him that this one you do it like this and that, and that. When you are done, I will bring the books and you will show me what we were doing" (Nkhensani, Caregiver).

"Sometimes he would come with a paper, I would check his homework and how he writes" (Lungisa, caregiver).

"I went to school because since I attended Sihleng'imizi we had that thing that we have to see how the progress is in the classes, so once a week before..., like if this Thursday I am attending, I will go the following Tuesday so that on Thursday when I go back to Sihleng'imizi I give them a feedback of how she's coping at school" (Lindiwe, Caregiver).

"We spoke with the teachers. It was his class teacher, I don't know if it's the HOD at school or not because you don't just sit with the teacher alone when talking, there is someone else. You would talk to the child, you would make him aware, they also discipline him in front of you and you..., and they also tell you that when you get home, you shouldn't be harsh on the child. Because the issue of the child, when we have talked about it, we have talked about it" (Ayanda, caregiver).

"I would assist him, sometimes because their syllabus is not the same as the things we were learning before. Maybe there are other children you wouldn't ask that 'can you please help me here, don't do that'. This child who passed here with a small baby, he would sit with them and he has the patience for children sometimes. He would say 'we didn't do this one, it's things you do now' and he would help him. Sometimes they would be sitting..., do you see the kitchen where they like sitting, yes they would sit there. He would say 'go and get your things' and when they need something he would come and say

'Mama N do you have magazines, there is something from school that needs pictures so that we can paste the pictures they want' that child would help. I also help where I can, with what I know we do sit down and do it and with what I don't know I ask the other kids that 'can you please help him with 1, 2, 3. I understand this but I don't understand this one, the way you are being taught'" (Ayanda, caregiver).

4.3.1.3 Dimension 3: Social and community connectedness

a) Improvement in social networks

"These ones from the hostel I think they are near, I will go and see them. And then the other one we promised each other that it will be sometimes because she is far, but we will contact each other over the phone" (Kedi, Caregiver).

"I've got N. We also met on the programme, so I have her on WhatsApp and we have been speaking throughout the program" (Mashudu, Caregiver).

"Even now we were suggesting ...that maybe we should have a day, meet at the same place for entertainment. Just to have fun, talk about it because now it passed" (Lindiwe, Caregiver).

"I've got N. We also met on the programme, so I have her on WhatsApp and we have been speaking throughout the program" (Mashudu, Caregiver).

"Another issue is with the languages, some speak isiZulu others speak isiXhosa, yes we used to talk and we got to understand other people's cultures and what is happening if you are a Pedi, but it was fun" (Motlalepula, Caregiver).

"Even yesterday we were together...It helps because we can make a group and exchange contact numbers, sometimes when I am writing the homework and maybe I don't understand number 1, then I will call and say 'eish, there is something I don't understand' then we are able to help each other and things like that" (Khanyisile, Caregiver).

"The program helped a lot... You see, communicating with people you never thought you would know, yes" (Ayanda, caregiver).

"What has changed is that I now talk to a lot of people. I am a quiet person, I don't like talking. They would say 'you are quiet, you don't want people' but now I am able to talk to people. I greet them and they would see that 'oh, Z is a good person'" (Nobuhle, Caregiver).

"They taught us that if you see that if you talking to your child and is continuing doing the same thing... like the buddies that we were learning with them in the group you are able to ask one of them maybe to talk to that child...maybe they could understand better that you the way you are doing it... maybe they can do it better and you ended up understanding" (Nomvula, Caregiver).

"We do visit each other...We communicate, we also call each other sometimes" (Lungisa, caregiver).

"We are still in contact with others. We are three, yeah...We just talk on the phone, yeah. We have also said we are going to meet, not only alone but with the children so that they can also continue. It's possible that maybe some forgot some things, they continued with others and left others. Another one maybe had something else than the other, then when they are together they will remind each other that 'the social worker said that, hay even that day she said this and that' ...Maybe the children didn't know each other before and maybe they met at the group, they now even know each other at school. I would see when I go to school, when I go to this one's class, I would also see the others also calling me. Maybe I wouldn't hear them because there are maybe children 'Mama H and others would ask 'who is she?' and they would say 'it's H's mom, we were with at the group, or group' you see. We ended up having that relationship we never had before. Because even this one, there is another child we used to attend the group with and they were in the same class, they were not children who would talk and all that, the child was quiet but now they can talk. They are all used to each other from the group" (Phindile, Caregiver).

"I saw that even yesterday as ...although we were taking children to... at...the M all of us but before Sihleng'imizi we were not getting along that way but after joining Sihleng'imizi Z's father...L's mom all of them even yesterday when our children were graduating they all gathered here and we travelled

together even when we get there we became that group laughing...Even our children took photos together... I have their children on the photo together with my child you see it is like I got myself friends" (Nomvula, Caregiver).

"Like, what can I say? My sisters, there are some who we were not talking due to what happened before. They were not talking to me and I ended up moving out of the yard, but at least I am able to come and sit with them, and enjoy. Which is something I wasn't doing when we had just fought" (Oratile, Caregiver).

(Since being at Sihleng'imizi) "I am now able to communicate with them (aunts and cousins), we are now able to talk...we are able to visit each other. They come a lot" (Khanyisile, Caregiver).

4.3.1.4 Dimension 4: Financial capabilities

a) Improvement in budgeting behaviour

"Yes, I am able to budget. If I have got R50.00, I am able to buy some tomatoes, cooking oil and leave R20.00 aside and give R2.00 for school lunch. Then I cook tomatoes and potatoes and if they say that they need about R2.00 at school, like N comes to me and says 'mama, may I have R2.00 for lunch at school to buy Simbas (potato crisps) I am able to give it to her from that money" (Motlalepula, Caregiver).

"We didn't understand budget but when we met with them, they were able to tell us what budget is about. So I know that when you budget you must take this much money and keep it for this and that, and you must buy food like this and that so you will be able to save the money you see. So we've learnt a lot" (Siphokazi, Caregiver).

"I learned out of the R2200 that we have, you must always remember to save the R200 but how much you save, you must try to cut down like the DSTV, the unnecessary things that you don't really need...I was the person who would 'tomorrow would see for itself', if I had R50 I want to finish that R50 now... Now, I can see if I have R50, I would keep R20 and try to buy a small packet of rice, and a small packet of sugar, and then you are going to have R10 left for tomorrow" (Dinah, Caregiver).

"I learnt a lot about how to budget and how you can make means even if the money is little. How you can stretch it to reach there, you see. I find that it is working because, we learnt that you can budget with a two litre bottle, by placing R1 or R2 coins in it. I see it being an easy thing that I can do, it is better than the bank because I won't be able to bank a thousand rand upwards and I don't have that kind of money, so with the bottle you can save gradually. Even with buying food, how you can buy food with this little money you have" (Faith, Caregiver).

"For example, now I know that when I have money I don't buy wants before needs. When I still have money that's where I would say 'let me buy things that would make me happy buy important things come first'" (Lesedi, Caregiver).

"There was change that we have to do a budget for each and every month so that we can know that we are buying needs first. So, if there is some left then we can buy things for entertainment" (Naledi, Caregiver).

"We have learned that there are needs, there are wants, there are obligations from the things we need. You should know which one is more important than all of them, there are those we do for fun and there are those that are your needs" (Ayanda, caregiver).

"It makes a difference to know that we should use money when there is a need, we shouldn't use money when there is no need" (Aubrey, male caregiver).

"You shouldn't buy sometime and say 'because I saw someone buying something, you should look at your capabilities and the things that are a need here at home first'. I already have that thing, that with the first money I have I would look at the things that are needs at home. Everything else will follow" (Ayanda, caregiver)

b) Improvements in savings behaviour

"They even taught us to save that you must save as person...When you save money don't save it in the house because it happens that you put it in the bank but we also save in the house that it happens that the house can be burned or a thief come into your house... they also encouraged us that if you

are a person you are supposed to use a bank because even if the bank is robbed but your money will always be there but if it is the house. When it is burned it is burned it is done you don't have anything" (Samke, Caregiver).

"We have also learned about saving and I think it's very important to save so that..., when life is good financially then it's easy to do a lot of things because even the children would have a lot of opportunities as everything needs money. It's not something that important, but for you to have good things you need money then you would be able to do things like that, yeah" (Phindile, Caregiver).

"I learnt something and I enjoyed it, it taught me something, especially the story about Nonhlanhla, and her mother had two children. One loved to learn and the other one loved soccer, they want to achieve (something with their lives), but their mother could not afford them that life. Their father was paying maintenance but it was not enough, so the mother would try to get piece jobs and receive the grant money and her brother would also contribute something but it was also not enough. The mother tried to save up and put something away so that her children would be successful" (Catherine, Caregiver)

c) Improvement in spending money wisely & avoiding loans

"On how money is supposed to be used, it shouldn't be used carelessly...(Before) we used it carelessly because you would maybe go somewhere and see something worth R400 and not get anything for home" (Aubrey, male caregiver).

"It helped me to be able to budget for the future, and also not to take risk about loan sharking" (Muzi, male caregiver).

"Eish, it's bad. Because when you have to pay it back there are other needs that would just come unnecessarily" (Phunzo, Caregiver).

"I don't like borrowing money from a loan shark because you end up having a problem when you can't pay or when you don't have that money. I just don't like it, I would hear others saying that they borrow from SASSA but I don't even go" (Lungisa, caregiver).

"I borrow, every month I am in the finance debt, but like I said I will try my best not to do it. Not to borrow" (Dinah, Caregiver).

(Our view of loaning money) "has changed a lot. Because we don't go for a loan that much" (Khanyisile, Caregiver).



