

THE INFLUENCE OF THE CHILD SUPPORT GRANT ON EDUCATION AND HEALTH CAPABILITIES OF CHILDREN

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ABSTRACT

This article describes research which sought to understand how the Child Support Grant, an unconditional cash transfer in South Africa, influences children's capabilities in education and health. Of children aged five to 14 years, who are legally required to attend school, the presence of the grant was found to enhance enrolment in the early years of education and resulted in healthier body mass indices. This finding was despite child beneficiaries residing in poorer households with lower access to services than children not receiving the grant. Some services, however, such as water and electricity proved vital to the promotion of school enrolment and the health of these children. The research highlighted the need for resources in the form of basic services to supplement household income in order to enhance child capabilities required for development.

Keywords: child well-being; capabilities; child support grant; body mass index; education



CHILDREN IN SOUTH AFRICA AND THE CHILD SUPPORT GRANT

With approximately 63 per cent of children in South Africa living in poverty, and the majority of these children being black African (Hall and Sambu 2015), it is important to constantly monitor the circumstances of children. Investments in children are crucial because in the long term, they result in economic and social benefits for society (Wallander and Koot 2016). The reason so many children live in poverty is largely because of the high levels of inequality and adult unemployment still present in the country as a result of apartheid, where racial segregation served to inhibit education, health, income and employment opportunities for non-white South Africans (Child 2016; Delany, Grinspun and Nyokangi 2016; Department of Performance Management and Evaluation 2014). The restriction on opportunities for certain race groups is therefore still playing a significant role in determining the development of children today. From a human capability perspective, education, longevity and income are recognised as vital for human development (Sen 2004). These aspects are central for child development specifically, but also translate into positive well-being effects in the later life stages of an individual.

Within education, there are well-documented struggles about the quality of education provided in the public sector (Child 2016). Improvements in teacher competencies, improvement in subject and curriculum knowledge and an improvement in the management of schools and district level offices are recognised as key areas for the enhancement of education. These competencies are particularly important to explore given that the majority of children enrol into public schools. Child (2016) also reported that access to running water and toilets at home determined how well children performed in schooling.

Within the healthcare sector, discrepancies lie in the services offered through public and private healthcare sectors. People that rely on public healthcare are not guaranteed the level of care and access to the same resources that would be available to those who access private healthcare. The South African government recognises the need to improve the quality of public healthcare, and focuses on areas such as “inefficient administrative and clinical processes, lack of essential equipment, unclean health facilities, poor staff attitudes, long waiting times and patient dissatisfaction” (Department of Performance Management and Evaluation 2014, 61).

The democratic South African government had implemented many poverty-alleviating mechanisms in an effort to restore social justice. One such investment in children that has been in existence since 1998 in South Africa is the Child Support Grant (CSG), which is an unconditional means-tested cash transfer. The CSG provides a resource that enables caregivers to care for children to enhance child development and contribute to well-being.

The CSG was introduced in order to provide social protection for the large numbers of poor children and families (DSD, SASSA, and UNICEF 2012). The assistance provided by the CSG was envisaged to “ensure that caregivers of young children living in extreme poverty were able to access financial assistance in the form of a cash transfer to supplement, rather than replace, household income” (Delany et al. 2008). At present, the CSG is South Africa’s largest social protection programme, reaching almost 12 million children monthly (Delany, Grinspun, and Nyokangi 2016).

The administration of the grant has evolved since its inception from being targeted at children under the age of seven, and by 2012, all children until the age of 18 years were eligible for the CSG if single caregivers earned less than R33 600 per annum or if couples earned less than R67 000 per annum (DSD, SASSA, and UNICEF 2012; Eyal and Woolard 2014). Importantly, while the CSG is targeted at children, the money is paid to the primary caregiver of the child. In cases where the primary caregiver is not the biological parent or guardian of the child, legal parents or guardians need to provide evidence that the applicant of the CSG is the main caregiver (Eyal and Woolard 2014). This provision in the administration of the grant was made to accommodate the changing nature and form of families in South Africa where the majority of families are not nuclear (Department of Social Development 2012).

CHILD WELL-BEING AND SOCIAL PROTECTION THROUGH THE CAPABILITY APPROACH LENS

The Capability Approach, pioneered by Amartya Sen and other scholars including Martha Nussbaum, views human life as a set of “beings and doings”. These beings and doings within the approach are called functionings. Examples of functionings would be if children are enjoying good health or if they are taking part in the life of a community. However, within the approach, Sen also places value on people’s capabilities, defined as a set of functionings that a person could possibly achieve (Sen 1999; 2004). These capabilities are often influenced by conversion factors within the individual (for example skills, talents), society (for example public policies) or the environment (for example climate) that determine the ability to convert resources into functionings and capabilities.

Despite Sen contending that capabilities enjoyed by adults are conditioned in childhood, this theory remains underutilised in developing countries such as South Africa. When human capabilities are measured in developing countries, the resources available to children are of utmost importance. The reasoning is that children may require different resources to enable them to enjoy the same capabilities as adults (Comim et al. 2011). This fact is evidenced in research that shows a mother’s level of education determines her children’s opportunities (Comim et al. 2011).

Investigations into social protection specifically suggest that globally, unconditional cash transfers have had a positive impact on child well-being (Adato and Bassett 2009; Paes-Sousa, Santos, and Miazaki 2011). In Latin America, where education is not a condition of cash transfers, the additional financial resources which could be spent on higher quality food and school-related expenses resulted in children staying in school (Adato and Bassett 2009). Children aged 0 to 5 years exposed to Brazil's cash transfer programme were also 26 per cent more likely to have normal height for age than those from non-exposed families; this difference also applied to weight for age, indicating a positive effect on child health (Paes-Sousa, Santos, and Miazaki 2011). These studies showed that resources were effectively converted into positive education and health capabilities for children.

In South Africa, however, studies are less conclusive. Research to date has found that CSG beneficiaries are likely to live in larger households where unemployment is rife and dependency on social grant income is high. Additionally, these households are likely to have fewer family members who have attained an education and are more likely to be found in rural areas in South Africa (Aguero, Carter, and Woolard 2007; Delany et al. 2008; Eyal and Woolard 2014). Although there are no restrictions on gender and race profiles for caregivers of children in terms of who can access the grant, approximately 98 per cent of CSG applicants are black African women (Aguero, Carter, and Woolard 2007; Delany et al. 2008).

Research specifically aimed at understanding the direct impacts of the CSG on children has been inconsistent in its conclusions. On the one hand, some research has shown no discernible differences between CSG and non-CSG children concerning their school attendance and health (Coetzee 2013; Delany et al. 2008), while on the other hand, research has shown positive developmental impacts. These impacts are specifically in relation to improved school enrolment, better health and nutrition and greater caregiver or family involvement in children's development (Aguero, Carter, and Woolard 2007; Coetzee 2013; Delany et al. 2008; DSD, SASSA, and UNICEF 2012; Patel et al. 2012; Woolard and Leibbrandt 2010). The majority of these investigations were either focused on the early years of a child's life (as it is viewed as a critical period for physical and cognitive development) or smaller investigations have been undertaken into the specific research questions. These smaller investigations include that by Adato and Bassett (2009) who focused on six- and seven-year olds and found positive education and nutrition outcomes for children who receive the CSG. These studies, although useful, make it difficult to draw broader conclusions regarding the conversion of resources within households into functionings and capabilities of children.

Therefore, this study aimed to measure child well-being outcomes using the human capability perspective in relation to income, educational enrolment and health (Sen 2004). The focus of this study was children aged five to 14 years, who are legally required to attend school, according to the South African Schools Act of 1996 (South Africa 1996). The research questions were:

1. What is the socio-demographic profile of children who receive the CSG compared to those who do not?
2. How do children in receipt of a CSG fare in terms of educational enrolment and anthropometric measures compared to children who do not receive the CSG?
3. What are the resources within households that contribute to child education and health capabilities?

METHOD

Study Design

This study made use of a quantitative research design (Field 2013), which included a secondary analysis of Wave 3 of the National Income Dynamics Study (NIDS) (Southern Africa Labour and Development Research Unit 2016). The NIDS is a nationally representative panel data set and according to Leibbrandt, Woolard and De Villiers (2009), sampling for NIDS involved a stratified, two-stage cluster sample design. The target population for NIDS was private households, as well as respondents living in workers' hostels, convents and monasteries. In Wave 3, a total of 4 663 households in the NIDS housed children aged 5 to 14 years. Residing in these households, were 8 310 children who were the focus of this study. Households without children and those that only had children who were younger or older than the compulsory schoolgoing age were omitted from the sample.

Variables and Data Analysis

In this study, health was measured by the body mass index (BMI). Data on child weight and height are collected in all waves of the NIDS to allow for the calculation of the BMI. Further, enrolment in education was measured in two ways. For children aged 5 to 7 years, attendance at a primary school, Grade R, pre-primary and a crèche was recorded while for children aged 8 to 14 years, caregivers indicated if children were currently enrolled in school.

In order to assess differences in educational enrolment and the BMI for children in CSG households compared to non-CSG households as well as to explore the factors determining school attendance and a healthier BMI, measures of central tendency, Pearson's chi-squared test and logistic regression analysis (Field 2013) were conducted.

Reliability and Validity

Reliability and validity of the instruments used in the NIDS were enhanced during the design and testing of the questionnaires. According to Leibbrandt, Woolard, and

De Villiers (2009), a team of experts served as consultants on the development of the questionnaire. In addition, the questionnaire was tested during a pilot phase of the study (Leibbrandt, Woolard, and De Villiers 2009) under the supervision of various researchers involved in the creation of the NIDS. Professional services were used to translate the questionnaires into all the South African languages to ensure that the interviewers did not interpret questions differently.

Ethical Considerations

The NIDS data collection was approved by the Commerce Faculty Ethics Committee of the University of Cape Town (Leibbrandt, Woolard, and De Villiers 2009). The study adhered to ethical principles of confidentiality, anonymity, voluntary participation and informed consent. The data in the child questionnaire were specifically collected from the primary caregiver of the child who consented to participate in the study. Because anthropometric measures were more invasive and required direct participation from children, child assent was also obtained.

Limitations of the Study

The NIDS was subject to non-response bias owing to a large number of refusals among affluent respondents, which in the South African context still tend to be white. While this study explored enrolment in schooling, no data on the quality of schooling can be extricated from the NIDS. Despite these limitations, the NIDS was considered the best data set for this study as it is South Africa's first nationally representative panel data set, which allows for longitudinal investigations into child well-being in South Africa.

RESULTS

Socio-Demographic Profile

There were 4 663 households in the sample, and 70 per cent of these households (3 271) received at least one CSG. On an individual level, of the 8 310 children, 5 606 (67%) received a CSG and 2 704 (33%) did not receive a CSG. The gender distribution of the children in the sample was fairly equal between male and female beneficiaries and non-beneficiaries. The average age of both CSG and non-CSG children was nine years. Overall, significantly more black African children (89%) received the CSG compared to other race groups. In terms of the average size of households in the study, CSG households were significantly larger with an average of six people, compared to non-CSG households with an average of four people. These demographics are consistent with other research studies on the CSG (Aguero, Carter, and Woolard 2007; Delany et al. 2008; Eyal and Woolard 2014).

Table 1: The presence of family support for care of children

Family support for care of children	CSG	Non-CSG
Yes	44.8%	46.4%
No	55.2%	53.6%
Total	100%	100%
N	5 605	1 912

As seen in Table 1, despite living in households with larger numbers of family members, CSG children were marginally less likely (44.8%) than non-CSG children (46.4%) to have family members involved in their care. It is important to note that the questions on family support for care of children do not differentiate if the adults involved in care of children lived within the same households as the children. Hence, minimal conclusions could be drawn in relation to family size and the presence of support for care.

Table 2: Relationship status of parents

Relationship status of parents	CSG	Non-CSG
In a relationship	50.6%	61.9%
Not in a relationship	49.4%	38.1%
Total	100%	100%
N	4 693	1 496

Overall, Table 2 highlights the fact that CSG children were more likely to have parents who were no longer in a relationship with each other, $X^2(1) = 59.01$, $p = 0.000$. Furthermore, there were no differences in relation to the physical presence of mothers in households or financial support of children from mothers. Across both types of households, approximately 71.8 per cent of mothers lived with their children and 48.2 per cent of mothers supported their children financially. Data on fathers told a different story. CSG children were less likely (27.4%) to have their fathers living in the same households as themselves compared to non-CSG children (48.8%), $X^2(1) = 224.2$, $p = 0.000$. In addition, CSG children were less likely (31.3%) to be supported financially by their fathers than non-CSG children (44.4%), $X^2(1) = 44.1$, $p = 0.000$. The findings on the absence of fathers in households were in line with those by Richter et al. (2011) who found that South Africa has one of the highest rates of absent fathers with over 50% of children living without daily contact with their fathers. The situation, however, was worse for children who received the CSG.

Table 3: Educational attainment of mother

Education level of mother	CSG	Non-CSG
Primary	25%	18%
Some secondary	42%	35%
Completed secondary	33%	47%
Total	100%	100%
N	1 443	537

Mothers of children who received the CSG were more likely to have a primary school education and were less likely to have completed secondary school, $X^2(2) = 31.9$, $p = 0.000$. These results are contained in Table 3. The same pattern of educational attainment was seen for fathers of CSG children in Table 4, $X^2(2) = 75.5$, $p = 0.000$. Parents of CSG children were therefore less likely to have completed secondary schooling, resulting in them achieving lower education levels than parents of children who did not receive the grant. Given that education levels of the mother are known to directly affect school attendance of children (DSD, SASSA, and UNICEF 2012), this finding does raise concerns about the well-being of children.

Table 4: Educational attainment of father

Education level of father	CSG	Non-CSG
Primary	29%	22%
Some secondary	31%	19%
Completed secondary	40%	59%
Total	100%	100%
N	2 269	603

Lower levels of education are known to result in lower levels of income (Spaull 2015) due to the limited job opportunities available when education is restricted. The lower levels of education in CSG households were therefore reflected in the fact that they were significantly poorer with a per capita income of R724 per month compared to R2 668 per month in non-CSG households. This finding was not surprising because to qualify for the CSG, caregivers are required to earn below a certain threshold.

Table 5: Geographic location of households

Geographic location of households	CSG	Non-CSG
Urban	40%	67%
Rural	60%	33%
Total	100%	100%
N	3 269	1 192

Table 5 shows that households receiving the CSG were more likely to be found in rural areas, $X^2(1) = 262$, $p = 0.000$. This finding about geographic location corroborates other research on the CSG in South Africa (Aguero, Carter, and Woolard 2007; Delany et al. 2008; Eyal and Woolard 2014).

Table 6: Dwelling type

Dwelling type	CSG	Non-CSG
Brick structure	66%	78%
Traditional dwelling	17.8%	5.4%
Flat/Apartment	1%	2%
Townhouse	1%	2%
House in a backyard	6%	6%
Informal dwelling	8%	6%
Total	100%	100%
N	3 261	877

In terms of housing and services, the analysis revealed that fewer CSG households (66%) were brick structures compared to non-CSG households (78%). Furthermore, CSG households were more likely to be traditional households or informal households (25.8%) compared to non-CSG households (11.4%). The traditional households were typically constructed from materials such as clay, mud or thatch.

Table 7: Access to water

Access to water	CSG	Non-CSG
Piped water in the dwelling	29%	62%
Piped water in the stand	31%	21%
Public tap	24%	10%
Other	15%	7%
Total	100%	100%
N	3 261	877

Data on access to services such as water, electricity and sanitation are given in Tables 7, 8 and 9, respectively. The data revealed that CSG households were less likely to have access to water in their dwellings (29%) compared to non-CSG households (62%), $X^2(3) = 349.7$, $p = 0.000$. Additionally, fewer CSG households (80%) had access to electricity, compared to 91 per cent of non-CSG households, $X^2(1) = 59.2$, $p = 0.000$. Lastly, in relation to sanitation, CSG households were far less likely to have access to flush toilets, $X^2(6) = 364.8$, $p = 0.000$. These discrepancies could be explained by the fact that the majority of CSG households were located in rural areas where the delivery of basic services is less effective.

Table 8: Access to electricity

Access to electricity	CSG	Non-CSG
Yes	80%	91%
No	20%	9%
Total	100%	100%
N	3 267	878

Table 9: Sanitation

Sanitation	CSG	Non-CSG
Flush toilet with on-site disposal	22%	50%
Flush toilet with off-site disposal	16%	23%
Chemical toilet	5%	2%

Pit latrine with ventilation pipe	19%	8%
Pit latrine without ventilation pipe	29%	13%
No toilet	6%	3%
Total	100%	100%
N	3 259	877

The socio-demographic profile of the children in this study revealed that the CSG is effectively reaching poorer South African children in households that are under-resourced. Using a capability lens, these findings showed that CSG households were restricted in their access to household resources (such as water and electricity) and parent capabilities (such as parents' level of education) which could determine the well-being of children. These restrictions were reflected in the fact that children who received the grant were more likely to live in informal households. Despite the presence of a larger number of extended family members in households, this factor did not translate into more adults being available for the care of children. CSG households had a lower per capita income and parents of CSG children were likely to have lower levels of education than non-CSG parents. For children who received the grant, there was a lower likelihood of their fathers residing in their households or supporting them financially compared to non-CSG children. Investigations into access to services such as water, electricity and flush toilets revealed that CSG children had overall lower levels of access to services in their households than non-CSG children. In order to understand the impact of these factors on children, attention is now given to the education and health capabilities of children, again comparing children who received the grant with those who did not.

Child Health and Education Capabilities

First, investigations into health capabilities presented in Table 10 revealed that CSG children were healthier than non-CSG children, $X^2(4) = 34.5$, $p = 0.000$. A total of 70.9 per cent of CSG children fell into the "normal" range when their BMI was analysed compared to 65.1 per cent of non-CSG households. Interestingly, despite residing in financially better resourced households, non-CSG children were more likely (29.8%) than CSG children (23.4%) to be unhealthy and had a higher incidence of being "overweight" or "obese". These statistics were higher than the numbers of obese children reported by the South African National Health and Nutrition Examination Survey (SAHANES) in 2012 (Mchiza and Maunder 2013). While CSG children were healthier, they were also far less likely to have medical insurance (1.5%) compared to non-CSG children (21.8%), largely making use of public healthcare in South Africa.

Table 10: Comparing BMI of children

BMI of children	CSG	Non-CSG
Severe thinness	2.2%	1.4%
Thinness	3.5%	3.7%
Normal	70.9%	65.1%
Overweight	14.8%	18%
Obese	8.6%	11.8%
Total	100%	100%
N	5 227	1 724

Second, for education capabilities of children aged 5 to 7 years, attendance at a primary school, Grade R, pre-primary and a crèche was recorded. According to the results in Table 11, CSG children (79.6%) were more likely to be enrolled in primary school and Grade R than non-CSG children (74.6%), $X^2(5) = 20.6$, $p = 0.001$. Table 12 shows that overall enrolment rates were consistently high for children aged 8 to 14 years. Differences in schooling were present in the fact that CSG children were more likely to attend no-fee schools (59.4%) than non-CSG children (51.4%), which was not surprising given that CSG children resided in poorer households, $X^2(1) = 34.1$, $p = 0.000$.

Table 11: Educational enrolment for children aged 5 to 7 years

School enrolment for children aged 5 to 7 years	CSG	Non-CSG
Primary	54.8%	52%
Grade R	24.8%	22.6%
Pre-primary	1.5%	3.8%
Crèche	6%	7.3%
Not in school	12.8%	14.2%
Total	100%	100%
N	1 840	549

Table 12: Educational enrolment for children aged 8 to 14 years

School enrolment for children aged 8 to 14 years	CSG	Non-CSG
Yes	99.7%	99.5%
No	0.3%	0.5%
Total	100%	100%
N	3 753	1 343

The results presented in this section revealed that despite living in households that were restricted in resources (both in terms of income and access to services), children who benefited from the CSG were more likely to have a normal BMI than children who did not receive the grant. In fact, larger numbers of children who were not recipients of the grant fell into the overweight or obese categories. This finding means that the resources in CSG households were more adequately converted into opportunities that promote child well-being.

In addition to being healthier, younger CSG children (aged 5 to 7 years), were more likely to be enrolled in primary school and Grade R. These differences in educational enrolment levelled off in later years of children's lives (aged 8 to 14 years), where less than 0.5 per cent of children were not enrolled in education overall.

In order to understand the factors contributing to health and education capabilities of children, logistic regressions explored the effects of parent characteristics on education and health before looking into household characteristics. The analysis was also conducted to highlight differences between CSG and non-CSG children. Only the significant results are reported in this paper, and these are discussed in the next section.

Explanatory Analysis for Outcomes in Health and Education Capabilities of Children

Correlation and regression analyses revealed that there was no direct relationship between education and the BMI of children. As these were dependent variables, explorations into the resources and characteristics contributing to child health and education were conducted separately. All the results presented were significant at a 95 per cent confidence interval.

Using logistic regressions to identify the determinants of education, the analysis revealed that the odds of CSG children being enrolled in school were 2.5 times higher if the biological parents were still in a relationship with each other. This finding corroborated the results of Tippoo (2012) who found greater well-being of children who lived with both biological parents, largely because of the additional support present for

the care of children. Furthermore, children who had access to piped water either in the dwelling or on the stand were 10 times more likely to be enrolled in education.

In non-CSG households, the presence of family support for care of children raised the odds of children being enrolled in education 6.6 times. This element of family support for care of children was less prevalent in CSG households despite the latter households being larger. The determinants of healthier BMI measurements were less revealing, with only access to electricity raising the odds of children falling into the “normal” BMI category by 1.2.

These results revealed the importance of additional resources in addition to CSG income, namely support for care of children and access to services, to be able to adequately convert resources into opportunities to enhance children’s education and health.

DISCUSSION AND RECOMMENDATIONS

In terms of the socio-demographic profile of children who received the CSG compared to those who did not, analysis of the Wave 3 NIDS data has shown that 67 per cent of children between the ages of five to 14 years received the CSG in South Africa. The majority of these children were black African and lived in larger households than children who did not receive the CSG. Although CSG children lived in larger households, the data revealed that there was limited family support for care of children in these households. Parents of children who received the CSG were less likely to be in a relationship with each other. As such, mothers were identified as the main caregivers of these children, while fathers were largely physically and financially absent from the lives of their children. In relation to educational attainment, parents of CSG children were less likely to have completed secondary schooling. However, the data showed that the parental level of education did not significantly influence the school enrolment of children. Households that received the CSG were shown to have a lower income per capita and were largely found in rural areas, with the dwellings themselves being built from traditional materials. These households were less likely to have access to basic services such as water, electricity and flush sanitation. Overall, the findings pointed to the fact that the CSG is effectively reaching children who have fewer resources within their homes as a means to contribute to child well-being.

When the education and health capabilities of children who receive the CSG were measured against those who did not receive the grant, the findings indicated that despite having access to fewer resources, these resources were more effectively converted into opportunities to promote child well-being in CSG households. In terms of education capabilities, the findings revealed that children who received the CSG were more likely to be enrolled in schools earlier (between 5 and 7 years of age). This distinction in educational enrolment levelled off as children got older (8 to 14 years) and overall enrolment in education was generally high. The NIDS did not contain data on the reasons

for early enrolment of children in education. Investigations into health capabilities revealed that CSG children were more likely to have a “normal” BMI than children who did not receive the CSG. These results on education and health pointed to the assumption that the CSG was a resource effectively being used to promote child well-being. However, what is of particular importance was to understand the other resources, in addition to income, that played a role in promoting child well-being.

The regression analysis therefore revealed that a combination of resources facilitated educational enrolment and a healthier BMI in households. For children in CSG households, access to piped water in the household as well as the biological parents of the children still being in a relationship with each other seemed to increase the odds of the children being enrolled in education. Tippoo (2012) explained that this finding was largely because of the additional support present for the care of children. For non-CSG households, the support of the extended family for the care of children was shown to have a positive impact on educational enrolment. Additionally, access to electricity specifically raised the odds of children having a healthier BMI.

The Capability Approach allows us to think about the implications of this research in ways that are important to promote child capabilities (Comim 2011). The results of this research give rise to four main recommendations for practice, policy and research.

First, from a practice perspective, there is a need to focus on child-centred development that harnesses the support of families and emphasises the importance of time spent with family. This time, as described by Comim (2011), includes time to play, be creative and be happy while children are protected. Given that family support was found to significantly increase child well-being in non-CSG households, this finding provides an additional motivation to enhance such support in CSG households. One way in which this support could be accessed is to connect families who receive the CSG with community-based family strengthening programmes. However, a vital element in the success of family strengthening in this way is to evaluate programmes to ensure that they are in fact contributing to the cohesion of entire families and therefore expanding the capabilities of children.

Second, while it is promising that children who are recipients of the grant are healthier, there is a need to provide parents with nutritional information for children. This need is demonstrated by the number of children in this study who was obese or overweight, specifically in non-CSG households. Despite the same argument being made in 2012 for improvements in health awareness on child nutrition arising from the SANHANES (Mchiza and Maunder 2013), the numbers presented in this research show that there is an overall increase in childhood obesity, specifically in non-CSG households.

Third, and with regard to policy implementation, the importance of basic services as a resource for child well-being was made evident when investigating factors contributing to education and health capabilities. Where water and electricity were present in households, children were significantly healthier and more likely to be

enrolled in education. Basic services are also known to contribute to improved school performance in South Africa (see for instance Child 2016). While a free basic services package is made available to recipients of the CSG in one metropolitan municipality in South Africa, the research presented here reveals the need to implement this policy on a broader scale. The implementation of this type of policy would mean that children are also afforded their rights to an adequate standard of living in South Africa. From a social work practice perspective, this change in policy and implementation would also assist social workers and community development practitioners to advocate on behalf of families and those who do not have access to these vital resources for child development.

Fourth, the expansion of child capabilities for social development in South Africa can only be guided by the research. South Africa has come a long way in implementing panel studies and cross-sectional studies that measure child well-being. However, large-scale studies omit intra-household dynamics, the views and challenges within the healthcare and education sectors as well as the unique needs of children themselves for instance. Further investigations which unpack the impacts of the aforementioned factors on child well-being could help researchers and policymakers with comprehensive knowledge of what work is still required for children to be able to live the lives they value.

CONCLUSION

The CSG was positively associated with education and health capabilities of children in South Africa. However, in addition to this income resource, support available to families for care of children and the presence of basic services such as water and electricity were vital elements required for child development.

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