Follow-up/ Endline Survey of Factors Affecting the Social Determinants of Health targeted by CSS for Health: A comparison of Six Communities in the Western Cape

December 2019

Community Systems Strengthening for Health

Programme funded by the EUROPEAN UNION

Acknowledgements

We would like to acknowledge our CSS Project partners:
Women on Farms Project,
Training For Transition
Belhar and Gugulethu Health Committees under the Cape Metro Health Forum
and Health Monitors in Klapmuts
and

UCT CSS project and administrative staff

And funders, the South African Medical Research Council (MRC) and European Union Mission to South Africa

Thanks to the following authorities for permission to conduct the study and cooperation in enabling data collection:
The Department of Social Development
The South African Police Service
City of Cape Town Health Department

Special thanks to all of the fieldworkers in Belhar, Bellville South, Lwandle, Gugulethu, Klapmuts, and Montana (Wolseley).

Prepared by Mayara Fontes Marx, MA, Follow-Up Survey/ Endline Research Coordinator

Table of Contents

Executive Summary

Background: The Community Systems Strengthening Project (CSS) is a community level intervention aimed at building the capacity of community members to address the social determinants of health regarding child protection, violence reduction (peacebuilding), food and nutrition, and chronic illnesses (health promotion). This involves extensive training and leadership development through health committees and community members in a collaboration between the University of Cape Town, Women on Farms Project (WFP), and Training for Transition. Interventions were implemented in three, purposively selected, residential areas in the Western Cape: Belhar, Gugulethu and Klapmuts, with the support of Belhar Health Committee and Gugulethu Health Committee under the Cape Metro Health Forum, and WFP and health monitors in Klapmuts. Three socioeconomically and culturally equivalent control areas were identified in Bellville South, Lwandle, and Montana (Wolseley) for comparison for purposes of evaluation.

This report describes the Baseline follow up survey ("Endline assessment") of the core social determinants targeted for intervention by the CSS project.

The Baseline follow up (Endline) survey repeated the Baseline assessment conducted in 2017. Compared to the baseline results, findings from the follow up survey can provide an indication of changes in the community which may have been influenced by the program's training and activities implemented in the pilot communities.

Note: The Endline survey does not include the input of direct beneficiaries of the CSS project i.e. community members who attended training and were directly involved in CSS activities. The report collates the perceptions on the Social Determinants of Health of community members within pilot areas which may have been influenced by the training/projects of the direct beneficiaries as well as related CSS activities and compares this with control sites. Please see the CSS evaluation for direct target impact which includes CSS Monitoring and Evaluation data and perceptions of direct CSS beneficiaries.[1]

Aim: The aim of both Baseline and Endline surveys was to record the beliefs, attitudes, experiences and knowledge of community members about community health and security services to do with Child Protection, Food and Nutrition, Peace Building, and Chronic Illnesses and compare 2019 data to the data previously collected in 2017. Following training and activities in three areas (Belhar, Gugulethu and Klapmuts), the Baseline follow up survey is the Endline survey to track any changes that the training and activities may have had in those communities by comparing Baseline and Endline survey findings.

Findings: There was an increase in reported unemployment, particularly amongst men in both controls and intervention sites, suggesting that overall poverty is worsening in the area. Compared to the Baseline survey, the respondents reported a significant decrease in the perception of the frequency of episodes of child abuse, gang violence and rape in intervention areas, which was not significant in control areas.

[1] The CSS Evaluation will be made available on the following website:
http://www.salearningnetwork.uct.ac.za/community-systems-strengthening-css-health-2016-2019

A significant increase in the following indicators was reported in the intervention areas: Households receiving at least one grant; the density of child care grants; crèche attendance among children aged less than five years; children reported to have visited a clinic/health facility within the four weeks prior to the survey; patients in care and attending in the past month for hypertension and diabetes; participation in Care Clubs for hypertension.

Indicators which remained constant included frequencies of High Blood Pressure and Diabetes; and perceptions of neighbourhoods as unsafe for children. There was a decline in receipt of food parcels in intervention areas, despite regular daily to monthly hunger. All sites, save for Belhar, reported an increase in violent robbery. Hunger experienced in the household at any point in the past month declined in both intervention and control areas, but not significantly. Hunger experienced on a daily basis rose sharply in one of the three intervention sites, but overall, there was no significant change in either daily or monthly hunger in intervention areas.

Social circumstances in all six sites remain challenging and may reflect deteriorating economic conditions. In areas targeted by the CSS intervention, limited improvements could be identified, mostly related to Child Protection, Peace Building, and chronic Illnesses while indicators related to Food and Nutrition did not show clear improvements. However, as stated, the survey does not include the perceptions of direct beneficiaries of the CSS interventions.

Based on the results from this report, programmes such as employment training and matching, increase after school activities for the youth, continue the CSS food garden project and create lifestyle improvements programmers, facilitate and support the registration of informal early childhood development centres (ECDs) should be considered by relevant government departments as well as NGOs and community based organisations to reduce poverty and inequality burden in these communities.

Background

The Community Systems Strengthening (CSS) Project is a community level intervention aimed at building the capacity of community members to address the social determinants of health regarding child protection, violence reduction (peacebuilding), food and nutrition, and chronic illnesses (health promotion). This involved extensive training and leadership development for health committee and community members in three sites in a collaboration between the University of Cape Town, Women on Farms Project, and Training for Transition. The three residential areas in the Western Cape purposively selected for CSS interventions were Belhar, Gugulethu and Klapmuts, with the support of Belhar Health Committee and Gugulethu Health Committee under the Cape Metro Health Forum, and WFP and health monitors in Klapmuts. Three socioeconomically and culturally equivalent control areas were identified in Bellville South, Lwandle, and Montana (Wolseley).

The overall aim of the CSS project is to contribute to improve governance and access to health and social services for the disadvantaged and marginalized in three pilot communities in the Western Cape by (1) community health committees and health activists actively taking part in actions to address social determinants of health and (2) strengthened coordination of services through community leadership, networks, partnerships and linkages with local government.

Over a period of three years, the project went through a training and then an implementation phase. A baseline survey assessment aiming to record the beliefs, attitudes and knowledge of community members about community health and security services to do with Child Protection, Food and Nutrition, Peace Building, and Chronic Illnesses as well as households' demographic, economic and social data was collected in 2017. This baseline assessment data served as a benchmark of the core social determinants targeted for interventions by the CSS project.

After two years of the CSS interventions, a Baseline Follow-up survey ("Endline assessment") using the same methods employed in the Baseline assessment collected in 2017 was performed. This report describes the findings related to the core social determinants targeted for intervention by the CSS project. Findings from the Endline assessment may assist in assessing impacts which may be linked to the program's training and activities implemented in the pilot communities.

Note: The Endline survey does not include direct beneficiary perceptions. Please see CSS evaluation.[2]

[2] The CSS Evaluation will be made available on the following website:
http://www.salearningnetwork.uct.ac.za/community-systems-strengthening-css-health-2016-2019

Methods

Study Design

This Follow-up survey ("Endline assessment") used the same methods employed in the Baseline assessment collected between September and November in 2017. In this report, Follow-up survey and Endline survey will be used interchangeably throughout the study.

The Endline survey data were collected between April and July 2019 to record the beliefs, attitudes and knowledge of community members about community health and security services to do with Child Protection, Food and Nutrition, Peace Building, and chronic Illnesses and to compare to the data previously collected in 2017. The field workers also collected households' demographic, economic and social data.

Study Sample

Household Survey

The Baseline surveys gather detailed cross-sectional information collected at two points in time about the living conditions of 600 random selected Households in six sites (100 households per site). Three of the sites were intervention sites for the CSS project and three were selected as controls. As previously explained in the 2017 Baseline Report[3], sites with poor health and socio-economic indicators were purposively selected for participation in the CSS project. An effort was made to 'match' sites assigned to study groups with respect to socioeconomic and demographic indicators, given the relative cultural heterogeneity within, and distinction between, residential areas that persists in the Western Cape Province. The suburbs of Belhar, Gugulethu and Klapmuts were selected to receive the intervention, with Bellville South, Lwandle, and Montana (Wolseley) serving as control sites for this CSS assessment.

Random Household Selection

The Endline survey track the same sample - all the erf (plot) sampling numbers (N=600) from the previous 2017 Baseline survey. Briefly, a random number generator was used to select the 600-Households Baseline sample in 2017. The precise location of plots represented by the random numbers, was determined with the use of aerial maps supplied by the City of Cape Town Municipality. The same list of erf numbers was used to identify respondent households for this study.

The CSS Interventions

The CSS project was planned to run from May 2016 to May 2019. However, the project was extended by seven months and ended in December 2019 to assist delivery in the implementation phase. The interventions were not implemented in the same way at the same time across the different sites. Figure 1 summarises the intervention timelines for the three sites as well as the timing of the two data collection exercises. The interventions included training, community dialogues, advocacy events, workshops, networking and knowledge sharing events and mentoring sessions.

[3] Baseline Assessment of Factors Affecting the Social Determinants of Health in Six Communities in the Western Cape Baseline, Baseline Survey Report July to December 2017.

Figure 1: Intervention Timelines Summary

Sites	Phase 1	Phase 2	Phase 3
Belhar	From May 2016 until May 2017	From End May 2017 until May 2018	From End May 2018 until December 2019
Klapmuts	From May 2016 until May 2017	From End May 2017 until May 2018	From End May 2018 until December 2019
Gugulethu	From May 2017 until May 2018	From End May 2018 until May 2019	From End May 2019 until December 2019

Survey Data Collection Timelines Summary

Baseline Assessment Survey	Collected between September and November in 2017
Endline Survey	Collected between April and July 2019

The interventions

The CSS project has trained community members and health committees; (both direct beneficiaries) in four cross-cutting themes namely food and nutrition, child protection, peacebuilding and health promotion. Within child protection, there is an emphasis on increasing knowledge of children's rights, types of abuse, child health, the need for early childhood development and community responses to child protection. Food and nutrition aim to respond to high rates of hunger and focuses on food security, developing home and community gardens while also improving knowledge on healthy living. Peace Building concentrates on violence reduction and prevention as well as developing positive behaviors and life skills with a strong commitment to youth leadership and change. Health promotion has a prevention and an awareness focus on chronic conditions such as high blood pressure and diabetes. In addition, access to the UCT Adult Education programme was also provided to 24 participants (8 per site) to develop strong community leadership skills with 17 of them graduating. Other interventions included advocacy campaigns and community dialogues, networking opportunities and community research.

Data Collection

Local community Fieldworkers who participated in the previous Baseline data collection in 2017 were approached to participate in the Endline survey data collection. There were 42 Veteran fieldworkers (who had participated in 2017) and 19 new fieldworkers in 2019. Field workers attended one of the three training sessions conducted at a location central to the three control or three intervention sites. During training workshops, the overarching goal of the research and specific objectives of the survey were explained, the questionnaire instrument was introduced, and the significance of each item explained. Survey administration was practiced using role-play. Upon conclusion of the workshop, on average 9 fieldworkers were contracted to conduct the household interviews per site, together with one Supervisor per site-elected to manage the fieldwork operation on the ground and serve as the liaison with the investigators and to perform quality assurance together with the project coordinator. While contracted to undertake 10 surveys each, for security reasons, fieldworkers were encouraged to work in pairs to complete 20 household surveys. A stipend was paid, based on the number of completed surveys returned.

The previous randomly selected Households used in the Baseline survey (N=600) were identified for the fieldworkers on the aerial maps, from which local teams divided up the Households at

their convenience. Self-identified Heads of Household at the selected plots were informed of the purpose of the study and invited to participate. Sufficient information was supplied to enable participants to decide whether to participate. Those participants willing to participate provided written informed consent. Where the Head of Household was not accessible, or could not be identified, e.g., among young adults sharing accommodation, the oldest available adult in the household was interviewed.

Erf (plots) sample numbers from previous Baseline survey which were now empty plots, and which did not represent a home where families live, or head of the household was not willing to participate in the survey were replaced with a new random Erf (plot) number within the same site. For data quality assurance purposes, 10% of Households from each site were contacted by the study coordinators and surveyed a second time.

Routine Data

Where available, routine surveillance data on health, social development and security services were obtained from local government services (e.g. number of neighbourhood crèches, employment rates). Monthly and annual crime statistics for the respective geographical areas were drawn from the South African Police Service website at www.saps.gov.za. Health and Ideal Clinic Measures were derived from the National Department of Health and Early Child Development Centre information was abstracted from records maintained by the Western Cape Department of Health.

Ethical Approval

The study was approved by the Human Research Ethics Committee of the Faculty of Health Sciences at the University of Cape Town (HREC REF 524/2017).

Data Analysis

Quantitative household survey data, collected with pencil and paper interviews, were captured in MS Excel 2016 and exported to STATA 15 for statistical analysis. Using the same data approach analysis from the 2017 Baseline survey, nominal (e.g. employment status; recent child health service utilization; exposure to violence) and ordinal (e.g. perceived safety; frequency of violence; food insecurity) variables were tabulated and distributions compared by site, and study group, using Pearson's chi-squared test of homogeneity. Ratio data (e.g. number of crèches in the community; number of household grants received) were averaged and group 4 means compared using Student’s t-tests for Study Groups and ANOVA for sites.

Results

1. Demographics

A final sample of 572 Households was surveyed; 87 from Belhar, 100 from Belville South, 92 from Gugulethu, 100 from Klapmuts, 94 from Lwandle and 99 from Montana. A total of 2488 household members were captured within the sample. Mean household size ranged from <4 (Klapmuts= 3.88) to >4 (Montana= 4.94) giving an overall mean of 4.44 inhabitants per household. Compared to 2017, when the sample realized was 594 (response rate of 99%), the 2019 sample was 572 which represented a response rate of 95%. The response rate in the intervention sites in 2019 was 93% while that in the controls was 97%, both representing a more than adequate response rate.

1.1 Gender

Although female householders' members have slightly decreased from 53.5% in 2017 Baseline survey to 52.9% in 2019, female householders' members continue to outnumber males at all sites other than Belhar. However, t-testing shows that gender distribution does not differ significantly by survey year ($Pr(|T| > |t|) = 0.6468$).

Similar to the previous Baseline survey, the greatest disparity was evident in the control group where a Female-to-Male ratio of 1:2 was observed at Lwandle. Chi-squared testing shows that gender distribution of the full sample does not differ significantly by site ($\chi2 = 4.01$, $p=0.548$). In the control areas, the percentage of females amongst household members was slightly higher than in the intervention area both at baseline (56% versus 51%) and at Endline (55% versus 51%) but these differences were not statistically significant.

Table 1.1 Gender Distribution of household members by Study Site Per Year (2017 and 2019)

	Bellville South N (%)	Lwandle N (%)	Montana N (%)	Belhar N (%)	Gugulethu N (%)	Klapmuts N (%)	Total N (%)
2017							
Males	188 (44.9)	182 (43.0)	207 (43.6)	232 (50.8)	239 (47.1)	195 (49.6)	1243 (46.5)
Females	231(55.1)	241 (57.0)	268 (56.4)	225 (49.2)	268 (58.9)	198 (50.4)	1431 (53.5)
Total	419 (100)	423 (100)	475 (100)	457 (100)	507 (100)	393 (100)	2674 (100)
N=2674 Household Members							
2019							
Male	191 (45.8)	168 (44.8)	223 (45.1)	214 (50.0)	186 (48.2)	190 (49.0)	1172 (47.1)
Female	226 (54.2)	207 (55.2)	271 (54.9)	214 (50.0)	200 (51.8)	198 (51.0)	1316 (52.9)
Total	417 (100)	375 (100)	494 (100)	428 (100)	386 (100)	388 (100)	2488 (100)
N=2488 Household Members							

More Households were headed by males (51%) in the Endline survey compared to the previous Baseline survey which had 54% of Households headed by females (Table 1.2). This increase was present both for control areas (from 47% to 50%) and in intervention areas (from 44% to 53% but was statistically significant only in the intervention area ($\chi2$ testing, $p=0.04$). Self-identification as Head of Household may have been influenced by the employment status of family members, and the time of day during which the survey was administered. Some respondents interpreted "Head of Household" to be the home owner, whereas others nominated

the oldest household member or the chief breadwinner. Single-parent Households were commonly headed by a mother. Chi-squared testing confirmed that Head of Household gender distribution differed significantly by site ($\chi 2 = 11.91$, p=0.036).

Table 1.2 Gender Distribution of Heads of Household by Study Site by Year

		Bellville South	Lwandle	Montana	Belhar	Gugulethu	Klapmuts	Total
2017								
Male	N	38	57	43	53	26	54	271 (46%)
Female	N	62	42	52	47	74	46	323 (54%)
Total	N	100	99	95	100	100	100	594 (100%)
N=594 Household Members								
2019								
Male	N	45	55	47	53	38	56	294 (51%)
Female	N	55	39	52	34	54	44	278 (49%)
Total	N	100	94	99	87	92	100	572 (100%)
N= 572 Heads of Household								

Table 1.2a Gender Distribution of Heads of Household by Intervention versus Controls by Year

	Control Group 2017	Control Group 2019	Intervention Group 2017	Intervention Group 2019
Total households (n)	294	293	300	279
Female Headed (%)	53%	50%	56%	47%
Male Headed (%)	47%	50%	44%	53%

1.2 Age

Household Members who participated in the 2017 Baseline survey ranged in age from 2 days to 95 years; while in the 2019 Endline survey, Household Members ranged in age from 1 day to 92 years.

The mean age in the 2017 Baseline survey was 31.1 yrs; compared to 32.0 yrs in the 2019 Endline survey. This small difference in mean age, an increase of about a year, was not statistically significant ($Pr(|T| > |t|) = 0.1261$). In any event, since the study was repeated more or less two years since the baseline, a one year increase in average age probably reflects an over negative difference of one year if aging is accounted for. Nevertheless, there was no statistically significant difference in overall age.

Student's t-tests ($t = -3.49$, p=0.0005) confirmed that mean age was lower among male respondents (M= 30.4 yrs) than females (F= 33.4 yrs). Significant age differences were evident in joint comparisons by gender and site (ANOVA: F= 11.67, p< .0001). Mean age in 2019 ranged from 25.7 years (Lwandle males) to 38.6 years (Bellville South females).

Table 1.3 Mean Age by Study Site and Gender: N=* Household Members

Site	Bellville South		Lwandle		Montana		Belhar		Gugulethu		Klapmuts	
Sex	M	F	M	F	M	F	M	F	M	F	M	F
2017												
Age	32.3	36.9	25.4	23.9	25.7	30.3	31.6	34.1	28.1	36.0	32.7	31.0
N	185	228	182	241	193	254	214	213	230	264	194	197
SD	21.2	21.8	18.2	16.2	19.4	21.5	21.2	21.3	20.2	22.3	20.6	20.7
*N=79 missing; M= Male; F= Female; Age= Years; N= Number of HH Members; SD= Standard Deviation												
2019												
Age	34.8	38.6	25.7	25.8	29.6	33.0	29.9	35.1	29.4	35.1	32.7	31.8
N	186	220	161	196	215	265	203	204	185	198	181	192
SD	21.4	22.1	17.8	16.0	20.6	21.7	20.0	21.4	20.3	21.3	20.4	20.0
*N=82 missing; M= Male; F= Female; Age= Years; N= Number of HH Members; SD= Standard Deviation												

About 8.6% of the sample were of pre-school age, 7.1% had reached retirement age, and for 3.3%, age was not reported. Age category distribution in households differed significantly between study groups ($\chi 2 = 97.16$, p=0.000). Males and females in the Bellville South control site were slightly older than the intervention site, Belhar, while males and females in the Gugulethu and Klapmuts sites were slightly older than the control sites, Lwandle and Montana, respectively. This pattern was the same in 2017 and in 2019, save that females in Montana in 2019 were older than females in the intervention site, Klapmuts.

Table 1.4 Age Category by Study Group: N=2674 Household Members

	Control		Intervention		Total	
	N	%	N	%	N	%
2017						
0 - 5 years	138	(10.5)	137	(10.1)	275	(10.3)
6 - 12 years	192	(14.6)	163	(12.0)	355	(13.3)
13 - 19 years	191	(14.5)	135	(9.9)	326	(12.2)
20 - 39 years	361	(27.4)	393	(29.0)	754	(28.2)
40 - 64 years	314	(23.8)	391	(28.8)	705	(26.4)
65 + years	83	(6.3)	97	(7.1)	180	(6.7)
Unknown	38	(2.9)	41	(3.0)	79	(3.0)
Total	1317	(100)	1357	(100)	2674	(100)
2019						
0 - 5 years	109	(8.5)	104	(8.6)	213	(8.6)
6 - 12 years	157	(12.2)	136	(11.3)	293	(11.8)
13 - 19 years	174	(13.5)	130	(10.8)	304	(12.2)
20 - 39 years	365	(28.4)	381	(31.7)	746	(30.0)
40 - 64 years	344	(26.7)	329	(27.4)	673	(27.0)
65 + years	94	(7.3)	83	(6.9)	177	(7.1)
Unknown	43	(3.3)	39	(3.2)	82	(3.3)
Total	1286	(100)	1202	(100)	2488	(100)

N= Number of Household Members; %= within Study Group (column)

Among Heads of Household, mean age was 53.3 in the 2017 Baseline survey; while in the 2019 Endline survey mean age was 53.6 years. As might be expected, the overwhelming majority of

Heads of Household were adults of work-eligible age (65 years or less). Age category distribution among Heads of Household was similar in both surveys (Pr(|T| > |t|) = 0.6602).

Comparability of the 2017 and 2019 samples

The age and gender demographics data comparisons between the 2017 and 2019 samples displayed above, confirms that there are no substantial differences in the samples between 2017 and 2019. Both controls and intervention areas experienced a slight increase in male-headed households from 2017 to 2019 but the size of this shift was small. The overall age and gender similarities suggest that any changes in outcome (e.g. beliefs, attitudes and knowledge of community members about community health and security services) data reflect true changes in the outcomes rather be a result of changes in the demographics (e.g. age and gender) of the sample.

2. Income

2.1. Employment

In 2019, a total of N=571 people (Males=272; Females= 299) were reportedly employed – defined as an individual who is currently working, representing 35.4% of the 1611 household members known to be between 16-65 years of age. Compared to the previous survey, the number of household members who reportedly being employed decreased by 2.8 percentage point ($\chi 2$ = 1.018, p=0.3129). The decline was evident exclusively in males where the percentage employed fell from 42% to 36% ($\chi 2$ testing, p=0.02), while in females, the employment percentage remained stable at 35%.

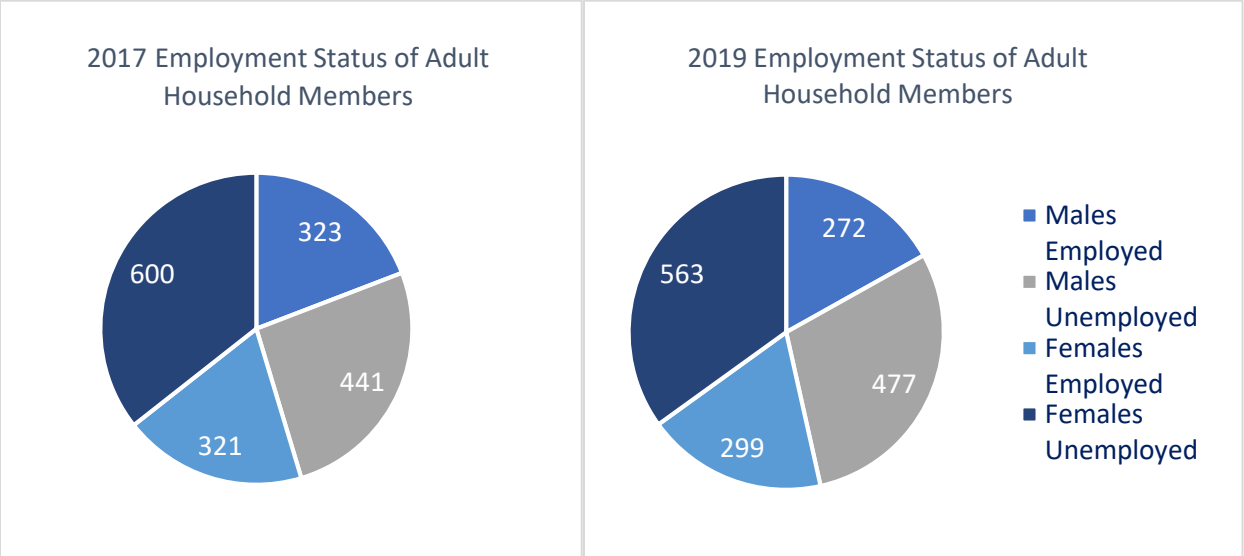

Figure 2.1 Employment by Gender: N=1685 Adult Household Members in 2017; N=1611 Adult Household Members in 2019

Employment status differed significantly by site in 2019 ($\chi 2$= 48.62 p<0.000). Lwandle (48.7%) and Belhar (42.8%) had the highest proportion of employed persons among eligible household members. At 76.6%, unemployment was greatest in Gugulethu.

Compared to the previous Baseline survey, Bellville South, Montana, Belhar and Gugulethu experienced a decrease in employment; while there was an increase in employment in Klapmuts,

and Lwandle. Overall, reported unemployment was slightly higher in 2019 compared to 2017 in both intervention (from 63% in 2017 to 65% in 2019) and control sites (61% in 2017 to 64% in 2019), although these changes were not statistically significant.

Table 2.1 Employment Status by Study Site

		Control Group			Intervention Group			
		Bellville South	Lwandle	Montana	Belhar	Gugulethu	Klapmuts	Total
2017 (N=1685)								
Employed	N	122	100	97	129	102	94	644
	%	43.9	38.8	35.4	44.0	31.5	36.4	38.2
Unemployed	N	156	158	177	164	222	164	1041
	%	56.1	61.2	64.6	56	68.5	63.6	61.8
Total	N	278	258	274	293	324	258	1685
	%	100	100	100	100	100	100	100
2019 (N=1611)								
Employed	N	95	111	89	116	61	99	571
	%	33.8	48.7	28.4	42.8	23.4	38.5	35.4
Unemployed	N	186	117	224	155	200	158	1040
	%	66.2	51.3	71.6	57.2	76.6	61.5	64.6
Total	N	281	228	313	271	261	257	1611
	%	100	100	100	100	100	100	100

N= Number of Adults; % = within Site (column)

2.3. Grants

The proportion of Households receiving one or more grant differed by site and grant type (Table 2). There was wide variation between sites in the number of Households at each site receiving at least one grant and in the distribution of different types of grants, both in 2017 and in 2019. Grant support was more likely to be reported by female-headed Households (77.0%) than male-headed Households (59.2%).

Table 2.2 Household Grant Support by Type and Study Site: N varies by Grant Type

		Control Group			Intervention Group			Total
		Bellville South	Lwandle	Montana	Belhar	Gugulethu	Klapmuts	Household
2017								
Child Support	N	24	58	56	21	43	42	244
% within type		9.8	23.8	22.9	8.6	17.6	17.2	35.1
Old Age Pension	N	42	11	31	39	41	27	191
% within type		22.0	5.8	16.2	20.4	21.5	14.1	27.4
Disability	N	10	5	13	5	11	10	54
% within type		18.5	9.3	24.1	9.3	20.4	18.5	7.8
Maintenance	N	0	1	2	0	2	1	6
% within type		0	16.7	33.3	0	33.3	16.7	0.9
Other Grants	N	1	0	2	1	3	3	10
% within type		10	0	20	10	30	30	1.4
No Grants	N	39	34	12	47	31	28	191
% within type		20.4	17.8	6.3	24.6	16.2	14.7	27.4
Total Household grant								696 (100%)

		Control Group			Intervention Group			Total
		Bellville South	Lwandle	Montana	Belhar	Gugulethu	Klapmuts	Household
2019								
Child Support	N	28	55	57	22	34	31	227
% within type		12.3	24.2	25.1	9.7	15	13.7	33.2
Old Age Pension	N	46	11	39	29	38	30	193
% within type		23.8	5.7	20.2	15	19.7	15.5	28.3
Disability	N	11	2	18	10	10	9	60
% within type		18.3	3.3	30	16.7	16.7	15	8.8
Maintenance	N	0	0	6	0	0	7	13
% within type		0	0	46.1	0	0	53.8	1.9
Other Grants	N	1	2	1	4	2	0	10
% within type		10	20	10	40	20	0	1.5
No Grants	N	33	34	19	33	29	32	26.4
% within type		18.3	19	10.6	18.3	16.1	17.8	100
Total Household grant								683 (100%)

N= Number of Households/% within Site; % within Type= % of the awarded Grants of this Type (row); Note: a) Some Households received >1 Grant Type; b) Some HH received >1 awards of the same Grant Type

Tables 2.2 and 2.2a show that the proportion of households where a grant (of any sort) was received was high both in the control and the intervention sites. In the control sites this remained at 71% of households in 2017 and 2019; in the intervention areas, it rose significantly from 65% in 2017 to 69% in 2019 ($\chi 2$ testing; p=0.001).

The child support grant was the most commonly reported grant in both intervention and control sites. Of note is that the number of child support grants expressed as a proportion of all households remained more or less constant in the control sites (47% in 2017 and 48% in 2019) but rose substantially by about a third (from 35% in 2017 to 48% in 2019; $\chi 2$ testing; p=0.01) in the intervention sites (based on an absolute increase of 28 more child support grants reported in 2019 compared to 2017). Overall, the percentage that child support grants comprised of all grants rose in the intervention areas from 43% in 2017 to 52% in 2019 but declined in the controls from 54% to 43% in 2019.

There was also a small increase in reported disability grants in the intervention area (from 9% to 12%) whereas the disability grants as a percentage of households was more or less static in the control sites (10% in 2017 and 11% in 2019). Conversely, pension grants declined in the intervention areas as a percentage of households (36% in 2017 to 31% in 2019), partly as a result of the increase in other grants, particularly, the child care grant, but rose in the control areas (29% to 33%). These changes were, however, not statistically significant.

The finding that more households in the intervention sites were in receipt of some form of a grant by 2019 (65% in 2017 to 69% in 2019) but remained static in the control areas (71% in both 2017 and 2019), suggests a greater spread of social security in intervention areas in 2019 and that the intervention areas were more similar in the density of grants being received by the end

of the intervention (69% in intervention and 71% in controls) than compared to the start of the period (65% in intervention and 71% in controls).

Table 2.2a Household receipt of grants by intervention versus control: Comparing 2017 to 2019

	Control Group 2017	Control Group 2019	Intervention Group 2017	Intervention Group 2019
Number of households	294	293	300	279
Child Support*	138 (47%)	140 (48%)	106 (35%)	134 (48%)
Old Age Pension*	84 (29%)	96 (33%)	107 (36%)	79 (31%)
Disability*	28 (10%)	31 (11%)	26 (9%)	30 (12%)
Maintenance*	3 (1%)	6 (2%)	3 (1%)	6 (2%)
Other Grants*	3 (1%)	4 (1%)	7 (2%)	7 (3%)
Total grants*	256	277	249	256
Total households in receipt of any grant (n)	171 (71%)	191 (71%)	143 (65%)	170 (69%)
Total Households with No Grants (n)	85 (29%)	86 (29%)	106 (35%)	86 (31%)
Total grants to total household ratio	0.87	0.95	0.83	0.92
Child support as proportion of all grants	54%	43%	35%	52%

In 2017, female-headed Households were significantly more likely to derive income from both grants and employment (49%), followed by grants alone (27%), whereas in 2019, female-headed Households derive income from grants alone (42%) ($\chi2= 4.873$, $P= 0.0273$), followed by grants and employment (35%) ($\chi2= 4.781$, $P= 0.0288$). On the other hand, in both surveys, male-headed Households were more likely to rely on both grants and employment, followed by employment alone.

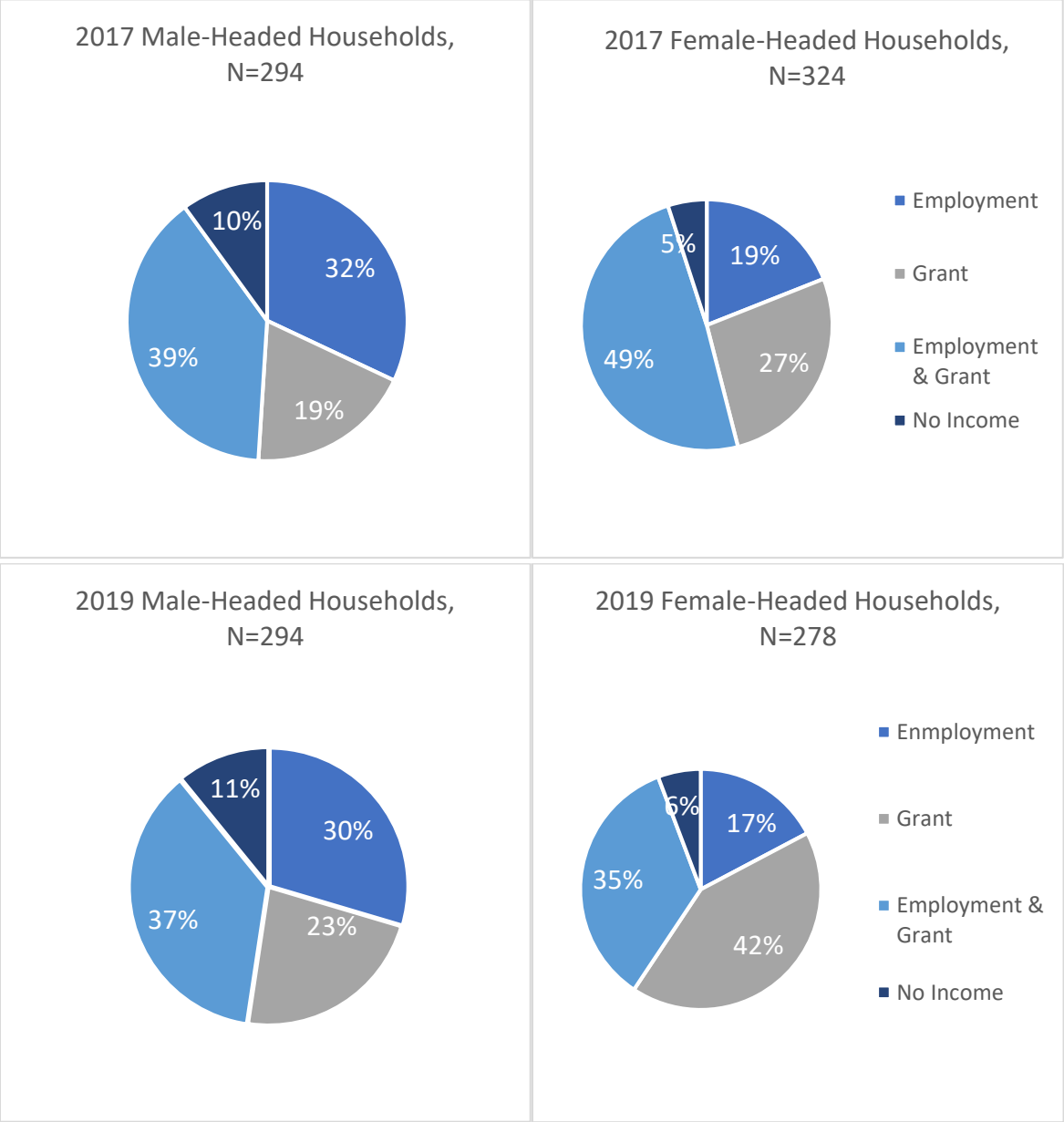

Figure 2.2 Sources of Household Income, by Head-of-Household Gender: 2017 N=594 Households; 2019 N=572 Households

3. Child Protection

3.1. Crèche Attendance and Availability

Crèche attendance among children aged 5 years or younger varied between surveys. It increased from 32.6% to 33.9% for the control group ($\chi 2$ =0.046, p= 0.8297), while in the intervention group the increase from 35.0% to 38.5% was more than double that of controls. However, this difference was not statistically significant ($\chi 2$ =0.311, p=0.5770).

There was a considerable difference between study sites with 55.3% attendance in Lwandle, versus just 16.7% in Bellville South (p<.0001). Compared to previous survey, only Belhar ($\chi 2$ =8.731, p=0.0031) had a significant increase in crèche attendance.

Table 3.1. Crèche Attendance (Children Aged <6 years)

Crèche Attendance by Control and Intervention Groups (Children Aged <6 years)

		Control Group		Intervention Group	
		2017	**2019**	**2017**	**2019**
Yes	N	45	37	48	40
	%	32.6	33.9	35.0	38.5
No	N	44	72	40	64
	%	31.9	66.1	29.2	61.5
Unknown	N	49	-	49	-
	%	35.5	-	35.8	-
Total	N	138	109	137	104
	%	100	100	100	100

Crèche Attendance by Study Site (Children Aged <6 years)

2017 (N=275)

		Bellville South	Lwandle	Montana	Belhar	Gugulethu	Klapmuts	Total
Yes	N	6	32	7	7	29	12	93
	%	18.2	59.3	13.7	14.0	59.2	31.6	33.8
No	N	21	12	11	19	5	16	84
	%	63.6	22.2	21.6	38.0	10.2	42.1	30.5
Unknown	N	6	10	33	24	15	10	98
	%	18.2	18.5	64.7	48.0	30.6	26.3	35.6
Total	N	33	54	51	50	49	38	275
	%	100	100	100	100	100	100	100

2019 (N=213)

		Bellville South	Lwandle	Montana	Belhar	Gugulethu	Klapmuts	Total
Yes	N	4	21	12	16	17	7	77
	%	16.7	55.3	25.5	42.1	41.5	28.0	36.1
No	N	20	17	35	22	24	18	136
	%	83.3	44.7	74.5	57.9	58.5	72	63.8
Total	N	24	38	47	38	41	25	213
	%	100	100	100	100	100	100	100

N= Number of Children; % = within Site (column). Note: The N is much lower than the number of households since not all the households had children under 6 years old.

When asked about the availability of neighbourhood day-care facilities for preschool children, 87.4% of household heads (N=500) were able to provide an estimate of the number of crèches in their communities. Mean estimates were consistent for the two study groups between the two survey years. For instance, in 2017 the estimates of available neighbourhood crèches for the control group was 2.96; while in 2019 the mean was 2.93 (Pr (|T| > |t|) = 0.8186). For the intervention group, in 2017 the mean number of neighbourhood crèches reported as available was 3.03 while it decreased slightly to 2.90 in 2019 (Pr (|T| > |t|) = 0.5493).

3.2. Child Health-Care Utilisation

For the N=762 children aged between 1 and 18 years identified in the sample households, clinic attendance within or beyond the past 4 weeks was assessed, together with precipitating indications and outcomes. When compared to the previous Baseline survey, the proportion of all children (between 1 and 18 years) who visited a clinic/health facility within the 4 weeks prior to the survey has significantly increased from 27% to 41% ($\chi 2 = 9.581$, $p=0.002$). For children 5 years of age or younger, visiting a clinic/health facility within 4 weeks prior to the survey remained the same (60%).

Similar to the previous Baseline survey, at all sites, recent health facility attendance was highest among children in the birth to 5-year age category (59.6%), followed by the 6 to 12-year age category (38.5%) and 13 to 18-year age category (6.8%). A high proportion of these visits were routine baby clinic visits for immunization, growth monitoring and general early infant care services. Aside from these, across all three age categories, the most common reasons for clinic attendance in descending order were colds, flu, fever, diarrhea or stomach ache and deworming.

For the 58.5% of the children in the sample who had not visited a health facility or provider within the prior 4 weeks, an estimate of the time since their last visit was obtained. Children visiting within the preceding year (>1 to ≤ 12 months prior) significantly increased from 7.4% to 14.6% across both control and intervention groups ($\chi 2 = 4.128$, $p=0.0422$). The most common reasons for seeking care were immunization, vaccines and check-ups, flu, cold and fever, skin rashes or eczema and Tonsillitis. This increase in visiting between the two surveys might be explained by the difference in the months which the data collection took place (2017 data was collected between September and November while 2019 data was collected between April and July 2019 – e.g. data collection during the flu season).

3.3. Neighbourhood Safety for Children

The perception of safety for children has not changed substantially from the previous Baseline survey. Most Heads of Household continue to view their residential neighbourhood as unsafe or very unsafe for children (Table 3.3a). This has not changed for both controls (57%) and intervention (60%) in both sites across 2017 and 2019.

Assaults and violence continue to be an issue in the communities. Almost 74% reported that assaults and violence were a problem, big or very big problem, particularly among adolescents compared to 75% from the previous Baseline survey. However, this perception declined slightly in the intervention sites (73% to 69%) while it remained unchanged in control sites (80% and 79%) from 2017 to 2019. The perception of adolescent fighting as a problem or worse declined from 73% in the intervention sites in 2017 to 69% in 2019 while it went up in the control sites from 72% to 77%. While most of these changes were not statistically significant, except for the modest increase in the perception of adolescent fighting as a problem or worse in control sites ($p<0.001$), they were consistent with the study logic model.

However, awareness of services in the community to combat violence, both overall and when stratified by intervention versus control, did not appear to change for the better in intervention

sites from 2017 to 2019. Overall awareness decreased from 48.8% in the previous survey to 45.6% ($\chi 2$= 1.194, P=0.2745), and also declined in both intervention (57% to 55%) and control groups (40% to 36%), respectively, but neither of these changes were statistically significant. However, for awareness of school-based programmes, knowledge declined (not significantly) in the intervention sites (21% to 17%) but remained the same in control sites (21% and 22% in 2017 and 2019, respectively).

This suggests that either no additional services to combat violence have been implemented in the communities or that awareness of such services has not been sufficiently prioritised. For instance, 80.1% of the Households were not aware of school programs in the community to combat violence. Perceived neighbourhood safety differed significantly by site ($\chi 2$= 57.63, p<0.0001) with highest perceptions of low safety (unsafe and very unsafe) being reported in Klapmuts and Montana, the rural intervention and control sites.

Table 3.3 Child and Adolescent Neighbourhood Safety

	Control Group			Intervention Group			
	Bellville South N	Lwandle N	Montana N	Belhar N	Gugulethu N	Klapmuts N	Total N (%)
Safety for Children 2017							
Very Safe	5	10	2	7	12	2	38 (6.4)
Safe	41	46	23	41	32	25	208 (35)
Unsafe	31	38	52	27	28	50	226 (38.1)
Very Unsafe	23	5	18	25	28	23	122 (20.5)
Total	100	99	95	100	100	100	594 (100)
2019							
Very Safe	9	8	4	11	14	4	50 (8.74)
Safe	37	46	21	23	35	23	185 (32.3)
Unsafe	41	26	40	27	25	46	205 (35.8)
Very Unsafe	13	14	35	24	18	27	131 (22.9)
Unsure	-	-	-	1	-	-	1 (0.2)
Total	100	94	100	86	92	100	572 (100)
Assaults/Violence 2017							
Not a problem	8	18	1	15	25	11	78 (13.1)
A small problem	10	12	11	18	21	7	79 (13.3)
A problem	35	23	19	16	8	15	116 (19.5)
A big problem	22	26	26	22	8	32	136 (22.9)
A very big problem	25	20	38	29	38	35	185 (31.2)
Total	100	99	95	100	100	100	594 (100)
Assaults/Violence 2019							
Not a problem	23	7	0	18	14	16	78 (13.6)
A small problem	15	13	5	16	17	6	72 (12.6)
A problem	27	23	26	14	17	20	127 (22.2)
A big problem	20	16	28	8	11	29	112 (19.6)
A very big problem	15	35	41	30	33	29	183 (32.0)
Total	100	94	100	86	92	100	572 (100)

	Control Group			Intervention Group			
	Bellville South N	Lwandle N	Montana N	Belhar N	Gugulethu N	Klapmuts N	Total N (%)
Adolescents Fighting Violently							
2017							
Not a problem	21	24	1	30	33	14	123 (20.7)
A small problem	14	12	9	12	6	6	59 (9.9)
A problem	23	19	19	9	6	13	89 (15.0)
A big problem	18	19	26	15	10	36	124 (20.9)
A very big problem	24	25	40	34	45	31	199 (33.5)
Total	100	99	95	100	100	100	594 (100)
2019							
Not a problem	34	6	2	28	18	18	106 (18.6)
A small problem	9	12	5	13	14	8	61 (10.7)
A problem	22	26	27	8	15	16	114 (20)
A big problem	20	19	30	13	11	25	118 (20.7)
A very big problem	15	31	36	22	34	33	171 (30.0)
Total	100	94	100	84	92	100	570 (100)
Services to Address Violence							
2017							
Yes	62	67	40	25	64	32	290 (48.8)
No	38	32	55	75	36	68	304 (51.2)
Total	100	99	95	100	100	100	594 (100)
2019							
Yes	49	75	37	27	48	24	260 (45.6)
No	51	17	63	59	44	76	310 (54.4)
Total	100	92	100	86	92	100	570 (100)
School Programmes to Address Violence							
2017							
Yes	20	10	32	14	24	24	124 (20.9)
No	78	84	62	81	74	72	451 (75.9)
Unsure	2	5	1	5	2	4	19 (3.2)
Total	100	99	95	100	100	100	594 (100)
2019							
Yes	20	6	39	16	22	8	111 (19.5)
No	80	85	61	69	69	91	455 (80.11)
Unsure	0	0	0	1	0	1	2 (0.35)
Total	100	91	100	86	91	100	568 (100)

N= Number of Heads of Household; % = within Site (column).

Table 3.3a Child and Adolescent Neighbourhood Safety: by intervention versus control: Comparing 2017 to 2019

	Controls 2017	Controls 2019	Intervention 2017	Interventions 2019
Households (n)	294	294	300	278
Safety for children ranked unsafe or more	57%	57%	60%	60%
Assaults/violence ranked problem or worse	80%	79%	73%	69%
Adolescents fighting ranked problem or worse	72%	77%	72%	64%
Know of programmes to address violence (yes)	57%	55%	40%	36%
Know of school programmes (yes)	21%	22%	21%	17%

3.4. Measures to Improve Neighbourhood Safety for Children

Safe space and more programmes for children were the most frequent suggestions for improving neighbourhood safety offered by survey respondents; followed by increased police visibility and patrols such as a Neighbourhood Watch, parents' responsibilities to protect, educate and watch their children and speedbumps.

Compared to the previous Baseline survey, it seems that not much had changed to improve neighbourhood safety for children. Respondents from both control and intervention groups continue to suggest the development of parks, youth centres with recreational programmes and after school activities and an increase in police visibility and Neighborhood Watch to improve safety in the community.

Different from the previous survey was the suggestion from both control and intervention respondents that improving neighborhood safety for children was related to parents' responsibilities (care). According to the respondents, parents should keep their children indoor and not allow them alone on the streets. In the case where children want to play outside or in the playground, respondents answered that parents must supervise their children and never leaving them alone.

4 Violence Reduction

4.1. Personal Experience of Crime/ Safety

Heads of Household were asked about their own exposure to and direct experience as victims of crime and violence over the prior 12 months. Specifically, they were asked to indicate whether they had a) been mugged or had property taken from them with actual or threatened violence in their home or on the street (violent robbery), b) had their homes broken into but not come into contact with the perpetrator (home burglary), c) lost someone close to them as a result of murder (murder of friend/ relative), d) been purposefully injured with a weapon such as a gun or knife (injury with weapon), e) experienced any form of violence in their home (domestic violence), and f) been the victim of violence on the basis of their gender, sexual orientation, race or nationality (bigotry).

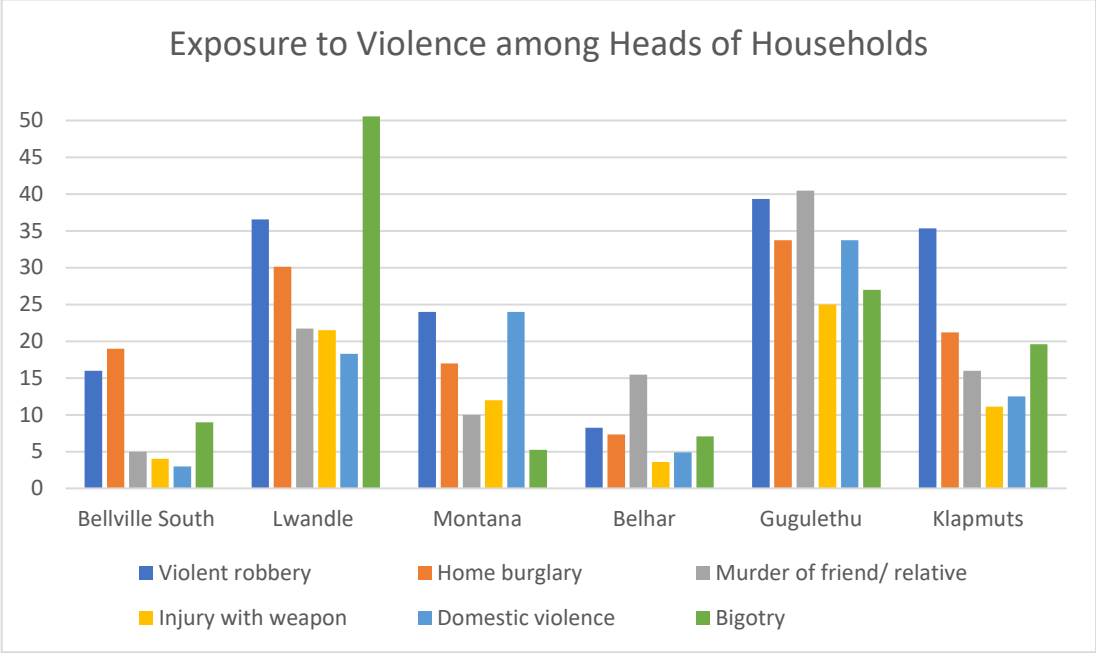

Figure 4.1 Percent of Heads of Household with Exposure to Violence, by Site and Category

Similar to the previous Baseline survey, overall, Gugulethu, Lwandle and Klapmuts consistently reported more violence than the other three sites. These differences between sites were significant with respect to violent robbery ($\chi2= 36.70$ $p<0.000$), home burglary ($\chi2= 23.30$ $p<0.000$) murder of a relative or close friend ($\chi2= 48.28$ $p<0.000$), injury with a weapon ($\chi2= 31.60$ $p<0.000$), domestic violence ($\chi2= 46.71$ $p<0.000$) and acts of bigotry ($\chi2= 87.29$ $p=0.001$).

Violence is still a major problem among all sites. Compared with the previous Baseline survey, there was an increase in reports of violent robbery affecting the Head of Household in all sites, except for Belhar. Gugulethu experienced an increase in murder of friend/relative; while the other sites remaining the same or had a slight decrease in murder of friend/relative.

Reports of injury with weapons continued more or less unchanged in Montana and Klapmuts; while a decrease was reported in Bellville South, Belhar, Gugulethu. Lwandles' was the only site which has experienced an increase in injury with weapons. For domestic violence, Bellville South, Lwandle and Belhar experienced a decrease, while Montana and Gugulethu had an increase in domestic violence and Klapmuts remained the same. Except for Lwandle, there was a decrease in bigotry for all other sites.

4.2. Neighbourhood Crime

Frequent violent crime and abuse was reported for all sites. Compared to 2017, there was an increase from 44% to 54% in reported child-abuse on a daily basis in Montana ($\chi2 = 1.939$, $p= 0.1637$); while there was a significantly decrease from 35% to 21% in Klapmuts ($\chi2 = 4.837$, $p= 0.0279$). Daily occurrences of gang violence were reported from more than 40% of the Households in Lwandle and Montana. Montana had a significantly increase in Heads of Household who believed rape to be a daily occurrence, from 6.3% in the previous survey to 34% ($\chi2 = 22.815$, $p<0.0001$).

Table 4.2 Neighbourhood Crime and Violence

	Bellville South N	Lwandle N	Montana N	Belhar N	Gugulethu N	Klapmuts N	Total N (%)
Violence Between Family/Friends							
2017							
Every Day	5 (5.0)	2 (2.0)	21 (22.1)	5 (5.0)	9 (9.0)	12 (12.0)	54 (9.1)
Every Week	4 (4.0)	6 (6.1)	15 (15.8)	6 (6.0)	10 (10.0)	20 (20.0)	61 (10.3)
Every Month	14 (14.0)	5 (5.1)	17 (17.9)	7 (7.0)	14 (14.0)	15 (15.0)	72 (12.1)
Once or Twice a Year	17 (17.0)	15 (15.2)	24 (25.3)	19 (19.0)	15 (15.0)	14 (14.0)	104 (17.5)
Never	59 (59.0)	70 (70.7)	16 (16.8)	61 (61.0)	50 (50.0)	39 (39.0)	295 (49.7)
No Response	1 (1.0)	1 (1.0)	2 (2.1)	2 (2.0)	2 (2.0)	0	8 (1.3)
Total	100 (100)	99 (100)	95(100)	100 (100)	100 (100)	100 (100)	594 (100)
2019							
Every Day	4 (4.0)	2 (2.1)	15 (15.0)	4 (4.6)	9 (9.8)	6 (6.0)	40 (7.0)
Every Week	12 (12.0)	6 (6.4)	15 (15.0)	6 (7.0)	9 (9.8)	14 (14.0)	62 (10.8)
Every Month	4 (4.0)	6 (6.4)	15 (15.0)	6 (7.0)	14 (15.2)	14 (14.0)	59 (10.3)
Once or Twice a Year	16 (16.0)	24 (23.5)	16 (16.0)	14 (16.3)	31 (33.7)	21 (21.0)	122 (21.3)
Never	64 (64.0)	56 (59.6)	39 (39.0)	56 (65.1)	28 (30.4)	45 (45.0)	288 (50.3)
No Response	0	0	0	0	1 (1.0)	0	1 (0.2)
Total	100 (100)	94 (100)	100 (100)	86 (100)	92 (100)	100 (100)	572 (100)
Gang Violence							
2017							
Every Day	6 (6.0)	22 (22.2)	23 (24.2)	14 (14.0)	20 (20.0)	21 (21.0)	106 (17.8)
Every Week	9 (9.0)	26 (26.3)	10 (10.5)	15 (15.0)	12 (12.0)	24 (24.0)	96 (16.2)
Every Month	16 (16.0)	16 (16.2)	16 (16.8)	9 (9.0)	23 (23.0)	19 (19.0)	99 (16.7)
Once or Twice a Year	19 (19.0)	17 (17.2)	39 (41.0)	11 (11.0)	12 (12.0)	9 (9.0)	107 (18.0)
Never	49 (49.0)	15 (15.1)	5 (5.2)	50 (50.0)	31 (31.0)	27 (27.0)	177 (29.8)
No Response	1 (1.0)	3 (3.0)	2 (2.1)	1 (1.0)	2 (2.0)	0	9 (1.5)
Total	100 (100)	99 (100)	95 (100)	100 (100)	100 (100)	100 (100)	594 (100)
2019							
Every Day	5 (5.0)	40 (42.5)	42 (42.0)	7 (8.1)	16 (17.4)	19 (19.0)	129 (22.5)
Every Week	14 (14.0)	12 (12.8)	25 (25.0)	6 (7.0)	14 (15.2)	19 (19.0)	90 (15.7)
Every Month	10 (10.0)	18 (19.1)	16 (16.0)	10 (11.6)	17 (18.5)	17 (17.0)	88 (15.4)
Once or Twice a Year	15 (15.0)	5 (5.3)	9 (9.0)	10 (11.6)	22 (23.9)	13 (13.0)	74 (13.0)
Never	56 (56.0)	18 (19.1)	8 (8.0)	51 (59.3)	22 (23.9)	32 (32.0)	187 (32.7)
No Response	0	1(1.1)	0	2 (2.3)	1 (1.1)	0	4 (0.5)
Total	100 (100)	94 (100)	100 (100)	86 (100)	92 (100)	100 (100)	572 (100)
Child Abuse/Neglect							
2017							
Every Day	15 (15.0)	15 (15.1)	42 (44.2)	14 (14.0)	18 (18.0)	35 (35.0)	139 (23.4)
Every Week	6 (6.0)	15 (15.1)	13 (13.7)	2 (2.0)	11 (11.0)	8 (8.0)	55 (9.3)
Every Month	2 (2.0)	17 (17.2)	19 (20.0)	4 (4.0)	10 (10.0)	9 (9.0)	61 (10.3)
Once or Twice a Year	5 (5.0)	16 (16.2)	10 (10.5)	5 (5.0)	10 (10.0)	8 (8.0)	54 (9.1)
Never	71 (71.0)	36 (36.4)	9 (9.5)	74 (74.0)	49 (49.0)	40 (40.0)	279 (47.0)
No Response	1 (1.0)	0	2 (2.1)	1 (1.0)	2 (2.0)	0	6 (1.0)
Total	100 (100)	99 (100)	95 (100)	100 (100)	100 (100)	100 (100)	594 (100)
2019							
Every Day	10 (10.0)	4 (4.3)	54 (54.0)	15 (17.4)	12 (13.0)	21 (21.0)	116 (20.3)
Every Week	2 (2.0)	4 (4.3)	16 (16.0)	2 (2.3)	6 (6.5)	5 (5.0)	35 (6.1)
Every Month	7 (7.0)	14 (14.9)	11 (11.0)	3 (3.5)	9 (9.8)	5 (5.0)	49 (8.6)
Once or Twice a Year	4 (4.0)	25 (26.6)	8 (8.0)	7 (8.1)	25 (27.2)	3 (3.0)	72 (12.6)
Never	77 (77.0)	47 (50.0)	11 (11.0)	58 (67.4)	39 (42.4)	65 (65.0)	297 (51.9)
No Response	0	0	0	1 (1.2)	1 (1.2)	1 (1.0)	3 (0.5)
Total	100 (100)	94 (100)	100 (100)	86 (15.0)	92 (100)	100 (100)	572 (100)

	Bellville South N	Lwandle N	Montana N	Belhar N	Gugulethu N	Klapmuts N	Total N (%)
Rape/Sexual Assault							
2017							
Every Day	2 (2.0)	4 (4.0)	6 (6.3)	2 (2.0)	13 (13.0)	11 (11.0)	38 (6.4)
Every Week	1 (1.0)	11 (11.1)	8 (8.4)	0	8 (8.0)	8 (8.0)	36 (6.1)
Every Month	4 (4.0)	24 (24.2)	27 (28.4)	1 (1.0)	7 (7.0)	10 (10.0)	73 (12.3)
Once or Twice a Year	8 (8.0)	11 (11.1)	33 (34.7)	6 (6.0)	10 (10.0)	18 (18.0)	86 (14.5)
Never	84 (84.0)	49 (49.5)	19 (20.0)	88 (88.0)	60 (60.0)	53 (53.0)	353 (59.4)
No Response	1 (1.0)	0	2 (2.1)	3 (3.0)	2 (2.0)	0	8 (1.3)
Total	100 (100)	99 (100)	95 (100)	100 (100)	100 (100)	100 (100)	594 (100)
2019							
Every Day	0	2 (2.1)	34 (34.0)	2 (2.3)	5 (5.4)	5 (5.0)	48 (8.4)
Every Week	2 (2.0)	5 (5.3)	4 (4.0)	0	3 (3.3)	4 (4.0)	18 (3.1)
Every Month	2 (2.0)	6 (6.4)	14 (14.0)	1 (1.2)	8 (8.7)	3 (3.0)	34 (5.94)
Once or Twice a Year	9 (9.0)	30 (31.9)	29 (29.0)	5 (5.8)	30 (32.6)	10 (10.0)	113 (19.8)
Never	87 (87.0)	51 (54.3)	19 (19.0)	78 (90.7)	45 (48.9)	75 (75.0)	355 (62.1)
No Response	0	0	0	0	1 (1.1)	3 (3.0)	4 (0.7)
Total	100 (100)	94 (100)	100 (100)	86 (100)	92 (16.1)	100 (100)	572 (100)

N= Number of Heads of Household; % = within Site (column).

Overall, perceptions of the frequency of neighbourhood crime and violence declined in intervention sites for all measures of violence (Table 4.2a). In particular, perceptions of child abuse episodes being weekly or more often declined about 26% in intervention sites ($p=0.04$), perceptions of rape/sexual assault being weekly or more often declined about 50% ($p=0.04$) and perceptions of gang violence or more often declined about 20% ($p<0.001$). In contrast, perceptions of the frequency of neighbourhood crime and violence being weekly or more frequent either rose in the control sites (gang violence rose 42%; $p<0.001$ and rape rose 45%; $p=0.07$) or remained static (family violence stayed at 18%). It was only perceptions of the frequency of child abuse that declined in control areas, but even then, the decline was much more modest (9%; $p=0.2$) than that found in intervention areas (26%; $p=0.04$).

Table 4.2a Perceptions of Neighbourhood crime and violence by intervention versus control: Comparing 2017 to 2019

	Controls 2017	Controls 2019	Intervention 2017	Interventions 2019
Violence between family/friends weekly or more often	18% (n=290)	18% (n=294)	21% (n=296)	18% (n=267)
Gang violence weekly or more often	33% (n=288)	47% (n=293)	36% (n=297)	29% (n=275)
Child abuse/neglect episodes weekly or more often	36% (n=291)	32% (n=284)	30% (n=297)	22% (n=275)
Rape/sexual assault weekly or more often	11% (n=280)	16% (n=294)	14% (n=295)	7% (n=274)

4.3. Awareness of Violence Reduction Services

Similar to the previous Baseline survey, the most frequently cited violence reduction service was SAPS, routinely accompanied with the comment that they were often unresponsive and a need to increase their visibility in the community, especially in Montana. The local Neighbourhood Watch was commonly cited next, especially in Belhar and Klapmuts respectively.

4.4 Measures to Reduce Crime

All areas reported measures needed in the community to reduce crime. Increased visibility and responsiveness of the police was the most common measure reported as needed to address crime. Tougher sentencing for criminal activity was reported as a necessary deterrent, followed by a need for community engagement through working together to address communities' problems, specifically in Klapmuts and Montana. It was suggested that the community unite against crime by creating street committees, establishing Neighborhood Watches and partnerships between police and communities.

Respondents also communicated a need for an increase in employment opportunities, specifically in Lwandle, and education, specifically in Belhar. The respondents also emphasized a need for activities to protect and occupy the youth in order provide them with potential upward mobility and alternatives to criminal activity.

5. Food and Nutrition

Overall, 26% of Households in 2019 reported that members had insufficient food at some time during every month compared to 30% from the previous survey. This decline was present in both control and intervention areas, but the change was not statistically significant. Hunger in the past month was reported more commonly in 2019 in the intervention areas (30% of households) when compared to the controls (23%) but the difference was not statistically significant ($\chi 2$ testing; p=0.07). There was a bigger difference in 2017 where 34% of intervention households reported monthly hunger while the equivalent was 25% of control households, a difference that was statistically significant ($\chi 2$ testing; p=0.02). The decline in the percentage of monthly hunger in the intervention areas from 34% in 2017 to 30% in 2019 was not statistically significant ($\chi 2$ testing; p=0.2).

Table 5.1a Household Hunger by intervention versus control: Comparing 2017 to 2019

	Control 2017	Control 2019	Intervention 2017	Intervention 2019
Hunger experienced daily	6%	6%	9%	11%
Hunger experience in last month	25%	23%	34%	30%

In 2019, 8% percent of Households reported a food shortage every day. Compared to 2017, hunger on a daily basis has increased in two control sites (Bellville South, Lwandle) and one intervention site (Gugulethu), while it decreased in two intervention sites (Belhar and Klapmuts) and in one control site (Montana). Gugulethu showed a substantial increase in Households

reporting experience of hunger on a daily basis, from 14% in 2017 to 25% in 2019 ($\chi 2 = 3.707$, p= 0.0542), meaning that one in four households reported experiencing hunger on a daily basis in Gugulethu in 2019. Overall, daily hunger remained stable at 6% in control areas, but rose from 9% in 2017 to 11% in intervention areas in 2019. While this change meant that intervention areas experienced significantly more daily hunger than control areas in 2019 ($\chi 2$ testing; p=0.02), the change within the intervention area from 9% to 11% was not statistically significant ($\chi 2$ testing; p=0.4).

The variable of monthly hunger is cumulative and includes hunger experienced either daily or in the last week or at any time in the past month. For Gugulethu, analysis of the detailed data show that the increase in monthly hunger was due to an increase of 10 more households (from 13 in 2017 to 23 in 2019) reporting hunger daily, while households reporting hunger at any time in the past week or month was slightly lower (from 36 in 2017 to 33 in 2019). This means that the increases in daily and monthly hunger in the intervention areas were almost entirely contributed by some households in Gugulethu in 2019 experiencing more daily hunger, while there was less daily and monthly hunger reported in both Klapmuts and Belhar. It seems that within Gugulethu there was a cluster of particularly disadvantaged households for whom food security declined in particular over the intervention period and may be families beyond the reach of any interventions.

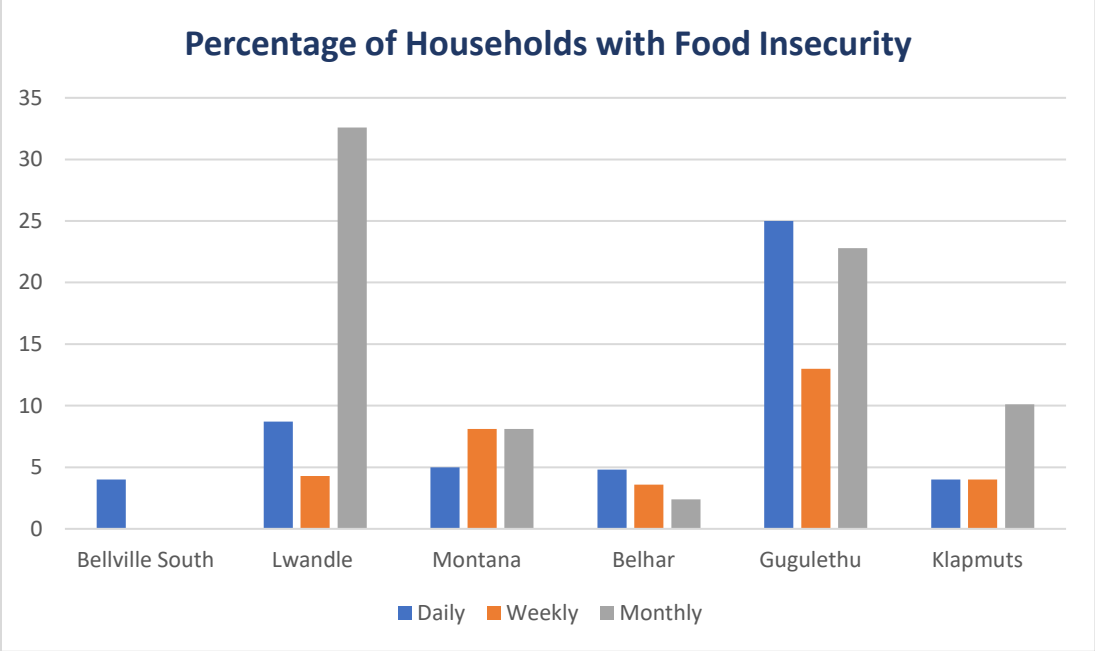

Figure 5.1 Percent of Households with Food Shortages, by Site and Rate of Occurrence

Overall, there was a decrease from 5.2% to 3.4% in Households who had a member who was a food parcel recipient ($\chi 2 = 1.836$, p= 0.1754). When compared by control and intervention groups, there was no real change (4.1% to 3.5%) for the control group, while the intervention group decreased from 6.3% to 3.2% (Table 5.1c. Although this change was not statistically significant ($\chi 2 = 3.096$, p=0.0785), it may signal lack of access to important resources; alternatively, it may indicate participants finding food from other sources, such as food gardens. Parcels were provided on an irregular basis, typically by churches or other private organizations, i.e., not social

welfare services. The low number of members receiving food parcels might be due to Heads of Household not knowing how to access these services.

Table 5.1b Household Food Sources, by Site and Type

	Control Group			Intervention Group			
	Bellville South N	Lwandle N	Montana N	Belhar N	Gugulethu N	Klapmuts N	Total N (%)
Any Food Parcels							
2017							
Yes	8	0	4	8	2	9	31 (5.2)
No	87	95	86	86	97	91	542 (91.3)
Unsure	5	4	5	6	1	0	21 (3.5)
Total	100	99	95	100	100	100	594 (100)
2019							
Yes	7	1	2	2	2	5	19 (3.4)
No	93	89	97	84	90	95	548 (96.6)
Total	100	90	99	86	92	100	567 (100)
Current Food Garden Participation							
2017							
Yes	10	4	10	11	14	18	67 (11.3)
No	90	95	85	89	86	82	517 (88.7)
Total	100	99	95	100	100	100	594 (100)
2019							
Yes	3	11	10	5	8	3	40 (7.2)
No	97	82	89	81	84	97	530 (92.8)
Total	100	93	99	86	92	100	570 (100)
Future Food Garden Participation							
2017							
Definitely	38	38	59	34	35	53	257 (43.3)
Perhaps	29	21	23	29	14	24	140 (23.5)
Unlikely	6	9	4	10	21	4	54 (9.1)
Not at all likely	27	31	9	27	30	19	143 (24.1)
Total	100	99	95	100	100	100	594 (100)
2019							
Definitely	34	48	68	32	44	39	265 (46.8)
Perhaps	16	23	20	25	14	27	125 (22.1)
Unlikely	8	11	5	11	8	6	49 (8.7)
Not at all likely	42	11	5	16	26	27	127 (22.4)
Total	100	93	98	84	92	99	566 (100)

N= Number of Heads of Household; % = within Site (column).

Comparing to the previous survey, there was a significantly decrease in current food garden participation from 14% to 6% ($\chi 2 = 5.844$, $p=0.0156$) in the intervention group. For the control group, current food garden participation continued more or less unchanged (8.2%) between surveys years. Although, current food garden participation is low there is a possibility of increasing participation as almost 47% of the Households reported to definitely be willing to be involved in a food garden.

Table 5.1c Household Food Sources by intervention versus control: Comparing 2017 to 2019

	Control 2017	Control 2019	Intervention 2017	Intervention 2019
Any receipt of food parcel	4%	3%	6%	3%
Current Food Garden participation	8%	8%	14%	6%
Future Food Garden participation definite	46%	52%	41%	42%

In general, outcomes for food security were not as promising as that found for safety and child protection above.

6. Chronic Illness and Adult Health Service Utilisation

6.1 Prevalence of Chronic Illnesses

The study focused on High Blood Pressure, Diabetes, Epilepsy, Heart Failure plus 'other' chronic illnesses. The 'other' category consisted predominantly of cases of HIV/AIDs, tuberculosis (TB), and mental illness, when these conditions were disclosed.

Similar to the previous survey almost 56% of all Households reported at least one member living with a chronic condition. Lwandle continue to have significantly lower prevalence than elsewhere, a finding consistent with the younger mean age of the Household members at that site. Belville South on the other hand has the highest prevalence than elsewhere, this finding consistent with the older mean age of the Household members at that site.

Table 6.1a Any Chronic Disease

	Control Group			Intervention Group			
	Bellville South	Lwandle	Montana	Belhar	Gugulethu	Klapmuts	Total
2017							
Yes	67	24	59	65	55	61	331 (55.7%)
No	33	75	36	35	45	39	263 (44.3%)
Total	100	99	95	100	100	100	594 (100%)
2019							
Yes	73	23	62	54	53	54	319 (55.8%)
No	27	67	0	31	35	44	204 (35.7%)
Unknown	0	4	37	2	4	2	49 (8.6%)
Total	100	94	99	87	92	100	572 (100%)

N= 594 Number of Heads of Household in 2017. N= 572 Number of Heads of Household in 2019.

Similar to the previous survey, High Blood Pressure continues to be the most prevalent chronic disease across all sites at 260 cases (some Households had more than one case), followed by diabetes with 86 cases overall.

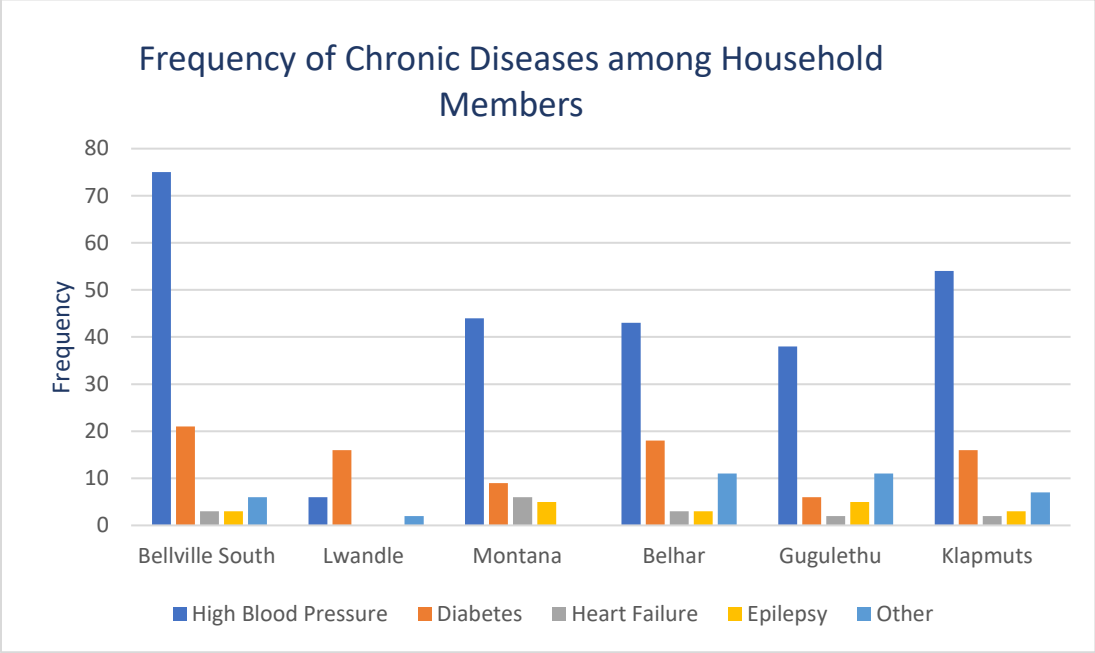

Figure 6.1 Number of Household Members with Chronic Disease, by Site and Type

Table 6.1b Number of Household Members facility attendance, by Site and Type

	Control Group			Intervention Group			Total
	Bellville South	Lwandle	Montana	Belhar	Gugulethu	Klapmuts	
2017							
High BP: Total Patients	63	12	54	60	22	53	264
Currently in care	49	12	50	40	22	47	220
Attendance in past	49	12	47	40	22	49	219
Care club member	4	7	2	3	19	5	40
HBC Visit in past 4 weeks	15	1	1	9	1	4	31
2019							
High BP: Total Patients	75	6	44	43	38	54	260
Currently in care	71	6	42	40	36	54	249
Attendance in past	72	6	41	39	37	54	249
Care club member	10	2	0	9	31	2	54
HBC Visit in past 4 weeks	11	0	6	3	2	2	24
2017							
Diabetes: Total Patients	25	9	9	28	4	14	89
Currently in care	20	7	9	20	4	14	74
Attendance in past	18	8	9	14	4	14	67
Care club member	3	2	0	2	3	1	11
HBC Visit in past 4 weeks	9	1	0	2	0	4	16
2019							
Diabetes: Total Patients	21	16	9	18	6	16	86
Currently in care	20	15	8	18	6	16	83
Attendance in past	20	16	8	15	6	16	81
Care club member	2	5	0	4	4	1	16
HBC Visit in past 4 weeks	2	8	1	1	1	1	14

	Control Group			Intervention Group			Total
	Bellville South	Lwandle	Montana	Belhar	Gugulethu	Klapmuts	
2017							
Heart Failure: Total Patients	6	1	5	4	6	4	26
Currently in care	6	1	5	4	5	3	24
Attendance in past	5	1	5	2	6	3	22
Care club member	0	0	1	1	5	0	7
HBC Visit in past 4 weeks	3	0	0	1	0	0	4
2019							
Heart Failure: Total Patients	3	0	6	3	2	2	16
Currently in care	3	0	6	2	2	2	15
Attendance in past	3	0	5	3	2	2	15
Care club member	0	0	1	1	1	0	3
HBC Visit in past 4 weeks	0	0	3	0	0	0	3
2017							
Epilepsy: Total Patients	3	2	3	1	1	2	12
Currently in care	3	2	3	1	1	2	12
Attendance in past	3	2	3	1	1	2	12
Care club member	0	0	0	0	0	0	0
HBC Visit in past 4 weeks	1	1	0	1	0	0	3
2019							
Epilepsy: Total Patients	3	0	5	3	5	3	19
Currently in care	3	0	5	3	5	3	19
Attendance in past	3	0	5	3	4	2	17
Care club member	0	0	1	1	3	0	5
HBC Visit in past 4 weeks	0	0	0	1	0	0	1
2017							
Other: Total Patients	12	7	8	15	42	4	88
Currently in care	10	6	8	11	40	4	79
Attendance in past	10	6	8	5	40	4	73
Care club member	3	4	0	0	30	0	37
HBC Visit in past 4 weeks	6	1	1	1	2	1	12
2019							
Other: Total Patients	6	2	0	11	11	7	37
Currently in care	6	2	0	10	9	7	34
Attendance in past	6	2	0	10	11	7	36
Care club member	0	0	0	3	6	1	10
HBC Visit in past 4 weeks	1	0	0	1	2	0	4

* Includes facility attendance within past week. Note: Some Household members had more than one disease.

Comparing all intervention groups to all control groups for changes from 2017 to 2019 (Table 6.1c), it appeared that the intervention areas experienced slightly larger improvements in patients with hypertension being in care and attending in the past month than improvements also seen in the controls. For example, the percentage of patients with self-reported

hypertension reported to be in care in the control areas rose from 86% in 2017 to 95% in 2019 ($\chi 2$ testing; p=0.01), while that in the intervention areas rose from 81% to 95% ($\chi 2$ testing; p<0.001). The percentage of patients with self-reported hypertension who were said to have attended for care in the past month in the control areas rose from 84% in 2017 to 95% in 2019 ($\chi 2$ testing; p=0.003), while that in the intervention areas rose from 82% to 96% ($\chi 2$ testing; p<0.001).

The percentage of patients with self-reported hypertension attending care clubs was unchanged in control areas but rose by more than 50% from 20% to 31% in intervention areas ($\chi 2$ testing; p=0.03). While the percentage of reports of visits in the past month by home-based care workers remained unchanged in control areas, it declined by 50% in the intervention areas, but this change was not statistically significant (10% in 2017 versus 5% in 2019; $\chi 2$ testing; p=0.1).

For diabetes, process measures were also largely improved in the Intervention Group. For controls, the percentage of patients being in care, attending in the past week and being part of a Care club rose modestly (84% to 93%, $\chi 2$ testing p<0.001; 81% to 96%, $\chi 2$ testing p=0.03; and 12% to 15%, $\chi 2$ testing; p=0.6, respectively). In the intervention areas, the percentage of patients being in care rose from 83% to 100% ($\chi 2$ testing; p=0.006), attending in the past month from 70% to 93% ($\chi 2$ testing; p=0.008) and being part of a Care club rose from 15% to 23% ($\chi 2$ testing; p=0.2). Although the rise in care club membership amongst diabetic patients was, unlike the case for hypertension, not statistically significant, this was probably due to the smaller number of patients with diabetes. The increase in Care club membership for diabetes in the intervention group (a rise of 73%) was higher than the statistically significant increase found for hypertension (56%). As was the case for hypertension, home based care worker visits in the intervention patients declined from 13% to 8% but the difference was not statistically significant ($\chi 2$ testing; p=0.4).

Overall, the evidence suggests intervention areas experienced slightly greater improvements in care measures for both hypertension and diabetes, particularly in the uptake into care groups. Care groups are a key strategy for the health system to cope with the burgeoning Non-Communicable Disease (NCD) epidemic and this suggests community-based interventions of this sort can assist health system efforts to cope with this growing epidemic.

Notably, HBC visits in the intervention areas declined relative to controls. This may be the result of greater emphasis on Care groups or may reflect changes in policy related to Community Health Workers happening at the same time as the intervention.

For conditions other than diabetes and hypertension, the numbers are too low to compare changes in care measures between controls and intervention groups.

Table 6.1c Household Members with high blood pressure and diabetes: Comparing care measures 2017 to 2019

	Control Group 2017	Control Group 2019	Intervention Group 2017	Intervention Group 2019
High BP:				
Total Patients (n)	129	125	135	135
Currently in care (%)	86%	95%	81%	95%
Attendance in past (%)	84%	95%	82%	96%
Care club member (%)	10%	10%	20%	31%
HBC Visit in past 4 weeks (%)	13%	14%	10%	5%
Diabetes				
Total Patients (n)	43	46	46	40
Currently in care (%)	84%	93%	93%	100%
Attendance in past (%)	81%	96%	70%	93%
Care club member (%)	12%	15%	13%	23%
HBC Visit in past 4 weeks (%)	23%	24%	13%	8%

Quality of care available to chronic disease patients was statistically perceived to be 'good' by 54.7% of households in 2019 compared to 47.8% from the previous survey ($\chi 2 = 5.226$, $p=0.0222$).

Participants in Bellville South (76%) and Lwandle (59.9%) were more likely to report good care than those from Montana (36.0%) or Gugulethu (40.0%) which have seemed to decrease when compared to the previous survey. Respondents reported sufficient medical supplies yet staff shortages and limited access to allied health professionals. In Montana, respondents reported that the clinic is too small and understaffed.

6.2 Measures to Assist Chronic Illness Patients

Similar to the previous survey, respondents reported a need for greater awareness regarding chronic illnesses to motivate communities to implement changes such as healthy diet, exercise and other lifestyle habit improvements. In addition, the respondents suggested a creation of an awareness program on how to eat healthy and exercise. The respondents also suggested that individuals must take their medications and patients should be monitored to see if they are following their treatments.

For chronic illnesses patients who are attempting to follow a healthier lifestyle, respondents continue to suggest that food supplements, food parcels or food garden initiatives could provide an alternative for patients who do not have enough food to take with their medication. Another challenge facing chronic illnesses patients is that most are unable to travel to clinics due to their poor health or financial constraints and therefore are less likely to follow up on their treatments. Respondents suggested that a health delivery service or the aid of community care workers could improve medication adherence.

Discussion

This is a follow up report aiming to update the core social determinants targeted for intervention by the CSS project.

Employment

In all sites, there was a slight non-significant decrease in reported employment from the previous survey in 2017 from 38.2% to 35.4%. This occurred in both the control and intervention areas. This decrease is in line with the overall South African unemployment rate which increased from 27.7 million in 2017 to 29.1 million in 2019 which suggests economic conditions for the poor are deteriorating. The deteriorating background social circumstances may be important to consider when assessing how effective the CSS intervention has been.

The gender impacts of poverty are also evidence. Women continue to be the head of the household in approximately half of all households and, where they are heads of households, they were also more likely to be solely dependent on a grant compared to the previous survey in 2017.

With an increase in unemployment and an increase in the young and 65+ years old populations who are eligible for social security; social grants are crucial source of income for Households. Compared to the previous survey, the percentage of Households who receive at least one grant increased slightly. In the intervention areas, this increase of 4% was statistically significant while in the control areas, the percentage remained static, suggesting the intervention was successful in increasing access to grants in the intervention areas. There was also an increase of Households receiving more than one grant, both in the intervention and control areas (an increase in total grants to total household ratio of 11% and 9%, respectively from 2017 to 2019), probably reflecting the increasing background poverty experienced.

This increase in grant support reported by the Baseline follow up (Endline) survey is in line with the South African Government report which suggests and increasing number of households benefiting from the social grants programmes since 2003[4].

Child Protection and Development

Children are vulnerable to ill-health, at-risk of violence as victims or perpetrators, and at risk of becoming substance abusers. Child protection and development programmes and services are a necessity to mitigate the effects of poverty and inequality as these programmes and services can enable vulnerable young children to grow and develop to their full potential.

The intervention appeared to succeed in increasing uptake of the child support grant in the intervention areas and, to a lesser extent, uptake of the disability grant. This increase was both in absolute numbers (a 37% increase in the density of child support grants) and in the proportion of all grants comprised of child support grants in the intervention area (increased by 11%). This was accompanied by positive changes in different indicators of child safety in the intervention areas: (a) a 3.5% increase in crèche attendance among children aged 5 years or younger (more than double the small increase in controls; (b) a significant increase in all children (between 1 and

[4] https://mg.co.za/article/2018-09-28-00-sas-welfare-state-is-in-trouble

18 years) who visited a clinic/health facility within the 4 weeks prior to the survey; (c) non-significant decreases in perceptions of assaults in the neighbourhood and adolescent fighting as a problem; (d) perception of child abuse being frequent in the community. Nonetheless, both control and intervention sites continued to report their community environments as unsafe or very unsafe for children; unchanged from 2017 reports. Notably, the increase in crèche attendance could be due to an increase in the number of crèches reported in Lwandle (control group), Belhar and Gugulethu (intervention group) according to the Western Cape Government.

All the sites are still struggling with the lack of access to school and after school activities for children of all ages and with lack of safety. For instance, all of the sites continue to suggest the development of parks, safety features in their community environments (e.g. speedbumps), youth centres with recreational programmes and after school activities. Currently, there are only 32 Early Childhood Development (ECD) facilities displayed in the City of Cape Town homepage[5]. According to the City of Cape Town ECD report[6], there are more unregulated ECDs than regulated ECDs in the Cape Metro area. Unregulated ECDs may not have the same safety, development activities and government support for the children to develop their skills to succeed in life.

Peace-Building

Assaults and violence continue to be a problem, big or very big problem, particularly among adolescents. The communities are still experiencing alarmingly high prevalence of violence of all types. This seems to be a problem facing most of the townships in South Africa and would be difficult to decrease violence in the communities without job creation, education and police and the community commitment for change.

Overall, Gugulethu has the highest exposure to violence among Head of Households than any other sites. This finding is similar to the findings reported at SAPS. According to SAPS Crime Statistics 2018[7], Gugulethu has the highest level of murder, sexual offences and assault than any other sites. The violence statistics provided by the Baseline survey and SAPS Crime Statistics might be underestimated and more alarming than described in this report. Crimes are usually not reported to the police due to victims being afraid of not being believed, insecurity, disbelief in the justice system, and intimidation.

Nonetheless, there were positive findings in the perception of the frequency of neighbourhood crime and violence being lower in intervention sites in 2019 compared to 2017 for all measures of violence, including perceptions of child abuse episodes, rape/sexual assault and gang violence. While perceptions may not reflect actual frequencies of crime, the direction of the changes are encouraging as they reflect community ability to manage these persistent problems better.

[5] https://www.capetown.gov.za/Family%20and%20home/See-all-city-facilities/Our-service-facilities/ECD%20centres

[6] http://resource.capetown.gov.za/documentcentre/Documents/Graphics%20and%20educational%20material/CCT_ECD_guide.pdf

[7] https://www.crimestatssa.com/precinct.php?id=1067

Food and Nutrition Services

Without having a source of income many members of the community are struggling with hunger, which also have major impacts on their health. Eight percent of the Households reported a food shortage every day. The intervention group experienced a decrease in food parcel recipients compared to the control group. In addition, many community members follow an insufficient and nutrient-poor diet due to price and convenience leading to a potential increase in chronic illness.

According to Statistics South Africa, the Consumer Price Index for food in the Western Cape increased almost 10% in prices since Dec 2016[8]; while South African wages only grew by 6%[9] and overall grants grew by 5%[10]. The increase in unemployment and slow increase in social payments grants and wages place pressure on Household disposable income for spending on food. Households budget constraints restricts individuals' access to healthy and nutritious food and a healthier life style.

Although programs teaching how to eat healthily on a limited budget were proposed, it is difficult to advocate for healthy diet when one has nothing to eat. Therefore, sustainable options should include community food gardens. In this regard, it is disappointing that the participation in food gardens in the intervention sites was reported to have declined from 14% to 6%. However, the impact of the severe drought was at its most extreme in 2018 and may have threatened food garden viability in areas where water restrictions were most severe. Anecdotal information suggestions that many of the gardens were started with enthusiasm but lost participation when there was no access to water to keep the gardens going.

Community Chronic Illness Support

Although risk for chronic illness has some inherited component, poor diet and lifestyle factors such as smoking, risky alcohol drinking, lack of exercise, are important contributors to the burden of disease due to chronic diseases. Poorer Households are more likely to suffer from chronic illness compared to richer Households. This is due to the fact that poorer Households cannot always afford healthy food and lack the education towards maintaining a heathy lifestyle. In addition, poorer Households have less ability to cope with a given exposure to chronic diseases than the richer Households. These increased risks place a higher burden on poorer households.

Chronic illness harm reduction can be achieved by prevention, early diagnosis and community-based care of the diseases. According to the Western Cape government[11], clinics and primary health facilities are responsible to promote education services by educating patients about the benefits of following a healthy lifestyle. Although these services are important, they might have a minimal impact on chronic illness prevention since people that are going to the clinic are likely to be looking for treatments and due to the high number of patients looking for treatment, the

[8] http://southafrica.opendataforafrica.org/kcsrrb/consumer-price-index-cpi-april-2019?region=1000000-western-cape

[9] https://www.sanews.gov.za/south-africa/increased-allocations-grants-education-and-health

[10] https://tradingeconomics.com/south-africa/wages

[11] https://www.westerncape.gov.za/service/chronic-care

staff might have to place emphasis on curative and chronic healthcare management services than preventive care.

Compared to the 2017 survey, patients in the intervention areas with self-reporting hypertension and diabetes appeared to show improvements for being in care, attending care in the past month and being part of a care club. While controls also reported improvements in being in care and attending care in the past month, the changes in the intervention areas were larger; moreover, the uptake in care clubs was not seen in the control areas. These are important health service improvements achieved that can assist in reducing the burden of complications from these conditions and care clubs are important for decongesting over-burdened primary care services. However, the lack of improvement in home-based care access is a worrying finding and suggests that community-based services are not reaching patients who might need them most. With the development of national policy on Community Health Workers and provincial implementation of a Community Oriented Primary Care (COPC) model, this should improve access to home-based/CHW care.

The communities suggested a creation of an awareness program on how to eat healthy and exercise and other lifestyle habits improvements (e.g. exercise) to decrease the prevalence of chronic diseases. Social and community training on health care topics can be a great opportunity for prevention; however, the programmes must be in a language that can be understood by the community and incorporate the lifestyle habits improvements that is related to that particular community. In addition, food and nutrition information programmes should focus on accessibility and affordability of healthy food.

Limitations of the Study

(a) Timeline of project and Long-term Impact

The time period for evaluating changes was limited. Two years is relatively short to anticipate many changes in outcome or impacts. This is particularly important for the complex, multifactorial problems this project was trying to address. A longer timeline may have seen some of these changes emerge or be consolidated.

The sample size may not have been large enough to demonstrate some genuine changes that failed to achieve statistical significance. In addition, there were some circumstances over which the researchers had no control, and which may have affected the results significantly – for example, the impact of the drought and severe water restrictions on the food garden interventions.

Lastly, similar to the previous Baseline survey, a number of challenges were encountered in the field work, some of which may have impacted the findings. These are detailed below.

(b) Language

The Supervisors and Fieldworkers were comprised of English, Afrikaans and Xhosa speakers, and the survey materials were made available in all three languages. The training on the Baseline project process, how to conduct the survey, and interview skills was however only conducted in English, with some support in Afrikaans. Study sites tended to have a dominant language, with a

probability of all three in languages to varying degrees. Study participation was contingent upon fluency in one of these three languages by at least one adult Household member. because households were randomly chosen, fieldworkers had to accommodate willing respondents in any of the three preferred languages. This language limitation may have been compounded by the varying education and literacy levels of the Fieldworkers. In an attempt to mitigate this, Fieldworkers conducted the surveys in pairs with fluency in three or at least two of the selected languages.

(c) Transport costs

Due to the varying sizes of the six study locations and availability of public transport, Fieldworkers in some areas faced challenges accessing their assigned Households. In rural and smaller sites, Fieldworkers travelled on foot, while in urban areas the cost of public transport due to the need for repeated attempts to make contact with Household members who were not home proved to be a challenge. Fieldworkers were given a standard transport stipend at the commencement of fieldwork which was not always sufficient.

(d) Dual Roles

Many of the Fieldworkers had other roles connected to community health as members of Health Committees, the Neighbourhood Watch, or other health forums. While this was advantageous in areas where these public bodies are well known and regarded and therefore improved access to homes for fieldworkers, this also challenged the survey process. Some Fieldworkers found that their dual roles inadvertently created false expectations in survey respondents, who in some cases only granted access to their homes and agreed to participate under the impression that they would receive some kind of immediate reward. In their other capacities these Fieldworkers would have previously brought food or housing supplies, helped secure funds from varying sources, or tended to have provided tangible support to families in the community. It became difficult to communicate that the survey was purely for research purposes with ultimate community upliftment goals, yet no immediate compensation due to ethical issues stemming from a similar scenario to be avoided.

This challenge was primarily seen in Gugulethu, where highly dedicated Health Forum and Health Committee members play a vital role in health activism. Fieldworkers in these dual roles then had to navigate these dynamics sensitively and ensure that all respondents were provided adequate information on the survey purpose and process. Elsewhere, such as Bellville South, these Fieldworkers were able to cohere the survey process and their interests as Health Committee members in gathering community feedback seamlessly.

Feedback and Dissemination

Feedback summary discussions on the survey have been held at intervention sites and/or with implementation partners/coordinators. Site specific summary pamphlets will be compiled for each study site in a style that is user friendly to assist in usability of the report.

Conclusion

This report provides insight on changes in the social determinants of health regarding Child Protection, Food and Nutrition, Peace Building, and Chronic Illnesses for the three communities where the interventions took place: Klapmuts, Gugulethu and Belhar and for three control communities of similar demographic and socio-economic status (Belville South, Lwandle and Montana (Wolseley).

Despite what appears to be a deteriorating social context, the results suggest that some progress has been made in the communities where the intervention was implemented: (a) improvements in indicators of Child Protection (increased uptake of the child support grant, increased crèche attendance, increased child health service usage, perceptions of improved community safety and of reduced incidents of child abuse; (b) although high levels of violence were still noted, there were improvements in perceptions of the frequency of child abuse episodes, rape/sexual assault and gang violence, which suggest that strengthened community systems may be able to manage these persistent problems better; (c) improvements in most aspects of chronic illness care – self-reported access to care, attendance in the past month and membership of a Care Club. Only with regard to home-based care access was there no improvement.

The intervention sites also had many suggestions for how to address prevention of chronic disease which could be adopted if community-based services were to be established effectively. Respondents also suggested that there was an increase in the quality of care available to chronic disease patients compared to the previous survey. Notably, the number of people with chronic illness, especially high blood pressure, has not changed and this points to the need for health services to focus on the prevention of chronic illness and not just curative care. The only area where indicators did not improve was in relation to food security. It is unclear why the intervention was unable to succeed in ameliorating some of the challenges experienced with regard to hunger and food security. To some extent, the crippling drought and water restrictions undermined the ability to implement food gardens and the impact may have been more severe in the intervention sites.

All sites are still suffering the negative effect of a jobless economy, decayed health system and lack of safety in their communities, with unchanged perceptions of community environments as unsafe or very unsafe for children.

Compared to the previous Baseline survey there was a decrease in employment and an increase in social grants among the sites. For these communities, social grants are crucial source of income for Households. The increased financial pressure on communities is likely to have an impact on crime, violence, hunger and ill health. For instance, violence is still a major problem among all sites. Except for Belhar, compared with the previous Baseline survey, there was an increase in violent robbery in all sites. Increased visibility and responsiveness of the police and tougher sentencing for criminal activity was reported as a necessary deterrent to address crime.

The CSS Project has been committed to improve the core social determinants problems by training members of the community in Child protection; Peacebuilding; Health promotion; and Food security and nutrition in 3 intervention sites. These findings will be used with other

evaluations[12] to assess the CSS project and will be reported back to communities and local service providers for them to use to improve access to services and to develop interventions to address the social determinants of health.

Recommendations

Based on the results from this report, the recommendations below should be considered by relevant government departments as well as NGOs and community based organisations.

Child Protection:

- Promote uptake of grants for eligible households to ensure community members know their rights and how to access grants of different descriptions.
- Strengthen support for creches in local communities – expand the number of facilities and the quality of their services so as to increase registered creches via a phased approach, allowing informal ECDs to access government subsidies as they progress along a process of formalizing/ registration.
- Improve health service interactions with both registered and unregistered creches in their areas.
- Build capacity of communities to understand threats to child protection, what can be done to enhance child protection and what resources to draw on to achieve child protection.
- Investment in after-school activities to enhance child protection; youth centres with recreational programmes.

Peace Building:

- Continue the community activities initiated under the CSS project – support for the Neighborhood watch, projects to clean and paint the parks, weekend events (free exercise workout e.g. park run).
- Community workshops and school-based training to address violence.

Food security:

- Continue to support food garden projects in communities and provide them with preferential access to needed inputs, including water even when restrictions are implemented. Inputs should include organics homemade pesticides, information on soil improvement methods and information on choice of drought resistant plants/ vegetables.
- Provide information to communities on healthy eating – for example, create a food pamphlet with affordable healthy recipes using ingredients collected in their gardens.
- Food and nutrition programmes delivered by DSD and the Health Department should be more strongly linked to promote prevention rather than cure – and integrate food gardens as part of community outreach.

[12] Additionally, there will be an evaluation of the training of a group of community activists in Adult Education (AE) in a Higher Certificate at UCT; a study of life stories of community activists (MPH thesis); programme; interviews with key informants; a study in Gugulethu of the impact of training on activities of Health Committee members directed at addressing social determinants of health.

- Food gardens should also be encouraged as income generation projects and linked to increasing numbers of creches at community level.

Chronic Illness:

- Health services should make use of community structures (particularly health committees) to improve uptake of services for chronic illness and promote care clubs as part of COPC.
- Develop stronger links with CHW/HBC services such that HBC workers are visiting patients with chronic illness at home.
- Reorient health services to support prevention activities addressing the Social Determinants of Health in the community through health committees.

In general, public policy should provide more integrated approaches to community development which provide holistic responses to the SDH experienced at household and thus community level.

References

1. https://www.westerncape.gov.za/social-development/facilities/669
2. https://mg.co.za/article/2018-09-28-00-sas-welfare-state-is-in-trouble
3. https://www.capetown.gov.za/Family%20and%20home/See-all-city-facilities/Our-service-facilities/ECD%20centres
4. http://resource.capetown.gov.za/documentcentre/Documents/Graphics%20and%20educational%20material/CCT_ECD_guide.pdf
5. https://www.crimestatssa.com/precinct.php?id=1067
6. http://southafrica.opendataforafrica.org/kcsrrb/consumer-price-index-cpi-april-2019?region=1000000-western-cape
7. https://www.sanews.gov.za/south-africa/increased-allocations-grants-education-and-health
8. https://tradingeconomics.com/south-africa/wages
9. https://www.westerncape.gov.za/service/chronic-care