Community of Practice for Social Systems Strengthening to Improve Child Well-being Outcomes

Findings from Wave 1: Tracking Child Wellbeing of Early Grade Learners and their Families

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Acronyms

ALCoP – Advisory Level Community of Practice
CoJ – City of Johannesburg
CoP – Community of Practice
CSG – Child Support Grant
CWTT – Child Wellbeing Tracking Tool
LLCoP – Local Level Community of Practice
PS – Primary School

Executive Summary

This Community of Practice (CoP) intervention research project is a multi- and trans-disciplinary collaboration between researchers and practitioners across different sub-fields, including social work, sociology, psychology, education psychology, education, mathematics and language curriculum specialists, mental health, nutrition, primary health care, community nursing, public health and school health care services. The CoP study targets children and their caregivers who receive a Child Support Grant (CSG) in the foundation years of schooling, namely, Grade R and Grade 1. Investing in children's nutrition and health, improving their emotional and social wellbeing and schooling outcomes are important social investments in the human resources of a country (Patel et al., 2017). These early interventions tailored to meet children's needs in poor families could lead to children securing better jobs with higher incomes in adulthood and the creation of more stable families and communities (Patel et al., 2017; Richter et al., 2018). In addition to social protection measures, collaboration between key sectors is assumed to be instrumental in accelerating child wellbeing outcomes, building capacity and developing contextually relevant innovative solutions.

In initiating the CoP we were interested in understanding, firstly, what constituted the most appropriate cross-sectoral interventions to step up child wellbeing outcomes, and secondly, how these interventions could be delivered across the health, education and social welfare sectors. We were also interested in evaluating the viability of the CoP approach for strengthening social sector systems to improve child wellbeing in urban communities.

The study began with the establishment of an Advisory Level Community of Practice (ALCoP) made up of academic and research partners who are responsible for the overall leadership and management of the project. The ALCoP developed the digital child wellbeing tracking tool (CWTT) which was pre-tested and first administered between October and December 2020 (phase one). During phase one, the CWTT assessed the levels of risk experienced by the child and his/her family. Children were conveniently selected from one Grade R and one Grade 1 class from the participating school in each community, all of which are quintile levels 1-3 schools in low income communities. Parents and caregivers in each of these classes were invited to participate in the study. Across all 5 schools, a total of 162 children and their families participated. Schools were situated in Meadowlands, Ivory Park, Doornkop, Malvern and Alexandra. Based on the results from this phase, intervention plans were developed for all children identified as being at high or moderate risk. This strategy entailed the establishment of Local Level CoP's (LLCoP) at each of the schools, which included key community stakeholders (that is, social workers, teachers, nurses and parents). Collaborative discussions were held between members of the ALCoP and the LLCoP to develop suitable interventions which included referrals to support services and specialised care. Following the intervention, it was planned that phase two of the child wellbeing assessments would be implemented between August and September 2021. In this research report we present the baseline findings from Phase one.

Key findings from the CoP baseline assessment

Conditions under which early grade learners/young children are living

Household access to services:

- Most children lived in households that have access to basic resources and services, such as water, sanitation, and electricity.
- Just over 90% of children lived in households that had protection from rain and wind, access to drinking water at home, electricity, and a toilet in the home.
- The majority of households (89%) received one or more Child Support Grants followed by the Old Age Pension (16%).
- In addition to the Child Support Grant, about 57% of households received other sources of income and only 35% had sufficient money to buy the things they needed.

Caregivers' educational, financial and psychosocial wellbeing

- Most caregivers had some secondary education (55%), 30% had completed school and 8% had post-secondary education.
- The majority of caregivers in the sample were unemployed (65%). Approximately 17% were employed full-time, 9% of caregivers were employed part-time and 5% of caregivers were self-employed (5%) and/or did some piece work (4%).
- Approximately 27% of respondents struggled to pay off their debts and 54% of caregivers were struggling to save money monthly.
- About 55% of caregivers in the overall sample had depressive symptoms. In some schools, there appeared to be higher depression scores, for example, caregivers from Meadowlands appeared to have the highest depressive symptoms (78%), followed by those in Doornkop (60%). Just over 40% of caregivers in Alexandra, Malvern and Ivory Park presented with depressive symptoms.
- The majority of the caregivers reported not having family or community support in times of need (63%).

How are young children faring?

Health, nutrition, education and psychosocial wellbeing indicators

Health

- Approximately 21% of children had some health concerns that indicated a need for support or health interventions.
- Approximately 13% of children were stunted, 6% appeared to be wasted, 7% were underweight, 4% were overweight.
- Approximately 15% of the caregiver's reported that their child's health was preventing them from going to school.
- Almost 39% of the children did not participate in any sporting activities outside of school hours.
- Health care workers reported that 33% of the children's vaccinations were not up to date and approximately 20% of the children had dermatological conditions.

Nutrition

- Approximately a third of caregivers reported that their children always (13%) or sometimes (20%) go to bed hungry, 13% of children did not have enough to eat in their households and 12% did not eat three meals a day.

Education

- Our sample included 46% of children in grade 1 and 54% in grade R. Of these children, 21% of them were older than the age expected for grade 1 (8 years of age) and 6% were older than the age expected for grade R (7 years of age).
- Caregivers appeared to have a positive view about the children's progress at school as well as their own involvement in their children's schooling.
  - Approximately 84% reported that their children were progressing with their schoolwork, 88% stated that their children did their homework as required and 94% said that there was always someone to help the child with their homework.
  - More than a third or 36% of the children were afraid or refused to go to school, the majority being in Grade R.
- Teachers' responses regarding child school attendance, progress and wellbeing appeared to be lower than that reported by caregivers.
  - Approximately 68% of children do their homework as required.
  - Teachers identified 22% of children with a learning difficulty.
  - Teachers reported that 80% of caregivers were involved in their child's education and 90% of children attended school and were well groomed.
- Teachers identified symptoms of anxiety in 13% of children and unhappiness in 7%.
- Teachers also reported that about 18% of the children had difficulty in controlling their behaviour and 14% of the children struggled to remain calm when they were upset.

Mathematics and Numeracy and vocabulary assessment

- The young learners were not ready for the pace of the school curriculum.
- There was the likelihood that children's low achievement on the standardised number concept test (MARKO-D SA) was limited by lack of early childhood learning opportunities.
- Vocabulary and syntax of the MARKO-D SA require sufficient language competence.
- The children's scores on the reading test were similar to tests conducted in other local schools.

Psychosocial wellbeing

- Just under two-thirds of 64% of caregivers reported being concerned about the safety of their children while 8% of the caregiver's reported that their children had been victims of abuse or violence and 67% had been exposed to some form of violence at home or in the community.
- One fifth or 20% of children appear to be experiencing challenges based on findings from the *Strengths and Difficulties* questionnaire.
- Findings from the *Child and Youth Resilience Measure* show that that over a quarter of the children (27%) exhibited exceptional resilience and under a fifth (18.5%) had low resilience

Next Steps

Based on findings from the baseline assessment, we implemented a number of interventions to support the child, the family, the school and the wider community. Child care plans were developed to ensure that all health-related challenges were referred to the relevant organizations and received attention (including vaccinations). Children not progressing as they should be at school were referred to educational psychologists for psychometric assessments, while food insecure children and families were connected to existing food networks. Family level interventions included access to and home visits by a social worker, and opportunities for families in need to participate in the Sihleng'imizi family strengthening

programme. At the school level, local level community of practice and referral networks have been established to ensure greater collaboration as well as mathematics and literacy capacity building of teachers.

Additionally, the CoP facilitated community education and information exchange by hosting a community radio campaign in two of the five areas, sessions focused on parental engagement in schooling; nutrition and health; tips for caregivers/parents; and financial capabilities. Lastly, findings from the study are being disseminated through various platforms, including government and non-governmental agencies, to raise awareness of the complex needs of children and to encourage greater collaboration, risk assessment, timely interventions and improve responsiveness to fast track child-well-being out-comes.

Conclusion

Meeting the multi-dimensional needs of children and their families in the foundation stages of their growth remains a national and a global priority. Findings from our baseline assessment highlight the diverse and multi-faceted challenges that children and families face. In order to address these challenges, both customised solutions as well as multi-component and complementary interventions across different sectors and disciplines is required. The CoP provides the opportunity to think and develop institutional and systemic change. Lessons learnt during the implementation of this innovative project could aid the search for holistic solutions.

Introduction

The rights of children are enshrined in the South African Constitution. The country's apex law, in Sections 27, 28 and 29, guarantees children's rights to basic education, health, food, care and social assistance (National Child Care and Protection Policy, 2019). In addition, South Africa has several social policies that are intended to improve child wellbeing outcomes, including free basic education and primary health care, the Child Support Grant (CSG), and the National School Nutrition Programme (NSNP). Reports from the Department of Social Development show that close to two-thirds of children – a total of 13.4 million beneficiaries received the Child Support Grant (CSG) at the end of April 2021. A range of other child protection and welfare services are also available through both state and civil society organisations. However, the daily reality for millions of South African children differs greatly from the protections promised by the Constitution and policies. These children, many of whom are African and Coloured, live in poor households that struggle to meet their basic needs for nutrition, clothing, and shelter; impacting both their short and long-term development (Hall & Sambu 2018; Van Der Berg, Patel & Bridgman, 2021). Cracks in service provision due to fragmentation and a lack of functional co-operation between the health, welfare, and education sectors, leaves them further behind (Richter, et al., 2018). A way to ensure that no children are left behind requires a coordinated response between these social sectors, collaborating and cohering around shared goals, actions and outcomes.

The Community of Practice (CoP) brings together researchers, practitioners and governmental and non-governmental partners to find break through solutions to fast-track child wellbeing outcomes. The CoP intends to harness existing resources across key social sectors in health, nutrition, learning, and social and community services. It builds on prior research that demonstrates the positive impact of the CSG on, for example, food poverty, child hunger and improving school attendance (Biyase, 2016; DSD, SASSA & UNICEF, 2012; Eyal & Woolard, 2013; Van der Berg et al., 2021). Other studies have found that the CSG also has positive nutrition effects, enables greater caregiver engagement in activities that are associated with children's wellbeing, and aids in women's empowerment in financial decision making (Patel,2021). Although cash transfers are necessary and critical to improving the material wellbeing of children and their families, on its own, it is unable to address the other dimensions of children's wellbeing (Patel et al., 2017; Patel & Ross, 2020). The CoP attempts to address this knowledge and service gap and employs a multi-systemic approach to child well-being that locates the child in a wider family, school and community context.

Background and Rationale

Adverse childhood experiences, such as poverty, hunger, experiences of or exposure to violence and abuse, loss of a significant attachment figure, caregiver depression, and low levels of educational attainment of caregivers compromises the overall wellbeing of children and has detrimental impacts on their long-term trajectories (Patel et al., 2017). In South Africa, the legacy of racial, spatial and social inequalities, ongoing systemic failures as well as exposure to familial and community level stressors severely compromises children's wellbeing.

The World Health Organization (WHO, 2020) estimates that worldwide, about 10-20% of children and youth experience mental disorders. Neuropsychiatric conditions are the leading cause of disability in young people in all regions internationally. If untreated, these conditions severely influence children's development, their educational attainments and their potential to live fulfilling and productive lives. Poor outcomes for children may for instance manifest in poor mental and physical health as well as poor school performance and high drop-out rates. Research suggests that poor school performance in the foundation years of schooling have 'knock on' effects on subsequent educational attainment (Henning & Ragpot, 2015; Shonkoff, Boyce, & McEwen, 2009).

Systemic risk factors that impact on child wellbeing outcomes, include poor coordination, a lack of seamless government, lack of organisation around child wellbeing outcomes instead of around activities and functions that operate in silos; different policy and organisational mandates; inadequate funding and human resource systems; different reporting lines, operating procedures, work styles and cultures and knowledge systems; resistance to new ways of working as well as competition between different spheres of government and implementing agencies.

Research suggests that prioritising and investing in children's nutrition, education and health and emotional wellbeing in the early years is an essential social investment in the human resources of a country (Patel, et al., 2017). It contributes to better employment and higher income opportunities in adulthood (Alex-Petersen, Lundborg, & Rooth, 2017; Haile, Nigatu, Gashaw, & Demelash, 2016), and creates more stable families and communities and ultimately, a more cohesive and peaceful society (Patel et al., 2017; Richter et al., 2018).

In order to promote better outcomes for children in the early years and in response to these multiple and intersecting challenges, international and South African social and education policy scholars and development agencies motivate for integrated and complementary services. Ensuring a coherent and consistent synergy across different social service sectors, includes (a) having access to quality learning opportunities; (b) supportive social and health services; (c) nutritional support; (d) material support; (e) promotion of the safety and security of children; and (f) the presence of responsive and informed caregivers and families, as well as well-versed and knowledgeable teachers.

Description of the CoP Project

In order to promote more integrated and synergistic interventions to improve children's wellbeing, the Communities of Practice (CoP) model was deployed in this study. Communities of practice are social entities, made up of like-minded individuals who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis, while innovating and developing a particular field (Vincent, Steynor, Waagsaether & Culla, 2018; Wenger et al., 2002). They work as "social learning systems where practitioners connect to solve problems, share ideas, set standards, build tools, and develop relationships with peers and stakeholders" (Snyder, Wenger & de Sousa Briggs, 2004, p. 17). Following this approach, the CoP was established as a multi- and trans-disciplinary two–year collaborative intervention research study, funded by the National Research Fund. This CoP brought together a community of researchers and practitioners, from social work, sociology, psychology, educational psychology, educators, mathematics and language curriculum specialists, mental health, nutrition, primary health care, community nursing, public health, school health care services and engineering. Working together the CoP developed a child wellbeing digital tracking tool as well as an intervention plan (discussed below).

Purpose: The purpose of this collaboration is to address the disparate and fragmented service provision in the social sector by integrating interventions across health, welfare and education to accelerate child wellbeing outcomes in South Africa.

Target group: The target group of this CoP is children in the foundation years of schooling (Grade R and Grade 1); a period of childhood with a known gap in integrated service provision. This age is also the period when the foundation for learning mathematics is laid, without which children are less likely to progress successfully (Aunio, Korhonen, Ragpot, Törmänen, & Henning, 2021).

Process: This two-phased study commenced with the development of a digital Child Wellbeing Tracking Tool (CWTT) to (a) conduct a risk assessment of participating children; and (b) inform the development and implementation of intervention and care plans for children at medium and high risk. We take the view that early interventions tailored to children's needs in poor families in the foundation years of schooling could improve their well-being in the short to medium term with positive benefits in later life (Patel et al., 2017).

In this report, we share details on the development of the CWTT, focusing on the findings from the baseline assessment (Wave 1) and present a brief overview of the intervention plans. Information regarding the collaborative process is not the focus of this report.

Conceptual Framework

The social development approach provides a useful framework for social systems strengthening for children and families. It is pro-poor, draws on inter-sectoral and interdisciplinary social science knowledge, partnerships in development, espouses a participatory ethos and a combination of micro, mezzo and macro level interventions that are well suited to address the needs of the target group of the study (Crea et al, 2018; Patel, 2015). This approach further resonates with the multi-systemic, ecological model of child development that draws together the proximal and distal intersecting structures (child, family, school and community and wider societal context) in shaping child development outcomes (Bronfenbrenner, 1977; Ungar, 2020). This multi-level, multi-systemic framework situates the child and his/her family at the centre of multiple and intersecting systems, all of which impact on the child's wellbeing.

Child Wellbeing: The concept of child wellbeing and its measurement has been the subject of much discussion and debate (Ben-Arieh, 2008; Bradshaw & Keung, 2011; UNICEF, 2007). Various governments, non-governmental organizations, and researchers have proposed both narrow and more expansive definitions. Initial indicators of child wellbeing focused on survival and negative outcomes but this approach developed into a more inclusive focus on wellbeing and positive outcomes that sought to include perspectives of children as well as those of adults (Ben-Arieh, 2008).

Child wellbeing outcomes may be objective (using validated assessment tools relating to education, health and psychosocial assessments, or subjective, (expressed from the child's or caregiver's point of view). Outcomes are influenced by the child, the immediate contexts of the child, such as caregiver wellbeing and family contextual factors and the material wellbeing of the family as well as the community and the wider society and the world at large (UNICEF, 2020). In conceptualising a rights-based approach to child wellbeing, deemed appropriate for the South African context. Bray and Dawes (2007) contend that indicators for child wellbeing should include inputs for wellbeing as well as child outcomes. As such it should include indicators of the quality of the child and his/her family's socio-economic and development context, the care situation, service access as well as the child's status, in terms of health, education and safety. Lippman et al. (2009) however, caution that it is important not to mistake measures of context with measures of child wellbeing outcomes.

In our study, we draw on and adapt these existing understandings of child wellbeing. We consider child wellbeing to refer to the whole child and include the child's physical health, development and safety, psychological and emotional development, social development and behaviour, cognitive development and educational achievement (Moore, 2013; Patel et al., 2017; UNICEF, 2013; 2020). At the same time, we assess the child and families' lived contexts recognising the significant impact that the wider system and policies have for children and families in South Africa (Bray & Dawes, 2007). Child wellbeing thus refers to the material, physical, educational, social and emotional wellbeing of children (Ben-Arieh, 2008; Bradshaw & Keung, 2011; Statham & Chase, 2010; UNICEF, 2007; 2013; 2020). We focus on five interconnected domains for child wellbeing and the requirements for children to achieve wellbeing within each of these domains. Measuring and assessing the wellbeing of children is necessary to enable us to understand how children are faring. In the table (Table 1) below we describe the domains that we include and the key indicators.

	Domains	Indicators
1	Good Health	Morbidity Inoculation Obesity/Stunting Exercise and activity Accessing health services
2	Optimal Nutrition and food	Food security Quality of food Quantity of food
3	Economic and material wellbeing	Access to financial resources Indebtedness Ability to save Household living conditions Access to basic services
4	Education and learning	School Attendance Progression Mathematics and language competency Caregiver involvement
5	Protection and Care	Family relationships Presence of supportive others Exposure to violence/conflict
6	Psychosocial health	Behaviour at home and in the classroom Coping Self-regulation Problem solving Depression Anxiety Resilience Strength and difficulties Caregiver mental health

Table 1: Child Wellbeing Indicators

Methodology

In the previous section, we briefly described the process of establishing the CoP. A primary objective in the creation of the CoP was to work together to develop a tool to assess how Grade R and Grade 1 children are faring across a number of key domains and to use findings generated from this baseline assessment to develop and implement a contextually relevant intervention. Following this intervention, it was planned that participating children would be re-assessed to determine the efficacy of the intervention. Figure 1 below provides a comprehensive overview of the research process and methods including partners, participants and the implementation plans for wave one (baseline), the intervention and wave two (following intervention). This report only reports on the baseline findings of the 162 children assessed at baseline.

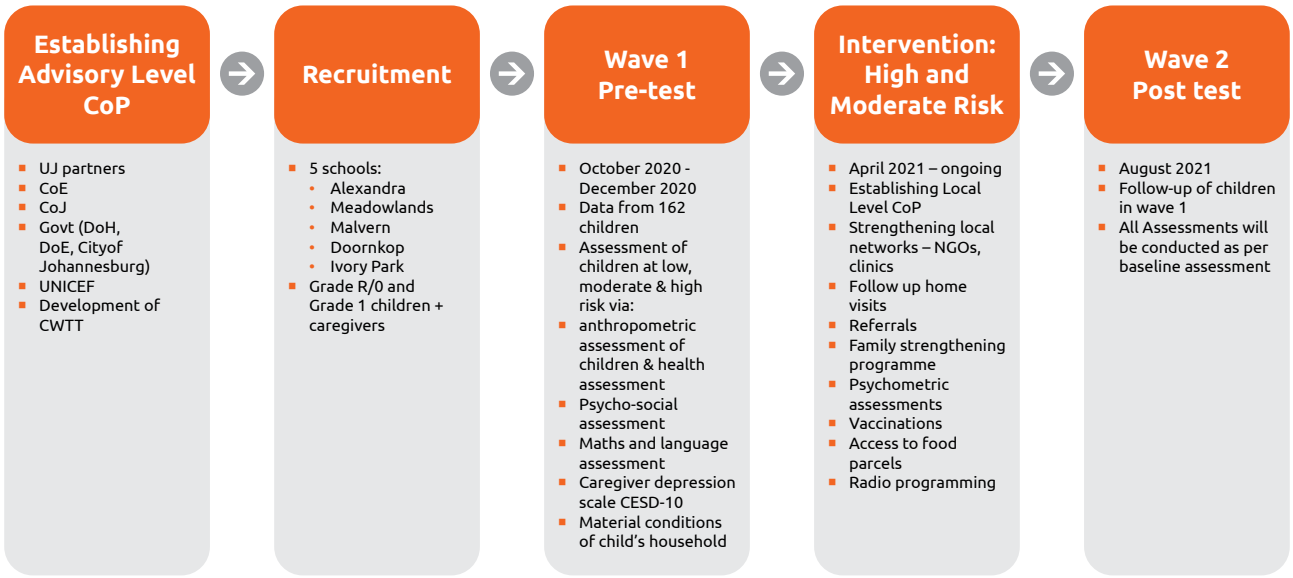

Figure 1: CoP Process and methods

In the sections that follow, we describe some of these processes in detail.

Developing the CWTT

The Child Wellbeing Tracking Tool (CWTT) questionnaire was co-designed by partners in the Advisory Level CoP (see above).

Both a literature review of child wellbeing and findings from various studies conducted by the respective chairs, informed the domains included in the questionnaire. For each child sampled, data were collected from important role players in terms of the child's overall wellbeing. These role players included: the caregivers, the school teachers, and the children themselves. The children and caregivers were interviewed by a social worker who completed the questionnaire. The teachers completed the questionnaires themselves. The nursing preceptors conducted a physical examination and completed questionnaires.

The CWTT contained six sections to generate data on various aspects of the children and their family contexts. The aim was to assess child wellbeing by including both subjective as well as objective indicators of child wellbeing. The focus was therefore on the child and his/her family as well as the systems surrounding the child. The CWTT further drew on some aspects of a similar child wellbeing tool developed by UNICEF to assess children of all age groups (UNICEF, 2007).

Questions captured demographic information about the household, the caregiver and the child. The caregivers' mental wellbeing and coping during Covid-19 was also assessed. The Centre for Epidemiological Studies' Depression Scale (CES-D-10), shown to be valid for the South African population (Baron, Davies, & Lund, 2017) was used to assess depressive symptomology. This information provided information on the child's living context and the surrounding systems.

Questions related to the domains of child wellbeing (see Table 1), that is, adequate nutrition, good health, educational achievement and progress, positive relationships/attachments and safety and security were used to assess the child's wellbeing. The questions in the CWTT (see questionnaire in Appendix I) aligned with these domains, focused on economic and material wellbeing, food and nutrition, education, health, and protection and care. Table 2 below describes the measures included in each domain. For each domain a set of questions were asked, with response options of yes, no or sometimes.

	Domains	Measurements included
1	Good Health	History of illness/hospitalisations/inoculations Anthropometric measures Ability to hear/see and talk Participation in sporting and other physical activities Access to available services
2	Optimal Nutrition and food	Availability and access to food Nutritional quality of available food
3	Economic and material wellbeing	Sources of household income Access to money to purchase necessary items Ability to save Ability to pay off debts Access to basic services (electricity and water) Safe, secure and comfortable physical home
4	Education and learning	Regular attendance at school Academic progression Ability to do homework Support in doing homework Access to resources Fear related to going to school Involvement of parents in school
5	Protection and Care	Caregiver awareness of child's whereabouts Presence of supportive, caring adults Concerns regarding child safety Exposure or witness to violence/conflict Victim of abuse/violence Disciplinary methods
6	Psychosocial health	Ability to problem solve Ability to make friends Ability to regulate behaviour Ability to focus and pay attention when needed Symptoms of depression and/or anxiety Child and Youth Resilience Measure Strength and Difficulties Questionnaire CES-D10 – Depression Scale

Table 2: Measures included in each domain

In order to corroborate what caregivers reported, a nursing preceptor assessed the child's physical wellbeing including their Body Mass Index. This assessment was carried out in accordance with the World Health Organisation's child malnutrition indicators (WHO, 2008). The school teacher was asked to assess and report on the child's competence, progress and psychosocial behaviour in class. Psychosocial development and wellbeing were further assessed using two standardised psychometric measures, that is, the Child and Youth Resilience Measure (CYRM) (Ungar & Liebenberg, 2011) and the Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997). The CRYM and the SDQ as well as the CES-D10 have been validated for use in South Africa.

Piloting of the CWTT

The CWTT was piloted on five parents of children in Grade R from various Early Childhood Development (ECD) Centres in Orange Farm. These ECD Centres were selected for the pilot as the CSDA has an existing relationship with them, and the demographics of the caregivers in Orange Farm are similar to the five schools selected for the study. The pilot interview participants were recruited via Day Mothers in Orange Farm who were part of the SmartStart Early Learning Programme. The pilot interviews were conducted telephonically. The questionnaire was not piloted on teachers because the schools were closed due to COVID-19. Following the pilot, no changes were made to the questionnaire.

Digital version of the CWTT

The CWTT technology was designed and developed by a CoP partner and his team in the Engineering Management Department at the University of Johannesburg. The team has been a part of previous application (App) development and data analytics projects, including Artificial Intelligence.

The application requirements were to create a digital database, with the ability to capture information on location (informal addresses) and photos, link diverse data to a child, and consolidate data and data analytics. Key features needed included: the ability for offline and online usage, the capacity to collect large data volumes with the ability to align multi -sourced data, ease of accessibility and cost effectiveness, and the system needed to be owned by the University of Johannesburg.

Based on these requirements, the team conducted an initial review and analysis and identified "Powerapps" as the tool of choice. A front end was developed for the definition, construction and development of questionnaires together with user authentication. A back end was developed to accommodate data extractions. The App was tested and deployed. The App was used to collect data from some 160 children for phase one of the project. The data collected were then analyzed using various basic and advanced statistical tools.

During the data cleaning cycle, various constraints were identified. These constraints were reviewed and fixed by the development team. The App has also been modified significantly to accommodate various additional functionality such as branching, single identification with interlinking instrument, enhanced offline capacities, improved globally unique identifiers (GUI) and various other functions. The team have completed phase 2 acceptance and are stress testing version 2 of the App.

The digital CWTT was piloted during the questionnaire pilot. It was further tested during the first phase of data collection where both a printed copy of the questionnaire and the Tablet were used to collect data during the interviews. The CWTT development continues as an iterative and ongoing process.

Sampling

Children in Grade R and Grade 1 who are recipients of the CSG and attending school in selected schools in the City of Johannesburg (CoJ) were identified as the target group. Five schools were chosen from areas defined as critically poor by the CoJ. The school sample was conveniently selected from a selection of schools in the City of Johannesburg with which the CSDA has an established relationship. Table 3 below provides a brief description of each of the sites.

With the exception of Malvern Primary, the schools are no-fee paying schools. Public schools in South Africa are divided into five quintile rankings; the lowest three quintiles are no fee-paying schools. A school's quintile ranking is determined by the Department of Basic Education based on the income, literacy and unemployment levels in a community. These schools are wholly subsidised by the government. The five schools are geographically spread through the CoJ.

Name of school	Region, Ward and Area name[1]	Area description[2]
Lejoeleputsoa Primary School	Region D: Meadowlands Zone 3, Ward 42	Meadowlands is located in Soweto. It has an average population of 23,974. The average monthly household income is R2, 500, with a 40% employment rate. Eighty-five percent of residents live in formal housing.
Mikateka Primary School	Region A: Ivory Park, Ward 77	Ivory Park has a population of approximately 38,546. The rate of employment is about 45%. Most people in Ivory Park have access to piped water (97%) and sanitation (93%), although 22% of households live in informal dwellings (shacks).
Malvern Primary School	Region F: Malvern, Ward 65	Malvern has an approximate population of 26,529 and most people live in formal housing. 52% of working-age residents are employed, and most people have access to piped water and sanitation.
Mayibuye Primary School	Region C: Doornkop, Ward 50.	Doornkop has an approximate population of 23 255 residents. About 36% of whom live in backyard shacks or informal housing, 97% have piped water access and 90% have access to sanitation services. There is a 36% unemployment rate and the average household income is R1, 200 per month.
Ekukhanyisweni Primary School	Region E: Alexandra, Ward 109	Commonly known as Alex, it is a high-density area. Informal housing makes up 28% of the homes, and 71% of the population has access to sanitation. Water provision reaches 96% of the ward. Over half the population are employed (61%).

Table 3: Brief description of the research sites

[1] Source: 1 https://www.joburg.org.za/about_/regions/Pages/Map%20of%20Regions/map-of-regions.aspx

[2] Source: Patel et al. (2019, p. 21)

It was initially envisaged that 200 children would be included in the study; 40 children per school, with 20 children each from a Grade R and Grade 1 class. Classes were to be randomly selected and the sample consisted of all the children in the selected grade. All children in the grade were invited to participate in the study. However, as data for this pre-test intervention (Wave 1) were gathered during the COVID-19 pandemic, children were not attending school full-time and most schools had implemented a rotational learning schedule; meaning that classes had half the usual occupancy. In light of this changed situation in the schools, we were unable to make a random selection of the classes as planned. Instead, convenience sampling was used and the classes were conveniently selected at each of the schools based on our original selection criteria. These were that the children were either in Grade R or Grade 1, received a CSG and parents had to grant parental consent. We worked with school principals in identifying Grade 1 and Grade R classes where we shared research information packs. The packs included a research information sheet, a caregiver consent form and a children's assent form. Interested caregivers were asked to sign and return the forms to school. Those parents who completed the forms and consented to participating in the research made up the sample. A total of 181 caregivers and children agreed to participate in the study and were interviewed. However, technical issues with the CWTT application meant that some data were missing and our final sample consisted of 162 caregivers and children.

During data collection, the fieldwork team adhered to strict COVID-19 health and safety protocols as stipulated by the government and the GDE. All participants and interviewers wore masks, children were provided with additional masks, furniture was sanitised, hand sanitisers were used when participants entered the interview rooms and social distancing was practised. In addition, all participants were screened by GDE appointed health and safety officers when entering school premises, their temperatures checked, hands sanitised, and the wearing of masks enforced.

Fieldwork and Data Collection

The fieldwork for Phase 1 of data collection was carried out between October and December 2020. The fieldwork team consisted of a fieldwork manager, two fieldwork supervisors, seven social workers and seven professional nursing preceptors. The field work manager is employed by the CSDA to project manage the CoP study and is a community social worker responsible for supporting the field work team in schools. The social workers were seconded from three non-governmental organisations (NGOs), working in the research areas. One social worker was recruited per area, and two were recruited privately to assist in schools when NGO social workers were unavailable to assist with interviews. The nursing preceptors (qualified nurses) work in the University of Johannesburg's Nursing department as part-time supervisors of nursing students. The fieldwork supervisors work part-time for the CSDA and are familiar with the communities in which the schools are situated.

The fieldwork team was trained in September 2020 in a 1-day workshop hosted by the CSDA CoP team as well as the University of Johannesburg's Nursing Department CoP partners. The training orientated the field workers to the aims and objectives of the study and gave an overview of the schools, communities and caregivers where the study took place. The importance of multi-disciplinary work and collaboration was emphasised. Techniques on interviewing children and caregivers were covered, as well as the importance of translating questions into mother tongue languages. The CWTT digital app was discussed and demonstrated. COVID-19 protocols and safety in the field and schools was discussed in detail.

Based on the research information forms returned, appointments to conduct interviews were made with caregivers via phone. In some instances, caregivers included an older sibling or a grandparent. Interviews were scheduled and were carried out on the premises of four schools. The research team was not permitted access to the physical premises at Ekukhanyisweni Primary School (Alexandra) due to COVID-19 safety protocols. Interviews for this school were carried out at an Early Childhood Development Centre located across the road from the school.

Caregivers and children were interviewed at school on days when the child was attending school. Occasionally, when the caregiver was unable to be interviewed at the school or ECD centre, interviews were carried out at the child's home. Interviews were carried out primarily in the local language spoken at the particular school.

Following the fieldwork, a half-day debriefing and reflection session was held with the fieldwork team. The session focussed on debriefing the fieldworkers and recording and evaluating their experiences and observations during the fieldwork.

Data collection: mathematics and language assessment

As indicated above, the CWTT was developed and used to collect data on various domains. In addition, participating children at the five schools were also assessed for their number concept development, their early reading competence, and their vocabulary. These tests were administered by CoP partners in Education and were carried out in 2021. These tests were not included in the CWTT digital application. Two standardized tests and one custom designed vocabulary test were used. The interview-based tests were administered individually per child over a period of one month. The differences between the groups of children were their specific school and its first-grade teachers, the language in which they are taught, as well as the everyday life in their communities.

The numeracy test, known by its German acronym, MARKO-D SA, has been translated into six South African languages, with four of them standardized and normed for South African use. In the schools where this study was conducted, four languages were used, namely Sesotho, Xitsonga, English and isiZulu. This test consists of 48 items, the difficulty of each situated on one of five levels.

The Meerkat Maths Language Test (MMLT) is a much shorter test and learners are required to identify a picture with words that the test administrator calls out. The words are qualifiers for number calculations, such as 'more', 'less', 'bigger, 'smaller' and so forth.

The initial reading test is the Early Grades Reading Assessment (EGRA) which assesses beginner readers' phonemic competence and comprehension of a short passage after having read it.

Research Questions

1. What is the profile of the children, caregivers (and households) in the sample?
2. How are the children faring across a number of domains?
3. What proportion of children are at risk in the different domains?

Data analysis

All the questionnaires were coded and captured in Microsoft excel. Thereafter the data were cleaned by running frequency distributions and deleting erroneous responses. Statistical Software for the Social Sciences (SPSS) was used to describe the sample in terms of the frequencies and cross-tabulations.

Data findings were reviewed by the research team and any discrepancies discussed and accounted for.

As indicated above, the CWTT was used to assess the risk of children based on various indicators (see Table 1 and Table 2). Although the tool asked several questions on particular measures, responses were clustered together to categorize children's risk categories. The clustering of the answers was informed by the literature and general knowledge of child wellbeing indicators. Children classified as falling in the high-risk category had substantial concerns that indicated a need for immediate referral. The measures are discussed when the findings are presented.

Ethics

Approval for the study was obtained from the University of Johannesburg's Faculty of Humanities Ethics Committee (REC – 01-050-2020), the Gauteng Department of Education's Research Office, the Department of Health, and the District Research Office in two districts. Consent to participate in the study was obtained from the five principals and each of the caregivers. Caregivers completed the consent forms in the presence of a social worker who explained the content to him/her, as well as what was required of them and their child. Social workers also discussed confidentiality and emphasised the voluntary nature of the study. Children were similarly informed, and gave assent in the presence of a social worker and their caregiver. Caregivers, in need, were referred to local social workers where they could access psychosocial support and other governmental support services. All quantitative data were anonymised.

Limitations

Unanticipated challenges caused by the pandemic as well as through initial technical difficulties of the digital application impacted on our sampling and sample size. While the results need to be interpreted cautiously, they do provide an indication of the overall situation of child-well-being in different domains in the foundation grades at the school where they were assessed. These baseline measures are useful for further monitoring and evaluation.

Safety regulations as a result of the pandemic also meant that we were not able to meet with parents/caregivers in person to discuss the study and participation requirements at the onset of the study, and to provide feedback after data were analysed. We have instead relied on written information and where possible home visits by fieldworkers.

Findings

Living conditions of the children and their families

Household composition and size

The household profile variables examined who was living in the household and the household's access to financial and material resources.

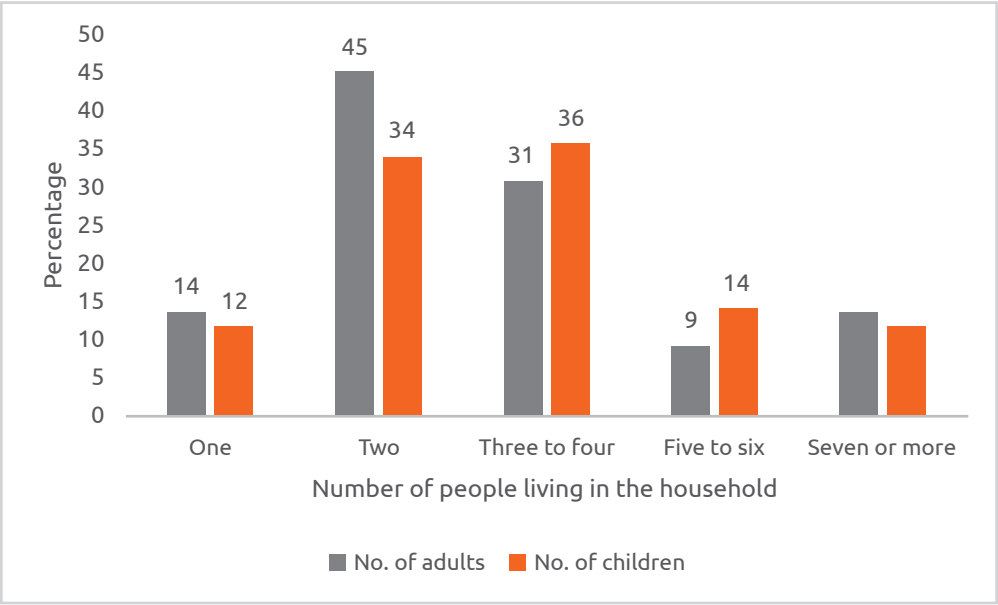

Figure 2: Percentage distribution of the number of children and adults living in the house

Figure 2 shows the percentage distribution of children and adults living in the household. Three quarters had two to three adults living in the house and 70% had between two and four children living in those homes. Our study sample shows that the average household size was 5 people. This figure is higher than the South African national average of 3.3 persons living in the sample household (STATSSA, 2016).

Findings from our data show that at the time of the data collection, the majority of children lived with a mother and another relative (29%), followed closely by children who lived with both parents (27%) and those that lived with a single parent (27%), only 2% lived with a father and another relative. Figure 3 provides an overview of the who the child is currently living with.

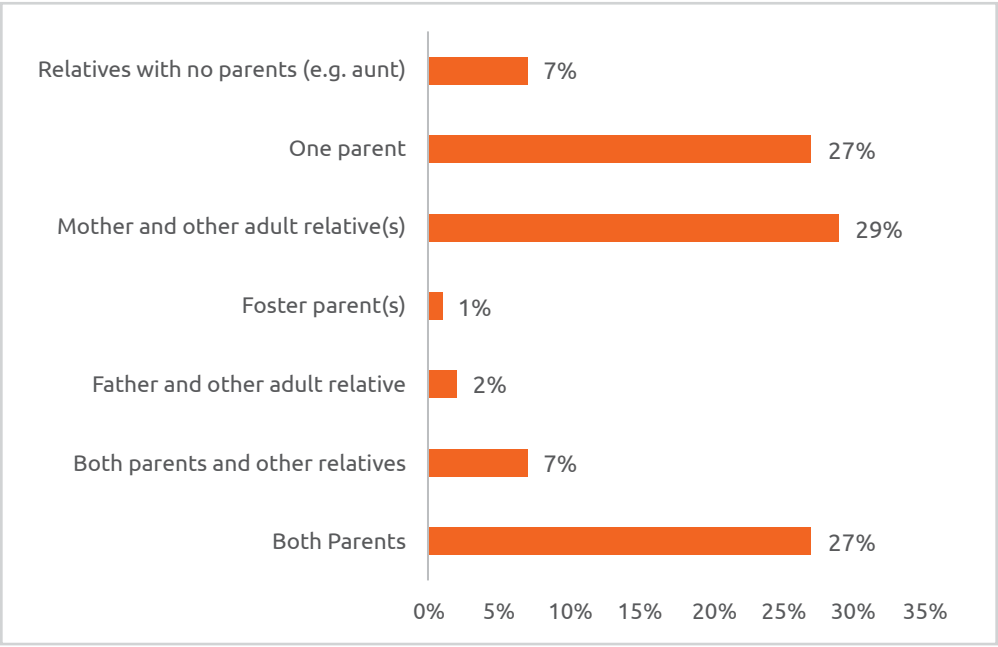

Figure 3: Children's living arrangements

Recipient of grant	Child Support Grants	Foster Care grants	Care Dependency Grants	Old Age Pension Grants	Disability grants	Social Relief of Distress Grant	Grant-in-Aid
Yes, grant received	141 (89%)	7 (4%)	5 (3%)	25 (16%)	14 (9%)	3 (2%)	8 (5%)
No, grant not received	18 (11%)	153 (96%)	154 (97%)	135 (84%)	146 (91%)	157 (98%)	152 (95%)
Total	159	160	159	160	160	160	160

Table 4: Household access to social grants

In 2019 in South Africa, nearly 12.4 million children were recipients of the Child Support Grant (Southern Africa Labour and Development Research Unit, 2021; UNICEF, 2019). Table 4 findings (Table 4 above) show that the majority of household's (89%) in our study received more than one Child Support Grant (CSG) and a very small number also received the Foster Care Grant (4%) and the Care Dependency Grant (3%). In addition to the child and care related grants, some families also accessed the Old Age Pension (16%) and Disability Grant (9%).

The Social Relief of Distress (SRD) is a new and temporary grant introduced in June 2020 to mitigate the impact of the COVID-19 pandemic. Only 2% of our participants appeared to be recipients. Country wide data suggests that the grant was accessed by approximately 6 million people (Republic of South Africa, 2021).

Household income	Yes	Sometimes	No	Total
In addition to grants, does your family have access to other income?	89 (57%)	10 (6%)	56 (36%)	155 (100%)
Does your family have enough money to buy the things you need?	60 (38%)	41 (26%)	55 (35%)	156 (100%)

Table 5: Household income

Household income, described in Table 5 above, show that about 57% of families had access to other additional sources of income compared to the 36% that had no additional income. About 35% of the families did not have enough money to buy the things that they needed, while 26% indicated that they sometimes had enough money to do so.

	Yes	No	Total
Child has a mattress/bed	138 (89%)	17 (11%)	155 (100%)
House protected from wind and rain	141 (90%)	15 (10%)	156 (100%)
Access to drinking water at home	155 (99%)	1 (1%)	156 (100%)
Electricity at home	151 (97%)	5 (3%)	156 (100%)
Toilet at home	140 (90%)	16 (10%)	156 (100%)

Table 6: Household access to goods and basic services

Table 6 presents household access to goods and basic services. It appears that most of the children in our sample live in households that have access to basic services like drinking water at home (99%) and electricity (97%) as well as basic sanitation (90%) and to basic comforts such as a mattress or a bed on which to sleep (89%). These figures are higher than those reported by the City of Johannesburg, which showed that 64.7% of households in the City of Johannesburg have piped water inside their homes, 87.1 % have a flushing toilet connected to the sewerage system and 90.8% have electricity (Statistics South Africa, 2021).

The Caregiver

The profile of caregivers includes the caregiver's characteristics such as age, level of education, employment status, income, mental well-being and access to support.

Age, level of education and Employment Status

Findings show that most caregivers were aged between 25 and 44 years of age (80%), 7% were between 16 and 24 years (7%) and 13% were over 45.

More than half (54%) of the caregivers had some secondary education, just under a third (30%) had matric and 8% had post-secondary education. Although educational attainment in South Africa is increasing, it is still low (OECD, 2019). Findings from our participants are similar to those reported by the OECD (2019); which showed that in 2018, a total of 59% of 25-65 years had attained upper secondary education (that is, final stage of secondary education (see International Standard Classification of Education).

Table 7 below shows the employment status of caregivers in our sample. The majority of caregivers were unemployed (65%), less than a fifth (17%) were employed full time, and 13% engaged in either part-time or piece work and 5% were self-employed. This rate of unemployment is double the national average, which is 32.6% (StatsSA, 2021) but lower than that found in a previous study by Patel et al., 2017, with caregivers in similarly under-resourced contexts where rates of unemployment was as high as 87%.

Employment status	Percentage
Full-time	17%
Part-time	9%
Piece work	4%
Self employed	5%
Unemployed	65%

Table 7: Employment Status of Caregivers

Level of indebtedness of the caregiver

Caregivers were asked about household income (above) as well as their ability to save and pay off debts. The levels of household debt provide insight into how much income is spent paying their monthly debts and how much is spent on day-to-day needs. Data, presented in Table 8, suggest that 27% of the caregivers were struggling with paying off their debts and 54% of caregivers were struggling to save monthly.

Ability to save and pay debts	Yes	No
Are you able to save?	46%	54%
Do you struggle to pay off debts?	**27%**	**73%**

Table 8: Caregiver's level of indebtedness

Caregiver mental health and access to social support

To assess caregiver mental health and wellbeing, we included the CES-D-10 (Andersen, Malmgren, Carter, & Patrick, 1994). This standardised, self-report scale is designed to measure depressive symptomology. The scale consists of 10 questions that ask whether certain feelings or behaviours occurred rarely or none of the time (scored 0), some or a little of the time (scored 1), occasionally or a moderate amount of the time (scored 2) or all the time (scored 3) in the past week.

In the table below (Table 9) presented, scores of 11 or over indicate depressive symptoms.

School	CES-D ≤10	CES-D ≥11 (depressive symptoms)	Total
Overall sample	69 (45%)	84 (55%)	153 (100%)
Ekhukhanisweni PS (Alexandra)	12 (57%)	9 (43%)	21 (100%)
Lejoelepustoa PS (Meadowlands)	8 (21%)	29 (78%)	37 (100%)
Malvern PS (Malvern)	18 (56%)	14 (44%)	32 (100%)
Mayibuye PS (Doornkop)	10 (40%)	15 (60%)	25 (100%)
Mikateka PS (Ivory Park)	21 (58%)	15 (42%)	36 (100%)

Table 9: Prevalence of depressive symptoms of caregivers

Over half of the caregivers (55%) in the overall sample appeared to have depressive symptoms. In some schools, there appeared to be higher depression scores. For example, caregivers from Meadowlands appeared to have the highest depressive symptoms (78%), followed by those in Doornkop (60%). Just over 40% of caregivers in Alexandra, Malvern and Ivory Park presented with depressive symptoms. These figures are significantly higher than those reported in the NIDS-CRAM study wave 5 in 2021 which found 29% of a nationally representative sample reporting depressive symptoms (Hunt et al., 2021; Southern Africa Labour and Development Research Unit, 2021). The figures do however appear similar to those found by South African Depression and Anxiety Group's online survey, which focused on participants' home life, their mental health before and during lockdown, access to information and coping strategies during the lockdown. They found that nearly 65% of people surveyed had heightened stress during lockdown (SADAG, 2020).

Caregiver's community or household support in times of need

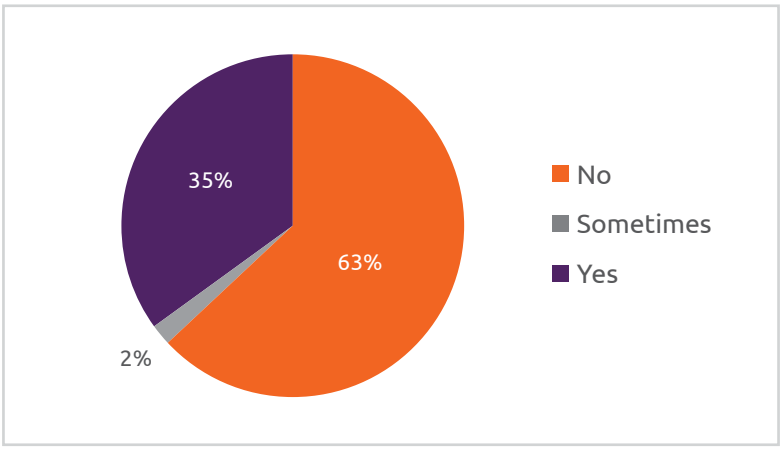

Figure 4: Community support in times of need

Figure 4 shows caregiver perception of community support. The majority of the caregivers reported not having family or community support in times of need (63%). Approximately 35% of the caregivers said they had support in times of need while 2% reported that sometimes they had support. This figure appears to be higher than other studies of CSG beneficiary families (see Patel et al., 2017).

How are the children faring?

We begin by providing a description of children included in our sample, this is followed by findings on how children were faring across multiple domains, including health, education, protection and care.

Age, grade and gender distribution of sample across the five schools

We had a total of 162 children in our sample. Across all five schools, 54% were in grade R and 46% were in Grade 1. The sample included 47% girls and 53% boys.

In South Africa, for Grade R, the recommended age is four turning five by 30 June in the year of admission. If the parent feels that their child is not ready for school, they are allowed to admit them at an older age. The recommended age for Grade 1 is six turning seven. From our sample, 5 children were older (7 years old to be in grade R) and 14 children were older than the expected age for grade 1 (8 years old).

Table 10 below provides a breakdown of the number of children in grade R and grade 1 across the five schools. The majority of the children included in the study are from Lejoeleputso Primary School (PS)(27.5%), followed by those from Mikateka PS (22.5%), Malvern PS (20%). Ekukhanyisweni PS (14%) and Mayibuye PS (16%).

School attended	Grade R	Grade 1	Total
Ekhukhanyisweni PS (Alexandra)	13	9	24 (15%)
Lejoeleputso PS (Meadowlands)	22	22	44 (27%)
Malvern PS (Malvern)	15	17	32 (20%)
Mayibuye PS (Doornkop)	14	12	26 (16%)
Mikateka PS (Ivory Park)	23	13	36 (22 %)
Total	87 (54%)	73 (46%)	162 (100%)

Table 10: The distribution of children by school

Caregiver's perception of children's health and nutrition

The health domain assesses whether the children's health is preventing them from playing or going to school, if the child can speak, see or hear well, if the child has any underlying health conditions i.e. malnutrition, cardiac condition, diabetes or seizures), if the child has been a victim of abuse and if their vaccinations are up to date. Questions and responses for this domain are presented in Table 11 below.

HEALTH	Yes	Sometimes	No	Total
Is your child's health stopping them from going to school?	23 (15%)	3 (2%)	128 (83%)	154 (100%)
Do you take your child to the clinic, hospital or doctor when they are sick?	146 (94%)	6 (4%)	3 (2%)	155 (100%)
Has your child been hospitalised?	19 (12%)	-	134 (88%)	153 (100%)
Does your child struggle to hear, see or talk?	29 (19%)	6 (4%)	120 (77%)	155 (100%)
Does your child have good hygiene habits?	130 (86%)	14 (9%)	7 (5%)	151 (100%)
Does your child participate in sporting, cultural, spiritual, arts or recreational activities outside of school hours?	82 (55%)	9 (6%)	59 (39%)	150 (100%)
Does your child engage in physical activities?	133 (86%)	5 (3%)	17 (11%)	155 (100%)

Table 11: Caregivers' perception of their child's health

Nine out of 10 parents/caregivers reported taking children to a clinic when they were sick which is an important indicator of responsive caregiving. Approximately 15% of the caregivers reported that their child's health was preventing them from going to school, nearly 12% were hospitalized, approximately 19% struggled to hear or talk and nearly 39% of the children did not participate in any sporting activities outside of school hours.

Health care workers' perception of child's health

In addition to asking caregivers about children's health and access to food, children were also assessed by a qualified healthcare professional (nurse). The nurse reviewed both the child's Road to Health card and carried out anthropometric assessments on each of the children and tested for diabetes as well. Table 12 below provides a summary of findings.

	Yes	No	Total
Is the child's vaccination up to date?	107 (67%)	52 (33%)	159 (100%)
Is the child on HIV treatment?	8 (5%)	152 (95%)	160 (100%)
Is the child on TB treatment?	3 (2%)	159 (98%)	161 (100%)
Does the child have diabetes?	6 (4%)	155 (96%)	161 (100%)
Does the child have a history of cardiac problems?	4 (2.5%)	157 (97.5%)	161 (100%)
Does the child have dermatological conditions?	32 (20%)	129 (80%)	161 (100%)
Does the child have respiratory problems?	9 (6%)	152 (94%)	161 (100%)
Did/does the child have seizures?	5 (3%)	156 (97%)	161 (100%)
Did/does the child have a diagnosed mental health condition?	4 (2.5%)	157 (97.5%)	161 (100%)
Does the child have difficulty seeing, hearing, walking or talking?	7 (4%)	154 (96%)	161 (100%)
Is there evidence of abuse?	6 (4%)	155 (96%)	161 (100%)

Table 12: The health care workers' perceptions on child's health

Health care workers reported that a third (33%) of the children's vaccinations were not up to date, approximately 20% of the children had dermatological conditions, and some children had existing chronic or medical conditions. Health care workers noted that in 4% of the children there was evidence of abuse, with this figure being lower than that reported

by caregivers (8%) and teachers (6%). The percentage (4%) of children with visual, auditory and mobility concerns was also lower than that reported by caregivers. Approximately 2.5% appeared to have an existing mental health condition. There seems to be insufficient data on children's hearing in South Africa. Mahomed-Asmail, Swanepoel and Eikelboom (2016) refer to studies dating as far back as 1985, 1988 and 2007. In their own study, they found that 5.6% of the children needed referral for hearing tests but the actual prevalence of diagnosed hearing loss was 2.2%. An earlier study by Rosenfeld et al. (1998) found that caregivers often report inaccurately on chidren's hearing levels as they tend to base their perceptions of the child's hearing on the child's behaviour.

Caregiver's perception of food access and nutrition

To determine levels of food access, hunger, sufficiency and quality of food intake, caregivers responded to the five questions in Table 13.

Food access and nutrition	Yes	Sometimes	No	Total
Does your child ever go to sleep hungry?	20 (13%)	31 (20%)	105 (67%)	156 (100%)
Does your child eat protein at least twice a week?	134 (87%)	-	21 (14%)	155 (100%)
Does your child eat vegetables at least twice a week?	132 (86%)	-	22 (14%)	154 (100%)
Is there enough food for your child to eat at every meal?	97 (63%)	37 (24%)	20 (13%)	154 (100%)
Does your child eat three meals a day?	102 (67%)	34 (22%)	19 (12%)	155 (100%)
Access to school feeding (NSNP)				
Does the child eat a meal provided by the school nutrition scheme?	91 (63%)	-	54 (37%)	145 (100%)

Table 13: Caregivers' perception of child hunger, food and nutrition

Findings related to food insecurity are disturbing, with a third of the children going to bed hungry sometimes (20%) or always (13%), thirteen percent children not having enough to eat in their households, 12% not eating three meals a day, and 14% not eating protein or vegetables at least twice a week. These rates are slightly lower than those reported in national level data from 2020 which found that in one in six households a child was going to bed hungry (Kalipa, 2021) and approximately 18% of children living in the poorest households experienced continuous hunger (Sambu, 2019). The number of children accessing school meals provided by the National School Nutrition Programme (NSNP) was 63%. This figure is most likely due to the rotational time tabling which compromised access to school meals during the COVID-19 pandemic (Hendriks & Olivier, 2020; Shepherd & Mohohlwane, 2021).

Child malnutrition indicators

Participating children were assessed according to the World health Organisation's child malnutrition indicators (Table 14) and scored according to the WHO guidelines for assessing child growth (WHO, 2008). Malnutrition is a risk factor for morbidity and mortality and the risk factors include stunting, wasting, underweight, overweight and obesity. Stunting is defined as low height for age and is measured using a standard deviation lower than -2. Stunting makes children more susceptible to illness and infections and impairs their cognitive and physical development (Modjadji et al., 2020). Wasting refers to a child whose weight is low for their height and it is measured using the weight for height of a standard deviation of –2 of the WHO Child Growth Standards median. Wasting negatively affects children as it impairs their linear growth and is associated with increased mortality (Nyati et al., 2019; UNICEF et al., 2020). Underweight refers to low weight for age and is measured using weight for age less than –2 standard deviations of the WHO Child Growth Standards median. Children who are underweight are at risk of having a weakened immune system and are susceptible to illnesses and an increased risk of death (UNICEF et al., 2020). Overweight refers to high weight for age and is measured using weight for height that is greater than +2 standard deviations of the WHO Child Growth Standards median. Obesity is defined as the high weight for height and is measured by a BMI for age that is above 2 standard deviations (WHO, 2021). Children who are overweight and obese have risk factors of getting non-communicable diseases such as diabetes, heart disease and high blood pressure in adulthood (Nyberg et al., 2018; Sahoo et al., 2015). These indicators of malnutrition have lasting long term adverse effects such as low productivity in adult life and poverty (WHO, 2021). Moreover, they contribute to the child's poor academic performance, reduced school attendance, poor academic achievements and decreased chances of survival in adulthood (Chowdhury, Chakrabarty, Rakib, Saltmarsh & Davis, 2018).

Indicator	Yes	No	Total
Stunting	21 (13%)	141 (87%)	162 (100%)
Wasting	9 (6%)	153 (94%)	162 (100%)
Underweight	11 (7%)	151 (93%)	162 (100%)
Overweight	7 (4%)	155 (96%)	162 (100%)
Obesity	5 (3%)	157 (97%)	162 (100%)

Table 14: Child malnutrition indicators

From our study sample, approximately 13% of children were stunted, 6% were wasted, 7% were underweight, and 4% were overweight. The provincial and national stunting rates in South Africa are higher (27.4%) than the findings from our sample, with stunting being the highest in Free State and Gauteng at 34%. Our study finding of 7% of underweight children closely aligns with the country's national figure of 6% but was double the figure for wasting, with the national rate being at 3%. (StatsSA, 2017).

Education Domain

The educational wellbeing of the child measures whether the child attends school regularly, if the child is progressing well with their schoolwork and whether or not the child is afraid of going to school. This domain is of particular importance as poor school performance in the foundation years of schooling have 'knock on' effects on subsequent educational attainment. The foundations for learning in school are laid in early childhood development (Shonkhoff, Boyce & McEwan, 2009). For young children to advance in the early grades, when they learn symbolically through written language and mathematical codification, they require interaction and care that can prepare them to learn symbolically (Henning & Ragpot, 2015).

In Table 15, we see that 96% of participating children were attending school regularly, 84% were progressing with their schoolwork and 88% were doing their homework and had the correct uniform supplies (82%). Only 2% were at educational risk and needed immediate interventions. The majority of caregivers responded that there was always someone in the household available to help the child with homework. Of concern is the 36% who were afraid or refused to go to school (Figure 5). The majority of children who were afraid to go to school were those in grade R (59%) compared to those in grade 1 (41%). In this regard, Darmody et al., (2021) states that the social and familial context in which children grow up influence children's education and wellbeing. Therefore, what happens outside the school is as important as what happens inside.

Education	Yes	Some/ sometimes	No	Total
Does your child attend school regularly?	150 (96%)	-	6 (4%)	156 (100%)
Is your child progressing with their school work?	131 (84%)	-	25 (16%)	156 (100%)
Does your child do homework as required?	136 (88%)	15 (10%)	4 (3%)	155 (100%)
Does someone in your home help the child with homework?	146 (94%)	5 (3%)	5(3%)	156 (100%)
Does your child have a school uniform and school supplies?	115 (74%)	28 (18%)	12 (8%)	155 (100%)
Is your child afraid of or refusing to go to school?	56 (36%)	17 (11%)	83 (53%)	156 (100%)

Table 15: Caregivers' perception of how child is faring in relation to school related indicators

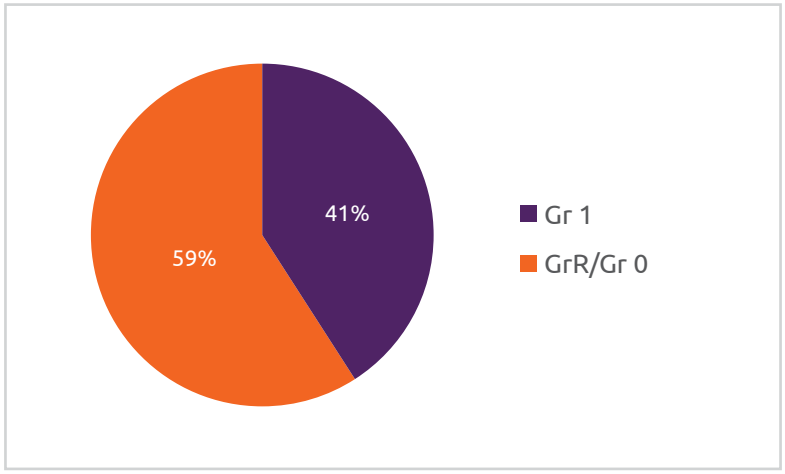

Figure 5: Fears related to going to school

Mathematics, reading and vocabulary assessment

The overall numeracy performance of the sample of children showed that they were not ready to engage with the curriculum of the first grade and that their number concept development was lower than that of a similar sample (n=600+) of learners who were tested in in a variety of schools in Gauteng in 2018 and 2019 (Bezuidenhout, 2018). Results from the EGRA, which assesses reading competency, were similar to Grade 1 learners in a study in an isiZulu speaking school in Soweto (Simelane, forthcoming). The MMLT which assesses vocabulary knowledge required for early mathematics learning, also showed similar results.

Teachers' assessments of child wellbeing at school

Children's learning, educational progress and wellbeing at school was assessed through interviews with class teachers. In Table 16 we share teacher responses to questions related to progress, attendance and parental involvement.

Does the child attend school regularly?	128 (88%)	-	17 (12%)	145 (100%)
Is the child progressing in their schoolwork?	129 (90%)	-	14 (10%)	143 (100%)
Does the child do homework as required?	96 (68%)	33 (23%)	13 (9%)	142 (100%)
Does the child have difficulty learning?	32 (22%)	28 (19%)	85 (57%)	145 (100%)
Does the child participate in class?	116 (82%)	15 (11%)	11 (8%)	142 (100%)
Does the child come to school with correct uniform and supplies?	126 (90%)	5 (4%)	9 (6%)	140 (100%)
Is the caregiver involved in the child's education?	116 (80%)	22 (15%)	7 (5%)	145 (100%)
Is the child neat and clean?	129 (90%)	7 (5%)	8 (6%)	144 (100%)

Table 16: Teachers' perceptions on child wellbeing

The teacher's responses regarding child attendance, progress and well-being appeared to be lower than that reported by caregivers. Although teachers reported that children came to school regularly (88%), they reported less compliance with school homework (68%); which was lower than that reported by caregivers. Teachers identified 22% of children as having a learning difficulty. It appeared as though for the most part (80%), caregivers were involved in their child's education and 90% of children attended school, looking clean and neat.

In addition to asking about children's educational development, teachers were also asked about children's psychosocial behaviour in the classroom. Table 17 provides an overview of the measures and responses. It appears that while 93% of children appeared to be happy, children did experience feelings of anxiety (13%) and sadness (9%). The majority of children were able to seek help when they need to (85%), were able to self-regulate their behaviour (76%), and were able to problem solve (65%). Approximately, 21.5% appeared to have difficulty completing tasks and teachers observed 5.5% who presented with evidence of abuse.

Child's emotional and mental health	Yes	Sometimes	No	Total
Does the child speak well?	139 (97%)	-	4 (3%)	143 (100%)
Does the child see well?	143 (97%)	-	2 (1%)	145 (100%)
Does the child hear well?	145 (100%)	-		145 (100%)
Does the child seem anxious, nervous or worried?	19 (13%)	18 (13%)	106 (74%)	143 (100%)
Is the child generally happy?	129 (93%)	-	10 (7%)	139 (100%)
Does the child seem sad or depressed?	12 (9%)	13 (9%)	117 (82%)	142 (100%)
Does the child have difficulty controlling his/her behaviour?	26 (18%)	10 (7%)	108 (75%)	144 (100%)
Can the child tell someone to stop doing something s/he doesn't like?	123 (87%)	9 (6%)	10 (7%)	142 (100%)
Does the child speak to you when s/he has a problem?	123 (85%)	13 (9%)	8 (6%)	144 (100%)
When the child is upset, are they able to calm themselves down?	107 (76%)	13 (9%)	20 (14%)	140 (100%)
Does the child fight with other children?	12 (8.5%)	8 (6%)	122 (86%)	142 (100%)
When the child has a problem, can s/he find a solution or ask for help?	93 (65%)	19 (13%)	31 (22%)	143 (100%)
Is there evidence of child abuse or neglect?	8 (5.5%)	-	137 (94.5%)	145 (100%)
Can the child sit long enough to complete tasks?	113 (78.5%)	-	31 (21.5%)	144 (100%)

Table 17: Teachers' responses to children's wellbeing and mental health

Protection and care domain

The protection and care domain assesses relationships in the household. It assesses whether there are significant others who are present and available to respond to the child's needs and an awareness of the child's whereabouts. It also probes safety concerns and direct or indirect exposure to violence at home or in the community. Questions asked and findings are presented in Table 18 below.

Protection and Care	Yes	Sometimes	No	Total
Is there an adult in the home who always knows where the child is?	146 (94%)	7 (4.5%)	3 (2%)	156 (100%)
Is there someone at home that the child trusts and can talk to?	150 (96%)	-	6 (4%)	156 (100%)
Does an adult or older sibling read, sing or spend time with the child?	126 (83%)	13 (7%)	12 (8%)	151 (100%)
Have you ever had concerns about the safety of your child?	97 (64%)	17 (11%)	38 (25%)	152 (100%)
Has the child seen people fighting, swearing or hurting each other at home or in the community?	89 (57%)	15 (10%)	51 (33%)	155 (100%)
Has the child been a victim of abuse or violence?	12 (8%)	-	141 (92%)	153 (100%)

Table 18: Protection and care domain

From parent/caregiver accounts it seemed that for the most part there was someone in the home who always knew where the child was (94%) and the child had people to talk to (96%) and spend time with (83%). About 64% of caregivers reported being concerned about the safety of their children and 57% of children had been exposed to some form of violence. Actual experiences of abuse were reported by 8% of caregivers, which was higher than abuse suspected by teachers and nurses.

Form that discipline takes

We asked caregiver respondents an open-ended question related to the methods they use to discipline their children. Positive parenting strengthens caregiver and child relationships; whereas harsh parenting and discipline manifest in both short and long term behavioural, cognitive and social problems (Lachman et al, 2020). In our sample, most caregivers relied on various methods of discipline, which included both physical and nonphysical forms. The majority (n=51) however reported hitting/spanking as the preferred method; many pointed out that it was often a light smack and one person indicated feeling remorse afterwards.

> *"I give him a smack\hiding but not too much".*
>
> *"I try to scare him with a little bit of hiding on the hand, nothing hectic".*
>
> *"I hit her but sometimes I feel so bad afterwards".*

Other respondents indicated that physical discipline, in the form of spanking, was accompanied by other measures such as shouting and grounding the child (n=30). For instance, caregivers said the following: "*I give him a hiding and sometimes shout at him*" "*Spanking and time out*". Pinching and pulling the child were also reported alongside hitting. Shouting as the primary measure of discipline was reported by 14 caregivers. The largest number said they talk to/communicate with the child (n=23) "*I just talk to her*". "*I don't hit him. I always talk to him and reprimand him*".

Additional forms of discipline included putting the child in a naughty corner. One participant shared that physical punishment was not successful and she is now trying an alternate, less harsh from of disciple, she said "*I used to give her a hiding but it didn't work. Now I use the naughty corner.*" For others, withholding privileges and treats was another alternative to physical discipline, one caregiver had this to say: "*I ground them and I don't give him a cellphone because he likes playing games*".

Child's psychosocial wellbeing

To complement the questions from caregivers and teachers regarding the child's social and emotional wellbeing, we included two standardised psychometric measures, namely, the Child and Youth Resilience measure (CYRM-R) and the Strengths and Difficulties questionnaire, both of which have been validated for use in South Africa. These two questionnaires were completed by the child.

The Child and Youth Resilience Measure (CYRM): This is a 28-item self-report measure that was developed to assess culturally grounded experiences of resilience. Resilience broadly defined, is an individual's ability to do well in spite of adversity. The socio-ecological perspective, which informs the CYRM, considers the centrality of ecological systems (families, communities, governments) in facilitating and supporting this process (Ungar, 2018). The CYRM includes two subscales; personal resilience (that is, intrapersonal and interpersonal resilience) and caregiver or relational resilience (that is, characteristics associated with important relationships with the primary caregiver or parent). In both dimensions, the social ecology is central to reinforcing resilience (Resilience Research Centre, 2018).

The scale was initially developed for use among young people aged 11-23 but has been adapted and now includes a shortened scale for children 5-10 years of age (Jefferies et al, 2018). The version we used consists of 17 items measured on a 3-point scale. The response options are no (scored 1), sometimes (scored 2) and yes (scored 3). For the overall measure and subscales, higher scores indicate characteristics associated with resilience. In any given context, there will be individuals with higher and lower levels of resilience. Findings per school are presented in Table 19 below.

Name of school	Low resilience: < 63	Moderate resilience: 63-70	High resilience: 71-76	Exceptional resilience: ≥ 77
Overall sample	30 (18.5%)	29 (18%)	42 (26%)	38 (27%)
Ekhukhanisweni PS	5 (17%)	5 (18%)	5 (12%)	3 (8%)
Lejoelepustoa PS	4 (14%)	10 (36%)	14 (33%)	6 (16%)
Malvern PS	7 (24%)	6 (21%)	7 (17%)	7 (18%)
Mayibuye PS	5 (17%)	3 (11%)	10 (24%)	7 (18%)
Mikateka PS	8 (28%)	4 (14%)	6 (14%)	15 (39.5%)
Column total	**29 (100%)**	**28 (100%)**	**42 (100%)**	**38 (100%)**

Table 19: Child's resilience scores by school

Findings suggest that the majority of children (71%) exhibited moderate, high and exceptional ability to cope with one or multiple adversities. This finding is consistent with findings from van Breda's (2017) study with over 500 youth, some of whom resided in low resourced communities; van Breda (2017) found that children from poor communities and no fee schools could be highly resilient.

The Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997, 2001): The SDQ is a brief behavioural screening questionnaire widely used to measure children's emotional and behavioural functioning.

The SDQ focuses on 25 attributes, some positive and others negative. These 25 items are divided into 5 scales: (1) emotional symptoms (5 items); (2) conduct problems (5 items): (3) hyperactivity/inattention (5 items); (4) peer relationship problems (5 items); and (5) prosocial behaviour (5 items). The emotional symptoms, conduct problems, hyperactivity/ inattention and peer relationship problems are added together to form the total difficulties score and classified in terms of normal, borderline and abnormal functioning (Goodman, 1997; 2001). Table 20 describes our findings.

Scores	**Normal** Average/close to suggests clinically significant problems in this area are unlikely	**Borderline** Slightly raised scores reflect clinically significant problems'	**Abnormal** High score indicates substantial risk of clinically significant problems in this area
Total Difficulties Score	92 (65%)	22 (15.5%)	28 (20%)
Emotional Symptoms Score	130 (87%)	11 (7%)	9 (6%)
Conduct Problem Score	93 (62%)	21 (14%)	37 (24.5%)
Hyperactivity Score	92 (62%)	20 (13%)	37 (25%)
Peer Problem Score	87 (59%)	46 (31%)	14 (9.5%)
Prosocial score	87 (59%)	46 (31%)	14 (9.5%)

Table 20: Children's strengths and difficulties (N=142).

The total difficulties score depicting children at increased risk was 20%; this is lower than that reported in Mellins et al.'s (2018) study with 6 to 8 year old children in rural Kwa-Zulu; Mellins et al. (2018) found a total difficulties score of 28%.

Proportion of children at risk

As indicated above, through the CWTT we aimed to identify children at high, moderate and low risk. Children classified as falling in the high-risk category had substantial concerns that indicated a need for immediate referral. Although the tool asked questions on several measures, responses were clustered together to categorize children's risk categories. The clustering of the answers was informed by existing literature, knowledge of child wellbeing indicators and through consensus discussions by team members. For example, to identify children at risk for food insecurity, responses on the food and nutrition domain would have been "yes" to sleeping hungry and "no" to whether there was enough food for the child to eat at every meal. With regard to children at risk in the educational domain, responses would have been "no" to attending school regularly and progressing at school and "yes" or "sometimes" to being afraid to go to school. See Appendix II for the clustering of CWTT questions used to inform the risk assessment for all the domains. Children at high/moderate risk would then be followed up with further assessment and an intervention plan. Figure 6 below highlights the number of children at risk across the different domains described above.

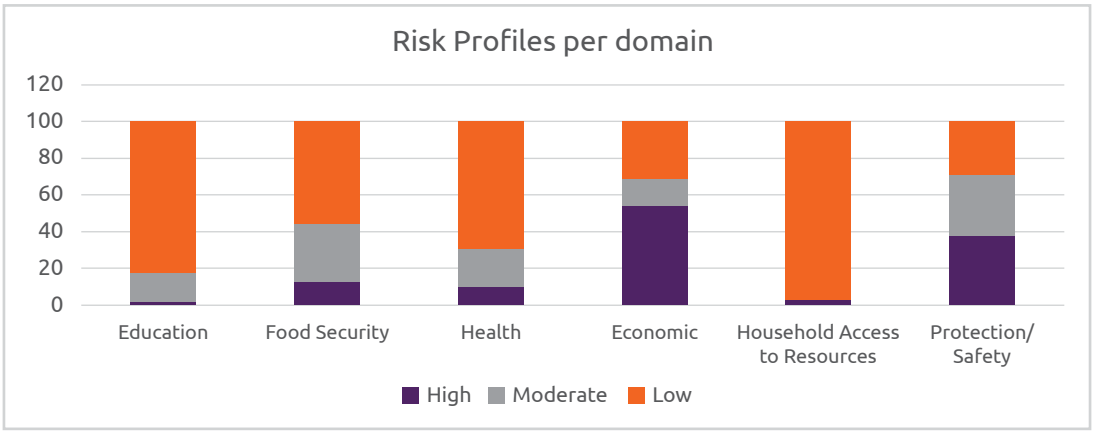

Figure 6: Children's risk profiles per domain

From the table above, the findings suggest that children were at highest risk in the economic, protection/safety and food security domain. Approximately 54% of children appeared at high risk economically, 38% of children appeared to be at high risk in terms of safety and 13% appeared to be at high risk in terms of food and nutrition access.

Implications of Baseline Findings: The Intervention

Findings from Wave 1 data highlighted the ways in which child wellbeing outcomes are influenced by multiple, intersecting factors, drawing attention to the need for innovative, multi-level solutions. Our findings suggest avenues for intervention at each level of the system: the child, the family, the school and the broader community and society. Figure 7 below provides an overview of key systemic interventions implemented by the LLCoP facilitated by the social workers and are discussed briefly below. We do not discuss these interventions in detail in this report.

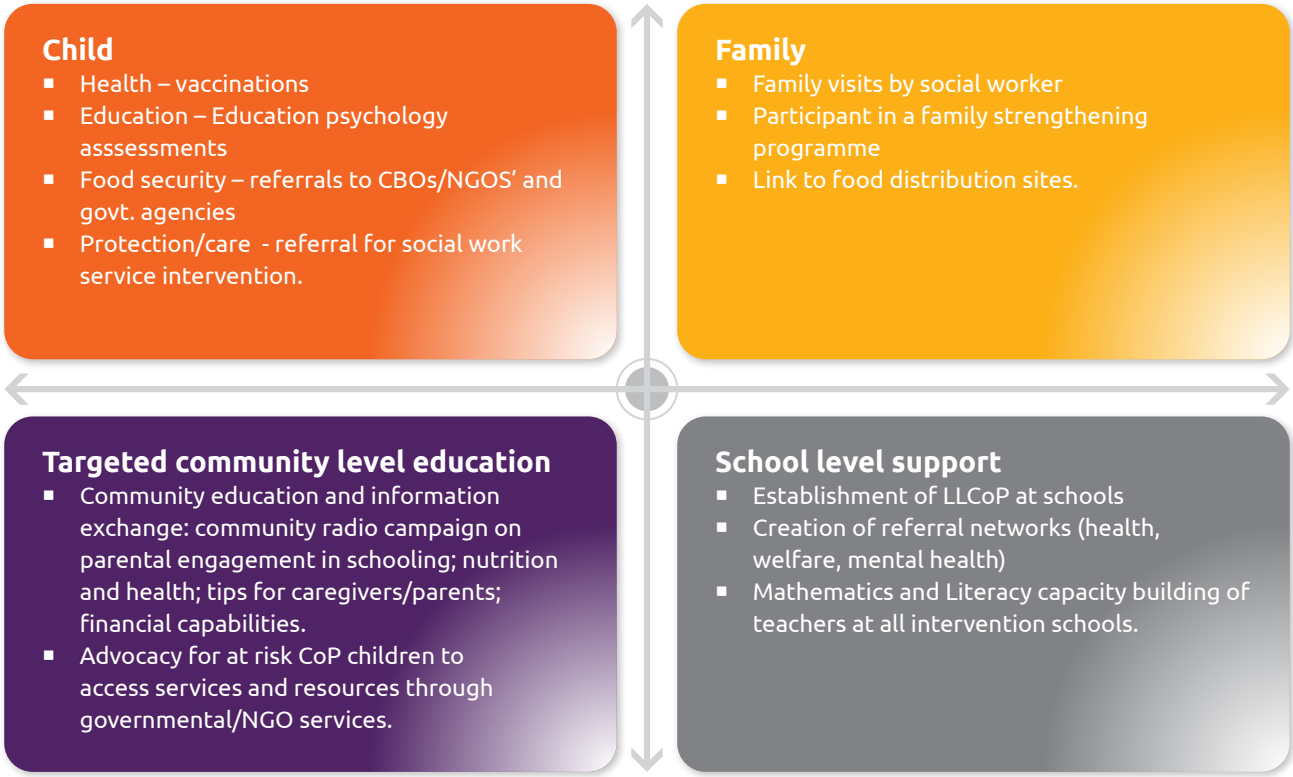

Figure 7: Multi-level child, family, school and community interventions.

Interventions at child and family level

- *Appropriate referrals for children and families at risk of hunger and food insecurity and linking them to community resources that distribute food parcels.*
  - Social Workers mapped out existing and available community resources and shared these with teachers and parents in need.
  - Social workers facilitated access of children and families in need to food relief programmes.
- *Ensuring children are accessing the School Nutritional Programme during school time and on days when they are not at school.*
  - Findings from the data identified children at risk of hunger, in all of these cases, social workers followed up with teachers and parents to ensure that these children are recipients of the NSNP at their school.
- *Provision of health education and coordination with local clinics to ensure that all children in the sample (and within the school) are brought up-to-date with vaccinations. This intervention component also involved referral of children who displayed health and nutrition difficulties (wasting, stunting, and obesity, eyesight, hearing and speech difficulties) to local health facilities.*
  - During home visits, social workers educated caregivers on the importance of vaccinating children and encouraged caregivers to take their children to local clinics to catch up on their missed vaccinations.
  - Relationships and collaboration with the local health departments are being fostered to ensure that parents referred for vaccinations, health screening, speech and hearing difficulties, are appropriately assisted.
- *Assessment of educational and psychosocial wellbeing of children at risk.*
  - Based on our findings and in consultation with teachers at each school, children (6 per school) in need of a full psycho-educational learning assessment were assessed by qualified educational psychologists. For each child assessed, an individual intervention plan was developed and shared with parents.

- Social workers facilitated parental feedback sessions as well as communication between the caregivers, educational psychologists, and teachers to better support the child.

- *Three month intervention to support and monitor progress of families and children in need and found to be at risk.*
  - On-going support and monitoring of children at risk by social workers, working in collaboration with foundation phase teachers and Heads of Department at schools.
  - Regular contact with and support of families in need by the social worker.
- *Inclusion of families in need for participation in the Sihleng'imizi family strengthening programme.*
  - Identification of families (5 each per area) in need of additional support and who were identified to benefit from participating in the Sihleng'imizi family strengthening programme. These families were invited to participate in the programme.
  - Consenting families have been included in the parenting programme, which entails weekly sessions with a social worker, over a period of 3 months. Read more about the programme and the manual can be found at https://communitiesforchildwellbeing.org/

Intervention at school level

- *Establishment of Local level CoPs (LLCoP) to address the challenges children and caregivers face.*
  - A LLCoP group was established in each school comprising the foundation phase teachers, CoP social worker and outside stakeholders e.g. nursing/health workers from the nearby clinics; local NGO community workers/ social workers; educational psychologists who assessed the children for learning difficulties as well as school governing body representatives. The purpose of this LLCoP was to support children and families in need, learn about how to make appropriate referrals to service providers and manage risk.
  - LLCoP members agreed to meet 5 times between April 2021 and September 2021 (extended due to COVID-19 lockdown) to discuss progress and follow up.
- *Provision of training by ALCoP partner to identify children with challenges related to numeracy and literacy.*
  - Teachers at each school will be invited to attend a training programme to improve learning support and improve numeracy and literacy outcomes.

Intervention at community level

- *Family strengthening awareness programmes*
  - A community radio programme was initiated in two of the five communities where the schools are based focusing on: (a) promoting parental involvement in children's schooling; (b) nutrition and healthy food practices; (c) tips for caregivers to manage stress and difficult behaviours in children; and (d) money matters.
  - The same material will be shared with all families participating in the study. Aural radio messaging will be shared via whatsapp and written text will be distributed to all parents to ensure wider access to the messaging.

Dissemination of information on multiple platforms and with key stakeholders in health, education and welfare, emphasising the need for inter-sectoral collaboration and advocating for greater access to services and for improved systemic interventions based on the study findings. See the CoP portal at https://communitiesforchildwellbeing.org/

Discussion and Conclusion

We may draw the following conclusions from the study findings. First, the material well-being of children was compromised by the high unemployment rate of caregivers which was significantly higher than the national unemployment rate in the third quarter of 2020 when the survey was conducted. Four out of 10 caregivers did not have enough money to buy the things that they needed such as food and basic necessities. Although different questions were used, the findings were similar to the NIDS-CRAM results for the same period in 2020 (Van der Berg et al., 2020).

Social grant monies were an important source of survival for these families with 89% of households receiving one or more social grants. Although just over half of the households received other sources of income, taken together, this income was insufficient to meet basic expenses and consequently almost a third struggled with indebtedness and over half could not save.

Second, despite the dire material deprivation of the children and their families, over half had access to food but this was insufficient for 13% of the children who did not have enough food to eat. This food insufficiency varied across the study areas with two areas (Doornkop and Meadowlands in Soweto) reporting higher rates of child hunger. These figures are slightly below the NIDS-CRAM findings of 16% at the same time in 2020 (van der Berg, Patel & Bridgman, 2020).

Of concern is that a fair proportion of children experienced health conditions that needed intervention and a third had incomplete vaccinations.

Third, the majority of children attended school, were well groomed and were progressing satisfactorily according to their caregivers and teachers. However, teachers had a less positive view about children doing their homework during the COVID-19 pandemic while the majority of parents reported that this aspect was not a challenge. What was worrying is that almost half of the children were older than they should have been for their grade and 22% were identified as having learning difficulties. However, the children scored poorly in the mathematics and language literacy tests and were found to not be ready to engage with the grade one curriculum. Their test scores were below the provincial scores assessed prior to the pandemic.

Fourth, caregiver and child mental health were most concerning. Over half of caregivers (54%) had depressive symptoms. Prevalence varied across the areas, with some areas such as Meadowlands and Doornkop having unusually higher rates of depression. Teachers reported that 13% of children presented with anxiety and expressed feelings of unhappiness. Two-thirds of caregivers were also concerned about child safety with similar numbers having been exposed to violence at home and in the community.

Despite these disconcerting findings about the material and psychosocial wellbeing of the children as well as experiences of violence in their households and communities, children were reported to be doing well on other indicators. For instance, 82% were attending school even though this attendance was on the basis of a rotational timetable, 69% were assessed to be in good health and almost all children were living in households where they had access to basic services, even though these may have been of poor quality.

Addressing children's needs holistically requires an inter-sectoral and transdisciplinary response. Although the social grants policy mitigates household poverty and food insecurity, the unusually high rates of unemployment means that the grants are clearly not sufficient to address these challenges. Complimentary services across different social sectors need to be better co-ordinated to respond to the diverse challenges facing children and their families. In view of the fragmentation of service provision, a lack of cooperation between the sectors and the silos in which services are delivered, collaboration is problematic. Each function is also governed by separate laws, organisational mandates, reporting lines, operating procedures, different work styles and cultures as well as different knowledge systems, budgets and human resources. Collaboration is easier said than done in such complex systems. Policy guidelines and protocols to promote cooperation between all the parties could improve service provision. Practitioner training and 'learning by doing' could also promote more seamless collaboration and the crossing of closely guarded boundaries between service agencies. The research thus far also shows that some children and their families have very particular needs and that customised interventions are needed to respond appropriately and timeously.

Finally, it is our contention that the CoP model provides a useful learning vehicle to understand how to break down silos, co-operate around a common purpose and find real life solutions with the school as the focal point of engagement. By placing the needs of the child and their family at the centre of our intervention strategies, we hope to find systemic solutions that could break down the barriers that perpetuate exclusion of groups of children who are left behind.

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APPENDICES

Appendix I: Child Wellbeing Tracking Tool

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CHILD WELL-BEING TRACKING TOOL

Introduction

1. This questionnaire consists of 6 sections which should be completed by the respective respondents who may be either the parent/caregiver of the child; educator; health care practitioner and the child. The sections are:

Section A: Demographic and social profile: child/family living circumstances (Respondent: Parent/Caregiver)

Section B: Child well-being domains (Respondent: Parent/Caregiver)

Section C: Parent/Caregiver health and well-being (Respondent: Parent/Caregiver)

Section D: Education and wellbeing domain (Respondent: Teacher)

Section E: Health domain (Respondent: Health Practitioner)

Section F: Subjective measures: (Respondent: Child)

Interview Information Sheet (this information will be picked up automatically in the app)

Unique identifier of child (to be prepopulated)	
Date of interview	
Interviewer name and surname	
Contact details of interviewer	
Name of school	
Ward number	

Section A: Demographic information regarding the Child and Parent/Caregiver (P/CG)

1. Child's name and surname	
2. P/CG name and surname	
3. Address	
4. Contact number	
5. Date of birth of child (DD/MM/YYYY)	
6. Date of birth of P/CG (DD/MM/YYYY)/Age	
7. Does the child have a birth certificate	Yes/No
8. Does the child have a Road to health card?	Yes/No
9. Do you (P/CG) have a South African ID or other documentation?	
10. Gender of child	
11. Grade child is in *	Grade R/Grade 1
12. How many adults live in your household?	
13. Number of other children living in the house	

14. Who is the child living with NOW	Refused to answer	Both parent	One parent	Both parents and other relative/s	Mother and other adult relative/s	Father and other adult relative/s	Relatives with no Parents for example, aunt, grandparent, sibling	Foster parent (s)	Place of safety/CY CC
15. How many other SASSA grants does the family receive? (Please indicate number of each type of grant received)	No grant	Don't know	Child support grant No:	Foster care grant No:	Care and depen-dency grant No:	Disability grant No:	Pension No:	Social relief of distress No:	Grant in aid No:

16. Educational level of Parent/CG	None Primary Some Secondary Completed Secondary (matric) Any Post-Secondary Education and Training
17. Employment status of parent/caregiver	Full time employed Part—time employed Piece work Self-employed Unemployed
18. Are there relatives in the household who help with care of the child/rent	Yes/No
19. Is there anyone in your household/family or community to support you in times of need	Yes/No/sometimes

SECTION B: Child's Wellbeing Domains (to be completed by Parent/Caregiver)

Domain 1: Education

D1.1. Does your child attend school regularly?	Yes No
D1.2. Is your child progressing with their schoolwork?	Yes No
D1.3. Does your child do homework as required ?	Yes Sometimes No
D1.4. Is there someone in your home that helps your child with homework?	Yes Sometimes No
D1.5. Does the child have a school uniform and supplies such as books and stationary?	Yes Some No
D1.6. Is the child afraid or refuses to go to school?	Yes Sometimes No

D2: Food and Nutrition

D2.1. Does your child ever go to sleep hungry?	No Sometimes Yes
D2.2. Does your child eat a protein (fish, chicken, meat, eggs, peanut butter) at least 2X a week?	Yes No
D2.3. Does your child eat vegetables at least 2 X a week?	Yes No
D2.4. Is there enough food for your child to eat at every meal?	Yes Sometimes No
D2.5. Does your child eat three meals a day?	Yes Sometimes No

Domain 3: Health

D3.1. Is your child's health stopping him/her from playing/going to school?	No Sometimes Yes
D3.2. Do you take your child to a clinic/ hospital or a doctor when they get sick?	Yes Sometimes No
D3.3. Has your child been hospitalized?	No Yes
D3.4. Compared to other children, does your child struggle to hear, see or talk?	No Sometimes Yes
D3.5. Does your child have good hygiene habits (for example, keeps hands and body clean)?	Yes Sometimes No
D3.6. Does the child participate in sporting, cultural, spiritual/religious, arts or recreational activities outside school hours?	Yes Sometimes No

D3.7 Does the child engage in physical activities?	Yes Sometimes No

Domain 4: Economic/Material Well-being

D4.1. In addition to the grant, does the family have access to other sources of income?	Yes Sometimes No
D4.2. Does your family have enough money to buy the things you need?	Yes Sometimes No
D4.3. Are you able to save a portion of your income/money? (e.g. are you part of a savings club (like a stokvel)?	Yes No
D4.5. Do you struggle with paying off debts?	Yes No
D4.4. Does your child have a mattress or bed in the house where he/she sleeps every night?	Yes No
D4.5. Do you live in a home that protects you from wind and rain?	Yes No
D4.6. Do you live in a home that has access to clean drinking water?	Yes No
D4.7. Do you live in a home with electricity?	Yes No
D4.8. Do you have a toilet with running water on your property/do you have access to a toilet with running water in your home/property/ yard?	Yes No

Domain 5: Protection/Care

D5.1. Is there an adult in the home that always knows where the child is?	Yes Sometimes No
D5.2. Is there someone in the home that the child trusts and can talk to?	Yes No
D5.3. Does an adult or older sibling read/sing/spend time with the child?	Yes Sometimes No
D5.4. Have you ever had concerns about the safety of your child?	No Sometimes Yes
D5.5. Has the child seen people that are fighting, swearing or hurting each other at home or in the community?	No Sometimes Yes
D5.6. Has the child been a victim of abuse or violence?	No Yes
D5.7. How do you discipline your child?	

SECTION C: Caregiver health and well-being (To be completed by P/CG)

1. Do you consider yourself to be in good health?	Yes/No

2. Please indicate how often you have felt this way during the past week by checking the appropriate box for each question.

	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)
1. I was bothered by things that usually don't bother me.	0	1	2	3
2. I had trouble keeping my mind on what I was doing.	0	1	2	3
3. I felt depressed.	0	1	2	3
4. I felt that everything I did was an effort.	0	1	2	3
5. I felt hopeful about the future.	0	1	2	3
6. I felt fearful.	0	1	2	3
7. My sleep was restless.	0	1	2	3
8. I was happy.	0	1	2	3
9. I felt lonely.	0	1	2	3
10. I could not "get going."	0	1	2	3

3. How did the lockdown affect you and your family?

4. What helped you to cope during the lockdown?

SECTION D: EDUCATION and Child's Well-being at School (these questions to be completed by the TEACHER)

Name of teacher	
Number of children in class	
Home language of child	
Language of Instruction in class	

1.	Does the child attend school regularly?	Yes / No
2.	Is the child progressing with their schoolwork?	Yes / No
3.	Does the child do homework as required?	Yes / Sometimes / No
4.	Compared to other children of their age, does the child have difficulty learning or remembering things or concentrating on an activity they enjoy?	No / Sometimes / Yes
5.	Does the child come to school with the correct uniform and supplies such as books and stationary?	Yes / Sometimes / No
6.	Is the caregiver involved in the child's education such as supporting with homework, attending school meetings, and discussing any challenges the child has with the school?	Yes / Sometimes / No
7.	Does the child eat a meal provided by the primary school nutrition scheme?	Yes / No
8.	Compared to children the same age, does the child speak well?	Yes / No
9.	Compared to children the same age, does the child see well?	Yes / No
10.	Compared to children the same age, does the child hear well?	Yes / No
11.	Is the child well cared for and looks neat and clean?	Yes / Sometimes / No
12.	Does the child seem anxious, nervous or worried?	Yes / Sometimes / No
13.	Is the child generally happy?	Yes / No
14.	Does the child participate in class activities?	Yes / Sometimes / No
15.	Does the child seem sad or depressed?	No / Sometimes / Yes
16.	Compared to other children of their age, does the child have difficulty controlling their behaviour?	No / Sometimes / Yes
17.	Can the child tell someone to stop doing something he/she doesn't like?	Yes / Sometimes / No
18.	Does the child speak to you when he/she has a problem?	Yes / Sometimes / No
19.	When the child is upset, are they able to calm themselves down?	Yes / Sometimes

		No
20. When the child has a problem can he or she either find a solution and/or ask for help?		Yes Sometimes No
21. Does the child fight with other children?		Yes Sometimes No
22. Can the child sit still long enough to complete tasks?		Yes No
23. Is there evidence of child abuse and/or neglect?		Yes No

SECTION E: HEALTH (Healthcare professional to complete)

Name of healthcare practitioner	
Position/title	
Name of clinic child usually goes to	

1. Child's weight	_____ kg
2. Child's height	_____ cm
3. Is the child's mid upper circumference (MUAC) below 11.5 cm?	Yes/No
4. Is the child presenting with extremity oedema in hands, feet or face?	Yes/No
5. Does the child present with any of the following danger signs: • Temperature (Body) • Respiration • Lethargy • Shock • Hypoglycemia • Hypothermia • Dehydration • Refusing feeds	 Yes/no Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No
6. Is the child's vaccination (EPI) up to date?	Yes/No
7. Is the child on HIV treatment?	Yes/No
8. Is the child on TB treatment?	Yes/No
9. Does the child have diabetes?	Yes/No
10. Does the child have a history of cardiac conditions?	Yes/No
11. Does the child have any dermatological conditions (Eczema, ringworms)?	Yes/No
12. Does the child have any respiratory conditions (pneumonia, asthma)?	Yes/No
13. Did/does the child have seizures?	Yes/No

	14. Did/does the child have a confirmed/diagnosed mental health condition?	Yes/No
	15. Compared to children the same age, does the child have difficulty seeing, hearing, walking, talking?	Yes/No
Notes:	16. Is there evidence of abuse?	Yes/No

SECTION F: SUBJECTIVE ASSESSMENTS (to be completed by/with the CHILD)

MATHS AND ENGLISH PROFIENCY TESTS

1. The Maths specific vocabulary test. [See attached]
2. The EGRA reading and pre-literacy test. [See attached]

CHILD WELL-BEING

1. Child and Youth Resilience Measure (CYRM-R, 5-9yrs) [see below]
2. SDQ

CYRM-R (child)				
Please choose one answer for each question. There are no right or wrong answers.		No [1]	Sometimes [2]	Yes [3]
1	Do you share with people around you?			
2	Is doing well in school important to you?			
3	Do you know how to behave/act in different situations (such as school, home, holy places)?			
4	Do you feel that your parent(s)/caregiver(s) know where you are and what you are doing all of the time?			
5	Do you feel that your parent(s)/caregiver(s) know a lot about you (for example, what makes you happy, what makes you scared)?			
6	Is there enough to eat in your home when you are hungry?			
7	Do other children like to play with you?			
8	Do you talk to your family/caregiver(s) about how you feel (for example when you are hurt or feeling scared)?			
9	Do you have friends that care about you?			
10	Do you feel you fit in with other children?			
11	Do you think your family/caregiver(s) cares about you when times are hard (for example, if you are sick or have done something wrong)?			
12	Do you think your friends care about you when times are hard (for example if you are sick or have done something wrong)?			
13	Are you treated fairly?			
14	Do you have chances to show others that you are growing up and can do things by yourself?			
15	Do you feel safe when you are with your family/caregiver(s)?			
16	Do you have chances to learn things that will be useful when you are older (like cooking, working, and helping others)?			
17	Do you like the way your family/caregiver(s) celebrates things (like holidays or learning about your culture)?			

For an unmodified 3-point measure (with responses going from 1-3), the minimum score is 17 and the maximum score is 51.
If a person skips or misses an item, their scores cannot be computed, as their overall score will be artificially lower than others who complete the measure. If this happens, you can discard the incomplete result or consider methods of managing missing data (e.g., http://www.stat.columbia.edu/~gelman/arm/missing.pdf).

Appendix II: Risk Assessment Clustering

Appendix II: Risk Assessment Clustering

Child wellbeing is categorised in various domains as:

- RED (3) – Major concerns that indicate a need for immediate referral
- AMBER (2) – Some concerns that indicate a need for support/intervention
- GREEN (1) – NO concerns

We consider various domains of wellbeing. There is not one overall wellbeing measure.

EDUCATION DOMAIN

- Educational wellbeing = RED (3) IF D1.1. == NO AND D1.2 == NO AND (D1.6 == YES OR D1.6 == SOMETIMES)
- Educational wellbeing = AMBER (2) IF (D1.1 == NO AND D1.2 ==YES) OR (D1.1 == YES AND D1.2 == NO)
- Educational wellbeing = GREEN (1) IF D.1. == YES AND D1.2 ==YES

FOOD AND NUTRITION DOMAIN

- Food security wellbeing = RED (3) IF D2.1==YES AND D2.4==NO
- Food security wellbeing = AMBER (2) IF D2.1==SOMETIMES AND D2.4 == SOMETIMES
- Food security wellbeing = GREEN (1) IF D2.1==NO AND D2.4=YES
- Food quality wellbeing = AMBER (2) IF D2.2==NO AND D2.3==NO
- Food quality wellbeing = GREEN (1) IF D2.2== YES AND D2.3==YES
- NOTE: No red flag for food quality sub-domain

HEALTH DOMAIN

- Health wellbeing = RED (3) IF D3.1== YES OR D3.4==YES OR Child is wasted (weight-for-age) OR Child is stunted (height-for-age) or SECTIONDQ8==NO OR SECTIONDQ9==NO OR SECTIONDQ10==NO OR SECTIONEQ9==YES OR SECTIONEQ10==YES OR SECTIONEQ12==YES OR SECTIONEQ13==YES OR SECTIONEQ14==YES OR SECTIONEQ16==YES
- Health wellbeing = AMBER (2) IF (D3.1 == SOMETIMES AND D3.4 == SOMETIMES) OR SECTIONEQ6==YES OR SECTIONEQ7==YES OR SECTIONEQ8==YES OR SECTIONEQ11==YES
- Health wellbeing = GREEN (1) IF (D3.1==NO AND D3.4==SOMETIMES) OR (D.3.1==NO AND D3.4==NO) OR (D3.1==SOMETIMES AND D3.4==NO)

MATERIAL DOMAIN

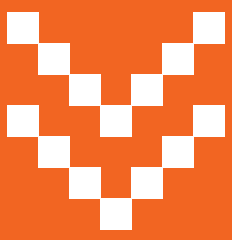
- Financial wellbeing = RED (3) IF D4.1==NO AND D4.2==NO AND D4.5(debts)==YES
- Financial wellbeing = AMBER (2) IF (D4.1==SOMETIMES AND D4.2==SOMETIMES AND D4.5(debts)==YES) OR (D4.1==NO AND D4.2==SOMETIMES AND D4.5(debts)==YES) OR (D4.1==NO AND D4.2==YES AND D4.5(debts)== YES) OR (D4.1==YES AND D4.2==NO AND D4.5(debts)==YES) OR (D4.1==SOMETIMES AND D4.2==NO AND D4.5(debts)==YES)
- Financial wellbeing = GREEN (1) IF D4.1 == YES AND D4.2 ==YES AND D4.5==NO
- Living conditions wellbeing = RED (3) IF D4.4==NO AND D4.5(protects)==NO AND D4.6==NO and D4.7==NO and D4.8==NO
- Living conditions wellbeing= AMBER (2) IF D.4.4==NO OR D4.5 (protects)==NO OR D4.6==NO OR D4.7==NO OR D4.8==NO
- Living conditions wellbeing=GREEN (1) IF D.4.4==YES AND D4.5 (protects)==YES AND D4.6==YES AND OR D4.7==YES AND D4.8==YES

PROTECTION AND CARE DOMAIN

Protection and Care wellbeing = RED (3) if D5.6==YES OR D5.5==YES OR SECTIONDQ23==YES

Protection and Care wellbeing= AMBER (2) if D5.1==SOMETIMES OR D5.1==NO OR D5.5==SOMETIMES OR (SECTIONDQ5==NO AND SECTIONDQ6==NO) OR (SECTIONDQ11==NO AND SECTIONDQ12==NO AND SECTIONDQ13==NO AND SECTIONDQ15==NO) OR (SECTIONDQ2==NO AND SECTIONDQ16==YES AND SECTIONDQ22==NO)

Protection and Care wellbeing= GREEN (1) if D5.6==NO AND D5.5==NO AND D5.1==YES



Communities of Practice web link:
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