



PSPPD

PROGRAMME TO
SUPPORT PRO-POOR
POLICY DEVELOPMENT



Family contexts, Child Support Grants and child well-being in South Africa

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List of Acronyms

BMI	Body Mass Index
CCF	Child Care Facility
CSG	Child Support Grant
ECD	Early Child Development
NIDS	National Income Dynamics Study
NSNP	National School Nutrition Programme
TAA	Tribal Authority Area
WHO	World Health Organisation

Executive Summary

Over 12 million children or 63% of South Africa's children will receive the Child Support Grant (CSG) in 2017. The CSG is the country's flagship poverty reduction programme for children. Initially designed to support poor households to promote food security, it has expanded significantly and is an important social investment in children's well-being. Despite significant progress in meeting the basic needs of children over the past two decades, six out of ten children are still living below the upper bounds of the poverty line. They continue to experience hunger and have sub-optimal living conditions. These are known risk factors associated with compromised well-being. There is therefore need for solutions that will accelerate the achievement of child well-being through holistic, appropriate and high impact interventions that can break the cycle of structural disadvantage facing families with young children under 8 years.

The aim of the study is firstly to contribute to our understanding of the interface between family contexts and child well-being outcomes. Secondly, to shed light on the perspectives of families themselves about various aspects of caregiving, family beliefs and their needs and challenges. A final aim is to provide recommendations for family and community based developmental welfare interventions to further scale up the already positive impacts of the CSG.

A mixed methods design was employed combining quantitative national statistical data with qualitative insights gained from CSG families. The quantitative data was drawn from the National Income Dynamics Survey (NIDS) Wave 1 of 2008. The analysis is based on a sample of 3 132 children and their families who were under eight years. Six focus groups and 40 respondents participated in the study in two areas: Doornkop in Soweto (urban area) and Moutse in the Sekhukhune district in Limpopo (rural area). In addition, ten key informant interviews were conducted with service providers engaged in the delivery of family interventions nationally. A literature study of family interventions internationally was also conducted.

In the quantitative data, subjective perceptions of child health were used as well as anthropometric measures as indicators of child health as this data was available for all age groups under eight years. We use child health and access to education as proxies for child well-being. While these are somewhat limited, and thus results should be treated with caution, they do provide insight into the direction of change that is associated with receipt of a CSG. The qualitative data explored issues related to caregiving in relation to family functioning, family beliefs, access to social support and services including an assessment of caregiver mental health.

Key findings from the NIDS analysis

Profile and household situation of CSG beneficiaries

- A third of children 0-8 years received the CSG. They were fairly evenly distributed across the age groups except for children who were under one year of age who had lower levels of access to the CSG (7%). The majority were African (90%) and Coloured (10%) and slightly more boys (2%) than girls received the CSG. Fifty eight percent of lived in the Tribal Authority Areas (TAAs); 27% lived in urban formal areas and the remaining (15%) lived in informal urban and rural areas.
- CSG households were generally larger (6.86) compared to the national average household size of 3.6 members in 2011 (Community Survey, 2016). This was especially marked in the TAAs where it was 7.22. The number of children per household was 2.40.
- The per capita income of members of their households was R394.21. Urban areas had higher per capita income than their rural counterparts and household size was also smaller.

Child well-being outcomes

Education, health and food security

- Ninety two percent of CSG beneficiaries of school going age were enrolled in either Grade R or in Grade 1.
- Fewer children, around 4 out of 10 aged 3-5 years, were enrolled in a child care facility (CCF). Enrolments in a CCF were much lower in rural areas due to a lack of services.
- With regard to the health of the children, two thirds of caregivers had a positive perception of the health of the child in their care.
- This was confirmed by the anthropometric measurements of the children. Eighty two percent of children under five years were in the normal range for their weight for height measurements and 91% were in the normal weight for age range. Eighty eight percent of children between 5-7 years were also within the normal Body Mass Index (BMI). Those who fell out of the normal range were 3.4 times more likely to be overweight than underweight, which is likely to be due to poor nutrition.
- Despite this, 17% of children aged 0 – 5 years old were moderately stunted and 9% were severely stunted. Stunting is a significant risk factor for sound physical and cognitive development of children (Casale et al., 2014).



Income poverty and living standards

- Although the nutrition and health benefits of the CSG are noteworthy, all children in this sample lived in households that had an income below the upper bound poverty line at the time, and most lived below the lower bound poverty line. The small value of the grant and low and precarious income of grant beneficiary families explains why four out of ten children continue to experienced hunger to some degree while 47% indicated that food supply was scarce. Rural households were poorer and more food insecure than their urban counterparts.
- Half of the children lived in households with medium living standards. CSG beneficiaries had access to three out of five of the services that made up the living standards measure devised for this study. Living standard was assessed in relation to the dwelling type, access to basic services, water, electricity, refuse removal and sanitation.

Caregiver characteristics, parental relations and mental health

- Caregivers were mainly women (97%) with a secondary education and were largely unemployed (87%). Few male primary caregivers receive the CSG
- One in two caregivers lived in a household where there was no one employed and they were therefore more vulnerable. Younger caregivers were more likely than older caregivers to be better educated and enjoyed a higher living standard.
- Almost seven out of ten primary caregivers were the biological parents of the child and lived with the child in the same household. A fifth of primary caregivers were grandparents followed by relatives.
- A fair number of primary care givers (29%) had a partner who lived with them in the same household with only 20% of couples being married. Non-resident mothers were more likely than non-resident fathers to give the household financial support. However, half of non-resident mothers and 60% of non-resident fathers did not provide any financial support.
- Father absence from the household was high with almost three quarters of fathers not being present, for many reasons, such as labour migration from rural to urban areas. In 30% of cases, fathers never saw their children. There is also an increasing trend of labour migration among mothers. However, more mothers (78%) were resident in the household than fathers (26%).
- We also see that large numbers of children (29%) continue to live apart from their parents largely with relatives.
- The majority of parents did not present with a high number of depressive symptoms. However, almost a third were at high risk of depression. Caregivers with low levels of education were at greater risk of the development of mental illness. There was also a relationship between the perception caregivers had of their health, and their mental health. Those who viewed their health more favourably were less likely to be depressed than those who saw themselves as having poor health. Similarly, those who perceived themselves as living in better-off households were more likely to have lower depression scores. A CES-D10 depression index administered in the focus groups with caregivers found higher rates of depression among women carers in an urban area (Doornkop) in Soweto compared to a rural area (Moutse).



Household structure

- The most common household structure of CSG beneficiaries was the child, the parent and adult relatives (34%).
- This was followed by a family made up of a child and adult relatives with no parents (29%), a child and both parents (15%); a child, both parents and adult relatives (11%) and a child and one parent with no relatives (11%).
- A quarter of CSG beneficiaries in the early years of life were growing up in nuclear families or single parent families with no relatives living with them.
- Families with relatives are by far the most common family structure for this age group (75%) and, most children were in households either with one parent or in households with no parents at all.

Access to social support and community environment

- What was positive was that 77% of caregivers had another family member to assist them with the care of the child(ren). This confirms the importance of other adults who were engaged in the care of children.
- Children are growing up in communities that had a medium level of social and community organisation. This means that there is a fair level of participation of caregivers in social groups, that they have some access to support from neighbours, perceive themselves to be fairly safe, that there was some trust in their neighbours and that they enjoyed moderate living conditions such as access to basic services, although they lacked adequate housing.

Factors influencing child well-being outcomes

The path analysis statistical model identified various predictors that are associated with child health outcomes and found the following.

First that there was no relationship between family structure as set out in the model and child health outcomes. However, there was a positive association between the caregivers' perception of child health and two parent households.

Second, caregivers who perceived their own health to be good and who were not depressed, were more likely to view the children's health favourably. Emotional well-being of the caregiver was also correlated with higher household income i.e. the economic circumstances of her household and higher education levels of the caregiver.

Third, the education of the caregiver was also positively associated with having the children in her care aged 3- 5 years old enrolled in a child care facility. Children who were slightly older (aged 6-7 years) were significantly more likely to be enrolled in school than those who were younger, as this is the age of mandatory schooling. Enrolment in a child care facility was also significantly associated with household size whereby enrolment declined as the household size increased. Similar outcomes were observed where there were larger numbers of biological children in the household. Higher living standards, higher educational attainment of the caregiver and younger caregivers led to a higher likelihood of enrolling in a child care

facility (CCF). Further, children aged 6-7 years were more likely to be enrolled in school than younger children in a CCF. Also, education of the parent or geo-type did not have a bearing on school enrolment.

Fourth, the findings derived from the path analysis shows clearly which predictors are associated with perceptions of child health and the weight and height for age of the child. This was found to occur via the increased access to food and underscores the important role that the CSG plays in enhancing food security and ensuring child well-being. The findings were different for rural and urban areas and provide some pointers for intervention. In rural areas larger households are more likely to need additional food security interventions. In urban areas caregiver depression had a significant effect on lower levels of child well-being, although other predictors such as income and living standards were also important.

In summary, having a relative in a household, presumably to assist with child care and the provision of social support, a higher living standard (access to basic services and shelter), higher income, good mental health and a positive view of the health of the caregiver, were protective factors. These findings are indicative of the complex inter-play between various factors and the mechanisms or processes by which child well-being is achieved in the South African context.

Family functioning and caregiving

- From the qualitative data we learnt that primary caregivers had a sound knowledge of the emotional and social care needs of the children. They were aware of the importance of emotional caregiving and the need to create caring environments for them. Evidence of positive, supportive and interactive family communication also existed.
- The need for knowledge and skills in alternative styles of discipline to more effectively manage the behaviour of children was emphasized. Primary caregivers were receptive to learning about new and different ways parenting. Communication needs further exploration.
- Challenges with the monitoring and supervision of children were directly related to poor living conditions, overcrowding, poverty and a lack of safe play areas in communities.
- Practical barriers to child safety were a lack of fences around the properties, poor quality locks to their houses or simply not having a security gate.
- Very high rates of depressive symptomatology was evident among respondents in the focus groups.
- Caregivers derived social and emotional support from family members, close adult relationships, material support from their family network and from their religious faith. Despite positive assistance, complex family relationships and obligations undermined the benefits of extended family support.
- Changing social relations in neighbourhoods due to an erosion of trust, high rates of crime, violence and drug use rates worked against the spirit of Ubuntu in communities and were drivers of isolationist behaviour. While community support engendered a sense of belonging, a wariness and a lack of trust of neighbours was evident in both urban and rural areas.
- The more social problems there were in communities,

the harder it was to maintain a network of social support. Positive community support should not be presumed to exist. The wider community context can be a 'disabling' rather than an enabling environment for child well-being.

- A lack of access to quality services in local communities such as child care, running water, a lack of transport, bad treatment by service officials including corruption and discrimination in the delivery of services were highlighted. The police and health care services were perceived to be poor especially in urban areas where services were over-subscribed and where community needs were overwhelming.

Interventions to scale up the impact of the CSG

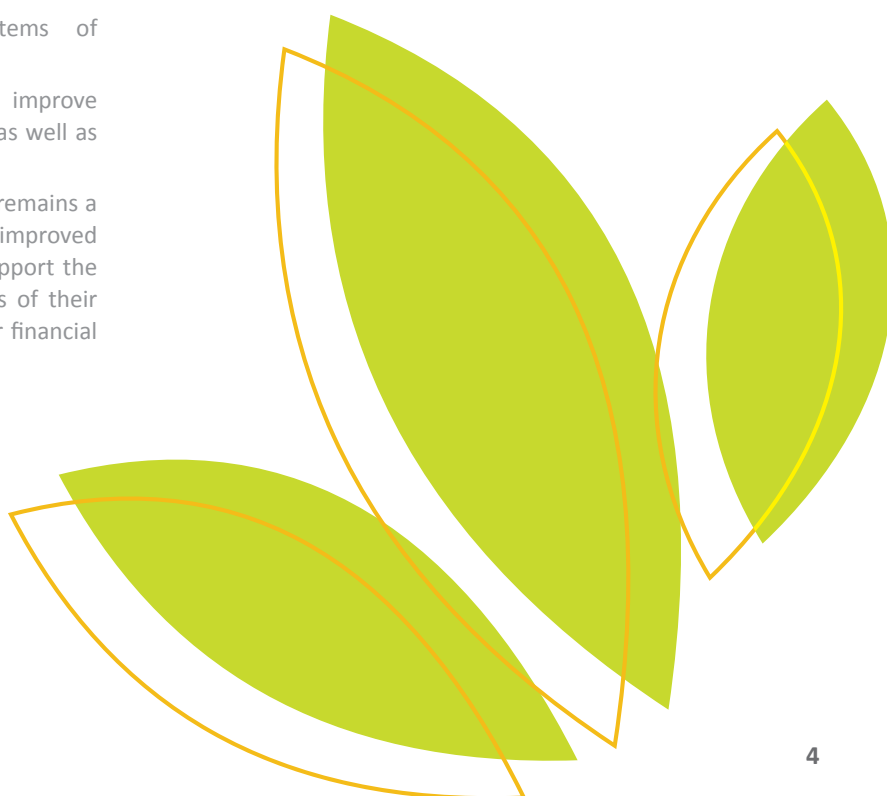
Enhancing child well-being

The findings provide pointers for scaling up the CSG through the following actions:

- The continued provision of income support to disadvantaged families is strongly indicated.
- National public action is needed to end child hunger especially in the early years of life. This can be achieved through a range of interventions such as: boosting nutritional support to larger households, providing education on child nutrition, enhancing household food security strategies, livelihoods support, and early intervention for children at risk of stunting.
- Devise additional measures to increase early access to the CSG for children under 12 months.
- Early identification of depressive symptoms of caregivers is needed as well as the provision of appropriate psychosocial support interventions.
- Improving access to quality basic services such as shelter, water, electricity, sanitation including access to child care services.
- Strengthening family and community systems of social support.
- Implementing community safety strategies to improve the safety and security of children and families as well as creating safe spaces for children to play.
- Increasing the income flows to CSG households remains a critical priority. This needs to be accompanied by improved access to child care services; mechanisms to support the livelihood strategies of caregivers and members of their households including measures to enhance their financial capabilities.

Preventive interventions for CSG beneficiaries and families

- The design of interventions needs to be sensitive to the different contexts of childhood, risks and different factors that influence child well-being in urban and rural areas.
- Complementary family and community-based preventative interventions are needed to strengthen CSG families in their caregiving roles. The content of the programmes need to include a focus on strengthening financial capabilities, information and education about nutrition, family connectedness, positive engagement with social networks and services, the provision of psychosocial support and improve parenting skills. Skills based parenting programmes delivered in time-limited, group-based interventions and by trained practitioners, are associated with positive child well-being outcomes.
- Public information and education campaigns that are well targeted including short-term group based interventions were also found to be successful.
- Funding allocations for preventive developmental family welfare interventions are needed.
- The potential for expanding the reach of family programmes exists through existing governmental agencies particularly at local government level and through community and faith-based organisations and non-governmental organisations.



Introduction: Family contexts, Child Support Grants and child well-being

Over 12 million children or 63% of South Africa's children will receive the Child Support Grant (CSG) in 2017. The CSG is the country's flagship programme designed to meet the basic needs of poor children and is widely held to be an important social investment in the well-being of children. Positive benefits have been noted in increased expenditure on food (Coetzee, 2014) and improved child nutrition (Agüero, Carter & Woolard, 2007), improvements in school attendance (Case, Hosegood & Lund, 2005) with positive effects on grade progression and learning outcomes (DSD, SASSA & UNICEF, 2012). Grant receipt is also associated with having protective effects in adolescence in reducing risk behaviour (DSD et al., 2012), in enabling caregivers to seek employment, contributing to education, travel and child care costs (Eyal & Woolard, 2011) and with increased caregiver engagement in children's well-being (Patel, Knijn & van Wel, 2015). The programme is well targeted at 40% of the poorest households and is positively associated with reducing poverty in social grant receiving households (Bhorat & Cassim, 2014).

These studies show the positive benefits for children receiving the CSG in different child development domains namely, material, physical, learning, social care and behavioural outcomes. Despite significant progress in meeting the basic needs of children over the past two decades, six out of 10 children continue to live below the upper bounds of the poverty line (Hall & Budlender, 2016). Poverty and poor standards of living are associated with compromised material well-being and are risk factors for sub-optimal growth and development of children (Meinck et al., 2017; Roelen, Delap, Jones, & Chettri, 2017). Despite South Africa's rights-based approach to social protection for children, 18% of eligible children are not accessing the CSG due to administrative reasons and factors related to caregiver characteristics, for example, maternal orphan-hood, or a lack of information; among other reasons (DSD, SASSA & UNICEF, 2016). While cash transfers are important in promoting child well-being, on their own they are not able to address the complex and multi-faceted needs of children and their families (Hochfeld, 2015).

The nexus between cash transfers, caring services and family support to enhance child well-being is receiving increasing attention in South Africa and in other African countries (Cluver et al., 2016; Roelen et al., 2017). How various social services and social support systems may work together in creating a circle of care is now firmly on the international social development agenda (UNICEF & DSD, 2017). There is growing interest in understanding child well-being and its determinants in low- and middle-income countries which could lead to a positive developmental trajectory for children (Pollard & Lee, 2003). This notion of well-being transcends a focus only on the factors affecting child well-being negatively, which is still the dominant approach internationally. This dominant approach tends to focus primarily on individual pathology, child and family deficits, statutory protections and interventions for children, and social treatment modalities to address specific social problems and disorders.





The developmental approach to child and family well-being adopts a positive frame of reference, and emphasises strengths, assets and enhanced capabilities of children and of their families. This is embedded in the social development approach to child welfare (Patel, 2015; Schmid, 2010, 2012). The primary focus of traditional child protection is on outcomes for children mainly. But children do not exist in isolation of their families and the communities in which they live. Understanding these interfaces is critical to child well-being. Such an approach is likely to take us further along the road towards achieving a positive developmental path for children. Understanding children and their family in a wider community, cultural, economic and societal context, could provide pointers for child and family interventions that are evidence-based and that are likely to contribute to positive long-term benefits for children (Schmid & Patel, 2016; Pollard & Lee, 2003). Families' optimal use of resources and the community and social environments in which children grow up are also known to exert a powerful influence in shaping adult outcomes (Heckman, 2008). In particular, interventions in the early years of life are associated with improved child development trajectories (Berry, Dawes & Biersteker, 2013) and in overcoming inequality gaps between advantaged and disadvantaged children (Cunha & Heckman, 2006).

But we know little about which factors are associated with child well-being in the South African context and how we may further strengthen efforts by families to enhance the well-being of CSG beneficiaries. While all the children receiving the CSG are poor, their family contexts differ significantly in terms of income, access to basic services, location, family structures, caregiver characteristics, care arrangements, family relations, family functioning, access to social support and social connectedness to family and community, among others. In this research, we ask the following questions: first, how do these different contexts influence child well-being of CSG beneficiaries? Second, what are the perspectives of CSG families of their own agency, of how their families are functioning and of the role of intra-family and community relations in enhancing child well-being? Third, what do we know about family interventions delivered in South Africa; and, finally, how might this knowledge inform family and community centred developmental welfare interventions to further scale up the positive impacts of the CSG? In this mixed methods study, combining quantitative national statistical data with qualitative insights gained from CSG families, the researchers hoped to fill this knowledge gap. The quantitative data was drawn from the National Income Dynamics Survey (NIDS) Wave 1 of 2008. The quantitative analysis was conducted on a sample of 3 132 children who were younger than eight years and their households, and the qualitative data comprised six focus groups in two areas: Doornkop in Soweto and Moutse in the Sekhukhune district in Limpopo. In addition, 10 key informant interviews were conducted with service providers engaged in the delivery of family interventions locally.

The results of the study could contribute to the search for solutions in the South African context in view of the country's legacy of racial discrimination and inequality, the effects of the HIV and AIDS epidemic on families, high rates of violence in families and communities, and persistently high rates of poverty and unemployment. These social and economic factors underlie the disruption of family life and a weakening of family functioning, with commensurate negative effects on the well-being of children.

The contribution of families to social and economic

development and in the building of stable and cohesive communities and societies is well recognised by the United Nations (2012; UNICEF, 2016), South Africa's White Paper on Families, and the National Development Plan (National Planning Commission, 2013; Department of Social Development, 2012). Significant resources have been dedicated over the past two decades to improve child health, education, social assistance coverage and welfare services for children and families in South Africa. Two key social development programmes are specifically targeted at promoting child and family well-being, namely, the CSG (a cash transfer), and child welfare services that provide supportive and care services for children and families such as counselling, child protection, statutory services and institutional care. Limited resources have been earmarked specifically for prevention of social problems and to promote the capabilities of families, beyond the income support provided by the CSG. Some parenting programmes are provided by non-governmental organisations (NGOs) and there is life-skills training for young people, but with limited emphasis on livelihoods support programmes. Although the need for synergy between social protection and developmental welfare services is acknowledged in various policy documents, research to inform such policies and social service interventions is limited.

The aim of the study is three-fold: the study first sets out to establish which family contextual factors influence child well-being in households that have children younger than eight years and who also receive a CSG. A second aim is to deepen our understanding of family perspectives about child well-being, intra-family and family-community relations in enhancing child well-being. Finally, the research aim is to develop a conceptual framework to guide the design of a family- and community-based intervention to further fast-track the well-being of CSG beneficiaries.

In the following section, the key concepts are defined and the conceptual approach to the study is outlined, followed by a description of the methods of the study. Thereafter, the findings are presented in two parts: in part one the quantitative data is presented; followed by the qualitative data in part two – the focus group discussions and the key informant interviews. The conclusions of the report are drawn from the findings, and outlines the conceptual framework for the design of a developmental family intervention; concluding with recommendations.

Conceptual building blocks of the study

In the absence of a consistent definition of child well-being, for the purpose of the study we view 'child well-being as a multi-dimensional construct made up of different dimensions of well-being' (Pollard & Lee, 2002: 64). Material (or economic), physical, cognitive, social and emotional well-being are the key dimensions that are associated with a positive approach to conceptualising child well-being (September & Savahl, 2009; Savahl, Adams, Isaacs, September, Hendricks, & Noordien, 2015). Each of these dimensions is described briefly. Beginning with the material or economic dimension, well-being is defined in terms of the societal context and the extent to which children and their families have access to financial resources such as employment, livelihood strategies and social assistance, such as the CSG. Besides family and household income, access to services to meet the basic needs of children for shelter, water, sanitation, and energy are crucial to ensure

a living standard that is conducive to growth and overall child development. Contextual or structural barriers to these resources are significant risk factors for compromised child well-being, with disadvantaged children being most severely affected (Laryea-Adjei & Sadan, 2012; Hall & Woolard, 2013).

Studies show that the health and physical development of children are similarly affected by structural barriers to material resources. Nutritional deficits in the early years of life are known to have negative effects on the cognitive development of children which in turn affects school performance, leading to lower employment prospects and lower income in adulthood (Casale, Desmond & Richter, 2014; Haile, Nigatu, Gashaw & Demelash, 2016). Parental perceptions of the health of children is often used as a subjective indicator to assess the health of a child, although such measures are best complemented by objective measures such as health screening and anthropometric measures; among others (Ardington & Case, 2006). Food insecurity is also associated with notable increases in behavioural problems of children and maternal depression (Black, 2012; Jyoti, Frongillo & Jones, 2005; Whittaker, Phillips & Orzol, 2006).

School and Early Childhood Development (ECD) enrolment and grade progression are ways of tracking educational performance; while social and emotional development are assessed using both parental or caregiver assessments of the general happiness of a child; and the absence of abuse and neglect is a further important indicator of well-being. A range of psychometric scales have been used and validated in South Africa in order to assess social and emotional areas of well-being of children (see Cluver et al. (2016) for an overview of those used in the Sinovuyo Caring Families research).

Preventive and supportive interventions in the early years of life are critical for longer-term benefits for children, and contribute to reducing the serious inequality gaps between rich and poor children in South Africa (Hall & Woolard, 2012). Key interventions include attendance at a quality ECD centre (Berry et al., 2013), healthy nutritional intake (Hendricks et al 2013; Casale et al., 2014), good primary health care services (Westwood et al., 2010), and a caring and loving home environment (Cederbaum et al, 2012; Meinck et al., 2015; Holte et al., 2014).

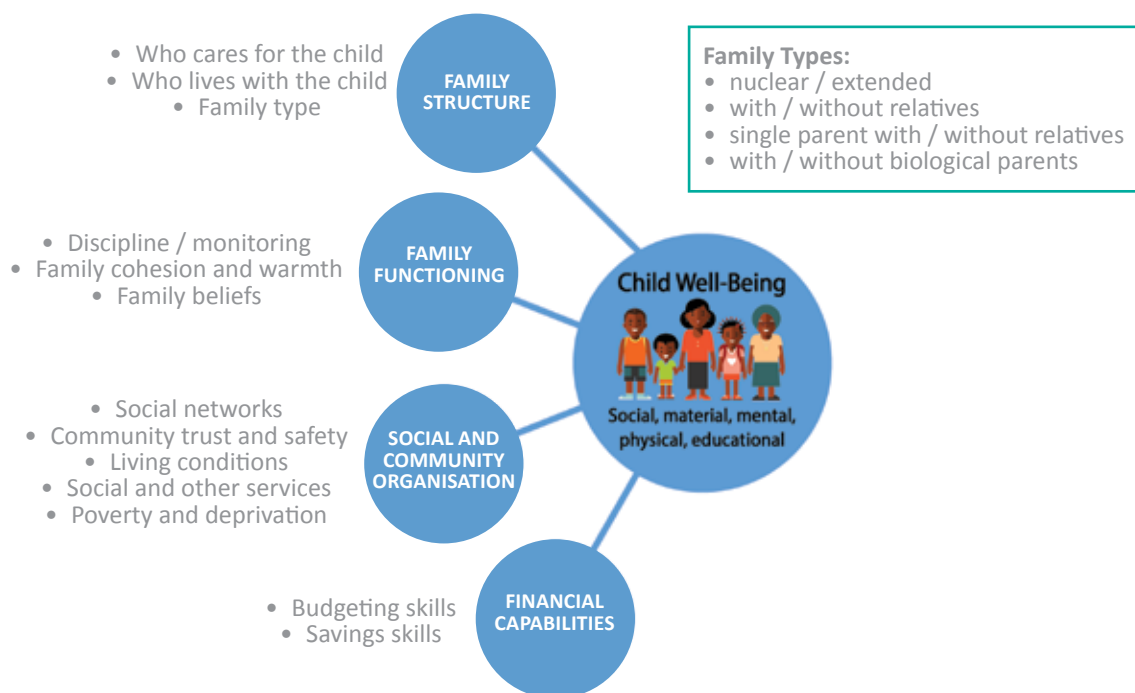
These dimensions of well-being are assumed to be interconnected, with one reinforcing the other and with the overall effects being cumulative in the long-term (Noble et al., 2009). However, in some instances, such as the effects of severe food deprivation, namely stunting, in the earlier years is known to have particularly harmful effects in the long-term development of children (Casale et al., 2014). This is particularly important in the South African context as one in five children are believed to be suffering from stunting (Shisana et al., 2014). Although a composite index of child well-being has not been developed and tested in South Africa, researchers have evaluated the impact of the CSG in relation to some of these dimensions using data drawn from national household studies, provincial and in some cases local level studies, some of which are not generalisable to all children. Child well-being is tracked using different data sets such as Statistics South Africa's General Household Survey, the National Income Dynamics Survey which is a longitudinal study, the National Census, and administrative data from government departments. In this way, progress and lack thereof is assessed among South Africa's children in meeting the Global Goals for every child (SAHRC & UNICEF, 2016).

However, child well-being assessments seldom take account of the subjective actions of the children and their family and how their agency affects the child's well-being. This approach to child well-being has been recently advocated and forms part of a new paradigm of studies on childhood (Minkinen, 2013). The inclusion of such a lens would require additional questions to be added to population studies which is not easy to do in view of cost, length of questionnaires, how the questions are formulated, and the use of measurement instruments that are locally validated. Additionally, few household studies gather data from children themselves; due regard would need to be taken of the age of the child. A further limitation with assessments of child well-being using current national studies is the fact that intra-familial and family and community relations as well as the level of social and community organisation in which the child grows up, have not been captured adequately in studies of child well-being. As indicated previously, children do not exist in isolation of their family and their caregivers who all have an impact on the child's development. Gorman-Smith, Tolan and Henry (2000) found in a longitudinal study of African American Youth that the social connectedness of children and their family in the community was critical to improved outcomes in later years. Accordingly, in our conceptualisation, we focused on understanding the social context of the children and their family as a potential determinant of child well-being. The importance of social networks and social support were also pertinent to our analysis. The protective effects of social support against the negative health consequences of life stress have been found in the United States. Cobb (1976) found that social support has had a moderating effect when experiencing crises such as loss of loved ones, illness or loss of employment. It is defined as the belief that one is 'cared for and loved, esteemed and a member of a network with mutual obligations' (Cobb, 1976).

Additionally, caregiver characteristics such as the geographic location of the children and their family (that is, urban/rural), age, gender, education and mental health of the caregiver, life stressors and their financial capabilities; were considered to be influential in well-being outcomes (Meinck et al., 2015). In South Africa, large numbers of children grow up apart from their parents (21%) and experience significant father absence in their lives (Hall & Sambu, 2016). Since the nuclear family form is not the dominant family structure among poor African children, who are the majority of South African children, we were interested to know what impact family structure might have on well-being outcomes. Tippoo (2012) found that children who lived with both biological parents in South Africa fared better than children in other family structures even when income, race and geographical type were accounted for using the 2010 General Household Survey data. We were therefore interested to understand what role if any, family structure had on the well-being outcomes of CSG recipients. The term family is broadly defined in this study and all family forms are acknowledged. Increasingly national data is pointing to a growing trend of the presence of relatives in families and households (Patel, 2009; Bureau for Market Research, 2007) and that this may be due to the need to share resources and care responsibilities while some authors point to receipt of social pensions as contributing to household formation and expansion (Klasen & Woolard, 2009; Schatz et al 2015).

These ideas and empirical research findings informed the conceptualisation of the study. Child well-being is understood as influenced by the following factors: family structure, family functioning, social and community organisation, and financial capabilities. This is depicted in the **Social Development Model of Child and Family Well-Being** as follows:

Figure 1: Social Development Model of Child and Family Well-Being





Social protection and family interventions

The growth and impact of cash transfers in African countries such as Kenya, Ghana, Rwanda, Senegal and South Africa have drawn attention to the positive benefits of social protection strategies to reduce poverty and improve food security for children and their families (Patel & Plagerson, 2016). Social protection was found to support the care of children and enhance child well-being especially when services are provided that are complementary, and are linked to social services (Roelen et al. 2016). Complementary services may include nutritional supports, foster and kinship care for orphans and vulnerable children, which leads to improved quality of family care (Roelen et al. 2017; Patel, Hochfeld, Moodley & Mutwali, 2012) and increased caregiver engagement in the care of children (Patel et al., 2015); among others. In contrast, poor quality of family care is associated with increased risks for abuse, poorer educational outcomes, and a lack of access to basic services. Low income and exposure to poverty over long periods is known to have dire consequences for the psychosocial development of children (Sarriera et al., 2014). Poverty can also have harmful effects on the quality of parental care and on the mental health of caregivers. There is therefore a need for an integrated package of social supports for children that could combine social protection and social services. Patel (2015) argues that in order to scale up the impact of the CSG, family interventions are needed to provide support for the psychosocial well-being of caregivers, enhance positive parenting practices, offer livelihoods support for families, improve access to services and nutritional support, and increase the financial capabilities of families.

While there are a number of parenting programmes in South Africa, there is a distinct lack of evidence around their design and efficacy; most are offered in urban areas and are inaccessible to the poor (Ward & Wessels, 2013). Research has identified the shortcomings which include a lack of formal needs assessments; programme content not being based on literature or other evidence; lack of training and supervision for programme facilitators; and a lack of external evaluations of the programmes (Ward & Wessels, 2013). Furthermore, family and parenting programmes tend to focus on one parent or caregiver and fail to consider the changing nature of families in South Africa (Richter & Naicker, 2013). It is therefore not known which programmes are most successful. Although programmes from high income countries have a strong evidence base, they tend to focus mostly on parental behaviour, are culture bound, labour intensive and costly to run in South Africa. The programmes also fail to link families to social and community networks and to consider long-term child well-being outcomes that could break the intergenerational cycle of poverty. There is therefore a need for appropriate family- and community-based interventions to support and promote families and child well-being and that build on South Africa's social protection programme. Qualitative data was collected to complement the quantitative data and to inform the design of a family intervention. The method of the study is outlined next.

Research design, methodology and aims

In order to accurately assess the effects of the CSG, longitudinal research is needed to tell the full story of the impact of the CSG on child well-being over time. In the absence of studies that are designed to specifically track child well-being of CSG beneficiaries in all its complex and multi-faceted ways, existing national data complemented by qualitative data was used in this study.

A mixed methods design was used that combined quantitative and qualitative methods. This is appropriate for the study as it enabled the researchers to use existing national household level data and to complement this with pertinent qualitative data on caregiver perspectives of CSG families, their needs, beliefs and child development practices. Service provider views of how family interventions work in the South African context were also solicited. The research questions could be better answered by using a mixed methods research design (Creswell, 2003).

The overall aim of the study is to develop knowledge and understanding of how family contexts shape the well-being of the CSG beneficiaries to inform the design of developmental family interventions that could scale up the impact of the CSG.

Objectives

- To determine the profile of children who receive a CSG in relation to the families they live with, their caregiver characteristics, their family functioning as well as the social organisation of the communities in which they live.
- To assess to what extent family structure, caregiver characteristics, family functioning and social organisation of the communities in which they live impact on their well-being.
- To identify the factors associated with child well-being outcomes.
- To gain knowledge and understanding of the family lives of CSG beneficiaries, their perspectives of caregiving and the challenges they face.
- To gain insight into family interventions in South Africa.
- To make recommendations for the development of a complementary developmental welfare family intervention for CSG beneficiaries.

Analysis model: variables and indicators

An analysis model was developed drawing on the factors that are hypothesised to influence child well-being and informed the analysis of the data. Child well-being in this study was assessed using four outcome measures in the NIDS; the first two related to health, and the second two related to education. These were the only outcomes measures that could be applied to children younger than eight years in the NIDS; other measures in the NIDS related only to the surveyed adults or the households in which children lived, not the children themselves. This is a limitation of the study as it restricts the analytical notion of well-being in this data to just educational and health outcomes, and thus is not able to capture the multi-faceted dimensions of child well-being in South Africa. However, the findings have use in relation to these two specific outcomes, and qualitative data was collected to complement the quantitative results.

For health well-being, the first indicator was a subjective measure of child health based on the caregiver's assessment of the health of the child, and a second, more objective, measure comprising anthropometric data based on guidelines set by the World Health Organisation (WHO).

For educational well-being, the first indicator was whether children aged 3 -5 years were enrolled in a childcare facility (such as an ECD). The second indicator was whether children aged six and seven were enrolled in formal schooling. Other outcome variables in the NIDS related to school performance which was not useful in this study as we are only interested in children younger than eight years, and tracking performance makes no sense at this young age.

Various factors were assessed as to whether they influenced child health and educational outcomes. The first set of factors was defined as caregiver characteristics. This was made up of demographic variables such as the gender, age, education level and mental health status of the caregiver. A second set of factors related to family structure and whether it influenced child health outcomes. A third factor assessed the influence of household income on child well-being and fourth, a composite measure of the level of social and community organisation was derived to assess whether it had an impact on child health and education. Finally, family functioning was considered to be a key variable in determining child well-being. This data was not available in the NIDS and was derived from qualitative data (six focus groups). In 'research findings part 2', we report on the findings from the qualitative data.



The Table below provides a description of the variable creation process for the analysis of the NIDS.

Table 1: Variables created for analysis of NIDS data

Variable Created	Description of how variable was created	Final variable categories
Family structure	Presence of biological mother or father Adult family relative who helps care for children	Child + 1 parent Child + 2 parents Child + 1 parent + adult relatives Child + 2 parents + adult relatives Child + adult relatives
Caregiver characteristics	Centre for Epidemiological Studies Short Depression Scale	No symptoms of depression Symptoms of depression
	Level of education of caregiver	Low level of education: combine primary & secondary education; Medium: Matric High: Post matric
	Negative stressors: presence of the following life events – death of resident or non-resident member; serious illness/injury of household member; job losses	No listed life stressors At least one life stressor
	Positive life events: presence of new job; increase in remittances; scholarships; government grants	No positive event At least one positive event
Household income	Income levels of household	Categorised into below average, average, above average Income assessed against geo-type
Level of social and community organisation	1. Member of a community group e.g. stokvel a. No = 0 b. Yes = 1 (if one or more options are listed out of 1-16 options) 2. Support from neighbours a. Never = 0 b. Very rarely and not common = 1 c. Fairly common and very common = 2 3. Community safety – how common is theft? a. Never = 2 b. Very rarely and not common = 1 c. Fairly common and very common = 0 4. Trust of neighbours a. Not likely = 0 b. Somewhat likely = 1 c. Very likely = 2	Composite measure 0/2 = low social organisation; 3/5 = medium social organisation; 6/7 = high social organisation
	Living conditions 1. Dwelling type a. Formal housing b. Informal housing 2. Water a. Access to water services b. Access to water from rivers, dams 3. Toilet a. Access to a toilet b. Access to a pit or bucket 4. Shared toilet a. No b. Yes 5. Electricity a. Yes b. No 6. Refuse removal a. Yes b. No	Composite measure Low living standards = 'a' score is 0 or 1 or 2 times. Medium living standards = 'a' score is 3 or 4 times. High living standards = 'a' score is 5 or 6 times.

Family functioning	<ol style="list-style-type: none"> 1. Caregiving 2. Communication 3. Monitoring and supervision of children 4. Discipline 5. Family beliefs 6. Family cohesion and warmth 7. Impact of services on caregiving 8. Financial capabilities 	Descriptive thematic analysis of 6 Focus Group discussions to complement NIDS analysis.
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The specific areas identified as domains of child well-being that had corresponding data in the NIDS wave 1 data were education and health. The specific outcome indicators used are listed as follows:

Table 2: Outcome indicators

Outcome domains	Outcome indicator in NIDS	Additional information
Education	Child access to a Child Care Facility (under the age of 5 years old)	Children under the age of 6 years old may attend an Early Childhood Development Centre at the discretion of their caregiver. While registered facilities are subsidised by the state, these all attract additional user fees and so attending an ECD facility has associated costs.
	Child access to school (grade R or grade 1; aged 6 and 7)	By law children are required to enrol in grade 1 in the year they turn 7. Although not yet mandatory, in the year children turn 6 they are strongly encouraged to enrol in grade R (reception year) and most public schools now offer grade R. In poor areas public schooling is free.
Health	Perceived health status of the child (by caregiver)	The primary caregiver of the child is most aware of the health needs of the identified child. While the perceived health status of the child is not an objective measure, it is a good gauge of the child's general health / illness.
	Weight for age (younger than 5 years) Height for age (younger than 5 years) Body Mass Index (aged 6 and 7)	In the NIDS sample every identified child was scientifically weighed and measured. Therefore the height for age, weight for age, and Body Mass Index measurements are an objective and accurate reflection of the child's anthropometric status. The WHO anthropometric standards were used.
	Food security	A simple scale assessing food security was used in the NIDS. The question asked about adult and child hunger over the past 12 months. We made use of this data by grouping the results into three groups: food secure, moderately food insecure, and severely food insecure.

Part 1: Quantitative design

This study made use of a quantitative research design which consisted of a secondary analysis of the NIDS and assesses relationships between social variables concerning the education and health of the child.

The NIDS is funded by the European Union via the South African Presidency, and is a nationally representative panel study which commenced in 2008 (South African Labour and Development Research Unit [SALDRU], 2008). According to Leibbrandt, Woolard and De Villiers (2008), the goal of the NIDS is to influence pro-poor policy development by collecting data pertaining to income, expenditure, assets, education, health and other dimensions of well-being in South African households.

The NIDS collected data through four questionnaire types – a household level questionnaire completed by an adult in the household on behalf of the household; an adult questionnaire completed by all adults in the household; a child questionnaire completed by caregivers on behalf of all children in the household; and a proxy questionnaire for members of the household who were not available for interviewing.

Research questions for quantitative research

- What is the profile of children who receive a CSG in relation to the families they live with, their caregiver characteristics, their family functioning as well as the social organisation of the communities in which they live?
- To what extent do family structure, caregiver characteristics, family functioning and social organisation impact on child well-being?

Sampling

Leibbrandt et al. (2009), indicated that the sampling for the NIDS involved a stratified, two-stage cluster sample design. A total of 400 Primary Sampling Units (PSUs) were proportionally allocated according to the 53 District Councils, and then randomly selected from Statistics South Africa's 2003 Master Sample of 3 000 PSUs. The target population for NIDS was private households, as well as respondents living in workers' hostels, convents and monasteries. Those residing in other living quarters and institutions such as hospitals, military barracks, old age homes and prisons were excluded. In total, 7 305 households were reached containing 28 255 participants.

The sample for this specific study was children younger than eight years who were recipients of the CSG, and for whom information on caregivers was available in the data set. Of the total of 9 605 children younger than 15 years (Chinhema et al., 2016), 5 549 received a CSG. Of these, 3 132 were younger than eight years and could be linked to a caregiver.

Variables and indicators

Refer to the analysis model above which includes the variables and indicators for the quantitative and the qualitative analyses.

Ethical considerations

Collection of the NIDS data followed all ethical guidelines, for which approval was granted by the Commerce Faculty Ethics Committee of the University of Cape Town. The committee ensured that the NIDS appropriately adhered to the ethical principles of confidentiality, anonymity, voluntary participation and informed consent (Leibbrandt et al., 2009).

Validity and reliability

A number of mechanisms enhanced the reliability and validity of the instruments used in the NIDS study. In the first instance, a team of experts was recruited to consult on the development of the questionnaire and to give input on the types of questions used (Leibbrandt et al., 2009). In some cases, standardised measures were incorporated into the questionnaire. For example, the Centre for Epidemiological Studies Short Depression Scale – CES-D10, was used for the mental well-being module.

Additionally, Leibbrandt, et al. (2009), report that the questionnaire was assessed through a piloting phase of the study which enabled the research team to gain insight into how respondents and interviewers interpreted questions; as well as the level of quality control. As a result of the pilot, data collection techniques were adjusted to ensure greater quality control and standardisation. Professional services were also used to translate the questionnaires into all South African languages to ensure that interviewers did not interpret questions differently.

Limitations of the NIDS study

Due to the fact that that NIDS is a panel study, data collection is conducted every two to three years and follows the same households and participants. This allows for researchers to track population changes over time by conducting longitudinal analysis. One drawback prevalent to this type of study is that it includes non-response errors and attrition (drop-out) rates over time. NIDS is subject to non-response bias because refusals are highest among affluent respondents, who still tend to be White in South Africa. Nevertheless, to help with the representativeness of the sample, weighting was applied to compensate for the bias in the study.

The use of secondary data to prove or negate a particular hypothesis can be problematic. As the research instrument is not specifically geared towards the extraction of results particular to a new study, the outcomes and analysis are often limited. In this instance, the use of the NIDS to determine the relationship between children's health, education and other factors was restricted by two key limitations.

- First, the only child well-being measures available in the NIDS were related to health and access to education of children. In this way, the well-being measures were restricted by the data collected in the NIDS. Despite this, health and education are considered key elements which are important for child development, and for successful progression out of poverty for children in South Africa (Hall et al., 2012).

- Second, the structure of household rosters in survey data identifies all household members in relation to the household head. This makes it difficult to place the child at the centre of the analysis and to construct direct family relationships pertaining to the child(ren). To overcome this, triangulation of the household roster and information present in the child questionnaire was conducted.

Quantitative data analysis

The data was analysed using the Statistical Package for the Social Sciences (SPSS). SPSS is a powerful data analysis tool and allows for the manipulation and interpretation and significance of data. For the purposes of this study, the data analysis consisted of frequency distributions, bi- and multi-variate associations and Pearson's correlations. Chi-square tests were applied to test the statistical validity of variable associations, and where applicable, correlation analysis was run on certain of these variables.

- Frequency tables were used for descriptive purposes of the sample in relation to the family structure, caregiver characteristics, family functioning and social organisation.
- For bi- and multi-variate relationships, dependent and independent variables were examined in relation to each other, to analyse whether associations between them existed. An independent variable is one whose variation is not dependent on that of another. When not looked at as a frequency or stand-alone variable, independent variables are often used to look at their impact (if any) on dependent variables. For example, when looking at the relationship between Body Mass Index (BMI) and the age of the child, the physiological state of the child (BMI), would be the dependent variable, and age the independent variable, because a change in the child's age may cause a change in the BMI of the child, but not the other way around.
- Only statistically significant associations are reported on in this report. A statistical relationship is only considered to be significant if the p-value is less than 5% ($p < 0.05$). In other words, with at least a 95% probability. To determine this, Chi-squared (significance) tests were applied to all multi-variate relationships.
- Correlation coefficients describe the strength and directional relationship between two (or more) variables. Because the relationship is linear, the variables themselves should be continuous and numeric. So, for example, the relationship between education levels and income, or age and education. Through statistical manipulation however, it is possible to measure the relationship between continuous data, and categorical, non-continuous data, which in some instances, occurs here. Correlation coefficients reflect the direction of a relationship. If both variables move in the same direction (e.g. Increase in salary is commensurate with an increase in education levels), one can say the relationship is positive. If the variables are reflective of the opposite relationship (e.g. The higher the income, the lower the education level), then the relationship is negative. If there is no linear relationship, there is no meaningful correlation. The strength of the correlation is dependent on how close the value is to -1 or +1. The closer to these values the correlation is, the stronger the relationship. Because not all of the relationships were meaningful, only

the ones that were statistically significant were reported on. The results of most of these relationships, while statistically significant, must be viewed with caution, as generally speaking, the correlations were moderate to weak. For this reason, further statistical analysis was conducted, which is set out in the path analysis model.

Path analysis model

The path analysis model was done to establish the relationship between the independent and the dependent variables via a mediation model. The analyses were conducted in Mplus, version 7.4 (Muthén & Muthén, 2012). Path models were run for, 1) perceived child health, and 2) height and weight for age. Child food security was tested as a mediator in both models. Bootstrapping with 5 000 bootstrap samples was used to examine the significance of indirect (mediation) effects (MacKinnon, Lockwood, & Williams, 2004; Shrout & Bolger, 2002). Significance at $p < .05$ was determined if 95% of the Confidence Intervals (CI) did not contain zero. Multiple group models were run to see if models differed by geo type (0 = rural, 1 = urban). For these analyses, an unconstrained model in which the path coefficients were allowed to vary across group (e.g., to vary across geo type), was compared to a constrained model in which path coefficients were constrained to be equal across groups.

The NIDS data set composed of 3 131 caregivers with a child between the ages of 0 and 7 ($M = 3.72$, $SD = 2.16$) was used. For the path model analysis, the outcomes of interest included perceived child health and height and weight for age (z-scores). To determine predictors, variables of interests were first examined via bivariate correlations. The scoring of the variables was reviewed and through this process, the variable "Level of social organisation" was excluded from analyses based on how the variable was scored. Next, bivariate correlations were run for all final variables and these were recoded as set out below.

Measures

Child well-being. Child well-being was assessed using three outcome measures (i.e., caregiver perceptions of child health, and child height and weight for age) in the NIDS, Wave 1 of 2008. These were the only outcome measures that could be applied to children under eight years in the NIDS; other measures in NIDS related only to the surveyed adults or the households in which children lived, not the children themselves. Perceptions of child health was a subjective measure based on the caregiver's assessment of the health of the child (e.g., "How would you describe [...]s health at present? Would you say it is excellent, very good, good, fair or poor?"). The other two outcome measures, height and weight for age, were more objective measures, comprising of anthropometric data based on guidelines set by the World Health Organisation. Each child was scientifically weighed and measured.

Predictors of child well-being. Various factors were assessed as to whether they influenced child well-being outcomes, including child food security, caregiver characteristics (i.e., gender, age, education level, mental health and perceived health of caregiver), family structure, household income, child educational enrolment and living standards. See table 1 and 2.

Food Security. Food security was assessed with the question: "in the past 12 months, how often did any child in this household go to bed hungry because there wasn't enough

food?” Caregivers rated this question on a scale of 1 = never to 5 = always. In the current study, responses were coded so that 0 = “often or always” and 1 = “never, seldom, or sometimes.”

Caregiver characteristics. Caregiver characteristics, including age, level of education, perceived health, and depression were assessed. Caregiver education was coded so that education status ranged from 0 = no schooling to 4 = tertiary schooling. Perceived caregiver health was assessed using the question: “How would you describe your health at present?” and was rated on a scale of 0 = poor to 4 = excellent. Caregiver depression was assessed using the 10-item Centre for Epidemiological Studies Short Depression Scale (Radloff, 1977). Caregivers rated each item (e.g., “I was bothered by things that usually don’t bother me”) on a scale of 1 = rarely or none of the time to 4 = all of the time.

Family structure. Family structure variables examined who was living in the household with the child and included 5 responses: 1 parent, 2 parents, 1 parent and adult relatives, 2 parents and adult relatives, and adult relatives. For the current study, two variables were created. One specifically examined if the child lived in a two-parent household or not. The other variable examined if a relative lived in the household with the child.

Household income. Household income was categorized into 0 = much below average to 4 = much above average based on participant responses.

Educational enrollment. Educational enrollment was captured by items asking about access to and enrollment in a child care facility (e.g., Early Childhood Development Centre, ECD) for children ages three to five years old, and enrollment in formal schooling for children ages six to seven. Children under the age of six years old may attend an Early Childhood Development Centre at the discretion of the caregiver. While registered facilities are subsidized by the state, these all attract additional user fees and so attending an ECD facility has associated costs. By law children are required to enroll in grade 1 in the year they turn seven. Although not yet mandatory, in the year children turn 6 they are strongly encouraged to enroll in Grade R (reception year) although not every public school offers Grade R. In poor areas, public schooling is free.

Living Standards. Household living standards were assessed using items about the accessibility of a toilet (a = access to a toilet or b = access to a pit or bucket), use of a shared toilet (a = no, b = yes), availability of electricity (a = yes, b = no), refuse removal (a = yes, b = no), access to water (a = access to water services, b = access to water from rivers, dams), and dwelling type (a = formal housing, b = informal housing). To assess these living standards, each condition was categorically coded. For example, if a household indicated an “a” score of 0-2 times, this indicated low living standards. Medium living standards represented an “a” score of 3-4 times, and high living standards represented an “a” score of 5-6 times.





Part 2: Qualitative design

2A: Focus groups

To shed light on the perspectives of families themselves about various aspects of caregiving, family beliefs and their needs and challenges, six focus groups with caregivers (40) were held in two target communities, three in each community.

Research sites

The two target groups of the study are families from Doornkop and Moutse respectively, who are in receipt of a CSG. Doornkop is an urban community while Moutse is located in a rural setting.

The first site, Doornkop, Soweto, falls into wards 49, 50, and 129 of Region D, and is among the poorest formal areas in Johannesburg (Patel, Hochfeld, Moodley, & Mutwali, 2012). The current population of Doornkop is large, at 58 000¹. It is located to the West of Johannesburg, adjacent to two Randfontein mine dumps which blow extensive dust into the area during windy periods. Doornkop, known locally as 'Snakepark' due to a proliferation of snakes in the early years of settlement, is a formal municipal area consisting of brick housing with backyard shacks and small pockets of informal housing. It has reasonably maintained tarred streets, basic services (such as piped water and electricity), social services (such as primary health care clinics, schools and non-governmental community services), and small local businesses such as spaza shops, shoe repairers, mechanics, and so on (Patel et al., 2012). Two primary schools, three large high schools, two clinics, a police station, and a large community hall can be found in Doornkop. It is therefore a relatively well-served, formal urban area, where the quality of life should be satisfactory. However, over 80% of households receive a CSG and earn below R2 500 per month (Patel et al., 2012), indicating low household income and therefore widespread poverty. Our local partner organisation in Doornkop was an NGO called Humana People to People, which is an international NGO with offices throughout South Africa. This NGO was our base from which to select and recruit focus group participants, the location for the focus group venue, and our referring source if any participant needed follow-up care.

The second research site is the Moutse area, located in the Elias Motsoaledi Local Municipality, Sekhukhune district, in the province of Limpopo. While Moutse itself is a small town, it is largely a rural site with most people living outside of the town, and has a population of 36 941². It is one of the poorest districts in the country characterised by a shortage of infrastructure and lack of safe water supply. There is a high rate of unemployment (61.6%) and poverty³. Service gaps identified in Moutse include a lack of municipal services including access to water and sanitation; lack of social services, no community food security programmes, high levels of malnourishment, a lack of educational services at ECD level; most pre-schools are private and offer day care rather than ECD learning. In

1
https://joburg.org.za/index.php?option=com_content&task=view&id=174&Itemid=168&limitstart=1

2
<https://census2001.adrianfrith.com/place/88303>

3
<http://www.hst.org.za/content/isds-site-greater-sekhukhune-district-municipality>

general there is a low level of awareness and knowledge of mothers on child-rearing and early detection of disease and developmental problems (Personal Communication with Mrs M. Slabbert, Chief Operating Officer, Ndlovu Care Group, 10 July, 2013). Moutse is characterised by high levels of poverty and unemployment, with many families in receipt of social grants. Our research partner was an NGO named Ndlovu Care Services, a community health care service provider in the area. The focus group facilitator is an experienced social worker employed by this NGO, and she held one of the focus groups in the NGO facilities. She also referred participants needing further assistance to Ndlovu Care Centre.

Sampling

Three focus groups were run in each research site, totalling six in all. There were 19 participants in Moutse and 21 participants in Doornkop; 40 participants in all. The selection criteria for the focus groups were that participants be adult (over 18 years) parents/caregivers/family members of children who are younger than eight years living in the same household; no more than two members from the same family could be included in the interview. We intended to stratify participants into different groups according to age, that is, each group having participants aged 18-25 years; 26-40 years; and 41 years upwards, respectively. It was thought that discussing confidential parenting and family details would be easier with peers rather than having a great age disparity in the groups which would have, we feared, introduced cultural barriers to discussing certain issues. Owing to practical challenges (such as location of the groups), the participants were eventually not grouped according to age and this did not seem to pose a problem with them sharing during the data collection.

The participants were recruited using convenience sampling at local SASSA pay points at each research site, where participants were collecting their CSG money. The researcher approached a person, asked to speak to them, explained the research very briefly, administered a short questionnaire, and asked for a phone number and permission to contact them at a later stage. The answers from the questionnaire were used to exclude those that were not eligible. Overall approximately 85 and 60 people were approached in Doornkop and Moutse respectively, and after excluding those ineligible and finding out who was willing to take part, a total of 21 (Doornkop) and 19 (Moutse) people took part in the focus groups. Focus groups were between five and eight people each.

Research instruments

A focus group guide (FGG) was developed for the focus group interviews. The FGG comprised six sections. The first section contained a three stage vignette which was designed to elicit information from focus group participants in relation to their family beliefs about caregiving, supervision of children, and family communication. Questions attached to vignettes “can be asked about how a character **should** ideally act and/or how **would** they realistically act. ‘Should’ questions focus participants’ attention on the moral dimensions of situations and ‘would’ questions on the pragmatic” (Braun & Clarke, 2013, p. 1). Questions for stages one and three asked largely ‘should’ questions, focusing on the values/beliefs of the participants, while stage two questions were more ‘would’ type questions, focusing on how things actually work in their experience. This elicited lively discussion and rich data.

Sections two to five of the interview schedule largely related to community and household resources, family functioning, service use/delivery and financial resources.

The final section of the interview schedule contained a depression index called the CES-D 10, Center for Epidemiologic Studies Short Depression Scale, 10 questions (Radloff, 1977). This particular scale has been validated for use in the South African context (such as in the NIDS).

The FGG was translated into isiZulu and SePedi as these were the most commonly spoken languages of the communities in which the focus group interviews were conducted. By translating the guide the group facilitator did not have to do any simultaneous translation from English during the group process, and could run the group process entirely in their chosen language without difficulty. A pre-test of the FGG was conducted to ensure appropriateness and changes were made to simplify and clarify certain questions within the FGG thereafter.

Data collection

Prior to the data collection, training was conducted with the focus group facilitator (one facilitator ran all six groups). The training covered the purpose of the research, why a focus group was chosen, and the role of the group facilitator. The research facilitator was taken through the FGG, where each section was explained in detail and the facilitator was instructed on how to use the FGG in the field.

Data was collected from August to September 2015. Each group was approximately two hours in duration. Participants were given sandwiches and drinks during the group as a small token of our appreciation for their time. At the end of the group, each participant was given airtime for their mobile phones to the value of R10, another small token of thanks.

At each group, there was a scribe to observe and note down the group dynamics during the interview, although groups were all audio recorded too (permission was sought from all participants first). After each group, the research facilitator wrote a report of the key discussion points as well as the process of the focus group. As the focus groups were conducted in either Zulu or Sepedi, the interviews were then transcribed and translated into English.

Data analysis

The analysis of the qualitative data was thematic and Atlas Ti. was used for this. The transcripts were coded through a deductive coding process, where a code tree was first created and the transcripts were coded according to pre-determined codes, although some new codes were added during the analysis process. The analysis of the interviews focused on how families function in relation to caregiving, communication, monitoring and disciplining of children, family beliefs and family warmth; the social connectedness of the family within the community and the support structures and resources available to the families; and the financial capabilities of the family and the perceived needs of these families. Cross-checking coding by different researchers was undertaken to ensure the minimisation of bias and maximum consistency and coherence in code usage (Lincoln & Guba, 1985; Friese, 2014).

Ethical considerations

Ethical clearance for the qualitative part of this research was granted from the University of Johannesburg's Faculty of Humanities Ethics Committee. The purpose of the research was explained to all the participants, they participated voluntarily, and they were given an opportunity to opt out of the research at any point in the process. Confidentiality was discussed in the groups and no names appear in this report. Lastly, the research was carried out in a manner that did not harm or negatively affect any of the participants or their families. There were a few cases where specifics concerning information was shared during the group, and the facilitator offered follow-up support via the NGO partners to these participants (such as in serious expressed conflict in the home, possible depression, and so on).

Limitations

While trends and issues are revealed in focus group methodology, generalisability is not possible using this design. As a form of convenience sampling was used, the group members were not necessarily representative of their communities, and therefore the data might reflect interests and issues that are somewhat skewed towards the particular areas of interest of the individuals in the group, rather than broader issues.



2B: Key informant interviews

Sampling

Ten key informant interviews were conducted with programme managers from organisations in South Africa. The programmes were selected based on a literature and a web-based search of family programmes in South Africa. Purposive sampling was used through a scoping exercise of the various family/parenting programmes offered in South Africa, where participants were identified based on their knowledge of one particular family programme in their organisation. This was appropriate as they had the attributes which most suited and served the purpose of the study (Strydom, 2011). In addition, some programmes were identified by using a snowball technique whereby some key informants referred the researchers to other programmes which were then followed up. Two organisations were based in the Western Cape, one was based in the Eastern Cape, and offered family programmes in those particular areas. The remainder of the organisations were from various parts of the Gauteng province.

Research instruments

A semi-structured interview schedule was designed for the key informant interviews, and pre-tested prior to data collection. The interview schedule aimed to elicit information on the particular programme the key informant knew best (at their organisation). The questions focused on the aim of the programme, target populations, the programme content, and monitoring and evaluation of programmes. The key informants were requested to make available their programme materials for review. Owing to substantial differences in programmes, deviations from the semi-structured interview guide were common during interviews.

Data collection

Data was collected from February 2016 to April 2016. Interviews were mostly conducted at the offices of the key informants, although in two cases telephone interviews were conducted, and in one case the interviewee came to the CSDA offices. All the interviews were conducted in English. Although the interviews were recorded, notes were taken down during the interviews by a scribe and both notes and recordings were used for referral afterwards.

Data analysis

The data from the key informant interviews was treated as a source of information rather than a source of meaning. Therefore, basic thematic content analysis was conducted using the interview schedule as a guide.



Research findings

Part 1: Quantitative findings

An overview of households in which CSG children reside

There were 3 132 children receiving a CSG younger than eight years in the NIDS. Of these, 51% were male and 49% female. Furthermore, 90% of children were Black African, 10% were Coloured, 0.2% Asian/Indian and 0.1% White. With the exception of children younger than one year, which constituted the smallest (7%) proportion of the overall sample, the distribution of the number of children across these age groups was quite even, and reflected only marginal variances (between 12% and 14% in each age group from one to seven years).

Location

Table 3: Location of residence

Household location	Frequency	Percentage
Urban informal	205	7
Rural formal	261	8
Urban formal	854	27
Tribal Authority Areas (TAAs)	1812	58
Total	3132	100

The majority of children (58%) lived in households situated in tribal authority areas (TAA), with a further 27% of children living in urban formal areas. Eight percent and 7% resided in rural formal and urban informal areas, respectively. TAAs are made up of communal land in rural areas that were previously designated as self-governing territories or 'Bantustans' under apartheid. These areas remain the poorest areas on the national map and, at smaller area levels, pockets of extreme poverty are found in small towns and townships on the outskirts of cities (Hall & Posel, 2012)⁴.

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Geographic types in the NIDS followed the 2001 Census definitions based on enumeration areas (EAs) during data collection. Each EA type fell into one or other of the four broad geography types (also known as settlement types): urban formal, urban informal, rural formal and tribal areas. The description of these areas is outlined in Appendix A.

Living standards and income

A composite measure of the living conditions was created. This measure *excluded* income, but *included* the dwelling type, access to water, toilets, electricity and refuse removal. Higher levels of access were equated to higher living standards.

Table 4: Living standards

Living standards	Frequency	Percentage
Low	715	23
Medium	1553	50
High	864	28
Total	3132	100

Half (50%) of the children in this study lived in households with medium living standards. This meant that they had access to three or four of the six items identified for this measure. An additional 28% of the children lived in households with high living standards, and the remaining 23% of the children lived in households with low living standards⁵.

- There was no correlation between the age of the child, and the living standards of the child.

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The six items making up the living standards index were as follows: dwelling type, access to water, toilet, electricity, and refuse removal.



Table 5: Per capita income (all sources) by household size and geo-type

Geo-Type (2001 Census)		Number of household residents	Monthly household income full (R)	Per capita (R)
Rural Formal	Mean	6.68	2641.28	395.40
Tribal Authority Areas	Mean	7.22	2456.57	340.25
Urban Formal	Mean	6.26	3240.75	517.69
Urban Informal	Mean	6.42	2740.09	426.81
Total	Mean	6.86	2704.34	394.21

The average number of household residents was 6.86, compared to the average South African household size of 3.6 people in 2011 (Community Survey, 2016).

- The mean per capita monthly income in this sample was R394.21 per month. This is below the lower bound poverty line of the same year (2008), which was R515 per month. In all households per capita income fell below the upper bound poverty line which was R949 per month in 2008.
- Urban areas had marginally lower number of household residents, but a greater mean per capita income than their rural counterparts.
- Those residing in the TAAs had larger households (7.22 residents per household), and the lowest per capita income of all the geo-types.

Caregiving and family structure

By far, the majority (97%) of caregivers were female, while 3% (86) of the caregivers in the NIDS were male. This very strongly gendered division of care has remained consistent among CSG recipients, and is a strong feature more broadly in South Africa in most households nationally (Vorster & De Waal, 2008; Patel & Hochfeld, 2011).

Table 6: Person responsible for the child

Person mainly responsible for child	Frequency	Percent
Uncle or aunt	125	4%
Other relatives	219	7%
Grandparent	640	20%
Parent	2175	69%
Total	3132	100%

When asked who the person mainly responsible for the child was (that is, the primary caregiver), a parent or grandparent accounted for 89% of responses. Four percent of children were cared for primarily by an uncle or aunt. The heightened involvement of extended family underlines the emphasis and responsibility placed on family in the care arrangements of children.

- ‘Other’ is mainly comprised of an in-law; cousin; sibling; son/daughter; grandchild; nephew/niece; great-grandparent; step-parent.

Table 7: Family structure of CSG beneficiaries

Family structure	Frequency	Percentage
Child and 1 parent	326	11
Child and both parents	451	15
Child, 1 parent and adult relatives	1043	34
Child, both parents and adult relatives	345	11
Child and relatives	897	29
Total	3062	100

A distinguishing feature of the family structure of CSG beneficiaries is that in 74% of cases relatives were present in the household.

- Seventy-one percent of CSG children lived in the same household as one or more biological parent. Of the children who resided with one or more biological parent, 64% were in households with an adult relative.
- Fifteen percent of children were living in nuclear families where the mother and father were present, but the most common family structure was made up of single parents and children (45%) of which single parent families with relatives were the most common family form of CSG beneficiaries.
- In their analysis of the NIDS, Hall and Wright (2010) indicated over a third of children lived with both biological parents, 23% lived with neither parent, 40% lived with a mother only, and a further 3% lived with a father only.
- These results are comparable to a limited extent with this study, as Hall and Wright (2010) did not consider adult relatives in households in which children resided.

Table 8: Marital status of child's biological parents

Relationship between parents of child	Frequency	Percent
Other	14	0
Engaged	16	1
Divorced	18	1
Never had a romantic relationship with each other	125	4
Not applicable - one or both parents deceased	287	9
Girlfriend/boyfriend living together	415	13
Married	579	19
Ex-boyfriend/ girlfriend	763	24
Girlfriend/boyfriend not living together	915	29
Total	3132	100

The greatest proportion (29%) of relationships, were those between a boy/girlfriend not living together.

- Twenty-four percent of children had parents who were ex-boy/girlfriend, while 19% of parents were married.
- Relationships between married couples or those between a current or ex-boy/girlfriend accounted for 72% of total relationships.
- 'Other' in this table refers to the response refusals and missing data.

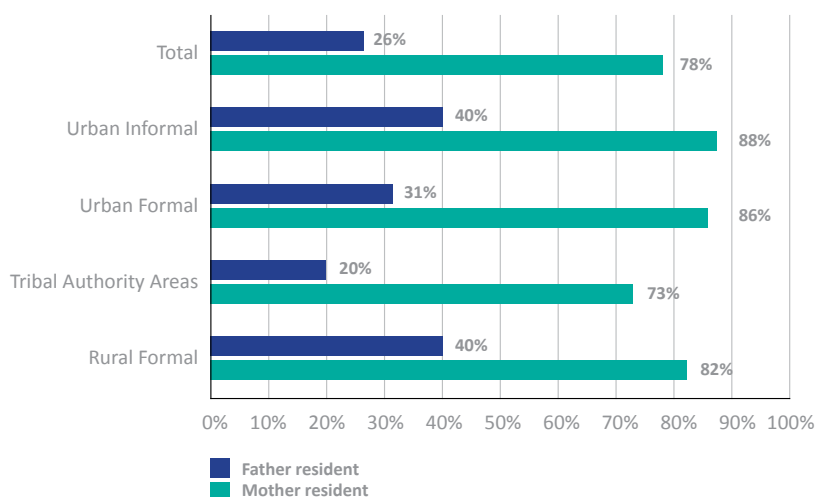
Table 9: Is there anyone else in the household who cares for the child?

Access to family support for childcare	Frequency	Percentage
Family support	2410	77
No family support	722	23
Total	3132	100

A total of 77% of children had other family members who cared for them in addition to the primary caregiver (such as parents, sisters, brothers, grandparents, and other relatives).

- The remaining 23% did not have additional carers.

Figure 2: Presence of parent in household by geo-type



- Figure 2 shows the discrepancy not only between the presence of mothers over fathers, but also the distribution of parental presence by urban and rural areas [$\chi^2(12; N=3132)=88.15; p<0.000$].
- Mothers were least likely to be resident if they lived in a TAA, and overall, were marginally more likely to be present if they lived in an urban area.
- Overall, fathers were three times less likely to be present than mothers. Again, as with mothers, the TAA was the area least likely to have a parent present.
- In the cases of the urban informal area, and the rural formal area, 40% of fathers were present, while in the case of the urban formal area, this applied to approximately 30% of fathers.

Table 10: Frequency of non-resident mother's contact with child

Presence of biological mother	Frequency	Percentage
Low	275	42
Medium	260	40
High	115	18
Total	650	100

When mothers were not present in the same households as children, 42% never saw their biological children, or saw them several times a year. This suggests low levels of contact with children when the mother is not co-resident. Forty percent saw their biological children monthly, and the remaining 18% saw their biological children weekly or daily.

Table 11: Frequency of non-resident father's contact with child

Presence of biological father	Frequency	Percentage
Low	1136	56
Medium	533	26
High	348	17
Total	2017	100

The percentage of fathers who were absent from homes was high. Overall, 74% of fathers were not residing with the child.

- Of these, 56% of fathers either never saw their biological children or saw them several times a year.
- Twenty-six percent saw their biological children several times a month, while the remaining 17% saw their biological children at least once a week or daily.
- Many parents who were absent from children's households were away, in part, as a result of labour migration. This is a trend that has continued in the post-apartheid period (Hall & Wright, 2010). Further, while historical labour migration was male dominated in South Africa, female labour migration has been increasing from rural households to cities.

Table 12: Does non-resident parent provide financial support?

Financial support from absent parent?	Mother		Father	
	Frequency	Percentage	Frequency	Percentage
Yes	319	50	732	37
No	323	50	1236	63
Total	642	100	1968	100

Half of non-resident mothers provided financial support to children, compared to 40% of non-resident fathers.

Social, economic and mental health of caregiver

The profile of the caregiver was analysed in relation to educational attainment, employment and income. The results of the mental health assessment are also presented including significant correlations between these variables.

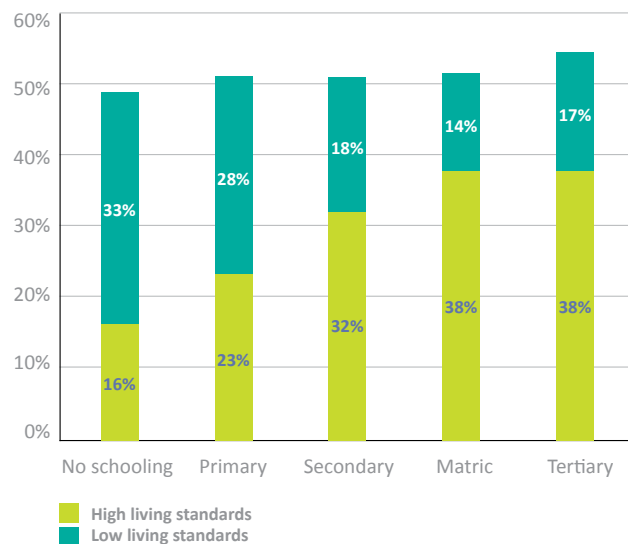
Table 13: Education level of caregiver

Education Level of Caregiver	Frequency	Percentage
No school	426	15
Primary	775	26
Secondary	1219	42
Matric	368	13
Tertiary	138	5
Total	2926	100

Overall, 41% of caregivers had very low levels of education (no schooling and only primary levels). Twenty-six percent of caregivers had a primary school education, while 42% of caregivers had a secondary school education. Approximately 13% had a matric, while a low 5% had a tertiary education.

- Fifteen percent of the caregivers had not received any education.
- The average age of the caregivers in relation to the level of education obtained, showed that caregivers with no schooling or primary education were older (average age of 54 years and 41 years, respectively) than those with secondary, matric and tertiary education (average age of 32 years, 29 years and 32 years, respectively). This phenomenon is due largely to the effects of apartheid policies on the educational attainment of older caregivers.

Figure 3: Correlation between education levels of caregiver and living standards



- There was a positive correlation and statistically significant relationship between the education levels of caregivers, and caregivers' living standards. Those who had a higher education were more likely to have a better standard of living than those who had a lower level of education [$\chi^2(8; N=2926)=143.31$; $p<0.000$].
- There was also a relationship between the level of education caregivers have, and the dwelling type in which they resided. Overall, caregivers residing in urban areas had higher levels of education than those who lived in rural areas.

Table 14: Employment status of caregiver

Caregiver was employed?	Frequency	Percentage
Yes	391	13
No	2580	87
Total	2971	100

- The majority (87%) of caregivers in the NIDS did not receive regular pay or wages from part-time or full-time work. The NIDS does not allow for a differentiation between these types of employment.
- Only 13% of caregivers indicated that they had some sort of regular income from either full-time or part-time employment. Of these caregivers, 5% indicated that they worked for themselves.

Table 15: Employment status of household members

Household member employment	Frequency	Percentage
Yes	1519	49
No	1611	51
Total	3130	100

- Half the number of households indicated that at least one other person had been employed/self-employed in the previous month.
- Average household income would seem to be influenced by the relative presence or absence of the mother and/or father.

Table 16: Household income by presence of parent

Average household income if...	...Mother is present	...Father is present
Rural formal	Higher	Much lower
Tribal authority areas	Higher	lower
Urban formal	Lower	Marginally higher
Urban informal	Much higher	Marginally higher

- In the rural formal and TAAs the presence of the mother was correlated with higher household income.
- Urban informal areas had a much higher income where the mother was present.
- The father's presence was correlated with much lower and lower household income, in rural formal and TAAs. This might be due to a lack of jobs, illness, or other barriers that are not known.



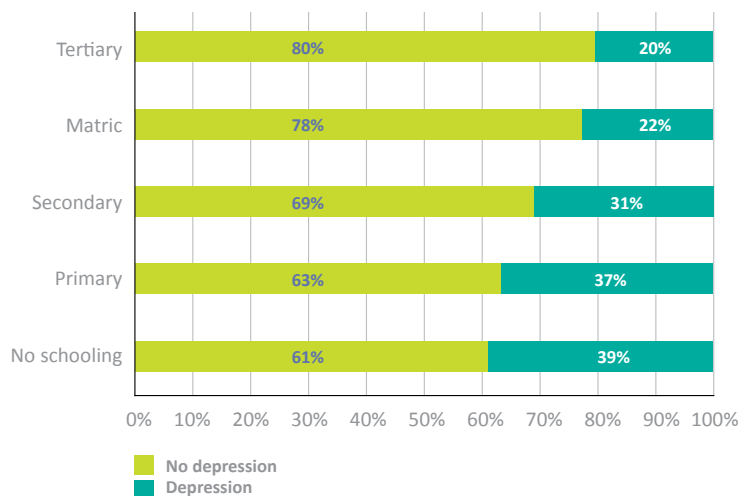
In the NIDS questionnaire, respondents were asked a series of questions relating to their mental well-being. Depression 'scores' were calculated based on the responses given. These scores were then stratified by certain variables to see if there were any correlations between depression and life circumstances. These are represented in the following charts and tables.

Table 17: Mental health of caregiver

Mental Health Status of Caregiver	Frequency	Percentage
No depression	1984	68
Depression	941	32
Total	2925	100

- In terms of caregiver characteristics, analysis of the Centre for Epidemiologic Studies Short Depression Scale (CES-D10) was conducted in order to reveal whether caregivers experienced feelings or behaviours associated with depression.
- The majority of caregivers (68%) did not present with a high number of depressive symptoms, while the remaining 32% had a high risk of depression. Bearing in mind the majority of caregivers were women, the results of this study were lower by 10% from the prevalence rate for depression among women with a low socio-economic status in an urban community (Moodley, 2014).

Figure 4: Relationship between education levels of caregiver and mental health of caregiver



- There was a relationship between the education level of the caregiver and depression.
- Depression was highest among caregivers who had limited education or no education at all [$\chi^2(20; N=3132)=2242.82; p<0.000$].

Section summary: overview of households and caregiver characteristics

The vast majority of primary caregivers (97%) were women. In the main, the primary caregivers, that is, the person responsible for the care of the children, were their parent(s) (69%) while 20% were grandparents and 11% of children were cared for by other relatives. Seventy-one percent of children lived in the same household as one or more biological parent.

Regarding the marital status of the parents, the greatest proportion (29%) of relationships were those between partners not living together. Only 20% of the couples were married.

The greatest proportion of caregivers (42%) had a secondary level of education. There was a relationship between the education levels of the caregivers and their average age. Younger caregivers were generally more likely than older caregivers to be better educated. Similarly, better educated caregivers were more likely to have a higher standard of living than lesser educated caregivers.

Eighty-seven percent of caregivers did not receive regular pay or wages from part-time or full-time work. This means that caregivers were more reliant on other household members to provide income and financial support. But CSG households where there was no other person employed, were particularly vulnerable. This was the case for one in two households.

Aside from the parents, grandparents or other family members played significant roles as caregivers of the child. Overall, 77% of caregivers indicated the presence of other family members for assisting with the care of the child. This confirms the importance of other adults who were engaged in the care of children. The lack of personal income for caregivers, and the reliance on other members of the household, underlines the importance of a wider conception of 'family' and of their contribution to material and social support for the caregiver. These findings need to be taken into account in the design of family interventions.

The important role of men in the care of children and in promoting child well-being is now widely acknowledged (Swartz & Bhana, 2009; Manyatshe, 2016). The complexity of South Africa's family structures and the living arrangements of children were closely associated with the migrant labour system that evolved under colonialism and apartheid. These family forms and patterns of family life continue in the present as in-migration continues at a significant pace.

Non-resident mothers were more likely than non-resident fathers to give the household financial support. However, half of non-resident mothers and 60% of non-resident fathers did not provide any financial support.

There was also a relationship between the perception caregivers had of their own health, and their mental state of mind. Those who viewed their health more favourably were less likely to be depressed than those who saw themselves as having poor health. Similarly, those who perceived themselves as living in wealthier households were more likely to have lower depression scores.

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Community characteristics

Table 18: Membership of a community group or organisation

Group membership	Frequency	Percentage
Yes	1065	34
No	2067	66
Total	3132	100

- One of the measures of social and community organisation included group membership. Sixty-six percent of caregivers of children in the NIDS were not a part of any community group such as stokvels, burial societies, and sport and study groups, for instance. The remaining 34% were members of one or more community groups. Of these, just over half (52%) were members of a burial society and 19% were members of a stokvel.

Table 19: Level of community support

Perception of support from neighbours							
Geo-type (2001 Census)	D/K	Never	Very rarely	Not common	Fairly common	Very common	Total
Rural formal	1%	9%	11%	17%	20%	41%	100%
Tribal authority areas	2%	6%	12%	11%	23%	46%	100%
Urban formal	0%	15%	14%	11%	25%	36%	100%
Urban informal	0%	15%	18%	14%	25%	28%	100%
Total	1%	9%	13%	12%	24%	42%	100%

- Perhaps ironically, while affiliation to a community organisation was greatest among urban informal dwellers, they were also the group who was least likely to feel that their community members were supportive of each other [$\chi^2(15; N=3132)=114.54$; $p<0.000$]. While overall, the level of support (fairly common, very common, or common) expressed was moderately high (66%), it was noticeably lower among urban informal dwellers. This points to the need for building community support networks in informal settlements.

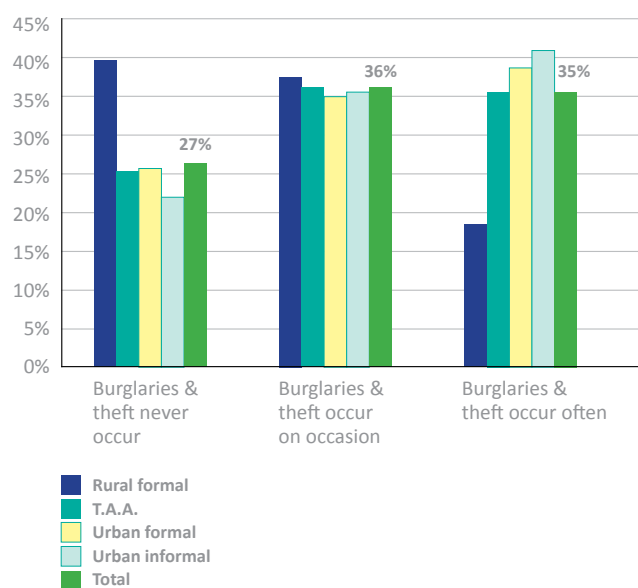
Table 20: Perception of trust of neighbours

Likelihood of...	...neighbour returning wallet	...stranger returning wallet (%)
Not likely	78%	88%
Somewhat likely	15%	8%
Very likely	7%	4%
Total	100%	100%

- There was little variance on issues of trust and perceptions of honesty in the community. When asked if they thought a neighbour would return a wallet to them, nearly eight out of 10 respondents thought it not likely. This applied to nearly nine out of 10 of those who thought it unlikely a stranger would return the wallet.
- Low levels of trust in neighbours, was the norm.



Figure 5: Perceptions of community safety by geo-type



- When perceptions of community safety were explored, 27% of caregivers indicated that burglaries and theft were never common in their communities [$\chi^2(15; N=3132)=92.05$; $p<0.000$].
- While the TAA and the two urban areas reflected similar sentiments regarding safety and crime in their communities, those who resided in rural formal areas were more likely to say crime of this nature never took place, or conversely, a fewer number said it occurred often.

A composite score, comprising affiliation to community groups; support from and trust of neighbours and perceptions of community safety; was created to provide an indication of the degree of social organisation in which children live. The scores ranged from 0-7 with three bands indicating different degrees of community cohesion. 0-2 represented low social organisation; 3-5 medium; and 6-7 high. These categories are displayed in the Table below.

Table 21: Level of community cohesion

Level of community/ social organisation	Frequency	Percentage
Low	734	23
Medium	1895	61
High	503	16
Total	3132	100

- Sixteen percent of children lived in communities with high social organisation, while the majority (61%) lived in medium social organisation communities. The remaining 23% lived in low social organisation communities.

Section summary: community characteristics

Affiliation to a community group was not particularly high. Two-thirds of caregivers did not belong to any community group, and for those who did, affiliation to a burial society or stokvel, accounted for 71% of total organisational membership. Those in urban formal areas were more likely than those in other areas to be a member of a community group. TAA residents were slightly more likely to have a higher degree of social

organisation than those living in other areas. There was little relationship between a person's education level, and their community organisation 'score'.

As part of the conceptual framework for this report, it was hypothesised that the household profiles, caregiver characteristics and community characteristics, are some of the above independent variables which may impact on child well-being. The selected measures of child well-being are specific to identified indicators related to the child's education and health. The significant associations between the independent variables and child well-being are presented next.

Education outcomes

Education: children aged 3 – 5 years

Well-being for children in the NIDS was first analysed in relation to enrolment in educational facilities. These were:

- Enrolment in a childcare facility (CCF) for children aged 3-5 years.
- Enrolment in school for children aged 6 and 7 years.

Table 22: Enrolment in a childcare facility

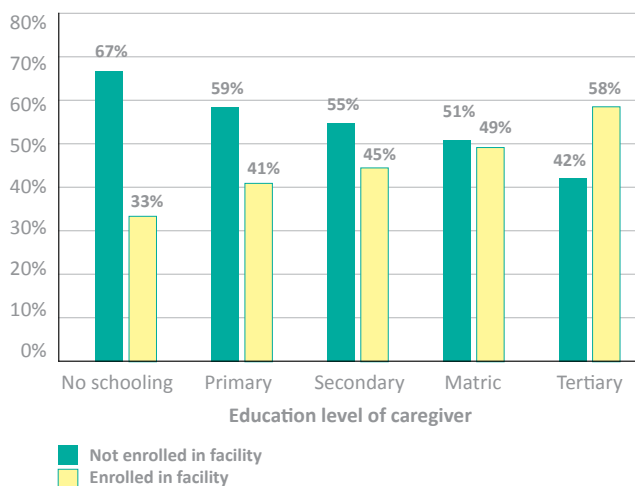
Is the child enrolled in a childcare facility? (age 3-5)			
Geo-Type (2001 Census)		Frequency	Percentage
Rural formal	No enrolment in facility	75	70
	Enrolment in facility	32	30
	Total	107	100
Tribal authority areas	No enrolment in facility	449	62
	Enrolment in facility	276	38
	Total	725	100
Urban formal	No enrolment in facility	146	45
	Enrolment in facility	177	55
	Total	323	100
Urban informal	No enrolment in facility	34	57
	Enrolment in facility	26	43
	Total	60	100
Total	No access	704	58
	Access	511	42

- Overall, enrolment in a CCF for children aged 3-5 years was low. In total, only 42% of children were enrolled in a facility.
- Rural areas were significantly less likely than urban areas to have a child enrolled in a CCF [$\chi^2(3; N=1215)=32.77$; $p<0.000$].

There was a positive correlation between the education level of the caregiver, and enrolment in a CCF. This relationship is quite clearly represented in the graph below.



Figure 6: Education level of caregiver by enrolment in a CCF



- As education levels of the caregiver increased, so did enrolment of children in a CCF. Conversely, those children who were not enrolled in a CCF were more likely to have a caregiver who had a lower level of education [$\chi^2(4; N=1215)=18.89$; $p<0.001$].

Section summary: enrolment in a childcare facility: (ages 3-5)

Less than half (42%) of the children were reported to be enrolled in a CCF. Of these children, those who lived in rural areas were less likely to be enrolled in a CCF.

There were statistically significant relationships between the child’s enrolment in a CCF, and the following:

- Household size: As household size increased, enrolment in a CCF diminished. [$r = -.085$; $p < 0.05$]
- Biological children living in the household: As the number of children increased, enrolment in a CCF decreased. [$r = -.110$; $p < 0.01$]
- Education levels of the caregiver: The higher the level of education of the caregiver, the greater the child’s enrolment in a CCF was. [$r = .122$, $p < 0.01$]
- Living standards: The higher the standard of living, the greater the enrolment in a CCF was. [$r = .72$; $p < 0.05$]

Children’s enrolment in school at the ages of 6-7

Table 23: Child’s enrolment in a school

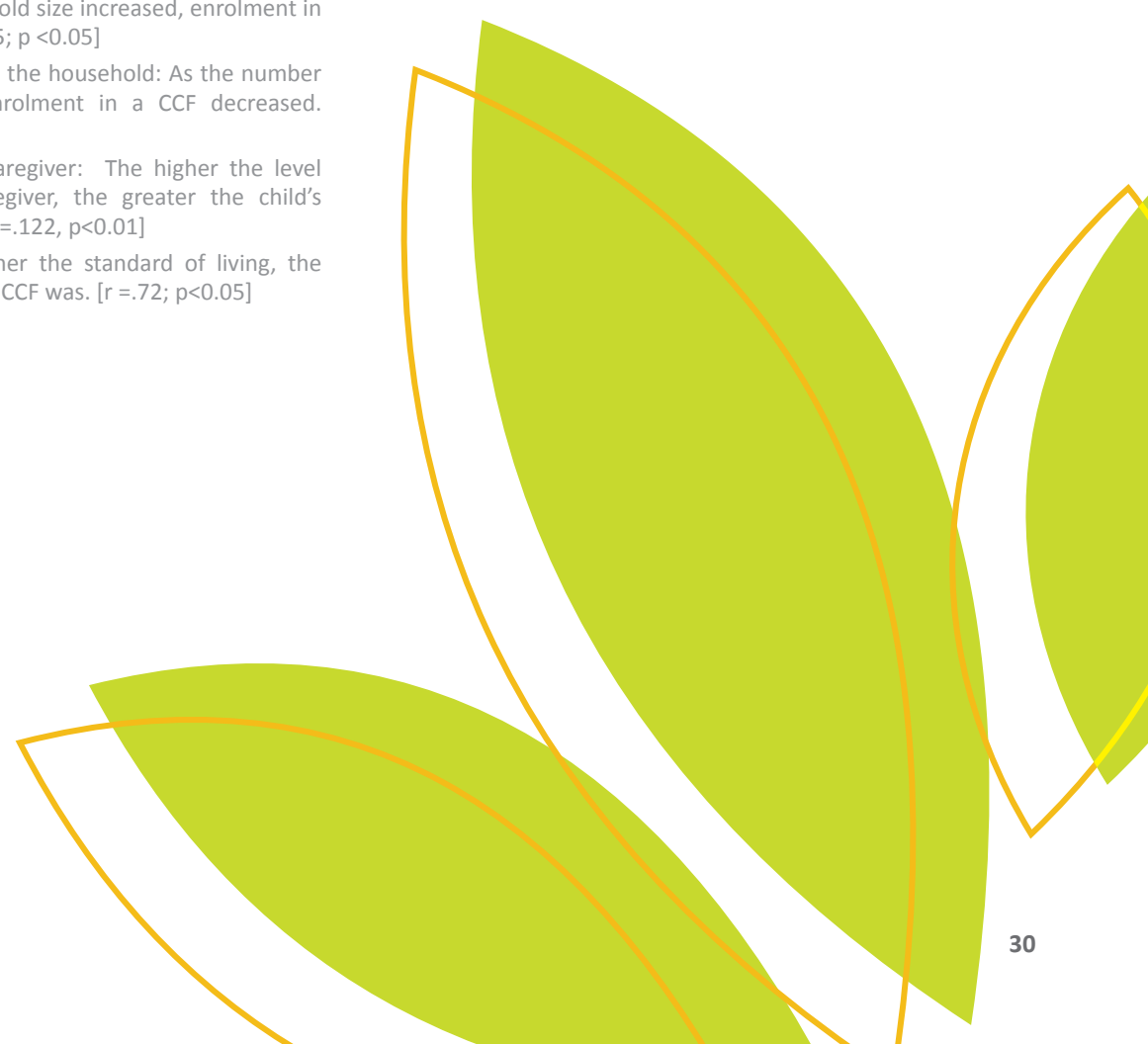
Does the child have enrolment in a school? Ages 6-7	Frequency	Valid Percentage
No enrolment in school	56	8
Enrolment in school	653	92
Total	709	100

Overall, 92% of children aged 6-7, were enrolled in a school.

As the vast majority of children aged 6-7 years were enrolled in a school irrespective of their geo-type, there was little benefit in cross-tabulating this data by other variables, as the information yielded would not be meaningful. Additionally, an examination of possible correlations between those children who were not enrolled in school with other variables was also not significant, as the number of cases where this applied (56) was too small to meaningfully disaggregate the variables.

Section summary: enrolment in a school (ages 6-7)

Overall, 92% of children aged 6-7 years were enrolled in a school. Children who came from rural areas were just as likely to be enrolled in an educational facility as those who came from an urban area. There was also little difference in relation to a child’s enrolment in school and the education level of the caregiver.



Health outcomes

Perceived health status of the child

Table 24: Perception of child's health by geo-type

Geo-Type	Poor	Fair	Good	Very Good	Excellent
Rural formal	3%	3%	19%	24%	51%
Tribal authority areas	1%	4%	19%	37%	39%
Urban formal	2%	4%	20%	29%	45%
Urban informal	3%	4%	22%	29%	42%
Total	2%	4%	20%	33%	42%

- People in rural formal areas were marginally more likely than those from other geo-areas to rate the health of children as being 'excellent', while those from TAAs were the group least likely to ascribe this rating to children in their care.
- Overall however, 75% of respondents rated the health of children in their care as being 'very good' or 'excellent' [$\chi^2(15; N=3132)=44.09$; $p<0.000$].

Table 25: Perception of the child's health by mental well-being of caregiver

Caregiver mental health	Poor	Fair	Good	Very good	Excellent	Total
No depression	56%	53%	69%	65%	72%	68%
Depression	44%	47%	31%	35%	28%	32%
Total	100%	100%	100%	100%	100%	100%

- Caregivers who were classified as 'not depressed' based on their responses to the CES-D10, were more likely to view the health of the child in a favourable light. Conversely, caregivers who were classified as depressed were more likely to view children's health poorly [$\chi^2(5; N=2925)=26.27$; $p<0.000$].

Table 26: Perceived health of child by level of community social organisation

Level of community social organisation	Perceived health status of child					Total
	Poor	Fair	Good	Very Good	Excellent	
Low	2%	4%	14%	33%	48%	100%
Medium	2%	3%	21%	34%	40%	100%
High	2%	6%	22%	30%	41%	100%
Total	2%	4%	20%	33%	42%	100%

- There was very little differentiation between the levels of community social organisation and their relationship to the perceived health status of the child [$\chi^2(10; N=3132)=36.97$; $p<0.000$].

Section summary: perceived health status of all children

Overall, two-thirds of children were reported to have ‘very good - excellent’ health.

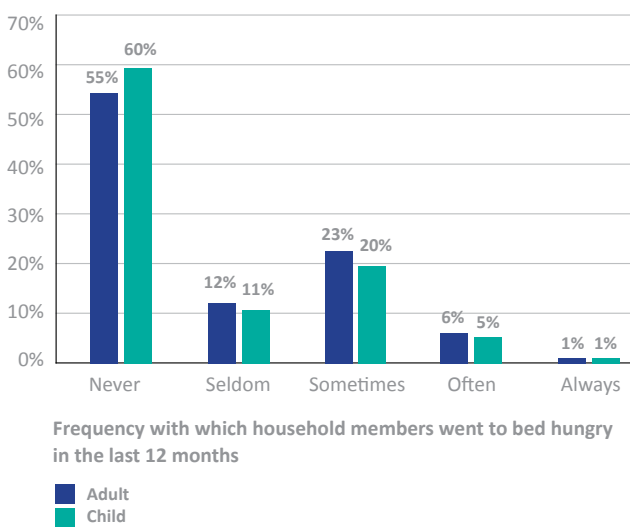
There were statistically significant relationships between the caregiver’s perception of the child and the following:

- Mental health of caregiver: The less depressed the caregivers, the more likely they were to view the health of the child in their care as favourable.
- Respondent’s perception of their own health: The more favourably the caregiver viewed their own health, the more likely they were to view the child’s health favourably.
- Life stress: Fewer life stresses for households in which children resided resulted in a more positive outlook on the child’s health.

Food security of the household

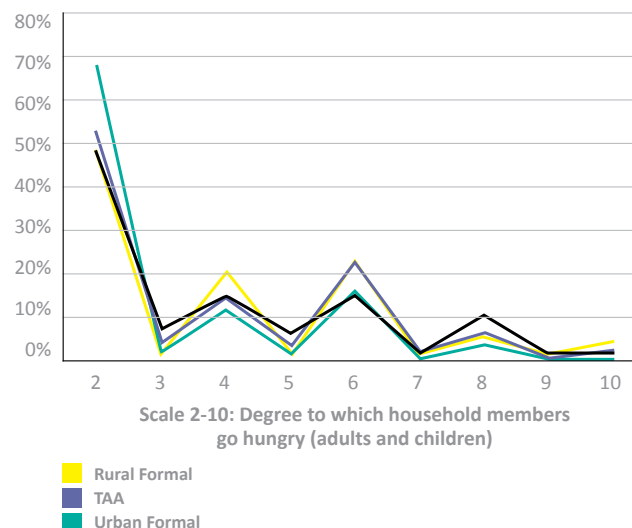
Households with children were asked to identify how often, in the last 12 months, any adult or any child went to bed hungry because there was not enough food. The results of this analysis are reflected in the chart below.

Figure 7: Frequency with which a household member went hungry in last 12 months



- In 55% and 60% of cases respectively, respondents said that an adult or child had never gone hungry due to a lack of food. Conversely, this means that in 40-45% of cases, household members had experienced hunger to some degree.
- Nearly 25% of adults, and 20% of children had ‘sometimes’ gone to bed hungry, while in 1% of cases, an adult or child had always gone to bed hungry as a result of there being insufficient food.

Figure 8: Degree to which household members go hungry



- By ascribing numerical values to responses given, it is possible to calculate a total score to determine the degree to which people went hungry in the last 12 months. With a value of 1 for ‘Never’, and 5 for ‘Always’, the combined scores for adults and children were calculated, to give a total score out of 10.
- Sixty-seven percent of those residing in urban formal areas, attained a composite score of 2, reflecting that they were the group least likely to experience hunger or food deprivation [$\chi^2(24; N=3118)=142.5$; $p<0.000$].
- Overall, there were only marginal differences in the total scores across the geo-types.

Table 27: Average hunger score by geo-type

Household hunger in last 12 months (adult-child score combined mean) (scale 2-10)		
Rural formal	Mean	3.90
Tribal authority areas	Mean	3.72
Urban formal	Mean	3.11
Urban informal	Mean	3.80

- The Table above reflects the average scores for each geo-type. Households in urban formal areas were marginally less likely to have experienced hunger in the last 12 months than those from other areas.

Table 28: Rating of household food consumption over the past month

	Less than adequate for household's needs	Just adequate for household's needs	More than adequate for household's needs	Total
Rural formal	47%	43%	10%	100%
Tribal authority areas	52%	37%	10%	100%
Urban formal	39%	52%	9%	100%
Urban informal	43%	43%	13%	100%
Total	47%	42%	10%	100%

- Nearly half the households with CSG children indicated that food consumption for the household in the last month had been 'less than adequate'. This was marginally more likely to be the case for those living in TAAs, and least likely to be for those from urban formal areas.
- Overall, 40% of households indicated that food consumption over the past month had been 'just adequate', while only 10% of households indicated that food consumption over the last month had been 'more than adequate' [$\chi^2(9; N=3132)=72.90$; $p<0.000$].

Section summary: food security

In 40-45% of cases, children or adults had experienced hunger to some degree or another. Additionally, nearly 50% of households reported that the food consumption had been less than adequate; indicating that food supply in 47% of households was scarce. While households in rural areas were slightly more likely to experience hunger or food deprivation than those in urban centres, overall, there were no major differences across the geo-types.

According to Hall and Sambu (2015), 2.5 million children (14%) lived in households where child hunger was reported in 2013. Child hunger in this instance is based on households where the child was reported to go hungry "sometimes", "often" or "always" because of a lack of food. While their data is reflective of children aged 0-17, their data suggests that there are no major differences in reported child hunger across the different age groups. Their analysis also did not take account of the presence or absence of the CSG. About 800,000 children younger than five years are reported to have experienced child hunger with dire consequences for children exposed to prolonged periods of lack of food (Hall & Sambu, 2015). Inadequate food intake compromises children's growth, health and development. It is also known to increase their risk of infection, and contributes to malnutrition and stunting (or low height for age) which affects 25% of children younger than five in South Africa (Hall & Sambu, 2015).

Given this scenario, it is unsurprising that the NIDS data indicated a higher degree of child (and adult) hunger, as the vast majority of households in this study were from the poorer strata of society.

Number of visits to a health practitioner

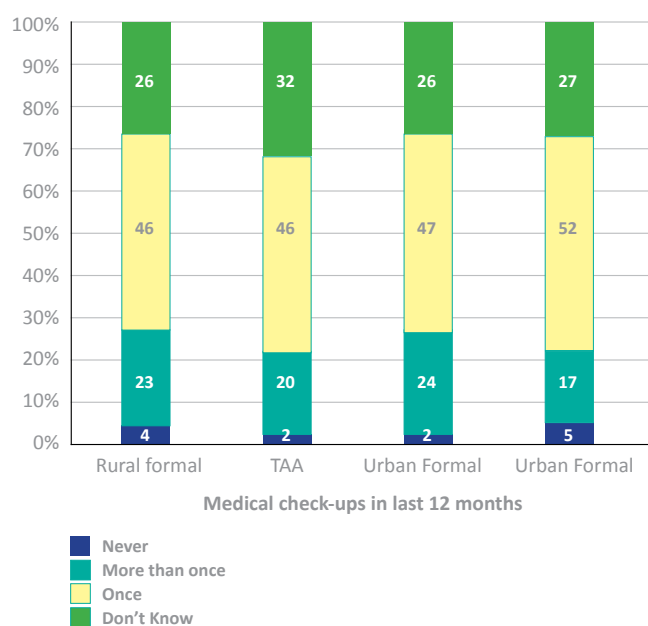
Caregivers in the NIDS survey were asked to identify how many times, in the last year, their child had been to a medical facility for a routine check-up. Because it is only a requirement that children aged three years and younger attend routine check-ups (for the purposes of weight/ height determination and vaccinations), this section will explore data related only to those who fall within this age bracket.

Table 29: Number of consultations in last year when child was not ill (Children three years old or younger)

	Frequency	Percentage
Don't Know	35	2
Once	306	21
More than once	691	47
Never	432	29
Total	1472	100

Overall, 29% of children had not visited a health care professional in the last 12 months; 20% had been once, and nearly 50% had been more than once.

Figure 9: Number of routine medical check-ups in last 12 months by geo-type (Children three years old or younger)



- Analysed in relation to geo-type, there was little to differentiate between the frequency of visits to a health care practitioner and the regional areas people came from.

Section summary: number of visits to a health practitioner (three years or younger)

A third of children had not been for a routine medical check-up in the last year, while 47% had been more than once. There was little to differentiate between the frequency of visits and the different geo-types. There were statistically significant relationships between the number of visits to a health care practitioner and the following:

- Perception of the child's health: Not surprisingly, those who perceived their child's health to be poor were more likely to take them for a routine check-up, than those who perceived the child's health to be good.
- There was also a weak relationship between the perception the caregivers had of their own health and the number of visits to a clinic or doctor. Children were slightly more likely to be taken to a doctor if their caregiver's perception of their own health was poor.

Anthropometric measurements of the child

During the NIDS data collection, anthropometric measurements of children were recorded. Children's height and weight were assessed according to the weight for their height, the weight for their age and height for their age for children younger than five years. In addition, the weight and height measures were applicable in the assessment of BMI for children aged 5-7 years.

Weight for height: Children younger than five years

Weight for height is a measurement to determine wasting. Wasting in children is a symptom of acute undernutrition, usually due to insufficient food intake, or sometimes the presence of infectious diseases, especially diarrhoea (WHO, 2010).

Table 30: Weight for height of children younger than five years

Weight for height category		
	Frequency	Percentage
Severe Wasting	28	2
Moderate Wasting	29	2
Normal	1052	82
Overweight	127	10
Obese	48	4
Total	1284	100

- In 82% of cases in this study, children's weight for height measurements, were deemed 'normal'. For those whose weights were outside of the normal range, (18% of sample, N= 232) children were three times more likely to be overweight, than underweight.
- In comparison, the results of the South African National Health and Nutrition Examination Survey (Shisana et al., 2014) for children in a similar age-group reflect the following: In boys aged 0-3 years, 1.9% experienced severe wasting, while 3.8% experienced wasting. Adjusted data⁶ to reflect the NIDS category of children younger than five years would be 3.2% who experienced wasting, while 1.3% experienced severe wasting. This differs very little to this study's data.

Weight for age: Children younger than five years

Table 31: Weight for age of children younger than five years

Weight for age category		
	Frequency	Percentage
Normal	1278	91%
Moderately underweight	80	6%
Severely underweight	46	3%
Total	1404	100%

- When the children's weight for age was assessed, the overwhelming majority (91%) were considered to be normal. Of those who were outside the normal range, children were twice more likely to be moderately underweight than severely underweight.

⁶ Adjusted scores were calculated by working on the presumption that the distribution across the age group 4-6 was relatively even. In order to compare the SANHANES data to the NIDS data, a comparison of the same age bands was necessary. A recalculation of the 4-6 group was done to show what the percentages would be if the data reflected only 4 year olds (as the NIDS data is concerned with children less than 5). Once this percentage was attained, it was added to the percentages for those in the 0-3 age group to reflect a total score for those boys and girls less than 5. This is done for other anthropometric measurements.

- Comparing again to the SANHANES study's data in adjusted scores, 7.3% of children younger than five were underweight, while 1.8% were severely underweight. Therefore the results in this study using NIDS were slightly lower for those who were underweight, while slightly higher for those who are severely underweight.

Height for age: Children younger than five years

Height for age will determine levels of stunting, which is a consequence of long-term nutritional deprivation rather than acute deprivation, and often results in delayed mental development, poor school performance and reduced cognitive capacity (WHO, 2010).

Table 32: Height for age of children younger than five years

Height for age category		
	Frequency	Percent
Normal	1028	74
Moderate stunting	236	17
Severe stunting	126	9
Total	1390	100

- In 75% of cases, the child's height for their age was considered to be normal. In nearly 20% of cases, the child was considered to have moderate stunting, while 10% of children had severe stunting.
- Again adjusting the SANHANES data for comparative purposes, approximately 30% of children aged younger than five are stunted, and 10% are severely stunted. This is significantly higher than the 'moderate stunting' figure of 17% in NIDS data analysed for this study, but very much in line with the 9% of the NIDS children who were afflicted with severe stunting.

Body Mass Index: Children aged 5-7

Table 33: Body Mass Index for children aged 5-7 years

Body Mass Index		
	Frequency	Percentage
Severe thinness	13	2
Thinness	22	3
Normal	499	78
Overweight	66	10
Obese	42	7
Total	642	100

- 78% of children had a normal BMI; 10% were considered to be overweight, and 7% obese. For those who fell out of the normal range, children were 3.4 times more likely to be overweight, than underweight.
- In order to compare the findings from this study to the SANHANES study, further adjustments had to be made⁷.

⁷

A reasonable comparison between NIDS and the SANHANES data would have to incorporate the re-calculation of two age categories (2-5; 6-9). This however, would more than likely prove more inaccurate than accurate, so instead, a more prudent approach may be to look at the means for these two groups, and see how they compare to the NIDS data for those aged 5-7 years.





- For the measurement of BMI, the NIDS data in this study focuses on those aged 5-7. In SANHANES, the national average for those aged 6-9 years, who are considered to be underweight or normal, is 88.2%, compared to the NIDS data for 5-7 year olds of 83% (underweight to normal).
- In the SANHANES research, children who are younger (2-5 years), are significantly more likely to be overweight than older children (6-9 years), and slightly more likely to be obese.
- While a direct comparison between SANHANES and the data from this study is not possible, these figures are congruent with each other, implying the findings are similar in the two studies.

Section summary: anthropometric characteristics

The findings showed that in every category - weight for height, weight for age, height for age and BMI - children of younger ages were more susceptible to wasting, severe wasting, stunting or overweight and obesity than older children. This is a critical area in terms of delivering appropriate interventions in the form of feeding schemes and health education.

In 80% of cases, the child's weight based on their height was deemed to be normal. The majority (78%) of children whose weight for height fell outside of the normal range, were overweight. Ninety percent of children were considered to be of normal weight for their age. Of those who were outside the normal range, children were significantly more likely to be underweight than overweight.

In 75% of cases, children were considered to have a normal height for their age. Of those who fell outside of the normal range, children were 1.8 times more likely to have moderate stunting, than severe stunting.

Seventy-eight percent of children had a normal BMI. For those who fell out of the normal range, children were 3.4 times more likely to be overweight, than underweight.

Findings of the path model

Path Models: Household and Caregiver Factors in Relation to Child Well-Being Outcomes

The path analysis identified various predictors that were associated with child health outcomes. Predictors included child food security, caregiver characteristics (i.e., age, education, health and depression), family structure (i.e., two-parent households, relatives in household, number of residents in household), household income, child educational enrolment, and living standards. Two models were run to examine the influence of these predictors on: 1) perceived child health and 2) height and weight for age. In both models we examined if child food security mediated the relationship between our predictor variables and child outcomes. The proposed model is shown in Figure 1 below.

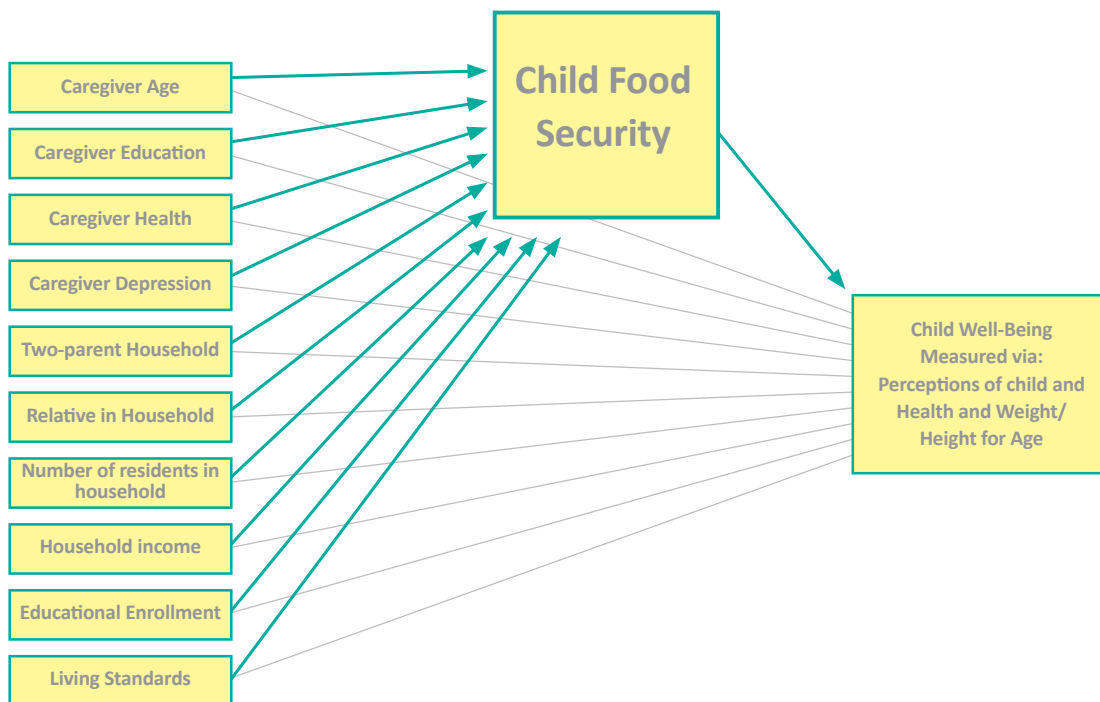


Figure 10. Path model testing the relation between caregiver and household predictors and child well-being, as mediated by child food security. This model was run twice: once with perceived child health as the outcome, and second with child height and weight for age as the outcomes.

Multiple group models were first run to examine if these path models could be held equal across urban and rural geo-types. To test this, a constrained model was tested where all pathways were constrained to be equal across urban and rural geo-types. This model was compared to an unconstrained model where pathways were allowed to vary across geo-types. In the model examining perceived child health as the outcome, the unconstrained model was favored, as the constrained model showed a decrease in model fit ($\Delta\chi^2 = 65.34$, $\Delta CFI = .07$, $\Delta RMSEA = .04$). In the model examining height and weight for age as outcomes, the unconstrained model was favored again, as the constrained model showed a decrease in model fit ($\Delta\chi^2 = 48.29$, $\Delta CFI = .02$, $\Delta RMSEA = .02$). Both comparisons of model fit indicated that there were significant differences in the pathways by geo-type for both child health outcomes. Thus, separate models were tested for urban and rural geo-types.

Perceived child health within a rural geo-type. In the first set of models, examining caregiver perceptions of child health, several variables were positively associated with this outcome for households in a rural geo-type. These variables included: food security ($\beta = .12$, $p < .001$), caregiver age ($\beta = .13$, $p < .001$), 2-parent households ($\beta = .06$, $p < .01$), and perceptions of caregiver health ($\beta = .39$, $p < .001$). Other variables showed a negative association with perceptions of child health, including caregiver education level ($\beta = -.08$, $p < .01$), educational enrolment ($\beta = -.05$, $p < .05$), and household income ($\beta = -.11$, $p < .001$).

In examination of indirect effects within the rural geo-type model, having a relative in the household ($\beta = .01$ [.01, .02]), having higher living standards ($\beta = .01$ [.01, .02]), and having better perceptions of caregiver health ($\beta = .01$ [.01, .02]), were all associated with better perceptions of child health, via higher levels of food security. However, having more individuals residing in a household was negatively associated with perceptions of child health, via having lower levels of food security ($\beta = -.02$ [-.03, -.01]). For all pathways, please see Table 34.

Perceived child health within an urban geo-type. In the model examining caregiver perceptions of child health, a few variables were positively associated with perceived child health for households in an urban geo-type, including food security ($\beta = .07, p < .05$), caregiver age ($\beta = .08, p < .01$), number of residents in the household ($\beta = .07, p < .05$), and perceptions of caregiver health ($\beta = .33, p < .001$). Other variables showed a negative association with perceptions of child health, including caregiver education ($\beta = -.10, p < .01$) and caregiver depression ($\beta = -.12, p < .001$).

In examination of indirect effects within the urban geo-type model, household income ($\beta = .01 [.01, .03]$), was associated with better perceptions of child health, via higher levels of food security. However, having more individuals residing in a household was negatively associated with perceptions of child health, via having lower levels of food security ($\beta = -.02 [-.03, -.01]$). For all pathways, see Table 34.

Table 34. Relations between caregiver and household predictors and perceived child health, with indirect effects via child food security.

Model 1: Perceived Child Health			
Geo-Type: Rural	Variable	Beta (Standardized)	p
	Child Food Security	0.12**	<0.001
	Caregiver Age	0.13**	<0.001
	Caregiver Education	-0.08**	0.01
	Caregiver Health	0.39**	<0.001
	Caregiver Depression	-0.01	0.72
	Two-parent Household	0.06**	.01
	Relative in Household	-0.01	0.93
	Number of Residents in Household	0.01	0.56
	Household Income	-0.11**	<0.001
	Educational Enrolment	-0.05*	0.03
	Living Standards	0.03	0.14
	Significant Indirect Effects	Beta (Standardized)	95% CI
	Caregiver Health -> Food Security -> Perceived Child Health	0.01*	.01, .02
	Relative in Household -> Food Security -> Perceived Child Health	0.01*	.01, .02
	Number of Residents in Household -> Food Security -> Perceived Child Health	-0.02*	-.03, -.01
	Living Standards -> Food Security -> Perceived Child Health	0.01*	.01, .02
Geo-Type: Urban	Variable	Beta (Standardized)	p
	Child Food Security	0.07*	0.04
	Caregiver Age	0.08*	0.02
	Caregiver Education	-0.10**	0.01
	Caregiver Health	0.33**	<0.001
	Caregiver Depression	-0.12**	<0.001
	2-Parent Household	0.04	0.26
	Relative in Household	-0.02	0.57
	Number of Residents in Household	.07*	0.02
	Household Income	0.04	0.24
	Educational Enrolment	-0.04	0.17
	Living Standards	0.01	0.87
	Significant Indirect Effects	Beta (Standardized)	95% CI
	Caregiver Depression -> Food Security -> Perceived Child Health	-0.01*	-.02, -.01
	Household Income -> Food Security -> Perceived Child Health	0.01*	.01, .03

Note. CI = Confidence Interval.

* $p < .05$; ** $p < .01$

Height and weight for age within a rural geo-type. In the second set of models, examining child height and weight for age, several variables were associated with these outcomes in a rural geo-type. Food security was positively associated with both weight for age ($\beta = .10, p < .001$) and height for age ($\beta = .06, p < .01$). Caregiver age ($\beta = .09, p < .01$) and caregiver education ($\beta = .06, p < .05$) were positively associated with height for age, while number of residents in household was negatively associated with height for age ($\beta = -.05, p < .05$).

In examination of indirect effects within the rural geo-type model, household income ($\beta = .01 [.01, .02]$), living standards ($\beta = .01 [.01, .02]$), and perceptions of caregiver health ($\beta = .01 [.01, .02]$) were all positively associated with child height

and weight for age via higher levels of food security. Number of residents in household ($\beta = -.01 [-.02, -.01]$) was negatively associated with both height and weight for age via lower levels of food security. Educational enrolment ($\beta = -.01 [-.02, -.01]$) was negatively associated with weight for age via lower levels of food security. For all pathways, see Table 35.

Height and weight for age within an urban geo-type. Finally, in examination of height and weight for age within an urban geo-type, there was only one direct relation between living standards and height for age ($\beta = -.09, p < .05$). There were no other direct relations or indirect relations. For all pathways, see Table 35.

Table 35. Relations between caregiver and household predictors and child weight/height for age, with indirect effects via child food security.

Model 2: Child Weight and Height for Age					
Geo-Type: Rural	Variable	Weight for Age		Height for Age	
		Beta (Standardized)	p	Beta (Standardized)	p
	Child Food Security	0.10*	<0.001	0.06**	0.01
	Caregiver Age	0.03	0.43	0.09**	0.01
	Caregiver Education	0.05	0.10	0.06*	0.04
	Caregiver Health	-0.04	0.13	0.01	0.97
	Caregiver Depression	-0.04	0.11	-0.03	0.20
	2-Parent Household	-0.03	0.26	-0.02	0.56
	Relative in Household	-0.02	0.57	-0.04	0.17
	Number of Residents in Household	-0.05	0.06	-0.05*	0.03
	Household Income	0.04	0.13	-0.01	0.85
	Educational Enrolment	0.01	0.96	-0.01	0.65
	Living Standards	-0.03	0.22	-0.02	0.53
	Significant Indirect Effects	Beta (Standardized)	95% CI	Beta (Standardized)	95% CI
	Caregiver Health → Food Security → W/H for Age	0.01*	.01, .02	0.01*	.01, .02
	Number of Residents in Household → Food Security → W/H for Age	-0.01*	-.02, -.01	-0.01*	-.02, -.01
	Household Income → Food Security → W/H for Age	0.01*	.01, .02	0.01*	.01, .02
	Educational Enrolment → Food Security → W/H for Age	-0.01*	-.02, -.01	--	--
	Living Standards → Food Security → W/H for Age	0.01*	.01, .02	0.01*	.01, .02
Geo-Type: Urban	Variable	Weight for Age		Height for Age	
		Beta (Standardized)	p	Beta (Standardized)	p
	Child Food Security	-0.03	0.52	0.02	0.68
	Caregiver Age	0.02	0.64	0.02	0.58
	Caregiver Education	0.07	0.07	0.06	0.15
	Caregiver Health	-0.01	0.95	-0.03	0.48
	Caregiver Depression	0.07	0.13	-0.08	0.07
	2-Parent Household	0.01	0.93	-0.02	0.60
	Relative in Household	0.06	0.16	0.02	0.65
	Number of Residents in Household	-0.08	0.08	-0.06	0.10
	Household Income	0.07	0.10	0.03	0.48
	Educational Enrolment	-0.03	0.48	0.04	0.27
	Living Standards	-0.06	0.13	-0.09*	0.04

Note. CI = Confidence Interval. W/H for Age = Weight and Height for Age

* $p < .05$; ** $p < .01$

Summary and discussion of findings

The CSG children described in this study were, for the most part, healthy. This was reflected in the anthropometric measurements of the children, where the vast majority (75% and upwards), fell within the normal range in terms of their physical development. This is in itself an important strength to build on and remember, even if nutrition interventions must be urgently prioritised in order to address the quarter of children under 5 years who are stunted and severely stunted.

The generally healthy status of CSG children was borne out by the perception the caregivers had of the child. Two thirds of caregivers viewed the health of the children they cared for to be 'very good – excellent'. Caregivers who perceived their own health to be good, were more likely to view children's health favourably. Similarly, the less depressed the caregivers were the more positive they were about the health of the child. In some instances, emotional well-being of the caregivers was related to their economic circumstances and educational levels. Those with higher education levels, or greater household income, were more likely to have lower depression scores than less educated or poorer caregivers.

The education of the caregiver played a role in a child's enrolment in a CCF. Children who were slightly older (aged 6-7 years) were significantly more likely to have been enrolled in a school than younger children were to have been enrolled in a CCF. Lack of enrolment in a CCF was particularly acute in rural areas, where the poorest households (measured in per capita income) were the least educated and living in larger households.

In rural formal areas, where 70% of children aged 3-5 years were not enrolled in a CCF, in 82% of cases, there was the support of relatives for childcaring purposes. However, this only applied to three quarters of the households in the TAAs. In a quarter of the cases where the child was not enrolled in a CCF, the primary caregivers did not have family support with childcare. This means that these children are at greater risk of compromised well-being.

A quarter of the children were living in nuclear families where the mother and father were present, but the most common family structure was made up of single parents and children (45%) of which single parent families with relatives were the most common family form of CSG beneficiaries. There was also no relationship between family structure and child well-being outcomes in the NIDS analysis. This finding is contrary to Tippoo's (2012) finding that children with both biological parents had better well-being outcomes than those who did not; even when income, race and geography were accounted for. These studies are not comparable as different national data sets were used, and different domains of well-being, age groups and income groups were studied.

Almost one in three children is not living with parents which informed the design of the CSG in 1998. This trend is continuing due to migration of parents, orphan-hood caused by the HIV and AIDS epidemic and social and family practices and dynamics that still remain poorly understood. The absence of parents is indicative of the fragmentation of families in

South Africa suggesting strong continuities with the past and continuing into the present.

A distinguishing feature of the family structure of CSG beneficiaries is that in 74% of cases relatives were present in the household. This is in keeping with population projections for 2001-2021 that suggests that households are being reconfigured and are likely to include more relatives than previously (Bureau of Market Research, 2007). This could also be due to the need to share resources and care responsibilities (Patel, 2009). While this may be interpreted as a positive development, it could also be a drain on household resources and impact food security negatively. Further analysis is needed to explore the implications of this changing trend on child well-being.

Fathers were significantly more likely to not live with the child than mothers, and significantly more likely to see the child with less frequency. In only 40% of cases where the father was absent, did he provide some financial support; which is in contrast to 50% of cases in which the mother was absent. Consequently, extended families carry the burden of economic, social and emotional support for one in three children or 30% of children in South Africa. Despite the burden of direct caregiving by extended families, in 77% of cases, caregivers indicated that they had additional support from family members for the care of the child. Family obligations to support caregiving are highly valued by family members despite the weight of caregiving that poor families have to bear.

In terms of income, overall, 63% of households had either below, or much below average household incomes. Urban households were better off than their rural counterparts. Regarding per capita income, urban areas had a greater mean per capita income than their rural counterparts.

Community affiliation was not especially high overall. While it was highest in urban informal areas, these communities were also the most likely to have felt unsupported by neighbours. While residents from rural formal areas were more likely than others to say they felt safe in their community, they were also the least likely to be affiliated to a community group.

Some of the data which resulted from the NIDS analysis must be viewed with caution. The limited number of indicators used, and the rigidity of the research instrument, means that the outcomes do not readily lend themselves to the provision of a more comprehensive understanding. Many of the correlations too, while indicative of relationships between certain variables, are for the most part, weak.

What the NIDS analysis does highlight however, and what can be considered rigorous, is that younger CSG children, and particularly those from rural areas, are the group most at risk. Younger children are also at greater risk health-wise, as borne out by the NIDS anthropometric data, as well as the SANHANES national data. CSG children's risks should be understood within the wider societal context of income shortages, migration, the HIV and AIDS epidemic and the fragmentation of families marked by the significant absence of fathers in children's lives. Individual characteristics of the caregiver were also relevant to child well-being such as lower levels of educational attainment of caregivers, the age of the caregiver and the mental health of the caregiver. Poverty and lack of employment of household members and poor living standards were also associated



with lower levels of well-being. But these factors appear to be moderated by social support from extended family members and the high value placed on kinship support despite the burden of care that they have to bear. This needs further exploration.

The findings of the path model shows the following significant relationship between the variables: first; having a relative in a household, having higher living standards and having caregivers who perceived themselves to be healthy, were associated with less food insecurity. Larger households in rural areas were associated with child food insecurity and with a caregiver being less likely to perceive the child to be healthy. Food security explains why these predictors were associated with the perception of improved health of a child. Second; regarding the outcomes measures for weight and height for age in rural areas, we found that having higher income, higher living standards and higher caregiver perceptions of their own health, were positively associated with higher weight for age of the children in their care. On the other hand, if there were more individuals in the household, this too was associated with more child food insecurity and this in turn was associated with lower weight and height for age. Third, in urban areas, caregiver depression was associated with greater child food insecurity, which in turn was associated with lower perceptions of child health. Regarding weight and height for age, no mediations or indirect effects were observed although several of the predictor variables were associated with food (in) security.



Part 2: Qualitative findings

2A: Focus group findings: family functioning, relations and services

This section reports on the qualitative findings from six focus groups run in two different research sites. We report on the perspectives of CSG caregivers of their own caregiving, the way their families function, family beliefs, intra-family and community relations, and services. As these findings draw from the six qualitative focus groups, they are not representative of all caregivers receiving the CSG, but they indicate some trends that can assist us in understanding families and caregiving in South Africa.

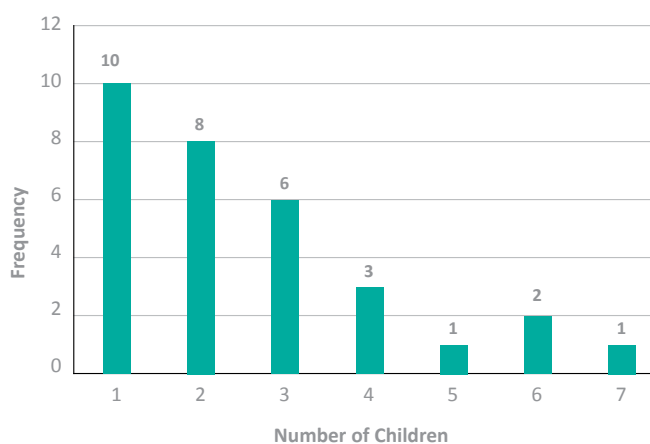
Demographics

Of the 40 caregivers in the research, only one was male. This is not surprising given South Africa's strongly gendered division of care, where women are expected to be the primary caregivers for children.

Caregivers ranged in age from 20 to 67 years, with the average age being 38 years, although there was some missing data. Caregivers were older in Moutse, while Doornkop caregivers were slightly younger. It is common in South Africa that older female relatives (usually maternal grandmothers) care for children in rural areas, while their biological parents look for work in urban areas (Budlender & Lund, 2011).

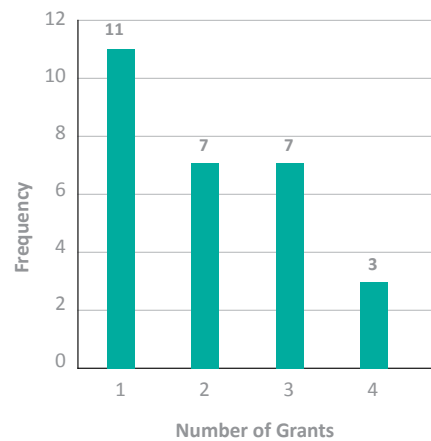
The figure below outlines the number of children each caregiver looked after. Missing data for some caregivers means the total number is 31. The majority (24) caregivers looked after between one and three children (with one child being most common). At the higher end, only three cared for between six and seven children each. CSG caregivers nationally get on average between 1 and 2 CSGs (SASSA, 2017), although caregivers commonly look after more children than this who may not be getting a CSG. Caregivers look after both their own biological children as well as those who are not biologically theirs, although they may be kin (Makiwane, Khalema & Nduna, 2016).

Figure 11: Number of children for each caregiver



The number of CSGs each caregiver received was modest, in line with national statistics which show caregivers on average receive two grants each (SASSA, 2017). In the figure below (n = 28 due to missing data) it is clear that many caregivers receive between one and two grants (18), with only three caregivers each receiving four grants, which is the maximum in this sample. The law allows the receipt of up to six CSGs per caregiver (www.sassa.gov.za).

Figure 12: Number of grants for each caregiver



Family functioning

We now turn to the results that relate to the internal functioning of families in the home. The focus is on processes related to giving care to children, including care responsibilities, communication, monitoring and supervision of children, discipline practices, and family beliefs.

Caregiving and schooling

Participants talked about their caring responsibilities in the home. They perceived caring to be comprised of both physical and emotional caring. They explained that physical caregiving activities included ensuring the safety of children and being able to provide for one's child.

In response to the question: *How do you show your children that you care about them?* participants mentioned a few different aspects to emotional caregiving, including being able to recognise a child's feelings, speaking to the child about school, and expressing their love towards their child verbally. Participants articulated that expressions of love towards children range from simply telling the child that the caregiver loves them to reading a book or doing an activity together.

It seems that in many cases, the emotional bond and activities the caregiver and child share are significant. One participant explained that being able to recognise the child's emotions, even without verbal expression, is important. Not only is this an indication of sensitivity in her caregiving, but also indicates a capacity to communicate effectively with her child. This also contributes towards strengthening the emotional bond between the caregiver and child:

"When I see a sad face I start to ask, "My child, what's wrong?" Maybe he will tell me that someone has beaten him, or some friends ill-treated him".

One participant mentioned a concern that well-off caregivers face far less than those struggling:

“Sometimes they will complain that we don’t love them if we don’t buy what they want but we explain to them that not buying doesn’t mean we don’t love them”.

This comment raises the difficult position in which poverty puts caregivers, who cannot provide what they or their children want them to provide in relation to material goods, and how this is a difficult issue to navigate with their children. This is an experience to which the other participants related strongly.

Participants indicated that their involvement in their child’s education was expressed through regular contact with the children’s teachers, or via letters or calls if there is a problem with the child. The participants also explained that spending time with the child and doing homework activities was important as well as keeping a check on the work that was being done at school and simply finding out about the child’s day at school. Not all of them felt able to help with homework though, and some found interaction with the school difficult.

Communication

The majority of participants recognised that it is important to communicate with family members and to keep communication lines within the family open. Participants explained that through communication, children are able to share their personal troubles and challenges with their caregiver; conflict in the family is addressed; children can be motivated to try and succeed; and families are able to provide support for each other.

As an example, one participant believes that explaining her financial circumstances to her child and also being open about the lack of support from the child’s father helps the child accept their difficult financial position.

“I sometimes do it because my child is too demanding. So, sometimes when he demands this and that I tell his father who will promise to provide on a particular date but fails to do so. Sometimes there is a school trip and I don’t have money to pay for him so I will inform the father and when he doesn’t give the money the child will want to know the problem and that is when I will explain. Sometimes if I say I don’t have money the child will remind me that he gets the child support grant, surprising me as to where he got the information and also not knowing that the little grant we get for him is used for other household needs. So I will explain that, [and also explain] the father made an empty promise”.

By communicating the dire financial circumstances, what she spends the CSG money on, and the lack of support from the father, the caregiver does help the child understand. The communication raises the issue of family dynamics and the relationship between parents, which can be strained or hostile.

Communication as a way to address conflict within the family was also highlighted. It was suggested that when dealing with conflict, one could talk directly to the family member concerned to try and come to a common understanding. If this is not possible, one participant commented:

“even if she is scared she can talk to the father of the kids that you know what, I have a problem with your mother ... can you try and talk to her about this and that we can help each other”.

Thus approaching someone within the household to assist with mediation of the issue or conflict also contributes towards open communication and problems being discussed in the family.

Participants explained that where there is conflict, it is important to have good communication, for example, communication between husband and wife. In two of the focus groups, tensions between extended family members were discussed, and group members felt that it was best to address this by discussing the problem between the husband and wife, and only then take the issue to the extended family members in the household. However, they also discussed how when a woman marries into a family, she would need to adopt the new family’s beliefs and follow those. However one participant explained that in some instances family dynamics can be difficult to adjust to:

“they will forget that your family was responsible for your upbringing, isn’t it all of us were raised/brought up at home, she will forget that you were also raised up by your own family”.

Communication within a family also assists in keeping children engaged in the family, gives them support, and keeps them motivated in relation to achieving goals. One participant explained:

“We are five [at home]. My one child is 17 like yesterday he told me something that scared me. [He said] that he is thinking of dropping school. He said he wants a job and I told him you are not working and you are not educated, you see, and how will you get that job. He said maybe he can use planks to do beds and sell he will get something. So that’s what we were talking about yesterday and I said that you cannot drop school, my child, as long the government is giving you [the CSG] we will make a plan. And he said, but mom my friends laugh at me that I stay in a squatter camp. You see things like that are the things we were talking about yesterday. So we ended up talking about that at home ... he ended up understanding because I told him go to school my child because education will open up jobs for you”.

Besides communication being used as a tool to keep children motivated, this also reveals the importance this mother places on education as a way to open up doors to be able to move out of poverty. Thus communication is used as a tool to keep children motivated and to keep their dreams of the future alive.

Monitoring and supervision of children

Participants explained that safety of children meant keeping watch over them and not allowing children to stray from your watch. It was highlighted that younger children needed more attention than older children. One participant explained that when looking after her child:

“I lock the burglar [security gate] and I do not care how the house will be dirty as long as my child will be safe and I will be able to watch whatever thing that she will [be] doing during that time”.

Participants were concerned about the safety of children on the streets when unmonitored. Their socio-economic and housing circumstances made monitoring children more difficult, as one caregiver explained:

"It's difficult to monitor a child if there is no dura hall [lock for the door] and/ or a key at the gate. The kids just leave and you will look for them and it's not a playing issue. So a child who is at crèche, you can say from 8 until 4 you can know he/she is safe there and they will give him/her food".

Group members also agreed with this participant that being able to send the child to a crèche is one way of ensuring the safety of the child as well as ensuring that the child will be fed, especially when unpredictable earnings mean that there is not always food in the house. These areas are moderately to severely food insecure, as indicated in the descriptions of the research sites.

In addition, there was strong consensus that responsibility for monitoring and supervision of children should lie with the family and the extended family; community members and educators. One participant expressed this view as follows:

"it's not only the family ... that is responsible, everyone in the community who sees a young child must take [responsibility]".

This echoes the idea that 'it takes a village to raise a child' which is a traditional African communal belief that children belong not to individuals, but to a community. This speaks to the sense of social connectedness in the family and the community. The sense of social connectedness in the family also contributes towards children not being isolated within the community (Synergos, 2014). While this is still espoused as a positive African value, the realities of contemporary African life can be very different.

Group members widely acknowledged that, in reality, most of the responsibility lies with the females in the household, as one participant expressed:

"the grandmother plays the mother's role when the mother is not there, since the grandmother has that care, the father does not have it".

This speaks to the gendered dynamic of care responsibilities within families, where it is still assumed that the women in the household should provide care for the children, and men are not trusted to be caregivers. However, there was some discussion about when there is no woman available, male adults should take responsibility for monitoring and supervising children. For example, one participant said:

"he stays there so he must look after the child, because if I go to work I work for all of us at home".

Research worldwide indicates that when women in the household bring in an income, this money is largely spent on household needs, while men are more likely to spend their income on personal needs rather than the household (Alam, 2012).

Participants spoke of barriers towards good monitoring and supervision of children. These include having little or no support from family, living in dangerous or insecure environments, poverty that prevents purchasing locks or gates, educators that do not pay full attention to children, and relying on the elderly who might not be physically capable of looking after children.

Discipline of children

The issue of discipline was a source of intense conversation in all of the groups. Corporal punishment, alternative punitive methods, and setting household rules; were mentioned as means of disciplining children and managing their behaviour. It is important to note that discipline and styles of parenting are imbued in the cultural beliefs and practices of local communities, such as the use of corporal punishment to discipline children.

Many caregivers used corporal punishment, as they indicated this approach was the only effective method of controlling behaviour they had found. In these instances, the caregivers indicated they hit the child either by hand, stick or a belt. One participant explained as follows:

"You need to give a child a hiding so that they can see that this thing is wrong ... You do not beat them anywhere either, you beat them on the bum or you beat them on the hands but you do not hit them hard".

Another caregiver explained this has worked for her in the past:

"When she finishes crèche, she doesn't want to sit down, she wants to be in the streets. I have taught her that when she comes from crèche she dresses, eats and I make her to sit down and if she cries I beat her up and she ended up dropping that habit, now she sits".

While physical punishment was not the majority approach, these comments were not challenged in the group.

In addition, it seems that even in the absence of physical punishment there was often an authoritarian parenting style. In her seminar work on parenting styles, Diana Baumrind (1966) differentiated between authoritarian, permissive and authoritative parenting styles, which is still used to categorise parental behaviour today (see O'Reilly & Peterson, 2014). Authoritarian parenting is strict and rigid, with the expectation that the child will bend to the will of the parent and needs to fit to set standards of behaviour, and will be punished if they do not. They control through power and coercion. Permissive parenting is laissez-faire without consistent boundaries, and in its extreme, is a form of neglect. In contrast, an authoritative style is when parents are consistent, clear and expect their child to behave, but are also loving and responsive to the child's needs. This helps the child develop internal self-discipline without crushing their self-esteem. Positive parenting as an approach attempts to instil skills and behaviours that match authoritative rather than authoritarian parenting.

For example, in this study, there was a concern from some about needing to 'control' children, that they should not be too 'playful', and that this process was a constant struggle. Alternative means of discipline were sometimes also punitive and authoritarian, such as in one case where a caregiver would withhold food if a child misbehaved:

"My grandchild last year she was playful and we threatened her because she plays and she is failing but this year it's better because sometimes we punish her by not giving her food".

However, a number of caregivers explained that they made use of other forms of discipline, more suited to authoritative parenting. These included guiding the child, reprimanding the child, talking and explaining to the child that what they did was wrong and confiscating meaningful things (such as cellphones).

Some participants explained that setting of household rules was another way in which they exercised discipline in the household. The majority of the participants indicated that as the caregivers and the heads of the households, they set the rules within the house. This allows for rules to be followed by everyone, as well as responsibilities being shared and that no particular child is favoured or feels unfairly burdened. One caregiver explained her method as follows:

“Children need to be given a timetable and just say on Monday you do this, Tuesday you do this. [They must all be treated equally] because if you [allow one to do less] they can see that you love this one, and they can ask that why do we do this and this one doesn’t do that which means mom loves her and children can grow [resentful] with it”.

Another caregiver commented that her mother is the authority on household rules, and this works well. She says:

“My mother is the one who set up the rules. She decides who must clean, wash dishes, etc. She tries to give duties according to the children’s abilities”.

Of course, this is not always a simple matter, as one caregiver commented:

“The challenge with my children they do not want to stand up unless I became angry at them and say today you will do dishes and you this. I give them duties that you doing this and that because honestly they drag their feet”.

The above are examples of strategies that are broadly called ‘positive parenting’. Positive parenting is understood as a set of strategies to manage children’s behaviour in constructive and non-damaging ways (Gould & Ward, 2015), such as the examples given in the groups.

Family cohesion and warmth

For participants, the following issues were related to family cohesion and warmth: emotional and practical support, physical or verbal demonstrations of warmth, parental support for school, and family bonding activities, and sadness and loss.

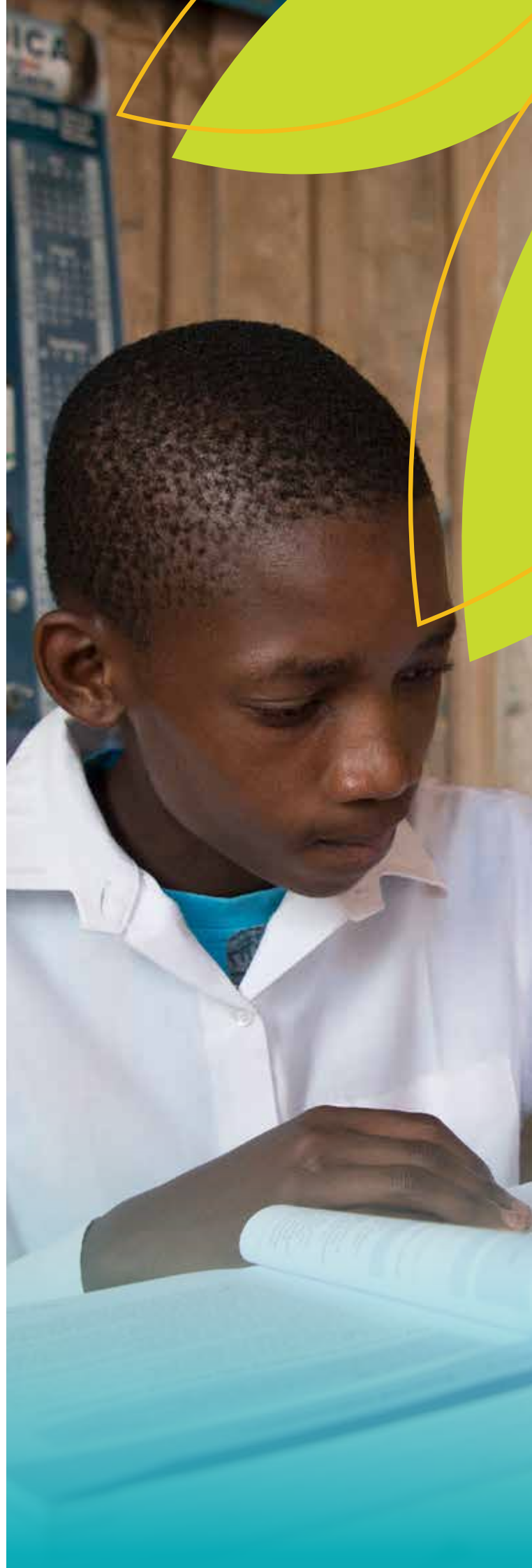
Regarding emotional and practical support, participants explained that they would share their personal achievements with friends and family members. Participants explained that extended family members such as aunts and cousins that do not live within the household also provide a lot of emotional and practical support. This kind of support for some participants even comes in the form of financial assistance from family members. One participant explained that within their family, sticking together was very important, and:

“[As] an inhabitant in the house, so you must participate”.

Practical assistance within the household was perceived as important. One participant explained that:

“if perhaps I am at work and then I come back at 5 ... we should assist each other since you can see that one is not there, let me do this and that so that when she comes back she can do something else”.

It was striking that a number of participants indicated that they experience a lack of emotional and practical support. In these instances, children within the household did not assist the caregiver with household chores, the father figure in the household did not assist and in some cases the extended family did not assist either.





Another aspect of family cohesion and warmth relates to the demonstrations of warmth between caregiver and child. Most of the participants shared that they tell their children directly that they love them. Other participants explained that they demonstrate warmth through reading to their children, giving the children hugs, spending quality time together, watching TV and sharing jokes. Two caregivers expressed this as follows:

“Every day in the morning I wake up and bath them all and prepare food, and sit with all of them, and when they are done eating, I hug them”.

“I do not play with them, [I am too old] (laughing) I hug them when they are coming back from school and they ask me, how are you granny and if they have anything they need from school and if I have money I give them so they can be happy”.

Family bonding activities were highlighted by participants as expressions of family cohesion and warmth. Activities mentioned were: draw, paint, and take walks with the children after attending church. Other activities are reflected in the following comments:

“I play with a ball with them at home”.

“We tell them [stories] about how we grew up and where we are from”.

One participant demonstrated how story-telling, family rituals, and prayer play a part in creating a family unit. This is believed to contribute to strengthening the emotional bond within families and providing emotional support for each other:

“Every day we sit [together] before we go to bed for about an hour or an hour and a half just the three of us. So we pray and we talk about God and we talk a lot about business and about future. What we want to do in future like I will ask the father of my child, what are his plans for the next five years”.

Similarly, a grandmother whose adult daughter is disabled after being hit by a car related how close her family is, and how ordinary activities such as watching TV can be an important family ritual:

“We watch TV and keep her [adult daughter] busy, watch jokes on TV and laugh and talk. She would say may God keep you for my children”.

However, a lot of sadness and loss was also expressed in the groups: caregivers often do not have the skills to manage the emotional needs of the family. One caregiver shared this:

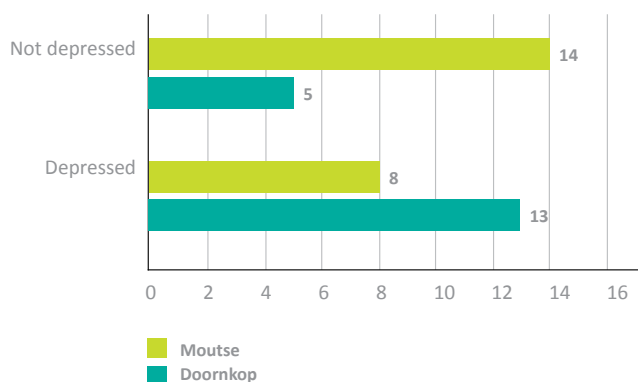
“I am saying it’s heavy for [me]... it is hard for me. ...it’s not like [I can’t] see, even in the morning if she doesn’t want to go to school and you ask what’s wrong? She will say I miss mom [who died]. My God what can I do with this because [I have spoken to her many times to forget], but you can see she will not write well at school because of missing the mother. She is hurting because of the idea that she will not see her again. She can’t remove that out of her head”.

This leads into the results of the depression index findings on caregivers, which were worrying.

Depression Index Findings: CES-D10

The CES-D10 is a 10 question scale, validated for the South African context. It is not a diagnostic tool, but rather indicates where symptoms of depression are high (depression is likely) or low (depression is unlikely). The figure below shows that more than half (13 out of 21) of the caregivers in Doornkop, and five out of 19 caregivers in Moutse had symptoms of depression. Depression scores were therefore higher among participants in urban focus groups. Although such small numbers preclude accurate comparison, the quantitative analysis in part one findings indicated that there was a depression symptom rate of 32% in the sample studied, less than the rate in the Doornkop groups and more than the rate in the Moutse group.

Figure 13: Depression by area



Caregiving while struggling with depression symptoms is particularly difficult, making managing challenges overwhelming (Petersen, 2010). It is particularly hard to care for young children, as they are very dependent on both physical and emotional care from adults. Studies in South Africa have demonstrated a positive association between poverty and depression; with being female an added risk for depression (Ardington & Case, 2010). A previous study in Doornkop found that 43% of female CSG recipients presented with symptoms of depression, higher than the national average of 25% (Moodley, 2012).

SOCIAL AND COMMUNITY ORGANISATION

The themes in this section relate to how the immediate community or social networks are organised and how they function for the benefit (or otherwise) of caregivers. The themes are: social networks and help-seeking, community trusts and safety, living conditions and poverty, service delivery in relation to access and quality.

Social networks and help-seeking beliefs

Caregivers spoke about various social networks that assisted them in times of need and were a source of collective support. Examples of whom they turned to in the family and community included their own mothers, other elders in their family, or church related supports, such as the pastor's wife. It appears that women tend to approach other women for emotional support, rather than men. Some caregivers indicated that their neighbours were important in their social networks. They mentioned that neighbours are of great assistance with parental advice in terms of raising children and looking after them. One of the participants articulated that:

"...If I have problems with my kids I go to my neighbours or street committees because here I do not have close people and my parental home is far and there are no living parent there..."

The support of neighbourhood shows the importance of community cohesion in how it creates a sense of belonging and mutual support. This also suggests that people who have migrated in the hope of securing employment often have to depend on the support of neighbours to take care of their children while they are working.

One of the most frequently mentioned sources of support in both Doornkop and Moutse was church. The caregivers indicated that church fulfils spiritual needs and provides practical guidance for individuals. Furthermore, church is a social structure that brings community members together and provides a sense of belonging. This is demonstrated in the following accounts:

"I do not want to see [my daughter] in the streets. Friday she goes to school and come back and then we go to the church [where it is safe]"

"If I have a problem I sit down with the pastor's wife, [not my] family, no"

"We also talk about life and everything in general. Yesterday we met together after prayer"

However some participants felt that when one experiences a problem, one should not share it with others. For some it is 'just the way things are done', and how they are normalised:

"In our community it is unusual that when one has some problems they will share with the neighbours. If you can do so, your problems will be known by everyone all over the community ... You keep them to yourself"

For some participants the reason for not sharing their problems stems from a fear of what others may think of them, thus being judged. One participant explained that:

"I stay alone, when I am upset, I stay alone ...I do not sit with people that I can speak to, I do not act upon my anger, I have a way of dealing with it better"

Lack of community trust and safety

Although participants from these two communities indicated that there are some strong communal relationships, there were also inconsistencies that were reported. Some participants indicated strong feelings of not belonging in their communities, largely due to the high rate of crime making them feel unsafe. Community members spoke often about needing burglar bars, of high rates of theft, and of feeling unsafe walking around. They also worry about their children being robbed or harmed when out on the street. Community members all know who the drug addicts are but they are defenceless against being robbed to feed a drug habit, which was cited as being relatively common.

Living conditions and poverty

All recipients of the CSG have to pass a means test in order to be eligible for the grant. It was therefore clear that all the participants would be poor, and this was corroborated in the focus group discussions. In these households deprivation manifests as difficulties with securing enough food for the household each month, no money for clothes, high levels of debt, modest to seriously inadequate housing, and a lack of

basic furnishing and household resources. The only male caregiver in the focus groups spoke about how a lack of basic material necessities make it hard to provide a good home, as follows:

“What we are looking for is to have a home where there is tables like this, a home with a fridge but all this doesn’t work. We have homes but do not have such things. Clothes are there, but you do not even know how you will bath”.

The lack of electricity, sanitation and water all impact enormously on especially women’s quality of life, as it is usually a woman that needs to find a way to collect fuel, water, and to keep her and her family hygienic (Chant, 2008). In the next section quotations are shared from participants who lack these things, and the impact this has on their lives.

Service delivery

The participants expressed a range of needs relating to social and other services. Most of the participants explained that the services were necessary to assist individuals in need of support in the community. Those in Moutse were particularly dissatisfied with service delivery. While in Doornkop services seem to work, long queues were common, for example, you need to get to the clinic at 03:00 to be attended to.

Police and ward councillors

Caregivers from both communities almost all agreed that increased presence of the police was necessary, as this would assist with issues around safety and crime. However, there was a lot of anger at the police, whom they perceive as offering an extremely poor service. While concerns were expressed in both areas, Doornkop residents were particularly vocal about their dissatisfaction with the police.

Caregivers complained that police officials failed to: prevent crime, collect evidence the community members told them about, conduct investigations; and about how police officials treated community members. Some caregivers explained they do not trust the justice system because of the corruption taking place and the lack of trust between community members and the police officials. The grievances from the participants ranged from receiving no response from a detective who takes the statement, victims not being notified about their attackers being released, and no feedback about a case. Stories from participants located in Doornkop are illustrative:

“...The disabled girl was robbed by her next door neighbour. The robber took her shoes and they reported him at the police station. When they arrived at the police station instead of them gathering the evidence that the story is true because the shoes were found there, they came up with a story to cover it. The robber is happy now; he took her belongings while we were watching and nothing was done by the police. The very same guy once beat a Pakistan with a sjambok and he also robbed my child in his shack but the police did not arrest him. Because of the corruption taking place in our community, innocent people will suffer...”

“...I would like to complain about the police station because so many times the drug addicts are too many because you know, eish, they give a hard time these youngsters. There was one who troubles his parents, he beats his father but still if they arrest him the following day they will release him and he will beat his parent and they still release him...”

“[Do not try and report a crime] on a Monday. Monday you don’t get someone arrested there because they will ask you what do you want, what case do you want to open and that person will be holding a ball pen playing with a ball pen [and effectively ignoring you]. There are those who will be ... drinking tea yet they won’t be drinking tea, they will be drinking alcohol. If they [think you are being troublesome] or that you are asking too much, they will be like sergeant Kubheka, can you solve this case, I am coming now, now. Across the street he will go sit and help his hangover...”

In essence community members feel that they are treated as though their tragedies do not matter. Drawing from the participant’s conversation it is clear that they have fraught relationships with the local police officials and this is beyond crime investigation it also illustrates other broader societal issues like how community members are selected for jobs within the police station. One participant describes her experiences in the following account:

“...The person who was working very hard with the patrol, they have removed him and put a girl who doesn’t even know how to chase a criminal or call other patrols. The police officers no longer appoint patrols according to the rules they used to apply in the beginning...”

While the above participant explains that people are being hired on the basis of whom they know rather than their qualifications; this further jeopardises their willingness to perform the duties assigned to them. Another participant supports this view, and believes that if government employees hear about any job opportunities the first people they will inform are their relatives and friends, which suggests an awareness of nepotism.

There was also dissatisfaction with the local representatives such as the local Ward Councillor. One participant mentioned that:

“We need a new councillor [because] the one we have will not do anything, we are still waiting”.

They believed that a good Councillor would be able to provide leadership within the community and would be able to assist in getting some of the issues and challenges in the community addressed.

Water, sanitation and electricity

Many participants complained about inadequate water supply and electricity, and poor sanitation. These quotes come from Doornkop community members:

“...we have problems the water runs into my house and when [I] am not at home I will find the house full of water. They come from here going to Block 9 and we have got a shortage of drains and it’s a problem of water in the houses when it’s raining...”

“...another challenge we have in Block 10 is sewage. It blocks from time to time and the councillor is ‘dom’ (stupid), he does nothing. People are always sick and it’s a risk and if they can improve the sewage system we will be happy. If you tell them that your sewage is blocked they will tell you that we are coming and they will come at 11 and they will tell you to clean your waste...”

But this was an even stronger theme in Moutse, where many participants indicated that they do not have access to adequate water supply and sanitation and this has cost implication which they cannot afford. Participants explained:

"...The government should supply us with water; it should erect taps like in the townships. Another challenge in our community is that certain parts have adequate water supply while other parts do not have adequate supply. This is a problem because buying water is costly. We pay for our children's fees at crèches, premiums at Societies, feed our children, etc. and so we cannot afford to buy water..."

"...I don't have water, I do not have electricity and I use paraffin..."

I don't have water, I don't have electricity and closer to my place there are pipes that were just placed there and the water just spills over. You see..."

"...I stay with three children and we do not have toilet at home..."

Inadequate access to and poor quality of basic services such as water, sanitation and electricity indicates poor living conditions which can undermine child health.

Health care and social services

A strong theme was the inadequacy of health and social services. Poor treatment and service at clinics is rife, both in Moutse and Doornkop. Long queues, rude staff and being turned away without a consultation was a regular experience in Doornkop particularly. Complaints such as the following were made:

"When we arrive late they (nurses at the clinic) scold at us..."

"If you complain they shout at you and we wake up at 3 and once it's 4 o'clock (pm) they knock off and go even [if you have been waiting all day]. Tuesday it's even worse they have to deal with high blood pressure patients..."

"The clinic at Block 10 is always full and they do not have enough staff and if you want your child to be given the drop for four years you will wake up at 3am..."

"... there are two clinics but they do not have all the services like dentals you will have to go to others..."

"...the clinic here in Block four on Fridays they help the ANC [Ante Natal Care] members only and the agents only and emergencies...they attend to ante natal care a lot and emergencies unless you pleaded or what. The last time I went there with my child who had allergies and I went there and I had to stay until four o'clock and without a chance that they will help my child. So, when... I arrive I know people who are pregnant it's their day, but what if I come with my child on that day [because she is] sick [with allergies] - they will say go to Block 11 and what if my child dies in the street. The trauma and blame will be on me that I slept with a child being sick yet [without getting a proper consultation how] would I have [known that]... the child is that sick so they must improve their services..."

"...They must extend the clinic and at the same time they must bring the nurses and doctors because you can go there with a problem and they will tell that we have only got one nurse or we have got two nurses [but no doctor today]..."

Social workers are not always viewed positively. Comments made include the following:

"...If we go there, we do not get assistance anyway especially from the social workers, you see there, there are a lot of things that they need to do and they [don't do them]..."

"There are social workers... [they are] not useful, they did not help me with anything, they once called me one day, when I got there, they said my documents were processed but they need the father of the child, [but this is my sister's child and she died and I don't know the father]... There are things that are private, you cannot go and check who is dating your sister, right, we look at children but there isn't that thing to say this one is for so and so. So I did not get assistance [they did nothing for me]..."

"...Some of the services like social development... their customer services are very poor so maybe they need to be trained..."

Service quality in health care and social services is therefore frustrating and poor. It acts as a barrier to caregivers who want to do the right thing for their children's health, such as meeting their immunisation requirements.

Access

Especially in Moutse, services can be very far from where people live. Not only is the transport system inefficient, it is also expensive to travel. These comments illustrate this point:

"There is no transport..."

"There is no taxi that side; you need to make sure that you have the contact numbers of a person who has a car..."

"Actually, we are far from things that are very important to us..."

"It's now expensive, you now pay R40..."

Education and vocational training facilities

Another interlinked theme that was common to both Doornkop and Moutse is lack of further educational programmes. The participants state that the effects of the social constraints that affect them could be improved if there were community development programmes or academic institutions put in place. A few examples follow:

"...I think we need a college here. Our matriculants need it. It will also not only benefit us in Thabakhubedu, even the neighbouring communities stand to benefit. Even if there are bursaries in the colleges, the fact that they are far from us creates a problem because they would still need accommodation and money for food. So the nearer we have a college, the better..."

"I think if they can give us more Expanded Public Works Programmes, like you asked in the beginning whether we had projects like that in our community. Or maybe even if there can be other different projects that can help members of the community. Things like dressmaking or sewing schools can help us..."

"...We are struggling, we have kids without parents, their parents have passed away, we do not work...others are going to school and we cannot afford to send them to University..."



ECD services

Discussion around day care and ECD centres occurred in all the groups. In this particular study, it was found that day care centres play an important role in contributing to the economy of the community and assisting parents with the support to do their chores during the day. This has in turn created a sense of commonality, cohesion and safe environment for members of the community. For instance, one participant stated that:

“The crèche helps us since we stay in households that do not have grandmother and we also do not have male partners, if you need freedom to do your things easy and in a rush so that by the time that time pass you are back and you are there when the child gets back”.

These sentiments were also expressed by another participant who stated that day care facilities are a supporting structure to parents who do not have other family members to look out for their children.

“Especially for you who do not have sisters-in-law, mother-in-law and brother-in-law if you need support”.

The other important factor that was demonstrated in these findings is that day care centres contribute to the development of children. These facilities foster an area of improvement in the socialisation, vocation and interaction of children.

“So a crèche has many advantages, a child learns... and plays with other children, grows and does everything and it's safe”

However, Moutse participants complained of too few ECD services, especially for children under the age of five.

Other service needs

Other needs that participants mentioned in both communities include receiving food parcels, a library, youth centres and RDP homes. One participant suggested that the grant money should be increased.

Moutse participants mentioned they needed better maintained roads. In Moutse there is also a perception that EPWP job allocation is unfair. Some complained about no municipal refuse collection causing a littered dirty environment.

Financial Literacy

Questions about financial literacy revealed evidence of some good financial management skills, but generally participants were keen to have help with money management, and identified this as a necessary skill. One caregiver remarked that:

“We need someone that will help us as mothers on how we can handle money in the homes”.

There was, encouragingly, evidence of the use of skills to manage debt. One caregiver explained carefully:

“When I owe anyone I write it all down...yes it helps [to remember]. I write down who do I owe, that I owe this person and that person let's say it amounts to 700. Let's

say i pay them, [then] I tick them off. If I failed to pay...I [talk to the person and tell the person that I will pay next month]”.

Other financial capabilities include a few managing short-term saving, such as in the following quote:

“Yes but I just save that I can get to the next month and for the emergency”.

In addition, some participants already had some savings and budgeting capabilities. The following illustrates this:

“I look at what is important and what is not”.

“I do write down a budget”.

Discussion and conclusions

Discussion of findings

The data from these six focus groups gives a rich picture of the family lives of the research participants and how their families function, provide care, how the social and community context affects caregiving. Three themes are apparent, drawing from the findings.

The first theme is the remarkable levels of care that many families manage to offer under very difficult circumstances, and the challenges they face, such as discipline, monitoring child safety, and dealing with grief. The second is the thinness of the support families have in order to manage many kinds of adversity, leading to increased insecurity, stress and precarious emotional states, which erodes the protective mechanisms of social care. This lack of support is a function of both poor state services as well as gaps in community support and social networks. These themes were interwoven in the lives of the participants, and are separated here for analytical purposes only, and are discussed further below.

A third theme that emerged across the focus groups related to social beliefs that families hold which shape how they function. These can be positive, such as when families ‘stick together’, and believing that child safety is a community responsibility. Social beliefs can also could be barriers to family well-being, such as those that discourage seeking help, and views about discipline. These were reported on in the data and provide rich insight that can inform family strengthening interventions.

In relation to the first theme of positive emotional care, studies show the protective role that strong caregiver relationships, caregiver closeness, and demonstrations of warmth have for children. These have positive well-being outcomes in relation to: child mental health (Cederbaum et al., 2012), reduced risk of child abuse (Meinck et al. 2015), reduced behaviour problems in childhood (Gardner, Sonuga-Barke, & Sayal, 1999) and adolescence (Gorman-Smith, et al., 2000); and can cushion negative social and community influences (Knerr, Gardner, & Cluver, 2011; Holte et al., 2014). In this study, there were moving accounts of the warmth and cohesion that exists, even under very difficult living conditions. Small family rituals and close interpersonal relationships, and the demonstration of care for others in word and deed; were described as the ‘glue’ that contributes to positive family connectedness. There was also an explicit recognition of the importance of emotional caregiving, and lovely examples of how ordinary family activities can create caring environments.

In addition, attempts to garner information about communication styles and processes in families; revealed examples of positive, supportive, and interactive family communication, including in cases where emotional or family difficulties made this achievement impressive. This data indicates real strengths in these families in relation to effective communication with children. However, as a caution, there was little discussion of the challenges of communication, and since this is a particularly difficult part of normal family life (Bhana et al., 2004), and therefore a key component of parenting programmes internationally (Richter & Naicker, 2013), it requires more research to make a generalised statement about the nature and the quality of communication in families.

Discipline and the management of the behaviour of children stimulated extensive discussion. In a 2003 study, 72% of caregivers in South Africa said they believed talking to children was a more effective way of managing child misbehaviour than physical punishment, however, 56% reported using physical punishment (Dawes et al., 2005). Physical punishment is a serious issue in South Africa, with high rates of severe violence against children (Bower & Dawes, 2014). In these group discussions, there was evidence of a range of discipline styles, from physical beating and harsh punishments to much more engaging communicative styles. Setting family rules was an alternative method of behaviour management that was seen as most effective. Examples of family rule-setting revealed quite sophisticated understandings of how to ensure rule consistency and family fairness.

However, the disciplining of children was a particularly contested, difficult and controversial area of discussion in the focus groups, with evidence of strong tendencies towards authoritarian styles. Harsh discipline and corporal punishment has been shown to cause direct physical and emotional harm to children and greatly increases the likelihood that children use aggressive ways to manage social conflicts, contributing to a cycle of aggression and violence (Bower & Dawes, 2014). Participants reflected that managing children's behaviour becomes harder as the child grows older. Two factors seemed to be important causes of authoritarian discipline: one was an articulated lack of knowledge of and skills in alternative styles of discipline; and two, was the theme of feeling that because the social context of children's lives were so very different from the caregiver's generation, children were 'out of control' and authoritarianism was seen as the only way to regain control. 'Positive parenting' is a set of skills accepted by experts as important ways to manage difficult behaviour at home in a caring and constructive manner (Gould & Ward, 2015). Objections that positive parenting principles are 'not culturally appropriate' have been challenged by the adoption of these principles in family programmes around

the world (Gould & Ward, 2015; Meija et al., 2012; Bauman et al., 2015). A lack of formal and informal support for effective and culturally appropriate positive parenting skills causes uncertainty, family conflict, and raises risks for poor well-being outcomes for children (Meinck et al., 2015; WHO, 2014). In addition to articulating a lack of alternate skills, caregivers were clear that they wanted to learn new ways and have a range of new and effective tools.

We will now consider some other areas where there are serious social support gaps. The first theme of protective care is not possible to enact without a range of social and emotional support to the caregiver (Armstrong et al., 2005). In order to maintain warm and caring spaces, participants identified religious faith, close adult relationships, and a sense of being helped and supported financially and emotionally, as critical in the ability of caregivers to provide positive caregiving.

In considering the second theme of the lack of support to families, it is clear that the reverse of the above is true too: a lack of support to the caregivers erodes their ability to offer positive emotional care. Family support was truly mixed, with many examples of positive assistance, but complex family relationships and obligations easily undermine the benefits of extended family. This is also a gendered experience; research shows social support is given more by women than men, and women receive less social support than men (Casale & Gibbs, 2015). Social support is a moderating factor in protecting against the negative impacts of life stress (Cobb, 1976).

One example drawn from the data of the need for further support for caregivers; is a woman caring for her granddaughter after the death of her daughter, which revealed terrible unresolved grief and loss for the child, and a real lack of support to the grandmother in both her own grief and in managing the intense feelings of the child. Loss and grief were recurring issues in these focus groups; clearly there is a need for emotional care that is not being adequately managed by our society generally and in a time of HIV and AIDS and high levels of violence. Emotional support and closeness is hard to achieve under stressful circumstances; your own emotional difficulties can be a real barrier to offering support to others, and raises the issue of a caregiver's mental health.

Worrying rates of depressive symptomology (18 out of 40 women had symptoms of depression) among these women has broad implications for caregiving competence in communities. A high rate of depression is not a new concern, and previous research has indicated a high prevalence of depressive symptoms in poor women in South Africa: estimates vary from 36% (Ardington & Case, 2010) to 43% (Moodley, 2012). While the consequences of this for caregiving is not well-researched in South Africa, the evidence that does exist plus studies from other parts of the world is sobering: research has demonstrated a strong connection between the mental health of caregivers and good well-being outcomes for children; and, conversely, caregiver depression and other mental health challenges as a major risk factor for children's well-being (Goodman et al., 2011; Menick et al., 2015). There is also a demonstrated connection between food insecurity and depression in peri-urban South Africa (Tsai, Tomlinson, Comulada, & Rotheram-Borus, 2016).



The monitoring and supervision of especially young children was discussed at length in these groups. Poverty, precarious livelihoods, and overcrowded living conditions can lead to a lack of monitoring and supervision of children, an important risk factor for child abuse (Mathews & Benvenuti, 2014). Concern for the safety of unmonitored children was widely expressed, and great effort was obviously expended on keeping children physically close and protected from the outside world, which was perceived to be very dangerous. Barriers to properly monitoring children were articulated, many deriving from poor living conditions and poverty, such as a lack of property fences, poor quality locks on house doors or no security gates, and a lack of safe play areas in the community. Others derived from changing social relations, such as a reduction in trust that members of the community would genuinely offer care for children, despite the articulation that communities 'ought to' care for any child living nearby, which is a traditional value in African communities (Patel, 2015; Lesejane, 2006). This issue is also strongly gendered, as men were not seen to be as trustworthy as women when it came to supervising children; a common perception in South Africa (Khunou, 2006).

Revealingly, a crèche or ECD Centre was seen as a space of safety and a predictable way to access food, rather than a space of educational stimulation. Research shows that ECD attendance has significant benefits for children, particularly disadvantaged children (Engle et al., 2011), but in South Africa subsidies from the state for ECD programmes are low, some ECD facilities are not registered, and they offer variable quality (Parenzee, 2015).

Participants perceived communities to have mixed value as a source of support; some felt a sense of belonging, but a lack of trust came through as a theme too. Neighbours are often not perceived to be 'on your side'. The wariness towards the outside community was largely due to perceived high crime and drug use rates. Safety and crime were major concerns for these participants in both rural and urban areas. We know that fear is a driver of isolationist behaviour, and the more social problems communities have to manage, the harder it is to maintain support structures. Therefore positive community support does not seem inherent in the social or community institutions, even traditional cultural ones. The support given is usually dependent on the individuals involved.

The ability of participants to provide for their children was severely hampered by poverty, and this was a recurrent theme. While all lived in difficult financial circumstances, some also suffered particularly bad living conditions, impacting severely on their ability to care for their children as they would have liked. While participants were not asked about food security, they did mention the stress of trying to provide for their children in a space of serious financial insecurity. Exacerbating this were serious problems with formal service delivery. It was remarkable how the discussions on access to and quality of service delivery generated so much data. In Moutse, the concern was a lack of services such as no running water, a lack of transport, and not enough ECD and educational facilities. In Doornkop, the services existed, but complaints about poor

quality of delivery were rife, especially terrible treatment from service officials, and corrupt and discriminatory services. Police and health care came under particular fire in Doornkop. It appears that the poor quality of service delivery in Doornkop is due in part to the over-subscription of services because of overwhelming community needs, and perceived corruption.

Finally, some participants indicated a basic competence in rudimentary financial capabilities, but were enthusiastic about developing their knowledge and skills in this area.

Conclusions

Ecological models of human development (largely drawing from Bronfenbrenner's 1979 seminal work on this) recognise that individual caregivers and families are the most powerful sphere of influence on children's well-being. The characteristics of the communities in which families live interact strongly with internal family processes, creating together both risk and protective factors for child well-being.

The data from these focus groups shows clearly that caregivers are able to create emotionally supportive and positive care environments for their children, even under the most difficult circumstances. However, a lack of support for caring arises from social and community gaps in caring and service delivery problems. Identified areas for high-impact caring tools are in parenting skills (especially around discipline), improved financial management skills, far better state service delivery that offers genuine support via competent and respectful staff and actual delivery. There is also a need for stronger community support and deeper social networks, both difficult processes to influence.

2B. Key informant interview findings: understanding family programmes in South Africa

This section summarises the findings from 10 interviews that were conducted in 2016 with key informants engaged in the delivery of family interventions in South Africa. The aim of the key informant interviews was to obtain information on the programmes delivered locally that might be relevant to the design of a family strengthening intervention for social grant beneficiaries. Details about the programmes are provided below such as their aims, target populations, programme content, delivery method, and the monitoring and evaluation of the programmes. We were particularly interested in interventions that were adapted to the South African context and that involved low income families. The programme materials were also reviewed by the research team. The findings are set out below.

The key informants came from the organisations set out in Table 36 below. Eight of the organisations were NGOs and two were research bodies; one being local and the other a UK based University that is collaborating with local partners.

Table 36: Name of organisations and family programmes

Name of organisation	Name of programme	Target groups
Synergos	Social connectedness	NGOs delivering services to families in the community
Johannesburg Child Welfare	Gogo Programme	Grandmothers are linked with residential services to support infant care
ACVV	Botswadi Parenting Programme	Parents/caregivers
Sinovuyo Caring Families Programme	Sinovuyo Caring Families Programme	Parents/caregivers - mostly mothers
Sinovuyo Teen Programme	Sinovuyo Teen Programme	Parents/caregivers of teenagers
The Parent Centre	Teen Parenting & Positive parenting course	Teenagers who are parents
Medical Research Council	Sexual Violence Research Initiative	Research of primary prevention programmes in East Africa to reduce sexual and gender based violence in families and communities. Target populations of these interventions are caregivers and children.
Khanya Family Centre	Thusano HIV/AIDS family programme	Grandmothers
Dee Blackie	Courage programme	Teenagers who are pregnant
FAMSA	Parenting programme	Parents and caregivers

Aims and target groups

All the programmes were targeted at families who are poor and are confronted with various social and economic challenges. The aims of the programmes were diverse such as improving parenting skills, exchanging information on child protection through education interventions, reducing child sexual violence, promoting positive parenting, reducing harsh and inconsistent discipline, improving child behaviour problems and the prevention of child abuse. The majority of the programmes targeted parents/caregivers and grandmothers; pregnant teenagers were specifically targeted in particular programmes. Only one of the programmes reached out to fathers specifically while one other programme was geared to both mothers and fathers. Sinovuyo Teen Programme included the caregiver and a teenager from the household while others focused only on the parents/caregivers. Other selected target groups were child-headed households and foster parents (Respondent from Botswadi programme) while the Thulisana programme targeted learners in grades seven to nine. The rationale of the programmes flowed from the fact that families experienced multiple problems that impacted on family functioning. Child protection was however, the overarching aim of the programmes; with the focus on high risk families presenting with specific problems, children at risk of child abuse, orphans and vulnerable children. There were no universal programmes targeted at poor families in general.

Recruitment and selection

Various recruitment processes were employed. Families receiving counselling services from organisations were referred to the programmes. Organisations also advertised their parenting programmes in the community through local newspapers. Two organisations used screening tools to assess eligibility to participate in the programme such as whether they experienced behavioural problems with the children or

whether there were 'regular arguments at home'. This was gathered from self-reported information gleaned from the screening interviews with the caregivers.

Once group members were selected for participation in the various programmes, all the groups were closed and mostly comprised 5-10 group members. Since the majority of the programmes focused on the parent or caregiver as the change agent, other family members who play a crucial role in the child's well-being, could be missed; especially where there are multiple caregivers which is often the case (see quantitative data reported on in part 1). Evidence from a review of programmes in high- and low-income contexts indicated that the most effective programmes included both caregivers and children, and offered opportunities for both to engage and test out new behaviours (Engle et al., 2011).

Programme content

Most of the programmes were informed by the expressed needs and concerns of community members such as absent fathers, teenage mothers, child maltreatment and child protection. These topics were then captured in the design of the programme. Some programmes were developed by exploring models of family/parenting interventions offered in other countries such as the USA, Bulgaria and Uganda. Some of the interviewees indicated that where international programmes were used, these inter-family/parenting models were adapted to the South African context. What was attractive about the programmes from high income Western countries was that they did have a strong evidence base. In view of the socio-economic and cultural differences between countries in the North and the South, some of the organisations adapted the programme content. Factors that were considered included the needs of caregivers or parents; running the intervention in a location that is accessible to where participants live as this would assist with regular and consistent attendance of the sessions. Sensitivity to the context and challenges were

considered such as poverty, unemployment, levels of literacy of parents/caregivers, social challenges, cultural beliefs and practices, as well as the need for programmes to speak to the everyday lives of the participants. These issues were also identified by Richter & Naicker (2013) in their review of family programmes internationally and their relevance to the local context. Organisations were cognisant of the importance of aligning their programme content with the needs and challenges of South African families.

Topics on parenting skills, communication, discipline of children and child development, were popular. Enhancing parents' skills and knowledge on how to engage more effectively with their children, that in turn would lead to better parenting, were underlying assumptions that informed the content. Interestingly, only one programme included a financial literacy component in its syllabus while none of the programmes included a nutritional component.

When asked about the theory of change that informed their particular intervention, only one person, from Sinuvoyo Caring Families, identified an explicit theory of change that guided the design of the programme. This programme is "a group-based parent-training model for parents of young children. It uses a research-based theoretical model for understanding these problems in terms of interacting predictors of child abuse in low-income settings. These predictors include poor parental mental health, social isolation, and escalating cycles of parent/child conflict. The group-based programme incorporates a social learning theory of change with programme content consistent with successful interventions in other regions (e.g., The Incredible Years, Triple P). By increasing parenting knowledge, skill, positive interaction, and improving parent mental health and social support, the programme aims to increase parenting capacity and reduce child maltreatment at this key stage of the child's development" (Respondent from Sinovuyo). The programme is described in greater detail in Cluver et al. (2016).

The respondent from the Courage Programme identified empowerment theory as being pertinent to its programme. This approach takes the starting point of the intervention as the need for personal empowerment of the parent or caregiver and through increasing knowledge about appropriate childcare and parenting. The respondent indicated that mind- shift changes were needed and that parents had to be empowered to make changes in their parenting styles and interactions with children. They also used Elizabeth Kubler Ross's model of loss and grief to provide support to pregnant teenagers to cope with their situation such as dealing with shock, denial, anger and acceptance of their situation.

Programme materials varied in depth and level of prescription. Few of the programmes had printed materials for each of the modules, including facilitator manuals. Some had guidelines on what had to be covered in the course and information on the content. Some of the programmes allowed skilled facilitators to adapt the programmes as necessary which could have positive effects. Lachman et al. (2016) caution against the use of a loose programme design and materials as this does not encourage replication or fidelity of the programme.

Programme length, duration and training

The programmes varied in length. Some programmes were offered for six weeks, while others were offered over a 12-week period. All of these programmes were run once a week and most of them were an hour in duration. The majority of the programmes included a facilitator training or 'train-the-trainer' component. In order to increase the reach of the programme the respondent from the Courage programme indicated that it targeted "NGOs, Child Protection organisations, Government, Social Workers, Teachers and Nurses". Training facilitators had varying backgrounds and qualifications, including Level 4 ECD training, auxiliary social work qualifications; and social workers who had a four-year Bachelor's degree. The train-the-trainer sessions ranged from short five hours sessions to several training days. In order to scale up the impact of the programmes in a resource constrained environment and to expand impact, preference for the use of paraprofessionals rather than clinicians and qualified social workers is advocated to expand the reach of the interventions (Lachman et al., 2016).

The facilitator training in most cases was run over a week and included facilitators having to role-play some of the sessions or exercises from the programme. In addition to this, some of the organisations offered facilitator supervision and mentoring during programme implementation. In a few cases, organisations expected the facilitators to submit process reports of sessions. These were used to monitor how the programme was being implemented and also as a way for facilitators to reflect on their role. Providing experiential training, support and mentoring to facilitators has been shown to build their confidence and competency over time, in programme delivery (Lachman et al., 2016).

Evaluation of programmes

Only two of the 10 programmes have been evaluated, where the impact was measured. Sinovuyo Caring Families first concluded a qualitative evaluation followed by a pre-post-test pilot study of the development of a parenting programme for adolescents in South Africa. The findings show positive initial effects of a 10 session intervention with 60 participants in poor rural areas in the Eastern Cape. Positive effects were noted in reducing child abuse and adolescent problem behaviours (Cluver et al. 2016). The Sinovuyo Caring Families Program (SCFP), which serves parents of two to nine-year-olds with challenging behaviour is currently being evaluated through a randomised controlled trial (RCT) in Khayelitsha and Nyanga with 296 parent/child dyads. Half of the parents were allocated to receive the programme, while the other half received services as usual. The respondents from Sinovuyo explained that monitoring and evaluation is ongoing and includes "reports, monthly supervision sessions, facilitator meetings, statistics on the programme and participant feedback on sessions".

When respondents were asked if their programmes worked, it became apparent that evaluations were more process evaluations rather than impact assessments. Respondents shared knowledge about the management and implementation of the programmes when probed about whether the intervention was working well or not. When asked about what could be done differently, all informants said no evaluation was done but they hoped to address this in future. While experimental designs could provide valuable information about the effectiveness and applicability of the programmes

in the South African context (Ward & Wessels, 2013), few programmes were rigorously evaluated.

Some of the strengths and challenges identified included the following: the train-the-trainer method was found to work well. A respondent explained that in the Botswadi programme, they worked with a small number of trainers, which encouraged a lot of interaction between the trainers in the training sessions. This format also allowed the new trainers to reach another layer of potential trainers, which meant that the programme could be expanded to other communities. Having the “sessions run close to the participant’s homes works well as it eliminates accessibility issues” said the respondent from Sinovuyo. High transport costs could be a barrier to participation in parenting programmes. A decline in support after the programme ended was another challenge that was identified. How to provide follow-up or a ‘booster session’ was suggested as an option to be included in the design of future programmes (Sinovuyo respondent). How to address sensitive topics such as father absence and HIV/AIDS in the programmes appeared to be another challenge. The respondent from the Khanya Family Centre pointed out that due to the stigma attached to such conversations, addressing this in a group format may not work so well. The need for mentorship and support for trainers was highlighted. Other gaps that were mentioned included the need to address issues around discipline and communication in families, as well as the importance of addressing capacity constraints to deliver the programmes, due to a lack of funding for parenting and preventative interventions.

Discussion of findings

This cursory review of family interventions in South Africa indicates that programmes are being implemented but are limited in scope and reach. Few of the programmes are supported by research and except for one programme, none has been rigorously evaluated to assess its effectiveness. The 10 programmes reviewed showed that innovation and experimentation is occurring and that there is much to learn from the different modalities that exist and what works in practice. All the programmes provided a training intervention in a small group setting.

A lack of funding and investment in preventative family interventions was identified as a major barrier to growing family- and community-based interventions. None of the programmes targeted social grant beneficiary families specifically. These families are the most vulnerable to poverty which is a known risk factor for child well-being (Evans & Cassels, 2014).

Social work services for families in South Africa are underdeveloped and tend to concentrate on clinical and statutory interventions to protect children against harm. There are limited interventions to enhance family functioning in general in South Africa that could prevent social problems from occurring. The CSG does play a positive role in preventing child poverty and food insecurity as outlined in part 1 based on the NIDS of 2008. But as the interviews with key informants revealed, there is need for development of parenting knowledge and skills for at risk families focusing on psychosocial aspects such as family relations, communication, discipline of children and support for caregivers. A need for a focus on developing the financial capabilities of families to cope with the socio-economic challenges that they face, was also emphasised. It is apparent that family-based interventions could be a valuable complementary intervention to support CSG beneficiaries. The



development of evidence-based interventions are however still in the early stages in South Africa, although promising results are emerging from pilot studies. There is therefore scope for research supported preventative interventions for CSG beneficiaries and their families.

What may be learnt from the current review and international studies that might be useful to the design and implementation of complementary family interventions for CSG beneficiaries in South Africa?

Given the dearth of evidence-based family interventions in South Africa and in low- and middle-income countries, organisations are more likely to rely on international interventions that have been rigorously evaluated in high-income countries (Cluver et al., 2016; Mikton & Butchari, 2009). Caution needs to be exercised in uncritically transposing these programmes in different countries with different cultural values and beliefs about families and caregiving and different resource levels. However, there is scope to adapt these interventions in South Africa. Gardner, Montgomery and Knerr (2015) found, in a systematic review of evidence-based parenting programmes, that these improved child behaviour for children aged 3-10. Moreover, these programmes were transportable to countries that were culturally diverse and that had very different social service systems and resources. The effects were stronger when the programmes were transported to countries that were from culturally more distant regions than where they originated. This is possibly due to differing parenting styles in diverse cultural contexts. These findings are encouraging in the search for effective interventions that might be useful in the South African context.

The majority of programmes attempted to respond to specific social problems such as the needs of teenage parents, child abuse, orphans and vulnerable children.

The Sinovuyo Caring Families programme was the only one that had prevention of child abuse as its main aim. There is scope for parenting programmes that are designed to prevent social and family problems by focusing on positive parenting, psychosocial support, and that address the particular social and economic challenges families face. International evidence points to positive social returns from preventative family interventions for children in high risk settings. Multi-component preventive parent education programmes were found to show great promise in reducing child maltreatment, in a systematic review (Mikton & Butchari, 2009). Positive outcomes were also associated with interventions that included multiple areas of social functioning and that focused on family relationships, linking families with other social systems such as teachers, parenting skills, facilitating communication, cohesion, opportunities to access and receive support from outside the family, and improve the management of the challenges they faced (Tolan, Gorman-Smith, & Henry, 2004). These dimensions have been tested in the SAFEChildren Preventative intervention for young children in high risk settings and in low-income communities in the USA. The findings showed an overall effect of increased academic performance, better parental involvement in school, improvements in parental monitoring, in child problem behaviours and in the social competence of the children (Gorman-Smith et al., 2000; Tolan et al., 2004).

The design of parenting intervention in South Africa could benefit from understanding the factors that are associated with child well-being outcomes and some of these were identified in part 1 of this study. A cross-sectional study of parenting and child outcomes in South Africa and Malawi revealed that factors such as being the biological parent of a child, parental mental health, poverty and stigma; were associated with child outcomes. Some of these factors were also found in this study to be associated with perceptions of child health and good nutritional outcomes. Although the presence of the biological parent was not associated with these outcomes in this study (see NIDS findings in parts 1 and 2), what we do learn from this study and others, is that multiple interventions are potential pathways to child well-being. These include health, nutrition, mental health, education and HIV and AIDS treatment to prevent parental mortality (Sherr et al., 2017). Richter and Naicker (2013) identified additional components that should be considered in responding to the challenges that families face in South Africa. These are related to improving child health outcomes, the need for father involvement and responsibility for children, and the provision of structural enablers to support families in their care responsibilities, such as childcare services. The focus group discussions confirm the need for social services for families and for practical enablers to enhance child and community safety and support (see part 2A).

In designing a parenting intervention locally, consideration will need to be given to the cultural fit of the programme, as well as human and financial resource implications of such programmes. In order to scale up the impact of combined cash and care programmes, quality, cost effective and high impact designs, will be needed and tested. This will require weighing up the advantages and disadvantages of using qualified social workers and paraprofessionals and what their respective roles would need to be.

While cash transfers do go a long way in mitigating the negative consequences of poverty on child well-being in South Africa, complementary family interventions may improve well-being outcomes if they address other social and developmental challenges that families experience. The family interventions reviewed provided valuable insight into programme content, recruitment and selection of participants, training and supervision, and monitoring and evaluation. Group formats for programme delivery are common locally and could contribute to the building of supportive networks between the caregivers that could extend beyond the intervention, which is also associated with successful outcomes (Morris et al., 2017). These supportive networks built through the family intervention continued after the programme ended and were associated with buffering the impact of parental stress that may be detrimental to parent-child interactions (McConnell et al., 2011 in Morris et al., 2017).

The above elements are important in the adaptation of international programmes locally and in the development of 'home grown' solutions to address the challenges that grant beneficiary families face in South Africa.

Conclusions

The study provides rich insight into the family and community context in which beneficiaries of the CSG live, the factors that influence their well-being outcomes, the perspectives of their families of caregiving, the range of family strengths, and the challenges that they face. It also provides pointers for the development of family interventions that could scale up the impact of the CSG with complementary family strengthening interventions. We begin by answering the key research questions, followed by recommendations for a conceptual framework to combine social protection (cash transfers) and family interventions to accelerate the achievement of child well-being outcomes.

The following questions are addressed: Who are CSG beneficiaries? What do we know about their caregivers, their families and households and the levels of social and community support that they enjoy? What factors influence their well-being outcomes? What may we learn from the families themselves about their strengths, their needs and challenges, and the kinds of family strengthening interventions that might be beneficial to them?

Key findings

Profile of CSG beneficiaries

A total of 3 132 children younger than eight years who received a CSG were identified in the NIDS Wave 1 of 2008 which is a third of the total number of children in the data set (Chinhema et al., 2016). The gender distribution was fairly even, although there were slightly more boys (2%) than girls. The majority were African (90%) and Coloured (10%). Children were fairly evenly distributed across the age groups except for children who were younger than one year who had lower levels of access to the CSG (7%). Most children lived in TAAs (58%) and a further 27% lived in urban formal areas. CSG households were generally larger (6.86) compared to the national average household size of 3.6 members in 2011 (Community Survey, 2016). This was especially marked in the TAAs where it was 7.22. The number of children per household was 2.40. The per capita income was R394.21. Urban areas had higher per capita income than their rural counterparts and household size was also smaller.

School enrolment was positive with 92% of CSG beneficiaries of school-going age being enrolled in either Grade R or in Grade 1. Fewer children, around four out of 10 aged 3-5 years, were enrolled in a CCF. Enrolments in a CCF were much lower in rural areas due to a lack of services. Regarding the health of the children, two thirds of caregivers had a positive perception of the health of the child. This was corroborated by the anthropometric measurements. Eighty-two percent of children younger than five years were in the normal range for their weight for height measurements and 91% were in the normal weight for age range. Eighty-eight percent of children aged 5-7 years were also within the normal BMI. Those who fell out of the normal range were 3.4 times more likely to be overweight than underweight, which is likely to be due to poor nutrition. These findings point to the positive benefits of the CSG in promoting food security and in promoting child health in early childhood. The CSG is therefore an important social investment in child health and resonates with findings from other studies (Agüero, Carter and Woolard, 2007). We

do however, need to take cognisance of the fact that 17% of children younger than five years in our sample were moderately stunted and 9% were severely stunted. Interventions do need to respond to this as the effects of stunting have negative impacts on the physical and cognitive development of children (Casale et al., 2014).

Other significant challenges remain; such as the increased vulnerability of children younger than one year who do not have access to the CSG. This is in keeping with previous findings that children younger than one year and infants in particular were most vulnerable to not accessing the CSG due to a lack of identity documents, knowledge of the CSG, how to apply and the barriers associated with the application process itself. Some caregivers indicated that they 'did not bother to apply' or 'did not get around to doing so' according to a study by DSD, SASSA and UNICEF (2016, p.7). Early receipt of the CSG in the first two years of a child's life is associated with long-term child health benefits in relation to growth and cognitive development (Agüero et al., 2007).

Although the nutrition and health benefits of the CSG are noteworthy, 63% of children lived in households that had either below, or much below average household income, of this sample. The small value of the grant and low and precarious income of grant beneficiary families explains why four out of 10 children continue to experience hunger to some degree while 47% indicated that food supply was scarce. Rural households were poorer and more food insecure than their urban counterparts. Half of the children lived in households with medium living standards. In the main, CSG beneficiaries had access to three out of five of the services that made up the living standards measure devised for this study. Living standard was assessed in relation to the dwelling type, access to basic services, water, electricity, refuse removal and sanitation. Income poverty, poor living conditions and food insecurity are significant risk factors that can be associated with compromised physical, cognitive and the social and emotional development of children (Sarriera et al., 2014). Other risks are related to lack of access to the CSG in the early years of life and lastly, children in the former homelands or TAA are particularly vulnerable as they have reduced access to services, food and income.

Caregiver characteristics, household and community factors

Caregivers were mainly women (97%) with a secondary education and were largely unemployed (87%). Besides a lack of employment, one in two caregivers lived in a household where no one was employed and they were therefore more vulnerable. Younger caregivers were more likely than older caregivers to be better educated and enjoyed a higher living standard. Almost seven out of 10 primary caregivers were the biological parents of the child and lived with the child in the same household. A fifth of primary caregivers were grandparents, followed by relatives. A fair number of primary caregivers (29%) had a partner who lived with them in the same household with only 20% of couples being married. Non-resident mothers were more likely than non-resident fathers to give the household financial support. However, half of non-resident mothers and 60% of non-resident fathers did not provide any financial support. Father absence from the household was high with almost three quarters of fathers not being present, for many reasons, such as labour migration from

rural to urban areas. In 30% of cases, fathers never saw their children. There is also an increasing trend of labour migration among mothers. However, more mothers (78%) were resident in the household than fathers (26%). We also see that large numbers of children (29%) continue to live apart from their parents mostly with relatives, which was one of the reasons why the CSG was designed to provide support to the primary caregivers of the child who could be parents, relatives or non-relatives (See Lund Committee of Enquiry, 1997).

Compromised mental health of the caregiver, exacerbated by stress especially related to poverty and coping with poor living conditions, is associated with increased risk of poor child well-being outcomes. The majority of parents did not present with a high number of depressive symptoms, however, almost a third had a high risk of depression. Caregivers with low levels of education were at greater risk of developing mental illness. There was also a relationship between the perception caregivers had of their own health, and their mental health. Those who viewed their health more favourably were less likely to be depressed than those who saw themselves as having poor health. Similarly, those who perceived themselves as living in better-off households were more likely to have lower depression scores. A CES-D10 depression index administered in the focus groups with caregivers found higher rates of depression among women carers in an urban context (Doornkop) in Soweto compared to a rural area (Moutse).

The most common household structure of CSG beneficiaries was the child, the parent and adult relatives (34%). This was followed by a family made up of a child and adult relatives with no parents (29%); a child and both parents (15%); a child, both parents and adult relatives (11%); and a child and one parent with no relatives (11%). This suggests first, that only a quarter of CSG beneficiaries in the early years of life were growing up in nuclear families or single parent families with no relatives living with them. Second, that families with relatives are by far the most common family structure for this age group (75%); and third, most children were in households, either with one parent or in households with no parents at all.

What was positive was that 77% of caregivers had another family member to assist them with childcare. This confirms the importance of other adults who were engaged in the care of children. The lack of personal income for caregivers, and the reliance on other members of the household, underlines the importance of a wider conception of 'family' and of their contribution to material and social support for the caregiver.

Turning to the significance of the communities in which children were growing up, we found that children younger than eight years were growing up in communities that had a medium level of social and community organisation. This means that there is a fair level of participation of caregivers in social groups; that they have some access to support from neighbours; they perceive themselves to be fairly safe; that there was some trust in their neighbours; and that they enjoyed moderate living conditions such as access to basic services, although they lacked adequate housing. But the poor quality of basic services was a recurrent theme that emerged from the qualitative data. Living in difficult circumstances hampered by poverty, challenging living conditions, concerns about crime and safety and the stress of trying to provide food for children; severely constrained the families in their caregiving capacities.

Factors influencing child well-being

The relation between the various factors (independent variables) and the outcome variables (dependent variables) were analysed by means of bi- and multi-variate analysis. The statistically significant relations are summarised with a p-value of less than 5% ($p < 0.05$). Various factors were assessed as to whether they influenced child health and educational outcomes. We found first that there was no relationship between family structure as set out in the model and child health outcomes. But caregivers who perceived their own health to be good and who were not suffering from depression were more likely to view the child's health favourably. Emotional well-being of the caregiver was also correlated with higher household income i.e. the economic circumstances of their household and higher education levels of the caregivers.

The education of the caregivers was also positively associated with having the children in their care aged 3-5 years enrolled in a CCF. Children who were slightly older (aged 6-7 years) were significantly more likely to be enrolled in school than those who were younger, as this is the age of mandatory schooling. Enrolment in a CCF was also significantly associated with household size whereby enrolment declined as the household size increased. Similar outcomes were observed where there were larger numbers of biological children in the household. Finally, higher living standards, higher educational attainment of the caregiver, and younger caregivers, led to a higher likelihood of enrolling a child in a CCF.

In view of the large numbers of children enrolled in school (92%), similar correlations could not be conducted as was the case with children in a CCF. But we may conclude that children aged 6-7 years were more likely to be enrolled in school than younger children in a CCF. Also, education of the parent or geo-type did not have a bearing on school enrolment.

The findings derived from the path analysis shows clearly which predictors are associated with perceptions of child health and the weight and height for age of the child. This was found to occur via the increased access to food and underscores the important role that the CSG has in enhancing food security and ensuring child well-being. The findings were different for rural and urban areas and provide some pointers for intervention. In rural areas larger households are more likely to need additional food security interventions. In urban areas caregiver depression had a significant effect on lower levels of child well-being, although other predictors such as income and living standards were also important. Having a relative in a household, presumably to assist with childcare and the provision of social support, a higher living standard (access to basic services and shelter), higher income, good mental health and a positive view of the health of the caregiver; were protective factors. These findings remind us of the complex inter-play between various factors and the mechanisms or processes by which child well-being is achieved in the South African context.

Family functioning and perspectives of caregiving

The qualitative data suggests that primary caregivers had a sound knowledge of the emotional and social care needs of the children growing up under difficult circumstances. There was explicit recognition of the importance of emotional caregiving and the need to create caring environments for the children. Evidence of positive, supportive and interactive family communication existed. However, the challenges with communication received limited attention in the focus group discussions. This will need further investigation. What featured prominently was the need for knowledge and skills in alternative styles of discipline to more effectively manage the behaviour of children. Severe forms of punishment are associated with violence against children (Bower and Dawes 2014). The need for 'positive parenting' interventions was identified that include culturally appropriate parenting styles and skills. Primary caregivers were receptive to learning about new and different ways of parenting.

Caregivers derived social and emotional support from family members, close adult relationships, material support from their family network and from their religious faith. Despite positive assistance, complex family relationships and obligations undermined the benefits of extended family support. While Cobb (1976) draws attention to the moderating effects of having access to family support, it could also have the opposite effect. Since women are the main providers of care for children as is evident in the case of the CSG, their own emotional and social needs may be overlooked; leading to burnout and the stress of providing care under very difficult circumstances. Very high rates of depressive symptomatology were evident in the qualitative data which could have a negative impact on child well-being. This is an important theme that has emerged from this study which was confirmed in both the qualitative and quantitative data.

Challenges with the monitoring and supervision of children were directly related to poor living conditions, overcrowding, poverty and a lack of safe play areas in communities. Other practical ways in which parents/caregivers were hampered in ensuring child safety were a lack of fences around the properties, poor quality locks to their houses or simply not having a security gate. Changing social relations in neighbourhoods due to the erosion of trust and high rates of crime, violence and drug use, worked against the spirit of Ubuntu in communities. Participants perceived communities to have mixed values as a source of social support; while engendering a sense of belonging, wariness and a lack of trust of neighbours was evident. These concerns were expressed in both urban and rural communities which led to fear and could be a driver of isolationist behaviour such as a lack of participation in community activities. The more social problems there were in communities, the harder it was to maintain a network of social support. Positive community support should not be presumed to exist and the wider community context can be a 'disabling' rather than an enabling environment for child well-being. A lack of access to quality services in local communities such as childcare, running water, a lack of transport, bad treatment by service officials including corruption and discrimination in the delivery of services; were highlighted. The police and health care services were perceived to be poor especially in urban areas where services were over-subscribed and where community needs were overwhelming.

Implications of the findings for scaling up the impact of the CSG

The study findings confirm the initial ideas and principles that shaped the design of the CSG in 1997. The importance of boosting nutritional support through the delivery of a cash transfer and the principle of payment of a grant via the primary caregiver of a child – parents, grandparents and relatives – remain critical features of the CSG that are still relevant in the lives of children and their families in present day South Africa. Twenty years after the conception and implementation of the CSG, the need for supplementary material support to disadvantaged families continues. This was especially the case in the former homelands with larger households experiencing greater food insecurity. This in turn impacted negatively on the perceptions of their health and nutritional status. Boosting nutritional support to larger households, providing education on child nutrition and enhancing household food security strategies in these areas, may be important complementary interventions besides the provision of a cash transfer. In urban areas, caregiver depression was associated with lower perceptions of child health and lower height and weight for age of children. A lack of income and access to food in urban communities coupled with possibly other stressors of urban life; may underlie high levels of symptoms of depression observed among the caregivers. The need for mental health support services and psychosocial support to families is critical in light of these findings. The gaps in service provision such as a lack of CSG access for children younger than one year, the persistently high stunting rates among children, and the fact that 40% of children still went to bed hungry over a period of a year; are red flags that require public attention and action.

Other predictors such as low income and a lack of access to quality basic services such as shelter, water, electricity and sanitation, are associated with poor child well-being. Although progress has been made in these areas, efforts need to be stepped up in service provision, but also in the improvement of the quality of these services where they do exist. High rates of crime and violence in communities, and a lack of measures to improve the safety of families, are other stressors that impede efforts to enhance child and family well-being. Calls from CSG beneficiaries to address service delivery failures, the poor treatment that they receive from officials, and allegations of corruption; should not go unnoticed by politicians as the votes of grant beneficiaries are not assured just because they receive a grant from the state (Patel, Sadie, Graham, Delany, & Baldry, 2014). Some research findings demonstrate how grant monies contribute to livelihood strategies and asset building at household level (Daidone, Pellerano, Handa & Davis, 2015; Neves, Samson, van Niekerk, Hlatshwayo, & du Toit, 2009), but this is simply not enough in a low growth economic and employment trajectory for especially women with low levels of education and skills. Increasing the income flows to CSG households remains a critical priority. This will however, need to be accompanied by improved access to childcare services for caregivers of young children as well as mechanisms to support caregivers' own livelihood strategies.

Looking ahead, the impact of the country's recent investment downgrade could reverse the positive gains made in the nutrition and health status of children via the CSG. This could have negative effects on child well-being such as increased caregiver depression and increased behavioural problems in children due to rising food insecurity, a link which has been observed elsewhere (Black, 2012). All efforts will be needed

to avoid further slippage and economic decline. While some economists see a trade-off between social grant spending and managing debt servicing costs, it is vital that this much needed social protection net is not eroded in difficult economic times when it is needed most. Besides these fiscal challenges, governance failures in the administration of social grants could subvert the positive effects of this system. Failure to find viable, ethical, effective and long-term solutions to the delivery of social grants will not only place the livelihoods of over 17 million people at risk, it will increase poverty and inequality, reduce food security and will erode confidence and public trust in our constitutional democracy. This will have dire consequences for people's everyday lives and for social, economic and political stability.

Toward designing family strengthening interventions for CSG beneficiaries

Despite the positive effects of the CSG, by itself it cannot solve the complex and interlocking structural, psychosocial and household and community level factors that need to work together to improve child well-being and break the inter-generational cycle of poverty and inequality in South Africa. One way to increase support to poor and vulnerable families in receipt of a CSG, is through the provision of family- and community-based preventative developmental welfare interventions that combine social and economic interventions, and that include information, education and prevention strategies (Patel, 2015). Preliminary evidence from a family intervention in the Eastern Cape – Sinovuyo Caring Families - shows that there is potential to improve parenting and reduce child abuse and adolescent problem behaviour (Cluver et al., 2016). The SAFEChildren programme, a preventative family intervention specifically designed for poor children in urban communities in the USA, has had positive developmental effects on decreased child aggression, maintained parental involvement in a child's schooling and improved or maintained the child's concentration and prosocial behaviour (Tolan, Gorman-Smith & Henry, 2004). Skills-based parenting programmes delivered by trained professionals to small groups were found to be particularly effective especially where parents had exercised harsh forms of discipline before the intervention (Gross, Breitenstein, Eisbach, Hoppe, & Harrison, 2014).

There is therefore much to learn from evidence-based interventions that could be adapted to the local context and that are specifically pertinent to the needs of CSG beneficiary families. Gaps that need to be addressed in programme development that emerged from the study findings are: the need for family and community services for CSG beneficiaries; addressing the psychosocial needs of caregivers; and the development of knowledge and skills in parenting and nutrition. Understanding the social dynamics of social and community support, intra-familial relations, father absence and shared parenting are significant themes that need to be considered in the design of family interventions. Although CSG beneficiaries indicated a basic competence in rudimentary financial capabilities, they were eager to improve their knowledge and skills in this area. Interventions of this kind are known to have had positive impacts on building the assets of poor people

and in promoting a savings culture. To develop the financial capabilities of members of low income households who struggle with financial decision-making and navigating their way through complex financial systems; is now recognised as an important social development intervention (Sherraden, 2013). Economic stress has significant psychosocial effects on people's well-being such as depression, health-related problems and a decline in positive social relationships. People's financial and social well-being is therefore inter-related. Financial literacy skills and increased financial capabilities play a vital role in breaking the cycle of poverty (Engelbrecht, 2008; Mckernan & Sherraden, 2008; Patel, 2015).

The aim of family strengthening interventions is to improve family functioning in the following domains:

- The provision of psychosocial support to families.
- Strengthening of child-caregiver relations via the building of family cohesion, bonding, improving family communication, use of positive parenting skills especially in relation to discipline, in the monitoring of the child's behaviour and in the supervision of children.
- Promoting social and community connectedness through improved family connectedness and positive engagement with community networks and services.
- Strengthening of the financial capabilities of the caregiver and the family via the inclusion of financial literacy skills, family budgeting and a savings component in the intervention.
- Increasing knowledge about nutrition.

The aspects outlined above could serve as a useful starting point for the design of preventive family strengthening interventions to scale up the impact of the CSG. In the main family interventions are not able to address all aspects of family needs. It is for this reason that the aims and the programme content needs to be carefully assessed against known risk factors for child and family well-being. However, there is need to promote the development of positive parenting styles and behaviours that are important not only for disadvantaged parents; but that are beneficial for all parents (Gross et al., 2014).

The theoretical model that underpins the intervention builds on South Africa's developmental welfare approach that advocates both social protection for children (cash transfers) and integrated family and community interventions, contained in recent strategy documents of the Department of Social Development (UNICEF & DSD, 2017), the Child Care Act of 2005 (DSD, 2005), and earlier welfare policies such as the White Paper for Welfare of 1997 (Department of Welfare and Population Development, 1997). The view that families contribute significantly to social and economic development and should be supported in the provision of warm, loving and caring environments for children is consistent with the commitment in the White Paper on Families in South Africa (DSD, 2012) to support for vulnerable families. A mandate therefore already exists to design and implement preventive family interventions of this kind.

In addition to social development theory, components of psychoeducational, functional and structural-strategic approaches to family intervention provide useful insights for programme design (Tolan, Guerra & Kendall, 1995; Gorman-

Smith, Tolan, & Henry, 2000). The psychosocial model of health promotion (Nutbeam & Harris, 2004) is widely used in bringing about individual behavioural change and has informed health education and prevention campaigns to respond to the HIV and AIDS challenge in South Africa. This model draws on the health belief model and cognitive and social learning theories to inform education and prevention programmes. It is assumed that people are likely to adopt new ways of parenting if they perceive the intervention to be beneficial to the children in their care and that the benefits may outweigh the risks of not doing so. In this regard, Patel (2015) argues that in a knowledge and information technology driven society and world, poor and marginalised people are often excluded from accessing knowledge and information to improve their lives.

Preventive educational interventions delivered in a group format can achieve these objectives 'by assisting families to manage the stresses and challenges of everyday life in poor and difficult circumstances' (Sihleng'imizi Family Group Intervention Facilitator Manual, 2016, p.8). The prevention model is also different to the 'treatment model' where children are identified because they have pre-existing social and behavioural problems and are in need of child protection. Instead, the prevention model invites families to participate in an intervention programme. Recruitment may be through their local school or a clinic if they live in a high risk poverty environment, receive a CSG and if children and their caregivers show some signs of difficulty. The purpose is to intervene before serious problems occur and become chronic. Some of the critical success factors of family interventions appear to be related to include multiple components, are delivered by trained facilitators, and are locally accessible to the respondents (Mikton & Butchari, 2009).

Group learning formats delivered once a week with the whole family group consisting of between 10 to 14 sessions were found to be most effective in the SAFEChildren Programme (Personal communication, Gorman-Smith, 2015). However, other programmes reported reduced substance misuse among adolescents who received short-term targeted interventions consisting of only three sessions (Gross et al., 2014). Community-wide use of positive parenting messaging using different print and social media has been used in the Positive Parenting Programme (Triple-P) to change community norms around parenting and to reduce stigma associated with help-seeking (Prinz, Sanders, Shapiro, Whitaker, & Lutzker, 2009). Other success factors in programme delivery pertain to culturally appropriate interventions that are offered in the language of the respondents and that connect with their real-life experiences. In addition, it is important to take into account levels of literacy of caregivers, as in this research 4 out of 10 caregivers had very low levels of literacy. Since there is a dearth of appropriate family interventions in low- and middle-income countries, adaptation to the local context will need to focus on seeking cost-effective solutions that deliver high impacts and that are replicable in the local context. Consideration will need to be given to the qualifications and level of skills needed to deliver the family intervention as this may have significant cost implications. Service delivery partners at local level such as community-based organisations, faith-based organisations, NGOs delivering services and local authorities, may be best suited as delivery partners. Schools and local clinics are often used as cited for collaboration in family programmes.

Funding support for family interventions will need to be secured from government who could allocate incentive funds to support research-based innovative solutions that are suited to the local context. Limited funds are allocated in national, provincial and local authorities for preventive interventions. Private donors are also potential funders for local level community interventions, if a strong case can be made with corporate social investment programmes. Finally, monitoring and evaluation of family-strengthening interventions to assess their feasibility and effectiveness is critical to finding solutions that can be scalable. Welfare and service agencies often do not have the expertise to conduct rigorous evaluations; and partnerships with academic institutions and research bodies could be a way to overcome these obstacles.

In conclusion, combining cash transfers with family strengthening interventions will require significant mind-shifts among policy-makers, practitioners and development agencies. There is great public pressure to respond to the immediate problems of children through established child protection measures, most of which are statutory in nature. Although these are necessary, more effective early intervention and preventive intervention is needed to respond to the growing challenge to enhance child well-being among the majority of South Africa's children. There is great scope for innovation and learning from practice, to find solutions suited to the South African, and indeed the African, context. Much more research is needed to track child well-being in national data sets over time. Although these data sets are limited in that they do not allow for a comprehensive analysis of all the dimensions of child well-being. But in the absence of such data mixed methods studies do provide insight into the direction of the changes that are occurring in the lives of children and their families.

The quantitative findings in this study is based on the wave 1 data from NIDS which was gathered in 2008, and there is a need to test the analysis model in subsequent waves of the NIDS data.



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Appendices

Appendix A: Description of geo-types

In this report we differentiate between urban and rural geo-types, and further between urban formal and informal, and rural formal and informal. Below is a table describing on what kind of dwellings fall into each category.

Description of Geo-types

EA Type	Geography Type	Urban/Rural
Vacant Smallholding Urban Settlement Recreational Industrial Area Institution Hostel	Urban Formal	Urban
Informal Settlement	Urban Informal	
Farm Smallholding Recreational Industrial Area Institution Hostel	Rural Formal	Rural
Vacant Tribal settlement Recreational Industrial Area Institution Hostel	Tribal area	

Appendix B: Focus group guide

Focus group guide

Families, the CSG and child well-being project

14 August 2015

Introduction to focus group

Thank you all for coming today. My name is _____ and I will be leading the group discussion today. My colleague is _____ and she will be listening and taking notes as part of the team. This conversation will take about 2 hours and we will have something to eat and drink while we are talking.

We're here today to discuss your family and how things work in your home. We want to find out more about families who get a Child Support Grant, and all of you are getting one or more grants at home. I am part of a team working with researchers at the University of Johannesburg. We are not from the government or SASSA, and we do not have any control over your grant so don't worry that what you say will mean your grant is stopped. We can't do that.

We would like to ask you to keep our conversation private between the people here in the group and not talk about what particular people have said after you leave the group today. We will use these conversations to try and understand what kinds of services can make people's lives better. We will not use your names in the reports that we will write on these groups. There are no right or wrong answers to the questions we will ask; we really want to listen to you and your ideas.

Over there you will see a recorder which will record our whole conversation. This is to make sure we don't miss anything important that you say, but the tapes will not be used for anything else. They will be kept in a safe and private place. Before we start please can you read these forms and sign them to say that you have agreed to take part in this group

Section A: Vignettes

We are going to start with a short story about a woman and her family and then we are going to ask you some questions about her. This is not a test and there are no right or wrong answers to the questions, we just want to hear your opinions.

Story stage 1

Tsakane is a mother of 4 children, aged 9, 7, 6 and 3 years. She lives in a RDP house with her children, her husband who is the father of the youngest child, her husband's mother and his brother. They live near a small river and near a taxi rank. Tsakane makes vetkoek and sells it at the taxi rank. Her husband is looking for work.

The school has sent a letter to Tsakane to tell her that her 7 year old is struggling in grade 1 and she never does her homework.

- What do you think Tsakane should do about this?

Story stage 2

Tsakane wants her husband's mother, Mme Maria, to go and live with his sister in Rustenburg. The main reason is Tsakane is very tired of doing the housework and running her vetkoek business and looking after the children, and her husband's mother expects her also to cook at home and does not help. Also Tsakane thinks Mme Maria doesn't like her because she is older than her husband.

- Will Tsakane speak to Mme Maria about this?
- Will Tsakane speak to her husband about this?
- What does Tsakane's husband think about this?
- What do you think happens?

Story stage 3

One day during the summer when it had been raining a lot Tsakane came home from selling vetkoek at the taxi rank and saw that her 3 year old was not home. No-one knew where he was. They started to call and look and finally they found him tangled in some rope in a fast flowing drain pipe near the river where the children had been playing earlier.

- Why do you think this happened?
- Is there is someone who is responsible for this? If yes, who?
- How could this have been prevented?

Section B: Community and household resources

Now we are going to ask you some questions about your own community and households.

- What services do you use in the community? (things government provides and things you get from church or other organisations in your community)

PROMPTS:

- Clinic / hospital
- Crèche / day care/ school
- social workers
- Nutrition programme [use the programme name if there is one]
- Community gardens
- EPWP [public works]
- Water/ electricity / sanitation
- SASSA offices / paypoints
- Other
- Are you happy with these services? (be specific about what you are happy with and why)
- Are there any problems with these services? (be specific about what you are unhappy with and why)
- Do you have suggestions of how to make these better?
- Do you have anybody in your community or family to turn to when you need help with your children?

PROMPTS:

- If yes, who helps you and how do they help? [family members, neighbours, friends, community organisations]
- If no, why do you have no support?
- Who do you talk to about good things / worries you have about your children?
- What help would you like to get?

Section C: Family functioning

Now we will discuss how you do things in your own home. Everybody's answers are going to be a bit different because we all have different families and ways of doing things.

- What do you talk about in your family? As an example, think about what conversations you had yesterday with your family.

PROMPTS:

- Do you talk to your child about their day at school?
- Do you ask questions like what did you do? Who were you with? Good things and bad things that happened?
- Do you talk about worries or problems you or your family members have?
- Do you tell your family 'news' about what you heard or saw that day? Do they do the same?
- Do you tell your family about your day at home / work?
- If you are angry, upset, or worried about something in the family, what do you do?

PROMPTS:

- Talk to someone about it (who?)
- Pray
- Decide what to do on my own
- I land up fighting about it
- What do you enjoy doing together with your family?

PROMPTS:

- watching sport / TV
- Visiting others
- Going to church
- Anything else?
- Do you share household chores at home? (eg cleaning, cooking, shopping, washing, gardening)

PROMPTS:

- Who does most of the chores?
- Who else helps eg children?
- Is the father /partner /adult man involved in chores? What?
- What are the rules in your family about how people should behave?

PROMPTS:

- Who makes the rules about how to behave in the family?
- What happens if someone disagrees with the rules?
- Do you ever think your children are 'out of control' or 'very naughty'? Describe.
 - What behavior do you think is 'naughty'?
 - Give examples.
- If your children are naughty, what do you do about it?

PROMPTS:

- What do you do to discipline your children?
- Do you think it is OK to hit your children? If yes, when do you hit them and what do you use? (hand, stick etc)
- Who is allowed to hit your children? (their father, grandmother, each other?)
- What other punishments do you give aside from hitting?
- How can you tell when your child is upset or sad?

PROMPTS:

- Child will cry, behave badly, fight with other children, stealing, bedwetting, not wanting to go to school
- What do you enjoy doing with your children?
- How do you show your children that you care about them?

PROMPTS:

- I hug them / kiss them
- I look after them by cooking and caring for them
- I play with them
- I tell them stories
- I cook them special / their favourite things to eat
- Is your family close? Explain your answer using examples

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?

- What would help you feel closer?
- Who do you turn to in your family when you need support?
- What is the hardest thing about being a parent / caregiver?
- What is the best thing about being a parent / caregiver?

Section D: Service development

- If there was a new organization in your community that was started to help parents with their families, what are the THREE kinds of help you think would be MOST useful?

PROMPTS:

- Budgeting
- Saving money
- parenting skills
- talking to my child
- how to find information or services
- Other (please say)

Section E: Financial resources

Now we will ask some questions about how you survive financially at home and the things you do to make your money go further. We want to learn from you who are experts in handling money when there is not enough for everything you want to buy or pay for. We don't need to know HOW MUCH you get, just where you get your money from and how you use it.

- How do you get money to feed your family and survive? Please mention the kinds of things you and other people in your family do to earn an income.

PROMPTS:

- Grants (what kind and how many)
- Remittances
- Employment
- Self-employment and other livelihood activities in the household
- Food gardens
- Other

- We want to know if you are ever able to SAVE any money that you get? How?

PROMPTS:

- Stokvel
- Savings account
- Savings group
- hidden in the house
- monthly
- occasionally
- never

- And for what?

PROMPTS:

- Emergencies
- Education
- Medical costs
- Transport
- Helping family
- Other (please say)

- Describe the things you do well in managing your money.

PROMPTS:

- Saving
- Budgeting
- Careful buying
- other

- 1.4. Is there anything you sometimes want help with in managing your money?

PROMPTS:

- Saving
- Budgeting
- Careful buying

71– other

Section F: Depression index

We are almost at the end of our questions. The last thing I will ask you to do is to fill in this form please. It has 10 questions about how you have been feeling in the last week. Please fill this in on your own but I will read each question and explain it so you can be sure you are answering the way you have really been feeling. [Hand out form for them to fill in. Also hand out pens.]

Please do not write your name on the form. Please just write your age, how many children you have, and how many are getting a CSG. Then you will see a list of some of the ways you may have felt or behaved in the past. Please say how often you have felt this way DURING THE PAST WEEK by circling the right number for each question.

- I was bothered by things that that usually don't bother me.
- Please circle the correct number for how often you felt this way over the past week.
- Number 1 is if you felt this Less than 1 day over the past week;
- Number 2 is if you felt this 1 – 2 days over the past week;
- Number 3 is if you felt this 3 – 4 days over the past week;
- Number 4 is if you felt this 5 – 7 days over the past week.
- I had trouble keeping my mind on what I was doing [repeat scale as above if necessary]
- I felt depressed. [repeat scale as above if necessary]
- I felt that everything I did was an effort. [repeat scale as above if necessary]
- I felt hopeful about the future. [repeat scale as above if necessary]
- I felt fearful. [repeat scale as above if necessary]
- My sleep was restless. [repeat scale as above if necessary]
- I was happy. [repeat scale as above if necessary]
- I felt lonely. [repeat scale as above if necessary]
- 6.10 I could not 'get going'. [repeat scale as above if necessary]

That is the end of our questions. Thank you very much for giving us your time and talking to us about your lives. This is a small gift to show how much we appreciate your helping us [give each participant airtime].

Appendix C: Center for Epidemiologic Studies Depression Scale Revised (CESD-R- 10)

About: This scale is a self-report measure of depression.

Items: 10

Reliability:

Internal consistency for the CES-D-10 = (Cronbach's $\alpha=0.86$)

Test-retest reliability for the CES-D-10 = (ICC=0.85).

Test-retest reliability for individual items = (ICC=0.11-0.73).

(Miller et al. 2008)

Validity:

Convergent validity = .91

Divergent validity = .89

Correlation of the CES-D-10 to SF-36 subscales varies depending on the subscale.

Physical Function (Pearson's $r=0.37$)

Mental Health (Pearson's $r=0.71$)

(Miller et al. 2008)

Scoring:

	Rarely or none of the time (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)
Questions 5 & 8	3	2	1	0
All other questions	0	1	2	3

The total score is calculated by finding the sum of 10 items. Do not score the form if more than 2 items are missing. Any score equal to or above 10 is considered depressed.

References

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Miller, W.C., Anton, H.A., Townson, A. F. (2008). Measurement properties of the CESD scale among individual with spinal cord injury. *Spinal Cord*, 46, 287-292.

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Scale in English

Center for Epidemiologic Studies Short Depression Scale (CES-D-R 10)

Below is a list of some of the ways you may have felt or behaved. Please indicate how often you have felt this way during the past week by checking the appropriate box for each question.

	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)
I was bothered by things that usually don't bother me.				
I had trouble keeping my mind on what I was doing.				
I felt depressed.				
I felt that everything I did was an effort.				
I felt hopeful about the future.				
I felt fearful.				
My sleep was restless.				
I was happy.				
I felt lonely.				
I could not "get going".				



Scale in IsisZulu

zempilo zemizwa

Sithanda ukwazi ukuthi impilo yakho enhle jikelele iye yaphela evikini eledlule.

Ngizofunda uhlu lwezinye zezendlela okungenzeka uzizwe unazo noma waziphatha ngazo evikini eledlule. Usebenzisa ikhadi lokubonisa, uyacelwa ukuba ubonise ukuthi uzizwe kangaki unje evikini eledlule.

	Akwenzeki noma nganoma yisiphi isikhathi (Ingaphansi kosuku olu-1)	Kwesinye noma ngesikhathi esincane (Izinsuku 1-2)	Ngezinye izikhathi noma isamba sesikhathi esilingene (Izinsuku ezi- 3-4)	Ngaso sonke isikhathi (Izinsuku ezi-5-7)
Evikini eledlule...				
Ngangikhathazwa izinto ezingajwayele ukungikhathaza.				
Ngibe nenkinga ekubekeni umqondo kulokho engangikwenza.				
Ngazizwa ngikhathazekile emoyeni.				
Ngazizwa ngisebenzise amandla ami onke kukho konke engagnikwenza.				
Ngazizwa nginethemba ngekusasa.				
Ngazizwa nginokwesaba.				
Nganginenkinga yokulala.				
Ngangijabulile.				
Ngazizwa nginomzwangedwa.				
Ngaphelelwa umfutho.				

Scale in SePedi

Maphelo ka ga maiktlo

Re rata go tseba boiketlo bja gago ka kakaretšo gore bo be bo le bjang mo bekeng ye e fetilego.

Key a go bala lenaneo la ditela / mekgwa ye mengwe yeo o ka go ba o ile wa ikwa goba wa itshawara ka gona mo bekeng ya go feta. O šomiša karata ya pontšho, hle laetša gore o ikwele ka tsela ye ga kae mo bekeng ye e fetilego.

	Ka sewelo goba ga se nke ka ikwa bjalo (ka fase ga letšatši le 1)	Ka mehla e mengwe goba nako ye nnyane (1-2 ya matšatši)	Ka sewelo goba nake ye e lekanetšego (3-4 matšatši)	Ka dinako ka moka (5-7 matšatši)
Mo bekeng ye e fetilego...				
Ke bo ke tshwenya ke dilo tšeo gantši di bego di sa ke di ntshwenya.				
Ke bile le bothata go bea mogopolo w aka go seo ke bego ke se dira.				
Ke ikwele ke nyamile.				
Ke ikwele o ka re se sengwe le se sengwe seo ke se dirilego e be ele maitekelo.				
Ke ikwele ken a le tshepo ka ga bokamoso.				
Ke ikwele ken a le letšhogo.				
Ke be ke sa kgone go ka robala.				
Ke be ke thabile.				
Ke ikwele ke le noši.				
Ke be ke sa kgone go ka tšwelapele.				

Appendix D: Consent form for Focus Groups



Centre for Social Development in Africa

University of Johannesburg
Phone: (011) 559-1907 Fax: (011) 559-1575
Director: Prof Leila Patel
www.uj.ac.za/csda

Ndlovu Care Centre and the University of Johannesburg are working together to find out more about families in Elandsdoorn and other areas close by. I agree to be part of the group discussion at Ndlovu with women like me getting a Child Support Grant. I understand that:

- I am free to decide to take part in this research and nothing bad would happen if I do not want to take part.
- I can stop any time I want to and I am allowed to decide not to share anything I don't want to share.
- I will not be paid or get any special services or information for taking part in the group.
- The discussion will take about 2 hours.
- The researchers will not use my real name when they write about this research.
- The researchers will be recording the interview and the tape of our voices will only be used for this research and will be kept safe and private.

Name

Signed

Date

I also agree for my photograph to be taken to be used for this research. This photograph will be kept by the University of Johannesburg and will only be used for their work and will not be given to anyone for other purposes.

Name

Signed

Date

Appendix E: Key Informant Interview Guide and Consent Form



Centre for Social Development in Africa

University of Johannesburg
Phone: (011) 559-1904 Fax: (011) 559-1575
tessah@uj.ac.za
www.uj.ac.za/csda

21 January 2016

Dear colleague

Invitation to be interviewed about your family programme for research on family support

The Centre for Social Development in Africa, at the University of Johannesburg, is conducting a research study on the kinds of supports poor families need to enhance well-being of children in the family. An assumption we make in this research is that family support in the form of programmes to enhance parenting, communication skills, relationship building, or other family skills, can positively impact child well-being outcomes.

We wish to find out more about the current family/parenting programmes being run in South Africa. As an expert and/or practitioner in this field, we would be grateful if you would grant us an interview to discuss the programme/s you know well.

If you agree to take part, the interview will be approximately an hour long. You will also be asked to send the interviewer your programme materials if you have permission to make these available to us. Your participation in the research is completely voluntary and there are no direct risks to you in participating, or repercussions for choosing to discontinue.

We wish to audio-record the interview for accuracy purposes. Your identity in the research report or other research outcomes will remain confidential, although it is possible that you could be recognised by people in the field if you run a programme that is easily identified.

If you have any research related questions you are welcome to contact me (see above for contact details).

Kind regards



Tessa Hochfeld
Senior Researcher
CSDA, UJ



Key informant interviews

Consent form

I consent to participate in the study and understand that participation is voluntary. I agree to be audio-recorded during the interview. I have been through the information letter with the researcher and have had an opportunity to ask any questions.

Name

Signed

Date

Date & time	
Organisation	
Programme name	
Name of interviewer	

Key informant interviews

Thank you for agreeing to take part in this research. Please note that we will speak about “the programme” during this interview. When referring to the programme, we would like for you to focus on one or perhaps more parenting or family programmes that your organisation offers and runs, or a programme that you know well from the past. If you are speaking about more than one programme, please specify this in your answers.

Section A: Programme information

- What is the main objective of the programme?
- How was the need for the programme identified?
- What is the theoretical framework or assumptions on which the programme is based?
- How was the programme developed? (*Is the programme an adaption of another programme/ are some programme activities or aims taken from another programme?*)
- Please specify the topics covered in the programme, and what each of these topics entail.
- How is the programme delivered?

PROMPTS:

- Number / duration /frequency of sessions
- Facilitation: how many facilitators and who are they?
- What are some of the activities done in the programme?
- What resources are needed to deliver the programme? (eg venue, materials, transport funding, human resources, other costs)
- Are the programme facilitators trained to run the programme? If yes, please describe the training.

PROMPTS:

- Who runs it
- Content
- Is there an assessment at the end
- Does it include role playing skills
- What supervision do they get during the programme

Section B: Target population

- To whom is the programme targeted? What is the motivation for this target group?

PROMPTS:

- Teenage parents
- Parents with teenage children
- Only men /women
- Families with older /sick people who require care
- How are members recruited into the programme?

PROMPTS:

- Is this an open programme, by invitation only, etc?
- Is there a screening process for the members of the programme?
- Motivation for screening?
- How does it work?
- How many people form part of a group?
- Is there any post-programme service offered? If yes, please explain the post-programme services.

Section C: Programme Evaluation

- What are the expected programme outcomes?

PROMPTS:

- What impact does the programme have on the target population?
- Are there indicators of these outcomes?
- How and when is the programme monitored and evaluated?

PROMPTS:

- How do the programme participants contribute towards the evaluation process?
- Has the programme been externally evaluated?
- Do you record and track the evaluation results / impact over time? (eg research, publications – explain in detail)
- What do you think works really well?
- Do you think that there is anything that could be done more effectively?

PROMPTS:

- In your opinion, what is missing from this programme?
- How would you change the programme if you could?
- On reflection, is this the best way to reach the participants? Are there other ideas which might work better?
- What kind of additional resources could enhance the programme?
- Is there anything else you think we need to know about the programme?

We have come to the end of the interview. We would like to request access to the programme material, whether it be the manual, review documents, internal or external reports, articles or other publications that are related to this.

Thank you for your time!

