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# Social and dietary practices of Soweto families who protect agains overt malnutrition in their children

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It is beyond the scope of the present study to discuss the specific techniques of behaviour modification. For instruction on the practice of this method, see Bandura (1969), Whaley and Malott (1969), Kanfer and Phillips (1970a; 1970b), and Stuart (1979).

**(b) Cognitive Restructuring**

> A cognitive approach holds that the principle determinant of emotions, motives and behaviour is an individual's thinking, which is a conscious process... Thinking, in turn, is primarily influenced by an individual's society, immediate environment, human relationships and experiences in general... Cognitive restructuring consists of expanding or modifying individual consciousness until perception more nearly approximates reality. This is done by talking to the client and/or guiding him/her into direct experiences that will alter his/her distorted thinking (Werner, 1979: 243-244).

For example, the difference between members of the 'broken' Case families and the members of the more intact Control families, may well be their way of thinking. Pavenstedt (1965:91) found that parents of disintegrated families were often hopelessly resigned, "revealing little capacity to achieve or produce or be something valuable in personal, childrearing, marital, learning or work terms". In contrast, the integrated families "refused to submit to the insidious attack on self worth. Never identifying themselves with the conditions surrounding them, they tirelessly maintained, and often achieved, the goal of bettering their living conditions" (Segal and Yahraes, 1979:270, in discussing Pavenstedt, 1965).

Cognitive restructuring is an effective method of promoting "mutual adjustment between individuals and their environment" (Werner, 1979:267). It promotes change in an individual's "situational attitudinal definitions" (Siporin, 1972:99), which results in changed behaviour. It is thus an appropriate response to a transitional state crisis.

The cognitively oriented practitioner bases treatment activity on the following premises:

- Change in perception alters emotions, motives (goals) and behaviour;
- Change in goal is especially influential in altering behaviour; and
- New activities and new kinds of behaviour alter perception (Werner, 1979:236).

The treatment techniques include:

- Contradicting the client whose perceptions of self, others and society are not accurate. Evidence supporting more realistic appraisals is introduced;

- When the client's problems are the consequence of antisocial or self-destructive goals, the worker points out the connection between the client's distress and his/her choice of goals. The worker then has the therapeutic task of helping the client reorient him/herself with a different set of goals; and

- Since the client him/herself has chosen the objectives he/she wishes to achieve in treatment, the worker recommends new experiences or behaviour which may bring him/her closer to those objectives (Werner, 1979: 263).

For a more detailed description of cognitive restructuring techniques, see Siporin (1972), White (1970), Ellis (1962), Werner (1965; 1970; 1979), and Nikelly (1971).

#### 7.2.2.3 Responding to a Cultural/Social-Structural Crisis

The above methods of intervention are likely to alleviate the immediate crisis, but any response to a cultural/social-structural crisis must be directed towards eliminating the sources of stress. This has been discussed in section 7.1.1.

### 7.2.3 Implementing family Intervention

The various recommendations suggested in the preceding sections could be implemented by a number of sources. These include:

(i) Family life organisations,
(ii) Child welfare agencies,
(iii) Hospitals and child health clinics, and,
(iv) Universities, especially social work and psychology departments.

These sources are all in a position, directly or indirectly, to reach out to 'broken' families. However, the above recommendations have not yet been implemented, because these

organisations are typically understaffed and overextended. As noted in chapter 3, health and welfare systems in South Africa are characterised by bureaucracy, fragmentation of services, and disproportionate allocation of resources among the races.

## 7.3 Enhancing Mothers' Social Support

The finding that Case mothers' had limited social support, as compared with Control mothers (see section 5.3.9.), suggests that improving Case mothers' social support may avert PEM in their children.

As discussed in section 6.3.6., social support systems seemingly facilitate the process of social and economic adaptation into society by providing appropriate informational resources as well as tangible and emotional supports. Usually however, to become a recipient of such social support, one must have already achieved some level of social and economic adaptation. Thus, social support intervention would be valuable to those individuals (eg. Case mothers) who, due to their social and economic circumstances, cannot avail themselves of social support.

Mental health professionals, especially social workers, have the "technologies for teaching people how to give and receive social support" (Marks, 1986:105). Furthermore, they can play a major role in planning, co-ordinating and developing the social resources from which support may be drawn (House, 1981). "Such efforts could perhaps be implemented by social agencies committed to family life and child welfare, or by trade union organisations" (Marks, 1986:105). Hospitals, child health clinics, churches, universities (particularly social work and psychology departments) and organisations working for social change are also in a position to become involved in a social support intervention focus.

The main strategy that may be used to enhance social support is networking.

### 7.3.1 Types of Networking

Networking involves facilitating the linkage of individuals to supportive structures in the environment, thereby increasing the individuals access to social support resources. Net-

working also includes creating new, and expanding existing social support resources (Maguire, 1983; Whittaker and Garbarino, 1983; Gottleib, 1981).

Hutchison, Searight and Stretch (1986) identify four distinct types of networking:

**(a) Natural Support Systems**

> In this type of networking, a professional intervenes to assist a family or individual by facilitating the linkage of the clients to their natural support systems, which are composed of other family members, friends or colleagues (Hutchison, Searight and Stretch, 1986:428).

For example, a social worker may help a mother develop a more trusting, confiding and intimate relationship with a neighbour. In such a relationship she would feel cared for, esteemed and closely involved with another person, and in fact be receiving the social support that is posited to be a buffer of stress.

**(b) Client-Agency Linkages**

> In the second type, a professional intervenes to facilitate the linkage of the client to other professional (and voluntary) services or to other agencies in the community (Hutchison, Searight and Stretch, 1986:428).

For example, a social worker may refer a mother to organisations which provide financial assistance or food parcels (eg. South African Council of Churches and Operation Hunger). These organisations offer instrumental aid which would directly and tangibly help a mother.

In between "Natural Support Systems" and "Client-Agency Linkages" are social clubs and religious groups. A social worker would do well to encourage a mother to join a women's group, a burial society, or to attend church regularly and become involved in the church's social activities. By belonging to a social club or religious group, a mother would be in a position to receive emotional, informational and appraisal support (see discussion in section 6.3.6).

**(c) Interprofessional Linkages**

> The third type of networking, that of linkage among professionals, is developed to facilitate agency goals (Hutchison, Searight and Stretch, 1986: 428).

For example, the social workers and pediatricians at Baragwanath Hospital could arrange a referral system regarding all children with PEM or severe diarrhoea: The pediatricians would report such patients to the social workers. The social workers would, in turn, notify a child welfare agency which would provide some type of support or assistance to the mothers of these children.

**(d) Human Service Organization Networking**

> The fourth type of networking is the development of coalitions among agencies and the establishment of top-level administrative ties among agencies (Hutchison, Searight and Stretch, 1986:428).

For example, a director of a family life organization could work with a task force of a number of other agency planners to facilitate a development project aimed at combating PEM in children. Funding for such a project could be applied for, from the State Department of Health and Population Development, or from business corporations.

## 7.3.2 Mobilizing Support From a Social Network

An important aspect of networking is to develop the mothers' ability to mobilize support from the network. The very socio-economic pressures and tensions which result in the need for additional social support, may diminish the individual's potential for obtaining support (Marks, 1986; House, 1981). Social work intervention should be directed towards developing the mothers' personal coping and adaptive strategies. This may be achieved through the social work methods of case work or group work, where the social workers' major role is to motivate, encourage and provide information regarding the use of the social network.

### 7.3.3 Integration into the Urban Setting

An individual who is the beneficiary of an urban social network, ranging from natural or informal support systems to human service organisations or formal support systems, is an individual who is adjusted to the urban environment. The process of networking in an urban setting, is thus the process of promoting urban integration.

### 7.3.4 Limits of Enhancing Social Support

Camasso and Camasso (1986:388) assert that under conditions of socio-economic deprivation, "a strategy targeted solely at enhancing social support would appear to be of limited value". Cassel (1976), Cobb (1976) and Mueller(1980) warn that social supports in disadvantaged classes are in constant risk of being overwhelmed. Garbarino (1983:5) illustrates this point: "When people feel that their own security is threatened by the neediness of others, they tend to become ambivalent, if not hostile, about neighbourly exchanges of goods and services".

Enlarging an individual's social support network does, however, lessen the demands placed on a single source of support, and thereby minimises the risk of overwhelming this source of support. Nevertheless, developing informal and formal support networks must be accompanied by efforts "to modify established social structures and processes that generate stress, e.g. unstable employment, poverty, residential mobility and crime" (Camasso and Camasso, 1986:388).

A comprehensive intervention aimed at creating the conditions where PEM in children may be eradicated, must undoubtedly include both a stress reduction component as well as networking strategies.

## 7.4 Improving Child-Care

The findings on child-care practices suggest that the quality of child-care received by Case children was inferior to that received by Control children. These findings refer to the child-care provided by both mothers and child-minders (see sections 5.2 and 6.2).

Child care is essentially providing the child with physical protection, food, emotional nurturance and intellectual stimulation (Bronfenbrenner, Goodson and Hess, 1974; Keniston, 1975). It is likely then that improvement in child care will result in a proportional improvement in the child's nutritional status.

### 7.4.1 Increasing Parental Capability

As a result of their relative impoverishment, Case mothers (compared with Controls) appeared to be subjected to greater stress and frustration (see section 6.2.1.1.). They also tended to be part of 'broken' families (see section 6.1.2), and they experienced less social support (see section 6.3.6). These factors are directly related to parental capability. Thus, increasing mothers' parental capability depends on eliminating their sources of stress and frustration; improving family functioning; and enhancing their social support.

For recommendations, see

- section 7.1, on eliminating sources of stress;
- section 7.2, on improving family functioning; and
- section 7.3, on enhancing social support.

### 7.4.2 Developing Community Child-minding

As discussed in section 6.2.1.2, the predominant form of child-care among the sample of working or school-going mothers was provided by the extended family (in particular older female adult relatives). Cases tended to use extra-familial care such as neighbours, servants and a creche, to a lesser extent than Controls. Child-care was thus supplied by people within the mothers' immediate socio-economic environment. Since Case mothers compared with Controls were more impoverished and had less social resources, their child-care arrangements reflected this and were less adequate.

The providers of child-care were female members of the Soweto working class community. Cock, Emdon and Klugman (1984) have established that these women have not received any training in child-care practices and are often ill-equipped for the task. Furthermore,

child-minders cost more than creches (which receive subsidization from private welfare groups or the State). Cock, Emdon and Klugman (1984) found that the average creche cost was R18 per month (including food), while childminders were charging an average of R25 per month (excluding food). Women using female adult relatives to look after their children were paying them an average of between R16 and R30 per month.

Responses to the well recognized deficiency in Soweto child-care arrangements (see section 3.5), have been recommendations to:

(i) increase the number of day care centres (eg. creches).

(ii) raise the subsidization of day care; and

(iii) extend subsidization to welfare, church, and other private groups involved in providing day care (recommendations of the Wiehahn Commission report. 1981, summarised by Cock, Emdon and Klugman, 1986:83). However they (Cock, et al) observe that State involvement has not changed as a result of these recommendations.

Creches alone are not the answer to Soweto's child-care problems. Besides the controversial and elitist practice of State subsidisation (see Cock, Emdon and Klugman, 1984), many working women cannot use creches because of unstable and unpredictable working hours. Childminding has distinct advantages over creches, as Cock, Emdon and Klugman (1986:87) explain:

> Childminders are being used by increasing numbers of working-class women because they are accessible and are prepared to look after children and babies in a manner which suits the mothers. They take babies from as young as one month old and are prepared to have the children for long hours or extra days if the mother has to work overtime. They fit into the lives of working class women in a flexible manner. Many childminders have themselves been in wage employment and can empathize with the insecurities and unstable hours which the mothers of their charges experience.

Cock, Emdon and Klugman (1984) estimate that there are approximately 2 500 childminders in Soweto, each caring for about seven children. The practices of these childminders are subject to no assistance, control or monitoring:

> Many of these arrangements are in fact 'illegal' in terms of the Children's Act. Any childminder who takes in more than six children is considered to be acting illegally as is any enterprising woman who converts her garage and takes groups of children into an informal mini-creche. Yet, because of the chronic shortage of facilities, childminding has become a major form of child care in working-class areas (Cock, Emdon and Klugman, 1986:85).

Existing legislation inhibits the improvement of informal child-care arrangements and ignores the enormity of the child-care problem in Soweto. Childminding needs to be acknowledged as a community response to the child-care crisis. Childminders need to be:

(i) trained in child-care practices;

(ii) involved in bulk buying of food (applying for discounts from supermarkets);

(iii) monitored regarding the quality of care they are able to provide, and the conditions under which they are working; and

(iv) subsidized and then restricted in the amount of money they charge mothers.

Childminding schemes that perform the abovementioned tasks may be implemented by private welfare agencies, street committees and trade union organizations. Funding for such schemes may be raised from people in business who are concerned about creating a positive image in the Black community, and from overseas governments.

Childminding schemes may be seen as a form of networking (described in section 7.3.1), and are a method of developing the informal structure of the community: they would achieve increased quality and quantity of child-care resources, as well as regular income for people who would otherwise be unemployed. Furthermore, childminding schemes could be used as a "means of uniting women to organize around a common problem, challenge authority, and learn the value of collective action" (Hill, 1983:88). As Hill (1983:88) indicates, such a response may ultimately "open the way for women's involvement in political struggle".

## 7.5 Reducing the PEM-Infection Cycle

The results of the present study point to the generally recognized synergism between PEM and infection, especially diarrhoea (see sections 5.5.1 and 6.5.1). To reduce the PEM-infection cycle, great effort in a multi-dimensional intervention strategy will be required. Some recommendations follow:

### 7.5.1 Promoting Constructive Use of Milk Formulae

The susceptibility of Case children to the PEM-infection cycle was increased by their relatively early use of commercial milk formulae (see sections 5.4.2 and 6.5.1). An important strategy to break the PEM-infection cycle is to promote breast feeding. The promotion of breast-feeding is unlikely to be successful, however, because Black urban working-class women are forced, out of economic necessity, to wean their children early and return to work. Thus, weaning infants to commercial milk formulae has become an established practice. It is perhaps more realistic to accept this and focus intervention strategies on constructive use of milk formulae.

Powdered milk formulae need to be mixed with water. Therefore, promoting constructive use of milk formulae can only be attempted in areas where the water is uncontaminated.

There were only about one third of the mothers in both groups who were diluting the formulae correctly i.e. according to the manufacturers' instructions. This is not surprising however, when one examines the way in which these instructions are presented to the consumer.

Firstly, due to the high proportion of Black infant milk formulae consumers, it seems inappropriate that the diluting instructions are written only in English and Afrikaans and not in any of the Black languages as well. Sue Cooper, the market research manager of Nestlé (a prominent producer of infant milk formulae), estimated that as much as 90% of infant milk formulae consumers are Black.

Secondly, the instructions are extremely complicated to understand and could easily be simplified by using drawings of measuring scoops and cups rather than the elaborate tables of figures. Also, an illustration of a teaspoon 'crossed out' and a measuring scoop 'ticked', would counter the common error which occurred in the sample of the present study, i.e. of using a teaspoon rather than the enclosed scoop with which to measure the powder.

Professional action by groups of paediatricians could pressurize the milk formulae producers to effect such changes.

Infant milk formulae is costly and this may force mothers' to use inferior quality products that are cheaper and less nutritious, eg. low-fat powdered milk. This could be overcome by the subsidization of infant milk formulae by the State, hospitals and clinics, welfare organizations, and the business community. To secure subsidization, this issue needs to be taken up by professional groups of doctors, social workers and the like.

### 7.5.2 Creating an Equitable Health System

As stated in section 6.5.1: The Case children who were victims of the PEM-infection cycle, had a history of one or more previous hospital admissions (see section 5.5). This indicates that their contact with medical resources is not breaking the PEM infection cycle.

The events which perpetuate the PEM-infection cycle can be prevented, largely, "by aggressive, early nutritional attention to diarrhoeal illnesses and their sequel" (Walker-Smith, Hamilton and Walker, 1983:81). This calls for preventative primary health care: a contrasting approach to the curative-based services currently dominating hospitals and clinics. South Africa's racist health policy results in the unequal and inferior allocation of health resources to Blacks. Furthermore, it reinforces the emphasis on curative medical interventions, despite the fact that the majority of Blacks clearly need preventative primary health care (see section 3.5.2). This is illustrated by the example of the PEM-infection cycle.

Coovadia(1987b:1-2) asserts that:

> The social, political and economic system which laid the foundations for development of these inequities has therefore to be radically altered in order to achieve a just social order, which among a number of other

social objectives, creates the conditions for the eradication of disease and the promotion of health for all South Africans.

Coovadia (1987b:29) outlines an alternative health care system "which is interwoven into the wider fabric of social development and is contingent on attainment of political liberation". Coovadia (1987b: 29-30) summarizes the ten essential features of this proposition, which are:

- the necessity for transformation of the state prior to social (including health) and economic changes;
- existence of private and public sector health care delivery, with gradual decay of the former and progressive expansion of the latter;
- acceptance of health as a basic human right;
- exploration of the production and distribution aspects of health care;
- establishment of a single, central co-ordinating National Council for Health Development which will determine priorities and strategies;
- a nationalised health service;
- nationalisation of the purchasing and distribution of drugs and medical supplies;
- restructuring the training of health professionals;
- a nationwide network of primary care clinics based on unified health teams, fused organically into local community and worker organisations through health committees, serving as the core of the new health service and as a crucial link between needs at the periphery and policy at the centre; and
- regional and tertiary hospitals with allocations for high technology care and research being influenced by the needs of the majority.

South Africans who are committed to achieving health for all need to investigate the precise mechanisms through which structural change in the health system can be made. Furthermore, change must also be made to the prevailing socio-economic and political structure (see section 7.1.1), since disease in the lower classes is largely related to poverty and injus-

tice. Perhaps the issue of health may be used as an entry point for organising people into mainstream political involvement.

## 7.6 Summary

This study of malnutrition in children has really been an exploration of peoples lives and their struggle to survive in a hostile environment.

The recommendations to combat child malnutrition were directed at:

(i) Changing the socio-economic and political system to a just, non-racial and democratic social order, eg. supporting mass based political groups, and organizing people around the issues of child-care, and health; and

(ii) Helping people adjust to the urban setting by responding to families in crisis,enhancing social support networks and developing childminding schemes.

These recommendations did not offer a simple one person-one group solution. The fabric of people's lives is too varied in texture for that. However, many intervention strategies were suggested, some of which could be implemented immediately and would certainly alleviate the problem of child malnutrition in South Africa's urban Black townships.

> There are risks and costs to a programme of action. But they are far less than the long-range risks and costs of comfortable inaction.
>
> John F. Kennedy, 1961

# Appendix A. Interview Schedule and Code Scheme

This appendix consists of the interview schedule, with the code schemes inserted where applicable. The code schemes were finalised after the interviews were completed to ensure that all responses could be included and processed.

## SOCIAL AND DIETARY PRACTICES OF SOWETO FAMILIES WHO PROTECT AGAINST OVERT PEM IN THE THEIR CHILDREN

A survey conducted by DEBBIE BLOOM in partial fulfilment of the degree of Master of Arts in Social Work, University of the Witwatersrand.

## INTERVIEW SCHEDULE

Dear Interviewer

The interview schedule must be completed in full. It is not, on the whole, an instrument for a question-answer session, but rather a guide for a discussion wherein the information can be obtained.

1. Mark only ONE item for each question, unless otherwise indicated.
2. Tables are to be completed in full.
3. The purpose of this study is to be explained to the mother/respondent according to the note on the following page.
4. Respondents are to be assured of complete confidentiality. Please maintain their trust in you.

CHILD'S NAME: _____

MOTHER'S NAME: _____

ADDRESS: _____

TIME MOTHER IS LIKELY TO BE HOME: _____

INTERVIEW NUMBER: _____

DATE OF THE INTERVIEW: _____

TIME STARTED: _____

TIME ENDED: _____

TOTAL TIME: _____

DEAR MOTHER

We know very little about the kind of environment that the children in Baragwanath Hospital, and the polyclinics, come from. In order to gain an understanding of the children's background, we need your help in discussing various aspects of your family life.

Some of the questions will be of a personal nature, and I would like to assure you that all of the answers which you give the interviewer will be treated with the utmost confidentiality by the interviewer and myself.

There are no right or wrong answers, so please don't be afraid to give your true answers.

Thank you very much for agreeing to be interviewed, and for contributing to this study, which will be published at the University of the Witwatersrand.

DEBBIE BLOOM
BSoc Sc(SW) (Hons) UCT
November, 1984.

# Maternal Factors Scale

1. **Age ?**

1. 15 - 17
2. 18 - 19
3. 20 - 24
4. 25 - 29
5. 30 - 34
6. 35 - 39
7. 40 - 44
8. 45 - 49
9. 50 plus

2. **Language group ? True home tongue/first language**

1. Northern Sotho
2. Southern Sotho
3. Zulu
4. Xhosa
5. Venda
6. Tswana
7. Shangaan
8. Swazi
9. Ndebele
10. Afrikaans

3. **Adopted tongue or language MOST OFTEN spoken in household?**

1. Northern Sotho
2. Southern Sotho
3. Zulu
4. Xhosa
5. Venda
6. Tswana
7. Shangaan
8. Ndebele
9. English

4. **Education. Have you ever been to school?**

0. No
1. Yes

**5. If yes, what was the highest standard that you passed?**

1. Grade I to standard I
2. Std II
3. Std III
4. Std IV
5. Std V
6. Std VI
7. Std VII
8. Std VIII
9. Std IX
10. Std X

**6. Have you had any other formal training/education or are you going to classes of any kind?**

0. No
1. Dressmaker, sewing machinist, leather-bag maker, knitter, domestic science course
2. Nurse aide/ward assistant
3. Secretarial work, computer work: including operating and programming
4. Tertiary education: Bachelor of Arts in teaching or nursing (completed or in the process of completing)

**REPRODUCTIVE HISTORY AND CHILD'S POSITION**
**(see definition of 'the child' in chapter 1)**

| **Pregnancy No.**<br><br>**Presently Pregnant ?** | **Mother's age at pregnancy** | **Father No.**<br><br>**If deceased, reason** | **Planned** | **Wanted** | **Date of birth of child – if deceased, age and reason.** |
|---|---|---|---|---|---|
| e.g. earliest pregnancy | e.g. 18 | 1. Father one<br>2. Father two<br>3. Father three<br><br>0. Not deceased<br>1. Dead – don't know reason.<br>2. Dead – accident<br>3. Dead – "natural causes" | 0. No<br>1. Yes<br>2. On contra-ceptive when fell pregnant. | 0. No<br>1. Yes | e.g. 12/06/81<br><br>0. Still Alive<br>1. Abortion, miscarriage<br>2. Still-birth<br>3. Dead – don't know reason<br>4. Dead – accident e.g. severe burns in a shack<br>5. Dead – "natural causes" |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

7. **How long was this child in hospital after birth? (i.e. not including those children who stayed in hospital due to the mother's post natal condition)**

1. Less than 24 hours
2. Between 25 hours and 48 hours
3. Between 3 days and 7 days
4. Between 8 days and 14 days
5. Between 15 days and 1 month
6. More than 1 month
7. Child not born in hospita clinic

8. **Was the child in an incubator?**

0. No
1. Yes

9. **How soon did you go back to work after the birth?**

1. Less than 1 week
2. Between 1 week and 1 month
3. Between 1 month and 2 months
4. Between 2 months and 4 months
5. After 4 months

10. **Is this child fathered by the current household head?**

0. No
1. Yes
2. Household head is a woman

11. **How many children are there in the household who have the same father as this child?**

1. None
2. Some - 1
3. Some - 2
4. Some - 3
5. Some - 4
6. All

## Alcohol Use

12. **Are you usually able to eat breakfast in the morning, i.e. without feeling sick and when you are not pregnant?**

0. No
1. Yes

**13. Do you often get pins and needles or cramps in your feet and calves?**

0. No
1. Yes

**14. Do you drink any alcohol? If so, how often do you drink?**

0. No
1. Yes, occasionally/when available - non specified frequency
2. Yes, on weekends
3. Yes, weekly (2 or 3 times a week)
4. Yes, daily

**15. How much alcohol do you drink?**

0. Non-specified amount
1. 1 - 3 glasses of wine
2. 1 - 3 cans of beer
3. A lot, until I'm drunk

## Observe and Comment Upon:

**16. If fingers and tongue shake**

0. No
1. Yes

**17. If speech if slurred**

0. No
1. Yes

**18. Personal cleanliness and overall appearance**

1. Good
2. Fair
3. Poor, eg. scars, bloodshot eyes, "puffiness of an alcoholic"

**19. Weight**

1. Underweight
2. Average
3. Overweight

**20. Empty beer or spirit bottles lying around**

0. No
1. Yes
2. Family runs a shebeen

**21. If breath smells of alcohol**

0. No
1. Yes

**22. Reactions to questions on alcohol – especially intense denial**

1. No denial, honest "non drinker"
2. Honest confession, drinks alcohol
3. Denial, suspected "drinker"
4. Unsure re denial or not. Don't know

# Household Inventory

**23. Do all the children own/possess shoes?**

0. No
1. Yes

# Observe and Comment Upon

**24. Crops and livestock**

0. No
1. Yes

**25. Fence**

0. No
1. Yes

**26. Electricity**

0. No
1. Yes

**27. Plumbing (indoor and outdoor taps)**

0. No
1. Outdoor taps only
2. Indoor taps only
3. Both in and outdoor taps

**28. Other structure on property**

0. No
1. Yes e.g. tin shack/s in yard

**29. Refrigerator**

0. No
1. Yes – working
2. Yes – not working

**30. Cleanliness – especially kitchen (see definition in chapter 1)**

1. Clean
2. Neither clean nor unclean
3. Unclean

**31. Radio**

0. No
1. Yes - working
2. Yes - not working

**32. Gramophone/tape-deck**

0. No
1. Yes – working
2. Yes – not working

**33. T.V.**

0. No
1. Yes - working
2. Yes - not working

### 34. Motor car

0. No
1. Yes - working
2. Yes - not working

### 35. Bicycle

0. No
1. Yes - working
2. Yes - not working

### 36. No. of rooms

1. One - tin shack, including bathroom and kitchen
2. Two - tin shack, including bathroom and kitchen
3. One - excluding bathroom and kitchen
4. Two - excluding bathroom and kitchen
5. Three - excluding bathroom and kitchen
6. Four - excluding bathroom and kitchen
7. Five - excluding bathroom and kitchen

### 37. Burglar proofing

0. No
1. Yes

## Household History and Marital Status

### 38. How often do you see the child's father?

1. Not at all
2. Rarely - irregularly
3. During holidays e.g. father is a migrant worker
4. Once - three times a month
5. Once - twice a week
6. Three - five times a week
7. Daily

**39. Have you ever lived with the child's father? Specify for how long**

0. No - including "on weekends"
1. Yes - 2 weeks - 1 month
2. Yes - 2 - 6 months
3. Yes - 7 months - 1 year
4. Yes - 2 - 3 years
5. Yes - 4 - 5 years
6. Yes - don't know how long; long time; etc.

**40. Where is the child's father living now?**

1. In the same house as me
2. Elsewhere - known
3. Elsewhere - unknown

**41. Are you living with someone else other than the child's father?**

0. No
1. Yes - for about 1 year
2. Yes - don't know how long

**42. Are you/have you ever been married?**

0. No
1. Yes

**43. If yes, what kind of marriage did/do you have?**

1. Church/Religious institution
2. Civil rights/Magistrate's office
3. Traditional/Customary

**44. How long have you lived in your present house?**

1. Less than 6 months
2. More than 6 months but less than one year
3. More than 1 year but less than 2 years
4. More than 2 years but less than 3 years
5. More than 3 years but less than 4 years
6. More than 4 years but less than 5 years
7. 5 years or more

**45. How many times have you moved your place of residence within the last five years?**

1. None
2. Once
3. Twice
4. Three times
5. Four Times
6. Five times
7. Six times or more

**46. Why have you not stayed in the same place? (mark all that apply)**

1. Individual choice/ambition eg. moved away from parents, moved into a bigger house, moved to Soweto from another area - including those seeking employment in the city, those visiting their boyfriends who live in Soweto etc.
2. Financial reasons eg. couldn't afford the rent
3. Housing problems eg. difficulty finding accommodation
4. Mass/forced removals eg. involuntary resettlements and evacuation after Kliptown floods - including a mother who had to leave her residence at employers because she had a child
5. Personal relationship difficulties eg. divorce, quarrelled with inlaws etc.

**47. Have the same adults been living in this house consistently for the last three years?**

0. No
1. Yes

**48. Under what circumstances do you have permission to be in the urban area of Soweto?**

0. No permission - illegal
1. No permission but eligible and awaiting issue of pass/reference book
2. Section 10 (permanent)

**49. How often do YOU actually sleep in this house?**

1. Once - twice a month or less
2. Three times a month or more
3. Once - twice a week
4. Three times a week or more
5. Every night - including returning home late

**50. Besides the child, is anyone in the household seriously ill? Specify whom.**

0. No
1. Yes, myself
2. Yes, female member, eg. own mother, sister, aunt: including inlaws and other non-blood relations
3. Yes, male member, eg. husband, boyfriend, uncle: including inlaws and other non-blood relations

**51. How many people in the household are seriously ill?**

0. None
1. One
2. Two
3. Three
4. Four

## Alcohol and Drug Use

**52. Does anyone in the household have a drinking problem? (See definition in chapter 1). Specify whom.**

0. No.
1. Yes, female member, eg. own mother, sister, aunt: including inlaws and other non-blood relations
2. Yes, male member, eg. husband, boyfriend, uncle: including inlaws and other non-blood relations

**53. How many people in the household have a drinking problem?**

0. None
1. One
2. Two
3. Three
4. Four

**54. Does anyone in the household have a drug problem? (See definition in chapter 1). Specify whom.**

0. No
1. Yes

## Social Support/Influence

**55. Do you belong to a group which meets regularly, eg. stokvel, burial society? Specify purpose of group.**

0. No,
1. Burial society
2. Stokvel, syndicate for money saving, including parties which are business ventures and shebeening
3. Womens club/help-mekaar

**56. Do you have any special hobbies or interests that you do with other people? Give examples.**

0. No.
1. Spectator sport, eg. soccer, basketball, boxing
2. Sporting activity, eg. tennis, swimming, dancing
3. Watching TV and movies
4. Playing a musical instrument
5. Arts and crafts, including knitting, plastic flower making
6. Cooking and baking with a friend
7. Reading to old relatives, children

**57. Do you belong to a church? Specify which church.**

0. No
1. Roman Catholic
2. Protestant/non-Catholic
3. Traditional/Culturally influenced, eg. Bantu church of Zion, African Gospel, Zion Apostolic, etc.

**58. In general, how many times a year do you go to church/Religious institution?**

0. Never
1. Occasionally
2. Regularly (i.e. monthly)
3. Very regularly (i.e. weekly)

**59. Whom do you talk to/consult when you have problems with the child/children? (Mark all that apply)**

0. Nobody
1. Female family, relatives, eg. own mother, sister, aunt: including inlaws and other non-blood relations
2. Male family, relatives, eg. own father, husband, boyfriend, uncle; including inlaws and other non-blood relations
3. Present friends and acquaintances including church elders, burial society friends, landlady
4. Clinic hospital workers, eg. doctors, nurses
5. Read books

**60. Before you brought the child to the hospital/clinic, did you take it to a traditional doctor?**

0. No
1. Yes

## Child Rearing

**61. How much time do you spend with the child per day?**

1. 1 - 2 hours per day
2. 3 - 4 hours per day
3. 5 - 6 hours per day
4. Daily/continual (18 - 24 hours per day)

**62. If you do not see the child daily, how much time do you spend with the child per week?**

1. Very little time, eg. a nurse who does night duty, mothers whose children live with grandparents
2. 2 - 4 hours once a week
3. Part of the weekend, i.e. 5 - 24 hours per week
4. Whole weekend, i.e. 48 hours per week

**63. Who taught you how to, or influenced the way, you bring up this child? (Mark all that apply)**

1. Own Mother
2. Family, relatives
3. Present friends, acquaintances, neighbours
4. Clinic/Hospital workers e.g. doctors, nurses
5. Mass media e.g. newspaper, magazine. radio, television.
6. Employers
7. Nobody – trial and error (including mothers who gained experience by looking after their own siblings)

**64. Do you think the child is being well looked after?**

0. No
1. Yes
2. Don't know

**65. If circumstances allowed, how would you like to change the way the child is being cared for when you are at work?**

1. Dissatisfied but don't know what to do
2. Would like to care for the child myself
3. Would like to be able to afford what the child requires for good development, eg. warm clothes when cold
4. Would like to find a good childminder or creche
5. Satisfied - no need for change, present childminder is good

**66. What is your occupation?**

1. Manual labourer, eg. domestic worker, car washer, road construction work, ward assistant, machine operator, hawking and shebeening activities
2. Non-manual labourer, e.g. secretarial and computer work - including operating and programming, dressmaker, hairdresser and a traditional doctor
3. Full-time housewife
4. Student - primary, secondary tertiary
5. Unemployed

**67. If working how long have you been at your present job?**

1. Less than 6 months
2. More than 6 months but less than 1 year
3. More than 1 year but less than 2 years
4. More than 2 years but less than 5 years
5. Five years or more

**68. How many jobs have you had in the last five years, including your present job?**

1. One
2. Two
3. Three
4. Four
5. Five or more

**69. Do your employers give you or your children presents? Specify frequency and what kind or presents.**

0. No
1. Yes, occasionally, eg. toys and old clothes at Christmas time

**70. If you are unable to go to work because of sickness, advanced pregnancy or nursing a new baby, is the period you are unable to work deducted from you pay? Specify frequency in the last 5 years.**

0. No
1. One - twice
2. Three - four times
3. Five or more times
4. Don't remember how many times

## Child Care when Mother is at Work/School

**71. Who looks after this child while you are at work?**

1. Non-professional female childminder: day care, non-relative
2. Non-professional female childminder: live in, non-relative
3. Non-professional female childminder: day care, relative
4. Non-professional female childminder: live in, relative
5. Professional, trained female childminder: day care, non-relative, e.g. creche worker

**72. How old is this person?**

1. Under 15
2. 17 - 19
3. 20 - 24
4. 25 - 29
5. 30 - 34
6. 35 - 39
7. 40 - 44
8. 45 - 49
9. 50 plus

**73. Do you have to pay this person to look after the child? Specify how much.**

0. No
1. What I can afford at the time, i.e. unspecified amount
2. Less than R25 per month
3. R26 - R40 per month
4. R41 - R60 per month
5. More than R60 per month

**74. Do you provide food for the child when he/she is with this person?**

0. No
1. Yes

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