RESEARCH BRIEF

Communities of practice for social systems strengthening to improve child wellbeing

Monkey Business Images/shutterstock.com

Can a family-strengthening intervention improve child wellbeing outcomes for early grade learners?

Findings from an intervention study in five public schools in Johannesburg

SONIA MBOWA, LEILA PATEL AND TANIA SANI

JUNE 2024

National Research Foundation

CSDA
CENTRE FOR SOCIAL DEVELOPMENT IN AFRICA

UNIVERSITY OF JOHANNESBURG

The community of practice is a multisectoral and interdisciplinary collaboration between academic researchers, practitioners, government and nongovernment agencies.

Email: Csdainfo@uj.ac.za | **Website:** www.uj.ac.za/faculties/humanities/csda

This research is supported with funding from the National Research Foundation (NRF), South Africa and the CSDA. The views expressed are those of the authors and not the NRF's.

About the authors: Leila Patel, principal investigator of the CoP, is a distinguished professor of Social Development Studies at the CSDA; Sonia Mbowa is a researcher at the CSDA, Tania Sani is the CoP project coordinator at the CSDA.

Suggested citation: Mbowa, S. Patel, L., & Sani, T. *Can a family-strengthening intervention improve child wellbeing outcomes for early grade learners? Findings from an intervention study in five public schools in Johannesburg*. Johannesburg: Centre for Social Development in Africa, University of Johannesburg.

June 2024

Introduction to the Sihleng'imizi family intervention

This research brief presents our findings from the Sihleng'imizi family-strengthening intervention (FSI) which was offered to forty-five children and their families in 2021. Sihleng'imizi means 'We care for families' in isiZulu (Patel & Ross, 2022). The intervention took place in five participating public schools in Johannesburg, Gauteng province, South Africa. Children and their families who were at risk of compromised wellbeing were selected for this FSI. The schools fell into quintile levels 1–3, which are schools in low-income communities. Our research sought to discover what changes happened in participating caregivers' parenting knowledge and practices following the intervention. This data went into an assessment of the usefulness of the programme.

Background to the family-strengthening intervention

The Sihleng'imizi family-strengthening intervention (FSI) is part of a three-year communities of practice (CoP) study to improve child wellbeing outcomes for early grade learners. We used a combination of quantitative and qualitative assessments in low-income communities in the City of Johannesburg to identify the changes in participating caregivers'[1] parenting knowledge and practices. The quantitative assessment is drawn from a larger CoP study on how well children are faring based on caregiver, teacher and child responses at baseline in the last quarter of 2020 (wave 1) and again at the end of 2022 (wave 3). Data were estimated from this larger quantitative data set for the sixteen families who participated in the FSI and completed three waves of the CoP study. We have a complete data set where families answered all questions in both surveys. Caregivers provided qualitative feedback when they exited the programme at the end of 2021. The research report has more details on this communities of practice study.

All caregivers responsible for the children in the study received the child support grant (CSG) for the children in their care. The CSG is one of South Africa's largest cash transfer programmes to reduce poverty (UNICEF 2020). The children were in grades R – formal school reception year – through to Grade 3, and were aged between six and eight. The FSI is a group-based family programme. Trained social workers, supported by auxiliary social workers and/or care workers, deliver it. The intervention was designed to promote child wellbeing through enhancing caregivers' knowledge, skills and practices in specific domains. These domains included caregiver engagement in their children's schooling, child nutrition, their financial capabilities, psychosocial wellbeing, and their access to social support, child-caregiver relations, and in managing children's difficult behaviours.

The Sihleng'imizi family-strengthening programme and theory of change

The Sihleng'imizi family-strengthening programme is an evidence-based psychosocial, educational and social development intervention. It was first piloted in 2016 in urban primary schools in Johannesburg, Gauteng province, and in rural Moutse Village, Limpopo province in South Africa. After this, in 2017 the programme content was modified, and more testing was done in ten of the poorest wards in the City of Johannesburg. This was done in partnership with United Nations Children's Fund (UNICEF) South Africa and was followed by an evaluation.

The Sihleng'imizi study: It's filling the gap

The intervention was found to be effective and feasible to implement in previous evaluations. We found positive changes in four out of five of the programme's domains listed earlier. There were small positive increases in mental health at follow up a year later (Patel, Hochfeld, Ross, et al., 2019; Patel & Ross, 2022; Ross et al., 2020). Sihleng'imizi builds on the benefits of the child support grant in reducing child poverty rates, improved school attendance and nutrition outcomes (Patel, Hochfeld, & Chiba, 2019). The CSG is a standalone cash transfer programme. The state does not offer any other much-needed complementary interventions to grant families who need psychosocial support, financial education, knowledge of nutrition, parenting knowledge, information on social and community services, and skills related to all of these. The family intervention attempts to fill this gap. It is aligned with the CoP's multidimensional concept of child wellbeing, and embeds a systemic ecological approach to understanding and intervening in children's and their families' lives at the individual, school, family and community levels (Patel et al., 2021). Child wellbeing refers to material, physical, social, emotional and educational wellbeing (Bradshaw & Keung, 2011). The theory of change of the family-strengthening intervention was informed by the five domains of child wellbeing, the relevant programme components, and the intended outcomes are shown in Figure 1.

[1] We define caregivers as those primarily responsible for the care of their children who could be their parents, grandparents or relatives.

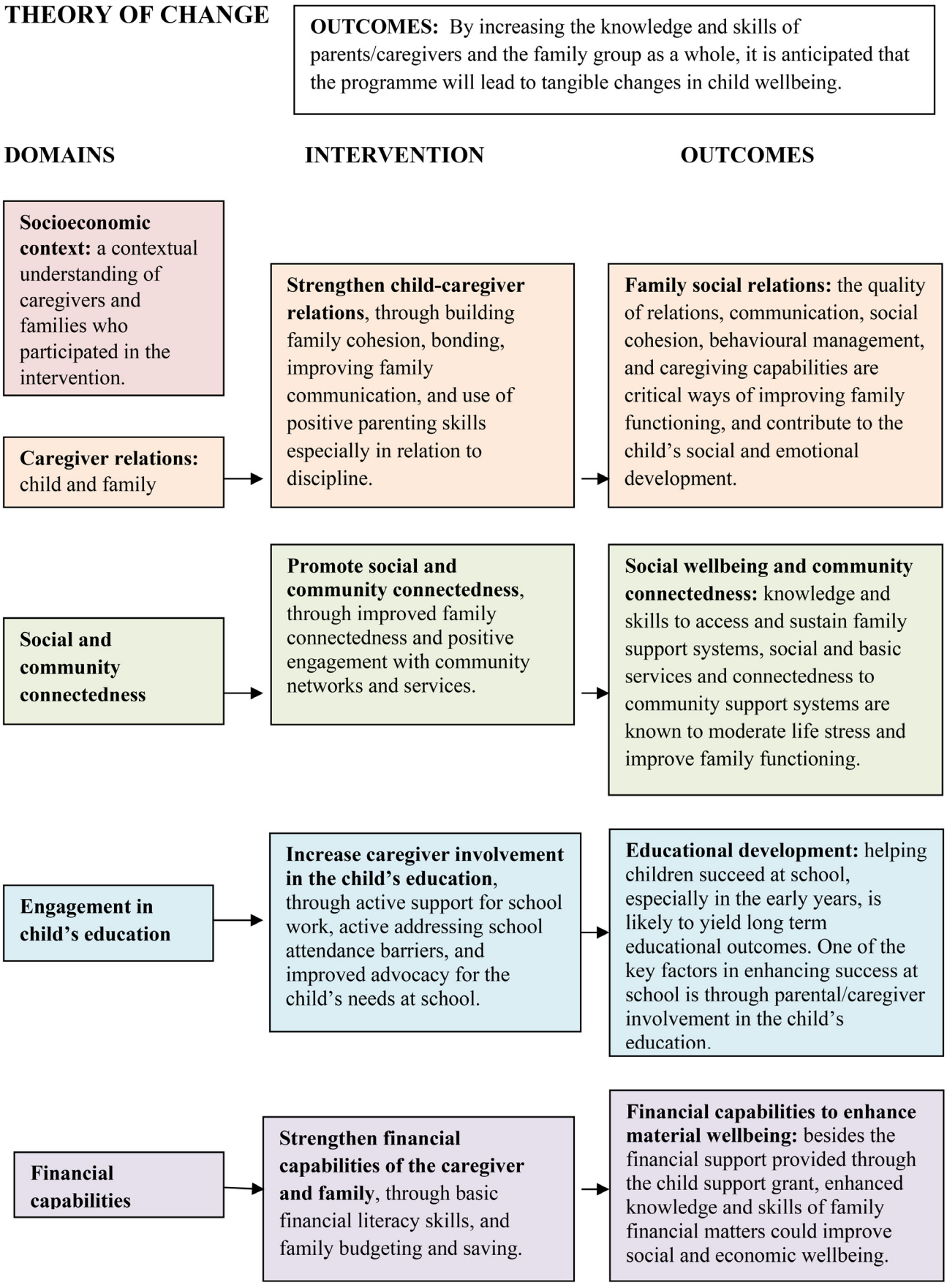

Figure 1: Theory of change of the family-strengthening intervention

Source: Chiba & Patel (forthcoming)

Further, this iteration of the Sihleng'imizi FSI was offered through a different implementing agency, the CoP consortium. A social work team located at the Centre for Social Development in Africa (CSDA), University of Johannesburg (UJ) led it.

The Sihleng'imizi programme (Patel et al. 2019) was considered appropriate for early grade learners and their families in the CoP study because they needed complementary family services and social support.

Key features of the Sihleng'imizi programme

A key feature of the programme is that all family members are invited to participate in the fourteen family group sessions, not only the child and their caregiver. The thinking behind this is to strengthen the family unit as a whole, and for caregivers and participants to share the knowledge and learning with other family members at home (Patel, Hochfeld & Chiba, 2021). Another important feature was the intentional pairing of families so they could support each another from the beginning of the programme. This is the Sihleng'imizi buddy system. The Sihleng'imizi programme was offered over fourteen weeks and a qualified social worker, supported by an auxiliary social worker or childcare worker, managed and facilitated it. Five social workers were trained to deliver the programme. They used the Sihleng'imizi training suite which included a facilitator manual, a family workbook and childcare worker manual (Patel, Hochfeld & Chiba, 2021). The manuals can be accessed here.

The family sessions

Social workers had weekly supervision, and ongoing mentoring and coaching to ensure the programme's reliability. The family sessions lasted two hours and took place at schools the participating children attended. The work sessions were designed to be highly participatory for all adults and children in a group setting. However, some parts of the sessions, depending on what they were about, were offered to parents only. For example, they included the discussions on how caregivers should communicate with other adults who relate to their children. Sessions 2, 5, 6, 10 and 12 had such parts. During these times, the children took part in a group session that the trained childcare worker or auxiliary social worker facilitated. They were guided by the childcare workers' manual which was connected to the learning theme of the adults' session. The whole group would reconvene after their separate activities were finished. In some sessions, families worked independently and in groups with other families, for example, on money management and rule setting. At the end of each session, families had homework that was explained in their family workbook, which every family received. The homework was to practise activities done in that session. The programme was structured around these topics:

1) relations between the child and their caregiver
2) social and community connectedness
3) caregiver engagement in the child's education
4) health and nutrition
5) financial capabilities.

Because caregivers' mental health is a significant risk associated with compromised child wellbeing, their mental health was also assessed. Different local (Patel et al. 2017) and international studies (Tolan, Guerra & Kendall, 1995) show that these factors are all associated with improved child wellbeing outcomes.

Content and purpose for each family session

The following outlines the topics and objectives for each of the fourteen sessions.

Session 1: Identify your family's strengths

- Encourage caregivers to see school and learning as a valuable and potentially enjoyable activity that helps families achieve their goals.
- Identify individual family member's strengths, and the strengths of each family.

Session 2: At home: Helping children to do their best at school

- Encourage caregivers to feel confident and comfortable in helping their children to do their best academically, and in their behaviour at school.

Session 3: How to work in a cooperative way with your child's school

- Guide and encourage caregivers' involvement in their child's learning.

Session 4: Healthy meal and nutrition guidelines

- Offer knowledge about nutrition.
- Promote caregivers' competency in making healthy food choices.

Session 5: Understand what can be expected in Grade R and Grade 1 children's development

- Caregivers learn what children in Grade R and Grade 1 should be expected to be able to do well.

Session 6: Strengthening communication with children and family members

- Encourage constructive communication with children through examples of positive communication.

Session 7: How to manage difficult behaviour

- Help families maintain, or regain control of angry feelings when dealing with each other.
- Learn how to respond to children's negative attention-seeking behaviour by distracting, redirecting, or ignoring behaviour caregivers want less of.

Session 8: Negative behaviour management

- Help caregivers deal with difficult behaviour.

Session 9: Ways to promote positive behaviour and ways to resolve conflict

- Help families, through specific methods, to learn positive ways to discipline children, and to resolve conflict.

Session 10: Redefine family rules and consequences

- Help families state, explain, and adjust family rules and consequences.

Session 11: Do a household budget

- Help everyone in the family understand and identify wants and needs and ways to manage money.
- Reduce family stress about money.

Session 12: Ways to save money and make a family saving plan

- Understand the different ways to save, and the risks of borrowing money.
- Come up with a family saving plan.

Session 13: How to get and use social support services

- Know about services and resources in the community that families can get.

Session 14: Social support and evaluate the programme

- Encourage active participation in family and community life.
- Evaluate the programme.

Source: Patel, Hochfeld & Chiba (2021)

Assessing the impact of the Sihleng'imizi intervention

Our aim was to assess what changes occurred in the children and families who went through the Sihleng'imizi programme. We looked at caregiver changes in these domains linked to the objectives and content of the fourteen sessions:

a) Change in caregivers' mental health between wave 1 and wave 3.
b) Whether caregivers strengthened their ability to save money and reduce debt.
c) Caregivers' ability to provide more nutritious food.
d) The types of discipline methods caregivers used.
e) Whether caregivers spent more quality time with their children. And whether they were able to build more trust. This included providing the child with a safe and trustworthy space to express their emotions.
f) Whether caregivers increased their involvement in their children's schoolwork, such as when doing homework.
g) Caregivers' views on what changed for them after they took part in the Sihleng'imizi family-strengthening programme. And also, how they have since applied their knowledge and the programme's various techniques towards enhancing their children's wellbeing and family relations.

Methods used for the study

We used a digital tool, the CWTT, for (a) to (f) to quantitatively assess changes. The tool asks questions on all aspects of children's wellbeing: materially, physically, educationally and about their psychosocial wellbeing. Sixteen children and their families were assessed at baseline in the last quarter of 2020. A follow-up was conducted a year after they received the family-strengthening intervention in 2022. Objective (g) was assessed qualitatively. We based this on feedback families provided in the final evaluation of the programme in the last quarter of 2021. A standardised feedback form was used to ask caregivers for their views about the changes that had happened (Patel, Hochfeld & Chiba 2021, p.20).

Study design

We used a combination of quantitative and qualitative methods to assess the changes that occurred as a result of the participants' engagement in the FSI.

The larger communities of practice study

Between October and December 2020, 162 children and caregivers were purposively sampled at each of the five participating schools in poor and disadvantaged communities in Johannesburg, Gauteng province. The CoP team, in consultation with local authority officials, identified the schools.

The schools were selected if:

- They were in poor and disadvantaged areas. This included the five schools in our study which were quintile 1 to 3 schools. Caregivers do not have to pay school fees at these quintile schools.
- The schools were willing to work together with the community of practice study. This was because taking part would be time consuming for teachers and heads of the foundation phase.

Specific school classes were only selected if:

- The class teachers were willing to participate. Therefore, once the schools were identified, the principal and heads of the Foundation Phase selected three classes respectively from the grade R cohort, which is the reception year, and from grades 1 and 2.

The process that followed:

- All children and their caregivers in the respective selected classes in grades R to 2 were included in the sample.
- We used a questionnaire to assess children in different domains. The data were collected using a digital tool, the Child Wellbeing Tacking Tool (CWTT). The CWTT was used to assess how well the children were faring. Field workers were trained to test and administered the tool. See the Wave 1 report here.
- The same cohort of children and families who were interviewed in 2020 were then followed up in wave 3 in the last quarter of 2022 to assess their wellbeing.
- The data were collected using the questionnaire loaded onto the CWTT. We gathered data from the child, the child's participating caregiver, who could be a parent, a grandmother, or a relative, and the child's class teacher. Fieldworkers were fluent in participants' languages. The data analysts used SPSS, a statistical data analysis package. Caregivers' levels of depression were measured using the Centre for Epidemiological Studies Depression Scale (CES-D-10). This scale has been validated in South Africa (Baron, Davies, & Lund, 2017).
- The Child and Youth Resilience Measure (Unger & Liebenberg, 2011), also validated for use in South Africa, was used. Data analysis included the construction of risk profiles of the child and their family's needs.

Research strategy to evaluate the family-strengthening intervention (quantitative component)

We now turn to describing the sample and research strategy used to evaluate the family intervention.

How we recruited and selected families for the study

We based our recruitment and selection of families for the study on the children's risk profiles. These profiles were constructed using the wave 1 data collected through the CWTT in 2020. Children were categorised as being at high, moderate or low risk. High risk indicates major concerns that require immediate referral. Medium risk indicates some concerns that require support and or intervention, and zero risk shows no indication for concern.

We asked questions for each wellbeing domain: material, education, health and psychosocial. We assigned scores to each indicator of vulnerability. Highest risk scored three, medium risk scored two, and zero risk scored one. Social workers

then conducted home visits to discuss the findings with families whose children were at high and medium risk to find out about how willing they were to participate in the family intervention. After the home visits, social workers selected the families who had agreed, and invited them to participate in the family-strengthening intervention. For every family invited, social workers filled in information sheets stating why they were selecting that particular family. An analysis of these forms showed that children were selected if they were at high and medium risk. See Table 1 for the outcome.

Table 1: The number of children who presented with different wellbeing concerns

Different wellbeing concerns about the children	No. of children
Health and nutrition-related concerns	17
Performing poorly in school	15
Caregivers presented with symptoms of depression	11
At high risk in all domains	8
Child abuse and safety, bereavement counselling	Small numbers
Total number of children in the programme who experienced high risk	51

Source: Authors

In total, 51 children experienced medium and high risk. Children with health concerns were referred to the local clinics and the research team followed them up on the next round of data collection. All children identified with learning difficulties were assessed by an educational psychologist and the assessments were shared with caregivers and teachers if the caregiver consented. Remedial plans were implemented. Forty-five of the total sample (N=162) of children who were at high and medium risk were selected for the Sihleng'imizi family strengthening intervention. These children presented largely with risks in the domains of material wellbeing, care and protection, children with difficult behaviours, and caregivers with symptoms of depression. Caregivers signed an informed consent form which stated what the intervention was about, what commitment it required, that participation was voluntary, and that their personal information would only be shared with other professionals with their permission. It also stated that the research findings would not give their names.

Sample size and participation rates

In Week 1, when the programme started, 45 families attended whose children went to the five selected schools. Participants were children, parents/caregivers and relatives in the household. However, only 21 families attended at least half (seven) of the sessions. The attendance was irregular for the remaining 24 families. Wessels, Lester and Ward (2016) report a trend of poor attendance in family programmes universally. In South Africa, when parents from the Western Cape province were interviewed about their lack of uptake in the Sinovuyo Caring Families Project, their reasons ranged from transport problems to "hunger, and having to plan how they were going to feed their children that day" (Ilifa Labantwana, 2014, p.4). Sihleng'imizi caregivers in the CoP study gave a variety of reasons, including transport difficulties, work commitments, and rainy weather for why they did not attend sessions. Other factors which upset the scheduling of sessions were because of a clash with South African Social Security Agency (SASSA) grant payment days and school holidays. This led to things such as a meeting venue not being available during the school holidays or participating families being away from Gauteng. Also, clinic appointments, school closures due to water shortages, and maintenance work at the groups' venues all contributed to reduced attendance.

Our research questions

We drew out 12 responses from the questions asked of the caregivers, teachers and children's responses from the CWTT. We selected these specific questions because they are indicators of modifiable changes that could have occurred as a result of the family-strengthening intervention. We envisioned modifiable changes in behaviours, access to support, and the caregivers' mental wellbeing. Examples of changes in behaviours were in the caregivers' methods of discipline, how regularly children attended school and did their homework, the caregivers' savings, level of debt, and nutrition practices.

Access to support included having a supportive network of people to turn to when both the children and caregivers needed it. The absence of a support network is associated with high-risk behaviour in children which negatively impacts their wellbeing (Patel & Ross, 2022). For children's direct report of their wellbeing, only item 8 from the Child and Youth Resilience Measure (Unger & Liebenberg, 2011) was found to be relevant to our family intervention. The question to

children for item 8 is: “Do you talk to your family/caregiver(s) about how you feel, for example, when you are hurt or feeling scared?” The question asked of caregivers about using physical and other forms of discipline was an open-ended question in wave 1. In wave 3, participants could select options for answering the question about the methods they used to discipline their child.

Data analysis

Data were analysed using SPSS, a statistical data analysis package. The qualitative data presented next is for the same 16 families who participated in the evaluation in the intervention’s final session, and those who completed the evaluation forms at the end of the programme. The evaluation form is in the facilitator manual found here. The sample was adequate for a qualitative study (Vasileiou et al., 2018). This paper has already outlined how the families were recruited and selected, including our sampling procedures. The family sessions started at the beginning of September 2021 and the last one was at the end of November 2021. Every week, respondents answered the question about what they found useful in that session. This feedback was in a qualitative format and was coded and analysed using thematic analysis as shown in the findings section below.

Ethical approval

Ethical approval for the community of practice study and for the family intervention was granted by the University of Johannesburg’s Faculty of Humanities (REC-01-050-2020-Amendment 1.0) and the Heath Research Ethics Committee (HREC) (NHREC Registration: REC 241112-035). Participating caregivers were informed about the voluntary nature of the programme and their right to withdraw at any point if they wanted to.

Limitations

These were the study’s limitations:

1) We recognise that participants may have given socially desirable responses.
2) Because the sample size was too small, we could not compare the Sihleng’imizi family programme participants with the rest of the community of practice sample (n=162) who did not take part in the programme.
3) At times, caregivers gave vague answers in the open-ended questions, such as “it was useful” and “it was good” which do not adequately capture what they learned, nor how they were applying it.
4) Improvements in some measures may be due to the tapering off of the economic and social impact of the Covid-19 pandemic.

Findings of the family-strengthening intervention

Quantitative analysis

In table 2 we present our quantitative findings for the 16 families who participated in the Sihleng'imizi family-strengthening intervention, and for whom we had a complete data set.

Table 2: Caregiver, teacher and child responses at baseline (wave 1) and end point (wave 3), n=16

Caregiver responses	Wave 1	Wave 3
1. Caregiver CES-D-10 (depressive symptoms)	10 (62.5%)	5 (31.3%)
2. Is there anyone in your household/family or community to support you in times of need? (Yes/Sometimes)	4 (25%)	13 (81.3%)
3. Are you able to save a portion of your income/money? For example, are you part of a savings club, such as a stokvel?	6 (37.5%)	10 (62.5%)
4. Do you struggle with paying off debts?	8 (50%)	8 (50%)
5. Does your child eat a protein, such as fish, chicken, meat, peanut butter at least twice a week?	12 (75%)	16 (100%)
6. Does your child eat vegetables at least twice a week?	13 (81.3%)	14 (87.5%)
7. Does an adult or older sibling read/sing/spend time with the child? (Yes/Sometimes)	14 (87.5%)	15 (93.8%)
8. How do you discipline your child? ▪ wave 1: open-ended question ▪ wave 3: closed-ended question	No. of parents using physical forms of discipline: 10	No. of parents using physical forms of discipline: 1
9. Is there someone at home who the child trusts and can talk to?	16 (100%)	16 (100%)
10. Does your child do homework as required? (Yes/ Sometimes)	16 (100%)	15 (93.8%)
11. Is there someone in your home who helps your child with homework?	16 (100%)	16 (100%)
Teacher responses		
1. Does the child attend school regularly? (Yes)	14 (87.5%)	13 (81.3%)
2. Does the child do homework as required? (Yes)	8 (50%)	6 (37.5%)
Child responses		
CYRM item 8 Do you talk to your family/caregiver(s) about how you feel, for example when you are hurt or feeling scared? (Yes)	8 (50%)	16 (100%)

Source: Authors

Depression

The CES-D-10 results indicate that most of the caregivers in our sample had symptoms of depression in wave 1 (62.5%). However, only 31.3% of them still had these symptoms at wave 3.

Access to support

Caregivers' access to a healthy support structure in times of need has been shown to have lasting impacts on their child rearing practices (Tomlinson, 2013). At wave 1, 25% of the participants reported having someone who could help them in times of need. This number tripled in wave 3 at 81.3%.

Financial capabilities

At wave 1, 37.5% of caregivers reported being able to save money. By wave 3, the figure had increased to 62.5%. However, there were no changes in caregivers' levels of debt. At both waves, 50% of caregivers reported that they were struggling to pay off debts.

Eating healthy food

A positive change was noted in children's increased consumption of protein. It rose from 75% in wave 1 to 100% in wave 3. The increase in vegetable consumption was marginal – only one more caregiver reported that their child was eating more vegetables (13 in wave 1, 14 in wave 3).

Caregivers' engagement in school

Caregivers consistently reported helping children with homework: 100% at both waves. Moreover, when talking about improvement in their children's lives due to the Sihleng'imizi programme, they said their children were doing homework more often. However, teachers did not share this sentiment. In wave 1, teachers reported that only 50% of the children were doing their homework, and by wave 3, the number had decreased to 37.5%.

Use of alternative forms of discipline

At baseline, just over half of the caregivers (10) reported using physical punishment to discipline their children. This was an open-ended question where caregivers were asked to list all the methods they used to discipline their children. We added up the number of caregivers who said they used physical discipline on their children. These included, in their words, "spanking", "hitting", "beating" and "pinching". Ten caregivers reported using physical discipline. Three caregivers listed it as the only way they gave punishment, while others listed using physical discipline with other methods. Five caregivers said they used communicating with their child, with one saying that they communicated and also verbally threatened to hit the child. In wave 3, only one caregiver said they used physical discipline.

Spending time with children

In response to the question: Does an adult or older sibling read/sing/spend time with the child?, small changes were found by wave 3 when one more caregiver reported spending more time with their child than they did in wave 1.

Child's access to a supportive adult

While all the caregivers reported that their children said they had someone they trusted and could talk to in their homes in both waves, at wave 1, the children themselves did not feel they had someone to talk to at home when they felt hurt or scared. Only 50% of the children reported being able to talk to someone at that time, but by wave 3 the number had increased to 100%.

Summary

We noted overall improvements in caregivers' access to community help and support, caregivers' depressive symptoms, children's ability to talk to someone in their families when upset, caregivers' ability to save money, and children's consumption of proteins. Levels of debt remained the same. Teachers reported a declining number of children who were doing their homework by wave 3.

Qualitative data

We asked caregivers' for feedback about the changes that occurred in the child and their families due to taking part in the Sihleng'imizi programme at the end of the intervention, in Session 14. Here, we only report on the recurring themes relating to improvements in programme outcomes. The themes discussed are: improved family relations; reduction in harsh types of discipline; improvements in caregiver engagement in the child's schooling, and peer support between families. Participants were asked questions about whether at home they were able to put into practise the knowledge and techniques they learned in the session; about the usefulness of the programme, and whether they would recommend it to others.

Improved family relations

Ten caregivers reported spending more time together as a family unit by sharing meals and through creating 'special time' to be together. The value of this was covered in the sessions. Caregivers said they had improved communication among their family members. They recognised this as an important practice in strengthening family bonds, and in promoting understanding among family members.

We spend more time with my kids. – Caregiver 1

We eat at the same time, and we bond a lot when we do special time. – Caregiver 3

A lot of changes. We understand each other well now compared to before. – Caregiver 13

There is a change in communication, the[re] is more understanding. – Caregiver 14

Caregivers' used less harsh discipline methods

Caregivers said they used harsh types of discipline less often. They reflected on what they learnt in the programme. In some cases, they reflected on their care practices. Others did not say what they replaced harsh discipline methods with. This is what some parents/caregivers said:

I have learnt how to better discipline the children and not to beat them. – Caregiver 10

I do not scold, and how l discipline my grandson has changed. – Caregiver 11

I have noticed change with how l treat my kids. I don't beat them a lot now. – Caregiver 9

[I learnt] how to treat my children and give them love; not to shout them. – Caregiver 15

I no longer raise my voice at my children. I am now able to explain myself and also listen to them when they talk to me. – Caregiver 4

Engagement in school

Whereas Patel and Ross (2022) reported improved caregiver involvement in doing homework in an earlier evaluation of the Sihleng'imizi evaluation, only two of the caregivers in the current sample alluded to such changes.

My child does homework more. – Caregiver 1

My kids enjoy being at school because l show support in schoolwork. – Caregiver 2

Strengthened peer support network

The Sihleng'imizi buddy system was designed to build a peer group support network beyond the weekly programme meetings. The system encouraged caregivers to visit each other and share learning, or help each other with weekly adult homework activities. These activities are in the training manual and in the family workbook and homework guide (Patel, Hochfeld & Chiba 2021). In the 2017 sample, Patel and Ross (2022) found that caregivers highly appreciated the buddy system part of the programme. The quotes that follow confirm this for the current sample:

Very helpful, due to the fact that l could consult with my buddy if ever l had a problem with understanding anything. – Caregiver 16

They [buddy] reminded me to do homework and give support. – Caregiver 3

[It was] very useful. We meet people with different life skills. – Caregiver 12

Now l can handle my anger. I shout less. And when l want to lose my cool, l remember how Sihleng'imizi buddy teaches [me how to] handle the anger. – Caregiver 15

Caregiver's application of learning

Caregivers shared mixed insights about the practical implementation of the programme content. As illustrated by the extracts below, some felt that they could easily put techniques into practice, while others struggled.

I find them very easy. I use them a lot, they have helped me. – Caregiver 4

I try a lot. It's not always easy. – Caregiver 1

Some are hard, my kids don't listen. It is making me tired. – Caregiver 2

Some are hard because saving is hard. I do some … like [the] cool down corner. – Caregiver 3

Sometimes it is too difficult to handle children without shouting. I cool with them. It's also hard to discipline them without shouting. I try my best without [losing my cool]. – Caregiver 14

Usefulness of the Sihleng'imizi programme

In response to the question about whether participants found the programme useful, all caregivers reported in the affirmative. They said they would recommend the programme to other people. Facilitators asked for feedback on the session's content at the end of each session, and how they experienced the session. Although most of the participants were vague in their responses, they wrote that they found the session was "okay", "good" or "nice", while others left the question unanswered.

Conclusions

The quantitative assessment of the changes that occurred for participants between waves 1 and 3 demonstrates promising improvements in some domains, such as caregivers having greater access to support from others in their family and community. Also, adults bonded more with their children and nutrition practices improved as children were eating protein more regularly. More children had access to a trusting adult to turn to when they experienced emotional difficulties. No changes occurred in caregivers' savings behaviour and their levels of debt did not change. Caregivers' and teachers' responses did not fully correspond with each other as caregiver engagement in children's schooling, in the completion of homework, and in how regularly their child attended school still needed attention. Caregivers appeared to have more positive responses compared to teachers. Similarly, caregivers and children had different views about whether they had access to a trusting adult. These differences may be due to caregivers giving the responses they thought facilitators wanted to hear.

Caregiver depression levels had improved by the end of wave 3 – only five caregivers reported depressive symptoms. We consider that this may have been influenced by Covid-19 pandemic restrictions being lifted by wave 3. We collected wave 1 data during the pandemic. Participants' access to extended family and community support doubled over the two-year period; this may be due to the family-strengthening intervention.

In the evaluation of the programme, caregivers showed they were aware that they needed to use alternative types of discipline that did not involve physical punishment. But they said it was still difficult to not shout when children were misbehaving. Despite their challenges, in wave 3, only one caregiver reported that they were still using physical punishment.

The qualitative findings validated the quantitative findings: caregivers confirmed improved family relations, better communication within the family unit, and doing more activities that would strengthen family bonds. Caregivers did not specifically mention more positive engagement in their child's school life. They reported improved family and peer support – with strong support for the buddy system. All participants found the intervention useful; they expressed a strong desire for it to be offered to other families.

We deduce from our findings that the family-strengthening intervention resulted in positive changes in some domains, such as family relations and in creating a system of social support around participants. School attendance remained constant. But perceptions about caregivers supporting their children with doing homework differed according to the caregivers, or the teachers' views. This discrepancy existed across all three waves of the larger community of practice study (Patel et. al. 2023). Savings and levels of debt, which is an indication of economic hardship, continued because of the economy's poor levels of recovery during and after the Covid-19 pandemic. In previous evaluations of the intervention, participants greatly valued the financial component of the programme (Patel et. al. 2019). Adaption of the programme content to include strengthening the livelihood activities of participants may be valuable in the future. The findings do suggest that participants' ability to save depends on them having increased access to employment opportunities and income. Economic stressors seemed to impact on caregivers' stress levels. This may have accounted for the high levels of depression among them. Hunt et. al. (2021) found that households experiencing high rates of hunger were more likely to experience depressed mood during the Covid-19 pandemic.

In conclusion, the findings suggest that the Sihleng'imizi family strengthening intervention, when offered as part of a wider school-based family and community intervention, could contribute to improvements in some domains that are associated with better child wellbeing outcomes. Structural economic factors limit the programme's potential impact on children's material wellbeing and that of their families. It will be important to follow up with participating families to assess if their situation has changed since this assessment. This study's findings could contribute to ongoing testing and evaluation of the family-strengthening interventions.

References

Baron, E. C., Davies, T., & Lund, C. (2017). Validation of the 10-item centre for epidemiological studies depression scale (CES-D-10) in Zulu, Xhosa and Afrikaans populations in South Africa. *BMC psychiatry*, 17, 1-14.

Ilifa labantwana G (2014). The Sinovuyo Caring Families Project: Testing Positive Parenting!. Lessons from the field, p. 1-12.

Bradshaw, J., & Keung, A. (2011). Trends in child subjective well-being in the UK. *Journal of Children's Services*, 6(1). https://doi.org/10.5042/jcs.2011.0122

Hunt, X., Breet, E., Stein, D. J., & Tomlinson, M. (2021). *The COVID-19 Pandemic, Hunger, and Depressed Mood Among South Africans.*

Patel, L., Hochfeld, T., & Chiba, J. (2019). Perspectives of South African caregivers in receipt of Child Support Grants: Implications for family strengthening interventions. *International Journal of Social Welfare, 28*(3), 307–317. https://doi.org/10.1111/IJSW.12364

Patel, L., Hochfeld, T., Ross, E., Chiba, J., & Luck, K. (2019). *Connecting cash with care for better child well-being An evaluation of a Family and Community Strengthening Programme for beneficiaries of the Child Support Grant.*

Patel, L., Pillay, J., Henning, E., Telukdarie, A., Norris, S., Graham, L., Haffejee, S., Sani, T., Ntshingila, N., Du-Plessis Faurie, A., Zembe Mkabile, W., Baldry, K., Sello, M., Mbowa, S., Setlhare-Kajee, R., Bezuidenhout, H., & Rhamasodi, R. (2021). *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.*

Patel, L., Hochfeld, T. and Chiba, J. (2021). Sihleng'imizi Family Strengthening Programme: Facilitator Manual, Childcare Worker Manual and Family Workbook. Johannesburg: Centre for Social Development in Africa (CSDA), University of Johannesburg.

Patel, L., & Ross, E. (2022). Connecting Cash Transfers with Care for Better Child and Family Well-Being: Evidence from a Qualitative Evaluation in South Africa. *Child and Adolescent Social Work Journal, 39*(2), 195–207. https://doi.org/10.1007/S10560-020-00714-Z/TABLES/3

Patel, L., Sello, M., Haffejee, S., Mbowa, S., Sani, T., Graham, L., Gunhidzirai, C., Pillay, J., Henning, E., Telukdarie, A., Norris, S., Ntshingila, N., Raniga, T., Zembe-Mkabile, W., Nyati, L., Nesengani, T.V., Setlhare-Kajee, R., Bezuidenhout, H. (2023). How well are children faring? A longitudinal assessment of child wellbeing in the COVID-19 pandemic in selected Johannesburg schools over three waves from 2020 -2022. Johannesburg: Centre for Social Development in Africa, University of Johannesburg.

Ross, E., Patel, L., Sitshange, M., & Matidza, K. (2020). *Connecting cash with care for better child well-being A nine-month post intervention follow-up evaluation of a Family and Community Strengthening Programme for beneficiaries of the Child Support Grant.*

Ungar, M., & Liebenberg, L. (2011). Assessing resilience across cultures using mixed methods: Construction of the child and youth resilience measure. *Journal of Mixed Methods Research, 5*(2), 126-149.

Vasileiou, K., Barnett, J., Thorpe, S., & Young, T. (2018). Characterising and justifying sample size sufficiency in interview-based studies: Systematic analysis of qualitative health research over a 15-year period. *BMC Medical Research Methodology, 18*(1), 1–18. https://doi.org/10.1186/S12874-018-0594-7/TABLES/3