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Familial and Contextual Influences on Children's Prosocial Behavior: South African Caregivers as Adult Protective Shields in Enhancing Child Mental Health

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Abstract

Background The mental health of children is too frequently overlooked in resource scarce low and middle-income countries. South Africa represents one of many country contexts struggling to meet the mental health needs of large numbers of young people. Family caregivers have been identified as potential protective influences on child mental health, even for those children being reared with high exposure to poverty.

Methods This paper explores contextual influences on South African caregiver's social-emotional health living in communities impacted by poverty and food insecurity as they attempt to support their children's prosocial skills and behavior. Structural Equation Modeling (SEM) was employed to explore the relationship between neighborhood social cohesion and caregiver report of child's prosocial behavior as mediated by the caregiver's mental health ($n=478$).

Results Results indicated that the more caregivers experience their communities as socially cohesive, the better their social-emotional well-being, thus positively related to their reports of children's prosocial behavior. Furthermore, when there is a male head of household, caregivers reported better social-emotional well-being in comparison to female headed of household. The more food secure caregivers also were likely to report better general health.

Conclusion South African community characteristics and caregivers, in particular male caregivers, are integral to child and caregiver mental health. Future research should examine the impact of interventions that mobilize community and caregiver supports for children's prosocial behavior and mental health.

Keywords South Africa · Caregivers · Male caregivers · Food security · Child mental health · Adult protective factor

Introduction

Almost 90 % of children and adolescents worldwide live in low- and middle-income countries. These youth constitute almost a third of the world's population (Kieling et al. 2011). Mental health challenges have been identified as accounting for a large percentage of disease burdens among young people across the world (Patel et al. 2007). South Africa, with a population of approximately 50 million, has more than 30 % of children under the age of 15 (UNDES 2012). Youth in South Africa are exposed to multiple influences that can undermine their mental health. Specifically, stressors associated with poverty and food insecurity can increase engagement in risk behaviors and potentially reduce acquisition of prosocial behavioral skills (Petersen et al. 2013). Lacking optimal behavioral skills in childhood is related to negative mental health and poorer development outcomes as children grow.

Many families in South Africa continue to be plagued by poverty, unemployment, and steep food prices. Food insecurity can adversely impact caregiver health and mental health, which can have negative consequences for their children (Chitlga-Mabugu et al. 2013). However, adults can serve as a protective shield to mitigate the impact of toxic contextual influences on their children (Bell and McKay 2004; Patel

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et al. 2007). Having an additional parental figure, at times referred to as a member of the adult protective shield, in the household, has been linked to child mental health and behavior. Understanding the ecological influences on and within South African families is important in order to support the development of child prosocial skills and behaviors. Youth prosocial behavior plays an important role in their social competence and relationships throughout their lives (Soenens et al. 2007; Sallquist et al. 2009; Yoo et al. 2013).

This paper seeks to explore the relationship between neighborhood characteristics, caregiver well-being, and children's prosocial behavior. Utilization of the data collected from the Collaborative HIV Prevention and Adolescent Mental Health Program in South Africa (CHAMPSA, Bell et al. 2008; Bhana et al. 2010) allows for the exploration of individual and contextual factors associated with South African caregiver and child mental health. Since 30 % of children in the study lived with a caregiver other than their biological parent, the adults in the lives of children are referred to as caregivers (Bell et al. 2008).

Global Child Mental Health

Mental health problems and disorders often begin during childhood and continue into adulthood without proper treatment. This may result in emotional impairments and negative prosocial outcomes (White et al. 1990; APA 1994; WHO 2007). Globally, approximately 20 % of youth experience mental health challenges or behavioral difficulties (WHO, n.d.). Countries throughout the world with large populations of individuals under the age of 19 have the poorest level of mental health resources, with most low and middle income countries having only one mental health professional for every 1 to 4 million people (WHO, n.d.). Child and adolescent behavioral patterns are developed within community and familial contexts. Relationships with family members contribute to positive social and psychological development (Yoo et al. 2013). Caregivers are a crucial factor associated with child outcomes (Barber et al. 2005). Behaviors demonstrated by caregivers can impact child behavior outcomes (Barber 1996). Parental monitoring and supervision also contribute to rates of child risk behaviors (McGrath and Zook 2011; Wang et al. 2007). Early negative behavioral patterns can serve as predictors for mental health risk throughout childhood and adolescence (Botha and Mels 1990; Valdez et al. 2011).

Child Mental Health in South Africa

According to Kleintjes et al. (2006), approximately one in five children, including adolescents, in South Africa suffers from some type of mental health challenge. The prevalence of

mental illness among this group is estimated to be nearly the same as that in adults (WHO 2001; Patel et al. 2007). Studies have found that social stressors such as historical impact of apartheid, poverty, and food insecurity may have a negative impact on caregivers' mental health and parenting capacity that subsequently disrupt a young child's healthy development (Belsky 1984; Lachman et al. 2014). In addition, previous research suggests that chronically stressed caregivers are more likely to be socially isolated, experience worse mental health and greater relationship problems, and engage in authoritarian, harsh parenting practices (Belsky 1993; Conger et al. 2010; Lachman et al. 2014). Consequently, low parenting capacity implies a less warm and close parent-child relationship which negatively impacts children's opportunity to learn how to care for others, since they are not recipients of care themselves. Therefore, social support and family networks serve to lessen the psychological impact of negative contextual factors on caregiver's and children's mental health (Betancourt and Khan 2008). The optimal development of children's social and emotional functioning is largely connected to family caregivers' ability to provide a supportive environment that fosters psychosocial development (Walker et al. 2007, 2011). The ability for caregivers to provide a healthy home environment for their children given the context of communities experiencing the perils of poverty, food insecurity, and history of apartheid influences children's development of mental health and prosocial behavior (Bell and McKay 2004; McKay et al. 2004; Flisher et al. 2003).

Context of Apartheid on Caregiver and Child Mental Health

Apartheid, meaning "the state of being apart," aimed to establish a system of separate and racially homogenous states in South Africa, marginalizing the social and civil rights of the majority of black inhabitants (Shore 2009; Patel 2012). Given that approximately 80 % of South Africans are of black African ancestry, the country was marred with racial stratification and discrimination with White Europeans at the top, Indians from Asia and multi-racial coloreds, in the middle and black Africans at the bottom (Lever and James 2000; Census 2012). Compared to Whites, the black Africans, coloreds, and Indians experienced systematic discrimination (Lever and James 2000). In a divided society caused by political unrest and throes of major social transition, children in particular experience of trauma growing up. Therefore, their mental health problems are exacerbated by the discrimination and the effects of poverty and food insecurity faced by many of these children (Mkhize 1994; Straker et al. 1996; Tolfree 2003). As such, the nature of apartheid delinked children's attachment to their parents which brings about pervasive

negative mental health consequences and behaviors (Dommissie 1986; Straker 1987; Mohutsioa-Makhudu 1989; Turton and Chalmers 1990).

Effects of Poverty on South African Children

Structures of social inequality are critical determinants of health (Kawachi et al. 1999; Denton and Walters 1999). Caregiver and child health and mental health are embedded in their social environment (Horton and Wallander 2001). South Africa is ranked 13th of the world's highest in terms of the proportion of population living under the poverty line (Burns 2011). Although the poverty level has dropped from almost 11 % in 2006 (57 %) to 2011 (46 %), the percentage of the population that is poor is still relatively high (Statistics South Africa 2014). Children living in poverty experience higher incidences of adverse emotional health, physical health, and developmental and other outcomes than nonpoor children (Brooks-Gunn et al. 1996). Family poverty can further exacerbate children's externalizing and internalizing behaviors that potentially can lead to less prosocial behaviors.

Food Insecurity in South Africa

There are more than 814 million people living in developing countries who are undernourished with 204 million living in countries of sub-Saharan Africa, including South Africa (Labadarios et al. 2011). Food insecurity is commonly associated with poverty-impacted families (DAFF 2011). Most South Africans lack the essential land and resources to grow their own food and purchase their items (Shackleton et al. 2001). Increased costs of foods in the staple diet of poor South Africans can be problematic for the urban and rural poor who purchase most of their food products (Altman, Hart, Jacobs 2009). Nationally, South Africa is food secure, but many families still struggle with household food stability (Labadarios et al. 2011). There is approximately 23 % of children and caregivers in KwaZulu-Natal, a province in South Africa, who have inadequate access to food (Aliber 2009; DAFF 2011). The primary cause is often attributed to widespread poverty and unemployment (HSRC 2007; Labadarios et al. 2011). The ongoing struggle to access basic needs of food, shelter, clothing, and healthcare can compromise caregiver and child well-being (McLaughlin et al. 2012). Youth experiencing food insecurity in more developed countries may experience weight gain and deficiencies in essential vitamins; conversely, children in low-income countries also experience adverse comorbid physical and mental health disorders (McLaughlin et al. 2012).

Family Structure and the Role of Kinship in South African Families

The structures of families are often determinants for the health and well-being of children. Family structure and family functioning can moderate the negative effects families might experience in their community (Kuther and Fisher 1998; Pierce and Shields 1998). Aspects of the family structure are important to consider, including the nature of the affective and supportive relationship between caregiver and child (Whitbeck et al. 1993; Carson and Parke 1996). Kinship systems in South Africa include extended and fictive kin relationships (Madhavan and Roy 2012). The kin group does not simply adapt to crises but reflects cultural markers of family strength and resilience (Sudarska 1981; McDaniel 1990; Madhavan and Roy 2012). Various male kin members in many black communities in South Africa take on specific parenting roles ranging from social to spiritual guidance even when the biological father is in residence with the child (Mkhize 1994; Madhavan and Roy 2012). The role of male caregivers in kinship does not absolve fathers of their responsibility but shifts the focus of fathering to a more communal approach to caregiving of children (Madhavan and Roy 2012). The social support from kinship male caregivers can help bolster family functioning and healthy outcomes in children. The role of family and the quality of relationship between caregiver and child as well as caregiver monitoring and support play an important role in promoting youth prosocial behavior (Wallander and Varni 1998; Dutra et al. 2000; Forehand et al. 2002; Barakat 2008; Mellins et al. 2008). Therefore, caregivers, in particular male caregivers, are necessary not only in family functioning and household support but also in children's mental health.

Male Caregiving Influences on Child Mental Health

In the last two decades, there has been increased interest in the roles of male caregivers in child development (LaRossa 1988; Lamb 1997; Marsiglio et al. 2000; Palkovitz 2002; Brotherson and White 2007; Jones and Mosher 2013). Even though caregiving for children has historically been regulated to women, research to date identify the added protective influence male caregivers can provide (Jones and Mosher 2013). Male caregiving can promote child development because involvement supports secure attachment to the caregiver that in turn promotes healthy child outcomes (Pleck 1997). Research has shown that male caregivers provide overall protective and positive effect on their children's behavioral, psychological, and social outcomes throughout their developmental phases (Panter-Brick et al. 2014). The historical context of migrant labor that resulted in delinking child-rearing from marriage led many South African men to be both social and biological

caregivers of children (Richter et al. 2010). The portrayal of Black South African male caregivers who are uninvolved and unwilling to contribute to the well-being of their children and families is currently being debunked (Swartz and Bhana 2009; Madhavan and Roy 2012). South African male caregivers make unique contributions to their children through provisions of social capital, emotional support, and inherently important, love, and support (Nsamenang 2000; Morrell 2006; Madhavan et al. 2014). In many South African communities, kinship structures are integral especially where children are most affected by poverty (Richter and Morrell 2006; Roy 2008; Swartz and Bhana 2009; Madhavan and Roy 2012). Having a male head of household who is involved in the caregiving and caretaking of children reduces the likelihood of children engaging in risky behavior (Richter and Morrell 2006; Roy 2008; Swartz and Bhana 2009; Madhavan and Roy 2012) while improving their psychological and social well-being (Harris and Marmar 1996; Pleck 1997; Yeung et al. 2000). It is essential for caregivers, in particular male caregivers, to provide an adult protective shield through parental supervision and monitoring, as poor parental warmth, acceptance, and affection are associated with high levels of conflict, hostility, and risk of mental disorder in later life (Bell 2001, 2007).

Research Methods

The current study is a secondary analysis of baseline data from the Collaborative HIV Prevention and Adolescent Mental Health Program in South Africa (CHAMPSA, Bell et al. 2008; Bhana et al. 2010). CHAMPSA is a family-based HIV, developmentally timed prevention intervention to reduce sexual risk behaviors among uninfected pre and early adolescents within township communities in South Africa. It is a manualized program that consists of 10 weeks of 10 to 90 minutes sessions with families (children and their caregivers). The program was tested and shows effectiveness in studies in the USA (Mckay et al. 2004; Madison et al. 2000) and in the Caribbean (Voisin et al. 2006).

Our analyses focused on baseline data collected from caregivers ($n=478$) and their children. The adult and child measures collected information at baseline and post-test concerning various parenting behaviors and styles, knowledge about AIDS and sexual transmission, mental health, neighborhood characteristics, and child prosocial behaviors. This study focuses on caregiver self-report of their social-emotional well-being, level of neighborhood social cohesion, and their children prosocial behaviors.

The inclusion criteria consisted of children enrolled in school between the ages of 9 and 13 years old that are reared by an adult caregiver older than 18 years who provides parenting responsibilities. Agreement to participate in the study

was through caregiver consent and child assent. Participants were recruited through 20 primary schools located within the four community areas of KwaDedangendalale located in the province of KwaZulu-Natal (Molweni, KwaNyusawa, KwaNgcolosi and Qadi, Bell et al. 2008) for 4 years (May 2003 to April 2006).

Measures

Neighborhood Social Cohesion

The Neighborhood Social Cohesion (NSCA) scale is based on 4-point Likert scale asking participants if their neighborhood is a safe place for children, “close knit,” if neighbors are willing to help each other, do neighbors get along, can neighbors can be trusted, and neighbors share the same values (Sampson et al. 1997). A total social cohesion score was calculated, and items were reversed scored with a higher score representing higher levels of neighborhood social cohesion (4 = *strongly agree*, 1 = *strongly disagree*). Reliability scores range from .90 (Echeverría et al. 2008) to .91 (Echeverría et al. 2004).

General Health Questionnaire

The General Health Questionnaire (GHQ) is a 12-item, short form self-administered instrument based on the respondent’s assessment of their current social-emotional well-being (Goldberg and Hillier 1979). A total score of the GHQ was obtained, and items were reversed scored with a higher score indicating higher GHQ scores (4 = *better than usual*, 1 = *much worse than usual*). Reliability scores from a comparable sample that consists of South African adults yielded an alpha coefficient of 0.85 (Pernice et al. 2000).

Child Risk Behavior Profile

The Child Risk Behavior Profile (CRBP) is a 37-item caregiver report on child’s prosocial behavior in the past 6 months. A total score for the scale was computed, and items were reversed scored with higher scores signifying more prosocial behavior in children (3 = *not true*, 1 = *very true*).

Food Insecurity

Respondents were asked a single question to indicate how long they gone without enough food in a given month (5 = *never*, 1 = *more than 6 times*).

Head of Household

Caregivers identified the gender along with additional information (age, education, employment status, and whether they receive a pension/disability grant) pertaining to the head of household (Table 1).

Data Analysis

Structural Equation Modeling (SEM) techniques using the Mplus Version 7.3, which accommodates continuous, count, ordinal, non-normal, and dichotomous exogenous and endogenous variables, were utilized (Muthén and Muthén 2008). Model fit was evaluated using standard global fit indices (e.g., RMSEA, CFI, and standardized RMR) and more focused fit indices (e.g., modification indices, standardized residuals). Model comparisons were enacted using chi square difference strategies with adjustments for robust estimation models (the Huber-White sandwich estimator) and also examining more traditional comparative fit indices (e.g., CFI). To explore model differences, equality constraints were imposed on targeted parameters and comparing the fit of such models with

unconstrained models. Missing data was treated using maximum likelihood robust (MLR) methods.

Results

The fit of the model in Fig. 1 was evaluated using a maximum likelihood robust algorithm. The model is statistically just-identified. A set of five indices of model fit was evaluated. The chi square test of model fit was statistically significant ($\chi^2(0) = 0.00, p < 0.05$) thus indicating a just-identified or saturated model. Chi square is affected by the size of the correlations and models with more than 400 cases that leads to poor model fit (Kenny 2014). A problem with this fit index is that there is no universally agreed upon standard as to what is a good model fit; therefore, alternative fit indices were explored (Kenny 2014). The root mean square error of approximation (RMSEA) was 0.000. The standardized root mean square residual was 0.00 indicating that the absolute average disparity between predicted and observed correlations is close to zero. The comparative fit index was 1.000 signifying that the model fits 100 % better than the independence model. Table 2 presents the parameter estimates for the coefficients of interest. Unstandardized path coefficients and their associated 95 % confidence intervals appear for each parameter estimate of interest, with standardized coefficients in parentheses. To reduce clutter, the correlations between exogenous variables are omitted.

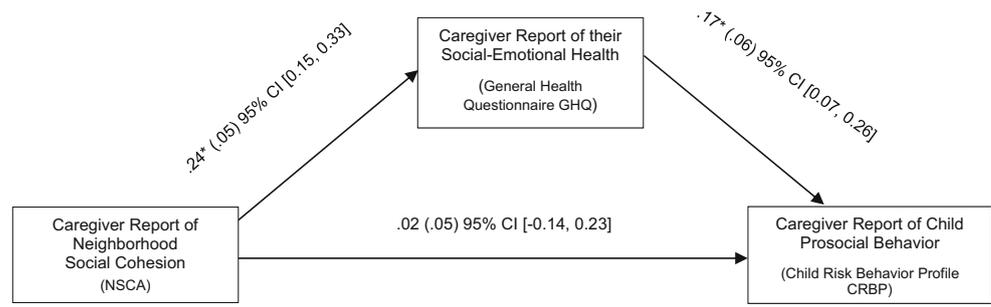
The model results were consistent with the level of cohesion in the caregiver's neighborhood impacting their social and emotional health that in turn accounts for how they report their children's prosocial behavior. All the paths in the mediated relationship were statistically significant ($p < 0.05$). For every one-unit increase in caregiver report on their health, the predicted number of prosocial child behavior increased, on average, by 0.17 ($p < .05, 95 \% CI [0.07, 0.26]$). For every one-unit increase in neighborhood social cohesion, there is a predicted 0.24 ($p < 0.05, 95 \% CI [0.15, 0.33]$) unit increase in caregiver report of their social and emotional health. Food insecurity and gender of the head of household were identified as covariates. For every unit increase in the level of food security a caregiver reports, there is a predicted 0.25-unit increase ($p < 0.05, 95 \% CI [0.18, 0.33]$) in their general health. When there is a female head of household, on average, there is an associated -0.10 ($p < 0.05, 95 \% CI [-0.11, -0.04]$) unit decrease in caregiver general health.

Based on the joint significance test of MacKinnon et al. (2002), caregiver report of their Social-Emotional health was a significant mediator of the estimated effects of neighborhood social cohesion on caregiver's report of child prosocial behavior. There was no support for the independent direct relationship between neighborhood social cohesion and child prosocial behavior ($0.02, p > 0.05, 95 \% CI [0.07, 0.26]$).

Table 1 Descriptive statistic for the sample

| Characteristics | (%) |
|---------------------------------------|------|
| Head of household ($n = 478$) | |
| Male | 52.3 |
| Female | 47.5 |
| Employment | |
| Yes | 29 |
| No | 12.4 |
| Recipient of pension/disability grant | |
| Yes | 18 |
| No | 41 |
| Children | |
| Gender | |
| Boy | 41.1 |
| Girl | 58.9 |
| Age | |
| 9 | 1 |
| 10 | 36 |
| 11 | 35.1 |
| 12 | 27 |
| 13 | .9 |
| Live with most of the time | |
| Mother | 67.4 |
| Father | 21.7 |
| Grandfather/grandmother | 33.3 |
| Uncle/aunt | 17.0 |

Fig. 1 Structural Model for Child Prosocial Behavior. * $p < 0.05$, standard error (in parenthesis)



Note: * = $p < 0.05$, parentheses = standard error

Coefficient estimates were derived in a way that permitted parameter estimation adjusted for measure unreliability. This involved creating a latent variable for each single indicator with a fixed factor loading of 1.0 and then constraining the random measurement error associated with the indicator to an a priori determined nonzero value reflecting the unreliability of the measure (Jöreskog and Sörbom 1996, p. 196). Reliability estimates were based on prior psychometric research (Achenbach and Edelbrock 1981; Sampson et al. 1997; Pevalin 2000). The standardized disturbance term for the number child prosocial behaviors was .90. Table 2 presents the estimated path coefficients.

Discussion

Few studies have examined the mechanisms that link neighborhood characteristics to specific caregiver social-emotional health and the effect on children prosocial behavior in the South African context. Using structural equation modeling, the study examined the relationships among neighborhood

social cohesion, caregiver report of their well-being, and children's behavior. Significant pathways were found between the mediated relationship of neighborhood characteristics, caregiver mental health, and children prosocial behavior. Given that many studies have shown that community experiences of poverty are major environmental risk factors that increase the burden of mental illness in children (Brooks-Gunn and Duncan 1997; Caspi et al. 2000; Yeung et al. 2002; Leventhal and Brooks-Gunn 2003; Xue et al. 2005; Amato 2010), in this study, there was not a direct relationship between neighborhood and prosocial behavior for this sample. The data supports how the adult protective shield is integral in promoting caregiver report of child prosocial behavior. When a caregiver maintains a level of well-being, it is inversely related to their reports of child conduct problems. Additionally, when there is a male head of household, caregivers report higher well-being and this could be contributed to having an additional income in the home or having an additional level of support in raising children (Madhavan and Roy 2012). These male caregivers appear to be identified as an additional adult protective shield in not only the reporting of better prosocial behavior in children but also increasing caregiver's mental health. The level of food security a family experiences appears to also play a role in caregiver mental health that corroborates with what the literature states (Casey et al. 2004; Stuff et al. 2004). The more food secure families are, the better caregiver reports their social-emotional well-being. The threat of poverty, food insecurity, and lack of neighborhood cohesion can be modifiable by a supportive family environment that provides a sense of cognitive reappraisal and safety (Chase-Lansdale et al. 1995).

Studies have shown that family caregivers who are poor are more likely to have higher rates of mental health challenges and impaired child interactions than caregivers who are not poor (Brooks-Gunn and Duncan 1996; Duncan and Brooks-Gunn 2000). Our study indicates that when caregivers feel that their community is socially cohesive and when they are food secure while there is a male head of household, they report better social and emotional well-being. Given the context of living in poverty impacted communities, caregivers report better mental health and in turn report better child prosocial behavior

Table 2 Unstandardized, standardized, and significance levels for model in Fig. 1 (standard errors in parentheses; $N = 478$)

| Parameter estimate | Unstandardized | Standardized | p value |
|--------------------------|----------------|--------------|-----------|
| Structural model | | | |
| CRBP → GHQ | .25 (.09) | .15 | .00* |
| CRBP → NSCA | .04 (.09) | .02 | .62 |
| GHQ → NSCA | .22 (.05) | .20 | .00* |
| Total effect | .05 (.02) | .03 | .02* |
| NSCA → GHQ → CRBP | | | |
| Measurement model | | | |
| CRBP → GHQ | .28 (.01) | .17 | .00* |
| CRBP → NSCA | .05 (.11) | .02 | .69 |
| GHQ → NSCA | .28 (.06) | .24 | .00* |
| Total effect | .08 (.03) | .04 | .02* |
| NSCA → GHQ → CRBP | | | |

CFI = 1.00, RMSEA = .00, SRMR = .00

* $p < 0.05$

when they are food secure and when there is an additional caregiver in the home. Although Black male caregivers in South Africa have been stereotyped as uninvolved (Posel and Devey 2006) and abusive (Richter and Dawes 2008), there is increased recognition and a societal shift to promote constructive male involvement in children's lives (Richter et al. 2010). Children benefit and greatly appreciate having an additional parental figure in the household (Penner 2002; Richter and Morrell 2006; Barry et al. 2008; Richter et al. 2010).

Limitations

Although the findings from this study are reflective of the data, the results must be interpreted in the context of the study's methodological limitations. Reliance on caregiver and child self-reports is subjected to measurement error that can yield bias in the parameter estimates. We assessed but did not comprehensively address the nature of South African poverty and the complex familial relationships/kinship within these dyads. The reliability of the measures used in CHAMPSA study has not been tested on a South African population. There is also limited information on what role South African male caregivers play in the household and how it relates to the caregiver's mental health and reporting of child prosocial behavior. Our results appear to show that when there is a male who is head of the household, caregivers of children are reporting better mental health. There is limited information, from this data, on who exactly the male caregivers are and how and to what extent they provide support to children.

Implications

To further understand and improve the burden of mental illness of children in low- and middle-income countries, it is necessary to understand youth within their context. Children are embedded within families and communities who have responsibility for their care (Hoagwood et al. 2009). Mental health interventions need to continue to collaborate with caregivers in families to improve the well-being of children. Prosocial behavioral change in youth is unlikely to be sustained if one caregiver is the sole target of a parenting intervention (Panter-Brick et al. 2014). Parenting programs that help improve child mental health should be respectful of cultural values and kinship structures of South African families. Specifically, male caregivers should be included and engaged in parenting interventions because their presence greatly impacts children and family well-being. Future research should closely examine the ways in which male caregivers and heads of household are supporting child prosocial

behavioral skills and improving caregiver mental health. This research should examine the multiple factors that contribute to child and caregiver social-emotional health across ecological domains. Moreover, this research should also examine how male caregivers can provide an additional adult protective shield in reducing risk behavior while improving the mental health of children. Interventions targeted to bolster South African child well-being should comprehensively understand the kinship structures within families and be sensitive to the various caregiving contexts.

Conclusion

South Africa has a history of communities greatly impacted by racism, apartheid, poverty, food insecurity, and HIV. The prevalence of child mental health problems in sub-Saharan Africa ranges up to 71 % (Cortina et al. 2012). In light of this, child health and mental health has been identified by the South Africa's 4-year National Strategic plan as one of the key populations that are at heightened risk (SANAC 2012). Our results indicate that caregivers are agents in helping improving prosocial behavior in their children when they are supported at home and in the community. Research has consistently found that there is a direct relationship between neighborhood characteristics and children's behavior. The present study identified that caregivers are influenced by neighborhood characteristics that then influence their reporting on child mental health. It is the role of researchers, practitioners, and policy makers to continue calling for family caregivers in promoting child social-emotional health that will interrupt negative pathways leading to conduct disorder and delinquency. It is essential to support the provision of interventions that engages the entire family unit in improving mental health of children in low- and middle-income countries.

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