

CHILDREN, SOCIAL ASSISTANCE AND FOOD SECURITY

A RESEARCH REPORT

This report was commissioned by the Black Sash

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Acknowledgments

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Ethics

This study received ethical approval from the South African Medical Research Council. Prior to the commencement of each interview, each participant was taken through an informed consent process which entailed the explanation of the purpose of the interview to ensure that participants understood the aims, objectives and purpose of the study as much as possible. A consent form was signed by all participants who took part in the study. All names were fictionalised to protect identities. Thank you to all the research participants for making themselves available to be interviewed.

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KEY FINDINGS:

- ✓ The Child Support Grant is not enough even to support a single mother and her young child, highlighting the need to increase the CSG to afford children (0-18 years) adequate nutrition.
- ✓ Food insecurity, manifest in high rates of child malnutrition, is an ongoing struggle and an emotional burden and distress for caregivers and community-based support systems.
- ✓ Mothers are aware of high value foods but these foods are too costly, highlighting the need for macro-food policies to subsidise the food basket of CSG recipients.
- ✓ Caregivers are forced to make choices between needs that are fundamental human rights – including choosing between food and education for their children.

RECOMMENDATIONS:

- ✓ The Child Support Grant should be linked to an objective measure of need, such as the Food Poverty Line.
- ✓ A Cash-Plus approach to the implementation of the CSG is needed, where each recipient and caregiver not only receives the cash grant but is formally linked to other essential free basic services such as ECD, free school uniform, free school transport, electricity, adequate housing, health care.
- ✓ Comprehensive and systematic food provisioning programmes should be put in place (e.g. soup kitchens, food parcels, onsite-feeding, food vouchers).
- ✓ Macro-food policies need to subsidise the food basket of CSG recipients (e.g. old buy-aid or current cash back loyalty programmes).
- ✓ Food security should be ensured throughout the life cycle of a child, including maternity protection for pregnant and breastfeeding women, and optimal food support for children at all contact points such as early childhood development, school-based and community-based feeding programmes.

INTRODUCTION

THIS STUDY AIMS TO MAKE SENSE OF THE RELATIONSHIP BETWEEN SOCIAL ASSISTANCE AND CHILD FOOD PRACTICES IN SOUTH AFRICA.

The Child Support Grant (CSG) in South Africa, which is the smallest of all the grants, is currently R460 per month after being increased from R450 in April 2021. This grant needs to cover many basic needs for a child – not least nutrition. However, the reality is that the grant is primarily used to buy food; food that is insufficient in quantity and quality to contribute to adequate nutrition. The grant for each child is paid out to a designated caregiver,

who manages the funds on a child's behalf.

Based on the understanding that even though poverty and hunger are economic issues, they are also deeply social and psychological, this study is grounded on twelve case studies in which caregivers of children on CSGs were interviewed in depth about the ways in which the cash transfer is managed by households in terms of food and other basic needs.

CONTEXT

From March 2020, South Africa was in various levels of lockdown due to the Covid-19 pandemic. The government's Disaster Management proclamations resulted in schools and early childhood development centres being closed. School feeding schemes came to a halt, adults and Caregivers lost jobs, and levels of food insecurity increased significantly.

While the pandemic and lockdown laid bare the flaws in our food system, food and nutrition insecurity have been a crisis in South Africa for years. During the lockdown in 2020, we witnessed long winding queues of people trying to access limited food parcels, often in violation of Covid-19 protocols. In Cape Town alone, roughly half of all households needed emergency food relief (1000 days. 2020. Why 1,000 Days). Even prior to Covid-19, at least 60% of Cape Town's population could not afford a nutritious diet.

Over 12 million children benefit from the Child Support Grant up to the age of 18 years. This grant of R460 is below the Food Poverty Line which is currently valued at R744,96 per person.¹

Chronic malnutrition is a long-standing public health challenge; a quarter of the country's children are stunted. In addition, food prices increased sharply during the Covid-19 pandemic

and, by October 2020 the average household monthly food basket increased by R329,74 (10.4%). A year later this trend had continued unabated with food basket calculations sitting at R4 317,56 – 10.2% more than the year before. (see https://pmbejd.org.za/wp-content/uploads/2021/10/PMBEJD_Media-Statement_October-2021_27102021.pdf). Hunger has been described as the “invisible pandemic” for poor households in South Africa.

The Department of Social Development (DSD) initially announced a R300 once-off monthly top-up of the Child Support Grant (CSG) in May 2020. A Caregivers Allowance or Caregivers Grant of R500 per month was in place between June and October 2020, with each Caregiver receiving one grant regardless of how many children on CSG's were in their care. Caregivers of children (over 97% women), who were already receiving CSG's, did not qualify for the Covid-19 SRD Grant – even though women caring for children were most likely to be working in vulnerable or short-term informal and temporary positions, and were more likely to suffer the effects of unemployment.

The Caregivers Grant was terminated in October 2020, and, at the end of April 2021, the Covid-19 SRD grant also came to an end. In July 2021, President Ramaphosa announced that the Covid-SRD Grant was to be reintroduced until March 2022, and that Caregivers receiving CSGs on behalf of children would now also be eligible for the Covid-SRD Grant of R350 a month.

In order to address the hunger levels children were

experiencing, Equal Education, with UCT's Children Institute as Amicus Curiae, instituted legal action which forced the Department of Basic Education and the Department of Social Development to reinstitute the school feeding schemes during lockdown.

Initiated in the midst of the Covid-19 pandemic, the purpose of this project has been to write up

a report based on case studies which reflect the lives, experiences and support systems of twelve children and their caregivers in the Western Cape during 2021, in order to inform advocacy work regarding the link between the current Child Support Grant provided to South Africans and the required levels of nutrition for children to thrive.



Children wait for food in Lavender Hill during the Covid-19 lockdown in Cape Town. Brenton Geach/GroundUp

¹ In November 2021, the average cost to feed a child a basic nutritious diet cost R744,96. As children grow older their nutritional needs increase, and the cost to feed a growing child increases. For example, on the PMBEJD Basic Nutritional Food Basket: It cost R653,70 to feed a small child aged 3-9 years of age per month. It cost R712,18 to feed a small child aged 10-13 years of age per month. It cost R756,43 to feed a girl child aged 14-18 years of age per month. It cost R857,52 to feed a boy child aged 14-18 years of age per month.

A HISTORY AND OVERVIEW OF SOCIAL ASSISTANCE PROVIDING FOR CHILDREN'S BASIC NEEDS

Following the destruction caused by World War II, and a particularly harsh European winter of 1946-47, the United Nations (UN) committed resources 'to be put to work for children' through a UN International Children's Emergency Fund.

In 1946, a resolution of the UN General Assembly -- number 57(I) -- brought UNICEF into being.

The Executive Director designate, Maurice Pate, made it a condition of his service that there were no caveats about where the aid (mostly dried milk) might go, insisting that UNICEF equally support children in vanquished as well as victorious countries across Europe. With time, that reach became global (UNICEF, 1996).

The establishment of an agency to take care of children speaks to the recognition of children's vulnerability and their longevity. They are the future adults, the future leaders, the future carers of the present cohort of adults.

There cannot be any greater investment in the future, than ensuring the health, safety and wellbeing of children. In spite of this, the world over, children are marginalised, victimised, and neglected, despite all the international, regional and national commitments that seek to provide for children. In 2020, South Africa's mid-year population was estimated to have increased to 59,62 million and 36.5% were children aged 0-19 years. That is roughly over 20 million children aged 0-18 years (Statistics South Africa, 2020a), meaning South Africa is a country with a very large child population. And most of those children are in living in poor households. At the end of 2020, South Africa's unemployment rate jumped to record highs of 32.5% in 2020 and 34.9% in 2021, as the economy was battered by the COVID-19 pandemic. When the national lockdown started, there were fewer people than ever working and those that did still have employment were mainly essential workers and mostly men. The only employment sectors that employ more women than men are the community and social services industry and private households. (Statistics South Africa, 2021)

Based on analysis of 2015 data, Statistics South Africa reported that more than six out of ten children (62,1%) aged 0-17 years were identified as multidimensionally poor. Children experience poverty very differently from adults because they must depend on others to meet their needs. They rarely have control over household finances, and they usually do not have the power to make

decisions about their day-to-day lives. A child is said to be multidimensionally poor when they are living in households where they are deprived of at least three out of seven dimensions of poverty (Health, Housing, Nutrition, Protection, Education, Information, Water and Sanitation). In 2015, about 13,1% of the children in South Africa were deprived in one dimension whilst about 80% were deprived in at least two dimensions. On average, the multidimensionally poor children were deprived in about four out of the seven dimensions in the South African Multiple Overlapping Deprivation Analysis (SA-MODA). The three main contributors to the state of poverty of children in the early childhood development phase (0-4 years) were: their housing circumstances; water, sanitation and waste disposal; and health circumstances. On the other hand, education, housing circumstances, as well as water, sanitation and waste disposal dimensions were the three main contributors to the poverty situation of children in the primary childhood development phase (5-12 years) and children in the adolescence phase (13-17 years). Given the deterioration in the economy, it is expected that multidimensional poverty has worsened since 2015 (Statistics South Africa, 2020b).

In the first wave of the pandemic, 22% of households reported that at least one adult had gone hungry in the past seven days, and children in 15% of households had been hungry before they were interviewed in May or June 2020 (NIDS CRAM). For the month of April, 47% of respondents reported that their household had run out of money (the first month of the lockdown, before social relief measures were instituted). In comparison, the General Household Survey of 2018 reported only 25% running out of money for food in the past year, a far less strict criterion. Loss of the main income source during April, the first full month of the lockdown, strongly increased the likelihood of household hunger and of running out of money to buy food (Bridgman, van der Berg & Patel, 2021).

Poverty underlies and fuels destructive and non-progressive manifestations in societies. It is the cancer that eats away at people's resilience and drive to prosper and progress. As asserted by the Statistics South Africa report on child poverty, addressing child poverty needs to be a national policy priority to ensure a better life and opportunities for all in the future. A key element in this is the quality of social security that the state provides for children and their caregivers.

FOOD AND NUTRITION FOR MOTHERS & CHILDREN IN SOUTH AFRICA

Child malnutrition is well documented in South Africa with studies dating back into the early 1950s. (Stoch & Smythe, 1963). Even though the right to access to sufficient food enshrined is in Sections 26 and 27 of our Constitution, and the right to adequate nutrition for children stipulated in Section 28, child malnutrition in South Africa has increased. More than one in four children under the age of one is stunted or too short for their age, and one in eight is overweight or too heavy for their age (NDoH et al, 2019). Both indicators are above the global nutrition target set by the World Health Organisation. A study conducted in Worcester reported that 11% of the children under five years were found to be overweight and 5%, obese (Matlwa Mabaso et al, 2021b). The recent Child Gauge on food security and nutrition for children in South Africa accurately termed this 'the slow violence of malnutrition against children' (May et al, 2020). The concept of slow violence is in the Child Gauge used "to illustrate how

food and nutrition insecurity during childhood is a silent threat to human development that casts a long shadow across the life course and contributes towards the intergenerational transfer of poverty, malnutrition and ill-health".

Child malnutrition has a double tax on children, affecting them both in their developing years and later in their adult years, with far-reaching consequences even for their own future children too. The epigenetics of nutrition explains how one's diet and nutritional status can cause changes that affect the way one's genes work. This was demonstrated by the Barker's Hypothesis that children deprived in vitro of nutrition are predisposed to being short of stature and overweight and those mothers who are short of stature and overweight are more likely to birth prematurely and/or have babies with low-birth weight, perpetuating intergenerational cycles of malnutrition.



Farida Rykklief in Delft, Cape Town, feeds over a thousand people in her community daily - Tariro Washinyira | GroundUp

HUNGRY MOTHER, HUNGRY CHILD

High rates of malnutrition translate into poor child health and developmental outcomes. Preventing this should start early with good nutrition and health of pregnant mothers and their children during the first 1,000 days - from conception to about two years. This is described as a unique window of opportunity for optimal human development. There is evidence that interventions during the adolescent phase may provide an opportunity for catch up (Why 1000 days, 2020). A 2020 study conducted in the Western Cape reported that 71% of participants did not have past-month employment or work-related income, 39% of pregnant respondents

reported going hungry in the previous week and 61% of women reported they had felt "down" or depressed in the week prior to the survey (Matlwa Mabaso et al, 2021). Stress about food is detrimental to both the pregnant mother and her unborn child, as stress hormones are linked to poor birth outcomes. And if there are other children in the household, this compromises the ability of mothers to feed and care for their children. There have been ongoing calls advocating for paid maternity protection and the extension of the child support grant into pregnancy (Gobind & Ukpere, 2012).

BREASTFEEDING IS FOOD SECURITY FOR CHILDREN

It is imperative not to forget that breastfeeding is food security for children, and that exclusive breastfeeding (EBF) during the first six-months is optimal for child health and survival. The most recent national data showed that in 2016 only 32% of children six-months and under were exclusively breastfed but the Worcester study reported that 41% of the children under six months included in that study were reportedly exclusively breastfed at the time of the survey (Matlwa Mabaso et al, 2021b). This much higher than expected exclusive breastfeeding rate is consistent with other studies of higher and longer breastfeeding during times of economic crises. Given the high unemployment and increased cost of living, it is reasonable to surmise that this increase in exclusive breastfeeding is because mothers have no alternative but to breastfeed their children. Unfortunately, the Worcester study did not

report on children not receiving any breast milk, while the national figure for 2016 reported that 25% of children were not breastfed at all. Under the current economic constraints, and the cost of appropriate infant formula, these children are at higher risk of inappropriate feeds such as sugar-sweetened water and teas, juices, and diluted cereals in feeding bottles.

Continued breastfeeding from 12-23 months is as low as exclusive breastfeeding with only 33% of children in this age group reported to be still breastfeeding. Breastfeeding between 12-23 months is still a significant source of much needed nutrients with breastmilk offering the older child a rich bioavailable source of micronutrients. In the context of poor dietary quality, efforts to encourage and support mothers to continue breastfeeding their older children are warranted.

POOR FOOD QUALITY AND DIETARY CHOICES FOR CHILDREN

Child dietary data is also a proxy for what is available in a household. Children's dietary practices and choices are dictated by the adult caregivers. To measure child nutrition adequately, a minimum acceptable diet is a composite indicator of minimum dietary diversity (number of different food groups from a standard of seven food groups), and minimum meal frequency of three or more times a day; for children 6-24 months of age who receive a minimum diversified diet and minimum meal frequency (apart from breast milk). In 2016, 50% of children met the minimum dietary diversity, but for minimum meal frequency,

only 23% met the minimum acceptable diet (NDoH et al, 2019). This illustrates the poor dietary practices in poor households where the diet is monotonous, and the feeding frequency is inadequate. The 2020 Worcester study showed that 32% of children aged 6-23 months had inadequate dietary diversity (Matlwa Mabaso et al, 2021b). While the NIDS CRAM data indicated that adults were shielding children from hunger (Bridgman, van der Berg & Patel, 2020), adults cannot shield children from poor quality diets when the household diet is limited in variety and nutrient quality. A chronic diet low in nutrients will lead to ill-health and premature death.

NUTRIENT-DENSE FOOD COSTS MORE

As the cost of food increases significantly, it is not unexpected that households would turn to high starch and fat food choices as bulking and stretching the food budget becomes the primary focus of caregivers. This is evident in the type of food "combos" being offered by food retailers which mainly includes starchy staples, fats and oils. Caregivers are

foregoing the expensive high-quality proteins like meats, fish, milk and eggs and nutrient-dense vegetables, fruits and legumes. The basic household monthly food basket - R4 272,44 - was reported to be above the cost of the minimum wage of a general worker - R3 643,92. (PMBJED November 2021) and far out of reach for the child support grant.

THE CHILD SUPPORT GRANT

Policy responses to child nutrition outcomes broadly comprise nutrition-specific interventions and nutrition-sensitive interventions (Ruel et al 2013). Nutrition-specific interventions are interventions that directly target nutritional outcomes. These include infant feeding counselling (exclusive breastfeeding counselling and promotion of nutrient-rich complementary foods), growth-monitoring, food fortification, micronutrient supplementation, integrated community case management (iCCM) of childhood illnesses under which community-based nutrition programs fall, and nutrition education.

Nutrition-sensitive interventions address the underlying causes of undernutrition. Such programmes include interventions that address poor living conditions, promoting maternal health and education, early childhood development programmes, agricultural programmes, and social sector reforms in the form of in-kind transfers such as school feeding schemes, and cash transfers (Ruel et al 2013). Nutrition-sensitive interventions are regarded as having strong potential to address child undernutrition as they deal with social determinants of health and malnutrition (Ramokolo et al 2018; Roeleen et al 2021). Nutrition-sensitive social protection programmes in the form of cash transfers having also emerged as a policy response to child malnutrition.

South Africa's response to childhood poverty and malnutrition consists of a package of policies and interventions that include therapeutic feeding, social grants, subsidised meals at registered early childhood development centres (ECDs), the National School Nutrition Programme (NSNP), and food parcels from the

Department of Social Development valued at R750 per month for children identified at risk of or presenting with underweight or wasting. Social grants form part of a well-developed social protection system that targets the elderly (Old Age Grant), children (Child Support Grant, Foster Care Grant, Care Dependency Grant), and those too ill to work (Disability Grant).

Within this package the Child Support Grant (CSG) is recognised as the most effective poverty alleviation strategy. It is also acknowledged to be an important nutrition-sensitive intervention. The CSG is a means-tested, non-contributory, and unconditional cash transfer programme targeting children from low-income households. It is the largest cash transfer programme on the African continent, transferring money to more than 12 million children each month.

While lauded as an important nutrition-sensitive instrument, concerns have been raised in recent years about the effectiveness of the CSG in addressing and improving child nutrition outcomes. In the first 20 years of democracy, SA experienced declines in food insecurity, child hunger, and poverty (StatsSA 2017). Much of the decline was attributed to social grants, especially the OAP and CSG, however steady increases in all three outcomes have been observed in the last 5 years. Early studies linked the CSG to reduced hunger and poverty (Samson et al, 2004, 2008; Pienaar & Von Fintel, 2013) and improved child height-for-age (Aguero et al, 2006, 2010; Coetzee 2014). However, recent studies have begun to show similarly high levels of food insecurity among both cash transfer recipients and non-recipients in South Africa (Battersby, 2011; Patel et al 2012; Zembe-Mkabile et al 2015; 2018).



Children waiting for a meal in Lavender Hill. Jeffrey Abrahams | Ground Up

PROJECT GOALS AND METHODOLOGY

The goal of this research has been to conduct qualitative research into children's rights to food security and social assistance, in order to inform advocacy work regarding the link between the current Child Support Grant provided to South Africans and the required levels of nutrition for children to thrive.

This project, funded by Abrahams Kiewitz attorneys, consists of three phases:

- 1** Case studies of 12 children (between zero to 18 years) in the Western Cape who are recipients of the Child Support Grant; and
- 2** Produce and publish a research report covering a thematic analysis of the key emerging issues as well as a series of recommendations regarding the Child Support Grant and food security.
- 3** Engage in advocacy actions with the Department of Social Development and SASSA regarding the recommendations in the report.

The research team comprised:

- Dr Wanga Zembe, South African Medical Research Council
- Dr Chantell Witten, University of the Free State
- Abigail Peters, Black Sash Paralegal Fieldworker in the Western Cape Regional Office
- Zoleka Ntuli, Black Sash Paralegal Fieldworkers in the Western Cape Regional Office
- Dr Theresa Edlmann, Black Sash National Programmes Manager and the coordinator of this project
- Black Sash community partners from Moorreesburg, Genadendal, Lavender Hill, Masiphumelele, Mannenberg, and Robertson, who assisted with interviews and the development of the case studies.



In terms of the values and ethos that have informed the methodological framing of this research, the Black Sash (and our research partners) recognise that communities, citizens, and public service users are active holders of fundamental rights, and not merely passive users of public services. Our Community Based Monitoring reports provide tangible feedback to policymakers and government in order to improve service delivery. This offers the opportunity for citizens, civil society, and civil servants to work together to build a capable state.

For this project, Black Sash has built on this tried and tested model, as well as recent qualitative, case-study based, research work focusing on various issues related to social security (i.e. the decommissioning of rural grant pay points, [reckless lending](#) to grant recipients, and the impact of the [Covid SRD Grant](#)).

Six case studies developed by the Black Sash are complemented by six case studies drawn from a longitudinal study by the South African Medical Research Council (SAMRC) titled: *The Child Support Grant and Child Nutrition: A birth cohort assessing the utilisation of the CSG and its link to dietary diversity, food security and child growth*. The SAMRC report recruited women in pregnancy in 2016 and 2017 and followed them from birth to two years. The primary outcomes were stunting, wasting, underweight and overweight for CSG recipients at two years. At the time of qualitative data collection for the case studies, the children from the birth cohort studies were between three and five years old.

For the six SAMRC case studies, caregivers of children receiving a CSG were interviewed once (see topic guide in Appendix 1), and a local community leader was interviewed once.

The six Black Sash case studies were developed in partnership with Community Based Organisations (CBOs) who identified caregivers in their community, facilitated the process of interviewing caregivers, and provided the Black Sash paralegal fieldworkers with background and contextual information. The six Black Sash case studies are based on the caregiver interviews as well as an interview with the partner CBO that knows the caregiver, the index child, and their context.

As the SAMRC case studies formed part of an existing research project, all the index children for the SAMRC case studies were roughly five years old. In order to provide as broad an overview of the 0-18 age group that receives CSGs as possible, the index children in all the Black Sash case studies were teenagers. In analysing the data, the research team found that there were no major discrepancies in the food context between younger and older index children. However, given the impact of poor nutrition in young children, specific attention has been given to recommendations for mothers and children under 5 years of age.

The communities represented in this research are both peri-urban and rural. The six SAMRC case studies are based in Langa (peri-urban); the six Black Sash case studies are drawn from Mannenberg (peri-urban), Genadendal (rural), Robertson (rural), Moorreesburg (rural), Masiphumelele (peri-urban), and Lavender Hill (peri-urban). While the settings may differ, the struggle to put adequate and nutritious food on the table is the same across all these settings.

All of the caregivers interviewed in this research are women, although the index children were both boys and girls. Gender bias has not been reported on access to food, dietary patterns or care patterns for children in South Africa but the nutrition profile of young children and adolescents shows a marked difference in rates of underweight and obesity with the burden carried by the girl-child (DoH et al, 2016). Erzse et al, 2021 reported that elderly women seemed to have a central advisory role with respect to maternal and child nutrition and that men and elderly women upheld patriarchal gender divisions of labour, which entrusted mothers with the primary responsibility for young children's nutrition. Young mothers relied on elderly women for provision of childcare and nutritious foods for children; however, they demonstrated some resistance to traditionally feminised forms of food preparation. The authors also found that men's involvement in children's nutrition was limited, even though men expressed a preference to be more involved in child nutrition and care practices.

The following table provides a summary of the characteristics of the 12 households where Child Support Grant beneficiaries reside, which form the basis of this study:

CHARACTERISTICS	UNDER 5 SAMPLE (6)	ADOLESCENT SAMPLE (6)
Household size range	2-9 people	3-12 people
Average household size	4.3	4.4
Age range of children	3-4 years old	13-16
Age range of caregivers	28-42	37-67
No. of CSGs per household (range)	1-6	1-8
No. of caregivers in formal employment	0	0
No. of caregivers in informal employment	2	6
No. of caregivers who have completed secondary school	2	2
No. of caregivers who have not completed secondary school	4	4
Index child in ECD	3	0
Index children at school	0	7
No. of children on medication via local health services	1	3
No. of caregivers who accessed food through community kitchens / gardens	2	4
No of caregivers who were tested positive or suspected they had COVID 19	0	2

ETHICAL CLEARANCE

This study was approved by the Human Research Ethics Committee of the South African Medical Research Council. Before each interview participants were taken through the information sheet which explained the

purpose and procedures of the study in detail. Each participant was given the opportunity to ask clarifying questions. Thereafter, participants who agreed to participate in the study provided signed consent.

THEMATIC ANALYSIS

The case studies were developed from the data collected from the 12 caregivers. Once the case studies had been developed, the research team worked on developing a network of themes that had emerged. These themes form the basis of the findings in the report.

The complexity of focusing on an index child who lives within a household with other children, and in the broader context of a community, made focusing specifically on the index child a challenge. The research therefore focused on general trends for the household, rather than specific and isolated individual-

specific analysis. However, what became clear was the extent to which providing adequate nutritious food for both the index child and the household was a daily challenge for caregivers, especially in the context of the Covid pandemic.

From the data four global themes have emerged related to i) Food and Nutrition, ii) Household Livelihoods, iii) Household Stressors and Coping Mechanisms, and iv) The impact of Covid. Each global theme has several sub-themes falling under it. Below we outline the themes and sub-themes emanating from the data.

CHAPTER 1 FOOD AND NUTRITION

WHAT A CSG CAN BUY

Caregivers are painstakingly aware of what they are able to afford with the grant money they receive. Many could recall off their fingertips what they bought with the grant money. For households dependent on only one CSG, the inventory is limited and quickly rattled off by the caregivers without hesitation. The pricing of the food items were consistent across the cases, especially when they were in the same area, such as Langa. Caregiver's food buying practices reflect the levels of time, thought and research that are invested in calculating what is

affordable and accessible: 'I look through the newspaper at Shoprite. I would buy the combo of R399, which has a 10kg rice, 10kg mielie meal, 10kg flour and sometimes there is 10kg sugar or 5kg chicken pieces. Or the R99 combo also. I would buy that too'. Caregivers make value-for-money choices about what they buy where, knowing that buying at the local outlets is not always cheaper or value-for-money, 'if I have a R100, I don't buy around here. I send them to town to maybe buy bones and rice. The potatoes I buy on the street for about R5 a bag'.



SASSA Queue in Bellville. Mary Anne Gontsana | GroundUp

The following are examples of what caregivers in this study spend a monthly CSG on:

This mother is unemployed. This household depends solely on the Child Support Grant; without the CSG, this household would be destitute. Because of the additional costs of cooking fuel and to conserve the limited electricity she can afford, this mother limits the number of times she cooks a meal, relying on snacks like fat cakes and flyers (soft packet popcorn) to feed her daughter during the day or on the generosity of her neighbours, 'She sometimes has some (snacks) when my neighbours buy her'. Because the only income is the CSG, this mother is very clear and able to share what are the costs that the grant is able to cover for the household.

- 2kg instant porridge (R20)
- 2L cooking oil (R45)
- 2kg sugar (R30)
- 5kg rice (R75)
- Yoghurt (pack of 6 small yoghurts) (R13.99)
- 7kg potatoes (R50)
- head of cabbage (R6)
- Small packet tomato (from local veg stall) (R5)
- Small packet onion (from local veg stall) (R5)
- 1 butternut (R8)
- 1 tin baked beans (R10)
- Electricity (R100)

These groceries cost a total of R367.99 a month. The rice and cooking oil are usually the only two items that last for the whole month. The caregiver also reports that the groceries run out, 'They (the groceries) last for 3 weeks because most of the time we cook rice'.

And every month she has electricity debt to pay from the CSG because the R100 electricity never lasts the whole month. The debt is usually R50 or more. And for this she has to borrow money from her neighbours. The caregiver explains the cost of additional electricity, 'To buy electricity, I just cut out certain items [from the grant] so that we have money to purchase it'.

During the lockdown the family survived with what they had and went to dish the food from the community feeding scheme that was available. **"The Muslims also assisted with their support as well. The children were invited to collect food parcels from school as well in their various classes or grades. Family relatives and friends also assisted without being asked by us. They thought about us during the difficult times."**

Another key strategy that the household uses involves buying small amounts of the more expensive food items such as sugar, coffee, milk (powdered version), and washing powder. This is so that they only consume these items as and when they need them if there is small change to pay for them. The items are sold at about R2 to R3 per teaspoon:

"If we run out of the food that we bought during the month, we buy those small teaspoons of sugar that are sold at spaza shop, [as well as] spoons of coffee, powder milk and washing powder that cost between R2.00 and R3.00."

When there is very little food left, usually towards the end of the month, the household skips one meal a day:

"[We eat] three times a day but if I run out of food we eat twice a day, breakfast and supper."

The caregiver is a young, struggling single mother, but as seen with other interviews in this study, even in a poor household such as this one, the children are shielded from hunger through the sacrifices that the caregiver makes, including going without food so that her child has enough to eat, and devising ways to make more money such as hair braiding.

The typical grocery list of this household consists of:

- 1kg Weetbix
- 5kg mielie meal
- Yoghurt (pack of 6 small yoghurts)
- 18 eggs
- Small packet onion (from local veg stall) (R5)
- 1 tin baked beans (R10)
- 2 litre cooking oil
- 6 packets of chips
- 6 pack milk
- 5kg rice
- 7kg potatoes (R50)
- Packet of tomatoes
- 1 butternut (R8)
- Electricity (R100)
- Peanut butter and jam
- 5kg County Fair Chicken Box

The caregiver says the index child's typical meals consist of: Weetbix with milk, or instant maize porridge for breakfast, umphokoqo (crumbly maize and maas) for lunch, and rice, chicken, potatoes and butternut. He drinks cordial juice when he is thirsty. He enjoys eating snacks, and when the caregiver has money she buys him Simba chips and bananas.

There is a general, intermittent shortage of food within the household. The index child is fed twice; cereal once in the morning, and whatever is cooked in the evening. There is some indication that he may get something else to eat during the day at his aunt's house, where he spends the day:

"I sometimes notice that when he goes that side at my sisters' place, he'd maybe get here and I'd ask "Likhona are you hungry?" he would say "No, I ate at my aunt's'."

The mother prioritises the child's cereals with money that she receives. However, because of the uncertainty of income, money is sometimes pooled to meet other, more pressing, household obligations. Usually, this is rent. Receipt of the CSG is helpful but also believed to be far too insufficient to take care of the child's basic needs:

"We're still crying now saying this R450 is too little."

The additional assistance that SASSA gave in the form of a temporary increase in the CSG during the lockdown went far in helping supplement usually unmet needs:

"I was able to buy some things for my child. I knew that R400 should buy his cereals, R500 I go buy some pants and shoes, everything. Get him a haircut so that he looks beautiful. The change I keep in my purse. I know that... I know him with the R1, "mama can you please buy me a bomp?""

During the Covid period they were also able to receive two food parcels. These were similar in content, providing them with months' worth of food items:

"There was a lot. There were 5kgs, but it was nice... rice, samp, everything... It helped a lot... we even left the shacks and came here with them."

Much of the income that the household receives is directed at acquiring food. When making food choices, the mother would purchase the bare basics, large units of staples like rice, samp, mealie meal, and oil.

"... so, when we buy things here at home, we buy these 10kgs that you see here in the buckets. We bought them in November."

Where there is excess, as it was during the Covid lockdown, she would buy vegetables and meat. These are bought ad hoc, and are the items that are usually out of supply.

"... So, what we're short of are tinned goods and beef stock and such. When he gets that piece job we go and buy such things."

When there is no money, the mother takes meat on credit in order to cook:

"No, I don't take food on credit, just meat."

NOT ENOUGH FOOD FOR EVERYONE OR FOR ALL THE TIME

Caregivers and their households faced a constant threat of food running out. Diets were generally starch-based with little diversity. Caregivers engaged in different strategies to make sure that they did not end up completely without food. These included the caregivers skipping meals so that there would be more food for their children, or meal rationing which led to all household members, including children, having smaller portions of food to eat at mealtimes. The threat of food shortage and the strategies

to prevent food running out were demonstrated by one of our Black Sash case studies where the family had a diet that was mostly made of starch. Whenever they had threats of food shortage the family would subsist only on plain bread and tea for two of the three meals and only eat a cooked meal at dinner time. During times of food shortage, the caregiver also bought less bread even though she knew it would not be enough to feed all the children:

“ We usually eat mealie-meal porridge in the morning, if we run out of mealie-meal then [the children] eat tea and bread in the morning before [they] go to school and after school. Over the weekend they eat the porridge if it is available, but when there is no porridge they eat the bread with tea, then after two hours they also have something to eat again. However, sometimes I buy a half [loaf] bread even though I know it will not be enough for them. In the evening, they eat cooked food or warm food. On Sunday mornings they do not really eat, they grab something on their way to the Muslim school. ”

Food bought with the CSG money does not last; in fact, the caregivers stated that they were only able to eat decent meals the first few days after payday:

“ We usually eat nice food for three to four days after or a week, such as chicken curry or a braai meat; afterwards, things go back to square one. ”

The caregivers were resourceful when food ran out. One caregiver shared that she takes pride in the knowledge that her family has never gone to bed without food, they might skip lunch, but they always have supper, even if this means dishing this out from the community soup kitchen where she volunteers:

“ On Tuesdays at Aunty Pat's soup kitchen, I dish more or extra food for my family while I am dishing for other community members since I am a volunteer. When I get home, I do not cook supper for my family because I know that the food I brought from the soup kitchen will be enough for them to eat for the night. ”

The agency of the caregiver, coupled with her social support network of local community based organisations, and friends and relatives, means that she found ways to make up for the inadequacy of the CSG.

CAREGIVERS' MAKING SACRIFICES SO CHILDREN CAN EAT

While the research showed a general shortage of certain types of food in all the households, caregivers sometimes ensured that there was something for their children to eat at the cost of the caregivers' own food needs. For instance, in

one case-study, the mother indicated that her daughter has a healthy appetite even if the food choices are not always what her daughter wants. The caregiver also explained how she forgoes food so that her daughter is shielded from hunger,

“ I only have supper if I did not eat lunch, I don't usually eat supper because I have to save the food for my daughter. ”

Another strategy for this mother to ensure that her daughter eats, is for her to snack rather than to eat a meal,

“ Sometimes I eat late, or I get R2 and I go buy myself fat cakes for lunch so that I can leave the food for my child. ”

When asked if her daughter had ever gone without food or gone hungry, the caregiver was resolute that as a mother it was her responsibility to ensure that her child eats, 'No, I try very hard, ... I am always forced to make a plan ...' she is only a child, she cannot go without food like I can'.

typically a mixture of rice, onion, potatoes, oil and spices.

One caregiver described making steam bread instead of buying bread every day, and when food is scarce she also makes one pot meals,

Other coping strategies included borrowing money, cutting down on 'luxury' items like margarine and peanut butter, replacing more expensive food options with cheaper options like maize meal for rice, reducing the consumption of coffee and tea to free up sugar and milk, and limiting the number of cooked meals to save on electricity.



A group of volunteers prepares to give soup to homeless people at the Hope Exchange. Ashraf Hendricks | GroundUp

GOOD FOODS ARE TOO EXPENSIVE

While mothers and caregivers are acutely aware of what constitutes good food and that it is important that their children eat regularly and have frequent meals, the lack of enough food and good quality foods means that often mothers and caregivers are not able to implement what they know are good food practices. As this caregiver indicated, there are foods that her household is not able to afford, 'We hardly buy milk and maas. Cheese and French polony we hardly have either'. With the income from her house cleaning jobs she is able to buy a few other foods, 'I only buy them (eggs) after I get money from my grandmother' (for house cleaning). When asked about specific foods like pilchards, fruit

and dried beans, the caregiver indicated that these items were not affordable with the grant money, 'I hardly afford that on the grant money'. Similar to what many other caregivers shared in the interviews, the caregiver acknowledged that her family was not consuming healthy foods, but that they were only eating what they could afford, and that she wished this were different. She talked about fruit as a luxury, something that she had to think twice before buying, and that she often simply could not afford. She was grateful for the school nutrition programme through which her children were able to get milk and fruit once a day, as this was the only time they can get these two foods:

“ Yes, I cannot buy the full school uniform for summer and winter, and the food in one month, and I would like to buy healthy food that can fill up my fridge and my cupboards full of groceries so that my children can eat whenever they are hungry. I know that the food that makes us full is not healthy, but we are eating because we do not have other choices. I do not usually buy fruit. I always think twice about using R10.00 to buy fruit since fruit is not part of our grocery list. I know they get fruit and small packets of fresh milk from school. I regard fruit as luxuries. I only cook potatoes on special days like Sundays with the braai. Masala is a good meal, no one can say your meal has meat or not. ”

Many of the households have also had to make concessions because of affordability. Also many of the foods that would ordinarily be considered as basic foods are seen as luxury foods by these households as illustrated by this caregiver. Even though the caregiver recognises that some items are expensive, she makes concessions because her children enjoy certain foods, 'Dried beans, the packet beans, sometimes it is expensive. But I buy packed beans and lentils. Sometimes. It is expensive

but I buy them because they like briyani'. From the description of the meals, it seemed that during the lockdown, this household had to embrace a different pattern of eating and had to get used to new foods, 'That combo helped us.³ Especially the mealie meal with a sauce, especially that tinned fish. I made pap with milk and sugar or with tinned fish and meatballs. Or rice food with tinned fish. Everything was expensive. There was no meat to talk of.'

3 A 'combo' is a package of basic foods sold at a discount price by retailers and spaza shops.

FOOD ASPIRATIONS

WHEN I GROW UP, WE WON'T BE HUNGRY ANY MORE

Aspirational food purchases for caregivers with children on CSGs would be considered basic foods for most other households. These included being able to buy yoghurt, commercial cereals like Weetbix, milk, and meat for the younger children. For caregivers of the older children, these included mayonnaise and other sauces,

fast foods, and branded fizzy drinks. The foods mentioned by caregivers when asked what they would like to buy for their children reveal the levels of poverty their families endure. Many caregivers were not even able to list what most people would describe as luxury foods because they were not in the caregivers' frame of reference.

ROLE OF FOOD PARCELS IN HOUSEHOLD FOOD SECURITY

Some households received limited support from food relief efforts and food parcels. These were often available through existing networks such as through the school, the child's creche, the church, or other community-based organisations. Sometimes the Department of

Social Development provided food parcels as part of Social Relief of Distress programmes. The research reveals that households did not have continuous support and often the availability of food parcels was sporadic and once-off.

FOOD VS EDUCATION

In one case study from this research study, the CSG is not able to buy any food for the index child because of the high cost of accessing Early Childhood Development (ECD) in Langa. : The entire Child Support Grant pays for the index child's ECD fees. It then falls on the caregiver to find the additional money to buy food for him every month. This places a significant strain on the caregiver because of the uncertainty of her income.

The caregiver is dependent on National Student Financial Aid Scheme (NSFAS) for her own studies, and they also do not pay out money to students during school holidays when tertiary institutions close. This creates enormous pressure for the caregiver.

The inadequacy of the CSG to pay for all of the needs of the growing child places caregivers in

the difficult position of having to choose between buying food or paying for other essential needs such as early childhood education. Both needs are important and critical to the growth and development of a child. Caregivers who have no means of generating additional income face difficult choices; the lack of free ECD services means that they are either forced to spend the CSG on food and forgo their children's need for early childhood education, or they pay the ECD fees and have very little money left for food.

This has serious implications for children, because attending and graduating from an ECD centre is a prerequisite for admission into primary school (Grade R). But all ECD centres in Langa, for example, charge fees - the cheapest being R150 a month.



Nokulunga Majola | GroundUp

CHAPTER 2

HOUSEHOLD LIVELIHOODS

While a social grant is a financial contribution to the livelihood of an individual, each individual grant beneficiary lives in a household in a social context that is often complex and vulnerable to many poverty induced shocks and stresses.

This study found that the effectiveness of a CSG in providing for the needs of a child was largely

dependent on the sustainability, vulnerabilities and challenges of the household within which the child lived.

This section of the report outlines some of the household livelihoods and other dynamics that impacted on the index children who were the focus of the study.

LEVELS OF RELIANCE ON SOCIAL GRANTS

In general, levels of reliance on social grants were very high - especially during the Covid-19 pandemic and related lockdowns. This is because the pandemic disrupted social and reciprocity networks that caregivers normally use to access additional financial resources to supplement income from the CSG. These networks enable caregivers to engage in informal work, and to borrow food and other items. Since the pandemic, especially during lockdown levels 5, 4 and 3, it has been much more difficult for caregivers to access these usual forms of assistance and support.

This is not to say that caregivers have not continued to find ways to access other sources of income and food, but these strategies are usually additional coping mechanisms - families

would simply starve if they did not receive their social grants.

Our data shows that there are levels of starvation in some families already, despite the CSG, but the children are more protected from it because adults in a household make the kinds of sacrifices described in the earlier section of this report.

In one case study, a mother of a 4 year old child had no other source of income besides a single R450 CSG a month. This caregiver shared about the daily struggle of attempting to meet the needs of her child through this small amount of money. Often, she had to make trade-offs between buying food or electricity.

I buy electricity, I just cut out certain items so that we have money to purchase it.

In another household with a single CSG, the only way the caregiver could ensure that there was enough food for her child from the R450 was to use it to buy food only for the index child, and she had to depend on her boyfriend for all the other needs of the household such as

rent, electricity, and soap. Even there, the food only managed to last because the child only ate breakfast and supper in the home, and ate lunch wherever he could find it during the day, usually from his relatives.

Caregivers did indicate that there are sometimes alternative sources of income in the household - but these are seldom consistent or reliable. The primary forms of income generation included hair braiding, "piece jobs" as gardeners

or domestic workers, and working for the Community Works Programme. Caregivers' options are very limited, as are those of other adult members of their household - including the fathers of children receiving CSGs.



Children at Levana Primary in Lavender Hill, Cape Town. Ashraf Hendricks/GroundUp

LEVELS OF RELIANCE ON SOURCES OF HELP OUTSIDE THE HOME - NEIGHBOURS, COMMUNITY MEMBERS

One of the challenges faced by caregivers is that of ensuring that the monthly grant payment lasts as long as possible in providing for all the children in the household. However, inevitably, money runs short and caregivers are forced to resort to others asking for help.

One caregiver described relying on the help of her daughter and her sister when she is unable

to provide for the home. She does however feel that she doesn't always want to ask. She does borrow from others, but only when she is desperately in need. During lockdown her partner/husband was still working so they could eat well enough. The one grant is not enough to solely support the household. The caregiver feels that the money needs to go to the child to provide for his needs.

Sometimes I have to look for something to eat. Because he eats a lot. I make sure he eats. He asks "Mama, is there a piece of bread". Do you understand? Then that hurts me. Because he is a child.

Other caregivers described how their husbands or boyfriends help to support the children in the home.

“ Me and my husband understand each other. He will go and look for something to do, brings something and we go on. We get through and we have struggled, but God has seen us through. We just make sure he has what he needs then I will see to my husband. But me and my husband will share and see that little man has something. ”

“ My boyfriend is a construction worker. So, he gets some money but he doesn't get a lot of money. He'd get a job and receive say 250, and keep that 250 and I wouldn't buy groceries with it. Then again at some other time get another piece job and receive 150... ”

Informal and part-time work is unpredictable, does not provide a reliable source of income, and cannot meet the needs of the household in a sustainable way. When money is scarce, caregivers are forced to look outside of their immediate family and household by getting food on credit, or borrowing money from relatives to supplement her groceries:

“ When he doesn't get any, I'm able to... I have a cousin that sells meat on credit, so I go and take from them if we're short of meat. Then we're able to cook. ”

“ I usually borrow from... I have a cousin that is married and living in the second block. I sometimes borrow from them... ”

“ I sometimes go to my cousins to eat there... when I see that there's nothing here at home. I go get food from them and tell them that I'm hungry, they must do something. ”

“ So, if I know that I don't have mealie meal, I go to my cousins... They'll give me whatever or give me rice... “No, take and go cook at home,” and I'd cook. When they also come asking for something I say “here, take and go cook. ”

The research team noted how vulnerable to exploitation women are when trying to find means to support their children. An example of this is that one caregiver hinted that she engaged in occasional sex work with local community members in order to make enough

money to feed her household. This was not spoken about explicitly in the interview, but was strongly hinted at in more than one way. This vulnerability extends to the risk of conflicts in households leading to violence amongst family and community members.

CHAPTER 3 HOUSEHOLD STRESSES AND COPING MECHANISMS

The constant uncertainty about a steady source of income understandably creates some stress for households, at times leading to conflict and vulnerability to violence. In some cases, the stress relates to being unable to cover basic costs like rent:

“ ... (my husband) was stressing a lot, you see that when we can't pay rent, he becomes very stressed... ” “This thing with the rent is really stressful, I notice that he even loses weight from stress. ”

Caregivers also describe the stress of knowing money is never enough because they are not able to pay for children's schooling needs like stationary, food and uniforms for school, and children's other clothing needs. In other cases, the stress is due to not receiving support from the index child's father.

“ You see... he said he would give me money for the child's food. That he would give me 400 for rent... no, for this thing... for creche... I've been waiting ever since. I went on Thursday and when I got there he was drunk and no longer saying any of that. ”



Lucinda Evans cooks meals for over a thousand children in Lavender Hill from her garage.
Brenton Geach | GroundUp

COPING MECHANISMS - SOURCES OF SUPPORT BEYOND MONEY

The study revealed some remarkable stories of community members assisting caregivers and children who were recipients of CSGs.

In one case, the caregiver and the children had struggled for many years with living in a one-room shack. In 2020, when social workers appealed to business community members, the family had a much larger three room shack erected for them. At the time of the caregiver's TB illness and subsequent hospitalisation, the family still lived in a one room-shack. And it was seeing the children in these living conditions without their mother present that prompted a community member to report the matter to local social workers who then fetched the children and placed them in care. The same

social workers then fundraised for a bigger shack to be erected for the family.

Another caregiver disclosed that her SASSA card was taken away by the social workers and it was given to a trusted community member. When asked what prompted the card to be taken away from her, the caregiver said it was because she had too many debts and a mashonisa had permanent possession of her SASSA card, meaning she was unable to buy food for the children. The caregiver's situation became widely known in the community and a community member eventually reported it to social workers in the area and they fetched the card from the mashonisa and selected a community member who could be entrusted with it

“ There is a lady who lives up the road from me; she went to tell the social workers that I am over indebted. They asked why I made the loan so I relayed the story to them and they said I should not to use it pay off my debts and said they will take over control of it. At the time even my boyfriend was sitting at home because he suffers from arthritis; so there was no money coming in. ”

The caregiver participated in the selection of the community member who would be a custodian for the card. When asked what the loans were for, the caregiver said she mainly borrowed money to buy food, electricity or if one of her children needed something for school.

The caregiver shared that since the card was taken away from her, each month she sends the community member a grocery list and the community member makes the purchases and delivers them to the caregiver's house with the till slip showing the total amount paid.

When we are about to get the grant money; she asks us to prepare a list of the items we need and then she goes and buys everything on the list for us and brings to us.

Community Based Organisations have also played a significant role in identifying families in need of support. Several CBOs that assisted the team with this study demonstrated the ways in which they can help to provide an extended social safety net for families during times of hunger. This mediated the extreme hardship that households would experience without this support. In particular, local soup kitchens provided families with at least

one meal a day when they were short of food, which played a crucial role in providing families with a reliable, predictable source of cooked food and, in some cases, food parcels.



Feeding scheme in Wolwerivier. Ashraf Hendricks/GroundUp

PSYCHOLOGICAL IMPACTS OF POVERTY

Caregivers of children on CSGs talk about hunger as a norm. Caregivers of the older children in the study recalled the pain of watching their children going to bed hungry from the time that they were very small. These children have to accept that hunger and suffering are a norm, and they already know that they have to endure and overcome the hardships this causes.

There is also the shame of neighbours and community members knowing that children in a household are hungry – as well as the sense of despair when witnessing neighbours also struggling and not being able to help. One caregiver said the following 'The children sent me around. Mommy go ask that aunty or that other aunty. The children cried all night. They woke up and I listened to them. They got up and ate the bread. They had to just pull through'. There was no saving them from hunger and suffering.

Another caregiver expressed the stress for her

of managing strained and difficult relations between the siblings in the household, "... she and her sister don't get along. They are constantly in conflict. If her sister knew, she will go around and tell everyone and that will cause problems.'

The stress of poverty also leads to a sense of isolation. A caregiver told us she sometimes does not want her son to go out and play with other children in the street. Every time he goes outside, he wants money to buy chips or lollipops which she cannot afford. She sometimes ends up locking him inside the shack to keep him from going outside. Her general lack of money to buy her children the necessities the need is emotionally draining, 'It affected me terribly, a lot, because sometimes they would want things and I wouldn't be able to provide as a parent. That would make me feel bad, a lot. I find that sometimes I would keep them in the house because, especially the little ones, they would long for what other children have. So that doesn't sit well with me.'



Children at Levana Primary in Lavender Hill, Cape Town. Ashraf Hendricks/GroundUp

INSTABILITY IN HOUSEHOLDS

The shocks and stresses caused by poverty have been exacerbated by the instability and hardships of the Covid pandemic, when neighbours and family members could not come to their assistance. Some examples that caregivers gave of the impacts of instability in households were the

impact of the deaths of family members – leading to a loss of social support as well as potential income income in the midst of the trauma and emotional bereavement. Another household with disabled children described the stress of caring for these children in the context of lockdown.

“ It was bad because my father got sick last year and died after sometime and now it is six months without him. It was not Covid but he died of his chronic illness he had in the past. Life at home is not the same anymore. We are struggling financially, because he used to contribute with his grant money at home, so that we can have enough money to pay the monthly basic needs. ”

HOUSEHOLD HEALTH

Households in contexts of poverty have to deal with a number of health related issues and challenges, both in relation to children on Child Support Grants and in relation to carers and other family members.

These challenges can range from not knowing how to deal with a child showing what could be minor symptoms such as loss of appetite or intestinal worms, to more serious issues.

“ He doesn't have appetite now. He was usually a child that liked to eat and would say 'mama I'm hungry,' and would finish his food. But now he takes two bites only. And a lady (inaudible) said that it's likely worms that are causing this. This child wasn't like this, he's lost weight...”

Caregivers also face the stress of managing their own health. In one case, a caregiver disclosed that she is HIV positive and on antiretroviral treatment. While the treatment is working and she is able to care for her children, this medication needs to be taken with food - which becomes a challenge when there is a shortage of food in the house.

hospitalisation, the children had to be placed in care and the older children were split from the younger ones. Some of the children were placed in an orphanage in Khayelitsha, and others in Athlone. The caregiver had some telephonic contact with the children during this period via the social workers but the children were only placed in care a month after her hospital admission during which time she had no contact with them, and then she was home a whole month before the children were returned to her. She cites this period as having been very difficult for the whole family, which resulted in the index child wetting his bed due to the impact on his mental health:

In another case, HIV related issues have had a serious impact on the caregiver's ability to provide for her children's safety and protection. The caregiver contracted Multi Drug Resistant Tuberculosis in June 2020 and had to be hospitalised for three months. During this period, because of the caregiver's

“ The only problem he had was when the social workers took him. He had a problem with his bladder; he could not hold his urine... At any time even when he was sitting around you just noticed that he was wet. But he has since stopped that he is fine now...I took him to the social workers...They referred him to the clinic and he got medication which I gave him and that stopped.”

The vulnerability of children in households to sexual abuse and exploitation was also hinted at during interviews. Caregivers were reluctant to divulge details. But this clearly had an impact on the index children.

When other adults in the household suffer from health issues, their inability to find employment results in less money coming in, and there being less food in the house.

THE IMPACT OF COVID

All caregivers interviewed for this study indicated that Covid had made life very difficult, both in the home and within the community. There were great concerns regarding infections and allowing others into their home, especially when people were already living with chronic conditions.

of the Caregiver Top-up, and the few months when caregivers were excluded from the R350 Social Relief of Distress Grant meant that this temporary small cushion was short-lived.

The Caregiver Top-up that was implemented in 2020 enabled families to provide for their nutritional needs, and even to buy shoes and clothing and sort out urgent issues such as repairs to their homes. However, the ending

Some caregivers described contracting Covid-19 and becoming very ill, which affected their ability to care for their children. Other adults in the home also became ill with Covid, some of them breadwinners, which meant a stressful loss of income. There was one particularly moving account:

“ Oh my darling I had Covid I almost died. I didn't have income and was at home. My husband also had. My son was luckily negative, he is the one was helping me so well. Put my oxygen on and brought my pills and brought my water to wash he helped me a lot. He said "Mama when mama was lying there and mama dies what would happen to me if mama died”.

One household was supported by family who brought food and dropped it at the door. The caregiver's husband and her son would cook the meals and helped her and her son to eat even though he also had Covid. The caregiver and her husband stayed in their room while the child also stayed in his room as a result of the virus. She mentions the child often checking in on her and sometimes just staring at her while she was

sleeping. The child had to take on a parental role during this time and the caregiver expressed deep gratitude for what the child did for her.

Caregivers also struggled to keep the index children inside their little shacks or homes during the hard lockdown. As a result, they experienced a lot of anxiety about children getting Covid.



Daniel Steyn/GroundUp

CHAPTER 4 FINDINGS AND RECOMMENDATIONS

The Child Support Grant as it currently functions is inadequate to meet the nutritional needs of children.

The impacts of these inadequacies are wide-ranging and debilitating for these children, their caregivers and the households within which they live. The CSG is also inadequate to provide for the other needs that children have

- shelter, clothing and education included. Serious consideration needs to be given to rethinking the current CSG model to provide for the basket of nutritional needs and other basic needs of children.

KEY FINDINGS:

- ✓ The Child Support Grant is not enough even to support a single mother and her young child, highlighting the need to increase the CSG to afford children (0-18 years) adequate nutrition.
- ✓ Food insecurity, manifest in high rates of child malnutrition, is an ongoing struggle and an emotional burden and distress for caregivers and community-based support systems.
- ✓ Mothers are aware of high value foods but these foods are too costly, highlighting the need for macro-food policies to subsidise the food basket of CSG recipients.
- ✓ Caregivers are forced to make choices between needs that are fundamental human rights - including choosing between food and education for their children.

RECOMMENDATIONS:

- ✓ The Child Support Grant should be linked to an objective measure of need, such as the Food Poverty Line.
- ✓ A Cash-Plus approach to the implementation of the CSG is needed, where each recipient and caregiver not only receives the cash grant but is formally linked to other essential free basic services such as ECD, free school uniform, free school transport, electricity, adequate housing, health care.
- ✓ Comprehensive and systematic food provisioning programmes should be put in place (e.g. soup kitchens, food parcels, onsite-feeding, food vouchers).
- ✓ Macro-food policies need to subsidise the food basket of CSG recipients (e.g. old buy-aid or current cash back loyalty programmes).
- ✓ Food security should be ensured throughout the life cycle of a child, including maternity protection for pregnant and breastfeeding women, and optimal food support for children at all contact points such as early childhood development, school-based and community-based feeding programmes.

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APPENDIX 1 CAREGIVER INTERVIEW TOPIC GUIDE

HOUSEHOLD FOCUS

Personal Information of Carer: This is information about the person being interviewed. Once the case studies are developed, these names will be changed to protect the caregiver's identity.

Name and Surname		Gender	
Phone Number		Number of CSG Grants you receive	
Full Address (street, township, province)		Bank used	
Age		Cash transfer	
What is your highest education level: primary, secondary, or tertiary		Are you a refugee, asylum-seeker, or migrant on special permit	

Household Information: Please fill in for all members of the household.

Names of other people in your household	Relation to person interviewed	Gender	Age	Education level	Grants received	If an adult, do they have money from a job, informal job, entrepreneur, selling things?

PART 1: DETAILS ABOUT THE CHILD ABOUT WHOM THE CASE STUDY WILL BE DEVELOPED

Age:		Sex:	
Has the child dealt with any health challenges so far in their life?			
How would you describe the child's mental and emotional health over the years they have been growing up? How are they now?			
Any special needs or other issues worth noting?			
How many meals does the child eat per day?			
Can you describe typical meals that your child eats per day?			
Can you maybe indicate which of the following items are easily available or scarce in your household?	<input type="checkbox"/> Cereal / Oatmeal / Mielie meal <input type="checkbox"/> Fresh meat, poultry, & seafood (fish, chicken, or other meats) <input type="checkbox"/> Tinned meat or fish <input type="checkbox"/> Beans <input type="checkbox"/> Peanut butter <input type="checkbox"/> Rice <input type="checkbox"/> Pasta <input type="checkbox"/> Bread (consider whole grain varieties) <input type="checkbox"/> Snacks - chips, sweets, chocolates <input type="checkbox"/> Flour <input type="checkbox"/> Sugar <input type="checkbox"/> Milk (fresh or powder) <input type="checkbox"/> Amasi <input type="checkbox"/> Oil for cooking <input type="checkbox"/> Cheese <input type="checkbox"/> Eggs <input type="checkbox"/> Fruits <input type="checkbox"/> Vegetables <input type="checkbox"/> Butter or margarine		
What do you usually use the money from the CSG grant to provide each month?			
What are the things you need to find other sources of money for to provide your child with food, shelter and clothing?			
What strategies do you use to ensure that your child/ren have food to eat? If pregnant, what strategies do you use to ensure that there is enough food for you to eat? Probe: Is food set aside or prioritized for children / pregnant.			

PART 2: HOUSEHOLD HEALTH QUESTIONS

How has the health of you and your family been in the last year?	
Have you or anyone in your family had an experience of COVID 19?	
Have you or anyone in your family succeeded or struggled to access healthcare for	
anything, including the virus, since the lockdown began?	

PART 3: HOUSEHOLD LIVELIHOOD DURING COVID QUESTIONS

How has Covid-19 affected the child / children in your home?	
Has the child / children in your home been able to eat every day? If so, how many meals?	
Has your household experienced hunger and or lacked money to buy food? If yes, when/how often?	
How have you coped with hunger and lack of food in the household? Probe: Have you or anyone in your family had to skip meals? Probes: What was a typical meal before lockdown? What was a typical meal during lockdown? What was a typical meal after getting the grant?	
What did you do to eat during the months of lockdown before you got this grant? Probes: Did you have to borrow money from family or from neighbours or from moneylenders? Did you have to take food on credit? Did you have to skip meals? If yes, tell me about your experience. <i>(This question seeks to find out what the household provisioning strategies were used during lockdown)</i>	
Did you ever get a food parcel since the Covid Lockdown started in March 2020 (DSD or civil society)? Probes: If yes, tell me about your experience. Who delivered the food parcel? How did you apply for the food parcel? When did you get the food parcel? How many times did you receive the food parcel?	

PART 4: HOUSEHOLD STRESSES

Do you control the CSG money that you get for this child or do you give it to another member of the household? If the latter, who? (This question seeks to find out about gendered power dynamics in the household.)	
How has the lack of food/loss of income affected relationships in your household? Probe: Have there been more conflicts around money in your household during this period of Covid? Probes: If yes, tell me about your experience. How have these affected the children in the household?	

PART 5: SUMMARY QUESTIONS

Are there things that you would like to do that you still cannot do with the CSG money?	
How has this CSG helped your child and your family or not helped you?	

APPENDIX 2

COMMUNITY PARTNER BASED ORGANISATION TOPIC GUIDE

COMMUNITY FOOD KITCHEN / SCHOOL FEEDING SCHEMES / OTHER COMMUNITY STAKEHOLDERS

<p>What do households in this area have access to? Probe: What does this household have access to? Please list specific services/support available</p>	
<p>What are some of the issues/challenges that prevent households from accessing available services/help? Probe: What is available in the community that households are not aware of?</p>	
<p>How do households in this community cope with hunger? Probe: What are the trends in this community in terms of coping / not coping with hunger and nutrition?</p>	
<p>What is the procedure for accessing available community resources/services/help/support? Probes: Are community meetings held to inform members about a new service/programme? What is the eligibility criteria, how does the community determine who is included and excluded? Who can access food / who is excluded? Why? (e.g. referrals from the clinic doctor)</p>	
<p>How can you tell if a family in this community has enough to eat in order to live well together? (Food, electricity, fuel to cook/heat homes)</p>	
<p>Can you tell me about the work you have done in this community? The project you run? What you are seeing happening in the community? What has changed since Covid came in terms of food security? Focus = Social cohesion / coordination - food networks</p>	



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