Well-being of South African Children: Household, Community and Policy Influences

Jake Leos-Urbel

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Overview

- Background
- The South African context
- Cash transfers (education & health)
- Aims of the study
- Study design
- Implications for causal inference

Background

- Funded by the National Institute for Health (NIH)
- Research partnership with the Human Sciences Research Council (HSRC) in South Africa

The Big Question

- How can government policies best help children in high needs South African communities?

  – How to improve cash benefits and services for these children?

South African Context

- Sixty percent of South African Children live in households with annual incomes under $2000 USD (Children's Institute, 2006).

- 5.3 million adults and children living with HIV/AIDS; more than any other country (UNAIDS/WHO, 2005).

- Overall HIV/AIDS prevalence rate is 11%, but it is over 30% among pregnant women attending public antenatal services in the worst affected areas (Department of Health, 2004).

- About 14% of all children 2-18 years of age have lost one or both parents. About half of these are orphaned due to HIV/AIDS. (Shisana et al., 2005)

Kwazulu-Natal

Cash Transfers

- Conditional Cash Transfers (CCTs)
  - Cash transfer conditioned on behavior (e.g. school attendance, health clinic visits)
  - Aim to meet short-term financial needs and promote investment in human capital
  - Research finds increased school enrollment, and attendance in some places, but little documented impact on achievement
  - Research finds some improved health impacts

Cash Transfers

- Unconditional Cash Transfers
  - Usually targeted to low-income families, without behavioral conditions for grant receipt
  - Some evidence from South Africa that grants increase school attendance
 - Limited research evidence on health outcomes

Cash grants that benefit children in South Africa

- Child Support Grant (CSG)

- Foster Care Grant

- Care Dependency Grant

- Old Age Pension

- *Proposed Conditional Cash Transfer would have been equivalent to 40% of CSG*

AIM 1: Household Influences

- What are the associations between household risk factors and adverse childhood experiences?

- What are the associations between adverse childhood experiences and children's psychosocial functioning, educational and health status?

Figure 1. Micro-Level Model of Influence of Major Household Risk Factors on Children's Adverse Experiences and Well-Being
(adapted in part from Foster & Williamson, 2000)
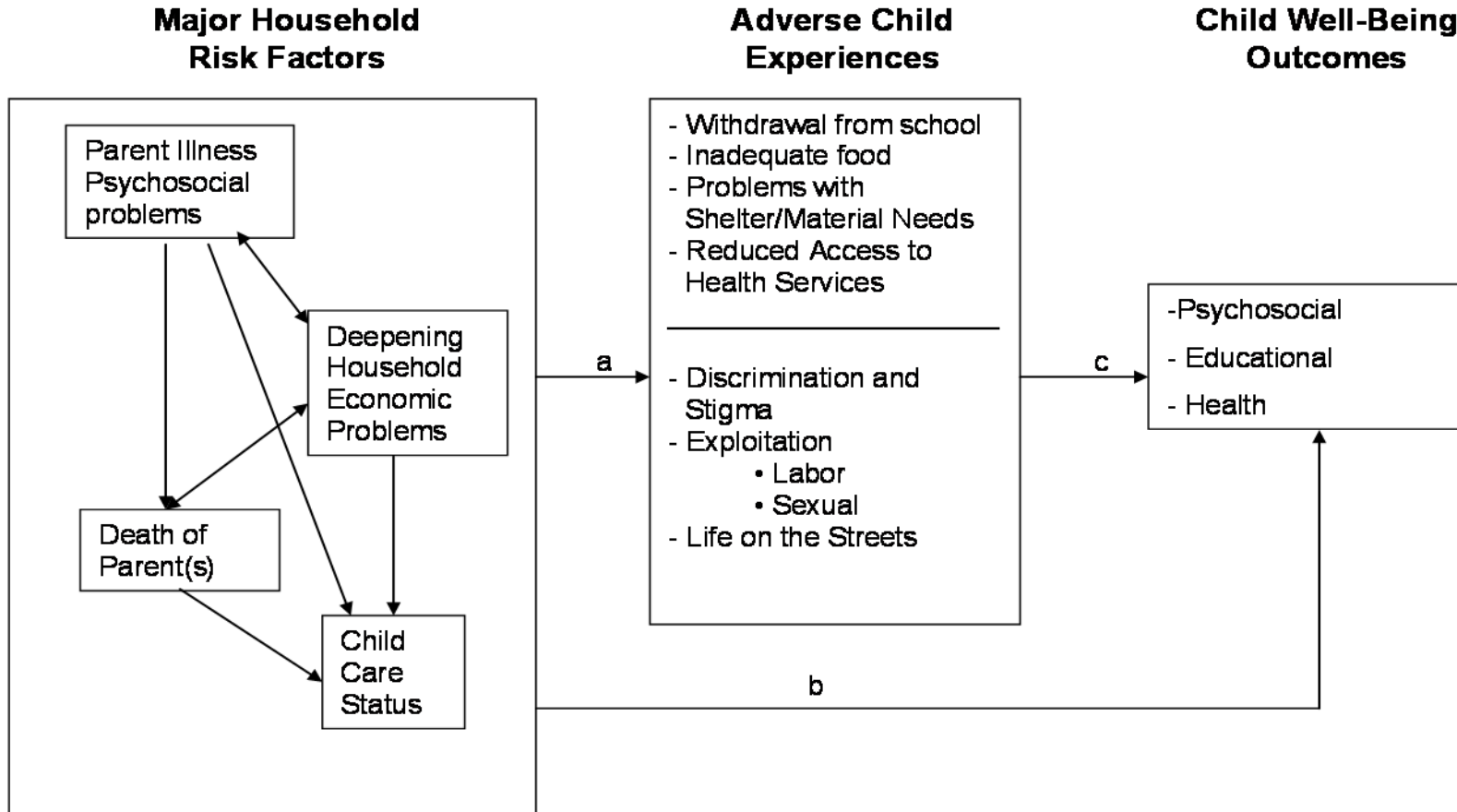
AIM 2: Community Influences

- To what degree do community factors moderate the influence of household risk factors on adverse childhood experiences, and in turn on key child psychosocial, educational and health outcomes?

Original AIM 3: Policy Influences

- What are the effects of CCTs on household conditions, children's adverse experiences, and children's outcomes?

Original Study Design

Community Randomization

– Kwazul-Natal Province

– 60 communities

– 6,000 households, screened for poverty

– Treatment: New CCT

Revised Study Aim 3

- **<u>AIM 3: Program/Policy Influences.</u>**
  - What factors explain differential take-up of services and benefits by households and children?
  - What is the impact of basic and complementary benefits and services on household process and children's adverse experiences and well-being (controlling for selective uptake)?

Revised Study Design

- Quasi-experimental
  - Kwazulu-Natal
  - 24-30 spatial communities
  - 1,800 households, not screened for income
  - Treatment: take up of existing grants
- Data collection
  - Baseline
  - 18-24 months (random)

Implications for Causal Inference

- Estimating effects of grants and services on children

- Requires successfully modeling selective take-up of grants and services
  - Understanding factors that could bias estimates

- Baseline at which to consider policy innovation

Professional Development

- Study Design
  - Identifying and developing measures
  - Policy context
- Adapting design to real world constraints
- Possible paper topic
  - Relative foster care: CSG vs. foster care grant