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Bridging the gap: The impact of home visiting programs for orphans and vulnerable children on social grant uptake in South Africa

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ABSTRACT

Cash transfer programs hold significant potential to mitigate the economic burdens resulting from the HIV epidemic and enhance the wellbeing of affected children. South Africa offers two cash transfers designed specifically to benefit children: the Child Support Grant, for low income families with children, and the Foster Child Grant, for children living outside of parental care. Given the high proportion of HIV-affected children who qualify for these grants, increasing grant access among eligible families is a natural objective for many programs targeting orphans and vulnerable children. We present results from a quasi-experimental study examining differences in grant uptake over a two year period among 1487 children enrolled in one of two types of supportive home visiting programming: volunteer-based or paraprofessional. The study also examined related outcomes including household food security and children's access to basic educational and material needs. Results show that programs staffed with trained paraprofessionals who received training, compensation and other support were significantly more effective at linking families to social grants for children. Controlling for important covariates, at follow-up participants in the paraprofessional model programs were nearly three times as likely as volunteer-based service recipients to have access to the highest grant they were eligible to receive. Grant receipt was also positively associated with household food security and children's obtainment of basic educational and material resources. Effective strategies for promoting social grant access among HIV-affected households therefore have the potential to yield significant improvements in wellbeing for orphans and vulnerable children.

1. Introduction

The HIV epidemic in sub-Saharan Africa exhibits profound effects on communities' economic stability. In addition to reducing human capital, HIV increases resource demands on affected families, many of whom are already poor. Chronically ill adults experience diminished capacity to work and provide care, while children in affected households—regardless of their HIV status—may be more likely to drop out of school to care for younger siblings or sick parents, or to seek employment themselves (United Nations Children's Fund, 2011). When children's caregivers die these social and economic stresses are magnified, and households that take in orphans assume new financial and caregiving burdens.

The elevated economic burdens imposed by HIV are particularly salient in South Africa, home to world's largest HIV epidemic (UNAIDS, 2013). In 2012 an estimated 61% of South Africans under age 18, more than 11 million children, were living in poverty (Berry, Biersteker, Dawes, Lake, & Smith, 2013). UNICEF reports that while 19% of the country's children have lost one or both parents, this estimate is 24% among children in the poorest income quintile compared to only 5% in the richest, suggesting that orphanhood and poverty are strongly linked (South African Human Rights Commission/UNICEF, 2011). According to some estimates, the HIV epidemic in South Africa could increase the prevalence of chronic poverty there by as much as 33% overall (Aliber, 2003). These severe economic challenges limit families' abilities to meet children's basic needs and may beget a vicious cycle of poverty and disease.

Cash transfer programs are one promising strategy for mitigating the financial hardships facing HIV-affected households in sub-Saharan Africa (Adato & Bassett, 2009; Richter, 2010). Literature reviews illustrate the beneficial effects of cash transfer programs on children's health, nutrition, education, and HIV prevention outcomes (Barrientos, Byrne, Peña, & Villa, 2014; Lagarde, Haines, & Palmer, 2007; Pettifor, MacPhail, Nguyen, & Rosenberg, 2012; Robertson et al., 2013; Vincent & Cull, 2009). Recognizing the proven utility of cash transfers, in 2006 thirteen African countries including South Africa signed the Livingstone Call for Action in support of the expanded adoption of social cash transfer programs (Intergovernmental Regional Conference, 2006).

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South Africa already offers one of the largest cash transfer initiatives on the continent, with two grant types oriented specifically to children. The child support grant (CSG), a means-tested cash transfer targeted to low-income individuals providing primary care for a child under age 18, was directed to more than 11 million beneficiaries in 2013. Fewer recipients, about 500,000 in 2013, were receiving a foster child grant (FCG), which is available to the court-appointed guardians of children living outside parental care (often as a result of orphanhood, abandonment, abuse or neglect) (Berry et al., 2013). The monetary value of the foster child grant is nearly three times that of the child support grant (310 ZAR/$30 and 830 ZAR/$80 respectively in 2014; www.services.gov.za).

These grants are highly responsive to the economic burdens and caregiving situations resulting from the AIDS epidemic. For instance, an estimated 50% of FCG recipients live in AIDS-affected households (Schubert, 2007). Moreover, promoting access to social grants is a key facet of the government's National Action Plan for support of orphans and vulnerable children (OVC) (South African National AIDS Council, 2012). However, the program's administrative complexity and other significant barriers limit the program's reach.

Receipt of either the child support or foster child grant requires a formal application to the government, including the submission of identity documents and other paperwork. The FCG additionally requires a court appearance, supplemental documentation such as parental death certificates and/or affidavits concerning parental whereabouts, a formal social work assessment, and biennial review. Substantial confusion exists around income thresholds, employment restrictions, nationality requirements, and other evolving eligibility criteria, leading many potential applicants to wrongly assume they are disqualified (DSD, SASSA, & UNICEF, 2012). Lack of identity documents and death certificates, literacy barriers and transport costs to government facilities further discourage eligible families from applying (Twine, Collinson, Polzer, & Kahn, 2007). Finally, considerable backlog in application processing, especially for FCGs, deters many eligible families from timely grant access (Hall & Proudlock, 2011).

While the CSG is targeted explicitly at poor children, nearly one-quarter of eligible children were not receiving it in 2013 (Berry et al., 2013). Access may be even lower among eligible HIV-affected children. A study in KwaZulu-Natal, the province with the highest HIV prevalence (Department of Health, 2011), found that less than 40% of CSG-eligible households that had experienced a recent death and only 30% of those fostering orphans were receiving the grant (Adato & Bassett, 2012). Another study of households suffering HIV and AIDS-related morbidity or mortality similarly found that less than one fifth received a CSG and less than 10% received a FCG (Booysen & Van Der Berg, 2005). Studies have also shown that orphans, particularly maternal orphans, are less likely than their peers to receive a CSG (Case, Hosegood, & Lund, 2005; Woolard & Leibbrandt, 2010). Finally, research suggests that only a small proportion of eligible children receive the FCG; instead, many receive a CSG or no grant at all (Hall & Proudlock, 2011).

Additional efforts are clearly needed to promote OVC's access to this critical safety net. Home visiting programs are the most common strategy for serving OVC in sub-Saharan Africa, aiming to provide multifaceted support that includes linkages to social services (Schenk & Michaelis, 2010). Home visitors may be particularly well-positioned to promote access to cash transfers through information provision, support and follow-up with high priority underserved households. They can educate caregivers about programs for which they may qualify, help obtain the necessary documentation, assist with completing applications, and check the status of pending applications. Home visitors in some program contexts can also guide caregivers through the process of obtaining legal recognition of their status as foster parents.

In light of substantial evidence suggesting that cash transfers are an effective, worthwhile investment, identifying best practices for ensuring that all children in need have access to this important resource is a priority. To our knowledge, there has been no study of interventions aimed at increasing access to social cash transfer programs among OVC generally, or of the role of the home visitor in these processes. The present study examines the capacity of a trained and compensated workforce of home visitors to link the OVC population in South Africa to child-focused cash transfer programs over a two-year period, using a quasi-experimental design. Analyses further explore the apparent effects of cash transfers on household food security and caregivers' ability to meet the basic material and educational needs of this highly vulnerable population.

2. Materials and methods

2.1. Study design and sample

The findings presented here are drawn from a longitudinal study designed to assess the effectiveness of OVC home visitation programs operating in rural KwaZulu-Natal, South Africa, where antenatal HIV prevalence nears 40% (Department of Health, 2011). Children aged 10–17 years who were newly enrolled in these OVC programs were invited to participate in the study. Information on children and their primary caregivers was collected in two survey rounds: at enrollment into the program in 2010, and at follow-up in 2012, after approximately two years of program engagement. A maximum of two age-eligible children per caregiver were included in the study. Face-to-face interviews were conducted in the local language isiZulu after obtaining informed consent from caregivers and assent from child participants; these visits took place privately at the participants' home. Up to three visits were conducted to locate children, and every effort was made to find and interview children who had moved within KwaZulu-Natal between survey rounds. The study successfully followed 80% of children interviewed at baseline. This investigation is limited to the 1472 children and 918 caregivers with survey data from both rounds. Further details about the panel study can be found elsewhere (Thurman, Kidman, & Taylor, 2014).

2.2. Intervention groups

This study capitalizes on the enormous variation in how OVC home visiting programs are structured and implemented in order to generate a quasi-experimental design. On one end of the continuum, small community-based programs operate with no external resources, rely on lay volunteers, and typically attain low levels of basic service delivery coverage. On the other end, well-resourced programs provide extensive accredited training and full-time compensation for their home visitors, and generally deliver a broader array of more intensive services to a higher proportion of enrollees. We thus classified the home visiting programs as utilizing either a paraprofessional model (those that offer training and compensation for the care workers who perform home visits) or a volunteer-driven model (those that rely primarily on lay volunteers). To enhance generalizability, this study included two distinct paraprofessional models operating across 14 sites, and volunteer-driven approaches being uniquely implemented by individual community based organizations within 16 different sites across KwaZulu-Natal.

Using improvement in the volunteer-driven group as a comparison, this study evaluates the impact of enrollment in a paraprofessional home visiting program on children's social grant uptake. Importantly, while randomization was not feasible, the volunteer-driven group closely approximates an untreated control group as only 34% reported ever receiving a home visit, dropping to only 14% who reported being visited in the year prior to the follow-up survey. More information on the OVC programs and services provided can be found in previous publications (Kidman, Nice, Taylor, & Thurman, 2014; Thurman et al., 2014) and in related case-studies (Neudorf, Taylor, & Thurman, 2011; Njaramba, Byenkya, Pillay, Oti, & Ntsala, 2008; Thurman, Yu, & Taylor, 2009).