



PSPPD

PROGRAMME TO
SUPPORT PRO-POOR
POLICY DEVELOPMENT



The Centre for Social
Development in Africa,
University of Johannesburg

Family contexts, child
support grants and
child well-being in
South Africa

Summary report

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PSPPD
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SUPPORT PRO-POOR
POLICY DEVELOPMENT





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Preface

Despite significant progress in meeting the basic needs of children over the past two decades, 6 out of 10 children are still living below the upper bounds of the poverty line, continue to experience hunger and nutritional deficits, and have sub-optimal living conditions. Cash transfers, such as the Child Support Grant (CSG), are important in promoting child well-being, but they cannot solve the complex and multifaceted issues that compromise child well-being outcomes on their own.

One way to increase support to poor and vulnerable families in receipt of a CSG is through the provision of family- and community-based preventative developmental welfare interventions that combine social and economic interventions and that include information, education and prevention strategies. Although this will require significant mind shifts among policy-makers, practitioners, and development agencies, there is great scope for innovation and learning from practice to find solutions suited to the South African, and indeed the African, context.

The Programme to Support Pro-Poor Policy Development (PSPPD)

The Programme to Support Pro-poor Policy Development (PSPPD) is a research and capacity-building programme located within the Department of Planning, Monitoring and Evaluation (DPME). The PSPPD is part of the larger National Development Policy Support Programme (NDPSP), the overarching Programme between the South African government and the European Union.

The core purpose of the PSPPD is to improve evidence-based policy-making (EBPM) and implementation on poverty and inequality at national and provincial levels through a variety of learning and capacity development tools, such as research, capacity building, training events, conferences and workshops, and study tours.

The PSPPD aims to improve evidence-based policy initiatives which transform the conventional relationship between policy-making and the use of social science evidence – making evidence an integral part of the decision-making around policies in policy development and implementation. The PSPPD also contributes to the building of an evidence base and sharing of knowledge through its partnerships with a range of organisations, academia, think tanks and the public sector.



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DISCLAIMER

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1. Acronyms

BMI	Body Mass Index
CCF	Child care facility
CSG	Child Support Grant
ECD	Early child development
FGG	Focus group guide
NGO	Non-governmental organisation
NIDS	National Income Dynamics Study



NSNP	National School Nutrition Programme
PSU	Primary Sampling Unit
SANHANES	South African National Health and Nutrition Examination Survey
SASSA	South Africa Social Security Agency
SPSS	Statistical Package for the Social Sciences
TAA	Tribal Authority Area

2. Introduction

Over 12 million, or 63%, of South Africa's children will receive the Child Support Grant (CSG) in 2017. The CSG is the country's flagship poverty reduction programme for children. Initially designed to support poor households to promote food security, it has expanded significantly and is an important social investment in children's well-being. Positive benefits have been noted in increased expenditure on food (Coetzee, 2014) and improved child nutrition (Agüero, Carter & Woolard, 2007), improvements in school attendance (Case, Hosegood & Lund, 2005) with positive effects on grade progression and learning outcomes (DSD, SASSA & UNICEF, 2012). Grant receipt is also associated with having protective effects in adolescence by reducing risk behaviour (DSD et al., 2012); enabling caregivers to seek employment; contributing to education, travel and child care costs (Eyal & Woolard, 2011); and increased caregiver engagement in children's well-being (Patel, Knijn & van Wel, 2015).

However, despite significant progress in meeting the basic needs of children over the past two decades, 6 out of 10 children are still living below the upper bounds of the poverty line, continue to experience hunger and nutritional deficits, and have sub-optimal living conditions. These are known risk factors associated with compromised well-being. While cash transfers are important in promoting child well-being, on their own they are not able to address the complex and multi-faceted needs of children and their families (Hochfeld, 2015). There is therefore a need for solutions that will accelerate the achievement of child well-being through holistic, appropriate and high impact interventions that can break the cycle of structural disadvantage facing families with young children under eight years.

The primary focus of traditional child protection is on outcomes for children; but children do not exist in isolation of their families and the communities in which they live. Understanding children and their families in a wider community, cultural, economic and societal context could therefore provide pointers for child and family interventions that are evidence-based and that are likely to contribute to positive long-term benefits for children (Schmid & Patel, 2016; Pollard & Lee, 2003). Comprehending these interfaces is critical to child well-being. In particular, interventions in the early years of life are associated with improved child development trajectories (Berry, Dawes & Biersteker, 2013) and in overcoming inequality gaps between advantaged and disadvantaged children (Cunha & Heckman, 2006). However, we know little about which factors are associated with child well-being in the South African context and how we may further strengthen efforts by families to enhance the well-being of CSG beneficiaries. Unlike the traditional approach to child protection, the developmental approach to child and family well-being adopts a positive frame of reference, and emphasises strengths, assets and enhanced capabilities of children and of their families. This perspective is embedded in the social development approach to child welfare (Patel, 2015; Schmid, 2010, 2012).

Despite significant resources having been dedicated over the past two decades to improve child health, education, social assistance coverage and welfare services for children and families in South Africa, limited resources have been earmarked specifically for prevention of social problems and to promote the capabilities of families, beyond the income support provided by the CSG. Although the need for synergy between social protection and developmental welfare services is acknowledged in various policy documents, research to inform such policies and social service interventions is limited.

Hence, the aim of this study was firstly, to contribute to our understanding of the interface between family contexts and child well-being outcomes; secondly, to shed light on the perspectives of families themselves about various aspects of caregiving, family beliefs and their needs and challenges; and thirdly, to provide recommendations for family and community-based developmental welfare interventions to further scale up the already positive impacts of the CSG. It was anticipated that the study would contribute to the search for solutions to some of the social and economic factors underpinning the disruption of family life and a weakening of family functioning, with commensurate negative effects on the well-being of children.

3. Methodology

Research design

A mixed methods design was employed combining quantitative national statistical data with qualitative insights gained from families in receipt of CSGs. Secondary quantitative data were drawn from the National Income Dynamics Survey (NIDS) Wave 1 of 2008. The analysis is based on a sample of 3 132 children and their families who were under eight years. Qualitative data were collected to complement the quantitative data and to inform the design of a family strengthening intervention. Six focus groups comprising 40 respondents participated in the study in two areas: Doornkop in Soweto (an urban area) and Moutse in the Sekhukhune district in Limpopo (a rural area). In addition, 10 key informant interviews were conducted with service providers engaged in the delivery of family interventions nationally. A literature study of family interventions internationally was also conducted.

Objectives

1. To determine the profile of children who receive a CSG in relation to the families they live with, their caregiver characteristics, their family functioning, as well as the social organisation of the communities in which they live.
2. To assess to what extent family structure, caregiver characteristics, family functioning, and community level social organisation impact on their well-being.
3. To identify the factors associated with child well-being outcomes.
4. To gain knowledge and understanding of the family lives of CSG beneficiaries, their perspectives of caregiving, and the challenges they face.
5. To gain insight into family interventions in South Africa.
6. To make recommendations for the development of a complementary developmental welfare family intervention for CSG beneficiaries.

4. Part 1: Quantitative component

Variables and indicators

For the purposes of the study, child well-being was defined as a multi-dimensional construct made up of different dimensions of well-being (Pollard & Lee, 2002: 64), including material (or economic), physical, cognitive, social and emotional dimensions. Child well-being was understood to be influenced by factors such as family structure, family functioning, social and community organisation, and financial capabilities.

In the quantitative data, subjective perceptions of child health based on the caregiver's assessment of the health of the child were used, as well as anthropometric measures based on guidelines set by the World Health Organization (WHO) as indicators of child health as these data were available for all age groups under eight years. We used child health and access to education as proxies for child well-being. These proxies are, however, limited and should be treated with caution. Nevertheless, they do provide insight into the direction of change that is associated with receipt of a CSG. The qualitative data explored issues related to caregiving in relation to family functioning, family beliefs, access to social support and services, including an assessment of caregiver mental health.

For educational well-being, the first indicator was whether children aged three to five years were enrolled in a childcare facility, such as an early child development (ECD) centre. The second indicator was whether children aged six and seven were enrolled in formal schooling.

Various factors were assessed as to whether they influenced child health and educational outcomes. The first set of factors was defined as caregiver characteristics, which were made up of demographic variables such as the gender, age, education level, and mental health status of the caregiver. A second set related to family structure and whether it influenced child health outcomes. The third factor assessed the influence of household income on child well-being, and the fourth, a composite measure of the level of social and community organisation, was derived to assess whether it had an impact on child health and education. Finally, family functioning was considered to be a key variable in determining child well-being. These data were not available in the NIDS and was derived from qualitative data (six focus groups). The findings from the qualitative data can be found further on in this report.

Sampling

Leibbrandt et al. (2009) indicated that the sampling for the NIDS involved a stratified, two-stage cluster sample design. A total of 400 Primary Sampling Units (PSUs) were proportionally allocated according to the 53 district councils, and then randomly selected from Statistics South Africa's 2003 master sample of 3 000 PSUs.

The sample for this specific study was children younger than eight years who were recipients of the CSG, and for whom information on caregivers was available in the data set. Of the total of 9 605 children younger than 15 years (Chinhema et al., 2016), 5 549 received a CSG. Of these, 3 132 were younger than eight years and could be linked to a caregiver.

Ethical considerations

Collection of the NIDS data followed all ethical guidelines, for which approval was granted by the Commerce Faculty Ethics Committee of the University of Cape Town. The committee ensured that the NIDS appropriately adhered to the ethical principles of confidentiality, anonymity, voluntary participation and informed consent (Leibbrandt et al., 2009).

Validity and reliability

A number of mechanisms enhanced the reliability and validity of the instruments used in the NIDS study. In the first instance, a team of experts was recruited to consult on the development of the questionnaire and to give input on the types of questions used (Leibbrandt et al., 2009). Additionally, Leibbrandt, et al. (2009) report that the questionnaire was assessed through a piloting phase of the study.

Limitations of the NIDS

One limitation of the NIDS is that it is subject to non-response bias because refusals are highest among affluent respondents, who still tend to be white in South Africa. Nevertheless, to help with the representativeness of the sample, weighting was applied to compensate for the bias in the study. A further weakness was that child well-being measures were restricted by the data collected in the NIDS.

Quantitative data analysis

The data were analysed using the Statistical Package for the Social Sciences (SPSS). For the purposes of this study, the data analysis consisted of frequency distributions, bi- and multi-variate associations, and Pearson's correlations. Chi-square tests were applied to test the statistical validity of variable associations, and, where applicable, correlation analyses were run on certain of these variables. A 5% confidence level was used to determine significance of findings.

Path analysis model

The path analysis model was used to establish the relationship between the independent and dependent variables via a mediation model. Thereafter, bivariate correlations were run for all the variables and coded as follows:

Predictors

- Caregiver age: continuous (range 15-87, M = 36.72, SD = 14.48)
- Caregiver education: 0 (no schooling) to 4 (tertiary schooling)
- # parents in household: 0 (not a 2-parent household), 1 (2-parent household)
- Relative in household: 0 (no relatives in household), 1 (relatives in household)
- # of household residents: continuous
- Access to family support: 0 (no access), 1 (access)
- Household income: 0 (much below average) to 4 (much above average)
- Living standards: 0 (low), 1 (medium), 2 (high)
- Caregiver health: 0 (poor) to 4 (excellent)
- Caregiver depression: continuous score (higher means more depressive symptoms)

Outcomes

- Perceived child health: 0 (poor) to 4 (excellent)
- Height and weight for age: continuous, z-score
- Child food security: 0 (food insecure), 1 (food secure)

5. Part 2: Qualitative component

Focus groups

To shed light on the perspectives of families themselves about various aspects of caregiving, family beliefs, and their needs and challenges, six focus groups with caregivers (40) were held in two target communities.

Research sites

The two target groups of the study were families who receive a CSG from Doornkop in Soweto (an urban area) and Moutse in the Sekhukhune district in Limpopo (a rural area).

Doornkop falls into wards 49, 50, and 129 of Region D, and is among the poorest formal areas in Johannesburg (Patel, Hochfeld, Moodley, & Mutwali, 2012). The current population of Doornkop is large, at 58 000¹. It is located to the West of Johannesburg, adjacent to two Randfontein mine dumps which blow extensive dust into the area during windy periods. Over 80% of households receive a CSG and earn below R2 500 per month (Patel et al., 2012), indicating low household income and, therefore, widespread poverty. Our local partner organisation in Doornkop was an international non-governmental organisation (NGO) called Humana People to People.

Moutse area, located in the Elias Motsoaledi local municipality, is one of the poorest districts in the country, characterised by a shortage of infrastructure and lack of safe water supply. There is a high rate of unemployment (61.6%) and poverty², with many families receiving social grants. Our research partner was an NGO named Ndlovu Care Services, a public health care service provider in the area.

Sampling

Three focus groups were run in each research site, with 19 participants in Moutse and 21 participants in Doornkop, that is, a total of 40 participants in all. The selection criteria for the focus groups were that participants be adult (over 18 years) parents/caregivers/family members of children who are younger than eight years living in the same household.

¹ https://joburg.org.za/index.php?option=com_content&task=view&id=174&Itemid=168&limitstart=1.

² <http://www.hst.org.za/content/isds-site-greater-sekhukhune-district-municipality>.

The participants were recruited using convenience sampling at local South Africa Social Security Agency (SASSA) pay points at each research site, where participants were collecting their CSG money. The researcher approached a person, asked to speak to them, explained the research very briefly, administered a short questionnaire, and asked for a phone number and permission to contact them at a later stage.

Research instruments

A focus group guide (FGG) was developed for the focus group interviews. The FGG comprised six sections. The first section contained a three stage vignette which was designed to elicit information from focus group participants in relation to their family beliefs about caregiving, supervision of children, and family communication. Sections two to five of the interview schedule largely related to community and household resources, family functioning, service use/delivery, and financial resources. The final section of the interview schedule contained a depression index called the CES-D 10, Center for Epidemiologic Studies Short Depression Scale, 10 questions (Radloff, 1977). The FGG was translated into isiZulu and SePedi as these were the most commonly spoken languages of the communities in which the focus group interviews were conducted.

Data collection

Prior to the data collection, training was conducted with the focus group facilitator. Groups were all audio recorded as well (permission was sought from all participants first). As the focus groups were conducted in either isiZulu or SePedi, the interviews were then transcribed and translated into English.

Data analysis

The analysis of the qualitative data was thematic and Atlas Ti was used for this purpose. The transcripts were coded through a deductive coding process, where a code tree was first created and the transcripts were coded according to pre-determined codes, although some new codes were added during the analysis process. Cross-checking coding by different researchers was undertaken to ensure the minimisation of bias and maximum consistency and coherence in code usage (Lincoln & Guba, 1985; Friese, 2014).

Ethical considerations

Ethical clearance for the qualitative part of this research was granted from the University of Johannesburg's Faculty of Humanities Ethics Committee.

Limitations

The small, non-probability convenience sample employed precluded generalisation of the findings beyond the communities concerned.

Key informant interviews

Sampling

A total of 10 key informant interviews were conducted with programme managers from organisations in South Africa. The programmes were selected via purposive sampling based on a literature and a web-based search of family programmes in South Africa. In addition, some programmes were identified by using a snowball technique whereby some key informants referred the researchers to other programmes, which were then followed up.

Research Instruments

A semi-structured interview schedule was designed for the key informant interviews, and pre-tested prior to data collection. The interview schedule aimed to elicit information on the particular programme the key informant knew best (at their organisation).

Data collection

Interviews were mostly conducted at the offices of the key informants. Both notes and recordings were used for referral afterwards.

Data analysis

The data from the key informant interviews were analysed using basic thematic content. Analysis was conducted using the interview schedule as a guide.

6. Results

Key findings from the NIDS analysis

Profile and household situation of CSG beneficiaries

- A third of children 0-8 years received the CSG. They were fairly evenly distributed across the age groups, except for children who were under one year of age who had lower levels of access to the CSG (7%). The majority were African (90%) and coloured (10%), and slightly more boys (2%) than girls received the CSG. A total of 58% of children lived in the Tribal Authority Areas (TAAs); 27% lived in urban formal areas; and the remaining (15%) lived in informal urban and rural areas.



- CSG households were generally larger (6.8 persons) compared to the national average household size of 3.6 members in 2011 (Community Survey, 2016). This finding was especially marked in the TAAs, where it was 7.22. The number of children per household was 2.40.
- The per capita income of members of their households was R394.21. Urban areas had higher per capita income than their rural counterparts, and household size was also smaller.

Child well-being outcomes

Education, health and food security

- Of the CSG beneficiaries of school going age, 92% were enrolled in either Grade R or Grade 1.
- Fewer children, around 4 out of 10 aged 3-5 years, were enrolled in a CCF. Enrolments in a CCF were much lower in rural areas due to a lack of available services.
- With regard to the health of the children, two-thirds of caregivers had a positive perception of the health of the child in their care.
- This perception was confirmed by the anthropometric measurements of the children, which revealed that 82% of children under five years were in the normal range for their weight for height measurements, and 91% were in the normal weight for age range, while 88% of children between 5-7 years were also within the normal Body Mass Index (BMI). Those who fell outside the normal range were 3.4 times more likely to be overweight than underweight, which is likely to be due to poor nutrition.
- Despite this finding, 17% of children aged 0-5 years were moderately stunted and 9% were severely stunted. Stunting is measured by height for age and is a consequence of long-term nutritional deprivation rather than acute deprivation (WHO, 2010). It is a significant risk factor for sound physical and cognitive development of children (Casale et al., 2014).

Income poverty and living standards

- Although the nutrition and health benefits of the CSG are noteworthy, all children in this sample lived in households that had an income below the upper bound poverty line at the time, and most lived below the lower bound poverty line. The small value of the grant and low and precarious income of grant beneficiary families explains why 4 out of 10 children continue to experience hunger to some degree, while 47% indicated that their food supply was scarce. Rural households were poorer and more food insecure than their urban counterparts.

- Half of the children lived in households with medium living standards. CSG beneficiaries had access to three out of five of the services that made up the living standards measure devised for this study. Living standard was assessed in relation to the dwelling type and access to basic services, including water, electricity, refuse removal and sanitation.

Caregiver characteristics, parental relations and mental health

- Caregivers were mainly women (97%) with a secondary education, and were largely unemployed (87%). Few male primary caregivers received the CSG.
- One in two caregivers lived in a household where there was no one employed and they were therefore more vulnerable. Younger caregivers were more likely than older caregivers to be better educated and enjoyed a higher living standard.
- Almost 7 out of 10 primary caregivers were the biological parents of the child and lived with the child in the same household. A fifth of primary caregivers were grandparents, followed by relatives.
- A fair number of primary caregivers (29%) had a partner who lived with them in the same household, with only 20% of couples being married. Non-resident mothers were more likely than non-resident fathers to give the household financial support. However, half of non-resident mothers and 60% of non-resident fathers did not provide any financial support.
- Father absence from the household was high, with almost three-quarters of fathers not being present for many reasons, such as labour migration from rural to urban areas. In 30% of cases, fathers never saw their children. There was also an increasing trend of labour migration among mothers. However, more mothers (78%) were resident in the household than fathers (26%).
- We also noted that large numbers of children (29%) continued to live apart from their parents, largely with relatives.
- The majority of parents did not present with a high number of depressive symptoms. However, almost a third were at high risk of depression. Caregivers with low levels of education were at greater risk of the development of mental illness. There was also a relationship between the perception caregivers had of their health and their mental health. Those who viewed their health more favourably were less likely to be depressed than those who saw themselves as having poor health. Similarly, those who perceived themselves as living in better-off households were more likely to have lower depression scores. A CES-D10 depression index administered in the focus groups with caregivers revealed higher rates of depression among women carers in the urban area (Doornkop) in Soweto compared to the rural area (Moutse).

Household structure

- The most common household structure of CSG beneficiaries was made up of the child, the parent, and adult relatives (34%).
- This structure was followed by families made up of a child and adult relatives with no parents (29%), child and both parents (15%); child, both parents and adult relatives (11%), and the child and one parent with no relatives (11%).
- A quarter of CSG beneficiaries in the early years of life were growing up in nuclear families or single parent families with no relatives living with them.
- Families with relatives were by far the most common family structure for this age group (75%), and most children were in households either with one parent or in households with no parents at all.

Access to social support and community environment

- A positive result was that 77% of caregivers had another family member to assist them with childcare. This finding confirms the importance of other adults who were engaged in the care of children.
- It emerged that children were growing up in communities that had a medium level of social and community organisation. The implication is that there was a fair level of participation of caregivers in social groups, they had some access to support from neighbours, perceived themselves to be fairly safe, there was some trust in their neighbours, and they enjoyed moderate living conditions, such as access to basic services, although they lacked adequate housing.

Factors influencing child well-being outcomes

The path analysis statistical model identified the following relationship predictors that are associated with child health outcomes:

- 1) There was no relationship between family structure as set out in the model and child health outcomes except in rural areas where child health was associated with living in a two-parent family.
- 2) Caregivers who perceived their own health to be good and who were not depressed were more likely to view the children's health favourably. Emotional well-being of the caregiver was also correlated with higher household income i.e. the economic circumstances of the household and higher education levels of the caregiver.

- 3) The education of the caregiver was also positively associated with having the children in her care aged 3-5 years enrolled in a CCF. Children who were slightly older (aged 6-7 years) were significantly more likely to be enrolled in school than those who were younger, as this is the age of mandatory schooling. Enrolment in a CCF was also significantly associated with household size, whereby enrolment declined as the household size increased. Similar outcomes were observed where there were larger numbers of biological children in the household. Higher living standards, higher educational attainment of the caregiver, and younger caregivers were associated with a higher likelihood of enrolling in a CCF. Further, children aged 6-7 years were more likely to be enrolled in school than younger children in a CCF. Also, education of the parent or geo-type (i.e. rural formal, TAA, urban formal, or urban informal location) did not have a bearing on school enrolment.
 - 4) The findings derived from the path analysis clearly showed which predictors were associated with perceptions of child health and the weight and height for age of the child. Predictors were found to occur via the increased access to food and underscores the important role that the CSG plays in enhancing food security and ensuring child well-being. The findings were different for rural and urban areas and provide some pointers for intervention. In rural areas, larger households are more likely to need additional food security interventions. In urban areas, caregiver depression had a significant effect on lower levels of child well-being, although other predictors such as income and living standards were also important.
- Practical barriers to child safety were the lack of fences around the properties, poor quality locks to their houses, or simply not having a security gate.
 - Very high rates of depressive symptomatology were evident among respondents in the focus groups.
 - Caregivers derived social and emotional support from family members and close adult relationships, and material support from their family network and their religious faith. Despite positive assistance, complex family relationships and obligations undermined the benefits of extended family support.
 - Changing social relations in neighbourhoods due to an erosion of trust and high rates of crime, violence and drug use worked against the spirit of Ubuntu in communities and were drivers of isolationist behaviour. While community support engendered a sense of belonging, a wariness and a lack of trust of neighbours was evident in both urban and rural areas.
 - The more social problems there were in communities, the harder it was to maintain a network of social support. Positive community support should not be presumed to exist. As a result of crime and drug addiction, the wider community context can be a 'disabling' rather than an enabling environment for child well-being.
 - A lack of access to quality services in local communities, such as child care, running water, and transport, as well as bad treatment by service officials, including corruption and discrimination in the delivery of services, were highlighted. The police and health care services were perceived to be of poor quality, especially in urban areas where services were over-subscribed and where community needs were overwhelming.
 - Despite the positive effects of the CSG, by itself it cannot solve the complex and interlocking structural, psychosocial, and household community level factors that need to work together to improve child well-being and break the inter-generational cycle of poverty and inequality in South Africa. One way to increase support to poor and vulnerable families in receipt of a CSG is through the provision of family- and community-based preventative developmental interventions that combine social and economic aspects, such as information, education and financial literacy (Patel, 2015).

Key findings from the qualitative analysis

Family functioning and caregiving

- From the qualitative data, we learnt that primary caregivers had a sound knowledge of the emotional and social care needs of the children. They were aware of the importance of emotional caregiving and the need to create caring environments for them. Evidence of positive, supportive and interactive family communication also existed.
- The need for knowledge and skills in alternative styles of discipline to more effectively manage the behaviour of children was emphasised. Primary caregivers were receptive to learning about new and different ways of parenting. Communication between family members needs further exploration.
- Challenges with the monitoring and supervision of children were directly related to poor living conditions, overcrowding, poverty, and a lack of safe play areas in communities.

7. Discussion

Quantitative findings

The CSG children described in this study were, for the most part, healthy, as reflected in the anthropometric measurements of the children where the vast majority (75% and upwards) fell within the normal range in terms of their physical development. This finding is in itself an important strength to build on, even if nutrition interventions must be urgently prioritised in order to address the quarter of children under five years who are stunted and severely stunted.

The generally healthy status of CSG children was borne out by the perception the caregivers had of the child. Two-thirds of caregivers viewed the health of the children they cared for to be “very good to excellent”. Caregivers who perceived their own health to be good were more likely to view children's health favourably. Similarly, the less depressed the caregivers were, the more positive they were about the health of the child. Those with higher education levels, or greater household income, were more likely to have lower depression scores than less educated or poorer caregivers.

The education of the caregiver played a role in a child's enrolment in a CCF. Children who were slightly older (aged 6-7 years) were significantly more likely to have been enrolled in a school than younger children were to have been enrolled in a CCF. Lack of enrolment in a CCF was particularly acute in rural areas, where the poorest households were the least educated and living in larger households.

In rural formal areas, where 70% of children aged 3-5 years were not enrolled in a CCF, in 82% of cases there was the support of relatives for child-caring purposes. However, in a quarter of the cases where the child was not enrolled in a CCF, the primary caregivers did not have family support with childcare, suggesting these children are at greater risk of compromised well-being.

A quarter of the children were living in nuclear families where the mother and father were present, but the most common family structure was made up of single parents and children (45%), of which single parent families with relatives was the most common family form for CSG beneficiaries. There was also no relationship between family structure and child well-being outcomes in the NIDS analysis except in rural areas where child health was associated with living in a two-parent family. This finding is contrary to Tippoo's (2012) finding that children with both biological parents had better well-being outcomes than those who did not; even when income, race and geography were accounted for.

Almost one in three children were not living with parents, which informed the design of the CSG in 1998. The absence of parents is indicative of the fragmentation of families in South Africa, suggesting strong continuities with the past and the present.

A distinguishing feature of the family structure of CSG beneficiaries was that in 74% of cases, relatives were present in the household, which could be due to the need to share resources and care responsibilities (Patel, 2009). While this finding may be interpreted as a positive development, it could also be a drain on household resources and impact food security negatively.

Fathers were significantly more likely to not live with the child than mothers, and significantly more likely to see the child less often. In only 40% of cases where the father was absent did he provide some financial support; which is in contrast to 50% of cases in which the mother was absent. Consequently, extended families carry the burden of economic, social and emotional support for one in three children, or 30%, of children in South Africa. Despite the burden of direct caregiving by extended families, in 77% of cases, caregivers indicated that they had additional support from family members for the care of the child.

Community affiliation was not especially high overall. While it was highest in urban informal areas, these communities were also the most likely to have felt unsupported by neighbours. While residents from rural formal areas were more likely than others to report feeling safe in their community, they were also the least likely to be affiliated to a community group.

What the NIDS analysis does highlight is that younger CSG children, and particularly those from rural areas, are the group most at risk. Younger children are also at greater risk health-wise, as borne out by the NIDS anthropometric data, as well as the South African National Health and Nutrition Examination Survey (SANHANES) national data. CSG children's risks should be understood within the wider societal context of income shortages, migration, the HIV and AIDS epidemic, and the fragmentation of families marked by the significant absence of fathers in children's lives. Individual characteristics of the caregiver were also relevant to child well-being, such as lower levels of educational attainment, age, and mental health. Poverty and lack of employment of household members and poor living standards were also associated with lower levels of well-being. However, these factors appear to be moderated by social support from extended family members and the high value placed on kinship support, despite the burden of care that they have to bear.

The findings of the path model showed the following significant relationship between the variables. First; having a relative in a household, higher living standards, and caregivers who perceived themselves to be healthy were associated with less food insecurity. Larger households in rural areas were associated with child food insecurity and with a caregiver being less likely to perceive the child to be healthy. Food security explains why these predictors were associated with the perception of improved health of a child.

Second, regarding the outcome measures for weight and height for age in rural areas, we found that having higher income, living standards and caregiver perceptions of their own health were positively associated with higher weight for age of the children in their care. On the other hand, if there were more individuals in the household, this factor was associated with more child food insecurity, which in turn was associated with lower weight and height for age.

Third, in urban areas, caregiver depression was associated with greater child food insecurity, which in turn was associated with lower perceptions of child health. Regarding weight and height for age, no mediations or indirect effects were observed, although several of the predictor variables were associated with food security/insecurity.

Qualitative findings

The data from the six focus groups provides a rich picture of the family lives of the research participants and how their families function and provide care, as well as how the social and community context affects caregiving. Three themes were apparent:

- 1) The first theme is the remarkable levels of care that many families manage to offer under very difficult circumstances, and the challenges they face, such as discipline, monitoring child safety, and dealing with grief.
- 2) The second is the tenuous support families have in order to manage many kinds of adversity, leading to increased insecurity, stress and precarious emotional states, which erodes the protective mechanisms of social care. This lack of support is a function of both poor state services and gaps in community support and social networks.
- 3) A third theme was related to social beliefs that families hold which shape how they function. These can be positive, such as when families 'stick together', and the belief that child safety is a community responsibility. Social beliefs can also be barriers to family well-being, such as those that discourage help-seeking, and views about discipline.

In relation to the first theme of positive emotional care, studies show the protective role that strong caregiver relationships, caregiver closeness, and demonstrations of warmth have for children. These have positive well-being outcomes in relation to child mental health (Cederbaum et al, 2012), reduced risk of child abuse (Meinck et al 2015), and reduced behaviour problems in childhood (Gardner, Sonuga-Barke, & Sayal, 1999) and adolescence (Gorman-Smith, et al., 2000), and can cushion negative social and community influences (Knerr, Gardner, & Cluver, 2011; Holte et al., 2014).

In this study, there were moving accounts of the warmth and cohesion that exists, even under very difficult living conditions. Small family rituals and close interpersonal relationships, and the demonstration of care for others in word and deed, were described as the 'glue' that contributes to positive family connectedness. There was also explicit recognition of the importance of emotional caregiving, and examples of how ordinary family activities can create caring environments.

In addition, attempts to garner information about communication styles and processes in families revealed examples of positive, supportive, and interactive family communication. The data indicate real strengths in these families in relation to effective communication with children. However, there was little discussion of the challenges of communication.

Discipline and the management of the behaviour of children stimulated extensive discussion. There was evidence of a range of discipline styles, from physical beating and harsh punishments, to more engaging communicative styles. Setting family rules was an alternative method of behaviour management that was seen as most effective. However, the disciplining of children was a particularly contested, difficult and controversial area of discussion in the focus groups, with evidence of strong tendencies towards authoritarian styles. Participants reflected that managing children's behaviour became harder as the child grew older. Two factors seemed to be important causes of authoritarian discipline: one was an articulated lack of knowledge of and skills in alternative styles of discipline; and two, was the feeling that because the social context of children's lives were so very different from the caregiver's generation, children were 'out of control' and authoritarianism was seen as the only way to regain control. In addition to articulating a lack of alternate skills, caregivers were clear that they wanted to learn new ways and have a range of new and effective tools.

In order to maintain warm and caring spaces, participants identified religious faith, close adult relationships, and a sense of being helped and supported financially and emotionally as critical in the ability of caregivers to provide positive caregiving. However, a lack of support to the caregivers eroded their ability to offer positive emotional care. Family support was truly mixed, with many examples of positive assistance, but complex family relationships and obligations easily undermined the benefits of extended family.

Loss and grief were recurring issues in the focus groups; clearly there is a need for emotional care that is not being adequately managed by our society generally and in a time of HIV and AIDS and high levels of violence. Emotional support and closeness is hard to achieve under stressful circumstances; your own emotional difficulties can be a real barrier to offering support to others, and raises the importance of caregivers' mental health.

Worrying rates of depressive symptomology (18 out of 40 women had symptoms of depression) among these women have broad implications for caregiving competence in communities. In this regard, research has demonstrated a strong connection between the mental health of caregivers and good well-being outcomes for children; and, conversely, caregiver depression and other mental health challenges as a major risk factor for children's well-being (Goodman et al 2011; Meinck et al 2015).

The monitoring and supervision of especially young children was discussed at length in the groups. Concern for the safety of unmonitored children was widely expressed, and great effort was obviously expended on keeping children physically close and protected from dangers. Barriers to properly monitoring children were articulated, many deriving from poor living conditions and poverty, such as a lack of property fences, poor quality locks on house doors or no security gates, and a lack of safe play areas in the community. Others derived from a reduction in trust that members of the community would genuinely offer care for children, despite the articulation that communities 'ought to' care for any child living nearby, which is a traditional value in African communities (Patel, 2015; Lesejane, 2006). Revealingly, a crèche or ECD centre was seen as a space of safety and a predictable way to access food, rather than a space of educational stimulation.

Participants perceived communities to have mixed value as a source of support; some felt a sense of belonging, but a lack of trust also came through. Neighbours were often not perceived to be 'on your side'. The wariness towards the outside community was largely due to perceived high crime and drug use rates.

The ability of participants to provide for their children was severely hampered by poverty. While all lived in difficult financial circumstances, some also suffered particularly bad living conditions, impacting severely on their ability to care for their children. While participants were not asked about food security, they did mention the stress of trying to provide for their children in times of serious financial insecurity, exacerbated by serious problems with formal service delivery. Moutse residents were concerned about the lack of running water and transport, and insufficient ECD and educational facilities. In Doornkop, the services existed, but complaints about poor quality of delivery were rife, especially poor treatment from service officials, and corrupt and discriminatory services.

Finally, some participants indicated a basic competence in rudimentary financial capabilities, but were enthusiastic about developing their knowledge and skills in this area. The data from the focus groups show clearly that caregivers are able to create emotionally supportive and positive care environments for their children, even under the most difficult circumstances. However, a lack of support for caring arises from social and community gaps in caring and service delivery problems.

Identified areas for high-impact caring tools are in parenting skills (especially around discipline), improved financial management skills, far better state service delivery that offers genuine support via competent and respectful staff, and actual delivery. There is also a need for stronger community support and deeper social networks, both difficult processes to influence.

A cursory review of family interventions in South Africa (based on interviews with key informants and a literature review) indicates that programmes are being implemented, but are limited in scope and reach. Few of the programmes are supported by research and for one programme, none has been rigorously evaluated to assess its effectiveness. The 10 programmes reviewed showed that innovation and experimentation are occurring and that there is much to learn from the different modalities that exist and what works in practice. All the programmes provided a training intervention in a small group setting.

A lack of funding and investment in preventative family interventions was identified as a major barrier to growing family- and community-based interventions. Social work services for families in South Africa are under-developed and tend to concentrate on clinical and statutory interventions to protect children against harm. There are limited interventions to enhance family functioning in general in the country that could prevent social problems from occurring. The CSG does play a positive role in preventing child poverty and food insecurity as outlined in part 1 based on the NIDS of 2008, but as the interviews with key informants revealed, there is a need for development of parenting knowledge and skills for at-risk families focusing on psychosocial aspects, such as family relations, communication, discipline of children and support for caregivers. A need for a focus on developing the financial capabilities of families to cope with the socio-economic challenges that they face was also emphasised. It is apparent that family-based interventions could be a valuable complementary intervention to support CSG beneficiaries.

Given the dearth of evidence-based family interventions in South Africa and in low- and middle-income countries, organisations are more likely to rely on international interventions that have been rigorously evaluated in high-income countries (Cluver et al., 2016; Mikton & Butchari., 2009). Although caution needs to be exercised in uncritically transposing these programmes in different countries with different cultural beliefs about families and caregiving and different resource levels, there is scope to adapt these interventions in South Africa. In order to scale up the impact of combined cash and care programmes, quality cost-effective and high impact designs will be needed.

While cash transfers go a long way in mitigating the negative consequences of poverty on child well-being in South Africa, complementary family interventions may improve well-being outcomes if they address other social and developmental challenges that families experience. The family interventions reviewed provided valuable insight into programme content, recruitment and selection of participants, training and supervision, and monitoring and evaluation. Group formats for programme delivery are common locally and could contribute to the building of supportive networks between the caregivers that could extend beyond the intervention, which is also associated with successful outcomes (Morris et al., 2017).

8. Conclusions

Despite the positive effects of the CSG, by itself it cannot solve the complex and interlocking structural, psychosocial, and household and community level factors that need to work together to improve child well-being and break the inter-generational cycle of poverty and inequality in South Africa. One way to increase support to poor and vulnerable families in receipt of a CSG is through the provision of family- and community-based preventative developmental welfare interventions that combine social and economic interventions and that include information, education and prevention strategies (Patel, 2015).

The theoretical model that underpins these interventions builds on South Africa's developmental welfare approach that advocates both social protection for children (cash transfers) and integrated family and community interventions, contained in recent strategy documents of the Department of Social Development (UNICEF & DSD, 2017), the Child Care Act of 2005 (DSD, 2005), and earlier welfare policies such as the White Paper for Social Welfare (Department of Welfare and Population Development, 1997). The view that families contribute significantly to social and economic development and should be supported in the provision of warm, loving and caring environments for children is consistent with the commitment in the White Paper on Families in South Africa (DSD, 2012) to support for vulnerable families. A mandate therefore already exists to design and implement preventive family interventions of this kind. In addition to social development theory, components of psycho-educational, functional and structural-strategic approaches to family intervention provide useful insights for programme design (Tolan, Guerra & Kendall, 1995; Gorman-Smith, Tolan, & Henry, 2000).

Preventive educational interventions delivered in a group format can assist "families to manage the stresses and challenges of everyday life in poor and difficult circumstances" (Sihleng'imizi Family Group Intervention Facilitator Manual, 2016, p.8). The prevention model is also different to the 'treatment model' where children are identified because they have pre-existing social and behavioural problems and are in need of child protection.

Instead, the prevention model invites families to participate in an intervention programme that could strengthen functioning and enhance well-being of their families as a whole.

In conclusion, combining cash transfers with family strengthening interventions will require significant mind shifts among policy-makers, practitioners and development agencies. There is great public pressure to respond to the immediate problems of children through established child protection measures, most of which are statutory in nature. Although these are necessary, more effective early intervention and preventive intervention is needed to respond to the growing challenge to enhance child well-being among the majority of South Africa's children. There is great scope for innovation and learning from practice to find solutions suited to the South African, and indeed the African, context. More research is needed to track child well-being in national data sets over time, although these data sets are limited in that they do not allow for a comprehensive analysis of all the dimensions of child well-being. However, in the absence of such data, mixed methods studies do provide insight into the direction of the changes that are occurring in the lives of children and their families.

9. Recommendations: interventions to scale up the impact of the CSG

Enhancing child well-being

The findings provide pointers for scaling up the CSG through the following actions:

- The continued provision of income support to disadvantaged families is strongly indicated.
- National public action is needed to end child hunger, especially in the early years of life. This goal can be achieved through a range of interventions such as boosting nutritional support to larger households, providing education on child nutrition, enhancing household food security strategies, livelihoods support, and early intervention for children at risk of stunting. Such interventions would complement the provision of cash transfers.
- Additional measures need to be devised to increase early access to the CSG for children below the age of 12 months.

- Early identification of depressive symptoms of caregivers is needed, as well as the provision of appropriate psychosocial support interventions.
- Access to quality basic services, such as shelter, water, electricity, and sanitation, including access to child care services, needs to be improved.
- It is important to strengthen family and community systems of social support.
- Implementing community safety strategies to improve the safety and security of children and families as well as creating safe spaces for children to play is imperative.
- Increasing the income flows to CSG households remains a critical priority. This type of action needs to be accompanied by improved access to child care services and mechanisms to support the livelihood strategies of caregivers and members of their households, including measures to enhance their financial capabilities.

Preventive interventions for CSG beneficiaries and families

- The design of interventions needs to be sensitive to the different contexts of childhood, risks, and different factors that influence child well-being in urban and rural areas.
- Complementary family- and community-based preventative interventions are needed to strengthen CSG families in their caregiving roles. The content of the programmes needs to include a focus on strengthening financial capabilities, information and education about nutrition, family connectedness, positive engagement with social networks and services, the provision of psychosocial support, and improved parenting skills. Skills-based parenting programmes delivered in time-limited group-based interventions and by trained practitioners have been found to be associated with positive child well-being outcomes.
- Public information and education campaigns that are well targeted, including short-term group-based interventions, were also found to be successful.
- Funding allocations for preventive developmental family welfare interventions are needed.
- There is the potential for expanding the reach of family programmes through existing governmental agencies, particularly at local government level and through community and faith-based organisations and NGOs.

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