



SOUTH AFRICAN

2012

Child Gauge™

Katharine Hall, Ingrid Woolard, Lori Lake & Charmaine Smith



UNIVERSITY OF CAPE TOWN
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Broad overview of the *South African Child Gauge*[™] 2012

The *South African Child Gauge* is published annually by the Children's Institute, University of Cape, to monitor government and civil society's progress towards realising children's rights. This issue focuses on children and inequality.

The *South African Child Gauge* is divided into three parts:

PART ONE: Children and law reform

Part one discusses recent legislative developments affecting children. This issue comments on litigation and law reform in relation to the Children's Act; the Criminal Law (Sexual Offences and Related Matters) Amendment Act; the Social Assistance Act regulations; the National Health Act; and the Traditional Courts Bill. See pages 14 – 19.

PART TWO: Children and inequality: Closing the gap

Part two presents 10 essays – the first four essays set the scene by defining children's equality rights and explaining the nature and extend of inequality, the spatial dimensions of child deprivation in South Africa, and the impact of place, care and migration on children's lives. The following five essays outline the potential of particular policies and programmes to reduce inequalities amongst South Africa's children, including social grants, early childhood development services, access to health care, HIV treatment and prevention services, and access to quality education. The final essay reflects on emerging opportunities and challenges, and critical considerations for policy. See pages 22 – 77.

PART THREE: Children Count – the numbers

Part three updates a set of key indicators on children's socio-economic rights and provides commentary on the extent to which these rights have been realised. The indicators are a special subset selected from the website www.childrencount.ci.org.za. See pages 80 – 105.

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Acknowledgements

The editors are grateful to all those who contributed to this seventh issue of *the South African Child Gauge*TM:

- The authors, who remained committed throughout in spite of busy schedules.
- The Honourable Minister in the Presidency: National Planning Commission, Trevor Manuel, for his *Reflections on child poverty and inequality*; and the Vice-Chancellor of the University of Cape Town, Dr Max Price, for the *Foreword*.
- The peer-reviewers who so unselfishly gave their time to comment on the essays and recommended improvements:
 - Leslie Bamford, Child and Youth Health Directorate, Department of Health
 - Fiona Burt, ELMA Philanthropies
 - Thabani Buthelezi, Department of Social Development
 - Pam Christie, School of Education, University of Cape Town
 - Mark Collinson, School of Public Health, University of the Witwatersrand
 - Carina du Toit, Centre for Child Law, University of Pretoria
 - Ameena Goga, Health Systems Research Unit, Medical Research Council
 - Doron Isaac, Equal Education
 - Debra Jackson, School of Public Health, University of the Western Cape
 - Prinslean Mahery, School of Law, University of the Witwatersrand
 - Julian May, Institute for Social Development, University of the Western Cape
 - David McQuoid-Mason, Centre for Socio-Legal Studies, University of KwaZulu-Natal
 - Nadine Nannan, Burden of Disease Unit, Medical Research Council
 - Leila Patel, Centre for Social Development in Africa, University of Johannesburg
 - Paula Proudlock, Children’s Institute, University of Cape Town
 - Linda Richter, HIV, STIs and TB Unit, Human Sciences Research Council
 - Mastroera Sadan, Programme to Support Pro-poor Policy Development, the Presidency
 - Haroon Saloojee, Division of Community Paediatrics, University of the Witwatersrand
 - Julia Sloth-Nielsen, Faculty of Law, University of the Western Cape
 - Ivan Turok, Economic Performance and Development Unit, Human Sciences Research Council
 - Servaas van der Berg, Department of Economics, Stellenbosch University
- George Laryea-Adjei, UNICEF; Murray Leibrandt, Southern Africa Labour and Development Research Unit, University of Cape Town; and Shirley Pendlebury, Children’s Institute, University of Cape

Town, for their expertise and guidance as members of the editorial committee.

- Debbie Budlender for her technical assistance with Children Count.
- The children from the *Abaqophi BakwaZisize Abakhanyayo* Children’s Radio Project, and from Parkfields Primary School, Qingqa-Mntwana Primary School and Rosebank Junior School who created artwork for use in the book.
- The Frank Joubert Art Centre, for facilitating the children’s art workshops.
- Children’s Institute researchers who supported the editorial team in many ways, and administrative staff for their assistance in the distribution and marketing of the publication, especially Bronwyn Williams, Zelda Warrin and Glenda Vena.
- The Southern Africa Labour and Development Research Unit at the University of Cape Town for their contributions as a partner on this issue, and particularly to Ingrid Woolard for her guidance and expertise.
- UNICEF South Africa for their contributions to the editorial team and launch communication strategy, and for funding the production of the book and accompanying materials.
- The ELMA Foundation for their support to the Children’s Institute as a key donor over the past years.
- Atlantic Philanthropies for their financial support for this issue.
- Jenny Young for the design and layout of the book, and the accompanying poster, plain language summary and policy brief.
- J. Ryan for the printing, and Tina Southgate and Robert George from E-Graphics for print liaison.



Opinions expressed and conclusions arrived at are those of the authors and are not necessarily attributed to any of the donors or reviewers.

Citation suggestion

Hall K, Woolard I, Lake L & Smith C (eds) (2012) *South African Child Gauge 2012*. Cape Town: Children’s Institute, University of Cape Town.

ISBN: 978-0-7992-2489-4

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral treatment
ASSA	Actuarial Society of South Africa
CC	Constitutional Court
CCL	Centre for Child Law
CD4	Cluster of Differentiation 4
CDG	Care Dependency Grant
CSG	Child Support Grant
CHW	Community Health Worker
ECD	Early Childhood Development
FCG	Foster Child Grant
GHS	General Household Survey
HAART	Highly-Active Antiretroviral Treatment
HIV	Human Immunodeficiency Virus
ICC	Intraclass Correlation
MDG	Millennium Development Goal
NEEDU	National Education Evaluation and Development Unit
NIDS	National Income Dynamics Study
NHI	National Health Insurance
OAG	Old Age Grant
PCR	Polymerase Chain Reaction
PDOU	Planning and Delivery Oversight Unit
PMTCT	Prevention of Mother-to-Child Transmission
SAIMDC	South African Index of Multiple Deprivation for Children
SALDRU	Southern Africa Labour and Development Research Unit
SASSA	South African Social Security Agency
SOCPEN	Social Pensions (administrative data system)
Stats SA	Statistics South Africa
TB	Tuberculosis
U5MR	Under-5 Mortality Rate
UCT	University of Cape Town
UN	United Nations
UNICEF	United Nations Children's Fund
WHO	World Health Organisation







Foreword

Dr Max Price
Vice-Chancellor, University of Cape Town



The Children's Institute recently celebrated its 10-year anniversary, and the release of this seventh issue of the influential *South African Child Gauge* is an indication of its ongoing commitment to monitor the situation of children in South Africa.

This year also marks the centenary of the Faculty of Health Sciences at the University of Cape Town, and we are reminded of the core values on which the faculty was built. These have found their expression in the human rights focus and advocacy-based research that are synonymous with the Children's Institute.

This issue of the *Child Gauge* once again chronicles the health and welfare of the country's youngest citizens, many of whom live on the margins of society.

There is compelling evidence to show that children's survival, development, and life trajectories are largely determined by their early socio-economic

circumstances. Inequality is rising in emerging economies as well as in rich countries. In South Africa inequality and poverty, combined with HIV, have reduced life expectancy at birth, and education has not been delivered at a quality that can yet enable the next generation to escape the poverty trap.

Drawing on a child poverty and inequality roundtable that was co-hosted by the Programme to Support Pro-Poor Policy Development in the Presidency, UNICEF and the Children's Institute, this collection of 10 essays outlines the extent and impact of income inequality on children's living conditions, care arrangements, health and education, and identifies some interventions that have the potential to break the cycle of poverty and reduce inequality.

This publication is intentionally designed to make academic research and analysis useful and accessible to a wide range of readers – in government and civil society – as a basis for improved policy and practice and the progressive realisation of children's constitutional rights.

This issue of the *Child Gauge* also speaks to a broader initiative at the University of Cape Town which is bringing together academics, civil society and government around a Carnegie-like national inquiry on poverty and inequality. I am delighted that the Children's Institute is among the contributors to this important debate.

Reflection on child poverty and inequality

The Honourable Trevor Manuel
Minister in the Presidency: National Planning Commission



We need to think hard about how we bring up our children because the foundations laid in childhood will stay with them throughout their lives. The love and care they receive, the quality of health care, adequate nutrition and exposure to a stimulating environment all affect their physical, emotional and cognitive development.

In 2007 the medical journal *The Lancet* published a series of studies on the impact of poverty on a child's life chances. The studies estimated that cognitive development of over 200 million children under the age of five was held back by poverty, ill-health and under-nutrition,¹ and identified early childhood as "the most effective and cost-efficient time to ensure all children develop their full potential".²

Poverty has major long-term impacts on a child's development. For example, the debilitating effects of undernutrition last throughout the child's life. A five-country study that included Brazil, Guatemala, India, the Philippines and South Africa found that undernutrition was related to stunting, fewer years of schooling and reduced economic activity.³ The effects last across generations as women who were undernourished in childhood are more likely to give birth to underweight children.

The *South African Child Gauge* is an important contribution to evidence-based policy-making. It demonstrates the importance of using child-centred analyses to ensure that policies are responsive to children's needs. It tells us that while many development indicators are improving in South Africa, this is not always the case for children. It shows that far too many of South Africa's children are being left behind. One fifth of children have lost at least one of their biological parents.⁴ Nearly two-thirds of children lived below R575 per month.⁵ Over a third lived in households where no adult was employed and nearly two million children lived in informal houses and backyard dwellings.⁶ A third of children did not have access to drinking water at home.⁷

The poor quality of education that our children receive has been a focal issue for many years now. Despite high rates of attendance, the latest results from the 2011 annual national assessment shows that the average grade 3 learner scored 35% in literacy and 28% in numeracy.⁸ The painful fact is that most schools do not provide children with the skills they will need in adult life. Many children grow up in environments which expose them to violence from a very early age. Their safety is compromised in the home, schools and on the streets of their communities. They are exposed to substance abuse, and are vulnerable to unplanned pregnancy, HIV/AIDS and other sexually-transmitted diseases.

The National Development Plan⁹ focuses on how we can overcome these challenges. The plan proposes introducing a special nutrition programme for pregnant women and children under two. It identifies ways to improve both the quality and availability of health care for everyone, but especially for mothers, infants and children. To improve education standards, the plan suggests that all children should have access to two years of quality early childhood education before they start

formal schooling. It also identifies measures to improve the quality of school education, and make schools and communities both safer and more child-friendly.

The plan builds on our many laws, programmes and policies that are intended to improve children's lives and give them a better start in life. South Africa is a signatory to the United Nation Convention on the Rights of the Child. Our social security system is intended to ensure no child grows up without access to the basic means of subsistence. A recent study found that children who were enrolled on the Child Support Grant at birth stay at school longer and are less likely to suffer ill-health than those who only access this financial support later in childhood.¹⁰ The roll-out of universal access to grade R, the no-fee schools policy and the National School Nutrition Programme have also made a difference in tackling some of the effects of child poverty.

However, the implementation of policies and laws is uneven. The quality of services children can access varies depending on who they are and where they live. The legacy of apartheid continues to impact adversely on children's life chances. Children in rural areas and informal settlements have access to lower quality services than those in middle-class suburbs. Girls face more difficulties than boys, and children with disabilities are at an even greater disadvantage.

The most important investment that we can make as a country is to invest in the well-being and development of our children so that they can go on to lead healthy and active lives. The *South African Child Gauge* makes an important contribution to the debate on how we can best achieve this objective.

We must give meaning to the rights enshrined in our Constitution and create a society that is fair and just. We invite all sectors of society to work together to implement proposals in the National Development Plan and to continue to find ways to address poverty and inequality. We owe it to our children now, and to future generations.

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PART ONE:

Children and Law Reform

Part one examines recent legislative developments that affect children in South Africa.

These include the:

- Children's Act;
- Criminal Law (Sexual Offences and Related Matters) Amendment Act;
- Social Assistance Act regulations;
- National Health Act; and
- Traditional Courts Bill.

Legislative developments in 2011/2012

Lucy Jamieson, Paula Proudlock and Tendai Nhenga-Chakarisa (Children's Institute, University of Cape Town)

Legislative power is vested in Parliament and the provincial legislatures (collectively known as legislatures). This means that legislatures are responsible for the final decision on the content of the law. The executive is responsible for compiling draft laws for consideration by the relevant legislature, and for preparing sub-ordinate legislation such as regulations or norms and standards, which contain the fine detail of how a law must be implemented. The executive is also responsible for implementing the laws and making sure services reach the people.

The judiciary (courts) interprets a law when disputes arise, and assesses whether the law complies with the Constitution. Once a court has made a ruling, the executive must comply with the court's interpretation when implementing the law. The Constitutional Court can also instruct Parliament to change any law that it finds to be unconstitutional.

Many of the key 2011/2012 legislative developments affecting children came about as a result of civil society calling on the courts to interpret various laws.

Children's Act

The Children's Act¹ came into full effect on 1 April 2010. It provides for a comprehensive range of social services for children and their families and introduces a new developmental approach to South Africa's child care and protection system. The Act affects a number of government departments who need to re-train their staff and work together in new ways. This major conceptual shift for the child care and protection system has resulted in a number of implementation challenges and teething problems that should hopefully resolve with time.

However, some of the challenges have arisen because the policy choice made in the law is not reasonably conceptualised to deliver the service to the target group, or the policy choice was not clearly made by the legislature, which has left the law open to multiple interpretations. This is the case with the mechanism designed to provide social services and grants to orphaned children living with family members. In one place the Act says such children cannot be placed in foster care and in another it says that they can. Being placed in foster care determines whether or not a child can apply for the Foster Child Grant (FCG). The ambivalence in the Act has led different government departments and magistrates to interpret and apply the Act differently, resulting in unequal treatment of children and unconstitutional delays in access to both grants and services.

One way of getting clarity when there are varying interpretations of a law is to approach a High Court to interpret the Act. When all affected parties admit there is a problem, a solution can be achieved by the applicants (eg a civil society organisation, a child or

caregiver) and government negotiating and agreeing on a detailed court-ordered settlement. All parties are then bound by what has been agreed in the settlement because it is an order of the court. When no agreement can be reached, the applicants and government department will argue their interpretations in the High Court, and the court will determine the meaning of the Act via a judgment.

Lapsing grants

In *Centre for Child Law v Minister of Social Development and Others*¹ the Centre for Child Law (CCL) and the government worked together on a court-ordered settlement. This resulted in the re-instatement of a large number of FCGs that had lapsed due to court orders not being extended in time. The Children's Act requires most foster care orders to be renewed and extended by the courts every two years, while the Social Assistance Act requires the South African Social Security Agency (SASSA) to stop a grant payment if the extended court order is not submitted to SASSA in time. But social workers and magistrates courts are not able to extend children's foster care orders timeously because of the large number of children in the foster care system. As a result, over 113,000 children lost their FCGs between 1 April 2009 and 31 March 2011.³ This constitutes a serious violation of these children's constitutional rights to social assistance, nutrition, social services, health care services and education.

The settlement order between the CCL and the government allowed SASSA to re-instate the lapsed grants despite their expired court orders. As a result, approximately 80,000 lapsed grants were reinstated between 1 January and 30 November 2011.⁴ More grants are likely to have been reinstated since then. The settlement order also extended the expired court orders to May 2013. However, the settlement applies only to foster care orders granted between 1 April 2009 and 1 April 2010. Orders granted after this date, the majority of which expire in 2012, all have to go back to court to be extended. Taking into account the temporary nature of the settlement and its application only to some foster care orders, the parties agreed in the settlement that the Minister of Social Development must design and implement a comprehensive solution to address the foster care crisis by December 2014.

Backlog in applications for orphans living with extended family

While approximately 80,000 lapsed grants were reinstated between January and November 2011, only 20,000 new FCG applications were added to the system over the same period.⁵ This shows that, while the settlement addressed the problem of lapsed FCGs, the backlog in new FCG applications for the estimated 1.1 million orphans in need of social assistance is getting worse.

A second court case on foster care, *SS v The Presiding Officer of the Children's Court, District Krugersdorp and Others*,⁶ was heard

in the South Gauteng High Court in April 2012 and involved an appeal against a Children’s Court ruling that a 10-year-old orphaned child (identified only as ‘SS’) could not be placed in foster care with his great-aunt and uncle. As a result they could not be foster parents and therefore could not get the FCG for the child. The family was receiving the lower valued Child Support Grant (R280 per child per month in April 2012) but wanted to apply for the higher FCG (R770 per child per month in April 2012) due to the poverty faced by the family.

To access the FCG they had to approach the Children’s Court to have child SS declared a child “in need of care and protection”. Section 150(1)(a) of the Children’s Act requires a child to be orphaned and “without any visible means of support” before the court can find the child to be “in need of care and protection”. The Children’s Court found that child SS was already in the care of his extended family and had been in such care for the past eight years. He thus had “visible means of support” and did not qualify as a child “in need of care and protection”. The Children’s Court therefore ruled that he could not be placed in foster care, meaning the family could not apply for the FCG.

Towards an equitable and comprehensive solution

Currently there are approximately 1.1 million orphaned children living with extended family in similar conditions of poverty as child SS.ⁱ Some Children’s Courts are interpreting section 150(1)(a) in a way that allows orphaned children living with extended family to be placed in foster care, while others are interpreting it in the opposite way, or in variations between the two extremes. This

results in unequal treatment, with approximately 600,000 of these children getting the Child Support Grant (CSG), others getting the FCG (approximately 400,000), and a smaller number getting neither grant.⁷ The large number of families applying for foster care to access the higher grant amount is also putting strain on social workers and the courts. This has resulted in lengthy delays for children in receiving their grants as well as delays and inadequate services for abused and neglected children who require support and intervention from the same social workers and courts.

In the judgment in the case involving child SS, the High Court distinguished between orphan children who have an enforceable claim for support against relatives bearing a common law duty of support and those who do not. Child SS was living with his great-aunt and uncle who do not have a common law duty to support him – therefore the High Court upheld the appeal and ruled that SS could be placed in foster care with them. If they had been his grandparents or his adult siblings the final result could have been the opposite as the court stated that grandparents and adult siblings do have a common law duty to support. However, the court reiterated that, when making decisions on foster care, Children’s Courts should be guided by the spirit and purpose of the Constitution, the Children’s Act and, in particular, by the principle of the best interests of the child. The appeal binds all Children’s Courts in Gauteng and is of persuasive force for Children’s Courts in other provinces.

A comprehensive solution to the foster care crisis for the many orphans living with extended family requires the government to choose the most efficient and rights-based mechanism to provide an appropriate and adequate social grant, as well as a mechanism

ⁱ There are approximately 1.6 million maternal and double orphans living with family members. Of these, 1.1 million are living in similar conditions of poverty as child SS, and are in need of an adequately valued social assistance grant. (Statistics South Africa (2010) General Household Survey 2009. In: Hall K & Proudlock P (2011) *Orphaning and the Foster Child Grant: Return to the 'Care or Cash' Debate*. Children Count brief, July 2011. Cape Town: Children’s Institute, UCT.) The GHS 2011 shows a small increase in the number of maternal and double orphans (see p. 84).



to link these families to prevention, early intervention and protection services where needed. The Department of Social Development has finalised a commissioned study, with a costing, on this social assistance question and is in the process of reviewing the Children's Act towards amendments. However, this reform needs to be fast-tracked if the department is to make the deadline for a comprehensive solution to be in place by December 2014. The judgment in the case of child SS also heightens the urgency for an alternative solution as it potentially creates an inequitable situation where orphans living with aunts and uncles qualify for the FCG while those living with grandparents and adult siblings will generally have to rely on the lower CSG.

In September 2012, the Department has recently announced an intention to create a kinship grant that family members caring for orphans will be able to access directly from SASSA as a "top-up" to the Child Support Grant.⁸ This will ensure that orphans living with extended family can access an adequate grant timeously and it will also improve services for abused children because it will reduce the load on social workers and the courts. At the time of publication the department had not yet announced the timeframes for the reform.

Criminal Law (Sexual Offences and Related Matters) Amendment Act

The Criminal Law (Sexual Offences and Related Matters) Amendment Act⁹ defines and categorises sexual offences, and details prosecution procedures. The Act recognises that children and adolescents are vulnerable to the psychological influence of adults. It tries to protect them from abuse and exploitation by creating ages of consent to sexual activity – it is unlawful to perform a sexual act on a child younger than 16 years. The Act is commonly known as the Sexual Offences Act.

Consensual teenage sexual activity

The Act makes consensual sexual penetration between children aged 12 to 16 a crime. Other consensual sexual acts like kissing and caressing are also offences. This means that children between the ages of 12 and 16 who engage in sexual activities with other children can be charged, arrested, prosecuted and sentenced. Prosecutions must be authorised in writing by the national Director of Public Prosecutions, who may not delegate this power. Furthermore, all the children involved must be charged. However, in the case of non-penetrative consensual sexual acts it is a valid defence if the age difference between the children was not more than two years at the time of the offence.

Criminalising teenage sex potentially violates a number of children's rights enshrined in the Constitution and international law, namely, the best interests principle, the right to bodily and psychological integrity, and the right to privacy.¹⁰

The criminalisation of teenage sex is also ethically problematic for professionals providing support for these children, as the Act obliges anyone with knowledge of a sexual offence to report it to the police, and failure to report constitutes a crime. Doctors and

nurses working with young people find this requirement extremely challenging as reporting is in contravention of their obligation to respect the confidentiality of their patients, and to realise children's rights to health. This makes it harder for teenagers to access support like reproductive and counselling services, which in turn increases the likelihood of them engaging in risky behaviour.

Sexual experimentation is a normal developmental stage – in 2008, 38% of learners reported having had sex.¹¹ While children who experiment inappropriately require guidance from their caregivers or a social service professional, putting them through the criminal justice system that is designed to deal with serious criminals risks violating their right to dignity and best interests.

Although the Child Justice Act allows for diversion out of the criminal justice system, even diversion programmes potentially expose these children to harm and may bring them in contact with child sex offenders. Children engaging in consensual sex are neither victims, nor offenders, and they don't fit into sex offender or victim programmes psychologically and developmentally. Placing them in either programme has the potential to damage their sexual development.

In April 2012, the Teddy Bear Clinic and Resources Aimed at Protecting Children from Abuse and Neglect (RAPCAN) challenged the constitutionality of the criminalisation of consensual teenage sexual activity, and the reporting and registration as sex offender requirements. They also argued that the Act violates children's right to equality: "Because so many children engage in the conduct which the provisions criminalise, there is an intrinsic unfairness in the selection of which children are to be charged."¹² The judgment was still pending at the time of publication.

Lack of penalty clauses

The Sexual Offences Act lists 29 sexual offences that have no specific penalty. The offences include compelled rape, sexual assault, sexual grooming of children, exposing one's genitalia to children, and sexual exploitation of children. In May 2012 the Western Cape High Court ruled (in an appeal from a magistrate's court) that, in the absence of specific penalties, these offences do not constitute crimes and cannot be prosecuted.¹³ This ruling meant the courts could not send someone to prison when they committed any of these serious sexual offences.

Parliament responded quickly by passing an Amendment Bill¹⁴ on 7 June. The Amendment Act¹⁵ gives courts the power to use their discretion to apply a sentence where no penalty is specified in the Sexual Offences Act. This means that sexual offenders can be convicted and sentenced in future.

The Constitution prohibits criminal law from operating retroactively,¹⁶ so the 2012 amendments do not apply to people prosecuted under the original Act. Since the Act came into operation, there have been over 12,000 convictions for sexual offences, many of which were potentially vulnerable to legal challenge if the High Court judgment of invalidity stood.¹⁷

To prevent the mass release of convicted sexual offenders, the National Prosecuting Authority appealed the ruling, and children's

and women's organisations made submissions as *amici curiae* (friends of the court). The Supreme Court of Appeal heard the case as a matter of urgency in June 2012. The court had to consider the human rights of the people charged with the offences – who are protected by the principle of *nulla poena sine lege* (no punishment without a law) – as well as the rights of children and women as victims of sexual offenders:

*No judicial officer sitting in South Africa today is unaware of the extent of sexual violence in this country and the way in which it deprives so many women and children of their right to dignity and bodily integrity and, in the case of children, the right to be children; to grow up in innocence and, as they grow older, to awaken to the maturity and joy of full humanity. The rights to dignity and bodily integrity are fundamental to our humanity and should be respected for that reason alone.*¹⁸

On 15 June the Supreme Court of Appeal ruled that the penalty provisions in section 276(1) of the Criminal Procedure Act empower courts to impose sentences upon people convicted of offences under the Sexual Offences Act,¹⁹ and the fact that the Act does not contain penalty provisions does not justify nullifying charges laid or convictions secured under the Act.

Social Assistance Act regulations

There are three social grants for children: the Child Support Grant (CSG), the Foster Child Grant (FCG) and the Care Dependency Grant (CDG). Originally these grants were available only to caregivers who were South African citizens or permanent residents. However, the Refugees Act²⁰ states that a refugee enjoys full legal protection, including the rights set out in Chapter 2 of the Constitution.ⁱⁱ

Following litigation²¹ the Minister of Social Development amended regulations to the Social Assistance Act in 2008 to grant refugees access to certain social grants, including the FCG, but not the CSG or the CDG. Civil society continued to advocate for the full realisation of the right to social security for the children of refugees. However, there was no progress in this regard until Lawyers for Human Rights brought a High Court application in June 2011.²² The Minister of Social Development opposed the application but issued new amendments to the Social Assistance Act regulations, in August 2011 and March 2012 respectively, to allow refugees to claim the CDG and CSG.²³

National Health Act

Section 71 of the National Health Act²⁴ came into force in April 2012. This section specifies the requirements for therapeutic and

ii The Constitution provides that everyone has the right to have access to "social security, including, if they are unable to support themselves and their dependants, appropriate social assistance."



non-therapeutic research on children. Therapeutic research is research which aims to cure the disease or to ease the pain of a child. Such research, or experimentation, must be in the best interests of the child, with the expectation that the therapy will do more good than harm. The parent or guardian of the child must give consent and the child can also consent if s/he is capable of understanding the procedure. However, caregiversⁱⁱⁱ cannot consent to therapeutic research.

Non-therapeutic research is research that is unlikely to produce a diagnostic, preventive, or therapeutic benefit to children who are part of the study, but that aims to help patients with a similar condition in the future. Non-therapeutic research or experimentation requires the consent of the Minister of Health in addition to the parent and the child, if the child has the capacity to consent. The minister cannot consent to non-therapeutic research on children if:

- the objectives can be achieved by conducting the research on an adult;
- the research does not significantly improve scientific understanding of the child's condition, disease or disorder to such an extent that it will result in a significant benefit to the child or other children;
- the reasons for the consent by the parents or the child are contrary to public policy; or
- the potential benefit of the research does not significantly outweigh any risks to the health or well-being of the child.

Even when they cannot legally consent, children should be given information about any research or experimentation and the opportunity to express their views. The Department of Health guidelines recommend that children should be asked if they are willing to take part and that "a child's refusal to participate in research must be respected, i.e. such refusal settles the matter".²⁵

Non-therapeutic research includes descriptive and observational research; and qualitative research where subjects are interviewed about health services. The Act has come under criticism for being overly protectionist. For example, requiring ministerial consent for all non-therapeutic research with children will prevent even low-risk research with children. The requirement for parental or legal guardian consent is also problematic for the approximate 5.5 million children who live with relatives.²⁶ Children who have lost parents to AIDS are an extremely vulnerable group that need psycho-social support and health services, yet these provisions will make it almost impossible to conduct research with these children to determine their needs.

Traditional Courts Bill

The Traditional Courts Bill²⁷ regulates the traditional justice system, outlines the roles and responsibilities of traditional leaders, and provides for the structure and function of traditional courts. The Bill also sets out the penalties which traditional courts may hand

down, such as fines, damages or orders for specific performance. While the Bill aims to align the traditional justice system with the Constitution, women's and children's advocacy groups have criticised it for opening up opportunities for the violation of women's and children's rights. These include children's rights to have their best interests considered of paramount importance in matters that affect them; to participate in decisions that affect them; to legal representation; and to be protected from child labour; and the right of child offenders to be treated in a manner consistent with the promotion of the child's sense of dignity and worth.

The Bill was tabled in Parliament in early 2012 and was being debated in the National Council of Provinces at the time of publication.

Jurisdiction of traditional courts

Controversially, the Bill uses old apartheid boundaries to determine the geographic jurisdiction of the courts. Furthermore, the Bill does not provide adequate guidance on which legal system applies in what area and which court's decisions hold precedence. For example: Which law would apply if a respondent in a case lives in an urban area, holds modern values or is of European origin – African customary law or common or civil law? Experts have suggested that the jurisdiction of the courts should be governed by a person's consent, and that individuals voluntarily submit themselves to the jurisdiction of the court.²⁸ For children it is not clear who should have the right to decide which court or system of law has jurisdiction over the child. Will the child be given the choice or will an adult make the decision on the child's behalf? If the latter – what system of law governs who the adult should be? This is an important question to answer especially in rural areas and HIV-affected communities where many children are living with relatives.

Why type of cases can traditional courts hear?

Traditional courts have jurisdiction over a range of issues affecting children. They can hear civil disputes but not cases involving the care and guardianship of children, or the interpretation of wills. They can also hear a limited number of criminal matters in which children are victims or offenders: assault (where grievous bodily harm has not been inflicted), theft, malicious damage to property, and *crimen injuria* (the act of unlawfully, intentionally and seriously impairing the dignity of another).

Legal representation

The draft Bill suggests that no-one, including children, can have legal representation during traditional court proceedings. This is regarded by some as a violation of children's right to a fair trial. Others argue that allowing legal representation would change the nature of traditional courts, and that children can be represented by family members.

Child protection

The Traditional Courts Bill does not set standards to ensure the protection of children during court processes especially when it

ⁱⁱⁱ Caregivers include grannies, aunts or other relatives who care for the child with the consent of the parents or guardian of the child; foster parents; someone offering temporary safe care; the head of a shelter or a child and youth care centre; a child and youth care worker supporting children in the community; and a child (16 years and older) heading a child-headed household.

comes to publicity; the protection of child witnesses; and psychosocial support or counselling services for children who are witnesses, offenders and victims.

The Bill permits penalties such as performing “some form of service without remuneration”²⁹ for the benefit of the community. This extends to children and could open the door to abuse, forced labour or child labour. Only a limited number of a traditional court’s sentences can be appealed which leaves children open to potentially abusive sentences, and with no recourse.

The best interests principle

The Bill of Rights entrenches the principle that “a child’s best interests are of paramount importance in every matter concerning the child”.³⁰ The Traditional Courts Bill states that the Bill of Rights must be observed and respected during trial, and in judgment and penalties. However, without an explicit reference to the best interests principle there is a danger that presiding officers will not apply it.

Child offenders

The Child Justice Act makes provision for children to be diverted from the formal criminal justice system towards restorative justice programmes. The Act recognises the particular vulnerability of children in conflict with the law and the importance of a strong coordinated response to this. While allowing for diversion, it requires the engagement of state prosecutors, probation officers, defence lawyers and magistrates on all cases, including less serious matters. The Traditional Courts Bill, however, provides for none of these safeguards for children accused of crimes, thereby creating a lower standard for children under the jurisdiction of these courts than for those tried under civil law.

Different standards for children based on where they live

The Bill creates different standards for children living within the primarily rural jurisdiction of traditional courts. Children living in areas unaffected by the Bill on the other hand will have access to legal representation; enjoy the rights to participate in court decisions that affect them; may participate *in camera* (in closed court sessions) and will be protected against sentences that amount to forced and/or child labour.

The Constitution makes it clear that while everyone has the right to enjoy their culture, this right may not be exercised in a manner inconsistent with any provision of the Bill of Rights. The Traditional Courts Bill therefore needs to perform a delicate balancing act by providing forums for people to exercise their rights to practise and live within their preferred cultural norms but at the same time ensuring it does not violate children rights to equality, dignity, justice, protection and participation.

Conclusion

Laws are not static – they are living documents that evolve after Parliament passes them. This natural cycle of law-making ensures that ambiguities in laws are clarified and that laws continue to be relevant and practical to implement. When a law is not clear it becomes open to multiple interpretations – as has happened with

the Children’s Act. Sometimes the original law contains errors or omissions that need to be corrected, as was the case with the Sexual Offences Act. Changes to the laws by interpretation or amendment should help improve services for children.

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PART TWO:

Children and Inequality: Closing the Gap

Part two presents a series of 10 essays that explore the nature and extent of income inequality in South Africa and its impact on children's living conditions, opportunities and future prospects.

The essays focus on:

- children's equality rights;
- children, poverty and inequality;
- spatial dimensions of inequality;
- children's household contexts;
- income poverty and social grants;
- early childhood development services;
- inequalities in child health;
- children, HIV and access to services;
- education and inequality; and
- closing the inequality gaps for children.

Overview

Part 2 draws on a child poverty and inequality roundtable co-hosted by the Programme to Support Pro-Poor Policy Development in the Presidency, UNICEF South Africa and the Children's Institute, University of Cape Town. Focusing on the theme of *Children and inequality: Closing the gap*, a series of 10 essays outlines the extent and impact of income inequality on children's living conditions, care arrangements, health and education, and identifies interventions that have the potential to break the cycle of poverty and reduce inequality.

1. Equality rights and children: Moving beyond a one-size-fits-all approach

(pages 24 – 31)

Equality is both a founding value of the Constitution, and a fundamental right, but what kind of equality counts? This essay introduces the concepts of formal versus substantive equality and explores how the law can be used to achieve equality and advance social justice. It outlines children's rights to equality and non-discrimination in international and national law and evaluates the extent to which the Constitutional Court has championed children's socio-economic and equality rights in South Africa.

2. Children and inequality: An introduction and overview

(pages 32 – 37)

Children who grow up in poor households are likely to remain poor. In this way the inequalities of apartheid are reproduced. This essay

draws on child-centred data to illustrate how income inequality shapes children's living conditions, access to services, education and health outcomes. It also highlights the urgent need to identify the key drivers of inequality and intervene for children now to reduce inequalities in the next generation.

3. Spatial inequality: Persistent patterns of child deprivation

(pages 38 – 42)

The Centre for Analysis of South African Social Policy, University of Oxford, has developed the South African Index of Multidimensional Deprivation for Children to map the spatial dimensions of inequality across South Africa. Drawing on the 2001 Census and 2007 Community Survey, the essay shows little change in the patterns of relative deprivation over time – with the most severe deprivation concentrated in the former homelands.

4. Inequalities in children's household contexts: Place, parental presence and migration

(pages 43 – 47)

Where children live and who they live with has a significant impact on children's current and future prospects. This essay considers the relationships between income inequality and the characteristics of children's households, care arrangements and living environments. It also examines how families respond to spatial inequalities through a range of migration and care arrangements?



5. Income inequality and social grants: Ensuring social assistance for children most in need

(pages 48 – 51)

Social grants are the main source of income in poor households and are associated with improved nutrition, health and education outcomes for children. This essay examines the potential of the grants to address current and future income inequality and identifies current gaps in social assistance policy for children that must be addressed.

6. Early childhood development services: Increasing access to benefit the most vulnerable children

(pages 52 – 57)

Early childhood development services not only support children's health, well-being and early learning; they are increasingly recognised as a sound economic investment and a key strategy for reducing inequality. This essay explores young children's access to services, current gaps and constraints, and what is needed to ensure access for the poorest and most vulnerable children.

7. Inequities in child health: Challenges and opportunities

(pages 58 – 64)

Poverty and inequality have a significant influence on children's health, living environments and access to health care services. This essay raises concerns around the coverage and quality of health care services for children, and critically examines recent initiatives (such as the National Health Insurance and re-engineering of primary health care) to promote health equity and improve health outcomes for children.

8. Children and HIV: Monitoring equitable access to services

(pages 65 – 68)

The prevention of mother-to-child-transmission (PMTCT) programme has the potential to virtually eliminate paediatric HIV. This essay examines progress in achieving equity at three critical points along the PMTCT continuum: HIV testing for pregnant women, early infant diagnosis, and access to treatment.

9. Education, the great equaliser: Improving access to quality education

(pages 69 – 74)

Education has the potential to break the intergenerational cycle of poverty; yet learners in rich schools continue to have an edge over the poor. This essay explores current trends in educational access and attainment, identifies critical inequalities in both learning inputs and outputs, and considers critical areas for improving the quality of education.

10. Children and inequality: Closing the gap

(pages 75 – 77)

The National Development Plan outlines government's plan to reduce poverty and inequality by 2030. It is vital to take action to address the deep-rooted patterns of inequality that shape children's lives and life trajectories. This concluding essay identifies emerging trends, cross-cutting themes, opportunities and challenges, and the implications for policy and practice.



Equality rights and children: Moving beyond a one-size-fits-all approach

Sandra Liebenberg (Faculty of Law, Stellenbosch University)ⁱ

Equality is both a founding *value* of the South African Constitution, and a fundamental *right*. As a founding value, along with human dignity and freedom, equality must underpin how courts, tribunals or forums interpret the Bill of Rights. As a fundamental right, equality requires that everyone “is equal before the law and has the right to equal protection and benefit of the law”,¹ and that no-one is unfairly discriminated against on the grounds of race, gender, age and disability, for example.

Despite the centrality of equality in the Constitution, inequality persists. Children in particular experience multiple overlapping layers of inequality. Children are dependent on adult care and supervision for their safety and basic well-being. They are also vulnerable to various forms of neglect, exploitation and abuse by adults and older children. Yet they lack the power and resources to challenge these rights violations.

Children bear the brunt of poverty, inequality and violence, and face discrimination on the grounds of their caregivers’ status and beliefs. A review by the South African Human Rights Commission and UNICEF notes persistent racial and gender inequalities: African children are nearly 18 times more likely to grow up in poverty than White children.² Girls and young women are disproportionately disadvantaged by the HIV pandemic and gender-based violence. Also, children in female-headed households are more likely to experience hunger and are less likely to have access to adequate sanitation and water than children in male-headed households.

Despite the myriad forms of inequality which children experience, they are entitled to the equality rights guaranteed in section 9 of the Constitution.ⁱⁱ In order to understand the constitutional commitment to equality for children better, this essay considers the following questions:

- What kind of equality counts?
- How is the right to equality defined in South African law?
- How has the Constitutional Court interpreted children’s equality rights?
- What is the relationship between children’s equality and socio-economic rights?

What kind of equality counts?

Equality is a deeply contested philosophical and political concept and there is debate about which types of equality count in order

to fulfil the right to equality. The key area of debate is the relationship between equality, poverty and a just society. Is a just society one in which no poverty exists, despite high levels of inequality? Or is a just society a broadly equal one in which great disparities between rich and poor do not exist? Most political theorists within the liberal tradition regard equality as a key ingredient of a just society.

However, there are differences in what kinds of inequalities are seen as tolerable. Should we only be concerned about the equal distribution of civil and political rights, or are inequalities in the distribution of social and economic resources in society also of political and legal concern? For example, John Rawls’s first principle of justice is that each person is equally entitled to basic liberties (civil and political rights).³ His second principle of justice concerns the conditions under which social and economic inequalities in a society can be considered just: First, social and economic opportunities must be open to all (equality of opportunity). Second, inequalities in the distribution of goods and services are only justified if the worst-off in society are better off than they would be without those inequalities (the difference principle).⁴

Absolute or relative poverty

A closely related issue is the relationship between poverty and equality, and whether to focus on measures of absolute or relative poverty.

Absolute poverty is concerned primarily with defining the minimum required for each person to survive and meet their basic human needs. For example, one of the Millennium Development Goals aims to halve the proportion of people living on less than one US dollar per day. This notion of a basic threshold is similar to the concept of a minimum core which certain scholars argue should be a priority obligation of the state in the realisation of socio-economic rights.⁵ Although inequality is not unimportant within the absolute poverty perspective, it is seen as a separate and distinctive problem to that of poverty.

Critics of the absolute poverty perspective argue that structural inequality affects the ability of people to meet their basic needs.⁶ Significant social disparities can undermine the ability of people to participate as equals in all spheres of social life, thereby entrenching deep patterns of poverty and social exclusion. As Amartya Sen points out:

ⁱ I am indebted to Tarryn Bannister, LLM candidate in the SERAJ project, for her invaluable research assistance for the purposes of this chapter.

ⁱⁱ The rights in section 9 are guaranteed to “everyone” and would thus extend to children unlike, for example, the right to vote in section 19(3) of the Constitution to which only “adult citizens” are entitled.

*Being relatively poor in a rich country can be a great capability handicap, even when one's absolute income is high in terms of world standards ... [as] more income is needed to buy enough commodities to achieve the same social functioning.*⁷

Sen recognises that poverty is not simply about a lack of income or access to commodities, but about the complex economic, social, political, cultural and psychological barriers which impede people's ability to participate effectively in society. For example, children may have access to the basic necessities of life, but whether they are in fact well-nourished, educated and healthy will depend on the quality of the care, support and guidance of their caregivers. In other words, one cannot ignore the impact of disparate power relationships in determining whether access to resources and social services can be converted into valuable outcomes for adults or children.

Difficulties also arise concerning who defines the basic needs of the poor. Of particular concern is the paternalism inherent in absolute poverty measures, where experts define what the poor need thereby denying them agency and voice in defining their own needs.

However, relative measures of poverty are also problematic. Such measures tend to focus on the gaps between the best and worst-off in society, but can ignore significant inequalities between groups both below and above the poverty line. Even if a society is relatively equal, this doesn't mean it is not afflicted by poverty, as a large section of the population may still not enjoy decent living standards.⁸ In other words, poverty and inequality are closely inter-related, but they cannot be collapsed into a single construct.

Amartya Sen's capabilities theory represents one attempt to combine absolute and relative approaches to poverty. Sen argues that development theorists and policy-makers should look beyond income poverty and focus on expanding people's "... 'capabilities' to lead the kind of lives they value".⁹ Sen defines poverty in absolute terms as "the failure of basic capabilities to reach certain minimally acceptable levels".¹⁰ However, he recognises that the resources needed to achieve minimally acceptable functioning are relative – and vary according to the particular needs and circumstances of the group concerned and the structural features of the particular society in question. For example a child living with disabilities will need more resources and support than an able-bodied child to be able to participate in society.

Equality of status or equality of resources

Case law dealing with the right to non-discrimination tends to focus on inequality of "status", for example, discrimination and disrespect for certain groups on grounds such as race, gender, sexual orientation, religion and belief. It has proven far more difficult for inequalities in the distribution of resources and services to be recognised within the non-discrimination paradigm of equality law.¹¹ This is so, even though poverty is notoriously a source of deep disadvantage and stigma in society.

It is also well-known that many of the traditional groups addressed by non-discrimination law – Black people, women and those living with disabilities – are disproportionately affected by

poverty and the unequal distribution of resources. Where such overlaps can be proven it may be possible to bring a claim based on indirect discrimination on grounds such as race or gender. However, it remains difficult to challenge poverty as a form of discrimination in its own right.¹²

Formal or substantive equality

A further question for consideration is how courts should assess whether the equality norm has been violated and, if so, how should violations be redressed? These questions are also relevant to legislators, policy-makers, institutions such as the South African Human Rights Commission and civil society in formulating, implementing, monitoring and advocating for policies which respect and promote the right to equality and non-discrimination.

There is a key distinction between formal and substantive equality. Formal equality focuses on treating everyone exactly the same regardless of their actual situation or circumstances (equality of opportunity). In some circumstances, this may be justifiable, such as the principle of one person, one vote. However, in many other contexts, identical treatment ignores the very real differences between groups and socially constructed barriers to equal participation. For example, treating a child witness in a court case in the same way as an adult witness does not take into account the differences between children and adults, and children's relative lack of power within an adult-designed and -managed criminal justice system. So a formal approach to equality may simply end up entrenching existing inequalities. The United Nations Committee on Economic, Social and Cultural Rights has noted that:

*Eliminating discrimination in practice requires paying sufficient attention to groups of individuals which suffer historical or persistent prejudice instead of merely comparing the formal treatment of individuals in similar situations. State parties must therefore immediately adopt the necessary measures to prevent, diminish or eliminate the conditions and attitudes which cause or perpetuate substantive or de facto discrimination.*¹³

Substantive equality aims to achieve equal outcomes for people in real world situations. It is closely attuned to the historical, social, economic and political context of inequality in a particular society, and recognises that sometimes groups must be treated differently in order to compensate for existing inequalities and achieve fair outcomes.¹⁴ A substantive equality approach is also sympathetic to the use of affirmative action measures to redress systemic discrimination. Depending on the context, substantive equality may entail creating equal opportunities for disadvantaged groups ("levelling the playing fields") or redistributive measures in favour of such groups to enable them to achieve equal outcomes.

The legal theorist, Ronald Dworkin, argues that while certain rights may require equal treatment (eg the right to vote), equality in the distribution of goods and opportunities generally requires "the right to equal concern and respect" in political decisions about how these goods and opportunities are to be distributed.¹⁵ This

Box 1: The right to equality and non-discrimination

1. Everyone is equal before the law and has the right to equal protection and benefit of the law.
2. Equality includes the full and equal enjoyment of all rights and freedoms. To promote the achievement of equality, legislative and other measures designed to protect or advance persons, or categories of persons, disadvantaged by unfair discrimination may be taken.
3. The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.
4. No person may unfairly discriminate directly or indirectly against anyone on one or more grounds in terms of subsection (3). National legislation must be enacted to prevent or prohibit unfair discrimination.
5. Discrimination on one or more of the grounds listed in subsection (3) is unfair unless it is established that the discrimination is fair.

Source: Constitution of the Republic of South Africa, 1996. Section 9.

implies that those who will be disadvantaged by a particular policy choice have a right to have their needs and interests taken into account when weighing up the advantages and disadvantages of the policy for society. This is highly relevant to children whose needs and interests are often ignored or minimised by policy-makers, particularly in the case of policies that do not expressly refer to children (eg job creation programmes). There is seldom a serious and systematic audit and consideration of the impact of particular policies on children.

Levelling up or levelling down

A final consideration is deciding on the appropriate remedy if legislation or policy is found to be in breach of the right to equality. One possible approach is to say that it is acceptable for the benefits offered by a particular programme to be levelled up or down, providing that the affected groups are treated the same. In contrast, a substantive approach to equality would seek to achieve a fair distribution of resources, but avoid the result of inadequate services being delivered to everyone ("equality with a vengeance" or "equality of the graveyard"¹⁶).

For example, in the past men qualified for an Old Age Grant at 65, while women qualified at 60. To achieve formal equality (or the equal treatment of men and women), it is possible to either level up the benefits so that men can retire earlier, or level down, so that women wait until 65 before receiving a pension. While a formal

approach to equality would be content with levelling up or down, a substantive approach would be reluctant to deprive women of their existing benefits and more inclined to extend the benefits of early retirement to men. However, a substantive approach to equality would also consider the broader patterns of gender inequality in the work place which could be used to motivate for maintaining the *status quo* as an affirmative action measure.ⁱⁱⁱ

In a number of challenges to legislation that violates the equality clause in the Constitution, the Constitutional Court has preferred to include the excluded, and extend the benefits of the legislation to the excluded group rather than strike down the discriminatory legislation.¹⁷ This outcome is also reinforced by the express inclusion of socio-economic rights in the Bill of Rights which requires the progressive realisation of socio-economic rights.¹⁸ Any reduction in the level or quality of benefits delivered would require justification by the state as these "retrogressive measures" are contrary to the state's constitutional mandate to advance "as expeditiously and effectively as possible" towards the goal of full realisation of the relevant rights for everyone.¹⁹

How is the right to equality defined in South Africa law?

Equality before the law, and equal benefit and protection of the law, are basic guarantees to which everyone is entitled. This means that the state may not make arbitrary, irrational distinctions amongst various groups in society when it makes policy or adopts legislation.

It is significant that section 9(2) of the Constitution defines equality to include "the full and equal enjoyment of all rights and freedoms" (see box 1). This implies that the right to equality extends to the enjoyment of all the rights in the Bill of Rights – civil and political rights, as well as economic, social and cultural rights. The Constitution therefore does not limit the reach of equality rights to only the civil and political sphere. Section 9(2) also expressly mandates restitutionary equality (affirmative action measures) to promote the achievement of equality. It recognises that legislative and other measures to benefit disadvantaged groups are essential to redress the inequalities of the past and achieve substantive equality.^{iv}

Sections 9(3) and 9(4) of the Constitution prohibit direct or indirect unfair discrimination on different grounds. Grounds which are not expressly listed may also be recognised by the courts if they have the potential to affect people adversely or impair their human dignity.²⁰ On this basis, the Constitutional Court has, for example, recognised HIV-positive status²¹ and citizenship²² as potential grounds of prohibited discrimination.

The duty to refrain from unfair discrimination extends beyond the state to "any person". This means that the duty applies, for example, to independent schools, banks, private landlords, social welfare organisations and a wide spectrum of non-state entities.

iii In *Christian Roberts v Minister of Social Development*, case no 32838/05 (2010) TPD, the North Gauteng High Court rejected an application for the Old Age Grant to be equalised at 60 years for men and women. However, the Ministry of Social Development decided, prior to this judgment, to "level up" the age of eligibility for male pensioners to age 60 years, using a phasing-in approach over three years.

iv The criteria for affirmative action measures to comply with section 9(2) of the Constitution were established by the Constitutional Court in *Minister of Finance v Van Heerden* 2004 (6) SA 121 (CC).

How has the Constitutional Court interpreted the rights to equality and non-discrimination?

The Constitutional Court endorses a substantive approach to the interpretation of section 9. In the context of affirmative action it means encouraging carefully crafted measures which can enable disadvantaged groups to participate as equals in all spheres of society. A substantive approach is also used to assess whether discrimination is “unfair”. The Court’s approach is well captured in an extract from Justice Moseneke’s judgment in *Minister of Finance v Van Heerden*:

... a major constitutional object is the creation of a non-racial and non-sexist egalitarian society underpinned by human dignity, the rule of law, a democratic ethos and human rights. From there emerges a conception of equality that goes beyond mere formal equality and mere non-discrimination which requires identical treatment, whatever the starting point or impact. ... This substantive notion of equality recognises that besides uneven race, class and gender attributes of our society, there are other levels and forms of social differentiation and systemic under-privilege, which still persist. The Constitution enjoins us to dismantle them and to prevent the creation of new patterns of disadvantage. It is therefore incumbent on courts to scrutinise in each equality claim the situation of the complainants in society; their history and vulnerability; the history, nature and purpose of the discriminatory practice and whether it ameliorates or adds to group disadvantage in real life context, in order to determine its fairness or otherwise in the light of the values of our Constitution. In the assessment of fairness or otherwise a flexible but “situation sensitive” approach is indispensable because of shifting patterns of hurtful discrimination and stereotypical response[s] in our evolving democratic society.²³

Key factors in determining if a measure discriminates unfairly are:

1. the position of a group in society and whether they have been disadvantaged in the past;
2. the nature and purpose of the discriminating provisions; and
3. the impact of the measure on the human dignity of the group or the extent to which it seriously infringes their rights or interests.²⁴

Constitutional Court rulings have shown that discriminating between groups can sometimes be fair. For example, in one case the Court found that the remission of sentence granted to all mothers who were in prison and who had children younger than 12 years did not constitute unfair gender discrimination as mothers bore a disproportionate burden of child care responsibilities.²⁵ This

was particularly the case given that fathers did not experience the same deep patterns of economic and social disadvantage as mothers. However, the case illustrates the fine line between assisting disadvantaged groups to overcome entrenched patterns of disadvantage, and the danger of entrenching gender roles and other invidious stereotypes.

Some equality cases decided by the Constitutional Court have dealt with discrimination against various forms of relationships such as gay relationships,²⁶ customary law marriages,²⁷ religious marriages,²⁸ and long-term cohabiting partners.²⁹ These cases have implications for children adopted or born to couples in such relationships and may result in children not enjoying the benefit of parental rights and responsibilities to the same extent if their parents’ relationship was recognised.^v The failure to recognise certain relationships may also result in children’s primary caregivers (usually women) being denied resources such as maintenance payments for their children’s basic needs.

Certain common law or customary law rules may discriminate directly against certain categories of children, as illustrated in case 1.

Case 1: Challenging unfair inheritance laws

Mrs Bhe challenged the rule of primogeniture^{vi} to enable her two minor daughters to inherit a house from their deceased father. This rule was also challenged in the public interest on behalf of all female children, younger siblings and extra-marital children. Former Chief Justice Pius Langa confirmed that children “may not be subjected to unfair discrimination”.³⁰ He also pointed out that the primogeniture rule not only discriminated on grounds of sex (against female descendants), but also on the grounds of birth as it undermined the human dignity of extra-marital children by depriving them of their right to inherit from their deceased father.

Source: *Bhe and Others v Khayelitsha Magistrate and Others* 2005 1 SA 580 (CC).

The Promotion of Equality and Prevention of Unfair Discrimination Act³¹ gives effect to section 9(4) of the Constitution, and contains provisions for challenging unfair discrimination before the Equality Courts. It also endorses a substantive approach to equality and requires public and private institutions to take positive steps to address disadvantages and to accommodate diversity. For example, the Constitutional Court held that a public school had failed to reasonably accommodate the sincere religious and cultural beliefs and practices of a Hindu learner who sought to wear a nose stud to school in contravention of the official School Uniform Code.³² The Court found this to constitute unfair discrimination in terms of the Equality Act, and ordered the school to amend its uniform code to make reasonable provision for the religious and cultural beliefs of learners.

v For example: *Du Toit v Minister of Welfare and Population Development* 2003 (2) SA 198 (CC) (provisions in the Child Care Act of 1974 limiting adoption rights to married persons and excluding same-sex couples found to be unconstitutional); *J v Director-General, Department of Home Affairs* 2003 (5) SA 621 (CC) (section 5 of the Children’s Status Act of 1987 found to be unconstitutional as it didn’t allow for both parties in a gay relationship from being recognised as parents of children conceived through artificial insemination). The parental rights and responsibilities of unmarried fathers are now regulated by section 21 of the Children’s Act of 2005.

vi The right of the first born son to inherit the estate, where no will (testament) is left.

Legislative and policy measures which discriminate directly or indirectly against children must also consider the constitutional injunction that a child's best interests are of paramount importance in every matter concerning the child.³³ As explained by Justice Sachs, the law should strive to be "child-sensitive." He went on to state that statutes must be interpreted and the common law developed "in a manner which favours protecting and advancing the interests of children; and the courts must function in a manner which at all times shows due respect for children's rights".³⁴ Justice Sachs cited with approval Julia Sloth-Nielsen's view that courts and administrative authorities should be "constitutionally bound to give consideration to the effect their decisions will have on children's lives".³⁵

There is also a strong case for children's capacity and right to participate in matters that affect them, as outlined in the Children's Act.³⁶ The courts have on occasion recognised the importance of hearing children's voices in cases that affect their rights. For example, in a Constitutional Court case on corporal punishment in independent schools, Justice Sachs lamented the fact that a *curator ad litem* (legal representative) had not been appointed to represent the voices and interests of the affected children:

*A curator could have made sensitive enquiries so as to enable their [the learners at the relevant schools] voice or voices to be heard. Their actual experiences and opinions would not necessarily have been decisive, but they would have enriched the dialogue, and the factual and experiential foundations for the balancing exercise in this difficult matter would have been more secure.*³⁷

What is the relationship between children's socio-economic and equality rights?

There is an important overlap in the Constitution between the right to equality and socio-economic rights in the Bill of Rights. Children share the same range of socio-economic rights as adults including the right to have access to housing, health care, food, water, social security and education. Children are also entitled to additional protection which includes the "right to basic nutrition, shelter, basic health care services and social services"³⁸ (illustrated in figure 1 on p. 29).

In the *Grootboom* case, the Constitutional Court held that parents and families have the primary duty to fulfil children's socio-economic rights, while the state is only directly responsible for fulfilling these rights for children who are without family care.³⁹ The Court held that the state has a duty to create a legal and administrative infrastructure to give children living with parents or families the protection outlined in section 28.⁴⁰

In addition, the state is obliged to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of everyone's rights to housing, health care, food, water and social security.

In the case of the *Minister of Health and Others v Treatment Action Campaign and Others* the Court judgment went a step further and

implied that the state should take reasonable measures to assist parents to care for their children, and to ensure that they have access to critical social services, such as health care, when parents are too poor to provide access from their own resources.⁴¹

The Constitutional Court has held that the constitutional right to basic education⁴² imposes a direct and immediate obligation on the state.⁴³ This right may only be limited if it is considered "reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom" in line with the general limitations clause in the Constitution.⁴⁴

The overlap between these socio-economic rights provisions and the right to equality arises when groups are excluded unfairly from socio-economic programmes, or when services are delivered in ways which reinforce stereotypes and undermine the dignity of the recipients.⁴⁵ The *Khosa* case illustrates how it is possible to challenge policies on the grounds that they violate both socio-economic and equality rights (see case 2).

Case 2: Equal access to social grants for permanent residents

The case involved a challenge to certain provisions of the Social Assistance Act⁴⁶ and the Welfare Laws Amendment Act⁴⁷ which limited social grants to South African citizens. The applicants were Mozambican citizens who had lived in South Africa since 1980, and who had permanent residence status. They were destitute and needed access to social grants.

The applicants argued that limiting these grants to citizens, and excluding permanent residents, constituted unfair discrimination, and violated the right of "everyone" to have access to "appropriate social assistance".⁴⁸ The Court ruled that both constitutional provisions were violated and that the legislation should be amended to include permanent residents as a group eligible for social grants.

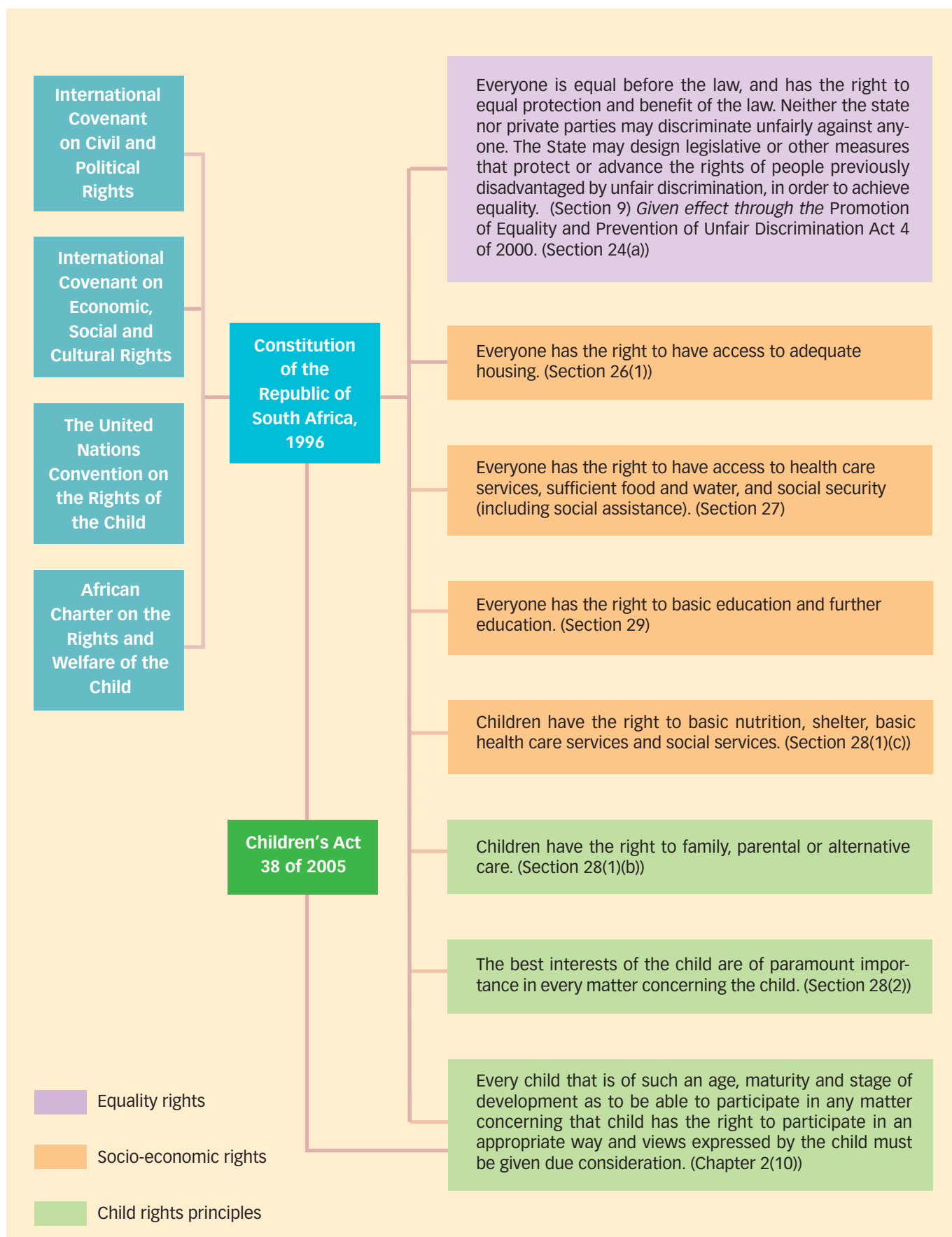
Source: *Khosa & Others v Minister of Social Development & Others* 2004(6) BCLR 569 (CC).

Case 3 on p. 30 explains another significant High Court judgment, which dealt with the overlap between unfair discrimination and socio-economic rights focusing on disability and the right to a basic education.

Litigants may face difficult strategic questions on whether to frame a case as a violation of their equality or socio-economic rights, or a combination of the two (as in the *Khosa* and *Western Cape Forum for Intellectual Disabilities* cases). The equality rights paradigm is often more responsive to claims involving exclusion of a particular group on the basis of their status such as race, gender, religion, etc.⁵⁰

Legislators and courts (in South Africa and internationally) are less likely to recognise and design remedies which respond effectively to poverty as a prohibited ground of discrimination in its own right. However, the Promotion of Equality and Prevention of Unfair

Figure 1: Children’s equality and socio-economic rights in South African law



Case 3: Equal access to education for children with intellectual disabilities

The case challenged policies of both the national and Western Cape provincial governments which had the effect of excluding children with severe or profound intellectual disabilities from schooling. It also challenged inadequate budgetary provision for the education of such children through Department of Health subsidies to over-subscribed non-governmental organisations such as the Western Cape Forum for Intellectual Disability.

The Court held that the policy failed the section 9 test in that government could not demonstrate that the policy was rational. In particular, the government had not explained why any budgetary shortfall in the provision of education should be borne exclusively by the most vulnerable group of children instead of being shared by all. In this regard, the Court drew on

the principles established in its socio-economic rights jurisprudence in the *Grootboom* case that the socio-economic needs of those who are especially vulnerable cannot be ignored in government policy and programmes.

The Court also held that the right of children with severe or profound intellectual disabilities to a basic education were being infringed by the relevant policies. They were not eligible for admission to special schools and inadequate budgetary provision was made for special care centres run by the Western Cape Forum for Intellectual Disability. This meant that many children with severe or profound intellectual disabilities would not have access to an appropriately tailored basic education programme.⁴⁹

Source: *Western Cape Forum for Intellectual Disability v Government of South Africa* (2011) 5 SA 87 (WCC).

Discrimination Act does include a directive principle on HIV/AIDS, nationality, socio-economic status and family responsibility and status as potential grounds of prohibited discrimination under the legislation.⁵¹ These grounds are yet to be formally included in the list of prohibited grounds under the Act. However, a court may still find that they are included within one of the listed grounds of discrimination, or fall within the open-ended category of grounds which cause or perpetuate systemic disadvantage, undermine human dignity, or seriously undermine the equal enjoyment of a person's rights and freedoms.⁵² These provisions carry much untapped potential to advocate for effective policy and judicial remedies for children experiencing various forms of systemic disadvantage and socio-economic marginalisation.

Given that the Constitution entrenches both equality rights and socio-economic rights, there is great scope for developing a creative synergy between these two sets of rights. Policy-makers and children's rights advocates can build on this rights framework to address the limitations of current policies and programmes and develop more effective responses to the mutually reinforcing patterns of disadvantage created by both discrimination and socio-economic deprivation.

What are the conclusions?

There are many complex questions when considering the position of children within an equality rights paradigm, but there are also very important insights to be gained in doing so. In particular, an equality and non-discrimination perspective helps illuminate the disparate impact of poverty on various categories of children.

It also highlights how the design or implementation of social programmes can fail to take into account the specific needs and circumstances of children, and in the process increase their vulnerability and disadvantage. When designing programmes and policy responses to poverty, it is particularly important that the "best interests of the child" are considered.

Children are embedded in communities and family relationships and specific measures supporting communities and families to care for children adequately are indispensable, as required by the United Nations Convention on the Rights of the Child and the African Children's Charter.⁵³

While law and policy should aim to promote the full and equal enjoyment of all rights, this may require differences in treatment, including adopting special measures in favour of disadvantaged groups of children and their caregivers. Achieving substantive equality requires a move beyond a "one-size-fits-all" approach. Policy-makers and programme managers need to analyse the differences between children and take account of factors such as their age, race, gender, location, caregivers' relationship status and income in policy and programme design.

A substantive equality right combined with the express inclusion of socio-economic rights in the Bill of Rights provides an optimal normative framework for the development of the capabilities of all children. Paying attention to children's equality rights can provide significant insights into the types of interventions that will assist them to participate as equals in South Africa's young democracy.

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Children and inequality: An introduction and overview

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There is growing concern about inequality, in South Africa and globally. A number of countries have experienced a rise in inequality despite economic growth, and there is compelling evidence that high rates of inequality have negative consequences not only for the poor but for society as a whole. The issue of inequality is particularly pertinent in South Africa, where inequities in access to resources and capital, opportunities and services have been structurally entrenched over many decades, and are hard to reverse.

Children who are born to poor parents and grow up in poor households are likely to remain poor, and in this way the inequalities of apartheid are reproduced. A key objective of the National Development Plan is to reduce inequality substantially by 2030.¹ This will require addressing the inequities which determine the opportunities available to people from the day they are born.

This essay considers the following questions:

- What is the difference between poverty and inequality?
- What do we know about inequality in South Africa?
- Why focus on children and inequality?
- What are some of the interrelated dimensions of inequality for children?

What is the difference between poverty and inequality?

Poverty and inequality are distinct, albeit linked, issues. Poverty is defined in reference to a poverty line – if a person or household has an incomeⁱ that is below this line, they are defined as being poor. Income inequality, on the other hand, refers to disparities in income, ie the gap between the rich and the poor. Inequality thus focuses on *relative* deprivation. At one extreme, one can imagine a society in which everyone is poor yet inequality is low because everyone has roughly the same income; at the other extreme, one can imagine a society in which nobody is very poor but inequality is high because some people are extremely rich compared to others.

These distinctions are important and can have important consequences for public policy. South Africa has high rates of both poverty and inequality. To address these it is necessary to reduce poverty while also reducing the gap between the rich and poor. In other words, while inequality could be reduced by “levelling down” (for example by introducing a maximum wage or increasing taxation) it is also necessary to ensure that poverty reduction strategies are

Box 2: Measuring poverty: Some common terms

Poverty line: Usually expressed in monetary terms, poverty lines are generally set at a minimal desired level of income (or expenditure) to cover the cost of basic needs. There is no single poverty line. Very low poverty lines are linked to the cost of basic nutritional needs (ie the cost of sufficient food to survive). Others are linked to a basket of goods, which may include the costs of essential clothing, accommodation, education access and so on. Some commonly used poverty lines are:

- The *international poverty line*: \$1.25 per person per day (equivalent to just under R200 per person per month in 2011, when adjusted for purchasing power parity. This line has been criticised for being below survival level in South Africa.)
- *South Africa minimal poverty line*: R458 per person per day in 2011 (recommended by the National Planning Commission as the minimum line, below which no person should live).
- *South Africa lower-bound poverty line*: R604 per person per month in 2011, or R575 in 2010. (This is an unofficial but commonly used poverty line proposed by Özler.²² It allows for sufficient nutrition to grow and develop, as well as some household necessities.)

- *South Africa upper-bound poverty line*: R1,113 per person per month in 2011. (Unofficial but commonly used, proposed by Özler. It is derived from the cost of meeting daily nutrition requirements, and also allows for a basic basket of goods.)

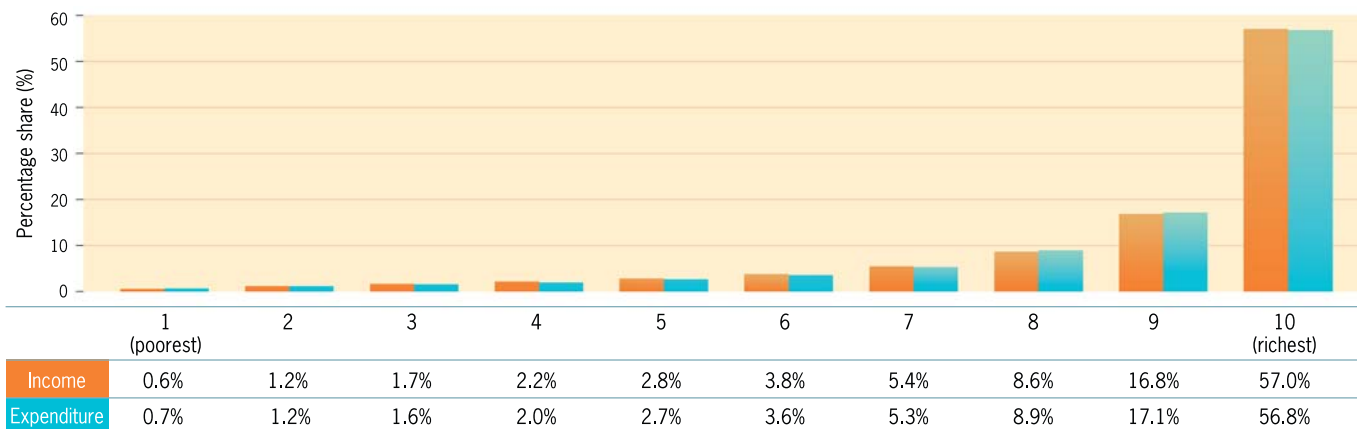
Poverty headcount

The number (or proportion) of people whose income is below a particular poverty line. The poverty headcount distinguishes the “poor” from the “non-poor”. An important limitation of the poverty headcount is that it does not reflect how poor people are. If the poverty line is for example set at R500 per month, then someone earning R499 per month would be counted as “poor”, while someone earning R501 per month would be counted as “not poor”, even though there is no real difference in their income. The difference between these two would be reflected the same as the difference between someone earning R1 per month and someone earning R1 million a month. The poverty headcount is therefore of little help in understanding inequality.

ⁱ Or expenditure or some measure of multiple deprivation. For simplicity, this discussion is restricted to income.

Figure 2: Distribution of income and expenditure shares across income deciles, 2008

(Y-axis reduced to 60%)



Source: Southern Africa Labour and Development Research Unit (2012) *National Income Dynamics Study 2008, Wave 1* [dataset]. Version 4.1. Cape Town: SALDRU, UCT [producer], DataFirst [distributor]. Calculations by Ingrid Woolard, SALDRU, UCT.

well targeted and sufficient to substantially improve the situation of poor households, who by most measures make up a large part of the population.

This raises the question of where one draws the line between the poor and the non-poor. It is generally acknowledged that “poverty” takes many forms: in addition to income poverty, one can talk of poverty or deprivation in the interrelated areas of health, nutrition, education, living standards, household assets and so on. But, in order to measure the level of deprivation in any of these dimensions, it is necessary to define the lines which distinguish those who are “poor” from those who are “not poor”.

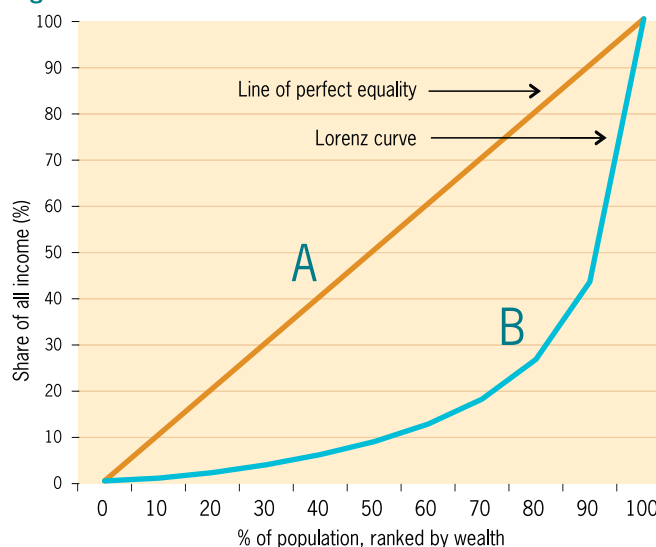
These lines can be quite arbitrary. In South Africa, a number of poverty lines are commonly used, ranging from around R200 per person per month to about R1,000 per person per month (see box 2 on p. 32). Counting the number of people above and below a poverty line can be useful – particularly for tracing poverty trends over time – but it tells us little about the differences between those who struggle to survive and those who live in comfort.

Many of the lines that separate the poor and non-poor are linked to a minimum core, or what is referred to as a “social protection floor”. This is a foundational level of income, assets and services that are seen as necessary for people to survive and live healthy and dignified lives.² The government provides targeted poverty alleviation programmes such as social grants, health-fee waivers and free basic services. But there would still be a gulf between the rich and poor even if the levels of basic “adequacy” were achieved for all. This matters because inequality is bad for society as a whole.

A large body of evidence suggests that growing inequality tends to impede economic growth and increase poverty.³ But inequality has also been directly linked to other indicators such as reduced life expectancy, lower educational outcomes and lower levels of trust within society.⁴ Most importantly, inequality harms the life chances of children.

Measures of poverty provide an indication of the quality of people’s lives and their ability to survive and develop. Measures of in-

Figure 3: A Lorenz curve for South Africa



Source: Southern Africa Labour and Development Research Unit (2012) *National Income Dynamics Study 2008, Wave 1* [dataset]. Version 4.1. Cape Town: SALDRU, UCT [producer], DataFirst [distributor]. Calculations by Katherine Hall, Children’s Institute, UCT.

equality tell us more about the nature of society. High levels of inequality require more than poverty alleviation efforts or economic growth; they require inclusive growth that enables “levelling up”.

It is therefore important to address not only poverty but also inequality.

What do we know about inequality in South Africa?

Like poverty, inequality can be measured across various dimensions, although the most common measure concerns the distribution of income across the population (see box 3 on p. 35). In South Africa the poorest 10% of the population receives a mere 0.6% of the national income, while the richest 10% receive more than half of the national income (57%). This pattern is consistent whether one uses income or expenditure, as illustrated in figure 2.

Table 1: Gini coefficients on per capita household income, for the whole population and for children,ⁱⁱ by race

Whole population	All races	African	Coloured	Asian/Indian	White
1993	0.67	0.55	0.43	0.46	0.42
2000	0.67	0.61	0.53	0.50	0.47
2008	0.70	0.62	0.54	0.61	0.50
Children	All races	African	Coloured	Asian/Indian	White
1993	0.65	0.53	0.42	0.52	0.41
2000	0.66	0.58	0.53	0.45	0.42
2008	0.69	0.58	0.55	0.61	0.50

Sources: Calculations by Arden Finn, SALDRU, UCT, based on data from the 1993 Project for Statistics on Living Standards and Development, *Income and Expenditure Survey 2000* and *National Income Dynamics Study 2008*.

The pattern of inequality is further illustrated by the Lorenz curve in figure 3, which also shows how the poorest 10% of the population in South Africa receive only 0.6% of all income, the poorest 50% receive 8.5% of all the income, with a sharp rise in the income share in the top two deciles.

The Gini coefficient is derived from the Lorenz curve and measures the extent of inequality in a population (see definitions in box 3 on p. 35). With a Gini coefficient of about 0.70, South Africa ranks as one of the most unequal societies in the world.⁵ Gini coefficients in table 1 show levels of inequality for the population as a whole, within race groups as well as for children. Contrary to expectations, overall inequality has continued to rise post apartheid. The analysis also confirms other evidence⁶ – that the rise in inequality is associated with a rise in within-race inequality. When analysing inequality between children, it is found that levels of inequality are slightly lower than for the overall population (because high-income households are less likely to contain children), but the trends in terms of

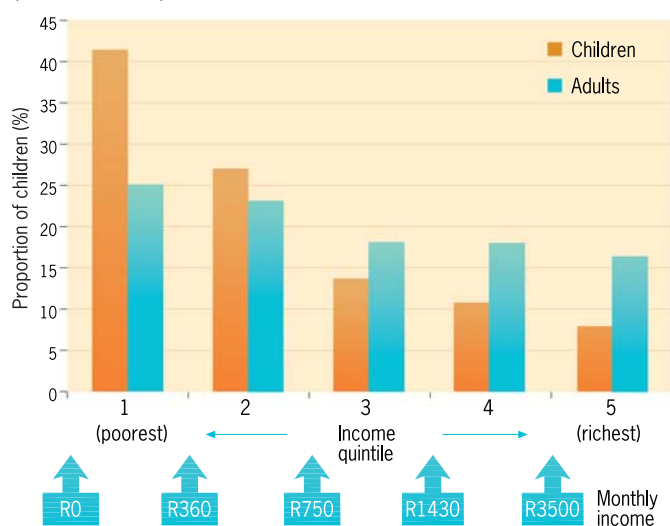
rising overall inequality and within-race inequality are the same.

There is little doubt that income inequality is firmly rooted in the labour market. Labour market income can be shown to have been “responsible for” 83% of income inequality in 1993 and 85% in 2008.⁷ Among the poorest quintile (the poorest 20% of the population), only 10% of adults are working versus 71% for the richest quintile. And even among those who are working, the average wage in the poorest quintile is less than one-tenth of that in the richest quintile.⁸

Two redistributive policies – progressive taxation and pro-poor social grants – have been shown to reduce South Africa’s Gini coefficient by about 6%.⁹ This level of redistribution is higher than that achieved by the tax-transfer systems in Latin America (where the Gini only shifted by about 2%) but much lower than that achieved in Europe (where the Gini shifted by almost 20%). In South Africa, the positive impact of redistributive policies on inequality has not been enough to offset other factors, such as unequal employment opportunities and wages, which have caused inequality to rise further post apartheid. Without progressive taxation and social grants, levels of inequality would be even higher.

Figure 4: Differences in the distribution of children and adults across income quintiles, 2010

(Y-axis reduced to 45%)



Source: Statistics South Africa (2011) *General Household Survey 2010*. Pretoria: Stats SA. Calculations by Katharine Hall, Children’s Institute, UCT.

Why focus on children and inequality?

There are three main reasons why it is important to consider children specifically when thinking about inequality. First, patterns of inequality are quite different for adults and for children. Second, inequality has particular consequences for children. Third, inequality within a generation of children is a marker of the likelihood that inequality will persist into the next generation, and can help us to understand the causes of inequality among adults.

Although inequality within the child population (as measured by the Gini) is no higher than that in the general population, there are inequalities between adults and children. Figure 4 shows that children are more likely than adults to live in poor households (the poorest two quintiles) and are under-represented in relatively non-poor households (quintiles 4 and 5).

These different distributions can be explained partly by the fact that households in which children live tend to be larger, so household income needs to be shared by more people. It is also related

ⁱⁱ The income of the household is assumed to be equally shared by all the members of the household, ie the per capita income of household is attached to each person, including the children. For the “child” analysis, the per capita household income is attached to each child under 18 years.

to where children live – many of them are in households where adults are not working or are absent migrants (see the essay on pp. 43 – 47).

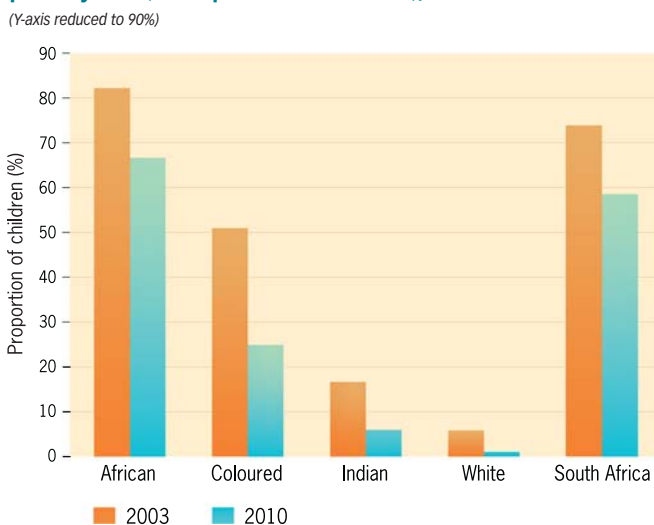
Richard Wilkinson and Kate Pickett examined the relationship between child well-being, income levels and inequality in different developed countries.¹⁰ They found that children’s well-being is significantly correlated to a country’s level of income inequality and to the percentage of children in relative poverty, but not to a country’s average income. Similarly, inequality is associated with a range of health and social problems. Irrespective of their average income, more unequal countries have higher infant mortality rates, higher pregnancy rates, higher homicide rates, greater prevalence of mental illness, lower educational outcomes and lower life expectancy than countries with more equal distribution of income. This suggests that reducing inequality would do more to promote children’s well-being than further increases in economic growth.

What are some of the interrelated dimensions of inequality for children?

There are 18.5 million children in South Africa; nearly 40% of the population is under 18 years.¹¹ Using a lower-bound poverty line (equivalent to R575 per person per month in 2010), 60% of children are poor.¹²

Looking at income poverty rates amongst children in South Africa, there are no significant differences between younger and older age groups, or between girls and boys. But there are notable spatial differences,

Figure 5: Poverty headcount by race: Proportion of children with per capita household income below the lower-bound poverty line (R575 per month in 2010), 2003 and 2010



Source: Statistics South Africa (2011) *General Household Survey 2010*. Pretoria: Stats SA. Calculations by Katharine Hall, Children’s Institute, UCT.

with child poverty rates ranging from 74% in the Eastern Cape to 31% in the Western Cape (using the lower-income bound).¹³ The most striking dimension of income inequality is the difference between races, as illustrated in figure 5. Income poverty rates have declined for children overall, and within race groups. But stark differences in poverty headcounts (see box 2 on p. 32), particularly between White and African children, illustrate the lasting effects of apartheid.

Unequal poverty rates are not the consequence of race; rather inequality between races is correlated with a range of other factors, such as location, adult employment and parental education, which are themselves correlated.

Income is not an end in itself; one cannot eat or wear money. Rather, it is a means to buy goods and services, acquire assets and exercise choice – for example to make deliberate and strategic decisions about where to educate children, which health services to use and where to locate one’s home. In a society where services and opportunities are publicly available and equally distributed, the ability to buy and choose would be less important.

Inequality is compounded when disparities in income are coupled with inequities in access to services or treatment. For example, health risks are greater for children in very poor households with poor living conditions, yet these children also have poorer access to quality health care services than those who are better off and carry a lower burden of disease. Inequalities are also compounded across dimensions: children who are poorly nourished and hungry are less likely to be able to perform well at school, for example.

Inequalities persist in multiple and interrelated forms. For children these include:

- Income inequality between child and adult populations (which is linked to inequalities in access to adult employment and the availability of wage income to households);

Box 3: Measuring inequality: Some common terms

Inequality measures

- **Income shares:** The total income of the population is divided into equal quintiles (five equal segments each containing 20% of the population) or deciles (10 equal segments each containing 10% of the population). The income share is the amount of all income that accrues to each segment (quintile or decile).
- **Lorenz curve:** It traces income distribution across the total population. A straight line would signify an equal society (where 10% of the population has 10% of the income and so on). The line is always curved to some extent, because no society is perfectly equal. The more pronounced the curve the more unequal the society.
- **Gini:** The Gini coefficient quantifies the extent of inequality in a population. It measure the area between the line of perfect equality and the Lorenz curve (area A in figure 3, divided by the total area (A+B)). The Gini has a value ranging from 0 to 1, with 0 representing a perfectly equal society, and 1 representing a perfectly unequal society, where one person has all the income and everyone else earns nothing. The higher the coefficient, the more unequal the distribution. In the social democratic states of Sweden, Denmark and Norway the Gini is about 0.25, whereas in Mexico and Chile it is about 0.50.²³

Table 2: Child-centred analysis of inequality in indicators of deprivation

Dimension of deprivation	Measure	Average for children	Poorest 20%	Richest 20%
Rural home*	Household is situated in rural area	47%	67%	10%
Inadequate housing*	Non-formal dwelling (informal settlement, backyard shack or traditional homestead)	27%	37%	3%
Inadequate water*	Household does not have piped water in dwelling or on site	36%	54%	3%
Inadequate sanitation*	Household does not have access to a flush toilet or improved pit latrine	33%	46%	3%
No electricity*	Household does not have a mains electricity connection	17%	23%	1%
Overcrowding	Household has a ratio of more than two people per room, excluding bathroom but including kitchen	23%	31%	2%
Maternal absence*	Child's biological mother does not live in the household	27%	31%	10%
Maternal/double orphaning*	Child's biological mother is deceased or her vital status is unknown	8%	9%	1%
Children out of school*	Children of school age (7 – 17) who are not attending an educational institution	3%	4%	2%
Inaccessible schools*	Children who travel more than half an hour to reach school	18%	21%	12%
Educational attrition*	16 – 17-year-old children who have not completed basic education (grade 9)	37%	46%	11%
Food insecurity*	Households where children sometimes or often go hungry	17%	26%	0%
Infant mortality rate [†]	Probability of dying before reaching first birthday, deaths per 1,000 live births	68	87	22

Sources: * Statistics South Africa (2011) *General Household Survey 2010*. Pretoria: Stats SA. Calculations by Katharine Hall, Children's Institute, UCT.
[†] World Health Organisation (2007) *World Health Statistics 2007*. Geneva: WHO.¹⁴

- income inequality within the child population, especially between races, provinces and types of residential areas (formal and informal, rural and urban);
- differences in household form, which may reflect inequities in care arrangements;
- spatial inequalities and related inequity in access to services, infrastructure and other public resources;
- inequalities in child health, linked to inequitable living environments and access to health services;
- inequalities in schooling and particularly in school resources and educational outcomes; and
- inequalities in access to early childhood interventions, including early learning programmes.

Using income quintiles, it is possible to compare the poorest 20% of children in South Africa with the least poor 20% across a range of child-centred indicators (see table 2).

These statistics demonstrate that children in relatively wealthy households are also consistently better off in a range of other ways, and are therefore likely to have better opportunities in life.

There are exceptions to this: children have very high rates of school attendance, irrespective of their income level. The most striking inequality is that children in the top quintile are much less likely to die in early childhood than those in the poorest quintile.

Persistent spatial inequalities are particularly relevant for children. Compared with adults, and certainly adults of working age, the child population is disproportionately located in the former homelands – about half of all children are “rural”. These areas remain under-resourced, often deprived of the most basic services and social infrastructure. Long distances to schools, clinics, social welfare offices and shops mean that valuable social grants are spent on transport. Spatial inequality is however not simply an urban/rural dichotomy – small area level analysis reveals geographic patterns of inequality that resemble apartheid-era arrangements. Even within wealthy provinces and cities, the inequalities between suburban and township areas remain stark.¹⁵ These inequalities are discussed in the next two essays.

Differences in living environments, and the extent and quality of service provision, including basic water and sanitation, take their toll on children's health. Social determinants and poor living environ-

iii For example, the *National Core Standards for Health Establishment in South Africa* (2011) and the National Health Insurance scheme.

ments underlie many childhood illnesses and contribute to high child mortality rates. For instance, 22% of hospital deaths in children aged 1 – 5 years are attributed to diarrhoea, and about 70% of children who die are malnourished or underweight for their age.¹⁶ South Africa faces serious health challenges, not least extremely high HIV and tuberculosis prevalence rates. There are questions about equity in access to preventative interventions and curative health care. This is now being addressed through the development of policies and guidelines which aim to provide quality health care to all through an improved public health service.ⁱⁱⁱ The underlying assumption is that remedying inequalities in health financing and service provision will reduce inequalities in health outcomes. This is discussed in the essay on pp. 58 – 64.

Social grants have been a significant contributor to income poverty reduction, with the greatest change affecting those at the lowest income levels.¹⁷ But adult grants have had a greater impact on child poverty rates than those targeted to children.¹⁸ This is because the main child transfer, the Child Support Grant, is a very small benefit, about a quarter of the value of the Old Age Pension. Currently, social grants may be the main mechanism for reducing inequality, albeit slightly, and there is evidence that the Child Support Grant effectively buffered poor households against shocks, including the worst effects of the global recession of 2009/10.¹⁹ Income poverty rates for children have declined, but it is not enough to shift patterns of inequality. In addition, weaknesses in the social assistance system reduce the ability of grants to shift inequalities between children. These are discussed in the essay on pp. 48 – 51.

Human development is widely seen as key to breaking inter-generational cycles of poverty and inequality. Children born into poverty are likely to remain poor, but if children are healthy and receive more and better education from early on, they may be able to transcend the poverty of their childhood, so that their children may in turn have better opportunities. Despite the majority of children diligently attending school, South Africa has struggled to improve the quality of education it offers poor (mainly Black) learners. This is despite attempts to redress the imbalances of apartheid through revisions to the school funding norms, which are now explicitly redistributive.²⁰

Completing 12 years of schooling is associated with a dramatic rise in the likelihood of employment, and better performance (university exemption) is associated with higher wages.²¹ This suggests that improvement in the quality of education – from the early years through to matric and beyond – is essential to break inter-generational cycles of poverty.

What are the conclusions?

Although South Africa's children have equal rights under the Constitution, the worlds into which they are born and their opportunities in life are very unequal. Children's survival, development and life trajectories are to a certain extent pre-determined by their circumstances at birth, and then by the contexts in which they

grow up. Like poverty, inequality is structural and is transmitted down generations.

Reducing inequality in the future requires shifting opportunities for children in the present. This extends beyond poverty alleviation, and requires levelling the playing field in a way that promotes children's optimal development irrespective of their characteristics or contexts.

The essays contained in this issue describe and explore various dimensions of inequality from the perspective of children, and highlight some critical strategies for reducing inequality. Early childhood development, education and health are foundational areas which need to be addressed to break the cycle of persistent inequality.

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Spatial inequality: Persistent patterns of child deprivation

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Maps are a useful way to illustrate spatial inequalities and how children's socio-economic status and access to services differs depending on where they live. This essay presents key findings from recent studies which measured child deprivation across the whole of South Africa.¹ The analysis used a child-focused perspective and was an attempt to put into practice a model of multi-dimensional child poverty in South Africa.²

The essay addresses the following key questions:

- Why is spatial mapping important?
- What is the Index of Multiple Deprivation for Children?
- What do the maps show?

Why is spatial mapping important?

It is widely recognised that high levels of deprivation not only impact on the lives of children during their childhood but also on their prospects as adults. In South Africa, the spatial patterns of deprivation and the resultant spatial inequalities are historically entrenched.³

By using municipality-level data about child deprivation, a 2009 study has demonstrated that child deprivation in South Africa in 2001 was spatially concentrated in the former "homeland" areas.⁴ This essay explores whether this remains the case if one drills down to below municipality level.

When analysing children's deprivation at the very small datazone levelⁱ – which could be viewed as an approximation to a neighbourhood – it is clear that child deprivation was still most prominent in the former homeland areas.⁵ Furthermore, at this spatial scale, pockets of deprivation in urban areas, particularly in informal settlements, are also identifiable – a nuance that is disguised by provincial or municipality-level analysis. A further advantage of a small area index of multiple deprivation is that it identifies areas with the most severe deprivation which can then be prioritised for policy interventions.

Using more up-to-date data from the 2007 Community Survey, it has been shown that the spatial legacy of apartheid continued for the general population.⁶ Changes in the spatial distribution of relative deprivation experienced by children between 2001 and 2007 show that this was also the case for children.

What is the Index of Multiple Deprivation for Children?

The South African Index of Multiple Deprivation for Children 2001⁷ (SAIMDC 2001) comprises five domains of deprivation which each contain one or more indicators relating to that domain of deprivation. The domains of deprivation are:

- Income and material deprivation – children in households below a relative poverty line or who live in a household without certain material possessions, such as a refrigerator.
- Employment deprivation – children living in households where no-one is in paid work.
- Education deprivation – children who are not in school or who are in the wrong grade for their age.
- Biological parent deprivation – children whose biological parents have both died, or who live in a child-headed household.
- Living environment deprivation – children living in poor quality environments such as without adequate sanitation and water supply.

Further details about the indicators, the methodology for combining them into domain scores and for combining the domain scores to produce the SAIMDC are described in detail elsewhere.ⁱⁱ

What do the maps show?

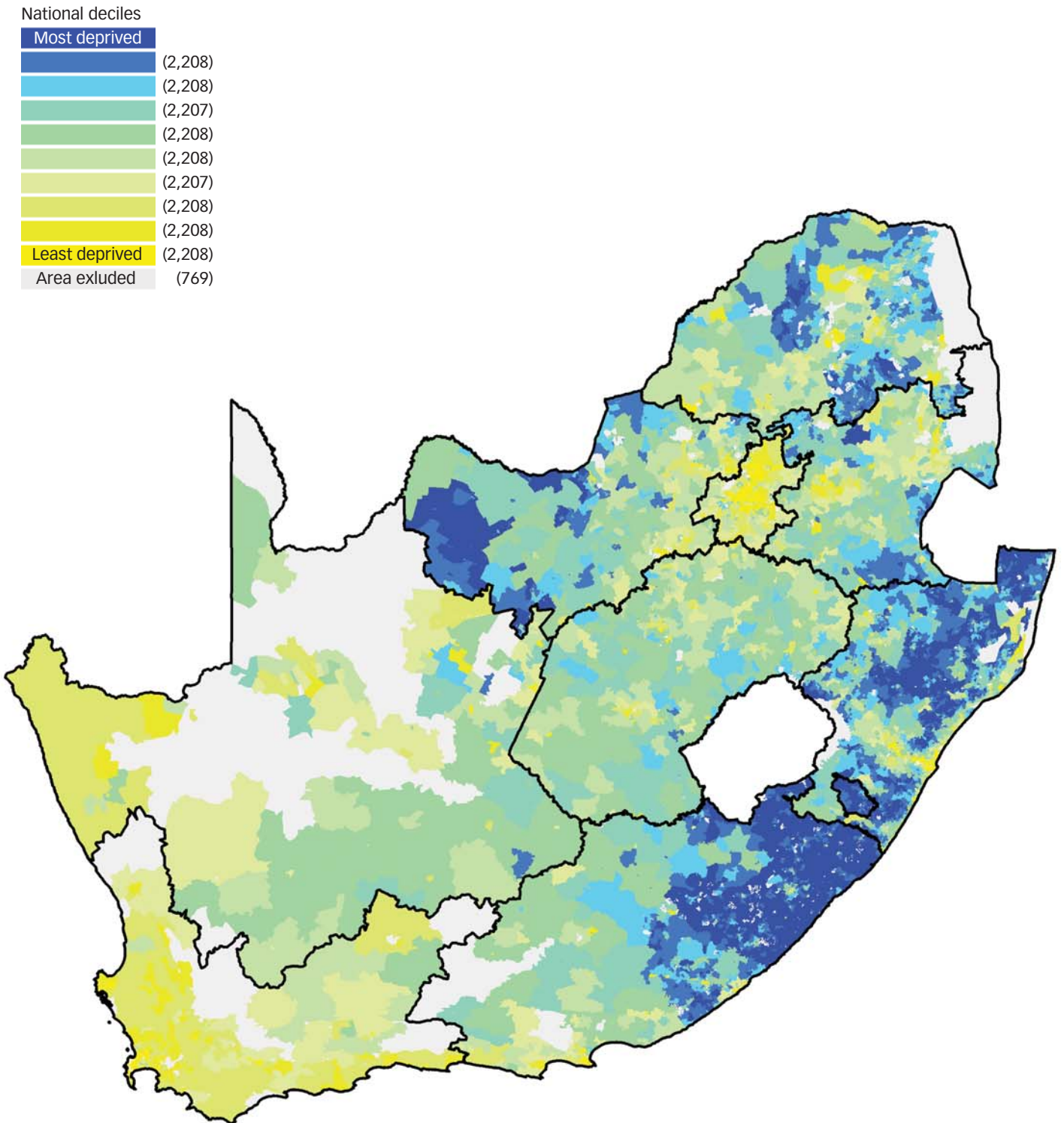
Figure 6 on p. 39 presents the SAIMDC 2001 at datazone level for the whole of South Africa. The datazones were sorted in order of deprivation, and ranked into 10 equal groups. The most deprived areas are shaded deep blue, and the least deprived areas are shaded yellow. Areas in the least deprived category are not without deprivation; they are simply relatively less deprived than other areas.

Figure 6 highlights the prominence of deprived children within the former homeland areas. In fact, at this fine-grained level of detail, the spatial echo of the former homeland boundaries are even more evident than at municipality level. If one "zooms in" to urban areas using the datazone-level maps, pockets of severe deprivation are identifiable, eg in informal settlements in parts of Nyanga and Khayelitsha in Cape Town, and Orange Farm and Lenasia in Johannesburg. Nevertheless, even though deprivation in townships is severe, it is deeper and more extensive in the rural former homeland areas.

ⁱ Datazones are small area level statistical geographical units which contain an average population of 2,000 people. The datazones nest within municipal boundaries and were constructed from Census enumeration areas.

ⁱⁱ For the datazone-level SAIMDC 2001, see reference no. 1 (Wright et al, 2009a); for the municipality-level SAIMDC 2007 see reference no. 1 (Wright et al, 2009b).

Figure 6: South African Index of Multiple Deprivation for Children, 2001, at datazone level



Source: Centre for the Analysis of South Africa Social Policy, University of Oxford.

Figure 7: South African Index of Multiple Deprivation for Children, 2001, at datazone level, Eastern Cape

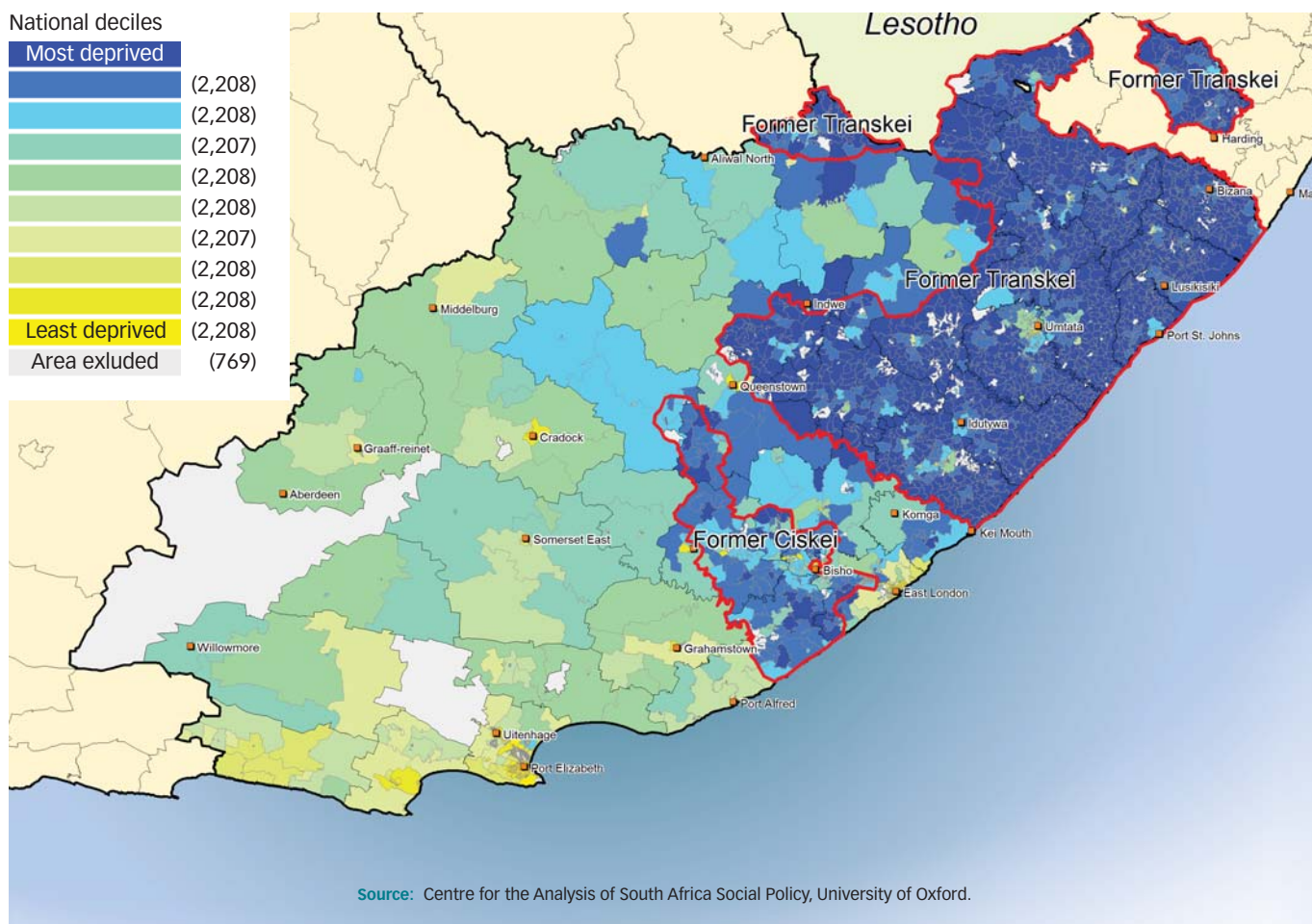


Figure 7 shows the spatial distribution of child deprivation in the Eastern Cape province, using the same data. Digitised boundaries of the former Ciskei and Transkei have been overlaid (the thick red lines) and it is evident that the areas with the highest levels of child deprivation fall within these former homeland areas.

Child deprivation across South Africa at municipality level in 2001 and 2007 was analysed by producing a SAIMDC for each time point, using the same indicators and the same 2001 boundaries.⁸ Figure 8 on the next page shows that spatial deprivation was concentrated in the same areas in both 2001 and 2007. Municipalities have been sorted in order of deprivation and ranked into five equal groups. Again, the most deprived areas are shaded in deep blue and the least deprived areas are shaded in yellow.

There has been very little change in the location of the most relatively deprived municipalities, and the former homeland areas are still most prominent.

It should of course be noted that municipality-level analysis disguises the presence of pockets of deprivation, as the domain scores in a larger area will average out the presence and absence of smaller areas with high levels of child deprivation. It is therefore very important that the datazone-level SAIMDC is updated once

the 2011 Census data have been released to enable the more fine-grained analysis of child deprivation to be brought more up to date.

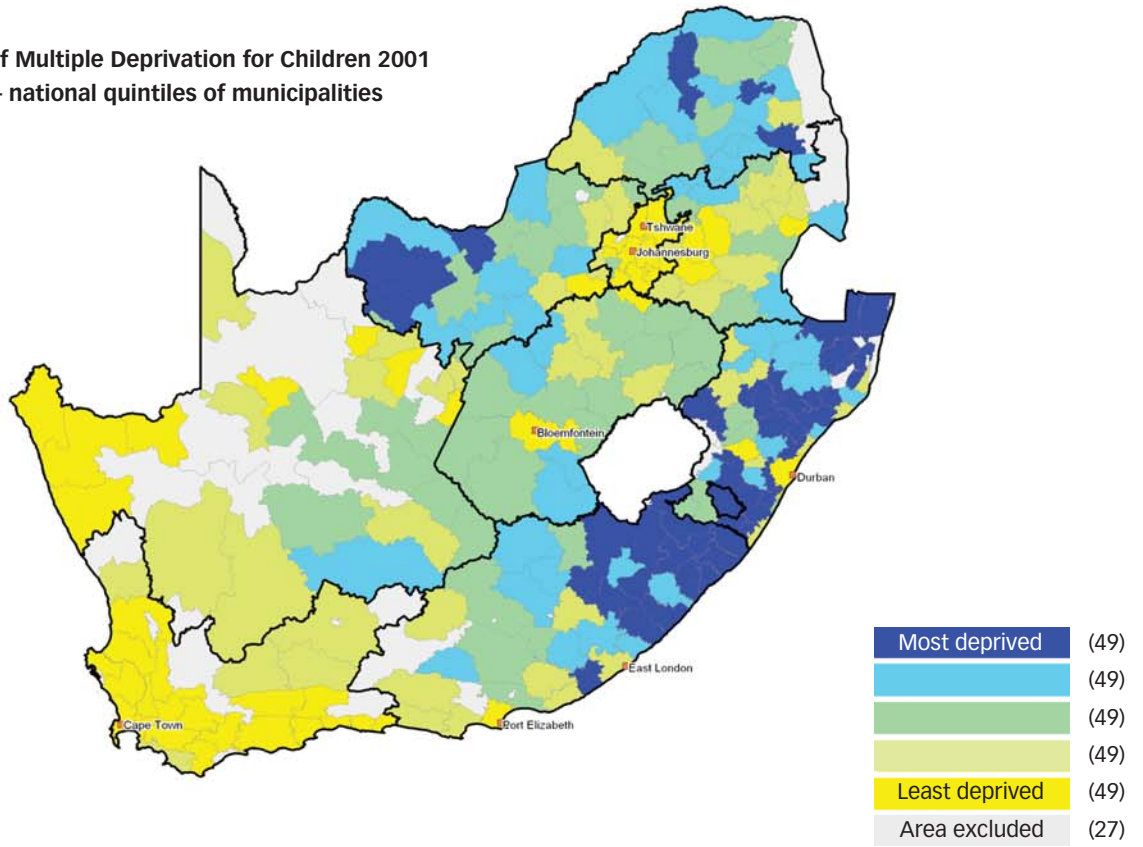
It is important that, when looking at spatial inequality, one does not regard equality as the only goal. Figure 9 on p. 42 shows Lorenz curves using the income deprivation domain of the SAIMDC 2001 at datazone level.ⁱⁱⁱ The straight blue line represents a situation of perfect equality; the closer a curve is to this straight line, the more equal the distribution of income deprivation affecting children, and the further a curve is from the straight line the more unequal is the distribution.

The pink curve furthest from the line of equality shows the area with the most unequal distribution of income deprivation affecting children in the Eastern Cape (Nelson Mandela Bay Municipality). The yellow line, closest to the line of perfect equality, represents the former Transkei where the levels of deprivation are at their highest. For comparison, the black curve represents all datazones in South Africa and the purple line above it represents the Eastern Cape. Although inequality is lowest in the former Transkei (because people are “equally poor”) the levels of deprivation are uniformly high. It is therefore important to consider not only inequality but also the levels of deprivation that people are enduring.

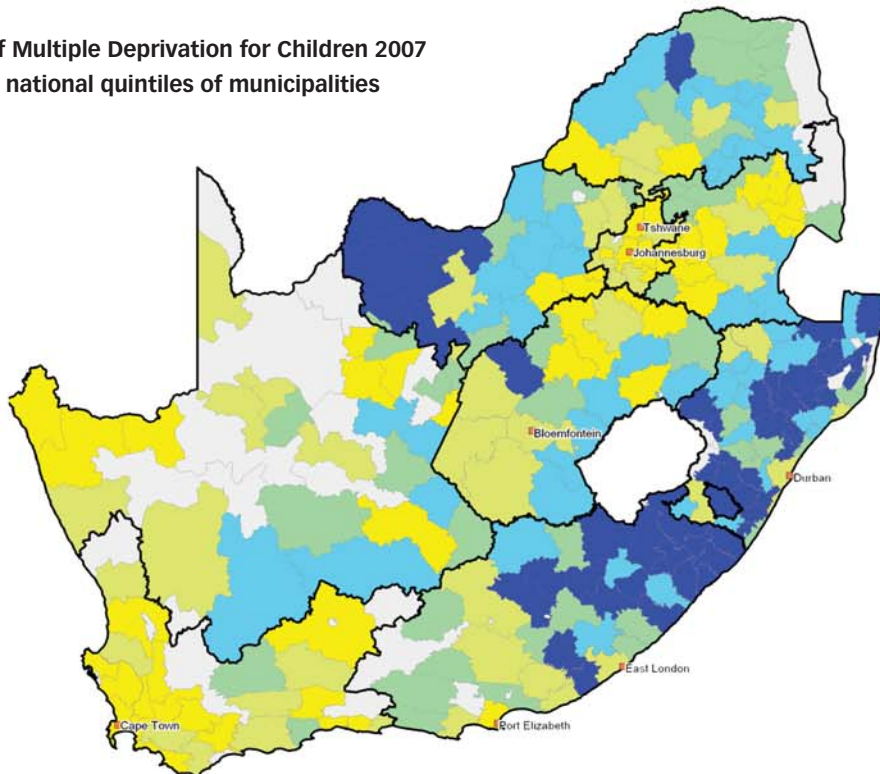
iii For more information about the Lorenz curve, see box 3 on p. 35.

Figure 8: Relative change in child deprivation, 2001 – 2007, at municipality level (2001 municipal boundaries)

South African Index of Multiple Deprivation for Children 2001
at municipality level – national quintiles of municipalities

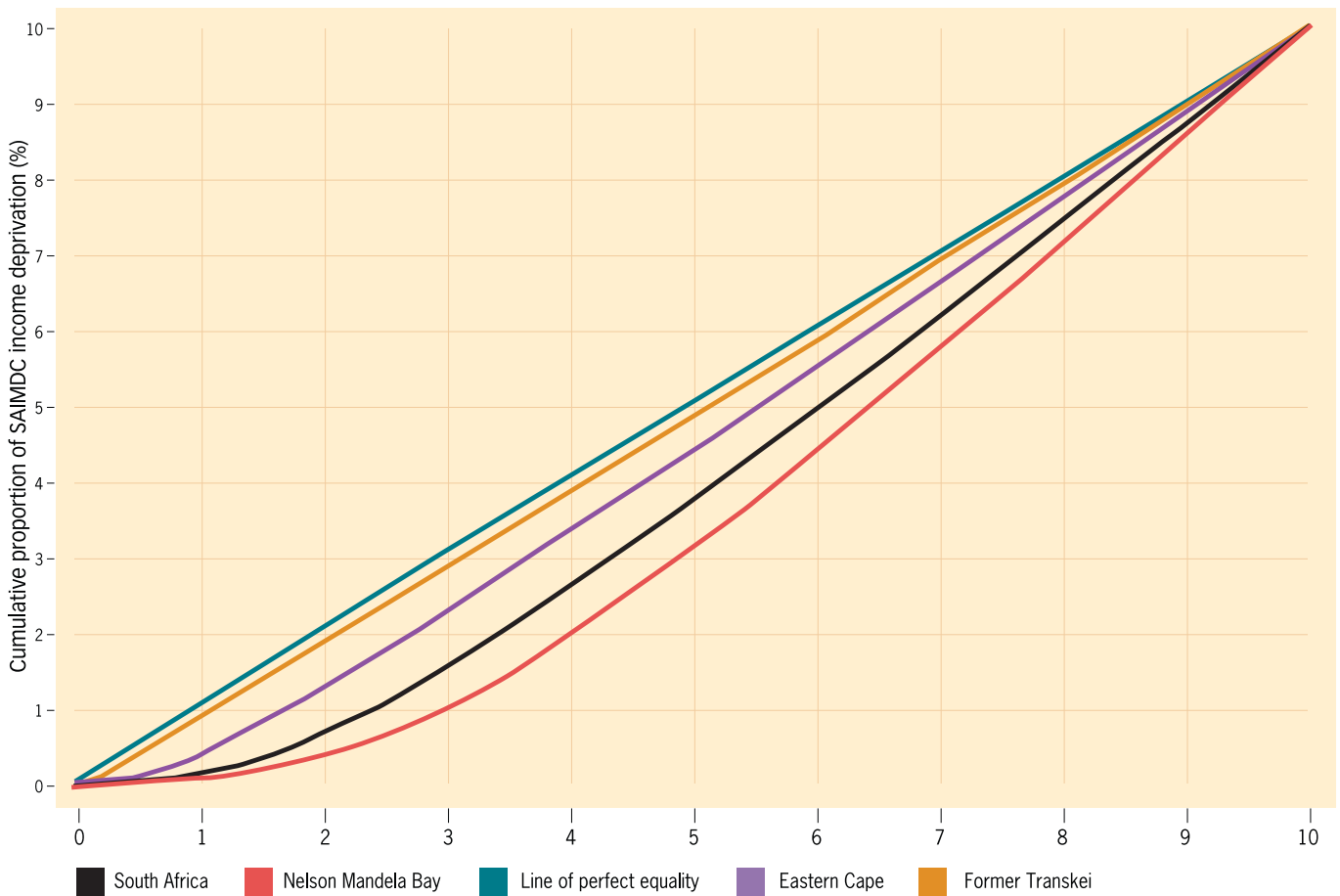


South African Index of Multiple Deprivation for Children 2007
at municipality level – national quintiles of municipalities



Source: Centre for the Analysis of South Africa Social Policy, University of Oxford.

Figure 9: Lorenz curves for SAIMDC income deprivation at datazone level, for South Africa, Eastern Cape, Nelson Mandela Bay Municipality and the former Transkei



Source: Centre for the Analysis of South Africa Social Policy, University of Oxford.

What are the conclusions?

Small area level data highlight spatial inequalities across South Africa. This essay has demonstrated that child deprivation is distributed unequally across the country and that the most deprived areas continue to occur within the former homeland areas.

A mapping of child deprivation in 2001 and 2007 shows that there has been very little change in the spatial distribution of relative deprivation.

The distribution of deprivation in South Africa raises important questions such as:

How can the standard of living of children in relatively deprived areas be improved effectively? And, how can the legacy of apartheid in such areas be interrupted to create a more equal society?

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- 5 See no. 1 above (Wright et al, 2009a).
- 6 Noble M & Wright G (2012) Using indicators of multiple deprivation to demonstrate the spatial legacy of apartheid in South Africa. *Social Indicators Research*. DOI: 10.1007/s11205-012-0047-3.
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Inequalities in children’s household contexts: Place, parental presence and migration

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High rates of poverty and inequality are reproduced over time and across generations. Amongst the many factors that perpetuate inequality – such as unequal education, unequal employment opportunities and earnings, and unequal health risks and health services – we need to consider the role of place and the unequal contexts in which children grow up.

Location, or where people live, plays a major role in determining the availability of resources and opportunities that support human development. In the two decades since democracy, there have been improvements in many public goods: road access, the construction of human settlements, service infrastructure, schools and clinics.¹ But vast disparities remain, and these will continue to reinforce human inequalities until more even levels of delivery and opportunity have been achieved.

This essay looks at how children are distributed spatially, and whether this is changing. It is structured by the following questions:

- Why is it important to consider where children live?
- Where do children live?
- Who do children live with?
- What are the implications?

Why is it important to consider where children live?

One of the ways in which South Africa’s unique history of apartheid continues to affect children’s lives relates to where, and with whom, children live. Decades ago, influx controls created a divided country in which most Black households lived outside the well-resourced towns and cities reserved for Whites – on the urban periphery or in “rural homelands”. Entire communities were often forcibly removed from urban areas to townships or “Bantustans”, as well as from rural areas designated for the White population. Pass laws permitted those who were considered economically useful – mainly working-age men and some female domestic workers – to remain in the towns and cities while they were employed. The homelands became dumping grounds for the “surplus” people: the unemployed, the disabled, and particularly old people, women and children. Patterns of circular labour migration were entrenched between urban and rural nodes.

Rural households carried a huge economic and care burden: the apartheid system relied heavily on the supportive networks of extended families and communities to justify ignoring the welfare

Table 3: Household resources, poverty and access to social infrastructure, 2010

Household resources	Urban		Rural	
	Formal %	Informal %	“Formal” (commercial farm) areas %	“Traditional authority” areas %
No piped water to site	9	18	39	65
Inadequate sanitation	4	54	44	62
No mains electricity supply	6	27	44	25
Overcrowding ⁱ	9	17	10	10
More than 30 minutes to nearest clinic	16	20	49	48
No employment in the household	34	35	22	65
Income poor (less than R575 per person per month)	29	41	31	66

Source: Source: Statistics South Africa (2011) *General Household Survey 2010*. Analysis by Katharine Hall, Children’s Institute, UCT.

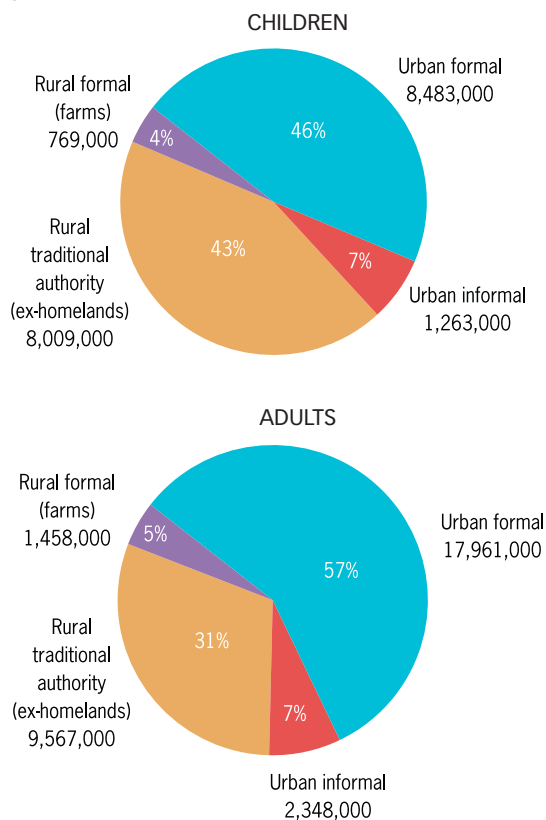
ⁱ Overcrowding is defined as a ratio of more than two people per room, including kitchen and living room, but excluding bathroom. A one-bedroom dwelling with a kitchen and living room would therefore be defined as overcrowded if there were more than six household members.

needs of the families of those it employed on the mines and elsewhere to serve the needs of the White ruling class. However, there has been little research which has investigated how these spatial arrangements continue to determine the quality of life and future opportunities for children growing up in post-apartheid South Africa, and how they contribute to persistent patterns of inequality. The previous essay showed that there has been little change in the spatial distribution of poverty – the former homelands remain the poorest areas on the national map and, at smaller area levels, pockets of extreme poverty are found in small towns and townships on the outskirts of cities.

Statistics South Africa uses broad definitions of area type, distinguishing between formal and informal urban areas, and between rural areas, which are formally demarcated (the commercial farming areas of the “old” South Africa) and what are referred to as “tribal” or “traditional authority” areas (ie areas under communal tenure which constituted the former homelands).

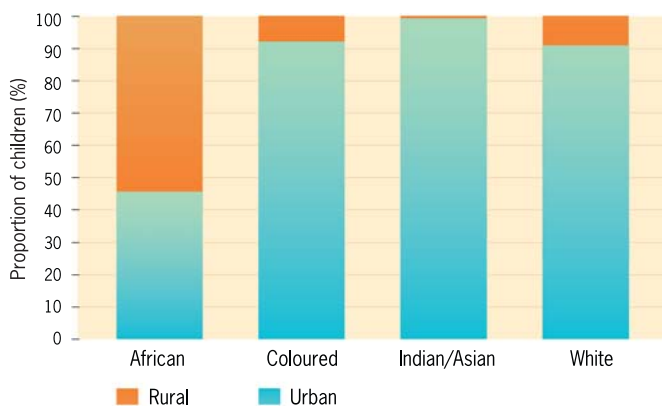
Comparing information on some basic services and resources across these categories, table 3 shows that, as recently as 2010, rural households remained far behind those in urban areas in terms of social infrastructure and employment opportunities. Among all rural households, those in traditional areas are considerably more resource-poor, but even in formal rural areas, approximately two-fifths of households had no access to water on site, or to electricity.

Figure 10: Distribution of children and adults, by area type, 2010



Source: Statistics South Africa (2011) *General Household Survey 2010*. Analysis by Katharine Hall, Children’s Institute, UCT.

Figure 11: Urban–rural distribution of children, by race, 2010



Source: Statistics South Africa (2011) *General Household Survey 2010*. Analysis by Katharine Hall, Children’s Institute, UCT.

Labour migration fragments families, but it may also bring economic benefits to rural households through the transfer of remittances. However, recent evidence suggests that remittance transfers in South Africa are falling, while agricultural production remains limited.² This combination leaves households trapped in deep poverty, without external income sources on the one hand, or local resources on the other. Rural households are disproportionately poor even when taking into account social grants, which are targeted mainly to children and pensioners.

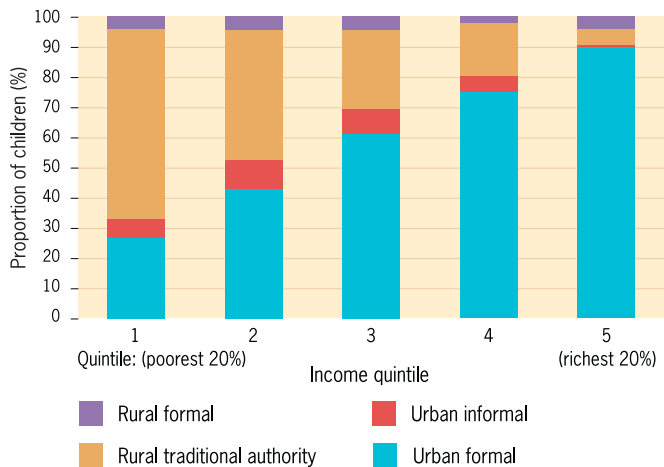
Where do children live?

Just over 40% of the 14 million households in South Africa consist of adults only. These tend to be relatively small households, with an average of two household members. By contrast, children live in larger households with an average of five members. It is partly for this reason that the spatial distributions for adult and child populations in South Africa are strikingly different.³ Compared with adults, children are disproportionately represented in rural areas, as illustrated in figure 10.

Apart from inter-generational differences in the location of “home”, there are also pronounced inequalities between children. Figure 11 shows that the relatively small Coloured, Asian and White populations are almost entirely urban, while more than half of all African children grow up outside the cities. Nearly a quarter of the 18.5 million children in South Africa live in KwaZulu-Natal, while the Eastern Cape and Limpopo together are home to another quarter (see p. 82). The majority of children in these three provinces live in the former homelands.

Income inequalities between geographic areas are apparent when one divides the child population into income groups based on the per capita income of households. Figure 12 on p. 45 shows that most children in the poorest 40% of the population live in rural households, while the majority of those in the upper quintiles live in towns and cities. These associations between income inequality and geographic location are likely to be related in circular ways: poorly resourced areas with few employment opportunities become poverty traps for those who live there.

Figure 12: Distribution of children by type of area and income quintileⁱⁱ, 2010



Source: Statistics South Africa (2011) *General Household Survey 2010*. Analysis by Katharine Hall, Children’s Institute, UCT.

While the rural child population is quite homogeneously poor (four out of five rural children live in households in the bottom two quintiles), there is great inequality within the urban population – between households in formal and informal settlements, across towns and cities, between and within races. Apart from income inequality, urban children – and particularly those in informal settlements – are exposed to particular risks associated with city life: densely populated settlements, overcrowded households, crime, theft, road accidents, erratic or inaccessible communal services, waste disposal hazards, shack fires, paraffin poisoning, flooding, and a lack of affordable and safe child care facilities.⁴

The pictures of inequality presented here are snapshots in time. But children are highly mobile. Slightly greater proportions of children under two years old live in informal settlements, while older children are more likely to live in the former homelands. This has been consistent over the years, suggesting a pattern of child mobility where children born in informal settlements stay with their mothers for the first year or two, after which some of them are sent to stay with family at the rural home.

Who do children live with?

Only a third of all children in South Africa live in a household together with both their mother and father, and nearly a quarter lives with neither parent (see p. 83). Children who live with only one parent are far more likely to be living with their mother than with their father. Figure 13 shows how patterns of co-residence vary enormously between urban and rural areas: urban children are more likely to live with both parents, or with at least one parent (almost invariably their mother). Single fathers are uncommon, irrespective of where children live.

Many children live separately from one or both of their biological parents for a wide range of reasons including orphaning, cultural

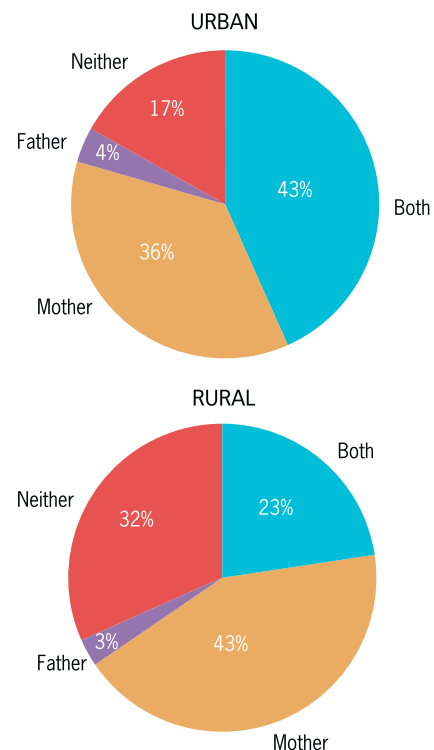
convention, financial or logistical necessity. Although orphanhood rates have risen steadily, mainly due to HIV/AIDS, only a small amount of parental absence can be explained by high mortality rates. In most cases, parents are absent from children’s households because they are living elsewhere. This is partly a result of labour migration – particularly from rural areas – as the temporary or circular migration of adults seeking work in the cities has persisted during the post-apartheid period.⁵

Although racial restrictions on the permanent settlement of migrants and their families in urban areas were lifted during the late 1980s, many adults continue to migrate to find work, leaving their children and spouses behind. Labour migration rates peaked during the early 2000s, when about 17% of all households, and 37% of African households in rural areas, included at least one household member who was a labour migrant.⁶

Historically labour migration was male dominated. But research indicates that female labour migration has been increasing,⁷ and that women are more likely to migrate when a (rural) “household of origin” receives a social pension. The fact that there are family members, and particularly grandmothers, who can care for children at the rural household enables working-age women, including mothers, to migrate to cities in search of employment.⁸

The enduring nature of the migrant labour system helps explain why only 22% of children in rural areas are co-resident with both their parents, compared to 42% of children in urban areas.

Figure 13: Children’s co-residence with parents, 2010



Source: Statistics South Africa (2011) *General Household Survey 2010*. Analysis by Katharine Hall, Children’s Institute, UCT.

ⁱⁱ Income quintiles are calculated on the basis of per capita income for all households. Households with children tend to be poorer than households without children, as discussed in the essay on pp. 32 – 37.

Higher rates of labour migration among men than among women also help to explain why far more fathers are absent from children's households than mothers. However, there are other important reasons for why children are more likely to live with, and be supported by, their mother than their father, including low marriage rates and low cohabitation rates among unmarried mothers.

Since at least the 1960s, marriage rates among African women have fallen considerably.⁹ By 2010, only a quarter of all African women were married compared to over 60% of White women. Declining marriage rates (in part associated with poverty and unemployment, and men's inability to pay *lobola*, or "bride wealth") reflect an "uncoupling of marriage and motherhood both as practice and as social identity".¹⁰ This has been accompanied by an increase in the number of children with absent fathers, and a decline in households built on a co-habiting partnership. Data from a 2008 national household survey indicate that less than 40% of all African mothers aged 20 – 50 years had ever been married compared to 92% of White mothers in the same age group.¹¹ Unmarried African mothers are also far less likely than unmarried White mothers to be cohabiting with the father of their child (23% compared to 59%).¹²

The absence of a parent from a child's household masks a range of possible contact between the parent and the child. Parents who migrate from the household of origin to find employment, for example, may return regularly or send remittances for the support of their children while they are away. Even in the event of divorce or separation, or when mothers are unmarried, an absent father may have extensive contact with his child, providing regular income (and other support) for his child. Nonetheless, in 2008 almost 60% of children with an absent mother or father, or an absent mother, did not receive any income support from their absent father, while slightly less than 50% did not receive income support from their absent mother.¹³

Who children live with, therefore, has significant implications for their economic status. Children who live with both their parents are more likely than other children to live in relatively wealthy households. Among children who live with only one parent, those living with their mother are more likely to be in poorer households. This reflects gender differences in employment opportunities and earnings. The role of women not only as caregivers of children but also as the primary providers is therefore important in understanding the context of child poverty in South Africa. (See pp. 83 – 85 for more data and commentary on children's living arrangements.)

Children are often mobile themselves. Movement across households and places is a feature of childhood which is highly relevant for social policy and the targeting of poverty alleviation programmes, such as child grants. Retrospective reporting on child mobility suggests that a fifth of all children (21%) are geographically mobile in that they have moved since they were born. The percentage of children who are mobile increases with age. While 14% of children aged 0 – 4 have ever moved, this increases to around 22% for children 5 – 14, and 31% for teenagers aged 15 – 17 years.¹⁴

National surveys between 2002 and 2010 suggest that child populations are increasing in provinces with large metropolitan

areas (Gauteng, KwaZulu-Natal and the Western Cape), and declining in more rural provinces (notably Limpopo, the Eastern Cape and North West).¹⁵ The proportion of children found in urban households has increased from 46% in 2002 to 53% in 2010. This apparent urban trend is a combined effect of internal migration and urban births, and the extent of it will need to be confirmed when the 2011 Census becomes available.

At present there is a shortage of national data to describe patterns of child mobility accurately, or to explain the reasons for movement of children. The availability of better social resources such as schools and health care facilities are possible pull factors. Push factors may include inadequate accommodation, concerns about crime and child safety, and the costs of child care if there are free alternatives to accommodate children with relatives elsewhere. (illustrated in case 4 on p. 47). There is some evidence that poorer children are more likely to migrate, implying that migration is a child care strategy for poorer households.¹⁶ The few studies that do focus on children's care and mobility in the context of labour migration¹⁷ are derived from surveillance site data, which present a particular problem in that households and individuals who move out of the study site are lost to the panel.

What are the implications?

The spatial map of poverty has changed little, with the previous homelands remaining the poorest and most under-resourced parts of the country.¹⁸ Half of all children continue to live in rural parts of the country, particularly the relatively under-resourced former homelands. Many more live in informal settlements, which tend to be inadequately serviced and are associated with particular risks to children's safety and healthy development. This distribution is an important consideration from a child poverty perspective, because, while development imperatives prioritise centres that are economic hubs, this kind of spatial targeting risks leaving a large proportion of the population in places that are under-serviced and under-developed.

Household fragmentation through temporary or circular migration remains a distinguishing characteristic of living arrangements in South Africa. Research suggests that this migration pattern is a means of survival, driven by a combination of economic and social strategies to maximise household income, minimise economic risk and increase exposure to social resources such as health care.¹⁹ Low employment opportunities in rural areas are a key factor explaining high rates of labour migration particularly from rural households.

Decisions about where children live, and who cares for them, are likely to be influenced by a range of considerations, which require further qualitative research. A better understanding of where children live and the directions in which they move, as well as the drivers (and constraints) to child mobility between households and across geographical areas will put planners in a better position to proactively target services and plan for growing child populations in places of in-migration, and to think about targeted programmes to ameliorate poverty in outlying areas.

Case 4: Deterrents and enablers of fluid care arrangements

I met Mrs Xumalo at her home in Krakrayo, a small rural village in the Amathole district of the Eastern Cape. She was caring for five grandchildren, all under the age of 14, while her daughter (the children's mother) was living in Cape Town. The understanding between Mrs Xumalo and her adult daughter was that once the daughter had found work and a suitable place for the family to live, the children would join her in Cape Town. In the meantime, the migrant daughter was sharing a shack belonging to acquaintances of the family from the same village.

Mrs Xumalo spoke about why it was both infeasible and inappropriate for the children to join their mother in this "temporary" accommodation: it would be too much of an imposition on the host family, who were from the same area but not relatives; there was not enough space for children in their small home; the mother did not want her children to live in the informal settlement, which was dangerous; things were too uncertain – their mother needed to find a job and have some kind of secure tenure before undertaking the risk and expense of bringing the children to join her.

It was because the care arrangement was considered temporary that the mother had applied for and was claiming the children's Child Support Grants in Cape Town, using some of the money to support herself while she looked for work and sending the rest to her mother in the Eastern Cape to spend on the children's needs.

This explanation suggested a series of strategic decisions around the care of the children in relation to her adult daughter's rather precarious housing and employment situation on the one hand, and the availability of free care and accommodation for the children on the other. Thus a combination of deterrents (which discourage simultaneous child migration) and enablers (which encourage continued residence at the place of origin) resulted in a decision to separate the children from their mother.

Source: Katharine Hall, Children's Institute, UCT. Based on field notes from the Eastern Cape, 2005.

Urbanisation is both necessary and unavoidable, and is not only about the movement of adult workers. Without good planning that takes into account the specific needs of children, urbanisation could exacerbate inequality, trap children in poverty (at either the urban or rural periphery) and perpetuate intergenerational cycles of poverty and inequality.²⁰

Work on child migration and mobility is relatively new in South Africa, and analyses thus far have been constrained by the limitations of available household surveys. From a policy perspective, there is a need for an expanded and rigorous evidence base on patterns, predictors and outcomes of child mobility.

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Income inequality and social grants: Ensuring social assistance for children most in need

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South Africa's social assistance system is better developed than those of most middle-income countries. This is in line with section 27(1) of the Constitution which states that "everyone has the right to have access to ... social security, including, if they are unable to support themselves and their dependants, appropriate social assistance". It is also in line with the Constitution that social grants are provided primarily for categories of individuals who are likely to be unable to provide for their own needs, namely the elderly, people with disabilities and children.

Most social grants aim to reduce poverty and include a means test that is intended to ensure that the grant reaches only those with income and assets below a given threshold. But to what extent do these grants also reduce inequality?

This essay explores the relationship between social grants and inequality by addressing the following questions:

- How can grants address inequality?
- How can grants address child inequality?
- Do grants address gender inequality?
- Where is the current grant system failing in terms of inequality?

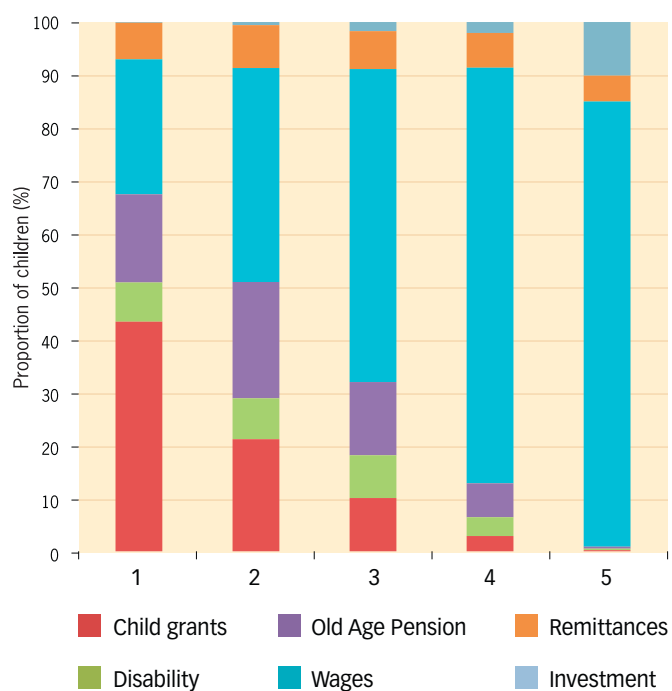
How can grants address inequality?

Grants are an important source of income for poor households. Figure 14 shows that more than half of the income flowing into the poorest 40% of households comes from social assistance.

It is well established that social grants reduce poverty. For example, one study has shown that the poverty rate in South Africa would be six percentage points higher in the absence of the grants.¹ There has been less research on the impact of the grants on inequality. Nevertheless, the evidence that does exist all points in the same direction: that the grant system as a whole reduces income inequality.² For example, a recent study found that the Gini coefficientⁱ would be reduced from 0.73 if no grants existed to 0.70 if everyone who was eligible took up their grant.³

South Africa's grant system includes three child grants alongside several adult grants. The Child Support Grant (CSG) is the main poverty-oriented child grant. It is available to all primary caregivers who pass a simple means test that is set at 10 times the value of the grant (or double this amount for the spouses' combined

Figure 14: Composition of household income, by quintile, 2008



Sources: Southern Africa Labour and Development Research Unit (2012) *National Income Dynamics Study 2008, Wave 1 [dataset]. Version 4.1*. Cape Town: SALDRU, UCT [producer], DataFirst [distributor]. Calculations by Ingrid Woolard, SALDRU, UCT.
Note: Agricultural income and imputed rent are excluded from income for this calculation.

income if the caregiver is married). The Care Dependency Grant (CDG) is provided to caregivers of severely disabled children on the basis that these caregivers will have limited opportunity to earn money given the intensive care needs of these children. The Foster Child Grant (FCG) is provided to foster parents of children who are placed in foster care because they are considered by the courts to be "in need of care and protection" in terms of the Children's Act (section 150).

In July 2012, the CSG was provided to 11.2 million children, the CDG to 117,256 children, and the FCG to 572,903 children.⁴ One would therefore expect the CSG to have a much greater impact on poverty and inequality than the other two grants. However, the

ⁱ The Gini coefficient is a measure of national income equality. It ranges from 0 (no inequality) to 1 (complete inequality). See box 3 on p. 35 for a more comprehensive discussion.

impact of the CSG is less than it might be otherwise because of the small size of the grant – R280 per month in 2012, as against R770 for the FCG and R1,200 for the Care Dependency Grant.

Children do not benefit from the poverty- and inequality-reducing impacts of the child grants alone. As children live in households, they can also benefit from the impact of adult grants. In particular, they can benefit from the Old Age Grant (OAG) if their households include grandparents who receive this grant. In addition, social grants are linked to other forms of poverty alleviation, such as school fee waivers and free public health care.

The OAG reached more than 2.7 million people aged 60 years and older in March 2012,⁵ and has a value of R1,200 – more than four times that of the CSG. Many children live in households which include their grandparents. In some cases these households include the child’s parents. In other cases – for example, where the parents have died or are living elsewhere to earn an income – the children live with only their grandparents. If, as is generally the case, the Old Age Grant money is shared among household members, children’s poverty will be reduced by this grant. This will not, however, happen for all poor children who live with grandparents as a large number of grandparents are below the age of 60.ⁱⁱ

The main purpose of the grants is to reduce poverty, not inequality. The grants do not always succeed in lifting households above a particular poverty line, but they do reduce poverty to the extent that any increase in income reduces income poverty. However, the grants are a rather blunt tool for reducing income inequality, given the relatively small grant amounts and the extreme differences between rich and poor in South Africa (illustrated in figure 2 on p. 33).

How can grants address child inequality?

Nevertheless, in South Africa there have been some elements in the design of grants that have specifically attempted to address inequality amongst children. Many of these have been designed to address substantive equality (or equity) rather than simply formal equality. This is in line with section 9 of the Constitution which prohibits both direct and indirect discrimination.

Formal equality is achieved when all individuals are treated in exactly the same way. Formal equality is reflected in policies that are implemented irrespective of the characteristics of the individual, such as race and gender. Formal equality thus aims at equality of opportunity. Substantive equality reflects a stance that recognises that individuals from different groups may be in different situations, and that policy needs to take these differences into account and, if necessary, treat individuals from different groups differently to achieve equal outcomes. Substantive equality thus aims at equality of outcome, rather than equality of opportunity. (For a more comprehensive discussion, see the essay on pp. 24 – 31.)

Means test or universal grant?

The first way in which the child grant system attempts to address inequality is by using a means test. The Lund Committee that designed the CSG in the late 1990s considered recommending a universal grant. After discussion, it was agreed that a universal grant was not appropriate in a country with levels of inequality as high as those in South Africa.⁶ This decision was further supported by the concern about how much money could be made available at the time, resulting in a stark trade-off between the amount of the grant and the number of children who would be reached. When introduced, the CSG was thus available only for children under seven years of age, and only for those whose caregivers passed a means test set at a relatively low level.

Today, the means test remains, but at a much higher level that renders 75% or more of all children eligible. Some might argue that at this point the means test could be dropped. However, this would almost certainly mean a trade-off between making the current small grant available for a larger number of children, and providing a somewhat bigger grant for only those children who are currently eligible. In this trade-off, it is clear that the second option would have greater impact in reducing both poverty and inequality.

Some might argue that the money used to provide the CSG, or a rebate to children in wealthier households, could be “clawed back” through tax. However, this would be possible for only part of the money spent by government given that the marginal tax rate does not reach 100% even for the wealthiest individuals.

A differentiated means test

When the CSG was first introduced, the means test was set at a lower level for caregivers of children in formal urban areas than for caregivers of children in informal urban and rural areas. This made it more difficult for caregivers in formal urban areas to access the grant. The dual approach was in line both with the notion of substantive equality and with the understanding that poverty does not relate only to inadequate income. The approach recognised that children in informal urban and rural areas were less likely to have access to a range of different services, were more likely to have poor quality services, and would also face greater obstacles in accessing these services.

The dual approach proved to be problematic for several reasons.⁷ Firstly, the approach was too complicated and there were difficulties for both officials and applicants in knowing in which category particular caregivers and areas fell. Secondly, many people – including applicants – felt that the approach was inequitable because, at face value, this is how it appeared. Thirdly, and importantly, because the threshold was low, the system essentially discriminated between different groups of poor children and their caregivers rather than between poor and not poor.

ii In the National Income Dynamic Survey Wave 2 data, just over half (55%) of household heads and their spouses that co-resided with their grandchildren were under the age of 60 in 2008.

In 2008 the means test was changed to a level 10 times the value of the grant – more than double the previous level. At the same time, the differentiation between children living in different areas was done away with.

“Follow the child”

A third design element aimed at avoiding inequity was the stipulation that the grant should be made available to the child’s primary caregiver, whoever this might be. The CSG replaced the State Maintenance Grant, which had a very different approach in that it was only available to a parent (primarily mother) of a child in cases where the other parent was unable to provide (eg because of death or imprisonment). The State Maintenance Grant was available for up to four legitimate children, but only one illegitimate child.

This approach was clearly inappropriate in a country such as South Africa where a child is as likely to be born outside marriage as to married parents. It was also inappropriate in a situation where 24% of South Africa’s children do not live with either of their biological parents.⁸

The CSG was thus explicitly designed to reach children irrespective of their family and living circumstance. In practice, the CSG has been claimed primarily by mothers, but it has also been claimed by many grandmothers. It would have been claimed by even more grandmothers if – as discussed later – policy confusion had not arisen about the respective functions of the FCG and CSG in terms of “care and protection” on the one hand, and poverty reduction on the other.

Do grants address gender inequality?

South Africa’s grant system reaches far more women than men. The OAG reaches more women than men because women tend to live longer than men and are thus eligible for longer, and because women tend to be poorer than men and therefore more likely to pass the means test. The child grants reach more women than men because women are far more likely than men to be the primary caregivers of children. Indeed, fewer than 40% of all South Africa’s children live with their biological fathers.⁹

The CSG could be seen as addressing gender inequality to the extent that it recognises the unpaid care work of women implied by having the responsibility of caring for children. In many cases, because of the absence of fathers, women bear this burden alongside having to find income to provide for the children. The Maintenance Act¹⁰ provides that fathers have a duty of support, whether or not they were ever married to the mother. In practice, however, many fathers are unable to provide because they are unemployed. Further, the whereabouts (or even identity) of many fathers are unknown. Where fathers are known and earning, the Act is so poorly implemented that maintenance amounts are either very low or not paid at all. In this situation, the small CSG provides some relief.

Do grants address current or future inequality?

It is clear that South Africa’s grant system addresses current inequality. What is less clear is if the grants reduce inequality in the long term.

Research has shown clearly that the grants result in increased school enrolment, better weight-for-height, and less hunger.¹¹ Some might argue that by improving the educational level and health of children the grants are placing these children in a better position to obtain employment and have sufficient earnings in their adulthood to avoid poverty – and to avoid being on the “wrong side” of inequality. It is this reasoning that has led to many other countries introducing education- and health-related conditions for grant recipients. Yet South Africa has achieved similar education and health outcomes without conditions.

In theory, access to school and health facilities should go some way to breaking the intergenerational transmission of poverty. Whether this happens in practice is questionable. It assumes, for example, that schooling is of decent quality, that jobs will be available, and that the type of schooling received will allow children to access well-paid jobs. In South Africa there is enough evidence of poor schooling, inequality of employment between Black and White youth with similar education, and inequality of earnings between Black and White, and women and men, with similar education to cast some doubt on whether this theoretical impact on future poverty or inequality will hold. A small grant such as the CSG can and does help reduce current poverty and inequality, and the system needs to be retained and strengthened for this reason. But we cannot and should not expect the social assistance system to improve children’s future economic opportunities significantly.

Where is the current grant system failing in terms of inequality?

Despite its strengths, South Africa’s current child grant system has several weaknesses. Perhaps the most important of these is the confusion around the purpose of the FCG, and the resultant inequities.

The FCG is designed for children in foster care. It caters for children who have been found by a court to be “in need of care and protection” because the child has been abused, neglected, abandoned, trafficked, or the like. Both the foster placement and the grant are thus intended to provide for adequate “care and protection” for the child, rather than to address poverty. Over recent years, however, this distinction has been blurred.

In the late 1990s, approximately 50,000 children were receiving the FCG. Currently, more than 10 times this number of children receive the grant.¹² This dramatic increase is the result of orphans being placed in foster care so that they can receive the grant. The majority of the orphans who benefit from FCGs live with grandparents or other close relatives.

The practice of using the FCG for orphans was explicitly promoted by former Minister of Social Development, Zola Skweyiya. The opportunity was eagerly taken up both by applicants and the social workers who assisted them. This was done because of the substantial difference in the monetary value of the CSG and FCG, and despite the fact that the foster placement involved a lengthy and expensive process in terms of social worker and court time.

This situation creates several inequalities. Firstly, it creates inequality between children on the basis of living and care arrangements – an outcome that contradicts the Lund Committee’s principle of “follow the child”. The inequality arises because, while African children living with their mothers (and not their fathers) are, on average, as poor as African children living with neither parent, the latter are eligible for a higher value grant than the former if they are orphans.¹³

Secondly, the situation creates inequities between children living in urban and rural areas. In rural areas, there is poorer access to social workers and courts. The result is that children in rural areas are more likely than those in urban areas to access the CSG rather than the FCG, despite the fact that only 65% of children in rural areas (and 64% in former “homeland” areas) live with their mother as compared to 78% of children in urban areas (calculations based on General Household Survey 2010). Thus, for example, in 2010 there were 21 children receiving the CSG for every child receiving the FCG in formal urban areas, compared to 31 children receiving the CSG for every child receiving the FCG in the former homelands).

The confusion around the purpose of the FCG not only has implications for income inequality, it also means that social workers and children’s courts do not have time to provide adequately for children truly “in need of care and protection” as they spend the bulk of their time processing applications for foster care. This reduced capacity to provide services to children who face severe threats to their health, well-being and survival can be seen as yet another aspect of inequality.

What are the conclusions?

Several steps are needed to achieve the full potential of the poverty and inequality impacts of grants for children. Firstly, the confusion around the purpose of the foster system needs to be addressed to remove the resultant inequities and to free up the social work and court systems to serve those in desperate need. Secondly, the CSG amount needs to be raised to increase the poverty and inequality

impacts, as well as to reduce the incentive for caregivers and social workers to favour the FCG over the CSG when considering options for poor orphans living with relatives.ⁱⁱⁱ

In addition, further steps need to be taken to ensure that all eligible children access the CSG as it is generally those who are most disadvantaged and most in need who do not access the grant because of lack of access to birth certificates and identity documents, distance from services, or costs incurred in applying. The necessary effort and resources need to be put into facilitating access for these children before resources are spent instead on extending the grant to those who are not poor. If this is not done, universalisation will increase, rather than reduce, inequality.

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- 2 See no. 1 above;
- 3 See no. 1 above;
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iii At the time of publication, the Department of Social Development announced its intention to introduce a kinship grant as a “top-up” to the CSG for family members caring for orphans.

Early childhood development services: Increasing access to benefit the most vulnerable children

Linda Biersteker (Early Learning Resource Unit)

There is growing awareness of the importance of supporting the development of young children as a key strategy for reducing inequality.¹ Yet despite the focus on early childhood development (ECD) in the Children’s Act,¹ the phasing in of grade R and a National Integrated Plan for ECD,² there remain great inequalities in access to quality ECD programmes and concern that not enough is being done to maximise the potential of this sensitive period of childhood. This is particularly true for the most vulnerable young children – those living in poverty, in remote rural areas, and children with disabilities. The failure of timely intervention is apparent in South Africa’s poor schooling outcomes and low skills base.

This essay discusses why ECD is a recognised priority, points to challenges and gaps, and suggests interventions for achieving better outcomes. While “early childhood” is defined differently depending on the sector and purpose, this essay focuses on birth to six years, including the reception year of formal schooling that is being phased in for five-year-olds. It addresses the following questions:

- Why is it important to invest in early childhood?
- What ECD services are available in South Africa?

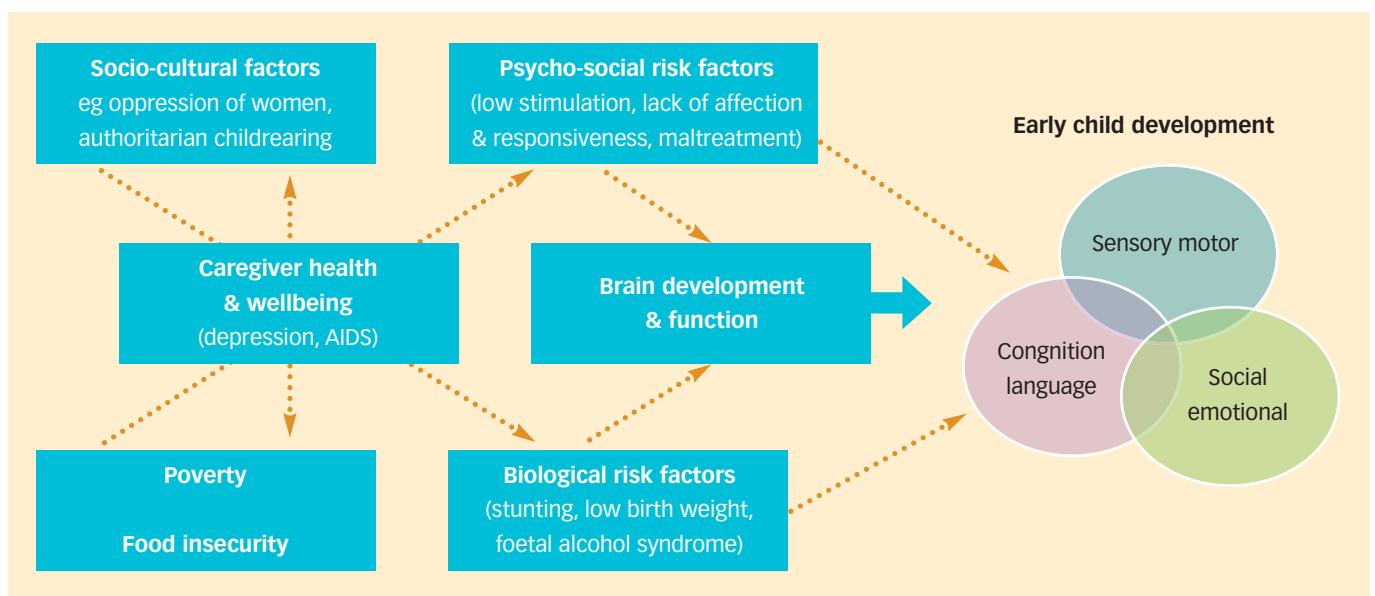
- Who has access to ECD services?
- What is needed to reach the poorest and most vulnerable children?
- What are the implications for policy and practice?

Why is it important to invest in early childhood?

Investment in ECD programmes has increased in low- and middle-income countries over the last two decades.³ Persuasive evidence from neuroscience, and of the economic returns of early intervention, have led to the realisation that supporting early development through services and programmes for young children and their families is one of the most promising approaches to alleviating poverty and achieving social and economic equity.

The first years of life, and especially the 1,000 days from conception to two years, are a particularly sensitive period for brain development. After this, brain development slows and builds on the base already acquired. Where the environment is not con-

Figure 15: Understanding the risk factors that influence early childhood development



Adapted from: Walker SP, Wachs TD, Meeks Gardner J, Lozoff B, Wasserman GA & Pollitt A (2007) Child development: Risk factors for adverse outcomes in developing countries. *The Lancet*, 369: 145-157. In: Dawes A, Biersteker L & Hendricks L (2012) *Towards Integrated Early Childhood Development: An Evaluation of the Sobambisana Initiative*. Cape Town: Ilifa Labantwana.

ⁱ Young children are highlighted in the *Diagnostic Review on ECD* that was commissioned by the Department of Performance, Monitoring and Evaluation in the Presidency, and in the National Integrated Plan for ECD. The 2012 national ECD stakeholder conference was hosted by the Minister of Social Development to plan for increasing access to quality ECD services. ECD is also a focus in the National Development Plan.

ducive to development, the deficits become more difficult and costly to address as children get older.⁴ Without intervention, disparities widen over time.⁵

In order to develop to their full potential children need good nutrition, good health, a healthy living environment, supportive parenting, cognitive stimulation and, if necessary, access to health care, social services and social assistance.

Factors such as malnutrition, poor health, home environments lacking in stimulation and encouragement for learning, and harsh discipline have a negative impact on children's development as illustrated in figure 15. Children living in households faced with significant caregiving burdens and poor access to resources, services and education are particularly at risk.⁶

In households with greater income, children usually benefit from better home circumstances (safer environments, better nutrition, and more stimulation of the kind that encourages exploration and learning and that prepares them for formal schooling). They also have better access to ECD services beyond the home, such as crèches and nursery schools, often through privately run schemes. Failure to get services to poor children whose development may be compromised already by poverty represents a double failure to address inequality.

ECD services have been shown to:

- improve physical and mental health and reduce reliance on the health system;
- enhance school readiness and related outcomes such as improved enrolment, retention and academic performance; and
- reduce high risk behaviours like unsafe sex, substance abuse, and criminal and violent activity.⁷

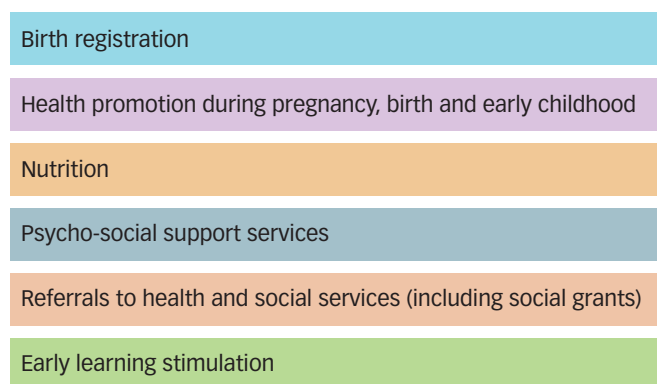
Arguments for ECD as a human capital development and cost-saving measure are a compelling motivation for public investment, but there is also a strong child rights argument for improving access to good ECD services. As outlined in the United Nations Convention on the Rights of the Child, young children have a right to develop to their full potential by growing up in a healthy, safe and stimulating environment.⁸ ECD also promotes social equity by giving disadvantaged and vulnerable children a better start to life. For all these reasons investment in ECD is neither a luxury nor a privilege – it is a key responsibility of government.

What ECD services are available in South Africa?

The South African government has responded to this imperative by greatly increasing investment in ECD services since 2007 and prioritising the poorest children. However, current strategies and programmes are not necessarily reaching those children most in need.

One of the largest public investments in ECD is the reception year of schooling. Grade R is being phased in for five-year-olds to support transition to formal learning with a target of universal access by 2014.

Figure 16: The ECD service package (0 – 4 years)



Source: Departments of Education, Social Development, Health & UNICEF (2005) *National Integrated Plan for Early Childhood Development 2005 – 2010*. Pretoria.

The National Integrated Plan for ECD (which is currently being updated) outlines a range of essential services for children aged 0 – 4 years. This ECD service package builds on existing public health, social assistance and ECD programmes, as outlined in figure 16. The plan recognises a number of different approaches to service delivery in addition to ECD centres, and brings together the departments of Social Development, Health and Basic Education in inter-departmental committees to address the developmental needs of young children.

The plan recognises that ECD services can be delivered in homes, communities and/or ECD centres using a range of approaches including:

- direct services to children (eg ECD centres, clinics or informal community-run playgroups);
- training of ECD practitioners (eg preschool teachers, ECD family workers);
- parenting education and support through workshops and home-visiting programmes;
- community development initiatives to improve the environment in which young children and their families live; and
- public awareness campaigns to encourage support for ECD and take up of services.

The plan provides an enabling policy framework that supports the delivery of integrated services for young children; however a number of challenges remain in ensuring access to quality services.

Who has access to ECD services?

Poor children are prioritised both in the National Integrated Plan and in the pro-poor grade R funding formula. But the roll-out of ECD services of different kinds is limited, with the greatest investment in centre-based programmes. There has been little integration of service delivery to ensure that all needs are met, and there is limited access for the most vulnerable young children.⁹ Furthermore, ECD services are not necessarily of sufficient quality to achieve potential child outcomes, and the poorest children are often the worst served.

Access to grade R

A major focus in ECD provisioning has been on grade R, which is offered in both public schools and registered community ECD centres. This is a responsibility of the Department of Basic Education and enrolment is moving towards universal access with 83% of grade ones in 2011 having attended a formal grade R class.¹⁰ Provincial enrolment indicates that some of the poorer provinces such as Limpopo and the Eastern Cape have the highest enrolments. This shows how public funding and the use of existing school infrastructure can enable greater access for the poor. Many poor children in public grade R classes also benefit from the National School Nutrition Programme. While figure 17 shows how access to grade R has increased, quality remains a challenge.

Access to ECD centre programmes

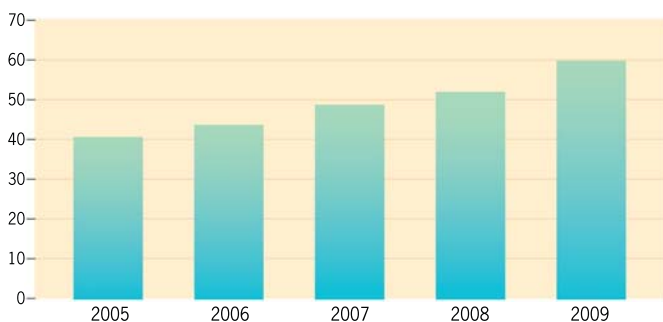
Prior to the National Integrated Plan, the Department of Social Development focused on regulating ECD centres and providing some means-tested subsidisation of poor children attending registered non-profit centres. ECD centres remain the dominant form of provision and much of the effort to reduce disparities for young children has been on increasing children's access to centres. The value of the subsidy and the proportion of 0 – 4-year-olds attending some form of ECD centre have increased steadily. However there are age, spatial, race and income disparities in access. Service quality also tends to be worse for younger and poorer children.

Figure 18 shows that access increases by age. While data quality may be limited, the General Household Survey 2010 shows that only 18% of 0 – 2-year-olds access centre-based care.¹¹ This is not necessarily a bad thing, as very young children are usually better off cared for at home than in large centres which may be of poor quality. However this does suggest a lack of affordable childcare for employed or work-seeking mothers.

By the age of three and four years educational programmes

Figure 17: Gross enrolment rates for grade R in ordinary schools, 2005 – 2009

(Y-axis reduced to 70%)

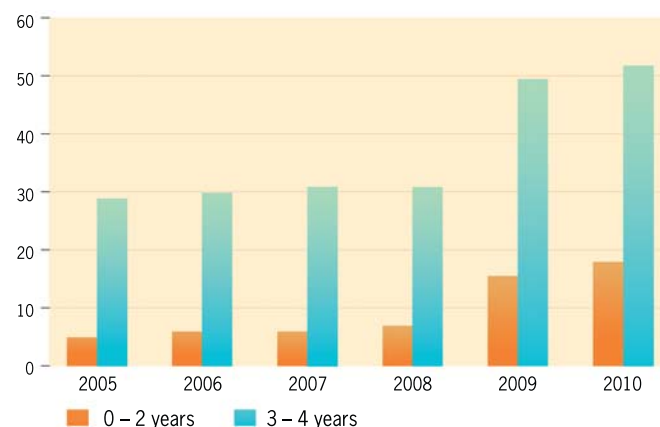


Source: Department of Education (2010) 2009 Country Report: South Africa. Pretoria: DBE.

Note: These figures do not reflect total grade R provision as they exclude grade R in community-based ECD centres.

Figure 18: Access to an ECD centre, by age, 2005 – 2010

(Y-axis reduced to 60%)



Source: Statistics South Africa (2006-2011) General Household Surveys (2005 – 2010). Pretoria: Stats SA.

outside the home become important for developing social skills and learning readiness¹² but only 52% of 3 – 4-year-olds access such services.¹³ Recent data suggest that attendance at preschool has a positive impact on reading and mathematics tests in grade 4.¹⁴ For this reason, the National Development Plan proposes at least two years of preschool education.¹⁵

Spatial location, race and income also determine access to centres. In 2010, enrolment of children under five was highest in the more affluent urban provinces of Gauteng (43%) and the Western Cape (39%) and lowest in KwaZulu-Natal (25%) and the Northern Cape (21%).¹⁶ White children have the greatest access to ECD centres (46% for ages 0 – 2, and 64% for ages 3 – 4) compared with African children (17% and 52% respectively). Only 22% of children in the poorest quintileⁱⁱ attend a centre compared with 51% of children in the richest quintile.¹⁷

Finally, children with moderate to severe disabilities have limited access, even though policy prioritises them for ECD services. An estimated 4% of children fall into this category;¹⁸ but in 2000, only 1% of the enrolment in ECD centres was by children with disabilities (including specialist services).¹⁹ A recent study of over 1,500 ECD centres in the Western Cape suggests that enrolment remains limited even though early identification and intervention are essential to assist children with disabilities to overcome barriers to learning.²⁰

ECD centres in the highest income quintile spend on average 2½ times as much per child as those in the lowest quintile because they are better able to raise fees.²¹ The Department of Social Development subsidy for children from poor families aims to improve quality and, where it is available, provides a major source of funding for registered non-profit centres in poor communities.

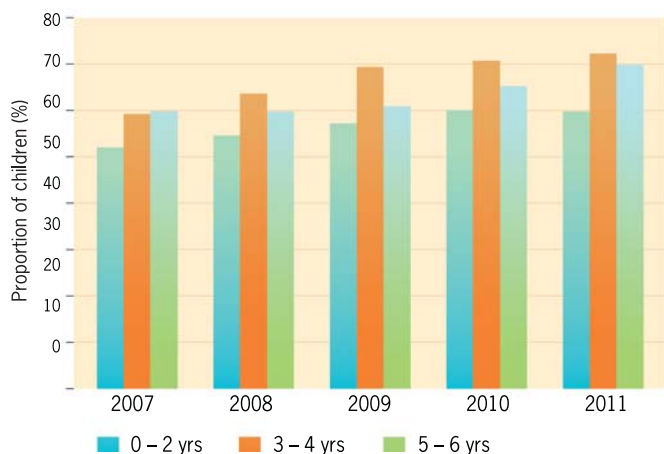
However, many centres are not yet registered. While 59% of children in registered centres received a subsidy, only 18% of all poor children under five years were subsidised in 2011.ⁱⁱⁱ Even

ii Quintile = 20% of all households in the country.

iii Calculation based on the number of children receiving subsidies as reported by the Department of Social Development in relation to the 2.6 million poor children who are the target of the National Integrated Plan for ECD.

Figure 19: Proportion of children receiving the Child Support Grant, by age, 2007 – 2011

(Y-axis reduced to 80%)



Source: South African Social Security Agency SOCPEN data 2007 – 2011; Actuarial Society of South Africa ASSA2008. Population and social grant data for July each year. Calculations by Katharine Hall, Children’s Institute, UCT.

where subsidies are provided, fees are usually charged, which excludes very poor children. With no mandatory public budget for infrastructure and start-up costs, there may not even be a centre in very poor communities.

A Western Cape study found that fees were highly related to quality – more so than the presence of trained practitioners.²² The same study found that ECD centres in areas where children are most deprived have poorer infrastructure, management and educational programmes. Children most in need are therefore not receiving the level of care and stimulation needed to offset the deprivation they experience at home and in the community.

Both the Children’s Act and the National Integrated Plan aim to prioritise funding of programmes in communities “where families lack the means of providing proper shelter, food and other basic necessities of life to their children”, and for children with disabilities.²³ But it is clear that these children are not being reached. While younger children stand to gain more, they have least service

access. Grade R has been much more successful in reaching poor rural communities, but by the age of five years an essential developmental opportunity has been lost.

Nutritional support

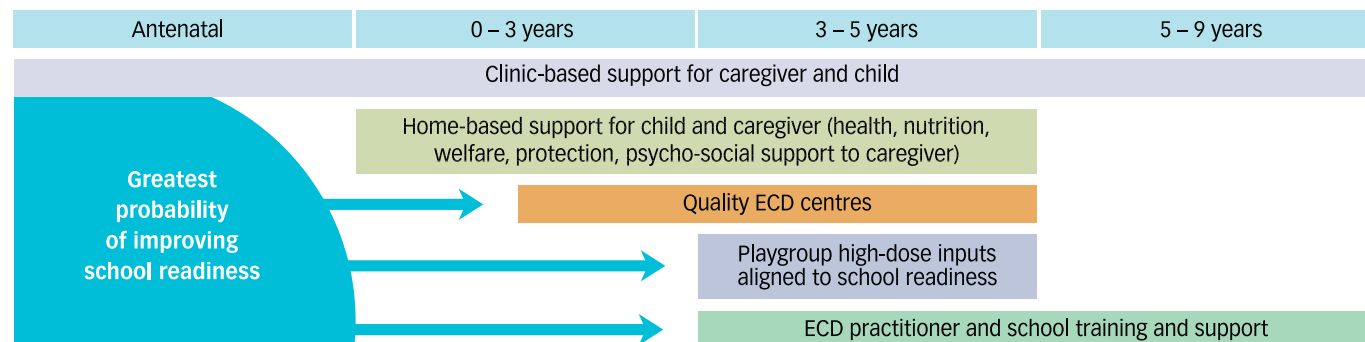
Of all risk factors affecting young children, stunting and poverty are major predictors of poor school achievement and diminished intellectual development. Poverty is linked to stunting, child mortality, disease and reduced cognitive development.²⁴ The most recent national data indicate that 20% of children under six years are stunted and 12% are underweight.²⁵ Children under four are most affected.

Currently, there is no effective public health programme to identify children at risk of malnutrition and stunting and to ensure that these children receive adequate nutrition.²⁶ Until this is addressed, the Child Support Grant (CSG) is the main instrument for addressing basic needs. It is associated with improved growth and preschool attendance.²⁷ However, other research shows that the CSG only has a positive impact on nutritional outcomes if the child receives the benefit *for at least* half of the first 36 months of life.²⁸ This suggests that early take-up of the grant is crucial to maximise its benefits for growth and neurological development. While grant access has improved over the last few years, figure 19 shows that take-up remains lower amongst very young children.

Not having complete documentation is the main barrier in applying for a grant. While birth registrations in the first year have increased to over 80% in the last three years, one in five infants is still not registered.²⁹

In addition to cash transfers, other interventions to reduce the impact of poverty on young children include free access to health care for pregnant women and young children, the National School Nutrition Programme for grade R children in public schools, and free water and electricity allowances for indigent^v families. However, even if these services are free, long distances and high transport costs or lack of infrastructure may limit access to essential services – especially for children in rural areas.

Figure 20: What local evidence tells us about how and when to intervene



Adapted from: Dawes A, Biersteker L & Hendricks L (2012) *Towards Integrated Early Childhood Development: An Evaluation of the Sobambisana Initiative*. Cape Town: Ilifa Labantwana.

^v This term is often used by the government to refer to poor people who are eligible for municipality-administered poverty relief programmes such as basic water and electricity.

Support for parents and caregivers

The primary caregiver and home environment are the strongest influence on the child in the early years. Healthy development requires nurturing and consistent care, play and stimulation by responsive caregivers.³⁰ In South Africa, women living in poverty carry significant burdens and have little access to services and support beyond family and social networks. Research shows that many women with young children suffer from stress and depression.³¹ When caregiver well-being is compromised, the capacity to care for young children suffers, and child outcomes such as health, nutritional status, and psychological development are also affected.³² While the National Integrated Plan prioritises support to caregivers, in practice there has been little departmental funding for family-based ECD programmes which are primarily delivered by non-governmental and community-based organisations.³³ There is no national data on how many families receive home-based ECD services.

Many household factors affect children's development and readiness for formal learning. These include access to material resources (from basic needs such as food, to writing materials, books and other print material); information (eg knowledge of services and the integrated management of childhood illnesses); caregiver education levels³⁴ and the degree to which household practices are aligned to the requirements of the schooling system (for example, the extent to which children are encouraged to ask and answer questions, and engage in activities that promote emergent literacy and numeracy).

What is needed to reach the poorest and most vulnerable children?

Given limited funding and infrastructure, it is particularly difficult for ECD services to reach poor, vulnerable and rural children whose caregivers are often struggling to meet basic needs. It is therefore important to evaluate the potential of different approaches to improve access and shift patterns of inequality. Different interventions yield more returns at different ages (see figure 20), but it is also important to review delivery strategies.

Case 5: Home visiting – reaching the most vulnerable young children

Many non-profit organisations employ home visitors to support vulnerable young children and their families. Ilifa Labantwana's Sobambisana Project included different home-visiting programmes in Lusikiski and the Queenstown district of the Eastern Cape, and in Grabouw in the Western Cape. These were run by the Early Learning Resource Unit, Khululeka Community Education Development Centre, and the Centre for Early Childhood Development respectively. Their staff trained and supervised community members to provide support to very vulnerable young children and caregivers in their homes.

Case 6: Improving service access through community advocacy

The Sobambisana Project included a stakeholder and community awareness campaign as part of creating an enabling environment for young children in the under-resourced Lusikiski area of the Eastern Cape. Regular community report-backs and *imbizos* which brought together community members, government officials and civil society organisations created interest in and demand for documents, grants, health and education services. The community became more active in pressing for better conditions for children and government services responded to the call in different ways. These included agreeing to staff a health post in one village which was far from other health services, providing a mobile Home Affairs unit, and helping ECD centres to register and apply for subsidies. These positive outcomes for ECD were due to advocacy carefully targeted to particular issues, and sustained over several years.

Source: Dawes A, Biersteker L & Hendricks L (2012) *Towards Integrated Early Childhood Development: An Evaluation of the Sobambisana Initiative*. Cape Town: Ilifa Labantwana.

Much greater emphasis needs to be placed on extending community coverage and outreach to caregivers using community-based ECD workers. Such interventions can provide an integrated approach by supporting the health, nutrition and stimulation needs of young children as early as possible. Home and community-based programmes (such as the Sobambisana project in case 5) reach children where they live, help link families to grants and other services, and provide psycho-social support and information to help caregivers cope with the demands of parenting. Good quality centres and playgroups are important for improving school readiness.

Case 6 illustrates how a community development approach can be very effective in securing greater government accountability for service provision and accessibility. This includes raising awareness of the importance of ECD, spelling out what services should be in place and mobilising communities to demand services.

Source: Dawes A, Biersteker L & Hendricks L (2012) *Towards Integrated Early Childhood Development: An Evaluation of the Sobambisana Initiative*. Cape Town: Ilifa Labantwana.

What are the implications for policy and practice?

During the past decade much has been done to improve the resourcing, training and provisioning of ECD services. Current interest in young children is unprecedented and provides a significant window of opportunity to scale up provision. However greater effort is needed to improve poor children's access to quality ECD services and redress social and economic inequalities. Priority interventions include:

- providing infrastructure and ECD services for children in the poorest quintiles, rural areas and children with disabilities;
- improving food security and nutrition for pregnant women and young children to prevent stunting;
- funding programmes to help caregivers and families give appropriate care and stimulation, especially for the earliest years;
- increasing access to group learning opportunities for children over three years – at least on a part-time basis and with a focus on language and stimulation;
- supporting efforts to improve the quality of ECD services through the provision of resources, training and monitoring;
- ensuring that coordinating mechanisms have the authority to hold different departments accountable, and ensuring young children access a full range of services from multiple service points in as integrated a way as possible;
- developing more reliable and comprehensive data on ECD services disaggregated to local level to assist planning and targeting – the planned national audit is a priority and should include ECD programmes and services of all kinds; and
- better monitoring and evaluation and further research on which interventions improve child outcomes in different settings most cost effectively to ensure that resources benefit the greatest number of young children.

These interventions should ensure the delivery of quality ECD services to those children most in need. While ECD services are essential, they are not sufficient to break the intergenerational cycle of poverty. In addition, children need access to good schooling and a range of other services to build on this foundation and realise their full potential.

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Addressing inequities in child health: Opportunities and challenges

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Over the past decade, there has been a reduction in the number of South Africa's children who live in conditions of poverty, and household surveys show increases in access to housing, electricity, water, and sanitation. Yet many children still live in poor households and massive inequalities remain. These backlogs have a profound impact on child health and are the main obstacles towards meeting Millennium Development Goal (MDG) 4 which aims to reduce under-five mortality by two-thirds by 2015.

This essay explores the relationship between poverty, inequality and child health. It considers how universal coverage of key health care interventions within and beyond the health sector could improve outcomes for children, and focuses on the following questions:

- What are the causes of under-five mortality?
- How do poverty and inequality impact on children's health?
- What interventions are needed to promote health equity?
- How is the government attempting to improve access and quality of care?
- What are the key challenges?

What are the causes of under-five mortality?

Under-five mortality rates (U5MR) in South Africa remain discrepantly high in comparison with similar middle-income countries.

While trends in child mortality are difficult to pin down accurately and published estimates vary widely, a recent review of child mortality data reveals a growing consensus on the general trend. Most projections reflect a rise in under-five mortality, from an estimated 50 – 60 deaths per 1,000 live births in the early to mid-1990s to an estimated peak of 70 – 80 deaths per 1,000 births in 2003 – 2005, thereafter the rates start to fall.¹ The latest official U5MR is an estimated 56 deaths per 1,000 live births in 2009.² Despite these gains, it is extremely unlikely that South Africa will reach its MDG target of 20 deaths per 1,000 live births by 2015.

This trend in under-five mortality echoes the rise in HIV prevalence amongst pregnant women in the 1990s, and under-five mortality began to decline following the national roll-out of the Prevention of Mother-to-Child Transmission (PMTCT) programme in 2003. HIV infection is a key driver of under-five mortality in South Africa³, and is associated with over 50% of child deaths in hospital.⁴ Other leading causes of death for young children include pregnancy

and childbirth complications, newborn conditions and childhood infections (such as diarrhoea and pneumonia – commonly associated with poverty). The introduction of vaccines for pneumonia and diarrhoea⁵ have also contributed to improved health outcomes for young children.

While malnutrition is not classified as a cause of death, it is a key risk factor: 35% of young children who died in hospital between 2005 and 2009 were severely malnourished and a further 30% were underweight for age.⁵ Injuries account for a growing proportion of deaths as children grow older and are accounted for over 50% of deaths amongst boys aged 15 – 17.⁶

A child's growth and development are dependent on the family's living conditions and access to services. These social determinants generate the biological risk factors that impact directly on the child's health through illness and injury. Access to maternal and child health care services (such as immunisation and PMTCT) is also critical as the majority of deaths from these conditions are preventable.

How do poverty and inequality impact on children's health?

Poverty and inequality have a significant influence on children's health, living environments and access to health care services. At the same time, poor child health imposes a heavy financial burden on families, and on health services. Low birth weight, malnutrition and HIV/AIDS permanently harm physical and mental development and contribute to non-communicable diseases in adult life. These long-term impacts perpetuate inequality, with adverse consequences for both the human and economic development of South Africa.

The social determinants of health

Table 4 on p. 59 shows how income inequality influences children's living conditions and access to services. These social determinants can, separately and in combination, adversely affect children's health. For example, food insecurity and undernutrition impair children's immunity while overcrowded, smoky and poorly ventilated housing, and poor hygiene due to inadequate water and sanitation, increase their exposure to infection. Poor maternal education is associated with suboptimal child care.⁷

Child poverty in South Africa remains extremely high. In 2010, six out of every 10 children lived in households with an income of

i Pneumococcal conjugate and rotavirus vaccines were introduced in 2008.

Table 4: Dimensions of deprivation and inequality in South Africa

Dimensions of deprivation	Children in poorest 20% of households	Children in richest 20% of households
Child hunger*	26%	0%
Inadequate water*	54%	3%
Inadequate sanitation*	46%	3%
Overcrowding*	31%	2%
Clinic far from home*	45%	19%

Source: Statistics South Africa (2011) *General Household Survey 2010*. Analysis by Katharine Hall, Children's Institute, UCT.

Note: See Part 3: *Children Count – The numbers* (pp. 80 – 105) for more information on these indicators.

less than R575 per person per month. Stark racial disparities persist, with 67% of African children living in poor households compared to only 4% of White children.⁸

Lack of household food security remains a major problem despite efforts to combat child hunger, such as the expansion of social grants and school feeding schemes. Over three million children live in hungry households.⁹

Nearly nine million children live in rural areas characterised by high levels of poverty and poor access to services.¹⁰ Nearly two million children live in informal housing where poverty, overcrowding, poor service delivery and shack fires put health at risk.¹¹

Access to clean domestic drinking water and sanitation are essential for health. While there have been improvements in delivery of sanitation there has been little improvement in access to safe water since 2002. Nearly seven million children are without access to clean drinking water at home,¹² while six million children

still use unventilated pit latrines, buckets or open land.¹³ Children living in poor households are particularly at risk.

These income and spatial inequalities have a significant impact on health outcomes. Figure 21 illustrates that children living in poor households are four times more likely to die before their first birthday than their richer counterparts. Children living in rural areas and with caregivers who have not completed matric are similarly at greater risk than children in urban and better educated households.

Access to health care services

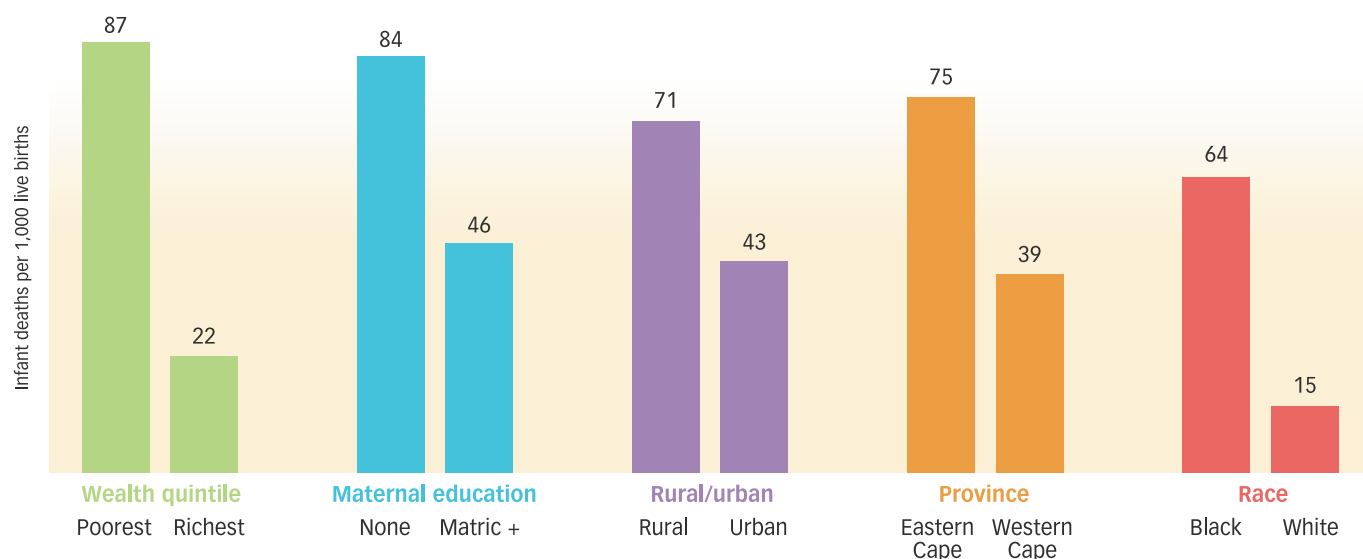
Private health insurance covers only 15% of the population, yet it accounts for 44% of total health care expenditure in South Africa.¹⁴ This system is hospital based, concentrated in urban areas and employs more than half of all health professionals. Only 31% of medical practitioners, 25% of specialists and 46% of professional nurses work in the public sector.¹⁵ While rural areas house 47% of South Africa's children,¹⁶ only 12% of doctors and 19% of nurses work there.¹⁷

A similar pattern applies to paediatricians. There were 1,001 paediatricians on the Health Professions Council of South Africa register in 2011, but this included retired individuals and those working overseas. It is estimated that, of the paediatricians working in the country, fewer than half work in the public sector.¹⁸

Paediatricians remain concentrated in the more urban provinces of Gauteng and Western Cape, resulting in huge provincial disparities. There was one public health paediatrician to 9,600 children in the Western Cape in 2009, and one paediatrician for one million children in Mpumalanga.¹⁹

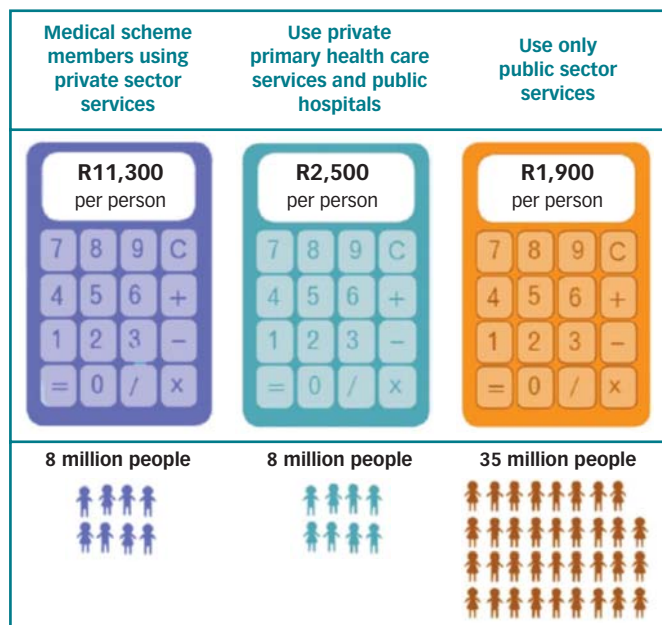
Figure 22 shows that most people in South Africa rely completely on the public health care system for their health care needs. While South Africa has made significant strides in providing free

Figure 21: Factors influencing infant mortality in South Africa – deaths per 1,000 live births



Source: Department of Health (2002) *South African Demographic and Health Survey 1998*. Pretoria: DoH; World Health Organisation (2007) *World Health Statistics 2007*. Geneva: WHO. Both in: Bradshaw D (2008) *Determinants of health and their trends*. In: Barron P & Roma-Reardon J (eds) *South African Health Review 2008*. Durban: Health Systems Trust.

Figure 22: Inequalities between public and private health care – usage and per capita expenditure



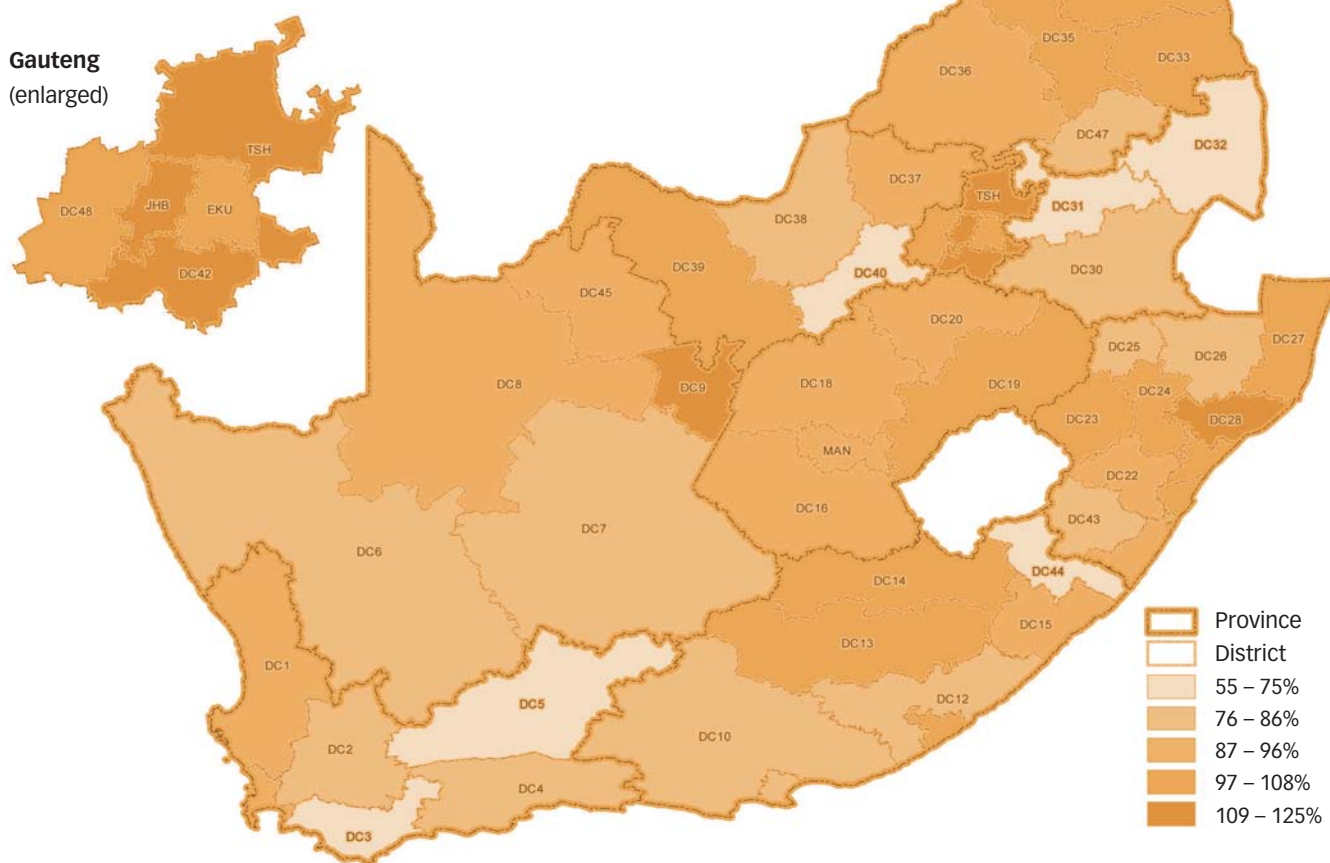
Source: Adapted from McIntyre D (2009) *The Public-Private Health Sector Mix in South Africa. HEU Information Sheet*. Cape Town: Health Economics Unit, UCT.

primary health care and expanding the network of primary health facilities, more than a third of children still live more than 30 minutes away from their health facility.²⁰

These primary health facilities provide basic preventive and treatment interventions that could avert up to two-thirds of under-five deaths in “developing” countries.²¹ For example, immunisation is both a useful measure of children’s access to health care services and an important opportunity for developmental screening, HIV prevention and care. National immunisation coverage (95%) is good but remains uneven, ranging from 125% to 55% (see figure 23).ⁱⁱ

Despite the government’s pro-poor policies, quality of services remains a problem.²² Government has done much to expand the network of clinics and provides free primary health care, and free public health care for pregnant women, children under six and recipients of social grants. Yet patients attending public health facilities complain of long waiting times, staff rudeness and problems with drug availability. Regardless of higher costs, patients – including those from very poor households – are opting to consult private health care providers.²³

Figure 23: Immunisation coverage for children under one year, 2011/2012



Source: District Health Information System (DHIS) data. Quoted in: (in press) *District Health Barometer 2011/12*. Durban: Health Systems Trust. [forthcoming]

ii Figures above 100% are likely to be linked to data problems, whilst low figures speak to problems of access and quality of care.

What interventions are needed to improve health equity?

The most important and lasting interventions to break this vicious cycle lie outside the health sector and involve addressing the social determinants of health such as food security, water and sanitation, housing and education. Intersectoral action needs to be complemented by efforts within the health sector to provide universal and equitable access to quality care. This section focuses on key interventions to improve child health, and a range of policies that aim to achieve this.

Priority interventions to address the leading causes of child morbidity and mortality are outlined in table 5.

Currently, both the coverage and quality of many of these priority interventions are inadequate, especially at community and primary levels and at first-level hospitals in rural and peri-urban settings. Only 35% of young children (12 – 59 months) received vitamin A supplements,²⁴ 38% of pregnant women received antenatal care in the first 20 weeks of pregnancy,²⁵ and only 26% of babies were exclusively breastfed for the first six months.²⁶

Key steps for increasing access and improving the quality of health care services for children include:

- a priority focus on districts and communities with the poorest living conditions and highest rates of malnutrition and HIV infection to reduce inequities and improve health outcomes;

- a well-functioning, standardised community health worker programme to deliver sustainable and universal coverage of the priority child care interventions at community level;
- a rapid improvement in staffing ratios and performance in child care activities in clinics and health centres, with support for mid-level workers and nurses;
- rapid expansion in the training and recruitment of community paediatricians to ensure not only a high level of general paediatric clinical skills, but also a full range of competencies necessary for planning, supporting and monitoring programmes that protect and promote child health in their districts; and
- greatly improved clinical care for sick children in district hospitals through focused training and support for generalist medical and nursing staff by community paediatricians.

How is government attempting to improve access and quality of care?

The government has recently initiated a number of important reforms to address the crisis in the health sector; these have the potential to address the key child health imperatives.

Specific legislative and policy reforms underway include:

- A National Health Insurance (NHI) as the main financing mechanism to promote universal coverage and eliminate inequity.

Table 5: Key interventions to address child morbidity and mortality

Causes	Intervention
HIV	Strengthen primary prevention and ensure universal coverage of prevention of mother-to-child transmission (PMTCT) which should virtually eliminate childhood HIV infection.
Neonatal causes	Improve maternal nutrition; reduce smoking and drinking alcohol during pregnancy; improve early antenatal and maternal care at district hospitals and community health centres; provide “kangaroo” mother care for low birth weight babies; promote exclusive breastfeeding; and improve coverage and quality of PMTCT.
Diarrhoea	Increase coverage of community-based integrated management of childhood illness to promote good hygiene practices, exclusive breastfeeding and oral rehydration therapy. Concerted efforts are needed to improve access to safe drinking water and sanitation.
Lower respiratory tract infection	Improve immunity (through PMTCT, nutrition and immunisation) and reduce exposure (through better housing, less indoor smoke pollution and better personal hygiene) to reduce infection. Early identification and treatment with antibiotics have been shown to reduce mortality.
Malnutrition	Improve pregnant mothers’ nutrition; promote exclusive breastfeeding, regular infant growth monitoring and the introduction of micronutrients and quality complementary foods; improve treatment of diarrhoea; and improve management of children with severe malnutrition. Work together with other government departments to address household food security: Social Development (early childhood development and social grants), Basic Education (female literacy), Agriculture (food security) and Trade and Industry (small-scale enterprise and food prices).
Injury	Integrate injury prevention within primary health care programmes and work with other departments to reduce burns, drowning, road traffic injuries and violence. These are strongly associated with drug or alcohol abuse, which require legislation and more focused community development efforts, and, in the longer term, reductions in unemployment and inequality.

- The re-engineering of primary health care which aims to strengthen the district health system through a greater emphasis on community-based services and a focus on the social determinants of health.
- These two initiatives are underpinned by a revised set of national core standards²⁷ and a number of reforms designed to improve the management and quality of health care services.

The proposed NHI aims to bridge the public–private divide and promote a more equitable sharing of health resources between the private and public sectors, and within the public sector. The NHI aims to achieve universal coverage of health care services by:

- extending access to all (population coverage);
- providing a comprehensive package of services – prevention, promotion, treatment and rehabilitation (service coverage); and
- protecting all households from the potentially devastating costs of ill health (financial risk protection).

The NHI plans to pool public and private health resources. This pool of funds will be used to purchase services from both public and private providers in an attempt to improve access to health care for all.

The re-engineering of primary health care is a central feature of the NHI and aims to achieve universal coverage of health care services by introducing:

- ward-based primary health care to be delivered by primary health care outreach teams consisting of a professional nurse, staff nurse and community health care workers;
- district specialist teams made up of a paediatrician, obstetrician, family medicine specialist, anaesthetist, advanced midwife, paediatric nurse, and advanced primary health care nurse; and
- school health services to be delivered primarily by school health nurses.

The proposed outreach teams will operate out of primary care clinics in the communities they serve. Each team will provide comprehensive primary health care services to a defined number of families, with one community health worker (CHW) for every 250 households. CHWs will undertake mainly promotive and preventive care, with a significant focus on young children and pregnant and breastfeeding women. They will also work with environmental health officers to address local social determinants of health.

The role of the district specialist teams extends beyond clinical care. District specialists will improve the quality of care provided by generalists at health facilities, and play a key role in clinical governance and the planning, supporting and monitoring of district programmes within their areas of specialisation.

School health services intend to address the health problems of school-aged children, to identify and address barriers to learning, and to promote healthy behaviours which support both the current and future health of learners.

What are the key challenges?ⁱⁱⁱ

While these policy initiatives are appropriate and necessary, there are major challenges in ensuring that they lead to equitable quality health care. These include the challenges of:

- partnering with the private sector
- improving governance and accountability, and
- investing in human resource development.

Partnering with the private sector

The private sector has contested the viability of the NHI but is now open to continuing engagement. Similar experiences elsewhere have shown that such engagement requires careful navigation to ensure that inequalities are addressed and not aggravated.²⁸ The NHI could easily worsen urban and rural inequities, given that health care expenditure is currently concentrated on private health care services and urban centres. Special effort is therefore required to ensure that public health facilities meet the criteria for accreditation so that those serving the poor and rural areas can benefit.

Improving governance and accountability

In addition to assessing health facilities' compliance with national core standards, enhanced leadership and improved governance are urgently needed to improve the quality of health care services – particularly in the 18 priority districts that are lagging behind in performance on key maternal and child health care indicators. District health councils and committees for clinics and community health centres need to be better resourced and strengthened. These structures, although presently weak, allow for community representation in health system governance and could strengthen accountability and improve management and service delivery.

Investing in human resources

The success of the NHI scheme will depend fundamentally on the availability, skills and motivation of health workers in the public sector. It is urgent that the health system ensures a more equal distribution of health workers. Efforts to re-engineer the primary health care system depend on having sufficient specialists and doctors as well as nurses who are central to the operation of the outreach teams. These health workers also need to possess the necessary skills to operate in poorly resourced districts, implement a primary health care approach and address the social determinants of health.

Increased investment in health personnel

The re-engineering of primary health care draws explicitly on Brazil's family health programme, which is supported by a heavy investment in human resource development.²⁹ Brazil has more than 2.5 million workers formally employed in the health sector, which represents about 1.3% of the country's population. This is a

ⁱⁱⁱ This section draws heavily on the contribution by David Sanders in chapter 10 of the National Development Plan (published by the National Planning Commission in the Presidency in 2011).

far greater concentration than in South Africa, which had only 150,509 health professionals in a population of 51 million (constituting 0.3% of the population) in 2010.³⁰ Brazil's numbers have been achieved by significant investment in the training of nurses and technicians, the upskilling of public health and auxiliary personnel (to promote problem solving and reflective thinking), and curricula reform in undergraduate programmes.

In stark contrast, South Africa has seen stagnation in the production of doctors and, until recently, a decline in the production of nurses. Training in public health, a core component of the primary health care approach, is minimally supported by government funding. Most health professionals – with the exception of nurses – work in the private sector, and have been trained to manage conditions similar to those in the private health sector.

In order to implement policies that ensure greater equity in access and that are more responsive to the health care needs of South Africa, the government urgently needs to invest in the production of appropriate and appropriately trained personnel in sufficient numbers and within a negotiated, but short, time frame.

Sufficient and appropriately trained community health workers

Research and experience from a growing number of countries show rapid improvements in child health when good household coverage is attained through the use of community-level workers who are supported by clinics and health centres and are equipped with basic skills to identify, prevent and treat common conditions.³¹

The number of tasks a CHW can reasonably perform depends on the ratio of CHWs to households, the duration and quality of their training, and the extent and quality of their supervision.³² In Thailand and Rwanda a high CHW-to-household ratio ensures that all households, including the poorest with the most vulnerable children, are visited regularly and health problems are detected early. Such a high ratio was achieved by employing both full-time and part-time CHWs, with ratios of between 1:10 and 1:20. In Thailand, for example, high coverage is achieved by instituting a two-tier system where there is one full-time CHW for every 300 – 500 households, and who supervises 10 part-time CHWs who have more limited training.³³

If South Africa were to adopt such an approach it would require a total of at least 700,000 community-based workers, the majority of them part-time. In addition to making health care more accessible and equitable, this system will create jobs, and indirectly improve health by reducing the prevalence and depth of poverty.

CHWs in several countries have proven effective in treating childhood pneumonia with antibiotics.³⁴ Yet CHWs in South Africa are prohibited from prescribing or dispensing any medication and the plans to re-engineer primary health care continue to limit their role in treatment. If this community-based model is to succeed, the power of conservative professional councils needs to be moderated to widen the scope of practice for nurses and CHWs and to enable CHWs to administer antibiotics for specific childhood diseases such as pneumonia.

Appropriately-skilled nurses

The outreach teams consist of nurses and CHWs and will require a significant increase in the number of trained nurses to support nearly 7,000 teams nationwide. These nurses will also require additional training in public health to complement their clinical skills, support a primary health care approach, and supervise CHWs to ensure more equitable coverage and access to health care.

This will require the rapid expansion and reorientation of nurse training. The policy decision to reopen and expand nurse training colleges is welcome. This must be accompanied by a curriculum review that includes input from advisers who have expertise in public health and experience in countries that have implemented a comprehensive, district-based approach.

Doctors and specialist support teams prepared for district work

Postgraduate specialist training in South Africa does not prepare paediatricians for district work. There is too little emphasis on prevention, primary health care, and quality of care in district hospitals and clinics.³⁵ Current specialist training encourages a continuing output of system sub-specialists, most of whom will seek and find employment only in teaching institutions or the private sector (or overseas). This is out of step with what South Africa needs and does not address the needs of the majority of the population, who live beyond the reach of the major city teaching centres, often in remote rural areas.

Clearly this challenge will require a major shift in the training, orientation and distribution of specialists – and the accelerated production of community child health specialists. Post-graduate training and qualifications in general and community paediatrics intend to help fill this gap.

Health personnel equipped to lead intersectoral action

Much of the work of the community outreach teams is linked to improving social determinants at the community level but the policy is vague on who will lead such challenging and long-term work. It is suggested that there should be “align[ment] [of] the intersectoral programme at district level through the IDP [Integrated Development Plan] process with that of the provincial and national clusters with specific time bound targets”.³⁶ However, it does not specify how CHWs will be supported to undertake this complex work in districts and wards.

A role has been suggested for environmental health officers; yet their current training and activities suggest that they are ill-equipped to lead such work in disadvantaged communities. This is an area for priority consideration. Key categories of health and health-related personnel and their respective roles need to be identified. Appropriate and practical training programmes need to be developed and combined with a facility for ongoing mentoring and support in the field. These actions are likely to require the active involvement of non-governmental organisations with a track record in addressing social determinants to ensure improved living conditions and access to services for children in poor communities.

What are the conclusions?

All those concerned with child health – practitioners, policy-makers, researchers, teachers, and communities themselves – need to advocate for greater equity in the social and environmental determinants of health, as well as in access to quality health care, especially at community and primary levels.

The NHI and re-engineering of primary health care could potentially mitigate the stark inequalities in child health. However, their successes depend fundamentally on reducing disparities between rich and poor, urban and rural areas, and private and public sectors. This will require large investments in physical infrastructure (housing, water, sanitation, etc), social programmes (welfare, education, etc) and especially in human resources for health. Child health data should also be disaggregated by income, race and district in order to target those districts where children are most in need, monitor progress and ensure a more equitable distribution of health care resources.

Only sustained government efforts to harness South Africa's considerable resources for the benefit of all – with priority to the poor – can achieve this. This will inevitably require significant social mobilisation to ensure that the government is responsive, and delivers services in an accountable manner.

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Children and HIV: Monitoring equitable access to services

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In 2010, South Africa had an estimated 518,000 HIV-infected children aged 0 – 14 years,ⁱ the highest number of children living with HIV of any country in the world.¹ The paediatric HIV pandemic in South Africa is driven primarily by the transmission of HIV from an HIV-positive mother to her child during pregnancy, birth or through breastfeeding.

Without intervention, the risk of infection in infants born to HIV-positive mothers ranges from 15 – 50%, depending on breastfeeding practices.² HIV-transmission rates can be significantly reduced with intervention to less than 3% by eight weeks post-delivery.³

HIV infection follows a more aggressive course among infants and children than it does among adults. Without access to early diagnosis and antiretroviral treatment (ART), an estimated 50% of HIV-positive infants die within two years.⁴ With early intervention the risk of death can be reduced by 76%.⁵

Given the efficacy of these HIV-prevention and -treatment interventions, and the consequences of not intervening, efforts to ensure service access for all mothers and infants are critical. These efforts fall within the national Prevention of Mother-to-Child Transmission (PMTCT) programme. It is also important to note that, in 2003, Cabinet approved a comprehensive care, management and

treatment plan for the country which enabled the government to provide free antiretroviral treatment for people living with HIV and AIDS.

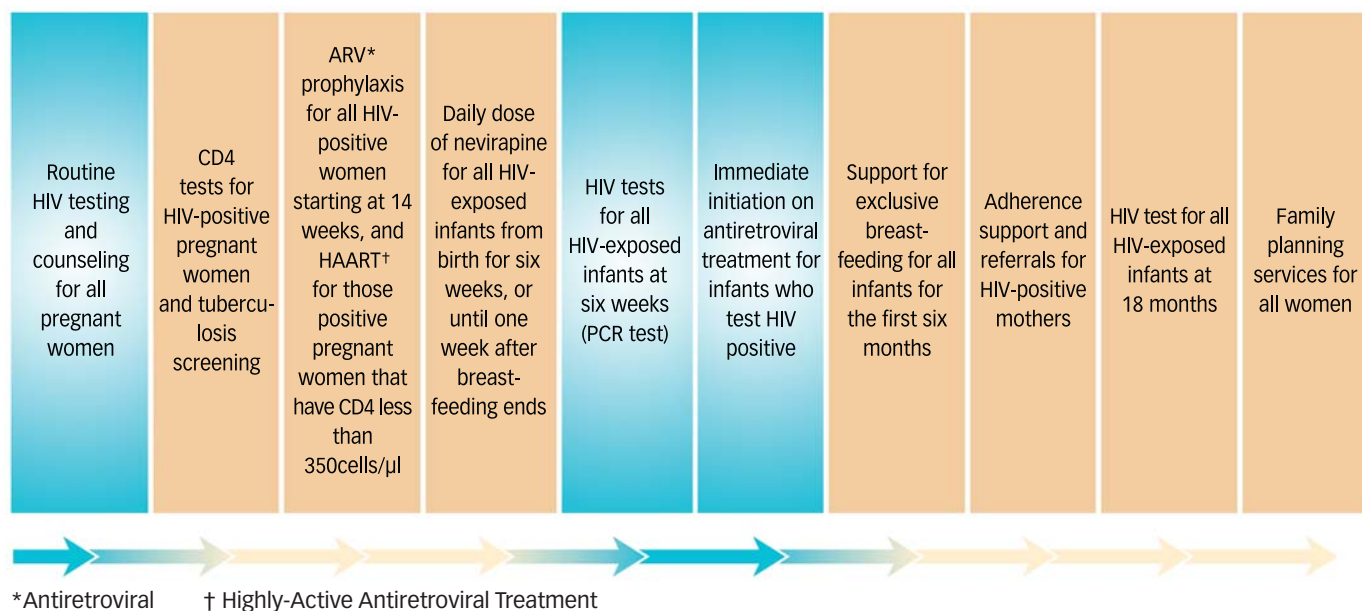
This essay looks at progress in achieving equity in the prevention and treatment of HIV in infants, with a focus on three service points along the PMTCT continuum. The essay explores the following questions:

- What is the PMTCT continuum?
- Has equity been achieved in HIV testing for pregnant women?
- Has equity in testing for HIV-exposed infants been achieved?
- Has equity in treatment access for HIV-positive infants been achieved?
- What needs to be done to address remaining inequities?

What is the PMTCT continuum?

The package of PMTCT services in South Africa has evolved substantially since the programme was piloted in 2001. It now encompasses a sequence, or continuum, of services beginning in the early stages of pregnancy and continuing well after the baby is born (outlined in figure 24).

Figure 24: The PMTCT continuum



ⁱ In terms of official health statistics, children are defined as younger than 15 years. This is not in line with the Constitution's definition of a child as aged 0 – 17 years, and places 15 – 17-year-old children in the same category as adults.

The progress that has been made over the past decade in the implementation of the national PMTCT programme has enabled South Africa to reduce mother-to-child transmission of HIV to an estimated 2.7% at six weeks after birth. Yet this national figure masks significant differences across provinces, from 1.98% in the Western Cape to 3.8% in the Eastern Cape and Free State.⁶

In order for the PMTCT programme to be most effective, each service intervention along the PMTCT continuum of care must be available to *all* pregnant women and their infants – 100% of pregnant women should be counselled and tested for HIV and receive their results ... 100% of HIV-infected pregnant women should receive appropriate ARV prophylaxis or treatment ... 100% of HIV-exposed babies should be tested at six weeks of age ... and 100% of those who test HIV positive should be initiated on treatment.

This essay examines the extent to which all those who need these services are being reached and focuses on three critical points on the continuum (highlighted in blue in figure 24):

- Routine HIV testing and counseling for all pregnant women.
- HIV tests for all HIV-exposed infants at six weeks.
- Immediate initiation on antiretroviral treatment for infants who test HIV positive.

Has equity in HIV testing for pregnant women been achieved?

HIV prevalence amongst pregnant women who are attending public sector health facilities increased from less than 1% in 1990 to over 30% in 2010, with rates as high as 40% in KwaZulu-Natal.⁷

Given these exceptionally high HIV-prevalence rates, routine HIV testing of all pregnant women is essential.

A recent national evaluation⁸ of the PMTCT programme reports PMTCT interventions in more than 95% of public antenatal and maternity facilities. The percentage of pregnant women with unknown HIV status prior to their first antenatal booking who had an HIV test during pregnancy was 98.8%, with very little variation across provinces. This figure exceeds the national target of 95% for 2011⁹ and suggests that maternal HIV testing has become a routine part of antenatal care.

Less progress has however been made with infant testing.

Has equity in testing for HIV-exposed infants been achieved?

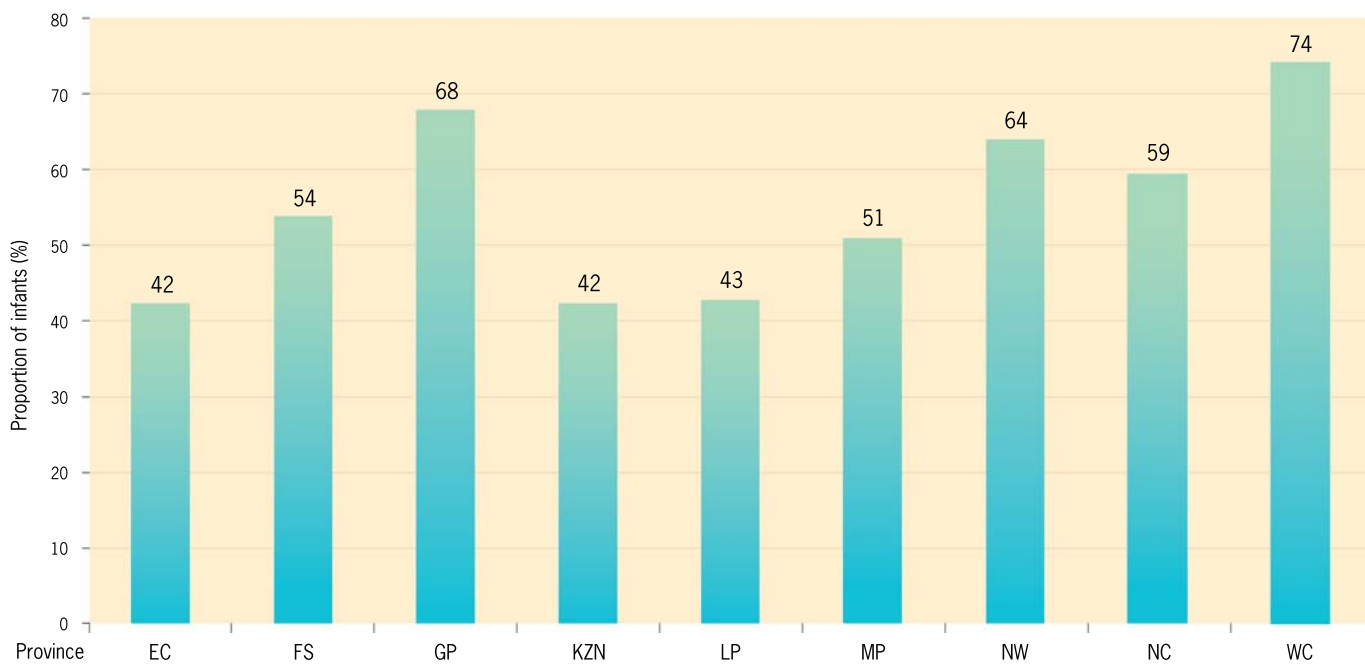
Early diagnosis and management of children with HIV is key to reducing mortality and improving long-term child outcomes. Early diagnosis in children is facilitated by a polymerase chain reaction (PCR) test administered to the infant at the six-week immunisation visit.

South Africa has made considerable progress in increasing the coverage of PCR testing but access to PCR testing is not available to all infants. There are lower levels of infant testing than HIV testing for pregnant women, and greater variation across provinces.

Data from the National Laboratory Information System indicate that the proportion of HIV-exposed infants who receive a PCR test before two months of age has increased dramatically over the past four years – from 36.6% in 2008 to 70.4% in 2011.¹⁰ This however remains below the national target of 85% for 2011.¹¹

Figure 25: Proportion of HIV-exposed infants who receive a PCR test within two months of birth, by province, 2010/11

(Y-axis reduced to 80%)



Source: Day C, Barron P, Massyn N, Padarath A & English R (2012) *District Health Barometer 2010/11*. Durban: Health Systems Trust.

Notes: Numerator = number of PCR tests done in infants under two months as recorded by the National Health Laboratory Service; denominator = current birth registrations from Stats SA x HIV prevalence (with 95% confidence interval) from the Antenatal Care Survey to calculate the estimated number of HIV-exposed infants.

The District Health Barometer includes a comparable indicator for PCR testing which points to significant variations across provinces (see figure 25). The provinces of the Western Cape (74%) and Gauteng (68%) have the highest coverage whilst rates of PCR testing are lowest in the Eastern Cape, KwaZulu-Natal and Limpopo. Children in urban centres are far more likely to get tested (60%) than those living in deprived rural districts (41%).¹²

High levels of HIV exposure combined with relatively low levels of service coverage in some provinces and districts create stark spatial inequities for infants. An infant born in Kwazulu-Natal for example has the greatest chance of being HIV-exposed (almost 40%) but only 42% are likely to be tested for HIV within the first two months after birth.

Without testing, these children will not have access to life-saving treatment.

More than half (51%) of childhood deaths in South Africa are HIV related with the majority of these occurring before the age of five years.¹³ In 2009 alone 30,000 children aged 0 – 14 years died as a result of AIDS.¹⁴ Many of these deaths could have been prevented with early infant diagnosis.

Has equity been achieved in treatment access for HIV-positive infants?

The presidential announcements on World AIDS Day 2009 revitalised HIV, AIDS and tuberculosis (TB) management. Since then, efforts to improve access to HIV treatment have included nurse-initiated antiretroviral treatment; treatment for children and adults at all health facilities; the revision of eligibility criteria for ART initiation; and a directive that all HIV-infected children younger than one year should start ART as soon as possible after diagnosis irrespective of CD4 count and World Health Organisation (WHO) clinical staging.¹⁵

Significant progress has been made since 2004 in increasing the number of children under 15 years on treatment (from approximately 4,200 in 2004 to over 150,000 in 2011¹⁶), with a paediatric coverage of 58% in 2010.¹⁷ While it is difficult to compare adult and paediatric measures of ART access directly,ⁱⁱ adult treatment coverage was close to 80% in mid-2011,¹⁸ highlighting substantial differences between adults and children in access to treatment relative to need. In addition, there remain challenges in determining the proportion of HIV-positive infants less than one year old who are initiated on treatment as per the paediatric guidelines. Ongoing effort is therefore required to strengthen data management systems to track and monitor paediatric treatment.

The effective implementation of policy guidelines for paediatric ARVs also requires a more equitable share of resources between adult and paediatric programmes and greater support on the ground for the implementation of policies, such as nurse-initiated ART for children.¹⁹

What needs to be done to improve equity?

Efforts to address inequities within the PMTCT continuum must include:

- Routine screening of all mothers and infants for HIV exposure as a core component of immunisation visits. Immunisation coverage for 2010/11 was 86.7%,²⁰ significantly higher than PCR-test coverage, pointing to missed opportunities within routine child health visits. A universal screening approach would dramatically increase the coverage of early infant diagnosis, an entry point to life-saving treatment.
- Reduced delays in obtaining infant HIV-test results as well as delays in communicating results to caregivers.²¹
- Improved tracing data to enable better follow-up of pregnant women and HIV-exposed infants, including those who do not return for PCR testing or results and those referred to other facilities.
- More effective supportive supervision and mentoring of nurses at primary health care level to initiate ART in children.
- Improved information management systems to track mothers and infants across the continuum of services and to monitor equity in service access and child outcomes. Data that are collected must be used more regularly and effectively to address service delivery challenges at facility level.
- Better understanding of the caregiver-related barriers to PMTCT, and what support is needed to help caregivers access prevention and treatment services, including information about the value of early infant diagnosis, testing and treatment.
- Strengthened links with social support structures and other potential entry points for early infant diagnosis and testing beyond health settings.

Given existing inequalities, unequal effort may be needed to ensure equal service access. In districts and provinces with high mother-to-child transmission rates, additional efforts are required to improve systems so that reduced transmission rates and improved access to care for mothers and infants will result in outcomes comparable with other areas.

What are the conclusions?

South Africa has achieved marked success in ensuring almost universal access to HIV testing of pregnant women. Further along the continuum of PMTCT interventions, however, two issues become apparent: coverage across the board reduces as service users “drop out” of the system, and there is greater variability in access across provinces.

Remaining inequities in access to and coverage of HIV-related services for children in South Africa are evidenced in the fact that HIV remains a risk factor in 50% of under-five deaths.²² Furthermore, while HIV infection in children is driven by the adult pandemic, children’s access to testing and treatment lags behind adults.

ii Since paediatric ART guidelines recommend that all HIV-infected children under 12 months are placed on ART, regardless of their immunological or clinical status, the annual number of new paediatric HIV infections is used to approximate the annual number of children newly eligible for ART (the denominator in the ART-enrolment ratio).

By 2016, the recently launched National Strategic Plan on HIV, STIs and TB (2012 – 2016) aims to reduce HIV transmission in infants to less than 2% at six weeks after birth and less than 5% at 18 months of age. The plan also aims to initiate and maintain on ART 90% of children in need.²³ As we strive towards these ambitious targets, greater efforts are needed to ensure and monitor equity in service access and quality of care across provinces and districts for the full spectrum of PMTCT services, and to ensure that infants and children who test HIV positive have access to early diagnosis, TB screening, treatment and care services to reduce infant and child mortality.

Towards this end, a directive was issued by the Department of Health in August 2012 stating that all children under five years of age were eligible for treatment regardless of CD4 count and/or WHO clinical staging.²⁴ The Department of Health is also in the process of developing a comprehensive action plan for paediatric and adolescent HIV and TB which addresses early infant diagnosis, treatment, care and support and includes a review of paediatric monitoring and evaluation systems.

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Education, the great equaliser: Improving access to quality education

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For decades, education in South Africa operated under the shadow of the Bantu Education Act of 1953. Recent reform has focused on creating a more equitable and accessible system of public education. This essay discusses current inequality in education for South Africa's children. It describes some of the main disparities in education and considers what policy options are available to ensure that educational opportunities are more equal and accessible.

There are many different lenses through which to reflect on the educational inequality that children face in South Africa. Given the historical context, the single most important area of attention is to what extent economically advantaged students have an edge over the poor.

This essay draws on analyses from a number of contemporary educational studies to address the following questions:

- Why is schooling important for addressing inequality?
- What are the trends in educational access and attainment?
- What are the disparities between rich and poor schools?
- What are the critical areas for improving quality?

Why is schooling important for addressing inequality?

Education plays an important role in promoting inequality in South Africa, as illustrated in figure 26, which highlights two critical points where interventions in education can contribute towards breaking the inequality cycle:

1. Equal access to quality education.
2. Increased access to higher education.

Success in the labour market is critical in determining household income. Earnings and unemployment are the key drivers of income inequality in South Africa.¹ Education plays a predominant role in determining who is employed, and the earnings they receive. School completion (matric), tertiary education and further education and skills training give young people entering the labour market an advantage. Yet the quality of schooling in poor schools results in high drop-out and low school completion rates. For those learners who do complete school, few are equipped with the necessary skills to succeed in the post-schooling education sector. Only a few poor learners get the education necessary to enter top income jobs. In this way, inequality is recycled and the stark differences in incomes between the rich and the poor in South Africa are reinforced.

Figure 26: Education and inequality

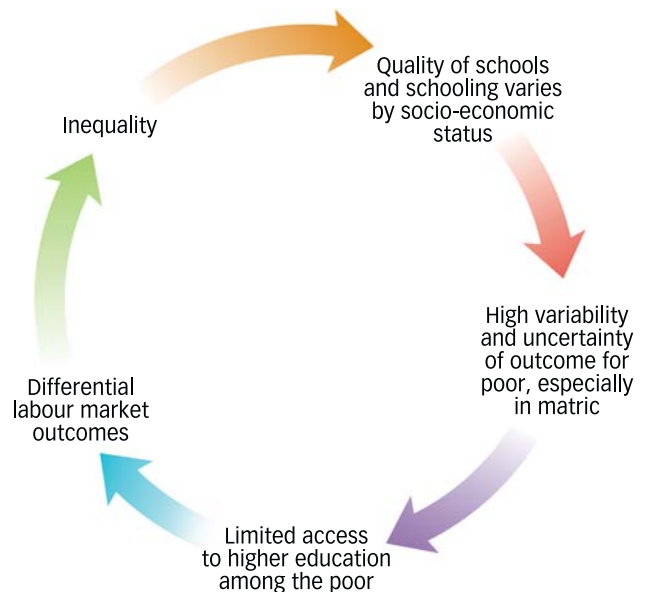
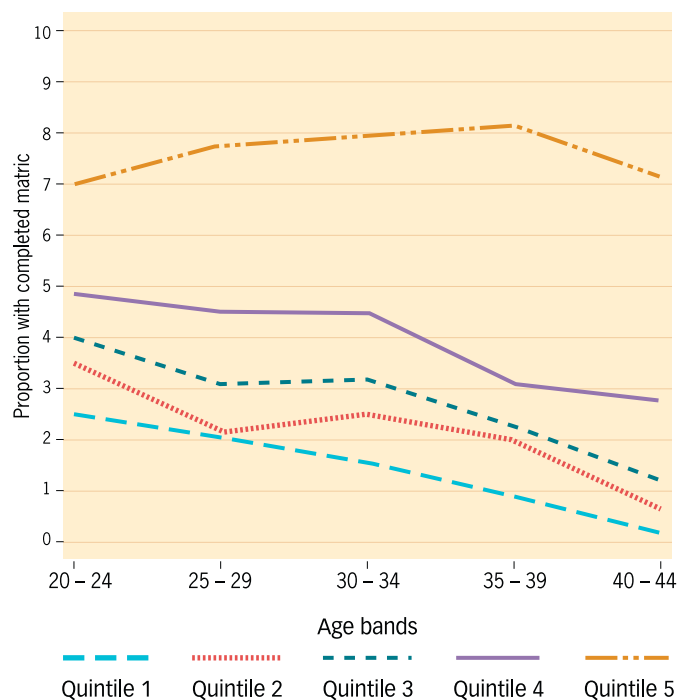


Figure 27: Proportion of adults who had completed matric by 2008, by household income quintile



Source: Southern Africa Labour and Development Research Unit (2012) *National Income Dynamics Study 2008, Wave 1* [dataset]. Version 4.1. Cape Town: SALDRU, UCT [producer], DataFirst [distributor]. Calculations by Nicola Branson and Tia Linda Zuze.

Table 6: Education inputs and outputs	Status
Public expenditure on schooling as a percentage of gross domestic product (2009/10)	4.1%*
Total public expenditure on education as a percentage of total government expenditure (2008)	17%‡
Real per school-going child expenditure on primary and secondary schooling (2009/10)	R7,307*
Public expenditure on the poorest learners as a percentage of public expenditure on the least poor learners (Western Cape example)	102,9%†
Percentage of public ordinary schools with average class size less than 40 (2009)	60.4*
Average percentage score for Grade 3 literacy in the 2011 annual national assessment	35%§
Average percentage score for Grade 3 numeracy in the 2011 annual national assessment	28%§
Average percentage score for Grade 6 language in the 2011 annual national assessment	28%§
Average percentage score for Grade 6 mathematics in the 2011 annual national assessment	30%§

Sources:

- * Department of Basic Education (2011) *Macro Indicator Trends in Schooling: Summary Report 2011*. Pretoria: DBE.
- ‡ United Nations Educational Scientific and Cultural Organisation (2011) *2011 EFA Global Monitoring Report*. Paris: UNESCO.
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- § Department of Basic Education (2011) *Report on the Annual National Assessments of 2011*. Pretoria: DBE.

What are the trends in educational access and attainment?

South Africa has almost universal enrolment until grade 9 and the average number of years of education attained has increased by over 50% in the past three decades. Yet most of this improvement is below the secondary school completion level. Figure 27 demonstrates that improved educational attainment has not translated into substantial increases in school completion rates among the poor, meaning large inequalities between the rich and poor remain. It shows that only 25% of 20 – 24-year-olds in the poorest 20% of households had completed matric in 2008, compared to 70% of the richest quintile.¹¹ This high level of educational attainment does not reflect the quality of learning in the majority of South Africa's schools.

Table 6 highlights the disconnection between education inputs and outputs in South Africa. By all accounts, expenditure on public education is high. Over 17% of government expenditure goes towards funding education programmes. This figure is higher than estimates for both developed and developing countries (12% and 16% respectively). Educational outcomes are however persistently poor and highly unequal across schools, at all education levels.

Performance in annual national assessments has raised concerns about the quality of teaching and learning. Table 6 shows that the average Grade 3 and 6 learner did not achieve at the appropriate level in the 2011 annual national assessment. Children whose marks ranged between 35% and 50% were said to have "partially achieved" an acceptable level of performance. Students with marks of above 50% had "achieved" an acceptable level. Student achievement is cumulative. Therefore it should come as no surprise that the results of the grade 6 assessment are equally poor.

South Africa's schools are assigned a quintile ranking based on the relative poverty level of the school's neighbourhood, with schools in quintile 1 encompassing the poorest schools.² Table 7 shows that the annual national assessment results vary substantially across these quintiles. In the table, schools where more than 95% of learners scored below 35% are classified as struggling (x) and schools where more than 50% of learners scored over 50% are classified as performing (✓). It is clear that most schools in the lower quintiles are underperforming and that the majority of quintile 5 schools are performing well. For grade 6 numeracy, 45% of schools in the lowest quintile are classified as struggling compared to only 8% of schools in the highest quintile.

Table 7: Percentage of schools struggling (x) and performing (✓), by school quintile, 2011

Assessment	Quintile 1		Quintile 2		Quintile 3		Quintile 4		Quintile 5		All schools	
	x	✓	x	✓	x	✓	x	✓	x	✓	x	✓
Gr 3 literacy	17	45	16	42	12	52	7	58	9	66	12	54
Gr 3 numeracy	38	19	35	11	34	25	26	30	10	41	30	25
Gr 6 literacy	46	13	56	9	32	16	18	35	3	62	31	27
Gr 6 numeracy	45	13	33	11	26	10	17	24	8	60	26	23

Source: Department of Basic Education (2011) *Report on the Annual National Assessments of 2011*. Pretoria: DBE.

i A quintile represents 20% of households in the country.

The allocation of total government education spending is not directly linked to the level of need within schools.³ The National Norms and Standards for School Funding allocates non-personnel expenditure budgets based on school quintile ranking and is therefore redistributive but captures only 9% of the education budget.⁴ Personnel expenditure accounts for the lion's share of total education expenditure and is not allocated redistributively. In fact, current regulation for the creation of educator posts uses a "post-provisioning formula" that effectively results in government personnel expenditure being higher, on average, for educators in richer schools.⁵ As a result, and as the example from the Western Cape in table 6 shows, total government expenditure per learner is relatively equal between learners in rich and poor schools.⁶ Yet schools in quintiles 4 and 5 have the discretion to charge school fees to supplement their resources while quintile 1 – 3 schools rely solely on government resources.

Repetition rates are high. It is only in the top income quintile that a majority of learners progress at the desired pace.⁷ The pattern of repetition – rates over 10% in grade 1 and grades 10 to 12 – speaks both of insufficient pre-schooling preparation and the inability of primary schools to prepare learners for successful school completion. Another consequence of low quality schooling is high levels of drop-out in post-compulsory school grades. The National Income Dynamics Study (NIDS) data show that 25% of grade 9 learners in 2008 had dropped out of school without completing matric when reinterviewed two years later.⁸ Only 16% of those who had left were employed or in alternative education. This means that 84% were neither working nor enrolled.

Post-schooling education has the potential to provide children who drop out from school with a second chance by providing them with skills that are valued in the labour market. While opportunities for training exist beyond the formal schooling system, there remain concerns about quality and accessibility of post-schooling institutions. The post-apartheid government has placed much emphasis on restructuring the higher education and college sector, yet in the process the educational opportunities available to school leavers have declined.⁹ The N1 – N3 vocational training for post-grade 9 learners is being phased out and replaced by the National Certificate Vocational; however few learners choose this route.¹⁰ Only 155,000 learners were enrolled in N1 – N3 or in the National Certificate Vocational in 2010 compared to over 2.4 million learners in ordinary school grades 10 – 12.¹¹

What are the disparities between rich and poor schools?

Inequality in learning inputs

Opportunities to learn vary greatly in South Africa. While most learners from both rich and poor households have access to a school within one kilometre of their house, learners in wealthier households have on average two additional schools within 2 km of their household. The schools in the choice set of the rich have

lower pupil–teacher ratios and are more likely to be higher quintile schools.¹² Wealthier children are also more likely to attend schools that are further from their homes.¹³ What this implies is that children of the rich have a greater range of schools to choose from when compared to children of the poor.

Children who live in poor areas also have limited educational support outside of school.¹⁴ They have access to less reading material in their homes and often live in communities without public library facilities. Their parents are less likely to provide assistance with homework and their living conditions make studying difficult. Some children are expected to assist with domestic chores before and after school. They might even be responsible for taking care of sick relations. These additional responsibilities reduce the time that they can dedicate to their studies. In spite of these setbacks, they must remain in school and perform well enough at competitive school-leaving examinations to earn the right of passage to a better way of life.

The organisational and professional conditions in rich and poor schools also vary considerably. Schools in the top quintiles have additional funds to employ more or better trained staff because of the additional revenue they raise through school fees. However, increasing public funding to poor schools does not guarantee that available resources will be managed effectively. Organisational characteristics such as curriculum planning, regular learner assessment and high teacher attendance have been linked to better academic results. Many of these indicators of efficient management are lacking in poor schools.¹⁵

Equally troubling is the level of teacher content and pedagogical knowledge in many poor schools. A study of mathematics teachers in Gauteng showed that there remain large differences in teaching methods across schools.¹⁶ Some teachers showed that they had been trained in pedagogical methods that focused on relaying a full understanding of their subject. Other teachers, especially in African majority schools, followed a more rote learning approach with poor use of questioning and practice exercises. Many were also found to have a limited understanding of the content they taught, often presenting incorrect mathematical statements, sometimes as a result of language use but other times clearly a consequence of incorrect understanding or a limited grasp of the subject.

The implication is clear. It is absolutely critical that schools in poor communities are equipped with basic facilities, appropriate learning materials and adequately trained staff. Effective management and accountability systems are also essential to ensure these resources are used for teaching and learning.

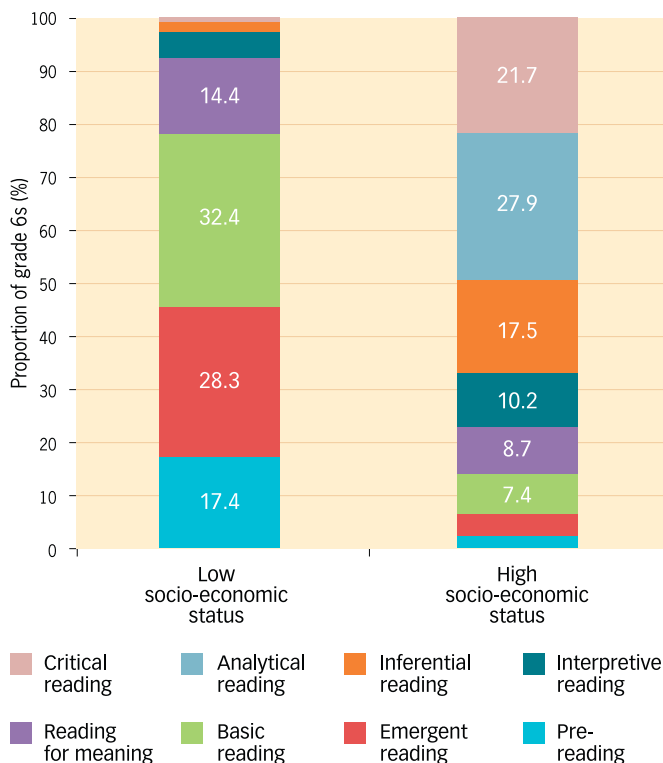
Inequality in learning outcomes

In a perfectly equitable schooling system, differences in academic performance among schools would be extremely low. A child would have the same opportunity for success irrespective of the school attended. By contrast, inequality in educational performance among South Africa's schools is exceedingly high. South Africa has one of the highest estimates of intraclass correlation (ICC), which

is a measure of variation in educational quality. It is usually measured by comparing academic achievement using a standardised test. It ranges from between 0 (for education systems whose schools perform equally) and 1 (for perfectly unequal systems). South Africa's ICC for reading skills obtained at the primary level remains above 0.60, which is considerably higher than many countries in the region.¹⁷ Like South Africa, Botswana is a middle-income country with a highly unequal income distribution. Unlike South Africa, however, Botswana's ICCs for the same primary school assessments were below 0.30.¹⁸ The intraclass correlation at secondary school level in South Africa is slightly lower but this can be partly attributed to high drop-out, repetition rates and a wide subject choice.

Figure 28 highlights alarming differences in the skills acquired by rich and poor primary school children. The graph contrasts the reading competency levels of the wealthiest 25% of grade 6 children (high socio-economic status) to the poorest 25% (low socio-economic status). Several points are obvious from these results. The majority of the poorest children had only acquired skills for reading at the basic reading level. In fact, nearly half were reading at a pre-reading and emergent reading stage. Whereas half of the wealthiest children were comfortable with critical and analytical reading, less than 1% of the poorest could read at these advanced levels. There have been a host of local and international

Figure 28: Percentage of grade 6 learners reaching reading competency levels, 2007



Source: Hungi N, Makuwa D, Ross KN, Saito M, Dolata S, van Capelle F, Paviot L & Vellien J (2010) SACMEQ III Project Results: Pupil Achievement Levels in Reading and Mathematics. Paris: International Institute for Education Planning.
Note: Percentages not shown represent less than 5% of the sample.

studies that show very similar patterns of achievement stratification between South Africa's schools. But there is no indication that these gaps narrow by the end of secondary school – quite the opposite is true. In 2003, African students made up 83% of the matric cohort but contributed only 8% of the A-aggregate marks that are essential for many advanced tertiary programmes.¹⁹

What are the critical areas for improving quality?

There are three broad areas that can be addressed to reduce quality differentials in the education available for South Africa's rich and poor. The first involves improving the quality of the schooling environment. This includes improving teaching and learning facilities and ensuring that children's basic needs are met. The second involves establishing effective accountability structures. The third focuses on assessing learner progress regularly.

Environment

Children cannot learn when they are hungry. The National School Nutrition Programme provides children at no-fee schools with a lunch meal. Children in quintiles 1 – 3 primary schools are guaranteed coverage by the scheme. As previously noted, most low-income families send their children to schools within their communities and would be covered by this scheme. There are some instances of poor children attending higher quintile schools who would not benefit from the feeding programme. The challenge is to ensure that there are measures in place to meet the needs of poor children who do not automatically benefit from the programme. The programme has been plagued by allegations of inefficiency and mismanagement. In some parts of the country, such as the Eastern Cape, this has led to sporadic delivery of meals and questions about the nutritional content and hygiene of food being provided to schools.²⁰

Some of South Africa's schools possess an excellent modern infrastructure but many lack basic services such as water and sanitation.²¹ According to the 2011 National Education Infrastructure Management Systems Report, 14% of schools have no access to electricity, 79% of schools do not have library facilities and 77% have no computer centres.²² The Accelerated Schools Infrastructure Delivery Initiative has been introduced to ensure consistency in the provision of infrastructure and to address backlogs in construction and maintenance, and it is vital that progress is monitored.²³

Similarly, providing schools in deprived areas with effective teachers and learning material is one of the key ways to narrow the inequality gap. Revising the "post-provisioning formula" to ensure equitable personnel expenditure across schools could alleviate some of the burden placed on teachers in overcrowded and under-resourced classes but would need to be coupled with effective school management.²⁴ One of the most practical policy innovations in this area has been the recent introduction of national workbooks. Workbooks are provided to children in grades R – 6, with plans to extend their availability to grades 7 – 9 during

2012. Children using well-designed workbooks have been found to make equivalent improvements as children using more costly standard textbooks.²⁵ As with any teaching aid, the use of workbooks needs to be monitored to ensure that it supports learning. Like textbooks, workbooks need to be developed in conjunction with curriculum developers, to be delivered on time and to be updated regularly.²⁶ Workbooks will make the greatest difference when they are adopted by competent teachers who are using a variety of instructional tools.

Effective teachers require both appropriate training and continued supervision and evaluation. Many teachers in the current education system were trained during the apartheid years and the quality of education training institutions varies by institution. Thus the legacy of unequal teacher training and pedagogical support remains in the classroom today.²⁷ Upgrading the skills of teachers who are already within the system and ensuring that they can teach the subjects assigned to them is a cost-effective approach to improving education outcomes.²⁸

Much contestation has taken place in finding the appropriate mechanism to supervise and evaluate teachers. In April 2008, the Occupational Specific Dispensation agreement, which rewards teachers who perform well or above the standard expected, was signed. However, many issues around teacher evaluation remain unresolved and it is not clear that the new system is effective.²⁹ Support for new and struggling teachers is limited in most, especially poor, schools.³⁰

Accountability

A sound infrastructure is no guarantee that a school functions well. The National Education Evaluation and Development Unit (NEEDU) and the Planning and Delivery Oversight Unit (PDOU) are two recently established institutions tasked with providing support to schools and to district offices. NEEDU reports to the minister on the state of schools and their developmental needs. It is responsible for identifying factors that are inhibiting school progress and formulating solutions to overcome these.³¹ The PDOU focuses on improving curriculum delivery and learner achievement at the district office level. Schools that are identified as continually underperforming are provided with management support.³² In addition, the proposed creation of the South African Institute for Vocational and Continuing Education and Training³³ is recognition of the need to strengthen post-school education in South Africa.

Assessment

Early intervention is recognised as key to ensuring that children in underperforming schools are not left behind. For decades, South Africa has participated in a number of international surveys of educational achievement. These have been useful in addressing a number of systemic issues in the education system. The Standardised Annualised National Assessments go a step further by monitoring the performance of all learners in grades 1 – 9. More work needs to be done to guarantee that tests are administered

uniformly, evaluated independently and that results are communicated effectively, and then acted upon.³⁴

As education differences emerge so early in children's schooling careers, it is vital that access to early schooling be extended. By 2014, all children of appropriate age will be required to attend grade R. The essay on early childhood development services on pp. 52 – 57 discusses the many benefits of early childhood programmes, and their potential to reduce existing inequality.

What are the conclusions

Educational inequality in South Africa remains a complex issue. In contrast to the situation in the past, some progress has been made in addressing racial differences in attainment. The pattern of progress has been uneven. In some instances, particularly in urban areas, racial differences have been replaced with class differences. Further work needs to be done to extend quality education to the poor.

Improving the quality of public education will involve ensuring an ordered environment for learning to take place. Part of the policy constellation for education should address whether available programmes support teachers sufficiently and allow all learners to complete school on an equal footing. This has the potential to address the divide between rich and poor in the labour market and move towards breaking the cycle of inequality and poverty.

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Children and inequality: Closing the gap

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Equality is both a founding *value* of the Constitution as well as a fundamental *right*. Yet, despite the Constitution's intent to "heal the divisions of the past and establish a society based on democratic values, social justice and fundamental human rights"¹, the legacy of apartheid continues to constrain efforts to address poverty and inequality in South Africa. While poverty has declined marginally, inequality – as measured by income – is rising.

This issue of the *South African Child Gauge* describes how inequality shapes the lives and life chances of millions of children in South Africa. The essays in this collection examine the interplay of different dimensions of inequality. Closing the divide between rich and poor is not just important for reducing gaps in intergenerational well-being, it is also essential for long-term economic growth and political stability.

This concluding essay pulls together the dimensions of child inequality as discussed in the various essays, highlights key opportunities and challenges, and flags some considerations for policy and practice. It is guided by the following framing questions:

- Why a rights-based approach to achieving equality?
- What are the dimensions of inequality amongst South Africa's children?
- What are the current opportunities and challenges?
- What are the critical considerations for policy?

Why a rights-based approach to equality?

The Constitution and a number of Constitutional Court judgments provide important guidance for addressing child inequality in the country, as outlined in Liebenberg's essay (pp. 24 – 31).

Firstly, the Constitution recognises children, by virtue of their age, as a specific and vulnerable group in need of protection, and thus requiring societal effort to promote and protect their best interests. Inequalities between the adult and child population need attention, and official statistics must be disaggregated to reveal particular challenges that children face – and these should receive special attention from policy-makers and planners.

Secondly, the Court's commitment to a substantive interpretation of the right to equality requires the government to move beyond a focus on equal opportunities and strive towards equal outcomes. For example, it is not sufficient to have equal access to education if the (poor) quality of education in poor communities fails to ensure equal outcomes. Quality service remains an important consideration, and any attempt to bridge equity gaps should be guided by the imperative of achieving equal child outcomes.

Achieving such outcomes should support upward mobility for all children, and not "level down" (p. 26).

Thirdly, a focus on the principles of equality and non-discrimination recognises the differences between groups of children and the social and historical drivers of these differences. This suggests the need to move beyond a one-size-fits-all approach and a greater consideration of appropriately designed policies that consider challenges faced by various groups of disadvantaged children.

What are the dimensions of inequality among South Africa's children?

From a global perspective, economic, spatial, social, cultural and political inequalities – though they exist on their own – usually intersect or converge upon identifiable groups of citizens, either simultaneously or sequentially over time.² As various dimensions of inequality converge on particular groups of citizens, these groups experience various degrees of exclusion from political, social and economic opportunities,³ in many cases culminating in the creation of "poverty traps" from which it is hard to escape either through personal effort or public policy. For children the impact is particularly severe, and may lead to long-lasting developmental setbacks. Understanding the interaction between the various dimensions of inequality is therefore essential for appropriate policy response.

Hall and Woolard's essay (pp. 32 – 37) indicate a high level of economic (income) inequality in South Africa. Children are more likely than adults to live in the poorest households. Stark racial differences in the economic circumstances of children show how the history of apartheid has given rise to the particular economic, social and spatial patterns of inequality amongst children in South Africa today. While pro-poor policies have helped reduce child poverty in the post-apartheid period, they have failed to reverse increases in income inequality. The structural nature of inequality therefore requires interventions that take a medium- to long-term view.

Income inequality has a significant impact on children's living conditions, access to services and life trajectories. This is illustrated in a 2011 review by the South African Human Rights Commission, the Department of Women, Children and People with Disabilities and UNICEF which found that:

... compared to a child growing up in the richest quintile, a child in the poorest income quintile is two times less likely to have access to adequate safe water and sanitation; two times less likely to be exposed to early childhood develop-

ment programmes; three times less likely to complete secondary education; seventeen times more likely to experience hunger; and twenty-five times less likely to be covered by a medical scheme.⁴

Wright and Noble also demonstrate stark spatial dimensions of inequality among children in South Africa, and how the most severe child deprivation remains concentrated in the former homelands (pp. 38 – 42). This raises questions about how to deal effectively with the cumulative disadvantage that children in the former homelands continue to face.

The essays on early childhood development (pp. 52 – 57), health (pp. 58 – 64) and education (pp. 69 – 73) also indicate stark dimensions of social inequality and that particular groups of children continue to be deprived of these critical opportunities for accelerated development. For example, quality ECD services offer huge long-term economic and social benefits – not only to individuals but to society at large. Yet, ECD centres are yet to reach the majority of children in poverty and those with disabilities (p. 54).

Overall, particular groups of children – very young children, children in poverty, many African children, children with disabilities, and children living in the former homelands and informal settlements – appear to experience multiple deprivations. This requires a combination of innovative and intersectoral approaches to close the equity gaps that they face. Further policy-related research and action are also needed to respond to the complex interplay of protective factors and the various dimensions of inequality.

What are the current opportunities and challenges?

Budlender and Woolard point out the positive effects of South Africa's extensive social assistance programme on child poverty (pp. 48 – 51). Social grants are the primary source of income for poor households in South Africa and are associated with positive health and educational outcomes for children. Yet they are unlikely to have a significant impact on inequality specifically, given the extreme differences between rich and poor and the relatively small value of the Child Support Grant (CSG) (p. 49). Other policy instruments are required to reduce income inequality, particularly those that would expand gainful employment. Among social grants, the impact of the CSG on multiple dimensions of child poverty would be even greater if more children are reached in their very early years.⁵

Early childhood development (ECD) is recognised as one of the surest ways of bridging intergenerational divides.⁶ Sound ECD offers tremendous benefits in terms of future income as well as development outcomes. Though some of the key components of ECD (such as grade R) are being provided at scale, many essential services are yet to reach disadvantaged groups in good measure. Children in richer quintiles have much greater access to quality ECD programmes, particularly from private providers (p. 55).

The successful roll-out of grade R provides an important lesson

on the central role of the state in expanding services to children in poverty. Yet ECD centres are failing to reach those most in need. While the ECD subsidy is pro-poor, it fails to cover the full costs of centre-based care, which effectively excludes children who cannot afford to pay fees. ECD programme implementation has largely focused on centre-based provision, and there are no home-based ECD programmes at scale for very young children, particularly those in the crucial first 1,000 days.

In this context, the state has to take on more responsibility by investing more, and in an equitable manner, in proven ECD services for the very young. While the relatively successful roll-out of grade R is to be welcomed, it does raise the question of which interventions at what time will have the most impact on child development. Policy instruments are urgently required to define appropriate delivery and funding models that will close the gap and expand the reach of both home and facility-based services to those most in need.⁷

The proposed National Health Insurance and the re-engineering of primary health care offer important opportunities to address the disparities between private and public health care spending and extend the reach and quality of health care services (pp. 58 – 64). The success of these initiatives, among others, depends on substantial investment in both the numbers and training of community health workers to ensure adequate coverage and quality of care.

Quality education is usually a great “equaliser” yet there has been little progress in bridging the inequality gaps in South Africa. Branson and Zuze demonstrate that while public expenditure is high, achievements remain poor (pp. 69 – 73). Schools in richer communities are able to raise additional funds to support a wide range of initiatives, including increasing the number and quality of teachers and management. Schools in poorer communities are unable to catch up, perpetuating unequal outcomes.

What are the critical considerations for policy?

South Africa has made significant progress in reducing multi-dimensional child poverty since the end of apartheid. Numerous programmes funded from public sources – including the CSG, free access to health care for pregnant women and young children, the National School Nutrition Programme, and subsidised water and electricity for poor families – are all associated with improved outcomes for children. However, greater effort is required to ensure that services reach those children most in need and to close the gap between rich and poor.

This issue of the *South African Child Gauge* alludes to weaknesses in the implementation of very good policies and laws. The National Development Plan similarly demands “increased focus on implementation” in the years ahead, and acknowledges many instances where implementation of good policies was “weak” or “patchy”.⁸

Furthermore, there is a close link between geography of child deprivation in South Africa and the “institutional vulnerability” and poor performance of local municipalities – particularly those in the

former homelands who are likely to have less economic and organisational capacity to speed up child development.⁹ This spatial dimension of inequality requires further policy-related work in the areas of governance and regional planning to strengthen and support services to families and children in these areas.

Overall, pro-poor programmes like the CSG and birth registration have been implemented well by global standards. However, several child-related programmes have not been implemented well, including quality education and prevention of violence. This raises the question: what are the underlying factors for weak implementation in some sectors? Do they lie in organisational capacity, the design of intergovernmental arrangements, leadership, accountability mechanisms, or perhaps in other factors? Further research is needed to identify the factors that help or hinder implementation of programmes that are meant to reduce child poverty and inequality.

Child outcomes are better where policy coherence exists. For example, the roll-out of grade R yielded better results when combined with access to the National School Nutrition Programme and the provision of appropriate infrastructure. Despite the benefits of integrated approaches to address multiple dimensions of inequality, the coordination of intersectoral programmes remains a challenge. The National Development Plan speaks of “coordination failures, split accountability and overlapping mandates that hinder the implementation of existing policies”.¹⁰ Addressing these challenges is particularly important in the context of early childhood development and primary health care, both of which rely on effective collaboration across different departments, including local government.

The political dimensions of inequality, in particular issues related to voice and power relations, also need attention from policy-makers. Children’s views are rarely considered in the development of services that directly affect their well-being. Yet, their resourcefulness, resilience and agency are well tested.

The publication of this issue of the *South African Child Gauge* is timely. As noted in the National Development Plan, “eighteen years into democracy, South Africa remains a highly unequal society

where too many people live in poverty and too few work”.¹¹ The plan acknowledges that inequality in South Africa is deeply structural and linked directly to the historical legacy of apartheid. Furthermore, it is compounded by factors such as race, geography, class, and gender, and limited access to economic opportunity.

This inequality will be further entrenched if the country fails to act decisively. Children born in 2012 will turn 18 in 2030 – the year when the National Development Plan hopes to have achieved a more equitable, just and prosperous South Africa. The challenge for government and society is to act decisively today in the best interest of all children in South Africa:


*There is a burning need for faster progress, more action and better implementation. The future belongs to all of us and it is up to all South Africans to make it work.*¹²

Trevor Manuel, Minister in the Presidency: National Planning Commission

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PART THREE:

Children Count – The Numbers

Part three presents child-centred data to monitor progress and track the realisation of children's socio-economic rights in South Africa. This year it presents data from 2002 – 2010 and identifies main trends over this nine-year period.

A set of key indicators track progress in the following domains:

- Demography of South Africa's children;
- Income poverty, unemployment and social grants;
- Child health;
- Children's access to education;
- Children's access to housing; and
- Children's access to basic services.

A full set of indicators and detailed commentary are available on www.childrencount.ci.org.za.

Introducing Children Count – *Abantwana Babalulekile*

Updated by Katharine Hall and Lori Lake (Children's Institute, University of Cape Town)

South Africa's commitment to the realisation of socio-economic rights is contained in the Constitution, the highest law of the land, which includes provisions to ensure that no person should be without the basic necessities of life. These are specified in the Bill of Rights, particularly section 26 (access to adequate housing); section 27 (health care, sufficient food, water and social security); section 28 (the special rights of children) and section 29 (education).

Children are specifically mentioned, and are also included under the general rights: every child has the right to basic nutrition, shelter, basic health care services and social services. These form part of what are collectively known as socio-economic rights. While these rights are guaranteed by the Constitution, *how well is South Africa doing in realising these rights for all children?* In order to answer this question, it is necessary to monitor the situation of children, which means there is a need for regular information that is specifically about them.

A rights-based approach

Children Count – Abantwana Babalulekile, an ongoing data and advocacy project of the Children's Institute, was established in 2005 to monitor progress for children. It provides reliable and accessible child-centred information which can be used to inform the design and targeting of policies, programmes and interventions, and as a tool for tracking progress in the realisation of children's rights.

Child-centred data

Any monitoring project needs regular and reliable data, and South Africa is fortunate to be a fairly data-rich country. There is an array of administrative data sets, and the national statistics body, Statistics South Africa, undertakes regular national population surveys which provide useful information on a range of issues. However, most information about the social and economic situation of people living in South Africa does not focus on children, but rather counts all individuals or households. This is the standard way for central statistics organs to present national data, but it is of limited use for those interested in understanding the situation of children.

"Child-centred" data does not only mean the use of data about children specifically. It also means using national population or household data, but analysing it at the level of the child. This is important, because the numbers can differ enormously depending on the unit of analysis. For example, national statistics describe the unemployment rate, but only a child-centred analysis can tell how many children live in households where no adult is employed. National statistics show what proportion of households is without adequate sanitation, but when a child-centred analysis is used, the proportion is significantly higher.

Monitoring inequality

As national data tend to mask inequalities between different groups of children, *Children Count – Abantwana Babalulekile* also disaggregates data by province, race, age and gender. This issue also tracks the relationship between income inequality and children's living conditions and access to services using income quintiles to compare the situation of children in the poorest 20% of households (quintile 1) with those in the richest 20% (quintile 5). For example: nearly all children (97%) in the richest 20% of households have adequate water, but this applies to less than half (46%) of children in the poorest quintile.

Counting South Africa's children

Children Count – Abantwana Babalulekile presents child-centred data on many of the areas covered under socio-economic rights. As new data become available with the release of national surveys and other data sources, it is possible to track changes in the conditions of children and their access to services over time. This year, national survey data are presented for each year from 2002 to 2010, and many of the indicators in this issue compare the situation of children over this nine-year period.

The tables on the following pages give basic information about children's demographics, care arrangements, income poverty and social security, education, health and nutritional status, housing and basic services. Each table is accompanied by commentary that provides context and gives a brief interpretation of the data. The data are presented for all children in South Africa and, where possible, by province and income quintile.

The indicators in this *South African Child Gauge* are a sub-set of the *Children Count – Abantwana Babalulekile* indicators on demographics and socio-economic rights. The project's website contains the full range of indicators and more detailed data, as well as links to websites and useful documents. It can be accessed at www.childrencount.ci.org.za.

Confidence intervals

Sample surveys are subject to error. The proportions or percentages simply reflect the mid-point of a possible range, but the true values could fall anywhere between the upper and lower bounds. The confidence intervals indicate the reliability of the estimate at the 95% level. This means that, if independent samples were repeatedly taken from the same population, we would expect the proportion to lie between upper and lower bounds of the confidence interval 95% of the time.

It is important to look at the confidence intervals when assessing whether apparent differences between provinces or sub-groups are

real: the wider the confidence interval, the more uncertain the proportion. Where confidence intervals overlap for different sub-populations or time periods, it is not possible to claim that there is a real difference in the proportion, even if the mid-point proportions differ. In the accompanying bar graphs, the confidence intervals are represented by vertical lines (I) at the top of each bar.

Data sources and citations

Children Count – Abantwana Babalulekile uses a number of data sources. Some are administrative databases used by government departments (Health, Education, and Social Development) to record and monitor the services they deliver. Some of the HIV/AIDS and child mortality data are from the ASSA2008 Aids and Demographic model, a statistical model developed by the Actuarial Society of South Africa, which uses many different types of data sources to derive estimates of the incidence of HIV, and treatment needs.

Most of the indicators presented were developed specifically for this project. Data sources are carefully considered before inclusion, and the strengths and limitations of each are outlined on pp. 103 – 105, and on the project website. Definitions and technical notes for the indicators are included in the accompanying commentary, and can also be found on the website.

As the Children Count data are derived from different sources, it is important to include details of the original data source in references. Here are a few examples of how to reference Children Count data correctly:

When referencing from the Demography domain in this publication, for example:

Statistics South Africa (2011) General Household Survey 2010. Pretoria: Stats SA. Cited in: Meintjes H & Hall K (2012) Demography of South Africa's children. In: Hall K, Woolard I, Lake L & Smith C (eds) *South African Child Gauge 2012*. Cape Town: Children's Institute, University of Cape Town.

When referencing from the online Income and Social Grants domain section, for example:

South African Social Security Agency (2012) SOCPEN database. Cited in: Hall K (2012) Income and Social Grants – Child Support Grant. *Children Count – Abantwana Babalulekile* website, Children's Institute, University of Cape Town. Viewed at: www.childrencount.ci.org.za/indicator.php?id=2&indicator=10.

Each domain is introduced below and key findings are highlighted.

Demography of South Africa's children

(pages 82 – 85)

This section provides child population figures and gives a profile of South Africa's children and their care arrangements, including children's co-residence with biological parents, the number and proportion of orphans and children living in child-only households. There were 18.5 million children in South Africa in 2010. Twenty-one percent of children are orphans who have lost a mother, father or both parents; 24% of children do not live with either of their biological parents; and 0.5% of children live in child-only households.

Income poverty, unemployment and social grants

(pages 86 – 90)

In 2010, nearly two-thirds of children (60%) lived below the poverty line (with a per capita income below R575 per month), and 35% lived in households where no adults were employed. Social assistance grants are therefore an important source of income for caregivers to meet children's basic needs. In July 2012, over 11 million children received the Child Support Grant; 573,000 children received the Foster Child Grant; and a further 117,000 children received the Care Dependency Grant.

Child health

(pages 91 – 94)

This section monitors child health through a range of indicators. The official under-five mortality rate was 56 deaths per 1,000 live births in 2009 and the infant mortality rate was 40 deaths per 1,000 live births. In 2011, an estimated 450,000 children under 15 years (3%) were estimated to be HIV positive. Nearly 37% of children travel far to reach their health care facility and 17% of children live in households that reported child hunger.

Children's access to education

(pages 95 – 97)

Many children in South Africa have to travel long distances to school. One in six children (16%) live far from their primary school and this increases to one in five children (22%) in high school. Despite these barriers, South Africa has made significant strides in improving access to education with a gross attendance rate of 97% in 2010. However, this does not necessarily translate into improved educational outcomes.

Children's access to housing

(pages 98 – 100)

This section presents data on children living in rural or urban areas, and in adequate housing. The latest available data show that, in 2010, 53% of children were living in urban areas, and 73% of children lived in formal housing. Just under two million children lived in backyard dwellings and shacks in informal settlements, and one in four children (23%) lived in overcrowded households.

Children's access to basic services

(pages 101 – 102)

Without water and sanitation, children face substantial health risks. In 2010, less than two-thirds of children (64%) had access to drinking water on site, while children's access to adequate toilet facilities rose to 67%.

Demography of South Africa's children

Updated by Helen Meintjes and Katharine Hall (Children's Institute, University of Cape Town)

The UN General Guidelines for Periodic Reports on the Convention on the Rights of the Child,¹ paragraph 7, says that reports made by states should be accompanied by "detailed statistical information ... Quantitative information should indicate variations between various areas of the country ... and between groups of children ...".

The number and proportion of children living in South Africa

In mid-2010, South Africa's total population was estimated at 50 million people, of whom 18.5 million were children (under 18 years). Children therefore constitute 37% of the total population. The child population has grown by about 6% (1.1 million) over the nine-year period from 2002 to 2010.

Exactly half of all children live in three of the nine provinces: KwaZulu-Natal (23%), Eastern Cape (14%) and Limpopo (12%). A further 18% of children live in Gauteng, a mainly metropolitan province, and 10% in the Western Cape.

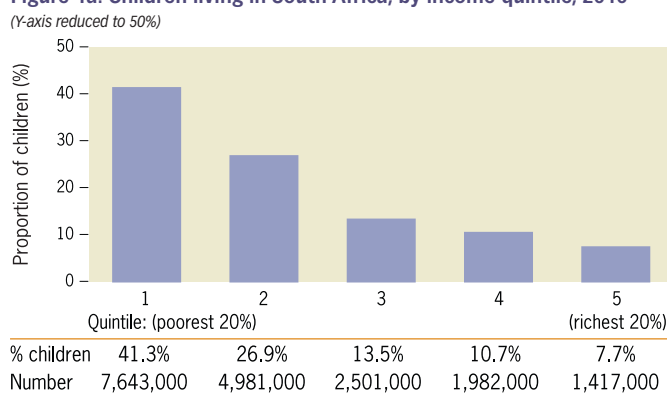
It is not uncommon in South Africa for children to live separately from their biological parents due to labour migration and care arrangements that involve extended families. The distribution of children across provinces is slightly different to that of adults, with a greater proportion of children living in provinces with large rural populations (Limpopo, the Eastern Cape and KwaZulu-Natal) and with greater proportions of adults in the largely metropolitan provinces. Despite being the smallest province in the country, Gauteng accommodates nearly a quarter (24%) of all adults, and 25% of households, but only 18% of children. This is because of the relatively large number of adult-only households in that province.

There have been striking changes in the provincial child populations since 2002. While there are slight decreases in the number of children living in the Eastern Cape, Limpopo and the North West provinces, the number of children living in Gauteng has risen by 21%. This may be caused by the migration of children to join existing households, or new births within the province. Either way, the increase suggests a more permanent migration pattern. The apparent increase in the child population in the Northern Cape is very pronounced due to the relatively small population in that province.

We can look at inequality by dividing all households into quintiles: five equal groups, with quintile 1 being the poorest 20% of households, quintile 2 being the next poorest, and so on. Quintile 5 consists of the least-poor 20%. The income quintiles are based on total income to the household including earnings and social grants. Nearly 70% of children live in the poorest 40% of households.

Children are fairly equally distributed across the age groups, with on average just over one million children in each year under 18. The gender split is equal for children, while it is slightly skewed towards females (53%) in the adult population.

Figure 1a: Children living in South Africa, by income quintile, 2010



Source: Statistics South Africa (2011) *General Household Survey 2010*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

Table 1a: Distribution of households, adults and children in South Africa, 2010

Province	Households		Adults		Children		% change 2002 – 2010
	Number	%	Number	%	Number	%	
Eastern Cape	1,667,000	13	3,971,000	13	2,684,000	14	-5.4
Free State	817,000	6	1,848,000	6	1,071,000	6	8.2
Gauteng	3,208,000	25	7,442,000	24	3,310,000	18	20.8
KwaZulu-Natal	2,408,000	19	6,283,000	20	4,264,000	23	11.2
Limpopo	1,240,000	10	2,991,000	10	2,258,000	12	-9.7
Mpumalanga	922,000	7	2,179,000	7	1,459,000	8	11.7
North West	961,000	7	2,203,000	7	1,276,000	7	-10.8
Northern Cape	293,000	2	724,000	2	430,000	2	42.9
Western Cape	1,467,000	11	3,694,000	12	1,771,000	10	11.3
South Africa	12,983,000	100	31,334,000	100	18,524,000	100	6.1

Source: Statistics South Africa (2011) *General Household Survey 2010*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

The number and proportion of children living with their biological parent(s)

South Africa has a long history of children not living consistently in the same dwelling as their biological parents as a result of poverty, labour migration, educational opportunities, or cultural practice. It is common for relatives to play a substantial role in child-rearing. Many children experience a sequence of different caregivers, are raised without fathers, or live in different households to their biological siblings.

The vast majority (86%) of children live in households where there are two or more co-resident adults. This indicator examines co-residence between children and their biological parents specifically. Although many children live with just one of their biological parents (invariably their mother), this does not mean that the mother is a “single parent” as she is not necessarily the only adult caregiver present in the household. In most cases there are other adult household members, such as aunts and grandparents, who may help to care for children.

The proportion of children living with both parents decreased from 38% in 2002 to 33% in 2010. Thirty-nine percent of all children – more than seven million children – live with their mothers but not with their fathers. Only 3% of children live in households where their fathers are present and their mothers absent. Twenty-four percent do not have either of their biological parents living with them. This does not necessarily mean that they are orphaned: in most cases (79%) at least one parent is alive but living elsewhere, and over half of all children who live without co-resident parents have both parents living elsewhere.

There is some provincial variation in these patterns. In both the Western Cape and Gauteng, the proportion of children living with both parents is significantly higher than the national average, with around half of children resident with both parents (54% and 50% respectively). Similarly, the number of children living with neither parent is low in these two provinces (11% and 12%). In contrast, over a third of children (34%) in the Eastern Cape live with neither parent. These patterns are consistent from 2002 to 2010.

Children in the poorest households are least likely to live with both their parents. Amongst children living in the poorest 20% of households, only 19% have both parents living with them, compared with 73% of children in the least-poor 20% of households.

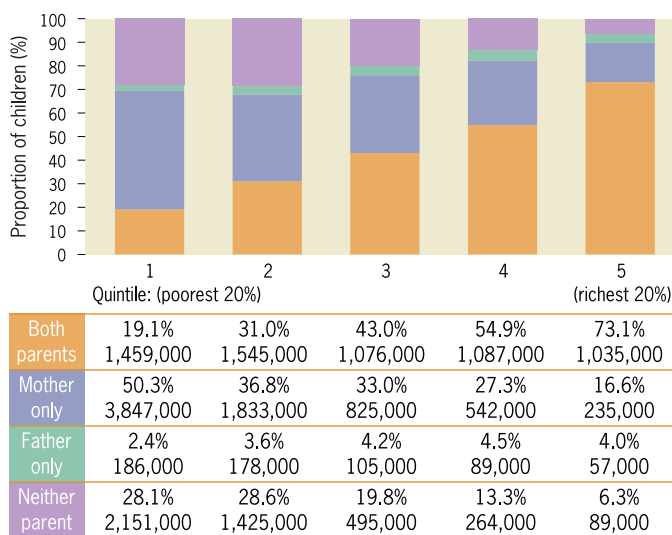
Less than a third (28%) of African children live with both their parents, while the vast majority of Indian and White children (81% and 77% respectively) are resident with both biological parents. Just over a quarter

(27%) of all African children do not live with either parent and a further 42% of African children live with their mothers but without their fathers. These figures are striking for the way in which they suggest the limited presence of fathers in the domestic lives of large numbers of African children.

Younger children (0 – 5-year-olds) are more likely to be living with their mothers (whether or not their fathers are present) than older children (6 – 17 years), who are more likely than younger children to be living with neither parent. While 15% of children aged 0 – 5 years were not resident with either parent in 2010, this situation applied to more than a quarter of children aged 6 – 17 years.

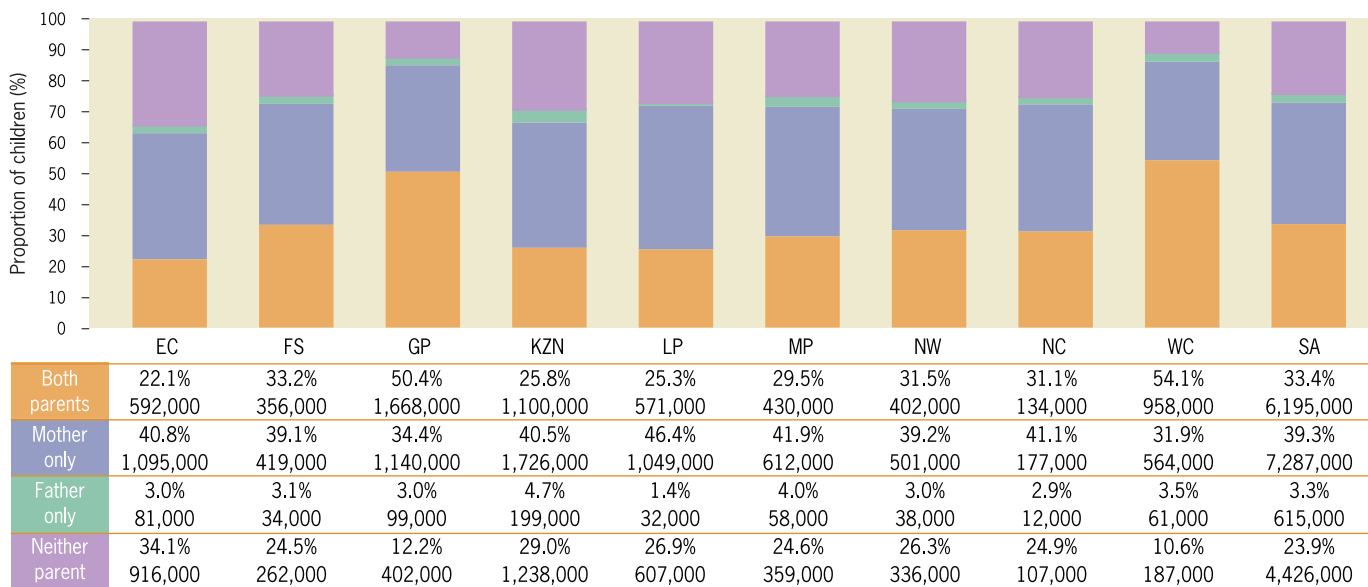
Only 19% of children living in the poorest 20% of households live with both parents, compared to 73% of children in the richest quintile. Children living in poorer households are also more likely to be living with neither parent.

Figure 1c: Children living with parents, by income quintile, 2010



Source: Statistics South Africa (2011) *General Household Survey 2010*. Pretoria: Stats SA. Analysis by Katharine Hall, Children’s Institute, UCT.

Figure 1b: Number and proportion of children living with biological parents, 2010



Source: Statistics South Africa (2011) *General Household Survey 2010*. Pretoria: Stats SA. Analysis by Katharine Hall, Children’s Institute, UCT.

The number and proportion of orphans living in South Africa

An orphan is defined as a child under the age of 18 years whose mother, father, or both biological parents have died (including those whose living status is reported as unknown, but excluding those whose living status is unspecified). For the purpose of this indicator, orphans are defined in three mutually exclusive categories:

- A maternal orphan is a child whose mother has died but whose father is alive.
- A paternal orphan is a child whose father has died but whose mother is alive.
- A double orphan is a child whose mother and father have both died.

The total number of orphans is the sum of maternal, paternal and double orphans. This definition differs from those commonly used by United Nations agencies and the Actuarial Society of South Africa (ASSA), where the definition of maternal and paternal orphans includes children who are double orphans. As the orphan definitions used here are mutually exclusive and additive, the figures differ from orphan estimates provided by the ASSA models.

In 2010, there were approximately 3.8 million orphans in South Africa. This includes children without a living biological mother, father or both parents, and is equivalent to 21% of all children in South Africa. The total number of orphans has increased substantially, with 845,000 more orphaned children in 2010 than in 2002. This is an increase of 28% in the number of orphaned children since 2002.

Orphan numbers do not say anything about the nature or extent of care that children are receiving. It is important to disaggregate the total orphan figures because the death of one parent may have different implications for children than the death of both parents. In particular, it seems that children who are maternal orphans are slightly more at risk of poorer outcomes than paternal orphans – for example, in relation to education.²

In 2010, 17% of children in South Africa did not have a living biological father; 8% did not have a living biological mother; 3.5% were maternal orphans with living fathers; and a further 4.8% were recorded as double orphans. In other words, the vast majority (60%) of all orphans in South Africa are paternal orphans (with living mothers). The numbers of paternal orphans are high because of the higher mortality rates of men in South Africa, as well as the frequent absence of fathers in their children's lives (1.3%, or 244,000 children, have fathers whose vital status is reported to be "unknown").

The figures illustrate notable increases in the number and proportion of double orphans over the nine-year period. The number of children who have lost both a mother and a father has more than doubled since 2002 (from approximately 350,000 to 885,000), indicating an increase of nearly three percentage points in double orphans in South Africa (2002: 2.0%;

2010: 4.8%). These increases are likely to be driven primarily by the AIDS pandemic. Three provinces carry particularly large burdens of care for double orphans: 7% of children living in KwaZulu-Natal and the Free State have lost both parents, and 6% of children in the Eastern Cape are double orphans.

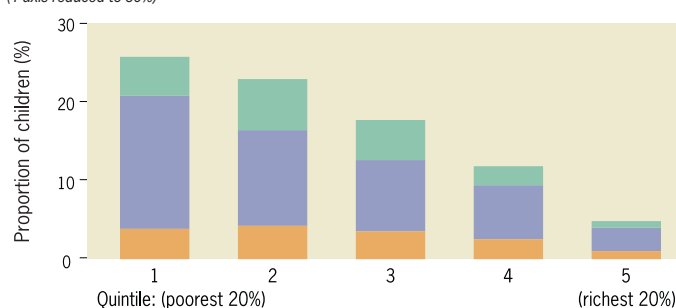
Throughout the period 2002 – 2010, roughly half of all orphans in South Africa have been resident in only two of the country's nine provinces: KwaZulu-Natal and the Eastern Cape. KwaZulu-Natal has the largest population and the highest orphan numbers, with 27% of children in that province recorded as orphans who have lost either a mother, a father or both parents. Orphaning rates in the Eastern Cape are similarly high, at 26%, followed by the Free State, at 24%. The lowest orphaning rates are in the Western Cape (10% of children have lost at least one parent) and Gauteng (15%).

Children are more likely to be orphaned as they get older. In 2010, 80% of all child orphans were of school-going age (between seven and 17-years-old) and half were 12 years or older.

Orphaning is associated with poverty in that orphaning rates are higher for poor children than for relatively well-off children. Around a quarter of children in the poorest 20% of households are orphans, compared with the richest 20% where total orphaning rates are around 5%.

Figure 1e: Orphans by income quintile, 2010

(Y-axis reduced to 30%)

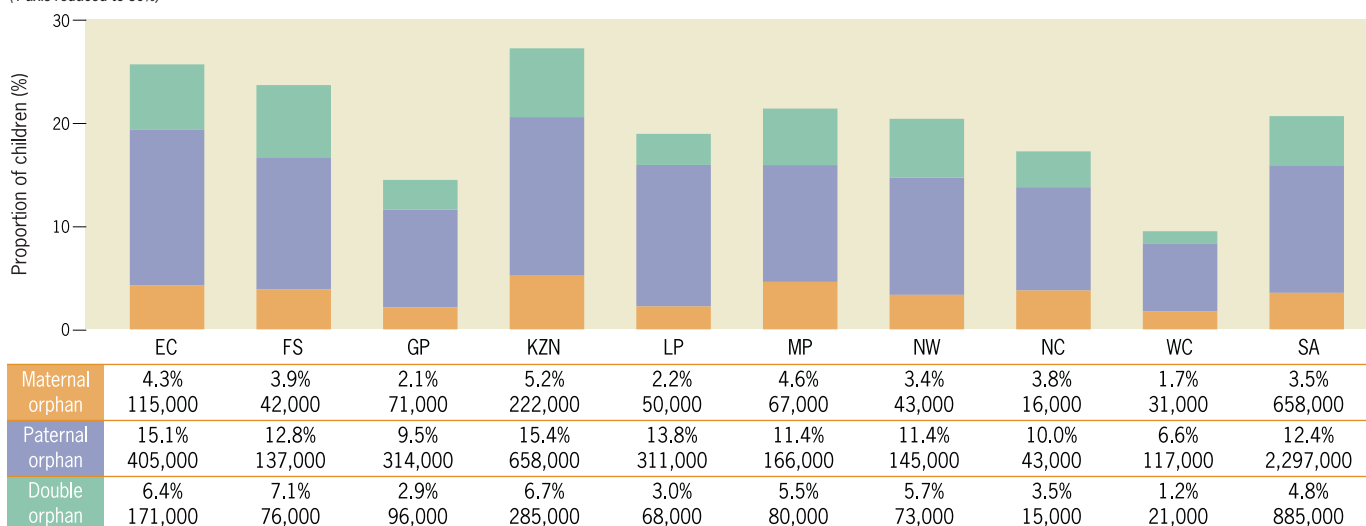


	1	2	3	4	5
	Quintile: (poorest 20%)				(richest 20%)
Maternal orphan	3.8%	4.2%	3.5%	2.5%	1.0%
	294,000	211,000	88,000	50,000	14,000
Paternal orphan	16.9%	12.1%	9.0%	6.8%	3.0%
	1,289,000	604,000	226,000	136,000	42,000
Double orphan	4.9%	6.5%	5.1%	2.4%	0.8%
	377,000	322,000	127,000	48,000	12,000

Source: Statistics South Africa (2011) *General Household Survey 2010*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

Figure 1d: Number and proportion of orphans, 2010

(Y-axis reduced to 30%)



Source: Statistics South Africa (2011) *General Household Survey 2010*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

The number and proportion of children living in child-only households

A child-only household is defined as a household in which all members are younger than 18 years. These households are also commonly known as “child-headed households”.

There is much concern within government and civil society that the number of children living in child-only households is escalating as the number of orphaned children increases due to AIDS-related deaths of parents. Many argue that kinship networks are stretched to their limits and are struggling to provide support to orphaned children. While orphaning undoubtedly places a large burden on extended families, there is little evidence to suggest that the capacity of extended families to care for orphans has been saturated, as commentators have feared. Rather than seeing increasing numbers of orphaned children living without adults, the vast majority of orphans live with family members, and child-headed households are not primarily the result of orphaning.³ Nevertheless it will be important to monitor the prevalence and nature of child-headed households as the HIV/AIDS pandemic continues.

There were just under 90,000 children living in a total of 50,000 child-only households across South Africa in 2010. This equates to 0.5% of all children. While children living in child-only households are rare relative to those resident in other household forms, the number of children living in this extreme situation is of concern.

Importantly, however, there has been no significant change in the proportion of children living in child-only households in the period between 2002 and 2010, nor has there been any change in the proportion of child-only households over the same period. This is despite a marked increase in orphans in South Africa over the same period. Predictions of rapidly increasing numbers of child-headed households as a result of HIV are at this point unrealised. An analysis of national household surveys to examine the circumstances of children in child-headed households in South Africa reveals that most children in child-only households are not orphans.⁴ These findings suggest that social phenomena other than HIV may play important roles in the formation of these households.

While it is not ideal for any child to live without an adult resident, it is positive that over half (58%) of all children living in child-only households are aged 15 years and above. Research suggests that child-only households are frequently temporary households, and often exist just for a period, for example while adult migrant workers are away, or for easy access to school during term-time, or after the death of an adult and prior to other

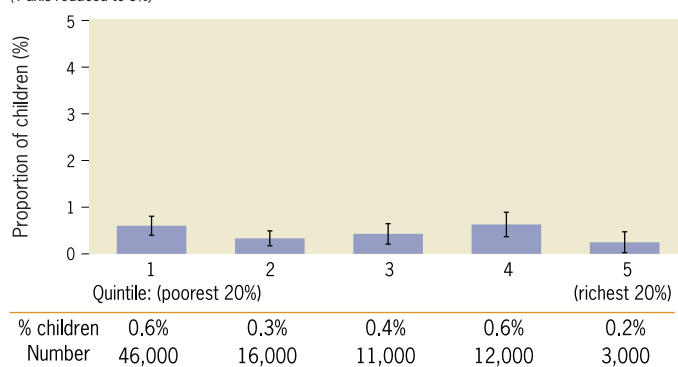
arrangements being made to care for the children (such as other adults moving in or the children moving to live with other relatives).⁵

Nearly 80% of all children living in child-only households live in three provinces: Limpopo (accounts for 31% of children in child-only households), Eastern Cape (25%) and KwaZulu-Natal (21%). From 2002 to 2010, these provinces have consistently been home to the majority of children living in child-only households.

Relative to children in mixed-generation households, child-only households are vulnerable in a number of ways. Child-only households are predominantly clustered in the poorest 20% of households. In addition to the absence of adult members who may provide care and security, they are at risk of living in poorer conditions, with poor access to services, less (and less reliable) income, and low levels of access to social grants.

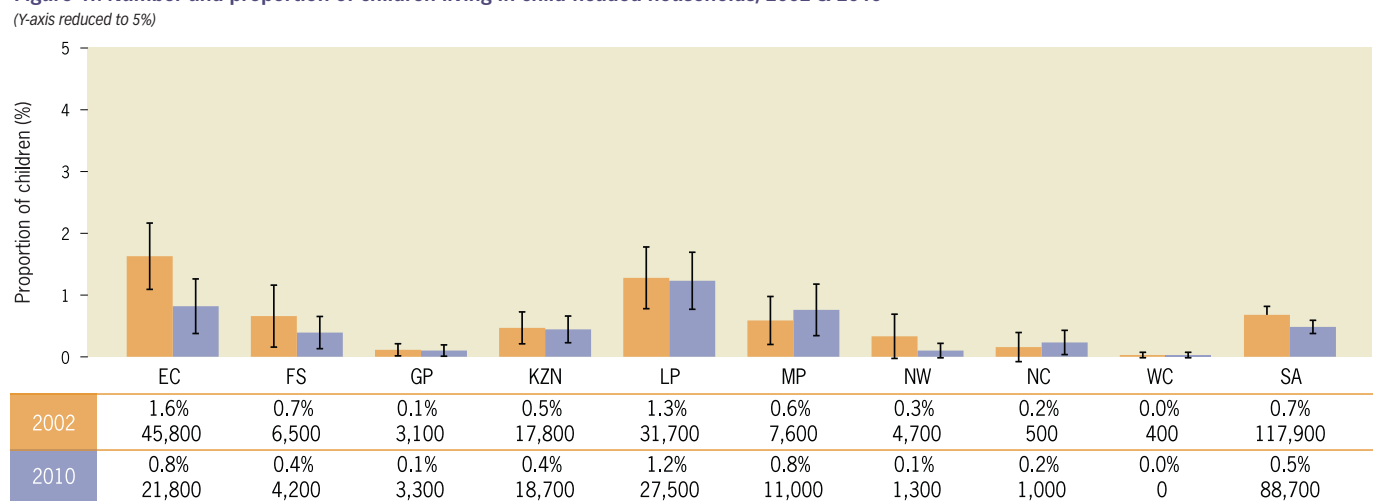
There has been very little robust data on child-headed households in South Africa to date. The figures should be treated with caution as the number of child-only households forms just a very small sub-sample of the General Household Survey. In particular, we caution against reading too much into the provincial breakdowns, or into apparent differences between the 2002 and 2010 estimates.

Figure 1g: Children in child-headed households, by income quintile, 2010
(Y-axis reduced to 5%)



Source: Statistics South Africa (2011) *General Household Survey 2010*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

Figure 1f: Number and proportion of children living in child-headed households, 2002 & 2010
(Y-axis reduced to 5%)



Sources: Statistics South Africa (2003, 2011) *General Household Survey 2002; General Household Survey 2010*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

References

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- Meintjes H, Hall K, Marera D & Boule A (2010) Orphans of the AIDS epidemic? The extent, nature and circumstances of child-headed households in South Africa. *AIDS Care*, 22 (1): 40-49; Meintjes H & Giese S (2006) Spinning the epidemic: The making of mythologies of orphanhood in the context of AIDS. *Childhood: A Global Journal of Child Research*, 13 (3): 407-430.

- See no. 2 above (Meintjes et al, 2010).
- See no. 2 above (Meintjes et al, 2010).
- See no. 2 above (Meintjes et al, 2010); Hill C, Hosegood V & Newell M-L (2008) Children's care and living arrangements in a high HIV prevalence area in rural South Africa. *Vulnerable Children and Youth Studies*, 3 (1): 65-77.

Income poverty, unemployment and social grants

Updated by Katharine Hall (Children's Institute, University of Cape Town)

The Constitution of South Africa,¹ section 27(1)(c), says that "everyone has the right to have access to ... social security, including, if they are unable to support themselves and their dependants, appropriate social assistance".

The UN Convention on the Rights of the Child,² article 27, states that every child has the right "to a standard of living adequate for his or her development" and obliges the state "in case of need" to "provide material assistance". Article 26 guarantees "every child the right to benefit from social security".

Number and proportion of children living in income poverty

This indicator shows the number and proportion of children living in households that are income-poor. These households fall below a specific income threshold. The measure used is a lower-bound "ultra" poverty line, set at R322 per person per month in 2000 prices.³ The poverty line increases with inflation and was equivalent to R575 in 2010. Per capita income is calculated by adding all reported income for household members older than 15 years, including social grants, and dividing the total household income by the number of household members.

One way of identifying how many children are living without enough resources to meet their needs is to use a poverty line and measure how many children live under it. As money is needed to access a range of services, income poverty is often closely related to poor health, reduced access to education, and physical environments that compromise personal safety. A lack of sufficient income can therefore compromise children's rights to nutrition, education, and health care services, for example.

International law and the Constitution recognise the link between income and the realisation of basic human rights, and acknowledge that children have the right to social assistance (social grants) when families cannot meet children's basic needs. Income poverty measures are therefore important for determining how many people are in need of social assistance, and for evaluating the state's progress in realising the right to social assistance.

No poverty line is perfect. Using a single income measure tells us nothing about how resources are distributed between family members,

or how money is spent. But this measure does give some indication of how many children are living with severely constrained resources.

South Africa has very high rates of child poverty. In 2010, 60% of children lived below the lower poverty line (R575 per month). Child poverty rates have fallen consistently since 2003. Significant decreases in child poverty occur across all provinces except the Northern Cape. This poverty reduction is likely to be partly the result of a massive expansion in the reach of the Child Support Grant over the same period.

There are substantial differences in poverty rates across the provinces. Using the lower poverty line, over 70% of children in Limpopo and the Eastern Cape are poor. Gauteng and the Western Cape have the lowest child poverty rates – calculated at 38% and 31% respectively.

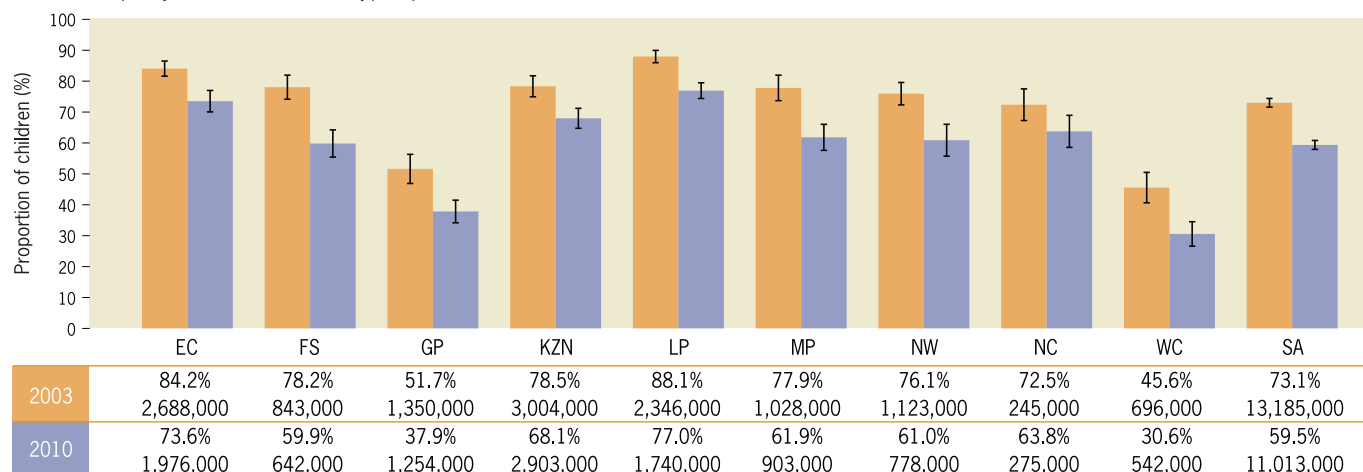
There are glaring racial disparities in income poverty: while two-thirds (67%) of African children lived in poor households in 2010, only 2% of White children lived below this poverty line, and poverty rates for Coloured and Indian children were 29% and 12% respectively.

While other Children Count indicators span the period from 2002 onwards, the poverty analysis uses 2003 as its baseline. This is because the General Household Survey (GHS) did not capture information on social grants in its first year, and so income from grants could not be included in household income for 2002.

Other poverty lines can be used to analyse and compare different levels of income poverty. See www.childrencount.ci.org.za for additional poverty lines ("upper-bound" and \$2-a-day).

Figure 2a: Children living in income poverty, 2003 & 2010

("Lower-bound" poverty line: Households with monthly per capita income less than R575, in 2010 Rands)



Sources: Statistics South Africa (2004; 2011) *General Household Survey 2003; General Household Survey 2010*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

The number and proportion of children living in households without an employed adult

This indicator measures unemployment from a children’s perspective and gives the number and proportion of children who live in households where no adults are employed in either the formal or informal sector. It therefore shows the proportion of children living in “unemployed” households where it is unlikely that any household members get income from labour or income-generating activities.

Unemployment in South Africa is a serious problem. In mid-2010 (the same time as the 2010 GHS), the official national unemployment rate was 23%.⁴ This rate is based on a narrow definition of unemployment that includes only those adults who are defined as economically active (ie they are not studying or retired or for some reason voluntarily at home) who actively looked but failed to find work in the four weeks preceding the survey.⁵ An expanded definition of unemployment, which includes “discouraged work-seekers” who were unemployed but not actively looking for work in the month preceding the survey, would give a higher, more accurate, indication of unemployment. Gender differences in employment rates are relevant for children, who are more likely to co-reside with their mother than their father (see page 83). Unemployment rates remain considerably higher for women than for men.

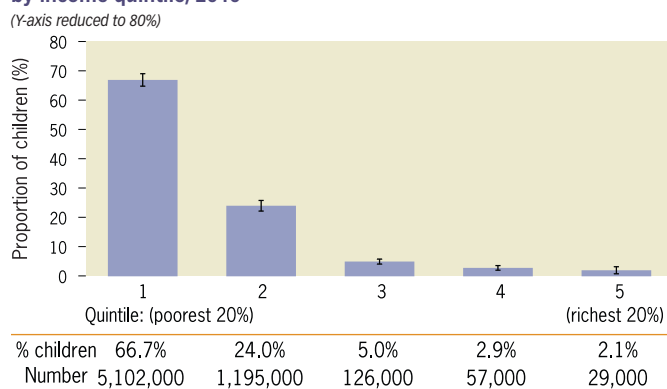
Apart from providing regular income, an employed adult may bring other benefits to the household, including health insurance, unemployment insurance and maternity leave that can contribute to children’s health, development and education. The definition of “employment” is derived from the Quarterly Labour Force Survey and includes regular or irregular work for wages or salary, as well as various forms of self-employment, including unpaid work in a family business.

In 2010, 65% of children in South Africa lived in households with at least one working adult. The other 35% (over 6.5 million children) lived in households where no adults were working. There has been only a small decrease from 2003 to 2010, with the proportion of children who live in unemployed households hovering in the mid-30% despite an overall drop in the official unemployment rate from 28% to 23% over the same period.

This indicator is very closely related to the income poverty indicator in that provinces with relatively high proportions of children living in unemployed households also have high rates of child poverty. Gauteng and the Western Cape have the lowest levels of income poverty, and less than 20% of children in these provinces live in unemployed households. In contrast, around 50% of children in the Eastern Cape and Limpopo live in households without any employed adults. These two provinces are home to large numbers of children, and have the highest rates of child poverty.

Racial inequalities are striking: 40% of African children have no working adult at home, while 13% of Coloured children, 7% of Indian children and 3% of White children live in these circumstances. Unemployment is clearly associated with child poverty, with over five million children living without an employed adult in the poorest 20% of households.

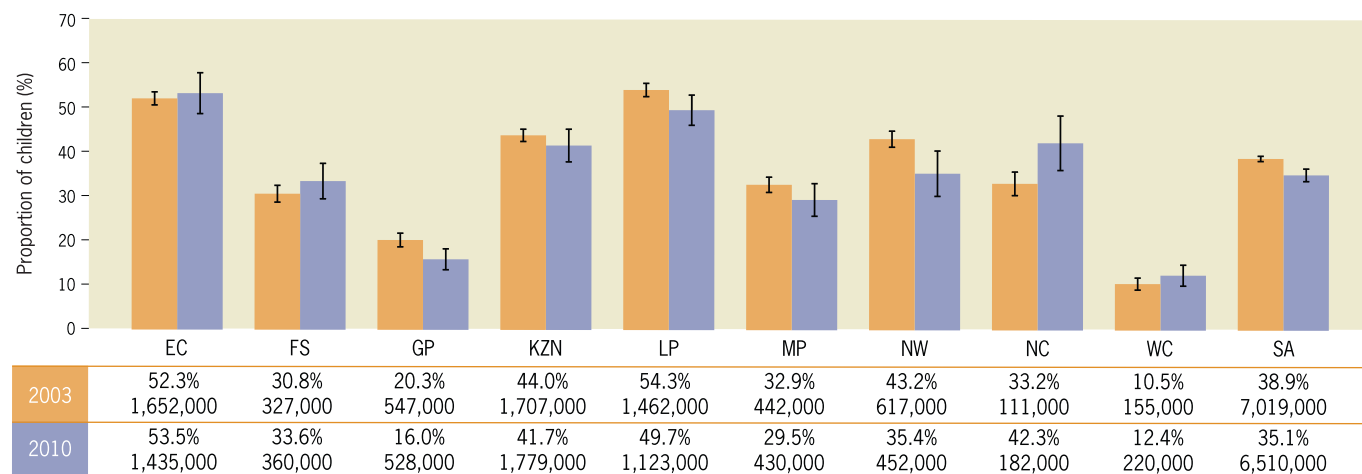
Figure 2c: Children in households with no employed adults, by income quintile, 2010



Source: Statistics South Africa (2011) *General Household Survey 2010*. Pretoria: Stats SA. Analysis by Katharine Hall, Children’s Institute, UCT.

Figure 2b: Number and proportion of children living in households without an employed adult, 2003 & 2010

(Y-axis reduced to 70%)



Sources: Statistics South Africa (2004) *Labour Force Survey 2003*. Pretoria: Stats SA; Statistics South Africa (2011) *General Household Survey 2010*. Pretoria: Stats SA. Analysis by Katharine Hall & Matt Chennells, Children’s Institute, UCT.

The number and proportion of children receiving the Child Support Grant

This indicator shows the number of children receiving the Child Support Grant (CSG), as reported by the South African Social Security Agency (SASSA), which disburses social grants on behalf of the Department of Social Development.

The right to social assistance is designed to ensure that people living in poverty are able to meet basic subsistence needs. Government is obliged to support children directly when their parents or caregivers are too poor to do so. Income support is provided through social assistance programmes, such as the CSG, which is an unconditional cash grant paid to the caregivers of eligible children.

Introduced in 1998 with a value of R100, the CSG has become the single biggest programme for alleviating child poverty in South Africa. Take-up of the CSG has increased dramatically over the past decade and, in July 2012, a monthly CSG of R280 was paid to over 11.2 million children aged 0 – 17 years.

There have been two important changes in eligibility criteria related to the age and income thresholds. At first the CSG was only available for children 0 – 6 years old. Later it was extended to older children up to the age of 14. A subsequent amendment to the regulations defined the age threshold differently: Rather than setting a specific age limit, all children born after 31 December 1993 are defined as eligible. This means that, from January 2012, children under 18 years are eligible. Defining the age threshold by date of birth rather than current age circumvents a previous problem where children had their grants terminated when they reached

the age threshold and then had to reapply when the age limit was extended.

From 1998, children were eligible for the CSG if their primary caregiver and his/her spouse had a joint monthly income of R800 or less and lived in a formal house in an urban area. For those who lived in rural areas or informal housing, the income threshold was R1,100 per month. This threshold remained static for 10 years until a formula was introduced for calculating income threshold – set at 10 times the amount of the grant. Therefore the 2012 income threshold is R2,800 per month for a single caregiver (and R5,600 per month for the joint income of the caregiver and spouse, if the caregiver is married).

Using the 2004 GHS, it was calculated that 65% of all children under the age of 14 were eligible for the CSG in that they passed the old means test.⁶ Following the adjustment of the means test in 2008, the calculation was repeated, this time using the new means test and the 2007 GHS, which suggested that around 82% of children aged 0 – 13 years were eligible for the grant.⁷ Applying this eligibility rate to Stats SA mid-term population estimates for children aged 0 – 15 years (the eligible age group in 2010), it is estimated that 73% of eligible children were accessing the CSG (although the actual take-up rate would be lower due to errors of inclusion).

There is substantial evidence that grants, including the CSG, are being spent on food, education and basic goods and services. This evidence shows that the grant not only helps to realise children's right to social assistance, but also improves their access to food, education and basic services.⁸

Table 2a: The number of children receiving the Child Support Grant, 2005 – 2012

Province	Number of child beneficiaries							
	2005	2006	2007	2008	2009	2010	2011	2012
Eastern Cape	1,078,442	1,413,830	1,497,736	1,491,223	1,605,479	1,707,445	1,788,842	1,860,405
Free State	361,318	417,076	441,397	457,169	494,433	547,694	591,301	627,663
Gauteng	723,432	862,346	926,179	969,267	1,067,729	1,207,344	1,325,598	1,434,186
KwaZulu-Natal	1,338,045	1,746,944	1,963,944	2,128,967	2,344,413	2,512,787	2,655,721	2,783,213
Limpopo	990,194	1,200,185	1,253,794	1,278,711	1,392,140	1,493,705	1,419,831	1,552,616
Mpumalanga	489,663	613,008	645,565	662,316	717,075	771,326	959,122	1,044,551
North West	465,242	604,525	613,002	637,557	682,991	742,699	758,041	823,899
Northern Cape	101,728	121,332	175,250	184,183	209,818	232,355	255,162	270,371
Western Cape	365,655	431,514	458,980	480,394	557,784	666,577	756,129	830,928
South Africa	5,913,719	7,410,760	7,975,847	8,289,787	9,071,862	9,881,932	10,509,747	11,227,832
CSG amount	R 180	R 190	R 200	R 220	R 240	R 250	R 270	R 280

Source: South African Social Security Agency (2005 – 2012) SOCPEN database – special request. Pretoria: SASSA.

Notes:

1. SOCPEN figures are taken from mid-year to coincide with data collection for the annual General Household Survey.
2. For the years 2005 to 2008, the CSG was only available to children aged 0 – 13 years (under-14s). In 2009, the grant was extended to include children aged 14 years (under-15s), in 2010 to children aged 15 years (under-16s), and in 2011 to children aged 16 (under-17s). In 2012, 17-year-olds also became eligible to receive the grant.

The number of children receiving the Foster Child Grant

This indicator shows the number of children who are accessing the Foster Child Grant (FCG) in South Africa, as recorded in the SOCPEN administrative data system of the SASSA.

The FCG is available to foster parents who have a child placed in their care by an order of the court. It is a non-contributory cash grant valued at R770 per month in 2012. The grant was initially intended as financial support for children removed from their families and placed in foster care for protection in situations of abuse or neglect. However, it is increasingly used to provide financial support to caregivers of children who have lost their biological parents because of the AIDS pandemic. The appropriateness and effectiveness of this approach have been questioned.⁹

The number of FCG grants has doubled since 2004, with figures increasing by more than 100% in the Eastern Cape, KwaZulu-Natal, Limpopo and Mpumalanga. Take-up varies substantially between provinces, and nearly half of all grants go to just two provinces: KwaZulu-

Natal (151,000) and Eastern Cape (124,000). By July 2012, 573,000 FCGs were paid each month to caregivers of children in foster care.

The overall rate of increase in FCG take-up appears quite slow and stable, but the large numbers of new FCGs are offset by the drop-off in beneficiaries, particularly in December of each year when the grants of children who turned 18 are terminated. In addition, there have been concerns about considerable numbers of FCGs lapsing due to court orders not being extended. This is related to a systemic problem: the FCG is administratively burdensome for both social workers and the courts, resulting in a backlog of cases needing extension. For more information and the latest policy developments, see pp. 14 – 16.

It is not possible to calculate a take-up rate for the FCG as there is no accurate record of how many children are eligible for placement in foster care – and indeed, no clear guidelines about how it should be targeted in the context of rising orphaning rates.

Table 2b: The number of children receiving the Foster Child Grant, 2005 – 2012

Province	Number of child beneficiaries							
	2005	2006	2007	2008	2009	2010	2011	2012
Eastern Cape	53,383	68,197	81,404	92,556	86,176	107,781	115,110	124,291
Free State	33,653	40,712	45,122	48,685	49,030	45,506	47,386	46,542
Gauteng	34,647	40,576	51,719	59,405	64,047	64,775	61,522	59,347
KwaZulu-Natal	57,351	81,420	111,582	113,459	137,463	126,719	143,466	150,898
Limpopo	25,615	36,020	44,201	50,709	55,689	57,051	54,504	61,740
Mpumalanga	12,662	18,252	21,813	25,664	29,293	27,428	33,219	35,515
North West	19,000	27,737	31,821	38,351	43,656	36,803	44,148	49,077
Northern Cape	9,480	11,462	14,494	15,376	16,307	15,855	16,187	15,588
Western Cape	26,026	27,326	28,735	28,955	29,818	19,692	29,681	29,905
South Africa	271,817	351,702	430,891	473,160	511,479	510,298	545,223	572,903
FCG amount	R 560	R 590	R 620	R 650	R 680	R 710	R 740	R 770

Source: South African Social Security Agency (2005 – 2012) SOCPEN database – special request. Pretoria: SASSA.

Note: SOCPEN figures are taken from mid-year to coincide with data collection for the annual General Household Survey.

The number of children receiving the Care Dependency Grant

This indicator shows the number of children who are accessing the Care Dependency Grant (CDG) in South Africa, as recorded in the SOCPEN administrative data system of the SASSA.

The CDG is a non-contributory monthly cash transfer to caregivers of children with severe disabilities who require permanent care. It excludes those children who are cared for in state institutions because the purpose of the grant is to cover the additional costs (including opportunity costs) that the parent or caregiver might incur as a result of the child's disability. It also excludes infants under one year because young babies need full-time care, whether or not they have disabilities. To qualify for the CDG, the child needs to undergo a medical assessment and the parent must pass an income or "means" test.

Although the CDG targets children with severe disabilities, children with chronic illnesses are eligible for the grant once the illness becomes disabling, for example children who are very sick with AIDS-related illnesses. Children with severe disabilities and chronic illnesses need

substantial care and attention, and parents may need to stay at home or employ a caregiver to tend to the child. Children with health conditions may need medication, equipment or to attend hospital often. These extra costs can put strain on families that are already struggling to make ends meet. Poverty and chronic health conditions are therefore strongly related.¹⁰

It is not possible to calculate a take-up rate for the CDG because there is little data on the number of children who are living with disabilities in South Africa, or who are in need of permanent care. In mid-2012, nearly 120,000 children were receiving the CDG, then valued at R1,200 per month.

The provincial distribution of CDGs is fairly consistent with the distribution of children. The provinces with the largest numbers of children, KwaZulu-Natal and the Eastern Cape, receive the largest share of CDGs. There has been a consistent and gradual increase in access to the CDG since 2005.

Table 2c: The number of children receiving the Care Dependency Grant, 2005 – 2012

Province	Number of child beneficiaries							
	2005	2006	2007	2008	2009	2010	2011	2012
Eastern Cape	19,925	20,367	20,253	19,269	19,452	18,523	18,392	18,267
Free State	3,401	3,679	3,924	4,187	4,325	4,501	4,927	5,559
Gauteng	11,468	12,140	12,667	12,740	13,020	13,381	13,919	14,528
KwaZulu-Natal	20,994	24,098	27,855	30,878	32,798	33,551	34,328	35,513
Limpopo	9,609	10,553	11,396	12,004	12,475	12,098	11,191	11,554
Mpumalanga	4,273	4,532	5,018	5,449	5,758	5,755	7,539	8,270
North West	6,961	7,791	7,795	8,542	9,022	8,891	8,653	8,971
Northern Cape	2,186	2,582	3,403	3,642	3,873	3,911	4,156	4,356
Western Cape	6,881	7,111	7,310	7,503	8,365	8,892	9,516	10,238
South Africa	85,698	92,853	99,621	104,214	109,088	109,503	112,621	117,256
FCG amount	R 780	R 820	R 870	R 940	R 1,010	R 1,080	R 1,140	R 1,200

Source: South African Social Security Agency (2005 – 2012) SOCPEN database – special request. Pretoria: SASSA.

Note: SOCPEN figures are taken from mid-year to coincide with data collection for the annual General Household Survey.

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Child health

Updated by Katharine Hall, Lori Lake & Lizette Berry (Children’s Institute, University of Cape Town)

Section 27 of the Constitution of South Africa¹ provides that everyone has the right to have access to health care services. In addition, section 28(1)(c) gives children “the right to basic nutrition and basic health care services”.

Article 14(1) of the African Charter on the Rights and Welfare of the Child² states that “every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health”.

Article 24 of the UN Convention on the Rights of a Child³ says that state parties should recognise “the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health”. It obliges the state to take measures “to diminish infant and child mortality” and “to combat disease and malnutrition”.

The infant mortality rate and under-five mortality rate

Infant and under-five mortality rates are widely used indicators of health status and socio-economic development because they reflect not only child mortality levels but also the health status of the broader population. The infant mortality rate (IMR) is defined as the probability of dying within the first year of life and refers to the number of babies under 12 months old who die in a year, per 1,000 live births during the same year. Similarly, the under-five mortality rate (U5MR) is defined as the probability of children dying between birth and their fifth birthday. The U5MR refers to the number of children under five years old who die in a year, per 1,000 live births in the same year.

A child’s growth and development are dependent on the family’s living conditions and access to services and resources in the surrounding community. These conditions generate the biological risk factors that impact directly on the child’s health through the occurrence of illness and injury, of which death is the most extreme outcome. The IMR and U5MR in developing countries are therefore associated with a broad range of bio-demographic, health and social risk factors. These include access to maternal and child health care services, maternal nutrition status, breastfeeding and infant feeding practices; environmental health factors such as safe drinking water, hygiene and sanitation; and socio-economic factors such as levels of maternal education and household conditions. The IMR and U5MR, as indicators of health and overall societal development, are therefore intrinsically linked to the right to a healthy and safe childhood and an array of socio-economic rights.

Monitoring IMR and U5MR has proved challenging in South Africa. The country has primarily relied on survey data and modelled estimates because the vital registration system is not adequate for this purpose. However, the last reliable survey data on child mortality were collected in the 1998 South African Demographic and Health Survey. In the absence of more recent survey data, previous issues of the *South African Child Gauge* have reported on modelled estimates from the ASSA2008 AIDS and Demographic model of the Actuarial Society of South Africa.

According to ASSA2008 estimates, the IMR gradually decreased from 52 in 2000 to 33 in 2012, while the U5MR increased gradually in the decade leading up to 2003, reaching a high of 74, after which it steadily decreased to an estimated 48 deaths per 1,000 live births in 2012.⁴ The rise in under-five mortality in the late 1990s and early 2000s correlates with a rise in HIV prevalence amongst pregnant women, while the downward trend correlates with the national roll-out of the Prevention

of Mother-to-Child Transmission programme from 2003 onwards.

While there is growing consensus that the ASSA2008 model reflects the general trend of infant and under-five mortality, these estimates do not necessarily reflect the impact of recent changes in South Africa’s HIV prevention, treatment and infant feeding guidelines.

Given the uncertainties surrounding this indicator, the Health Data Advisory and Coordination Committee (HDACC) has recommended drawing on the Rapid Mortality Surveillance system established by the Medical Research Council to provide details of deaths of people on the National Population Register by age and sex, with only a six-month delay.⁵ This methodology for monitoring U5MR is new, and will need to be benchmarked through periodic surveys that include a full birth history.

The HDACC also recommends the following baselines and targets for 2014:

Table 3a: Child and infant mortality rates

Indicator	Baseline (2009)	Target (2014)
Under-5 mortality rate (per 1,000 live births)	56	50
Infant mortality rate (per 1,000 live births)	40	36

Source: Department of Health (2012) Health Data Advisory Co-ordination Committee (HDACC) Report, February 2012. Pretoria: DOH.

Reducing child mortality is one of the eight Millennium Development Goals, and the target for MDG 4 is to reduce under-five mortality by two-thirds between 1990 and 2015. Efforts to reduce HIV infection and tuberculosis, improve immunisation coverage and vitamin A supplementation, and promote exclusive breastfeeding, together with the introduction of the rotavirus and pneumococcal vaccines, should enable a significant reduction in the IMR and U5MR. However, it remains unlikely that South Africa will meet its U5MR target of 20 deaths per 1,000 live births by 2015.

Neonatal deaths (in the first 28 days of life) appear to be fairly static at 14 deaths per 1,000 live births, and currently account for about one-third of all deaths in children under five. It is therefore essential to improve the quality of maternal and newborn care in district and regional hospitals.

HIV prevalence in children

This indicator refers to the proportion of children, in a given period, who are HIV positive. South Africa currently has the largest number of people living with HIV in the world. The adult prevalence rate is estimated to have stabilised at 17 – 18% over the 2008 – 2010 period.⁶ Children are profoundly affected by the HIV pandemic, with an estimated 450,000 children under 15 years of age who were HIV positive in 2011,⁷ while others have become ill and died due to AIDS or AIDS-related illnesses.

Children are mainly infected before and during the birth process and some later through breastfeeding – in other words, paediatric HIV is driven by the adult pandemic. HIV prevalence rates among women attending antenatal public health services were 30% in 2010.⁸ The probability of infection from mother to child is considerably high in the absence of interventions to prevent mother-to-child transmission. Children may also become infected through sexual intercourse, including sexual abuse.

Estimates of the number of children infected with HIV are essential for planning responsive health services. Knowing the prevalence of paediatric HIV also helps to monitor the pandemic and gives an indication of the effectiveness of prevention and treatment measures such as the Prevention of Mother-to-Child Transmission (PMTCT) programme and antiretroviral therapy (ART). An evaluation of the effectiveness of the PMTCT programme in 2010 indicates that uptake of PMTCT services is high, with 92% of HIV-positive women included in the sample receiving antiretroviral treatment or prophylaxis. The study also found a national mother-to-child-transmission rate of 3.5% during pregnancy and child birth,⁹ an indication of the successful implementation of the programme.

In the absence of empirical data, ASSA's latest AIDS and Demographic model, ASSA2008, provides estimates of paediatric HIV prevalence in South Africa. It suggests that – while prevalence is increasing over time – the rate at which it is doing so is decreasing. The increase in prevalence could be explained by the increased survival rates for children as a result of increased access to treatment. However, there are significant provincial differences in the prevalence estimates for children, which range from 1.3% in the Western Cape to 4.2% in KwaZulu-Natal in 2011. The modelled data estimate that 3% of children under 15 years of age were HIV positive in 2011.

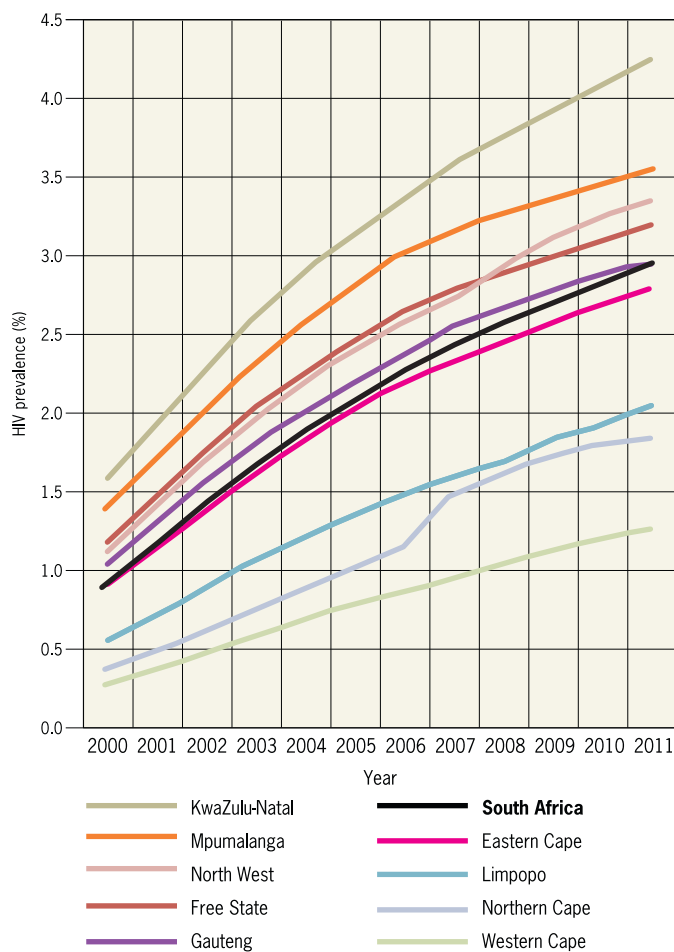
A recent paediatric model projects the number of infected children to be slightly higher than the ASSA2008 estimates.¹⁰ This is partly because it includes more detailed modelling of breastfeeding rates. The probability of infection through breastfeeding is reduced by 80% if breastfeeding mothers receive highly-active ART (HAART) during this period.¹¹ This model takes into account the 2010 treatment guidelines that introduced prophylactic treatment for babies exposed to HIV. According to this model, an estimated 3.8% of children aged 0 – 14 years old were infected with HIV in 2008,¹² compared with 2.6% estimated by the ASSA2008 model. The PMTCT programme evaluation indicates that infant feeding practices should receive greater priority, with only 20% of HIV-positive mothers included in the study exclusively breast-feeding and 18% practicing high-risk mixed feeding.¹³

Children born HIV positive need to receive treatment early because, without treatment, more than 30% of infected children would die before their first birthday.¹⁴ The rapid roll-out of the ART programme since 2002 suggests that increasing numbers of infected babies are receiving treatment, and surviving.

However, the PMTCT programme evaluation points to ongoing missed opportunities in the PMTCT programme and indicates that only 35% of HIV-positive mothers included in the study intended to have their infant tested for HIV at six weeks. The study's method of surveying infants attending immunisation services at six weeks resulted in high take-up rates of early infant HIV testing. These factors suggest that the current approach of testing only HIV-exposed infants requires review and that a universal approach that tests all infants at six weeks should be considered. Linking infant HIV-testing with the six-week immunisation visit is likely to reduce missed opportunities to identify HIV-positive infants in need of treatment.¹⁵

Figure 3a: HIV prevalence in children (0 – 14 years) by province, 2000 – 2011

(Y-axis reduced to 4.5%)



Source: Actuarial Society of South Africa (2011) ASSA2008 AIDS and Demographic Model. Available: www.actuarialsociety.org.za.

The number and proportion of children living far from their health facility

This indicator reflects the distance from a child's household to the health facility they normally attend. Distance is measured through a proxy indicator: length of time travelled to reach the health facility, by whatever form of transport is usually used. The health facility is regarded as "far" if a child would have to travel more than 30 minutes to reach it, irrespective of mode of transport.

The health of children is influenced by many factors, including nutrition, access to clean water, adequate housing, sanitation and a safe environment. Primary health care facilities provide important preventative and curative services, and increased access to such facilities could substantially reduce child illness and mortality. Children therefore need access to good and reliable health services to ensure that they receive life-saving interventions such as immunisation and antiretroviral therapy.

A review of international evidence suggests that universal access to key preventive and treatment interventions could avert up to two-thirds of under-five deaths in developing countries.¹⁶ Preventative measures include promotion of breast- and complementary feeding, micronutrient supplements (vitamin A and zinc), immunisation, and the prevention of mother-to-child transmission of HIV, amongst others. Curative interventions provided through the government's Integrated Management of Childhood Illness strategy include oral rehydration, infant resuscitation and the dispensing of drugs such as antibiotics and anti-malarials.

According to the UN Committee on Economic, Social and Cultural Rights, primary health care should be available (in sufficient supply), accessible (easily reached), affordable and of good quality.¹⁷ In 1996, primary level care was made free to everyone in South Africa, but the availability and physical accessibility of health care services remain a problem, particularly for people living in remote areas.

Physical inaccessibility poses particular challenges when it comes to health services, because the people who need these services are often unwell or injured, or need to be carried because they are too young, too old or too weak to walk. Long distances, poor roads and high transport costs can make it difficult for children to reach health care facilities and for mobile clinics and emergency services to reach outlying areas. Physical inaccessibility and other barriers or constraints require urgent attention if the majority of children in South Africa are to gain meaningful access to primary level health care.

Over a third (37%) of South Africa's children live far from the primary health care facility they normally use, and over 90% attend the facility closest to their home. Amongst households with children, only 8% do not usually attend their nearest health facility, and within the poorest 40% of households, only 5% do not use their nearest facility. The main

reasons for attending a more distant health service relate to choices based on perceptions of quality: preference for a private doctor, long waiting times at clinics and non-availability of medicines.¹⁸

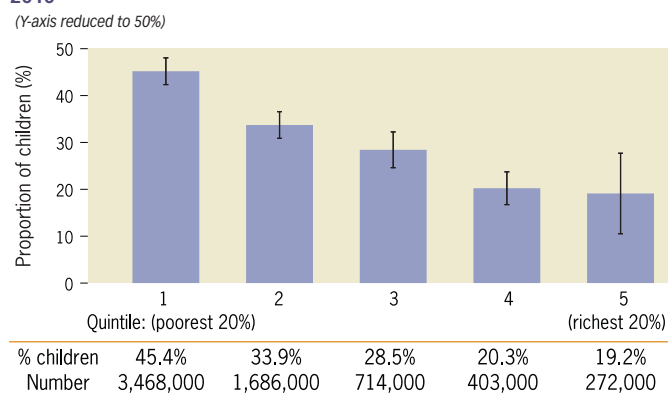
Nearly seven million children would have to travel more than 30 minutes to reach their usual health care service provider. Nationally, the distance to health services has remained relatively constant between 2002 and 2010.

There is considerable variation between provinces, however. While over 40% of children in the Limpopo, KwaZulu-Natal and the Eastern Cape do not have a health facility within 30 minutes travel of their homes, this proportion is much lower for other provinces, and lowest in the largely metropolitan provinces of Gauteng (21%) and the Western Cape (14%).

There are also significant differences between population groups. Nearly four out of 10 African children would have to travel far to reach a health care facility, compared with only 13% – 22% of Coloured, Indian and White children.

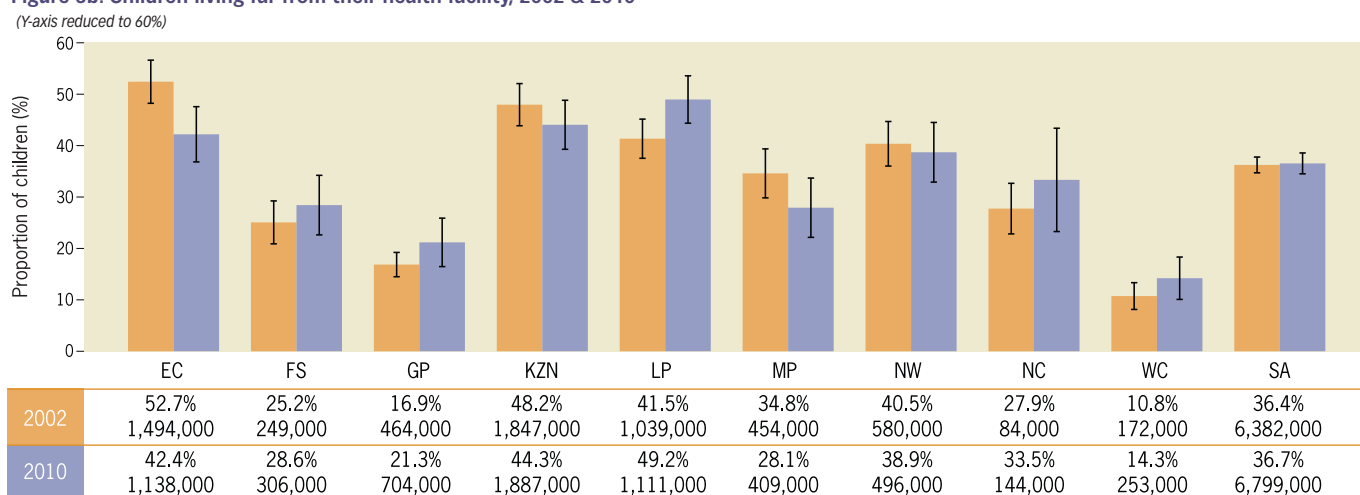
Poor children bear the greatest burden of disease, partly due to poorer living conditions and levels of services (water and sanitation). Yet health facilities are least accessible to the poor. Nearly half of children (45%) in the poorest 20% of households have to travel far to access health care, compared with 19% of children in the richest 20% of households.

Figure 3c: Children living far from their health facility, by income quintile, 2010



Source: Statistics South Africa (2011) *General Household Survey 2010*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

Figure 3b: Children living far from their health facility, 2002 & 2010



Sources: Statistics South Africa (2003, 2011) *General Household Survey 2002; General Household Survey 2010*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

The number and proportion of children living in households where there is reported child hunger

Section 28(1)(c) of the Constitution provides every child with the right to basic nutrition. The fulfilment of this right depends on access to sufficient food. This indicator shows the number and proportion of children living in households where children are reported to go hungry “sometimes”, “often” or “always” because there isn’t enough food. Child hunger is emotive and subjective, and this is likely to undermine the reliability of estimates on the extent and frequency of reported hunger, but it is assumed that variation and reporting error will be reasonably consistent so that it is possible to monitor trends from year to year.

The government has introduced a number of programmes to alleviate income poverty and to reduce hunger, malnutrition and food insecurity, yet over three million children (17%) lived in households where child hunger was reported in 2010. There was a significant drop in reported child hunger from 30% of children in 2002 to a low of 16% in 2006. Since then the rate has remained fairly consistent, suggesting that despite expansion of social grants, school feeding schemes and other efforts to combat hunger amongst children, there may be targeting issues which continue to leave households vulnerable to food insecurity.

There are large disparities between provinces and population groups. Although the Northern Cape has the smallest child population, it had the highest rate (36%) of reported child hunger in 2010. However, this deviates from previous years when its hunger rates were within the national average. Either there had been a significant increase in household food insecurity in the Northern Cape, or misreporting from within the very small provincial population has caused this sudden spike in 2010.

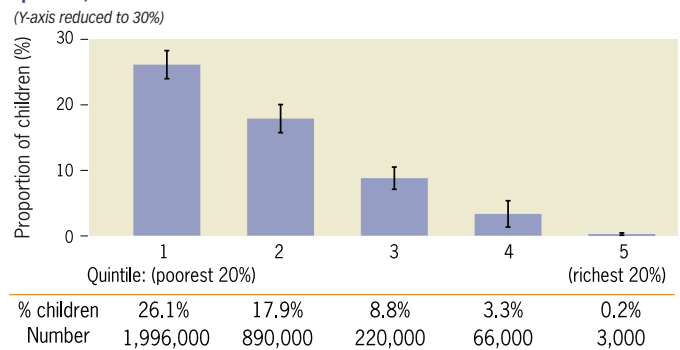
Other provinces with relatively large numbers of children and high rates of child hunger are KwaZulu-Natal (25%), the Eastern Cape and North West (both 22%). These provinces reported high rates of child hunger throughout the nine-year monitoring period, although the proportion of children experiencing hunger has declined over this period. Child hunger rates are lowest in Gauteng (9%) and Limpopo (8%). Gauteng is a relatively wealthy and urbanised province and performs

well on most child indicators. By contrast, Limpopo has a large rural child population with high rates of unemployment and income poverty, yet reported child hunger has remained well below the national average.

Hunger, like income poverty and household unemployment, is most likely to be found among African children. In 2010, some three million African children lived in households that reported child hunger. This equates to nearly 20% of the total African child population, while relatively few Coloured (13%), Asian (5%) and White (0%) children lived in households where child hunger was reported.

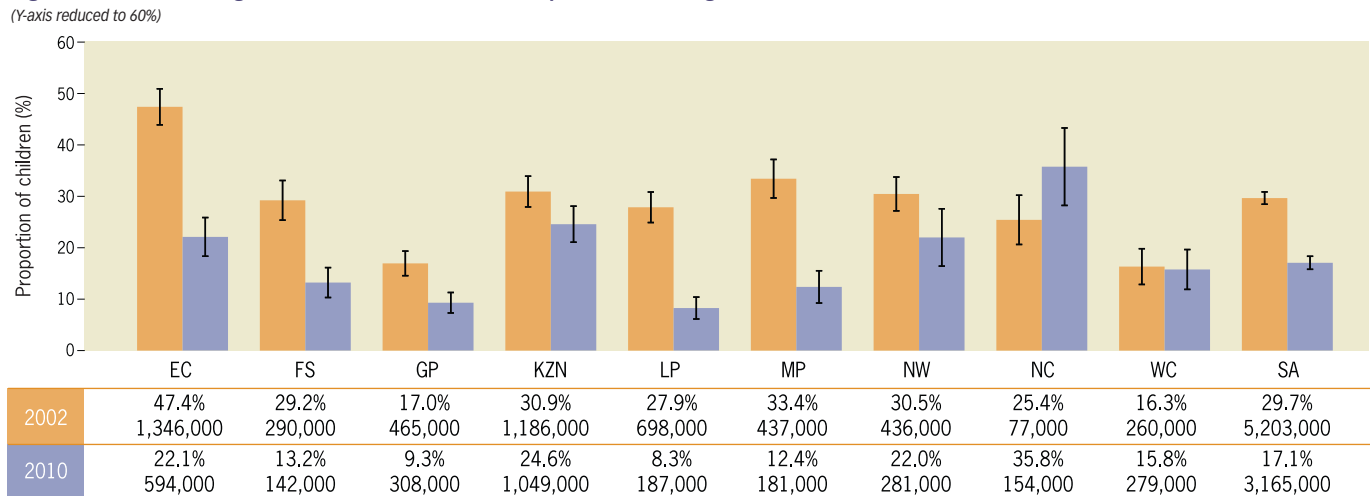
Although social grants are targeted to the poorest households and are associated with improved nutritional outcomes, child hunger is still most prevalent in the poorest households: 26% of children in the poorest quintile go hungry sometimes, compared with less than 1% in the wealthiest quintile of households.

Figure 3e: Children in households with reported child hunger, by income quintile, 2010
(Y-axis reduced to 30%)



Source: Statistics South Africa (2011) *General Household Survey 2010*. Pretoria: Stats SA. Analysis by Katharine Hall, Children’s Institute, UCT.

Figure 3d: Children living in households where there is reported child hunger, 2002 & 2010
(Y-axis reduced to 60%)



Sources: Statistics South Africa (2004) *Labour Force Survey 2003*. Pretoria: Stats SA. Statistics South Africa (2011) *General Household Survey 2010*. Pretoria: Stats SA. Analysis by Katharine Hall & Matt Chennells, Children’s Institute, UCT.

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Children's access to education

Katharine Hall (Children's Institute, University of Cape Town)

Section 29(1)(a) of the South African Constitution¹ states that "everyone has the right to a basic education", and section 29(1)(b) says that "everyone has the right to further education", and that the state must make such education "progressively available and accessible".

Article 11(3)(a) of the African Charter on the Rights and Welfare of the Child² says "States Parties to the present Charter shall take all appropriate measures with a view to achieving the full realisation of this right and shall in particular ... provide free and compulsory basic education".

Article 28 of the UN Convention on the Rights of the Child³ recognises "the right of the child to education" and also obliges the state to "make primary education compulsory and available free to all".

Number and proportion of children attending an educational institution

This indicator reflects the number and proportion of children aged 7 – 17 years who are reported to be attending a school or educational facility. This is different from "enrolment rate", which reflects the number of children enrolled in educational institutions, as reported by schools to the national department early in the school year.

Education is a central socio-economic right that provides the foundation for life-long learning and economic opportunities. Children have a right to basic education and are admitted into grade 1 in the year they turn seven. Basic education is compulsory in grades 1 – 9, or for children aged 7 – 15. Children who have completed basic education also have a right to further education (grades 10 – 12), which the government must take reasonable measures to make available.

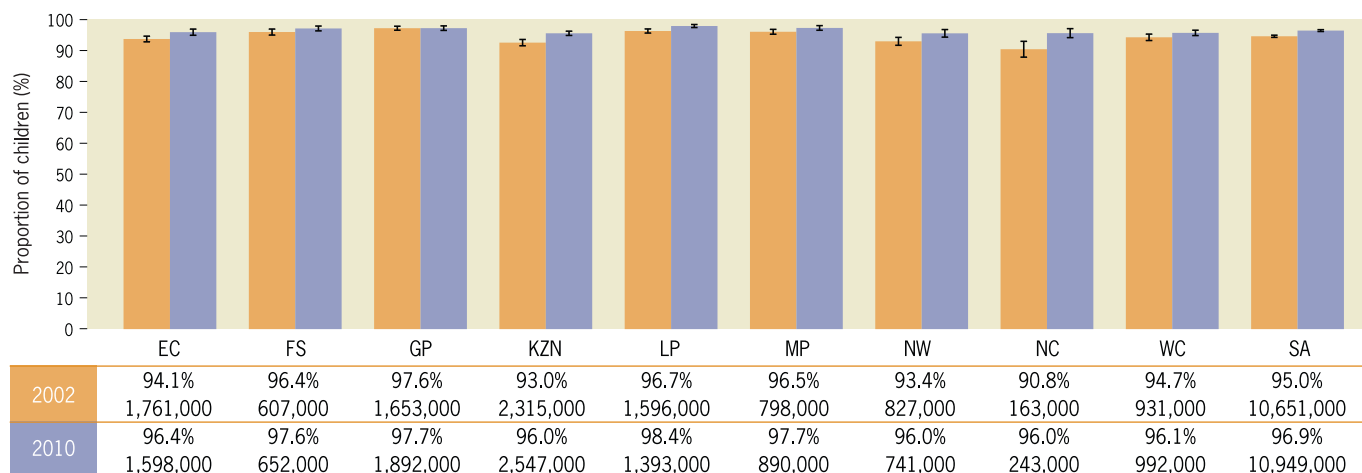
South Africa has high levels of school enrolment and attendance. Amongst children of school-going age (7 – 17 years) the vast majority (97%)

attended some form of educational facility in 2010. Since 2002, the national attendance rate has seen a two percentage point increase. Of a total of 11.3 million children aged 7 – 17 years, just over 350,000 are reported as not attending school in 2010.

At a provincial level, the Eastern Cape, Northern Cape and KwaZulu-Natal have all seen significant increases in attendance rates. In the Northern Cape, attendance increased by five percentage points from 91% in 2002 to 96% in 2010, while attendance in KwaZulu-Natal increased by three percentage points and attendance in the Eastern Cape by two percentage points.

There has been a small but real increase in reported attendance rates for African and Coloured children over the nine-year period from 2002. Attendance rates for Coloured children remain slightly below the national average.

Figure 4a: School-age children attending an educational institution, 2002 & 2010



Sources: Statistics South Africa (2003; 2011) *General Household Survey 2002*; *General Household Survey 2010*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

Overall attendance rates tend to mask the problem of drop-out among older children. Analysis of attendance among discrete age groups shows a significant drop in attendance amongst children older than 14. Whereas 99% of 13-year-olds were reported to be attending an educational institution in 2010, the attendance rate dropped to 98% and 96% for 14- and 15-year-olds respectively. As schooling is compulsory only until the age of 15 or the end of grade 9, the attendance rate decreases more steeply from age 16 onwards, with 93% of 16-year-olds, 86% of 17-year-olds, and 71% of 18-year-olds reported to be attending school.⁴ There is no significant difference in drop-out rates between boys and girls overall. The cost of education is the main reason for non-attendance in the high school age group, followed by a perception that “education is useless”.⁵ Other reasons for drop-out are illness and exam failure. Pregnancy accounts for around 8% of drop-out amongst teenage girls not attending school.⁶

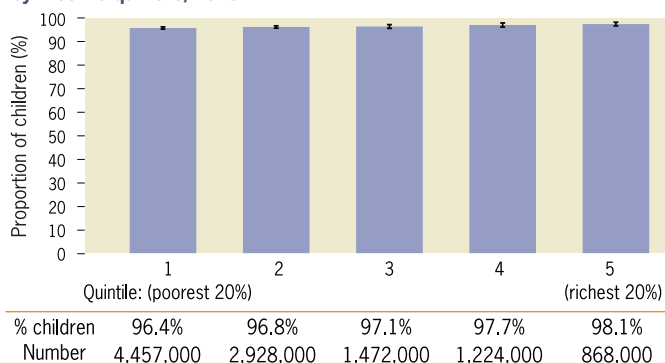
It is encouraging to note that 88% of children (just over 1.9 million) in the pre-school age group (5 – 6-year-olds) were attending some kind of educational institution in 2010, and 77% of children in the younger age group 3 – 4 years were attending an educational institution or ECD facility.⁷

Attendance rates alone do not capture the regularity of children’s school attendance, or their progress through school. Research has shown that children from more “disadvantaged” backgrounds – with limited economic resources, lower levels of parental education, or who have lost one or both parents – are indeed less likely to enrol in school and are more prone to dropping out or progressing more slowly than their more advantaged peers.⁸ Similarly, school attendance rates tell us nothing about the quality of teaching and learning that takes place in school. Systemic evaluations by the Department of Education have

recorded very low pass rates in numeracy and literacy amongst both grade 3 and grade 6 learners,⁹ and continued inequities in the quality of education offered by schools reinforce existing social inequalities, limiting the future work opportunities and life chances of poor children.¹⁰

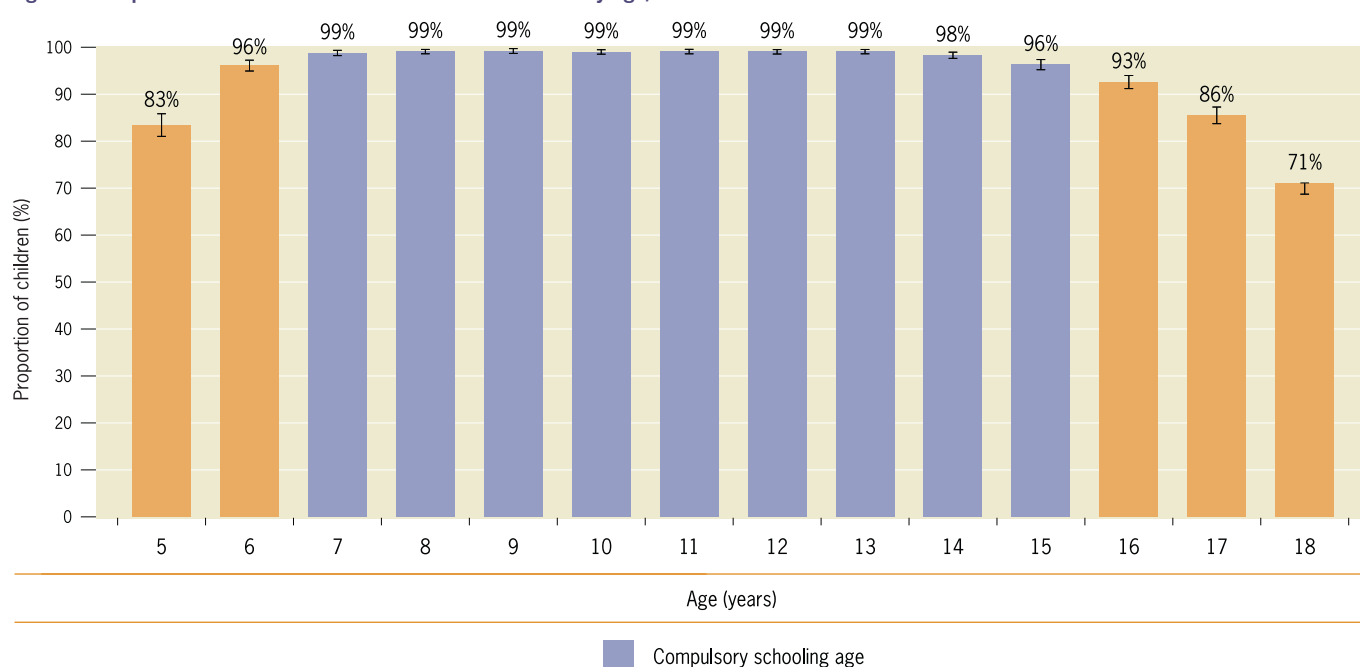
Despite the inequities in the school system, there is little variation in school attendance rates across the income quintiles. Irrespective of whether they live in the poorest or wealthiest 20% of households, children’s school attendance rates remain high – between 96% and 98%.

Figure 4c: Reported attendance at an educational institution, by income quintile, 2010



Source: Statistics South Africa (2011) *General Household Survey 2010*. Pretoria: Stats SA. Analysis by Katharine Hall, Children’s Institute, UCT.

Figure 4b: Reported attendance at an educational institution by age, 2010



Source: Statistics South Africa (2011) *General Household Survey 2010*. Pretoria: Stats SA. Analysis by Katharine Hall, Children’s Institute, UCT.

The number and proportion of children living far from school

This indicator reflects the distance from a child's household to the school s/he attends. Distance is measured through a proxy indicator: length of time travelled to reach the school attended, which is not necessarily the school nearest to the child's household. The school is defined as "far" if a child would have to travel more than 30 minutes to reach it, irrespective of mode of transport. Children aged 7 – 13 are defined as primary school age, and children aged 14 – 17 are defined as secondary school age.

Access to schools and other educational facilities is necessary for achieving the right to education. A school's location and distance from home can be a barrier to education. Access to schools is also hampered by poor roads, unavailable or unaffordable transport, and danger along the way. Risks may be different for young children, for girls and boys, and are likely to be greater when children travel alone.

For children living far from schools, the cost, risk and effort of getting to school can influence decisions about regular attendance and participation in extramural activities and after-school events. Those who travel long distances may wake very early and risk arriving late or physically exhausted, which may affect their ability to learn. Walking long distances to school may also lead to learners being excluded from class or attending school regularly.¹¹

Three-quarters of South Africa's learners walk to school, while 9% use public transport. Around 2% report using school buses or transport provided by the government. The vast majority (80%) of White children are driven to school in private cars, compared with only 7% of Black children.¹² These figures provide a picture of pronounced disparity in child mobility and means of access to school.

The ideal indicator to measure physical access to school would be the distance from the child's household to the nearest school.¹³ This analysis is no longer possible due to question changes in the General Household Survey. Instead, this indicator shows the number and proportion of children who travel far (more than 30 minutes) to reach the actual school that they attend, even if it is not the closest school. School-age children not attending school are therefore excluded from the analysis.

Overall, the vast majority (82%) of the 11.3 million children of school-going age travel less than 30 minutes to reach school, and most learners

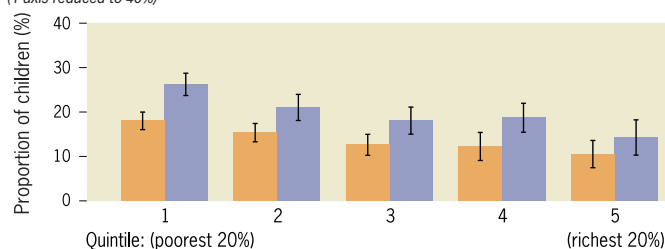
(84%) attend their nearest school. Children of secondary age are more likely than primary school learners to travel far to school. In mid-2010 there were approximately seven million children of primary school age in South Africa. Over a million of these children (16%) travel more than 30 minutes to school every day. Of the 4.2 million children of secondary school age, 22% travel more than 30 minutes to reach school.

Physical access to school remains a problem for many children, particularly those living in more remote areas where public transport is lacking or inadequate and where households are unable to afford private transport.¹⁴ A number of rural schools have closed since 2002, making the situation worse for children in these areas. Nationally, the number of public schools has dropped by 8% (over 2,000 schools) between 2002 and 2010, with the largest decreases in the Free State, North West and Limpopo. Over the same period, the number of independent schools has risen by 21% (239).¹⁵

Children living in the poorest 20% of households are more likely to travel far to school than children living in the richest 20% of households.

Figure 4e: Children living far from school by income quintile, 2010

(Y-axis reduced to 40%)

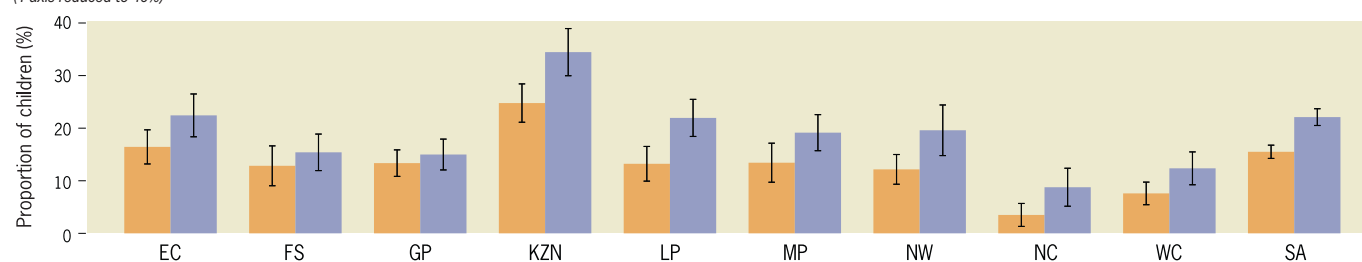


	1 (poorest 20%)	2	3	4	5 (richest 20%)
Primary	18.2%	15.5%	12.7%	12.4%	10.6%
	526,000	299,000	120,000	97,000	57,000
Secondary	26.5%	21.2%	18.2%	18.9%	14.4%
	457,000	231,000	105,000	88,000	50,000

Source: Statistics South Africa (2011) *General Household Survey 2010*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

Figure 4d: Children living far from school, 2010

(Y-axis reduced to 40%)



	EC	FS	GP	KZN	LP	MP	NW	NC	WC	SA
Primary	16.4%	12.8%	13.3%	24.8%	13.2%	13.4%	12.2%	3.5%	7.6%	15.5%
	165,000	55,000	169,000	405,000	110,000	78,000	60,000	6,000	52,000	1,099,000
Secondary	22.4%	15.4%	15.0%	34.4%	21.9%	19.1%	19.6%	8.8%	12.4%	22.1%
	146,000	37,000	101,000	351,000	128,000	63,000	54,000	8,000	43,000	930,000

Source: Statistics South Africa (2011) *General Household Survey 2010*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

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- 2 Secretary General of the Organisation of the African Union (1990) *African Charter on the Rights and Welfare of the Child, OAU resolution 21.8/49*. Addis Ababa: OAU.
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Children's access to housing

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Section 26 of the Constitution of South Africa¹ provides that "everyone has the right to have access to adequate housing", and section 28(1)(c) gives children "the right to ... shelter".

Article 27 of the UN Convention on the Rights of the Child² states that "every child has the right to a standard of living adequate for his/her development" and obliges the state "in cases of need" to "provide material assistance and support programmes, particularly with regard to ... housing".

Distribution of children living in urban and rural areas

This indicator describes the number and proportion of children living in urban or rural areas in South Africa.

Location is one of the seven elements of adequate housing identified by the UN Committee on Economic, Social and Cultural Rights.³ Residential areas should ideally be situated in areas close to work opportunities, clinics, police stations, schools and child-care facilities. In a country with a large rural population, this means that services and facilities need to be well distributed, even in areas which are not densely populated. In South Africa, service provision and resources in rural areas lag far behind urban areas.

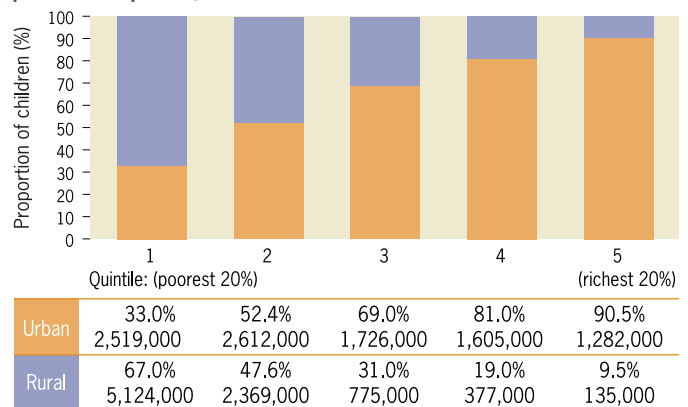
The General Household Survey captures information on all household members, making it possible to look at the distribution of children in urban and non-urban households and compare this to the adult distribution. Nearly half of South Africa's children (47%) lived in rural households in 2010 – equivalent to almost nine million children. Looking back over nearly a decade, there seems to be a slight shift towards urban areas: in 2002, 46% of children were found in urban households, increasing to 53% in 2010. However, this possible trend can only be confirmed when the results of the 2011 Census become available, particularly as type of area is determined by the sample design. All we can say for now is that slightly more children were found to be in sampled urban households in 2010 than in 2002.

What remains consistent over the years is that children are more likely to live in rural areas than adults: 65% of the adult population is urban, compared with only 53% of children. There are marked provincial differences in the rural and urban distribution of the child population. This is related to the distribution of cities in South Africa, and the creation of "homelands" under the apartheid state, which were populated mainly by women, children and older people. The Eastern Cape, KwaZulu-Natal and Limpopo provinces alone are home to about three-quarters (74%) of all rural children in South Africa. KwaZulu-Natal has the largest child population in numeric terms, with 2.7 million children (63%) of its child population being classified as rural. The province with the highest proportion of rural children is Limpopo, where only 10% of children live in urban areas.

Children living in the Western Cape and Gauteng are almost entirely urban-based (94% and 95% respectively). These provinces have historically had large urban populations. The greatest provincial increase in the urban child population has been in the Free State, where the proportion of children living in urban areas increased from 67% of the child population in 2002 to 85% in 2010. In the Eastern Cape, the urban child population has increased by nearly 10 percentage points, signifying a possible urban trend there.

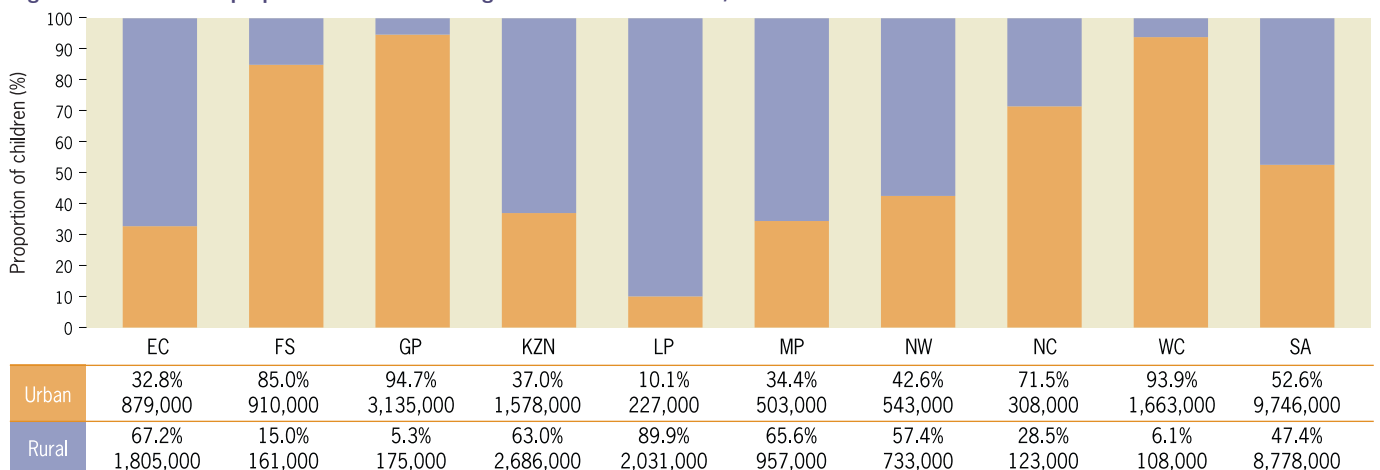
Rural areas, and particularly the former homelands, are known to have much poorer populations. Children in the poorest 20% of households are more likely to be living in rural areas (67%) than those in the richest 20% of households (10%). These inequalities also remain strongly racialised. Over 90% of White, Coloured and Indian children are urban, compared with 46% of African children.

Figure 5b: Number and proportion of children living in urban areas, per income quintile, 2010



Source: Statistics South Africa (2011) *General Household Survey 2010*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

Figure 5a: Number and proportion of children living in rural and urban areas, 2010



Sources: Statistics South Africa (2004; 2011) *General Household Survey 2003; General Household Survey 2010*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

The number and proportion of children living in adequate housing

This indicator shows the number and proportion of children living in formal, informal and traditional housing. For the purposes of the indicator, “formal” housing is considered a proxy for adequate housing and consists of: dwellings or brick structures on separate stands; flats or apartments; town/cluster/semi-detached houses; units in retirement villages; rooms or flatlets on larger properties. “Informal” housing consists of: informal dwellings or shacks in backyards or informal settlements; dwellings or houses/flats/rooms in backyards; caravans or tents. “Traditional dwelling” is defined as a “traditional dwelling/hut/structure made of traditional materials”. These dwelling types are listed in the General Household Survey, which is the data source.

Children’s right to adequate housing means that they should not have to live in informal dwellings. One of the UN Committee on Economic, Social and Cultural Rights’s seven elements of adequate housing is that the housing must be “habitable”.⁴ To be habitable, houses should have enough space to prevent overcrowding, and should be built in a way that ensures physical safety and protection from the weather.

Formal brick houses that meet the state’s standards for quality housing could be considered “habitable housing”, whereas informal dwellings such as shacks in informal settlements and backyards would not be considered habitable or adequate. Informal housing in backyards and informal settlements makes up the bulk of the housing backlog in South Africa. “Traditional” housing in rural areas is a third category, which is not necessarily adequate or inadequate. Some traditional dwellings are more habitable than new subsidy houses – they can be more spacious and better insulated, for example.

Access to services is another element of “adequate housing”. Children living in formal areas are more likely to have services on site than those living in informal or traditional dwellings. They are also more likely to be close to facilities like schools, libraries, clinics and hospitals than those living in informal settlements or rural areas. Children living in informal settlements are also more exposed to hazards such as shack fires and paraffin poisoning. The environmental hazards associated with informal housing are exacerbated for very young children. The distribution of children in informal dwellings is slightly skewed towards younger children and babies: 41% of children in informal housing are in the 0 – 5 year age group.

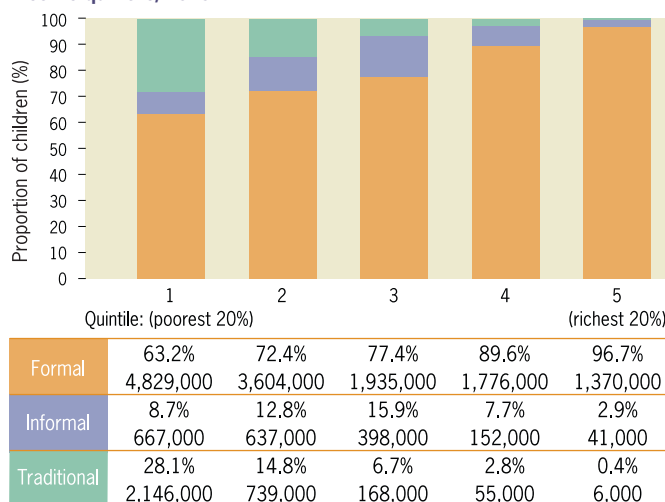
In 2010, nearly 1.9 million children in South Africa lived in backyard dwellings or shacks in informal settlements. The greatest proportions of inadequately-housed children are in the provinces with relatively large metropolitan centres and small rural populations. This is probably associated with urban migration and the growth of informal settlements around urban centres. The main provinces with informally-housed child populations are the Western Cape (where 22% of children live in informal

dwellings), Gauteng (19% of children) and North West (17%). Limpopo has the lowest proportion (2%) of children in informal housing and the highest proportion in formal dwellings. The Eastern Cape and KwaZulu-Natal also have low proportions of children (both around 5%) in informal housing, but also have by far the largest proportions of children living in traditional dwellings (51% and 34% respectively).

The distribution of children in formal, informal and traditional dwellings has remained fairly constant over the nine-year period since 2002. But racial inequalities persist. Almost all White children live in formal housing, compared with only 67% of African children. Access to formal housing increases with income. Virtually all children in the wealthiest 20% of households live in formal dwellings, compared with only 63% of children in the poorest 20% of households.

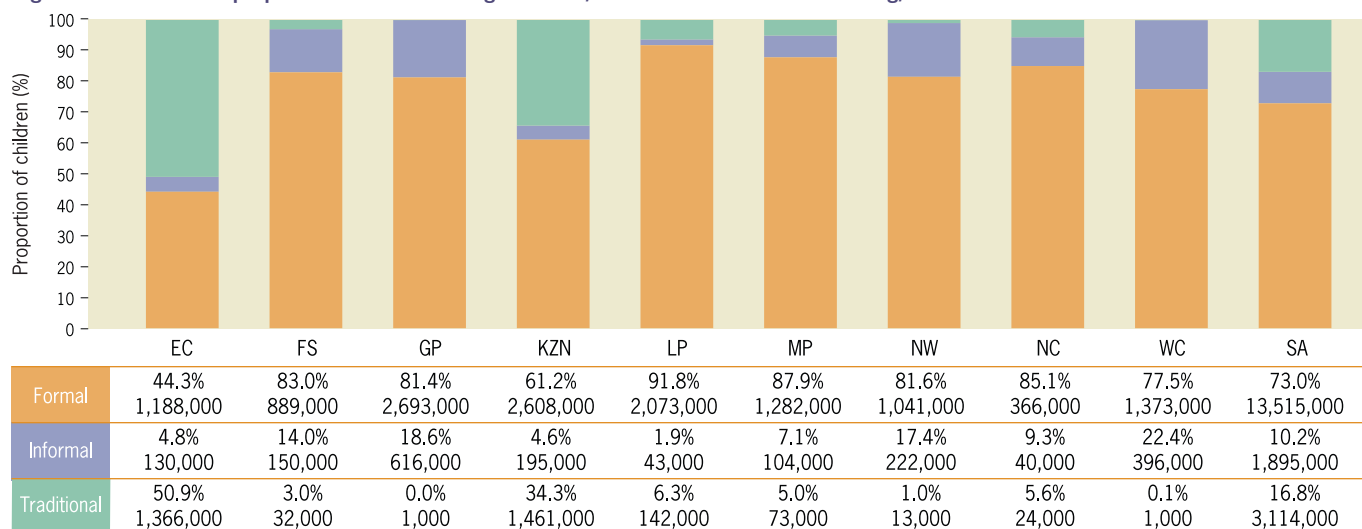
Housing provides the context for family life. In the context of adult mobility and migrant labour many children live apart from their biological parents. Around a quarter of all children in South Africa live apart from their mothers. It is possible that increased delivery and the prioritisation of women in the urban housing process would enable more children to live with one or both parents.

Figure 5d: Children living in formal, informal and traditional housing, by income quintile, 2010



Source: Statistics South Africa (2011) *General Household Survey 2010*. Pretoria: Stats SA. Analysis by Katharine Hall, Children’s Institute, UCT.

Figure 5c: Number and proportion of children living in formal, informal and traditional housing, 2010



Source: Statistics South Africa (2011) *General Household Survey 2010*. Pretoria: Stats SA. Analysis by Katharine Hall, Children’s Institute, UCT.

The number and proportion of children living in overcrowded households

Children are defined as living in overcrowded dwellings when there is a ratio of more than two people per room (excluding bathrooms but including kitchen and living room). Thus, a dwelling with two bedrooms, a kitchen and sitting-room would be counted as overcrowded if there were more than eight household members.

The UN Committee on Economic, Social and Cultural Rights defines “habitability” as one of the criteria for adequate housing.⁵ Overcrowding is a problem because it can undermine children’s needs and rights. For instance, it is difficult for school children to do homework if other household members want to sleep or watch television. Children’s right to privacy can be infringed if they do not have space to wash or change in private. The right to health can be infringed as communicable diseases spread more easily in overcrowded conditions. Overcrowding also places children at greater risk of sexual abuse, especially where boys and girls have to share beds, or children have to sleep with adults.

Overcrowding makes it difficult to target services and programmes to households effectively – for instance, urban households are entitled to six kilolitres of free water, but this household-level allocation discriminates against overcrowded households because it does not take account of household size.

In 2010, 4.3 million children lived in overcrowded households. This represents 23% of the child population – much higher than the proportion of adults living in crowded conditions (14%). Overcrowding is associated with housing type: 57% of children who stay in informal dwellings also live in overcrowded conditions, compared with 32% of children in traditional dwellings and 16% of children in formal housing.

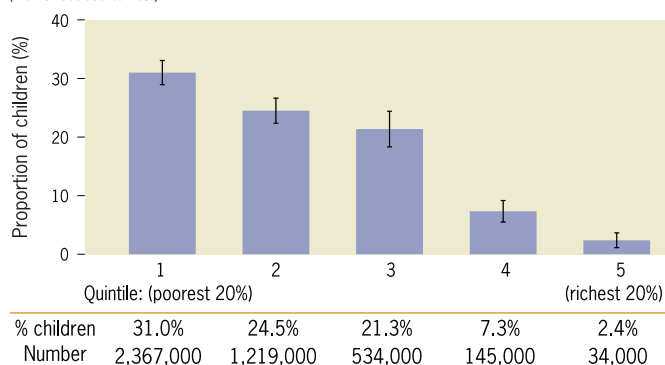
There is a strong racial bias in children’s housing conditions. Coloured children (23%) and African children (25%) are significantly more likely to live in crowded conditions than Indian and White children (5% and 2%

respectively). Children in the poorest 20% of households are more likely to be living in overcrowded conditions (31%) than children in the richest 20% of households (2%).

The average household size has gradually decreased from 4.5 in 1996 to around 3.7 in 2010, indicating a trend towards smaller households, which may in turn be linked to the provision of small subsidy houses. Households in which children live are much larger than the national average. The median household size for adult-only households is two people, while the median for households with children is five members.⁶

Figure 5f: Children living in overcrowded households, by income quintile, 2010

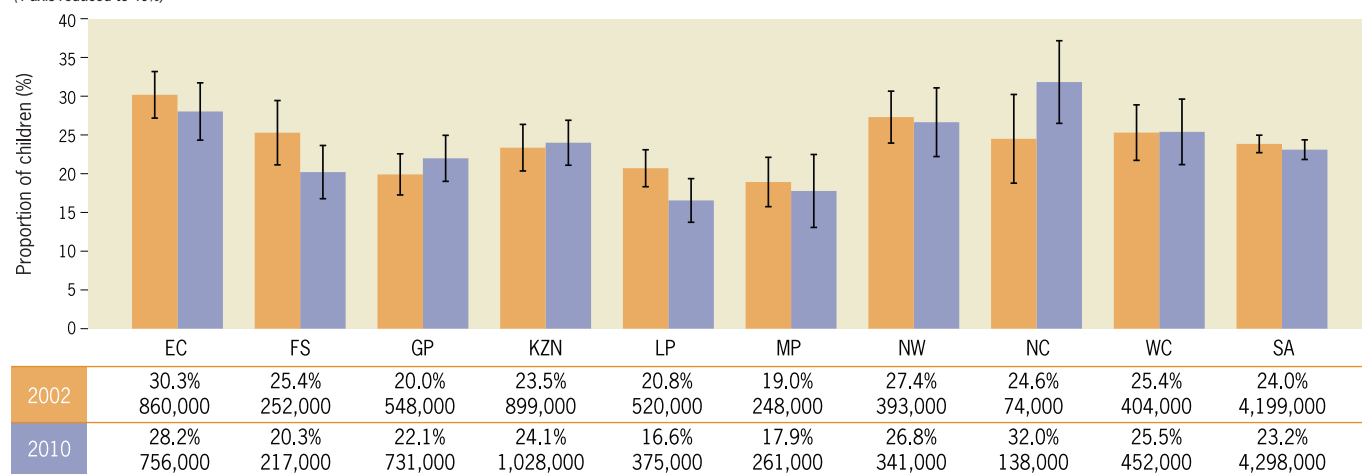
(Y-axis reduced to 40%)



Source: Statistics South Africa (2011) *General Household Survey 2010*. Pretoria: Stats SA. Analysis by Katharine Hall, Children’s Institute, UCT.

Figure 5e: Children living in overcrowded households, 2002 & 2010

(Y-axis reduced to 40%)



Sources: Statistics South Africa (2004; 2011) *General Household Survey 2003; General Household Survey 2010*. Pretoria: Stats SA. Analysis by Katharine Hall, Children’s Institute, UCT.

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Children's access to basic services

Updated by Katharine Hall (Children's Institute, University of Cape Town)

Section 27(1)(b) of the Constitution of South Africa¹ provides that "everyone has the right to have access to ... sufficient ... water" and section 24(a) states that "everyone has the right to an environment that is not harmful to their health or well-being".

Article 14(2)(c) of the African Charter on the Rights and Welfare of the Child² obliges the state to "ensure the provision of ... safe drinking water".

Article 24(1)(c) of the UN Convention on the Rights of the Child³ says that states parties should "recognise the right of the child to the enjoyment of the highest attainable standard of health ..." and to this end should "take appropriate measures to combat disease and malnutrition ..., including the provision of clean drinking-water".

The number and proportion of children living in households with basic water

This indicator shows the number and proportion of children who have access to a safe and reliable supply of drinking water at home – either inside the dwelling or on site. This is used as a proxy for access to adequate water. All other water sources, including public taps, water tankers, dams and rivers, are considered inadequate because of their distance from the dwelling or the possibility that water is of poor quality. The indicator does not show if the water supply is reliable or if households have broken facilities or are unable to pay for services.

Clean water is essential for human survival. The World Health Organisation has defined the minimum quantity of water needed for survival as 20 litres per person per day.⁴ This includes water for drinking, cooking and personal hygiene. This water needs to be supplied close to the home, as households that travel long distances to collect water often struggle to meet their basic daily quota. This can compromise children's health and hygiene.

Young children are particularly vulnerable to diseases associated with poor water quality. Gastro-intestinal infections with associated diarrhoea and dehydration are a significant contributor to the high child mortality rate in South Africa⁵ and intermittent outbreaks of cholera pose a serious threat to children in some provinces. Inadequate access to water is closely related to poor sanitation and hygiene. In addition, children may be responsible for carrying water to their homes from communal taps, or rivers and streams, which is a physical burden and can place them at risk.

It is of concern that nearly seven million children live in households without access to clean drinking water on site. In 2010, nearly three-quarters (74%) of adults lived in households with drinking water on site – compared to only 64% of children. There has been little improvement in children's access to water from 2002 to 2010.

Provincial differences are striking. Over 90% of children in the Free State, Gauteng and the Western Cape provinces have an adequate supply of drinking water. However, access to water remains poor in KwaZulu-Natal (49%), Limpopo (45%) and the Eastern Cape (34%). The Eastern Cape appears to have experienced the greatest improvement in water

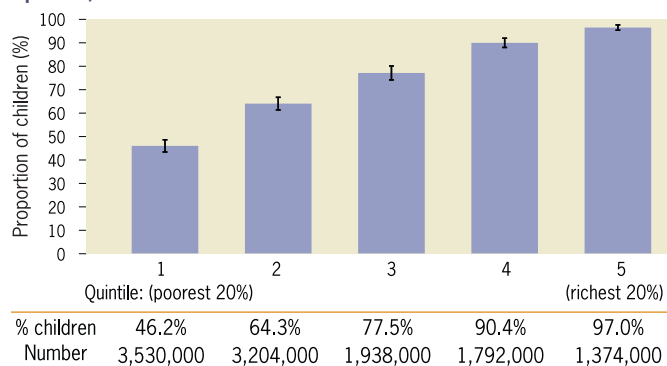
provisioning since 2002 (when only 25% of children had water on site).

Children living in formal areas are more likely to have services on site than those living in informal or traditional dwellings. While the majority of children in formal dwellings (75%) and informal dwellings (67%) had water at home in 2010, only 17% of children living in "traditional" housing had clean water available on the property.

The vast majority of children living in "traditional" dwellings are African, and so we see pronounced racial inequality in access to water. Just 58% of African children had clean water on site in 2010, while over 95% of all other population groups had clean drinking water at home.

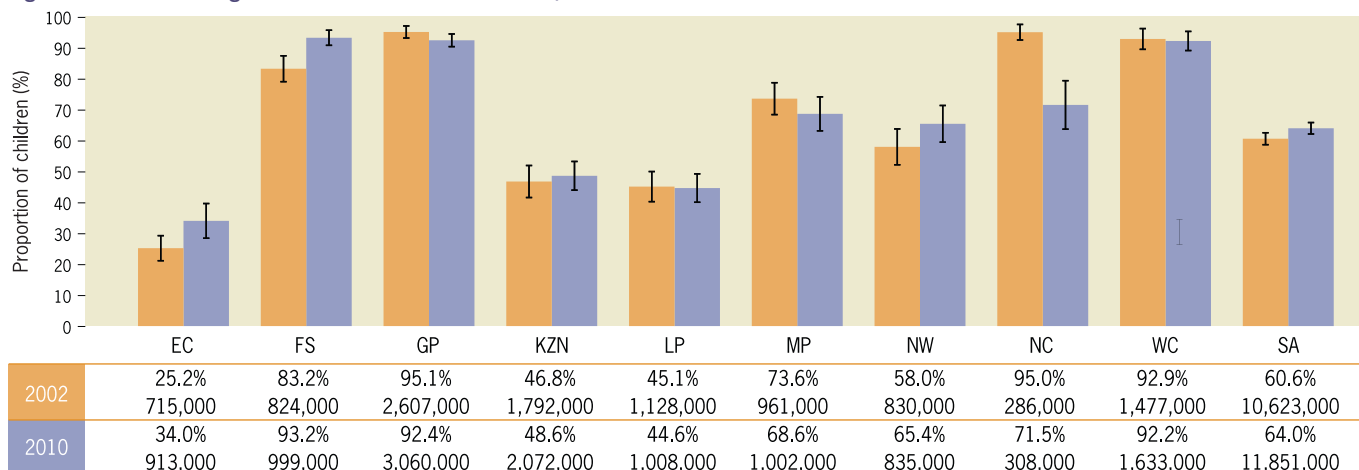
There are also stark income inequalities. Amongst children in the poorest 20% of households, less than half (46%) have access to water on site, while over 90% of those in the richest 20% of households have this level of service. In this way, inequalities are reinforced: the poorest children are most at risk of diseases associated with poor water quality,

Figure 6b: Children living in households with water on site, by income quintile, 2010



Source: Statistics South Africa (2011) *General Household Survey 2010*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

Figure 6a: Children living in households with water on site, 2002 & 2010



Sources: Statistics South Africa (2003; 2011) *General Household Survey 2002; General Household Survey 2010*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

The number and proportion of children living in households with basic sanitation

This indicator includes the number and proportion of children living in households with basic sanitation. Adequate toilet facilities are used as proxy for basic sanitation. This includes flush toilets and ventilated pit latrines that dispose of waste safely and that are within or near a house. Inadequate toilet facilities include pit latrines that are not ventilated, chemical toilets, bucket toilets, or no toilet facility at all.

A basic sanitation facility is defined in the government's *Strategic Framework for Water Services* as the infrastructure necessary to provide a sanitation facility which is "safe, reliable, private, protected from the weather and ventilated, keeps smells to a minimum, is easy to keep clean, minimises the risk of the spread of sanitation-related diseases by facilitating the appropriate control of disease carrying flies and pests, and enables safe and appropriate treatment and/or removal of human waste and wastewater in an environmentally sound manner".⁶

Sanitation aims to prevent the spread of disease and promotes health through safe and hygienic waste disposal. To do this, sanitation systems must break the cycle of disease. For example the toilet lid and fly screen in a ventilated pit latrine stop flies reaching human faeces and spreading disease. Good sanitation is not simply about access to a particular type of toilet. It is equally dependent on the safe use and maintenance of that technology; otherwise toilets break down, smell bad, attract insects and spread germs.

Good sanitation is essential for safe and healthy childhoods. It is very difficult to maintain good hygiene without water and toilets. Poor sanitation is associated with diarrhoea, cholera, malaria, bilharzia, worm infestations, eye infections and skin disease. These illnesses compromise children's nutritional status. Using public toilets and the open *veld* (fields) can also put children in physical danger. The use of the open *veld* and bucket toilets is also likely to have consequences for water quality in the area and to contribute to the spread of disease. Poor sanitation undermines children's health, safety and dignity.

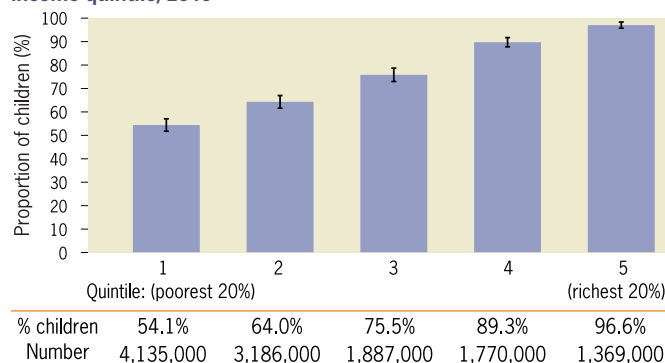
The data show a gradual and significant improvement in children's access to sanitation over the period 2002 to 2010, although the proportion of children without adequate toilet facilities remains worryingly high. In 2002 less than half of all children (47%) had access to adequate sanitation. Children (33%) are more likely than adults (26%) to live in households without adequate sanitation facilities. By 2010 the proportion of children with adequate toilets had risen to 67%. Over six million children still use unventilated pit latrines, buckets or open land, despite the state's reiterated goals to provide adequate sanitation to all, and to eradicate the bucket system.

As with other indicators of living environments, there are great provincial disparities. In provinces with large metropolitan populations, like Gauteng and the Western Cape, over 90% of children have access to adequate sanitation, while provinces with large rural populations have the poorest sanitation. The provinces with the greatest improvements in sanitation services are the Eastern Cape (where the number of children with access to adequate sanitation increased by nearly 150% in nine years), KwaZulu-Natal (increased from 36% of children in 2002 to 61% in 2010) and the Free State (improved from 55% in 2002 to 79% in 2010).

Although there have also been significant improvements in sanitation provision in Limpopo, this province still lags behind, with only 38% of children living in households with adequate sanitation in 2010. It is unclear why the vast majority of children in Limpopo are reported to live in formal houses, yet access to basic sanitation is the poorest of all the provinces. Definitions of adequate housing such as those in the UN-HABITAT and South Africa's National Housing Code include a minimum quality for basic services, including sanitation.

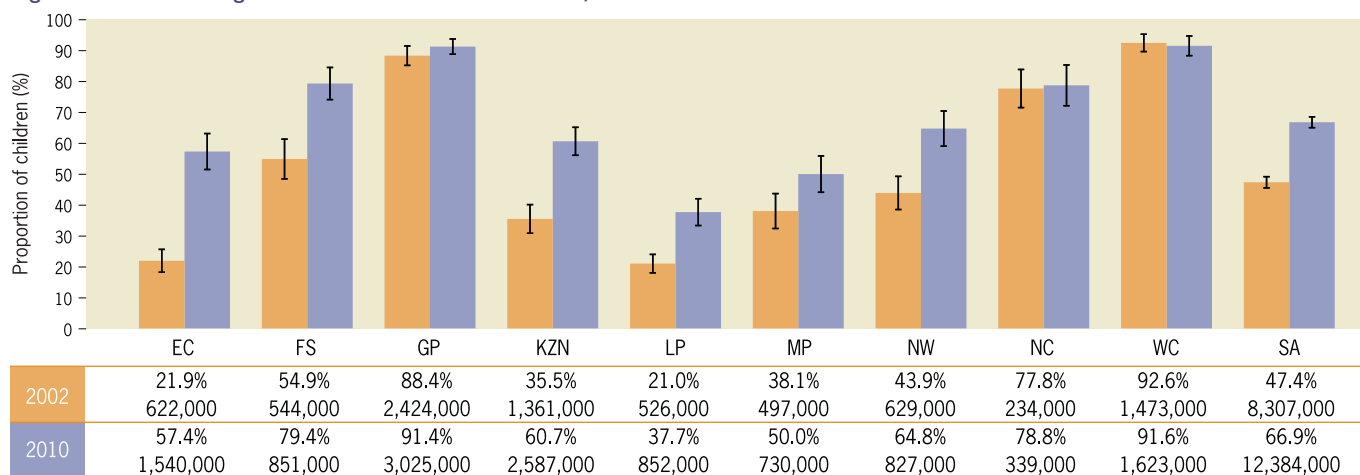
The statistics on basic sanitation provide yet another example of persistent racial inequality: over 95% of Indian, White and Coloured children had access to adequate toilets in 2010, while only 61% of African children had access to basic sanitation. This is a marked improvement from 38% of African children in 2002.

Figure 6d: Children living in households with basic sanitation, by income quintile, 2010



Source: Statistics South Africa (2011) *General Household Survey 2010*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

Figure 6c: Children living in households with basic sanitation, 2002 & 2010



Sources: Statistics South Africa (2003; 2011) *General Household Survey 2002; General Household Survey 2010*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

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Technical notes on the data sources

General Household Survey¹

The GHS is a multi-purpose annual survey conducted by the national statistical agency, Statistics South Africa (Stats SA), to collect information on a range of topics from households in the country's nine provinces. The survey uses a sample of 30,000 households. These are drawn from Census enumeration areas using a two-stage stratified design with probability proportional to size sampling of primary sampling units (PSUs) and systematic sampling of dwelling units from the sampled PSUs. The resulting weighted estimates are representative of all households in South Africa.

The GHS sample consists of households and does not cover other collective institutionalised living-quarters such as boarding schools, orphanages, students' hostels, old-age homes, hospitals, prisons, military barracks and workers' hostels. These exclusions should not have a noticeable impact on the findings in respect of children.

Changes in sample frame and stratification

The sample design for the GHS 2010 was based on a master sample that was originally designed for the Quarterly Labour Force Survey (QLFS) and was used for the GHS for the first time in 2008. The same master sample is shared by the GHS, the QLFS, the Living Conditions Survey and the Income and Expenditure Survey. The previous master sample for the GHS was used for the first time in 2004. This again differed from the master sample used in the first two years of the GHS: 2002 and 2003. Thus there have been three different sampling frames during the nine-year history of the annual GHS, with the changes occurring in 2004 and 2008. In addition, there have been changes in the method of stratification over the years. These changes could compromise comparability across iterations of the survey to some extent, although it is common practice to use the GHS for longitudinal monitoring and many of the official trend analyses are drawn from this survey.

Provincial boundary changes

Provincial boundary changes occurred between 2002 and 2007, and slightly affect the provincial populations. The sample and reporting are based on the old provincial boundaries as defined in 2001 and do not represent the new boundaries as defined in December 2005.

Weights

Person and household weights are provided by Stats SA and are applied in *Children Count – Abantwana Babalulekile* analyses to give estimates at the provincial and national levels.

Survey data are prone to sampling and reporting error. Some of the errors are difficult to estimate, while others can be identified. One way of checking for errors is by comparing the survey results with trusted estimates from elsewhere. Such a comparison can give an estimate of the robustness of the survey estimates. The GHS weights are derived from Stats SA's mid-year population estimates. For this project, weighted GHS population numbers were compared with population projections from the Actuarial Society of South Africa's ASSA2008 AIDS and Demographic model (full version), which is regarded as a "gold standard" for population estimates.

Analyses of the nine surveys from 2002 to 2010 suggest that over- and under-estimation may have occurred in the weighting process:

- When comparing the weighted 2002 data with the ASSA2008 AIDS and Demographic model estimates, it seems that the number of children was under-estimated by 5% overall. The most severe under-estimation is in the youngest age group (0 – 9 years) where the weighted numbers of boys and girls yield under-estimations of 15% and 16% respectively. The next age group (5 – 9 years) is also under-estimated for both boys and girls, at around 7% each. The difference is reduced in the 10 – 14-year age group, although boys are still under-estimated by around 1% and girls by 3%. In contrast, the weighted data yield over-estimates of boys and girls in the upper age group (15 – 17 years), with the GHS over-counting these children by about 5%. The pattern is consistent for both sexes, resulting in fairly equal male-to-female ratios of 1.02, 1.01, 1.03 and 1.01 for the four age groups respectively.
- Similarly in 2003, there was considerable under-estimation of the youngest age groups (0 – 4 years and 5 – 9 years) and over-estimation of the oldest age group (15 – 17 years). The pattern is consistent for both sexes. Children in the youngest age group are under-estimated by as much as 16%, with under-estimates for babies below two years in the range 19 – 30%. The results also show that the over-estimation of males in the 15 – 17-year age group (9%) is much more severe than the over-estimation for females in this age range (1.4%), resulting in a male-to-female ratio of 1.09 in this age group, compared with ratios around 1.02 in the younger age groups.
- In the 2004 results, all child age groups seem to have been under-estimated, with the under-estimate being more severe in the upper age group (15 – 17 years). This is the result of severe under-estimation in the number of girls, which outweighs the slight over-estimation of boys in all age groups. Girls are under-estimated by around 6%, 8%, 8% and 12% respectively for the four age bands, while over-estimation in the boys' age bands is in the range of 2 – 3%, with considerable variation in the individual years. This results in male-to-female ratios of 1.10, 1.11, 1.12 and 1.14 for the four age groups.
- In 2005, the GHS weights seem to have produced an over-estimate of the number of males and an under-estimate of the number of females within each five-year age group. The extent of under-estimation for girls (by 7% overall) exceeds that of the over-estimation for boys (at 2% overall). These patterns result in male-to-female ratios of 1.06, 1.13, 1.10 and 1.13 respectively for the four age groups covering children.
- The 2006 weighting process yields different patterns from other years when compared to population estimates for the same year derived from ASSA2008, in that it yielded an under-estimation of both females and males. The under-estimation of females is greatest in the 0 – 4 and 5 – 9-year age groups, while the under-estimation of males is in the range 3 – 10% in the 5 – 9 age group and 1 – 6% in the 10 – 14-year age group. This results in male-to-female ratios of 1.09, 0.99, 0.96 and 1.00 respectively for the four age groups covering children.
- The 2007 weighting process produced an over-estimation for boys and an under-estimation for girls. The under-estimation of females is in the range of 4 – 8% while the over-estimation for boys is in the range of 1 – 5%. This results in male-to-female ratios of 1.07, 1.06, 1.08 and 1.06 respectively for the four age groups covering children.

- In 2008, the GHS weighted population numbers when compared with ASSA2008 over-estimated the number of boys aged 10 and over, in the range of 3% for the 10 – 14 age group, and 8% for the 15 – 17 age group. The total weighted number of girls is similar to the ASSA population estimate for girls, but this belies an under-estimate of female babies below two years (by 7 – 8%), and an over-estimate of young teenage girls. The GHS 2008 suggests a male-to-female ratio of 1.03 for children aged 0 – 4 years, which is higher than that of the ASSA2008 model.
- A comparison of the GHS and ASSA for 2009 suggests a continuation of the general pattern from previous years, which is that GHS weights result in an under-estimation of children in the 0 – 4 age group (especially infants), and an over-estimate of older children. In 2009 the under-estimation in the 0 – 4 age group ranges up to 4% for boys and 5% for girls. In the 15 – 17 age group, the GHS-weighted data produce population numbers that are 7% higher than ASSA for boys, and 3% higher for girls. The male-to-female ratios in 2009 are in keeping with those in ASSA2008, with the exception of the 15 – 17 age group where the GHS-derived ratio is higher, at 1.08, compared to 1.00 in ASSA.
- In 2010, the GHS weights again produce an underestimation of children in the 0 – 4 age group and an over-estimate of children aged 15 – 17 years. For the middle age groups, and for the child age group as a whole, there is less than 1% difference in the estimates from the two sources. For the 0 – 4 age group the under-estimate is lower than previously, at 2%, but for the oldest age group there is an over-estimate of 5%. The male-to-female ratios are similar across the two sources, although the ratio is 1.00 for all but the 0 – 4 age group in ASSA as against 1.01 for the youngest age group in ASSA and for all age groups in the GHS.

The apparent discrepancies in the nine years of data may slightly affect the accuracy of the *Children Count – Abantwana Babalulekile* estimates. From 2005 to 2008, consistently distorted male-to-female ratios means that the total estimates for certain characteristics would be somewhat slanted toward the male pattern. This effect is reduced in 2009, where more even ratios are produced, in line with the modelled estimates. A similar slanting will occur where the pattern for 10 – 14-year-olds, for example, differs from that of other age groups. Furthermore, there are likely to be different patterns across population groups.

Disaggregation

Stats SA suggests caution when attempting to interpret data generated at low level disaggregation. The population estimates are benchmarked at the national level in terms of age, sex and population group while, at provincial level, benchmarking is by population group only. This could mean that estimates derived from any further disaggregation of the provincial data below the population group may not be robust enough.

Reporting error

Error may be present due to the methodology used, ie the questionnaire is administered to only one respondent in the household who is expected to provide information about all other members of the household. Not all respondents will have accurate information about all children in the household. In instances where the respondent did not or could not provide an answer, this was recorded as “unspecified” (no response) or “don’t know” (the respondent stated that they didn’t know the answer).

Labour Force Survey (LFS) and Quarterly Labour Force Survey (QLFS)²

The LFS and its recent replacement, the QLFS, are nationally representative surveys conducted by the national statistics agency Statistics South Africa to provide population data on labour market participation. The LFS was a bi-annual survey, conducted in March and September each year from 2000 to 2007. This was replaced in 2008 by the QLFS, which is conducted four times a year.

The sample frame is designed as a general purpose household survey frame and is used by a range of other surveys including the General Household Survey (GHS), the Living Conditions Survey and the Income and Expenditure Survey. The sample covers the non-institutional population (ie private dwellings only) with the exception that it also includes workers’ hostels. The sample size is roughly 30,000 dwellings, yielding individual data on approximately 100,000 resident individuals.

The sample is drawn from Census enumeration areas using a stratified two-stage design with probability proportional to size sampling of primary sampling units (PSUs) and systematic sampling of dwelling units from the sampled PSUs. The resulting weighted estimates are representative of all households in South Africa, and are designed to be representative at provincial level and within provinces at the metro/non-metro level.

The QLFS uses a rotating sample in which the 3,080 selected PSUs are divided into four rotation groups, from which dwellings are selected. Each sampled dwelling remains in the sample for four consecutive quarters. Rotation is phased so that, at the end of each quarter, one quarter of the sample dwellings are rotated out of the sample and replaced by new dwellings.

In calculating the number and proportion of children living in households with no employed members, *Children Count – Abantwana Babalulekile* in 2009 shifted from using the GHS to using the LFS and the newer QLFS. The labour force-oriented surveys provide a more accurate depiction of employment in South Africa than the GHS, and the derived results are comparable with other analyses such as the government’s Development Indicators.

Calculations for each year were backdated to 2003 using the LFS September data for the years 2003 to 2007 and the QLFS 3rd quarter data for 2008. Calculations for 2009 and 2010 are similarly based on 3rd quarter data. Due to the change in survey used, the rates of children living in unemployed households provided in 2009 and later editions are not directly comparable to rates in previous calculations of the *Children Count – Abantwana Babalulekile* project (which drew on data from the GHS).

For more information about the design and limitations of the Labour Force Surveys, see the discussion on the GHS above, and the metadata for the LFS and QLFS, available online.

SOCPEN database³

Information on social grants is derived from the Social Pensions (SOCPEN) national database maintained by the South African Social Security Agency (SASSA), which was established in 2004 to disburse social grants for the Department of Social Development. Prior to this, the administration of social grants and maintenance of the SOCPEN database was managed directly by the department and its provincial counterparts.

There has never been a published, systematic review of the social grants database, and the limitations in terms of validity or reliability of the data have not been quantified. However, this database is regularly used by the department and other government bodies to monitor

grant take-up, and the computerised system, which records every application and grant payment, minimises the possibility of human error. Take-up data and selected reports are available from the department on request throughout the year. *Children Count – Abantwana Babalulekile* reports the mid-year grant take-up figures for the sake of consistency with the General Household Survey, which is conducted in June/July each year.

ASSA2008 AIDS and Demographic model⁴

The ASSA2008 suite of demographic models produces time series data on population and HIV-related indicators nationally and by province, population group, sex and age. The models use empirical evidence from surveys and administrative datasets as well as a series of demographic, epidemiological and behavioural assumptions as input. The underlying parameters and assumptions are well accepted and thus the models have been regarded as the “gold standard” in HIV and AIDS, mortality and population projections in South Africa.

ASSA2008, released in March 2010, is the most recent version of the model. It is similar to the previous version, ASSA2003, but has been recalibrated and incorporates some important changes to the underlying assumptions. These include taking into account the slower than anticipated pace of roll out of the Prevention of Mother-To-Child Transmission (PMTCT) programme, allowing for separate antiretroviral treatment (ART) roll-out rates for men, women and children and for higher rates of retention on ART, changes in the way condom usage is modelled and adjusting HIV-survival rates, leading to a longer mean survival time, and even allowing for some infected children to reach adulthood. These changes address some of the limitations of ASSA-2003, amongst which were a tendency to under-estimate paediatric HIV prevalence and survival.⁵ The model “represents the triangulation of data from the population census, antenatal survey and registered deaths by some of the country’s top actuaries, demographers and epidemiologists”.⁶

The ASSA2008 model is available in both a *lite* and *full* version. The *Children Count – Abantwana Babalulekile* analyses have been derived from the full version.

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About the contributors

Lizette Berry holds an MA in social policy and management. She has more than 10 years' experience in child policy research and previously worked as a social worker. Her main areas of research have been child poverty and social grant systems. Lizette has an interest in the care and development of children and recently contributed to a Southern Africa Development Community policy framework that promotes learner care and support. She also co-authored a legal guide on the Children's Act for early childhood development practitioners, and contributed to research on the government's funding of ECD, and to the Department of Social Development's draft White Paper on Families.

Sanjana Bhardwaj is the Prevention of Mother-To-Child Transmission and paediatric HIV specialist at UNICEF South Africa. She has worked for over 18 years in the area of public health and HIV and AIDS in different parts of the world, including India, the USA, the Caribbean and Papua New Guinea. She has worked as a clinician, researcher, trainer and programme manager. Sanjana has extensive experience in evidence-based policy development and would like to continue contributing, influencing and learning more about the science of implementation for public health programmes in different contexts.

Linda Biersteker is head of research at the Early Learning Resource Unit. She has done extensive research towards developing policy, programming and training strategies for the early childhood development sector. Her current research includes a focus on a local knowledge approach to ECD programming, exploring models for scaling up integrated quality services for vulnerable young children and their families, and career-pathing and qualifications for ECD practitioners.

Nicola Branson is a post-doctoral research fellow at the Southern Africa Labour and Development Research Unit at the University of Cape Town. She holds a PhD in economics and engages in quantitative research using South African survey data. Her current topics of interest include education inequality, the links between education and the labour market and the intergenerational consequence of teenage childbearing.

Debbie Budlender is an independent research consultant. She was employed as a specialist researcher with the Community Agency for Social Enquiry (CASE), a non-governmental organisation working in the area of social policy research, from 1998 to June 2012. She continues to work on social policy issues, with a special interest in government budgets, statistics, gender, labour and children.

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Katharine Hall is a senior researcher at the Children's Institute, University of Cape Town. Her work focuses on the targeting of government services and poverty alleviation programmes for children. She has a Masters in sociology and leads *Children Count – Abantwana Babalulekile*, an ongoing data and advocacy project of the Institute, established in 2005 to monitor progress for children.

Lucy Jamieson is the senior advocacy co-ordinator at the Children's Institute, University of Cape Town. She has a BA (Hons) in politics and is busy completing an MA in democratic governance. She has 17 years of experience in political campaign management, communications co-ordination and public consultation.

Lori Lake is commissioning editor at the Children's Institute, University of Cape Town, and has spent over 16 years developing educational support materials for government and civil society. She has worked extensively in the fields of health promotion, child protection, and early childhood development and takes pleasure in finding creative ways to make complex ideas accessible to a wider audience.

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Trevor Manuel has been a government minister for the past 18 years, 13 of them as Finance Minister. He is currently Minister in the Presidency: National Planning Commission. He was an activist and anti-apartheid leader, serving on the National Executive Committee of the United Democratic Front, a mass movement of anti-apartheid organisations. Prior to taking a position in the first democratic government, he headed the Department of Economic Planning set up by the African National Congress, and has since served four terms on the ANC's National Executive Committee. He has served on several national and international bodies, and has received a number of awards including Africa's Finance Minister of the Year and the Woodrow Wilson Public Service award.

Helen Meintjes is a senior researcher at the Children's Institute at the University of Cape Town. Her research at the Institute to date has focused primarily on the nature and provision of formal and informal care for children in the context of the AIDS pandemic in South Africa. She is one of the founders of the *Abaqophi BakwaZisize Abakhanyayo*

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Mastoera Sadan works in the National Planning Commission in the Presidency where she manages the Programme to Support Pro-poor Policy Development which focuses on poverty and inequality. The PSPPD aims to increase the use of research and other evidence in the policy process. Mastoera in addition manages the National Income

Dynamics Survey, South Africa's first national panel study. She has a particular interest in child poverty and inequality.

David Sanders, emeritus professor and founding director of the School of Public Health at the University of the Western Cape, is a paediatrician qualified in public health. He has over 30 years experience of health policy development, research and teaching in Zimbabwe and South Africa, having advised governments and United Nations agencies in primary health care, child health and nutrition. He has over 100 peer-reviewed articles, including three books, and was Heath Clark lecturer at the London School of Hygiene and Tropical Medicine in 2004/05 and on the Steering Committee of the UN Standing Committee on Nutrition 2002 – 2006. He is on the Global Steering Council of the People's Health Movement.

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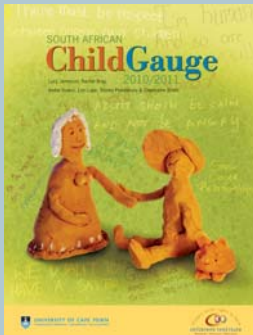
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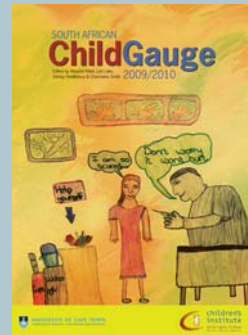
Tia Linda Zuze is a senior lecturer in economics at the Wits Business School, University of the Witwatersrand. She is an affiliate of the Southern Africa Labour and Development Research Unit where she has researched transitions into the labour market for young South Africans. Her research interests include poverty and inequality, youth unemployment, education economics and comparative studies of education.

Previous issues of the *South African Child Gauge*™



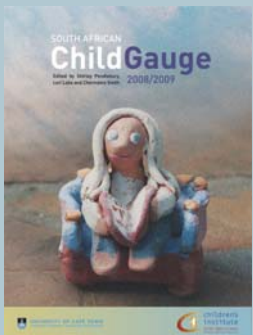
2010/2011: Children as citizens: Participating in social dialogue

The essays in this issue show how children's participation in health, schools, government and the media can improve service delivery, strengthen democracy and contribute to children's optimal development. The book is accompanied by a double-sided poster on children's participation, and a plain language summary suitable for children.



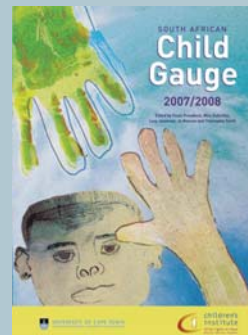
2009/2010: Healthy children: from survival to optimal development

This issue focuses on children's health rights; the status of child health in South Africa; HIV and tuberculosis; malnutrition; mental health and risk behaviour; basic health care services, building capacity and managing resources; community-based health care; child- and family-friendly services; the social determinants of health; and the Minister of Health's vision for child health. It includes a poster-map on child health indicators.



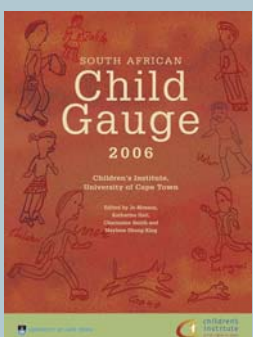
2008/2009: Meaningful access to basic education

Essays focus on the right to education; meaningful access; budgetary frameworks; school-fee waivers; children who are out of school; the relationship between poverty and exclusion; partnerships between schools and communities; and what is required to build a strong foundation in numeracy and literacy. It includes a pull-out poster-map of national and provincial education provisions and outcomes.



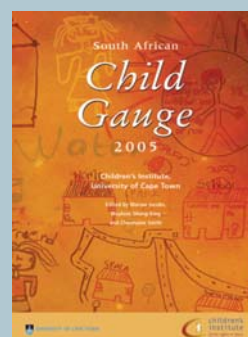
2007/2008: Children's constitutional right to social services

Within the context of a developmental social welfare system, the essays describe and analyse the law and policies that aim to give effect to children's right to social services, and explore and make recommendations on key budgetary, human resource and implementation challenges related to the Children's Act.



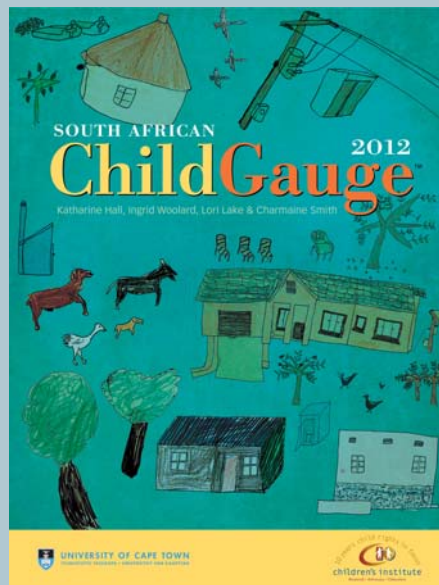
2006: Children and poverty

This issue reviews barriers to key poverty alleviation programmes that benefit children, including access to social assistance, education, primary health care, housing and water. It contains a pull-out poster-map that provides provincial data on a few key child-centred socio-economic indicators.



2005: Children and HIV/AIDS

The essays discuss antiretroviral roll-out to children, social security for children in a time of AIDS, schools as nodes of care and support for children affected by HIV/AIDS, and children's participation in law-making processes.



The *South African Child Gauge*™ 2012 is accompanied by a pull-out poster on children and inequality, a plain language summary, and a policy brief.

All issues of the *South African Child Gauge*™ are available for download at www.ci.org.za.

Paper copies can be ordered online, or by calling +27 (0)21 689 5404 or e-mailing info@ci.org.za.



The Children's Institute, University of Cape Town, has been publishing the *South African Child Gauge*TM every year since 2005 to track progress towards the realisation of children's rights.

This 2012 issue is seventh in the series and focuses on children and inequality. It also discusses recent legislative developments affecting children, and provides child-centred data on children's access to social assistance, education, health care, housing and basic services.

The Children's Institute aims to contribute to policies, laws and interventions that promote equality, and improve the conditions of all children in South Africa, through research, advocacy, education and technical support.

What readers say about the *South African Child Gauge*:

"The most important investment that we can make as a country is to invest in the well-being and development of our children so that they can go on to lead healthy and active lives. The *South African Child Gauge* makes an important contribution to the debate on how we can best achieve this objective."

Trevor Manuel, Minister in the Presidency: National Planning Commission

"[T]he *South African Child Gauge* is the only publication in South Africa that combines detailed empirical data ... in a user-friendly and accessible format, with insightful and thought-provoking research and commentary in the sphere of children's rights."

Belinda van Heerden, Supreme Court judge

"The *South African Child Gauge* is a tremendous resource. What is most useful is the data and the information that it provides. It helps us with lobbying, it helps us with our advocacy work, and it generally informs both practitioners and the public about the situation of children in the country.

Eric Atmore, Centre for Early Childhood Development/Department of Social Development, University of Cape Town

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ISBN: 978-0-7992-2489-4



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