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To cite this article: ML Marais, E Lessing & T Frank (2021): Assessment of the realisation of the right to adequate food in the Blue Crane Route (Eastern Cape, South Africa), South African Journal of Clinical Nutrition, DOI: [10.1080/16070658.2021.1996754](https://doi.org/10.1080/16070658.2021.1996754)

To link to this article: <https://doi.org/10.1080/16070658.2021.1996754>



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Published online: 19 Nov 2021.



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Assessment of the realisation of the right to adequate food in the Blue Crane Route (Eastern Cape, South Africa)

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Objectives: To assess whether the right to adequate food (RtF) is realised by children and primary caregivers and what actions are required to fully realise this right.

Design: A cross-sectional, descriptive study was undertaken using a mixed-methods approach.

Setting and subjects: Rural and urban primary caregivers of children (one to five years old) were recruited if they had resided in the Blue Crane Route (Eastern Cape) for at least six months. Purposefully selected key informants (KIs) involved in nutrition and food security, health or governance participated in in-depth interviews.

Outcome measures: Primary caregivers responded to interviewer-administered questionnaires (IAQ) ($N = 161$), which investigated various indicators supporting the realisation of the RtF. Statistical analysis of quantitative data examined relationships between urban and rural participants. Significance was considered at $p < 0.05$. In-depth interviews with key informants (KIs) examined the perceptions of 11 prominent community leaders. Qualitative data were coded deductively and common themes identified.

Results: Based on the IAQ, half (51%) of the caregivers had experienced risk of, or food insecurity in the past month. Common themes indicative of suboptimal realisation of the RtF included insufficient employment opportunities, inadequate policies and programme implementation, and inadequate agrarian practices, while the child support grant partially supported the realisation of the RtF. Caregivers felt disempowered by a sense of inability to realise the right themselves without government assistance but KIs suggested that caregivers needed to take responsibility.

Conclusion: The RtF of children and their caregivers is not fully realised in the Blue Crane Route. Concerted, multidisciplinary approaches using a rights-based approach to implement policies and programmes are needed, together with the empowerment of the community with necessary skills and resources to further the realisation of the RtF.

Keywords right to food, food security, children, Eastern Cape

Introduction

Global and in-country commitments to the realisation of the right to adequate food (RtF) are not reflected in the situation experienced by communities in South Africa. Despite international recognition of the RtF as a fundamental human right,¹ undernutrition affects 13% of the population in developing countries.² There is enough food available globally³ but the unequal distribution and lack of access to food^{2–5} still results in many food-insecure individuals. The South African government has made a commitment to the progressive realisation of the RtF by ratifying international Human Rights instruments^{1,6,7} and embedding the RtF and nutrition in the Constitution.^{5,8} Yet, 26% of the country's population remain food insecure⁹ with more than half a million South African households with children aged five years or younger experiencing hunger.³

Previously food insecure households were more likely to be situated in rural areas;⁹ however, food insecurity has now become more prevalent in urban areas.^{10,11} More than 60% of South African households experiencing hunger are in urban areas.³ Urban informal settlements are characterised by poor food production and availability, low incomes and inadequate spending power.¹² Furthermore, between 2011 and 2016 South African data have shown a decline in the proportion of households involved in agricultural activities.³ Urban food insecurity is

caused not only by unavailability but by problems pertaining to employment patterns and the spatial configuration of the city.^{12,13} Although urban households have a more diverse food intake than their rural counterparts,¹⁴ the types of food consumed do not impact positively on healthy dietary intake.¹³ A dietary intake with inadequate micronutrients leaves one vulnerable to nutritional deficiencies and chronic diseases of lifestyle.^{15–17}

The Eastern Cape is the most food insecure province in South Africa, with four out of every five households experiencing hunger,⁹ leaving women and children most vulnerable to its effects.¹⁵ This research used a human-rights-based approach (HRBA) that recognises empowerment, participation and non-discrimination as essential components to reduce the causes of malnutrition in a sustainable manner.¹⁵ This HRBA was followed to investigate role players (referred to as duty-bearers), who contribute to realising the rights of the child (as the right-holder) at different levels. These levels of responsibility are equated to nested circles of responsibility with the child in the centre of the nest.¹⁸ Parents and immediate family who ensure that their child is nurtured form the inner circle around the child, while the government forms the outer circle of protection. If the inner circles fail to meet their responsibility as duty-bearer, the outer circles need to fulfil the obligation.^{18,19} This study aimed to investigate whether the RtF was realised

and what the determinants were that related to the realisation of the RtF of children (aged 1–5) and their primary caregivers living in rural and urban areas in the Blue Crane Route region of the Cacadu District in the Eastern Cape. The intention of this study was to identify gaps in realising the RtF in the Blue Crane Route, and how these gaps could be bridged.

Methodology

Study design and sampling

A cross-sectional, descriptive study employing a mixed-methods approach was conducted in the Blue Crane Route to have a better understanding of the realisation of the RtF of children one to five years old and their primary caregivers. For this study the definition of the primary caregiver is the person who lives with the child and is mainly responsible for the upbringing and care of the child, namely the mother, father or grandparent.

The Blue Crane Route is a predominantly agrarian area in the Cacadu District of the Eastern Cape of South Africa and includes three towns: Somerset East, Cookhouse and Pearston. It has a population of 36 002 people, of whom 80% reside in urban areas and 4 069 are between the ages of one and five years.²⁰ For a representative sample, a minimum sample size of 119 participants was calculated using the Bernoulli Trial with a *p*-value of 0.5, a confidence percentage of 95 and an error percentage of 9. The higher error percentage was chosen due to logistical and time constraints. To ensure the same proportion was achieved within the study sample as the general population, 80% were urban and 20% were rural participants.

Interviewer-administered questionnaires (IAQ) and in-depth interviews were used to explore the household situation and perceptions of caregivers and key informants (KIs). Capacity gaps of duty-bearers that inhibit the full realisation of the RtF were examined during the IAQs and KI interviews.

The persons identified for the KI interviews were purposefully selected provided they had worked in the study area for the past 12 months. Key role-players acting as duty-bearers involved in nutrition and food security, health or governance in the Blue Crane Route Local Municipality region were approached to participate in the study.

Rural and urban primary caregivers of children (one to five years old) were recruited to complete IAQs if they had been living in the Blue Crane Route for at least six months. All caregivers present at the clinic who were well enough to participate and met the selection criteria were invited to participate voluntarily until the sample size was met. Selection criteria included ability to speak English, Afrikaans or isiXhosa, and presence of a child between the age of one to five, residing with the primary caregiver.

All urban clinics (*n* = 6) in the Blue Crane Route were visited on various weekdays. Mobile clinics, which cover different routes each day, were used to gain access to rural participants. Because the roads were in poor condition and the farms were difficult to find, the researcher accompanied the clinic sisters on their mobile clinic visits. For logistical reasons, two mobile clinics that operated from the largest town, Somerset East, were accompanied for data collection. To ensure that random selection of study participants was enforced when visiting mobile clinics, the researcher went on whichever route the mobile clinic sister had scheduled for that day.

Data collection

Data were collected between September 2013 and January 2014. All interviews were conducted by one of the authors (TF), a registered dietitian fluent in English and Afrikaans. She was assisted during the IAQs by an isiXhosa interpreter, a social worker trained and standardised in questionnaire techniques, before data collection began. The interpreter also translated into English before data analysis isiXhosa responses to open-ended questions.

IAQs, which took on average 30 minutes to complete, were done in the caregiver's preferred language. The questionnaire consisted of three sections: the first section included sociodemographic questions relating to the child and primary caregiver's information, household information and the household income. The second section contained questions to ascertain food security as a measure to assess whether the RtF is realised for children and their primary caregivers. These questions were adopted from the National Food Consumption Survey,²¹ the South African Food Insecurity and Vulnerability Information and Mapping System²² and the Childhood Hunger Identification Project hunger score.²³ This section consisted of 7 questions assessing the food security situation of the child and family; and 11 questions exploring food insecurity coping strategies. The number and type of meals eaten the previous day, dietary diversity, hunger months, household income spent on food, and coping methods when experiencing hunger were investigated. The standardised dietary diversity score (DDS)²⁴ was adjusted and food groups were combined to shorten the questionnaire. Dietary diversity was defined as low (less than four different food groups consumed on the day prior to the questionnaire), medium (four to five food groups) or high (six or more food groups). The seven food groups included in this comparison were starch, protein, vegetables, fruit, legumes, dairy and fats. The third section contained seven open-ended questions investigating caregiver perceptions of ways to improve food security and the realisation of the RtF. Responses to open-ended questions were written down verbatim and used to gain an understanding of caregivers' perceptions concerning their food security situation.

Purposefully selected KIs participated in in-depth interviews lasting approximately 50 minutes. A semi-structured discussion guide was used and themes discussed included food security, perceived obstacles to the realisation of the RtF and suggestions for improvement. Interviews were voice recorded with consent and transcribed verbatim. All transcriptions were checked to ensure a true version of the original interview was obtained. The number of KIs interviewed was informed by data saturation.

Face validity of the IAQ was evaluated by 10 caregivers of children during a pilot study at Andries Vosloo Hospital in Somerset East during September 2013. This hospital was chosen as it provided access to the study population and was not one of the points used for data collection of the study. Data from the pilot study were excluded and minor changes were made to the IAQ. The questionnaire was submitted to two experts in the field of food security and the RtF, who evaluated the content validity of the questionnaire and its relevance to meet the aims of the study.

Ethics approval was granted by the Health Research Ethics Committee at Stellenbosch University (S13/05/095) and permission to conduct the research was obtained from the Eastern Cape

Department of Health. Participants gave informed written consent. Confidentiality and anonymity were ensured by using participant codes.

Data analysis

Quantitative data were captured using Microsoft Excel (Microsoft Corp, Redmond, WA, USA) while the computer programs STATISTICA version 10 (TIBCO Software, Palo Alto, CA, USA) and IBM SPSS version 22 (IBM Corp, Armonk, NY, USA) were used for statistical analysis. Contingency tables were used to present results, and the Pearson chi-square test (or Fisher's exact test for counts of less than five) was used to examine differences between urban and rural participants. Significance was considered at $p < 0.05$. Qualitative data obtained from the open-ended questions in the IAQs were coded deductively to sort responses into categories and themes. The content of the interviews with the KIs was summarised into discussion points by means of deductive coding and identifying common themes.

Results

Background

In total, 161 primary caregivers of children between one and five years old participated in the study (78% urban, 22% rural). Caregivers were mostly female (99.4%; $n = 160$), and had a mean age of 32 years (range 17–73 years) (Table 1).

Table 1: Sociodemographic information of caregivers ($N = 161$) and key informants ($N = 11$)

Category	Urban ($n = 126$) n (%)	Rural ($n = 35$) n (%)	Total ($N = 161$) n (%)
Caregivers ($N = 161$)			
Gender:			
Female	125 (77.6)	35 (21.7)	160 (99.4)
Male	1 (0.6)	0 (0.0)	1 (0.6)
Age: [#]			
15–19 years	7 (4.3)	5 (3.1)	12 (7.5)
20–29 years	57 (35.4)	20 (12.4)	77 (47.8)
30–39 years	32 (19.9)	5 (3.1)	37 (23.0)
40–49 years	13 (8.1)	5 (3.1)	18 (11.2)
> 49 years	17 (10.6)	0 (0.0)	8 (5.0)
Level of education:			
No schooling	6 (3.7)	0 (0.0)	6 (3.7)
Grd 0–4	11 (6.9)	1 (0.6)	12 (7.5)
Grd 5–7	20 (12.4)	23 (14.3)	43 (26.7)
Grd 8–10	36 (22.4)	10 (6.2)	46 (28.6)
Grd 11–12	48 (29.8)	1 (0.6)	49 (30.4)
Further qualification	5 (3.1)	0 (0.0)	5 (3.1)
Key informants ($N = 11$)			
Age: ^{##}	Female n (%)	Male n (%)	Total n (%)
30–39 years	1 (9.1)	2 (18.2)	3 (27.3)
40–49 years	1 (9.1)	2 (18.2)	3 (27.3)
50–59 years	3 (27.3)	0 (0.0)	3 (27.3)
60–69 years	2 (18.2)	0 (0.0)	2 (18.2)
Total	7 (63.6%)	4 (36.4%)	11 (100.0)

[#]Ages ranged from 17 to 73 years. Mean age 32 years. Standard deviation ± 11.92 .
^{##}Ages ranged from 31 to 66 years.

Eleven (seven female, four male) respected and influential role-players in the community participated as KIs. They represented various sectors in the community and included: a hospital manager, nursing services manager, Integrated Nutrition Programme manager; a social worker, two clinic supervisors, two officials from the Department of Agriculture, two members of community services committee and a hospice support group coordinator. Their ages ranged from 31 to 66 years (Table 1).

Aspects of food security relevant to the realisation of the right to adequate food

Nearly half of the caregivers (42.2%, $n = 68$) were at risk of food insecurity and 8.7% ($n = 14$) were food insecure for five or more days during the past month (Table 2). Based on the DDS, caregivers had consumed mostly energy-dense food sources with a high carbohydrate, sugar and/or fat content and beverages on the previous day. Urban participants consumed significantly more protein-rich foods (77.0%, $n = 97$ versus 57.1%, $n = 20$; $p = 0.02$), vegetables (57.1%, $n = 72$ versus 14.3%, $n = 5$; $p < 0.001$) and fruit (45.2%, $n = 57$ versus 20.0%, $n = 7$; $p = 0.007$) than the rural sample.

Caregivers had experienced hunger for a mean of 2.5 months in the past year due to a shortage of food. Caregivers had inadequate money to purchase food and 13.9% (20/144) were spending less than R100 per week on food for the household. As a coping mechanism, caregivers (35.4%, $n = 57$) had purchased food on credit for up to 10–12 months of the previous year (31.6%, $n = 18$). A third of all caregivers (34.8%, $n = 56$) borrowed food from others, and this most commonly occurred for one to three months of the year (64.3%, $n = 36$) (Table 3).

Capacity gaps of duty-bearers in the realisation of the right to adequate food in the study population

Inadequate living standards. More urban caregivers (91.3%, $n = 115$) had access to their own tap either in their house or garden, as opposed to the rural caregivers (20.0%, $n = 7$). The majority of caregivers (80.6%; $n = 129$) reported using a flush toilet, although only a quarter of the rural caregivers (23.5%, $n = 8$) had flush toilets. Most caregivers (81.4%, $n = 131$) reported using electricity for cooking but half of the caregivers living in rural areas used an open fire or a wood/coal stove (45.7%, $n = 16$).

Barriers to entering the workforce. Unlike the perception held by KIs, caregivers indicated men had more job opportunities (65.6%, $n = 82/125$). Fewer rural (74.3%, $n = 26$) than urban households (92.9%, $n = 117$) had employed adults and the overarching reason was a lack of work opportunities (60.1%, $n = 86$). Urban caregivers gave receiving an income from social support grants (36.8%, $n = 43$) as a reason for unemployment (Table 3).

Caregivers felt it was important that their children should attend school to enhance future employability: 'I didn't have the opportunity to finish school and am now unemployed; I don't want that to happen to my children.' There was a strong plea from one KI towards encouraging the youth to start enterprises, although there was a perceived resistance and youth were regarded as lazy because they 'have taken a back seat in taking ownership of their livelihoods' (Table 4).

Need for social grants as source of income. The majority of caregivers (90.7%, $n = 146$) relied on social grants as a source of income. The child support grants (CSG) had the highest

Table 2: Category of food insecurity and dietary diversity categories

Category of food insecurity	At some point within the past 30 days				Five or more days in the past 30 days			
	Urban sample (n = 126) n (%) or mean (SD)	Rural sample (n = 35) n (%) or mean (SD)	Total sample (N = 161) n (%) or mean (SD)	p-value	Urban sample (n = 126) n (%) or mean (SD)	Rural sample (n = 35) n (%) or mean (SD)	Total sample (N = 161) n (%) or mean (SD)	p-value
Food insecure	24 (19.0)	10 (28.6)	34 (21.1)	–	10 (7.9)	4 (11.4)	14 (8.7)	–
At risk of food insecurity	72 (57.1)	18 (51.4)	90 (55.9)	–	52 (41.3)	16 (45.7)	68 (42.2)	–
Food secure	30 (23.8)	7 (20.0)	37 (23.0)	–	64 (50.8)	15 (42.9)	79 (49.1)	–
Overall food security score	2.4 (±2.2) At risk	3.2 (±2.6) At risk	2.6 (±2.3) At risk	0.120	1.3 (±1.8) At risk	1.6 (±2.0) At risk	1.4 (±1.9) At risk	0.511
Dietary diversity categories	Primary caregivers				Children			
	Urban Sample (n = 126) n (%) or mean (SD)	Rural Sample (n = 35) n (%) or mean (SD)	Total Sample (N = 161) n (%) or mean (SD)	p-value	Urban Sample (n = 126) n (%) or mean (SD)	Rural Sample (n = 35) n (%) or mean (SD)	Total Sample (N = 161) n (%) or mean (SD)	p-value
Low Dietary Diversity (≤ 3 food groups)	38 (30.2)	19 (54.3)	57 (35.4)	–	32 (25.4)	18 (51.4)	50 (31.1)	–
Medium Dietary Diversity (4–5 food groups)	70 (55.6)	15 (42.9)	85 (52.8)	–	68 (54.0)	15 (42.9)	83 (51.6)	–
High Dietary Diversity (6–7 food groups)	18 (14.3)	1 (2.9)	19 (11.8)	–	26 (20.6)	2 (5.7)	28 (17.4)	–
Overall Dietary Diversity Score	4.1 (±1.5) Medium	3.6 (±1.1) Low	4.0 (±1.5) Medium	0.018*	4.4 (±1.4) Medium	3.7 (±1.2) Low	4.3 (±1.4) Medium	0.005*

Chi-square was used to find differences by urban/rural residence. Significant at *P*-value < 0.05; identified by *.

Table 3: Reasons given by caregivers for unemployed adults in households ($n = 143$), type of grants received as a source of income ($N = 161$) and coping mechanisms used by caregivers to manage shortages of income and/or food ($N = 161$) in the Blue Crane Route

Reasons adults unemployed [#]	Urban ($n = 117$) n (%)	Rural ($n = 26$) n (%)	Total ($n = 143$) n (%)	p -value
Lack of work opportunities	71 (60.7)	15 (57.7)	86 (60.1)	0.157
Receive an income from a social support grant	43 (36.8)	4 (15.4)	47 (32.9)	0.009*
Poor health preventing ability to work	20 (17.1)	3 (11.5)	23 (16.1)	0.275
No desire to work	3 (2.6)	1 (3.8)	4 (2.8)	0.629
Caring for the family	33 (28.2)	4 (15.4)	37 (25.9)	0.066
Still studying	12 (10.3)	2 (7.7)	14 (9.8)	0.479
Type of grant	Urban ($n = 126$) n (%)	Rural ($n = 35$) n (%)	Total ($N = 161$) n (%)	p -value
Child support grant	122 (96.8)	21 (60.0)	143 (88.8)	< 0.001*
Old age pension	43 (34.1)	4 (11.4)	47 (29.2)	0.009*
Disability grant	12 (9.5)	1 (2.9)	13 (8.1)	0.200
Foster care grant	4 (3.2)	0 (0)	4 (2.5)	0.371
Care dependency grant	2 (1.6)	1 (2.9)	3 (1.9)	0.523
Coping mechanisms	Urban ($n = 126$) n (%)	Rural ($n = 35$) n (%)	Total ($N = 161$) n (%)	p -value
Borrowed food from others	39 (31.0)	17 (48.6)	56 (34.8)	0.053
Borrowed money from employer to purchase food	13 (10.3)	15 (42.9)	28 (17.4)	< 0.001*
Took loan out from financial company to buy food	17 (13.5)	4 (11.4)	21 (13.0)	0.748
Begged for food	8 (6.3)	10 (28.6)	18 (11.2)	< 0.001*
Had to work for food in kind	30 (23.8)	9 (25.7)	39 (24.2)	0.816
Received food as a gift	38 (30.2)	13 (37.1)	51 (31.7)	0.432
Received food parcel/nutritional supplements	16 (12.7)	1 (2.9)	17 (10.6)	0.094
Purchased food on credit	39 (31.0)	18 (51.4)	57 (35.4)	0.025*
Coping mechanisms ^{##}	Urban ($n = 126$) n (%)	Rural ($n = 34$)	Total ($n = 160$)	p -value
Had to eat wild food through hunting/gathering	1 (0.8)	11 (32.4)	12 (7.5)	< 0.001*
Coping mechanisms ^{##}	Urban ($n = 30$) n (%)	Rural ($n = 15$) n (%)	Total ($n = 45$) n (%)	p -value
Ate food they grew themselves	26 (86.7)	14 (93.3)	40 (88.9)	0.502
Coping mechanisms ^{##}	Urban ($n = 26$) n (%)	Rural ($n = 13$) n (%)	Total ($n = 39$) n (%)	p -value
Had to buy staple foods as produce from garden was inadequate	20 (76.9)	10 (76.9)	30 (76.9)	1.00

[#]Please note that these options do not add up to 100% as caregivers gave more than one reason for unemployment in their households.

^{##}The number of participants varies depending on the response rate for these coping strategies.

*Pearson's chi-square test was used to find differences by urban/rural residence. Fisher's exact test was used to run the analysis for counts less than 5. Significant at p -value < 0.05; identified by *.

uptake (88.8%, $n = 143$) and uptake was markedly higher in urban (96.8%, $n = 122$) than rural areas (62.9%, $n = 22$) (Table 3).

When prompted, caregivers recognised that 'government has money and can help, there are a lot of people that rely on government grants for an income'. Some caregivers felt content: 'I am happy with the amount of money I receive for the CSG, it is enough', while others complained: 'the CSG is not enough and the food prices are increasing'. Some caregivers remarked that grant money was misused by other grant recipients: 'I often see the CSG being abused by parents buying things for themselves, such as alcohol instead of food for the children'. Some caregivers asked for food parcels because they needed to utilise the CSG to pay off debts or purchase personal items (Table 5).

KIs expressed similar concerns and had mixed feelings regarding the social support grants. On the one hand it was a necessity to assist the people who were unable to provide for themselves, but 'people are now social grant dependent ... instead of being

able to create, and be proactive, and have their own food security'. Mismanagement of the grants was a concern for KIs. At times people received grant money partially or not at all, forcing people to borrow money from loan sharks.

Inadequate support of agrarian practices. The majority of caregivers did not have vegetable gardens or livestock (69.6%, $n = 112$) although 77.6% ($n = 125$) had access to land for growing vegetables and access to water for irrigation (85.1%, $n = 137$). The main reason for not using the land for food production was a lack of seeds (38.4%, $n = 43$), and urban participants identified a lack of knowledge of agricultural practices (18.4%, $n = 18$) as a limiting factor. KIs sensed that the community needed to be educated on how to grow vegetables, that theft of vegetables was problematic and inadequate fencing meant roaming animals could not be kept out of the gardens.

Inadequate programme and policy implementation. Nutrition was repeatedly highlighted as important by government officials, yet programmes were poorly implemented without

Table 4: Inadequate employment opportunities as a capacity gap

Caregivers' perceptions	Key informants' perceptions
'If the government helps we will be able to get better jobs' 'Create jobs and employ people in permanent positions' 'Increase the salaries of people working' 'Most people are unemployed and can't provide for their families' 'With a lack of jobs it's not always easy to ensure that people eat enough of the correct food' 'I didn't have the opportunity to finish school and am now unemployed, I don't want that to happen to my children' 'Children need to be educated in order to get a proper job one day'	'The problem revolves around unemployment and poverty, because even if you are to grow your own vegetables, you must have money to buy the seeds, you have to water that garden, you have to pay for that water, not so? ... So, OK, these problems of poverty, or inadequate food supplies, and so on, or hunger, emanates from some of us ... not having enough financial resources' (KI nr 6) 'Our mind is centred in thinking that the municipality is the only institution that can create jobs for them, which is not the case. We are also there to create opportunities for people to make them self-employed. ... But they are not taking those opportunities' (KI nr 3) '... [the youth] have taken a back seat in taking ownership of their livelihoods' (KI nr 7)

Table 5: Perceptions of caregivers and key informants about the implementation and management of social grants

Caregivers' perceptions	Key informants' perceptions
<ul style="list-style-type: none"> <i>Role of government</i> '[Government] have money and can help, there are a lot of people that rely on government grants for an income' '[Government] already help with the CSG and pension, they don't need to do more than this' 'My mother's disability grant was stopped and hasn't been started again, even though she can't do anything for herself' <i>Adequacy of grants</i> 'I am happy with the amount of money I receive for the CSG, it is enough' 'The CSG is not enough and the food prices are increasing' '[Government] could increase the grant, it isn't enough to feed and clothe the child' <i>Utilisation of grants</i> 'There are a lot of people who use the grant money to buy alcohol instead of food; especially the young adults do this' 'They [the government] are already giving us the CSG because we need it, at least we can feed our children with it' 'A lot of the parents use the child's grant incorrectly, using it to pay debts for themselves' 'I have seen people spending CSGs on alcohol and giving the cards [South African Social Security Agency cards] in to the cash loans' 'Food parcels would help so that the state pension and CSG can be used to pay debts' 	<ul style="list-style-type: none"> <i>Role of government</i> 'A lot of people go to bed hungry, I really do believe that. There are many families that are living basically just on the CSG' (KI nr 2) 'People are now social grant dependants ... instead of being able to create and be proactive and have their own food security' (KI nr 7) <i>Adequacy of grants</i> 'All the grants are promoting food insecurity' (KI nr 10) 'It's a vicious cycle, you go in and you fetch the [SASSA] card, you stabilise the person for one, two, three months, and then they go and give the card in again. ... For maybe a while they will be able to survive, but then due to circumstances they are forced to go and give their [SASSA] card in again, because there isn't food' (KI nr 5) <i>Utilisation of grants</i> 'It's not being used for food security for the child. ... I actually saw, there were a group of women sitting outside ... they were farm workers, and the one was saying "With your child's one hundred and eighty [South African Rand] we are going to have a nice party this weekend" [Translated: Met jou kind se one eighty [Rand] gaan ons 'n lekker paartie hou die naweek] (KI nr 2)

focus. As stated by a KI, 'nutrition is everyone's business ... but no-one's responsibility'. KIs were concerned that government officials involved in primary health care did not understand the importance of how programmes impact on children and the community, and needed further training (Table 6.1)

Programmes run by the Department of Social Development were viewed in a negative light as KIs felt they were not implemented or managed well and there was no cooperation between government departments, resulting in unresolved problems. KIs were quite negative towards the efficacy of the Department of Agriculture's programmes (Table 6.1).

You give things out to the communities, you don't make an assessment what impact these things have in the community, and that's a problem. ... Not educating why we are giving you this. ... It's because we want you to self-sustain in terms of food security. But that is not done. (KI 4)

Perceptions regarding the actions required to realise the right to adequate food

The majority of caregivers (74.5%, $n = 120$) indicated they were not in a position to do anything more to improve the food security of their children unless they could find employment:

'if the government helps, we will be able to get better jobs'. They (70.8%, $n = 114$) indicated that the responsibility to ensure food security lay elsewhere. Government should help, 'they can provide food parcels once a month, it would really help'. Caregivers thought their families should assist them (71.4%, $n = 115$) by providing food or money (53.0% $n = 61/115$). A few caregivers (4.3%, $n = 7$) felt they should make a bigger effort to spend their money more wisely and not waste the food they had available to them. Some caregivers said, 'we must be responsible ourselves, we should try to create our own jobs' and 'it is not the responsibility of government to ensure people do have food'. KIs agreed:

The individual themselves has got to take some kind of responsibility. ... You can provide whatever you like, but if they are not listening they will never have food security. ... They won't! (KI 2 [aggressive tone])

KIs argued that the community should look for initiatives such as growing home vegetable gardens, actively pursuing employment opportunities, ensuring good education for their children and not blaming other people for their situation. However, there was also a sense that it was quite difficult for people to take responsibility for their situation when they were living in poverty and had lost hope (Table 6.2).

Table 6: Selected themes emerging from key informant interviews

6.1. Inadequate programme and policy implementation as a capacity gap	
Theme	Key informant quote
Poor implementation of programmes, no follow-up	'... although the clinics are accessible ... for the community ... they don't follow up ... the referral system ... from hospital to the clinic is good. ... But the referral system back from the clinic to the hospital is not, it's not good ... you can almost say it's non-existent. ... And also between the other department, that's Social Development, it's non-existent' (KI nr 10)
Educate clinic staff	'... every member of the staff, whether it's the clinic educator, the cleaner, or the sister in charge, they need to be made aware of their responsibility, their role that they have got to play in ensuring food security for these people' (KI nr 2)
Nutrition therapeutic programme	'But I also want to say that [nutrition supplements] it's too stop start ... sometimes they have products and sometimes they don't have products. ... Now you have got a hungry person coming to the clinic thinking they are going to get something, and they don't get anything' (KI nr 2)
Department of Agriculture	'By the way, the Department of Agriculture who is supposed to help and provide seeds and that kind of thing, are not doing it. ... You don't see them in the township ... to maybe also do the education of people who have got cattle that are not immunised for TB' (KI nr 2) 'The Department [of Agriculture] do have a scheme supposedly offer seeds and, and things. But in general there isn't seed available, so when enquiries are made, no there is no seed. ... The system's not working' (KI nr 4) 'But there were several attempts by [the] Department of Agriculture for a food garden, providing them with resources, like, hosepipes, wheelbarrows, forks, so that we can have a veggie garden at the back of your yard. ... Not ... educating why we are giving you this; it's because we want you to self-sustain in terms of food security' (KI nr 3)
Integrated approach	'... hunger, food insecurity ... it cannot be addressed only solely by the PHC system. We need to have an integrated approach in terms of ... all the departments. ... Social Development, Labour and also Agriculture. ... There's a lot of duplication ... where you give to the facilities, organisations. ... And you would find that Agriculture is also giving to the same people ... because there is no ... proper coordination between [the departments]' (KI nr 10) 'They are trying to assist in terms of getting food parcels to the needy people through ... Social Development and SASSA. But the cooperation amongst ourselves and these departments is not ... a hundred percent good. Because you will find that, those who are getting these food parcels, some of them really don't need these parcels ... as ward councillor in the area, I have to be informed about these food parcels. ... And I can say, yes, this is the right person to get the food. And an assessment, it's not done after delivery. There is no come back to see the impact of these food parcels' (KI nr 3) 'Ya, because sometimes Social Development [help] with projects in your area and they don't communicate with you, it's a problem. Sometimes you finance a project from two sides, I think because the people aren't aware of each other and the projects and things' (KI nr 11)
Finance/mismanagement	'It depends on the budget that we get from Bisho, who manages it, for instance at the moment the MEC, she likes maize production, but not so much animal production. ... But they try to provide for food security ... it fluctuates, one year there is a suddenly a lot of money available, and the next year there isn't a budget' (KI nr 11) '... our Blue Crane Development has lots of developments ... which just didn't realise. So I think poor management is definitely a problem for me, mismanagement of finances that are available' (KI nr 6) 'Unfortunately ... a person comes in now, from nowhere into this town from nowhere, but he's verbally equipped, he can talk, smooth talk ... he knows how to do the business plans ... and then the community think, ah this is the person; make him the manager of this project. ... One minute he's gone. ... So I think, what the department should ... properly screen those in charge of these financial things' (KI nr 10)
6.2. Perceptions regarding the actions required to realise the right to adequate food	
Theme	Key informant quote
Rights and responsibilities	'And I mean, poverty is, is always going to be with us, let's face it. But you get people that are poor, but are still able to do something. They have the food garden, you know, they see that I can do something, I can make a plan. So you might well have the right to have good food, but if you are wasting your money, not prepared to work etcetera, then you know, are you not forfeiting your right?' (KI nr 2)
Nutritional education	'... you can have money to buy enough food ... for your family, it is also important for you to know which food to buy. I mean the nutritional part of it is important and how to prepare it ... the proper way ... you have to know something about healthy cooking and healthy food' (KI nr 6)
Land redistribution	'If I was a government I would be proud of having given the farm to ten people who ordinarily were unemployed, un-affording, but keen on starting farming. Because by virtue I am saying these ten people now will no longer be my burden' (KI nr 7)
Community input	'... our policies are politically informed and they are always aligned to the government of the day. So even if government change next year they will want another policy review. ... So where we can make an input, informed and serving as servants of the department, I feel that it will make a, a huge difference. Unlike allowing it to be a terrain of politicians whereby the impact and the influence might not be necessarily what we want as officials' (KI nr 7) '... with societal problems now, what needs to change is, instead of saying, government do something about this, we must start having people talk about these things. Let it come from them, what is it that can be done. ... So that people must start saying, we cannot always say government must feed us. With what? Um, we are here now, what is it that when you look around can be a source of food. So that we make our own decisions, then start taking responsibility thereof' (KI nr 7) '... if we can just get together as a community and talk about these issues that affects a communities ... talk about assisting ourselves' (KI nr 3)

(Continued)

Table 6: Continued.

6.1. Inadequate programme and policy implementation as a capacity gap	
Theme	Key informant quote
Education	<p>'However, education should be such that it would help one identify that where are my weaknesses, where are my strengths, which route I am supposed to take. That should be through the education system; to help me identify and see my gaps ... that's where the education system is failing us, it is now more of a paper based ... instead of the content of looking at the overall learner, and that, what is it that we can, we can develop this person, even to stand outside school, what is it that will distinguish someone who is at school from someone who is not at school Even in terms of thinking, in terms of behaviour and all those things' (KI nr 6)</p> <p>'... maybe we concentrate too much on the uneducated masses. There are a certain number of ... young people in the ... community, that have got a matric, that are a bit educated. And maybe we should aim our education [at] them ... try to influence them, and through them they will influence their community, because they will maybe be more prepared to listen to our story and what we have got to say' (KI nr 2)</p>

Discussion

Assessment of the realisation of the right to adequate food

The complex and multifactorial dimensions of human rights complicate objective measuring of the realisation of the RtF; therefore health, living standards and access to the labour market are some of the indicators generally used.⁴ Accordingly, the high level of food insecurity, substandard living conditions, high levels of unemployment and dependency on support grants in the Blue Crane Route reported in this study are indicative of the RtF not being fully realised by all of the caregivers who participated in the study.

The literature shows economic inaccessibility of food as a major limiting factor amongst the poor.^{2,3,13} Caregivers reported having inadequate money to purchase food, making them more sensitive to the impact of economic shocks.³ It is unlikely that caregivers were able to make nutritious food choices to alleviate hunger and undernutrition as financial circumstances dictated the need for less expensive food, which is filling but ultimately more energy dense and inadequate in vitamins and minerals.^{25,26} Contrary to the recommended intake of at least five portions of fruit and vegetables per day to provide essential micronutrients,²⁷ only half of the Blue Crane Route participants had consumed any fruit or vegetables the previous day, leaving them nutritionally vulnerable.¹⁶ These findings are not aligned with the definition of the RtF, which highlights that food must be of a sufficient quality to meet the dietary needs of an individual.¹⁹

Walsh and van Rooyen found that vegetable production was a predictor of food security in rural areas.¹¹ Statistically the Eastern Cape is one of the provinces with the highest proportion of households (20%) involved in agricultural activities.³ Therefore, in an area such as the Blue Crane Route, subsistence farming can be seen as a sustainable, non-income-dependent approach to alleviate food insecurity^{10,15} by supplementing food for household consumption.³ However, appropriate education, assistance and well-targeted interventions to promote agricultural development and economic growth are needed in order to mitigate the underlying causes of chronic hunger, and in turn improve health and well-being.^{3,4}

Human rights are interrelated, interdependent and indivisible and as such the right to health, housing and water affects the realisation of the RtF.¹⁹ Not all caregivers had access to reliable and safe sources of water and ablution facilities. The United Nations' Sustainable Development Goals aim to 'ensure access to water and sanitation for all' (Goal 6) and the UN recognises that inadequate sanitation and poor water quality can negatively impact on food security and health.²⁸ The South African government, as the main duty-bearer, has made an effort with the provision of ablution facilities, water and electricity supply within the urban setting in the Blue Crane Route, but the rural areas still experience a lack of infrastructure in this regard. More can and should be done to provide adequate municipal services to all citizens. According to the South African Human Rights Commission (SAHRC), service provision should target the poorer population groups and rural areas through support from the national treasury and governmental monitoring of municipalities to provide such services.²⁹

The unemployment rate in the Eastern Cape (47.1%) remains higher than the national figure (34.4%).³⁰ Unsurprisingly,

caregivers expressed frustration at a lack of employment opportunities in the Blue Crane Route. Caregivers' experience of gender discrimination regarding employment opportunities' remuneration is contradictory to human rights principles of equality and non-discrimination.¹ Yet, government officials in this study, acting as duty-bearers as an extension of the government, did not perceive this as problematic. Despite the harsh reality of an inability to secure job opportunities, government officials blamed the community for not taking responsibility for their employment themselves. It is true that the informal sector in the Eastern Cape accounts for a large share of total employment,³ yet to become actively involved in agricultural programmes the unemployed need support and resources to generate short-term/casual jobs. If an HRBA had been followed by the local government, the community would have been involved in the decision-making process and identification of suitable programmes they wanted to participate in,^{1,31} thus empowering the community to take responsibility for their situation and find sustainable solutions.³¹

Some caregivers embraced the role as duty-bearer by acting on behalf of their children. They adopted coping mechanisms to utilise the available resources to their own detriment such as eating less or buying food on credit. Literature shows that caregivers skip meals^{12,15,25,32,33} or limit the variety of foods served.³³ However, the caregiver's RtF should be protected¹⁹ and these coping mechanisms do not offer sustainable solutions but, rather, disempower the community.¹²

A growing body of evidence points towards social grants having a positive impact on the lives of poor children living in South Africa.^{29,32,34,35} Specifically, the CSG contributes up to half of the total household income in the Eastern Cape.^{32,34} A tenth of the caregivers in the Blue Crane Route reported that social grants were their sole source of income. Receiving an income from grants was offered as the reason why some adults were not actively seeking employment, leading to KIs' perception that caregivers were becoming 'social grant dependants'. Similar to this study, the literature shows that income received from support grants was pooled and spent on general household needs and/or personal expenses.²⁵ On a positive note, research shows that households receiving CSGs spend pro rata more money on food and other essentials such as education and basic services.³⁴ The success of the CSG could be ascribed to the fact that unconditional cash transfers have the benefit of being relatively simple to implement and carry a smaller administrative burden compared with food coupons.²⁹

Actions to facilitate the realisation of the right to adequate food

Education. Literature shows that educating mothers is key to children being food secure,^{5,25,35,36} thus information campaigns may be an important way of dealing with some of the limitations mentioned.³⁷ As drivers of malnutrition, maternal education and child care, as well as dietary quality, need analytical and policy attention.²⁵ In 2012 the South African government had already identified education as an important policy target, with the Presidency's National Planning Commission emphasising that 'effective nutrition education for health workers, mothers and other caregivers should be a national priority'.^{38,39} Sustainable targets should be set to improve food security in consultation with the target population. Unfortunately, the National Policy on Food and Nutrition Security⁴⁰ has not set quantifiable targets. Laws, policies and programmes

make little difference, unless they are effectively implemented, continuously monitored and re-evaluated.⁵

Behaviour change. The government should consider other ways to encourage caregivers to change behaviour. There are examples in other countries such as Mexico and Colombia where conditional grants were successfully implemented and measured over the long term.²⁹ A project conducted in Bangladesh found positive outcomes using a 'cash+ model' where cash transfers were linked to access to basic services and to behaviour change through communication on nutrition, hygiene and sanitation.⁴¹ Imposing qualifying conditions for the receipt of cash transfers could facilitate acquisition of nutrition information, which may increase the desired effect of a given programme provided that the government creates adequate infrastructure in order to provide the services on which the programme benefits are conditioned.^{38,39,42}

Progressive realisation of each of the human rights. The South African Constitution states: 'the State must take reasonable legislative and other methods, within its available resources, to achieve the progressive realisation of each of the human rights'.⁸ The SAHRC reported that the high cost of realising the RtF in South Africa hampers the progressive realisation of rights relevant to the RtF.⁴ The National Development Plan recognises agricultural productivity and rural development among the essential priorities for creation of employment, economic growth, reducing poverty and addressing food security in South Africa.⁴ Applying an HRBA addressing related factors such as inadequate sanitation and water and access to the labour market, supported by opportunities to increase agricultural activities, will contribute towards the eradication of malnutrition at the immediate, underlying and root-cause levels.^{1,4}

Limitations

Although dietary diversity categories are presented in this paper, the standardised calculation of the DDS was not used, which limited the interpretation of the findings. The small sample size and a high error percentage of 9% is due to time constraints and limits the generalisability of findings. Logistical practicalities had to be considered and because of this the data were only collected at clinics. This meant that caregivers interviewed were more likely to be responsible individuals who looked after their children. One must be aware that to some degree bias is always present in a study of this nature as information bias and recall bias from the caregivers, as well as interviewer bias, could be present.

Conclusion

The RtF is not fully realised in the Blue Crane Route. Although the South African government has committed itself to progressively fulfil the realisation of the RtF, progress has been slow and insufficient. Identified capacity gaps of the government were insufficient employment opportunities, misspending of social grants and poor management of programmes, especially in rural areas. Efforts are being made to improve, but actions are suboptimal. This can be seen by the caregivers having the need to put coping mechanisms in place, such as purchasing food on credit. Caregivers, as rights-holders, felt disempowered from improving their situation themselves without assistance from the government as a duty-bearer. In order to bring about change, concerted, multidisciplinary approaches using a rights-based approach to implement policies and programmes are needed. This must be done together with the

empowerment of the community with the necessary skills to accept responsibility and make changes. Ongoing monitoring, evaluation and reassessment of programmes is crucial to ensure efforts are effective at achieving the goal of realising the RtF for all in a sustainable manner.

Acknowledgements – The research was funded by the Norwegian Government's Programme for Master's Studies (NOMA). The authors would like to convey their sincere thanks to the Eastern Cape Department of Health for granting permission to conduct the survey. Importantly, they wish to convey their sincere gratitude to all the caregivers and KIs who were all very gracious in giving of their time; and the personnel at the clinics and mobile clinics who allowed the authors to occupy their space and Prof. D Nel from the Centre for Statistical Consultation, Stellenbosch University, for his help with statistical analyses.

Funding – The research was funded by NORAD's Programme for Master Studies (NOMA; Norad [Norwegian Agency for Development Cooperation]).

Copyright – The main findings of the paper were presented at the 2016 Autumn International Scientific Conference on Food Safety and Security (FSaS) and the abstract was published in the conference proceedings.

Declaration – The research forms part of a postgraduate thesis for a Master's in Nutrition degree.

Disclosure statement – No potential conflict of interest was reported by the authors.

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Received: 24-07-2020 Accepted: 18-10-2021