Community of Practice for Social Systems Strengthening to Improve Child Wellbeing Outcomes

How well are children faring?

Findings from a CoP study to strengthen child wellbeing in rural Moutse, Limpopo province, South Africa in 2023

In collaboration with the Ndlovu Care Group

June 2024

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Acknowledgements

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Acronyms

ALCoP	Advisory Level Community of Practice
CRYM	Child and Youth Resilience Measure
DBE	National Department of Basic Education
CoP	Community of practice
CSG	Child Support Grant
CWTT	Child Wellbeing Tracking Tool
DDM	District Development Model
ISHP	Integrated School Health Programme
LLCoP	Local Level Community of Practice
NSNP	National School Nutrition Programme
SDQ	Strengths and difficulties questionnaire

Introduction: Community of practice around child wellbeing in Moutse

Children in South Africa face tough and ongoing challenges. These include living in poverty, having food insecurity and being exposed to different types of violence. This has a significant impact on their development both in the short and long term. To improve their development trajectories, it is crucial to prioritise interventions that protect and support children's wellbeing outcomes (Savahl et al., 2015).

In South Africa, Grades R to Grade 3 in primary schools make up the Foundation Phase of basic education. Grade R is known as the reception year before children start Grade 1. It covers learners from the age 4 turning 5 before June in the same year. Grade R is included in the ages of children in foundation phases who are between five to nine years. The Foundation Phase focuses on literacy, numeracy and life skills. This period lays the groundwork for their future learning.

Given how critical the Foundation Phase is, that support services for early grade learners who attend public schools in disadvantaged areas are fragmented is cause for concern. The support services need to have a coordinated response across sectors such as education, health and social welfare so they can address gaps and strengthen social services for children.

In pursuit of tracking child wellbeing, between 2020 and 2022 the Centre for Social Development in Africa (CSDA) drove a community of practice initiative, in collaboration with other partners in academia, government and nongovernment organisations in five urban primary schools in Gauteng province, South Africa.

To better understand how the multisectoral community of practice (CoP) approach works in a rural setting, the CoP team, located at the CSDA, University of Johannesburg, and its collaborating partners initiated a one-year study to improve children's wellbeing in the early years of their schooling in the predominantly rural area of Moutse, Limpopo province, South Africa.

The Moutse study was implemented in partnership with the local Ndlovu Care Group, a community healthcare service provider. The care group was founded in 1994 in Moutse. The baseline assessment was between September to November 2023.

This report focuses on the baseline assessment of a sample of children's wellbeing in the Foundation Phase – Grade R to Grade 3 – at Ekucathuleni primary school in Moutse. It gives an overview of their wellbeing and aims to identify existing areas of strength and areas for improvement in the social systems responsible for supporting these children. The aim of the assessment was to inform actions to strengthen social outcomes for children and their families.

The intervention component of the study followed after the initial child wellbeing assessments and ran from March 2024 to April 2024. It brought together researchers, practitioners and government and nongovernment partners to work collaboratively with the aim of strengthening support services at the primary school level. The intervention component is not reported on here.

An integrated approach to child wellbeing

Intervening in the early years of children's lives is particularly important because it yields substantial benefits for both the child and society (Cannon et al., 2018; Coles et al., 2015; Yousafzai, 2020). Research shows that factors such as birth weight, nutrition and growth, and optimal physical and cognitive development in childhood are associated with – or predictive of – physical and cognitive capacities and life expectancy in adulthood (Clark et al., 2020). Improved education outcomes in childhood also contribute to employability and increased income in adulthood (Haile et al., 2016).

The World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) have outlined guiding principles for promoting children's wellbeing (WHO & UNICEF, 2021). These principles target the broader determinants of wellbeing, advocate for child rights, and encourage service users' meaningful participation in improving children's wellbeing outcomes. Children's wellbeing is best supported through a collaborative approach. This means recognising the central role of families and making sure they have a well-functioning network of care, including schools, health and social services.

South African policy documents reflect a shift toward a more holistic and integrated approach for ensuring children's wellbeing. For example, the Department of Social Development's National Child Care and Protection Policy (2019) serves as a blueprint for coordinated and integrated childcare and protection programmes. The White Paper for Social Development (1997) promotes intersectoral collaboration; it envisions the delivery of family and community-based developmental welfare services. Similarly, the Integrated School Health Programme (ISHP) (2012) advocates for integrated services to be provided across health, education and social development sectors, and for a partnership approach to service delivery. School-level care and support teams are expected to coordinate in providing children's

wellbeing services in public schools. Additionally, the government's District Development Model (DMM), launched in 2019, aims to enhance collaboration, integrated planning and budgeting across all sectors of local government.

We can see that there is considerable policy support for the CoP approach at school level, and for intervention and promotion of children's wellbeing in the early years. But there is limited evidence of multidimensional assessments of child wellbeing in the Foundation Phase to inform actual and practical multisectoral interventions. The CoP initiative attempts to address this gap.

The CoP approach is described in Box 1.

What is the community of practice approach?

The community of practice (CoP) for social systems strengthening is a practice-based learning initiative that was established in Gauteng province, South Africa in 2020. It is informed by previous research that highlighted the importance of integrated services for enhancing child wellbeing. It aims to address gaps in existing service provision for young children by using a multisectoral approach to child wellbeing. This approach locates the child in the wider context of their family, school and community. The CoP approach draws together diverse sectors that impact on children's wellbeing. These sectors include health, education, mental health, material wellbeing, and safety and protection.

The Centre for Social Development in Africa (CSDA), in piloting of this approach, has focused on children in the Foundation Phase of schooling, from Grade R to Grade 3. This is a critical developmental period for children. But often children do not receive the comprehensive and coordinated services they need. And so, it is crucial to address the gaps in children's support and care, including gaps in the coordination of the services. To effectively address coordination gaps, the pilot study established: (a) an advisory level CoP (ALCoP) to guide the study and develop an assessment tool to track child participants' wellbeing, and (b) local level CoPs (LLCoPs) to guide the CoP implementation at the schools in both Gauteng and Limpopo provinces.

We used a digital assessment tool, the Child Wellbeing Tracking Tool (CWTT), to gather essential data on a cohort of children enrolled in the Foundation Phase at five schools in Johannesburg, Gauteng, over three waves: 2020, 2021 and 2022. We used the data to inform the CoP team's interventions that addressed the specific needs of children identified as being at risk or vulnerable. By implementing tailored strategies across different social sectors, the CoP approach aims to make sure that each child receives the support and resources necessary for their optimal growth and development.

Children's wellbeing indicators

Measuring children's wellbeing is crucial to finding out about their welfare. A range of indicators are used to evaluate wellbeing. They include child health, nutrition, education, socioeconomic status, poverty levels, food accessibility, hunger, family and community life, in the environment where they live, whether services are available, and safety concerns beyond their immediate family. For objective indicators, validated assessment tools are used to gauge factors such as education, poverty and psychosocial wellbeing. For subjective factors, regarding the children's perspectives, we administered the Child and Youth Resilience Measure (CYRM). For the caregivers' perspectives, we administered the Strengths and Difficulties Questionnaire (SDQ) about their child. The CRYM and the SDQ have been validated for use in South Africa. Teachers also gave their perspectives on how the children were faring at school.

In the CoP study we identified six interconnected domains that contribute to child wellbeing. Figure 1 shows the domains: good health, optimum nutrition and food, economic and material wellbeing, education and learning, protection and care, and psychosocial wellbeing of the children, their caregivers and their families.

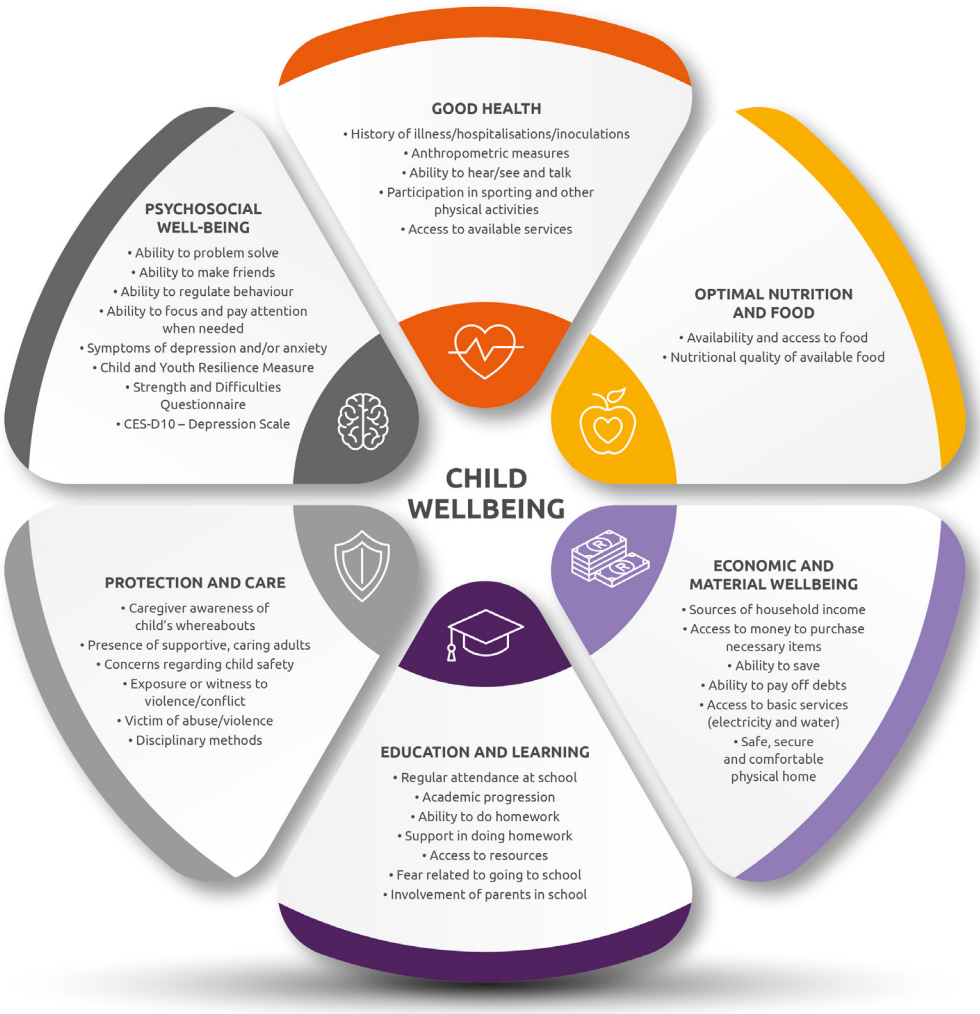

Figure 1: CoP initiative child wellbeing domains and indicators

These domains collectively offer a comprehensive framework for evaluating and promoting children's wellbeing. When we consider these interconnected domains, we can gain a holistic understanding of children's wellbeing. We can develop and put into action relevant and appropriate interventions to promote their optimal development.

Research methodology: Moutse children's wellbeing

In this report, we present the findings of the baseline assessment of 87 children using the CWTT.

Why we chose Moutse as our study site

Moutse is in the Elias Motsoaledi Local Municipality, Sekhukhune district, Limpopo province. While Moutse is a small town, the district is largely a rural area with most people living outside of the town (Patel et al., 2017). Approximately 140 000 people live in Moutse (Ndlovu Care Group, 2021).

Previous census data (Stats SA, 2011) suggests that most (90.5%) of the population in Elias Motsoaledi Local Municipality live in formal dwellings and have electricity (91.1%). Nighty percent of families in the Sekhukhune district municipality rely on social grants to make ends meet. This highlights the widespread economic hardship in the area, where unemployment sits at 33.8%, and 57.7% of the population lives on the lower bound poverty line (COGTA, 2020). The area has poor infrastructure, poor transportation, and does not have a safe water supply (Patel et al., 2017).

We chose Moutse for this rural study for several reasons. One was because the research team had already conducted research there on family contexts, recipients of the Child Support Grant (CSG) and child wellbeing. The team developed good working relationships in the area, including with the Ndlovu Care Group. A team of trained field workers was already in place. Also, since this is an intervention study, our ongoing partnership with Ndlovu Care Group meant that the local social workers and healthcare practitioners the group employed would be able to carry out the intervention. Additionally, the Elias Motsoaledi Local Municipality borders on Gauteng which gives the Johannesburg-based research team easy access. Moutse's sociodemographic indicators were similar to those in the urban study sites in Gauteng which meant we could compare them.

How we arrived at our sample

Children in Grade R to Grade 3 who are recipients of the Child Support Grant (CSG) and attend Ekucathuleni Primary School in Moutse were identified as the target group. The Ndlovu Care Group chose this school because the Department of Basic Education (DBE) classifies it as a quintile 1 school. Such schools are 'no-fee paying' schools and cater to the most economically disadvantaged communities. Since these schools do not charge fees and rely solely on government subsidies, they often face challenges such as buildings not being maintained, and there are not enough learning resources for teachers and children.

Originally, our proposed sample was 60 children across the four grades – 15 children each from Grade R, Grade 1, Grade 2 and Grade 3. However, following a recruitment drive by the research team, caregivers who attended a briefing meeting at the school opted to participate in the study. Consent forms were sent to caregivers via the children. Caregivers who returned the signed consent forms were contacted and invited to visit the Ndlovu Care Group offices for an interview with their child.

Collecting the data

Data was collected between 1 September 2023 and 7 November 2023. Two social workers and one nurse from the Ndlovu Care Group collected the data using the digital CWTT, which was preloaded onto tablet computers. In some cases, where there were challenges with internet connectivity and available data, questionnaires were completed on paper in the field and later captured using the tablets. Data were collected from caregivers, children, their teachers and health practitioners. Data were collected for 109 child participants, but in 22 cases there was too much information missing from one or more of the respondents, and they were excluded from the final analysis. In total, a sample of 87 children were included in the baseline assessment analysis. This was after cleaning the data and removing duplicates and questionnaires with incomplete information.

Data analysis

All the questionnaires were coded and captured in Microsoft Excel. After that, the data were cleaned by running frequency distributions and deleting or correcting incorrect responses. SPSS 29 and Stata 18 were used for the data cleaning and descriptive analysis. Where validated, we used standardised assessment tools, and the responses were scored using the required scoring procedures; scales were checked for reliability.

Ethics approval for the Moutse study

The University of Johannesburg's Faculty of Humanities Ethics Committee (REC-01-050-2020) and the University of Johannesburg's Faculty of Health Science Research Ethics Committee (REC-241112-035) gave their approval for the study in March 2020. The national Department of Basic Education (DBE) and Ekucathuleni Primary School's principal gave us permission to work in the school.

Caregivers gave written consent for their child to participate in the study and to their child being interviewed. They did this in front of a social worker who explained the content and consent to them, and what they and their child needed to do in the study. Social workers also discussed confidentiality with them and emphasised that taking part in the study was voluntary. This was also explained to the children. Health assessments were done with the caregiver present. Caregivers who needed help were referred to local social workers for psychosocial support and other governmental support services, such as applying for the Child Support Grant (CSG). To protect privacy, all quantitative data was made anonymous during data analysis.

Limitations of the Moutse study

The data were collected from a sample of children who attended the same school, and so the findings cannot be generalised to a wider population of children. Given the sensitive nature of the questions we asked, it is likely that some caregivers may have given responses they thought the researchers wanted to hear (van der Schyff et al., 2022).

We noted some non-responses and incomplete information. We then excluded some questionnaires from the analysis because they had insufficient data. Although this was intended to be a small study, the implication of the small sample size is that it may impact on the generalisability of the findings. For example, the findings on child malnutrition may not reflect the status of children in the Moutse area more broadly. Also, a small sample size may lack statistical power to detect a true effect on child wellbeing outcomes, such as in the case of the child resiliency measures.

While the study's results need to be interpreted cautiously, they do provide an indication of the overall wellbeing of children across different domains in the foundation grades at Ekucathuleni Primary School. A significant number of government primary schools are in the same quintile in the Elias Motsoaledi area. These baseline measures provide a useful platform for informing future interventions in more primary schools and for further monitoring and evaluation of child wellbeing.

Findings from the CoP study to strengthen children's wellbeing in rural Moutse

The next sections of this report present the analysis of the data from the caregivers, their children, the class teachers and a qualified healthcare worker. We begin by describing the households the children live in, and the characteristics of the caregivers we interviewed. We then give a comparative analysis of how the children are faring across the key domains we investigated of health and nutrition, education and learning, economic wellbeing, protection and care, and psychosocial wellbeing.

The children's households

Who makes up the households?

Our findings suggest that children in our sample live in a range of household configurations, with many relatives involved in the children's care giving. This reflects similar trends nationally (Hall & Mokomane, 2018).

Three-quarters (75%) of the caregivers we interviewed were the mother of the participating child; 18% were grandparents, and the rest were evenly split between aunts or uncles, fathers and older siblings.

Figure 2 gives more data on who the children live with. Almost half (49%) of the children live with their mother and another adult relative. This is consistent with the findings of the CoP study in five schools in Gauteng (Patel et al., 2023). Our Gauteng province study also found that children were mostly living with their mothers and other adult relatives.

In our Moutse sample, 17% of children lived with both of their parents, 11% lived with one parent, and 5% lived with both parents and other relatives. Almost a fifth (17%) of children did not live with a parent but did live with relatives. In South Africa, many families in poor rural areas, it is particularly grandparents who end up raising children whose parents go to cities for jobs and stay there (Hall & Mokomane, 2018).

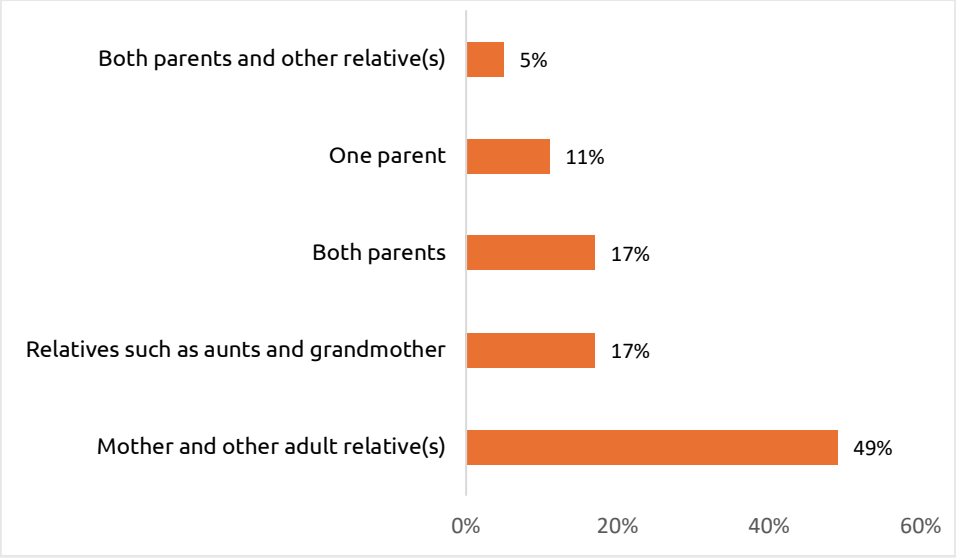

Figure 2: Child's relationship to the adult caregivers they live with, Moutse, Limpopo

Figure 3 gives an overview of the distribution of children and adults in these households. More than three-quarters (78%) of the households consisted of between two to four adults. A third (34%) had three to four children living in the home, while 57% had five or more children living in the home. Households tended to have more children than adults.

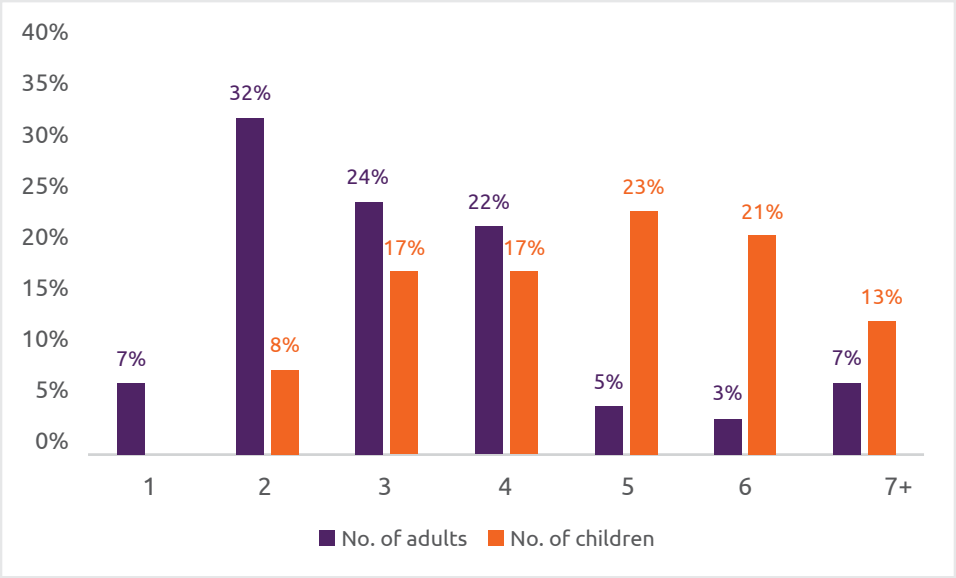

Figure 3: Percentage distribution of children and adults living in the households in Moutse, Limpopo

Household's access to resources and services

A household's access to goods and basic services is an important indicator of the environment children live in. Table 1 shows that all families in this sample reported living in a house that protects them from wind and rain. The caregivers also all reported living in a home with electricity and having access to clean drinking water – although they did not specify if this was piped water in the home, or if it was water they got from their yard, or from a communal site. However, only half (53%) of the children have basic comforts, such as a mattress or a bed to sleep on every night. Sanitation remains a challenge – 62% of families have access to a toilet with running water inside their yards.

Table 1: Households' access to goods and basic services (n=87) in Moutse, Limpopo

Goods and basic services that children get	Yes
House that protects from wind and rain	87 (100%)
Access to clean drinking water at home	87 (100%)
Electricity at home	87 (100%)
Toilet at home	54 (62%)
Child has a mattress/bed	46 (53%)

Without birth certificates for children, and identity documents for adults, it is difficult for families to get services, such as applying for social grants or applying for children to be admitted to schools. The Road to Health cards, given to a parent when their child is born, provides important information to track the developmental and vaccination status from when they are a baby up to when they are 6 years' old. In our sample, all the children had birth certificates and Road to Health cards, and all the caregivers had South African identity documents.

Household access to social grants

At a national level, more than 13 million children in South Africa received a child support grant (CSG) in December 2023, a further 160 000 received a care dependency grant, and 220 000 children received a foster care grant (SASSA, 2023). In this sample, all but one of the households received a CSG for the participating child (see Table 2). But even the exception household received the CSG for other children in the home, meaning that all households accessed at least one CSG. The CSG is available to primary caregivers whose monthly income is below a certain level – this is the means test threshold. But the CSG is the lowest of all the grants, and is too little money to protect the poorest children from hunger and malnutrition (Hall et al., 2023; Zembe-Mkabile et al., 2022). Only two households received a foster care grant which is provided to caregivers with a foster child legally placed in their care. None received the care dependency grant for children who need full-time care.

In addition to grants that support children, more than a third (37%) of households received the old age grant, which is paid to people who are sixty years and older and whose monthly income is below the means test threshold. Ten per cent of participating households received a disability grant for an adult, while 13% of the households received a grant-in-aid.[1]

The Social Relief of Distress grant was a new grant, introduced in June 2020, to mitigate the impact of the Covid-19 pandemic. Only 2% of households received this grant.

Table 2: Households (n=87) that received social grants in Moutse, Limpopo

Received the grant	Yes
Child support grant	86 (99%)
Foster care grant	2 (2%)
Care dependency grant	0 (0%)
Older person's grant	32 (37%)
Disability grant	9 (10%)
Social relief of distress grant	2 (2%)
Grant-in-aid	11 (13%)

Households' income in addition to social grants

Table 3 shows that almost two in five households (39%) did not have any income in addition to the social grants they receive. Only two households said they regularly had enough money to buy the things they need; 31% of households sometimes had enough money to buy the things they need, and more than two-thirds (67%) of households did not.

Table 3: Households' (n=87) access to income in Moutse Village, Limpopo

Household income	Yes	Sometimes	No
In addition to grants, does your family have access to other income?	38 (44%)	15 (17%)	34 (39%)
Does your family have enough money to buy the things you need?	2 (2%)	27 (31%)	58 (67%)

Who are the caregivers?

We gathered information on various Moutse caregivers to give us a comprehensive understanding of their circumstances. These are circumstances that influence both caregivers' wellbeing and that of the children in their care. The information we collected included caregivers' age, level of education, employment status, amount of money they owed, mental wellbeing, and access to support networks.

Age, level of education and employment status

The caregivers interviewed for this study ranged in age from 22 to 70 years old. More than three-quarters of the caregivers (77%) were 25 to 45 years of age, and another 20% were above 45 years old.

Almost half of the caregivers (49%) had some secondary education but had not completed matric – or Grade 12 – the final year of high school. Thirty-eight percent of caregivers had completed matric and 6% had post high school education. The Moutse findings reflect the situation in the rest of South Africa. For example, there is a significant association between level of education and employment, with unemployment rates for those with Grade 12 or lower qualifications being higher than the national rate of 31.9% (Stats SA, 2023).

Table 4 shows caregivers' employment status. Most (86%) were unemployed. Only 7% were employed full time and another 7% did either part time or piece work. This rate of unemployment is almost three times the official national average of 31.9% in the third quarter of 2023 (Stats SA, 2023). However, when discouraged jobseekers who are not actively seeking work are included, the national unemployment rate rises to 41.2%. The unemployment rate in this Moutse sample is also higher than that of Limpopo province, which stood at 30.8% officially and at 45.1% when discouraged

[1] A person can receive a grant in aid if they are living on a social grant but can't look after themselves. There is also an additional grant they can get to pay the person who takes full-time care of them.

jobseekers were included (Stats SA, 2023). The unemployment rate in this study was closer to – but still higher than – the unemployment rate found in the Gauteng province CoP study, which was 63% in wave 3 (Patel et al., 2023).

Table 4: Caregivers' (n=87) employment status in Moutse, Limpopo

Caregivers' employment status	
Full-time work	6 (7%)
Part-time work	4 (5%)
Does piece work	2 (2%)
Unemployed	75 (86%)

Caregivers and dealing with debt

We asked caregivers about whether they were able to save, and to pay off debts. This gives an indication of how much income is used for immediate needs and how much is available for reducing debt or saving for the future. Table 5 shows that 60% of caregivers said they were unable to save and 22% were struggling to pay off their debts. This suggested they were financially insecure.

Table 5: Caregiver's (n=87) ability to save and to pay their debts in Moutse, Limpopo

Ability to save and pay debts	Yes
Are you able to save?	35 (40%)
Do you struggle to pay off debts?	19 (22%)

Caregivers' reports of their mental health

Caregivers completed the CES-D-10 scale to provide an assessment of their mental health status (Andersen et al., 1994). This is a standardised, self-report scale to measure symptoms of depression. Table 6 presents the findings from our sample. Scores of 11 or over indicate that the caregivers were experiencing symptoms of depression.

Almost a third of caregivers (31%) reported experiencing symptoms of depression. This is concerning, both for the caregivers' wellbeing and because depression impacts on their ability to care for children which in turn can negatively impact the child's development. For example, the South African Birth to Thirty study found that mothers' depression after giving birth – maternal postnatal depression – is associated with unfavourable psychological outcomes in children up to ten years later (Verkuijl et al., 2014).

Table 6: Caregivers (n=87) who experienced symptoms of depression in Moutse, Limpopo

CES-D[2] ≤10	CES-D ≥11 (depressive symptoms)	Total
60 (69%)	27 (31%)	87 (100%)

Caregivers' access to social support

When caregivers are given support, it can promote children's wellbeing outcomes because they play the most important role in supporting the physical, emotional and cognitive development of children. Table 7 shows the caregivers' perceptions of the social support available to them. About half (52%) of the caregivers said they had relatives in the household who could help with child care. Most (82%) reported that they have family or community support that they can call on in times of need. But 18% of caregivers did not feel they had family or community support. A recent study in an HIV-endemic, urban community without many resources in South Africa explored the protective effect of social support for caregivers on children's wellbeing (Casale & Crankshaw, 2015). Caregivers reported that the social support they received positively affected their children's health and behaviour. This was both as a direct result of the support they received, and indirectly through the effect the support had on improving caregivers' mental health and parenting (Casale & Crankshaw, 2015).

[2] The CES-D stands for the Centre for Epidemiologic Studies Depression Scale. It is a brief 20-question self-report survey used to assess symptoms of depression in the general population.

Table 7: Social support for caregivers (n=87) in Moutse, Limpopo

Social support	Yes
Are there relatives in the household who help to care for the child/ren?	45 (52%)
Is there anyone in your household/family or community to support you in time of need?	71 (82%)

How are the children faring?

In this section we provide a short profile of the children in this sample. After that we present our findings on how they were faring across the domains of health, nutrition status, education, protection and care, and psychosocial wellbeing.

Profile of children: Age, grade and gender

The children in this sample ranged in age from five to ten years' old. There were more girls (57%) than boys (43%). Twenty-five percent of the children were in Grade R. One-third (33%) were in Grade 1, 17% were in Grade 2 and the remaining 24% were in Grade 3. As seen in Figure 4, there was a relatively even distribution of girls and boys in each grade, except for Grade 2 where 12 of the 14 children were girls.

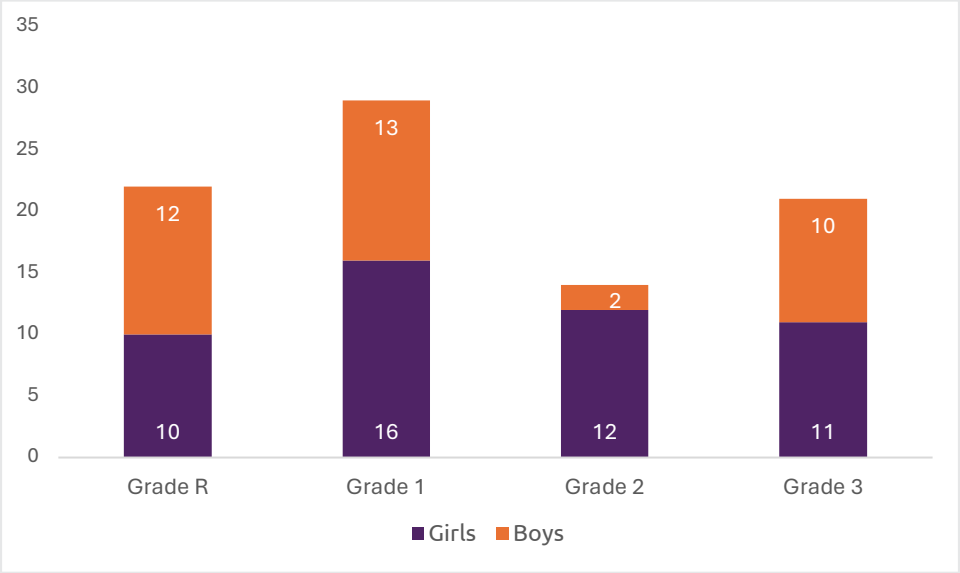

Figure 4: Distribution of children's sample by grade and gender (n=87)

In South Africa, the recommended age for Grade R is four turning five by 30 June in the year they are admitted to school. The recommended age for Grade 1 is six turning seven. In this sample, all children were in the expected age range for Grade R and only one child was older than the expected age for Grade 1 (eight years old). There were four older children in Grade 2 (aged nine) when the expected range is seven turning eight. In Grade 3 there was a broader range, with two younger children (aged six and seven) and five older children (aged ten) than the expected age range of eight turning nine.

Children's health in the Moutse study sample

Children's health and taking part in physical activity

This section of the health domain assessed whether the children's health prevented them from playing or going to school, if the child could speak, see and hear well, if the child had any underlying health conditions, and if the child had been abused.

Table 8 shows that 15% of caregivers reported that their child's health stopped them from playing, or attending school. Almost all caregivers (97%) took their child to healthcare professionals when they were sick, which is an indicator of being a responsive caregiver. And most (95%) indicated that their child had good hygiene habits. Of concern is that a quarter (25%) reported that their child had difficulties seeing, hearing or talking. While most (82%) caregivers said their child engaged in physical activity, 15% of children in this sample did not, and only 43% participated in recreational activities. The latter is lower than the participation reported in the Gauteng CoP study, where more than three quarters of the children (77%) took part in recreational activities.

Table 8: Child health and participation in out-of-school activity indicators from (n=87) caregivers' perspectives, Moutse, Limpopo

Children's health and participation in out-of-school activities	Yes	Sometimes	No
Does your child's health stop them from playing/going to school?	13 (15%)	12 (14%)	62 (71%)
Do you take your child to the clinic, hospital or doctor when they are sick?	84 (97%)	1 (1%)	2 (2%)
Has your child been hospitalised?	19 (22%)	-	68 (78%)
Does your child have good hygiene habits?	83 (95%)	-	4 (5%)
Does your child struggle to hear, see or talk?	22 (25%)	13 (15%)	52 (60%)
Does your child participate in sporting, cultural, spiritual, arts/ recreational activities outside of school hours?	37 (43%)	2 (2%)	48 (55%)
Does your child engage in physical activities?	71 (82%)	1 (1%)	15 (17%)

Children's health assessment and vaccination status

A nurse reviewed the children's Road to Health cards, carried out anthropometric assessments – height and weight measurements – on each child, and tested, among others, for childhood illnesses such as diabetes, tuberculosis (TB), skin conditions or problems, and respiratory problems. Table 9 gives a summary of the findings.

Table 9: The nurse's assessment of the children's (n=87) health in Moutse, Limpopo

Child health indicators	Yes	No	Don't know	Total
Are the child's vaccination up to date?	66 (76%)	21 (24%)		87 (100%)
Is the child on HIV treatment?	1 (1%)	85 (99%)		86 (100%)
Is the child on tuberculosis (TB) treatment?	3 (3%)	84 (97%)		87 (100%)
Does the child have diabetes?	1 (1%)	86 (99%)		87 (100%)
Does the child have a history of cardiac (heart) problems?	1 (1%)	83 (95%	3 (3%)	87 (100%)
Does the child have dermatological (skin) problems?	10 (12%)	77 (82%)		87 (100%)
Does the child have respiratory (breathing) problems?	6 (7%)	76 (88%)	4 (5%)	86 (100%)
Did/does the child have seizures?	4 (5%)	82 (94%)	1 (1%)	87 (100%)
Did/does child have a diagnosed mental health condition?	3 (3%)	83 (95%)	1 (1%)	87 (100%)
Does child have difficulty seeing, hearing, walking or talking?	8 (9%)	78 (91%)		87 (100%)

A key finding in this domain is that close to a quarter (24%) of children were not up to date with their vaccinations. This is similar to the share of children in the Gauteng CoP study who had outstanding vaccinations by Grade 3. A focus for future intervention should be to make sure that all children participating in the study are up to date with their vaccinations. Children not up to date would need to be referred to healthcare facilities.

Twelve percent of the children had skin conditions such as ringworm and eczema, and 7% had respiratory problems such as asthma. The nurse identified eight children who had difficulty seeing, hearing, walking or talking compared to other children their age. This is lower than the number of children caregivers reported having such difficulties. This discrepancy should also be followed up in future interventions to make sure that all children in need of healthcare treatment are identified.

Children's access to optimum nutrition and food

Hunger and children's access to food and nutrition

No children were reported to regularly go to sleep hungry. For 21% of children, this was 'sometimes' the case, suggesting that food insecurity was a concern in these households (see Table 10). There appeared to be some dietary diversity, with 92% of children eating protein at least twice a week and a similar proportion (93%) eating vegetables twice a week. For a third (33%) of children, there was only 'sometimes' enough food to eat at every meal, and for 7% there was regularly not enough food at every meal. Approximately a quarter (26%) of children did not regularly eat three meals a day.

Most (87%) of the children received food from the National School Nutrition Programme (NSNP) during the school term, which provides children with one meal a day when attending school. This is an important service in the context of food insecurity. We did not ask questions about the quality of food bought or the food portion sizes at home, which have a bearing on children's malnutrition status.

Table 10: Children's (n=87) access to food and nutrition in Moutse, Limpopo province

Children's access to food and nutrition	Yes	Sometimes	No	Refused to answer/ Don't know
Does your child ever go to sleep hungry?	0%	18 (21%)	68 (78%)	1 (1%)
Does your child eat protein at least twice a week?	80 (92%)	-	6 (7%)	1 (1%)
Does your child eat vegetables at least twice a week?	81 (93%)	-	5 (6%)	1 (1%)
Is there enough food for your child to eat at every meal?	51 (59%)	29 (33%)	6 (7%)	1 (1%)
Does your child eat three meals a day?	63 (72%)	21 (24%)	2 (2%)	1 (1%)
Does the child eat a meal at school from the NSNP?	76 (87%)		10 (12%)	1 (1%)

Signs of child malnutrition

There are different indicators for child malnutrition. Malnutrition includes undernutrition, which is wasting, stunting, underweight, a child not getting enough vitamins or minerals, being overweight and having obesity. The impacts of a child having malnutrition in their childhood are both immediate and long term. They include an increased risk of being sick and dying. In this study, the nurse took weight and height measurements and used the WHO Child Growth Standards measurements to assess the children for stunting, wasting, underweight, and overweight (World Health Organization, 2008).

Stunting, wasting and other weight health conditions

Stunting is when a child is short for their age. It is caused by chronic or repeated undernutrition over time (WHO, 2021). Stunting has a negative impact on children's physical and cognitive development with possible long-term effects. A child's cognitive development is how, over time, a child learns to think, understand and solve problems. A child has wasting when their weight is low for their height. It usually means the child has had a recent and big weight loss because they have not had enough food to eat, or because they were ill. Wasting increases a child's risk of ill-health but it can be treated. Underweight refers to a child's low weight-for-age; overweight is when a child has a high weight-for-age or BMI for age when measuring obesity.

As shown in Table 11, a relatively small proportion of children (2%) were found to be stunted, underweight or overweight. The nurse assessed 15% of the children as being wasted: they did not have enough food to eat, or ate food that was of poor quality. This is in line with the finding that most households rely on grant incomes which are often crucial for survival but, in the case of the CSG, is not enough money. This limits both the quality and quantity of food households can provide. These findings align with the caregivers' reports of food insecurity. Approximately a third of children sometimes did not have enough food to eat at each meal, and a quarter of children did not regularly eat three meals a day. These findings highlight the importance of both providing meals through the NSNP and ensuring these meals are sufficiently nourishing and designed to meet young children's nutritional needs.

Table 11: Malnutrition indicators for children (n=87) in Moutse, Limpopo

Indicator of malnutrition	Yes	No	Total
Stunting	2 (2%)	85 (98%)	87 (100%)
Wasting	13 (15%)	74 (85%)	87 (100%)
Underweight	4 (5%)	83 (95%)	87 (100%)
Overweight	3 (3%)	84 (97%)	87 (100%)

The low levels of child malnutrition noted in this study are surprising, given that childhood stunting in South Africa is persistently high. At a national level, the South African Demographic and Health Survey conducted in 2016 reported that more than a quarter (27%) of children under five are malnourished, with stunting found to be higher in rural areas (29%) than urban areas (26%) (National Department of Health et al., 2019). Levels of stunting were slightly lower in Limpopo (22%), although the authors noted that the percentage of children with valid anthropometry data – complete height and weight measurements – varied widely by province and may have affected the provincial results (National Department of Health et al., 2019). A 2020 study assessed the prevalence of malnutrition among children under five attending primary healthcare facilities in the Waterberg District of Limpopo province. It reported even higher levels of stunting, noting that stunting (45.3%) was the most prevalent type of malnutrition among children under five years' old.

The CoP study in five schools in Gauteng also found slightly higher levels of child malnutrition across the three waves than our rural study. To be noted, the prevalence of stunting found in our Gauteng CoP study was also lower than the national figures, and showed a small decrease between 2020 and 2022 (from 13.5% to 11.1%). Given this context, the findings from this study on child malnutrition should be treated with caution and not be generalised. This small sample from one school may not reflect children's status in the area more broadly.

However, it is worth noting that through their work on Children Count, which monitors the situation of children in South Africa, Hall and Sambu found that child hunger has decreased in South Africa over the last two decades, and "despite high poverty rates, Limpopo has always reported child hunger rates below the national average, perhaps because of its highly fertile and productive land in rural areas where most of the population lives" (Hall & Sambu, 2023). In future, the study team will pay particular attention to issues of hunger and nutrition in this sample of children.

Children's education and learning domain

Children's educational wellbeing includes whether they attend school regularly, if they are progressing well with their schoolwork, and whether they are afraid of going to school. This domain is important because a child's poor school performance in the Foundation Phase can negatively impact their future education achievements.

Caregivers' perceptions of their children's educational participation and progress

As shown in Table 12, almost all caregivers (97%) reported that the children attended school regularly; 86% were progressing with their schoolwork, 86% were doing their homework as required, and 92% had someone in the home to help the child with homework. This support for children's education at home is important for building a solid foundation for later schooling.

Table 12: Caregivers' (n=87) perceptions of how their child is faring on educational wellbeing indicators in Moutse, Limpopo

Domain: Educational wellbeing	Yes	Sometimes	No	Total
Does your child attend school regularly?	84 (97%)	-	3 (3%)	87 (100%)
Is your child progressing with their school work?	75 (86%)	-	12 (14%)	87 (100%)
Does your child do homework as required?	75 (86%)	8 (9%)	4 (5%)	87 (100%)
Does someone in your home help with homework?	80 (92%)	2 (3%)	5 (6%)	87 (100%)
Does your child have a school uniform and school supplies?	48 (55%)	30 (35%)	9 (10%)	87 (100%)
Is your child afraid of or refusing to go to school?	5 (6%)	11 (13%)	70 (81%)	86 (100%)

The key educational challenge in Moutse, according to caregivers, was children's access to school uniforms and school supplies such as books and stationery. More than a third of caregivers (35%) reported that their child only 'sometimes' had access to these resources, while 10% of caregivers reported that their child did not have them at all. A small proportion of children (6%) were afraid to go to school, or refused to go; another 13% were sometimes afraid. The children of caregivers who responded 'yes' to this question about being afraid to go to school were in Grades R, 1 and 2. A similar pattern was noted in the Gauteng CoP study. Teachers said this was because of difficulties children had in adjusting to the school environment (Patel et al., 2021). The children whose caregivers reported that this was 'sometimes' the case were evenly spread across the four grades.

Teachers' assessments of educational participation and progress

There were some slight differences in caregivers' and teachers' responses on some of the educational wellbeing indicators (see Table 13). Teachers reported slightly lower levels of regular attendance at school (91% compared to the 97% caregivers reported) and slightly lower levels of compliance with homework (caregivers at 79% compared to teachers at 86%). According to the teachers, most children were able to speak (95%), see (95%) and hear (98%) well. Teachers and caregivers reported similar progress with their children's school work (85% compared to 86%) and teachers reported relatively high levels of the children participating in class (84%). Caregivers were notably less likely than the teachers to report that children had the correct school uniform and school supplies (55% compared to 92% reported by teachers). Teachers reported that 91% of children attended school looking neat and clean but felt that in only 28% of cases were caregivers involved in their children's education. This low level of parental involvement is at odds with the caregivers' reports of support at home for children's education. Moreover, teachers reported that 28% of children had a learning difficulty. This is a potential risk for children's educational progression.

A further concern is that teachers identified more than a quarter of the children (28%) as having a learning difficulty.

Table 13: Class teachers' assessment of how the children (n=87) were faring on educational wellbeing indicators in Moutse, Limpopo

Educational wellbeing	Yes	Sometimes	No	Don't know
Does the child attend school regularly?	79 (91%)	-	8 (9%)	-
Is the child progressing in their schoolwork?	74 (85%)	-	12 (14%)	1 (1%)
Does the child do homework as required?	69 (79%)	11 (13%)	7 (8%)	-
Does the child have difficulty learning?	24 (28%)	17 (20%)	44 (52%)	-
Does the child speak well?	83 (95%)	-	3 (3%)	1 (1%)
Does the child see well?	83 (95%)	-	3 (3%)	1 (1%)
Does the child hear well?	85 (98%)	-	1 (1%)	1 (1%)
Does the child participate in class?	73 (84%)	11 (13%)	3 (3%)	-
Does the child come to school with the correct uniform and supplies?	80 (92%)	5 (6%)	2 (2%)	-
Is the child neat and clean?	79 (91%)	7 (8%)	1 (1%)	-
Is the caregiver involved in the child's education?	24 (28%)	17 (20%)	44 (52%)	-

Domain: Protection and care of the children

The protection and care domain assesses relationships in the household. It notes whether there are caregivers or others present in the home who are available to respond to the child's needs, and aware of the child's whereabouts. It also probes safety concerns and the child's direct or indirect exposure to violence at home or in the community.

From the caregivers' accounts (see Table 14), it appears that most (97%) of the children had an adult in the home who always knew where the child was. There was also someone at home who they could talk to (91%) and spend time or read or sing with (94%). Despite this, 40% of caregivers said that they had concerns about their child's safety at home, school and or in the community. Another 23% reported that they 'sometimes' have these safety concerns. Almost half (46%) reported that their child had been exposed to some type of violence at home or in the community.

Table 14: Protection and care indicators of the children (n=87) in Moutse, Limpopo province

Domain: Protection and care	Yes	Sometimes	No	Total
Is there an adult in the home who always knows where the child is?	84 (97%)	3 (3%)	-	87 (100%)
Is there someone at home that the child trusts and can talk to?	79 (91%)	-	8 (9%)	87 (100%)
Does an adult or older sibling read, sing, or spend time with the child?	82 (94%)	3 (3%)	2 (2%)	87 (100%)
Have you ever had concerns about your child's safety at home/school/community?	35 (40%)	20 (23%)	32 (37%)	87 (100%)
Has the child seen people fighting, swearing or hurting each other at home or in the community?	40 (46%)	5 (6%)	41 (47%)	86 (100%)
Has the child been a victim of abuse?	10 (12%)	-	76 (88%)	87 (100%)

In the nurse's and teachers' assessments during the Moutse, study, the nurse identified one case where there was evidence that a child had been abused. The teachers reported two cases in which they suspected child abuse and or neglect. In both cases, this was fewer than the ten children (12%) caregivers reported, although the caregiver reports were in response to a slightly broader question as to whether the child had been a victim of abuse or violence at home, school or in the community.

Methods of discipline

Caregivers were asked what discipline methods they used with their children (see Table 15). Some caregivers stated only one method, while others spoke of using a combination of discipline methods. More than three-quarters (76%) of the caregivers reported talking to their child, which is a form of positive parenting that is likely to strengthen the caregiver-child relationship. However, this method was often mentioned in conjunction with other harsher practices, such has giving the child a hiding and shouting at the child.

Table 15: Caregivers' methods of disciplining[3] their children (n=87) in Moutse, Limpopo province

Caregivers' discipline methods	Yes
Talking to the child	66 (76%)
Giving the child a hiding	40 (46%)
Shouting at the child	39 (45%)
Depriving the child of treats/privileges	22 (25%)
Not allowing the child to play with friends	11 (13%)
Pinching the child	1 (1%)
Other	9 (10%)

Almost half the caregivers (46%) reported using physical punishment by giving the child a hiding. Research evidence shows that physical punishment increases children's behavioural problems over time. It is linked to a range of negative outcomes for children, including physical and mental ill-health, impaired cognitive and socio-emotional development, poor educational outcomes, increased aggression, and being violent themselves (WHO, 2023).

Other types of discipline caregivers mentioned included giving the child extra chores (2), threatening to give the child a hiding/beating (3), threatening them (1), or ignoring them (1).

[3] This question allowed for more than one response.

Domain: The children's psychosocial wellbeing

Teachers' assessments of children's psychosocial behaviour

Teachers were asked about children's psychosocial wellbeing and behaviour in the classroom (see Table 16). In most cases (93%), teachers reported that children were generally happy, with only a small proportion reported to be anxious (3%) or sad (2%). While 13% reportedly fought with other children, the majority of children (79%) were able to calm themselves when they were upset, to tell someone to stop doing something being done to them that they did not like (76%), and to problem solve (71%). Fewer children (62%) talked to their class teacher when they had a problem, and only half (52%) could sit still long enough to complete tasks. As noted, teachers identified two cases of possible child abuse or neglect.

Table 16: Teachers' perceptions of children's (n=87) social and emotional wellbeing in Moutse, Limpopo province

Child's emotional and mental health	Yes	Sometimes	No	Don't know
Is the child generally happy?	81 (93%)	1 (1%)	1 (1%)	4 (5%)
Does the child seem anxious, nervous, or worried?	3 (3%)	7 (8%)	77 (89%)	-
Does the child seem sad or depressed?	2 (2%)	-	84 (97%)	1 (1%)
Does the child fight with other children?	11 (13%)	20 (23%)	56 (64%)	-
When the child is upset, are they able to calm themselves down?	69 (79%)	14 (16%)	2 (2%)	2 (2%)
Can the child tell someone to stop doing something they doesn't like?	66 (76%)	8 (%)	12 (14%)	1 (1%)
When the child has a problem, can they find a solution or ask for help?	62 (71%)	16 (18%)	5 (6%)	4 (5%)
Does the child speak to you when they have a problem?	54 (62%)	21 (24%)	11 (13%)	1 (1%)
Can the child sit long enough to complete tasks?	45 (52%)	-	40 (46%)	2 (2%)
Is there evidence of child abuse or neglect?	2 (2%)	-	81 (93%)	4 (5%)

Psychometric measures of children's psychosocial wellbeing

In addition to asking caregivers and teachers about the children's social and emotional wellbeing, the CWTT included two standardised psychometric measures as part of the questionnaire. They were the Child and Youth Resilience Measure (CYRM) and the Strengths and Difficulties questionnaire (SDQ). Both have been validated for use in South Africa and each child completed the CYRM while caregivers completed the SDQs on the children's behalf (Goodman, 1997; Ungar & Liebenberg, 2011). However, in this study, analysis of the responses to these two assessments showed low internal consistency (Cronbach's Alpha = 0.59 for CYRM-R, 0.45 for the SDQ). This means the assessments were not found to be a reliable measure of children's psychosocial wellbeing in this context. For this reason, these measures are not discussed further here.

Risk profile of children for each domain

A key goal of this study is to identify children at high, moderate and low risk. A 'high-risk' classification based on this assessment points to a need to refer the child immediately. Selected measures – questions – have been clustered together to assess and categorise children's risk. The clustering of the answers was informed by existing literature, knowledge of child wellbeing indicators, and through consensus discussions with team members. See Appendix I for the clusters of questions we used to inform the risk assessment for each domain. Children at high or moderate risk will be followed up for further assessment to inform an intervention plan.

The findings in Figure 5 suggest that children were at highest risk in the protection and safety domain and in the financial and material wellbeing domain. In the protection and safety domain, almost half (48%) of the children were assessed at being at high risk. These are children for whom there was a 'yes' response on whether the child had been a victim of abuse or violence, had seen people fighting in the home and community, or if the child got along better with adults than with other children.

Approximately 39% of children were at high risk due to limited financial or material resources. In this economic and material wellbeing domain, children and their families were considered to be at high risk if their caregivers had no access to other sources of income aside from social grants, or if they struggled to pay off their debts. At the other end of the spectrum, it was encouraging to note that the risk to children's educational wellbeing in this sample was low. This was measured by positive responses to whether the child was attending school and progressing with their school work as expected.

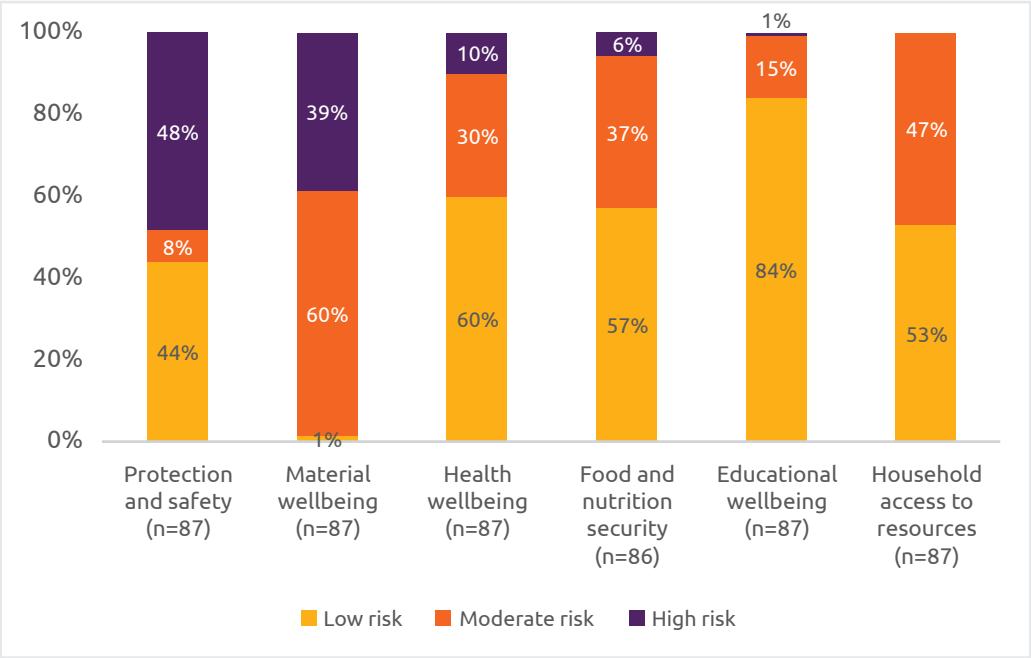

Figure 5: Risk profiles for each domain

So, how well are the Moutse children faring?

This report presents the findings of the baseline assessment of a cohort of children in rural Moutse, Limpopo.

Economic and material wellbeing

We found that adult members' high unemployment rate in these households negatively affected the children's material wellbeing. The sample's unemployment rate was more than double the official national and provincial unemployment rate in the third quarter of 2023. Two-thirds (67%) of households did not have enough money to buy the things they needed, such as food and other necessities.

Social grants were an important source of survival. All the households received at least one child support grant, while a little over a third (37%) included a family member who received an older person's grant. But fewer than half (44%) of the households had income in addition to the grants: three out of five caregivers were not able to save, and one in five struggled with debt repayment.

Food insecurity and malnutrition

Material deprivation was reflected in the food insecurity children and their families experienced. Child hunger was not identified as a challenge, and most children received the minimum requirements of eating protein and vegetables at least twice a week. But more than one-third of children in our sample did not have enough food to eat at every meal, and almost a quarter did not regularly eat three meals a day. The consequence of this was reflected in the nurse's finding that 15% of the children had malnutrition in the form of wasting: they did not have sufficient food, or were eating food of poor nutritional quality.

Children's health

It was positive to note that all the children had a Road to Health Card that indicated their vaccination status. But it is concerning that a quarter of children have incomplete vaccinations. They need to be vaccinated to make sure they are protected against preventable childhood illnesses. Furthermore, there are additional areas for potential intervention. These areas include further assessment of the quarter of children whose caregivers reported their child having difficulties seeing, hearing or talking – although teachers did not identify this as a concern; and encouraging children to take part in physical and recreational activities.

Education and learning

There were encouraging findings around educational wellbeing in our sample of children. Almost all attended school and most were progressing in their schoolwork, according to both their caregivers and teachers. Caregivers were concerned about children not having school uniforms and school supplies, such as books and stationery, although teachers were not as concerned as caregivers about this. From the teachers' perspective, educational challenges included low levels of caregivers' involvement in their children's education, and the finding that more than a quarter of children had a learning difficulty.

Protection and care

While caregivers reported that the children enjoyed relatively high levels of supervision and engagement in the home, almost two-thirds of caregivers were concerned about their child's safety. Almost half of the children had been exposed to violence at home or in the community, and a similar proportion had been dealt physical punishment at home.

Psychosocial wellbeing

Caregivers' mental health is of concern: almost a third (31%) said they had experienced symptoms that point towards depression. This could have negative impacts on their child's development and ability to thrive.

What lies ahead?

This comprehensive assessment of our cohort of young children's wellbeing in Moutse provides a solid foundation from which to develop informed and tailored interventions. Such interventions need to prioritise the children who are at high or moderate risk across the six domains. The experience of 'learning through practice' by putting the CoP initiative into action in five schools in Gauteng over three years has demonstrated two vital things:

- the importance of monitoring the children and their families' multidimensional wellbeing in their home, school and community context, and
- the need to build and strengthen supportive and integrated services for children and their families at home, school and community level.

For positive child wellbeing outcomes to be realised, multidisciplinary teams need to monitor children's wellbeing needs. The teams directly working with the children, such as the teachers and social workers, need sufficient capacity and support from government departments, nongovernment organisations and civil society to work together on an ongoing basis. This would make it possible to share knowledge, and identify and put tailored and tangible solutions into practice to promote children's growth and development outcomes in the early years of schooling.

This baseline assessment report represents the first step in exploring how a community of practice approach can support rural children's wellbeing, such as for the Moutse children, through them getting effective and quality school-based support services and care. After all, the intention of policies and programmes, such as the Integrated School Health Programme (ISHP), is to improve children's health, reduce health barriers to learning, improve their psychosocial wellbeing and assist learners to stay in school and perform to the best of their abilities. These investments are critical to ensuring their wellbeing, productivity and overall levels of happiness in later life.

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Annexure 1: Child wellbeing domains

The state of a child's wellbeing is categorised as:

RED HIGH RISK (3) Major concerns that indicate a need for immediate referral

AMBER MODERATE RISK (2) Some concerns that indicate a need for support/intervention

GREEN LOW RISK (1) No concerns

There is no one single overall measure of wellbeing. We consider various domains of wellbeing.

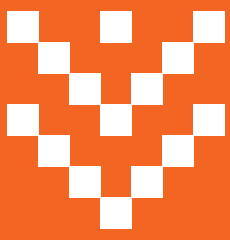
EDUCATIONAL WELLBEING DOMAIN	
RED	Does your child attend school on the days that they are supposed to? = No AND Is your child progressing with their schoolwork? = No AND Is the child afraid or refuses to go to school? = Yes or sometimes
AMBER	Does your child attend school on the days that they are supposed to? = No AND Is your child progressing with their schoolwork? = Yes OR Does your child attend school on the days that they are supposed to? = Yes AND Is your child progressing with their schoolwork? = No
GREEN	Does your child attend school on the days that they are supposed to? = Yes AND Is your child progressing with their schoolwork? = Yes
FOOD AND NUTRITION DOMAIN	
RED	Does your child ever go to sleep hungry? = Yes AND Is there enough food for your child to eat at every meal? = No
AMBER	Does your child ever go to sleep hungry? = Sometimes AND Is there enough food for your child to eat at every meal? = Sometimes
GREEN	Does your child ever go to sleep hungry? = No AND Is there enough food for your child to eat at every meal? = Yes
HEALTH DOMAIN	
RED	Is your child's health stopping them from playing/going to school? = Yes OR Compared to other children, does your child struggle to hear, see or talk? = Yes OR Is the child is wasted or stunted? = Yes OR Compared to children the same age, does the child speak well? = No OR Compared to children the same age, does the child see well? = No OR

	Compared to children the same age, does the child hear well? = No OR Does the child have diabetes? = Yes OR Does the child have any respiratory conditions, such as pneumonia or asthma)? = Yes OR Did/does the child have seizures? = Yes OR Did/does the child have a confirmed/diagnosed mental health condition? = Yes OR Is there evidence of abuse? = Yes
AMBER	Is your child's health stopping them from playing/going to school? = Sometimes AND Compared to other children, does your child struggle to hear, see or talk? = Sometimes OR Are the child's vaccinations (EPI) up to date? = Yes OR Is the child on HIV treatment? = Yes OR Is the child on TB treatment? = Yes OR Does the child have any dermatological conditions, such as eczema or ringworms? = Yes
GREEN	Is your child's health stopping them from playing/going to school? = No AND Compared to other children, does your child struggle to hear, see or talk? = Sometimes OR Is your child's health stopping them from playing/going to school? = No AND Compared to other children, does your child struggle to hear, see or talk? = No OR Is your child's health stopping them from playing/going to school? = Sometimes
MATERIAL DOMAIN	
RED	In addition to the grant, does the family have other income? = No OR Does your family have enough money to buy the things you need? = No OR Do you struggle with paying off debts? = Yes
AMBER	In addition to the grant, does the family have access to other sources of income? = Sometimes AND Does your family have enough money to buy the things you need? = Sometimes AND Do you struggle with paying off debts? = Yes OR In addition to the grant, does the family have other sources of income? = No AND Does your family have enough money to buy the things you need? = Sometimes AND Do you struggle with paying off debts? = Yes

	OR In addition to the grant, does the family have other sources of income? = No AND Does your family have enough money to buy the things you need? = Yes AND Do you struggle with paying off debts? = Yes OR In addition to the grant, does the family have other sources of income? = Yes AND Does your family have enough money to buy the things you need? = No AND Do you struggle with paying off debts? = Yes OR In addition to the grant, does the family have other sources of income? = Sometimes AND Does your family have enough money to buy the things you need? = No AND Do you struggle with paying off debts? = Yes OR In addition to the grant, does the family have other sources of income? = Sometimes AND Does your family have enough money to buy the things you need? = No AND Do you struggle with paying off debts? = No OR In addition to the grant, does the family have other sources of income? = Sometimes AND Does your family have enough money to buy the things you need? = Sometimes AND Do you struggle with paying off debts? = No OR In addition to the grant, does the family have other sources of income? = No AND Does your family have enough money to buy the things you need? = Sometimes AND Do you struggle with paying off debts? = No OR In addition to the grant, does the family have other sources of income? = Yes AND Does your family have enough money to buy the things you need? = Sometimes AND Do you struggle with paying off debts? = No

	OR In addition to the grant, does the family have other sources of income? = Yes AND Does your family have enough money to buy the things you need? = No AND Do you struggle with paying off debts? = No
GREEN	In addition to the grant, does the family have other sources of income? = Yes AND Does your family have enough money to buy the things you need? = Yes AND Do you struggle with paying off debts? = No
LIVING CONDITIONS WELLBEING	
RED	Does your child have a mattress or bed in the house where they sleep every night? = No AND Do you live in a home that protects you from wind and rain? = No AND Do you live in a home that has access to clean drinking water? = No AND Do you live in a home with electricity? = No AND 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? = No
AMBER	Does your child have a mattress or bed in the house where they sleep every night? = No OR Do you live in a home that protects you from wind and rain? = No OR Do you live in a home that has access to clean drinking water? = No OR Do you live in a home with electricity? = No OR 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? = No
GREEN	Does your child have a mattress or bed in the house where they sleep every night? = Yes AND Do you live in a home that protects you from wind and rain? = Yes AND Do you live in a home that has access to clean drinking water? = Yes AND Do you live in a home that has access to clean drinking water? = Yes AND/OR Do you live in a home with electricity? = Yes AND 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

PROTECTION AND CARE DOMAIN	
RED	Has the child been a victim of abuse or violence at home, in the community or school? = Yes OR Has the child seen people fighting, swearing or hurting each other at home, school or in the community? = Yes OR Is there evidence of child abuse and/or neglect? = Yes
AMBER	Is there an adult in the home who always knows where the child is? = Sometimes OR Is there an adult in the home who always knows where the child is? = No OR Has the child seen people fighting, swearing or hurting each other at home, school or in the community? = Sometimes OR Does the child come to school with the correct uniform and supplies such as books and stationery? = No AND Is the caregiver involved in the child's education, such as support with homework, attending school meetings, and discussing any challenges the child has with the school? = No OR Is the child well cared for and looks neat and clean? = No AND Does the child seem anxious, nervous or worried? = No AND Is the child generally happy? = No AND Does the child seem sad or depressed? = No OR Is the child progressing with their schoolwork = No AND Compared to other children of their age, does the child have difficulty controlling their behaviour? = Yes AND Can the child sit still long enough to complete tasks? = No
GREEN	Has the child been a victim of abuse or violence at home, in the community or school? = No AND Has the child seen people fighting, swearing or hurting each other at home, school or in the community? = No AND Is there an adult in the home who always knows where the child is? = Yes



Communities of Practice web link:
https://communitiesforchildwellbeing.org/