EVALUATING INCOME GENERATION, NUTRITION, AND PARENTING

PROGRAMS ON MATERNAL AND CHILD HEALTH OUTCOMES:

A MULTI-PROGRAM CASE STUDY OF A COMMUNITY-BASED

ORGANIZATION IN THE WESTERN CAPE, SOUTH AFRICA

by

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ABSTRACT OF THE DISSERTATION

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Dissertation Director:
Dr. Jeffrey Backstrand

The Western Cape Province of South Africa captivates tourists from all over the

world who flock to the region to visit the spectacular view from Table Mountain, take in

the beauty of wildlife on a safari tour, and sip some of the best wines in the world at any

one of the region's stunning vineyards. However, while the Western Cape prides itself as

a vacation destination for visitors, residents are faced with social and health problems on

an everyday basis as a result of the country's complex apartheid history. The province

remains socially stratified by social class, gender, age, and race in which socio-

economically disadvantaged groups, specifically Black and Coloured women and

children, are treated differently and live under unfavorable conditions. Maternal poverty,

poor maternal nutrition and health, and maternal alcohol abuse, the three risk factors

explored in this study, have resulted in malnourished infants and children. One response

to this is that community-based organizations have been developed throughout the

province to provide at-risk, low-income Black and Coloured mothers with income

generating programs in order to lessen poverty and maternal and child health disparities,

nutrition and health support groups, and early childhood development centers for young children in tandem with parenting workshops and counseling programs.

Although there is significant research that indicates participating in evidence-based parenting programs can improve child health outcomes in high-income countries (Lachman et al., 2016), few studies have examined their impact in low-and middle-income countries and what constitutes effective implementation of parenting interventions in severely impoverished rural communities. This multi-program case study will examine how a community-based organization helps at-risk Black and Coloured mothers make better behavioral, nutritional, and parenting choices through a process evaluation using document analyses and 48 semi-structured qualitative interviews with staff and participants. Life Course Theory and the Social Determinants of Health are the guiding conceptual models to frame this research which stress that barriers to health, including economic disparities and health inequity in the early years of life, can have an impact on the health trajectories of children and that a mother's social position is the main determinant of inequity, respectively.

Dedication

This dissertation is dedicated to my family and close friends – Gloria Edwards, Gordon Martin, Frederick Clarke, Anthony Tait, Lisa-Marie Aird, Sue-Ann Banfield, and the Aird clan. A special thank you to my mother, Gloria Edwards, and my late father, Gordon Martin, who shaped me into the woman that I am today. A special thank you to my late cousin, Dr. Tony Martin, well-known Professor Emeritus and founding member of the Department of Africana Studies at Wellesley College, who told me to pursue my passion of obtaining a doctorate degree three months before suddenly passing away. Lastly, a special thank you to Jerry Howard II, whose love and support throughout my doctoral journey has been unfailing.

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Acronyms

ABU	Abuse by Spouse
AGE	Age
ALC	Alcohol Usage
AUDP	Alcohol Use During Pregnancy
BF	Breastfeeding
CBC	Computer and Business Course Program
CBIs	Community-Based Interventions
CBOs	Community-Based Organizations
CF	Complementary Feeding
CHWs	Community Health Workers
CMR	Child Mortality Rate
CP	Counseling Program
DALYs	Disability-Adjusted Life Years
DOH	Department of Health
DSD	Department of Social Development
EBF	Exclusive Breastfeeding
ECD	Early Childhood Development
ECDA	Early Childhood Development Learning/Aftercare Programs
EDU	Educational Attainment
FAS	Fetal Alcohol Syndrome
FASD	Fetal Alcohol Spectrum Disorders
FS	Feeding Scheme
GDP	Gross Domestic Product
GII	Gender Inequality Index
GNI	Gross National Income
HEWs	Health Extension Workers
IMR	Infant Mortality Rate
IPC	Interpersonal Communication
IYCF	Infant and Young Child Feeding
LBW	Low Birth Weight
LCT	Life Course Theory
LMICs	Low and Middle Income Countries
MAR	Marital Status
MCH	Maternal and Child Health
MMR	Maternal Mortality Rate
NCDs	Non-Communicable Diseases
NDP	National Development Plan
NGO	Non-Governmental Organizations
NHSG	Nutrition and Health Support Group
OG	Organic Garden
PAE	Prenatal Alcohol Exposure
PAP	Poverty Alleviation Program
PW	Parenting Workshops

SA	South Africa
SASSA	South African Social Security Agency
SBCC	Social and Behavioral Change
SDH	Social Determinants of Health
SHD	Sustainable Human Development
SBP	Sewing and Beading Project
TEP	Teenage Pregnancy
U5MR	Under-Five Mortality Rate
UHC	Universal Health Coverage
UMICs	Upper Middle Income Countries
UN	United Nations
UNDP	United Nations Development Programme
UNMDGs	United Nations Millennium Development Goals
UNSDGs	United Nations Sustainable Development Goals
USAID	United States Agency for International Development
WCP	Western Cape Province
WHO	World Health Organization

Chapter 1: Introduction

Introduction to the Research Problem

One of South Africa's (SA) most visited and wealthiest provinces, the Western Cape Province (WCP) captivates tourists from all over the world who flock to the region to visit the spectacular view from Table Mountain, take in the beauty of wildlife on a safari tour, and sip some of the best wines in the world at any one of the region's stunning vineyards. However, while the WCP prides itself as a vacation destination for visitors, residents are faced with social and health problems on an everyday basis due to the country's complex apartheid history. SA remains a country socially stratified by social class, gender, age and race in which socio-economically disadvantaged groups, specifically Black and Coloured women and children, are treated differently and live under unfavorable conditions. The child survival picture at the beginning of the 1990s was stark for the majority of children, who had been systematically excluded from access to quality services by apartheid policies (Statistics SA, 2015c). Although apartheid ended over two decades ago, inequalities in maternal and child health (MCH) outcomes still exist in the province.

When compared to other relatively high-income African countries such as Gabon, Botswana and Equatorial Guinea (based on gross national income adjusted for purchasing power parity) SA appears to be doing quite well from an economic standpoint (May & Timæus, 2014). However, income inequality in the country is among the highest in the world (Statistics SA, 2004), high levels of poverty and unemployment exist (Klasen & Woolard, 2009) and poverty varies from province to province (Serumaga-zake et al., 2005). The high levels of poverty found among Black and Coloured women and children

is evident in high maternal mortality rates (MMR), infant mortality rates (IMR), and under-five mortality rates (U5MR) in the WCP. Maternal poverty, poor maternal nutrition and health, and maternal alcohol abuse, the three risk factors explored in this study, have resulted in malnourished infants and children. Despite being an upper middle-income country (MIC), many South African households face absolute poverty (May et al., 1998), the country is classified as one of 36 high-burden countries for child malnutrition (Black et al., 2008) and SA has one of the riskiest drinking patterns in the world (World Health Organization, 2011). And although WCP residents are, on average, the most affluent of all South Africans, the province is still marred by high poverty rates, unemployment and inequalities in the distribution of income between various population subgroups (Pauw & DuPlessis, 2005).

The need for and value of MCH programs has been well documented (Burgard, n.d.; Adam et al., 2005; Graham et al., 2006; Jowett, 2000; Kunst & Houweling, 2001). Although evidence-based parenting programs have been shown to reduce rates of child maltreatment in high-income countries, few studies have examined their impact in low- and middle-income countries (Lachman et al., 2016). Mothers of lower socio-economic class tend to have unhealthy behaviors such as poor nutritional choices and alcohol abuse. In the WCP, this is in part a result of scarce food choices in their communities and a legacy of prenatal alcohol abuse that spans back to colonial times. As a result, children under the age of five in SA continue to live in hunger and are malnourished as a result of instability, neglect and community disorder (Atmore, 2013).

Investment in MCH programs promotes equity between the rich and poor, and community-based organizations (CBOs) that address MCH outcomes through income

generation, nutrition and health, and parenting programs play a large part in alleviating poverty on a national and global level. However, there is limited research about what constitutes effective implementation of early parenting interventions (Hickey et al., 2016). The increasing need for CBOs and the socio-economic gap between racial groups requires there be further examination into programs that provide services that empower at-risk, low-income Black and Coloured mothers through income generating projects, nutrition and health support groups, and parenting skills.

Context and Background

In SA, several national policies and interventions have been put in place in response to the issue of poor MCH such as the South African Constitution, the National Health Insurance, the National Development Plan, the establishment of Ministerial Committees and the development and adoption of the Maternal, Neonatal, Child and Women's Health and Nutrition Strategic Plan 2012-2016. However, these interventions focus on the healthcare system and treatment, not on public health and prevention. This multi-program case study is focused on public health and prevention. There is increasing recognition of the importance of effectively implementing community-based prevention and early intervention programs in order to ensure positive outcomes in children (Durlak & DuPre, 2008; Halle et al., 2013). While improvements in a country's healthcare system have important implications for MCH outcomes, public health and prevention programs through CBOs may have a greater effect because they provide a bottom-up approach to empower impoverished communities and change maternal behaviors.

One response to this is that CBOs have been developed throughout the province to provide at-risk, low-income Black and Coloured mothers with income generating

programs in order to lessen maternal poverty and MCH disparities, nutrition and health support groups, and offer early childhood development (ECD) centers for young children in tandem with parenting workshops and counseling programs. Evidence shows that ECD programs can have significant long-term health and socio-economic advantages (Kuruvilla et al., 2016). The demographic characteristics of many developing nations imply that interventions targeting the period of ECD have tremendous potential to promote population health and socio-economic development (Binagwaho et al., 2016). A number of other studies have identified factors which are associated with the success of these programs, including parental attitudes towards program content, changes in parenting skills and confidence, and positive experiences of the group process (Furlong & McGilloway, 2011; Gardner et al., 2006; Gardner et al., 2010).

Purpose and Significance of the Study

The purpose of this multi-program case study was to describe the ways in which *Table Views Foundation (Table Views)* contributes to at-risk, low-income Black and Coloured mothers' decisions to make better behavioral, nutritional, and parenting choices. This study investigated income generation opportunities, nutrition and health support groups, parenting skills, and counseling through a program process evaluation. Women's choices are influenced by social networks that convey behavioral norms, health information, social support, and other resources that impact women's social capital (Story, 2013). Table Views combines a range of group-based parenting supports and entails partnerships with various key stakeholders that address family and community needs, tackles multiple risk factors (specifically maternal poverty, poor maternal nutrition and health, and maternal alcohol abuse), tackles gaps in prevention, and focuses on barriers to engagement for at-risk families. This multi-program case study will include an in-depth

examination of the organization's history, various organizational components, and the perspectives of program participants, program administrators, and program staff through the use of qualitative interviews and observations. Findings from this research could add to the knowledge of CBOs, public health providers, ECD teachers, and at-risk families in improving MCH outcomes in the WCP, SA. This type of research is necessary to understand how CBOs attempt to diminish socio-economic and MCH inequities by providing income generating programs, nutritional and health projects, feeding schemes, and computer training to improve parenting skills and foster better MCH outcomes for at-risk, low-income Black and Coloured mothers, and the impact of such programs.

Research Questions

I will investigate a CBO that specifies as its primary goal to "holistically alleviate the social effects of poverty and substance abuse by restoring human dignity in the lives of the marginalized individuals in Maraval and surrounding areas" (Organization Brochure). The research questions are divided into two components based on the organization's program logic models and program process using qualitative data. Exploratory research on the various program logic models was conducted in June and July of 2016. I reviewed each program's documents, discussed selection of each program with leadership to ascertain if the organization would be a good fit for the intended study, conducted site visits, and observed each program's functions. I reviewed documents on the organization's vision and mission as well as the foundation's social upliftment and awareness programs and training and development courses. From these sources, the researcher may be able to obtain the program's goals and objectives; the program's functions, components, and activities; and the logic or sequence linking program functions, activities, and components (Rossi et al., 2003).

Review of the organization's theory provides a better understanding of each program's processes and implementation. The overarching aims of this process evaluation are to gain an understanding of the functioning components of *Table Views* to systematically assess the processes and contexts which impact program implementation and effectiveness. This segment of the evaluation will investigate the range of services provided by *Table Views* and examine how each program works (or does not work) and whether there are facilitators and/or challenges to program implementation and effectiveness. Assessing the adequacy of program process is an important evaluation function because it compares the program activities that actually take place with the services that are actually delivered (Rossi et al., 2003). Evaluation of the program's process will also examine the perceptions of participants of the impact of the programs. The study will look at parent responses to the intervention and examine any possible barriers and challenges to program participation.

The following overarching question will guide the program process evaluation:

1) How do key stakeholders, including program staff and parent participants, participate in and respond to each intervention and to each program?

The following sub-questions will also guide the program process evaluation:

Staff:

1) How did the organization come to exist and continue to exist?

2) How are the programs intended to be delivered?

3) Are there any barriers and challenges to program implementation?

4) What aspects of *Table Views* does staff perceive as having the greatest impact on participant knowledge, nutritional choices, and parenting approaches?

Participants:

      1) What are the larger contextual factors which influence participant experiences?

      2) What has it been like to participate in the organization's programs?

      3) Are there any barriers and challenges to program participation?

      4) What aspects of *Table Views* do participants perceive to have the greatest

      impact on knowledge, nutritional, and parenting approaches?

The Researcher's Background

The study examines the effectiveness of a CBO that provides low-income Black and Coloured mothers, who suffer from poor health and nutritional habits and substance abuse, with the opportunity to generate income, attend a nutrition and support group, register their children in a low cost ECD center, and equip them with parenting skills. My perceptions of providing at-risk, low-income mothers with these opportunities has been shaped by my experiences as a Community Relations Specialist for the New York City Department of Health and Mental Hygiene – Bureau of Intergovernmental Affairs, as an Administrative Analyst at the Onondaga County Health Department, and in my capacity as a Health Consultant for SUNY Upstate Medical University. In my position as Community Relations Specialist I visited health organizations that provide substance abuse counseling to men and women in the city and served as a liaison between government officials and CBOs. In my position as Administrative Analyst I oversaw a program evaluation audit of Early Childhood Intervention Services, including family education and counseling, home visits and parent support groups and facilitated a community-wide conference on child trauma for the under-five population in the county. Lastly, in my role as Health Consultant I analyzed organizational background material and data, conducted operational reviews and semi-structured interviews with hospital

staff, and provided a detailed report of findings and recommendations based on implementation issues and legislative requirements. My background in community relations building, program evaluation and qualitative interviewing, respectively, have allowed me to work with employees and participants and required that I analyze the effectiveness of government policies and CBOs in providing services for at-risk, low-income groups.

I lived in Cape Town in June and July 2016 on a grant from Rutgers University-Newark and the United States Agency for International Development (USAID) to collect preliminary dissertation research. Through my host organization, the Community Chest of the Western Cape (Community Chest), I was invited to several events held by government leaders such as the final Western Cape Parliament Meeting before the Western Cape Provincial Election held in August 2016. At this meeting, I was able to meet MEC Albert Fritz, the Minister of Social Development in the government of the WCP of SA; MEC Fritz's Communications Director, Ms. Esther Lewis; and Dr. Nomafrench Mbombo, the Minister of Health in the government of the WCP of SA. I scheduled meetings with all three individuals in order to discuss their views of the First 1000 Days Campaign.

Launched in the WCP in February 2016, the goal of the First 1000 Days Campaign is to raise awareness around the first 1000 days of a baby's life. The First 1000 Days Campaign is focused on growth and development of children in the first two years. The campaign is a joint collaboration between the Department of Social Development (DSD) and the Department of Health (DOH). According to the South African Government website (2016):

> We believe that the First 1000 Days of a child's development, starting from conception, moving through pregnancy, birth, and the first two years of life, are crucial for securing a child's bright future...through three pillars that are important in ensuring the healthy development of children in the First 1000 Days: 1) Ensuring the health and nutrition of both mother and baby; 2) Providing mothers and babies with support from fathers, families and the whole community; and 3) Providing the right stimulation for the baby's learning needs and giving them a safe substance abuse free environment which promotes well-being.

Preliminary interviews with MEC Fritz, Esther Lewis, and Dr. Mbombo provided vital information on the First 1000 Days Campaign and excerpts from these three interviews are discussed and analyzed in Chapter 3.

One of the goals of this study is to understand the risk factors that contribute to poor MCH outcomes. The data gathered from these discussions at the provincial level allowed me to identify and categorize the primary themes around the risk factors that affect MCH outcomes. I found it vital to first interview government officials on a macro-level that would later inform my selection of a CBO in the WCP that provides services to women and children in an attempt to diminish these factors. Preliminary data analysis of interviews with MEC Fritz and Ms. Lewis (interviewed at the same time) and Dr. Mbombo about the First 1000 Days Campaign revealed that there are a number of risk factors associated with the improvement of MCH outcomes in the WCP. As a result of the analysis, three risk factors became apparent: 1) maternal poverty; 2) poor maternal nutrition and health; and 3) maternal alcohol abuse.

<u>Chapter Overviews</u>

Chapter 2 provides a review of global literature relevant to the themes of this dissertation. It examines the literature about the size of the MCH problem and definitions (MMR, IMR, U5MR, neonatal mortality and perinatal deaths), discusses the theoretical framework used in this study (life course theory, the social determinants of health and

health disparities that consider upstream, midstream and downstream factors), the upstream causes of global MCH problems (maternal poverty), downstream causes of global MCH problems (poor maternal nutrition and alcohol abuse by expectant mothers) and explores global MCH programs and policies that have worked (the First 1000 Days Campaign and community-based interventions that have worked in Egypt, Ethiopia, Rwanda and India) with global interventions that have not worked (the United Nations Millennium Development Goals).

Chapter 3 provides a contextual review of literature relevant to the risk factors as it relates to SA and the WCP specifically. The chapter provides general background of SA and the WCP (the history of apartheid and overall population demographics), the nature of the MCH problem in SA and the WCP (demographics specific to MCH), upstream and downstream causes of MCH problems in SA and the WCP (maternal poverty, poor maternal nutrition and health and maternal alcohol abuse), looks at MCH programs and policies in SA (the Constitution, National Health Insurance, the National Development Plan, Ministerial Committees and the Maternal, Neonatal, Child and Women's Health and Nutrition Strategic Plan) and the WCP (the First 1000 Days Campaign) and concludes with preliminary qualitative analysis of semi-structured interviews with government officials from the DSD and DOH – the two provincial departments that created the First 1000 Days Campaign.

Chapter 4 describes research methods, explains the specific research objectives, provides an overview of the research design (qualitative multi-program case study), explains why the study site was selected for this case study, and why qualitative data,

inclusive of document analysis and semi-structured interviews, were gathered to understand provider and parent perceptions and experiences.

Chapter 5 provides general background on the Table Views Organization which includes organizational make-up, staff demographics, staff backgrounds and funding information. This is followed by environmental contextual factors that impact participant engagement according to discussions with administrative and programmatic staff, background information of each of the seven programs aligned with the study's three main risk factors: maternal poverty, poor maternal nutrition and health, and maternal alcohol abuse, overall staff perceptions of organizational and programmatic goals, barriers/challenges to organizational and programmatic goal achievement, facilitators to organizational goal achievement, and overall organizational and programmatic successes.

Chapter 6 includes participant demographics and behavior divided by each program – the Computer and Business Course Program and the Sewing and Beading Project, programmatic overlap and comparisons, findings on the most common environmental and individual contextual factors according to participants, barriers/challenges and facilitators to participant engagement, and each program's impact on participant knowledge.

Chapter 7 includes participant demographics and behavior on the women who participate in the Nutrition and Health Support Group, programmatic overlap and comparisons, findings on the most common environmental and individual contextual factors according to participants, facilitators to participant engagement and the program's impact on participant's behaviors and nutritional choices.

Chapter 8 includes participant demographics and behavior divided by each program – the Parenting Workshops and the Counseling Program, programmatic overlap and comparisons, findings on the most common environmental and individual contextual factors according to participants, facilitators to participant engagement, and the program's impact on participant's parenting approaches.

Finally, Chapter 9 includes a different theoretical framework that Table Views should consider in the program-planning phase, provides recommendations to improve the organization's challenges, community/environmental challenges, programmatic challenges, and individual-level challenges that the organization should consider to improve maternal and child health outcomes for new participants moving forward.

Chapter 2: Theoretical Framework and Literature Review of

Global Maternal and Child Health

Introduction

In this chapter, I first provide the study's theoretical framework – life course theory and the social determinants of health. This is followed by an extensive literature review of the size of the global maternal and child health problem and definitions. Next, I present the global causes of maternal and child health problems, which include maternal poverty as an upstream cause and poor maternal nutrition and health and maternal alcohol abuse as two downstream causes. This is followed by an analysis of global maternal and child health programs and community-based interventions including global responses that have not worked in reducing maternal and child mortality and responses that have worked. Specifically, I provide short case studies on community-based interventions in four countries that have made strides in reducing maternal and child mortality.

Life Course Theory, the Social Determinants of Health and Health Disparities

Life Course Theory

Based on the central tenets of the Barker hypothesis, life course theory (LCT) focuses on the need for a longitudinal approach to maternal and child health (MCH) programs. LCT suggests that an individual's environment and culture heavily influence the manifestation and management of disease (Brown et al., 2013). The theory gained importance in the 1980s after the Barker theory found correlations between low birth weight (LBW) and high rates of particular chronic diseases. Research suggests that there are two critical changes that occur in utero that contribute to poor health outcomes:

plasticity, which is a period when developing organs adapt to stressors in the fetal environment, and epigenetics, which is a response to external environmental stressors that causes a differential expression of genes that may also be protective in the short term (Hogan et al., 2012). LCT also stresses that barriers to health, including economic disparities and health inequity, in the early years of life can have an impact on the health trajectories of children as they mature into adolescents and adults (Fraser, 2013). Events that occur early in an individual's life can impact them later on so it is important that infant health is addressed at different stages in the life course.

LCT is comprised of four implicit tenets: timelines, timing, equity, and environment. The first tenet (timelines) is based on the notion that health behaviors and attitudes persist across generations, often handed down from parent to child (Brown et al., 2013). The second tenet (timing) is based on the notion that periods of vulnerability influence lifelong health as well as social and economic trajectories (Brown et al., 2013). The third tenet (equity) is based on the notion that diseases and treatments affect individuals (via race), families (via cultural beliefs), and communities (via the environment) differently, leading to variations in disease incidence, prevalence, and impact (Brown et al., 2013). The fourth and last tenet of LCT is the view that the broad environment strongly affects the capacity to be healthy.

The environment is conceptualized as three levels: the macro-level nutrition environment, the physical and social nutrition environment, and the biological/nutritional environment. The macro-level nutrition environment is defined by societal and cultural norms and values, which are often expressed as policies made as a society (Herman et al., 2014). The macro-level nutrition environment as it relates to equity includes policies that

influence the steadiness of food access and accessibility such as food assistance programs and legislations that affect nutritional content. The physical/nutrition environment includes home and neighborhood influence. The social/nutrition environment includes influences by friends and family on food values. The biological/nutritional environment includes the cycle from prenatal to infancy/early childhood to adolescence to adulthood/late adulthood. With early life events known to exert strong influences on health status in childhood and beyond, many child health researchers now consider a wide range of early life exposures in research on social determinants: these include care giving and quality of parenting, maternal depression and neighborhood safety (Halfon et al., 2009).

Research shows that many challenges in adult society stem from early childhood development (ECD). These challenges include mental health problems, obesity or stunting, heart disease, criminality, and competency in numeracy and literacy which eventually become an economic burden for any country (Irwin, Siddiqi, & Hertzman, 2007). Therefore, ECD has become recognized as the most important contributor to long-term social and emotional development (Cummins & McMaster, 2006). Evidence shows that ECD programs can have significant long-term health and socio-economic advantages (Kuruvilla et al., 2016). Parenting resources for ECD, school-community outreach and health services have measureable physical, intellectual, and socio-economic benefits for children, their families, and communities (Kuruvilla et al., 2016). The result of positive parenting styles sets the child's development on a positive trajectory as children who are allowed to explore their environments acquire positive learning experiences (September

et al., 2016). Thus, whatever occurs in a child's life in the early years may be an indicator of the child's developmental trajectory and life course (September et al., 2016).

The Social Determinants of Health

Also important to LCT is the idea that social determinants of health (SDH) (economic status, race, educational attainment, etc.) lead to health disparities and inequities in health and these have an early and profound impact on health status across the life course of individuals (Fraser, 2013). Health equity, defined as: "the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically, or geographically" (WHO, 2005a) is increasing becoming a pressing public health issue globally. Health inequities are health differences that are socially produced, systematic across the population, and unfair (Whitehead & Dahlgren, 2006). The key feature of the theoretical framework is the emphasis on social position as the main determinant of inequity (Malqvist et al., 2012). Social position is defined by relations of ownership or control over productive resources and can be captured through social markers such as ethnicity, income, gender, and education (Malqvist et al., 2012). The weight and relevance of the assigned social position is influenced by the socio-economic and political context, including governmental policies, cultural values, and the macroeconomic condition of a country (Malqvist et al., 2012). The impact of these structural factors on equity in health and well-being is mediated by behaviors and living conditions (Solar & Irwin, 2007). Examples of SDH also include income and income distribution, education, social safety networks, employment and working conditions, unemployment and job security, ECD,

gender, race, food insecurity, housing, social exclusion, and access to health services (Mikkonen & Raphael, 2010).

SDH are factors that have an effect on people's health. Social, economic, and environmental inequities can persist across generations, collectively limiting individuals' future health and creating variations in incidence and impact of many diseases (Brown et al., 2013). Society continues to change at a rapid pace in this era of globalization and a better understanding of SDH is therefore becoming increasingly important (Kondo, 2012). A growing body of international evidence suggests that strengthening the determinants of health and well-being beyond the provision of health care services, such as housing, social support, income and food security, is essential to prevent or reduce inequities in health (Commission on Social Determinants of Health, 2008; Health Council of Canada, 2010). Ethnicity is also regarded as a social determinant although emphasis is usually placed on substructures defined by race, culture, family structure, and gender (Baker et al., 2005). These factors directly affect health, specifically maternal health and child mortality. If these factors are negative, a cycle of adverse conditions will ensue.

According to Ansari et al. (2003), a theoretical framework is needed which encompasses a role for SDH while also acknowledging the importance of behavior and biology, and the inter-connectedness of all these factors. International organizations such as the World Health Organization (WHO) and the United Nations (UN) have indeed realized the need for this all-encompassing theoretical framework. The 2008 WHO Commission on Social Determinants of Health (CSDH) identifies persistent and widening health inequities as avoidable and calls for closing the health gap in a generation (CSDH, 2008). In South Africa (SA) and in the Western Cape Province (WCP), maternal poverty,

poor maternal nutrition and health, and maternal alcohol abuse are three risk factors
(mediated by SDH) that have contributed to poor MCH outcomes.

Health Disparities

Addressing SDH disparities rests on evidence of the relationship between these
determinants and health outcomes (Baker et al., 2005). As the first group to offer an
"official" definition for this term, the National Institutes of Health (NIH) specified that
"health disparities are differences in the incidence, prevalence, mortality, and burden of
diseases and other adverse health conditions that exist among specific population groups
in the United States" (Krieger, 2005). This definition has been expanded to the global
population. Health disparities occur by race, ethnicity, sex, socio-economic status, and
sexual orientation, with inequities in screening, incidence, treatment, and mortality across
a number of diseases and conditions, including cancer, diabetes, cardiovascular disease,
infant mortality, and HIV/AIDS (Gehlert et al., 2008). Although a host of hereditary and
individual behavioral factors are linked to health outcomes, we now understand that
social circumstances and environmental factors place minority groups at a distinct
disadvantage in health and disease (Gehlert et al., 2008).

When considering the chain of causation in health disparities, one must consider
upstream, midstream, and downstream factors. Schroeder (2007) estimates that only 10%
of population health differences in the U.S. can be attributed to health care and points to
upstream causes – factors that influence people's underlying health – in order to explain
the bulk of health outcome differences among large social groups defined by
race/ethnicity, class, or country. Upstream factors include social class, gender, age, race,
and level of education. These are the inequities within a society. Upstream interventions

are aimed at fundamental social and economic reform and involve mechanisms for the

redistribution of wealth, power, opportunities, decision-making capacities, and other

resources (Whitehead & Dahlgren, 2006). Low and middle income countries (LMICs)

have attempted to tackle health disparities from a local, regional, or national framework

through inter-sectoral programs based on these three factors.

Upstream or structural interventions are likely to have the greatest impact in terms

of reducing health inequities because they change the underlying conditions in which

people live, work, and play (CSDH, 2008; Marmot et al., 2008). However, previous work

has noted the challenge of addressing upstream determinants of health (Bambra et al.,

2009). According to Gehlert et al. (2008) societal factors that represent upstream

determinants should be included in frameworks for determining population health. In

these frameworks, upstream determinants are defined as features of the social

environment, such as socio-economic status and discrimination that influence individual

behavior, disease, and health status (Gehlert et al., 2008). This relates to the macro-level

environment previously discussed under the fourth tenet of life course theory.

Midstream factors include employment and working conditions, ECD, housing,

and social and physical environments. Midstream interventions aim to reduce risky

behaviors or exposures to hazards and may include strategies to affect health behaviors or

psychosocial factors, and/or to improve material working and living conditions

(Whitehead & Dahlgren, 2006). In this multi-program case study, Table Views provides

the midstream intervention to alleviate the upstream and downstream factors that impact

at-risk Black and Coloured women in the WCP. The physical environment in which a

child lives, including the home, green spaces and parks, has direct effects on health. This

relates to the physical and social environment previously discussed under the fourth tenet

of life course theory. The impact of midstream and upstream interventions on health

equity and SDH is more difficult to evaluate (Sume & Moffatt, 2013). Evaluating

downstream interventions is less complicated.

Downstream factors include behaviors and individual lifestyle factors (such as

poor maternal nutrition and health and maternal alcohol abuse) that influence health

outcomes such as infant/child mortality and life expectancy. Downstream factors also

consider the importance of social and community networks. Downstream interventions

aim to mitigate the inequitable impacts of upstream and midstream determinants of health

and disease through efforts to increase equitable access to health care services and

behavior (Whitehead & Dahlgren, 2006). This relates to the biological/nutritional

environment also previously discussed under the fourth tenet of life course theory.

Viewing health disparities through a lens that incorporates social/environmental

conditions as upstream factors in multilevel models better allows us to design and

implement interventions targeted at levels downstream from those conditions (Gehlert et

al., 2008).

According to Koh et al. (2010), eliminating health disparities first requires

broadening the lens to understand health. Traditionally, the medicine field has looked at

health inequalities through an individual lens that was biological in nature. However,

such an approach, while critically important, represents only part of a needed and broader

population approach (Koh et al., 2010). Expanding to an integrated, multi-level, social

determinants approach complements a focus on individual biology of disease with

attention to social and economic factors, social support networks, physical and social

environment, and social and health policies (Durch et al., 1997; Berkman & Kawachi, 2000; Krieger, 2001). Reducing health disparities, therefore, involves a "whole stream" strategy that combines such upstream and downstream approaches (Koh et al., 2010). An integrated social determinants approach provides varied and complementary lenses through which to view and address health disparities (Koh et al., 2010). The integrated social determinants approach advocated by Koh et al. (2010) can be used to understand health disparities in the WCP as it relates to MCH outcomes. In addition to observing types of disorders (e.g., fetal alcohol syndrome (FAS), LBW babies), this approach includes added lenses involving socio-demographic factors (e.g., social class, gender, age, race, level of education), risk factors (e.g., poor maternal nutrition and health, maternal alcohol abuse), and geography (e.g., rural versus urban).

Size of the Global Maternal and Child Health Problem and Definitions

MCH outcomes are closely linked (Filippi et al., 2006). There were 529,000 maternal deaths in 2000 (WHO, 2004) and it is calculated that around 9.7 million children under the age of five die in the world every year (UNICEF, 2015). Despite widespread gains in access to antenatal care and skilled delivery attendance, contributing to a 45% global reduction in the maternal mortality rate (MMR) over the past quarter century, nearly 300,000 women died from pregnancy and childbirth-related causes in 2013 (UNSCN, 2014). In 17 countries, MMR has actually increased—in some cases substantially (UNSCN, 2014). Between 1990 and 2015, the overall under-5 mortality rate (U5MR) declined by 53%, resulting in approximately 48 million more children reaching their fifth birthday than would have occurred had 1990 mortality rates continued (UNICEF, 2015).

Although some countries have been able to substantially improve infant mortality rates (IMR) of breastfed babies (IMR<1year), children (IMR<5years) and MMRs during the last century, improvements have decreased (Schell et al., 2007). A nation's child mortality rate (CMR), which is also correlated to the nation's MMR, is a key indicator of a country's progress, the quality of its public health system, and its overall environment (Liu et al., 2015; You et al., 2015). Health inequalities, as well as social and environmental determinants may explain the behavior of mortality rates as well as the performance of national health systems (Marmot & CSDH, 2007). About half of under-five deaths occur in five countries: China, Democratic Republic of Congo, India, Nigeria and the Islamic Republic of Pakistan (Liu et al., 2015; WHO et al., 2013). Accelerating progress in child survival urgently requires greater attention to ending preventable child deaths in sub-Saharan Africa as 1 child in 12 in sub-Saharan Africa dies before his or her fifth birthday – far higher than the average ratio of 1 in 147 in high-income countries (WHO, 2015).

MCH is a priority in many countries because it reflects the general quality of life in a society, and a comparison of MCH outcomes across groups reveals important fault lines of inequality (Burgard, n.d). MCH is best understood by two indicators: the IMR and the U5MR and these two indicators are the most insightful indicators of the health of a population. According to UNICEF (2016), the IMR is defined as the probability of dying between birth and exactly one year of age expressed per 1,000 live births. According to the United Nations website (2016), the U5MR is the probability of a child born in a specified year dying before reaching the age of five if subject to current age-specific mortality rates. The IMR is broken down in terms of death by rates of neonatal

mortality and post-neonatal mortality. Although MCH outcomes are associated across the whole life-cycle and into the next generation, the most extreme effects of maternal mortality on child survival are in the pregnancy and neonatal period (Filippi et al., 2006).

Generally speaking, neonatal mortality refers to deaths that occur among infants fewer than 28 days old and post-neonatal mortality refers to deaths that occur among infants that are between 28 days old and one-year-old. Neonatal mortality is becoming increasingly important not only because the share of under-five deaths occurring during the neonatal period has been increasing, but also because the health interventions needed to address the major causes of neonatal deaths generally differ from those needed to address other under-five deaths, and are closely linked to those that are necessary to protect maternal health (WHO, 2015). About 44% of child mortality occurs in the neonatal period (Liu et al., 2015; Wang et al., 2014; WHO, 2013, UNICEF, 2015a), and 45% of child deaths are related to malnutrition, with approximately 70% of child mortality attributed to diarrhea, pneumonia, malaria, neonatal infection, preterm delivery and lack of oxygen at birth, all of which are largely preventable (Liu et al., 2015; UN, 2016a; WHO, 2013). Globally, the neonatal mortality rate fell from 36/1,000 live births in 1990 to 19/1,000 live births in 2015 (WHO, 2015). However, the decline in neonatal mortality from 1990 to 2015 has been slower than that of post-neonatal U5MR: 47% compared with 58% globally (WHO, 2015). Many of these children, however, continue to live in conditions of adversity—marked by extreme poverty, under-nutrition, conflict, and insecurity—and are not afforded the level of care required to ensure that they meet their developmental potential (Grantham-McGregor et al., 2007).

According to Filippi et al. (2006), stillbirths, neonatal deaths, and maternal morbidity and mortality fit together as public health priorities. A significant proportion of perinatal deaths are preventable because they occur as a result of the type of place of delivery and the quality of care received during delivery and accordingly, the prevention of these perinatal deaths is largely reliant on ascertaining the underlying causes (Statistics SA, 2013). Type of place refers to if the birth was an institutional delivery and the quality of care received during delivery refers to if a skilled birth attendant was present. However, skilled attendance is uncommon in many places (Knippenber et al., 2005), and advocates for neonatal care are pessimistic about the likelihood of achieving skilled attendance (Filippi et al., 2006). Infectious diseases, prematurity and complications during labor and delivery are the main causes of under-five deaths globally (WHO, 2015; UNICEF, 2015a).

Investing in maternal health is paramount. In addition to the proven effectiveness and cost effectiveness of many maternal health care interventions (Adam et al., 2005; Graham et al., 2006; Jowett, 2000), there are numerous benefits in addition to the maternal lives saved (Ensor & Ronoh, 2005). Most maternal interventions also directly benefit newborn babies in terms of reduced mortality and morbidity (Becher et al., 2004). Investment in maternal health has valuable equity benefits, since differences in maternal mortality mirror the huge discrepancies between rich and poor people both within and between countries (Kunst & Houweling, 2001). Poor people are especially vulnerable during pregnancy; they have less access to cash and often live further away from health facilities, limiting the health care options available to them (Borghi et al., 2006).

Addressing maternal health, therefore, contributes to global and national efforts to alleviate poverty (Fraser et al., 2004).

Global Upstream Causes of Maternal and Child Health Problems

Maternal Poverty

It is widely accepted that social and economic factors, in particular systemic inequality, influence health negatively (Marmot et al., 2008). Growing socio-economic disparity is a global concern, as it affects population health (Kondo, 2012). Health inequalities become inequitable when such differences are unevenly affected or mediated by social circumstances that are unavoidable, such as income or ethnicity, e.g. (Malqvist et al., 2012). Social forces such as discrimination, segregation, and urban inequality have a direct impact on neighborhoods and further affect social interaction by shaping how people perceive their circumstances, influencing where and with whom they live, and shaping available resources (Gehlert et al., 2008). According to Schroeder (2007), class is a composite construct of income, total wealth, education, employment, and residential neighborhood. Social class encompasses factors influencing health and extends beyond simple measures of occupation and income; it includes family wealth, health literacy, education, employment, degree of autonomy in one's job, and quality of housing (Marmot et al., 2010). One reason for the class gradient in health is that people in lower classes are more likely to have unhealthy behaviors, in part because of inadequate local food choices and recreational opportunities (Schroeder, 2007).

Social inequalities as it relates to MCH also cross gender lines. Gender based stereotypes lead to inequalities in access to fundamental human rights, including nutrition, education, employment, health care, autonomy, and freedom (Brinda et al., 2015). The

consequences of gender inequality are extensive (Brinda et al., 2015). Beyond harming

the health of women, gender inequality hinders global economic growth and overall

social development (Chaaban & Cunningham, 2011). Indeed, a recent World

Development Report identifies gender equality as an instrument to enhance overall

economic productivity of a society and positive health outcomes of children (World Bank

Group (Ed.), 2012). Gender inequality fuels maternal under-nutrition and increases the

incidence of LBW babies (Shah & Shah, 2010) and malnutrition among children of both

genders (Yount et al., 2011; Sethuraman et al., 2006). Furthermore, gender inequality

harms children during antenatal, perinatal, postnatal periods, and during further

development (Brinda et al., 2015).

Recent research by Brinda et al. (2015) used data from the United Nations

Development Programme (UNDP) in which the international organization developed a

Gender Inequality Index (GII). At publication, their study was the first to use GII. Using

an ecological study design, Brinda et al. (2015) examined the association between GII

and various child mortality rates among 138 countries (comprised of 27 low income, 38

low middle income, 30 upper middle income and 43 high income countries that span all

six WHO regions including African, American, East Mediterranean, European, South

East Asian and Western Pacific regions). They found that women living in LMICs suffer

significantly more gender inequality than those living in high income countries; the mean

value of U5MR of 138 countries was 42 per 1,000 live births; and the U5MR was

significantly higher in LMICs than in high income countries (Brinda et al., 2015). The

study confirmed that there were significant positive associations of GII with neonatal,

infant as well as under-five child mortality rates, after adjusting for the effects of major

economic and health service variables (Brinda et al., 2015). Lastly, Brinda et al. (2015)

identified several pathways in which GII may cause child mortality supported by

previous research:

- LMICs with high GII have higher prevalence of maternal under-nutrition (Osmani & Sen, 2003)
- Maternal exposure to domestic violence increases the risk for LBW and preterm births (Shah & Shah, 2010), and
- The reduction of 4.2 million deaths of children below five years, between the years 1970 and 2009, was attributed to the better educational attainment of women (Gakidou et al, 2010)

Findings from the study illustrate the association between upstream causes of MCH

problems (gender, poverty, domestic violence, and maternal education) and poor MCH

outcomes.

Global Downstream Causes of Maternal and Child Health Problems

Poor Maternal Nutrition and Health

Parents play an important role in the development of children's eating habits and

weight status as they are responsible for shaping child's family environments and their

eating environment (Moreira et al., 2016). Maternal nutrition is an important determinant

of young child growth failure (Shrimpton, 2012). Studies have associated children's

malnutrition with maternal illiteracy, lack of education, lack of support in the home,

mothers going back to work early, and neglect (Rikimaru et al., 1998; Ighogboja, 1992;

Maleta et al., 2003; Adekunle, 2005; Van de Poel et al., 2007; Ruel et al., 1999). Poverty

and lack of knowledge play important roles in malnutrition, especially in the developing

world and the nutritional status of children has an impact on their health and development

(AbdElAziz & Hegazy, 2012). The potential detrimental effects of malnourishment are

vast. Malnourishment can cause direct and irreversible structural damage to the brain,

impair motor development, cause significant developmental retardation, affect cognitive development, impair exploratory behavior, impair learning abilities and educational achievement, and can have long-lasting impact on a child's health (Duggan et al., 2008; Victoria et al., 2008). Children who survive malnutrition are at risk of a cycle of recurrent infection and malnutrition as well as learning disabilities which reduce their ability to develop to their full potential and contribute positively to economic development (Victora et al., 2008).

Globally, the prevalence of acute and chronic malnutrition and micronutrient deficiency is high in young children in developing countries, where malnutrition affects one out of every three preschool children (UNSCN, 2004). Although there has been a gradual reduction in the incidence of the condition over the past decade, globally it is estimated that about 52 million children (8%) under the age of five years are malnourished and wasted (low weight-for-height) (UNICEF, WHO, the World Bank, 2014). Black et al. (2013) estimated that 3.1 million child deaths annually, or 45% of all child deaths in 2011, were due to under-nutrition. Under-nutrition affects all age groups and is especially common among the poor and those lacking clean water and good sanitation (Moore et al., 2010). All member states are being encouraged by the World Health Assembly to scale-up efforts to improve maternal infant and young child nutrition (Shrimpton, 2012). The lack of importance given to maternal nutrition is related in part to a weakness of evidence, related to the difficulty of conducting research, as well as a generalized tendency to downplay the importance of those interventions found to be efficacious (Shrimpton, 2012). One of the reasons why the condition has been difficult to control, even though it is largely preventable, is that it is often the result of a constellation

of factors which include socio-demographic, economic, health, and biologic determinants of both the mother and child (Rikimaru et al., 1998; Ighogboja, 1992; Maleta et al., 2003; Adekunle, 2005; Van de Poel et al., 2007; Ruel et al., 1999).

Recent research in Africa has looked at malnutrition as one of the main causes of MCH problems. Tette et al. (2016) considered maternal profiles, social determinants of malnutrition, and the United Nations Millennium Development Goals (MDGs) in their study. Using case-control qualitative methods, Tette et al. (2016) conducted semi-structured interviews with a total of 371 mothers (182 mothers of malnourished children and 189 mothers of well-nourished children) at Princess Marie Louise Children's Hospital in Accra, the largest facility for treating malnourished children in Ghana. Children under the age of 5 years with Moderate Acute Malnutrition (MAM) or Severe Acute Malnutrition (SAM), determined by weight-for-height measurements, their mothers, as well as their unmatched controls and their mothers were studied (Tette et al., 2016). They found that malnutrition in children was associated with socio-economic and demographic characteristics, maternal health and malnutrition, and types of child care.

More specifically, Tette et al. (2016) found that: 1) childhood malnutrition in this population was associated with mothers who were single or cohabiting with a partner, 2) basic education was the predominant educational attainment in the malnourished group recorded by 112 mothers (62.6%), and 3) malnutrition was prevalent in children whose mothers took them to work and those who stayed with their children at home compared with children whose mothers took them to crèche or nursery. This last finding illustrates the importance of ECD centers mentioned under LCT. Interventions specifically targeted at supporting single mothers are likely to prevent malnutrition (Tette et al., 2016). They

have the potential to not only improve maternal well-being but to ultimately protect

against child mortality, which is strongly associated with malnutrition in this and other

settings (MDG4) (Black et al., 2003). Poverty and low maternal education have also been

identified as major determinants of malnutrition in Ghanaian children (Van de Poel et al.,

2007; Ruel et al., 1999). As in the Brinda et al. (2015) study of gender inequality among

138 countries, we again see in the Tette et al. (2016) study the association between

gender, poverty and maternal education and its effect on poor MCH outcomes.

Maternal Alcohol Abuse

Alcohol use contributed an estimated 3.9% to the global burden of disease in 2010,

moving from the eighth highest ranked risk factor in 1990 to the fifth highest ranked risk

factor in 2010 (Lim et al., 2013). Alcohol use during pregnancy (AUDP) is a leading

cause of still birth, spontaneous abortion, preterm delivery, and various child

neurobehavioral problems (Meyer-Leu et al., 2011). In addition, excessive alcohol

consumption postnatal, often accompanied by maternal distraction, neglect, unpredictable

behavior, and other mental health issues, can contribute to a deficient child rearing

environment (Jester et al., 2000). Research over the last three decades around alcohol

consumption shows variation in the drinking habits of pregnant women across the globe.

Prenatal drinking varies among and within populations of the world (Abel, 1998). In the

United States, England, and Canada, 20 – 32% of pregnant women drink, and in some

European countries the rate may exceed 50% (Alvik et al., 2006; Bonati & Fellin, 1991;

Centers for Disease Control and Prevention, 1997; Primatesta et al., 1993; Waterson &

Murray-Lyon, 1989). With regards to world regions, the overall highest rates of heavy

episodic alcohol consumption among men and women are observed in sub-Saharan

Africa (WHO, 2015b). Although Africa has a per capita consumption rate consistent with world averages, men and women in this region report high rates of abstaining from alcohol use, therefore, alcohol consumption among those who do drink is alarmingly high (Hahn et al., 2011).

Substance abuse during pregnancy is an important public health issue affecting both the mother as well as the growing infant (Albrecht et al., 2011). Health concerns related to prenatal substance use have led to public policies and highly visible public health campaigns aimed at reducing alcohol and tobacco use during pregnancy among women (Kulig, 2005; Frohna et al., 1999). The WHO (2016b) advocates community action to reduce risky alcohol consumption and harm, arguing that all members of a community are responsible for action because the burden of alcohol harm is spread across multiple settings, including health services, police services, public spaces, and workplaces. Heavy alcohol consumption during pregnancy may result in high rates of Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Spectrum Disorders (FASD). FASD is the spectrum of disorders caused by maternal alcohol consumption during pregnancy (Hoyme et al., 2005). While the term FASD is an umbrella term used to categorize various outcomes caused by prenatal alcohol exposure; the term FAS is used when the diagnosis is based on different birth defects (craniofacial abnormalities, growth deficiencies, and central nervous systems (Roozen et al., 2016).

Global Maternal and Child Health Programs and Community-Based Interventions

Globally, there have been several programs that have not been successful in improving MCH outcomes and some that have been quite successful. When considering what does not work and what works in improving MCH outcomes, it is apparent that no single intervention alone can address the diverse range of causes of poor MCH outcomes. The UN MDGs is an example of a global program that was not particularly successful in improving MCH outcomes. However, we can look at the First 1000 Days Campaign (from a global and government standpoint) and community-based interventions/community-based organizations (CBIs/CBOs) in several countries that have proven successful in reducing the IMR, U5MR, and MMR. CBIs and CBOs are used interchangeably in this study and refer to community-based initiatives as a whole that receive global or government support but fulfill gaps that international programs and government policies are unable to meet politically or logistically.

Research on the First 1000 Days Campaign, for example, has shown how critical proper nutrition and a stress free environment that is free of alcohol are from conception to the age of two. Evidence also indicates that countries can accelerate progress in health and sustainable development through integrated action within the health sector and across social, economic, and environmental sectors (The Partnership for Maternal, Newborn & Child Health, 2014). The Partnership for Maternal, Newborn & Child Health (2014) conducted a three-year multidisciplinary, multi-country series of studies which were coordinated by PMNCH, WHO, World Bank, and the Alliance for Health Policy and Systems Research, working closely with Ministries of Health, academic institutions, and other partners. The objective was to understand how some countries accelerated progress

to reduce preventable maternal and child deaths (The Partnership for Maternal, Newborn & Child Health, 2014). The Partnership (2014) identified 10 "fast-track" countries that share the same strategies in progressing across three main areas to improve women's and children's health: 1) multi-sector progress to address crucial health determinants; 2) catalytic strategies to maximize health outcomes; and 3) guiding principles to align action and orient progress.

The 10 countries are Bangladesh, Cambodia, China, Egypt, Ethiopia, Lao PDR, Nepal, Peru, Rwanda, and Vietnam. To show a regional perspective, I provide brief case studies of CBIs that focus on maternal knowledge, attitudes, and practices (KAPs) in three African countries (Egypt, Ethiopia, and Rwanda) that have made progress in improving MCH outcomes. Lastly, I present a synopsis of a non-African country, India, a country that has one of the highest CMRs in the world. Although India was not one of the "fast-track" countries identified by the Partnership for Maternal, Newborn & Child Health has still made strides in improving MCH outcomes.

What Has Not Worked

United Nations Millennium Development Goals

The global response to child mortality was viewed by the international health community within the context of the UN MDGs and is now viewed through the new Sustainable Development Goals (SDGs). In September, 2000, 189 countries pledged to support the UN MDGs (Filippi et al., 2006). Globally, several of the eight UN MDGs either directly or indirectly addressed the elimination of health disparities via eradicating extreme poverty and hunger, achieving universal primary education, and promoting

gender equality and empowering women (Koh et al., 2010). The UN MDGs was comprised of 8 goals, 20 targets, and 60 indicators and, while there has been huge progress globally, there are countries that have not shown as much progress. Goals three, four, and five, to promote gender equality and empower women, to reduce child mortality, and to improve maternal health, respectively, are concerned with sustainable human development (SHD) and are directly related to MCH outcomes. The achievement of these three goals reflects a universal concern towards improving the welfare of rich and poor populations around the world, particularly women and children. However, despite the commitment expressed with the Millennium initiative, maternal, newborn, and child health have not been given financial priority internationally (Filippi et al., 2006).

Maternal mortality only affects women in a narrow age range; one dilemma is that the number of maternal deaths can seem small compared with deaths due to other disorders (Filippi et al., 2006). Safe motherhood programs, for example, compete for funding with other priorities such as tuberculosis (2.4 million yearly deaths), malaria (1 million), and HIV/AIDS (3 million) (Filippi et al., 2006). The MDG declaration after the 2005 G8 summit in Scotland referred mostly to infectious diseases and did not draw attention to MCH as an important problem to which further resources should be channeled (Filippi et al., 2006). Furthermore, maternal health represents only a tiny proportion of the overall aid budget in most countries (1% of the aid budget of one of the main donor countries) (Bellagio Study Group on Child Survival, 2003).

Child mortality has decreased by 49% and maternal mortality has decreased 45% worldwide since 1990, but the pace of reduction has varied across countries and 6.6 million children and 300,000 mothers continue to die every year from preventable causes

(Wang et al., 2014; Fenton, 2008; Bhutta et al., 2010; Hsu et al., 2012; Rajaratnam et al., 2010; Lozano et al., 2011). Countries with similar geography, wealth, U5MR and MMR levels have shown wide differences in health progress over the last 40 years (Verguet & Jamison, 2013). According to the Building a Future for Women and Children Report (2012), of the 75 countries where more than 95% of all maternal and child deaths occur, only 23 are on track to achieve MDG 4 (reduce the mortality rate by two thirds among children less than five years of age) and only 9 are on track to achieve MDG 5 (reduce the maternal mortality ratio by three quarters). As the MDGs era draws to a close, there is evidence that the least progress has been made toward the maternal health goal (MDG 5) (Bhutta et al., 2010). A major criticism of the MDGs is that a preoccupation with aggregate outcomes has detracted from much needed attention to the poor and vulnerable, groups that are more difficult to reach than the rest of the population (Gwatkin & Ergo, 2011).

The UN MDGs were focused on social sectors because it was donor-led. As a result, many member states were not happy with this. Furthermore, when the UN MDGs were created there was no formal review process embedded within the indicators. However, reviews were presented through UN reports and outside-UN reports. Created in 2015, the SDGs include 17 goals, 169 targets and an even greater number of performance indicators (McDougall, 2016). Several goals in the SDGs are conditioned by the need for greater progress on women's and children's health, including those on education, gender, water and sanitation, and others (McDougall, 2016). Internationally, MCH remains a key area of focus in the third goal of the UN SDGs that relate to health (Van Minh et al., 2016). According to the UN website (2016b), the goal of UN SDG 3 is to: "Ensure

healthy lives and promote well-being for all at all ages through thirteen targets." The

targets that best fall under the focus of this study are 2 and 7:

> 2) By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births; and 7) By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs.

According to the UN General Assembly (2015), the 2030 SDGs are an ambitious global

commitment to health: more holistic than the MDGs in terms of health needs and

intended to leave no one behind. The creation of the SDGs brings new opportunities to

continue progress towards improving MCH outcomes.

The UN MDGs were viewed as a poverty agenda and developing member states

wanted to bring SHD to the forefront. Instead of dealing with problems in isolation,

member states wanted to look at institutional arrangements to support the UN SDG

agenda. This was due in part to the United Nations Conference on Sustainable

Development in Rio de Janeiro, Brazil in 2012, which was viewed as a turning point in

shifting the agenda and pushing forth a new consensus among member states – a

consensus towards sustainable development. Furthermore, unlike its predecessor, that

lacked a formal review process, the UN SDGs created a forum in which member states

are now discussing a review process and there is growing pressure for countries to report

(however, they are not mandated to report). While only time will tell, a formal review

process will encourage implementation, accountability, and transparency. A formal

review process will ensure that the public is cognizant of the UN SDGs and that the goals

are in the national consciousness. A well-informed public reflects the participatory nature

of the UN SDGs and, indeed, civil society needs to employ pressure on their governments

for progress and national goals that are aligned with the international agenda.

In this vein, the SDGs also look at the role of non-state actors more than the

MDGs did. In public-private or multi-stakeholder partnerships, non-state actors (such as

civil society organizations and businesses) and state actors (such as international

organizations (IOs) and national governments) collaborate across transnational, national,

and local levels to provide collective goods (Beisheim & Liese, 2014). Non-state actors

from within the host country (non-governmental organizations (NGOs) and private sector

entities) and CBOs can also serve as implementing partners and are able to contribute

toward achieving high levels of success in development projects (Shin et al., 2017).

These non-state actors can act as a monitoring group and there is less chance that the

project funding will be wasted (Shin et al., 2017). Along with being more transparent,

non-state actors are more experienced and better equipped to implement development

projects than host governments and are thus more effective and efficient (Edwards &

Hulme, 1996; Woods, 1999). Changing MCH outcomes focuses on actor behavior and

the efficacy of these behaviors has been determined, in part, by the expanding power of

non-state actors within the global health governance arena (McDougall, 2016). In short,

the UN SDGs are much more comprehensive than the previous UN MDGs and hopefully,

with the creation of the new goals, a country like South Africa (SA) will benefit from this

more engaged and focused global policy response to reducing child mortality.

<u>What Is Working</u>

Global First 1000 Days Campaign

It is estimated that more than 200 million children under 5 years of age in developing countries do not attain their developmental potential (Grantham-McGregor et al., 2007). The cognitive and physical development of a child is influenced by the first 1000 days of life, from conception to the second birthday (Gopalan, 1961; Singh, 2001; Pollitt et al., 1997). This, in turn, is affected by biological factors, such as nutrition of the mother during pregnancy, gestational age, birth weight, duration of breastfeeding, childhood malnutrition, childhood infections and psychosocial factors, such as economic status, parental education, and environmental exposure (Masten et al., 2003). It is well accepted that the process of child linear growth faltering in children from developing countries occurs in a critical 1000 day 'window of vulnerability' from conception to 2 years of age (Shrimpton et al., 2001). Policymakers have recently placed a great deal of emphasis on the "first 1000 days" and "0-3" (years) as golden opportunities to influence child outcomes (Cusick & Georgieff, 2016).

The focus on the "First 1000 Days" builds on 3 main sources of evidence: 1) a longitudinal intervention study in Guatemala demonstrated that the growth impact of a high-protein/energy food supplement was largest among children who were exposed to the intervention during their first 2–3 years of life compared with those exposed at older ages (Ruel & Habicht, 1995), 2) an analysis of 54 nationally representative surveys from LMICs that showed a universal pattern of steep decline in children's height-for-age Z-scores (HAZs) from birth until age 23 months, with no evidence of additional

deterioration between ages 24 and 59 months (Victora et al., 2010), and 3) that the importance of the prenatal period for stunting (poor linear growth) is well established (Leroy et al., n.d). Furthermore, a recent meta-analysis estimated that being small-for-gestational age is responsible for an estimated 20% of stunting in children aged 12–60 months (Christian et al., 2013). Indeed, a growing body of evidence is intensifying the focus and interest around the importance of nutrition during the first 1000 days of life, i.e. from pregnancy up to a child's second birthday (Bhutta et al., 2008; Dewey & Huffman, 2009; Victoria et al., 2008). The trajectory of length growth after birth seems to be largely set in uterus (Binkin et al., 1988) even though it can falter from birth to 2 years, such that poor maternal nutrition may be as important as inadequate infant and young child feeding practices in determining height at 2 years of age, depending on the country setting (Dewey & Huffman, 2009; Li et al., 2003).

Global Community-Based Interventions

Many CBIs to improve MCH outcomes have been modeled with the UN MDGs in mind as well as other global initiatives. For example, UNICEF (2015a) has found that: 1) infants who are exclusively breastfed and those who begin breastfeeding soon after delivery have substantially better health outcomes, 2) nutrition interventions can help prevent stunting and/or reduce child mortality, and 3) improvement in drinking water, sanitation, and hygiene are reducing diarrheal infections. CBIs in Egypt and Ethiopia focused on increasing breastfeeding behaviors. Interventions in Ethiopia and Rwanda concentrated on the importance of nutrition. Finally, interventions in Rwanda and India centered on reducing diarrheal infections. In evaluating these interventions it is apparent that environmental contextual factors such as poverty, food insecurity, and poor living

conditions affect vulnerable populations in these countries. Additionally, in Egypt, lack of decision-making power in the household was mentioned as an individual contextual factor that impacts maternal outcomes. Lastly, nutrition counseling, interpersonal communication, the importance of parental-child bonds, health education, and kitchen gardens have shown to be successful practices in improving MCH outcomes across these four countries.

Egypt

Egypt has achieved the MDG 4 target (to reduce child mortality) with a decline of 75% in under 5 mortality between 1990 and 2012: the U5MR was 28 per 1,000 live births in 2008 and 21 per 1,000 live births in 2012, according to UN Interagency modeled data and according to the Egypt Demographic and Health Survey (UNICEF, WHO, World Bank, UN-DESA Population Division, 2013; El-Zanaty & Way, 2008). Egypt nearly halved U5MR between 1990 and 2000 (from 85 to 45 deaths per 1,000 live births) and more than halved the rate further between 2000 and 2012 (45 to 21) (Ministry of Health and Population Egypt, Partnership for Maternal, Newborn & Child Health, WHO, World Bank and Alliance for Health Policy and Systems Research, 2014). The MMR in Egypt has decreased from 106/100,000 in 1990 to 33/100,000 in 2015 (WHO and UNICEF, 2014). National demographic data from Egypt show that many reproductive and MCH outcomes for the country improved between 1990 and 2011 (El-Zanaty & Way, 2008), however, challenges remained, including stagnating neonatal mortality rates and an increase in stunting among children younger than five, from 23% in 2005 to 29% in 2008.

While the country has seen some gains on MCH outcomes, the opposite is true for socio-economic determinants or upstream causes of MCH problems. The share of the

population living below the poverty line has steadily risen since 2000, particularly among

rural inhabitants (WHO, 2010a). The present challenge for Egypt is to reduce regional

and socio-economic disparities, as well as to reduce infant and neonatal mortality (WHO,

2010a). The association between level of education, poverty, and child mortality in Egypt

is clear. For example, a child whose mother has a secondary or higher level of education

has almost half the chance of dying than a child whose mother has no education; likewise,

for the poorest households, the chance of death is more than twice as high as in the

wealthiest households (El-Zanaty & Way, 2008).

Community-Based Interventions in Egypt – Short Case Study

Although health services are widely available and utilized in Egypt, there is little

emphasis on effective counseling and other communication to improve maternal and

newborn health behaviors (Stephenson & Elfstrom, 2012). Families in Egypt frequently

make unhealthy decisions because they lack accurate information, do not feel confident

in their ability to act, or think that others will disapprove of their actions (Brasington et

al., 2016). Comprehensive reviews of strategies to improve maternal and newborn health

have concluded that CBIs encouraging healthy behaviors and appropriate utilization of

health services can be an effective way to reduce morbidity and mortality (Lassi et al.,

2013; Bahl et al., 2010). To tackle these challenges, several sites in Upper and Lower

Egypt were selected to take part in the Smart Choices for Healthy Living (SMART)

project, a joint venture between the United States Agency for International Development

(USAID) and the Maternal and Child Health Integrated Program. Upper Egypt has long

been a focus for development efforts because of high concentrations of poverty; the

region is home to about half of the nation's total population, but 87% of Egyptians who

are extremely poor (Ghanem, 2014). The SMART Community-based Initiatives Program adopted an approach aimed at both individual women and the influencers of their decisions, with the goal of improving neonatal health, and child nutrition outcomes (Brasington et al., 2016).

The project was designed to address the increase in child malnutrition rates by introducing an integrated, community-based reproductive and MCH intervention package (Cooper et al., 2017). The intervention was based around the critical 1,000 day period (the First 1000 Days) and according to a study by Save the Children (2012) can dramatically improve a child's chances of surviving and living a healthy life. The SMART package was comprised of activities around maternal nutrition, exclusive breastfeeding (EBF), and the role of gender and decision-making power in the household, to name a few. Women received these services from CBOs, NGOs, and the private sector. Female community health workers (CHWs) recruited from within the community formed the backbone of the program (Brasington et al., 2016). Intervention activities were conducted in three stages: the individual level, the family level, and at the community level (which was directed at public health leaders and local leaders). Women attended monthly group counseling programs and received nutrition counseling from well-trained CHWs. In their evaluation of the overall impact of the SMART intervention on MCH, Brasington et al (2016) found that the activities reached most women with young children, there was greater coverage and exposure in Upper Egypt, and the intervention had a significant impact on maternal knowledge and, to a lesser extent, behavior, which is consistent with other studies.

Ethiopia

Ethiopia has achieved its MDG 4 target according to the UN Interagency Group for Child Mortality Estimation modeled data, which indicates that Ethiopia reduced its U5MR to 64/1,000 live births in 2013, a 69% reduction since 1990 (UNICEF, 2011). Furthermore, the Ethiopian government reduced poverty from 48% in 1990 to 23% in 2015, and the country experienced improvements in education, roads, water, sanitation, and hygiene (Kuruvilla et al., 2016). Over the same period, child and maternal mortality declined by 71% and 72%, respectively (The Partnership for Maternal, Newborn & Child Health, 2014; You et al., 2012; WHO & UNICEF, 2014). Specifically, the MMR in Ethiopia has decreased significantly from a staggering 1250/100,000 in 1990 to 353/100,000 in 2015 (WHO and UNICEF, 2014). However, this was just shy of achieving the MDG 5 target of 75% reduction and the country is one of the ten countries that contribute to 59% of global maternal deaths (WHO and UNICEF, 2014). Furthermore, Ethiopia also has a disproportionately high number of neonatal deaths; 43% of the under-5 deaths are neonatal deaths (WHO, 2015a). Additionally, child under-nutrition remains high, however, with an estimated prevalence of stunting of 40% among children less than five years of age in 2014, down from 51% in 2005 (Kim et al., 2016). The high maternal and neonatal mortality reflect poor coverage of maternal and neonatal health care services, poor quality of care provided in health facilities, and inequity in access to health services (Wilunda et al., 2016).

Community-Based Interventions in Ethiopia – Short Case Study

The benefits of breastfeeding (BF) and EBF specifically, have been well documented; however, research has also looked at complementary feeding (CF). Typically, CF is introduced after the first 6 months when breast milk is no longer sufficient in meeting the nutritional demands of infants. Complementary food includes the introduction of solid, semi-solid, or soft foods. Adequate infant and young child feeding (IYCF) practices contribute to healthy child growth and development (Bhutta et al., 2013). Infant-feeding practices constitute a major component of child caring practices apart from socio-cultural, economic and demographic factors (Kumar et al., 2006). In Ethiopia, Demographic Health Survey data from 2011 indicated that several IYCF practices were sub-optimal, with only 52% of infants starting breastfeeding within one hour of birth (a decline from 69% in 2005) and 52% of children 0–6 months of age being exclusively breastfed (EBF) (a slight increase from 49% in 2005) (Demographic, 2012).

To tackle these challenges, Alive & Thrive (A&T) Ethiopia was created in 2009 as a multi-year initiative aimed at reducing under-nutrition caused by suboptimal BF and CF practices in four of the most populous regions (Baker et al., 2013). Although the intervention was implemented using a four-component framework, interpersonal communication (IPC) and community mobilization were the focal point of this short case study. IPC focused on the delivery of seven key messages on IYCF to targeted mothers, and community mobilization and mass media interventions were directed at opinion leaders, fathers, and other caregivers (Kim et al., 2016). These messages are also the crux of the Western Cape's First 1000 Days Campaign – discussed in detail in Chapter 3. Funded by USAID, the CBI is a partnership with NGOs and local organizations and

utilizes CHWs and female health extension workers (HEWs) to counsel women at the health facility site or during routine home visits to provide mothers with food demonstrations.

Through these initiatives, A&T encourages social and behavioral change communication (SBCC). SBCC to promote healthy feeding practices is central to any intervention aiming to improve infant and young child nutrition (Lutter et al., 2013). In their evaluation of A&T, Kim et al (2016) found that exposure to large-scale SBCC interventions was associated with large improvements in BF and CF practices in two of the four food-insecure regions. However, several CF practices (dietary diversity, acceptable diet, and consumption of iron-rich food) remained poor as a result of household food insecurity, limited food availability, and resources.

Rwanda

Rwanda's 2015 MDG goal for child mortality was 52 deaths per 1,000 live births (Ministry of Health Rwanda, PMNCH, WHO, World Bank, AHPSR and participants in the Rwanda multi-stakeholder policy review, 2014). According to the UN Interagency Group for Child Mortality Estimation, it had already achieved a U5MR of 54/1,000 live births by 2015, a reduction of more than 70% (WHO & UNICEF, 2014; UNICEF, WHO, World Bank, UN-DESA Population Division, 2013). The MMR in Rwanda has decreased significantly from a staggering 1300/100,000 in 1990 to 290/100,000 in 2015 (WHO and UNICEF, 2014). Rwanda has achieved MDG 4 (WHO, 2016d; WHO & UNICEF, 2014) and MDG 5A (Bucagu, 2016). Like Ethiopia, Rwanda has seen significant reductions in the MMR over the last twenty-five years. However, despite these impressive health gains,

the country still faces significant challenges, including one of the most severe shortages of human resources for health on the continent (Binagwaho et al., 2013). To improve maternal health, the Government of Rwanda, in the context of its vision 2020 and related health sector reforms and policies, has been investing in the essential health interventions for reducing maternal mortality (Bucagu, 2016). Reductions in mortality are associated with both improved coverage of effective interventions to prevent and treat the most important causes of child mortality and with improvements in socio-economic conditions (Ministry of Health Rwanda, PMNCH, WHO, World Bank, AHPSR and participants in the Rwanda multi-stakeholder policy review, 2014).

Community-Based Interventions in Rwanda – Short Case Study

Since 2007, a reform was implemented nationwide with the goal of optimizing the role of CHWs in improving access to the maternal health interventions in Rwanda (Condo et al., 2014). Several studies and reports from governments, United Nations agencies, NGOs, and global partners support the role of CHWs in increasing access to primary health care interventions and services in LMICs (Bucagu, 2016). Bucagu (2016) explored the role of CBIs in improving maternal health in the specific MDG related context of Rwanda through a systematic literature review. The utilization of CHWs was also successful in improving MCH outcomes in Egypt. Some highlights of Dr. Bucagu's work, as it relates to this present study, include the importance of ECDs in impoverished communities (Binagwaho et al., 2016) and the value of CHWs who have been integral in improving MCH outcomes in Rwanda (Condo et al., 2014).

According to Binagwaho et al (2016), the demographic characteristics of many developing nations imply that interventions targeting the period of ECD have tremendous potential to promote population health and socio-economic development. The researchers believe that ECD is a child's human right and when this right is inhibited it plays a factor in the cycle of intergenerational poverty. In addition to recognizing the value of CHWs, the authors agree that CBIs such as ECDs are integral for child development and support the recent election of volunteer women's council's at the village level that champion women's issues, support expectant and new mothers, raise ECD awareness, and promote interaction between parents and children (Binagwaho et al., 2016). In short, Binagwaho et al (2016) argue that combining population level activities with those at the local level, led by local CHWs and women's councils, can bolster community education and ensure uptake of ECD services.

CHWs are increasingly being utilized to alleviate the shortage of human resources for health, particularly in the delivery of interventions for maternal and child health (Bhutta et al., 2010a). By serving as intermediaries between the community and the formal health system, CHWs are uniquely placed to serve resource-poor settings (Condo et al., 2014). CHW systems have been found to be effective in implementing interventions to prevent under-five deaths, including malaria prevention, health education, breastfeeding promotion, essential newborn care and psychosocial support (Gilmore & McAuliffe, 2013). Research by Condo et al (2014) qualitatively evaluated the CHW system in Rwanda through interviews with CHWs and their beneficiaries and identified factors and challenges that impact the CHW system and can inform system improvements. The descriptive study employed focus groups to ascertain the knowledge and practices of

CHWs juxtaposed with the perceptions of CHWs from women in three districts with varying levels of food insecurity. Condo et al (2014) found that while CHWs perceived themselves as key assets to directly improving their communities' health, the effectiveness of CHW system was hampered by an irregular system of supervision and trainings, and many CHWs did not have an educational background in health prior to delivery of health services. However, beneficiaries explained that CHWs provided them with educational messages about topics such as the basics of nutrition, kitchen gardens, healthy meal preparation, and hygiene and were perceived to be very influential in the lives of the women (Condo et al., 2014).

India

India, a MIC with approximately 1.24 billion people (UNICEF, 2013a), has one of the highest child mortality rates in the world. The IMR in India has decreased from 80/1,000 in 1990 to 40/1,000 in 2015 and the U5MR has decreased from 115/1,000 to 52/1,000 in this same period (NIMS, ICMR, & UNICEF, 2012). However, based on robust projections, at the current rate of decline, India was unlikely to meet the targets for MDG 4 (NIMS, ICMR, & UNICEF, 2012). Furthermore, the MMR in India has decreased significantly from 556/100,000 in 1990 to 174/100,000 in 2015 (WHO and UNICEF, 2014). Yet, globally, India contributes the largest share in sheer numbers to the burden of maternal and infant under nutrition, morbidity, and mortality (Raman et al., 2014).

Though "Untouchability" was abolished by the Constitution more than 50 years ago, members of social castes continue to be victims of various forms of discrimination

(Kurian, n.d.). These disadvantaged groups have been divided into the Scheduled Castes (SC), Scheduled Tribes (ST), and to some extent, the Other Backward Castes (OBC). More than 50 years later and in spite of a weakening of the more forbidding caste barriers, SC and ST households remain overrepresented among India's rural poor, illiterate, and in the former case, also the landless (Iverson et al., 2014). The "Untouchability" legacy in India can be compared to the "Apartheid" legacy in SA and while apartheid was abolished more than 20 years ago, Blacks and Coloureds are discriminated against and, as a result, face MCH disparities when compared to their White and Asian counterparts. The social discourse on race views Coloureds as "better" than Blacks in SA, and a social hierarchy exists in SA much like India.

Community-Based Interventions in India – Short Case Study

As previously stated earlier in this chapter, approximately 70% of child mortality is attributed to diarrhea, pneumonia, malaria, neonatal infection, preterm delivery and lack of oxygen at birth, all of which are largely preventable (Liu et al., 2015; UN, 2016a; WHO, 2013) and according to UNICEF (2015a) improvements in drinking water, sanitation, and hygiene are reducing diarrheal infections. In India, diarrhea is one of the big public health challenges, particularly in the unhygienic environment of rapidly-growing urban slums (Pahwa et al., 2010). India experiences more than half a million deaths due to diarrheal disease among under-five children (Boschi-Pinto et al., 2008). The number of these deaths can be substantially reduced by simple remedies, such as rehydration with oral rehydration salt (ORS) and fluids available in the home, continued feeding during diarrheal episode, and breastfeeding (Pahwa et al., 2010). Poor environmental hygiene, coupled with low literacy level and poor awareness of residents,

adversely affects the management of diarrhea in slum areas and contributes to the burden of the disease (Alberini et al., 1996).

Pahwa et al (2010) conducted a community-based health and nutrition-education intervention study in an urban slum in Delhi, India. To reduce the rates of diarrheal infections, the intervention provided women with health and nutrition education on infant-feeding practices, counseling on general diet for better nutritional status, and proper hygiene information (Pahwa et al., 2010). The study was carried out in an impoverished community comprised of a large population of *jhuggis* (shacks or shanty homes) and the target population included a large proportion of young mothers (under the age of 29) with high rates of illiteracy. The researchers educated the participants through the use of focus groups, handouts, demonstrations, group participation, and peer learning. The study revealed that, in the post-intervention period, there was a significant improvement in maternal knowledge of the term ORS, improved knowledge about the dehydration-preventing role of ORS, and the importance of continuing breastfeeding during diarrhea (Pahwa et al., 2010). The study was beneficial in improving the knowledge and attitudes of mothers in the target area (Pahwa et al., 2010).

Conclusion

This chapter provides the theoretical framework for this multi-program case study evaluation and an extensive literature review that included the size of the global MCH problem and definitions, global causes of MCH problems, examples of global responses that have not worked, and examples of global programs that have been quite successful along with short case studies of CBIs in Egypt, Ethiopia, Rwanda, and India. LCT and

SDH are interaction theories and are the best theoretical frameworks to understand the impact an individual's environment can have on the appearance and management of disease. LCT is comprised of four main tenets (timelines, timing, equity, and the environment). SDH are factors that have an effect on people's health and emphasizes an individual's social position as the main determinant of inequity. Health disparities, understood through upstream (maternal poverty), midstream (the intervention – CBO/CBI) and downstream causes (poor maternal nutrition and health and maternal alcohol abuse), explain global trends in maternal and child mortality rates.

While some countries have improved MCH outcomes over the last twenty-five years, hundreds of thousands of mothers and millions of children die in the world every year. MCH is a priority because it indicates the general quality of life in a society and investing in MCH is vital. The global causes of MCH programs are divided into upstream causes (maternal poverty) and downstream causes (poor maternal nutrition and health and maternal alcohol abuse). Maternal poverty arises out of race, ethnicity, educational attainment, and employment, to name a few and can negatively impact unhealthy behaviors. Poor maternal nutrition and health affects child health outcomes such as young child growth failure, malnutrition, and cognitive deficiencies. Maternal alcohol abuse, especially alcohol use during pregnancy, causes preterm delivery, neurobehavioral problems, FAS, and FASD. Recent empirical data is provided to support the upstream causes (Brinda et al., 2015), downstream causes of MCH problems as it relates to poor maternal nutrition and health (Tette et al., 2016), and maternal alcohol abuse (Roozen et al., 2016).

On a global scale, there have been global interventions (UN MDGs) that have not been particularly successful and global programs and CBIs that have been successful in improving MCH outcomes (the First 1000 Days Campaign, Egypt, Ethiopia, Rwanda, and India). The MDGs made the least progress toward the maternal health goal (MDG 5) and has been criticized because it was donor-led, for its preoccupation with aggregate outcomes, and because it lacked a formal review process. The creation of the UN SDGs brings new opportunities to continue progress towards improving MCH outcomes because it is more holistic than the MDGs, looks at institutional arrangements to support its agenda, has a formal review process in the works, and looks at the role on non-state actors more than its predecessor.

The global First 1000 Campaign was developed out of empirical research and has gained the support of policymakers who believe in the importance of nutrition from pregnancy up to a child's second birthday. CBIs in Egypt encourage healthy maternal behaviors by looking at nutrition, EBF, and the role of decision-making power in the household while CBIs in Ethiopia reduced child under-nutrition through messaging targeted at mothers, fathers, and other caregivers. Lastly, CBIs in Rwanda improved maternal health outcomes through CHWs and a focus on the importance of ECDs in impoverished communities while CBIs in India reduced diarrheal infections through nutrition and health education, diet counseling, and proper hygiene information.

Chapter 3: Literature Review – South Africa and the Western Cape Province

<u>Introduction</u>

In this chapter, I first provide an extensive literature review of the general background of South Africa and the size of the country's maternal and child health problem. This is followed by the causes of maternal and child health problems in South Africa which include maternal poverty as an upstream cause and poor maternal nutrition and health and maternal alcohol abuse as two downstream causes. This is followed by a list of maternal and child health government programs and community-based interventions in the country. Next, I offer an extensive literature review of the general background of the Western Cape Province of South Africa and the size of the province's maternal and child health problem. This is followed by the causes of maternal and child health problems in the province, specifically, which are less studied compared to the national level. Next, I provide an analysis of provincial maternal and child health programs that have been successful in reducing poor maternal and child health outcomes. Specifically, I present findings from qualitative interviews with government officials from the Department of Social Development and the Department of Health in the Western Cape which helped inform the selection of Table Views as the site for this multi-program case study.

<u>South Africa – General Background</u>

For several hundred years, South Africa (SA) was a country where quality of life depended on skin color and Black South Africans' human rights were denied. Young children lived a life of hunger and malnutrition, insecurity and trauma, instability, family

breakdown and dislocation of communities, a lack of primary health care and educational opportunities, and the absence of adequate housing, electricity, running water, and sanitation (Atmore, 2013). Apartheid, which lasted from 1948-1994, gave rise to a new form of racism in SA. During apartheid, white "superiority" created discrimination and separation. Afterwards, the principle of "separation in equality" led to systematic racial segregation and to a "positive apartheid" based on a separated development of potentially equal nations (Charasse-Pouele & Fournier, 2006). SA's apartheid history legitimized disparity, the unjust distribution of resources, inferior education, and unequal access to health (Tomlinson, 2014).

The policies of apartheid and the whole social system in SA have created institutional and structural discriminations and large disparities between racial groups in terms of socio-economic status, employment, education, housing, and health services (Charasse-Pouele & Fournier, 2006). The complex history of the country has resulted in a high concentration of impoverished women and children, most of Black or Coloured descent, and subsequent elevated rates in the infant mortality rate (IMR) and the under-five mortality rate (U5MR). When apartheid ended over twenty years ago, there was an optimistic view that health disparities between the four main racial groups would come to an end, or at the very least diminish. However, the legacy of the racist apartheid system of state-sanctioned discrimination continues to manifest itself in unequal health conditions, with a three- to four-fold difference in the IMR between Blacks and Whites (Burgard & Treiman, 2006).

The apartheid bureaucracy collected census and vital information according to the following categories: Black (of African descent), White (European), Asian (Indian and

Pakistani), and Coloured ("mixed race") and every public agency in the country used these data to enforce differential treatment under the law, unequal distribution of education and welfare funds, and so on, further reifying these constructed racial categories (Birn, 2009). These designations have historical significance, and their continued use in SA is important for monitoring improvements in health and socio-economic conditions, identifying vulnerable elements of the population, and planning effective prevention programs (Gossage et al., 2014). Because of past apartheid policy (enforced segregation by race/ethnicity), darker-skinned peoples are overrepresented in the lower SES categories (May et al., 2000). Statistics SA (2015), which provides the most up-to-date population information, estimated that the mid-year population in 2015 was 54.96 million. The mid-year population estimates in 2015 by population group was approximately 44,228,000 (80.5%) African, 4,832,900 (8.8%) Coloured, 1,362,000 (2.5%) Indian/Asian, and 4,534,000 (8.3%) White (Statistics SA, 2015). There are eleven official languages in SA – Afrikaans, English, IsiXhosa, IsiNdebele, IsiZulu, Sepedi, Sesotho, Setswana, SiSwati, Tshivenda and Xitsonga (SA Census, 2011).

SA, officially the Republic of South Africa, is a parliamentary republic. The World Bank classifies the country as an upper middle income country (UMIC) and, according to the World Health Organization, the GNI per capita was $12,240 in 2013 (WHO, 2015). However, it is marked by very high levels of inequality (Coovadia et al., 2009). According to the results in the Quarterly Labor Force Survey for quarter 2 in 2015, the working-age population was 36 million – 15.7 million employed, 5.2 million unemployed, and 15.1 million not economically active thus resulting in an unemployment rate of 25% (Statistics SA, 2015a). As of 2010, the poverty headcount ratio at national

poverty lines was 53.8% (World Bank, 2016). The poverty headcount ratio is an indicator

used by the World Bank that represents the percentage of a population that lives below

the poverty line.

Income inequality in the country is among the highest in the world (Statistics SA,

2004) and high levels of poverty and unemployment exist (Klasen & Woolard, 2009). As

of 2013, life expectancy at birth for 2015 was estimated at 60.6 years for males and 64.3

years for females in SA (Statistics SA, 2015). The WHO life expectancy for the sub-

Saharan region at birth was 59 years (WHO, 2013). However, the life expectancy in

countries similar to SA on income is 74 years (WHO, 2013). Clearly, when compared to

other (UMICs), SA's life expectancy is not faring as well as might be expected.

South Africa – Size of the Maternal and Child Health Problem

It is important to understand SA's main demographics specific to maternal and

child health (MCH) – the under-five population, maternal mortality rate (MMR), IMR

and the U5MR – in order to completely understand the nature of the problem. According

to the Countdown to 2015: Maternal, Newborn & Child Survival country profile on SA

for 2015, the total under-five population was 5,370,000 (WHO, 2015a). The MMR for

2015 was estimated at 138/100,000 live births, the IMR was estimated at 34/1,000 live

births, and the U5MR was estimated at 41/1,000 live births (WHO, 2015a). This was

significantly higher than the United Nations Millennium Development Goals (UN

MDGs) target of 27/100,000 for the MMR and 20/1,000 for the U5MR (WHO, 2015a).

The MMR in SA has increased from 108/100,000 in 1990 to 138/100,000 in 2015 (WHO

and UNICEF, 2014). While SA's MMR was comparable to Egypt's MMR in 1990 at

106/100,000 (see Chapter 2), we see that while Egypt has main significant strides in reducing maternal mortality, SA has not fared as well.

SA faces a quadruple burden of disease (tuberculosis, HIV and AIDS, high levels of maternal and child mortality and other communicable diseases, injuries, and non-communicable diseases, or NCDs) that is linked to poverty and deprivation (Ataguba et al., 2015). The Global Burden of Diseases, Injuries, and Risk Factors Study (GBD) is the largest and most comprehensive effort to date to measure epidemiological levels and trends worldwide with more than 1,600 GBD collaborators from 120 countries participating in the most recent update (Institute for Health Metrics and Evaluation, 2016). In terms of DALYs (disability-adjusted life years) in SA, unsafe sex, alcohol and drug use, and child and maternal malnutrition were the leading risk factors in 2013 (Institute for Health Metrics and Evaluation, 2016a).

Life Course Theory (LCT), explained in the previous chapter, considers the chain of causation in health disparities; through upstream, midstream, and downstream factors. In this chapter, I focus on the upstream and downstream factors, exclusively. Midstream factors and interventions will be discussed in Chapter 5 – Provider Views of the Community. The upstream causes of MCH problems in SA and, more specifically, the Western Cape Province (WCP) include social inequities in class, gender, age, race, level of maternal education, and living conditions. Higher rates of U5MR reflect longstanding sources of disadvantage and persistent inequities (UNICEF, 2015a). When looking at class, maternal education and living conditions, specifically, children from the poorest households are, on average, 1.9 times as likely to die before the age of 5 as children from the richest households, children of mothers who lack education are 2.8 times as likely to

die before the age of 5 as children whose mothers have a secondary education and

children from rural areas are 1.7 times as likely to die before the age of 5 as children from

urban areas (UNICEF, 2015a). The downstream causes of MCH problems in SA and,

more specifically, the WCP are poor maternal nutrition and health and maternal alcohol

abuse. Inequalities in class, gender, age, race, and level of maternal education have

impacted the nutritional and health status of mothers which has resulted in a high

prevalence of stunting and underweight children and has impacted the drinking patterns

of pregnant women which has resulted in a high prevalence of Fetal Alcohol Syndrome

(FAS) and Fetal Alcohol Spectrum Disorder (FASD), respectively.

Upstream Causes of Maternal and Child Health Problems in South Africa

Maternal Poverty

Past policies of segregation and discrimination have left a legacy of inequality and

poverty and, in more recent decades, low economic growth (Woolard, 2002). The

apartheid system was heavily biased towards providing health, education, and housing

services to the White minority, to the detriment of the Black population, who were denied

the opportunity to accumulate human and physical capital (Woolard, 2002). As a result,

large populations of women in SA suffer from unemployment or underemployment, low

levels of educational attainment, and substandard living and working conditions.

According to May et al. (1998), in a report to the Deputy State President, SA is an UMIC

in per capita terms, but despite this relative wealth, the experience of most South African

households is of outright poverty or of continuing vulnerability to being poor. In SA,

poverty varies from province to province because of large differences in economic

structure between the provinces (Serumaga-zake et al., 2005).

The government of SA has, for some time, put in place socio-economic policies and programs to alleviate poverty, such as affirmative action, feeding schemes for school children, free medication for pregnant women and children, and programs to promote education and skill acquisition (Serumaga-zake et al., 2005). A democratic SA recognized the challenge of poverty and designed a specialized Poverty Alleviation Programme (PAP) to address rural poverty with specific reference to the socio-economic conditions of women, the disabled, and the youth (Tsheola, 2012). However, Bado (2012) shows that poverty alleviation interventions in many African countries, including those implemented by state agencies, have been largely ineffective. According to Bado (2012), the ineffectiveness of poverty alleviation interventions is a result of the reliance on a top-down development approach which disempowers communities. Therefore, an evaluation of a community-based organization (CBO) that was created to alleviate poverty through income generating projects, for example, are vital and provides a bottom-up approach that may empower impoverished communities in the WCP.

Despite the priority given to reducing poverty and inequality by successive governments since the end of the apartheid era in 1994, most studies document an increase in poverty rates in SA between 1993 and 2000, which has declined only marginally since 2000 (Statistics SA, 2002; Özler, 2007; Leibbrandt et al., 2010a, 2010b). Apartheid also unequally distributed resources (including land, mining rights, and access to capital) thereby marginalizing a large sector of the population to menial and poorly paid sectors of the labor market, if granting access at all (Woolard, 2002). This inequality affects the majority of its population, who still live in poverty-stricken areas with inadequate material resources and poor service delivery (Møller, 2007). In turn, these

negative factors have resulted in poor MCH outcomes. Furthermore, SA has socio-economic challenges that may affect or influence parental knowledge and parenting styles (September et al., 2016).

In SA, experiences of parenting are strongly shaped by context (Walker, 1995), which is intimately tied to the geographies of apartheid (and post-apartheid), structures of economic inequality, and state policymaking. In addition, the distribution of income and wealth in SA is among the most unequal in the world, and many households still have unsatisfactory access to education, health care, energy, and clean water (Stellenberg et al., 2008). In 2012, it was reported that there were approximately 5.3 million children under the age of five living in SA (September et al., 2016). As per the General Household Survey conducted in 2011, 58% of these children are living in poverty where the household family income is R604 per month (Ataguba et al., 2015). This translates to approximately $40US per month.

After the new democratic government came to power in 1994, Blacks migrated in large numbers, especially to areas in which they had previously been denied the right to live and to areas from which they had been forcibly removed during apartheid (Serumaga-zake et al., 2005). It is common knowledge that many large informal settlements were established and grew dramatically in or near the cities during the 1990s (Serumaga-zake et al., 2005). Informal settlements, particularly in the South African context, refer to "settlements of the urban poor that have developed through unauthorized occupation of land," are, in variable ways, dangerous and unhealthy living environments (Huchzermeyer & Karam, 2006:3). The term informal settlements are sometimes viewed negatively by both residents and outsiders, especially as a place where children face harsh

conditions. Bartlett et al. (1999) explored the dimensions of poor (often informal)

housing and identify a host of material and social concerns for impoverished children,

including overcrowding, sanitation, neighborly relations and violence, among others.

In low-and- middle income countries (LMICs), children experience high levels of

violent discipline and psychological aggression (UNICEF, 2014). For instance, in SA, a

recent survey using child-report data in low-income contexts found lifetime prevalence

rates of 55% for physical abuse and 36% for emotional abuse, with caregivers as the

primary source of abuse (Meinck et al., 2016). Research shows that poverty may result in

poor health, poor parenting, and child maltreatment. Systematic reviews have

demonstrated promising evidence that parenting programs may reduce the risk of child

maltreatment and child behavior problems while improving positive parenting, parental

mental health, and ECD outcomes in families with young children (Barlow et al., 2006;

Chen & Chan, 2016; Furlong et al., 2013).

Downstream Causes of Maternal and Child Health Problems in South Africa

Poor Maternal Nutrition and Health

Considering SA's burdens of malnutrition, the lack of food and nutrition security

and the need for multi-sectoral interventions, the low health sector budgetary allocation

by government to nutrition (less than 0.3% of the health budget) is a further problem

(Hansen et al., 2015). SA is classified as one of 36 high-burden countries for child

malnutrition, with specific reference to a stunting prevalence of higher than 20% (Black

et al., 2008). In SA, 7% of children under 5 die each year; and 12% of under-5 children

are underweight; 5% of South African children less than 5 years old suffer from wasting

(low weight for height), and over a quarter of under-5 children suffer from stunting (low

height) for age (UNICEF, 2013). At first sight, these figures may appear low compared with stunting rates that exceed 40% in countries such as Bangladesh, Ethiopia, or Malawi (May & Timæus, 2014). Yet, when compared with its gross national income (GNI) adjusted for purchasing power parity, SA, along with other relatively high-income African countries such as Gabon, Botswana and Equatorial Guinea, lies well above the global trend for countries that enjoy a similar level of economic prosperity (May & Timæus, 2014).

Exclusive breastfeeding (EBF) and immunological protection has been identified as the best way to provide infants with the necessary nutrients, especially within the first six months of life. The lowest rate of EBF is noted in some African countries, like South Africa at 13.7% (Henriques, 2015). Globally, only two out of five newborns are put to the breast within an hour of birth and two, and two out of five infants worldwide are exclusively breastfed for six months, as recommended, with large disparities among countries (UNICEF, 2015a). In SA, fluids and food are introduced to infants as early as 2 - 4 weeks after birth (Sibeko et al., 2005; Mamabolo et al., 2004; Steyn et al., 1993). A variety of foods in the diet is needed to ensure that the nutrient needs of breastfed and non-breastfed children are met (WHO 2001, 2005) and the concept of dietary variety is embedded in the South African pediatric food-based dietary guidelines (Bowley et al., 2007). Furthermore, poverty, insufficient knowledge on infant feeding, and cultural practices may affect the adequacy of the complementary diet (Du Plessis et al., 2013).

In the post-apartheid era since 1994, a major challenge has been to monitor the nutritional status of all South Africans, since data reported during the apartheid years often excluded the majority of the population, namely mainly Black South Africans as

well as Coloureds and those of Asian/Indian descent (Iversen et al., 2011). Since the end of apartheid, the South African government has taken strides to improve nutritional outcomes for mothers and children. In 1994, the Integrated Nutrition Programme (INP) was established to replace previous fragmented nutrition programs and is supported by the fact that sound nutrition is considered a basic human right according to the South African Constitution (Iverson et al., n.d.). The INP is a broad national nutrition strategy focusing on infants and young children, at-risk pregnant and lactating women, and those affected by chronic diseases (Andreson et al., 2009). This was later advanced by three other nutritional programs, the Nutrition Supplementation Programme (NSP), the Nutrition Therapeutic Programme (NTP) and the National School Nutrition Programme (NSNP).

NSP gives nutrition supplements, education, and guidance to expectant women and children in the country. The main components of the NSP are provision of nutrition supplements according to age-specific criteria, including breast milk substitutes, infant porridge, energy (high caloric) drinks and maize meal porridge, together with nutrition education and consultation on long-term solutions for the clients (Western Cape Department of Health, 2007). Porridge made with maize meal is commonly used as complementary food by South African mothers (Mamabolo et al., 2004; Faber, 2005; Mushaphi et al., 2008) and although fortification of commercial maize meal was mandated in 2003 (Department of Health, 2004), the impact thereof on infant nutrition is probably minimal because of the small amounts that infants and young children consume.

NTP, a component of the INP, is a targeted supplementary feeding program which involves the provision of food supplements at primary health clinics (PHCs) to correct

nutritional deficiencies in vulnerable groups (Implementation Policy Guidelines for Nutrition Therapeutic Programme, 2011). These groups include babies and children (0–18 years), pregnant and lactating women, and patients diagnosed with HIV, Tuberculosis (TB), and other chronic diseases (Hansen et al., 2015). In 1994, the NSNP under the Department of Basic Education was created as a school feeding scheme for student learners in less advantaged communities in SA. Indeed, schools are uniquely positioned to promote healthy eating behaviors and attitudes among children, which may be the foundation for future dietary preferences and eating behavior in their adult lives (Perez-Rodrigo & Aranceta, 2001; Weichselbaum & Buttriss, 2011).

Maternal Alcohol Abuse

Alcohol consumption in SA has a long and complex social, cultural, and political history (Olivier et al., 2016). In the past, South Africans consumed alcohol in their homes as rituals and used the barter system where alcohol was traded for cattle. During the colonial times from 1652 to 1948, settlers introduced the 'dop' system whereby farm workers were partially paid with alcohol for their labor (London et al., 1998; London, 2000). When apartheid began in 1948, alcohol was used paternalistically to economically and socially control mine and farm workers (Olivier et al., 2016). Heavy drinking among men and women, including pregnant women, in SA can be traced back to a time during apartheid when workers, in particular, persons of mixed race (Coloureds), were paid in the form of alcohol (Eaton et al., n.d). These South Africans were banned from consuming alcohol in White-owned establishments and, as a result, taverns (also known as *shebeens*) were created in Black and Colored townships.

According to the WHO (2011), SA has been rated as one of the countries with the riskiest drinking patterns. In SA, 34% -51% of women report prenatal drinking (Croxford & Viljoen, 1999; May et al., 2007). SA also fell into the second highest category (medium consumption level) of countries that have harmful patterns of drinking and into the category of countries with the highest level of past year heavy episodic drinking, for both male and female drinkers (WHO, 2011). Alcohol consumption in the country is the result of SA's complex history and consumption has produced high rates of FAS and FASD, rates that remained under-reported until the end of the last century (Olivier et al., 2016).

Heavy alcohol consumption has resulted in social and health problems for the South African population in the form of FAS and FASD. According to the Centers for Disease Control and Prevention (2017) website, FAS is a condition that causes physical and mental disorders in children whose mothers drank alcohol heavily during pregnancy and is characterized by abnormal facial features, growth retardation, and central nervous system problems. FASD is the term used to describe the spectrum of effects that can result in persons who mothers drank alcohol during pregnancy (Centers for Disease Control and Prevention, 2005). FASD is directly linked to a multitude of negative health outcomes including deficiencies in the growth and development of mental and physical capabilities, particularly damage to the central nervous system (Eaton et al., n.d). FASD is an umbrella term describing the range of a spectrum of physical, mental, behavioral and/or learning disabilities which are caused by maternal alcohol consumption during pregnancy (Murthy et al., 2009). In an in-school study of nine schools conducted in SA,

Italy and the USA, May et al. (2007) found that SA has the highest FASD among the

three countries with an average of 72.3 FASD children per 1,000.

South Africa – Maternal and Child Health Government Programs and Community-Based Interventions

Several national programs have been put in place in response to the issue of poor

MCH in SA. As a UMIC that has dedicated substantial resources to health and human

capital investments, SA has a progressive Constitution that guarantees the right to health

care and a vibrant civil society. The South African Constitution binds the state to work

towards the progressive realization of the right to health (Eyles et al., 2015). Specifically,

according to Chapter 2: Bill of Rights of the Constitution of the Republic of SA (1996):

> Everyone has the right to have access to health care services, including
> reproductive health care; sufficient food and water; and social security, including,
> if they are unable to support themselves and their dependents, appropriate social
> assistance.

National Health Insurance (NHI) is the fundamental agency by which the South African

government aims to achieve universal healthcare coverage (UHC).

The MDG target for the U5MR for 2015 was 20 per 1,000 live births and while

South Africa has successfully reduced this rate over the 15 year time period, there is

much more to be done. According to the Assembly of the UN General (2015), the 2030

SDGs show an ambitious global commitment to health: more holistic than the MDGs in

terms of health needs, underpinned by UHC, and intended to leave no one behind. This

new approach is also reinforced by the Every Woman Every Child Global Strategy for

Women's, Children's and Adolescents' Health (2016–2030) with its "survive, thrive, and

transform" objectives together with a target to achieve UHC (Kuruvilla et al., 2016).

UHC is elaborated in the South African National Development Plan (NDP). The NDP

aims to eliminate poverty and reduce inequality by 2030 (National Development Plan, 2012). In addition, a key emphasis in the first phase of the NHI reforms in SA is on ensuring that not only curative, but also preventive primary health services, which engage other relevant sectors, are dramatically improved (Ataguba et al., 2015).

Another critical factor that facilitated improvements in MCH was the establishment of Ministerial Committees that review and analyze newborn and child deaths, provide oversight, and make recommendations for improving newborn and child health (Statistics SA, 2015b). The Maternal, Neonatal, Child and Women's Health and Nutrition (MNCWH&N) Strategic Plan 2012–2016 aims to identify and strengthen priority interventions that would have the greatest impact on reducing maternal, neonatal and child mortality and is comprised of eight key strategies which are identified for improving coverage, quality and equitable access of these interventions (Statistics SA, 2015b). The introduction of large-scale social programs, including the implementation of better sanitation and infrastructure in poor areas and free medical care for pregnant women and young children, was an effort to reduce the prevalence of many of the major risk factors for death in infancy and childhood (Burgard & Treiman, 2006). Additionally, there are social service programs funded by the South African Social Security Agency (SASSA) that give mother's money because of their socio-economic status and to support their children.

The Western Cape Province – General Background

SA is comprised of nine provinces: the Eastern Cape, the Free State, Guateng, KwaZulu-Natal, Limpopo, Mpumalanga, the Northern Cape, the North West and the Western Cape. The WCP is the southernmost province in SA and is divided into six municipalities: the Cape Winelands District Municipality, Central Karoo District, the City of Cape Town Metro Municipality, Eden District Municipality, Overberg District Municipality and the West Coast District Municipality. **Figure 1** below is a map of the Western Cape:

Source: Retrieved from http://www.samj.org.za/index.php/samj/article/viewFile/8158/6400/46146

Of the 6.2 million people in the WCP, the location of this study, 50.7% (approximately 3.1 million) are female (Statistics SA, 2015). The percentage distribution of the WCP by population group is approximately 48.8% Coloured, 32.8% Black African,

15.7% White, 1.6% identified as other, and 1% Indian/Asian (SA Census, 2011). Almost

half of the population residing in the WCP is Coloured and the WC is the only province

in the country where the black African population is not the majority (SA Census, 2011).

The racial demographics of the WC are significant and why the province was selected as

the location for this multi-program case study. While there are eleven official languages

spoken in the province, Afrikaans (49.6%), IsiXhosa (24.7%) and English (20.2%)

comprise the three languages most spoken in the WCP (SA Census, 2011). The majority

of people in all districts, except the City of Cape Town were Afrikaans speaking (SA

Census, 2011). Language and race are interlinked. People who identify as Black African

generally speak IsiXhosa and people who identify as Coloured generally speak Afrikaans.

According to the Western Cape Government Provincial Strategic Plan (2015), in

terms of economic contribution to national Gross Domestic Product (GDP), the Western

Cape is the third largest contributor province behind Gauteng and Kwazulu-Natal.

However, in per capita income terms, the WCP residents are, on average, the most

affluent of all South Africans (Pauw & Du Plessis, 2005). Despite these, the province is

still marred by high poverty rates, unemployment, and inequalities in the distribution of

income between various population subgroups, (Pauw & Du Plessis, 2005). In 2014, the

Western Cape economy contributed 13.8% of the national GDP (Western Cape

Government Provincial Strategic Plan (2015). The Western Cape's broad unemployment

rate, including discouraged work seekers, stood at 25.5% in 2014 and is a driving factor

of multiple social ills in the province (Western Cape Provincial Strategic Plan, 2015).

Compared to the other nine provinces in SA, the WCP has the highest overall life

expectancy at birth is 68 years old (Msemburi et al., 2014). This is higher than the

national life expectancy at birth of 60.6 years for males and 64.3 years for females

(Statistics SA, 2015).

The Western Cape Province – Size of the Maternal and Child Health Problem

It is important to understand the WCP's main demographics specific to MCH

(under-five population, MMR, IMR, and the U5MR). About 10% of the population is

under the age of five (Groenewald et al., 2016), which is similar to the national under-

five population. According to the Western Cape Government Department of Health

Annual Report (WCDOH) (2015) and Groenewald et al (2016), the MMR in the province

was 75.99/100,000 live births in 2013, which is significantly lower than the national

average of 138/100,000. The IMR for 2012 was estimated at 19/1,000 live births and the

U5MR was estimated at 23/1,000 live births (WCDOH, 2015). Compared to the

country's overall IMR and U5MR at 34/1,000 and 41/1,000, respectively, the WCP has

also seen strides in reducing the child mortality rates.

Data from the WCDOH Annual Report (2015) found that the leading causes of

maternal deaths were non-pregnancy related infections (33.5%), medical and surgical

disorders (19.5%), hypertension (18%), pregnancy-related sepsis (8%), and obstetric

hemorrhage (7%). The proportion of deaths due to medical and surgical disorders

continues to increase (11% in 2008 to 2010, compared with 19.5% in 2011 to 2013);

highlighting the need to improve services that manage pregnant women with pre-existing

conditions especially HIV and antiretroviral therapy (ART) (WCDOH, 2015). Data from

the WCDOH Annual Report (2015) found that the leading causes of death in children

under the age of five in 2012 were neonatal causes, diarrhea, pneumonia, injuries, and

congenital causes. Neonatal causes may be as a result of the three risk factors looked at in

this study: maternal poverty, poor maternal nutrition and health, and maternal alcohol abuse.

Upstream Causes of Maternal and Child Health Problems in the Western Cape Province

Maternal Poverty

The WC is the third richest province in SA, but poverty, inequality and unemployment remain real issues (Pauw & Du Plessis, 2005). The majority of the WCP population (64.2%) resides in the City of Cape Town Metro Municipality – the location of this study (SA Census, 2011). Poverty is closely correlated with race and gender, and is concentrated in rural areas (Du Toit, 2004). There are vast differences in poverty and unemployment rates between racial groups, and although income inequality in the province is lower than the rest of SA, it is still high according to international standards (Pauw & Du Plessis, 2005). The majority of agricultural households in the WCP are Coloured (Pauw & Du Plessis, 2005). Furthermore, female-headed households also tend to be disproportionately poor, which Woolard & Leibbrandt (1999) attribute to a combination of factors: female-headed households are more likely to be in the rural areas where poverty is concentrated, female-headed households tend to have fewer adults of working age, and female unemployment rates are higher than men.

The causes of poverty in the WCP are complex and multi-leveled (De Swardt et al., 2005). Increasing levels of monetization and the marginal and underdeveloped nature of agrarian livelihoods in the Eastern Cape Province (one of the nine provinces in SA) clearly play an important part, which has meant that urban in-migration from the Eastern Cape Province to Cape Town has continued unabated (De Swardt et al., 2005). Mirroring

what occurred on the national level after the new democratic government came to power in 1994; Blacks in the WCP migrated to large informal settlements within the province (Serumaga-zake et al., 2005). There was a rising trend in the WCP for the percentage of Black households living in shacks or huts in urban informal settlements (colloquially known as 'squatter camps') (Serumaga-zake et al., 2005). And overall, the percentage of urban households living in shacks or huts rose from 10% in 1995 to 13.5% in 1999 (Serumaga-zake et al., 2005).

<u>Downstream Causes of Maternal and Child Health Problems in the Western Cape Province</u>

Poor Maternal Nutrition and Health

Research on malnutrition among mothers and children under the age of five in the WCP is limited. Recent evaluations have been completed, however, to look at the effects of malnutrition among parents and school-aged children in primary schools (de Villers et al., 2015) and nutrition programs offered to HIV-positive women (Hansen et al., 2015) in the province. For example, in a study by de Villers et al. (2015) on the HealthKick (HK) intervention (initiated in primary schools in low-income settings in the WCP to promote healthy lifestyles), the study showed that learners lacked physical activity, had unhealthy diets, and were underweight. Top health priorities identified for parents were substance abuse, tobacco use, and unhealthy diets (de Villers et al., 2015). In their evaluation of selected aspects of the Nutrition Therapeutic Programme (NTP), which is offered to HIV-positive women of child-bearing age in the WCP, Hansen et al. (2015) found that the majority of women were unemployed, indicated severe household food insecurity, and had low educational attainment.

Maternal Alcohol Abuse

Known for its beautiful and vast vineyards and wineries, which produce some of the world's best wines, the WCP attracts tourists from all over the globe. However, the legacy of prenatal alcohol exposure (PAE) in South Africa spans back to the 1700s when Europeans began wine farming in the Cape (McKinstry, 2005). SA is economically dependent on the multi-billion Rand liquor industry (Falletisch, 2008) and the WCP is the hub for wine production. Indeed, fruit orchards, grape-growing, wine production, and agriculture dominate large areas of the WCP of SA (May et al., 2007). Many people of the WCP are involved in growing grapes and producing wine and this has influenced the modal regional drinking patterns (May et al., 2000). For several centuries, wine was distributed among and consumed daily by workers as partial payment for labor (May et al., 2000). This custom is referred to as the "dop" system (May et al., 2000).

A number of studies contend that current problematic drinking practices in low-income WC Coloured farm worker communities are vestiges of the "dop" system practiced during the colonial and apartheid eras in SA, which entailed farm workers receiving crude wine several times during a working day as part of their payment (Lesch & Adams, 2016). Coloured farm workers were viewed as cheap laborers and were therefore paid as such. London (1999, 2000) contends that the "dop" system still impacts current generations of low-income Coloured communities in the WCP. While the "dop" system has been prohibited by legislative acts, its history is still very much alive among residents of the province. The practice has been illegal since 1928, but in 1998 researchers found that the system was still practiced on 20% of the fruit farms in 1993 and on 9.5% of the farms in the Stellenbosch area in 1998 (London, 1999; Te Water Naude et al., 1998; Ferreira, 1998). Additionally, cheap spirits to include liquor, wine,

and beer are available for purchase in illegal bars (known as *shebeens*) within the province.

Alcohol is readily available and often consumed by residents, specifically women, which has created child health outcomes in the form of FAS and FASD. Nearly half (42.8%) of pregnant women surveyed in a WCP study reported drinking alcohol during pregnancy, and over half who drank consumed enough alcohol to place their unborn children at "high risk" for FAS (Croxford & Viljoen, 1999). The rates of FAS in the WCP of SA are among the highest reported in the world (Crede et al., 2011). In 2000 it was estimated, in one high-risk community in the WCP (which was anonymous in the study), that the rates of FAS were 40.5-46.4/1,000 (May et al., 2000). Two later studies, conducted in the same area, estimated higher rates of FAS of 65.2-74.2/1,000 (Viljoen et al., 2005) and 68-89.2/1,000 (May et al., 2007). Even more alarming, according to May et al. (2013), the prevalence of FASD in the WCP is the highest documented in the world (136 to 209 per 1,000 children or 13.6% to 20.9%). In a follow-up study, May et al. (2014) found that mothers of children with FASD had significantly lower mean weight and BMI (24.9 vs. 27.3) than did mothers of controls, mothers of children with FASD were two times more likely to reside in a rural area during the pregnancy (which generally means lower SES), and mothers of children with FASD had three fewer years of education.

In the WCP farm worker community, the legacy of the 'dop' system is manifested in the growing incidence of FAS among children of farm workers (Viljoen et al., 2005), high levels of interpersonal violence over weekends (London et al., 1998), and neglected children in dysfunctional families, where women often bear the brunt of their partner's

alcohol misuse (te Water Naude et al., 1998). Specifically, WC Coloured male farm

workers have been identified as a subgroup of Coloured men that display particularly

high rates of harmful alcohol consumption (Gossage et al., 2014; Holtman et al., 2011).

High rates of harmful alcohol consumption also extend to teenagers and more research

should be done to understand if adolescent pregnancy was a result of sexual intercourse

while intoxicated. Surveys found that young persons in grades 8 to 11 in the WCP

reported substantially higher levels of binge drinking in the past 30 days than in other

provinces (Reddy et al., 2003; 2010), 34% in 2003 and 41% in 2008. Excessive alcohol

use is linked to, amongst others, high prevalence rates of interpersonal violence, FAS,

and child neglect in these [Coloured] communities (Gossage et al., 2014; May et al.,

2007; Parry et al., 2012).

Western Cape Province – Maternal and Child Health Government Programs

The Western Cape Province's First 1000 Days Campaign

I conducted interviews with three government individuals in order to discuss their

perceptions of the WCP's First 1000 Days Campaign, modeled after the Global First

1000 Days Campaign. During the interviews, MEC Albert Fritz (the Minister of Social

Development in the government of the WCP), Ms. Esther Lewis (MEC Fritz's

Communications Director), and Dr. Nomafrench Mbombo (the Minister of Health in the

government of the WCP) were asked about their overall thoughts on the First 1000 Days

Campaign, which elicited discussions about the risk factors that contribute to poor MCH

outcomes in the WCP. The underlying theme during the discussions was about

inequalities in class and ways that low-income mothers can change their behaviors to still

provide a learning environment for their children that is stimulating, loving, and full of

play. Three risk factors were identified: 1) maternal poverty; 2) poor maternal nutrition and health; and 3) maternal alcohol abuse. The three risk factors identified in these interviews are aligned with the risk factors found in the larger literature of causes of MCH problems in SA and in the WCP. Additionally, to improve MCH outcomes, government leaders expressed the importance and value of ECD Centers in at-risk communities in the province.

Government Officials' Views of the Province

Risk Factor 1: Maternal Poverty

Government officials were asked several questions to ascertain their opinions on the impact of the First 1000 Days Campaign on MCH outcomes in the WCP. From the discussions, maternal poverty emerged as the first risk factor that contributes to poor MCH outcomes. When asked if she thinks [the community] has equal access to resources and services, Ms. Lewis replied:

> …No probably not. I mean, if everybody had the same kind of access, there would not be a need for this campaign…If you are poor…we are trying to make it so that you are not at a disadvantage than your more educated counterparts – middle class people. So, it is a difficult space to navigate. But the services are there…and it is just [a matter] of making people aware of where they have to go…

Ms. Lewis explained that while it is difficult to reach the most at-risk people of the WCP, the Department of Social Development (DSD) is trying to make residents cognizant of the services through billboards and posters found in taxi stands and metropolitan areas with the most foot traffic. This is similar to the messaging techniques used in Ethiopia (discussed in Chapter 2). As it relates to ECD centers, Esther went on to explain that parents "want the best for their kid" but some "think that they must wait until school for

the child to start learning, they don't know that actually we can start [learning] at home."

She wants mothers to know that "even if [they] are poor… [They] can use apples to

stimulate the child. If you are illiterate, tell your child a story." The department believes

that impoverished women can play a part in their child's learning and development,

regardless of their socio-economic status.

MEC Fritz also voiced his opinion on class inequities while discussing

campaigning throughout the province and specifically "very heavily in the working class

areas." He provided examples of poor living conditions where "there is no personal

hygiene" and "conditions [in many of our areas] that are just not conducive for child

development." My follow-up question focused on barriers and challenges to achieving

the goals and objectives of the First 1000 Days Campaign. Specifically, I discussed the

social determinants of health (SDH) paradigm (which is embedded within LCT – the

main theoretical framework of this study) and concepts such as housing, sanitation, water,

food and nutrition, and criminal activity, for example, all of which may affect people that

would benefit from the campaign. I asked the Minister if he believed these determinants

may have an effect on the campaign. MEC Fritz's response discussed the issue of

criminal activity and housing inequalities in the WCP:

> Crime I think is a very big problem that's why we emphasize the whole issue of
> safety. That is why we are stressing the importance of the environment. And
> issues around sanitation, I can tell you, I have seen it. [In addition to the fact that]
> we don't have proper housing.

Risk Factor 2: Poor Maternal Nutrition and Health

From the discussions, poor maternal nutrition and health emerged as the second

risk factor that contributes to poor MCH outcomes in the WCP. According to Dr.

Mbombo who heads the Department of Health (DOH):

The campaign is focused on three aspects: 1) play, 2) love, and 3) nutrition. Historically, child health services have been mostly disease focused and physical examinations monitored growth. But the campaign is beyond that, instead it is focused on stimulation and play.

Dr. Mbombo explained that "in this way, the campaign is viewed as a holistic approach to improving child health outcomes." The campaign is made possible by community health workers (CHWs), caregivers, and occupational therapists.

According to the Minister of Health, Dr. Mbombo, the love that mothers give to their children is paramount: "the way that you show love during the 40 weeks inside the womb is as important as the first 6 months after birth." Furthermore, she indicated that "the first 6 months is very important and EBF during this time is essential." Ms. Lewis also added to the conversation on maternal nutrition and health and the importance of breastfeeding:

> …It is about maternal health, it's about women taking care of themselves when they are trying to conceive and when they have conceived. It is about making healthy choices, once the baby is born…You know tracking the development goals…it is the breastfeeding, nutrition…that's one part of it.

She is referring to the SDGs that focus on maternal nutrition and health. The DSD references the SDGs as a benchmark that women in the province should follow.

Risk Factor 3: Maternal Alcohol Abuse

The third main risk factor, maternal alcohol abuse, included discussions around the detrimental effects of alcohol abuse by expectant mothers. When asked his thoughts on barriers or challenges to achieving the goals and objectives in the First 1000 Days, MEC Fritz stated:

> One of the other issues that we are really concerned around is during pregnancy or before conception, and when people decide to have a baby, the issue around

substance abuse and specifically alcohol because we have seen how children with FAS are eventually born…

As a result of high rates of alcohol use while pregnant, the campaign has focused on educating women on the consequences of drinking and telling women "…that if you decide to have a baby, then stop drinking…not even one glass of beer – stop drinking completely." According to MEC Fritz, alcohol use while pregnant is "specifically prevalent in our poorer areas." He believes that this risk factor is one of the "more important challenges and barriers for [the government] because [alcohol use] will impact intellectual development." Dr. Mbombo also discussed the impact of alcohol use on child health outcomes and the importance of social support networks. According to her:

> Under the campaign, families are encouraged to give support to expectant mothers and provide a conducive environment for both mother and child. This is an environment in which the mother avoids alcohol…and is one that prevents harm against the growth of the baby's brain.

Dr. Mbombo echoed the views of MEC Fritz but adds an aspect not previously discussed – research that led to the creation of the campaign:

> Researchers have begun to look at the educational capacity of children and the ramifications of FAS which has affected a child's intellectual capacity and coping mechanisms.

Importance of Early Childhood Development Centers in At-Risk Communities

Government leaders also expressed the importance and value of CBOs in at-risk communities that provide ECD centers for young children. To improve MCH outcomes in the WCP, officials believed that ECD centers should provide the following criterion: 1) child safety and school-readiness, 2) education and information sharing for parents, and 3) fully-trained providers. When asked his opinion on the First 1000 Days campaign's goals, MEC Fritz explained:

> [The mothers] are really worried about the safety of their children and they prefer to keep the child with the grandmother or the aunty, who are not really doing anything to build relationships with the child, they just look after the child physically…

Mothers are worried about the safety of their children upon leaving their homes because of the growing community violence in many impoverished communities and perceived lack of safety in the ECD centers. So they believe that the child would be safer at home. Ms. Lewis explained that "the cycle of substance abuse [in the community] gets perpetuated and then it becomes a community safety issue [in the ECDs] as well."

> However according to MEC Fritz, who acknowledged the lack of safety:

> The Western Cape Government of SA is moving towards getting our ECD centers to be safe spaces…places where children can be intellectually stimulated, where children can get a plate of food, something to eat, because that is very important…

His response is associated with Dr. Mbombo's statement on stimulation and play but also adds the aspect of food insecurity, which is widespread in the informal settlements. ECD centers provide an environment where undernourished children can receive food which will help to positively impact their growth and development. Furthermore, he discussed how non-participation in ECD centers has led to children who are not school-ready:

> A lot of children [are not ready for Grade 1] because they haven't been to any of our ECD programs. We had a huge failure rate in Grade 1, and it is interesting because it has now come down [to] interventions specifically around ECD, and specifically in the early part of the First 1000 Days of a child's development.

> When asked if she believes that the First 1000 Days Campaign may be missing

some people who should be receiving services, Ms. Lewis discussed the ways that the campaign plans to expand outreach in the next phase. According to her: "we want to pass information on to our ECDs, to clinics, and to health networks…" She also spoke about the need for more information sharing among "nurses to actually educate people as they

come through the clinics" about the importance of ECD centers. To follow-up, I asked

what do you think can be done to lessen those barriers, to which Ms. Lewis answered: "I

think it all starts with education of the parents. Parents get to know about these things and

they just encourage their kids…" The DSD also believes that "no government institution

[or intervention] can take over the place or the role of the parent", therefore, the

government must "give the citizens and families the kind of tools that they need" to

become successful in raising their children. To support the government's role in assisting

families, Ms. Lewis explained:

> The research has shown that children whose parents or caregivers follow the rules
> of the First 1000 Days have [higher] chances that they are going to have healthier
> families themselves, they go on to be more successful…The children, they grow
> up to look after their parents, and they also know that this is a good way to raise
> my child. So you, you can almost raise a generation out of poverty.

Her statement illustrates how participation in the campaign can impact two risk-factors:

maternal poverty and maternal nutrition and health.

In response to the same question, Dr. Mbombo stated that the proactive technique

that her department has employed to ensure that ECD providers are well-trained:

> ECD [centers] provide the same [conducive] environment [that we want families
> that benefit from the campaign to have]. ECD staff is being trained by the DOH to
> incorporate these messages.

When asked about potential barriers or challenges to achieving the campaign's goals and

objectives, Dr. Mbombo replied: "the First 1000 Days Campaign is fairly new. It is not a

package of services but it is more about the importance of messaging." If ECD caregivers

are not properly trained it will impact the mother's perception of the campaign. In

response to this same question, Ms. Lewis discussed the issue of both departments (DSD

and DOH) "working in isolation." However, she doesn't think this issue of working in

silos is much of a challenge; instead, "it is just trying to get everyone to work together to see this picture holistically as not just a DSD thing or Health [thing]…"

Conversely, when asked what have been facilitators to achieving the goals and objectives of the campaign, MEC Fritz countered: "I think that now that we work together in a transversal way…across Departments, you can see the impact [of] that." He provided an example of how he personally worked with Dr. Mbombo: "both I and the Health Minister went out and handed out papers with information and visited places where many people come." Furthermore, he believes that "the operation of ECD centers" is also:

> Facilitating the promotion of the program…because now parents are realizing (if you speak to them on their own) the importance of loving their babies, caring for their babies, stimulating their babies in those First 1000 Days and I think those are all kinds of factors that facilitate a successful program.

While Dr. Mbombo focused on poorly trained nurses and ECD providers and Ms. Lewis discussed initial non-collaboration between the two departments, MEC Fritz expressed that, in fact, DSD and DOH are working together and through this partnership they are able to reach their target population.

<u>Conclusion</u>

This chapter provides an extensive literature review that included a general background of SA, the size of the MCH problem in SA, causes of MCH problems in SA, and examples of MCH government programs and CBIs in the country. Next, the chapter offered a general background on the WCP, the size of the MCH problem in the province, causes of MCH problems in the Western Cape, and examples of MCH government programs, which included findings based on interviews with three government officials who have spearheaded the provincial's First 1000 Days Campaign. Apartheid has

impacted the MCH outcomes of at-risk Black and Coloured women and children in SA.

Although SA is an UMIC, it is marked by high levels of inequality and we see disparities

between Blacks/Coloureds and Whites in health, education, income, and living conditions,

to name a few. SA has not made progress in achieving the UN MDGs goals around

reducing maternal and child mortality and the country faces a quadruple burden of

disease (TB, HIV/AIDS, and NCDs).

     As reviewed in Chapter 2, the causes of MCH in the country are best understood

through upstream (maternal poverty) and downstream causes (poor maternal nutrition and

health and maternal alcohol abuse). In SA, specifically, large populations of women

suffer from unemployment, low levels of educational attainment, and substandard living

conditions and while the SA government has put in place socio-economic policies to

alleviate poverty, research indicates that bottom-up approaches (like CBIs/CBOs) provide

a better approach to empower vulnerable communities. As it relates to maternal nutrition

and health, the country is burdened by high rates of malnutrition, food insecurity, and low

budget allocations to nutrition. SA has high stunting and wasting rates compared to other

UMICs with similar GNI and has one of the lowest rates of EBF among African countries.

Lastly, alcohol consumption in the country is extremely high and is tied to a history of

the "dop" system in which Coloured farm and wine workers were paid in alcohol instead

of money. Both men and women in the country, including pregnant women, have some of

the riskiest drinking patterns in the world. These patterns, along with episodic and binge

drinking, has resulted in social and health problems in children such as FAS, FASD,

growth deficiencies, and learning disabilities. In response to these various social and

health challenges, the SA government implemented various programs such as the

National Health Insurance, the National Development Plan, and the South African Social Security Agency.

The Western Cape Province is one of the wealthiest provinces in SA; however, it is still marred with high poverty rates and unemployment. The causes of poverty in the province include high rates of urban in-migration from the Eastern Cape, increased percentages of squatter camps in informal settlements, and a large rural population which is severely impoverished. As it relates to poor maternal nutrition and health in the province, research by de Villers et al (2015) found that primary school children lacked physical activity, had unhealthy diets, and were underweight; and research by Hansen et al (2015) found that the majority of HIV-positive women were unemployed, had low levels of education, and indicated severe household food insecurity. Finally, the province is the hub for wine production in the country and the dop system is still very much used among Coloured farm workers and women. Research by Croxford & Viljoen (1999) found that nearly half of pregnant women reported drinking alcohol while pregnant, the rates of FAS in the province are among the highest reported in the world (Crede et al., 2011), and the prevalence of FASD in the province is the highest documented in the world (May et al., 2013).

In response to these social and health challenges, the WCP government has implemented the First 1000 Days Campaign. A joint initiative between the DSD and the DOH, the campaign seeks to improve MCH outcomes through a messaging campaign that educates women on the importance of stimulating, playing, and loving their children. Government leaders admitted that residents do not have equal access to resources and services, that it is difficult for government workers to reach the most at-risk people in the

province, that poor living conditions are not conducive for child development, and that

criminal activity affects community engagement. However, what is most important to the

officials is making sure that residents are aware that the services do exist and that they

must take advantage of these opportunities regardless of their socio-economic status. The

Minister of Health views the campaign as a holistic approach to improving child health

outcomes and the Minister of Social Development believes that educating women on the

consequences of drinking while pregnant is paramount to the campaign's success. Finally,

the officials also discussed the importance of ECD centers in at-risk communities because

the centers provide an environment for stimulation and play, positively impact a child's

growth and development, and prepares children for primary school.

Chapter 4: Methodology

<u>**Introduction**</u>

In this chapter, I present the study's specific research objectives, which include the research questions. Then, I offer an overview of the research design, which includes how the case study site was selected, information on document collection, and background on the study's semi-structured interviews. Next, I provide sampling methods for the administrative and programmatic staff as well as the parent participants. This is followed by data collection procedures, data analysis, and information on the human subject protocol.

<u>**Specific Research Objectives**</u>

While there have been national and provincial policy and community-based interventions (CBIs) to improve maternal and child health (MCH) outcomes in South Africa (SA) and in the Western Cape Province (WCP), more has to be done. This evaluation used a multi-program case study approach to document the knowledge, attitudes, and practices (KAPs) as well as the experiences and behaviors of providers and participants in a smaller CBO that addresses MCH outcomes through income generating projects, a nutrition and health support group, and an early childhood development (ECD) and aftercare center for young children in tandem with workshops and counseling programs for parents. My objectives were multifold: I documented the organization's history and goals, various organizational and structural components, and the perspectives of program participants, program administrators, program staff, and other key stakeholders through the use of observations, document analysis, and semi-structured

qualitative interviews within a local, culturally relevant context. This multi-program case study seeks to mainly answer:

1) How do key stakeholders, including program staff and parent participants, participate in and respond to each intervention and what is the impact of each intervention and each program?

The following sub-questions will also guide the program process evaluation:

Staff:

1) How did the organization come to exist and continue to exist?

2) How are the programs intended to be delivered?

3) Are there any barriers and challenges to program implementation?

4) What aspects of *Table Views* does staff perceive as having the greatest impact on participant knowledge, nutritional choices, and parenting approaches?

Participants:

1) What are the larger contextual factors which influence participant experiences?

2) What has it been like to participate in the organization's programs?

3) Are there any barriers and challenges to program participation?

4) What aspects of *Table Views* do participants perceive to have the greatest impact on knowledge, nutritional, and parenting approaches?

The study links the intended actions and goals of the CBO to empirical evidence that the program is being carried out as planned and that it has the desired effects. After data collection, I identified common themes between and among staff and participants through a within-case and cross-case programmatic analysis of the qualitative data using content-analysis which involved identification, coding, and categorization of primary themes.

Findings from this research could add to the knowledge of CBOs, public health providers, ECD teachers, and at-risk families in improving MCH outcomes in the WCP, SA.

<u>Overview of Research Design</u>

A qualitative, instrumental multi-program case study was completed. Case study research involves the study of an issue (poor MCH outcomes) explored through one or more cases (multiple programs) within a bounded system (Table Views) (Creswell & Poth, 2017). Multiple case studies are used to enhance generalizations. As Yin (2003) comments, "you would use the case study method because you deliberately wanted to cover contextual conditions – believing that they might be highly pertinent to your phenomenon of study." I selected several programs from one research site to provide an in-depth picture of different perspectives on the issue of poor MCH outcomes and, to later, compare several cases. According to Yin (1993), the development of consistent findings, over multiple cases, can then be considered a very robust finding. One benefit of case studies is that they provide rich insights into the particular situations (Rule & John, 2011) that staff and participants find themselves as well as the organizations with which they interact (Cloete & Ramugondo, 2015). The goal of this study is to provide much-needed insight into this community by presenting a variety of voices that are underreported in the literature. This multi-program evaluation design allowed me to detect the unique opinions and experiences of staff and participants in different programs at one organization.

Program evaluation is a concept of qualitative research, and qualitative researchers can influence social policy in important ways (Denzin & Lincoln, 2000). Rossi & Freeman (1993) define program evaluation as "the systematic application of

social science research procedures for assessing the conceptualization, design, implementation, and utility of social intervention programs." Table Views has created social intervention programs around MCH to address maternal poverty, poor maternal nutrition and health, and maternal alcohol abuse. Qualitative researchers can isolate target populations, show the immediate effects of certain programs on such groups, and isolate the constraints that operate against policy changes in such settings (Denzin & Lincoln, 2000). Selection bias is a factor in evaluation studies that affects participation because the really at-risk people may not have access to these services. However, I spoke to staff and participants about recruitment methods to address this potential issue. Employees recruit potential women while visiting the communities, women hear about the program through friends and neighbors, and women are assisted by Table Views after the organization receives complaints about the individual's poor living conditions.

This study utilizes a qualitative multi-program case study analysis firmly grounded in constructivist approaches to inquiry. Using the constructivist paradigm, staff and participants shared and constructed their stories while creating multiple realities (Cloete & Ramugondo, 2015). The constructivist paradigm assumes a relativist ontology (there a multiple realities), a subjectivist epistemology (knower and respondent co-create understandings), and a naturalistic (in the natural world) set of methodological procedures (Denzin & Lincoln, 2000). I collected up-close information by talking directly to staff and participants in a natural setting – at the organization. Constructivist researchers focus on the specific contexts in which people live and work in order to understand the historical and cultural settings of the participants (Creswell & Poth, 2017). Case study methodology is also known for considering the contextual conditions as well

as clearly defining the boundaries between the context and the phenomenon (Baxter & Jack, 2008; Stake, 2013; Yin, 2003) namely maternal poverty, poor maternal nutrition and health, and maternal alcohol abuse. Furthermore, according to Frankfort-Nachimas & Nachmias (2008), "subjective experience involves the respondents' beliefs, attitudes, feelings, and opinions."

In this study, I employed qualitative interviewing to capture the individual's point of view. Additionally, I looked at the value of obtaining rich, thick descriptions of experiences within this organization. Within data collection, qualitative research allows social scientists the ability to "gain an emphatic understanding of societal phenomena, and they must recognize both the historical dimension of human behavior and the subjective aspects of the human experience" (Frankfort-Nachmias & Nachmias, 2008). According to Frankfort-Nachmias & Nachmias (2008), "the personal interview is a face-to-face, interpersonal role situation in which an interviewer asks respondents questions designed to elicit answers pertinent to the research hypotheses." The questions, their wording, and their sequence define the structure of the interview.

Selection of the Case Study Site

I was employed through USAID and the Rutgers Graduate School Newark as a fellow for two months during the summer of 2016. Recruitment of the organization was facilitated by my host organization, the Community Chest of the Western Cape (the Community Chest), a funding organization that is similar to the United Way in the United States. The Community Chest provides financial support to hundreds of organizations in SA around health, education, community development, and entrepreneurship. Working with the Community Chest enabled me access to resources in terms of literature,

documents, and archival material and the opportunity to utilize the organization's vast

contacts with CBOs and government organizations such as the Department of Social

Development (DSD) and the Department of Health (DOH). No conflicts were posed by

the recruiting organization.

To understand the risk factors that contribute to poor MCH outcomes, I conducted

semi-structured interviews with three government officials from the DSD and the DOH

of the WCP. Three risk factors that contribute to poor MCH outcomes emerged from

these interviews: 1) maternal poverty, 2) poor maternal nutrition and health, and 3)

maternal alcohol abuse. The analysis of interviews with government officials can be

found in Chapter 3. Also the recommendation that emerged from the interviews was the

importance and value of ECD centers in at-risk communities. The WCP provincial

government's response to these risk factors was the creation of the First 1000 Days

Campaign. Data collected from these interviews informed my decision to select a CBO

that provides services to Black and Coloured women in the WCP who are at-risk of these

three factors.

Through the Community Chest's network of contacts and organizations that

receive or received funding in the past, I invited several organizations to take part in the

study. From a list of 12 potential CBOs in the WCP, SA, 3 CBOs met the criteria

required. Inclusion criteria consisted of being a fairly new organization that worked with

at-risk parents in the WCP and an organization comprised of programs that focused on

one or more of the following risk factors: maternal poverty, poor maternal nutrition and

health, or maternal alcohol abuse. While three CBOs accepted the invitation to participate

in the study, I selected one organization, *Table Views,* in order to conduct a more in-depth

study and program process evaluation. After receiving a signed agreement from the

organization expressing their commitment to assist me in my dissertation research, I sent

email invitations to the organization's Director and Program Manager and visited *Table*

Views to hand out paper invitations to potential subjects to participate. I followed up with

dates and times convenient to the research participants and staff to review the consent

procedures and to conduct interviews.

Document Collection

Exploratory research was conducted in June and July of 2016 through document

reviews of the program, discussion with the program's leadership to identify if the

organization would be a good fit for the study, site visits and observation of the

program's functions and circumstances, and reviews of the social science literature based

on sources that the researcher identified on her own and from source referrals from

program leadership staff. From these sources, I obtained information on each program's

goals and objectives; functions, components, activities; and the logic or sequence linking

program functions, activities, and components (Rossi et al., 2003). I reviewed documents

on the organization's vision and mission as well as the foundation's social upliftment and

awareness programs and training and development courses.

Semi-Structured Interviews

To evaluate the organization's process, I created a semi-structured interview for

staff (Appendices A, B and C in English, Afrikaans and IsiXhosa, respectively) and

parent participants (Appendices D, E and F in English, Afrikaans and IsiXhosa,

respectively) that include questions about program operations, implementation, service

delivery, behaviors, experiences and attitudes. The researcher was assisted by a translator,

independent of the CBO, who spoke all three languages fluently. The translator also

provided the translations that are found in Appendices B, C, E, and F.

Smith (1989) suggests keeping the discussion concrete and specific, the evaluator

should use a line of questioning that does not ask about goals directly but asks instead

about consequences. An important evaluation function, therefore, is to assess the

adequacy of program process: the program activities that actually take place and the

services that are actually delivered in routine program operation (Rossi et al., 2003). In

addition, socio-demographic data was obtained from all study participants to provide

background information at the beginning of the interview. This type of research design

allowed me to obtain a more comprehensive understanding of the factors that shape staff

and participant personal background and experience.

Qualitative interviewing, specifically a nondirective and semi-structured interview,

differs from surveys because these interview questions should flow based on the response

to the previous question and are therefore more unstructured in nature. The questions

were not asked in a specific order because I wanted respondents to "relate their

experiences, to describe whatever events seem significant to them, to provide their own

definitions of their situations, and to reveal their opinions and attitudes as they see fit"

(Frankfort-Nachmias & Nachmias, 2008). The interviewer has a great deal of freedom to

probe various areas and to raise specific queries during the course of the interview"

(Frankfort-Nachmias & Nachmias, 2008).

Interview questions were derived from the literature on program process

evaluation and modified with feedback from members of my dissertation committee. The

questions were carefully designed to offer sufficient coverage for the purpose of the

research. The choice of a semi-structured rather than a structured interview was employed because it offers sufficient flexibility to approach several respondents differently while still covering the same areas of data collection (Noor, 2008). The interview contains main questions and follow-up probes for responses that were informative for analytic purposes. Finally, parent participants were compensated in the form of various items for personal use and for their children including bars of soap, combs, brushes, barrettes, rulers, pencils, pens, erasers, small notepads, toothpaste, deodorant, bracelets, infant clothing, crayons, and small sewing kits. These items were donated to the Principal Investigator to give parent participants by her aunt who owns an orphanage in Trinidad, West Indies.

Sampling Strategy

Administrative Staff/Programmatic Staff

Purposive sampling was utilized in this research as a sampling strategy. After choosing the organization that I would work with, I spoke to the Director and Project Manager who identified the administrative and programmatic staff members that I could interview. The Project Manager identified 5 administrative staff members that I interviewed (himself, the Founder/Director, the Administrator, Bookkeeper, and Marketing and Events Manager). He also identified a total of 6 programmatic staff members that I also interviewed (the Sewing and Beading Center Manager/Trainer, one Gardener, the Adherence Counselor for Health and Nutrition, the ECD Principal, one ECD Teacher, and one ECD Volunteer).

Participants

Recruitment of female participants was conducted with the assistance of the Director, Program Manager, and Adherence Counselor for Nutrition and Health who were familiar with the parental status of the women and to some extent, and if applicable, their socio-economic status, nutritional and health habits, and drinking patterns. The staff members identified 37 representative parents spread across the seven programs *(Computer and Business Course Program/Sewing and Beading Project; the Organic Garden/Feeding Scheme and Nutrition and Health Support Group; and the Patrick Early Childhood Development Learning and Aftercare Programs, Parenting Workshops, and Counseling Program)* subsumed under the risk factors.

Data Collection Procedures

The data collection in case study research is typically extensive, drawing on multiple sources of information, such as observations, interviews, documents, and audiovisual materials (Creswell & Poth, 2017). This research design utilized three methods of collection – observations, document analysis, and interviewing. The semi-structured interview was the primary data gathering instrument. Most of the fieldwork entailed interviews using questions with several categories of respondents from each program. The research was carried out at the CBOs site location.

My identity and purpose was known to the research subjects; therefore, when conducting the interviews, I audio-recorded responses on the spot and jotted down notes immediately – which improved accuracy and reduced the possibility of flawed recall. Additionally, I asked respondents if they would not mind being audio-recorded and

informed them that the recording would be deleted after the interview was transcribed and the final dissertation defense. Interviews were conducted on a one-to-one basis as opposed to in a group because the latter may "serve as a reminder of the researcher's agenda, which may influence the behavior of the group, and also may limit the researcher's ability to participate in group activities" (Frankfort-Nachmias & Nachmias, 2008).

<u>Data Analysis</u>

From the interview transcripts, I identified similarities and differences within and across all the cases and pinpointed themes using a general inductive approach analysis. A general inductive approach is useful across a number of qualitative traditions, and appropriate for the purpose of allowing research findings to emerge from the frequent, dominant, or significant themes inherent in raw data (Thomas, 2006). Because I reported theme frequencies, the underlying ontology of this method is best described as post-positive. Post-positivism is about a reality which is socially constructed rather than objectively determined; therefore, my goal was to appreciate the different constructions and meanings that people place upon their experience (Easterby-Smith et al., 1991). Post-positivism relies on multiple methods as a way of capturing as much of reality as possible while it emphasizes the discovery and verification of theories (Denzin & Lincoln, 2000). I also "looked for certain regularities or patterns that emerged from the numerous observations made during the fieldwork stage" (Frankfort-Nachmias & Nachmias, 2008) and the research was conducted until saturation of themes or ideas was achieved. Furthermore, following an iterative reflexive approach, transcripts and extensive field notes were read, re-read and coded (Holtman et al., 2011).

I focused on an analysis of themes, not for generalizing beyond the case, but for understanding the complexity of the case (Creswell & Poth, 2017). One analytic strategy that I used was the identification of issues within each case and then I looked for common themes that transcended the cases (Yin, 2003). This analysis is rich in the context of the case or setting in which the case presents itself (Merriam, 1988). Through a recursive process, themes were subsequently clustered into main and sub-themes (Smith & Osborn, 2003). When multiple cases are chosen, a typical format is to first provide a detailed description of each case and themes within the case (within-case analysis) followed by a thematic analysis across the cases (cross-case analysis) as well as assertions or an interpretation of the meaning of the case (Creswell & Poth, 2017).

Rich, thick description was utilized in this study as a validation strategy (Creswell & Poth, 2017) because it allows readers to make decisions regarding transferability (Erlandson et al., 1993; Lincoln & Guba, 1985; Merriam, 1988) because the writer describes in detail the participants or setting under study. In Chapters 5-8, I spent considerable time describing the context for the case and presented several themes that help the reader understand each program. In addition to utilizing rich, thick descriptions as a validation strategy I also employed the use of triangulation. This process involves corroborating evidence from different sources to shed light on a theme or perspective (Creswell & Poth, 2017) and in this study, data on participant drinking habits was triangulated by two staff members who are familiar with the parents. In this way, I provided validity to my findings around one of the main risk factors – maternal alcohol abuse. In Chapter 9, I developed generalizations about the cases in terms of the themes and how they compared and contrasted with published literature on the causes of poor

MCH outcomes and I grounded my assertions in the current literature on this issue (Creswell & Poth, 2017). Lastly, I hand-coded the data and used the software program Dedoose as well to code and analyze the data.

Human Subjects

Human subjects were selected from the population that the CBO employs and targets in the WCP of SA. This study asked employees (administrative and programmatic staff) and participants (mothers who received these services) about their views, perceptions, experiences, and behaviors around MCH in SA, including what can be done in the province to improve these health issues. All data remains confidential and individual responses are not identified with the participants who provided them. I protected the identity of research participants by not retaining individual names or any other direct identifying information, except as needed to schedule the interview. All of the proper names (location of study, staff and participant names, additional locations such as neighboring villages or schools, and the names of the two rival gangs) are pseudonyms.

The transcriptions were de-identified and checked for accuracy. Paper based information and consent forms to participate in the research was printed by the PI, deleted from her email server, and kept in a locked file box at her home office. The information and consent forms will be destroyed five years hence. Additional copies of the audio recordings were not be made nor was any personally identifying information discussed with anyone else. The audio recordings will also be destroyed five years hence. Research participants will be provided with a summary of the findings when it is completed, upon successful dissertation defense, approximately by October 2017.

The only discernible risk that staff and participants may face is sharing critiques of the CBO that employs them and where they receive services, respectively. This has been addressed by providing complete freedom for participants to choose not to take part in the study or to withdraw from the study during or after they have completed an interview, and stated clearly in the consent form that the decision to participate is completely voluntary and will not affect their relationship to the CBO. While I interviewed women who have participated or currently participate in the CBO, I did not ask any of the women if they have lost a child or employed purposive sampling to select women that had lost a child. Discussing this may have caused harm to the subject. As stated in the Information Sheet and Consent Form (Appendices G, H and I in English, Afrikaans and IsiXhosa, respectively):

> Please understand that your participation is voluntary and you are not being forced to take part in this study. The choice of whether to participate or not, is yours alone. If you choose not to take part, you will not be affected in any way whatsoever. If you agree to participate, you may stop participating in the research at any time and tell me that you don't want to continue. If you do this, there will be no penalties and you will not be prejudiced in any way.

These measures minimized potential harms.

As stated, the staff (administrative and programmatic staff) and participant (parents) interview protocols and information sheet and consent form are available in Afrikaans, English and IsiXhosa and are found in Appendices A-I. These documents were translated by a hired translator and Community Chest staff. All forms were verbally explained in English and/or Afrikaans/Xhosa to ensure voluntary informed consent. Staff had to: 1) be currently employed at the organization in the capacity of administrative or programmatic staff and, 2) be over the age of 18 (as per Rutgers IRB and HSRC

guidelines). Participants had to: 1) have had one or more children at the time of the research and, 2) be over the age of 18 (as per Rutgers IRB and HSRC guidelines). The information sheet and consent form and staff and participant interview protocols have received full ethics approval by Rutgers University Office of Research and Regulatory Affairs Institutional Review Board (IRB) and the Human Sciences Research Council (HSRC) in Pretoria, SA.

Conclusion

This chapter provides the study's specific research objectives, an overview of the research design (which included information on case study site selection, on document collection, and on the staff and parent participant semi-structured interviews), the sampling strategy (for administrative/programmatic staff and parent participants), data collection procedures, data analysis, and human subjects information. This evaluation used a multi-program case study approach to document the perspectives of staff and parent participants in a small CBO in the WCP of SA that was created to improve MCH outcomes through income generating projects, a nutrition and health support group, an ECD and a Aftercare center, parenting workshops, and a counseling program. The overarching question was: *How do key stakeholders, including program staff and parent participants, participate in and respond to each intervention and what is the impact of each intervention?* This question was accompanied by sub-questions around organizational history, program process, barriers and challenges to program implementation and participation, and perceptions of the program's impact of behavioral, nutritional, and parenting choices. Research by various authors (Creswell & Poth, 2017; Yin, 2003; Noor 2008; Rule & John, 2011; Cloete & Ramugondo, 2015; Baxter & Jack,

2008; Stake, 2013) was presented to support the Principal Investigator's decision to conduct a case study as the best qualitative method for this research design. Research by Denzin & Lincoln (2000) and Rossi & Freeman (1993) was also presented to support the PI's decision to conduct a program evaluation.

The case study site was selected with the assistance of the Community Chest of the Western Cape, a funding organization that the PI worked for over the course of two months in 2016. Preliminary interviews with two government officials from the Western Cape Department of Social Development and one government official from the Western Cape Department of Health about the province's First 1000 Days Campaign, further informed the researcher of the three main risk factors that impact MCH outcomes, which is supported by the broader literature. Although three CBOs agreed to participate in the study, the researcher chose Table Views as the site of her case study because it allowed the PI to conduct a more in-depth analysis. Furthermore, the PI was focused on learning more about an organization that is smaller and, therefore, less known and about a sub-population that is under-reported in the literature. After reviewing programmatic documents, engaging in multiple discussions with the organization's leadership, conducting site visits and observations, and reviewing the social science literature around the issues, the PI created semi-structured interviews and information and consent forms in English and hired an outside individual to translate the documents into Afrikaans and IsiXhosa.

The researcher employed purposive sampling and with the help of staff identified eleven administrative and programmatic employees who consented to the interview. Staff also assisted the PI in recruiting thirty-seven parents for a total of 48 participants. After

participants were informed of the study and provided consent, interviews were conducted on an individual basis using an audio-recorder and notes. Participants were given complete freedom to choose not to take part in the study or to withdraw from the study at any time during or after they completed the interview. The researcher de-identified each transcript and checked for accuracy by re-reading each interview transcription multiple times. To analyze the data, the PI used a general inductive approach to discover salient themes inherent in the raw data. Finally, the researcher conducted a within-case and cross-case analysis to form assertions and generalizations.

Chapter 5: Provider Views of the Community

<u>Introduction</u>

In this chapter, I first provide general background on the Table Views Organization, which includes organizational make-up, staff demographics, staff backgrounds and funding information. Next, I present perceptions of barriers/challenges to organizational goal achievement and offer findings on the four most common environmental contextual factors that impact participant engagement according to discussions with administrative and programmatic staff. This is followed by background information of each of the seven programs aligned with the study's three main risk factors: maternal poverty, poor maternal nutrition and health, and maternal alcohol abuse. Then, I offer findings on overall staff perceptions of organizational and programmatic goals which include administrative staff perceptions of organizational goals and overall staff perceptions of programmatic goals. This is followed by the main barrier/challenge to programmatic goal achievement and facilitators to organizational goal achievement. Finally, I present overall organizational successes and overall programmatic successes according to staff.

<u>The Table Views Organization – General Background</u>

Maternal poverty, poor maternal nutrition and health, and maternal alcohol abuse are the three risk factors that this study explores through a qualitative multi-program case study of a community-based organization (CBO) in the Western Cape Province (WCP): Table Views Foundation (Table Views). According to the annual report, the stated organizational goal of Table Views is:

> To accomplish social and economic improvement through various programs that educate, inform, and support the people of Maraval and its surrounding communities.

The organization has several programs which seek to improve the living conditions of people in the community who are encouraged to take responsibility for their own lives, their families, and the situation in Maraval. The individuals that participate in the organization are also provided with enhanced skills in order to reduce unemployment, thereby decreasing drug abuse, domestic violence, child neglect, and other social problems. Located in one of the most impoverished informal settlements in the WCP, Table Views is "one of the leading CBOs with a vision of holistically alleviating the social effects of poverty and substance abuse by restoring human dignity in the lives of the marginalized individuals in Maraval and surrounding areas" (Organization Brochure). One administrative staff member best illustrated the holistic nature of Table Views during the interview:

> "For every project we got, there is a program for it. If you come to the Sewing and Beading Project you take part in the Computer Course, if you come in the line for the Feeding Scheme [and Organic Garden] you go to the Nutrition and Health Support Group, if your child is in the ECD [Early Childhood Development Center] you come to the Parenting Workshop [and Counseling Program] so there is always something that is linked to something else."

Approximately eight years ago, the Founder/Director of Table Views resigned from her previous employment at a local foundation. Although there were other CBOs in Maraval, her community called on her to do some development in the neighborhood. While she was overwhelmed at first because the proposed area for the organization did not have any buildings or equipment, she relied on her resources and previous workshop materials to create Table Views. After visiting the Maraval community and feeling an empty void as she looked at the neighborhood, the Founder decided "this is where I

should be." She started working out of her car looking at social cases and would work with the youth, who would come to her for advice, so that they could take ownership of their community. By social cases, the Founder is referring to her background as a social worker where she works with people from all walks of life, those that are impoverished, abuse drugs and alcohol, women who are abused by their spouses, and children that are abused by their parents. While her vision and passion was mostly focused on youth, the needs of Maraval were bigger than that specific population and she believed that the broader community, specifically women, could also benefit from the organization's services. According to the Founder,

> There was nothing happening for kids whose parents were addicted to drugs and alcohol, the kids were just roaming the streets, there was nothing to stimulate the women because they were asking for support yet nothing was being given to them.

The organization fulfills its mission through seven programs which have been broken down into subgroups that align with the three aforementioned risk factors:

- *Maternal Poverty:* the *Computer and Business Course (CBC) Program* and the *Sewing and Beading Project (SBP)*;

- *Poor Maternal Nutrition and Health:* the *Organic Garden/Feeding Scheme (FS)* and the *Nutrition and Health Support Group (NHSG)*; and

- *Maternal Alcohol Abuse*: the *Patrick Early Childhood Development Learning/Aftercare Programs (ECDA)*, *Parenting Workshops (PW)* and *Counseling Program (CP).*

These seven initiatives attempt to decrease poverty and put an end to poor maternal nutrition, compromised health, and child maltreatment by alleviating hunger, giving

women the opportunity to participate in the cultivation of crops and engage in income generating projects, giving the community the opportunity to learn English and enroll in basic computer courses, giving mothers a safe haven for their infants and young children by providing a place for adolescents and teens to go to after school, and through workshops and counseling for parents with histories of substance abuse. Participants are recruited by word of mouth or through complaints/reports from other community members who believe that an individual needs assistance or is a nuisance. Specifics on participant recruitment are discussed in detail in Chapters 6, 7, and 8. To ensure that these at-risk people have access to the organization's services, administrative and programmatic staff responds to complaints from the community by going to the house or site of the individual that needs help and by providing assistance.

Organizational Make-Up

The organization is comprised of a total of 18 employees and a Board of Directors. The Board of Directors oversees the Foundation, ensures that everything runs effectively, and makes certain that funds are not being misused. The Board of Directors is comprised of seven members that meet once a month.

Staff Demographics

Table 1 below provides a breakdown of all administrative and programmatic staff at Table Views. Of the 18 employees, 11 individuals were interviewed in this study. All 5 of the administrative staff were interviewed. Of the programmatic staff, the Sewing and Beading Center Manager/Trainer, 1 Gardener, the Adherence Counselor for Health and Nutrition, the ECD Principal, 1 ECD Teacher, and 1 ECD Volunteer were interviewed.

Table 1: Table Views' Total Staff Demographics (N=18)

Positions	
Administrative Staff	
Administrative Office Staff	N=5
Founder/Director	
Project Manager	
Administrator	
Bookkeeper	
Marketing and Events Manager	
Programmatic Staff	
Sewing and Beading Center Staff	N=3
Manager/Trainer	
Supervisor	
Beading Facilitator	
Organic Garden/Feeding Scheme Staff	N=5
Gardener 1	
Gardener 2	
Cook 1	
Cook 2	
Cook 3	
Counseling Center Staff	N=1
Adherence Counselor for Health and Nutrition	
Patrick ECD Learning/Aftercare Staff	N=4
ECD Principal	
ECD Teacher	
ECD Teacher	
ECD Volunteer	

Staff Backgrounds

Table 2 below illustrates the staff backgrounds of the sample of eleven

individuals interviewed in this study. As previously mentioned, Maraval is a majority

Coloured community and Table Views is a majority Coloured organization. Therefore, it

comes as no surprise that less than 30% of the employees identify as Black.

Approximately 50% of the staff has been employed at the organization for less than 5

years, while the other half have been at Table Views between 5-10 years.

Table 2: Table Views' Staff Backgrounds (N=11)

Positions	
Administrators	N=6
Program Staff	N=5
Race	
Coloured	N=8
Black	N=3
Time at Organization	
< 5 years	N=6
5-10 years	N=5
Educational Attainment	
Less than High School	N=2
Some High School	N=4
High School Diploma	N=4
University Degree	N=1

The issue of the number of people related to the Founder was raised by two

programmatic staff members both in terms of the number of employees connected to the

Founder and perceived preferential treatment. The Founder was not asked directly which

employees were related to her. However, in terms of staff composition, many are related

to the Founder. Indeed, almost all of the administrative staff is related to the Founder. As

illustrated in **Table 3** below, 40% of the staff interviewed (N=4) are related to the

Founder, who is the only individual with a university-level degree. Of the total staff of 18,

28% of employees are related to the Founder and one staff member (who was not

interviewed) is also the Founder's daughter-in-law.

Table 3: Table Views' Staff Educational Attainment (N=10)

Administrative Staff (N=4)			
Title	*Related to Founder?*	*Educational Attainment*	*Technical Education?*
Administrator	*Yes*	Some High School	*Yes*
Bookkeeper	*Yes*	Some High School	*Yes*
Marketing/Events Manager	*Yes*	High School Diploma	*Yes*
Project Manager	*No*	High School Diploma	*Yes*
Programmatic Staff (N=6)			
Sewing and Beading Center Manager	*Yes*	Less than High School	*Yes*
Organic Garden Staff	*No*	Less than High School	*No*
ECD/Aftercare Volunteer	*No*	Some High School	*Yes*
ECD/Aftercare Teacher	*No*	Some High School	*Yes*
ECD/Aftercare Manager	*No*	High School Diploma	*Yes*
Adherence Counselor for Health and Nutrition	*No*	High School Diploma	*Yes*

Only one of the Founder's family members has a high school diploma; however, three of

her four family members hold administrative positions in the organization and one, who

never attended high school is a programmatic manager. The OG Staff member with the

same level of education (less than high school) as the Founder's family member (Sewing

and Beading Manager) is a volunteer. He is faring worse professionally at the

organization when compared to the Founder's relative because he is in a lower position

and not in a managerial position. However, the family member that did not go to high school has years of supervisory experience and has received managerial training while the non-familial member never pursued further education. It can be argued that the Founder hired a member of her family as the Sewing and Beading Center Manager because she has a lot of experience and can positively contribute to Table Views' success and not simply because she is related to her.

The two programmatic staff employees (ECDA Volunteer and Teacher) that dropped out of high school are both currently enrolled in college to receive their diploma and Level 3 ECD training. When compared to the Founder's two family members (Administrator and Bookkeeper), who have the same level of education (some high school), these two employees are also faring worse professionally at the organization because they are in programmatic roles not administrative roles. Of the three non-familial staff members who graduated from high school, one is an administrator who obtained technical education in project management, office administration, organizational governance, field marketer training, and business and another is a programmatic staff member who obtained technical education in health and nutrition, adherence counseling, and previously served as a community health worker (CHW). When compared to the Founder's family member, who has the same level of education (high school diploma), these three employees are faring about the same professionally because they have received similar technical training after high school and are also in administrative or supervisory roles. Many of the employees take advantage of the free training and development programs that they receive through the WCP government or through other

organizations. The organization also assists staff members that have not graduated from high school with funding and support to finish their schooling and receive their diplomas.

Funding

Funding is generated by proposals that three administrative staff members (the Founder, Marketing/Events Manager, and Project Manager) draft and send out to potential international and local donors, by small events that the Founder hosts at the organization for international volunteers, and through networking with local CBOs. Details from the most recent General Proposal (March 2016 – March 2017) showed that the basic operational costs (staff salaries, participant stipends, outreach, printing and stationary, staff development, transport costs, workshop materials, electricity and gas, and other expenses) to run Table Views are approximately R2,100,000 ($165,000) per year. International organizations and volunteers who invest in the organization, mainly from Denmark and Germany, provide the bulk of grants (70%) for the programs, while government and local assistance is limited. Local funding can help keep the organization going if international funding is no longer available. The SBP is the only program that brings money into the organization, the ECDA receive funds from a trust in South Africa and international donors, and donors provide laptops for the Computer Course. Table Views is attempting to broaden their funding sources by applying for financial support from local entities and CBOs. The Director is currently in the process of reapplying for more funds for the ECDA because current funding is due to expire within the next few months. Operational costs are covered by general funds but these do not cover the entire year which is supplemented by international organizations that provide funds towards Table Views' development programs.

Barriers and Challenges to Organizational Goal Achievement

Staff were asked: 1) *What do you think have been barriers or challenges to achieving the organization's or program's goals and objectives?* Responses to these questions convey that funding challenges impact organizational goal achievement and manifests into two categories: the impact of religion and race on funding (N=8) and lack of transparency related to funding (N=6). Additionally, lack of communication among staff was the third barrier to organizational goal achievement (N=4).

Category: The Impact of Religion and Race on Funding

Staff discussed two types of funding constraints, one based on religion and one based on race. This is illustrated in two examples. There were two different organizations that were considering funding Table Views, one was a local Christian organization and the other was a local Muslim corporation. The Christian organization declined to sponsor the organization because the Director is Muslim. On the contrary, the Muslim corporation wanted a certain percentage of the beneficiaries to identify as Muslim and the Director said "go to hell!" Another staff member explained that Table Views would rather "cut ties with [the Muslim corporation]" than lie about the percentage of Muslim beneficiaries. The Director stated: "for us, it is all about humanity because we are born as human beings first and if we can look at each other as human beings the rest will follow."

In trying to broaden Table Views' funding streams, this was one of the issues that they faced. Table Views serves the entire community, regardless of religion. However, religion is a factor in this culture. According to the Western Cape Government Provincial Profile (2015), the main religion in the province is Christianity at 81.9%; 6.5% of the

population practices Islam (Statistics SA, 2004). The Founder is a Muslim woman, the minority religion, but the majority of the people who work for her are not Muslim. Table Views is not religious-based; however, in the context of the community, religion is potentially an important piece, and so getting local funding is an issue.

Race is also an issue at Table Views when it comes to funding. According to a programmatic staff member, "some funders want to see that the organization has a database [list of beneficiaries by race] and that they need to be a BEE Organization." South Africa's Black Economic Empowerment (BEE) policy, enacted in 2003 and amended in 2011, is the country's initiative to change its racist past of systematically excluding Blacks, Indians, and Coloured people from joining the mainstream economy during apartheid. While SA is an upper middle-income country (UMIC) and WCP residents are, on average, the most affluent of all South Africans, the province is still marred by high poverty rates, unemployment and inequalities in the distribution of income between various population subgroups (Pauw & DuPlessis, 2005). The BEE policy strives for employment equity among all four legal racial categories and the government has labeled it as a growth strategy to close the inequality gap and foster economic growth. Some of the policy's objectives include access promotion to financing opportunities to start new businesses, empowering impoverished rural communities through access to land and ownership and encouraging Black-owned businesses with a specific focus on Black female small businesses. Potential funders want to see a list of staff and participant names and can tell from their surnames if an individual is Black or Coloured, which can affect funding.

Race plays a very important role in South African culture, specifically in the WCP, where almost half of the population (48.8%) residing in the province is Coloured and the WC is the only province in the country where the black African population is not the majority (SA Census, 2011). As a result of this and supported by discussions with key informants about the history of the WCP, segregation and discrimination still exists between the Coloured race and the Black race. These key informants were two Black/Xhosa women in their late 30s and early 40s, respectively, who have resided in the Western Cape all of their lives and work in the business field. According to the Founder, in addition to religion, race played an integral part when she created Table Views in 2008 and still plays a significant role in funding today. During my time at the organization, it was apparent that Table Views is in fact run by Coloured people and not by Black people.

The term "Coloured" is a "race" by legal definitions. However, to some it is viewed as more cultural than racial. There is a social hierarchy that exists based on these aforementioned characteristics. To many key informants that I spoke to, if you are not White then you are Black. The term Coloured goes back to the Khoi-San people of the Western Cape, the native or indigenous people, if you will, who had children with the White Boer slave owners that were mixed race. In order to further segregate the non-White people, key informants claim that the Blacks, Coloureds and Asians were given racial categories to differentiate themselves because they were the majority not the minority as you see in the United States where Blacks are a small percentage of the population.

The Director finds "it is very challenging as a Black South African running [her] organization." By looking at her, however, anyone in Cape Town or in SA for that matter

would say that she is Coloured (because of her skin color, hair texture and the fact that

she speaks Afrikaans and not Xhosa – the language spoken by the Black population).

Local funding from the province and the country is given more to Black organizations,

under the BEE policy, so it is in her best interest to identify as Black and to highlight the

fact that Table Views employs people who are Black in positions of authority. The

Director explained that she is disadvantaged compared to White organizations in the

community because she is Black and this has presented a challenge when applying for

funding. This identity impacts her ability to obtain funding and resources and continues

to reinforce her perception that:

> At some point we feel that the color of our skin has a lot to do with it…who is in
> charge of the Foundation. Internationally, Table Views is at a disadvantage
> because it is disadvantaged people who started the organization. If I was a White
> South African it would have been much different, because we see it every day.

The Director feels that the Black voices in her community are not heard, that her

organization is not being recognized, and that it is not well respected.

Category: Lack of Transparency Related to Funding

All staff members were asked: *Who provides the funds for Table Views?* However,

there were multiple employees that acknowledged funding is a secret. People who are

implementing the various programs, even at the administrative level, may not know

anything about where the money comes from or where the money goes. Knowledge about

funding is not allotted to everyone. When asked this question, one staff member

nervously laughed and whispered: "I am not sure because we are not allowed to ask about

the funding."

Another programmatic staff member stated "we don't know that information…I do not know who is funding it" and informed me that I should ask the Director about this topic. Other staff members indicated that they "honestly didn't know" and that administrative staff members have stated at meetings that "there is no funding." One staff member stated that I was the first person that knew of a stipend because it was confidential. Discussing funding is a very sensitive subject at the organization. Many staff members either do not know about funding streams or are scared to express their opinion. While reports such as the General Proposal are transparent to funding agencies, it is not evident to the people who work at the organization.

Category: Lack of Communication among Staff

Lack of communication among staff was the third category under overall barriers and challenges to organizational goal achievement that four staff members mentioned. One individual said that "members of the executive staff have no communication skills at all…you don't know what is going on in the organization until later you find out that something happened." A member of the administrative staff suggested that "if [certain individuals] would speak up more then I could help [them]. There needs to be more communication." A programmatic staff member shared an example where a teacher spoke to a parent about a child that was bullying other children in the class. The child was subsequently put out of the class in "time out." However, the parent had an issue with this form of punishment and went to the Director instead of to the staff member directly to complain about the situation, which led to the staff member getting in trouble. According to the staff member, "it looks bad because it looks like we [administrative and programmatic staff] are not communicating with each other."

Environmental Contextual Factors that Impact Participant Engagement

All staff were asked: 1) *Tell me about the organization's/your program's participants, who does the organization/program serve?,* 2) *Is the organization/program missing people who should be receiving services?, and* 3) *What are the barriers for clients to effectively use the resources/services of this organization/program?* Responses to these questions reflect environmental contextual challenges that impact participant engagement and manifest into four categories: community violence (N=8) (which is divided into three sub-categories: criminal activity and gangsterism, lack of decision-making power in the household, and abuse of women), poverty (N=7) (which is encapsulated into one sub-category: poor living conditions), child abandonment and neglect (N=7), and negative mentalities derived from racial and cultural tensions and acts of racism (N=5). Fear of being judged by the community and staff was mentioned by two employees as an issue that impacts participant engagement. For example, an administrative employee believed that, in addition to fear, participants are embarrassed or believe that they do not need help from outsiders. Furthermore, according to these 2 employees, some beneficiaries are worried that after attending a program at Table Views that knowledge of their participation will get back to people in their neighborhood and they will be stigmatized.

Category: Community Violence

The first common category under environmental contextual challenges that impact participant engagement is community violence. Community violence is divided into three sub-categories: criminal activity and gangsterism which has affected both

participants and employees (N=7), lack of decision-making power in the household

(N=6), and spousal/partner abuse (N=4).

Sub-category: Criminal Activity and Gangsterism

Gangsterism's negative impact on participant engagement was mentioned by

seven employees. According to a programmatic staff member:

> They [the community] are too scared to stand up to these gangsters and they are
> the ones that provide the drugs. They don't even put their children in schools and
> stuff because they are using the money that the children get from the government
> to use on drugs and alcohol…the outside people are more scared to come in here
> because they are always here, there are gangsters in Santa Monica, and you can
> die if you walk alone at night. People are scared to come in here.

An administrative member admitted:

> I think gangsterism affects them coming here. We have had many cases where
> [participants] couldn't come to class because they were shooting in Maraval, for
> example.

However, gangsterism is not just restricted to the Western Cape, "it is everywhere you

go," according to a programmatic employee. She admitted that it is worse here "because a

lot of youngsters didn't finish school and many of the gang people are using the

youngsters to work for them." The youth of Maraval work for the gangsters by

committing crimes in exchange for money to buy sneakers. For young boys who don't

have much, a life of crime creates an opportunity to reach the materialistic "South

African Dream," if you will. A programmatic staff member exclaimed that the number

one challenge to participant engagement is: "…the gangsterism, some of the people got

young children and they have to maybe walk past the gangsters and they interfere with

the children. It is very bad."

Violence in the community has also affected the employees. Three staff members

sometimes experienced fear because of the gangsters or it affected their ability to come to work. A programmatic staff member replied: "…I can be afraid because I have to walk a long distance…so I can go different ways but I have to be here." An administrative staff member discussed the increasing violence among taxi drivers and how it has impacted her ability to come to work. She explained that, at times, there are no taxis and because "drivers shoot one another and sometimes the taxis can't come in because they [other drivers] are burning tires in the road." Lastly, a programmatic employee discussed the shooting where she lives: "there were days that I could not come because of the shooting and robbing people and I would not come to the site." The shooting has also affected participant engagement because "if there is shooting they [the children] can't come to crèche."

Sub-category: Lack of Decision-making Power in the Household

Six employees discussed lack of decision-making power in the household as a barrier to engagement for participants. According to an administrative employee, "[a challenge] has to do with who makes the decisions in the household." A programmatic staff member confirmed that the men make the decisions at home; however, she has seen it most commonly among the foreigners:

> Women from Nigeria, Zimbabwe, Malawi, Mozambique, you name it. I think it is the law where they come from where they still feel that a man is the home decider. They have no say.

She is trying to put an end to these behaviors by explaining to the women that they have their own rights and to "take a stand." The Founder replied that while lack of decision-making power in the household does occur among the foreign national community, it also occurs among the Xhosa women who "have to speak to their husbands, get permission,

and the husband must support whatever they do." Another administrative employee expressed that this factor affects the level of participant engagement in the SBP "because the decision-making only lies with the husband…and not only if they are married but even if they just live together." Lastly, according to two other employees, the husband "is very strict and doesn't want other people to know their business", so demands that his wife not participate in Table Views' programs.

Sub-category: Abuse of Women

Lastly, four employees discussed how abuse of women affects participant engagement. An administrative staff member shared an example in which a young girl who wanted to access Table Views' services but her boyfriend was physically stopping her from going by holding her hand. The boyfriend, a local gangster, was abusing his girlfriend and the staff member approached him and demanded that he let go of his girlfriend's hand. The administrative employee also shared another example of a woman whose "husband abused her every day and didn't want her to come to class and empower herself." He explained that the abuse of women is specifically high in the foreign national community such as the Congolese but also among "the Xhosas, Zulus, and Sithus where the men are still the more dominant member in the household." The Founder further substantiated these contextual factors and spoke about "refugee women that are suffering and take the punches [from their husbands] in order to take care of their kids, and that they have nowhere to go."

The women in the SBP face different challenges than those in the CBC Program, according to the providers. Many of the women come to Table Views for help from their

abusive home situations. It appears that the women who are placed in the SBP face more domestic abuse than the women in the CBC Program. According to an administrative employee, the SBP "is a woman's program for women who come from very scary backgrounds, their husbands might be abusive at home and they have nowhere to go and come for us for help." During the intake process, the Adherence Counselor will recommend a program to each woman based on their individual backgrounds.

If the potential client expressed that she currently engages in home-making skills like arts and crafts, she is also placed in the Sewing and Beading Project where she can expand on her basic skills. According to an administrative employee, Table Views wants victims of spousal abuse "to come out of their comfort zone where they get abused, battered, insulted, humiliated, and they feel that they have nowhere else to go." The Founder and this employee both mentioned a common factor, when the woman feels like she has "nowhere to go." The women view Table Views as a safe space away from their abusive husbands and many of them stay for a long time because it is a comforting and secure environment.

Category: Poverty

Poverty is the second most mentioned environmental contextual factor according to staff. Examples of poverty include poor living conditions such as included issues with water, housing, and homelessness. Under Life Course Theory (LCT), the physical environment and social position are the main determinants of inequity. The underlying theme here is: organizational assistance. The organization assists their beneficiaries with overcoming the contextual factors that impact participant engagement. The participants

call on Table Views to assist them with their living conditions if they do not have water or if their places are flooded because of defective roofs.

Sub-category: Poor Living Conditions

One administrative staff member provided an example of a woman who was physically living under a boat with her two children because she had no other options for housing. According to him, the Founder "brought her in, gave her nice clothes and put her in a house. Her children are in the crèche now." A programmatic staff discussed this same situation and explained: "some of our kids, they don't live in housing they live in boats and they don't come because of rainy days, for example." In another example, the Founder discussed the living conditions in a home and:

> Immediately understood the suffering in that house, the unemployment rate was very high, nobody was working there, and the only income is the mother's disability.

Her example illustrated the various contextual factors that people of this impoverished community face.

Water shortage is another challenge that residents of Maraval face and many rely on Table Views to assist them with this issue. According to a programmatic staff member: "oh, water is a big problem because water always goes off" and according to an administrative employee "when people have a water problem they come to us…but somehow when we phone the water department for them they get help quicker than when they phone themselves." Another administrative staff member said:

> Where water is concerned, people would say that they can't come to class because their place is flooded and need clothing or if their house burned down. We tell

them that is important and we go and assist them. This is what we have done to lessen that barrier.

Flooding occurs mostly during the winter season (May to August) when the country is in its rainy season. Table Views lessened the barriers that a family faced through the provision of clothes and shelter. Water shortages have affected participant engagement. According to a programmatic employee: "if the water is out and a participant can't bathe that might affect them coming…the children do not come because the parent can't wash the child." This individual's statement implies that parents may be ashamed to have a dirty child.

Another programmatic staff member replied: "most people do not have houses or a place to stay, this is very common. They stay in shacks; some don't even have a shack." An administrative employee explained that Table Views assist people:

> By giving food or clothing or whether if the roof is leaking, then we will go out as staff and fix the roof...you know you can't change the living conditions but we can do something to improve it.

For example, the staff went to the house of this disabled woman and her child and patched up the roof. Lastly, the Founder shared an example of a situation where a family "lives off of the dumping site to generate an income. And they get whatever...if I throw a cabbage on that dump that is going to be the meal for the home. And that is a complete health risk."

Category: Child Abandonment and Neglect

Substance abuse leads to neglectful parents. The Founder shared an example where a child said "our parents left me with the kids so the cycle continues." Mothers leave their younger children in the care of their older siblings while they go get high. The

Founder also described a situation where she went into the home of one of the mothers and saw that one of the children was "sick and under-nourished…the eyes were depleted, the sores here in the mouth…" The child that she was referring to was infected with TB and the child's mother had neglected her for quite some time until the Founder stepped in and informed the child's grandmother that she must go seek medical attention.

One administrative staff member stated:

> …The backgrounds of the people here is very different…like how the children walk around the streets dirty…and children that get taken away from the parents because the parents don't look after them because of drugs and alcohol.

Her physical description of the children of the community mirrors the Founder's perceptions of child abandonment and neglect as a result of parental substance abuse. One programmatic staff member explained that "…most of the parents will sell themselves for drugs and sleep around for drugs. They are selling themselves for their habit not for food for their children." This illustrates a potential bias that the staff member feels towards the clients. A programmatic staff member also described the community:

> If you go through the roads now, you will see [drug addicted] mothers walking with the children…and the child gets exposed to that and at the end of the day the child can tell you at 2 years old that my mommy is doing this or that.

She explained that examples like this are the main reason why the ECD [Early Childhood Development] center was created.

Two more employees tied the issue of child abandonment and neglect to the creation of the ECD. One programmatic staff member discussed that the ECD was created "because a lot of young mothers are more into drugs and alcohol and…some kids come here with black and blue eyes, marks saying that their mother stabbed them..." And

one administrative employee explained how important the ECD is in the community because: "early childhood development starts at a young age, where there is drug abuse or any substance abuse for that matter and abuse in the homes…" Lastly, a programmatic staff member gave an example of a time where a resident was aware that their neighbor was neglecting their children and contacted Table Views. After a site visit was conducted, programmatic staff asked the parent to join the organization and "equipped the parent with the Parenting Workshop, the Computer Course, and the SBP." She drove the mission of Table Views home and showed the link between each program. Furthermore, some parents neglect their children by not helping them with homework when they come home from school, by not sending them to the ECDA on a regular basis, or by completely removing their children from the ECDA.

Category: Negative Mentalities Derived from Racial and Cultural Tensions and Acts of Racism

Because Table Views is a majority Coloured organization (staff and participants), non-Coloured women from the community (especially foreign nationals) are scared to go to the organization for help in fear of government affiliation and subsequent deportation. According to an administrative staff member:

> Some people still feel that [negative mentality] because we are Coloured and our services are mainly for Coloureds but these are the people coming in for help more than others.

However, the organization has seen an influx of foreign nationals over the last two years because they are now cognizant of the services and now know that it is a safe place. Table Views prides itself as an organization of unity, where anyone regardless of race, skin color, language or religion can access their services but another administrative

employee stated that race still plays a big role among Black participants and White volunteers who see themselves as different from the majority in the organization. These beliefs have a lot to do with the mindset of the people from the community because race has played such a huge role in their lives.

A programmatic staff member expanded on this negative mentality and wasn't sure herself about the difference between Africans (people from Zimbabwe and Somalia, for example), Coloured South Africans (who are not viewed as being African) and Black South Africans (who are viewed as Xhosas and therefore culturally African). According to her, "[in South Africa] you can be Black depending on your skin color, on the way you speak, your hair." She believed that "there needs to be something that is going to change people's mentality of thinking and also tell them that you are Coloured or Khoi-San." My conversation with her was eye-opening. She had a difficult time explaining what the term "African" meant to her. Black people from any other country on the African continent other than South Africans identify as or are viewed as Black or Xhosa. But Coloured "is just Coloured" to her. Xhosas are African but Coloureds are South African, according to some of the staff – there is a deep divide. Race is a label given to people in South Africa based on complexion, hair type, level of education and even the way in which you speak. I experienced the confusion myself while in the country where some individuals would say I was Black based on my skin complexion but others would say I was Coloured after I began to speak.

Acts of racism were mentioned as well. According to an administrative staff member, "here in Maraval, we had a lot of xenophobic attacks not just on outsiders but on the Xhosas and the Zulus as well." She expressed that different ethnic groups were

uncomfortable speaking to staff that were different racially or culturally. A programmatic

staff member said that people from other countries are judged and, in addition to violent

xenophobic attacks, racism is personified through name calling within the organization.

Furthermore, an administrative employee stated bluntly that: "some of the [participants]

are racist towards the foreigners" and the foreign nationals and Coloureds would speak in

their own language so that the other group wouldn't understand. However, she made it

clear that this was handled by the organization and is no longer an issue. Race is a

socially constructed label than can be interpreted many different ways. Unfortunately,

while Table Views claims that "all are welcome", because of this racial undertone and

actual racist actions not all may actually feel welcome.

Table Views – Program Backgrounds

Risk Factor 1: Maternal Poverty

Program 1: Computer and Business Course Program (CBC)

The participants receive a small stipend, a hot meal every day, as well as training

covering life skills, English, and computers (Table Views Overall Budget Proposal).

Participants from the community have the opportunity to attend free basic computer

courses in the afternoon and become proficient in Microsoft Word, Excel, and

PowerPoint as well as receive general internet skills.

Program 2: Sewing and Beading Project (SBP)

Created in 2011, the SBP was started by three women from Maraval and the

Project was designed specifically for destitute and abused women. Historically, rural

South Africans engaged in multiple economic activities, including agricultural production, small and micro-enterprises (May, 1998, 1999, 2000), handcraft making, selling cooked food, dressmaking, selling fruit, and informal employment (Seethal, 2002; McCusker, 2002). The South African legacy of handcraft making and dressmaking still exists at Table Views. Since its inception, the project has grown to approximately twenty women who work out of shipping-like containers on the foundation's lot. The containers are industrial equipment that businesses use to house their staff and participants when they are unable to afford buildings.

The SBP garners more external funding than the CBC Program. The clothes and beadwork are sold to the community at fundraisers every month. However, since most of the community is impoverished and cannot afford to purchase clothes and beaded jewelry, the Project mostly relies on international volunteers to buy their goods. The proceeds also keep the Project running by allowing the organization to buy more fabric and materials. After volunteering in the SBP for 3 months, the women receive a stipend of R500 [$38] from the Project's proceeds. The women in the Project also receive meals throughout the day (porridge, vegetables, a snack, a sandwich) and also get a container of food to take home at the end of the work day at 4:30 pm. It is a holistic concept in which some of the women also take part in the CBC Program and belong to the NHSG, which will be covered later.

<u>*Risk Factor 2: Poor Maternal Nutrition and Health*</u>

Program 3: Organic Garden/Feeding Scheme (OG/FS)

Started in 2011, the OG grows vegetables that are later cooked in the

organization's kitchen (FS) and served or sold to the men, women, and children in

Maraval. According to the Founder:

> We grow all kinds of vegetables here, cabbage, spinach, beetroot, onions,
> cauliflower, broccoli…and we sell it to the community not to really make money
> but at a rate where it is affordable and healthy because it is organic…The project
> was not started as a business. It was started to uplift the community socially and
> economically.

The FS provides up to 1,000 meals per week by feeding community residents and the

ECDA children. In the future, the organization wishes to develop the FS into an income

generating project for the participants (Table Views Overall Budget Proposal). The

Program targets children, people with HIV/AIDS, TB, and other chronic diseases, seniors,

people attending awareness events, project-related workers, and volunteers. The fruits

and vegetables are donated from a farm in a neighboring community and whatever grows

in the OG is given to the FS to feed the community.

Program 4: Nutrition and Health Support Group (NHSG)

The NHSG meets every Monday and Thursday and was created for the women

who participate in the SBP and the mothers who have children in the ECDA. The Support

Group is run by the Adherence Counselor for Health and Nutrition, along with

nutritionists from the Human Rights Project. Participants are provided with brochures and

handouts on health issues such as HIV prevention and ARV treatment and how to lower

cholesterol, for example. It is a two-tier system because women are able to receive health education and talk privately about their personal issues to a qualified Counselor.

Risk Factor 3: Maternal Alcohol Abuse

Program 5: Patrick ECD Learning/Aftercare Program (ECDA)

The program is named after Patrick, a 3-year old boy who was found roaming the streets and who came to the organization every day for help. His parents were addicted to drugs and alcohol. The ECDA has a criteria – it is only for kids that come from socially ill backgrounds that need the organization's help and assistance. The ECD Learning Program targets children between the ages of 1-6 through the daycare facility (or crèche), Aftercare (for children between the ages of 6-13), and PW. According to the Founder, "the Aftercare Program has over 90 kids that need assistance with reading, math, and life skills."

The ECD is free of charge, while other ECD centers in the area charge parents R400-R600 (approximately $30-45) per month. The parents pay a one-time "commitment" fee of R100 (approximately $8) but they get it back after staff observes that they are taking part in other programs that the organization offers such as the CBC Program, SBP, OG/FS, NHSG, the PW, or the CP, which will be covered shortly. All parents who want to take part in the FS or SBP have to come and talk with the Adherence Counselor first so that she can decide which program is best suited for their needs and place them accordingly. She also has to ensure that they are adhering to the programs and are actually attending the PW that are designed to uplift them out of poverty and make them aware of the social and health issues that they face.

Program 6: Parenting Workshops (PW)

Providers saw that when the parents would drop their children off at the crèche, they would leave to go home and abuse illegal substances. When they would come to pick up their children in the afternoon they were drunk or high and staff would be concerned as to what would happen to the child. After the success of the ECDA, providers decided that it wasn't enough to just feed and educate the children but parents needed to become a part of the organization so that their mindsets could also be changed and so that parents could become better role models to their children. During workshop sessions, parents talk about the challenges they face every day and share their experiences (Table Views Overall Budget Proposal). The Parenting Workshops (PW) is compulsory for the participants who have children in the ECDA and it is run by staff, local, and international volunteers. The parents must commit themselves to the meetings and attend every week. This was a programmatic change for the organization as staff saw the need to alter the program so that they could begin to change participant behavior. Indeed, the organization has evolved over time to expand through the creation of the PW.

Program 7: Counseling Program (CP)

Table Views services the needs of the community through education, information, and support. The latter is the focus of the Counseling Program (CP). On Mondays, lawyers from the community and from abroad come into the program and volunteer their time to assist and provide counsel to the women of Maraval with any issues they may have. The majority of women that participate in the CP have children that are registered in the ECDA. The CP is also run by the Adherence Counselor for Health and Nutrition.

Overall Staff Perceptions of Organizational and Programmatic Goals

Staff were asked: 1) *Tell me about the organization/program, why was it created and what are its goals?*, 2) *Tell me what you think about the organization/program, what do you think about its goals?*, 3) *What do you think have been barriers or challenges to achieving the organization's or program's goals and objectives?*, 4) *What do you think have been facilitators to achieving the organization's or program's goals and objectives?*, 5) *Do you believe that the organization empowers women to make better decisions around their own health and the health of their child/children? Why or why not?, and* 6) *What program has been the most successful for clients?* Responses to questions 1 and 2 convey **administrative staff perceptions of organizational goals:** to motivate and help the impoverished community (which includes the one sub-goal: to educate and develop skills) and **overall staff perceptions of programmatic goals** (which is broken down into primary and secondary goals for all seven programs). Responses to question 3 illustrate two main **barriers or challenges to organizational goal achievement:** funding challenges (which includes the impact of religion and race on funding and lack of transparency related to funding) and lack of communication among staff and one main **barrier or challenge to programmatic goal achievement:** the need for a bigger ECD and Aftercare. Responses to question 4 suggest two main **facilitators to organizational goal achievement:** positive staff relationships and a passionate and dedicated staff. Responses to question 5 illustrate main **overall organizational successes:** improved self-esteem (which includes the sub-category of positive life changes). Lastly, responses to question 6 demonstrate **overall programmatic successes:** job placement success stories.

Administrative Staff Perceptions of Organizational Goals

To reiterate, the stated goal of the organization is "to accomplish social and economic improvement through various programs that educate, inform, and support the people of Maraval and surrounding communities."

Main Goal: To Motivate and Help the Impoverished Community

Analysis of the interviews showed that four of the six administrative staff members believed that the organization's main goal is to motivate and help the impoverished community and this objective is further enhanced through a secondary goal: to educate and develop skills. The Founder stated that programmatic and administrative staff must:

> Educate and empower and speak [to the participants] one on one. But you have to do it in a way that you don't break the person down. And you don't have to point a finger, but you have to make it exciting and so motivating that they feel good. Like 'yes, this is something that I want my child to be a part of!'

Her response is consistent with the organization's stated goal. She is aware that to successfully reach these women you have to use an approach that is not condescending or judgmental but an approach that motivates them to participate in the programs. Since the organization is dealing with a population where many of the people are on drugs or abuse alcohol, the staff's approach has to be sensitive to these contextual factors.

Another staff member stated that:

> The ultimate goal is to see that everyone in the community is living with respect and dignity, that they have a job, their kids are going to school, and they are able to feed their family.

This employee's statement refers to ensuring that the organization is able to help individuals find employment and is able to support their families. This response is also consistent with the organization's description of the stated goal. A third employee stated that the goal is "mostly about helping the people…because I am a people person and I interact with a lot of people every day."

Sub-Goal: To Educate and Develop Skills

Table Views wants its participants to be cognizant of their potential and build themselves up by using their individual talents. An administrator mentioned a success story of one participant who had received a promotion because now she has basic computer skills – skills much needed in any professional field. According to her,

> Our goal is where there is potential we will develop them; we want to show you that you are here for a purpose, you have a talent, use it. We want someone to say for example 'Last year I was a cleaner [at the local supermarket] and this year I was promoted to management. Why [you may ask]? Because I have computer literacy now.'

Another administrator believed that Table Views is helping their participants in a holistic way by exploring each participant's skill level in order to prepare them for the job that they will receive in the future. Their responses are also consistent with the stated goal.

Overall Staff Perceptions of Programmatic Goals

For each program, the staff associated with the particular program was asked: *What do you think about the program's goals?* In some cases, all staff were asked about a program's goals as some staff work across programs in multiple roles.

Program 1: Computer and Business Course Program

The stated goal of the CBC Program is to "reduce the unemployment rate and create new income opportunities" (Table Views Overall Budget Proposal).

Primary Goal: To Educate the Unemployed Community

Analysis of the interviews showed that three of the eleven staff members believed that the program's primary goal is to educate the unemployed community. One employee who does not work in the CBC Program responded: "[the program] is for unemployed youth and if you are [an] unemployed and you want to start your own business…" While the Computer Course reaches a larger population, the Business Course educates the unemployed who desire to become business owners. An administrative staff member replied:

> That [program] is for people who are unemployed. They give you the course and you can always come afterwards if you need to make your CV or if you need to look for jobs on the internet.

After completing the Computer Course, participants can reach out to Table Views and learn about employment opportunities with the city.

Another employee who does not work in the CBC Program discussed the backgrounds of the beneficiaries: "Some of them they don't have a lot of education, so we have the Computer Course so that we can help them up their skills…" These three employees were able to articulate a shared goal that is consistent with the program's primary goal. In order to reduce the unemployment rate, the program educates the impoverished community with basic computer skills so that they are better equipped for

the job market. After completing the Computer Course, participants are contacted by Table Views' staff if new jobs become available; therefore, creating new income opportunities. The staff believed that education is the tool they must use to reach the stated primary goal.

Program 2: Sewing and Beading Project

The stated primary goal of the SBP is to "equip women in the community with needed self-esteem and professional skills to enable them to support their children and be strong role models in the area" (Table Views Overall Budget Proposal).

Primary Goal: To Provide Skill Development for Women

Analysis of the interviews showed that four of the eleven staff members believed that the program's primary goal is to provide skill development for women and two believed that the secondary goal is to provide income generation for the organization. According to an administrative staff member, the women "learn how to sew, to bead and they learn a skill…they graduate at the end of the year and they can take that skill to another workplace..." The year-end Sewing and Beading Graduation Ceremony is very inspiring for the women who participate in the Project. It shows them that they can make beautiful clothing and jewelry and gives them the motivation to open up their own shop if they would like. A programmatic staff member, who is not directly involved with the SBP, replied "[I tell the women] if you [are unemployed], we've got training and skills inside which is the beadwork and sewing."

Another administrative staff member responded: "the SBP teaches them how to do this kind of stuff" (points to the artwork and beadwork in the container). According to the Director:

> We have trained and placed many women in the sewing industry. Some have started a small bead workshop; for example, in the community and some have been placed in other companies doing administration.

These four staff members were able to articulate a goal that is consistent with the program's stated primary goal of equipping women with professional skills. However, it is not clear, from their responses, if employees believed that obtaining these skills would enable women to support their children and be strong role models, although that can be a potential outcome of professional development.

Secondary Goal: To Provide Income Generation for the Organization

One administrative staff member stated: "It is a training facility and an income generating project. So whatever they sell, it goes back into the project and they receive an income monthly." Another administrative employee responded:

> It was created to help the organization because most of the funds come from them [the SBP participants] to keep the organization afloat, so whatever they make and sell, it goes into the Project and the money that comes in from the sales goes into operational costs for the FS.

These two responses are not consistent with the stated primary goal of the program. It is not mentioned in the Overall Budget Proposal that the Project was created to support the organization financially.

Program 3: Organic Garden/Feeding Scheme

The stated shared goal of the OG and FS is: "to ensure that all vulnerable and disadvantaged groups get the support, guidance and mentoring that they need to fulfill their aspirations…by alleviating hunger in the community and encouraging a healthy lifestyle" (Table Views Overall Budget Proposal).

Primary Goal of the Organic Garden: To Provide Income Generation for the Community and for the Organization

Analysis of the interviews showed that three of the eleven staff members believed that the program's primary goal is to provide income generation for the community and for the organization. One administrative staff member replied: "the Garden [was created] not just to feed the community, but also to sell [the vegetables] to various small business owners…and then that money goes back into the Garden where we buy seedlings and compost." The vegetables are sold to members of the community at an affordable price that is lower than what they would pay at the market so that they can create a stable income. Another administrative staff member replied: "it is an income generating program where they grow the vegetables and sell them and some of the money gets put back into the project to buy seedlings and compost." His response was almost identical to the previous staff member. It is clear that this goal is shared among two of the five office employees.

A third administrative staff member extended the goal to include the older children of the community and explained: "it is for the Aftercare children that come out of school to teach them how to start their own vegetable garden at home." He believed

that the Garden benefits everyone in the community of any age and that the program is

teaching the youth from a young age how to be self-sustaining with hopes that, in turn,

this will push their parents to become independent as well. These three responses are

NOT consistent with one facet of the stated primary goal of the program: "…encouraging

a healthy lifestyle." The Garden allows the vulnerable and disadvantaged members of the

community eat nutritious and organic vegetables, thus promoting healthier eating and a

healthy lifestyle.

Primary Goal of the Feeding Scheme: To Feed the Community

Analysis of the interviews showed that four of the eleven staff members believed

that the program's primary goal is to feed the community. One programmatic staff

member that is directly related to the FS stated: "I think it [the FS] was created to feed

people outside in the community, for the people on drugs." As previously described,

Maraval is a community that is ridden with drug users, many of whom benefit from the

various services that Table Views offers. In his response, this program staff member also

argued that if people were able to buy drugs then they can definitely afford food. It is

impossible for Table Views to force people to stop using drugs but they can deliver

positive services to the community in an attempt to change behavior.

Two administrative staff members explained that the FS started off with handing

out food to the needy. According to another administrative staff member, "[the food] is

mostly for the *'chronics'* [people with chronic illnesses like HIV/AIDS, TB, and

diabetes] who are in the NHSG." Her response is an example of the holistic

characteristics of the organization. The OG provides fruits and vegetables for the FS

which serves the chronically ill people who participate in the NHSG. These four

responses are consistent with one facet of the stated primary goal of the program:

"…alleviating hunger in the community…" It is clear from the staff member's responses

of the goals of the OG and the FS that their perspectives are not entirely consistent with

the stated primary shared goal. No staff member explicitly discussed how vulnerable and

disadvantaged groups get guidance or mentoring.

All four employees believed that the implementation of the program needed to

change. The one programmatic staff member that is directly related to the OG/FS stated

that "people shouldn't just come [to Table Views] because the food is free; they should

do something to receive food." He felt that people were taking advantage of the program

and using it as a handout. An administrative staff member explained how, as a result of a

shared feeling among administrative and programmatic staff that the beneficiaries were

taking advantage of the program, the program has evolved and stated: "instead of them

just standing on a line, we said come into the program, do something, and then you will

get your meal at the end of the day."

A programmatic staff member, who is indirectly involved in the OG/FS and

believes that people should work hard, stated that she "wanted people to take charge of

their lives…because if we can allow everybody then they would go and come as they

please." Therefore, she worked with employees to change the program's implementation

by ensuring that new beneficiaries are interviewed and after discussing their challenges

and issues are given something to eat. Lastly, another administrative staff member

explained that the criteria of who can participate in the program had changed. Previously,

"the vegetables that went into the FS would feed the elderly, disabled, and children of the

community…;" however, that was altered and "in order for anyone to receive a plate of food they have to attend the [NHSG] classes and create independence for themselves." This is another example of Table Views' mission as a holistic organization by showing the connection between the FS and the NHSG.

Program 4: Nutrition and Health Support Group

The stated goal of the NHSG is to: "target and equip the women in the community with chronic problems such as diabetes, HIV/AIDS, TB, high blood pressure, and high cholesterol with the skills to manage their individual diseases" (Table Views Overall Budget Proposal).

Primary Goal: To Promote Healthy Eating and Living to the Community

Analysis of the interviews showed that six of the eleven providers believed that the program's primary goal is to promote healthy eating and living to the community. One programmatic staff member promotes healthy eating and living through the dissemination of "information and programs that they must adhere to for their health." Another programmatic staff member, who does not work directly with the program, provided more information about the goal: "we have a group for people that are sick, like we call it 'chronics'…it teaches them how to eat healthier, check their blood pressure…" The Founder supported this response and explained: "they get health education and discuss all of their issues."

One administrative staff member discussed how the program was implemented:

> We decided we would have the NHSG where people could learn a skill and also learn nutritional information about what to eat and what is good for your health and then they will [also] get a plate of food.

This employee is referring to the aforementioned skills of eating healthier and knowledge of how to check their blood pressure correctly. A programmatic staff member who is not directly involved with the NHSG affirmed: "young girls from across the country come and learn how to eat healthy, how to live healthy and what not to do…" It is interesting that this individual described beneficiaries as only "young girls" when in fact; the program serves women of all age groups. Also, according to this staff member, Table Views serves women from "across the country," which could be interpreted as the organization's mission to help everyone regardless of their ethnicity or nationality and the influx of foreign nationals.

Lastly, another programmatic staff member who is not directly involved with the program explained how the women "take back [what they learned] to their children and the children will know how to eat better." Again, it is evident that Table Views focuses on a holistic approach to reaching the entire community – the NHSG serves parents who will take the knowledge they have acquired from the program and use it in their households with their children, thus perpetuating a positive cycle of healthy eating and living. These six responses are consistent with the stated primary goal of the program. To "equip the women in the community with chronic problems," staff promote healthy eating and living through brochures and handouts, teach participants how to check their blood pressure, learn nutritional information on what to eat and receive food, what not to do [how to avoid negative behaviors], and how to take the skills that they have learned at Table Views back to their children.

Program 5: Patrick ECD Learning/Aftercare Program

The stated goal of the ECDA is "to target neglected and abused children whose parents are addicted to drugs and/or alcohol through learning programs" (Table Views Overall Budget Proposal).

Primary Goal: To Educate and Empower the Children of the Community

Analysis of the interviews showed that three of the eleven providers identified the program's main goal as to educate and empower the children of the community, and this objective is further enhanced through a secondary goal: to change behavior. When asked about the program's goal, an administrative staff member answered: "the Aftercare is a tutoring program where we help them with their homework and mentoring and evaluation…" According to another administrative staff member, "we have a lot of different educational programs we offer and I feel like it is needed." Indeed, educational programs are needed in a province with low educational attainment levels. A programmatic employee, who is involved with the ECDA directly, stated: "the goals for the ECDA are to teach our children, make them stronger, and make them more powerful children." The responses of these three employees are consistent with the program's stated goal. To "target neglected and abused children whose parents are addicted to drugs and/or alcohol," the program has developed "learning programs" through homework help, mentoring, evaluation, and educational programs to make the children more empowered and end the cycle started by their substance-abusing parents.

Secondary Goal: To Change Behavior

In order to accomplish the primary goal of educating and empowering the children of the community, administrative and programmatic staff believed that they must change the behavior of these children. One administrative employee explained that staff assists children by looking into "their behavior and whatever social ills or challenges that they face at home." Another administrative staff member stated:

> We need to target the small kids and change their mindset. Because the things they see is what they become. We need to make them see that is not the right way to live.

To change the cycle of substance abuse started by parents, the program targets young and older children so that they do not imitate the behaviors of their mothers and fathers.

The programmatic staff member, who is involved with the ECDA directly, replied:

> [I want children] to look up and say that they don't want the lives that they have outside of Table Views…to not become the people who live in Maraval and Santa Monica…to not use the people around them as mirrors.

The staff member does not want the negative cycle of poverty and low educational attainment of the parents to trickle down to the children of the community. He wants them to excel in school and dream for a better life outside of Maraval. Furthermore, according to the Director, "Everyone would ignore the child on the street whose mother or father is on drugs or alcohol. No one has time for a child [like] that…" Fortunately, the staff at Table Views does have time for children "like that" and are in agreement with the stated goal.

Program 6: Parenting Workshops

The stated goal of the PW is to "target parents addicted to drugs and/or alcohol whose children participate in the ECDA through learning programs" (Table Views Overall Budget Proposal).

Primary Goal: To Educate and Motivate Mothers and Fathers to Become Better Parents

Analysis of the interviews showed that five of the eleven employees identified the program's primary goal as the education and motivation of mothers and fathers to become better parents. The PW, like other programs, are holistic in nature. In support of this principle, one administrative staff member responded:

> If we know the parents, we know where the child is going. We educate the parents about nutrition, the importance of doing homework with their kids, spending time, and just being better parents.

Another administrative staff member ensured that "the parents must be interested in the child's life and where the ECDA is concerned."

A third administrative employee stated that: "the goal is for the parent to step up and realize their mistakes." The staff believes that the parents are able to speak frankly and honestly in the workshops and once they comprehend where they may have gone wrong as parents, the staff is able to educate and motivate mothers and fathers to become better role models for their children. A programmatic staff member, who works directly with the PW, "motivates women to become better mothers" and a second programmatic staff member, who is not directly involved in the program, stated that: "the goal is that I can see that [a parent] is doing what she must do but also…becoming a better person."

Again it is evident that the programs are all tied to one another. The mothers and fathers

in the PW are also educated by programmatic staff and volunteers in the NHSG. The

responses of these five staff members are consistent with the primary goal. The program

is targeting parents who are addicted to drugs and/or alcohol by helping them see where

they may have failed their children in the past, change their behavior in a positive way,

and use the skills that they learn at the PW as self-development, in anticipation that the

skills parents learn will hopefully result in them becoming not only better parents but

better individuals overall.

Program 7: Counseling Program

The stated goal of the CP is: "to provide a safe environment where people in the

community are comfortable to consult with [staff] on issues they are facing in their lives"

(Table Views General Proposal). The stated secondary goal of the CP is: "to link people

with other social institutions (social development, schools and colleges, hospitals) and to

offer support in legal and governmental affairs" (Table Views General Proposal).

Primary Goal: To Provide Counseling and Advice to Women in the Community

Analysis of the interviews showed that three of the eleven employees identified

the program's primary goal as providing counseling and advice to women in the

community. One programmatic employee, who works directly with the women in the CP,

stated that it was "created to talk about their problems…and social challenges." These

social challenges range from divorce to land and housing rights. The need for these

services related to counseling was confirmed by the Founder who stated:

> The participants are all broken down people that are coming in here that need time to vent…and with counseling, there are times when people just want to let go and you need to allow that space.

The program supports the beneficiaries on a broader basis that extends counseling and includes free legal services from lawyers and law students, and education on the rights of mothers and children. When asked which program is the most successful in their opinion, one programmatic employee replied: "…the Counseling Program…because most of them can sort out their problems there and get help, they can talk privately and confidentially." According to the staff's responses, the CP has achieved its stated primary goal through counseling and secondary goal by linking participants with lawyers who can provide legal support.

Barriers or Challenges to Programmatic Goal Achievement

Staff were asked: *What do you think have been barriers or challenges to achieving each program's goals and objectives?* One of the programs that fall under the third risk factor Maternal Alcohol Abuse (the ECDA) proved to have the most barriers or challenges. As a result of the analysis, barriers or challenges to programmatic goal achievement fell into one main category: the need for a bigger ECDA (N=4).

Category: The Need for a Bigger ECDA

Staff argued that the organization needs a bigger ECDA facility to accommodate the growing number of children that are coming to the program. However, lack of funding is a barrier to achieve this goal. According to an administrative staff member and programmatic staff member, it is hard for the organization to turn kids away because either "the parents don't have money" or "a child didn't find a school," respectively. Table Views does not want to turn children away because it is a possibility that

something bad may happen to them at the hands of their parents or by members of the

community which is infested with drugs and criminal activity. According to a staff

member directly related to the program, "I think we need more [funding] because the

space is so cramped up. We have almost 90 kids in the ECD and it is so small."

One of the ECD staff gave an example of the high level of overcrowding. A

toddler passed out the week before I conducted the interview because it was so hot and

overpopulated in the container. According to the employee:

> The ECD is very small for all of those children, it is cramped up, and sometimes it
> is very hot, and we get very frustrated. We need a bigger structure so that it will
> work better in that way.

The size of the ECD is affecting employee productivity because the stifling environment

has resulted in increasing levels of staff irritation.

Facilitators to Organizational Goal Achievement

Staff were asked: 1) *What do you think have been facilitators to achieving the*

organization's or program's goals and objectives? Facilitators to organizational goal

achievement fall into two categories: positive staff relationships (N=4) and a passionate

and dedicated staff (N=3).

Category: Positive Staff Relationships

There are not many staff in programs who work across the organization. Instead

they tend to stay within their own programs. While gossiping and cliques were negative

behaviors mentioned by two staff members, ultimately employees said that relationships

were overall good. Four staff members agree that the relationships are positive. This

theme was manifested through respect among staff members and the sharing of ideas and

collaboration. Some of the administrators demonstrate respect and caring by engaging with programmatic staff. According to one staff member:

> The manager always comes into our crèche, greets us, comes and sits by us or he will come and eat there, you know have a conversation, laugh, and everything yea. It is a good relationship.

The manager shows his staff respect by engaging with them and maintaining positive relationships with everyone, regardless of their level in the organization. Another programmatic staff member revealed that staff "all respect and understand each other" most of the time.

One programmatic staff member stated that the staff relationships "are good because we can share our ideas. We can talk to each other and there is a no wrong answer." An administrative staff member shared this sentiment and discussed how all employees shared their ideas about an upcoming annual event and stated:

> The relationships are quite cool because where there is an event, like June 16th for example, what we do is we come together and we ask everyone's opinion on how are we going to run this event…

The 16th of June is Youth Day in South Africa and is a public holiday in the country. The holiday celebrates the beginning of protests about the Bantu Education Act. The Act required that Afrikaans would be the official language taught in Black schools and led to the Soweto uprising in 1976. During the protests a young boy, Hector Pieterson, was shot and killed by the police. In Soweto there is a monument to Hector that brings thousands of visitors each year who reflect on this historic period of time in the country.

Category: A Passionate and Dedicated Staff

In order for any organization to run successfully, management and staff must work together to meet the organization's goals. Because of insufficient funding, the staff are underpaid and overworked. However, their dedication to and passion for the work of the organization is what is keeping it afloat. One administrative staff member asserted, "Firstly, if you are working for an NGO, you have to have a love for what you do. If you are looking for the money, you are not going to find it here..." This individual is passionate about what he does and in his role at the organization. Although he, along with other staff members, may work overtime at times he does not expect to be paid additionally for his time.

Another staff member is inspired to stay at Table Views because he feels loved by his colleagues and the participants that he serves. One programmatic staff member remains at the organization because of her love for the community that she serves and because she "always wanted to be deep in [her] community." She went on to explain that she "needed a platform and Table Views gave [her] that platform." These examples illustrate the level of passion and dedication shared among employees at the organization at different levels.

Overall Organizational Successes

Staff were asked: *Do you believe that the organization empowers women to make better decisions around their own health and the health of their child/children? Why or why not?* Six of the eleven employees responded affirmatively and presented success

stories around one main category: improved self-esteem which included one sub-

category: positive life changes.

Category: Improved Self-Esteem

One programmatic staff member shared an example of a woman who had the

courage to leave her abusive husband, won her case in court, and gained custody of her

children. The woman came to the organization and expressed "…I have won my house,

and I have won my children's rights from him!" The staff member was delighted that she

was able to inspire this woman's need to divorce her abusive husband and is proud that

mothers who participate in the organization's various programs are gaining a cultural

understanding of their individual democratic rights as women. Another staff member

stated that without Table Views she wouldn't have been able to take part in this interview

because she was too shy before and didn't like speaking. However, after years of working

with and for the organization, "it built up [her] self-esteem." The organization has also

empowered her to be more involved in her child's life instead of relying on her mother's

assistance. The Director indicated that many women share this same shy nature but she

(along with her staff) is working on improving the self-esteem of all the women at Table

Views. The Director went on to explain that after joining the organization:

> Women become more confident, they have more pride in themselves, they
> express themselves more where the social problems are concerned, they express
> themselves more where the spouse is concerned…and for us to hear the feedback
> where women are saying that they have had enough or that 'last night I told my
> husband this or that.' That for us is a good thing, because many women are
> introverts when they come into the organization.

Sub-Category: Positive Life Changes

Women who participate in Table Views' various programs have made positive changes in their lives from improvements in their living spaces, healthier eating habits, and mindset changes. One administrative staff member provided examples of women that have made positive life changes ever since they began to volunteer at Table Views. He has seen changes in their housing environments during home visits and has noticed the difference in cleanliness from the initial home visit compared to visits made after several months. A programmatic staff member shared examples of women who participate in the PW and "learn healthy living and healthy eating…which they would take back to their children…" Lastly, the Founder believed that:

> The development programs that Table Views has to offer are a total mindset change for the community. We see it when the people come in here, we experience the before and the after and throughout the training while they are attending, the changes that women go through…

Her response is related to the difference in living conditions throughout the training that the administrative staff member also discussed.

Overall Programmatic Successes

Finally, staff were asked: *What program has been the most successful for clients?* One of the programs that fall under the first risk factor: *Maternal Poverty* (the SBP) was the most successful program according to five of the eleven staff members. Some shared participant success stories in their responses.

Category: Job Placement Success Stories

A staff member, who is not directly involved with the Project, believed that it was the most successful program because "[the women in the Project] always get orders from

people who say they want [clothes or beadwork]." A SBP staff member agreed that the

project was most successful because of "the quality." An administrative staff member

stated that the Project was the most successful because sometimes the women:

> Get immediate work. [For example], someone from a factory might phone and ask
> for a sewing machinist…and a 21 year old was in the project…and by the end of
> the year she started working for [an organization] doing sewing full-time.

Furthermore, the Founder supported this previous response and replied:

> We have trained and developed many women and placed many women in the
> sewing industry…some started a little bead shop/workshop and some have been
> placed in other companies within administration.

Lastly, an administrative staff member expressed how the Project fulfilled its primary

goal to "equip women in the community with needed self-esteem…skills to enable them

to…be strong role models in the area" because "it helps the abused and battered

women…we don't see bruises on the women anymore…" To summarize the provider's

examples, participation in the SBP has given some women the self-esteem to leave their

abusive husbands, the courage to stand up for themselves, and the strength to remove

themselves from harmful relationships. It could also be argued that many providers also

view the SBP as the most successful program because it is the only program that

generates income for the organization.

Conclusion

This chapter focuses on provider views of the community in addition to

information about Table Views' organizational make-up, staff demographics, staff

backgrounds, information on funding, barriers or challenges to organizational goal

achievement, environmental contextual factors that impact participant engagement, and

backgrounds on each of the seven programs. The chapter also discussed administrative

staff perceptions of organizational goals, overall staff perceptions of programmatic goals,

the main barrier or challenge to programmatic goal achievement, facilitators to

organizational goal achievement, overall organizational successes, and overall

programmatic successes. The organization was created to educate, inform, and support

the Maraval community through various training and development programs. The small

organization is comprised of a total of 18 staff and for the purposes of this current study,

11 were interviewed on an individual basis. Variation exists among the staff positions,

length of time at the organization, and educational attainment levels; however, less

variation exists as it relates to race and religion. The issue of familial ties, if you will, was

mentioned among some of the employees and, indeed, four of the ten staff members are

related to the Founder. Local funding from the government is scarce and Table Views'

funds are generated through proposals, small events at the organization, networking

events with local CBOs, donations from international organizations, and donations from

volunteers from Denmark and Germany.

According to staff, there are three barriers or challenges to organizational goal

achievement: the impact of religion and race on funding, lack of transparency related to

funding, and lack of communication among staff. Employees mentioned a funding issue

between two local organizations that were considering donating to the organization, how

race can affect funding because of the country's new BEE policy, and challenges to

funding because of the Founder's racial identity. Staff also discussed lack of transparency

related to funding, acknowledged that funding is a secret to most, and some indicated that

they were completely unaware of funding streams. Additionally, some employees

discussed lack of communication among staff citing lack of communication skills at the executive staff level and between administrative and programmatic staff.

According to staff, there are four main environmental contextual factors that impact participant engagement: community violence, poor living conditions, child abandonment and neglect, and negative mentalities derived from racial and cultural tensions and acts of racism. Community violence is further divided into criminal activity and gangsterism, lack of decision-making power in the household, and the abuse of women. Criminal activity and gangsterism affects both staff and participants and staff provided examples of drug sales, murders, and shooting which impact participant engagement because of fear. Lack of decision-making power in the household affects foreigners, Xhosa women, and Coloured women at varying levels. Lastly, staff provided examples of assault and battery when referring to the abuse of women as a contextual factor that also impacts participant engagement.

Poverty, the second most common environmental contextual factor, included challenges with water shortages, deplorable housing situations, and homelessness. These poor living conditions also brought out issues regarding sanitation and food insecurity. Child abandonment and neglect, the third factor, was illustrated through examples of parental substance abuse, under-nourished children, sick children, children that are roaming the streets, and child physical abuse. Lastly, the fourth most common factor brought forth feelings of racial inferiority and examples of xenophobic attacks. Sadly, even though Table Views would like to be viewed as a place where everyone is welcome, racial undertones and actual racist actions are contradicting this vision.

Each program was described in detailed and separated into the three main risk factors: maternal poverty, poor maternal nutrition and health, and maternal alcohol abuse. Goals for each program were offered and then overall staff perceptions of organizational and programmatic goals were presented. Administrative staff perceptions of organizational goals were consistent with the organization's stated goal. Overall staff perceptions of programmatic goals were consistent with the stated goals of the CBC Program, the NHSG, the ECDA, the PW, and the CP. Overall staff perceptions of programmatic goals were not consistent with the stated goals of the SBP and the OG/FS.

The main barrier or challenge to programmatic goal achievement according to staff was the need for a bigger ECDA which is a result of insufficient funding. To support this need, staff provided examples of overcrowding, which has resulted in staff frustration. Conversely, facilitators to organizational goal achievement included positive staff relationships and a passionate and dedicated staff. Positive staff relationships are facilitated through the sharing of ideas, collaboration, respect, and staff engagement on all levels. Although the staff are overworked and underpaid, they remain passionate to the organization and do not expect to be paid overtime for longer hours worked. Lastly, overall organizational successes were presented through participant success stories such as improved self-esteem and positive changes in life and overall programmatic successes was communicated through job placement success stories, particularly in the Sewing and Beading Project – agreed among 45% of staff as the most successful and profitable program for participants and the organization, respectively.

Chapter 6: Participant Perspectives:

Maternal Poverty – Computer and Business Course Program

and Sewing and Beading Project (CBC & SBP)

<u>**Introduction**</u>

In this chapter, I first provide participant demographics and behavior divided by each program – the Computer and Business Course Program and the Sewing and Beading Project. This is followed by programmatic overlap and comparisons between both programs. Next, I offer findings on the four most common environmental contextual factors according to participants followed by the three most common individual contextual factors. This is followed by barriers/challenges and facilitators to participant engagement. Finally, I provide each program's impact on participant knowledge.

<u>**Participant Demographics and Behaviors by Program**</u>

To obtain information about the parent's individual backgrounds and to start the conversation, participants were asked the following question: *Tell me a little about yourself?* Responses to this question included racial identity, age, level of education, and marital status. Behaviors and personal background were also obtained from responses to this question in addition to questions asked later in the interview. **Table 4** below provides a breakdown of participant demographics and behaviors by program.

Table 4: Participant Demographics and Behaviors by Program (CBC/SBP) (N=13)

	CBC	SBP	FS	NHSG	ECDA	PW/CP	RAC	AGE	EDU	TEP	MAR	ALC	AUDP	ABU
Pearl	*Main*		Yes				CO	36-70	LTHS	Yes	MAR	Yes	No	No
Brianna	*Main*		Yes				CO	36-70	SHSD	No	SING	No	Yes	No
Savannah	*Main*		Yes				CO	18-35	SHSD	Yes	SING	Yes	No	No
Maryann	*Main*		Yes				BL	18-35	SHSD	No	SING	No	No	No
Kenya	*Main*		Yes				BL	18-35	SHSD	Yes	MAR	Yes	No	Yes
Porsha	*Main*		Yes		Yes	Yes	BL	18-35	SHSD	No	SING	Yes	No	No
Pamela	*Main*		Yes		Yes		CO	18-35	SHSD	No	SING	Yes	No	No
Rudy		*Main*	Yes	Yes	Yes	Yes	CO	36-70	LTHS	Yes	MAR	Yes	No	No
Haley		*Main*	Yes	Yes			CO	36-70	LTHS	No	MAR	No	No	No
Marcella	Yes	*Main*	Yes				CO	36-70	LTHS	No	SING	Yes	Yes	Yes
Sue	Yes	*Main*	Yes	Yes			CO	36-70	LTHS	No	SING	Yes	Yes	Yes
Cindy		*Main*	Yes		Yes	Yes	BL	18-35	SHSD	No	SING	No	No	Yes
Rachel	Yes	*Main*	Yes		Yes		CO	18-35	LTHS	Yes	SING	Yes	No	Yes

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Key

CBC: Computer and Business Program
SBP: Sewing and Beading Project
FS: Feeding Scheme
NHSG: Nutrition and Health Support Group
ECDA: Early Childhood Development and Aftercare Programs
PW: Parenting Workshops
CP: Counseling Program
RAC: Race (Black (BL) and Coloured (CO))
AGE: Age (18-35 and 36-70)
EDU: Educational Attainment (Less than High School (LTHS) and Some High School or High School Diploma (SHSD))
TEP: Teenage Pregnancy (Yes or No)
MAR: Marital Status (SING – which to preserve anonymity includes women who have never married, are divorced, or are widowed – and Married (MAR))
ALC: Alcohol Usage (Yes or No)
AUDP: Alcohol Use during Pregnancy (Yes or No)
ABU: Abuse of Women (Yes or No)

The Computer and Business Course Program and the Sewing and Beading Project are the two main programs that the women participated in; however, overlap exists among the other four programs: the Feeding Scheme, the Nutrition and Health Support Group, the Early Childhood Development and Aftercare Programs, and the Parenting Workshops/Counseling Program. The Organic Garden has been subsumed into the Feeding Scheme. Analysis of the data showed that the common theme that emerged was that the majority of participants were recruited through word of mouth (n=5). This is not in agreement with the staff interviews in the previous chapter which indicated that participants are most commonly recruited through complaints or reports from neighbors who view them as a nuisance in the community.

Without being asked directly, one woman spontaneously disclosed that she used drugs in the past. Fifty-four percent or (N=7) of women participated in the CBC as their main program while 46% or (N=6) of women volunteered in the SBP as their main program. The majority of women in this sample identify as Coloured (N=9). However, while Black women only comprise approximately 30% of participants in the overall sample, more Black women (43%) participated in the CBC Program compared to the SBP (17%). The sample is almost equally divided into women who fall between the ages of 18-35 (54%) and women between the ages of 36-70 (46%). Interestingly, the four Black women fall into the 18-35 age category whereas the nine Coloured women range in age from 36-70.

Forty-six percent or (N=6) of women have a LTHS level of education and have never attended high school and 54% of women have SHSD. More specifically, as it relates to race and educational attainment, all of the women who have a LTHS level of

education are Coloured (N=6). Variation exists among the SHSD women: 3 of the women are Coloured and 4 of the women are Black. Black women have higher levels of education than Coloured women in the sample. Thirty-eight percent (N=5) of women had children as teenagers (at the age of 19 or younger). Almost 62% of the women are divorced, widowed, or single. Five of the thirteen women (40%) disclosed that they have endured physical abuse at the hands of their spouses or significant others. Lastly, the women were asked if they currently drink alcohol or if they have in the past and the majority (N=9) or approximately 69% responded affirmatively.

As stated in the Methodology chapter, alcohol use was triangulated by discussions with staff who confirmed if a participant currently drinks alcohol or if they have in the past. Of the 69% of participants who admitted that they drink, the staff confirmed that 46% or (N=6) of the women do drink. The staff were unaware of the drinking habits of the remaining 23% or (N=3) of women who do use alcohol, however, in their interviews these participants disclosed that they do drink alcohol. Therefore, the information provided by participants during the interviews about drinking habits is accurate as they were honest about their drinking habits. Due to the program's short length (rotations of twelve weeks) parents who participate in the CBC are not always screened during the intake process, a definite problem in program procedure. As a result, staff members are unaware of their drinking habits. Furthermore, of the 31% of women that stated they don't currently drink or never have, the staff confirmed that these 4 women do not drink which further supports the findings. Finally, twenty-three percent of women (N=3) admitted that they drank alcohol during pregnancy.

Table 5 below provides the impact of age on alcohol use for CBC/SBP participants:

Table 5: Impact of Age on Alcohol Use (CBC/SBP) (N=13)

	YES	NO
18-35 (N=7)	71%	29%
36-70 (N=6)	67%	33%

As the table illustrates, the younger women in the sample currently drink alcohol or have in the past at a slightly higher degree (71%) compared to women between the ages of 36-70 (67%). This demonstrates that alcohol does not appear to decrease drastically as people get older in the Maraval community. It is a habit that continues long into adulthood.

Table 6 below provides the impact of educational attainment on alcohol use for CBC/SBP participants:

Table 6: Impact of Educational Attainment on Alcohol Use (CBC/SBP) (N=13)

	YES	NO
Less than High School (N=6)	83%	17%
Some High School or High School Diploma (N=7)	57%	43%

As the table illustrates, the women with lower educational attainment (primary school level of education or less) currently drink alcohol or have in the past at a considerably higher degree (83%) compared to the women who have some high school or graduated from high school (57%). This demonstrates that higher levels of education notably decrease the likelihood of alcohol use.

Programmatic Overlap and Comparisons

Three women who volunteered in the SBP also participated in the CBC Program. These 3 participants differ only in age. However, they are all Coloured, have a LTHS level of education, are single, abused alcohol in the past or currently do, and were abused by their spouse or significant other. It can be argued as a result of their marital status and past experiences with alcohol abuse and spousal abuse, these 3 women participated in the CBC Program to improve their knowledge and skills and wanted to receive the Computer Course certificate to become more marketable. None of the women who identified the CBC Program as their main group volunteered in the SBP. This can be as a result of the longevity of the SBP. Many of the SBP participants have been there for a number of years for reasons which will be discussed later in the chapter. On the contrary, the CBC Program is for a limited period of time and results in a certificate of completion as discussed in Chapter 5.

All of the women receive food for themselves and their children through the FS. None of the women in the CBC Program participated in the NHSG, while 3 SBP participants did. This may also be due to the short amount of time that the CBC Program participants spend at the organization compared to the SBP participants. The three SBP women who participated in the NHSG only share two common characteristics: EDU – all 3 women have a LTHS level of education and RAC – all are Coloured. Two of the seven CBC participants have children that are enrolled in the ECDA. Interestingly, these women are both between the ages of 18-35, are single, and abused alcohol in the past or currently do. It can be argued that these women utilize the ECDA services because they are young, are the head of their households/sole provider and therefore need to send their

children to a crèche, or need this service (which includes parenting workshops and a counseling program) because of their alcohol problems.

Overall, the women in the CBC Program are more racially diverse, younger, and have higher levels of education than the women in the SBP. The women in each group have abused alcohol in the past or currently do at approximately the same rate: CBC (71%) and SBP (67%). The women in the SBP have been abused by spouses at higher rates (67%) than CBC women (14%). More specifically, a relationship exists between alcohol abuse and spousal abuse among the SBP group: half of the women have abused alcohol in the past or currently do and have also been victims of domestic violence.

Environmental Contextual Factors

Environmental contextual factors are divided into four categories: community violence (N=9), food insecurity (N=5), poverty (N=5) – which includes one sub-category: maternal laziness, and lack of social support networks (N=3). For some women these contextual factors affected their ability to come to the CBC or SBP. However, for others, these factors do not influence their participation and they cope by avoidance.

Category: Community Violence

Analysis of the data showed that the common environmental contextual theme that emerged was that the majority of participants (69%) are affected by community violence (home invasion, burglary, theft, murder, and shootings). Community violence is a theme that impacts participant engagement according to staff (Chapter 5). Five participants have experienced gangsterism firsthand and one woman knows that gangsterism is prevalent in the area and fears going out as a result. Brianna, a CBC

participant, stated that: "break-ins happen all the time [at home]. Or when you do your washing and you leave it there, they can take it from the line." According to Maryann, a CBC participant:

> They have broken into my home…if you hang the washing and there is no one in the yard, those boys [gang members] are walking all around and will come and steal your clothes, anything that you left outside.

Savannah, a CBC participant, has been the victim of home invasion four times by drug "tik people" [cocaine users]. Like Savannah, Kenya, a CBC participant, has also been the victim of home invasion and burglary:

> I woke up in the middle of the night and there was this guy standing next to me. He only took my phone. He didn't hurt me. He could've stabbed me to death while I was sleeping.

Marcella, a SBP participant, explained that her living situation is "something very dangerous for us [her and her children]." The gangsters have broken down Marcella's fence.

Other participants are aware that gangsterism exists in the community but it has not affected them personally. For example, Porsha, a CBC participant, shared that:

> It was dangerous for us to walk outside because at a certain point there were 8 bodies being found in the field there so we wouldn't know if somebody would jump out of the field, kidnap you and actually kill you there. So we don't know to classify it as "gangsterism" or pure crime. So those were the only obstacles we had because we had to go down there on the other side when we live on this side.

Two participants expressed that gangsterism impacts their ability to come to the organization for services. According to Rudy, a SBP participant, "…the shooting [makes it difficult to come sometimes]" and Savannah is constantly worried about leaving her home to attend the CBC Program because of multiple break-ins. For four other women

(33%), however, gangsterism does not impede their participation in the programs. Although Brianna has been a victim of home invasions and burglary several times, gangsterism hasn't stopped her from attending the CBC Program. Like Brianna, Maryann is worried about her clothes being stolen when she is at the program during the day. However, she copes with her environment by avoidance and claimed: "I don't like to be involved in that [community violence]…I just keep my mind away from those things." It has not impeded her participation in the program.

Haley, a SBP participant, admitted that while gangsterism is highly prevalent in the community: "I don't concern myself with those things, so they don't affect me much." Her response was also similar to Maryann. They both try and ignore the violence that surrounds them so that it doesn't concern them personally. Finally Rachel, a SBP participant, agreed that yes "there are gangsters…but I would still come to [the program]." Overall, these findings are supported by what was discovered during interviews with staff: eight of the eleven providers mentioned how gangsterism in Maraval *may* affect participant engagement. However, according to the data, gang violence does not have a strong and negative impact on their engagement and participation in the CBC Program and the SBP. For almost half of the women who discussed community violence, coming to the programs helps them cope with their environment. Even faced with home invasion, burglary, theft, murder, and shootings these women were determined to attend the Program or the Project and remained persistent despite the rampant criminal activity in their community.

Category: Food Insecurity

Food insecurity is the second most common environmental contextual factor that 38% of the women mentioned as an issue in the community. When asked how helpful the CBC/SBP has been for them and their children, five women expressed the need for food and how Table Views filled this gap. For example Cindy, a SBP participant, was "stranded for food and my kids would just go to sleep with water." Maryann also thinks that the organization is "very helpful…like if you don't have food in your home, they don't only give food to people working (SBP volunteers) in the organization, they give to everyone." Rudy shared:

> Sometimes you worry during the day what you are going to eat and if you are a mother…and every night we take a bucket of food down so I had something for them to eat also, so you do not worry a lot here…

However, while the program provides participants with food during the day during working hours and a container to take home, the organization is closed on the weekends. It is during the weekend hours that participants face the most difficulty with obtaining food for themselves and for their children. Furthermore, socio-economic status plays an important role in food choices. As stated in the literature review, mothers of lower socio-economic class tend to have unhealthy behaviors such as poor nutritional choices, and in the WCP this is in part a result of scarce food choices in their communities. Furthermore, if a mother is not able to provide healthy food, which is generally more expensive than unhealthy food, it is almost impossible to completely change nutritional behavior. So while the organization has obtained its goal of changing attitudes around health and nutrition during the week, it is not reaching this goal of changing behaviors on the weekends or when there is no money to buy groceries.

Category: Poverty

Poverty is a contextual factor that affects every woman in this sample and all of the women in this study. Poverty is linked to government assistance, low levels of educational attainment, and unemployment. However when discussing poverty five participants shared that, in their opinion, mothers in the community are taking advantage of Table Views' services. The South Africa Social Security Agency (SASSA) provides grant to mothers for their children. According to Brianna mothers (many of them who are high school dropouts) receive approximately "R350 ($27) per child a month from SASSA" and "sit on the corner begging for R2." Brianna explained that, "the mothers in the community "just sit at home, they don't go out…they want to rely on the social grant [SASSA]." She was appalled that some of the other mothers have:

> Better lives than me but still don't want to do anything about it. I mean for four hours to sit there and listen [to the facilitators in the CBC Program] then you get a certificate for it. You never know maybe this can open many doors for you.

Her response is shared among staff who expressed their disdain that some people were taking advantage of the program and using it for a handout.

According to Rachel, Table Views is "very good [for mothers] because then they don't have to sit at home, they can at least come here and at least learn something and equip themselves." Like Brianna, Rachel highlights on a common practice of mothers in the community – those that sit at home and do nothing. Savannah stated: "…I think they are abusing this organization." Savannah's response also mirrors Brianna's statement and the responses some providers that women are taking advantage of Table Views' services. Brianna, Rachel and Savannah are referring to what they consider a growing trend in the Maraval community. According to them, as more women are learning about Table Views

and the various free services that they offer to women, they are coming in droves to register and receive a handout. The mothers in the community are aware that if they look the neediest or impoverished that the organization will assist them and their children.

This has implications for organizational change so that people are not taking advantage of Table Views' kindness and are using the childcare services to engage in disastrous behaviors such as substance abuse. For example, if their children are now in the crèche and they are unemployed, upon dropping them off in the morning mothers are able to return home to do nothing, use drugs, or abuse alcohol. Of course, Table Views has attempted to put an end to this behavior by giving mothers the opportunity to take part in the CBC Program and the SBP but there is not enough space at the location for everyone to be involved in the different projects. However, the organization can't control what the women do upon dropping their children off, they can only attempt to give them the skills that the need. As staff mentioned in Chapter 5, it is hard for them to turn someone away, especially someone with a young child that is in need of a crèche and, as a result, the ECD and the Aftercare are at capacity.

Category: Lack of Social Support Networks

Customarily, the medical field has viewed health inequalities through a lens that was biological. However, according to Koh et al. (2010) in order to reduce disparities, maternal health has to be examined at the population level. This belief has been supported by researchers who agree that an expansion to a multi-level social determinants approach that looks at all factors: social and economic factors, *social support networks*, physical and social environment, access to health services, and social and health policies

(Durch et al., 1997; Berkman & Kawachi, 2000; Krieger, 2001). Other CBOs, such as the Parent Centre, in the WCP have implemented programs and initiatives that focus on peer support groups facilitated by mothers from the community. Therefore, this study looked at this new integrated approach by asking participants about their social support networks both within the programs and outside the programs through friends, family, and neighbors.

Three participants discussed the lack of social networks from a cultural context. One SBP participant stated: "no I don't have friends and family that I can talk to…" The definition of family is different in Western society compared to African society. In African society generally, and among the Xhosa in particular, "family" refers to a much wider circle of people (Nombulelo, 1998). However, among this group of women, their family is very small, non-existent, or insensitive to their personal issues. For example, a CBC participant stated: "you know as Xhosas we don't do those emotional things like 'oh I need a hug'…we really don't do that. So no I don't [have social supports]."

Lastly, a CBC participant, who recently experienced multiple deaths in her family over a short period of time, explained the strong and cold nature of the Xhosa people during her time of pain and loss: "…Our family is kind of like 'each one for themselves' it is a Xhosa proverb." When she was going through her grief, her family told her that "life goes on." She went on to explain: "so you fend for yourself and see to yourself. It is a biology term where they say 'survival of the fittest' and if you are fit then you will go through it…" This lack of support in the Xhosa community was also articulated by two key informants (first introduced in Chapter 5) who are Black women in their late 30s and early 40s, respectively, that have grown up in SA and have also faced trouble talking to

family members (specifically parents) about their problems, so in turn, they internalize their issues and handle their problems on their own. In informal settlements like Maraval, preoccupation with external problems (e.g. poverty, lack of partner support), as well as more immediate difficulties (e.g. trauma and losses), among the Xhosa community may directly affect the parent's capacity to be responsive to their child (Tomlinson, et al., 2005). However, social networks are important and are an example of the social determinants of health (SDH) and also have an impact of health outcomes (Mikkonen & Raphael, 2010).

Individual Contextual Factors

Individual contextual factors are divided into three categories: abuse of women (N=5), outside social support networks (N=5), and emotional issues (N=2). For some women these contextual factors have impacted their ability to come to the CBC or SBP and for others these factors do not impact their participation and they cope by avoidance.

Category: Abuse of Women

Analysis of the data showed that the common individual contextual theme that emerged was that 5 of the 13 participants were abused by their husbands or significant others. These findings are supported by what was discovered during interviews with staff: four of the eleven employees mentioned how the abuse of women by their spouse may affect participant engagement. Furthermore, economically vulnerable women [in South Africa] are highly dependent on men's financial contributions and are thus less likely to succeed in negotiating protection and less likely to leave relationships that they perceive

to be risky (Jewkes, Levin & Penn-Kekana, 2003). For example Sue, a SBP participant, stated:

> The abuse [from my husband] started again after I gave birth…I had nowhere to go…and then I had to stay in the marriage for [decades] being abused; I had to run for my life, sleep outside…

This theme of "nowhere to go" that she conveyed was also mentioned by the Founder and an administrative staff member in Chapter 5 as a contextual challenge for participants.

Cindy disclosed that her husband abused her physically and further divulged "that is why we separated." Kenya stated: "the marriage thing didn't work out because he [her husband] was abusive and stuff so I went back home to my family." Unlike Sue, Kenya had somewhere to go and was able to leave her abusive husband and live with her family. Kenya is currently separated from her husband and, according to her, since no marriage papers are signed during traditional Xhosa marriages nothing has to be legally filed for a divorce. Rachel also revealed that the abuse extended to her children: "and the reason why I left my husband was because one day he rubbed himself up against my daughter." Rachel's story is supported by research from te Water Naude et al. (1998) of the prevalence of neglected children in dysfunctional families in the WCP community where women (and in her case children) often bear the brunt of their partner's alcohol misuse. Like Kenya, Rachel was able to leave her abusive husband and go back home to her family.

Lastly, one participant discussed abuse by several husbands and highlighted on the abuse she endured during her pregnancy:

> I was underfed, I was very skinny because most of the time my child's father would abuse me. He would hit me, look at this one [she pulls down her pants and

she has a big stab wound from a knife that her child's father stabbed her with] and on my head and my back all around. He was very aggressive over me.

Because she was malnourished during her pregnancy, two of her children were premature at 6 and 6.5 months, respectively. When compared to the women who participate in the CBC Program, the women in the SBP disclosed that they endured more abuse at the hands of their spouses: approximately 67% of the women in the SBP were abused.

Category: Outside Social Support Networks

Five women (4 CBC participants and 1 SBP participant) referred to their families (fathers, husbands, and children) as their social support networks outside of the programs including Maryann, who received support from her friends as well:

> …They are supportive and tell me if I am willing to do what I am doing I can go for it [the computer course]. Because I am a mother and the first born at home and I sacrificed a lot for them for 10 years, so they support me now…

Her response illustrates a tradition in the Xhosa community, where the first born is supposed to financially support their parents and younger siblings. However, unlike the 3 Black participants that lack social support networks, she is supported. Pearl, a CBC participant, expressed: "my husband and my aunt were 100% [supportive of] me, and I would tell [my aunt] what I was doing in the program and she wanted me to finish my matric (high school diploma)." Brianna stated:

> My family really supported me because this was my first graduation [CBC graduation and certificate]. All of them encouraged me to come to the program. And my kids as well, they were my competition throughout the course to do well.

Maryann and Brianna both shared that their children were their competitors and they would try to outdo their children in computer literacy. Rudy was supported by her husband and children and Savannah stated that "my father is always there for me."

Pamela explained that she is supported by her mother and siblings and that "whenever something happens we are there for each other." Savannah and Pamela, both CBC participants, are the only two women that indicated they received support both from within and outside the various programs. As the providers stated previously, the women from the SBP differ from the women in the CBC Program in that the former have been victims of spousal abuse at a higher proportion. Therefore, it comes as no surprise that a greater number of CBC participants shared that they received supports from both within and outside the program.

Category: Emotional Issues

Emotional issues were mentioned by two women in the sample. Marcella "feels depressed because I am worried at home, about tomorrow, about my children." But when she feels this way because of her circumstances, she revealed that she would rather come to the program and "although I have those issues at home, for me I feel like [I am] at home when I am here." Marcella copes with her circumstances by avoidance and sees the SBP as a safe haven. When asked to tell me a little bit about herself one SBP participant, who is currently separated from her physically abusive and alcoholic husband, expressed that she has "a self-esteem problem and tends to get depressed a lot" and is on medication for her emotional issues. While her emotions does make it difficult to participate "most of the times…it is much better to come than stay home, because why…I can keep myself busy…and keep my mind off [of everything]." Both women do not let their emotional issues impede them from coming to the programs.

Barriers and Challenges to Participant Engagement

Category: Disrespect from Staff and Fellow Participants

All of the women were asked: *Tell me what has it been like to participate in this program?* Analysis of the data showed that the common theme that emerged was that four of the women experienced disrespect from both staff and fellow participants which reflects potential barriers and challenges to participant engagement. When asked about her overall experience, one participant responded: "to me, when I see that you're avoiding me or something like that then I just carry on…." Her response revealed that she feels that certain individuals are ignoring her and that can be interpreted as a sign of disregard. Later in the interview, she was asked a follow-up question to participant experiences: *Is there a time that you ever felt disrespected here?* This question was asked to all of the women as a follow-up question. She replied: "that happens a lot. There are times when I feel like taking my bag and leaving…They exclude me from everything…"

Referring to the CBC Program, one participant expressed that the organization's Founder:

> Is not friendly and didn't make me feel like I was at home… I don't think she has people skills. The way she treats [certain] people is like you are a beggar when you ask for something.

The CBC participant is referring to a time when she asked the Founder for items for her children and "felt like [the Founder] was looking down at me when I asked for things and her attitude is why so many people don't want to come here." She also expressed that she felt disrespected by an administrator at one point. A SBP participant stated: "this organization is supposed to be that we as women have to lift each other up, [but] we are breaking each other down though." According to her, jealousy exists among the

participants because some of them believe that the administrator shows her preferential treatment. Based on this participant's statement, it would appear that the other parents may not be supportive of her overall but her close relationship with the administrator makes the organization a caring environment in her opinion

One participant conveyed feelings of disrespect from the onset of the interview. When asked *Can you tell me a little about yourself?* She said:

> I love learning that is why I am here but there are some challenges here in this place, like the people that have been here longer tend to push around the new ones…

She also communicated that she felt disrespected by the Founder: "even [the Founder] is also strange with me sometimes...she is not like the people's person that she pretends or sets out to be." The participant believed that she wasn't welcomed by the organization and that some people get preferential treatment while others do not. She shares the same feelings of favoritism that the two other participants expressed. Of the four women that have experienced disrespect from staff or fellow participants, only one participates in the CBC. It could be argued that the women in the SBP feel higher levels of disrespect because they are there for longer periods of time compared to the CBC participants and therefore interact with staff and other parents on a regular basis. Additionally, women who participate in the SBP may have lower self-esteem to begin with and therefore sees their interaction with the Founder as a form of disrespect.

Facilitators to Participant Engagement

Social support networks were discussed from a contextual context that is important to the entire community. Under environmental contextual factors, three women

expressed that they lacked social support networks within their families. Under individual contextual factors, five women communicated that they received social support from their family and friends. As it relates to the program specifically, social support networks within the CBC Program and SBP can be very helpful to participants who come from challenging backgrounds and need this support.

Category: Social Support Networks within the Programs

Five women (3 CBC participants and 2 SBP participants) expressed how helpful it is to receive social support from within the programs. Savannah found support from staff members when she first came to the organization: "they told us that if we have problems we can talk to [the Adherence Counselor] and lawyers as well." A CBC participant, found support from the organization for many needs:

> I think it is more of a financial situation whereas they helped me out when I was in college and they gave me books which I couldn't afford and calculators, pencils, and stuff like that for college.

Porsha stated: "I received plenty of support…the main thing that they have given me is mental growth. They have actually taught me to be the strong person that I am today."

Rudy expressed that the organization:

> Is something very good for people because here they can train you as a beader, can train on the sewing machine, you can have computer class and business classes…at the end of the day when you walk out of here you have a lot of qualifications. You see, it is how you build up as a woman.

Rudy's response implies that the program is holistically supportive for women in the community. And according to Haley, the program "looks after me here, they support me." Because she volunteers, she is able to eat and "take my medication on time." Two of the

six SBP participants provided examples of support within the program while three of the seven CBC participants provided examples. Based on the interviews, it appears that social support networks within the programs are almost equal among the women in the SBP and the CBC Program.

Programmatic Impact on Participant's Knowledge

Computer and Business Course Program

The short-term outcomes of the CBC Program obtained from Table Views' General Report are: 1) students begin to develop knowledge on computers and how to start their own business, and 2) obtain greater knowledge of how to become more marketable in order to receive job opportunities. The medium-term outcomes are: 1) students are referred to job opportunities by Table Views based on their new developed and marketable skills, and 2) students are able to assist their children with homework assignments because of the skills they learned in the Program. The long-term outcome is: 1) closing the socio-economic gap of at-risk Black and Coloured women in the WCP.

The women were asked several questions to measure the program's impact: *1) How have the Computer Course and Business Course helped you in finding employment; 2) Do you think the services were sufficient?; 3) Would you think of using what you learned to start your own business?; and 4) Now that you have attended the Computer Course, what change has it brought to how you are raising your child or children?* Analysis of the data showed that two themes emerged: improved knowledge and skills (N=5 and increased bond with child/children (N=4).

Theme: Improved Knowledge and Skills

Five of the seven women in the CBC Program explained that completing the Course has improved their knowledge and skills. Women compared the learning materials in the program to previous course materials that were not as informative. Brianna explained that the program taught her a lot because previously:

> I didn't even know how to open an email address before. I had to wait for my son to come home to help me. Before if I saw a laptop I didn't want to touch it but now I know how to use it!

Furthermore, she would like to use the skills she learned from the Business Course to start her business and now knows how to advertise her business online. Pearl expressed that in addition to learning how to use the complete Microsoft Office Suite Programs, she learned how to job search and was excited because she learned "how to make your own email address! And we learned how to make a budget. That was very helpful."

According to Savannah: "I can put the certificate on my CV and maybe I can get something better. It is like an income generating program." She believes that graduation from the program will allow to her to obtain a better job. And Maryann shared that although it is difficult for her to find employment because she did not graduate from high school that: "when I begin to work, I think that it [the certificate] can be helpful…so it will be easier for me if I pass Grade 12 then I can look for a job like as a receptionist and stuff." Kenya especially enjoyed learning how to use Excel to create budgets because of her previous interest in accounting while in high school. Like Brianna, Kenya agreed that the services she received from the CBC Program were sufficient because prior to enrolling in the course, she "didn't know anything about computers" which prevented her from applying for a call center position. After completing the course and receiving her

certificate, however, she has "been applying to more jobs." Savannah, Maryann and Kenya each expressed optimism that they could perhaps now obtain a job with the skills that they learned from the CBC Program and how beneficial the certificate can be when going on the job market.

One woman replied that after participating in the Computer Course, she was able to find temporary employment [a 3 month contract] with the City of Cape Town at a primary school as a substitute teacher. However since then she has not found permanent employment. Kenya's sister, who also participated in the Computer Course, was able to find permanent employment but Kenya is still unemployed. However, when asked the third question regarding using what she learned to possibly start her business, Kenya replied:

> Yes, it would…there was this girl who contacted me who I knew…from school. She was [a representative] in a company like they sell [slimming] products and…she wanted to talk to me about it. And after taking the course and knowing how to use the computer, I will Google it and do some research. The Computer Course made me feel more empowered to start my own business because I thought everyone knew how to use a computer but I didn't know about that before taking this course. I didn't even know how to start a folder before [to save my files] and as I learned how to do it, I realized it was so simple.

And while Porsha was able to use the skills that she learned after taking the Computer Course and was subsequently promoted three times to a supervisory level, it took her almost 2 years to obtain the job after completing the course and she is currently unemployed. Therefore, the CBC Program did not have a significant impact on finding employment for the women in the sample and has not reached its medium-term outcomes: refer students to job opportunities. However, participation in the CBC

Program has met one of its mid-term outcomes: assist children with homework and its short-term outcome: develop knowledge on computers.

Theme: Increased Bond with Child/Children

The majority of women (N=6/7) in the CBC Program explained that completing the course has increased the bond with their child or children. Pearl stated that the program "gave me patience with my children because before I could never sit with them and [work with them on their] homework together." She further explained that participating in the program was "a very nice experience and my family bonded well because of this course." Prior to the course, Pearl would shout at her children, was often angry, and viewed her children as a "nuisance." She has learned how to show her children respect in order to receive respect back and how to listen to them.

Participation in the program has also increased the bond that Brianna has with her children. According to her: "before it was like you [her children] go to school, [because they] have to go but now my children can ask me about stuff and I can answer them and help them." She has now become more interested in what they learn in school every day. Savannah stated: "I have more patience with my son who is already good in computers." Kenya confessed that:

> I think before I wasn't paying attention much to what my son was doing in school, he would come home and he would say the days in the week and I was not paying attention to him. I would just tell him he is making noise. And I learned that you have to teach your child how to read and write and now when he comes from school I ask him where his homework is and then we do it together.

After participating in the Computer Course, Pearl, Brianna and Savannah have increased the bonds with their children because they have developed one of the most important virtues – patience. Brianna and Kenya are now interested in what their children learned in

school and want to sit and down and interact with them now as a result of participating in

the course. Maryann thought that the services she received in the CBC Program were

"good" and prior to starting the Computer Course, she:

> Was scared to do it [computer training] while I was in school because I thought if I touched a computer I would break it. The course was helpful because growing up I never knew anything about computers…It [participation in the course] will make a difference, because as I am learning here…it would be easier for her [daughter] to do her schoolwork.

Finally, Porsha believed that the program:

> Taught me more how to be a parent, how to nurture and love your child, not just your own child but other children as well. Because my neighbor's child is my child and the child is raised by a village, we are a community.

Sewing and Beading Project

The short-term outcomes of the SBP are: 1) students begin building their self-

esteem and professional skills to generate their own project and 2) obtain greater

knowledge by learning a new trade so that they can start their own independent sewing or

beading program out of their own homes. The mid-term outcomes are: 1) students are

referred to job opportunities by Table Views' partnership with local manufacturing

companies based on their new developed and marketable skills and placed in other

companies doing administration and 2) students learn skills to develop into a CMT (Cut,

Make & Trim) operation so that ladies can begin to earn decent wages. The long-term

outcome is: 1) closing the socio-economic gap of at-risk Black and Coloured women in

the WCP through independent income generation businesses.

The women were asked several questions to measure the program's impact*: 1)*

How has the Sewing and Beading Project helped you participate in income generating

activities; 2) Were you able to start your own business?; and 3) Would you think of using what you learned to start your own business? Analysis of the data showed that the common theme among the 6 women in the SBP that emerged was that the majority wanted to start their own business (N=5).

Theme: Idea to Start Their Own Business

According to Rudy, "I think about it a lot…like if you want to start your own business you have to make something that the people are going to buy..." While Rudy was optimistic about the idea to one day start her own business in sewing and beading, the other four women have tried but lack of finances are a barrier in terms of the cost of and obtaining materials such as cloth, beads, needles, etc. For example, Marcella replied: "last week we had that conversation because it was something I always wanted to do but money was always the cause of why I couldn't do it. I want to start a small business…"

Sue has "tried [to start a sewing and beading business] many times but due to finances I can't afford to buy the materials." Cindy wants to use what she learned from participating in the Project but "the problem is I can't manage to find the beads to make jewelry. It is hard to buy the beads." The beads come from factories in the Western Cape and from abroad and vary in size and shape. Unfortunately, Cindy does not have access to the manufacturers and is unable to obtain the necessary materials she needs to be successful. And Rachel revealed that she hasn't tried to start her own business yet and stated:

> Obviously the problem is financial in terms of buying the products and things to sell it. That's the only problem but other than that I will make time to do the things at home and try to sell it.

These five women have tried to obtain one of the Project's short-term outcomes*:* Greater knowledge by learning a new trade so that they can start their own independent sewing or beading program out of their own homes. However, due to financial circumstances out of the Project's control, they are not able to afford the materials to make the jewelry such as beads, for example.

Conclusion

This chapter focuses on an analysis of 13 women who participated in either the CBC Program or the SBP. When we look at **Table 4**, we see that variation only exists among two demographic descriptions: age and educational attainment. There is little variation among racial identity and marital status. When we look at **Table 5**, we see that there is a relationship between age and alcohol use and in **Table 6**, it is clear that there is also a relationship between educational attainment and alcohol use. On a programmatic level, the women who mainly participate in the SBP are also involved in other programs such as the NHSG, ECDA, or PW. While Black participants only comprise 30% of the overall sample, they have higher levels of education and are, in general, younger when compared to their Coloured counterparts.

Community violence was the most common environmental contextual factor among the women in this sample. Overall, many of the women cope with these environmental contextual factors through avoidance and go to Table Views to escape their harsh reality. Food insecurity and poverty are tied as the second most common environmental factor. Thirty-eight percent of participants believed that Table Views is important to Maraval because many mothers in the community are too lazy to leave their

homes and receive needed services. Instead of utilizing these services, some women in the community feel bad for themselves and live off of the country's social grants instead of taking an active stance on changing their lives. Additionally, these participants feel that many of the women who are actually using the organization's services are taking advantage of Table Views, using their children as pawns to obtain food, or using drugs while the ECDA teachers and volunteers are watching after children.

Lack of social support networks is the third most common environmental contextual factor that women identified. Black, or Xhosa women, lack social support networks at higher rates than their Coloured counterparts. Lack of social support networks in the Xhosa community is reinforced by interviews with key informants, who are not connected to the organization that have also experienced no support or encountered insensitivity from their family members when faced with problems and therefore cope with their issues on their own. This coping mechanism was also mentioned by Black and Coloured participants when the issue of community violence was previously discussed.

Abuse of women, the most common individual contextual factor, affects the SBP participants to a higher degree than the CBC participants; however, there is variation among the women in each program as it relates to having somewhere to go to get away from their abusive husbands. Furthermore, spousal abuse has resulted in divorce, emotional issues, and maternal malnourishment. Disrespect from staff and fellow participants is a barrier or challenge to participant engagement. Women in both programs provided examples of disrespect from the Founder and an administrative staff member specifically as well as disrespect from fellow participants. These instances of disrespect

are displayed in the form of avoiding or ignoring another participant, feelings of mistreatment by the Founder, and jealousy among participants because of perceptions of preferential treatment of certain women by staff.

Facilitators to participant engagement were described by the women as social support networks within and outside of the programs. Women found that the programs provided support from a financial aspect, increased their mental growth and awareness, increased knowledge, skills, and self-esteem, and improved nutrition and healthy behaviors. Specifically, as it relates to mental growth, the program helped a Xhosa woman through a trying time in her personal life when her family was not there for her. According to women in both programs, social support from within the programs was received equally. Women shared that outside of the programs they found support from family members and friends who wanted to see them graduate with the CBC certificate and improve their computer literacy. However, perhaps as a result of higher levels of spousal abuse in the SBP group, a greater percentage of CBC participants were able to provide examples of outside social support.

The CBC Program has impacted participant's behavioral and parenting choices in two main ways. Seventy-one percent of the women have improved their knowledge and skills since joining the program. The women believe that the teaching style of training facilitators and learning materials were sufficient, they learned how to use various computer software programs and how to create personal email addresses, and many were not scared to touch a computer anymore. Furthermore, they believe that receiving the Computer Course certificate would result in better employment opportunities in the

future. However, participation in the CBC Program has not resulted in permanent employment for the majority of women in the sample.

Since joining the program, 86% of women reported assisting their children with homework. Before joining Table Views, the women lacked patience with their children, avoided helping with homework, were angry or screamed at their children on a normal basis, lacked interest in their child's development, and did not nurture or show love to their children. Finally, the SBP has impacted the participant's behavioral choices in one main way. Eighty-three percent of women want to start their own sewing and beading business. However, due to financial constraints and the costs associated with the materials, none of the women have been successful.

Chapter 7: Participant Perspectives:

Poor Maternal Nutrition and Health – Nutrition and Health Support Group

(NHSG)

<u>**Introduction**</u>

In this chapter, I first provide participant demographics and behavior on the

women who participate in the Nutrition and Health Support Group. This is followed by

programmatic overlap and comparisons. Next, I offer findings on the three most common

environmental contextual factors according to participants followed by the most common

individual contextual factor. This is followed by facilitators to participant engagement.

Finally, I provide the program's impact on participant's behaviors and nutritional choices.

<u>**Participant Demographics and Behaviors by Program**</u>

To obtain information about the parent's individual backgrounds and to start the

conversation, participants were asked the following question: *Tell me a little about*

yourself? Responses to this question included racial identity, age, level of education, and

marital status. Behaviors and personal background were also obtained from responses to

this question in addition to questions asked later in the interview. **Table 7** below provides

a breakdown of participant demographics and behaviors of all the women in the NHSG.

Like the women in the Computer and Business Course Program sample, women in the

Nutrition and Health Support Group also receive food from the Feeding Scheme.

Table 7: Participant Demographics and Behaviors in the NHSG (N=12)

	CBC	SBP	FS	ECDA	PW	RAC	AGE	EDU	TEP	MAR	ALC	AUDP	ABU
Mariam			Yes			BL	36-70	LTHS	No	SIG	Yes	No	No
Destiny	Yes		Yes			CO	36-70	LTHS	Yes	SIG	Yes	No	No
Michelle			Yes	Yes		CO	36-70	SHSD	No	SIG	Yes	Yes	No
Lisha			Yes	Yes		BL	36-70	SHSD	No	SIG	Yes	No	Yes
Angela	Yes		Yes			BL	36-70	SHSD	No	SIG	Yes	Yes	Yes
Mfuni			Yes	Yes		BL	36-70	SHSD	No	MAR	No	No	Yes
Caitlyn			Yes			BL	36-70	LTHS	Yes	MAR	Yes	Yes	No
Sherice			Yes			CO	36-70	LTHS	No	SIG	Yes	Yes	No
Gwen	Yes	Yes	Yes			CO	36-70	SHSD	No	SIG	Yes	Yes	No
Kerri			Yes	Yes		CO	36-70	LTHS	No	SIG	Yes	Yes	No
Yulissa		Yes	Yes			BL	36-70	SHSD	No	SIG	No	No	No
Kamala		Yes	Yes	Yes		CO	36-70	LTHS	No	SIG	Yes	No	Yes

Key

CBC: Computer and Business Program
SBP: Sewing and Beading Project
FS: Feeding Scheme
NHSG: Nutrition and Health Support Group
ECDA: Early Childhood Development and Aftercare Programs
PW: Parenting Workshops
CP: Counseling Program
RAC: Race (Black (BL) and Coloured (CO))
AGE: Age (18-35 and 36-70)
EDU: Educational Attainment (Less than High School (LTHS) and Some High School or High School Diploma (SHSD))
TEP: Teenage Pregnancy (Yes or No)
MAR: Marital Status (SING – which to preserve anonymity includes women who have never married, are divorced, or are widowed – and Married (MAR))
ALC: Alcohol Usage (Yes or No)
AUDP: Alcohol Use during Pregnancy (Yes or No)
ABU: Abuse of Women (Yes or No)

Analysis of the data showed that the common theme that emerged was that 75% or (N=9) of participants were recruited through word of mouth (through a friend or neighbor). Three of the participants were recruited through outreach as the Founder drove around the community and asked women who she thought were in need to come to the organization for assistance. This is a greater percentage of women than the 38% or (N=5) of women in the Computer and Business Program (CBC) or the Sewing and Beading Project (SBP) in Chapter 6 that also learned of Table Views through word of mouth. This is also not in agreement with staff interviews in Chapter 5 which indicated that participants are most commonly recruited through complaints or reports from neighbors who view them as a nuisance in the community.

Without being asked directly, 31% or (N=4) of women spontaneously disclosed their HIV positive status. However, to preserve confidentiality, **Table 7** does not provide a column for HIV, instead the data is aggregated. The nature of responses changed drastically among the women who participate in the NHSG compared to those who participate in the CBC/SBP. This change could be attributed to the mother's health status. All of the women in this sample are *"chronic"* (suffer from chronic diseases like HIV, TB, high blood pressure, diabetes and arthritis) and were therefore more willing to disclose health complications during the interview after being fully informed of the study and giving consent.

Unlike the homogeneous racial composition of the women who participated in the CBC/SBP, there was more diversity among this sample – half of the women (N=6) identify as Black or Xhosa while the other half identify as Coloured. No variation is seen, however, among the ages of the women in the NHSG when compared to the CBC/SBP

sample – all of the women are between the ages of 36-70. Fifty percent or (N=6) of

women have a less than high school (LTHS) level of education and have never attended

high school while the other half have some high school or a high school diploma (SHSD).

This is similar to the educational attainment levels of the women in the CBC/SBP sample.

More specifically as it relates to race and educational attainment, Black women in this

sample have higher levels of education than Coloured women.

Sixteen percent (N=2) of women had children as teenagers. Over 83% (N=10) of

the women are divorced, widowed, or single. Four of the twelve women (33%) disclosed

that they have endured physical abuse at the hands of their spouses or significant others.

The women were asked if they currently drink alcohol or if they have in the past and

(N=8) or 67% responded affirmatively. As stated in the Methodology chapter, alcohol use

was triangulated by discussions with staff who confirmed if a participant currently drinks

alcohol or if they have in the past. Of the eight participants who admitted that they drink,

the staff confirmed that all 8 of these women do, in fact, drink. However, of the 33% or

(N=4) of women that said that they never indulged in any alcoholic beverages, the staff

stated that two of these women were not being honest and do currently drink. Therefore,

actually 83% or (N=10) of the women currently drink alcohol or have in the past.

Fifty percent of women (N=6) admitted that they drank alcohol during pregnancy.

Unlike the findings in the CBC/SBP sample, the staff was fully aware of the drinking

habits of all of the women in the NHSG. Perhaps the honesty of the women during the

intake process conducted by the Founder and Adherence Counselor for Nutrition and

Health for the Support Group (as it relates to alcohol use and HIV status) has impacted

participant candor during interviews with staff and the Principal Investigator. On the

other hand, because parents who participate in the CBC Program are not always screened during the intake process because of the program's length, staff members are unaware of their drinking habits.

Table 8 below provides the impact of race on alcohol use for NHSG participants:

Table 8: Impact of Race on Alcohol Use (NHSG) (N=12)

	YES	NO
Coloured (N=6)	83%	17%
Black (N=6)	50%	50%

As the table illustrates, Coloured women in the sample currently drink alcohol or have in the past at a considerably higher degree (83%) compared to Black women (50%). In a conversation with a key informant who is Coloured, Coloured people have a certain way of drinking socially – "we drink until the bottle is finished." According to her, this amount can range from a six pack of beer to 750 milliliters of wine to a 1.75 liter of vodka. I saw this "custom", if you will, in several different settings with Coloured people that I spent time with socially while conducting my research. The findings from this sample corroborate the custom I saw while spending time with both Black and Coloured women.

Table 9 below provides the impact of educational attainment on alcohol use for NHSG participants:

Table 9: Impact of Educational Attainment on Alcohol Use (NHSG) (N=12)

	YES	NO
Less Than High School (N=6)	83%	17%
Some High School or High School Diploma (N=6)	50%	50%

As the table illustrates, the women with lower educational attainment (primary school level of education or less) currently drink alcohol or have in the past at a considerably higher degree (83%) compared to the women who have some high school or graduated from high school (50%). Similar to the women in the CBC/SBP sample, this demonstrates that higher levels of education do not appear to notably decrease the likelihood of alcohol use.

Programmatic Overlap and Comparisons

Three of the twelve women in the NHSG also participated in the CBC Program. The participants vary in race, educational attainment, and spousal abuse. However, they are all single and all abused alcohol in the past or currently do. It is difficult to make any inferences here as to why these women decided to join the CBC Program except that perhaps their marital status and/or drinking habits may have impacted their decision to improve their knowledge and skills to better provide for their children. Two women in the NHSG also participate in the SBP. These women only vary in race and alcohol usage – they have the same level of education, are both single, and were both abused. Only one woman participates in the NHSG, CBC Program, and the SBP.

Five women in the NHSG also participate in the ECDA. These women vary in race, educational attainment, marital status, and spousal abuse. Only one woman participated in the NHSG, SBP and ECDA. As stated in Chapter 6, the women in the SBP are less racially diverse, are older, have lower levels of education, and have been abused by spouses at significantly higher rates than the women in the CBC. This individual fits the criteria that the majority of the women in the SBP share – she is Coloured, between the ages of 36-70, obtained a LTHS level of education, and was abused by her significant

other. Lastly, no one in the NHSG also participates in the PW. This is interesting because

many of the women may benefit from the services of the PW which would complement

what they are currently learning in the NHSG but with more of an emphasis on increasing

the bond these mothers have with their children.

Environmental Contextual Factors

Environmental contextual factors are divided into three categories: community

violence (N=11), poverty (N=7) – which includes one sub-category: government

assistance, and food insecurity (N=7). For some women these contextual factors affected

their ability to come to the NHSG. However, for others, these factors do not influence

their participation and they cope by avoidance.

Category: Community Violence

Analysis of the data showed that the most common environmental contextual

theme that emerged was that the majority of participants (92%) are affected by

community violence (arson, murder, shootings, burglary, robbery, and "gangsterism").

Community violence is a theme that impacts participant engagement according to staff

(discussed in Chapter 5) and is an environmental contextual factor that 69% of

participants in the CBC/SBP (discussed in Chapter 6). The women in the NHSG provided

examples of different forms of community violence than the women in the CBC/SBP.

The NHSG women's responses also brought forth examples of help from Table Views in

which the organization assisted participants with rebuilding their homes after acts of

arson, paid for the burials of children who were murdered, and replaced items (such as

televisions and cell phones) when participants were victims of burglary or robbery,

respectively. Furthermore, many of the women discussed drugs as a big factor that impacts criminal activity and gangsterism.

The two main gangs in Maraval are the Falcons and the Patriots. The gangs wear different colors and according to a participant:

> Teenagers are the gangsters now. And they are not scared to take life; it is nothing [to them]. If someone gives a youngster a gun, he is going to come shoot you and you must die. And they are like, 13, 14, 15, 16 years old dying.

I compared these two rival Maraval gangs to the Crips (who wear blue) and the Bloods (who wear red) in New York City and gave an example to a woman that if a Crip gang member sees a Blood gang member or a non-gang member wearing blue, he may want to rob that individual of his or her jacket. The participant replied:

> No, here they are not robbing you, they are killing you. They knock up on your door and say is that one here, you say yes, and they kill the person and leave, just like that. And when the police come nobody knows who did it.

This is similar to the "no snitching" culture that exists in the United States.

Seven participants have experienced gangsterism firsthand and four know that gangsterism is prevalent in the community and are in fear. When asked to tell me a little bit about herself, one participant shared that "I am a single parent, living in shack…and my son died last year." Her son, who was a member in one of the local gangs, was shot multiple times. Her younger son was threatened by the Patriots who were looking for his cousin and is now scared to go to school in fear of being shot and killed like his brother.

When asked what services she received from the program, Mariam replied: "I get clothes. They [a gang] broke into my house and took everything, I didn't have anything." Lisha was also a victim of burglary: "one December holiday…they broke into my house.

They took the TV, DVD set, and music system." Gwen stated that she "had two break-ins already at my house…" and another participant has a child who is addicted to drugs and was robbed by one of the gangs on his way home. One participant has not been a victim of burglary in Kingston Village (the squatter camp she currently resides in near Maraval) but she was burglarized when she lived in a neighboring community.

Three women voiced their attitudes toward violence in the community citing lack of police legitimacy and the impact of drug abuse on gangsterism. When asked what has made it difficult to participate in the program Michelle said that gangsterism is a serious problem in the community and that the Falcons "are like the Police Station. Everything that happens you complain to them and they deal with it. And it gets taken care of faster than the police." The police lack legitimacy in Maraval because the gang members take care of resident problems before actual law enforcement can, if the police even react. When asked about potential challenges to participation, Gwen replied: "[gangsterism] is a very big problem in this area. People get house break-ins and…that is because of drugs. It is drug-related, because that is affecting most of us." Gwen's response is interesting because unlike other participants she admitted that drug use affects many women in the community. Angela also discussed the impact of drugs on criminal activity:

> …Sometimes you can't even walk outside or down the street because people are running over our roofs at night and you must just switch off your lights. And it is always with these drugs and everything…it is a big problem.

Unfortunately it is so common to hear drug users running over her head; Angela knows that her and her family must just stay quiet until it passes.

Two participants expressed that gangsterism impacts their ability to come to the organization for services. When asked what can make it difficult to participate in the

program, one participant who was a victim of a home invasion and lost two family

members to gang violence, stated: "I am sometimes afraid [to come to Table Views]

because our shacks were burned or you would be walking along the street and they rob

you…" According to Lisha:

> It is very difficult in the area where I live because it is hard to go to the shop [supermarket] because they take your money away from you and the boys who sell drugs, some of them rob people and shoot people right in front of your children. So it has been very bad.

While she does not say that gangsterism affects her participation in the NHSG directly, it

does affect weekly activities like going to the supermarket. Therefore, it can be implied

that gangsterism may also impact her ability to attend the program's activities on a

weekly basis or on a more frequent basis.

Gangsterism does not impede half (N=6) of the women's program participation

levels. When asked if gangsterism makes it difficult for her to participate in the program,

Destiny replied:

> It [the gangsterism] makes you a stronger person. Where we stay [there] is gangsterism but if you not connected with them then nothing will happen to you. I only fear God, not gangsters or anyone else.

Michelle indicated that she feels safe even though she has to walk by the Falcons on her

way to the NHSG: "I pass them every day with my children and I just greet them and

they say hello back." When asked what can make it difficult to participate in the program

Mfuni replied:

> There is gangsterism but I don't worry much about those things. My thing is that I am a mother…The only thing that I am looking for and the only needs I need is for my children to have a successful life and for their needs to be fulfilled.

According to Kamala: "I can't wait to come here, I am very happy that [gangsterism] does not affect me very much." Women in the NHSG sample still attend the program's activities regardless of community violence and cited that their belief in God, fulfilling the needs of their children, and feelings of empowerment when participating outweigh the potential consequences of leaving their house.

Category: Poverty

Maraval is an extremely impoverished community and, as a result, many of the women receive public assistance from the South African government. Analysis of the data found that almost sixty percent of mothers receive government assistance to alleviate their financial burdens.

Sub-category: Government Assistance

Every woman in the NHSG has health issues and therefore examples of their medical complications are included in this section because it is linked to why they receive government support. Seven of the twelve women stated that they receive money from the government each month as a result of their disability as a "chronic" individual or for their children (similar to the WIC program in the United States). The grant is made possible through the South Africa Social Security Agency (SASSA) and assists women with money to buy medication, support their children, and pay for monthly expenses like rent and utilities. The SASSA grant complements the stipends that some of the women receive from Table Views. Table Views also assists women with the SASSA application process (and reapplication in some cases) which can be difficult because of varying literacy levels. The women suffer from a range of illnesses including high blood pressure, heart disease,

diabetes, gastrointestinal pain, epilepsy, arthritis, and HIV/AIDS. The most common medical condition is high blood pressure.

When asked about any difficulties to program participation, one participant spontaneously disclosed that she is a "medical client and HIV positive" and is "getting a child support grant from SASSA." Another participant spontaneously disclosed that in addition to a child support grant from SASSA, she:

> Received a grant also for my disability because I am chronic…I've got [multiple medical conditions] and HIV…so I qualify. The medication is just for relief or to make you live longer.

While a total of four women disclosed their HIV status during the interview, only two discussed the government assistance they receive as a result of their medical status. It appears that although they were willing to divulge personal information about their status they were reluctant to reveal that they receive support from SASSA. Three women believe that the South African government can do more for mothers, particularly single mothers. The amount of money that they receive from SASSA still makes it difficult to pay rent each month. The grant is also not enough money to purchase food for themselves and their children. This issue of food insecurity over the weekend was first mentioned in Chapter 6. Since Table Views is closed on the weekends, mothers face difficulty obtaining food during these two days and unfortunately SASSA denies some women the benefit of receiving a food parcel in addition to their monthly disability and child grant.

Category: Food Insecurity

Food insecurity is tied with government assistance (poverty) as the second most common environmental contextual factor that seven of the twelve (58%) women mentioned as an issue in the community. When asked how they came to participate in the

organization, three of the women stated that they were recruited by the Founder while she was driving around the community and looking for people who she thought were in need of the organization's services. The Founder encouraged these women to come to Table Views and supplied them with food while at the organization and containers to take home to their children. One participant, who was recruited by the Founder, illustrates this theme clearly: "I was struggling a lot…very much. I was not eating, I didn't have food. I didn't have anything." Her statement and responses from the other two women substantiate conversations with the Founder, discussed in Chapter 5, about the mission and purpose of the organization.

When asked what they expected to get from the program, four women expressed the need for food for themselves and their children. These women learned of the organization through word of mouth. Kerri shared that "…this is the only place that I can come to if there is no food in the house." While discussing food insecurity in her household, Destiny referred to the importance of food for her children who are her: "First priority, kids…because [as an adult] I can go to sleep without food, not kids. I will cry at night, if they sleep without."

Destiny further discussed how inflation has affected food prices in the community:

> Money isn't like it was before, [in the past] you can stand with R2000 ($149) in [the local supermarket] and you come out with 5-6 plastic bags but now money isn't like money anymore. It is more expensive to buy stuff now.

Food inflation has negatively impacted people in Maraval. One participant illustrated the widespread lack of food in Maraval: "…If I go to your house to ask for bread, they say they don't have, but by the end of the day you see them buying milk and sugar." Food

insecurity within the community has resulted in several neighbors refusing to share their food with others. Instead, the main priority of residents is to feed their own family before assisting others in the same situation. Fortunately, Table Views fills this void during the week and has positively impacted maternal health outcomes for these women through the provision of food. For example, according to Michelle, "…coming to this organization was a good environment…it made a huge impact in my life and my [family's] life."

Individual Contextual Factors

Individual contextual factors are encapsulated into one main theme: emotional issues brought on by stress (N=10) which includes three sub-categories: abuse of women (N=4), children on drugs (N=4), and participants' role as foster parents (N=3). The three sub-categories bring on varying levels of stress for these women.

Theme: Emotional Issues Brought on By Stress

Women in this sample are stressed out because they are the main breadwinners in the household and often do not have money for food or to pay rent or have emotional issues because of the loss of a spouse, child, or family member. High stress levels have impacted physical and mental health outcomes leading to high blood pressure in one mother and thoughts of suicide in another. When asked what she expected to get from the program, Mariam replied: "My heart is troubled…one would look at me and think that I am okay but it is a lot of burden." She is the sole provider for her family because her children are unable to find employment even though they are educated. She described how her stress would lead to multiple hospitalizations in one week, for example. When asked what can make it difficult to participate in the program, Angela stated: "sometimes

when I got depression…I just lock myself in the house and I don't feel like talking to anybody…"

When asked what it has been like to participate in the NHSG, Mariam further explained: "[It has been good] because it gives me power, it gives me strength…because when I was at home the stress was too much…" When asked what it has been like to participate in the NHSG, Destiny stated:

> To participate here I am stress free, because when I'm at home, I stress a lot…
> [Being here] gives me more strength and it takes my mind away from a lot of things…

When asked what can make it difficult for her to participate in the program Caitlyn responded:

> I feel depressed sometimes…but I thank God for Table Views because they make me feel better and they lift you up and make you strong and forget about your issues.

Interestingly, Mariam, Destiny, and Caitlyn all mentioned the word "strength". The program is having a positive impact on three women who have experienced pain and suffering in many different ways and is making them stronger. Gwen's emotional issues stem from home so coming to Table Views is beneficial and "mixing with other people is good for me." This is another example of the positive impact that the organization has made on participant outcomes.

Finally, two participants expressed that dealing with emotional issues does not impact their ability to come to the organization for services. When asked what can make it difficult to come to the organization, Kerri said that, "my depression makes it difficult but when I feel depressed…I take a tablet [for my medical condition] and then I just

come to the organization." Here, we see a woman that is coping with stress by attending

the program instead of staying home. When asked what it has been like to participate in

the program, Kamala replied:

> I just want to stay here; I do not feel like going home. It is more stressful at home…so every time when I come here and it is time to go home, I remember the stress and I hurry to come back here to work the following day. So I am happy here, it is like home.

Like Kerri, Kamala copes with the stress at home by attending the program. When asked

what can make it difficult to participate in the program, Kamala said: "some days there is

no money…so I stress, or for electricity at home, so that affects me." However, she still

comes to the NHSG every day.

Sub-category: Abuse of Women

Of the ten women who expressed emotional issues brought on by stress, four of

them are also victims of abuse from their significant others. One participant doesn't

"value her life anymore" because her boyfriend "puts her down." She is physically and

mentally abused by her boyfriend who "stabbed me on my arm and he swears at me ugly"

and has tried to commit suicide several times because of her emotional issues and chronic

medical condition. According to her: "sometimes I feel like I should drink my own

medicine and give it to my child [to kill both of us] because I don't want to leave my

child with [my boyfriend either]." Another woman also endures abuse from her boyfriend

who she is still in a relationship with and would physically fight with her child's father in

the past. She provided an example of a cycle of violence towards women in which she

left one abusive relationship for another one.

Kamala's emotional issues are brought on by her living situation with her boyfriend: "we [me and my children] can't stay with that boyfriend anymore. But because it is his place, we do not have anywhere to go." This feeling of "nowhere to go" was first mentioned as an issue for participants according to the Founder and an administrative staff member in Chapter 5 and later by a SBP participant. Lastly, one participant was raped repeatedly by the same man over several decades, raped by a family member, and dealt with her child being a rape victim at a young age. When asked what she expected to get from the program, she replied: "I needed a lot of help…I did not expect anything but I went to [Table Views] for help and got comfort because I came with a broken soul…"

Sub-category: Children on Drugs

Four women discussed their children's drug habits as a source of their stress and emotional issues. When asked how helpful the program has been for her and her family, one participant stated: "I am happy when I am here….because sometimes I have a lot of stress with my children especially my son because he was very deep into drugs." She has since put her son in rehab and has "learned to appreciate more of what I've got…because there are people who have bigger problems than me." Another woman said that her son "has become involved with the wrong crowd" and is "smoking takka (marijuana) with some wrong friends."

Sub-category: Participant's Role as Foster Parents

Several of the women are the sole breadwinners in their family and also play the role of mother, grandmother, and foster mother. Of the 12 women, 25% of them are

foster parents or have adopted the children of their siblings who have passed away. One woman has "two [children] from her sister", another is "raising five other children [her brother's children] who are orphans" and the third woman has "five foster children". These roles bring varying levels of stress because although the women receive grants for their foster children it is still not sufficient to pay for all their expenses. For example, one participant who has several foster children finds solace in solitude: "I have a sand dune in the back of my yard and usually when I am depressed I go there and I am by myself and at peace." The sand dune is her get away from her reality.

Facilitators to Participant Engagement

In Chapter 6, social support networks were discussed from a contextual context that is important to the entire community. As it relates to the program specifically, social support networks within the NHSG can be very helpful to participants who come from challenging backgrounds and need this support.

Category: Social Support Networks within the Programs

Eight women expressed how helpful it is to receive social support from within the program. Women have received money to pay for their children's school fees, have received stationary, medical apparatus such as wheelchairs, and were given moral support after the death of children and finding about their positive HIV status. One woman learned she was HIV positive after talking to a staff member who realized that she didn't look right and told her to "go and check myself out." She continued, "The staff member "interviewed me, motivated me, and talked to me…and I feel like a better person."

Another participant who also has HIV found the NHSG great because "we are all in the same boat, we are all sick so we support each other and console each other in everything…we would bond." She is referring to group sessions that chronic patients attend and believes that this is now her support system within the program. According to another participant, "they give good support, they talk to me and make me feel comfortable and they ask me questions about what I am going through." Finally, another woman stated that:

> …The best support was love…because the people here, they all are wonderful and they treat you with respect and love you for who you are and not judge you and I actually learned that is how I was going to get stronger…I did not have to feel shy to cry and sob in front of someone.

Programmatic Impact on Participant's Behaviors and Nutritional Choices

The short-term outcomes of the NHSG include the following changes in behavior obtained from Table Views' General Report: 1) increased numbers of participants that change their nutritional habits engage in healthy nutritional behaviors and attend all clinic and hospital visits, and 2) adherence to medication on a daily basis to improve health outcomes. Change in participant knowledge includes: 1) greater awareness to medical adherence for chronic conditions. The mid-term outcome of the NHSG is that: 1) participants begin to see improvements to their medical conditions such as lowered cholesterol and blood pressure and improved disease management. The long-term outcome of the NHSG is 1) decreasing the amount of women who suffer from chronic health problems by teaching them pain management and adherence.

The women were asked several questions to measure the program's impact: 1) *What have you learned (proper nutrition, consequences of substance abuse),* 2) *Have you*

used what you learned at home?, 3) *How has participating in the program changed your ability to make decisions around your health and your child's health?, and* 4) *Tell me about your behaviors (current nutritional habits, nutritional habits while pregnant, current drinking habits, drinking habits while pregnant, and breastfeeding practices).* Responses to questions 1-3 are encapsulated into one main category: change in nutritional choices (N=7). Two women mentioned the difficulty they face when trying to eat healthier because of other needs or the cost of food which is a potential challenge to positive nutritional change. Responses to question 4 are illustrated in **Table 10**: Programmatic Impact on Participant's Behaviors and Nutritional Choices.

Theme: Change in Nutritional Choices

All of the women were asked what they learned in the program in terms of proper nutrition or the consequences of substance abuse. The women learned to eat more vegetables, to consume less meat, to eat less salt, to avoid drug use, the importance of exercising regularly, and the importance of taking medication for chronic illnesses. Changing their diets has also improved the medical conditions of some participants. After participating in the NHSG, over half of the sample (58%) changed their nutritional choices. Participation in the program has improved Mariam's medical condition: "I used to have a serious problem with high blood pressure but now they say I don't have it anymore."

Eating less meat was something that Destiny found hard because:

As Coloured mothers we like to eat the chicken with the skin, but I learned that when we buy the chicken to always take the skin off. It does not taste as good but I do it because I must look after my health.

Her statement illustrates how culture impacts nutritional choices. Yet, she reduced her fat intake because every time she ate meat her blood pressure would elevate and she would have to go to the hospital to receive medication. The program has positively impacted Destiny's nutritional choices: "If I do eat it [chicken], it is like one piece." She is now mare careful in terms of how she eats and what she eats. When asked how participation in the NHSG changed her ability to make decisions around her health and her children's health, Caitlyn's response reflects the positive impact the program made on her and her family: "I can make better decisions now when it comes to my family's life because I can now get 2 meals a day instead of 1 meal." Caitlyn benefits from receiving food at the organization and by learning how to make better food choices when she cooks at home. The program has achieved one of its short-term outcomes: participants change their nutritional habits and engage in healthy nutritional behaviors and one of its mid-term outcomes: participants begin to see improvements to their medical conditions.

Although the women all learn the benefits of eating healthier, actually doing it can be difficult for some. According to Mariam, "It is difficult to always eat healthy because I have to choose between buying things for my child and buying nutritious food." The battle between tending to her child's school needs and following the advice from staff in terms of nutrition troubles Mariam "…because it is expensive to eat that way [healthy]. It is not affordable." Angela finds the NHSG very helpful "so that you can look better after yourself, get your medication on time, and [learn] what kinds of foods you must eat…" However, like Mariam eating healthy isn't always easy for Angela. She explained: "we learned about eating veggies and the right foods but since we are not working [it is difficult] …"

Table 10 below provides a breakdown of the program's impact on participant's behaviors and nutritional choices of all the women in the NHSG:

Table 10: Programmatic Impact on Participant's Behaviors and Nutritional Choices (N=12)

	RAC	EDU	CNH	NHP	ALC	AUDP
Mariam	BL	LTHS	Unhealthy	Unhealthy	Yes	No
Destiny	CO	LTHS	Healthy	Unhealthy	Yes	No
Michelle	CO	SHSD	Healthy	Unhealthy	Yes	Yes
Lisha	BL	SHSD	Unhealthy	Unhealthy	Yes	No
Angela	BL	SHSD	Unhealthy	Unhealthy	Yes	Yes
Mfuni	BL	SHSD	Healthy	Healthy	No	No
Caitlyn	BL	LTHS	Healthy	Unhealthy	Yes	Yes
Sherice	CO	LTHS	Healthy	Unhealthy	Yes	Yes
Gwen	CO	SHSD	Healthy	Unhealthy	Yes	Yes
Kerri	CO	LTHS	Healthy	Healthy	Yes	Yes
Yulissa	BL	SHSD	Healthy	Unhealthy	No	No
Kamala	CO	LTHS	Unhealthy	Unhealthy	Yes	No

Data on two additional behaviors are introduced: Current Nutritional Habits (CNH) and Nutritional Habits When Pregnant (NHP).

Current Nutritional Habits vs. Nutritional Habits When Pregnant

Sixty-seven percent of all women or (N=8) stated that they currently eat healthy. Seventeen percent of all women or (N=2) admitted that their nutritional habits were healthy when they were pregnant. From the data, it is clear that participation in the NHSG has positively impacted current nutritional outcomes demonstrated by a fifty percent change in healthier nutritional habits. Coloured women (83%) currently eat healthier than Black women (50%). However, both Black and Coloured women had poor nutritional habits while pregnant – only 17% of mothers in each race ate healthy.

Category: Improved Nutritional Habits

The women were asked: *What about when you were pregnant, did you eat the same way you eat now or differently?"* Specifically, since participating in the program, six women have improved their nutritional habits compared to when they were pregnant. Sherice uses what she learned at Table Views at home and eats healthy now but when she was pregnant: "I ate differently. I ate unhealthier when I was pregnant because of what I craved, so I ate whatever I wanted." Caitlyn, who now eats healthy, stated that when she was pregnant: "my eating habits were different back then…I didn't eat right because of stress and…I would go the whole day without eating." When asked if she thinks the way she eats now is healthier than when she was pregnant, Michelle replied: "No, I don't think so, I am eating much more healthier now than when I was pregnant. This program has changed the way I eat." And when asked the same question, Gwen responded: "I eat better now because I have more knowledge [of proper diet] now."

Current Drinking Habits vs. Drinking Habits While Pregnant

The majority of women (83%) or (N=10) currently drink. All six of the Coloured women in the sample currently drink. The sample was divided equally among the women who consumed alcohol while pregnant (N=6) and those who did not drink while pregnant (N=6). AUDP was higher among Coloured women (50%) compared to Black women (33%). Overall, Coloured women admitted current drinking habits and AUDP at higher levels than Black women.

Category: Social and Weekend Drinking

Of the eight women that *admitted* they currently drink, the most common theme among six participants was that they either drink socially or on the weekend. The women were asked: *Do you currently drink alcohol?* Sherice stated: "Yes, I am a social drinker like when there is a friend around who wants to have a beer then I would join the friend." Caitlyn replied: "Yes. I would drink for my child's birthday, I was a social drinker. But not like before, before it was bad. I would drink for the whole day." Lisha explained that she does drink but "just on the weekends" and Angela responded:

> Yes, I do, most of the time I like to drink on weekends if we got money. If we don't have money we just sit and chat...I usually drink wine because liquor is too expensive.

Destiny replied: "actually I am not going to lie to you. I am honest…I am a drinker…but at the moment I did make a decision in 2017 that I would stop because I am not spending money for wine." It can be inferred from her response that she wants to stop drinking because of the cost of alcohol not because it is harmful to her health. Like Angela, Destiny drinks wine because it is less expensive than liquor. Lastly, Kerri explained that after she separated from her child's father "we had a problem and that is where the drinking started to come into place."

Category: Rationalization of Behavior vs. Acknowledgement of Behavior

Of the five women that admitted they drank alcohol while pregnant, the most common theme among two participants was rationalization of behavior. The women were then asked: *Did you drink when you were pregnant?"* Angela replied: "Yes I did but just on the weekends." Caitlyn admitted that she drank when she was pregnant: "it was daily

but not as much as when I wasn't pregnant." Like Angela, Caitlyn attempts to justify

drinking while pregnant compared to her drinking habits when she wasn't pregnant.

Three women gave straightforward answers regarding their drinking habits while

pregnant. In response to the question, Sherice stated: Yes. I drank a lot when I was

pregnant." When asked the same question, Michelle simply replied "yes" and when

Gwen was pregnant, she "was out of order, I was on alcohol."

<u>Conclusion</u>

This chapter focuses on an analysis of 12 women who participated in the NHSG.

When we look at **Table 7** we see that variation only exists among two demographic

descriptions: race and educational attainment. There is little variation in age and marital

status (which is similar to the CBC/SBP sample in Chapter 6). Four of the women

spontaneously disclosed that they are HIV positive which can be attributed to the nature

of the Support Group as an environment that is viewed as a safe space for these women

where they will not be judged or stigmatized because of their status. When we look at

Table 8 we see that there is a relationship between race and alcohol use – Coloured

women drink alcohol at higher rates than Black women. In **Table 9** it is clear that there is

also a relationship between educational attainment and alcohol use – women with lower

educational attainment currently drink alcohol or have in the past at a higher rate than

those who are more educated. Furthermore, like the CBC/SBP sample, Black women in

the NHSG also have higher levels of education than Coloured women. On a

programmatic level, more women participate in the ECDA than any other program and

nobody participates in the PW.

Community violence, poverty (which includes government assistance), and food insecurity were described by the women as environmental contextual factors that affect the entire community. Examples of community violence include arson, murder, and burglary, to name a few. Community violence was also a shared theme among the CBC/SBP participants in Chapter 6 as well as staff in Chapter 5. While community violence does not present a barrier or challenge for the majority of women, it does affect engagement among some of the participants.

The majority of women receive government assistance, which is subsumed under poverty, because of their socio-economic status and various medical conditions. However, some of the participants do not believe it is sufficient and are appreciative of the stipend that they receive from Table Views to supplement their income. Furthermore, most women only receive social support from within the organization. Food insecurity, the third most common environmental factor in the community and the women rely on Table Views to assist them with food while at the organization and a container of food to take home for their families. This environmental factor was also mentioned by the CBC/SBP sample.

Emotional issues brought on by stress are the main individual contextual factor among the NHSG women. Many women deal with emotional issues because they are victims of physical abuse by their spouses or significant others, have children that are on drugs, have loss children because of health complications or violence, or have increased levels of stress as a result of their roles as foster parents. Some women are constantly worried about their financial situation because they are the sole breadwinners in their families, are suicidal, or feel like they have nowhere to go. Other women have become so

stressed that they have been hospitalized or are under medication. However, coming to Table Views helps lift many of the women out of their emotional states and makes them happy. Facilitators to participant engagement were described by the women as social support networks within the program. Women found that the program provided support financially and through moral support after dealing with life-changing situations.

The NHSG has impacted participant's behavioral and nutritional choices in one main way. The majority of women have learned to change their nutritional choices by maintaining a proper diet (more vegetables and less meat). Participation in the program has improved medical conditions, enabled women to make better decisions regarding their health and the health of their children, and educated women on the importance of taking their medications and avoiding drugs and alcohol. However, because eating healthier is more expensive than eating less nutritious food, some women find it difficult to always follow a proper diet. At times, they must decide between buying clothes or school supplies for their children and putting healthy food on the table. This was also a challenge mentioned by the CBC/SBP sample.

Lastly, when we look at **Table 10** we see that the majority of women stated that they currently eat healthy and more acknowledged that they didn't eat healthy when they were pregnant. Coloured women currently eat healthier than Black women and Black women ate worse than Coloured women when they were pregnant. Five women improved their nutritional habits compared to when they were pregnant and believe that the program played a major role in this change in behavior. Eighty-three percent of women currently drink and 42% admitted that they drank alcohol while pregnant. All of the Coloured women currently drink and Coloured women drank alcohol at a higher rate

than Black women when pregnant. Finally, participants who currently drink claim that it

is only socially or over the weekend and those that drank alcohol while pregnant

rationalized their behavior back then.

Chapter 8: Participant Perspectives:

Maternal Alcohol Abuse – Parenting Workshops and Counseling Program

(PW & CP)

Introduction

In this chapter, I first provide participant demographics and behavior divided by each program – the Parenting Workshops and the Counseling Program. This is followed by programmatic overlap and comparisons between both programs. Next, I offer findings on the three most common environmental contextual factors according to participants followed by the most common individual contextual factor. This is followed by facilitators to participant engagement. Finally, I provide the program's impact on participant's parenting approaches.

Participant Demographics and Behaviors by Program

To obtain information about the parent's individual backgrounds and to start the conversation, participants were asked the following question: *Tell me a little about yourself?* Responses to this question included racial identity, age, level of education, and marital status. Behaviors and personal background were also obtained from responses to this question in addition to questions asked later in the interview. **Table 11** below provides a breakdown of participant demographics and behaviors by program. The PW and CP are the two main programs that the women participate in. However overlap exists among the other four programs: the Computer and Business Program, the Sewing and Beading Project, the Feeding Scheme, and the Nutrition and Health Support Group. Like

the women in the other samples, women in the Parenting Workshops and Counseling

Program also receive food from the Feeding Scheme.

Table 11: Participant Demographics and Behaviors by Program (PW/CP) (N=12)

	PW	CP	CBC	SBP	FS	NHSG	RAC	AGE	EDU	TEP	MAR	ALC	AUDP	ABU
Mariah	Main		Yes		Yes	Yes	CO	36-70	LTHS	No	MAR	Yes	Yes	Yes
Tisha	Main				Yes	Yes	CO	18-35	LTHS	Yes	MAR	Yes	No	No
Summer	Main			Yes	Yes		CO	36-70	LTHS	No	MAR	Yes	Yes	Yes
Chloe	Main		Yes	Yes	Yes		CO	18-35	LTHS	Yes	SIG	Yes	No	No
Carrie	Main	Yes	Yes	Yes	Yes		CO	18-35	LTHS	Yes	SIG	Yes	No	Yes
Aisha	Main	Yes			Yes	Yes	CO	18-35	LTHS	Yes	SIG	Yes	No	Yes
Keisha		Main			Yes	Yes	BL	18-35	LTHS	No	SIG	Yes	No	No
Lauren		Main			Yes		BL	18-35	SHSD	Yes	SIG	Yes	Yes	Yes
Nancy		Main			Yes		CO	18-35	LTHS	No	SIG	Yes	No	No
Gloria		Main			Yes	Yes	CO	36-70	LTHS	Yes	SIG	Yes	Yes	No
Barbara		Main			Yes		CO	36-70	LTHS	No	MAR	Yes	No	Yes
Debra		Main			Yes		BL	18-35	LTHS	No	SIG	No	No	No

Key

CBC: Computer and Business Program
SBP: Sewing and Beading Project
FS: Feeding Scheme
NHSG: Nutrition and Health Support Group
ECDA: Early Childhood Development and Aftercare Programs
PW: Parenting Workshops
CP: Counseling Program
RAC: Race (Black (BL) and Coloured (CO))
AGE: Age (18-35 and 36-70)
EDU: Educational Attainment (Less than High School (LTHS) and Some High School or High School Diploma (SHSD))
TEP: Teenage Pregnancy (Yes or No)
MAR: Marital Status (SING – which to preserve anonymity includes women who have never married, are divorced, or are widowed – and Married (MAR))
ALC: Alcohol Usage (Yes or No)
AUDP: Alcohol Use during Pregnancy (Yes or No)
ABU: Abuse of Women (Yes or No)

Analysis of the data showed that the common theme that emerged was that 92% or (N=11) of participants were recruited through word of mouth (through a friend, neighbor, or relative). This is the highest percentage of women that learned of the organization through word of mouth in the entire study. Thirty-eight percent of the women in the Computer and Business Program (CBC)/the Sewing and Beading Project (SBP) and seventy-five percent of the women in the Nutrition and Health Support Group (NHSG) were recruited through word of mouth. One participant was recruited through outreach after the organization received complaints about her living situation and requested that Table Views provide assistance. Like Chapters 6 and 7, participant recruitment for the women in PW/CP is also not in agreement with staff interviews in Chapter 5 which indicated that participants are most commonly recruited through complaints or reports from neighbors who view them as a nuisance to the community.

Without being asked directly, 33% or (N=4) of women spontaneously disclosed that they either currently use drugs or have used drugs in the past. However, to preserve confidentiality, **Table 11** does not provide a column for drug use, instead the data is aggregated. In this sample, one woman who abused drugs also disclosed her HIV positive status. Like the women who participate in the NHSG, the women in the PW/CP are dealing with a myriad of social problems and were therefore more willing to disclose their histories of substance abuse during the interview after being fully informed of the study and giving consent.

The majority of women (75%) in this sample identify as Coloured (N=9) and there is less racial diversity in this sample than the NHSG sample in Chapter 7. Some variation is seen, however, among the ages of the women in this sample – 67% or (N=8)

of participants were between the ages of 18-35 and 33% or (N=4) are between the ages of 36-70. This is more variation than the women in the NHSG sample, who all fall into the older age group; however, there is less age variation among the women than in the CBC/SBP sample who were almost equally distributed. Interestingly, of the three Black women in the entire sample, all of them fall into the 18-35 age group. This is similar to the CBC/SBP sample in which all of the Black women were also younger than the Coloured women.

Ninety-two percent or (N=11) of women have a less than high school (LTHS) level of education and have never attended high school while only one woman has some high school or a high school diploma (SHSD). The educational attainment levels of the women in this sample are considerably lower than the women in the CBC/SBP (46% LTHS) and NHSG samples (50% LTHS), respectively. There are many factors that may have influenced this variable. First, the majority (92%) of women in this sample currently drink alcohol or have in the past (unlike the other two samples) and, depending on the age when it first started, this problem may have impacted school attendance and graduation rates. Second, the social challenges that they have to face, which will be discussed in detail later in the chapter, may have been traumatic for them and had an effect on school attendance.

Interestingly, teenage pregnancy might have the biggest impact on lower educational attainment among this sample. All participants were asked: *How old were you when you had your first child?* In the CBC/SBP sample, 38% or (N=5) of women had children as teenagers (at the age of 19 or younger) and in the NHSG sample, 16% (N=2) of women had children as teenagers. However, in this sample, 50% or (N=6) of women

had children as teenagers. The women in the PW/CP sample comprise the highest

percentage of teenage mothers in the entire study and the lowest level of overall

educational attainment.

As stated, the majority (92%) of women in this sample currently drinks alcohol or

have in the past. Similar to previous samples, alcohol use was triangulated by discussions

with staff. Only one woman's response was unsubstantiated. Approximately thirty-three

(N=4) of the participants abused alcohol when they were pregnant. Interestingly, three

out of the four (75%) women that drank while pregnant were also abused by a spouse or

partner. Perhaps there is a relationship between alcohol abuse by expectant mothers and

domestic violence – women may use alcohol as a coping mechanism to deal with abuse.

The women who mainly participate in the PW (2/6) abused alcohol in pregnancy

at the same level as the CP participants (2/6). Overall, these women were more

forthcoming about their current and prior drinking habits than the other two samples.

Lastly, 50% of the women disclosed that they have endured physical and/or verbal abuse

at the hands of their spouses or significant others. It would appear that the PW and CP

were also modeled in the same fashion as the SBP – for destitute and abused women –

and these statistics support the program's intended goals and target population.

Programmatic Overlap and Comparisons

Two women who participate in the PW as their main program also participated in

the CP. These women are the same race, are in the same age group, have a LTHS level of

education, are single, abused alcohol in the past or currently do, and were abused by their

spouse or significant other. One of them also participated in the NHSG. None of the

women who primarily attend the CP also participate in the PW; however all of the

women have children registered in the ECDA. In discussions with staff it was mentioned

that although mothers with children in the ECDA "MUST" attend the PW and speak to

the Adherence Counselor, this does not happen all the time and the table illustrates this

discrepancy. Therefore, the statistics do not support the program's intended goal. One

programmatic staff mentioned that in the PW: "it is normally not a big turnout, like you

would get maybe 3 parents; a lot of them cancel…" While conducting interviews it

became apparent that at least 3 ECDA parents have never even spoken to the Adherence

Counselor. When asked about this disconnect, one administrative staff member replied:

"no everybody must go" and when further pushed on the issue stated:

> All the parents must go through [the Counselor]…they have to adhere to the rules
> as well and we can't control that [if they do not]. Sometimes we look at a child
> and we take a child out of [a bad] situation. You have to speak to her first, we
> register the child, and we need all legal documents for the child. So sometimes the
> parents slip up and as time passes it slips the mind of the teachers so there is
> constantly a checklist with the requirements.

Putting the child into the ECDA appears to be the organization's first priority and

sometimes staff might miss registering women into programs that may help them

improve their parenting skills or discuss their problems with a trained counselor. Since

funding is scarce it is difficult for the organization to hire another full-time Counselor to

assist Faith. However, an additional Counselor is much needed to meet the needs of the

community and to achieve Table Views' stated goal and mission.

Three women who participate in the PW also participate in the CBC Program.

These women vary in age, marital status, and spousal/partner abuse. Of these three

women, two also participate in the SBP and these two women only differ on

spousal/partner abuse: one was abused while the other was not. Five women participate in the NHSG and vary in demographics and behavior. Only two CP women also participate in any other program (in this case – the NHSG). Overall, the women who identify the PW as their main program participate in other programs at a higher proportion than those in the CP. This could be a result of the weekly meetings that the PW participants are supposed to attend and, as a result, they are at the organization more often than the CP participants who may just come when they need to speak to the Counselor after a traumatic event.

Environmental Contextual Factors

Environmental contextual factors are divided into three categories: community violence (N=8) – which includes one sub-category: lack of decision-making power in the household, food insecurity (N=8), and poverty (N=8) – which includes two sub-categories: spousal unemployment and government assistance. For some women these contextual factors have affected their ability to come to the PW or CP. However, for others, these factors do not influence their participation and they cope by avoidance, similar to some of the women in Chapters 6 and 7.

Category: Community Violence

Analysis of the data showed that the most common environmental contextual factor that emerged was that the majority of participants (67%) are affected by community violence (shooting, burglary, extortion, murder, and arson) as a result of "gangsterism". Extortion of business owners (by gang members) is the only crime mentioned by one woman in this sample that was not a factor to women in the previous

samples. Community violence is a theme that impacts participant engagement according to staff (Chapter 5), is an environmental contextual factor that 69% of participants in the CBC/SBP mentioned (Chapter 6), and was mentioned by 92% of participants in the NHSG (Chapter 7). Like the women in the NHSG sample, these women also discussed drugs as a big factor that impacts criminal activity and gangsterism. Four participants have experienced gangsterism firsthand and two know that gangsterism is prevalent in the area and fear going out as a result.

Tisha, a PW participant, stated:

[A few] months ago I moved into a bungalow and when we went there, the gangsters were making us targets because every night they would come and try to break into the bungalow. One night they came in and my husband woke up and there were two guys standing in front of our bed and as he woke up they grabbed his phone, wallet, and shoes, and stuff they could grab.

Tisha continued to explain that the gangsters would come "every second night" and would "fiddle with the doors" and that her child is in constant fear that something may happen. According to Keisha, the gangsters:

Broke into my house last year and took my flat screen TV. I was at work when this happened. So what I think is what if they decided to come back and they get my kids alone there, it is not easy sometimes. So I am actually sitting with fear.

Keisha comes to the CP for counseling because of this constant fear in addition to dealing with emotional issues, which will be discussed later. Nancy, a CP participant, was also a victim of burglary:

The gang broke into my place [in December] and took all my children's clothing and my cell phone…I was afraid to live there because what if they come at night, what is going to happen to me?

Lauren, a CP participant, had her own business but after it took "a dive" she found herself "in need of assistance". According to her it not only affected her but other business owners in Maraval:

> Gangsterism has affected this community especially for people who want to do business. Because the business that we do here contributes to improving the community and make it a better place. Whatever business it is you are trying to do they would come and knock on your door and tell you that you have to give them a percentage [of your earnings] that is the new thing now. Kind of like mafia-style and it puts your life at risk. They burned down a man's *shebeen* [bar] and it was a legal *shebeen*.

As previously mentioned in Chapter 3, in the past, Black and Coloured South Africans were prohibited from consuming alcohol in White-owned taverns or bars and, as a result, some created *shebeens* in their own townships. Many of them are illegal but some owners have followed the correct protocols to open and run their businesses legally. The *shebeen* that Lauren is referring to is legal and she expressed how unfortunate it is that the gangsters are resorting to committing acts of violence on legitimate business owners.

Other participants are aware that gangsterism exists in the community but it has not affected them personally. Barbara, a CP participant, stated: "there is gangsterism in our area. They never broke into my place but they have robbed my neighbors or hurt them." When asked what can make it difficult to participate in the program Debra, a CP participant, replied: "there are so many challenges that make it difficult, especially the gangs because most of the [gang members] like to break into people's houses." Like Barbara, Debra has never been a victim of burglary personally but is still in fear.

Three women voiced their attitudes toward violence in the community. For example, at 6pm, Mariah stated: "I tell my children to get in the house because of the

guns and how they shoot here…" Furthermore, Lauren discussed the lack of police

legitimacy among residents that was also mentioned by Michelle in Chapter 7:

> The gangsters are taking over and the worst part is that there are people in the community who work with them, like if someone comes and breaks into their house and steals their television, instead of going to the police, they call the gangsters and they will come check up on them. Instead of us supporting the law and abiding to the law, we now trust these thugs who live among us.

Carrie said: "…at night we hear [the rival gangs] shooting. We don't know who they are

shooting at but the next day we just hear that that one is dead or that one has been shot."

Shooting between the two rival gangs (the Patriots and the Falcons) and lack of police

legitimacy were also brought up by NHSG participants. Furthermore, while the women in

this sample discussed how violence impacts their children's safety, some NHSG

participants focused more on the impact of drug abuse on community violence.

Two participants in this sample expressed that gangsterism impacts their ability to

come to the organization for services. Although she has not been personally affected by

gangsterism, Barbara lives in fear and this trepidation has impacted her engagement in

the CP: "it has made me scared to leave the house at times." Gangsterism also makes it

difficult for Tisha to attend the program. Tisha, a victim of a home invasion, stated: "I

would rather just stay at home [than attend the program] and look after my children

because you don't know what could happen". For two other women, gangsterism does not

impede their participation in the programs. Although Carrie discussed shooting between

the two rival gangs, it "doesn't affect me coming here". Even though Nancy has

personally experienced gangsterism, it does not present a barrier or challenge to her

participation in the CP. She explained: "gangsterism has nothing to do with me because

they don't bother me."

Sub-category: Lack of Decision-Making Power in the Household

Twenty-five percent of women indicated that lack of decision-making power in the household affects their engagement levels. Carrie's boyfriend was the decision-maker in the household. While she didn't need permission to attend any of the programs, "when there are functions [Table Views' events or parties] and stuff, then I needed his permission…he was always against functions because he is jealous." Like Carrie, Lauren's husband is the decision-maker in the household and this has made it difficult for her to participate in the program. She further explained:

> …In most cases I do have to get permission from him [to go to the program]. If he says no, then if I need to, I will go against his will and then I will have to come back home and face the music. If I am not in the mood to fight, then I won't go.

Lauren has to constantly make a choice if leaving the house, even to "go to the supermarket" is worth the argument she and her husband will get into upon her return. Summer also lacks decision-making power because she has to ask her husband for permission to leave the house. Like Carrie's boyfriend, Summer's husband has an issue with her going to functions that the organization puts on throughout the year. Overall, it appears that women in both programs deal with social problems (community violence, food insecurity, disability/poverty, and spousal/partner unemployment) at similar rates. These are issues that affect the entire community of Maraval.

Category: Food Insecurity

Food insecurity is the next most common environmental contextual factor that 67% of the women mentioned as an issue in the community. This is an interesting finding because as previously mentioned some of the PW/CP women have recently been

employed or are currently employed so you would assume that they would have lower

levels of food insecurity. This statistic indicates that many of the women who are

employed are underpaid because they are still unable to make ends meet every month.

When asked to tell me a little about her background, Mariah discussed her tumultuous

relationship with her husband (which will be discussed in detail later) and stated: "…I

had to go out and go look for food…and [my children] did not get the nutrition that I

needed to give them." She also participates in the NHSG and divulged that the group:

> Was very helpful for me because I learned a lot…I really didn't know [to drink
> water every day and eat healthy foods] and sometimes I feel so guilty because my
> child didn't have that nutrition because I didn't have money to buy that kind of
> food [healthy food].

> Mariah further explained that when she was pregnant: "I did not even have milk

because I did not have the food to eat." She believes that as a result of food insecurity in

her household her children "are growing up slow of skills…and that is why one of them

has a [chronic health condition] and the other one has [developmental delays]." Lastly,

when asked about the services that she received from the program, Mariah expressed that

the organization has been great because "I get my nutrition every day and I get my food

home…" This statement indicates that prior to participation she did not get proper

nutrition on a daily basis.

Nancy was also asked to tell me a little bit more about her background and after

divulging that one of her children was a stillborn due to her "high blood pressure" she

discussed her difficulties as a single mother. Food insecurity was a factor in her

household as well:

> It was very difficult with their father, man, and we were trying to live on our own.
> Every night, [my son] is hungry, he must have something to eat…I had to go and

> ask for food for [my children] and I have pride so I did not want to do that but I had to learn the hard way.

Learning "the hard way" was her way of explaining how she became involved in the organization – after explaining her situation she was eligible to receive free food. She also put her pride to the side and asked her neighbors for food:

> I am not shy, I will go and knock on your door and ask for potatoes or peas. I don't believe in just eating bread all the time…I believe children should have meals…I am trying.

Bread is cheap to purchase and is an inexpensive way for the women to feed their children. When asked what has made it difficult to participate in the program, Tisha lamented: "I don't have anything. If there is nothing for my children [to eat in the house] they must go to school..." She is sad because she has to send her older children to school hungry and feels helpless in the situation.

When asked how she came to participate in the program, Chloe replied: "I came over here to fetch food…" It is clear from her response that food insecurity was also an issue in her household and Table Views provided a channel to nutrition for her and her family. Aisha is another example of a participant who is employed but still relies on the organization for services because she needs the additional help: "after work, I would come to fetch food and pick up my [child] who is in the ECDA." Lauren was asked what she expected to get from the program and replied: "…women in our position, it is not easy when you go home to an empty fridge…" Lauren, the only woman in the sample with a high school diploma, went from "being this independent woman to someone who feels like I have nowhere else [to go], like I am running out of options." This phrase "nowhere else to go" was also mentioned by the Founder and an administrative staff member in Chapter 5, by Sue in Chapter 6, and by Kamala in Chapter 7. Across the

programs some women feel like they have nowhere else to go because of their dire

situations or abusive relationships.

In response to how helpful the program has been to her and her family, Carrie

expressed: "I was going through a difficult time…my child's father doesn't support [our

daughter] …or think about what she is eating…so it helped me a lot." Furthermore, she

stated: "the program has been very helpful because they also take care of us by letting us

take food home…I know that when there is no food at home, I can come here." Lastly,

one participant who was homeless and lived under a boat, mentioned obvious "issues

with water, sanitation, and electricity because of where I live," which makes it difficult

for her to participate in the program. However, she learned about proper nutrition in the

program: "like I should feed my kids not the stuff I want to feed them but things that are

healthy for them like vegetables…what they should eat not just whatever I can get..." Of

course because of her living conditions, food insecurity is a huge factor: "sometimes I get

food for my kids...like sometimes I get a big bag of meat but I do not know what to do

with it because I don't have a fridge to keep it in…" Her situation is different than the

other women but the organization is working on getting her a shack. Her housing

situation was discussed by several staff members in Chapter 5.

Category: Poverty

In the WCP, high levels of poverty and unemployment exist (Klasen & Woolard,

2009), the province's broad unemployment rate stood at 25.5% in 2014 and is a driving

factor of multiple social ills (Western Cape Provincial Strategic Plan, 2015), and

unemployment is another important SDH (Mikkonen & Raphael, 2010). Analysis of the

data found that spousal unemployment is a cause of poverty for half of the mothers and that half receive government assistance to alleviate their financial burdens.

Sub-category: Spousal Unemployment

Five of the twelve women (42%) stated that their spouse/partner was unemployed. When telling me more about her background, Mariah discussed financial issues in her marriage: "he did not work, I did not work". Summer, a PW participant, talked about her husband when asked how she learned about the organization: "[I came here for assistance] because there is no income at my home; my husband is not working…I am the only one working." While she gets a small monthly stipend from the SBP she does not get assistance from SASSA. When asked how then she survives, she simply replied: "we just survive." Women in this community basically do what they have to do to live.

While discussing break-ins in Maraval, Nancy explained: "I built my bungalow myself…because the [children's] father is not really working…" Although her partner wasn't working, Nancy took it upon herself to provide housing for her children. Gloria and her boyfriend are both "unemployed at the moment", which would imply previous or recent employment. Lastly, Barbara "was the only breadwinner for [her husband] and his children…he did not work." These five women are the head of their households and have to take on the role of sole provider, even when their partners are abusive, which is discussed in the following section. In Chapter 5, the Founder discussed a case where she saw that "nobody was working [in the household] and the only income is the mother's disability." This statement illustrates a relationship between government assistance and spousal/partner unemployment – many of the households in this study are female-headed.

SASSA and Table Views are providing assistance so that many women are able to make ends meet, to a certain extent.

Sub-category: Government Assistance

Five of the twelve women (42%) stated that they receive money from the government each month through the South African Social Security Agency (SASSA). In addition to the support that she receives from the organization, Chloe receives "SASSA for my child" and Carrie "only receives R360 ($27) a month for my child…" Aisha "receives help from SASSA and the program helps me with services such as getting my ID" and Barbara gets "R1500 ($113) from SASSA a month". It is clear that the monthly amount of government assistance that participants receive varies depending on different personal factors. Lastly, Gloria, a CP participant, gets "support from SASSA for [one of her kids] but I am still in the process of finalizing support for my [other child].

<u>Individual Contextual Factors</u>

Individual contextual factors is encapsulated into one theme: emotional issues (N=10) which includes two categories: abuse of women (N=7) and participant drug use (N=4). These two categories are associated with emotional issues for these women. Emotional issues were also the main individual contextual factor for ten out of twelve women in the NHSG sample. While abuse of women was also a common factor among the NHSG sample, the women in this sample disclosed an additional factor: personal drug use.

Theme: Emotional Issues

When asked what can make it difficult to participate in the program, Tisha stated: "…I just don't feel like I should come and work and be amongst people. I feel depressed. And I feel that if someone tells me something then I would snap." Tisha's feelings are a challenge to program engagement. Although she is not involved in the CP, perhaps talking to someone can help her get through everything that she is dealing with. Participating in the CP is challenging for Gloria because of a traumatic event that occurred in her life several years ago. After seeing family members murder someone in front of her, Gloria: "…started getting depressed and I had anxiety attacks…"

According to Gloria, the event "never really bothered me until I started coming here and talking about it." Coming to the program forced her to discuss traumatic events that she suppressed for many years and she stated: "I would still come because I think and I know and believe that I am not depressed anymore." Furthermore, when asked how helpful the CP has been for her and her family, Gloria replied: "the counseling is making me stronger as a person." When she first joined the program she felt:

> Like a puppy that had lost its mother…here they lift you up…and you realize where you have gone wrong. If you can't lift yourself up and someone comes your way to lift you, I think you should get up!

Keisha's emotional problems stem from a miscarriage, the death of her child's father, and the death of her father soon after. She was asked what she has learned from the Counseling Program and replied:

> That I must just leave the past how it is and just move forward. Because the thing is, is that before I came here I was suffering [because of everything I've been through in a short period of time].

Her response is another example of the program's positive impact on participant

outcomes. Keisha's emotional problems do not stop her from attending the CP or NHSG.

According to her:

> Coming here helps me because I have wanted to come and see someone but I did
> not know where to go, until someone told me about Table Views and to go there
> and ask to talk to someone. It was not easy for me to talk to people before.

Her personal motto to help come out of her emotional state is: "I always tell myself that I

will get through this…" which she learned from the program. Although, Lauren stated

that her emotional issues do not affect her ability to come, it has affected her mental

health: "my problems have affected me in other ways…there was a time when I was on

anti-depressants." Unlike Tisha, emotional issues are not a barrier to engagement for

Gloria, Keisha, or Lauren.

Sub-category: Abuse of Women

Like Keisha, Nancy's emotional problems stem from losing a child and the death

of family members. Additionally, she is constantly stressed from always being there for

her family in handling legal affairs and going to the jail for visits. These are just some of

the reasons that she attends the CP. When asked to tell me a little bit about her

background, Nancy replied: "me and my boyfriend are always arguing and in each other's

face because there is no money. It is just verbal not physical." It appears that she is

justifying the abuse and made it clear several times during her interview that the abuse is

only verbal. Like Keisha, Nancy's emotional issues do not stop her from participating in

the CP. According to her, "it is a relief to come here and get counseling because

sometimes other people judge you. I come here and I don't lie, I am very honest."

Mariah lacked love from her mother when she was a little child and was physically and verbally abused by her husband for years as an adult. Her mother "was not around…I did not have that love and connection with my mommy…my mommy always rejected me and pushed me away". This feeling of maternal rejection was also voiced by a SBP participant in Chapter 6 and also caused the participant to feel guilt over the years. Due to her background, Mariah would always think "am I the problem that [my children] are like that?" She has feelings of guilt and when referring to her children's developmental delays.

After years of abuse from her husband she stated that: "when I was in my marriage, I put myself in to see a psychiatrist…" to deal with her emotional problems. She admitted that:

> I was never able to stand up for myself because I was thinking it is only him [in my life], I cannot go back to my parents because my mother said I was married now and wouldn't take me back.

Again, we see another woman who felt that she had "nowhere to go" and stayed in an abusive relationship, similar to Lauren in this sample, Sue (in Chapter 6) and Kamala (in Chapter 7). The abuse was to the point where her husband would "say things to me and I would think I was anything on the streets. He would tell me that I was like a piece of dirt and he would threaten to stick a pipe up my…"

Aisha's emotional issues are also caused by her abusive boyfriend: "I feel depressed if he shouts at me at home but I can't be [depressed] because then he will kick me out of the house." However, the abuse does not impact her participation:

> But when I come here I forget about everything that happens at home and I keep a smile on my face. I hold it in, whatever I am going through. Coming here gives me the energy to move on and…feel normal.

When asked what it has been like to participate in the PW, Carrie said:

> It was very helpful. I was going through a difficult time because I had just broken up with my child's father because he was abusive, not physically, but the words he would say…"

The abuse also made it difficult for Carrie to participate in the program in the beginning. According to her:

> [It was difficult] just at first when I was living with my boyfriend, the verbal abuse…that kept me down but I have told myself to be stronger than that and I am not going to let him control me.

While the abuse was a challenge at first, Carrie gained strength by participating in the program. The words "strength" or "stronger" (stated by Gloria and Carrie) were also mentioned by Porsha in Chapter 6 and by three women in Chapter 7 and illustrate the program's positive impact on participant outcomes. Like Aisha, Carrie did not let her boyfriend stop her from continuing to attend.

> Lauren was asked about her expectations of the CP and replied:

> When I came here, I was not sure, I was in a really bad state of mind, I am not going to lie…I just needed someone to listen to me and [the Adherence Counselor was that person]. I needed to get things out and honestly when I walked out of here I was lighter, I felt like I had met like a mother type of person.

Lauren is very thankful for the counseling she received from Faith, the Adherence Counselor. She explained that she was accustomed to CBOs and government agencies that "just comfort me and listen to my problems but [Table Views] actually went the mile to help me...they acted on it." She "actually got something out of it – for my children to come to the ECDA because I was stressing…" Table Views has positively impacted Lauren and her children.

Lauren's "really bad state of mind" stems from years of abuse at the hands of her husband. According to her:

>…Our relationship has always had a physical abusive part to it but it has escalated over the years to the point where I actually am afraid for my life…I have had to go to the doctor a few times [after a physical fight].

Her husband has isolated her from her friends and "chases them away, even my church friends. So it is not easy for me because I am constantly locked in the house alone."

Barbara has been in an abusive marriage for several years and her husband's abuse extends to her child as well. When asked what she expected to get from counseling, Barbara replied: "I came to the lawyers and asked them if they could assist me in getting a divorce…" Her husband has:

>Told me he would kill our kids and when we were asleep one time, he had a big ax [just standing over me]…and then started punching me. So I have been in fear all the years."

When asked what can make it difficult for her to participate, Barbara responded:

>My depression does not affect me coming here, I still come because I can be free with her [the Adherence Counselor] and I feel the love that she has in her. So coming here is better than staying home because I am comfortable with her.

Although Summer did not express that she deals with emotional issues, she shared examples of her battles with domestic abuse. At the onset of the interview, Summer began to discuss problems with her husband after being asked to tell me a little bit about her background. She stated:

>I just want to tell about and complain about my husband, about the problems with him. I have a problem with my husband every evening…every evening he is drunk…and every evening he curses at me and my child…and I can't take it anymore.

She further disclosed that he "told me that at any time he can come home and tell me that I must leave. Every night I am afraid and he said that "when all of you [me and my children] are inside, I will burn the shack. He says all these things when he is drunk." Like Lauren's husband, Summer's husband has also isolated her from her friends. Spousal/partner abuse has not impacted the engagement levels of Nancy, Aisha, Carrie or Barbara. However, it may have impacted the ability of Mariah, Lauren, and Summer to fully participate in the various programs.

Sub-category: Participant Drug Use

Thirty-three percent (N=4) of women spontaneously disclosed that they either currently use drugs or have used drugs in the past in response to various unrelated questions. When asked which program was the main program she participates in, one woman replied:

> When you stay in a community where a lot of people are doing drugs you get used to this. So when one person says we are going to this or go there, you want to feel a part of a community or you want to feel like you belong. So you know that it is wrong and you know the consequences but…you still go and [engage in that behavior].

The participant disclosed: "I was on drugs for [over a decade] but I have been sober for [several] months…the only drug that I did was crystal meth…" However, she acknowledges that "I can do better for my kids and I want a better life for them, because if I was using, then I can't be a good mom." According to her, the program has taught her the consequences of substance abuse and was the catalyst to her sobriety.

When asked about her drinking habits, another participant spontaneously disclosed her prior drug use. She responded:

> When I was younger yes I used to do things but I don't [do it] now, I smoke cigarettes…I am not going to lie to you, I did experiment with drugs, I used ecstasy pills and I smoked weed but I did not like it, it made me feel very ill. I started feeling and talking slow and I did not like it. This was years ago before I had the babies.

When asked the same question another woman spontaneously disclosed her prior drug use:

> …I started experimenting with methamphetamine. You know it was a hell of a time. It was a very dark depressing period in my life and when you are doing that you are in your own world and there is no one else around you...it was one of the lowest places of my life.

Both of these women explain their prior drug use as an "experiment." For these two women, using drugs could have been a form of self-medication to handle the various stressors in their lives. On the contrary, when asked about her drinking habits one participant spontaneously disclosed: "I do not drink alcohol. But I am still on drugs; sometimes I use marijuana and cocaine." Unlike the previous women, she was forthcoming about her current drug use and made no excuses as to why she engaged in the behavior.

Facilitators to Participant Engagement

In Chapter 6, social support networks were discussed from a contextual context that is important to the entire community. As it relates to the program specifically, social support networks within the PW/CP can be very helpful to participants who come from challenging backgrounds and need this support for not only themselves but for their children as well.

Category: Social Support Networks within the Programs

Eight women expressed how helpful it is to receive social support from within the program. This is also three more women than in the CBC/SBP sample, which isn't surprising as the women in this sample have been through very traumatic events in their lives and the same number of women that receive support in the NHSG sample. Women are able to talk freely about their problems in group sessions, had staff call their doctors on their behalf to make appointments, and were given moral support to deal with children who are members of one of the rival gangs and on drugs. According to Mariah, the social support that she receives from the PW is valuable because, "sometimes you don't want to talk about things but it is killing you inside and you can talk about it and you see that [talking to someone] can be powerful." Aisha also finds refuge in the PW because she is able to talk about her problems in a group and said the women "would talk about how their lives were compared to our lives."

According to Carrie:

> Everybody is caring here. Because things are bad…when you have social problems, you can just come speak to [the Adherence Counselor] and she will help you through it.

Barbara is very pleased with the staff in the CP and the organization as a whole:

> There is so many good stuff that they are doing in our community and I look up to everyone that works in this organization, I admire them, they are amazing people, they are full of love and support for our community…and they are doing a great service.

Lastly, one PW participant compared Table Views to another daycare facility that her children previously attending. According to her, "being here as made a huge difference because now I can speak to someone, I have more support here than I did [at the other crèche]."

Programmatic Impact on Participant's Parenting Approaches

The short-term outcomes of the PW/CP obtained from Table Views' General Report include the following changes in behavior: 1) participants in the Parenting Workshops treat their children differently and in a more positive fashion, and 2) increased numbers of participants that stop using drugs and/or alcohol. Changes in participant knowledge include: 1) greater awareness to parent roles and responsibilities. The mid-term outcome of the PW/CP is that: 1) participants begin to see improvements in their relationships with their children, can communicate more effectively, and begin to have a stronger bond with their children. The long-term outcome of the PW/CP is: 1) decreasing the amount of parents who use drugs and/or alcohol and increasing the parent-child bond in the Maraval community.

The women were asked several questions to measure the program's impact: 1) *What did you expect to get from the ECDA/PW/CP?,* 2) *Tell me what is has been like to participate in the ECDA/PW/CP?,* 3) *How helpful has the ECDA/PW/CP been to you and your family?,* 4) *What have you learned (proper parenting skills)?, and* 5) *How has having your children in the ECDA changed your parenting skills/the way you are raising your children?* Responses to these questions fall under one main theme: change in parenting skills (N=8).

Theme: Change in Parenting Approaches

Specifically, change in parenting approaches is divided into three categories: improved communication skills with their children (N=5), increased love and attention towards their children (N=4), and better educational outcomes for their children (N=4). As previously mentioned, all of the women have children who are registered in the

ECDA. Therefore, the analysis combines their responses around parenting skills

regardless if the woman's main program is the PW or the CP. When asked how the

ECDA changed her parenting skills and the way she is raising her children, Tisha replied:

> It changed a lot; it keeps me on my toes…because…when I used to drink, and now that I don't drink I made that choice because I said it is getting worse…I realized I don't want that for my children.

When asked how the same question, Summer responded:

> I am a better parent for my grandchildren and my children. I am every day with [my grandchildren]…my children are very attached to me unlike their father. My granddaughter, she is [also] very close to me and attached to me.

Participation in the PW has also positively changed Summer's relationship with her

children and grandchildren and has strengthened their bonds.

Category: Improved Communication Skills with Their Children

When asked how helpful the PW has been for her and her family, Aisha replied:

> I can see that there is a change in my family and me and my kids…I used to be very vulgar to my children and swear at them. But now I do not. I talk to them nicely and draw them to me and explain to them [for example] 'don't do that that will hurt you.'

Participation in the PW has impacted the way Aisha interacts and communicates with her

children, has changed her parenting choices, and has improved her parenting skills. She

learned "…that there has to be a balance between how I bring my child up at home and

how they bring up the child here at the crèche (ECDA)." The program is teaching the

participants to employ the same positive methods at home so that the child will not be

confused. Aisha believes that the PW's services were sufficient "because you can learn a

lot from them [staff and international volunteers] like how to be independent."

After being asked what she expected to get from the PW, Mariah shared:

> For me…I did not know how to interact with children, I always just say 'go or leave me alone!' But I learned…to talk to them and always have a smile…

The neglect that Mariah endured from her mother as a child impacted the relationships she has with her children as an adult. The program taught Mariah how to better communicate and interact with children instead of pushing them away. When asked what it has been like to participate in the PW, Mariah further explained what she learned from the workshops:

> ...It is important to look children in their eyes…and even talk about the future...because my parents never sat with me and talk with me because they did not have an education, they were also young…

Mariah, who suffers from deep-rooted emotional issues, was not embraced by her parents and as a result the cycle of neglect continued to her children.

Lastly, when asked how the ECDA and PW changed her parenting skills, she replied:

> I feel like I am a woman and I can do it alone [now] and I can stand as a mother and a father… [This program] has changed me a lot because with my two eldest children, through the abuse I never spoke with them, I never interacted with them, sometimes I blame myself…(begins to cry)...But now that I have received this education about how you must interact with your child…

Mariah's response reveals a feeling of independence and empowerment, a feeling also mentioned by Aisha. Even though Mariah is married, unlike Aisha, she is in an abusive relationship and feels as if she has to play the dual parent role because of her husband's behavior in front of the children. However, participation in the workshops has positively changed her parenting skills. For example, she is trying to quell her feelings of maternal guilt through words of affirmation such as telling her daughter: "you are unique, you are pretty, and you are beautiful." She also tries to instill in her daughter that domestic abuse

is not right and told her daughter: "if your husband ever lift his hands once on you, you come tell me and I will sort him out because of what I went through."

Summer, also a victim of domestic abuse, did not know how to positively communicate with her children. She used "to get angry and shout [at her children]" because her husband would come home "and shout at me and it [weighs on my head]." As a result of being verbally abuse by her husband, Summer would take it out on her children and "shout at them and sometimes I get very angry with them." When asked how the CP changed her parenting skills, Nancy replied: "...now I sit with [my children] and chat with them..." The program has changed her communication skills. Furthermore Nancy, also found that counseling is helpful for her because "this is a place where I can sort myself out." Chloe was also asked about the program's impact on her parenting skills. She replied: "my son didn't talk [but now] like we are talking...now he can say mommy and mama and stuff now." Before she joined the workshop she felt like her child "was talking like another language" but now their communication skills have improved.

Category: Increased Love and Attention towards their Children

Four of the women learned how to show love and give their children attention. One participant, who admitted she used crystal meth in the past, expressed that the program increased the bond between her and her children. She stated:

> ...When I used to use drugs, I would give them attention but not all the attention they really needed or wanted...sometimes I would just shove them to the side. These days when one of them falls or hurts themselves, I go and pick them up and comfort them and make them stop crying, but other times I will scream at them.

While she has noticed a change in the way she shows her children love and attention she acknowledged that she still struggles with the relationship. When asked how having her children in the ECDA changed her parenting skills, Nancy shared the following:

> I used to not like to kiss them [my children] and that is why they were not getting the love that they needed but now I tell them 'I love you'. Because I see the look on the child's face [when I say I love you] …it is priceless.

Nancy sees how happy her children have become now that she shows them more love. In response to the same question, Mariah replied: "I did not know how to hug my children, and say 'I love you' but now I am learning more about children, I understand now." Lastly, when asked what she learned in terms of proper parenting skills, Tisha explained:

"You don't have to be rich or have the biggest house, as long as there is love in the family…children look up to you so you have to take care of them."

Category: Better Educational Outcomes for their Children

Lauren was asked about the ECDA's impact on the way she is raising her children. She explained that her son "struggles with reading and math" and expressed guilt because she feels that his academic challenges are a result of her "working overtime and I began to neglect my children and that is where I lacked as a mother." However, she hopes that the ECDA will continue to give her children "the time that I did not give them to do homework and emphasize on their special needs." And Tisha believed that the ECDA has been helpful to her and her family because "if you need help it is here, my children can come here and learn something." The program has helped Lauren and Tisha with their children's educational needs.

When asked how helpful the ECDA has been to her and her family, Debra's response demonstrates a change in her children's behaviors: "like when they come in the house now, they know how to open their books and color and start writing their homework on their own." Lastly, in response to the same question, Nancy replied: "I thought that [my child] has to be in the crèche. And then I can also spend more time with my son. When he comes to the ECDA he can learn to read…" Nancy grew up around gangsterism her entire life but doesn't want her children to go down the same path and believes that the ECDA provides a way "to keep them busy."

The programs have achieved two short-term outcomes: participants treat their children differently and in a more positive fashion and greater awareness to parent roles and responsibilities by showing increased love and attention towards their children. The programs have also achieved one facet of the mid-term outcome: participants can communicate more effectively with their children. As previously stated, four participants spontaneously disclosed their experiences using drugs. Of these four, two stated that they no longer use drugs, one admitted that she currently still abuses drugs, and one didn't clarify if she is a current drug user. Therefore, the programs have achieved one short-term goal: increased numbers of participants that stop using drugs and/or alcohol. Of the eleven women that stated current or prior alcohol use, the majority (N=7) admitted that they stopped drinking alcohol. Thus, the programs have achieved this short-term goal as more women have stopped drinking compared to those who still drink alcohol.

Conclusion

This chapter focused on an analysis of 12 women who participated in either the PW or the CP. When we look at **Table 11** we see that there is little to no variation among

the participant's demographics: race, age, educational attainment, and marital status. The racial make-up of this sample is similar to that of the CBC/SBP sample in Chapter 6. Four women spontaneously disclosed that they either currently use drugs or have used drugs in the past, which can be attributed to the nature of the Parenting Workshop and Counseling Program which were created to "target parents addicted to drugs and/or alcohol whose children participate in the ECDA through learning programs" and "to provide a safe environment where people in the community are comfortable to consult with us on issues they are facing in their lives", respectively. When we compare programmatic participation levels, women in the PW are involved in other programs at a higher percentage than those in the CP.

Community violence, food insecurity, government assistance, and spousal/partner unemployment were voiced by the women as environmental contextual factors that affect the entire community. Examples of community violence include shootings, extortion, and arson, to name a few. Community violence was also a shared contextual factor among the CBC/SBP and NHSG participants as well as staff. Food insecurity, the second most common environmental contextual factor, affects almost 70% of the women in the PW/CP. Several women in this group are currently employed or were recently employed and therefore we might expect to see a negative relationship – as employment increases, food insecurity decreases. Yet, more women in this sample report suffering from food insecurity in comparison to the CBC/SBP and NHSG samples.

Sixty-seven percent of the women in the sample provided examples of maternal poverty in the form of spousal unemployment and government assistance. As a result of their partner's unemployment, five women have taken on the role of sole provider.

A little over 40% of women in this sample receive government assistance because of their socio-economic status or for their children. These women collect less government assistance than the NHSG sample because of their employment status. In general, women in both programs deal with these same social problems to the same degree.

Emotional issues are the main individual contextual factor among the PW/CP women. This was also the main factor expressed by the NHSG women at a similar percentage. Many participants face different emotional issues because they are victims of physical or verbal abuse by their spouses or partners and/or lack decision-making power in their households which has affected their emotional state. Abused women have been threatened with weapons, have witnessed their children being abused, feel as though they have nowhere to go, have been kicked out of their homes, and are in constant fear for their lives. Those who have used drugs experimented with methamphetamine, ecstasy, marijuana, and cocaine. The women who lack decision-making power in the household have to ask their spouses/partners for permission to leave the house to attend programs or events at the organization and physically fight with their partners if they do not follow their rules. While these individual contextual factors present barriers or challenges for some of the women, coming to the PW or CP provides others with an escape from their realities and is a safe space for them and their children.

Women report that he PW/CP has changed some of their parenting approaches. The programs have impacted participant's parenting skills in three main ways. Almost half of the sample has learned how to better communicate with their children. For example, some women have stopped swearing at their children and have adopted more positive interaction techniques, others have utilized the positive teachings that they

learned at the workshop at home with their children, and some stopped pushing their children away and instead opened the lines of communication. Others talk to their children about the future, provide words of affirmation when talking to their children, and have become more attached to their children and grandchildren.

Second, more than thirty percent of women learned how to love and show their children attention. Some participants have stopped shoving their children to the side and now comfort their children when they are hurt and tell their children they love them more. Third, four women report improved educational outcomes in their children. One participant believes the ECDA gives her children the time they need to complete their homework while another woman sends her children to the program because she is cognizant of their ability to learn in the ECDA. Finally, one woman has noticed a positive change in her children's homework habits and another knows that the ECDA will keep her children busy so that they don't become gang members like so many youth around them.

Chapter 9: Conclusion and Recommendations

<u>**Introduction**</u>

In this chapter, I first introduce a different theoretical framework that Table Views should consider in the program-planning phase. Next, I reiterate the organization's challenges and provide recommendations that Table Views should take into account in going forward. Then, I summarize community/environmental challenges discussed by staff and parent participants as well as recommendations to improve overall structural challenges in Maraval. Next, I present the organization's stated goals and programmatic goals juxtaposed with the participant's perspectives and outcomes. Finally, I present individual-level challenges and recommendations that the organization should consider to improve maternal and child health outcomes for new participants moving forward.

<u>**Theoretical Framework Recommendations**</u>

According to Rimer and Glanz (2005), theory can help to explain the dynamics of health behaviors, including processes for changing them, and the influences of the many forces that affect health behaviors, including social and physical environments. Theory guides the search for reasons of why people do or do not engage in certain health behaviors and suggests how to devise program strategies that reach target audiences and have an impact (Rimer & Glanz, 2005). The characteristics of a useful theory include assumptions about a behavior, health problem, target population, or environment that are logical, consistent with everyday observations, similar to those used in previous successful programs, and supported by past research in the same area or related ideas (Rimer & Glanz, 2005). While Life Course Theory (LCT) and the Social Determinants of

Health (SDH) help to explain the causes of the three main risks factors that this study explores – maternal poverty, poor maternal nutrition and health, and maternal alcohol use – a different theoretical orientation is needed to understand how Table Views can better connect their parent participants to the goals of its various programs. It is important to understand the cultural backgrounds and life experiences of community members when developing effective interventions (Rimer & Glanz, 2005). It does not appear that the Founder and administrative staff utilized a clear theoretical framework in the planning and implementing stage that was tailored to each program to elicit change among the women in the Maraval community.

Targeting involves the development of a single intervention approach for a defined population subgroup that takes into account characteristics shared by the subgroup's members, which may be small and quite specifically defined (Kreuter & Skinner, 2000). In contrast, tailoring is a process that uses an assessment to derive information about one specific person, and then offers change or information strategies for an outcome of interest based on that person's unique characteristics (Kreuter & Skinner, 2000; Rimer & Glanz, 2005). Table Views should consider the Stages of Change theoretical approach that tailors programs to different people depending on where they are at in their lives. The model's basic premise is that behavior change is a process not an event, the model is circular not linear, and that individuals may enter the change process at any stage, relapse to an earlier stage, and begin the process once more (Rimer & Glanz, 2005). Similar to the central tenet in LCT, people benefit from different interventions during their life course and the way in which each individual passes through these stages differ.

Recommendation:

1. Table Views should reevaluate the theory behind their work and look at the benefits of multi-level interventions that combine environmental and community factors with behavioral components.

Organizational Challenges and Recommendations

It is clear that Table Views is organized. The organization is structured, receives the bulk of funding and grants from international donors, and has a passionate and dedicated staff that often works overtime but does not expect to be paid additionally for their time. The organization exists to achieve established goals and objectives and it has increased efficiency through the appropriate division of labor: a) Founder who is college-educated in social work with years of experience in the field and in the community that she serves, b) an administrative staff that draft proposals for funding, c) staff who have received certifications in early childhood development (ECD), d) programmatic staff who are placed in areas where their skills are best utilized, and e) suitable forms of coordination and control to ensure that diverse efforts of individuals and units mesh (Bolman & Deal, 2017). The organization has rules, individuals have clear roles, there is a mission statement, a clear organizational vision, and programmatic goals. The architecture of Table Views, if you will, has shaped and channeled the organization's decisions and activities (Bolman and Deal, 2017).

However, the organization has not been successful at being transparent to staff when it comes to funding. According to Bolman and Deal (2017), most successful

organizations comprise variations on basic human resource strategies which include

investing in staff (invest in learning and create development opportunities) and

empowering staff (provide information and support). Table Views' focus on investing in

staff could explain why approximately 50% of the staff has been employed at the

organization for less than 5 years, while the other half have been at Table Views since the

organization was founded in 2008, as discussed in Chapter 5. While Table Views has

achieved the first strategy by providing opportunities for staff to attend professional

development seminars and trainings and obtain certificates in their respective fields, it

has not empowered the staff. Lack of transparency related to funding was reported by six

staff members as a barrier or challenge to organizational goal achievement. When asked

about funding streams, most employees were unaware of where the money comes from,

where the money goes, or were nervous when responding to questions about funding.

Discussing funding is a sensitive topic at the organization and while reports such as the

General Proposal are transparent to funding agencies, it is not evident to people who

work at the organization. Progressive organizations give power to employees as well as

investing in their development and empowerment that includes keeping employees

informed (Bolman & Deal, 2017).

> *Recommendations:*
>
> 1. Table Views should share funding reports with all staff at monthly
>   meetings, and
> 2. Administrative staff should ask programmatic staff for input on ways to
>   diversify funding streams.

Community/Environmental Challenges and Recommendations

According to staff in Chapter 5, there are four main community/environmental contextual factors that influence participant engagement: community violence, poverty, child abandonment and neglect, and negative mentalities derived from racial and cultural tensions and acts of racism. Community violence, food insecurity, poverty, and the lack of social support networks were the four most common community/environmental contextual factors according to participants from the Computer and Business Course (CBC) Program and the Sewing and Beading Project (SBP) in Chapter 6. In Chapter 7, parent participants in the Nutrition and Health Support Group (NHSG) reported community violence, poverty, and food insecurity as the three most common community/environmental challenges. Finally, in Chapter 8, the women in the Parenting Workshops (PW) and the Counseling Program (CP) identified community violence, food insecurity, and poverty as community/environmental challenges. It is clear that community violence, poverty, and food insecurity are overall challenges for women across all of the programs. While only mentioned by one group of parents, lack of social support networks is also a challenge in the community. These factors are huge problems in Maraval; however, little is being done by the organization at the community level to address these issues. Table Views is trying to affect change at the individual level, but its impact is therefore limited.

Table Views was created to change behavior at the individual level. The organization was founded to address poverty and food insecurity, specifically, through the CBC Program, SBP, Feeding Scheme (FS), and the Organic Garden (OG); however, these programs are done on a one on one basis. There is a conflict within the organization,

if you will, between helping individuals and changing the Maraval community. The

organization needs to go one step further and look at a theory of change model that also

focuses on the community through their work on individuals and one that looks at the

levels of impact of their work. The ecological perspective, for example, is a multi-level

and interactive approach that focuses on people's interactions with their physical and

socio-cultural environments (Rimer & Glanz, 2005). The perspective focuses on two key

concepts to help identify intervention points for promoting health: that behavior is

affected by multiple levels of influence and that individual behavior both shapes and is

shaped by the social environment (Rimer & Glanz, 2005).

Rimer and Glanz (2005) contend that initiatives serving communities and

populations, not just individuals, are at the heart of public health approaches to

preventing and controlling disease. Community-level models embody an ecological-

perspective and explore how social systems function, change, and how to mobilize

community members and organizations (Rimer & Glanz, 2005). When planning

community-level interventions, it is critical to learn about the community's unique

characteristics (Rimer & Glanz, 2005). Although staff and parent participants are well

aware of the challenges that the community faces, it is not clear if Table Views involved

the community during the planning and implementation phase almost ten years ago or are

currently involved in the expansion or evolution of the programs. Staff and participants

across programs reported violence, poverty, and food insecurity as environmental

contextual factors, which illustrates that these community level barriers remain.

The organization is heavily focused on clinical services but it is not looking at

these important structural challenges. Furthermore, the programs do not appear to be

user-centered, instead, it seems as though the programs were designed by the Founder, administrative or senior-level staff, and by individuals who fund the organization. Table Views needs to incorporate a more community-level approach to reduce these barriers. Moving forward, new programs should become more participant-oriented and involve parents when implemented. Additionally, current programs should be restructured after community buy-in is achieved. In doing so, the organizational and programmatic goals would reflect the overall goals of the participants as well as the goals at the community. Indeed, contemporary health promotion involves more than simply educating individuals about healthy practices but includes efforts to change organizational behavior, as well as the physical and social environment of communities (Rimer & Glanz, 2005).

Community organizing is a process through which community groups are helped to identify common problems, mobilize resources, and develop and implement strategies to reach collective goals (Rimer & Glanz, 2005). The organization does not focus on the community as a broader aspect and, because of this narrow focus; Table Views' various interventions are not as effective as they could possibly be. The organization needs to engage other community organizations and individuals in the community, not just the mothers in the programs but also fathers, grandmothers, aunts, uncles, etc, in hopes that this change would result in better environments for their target population. Table Views should work on improving the Maraval community through community organization and other participatory models. Many health disparities may be addressed at the community or local levels (Shi & Singh, 2015). Furthermore, societal cohesion and support contribute to the level of inequalities in a community and community partnerships reflect the priorities of a local population, community solutions benefit from participatory

decision-making, minimize cultural barriers, and improve community buy-in to the program (Shi & Singh, 2015). Community organizing is consistent with an ecological perspective in that it recognizes multiple levels of a health problem and involves different approaches to effecting change (Rimer & Glanz, 2005).

Community organization is divided into three general types that are crucial to achieve and measure change: locality development, social planning, and social action (Rothman, 2001; Rimer & Glanz, 2005). In particular, locality development (or community development) is process oriented and the goals are to develop group identity and cohesion and focuses on building consensus (Rimer & Glanz, 2005). According to Rimer & Glanz (2005), community organizing is further broken down into different approaches to include empowerment, community capacity, participation, relevance, issue selection, and critical consciousness. However, as it relates to this current study in particular, Table Views should consider two of the six approaches specifically (community capacity and critical consciousness) when moving forward. Community capacity is defined as characteristics of a community that affect its ability to identify, mobilize around, and address problems (Rimer & Glanz, 2005). Critical consciousness is defined as awareness of social, political, and economic forces that contribute to social problems (Rimer & Glanz, 2005).

When we look at community capacity, social networks are an example of a critical change strategy. The women have become members of social networks while participating in Table Views' various programs and projects. In the Sewing and Beading Project, for example, many women are content with staying at the organization for long periods (some as many as years) because they have developed relationships with staff and

other women who have also been there for multiple years. Although not an explicit goal, the SBP has become a support group or social network for some women who come from similar backgrounds, women look to the Project as a sisterhood, and mothers have stayed in the organization because of this camaraderie.

Mothers at Table Views are poor in their social capital as well as their economic capital. They are often alone. The majority of women (73% or N=27) in the total sample of thirty-seven parents are single, divorced, or widowed. The SBP fills this gap informally by giving participants a stipend, providing mothers with an opportunity to receive social support, and supplying women and children with food. However, the program can diminish the vulnerability of participants if the women would go into the environment and create broader social networks and support groups with other women in the area by talking to women about their situations and developing relationships around shared challenges.

When we consider critical consciousness, it is obvious that various social, political, and economic forces contribute to the community's social problems. In practice, addressing the community level requires taking into consideration community factors (violence, poverty, and food insecurity) that may constrain recommended behaviors. The police are not respected in the community and lack legitimacy. As a result, gang violence is rampant in Maraval. Therefore, the organization should work in partnership with local law enforcement officials to determine ways to handle criminal activity, reduce community violence, and make an impact in decreasing the rate of gangsterism.

To reduce poverty in Maraval, Table Views should work with members of the community to create microcredit/microfinance programs, which is a grass-roots tool for

alleviating poverty and enhancing access to financial services (savings and technical assistance) for the poorest populations in developing countries. Greene and Gangemi (2006) place microcredit at the heart of microfinance, where it is widely understood as the practice of offering small, collateral free loans to members of cooperatives who otherwise would not have access to the capital necessary to begin small businesses and people who are not served by banks (Hossain, 2002). Borrowers are usually women, in part because studies show that women are more likely to use their earnings to pay for family needs than men (Greene & Gangemi, 2006). Research by Hietalahti and Linden (2006) in South Africa revealed that a number of the poorest women have been released from the deepest poverty through opportunities provided by microcredit village programs. Although the organization provides women with stipends, this money is not helping to lift participants out of poverty and although the women are learning skills in the SBP, they are not able to start their own sewing and beading businesses because the beads and materials are too expensive. Therefore, the introduction of microcredit types of arrangements would benefit the women by providing them with funds to buy materials and assist them with income generation.

Finally, food insecurity was reported as a huge challenge for participants across all programs. One woman provided an example where she had to ask a neighbor for food for her and her children. However, the neighbor told her that she could not provide her with food because she was also struggling to feed her own family. Yet, the next day the neighbor was seen bringing groceries home. Food insecurity does not only affect the participants on an individual level but also affects the community. Food insecurity has resulted in malnourished women and children.

Table Views should develop initiatives that involve all the residents in Maraval and outreach strategies that engage the support group with women in the community, create food pantries, and promote community gardens. Participants and staff who teach community women to start and maintain their own small gardens, thereby augmenting their own diet and, perhaps, creating informal social support groups or networks, can accomplish this through outreach. Research by De and Sarker (2011) illustrates the relationships between support groups, microcredit programs, poverty, and food insecurity. De and Sarker (2011) found that most of the self-help groups that are formed under current microcredit initiatives are those of women in part because hunger and poverty are more of a woman's issue than a male issue. This is because women experience hunger and poverty in much more intense ways than men do because women constitute the majority of the poor, the underemployed, and the economically and socially disadvantaged (De & Sarker, 2011).

Recommendations:

1. Table Views should utilize the community capacity approach (adapted from Rimer & Glanz, 2005).

   a. Potential Change Strategy: Community members participate actively in community life, gaining leadership skills, social networks, and access to power.

      i. Issue: Lack of Social Support Networks

         1. Create broader social networks and support groups with other women in the area.

2. Table Views should engage the community through the critical consciousness approach (adapted from Rimer & Glanz, 2005).

    a. Potential Change Strategy: Community members discuss the root causes of problems and plan actions to address them.

        i. Root Cause: Community Violence

            1. Work with the police and/or community activists to develop solutions to reducing "gangsterism", and

            2. Incorporate programs such as the Group Violence Reduction Strategy used in New Orleans, Louisiana (Corsaro & Engel, 2015) which is a deterrence strategy that has proved successful in reducing homicide rates and criminal activity in the community.

        ii. Root Cause: Poverty

            1. Create cooperative microcredit programs in the community.

        iii. Root Cause: Food Insecurity

            1. Create a food pantry that serves the entire community, and

            2. Expand the Organic Garden by promoting community gardens throughout Maraval, which would help feed small sections of the population.

Programmatic Challenges and Recommendations

The purpose of this multi-program case study was to describe the ways in which a community-based organization (CBO), Table Views, contributes to the knowledge of at-risk, low-income Black and Coloured mothers and their decisions to make better behavioral, nutritional, and parenting choices. The study links the intended actions and goals of the CBO to reports from staff and parents. Assessing the adequacy of program process is an important evaluation function because it compares the program activities that actually take place with the services that are actually delivered (Rossi et al., 2003). According to the annual report, the stated organizational goal of Table Views is:

> To accomplish social and economic improvement through various programs that educate, inform, and support the people of Maraval and its surrounding communities.

The organization intends to accomplish this goal through five programs (that specifically target mothers): the Computer and Business Course Program, the Sewing and Beading Project, the Nutrition and Health Support Group, Parenting Workshops, and the Counseling Program.

Computer and Business Course Program

The stated goal of the Computer and Business Course Program (CBC) is "to reduce the unemployment rate and create new income opportunities" for women in the community. This goal is measured through short-term, mid-term, and long-term outcomes obtained from the Organization's General Report. The short-term outcomes of the CBC Program are: 1) students begin to develop knowledge on computers and how to start their own business, and 2) obtain greater knowledge of how to become more marketable in order to receive job opportunities. The medium-term outcomes are: 1)

students are referred to job opportunities by Table Views based on their newly developed

and marketable skills, and 2) students are able to assist their children with homework

assignments because of the skills they learned in the Program. The long-term outcome is:

1) closing the socio-economic gap of at-risk Black and Coloured women in the WCP.

The majority of women in the program (five of seven) reported that participation

in the program resulted in improved knowledge and skills – which is one of the course's

short-term outcomes. Fifty-seven percent of mothers reported that after participating in

the program they began to assist their children with homework on a regular basis – one of

the course's mid-term outcomes. Parents also discussed how the program taught them

how to create an email address, advertise their businesses online, and use the complete

Microsoft Office Suite Program. As a result of learning these skills, the women are more

marketable and therefore positioned to receive more job opportunities. However, none of

the women has found permanent employment. Therefore, the CBC has not achieved all of

its medium-term outcomes and more work is needed to decrease maternal poverty in the

Maraval community.

Recommendations for the CBC Program:

1) Modify the current program so that in addition to classroom training,
    participants must complete an internship at a business of their choice in
    the community and provide transportation to and from the internship,

2) At the end of each cohort and as part of their graduation ceremony,
    provide each participant with the opportunity to pitch their business
    ideas and plans, and receive advice from experts in their respective

fields. This is also an opportunity for entrepreneurs to see if there are any businesses that are interested in their ideas and would like to fund their respective projects,

3) Follow-up with CBC participants on a monthly basis to determine if they require more computer skills,

4) Ask participants to keep a log of the jobs that they applied to and to bring the log into follow-up meetings,

5) Look over cover letters, resumes, and job applications to ascertain where participants need assistance,

6) Research potential job opportunities with participants in-person on a weekly basis,

7) Collaborate with community employers so the organization has a better idea of what is needed and that employers know that Table Views has a Computer Course Program,

8) Connect participants with the Department of Social Development's Entrepreneurship Program (which trains approximately 300 young people in the province),

9) Pair participants with professionals and entrepreneurs in the province with established businesses in their proposed career fields so that the participants can receive support and mentorship,

10) Assist participants with the development of business plans, and

11) Connect participants with crowd funders who will donate to their proposed business ideas.

Sewing and Beading Project

The stated goal of the Sewing and Beading Project (SBP) is to "equip women in the community with needed self-esteem and professional skills to enable them to support their children and be strong role models in the area." This goal is measured through short-term, mid-term, and long-term outcomes obtained from the Organization's General Report. The short-term outcomes of the SBP are: 1) students begin building their self-esteem and professional skills to generate their own project and 2) obtain greater knowledge by learning a new trade so that they can start their own independent sewing or beading program out of their own homes. The mid-term outcomes are: 1) students are referred to job opportunities by Table Views' partnership with local manufacturing companies based on their new developed and marketable skills and placed in other companies doing administration and 2) students learn skills to develop into a CMT (Cut, Make & Trim) operation so that women can begin to earn decent wages. The long-term outcome is: 1) closing the socio-economic gap of at-risk Black and Coloured women in the WCP through independent income generation businesses.

The majority of women in the program (five of six) reported that participation in the program resulted in the idea of starting their own businesses – which is one of the course's short-term outcomes. However, due to the financial costs of starting a sewing and beading business (such as the cost of beads, clothing, and materials) participants are unable to get started. Therefore, the SBP has not achieved all of its medium-term outcomes and more work is needed to close the socio-economic gap of at-risk Black and Coloured women in the WCP through independent income generation businesses.

Recommendations for the SBP:

1)   Modify the current project so that in addition to classroom training, participants must complete an internship at a professional CMT business in the community and provide transportation to and from the internship,

2)   As part of their graduation ceremony, provide each participant with the opportunity to display their sewing and beading work and receive advice from experts in crafts and retail such as small business owners (SBOs) who have stores in the V&A Waterfront – a high tourist attraction. This is also an opportunity for women to see if there are any (SBOs) that are interested in their work and would like to fund their respective projects,

3)   Reach out to local businesses for increased sponsorship, and

4)   Increase marketing via online networks to display participant work and reach a broader audience of potential buyers.

Nutrition and Health Support Group

The stated goal of the Nutrition and Health Support Group (NHSG) is to: "target and equip the women in the community with chronic problems such as diabetes, HIV/AIDS, TB, high blood pressure, and high cholesterol with the skills to manage their individual diseases." The NHSG is assisted through volunteers in the Organic Garden and the Feeding Scheme. This goal is measured through short-term, mid-term, and long-term outcomes obtained from the Organization's General Report. The short-term outcomes of the NHSG include the following changes in behavior: 1) increased numbers of

participants that change their nutritional habits engage in healthy nutritional behaviors and attend all clinic and hospital visits, and 2) adherence to medication on a daily basis to improve health outcomes. Change in participant knowledge includes: 1) greater awareness to medical adherence for chronic conditions. The mid-term outcome of the NHSG is that: 1) participants begin to see improvements to their medical conditions such as lowered cholesterol and blood pressure and improved disease management. The long-term outcome of the NHSG is 1) decreasing the amount of women who suffer from chronic health problems by teaching the women about pain management and adherence.

The majority of women in the program (seven of twelve) reported that participation in the program resulted in a change in nutritional choices – which is one of the support group's short-term outcomes. One parent also discussed how the program improved her medical condition (high blood pressure) – which is the support group's mid-term outcome. However, she is only one of twelve women that reported a change in medical condition. Furthermore, many women discussed the difficulty of eating healthier over the weekends when the organization is closed and money is scarce. Therefore, the NHSG has not achieved all of its short and medium-term outcomes and more work is needed to decrease the number of women who suffer from chronic health problems by teaching them pain management and adherence.

Recommendations for the NHSG:

1) The organization should open the Organic Garden and Feeding Scheme with limited hours during the weekend so that women are able to receive food for themselves and their families,

2)   Work in conjunction with other Feeding Schemes and churches that are open on the weekend to assist women and decrease food insecurity,

3)   Organize food drives on the weekends and ask participants to volunteer so that both the organization and parents benefit from the proceeds and store excess food in the kitchen until Monday,

4)   Work with the Department of Health's community health workers (CHWs) to provide participants with more information on pain management and adherence,

5)   Follow-up with NHSG participants on a more frequent basis to determine if they are adhering to disease management, and

6)   Request volunteer assistance from medical students and public health students from local colleges and universities who can support the Adherence Counselor for Nutrition and Health on a weekly basis.

Parenting Workshops and Counseling Program

The stated goal of the Parenting Workshops (PW) is to: "target parents addicted to drugs and/or alcohol whose children participate in the ECDA through learning programs." The stated primary goal of the Counseling Program (CP) is: "to provide a safe environment where people in the community are comfortable to consult with staff on issues they are facing in their lives." The stated secondary goal of the CP is: "to link people with other social institutions (social development, schools and colleges, and hospitals) and to offer support in legal and governmental affairs." These goals are measured through short-term, mid-term, and long-term outcomes obtained from Table Views' General Report. The outcomes of the programs are combined.

The short-term outcomes of the PW/CP include the following changes in behavior: 1) participants in the Parenting Workshops treat their children differently and in a more positive fashion, and 2) increased numbers of participants that stop using drugs and/or alcohol. Changes in participant knowledge include: 1) greater awareness to parent roles and responsibilities. The mid-term outcome of the PW/CP is that: 1) participants begin to see improvements in their relationships with their children, can communicate more effectively, and begin to have a stronger bond with their children. The long-term outcome of the PW/CP is: 1) decreasing the amount of parents who use drugs and/or alcohol and increasing the parent-child bond in the Maraval community.

The majority of women in the PW/CP (eight of twelve) reported that participation in the program resulted in a change in parenting skills – which is one of the Parenting Workshops/Counseling Program's short-term outcomes as it relates to changes in behavior and changes in participant knowledge. These changes include improved communication skills with their children, increased love and attention towards their children, and better educational outcomes for their children. Therefore, the programs have also accomplished the mid-term outcome of improvements in parent-child relationships and more effective communication. The programs have also achieved one short-term goal: increased numbers of participants that stop using drugs and/or alcohol and are on path to accomplishing the long-term outcome of decreasing the amount of parents who use drugs and/or alcohol and increasing the parent-child bond in the Maraval community. The accomplishments of the PW are supported by the broader literature. A number of other studies have identified factors which are associated with the success of these programs including parental attitudes towards program content, changes in

parenting skills and confidence, and positive experiences of the group process (Furlong & McGilloway, 2011; Gardner et al., 2006; Gardner et al., 2010), ECD has been recognized to be the most important contributor to long-term social and emotional development (Cummins & McMaster, 2006), and the result of positive parenting styles sets the child's development on a positive trajectory as children who are allowed to explore their environments acquire positive learning experiences (September et al., 2016).

Recommendations for the PW/CP:

1) Work with the Department of Health's community health workers (CHWs) to provide participants with more information on the consequences of substance abuse,

2) Follow-up with PW/CP participants on a more frequent basis to determine if they are still abusing drugs and alcohol and provide participants with support to reduce substance abuse,

3) Request volunteer assistance from mental health practitioners and students from local facilities, colleges and universities who can support the Adherence Counselor for Nutrition and Health on a weekly basis,

4) Reach out to the Parent Centre, a local CBO that has been successful in teaching mothers and fathers about improved parenting skills, for assistance in trainings and program development, and

5) Reach out to the USAPHO Foundation, a local CBO that has been successful in teaching teenage and adolescent mothers and fathers about improved parenting skills, for assistance in trainings and program development.

<u>Parent-Participant Challenges and Recommendations</u>

As previously stated under the theoretical framework and recommendations section, Table Views should consider the Stages of Change Model that tailors programs to different people depending on where they are at in their lives. According to Rimer & Glanz (2005), people move through five stages: pre-contemplation (has no intention of taking action within the next six months), contemplation (intends to take action in the next six months), preparation (intends to take action within the next thirty days and has taken some behavioral steps in this direction), action (has changed behavior for less than six months), and maintenance (has changed behavior for more than six months). Based on reports from the mothers at Table Views, the women's behaviors and attitudes fall into each of the five stages.

For example, the women in the CBC Program are in the preparation phase: they believe that receiving the Computer Course certificate would result in better employment opportunities in the future and six of the seven women are in the maintenance phase: they reported assisting their children with homework. The majority of the women in the SBP are in the contemplation phase: five of the six women want to start their own sewing and beading business but have not yet taken action. The majority of women in the NHSG are in the maintenance phase: they have learned to change their nutritional choices by maintaining a proper diet (more vegetables and less meat). Finally, the women in the PW and the CP are also in the maintenance phase: almost half of the sample has learned how to communicate with their children, more than thirty percent of women learned how to love and show their children attention, and some women report improved educational outcomes in their children. The woman in the PW/CP who spontaneously disclosed "I am

still on drugs; sometimes I use marijuana and cocaine" is in the pre-contemplation phase and did not discuss any intention of taking action within the next six months to stop her behavior. Conversely, the woman who disclosed that she "was on drugs for [over a decade]" but has been sober for several months is in the action phase.

As stated in previous chapters, the majority of participants in each program heard of the organization through word of mouth. They were told to attend the various programs by friends or family members who are current participants. A small proportion of women were asked to join the organization after the Founder and administrative staff canvassed the community looking for women who could benefit from the program. Other women were recruited through complaints from neighbors who called on the organization to assist women in dire situations, such as the woman who was physically living under a boat with her children because she was homeless. The organization should expand their recruitment beyond word of mouth or the occasional venture into the community. Now, when recruiting new participants, Table Views should utilize the Stages of Change Model to assess what phases of contemplation potential parent participants are currently in. Once this is accomplished, staff will be equipped with more knowledge on where the parents are on the continuum of change and would be better able to tailor programs that are more suitable for their different needs. Indeed, the Stages of Change Model has been applied to a variety of individual behaviors, as well as to organizational change (Rimer & Glanz, 2005).

Recommendations:

1. Table Views should use the Stages of Change Model in their recruitment
   methods and in ongoing assessments on the impact their programs are
   making on parent participants. For example, in the PW and the CP (which
   focus on reducing maternal alcohol abuse), the Founder and programmatic
   staff can ask the following questions (adapted from Rimer & Glanz,
   2005):

   a. Are you interested in trying to stop drinking alcohol and/or using
      illegal drugs? (Pre-contemplation)

      i. Potential Change Strategy: Table Views can increase
         awareness of the need for change and personalize
         information about the risks and benefits of drinking alcohol
         and using illegal drugs.

   b. Are you thinking about quitting drinking alcohol and using illegal
      drugs soon? (Contemplation)

      i. Potential Change Strategy: Table Views can motivate and
         encourage individuals to make specific plans to actually
         stop drinking alcohol and using illegal drugs.

   c. Are you ready to plan how you will stop drinking and/or using
      illegal drugs (Preparation)

      i. Potential Change Strategy: Table Views can assist
         individuals with the development and implementation of
         concrete action plans and help set gradual goals.

    d. Are you in the process of trying to stop drinking alcohol and/or using illegal drugs (Action)

        i. Potential Change Strategy: Table Views can assist individuals through feedback, problem solving skills, social support, and reinforcement of goals.

    e. Are you trying to stay alcohol-free and drug-free? (Maintenance)

        i. Potential Change Strategy: Table Views can assist individuals with coping, reminders, finding alternatives, and avoiding slips/relapses.

Conclusion

This chapter focuses on introducing a theoretical framework that Table Views should consider moving forward and recommendations to improve challenges at the organizational, community/environmental, programmatic, and participant levels for the CBO to become more successful in improving maternal and child health outcomes in the Western Cape Province. Table Views should align program strategies based on the Stages of Change theoretical approach. The central tenet of this framework is that strategies are tailored to different people depending on their individual circumstances. The organization should reevaluate the theory behind each of the programs and consider multi-level interventions. From an organizational perspective, the CBO is doing an excellent job with employee retention; however, Table Views is not transparent to their staff about funding, which has resulted in fear and nervousness among staff when asked about funding streams. Table Views should share funding reports with employees and diversify funding streams.

Table Views is a CBO located in one of the most impoverished and crime-ridden informal settlements in the Western Cape Province; however, the organization was created to change behavior only at the individual-level and has not considered the importance of involving the entire community in order to improve various structural challenges (community violence, poverty, and food insecurity). Although several programs (the CBC Program, SBP, FS, and OG) were created to address these structural challenges, more needs to be done before a real impact is realized. Table Views should consider the multi-level approach of the ecological perspective, embrace a more user-centered approach during the program-planning phase, restructure programs based on community buy-in, and focus on community organizing which looks at community capacity and critical consciousness. These two approaches mobilize communities, address structural problems, and raise awareness of social, economic, and political forces that contribute to social dilemmas. The organization should create social networks and support groups as an explicit goal for the entire community to achieve, collaborate with local police to increase legitimacy and reduce violence, work with the community to initiate sustainable microcredit programs, and create food pantries and community gardens.

When we look at the organization from a programmatic level, the CBC Program has reached one of its short-term outcomes; however, has not achieved all of its medium-term outcomes. To help reach the goal, I provided eleven recommendations that include program modification, partnerships with local business experts, monthly follow-up with participants, cover letter and resume review, and partnerships with the Department of Social Development, to name a few. The SBP has reached one of its short-term

outcomes; however, it has not achieved all of its medium-term outcomes. To help reach the goal, I provided four recommendations which include project modification, partnerships with local small business owners, sponsorship requests, and marketing suggestions.

The NHSG has reached one of its short-term outcomes; however, it has not achieved all of its short and medium-term outcomes. To help the reach the goal, I provided six recommendations which include weekend hours, partnerships with other Feeding Schemes and kitchens, food drives, and volunteer assistance, to name a few. Lastly, the PW/CP has reached both of its short-term outcomes and its medium-term outcome. To become more successful and reach its long-term goal, I provided five recommendations, which include partnerships with the Department of Health and community health workers, frequent follow-up on substance abuse counseling, and partnerships with local CBOs that provide parenting skills to young mothers and adults.

At-risk, Black and Coloured women face various community and individual level factors that influence their engagement in CBOs like Table Views Foundation. In seeking to understand the complexity of women's experiences, it is important to consider a holistic approach to improving maternal and child health outcomes in the Western Cape, South Africa. I recommend that future research focus on evaluating at-risk Black and Coloured mothers experience in other CBOs, especially those with more traditional theoretical frameworks. The studies should take place over an extended period of time as well as comprise more in-depth interviews with key stakeholders in the target community. Furthermore, larger sample sizes should be considered in further research.

Bibliography

AbdElAziz, S. B., & Hegazy, R. (2012). Socioeconomic risk factors of malnutrition among Egyptian children between 6 months and 2 years of age, Cairo, Egypt. *The Journal of the Egyptian Public Health Association, 87(5 and 6),* 124-130.

Abel, E.L. (1998). *Fetal Alcohol Abuse Syndrome.* Plenum Press; New York.

Adam, T., Lim, S. S., Mehta, S., Bhutta, Z. A., Fogstad, H., Mathai, M., & Darmstadt, G. L. (2005). Cost effectiveness analysis of strategies for maternal and neonatal health in developing countries. *British Medical Journal, 331(7525),* 1107.

Adekunle, L. (2005). The effect of family structure on a sample of malnourished urban Nigerian children. *Food and Nutrition Bulletin, 26(2),* 230-233.

Alberini, A., Eskeland, G. S., Krupnick, A., & McGranahan, G. (1996). Determinants of diarrheal disease in Jakarta. *Water Resources Research, 32(7),* 2259-2269.

Albrecht, J., Lindsay, B., & Terplan, M. (2011). Effect of waiting time on substance abuse treatment completion in pregnant women. *Journal of Substance Abuse Treatment, 41(1)*, 71-77.

Alvik, A., Heyerdahl, S., Haldorsen, T., & Lindemann, R. (2006). Alcohol use before and during pregnancy: a population-based study. *Acta Obstetricia et Gynecologica Scandinavica, 85(11)*, 1292-1298.

Andresen, E. C., Wandel, M., Eide, W. B., Herselman, M., & Iversen, P. O. (2009). Delivery of the Nutrition Supplementation Programme in the Cape Town metropolitan area from the perspective of mothers of under-5s: A qualitative study. *South African Journal of Child Health, 3(3).*

Ansari, Z., Carson, N. J., Ackland, M. J., Vaughan, L., & Serraglio, A. (2003). A public health model of the social determinants of health. *Sozial-und Präventivmedizin, 48(4),* 242-251.

Assembly, U. G. (2015). *Transforming our world: the 2030 Agenda for Sustainable Development.* New York: United Nations.

Ataguba, J., Day, C., & McIntyre, D. (2015). Explaining the role of the social determinants of health on health inequality in SA. *Global Health Action, 8.*

Atmore, E. (2013). Early Childhood Development in SA--Progress Since the End of Apartheid. *International Journal of Early Years Education, 21(2-3)*, 152-162.

Bado, N. (2012). Community-driven Development: A Viable Approach to Poverty Reduction in Rural Burkina Faso. *African Development Review, Vol. 24, No. 1*, pp. 34–40.

Bahl, R., Qazi, S., Darmstadt, G. L., & Martines, J. (2010, December). Why is continuum of care from home to health facilities essential to improve perinatal survival? *In Seminars in perinatology (Vol. 34, No. 6, pp. 477-485).* WB Saunders.

Baker, E. A., Metzler, M. M., & Galea, S. (2005). Addressing social determinants of health inequities: learning from doing. *American Journal of Public Health, 95(4),* 553-555.

Baker, J., Sanghvi, T., Hajeebhoy, N., Martin, L., & Lapping, K. (2013). Using an evidence-based approach to design large-scale programs to improve infant and young child feeding. *Food and Nutrition Bulletin, 34(3_suppl2),* S146-S155.

Bambra, C., Gibson, M., Amanda, S., Wright, K., Whitehead, M., & Petticrew, M. (2009). Tackling the wider social determinants of health and health inequalities: evidence from systematic reviews. *Journal of Epidemiology and Community Health,* jech-2008.

Barlow, J., Johnston, I., Kendrick, D., Polnay, L., & Stewart-Brown, S. (2006). Individual and group-based parenting programmes for the treatment of physical child abuse and neglect. *Cochrane Database System Review, 3.*

Bartlett, S., Hart, R., Satterthwaite, D., de la Barra, X., & Missair, A. (1999). *Cities for Children: Children's Rights, Poverty and Urban Management.* Routledge.

Baxter, P., & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. *The Qualitative Report, 13(4)*, 544-559.

Becher, J. C., Laing, I. A., Keeling, J. W., & McIntosh, N. (2004). Why are 4 million newborn babies dying every year? *The Lancet, 364,* 399-401.

Beisheim, M., & Liese, A. (Eds.). (2014). *Transnational partnerships: effectively providing for sustainable development?* Springer.

Bellagio Study Group on Child Survival. (2003). Knowledge into action for child survival. *The Lancet, 362(9380),* 323-327

Berkman, L. F., & Kawachi, I. (2000). A historical framework for social epidemiology. *Social Epidemiology*, 3-12.

Bhutta, Z. A., Ahmed, T., Black, R. E., Cousens, S., Dewey, K., Giugliani, E., & Shekar, M. (2008). What works? Interventions for maternal and child undernutrition and survival. *The Lancet, 371(9610),* 417-440.

Bhutta, Z. A., Chopra, M., Axelson, H., Berman, P., Boerma, T., Bryce, J., & de Francisco, A. (2010). Countdown to 2015 decade report (2000–10): taking stock of maternal, newborn, and child survival. *The Lancet, 375(9730),* 2032-2044.

Bhutta, Z. A., Lassi, Z. S., Pariyo, G., & Huicho, L. (2010a). Global experience of community health workers for delivery of health related millennium development goals: a systematic review, country case studies, and recommendations for integration into national health systems. *Global Health Workforce Alliance, 1(249)*, 61.

Bhutta, Z. A., Das, J. K., Rizvi, A., Gaffey, M. F., Walker, N., Horton, S., Webb, P., Lartey, A., & Black, R.E. Maternal and Child Nutrition Study Group. (2013). Evidence-based interventions for improvement of maternal and child nutrition: what can be done and at what cost? *The Lancet, 382(9890),* 452-477.

Binagwaho, A., Kyamanywa, P., Farmer, P. E., Nuthulaganti, T., Umubyeyi, B., Nyemazi, J. P., Mugeni, S.D., Asiimwe, A., Ndagijimana, U., Lamphere McPherson, H. & Ngirabega, J. D. D. (2013). The human resources for health program in Rwanda—a new partnership. *New England Journal of Medicine, 369(21),* 2054-2059.

Binagwaho, A., Scott, K. W., & Harward, S. H. (2016). Early childhood development in Rwanda: a policy analysis of the human rights legal framework. *BMC International Health and Human Rights, 16(1),* 1.

Binkin, N. J., Yip, R., Fleshood, L., & Trowbridge, F. L. (1988). Birth weight and childhood growth. *Pediatrics, 82(6),* 828-834.

Birn, A. E. (2009). *Textbook of International Health: Global Health in a Dynamic World.* Oxford University Press.

Black, R. E., Allen, L. H., Bhutta, Z. A., Caulfield, L. E., De Onis, M., Ezzati, M., & Maternal and Child Undernutrition Study Group. (2008). Maternal and child undernutrition: global and regional exposures and health consequences. *The Lancet, 371(9608),* 243-260

Black, R. E., Victora, C. G., Walker, S. P., Bhutta, Z. A., Christian, P., De Onis, M., & Uauy, R. (2013). Maternal and child undernutrition and overweight in low-income and middle-income countries. *The Lancet, 382(9890),* 427-451.

Bolman, L. G., & Deal, T. E. (2017). *Reframing organizations: Artistry, choice, and leadership.* John Wiley & Sons.

Bonati, M., & Fellin, G. (1991). Changes in smoking and drinking behaviour before and during pregnancy in Italian mothers: implications for public health intervention. *International Journal of Epidemiology, 20(4),* 927-932.

Borghi, J. O., Ensor, T., Somanathan, A., Lissner, C., Mills, A., & Lancet Maternal Survival Series steering group. (2006). Mobilising financial resources for maternal health. *The Lancet, 368(9545),* 1457-1465.

Boschi-Pinto, C., Velebit, L., & Shibuya, K. (2008). Estimating child mortality due to diarrhoea in developing countries. *Bulletin of the World Health Organization, 86(9),* 710-717.

Bowley, N. A., Pentz-Kluyts, M. A., Bourne, L. T., & Marino, L. V. (2007). Feeding the 1 to 7-year-old child. A support paper for the South African paediatric food-based dietary guidelines. *Maternal & Child Nutrition, 3(4)*, 281-291.

Brasington, A., Abdelmegeid, A., Dwivedi, V., Kols, A., Kim, Y. M., Khadka, N., Rawlins, B., & Gibson, A. (2016). Promoting healthy behaviors among Egyptian mothers: a quasi-experimental study of a health communication package delivered by community organizations. *PloS one, 11(3),* e0151783.

Brinda, E. M., Rajkumar, A. P., & Enemark, U. (2015). Association between gender inequality index and child mortality rates: a cross-national study of 138 countries. *BMC Public Health, 15(1),* 1-6.

Brown, H. L., Smith, M., & Beasley, Y. (2013). "The life course theory: Are public health programs the answer to racial disparities in prematurity and infant mortality?" *Contemporary OB/GYN, 58(9),* 48-52.

Bucagu, M. (2016). Improving Maternal Health in Rwanda: the role of Community-Based interventions. A Systematic Review. *Journal of Community Medical Health Education, 6.*

Building a Future for Women and Children: the 2012 report. (2012). Washington: Countdown to 2015. Retrieved from: http://www.countdown2015mnch.org/reports-and-articles/2012-report

Burgard, S. A. (n.d). Race and pregnancy-related care in Brazil and SA. *Social Science & Medicine, 59(6),* 1127-1146.

Burgard, S. A., & Treiman, D. J. (2006). Trends and racial differences in infant mortality in SA. *Social Science & Medicine, 62(5),* 1126-1137.

Centers for Disease Control and Prevention (1997). Alcohol consumption among pregnant and childbearing-aged women-United States, 1991 and 1995. MMWR. *Morbidity and Mortality Weekly Report, 46(16),* 346.

Centers for Disease Control and Prevention. (2005). Guidelines for identifying and referring persons with Fetal Alcohol Syndrome. *Morbidity and Mortality Weekly Report. 54(RR-11):* 1-14.

Centers for Disease Control and Prevention. (2017). *Fetal Alcohol Syndrome.* Retrieved from: https://www.cdc.gov/healthcommunication/toolstemplates/entertainmented/tips/fas.html

Chaaban, J., & Cunningham, W. (2011). Measuring the economic gain of investing in girls: the girl effect dividend. *World Bank Policy Research Working Paper Series.*

Charasse-Pouélé, C., & Fournier, M. (2006). Health disparities between racial groups in SA: a decomposition analysis. *Social Science & Medicine, 62(11),* 2897-2914.

Chen, M., & Chan, K. L. (2016). Effects of Parenting Programs on Child Maltreatment Prevention A Meta-Analysis. *Trauma, Violence, & Abuse, 17(1),* 88-104.

Christian, P., Lee, S. E., Angel, M. D., Adair, L. S., Arifeen, S. E., Ashorn, P., & Hu, G. (2013). Risk of childhood undernutrition related to small-for-gestational age and preterm birth in low-and middle-income countries. *International Journal of Epidemiology, 42(5),* 1340-1355.

Cloete, L. G., & Ramugondo, E. L. (2015). "I drink": Mothers' alcohol consumption as both individualised and imposed occupation. *South African Journal of Occupational Therapy, 45(1),* 34-40.

Commission on Social Determinants of Health (CSDH). (2008). *Closing the gap in a generation: health equity through action on the social determinants of health: final report of the commission on social determinants of health.*

Condo, J., Mugeni, C., Naughton, B., Hall, K., Tuazon, M. A., Omwega, A., Nwaigwe, F., Drobac, P., Hyder, Z., Ngabo, F., & Binagwaho, A. (2014). Rwanda's evolving community health worker system: a qualitative assessment of client and provider perspectives. *Human resources for Health, 12(1),* 71.

Cooper, C. M., Charurat, E., El-Adawi, I., Young-Mi, K., Emerson, M. R., Zaki, W., & Schuster, A. (2016). Postpartum Family Planning During Sociopolitical Transition: Findings from an Integrated Community-Based Program in Egypt. International Perspectives on Sexual & Reproductive Health, 42(2), 57-69.

Coovadia, H., Jewkes, R., Barron, P., Sanders, D., & McIntyre, D. (2009). The health and health system of SA: historical roots of current public health challenges. *The Lancet, 374(9692),* 817-834.

Corsaro, N., & Engel, R. (2015). Most Challenging of Contexts: Assessing the Impact of Focused Deterrence on Serious Violence in New Orleans Corsaro and Engel Focused Deterrence in New Orleans. *Criminology and Public Policy, 14(3),* 471-505.

Credé, S., Sinanovic, E., Adnams, C., & London, L. (2011). The utilization of health care services by children with Foetal Alcohol Syndrome in the Western Cape, South Africa. *Drug and Alcohol Dependence, 115,* 175-182.

Creswell, J. W., & Poth, C. N. (2017*). Qualitative inquiry and research design: Choosing among five approaches.* Sage publications.

Croxford, J., & Viljoen, D. (1999). Alcohol consumption by pregnant women in the Western Cape. *South African Medical Journal, 89*(9), 962-965.

Cummins, C., & McMaster, C. (2006). *Child Mental and Emotional Health: A Review of Evidence.* Sligo: Health Service Executive.

Cusick, S. E., & Georgieff, M. K. (2016). Medical Progress: The Role of Nutrition in Brain Development: The Golden Opportunity of the "First 1000 Days". *The Journal of Pediatrics, 175,* 16-21.

De, S., & Sarker, D. (2011). Women's Empowerment through Self-help Groups and its Impact on Health Issues: Empirical Evidence. *Journal of Global Analysis, 2(1),* 49-73.

Demographic, E. (2012). *Health Survey 2011 Central Statistical Agency Addis Ababa.* Ethiopia ICF International Calverton, Maryland, USA.

Denzin, N. K., & Lincoln, Y. S. (2000). The discipline and practice of qualitative research. *Handbook of Qualitative Research, 2*, 1-28.

Department of Health. (2004). *The 2003 South African Demographic and Health Survey.* Pretoria: Department of Health.

De Swardt, C., Puoane, T., Chopra, M., & Du Toit, A. (2005). Urban poverty in Cape Town. *Environment and Urbanization, 17(2),* 101-111.

de Villiers, A., Steyn, N. P., Draper, C. E., Hill, J., Dalais, L., Fourie, J., & Lambert, E. V. (2015). Implementation of the HealthKick intervention in primary schools in low-income settings in the Western Cape Province, South Africa: a process evaluation. *BMC Public Health,* 15818.

Dewey, K. G., & Huffman, S. L. (2009). Maternal, infant, and young child nutrition: combining efforts to maximize impacts on child growth and micronutrient status. *Food and Nutrition Bulletin, 30(2 suppl2),* S187-S189.

Du Plessis, L. M., Kruger, H. S., & Sweet, L. (2013). Complementary feeding: a critical window of opportunity from six months onwards. *South African Journal of Clinical Nutrition, 26(3),* S129-S140.

Duggan, C., Watkins, J. B., & Walker, W. A. (2008). *Nutrition in Pediatrics: Basic Science, Clinical Applications.* PMPH-USA.

Durch, J. S., Bailey, L. A., & Stoto, M. A. (1997). *Improving Health in the Community: A Role for Performance Monitoring: Summary.*

Durlak, J. A., & DuPre, E. P. (2008). Implementation matters: A review of research on the influence of implementation on program outcomes and the factors affecting implementation. *American Journal of Community Psychology, 41(3-4),* 327-350.

Du Toit, A. (2004). 'Social exclusion' discourse and chronic poverty: a South African case study. *Development and Change, 35(5),* 987-1010.

Easterby-Smith, M., Thorpe, R., & Lowe, A. (1991). *Management Research: An Introduction.* Sage Publication, London.

Eaton, L., Pitpitan, E., Kalichman, S., Sikkema, K., Skinner, D., Watt, M., & Cain, D. (n.d). Beliefs about fetal alcohol spectrum disorder among men and women at alcohol serving establishments in South Africa. *American Journal of Drug And Alcohol Abuse, 40(2),* 87-94.

Edwards, M., & Hulme, D. (1996). Too close for comfort? The impact of official aid on nongovernmental organizations. *World Development, 24 (6),* 961–973.

El-Zanaty, F., & Way, A. (2008). *Egypt Demographic and Health Survey*. Cairo, Egypt: Ministry of Health, El-Zanaty and Associates, and Macro International; 2009.

Ensor, T., & Ronoh, J. (2005). Effective financing of maternal health services: a review of the literature. *Health Policy, 75(1)*, 49-58.

Erlandson, D.A., Harris, E.L., Skipper, B.L., & Allen, S.D. (1993). *Doing naturalistic inquiry: A guide to methods.* Newbury Park, CA: Sage.

Eyles, J., Harris, B., Munyewende, P., Fried, J., & Govender, V. (2015). Endurance, resistance and resilience in the South African health care system: Case studies to demonstrate mechanisms of coping within a constrained system. *BMC Health Services Research.*

Faber, M. (2005). Complementary foods consumed by 6–12-month-old rural infants in South Africa are inadequate in micronutrients. *Public Health Nutrition, 8(04),* 373-381.

Falletisch, L. A. (2008). *Understanding the Legacy of Dependency and Powerlessness Experienced by Farm Workers on Wine Farms in the Western Cape* (Doctoral dissertation, Stellenbosch: University of Stellenbosch).

Fenton, P. M. (2008). Countdown to 2015 for maternal newborn and child survival [letter]. *The Lancet, 372(9636),* 369.

Ferreira, M., Charlton, K., & Mosaval, Y. (1998). *Retired Farm Workers, Farm Evictions and Dop System: An Exploratory Study in Three Towns in the Western Cape Province.* University of Cape Town. HSRC/UCT Centre for Gerontology.

Filippi, V., Ronsmans, C., Campbell, O. M., Graham, W. J., Mills, A., Borghi, J., & Osrin, D. (2006). Maternal health in poor countries: the broader context and a call for action. *The Lancet, 368(9546),* 1535-1541.

Frankfort-Nachmias, C. & Nachmias, D. (2008). *Research Methods in the Social Sciences.* New York, NY: Worth Publishers.

Fraser, A., Kamal-Yanni, M., & Watkins, K. (2004). *The Cost of Childbirth: How Women are Paying the Price for Broken Promises on Aid.*

Fraser, M. (2013). Bringing it All Together: Effective Maternal and Child Health Practice as a Means to Improve Public Health. *Maternal & Child Health Journal, 17(5),* 767-775.

Frohna, J. G., Lantz, P. M., & Pollack, H. (1999). Maternal substance abuse and infant health: Policy options across the life course. *Milbank Quarterly, 77(4),* 531-570.

Furlong, M., & McGilloway, S. (2011). The Incredible Years Parenting program in Ireland: A qualitative analysis of the experience of disadvantaged parents. *Clinical Child Psychology and Psychiatry.* 1359104511426406.

Furlong, M., McGilloway, S., Bywater, T., Hutchings, J., Smith, S. M., & Donnelly, M. (2013). Cochrane Review: Behavioural and cognitive-behavioural group-based parenting programmes for early-onset conduct problems in children aged 3 to 12 years (Review). *Evidence‐Based Child Health: A Cochrane Review Journal, 8(2),* 318-692.

Gakidou, E., Cowling, K., Lozano, R., & Murray, C. J. (2010). Increased educational attainment and its effect on child mortality in 175 countries between 1970 and 2009: a systematic analysis. *The Lancet, 376(9745),* 959-974.

Gardner, F., Burton, J., & Klimes, I. (2006). Randomised controlled trial of a parenting intervention in the voluntary sector for reducing child conduct problems: outcomes and mechanisms of change. *Journal of Child Psychology and Psychiatry, 47(11),* 1123-1132.

Gardner, F., Hutchings, J., Bywater, T., & Whitaker, C. (2010). Who benefits and how does it work? Moderators and mediators of outcome in an effectiveness trial of a parenting intervention. *Journal of Clinical Child & Adolescent Psychology, 39(4),* 568-580.

Gehlert, S., Sohmer, D., Sacks, T., Mininger, C., McClintock, M., & Olopade, O. (2008). Targeting health disparities: A model linking upstream determinants to downstream interventions. *Health Affairs, 27(2),* 339-349.

Ghanem, H. (2014). Improving Regional and Rural Development for Inclusive Growth in Egypt. *Brookings Global Working Paper Series.*

Gilmore, B., & McAuliffe, E. (2013). Effectiveness of community health workers delivering preventive interventions for maternal and child health in low-and middle-income countries: a systematic review. *BMC Public Health, 13(1),* 847.

Gopalan, C. (1961). Maternal and infant nutrition in underdeveloped countries. *Journal of the American Dietetic Association, 39(2),* 129-31.

Gossage, J. P., Snell, C. L., Parry, C. D., Marais, A. S., Barnard, R., De Vries, M., & May, P. A. (2014). Alcohol use, working conditions, job benefits, and the legacy of the "Dop" system among farm workers in the Western Cape Province, SA: Hope despite high levels of risky drinking. *International Journal of Environmental Research and Public Health, 11(7),* 7406-7424.

Graham, W. J., Cairns, J., Bhattacharya, S., Bullough, C. H., Quayyum, Z., & Rogo, K. (2006). *Maternal and Perinatal Conditions.*

Grantham-McGregor, S., Cheung, Y. B., Cueto, S., Glewwe, P., Richter, L., Strupp, B., & International Child Development Steering Group. (2007). Developmental potential in the first 5 years for children in developing countries. *The Lancet, 369(9555),* 60-70.

Greene, J., & Gangemi, J. (2006). Taking Tiny Loans to the Next Level. Businessweek, (4011), 76.

Groenewald, P., Bradshaw, D., Neethling, I., Martin, L. J., Dempers, J., Morden, E., & Coetzee, D. (2016). Linking mortuary data improves vital statistics on cause of death of children under five years in the Western Cape Province of South Africa. *Tropical Medicine & International Health, 21(1),* 114-121.

Gwatkin, D. R., & Ergo, A. (2011). Universal health coverage: friend or foe of health equity? *The Lancet, 377(9784),* 2160-2161.

Hahn, J. A., Woolf-King, S. E., & Muyindike, W. (2011). Adding fuel to the fire: alcohol's effect on the HIV epidemic in Sub-Saharan Africa. *Current HIV/AIDS Reports, 8(3),* 172-180.

Halfon, N., Larson, K., & Russ, S. (2009). Why social determinants? *Healthcare Quarterly (Toronto, Ont.), 14,* 8-20.

Halle, T., Metz, A., & Martinez-Beck, I. (Eds.). (2013). *Applying Implementation Science in Early Childhood Programs and Systems.* Paul H. Brookes Publishing Company.

Hansen, T. T., Herselman, M., du Plessis, L., Daniels, L., Bezuidenhout, T., van Niekerk, C., & Iversen, P. O. (2015). Evaluation of selected aspects of the Nutrition Therapeutic Programme offered to HIV-positive women of child-bearing age in Western Cape Province, South Africa. *Southern African Journal of HIV Medicine, 16(1)*, 1.

Health Council of Canada. (2010). *Stepping it Up: Moving the Focus from Health Care in Canada to a Healthier Canada.* Health Council of Canada, Toronto.

Henriques, S. (2015). *South Africa improves exclusive breastfeeding monitoring using nuclear technique.* IAEA Bulletin, 11.

Herman, D. R., Baer, M. T., Adams, E., Cunningham-Sabo, L., Duran, N., Johnson, D. B., & Yakes, E. (2014). Life course perspective: Evidence for the role of nutrition. *Maternal and Child Health Journal, 18(2),* 450-461.

Hietalahti, J., & Linden, M. (2006). Socio-economic impacts of microfinance and repayment performance: A case study of the Small Enterprise Foundation, South Africa. *Progress in Development Studies, 6(3),* 201-210.

Hickey, G., McGilloway, S., Furlong, M., Leckey, Y., Bywater, T., & Donnelly, M. (2016). Understanding the implementation and effectiveness of a group-based early parenting intervention: a process evaluation protocol. *BMC Health Services Research, 16*:1-14.

Hogan, V., Rowley, D., Bennett, T., & Taylor, K. (2012). Life Course, Social Determinants, and Health Inequities: Toward a National Plan for Achieving Health Equity for African American Infants-a Concept Paper. *Maternal & Child Health Journal, 16(6),* 1143-1150.

Holtman, Z., Shelmerdine, S., London, L., & Flisher, A. (2011). Suicide in a poor rural community in the Western Cape, SA: Experiences of five suicide attempters and their families. *South African Journal of Psychology, 41(3),* 300-309.

Hossain, F. (2002). Small Loans, Big Claims. *Foreign Policy, (132),* 79.

Hoyme, H. E., May, P. A., Kalberg, W. O., Kodituwakku, P., Gossage, J. P., Trujillo, P. M., & Viljoen, D. L. (2005). A practical clinical approach to diagnosis of fetal alcohol spectrum disorders: clarification of the 1996 institute of medicine criteria. *Pediatrics, 115(1),* 39-47.

Hsu, J., Pitt, C., Greco, G., Berman, P., & Mills, A. (2012). Countdown to 2015: changes in official development assistance to maternal, newborn, and child health in 2009–10, and assessment of progress since 2003. *The Lancet, 380(9848),* 1157-1168.

Huchzermeyer, M. and A. Karam. (2006). The continuing challenge of informal settlements: an introduction. In M. Huchzermeyer and A. Karam (eds.), *Informal Settlements: a Perpetual Challenge,* UCT Press, Cape Town.

Ighogboja, S. I. (1992). Some factors contributing to protein-energy malnutrition in the middle belt of Nigeria. *East African Medical Journal, 69(10),* 566-571.

Implementation Policy Guidelines for Nutrition Therapeutic Programme. (2011). *Guidelines for Care at District and Community Level including Clinics, CHC, District Hospitals and Community Facilities in the Western Cape.* Pretoria: Department of Health.

Institute for Health Metrics and Evaluation. (2016). *Global Burden of Disease (GBD).* Retrieved from http://www.healthdata.org/gbd

Institute for Health Metrics and Evaluation. (2016a). *South Africa.* Retrieved from http://www.healthdata.org/south-africa

Irwin, L.G., Siddiqi, A., & Hertzman, C.(2007). *Early Child Development: A Powerful Equalizer (Final report to the WHO Commission on Social Determinants of Health).* Geneva: WHO Commission on Social Determinants of Health.

Iversen, P., du Plessis, L., Marais, D., Morseth, M., Høisæther, E., & Herselman, M. (2011). Nutritional health of young children in SA over the first 16 years of democracy. *South African Journal of Child Health, 5(3)*, 72.

Iverson, V., Kalwij, A., Verschoor, A., & Dubey, A. (2014). Caste Dominance and Economic Performance in Rural India. *Economic Development & Cultural Change, 62(3),* 421.

Iversen, P., Hoisaether, E., Morseth, M., & Herselman, M. (n.d). Diverging opinions of supplementation programmes between mothers of small children and staff at primary health clinics in the Western Cape Province of South Africa. *Public Health Nutrition, 14(5),* 923-930.

Jester, J. M., Jacobson, S. W., Sokol, R. J., Tuttle, B. S., & Jacobson, J. L. (2000). The influence of maternal drinking and drug use on the quality of the home environment of school-aged children. *Alcoholism: Clinical and Experimental Research, 24(8),* 1187-1197.

Jewkes, R. K., Levin, J. B., & Penn-Kekana, L. A. (2003). Gender inequalities, intimate partner violence and HIV preventive practices: findings of a South African cross-sectional study. Social science & medicine, 56(1), 125-134.

Jewkes, R., Morrell, R., & Christofides, N. (2009). Empowering teenagers to prevent pregnancy: lessons from South Africa. *Culture, Health & Sexuality, 11(7),* 675-688.

Jowett, M. (2000). Safe motherhood interventions in low-income countries: an economic justification and evidence of cost effectiveness. *Health Policy, 53(3),* 201-228.Karlberg, J. (1989). A Biologically-Oriented Mathematical Model (ICP) for Human Growth. *Acta Paediatrica, 78(s350),* 70-94.

Kim, S. S., Rawat, R., Mwangi, E. M., Tesfaye, R., Abebe, Y., Baker, J., Frongillo, E., Ruel, M., & Menon, P. (2016). Exposure to Large-Scale Social and Behavior Change Communication Interventions Is Associated with Improvements in Infant and Young Child Feeding Practices in Ethiopia. *Plos ONE, 11(10),* 1-18.

Klasen, S., & Woolard, I. (2009). Surviving unemployment without state support: unemployment and household formation in South Africa. *Journal of African Economies, 18(1),* 1-51.

Knippenberg, R., Lawn, J. E., Darmstadt, G. L., Begkoyian, G., Fogstad, H., Walelign, N., & Lancet Neonatal Survival Steering Team. (2005). Systematic scaling up of neonatal care in countries. *The Lancet, 365(9464)*, 1087-1098

Koh, H. K., Oppenheimer, S. C., Massin-Short, S. B., Emmons, K. M., Geller, A. C., & Viswanath, K. (2010). Translating research evidence into practice to reduce health disparities: a social determinants approach. *American Journal of Public Health, 100(S1),* S72-S80.

Kondo, N. (2012). Socioeconomic disparities and health: impacts and pathways. *Journal of Epidemiology, 22(1),* 2-6.

Krieger, N. (2001). Theories for social epidemiology in the 21st century: an ecosocial perspective. *International Journal of Epidemiology, 30(4),* 668-677.

Krieger, N. (2005). Defining and investigating social disparities in cancer: critical issues. *Cancer Causes & Control, 16(1),* 5-14.

Kreuter, M. W., & Skinner, C. S. (2000). *Tailoring: What's in a Name?*

Kulig, J. W. (2005). Tobacco, alcohol, and other drugs: the role of the pediatrician in prevention, identification, and management of substance abuse. *Pediatrics, 115(3),* 816-821.

Kumar, D., Goel, N. K., Mittal, P. C., & Misra, P. (2006). Influence of infant-feeding practices on nutritional status of under-five children. *Indian Journal of Pediatrics, 73(5)*, 417-421.

Kunst, A. E., & Houweling, T. (2001). Inequalities in the utilisation of delivery care and other maternal health services. *Studies Health Services Organ Policy, 17,* 297-315.

Kuruvilla, S., Bustreo, F., Taona, K., Mishra, C. K., Taylor, K., Fogstad, H., & ... Khosla, R. (2016). The Global strategy for women's, children's and adolescents' health (2016-2030): a roadmap based on evidence and country experience. *Bulletin of The World Health Organization, 94(5),* 398-400.

Kurian, N. (n.d). Widening economic & social disparities: Implications for India. *Indian Journal of Medical Research, 126(4),* 374-380.

Lachman, J. M., Sherr, L. T., Cluver, L., Ward, C. L., Hutchings, J., & Gardner, F. (2016). Integrating evidence and context to develop a parenting program for low-income families in South Africa. *Journal of Child and Family Studies*, 1-16.

Lassi, Z. S., Majeed, A., Rashid, S., Yakoob, M. Y., & Bhutta, Z. A. (2013). The interconnections between maternal and newborn health–evidence and implications for policy. *The Journal of Maternal-Fetal & Neonatal Medicine, 26(sup1),* 3-53.

Leibbrandt, M., Levinsohn, J. A., & McCrary, J. (2010a). Incomes in South Africa after the fall of apartheid. *Journal of Globalization and Development, 1(1).*

Leibbrandt, M., Woolard, I., Finn, A., & Argent, J. (2010b). *Trends in South African income distribution and poverty since the fall of apartheid.*

Leroy, J., Ruel, M., Habicht, J., & Frongillo, E. (n.d). Linear Growth Deficit Continues to Accumulate beyond the First 1000 Days in Low- and Middle-Income Countries: Global Evidence from 51 National Surveys. *Journal of Nutrition, 144(9),* 1460-1466.

Lesch, E., & Adams, A. R. (2016). Couples living with and around alcohol abuse: A study of a farmworker community in the Cape Winelands, SA. *Social Science & Medicine, 156,* 167-174.

Li, H., Stein, A. D., Barnhart, H. X., Ramakrishnan, U., & Martorell, R. (2003). Associations between prenatal and postnatal growth and adult body size and composition. The *American Journal of Clinical Nutrition, 77(6),* 1498-1505.

Lim, S. S., Vos, T., Flaxman, A. D., Danaei, G., Shibuya, K., Adair-Rohani, H., & Aryee, M. (2013). A comparative risk assessment of burden of disease and injury attributable to 67 risk factors and risk factor clusters in 21 regions, 1990–2010: a systematic analysis for the Global Burden of Disease Study 2010. *The Lancet, 380(9859),* 2224-2260.

Lincoln, Y.S. & Guba, E.G. (1985). *Naturalistic inquiry.* Beverly Hills, CA: Sage.

Liu, L., Oza, S., Hogan, D., Perin, J., Rudan, I., Lawn, J. E., & Black, R. E. (2015). Global, regional, and national causes of child mortality in 2000–13, with projections to inform post-2015 priorities: an updated systematic analysis. *The Lancet, 385(9966),* 430-440.

London, L., Sanders, D., & te Water Naude, J. (1998). Farm workers in SA — the challenge of eradicating alcohol abuse and the legacy of the 'dop' system. *South African Medical Journal, 88,* 1092-1095.

London, L. (1999). The dop system, alcohol abuse and social control amongst farm workers in SA: a public health challenge. *Social Science & Medicine, 48(10),* 1407-1414.

London, L. (2000). Alcohol consumption amongst South African farm workers: a challenge for post-apartheid health sector transformation. *Drug and Alcohol Dependence, 59(2),* 199-206.

Lozano, R., Wang, H., Foreman, K. J., Rajaratnam, J. K., Naghavi, M., Marcus, J. R., & Lopez, A. D. (2011). Progress towards Millennium Development Goals 4 and 5 on maternal and child mortality: an updated systematic analysis. *The Lancet, 378(9797),* 1139-1165.

Lutter, C. K., Iannotti, L., Creed-Kanashiro, H., Guyon, A., Daelmans, B., Robert, R., & Haider, R. (2013). Key principles to improve programmes and interventions in complementary feeding. *Maternal & Child Nutrition, 9101.*

Maleta, K., Virtanen, S. M., Espo, M., Kulmala, T., & Ashorn, P. (2003). Childhood malnutrition and its predictors in rural Malawi. *Paediatric and Perinatal Epidemiology, 17(4),* 384-390.

Malqvist, M., Dinh Thi Phuong, H., & Thomsen, S. (2012). Causes and determinants of inequity in maternal and child health in Vietnam. *BMC Public Health, 12(1),* 641-650.

Mamabolo, R. L., Alberts, M., Mbenyane, G. X., Steyn, N. P., Nthangeni, N. G., Delemarre-van De Waal, H. A., & Levitt, N. S. (2004). Feeding practices and growth of infants from birth to 12 months in the central region of the Limpopo Province of South Africa. *Nutrition, 20(3),* 327-333.

Marmot, M., & Commission on Social Determinants of Health. (2007). Achieving health equity: from root causes to fair outcomes. *The Lancet, 370(9593),* 1153-1163.

Marmot, M., Friel, S., Bell, R., Houweling, T. A., Taylor, S., & Commission on Social Determinants of Health. (2008). Closing the gap in a generation: health equity through action on the social determinants of health. *The Lancet, 372(9650),* 1661-1669.

Marmot, M. G., Allen, J., Goldblatt, P., Boyce, T., McNeish, D., Grady, M., & Geddes, I. (2010). *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post-2010.*

Masten, A. S., Powell, J. L., & Luthar, S. S. (2003). A resilience framework for research, policy, and practice. *Resilience and Vulnerability: Adaptation in the Context of Childhood Adversities,* 1-25.

May, J., Govender, J., Budlender, D., Mokate, R., Rogerson, C., & Stavrou, A. (1998). *Poverty and Inequality in SA: Report prepared for the Office of the Executive Deputy President and the Inter-ministerial Committee for Poverty and Inequality.* Final Report, May, 13.

May, J. (1999). *The Structure and Composition of Rural Poverty and Livelihoods in SA', paper presented at the Conference on 'Land and Agrarian Reform in SA: Successes, Problems, and the Way Forward',* 26–28 July, Pretoria, Department of Land Affairs.

May, J. (ed.), (2000). *Poverty and Inequality in SA: Meeting the Challenge*. David Philip, Cape Town.

May, P. A., Brooke, L., Gossage, J. P., Croxford, J., Adnams, C., Jones, K. L., Robinson, L., & Viljoen, D. (2000). Epidemiology of fetal alcohol syndrome in a South African community in the Western Cape Province. *American Journal of Public Health, 90(12),* 1905.

May, P. A., Gossage, J. P., Marais, A. S., Adnams, C. M., Hoyme, H. E., Jones, K. L., & Hendricks, L. (2007). The epidemiology of fetal alcohol syndrome and partial FAS in a SAn community. *Drug and Alcohol Dependence, 88(2),* 259-271.

May, P. A., Blankenship, J., Marais, A. S., Gossage, J. P., Kalberg, W. O., Barnard, R., & Manning, M. (2013). Approaching the prevalence of the Full Spectrum of Fetal Alcohol Spectrum Disorders in a South African population-based study. *Alcoholism: Clinical and Experimental Research, 37(5),* 818-830.

May, J., & Timæus, I. M. (2014). Inequities in under-five child nutritional status in South Africa: What progress has been made? *Development Southern Africa, 31(6),* 761-774.

McCusker, B. (2002), 'The Impact of Membership in Communal Property Associations on Livelihoods in the Northern Province, South Africa', *Geo Journal, Vol. 56, No. 2,* pp. 113–22.

McDougall, L. (2016). Discourse, ideas and power in global health policy networks: political attention for maternal and child health in the millennium development goal era. *Globalization & Health, 121.*

McKinstry, J. (2005). Using the past to step forward: Fetal Alcohol Syndrome in the Western Cape Province of South Africa. *American Journal of Public Health, 95,* 1097–1099.

Meinck, F., Cluver, L. D., Boyes, M. E., & Loening-Voysey, H. (2016). Physical, emotional, and sexual abuse of children in South Africa: Incidence, prevalence, perpetrators, and locations. *Journal of Epidemiology and Community Health* (Manuscript accepted for publication).

Merriam, S. (1988). *Case Study Research in Education: A Qualitative Approach.* San Francisco: Jossey-Bass.

Meyer-Leu, Y., Lemola, S., Daeppen, J. B., Deriaz, O., & Gerber, S. (2011). Association of moderate alcohol use and binge drinking during pregnancy with neonatal health. *Alcoholism: Clinical and Experimental Research, 35(9),* 1669-1677.

Mikkonen, J., & Raphael, D. (2010). *Social Determinants of Health: The Canadian Facts.* York University, School of Health Policy and Management.

Ministry of Health and Population Egypt, Partnership for Maternal, Newborn & Child Health, WHO, World Bank and Alliance for Health Policy and Systems Research. (2014). *Success Factors for Women's and Children's Health: Egypt.* Geneva: World Health Organization.

Ministry of Health Rwanda, PMNCH, WHO, World Bank, AHPSR and participants in the Rwanda multi-stakeholder policy review. (2014). *Success Factors for Women's and Children's Health: Rwanda.*

Møller V. (2007) Satisfied and dissatisfied South Africans: Results from the General Household Survey in international comparison. *Social Indicators Research 81:* 389–415.

Moore, S., Hall, J. N., Harper, S., & Lynch, J. W. (2010). Global and national socioeconomic disparities in obesity, overweight, and underweight status. *Journal of Obesity,* 2010.

Moreira, I., Severo, M., Oliveira, A., Durão, C., Moreira, P., Barros, H., & Lopes, C. (2016). Social and health behavioural determinants of maternal child-feeding patterns in preschool-aged children. *Maternal and Child Nutrition, 12(2),* 314-325.

Msemburi, W., Pillay-van Wyk, V., Dorrington, R., Neethling, I., Nannan, N., & Groenewald, P. (2014). *Second National Burden of Disease Study for South Africa: Cause-of-Death Profile for South Africa, 1997–2010.* Cape Town: South African Medical Research Council.

Murthy, P., Kudlur, S., George, S. & Mathew, G. (2009). A clinical overview of Fetal Alcohol Syndrome. Addictive *Disorders and their Treatment, 8,* 1-12.

Mushaphi, L. F., Mbhenyane, X. G., Khoza, L. B., & Amey, A. K. A. (2008). Infant-feeding practices of mothers and the nutritional status of infants in the Vhembe District of Limpopo Province. *South African Journal of Clinical Nutrition, 21(2),* 36-41.

National Development Plan of South Africa. Executive Summary. (2012). Retrieved from http://www.gov.za/sites/www.gov.za/files/Executive%20Summary-NDP%202030%20-%20Our%20future%20-%20make%20it%20work.pdf

NIMS., ICMR., & UNICEF. (2012). *Infant and child mortality in India: Levels, trends and determinants.* National Institute for Medical Statistics (NIMS), Indian Council of Medical Research (ICMR), and UNICEF, India Country Office, New Delhi.

Nombulelo, S. (1998). Rural African Family Structure in the Eastern Cape Province, South Africa. *Journal of Comparative Family Studies, (2),* 407.

Noor, K. B. M. (2008). Case study: A strategic research methodology. *American Journal of Applied Sciences, 5(11),* 1602-1604.

Olivier, L., Curfs, L. M. G., & Viljoen, D. L. (2016). Fetal alcohol spectrum disorders: Prevalence rates in South Africa. *South African Medical Journal, 106(6)*, S103.

Osmani, S., & Sen, A. (2003). The hidden penalties of gender inequality: fetal origins of ill-health. *Economics & Human Biology, 1(1),* 105-121.

Özler, B. (2007). Not separate, not equal: poverty and inequality in post-apartheid SA. *Economic Development and Cultural Change, 55(3),* 487-529.

Pahwa, S., Kumar, G. T., & Toteja, G. S. (2010). Performance of a community-based health and nutrition-education intervention in the management of diarrhoea in a slum of Delhi, India. *Journal of Health, Population, and Nutrition, 28(6),* 553.

Parry, C. D., Gossage, J. P., Marais, A. S., Barnard, R., de Vries, M., Blankenship, J., Seeday, S. & May, P. A. (2012). Comparison of baseline drinking practices, knowledge, and attitudes of adult s residing in communities taking part in the FAS prevention study in South Africa. *African Journal of Drug and Alcohol Studies, 11(2).*

Pauw, K., & Du Plessis, L. (2005). *A Profile of the Western Cape: Demographics, Poverty, Inequality and Unemployment.*

Perez-Rodrigo, C., & Aranceta, J. (2001). School-based nutrition education: lessons learned and new perspectives. *Public Health Nutrition, 4(1a),* 131-139.

Pollitt, E., Watkins, W. E., & Husaini, M. A. (1997). Three-month nutritional supplementation in Indonesian infants and toddlers benefits memory function 8 years later. *The American Journal of Clinical Nutrition, 66(6),* 1357-1363.

Primatesta, P., Del Corno, G., Bonazzi, M. C., & Waters, W. E. (1993). Alcohol and pregnancy: an international comparison. *Journal of Public Health, 15(1),* 69-76.

Rajaratnam, J. K., Tran, L. N., Lopez, A. D., & Murray, C. J. (2010). Measuring under-five mortality: validation of new low-cost methods. *PLoS Med, 7(4),* e1000253.

Raman, S., Srinivasan, K., Kurpad, A., Razee, H., & Ritchie, J. (2014). Nothing Special, Everything Is Maamuli: Socio-Cultural and Family Practices Influencing the Perinatal Period in Urban India. *Plos ONE, 9(11),* 1-8.

Reddy, S. P., Panday, S., Swart, D., Jinabhai, C. C., Amosun, S. L., James, S., Monyeki, K. D., Stevens, G., Morojele, N., Kambaran, N. S., Omardien, R. G., & Van den Borne, H. W. (2003). *Umthenthe Uhlaba Usamila: The South African Youth Risk Behaviour Survey 2002.* Cape Town: South African Medical Research Council.

Reddy, S.P., James, S., Sewpaul, R., Koopman, F., Funani, N.I., Sifunda, S., Josie, J., Masuka, P., Kambaran, N.S., Omardien, R.G. (2010). *Umthente Uhlaba Usamila – The South African Youth Risk Behaviour Survey 2008.* Cape Town: South African Medical Research Council.

Rikimaru, T., Yartey, J. E., Taniguchi, K., Kennedy, D. O., & Nkrumah, F. K. (1998). Risk factors for the prevalence of malnutrition among urban children in Ghana. *Journal of Nutritional Science and Vitaminology, 44(3),* 391-407.

Rimer, B. K., & Glanz, K. (2005). *Theory at a Glance: A Guide for Health Promotion Practice.* US Dept. of Health and Human Services, Public Health Service, National Institutes of Health, National Cancer Institute.

Roozen, S., Kok, G., Townend, D., Nijhuis, J., Curfs, L., & Peters, G. (2016). Worldwide Prevalence of Fetal Alcohol Spectrum Disorders: A Systematic Literature Review Including Meta-Analysis. Alcoholism: *Clinical and Experimental Research, 40(1),* 18-32.

Rossi, P. H., & Freeman, H.E. (1993). *Evaluation: A Systematic Approach.* London: Sage.

Rossi, P. H., Lipsey, M. W., & Freeman, H. E. (2003). *Evaluation: A Systematic Approach.* Sage Publications.

Rothman J. (2001). *Approaches to Community Intervention*: *Strategies of Community Intervention.* Peacock Publishers.

Ruel, M. T., & Habicht, A.P. (1995). Age differences in the impact of nutritional supplementation on growth. *The Journal of Nutrition. 125(Suppl 4):*1051S–59S.

Ruel, M. T., Levin, C. E., Armar-Klemesu, M., Maxwell, D., & Morris, S. S. (1999). Good care practices can mitigate the negative effects of poverty and low maternal schooling on children's nutritional status: evidence from Accra. *World Development, 27(11),* 1993-2009.

Rule, P., & John, V. (2011). *Your Guide to Case Study Research.* Pretoria: Van Schaik.

Save the Children. (2012). *Nutrition in the first 1,000 days: State of the World's Mothers 2012.*

Schell, C. O., Reilly, M., Rosling, H., Peterson, S., & Ekström, A. M. (2007). Socioeconomic determinants of infant mortality: a worldwide study of 152 low-, middle-, and high-income countries. *Scandinavian Journal of Public Health, 35(3),* 288-297.

Schroeder, S. A. (2007). We can do better—improving the health of the American people. *New England Journal of Medicine, 357(12),* 1221-1228.

Seethal, C. (2002). Regenerating Rural Economies: The Case of Limehill, South Africa. *Geo Journal, Vol. 57, No. 1–2,* pp. 65–77.

September, S., Rich, E., & Roman, N. (2016). The role of parenting styles and socio-economic status in parents' knowledge of child development. *Early Child Development and Care, 186(7),* 1060-1078.

Serumaga-zake, P., Kotze, D., & Madsen, R. (2005). A descriptive study of the dynamics of relative poverty in the Western Cape province of South Africa. *Development Southern Africa, 22(1),* 143-160.

Sethuraman, K., Lansdown, R., & Sullivan, K. (2006). Women's empowerment and domestic violence: the role of sociocultural determinants in maternal and child undernutrition in tribal and rural communities in South India. *Food and Nutrition Bulletin, 27(2),* 128-143.

Shah, P. S., & Shah, J. (2010). Maternal exposure to domestic violence and pregnancy and birth outcomes: a systematic review and meta-analyses. *Journal of Women's Health, 19(11),* 2017-2031.

Shin, W., Kim, Y., & Sohn, H. (2017*). Do Different Implementing Partnerships Lead to Different Project Outcomes?* Evidence from the World Bank Project-Level Evaluation Data. World Development, 95268-284.

Shrimpton, R. (2012). Global Policy and Programme Guidance on Maternal Nutrition: What Exists, the Mechanisms for Providing It, and How to Improve Them? *Pediatric & Perinatal Epidemiology, 26,* 315-325.

Sibeko, L., Dhansay, M. A., Charlton, K. E., Johns, T., & Gray-Donald, K. (2005). Beliefs, attitudes, and practices of breastfeeding mothers from a periurban community in South Africa. *Journal of Human Lactation, 21(1)*, 31-38.

Shi, L., & Singh, D. (2015). *Essentials of the U.S. Health Care System.* Burlington, MA: Jones and Bartlett Publishers.

Singh, M. (2001). *The Art and Science of Baby and Child Care.*

Smith, M.F. (1989). *Evaluability Assessment: A Practical Approach.* Norwell, MA: Kluwer Academic Publishers.

Smith, J. A., & Osborn, M. (2003). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative Psychology. A Practical Guide to Research Methods* (pp.51-80). London, UK: Sage.

Solar, O., & Irwin, A. (2007). *A Conceptual Framework for Action on the Social Determinants of Health.*

South African Government Website. (2016, February 17). *Western Cape Government introduces first 1000 Days Campaign.* Retrieved from http://www.gov.za/speeches/western-government-introduces-first-1000-days-campaign-17-feb-2016-0000

Stake, R. E. (2013). *Multiple Case Study Analysis*. Guilford Press.

Statistics SA. (2002). *Earning and Spending in South Africa. Selected Findings and Comparisons from the Income and Expenditure Surveys of October 1995 and October 2000.* Pretoria: Statistics SA.

Statistics SA. (2004). *Provincial Profile 2004: Western Cape.* Retrieved from http://www.statssa.gov.za/publications/Report-00-91-01/Report-00-91-012004.pdf

Statistics SA. (2011). *Census 2011 - Provincial Profile: Western Cape*. Retrieved from http://www.statssa.gov.za/publications/Report-03-01-70/Report-03-01-702011.pdf

Statistics SA. (2013). *Perinatal deaths in SA: 2011-2013.* Retrieved from http://www.statssa.gov.za/publications/P03094/P030942013.pdf

Statistics SA. (2015). *Mid-year Population Estimates.* Retrieved from https://www.statssa.gov.za/publications/P0302/P03022015.pdf

Statistics SA. (2015a). *Quarterly Labour Force Survey Quarter 2: 2015.* Retrieved from http://www.statssa.gov.za/publications/P0211/P02112ndQuarter2015.pdf

Statistics SA. (2015b). *Millennium Development Goals: Reduce Child Mortality.* Retrieved from http://www.statssa.gov.za/MDG/MDG_Goal4_report_2015_.pdf

Stellenberg, E., Welmann, E., & Groenewald, J. (2008). Investigation into the relationship between the socio-economic and health status of the coloured people of the Western Cape in an urban setting. *Curationis, 31(2),* 50-59.

Stephenson, R., & Elfstrom, K. M. (2012). Community influences on antenatal and delivery care in Bangladesh, Egypt, and Rwanda. *Public Health Reports, 127(1),* 96.

Steyn, N. P., Badenhorst, C. J., Nel, J. H., & Ladzani, R. (1993). Breast-feeding and weaning practices of Pedi mothers and the dietary intakes of their preschool children. *South African Journal of Food Science and Nutrition, 5(1),* 10-13.

Story, W. T. (2013). Social capital and health in the least developed countries: a critical review of the literature and implications for a future research agenda. *Global Public Health, 8(9),* 983-999.

Sume, N., & Moffatt, H. (2013). Intersectoral action for health equity: a rapid systematic review. *BMC Public Health, 13(1),* 1-27.

te Water Naude, J., London, L., Pitt, B., & Mahomed, C. (1998). The 'dop' system around Stellenbosch — results of a farm survey. *South African Medical Journal, 88,* 1102-1104.

Tette, E. A., Sifah, E. K., Nartey, E. T., Nuro-Ameyaw, P., Tete-Donkor, P., & Biritwum, R. B. (2016). Maternal profiles and social determinants of malnutrition and the MDGs: What have we learnt? *BMC Public Health,* 161.

The Constitution of the Republic of SA. (1996). Retrieved from http://www.gov.za/documents/constitution/constitution-Republic-South-Africa-1996-1

The Partnership for Maternal, Newborn & Child Health. (2014). *Success Factors for Women's and Children's Health: Multisector Pathways to Progress.* Geneva: Retrieved from: http://www.who.int/pmnch/successfactors/en/

The World Bank (2016). *Data – South Africa*. Retrieved from http://data.worldbank.org/country/south-africa#cp_wdi

Thomas, D.R. (2006). A general inductive approach for analyzing qualitative evaluation data. *American Journal of Evaluation, 27,* 237-246.

Tomlinson, M., Cooper, P., & Murray, L. (2005). The mother–infant relationship and infant attachment in a South African peri-urban settlement. *Child Development, 76(5),* 1044-1054.

Tomlinson, M. (2014). *Maternal Mental Health in the Context of Community-based Home Visiting in a Re-engineered Primary Health Care System: A Case Study of the Philani Mentor Mothers Programme* (No. IDS Evidence Report; 67). IDS.

Tsheola, J. (2012). Rural women's survivalist livelihoods and State interventions in Ga-Ramogale village, Limpopo Province. *African Development Review, 24(3),* 221-232.

UNICEF. (2011). *United Nations Inter-Agency Group for Child Mortality Estimation: Levels and Trends in Child Mortality.* New York: UNICEF.

UNICEF. (2013). *South Africa Statistics*. Retrieved from http://www.unicef.org/infobycountry/southafrica_statistics.html

UNICEF. (2013a). *Statistics on India*. Retrieved from http://www.unicef.org/infobycountry/india_statistics.html

UNICEF. WHO, World Bank, UN-DESA Population Division. (2013). *Levels & trends in Child Mortality, Report 2013. Estimates developed by the UN Inter-agency Group for Child Mortality Estimation.* New York: UNICEF. Retrieved from http://www.who.int/maternal_child_adolescent/documents/levels_trends_child_mortality_2013/en/

UNICEF, WHO, the World Bank. (2014). *Levels and Trends in Child Malnutrition.* UNICEF 2014, UNICEF-WHO-The World Bank Joint Child Malnutrition Estimates for 2013.

UNICEF. (2014). *Hidden in Plain Sight: A Statistical Analysis of Violence against Children.* New York: UNICEF.

UNICEF. (2015). *For Every Child, a Fair Chance: The Promise of Equity.* New York, NY: UNICEF.

UNICEF. (2015a). *Committing to Child Survival: A Promise Renewed.* eSocialSciences. Retrieved from https://www.unicef.org/publications/files/APR_2015_Key_Findings_8_Sep_15.pdf

UNICEF. (2016). *Basic Indicators*. Retrieved from http://www.unicef.org/infobycountry/stats_popup1.html

UNSCN. (2004). *Fifth Annual Report on the World Nutrition Situation: Nutrition for Improved Development Outcomes.* Sudbury, UK: Lavenham Press.

United Nations Millennium Development Goals Indicators. (2016). *Children under Five Mortality Rate per 1,000 Live Births.* Retrieved from http://mdgs.un.org/unsd/mdg/Metadata.aspx?IndicatorId=0&SeriesId=561

United Nations Sustainable Development Goals. (2016a). *17 Goals to Transform Our World.* Retrieved from http://www.un.org/sustainabledevelopment/sustainable-development-goals/

Van de Poel, E., Hosseinpoor, A. R., Jehu-Appiah, C., Vega, J., & Speybroeck, N. (2007). Malnutrition and the disproportional burden on the poor: the case of Ghana. *International Journal for Equity in Health, 6(1),* 1.

Van Minh, H., Giang, K. B., Hoat, L. N., Chung, L. H., Huong, T. G., Phuong, N. K., & Valentine, N. B. (2016). Analysis of selected social determinants of health and their relationships with maternal health service coverage and child mortality in Vietnam. *Global Health Action,* 928836.

Verguet, S., & Jamison, D. T. (2013). Estimates of performance in the rate of decline of under-five mortality for 113 low-and middle-income countries, 1970–2010. *Health Policy and Planning,* czs143.

Victora, C. G., L. Adair, C. Fall, P. C. Hallal, R. Martorell, L. Richter, and H. S. Sachdev. (2008). Maternal and Child Undernutrition 2: Consequences for Adult Health and Human Capital. *The Lancet, 371 (9609):* 340–357.

Victora, C. G., de Onis, M., Hallal, P. C., Blössner, M., & Shrimpton, R. (2010). Worldwide timing of growth faltering: revisiting implications for interventions. *Pediatrics,* Peds-2009.

Viljoen, D. L., Gossage, J. P., Brooke, L., Adnams, C. M., Jones, K. L., Robinson, L. K., Hoyme, E., Snell, C., Khaole, N.C.O, Kodituwakku, P., Asante, K.O., Findlay, R.F., Quinton, B., Marais, A.-S., Kalberg, M.A., & May, P.A. (2005). Fetal alcohol syndrome epidemiology in a SAn community: a second study of a very high prevalence area. *Journal of Studies on Alcohol, 66(5),* 593.

Wallerstein, N. (1992). Powerlessness, empowerment, and health: implications for health promotion programs. *American Journal of Health Promotion, 6(3),* 197-205.

Walker, C. (1995). Conceptualizing motherhood in twentieth century South Africa. *Journal of Southern African Studies, 21(3),* 417-437.

Wang, H., Liddell, C. A., Coates, M. M., Mooney, M. D., Levitz, C. E., Schumacher, A. E., & Sandar, L. (2014). Global, regional, and national levels of neonatal, infant, and under-5 mortality during 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013. *The Lancet, 384 (9947),* 957-979.

Waterson, E. J., & Murray-Lyon, I. M. (1989). Drinking and smoking patterns amongst women attending an antenatal clinic—II. During pregnancy. *Alcohol and Alcoholism, 24(2),* 163-173.

Weichselbaum, E., & Buttriss, J. (2011). Nutrition, health and schoolchildren. *Nutrition Bulletin, 36(3)*, 295-355.

Western Cape Department of Health. (2007). *Policy and Implementation Guidelines for the Nutrition Supplementation Programme of the Health Facility Based Nutrition Programme (HFBNP).* Cape Town: Western Cape Provincial Government.

Western Cape Government Department of Health. (2015). *Annual Report*. Retrieved from https://www.westerncape.gov.za/assets/departments/health/wcghannual_report2014_2015.pdf

Western Cape Government (2015). *Provincial Strategic Plan 2014-2019.* Retrieved from https://www.westerncape.gov.za/text/2015/October/western_cape_provincial_strategic_plan_2014-2019.pdf

Whitehead, M., & Dahlgren, G. (2006). Concepts and principles for tackling social inequities in health: Levelling up Part 1. World Health Organization: *Studies on Social and Economic Determinants of Population Health, 2.*

Wilunda, C., Shiro, T., Putoto, G., Tsegaye, A., & Koji, K. (2016). Evaluation of a maternal health care project in South West Shoa Zone, Ethiopia: before-and-after comparison. *Reproductive Health, 131.*

Woods, N. (1999). Good governance in international organizations. *Global Governance, 5(1)*, 39–61.

Woolard, I. & Leibbrandt, M. (1999). *Measuring Poverty in South Africa. Development Policy Research Unit University of Cape Town*. DPRU Working Papers No 99/33.

Woolard, I. (2002). *An Overview of Poverty and Inequality in South Africa*. Unpublished briefing paper, HSRC, Pretoria.

World Bank Group (Ed.). (2012). *World Development Indicators 2012*. World Bank Publications.

World Health Organization. (2001) *Guiding Principles for Complementary Feeding of the Breastfed Child.* World Health Organization: Geneva.

World Health Organization. (2004). *UNFPA: Maternal Mortality in 2000: Estimates developed by WHO, UNICEF and UNFPA*. Geneva, Department of Reproductive Health and Research, WHO.

World Health Organization. (2005). *Guiding Principles for Feeding Non-Breastfed Children 6–24 Months of Age.* World Health Organization: Geneva.

World Health Organization. (2005a). *"Equity Team" Definition.* Health and Human Rights and Equity Working Group Draft Glossary Unpublished.

World Health Organization. (2010). *A Conceptual Framework for Action on the Social Determinants of Health.*

World Health Organization. (2010a). *Country Cooperation Strategy for WHO and Egypt 2010–2014.* Retrieved from http://www.who.int/countryfocus/cooperation_strategy/ccs_egy_en.pdf

World Health Organization. (2010b). *Global Strategy to Reduce the Harmful Use of Alcohol.*

World Health Organization. (2010c). *Increasing Access to Health Workers in Remote and Rural Areas through Improved Retention: Global Policy Recommendations*. World Health Organization.

World Health Organization. (2011). *Global Status Report on Alcohol and Health.* Report. WHO Press, Switzerland.

World Health Organization. UNICEF. The World Bank. United Nations. (2013). *Levels & Trends in Child Mortality. Estimates developed by the UN Inter-agency Group for child mortality estimation 2013.*

World Health Organization. (2015). *South Africa: WHO Statistical Profile*. Retrieved from http://www.who.int/gho/countries/zaf.pdf?ua=1

World Health Organization. (2015a). *Countdown to 2015: Maternal, Newborn & Child Survival – A Decade of Tracking Progress for Maternal, Newborn and Child Survival – The 2015 Report.* Retrieved from http://countdown2030.org/documents/2015Report/Countdown_to_2015_final_report.pdf

World Health Organization. (2015b). *Levels and Trends in Child Mortality: Report 2015: Estimates Developed by the UN Inter-Agency Group for Child Mortality Estimation (IGME).*

World Health Organization. (2016). *Maternal, Newborn, Child and Adolescent Health.* Retrieved from http://www.who.int/maternal_child_adolescent/topics/maternal/maternal_perinatal/en/

World Health Organization (2016a). *Social Determinants of Health*. Retrieved from http://www.who.int/social_determinants/sdh_definition/en/

World Health Organization. (2016b). *Expanded Programme on Immunization*. Retrieved from http://www.who.int/immunization/programmes_systems/supply_chain/benefits_of_immunization/en/

World Health Organization. (2016c). *Atlas of African Health Statistics 2016: Health Situation Analysis of the African Region.* World Health Organization. Regional Office for Africa. Retrieved from http://www.aho.afro.who.int/sites/default/files/publications/921/AFRO-Statistical_Factsheet.pdf

World Health Organization. (2016d). *Adolescent Pregnancy*. Retrieved from http://www.who.int/maternal_child_adolescent/topics/maternal/adolescent_pregnancy/en/

World Health Organization & UNICEF. (2014). *Trends in Maternal Mortality: 1990 to 2013: Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division: Executive Summary.* Retrieved from http://apps.who.int/iris/bitstream/10665/194254/1/9789241565141_eng.pdf?ua=1

Yin, R. K. (1993). *Applications of Case Study Research*. Applied Social Research Methods Series. London and New Delhi: Sage Publications.

Yin, R. K. (2003). *Case Study Research: Design and Methods*. (3rd ed.). Thousand Oaks, CA: Sage.

You, D., Hug, L., Ejdemyr, S., Idele, P., Hogan, D., Mathers, C., & Alkema, L. (2015). Global, regional, and national levels and trends in under-5 mortality between 1990 and 2015, with scenario-based projections to 2030: a systematic analysis by the UN Inter-agency Group for Child Mortality Estimation. *The Lancet, 386(10010),* 2275-2286.

Yount, K. M., DiGirolamo, A. M., & Ramakrishnan, U. (2011). Impacts of domestic violence on child growth and nutrition: A conceptual review of the pathways of influence. *Social Science & Medicine, 72(9),* 1534-1554.

Appendix A
Qualitative Interview – Providers (English)

1. Tell me how you got involved in the program:
    a. What interested you?
    b. How long have you worked on this program?
    c. What is your role?
2. Tell me about the program:
    a. Probes: Why was it created? What are its goals?
    b. What does the program do? Tell me about its services?
        i. Probes: (needed services, missing services?)
3. Tell me about your program participants? Who does the program serve?
    a. Probes: Are these the intended program targets? Is the program missing people who should be receiving services?
        i. *IF YES:* Why do you think is occurring? (*probes:* transportation issues; convenience; primary caregiver; decision-making power in the household; permission from husband if married; neighborhood conditions; socio-cultural values, other reasons)
        ii. *IF YES:* What should be done to lessen these barriers?
4. Tell me what you think about the program:
    a. What do you think about its goals?
    b. What do you think have been barriers or challenges to achieving goals and objectives?
    c. What have been facilitators?
    d. How well does the program function?
        i. Program objectives being met?
        ii. Service delivery?
        iii. Sufficient staff, funding?
        iv. Equal access to resources, services for all participants? (why/why not)
        v. Do participants engage in appropriate follow-up behavior after service?
5. What service(s) have been the most successful for clients?
6. What are the barriers for clients to effectively use the resources/services of this program?
        i. (*probes:* living conditions – housing; sanitation; water; food and nutrition; criminal activity; other reasons)
    b. What can be done to lessen these barriers?
        i. Do you think the resources and services are helpful?
7. Describe the program's support functions?

          i. (*probes:* fund-raising, public relations to enhance the program's image with potential sponsors, decision makers, or the general public, staff training, staff relationships, recruiting and retention of key personnel, adequate clerical and logistical support, proper facilities and equipment, obtaining materials required for services, general advocacy on behalf of the target population served)

    b. How might these support functions be improved?

8. Describe the program's management functions?

    a. (*probes:* credentials and skills required for senior staff, establish priorities, allocate resources, staff-management relationships, monitor program)

    b. How might they be improved?

9. Tell me about the counselors/supervisors, specifically, what do they do?

    a. (*probes:* interview clients, assess service needs, refer to services, make initial appointment, assist with transportation, follow up with client, ongoing assessment, etc)

    b. How well do they perform?

    c. What do they need to improve their effectiveness?

10. Who are the key stakeholders in the program?

    a. How do these stakeholders affect the program's objectives, services and practices?

        i. Probe: Do the stakeholders agree on the program's objectives, services, and practices?

11. Is there anything I didn't ask you about that you think is important for me to know?

12. Do you have any questions for me?

THANK YOU SO MUCH FOR TALKING WITH ME!

Appendix B
Qualitative Interview – Providers (Afrikaans)

1. Hoekom het die program ontstaan?
    a. Wat is die doelwitte van die program?
    b. Dink U dit is die korrekte program doelwitte?
2. Watter populasies ontvang julle hulpbronne en/of dienste?
    a. Diegene wie julle dienste ontvang, is hulle die bepaalde teikengroep? Is daar mense wie hierdie dienste moet ontvang, wie nie deur die progam bereik word nie?
        i. *Indien JA:* hoekom dink U gebeur dit? (*Ondersoek:* probleme met vervoer; gerieflikheid; primêre versorger; besluitnemingsvermoë in die huis; toestemming van eggenoot indien getroud; omstandighede in die woongebuurte; sosio-kulturele waardes; ander redes)
        ii. *Indien JA,* wat kan gedoen word om hierdie hindernisse te verminder?
3. Kan U my vertel oor die dienste wat die program aanbied?
    a. Voel U dat hierdie dienste werklik benodig word?
    b. Is daar ander dienste wat benodig word, maar nie aangebied word nie?
4. In U opinie, word die program se dienste goed aangebied?
    a. Word die nodige funksies van die program voldoende uitgevoer?
    b. Is daar genoeg personeel om die nodige dienste te verskaf?
5. Dink U dat die hulpbronne en dienste ewe beskibaar is aan alle deelnemers?
6. Is daar hindernisse wat dit moeilik kan maak vir kliente om sukses te behaal in die program? (*Ondersoek:* lewensomstandighede - behuising, sanitasie, water, kos en voedsaamheid; ander redes)
    a. *Indien JA:* Wat kan gedoen word om hierdie hindernisse te verminder?
    b. Dink U die hulpbronne en dienste help?
    c. Betoon deelnemers toepaslike gedrag na hulle 'n diens ontvang het?
7. In U opinie, watter diens het die meeste sukses behaal vir kliente?
8. Kan U die program se ondersteunende funksies beskryf? (*Ondersoek:* fondswerwing, publieke verhoudings om die program se beeld met voornemende borge, besluitnemers of die algemene publiek te verbeter, personeel opleiding, personeel verhoudings, werwing en behoud van sleutel personeel, voldoende klerklike en logistieke ondersteuning, behoorlike fasiliteite en toerusting, verkryging van materiaal benodig vir dienste, algemene voorspraak terwille van die teikengroep wat bedien word)
    a. Kan hierdie ondersteunende funksies verbeter?
9. Kan U die program se bestuursfunksies beskryf? (*Ondersoek:* kwaliteit en vaardighede benodig in senior personeel, bepaal proriteite, toekenning van hulpbronne, personeel-bestuur verhoudings, monitor program)

a. Indien onvoldoende/oneffektief, kan dit verbeter word?

10. Wat van gevalle bestuurders, spesifiek? (*Ondersteuning:* onderhoud met kliente, bepaal dienste behoeftes, verwys na dienste, maak aanvanklike afspraak, help met vervoer, volg op met klient, deurlopende assessering, ens)

a. Indien onvoldoende/oneffektief, hoe kan dit verbeter?

11. Wie is die sleutel belanghebbendes in die program?

a. Beinvloed die belanghebbendes die program se doelwitte, dienste en praktykwyse?

b. Stem die belanghebbendes saam oor die doelwitte, dienste en praktykwyse?

12. Is daar enigiets wat ek nie gevra het nie wat U dink is belangrik vir my om te weet? Het U enige vrae vir my?

BAIE DANKIE DAT U MET MY GEPRAAT HET!

Appendix C
Qualitative Interview – Providers (IsiXhosa)

1. Khawundixelele uzibandakanye njani kule nkqubo?
   a. Yintoni eyeyaba nomtsalane kuwe?
   b. Lixesha elingakanani usebenza kule nkqubo?
   c. Yintoni indima yakho kuyo/Wenza umsebenzi oyintoni kule nkqubo?
2. Ndichazele ngale nkqubo:
   a. Imizekelo: Yayenzelwe ntoni le nkqubo? Ijonge ukuphumelelisa ntoni?
   b. Kwenziwa ntoni kule nkqubo? Ndichazele ngeenkonzo enizenzayo?
      i. Imizekelo: (iinkonzo ezidingekayo, iinkonzo ezingekhoyo?)
3. Ndichazele ngabantu abathatha inxaxheba kule nkqubo yakho? Inceda bani le nkqubo?
   a. Imizekelo: Ingaba ngabo nqo abantu eyenzelwe bona le nkqubo? Ingaba kuna bantu ebekumele bafumana oluncedo lwale nkqubo, kodwa abekho kuyo?
      i. UKUBA UTHI EWE: Ucinga ukuba kutheni kwenzeka njalo? (*imizekelo:* inzima ngento yakukhwela; ukwenza uncedo lufumaneke lula; ukuba ngumkhathaleli oyintloko; ukuba namandla okuthatha isigqibo endlwini yakho; ukufumana imvume kumyeni ukuba utshatile; isimo ebumelwaneni; inkqubo yenkolo yezithethe zoluntu ezixabisekileyo; ezinye izizathu)
      ii. *UKUBA UTHI EWE:* Kungenzwa ntoni unkunciphisa le miqobo?
4. Ndichazela yintoni oyicingayo ngale nkqubo:
   a. Yintoni oyicingayo ngemiphumela ecetyiwe yale nkqubo?
   b. Ucinga ukuba yeyiphi imiqobo okanye iintsalela ezivimba ukufikelela kule miphumela nenjongo zale nkqubo?
   c. Isebenza kakuhle kangakanani le nkqubo?
      i. Ngokwezinga lokufikelela kwiinjongo zale nkqubo?
      ii. Ngokwezinga lokudlulisela iinkonzo
      iii. Ngokwezinga lokuba nenani elaneleyo labasenzi, kunye nemali eyaneleyo?
      iv. Ngokwezinga lokufikeleleka ngokulingana kwizinto ezinikwa abantu, nakwiinkonzo ezinikwa bonke abathathi nxaxheba? (nika isizathu kutheni kunjalo/ okanye kungenjalo)
      v. Ingaba abathathi nxaxheba bayilandela ngendlela efanelekileyo kuhlelo lokubuya bazekuhlolwa njengoko kuhleliwe emveni befumene iinkonzo?
5. Zeziphi iinkonzo okanye inkonzo iyiyeyona iyimpumelelo kubasebenzisi bezinkonzo?

6. Yeyiphi imiqobo ethintela ukba abasenzisi bezinkonzo bakwazi ukufumana uncedo/ okanye iinkonzo zale nkqubo?
   i. (imizekelo: isimo sokuhlala-uhlobo lwendlu; ugutyulo lwelindle; amanzi; ukutya kunye nokondleka; ubugebenga; ezinye izizathu)
   b. Kungenzwa ntoni ukunciphisa lemiqobo?
   i. Ucinga ukuba oluncedo nezinto ezifumanekayo kunye neenkonzo ziluncedo?

7. Chaza imisebenzi nendlela yokuxhasa le knqubo?
   i. (imizekelo: ukhuliso ngxowa mali; inxibelelwano likawonke-wonke ukuphuhlisa inkangeleko yale nkqubo kwabo banokuyixhasa ngemali, kwabathatha izigqibo, okanye kuluntu lonke, ukufundiswa kwabasebenzi, ukubambisana kwabasebenzi, ukuqasha nokuvimbela ukuhamba kwabaqashwa ababalulekileyo, inxaso eyaneleyo ngokomsebenzi wonabhala nabaququzeleli, indawo kunye nezixhobo ezilungelele ukusebenza, ukufumana zonke izidingo nezinto zokwenza iinkozo ziqhubeke, ukumela jikelele abobantu inkqubo ijonge ukubanceda)
   b. Ingaphuculwa njani lemisebenzi ixhasa le nkqubo?

8. Chaza ngemisebenzi yabaphathi kule nkqubo?
   a. (imizekelo: izinga lwemfundo kunye nesakhono ekufuneka babenaso abaphathi, ukumilisela umsebenzi ekufuneka wenziwe kuqala, ukwaba izixhobo zokusebenza nezinye izinto njengemali, ulawulo lwabasebenzi nokubambisana kwabo, ukulawula inkqubo)
   b. Ingaphuculwa njani?

9. Ndichazele ngabacebisi/okanye abaphathi abancinci, ngukuphathelene nqo nomsebenzi wabo?
   a. (imizekelo: benza udliwano ndlebe nabasebenzisi benkonzo, bancedisa ngenkonzo yokuthutha abantu, balandelela abasebenzisi benkonzo, bahlalutya inkqubo rhoqo, njalo-njalo)
   b. Ingaba baphumelela kangakanani ekwenzeni umsebenzi wabo?
   c. Kufuneka bephucule ntoni ukunyusa izinga legalelo labo?

10. Ngawaphi amanye amaqela asebenzisana nale nkqubo?
    a. Lamaqela ayichaphazela njani injongo, neenkonzo kunye neendlela zokusebenza zale nkqubo?
    i. Imizekelo: Ingaba lamaqela ayavumelana ngenjongo zalenkqubo, nangeenkonzo, kunye nendlela yokwenza izinto?

11. Ikhona into endingakubuzanga yona ochinga ukuba ibalulekile ukuba ndiyazi?

12. Unemibuzo ofuna ukundibuza yona?

ENKOSI KAKHULU NGOKUTHETHA NAM!

Appendix D
Qualitative Interview – Participants (English)

1. Tell me a little about yourself.
   a. Probes: Race, age, occupation/income, marital status, occupation of husband, district/municipality where you reside, level of education, marital status, number of children, age(s) of children, and age of first child.
2. Tell me how you came to participate in this program?
   a. How did you hear about it?
   b. Did you try to contact an organization like this before?
   c. What happened?
3. What is the main program that you participated in?
   a. Computer Course Program and/or Sewing & Beading Project (Maternal Poverty), Nutrition and Health Support Group (Poor Maternal Nutrition and Health) and Parenting Workshops and/or Counseling Program (Maternal Alcohol Abuse).
   b. What did you expect to get from the program?
4. Tell me what it has been like to participate in this program?
   a. How helpful has it been to you and your family?
   b. What have you learned? Examples?
      i. Probes: Child rearing, accessing needed services, parenting skills, income generation, proper nutrition, consequences of substance abuse, other reasons, etc.
   c. What services did you get from the program?
      i. Do you think these are/were sufficient? (why/why not?)
   d. Tell me about a time when you felt disrespected?
      i. *IF YES:* What happened?
      ii. Probes: Race, socioeconomic status, marital status, other reasons, etc.
5. Were the program's materials helpful?
   a. How can the materials be improved?
6. What has made it difficult to participate in the program?
   a. Probes: transportation issues, convenience, economic costs of taking time off work, primary caregiver, decision-making power in the household, permission from husband if married, neighborhood conditions, depression, anxiety, other reasons, etc.
      i. *IF YES:* What should be done to reduce these barriers?
   b. Were there any barriers to being successful in the program?
      i. Probes: living conditions – housing, sanitation, water, food and nutrition, criminal activity, other reasons, etc.

        ii.   What would have helped you to be more successful?

7. What kinds of support did you receive from the program? Examples?
   a. What about support from other people/places? Examples? (In what ways?)
      i. Probe: Social support?
8. For Computer Course Program and/or Sewing & Beading Project (Maternal Poverty) participants:
   a. How has this program helped you participate in income generating activities?
   b. Were you able to start your own business?
   c. How did the program help you with that?
9. For Nutrition and Health Support Group (Poor Maternal Health and Nutrition) participants:
   a. How has participating in the program changed your ability to make decisions around your own health and your child's health?
   b. How so? Can you give me any specific examples?
      i. Probes: healthy food choices, exercise, nutritional packets, health pamphlets, primary health care check-ups, other reasons, etc.
   c. Lastly, tell me about your behaviors?
      i. Probes: current nutritional habits, nutritional habits while pregnant.
10. For Parenting Workshops and/or Counseling Program (Maternal Alcohol Abuse) participants:
    a. How has this program changed your parenting skills?
    b. What about the way that you are raising your child/children?
       i. Probes: infant and child immunizations, breastfeeding, parent-infant bond attachment, dietary/nutritional choices, maternal alcohol usage, spiritual dancing, discussing parental challenges with other mothers, other reasons, etc.
    c. Lastly, tell me about your behaviors?
       i. Probes: current drinking habits, drinking habits while pregnant, breastfeeding practices.
11. Overall, how important do you think [insert program name] is for mothers and for mothers of children under the age of five in Maraval?
    a. Would you recommend the organization or specific program to your friends/neighbors?
12. Is there anything I didn't ask you about that you think is important for me to know?

THANK YOU SO MUCH FOR TALKING WITH ME!

Appendix E
Qualitative Interview – Participants (Afrikaans)

1. Vertel my 'n bitjie van jouself?
    a. Ras; Jaar; Beroep; Inkomste; Huwelik staat; Werk van man; Distrik/munisipalitiet waar jy woon; Waar het jy skool klaar gemaak? Het jy n graad of matriek? Hoeveel kinders het jy en die jaar van die kinders, van oud tot jonk.
2. Vertel my hoe het dit gebeur dat jy by hierdie oganisasie betroke raak?
    a. Hoe het jy van die gehoor?
    b. Het jy al voorheen 'n organasasie soos hierdie gekontak?
    c. Wat het gebeur?
3. Wat is die hoofprogram wat jy deel geneem het?
    a. Computer Course Program and/or Sewing & Beading Project (Maternal Poverty), Nutrition and Health Support Group (Poor Maternal Nutrition and Health) and Parenting Workshops and/or Counseling Program (Maternal Alcohol Abuse).
    b. Wat verwaag jy van hierdie program af?
4. Vertel my hoe was dit om in hierdie organisasie deel te neem?
    a. Hoe helpvaardig was dit vir jou en jou gesin?
    b. Wat het jy geleer? Gee vorbeelde as jy kan?
        i. Kinder agtergront, Om hulp te kry van verskulinde dienste; Ouerskap; Hoe kry jy geld; Voeding van die familie; Die gevolge van dwelms misbruik; En nog ander rede wat jy kan gee.
    c. Watter soorte dienste het jy van die program ontvang?
        i. Dink jy al hierdie goed wat ons vra is genoeg? (hoekom/hoekom nie?)
    d. Se my waneer het jy gevoel dat jy nie gerispekteer word nie?
        i. As jy voel dit was wel so – Wat het gebeur?
        ii. Ras grope, Ekonomiese staat. Huwelik staat, En ander rede.
5. Was die programm se materiaal behulpsaam?
    a. Hoe kaan ons dit verbeuter?
6. Wat het dit mooilik gemaak om aan die programm deel te neem?
    a. Vervoer redes; Gemaaklikheid; Geldsake om tyd af te vat van die werk af; Primere oppaaser; Besliut nemer van die huishoudlikheid; Toestemming van die gade as getrout is; Woonbuurt se omstandigheede; Depresie; Angstigheid en ander rede.
        i. As die antwoord ja is: Wat dink jy kan gedoen word om hierdie probleeme te voorkom?
    b. Was daar enige probleeme om die programm n sukses te maak?
        i. Wooning toestand-behuising, sanitasie, water, kos and gesondheids, voeding.
        ii. Wat het jou gehelp om meer suksesvol te word?

7. Wat soorte ondersteuning het jy van die programm ontvang? Gee bevoorbelde?
   a. Die ondersteuning wat jy gekry het van ander mense en plekke hoe was dit? Gee byvoorbelde.
      i. Maatskaplikke hulp?
8. For Computer Course Program and/or Sewing & Beading Project (Maternal Poverty) participants:
   a. Hoe het die programm jou gehulp om geld te maak of inbring?
   b. Kon jy jou uie besigheid begin?
   c. Hoe het die programm gehulp met dit?
9. For Nutrition and Health Support Group (Poor Maternal Health and Nutrition) participants:
   a. Hoe het jou deelneeming in die programm gehulp met jou besluitings rond om jou gesondheid en jou kind sin?
   b. Hoe so? Gee spesifieke redes?
      i. Byvoorbeeld-Voedsel keuse, Oefeninge, voedingswaarde pakkies;, gesondheid pamflette, primere gesondheidsorg ondersoeke en ander rede.
   c. Op laas vertel my van jou gedraag?
      i. Huidige voeding gewoontes; Voeding gewoontes terwyl hulle swanger is.
10. For Parenting Workshops and/or Counseling Program (Maternal Alcohol Abuse) participants:
    a. Hoe het hierdie programm jou ouerskap ge veraander?
    b. Wat van die menier hoe jy jou kind/kinders opbring?
       i. Klein kind en kinder enting; Borsvoeding; Ouer-baba gehegnis; Voedings keuse; Moederlike alkohol gebruik; Geestelike dans; Uitdaging met ander ouers en ander redes.
    c. Op laas vertel my van jou gedraag?
       i. Hoe drink jy, drink jy as jy swanger is, hoe gereeld borsvoed jy.
11. As jy kan opsom hoe dink wat is die programm se belangrikheid vir kinder sonder die jaar van vyf in Maraval?
    a. Gaan u die organisasie of die programm kan vir jou vriende en bure aanbeveel?
12. Is daar enige iets wat ek nie vir u gevrae het nie, wat van belang is?

DANKIE DAT U MET MY KON PRAAT!

Appendix F
Qualitative Interview – Participants (IsiXhosa)

1. Khandixelele kancinci nje ngawe?
    a. Uphandisiso: Ubuhlanga, iminyaka, umrholo, utshatile okanye hayi, umsebenzi womyeni wakho, umasipala ophuma kuye, iqondo lemfundo, inani labantwana, Iminyaka yabantwana, iminyaka kamafungwashe wakho.
2. Khawutsho, waqala njani kolu mbutho?
    a. Weva njani ngayo?
    b. Ubukhe wazama ukuqhagamshelana nombutho ololuhlobo ngaphambili?
    c. Kwenzeka ntoni?
3. Yeyiphi le nkqubo ephambili othe wathatha inxaxheba kuyo?
    a. Computer Course Program and/or Sewing & Beading Project (Maternal Poverty), Nutrition and Health Support Group (Poor Maternal Nutrition and Health) and Parenting Workshops and/or Counseling Program (Maternal Alcohol Abuse).
    b. Yintoni ubulindele ukuyifumana kulenqubo?
4. Khandixelele ukuba ufumanise kunjani ukuba yinxalenye kule nqubo yolu phulo?
    a. Lukuncede njani wena nosapho lwakho?
    b. Ufunde ntoni? Umzekelo?
        i. Uphandisiso: Ukukhulisa umntwana, ukuqeqesha, ukukhulisa, ukuphuhlisa umnoto, ukudla okuya empilweni, iziphumo zokusetyenziswa kweziyobisi ngokubaxekileyo, nezinye izizathu.
    c. Ziziphi iinkonzo othe wazizuza kolu phulo?
        i. Ingaba ucinga ezizinto bezanele? (Ngoba/Okanye ngoba kutheni ungacingi njalo?)
    d. Ndixelele ngexesha apho ukhe waziva ungahloniphekanga?
        i. Kwakwenzeke ntoni?
        ii. Uphandisiso: Bubuhlanga, isimo sakho sezomnotho, isimo sakho somtshato, ezinye izizathu.
5. Ingaba iincwadi zoluphulo zona beziluncedo?
    a. Zingathi ziphuculwe njani zono?
6. Yintoni mhlawumbi eyenza kubenzima ukuthabatha inxaxheba kolu phulo?
    a. Uphandisiso: Umba wezinto eziqatyelwayo, ufikeleleko, ixabiso lokuthabatha ixesha ungekho emsebenzini, ukuba ngumnakekeli oyintloko, isihlalo sokuthatyathwa kwezigqibo ekhaya, imvume ngokusuka emyenini ukuba utshatile, ubume bobummelwana, uxinzelelo, umothuko/uloyiko, ezinye izizathu.
        i. Ukuba kunjalo: Kungenziwa njani ukuze kukhawulelwane nale miceli mngeni?
    b. Ingaba bezikhona izithinteli mpumelelo kolu phulo?

    i. Imeko ophila phantsi kwayo, izindlu, ucoceko, amanzi, ukudla nezondlo, ubugulukudu, ezinye izizathu.

    ii. Yintoni ebinokukhokelela ekubeni uphumelele nangakumbi?

7. Yiyiphi inkxaso othe wayizuza kolu phulo? Umzekelo?

  a. Ungathini ngenkxaso ngokusuka kwabanye okanye iindawo? Umzekelo? Ngayiphi indlela?

    i. Uphandisiso: Ukuxhaswa kukuhlala?

8. For Computer Course Program and Sewing & Beading Project (Maternal Poverty) participants:

  a. Ingaba ukuba yinxalenye yoluphulo kukuncede njani ukuze uthabathe inxaxheba ekuveliseni umnotho?

  b. Ingaba uthe wakwazi ukuziqalela ishishini lakho?

  c. Oluphulo luthe lakunceda njani koko?

9. For Nutrition and Health Support Group (Poor Maternal Health and Nutrition) participants:

  a. Ingaba ukuba yinxalenye yoluphulo kusitshintshe njani isakhono sakho sokuthabatha isigqibo ngempilo yakho naleyo yabantwana bakho?

  b. Utsho njani? Ungandinika umzekelo ongqalileyo?

    i. Uphandisiso: Ukutya okukhethayo, ukuzilolonga, ukuncancisa ibele, ukuphuhla kwezakhono zokunakekela, ezinye izizathu.

  c. Okokugqibela, khakhe undixelele ngokuziphatha kwakho?

    i. Uphandisiso: Indlela osela ngayo, imiikhwa yokusela usakhulelwe.

10. For Parenting Workshops and/or Counseling Program (Maternal Alcohol Abuse) participants:

  a. Ingaba ukuba yinxalenye yolu phulo kuthe kwakunceda njani ukutshintsha indlela yakho yokuqeqesha abantwana?

  b. Indlela yokukhulisa umntwana/abantwana yona?

    i. Uphandisiso: Ukugonywa komntwana, lokuncancisa, ukunxulumana komzali nomntwana, ukusetyenziswa kotywala ubani ekhulelwe, ukujuxuza ngokomoya, ukuxubusha imiceli mngeni yobuzali nabanye oomama, ingcebiswano, ukuphuculwa ubuchule ukunika ukhathalelo, ezinye izizathu.

  c. Okokugqibela, khakhe undixelele ngokuziphatha kwakho?

    i. Uphandisiso: Indlela osela ngayo, indlela osela ngayo ukhulelwe, ukuncancisa kwakho.

11. Lilonke, ucinga lubaluleke kangakanani [Faka igama lophulo] koomama kwakunye noomama babantwana abangaphantsi kweminya emihlanu apha e Maraval?

  a. Ingaba ungalubabaza oluphulo anlombutho kubahlobo bakho?

12. Ingaba ikhona into endingakubuzanga yona ocinga ukuba ibalulekile ukuba ndiyazi?

ENKOSI KAKHULU NGOKUTHETHA NAM!

Appendix G
Information Sheet and Consent Form (English)

Evaluating Income Generation, Nutrition, and Parenting Programs on Maternal and Child Health Outcomes: A Multi-Program Case Study of a Community-Based Organization in the Western Cape, South Africa

Who we are
Hello, I am Simone Martin, a doctoral candidate in the Department of Global Affairs at Rutgers University-Newark. I am working for Rutgers University and the Community Chest of the Western Cape.

What we are doing
I am conducting research on the processes and outcomes of maternal and child health programs and services and its impact on child health outcomes in the Western Cape, South Africa. I am conducting a study to assess what more needs to be done in the province to improve these health issues through qualitative data collection and analysis and recommend pragmatic solutions to these issues. This study is being done as independent research and the findings will be included in my dissertation for the PhD in Global Affairs at Rutgers University-Newark.

Your participation
I am asking you whether you will allow me to conduct an interview with you about your knowledge and opinions around maternal and child health programs and services in South Africa. The purpose is to ascertain why the Western Cape, a province in an upper middle income country, has relatively high child mortality rates, and what can be done to improve these health issues. If you agree, I will ask you to participate in one interview for approximately one hour, maximum.

Please understand that **your participation is voluntary** and you are not being forced to take part in this study. The choice of whether to participate or not, is yours alone. If you choose not to take part, you will not be affected in any way whatsoever. If you agree to participate, you may stop participating in the research at any time and tell me that you don't want to continue. If you do this, there will be no penalties and you will not be prejudiced in any way.

Confidentiality
All identifying information will be kept in a locked file cabinet and will not be available to others and will be kept confidential to the extent possible by law. The records from your participation may be reviewed by people responsible for making sure that research is done properly, including members of the ethics committee at the Human Sciences Research Council. (All of these people are required to keep your identity confidential.) Otherwise, records that identify you will be available only to people working on the study, unless you give permission for other people to see the records.

I am asking you to give me permission to tape-record the interview so that I can accurately record what is said.

Your answers will be stored electronically in a secure environment and used for research or academic purposes now or at a later date in ways that will not reveal who you are. All future use of the stored data will be subject to further Rutgers University Institutional Review Board and/or HSRC Research Ethics Committee review and approval.

I will not record your name anywhere and no one will be able to connect you to the answers you give. Your answers will be linked to a fictitious code number or a pseudonym (another name) and I will refer to you in this way in the data, any publication, report or other research output.

Risks/discomforts
At the present time, I do not see any risk of harm from your participation. The risks associated with participation in this study are no greater than those encountered in daily life.

Benefits
There are no immediate benefits to you from participating in this study. However, this study will be helpful to me in that I hope the results will increase understanding of how to reduce child mortality and improve maternal health in the Western Cape, South Africa and how these health issues are prioritized.

If you would like to receive feedback on my study, I will record your phone number on a separate sheet of paper and can send you the findings of the study when it is completed sometime after May 2017.

Who to contact if you have been harmed or have any concerns
This research has been approved by the Rutgers University Institutional Review Board (IRB) and the HSRC Research Ethics Committee (REC). If you have any complaints about ethical aspects of the research or feel that you have been harmed in any way by participating in this study, please call HSRC's toll-free ethics hotline 0800 212 123 (when phoned from a landline from within South Africa) or contact the Human Sciences Research Council REC Administrator, on Tel 012 302 2012 or e-mail research.ethics@hsrc.ac.za .

Also, you can reach the IRB at:

Institutional Review Board
Rutgers University, the State University of New Jersey
Liberty Plaza / Suite 3200
335 George Street, 3rd Floor
New Brunswick, NJ 08901
Phone: 732-235-9806
Email: humansubjects@orsp.rutgers.edu

Lastly, if you have concerns or questions about the study or study procedures, you may reach me at:

Simone Martin
PO Box 1468
New York, NY 10113-1468
Email: simone.martin@rutgers.edu
Phone: 646-824-3073

Or reach my faculty advisor at:

Jeffrey R. Backstrand, Ph.D.
Associate Professor of Practice
School of Public Affairs & Administration
Chair, Department of Urban Public Health Administration
School of Public Health
Director, Center for Collaboration and the Urban Child
Rutgers University
111 Washington Street, Rm 128
Newark, New Jersey 07102-1801
Phone: 973-353-3800

CONSENT

I hereby agree to participate in research on *Evaluating Income Generation, Nutrition, and Parenting Programs on Maternal and Child Health Outcomes: A Multi-Program Case Study of a Community-Based Organization in the Western Cape, South Africa.* I understand that I am participating freely and without being forced in any way to do so. I also understand that I can stop participating at any point should I not want to continue and that this decision will not in any way affect me negatively. I understand that this is a research project whose purpose is not necessarily to benefit me personally in the immediate or short term. I understand that my participation will remain confidential.

Subject Name (Print) _____

Subject Signature _____ Date: _____

Principal Investigator Signature_____ Date:_____

CONSENT FOR TAPE RECORDING

I hereby agree to the tape-recording of my participation in the study.

_____

Subject Signature   Date: _____

_____

Principal Investigator Signature   Date: _____

I understand that the information that I provide will be stored electronically and will be used for research purposes now or at a later stage.

_____

Subject Signature   Date: _____

_____

Principal Investigator Signature   Date: _____

Appendix H
Information Sheet and Consent Form (Afrikaans)

**Evaluering van inkomste generasie-, voeding- en ouerskapsprogramme oor moeder-
en kindergesondheid uitkomste: 'n Multi-program gevallestudie van 'n gemeenskap-
gebaseerde organisasie in die Wes-Kaap, Suid-Afrika**

Wie ons is
Hallo, ek is Simone Martin, 'n doktors kandidaat in die Global Affairs Departement by
Rutgers Universiteit - Newark. Ek werk tans vir Rutgers Universiteit and die
Gemeenskapskas Weskaap.

Wat ons doen
Ek onderneem navorsing oor die prosesse en resultate van materne en kindergesondheids
programme en dienste en hulle impak op kindergesondheids resultate in die Weskaap,
Suid Afrika. Ek onderneem 'n studie om vas te stel wat nog meer gedoen kan word in die
provinsie om hierdie gesondheids kwessies te verbeter. Ek doen dit deur middle van
kwalitatiewe data kolleksie en aanbeveling van pragmatiese oplossings vir hierdie
kwessies. Dit is onafhanklike navorsing en die bevindinge sal ingesluit word by my
verhandeling vir my doktorsgraad in die Global Affairs Departement van Rutgers
Universiteit - Newark.

U deelname
Ek wil graag weet of ek U mag ondervra oor U kennis en opinies van materne en
kindergesondheids programme en dienste in Suid Afrika. Die doel is om vas te stel
waarom die Weskaap, 'n provinsie in 'n land met bo gemiddelde imkomste, so 'n
relatiewe hoë kindersterfte koers het, en wat gedoen kan word om hierdie kwessies te
verbeter. As U instem, wil ek 'n onderhoud met U voer wat ongeveer een uur sal duur.

Neem asseblief kennis dat U deelname vrywillig is en dat U nie geforseer word om aan
die studie deel te neem nie. Slegs U kan besluit of U wil deelneem of nie. As U besluit
om nie deel te neem nie, sal U nie in enige opsig benadeel word nie. Indien U instem om
deel te neem, mag U enige tyd tydens die navorsing besluit dat U nie langer wil deelneem
nie en my daarvan in kennis stel. As U dit sou doen, sal daar geen nagevolge wees nie en
U sal geensins benadeel word nie.

Vertroulikheid

Alle identifiserende besonderhede sal in 'n geslote kas gebêre word en sal nie aan enigeen
beskikbaar wees nie, en die vertroulikheid daarvan sal so ver moontlik, deur die wet
beskerm word. Die rekord van U deelname mag hersien word deur persone wie
verantwoordelik is om seker te maak dat die navorsing reg uitgevoer is. Dit sluit in lede
van die etiese kommittee by die Human Sciences Research Council. (Hierdie persone is
verplig om U identiteit vertroulik te hou). Anders, sal die rekords wat U identiteit behels
net beskikbaar wees aan persone wat op die studie werk, tensy U toestemming gee dat
andere dit mag sien.

Ek verlang U toestemming om die onderhoud op band op te neem, ten einde seker te maak dat ek die gesprek akkuraat vaslê.

U antwoorde sal elektronies gebêre word in veilige omstandighede. Dit sal gebruik word vir navorsing of akademiese doeleindes, nou of later, maar op 'n wyse wat nie U identiteit sal openbaar nie. Alle toekomstige aanwending van die geborge data sal noodwendig aan die Rutgers Institutional Review Board en Human Sciences Research Council voorgelê word vir hersiening en toestemming.

Ek sal nie U naam neer skryf nie en niemand sal U identiteit kan verbind met die antwoorde wat U gee nie. U antwoorde sal verbind word aan 'n fiktiewe kode of 'n skuilnaam en ek sal U deurgaans as sulks aanwys in die data, enige publikasie of navorsing uitgawe.

Risikos
Op hierdie stadium voorsien ek nie enige risiko as gevolg van U deelname nie. Die risikos verbonde as gevolg van U deelname aan hierdie studie is nie meer as dié wat U in daaglikse lewe ondervind nie.

Voordele
Daar is nie onmiddelike voordele verbonde aan U deelname aan die studie nie. Ek hoop wel dat die resultate van die studie sal lei tot groter begrip oor hoe om kindersterfte te verminder en materne gesondheid te verbeter, so wel as die prioritasie van gesondheids kwessies.

As U wil terugvoer kry oor my studie, sal ek U nommer neer skryf op 'n aparte blaai. Ek sal die uitslae stuur ná Mei 2017.

Wie om te kontak indien U tenagekom is of bekommernisse het
Hierdie navorsing is goedgekeur deur Rutgers University Institutional Review Board (IRB) en die HSRC Ethics Committee (REC). As U enige klagtes het oor die etiese aspekte van die navorsing of as U voel U was enigsins tenagekom as gevolg van U deelname aan die studie, skakel asseblief die HSRC se tolvrye nommer 0800 212 123 (as U van 'n landlyn skakel binne Suid Afrika) of kontak die Human Sciences Research Council REC administrateur by Tel 012 302 2012 of stuur epos aan research.ethics@hsrc.ac.za.

U kan ook die IRB kontak by:

Institutional Review Board
Rutgers University, the State University of New Jersey
Liberty Plaza / Suite 3200
335 George Street, 3rd Floor
New Brunswick, NJ 08901
Phone: 732-235-9806
Email: humansubjects@orsp.rutgers.edu

Ten laaste, as U enige onsekerhede of vrae het oor die studie of prosesse, kontak my by:

Simone Martin
PO Box 1468
New York, NY 10113-1468
Email: simone.martin@rutgers.edu
Phone: 646-824-3073

Of my fakulteit raadgewer:

Jeffrey R. Backstrand, Ph.D.
Associate Professor of Practice
School of Public Affairs & Administration
Chair, Department of Urban Public Health Administration
School of Public Health
Director, Center for Collaboration and the Urban Child
Rutgers University
111 Washington Street, Rm 128
Newark, New Jersey 07102-1801
Phone: 973-353-3800

TOESTEMMING

Hiermee, stem ek in om deel te neem aan die *Evaluering van inkomste generasie-, voeding- en ouerskapsprogramme oor moeder-en kindergesondheid uitkomste: 'n Multi-program gevallestudie van 'n gemeenskap-gebaseerde organisasie in die Wes-Kaap, Suid-Afrika.* Ek verstaan dat ek vrywilliglik deelneem en is nie op enige wyse gedwing om dit te doen nie. Ek verstaan ook dat ek op enige stadium my deelname kan stop en dat so 'n besluit my nie sal benadeel nie. Ek verstaan dat die doel van die navorsingsprojek nie noodwendig is om my persoonlik, nou of in die nabye toekoms, te bevoordeel nie. Ek verstaan dat my deelname vertroulik sal bly.

Subjek Naam (Drukskrif)_____

Subjek Handtekening _____

Datum _____

Hoof Navorser Handtekening_____

Datum _____

TOESTEMMING VIR BANDOPNAME

Hiermee, gee ek toestemming vir die gebruik van'n bandopname vir my deelname in die studie

_____

Subjek Handtekening   Datum_____

_____

Hoof Navorser Handtekening   Datum _____

Ek verstaan dat alle identifiserende besonderhede sal in 'n geslote kas gebêre word en sal nie aan enigeen beskikbaar wees nie, en die vertroulikheid daarvan sal so ver moontlik, deur die wet beskerm word.

_____   _____

Subjek Handtekening   Datum

_____   _____

Hoof Navorser Handtekening   Datum

<u>**Appendix I**</u>
<u>**Information Sheet and Consent Form (IsiXhosa)**</u>

Ukuphononga umvuzo, Ukutya, kunye neziphumo kwiNkqubo zabazali kwe zempilo kunye nabantwana: Into yokuphononongwa kwe Multi-Programme yombutho osekelwe kuluntu, ENtsona Koloni, eMzantsi Afrika

Singobani
Molo, ndinguSimone Martin, ndifundela izinga lobugqirha kwiCandelo lweMiba yeLizwe Jikelele eRugters Dunivesithi eseNewark, ndisebenzela iRugters Dunivesithi kwakunye neCommunity Chest yaseNtshonalanga.

Senza ntoni
Ndiqhuba uphando kwiinkqubo neziphumo zazo ngokuphathelene nokubelekisa kunye neenkquubo zempilo yomntwana neenkonzo zakho ukuba negalelo elinjani kwimiphumela yempilo yomntwana kwisiphaluka saseNtshonalanga, eMzantsi Afrika. Ndenza isifundo sokufumanisa ukuba yinto edluleleyo enokwenziwa kwesisiphaluka ukuphucula lemiba yempilo ngokuqokelela ulwazi silucwaninge kwaye senze iziphakamiso ezibambekayo ezizisombululo kwimiba esiyifumanisileyo. Esisifundo ndisenza ndizimele ngokwam kwaye izinto endizifumanisayo ndizakuzifaka kwinkcazelo ebhalwe kubanzi (ithisisi) yePhD kwiCandelo lweMiba yeLizwe Jikelele phaya eRugters Dunivesithi yase Newark.

Ukuthatha kwakho inxaxheba
Ndiyacela, ndibuza ukuba ungandivumela ndenze ucwaningo kunye nawe malunga nolwazi nengcamango zakho ngokuphathelane nenkqubo yokubelekiswa kunye nenkqubo yempilo yomntwana kunye neenkozo zakhona eMzantsi Afrika. Injongo kukufumanisa ukuba kutheni iNtshonalanga, njenge siphaluka esikwilizwe elinengeniso zezimali ephezulu naphakathi, esisphaluka sibenezinga eliphezulu lokufa kwabantwana, kwaye kungenziwa ntoni ukuphucula lemiba yempilo. Ukuba uyavuma, ndizakuceka ukuba uthathe inxaxheba kucwaningo oluzakuthatha iyure, ubuninzi.

Ndicela uqonde ukuba ukuthatha inxaxheba ngokuzinikela kwaye akunyazelwa ukuba uthathe inxaxheba kwesisifundo. Ukukhetha ukuba uthatthe inxexheba okanye ungenzi njalo, sisigqibo sakho wedwa. Ukuba igqaba ukungathathi nxaxheba, akukho nto izakuchapazela nangaluphi uhlobo. Ukuba uyavuma ukuthatha inxaxheba, unelungelo lokuyeka phakathi nanini undichazele ukuba awufuni ukuqhubekeka. Ukuba wenza lonto, akukho sohlwayo kwaye awuzokugwetywa nangaluphina uhlobo.

Imfihlelo
Zonke inkcukanca zozazisa zizakugcinwa zivalelwe kwikhabhathi yeefile etshixwayo kwaye ayizokufumaneka kwabanye abantu kwaye izakugcinwa iyimfihlo ngokwasemthethweni. Ushicelelo lwegalelo lakho xa ubuthatha inxaxheba lunga phehlululwa ngabantu ongumsebenzi wabo ukuqinisekisa ukuba oluphando-sifundo lwenziwe ngokufanelekileyo, kwakunye namalungu ekomiti yeenkqubo ezesesikweni kwiBhunga loCwaningo ngezoLuntu ngobuNzululwazi. (Bonke ababantu banyazelekile bayigcine iyimfihlo ukuba ungubani.) Okunye ushicilelo oluchaza ukuba ungubani

luyakuvuleleka kuphela kubantu abasebenza kolucwanigo, ngaphandle kokuba wena Unikezele ngelungelo lokuba abanye abantu babone olushicilelo lakho.

Ndicela undiphe imvume yokuba ndishicilele intetho yethu yocwaningo ukuze ndikwazi ukushicela nqo okuthethayo.

Impendulo zakho zizakugcinwa ngezixhobo zombane kwindawo ephephileyo zisetyenziswe kucwaningo okanye kwizifundo zezinga lweduniveisithi ngoku okanye kwixesha elizayo ngendlela apho engazokuveza ukuba ungubani. Konke ukusetyenziswa kwelixa elizayo yolulwazi luzakugcinwa lokuxhomekeka kwiBhodi eliZiko lokuHlola leDunivesithi iRugters kunye/okanye iKomiti yoCwaningo leeNkqubo Ezisesikweni iHSRC ukuze bayihlole kwaye bayivume.

Andizi kulibhala igama lakho naphina kwaye akukho namnye umntu ozokwazi ukukuxhulumanisa neempendulo ondinika zona. Impendulo zakho zizakuhlanganiswa nenani elibubuxoki okanye ndizakusebenzisa igama elingelinye (ndakuthiya elinye igama) kwaye ndakubiza njalo nakoko ndizakubhala, nakulo naliphi upapasho, nakwinxelo okanye olunye ucwaningo.

Ubungozi/ubunzima
Ngelithuba, andiboni bungozi obunukuhlela ngokuthatha inxaxheba. Ubungozi obuhlanganiswa nokuthatha inxaxheba kolucwaningo-sifundo azizodlule ingozi esihlala sihlangabezana nazo ebomini mihla le.

Inzuzo
Akukho nzuzo azakuyifumana zisasuka ngokuthatha inxaxheba kolucwaningo-sifundo. Kodwa olucwaningo-sifundo luzakuba luncedo kum ngohlobo lokuba ndinethemba iziphumo zalo zizakongeza ukuqonda ukuba kungancitshiswa njani ukufa kwabantwana kwaye luphuhlise impilo kwezobelekiso kwisiphaluka saseNtshonalanga, eMzantsi Afrika kwaye nokuba zithathelwa njani ingqalelo ezinxaki ngezempilo.

Ukuba ungathanda ukufumana imiphumela yolucwanigo-sifundo, ndingayithatha inombolo yakho yomnxeba ndiyibhale kwiphepha limbi ndikwazi ke ukuthumelela izinto endizifumanisileyo xa ndigqibile pha emva kukaMeyi 2017.

Unganxibelelana nabani ukuba uye wonzakala okanye unento ekukhathazayo
Olucwaningo luvinywe yiiBhodi eliZiko lokuHlola leDunivesithi iRugters (IRB) kunye neKomiti yoCwaningo leeNkqubo Ezisesikweni iHSRC (REC). Ukuba unesikhalzo ngenkqubo esesikweni ezithile kolucwaningo okanye uziva ukuba wonzakalisiwe nangaluphi uhlobo xa uthe wathatha inxaxheba sicela utsalele umxeba kwiHSRC kumnxeba wabo wamahala 0800 212 123 (xa usebenzi umnxeba ongasingo makhale khukhwini ulapha eMzantsi Afrika) okanye uxhumane neBhunga loCwaningo ngezoLuntu ngobuNzululwazi REC Unobhala, kumnxeba 012 302 2012 okanye ubhalele nge e-mail ku - research.ethics@hsrc.ac.za

Kwaye ungayifumana i-IRB apha kule dilesi ingezantsi:

Institutional Review Board
Rutgers University, the State University of New Jersey
Liberty Plaza / Suite 3200
335 George Street, 3rd Floor
New Brunswick, NJ 08901
Phone: 732-235-9806
Email: humansubjects@orsp.rutgers.edu

Okokugqibela, ukuba unenxalabo okanye imibuzo malunga nolucwaningo-sifundo okanye inkqubo yaso, ungandifumana kuledilesi nomnxeba ulandelayo:

Simone Martin
PO Box 1468
New York, NY 10113-1468
Email: simone.martin@rutgers.edu
Phone: 646-824-3073

Okanye uxhumane nomcebisi wam ngoluncwaningo-sifundo kudelesi nomnxeba:

Jeffrey R. Backstrand, Ph.D.
Associate Professor of Practice
School of Public Affairs & Administration
Chair, Department of Urban Public Health Administration
School of Public Health
Director, Center for Collaboration and the Urban Child
Rutgers University
111 Washington Street, Rm 128
Newark, New Jersey 07102-1801
Phone: 973-353-3800

IMVUME

Ndiyavuma ukuthatha inxaxheba *Ukuphononga umvuzo, Ukutya, kunye neziphumo kwiNkqubo zabazali kwe zempilo kunye nabantwana: Into yokuphononongwa kwe Multi-Programme yombutho osekelwe kuluntu, ENtsona Koloni, eMzantsi Afrika*. Ndiyaqonda ukuba ndizikhethele ukuthatha inxaxheba andinyanzelwanga nangaluphi uhlobo ukuba ndenze njalo. Kwaye ndikwa qonda ukuba ndingayeka nanini xa ndithe andafuna ukuqhubekeka kwaye esisigqibo esiyi kuba nagalelo libi kum. Ndiyaqonda ukuba olucwaningo luyinkqubo enjongo yayo ingakukundika inzuzo buqu ngoku okanye exesheni. Ndiyaqonda ukuthatha kwam inxaxheba kuzakuhla kuyimfihlo.

Igama _____

Tykitya_____Umhla:_____

_____   _____

Umcwaningi Uyintloko Tyikitya   Umhla

IMVUME YOSHICILELO YELIZWI

Ndiyavuma ukushicilelwa kwento endiyithethayo kolucwaningo.

_____

Tyikitya   _____

                        Umhla

_____

                        _____

Umcwaningi Uyintloko Tyikitya   Umhla

Ndiyaqonda ukuba inkcukanca endizinikezayo zizakugcinwa ngezixhobo zombzne kwaye ziyakusetyenziswa kucwaningo ngoku nakwixesha elizayo.

_____

Tyikitya   _____

                        Umhla

_____

                        _____

Umncwaningi Osentloko Tyikitya   Umhla