ASSESSING THE RELATIONSHIP BETWEEN FOOD INSECURITY, THE CHILD SUPPORT GRANT AND CHILD CARE ARRANGEMENTS

By

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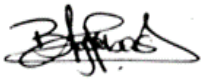
DECLARATION

I, **Babalwa Tyabashe-Phume**, hereby declare that the research project titled **'Assessing the relationship between food insecurity, the child support grant and child care arrangements'** towards the qualification to be awarded is my own work and that it has not previously been submitted for assessment or towards the completion of any research study to another university or towards another qualification.



December 2019

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DEDICATION

This thesis is dedicated to my late parents. To my father, who passed away in 2015, who taught me the importance of education even though he was uneducated. He once told me that in order to be a “master”, I must go to university to study and work hard. To my recently late mother, who never gave up, who taught me the importance of working hard and striving to be the best that I could be in everything I do.

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ACRONYMS AND ABBREVIATIONS

BMI	Body Mass Index
CSG	Child Support Grant
DSD	Department of Social Development
ECD	Early Childhood Development
EPRI	Economic Policy Research Institute
FAO	Food and Agricultural Organization
FBO	Faith-Based Organisation
FGD	Focus Group Discussion
HAZ	Height for Age
HHS	Household Hunger Scale
HSRC	Human Sciences Research Council
IFSS	Integrated Food Security Strategy for South Africa
NGO	Non-Governmental Organisation
NICHD	National Institute Of Child Health And Human Development
NRF	National Research Foundation
OAG	Old Age Grant
PACSA	Pietermaritzburg Agency for Community Social Action
SA	South Africa
SAMRC	South African Medical Research Council
SASSA	South African Social Security Agency
SPSS	Statistical Package for the Social Sciences
STATS SA	Statistics South Africa
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
UWC	University of the Western Cape
WHO	World Health Organization

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ABSTRACT

Food insecurity exists when people lack access to sufficient quantities of safe and nutritious food which encourages normal growth and development. Given South Africa's high poverty and unemployment levels, food insecurity has become endemic in many communities. The purpose of the study was to determine and explore the relationship between food insecurity, child care arrangements and the child support grant (CSG).

The study was conducted among a sample of 120 participants, comprising both CSG recipients and non-recipients (who were purposefully selected from an ongoing cohort study), residing in Langa township in Cape Town. A sequential, mixed-model research design was used, in which both qualitative and quantitative research methods were applied. Data was collected by means of questionnaires, interviews and focus groups. The results were analysed using SPSS and Atlas ti software. The ecological systems theory being used as a theoretical framework to explore the different dimensions of child care arrangements.

In the literature it is hypothesised that food insecure families are more likely to have child care arrangement instabilities. Interestingly, the study's findings did not support this hypothesis. Although most of the participants were unemployed, they generally stayed at home to care for their children because they were recipients of the CSG. Therefore, despite being food insecure, many households had stable child care arrangements because of the CSG. Child support grant recipient households experienced hunger less acutely than households that did not receive the grant. Of course, social protection mechanisms, like grants, do not represent a sustainable solution to South Africa's unemployment and food insecurity challenges. The researcher therefore provides a number of recommendations on how government and civil society can ameliorate the plight of poor households.

Key words

Food insecurity, Child care arrangements, Child development, Child support grant, Household hunger scale, South Africa

CHAPTER 1: INTRODUCTION

1.1 Background

According to Statistics South Africa (2015, p. 1), "in 2012, there were about 5.3 million children aged 0–4 years in South Africa, representing 10.1% of the total population". Children are an integral part of communities and deserve to live in an environment that allows them to grow and reach their potential. Because of their vulnerability, their rights should be protected at all times.

There are various factors that may adversely affect child care and development. These include socio-economic factors, such as food insecurity, poverty and unsatisfactory child care arrangements. Cash transfers such as the child support grant (CSG) have been used as a policy instrument to reduce childhood poverty. Early evidence suggests a positive correlation between the CSG and child growth (Aguero, Carter & Woolard, 2006; DSD, SASSA & UNICEF, 2012). However, few studies have assessed the continued impact of the grant in recent times, while even fewer studies have investigated the role of the CSG in the light of the nexus between food security and child care arrangements. This study aims to explore and assess the relationship between food insecurity, the CSG and child care arrangements among a cohort of mother–child pairs participating in a longitudinal study in Langa, Cape Town.

1.2 Aim and Objectives

Aim:

To determine and explore the relationship between food insecurity, the child support grant and child care arrangements in families in Langa, Cape Town.

Objectives:

- To explore the extent of food insecurity among CSG recipients and non-recipients in Langa, Cape Town;
- To explore the extent to which food insecurity contributes to child care arrangement instabilities;
- To explore the relationship between child care arrangement instabilities and food insecurity in CSG recipients and non-recipients.

1.3 Research Methodology

1.3.1 Research problem/hypothesis

Food insecure households experience child care arrangement instabilities because caregivers spend time away from their children looking for work or spending long hours at work, or physically move away from their children in order to work in faraway cities. The research question underpinning this research is: What role does food insecurity play in child care arrangement instabilities in the context of the child support grant in Langa, Cape Town?

1.3.2 Delimitation of the study area

According to Wright, Neves, Ntshongwana and Noble (2015), parents from low-income households often find it difficult and stressful to manage child care arrangements. This study departed from the assumption that food insecure families are most likely to face child care arrangement instabilities because caregivers spend less time with their children as they have to look for work or generate income for their households. The role of social protection interventions such as the CSG, in disrupting and mediating the link between food insecurity and child care arrangement instabilities, is unknown.

This study was conducted among parents of children from 0 to two years of age from Langa, Cape Town, who are participating in an ongoing longitudinal cohort study investigating the impact of the CSG on child nutritional status and food security in Langa, Cape Town. This study was an extension of the cohort study that sought to determine and explore the relationship between food insecurity, the CSG and child care arrangements among the families in question.

The township of Langa, Cape Town was considered to be the most suitable setting for this study as it is considered to be one of the urban poor communities in Cape Town. According to Battersby (2011) due to increased poverty, food insecurity has increased for the urban poor of Cape Town. Thus, Langa is one of the communities that has increased food insecurity due to poverty.

1.3.3 Study design

The study design employed was an explanatory, sequential mixed-method design. De Vos, Strydom, Fouche and Delport (2011) mention that a mixed-method design is based on philosophical assumptions and methods of inquiry which guide the processes of data collection and analysis through qualitative and quantitative approaches. In order to determine and explore the relationship between food insecurity, the child support grant and child care arrangements in families in Langa, Cape Town, the explanatory, sequential mixed-method design was used. Such a design has two phases, which were followed in the study:

i) Collection and analysis of the quantitative data and administration of the quantitative questionnaire, including the household hunger scale;
ii) Selection of a sample for the qualitative component of the study, conducting of interviews and focus group discussions, and analysis of qualitative data. Thereafter integrate both the quantitative results and qualitative findings, and their interpretation in the form of a discussion.

1.3.4 Population and sampling

Kemper, Stringfield and Teddlie (2003) state that sampling plays a significant role in mixed-method research and is linked to the study design. The population for this study were mothers who were identified and recruited while pregnant (+/- seven months) from Langa Clinic and Vanguard Community Health Centre. These are the community clinics which provide health care services for the people living in Langa and other neighbouring communities. The mother and child pairs were followed up from six weeks after birth and data was collected at three–six weeks, at six months, at one year and at two years of age. The sample for this study was selected purposefully. It comprised all participants who were followed up during the primary study during a period of three months (March to June 2018) and provided a sample of 120 mother–child pairs. Moreover, the population for the focus group discussions was purposefully selected from groups of community members and community workers, who shared and discussed their views about food insecurity, child care arrangements and the role that the CSG plays.

1.3.4.1 Quantitative data collection

In the longitudinal birth cohort study, experienced data collectors were employed to recruit pregnant women from the Langa Clinic and the Vanguard Community Health Centre, as well as collect data at the homes of the participants after the birth of their children. For the purpose of this study, data was collected on mother–child pairs, who were followed up in the birth cohort study during the three-month period designated for data collection. The period of three months was deemed appropriate as it allowed a sufficient number of food insecure participants to be identified for the qualitative component, while also affording the researcher time for data collection, data analysis and write-up within the academic year.

The purpose of the quantitative component was to reveal the demographic characteristics of the respondents and to determine and distinguish households that were food insecure. The HHS

was incorporated into the questionnaires that were used for the cohort study as it is a quantitative tool. According to Ballard, Coates, Swindale and Deitchler (2011, p. 1), "the household hunger scale (HHS) is a new, simple indicator used to measure household hunger in food insecure areas". The HHS has three main questions which have a series of sub-questions used in the follow-up process. Answering these questions helps to reveal which participants are food secure and food insecure, respectively.

The data collectors trained for the cohort study, together with the researcher (a Master's student), administered the household hunger scale to participants in order to identify the households that were food insecure. Thereafter, participants who were food insecure were purposefully selected for the qualitative component of the study. This sample was divided into two groups – CSG recipients and non-recipients.

1.3.4.2 Qualitative data collection

Individual interviews were conducted with 23 purposefully selected participants. Thereafter, three focus group discussions were conducted with eight randomly selected members of the community per group. These comprised 16 community workers and eight members of the community. The researcher asked for permission from their supervisor to conduct the study and it was granted.

The researcher and the fieldworkers approached the community workers and other members of the community, and asked them to participate in the study. They all agreed to participate in and signed the consent form. The interviews and focus group discussions (FGDs) were conducted to gain an in-depth understanding of child care arrangements within households and the community as a whole, to explore the phenomenon of child care arrangement instabilities and the reasons for such instabilities, and to understand the role of food insecurity in care arrangements and the impact of the CSG on their households. Data from both the individual

interviews and the FGDs was collected with a view to developing a thorough grasp of the link between food insecurity and child care arrangements. The interviews and FGDs used both closed and open-ended questions.

1.3.5 Data collection instruments and analysis: Quantitative component

The quantitative data was analysed through the Statistical Package for the Social Sciences (SPSS) version 25 and two types of indicators: a categorical HHS indicator and a median HHS score for the sample of data collected. The SPSS was used to analyse and to formulate tables and graphs to describe and summarise the demographic data collected. Both types of HHS indicators can be used for assessment, monitoring and evaluation purposes (Ballard et al., 2011). The HHS score for every responding household was computed after re-coding of the variables. Each household was classified as experiencing little/no food insecurity, moderate food insecurity and severe food insecurity. Thereafter, tables and graphs were created to describe and summarise the data collected.

1.3.6 Data collection instruments and analysis: Qualitative component

Semi-structured topic guides were developed and piloted for in-depth individual interviews and FGDs. The development of guides conformed to the standard set in the literature. Interviews (generating both verbal and non-verbal data) were transcribed into a written format so that the researcher could familiarise herself with the data. Thereafter, data was coded according to what was found to be key information and of particular interest. Coding was done with the aid of the Atlas TI software. The codes were sorted into themes, this being done with the use of thematic maps, mind maps and tables. The identified themes were then reviewed to check if they formed a coherent pattern. Finally, the themes were refined and defined by identifying the essence of each theme and what data it captured. This was done to reveal the story that each theme told and how it fitted into the broader context of the study.

1.3.7 Trustworthiness of the study

The researcher used bracketing, i.e. writing down preconceived ideas and beliefs, before embarking on the study. This was done for the purpose of later reflection and to avoid bias. A peer review process was also followed to ensure the trustworthiness of the study. Gunawan (2015) mentions that peer reviews are used as a way of ensuring the trustworthiness of a study and to ensure that the researcher has analysed the data correctly. In this regard, the researcher worked with the fieldworkers to verify that the HHS data was analysed correctly. Overall, the trustworthiness of this study was assured through bracketing, detailed transcription, a systematic plan, coding and peer reviews.

1.3.8 Conclusion: Study outputs

This study will contribute to the existing body of knowledge about child care, food insecurity and the child support grant (CSG) in South Africa. Valuable insights emerging from this project include greater knowledge and an improved understanding of the impact of food insecurity on child care arrangements and the role that cash transfers, such as the CSG, play in reducing child care arrangement instabilities in low-income households.

1.3.9 Ethical considerations

The primary study, i.e. the CSG longitudinal birth cohort study, received ethical approval from the South African Medical Research Council (SAMRC). The proposal for this study was approved by the Senate Higher Degrees Committee and received ethical approval from the Humanities and Social Sciences Research Ethics Committee (HSSREC) of the University of the Western Cape (UWC) (reference number HS18/4/20). The following measures were employed to ensure that the study was conducted in an ethically correct manner.

1.3.9.1 Informed consent

All participants in this study gave their written consent before participating. Adequate information about the study was given to participants prior to their giving consent in their own language. All participants were informed about the purpose of the study, the procedures involved, the risk and benefits of the study, and their rights as participants. It was also made clear to all participants that taking part in this study was voluntary. They were informed that they had the right to refuse to take part and that if they decided to be in the study and then changed their mind at any point, they would be able to withdraw. It was made clear to each participant that their decision would not affect the services they received from any institutions in the area, including social services.

1.3.9.2 Risk to informants

There were no known risks to participating in this study as it was non-invasive and concerned a well-known topic. However, it was recognised that questions would be asked about issues that could be perceived as sensitive by some research participants and that some questions might evoke sadness or painful recollections. During the initial consent phase, participants were informed that in the study they would be asked various things about their lives and that this might include information that they might not feel comfortable talking about or that was painful or sad to think about. The potential difficulty was minimised by the participants being informed that they did not have to answer any questions they were not comfortable with and that they could stop the interview if they wished.

Interview data was collected in the participants' homes as it was a safe and private place where no other people but the researcher, fieldworker and participant were present. Furthermore, no personal names were recorded; the participants were anonymised through the use of unique participant numbers. The focus group discussions were conducted in one of the participants'

houses that the community workers often use as their meeting place. This was a safe and private house that was access controlled. Participants in the FGDs signed a confidentiality agreement to ensure that they upheld and maintained the confidentiality of the discussions.

1.3.9.3 Protection of confidentiality

Confidentiality was maintained at all times. Protection of participants' information was ensured by assigning them each a unique identifier code. The data collected was kept safe by storing it in a computerised system, with a password used to lock and unlock the system. Only the researcher had access to the password. Written and printed hard copies of transcripts and informed consent documents were locked in a storage box that can only be accessed by the researcher. This data would be kept safe and stored for five years as per the University of the Western Cape's policy. Thereafter, the researcher undertook to shred all documents pertaining to the research and dispose of them. Similarly, electronic data would be deleted from the password-protected computer once the thesis had been published as a journal article and when the five year period had lapse (by the end of 2024).

1.3.9.4 Benefits and costs of participation

It was made clear to the participants that there was no direct benefit or cost of participation in the study. Participants were, however, reimbursed for their time at a rate of R100 per person, which was the same amount applied in the primary study. The researcher and fieldworker travelled to participants' homes.

1.4 Thesis Outline

Each chapter begins with an introduction providing an outline of the chapter and closes with a comprehensive conclusion. The chapters are arranged as follows:

- **Chapter 1:** Introduces the study and the background to the research, and proceeds to introduce the components of the remaining chapters.
- **Chapter 2:** Provides a comprehensive literature review. The relevant current literature on food insecurity, child care arrangements and the child support grant in South Africa is reviewed. In addition, the theoretical framework pertaining to this study is introduced and extensively discussed.
- **Chapter 3:** Focuses on the research methodology and covers the research design, the target population, sampling techniques, the methods used to collect and analyse the data, and the ethical standards for conducting research in the social sciences arena.
- **Chapter 4:** Presents the quantitative and qualitative data, how it was analysed and a discussion of the findings.
- **Chapter 5:** Concludes the research study. The chapter summarises the results and findings, and provides recommendations based on the latter as well as recommendations for future research. The chapter also reflects on the research process, alongside the limitations of the study. The chapter is brought to a close with some final remarks from the researcher.
- **Chapter 6:** Presents the list of references consulted for the study.

1.5 Chapter Summary

This chapter provided a general overview of the research topic and the nature of the study. The aim and objectives of the study were highlighted. This led to the formulation of the research methodology where a hypothesis was formulated and the study design was described, with the focus being on data collection and data analysis. The ethical considerations of the study were also highlighted. Thereafter, the sequence of remaining chapters was outlined.

The aim of this chapter was to introduce the main points of discussion in each of the chapters to follow, thereby laying an effective foundation for the structure of the thesis. The next chapter, Chapter 2, provides a review of the literature, focusing on both national and international sources.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

Children are an important part of any society. In South Africa, it is estimated that the number of children aged 0–15 years is 17 million (28.8%), making them the second largest group in the South African population (Stats SA, 2019, p. 5). Children are the future and they deserve to live in an environment and be taken good care of so that they can grow and realise their potential. However, there are various factors that may affect child care and development; these include socio-economic factors, such as food (in) security, economic circumstances (especially poverty), parental involvement and living conditions (Berk, 2000).

This chapter presents the literature reviewed on the child care, food insecurity and social protection nexus, with a particular focus on cash plus care interventions and the child support grant (CSG). The concept of child care is explored in depth, covering (among others) parental care, maternal care and alternative care. The outcomes of child care are discussed by means of Bronfenbrenner's ecological systems theory. Furthermore, the literature on food insecurity in the South African context is reviewed, concurrently highlighting the nutritional implications that food insecurity has for children. Intervention strategies for food insecurity, such as cash transfers, are examined and discussed. Finally, the literature on cash plus care is reviewed with the intention of determining the link between the CSG and child care arrangements.

The thrust of the literature review is to explore and apply fresh thinking to the link between food insecurity, child care arrangements and the CSG, thereby uncovering new insights that will enhance people's understanding of, and potentially steer decision-making in, the child care arena in South Africa.

2.2 Child Care

Child care refers to the care, supervision and nurturing of a child by a parent, caregiver or family member(s). It can also be provided in a formal setting by trained caregivers such as those at early childhood development (ECD) centres and foster care centres. Child care also refers to any care provided regularly by someone who is not the child's parent (NICHD, 2006). Phillips and Adams (2016) concur with this, stating that a caregiver is not limited to the child's parent exclusively. Caregivers can be people who are either related or not related to a child. Therefore, a definition of child care could be the care provided by the child's father, babysitter, grandparents, relatives and centre-based caregivers (NICHD, 2006).

Sherr, Macedo, Tomlinson and Cluver (2017) refer to child care as good parenting, nurturing and psychosocial support that a child receives from a parent or caregiver. According to the NICHD (2006), positive caregiving behaviours include:

i) showing a positive attitude, which means that the caregiver is encouraging when interacting with the child;
ii) having positive physical contact, including hugging and comforting the child;
iii) responding to vocalisations, including repeating the child's words and commenting on what the child says or tries to say;
iv) asking questions, including encouraging the child to communicate by asking questions that the child can answer easily;
v) praising or encouraging the child and teaching the child; and
vi) Encouraging development by satisfying the child's developmental needs, including helping the child to stand up and walk.

According to Statistics South Africa (2018, p. 8), approximately 33.8% of children live with both parents, 43.1% live only with their mothers and a much smaller percentage of

3.3% of children live only with their fathers. Families and households are important for the developmental, emotional and cognitive growth of children. The value of living with biological parents, however, depends on the quality of care they can provide; children, for example, are often left in the care of other relatives, such as grandparents. Therefore, caregiving is central to child development, whether the caregiver is a parent, a grandparent, a teacher or a practitioner in a child care centre. Essentially, child care is not primarily about who provides care, but rather about the provision of care to the child.

2.2.1 Types of child care

2.2.1.1 Parental care

Parental child care refers to the care that children receive solely from their parents. Del Boca, Piazzalunga and Pronzato (2014) mention that being a caregiver to a child is not determined by gender. Both mothers and fathers have inputs in the child development function. According to Statistics South Africa, 92.7% of young children (0–4 years) have both their parents alive. This proportion is highest for infants (<1 year) at 96.7%, and then decreases gradually to 93.5% for children aged 1–2 years and 90% for those aged 3–4 years (Stats SA, 2015). These statistics show that there are a large number of children whose parents are alive. Having both parents in the same household may have an added benefit of close proximity to the child, which in turn might facilitate both parents assuming the role of caregiver.

The study conducted by Del Boca et al. (2014) also indicated that fathers are as productive as mothers in child care, especially as the children get older, and make a significant contribution to their children's cognitive outcomes. This shows that both parents can play an equally valuable role in the child's development through the care that they provide. However, in some households, the fathers of children are not always present to take care of their children, thus

leaving the mothers to be the primary caregivers. According to Statistics South Africa (2018, p. 5), approximately 6.1 million (37.9%) of the households in South Africa are headed by women. In the Eastern Cape, 46.9% of households are headed by women. In Limpopo and KwaZulu-Natal, 45.8% and 45% of households, respectively, are women-headed. Women-headed households are least common in the most urbanised provinces, namely Gauteng and the Western Cape where the proportions are 29.8% and 325%, respectively. This indicates that almost half the households in South Africa are headed by single mothers; thus, children in these households receive maternal care.

2.2.1.2 Maternal care

Graves (1976) defines maternal care as the nurturing, love, comfort and responsiveness that a mother shows to a child. Maternal care means that the mother is a primary caregiver to her children. Eshel, Daelmans, Cabral de Mello and Martines (2006) mention that maternal responsiveness is one of the key characteristics of maternal care, especially when mothers are taking care of infants. Maternal responsiveness has positive effects on attachment and the development of an effective bond between mother and child. Furthermore, responsive caregiving gives rise to a warm and trusting relationship, which leads to social competence and fewer behavioural problems.

However, according to Belsky, Vandell, Burchinal, Clarke-Stewart, McCartney and Owen (2007), some mothers – especially single mothers – struggle with their maternal caregiving role. In most cases, they cannot be the sole caregiver to their children because they have to go to work or look for work, which in turn impacts their children's development. Byrne and O'Toole (2015) add that in some households where the caregiver is employed, parents are most likely to use non-parental child care for their children, in contrast to those households where the parent is unemployed. In the South African context, mothers – especially poor, single

mothers – struggle with their maternal caregiving role (Ntshongwana, Wright & Noble, 2010). Often, single mothers cannot be the sole caregiver to their children because they have to move away from their homes to bigger cities in search of employment (Ntshongwana et al., 2010) or have to be absent from the home for many hours during the day in order to go to work or look for work.

Hill, Waldfogel, Brooks-Gunn and Han (2005) state that children whose mothers are working by the time the children have reached the age of nine months have lower cognitive development scores than the children of non-working mothers. This is corroborated by Brilli, Del Boca and Monfardini (2013) who assert that a reduction in maternal time with the child induces a negative effect on their cognitive development, but that high-quality child care can help counterbalance this effect. Overall, mothers who are working usually choose an alternative care arrangement for their children. Some choose to leave their children in the care of other family members, neighbours or ECD centres.

2.2.1.3 Alternative care

According to Statistics South Africa (2018):

> Individuals rely on their families and households for their physical, social and economic well-being and survival and most people consider families and households as their most important social institutions and social reference groups. Although traditional family structures are changing, they remain very important in countries such as South Africa where large proportions of the population are subject to debilitating poverty and unemployment and institutional support is inadequate (Stats SA, 2018, p. 4).

Over the past few decades, there has been a radical transformation in the labour market, which has seen an increase in maternal employment and the roles that women play in society (Department of Labour, 2005). When mothers join the workforce, their children have to be in alternative care. Alternative care can be defined as the type of care that is provided by other people who are not the child's parents (NICHD, 2006). There are various types of alternative care and each type has its strengths and weaknesses. Alternative care arrangements can offer children the chance to develop in new ways; however, some may not be as effective for children as others.

Types of alternative care

1. Child care centres: These are usually located in a home or a designated building, often with one or more adults caring for a small number of children. These include ECD centres, which are considered to be any building or premises used for the care and protection of six or more children away from their parents (Department of Social Development, 2006, p. 6).
2. Family, friends and neighbours: This is the care that is provided in a home setting, often with one adult caring for a small number of children. These caregivers are acquainted with the families they serve. Ages of children and hours of care are based on agreements between the caregiver and the parent (NICHD, 2006).

3. In-home care: This involves a private caregiver hired to provide care in the home of the child. It can also refer to the care provided to children living in children's homes and places of safety.
4. Foster care: This is an alternative care option that protects and safeguards children at risk. A child is in foster care if they have been placed in the care of a person who is not

their parent or guardian as a result of a court order by a children's court (Children's Act 38 of 2005).

5. Grandparents providing care: This type of care is similar to the care provided by family, friends and neighbours. However, it focuses on grandparents, particularly grandmothers, providing care to their grandchildren. This type of care is more common in the African culture. According to Makiwane (2011), grandparents in black families in South Africa tend to take care of their grandchildren when their parents migrate from the rural areas to the urban areas to look for work. This practice began during the apartheid era and is still common today.

Overall, child care is a very broad concept which may be defined differently by different people or scholars. However, children's wellbeing and child protection are at the core of child care. There are various care arrangements that different people employ and each child care arrangement has an impact on child development.

2.3 Outcomes of Child Care: Understanding child development through the ecological systems theory

According to Sherr et al. (2017), parenting and child care impact child development. How a caregiver provides care has a direct influence on the child's development and cognitive outcomes. The ecological systems theory was developed by Bronfenbrenner to understand child development. This theory looks at a child's development within the context of the system of relationships that constitute their environment.

The ecological systems theory has five levels, namely: microsystem, mesosystem, exosystem, macrosystem and chronosystem (Bronfenbrenner, 1994). Within the microsystem there are the family, school, neighbourhood and child care environments. At this level, the child is influenced by the people in their immediate environment and the child in turn also has an

influence on these people. The influences at this level are strongest and have the greatest impact on the child and their development (Paquette & Ryan, 2009). Furthermore, what happens at the microsystem level may overlap with that at the mesosystem level.

The mesosystem level provides the connection between the structures of the child's microsystem (Paquette & Ryan, 2009). This means that within the mesosystem, people in the microsystem are connected – for instance, the connection between the child's parents and their teacher.

Moreover, the exosystem level refers to society at large, in which the child does not function directly. For instance, the parent's work schedule may influence the parent's availability and interaction with their child (Berk, 2000).

The macrosystem refers to the outer-most layer in the child's environment. This level comprises cultural values, customs and laws (Berk, 2000). The effects of larger principles defined by the macrosystem have a cascading influence throughout the interactions of all other layers. For example, if it is the belief of the culture that parents should be solely responsible for raising their children, that culture is less likely to provide resources to help parents (Paquette & Ryan, 2009).

Furthermore, the chronosystem encompasses the dimension of time relating to a child's environments. Elements within this system can either be external, such as the timing of a parent's death, or internal, such as the physiological changes that occur with the aging of a child. As children get older, they may react differently to environmental changes and may be more able to determine how that change will influence them (Paquette & Ryan, 2009).

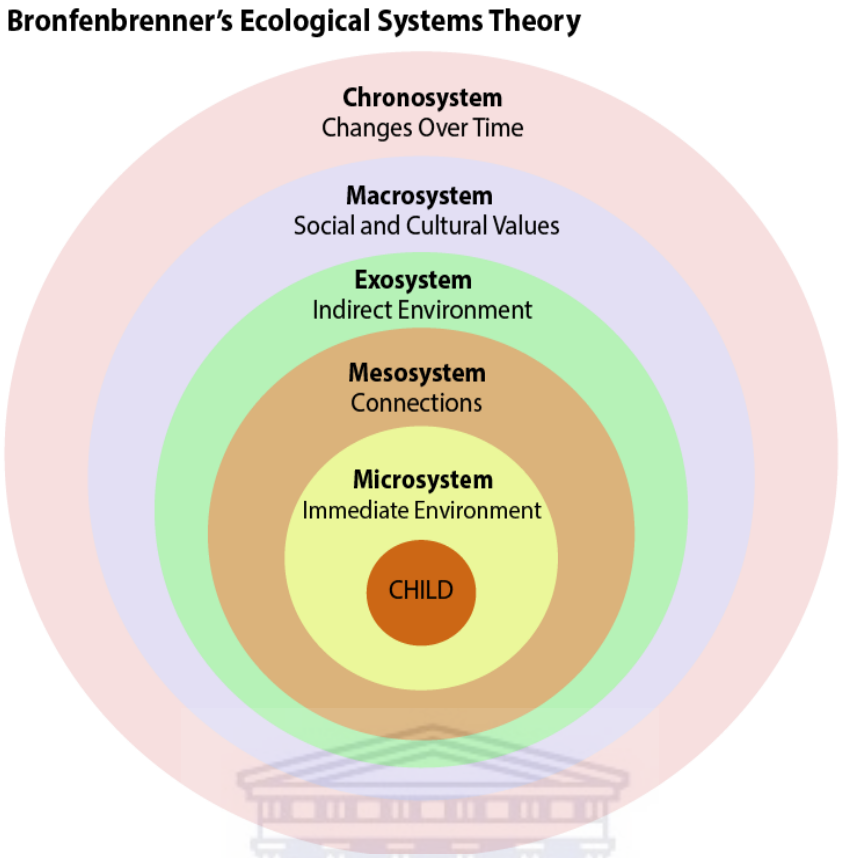

Figure 2.1: Bronfenbrenner's ecological systems theory

Source: The Psychology Notes HQ (2019)

Therefore, child development is influenced by the care that children receive at all levels, as discussed above. This then means that the care that the parent or caregiver provides to a child at each level has an influence on the child's holistic development.

While early studies emphasised the need for maternal care solely, more recent studies have shown that other child care arrangements do not necessarily produce negative outcomes (Del Boca et al., 2014). Most of the emerging literature on child care arrangements and child outcomes over the last few years shows that children's outcomes, including cognitive, health and behavioural outcomes, are the result of inputs provided by people at all levels of the child's environment (Del Baco et al., 2014).

2.3.1.1 Cognitive outcomes

A child's cognitive outcomes are largely influenced by the care they receive. Sherr et al. (2017) report that higher scores on parenting are strongly associated with better cognitive outcomes. This confirms the finding of Phillips and Adams (2016) that early exposure to child care can foster children's learning and enhance the quality of their lives. However, this depends largely on the quality of the child care setting. It has been suggested that children who experience good child care are most likely to be ready for school by the age of 4½ years (NICHD, 2006). Moreover, Belsky et al. (2007) mention that children who attended child care centres display slightly better cognitive and language development compared to those who experienced other types of non-maternal child care arrangements. Thus, children who experience higher-quality child care show consistently better cognitive functioning.

2.3.1.2 Health and nutritional outcomes

According to Ruel and Hoddinott (2008), nutrition is essential for children's physical and cognitive development. Good child care and appropriate child stimulation are of paramount importance for child development and health. According to the United Nations Children's Fund (2015), good parenting yields good nutritional outcomes, although the latter is not only about good parenting. Good nutrition depends on a myriad of factors, such as access to nutritious food, good hygiene practices and conditions, safe drinking water, acceptable housing and good maternal education.

Eshel et al. (2006) state that responsive feeding is one of the most important elements in quality child care. Therefore, children who experience responsive feeding tend to have good nutrition. Moreover, McGinnity et al. (cited in Byrne & O'Toole, 2015, p. 31) "found that infants who attend child care centres such as crèches have a higher risk of being rated as 'less healthy' than those with parental care only (in the order of almost three times more likely)". Their study also

found an association between child care placement and a range of common child-acute illnesses, including colds, chest infections, ear infections, wheezing or asthma, persistent or severe vomiting, and persistent or severe diarrhoea or constipation. These illnesses, which required medical attention, were significantly more likely in the case of children experiencing centre-based child care.

Based on the above findings, it can be deduced that children who attend crèches are more likely to be exposed to illnesses than children at home.

2.3.1.3 Behaviour

According to Hungerford and Cox (2006), a child's behaviour can be associated with child care and family experiences. It is further stated that behavioural problems can be associated with negative family experiences. Another study conducted by the NICHD (as cited in Hungerford & Cox, 2006) found associations between low-quality child care and increased behavioural problems in children aged 24–36 months. Byrne and O'Toole (2015) mention that the amount of time that a child spends in non-parental child care has an important influence on child outcomes, predominantly behavioural outcomes. Therefore, it can be said that the quality of child care has an impact on the child's behaviour as they grow. In some instances, poor child care is the result of factors that affect parents on a day-to-day basis.

2.3.2 Factors affecting child care

There are various factors that affect parents' or caregivers' ability to provide the best care that they can to their children. These factors either hinder good child care or contribute to the poor care of children. Poverty, the socio-economic status of the household and child care instabilities are some of the factors affecting child care.

2.3.2.1 Socio-economic status

Poverty is a global problem that affects many households. In South Africa, there are a huge number of households that are affected by poverty. According to Statistics South Africa (2017, p. 14), "more than one out of two South Africans were poor in 2015, with the poverty headcount increasing to 55.5% from a low of 53.2% in 2011. This translates into over 30.4 million South Africans living in poverty in 2015". According to Zembe-Mkabile, Surrender, Sanders, Jackson and Doherty (2015), there is a higher proportion of children living in poverty than adults, with children generally exposed to higher levels of poverty than adults. Therefore, it can be said that there are many poor households in South Africa and children are the ones who are mostly severely affected.

Studies also indicate that the low socio-economic status of the household contributes directly to poor child outcomes. Thus, children living in poor households are most likely to be raised by parents with low levels of education and limited knowledge of child development. These factors increase the risk of impaired child development (Conger & Donnellan, 2007). Fernald, Kagawa, Knauer, Schnaas, Guerra and Neufeld (2017) add that living in poverty is associated with poor child outcomes, influenced by factors such as quality of parental care, family dynamics and environmental characteristics. For instance, children who are raised in poverty-stricken homes do not receive the care, stimulation or nutrition needed to promote ideal child development and may be unreasonably exposed to risk factors that can interfere with their development process.

According to Wu and Schimmele(cited in McCurdy, Gorman & Metallinos-Katsaras, 2010) the family stress theory presumes that poverty puts high economic weight on certain families as parents battle to provide sufficient food and resources for themselves and their children. This

economic pressure harms parental mental health and increases emotional problems for parents, especially depression.

This theory suggests that economic pressure has an impact on the stress in the family, which may harm parental mental health and increase emotional problems.

According to the findings of Parke, Simpkins, McDowell, Kim, Killian, Dennis, Flyr, Wild and Rah (cited in Dunn & Keet, 2012), the entrenchment of poverty increases the likelihood of children's maladjustment due to parental incompetence. Therefore, there are some indications that low levels of income may lead to parental depression, which in turn will influence their parenting skills and the quality of care that they provide.

The family stress theory helps to explain how poverty, parenting and child outcomes may be related. According to this theory, parents struggling to make ends meet because of a lack of income, underemployment and low-salary jobs experience heightened stress levels. This leads to changes in emotions and behaviours that hurt their parenting and affect their children adversely (McCurdy et al., 2010). This theory thus shows that socio-economic factors affect the quality of child care and may also result in child care instabilities.

2.3.2.2 Child care arrangement instabilities

Child care arrangements vary from household to household. Every household has their own care arrangements for their children. Child care instabilities occur when a child in a particular household is taken care of by different people or attends different child care centres over a period of time. Pilarz and Hill (2014) define child care instabilities as the change in non-parental caregivers over a period of time, such as at birth and kindergarten entry, when a child leaves a particular child care arrangement and goes to another.

According to Pilarz and Hill (2014), child care arrangement instabilities can have an impact on the quality of care provided to the child. Byrne & O'Toole (2015) state that global research has established that quality is the most significant variable in deciding how childcare influences children's socioemotional and psychological outcomes. It is likely that access to quality settings is biased toward those with the most assets to access such care. Therefore, quality childcare can be compromised if there are child care arrangement instabilities.

Stability and continuity in child care providers promote positive interactions between children and caregivers as well as the development of secure attachment relationships. Separate or different caregivers prevent these secure relationships from creating child care stability, which may result in adverse behavioural and socioemotional outcomes in early and middle childhood. Furthermore, some studies indicate that infants are most vulnerable to the potentially adverse effects of child care instability. Morrissey (2009) found that children who experienced multiple arrangements at younger ages (24 months) demonstrated more behavioural problems than those who experienced such arrangements at older ages (36 months).

Children in low-income families may also be more likely to suffer the adverse effects of child care instability and also instability in other areas of their lives (Adam, 2004). Some studies concur by suggesting that parents, particularly those with low incomes, often find it difficult and stressful to manage changing employment demands and child care arrangements.

However, a study conducted by Byrne and O'Toole (2015) suggested that children in low-income households are significantly less likely to use non-parental childcare. The study examined the employment status of mothers and it was found that primary caregivers in employment were most likely to use non-parental child care compared to primary caregivers who were not in employment.

In a study conducted by Pilarz and Hill (2014), it was found that the number of changes in care arrangements experienced between birth and the age of three (long-term instability) was correlated with externalising behavioural problems. In particular, children who changed arrangements several times demonstrated more behavioural problems compared to children who experienced no change. In addition, children who experienced back-up arrangements at the age of three demonstrated higher levels of internalising behavioural problems compared to children in non-parental care who did not experience back-up arrangements. Moreover, it was found that multiplicity was also associated with more behavioural problems.

However, not all changes in child care arrangements are harmful to children's development. Changes that are planned and purposeful and that lead to higher-quality or more developmentally appropriate care, such as transitioning from in-home care to centre-based care during the preschool years, may produce more positive outcomes (Ansari & Winsler, 2013). In these cases, any negative effects of changing to a new setting or a new caregiver may be short-lived or may be outweighed by the benefits.

Overall, it can be deduced that not all care arrangement changes are harmful to a child's development; they can also be beneficial. Most care arrangements change due to a variety of factors, but poverty and low income are often associated with food insecurity and poor nutritional outcomes. Thus, a negative intergenerational cycle emerges.

2.4 Food Insecurity

According to the Food and Agriculture Organization (FAO) of the United Nations, "food insecurity is a situation that exists when people lack secure access to sufficient amounts of safe and nutritious food for normal growth and development and an active and healthy life" (FAO, 2011, p. 9). Altman, Hart and Jacobs (2009) state that the depth of food insecurity differs from household to household and that food insecurity in households is sensitive to livelihood

stressors and can change over time. For example, rapid food inflation is a factor contributing to food insecurity (FAO, 2009).

2.4.1 Food insecurity in South Africa

Food insecurity is a global challenge, which South Africa as a country is also facing. According to the HSRC (cited in Altman et al., 2009), South Africa has a food insecurity problem that is mainly caused by chronic poverty and unemployment. In South Africa, there are many households that are vulnerable to or are currently experiencing food insecurity. South Africa is one of the many countries in the world that are food insecure, but there is uncertainty about South Africa's actual food insecurity status because there are no standardised ways of monitoring it (Altman et al., 2009). The HSRC continues to state that there are certainly a huge number of households in South Africa that are food insecure but the baseline estimate cannot be determined, thus making it difficult to monitor and evaluate food insecurity (Altman et al., 2009).

According to the General Household Survey conducted by Statistics South Africa (2017, p. 1) the overall number of South African households that experienced hunger between 2010 and 2016 has decreased. Families with inadequate access to food decreased from 23.9% to 22.3% and the percentage of households that experienced hunger decreased from 23.8% to 11.8% over the same period. Although food insecurity is an issue in South Africa, the statistics indicate that it has decreased, proving that food insecurity can change over time.

In terms of food access, the proportions were high for households of black African children (30.1%), followed by those for households of the Coloured population group (24.9%). Proportions were lower for the Indian/Asian population group (2.0%). However, 31.5% of children below the age of five from the black African and 25.0% from the Coloured population groups lived in households that ran out of money to buy food, while only 2.0% from the

Indian/Asian and 2.3% from the white population groups experienced the same problem (Stats SA, 2017).

There is more circulation in and out of poverty than what might be anticipated. A household might experience poverty in one year and not experience it the next year. Aliber (cited in Altman et al., 2009) conducted an analysis that showed that some households were not hungry in 2006 but were hungry in 2007. This was caused by an increase in the number of children in the household, a decline in the average number of elderly people, a decrease in the average number of adults in employment and a moderate increase in grant income. Clearly, there are many reasons why poverty is in a state of flux and may not be permanent, which goes to show that being food secure one year is no guarantee that the situation will not change the next year or in subsequent years.

One of the major causes of food insecurity in South Africa is hikes in food prices. This makes it very difficult for low-income households to afford proper nutritious food and even basic staple food, such as maize meal. In support of this view, Venter, Van der Merwe, De Beer, Kempen and Bosman (2011) indicate that in 2011 the price of both maize meal and bread rose by 20% over the previous year and dairy products rose by 3%. The authors add that low-income households spend about 37% of their income solely on these basic food items, thus reducing the accessibility of food for many households. Moreover, access to satisfactory food at the household level relies increasingly on how food markets and distribution systems function and not only on agricultural outputs (Altman et al., 2009).

Ruel and Garrett (cited in Venter et al., 2011) highlight that food prices depend on five factors: efficiency of food marketing systems, buying patterns, ability of the household to produce some of the food, access to public transfers and government's macroeconomic policies. Therefore, food prices increase and decrease as a result of these factors, which also makes a huge

contribution to the food security status of households. Such a conclusion is supported by Venter et al. (2011) who state that food security depends on the amount of food produced in a country. Countries that produce insufficient amounts of food tend to import from other countries, which in turn increases the price of food, leading to food insecurity.

The main factors impacting food prices are bio-fuel production, speculation in commodity markets and the influence of agents in the agro-food chain, including supermarkets, processors and distributors. Rising food prices constitute key problems for urban and rural poor households who are the net buyers of large amounts of food (Altman et al., 2009). Other contributing factors include electricity supply constraints and price hikes. Clearly, then, a large number of factors contribute not only to food price increases but also to the prevalence of food insecurity in South Africa.

South Africa produces its main staple foods and exports any surplus amounts of food which are mainly sourced from large-scale commercial farms. Field crops, livestock and horticulture are the main agricultural sectors in South Africa, with wine and fruit production having grown substantially in the past decade. South Africa has a dualistic agricultural economy, which means that a well-developed commercial farming sector co-exists with a small-scale farming sector that mainly operates at a subsistence basis (Venter et al., 2011). Hence, commercial farming is regarded as the sector that is the main contributor to food security in the country.

Subsistence farming also influences the country's food security status. For example, Altman et al. (2009) assert that about four million people (or about 2.5 million households) are engaged in some kind of own production, of which approximately 300 000 to 400 000 are full-time subsistence farmers. For the others, the predominant reason for engaging in agriculture is to procure an extra source of food. This suggests that families who are full-time farmers are using

their produce as a source of extra food. Small-scale farming enables the families to cope better when there is economic stress and also to produce extra food for their households.

On the one hand, commercial farmers have adequate financial resources to implement modern farming technologies and improved farming strategies that promote productivity. On the other hand, subsistence farmers are most likely to be in rural areas. They lack adequate financial resources and technological inputs, which makes them vulnerable to disasters such as droughts and flooding (Venter et al., 2011). Therefore, commercial farming is the most favourable type of farming because of its positive impact on, and contribution towards, food security in the country. However, the impact of subsistence farming should not be overlooked – it, too, plays a role in curbing hunger and food insecurity in the country, especially in rural areas.

2.4.1.1 Food insecurity in rural areas

As mentioned above, income and expenditure play a huge role in food security. According to Altman et al. (2009, p. 352) "rural households spend more on food but less per person than their urban counterparts, by expenditure decile. One possible interpretation is that rural households tend to pay higher prices so they must spend more to acquire a comparable food basket. However, rural households spend 15% less in Rand terms on each household member than their urban counterparts". Most households in the rural areas of South Africa are not food secure, and how they spend their income on food differs from that among the poor in urban areas.

As mentioned above, the manner in which people from different households spend their income on food varies, with the types of food that they spend it on also differing in terms of nutritional content. "Nationally, one in five households spends enough on food to afford a nutritionally adequate food basket. However, a rural–urban breakdown shows that a substantially smaller number of rural households can afford such a food basket: one in ten rural households

compared to one in four urban households" (Altman et al., 2009, p. 352). The differences between urban and rural food expenditure patterns can also be traced to particular food types.

Furthermore, it has been found that, compared to their urban counterparts, most rural households spend a larger amount of money on food products such as grain products, fruit and vegetables and a smaller amount on meat. This could be because land resources in rural areas are becoming increasingly underutilised, effectively allowing more space for livestock. It could also be because some rural households are suppliers of meat. Consequently, this could be a reflection that higher rural food prices force poor households to reduce their consumption of meat so that they can buy staples (Altman et al., 2009). This is an indication that people from the rural areas have different food choices compared to people from urban areas, even when they are both experiencing food insecurity.

2.4.1.2 Food insecurity in urban areas

With reference to a study conducted by Van der Merwe (2011, p.2) "three key dimensions to urban household food security can be identified. These are food availability, food access and food utilisation". People in the rural areas can produce their own food, however one of the main issues is that urban residents have to purchase most of the food they consume. Therefore, urban food security is mostly dependent on money and thus it becomes imperative that sufficient attention is given to the challenges of generating efficient and stable income as a prerequisite for ensuring food security in urban areas.

Although people from rural areas purchase their food as well, the above text highlights that people in urban areas are the ones who mainly buy food since they are limited by the fact that they cannot engage in farming or produce their own food.

Venter et al. (2011) further state that the availability and accessibility of food in urban areas are greatly determined by food supply, which is dependent on distribution. The distribution chain includes supermarkets, wholesalers, street vendors and many others, which in turn may have an impact on food prices. Moreover, the urban food insecure households often pay more for food because they tend to regularly buy food in small quantities because of their low income.

Another significant dimension of urban food security is food utilisation. Different ethnic groups in both rural and urban areas in South Africa have different eating patterns and styles. Van der Merwe (2011, p. 2) mentions that "the white population of South Africa typically consumes a diet which has a high fat intake, low carbohydrate, low fibre and high free sugar. On the other hand, the rural black African population follows a traditional diet, which is high in carbohydrates, low in fat and sugar and moderately high in terms of fibre intake. The black urban residents have lower fat intake and higher carbohydrates".

This shows the different food utilisation styles in South African communities. It also highlights that different ethnic groups consume food differently, while people from the same ethnic group but different geographical areas utilise food differently. Therefore, the environment does have an impact on how people utilise food.

Since most urban households rely on their income to ensure that they have food, it is recommended that people from urban areas engage in urban agriculture to curb food insecurity. Rogerson (cited in Venter et al., 2011) mentions that urban agriculture in South Africa is seen as one of the ways in which citizens can engage to strengthen the asset base of the urban poor. In a study conducted by Van der Merwe (2011) it was found that urban agriculture in Cape Town offers gardeners an opportunity to become involved in a development strategy which holds tremendous potential and can expand into an entrepreneurial activity.

This idea is also supported by Altman et al. (2009) who state that since the population in cities is rising, food policies should stress that urban farming has the potential to address food insecurity in urban areas. According to Altman et al. (2009, p. 354) "a very large proportion of seriously hungry households live in a few urban districts. More than 30% of all seriously hungry households lived in Cape Town, Ekurhuleni and Johannesburg in 2007". Van der Merwe (2011) goes on to say that the increase in and prevalence of food insecurity in urban areas are cause for great concern and need to be addressed in order to tackle the effects of food insecurity, particularly the nutritional implications.

2.4.2 Nutritional implications of food insecurity for children

According to Zembe-Mkabile, Ramokolo, Jackson and Doherty (2015, p. 356) "while there has been a significant drop in reported child hunger (from 30% of all children in 2002 to 16% in 2006), the fact that 3 million children were still living in households where hunger was reported in 2010 remains a cause for concern". Although, child hunger was reduced during this period it was found that the rate of hunger remained fairly constant from 2006 until 2010: 16% in 2006, 18% in 2008 and 17% in 2010 (Zembe-Mkabile et al., 2015).

In the various households that are experiencing it, food insecurity has negative nutritional implications. In some studies, it has been suggested that food insecurity may be linked to poor health outcomes for children, including vitamin deficiency, assorted illnesses (including chronic illnesses), poor health status and infections. Some studies have also found that food insecure children are more likely to experience lower reported physical and psychological functioning (Bronte-Tinkew, Zaslow, Capps, Horowitz & McNamara 2007). This means that children from households that are food insecure are prone to having poor nutrition.

Other studies highlight the fact that between 31% and 33% of low-income, preschool-aged children are overweight or obese, with sex-specific BMI-for-age at or above the 85th percentile,

as compared to 24% of US pre-schoolers in the general population (McCurdy et al., 2010). These statistics demonstrate that children from families who may experience low-income-induced family stress are more overweight than children from families who are not from low-income households. Thus, food insecurity can be a direct predictor of children's poor nutritional state.

McCurdy et al. (2010, p. 145) suggest that "early exposure to poor nutrition may produce lasting effects". It can be deduced that children who are exposed to food insecurity at a young age are most likely to have lasting nutritional problems. Furthermore, low-income families experience stress as they struggle to provide an adequate diet for their children. Some studies suggest that low-income households use various strategies to acquire and manage their limited food resources and that these strategies may influence the development of food insecurity and/or overweight. For example, having limited access to highly nutritious foods, buying poor-quality (high-calorie, high-fat, low-nutrient) but low-cost food, and overeating when food is available after prolonged and repeated shortages of food could (according to researchers) help to explain how food insecurity may increase overweight prevalence among household members.

According to Nzinyane and Alpaslan (2012), orphaned children are at greater risk of malnutrition than any other children. The findings from this study confirm the sentiments revealed in the literature as all the child participants experienced severe economic stress in their households, with a lack of food being a major indicator of their destitution. Having sufficient food is a necessary condition for children's normal growth and development, with recent evidence showing that food deprivation can be a precursor to nutritional and health problems.

Poverty affects the resources and strategies that parents use to acquire and manage limited food resources. It can also be said that depression among poor mothers of young children negatively

affects family food behaviour by inhibiting the adoption of active and responsive food acquisition strategies (such as buying in bulk) and management strategies (such as eating as a family). “In line with family stress theory, we hypothesize that these maternal behaviours result in food insecurity or overweight among children” (McCurdy et al., 2010).

Food inaccessibility may have a negative impact on the nutritional status of households that are food insecure. Larson, Russ, Crall and Halfon (2008) show the link between fewer neighbourhood supermarkets and reduced consumption of fruits and vegetables, and unhealthy weights and diets. Furthermore, fast food restaurants tend to be concentrated in low-income and minority communities, which may affect diet and contribute to weight gain because of the poor nutritional content of this food (Larson et al., 2008). A study conducted by Nyamukapa (2016) found that although food availability was addressed, the food’s nutritional value might not be good, which is important as far as children are concerned.

The damage resulting from undernutrition in the first two years of a child’s life is largely irreversible. Less well known are the high economic costs of childhood undernutrition. These costs include the resources required to deal with diseases and other problems related to undernutrition, both in the short term and the long term, since childhood undernutrition is linked to an increased risk of chronic diseases in adulthood, such as diabetes, coronary heart disease and obesity (Larson et al., 2008). Other costs are indirect, arising from the link between nutritional status and cognitive development, schooling and subsequent adult productivity. Poorly nourished children may experience delayed motor and cognitive development, which can prompt parents to postpone the start of their schooling. These same children may progress through school more slowly, demonstrate poorer academic results, and perform less well in cognitive achievement tests when in school and later on during adulthood (Kesari, Handa & Prasad, 2010).

The prevalence of, and increase in, food insecurity are cause for great concern. Therefore, food insecurity needs to be addressed through concrete and clear policies that will be effectively implemented and translated into workable strategies. Clearly, the time has come to rethink and overhaul existing policies and implement new strategies that address food insecurity in innovative and sustainable ways (Van der Merwe, 2011).

2.5 Intervention Strategies to Address Food Insecurity

Various strategies have been put in place by the government and the private sector to try and tackle food insecurity in South Africa. Ideally, poverty and food insecurity should be addressed by expanding employment opportunities, thereby enhancing household incomes. Employment has expanded substantially since the mid-1990s, but not enough to address income poverty in a meaningful way. Income security is an essential ingredient when tackling food insecurity. The evidence shows that social grants have played an important role in improving household food security since 2001, but improvements in employment status are also important (Altman et al., 2009). While social grants are among the current strategies that have been implemented, there are others that the South African government has introduced.

Around the 2000s, the government formulated a national strategy to deal with food security in the country. “This strategy is called the Integrated Food Security Strategy for South Africa (IFSS). The vision of the IFSS is in accordance with the definition of food security offered by the Food and Agricultural Organization of the United Nations (FAO)” (Van der Merwe, 2011, p. 3). The aim of the IFSS is to attain universal physical, social and economic access to sufficient, safe and nutritious food for all South Africans at all times, which meet their dietary and food preferences for an active and healthy life. Therefore, the strategy utilises an approach that “entrenches public–private civil society partnerships and focuses on the food security of households while still keeping national food security in mind” (Van der Merwe, 2011, p. 3).

Van der Merwe (2011) outlines the IFSS as follows:

- Food security interventions will ensure that the target population who is experiencing food insecurity will gain access to productive resources;
- If a segment of this population is unable to gain access to such resources, the interventions will guarantee that those people will acquire access to income and job opportunities to heighten their purchasing power;
- The interventions will also empower people to gain access to safe and nutritious food;
- The interventions will provide that the state provide relief measures in conditions of disability or extreme destitution; and
- The interventions will be based on the use of analysis that is grounded in accurate information, the impact of which will be constantly monitored and evaluated.

2.5.1 Cash transfers as an intervention strategy

Social safety nets are programmes that distribute transfers to low-income households. These programmes raise income among vulnerable groups and enhance resilience by preventing destitution brought about by the loss of assets or reduced investment in human capital during times of crises.

Transfers can be in the form of cash or food, although with improved technology for tracking income transfers, cash transfers are increasingly the preferred means to support chronically poor households (Ruel & Hoddinott 2008). Zembe-Mkabile et al. (2015) add that existing policy strategies addressing childhood poverty and vulnerability include the provision of basic services, such as education, health care and clean water, and in-kind transfers, such as school feeding schemes and nutritional supplements, and more recently cash transfers. Cash transfers are the most desirable for the recipients. People prefer monetary assistance over any other form of assistance because it allows them to be flexible in their usage thereof.

Nyamukupa (2016) refers to cash transfers as non-contributory grants targeted to assist poor households. These include income support, child grants and foster care grants that are given to target beneficiaries to help them achieve a particular outcome. These grants are designed to alleviate poverty, promote school enrolment and support food availability. Altman et al. (2009) corroborate this by stating that social grants are unquestionably one of the most important contributors towards the reduction of poverty and food insecurity in households. There are a large number of households in South Africa that rely on social grants as a source of income – in some cases, the only source of income. The distribution of social grants is one of the strategies that the government has implemented.

Furthermore, in some communities, food parcels are distributed as a means of addressing food insecurity. One of the studies conducted by Nzinyane and Alpaslan (2012) highlighted that the Department of Social Development plays an important role in providing households with food parcels. Mkhize (cited in Nzinyane & Alpaslan, 2012) found in her study that social security grants served as a supplementary measure for the care of orphaned children in child-headed households. Therefore, social grants can be distributed together with food parcels. This serves as confirmation that social grants have played an important role in improving household food security since 2001 (Altman et al., 2009).

The old age grant (OAG) is one of the primary sources of income for the majority of households headed by the elderly in South Africa. In fact, in many cases, the elderly are likely to use their old age grant to support the entire household, which is usually multigenerational (Makiwane, 2011). In addition, the child support grant was introduced by the post-apartheid state to alleviate poverty in poor households. Commonly, it is the grandparents, as carers of grandchildren, who make claims on behalf of these children (Makiwane, 2011). Most families that are destitute depend on the social security grants that the government provides. Moreover, households with children rely heavily on the child support grant.

2.5.1.1 Child support grant (CSG)

According to UNICEF (2015, p. 20) "the South Africa Child Support Grant (CSG) began to deliver cash transfers to children and their families in 1998, leading the way for social protection in Sub-Saharan Africa. The CSG has expanded to include all children in low-income households under the age of 18 (initially the programme targeted only children under seven) and the transfer amount has been adjusted for inflation". This programme is considered to be an integral part of one of the most comprehensive social protection systems in the developing world, as it now reaches over 10 million children across the country every month.

According to Roelen, Delap, Jones and Karki Chettri (2017) the CSG provides a monthly cash transfer for children up to 18 years of age living in poor households. A child's primary caregiver can apply by going to the nearest South African Social Security Agency (SASSA) office. The grant is means-tested with lower income thresholds for single compared to married caregivers. The CSG reached 11.3 million children and is one of the largest transfer schemes in the region.

According to Statistics South Africa (2015) "A total of 3.2 million (20.9%) children aged below 5 years received social grants in 2012. A total of 60.8% of children aged below 5 years received a social grant, mainly in the form of a child support grant (60.5%), while 0.3% received the foster child grant. Children aged 3–4 years (67.1%), followed by those aged 1–2 years (62.2%) and 44.0% of infants, received the child support grant in 2012. Children who received a social grant during their infancy while living with their biological mother totalled only 53.0%. The percentage increased to 77.7% for children aged 1–2 years and further to 81.2% for those aged 3–4 years. Overall, 73.1% of children aged 0–4 years who lived with their biological mother received a social grant (Stats SA, 2015).

In 2009, in a study conducted by a consortium led by the Economic Policy Research Institute (EPRI), it was found that the CSG had a significant, positive influence on the educational, nutritional and health outcomes of children. The grant was used for the needs of the whole household (not just the eligible child), with 95% of the cash being spent on five main types of commodities: food, education, clothing and household durables, health and transport. Generally the mother (or main female caregiver) received the grant and had control over the way in which it was spent. With very few exceptions, men had limited access to, or control over, the CSG (UNICEF, 2015). Most families spend additional financial resources, such as support grants, on school-related expenses, including fees and uniforms.

Overall, child support grants are used as an aid to alleviating childhood poverty in families and addressing food insecurity, while also covering other household expenses. Devereux and Waidler (2017) support this view by stating that only a certain proportion of the CSG is spent on food; the money is also used for other expenses. Figure 2.2 below is an illustrative example of the living costs for a family of five, comprising two children, one elderly person and two adults.

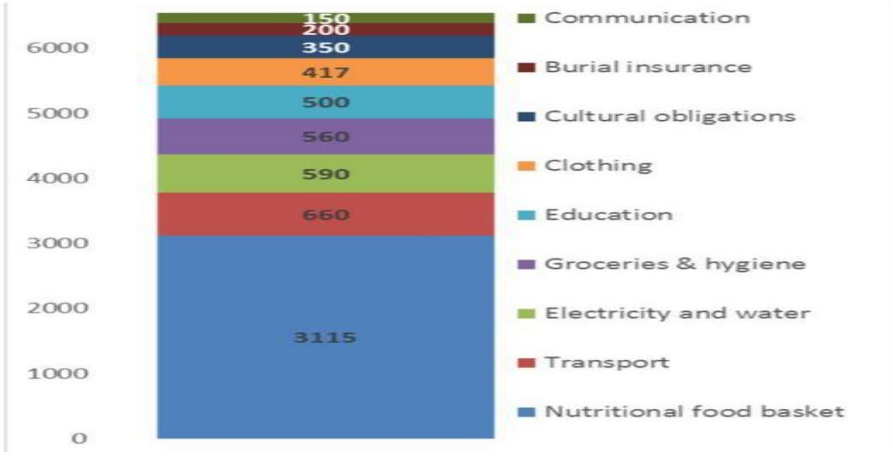

Figure 2.2: Living costs (Rands/month) for a family of five

Source: PACSA (2016, p. 8)

In addition, a study conducted by Devereux and Waidler (2017) revealed that social grants were insufficient to meet food needs. In 2016, the CSG rose from R330 to R360, thus increasing by 6%, but food prices rose by 10% (figure 2.4). The authors stated that the Pietermaritzburg Agency for Community Social Action (PACSA): "estimated that the cost of a nutritionally adequate diet for a young child (aged 3–9 years) in May 2016 was R557 and for an older child (10–13 years) it was R604" (Devereux & Waidler, 2017, p. 16).

Given the above findings, it can be inferred that even if the CSG could be used in its entirety to buy food, it would not be adequate.

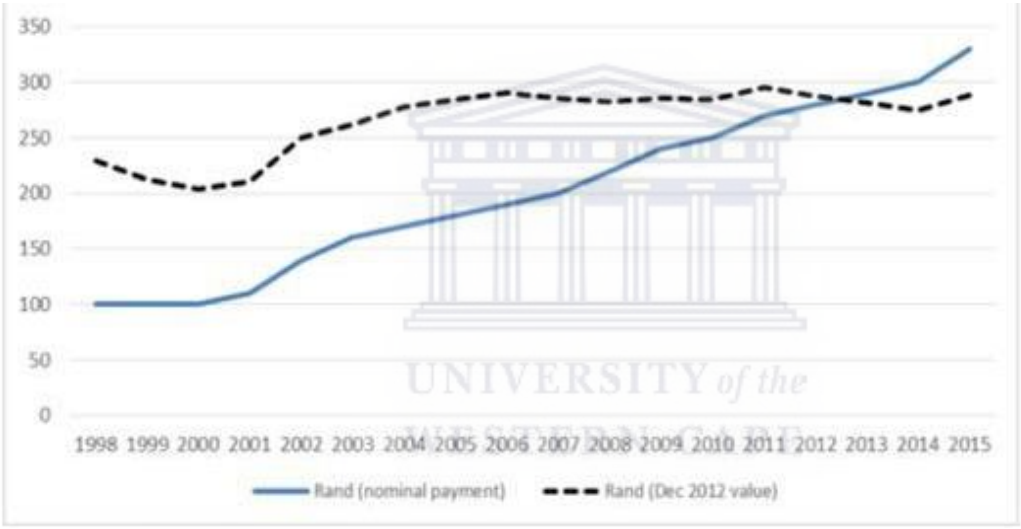

Figure 2.3: Child support grant – nominal and real value, 1998–2015 (Rand/month)

Source: Beukes et al. (2015) (cited in Devereux & Waidler, 2017, p. 16)

Although cash transfers have an impact, on their own they are not enough. Child care is also pivotal. Thus, cash and care are often used collaboratively to yield a better outcome in terms of child development.

2.6 Cash plus Care

UNICEF (2015) defines cash plus care as an integrated strategy used to address childhood poverty. This strategy entails cash transfers being given to families to help reduce household poverty and in turn improve the care that is provided to children. Nyamukupa (2016) states that a logical family support strategy aimed at encouraging adequate early childhood care and development includes cash transfers. The provision of cash enhances a family's ability to take better care of their children.

Cash transfers and care used collaboratively can have a major, positive impact on child development. Other studies have revealed that cash complemented by care can be linked to a reduced risk of HIV infection among boys and girls, and is associated with lower school dropout rates, violence and substance use among adolescents (Sherr et al., 2017). This indicates that children from households benefiting from both cash and care may produce positive behavioural outcomes. Cash plus care has been established as an effective intervention to lower HIV-risk behaviour among adolescents. Cash transfers are also linked to improved cognitive outcomes for children, while cash plus good parenting enhances children's memory, cognition and learning capabilities.

Given that cash plus care is associated with good behavioural outcomes for children and adolescents, most studies exploring this phenomenon have focused on cash transfers within the HIV context. Furthermore, child-focused grants, parental monitoring, free schooling, school feeding and teacher support each shows significant prevention effects, independently of other social interventions and after controlling for covariates and baseline HIV-risk behaviour (Cluver, Toska, Orkin, Meinck, Hodes, Yakubovich & Sherr, 2016). Therefore, cash plus good parenting (child care) is positively associated with good child behavioural and cognitive outcomes.

According to Cluver et al. (2016), cash plus care has been established as an effective intervention for lowered adolescent HIV-risk behaviour, with data now showing evidence of the specific advantages, in an HIV-prone environment, of cash (in the context of good parenting) on cognitive functioning. The data clearly indicates that cash transfers are associated with improved cognitive outcomes. Moreover, cash plus good parenting enhances the effects. This holds true for memory (measured by digit span), overall cognition (measured by the draw-a-person test) and learning and recall (measured by the caregiver's report).

Cash transfers (i.e. child support grants) are important poverty and food insecurity interventions. They are among the interventions currently under scrutiny which are aimed at social protection. Some of the recent literature that has emerged reveals the effectiveness of cash transfers insofar as positive child outcomes are concerned. Other cash transfer studies have been conditioned on parental behaviours that may enhance child wellbeing, such as birth registration, immunisation, parenting class attendance and school enrolment (Sherr et al., 2017).

Overall, recent studies have revealed the positive effects of cash transfers both on parents and their children. However, there is limited information and/or few studies have been conducted on the effects of food insecurity and cash transfers, particularly the CSG, on child care arrangements. More research needs to be done on how food insecurity, child care arrangements and the CSG influence child development.

2.7 Chapter Summary

This chapter has served the purpose of exploring and discussing the existing literature on child care, food insecurity and cash transfers. The review was done by looking at child care holistically, including an in-depth analysis of various types of child care. It was found that good child care entails a child receiving good parenting, nurturing and psychosocial support from a

parent or caregiver, which in turn contributes to their development. Thereafter, the literature on food insecurity was reviewed, with evidence pointing to the fact that there is extensive childhood poverty and food insecurity in South Africa. It was evident that food insecurity has severe implications for child development and nutrition.

In addition, the literature on cash plus care was probed and discussed. It was discovered that the CSG plays an extremely important role in addressing food insecurity. In addition, cash plus care used collaboratively was found to have a significantly positive impact on child development within an HIV context.

Ultimately, this literature review revealed that there is a paucity of data on the relationship between food insecurity, child care arrangements and the CSG (cash plus care) and the implications for child development.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

Chapter 2 reviewed the existing literature and revealed the current knowledge regarding food insecurity, child care arrangements and the child support grant (CSG). Based on the literature review, the following hypothesis was formulated:

Food insecure households experience child care arrangement instabilities because caregivers spend time away from their children looking for work or spending long hours at work, or physically move away from their children in order to work in faraway cities.

The research question was derived from this review of the literature and is restated as follows:

What role does food insecurity play in child care arrangement instabilities in the context of the child support grant in Langa, Cape Town?

3.1.1 Delimitation of the study area

Most research studies on child care arrangements suggest that parents from low-income households often find it difficult and stressful to manage child care arrangements (Adam, 2004; Byrne & O'Toole, 2015). This study deviated from the assumption that food insecure families are more likely to have child care arrangement instabilities because caregivers spend less time with their children as they have to look for work or engage in income-generation efforts that take them away from home.

The role of social protection interventions, such as the CSG, in disrupting and mediating the link between food insecurity and child care arrangement instabilities is largely unknown. This study was conducted among parents from Langa, Cape Town, who were mostly CSG recipients, with a small number of non-recipients participating in an ongoing longitudinal

cohort study. The intention was to determine and explore the relationship between food insecurity, the CSG and child care arrangements in families in Langa, Cape Town.

This chapter explores the study design used in and the rationale for this study. It also offers a definition of the mixed-method design and discusses the latter in the context of the study. The study's population and sampling framework are introduced and discussed in some detail. Thereafter, the different stages of data collection, both quantitative and qualitative, are discussed. Finally, ethical considerations that were considered are highlighted, while a summary of the chapter is provided as part of the conclusion.

3.2 Research Design and Rationale

Trochim (2006) states that the process of designing a research methodology should be as unique as the problem that is being investigated. He goes on to list the five characteristics that together constitute a good research design: (i) theoretically grounded, reflecting the theories that are being investigated; (ii) situational, revealing the settings of the investigation. (iii) feasible, which means that the design can be implemented and the sequence and timing of events and potential problems have been carefully thought through, (iv) redundant, which allows some flexibility (v) efficient, which strikes a balance between redundancy and the tendency to overdesign (Trochim, 2006).

When selecting a study design, one should therefore take these characteristics into consideration. For the purpose of this study, a mixed-method design was selected as the most suitable.

3.2.1 Study design

According to De Vos et al. (2011), a mixed-method design is based on philosophical assumptions and methods of inquiry that guide the processes of data collection and analysis,

using qualitative and quantitative methods. Cresswell (cited in Cameron, 2009, p. 143) states that "mixed-method research designs use both quantitative and qualitative approaches in a single research project to gather and analyse data". In this study, a mixed-method design was used to address the link between food insecurity and child care arrangements in the context of the child support grant (CSG).

An explanatory, sequential, mixed-method design was employed. This is a design in which quantitative and qualitative data is collected sequentially and analysed separately, with the qualitative data explaining the quantitative results (Cameron, 2009). The overall aim of this study design is to use the qualitative data to help explain or build on the initial quantitative results from the first phase of the study (De Vos et al., 2011). Cresswell and Plano Clark (2011) state that one of the advantages of this design is that it is two-phased, which makes it uncomplicated to implement and report on, as the researcher collects only one type of data at a time.

Tashakkori and Teddlie (1998) mention that the explanatory, sequential, mixed-method design is suitable for studies where the researcher wants qualitative results to explain or build on significant, non-significant or surprising quantitative results. According to Creswell and Plano Clark (2011), this design is also useful if the researcher wants to form groups based on quantitative results and follow up with those groups using qualitative research.

Some of the additional advantages of this design include its strong quantitative orientation, the two-phase structure and the link to emergent approaches where the second phase can be designed on the basis of the outcomes of the first phase (Creswell & Plano Clark, 2011). Figure 3.1 illustrates the flow of the quantitative and qualitative research phases, where the quantitative data is collected and analysed first and then the qualitative date is collected. This is done so that the qualitative data can build on the results emanating from the quantitative data.

Figure 3.2, in turn, shows the researcher's sequence of steps in the data collection and analysis phases.

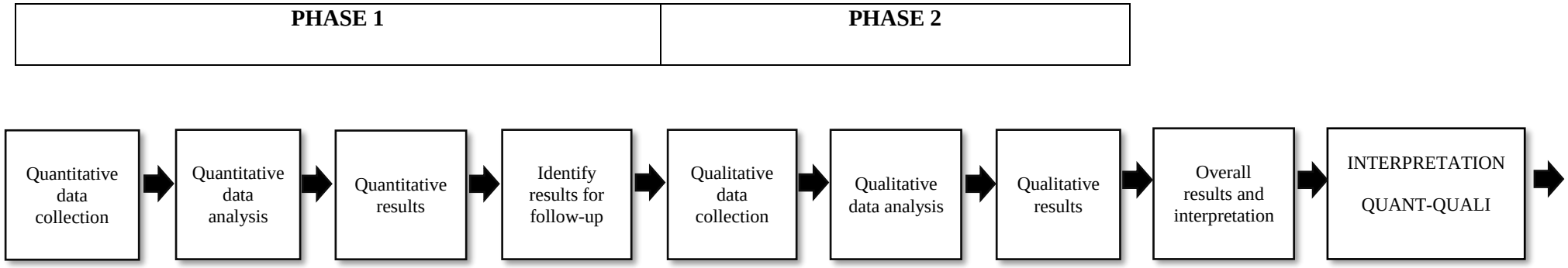

Figure 3.1: Explanatory, sequential, mixed-method model

Source: Creswell and Plano Clark (2011, p. 73)

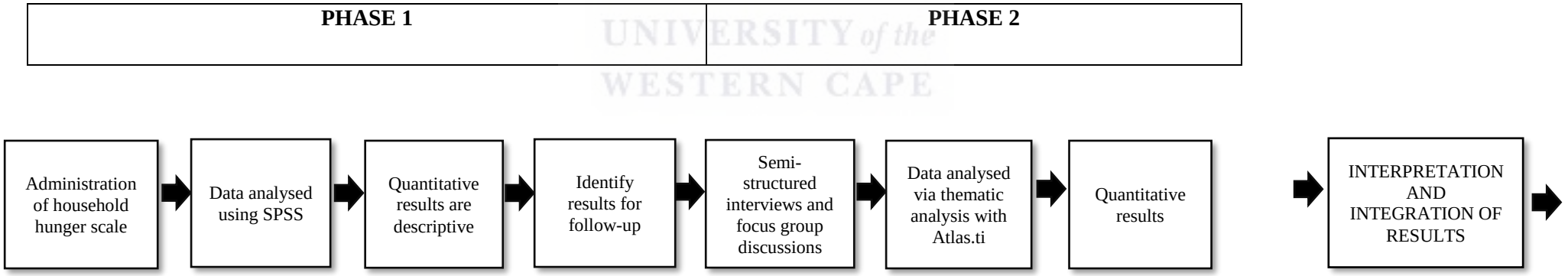

Figure 3.2: Explanatory, sequential, mixed-method model to determine and explore the relationship between food insecurity, the child support grant and child care arrangements in households in Langa, Cape Town

The two phases of the explanatory, sequential, mixed-method design were followed in this manner:

- The first phase entailed the collection and analysis of the quantitative data. The HHS was incorporated into the questionnaires that were used for the cohort study as it is a quantitative tool. The SPSS software was used to analyse and tabulate demographic data and the HHS categorical indicator was used to determine food insecure households. Thereafter, a follow-up was done on the quantitative results in order for the second phase to take place – which was where the quantitative and qualitative data were connected. The sample for the qualitative data collection was purposefully selected from the quantitative results.
- In the second phase, the participants who were found to be food insecure were selected for the qualitative component of the study. A total of 23 semi-structured interviews were conducted among the participants who were purposefully selected. In the first three interviews, the initial questionnaire was administered, and the interviews were transcribed and analysed by the researcher and the co-supervisor. It was found that the topic guides needed to be adjusted in order for the participants to best narrate their experiences. In addition, three focus group discussions were held with 24 members of the community, each group consisting of eight participants. The qualitative data was thematically analysed with the aid of Atlas TI. Thereafter, both the quantitative results and qualitative findings are integrated, and interpreted in the form of a discussion. This is discussed in detail in Chapter 4.

3.2.2 Study rationale

The previous chapter, Chapter 2, reviewed the existing literature on food insecurity, child care arrangements and cash plus care, with the focus on the CSG. However, there is no literature that links these three phenomena. Throughout the literature review it was evident that there is a paucity of data on the relationship between food insecurity, child care arrangements and social protection (the CSG/cash plus care) and the implications for child development. Most of the existing literature highlights the fact that the CSG plays a significant role in addressing food insecurity (Zembe-Mkabile et al., 2015). In addition, cash plus care used collaboratively has been found to have a more positive impact on child development within an HIV context (Cluver et al., 2016).

The realisation that there is a paucity of data regarding the important relationship between food insecurity, child care arrangements and the CSG was the driving force behind this study being conducted. With the gap in the existing literature having been identified, the aim of this study was to determine and explore the relationship between food insecurity, the child support grant and child care arrangements. In essence, this study was conducted with the intention of provoking new thinking, adding to the existing literature, creating a new line of inquiry into how these three phenomena relate to one another and paving the way for future research.

Using the sequential, mixed-method approach provided sufficient freedom to extract and analyse the data and themes that emerged during the data collection phase and also to be alert and responsive to opportunities to gather additional data. The flexibility of this design allowed the researcher to probe for more detailed information and experiences from participants. At the same time, the researcher was fully aware of the sensitivity surrounding the interviews and ensured that the participants who were from a vulnerable group in the community were comfortable and

understood that they could withdraw at any time without losing any benefits to which they were entitled.

3.3 Population and Sample

Wilson and MacLean (2011, p. 161) define a population "as an entire group or entire set of scores that is of interest to you as a researcher". The target population for this study were the participants of an ongoing longitudinal cohort study investigating the impact of the CSG on child nutritional status and food security in Langa, Cape Town. Moreover, the target population for the focus group sessions were selected members of the community, who shared and discussed their views about food insecurity, child care arrangements and the role that the CSG plays.

3.3.1 Sampling

A sample is a smaller subgroup that is drawn from the larger population used in the study. Sampling is a way of gathering and obtaining data on the population without testing every member of the population (Wilson & MacLean, 2011). Sampling plays a significant role in mixed-method research and is linked to the study design (Kemper et al., 2003). Usually the size of a quantitative sample would be larger than that of the smaller qualitative sample (Creswell & Plano Clark, 2011). In sequential mixed-method designs, data collection is not independent but is rather dependent, with one form of data adding to or building on another. In this sequential, explanatory design the qualitative data provides more detail about the quantitative results.

Creswell (2007) emphasises the importance, when a sequential design is applied, of using the same participants in both phases of the study. He goes on to say that even though it is important that the same participants are used, maintaining the same sample size for the qualitative phase is not

compulsory. What is significant is that the qualitative sample is purposively selected from the quantitative sample and is made up of participants who are best able to provide the detail needed to expand on the quantitative results (Creswell & Plano Clark, 2011).

3.3.1.1 Sample size calculation for the primary study

About 500 children under the age of two made up the birth cohort sample. The sample size calculations were done with the assistance of a senior biostatistician from the South African Medical Research Council (Prof. Carl Lombard). The comparison of the primary outcome, height for age (HAZ), between CSG recipients and non-recipients at two years of age was used to calculate the sample size required for the primary study. The following assumptions were made: It was expected that at two years of age, 80% of the established cohort would be CSG recipients. This implied an expected ratio of 4:1 in the size of the groups. At two years, it was expected that the mean HAZ=-.8 for CSG recipients and the mean HAZ=-1.0 for non-recipients. Therefore, the expected difference was 0.2 standardised deviation units. A common standard deviation for both groups of 1.5 units, at 90% power and a significance level of 5% using a 2-sample t-test in the statistical analyses.

Under these assumptions the total sample size required 305, comprising 244 CSG recipients and 61 non-recipients. To make provision for loss to follow up at two years, the sample size was increased to 500.

The population for this study were mothers who were identified and recruited while pregnant (+-seven months) Langa Clinic and Vanguard Community Health Centre. These are the community clinics which provide health care services for the people living in Langa. The mother and child pairs were followed up from six weeks after birth and data was collected at three–six weeks, at six

months, at one year and at two years of age. The sample for this study was selected purposefully. It included all participants followed up for the primary study over a period of three months (March to June 2018) and provided a sample of 120 mother–child pairs. All these participants completed the household hunger scale (HHS). Participants who were deemed food insecure on the basis of the HHS analysis formed the pool from which 23 participants were selected for the qualitative key information interviews. These participants gave an in-depth understanding of their lived experiences.

Participants of the focus group discussions were purposefully selected from community workers and community members. The FGDs comprised of 16 community workers and eight members of the community. The researcher asked for permission from their supervisor to conduct the study and it was granted. The researcher and the fieldworkers approached the community workers and other members of the community, explained what the study is about and asked them to participate in the study. They all agreed to participate in and signed the consent form.

These FGDs were conducted to gain an in-depth understanding of child care arrangements within households and the community as a whole, to explore the phenomenon of child care arrangement instabilities and the reasons for such instabilities, and to understand the role of food insecurity in care arrangements and the impact of the CSG on their households.

3.3.1.2 Inclusion criteria for the primary study

Participants were all residents of Langa township in Cape Town. All participants met the following inclusion criteria:

- They were mothers of children from six weeks to two years of age;

- They were over the age of 18 years and consented to the study;
- They were proficient in spoken and written English and IsiXhosa;
- They were mothers living in households affected by poverty.

The township of Langa, Cape Town was considered to be the most suitable setting for this study as it is considered to be one of the urban poor communities in Cape Town. It is one of the communities that has increased food insecurity due to poverty. This study included all mothers followed up for the primary study in the three-month period spanning March to June 2018.

3.4 Data Collection

In the longitudinal birth cohort study, experienced data collectors were employed to recruit pregnant women from the Langa Clinic and the Vanguard Community Health Centre, as well as collect data at the homes of the participants after the birth of their children. For the purpose of this study, data was collected from mother–child pairs, whose socio-demographics were initially unknown as these details were only identified during the quantitative data collection phase.

The quantitative data was collected for a period of three months during which time the household hunger scale (HHS) was administered to all birth cohort participants active within that period. The period of three months was considered appropriate because it allowed for the HHS to be administered to as many participants as possible – in this case, 120 participants. This also gave the researcher sufficient time to collect and analyse the data and write it up within the prescribed academic year.

The qualitative data was collected in two different ways: firstly, semi-structured individual interviews were conducted and secondly, three focus group sessions were conducted. Of the 120

quantitative participants, only 23 were purposefully selected as they could best provide the detail needed to expand on the quantitative results. Thereafter, three focus group discussions were conducted with 24 randomly selected members of the community. The latter were divided into three groups, with the first two groups comprising community workers and the third group comprising mothers within the community who were not participants of the cohort study. These participants provided insights on food insecurity, the CSG and care arrangements in Langa community. This was done to gain an in-depth understanding of child care arrangements in individual households and the community, to identify the existence of child care arrangement instabilities (and the reasons), and to understand the role of food insecurity in relation to care arrangements and the influence of the CSG in the households.

Data from both the individual interviews and the focus group discussions was obtained using both closed and open-ended questions. The individual interviews were collected in participants' homes and the FGDs were conducted in one the participants' house. This is the house that they usually have their meetings. The participant offered her house as it is safe and the community workers are familiar with the house. Consequently, the community members were also invited to participate in a FGD in the same house.

The quantitative data for this study was collected between March and June 2018 and the follow-up qualitative data was collected between June and November 2018. Participants were contacted via telephone to enquire about their availability. Thereafter, appointments were arranged that were suitable for the participants. Data collection took place at the participants' homes. At the first meeting, the trained data collectors, together with the researcher, outlined the purpose of the study and the procedures involved and also answered any questions. Written informed consent was obtained from all the eligible participants prior to any data being collected. Data was collected in

two phases: quantitative data collection and analysis, followed by qualitative data collection. (Refer to Figures 3.1 and 3.2 for an illustration of the data collection process followed in this study).

3.4.1 Quantitative data collection

In this study, quantitative data was collected from mother–child pairs, with the mothers aged 18 years and older and the children aged six months to two years. The quantitative data was collected over a three-month period during which time the HHS was administered to all birth cohort participants active within that period. The total number of participants to whom the hunger scale was administered was 120. The purpose of the quantitative component was to reveal the demographic characteristics of the respondents and to determine and distinguish households that were food insecure.

According to Ballard et al. (2011, p. 1), "the household hunger scale (HHS) is a new, simple indicator used to measure household hunger in food insecure areas". The HHS has three main questions and sub-questions used for follow-up purposes. The answers to these questions help identify participants who are food secure and those who are food insecure. An illustration of the HHS appears in Appendix 2.

The researcher was trained by the supervisor who is skilled in using the HHS. Thereafter, the researcher provided training on the use of the HHS to the data collectors who had already been trained for the cohort study. Ballard et al. (2011) mention that the HHS questions are worded so as to be as universally relevant as possible. However, in some settings, the questions may need to be translated into another language. "Some phrases included in the HHS may require clarification or 'adaptation' to the local context" (Ballard et al., 2011, p. 7).

During the training the researcher, together with the data collectors, translated the questions into IsiXhosa so as to fit the local context and in case the participants did not understand the questions asked in English. They all reached consensus regarding the wording of the questions and that the questions in IsiXhosa were a true reflection of the initial questions composed in English. This was a useful back-up as not all participants would clearly understand the questions when asked in English.

The researcher, together with the data collectors, administered the hunger scale to participants with a view to determining the households that were food insecure. The HHS was incorporated into the questionnaires that were used for the cohort study as the HHS is a quantitative tool. The tool also helped to capture the demographics of the participants and their children. Collecting the quantitative data took 45 minutes to an hour per participant. Participants were asked if they would be interested in participating in the second phase of the study and if they agreed, arrangements were made to contact them again for that purpose.

3.4.1.1 Data analysis: Quantitative component

The quantitative data was analysed using two types of indicators: a categorical HHS indicator and a median HHS score for the sample of data collected. Both types of indicators can be used for assessment, monitoring and evaluation purposes (Ballard et al., 2011). The HHS score for every responding household was computed after the recoding of the variables. Each household was then classified as experiencing little/no food insecurity, moderate food insecurity and severe food insecurity. Moreover, the Statistical Package for the Social Sciences (SPSS) version 25 was used to formulate tables and graphs to describe and summarise the data collected.

Once the data analysis for the quantitative component of the study had been completed, participants who were found to be food insecure were identified and purposefully selected for the second phase, i.e. the qualitative component of the study. All the participants who had fully completed the HHS and were willing to participate were approached for individual interviews.

3.4.2 Qualitative data collection

De Vos et al. (2011, p. 351) mention that semi-structured interviews are used "to gain a detailed picture of a participant's beliefs about, or perceptions, or accounts of, a particular topic. The method gives the researcher and participant much more flexibility. Participants share more closely in the direction the interview takes and they can introduce an issue the researcher had not thought of". Thus, interviews were conducted with 23 purposefully selected participants from the quantitative component of the study. This was done to gain more insight and understanding from the participants' perspectives (Annexure 2).

The interviews took place at each participant's home on the date and at the time that was suitable for both the researcher and the participant. The data collectors were not involved in this part of the study. The purpose of the study was again explained to the participant and they were also given an information sheet regarding the study. Interviews were recorded using a digital recorder and the audio files were saved and then later transcribed in a verbatim format. These interviews took about 30 to 45 minutes each.

Thereafter, three focus group discussions were conducted with 24 randomly selected members of the community, who gave their insights on food insecurity, the CSG and care arrangements in the community of Langa. According to De Vos et al. (2011, p. 360) focus groups "are a means of better understanding how people feel or think about an issue, product or service. Participants are

selected because they have certain characteristics in common that relate to the topic of the focus group".

There were three focus group discussions in total, with eight participants in each group. Two of these groups comprised community workers and one group comprised mothers in the community who were not participants in the cohort study. Data from both the individual semi-structured interviews and the FGDs was collected in order to arrive at an in-depth understanding of the association between food insecurity and child care arrangements. The interviews and FGDs involved both closed and open-ended questions.

3.4.2.1 Data analysis: Qualitative component

Semi-structured topic guides were developed and piloted for the in-depth individual interviews. The development of the guides conformed to the standard set in the literature. Interviews (generating verbal and non-verbal data) were transcribed into a written format in order for the researcher to familiarise herself with the data. A total of 23 semi-structured interviews were conducted with the participants.

In the first three interviews, the initial questionnaire with topic guides was administered, and the interviews were transcribed and analysed by the researcher and the co-supervisor. Based on the feedback provided by the co-supervisor, it was found that the topic guides needed to be adjusted and the interviewing style had to be changed in order to extract more in-depth information from the participants and for the participants to best narrate their experiences. Thereafter, the adjusted questionnaire was administered to 20 participants, with different styles of interviewing being used to obtain the information needed.

Subsequently, data was coded on the basis of what was found to be key information and of particular interest. Coding was done with the aid of the Atlas ti software (Appendix 3). These codes indicated patterns or themes. The codes were then sorted into potential themes using thematic maps, mind maps and tables. The identified themes were reviewed to check if they formed a coherent pattern. Finally, the themes were refined and defined by identifying the essence of each theme and what data it captured. This was done in order to identify the story that each theme told and how it fitted into the broader context of the study.

3.4.3 Trustworthiness of the study

The researcher used bracketing, which is writing down preconceived ideas and beliefs before embarking on the study. This was done for the purpose of going back and reflecting, and in order to avoid bias. Peer reviews were also conducted to ensure the trustworthiness of the study. This is where the researcher worked with the fieldworkers to verify that the HHS data was analysed correctly. The fieldworkers helped in double-checking the scores, codes and HHS indicators given by the participants. Gunawan (2015) indicates that peer reviews are used as a way of ensuring the trustworthiness of a study and that the researcher has analysed the data correctly. Overall, the trustworthiness of this study was ensured through bracketing, detailed transcription, systematic planning, coding and peer reviews.

3.5 Ethical Considerations

The primary study, the CSG longitudinal birth cohort study, had already received ethical approval from the South African Medical Research Council (SAMRC). In addition, the hunger scale was submitted to the SAMRC and approval was obtained. The research proposal was registered with the Senate Higher Degrees Committee and received ethical approval from the Humanities and

Social Sciences Research Ethics Committee (HSSREC) of the University of the Western Cape (reference HS18/4/20). The following measures were introduced to ensure that the study was conducted in an ethically correct manner.

3.5.1 Informed consent

All participants in this study gave their written consent before participating. Adequate information about the study was provided to participants prior to their giving consent in their own language. (Refer to information sheet and consent form in Annexures 3 and 5). All participants were informed about the purpose of the study, the procedures involved, the risk and benefits associated with the study, and their rights as participants. It was made clear to all participants that taking part in this study was voluntary. They were also informed that they had the right to refuse to take part and that if they decided to be in the study and then changed their mind at any point, they were entitled to stop participating. It was made clear to each participant that their decision would not affect the services they received from any institutions in the area, including social services.

3.5.2 Risk to informants

There were no known risks to participating in this study as it was non-invasive and concerned a well-known topic. However, it was recognised that questions could be asked about issues that might be perceived as sensitive by some research participants and that some questions might evoke sadness or painful recollections. During the initial consent phase, participants were informed that they would be asked various things about their lives, including topics that they might not be comfortable talking about or that they found painful or sad to think about.

The researcher tried to minimise the participants' discomfort by informing them that they did not have to answer questions that they were not comfortable with, and that they were entitled to stop the interview if they found it too difficult to continue. The participants were briefly told that should they become triggered during or after the interviews they can contact the researcher on the number provided on the information sheet and they will be referred to a local social worker. Data was collected in a safe, private place where no other people but the researcher and/or the data collector and participant were present. Furthermore, no personal names were recorded; instead, the participants were anonymised through the use of unique participant numbers.

3.5.3 Protection of confidentiality

Confidentiality was maintained at all times. The protection of participants' information was ensured by assigning a unique identifier code to each participant. The identifying codes were first assigned during the quantitative data collection phase, and those participants who continued to the second phase kept their codes. Focus group participants were also given unique identifying codes to protect their confidentiality. They signed a confidentiality form to the effect that they would not disclose any information shared during the discussions with other people outside the groups.

3.5.4 Benefits and costs of participation

It was made clear to participants that there was no direct benefit or cost of participation in the study. Researchers travelled to the participants' homes. However, all the participants were reimbursed for their time. The amount of the reimbursement, as implemented in the primary study, was R100 per person. For the quantitative component the stipend was covered by the cohort study and for the qualitative component the researcher used money that she had received from the Department of Science and Technology (DST) / National Research Foundation (NRF) scholarship.

The community workers' supervisor was made aware of the reimbursement that the community workers would receive for participating in the study.

3.6 Chapter Summary

In this chapter, the delimitation of the study that stemmed from the literature review was outlined with a view to highlighting the assumption that the researcher had departed from. The study design, which was the explanatory, sequential, mixed-method design, was discussed in detail, with emphasis given to the two phases that the design entailed. Furthermore, the study rationale was briefly explained, with the paucity of data on the relationship between food insecurity, child care arrangements and the CSG being the driving force behind the study. Thereafter, the population and study sample were extensively discussed, and the sampling of the primary cohort study was also highlighted.

The data collection process in this study was extensively discussed. The data collection process was divided into two phases: Phase 1 entailed the quantitative data collection process, the quantitative tool (the household hunger scale/HHS) and the data analysis process. Phase 2 entailed the qualitative data collection process, which was two-fold (comprising individual semi-structured interviews and focus group discussions) and the data analysis process. The measures taken to ensure the trustworthiness of the study were then briefly highlighted. Finally, the ethical considerations in the study were explained.

This study will contribute to the existing body of knowledge on child care, food insecurity and the child support grant in South Africa. The potential knowledge 'nuggets' coming out of this project include an improved understanding of the impact of food insecurity on child care arrangements and the role of the CSG in reducing child care arrangement instabilities in low-income households.

The next chapter will present and discuss the results of this study and highlight significant patterns and trends.

CHAPTER 4: PRESENTANTION OF QUANTITATIVE AND QUALITATIVE RESULTS AND FINDINGS

4.1 Introduction

Chapter 3 focused on the methodology that was employed in this study. It also explained the quantitative and qualitative data collection processes. The study rationale and data collection tools that were utilised were highlighted and the process of data analysis was briefly outlined. This chapter focuses on the quantitative and qualitative data, how it was collected and analysed. It also presents and comprehensively discusses the results and findings.

4.2 Quantitative Data Analysis and Results

An explanatory, sequential, mixed-method design was employed in this study, whereby the researcher solicited qualitative data to explain or build on significant, non-significant or unanticipated quantitative results. According to Creswell and Plano Clark (2011), this design is also useful if the researcher wants to form groups based on quantitative results and follow up with those groups for the purpose of qualitative research.

4.2.1 Demographic data

The quantitative component of the study was conducted over a period of three months, with the quantitative questionnaire being administered to 120 participants of the child support grant (CSG) cohort. The purpose of the quantitative component was to reveal the demographic characteristics of the respondents and to determine and distinguish households that were food insecure. The HHS was incorporated into the questionnaires that were used for the cohort study as it is a quantitative

tool. The data collected in this phase was then analysed and sorted using SPSS. Table 4.1 provides the list of mother–child participant pairs and appears in Appendix 1.

The minimum age for the mothers was recorded as 18 years and the maximum age was 43 years. The youngest child in the study sample was six months old and the oldest was 24 months old (Table 4.1, Appendix 1). The mean and median for both mother and child ages were close together. Thus, both ages were normally distributed: median = 28 and mean = 28.28 for the mothers, and median = 12 and mean = 11.38 for the children (Table 4.2).

Table 4.2: Age of the study sample

	n	Minimum	Maximum	Median	Mean	Std deviation
Mother's age (in years)	120	18	43	28	28.28	5.59
Child's age (in months)	120	6	24	12	11.38	5.08

Source: Survey data

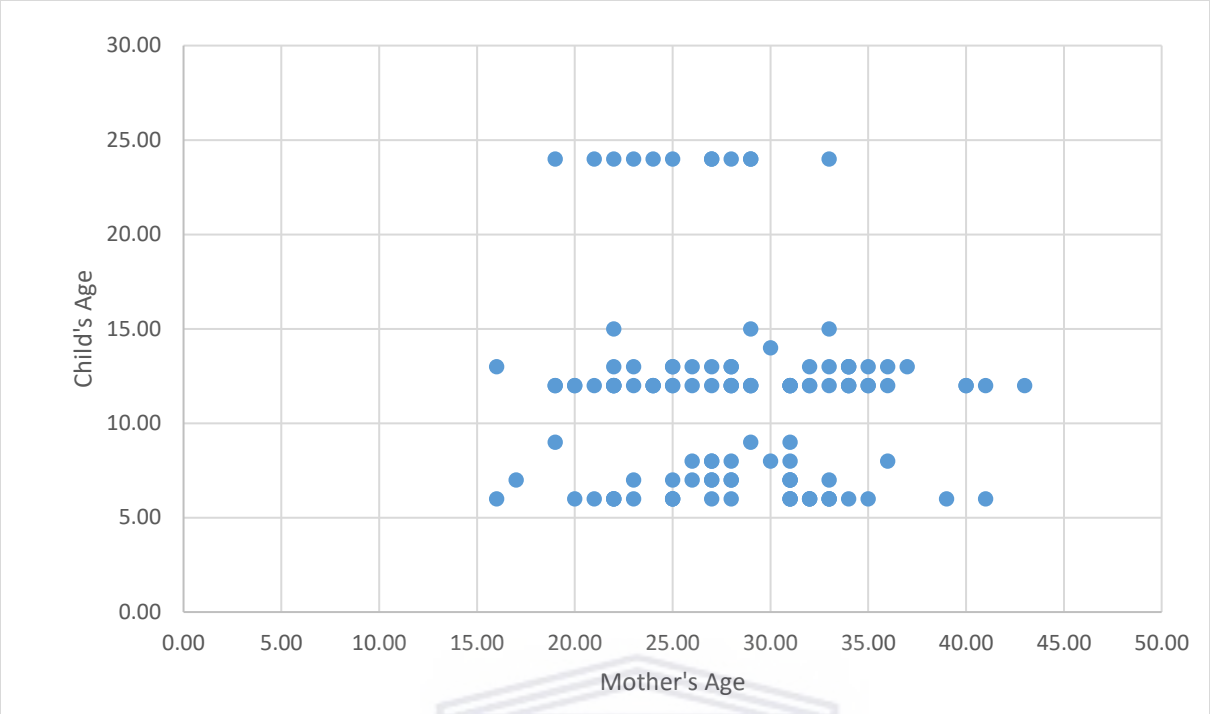

Figure 4.1: Mother's age x child's age

Source: Survey data

The mother and child pairs' ages were broken down into categories. Tables 4.3 and 4.4 below show the mothers' and children's ages broken down into three categories, respectively. Most of the mothers (29.17%) were in the age category 30–34 years, with only 14% of the mothers older than 35 years.

Table 4.3: Mother's age categories

Mother's age (in years)	**n**	**Percentage (%)**
18–24	32	26.67
25–29	39	32.50

30–34	35	29.17
>35	14	11.67
Total	120	100.00

Source: Survey data

The majority (50.83%) of the children fell into the age category 13–18 months (Table 4.4) followed by the age category 6–12 months (39.16%), with only a small proportion (10%) of the children falling into the age category 19–24 months.

Table 4.4: Child's age categories

Child's age (in months)	**n**	**Percentage (%)**
6–12	47	39.16
13–18	61	50.83
19–24	12	10.00

Total	120	100.00

Source: Survey data

Participating mothers had between one and six children (Table 4.5). The majority of the 46 mothers (38.33%) had only one child, while one mother (0.83%) had six children.

Table 4.5: Number of children per mother

Number of children per mother	**n**	**Percentage (%)**
1	46	38.33
2	36	30.00
3	24	20.00
4	11	9.17
5	2	1.67
6	1	0.83
Total	120	100.00

Source: Survey data

The largest number of people living in the household of participating mother–child pairs was 12 (Table 4.6), representing 2.5% of the population. The lowest smallest number of people in the household was two, also representing 2.5% of the population.

Table 4.6: Number of people living in the household

Number of people living in the household	n	Percentage (%)
2	3	2.50
3	19	15.83
4	26	21.66
5	32	26.66
6	14	11.66
7	8	6.66
8	7	5.83
9	6	5.00
10	2	1.66
12	3	2.50
Total	120	100.00

Source: Survey data

The majority (56.66%) of the mothers in the study indicated that they were single, 37% were married and 12.5% were co-habiting (Table 4.7).

Table 4.7: Marital status

Marital status	n	Percentage (%)

Married	37	30.83
Co-habiting	15	12.50
Single	68	56.66
Total	120	100.00

Source: Survey data

Table 4.8 below provides a breakdown of the highest level of education that the participating mothers had obtained. Thirty-six percent (36.66%) of the population had completed high school, with another 52% having done some high school but not completed matric. A further 2.5% of the participants had obtained a higher certificate and 5% had obtained a diploma or degree.

Table 4.8: Highest level of education

Highest level of education	n	Percentage (%)
Grade 6	1	0.83
Grade 7	3	2.50
Grade 8	4	3.33
Grade 9	7	5.83
Grade 10	24	20.00
Grade 11	28	23.33
Grade 12	44	36.66
Higher certificate	3	2.50
Diploma/degree	6	5.00
Total	120	100

Source: Survey data

Table 4.9 lists the questions that were asked about the participants' income and the means by which they earned it. The questions were allocated to four categories and the results revealed that 31.67% of the participating mothers earned money for themselves, 49.16% did not earn money and 19.16% did not disclose, when asked, if they earned money for themselves. Three additional questions were asked in order to determine the means by which the participants received their income. Some 9.17% of participants earned money through irregular employment, 17.5% earned money through regular employment and 1.67% earned money through home employment.

Table 4.9: Employment status

Employment status question	Yes		No		Undisclosed	
	n	%	n	%	n	%
Do you earn money for yourself?	38	31.67	59	49.16	23	19.16
Do you earn money through irregular employment?	11	9.17	109	90.83	0	
Do you earn money through regular employment?	21	17.5	99	82.50	0	
Do you earn money through home employment?	2	1.67	118	98.33	0	

Source: Survey data

In addition to the socio-demographic data, the results also revealed the socio-economic status of the participants regarding their housing and basic household utilities. Seventy percent (70%) of the participants owned the houses (formal and informal) that they lived in, 14.17% paid rent and 15.83% lived with their parents, relatives and other family members (Table 4.10).

Table 4.10: Household socio-economic status

Question	n	Percentage (%)
Do you own the house that you live in?	84	70.00
Do you pay rent for the house that you live in?	17	14.17
Other (living with parents, relatives and other family members)	19	15.83

Source: Survey data

The entire population (100%) revealed that they had electricity in their households, 55% of participants had access to tap water in the house and 45% had access to water from public taps. In addition, 75.83% of participants used a flushing toilet and 24.17% used a bucket toilet (Table 4.11).

Table 4.11: Household socio-economic status (household basic utilities)

Question	N	Percentage (%)
Do you have access to electricity?	120	100.00
Do you have access to water (tap water in the house)?	66	55.00
Do you have access to water (public tap)?	54	45.00
Do you use a flushing toilet?	91	75.83
Do you have to use a bucket toilet?	29	24.17

Source: Survey data

The research was conducted in an impoverished community where poverty was rife and people were hunger stricken. It was imperative that the households' overall socio-economic status was determined. However, that alone could not reveal the hunger experienced by each household, which in turn would indicate the level of food insecurity. The administration of the HHS was therefore necessary to distinguish the food insecure households from those that were food secure.

4.2.2 Household hunger and food insecurity

According to Ballard et al. (2011, p. 1), "the household hunger scale (HHS) is a new, simple indicator used to measure household hunger in food insecure areas". The HHS has three main questions which have sub-questions used for follow-up purposes. Acquiring answers to these questions helped to distinguish participants who were food secure and those who were food insecure. An illustration of the HHS is presented in Figure 4.2.

No.	Question	Response Option	Code
Q1	In the past [4 weeks/30 days], was there ever no food to eat of any kind in your house because of lack of resources to get food?	0 = No (Skip to Q2) 1 = Yes	|___|
Q1a	How often did this happen in the past [4 weeks/30 days]?	1 = Rarely (1–2 times) 2 = Sometimes (3–10 times) 3 = Often (more than 10 times)	|___|
Q2	In the past [4 weeks/30 days], did you or any household member go to sleep at night hungry because there was not enough food?	0 = No (Skip to Q3) 1 = Yes	|___|
Q2a	How often did this happen in the past [4 weeks/30 days]?	1 = Rarely (1–2 times) 2 = Sometimes (3–10 times) 3 = Often (more than10 times)	|___|
Q3	In the past [4 weeks/30 days], did you or any household member go a whole day and night without eating anything at all because there was not enough food?	0 = No (Skip to the next section) 1 = Yes	|___|
Q3a	How often did this happen in the past [4 weeks/30 days]?	1 = Rarely (1–2 times) 2 = Sometimes (3–10 times) 3 = Often (more than 10 times)	|___|

Figure 4.2: Household hunger scale (HHS)

Source: Ballard, Coates, Swindale and Deitchler (2011, p. 6)

Ballard et al. (2011) mention that the:

> … data collected with the HHS can be analysed to construct two types of indicators: a categorical HHS indicator and a median. To tabulate both indicators, it is first necessary to compute an HHS score for every responding household. This requires some recoding of the data collected (Ballard et al., 2011, p. 12).

After the data was collected from each participant, it was computed and recoded accordingly. Three steps were followed in analysing the data.

In the first step, the participants' responses to each frequency-of-occurrence question were recoded from three frequency categories ("rarely," "sometimes," "often") into two frequency categories, i.e. a frequency response of "rarely" (originally coded as "1") was coded as "1"; a frequency response of "sometimes" (originally coded as "2") was coded as "1"; and a frequency response of "often" (originally coded as "3") was coded as "2". The new variables were created and named NewQ1, NewQ2 and NewQ3. However, the original data was kept so as to not overwrite it.

In the second step, the researcher assigned the code "0" for participants who replied "No" to each corresponding occurrence question. After completing this step, all participants/households had a value of 0, 1 or 2 for each of the three new variables created, namely NewQ1, NewQ2 and NewQ3. Table 4.12 below lists the amended household hunger questions and the responses thereto.

The majority of the sample reported little to no hunger in the households (Table 4.12), while 28.33% reported that in the past month there had been instances when there was no food in the

household due to the lack of resources to get food. A further 22.5% reported having gone to sleep at night hungry because there was not enough food and 17.5% reported that someone in the household had gone the whole day and night without eating anything because there was not enough food.

Table 4.12: Household hunger scale (HHS) results

Amended household hunger questions	**Yes**		**No**	
	n	**%**	**n**	**%**
In the past month, was there ever no food to eat in your house because of a lack of resources to get food?	35	28.33	86	71.67
In the past month, did you or anyone in the household sleep at night hungry because there wasn't enough food?	27	22.50	93	77.50
In the past month, did you or anyone in the household go a whole day and night without eating anything at all because there wasn't enough food?	21	17.50	99	82.50

Source: Survey data

In the third step, the new variables were summed for each household/participant in order to calculate the HHS score. Ballard et al. (2011) mention that the correct tabulation should reflect the HHS score of 0 to 6. Figure 4.3 below illustrates how the data was recoded and tabulated in terms of categorical indicators.

Household Hunger Score	Household Hunger Categories
0–1	Little to no hunger in the household
2–3	Moderate hunger in the household
4–6	Severe hunger in the household

Figure 4.3: HHS categorical indicators

Source: Ballard, Coates, Swindale and Deitchler (2011, p. 13)

The HHS was administered to 120 participants, and 23 participants (19.2%) were found to be food insecure and 97 participants (80.8%) were found to be food secure. The standard deviation for this sample was 0.39526 and the standard error was 0.03608 (Table 4.13).

Table 4.13: Food insecurity status

			Mean	Std deviation	Std error
Food insecurity	**1 (Yes)**	**%**	1.8083	0.39526	0.03608
	23	19.2			
	2 (No)	**%**			
	97	80.8			
Total	120	100.0	1.8083	0.39526	0.03608

Source: Survey data

Ballard et al. (2011, p. 13) recommend that a score of 0–1 indicates households where there is little to no hunger; a score of 2–3 indicates households with moderate hunger; and a score of 4–6

indicates households with severe hunger. The food insecure participants had scores of 2–6. Of the food insecure, 5.83% (n=7) experienced severe hunger (Table 4.14).

Table 4.14: Experience of hunger

Household hunger score	n	%
0–1 Little to no hunger	97	80.83
2–3 Moderate hunger	16	13.33
4–6 Severe hunger	7	5.83
Total	120	100.00

Source: Survey data

The 23 participants who were identified as food insecure were invited to participate in the qualitative component of the study. As mentioned in Chapter 2, food insecurity can be the result of different factors. Therefore, the quantitative data was further explored to describe the socio-demographic characteristics of the participants with food insecurity.

4.2.3 Socio-demographic examination of the food insecure

Food insecurity and the extent thereof differ from household to household. As revealed in the reported results, all 23 households that were found to be food insecure experienced hunger differently. Most experienced moderate hunger while others experienced severe hunger. Altman et.al (2009) assert that the status of food insecurity in households is sensitive to livelihood stressors and can change over time. There are various livelihood stressors that can affect the status of food insecurity in different households, including the number of people living in the household, the number of children, the level of education and the source of income and food.

4.2.3.1 Number of people in the household and food insecurity

In their report, Statistics South Africa (2017) states that inadequate food access is mostly found in households that have a large number of people living in them. The report also highlights that "29.6% of households that comprised more than three children reported that food access was inadequate. This proportion is almost twice the national average" (Stats SA, 2017, p. 22).

Table 4.15 provides a cross-tabulation between the number of people living in the household and their HHS indicator. The lowest number of people living in the household was two and the highest number was 13. Both the food insecure and food secure families had one household with two people living in it and one food insecure family had 13 people living in it.

Table 4.15: Number of people in the household x food insecurity cross-tabulation

		Number of people in the household											Total
		2	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**12**	**13**	
Food insecurity	**Yes**	1	4	3	4	7	1	1	0	0	1	1	23
	No	1	16	22	29	8	7	5	6	2	1	0	97
Total		2	20	25	33	15	8	6	6	2	2	1	120

Source: Survey data

Table 4.16 shows the results of a chi-square test which indicates that there are 16 cells (72.7%) that have an expected count of less than 5. The minimum expected count is .19 and the likelihood ratio is 15.286.

Table 4.16: Chi-square tests for number of people in the household and food insecurity

	Value	df	Asymptotic significance (2-sided)
Pearson chi-square	12.069	10	0.280
Likelihood ratio	15.286	10	0.122
Linear-by-linear association	1.920	1	0.166
N of valid cases	120		

Source: Survey data

4.2.3.2 Number of children and food insecurity

The results showed that the highest number (n=13) of people living in food insecure households experienced moderate hunger and the lowest number (n=2) of people living in the household also experienced moderate hunger. The most common number (n=6) of people living in the household experienced both moderate and severe hunger (Table 4.17).

Table 4.17: Number of people in the household x HHS indicator cross-tabulation

		Number of people in the household									Total
		2	**3**	**4**	**5**	**6**	**7**	**8**	**12**	**13**	
HHS indicator	**2**	1	1	0	1	3	0	0	1	1	9
	3	0	1	2	2	1	1	1	0	0	8
	4	0	1	1	1	2	0	0	0	0	5
	6	0	1	0	0	1	0	0	0	0	2
Total		1	4	3	4	7	1	1	1	1	23

Source: Survey data

The minimum number of children in this sample was one and the maximum was six. There were eight food insecure households and 43 food secure households that had one child. Of the 120 participants, only one household had the most (n=6) number of children and that household reported being food secure (Table 4.18).

Table 4.18: Food insecurity x number of children cross-tabulation

		Number of children						Total
		1	**2**	**3**	**4**	**5**	**6**	
Food insecurity	**Yes**	8	8	4	3	0	0	23
	No	43	23	20	8	2	1	97
Total		51	31	24	11	2	1	120

Source: Survey data

The chi-square tests indicate that six cells (50.0%) have an expected count of less than 5. The minimum expected count is .19 and the likelihood ratio is 3 (Table 4.19).

Table 4.19: Chi-square tests for food insecurity and the number of children

	Value	df	Asymptotic significance (2-sided)
Pearson chi-square	2.556	5	0.768
Likelihood ratio	3.038	5	0.694
Linear-by-linear association	0.045	1	0.831
N of valid cases	120		

Source: Survey data

4.2.3.3 Level of education and food insecurity

The level of education refers to the highest grade passed. Grade 13 refers to a higher certificate and Grade 14 is a diploma or degree. The highest level of education obtained by the food insecure sample was a higher certificate and this was obtained by one participant only. On the other hand, the highest level of education obtained by the food secure group was a diploma or degree and this was obtained by two participants. The majority (n=8) of the food insecure participants had passed Grade 10 as their highest level of education and the majority (n=37) of the food secure group had passed Grade 12 as their highest level of education (Table 4.20).

Table 4.20: Food insecurity x highest level of education cross-tabulation

		Highest level of education									Total
		6	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	
Food insecurity	**Yes**	0	0	0	1	8	6	7	1	0	23
	No	1	2	2	6	15	27	37	4	2	97
Total		1	2	3	7	23	33	44	5	2	120

Source: Survey data

Table 4.21 illustrates that 12 cells (66.7%) have an expected count of less than 5. The minimum expected count is .19 and the likelihood ratio is 8.877.

Table 4.21: Chi-square tests for food insecurity and level of education

	Value	**df**	**Asymptotic significance (2-sided)**
Pearson chi-square	7.178	8	0.518
Likelihood ratio	8.877	8	0.353
N of valid cases	120		

Source: Survey data

4.2.3.4 Employment status and food insecurity

This study found that unemployment played a role in the participants' households. The results from the study showed that a large number (n=59) of participants were unemployed (Table 4.23).

The results further indicate that the majority (n=33) of the employed participants were food secure and the least number (n=5) of people who were employed reported that they were food insecure. Furthermore, 23 participants – both from food secure and food insecure households – did not disclose their employment status (Table 4.22).

Table 4.22: Food insecurity x employment status cross-tabulation

		Employed			Total
		Yes	**No**	**Undisclosed**	
Food insecurity	**Yes**	5	10	8	23
	No	33	49	15	97
Total		38	59	23	120

Source: Survey data

In Table 4.23, the chi-square tests indicate that one cell (16.7%) has an expected count of less than 5. The minimum expected count is 4.41 and the likelihood ratio is 4.259.

Table 4.23: Chi-square tests for food insecurity and employment status

	Value	df	Asymptotic significance (2-sided)
Pearson chi-square	4.693	2	0.096
Likelihood ratio	4.259	2	0.119
Linear-by-linear association	3.737	1	0.053
N of valid cases	120		

Source: Survey data

4.2.4 Examination of the food insecure households

After the identification of the food insecure, a qualitative questionnaire was administered with questions aimed at shedding light on the role of the CSG in food insecure households, the number of meals per day and the effects of unemployment on these food insecure households (Table 4.24).

Table 4.24: Food insecurity, the CSG and meals consumed per day

ID	CSG recipient	Meals per day	HHS indicator
CSG 001	Yes	2	3
CSG 016	No	1	3
CSG 337	Yes	2	2
CSG 343	No	1	6
CSG 406	Yes	2	3
CSG 440	Yes	1	2
CSG 517	Yes	2	3
CSG 544	Yes	2	2
CSG 554	Yes	2	2
CSG 577	Yes	1	4
CSG 600	Yes	1	2
CSG 614	Yes	1	3
CSG 629	Yes	2	3
CSG 647	Yes	2	3
CSG 296	Yes	2	4
CSG 217	Yes	2	6

CSG 231	Yes	1	2
CSG 318	Yes	2	3
CSG 475	Yes	1	2
CSG 333	Yes	2	2
CSG 215	Yes	2	2
CSG 363	Yes	1	3
CSG 653	Yes	2	4

Source: Survey data

4.2.4.1 The child support grant and the number of meals per day

Only two (8.7%) of the food insecure did not receive the CSG, while 21 (91.3%) received the CSG (Table 4.25).

Table 4.25: Receipt of the CSG

CSG receipt	**n**	**%**
Yes	21	91.3
No	2	8.7
Total	23	100

Source: Survey data

Both households that did not receive the CSG reported that they consumed only one meal per day. Consuming one meal per day was also reported by seven food insecure households who received the CSG. No food insecure households reported consuming three meals per day (Table 4.26)

Table 4.26: Number of meals consumed per day

Number of meals	n	%
1	9	39.1
2	14	60.9
Total	23	100.0

Source: Survey data

The participant with code CSG 016, who did not receive the CSG, had only one meal per day and had an HHS score of 3 (moderate hunger). Moreover, the participant with code CSG 343, who also did not receive the CSG, had only one meal per day and had an HHS score of 6 (severe hunger). However, this does not necessarily mean that households that did not receive the CSG experienced more severe hunger than those that received the grant.

Overall, the above results indicate the depth of food insecurity in different households. Although some households were identified as experiencing moderate hunger on the HHS, they ate only one meal per day, while other participants who were identified as experiencing severe hunger on the HHS, ate two meals per day.

4.2.4.2 Unemployment and food insecurity

The results showed that 82.6% (n=19) of participants were unemployed and 17.4% (n=4) participants were employed (Table 4.27).

Table 4.27: Employment status of the sample

Are you employed?	**n**	**%**
Yes	4	17.4
No	19	82.6
Total	23	100.0

Source: Survey data

Table 4.28 below illustrates the cross-tabulation between the employment status of the sample and the number of meals participants consumed per day. The majority (n=10) of the people who consumed two meals per day were unemployed, while the least number (n=4) of people who consumed two meals per day were employed.

Table 4.28: Employment status x meals per day cross-tabulation

		Meals per day		**Total**
		1	**2**	
Are you employed?	**No**	9	10	19
	Yes	0	4	4
Total		9	14	23

Source: Survey data

According to Blaauw and Bothma (2010), households experiencing poverty are often characterised by uncertain and dramatically fluctuating levels of income, which obliges them to devote all of their resources to merely surviving and maintaining equilibrium. Similarly, Collins, Morduch, Rutherford and Ruthven (2009) explain that members of poor households often skip meals and the quality of the food that they consume varies considerably. Although the quantitative data revealed the existence of food insecurity, it did not provide in-depth insights or an underlying meaning, and did not probe the experiences of the households that were food insecure. Hence, data was also collected qualitatively in order to explore the extent to which food insecurity impacted the participants' lives and the relationship between food insecurity, the CSG and child care arrangements.

The descriptive data that the quantitative analysis generated was amplified with quotes from the verbal responses provided by the participants to the open-ended questions in the questionnaire. Relevant literature that was reviewed has also been incorporated into the discussion of the qualitative findings. In the next section, the experiences of the participants in food insecure households are thoroughly explored.

4.3 Qualitative Data Analysis and Findings

The previous chapter, Chapter 3, described in detail the qualitative and quantitative methods chosen and used to design the study, to collect and analyse data, and to extract meaning from the results and findings. In this section, the findings from the qualitative component of the study are discussed.

To reiterate, the qualitative phase of the study was conducted in order to probe the experiences of the participants who were food insecure. It was also conducted with a view to arriving at an in-

depth understanding of what food insecurity meant to the participants and how it affected them. All of this was done for the purpose of establishing and exploring the relationship between food insecurity, child care arrangements and the child support grant, using the responses of participants in relation to the three exploratory objectives of the study, as highlighted in Chapter 1:

- To explore the extent of food insecurity among CSG recipients and non-recipients in Langa, Cape Town;
- To explore the extent to which food insecurity contributes to child care arrangement instabilities;
- To explore the relationship between child care arrangement instability and food insecurity in CSG recipients and non-recipients.

4.3.1 Socio-demographics of the qualitative sample

This section focuses on the socio-demographic data on the 23 participants who were identified as food insecure. Although the questionnaire administered in the qualitative phase of the study contained questions whose answers required qualitative analysis, some of the questions were aimed at identifying the demographic characteristics, such as age and level of education, of the food insecure participants.

Table 4.29 below sets out the ages of the mother–child pairs who were identified as food insecure. The youngest mother was 23 years old and the oldest was 38 years old. In addition, the youngest child was eight months old and the oldest was 24 months old.

Table 4.29: Mother and child ages

Mother's age (in years)	Child's age (in months)
29	18
28	11
27	12
31	11
25	22
29	13
35	19
24	13
30	11
36	11
24	11
28	13
33	24
38	11
27	13
25	9
27	14
29	18
30	8

23	10
27	12
36	13
38	8

Source: Survey data

Table 4.30 illustrates the mother's ages broken down into categories. In this sample, most mothers were in the age category 23–27 years and the least number of mothers were 33 years and older.

Table 4.30: Mother's age categories

Mother's age (in years)	**n**	**Percentage (%)**
23–27	9	39.13
28–32	8	34.78
33+	6	26.00
Total	23	100.00

Source: Survey data

Table 4.31, in turn, illustrates the age categories of the children, recorded in months. The majority of the children, were in the age category eight to 12 months and the minority of the children were 19 months and older.

Table 4.31: Child's age categories

Child's age (in months)	n	Percentage (%)
8–12	12	52.17
13–18	7	30.43
19+	4	17.39
Total	23	100.00

Source: Survey data

The highest level of education was a higher certificate, which had been obtained by one person in the sample. The lowest grade passed was Grade 9, which pertained to one person in the sample (Table 4.32).

Table 4.32: Highest level of education achieved

Highest level of education	n	Percentage (%)
Grade 9	1	4.34
Grade 10	8	34.79
Grade 11	6	26.09
Grade 12	7	30.43
Higher certificate	1	4.34
Total	23	100.00

Source: Survey data

The socio-demographic data was obtained through the qualitative questionnaire. The questionnaire had additional questions that enabled the participants to share more details of their experiences and also give meaning to the quantitative data presented above. The qualitative data was analysed and during the analytical process, themes that were generated by the interviews were identified, arranged and summarised. These appear in Table 4.33. Findings from this study will be first presented under a theme, followed and substantiated by a quote from either an individual interview or FGD.

Table 4.33: Themes and sub-themes

Themes	**Sub-themes**
1. Existing child care arrangements of food insecure families	1.1: *Child care* • Primary caregivers • Grandparents as caregivers • Parenting/parent behaviours 1.2: *Care arrangements* • Alternative care arrangements • The role of money and access to food in child care arrangements
2. Experience of hunger in food insecure households	2.1: *Food accessibility* • Sources of food

	2.2: *Food insecurity* • The impact of food insecurity on child care arrangements
3. Household income	3.1: *Child support grant* • The role of the CSG in child care arrangements • The role of the CSG in food insecurity 3.2: *Alternative sources of income* • Other social grants (old age, foster care and disability grants)

Source: Survey data

4.3.2 Theme 1: Existing child care arrangements of food insecure families

Qualitative data was collected with objectives of exploring the extent of food insecurity experienced by food insecure participants. To explore the extent to which food insecurity contributes to child care arrangements and to explore the relationship between child care arrangement instability and food insecurity in CSG recipients and non-recipients.

This study revealed that child care arrangements in food insecure households are not straightforward; they do not allow for a simple binary analysis of "yes, there are care arrangement instabilities" or "no, there are no care arrangement instabilities". While in many of the households interviewed children lived with their biological parents (often mothers), the extended family played a big role in child rearing, with mothers often sending their children to live with

grandmothers, sisters and other relatives for short periods of time. These findings have been broken down into themes and sub-themes and are discussed in the next section.

4.3.2.1 Sub-theme 1.1: Child care

The researcher found that in most food insecure households, children were taken care of by their parents as primary caregivers, while the extended family often assisted in taking care of the children, especially grandparents. Participants were asked who the primary caregiver of the child was and some of the interviewees replied as follows:

It's me, but I sometimes leave my baby with my other sister (CSG 016, CSG non-recipient).

I take care of my children, but I sometimes leave them with my cousin if my boyfriend and I are going somewhere together (CSG 544, CSG recipient).

Furthermore, the responses of the participants in the focus group discussions revealed that children from households in the community were taken care of by their parents and some members of the extended families. In particular, single motherhood was a prominent theme in the interviews, with participants often citing that grandmothers were the ones who stepped in to close the gap left by absent fathers. Participant G (from FGD 2) mentioned that:

P (G): *In my view, most children live with both parents. Children are taken care of by both the mother and father, even if the parents are not married.*

Participant CSG 554 mentioned that:

I sometimes leave them with my cousin if my boyfriend and I are going somewhere together.

The participant was also asked if she paid her cousin to take care of her children. She responded as follows:

No I don't, she's their aunt. Besides, I also look after her children when she has to go somewhere.

This goes to show the unity displayed by the families and their sense of obligation to provide care to each other's children without getting something in return. Even though in some households both parents were considered to be primary caregivers, in most households child care was provided by single mothers and there were also some households where grandparents were the primary caregivers to the children.

- *Single mothers as primary caregivers*

The findings from a study conducted by Belsky et al. (2007) show that some mothers, especially single mothers, struggle with their maternal caregiving role. In most cases, they cannot be the sole caregiver to their children because they have to go to work or look for work. These findings are also reflected in the current study where the researcher found that most mothers from food insecure families were the sole caregivers to their children and they sometimes struggled as they had to go and look for employment. The participants illuminated this point by stating that:

I sometimes go to look for a job or when I am called for an interview. This one time I had to work temporarily in Epping for 3 days a week for 2 months. During that time I would leave my baby with my other sister. She helped me a lot, you know (CSG 016, CSG non-recipient).

Sometimes, when I have to go to town to look for a job, I leave my daughter with my neighbour. She also does the same; she also leaves her child with me when she has to go somewhere or when she has commitments (CSG 343, CSG non-recipient).

Not having a secondary caregiver or the father of the child present made it very challenging for the mothers as they had to leave their children in the care of other people when they had to go to work. Furthermore, it was found that in other households where the father was known but did not take care of the child(ren), mothers struggled because they did not trust the fathers of their children to take care of them. They would much rather leave their children in the care of other people than their fathers. Furthermore, where the participants (single mothers) were asked if they had ever left their children in the care of the children's fathers, their responses were:

"(Chuckles) No I don't, he is a man. He knows nothing about taking care of a child, he has never changed his diaper ever so imagine if I were to leave him with the baby" (CSG 016, CSG non-recipient).

No I don't, he just comes by sometimes to see them. That's it. I don't know if he can take care of children, actually I don't trust him, I'm sure he would leave them alone and go out with his friends (CSG 517, CSG recipient).

Moreover, Byrne and O'Toole (2015) mention that in some households where the primary caregiver is employed, parents are more likely to use non-parental child care for their children. This is in contrast to households where the parent is unemployed. The current study conducted in Langa concurs with these findings as the quantitative section above indicated that 82.6% of the participants (mothers) were unemployed and were single mothers. Most of these mothers were forced to stay at home and care for their children because they were unemployed and would not opt for non-parental child care. Some mothers were primary and sole caregivers to their children because they had no-one to take care of their children should they secure employment. This is what one of the participants said:

I was employed before I gave birth but I couldn't return back to work because I worked night shifts. I have no-one to take care of my baby at night. It would be better if I get a day time job, then I would take my child to a crèche during the day (CSG 544, CSG recipient).

Overall, most of the existing literature confirms that single mothers struggle with being sole caregivers to their children because they have to search for employment or have to go to work. The findings from this study indicate that single mothers were often unemployed because they had to stay at home and care for their children. It also highlights the fact that single mothers who sought employment often had to leave their children in the care of other people. Therefore, it can be concluded that those primary caregivers in food insecure households who are most vulnerable to child care arrangement instabilities are single mothers.

- *Grandparents as primary caregivers*

A study conducted by Ntshongwana et al. (2010) showed that in the South African context, single mothers are often not able to be the sole caregiver to their children because they have to move away from their homes to bigger cities in search of employment opportunities or have to be absent from home for many hours during the day to go to work or to look for work. As a result, they leave their children in the care of their grandparents. The findings from the focus group discussions in the current study concur with this. Below are a few responses from participants in the focus group discussions:

P (A): *Most parents who are poor leave their children with their grandparents in the rural areas and come to Cape Town to work or look for jobs.*

P (B): *Some food insecure parents send their children to live with their grandparents or other relatives in the Eastern Cape. However, some relatives demand that the parents send their children*

with the SASSA card so that they can use the CSG money as well. They don't consider the fact that these parents might need this money to provide for themselves; they only sent the child away to the relatives believing that they are well off and would be able to take care of the child without the aid of the CSG.

From the study it was also found that some parents migrated from the rural areas to the cities to seek employment and left their children in the care of grandparents, thus making them the children's primary caregivers. The study conducted by Makiwane (2011) supported these findings, asserting that grandparents among black South African families tend to take care of their grandchildren when their parents migrate from the rural areas to the urban centres to look for jobs. One of the interviewees elaborated on this by stating that:

My mother is the primary caregiver of my child. I had to leave my child with her after maternity leave because I had to return to Cape Town to work and could not afford to lose my job because my family relies on me (CSG 215, CSG recipient).

It was also found that some mothers, after giving birth to their children, struggled to care for them. They chose to send them to the Eastern Cape to live with their grandparents because there the children would be provided with better care than they would otherwise have received if they lived with their parents in poverty. One participant, who was asked if she lived with her child after mentioning that the child was not around, replied that:

No I don't live with my child, I recently sent her to live with my mother in the Eastern Cape (looks down). I sent her to live with my mother because I wasn't coping with her (crying). I am unemployed and I don't have any sort of income so I was struggling with taking care of her. I didn't have money to buy food for her (CSG 440, CSG recipient).

Additionally, participant P (G) from the second focus group reiterated the challenge of caregiving by mentioning that:

Some parents send their children to the Eastern Cape because they are unable to provide food for their children. They would rather starve alone than have the children starving with them.

These findings highlight that there are different types of caregivers – they can be the parents or the grandparents of the children, depending mostly on their day-to-day experiences and living conditions. Some living conditions may hinder a caregiver's ability to provide adequate child care.

- *Parenting: Factors that hinder adequate child care*

Several studies have also indicated that the low socio-economic status of the household contributes directly to poor child outcomes. Thus, children living in poor households are most likely to be raised by parents with low levels of education and limited knowledge of child development – factors that increase the risk of impaired child development (Conger & Donnellan, 2007). The current study found that child care was impacted by parents' behaviours. If parents provided inadequate child care, it might have had a negative effect on the growth and development of the child. Anecdotes provided by participants in the focus group discussions suggested that some parents from food insecure households might not have always provided suitable care to their children.

Participant P5 from the first focus group discussion stated that:

P5: *The parents who are drunkards tend to just buy instant porridge and the rest of the money is used to buy alcohol. They even go with the children to the taverns where the child will only eat a yoghurt for the whole day, resulting in child malnutrition.*

Participant P2 elaborated by saying that:

P2: *Sometimes parents from poor households neglect their children. They use the SASSA to buy alcohol. Children end up roaming around the streets begging for food and money. Some children are at risk of being raped because they are busy begging for food and some people tend to take advantage of that situation and rape children.*

P (E): *Some parents are reckless with the money. They don't buy food for their children. Instead they buy alcohol and then ask food from the neighbours or even ask their neighbours to take care of their children because they can't take care of their own children.*

These findings are supported by Fernald et al. (2017) who mentioned that living in poverty is associated with poor child outcomes because of factors such as the quality of parental care. For instance, children who are raised in poverty-stricken homes may not receive suitable care, stimulation or nutrition, which are needed for a child's growth and development. In this regard, participant P10 from the second focus group discussion mentioned that:

P10: *This reminds me of an incident that I once experienced. I once found one of my neighbours passed out on the couch drunk and the children were sharing only 1 burger. She had received the CSG earlier that day and bought herself alcohol and 1 burger for her children to share. She didn't even buy groceries for the household with the CSG money.*

These findings also illustrate how parental care is affected by various stresses that parents experience, more especially economic stress. Wu and Schimmele (cited in McCurdy et al., 2010) corroborate this by mentioning that poverty causes high economic stress in some families as parents struggle to provide adequate food and resources for themselves and their children. This economic pressure harms parents' mental and emotional health, making it difficult for them to

provide adequate care to their children. It was also found in the current study that in some food insecure households, parents who were under economic pressure tended to be abusive towards one another, thus exposing the children to violence. Participant P30 from the focus group discussion elaborated on this by stating that:

P30: *Just to add on, I know of this one family where both parents are unemployed, they fight for the CSG. Both parents claiming that this money is theirs and not use it for the children. Then children are exposed to domestic violence because the parents are fighting for this money. Even if the father is given a share of the money they don't buy anything for the children, they use this money for their own needs as they feel entitled to it.*

Overall, this study's findings illustrate that parents' behaviours have a huge impact on the way in which they provide care to their children. They also highlight that there are various factors influencing the manner in which parents care for their children which, in turn, affects the child's development. Furthermore, these findings show that socio-economic factors affect the quality of child care and that these factors may also lead to child care arrangement instabilities.

4.3.2.2 Sub-theme 1.2: Care arrangements

2.7.1.1.1 *Alternative care arrangements*

There are various alternative types of care and each type has its strengths and weaknesses. Alternative care arrangements can offer children the chance to develop in new ways; however, some may not be as effective for the children.

The findings from this study suggest that most parents were the primary caregivers to their children. Children in these households spent most of their time with their parents and were rarely

taken care of by other people (besides their parents) for long periods of time. However, some parents chose alternative care arrangements for their children when they had to run errands or when they looked for jobs or went to work.

In addition, the most desirable alternative care arrangement based on the findings was to leave a child in the care of a relative. The participants were asked if they left their children in the care of other people and this is what they said:

Sometimes, when I have to go to town or when my mother sends me somewhere, I leave my baby with whoever is in the house except for my brother (CSG 544, CSG recipient).

I hardly leave the baby with my dad for the whole day; it's usually for 3 hours. For instance, I would be visiting my father and then I have to go somewhere, then I leave the baby in the care of my father (CSG 296, CSG recipient).

The findings above clearly illustrate that most parents chose their families as the source of alternative care for their children. In addition to family members, some parents left their children in the care of their neighbours. One of the interviewees stated that:

I leave my baby with one of my neighbours; she lives 2 houses away from us. This lady has a child who is the same age as my son; she is more like a friend. We help each other out. When she has to go somewhere she also leaves her child with me (CSG 337, CSG recipient).

These findings demonstrate that some parents relied on their neighbours for alternative child care because they also assisted their neighbours by taking care of their children. This shows unity in the communities and a spirit of Ubuntu. One participant elaborated on this by mentioning that:

Sometimes, when I have to go to town to look for a job, I leave my daughter with my neighbour. She also does the same. She also leaves her child with me when she has to go somewhere or when she has commitments. We don't pay each other; we do this out of kindness and having Ubuntu (CSG 343, CSG non-recipient).

However, from the same findings it can be inferred that parents chose these alternative care arrangements because they could not afford to pay for other arrangements such as early childhood development (ECD) centres and nannies. The participants were asked if they would choose the same alternative care arrangements if they were employed or if they had money. Below are some of the responses that the interviewees gave:

I would take him to a good crèche where he gets good meals, gets to learn and be with children his own age. If I were to get a good paying job I would take him to a crèche in town (CSG 016, CSG non-recipient).

Yes I would, I would take him to a crèche. I love crèches because children get to be with other children and they get to learn. Unlike when they are with child minders, there they don't get the simulation that is appropriate for their age and growth (CSG 544, CSG recipient).

Generally, from the findings it can be deduced that fixed, long-term alternative care arrangements were not the primary child care arrangements in these food insecure households. These alternative care arrangements were pursued only when parents had to be away from their children for a few hours in a week or month. Having different and inconsistent child care arrangements can lead to child care arrangement instabilities. However, this did not seem to be the case with these households as the parents spent most of their time with their children since they were unemployed.

2.7.1.1.2 *Child care arrangement instabilities*

Pilarz and Hill (2014) define child care instabilities as the change in non-parental caregivers over a period of time, such as between birth and kindergarten entry, which occurs when a child leaves a particular child care arrangement and goes to another. The findings from the current study do not suggest any child care arrangement instabilities. Contrary to the assumption that children in food insecure households tend to experience care arrangement instabilities, this study showed that the care arrangements for the majority of children in these households were quite stable as almost all the children were taken care of by their parents. However, what seems to explain the lack of care arrangement instabilities is, somewhat ironically, unemployment. An overwhelming majority of mothers sampled for this study were unemployed and thus spent much of their time at home.

The quantitative component presented in the first part of this chapter highlighted that out of the 23 mothers interviewed, only four of them were employed. When these mothers were asked about their current arrangements, only one parent took her child to the ECD centre when she went to work. This is what she said when she was asked about who took care of her child when she went to work:

I am the primary caregiver but she stays at crèche during the day when I go to work……if my baby is not at crèche, she's with me (CSG 406, CSG recipient).

On the other hand, when the other three participants were asked the same question, they replied that they left their children in the care of their families. For instance, one interviewee had this to say:

I am the primary caregiver of my children….I leave my baby with my younger sister when I have to go to work. She takes good care of her and she loves my children like they are her own. She is

very helpful because if it weren't for her, I would have to take my child to an ECD and I honestly don't have money for that (CSG 318, CSG recipient).

Adam (2004) mentions that children in low-income families may also be more likely to suffer the effects of child care instability, as well as instability in other aspects of their lives. Some research studies concur with this view by suggesting that parents, particularly those earning a low income, often find it difficult and stressful to manage changing employment demands and child care arrangements. Contrary to those studies, findings from this study suggest that children from low-income or food insecure households are most likely to have stable care arrangements because their parents are unemployed and thus spend more time at home.

The current literature suggests that parents from low-income households will not tolerate destitution and food insecurity and will thus go out and look for work, and this will lead to care instability. It also assumes that where there is care instability, there is no food insecurity. The findings from the current study complicate this simple hypothesis in the literature which assumes that low socio-economic status is central to adverse childhood outcomes and that much centres on whether the parent is available or not. The findings from the current study, however, show that this is not necessarily the case.

2.7.1.1.3 *The role that money plays in child care arrangements*

The findings from this study highlight that money plays a huge role in the care arrangements that parents choose for their children. When one interviewee was asked whether, if she had adequate money, she would take her children to crèche, she stated that:

I would love to take my child to a crèche and pay for results that I can see because I know that he will learn a lot of things at the crèche than when he is with me here at home (CSG 629, CSG recipient).

Some parents would have loved to take their children to a crèche where they would receive the type of stimulation that would nurture positive child development. However, because they did not have enough money, they could not send their children to a crèche. This is what some interviewees had to say in this regard:

Definitely I would, I would take him to a good crèche where he gets good meals, gets to learn and be with children his own age (CSG 600, CSG recipient).

Crèches are very safe and they are good places to keep your children during the day because they learn and get food as well. I would also pay school fees for my grandchild as well if I had a job (CSG 647, CSG recipient).

From the quantitative findings, it is apparent that 91.3% (21 out of 23) of the participants were CSG recipients. None of them used the money for ECD centres; instead, they used the money for other 'important' things, such as food and other household necessities. More findings in relation to this theme are discussed below under *Sub-theme 3.2*.

4.3.3 Theme 2: Hunger experienced by food insecure households

As shown in the quantitative findings above, 78.2% of food insecure households experienced moderate hunger and 21.8% of these households experienced severe hunger on a daily basis. Interviewees were asked about the number of meals that they ate per day. These were their responses:

We eat once or 2 times a day, but it's mostly once. We are used to it now (CSG 343, CSG non-recipient).

2 or 3 times, it all depends on how much food we have…. I feed my baby whenever he's hungry, so I think he eats 4 or 5 times a day (CSG 296, CSG recipient).

Although in some households children eat more meals than their parents, it is concerning that children grow up in households where hunger is so prevalent. Zembe-Mkabile et al. (2015, p. 356) elaborate on this by saying that "while there has been a significant drop in reported child hunger (from 30% of all children in 2002 to 16% in 2006), the fact that 3 million children were still living in households where hunger was reported remains a cause for concern". During the focus group discussions, some participants shared the same concerns and also highlighted the effects of household hunger:

P1*: Children from food insecure households are most likely to roam around the streets and beg for food and money. Some children are at risk of being raped because they are busy begging for food and some people tend to take advantage of that situation and rape children.*

P5: *Some children join gangs and become thieves because they have to steal food or money because of their own hunger.*

Hunger in these households was mainly caused by the inability to access enough food for the household. The findings from this study also show that most of these households were unable to source and acquire enough food to consume on a daily basis.

4.3.3.1 Sub-theme 2.1: Food accessibility

The literature on food insecurity in Chapter 2 cites food inaccessibility as one of the factors contributing to household food insecurity. Food security is highly dependent on money and it becomes imperative that sufficient attention is given to the challenges of generating an efficient and stable income as a prerequisite for ensuring food security (Venter et al., 2011). As established from this study, only 17.4% of the participants were employed. This means that only a very small proportion of the sample had income that they could use to access food for their households.

2.7.1.1.4 *Sources of food*

It was found that these households accessed food in various ways, besides earning money from their jobs. The qualitative questionnaire asked the participants where and how they got their food. The responses differed from household to household, although some of the responses were similar. In answer to one of the questions regarding where the participants bought their food, some of the interviewees responded as follows:

We buy food at Shoprite and at the spaza shops. Sometimes I go to the market at Epping to pick up the vegetables and fruits that are not too spoilt and salvageable to eat (CSG 343, CSG non-recipient).

I take some food items on credit at the spaza shops and then pay them back month end. I also go to pick up food from the market or ask my neighbour for food, more especially for my children (CSG 614, CSG recipient).

We take some food items on credit at the spaza shops and then pay them back month end. I sometimes contribute towards food from the CSG money that I receive (CSG 544, CSG recipient).

These responses show that most of the participants had a similar approach to accessing food. They bought their food at the local supermarkets, took food on credit and even went to extra lengths to pick up food that was thrown away at the markets. These food items were thrown away because they had expired, but they salvaged them in order to have something to eat. Participants from the focus group discussions who witnessed this happening said the following:

P (D): *Some people from these households go to the fruit and veg market (factory) in Epping to pick up spoilt fruits and vegetables and salvage them so that they can at least go to bed with something in their stomach.*

P3: *There are some people I know who are unemployed and rely on the grant but still it's not enough. So they tend to go to a place not far from here where people dump the spoilt fruits and vegetables. So people go there to pick the ones that are not too spoilt and salvage and eat them. Others salvage them and sell the ones that are still ok.*

Further findings reveal that some participants went so far as to ask for food from their neighbours. The interviewees elaborated on this by stating that:

We sometimes ask from the neighbours or my sister goes to her boyfriend's place and brings food from there. On difficult days we eat once, at night, and save the food for the next day.

Sometimes I ask for food from the people I live with here and sometimes they just offer me a plate. Other times I go to the spaza to loan a loaf of bread and tin fish (CSG 016, CSG non-recipient).

4.3.3.2 Sub-theme 2.2: Food insecurity

According to the HSRC (cited in Altman et al., 2009), South Africa has a food insecurity problem that is mainly caused by chronic poverty and unemployment. One of the major causes of food

insecurity in South Africa is rising food prices. This makes it very difficult for low-income households to afford proper, nutritious food. The findings from this study demonstrate that having low or no income is very challenging and leads to such households being food insecure. Van der Merwe (2011) supports this finding by stating that low-income households spend about 37% of their income solely on basic food items, thus reducing the accessibility of food for many households. They use the little money that they have to buy food. Poor households use different strategies to try and stretch the little resources that they have to obtain food. In some households, everyone contributes the little that they have towards food. One interviewee elaborated on this by mentioning that:

We all contribute money towards buying the food. Since my mother receives more money than us, she is the one who contributes more money than others and the rest of us contribute a small amount of money. Each and every one of us who receives CSG we contribute R75 towards groceries (CSG 600, CSG recipient).

Another participant mentioned that:

My brother also hustles to give us money for food. He would make extra money sometimes from his taxi driving and give us R100 to buy food (CSG 318, CSG recipient).

These findings show that a little does go a long way. The little money that they had, they used to buy food. The findings also show that the maximum money used to buy food in a household was R1000 per month. Even in a household like this, they were able to spend this much because the participant's boyfriend was employed and managed to give her money to contribute towards the household food.

It depends. Sometimes we buy food for R500, R700 or R1000. It depends on how much he got paid that month, it also depends on how much my sisters have or contribute. (CSG 016, CSG non-recipient).

The literature cites food prices as one of the major contributors to people's inability to buy nutritious food for their households. The findings from this study corroborate this. Since people spent these above-stated amounts of money on food, clearly means that they could only afford to buy staple food which did not last the whole month. Food in these households ran out shortly after it was purchased. The interviewees emphasised that the food they purchased at the beginning of each month ran out during the month.

Food usually runs out around the 20th of every month, it hardly lasts the whole month. When my brother used to work we would buy enough food that would last the whole month because it was the 3 of us who contribute towards food, but now it's just me and my stepfather (CSG 217, CSG recipient).

The participants further elaborated on what they would do when they ran out of food supplies during the month.

I borrow money from my friends or take some food items on credit from the spaza shop and pay back the money whenever we have it. Sometimes my mother goes to the market in Epping with her friends to pick up some vegetables that are thrown away but can still be eaten. Then we eat that until we have money to buy food.

Another participant mentioned that:

I ask my friends or colleagues for money and buy food with it. I also ask for food from my friend who lives next door (CSG 337, CSG recipient).

Subsequently, participants were asked about the types of food that they bought and they listed maize meal to make pap and soft porridge, vegetables, tin fish (pilchards), samp and bread. The food items that they bought and consumed on a daily basis were not of a good nutritional character. They bought food that would fill up their stomachs and give them the energy that they needed to get by. These findings also show that they consumed starchy food which was not nutritious. The interviewees mentioned that:

Well, we eat bread or fat koeks in the morning and rice or pap with vegetables or meat at night. Sometimes when we don't have meat we eat tin fish (pilchards) or corned beef. It depends on what we have, but my baby eats porridge (CSG 016, CSG non-recipient).

We eat rice, pap, samp, vegetables, meat and soup. But mostly we eat pap and soup. It is much better now that my baby eats solid food because he can eat whatever that we eat I don't have to buy Purity and baby cereals as much as I used to (CSG 337, CSG recipient).

When one participant was asked for her opinion on the food that her children ate, she stated that:

I don't care that much, I always make sure that he has something to eat. Even if it means he should eat porridge the whole day. At least I know that he is fed (CSG 016, CSG non-recipient).

These findings show that most participants mostly cared about having something to eat and not going to bed hungry, especially their children. The findings also reveal that some parents ate once or twice a day and made sure that their children ate at least three times a day, regardless of what they ate – as long as their children were fed.

2.7.1.1.5 *Impact of food insecurity on child care arrangements*

There is a paucity of research on the role that food insecurity plays in child care arrangements. The findings from this study reveal a link or relationship between the two. The participants in the focus group discussions were asked about household hunger and how they thought it affected their existing child care arrangements. This is what they had to say:

P30: *Not having food in the household is very challenging because you end up giving your child away. Not that you want to but because of circumstances you send your child away to live with other relatives. It is really painful to see your child cry because they are hungry and there's nothing you can do about it.*

P (B): *It is very hard having your child live with you when you don't have food in the household. The child doesn't understand whether there's food or not, when they are hungry they need to be fed. That's why as a parent you end up sending your child to the rural areas to live with their grandmother because there's no food at home.*

The above quotes show that food insecurity plays a part in parents sending their children away or leaving them in the care of other people. These findings further illustrate that little or no food in the household is a driving force behind parents choosing alternative care arrangements for their children. One of the interviewees expanded on this by mentioning that:

I took my baby to live with my mother because I don't have the means to provide for my baby. I saw that I was struggling when I couldn't even buy my child formula milk that lasts him for the whole month. I didn't want to starve my baby and my mother is the one who suggested that I bring him to her. She is doing a better job than me (CSG 440, CSG recipient).

Some parents who were struggling to access food for their children opted for alternative care arrangements where they knew that their child would not starve. In particular, they chose alternative care arrangements that were more food secure.

4.3.4 Theme 3: Household income

There are potentially various sources of income in food insecure households. These include income from employment, social grants and child maintenance money. Ideally, poverty and food insecurity should be addressed by expanding employment opportunities, which would enhance household incomes (Altman et al., 2009). However, employment proves to be one of the greatest challenges facing South Africa, evidenced in a very high unemployment rate. Thus, people are forced to look for other sources of income. The findings from this study indicate that people largely rely on the CSG and the OAG as their sources of income.

Not surprisingly, given South Africa's massive unemployment problem, only four of the 23 participants who were interviewed were employed. Some participants had previous employment and had lost their jobs and most remained unemployed. When asked to elaborate on this, some interviewees mentioned that:

I was working but the firm that I worked for closed down, so I don't work at the moment. (CSG 001, CSG recipient).

No I am not working. I was working until I was 7 months' pregnant. My boss relocated overseas, that's how I lost the job (CSG 343, CSG non-recipient).

Although most of the participants were unemployed, some of them lived with people who were employed in their households, thus making employment one of their sources of income. When participants were asked about the source of income for the household, they said that:

No I am not employed, my mother receives the old age grant and my brother is the only one who is working, he is a taxi driver (CSG 544, CSG recipient).

No I am not. My husband is the only one who is working in this household (CSG 647, CSG recipient).

My sister is employed so she spends some of her salary on the food, her boyfriend also gives her money ... and I also contribute money from the CSG and the money that my boyfriend gives me (CSG 333, CSG recipient).

These findings correlate with those of Altman et al. (2009) who assert that employment is one of the primary sources of income in most households, even food insecure households.

4.3.4.1 Sub-theme 3.1: Child support grant

Most families who are destitute depend on the social security grants that the government provides. Findings from this study indicate that food insecure households largely relied on the CSG as their source of income. As shown in the quantitative component of the study, 91.3% of the participants were CSG recipients. These families received the grant as their primary source of income. One interviewee, who was asked about her primary source of income, mentioned that:

I am going to be honest with you, the CSG is my only income at the moment, and I don't have any other source of income (CSG 440, CSG recipient).

In a study conducted by Altman et al. (2009), the evidence showed that social grants have played an important role in improving household food security since 2001. In fact, the CSG still plays a role in addressing food insecurity. The findings from the current study support this, showing that the recipients of the CSG used it mainly to buy food and provide for their families. Interviewees elaborated on this by mentioning that:

I mostly use the CSG money to buy things for the baby but I also buy a couple of food items for the household (CSG 217, CSG recipient).

The CSG is very helpful, you know. It is my only source of income so I rely on it for everything. I buy food with it (CSG 343, CSG non-recipient).

Furthermore, this study revealed that the CSG was an additional form of income that was used as a substitute for employment income in some households. This was revealed in the focus group discussions where the participants stated that:

P20: *The CSG contributes a lot. I don't receive my salary on the 1st. So when I receive the CSG I buy food with all of it. It helps substitute my income.*

P30*: The CSG usually acts as a substitute, say for instance I'm unemployed and my family helps with buying or giving me food. Then I will use the CSG money to top up the food I have received from my family.*

UNICEF (2015) points out that the CSG is used to help meet the needs of the whole household (not just the eligible child), with 95% of the cash being spent on five main types of commodities: food, education, clothing and household durables, health and transport. Generally, the mother receives the grant and has control over the way in which it is spent. The findings in the current

study corroborate this, as participants reported not using the money only for food but also to cover other household expenses. Participants were asked about their use of the CSG and they said that:

I use it for all the household necessities, including food, clothes, electricity and other things that we need (CSG 577, CSG recipient).

I spend it for everything in the household. I buy food, washing powder, toiletries, electricity and everything else that we need here at home (CSG 647, CSG recipient).

Overall, child support grants were used to help alleviate childhood poverty in families, address food insecurity and also cater for other household expenses. Devereux and Waidler (2017) support this finding by mentioning that the effectiveness of grants is diluted by multiple users and multiple uses, as only a certain proportion of the CSG is spent on food and the rest of the money is used for other expenses. The provision of cash enhances the family's ability to take better care of their children, even though the CSG is inadequate. The amount is too small and is used for too many expenses which go beyond the needs of the child.

2.7.1.1.6 *The role of the CSG in child care arrangements*

There is limited literature on the role that the CSG plays in child care arrangements. However, other studies conducted on cash transfers (i.e. CSGs) reveal that the CSG has a positive impact on parental behaviours, which may enhance child wellbeing (Sherr et al., 2017). The current study aimed to fill this knowledge gap and provide data in this regard. Consequently, the findings from this study show the relationship between the CSG and child care arrangements. It is evident from these findings that parents who were CSG recipients chose more stable care arrangements for their children. One participant from the FGD mentioned that:

P (B): *The CSG plays a huge role in a sense that parents are able to keep their children because they are able to provide food for them. If it wasn't for this money there would be no food in the household. The parents would send their children away to their well-off relatives.*

The above statement clearly highlights that the care arrangement in that particular household was such because of the parent's ability to provide food for her child. Another interviewee added that:

If it wasn't for the money that I receive from the grant I would've sent my children to live with their fathers because I wouldn't be able to provide for them. I don't have any other income besides the grant (CSG 554, CSG recipient).

From these findings it is also evident that parents who chose alternative care arrangements were CSG recipients and used the CSG money for such alternative care arrangements. For instance, some participants used the CSG money to pay the fees at the ECD centres. One of the participants expounded further on this:

P (G): *Some parents use the CSG to pay for ECD centres, for transport fare and to buy food.*

P40: *Some parents become day mothers, where they take care of their own children and other children from the community. These mothers tend to charge less money than the ECD. Some parents prefer this kind of care arrangement for their child because there are few children that are taken care of by the day mother compared to ECD centres and they use the little money that they receive from the CSG to pay the day mothers.*

Therefore, the CSG money was used interchangeably by parents for their care arrangements. On the one hand, some parents used the money within their households to provide for their children's basic needs instead of sending them away because of their inability to satisfy such needs. On the

other hand, some parents used the CSG money to pay for alternative care arrangements. Moreover, there were some parents who were able to keep their children in their household with them because there were other sources of income besides the CSG.

4.3.4.2 Sub-theme 3.2: Alternative sources of income

2.7.1.1.7 *Other social grants (old age, foster and disability grants)*

The old age grant (OAG) is one of the primary sources of income for the majority of the households headed by the elderly in South Africa. Furthermore, in many cases, the elderly are likely to use their old age grants to support the entire household, which is usually multigenerational (Makiwane, 2011). Findings from this study resonate with this view – that is, in food insecure households, families also rely on other types of social security grants as their source of income. Participants were asked about alternative forms of income, besides the CSG. They mentioned that:

We do everything together, seeing that we are all unemployed we mostly rely on our mother. We rely mostly on my mother's old age grant but we also receive the child support grants for our children (CSG 600, CSG recipient).

I am not employed, my mother receives the old age grant and we use most of her money to pay for most of the things (CSG 544, CSG recipient).

My stepfather receives the old age grant and he is the one who contributes more money in the household. His grant comes in very handy in covering the household expenses (CSG 217, CSG recipient).

These findings clearly show that the old age grant was used to support the entire multigenerational household. In addition to the old age grant, some families relied on the foster care grant as their

source of income. One participant was also a primary caregiver to her late sister's child. She elaborated on this by stating that:

I live off the CSG that I receive for my children and the foster care grant that I receive for my niece (CSG 577, CSG recipient).

In addition to the two grants mentioned above, some participants relied on the disability grant. The disability grant was introduced to assist low-income families with a family member living with disabilities. However, findings from this study suggest that the disability grant is not only used for the child living with disabilities. Like the old age grant, it is used to cover household expenses, thus supporting the entire family. This was explained in detail by a participant in a focus group discussion:

P (G): *In other households, they rely on the CSG, the disability grant and old age grant. There's this one family I know of, that receives the disability grant. The mother is unemployed and uses the CSG grant for her youngest child to pay for the crèche fees and uses the disability grant to cover all the expenses in the household.*

In addition, one interviewee mentioned that she received the CSG and the disability grant for her children. She stated further that the disability grant was more helpful than the CSG. She went into more detail by stating that:

I don't receive the CSG for my oldest daughter because she is 18 now but I receive it for my other 3 children and my daughter receives it for her child. In fact, for my 2nd born I receive a disability grant, as he is physically disabled. His money is the most helpful out of the 3 that I receive because it's a lot compared to the CSG. With the disability grant I am able to do a lot of things that I can't do using the CSG (CSG 647, CSG recipient).

Overall, these findings highlight the fact that the food insecure households had various sources of income. Although the majority of the participants were unemployed, they did have other means of getting income and providing for their children's basic needs. Therefore, from these findings it can be deduced that the main source of income was the CSG because the majority of these households received the CSG as their primary income. Other grants, such as the old age grant and disability grant, were used as additional sources of household income.

4.4 Summary and Conclusion

This chapter provided a detailed presentation, discussion and analysis of the results and findings of both the quantitative and qualitative components of the study.

The quantitative component endeavoured to provide a comprehensive, descriptive analysis of the circumstances and living conditions of the participants. The initial focus was on establishing the participants' demographic details, concentrating on the participants' ages and the mother's level of education. Furthermore, the quantitative section presented the findings from the administered household hunger scale, which revealed that of the 23 participants who were found to be food insecure, 78.2% experienced moderate hunger and 21.8% experienced severe hunger.

Furthermore, the quantitative section revealed that the number of people living in a particular household contributed to the extent to which hunger was experienced in that household. The more people who lived in a household, the more severe was the hunger experienced. The link between the CSG and the extent of household hunger experienced was then established. It was found that in households that received the CSG, hunger was not as severe as it was in households where there was no CSG recipient. Thus, households in which there was a CSG recipient consumed more meals per day than households that did not receive the CSG.

Finally, the quantitative section examined the participants' employment status. It was found that over 91% of participants were unemployed. An important discovery was that unemployment played a huge role in food insecurity. It was found that of the 19 unemployed participants, nine consumed one meal per day and 10 consumed two meals per day.

The quantitative findings were analysed using the SPSS software. The descriptive statistics that the analysis yielded were augmented by relevant excerpts from the verbal responses of the participants to the open-ended questions in the questionnaire. Relevant material from the reviewed literature was integrated into the discussion of the results from the quantitative study, thereby placing these results within an appropriate research context.

The subsequent section took the form of a comprehensive summary of the findings, discussion points and analysis of the qualitative study. Three principal themes and a number of sub-themes emerged from the thematic analysis of the qualitative data. The main findings from the qualitative study are as follows: Child care and child care arrangements varied from household to household. In this regard, the findings show that in most food insecure households, children were taken care of by their parents as primary caregivers, while the extended family often assisted in taking care of the children, especially grandparents. In these households, mothers were sole caregivers for their children and sometimes struggled as they had to go and look for employment. They therefore often relied on their parents (grandparents) for help in caring for their children, and sometimes relied on relatives (sisters) and neighbours.

Furthermore, the study found that children living in poor households were most likely to be raised by parents with low levels of education and limited knowledge of child development. Thus, only eight parents out of the 23 had completed their Grade 12, with the rest of the parents having

completed between Grade 9 and Grade 11. Child care was affected by various factors, particularly those mentioned above.

The findings further highlight that alternative care arrangements were not the primary child care arrangements in food insecure households. They were only resorted to when the parents had to be away from their children for a few hours during a week or month. The findings also show that having different and inconsistent child care arrangements could result in child care arrangement instabilities.

Moreover, this study has thrown light on the experience of hunger in food insecure households. As revealed in the quantitative results above, 78.2% of the food insecure households experienced moderate hunger and 21.8% of these households experienced severe hunger on a daily basis. Hunger in these households was mainly caused by the inability to access enough food for the household. It was evident that having low or no income was very challenging and was what led to the households' food insecurity. Thus, the people used the little money that they had to buy food. In some households, everyone contributed what they had towards food purchases.

The literature on the role that food insecurity plays in child care arrangements is limited. Hence, this study was intended to determine the link or relationship between the two phenomena. The study revealed that, interestingly, food insecurity in households did not necessarily lead to child care arrangement instabilities because most mothers lived with their children.

In addition, the qualitative results indicated that people living in food insecure households had various sources of income, despite being unemployed. They largely relied on the CSG and/or the old age grant as their source of income. The child support grant was used as an aid to alleviate childhood poverty in families, address food insecurity and also cover other household expenses.

The old age grant, in turn, was used to support the entire household, which was multigenerational. In addition to the old age grant, some families relied on the foster care grant and/or the disability grant as their source of income.

Overall, the quantitative and qualitative results and findings presented in this chapter show that there is a relationship between food insecurity, child care arrangements and the CSG. In most of the food insecure households, the child care arrangements were stable. The primary caregiver of the child was the parent (mother) who was a CSG recipient and used the money to reduce household hunger by buying food. The CSG reduced the possibility of child care arrangement instabilities as some of the parents used the money to pay for a stable alternative care arrangement for their child. If the child was not with them, they should ideally be at an ECD centre or with a trusted family member. This then highlights how the CSG fostered the stability of the existing care arrangements. The CSG money also played a huge role in addressing food insecurity in the household.

The next and final chapter, Chapter 5, first presents the conclusions that can be drawn from the results and findings, with reference to the objectives guiding the study. The chapter then offers a number of recommendations based on the conclusions as well as suggestions for further research.

CHAPTER 5: SUMMARY OF RESULTS AND FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

Chapter 4 presented and discussed the study's quantitative results and qualitative findings. The quantitative data was first analysed and the results were presented in tables and figures, which were explained in depth. The qualitative data was then analysed and the key findings were presented, with relevant quotes from the participants. References were made to the literature to illuminate and support these findings.

This chapter integrates and summarises the quantitative and qualitative results and findings with a view to drawing meaningful conclusions from them, after which it makes a number of recommendations and offers suggestions for future research. It also discusses the limitations of the study.

5.2 Quantitative Results: Summary and Conclusions

The primary purpose of collecting the quantitative data was to determine which households were food insecure. This was done through the administration of the household hunger scale (HHS). The results from this data collection process showed that of the 120 households, 23 were found to be food insecure. The data also revealed that the latter households experienced moderate to severe hunger: 16 households experienced moderate hunger and seven experienced severe hunger.

It was also found that the number of people in a particular household did not play a significant role in the severity of hunger in the household. For example, the household that had the most number of people (n=13) experienced moderate hunger, whereas a household with three people

experienced severe hunger. In addition, the findings showed that the number of children in the household did not have a major impact on the household food security status. Of the 23 food insecure households, eight had the least number (n=1) of children. In contrast, the household with the most number of children (n=6) was food secure. From these results it can be inferred that the number of children and the people who live in the household do not contribute heavily to food insecurity or the severity of hunger experienced in households.

A link was established between the child support grant (CSG) and the hunger experienced. It was found that in households that received the CSG, hunger was not experienced as severely as in households where there was no CSG recipient. Thus, households with CSG recipients consumed more meals per day than those that did not receive the CSG.

Finally, the results revealed that the majority (59%) of participants were unemployed. Of the 23 food insecure participants, 19 were unemployed. Only four were employed and all four had two meals per day. On the other hand, nine unemployed participants had one meal per day while 10 had two meals per day. The quantitative findings were analysed using the SPSS software. The descriptive statistics that the analysis yielded were augmented by relevant excerpts from the verbal responses of the participants to the open-ended questions in the questionnaire. Relevant material from the literature that was reviewed was integrated into the discussion of the findings from the qualitative study, thereby placing the findings within an appropriate research context.

5.3 Qualitative Findings: Summary and Conclusions

The ensuing section takes the form of a comprehensive summary of the findings from the qualitative study and the related analysis and discussion.

Three principal themes and a number of sub-themes emerged from the thematic analysis of the qualitative data. The main findings from the qualitative study can be summarised as follows: Child care and child care arrangements vary from household to household. In most food insecure households, children were taken care of by their parents as primary caregivers while the extended family often assisted in taking care of the children, especially grandparents. In those households, mothers were the sole caregivers to their children and sometimes struggled in their role as they had to go and look for work. As a result, they often relied on their parents (grandparents), other relatives and neighbours to help them care for their children.

The findings further highlighted the fact that alternative care arrangements were not the primary child care arrangements in food insecure households. They were only resorted to when parents had to be away from their children for a few hours in a week or month.

Moreover, the findings highlighted the experience of hunger by food insecure households. As shown in the quantitative findings above, 69.6% of food insecure households experienced moderate hunger while 30.4% of these households experienced severe hunger on a daily basis. Hunger in these households was mainly caused by the inability to access enough food for the household. These findings amplify the fact that having a low or no income is very challenging and leads to food insecurity. Thus, people used the little money that they had to buy food and in some households, everyone contributed a proportion of their income towards food.

The literature on the role that food insecurity plays in child care arrangements is limited. In view of this, this study set out to determine the link or relationship between the two. A key finding was that food insecurity played a part in parents sending their children away or leaving them in the care

of other people. Furthermore, having little or no food in the household was a driving force behind parents choosing alternative care arrangements for their children.

However, the findings also revealed complexities in the link between food insecurity and child care arrangement instabilities because a number of households in this study were food insecure and yet the children lived with their biological parents, many of whom were unemployed. These seemingly contradictory findings can be explained in different ways. One possible explanation is that parents who are unemployed, living in poverty and confronted by food insecurity attempt to keep their children with them for as long as possible before sending them off to live with relatives if their circumstances do not change. (Caregivers did indicate, though, that severe food insecurity forced mothers to part with their children.) As the data was collected when many of the children were still very young (under the age of two), it may have been too early to observe this shift. Another explanation is that social grants play a role in helping to maintain child care arrangement stability since unemployed caregivers are able to keep their children because of the (albeit small amount of) money coming in.

The qualitative results also indicated that people living in food insecure households had various sources of income, despite being unemployed. They largely relied on the CSG and/or the old age grant (OAG) as their source of income. The child support grants were used to help alleviate childhood poverty in families, address food insecurity and also cater for other household expenses. An important finding was that the old age grant was typically used to support the entire household, which was multigenerational. In addition to the old age grant, some families relied on the foster care grant and the disability grant as a source of income.

Overall, the quantitative and qualitative studies showed that there is a relationship between food insecurity, child care arrangements and the child support grant. A key finding was that in most of the food insecure households, the child care arrangements were stable. This was generally because the primary caregiver of the child was the parent (mother) and a CSG recipient who used the grant money to buy food in order to reduce household hunger. In some cases, the CSG reduced the risk of child care arrangement instabilities as certain parents used the money to pay for a stable alternative care arrangement for their child. If the child was not with them, they should ideally be at an ECD centre or with a trusted family member. This highlights how the CSG can be an instrument of stability as far as care arrangements are concerned. Importantly, too, the CSG money had a major role to play in addressing the risk or reality of household food insecurity.

5.4 Recommendations

In order to ensure that children in poor households receive proper and adequate care, which will encourage positive developmental outcomes, the households need to experience food security. To this end, cash plus care strategies need to be implemented. In addition, families and community-based organisations should work together to design and introduce stable child care arrangements. The following recommendations are aimed at realising these aims.

5.4.1 Development of food accessibility strategies

It is recommended that the City of Cape Town (municipality), the provincial government and the Food and Agricultural Organization (FAO) collaborate in formulating food security strategies that are suitable for poor households in the township of Langa and similar communities around Cape Town. Such strategies should enhance food accessibility for vulnerable residents. One approach would be to establish community gardens where members of the community could plant and

harvest their own vegetables for domestic consumption. Another approach would be to set up daily soup kitchens in the community where the poor could get soup or a simple meal. Feeding schemes could also be initiated to combat food insecurity.

The Department of Social Development currently runs a programme in which food parcels are provided to poor households, but this is a discretionary programme and short-term in nature (maximum six months). Another possible route to follow would be the implementation of food subsidies in low-income areas. These subsidies could be used to make healthy foods, like fresh vegetables and good-quality protein, more affordable for disadvantaged people.

5.4.2 Establishment of NGOs and FBOs to assist the community with basic necessities

Faith-based organisations (FBOs) are known for taking care of the poor. Churches around Langa could be called upon to help provide basic necessities to poor households, such as food, clothing, stationery, sanitary towels, toiletries and so on. Well-off people could donate and contribute items to these churches, which could become collection points for people who are in need. Soup kitchens could also be accommodated on church premises. In addition, NGOs could be established to focus specifically on tackling the causes and consequences of food insecurity. Like the FBOs, such NGOs could also engage directly with needy, impoverished communities.

As FBOs are known to play an active role in various low-income areas, there may already be a church presence in Langa and other settlements. Perhaps, though, their activities could be better organised and coordinated through a central body, and awareness created in different communities to ensure that everyone knows where to get food.

5.4.3 Establishment of a training institution or skills centre

Clearly, unemployment is a huge contributor to food insecurity. Most of the participants in the study were unemployed and had attained low levels of education. Establishing a non-fee skills training centre would be very beneficial for the Langa community. People could undergo training and acquire basic skills to improve their prospects of entering the job market. Alternatively, they could be guided in establishing their own businesses, which would put them in a better position to create other jobs. Tackling unemployment head on in this way would also help to tackle food insecurity in communities.

5.4.4 Implementation of cash plus care strategies

Social security grants have been deemed very helpful in alieving poverty and enhancing child care. However, it is widely acknowledged that cash combined with care has a more positive impact on childhood development. The South African government should give greater attention to rolling out child care initiatives that enable parents to provide the best possible care for their children. One way to achieve this is to introduce public ECD centres, where fees are subsidised or waived in the case of some parents, depending on their needs and circumstances. Every parent who receives a CSG should be eligible to take their child to a public ECD centre when they have to go to work or are away from home looking for employment. It goes without saying that children should receive proper care and stimulation at these centres, together with nutritious meals daily.

Another cash plus care strategy might involve the establishment of NGOs to focus specifically on the challenges associated with child care, particularly in the face of severe financial constraints. Child care workers could be employed to go into poor households to teach parents how to stimulate their children when they are sitting with them at home. Furthermore, these organisations could

host workshops and training sessions on parenting skills and could offer early childhood development courses aimed at day mothers so as to improve their capacity to provide care to the children for whom they are responsible.

What emerged clearly from the findings was the pervasive poverty in the township of Langa. The situation in Langa is by no means unique – it mirrors the poverty and food insecurity evident in townships and impoverished areas all over South Africa. What needs to be done to alleviate these problems is nothing short of staggering. In particular, social policy and social work intervention strategies need to be prioritised, examined and improved. Specific recommendations in this regard are provided in the next section.

5.4.5 Recommendations for social policy and social work interventions

5.4.5.1 Implementation of appropriate policies

Appropriate child care is very important for early and later development. To achieve this, good parenting skills and suitable child care arrangements need to be in place – which, in turn, must be fuelled by supportive policies and practical assistance on the part of government and other stakeholders. Polices on their own, however well designed, will have little impact. It is only through effective implementation that policies will be able to make a difference to families, communities and whole regions. Effective, inclusive child care policies and strategies, which should inform social work practice, should be based on relevant data, including reliable facts and figures. Policies should also be formulated in consultation with child caregivers, including primary and secondary caregivers, who are often the voices of those who cannot speak for themselves.

5.4.5.2 Recommendations for social work interventions

Social workers are known to be agents of change because part of their work involves influencing policies (in both the public and social spheres) and working towards the attainment of social justice. Social workers encourage the implementation of policies and strategies that end discrimination, address unemployment and alleviate poverty. In the wake of this study's revelations, it is recommended that more social workers take up the challenge and become activists and advocates for poor communities. Steps need to be taken by social work professionals to ensure that such communities have access to social services that effectively combat social injustices.

The literature review and the study's findings highlighted that people in communities like Langa are marginalised, do not have a voice and have all but lost hope of a better life. Therefore, intervention strategies, grounded in advocacy, need to be put in place, evidenced in social workers becoming the voice of the voiceless and advocates for the rights of the economically disempowered, particularly children. Children have a basic right to nutritious food and proper care; thus, they need professionals to advocate for them. In a broader sense, social workers also have a responsibility to empower marginalised groups and help them to improve their lives, using social work interventions like engaging directly with communities, assessing their needs and collaborating with community members to bring about meaningful and lasting change.

Socio-economically vulnerable members of society need sufficient access to holistic social services. This study revealed that the Langa community had limited access to social services, yet it is the availability of such services (including psychosocial support) goes to the core of a community's quest to achieve social justice and social development. Skilled social workers therefore need to be placed in locations that will give people convenient access to them. The

establishment of specialised NGOs could in turn ensure that broad or holistic family support is offered to marginalised people.

5.5 Suggestions for Future Research

The results and findings from this study have the potential to make a significant contribution to the existing body of knowledge on child care, child care arrangements and food insecurity. Building on this foundation, future research might include the following:

- A follow-up mixed-method study could be conducted in a few years' time to determine if the households are still food insecure and to establish their care arrangements at that point in time. The aim would be to find out if the food security status of these families had improved or worsened and how this had impacted their child care arrangements.

- A qualitative study could be conducted focusing on unemployment and the role that it plays in the quality of care provided by caregivers. The study could possibly investigate unemployed parents' or caregivers' behaviours, the kind and quality of care provided to children, and the effects that unemployment might have on childhood development.

- A study could be conducted on the extent to which the launch of skills training centres is able to increase the likelihood of unemployed parents securing employment and/or creating jobs. This study highlighted the low levels of education among the participants. From this one can conclude that if they were able to develop relevant and necessary skills, they would be more likely to obtain employment. The study could put this theory to the test and determine whether training centres would offer a feasible solution to the high unemployment problem.

- The literature review and the study's findings revealed that cash transfers are an effective means of poverty alleviation. However, very little research has been conducted on the impact of cash plus care on childhood development in South African townships. Therefore, a study could be conducted on the social security policies currently in place that pertain to cash plus care. The study could include how the current policies are implemented and the effectiveness thereof.

- This study revealed that the CSG reduced the possibility of child care arrangement instabilities, as some of the parents used the money to pay for a stable alternative care arrangement for their child. A more in-depth study could be conducted to analyse the role that the CSG plays in terms of child care and whether or not such care arrangements are suitable for the children.

5.6 Researcher's reflexivity

The population for this study was derived from the participants of the birth cohort study. The researcher came in as an additional member of the research team. While the participants were already familiar with the fieldworkers, some were a little wary of the researcher (whom they did not know) and were not as open with her as they were with the fieldworkers.

During the quantitative phase of the study, the participants were a little uncomfortable and showed some reluctance to participate and answer questions. However, the researcher and the fieldworkers reassured them about confidentiality and reiterated that the highest ethical standards would be upheld in the study. The researcher was introduced as a social worker to some of the participants who then became significantly more amenable to the prospect of participating in the study.

However, being identified as a social worker created some expectations on the part of the participants, as they asked questions such as:

Is my participation in this going to be beneficial for me; am I going to get food parcels?

The researcher explained the ultimate purpose of the research – that it was to develop relevant recommendations that could be useful to people tasked with the formulation and implementation of policy, which in turn would be translated into social work interventions to address food insecurity and the matter of child care.

Another challenge that the researcher faced was getting participants for the focus group discussions. Initially, when the community workers were recruited for the focus group discussions, they somehow informed other members of the community about the research that would be taking place. As a result, some of the people from the community who volunteered to be part of the research study had preconceived ideas about what their involvement would entail. Some people asked:

If we participate in this study, are we also going to get jobs as community workers?

The nature of the study and its ultimate purpose were explained to them and they were also told that participation was voluntary. Furthermore, they were informed that the study was by no means affiliated to the NGO where the community workers were employed and that the study did not constitute a job opportunity. When they heard this, some were no longer willing to participate. The recruitment for this part of the study was therefore somewhat challenging. However, this challenge was overcome and the researcher managed to recruit eight more people to take part in the focus group discussions.

5.7 Limitations of the Study

This study departed from the assumption that food insecure households have child care arrangement instabilities. In fact, the study proved this assumption to be incorrect and concluded that the reality in South Africa is far more complex. The assumption was based on the existing literature that was reviewed but which offered little insight into the topic under investigation. In other words, little research has been done on the relationship between food insecurity, the CSG and child care arrangements. The researcher's own bias at the beginning of the study was a complicating factor – the researcher commenced the study under the impression that food insecure households have unstable care arrangements and that the CSG is enough to address household poverty.

5.7 Chapter Summary

The quantitative and qualitative components of the study have delivered valuable insights and addressed each of the research questions as they relate to the relationship between food insecurity, the child support grant and child care arrangements in the township of Langa. With the results and findings having been successfully synthesised and integrated in the foregoing discussion, one can conclude that the aim and objectives of the study have been met.

The quantitative results highlighted certain demographic information about the food insecure participants and also exposed the intensity of hunger experienced in the households in question. The qualitative findings, in turn, highlighted the experiences and behaviours of these participants in relation to food insecurity, child care arrangements and the CSG. The study provided the foundation on which a series of recommendations were made, notably in the area of social policy and social work interventions, where there are clear gaps.

In conclusion, this study will be a valuable addition to the existing body of knowledge about food insecurity, child care and the child support grant, and how these relate to one another. It will also inform good social work practice at the micro, meso and macro levels.

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APPENDIX 1: MOTHER AND CHILD PAIRS (AGES)

Table 4.1: Mother and child pairs – Ages

CSG participant ID	Mother's age (in years)	Child's age (in months)
001	27	12
012	35	13
016	28	12
023	31	12
033	25	13
039	20	12
047	33	13
051	34	12
476	28	13
664	26	12
621	43	12
255	32	12
228	22	12
337	22	15
351	24	12
319	24	12
401	23	12
405	28	24
440	29	24
424	22	24
554	34	13
643	27	7
665	29	9
671	28	8
670	33	24
394	19	24
175	27	7

227	28	7
231	21	6
265	22	6
271	25	13
270	24	12
296	25	12
297	22	12
309	35	12
217	33	15
318	22	12
325	22	12
333	35	12
336	27	13
339	19	12
317	18	13
348	34	12
349	41	12
340	32	13
358	30	14
368	27	24
367	29	24
363	34	6
371	25	6
375	31	6
377	18	6
345	39	6
379	32	12
215	35	6
385	26	7
409	19	12

406	25	12
400	18	7
448	36	8
475	32	6
428	32	6
476	28	7
538	28	12
552	34	13
620	31	12
622	40	12
600	22	13
627	23	13
645	26	13
653	36	13
666	30	8
660	29	12
669	20	12
672	29	12
550	26	8
551	27	8
454	28	12
577	31	7
308	31	7
597	21	12
590	31	12
488	33	7
634	33	6
636	25	6
565	41	6
587	27	6

614	31	9
619	28	13
624	29	12
637	34	13
641	21	24
617	29	15
646	34	12
602	31	6
629	33	6
527	31	6
532	32	6
517	23	6
647	33	6
656	22	6
657	25	6
62	31	8
71	40	12
249	36	12
332	27	24
343	24	24
386	23	24
388	22	6
478	28	6
482	27	8
544	31	7
548	23	7
668	37	13
522	25	24
683	33	12
684	19	9

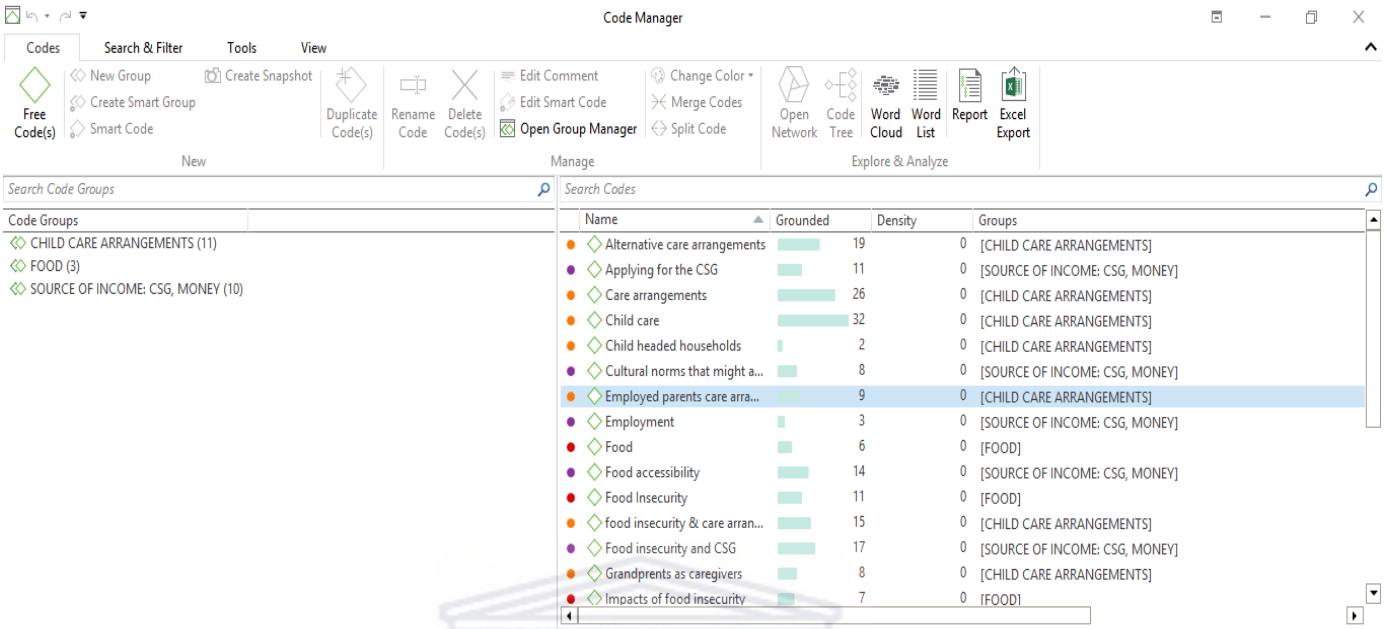
688	20	6
691	31	12
362	25	7

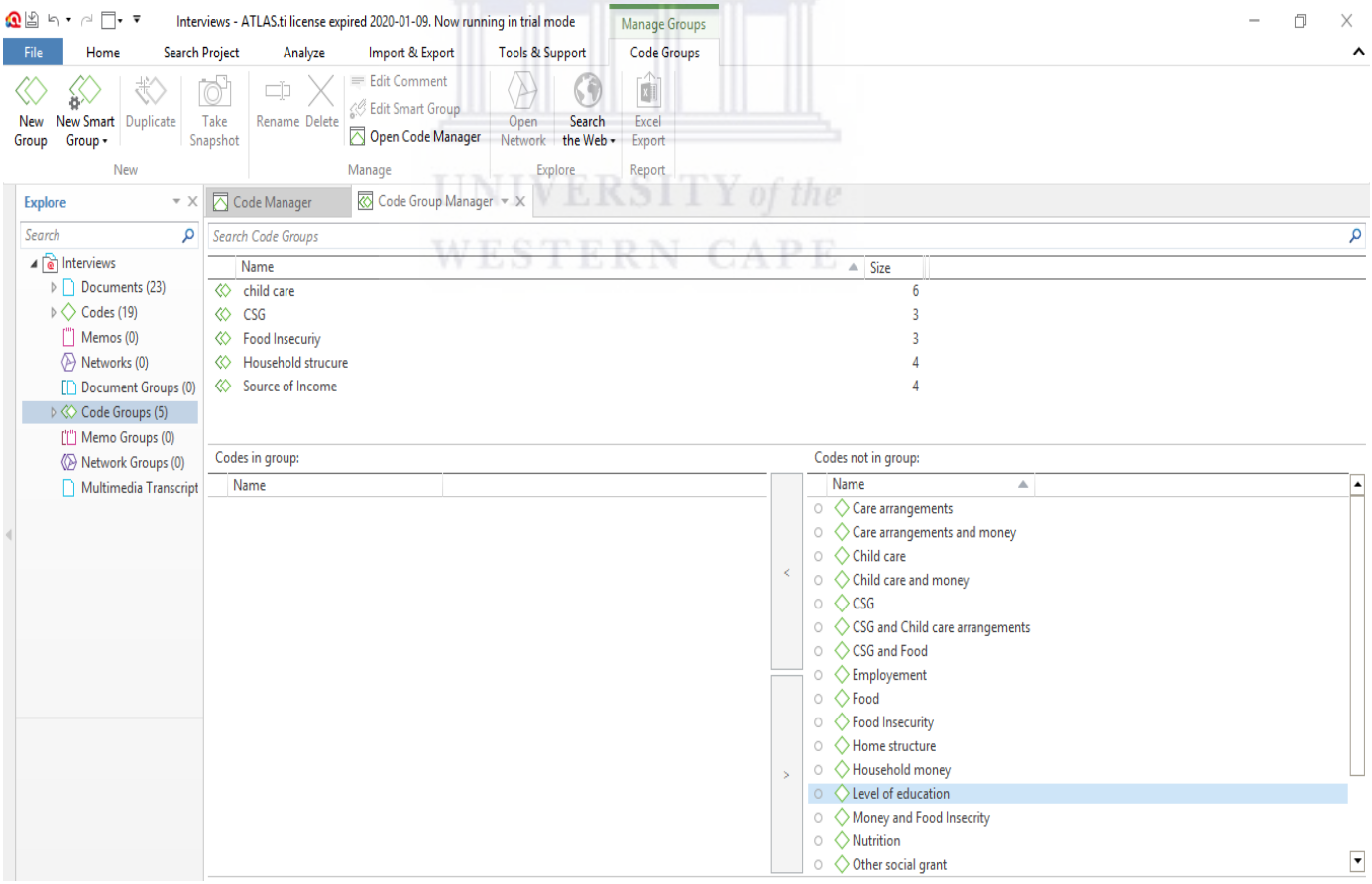
Source: Survey data

APPENDIX 2: HOUSEHOLD HUNGER SCALE

No.	Question	Response option	Code
Q1	In the past [4 weeks/30 days], was there ever no food to eat of any kind in your house because of a lack of resources to get food?	0 = No (Skip to Q2) 1 = Yes	|___|
Q1a	How often did this happen in the past [4 weeks/30 days]?	1 = Rarely (1–2 times) 2 = Sometimes (3–10 times) 3 = Often (more than 10 times)	|___|
Q2	In the past [4 weeks/30 days], did you or any household member go to sleep at night hungry because there was not enough food?	0 = No (Skip to Q3) 1 = Yes	|___|
Q2a	How often did this happen in the past [4 weeks/30 days]?	1 = Rarely (1–2 times) 2 = Sometimes (3–10 times) 3 = Often (more than 10 times)	|___|
Q3	In the past [4 weeks/30 days], did you or any household member go a whole day and night without eating anything at all because there was not enough food?	0 = No (Skip to the next section) 1 = Yes	|___|
Q3a	How often did this happen in the past [4 weeks/30 days]?	1 = Rarely (1–2 times) 2 = Sometimes (3–10 times) 3 = Often (more than 10 times)	|___|

APPENDIX 3: ATLAS TI DATA ANALYSIS





ANNEXURE 1: FOCUS GROUP DISCUSSION – TOPIC GUIDE

CHILD CARE ARRANGEMENTS

What are the most common child care arrangements in the community?

Probes:

- Who are the primary caregivers to the children?
- Who is most likely to care for your child(ren) besides their parents?
- What are the most preferred care arrangements in the community?
- What are the existing child care arrangements in the households?
  - Probe for reasons
  - Any cost involved in existing care arrangements?
  - If yes, how do people pay for such arrangements?
- Which alternative care arrangements do you prefer (day care centre, nannies, extended families, etc.)?
  - Probe for reasons
  - Would they cost you money? If so, how much?
  - If so, how do you pay for them?

CHILD SUPPORT GRANT

What is the main source of income for the majority of people in this community?

Probes:

- How reliant are households in this community on social grants and the CSG in particular?
- What, if any, are the community/cultural norms/rules regarding when new mothers should go out of the home to attend to personal business in town, such as applying for the CSG or looking for work?

- When do new mothers generally start applying for the CSG and how long does it normally take for them to receive their first grant payment?
- When do new mothers go back to work if they are employed or when do they go out to seek jobs if they are not working?
- What might affect a new mother's decision about when to apply for the CSG after the birth of her child?

THE CSG AND ACCESS TO FOOD

How do people access food in this community?

Probes:

- Where do most people buy food (spazas, local supermarkets, national food chain stores [Shoprite, Spar])?
- What influences people's choices about where to buy (prices? accessibility? variety? access to credit?)
- Does the access to food vary during the course of the month? Is seasonality an issue?
- How has access to the CSG affected the availability of food in households?

FOOD INSECURITY, THE CSG AND CHILD CARE ARRANGEMENTS

How do you think access to food and the accessibility of the CSG affect the care arrangements that parents choose?

Probes:

- How do you think food insecurity affects decisions regarding the care arrangements in households?
    - If you were food secure, which care arrangements would you choose and why?

- Are food insecure households more likely to experience child care instabilities?
    - Probe for reasons.
- How does access to the CSG contribute to the child care arrangements that households in the community have?
- How likely are CSG non-recipients to experience care arrangement instabilities?
    - Probe for reasons.
- How does the accessibility of the CSG affect the likelihood of care arrangement instabilities?
    - Probe for reasons.

ANNEXURE 2: TOPIC GUIDE FOR INDIVIDUAL PARTICIPANTS

(Mothers of children)

CSG STUDY TOPIC GUIDE

Before the interview:

1. Introduce myself to interviewee; provide brief explanation of study topic, study purpose: "We are conducting a study about child care arrangements and food insecurity. We are especially interested in the experiences of mothers who are food insecure and the care arrangements they put in place for their children. This is important as it will help us understand how food insecurity impacts child care arrangements in households with mothers who are CSG recipients and non-recipients, and whether CSG plays a role in reducing care arrangement instabilities."
2. Read Information Sheet, reassure confidentiality, signing of consent form.
3. State expected length of interview – 1 hour max.
4. Explain interview process: "This interview is really about getting a sense of how your life is here at home and your experience of raising and providing for your children. I am going to start off by asking you broad questions about your general home life, how you are living here with your family and children. Then I will move on to specific questions about your children, the household child care arrangements, access to the child support grant, and access to food."

Topic guide:

1. Please tell me a little about yourself:
    a. Home life
        - Age, education
        - Who you live with (family, children – including ages)
        - Employment

- Interests/activities during a typical week

2. Tell me about your household child care arrangements:

    a. Who is (are) the child(ren)'s primary caregiver?

    b. Are there any other people who take care of your child(ren)? If so, who are they?

        - Probe for reasons

    c. Do you sometimes have to leave your child(ren) with other people who are not members of your household?

        - How often do you leave them with these people?
        - Probe for reasons

    d. Who are your support networks (neighbours, friends, relatives, sexual partners)?

    e. Do you take your child(ren) to an ECD centre?

        - If so, for how long (days per week/hours per day)?

        - How much do you pay for these services?

        - How do you pay for them?

    f. Do you use the services of babysitters or nannies?

        - How often?

        - Probe for reasons

    g. What role do you think money plays in the child care arrangements that you choose?

        - Probe for reasons

    h. If you had 'enough' money, would you choose different care arrangements?

        - What would they be and why?

3. Food insecurity questions:

    a. How many times do you and your child(ren) eat per day?

        - Probe for the types of meals they eat and how often they eat

    b. Do you sometimes worry about what you and your child(ren) are going to eat?

        - Probe for reasons

    c. Tell me about the source of food for your household

        - Who buys the food?

        - Where do you buy food (spazas, local supermarkets, national food chain stores [Shoprite, Spar])?

    d. Do you have a secondary source of food besides the one mentioned above?

        - Probe for food parcels, donations, gifts, etc.

    e. What role do you think having enough/adequate food or not having enough plays in the care arrangements you chose for your child(ren)?

        - Probe for reasons

        - Probe for preferred child care arrangements

4. CSG-specific questions:

    a. Tell me about all the sources of income in this household (look out for mention of the CSG)

    b. Probe for child maintenance

    c. If not in receipt of the CSG: Why are you not receiving the CSG for your child(ren)? Probe for barriers to accessing the CSG.

    d. What kinds of expenses do you use the CSG for? Probe for food, schooling, and medical costs.

e. What proportion of the CSG pays for food (half, almost all, etc.)?

f. What impact does having the CSG (or the lack of it) have on the existing child care arrangements?

- Probe for reasons and examples.

End

- Reiterate confidentially: "I just want to remind you again that everything we have discussed here will remain between me, the research team in this study and yourself. No outside person will have access to this information, and your name will not be on any of the publications and reports that will be written about this study."
- "I am going to leave the information sheet I read to you at the beginning of this session with you so that you can read it again in your own time. If any other questions or concerns should come up after this interview, please feel free to contact me or send me a "please call me" on 082 550 6818 or a WhatsApp message on 084 895 7152."

Thank you….

ANNEXURE 3: INFORMATION SHEET

UNIVERSITY *of the*
WESTERN CAPE

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2852 Fax: 27 21-959 2755

E-mail: **chs-deansoffice@uwc.ac.za**

INFORMATION SHEET

Project Title: Assessing the relationship between food insecurity, the child support grant and child care arrangements

What is this study about?

This is a research project being conducted by Babalwa Pearl Tyabashe at the University of the Western Cape. We are inviting you to participate in this research project because you have been identified as a participant of the on-going cohort study. The purpose of this research project is to determine and explore the relationship between food insecurity, the child support grant and child care arrangements.

What will I be asked to do if I agree to participate?

You will be asked to engage in an interview and/or participate in a focus group. The information we are seeking is your experiences regarding food insecurity, child care arrangements and the child support grant. The interviews will take place in the comfort of your own home or a venue of your choosing, where you will be comfortable and the focus group discussions will be held at a mutually agreed upon venue that all participants are comfortable with. The interview and focus group discussion will be 1 hour long, or even less. The questions that will be asked are about your current child care arrangements, how food insecurity affects the care arrangements and how the child support grant assists.

Would my participation in this study be kept confidential?

The researchers undertake to protect your identity and the nature of your contribution. To ensure your anonymity, the surveys are anonymous and will not contain information that may personally identify you. If applicable, (1) your name will not be included on the surveys and other collected data; (2) a code will be placed on the survey and other collected data; (3) through the use of an identification key, the researcher will be able to link your survey to your identity; and (4) only the researcher will have access to the identification key.

To ensure your confidentiality, the data that will be collected will be transcribed and filed. The hand-written transcriptions will be stored in a locked cabinet and typed documents will be stored in a computer that is protected by a password known by the researcher only. On data forms, your name won't be used but there will be a code allocated to you. If we write a report or article about this research project, your identity will be protected.

This study will use focus groups. Therefore, the extent to which your identity will remain confidential is dependent on participants in the focus group discussions maintaining confidentiality.

What are the risks of this research?

There are no known risks to participating in this study as it is non-invasive and it concerns a well-known topic. However, it is recognised that questions may be asked about issues that may be perceived as sensitive by some research participants and that some questions may evoke sadness or painful recollections. During the initial consent phase, participants will be informed that they will be asked various things about their lives and that this may include information that they may not be comfortable to talk about or that they may find painful or sad to think about. We will try to minimise the risk of this happening by informing the research participants that they do not have to answer questions that they are not comfortable with, and that they may stop the interview if they do not wish to continue. Interview data will be collected in a safe, private place where no other people but the fieldworker and participant will be present. Also, no personal names will be recorded and the participants will be anonymised through the use of unique participant numbers.

All human interactions and talking about self or others carry some degree of risk. We will nevertheless minimise such risk and act promptly to assist you if you experience any discomfort (psychological or otherwise) during your participation in this study. Where necessary, an appropriate referral will be made to a suitable professional for further assistance or intervention.

What are the benefits of this research?

It will be was made clear to participants that there is no direct benefit or cost of participation in the study. Researchers will travel to the participant's home or to any location that the participant feels comfortable to talk in. If travel costs are incurred by participants, the project will reimburse the cost. Participants will also be reimbursed for their time. The amount of the reimbursement will be R100 per person.

What if I have questions?

This research is being conducted by Babalwa Pearl Tyabashe, a Master's student at the University of the Western Cape. If any other questions or concerns should come up after this interview, please feel free to contact me or send me a WhatsApp message on: 082 550 6818.

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Prof E.C Swart
Head of Department
University of the Western Cape
Private Bag X17
Bellville 7535
r.swart@uwc.ac.z

Prof José Frantz
Dean of the Faculty of Community and Health Sciences
University of the Western Cape
Private Bag X17
Bellville 7535
chs-deansoffice@uwc.ac.za

ANNEXURE 4: FOCUS GROUP CONFIDENTIALITY BINDING FORM

UNIVERSITY of the
WESTERN CAPE

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Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2852 Fax: 27 21-959 2755

E-mail: chs-deansoffice@uwc.ac.za

FOCUS GROUP CONFIDENTIALITY BINDING FORM

Title of Research Project: Assessing the relationship between food insecurity, the child support grant and child care arrangements

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone by the researchers. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits. I understand that confidentiality is dependent on participants in the focus group maintaining confidentiality.

I hereby agree to uphold the confidentiality of the discussions in the focus group by not disclosing the identity of other participants or any aspects of their contributions to members outside of the group.

Participant's name……

Participant's signature……..

Date……..

ANNEXURE 5: CONSENT FORM

UNIVERSITY of the
WESTERN CAPE

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Private Bag X 17, Bellville 7535, South Africa

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CONSENT FORM

Title of Research Project: Assessing the relationship between food insecurity, the child support grant and child care arrangements

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits.

Participant's name……...

Participant's signature…….

Date……..…