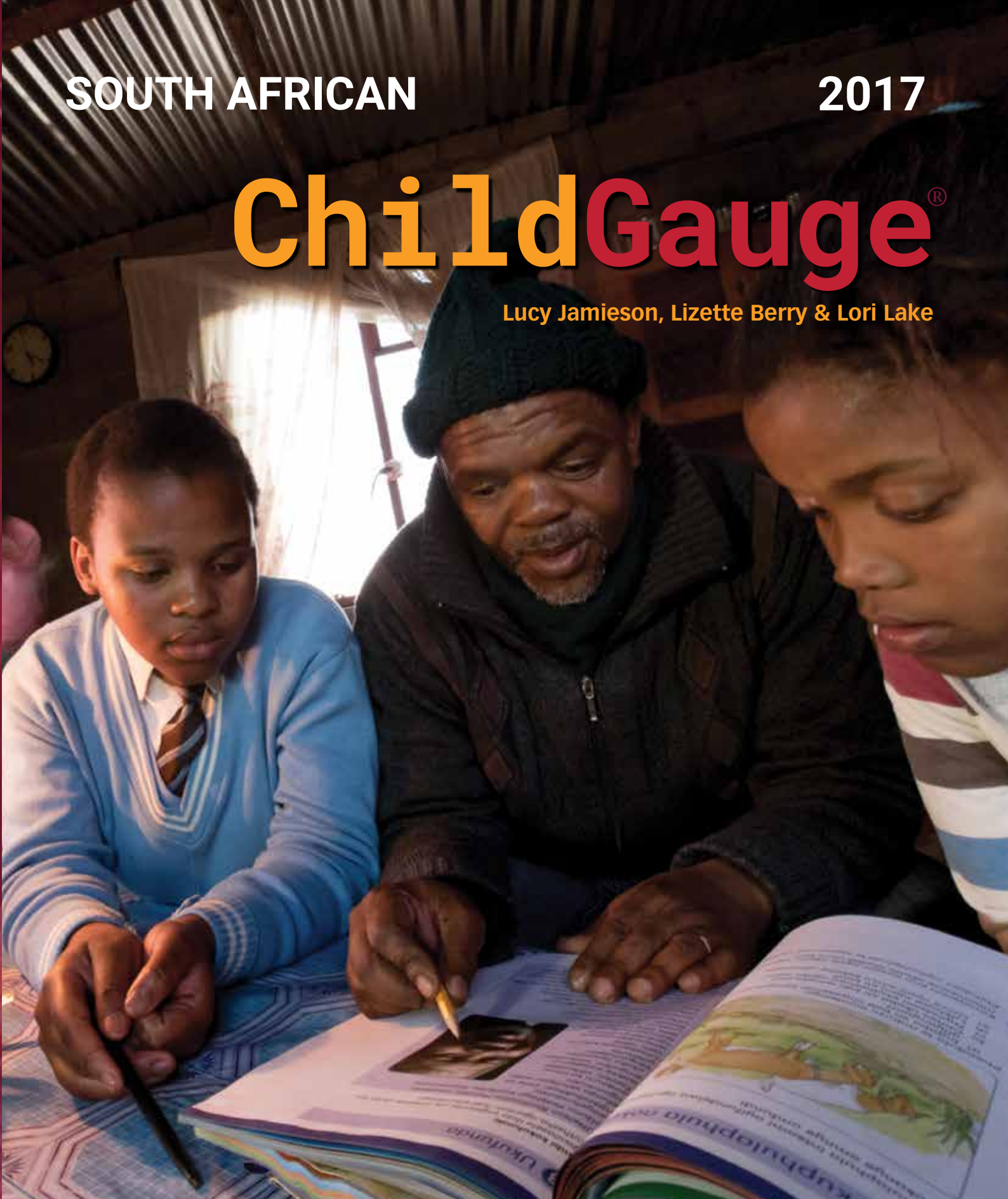


SOUTH AFRICAN

2017

ChildGauge[®]

Lucy Jamieson, Lizette Berry & Lori Lake



UNIVERSITY OF CAPE TOWN
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Broad overview of the South African Child Gauge 2017

The *South African Child Gauge*[®] is published annually by the Children's Institute, University of Cape Town, to monitor progress towards realising children's rights. This issue focuses on children and the Sustainable Development Goals.

PART ONE: Children and Law Reform

Part one outlines recent legislative developments that affect the lives and rights of children. This issue comments on developments in international child law, the Refugees Amendment Bill and Green Paper on International Migration, the National Minimum Wage, the Social Assistance Amendment Bill, a revised Traditional Courts Bill, the Eastern Cape Customary Male Initiation Practice Act, and amendments to the Children's Act.

See pages 10 – 17.

PART TWO: Survive • Thrive • Transform

Part two presents a collection of nine essays that motivate for greater prioritisation of South Africa's children to ensure that all children not only survive but thrive and reach their full potential. The first two essays introduce the Sustainable Development Goals and consider the extent to which the 2030 Global Agenda promotes children's survival and development. Essay three reflects on South Africa's recent progress and identifies critical gaps and local priorities. A series of five essays then focus on nurturing care, child nutrition, preventing violence against children, getting reading right, and creating inclusive and enabling environments, culminating in a call to action.

See pages 18 – 93.

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 select subset from the website www.childrencount.uct.ac.za.

See pages 94 – 133.

Front cover photograph:

Isibindi recognises that children need care, safety and support in order to reach their full potential

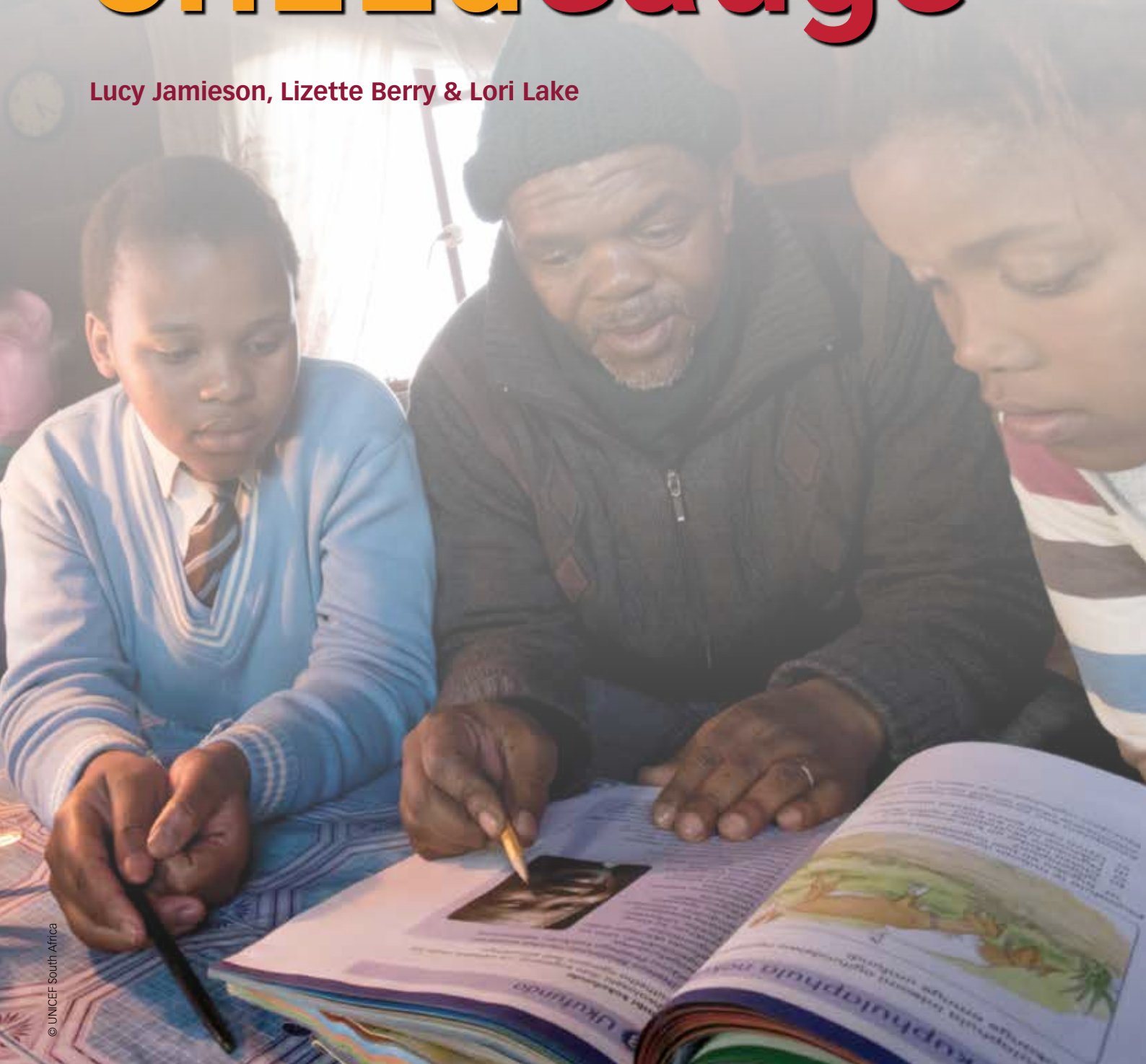
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Contents

Acknowledgements	2
Contents	3
List of boxes, cases, figures and tables	4
Abbreviations	6
Foreword <i>Benyam Mezmur, Chairperson of the African Committee of Experts on the Rights and Welfare of the Child</i>	7
Reflections <i>Jeff Radebe, Minister of Planning, Monitoring and Evaluation</i>	8
PART ONE: CHILDREN AND LAW REFORM	
Legislative and policy developments 2016/2017 <i>Stefanie Röhrs, Paula Proudlock and Anjuli Maistry</i>	12
PART TWO: SURVIVE • THRIVE • TRANSFORM	
Overview	20
Setting an ambitious agenda for children: The Sustainable Development Goals <i>Sanjana Bhardwaj, Winnie Sambu and Lucy Jamieson</i>	22
Striving for the Sustainable Development Goals: What do children need to thrive? <i>Lucy Jamieson and Linda Richter</i>	32
Investing in children: The drivers of national transformation in South Africa <i>David Harrison</i>	43
Caring for children: Relationships matter <i>Lizette Berry and Elmarie Malek</i>	51
Preventing violence: From evidence to implementation <i>Shanaaz Mathews and Chandré Gould</i>	61
Ending stunting: Transforming the health system so children can thrive <i>David Sanders and Louis Reynolds</i>	68
Getting reading right: Building firm foundations <i>Nic Spaull and Ursula Hoadley</i>	77
Welcoming all children: The inclusion imperative <i>Sue Philpott and Judith McKenzie</i>	84
Transforming South Africa: A call to action <i>Lucy Jamieson, Lizette Berry and Lori Lake</i>	91
PART THREE: CHILDREN COUNT – THE NUMBERS	
Introducing Children Count – Abantwana Babalulekile	98
Demography of South Africa’s children <i>Katharine Hall and Winnie Sambu</i>	100
Income poverty, unemployment and social grants <i>Katharine Hall and Winnie Sambu</i>	105
Child health <i>Katharine Hall, Nadine Nannan and Winnie Sambu</i>	111
Children’s access to education <i>Katharine Hall</i>	119
Children’s access to housing <i>Katharine Hall</i>	126
Children’s access to services <i>Katharine Hall and Winnie Sambu</i>	129
Technical notes on the data sources	132
About the contributors	134

List of boxes, cases, figures and tables

Part Two: Survive • Thrive • Transform

Boxes

Box 1:	Children’s right to survival and development in the South African Constitution.....	24
Box 2:	National reviews of progress towards the SDGs.....	27
Box 3:	Cross-cutting national priorities for children: What’s worked in other countries?	48
Box 4:	What is nurturing care?.....	52
Box 5:	What is child safety?	61
Box 6:	Findings from key classroom-based studies on teaching reading in South African primary schools	80

Cases

Case 1:	Isibindi: Sinako Youth Development Programme – From vulnerable child to independent adult	38
Case 2:	“What I do, matters”.....	40
Case 3:	A children’s National Development Plan	47
Case 4:	Nal’ibali – Transforming children’s literacy learning opportunities	49
Case 5:	Care in pregnancy – The First 1,000 Days Initiative.....	56
Case 6:	Parenting programmes – Critical questions when translating evidence into practice	58
Case 7:	The South African Child Death Review Project – Effective intersectoral collaboration	66
Case 8:	Beyond nutrition – Nurture and support in the first 1,000 days	72
Case 9:	Philani mentor mothers – Key ingredients for community-based care	74
Case 10:	Rigorous evidence of what works – The Early Grade Reading Study	82
Case 11:	A lonely journey of parenting.....	86
Case 12:	Siyakwazi – Promoting inclusive ECD services in KwaZulu-Natal	89
Case 13:	The Child Well-being Tracking Tool.....	93

Figures

Figure 1:	The global goals for sustainable development.....	23
Figure 2:	Children’s right to survival and development in the South African Constitution.....	24
Figure 3:	Child health is both an outcome and determinant of multiple SDGs.....	26
Figure 4:	Number of SDG indicators specific to children and adults.....	28
Figure 5:	Nurturing care, enabling environments and supportive contexts.....	33
Figure 6:	The socio-ecological model	34
Figure 7:	An intergenerational cycle of development	36
Figure 8:	The 17 SDGs create an enabling environment that supports nurturing care	39
Figure 9:	The trajectory of human capital development	44
Figure 10:	Elements of child development showing good progress	45
Figure 11:	Elements of child development showing little progress	46
Figure 12:	Enabling care across different layers of the socio-ecological system	52
Figure 13:	Opportunities for care and connection across the life course.....	53
Figure 14:	The SHANARRI wheel	57
Figure 15:	Determinants of violence victimisation	62
Figure 16:	Prevention framework	63
Figure 17:	Immediate, underlying and basic causes of maternal and child undernutrition.....	69
Figure 18:	Prevalence of stunting among children under five years old, by wealth quintile, 2016	70
Figure 19:	Prevalence of stunting among children under five years old, by level of maternal education, 2016.....	71
Figure 20:	How many learners in grade 4 can read?.....	78
Figure 21:	The prevalence of books in the home, 2013	79
Figure 22:	The availability of school libraries in primary schools in South Africa, 2013	81
Figure 23:	Children’s access to books anywhere, 2013	81
Figure 24:	Examples of diverse identities that may intersect to create compounded vulnerability	84
Figure 25:	Inclusion requires accommodation of diversity	85
Figure 26:	Levels of support for children with disabilities – An ecological system.....	87
Figure 27:	Social and child protection package of services	94

Tables

Table 1:	Key targets to ensure children survive, thrive and transform	25
Table 2:	A baseline analysis of the situation of children in South Africa, using child-centred indicators based on the SDGs	30
Table 3:	Scale of selected environmental stressors impacting on families and children.....	54
Table 4:	South Africa's progress in preventing violence against children	64

Part Three: Children Count – the numbers

Demography of South Africa's children

Figure 1a:	Children living in South Africa, by income quintile, 2015	100
Figure 1b:	Parental co-residence, by income quintile, 2015	101
Figure 1c:	Children living with their biological parents, by province, 2015	101
Figure 1d:	Orphans, by income quintile, 2015	102
Figure 1e:	Children living in South Africa, by orphanhood status, 2015	102
Figure 1f:	Orphans, by province, 2015	102
Figure 1g:	Children living in child-headed households, 2002 & 2015	103
Table 1a:	Distribution of households, adults and children in South Africa, by province, 2015	100

Income poverty, unemployment and social grants

Figure 2a:	Children living in income poverty, by province, 2003 & 2015.....	105
Figure 2b:	Children living in households without an employed adult, by income quintile, 2015	106
Figure 2c:	Children living in households without an employed adult, by province, 2003 & 2015	107
Figure 2d:	Children receiving the Child Support Grant, 1998 – 2017	107
Figure 2e:	Children receiving the Foster Child Grant, 1998 – 2017	109
Table 2a:	Children receiving the Child Support Grant, by province and age group, 2017	108
Table 2b:	Children receiving the Foster Child Grant, by province, 2012 & 2017	108
Table 2c:	Children receiving the Care Dependency Grant, by province, 2017	110

Child health

Figure 3a:	Children living far from their health facility, by income quintile, 2015	112
Figure 3b:	Children living far from their health facility, by province, 2002 & 2015	112
Figure 3c:	Children living in households where there is reported child hunger, by income quintile, 2015	113
Figure 3d:	Children living in households where there is reported child hunger, by province, 2002 & 2015	113
Figure 3e:	Child-bearing rate among young women aged 15 – 24 years, by age group, 2015	114
Figure 3f:	Annual child-bearing rates among young women aged 15 – 24 years, by province, 2009 & 2015	114
Figure 3g:	Malnutrition rates across early childhood age group, 2014/15.....	115
Table 3a:	Child mortality indicators, rapid mortality surveillance, 2012 – 2015	111

Children's access to education

Figure 4a:	School-age children (7 – 17-year-olds) attending an educational institution, by province, 2002 & 2015	118
Figure 4b:	Reported attendance at an educational institution, by age and sex, 2015	119
Figure 4c:	Children aged 5 – 6 years attending school or ECD facility, by province, 2002 & 2015	120
Figure 4d:	School-aged children living far from school, by province, 2015	121
Figure 4e:	Completion of grade 3 (10 – 11-year-olds) and grade 9 (16 – 17-year-olds), by income quintile, 2015	122
Figure 4f:	Children aged 10 – 11 years who passed grade 3, by province, 2002 & 2015	122
Figure 4g:	Children aged 16 – 17 years who passed grade 9, by province, 2002 & 2015.....	123
Figure 4h:	Youth (15 – 24 years) not in employment, education or training (NEETs), by province, 2002 & 2015.....	124

Children's access to housing

Figure 5a:	Children living in urban areas, by income quintile, 2015	125
Figure 5b:	Children living in urban areas, by province, 2002 & 2015	125
Figure 5c:	Children living in formal, informal and traditional housing, by province, 2015	126
Figure 5d:	Children living in overcrowded households, by income quintile, 2015	127
Figure 5e:	Children living in overcrowded households, by province, 2002 & 2015	127

Children's access to services

Figure 6a:	Children living in households with water on site, by income quintile, 2015	128
Figure 6b:	Children living in households with water on site, by province, 2002 & 2015	129
Figure 6c:	Children living in households with basic sanitation, by income quintile, 2015	129
Figure 6d:	Children living in households with basic sanitation, by province, 2002 & 2015	130

Abbreviations

ACERWC	African Committee of Experts on the Rights and Welfare of the Child	NGO	Non-Governmental Organisation
ACRWC	African Charter on the Rights and Welfare of the Child	NHI	National Health Insurance
AIDS	Acquired Immune Deficiency Syndrome	NIDS	National Income Dynamics Study
CAPS	Curriculum Assessment Policy Statement	NMR	Neonatal Mortality Rate
CBO	Community-Based Organisation	NPC	National Planning Commission
CDG	Care Dependency Grant	PMTCT	Prevention of Mother-to-Child Transmission
CDR	Child Death Review	RAB	Refugees Amendment Bill
CHW	Community Health Worker	RMS	Rapid Mortality Surveillance System
CSG	Child Support Grant	SADHS	South African Demographic and Health Survey
CSO	Civil Society Organisation	SALDRU	Southern Africa Labour and Development Research Unit
CYCW	Child and Youth Care Worker	SAM	Severe Acute Malnutrition
DBE	Department of Basic Education	SASSA	South African Social Security Agency
DHA	Department of Home Affairs	SDG	Sustainable Development Goal
DSD	Department of Social Development	SMT	School Management Team
ECD	Early Childhood Development	SOCPEN	Social Pensions
EGRS	Early Grade Reading Study	Stats SA	Statistics South Africa
FCG	Foster Child Grant	TCB	Traditional Courts Bill
GDP	Gross Domestic Product	TVET	Technical and Vocational Education and Training
GHS	General Household Survey	U5MR	Under-5 Mortality Rate
HIV	Human Immunodeficiency Syndrome	UCT	University of Cape Town
ILO	International Labour Organisation	UN-HABITAT	United Nations Human Settlements Programme
IMR	Infant Mortality Rate	UNCRC	United Nations Convention on the Rights of the Child
IPV	Intimate Partner Violence	UNCROC	United Nations Committee on the Rights of the Child
MDG	Millennium Development Goal	UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
MRC	Medical Research Council	UNICEF	United Nations Children's Fund
NACCW	National Association of Child Care Workers	V-ANA	Verification Annual National Assessment
NDP	National Development Plan	WBOT	Ward-Based Outreach Team
NEDLAC	National Economic Development and Labour Council	WHO	World Health Organisation
NEETs	Not in Employment, Education or Training		

Foreword

Benyam Dawit Mezmur

Dullah Omar Institute for Constitutional Law, Governance and Human Rights, University of the Western Cape
Chairperson, African Committee of Experts on the Rights and Welfare of the Child
Chairperson, United Nations Committee on the Rights of the Child (May 2015 – May 2017)

Thanks to the Convention on the Rights of the Child (UNCRC) and the African Charter on the Rights and Welfare of the Child, “survival and development” is not just a privilege for some. It is a human right for all children that the government of South Africa is legally bound to implement. This right is not just only about surviving, being alive, or subsisting; it is about having a fair chance in life and being offered the opportunity to thrive, as much as possible, and reach one’s full potential.

Governments should ensure, to the maximum extent possible, the survival, protection and development of every child including the physical, mental, moral, spiritual and social dimensions of their growth and development. Identification of the many risks and protective factors that underlie survival and development of the child across the life course is critical. In the context of health, for instance, birth weight, care arrangements, family history, poverty and violence threaten the survival and development of children. Timing and early intervention are critical for radically reducing equity gaps, and both early childhood and adolescence should be viewed as windows of opportunity.

The survival and development of children was a central tenet of the Millennium Development Goals. However, the focus on national averages concealed differences within countries, and among various groups of children, and left millions of the most disadvantaged children behind.

Inequities, often during early life, usually have lifelong effects, and manifest themselves in poor learning, health and employment outcomes. For example, stunting – children with a height far below the average for their age – is not only about the height of children, but that their brains have difficulty to develop fully, leading to poor learning outcomes, and lower employment rates. It should then not come as a surprise that in some corners of the continent, children could not read a single letter after going through three or four years of schooling. Inequity is also a recipe for a vicious intergenerational cycle of disadvantage.

How the Sustainable Development Goals (SDGs) address – in both conceptualisation and implementation – the threats to children’s survival and development is critical. “No child left behind” should go beyond being a slogan. The SDGs do not only assume that reaching the hardest to reach is realistic, but that it can be more cost-effective. Targeting evidence-based programmes

at the most disadvantaged, identified through disaggregated data, can accelerate efforts to overcome barriers to services.

This *Child Gauge* brings together nine essays that shed light on progress, and sometimes the lack thereof, towards the fulfilment of children’s right to survival and development. The authors of the articles range from academics and researchers to representatives from civil society and government. Each piece is based on research and evidence that contributes to – and resonates with – global discourses, challenges and strategies to promote children’s survival and development.

This issue of the *Child Gauge* is very timely and relevant, as implementation of the SDGs has started in earnest, with the first few Voluntary National Reviews already underway, and South Africa therefore needs to reflect deeply on how the implementation of the SDGs can contribute to the creation of a South Africa that is fit for *all* children.

The essays emphasise a South African context that is often characterised by poverty, and health system failures that continue to compromise children’s survival and development; where schooling outcomes remain poor despite high attendance; and where the interpersonal relational needs and emotional well-being of children are neglected. The impact of insecurity on children’s development across the life course, and failure to ensure substantive equality especially for children with disabilities are further challenges. The five key priorities, namely education, health and nutrition, caring relationships, safety, and inclusion rightly echo the aspiration in the preamble to the UNCRC that “the child, for the full and harmonious development of his or her personality, should grow up in a family environment, in an atmosphere of happiness, love and understanding”.

Some of the main messages – the benefits of a child rights approach to development; the added value of equity and evidence-based programming; robust data to identify the children who are missing out; a holistic understanding of survival and development that also recognises children’s evolving capacities; and community engagement for stronger systems for health, education and protection, deserve a serious attention by all stakeholders, in particular, policy-makers.

The contents of this *Child Gauge* are clear indication that we have our work cut out for us here in South Africa. I hope – and expect – that we are ready to rise to the challenge.



Reflections

Jeff Radebe

The Minister in the Presidency for Planning, Monitoring and Evaluation and Chairperson of the National Planning Commission

South Africa's children, particularly those from poor backgrounds, face numerous challenges including poverty, inadequate nutrition, poor parental care, poor quality education and limited prospects to access tertiary education, which according to the National Income Dynamic Study, offers passage out of poverty.

Despite democratic and economic reforms since 1994 that have resulted in average growth in the economy, many children are trapped in poverty and are excluded from important aspects of social, economic and political life. Compounding the problem is that 21% of children do not live with their parents. Poverty is highest amongst these children. Poverty is also higher for 62% of children growing up without their fathers, as on average women earn lower than men. Though measures such as the Child Support Grant (CSG) have been successful to reduce the proportion of children living below the food poverty line (from 60% to 30%), the absolute number of children still living below food poverty remains high at 5.5 million. If we use the upper bound poverty line (which others have argued is a more appropriate measure of child poverty), then over half of children in South Africa live in poverty. The implication is that many of South Africa's children experience malnutrition and 25% of children under five are reported to be stunted. Progress has also been made in terms of fulfilment of children's socio-economic rights. The vast majority of children (77%) live in formal housing thanks to government's investment in the National Housing Programme. In addition, 69% of children have access to clean drinking water on site. Though these numbers show progress, they also reveal the need to do more. More needs to be done to respond to the 3.4 million children who live in overcrowded housing conditions and the six million living without access to clean drinking water.

Globally, it is increasingly recognised that investing in early childhood development is cost effective and beneficial for long-term



development. South Africa joined the global community when the Sustainable Development Goals of Agenda 2030 were adopted by world leaders in 2015. The SDGs make a case for measuring progress that countries make in addressing challenges of poverty and hunger by tracking the experiences of children. They call on governments to: end hunger and malnutrition particularly in children; halve the number of children living in poverty by 2030; reduce maternal mortality; and end preventable deaths of newborns and children under the age of five.

Although adopted prior to the SDGs, the National Development Plan (NDP) aligns with Agenda 2030. The plan recommends interventions in health, water and sanitation, human settlements, education and social protection to unlock the potential in our children and allow South Africa to reap this demographic dividend by 2030. The plan acknowledges that without addressing poverty and inequality, the democratic project remains unfinished. It also emphasises responding to the needs of children. Improving the quality of education, skills development and innovation is a top priority for the country to achieve the targets in the development plan. In addition, the plan targets a reduction in the number of households living on R418 per month per person to zero, and infant mortality from 43 to 20 deaths per 1,000 live births; eradication of micronutrient deficiencies; improvement in literacy and numeracy levels, and an increase in the number of children who have at least 12 years of schooling. We need to build on the successes of programmes like the CSG to reduce the number of children experiencing hunger and malnutrition. Importantly, we also need to invest in programmes that strengthen capabilities of caregivers, recognising that most of our children are not living with their biological parents. The role of fathers in their children's well-being and development also needs to be more emphasised. Far too many children (62%) are growing up without their fathers.

To achieve these targets, improve the foundation we set for our children and unlock the transformation potential in children requires a capable and committed public service, capable of implementing government strategies and inspiring society to care for its young. Work done by the Department of Planning, Monitoring and Evaluation shows significant weaknesses in implementation of programmes targeted to children. Evidence from this and other work, such as the *South African Child Gauge*, must be used to strengthen the public service (and other role-players like private sector and civil society organisations) to respond better to the needs of children. We need to use the right indicators for the NDP to track progress that the country is making in addressing challenges faced by children. We must remove all barriers for children to access quality services, particularly in the first 1,000 days.

Moreover, South African society needs to be conscientised about the importance of investing in our children if we want to move the country forward. Parents, caregivers, teachers, and policy-makers need to remember that we are today deciding on what country we want in the future. The way we raise or treat children – and what we teach them about who they are, their potential and power – are all moulding the adults they will be tomorrow. Therefore, if we want to transform South Africa and build a society with stable families and communities, strong and accountable institutions, sustainable economic growth; and a country that maximises the potential of its people, that is culturally rich and has a place in the changing world; then we need to pay careful attention to how we are raising our children. To radically transform South Africa requires us to invest in their care, health, education and protection; and we need to do it from early on.



PART ONE

Children and Law Reform

Part one summarises and comments on policy and legislative developments that affect children. These include:

- developments in international child law
- the Refugees Amendment Bill and the Green Paper on International Migration
- the National Minimum Wage
- the Social Assistance Amendment Bill
- a revised Traditional Courts Bill
- the Eastern Cape Customary Male Initiation Practice Act
- amendments to the Children's Act.

Programmes like Philani cultivate a love a learning and provide a strong foundation for further education © Eric Miller

Legislative and policy developments 2016/2017

Stefanie Röhrs and Paula Proudlock (Children's Institute, University of Cape Town)
and Anjuli Maistry (Centre for Child Law, University of Pretoria)

This chapter summarises and analyses policy and legislative developments between August 2016 and July 2017. These include:

- developments in international child law
- the Refugees Amendment Bill and the Green Paper on International Migration
- the National Minimum Wage
- the Social Assistance Amendment Bill
- a revised Traditional Courts Bill
- the Eastern Cape Customary Male Initiation Practice Act
- amendments to the Children's Act.

Developments in international child law

The thematic focus of the *South African Child Gauge 2017* – survive, thrive, transform – is at the heart of South Africa's obligations under international law. The African Charter on the Rights and Welfare of the Child (ACRWC) and the United Nations Convention on the Rights of the Child (UNCRC) both protect the right to life, survival and development, alongside many other rights. The ACRWC and UNCRC are important for promoting children's rights because they require governments to report regularly on their progress in realising children's rights.¹ Civil society organisations can participate in the monitoring process by submitting so-called "shadow" reports that add to or challenge information provided by governments.

In 2016, the UN Committee on the Rights of the Child (UNCROC) released its concluding observations on South Africa's most recent country report.² The concluding observations acknowledge that South Africa has made significant progress in realising children's rights. The Committee welcomed, for instance, the reductions in infant and child mortality and in mother-to-child transmission of HIV/AIDS, as well as improvements in the legal and policy framework to combat violence against children.³ However, the concluding observations raise numerous concerns, particularly the lack of implementation of legislation. The UNCROC also rebuked the government for its failure to follow some of the Committee's previous recommendations.⁴ In terms of the right to life, survival and development, the UNCROC asked government to:

- address poverty and structural inequalities underlying the high child mortality rate;
- enhance its efforts to reduce infant and child mortality by addressing, amongst others, high levels of violence against children, child malnutrition, HIV/AIDS and other preventable diseases;

- provide support to families to prevent violence, abuse, neglect and abandonment of children; and
- strengthen its efforts on firearm control.⁵

In January 2017, the government submitted its second country report to the African Committee of Experts on the Rights and Welfare of the Child (ACERWC). Subsequently, various civil society organisations, including a large coalition of children's organisations, submitted shadow reports to the ACERWC.⁶ Oral presentations by both government and civil society organisations are expected to take place in late 2017 and concluding recommendations by the ACERWC will be released in 2018.

In addition to the report submitted to the African Committee, South Africa also submitted its initial report on the UN Convention on the Rights of Persons with Disabilities and on the International Covenant on Economic, Social and Cultural Rights. While these conventions are not child-specific, they both have relevance for children's rights.⁷

Refugees Amendment Bill and Green Paper on International Migration

In its concluding observations, the UNCROC highlighted the need to prevent statelessness of migrant and refugee children. To ensure that such children are properly documented and have access to a nationality, the Committee recommended, amongst others, that South Africa:

- consider providing migrant, asylum-seeking and refugee children with an option of permanent settlement in South Africa;
- amend legislation and regulations relevant to birth registration and nationality, where necessary, to ensure their full conformity with the UNCRC; and
- ensure that the Refugees Amendment Bill (RAB) is fully consistent with the UNCRC.

The RAB was passed by the National Assembly in 2017 and at the time of writing was being considered by the National Council of Provinces.⁸ If passed, the Bill will amend the Refugees Act. The RAB reduces the legal protection of separated refugee and asylum-seeker children and fails to address legal gaps in relation to such unaccompanied children.

In its current version, the Refugees Act entitles "dependants" of refugees or asylum seekers to the same status as those they are deemed to be dependent on. The definition of who a "dependant"

was initially included “any unmarried dependent child ... of such asylum seeker or refugee”.⁹ This implied that they would have to be the biological child of the adult asylum seeker or refugee to qualify as a dependant. However, the definition of “dependant” was expanded in 2015 to ensure that children who were separated from their biological parents and were seeking asylum with adults who were their primary caregivers (“separated children”) were also recognised as dependants – of the primary caregiver.¹⁰

Unfortunately, the RAB does away with this protection by redefining dependants to exclude separated children. The definition once again only includes the biological children of refugees and asylum seekers. The planned amendment therefore leaves separated children without a pathway to obtaining documentation. Without documentation, they are unable to access basic services like health care, social assistance and education, and are at risk of statelessness.

The RAB also fails to protect children who are unaccompanied by their parents or any adult, and who seek asylum alone (“unaccompanied minors”). Currently, the Refugees Act requires that unaccompanied minors whose circumstances indicate that they have a claim for asylum must be referred to the children’s court, which in turn “may” (rather than “must”) make an order that such children are assisted to apply for asylum.¹¹ These children will then be assisted by a social worker to submit their applications for asylum. However, if the court does not grant this order, then there is no obligation on a social worker (or any other adult) to assist the children with their applications. The children would consequently remain undocumented as they cannot apply for asylum without adult assistance.

Despite this gap, the RAB does not create a mechanism for unaccompanied minors to apply for asylum themselves during the children’s court enquiry – leaving it to the discretion of the court to order that a child is assisted by an adult to apply for asylum. Thus, unaccompanied minors are likely to remain undocumented and unable to access essential basic services. Furthermore, because unaccompanied children often reside in the country of asylum for long periods and lose (or never had) ties to their country of origin, the risk of statelessness grows.

In addition to unaccompanied minors who have travelled to South Africa alone to seek asylum, it sometimes happens that children are in South Africa as dependants of their asylum-seeking or refugee parents who then pass away or abandon their child. These children lose their status as dependants, and are often too young or immature to recount the events that led to their parents leaving their country of origin. Despite this, there is currently no mechanism under the Refugees Act to ensure that these children remain documented – something which the RAB fails to remedy. This leaves this group of children undocumented, and subject to the same exclusion and risks described above.

Considering these shortcomings, the Bill is not fully consistent with the UNCRC and fails to comply with the UNCROC’s concluding

observations relating to the prevention of statelessness of migrant and refugee children.

Around the same time as the introduction of the RAB, the Department of Home Affairs introduced the Green Paper on International Migration (the Green Paper).¹² Ideally, the Green Paper should have informed the drafting of the RAB but the law reform process was not halted. The Green Paper is worryingly silent on child migrants and refugees. Despite its purpose, part of which is to inform legislation, the Green Paper does not provide any guidance on the “management” of separated or unaccompanied minors, the birth registration of children born to undocumented migrants in South Africa, and the ability of children who are long-term residents of South Africa to naturalise.

Most worryingly, the Green Paper introduces “asylum-seeker processing centres” and “administrative detention centres”.¹³ These centres are meant to accommodate certain asylum seekers while assessing their eligibility for asylum. Although the Green Paper envisions that these centres be used for asylum seekers who present a security or public health risk, it also provides for “vulnerable groups and those whose identity needs to be established” to be detained at these centres.¹⁴ While the Green Paper does not define “vulnerable groups”, children could certainly be considered “vulnerable”. This means that, if passed into law in its current form, it would allow officials to detain children. Civil society submissions addressing these concerns will hopefully be considered in the White Paper, which is currently being drafted.

National Minimum Wage

The agreement on a national minimum wage is a noteworthy development in addressing poverty and inequality as recommended in the UNCROC’s concluding observations. The National Economic Development and Labour Council (NEDLAC) has agreed to introduce a national minimum wage of R20/hour, which translates to R3,500 and R3,900 per month for workers working 40 hours and 45 hours per week, respectively.¹⁵ The national minimum wage will create a “floor” below which no worker in South Africa may be paid, with limited exceptions for certain sectors!¹⁶ The national minimum wage will come into effect after the necessary legislation has been developed and passed by Parliament, which, according to NEDLAC, will happen by May 2018.

The national minimum wage is contentious, but some researchers argue that it can contribute to reducing poverty and inequality and, if set at an appropriate level, it can support economic growth and not lead to job losses.¹⁷ Caregivers of children who earn the minimum wage of R3,500 would still be eligible to receive the Child Support Grant (CSG), which, as of April 2017, is available for caregivers who earn less than R3,800 per month.¹⁸ Continued access to the grant is important because the minimum wage was set relatively low and below the subsistence level of living.¹⁹ The minimum wage may have a positive effect on some, but not all children living in poverty. It will not make a difference

ⁱ Domestic workers will be paid 75% and agricultural workers will be paid 90% of the national minimum wage, respectively, for the first two years. Furthermore, certain businesses, for instance small businesses and start-ups, will be allowed to apply for exemptions.

for children who live in households where the caregiver is working in the informal sector, or is unemployed. In 2015, 31% of children were living in households where no adult was working;²⁰ although, these children might benefit from remittances of extended family who are employed in the formal sector.

Social Assistance Amendment Bill

A further development that may help mitigate child poverty is the proposed amendment of the Social Assistance Act. At the end of 2016, the Minister of Social Development gazetted a Social Assistance Amendment Bill for comment.²¹ The Amendment Bill gives the ministers of Social Development and Finance the authority to add additional amounts to an existing grant, based on need. If enacted, the Bill will allow for the payment of a top-up amount to the CSG to relatives caring for orphans (colloquially called a “CSG top-up”).²² The CSG top-up is aimed at ensuring that orphans in the care of relatives receive an adequately valued social grant without delay. The reform is needed because the Foster Child Grant (FCG) is not reaching the majority of orphans in need.²³ This is primarily because the FCG application process involves a social worker investigation and a court order and these cause long delays in accessing the grant. A further potential positive impact of the reform would be a reduction in foster care caseloads, which would give social workers and children’s courts more time to provide child protection services for children who have been abused and neglected.²⁴

The Amendment Bill does not provide any details about the CSG top-up because these will be dealt with in the regulations which are expected after the Bill is passed. Key details still to be determined via the regulation process include:

- a. *The amount of the top-up:* The Department of Social Development has proposed a top-up that is 50% of the CSG value. This would mean that orphans in the care of relatives would receive a CSG of R570 per month in 2017 Rands, while children on the standard CSG would receive R380. Whether this top-up amount is adequate needs further debate.
- b. *The targeted orphan category(s):* The Department of Social Development has indicated an intention to first target double orphans (where both parents are deceased) and to consider extending the top-up to maternal orphans later. This would be problematic as maternal orphans living with relatives currently do qualify for the FCG in terms of the Children’s Act and therefore the grant proposed to replace the FCG needs to include them. Furthermore, in many cases it is impossible to distinguish between double and maternal orphans because proving or disproving paternal death is a challenge: many children do not know the whereabouts of their fathers or if they are alive, and over two-thirds of births registered with Home Affairs do not contain details of the father.²⁵
- c. *Proof of orphanhood:* Many applicants may not be able to produce death certificates of the child’s biological parents. For example, analysis of the 2014 General Household Survey shows that at least one-third of double orphans will not be able to produce death certificates for their fathers as their fathers’

identity or vital status is unknown to their family.²⁶ Furthermore, because over two-thirds of births registered with Home Affairs do not contain any details of the father, it will be impossible in most cases to verify that the death certificate submitted is in fact the child’s father.²⁷ Therefore it is important that the regulations are flexible and allow caregivers to submit an affidavit instead of a death certificate.

The Bill is expected to be tabled in Parliament in early 2018. Once tabled, there will be a call for submissions, followed by public hearings.

The Bill also contains other important amendments, including the establishment of an independent tribunal to hear appeals against decisions of the South African Social Security Agency, and a government fund to provide funeral benefits to beneficiaries (and possibly other benefits) to prevent them being exploited by private insurance companies.

Traditional Courts Bill

2017 saw the re-introduction of the Traditional Courts Bill (TCB) to Parliament.²⁸ Many civil society organisations, including child rights experts, had expressed serious concerns over the two previous versions of the TCB²⁹ on the grounds that they violated women’s and children’s rights, preserved patriarchal norms, and did not accurately reflect the nature of customary law.³⁰ The 2017 version of the TCB is a vast improvement as it includes an express commitment to the Bill of Rights and prohibits conduct which infringes on individuals’ dignity, equality and freedom.³¹

The TCB furthermore acknowledges that customary law is based on the principle of voluntary affiliation and that people have a choice whether or not their dispute is heard by a traditional court.³² Despite these improvements, the TCB fails to address a number of critical issues relating to children’s rights. The jurisdiction of traditional courts is now defined by a list of matters that can be heard by traditional courts. This list includes property-related offences (e.g., theft and damage to property, but only if the amount involved is below R5,000), *crimen injuria*, and altercations between members of the community.³³ Although the jurisdiction includes children who perpetrated any of these offences, the Bill fails to provide principles for dealing with child offenders, and lacks ages of criminal capacity. This undermines the objectives of the Child Justice Act, which creates guiding principles for proceedings involving child offenders to protect them from the adverse effects of the formal criminal justice system. These principles provide, for instance, that:

- the punishment of the child offender should be proportionate to the offence;
- a child should not be treated more severely than an adult would be treated in the same circumstances;
- participation of children in the proceedings needs to be ensured;
- unnecessary delays in the proceedings should be avoided; and
- parents, appropriate adults and guardians should assist children in proceedings.³⁴

These principles should also be adhered to in traditional court proceedings because they protect fundamental children's rights. There is further tension between the TCB and the Child Justice Act, the Children's Act and the Criminal Procedure Act. These laws provide protection for child victims, witnesses and offenders, for instance, by allowing or prescribing that proceedings be held *in camera* (in closed court). In contrast, the TCB stipulates that traditional court proceedings must be open to all members of the community.³⁵ While transparency of proceedings is an important legal principle, the TCB should create exceptions for matters involving child victims, witnesses and offenders to protect them from stigma and discrimination by community members. If, however, the procedural concerns are addressed, traditional courts would have an advantage over formal magistrate's courts for child offenders because the adjudication before a traditional court would avoid a criminal record.

A further concern is that the TCB allows traditional courts to hear matters involving assaults without grievous bodily harm.³⁶ This means that traditional courts can adjudicate assaults against children, which would include corporal punishment and physical child abuse. Children experience high levels of physical abuse which is mostly perpetrated by the child's caregiver, relative or teacher.³⁷ It is questionable whether traditional courts are the right forum to deal with cases of physical child abuse, particularly given that the Children's Act requires traditional leaders to report cases of physical child abuse to the formal child protection system. The Bill, however, is silent on how traditional courts are meant to engage with the formal child protection system, including social workers and the police.

The TCB stipulates that traditional courts are "competent" to give "advice" on customary law practices such as *ukuThwala*.³⁸ It is unclear what the term "advice" refers to. This uncertainty is concerning because, in some instances, *ukuThwala* involves sexual offences against children. Additional concerns include the failure to set an age from which a child can initiate proceedings before a traditional court, or can "opt out" if summoned before it. Opting out may be challenging for children in any case due to pressure from parents or other community members. In addition, the provision outlining prohibited court orders fails to prohibit court orders involving cruel, inhuman and degrading punishment, including corporal punishment.³⁹

At the time of writing, public hearings on the 2017 version of the Bill had not yet taken place.

Eastern Cape Customary Male Initiation Practice Act

The Children's Act provisions on male circumcision allow customary and traditional circumcisions of boys older than 16 years.⁴⁰ Circumcisions may only be undertaken if the male child has been counselled and has subsequently provided consent, and the Children's Act Regulations set out requirements for performing circumcisions (e.g., use of sterile surgical gloves, safe disposal of

instruments used for circumcision, etc.).⁴¹ The Children's Act does not regulate other initiation practices or initiation/circumcision schools. Given that national legislation has not yet been enacted – public hearings on the Customary Initiation Bill have not yet taken place⁴² – customary initiation practices continue to be regulated by provincial legislation.

Despite the provisions in the Children's Act and provincial legislation, botched circumcisions are reported every year. In the Eastern Cape – the province worst affected – a total of 936 circumcision initiates were admitted to hospitals, and 114 deaths and 47 penile amputations were reported between June 2012 and June 2013.⁴³ While a national framework on prevention and early intervention programmes to address unsafe circumcisions is still in the making, the Eastern Cape Provincial Legislature has attempted to respond to botched circumcisions by enacting new provincial legislation. The Eastern Cape Customary Male Initiation Practice Act, enacted in December 2016, replaces earlier provincial legislation to improve the safety of initiation rituals, including circumcisions.⁴⁴

The Act creates several mechanisms to monitor and formalise traditional initiation, particularly in relation to initiation schools.ⁱⁱ It sets out minimum qualifications for traditional surgeons and nurses, and creates a number of obligations for families of prospective initiates to ensure a safe initiation process. For instance, families must ensure that a prospective initiate is examined by a medical practitioner three months and again 14 days before going to an initiation school.⁴⁵

Neither traditional surgeons, who are meant to perform traditional circumcisions, nor other persons may perform circumcisions on individuals under the age of 18 years, i.e. children.⁴⁶ Children may also not attend initiation school.⁴⁷ In other words, only adults can undergo customary circumcision and attend initiation schools. In this respect, the Eastern Cape legislation is stricter than the Children's Act, which allows boys over the age of 16 years to undergo traditional circumcision – if they are appropriately counselled and if both the boy and his parents consent to the circumcision. The Eastern Cape legislation is also stricter than the proposed Customary Initiation Bill, which aims to regulate different initiation practices as well as initiation schools, and which allows boys between 16 and 18 years to undergo traditional circumcision, if certain requirements (e.g. consent, medical checks) are fulfilled.

The provincial Act furthermore regulates the opening of initiation schools by requiring the schools to obtain written permission from the provincial Minister for Health and the relevant traditional leadership.⁴⁸ Failure to obtain these permissions attracts a fine and/or imprisonment up to 12 months.⁴⁹ In light of the numerous injuries and deaths of children and young adults due to botched circumcisions, the provincial law is a welcome step to create strict and clear guidelines for the traditional practice of initiation. Provincial government and traditional leadership will need to work together closely to ensure the law's successful implementation, particularly to ensure that children are not traditionally circumcised.

ii For instance, it sets up a multi-sectoral provincial initiation coordinating committee, a provincial technical task team, district initiation forums and local initiation forums.

Amendments to the Children's Act

The Children's Amendment Act and Children's Second Amendment Act, which were discussed in the *South African Child Gauge 2016*, have not yet come into effect at the time of writing because the President has not yet proclaimed them. The envisioned amendments include changes to the National Child Protection Register, the removal of a child to temporary safe care, adoption, and foster care.⁵⁰ The drafting of a Child Care and Protection Policy, which will pave the way for the Third Amendment Bill to the Children's Act has been finalised by the Department of Social Development, but has not yet been made available to the public.

Conclusion

Addressing child poverty and inequality is essential if children are to survive, thrive and reach their full potential. It is therefore positive to see that South Africa is undertaking steps to reduce poverty and inequality, but the reach and impact on children remain unclear.

For instance, a large proportion of children will not benefit directly from the national minimum wage because they live in households where the adult caregiver works in the informal sector or is unemployed. Similarly, the effects of proposed changes to the Social Assistance Amendment Bill are unclear given that key decisions – the amount of the CSG top-up, the target group and eligibility criteria – have yet to be determined. What is clear though is that orphans are merely a sub-group of children living in poverty and the proposed changes will not affect the much larger group of children who are not orphaned but who also live in poverty. These children will continue to rely on the meagre CSG.

The proposed policy and legal changes in relation to migrant and refugee children are particularly concerning. If the RAB is enacted in its current form, migrant and refugee children will continue to be at risk of statelessness and will be unable to access basic services. Opportunities to survive, thrive and reach their full potential will remain limited for many children in South Africa until significant progress has been made in improving access to quality services, curbing poverty and inequality, and effectively addressing violence.

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PART TWO

Survive Thrive Transform

Part two motivates for greater investment to ensure South Africa's children not only survive but thrive and reach their full potential, by:

- focusing on the Sustainable Development Goals
- ensuring that the 2030 Global Agenda promotes children's survival and development
- identifying local priorities
- promoting nurturing care
- creating safe environments
- improving child nutrition
- getting reading right
- creating inclusive and enabling environments
- reflecting on progress and calling for action.

Overview

Part two comprises a set of nine essays that consider how we can use the Sustainable Development Goals (SDGs) to promote nurturing care and create enabling environments in which children not only survive, but thrive and reach their full potential.

Setting an ambitious agenda for children: The Sustainable Development Goals

(pages 22 – 31)

This essay introduces the global agenda for children and adolescents as set out in the SDGs and the Global Strategy for Women's, Children's and Adolescents' Health. It discusses how the SDGs relate to children's rights, and how these new global goals build on and extend the aspirations of the Millennium Development Goals. It also highlights the importance of tracking child-centred indicators to monitor progress for children, and concludes with an overview of the current status of South Africa's children.

Striving for the Sustainable Development Goals: What do children need to thrive?

(pages 32 – 42)

This essay draws on children's rights, scientific evidence, and economic arguments for investing in children's survival and optimal development to critically engage with the global agenda. It introduces the essential elements of nurturing care and highlights the importance of addressing children's needs holistically, across the life course, and in the context of their families and communities. It concludes by considering the extent to which the SDGs have the potential to create an enabling environment in which children can thrive and reach their full potential.

Investing in children: The drivers of national transformation in South Africa

(pages 43 – 50)

The third essay focuses on the South African context and explores how the global agenda aligns with local priorities. The essay acknowledges recent progress and points to outstanding challenges where greater investment in children could trigger a "tipping point" and help drive sustained social and economic transformation in South Africa.

Caring for children: Relationships matter

(pages 51 – 60)

Love, nurturing care and a sense of belonging are arguably the most essential elements for children's emotional and mental well-being. This essay focuses on children's interpersonal relationships and the factors that facilitate intimate and caring relationship building throughout the life cycle. The systems of care for South Africa's children are discussed including the potential role of families, professionals and communities. Factors that can compromise care, as well as interventions that can improve the quality of caring relationships, are foregrounded.

Preventing violence: From evidence to implementation

(pages 61 – 67)

Preventing violence is a strong focus in the SDGs which also aim to address many of structural and environmental factors that compromise children's safety. This essay details the high levels of violence and trauma experienced by South Africa's children and their impact on children's development across the life course. It introduces seven evidence-based strategies that have the greatest potential to reduce violence against children, and considers what is needed to bridge the gap between evidence and implementation in order to take violence prevention to scale.

Ending stunting: Transforming the health system so children can thrive

(pages 68 – 76)

Stunting continues to compromise the development of one in four young children in South Africa. This essay identifies what is needed to address the immediate, underlying and basic causes of child undernutrition. It motivates for greater investment in community health workers to extend the reach of health-care services and support children's optimal development and nutrition. It also calls for a broad social movement to advocate for child health equity and address widespread poverty, inequality and inadequate services – the drivers of malnutrition.



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Getting reading right: Building firm foundations

(pages 77 – 83)

The SDGs' focus on equal and quality education is particularly pressing in the South African context where schooling outcomes remain poor despite high attendance, and where inequalities are already deeply entrenched before young children enter formal schooling. Given these challenges, this essay identifies learning to read as a national priority and a critical foundation for formal education. The essay outlines the causes of South Africa's poor reading outcomes and identifies eight interventions that have the potential to enhance reading outcomes in the foundation phase.

Welcoming all children: The inclusion imperative

(pages 84 – 90)

The SDGs envisage an inclusive approach to development in which no one is left behind, but what does this mean in practice? This essay focuses on children with disabilities to deepen readers' understanding of inclusion. The authors illustrate how children

with disabilities experience multiple forms of exclusion that compromise their development. They then outline what is needed to create more enabling environments in which each and every child thrive.

Transforming South Africa: A call to action

(pages 91 – 95)

The final essay outlines the current risks and challenges, and identifies opportunities to transform systems and improve child outcomes. Building on the SDGs, this essay calls for an integrated and inclusive approach that mobilises all sectors of society to make sure that no child is left behind. It also foregrounds the need to shift attitudes and behaviour to create more welcoming and inclusive environments that are responsive to the needs of children and their caregivers.

Setting an ambitious agenda for children: The Sustainable Development Goals

Sanjana Bhardwaj (UNICEF), Winnie Sambu and Lucy Jamieson (Children's Institute, University of Cape Town)

In 2015, the United Nations (UN) member states adopted an ambitious new agenda, *Transforming our World: The 2030 Agenda for Sustainable Development*,¹ establishing 17 Sustainable Development Goals (SDGs) to be achieved by all countries and stakeholders by 2030.²

Children are at the heart of the 2030 Global Agenda, and the realisation of their rights is seen as the foundation of global security, sustainability and human progress.³ The SDGs impact every aspect of a child's life and outline a vision of a world in which all children not only "survive," but "thrive" and realise their full potential. This vision "encompasses the unfinished business of the Millennium Development Goals (MDGs), but goes well beyond poverty eradication, breaking significant new ground. The goals outline a universal, integrated and human rights-based agenda for sustainable development balancing economic growth, social justice and environmental stewardship and underlining the links between peace, development and human rights".⁴ However, translating these goals into practice is not without challenges. This essay considers:

- How do the SDGs relate to children's rights?
- How do the SDGs build on and extend the MDGs?
- How can the SDGs promote children's survival and development?
- How will the SDGs measure impact and track progress for children?
- What is the status of South Africa's children?

How do the SDGs relate to children's rights?

UNICEF has demonstrated how the SDGs map onto all the rights in the UN Convention on the Rights of the Child (UNCRC),⁵ for example, the commitment to ensure that no one is left behind⁶ echoes the right to non-discrimination, a general principle of the UNCRC.⁷ The SDGs are not "a radical reinvention of rights and development standards",⁸ rather they set time-bound targets for the realisation of human rights. The UNCRC was adopted in 1989; however, millions of children across the world – and especially in Africa – are still being denied their rights: they live in extreme poverty, die from preventable causes, are subjected to abuse, and fail to learn due to poor quality education.⁹ Recognising this lack of progress, the SDGs call for a new approach – a coordinated global effort to reach those left furthest behind first.¹⁰

All rights in the UNCRC are interdependent and, while the treaty must be considered as a whole, there are four overarching

rights called "general principles" that must be considered and applied in the implementation of all other rights. They are: equality, respect for the best interests of the child, the right to survival and development, and the right to be heard.¹¹ While the right to equality is universal, the other three are unique to children. Together they contribute to a general attitude towards children and their rights. They recognise that children are dependent on adults, but that they have equal worth and value, and that when adults do anything that affects children they must consider their opinions, prioritise their best interests, and that the results should enable children to thrive.

There are various synergies between the SDGs and children's rights. They both paint a vision of a transformed world. They both recognise that rights and development are interdependent; and they both promote international cooperation. Hence, the goals could be viewed as a strategy for giving effect to children's rights and a mechanism for monitoring progress. However, the SDGs have a broader view and give effect to the human rights of everyone, whilst promoting the sustainable and efficient use of resources and energy, providing access to basic services, green and decent jobs, and protecting the environment. In short, children are just one element of the 2030 Global Agenda – and one of many vulnerable groups.¹ Yet, the UNCRC declares that children should get special protection and care; that their best interests should be a primary consideration;¹² and that investment in children should be to the maximum extent of available resources¹³. While there is little danger that we will lose sight of children in the 2030 Global Agenda, there is a danger that children could simply be lumped together with other vulnerable groups in a way that fails to consider and respect their best interests.

How do the SDGs build on and extend the MDGs?

Over the past two decades, impressive progress was made towards the MDGs, yet these gains often failed to reach those most in need – culminating in stark inequalities at global, regional, national and sub-national levels.¹⁴ While the East Asia and Pacific regions met all the MDGs, sub-Saharan Africa failed to reach most targets. Progress also varied sharply along the rural–urban divide with significant disparities in under-five mortality and access to sanitation. Generally, people living in cities saw far more progress than those in rural areas due to urban economies of scale and the challenges of providing services in more sparsely populated rural areas.¹⁵ The overarching progress towards the MDGs therefore

ⁱ For example, the 2030 Global Agenda recognises the following vulnerable groups: children, youth, persons with disabilities, people living with HIV/AIDS, older persons, indigenous peoples, refugees and internally displaced persons and migrants.

masked inequalities between countries, while the focus on national averages obscured inequalities within countries and failures to reach vulnerable groups, such as children.

While focusing on and investing in solutions in one sector is important, this often led to a siloed approach and did not necessarily provide the impetus to achieve broader developmental goals. For example, the targets for extreme poverty reduction, access to safe drinking water, and gender equality in education were met by 2015. Yet, global progress on many of the remaining MDG targets lagged behind, including universal completion of primary school; reductions in infant, child and maternal mortality; and improved access to basic sanitation.¹⁶

The SDGs build on the strengths of the MDGs and aim to overcome the challenges. Like the MDGs, the SDGs are goal directed and designed to serve as a springboard to drive “transformational” change. The SDGs emphasise the principles of universalism and interdependence with the intention of ensuring that no one is left behind and that progress takes place across all goals, equally and for everyone. States are encouraged to “design backwards” – starting with a vision and defining steps towards achieving it – and then measuring and accounting for progress. The design of the SDGs reflects a greater appreciation of the interrelatedness of goals and targets; and an emphasis on collaboration both across and within sectors, as well as within and across institutions.

Importantly, the SDGs are seen as integrated and indivisible. The success of one leads to the success of others, and engagement and advocacy at both the global and local level are seen as essential to synergise efforts and multiply impact. By bringing different stakeholders together around common goals and targets, the SDGs provide a platform to stimulate out-of-the-box (rather than siloed) thinking, deepening our understanding of the interplay of different factors, and promoting an integrated approach in

designing solutions. A country’s ability to combat hunger, for example, is linked to its infrastructure, land-tenure and health-care systems, and its capacity to manage natural resources and mitigate disasters. All of these areas are essential to combat malnutrition in children, address poverty, support economic growth, reduce inequalities and promote a safe and sustainable environment. At the same time, improvements in children’s nutritional status will contribute to improved education, health and economic outcomes.

The SDGs have a much more explicit focus on inequality than the MDGs and emphasise reaching the poorest, most excluded, and most vulnerable to ensure that no one is left behind. This includes Goal 10 which aims to reduce inequality within and between countries, and a call to disaggregate data wherever possible by age, sex, disability, race, ethnicity, origin, religion and economic or other status. This is particularly important for children who are affected by multi-dimensional forms of poverty,¹⁷ including income poverty, food insecurity, poor living conditions and poor access to services. These challenges may be compounded by discrimination and/or harassment on the basis of disability or ethnicity that may further compromise children’s access to services and opportunities across the life course, and drive an intergenerational cycle of poverty.

The SDGs have a strong emphasis on inclusion and participation, and the 2030 Global Agenda was negotiated by UN member states and informed by a UN-led global conversation involving 10 million people from all walks of life including leaders, experts and marginalised communities. This consultative process gave rise to a set of 17 goals, 169 targets and 232 unique indicators, a significant increase when compared to the MDGs which comprised of eight goals and 60 indicators. This speaks to a broad policy agenda that aims to promote both social justice and sustainable development, and there will need to be continued focus and efforts to ensure that children are not lost amongst competing priorities.

Figure 1: The global goals for sustainable development

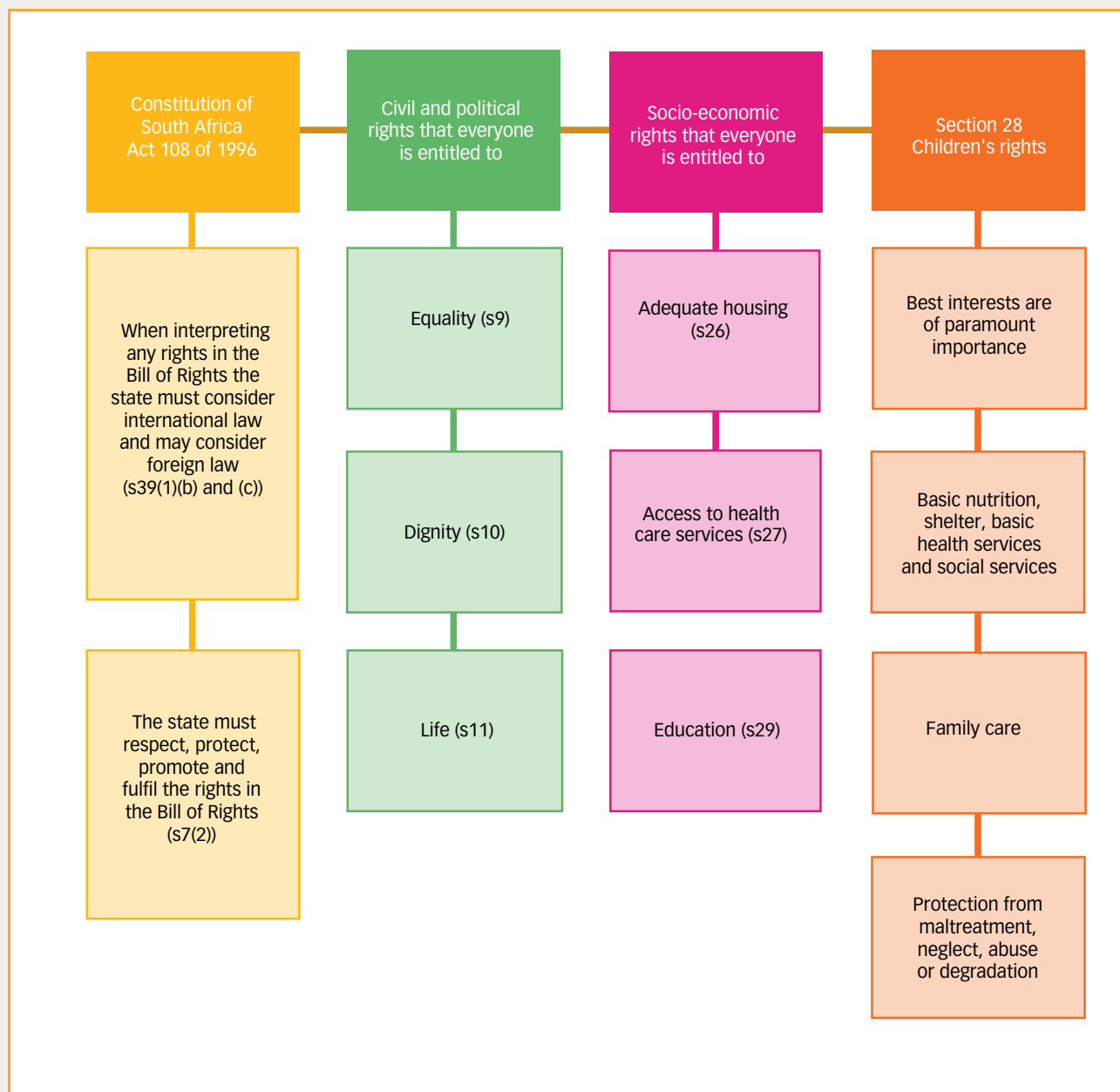


Box 1: Children's right to survival and development in the South African Constitution

The Constitution does not explicitly include a right to survival and development; however, all rights are interdependent and indivisible and, when read together, the rights to life, dignity, equality, education and the section on children's rights offer the same protection.¹⁸ The state has an obligation to provide services to prevent children from dying and to create an enabling environment in which children can develop to their full potential. Furthermore, the Constitutional Court ruled that: "The four great principles of the CRC ... guide all policy in South Africa in relation to children."¹⁹ Rights are legally binding, thus individuals or organisations can take the government to

court if the state violates or fails to realise any of the rights in the Constitution. Goals and targets such as the SDGs are not justiciable but, if linked to the rights framework, government can be held accountable for achieving the targets. For example, whilst the MDGs clearly put infant and child mortality on both the global and domestic agenda, the most important factor in reducing mortality rates in South Africa was the roll-out of antiretrovirals to prevent mother-to-child transmission of HIV.²⁰ In this instance social justice advocates, namely the Treatment Action Campaign, won changes to government policy following a legal battle.²¹

Figure 2: Children's right to survival and development in the South African Constitution



How can the SDGs promote children's survival and development?

The UNCRC obliges states to ensure “to the maximum extent possible the survival and development of the child”;²² where a child is anyone under the age of 18.²³ Many articles of the UNCRC specifically refer to the concept of development highlighting its physical, mental, cultural, spiritual, moral and social dimensions.²⁴ The Committee on the Rights of the Child has issued guidance showing that the fulfilment of the right to survival and development is contingent on the implementation of other rights, including “health, adequate nutrition, social security, an adequate standard of living, a healthy and safe environment, education and play ... , as well as through respect for the responsibilities of parents and the provision of assistance and quality services”.²⁵ In other words, child survival and optimal development are multi-faceted and require many role-players to work together. Parents and families are primarily responsible for ensuring that children thrive, but the state and civil society organisations also have an obligation to support families and provide services such as schools, clinics, protection services, child grants, infrastructure, water and sanitation. Most of these are addressed in the 2030 Global Agenda; thus, the SDGs promote children's right to survival and development.

The SDGs can only deliver on their promise for children if the world can ensure that every child is counted and that no one is left behind. It is therefore vital that the goals effect real change for all children, especially those most in need. It also is important that implementation strategies recognise and build on the interdependence and interrelatedness of the different goals, and adopt cross-sectoral and cross-institutional approaches, for example, working across education, health, water, agriculture and other sectors including academia, professional bodies and civil society to maximise potential synergies. These principles are clearly illustrated by the Global Strategy for Women's, Children's and Adolescents' Health²⁶ which builds on SDG 3: Good Health and Well-being.

The strategy outlines an ambitious vision: “By 2030, a world in which every woman, child and adolescent in every setting realises their rights to physical and mental health and well-being, has social and economic opportunities, and is able to participate fully in shaping sustainable and prosperous societies.”

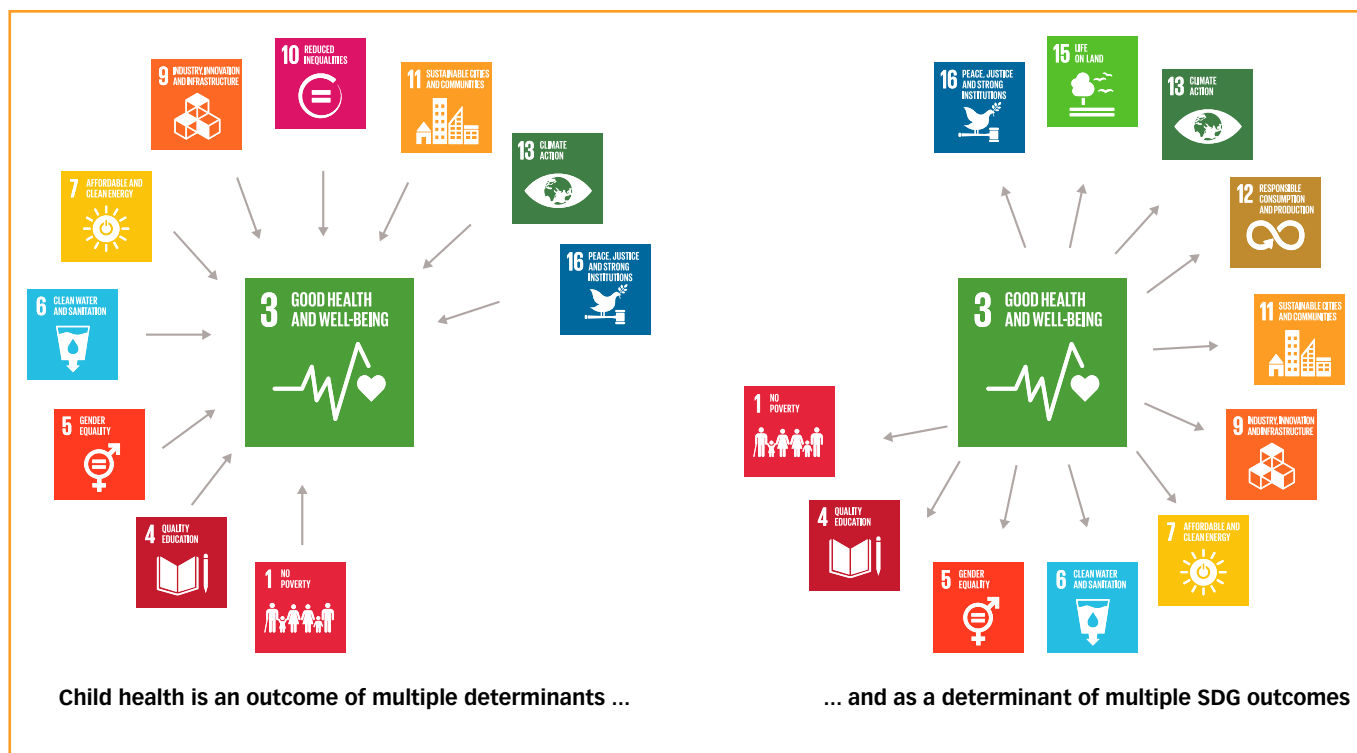
Survive, Thrive and Transform are three overarching objectives that drive the Global Strategy and aim to end preventable mortality, ensure health and well-being, and expand enabling environments in which women, children and adolescents can thrive.

Table 1: Key targets to ensure children survive, thrive and transform

Theme	Target	Indicators
Survive	End preventable deaths	<ul style="list-style-type: none"> Reduce global maternal mortality to less than 70 per 100,000 live births Reduce newborn mortality to at least as low as 12 per 1,000 live births in every country Reduce under five mortality to at least as low as 25 per 1,000 live births in every country End epidemics of HIV, tuberculosis, malaria, neglected tropical diseases and other communicable diseases Reduce by one third premature mortality from non-communicable diseases and promote mental health and well-being
Thrive	Ensure health and well-being	<ul style="list-style-type: none"> End all forms of malnutrition and address the nutritional needs of children, adolescent girls, and pregnant and lactating women Ensure universal access to sexual and reproductive health-care services (including family planning) and rights Ensure that all girls and boys have access to good quality early childhood development Substantially reduce pollution-related deaths and illnesses Achieve universal health coverage including financial risk protection and access to quality essential services, medicines and vaccines
Transform	Expand enabling environments	<ul style="list-style-type: none"> Eradicate extreme poverty Ensure that all girls and boys complete free, equitable and good quality primary and secondary education Eliminate all harmful practices and all discrimination and violence against women and girls Achieve universal and equitable access to safe and affordable drinking water and to adequate and equitable sanitation and hygiene Enhance scientific research, upgrade technological capabilities and encourage innovation Provide a legal identity for all, including birth registration Enhance the global partnership for sustainable development

Source: Every Woman, Every Child (2015) *The Global Strategy for Women's, Children's and Adolescents' Health (2016 – 2030)*. Survive, Thrive, Transform. Every Woman, Every Child. New York: EWEC.

Figure 3: Child health is both an outcome and determinant of multiple SDGs



The indicators in table 1 are used to monitor progress in realising the Global Strategy and are derived from the SDGs.

The 2030 Global Strategy is transformative in a number of ways. Firstly, it adopts a life-cycle approach by identifying a series of evidence-based intervention packages to promote optimal development and continuity of care across the life course. Adolescents feature for the first time along with women and children, in recognition of the pivotal role they play as drivers of change, as well as the unique and often unaddressed challenges facing young people.

Secondly, the strategy looks beyond the health-care system and has adopted an intersectoral and integrated approach identifying a range of factors that are needed to create an enabling environment. In other words, the strategy recognises that child health is both an outcome and a determinant of multiple SDG outcomes (as outlined in figure 3). For example: good health is dependent on access to adequate food, housing, water and sanitation – as well as access to health-care services. While good nutrition enhances cognitive development, education and employment outcomes.²⁷

By adopting an integrated approach, the Global Strategy – while focusing on good health and well-being – has a potential “domino” or multiplier effect that may help leverage progress for children across various sectors.

The concepts of survive, thrive and transform can also be applied to other contexts. For example, in education, children need to be able to read (survive), learn (thrive) and have opportunities to apply what they read and learn (transform). These concepts are explored further in subsequent chapters.

How will the SDGs measure impact and track progress for children?

Understanding the situation of children in relation to the SDGs is crucial both for the well-being of children and for achieving the global goals. While none of the goals exclusively addresses the needs of children, most SDGs have targets that are either directly, indirectly or broadly related to children. The world cannot, and will not, realise these goals unless the specific needs of children are monitored and addressed throughout the course of the 2030 Global Agenda.

In fulfilling the SDGs, national strategies should aim to ensure that no child is left behind, and that those furthest behind are made the first priority of implementation efforts.²⁸ Critical to the success of the SDGs are accountability mechanisms to ensure governments are answerable for delivering on the goals for all children everywhere; and opportunities for children, youth and civil society to participate in this process at all levels.

It is often said, “what gets counted, gets done”, so to what extent do children count, and get counted in the SDGs? While the SDGs call for the disaggregation of indicators, this does not necessarily ensure that data will be disaggregated to child level. Instead government status reports often focus on population and household-level data, and fail to include child-centred statistics. This creates a challenge when monitoring progress for children, as previous research has indicated that children are disproportionately affected by poverty.²⁹ In other words, there is a risk that children’s specific needs will be overlooked and that they will continue to lag behind – especially in cases where the indicators do not explicitly

Box 2: National reviews of progress towards the SDGs

As part of monitoring progress towards realising the SDGs, member states are encouraged to undertake voluntary national reviews. These internal reviews should be conducted regularly, at national and sub-national levels; be transparent, inclusive and participatory; and be led by the state with representation from civil society groups, the private sector, general public (including children) and other stakeholders.³⁰ The reviews should also be rigorous and informed by evidence. In a nutshell, the voluntary reviews provide a platform for countries to scrutinise the extent to which the SDGs are integrated into local policies and programmes and their progress towards achieving the SDGs. A report is prepared, submitted to, and presented at the United Nations High-level Political Forum on Sustainable Development. This report is expected to include achievements and challenges that hinder the realisation of the targets, and statistics on the SDGs indicators. In 2016, 22 countries conducted national reviews and submitted reports to the forum; four of these were in sub-Saharan Africa (Madagascar, Sierra Leone, Togo and Uganda).³¹ In 2017, the number nearly doubled to 43 countries, including seven from

sub-Saharan Africa (Benin, Botswana, Ethiopia, Kenya, Nigeria, and Togo).³² South Africa has not yet conducted a review, and it is unclear when the country will do so; as it has not yet signed up to submit a report in 2018.

It must be noted that these reviews are time intensive and demand human and financial resources, especially since they are to be conducted at different levels of government, and require involvement of various stakeholders. In addition, the lack of regular, high-quality and timely data means that developing countries are struggling to present national and disaggregated statistics for many of the SDG indicators. The majority of government departments and national statistical offices face capacity and financial constraints,³³ making it difficult for them to collect and analyse administrative data or conduct regular surveys. Consequently, some reports do not give a comprehensive picture on the welfare of children, and instead statistics are limited to “traditional” child indicators, such as malnutrition, education and mortality. Where data are available, not much focus is paid to disaggregating statistics across age, sex, geographical locations and other variables of interest.

ask for statistics to be disaggregated by age, or where indicators are not child specific.

In 2013, there was a call for a “Data Revolution”³⁴ – a significant increase in the production (quantitative and qualitative), use and dissemination of data to address inequalities in data access and use between and within countries, across people (information-rich and information-poor) and between the private and public sector, by 2020.³⁵ However, this will require significant financial investment to increase the capacity of national statistical offices, government departments and civil society organisations to produce, analyse and disseminate the data.

Child-centred indicators

To better understand the extent to which children’s specific needs are considered in the SDGs, we compared the measurement indices for the MDGs and SDGs, and focused on indicators that directly cover children (including those that mention children, and indicators where age disaggregation is specifically required).

While total number of child-centred indicators increased from the MDGs to the SDGs, the proportion of indicators directly focusing on children decreased from 50% to 37%,³⁶ raising concerns that children’s needs may get lost amidst competing interests.

This is not necessarily clear cut, as the goals and targets aim to promote the welfare of all people, including children. While some indicators such as household income or expenditure levels have a direct and immediate impact on children’s access to food, electricity, adequate water and basic sanitation, the links between other indicators and children’s welfare are more tenuous. Yet even the tracking of food price anomalies has an indirect impact on child

nutrition by limiting the volatility of food prices and safeguarding household food security.

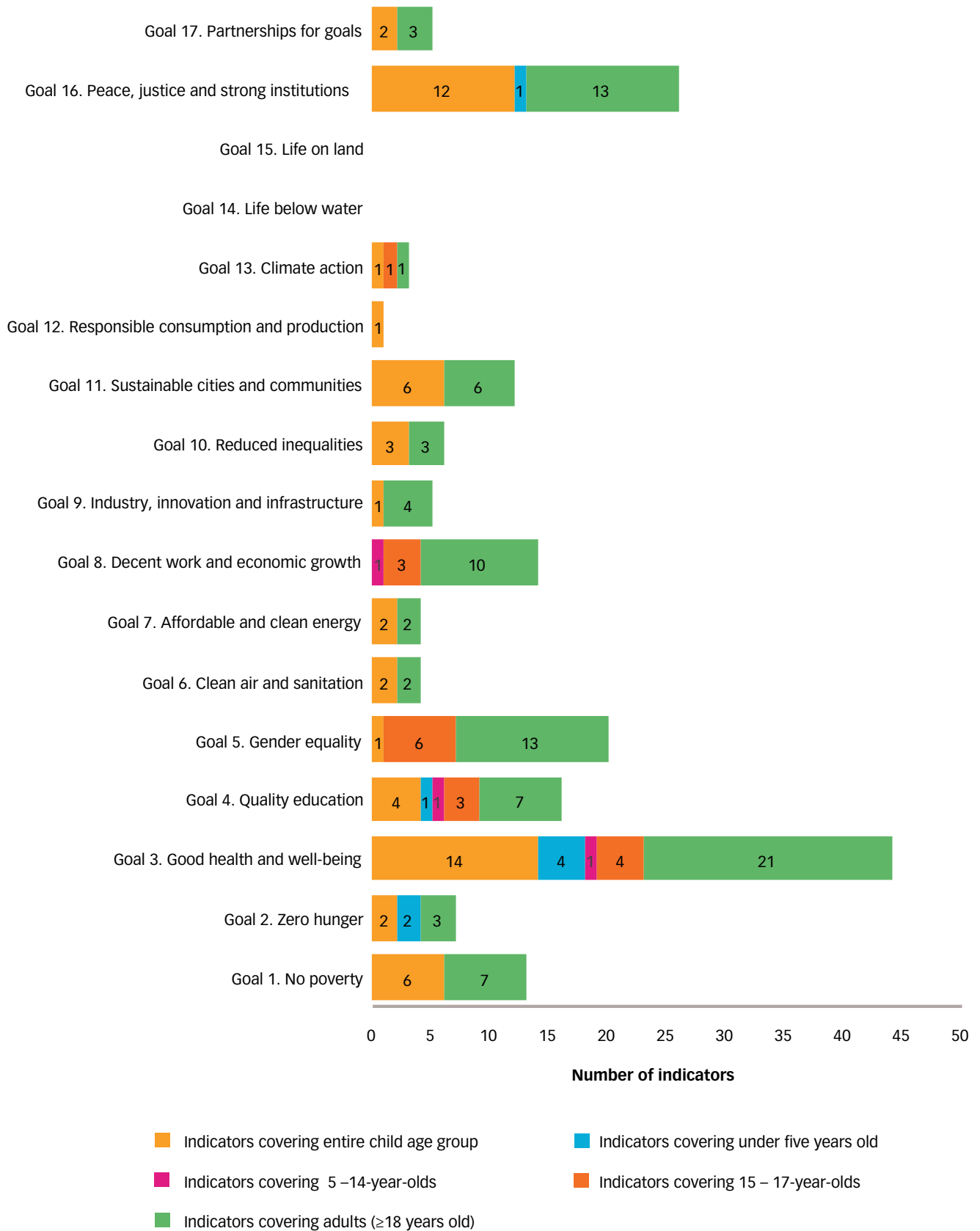
Figure 4 presents an analysis of the SDGs, showcasing the number of indicators that directly focus on children and adults across the 17 goals. Some goals have indicators that cover specific child age groups while the majority have at least one indicator that relates to all children. There are some goals, such as the one on gender equality, that have more indicators focusing on adults than on children.

Disaggregating statistics by age

At times it is important to disaggregate statistics by age to track progress at key points in the life course, as in the case of neonatal and under-five mortality as young children are particularly vulnerable. Yet this focus may also divert attention and resources away from other vulnerable groups. For example, Goal 2 contains several indicators to track stunting, wasting and overweight amongst children under five years of age, yet the goal fails to track the nutritional status of older children and the growing burden of overweight and obesity in adolescence. There are also indicators, such as those relating to education, employment, and sexual and reproductive health, that refer to individuals aged 15 years and older. This raises questions around the extent to which the specific needs of adolescents (15 – 17-year-olds) are addressed or obscured because they are conflated with those of “youth” or “adult women”.

In addition, there may be difficulties in measuring some indicators, including those that are child specific, as their interpretation, measurement and monitoring may differ across

Figure 4: Number of SDG indicators specific to children and adults



Analysis by Winnie Sambu, Children's Institute, UCT.

countries, government departments and civil society groups. Particularly in cases where indicators are not defined using easily understood measures such as incidence or prevalence, but focus on the extent or degree to which a condition (or service) exists.

As the SDGs are implemented, human rights should serve as a compass to guide effective delivery. The starting point is to ensure that implementation activities (and their unintended consequences) do not undermine children's rights. Secondly, the commitment to ensuring that no one will be left behind – and that those furthest behind will be reached first – is central to the realisation of children's rights. It requires placing the elimination of discrimination and reduction of inequalities at the forefront of efforts to implement the SDGs, alongside the prioritisation of efforts to reach those children at greatest risk of being excluded.³⁷

While there are certainly challenges in monitoring progress for children, the SDGs provide the opportunity to harness resources, measure impact and achieve better results for children.

What is the current status of South Africa's children?

The SDGs recognise that high-quality, timely and disaggregated data are essential at country level to direct government investments, shape policy and service delivery, achieve the SDGs, and, ultimately, fulfil the rights of every child. Therefore, Goal 17 includes a specific provision to strengthen data systems, and provides a unique opportunity for South Africa to review current data sources and close the data gaps.

Based on a child-centred analysis of the SDGs, table 2 lists a selection of indicators that capture the current status of South Africa's children, highlighting current strengths and challenges.

Table 2 shows that, while South Africa has met, or is on course to meet, some of the SDG targets, there are several areas where the country lags behind. Significant progress has been made in reducing under-five and infant mortality rates, and the country has already met the neonatal mortality target of 12 deaths per 1,000 live births. While nearly all school-going children attend school (97%),³⁸ the quality of education remains a concern, and a high percentage of children in grades 3 and 9 perform below the 50% mark in numeracy and literacy. A high proportion of children continue to live in households that lack access to basic services, such as adequate water and sanitation. There is also a significant proportion of children living in households where there are food insecurity and hunger. Stunting, a manifestation of inadequate

diets, disease and poor living environments is high and affects a large proportion of children in the country, particularly those in poor households. Significant investments are therefore needed to ensure that the country achieves SDG targets at all levels, especially where lagging behind. For example, Goal 1 (End poverty) targets a reduction in national poverty rates, by at least half, between 2015 and 2030. In 2015, 62% (11.6 million) of children in the country lived below an upper bound poverty line, down from 14.7 million children in 2003. This represents a 21% reduction in child poverty estimates over the 13-year period. If the country is to halve child poverty rates by 2030, then efforts to combat income poverty and inequality need to be intensified.

As highlighted in table 2, it is difficult to provide a complete picture of the status of children in South Africa due to the lack of certain data. In particular, data on child abuse are scarce. Where national estimates are available, they are limited to specific age groups, mainly focused on older children. This raises a concern about the extent to which younger children are overlooked, especially since some studies have shown that young children are particularly at risk.³⁹

Conclusion

The Sustainable Development Goals outline an ambitious agenda for all and, in particular, for children. They urge us collectively to reach every child, family and community and to change the trajectory of lives in a way that has never been done before. However, there are various challenges and constraints that must be addressed if we are to achieve the SDGs. In particular, many developing countries lack the financial and human resources to implement the SDGs, as well as to monitor and evaluate the programmes put in place to meet the targets and improve the welfare of all citizens, including children. Fiscal constraints remain a big challenge, particularly for low-income countries, and for middle-income countries like South Africa where there are competing national interests. Lack of regular administrative and survey data to monitor the SDGs, particularly for children, remains a serious concern; statistical agencies lack the resources and capacity to collect data at regular intervals, and on the scale that the SDGs require.

The emphasis on country-level action provides a huge opportunity to bring different sectors together to tailor a specific plan to address children's needs in the South African context. Let us maximise the opportunity. We owe it to our children.

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- 10 See no. 1 above.
- 11 See no. 7 above. Articles 2, 3, 6 and 12.
- 12 See no. 7 above. Article 3.
- 13 See no. 7 above. Article 4.

Table 2: A baseline analysis of the situation of children in South Africa, using child-centred indicators based on the SDGs

GOAL 1: End poverty in all its forms everywhere
<p>By 2030, eradicate extreme poverty (people living below \$1.25 a day) and halve the proportion of children living in poverty, based on national definitions.</p> <ul style="list-style-type: none"> In 2015, 13% of South Africa's children still lived in extreme poverty,⁴⁰ and 62% of children lived below an upper bound poverty line of R965 per person per month.⁴¹ 66% of children received a social grant in 2015.⁴² 11.7 million children received the Child Support Grant (CSG), 0.5 million the Foster Care Grant (FCG) and 130,000 received the Care Dependency Grant (CDG).⁴³ 18% of children eligible for the CSG did not receive the grant.⁴⁴ It is difficult to estimate the number of children excluded from the FCG and CDG as there are no estimates on the number of children with disabilities or in need of foster care.
GOAL 2: End hunger, achieve food security and improved nutrition, and promote sustainable agriculture
<p>By 2030, end hunger and malnutrition; ensure access to safe, nutritious and sufficient food; address nutritional needs of adolescent girls, pregnant and breastfeeding women; and achieve targets on stunting and wasting in children under five.</p> <ul style="list-style-type: none"> In 2015, 13% of children in South Africa lived in households that reported child hunger.⁴⁵ 29% of children lived below the food poverty line of R415 per person per day.⁴⁶ 25% of children 6 months – 2 years were stunted,⁴⁷ and 77% of children aged 6 – 23 months were not fed an acceptable diet.⁴⁸
GOAL 3: Ensure healthy lives and promote well-being for all at all ages
<p>By 2030, end preventable deaths and reduce under-five mortality to at least 25 deaths per 1,000 live births and neonatal mortality to 12 deaths per 1,000 live births.</p> <ul style="list-style-type: none"> In 2014, the under-five mortality rate was 37 deaths per 1,000 live births,⁴⁹ and the neonatal mortality rate stood at 12 deaths per 1,000 live births.⁵⁰
GOAL 4: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all
<p>By 2030, ensure that all girls and boys complete free, equitable and quality primary and secondary education leading to relevant and effective learning outcomes.</p> <ul style="list-style-type: none"> 41% of 3 – 5-year-olds in the poorest 40% of households do not attend an early learning programme, compared to 17% of those in the richest 20% of households.⁵¹ In 2014, 57% of grade 3 learners and 48% of grade 9 learners achieved at least 50% in their home language.⁵² 56% of grade 3 learners and only 3% of grade 9 learners achieved 50% or more in mathematics.⁵³
GOAL 5: Achieve gender equality and empower all women and girls
<p>By 2030, eliminate all forms of violence against women and girls in the public and private spheres, including trafficking, sexual and other types of exploitation.</p> <ul style="list-style-type: none"> 34% of girls aged 15 – 17 years have experienced some form of sexual abuse.⁵⁴ Data on intimate partner violence (IPV) are not available. The 2016 Demographic and Health Survey collected data on IPV in the home, focusing on adult women, but these data have not yet been made public; so it is impossible to derive estimates on number of children exposed to IPV.
GOAL 6: Ensure availability and sustainable management of water and sanitation for all
<p>By 2030, achieve universal and equitable access to safe, affordable drinking water for all; adequate and equitable sanitation and hygiene, and end open defecation (with special attention to women, girls and those in vulnerable situations).</p> <ul style="list-style-type: none"> In 2015, 68% of children lived in households with adequate water (access to piped water inside or on site).⁵⁵ Access varied across geographical areas: 91% of children in urban areas – but less than half (39%) of children in traditional areas or (44%) on commercial farms – had access to adequate water. 76% of children had access to basic sanitation (flush toilets or ventilated pit latrines), yet 2.4 million children (13%) lived in households where there was no tap or water point to wash their hands after using the toilet.⁵⁶

GOAL 7: Ensure access to affordable, reliable, sustainable and modern energy for all

By 2030, ensure universal access to affordable, reliable and modern energy services.

- In 2015, 89% of children in South Africa had access to a mains electricity supply.⁵⁷
- However, a significant proportion of children (34%) lived in households where biofuels (such as wood) and paraffin were used for cooking, heating or lighting.⁵⁸
- 25% of children living in informal housing used paraffin for cooking, lighting or heating.⁵⁹

GOAL 8: Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all

By 2030, achieve full and productive employment and decent work for all women and men, including for young people and persons with disabilities, and equal pay for work of equal value; and, by 2030, substantially reduce the proportion of youth not in employment, education or training.

- In 2015, 31% of children (and 70% of children in the poorest households) lived in households where no adult was employed.⁶⁰
- 3.3 million young people aged 15 – 24 years old (32%) were not in employment, education or training.⁶¹

GOAL 9: Build resilient infrastructure, promote inclusive and sustainable industrialisation and foster innovation

Develop quality, reliable, sustainable and resilient infrastructure to support economic development and human well-being, with a focus on affordable and equitable access for all; and significantly increase access to information and communications technology and strive to provide universal and affordable access to the Internet in least developed countries by 2020.

- There are no data on the proportion of rural children living within 2 km of an all-season road.
- Almost all children (99%) live in households where there is a working cellular phone, but there is no household level data on the proportion of the population covered by a mobile network.⁶²

GOAL 10: Reduce inequality within and among countries

By 2030, empower and promote the social, economic and political inclusion of all, irrespective of age, sex, disability, race, ethnicity, origin, religion or economic or other status.

- There are high levels of income inequality in South Africa, and 43.5% of children live below 50% of the median per capita income.⁶³
- Inequality is highly racialised: 81% of African children live in the poorest 50% of households, compared to only 7% of White children.⁶⁴

GOAL 11: Make cities and human settlements inclusive, safe, resilient and sustainable

By 2030, all people living in urban areas, including children, should have access to adequate, safe and affordable housing and basic services.

- 1.3 million children (12%) live in informal housing in South Africa.⁶⁵
- 19% of children residing in urban areas live in overcrowded conditions and this increases to 59% for children living in informal housing.
- 2 million children in urban areas (19%) live in households where there is irregular or no removal of waste.⁶⁶

GOAL 16: Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels

Significantly reduce all forms of violence; end abuse, torture, exploitation, trafficking and all forms of violence against children.

- South Africa has high rates of child abuse: 1 in 3 children aged 15 – 17 years old are reported to have experienced some form of sexual abuse.⁶⁷ National and sub-national data on child protection, especially amongst younger age groups, are lacking.

GOAL 17: Strengthen implementation and revitalise the Global Partnership for Sustainable Development

By 2030, build on existing initiatives to develop measurements of progress on sustainable development that complement gross domestic product, and support statistical capacity building in developing countries (including 100% birth registration).

- In 2015, 85% of children in South Africa were registered in their year of their birth.⁶⁸

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Striving for the Sustainable Development Goals: What do children need to thrive?

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If we change the beginning of the story, we change the whole story.

Raffi Cavoukian, *The Beginning of Life*¹

In the opening essay, Bhardwaj, Sambu and Jamieson assert that focusing on children is crucial both for the well-being of children and for reaching the Sustainable Development Goals (SDGs).² In signing the SDGs, states promised to leave no-one behind and to transform societies, economies and the environment to ensure a fairer and safer future for all. This essay critically engages with the 2030 Global Agenda and assesses the potential of the SDGs to transform our world to enable *all* children – regardless of race, gender, ability, or social background – to not only survive but thrive.

In this essay, we examine the following key questions:

- What enables children to thrive?
- What interventions are needed to ensure that all children thrive?
- To what extent do the SDGs promote nurturing care?
- Do the SDGs create an enabling environment for caregivers and families?
- Do the SDGs have the potential to transform the social, economic, political, climatic and cultural contexts in which families and children live?

Figure 5: Nurturing care, enabling environments and supportive contexts



Source: Adapted from: Daelmans B, Darmstadt GL, Lombardi J, Black MM, Britto PR, Lye S, Dua T, Bhutta ZA, Richter LM & Lancet Early Childhood Development Series Steering Committee (2017) Executive Summary: Early childhood development: The foundation of sustainable development. *The Lancet*, 389(10064): 9-11.

What enables children to thrive?

To thrive, children need nurturing care, an enabling environment and supportive contexts as outlined in figure 5. Reflecting on the early years, Black *et al* define nurturing care as having five domains: “health, nutrition, security and safety, responsive caregiving, and early learning.”³ Nurturing care is equally important for young children and adolescents although the exact nature of how support is provided, and who provides it, changes across the life-course. For example, in the early years nurturing care is provided by parents through family interactions; however, during adolescence peers, teachers, mentors, religious leaders and others join family in a broader social network providing different aspects of care.⁴ All children, regardless of ability, gender, race, etc., must be included – and enabled to participate – in the social institutions, such as schools and cultural communities, that support them to imagine and achieve a desired future.

Nurturing care

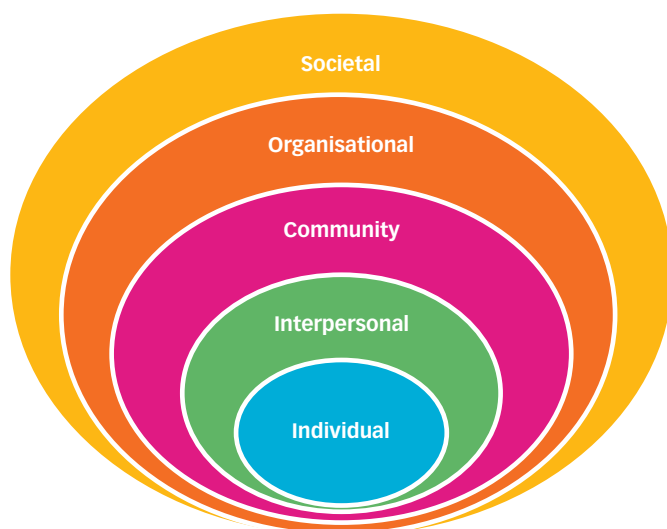
Human beings have evolved over thousands of years with unique and complex capacities to learn and to cooperate with one another. This is manifest in two, seemingly contradictory, features that become evident at conception and unfold during infancy. Firstly, the brains of babies develop very quickly to a blueprint that sets up the basic architecture of human potential.⁵ Secondly, the building blocks for this potential are totally dependent on an enabling environment, especially the stable, nurturing care of parents, whether they are biological parents or not.⁶

The fundamental architecture of a child’s brain is established by about two months after conception, from which time the developing foetus can receive and use information from the environment. As the brain gets bigger and more complicated, circuits for the senses, like hearing, taste and sight are formed, and these pave the way for the development of higher-order cognitive and language functions.⁷ Development throughout pregnancy and early childhood is progressive, with each stage building on the one before; thus, initial experience and learning sets the parameters or constraints for later learning. While the brain retains the capacity to adapt and change throughout the lifespan, this process of *entrenchment* means that our early childhood environment sets the foundation for how we develop.⁸

Babies only grow and develop – survive and thrive – in certain kind of environments. We know that the developing embryo and then the foetus need nutrition and protection from toxins, trauma and disease. Without these, life is not possible and the baby miscarries, is stillborn, or dies after birth. Some babies survive these threats, but only for a while, or survive with disabilities. For example, a child infected with HIV during pregnancy may survive the pregnancy and delivery but, without treatment, has only a 50% chance of living to their second birthday before being overwhelmed by illness.⁹ A foetus exposed to alcohol during pregnancy may fail to grow and have neurodevelopmental difficulties.¹⁰

The environments young children need must not only be free from harm. They must also provide the experiences which the brain and other systems need to grow and develop. For example, children must be exposed to communication to learn how to communicate,

Figure 6: The socio-ecological model



Individual: Biological and personal history factors influence a child’s development, such as age, gender, knowledge, attitudes, developmental history, economic status, literacy, stigma.

Interpersonal: Formal and informal social networks and support systems, including family, friends, peers and religious networks, can influence individual behaviour and contribute to the child’s range of experiences. These relationships are bi-directional in that the child’s reactions to others affects how people treat them in return.

Community: Relationships occur in community settings such as schools, faith groups and neighbourhoods. Many communities in South Africa have high levels of violence and even witnessing violence causes psychological distress in children.

Organisational: Rules and regulations affect how, or how well, services are provided to an individual or group. For example, youth-friendly health services are designed to meet adolescents’ health needs responsively, and encourage young people to return for continuing care.

Societal: Broad societal factors such as social norms, cultural practices, economic and social conditions, in conjunction with provincial, national and global laws and policies, shape the environment in which children develop – even when they are not directed at children, such as government policies on agriculture, labour or transport.

Source: Adapted from: Bronfenbrenner U & Morris PA (2006) The bioecological model of human development. In: Lerner RM & Damon W (eds.) *Handbook of Child Psychology: Theoretical Models of Human Development*. p. 793-828. Hoboken, NJ: John Wiley

and this needs to occur in the context of human affection and care. If infants receive only routine care for hygiene and feeding by staff on shifts, then no more than one in three babies reared in group orphanages survive. Those who survive, grow poorly and have severe cognitive and language delays.¹¹

Stable, caring relationships are essential for young children to thrive and to develop the basic human capacities they need to relate to and cooperate with other people. For example, infants get information about what is important to learn by following the gaze, interest and emotional responses of their parents. They learn to know who or what is friendly or hostile by interpreting their parents' emotional, postural and facial cues. Similarly, children experience their self-worth through their parents' attention, affection and encouragement. Together with support, they develop the self-confidence to explore the world and try new things. Positive social exchanges and interactions improve learning and productivity at all ages.

Older children and adolescents who have stable, affectionate relationships with families and friends, and encouragement and opportunities to achieve at school and in their communities, do better than young people who don't have these supports.¹² They are also more resilient to the challenges life presents as they are increasingly exposed to peer and media influences, and approach adulthood. Encouragement to participate in many dimensions of social life builds connections with others, enhances self-esteem and inspires confidence to make considered decisions about education, health, friendships and future aspirations. The 2016 Lancet Commission on Adolescence emphasises four channels for effectively promoting development in adolescence: secondary education as the most powerful determinant of adolescent health and human capital; enabling and protective legislation, policies, schools, communities and families; social media; and the participation of youth as advocates for their own health and well-being.¹³

Enabling environments and supportive contexts

Parenting is driven by culturally informed motives about the value of children and what it means to be a good parent, and by emotions of deep affection and commitment aroused by the baby's helplessness and dependence. These motives emerge and are supported by material and socio-cultural security that comes from support by a partner, relatives and community. Early and subsequent experiences in childhood and adolescence build life-long relationships of care and mutual responsibility. However, parenting can break down under the stress of conflict, financial hardship, interpersonal violence and social isolation. Parents and caregivers therefore depend on policies, living conditions and services that together create an enabling environment for them to function as supportive families and enable children to thrive.¹⁴ Key ingredients of such enabling environments include protection from disaster and despair; economic and social security; infrastructure to support daily life; health, education and social services; and social inclusion and support from loved ones.

Bronfenbrenner's ecological systems theory explains how a child's growth and development are affected by their social

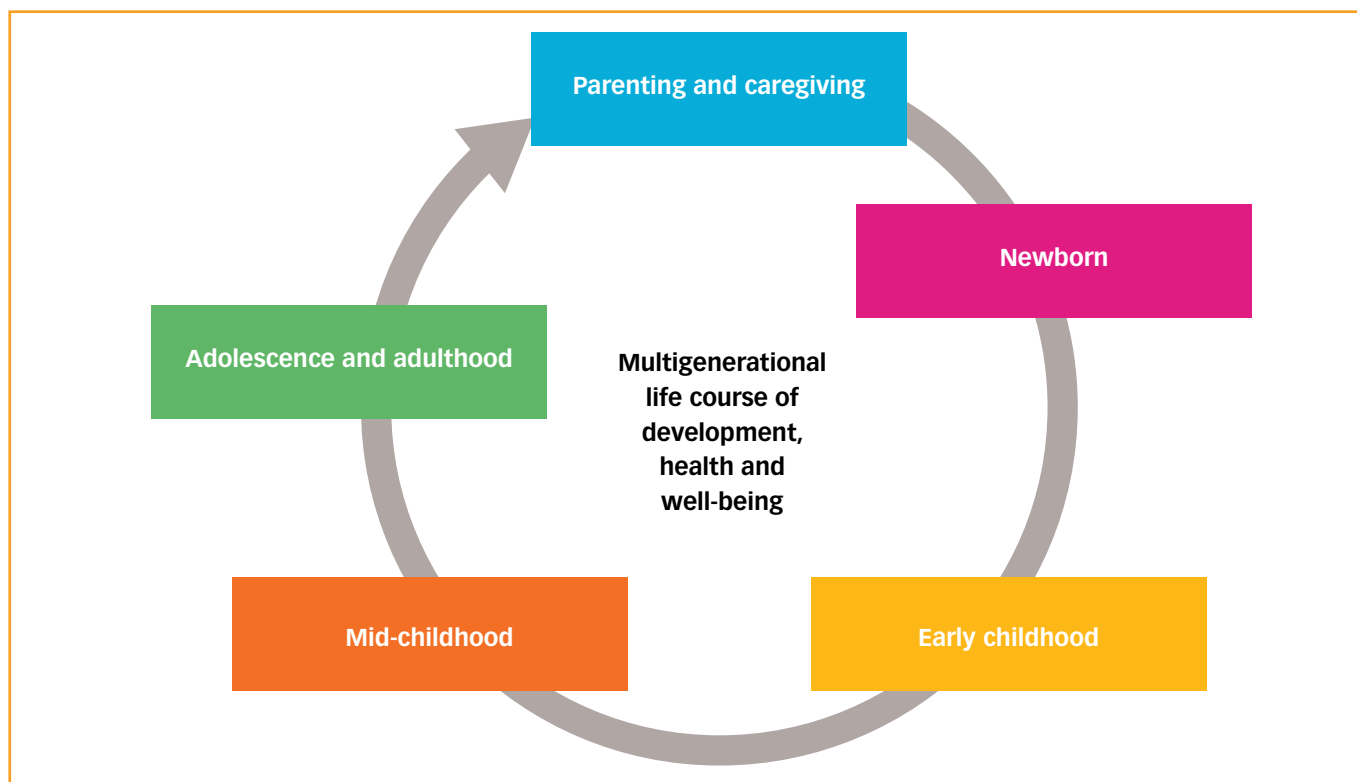
relationships and the world around them as outlined in figure 6. These factors and contexts interact and influence one another. If there is a change in one system, it may cause changes in another. Equally, transitions occur over the life course and major socio-historical events such as South Africa's transition to democracy, can impact several systems. On a more personal level, death of a parent is a major life transition that affects children's development and behaviour.

What interventions are needed to ensure all children thrive?

Ensuring all aspects of an enabling environment for families and children challenges states that have limited capacity and many demands on the government budget. It is therefore important to know what – and how – to prioritise. Long-term studies of children and families demonstrate the value of investing in young children, and guaranteeing they not only survive but thrive. There are three kinds of studies that provide evidence of early benefits: studies that follow children naturalistically in cohorts from birth to adulthood and into the next generation; studies that examine the effects of an intervention and follow the beneficiaries over time to see how robust the impact is and establish the cost-benefits; and studies that calculate the cost-benefits of natural variations in conditions (ecological interventions). These studies show how the life course of an individual forms part of an intergenerational cycle of development as illustrated in figure 7 on p. 36, where benefits and losses incur not only to the person concerned, but also to subsequent generations.

The best-known naturalistic follow-ups of children in low- and middle-income countries are those in Brazil, Guatemala, India, the Philippines and South Africa, jointly known as the Consortium of Health Oriented Research in Transitioning Societies (COHORTS).¹⁵ In these studies, more than 22,000 children enrolled during pregnancy or at birth have been followed up to adulthood and even middle age. Their findings show that early conditions that promote children's growth and development – including maternal health and education, household economic conditions, and services such as water and sanitation – influence health and well-being across the life course. Children whose growth falls below expected levels for their age and sex are more likely to die prematurely, suffer chronic diseases, have higher rates of personal and social problems, lower levels of cognitive development, complete fewer grades of schooling, and earn less as adults. Through intergenerational transmission of disadvantage, their own children are more likely to be born small, develop below expected norms for age and have lower levels of intellectual achievement.¹⁶ Several studies in low- and middle-income countries have tracked the effects of early interventions, none as successfully (or for as long) as a nutrition intervention in Guatemala and a psychosocial stimulation programme in Jamaica. In Guatemala, children in similar villages received either a protein supplement or a control drink. Children started to receive the supplement at different ages, enabling conclusions to be drawn about the periods of life during which the maximum benefits were derived. The participants have been followed up for more than 40 years. Children who received the

Figure 7: An intergenerational cycle of development



Source: Adapted from Black MM, Walker SP, Fernald LC, Andersen CT, DiGirolamo AM, Lu C, McCoy DC, Fink G, Shawar YR, Shiffman J & Devercelli AE (2017) Early childhood development coming of age: Science through the life course. *The Lancet*, 389(10064): 77-90. Figure 1. P. 79.

protein supplement before (but not after) three years of age, had higher reading comprehension and higher intelligence test scores, and boys who received the supplement before two years of age earned 46% more as adults than children in the control arm of the study.¹⁷

In Jamaica, para-professionals visited undernourished children under two years of age at home, showing their mothers how to make homemade toys and play with their children. The group who received only home stimulation was compared to a group who received nutritional supplements, a group who received stimulation and supplements, and a control group of non-stunted children. The intervention groups caught up with the non-stunted children after two years, but the effects of nutritional supplements had washed out by seven years. Follow-up at 22 years of age showed that the children stimulated in infancy performed better in cognitive, educational, social and mental health domains. Moreover, they earned 42% more than the other undernourished groups.¹⁸

Some 250 million children, about 43% of all children below five years of age in low- and middle-income countries, are estimated to be at risk of poor development because they live in extreme poverty or because their growth is stunted by undernutrition and disadvantage. South Africa is no exception.¹⁹ These children are likely to develop below the norm set by their more fortunate peers throughout childhood, adolescence and adulthood and, as a result, their own children will start off with drawbacks, making it harder and harder for them to catch up. These individual effects are aggregated to the national level.

The calculated cost of stunting is a substantial portion of Gross Domestic Product (GDP) in several African countries (5.6% in Uganda and 16.5% in Ethiopia).²⁰ Using the same methodology, the estimated cost of stunting in South Africa is 1.3% of GDP, or some R62 billion per annum. Violence also has a substantial impact on the economy; the cost of disability-adjusted life years lost to violence against children (including both fatal and non-fatal injury) and reduced earnings was estimated at R238 billion in 2015/16.²¹

The 2017 *Lancet* series, *Advancing Early Childhood Development: From Science to Scale*, assessed the affordability of two interventions known to benefit early childhood development: support for perinatally depressed women based on the World Health Organisation (WHO) Thinking Healthy Package and parenting support based on the WHO/UNICEF Care for Child Development Package. Universal coverage of these two interventions for children at risk of developmental delay is estimated to add US\$0.2 to the annual costs per mother and child, if integrated into existing maternal and child health and nutrition services.

Whilst experiences in early childhood can determine adolescent health and well-being, continued development depends on complementary biological and social experiences during adolescence and into adulthood.²² The Lancet Adolescent Commission stressed the importance of laws and policies to protect and support adolescents. In South Africa, these include the law against child marriage, the protection of the education of pregnant school girls, age restrictions on the purchase of alcohol and tobacco, and the Child Support Grant for children up to the

age of 18 years, amongst others. The Commission also noted the protective effects of the completion of secondary schooling against violence, substance abuse, and HIV infection. In South Africa the proportion of children who complete upper-secondary school (grade 12) within 12 years fluctuates at about 40%, which is very low in comparison with countries such as Turkey and Brazil.²³ However, 16% of 20 – 24-year-olds remain in school,²⁴ and the pass rate continues to climb so that ultimately 57% of youth obtain a National Senior Certificate.²⁵ Adolescents are also the next generation of parents; they not only need adolescent-friendly sexual reproductive health services to plan whether and when they would like to have a child, but their health and well-being directly affects that of their own children.

The needs of all children are affected not just by their age, but also their individual circumstances. The UN Committee on the Rights of the Child cautions that “generic policies designed for children or young people often fail to address adolescents in all their diversity and are inadequate to guarantee the realization of their rights.”²⁶ Packages of care should be tailored to the specific needs of each child and adolescent. For example, Isibindi aims to supplement the capacities of highly vulnerable families to provide nurturing care for children; it offers a range of development programmes throughout South Africa to support children of different ages from early childhood to adolescence. Each of these specialist programmes is adapted to suit the needs of the individual child and family. For example, the Isibindi: Sinako Youth Development Programme (outlined in case 1 on p. 38) takes advantage of local opportunities to ensure that adolescents acquire the knowledge, skills and confidence for independent adult life. The programme addresses each individual’s personal development needs and interests by involving young people in decision-making.

The elements of nurturing care are interconnected and mutually reinforcing but, as children develop, their needs change and their worlds expand as they enter new settings and meet an expanded range of people. Thus, the support that individual children and their families require is dependent on their age, stage of development and specific context.

To what extent do the SDGs incorporate the key elements of nurturing care?

In 2015, the UN member states adopted a new global development agenda, Transforming our World: The 2030 Agenda for Sustainable Development (2030 Global Agenda)²⁷ that established 17 SDGs to be met by 2030. The goals are designed to safeguard the future of the planet for generations to come and to build a more equitable world in which no one is left behind. Each state is encouraged to write national implementation plans that take account of the national context, capacities, levels of development and national priorities. These plans also provide an opportunity to plug some of the gaps relating to children. The SDGs provide for many of the elements of nurturing care; however, some elements are not explicit and there are a few critical omissions, for example, parents and families are rarely mentioned, and there is a lack of attention to responsive care and the need to listen children.

Health and nutrition

Whereas, the Millennium Development Goals had a strong focus on physical health, increasing survival rates of infants, children and mothers, and reducing infectious diseases such as HIV, TB and malaria, the SDGs set new targets for reducing non-communicable diseases and road traffic injuries, and place mental health on the global agenda,²⁸ including a drive to strengthen the prevention and treatment of substance abuse. Equally, nutrition is extensively catered for; alongside the elimination of hunger, the SDGs envisage the end of child poverty and a significant reduction in inequality,²⁹ both of which often lead to hunger. The internationally agreed targets include ending all forms of malnutrition including obesity, and focus on reducing both stunting and wasting in children under five and addressing the nutritional needs of adolescent girls.³⁰ There is no explicit focus on breastfeeding or education on child nutrition, but these are highlighted in the Global Health Strategy as the best means of meeting the targets.³¹

Responsive care

The SDGs require states to ensure that all children have quality early childhood development, care and pre-primary education, which is measured by the proportion of children under five years who are developmentally on track in health, learning and psychosocial well-being.³² But, there is no explicit support for parenting and stimulation of very young children, or supportive parenting programmes across the life course. However, the greatest omission is the lack of attention paid to fathers, though there is a specific target under the gender equity goal that refers to “the promotion of shared responsibility within the household and the family as nationally appropriate”.³³ Historically, in South Africa the role of fathers was limited to the provision of financial support, as men were forced to work away from home.³⁴ Patterns of family separation continue and, in 2014, over 60% of South Africa’s children – and 70% of African children – did not live with their fathers.³⁵ But children benefit from the love, care and attention of men, and more effort needs to be devoted to supporting men to be engaged fathers.³⁶ This is an area that South Africa should consider strengthening when developing local plans.

Safety and security

The creation of peaceful societies and an end to all forms of violence against children, such as abuse, neglect, trafficking, modern slavery, child labour, and other types of exploitation (including recruitment and use of child soldiers) are covered by several goals.³⁷ The goals tackle many of the determinants of violence such as poverty, intolerance and substance abuse; however, more intimate factors such as family structure and the presence of fathers, bullying by other children and interpersonal violence between adolescents and young men are not addressed. Another area not explicitly covered by the goals is parental education or parenting programmes; however, these kinds of programmes are covered in detail in the WHO’s INSPIRE strategy³⁸ and promoted by the Global Partnership to End Violence Against Children that was established to coordinate efforts to reach the goals.

Case 1: Isibindi: Sinako Youth Development Programme – From vulnerable child to independent adult

Donald Nghonyama (National Association of Child Care Workers)

Isibindi: Sinako Youth Development Programme is a comprehensive programme for orphaned and vulnerable young people and their families developed by the National Association of Child Care Workers. *Sinako* means “we can” and the name was chosen by young people in the programme. It aims to empower youth at the Isibindi sites to complete their education, acquire job-related skills, engage in healthy sexual and reproductive behaviour and become confident, self-supporting adults who contribute to their communities.

Sinako is one component of the broader Isibindi programme that was started in response to the HIV/AIDS pandemic. Isibindi sites serve communities in remote, rural areas with few existing social services, high unemployment rates, and where most households have incomes well below recognised poverty levels and children experience multiple deprivations and violations of their rights. A team of trained child and youth care workers (CYCWs) cares for orphans and vulnerable children in all aspects of their lives, providing services through home visits and supervising play in safe parks. CYCWs who are trained as youth development facilitators (YDF) use the child-and-youth-care approach in working with youth in the Sinako programme.

The programme responds to individual needs, interests and local opportunities. Each youth is supported by an individual youth development plan which is drafted in consultation with the young person. The plan incorporates elements of the Circle of Courage (which aims to meet young people’s developmental needs for belonging, mastery, independence and generosity) and it ensures that programme activities are chosen to suit the youth’s personal needs and is reviewed regularly.

To have completed the programme successfully youth are expected to complete at least three of the following programmes:

1. Educational support
2. Access to tertiary education
3. Job opportunities
4. Entrepreneurship opportunities
5. Life-skills and community engagement.

Thabo, a youth attending the programme wrote: “Isibindi: Sinako changed my life. I’m proud today. My future is brighter. Words cannot describe how the programme has impacted my life.”

Learning and stimulation

SDG 4 expands on earlier successes in ensuring access to free primary education in several ways.³⁹ Firstly, the new targets focus on education across the life course. They call for early childhood development and pre-primary education to prepare children for school, and extend universal education to include secondary school and promote life-long learning. Secondly, they focus on diverse types of education including technical and vocational training and measuring skills for employment and entrepreneurship, although the definition is restricted to information and communications technology skills. Thirdly, the targets and indicators measure not only access, but outcomes. Target 4.1 envisages that all girls and boys complete secondary education leading to relevant and effective learning outcomes defined as achieving at least a minimum proficiency level in (i) reading and (ii) mathematics, but states are only required to report outcomes until the end of lower secondary school, and not the end of secondary school. In South Africa, schooling is compulsory until the age of 15 or the end of lower secondary school i.e. grade 9, and whilst close to 100% of learners stay in school until the age of 15,⁴⁰ the attendance rate decreases steeply from age 16 onwards, with 94% of 16-year-olds, 92% of 17-year-olds, and 80% of 18-year-olds reported to be attending school.⁴¹ This means that approximately 140,000 16 – 17-year-olds and 200,000 18-year-olds each year do not benefit from the personal and social advantages and protection of the final years of secondary school.

Do the SDGs create an enabling environment for caregivers and families?

We have established that nurturing care is critical to ensure that children thrive and develop to their optimal potential through all stages of their life; however, parents can only provide nurturing care if they inhabit an enabling environment. Policies should therefore focus on equipping families with the time, resources, knowledge and skills they need to provide nurturing care.⁴²

The SDGs make only passing reference to parents and families; nonetheless, they do provide some support for non-family members caring for children. For example, pregnant women and mothers with young babies need financial security and nutritional support, which are included in the SDGs. The goals do not explicitly mention maternity leave or family responsibility leave, but call for compliance with International Labour Organisation regulations in which they are included.⁴³ Critically, the targets include decreases in maternal mortality that will necessitate investments in antenatal services, and indicators track the number of skilled health professionals attending births which will improve the safety of delivery. Although the SDGs provide for universal access to family planning, there is a lack of attention to adolescents’ need for dedicated services. The goals also address structural factors that contribute to creating a safe environment such as the design of human settlements, and risk factors such as poverty and alcohol abuse. Additionally, they include safe, non-violent and inclusive educational facilities to promote learning and better outcomes.

Figure 8: The 17 SDGs create an enabling environment that supports nurturing care



Inclusion is one of the fundamental principles of the SDGs. The goals seek to address inequality between and within countries and to prioritise the most vulnerable to make sure no one is left behind. The targets seek to end discrimination, promote inclusive learning environments, accessible transport and public spaces that everyone can enjoy.⁴⁴ The 2030 Global Agenda also recognises a number of vulnerable groups including children, refugees, and people with disabilities. The SDGs have adopted a mainstreaming approach,⁴⁵ but children with disabilities and other marginalised groups often need special measures to enable them to participate fully in society. The detail of such measures can be included in global strategies or promoted by global partnerships. But at present there is no strategy for disability and the Global Partnership for Disability and Development,⁴⁶ established to ensure the inclusion of people with disabilities in national and international efforts to reach the MDGs, seems to have lost momentum.

Another aspect of inclusion is participation in decision-making. The United Nations Convention on the Rights of the Child (UNCRC) guarantees children the right to be heard and have their views given due consideration by any adult or institution making decisions on their behalf, or taking actions that affect the child.⁴⁷ Participation is central to the right to dignity and linked to respect for evolving capacities and adult guidance, and the rights to information, privacy and expression, amongst others.⁴⁸ According to UNICEF, the right to participate is supported by several SDGs,⁴⁹ However, the SDG targets and indicators are restricted to high-level political decision-making processes, they do not even incorporate participation in school governance. Such high-level processes of engagement are an essential element in fostering a sense of belonging and active citizenship,⁵⁰ but do not capture the essence of what participation means to, and for, most children. Nor do they speak to the developmental necessity of building strong relationships with others

Case 2: “What I do, matters”

Mary Metcalfe (Programme to Improve Learning Outcomes (PILO))

Jika iMfundo is a campaign of the KwaZulu-Natal Department of Education that seeks to build routines and patterns of support within schools – and between districts and schools – that will have a long-term and sustained impact on curriculum coverage and learning outcomes. Launched in 2014, the programme currently reaches 1,209 schools and 652,320 learners from grades 1 – 12, and is being piloted at scale in the King Cetshwayo and Pinetown districts before roll-out across the province from 2018.

The overarching strategic objective is to improve learning outcomes. The theory of change is that if the quality of curriculum coverage improves, then learning outcomes will improve. In order for curriculum coverage to improve, the following behaviours must improve: *monitoring* curriculum coverage, *reporting* this at the level where action can be taken, and *providing supportive responses* to address problems.

The Jika iMfundo campaign therefore provides district officials, teachers and school management teams (SMTs) with the tools and training to have professional, supportive and evidence-based conversations about curriculum coverage between teachers – between teachers and the SMT – and between district staff and the SMTs. The goal is to make these behaviours routine practices that become embedded and sustained in the system. The tools and materials have been collaboratively developed with the intention of driving meaningful and substantive engagement – identifying problems and actively seeking the solutions together – and providing support and reciprocal accountability. The programme is proving effective:

- Teachers are more confidently tracking curriculum coverage.
- Heads of Department are using the tools and training to supervise and support teachers.
- Schools where teachers are planning and tracking progress, and are supported by SMTs, are reporting increased

curriculum coverage and improved learning outcomes.

- More principals (and deputies) are leading a school focus on curriculum management.
- Circuit managers and subject advisers are making significant progress using the data to focus their energies for greater impact, and share a collective focus on monitoring and improving curriculum management at school level.
- Curriculum coverage in the foundation phase has improved markedly between 2015 and 2016.

A number of factors have led to the success so far. A clear theory of change focused on the instructional core – teaching and learning through improved curriculum coverage in languages, mathematics and science. The programme is a change management intervention, building leadership capacity and responsibility to drive change within the education system. The programme is anchored in the system to ensure the intervention is sustained. The interventions have been designed for implementation at scale, with recurrent costing of less than R40 per learner that can be accommodated within the department’s budget. The programme focuses on districts supporting schools. The goal of using data for monitoring and reporting is to enable the district to support schools on a differentiated basis. And the monitoring, reporting and response process allows for identification and response to problems and blockages at all levels of the system. The programme builds reciprocal accountability between teachers, the SMT, the district and the provincial administration. A coaching programme in the schools supports SMTs – deepening their understanding of the tools and how to apply these in their context. The programme works actively with teacher unions who worked with PILO to design the programme, have endorsed it, and continue to identify implementation challenges so that the programme can respond to problems as they arise.

and how progressive responsibility for decision-making guided by an adult provides the foundation for autonomy.

Do the SDGs have the potential to create supportive social, economic, political, climatic and cultural contexts?

The SDGs address the outer circles of Bronfenbrenner’s “socio-ecological model” in many ways, as outlined in figure 8. The goals on ending poverty and creating decent work for all should create sufficient economic security for parents to support their families.⁵¹ At a community level, the aim is to build resilient infrastructure that is of sufficient quality to sustain and support families, and services such as schools, clinics and housing in communities that are structurally designed to reduce violence and improve safety

and security.⁵² At a national level, the SDGs set ambitious targets on reducing corruption, and developing effective, accountable and transparent institutions.⁵³

On a planetary level, the goals protect bio-diversity on land and in the oceans, and aim to curb rampant economic growth and the effects of climate change to ensure that the environment can sustain future generations.⁵⁴ The SDGs aim to create the conditions necessary to produce enough nutritious food to feed the global population and end food insecurity by improving farming methods, transport, and creating more equitable market conditions.

But to achieve the transformation envisaged by the SDGs requires new approaches to service delivery. For example, in South Africa, young people from the age of 12 have the right to consent to confidential health services independently, but judgmental

health professionals frequently deter adolescents. This is especially problematic in relation to access to family planning and antenatal services for pregnant teenagers.⁵⁵ Thus, transformation includes removing cultural and attitudinal barriers so that children's dignity is fully respected. Professionals need support and active encouragement to transform – case 2 demonstrates how Jika Mfundo campaign of the KwaZulu-Natal Education Department is monitoring data to provide differentiated support, and proactively support change.

A transformed approach also requires a different way of thinking about, and delivering, services. Efforts to promote children's survival and development extend beyond health and require coordinated efforts across sectors, including labour, health, nutrition, education, social services, social protection, housing and water and sanitation. However, states rarely consider children's needs holistically across the life course, or in the context of their families and communities. And whilst, the SDGs were developed to create an encompassing vision, progress towards that vision is measured by discrete indicators, which have the potential to recreate and reinforce a siloed approach to service delivery. To combat this tendency, SDG 17 aims to "strengthen the means of implementation and revitalize the global partnership for sustainable development".⁵⁶ In addition there is an emphasis on ensuring fair access to markets, and building global partnerships that facilitate the sharing of funding and technology so that no one is left behind. To this end, the United Nations (UN) is organising annual dialogues to bring together governments, civil society, the private sector, and other actors to foster cross-sectoral and innovative partnerships and address specific implementation challenges. For example, the Every Woman Every Child initiative brings together experts from different sectors to mobilise and intensify collaboration between governments, the UN, multilaterals, the private sector and civil society to implement the Global Strategy for Women's, Children's and Adolescents' Health. In other words, the goals provide a focal point around which states can collectively coordinate their actions. These partnerships and strategies will guide the flow of development aid and technical assistance from UN agencies, and they have the potential to drive advocacy and improved

implementation. There are many such partnerships,ⁱ but whether they translate into coordinated action on the ground remains to be seen.

Conclusion

Under the right conditions, all children can thrive. Children need nurturing care provided by families and caregivers in enabling environments and supportive contexts. Nurturing care is composed of responsive caregiving, health, nutrition, safety and security, learning and stimulation.

The SDGs are designed to be holistic and integrated as the intention behind the 2030 Global Agenda is to transform the entire world and prevent anyone from being left behind. It is therefore not surprising that the SDGs do not cover all the details necessary to create an environment for children to thrive. This analysis suggests that they omit some of the elements necessary to support families and caregivers, and ignore meaningful participation and adolescents' capacity for independent decision-making – elements that lie at the centre of the socio-ecological model. However, these elements are covered by the UNCRC and its General Comments. There is, therefore, a pre-existing obligation on states to fulfil these rights. Children's rights are indivisible and interdependent, and cover all the elements of nurturing care but they do not address the ingredients of the enabling environment at a societal level, such as employment for parents and caregivers. The strength of the SDGs is that they encourage states to provide many of the essential elements needed to support parents to care for children and to promote stable cooperative governance and inclusive societies, built on strong economies and the sustainable use of resources that safeguard the environment for everyone. Finally, they respond to development challenges holistically and promote an integrated approach to service delivery, through global strategies and partnerships.

Implementing the 2030 Global Agenda would transform society to create supportive social contexts and enabling environments, but realising the SDGs is not sufficient to ensure that children get the nurturing care they need to thrive; for that we must ensure that implementation strategies draw on the entire child rights framework and foreground children's best interests and participation.

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Investing in children: The drivers of national transformation in South Africa

David Harrison (DG Murray Trust)

The focus of the Global Strategy for Women's, Children's and Adolescents' Health on survive, thrive and transform comes at a time when South Africa is looking for the next wave of social and economic transformation. And the strategy highlights how we should look first to children if we are to create new impetus for sustained change.

Children are a highly concentrated nucleus of power. Their power to think, to imagine and to relate well to others is the nation's source of social intelligence and human capital. Tapping that power more effectively provides one of the greatest opportunities to transform South Africa over the next 20 years. If we fully develop the capabilities of young children so that they are able to learn when they go to school and get a decent job when they grow up, then South Africa would have fuller employment; greater economic growth; and a safer, happier society. *The key question is: how?* The answer is simple: If we nurture their normal growth and development – from conception to adulthood – we will unlock that human potential. Their innate genetic programming will do the rest, and children will flourish (as outlined in the essay on p. 32). Such radical change would disrupt intergenerational cycles of poverty and drive down levels of inequality.

The current gaps in the provision of early childhood development (ECD) services present major opportunities to change the trajectory of national growth over the next decade. However, these gains will be fully realised only if quality schooling and adolescent support follow intensified investment in the early years to enable young people to transition into productive adulthood.

While there has been progress in key areas of child development, it has not been enough to trigger a tipping point where public investments start to yield meaningful returns on education and training. Essentially, this essay argues that addressing three "critical gaps" could level the playing field and boost human capital development. These include national-scale efforts to: 1. prevent stunting; 2. ensure all children are ready to read by the time they go to school; and 3. develop networks of support for vulnerable children and teenagers.

In summary, this essay seeks to answer the following questions:

- Why is it essential to invest in South Africa's children?
- What do children need to thrive?
- What progress has been made to support children's optimal development?
- What else is needed to unlock children's potential?
- What can be done to address these critical gaps?
- How can we fast-track progress towards a "tipping point"?

Why is it essential to invest in South Africa's children?

Since 1994, South Africa has achieved significant gains with democratic institutions and service delivery infrastructure mostly in place. However, this progress has yet to transform South Africa into a safer, inclusive, growing economy. In the absence of significant economic growth, new gains will only come about by using resources better – by allocating and spending money more efficiently. In this regard, our greatest failure is that we have not invested properly in our children. Arguably, this is the single biggest reason for the persistent and seemingly intractable effects of apartheid, and the greatest threat to the success of our democracy. On the other hand, it presents a real opportunity to change the nation's trajectory over the next decade.

According to tax data,¹ 10% of the population owns 90 – 95% of all wealth, while the poorest half of the population owns no measurable wealth at all. The wealthiest 10% are predominantly White, while the poorest 50% are almost all Black. Such extreme inequality is a primary reason for persistently high rates of crime, violence and social unrest.²

If concentration of wealth is the measure of the health and stability of a nation, then South Africa is even more fragile now than it was in 1994.³ At the heart of the problem is a failure of broad-based skills development to drive productivity and inclusive economic growth. The increase in the national skills base has been relatively small (only 25% of the labour force were skilled in 2014 compared to 21% in 1994), and racial disparities have widened. For example, the increase in White skilled workers in the first two decades post-democracy was double that of Africans (a 45% increase versus 20%).⁴ This points to the enduring legacy of apartheid and the failure of post-apartheid South Africa to reverse the trends. One measure of progress would be younger workers becoming more skilled. However, official national statistics suggest that the reverse is true – and that the proportion of skilled African workers aged 25 – 34 actually decreased between 1994 and 2014.⁵

Any discussion of the state of skills development in South Africa almost invariably focuses on higher education and training, which is characterised by low in-take and high drop-out rates. South Africa's 26 universities and 50 technical, vocational and educational training (TVET) colleges all prepare young people for work. Yet only one in eight youth go to university, and of these, over 40% drop out without completing their degree.⁶ The university drop-out rate among Black students for three- and four-year degrees is one-and-

a-half times higher than for White students (58% vs 39%).⁷ In effect, this means that only 5% of all African and Coloured young people in South Africa successfully complete university.

The situation for students at TVET colleges is even worse with high drop-out rates, and those that stay the course battle to find practical experience to become certified. In effect, taking drop-out into account, the national throughput rates for many TVET courses are less than 30%.⁸

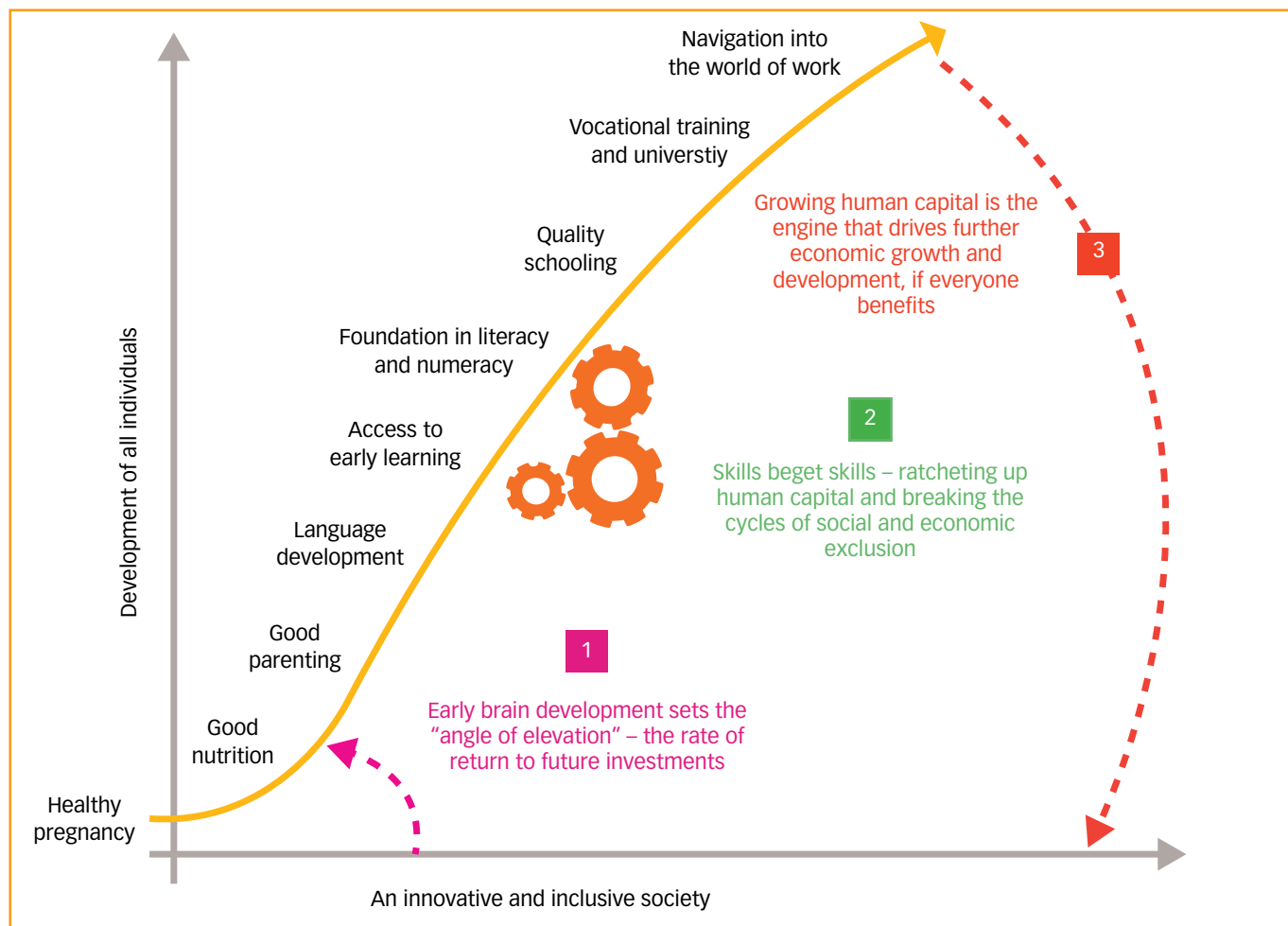
Many of these problems stem from children's struggle to learn, which is made worse by the poor state of basic education. Just 45% of children who enter grade 1 pass grade 12. Over two-fifths drop out of school and another sixth fail grade 12. Those that drop out are more likely to have failed a number of grades before dropping – or being pushed – out.⁹ In fact, the children in the poorest (quintile 1 and 2) schools enter school at a disadvantage – already scoring about 20% less on entry for maths and home language than children in higher quintile schools.¹⁰ These findings point to major deficits in language and cognitive ability that have already accrued by the age of five.¹¹ This is not surprising, given the intense sensory, language and cognitive development which instinctively happens in the first few years of life if the right ingredients are in place. Figure 9 illustrates the critical inputs that shape the trajectory of human

capital development. It draws on the famous Heckman equation which showed that pre-school education is the best investment in human capital that a country could make,¹² effectively setting the compound rate of return to subsequent investments in education and training. The diagram provides a framework for a comprehensive strategy for skills development which should start bottom-up by recognising that children are the source of human capital. Such a framework is not yet in place in South Africa.

Many models of human capital development focus simply on the amount of money earned by individuals, and fail to understand that these benefits must be widely and fairly distributed in order to capitalise fully on a nation's potential in the long run. Figure 9, therefore highlights how skills development thrives best in an innovative and inclusive society.¹³

This essay argues that the *normal* growth and development of children – from conception to adulthood – will unlock substantial human potential. In other words, creating an environment in which *all* children can thrive has the power to drive social and economic transformation and create a society where each person's brain is used to its full extent *and* where everyone stands to benefit. In the face of increasingly concentrated wealth in South Africa, investment in children is a powerful force for greater equality.

Figure 9: The trajectory of human capital development



Source: DG Murray Trust (2017) *Imagine a South Africa where Every Person has the Opportunity to Fulfill their Potential*. Cape Town: DGMT.

What do children need to thrive?

A thriving child is capable, motivated and connected, and able to act on a sense of real and imminent possibility.

- Children's *capabilities* are rooted in the stock of "physiological capital" that accumulates before and after birth.¹⁴ This includes children's innate capabilities (or genetic endowment), which are either enhanced or diminished by extrinsic factors (such as home and environmental conditions, nutrition and access to health care). This form of human capital largely accumulates in the first 1,000 days of life. It determines the brain's responsiveness to stimulation, and establishes the child's lifelong learning potential which is key to human productivity.
- The *motivation to succeed* promotes resilience and the ability to "bounce back" from adversity. A strong motivation to succeed – established in the early years – promotes learning, reduces adolescent risk-taking behaviour and enhances the prospects of lifelong achievement.¹⁵ Children respond well to rewards and incentives – and even modest opportunities can build a sense of real and imminent possibility in life. This goal-directedness can develop quickly in pre-schoolers if their parents and teachers know how to develop their skills of self-regulation and ability to get things done (executive function). Mastery of language and the ability to read are major milestones in the development of self-efficacy (one's belief in one's ability to succeed), which in turn drives the motivation to learn and to succeed.¹⁶
- *Healthy relationships* protect children and can help them thrive despite adversity. The psychologist Ann Masten synthesised the findings of dozens of studies¹⁷ which confirmed that parental love and care build resilience. Further protective factors include a child's *connectedness* to another significant adult in their life when they are young, and to groups of friends and classmates as they grow up. Effective schools and supportive community structures play a large part in buffering children and adolescents from adversity. Masten calls these simple, yet profound, factors the "ordinary magic" that can enable a child to keep bouncing back in the face of hardship.

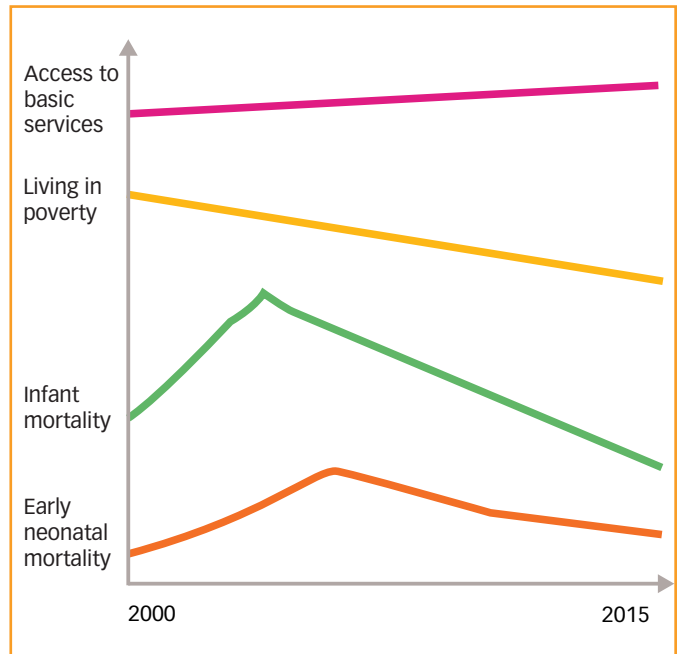
Together, these factors lay the foundation for effective education and training, and for the empathy, critical thinking and imagination that characterise an inclusive and innovative society.¹⁸

What progress has been made to support children's optimal development?

South Africa has made good progress in the past 15 years – in reversing the worsening infant and mortality rates due to HIV and in cushioning children from the extremes of poverty through child grants and state-subsidised electricity, water and sanitation (as outlined in figure 10).

The percentage of children under six living below the national upper bound poverty line (R965 per month in 2015) declined from 79% in 2003 to 62% in 2015. Over the same period, the proportion of children under six living in households with inadequate services declined from 40% to 30%.¹⁹

Figure 10: Elements of child development showing good progress



Source: Derived from: Hall K, Sambu W, Berry L, Giese S, Almeleh C & Rosa S (2016) *South African Early Childhood Review 2016*. Cape Town: Children's Institute, UCT & Ilifa Labantwana.

There also has been good progress in providing antenatal and obstetric care. Women are booking earlier for antenatal care (61% booked before 20 weeks in 2015/16 compared to 38% in 2010/11)²⁰ and more deliveries now take place in health facilities (96% in 2016, up from 83% in 1998)²¹. Antiretroviral treatment has dramatically reversed infant mortality by reducing the vertical HIV transmission rate at 18 months to 4.7%.²² These changes are significant, but on their own they are not enough to create the conditions for children to thrive.

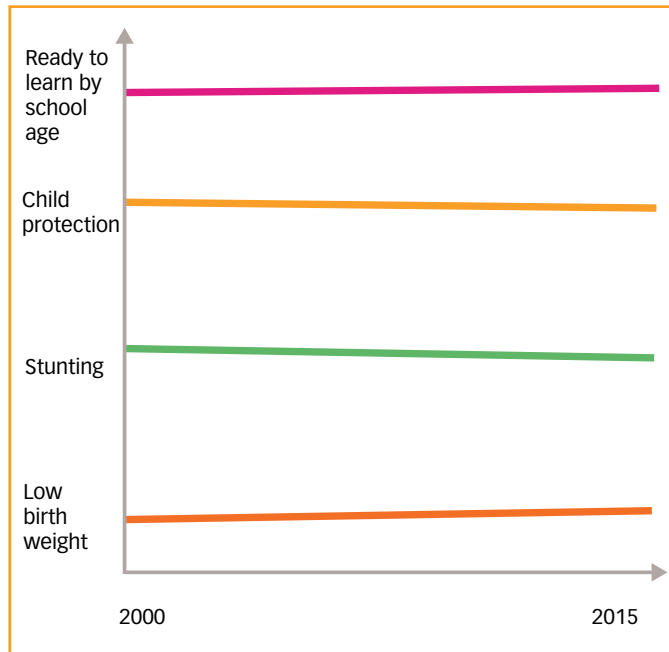
What else is needed to unlock children's potential?

There remain several crucial areas of child development where there has been little or no progress (figure 11 on p. 46) and increased investment in these areas has the potential to promote children's optimal development with significant long-term benefits.

- Preventing stunting could allow a million more young children to thrive each year, increasing the gross domestic product by at least 1.3% as noted on p. 36.
- If all children entered school ready to read, this would significantly boost their self-confidence and learning ability. A fully literate population would ultimately grow the economy by about 25%.²³
- Local networks of care and support could significantly reduce the vulnerability of babies with the poorest developmental outcomes, and provide a "second chance" to teenagers who missed out earlier in life (as illustrated by the case on p. 38).

Together these elements would help build children's capabilities, motivation to succeed and connectedness – and promote human capital development and social cohesion.

Figure 11: Elements of child development showing little progress



Source: Derived from: Hall K, Sambu W, Berry L, Giese S, Almeleh C & Rosa S (2016) *South African Early Childhood Review 2016*. Cape Town: Children’s Institute, UCT & Ilifa Labantwana.

Building capability: Good nutrition is the basis for good health and the ability to learn. However, the stunting rate of young children in South Africa has remained substantially unchanged over the past 20 years.²⁴ The 2016 Demographic and Health Survey found that 27% of children under five years were stunted.²⁵ Similarly, low birthweight (<2,500g) – a significant contributor to stunting – has remained unchanged, or perhaps even increased in the past decade.²⁶ Stunting thus represents a significant deadweight on the South African economy, and eliminating it would represent a significant boost to employment and gross domestic product.²⁷

Data from Bangladesh, India and Peru show that stunting is a product of deficiencies in three domains: food; environmental health (water, sanitation and hygiene); and care (including basic antenatal care, nutritional supplements in pregnancy, immunisation and breastfeeding).²⁸ Children with deficiencies across all three domains experienced stunting rates up to 30% higher than those with adequate food, environmental health and care. The multi-faceted causes of stunting pose challenges for effective intervention, and require concerted intersectoral commitment and action (see nutrition essay on p. 68). Nonetheless, it can be done. Brazil, Colombia, Malaysia, Peru and Senegal have all achieved marked gains in the nutritional status of their children.²⁹

Nurturing motivation to succeed: One of the most powerful tools in the hands of parents is early language development through reading and story-telling. This is the basis for both literacy and mathematics attainment, but is also a strong motivator for learning and personal achievement. Over a quarter (27%) of grade 6 learners are illiterate – unable to read or understand a simple text (see education essay on p. 77).³⁰ In South Africa, only 15% of adults with young children at home read aloud to them more than

once a week, and two-thirds do not read to their children at all.³¹ These facts point to arguably the most concentrated opportunity for socio-economic transformation in South Africa today: a mass mobilisation of parents, communities and teachers, together with widely available reading material, could substantially improve educational outcomes within a decade.

Strengthening connectedness: Most stunting and other forms of child vulnerability occur in households which are economically fragile and socially marginalised. These home and family factors place children at daily risk and lead to toxic stress and cumulative emotional-cognitive deficits. The burden of care rests heavily on mothers who themselves struggle to make ends meet, typically in the absence of fathers. Poorer access to early learning and schooling further disadvantages children with disabilities while high rates of violence against women and children compound economic vulnerability and add to the burden of physical and mental ill-health (see essays on safety and inclusion on p. 61 and p. 84).³² These patterns of risk and risk-tolerance tend to follow the child as he or she gets older, driving the intergenerational transmission of poverty.

Roughly a million babies are born in South Africa annually, of whom at least a quarter are socially and economically vulnerable – if living below the food poverty line is regarded as a reasonable proxy.³³ These mothers and their children need support from pregnancy onwards. Encouragingly, the proportion of women recorded as having follow-up postnatal care within two days after birth rocketed to 84% in 2016³⁴ from 5% in 2009.³⁵ However, there is insufficient interaction between health and social services and young children, especially between six weeks and two years after birth (except for vaccinations and clinic attendance for illness). Yet this period is critical in establishing lifelong trajectories of human development and achievement, and we need to find ways to create social safety nets that go beyond the provision of social assistance.

We need to place far greater attention on mobilising local networks of care and support for these infants living below the food poverty line – and then, as they grow older, continue to support those at high risk through failure to thrive, exposure to violence or disability (see care essay on p. 51). Well-supervised and supported community health workers (CHWs) dedicated to maternal and child care have been shown to improve child outcomes.³⁶ The challenge however is to ensure the level of quality and supervision required at scale; arguably a feat unlikely to be achieved as part of government service provision. The Isibindi model is instructive, in that a national non-governmental organisation (NGO) – the National Association of Child Care Workers (NACCW) – receives public funding to provide community-level support. The NACCW now reaches over 300,000 children, although that is still a small fraction of those who need support (0.6% of children under 15, or roughly 2.5% of those below the food poverty line).³⁷

The responsibility cannot fall on government and established NGOs alone, and it is crucial that broader civil society and the corporate sector take greater responsibility as well. Cape Town Embrace³⁸ is a voluntary initiative that tries to link mothers across class and race to build new “networks of possibility” for children.³⁸

Case 3: A children's National Development Plan

Christina Nomdo and Zarina Adhikari (National Planning Commission)

The National Planning Commission (NPC) was established in 2010 to advise Cabinet and guide government's long-term strategic vision for South Africa – which was then outlined in the National Development Plan (NDP). The NPC recognises children as a source of inspiration, energy and resourcefulness, and their right to participate in all decisions affecting their lives, and is therefore in the process of developing a children's NDP in collaboration with children.

The NPC plans to conduct child participation workshops in every province of South Africa and include children from all walks of life. The workshops will provide information about children's rights and how government works, and give children the opportunity to express their views on the NDP. The children's feedback will be collated into child-friendly products that communicate the NDP to other children. Insights from the children's workshops will also be shared at the monthly NPC plenary meetings, and salient matters will be shared with the President as part of an NPC report.

The first two workshops with children were conducted in March 2017 in the Western Cape. Children from the community of Groendal – a community housing mostly seasonal farm workers – were concerned about child abuse, housing, sanitation, education, drugs and pollution. They would like to see a future with better access to quality social services.

At the second workshop, the youth in the Groot Drakenstein Correctional Centre were concerned about crime, making rights real, household poverty, housing, water, drugs, gangsters, leadership, unemployment, abortion, the costs of university and election promises. They encouraged commissioners to dream of a gang-free South Africa. A child who had been used by adults to commit crimes articulated it quite well: "Die leaders moet nie die klein laaitjies gebruik om hulle vuil werk te doen nie; op die einde sit ons in die tronk en hulle worry nie." (The leaders must not use young children to do their dirty work; in the end we land up in jail and they don't care.)

Chapter 11 of the NDP focuses on nutrition, health care, education, social care and safety, while children's concerns about violence are addressed in Chapter 12 which focuses on building safer communities. In cases where children and youth raise issues that are not explicitly addressed in the NDP (such as abortion and election promises), the commissioner referred children to other laws and the nature of South Africa's democratic processes. The workshops have thus far served to encourage discussion amongst South Africans (whether they are appointed as commissioners to the NPC, children in communities or youth incarcerated in a facility) about the nature of governance in South Africa and the vision we all hold for our future.

To some extent, it has succeeded in bringing together diverse groups in support of young children, although its ability to sustain these relationships remains to be seen. It also recognises the risk that cross-cultural and cross-class relationships can be patronising and ultimately disempowering, and it is designed to recognise and assert the strengths and power of all parents.

While this essay has focused largely on young children – because the benefits are greatest at an early age – adolescence provides a second chance to "get it right", albeit at greater public expense.³⁹ Nonetheless, the cost is worth it because our society cannot withstand successive waves of unskilled young people entering the labour market and because young people need support and have a right to resources that promote their health, well-being and development. Like the first 1,000 days of life, adolescence is a time of rapid human development, which means that effective inputs can have enhanced effects. Such inputs include mentoring and healthy peer relationships that help young people navigate life transitions successfully and create the handholds for upward mobility.⁴⁰

There have been attempts to develop and sustain large-scale networks of support to young people. These include *LoveLife*, which at its peak sustained interaction with over 1.5 million young people a year.⁴¹ However, these initiatives have struggled with unpredictable funding and cash flows, reflecting fluctuating government support and donor interests. These experiences highlight some challenges of ensuring that resources are both allocated, and used efficiently, for national development.

What can be done to address these critical gaps?

South Africa is considered "strong on policy, but weak on implementation" and it is fair to say that, with few exceptions, South Africa has enough policy for children and adolescents. The country's long-term blueprint for change, the National Development Plan (NDP), recognises children and young people as the source of a "demographic dividend" – and how our youthful population may help accelerate economic growth. Specifically, it identifies nutritional support for pregnant women and young children, and the extension of ECD services as fast-track strategies for poverty alleviation.⁴² Unfortunately, the idea of children and young people at the centre of development is not carried through the NDP's sector-based chapters. This weakness is now recognised by the National Planning Commission, which aims to bring children more centrally into its consultative and implementation processes (see case 3 above).

The development of the second National Plan of Action for Children (2012 – 2017)⁴³ ran in parallel with the NDP.⁴⁴ While this plan for children represents an important translation of policy to action, it is questionable whether departments regularly refer to it in developing their annual plans. Certainly, there is no routine synthesis of the indicators of progress assigned in the NDP to every relevant department.

Both ECD and nutrition are high on the national policy agenda. In the past few years, the Presidency has commissioned diagnostic

reviews on the state of ECD⁴⁵ and on nutrition for children from conception to five years⁴⁶. The former led to the development of the National Integrated Early Childhood Development Policy²⁰ which signalled a significant shift in emphasis toward the period from conception to age two. An encouraging early outcome of this policy was the a new national Conditional Grant for ECD which will hopefully improve access to out-of-home early learning opportunities over the next decade.

The diagnostic review on nutrition acknowledged that the Integrated Nutrition Plan had failed to promote collaboration between government departments and had not achieved the anticipated nutritional gains. Similarly, the national nutrition roadmap 2013 – 2017 published by the Department of Health has struggled to achieve the required level of concerted action.⁴⁷

While nutrition and ECD have at least attracted political attention, early language development and reading have, until recently, received little consideration. Part of the problem has been that no government department has an explicit mandate for reading in children under six – as responsibility is shared by the Department of Basic Education (early learning), Arts and Culture (libraries) and Social Development (oversight of ECD centres). The National Reading Strategy published in 2008 by the Department of Basic Education assumes that reading development starts at school, instead of in the first year of life. It has been left to civil society initiatives such as *Nal'ibali* reading-for-joy campaign (see case 4) to advocate for an earlier start for language and reading development. These efforts are starting to bear fruit, having attracted the attention of the National Education Collaboration Trust, which plans to promote reading as a lever for educational improvement in South Africa.

The National Youth Policy 2015 – 2020 covers all the bases of economic participation, education, skills and second chances, health care and risk reduction, and social cohesion.⁴⁸ It describes key interventions for achieving these goals, but it carries little weight in national planning.

Arguably, the reason why so little progress has been made in addressing the critical gaps described above is that they require a broader national mobilisation than was required to install taps, build houses and provide cash transfers. Nutrition, early language development and reading, and local networks of care and support

do not fit easily into the remit of a single government department. In this regard, we have much to learn from Latin American countries such as Mexico, Peru, Chile, Brazil and Columbia. They have shown how the full extent of resources available across government, civil society and the private sector can be mobilised to address cross-cutting national priorities for children (see box 3 below).⁴⁹

How can we fast-track progress towards a “tipping point”?

The first step is to establish clear goals and national commitments; for example:

- By 2030, zero stunting among children under five years of age.
- By 2025, all children ready to read by the time they go to school.
- By 2020, networks of care and support for the most vulnerable quarter of a million children born each year, and for at least a million teenagers who constitute the nation’s “second chance” to get it right.

The second step is to define a lead agency to mobilise concerted action for each of these priorities. Generally, there is a great reluctance to establish another state agency when most of those that already exist have proved cumbersome and expensive. A case in point is the National Youth Development Agency, which has often become bogged down in political contests and administrative problems. However, there is no reason why such an agency must be based within government, provided there is sufficient political recognition of the status of a non-government agency. A *de facto* example in South Africa is the Health Systems Trust, which has both supported and monitored health systems development over the past 25 years. It is relatively nimble, autonomous and can mobilise both public and private funding – while still being nationally accountable.

The third step is to mobilise a sustained funding base for each of these national programmes. In this regard, there are private foundations eager and willing to support, provided that the government is also committed. Currently, many good ideas fail to materialise because it is so difficult to align public and private funding. Together with the respective lead departments, National Treasury should be more proactive in establishing co-funding mechanisms to address the critical gaps. These need not require the pooling of public and private funding but should ensure upfront commitments from both sides to sustain the national programmes over the long term.

Addressing the critical gaps requires a willingness to do things differently and the NDP recognises that the next big changes will require an unprecedented level of partnership between government, civil society and the corporate sector. This essay has argued that the next wave of transformation must tap into the power of children. Setting the precedent through innovative national programmes that address the critical gaps for children and adolescents could be a giant leap towards the tipping point where new skills drive national transformation and create a more equitable society.

Box 3: Cross-cutting national priorities for children: What’s worked in other countries?

- A clear set of national priorities.
- A lead agency (addressing one or more priorities).
- A well-defined national branded programme of action for children.
- Central strategies around which intersectoral action can be organised.
- Defined processes for implementation.
- Scorecards and tracking tools to gauge progress.
- Efficient mobilisation of resources, both public and private.

Case 4: Nal'ibali – Transforming children's literacy learning opportunities

Carole Bloch (Project for the Study of Alternative Education in South Africa, University of Cape Town)

Holistic approaches to teaching and learning, which nurture emotions at the same time as bodies and minds, are ones which give all children the opportunity to thrive educationally.⁵⁰ This view underpins the approach of the *Nal'ibali* reading-for-enjoyment campaign which aims to deepen meaningful reading and writing habits among communities across South Africa. Understanding how children learn helps us provide the attention, resources and conditions needed to nurture their potential for complex and creative learning. Evidence from neuroscience shows how inbuilt emotional systems drive learning – particularly attachment (bonding, belonging, being loved, being social), play (being curious, imagining, creating, exploring), and discovery (finding out, seeking, making meaning).⁵¹

Our brains work by recognising patterns and predicting what will happen next based on past experiences.⁵² The pattern of story is the organising framework we use to make sense of our lives⁵³ and imaginative play is the active manifestation of stories.⁵⁴ Reading and writing – like listening and speaking – begin and continue as purposeful activities in daily life.⁵⁵ Literacy therefore develops in young children when they understand the languages being used,⁵⁶ spend time with people who interact with them and role model the power and purposes of print in authentic ways,⁵⁷ and have opportunities to practise as they explore and play.

This informal apprenticeship⁵⁸ and “close-up encounters with print” motivate children to behave like readers and writers at the same time as they start to identify and master the sound and letter patterns which transmit written language. Drawing on these principles, *Nal'ibali* is driving a national media campaign,

providing multilingual reading materials; and partnering with organisations and government to train and mentor adults to run reading clubs in homes, schools and communities. In 2017 there were 1,660 reading clubs, reaching 47,150 children. Over 13,000 adults have been trained, and 30 million bilingual newspaper supplements have been distributed.

Training and mentoring focus on inclusive action, interest and enjoyment. In training sessions adults experience the same kinds of activities that they are encouraged to do with children – choosing stories, reading aloud, listening to one another's views, writing and acting out one another's stories.

Spending an hour in reading clubs where adults have grown to appreciate and act on these principles means interacting with a largely confident, curious and light-hearted group. There is usually some singing and game playing. Children are eager to lead and join in with lots of laughter and smiling. A sense of belonging pervades.

Some of the time children choose books to explore. They sit or lie comfortably, however they want to and there is a mix of different happenings. Some children mouth the words quietly or read to themselves, others pour over illustrations, in pairs or groups, chatting, paging backwards and forwards through a book together. Sometimes a story is told, and there is usually a story read aloud by an adult (or sometimes by a child). This might be followed by the children choosing to draw, write about or act a related scene or character – or, something else which they feel inspired to do. Nobody has to be there, nobody has to participate, but when the ethos is relaxed and welcoming, there is a serious desire to join in.

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Caring for children: Relationships matter

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Early scientific experiments on the behaviour of rats showed that baby rats that were groomed more frequently by their mothers displayed more advanced brain development and were better able to cope with stressful events than those who did not receive equal attention from their mothers. The outcomes are similar in humans.¹ These early studies underscore the significance of the social environment and human interaction in shaping human functioning and development.

Parents or caregiversⁱ are often referred to as a child’s “first teachers”. This is because of the centrality of the caregiving role, and the considerable influence that caregivers have on a child’s development and well-being – from conception onwards. In many cultures and societies, child-rearing and caregiving are perceived as not only the responsibility of the immediate family, but also the extended family, the broader community and the state – which all have an obligation to act as a safety net. “*It takes a village to raise a child*” is a well-known African proverb and principle to which many South African communities subscribe.

Nurturing care is an essential ingredient for optimal child and adolescent development together with other inputs such as maternal and child health care services, household food security, and educational opportunities. Nurturing care includes practical caregiving, stimulation, responsiveness and safety.² While each of these dimensions of care are interdependent and interrelated, this essay focuses on responsive care as the extent to which children and adolescents experience responsive care, belonging and acceptance has a significant impact on their physical, cognitive and long-term emotional development.

The essay responds to the following questions:

- Why are caring relationships important for children’s development?
- What do we know about systems of care for children in South Africa?
- What are the factors that can compromise care?
- What are the interventions that can improve the quality of caring relationships?

Why are caring relationships important for child development?

Children’s experiences of their environments and their relationships, especially early in life, profoundly shape their development and lifelong trajectory. Children and adolescents need – and have

the right – to feel secure in their everyday environments. And responsive care is arguably the most essential element required to ensure children and adolescents’ emotional security and mental well-being.

Establishing emotional attachment between parents and infant during the first 1,000 days of life is critical for survival in the short-term, and determines the pathway for lifelong healthy, sustained development. Neuroscience indicates that responsive care is fundamental for healthy brain development, while poor maternal care can cause emotional stress and anxiety in infants and young children, in turn impacting on brain structure and function, and reducing children’s ability to thrive.³

Toxic stress in early childhood is recognised as a major contributor to poor developmental outcomes, and is often related to the quality of the primary caregiving relationship. Toxic stress refers to frequent or prolonged activation of the body’s stress management system. Stressful events that are chronic, uncontrollable, and/or experienced without children having access to support from caring adults – such as verbal and physical abuse, witnessing domestic violence, severe maternal depression or prolonged absence of the primary caregiver – are likely to have a sustained and adverse impact on brain development.⁴

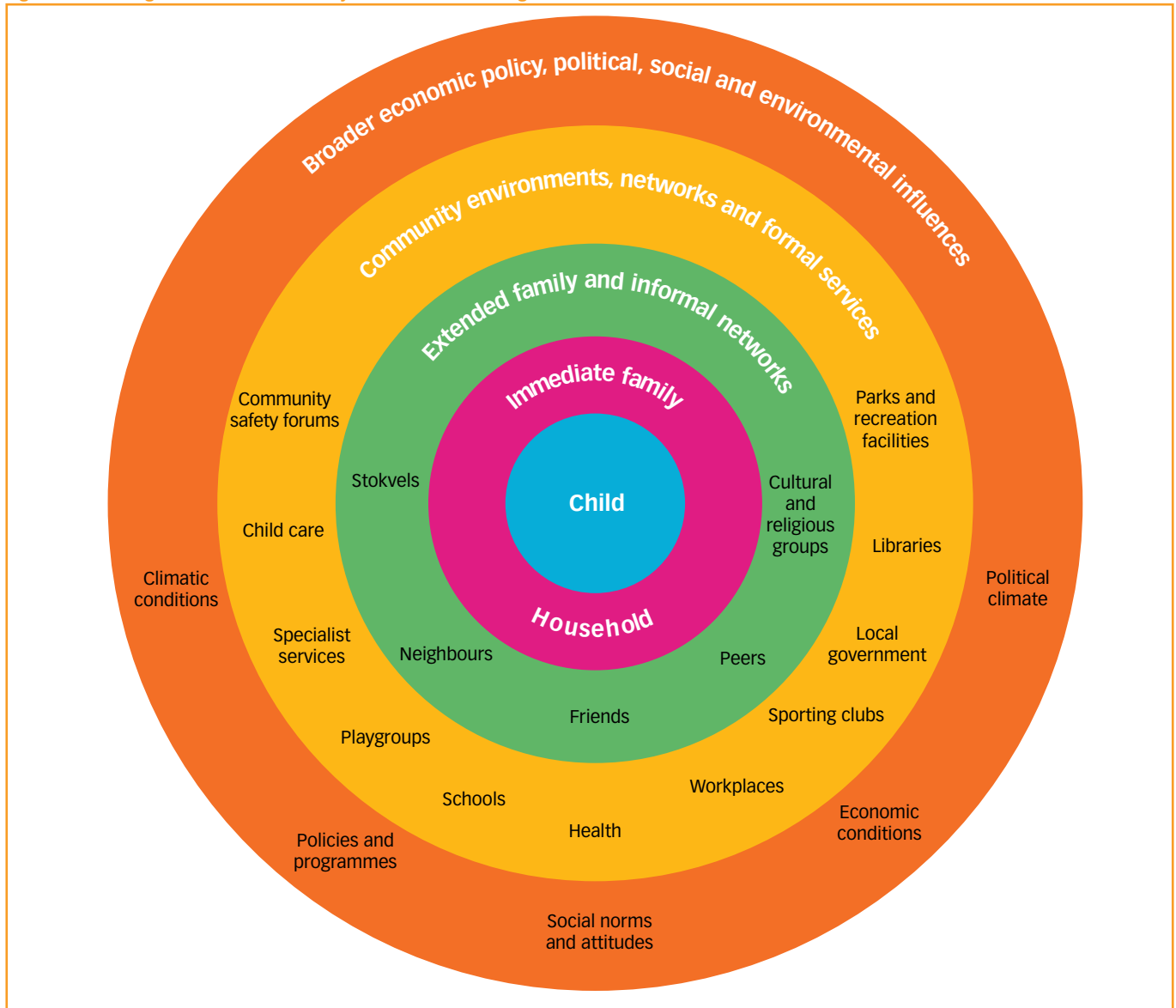
The environment in which children are raised is critical for early development, and primary caregivers have the important task of mediating between the child and his or her environment, and buffering the effects of environmental stressors.

A critical domain of early development is the formation of self and identity, and this is shaped by infants’ state of mind and their ability to recognise and regulate feelings. Psychologists note that the recognition and regulation of feelings are also central to survival.⁵ Studies of abandoned infants who were institutionalised and deprived of affection and interaction with a responsive caregiver indicate that such deprivation has long-term negative effects on children’s cognitive, behavioural and relational functioning.⁶ The presence of a responsive, involved caregiver, especially during the early years, is fundamental for children’s physical development, emotional security, resilience and awareness of self and others.⁷

Responsive caregiving throughout the life course provides emotional security and promotes trust and a sense of belonging, building the foundation for social-emotional competencies (e.g. self-control, self-motivation, and the ability to engage in purposeful action). Healthy parenting has been found to improve children’s

ⁱ The terms “parents” and “caregivers” are used interchangeably to describe the individuals who perform the primary caregiving and parenting role, including both biological and social “parents”.

Figure 12: Enabling care across different layers of the socio-ecological model



Source: Adapted from: The Spoke (2014) *A Little Known Way to Make your Service More Flexible and Improve Quality*. Viewed 17 October 2017: <http://thespoke.earlychildhoodaustralia.org.au/little-known-way-make-service-flexible-improve-quality/>

self-esteem, behaviour and food security; reduce educational risks;⁸ and enhance cognitive and language development.⁹

As children mature, their needs change and caregiving should respond to these developmental shifts accordingly. For example, older adolescents are generally independent and able to make

certain decisions, engage with challenges and problem-solve within their life space. While different risks and stressors come into play at each developmental stage, responsive, nurturing care remains essential in promoting development throughout childhood and adolescence. Early attachment lays the foundation for healthy relationships across the life course, and emotional and behavioural regulation learnt in infancy set the stage for children and adolescents' ability to function as competent social and relational individuals.

Childhood adversity (particularly exposure to multiple risks such as child maltreatment and parental substance abuse) has serious consequences for adolescent health and may lead to violence, substance use and mental health conditions that can compromise the health and well-being of the next generation.¹⁰ Adolescents are the caregivers of tomorrow, and their relationships with own caregivers and families will impact on their parenting styles and ability to provide nurturing care.¹¹

Box 4: What is nurturing care?

Nurturing care is defined as a stable environment that is sensitive to children's health and nutritional needs, and that provides protection from harm, opportunities for early learning, and interactions that are responsive, emotionally supportive, and developmentally stimulating.¹² These environments offer acceptance and a sense of belonging and connection demonstrated through an active and constant relationship with the child or adolescent.

Figure 13: Opportunities for care and connection across the life course



What do we know about systems of care for children in South Africa?

Children and adolescents generally grow up in families, located within communities and social groups that enable community life and facilitate access to resources, as illustrated in figure 12. South African society is diverse and heterogenous. Multiple family forms exist and the notion of who constitutes “family” is defined by individuals themselves. The White Paper on Families defines family relationships of “blood (kinship), adoption, foster care or the ties of marriage (civil, customary or religious), civil union or cohabitation, and go beyond a particular physical residence.”¹³

While the primary caregiver bears the main responsibility for providing nurturing care, there are frequently other members of the household who contribute to caregiving tasks. In South Africa, practical caregiving is mostly assumed by women who, by and large, spend more time on practical care than men. In general, fathers’ participation in caregiving duties is low, although many offer other forms of parental support.¹⁴

The HIV/AIDS epidemic has had a momentous impact on South African society, and on children as relatives such as grandmothers and aunts have often assumed caregiving responsibilities for orphaned children. Shared caregiving with the other parent, relatives or neighbours is relatively common. Both children and caregivers may move between households as families attempt to navigate suitable care arrangements for their children,¹⁵ and in 2015, 21% of children in South Africa were not living with either parent.¹⁶ While it is desirable for children to live with family when biological parents are deceased or living elsewhere, findings from a predictive modelling exercise identified parental absence as an important factor that increases children’s risk of violence and abuse.¹⁷

Child-care services, such as day mothers or childminders, are sometimes used for young children not yet in school, though these are not necessarily available or affordable. Current trends indicate that 46% of children under five years old are in the care of a parent or guardian, while 14% are cared for by a day mother during the day, and a further 33% attend early learning programmes.¹⁸

As children grow older, their reliance on the immediate family for caregiving shifts as they start to engage with different environments, including schools and other community fora such as youth groups, sport clubs and aftercare facilities, as outlined in figure 13. While these external environments cannot replace the intimate nature of family care, they nevertheless have a responsibility to create a nurturing environment and engage with children in a caring manner.

Schools and other community sites present opportunities for meaningful contact and support. The concept of schools as “nodes of care and support” was introduced in South Africa about a decade ago and recognises the potential of schools to identify vulnerable children and link them with support services.¹⁹ The Department of Basic Education intends to implement the Care and Support for Teaching and Learning policy framework which has a similar objective. Clinics are similarly in an ideal position to identify and support pregnant women, caregivers of infants and young children, and adolescents in need of care and support.

As children mature, their relationships with peers, teachers, health professionals and community workers play an increasingly important role in developing their sense of belonging and social connectedness, and have an enduring developmental impact. These external relationships become particularly influential in adolescence and have the potential to provide structural support and appropriate bridging relationships.²⁰ Youth development programmes and mentorship schemes provide a gateway for healthy social engagement and skills development, and opportunities to build enduring, caring relationships that can last into adulthood. Ideally, strong connections between these different environments should be made and maintained to enable the development of healthy, supportive contexts for children and adolescents in every community.

When families are particularly vulnerable and children are at risk of compromised care, community-based support services provided by non-governmental, faith-based and community-based organisations (CBOs) can play a critical role. For example, the Isibindi

Table 3: Scale of selected environmental stressors impacting on families and children

Measure	Status
Poverty	In 2015, 25% of the population were extremely poor, and 56% lived below the upper bound poverty line. ¹
Unemployment	In 2016, the official unemployment rate stood at 27%. This rate excludes discouraged work-seekers. ¹
HIV/AIDS	In 2017, an estimated 13% of the population was HIV positive; and 21% of women aged 15 – 49 years. ²
Maternal depression	Area-specific studies indicate that antenatal depression prevalence ranges from 18% to 47%, and postnatal depression from 32% to 35%. ³
Intimate partner violence	21% of women aged 18 and older report experiencing physical violence by a partner, and 6% report experiencing sexual violence. ⁴
Child maltreatment	42% of adolescents report experiencing some form of maltreatment in their lifetime and 35% report experiencing some form of sexual abuse. ⁵
Foetal Alcohol Spectrum Disorder	Foetal Alcohol Spectrum Disorder rates ranged from 29 to 290 per 1,000 live births between 2001 and 2011. ⁶

Sources: 1. Statistics South Africa (2017) *Poverty Trends in South Africa: An Examination of Absolute Poverty between 2006 and 2015*. Pretoria: Stats SA; 2. Statistics South Africa (2017) *Mid-year Population Estimates. Statistical Release P0302*. Pretoria: Stats SA; 3. Schneider M, Docrat S, Onah M, Tomlinson M, Baron E, Honikman S, Skeen S, van der Westhuizen C, Breuer E, Kagee A, Sorsdahl K & Lund C (2016) Integrating mental health into South Africa's health system: Current status and way forward. *South African Health Review 2015/16*. Durban: Health Systems Trust; 4. Department of Health, Statistics South Africa, Medical Research Council & ICF (2017) *South African Demographic & Health Survey 2016: Key Indicators*. Pretoria and Rockville, Maryland: DOH, Stats SA, MRC & ICF; 5. Burton P, Ward CL, Artz L & Leoschut L (2016) *The Optimus Study on Child Abuse, Violence and Neglect in South Africa (Research Report)*. Cape Town: Centre for Justice and Crime Prevention & UCT; 6. Olivier I, Curfs L & Viljoen D (2016) Fetal alcohol spectrum disorders: Prevalence rates in South Africa. *South African Medical Journal*, 106(6 Suppl 1): S103-S106.

“Circles of Care” programme has a large footprint in South Africa. Their services are concentrated in poor communities and provide practical, regular support to vulnerable families in communities with high HIV prevalence, poverty and unemployment, and with limited access to basic and social services. However, community-based and non-profit organisations have limited reach – especially in rural areas. Where they do have a presence, their interventions and impact are often curtailed due to limited resources. Despite these constraints, CBOs have a positive effect on vulnerable HIV-affected children reducing their exposure to violence and abuse, and improving mental health and behaviour.²¹

What are the factors that can compromise care?

Several factors can compromise the development of healthy, caring relationships. While a caregiver may be present in a child’s life, it is critical that a caregiver is emotionally available and connected, demonstrating interest and attention through regular, meaningful interaction. Allowing the child to lead these interactions and responding sensitively to the child’s needs places the child at the centre of these engagements. In addition, the use of positive rather than harsh discipline has better long-term developmental outcomes, such as reduced aggressive and risky behaviour.²² Caregiver responses are influenced by the child’s temperament and personality, their own personality and parenting style, and childhood experiences. Other factors that influence the caregiver’s capacity to provide warm, responsive caregiving include the caregiver’s physical and mental health, exposure to stress, coping measures, and access to support and resources.

High levels of unemployment, poverty, and inequality contribute to the adversity experienced by many families in South Africa outlined in table 3. For example, the intersections between poverty

and inequality, chronic illnesses including HIV/AIDS, and poor mental health have been well established.²³ Several studies also document the serious challenges associated with providing care in these circumstances.²⁴ Poverty and inequality also increase the risk of depression²⁵ and community-based studies in South Africa indicate rates as high as 47% during pregnancy.²⁶ Maternal depression, in turn, is associated with preterm birth, low birth weight, poor infant growth and reduced cognitive development.²⁷

Violence is pervasive in South Africa and is likely to impact directly on caregivers’ health and mental well-being, affecting their caregiving ability, and threatening the emotional security of children who witness conflict in their homes. Intimate partner violence is common and is associated with depression,²⁸ which may cause caregivers to become detached and emotionally unavailable.

Even in families where a biological parent is present, other factors (such as employment or seeking employment, education or training, physical or mental health conditions, including disability or chronic illness) may affect the parent’s ability to provide constant, nurturing care. Other common environmental stressors include alcohol and drug abuse, social isolation and stigma.²⁹

A recent study shows that good parenting is positively associated with biological parents, parental mental health, and living in the same household as other adults, while poverty and stigma were negatively associated.³⁰ Support systems for caregivers are therefore essential to provide practical assistance and emotional support, particularly during stressful periods. When social support networks are available, whether through the immediate and extended family or through community-based programmes, they play a valuable promotive and protective role.³¹

Addressing caregiver stress and providing interventions that buffer the effects of stress, especially during periods of high

stress such as the postnatal period, are critical to minimise risks and enhance the development of the caregiver–child relationship. Family support, community-based services and access to a range of support services, such as maternity leave, child care and social assistance, are therefore essential to address caregivers' multidimensional needs.³²

At a macro level, the Sustainable Development Goals (SDGs) are expected to address the widespread economic insecurity faced by South Africa's caregivers and families. While the current basket of social assistance programmes is supportive, it is limited as a poverty alleviation mechanism, and the Child Support Grant, in particular, is insufficient within the current economic environment.³³ Similarly, other SDG targets, such as addressing gender inequalities and gender-based violence; promoting peaceful, safe and secure environments; and recognising the value of unpaid care work are central to improving conditions for caregivers and families. The SDG focus on maternal health and well-being is also welcomed and will hopefully reinforce strategies to improve quality and access to maternal health services – as target 3.4 specifically includes the promotion of mental health.³⁴

What interventions can improve the quality of caring relationships?

Creating enabling and nurturing environments for children to develop and thrive is not only the responsibility of families. Government has an obligation to ensure that the necessary policy, funding and systemic measures are in place. Implementation of key programmatic responses are necessary to shift the *status quo* and enable improved outcomes for children and their caregivers.

Programmes that promote responsive and supportive caregiving

Programmes that promote responsive parenting are recognised as a valuable contribution to improving family life. Good parenting programmes focus on the caregiver–child relationship to strengthen the role of caregivers by promoting their understanding of child development, encouraging secure early relationships, providing a stimulating environment, and promoting positive behaviour management strategies.³⁵ Programmes should also include relationship and life-skills such as self-care strategies and emotional regulation techniques.³⁶

Parenting programmes are showing promise in improving parenting skills and reducing risky behaviours in children and caregivers in contexts similar to South Africa,³⁷ drawing on a range of delivery vehicles – from home-visiting programmes to health facilities. But there is also a need to identify family strengthening and parenting interventions that are best suited to the complex and fluid care arrangements and family forms in South Africa. For example, the skills gained through parenting interventions should ideally be transferred to other adults within the family; it is therefore important to target the primary caregiver, and to gain family support for the programme.³⁸

A number of parenting programmes have been implemented and tested in South Africa. This includes the Parenting for Lifelong

Health (PLH) initiative³⁹ which adopts an age-differentiated approach and targets programmes at caregivers of babies, toddlers, young children and adolescents. Initial results indicate some positive effects, and testing on larger samples are underway. The Parent Centre's Parent–Infant Home Visiting project was among the first evaluations to be conducted in South Africa, and demonstrates robust positive outcomes for low-income pregnant mothers and their infants.⁴⁰

While there is a strong emphasis on targeting vulnerable new mothers and caregivers with young children, the PLH adolescent programme, Sinovuyo Teens, targets caregivers of adolescents. The 14-week programme provides an environment for caregivers and teenagers to jointly discuss parenting and family issues during regular group sessions. Initial evaluation findings⁴¹ found reductions in child abuse and improvements in caregiver and adolescent outcomes, and a larger trial is underway to verify these findings.⁴² Important lessons can be garnered from these studies, including considerations for replication and scale-up to ensure broader reach (as outlined in case 6).

Despite the near-universal uptake of antenatal services and well-baby health-care visits there is currently no universal parenting promotion and support programme available to new parents in South Africa. Health-care packages such as Basic Antenatal Care and the Integrated Management of Childhood Illnesses are currently survival-oriented and present an opportunity to incorporate parental care components. The World Health Organisation (WHO) Care for Development package for community health workers (CHWs) is a readily available, affordable and scale-able package that could address this deficit.⁴³ Other potential strategies include providing supportive parenting materials (such as videos) in antenatal and clinic waiting areas. Innovative programmes exist that show promise, such as the Ububele Baby Mat project which provides psycho-emotional support to mother-and-baby pairs in primary health-care clinic settings.⁴⁴

Home-visiting programmes

Caregiver contact and support are critical to enhance the quality of child–caregiver relationships. There are several types of programme delivery channels that target vulnerable caregivers and their children in South Africa. While facility-based services perform a useful function, they rely on caregivers travelling to the facility to access services and support. Distance to facilities, poor transport services, and lack of finance are some of the reasons for limited access. Home-visiting programmes are therefore effective for reaching the most marginalised populations and ensuring more equitable access to services.⁴⁵ Studies from high-income countries show that home-visiting programmes are effective in producing good child and caregiver outcomes, particularly for families of young children, although the cost-benefit is not clear.⁴⁶ A number of South African programmes are showing promise in reaching vulnerable caregivers and children and promoting positive outcomes.⁴⁷ For example, Philani uses the concept of peer support to train mentor mothers to support at-risk families with young children (see case 9 on p. 74).

Case 5: Care in pregnancy – The First 1,000 Days Initiative

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The Western Cape province has recognised the significance of the first 1,000 days in promoting the health and wellness of pregnant mothers and infants and enabling children to thrive and reach their full potential.

The province's First 1,000 Days Initiative acknowledges that care in pregnancy encompasses both the pregnant mother and the unborn baby, and goes further to embrace the mother's supportive relationships (father of the baby, family and/or friends), appreciating these critical and interrelated layers of support, as shown in the ecological model on p. 52. The initiative aims to raise awareness of the critical and exquisitely sensitive window of opportunity of the first 1,000 days (starting at conception and continuing for the first two years of life).

Care in pregnancy starts as soon as pregnancy is confirmed, and support is provided through home visits by trained CHWs at selected pilot sites who complete household and individual psychosocial risk assessments and initiate referral to health facilities for antenatal care. Other antenatal clinics screen for psychosocial risk factors (including common mental health conditions, substance abuse and domestic violence) and referrals are made to CHWs who provide supportive home visits. As tools emerge and local resources are mapped, a process is underway to share, evaluate and further refine these tools and referral mechanisms.

CHWs provide psychosocial support for women with mild or moderate risk and link women to social support services (such as the Child Support Grant), whilst those with more serious psychological needs are directed to medical and mental health services. Pregnant women are encouraged to involve the fathers of their babies or a close supportive partner during antenatal clinic visits, and to secure a birthing companion to provide support during labour. Trained peer counsellors provide infant feeding information at each antenatal clinic visit. Some clinics have started antenatal support groups for mothers, and counseling packages are currently being developed to help parents prepare for their newborn baby.

Health promotion materials for the first 1,000 days – including videos on infant–parent socialisation and maps to help parents and caregivers access local social services (such as social grants, playgroups and ECD centres) – are being developed, and delivery models at primary health-care (PHC) level are being evaluated.

The package of services for the first 1,000 days is also being revised to enhance universal services and develop targeted interventions. For example, midwives are getting trained in perinatal mental health and empathetic skills, and a standardised training package for CHWs is underway, drawing on a set of evidence-based practices for the first 1,000 days period. Task sharing within community-oriented primary care teams (which include PHC staff and CHWs) is being explored, informed by best practice models and local needs as determined by CHW household surveillance. This requires the development of new tools for clinical practitioners, lay counselors and home-visitors. For example, a parenting preparedness package with parent information materials is being developed, and an antenatal motivational interview tool, which will provide a checklist of risk and protective factors for the health worker and mother to reflect on before the baby is born, is planned. This builds on longer-term measures of child wellness as outlined by the eight SHANARRI Wellness Indicators (see figure 14) which are used in Scotland to promote a transversal and integrated approach to service delivery across sectors. The tool will also draw on the mother's strengths and motivation to improve her home environment for her baby (for example, deciding to stop smoking).

The role of the CHW home-visitor in establishing a supportive relationship with the pregnant woman and her family is invaluable and lies at the core of the care package for the first 1,000 days. This relationship will provide the safety and support that many women need to cope with adversity and to provide infants with the nurturing care that they need to thrive.

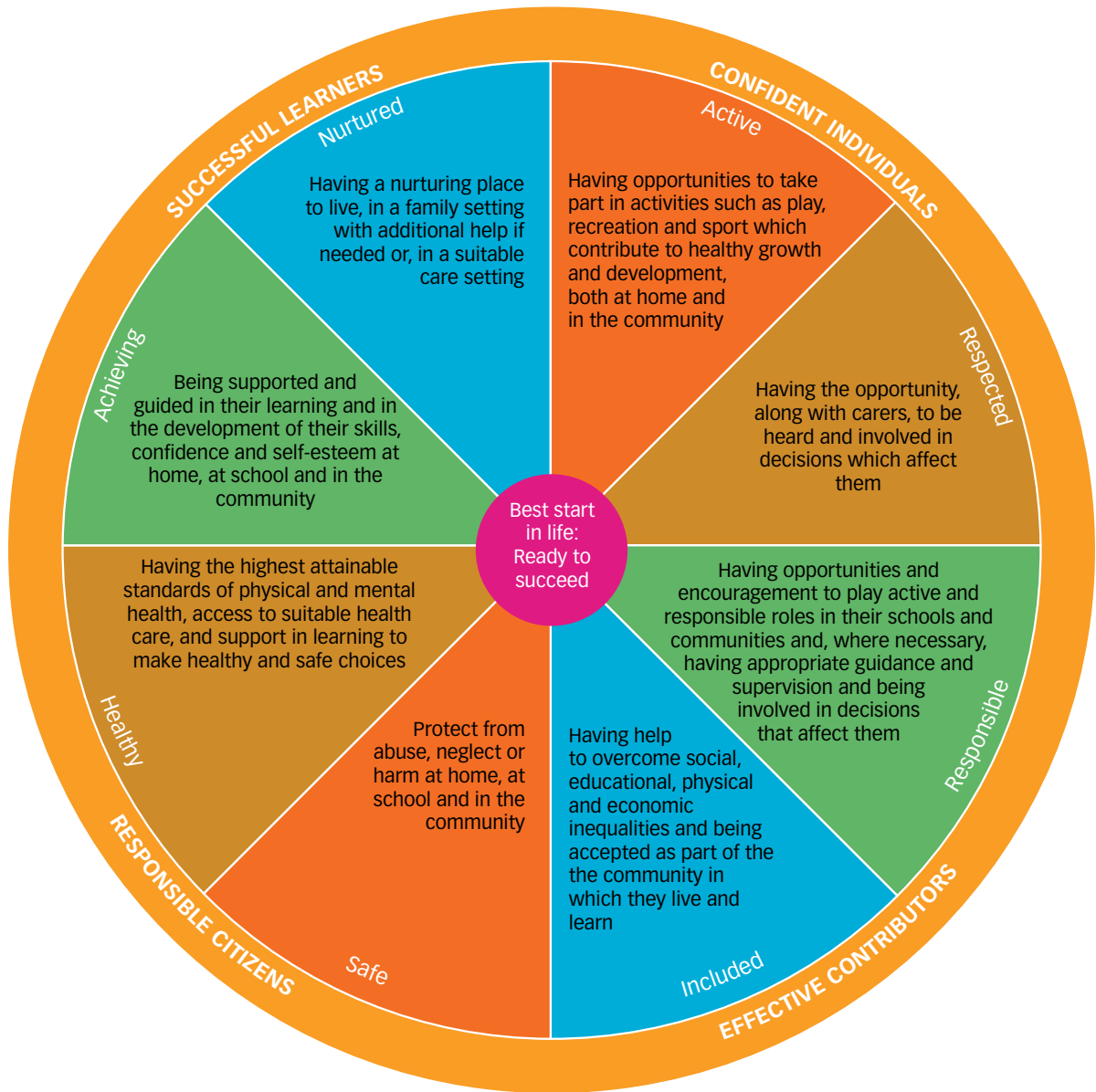
The government's CHW programme similarly intends to improve access to health-care services, and the revised Framework calls for an improved focus on delivery of maternal, neonatal, child and women's health and nutrition services through regular home visits.⁴⁸ Such home-visiting services have the potential to identify vulnerable caregivers and families and refer them for follow-up or specialist support. Ongoing support through regular home visits enables regular monitoring and continuity of services and support. Ideally, the home-visitor develops a caring and responsive relationship with the child and caregiver, and is able to model nurturing and responsive care. Taking this to scale would require a shift in focus in the training, mentorship and support of state-employed CHWs to ensure they are able to spend sufficient time to

build relationships with families and support responsive caregiving practices.

Community-based child care and youth development programmes

Programmes that support children and families within their communities also play a critical role, creating community awareness of child and youth well-being; liaising with community leaders; and negotiating for improvements in community structures, child protection, safety and health services when needed. Isibindi's "Circles of Care" programme is one such example. The programme offers support to vulnerable children, youth and families through regular home visits, and promotes child care, stimulation and

Figure 14: The SHANARI wheel



Source: Scottish Government (2017) *Wellbeing*. Viewed 15 September 2017: www.gov.scot/Topics/People/Young-People/gettingitright/wellbeing.

protection through Safe Park programmes. The programme also offers parenting skills training, family strengthening and practical support for caregivers and families. The programme is noted for its responsiveness to the needs of vulnerable children and families, the consistent presence and availability of child and youth care workers, and their invaluable referral role – however, documented evidence of the medium- to long-term impact of Isibindi is needed.⁴⁹ The programme’s emphasis on caring relationships is commendable and it is filling a significant void at family and community level.⁵⁰

It is also critical to explore the impact of community-based adolescent peer-support and mentoring programmes that may translate into positive adolescent development (such as Isibindi’s Adolescent Development Programme, outlined on p. 38).

Identification, referral and support of vulnerable children and families

Clinics, home-visiting programmes, early childhood development centres, child care services, schools and social grant pay-points are all services that caregivers use regularly and are therefore ideal vehicles for promoting additional services and support for caregivers and children.

Antenatal, postnatal and child health services are a key gateway to support services as they provide regular contact with pregnant women. About 90% of pregnant women attend antenatal care.⁵¹ This provides an opportunity for the identification of mental health problems, interpersonal violence, substance abuse, and other environmental risks which, if identified early, can be assessed and referred for appropriate support. The Perinatal Mental Health

The call for “evidence-based” programming has led to increasing investment in studies designed to test the efficacy and effectiveness of parenting interventions. However, lessons from implementation science⁵² and public health⁵³ suggest that the successful translation and up-take of this evidence require a particular set of conditions and expertise. The following questions are offered as a guide for practitioners who are considering implementing programmes that have had positive trial results.

Is the programme generalisable?

In answering this question, it is helpful to look at how representative the trial programme beneficiaries are of the broader group that the programme is designed for. For example, if the programme is designed for primary caregivers in lower-income settings, but the beneficiaries in the trial come from a small urban community in one country, can the results be generalised to communities in rural areas or to people with different cultures?

The participation rate of the target group in the study is also important. To what extent was the participation rate assisted by organisational support, such as transport and meals for participants, and can this level of support be sustained beyond trial interventions? What was the actual impact of the programme on participants; did the results have sustained impact; and what was required in terms of training and logistical support to ensure effectiveness? To what extent were the results influenced by cultural norms, the media, the geographical setting, or incentives such as food and transport?

Is the programme replicable in my setting?

It is important to establish whether the programme is relevant and possible to implement in your context. For example: To what extent does the purpose of the programme align with your organisation’s mission and values as well as the needs of your beneficiaries?

Is the programme sufficient to attain the intended outcomes, or does it require additional strategies, programmes and/or media campaigns to sustain the intended outcomes? For example, replacing corporal punishment with positive parenting requires multiple strategies to address pervasive social norms with consistent messages. What partnerships are needed to implement and monitor such a multi-pronged, integrated strategy?

What was the cost of the trial and what would it cost in your setting? This includes logistical support (such as co-ordination

and provision of materials) and incentives (such as food, child care and transport provided in the trial) and the extent to which these incentives are essential to ensure the fidelity of the programme.

It is also critical to consider who will deliver the programme. What competencies and qualities are required, and can your staff accommodate the programme given their existing workload and professional interests? What about training, mentoring and support? Do you have capacity in-house, or would you need to cover the costs of an external trainer? And to what extent does the pedagogy of the training fit with your value system. For example, does it recognise prior learning and follow principles of participative adult learning or does it simply tell people what to do? How will this learning be sustained in the long run?

Finally, what are the implications for your organisation’s administrative functions – including data collection for monitoring, evaluation and reporting?

What are the implications for policy?

Finally, it is essential to consider the policy environment. Firstly, which policy priority does parenting support align with and how can you position your programme to meet this objective? What government programmes offer the best fit – for example, early childhood development, youth, children and/or families, or prevention of child abuse and neglect? What are the mechanisms for registering and assuring compliance of your programme within the sector’s quality assurance systems, and ensuring that you qualify for resource allocation? Secondly, how can you ensure that lessons learnt in implementing programmes inform policy and programme development? And how can you align your efforts with other parenting programmes to enhance the reach and impact of parenting programmes?

It is therefore helpful to participate in broader networks and policy processes through national and sub-national structures. For example, the Tanzanian Parenting Task Force (chaired by that country’s Ministry of Health, Community Development, Gender, Education and Children, and supported by UNICEF) co-ordinates and maps parenting initiatives throughout their country. They are also the “parent body” of a home-grown parenting community dialogue programme. A similar model within South Africa’s National Child Protection Forum could help organisations delivering parenting programmes to build partnerships, access resources, share lessons learnt, and inform policy and programme design.

Project has been exploring how best to integrate mental health screening into routine antenatal care, and has developed a concise screening tool that can be administered as part of a mental health-care service package.⁵⁴ The National Integrated Early Childhood Development Policy aims to build on this foundation and mandates the Department of Health to play an expanded role during the first 1,000 days (as outlined in case 5 on p. 56). This, however, requires reorientation and training of health practitioners to ensure a broader focus on child development and parenting.

Networks of care and support

Community networks can act as a safety net for vulnerable children and families. This can be strengthened by enhancing communication and referral systems between schools, clinics, faith-based organisations and CBOs. For example, the Adolescent Youth Health Services Forum in Khayelitsha, Western Cape, enables NGOs and government services working in the areas of youth health and development to collaborate and share resources.

Informal and formal networks and gatherings – such as peer-support initiatives, stokvels, community policing forums and support groups for teen mothers or parents of children with disabilities – provide regular contact and opportunities to build relationships among neighbours and community members, and should be encouraged. Such activities build social cohesion, restore community trust and facilitate responsive and individualised care.

Conclusion

The promotion and support of nurturing caregiving relationships must be recognised and prioritised at the highest levels if we are to fulfil our vision of a society where children and adolescents are

thriving and reach their full potential. The interventions described in this essay can only be implemented effectively if systems and structures are adequately resourced and well-functioning.

Home-, school- and- community-based programmes are critical to reach children and families in their everyday environments, and to enable service providers to identify vulnerabilities and intervene early. These programmes are also more likely to reach those vulnerable families who are most in need of support. Investing in evidence-based preventive programmes that promote nurturing care will significantly contribute to addressing the equity gaps and minimise tertiary costs of mental health conditions, behavioural and relational problems and cognitive deficits.⁵⁵

While earmarked funding is required for certain programmes, there are a few possible quick wins that do not require much additional funding, such as including mental health screening at antenatal and well-baby visits, and using the WHO Care for Development package to provide basic support and information on positive parenting and practical caregiving. Professionals and paraprofessionals working in the health, education and social development sectors have a critical role to play, as every contact with a caregiver or child is a gateway to identify risks and offer appropriate support and referral.

Local implementation of the SDG framework provides a key opportunity to address the multiple risk factors that undermine families' capacity to provide nurturing care, and calls for the strengthening of government and civil society systems to foster the development of enabling environments. But, unless the adoption of the SDGs facilitates improvements in the quality of caregiving relationships and support for caregivers, they are likely to have a limited impact on children's care and development.

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Preventing violence: From evidence to implementation

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If we are serious about achieving the Sustainable Development Goals (SDGs) and ensuring that South Africa's children not only survive but also reach their full potential, then it is imperative that we invest in creating safer homes, schools and communities.

The Constitution guarantees children's rights to protection from abuse and neglect, and to freedom from violence.¹ Yet violence against children remains widespread. Exposure to abuse, neglect and other forms of violence continues to compromise children's ability to thrive, increases their risk of mental health problems and substance abuse,² and contributes to an intergenerational cycle of violence and poverty – with violence against children costing South Africa an estimated R238.58 billion – or 6% of the gross domestic product – in 2015³. Violence also impedes children's ability to thrive at school and achieve their potential.⁴

The good news is that South Africa now has a significant body of research that outlines the drivers of violence across the life course⁵ and what can be done to prevent violence against children. This understanding has informed a growing evidence base on effective multi-sectoral interventions to address the complex interplay of risk factors across different settings.¹

This essay builds on this evidence base to consider the following questions:

- What is known about the nature and extent of violence against children in South Africa?
- How does violence affect children's ability to thrive?
- How can violence be prevented?
- What is needed to bridge the gap between evidence and implementation?

What is known about the nature and extent of violence against children in South Africa?

There was no national estimate of children's experiences of violence until the 2016 Optimus Study on child abuse, violence and neglect in South Africa. The school-based study estimates that 35.4% of South Africa's children experience some form of sexual abuse, 34.8% of children experience physical violence, 26.1% experience emotional abuse, and 15.1% experience neglect. The study concluded that 42% of children had experienced some form

of violence and that there was no gender difference in reported experiences of sexual abuse.⁸

Violence against children also kills. The homicide rate in South Africa is 38.4 murders per 100,000 persons,⁹ almost six times the global homicide rate,¹⁰ and the child homicide rate is 5.5 per 100,000, more than double the global average. Children younger than five years are at risk of fatal child abuse by someone close to them, and teenage boys are most likely to be killed in the context of male-on-male interpersonal violence.¹¹

How does violence affect children's ability to thrive?

Safety from violence is critical for children to thrive. Children's safety is influenced by individual factors such as intellectual ability and gender; and conditions in the home, peer group, school and wider community. Children who are most at risk of abuse from their caregivers are those with chronic illnesses, those who have special needs (learning, physical and mental disabilities), and younger children (under five years). Children living in disorganised families experiencing high levels of stress are also at risk.ⁱⁱ Communities

Box 5: What is child safety?

Injuries are one of the leading causes of death and disability for children globally, and efforts to promote child safety have tended to focus on preventing injuries, and ensuring survival. However, the safety promotion paradigm does not take into account the psychological harm associated with violence, abuse and neglect, and the need to mitigate this to enable children to thrive. More recently, the World Health Organisation has recognised the non-fatal health consequences of injuries and violence.⁶ It is now accepted that children's exposure to violence, including abuse, neglect and harsh parenting has lasting effects that impact on a child's safety, well-being and ability to thrive; and that definitions of child safety must incorporate children's freedom from fear, and from physical and psychological harm within their homes and communities.⁷

i For example, the global *What Works to Prevent Violence Against Women and Girls* implemented by the Medical Research Council in South Africa and supported by funding from the UK Department for International Development (DFID) represents a massive investment in understanding the root causes of violence, and in the development and evaluation of primary violence prevention interventions in Africa, Asia and the Middle East. See www.whatworks.co.za/about/about-what-works.

ii A study in a community in the Western Cape found that more than a fifth of caregivers experienced high levels of parental stress and that parental stress, intimate partner violence, substance misuse and corporal punishment were associated with children's externalising disorders. See: Ward C, Gould C & Mauff K (2015) Spare the rod and save the child: Assessing the impact of parenting on child behavior and mental health. *South African Crime Quarterly*, 51: 9-22.

that experience high levels of crime, violence, unemployment and substance abuse are likely to have a negative impact on children's mental health and behaviour in the absence of protective factors. Similarly, unsafe school environments pose a significant risk for children who may be exposed to corporal punishment, cruel and humiliating forms of psychological punishment, sexual and gender-based violence, and bullying.¹² For this reason, SDG 4(a) clearly articulates the need to provide safe, non-violent and inclusive educational facilities for all to promote learning and better outcomes for children.¹³

At the same time, not all children growing up in risky environments have poor outcomes. It is therefore important to understand the protective factors that allow children to thrive. Fostering secure parent-child attachments early in life, and a nurturing family environment promote resilience and create a foundation for children to survive and thrive even in unsafe environments.¹⁴

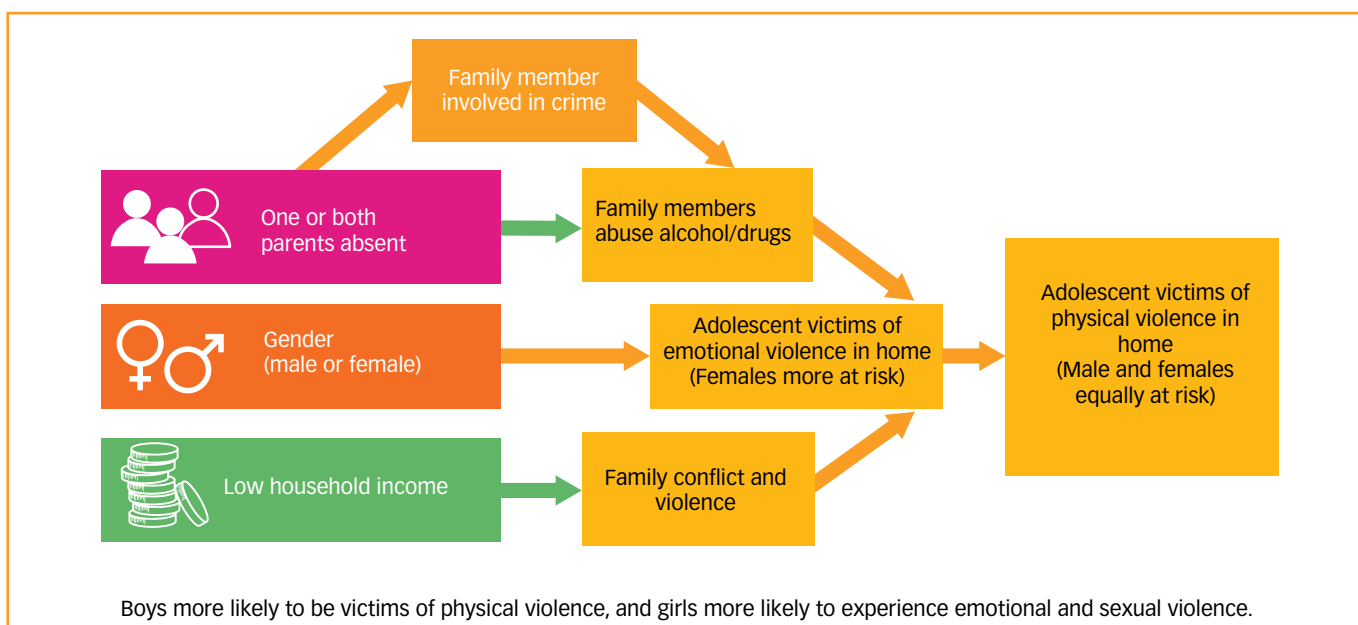
Early childhood (0 – 5 years), middle childhood (6 – 11 years) and adolescence (12 – 18 years) are the foundational years that help set the stage for adult relationships and behaviours. The early childhood years are when bonding and attachment take root and when the architecture of the brain starts to form. In this phase, a safe, stable and nurturing environment, responsive caregivers and positive social interaction prepare the developing brain to function well in a range of circumstances.¹⁵ On the other hand, harsh or inconsistent parenting has a damaging effect on neurodevelopment and may compromise cognitive development and result in increased aggression.¹⁶ Childhood trauma (not just during early childhood) has lasting intergenerational effects and increases the risk for both victimisation and perpetration.¹⁷ Reducing children's exposure to violence and protecting children from trauma are critical, as set out in SDG 3.4, which expresses the need to promote mental health and well-being across the life course.¹⁸

During middle childhood and adolescence, moral reasoning and social problem-solving skills develop; and attitudes and beliefs about violence are shaped. It is during this time that non-violent and respectful relationships, or their opposite, are cultivated. Values and skills are learned through experiences at home, with peers, at school and within the community, and they intersect to increase or decrease the risk of violence victimisation or perpetration. During this period children spend large parts of their day at school and this socialisation with peers and educators provides an ideal opportunity to introduce programmes to protect children from further risk.

The impact of violence and adversity varies across the life course just as children are vulnerable to different forms of violence at different times in their lives. For example, infanticide, parental abandonment and neglect may have a more profound impact on children under two than older children; bullying only affects children when they begin interacting with peers; while teenagers are at higher risk of alcohol and substance abuse than younger children.

Violence is seldom random. It results from a dynamic interplay between individuals and their environment. A study on the determinants of violence against children in South Africa¹⁹ was commissioned by the Inter-Ministerial Committee on Violence against Women and Children. This study aimed to determine the pathways to victimisation and perpetration by using existing longitudinal data from the Cape Area Panel Study. It was found that children are at a greater risk of experiencing or perpetrating violence when one or both parents are absent, when they are exposed to heightened conflict such as domestic violence in the home, when they live in poor households, and when they are exposed to alcohol or drugs and crime (in their households or community). The study also found that boys are more likely than girls to be victims of physical violence, while girls are more likely to suffer emotional and sexual violence (see figure 15). Adverse

Figure 15: Determinants of violence victimisation



Adapted from: Mathews S, Govender R, Lamb G, Boonzaier F, Dawes A, Ward C, Duma S, Baraacke L, Warton G, Artz L, Meer T, Jamieson L, Smith R & Röhrs S (2016) *Towards a More Comprehensive Understanding of the Direct and Indirect Determinants of Violence against Women and Children in South Africa with a View to Enhancing Violence Prevention*. Cape Town: Safety and Violence Initiative, University of Cape Town.

experiences are strongly linked to a number of negative health, economic and social outcomes.²⁰ In the absence of safe, stable, nurturing relationships and environments, changes in the brain architecture and function may result in aggressive and antisocial behaviour.²¹ These changes manifest in different ways, varying by age, gender and temperament²² and may include uncooperative and defiant behaviour in pre-schoolers; hitting others, bullying or lying in middle childhood; stealing, truancy, alcohol or drug use and involvement in crime and violence in adolescence; reckless driving, erratic work history, multiple and unstable relationships, partner violence, carrying a weapon, and the continuation of crime and violence into adulthood.²³

Qualitative life history research with men who were incarcerated for sexual offences, killing of an intimate partner and other serious violent crimes reveals the impact of adverse childhood experiences such as emotionally or physically unavailable parents, harsh parenting, neglect, abuse and fear.²⁴ This is exacerbated by antisocial and violent forms of masculinity that favour risk taking, displays of strength and violence, and sexual entitlement.²⁵ In addition, exposure to violence in particular during adolescence across settings increases young people's chances of engaging in risky or anti-social behaviour, and even crime.²⁶ Being a victim of violence increases the risk of depression, anxiety and post-traumatic stress disorder which often remain unrecognised, resulting in early school drop-out and long-lasting mental health problems.²⁷

There is a growing recognition that we need to develop a better understanding of the protective factors that can mitigate risk in order to avoid bad outcomes and ensure children can thrive.²⁸ This includes a shift in the societal norms, values and beliefs that support the use of violence, including corporal punishment.²⁹

Therefore, interventions to increase safety and reduce the risk or experience of violence should be carefully targeted and should be responsive to both the developmental needs of children, and the need to shift societal norms.³⁰

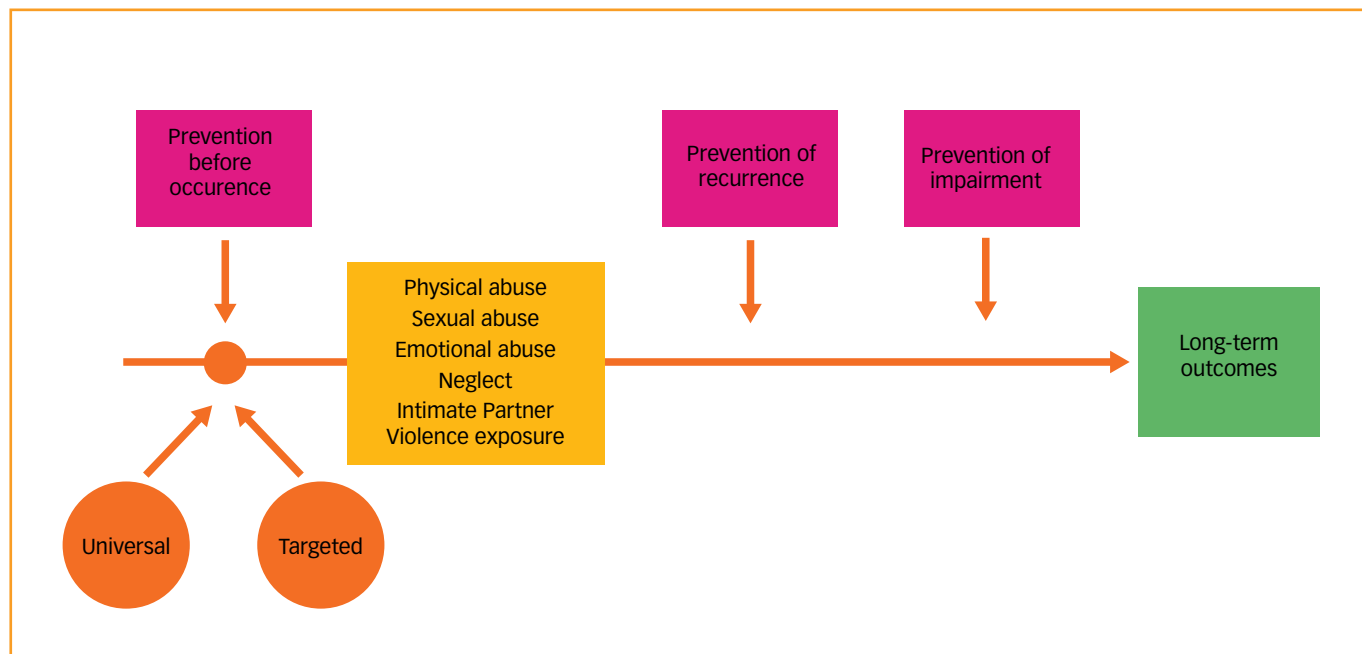
How can violence be prevented?

Preventing violence requires government, civil society and academia to work together to design sustainable interventions that address risk factors across the life course. It is important to prevent violence before it happens, and to provide treatment and support for victims, perpetrators and child witnesses when violence has taken place (see figure 16). Violence and trauma have long-term impacts on mental and physical health and may affect victims' ability to participate in the economy, form stable nurturing relationships and care for children.³¹ It is therefore essential to attend to both the physical and emotional needs of victims.

The Global Partnership to End Violence Against Children, launched in July 2016, is targeting a range of SDGs (3, 4, 5, 11, 16 and 17) in order to end all forms of violence against children by 2030. Alongside this global campaign, the World Health Organisation has launched the INSPIRE report³² that showcases seven evidence-based strategies that have the greatest potential to reduce violence against children, while indicators are being developed to track progress and help countries and communities intensify their focus on prevention programmes and services. Table 4 reflects South Africa's progress in relation to these seven strategies.

It is clear that there are a number of violence prevention initiatives already in place, but several of these interventions lack sufficient evidence to establish effectiveness. The challenge is to build the evidence base, increase the scope and reach of services, and ensure their sustainability.

Figure 16: Prevention framework



Source: MacMillan H, Wathen C, Barlow J, Fergusson DM, Leventhal JM & Taussig HN (2009) Interventions to prevent child maltreatment and associated impairment. *The Lancet*, 373(9659): 250-266.

Table 4: South Africa's progress in preventing violence against children

INSPIRE strategies	INSPIRE approaches	South African responses
Implementation and enforcement of laws	<ul style="list-style-type: none"> • Laws banning violent punishment of children by parents, teachers or other caregivers • Laws criminalising sexual abuse and exploitation of children • Laws preventing alcohol misuse • Laws limiting youth access to firearms and other weapons 	<p>The South African Schools Act bans the use of corporal punishment by teachers. However, a national study found that 22 – 74% of learners (depending on province) had experienced corporal punishment at school.³³</p> <p>The Liquor Act and the Prevention of and Treatment for Substance Abuse Act aim to combat substance abuse and reduce the demand and harm associated with substance abuse.</p> <p>The current Children's Act does not ban the use of corporal punishment by parents, but government is planning to amend the Act following a court case that effectively bans corporal punishment in the home.</p> <p>The Children's Act criminalises sexual abuse and exploitation of children.</p> <p>The Firearms Control Act regulates the possession of firearms by civilians. However, a national study found that 24% of learners claimed to know people who had brought weapons, such as firearms or knives, to school.</p> <p>The Criminal Law (Sexual Offences and related Matters Amendment Act criminalises sexual abuse and rape.</p> <p>The Prevention and Combatting of Trafficking in Persons Act criminalises all acts that support the trafficking of children.</p>
Social norms and values	<ul style="list-style-type: none"> • Changing restrictive and harmful gender and social norms • Community mobilisation • Bystander interventions 	<p>Sonke Gender Justice is currently evaluating a multi-level intervention in Diepsloot to change gender norms and reduce harmful expressions of masculinity while achieving a reduction in gender-based violence and other positive health outcomes.³⁴</p> <p>The Medical Research Council (MRC) is completing a cluster randomised controlled trial of a school-based programme to change gender norms and reduce gender-based violence.³⁵</p> <p>As yet, there are no programmes with national reach and no clear plans for scale-up.</p>
Safe environments	<ul style="list-style-type: none"> • Reducing violence by addressing "hot spots" • Interrupting the spread of violence • Improving the built environment 	<p>Sexual Violence against young girls in Schools in South Africa (SeVISSA) aims to reduce violence against children in South African schools.³⁶</p> <p>Violence Prevention through Urban Upgrading is working with communities in the Western Cape to address safety risks in formal and informal settlements.³⁷</p> <p>The Integrated Urban Development Framework³⁸ has a strong focus on creating safe environments.</p>
Parent and caregiver support	<ul style="list-style-type: none"> • Delivered through home visits • Delivered in groups in community settings • Delivered through comprehensive programmes 	<p>Parenting for Lifelong Health (PLH)³⁹ is developing and testing affordable parenting programmes for low-resource settings in South Africa to prevent violence. PLH's four programmes target parents and caregivers of babies and toddlers, young children, and adolescents. Randomised control trials are evaluating all four programmes in the Eastern⁴⁰ and Western Cape.</p> <p>In addition, a large number of non-profit organisations deliver parenting programmes. However, only a small number of these are evidence-informed and there is currently no coherent strategy or plan to scale up the small number of programmes that have been shown to be effective in reducing child abuse and neglect or improving infant attachment.</p>

INSPIRE strategies	INSPIRE approaches	South African responses
Income and economic strengthening	<ul style="list-style-type: none"> • Cash transfers • Group savings and loans combined with equity training • Microfinance combined with gender norm training 	<p>The Child Support Grant, a means-tested cash transfer, was introduced in 1998 to contribute towards the costs of supporting a child. Over 12 million children benefit from the grant.</p> <p>The MRC and partners are currently evaluating a Stepping Stones and Creating Futures intervention through a cluster randomised control trial. The trial will evaluate whether a gender transformative and livelihoods strengthening intervention delivered to young women and men (aged 18 – 30) in urban informal settlements in Durban can reduce women’s experiences – and men’s perpetration – of intimate partner violence and strengthen livelihoods.⁴¹</p>
Response and support services	<ul style="list-style-type: none"> • Counselling and therapeutic approaches • Screening combined with interventions • Treatment programmes for juvenile offenders in the criminal justice system • Foster care interventions involving social welfare services 	<p>Foster care is a key component of South Africa’s child protection system. Children found in need of care and protection (including orphans living with relatives) can be placed in foster care by a court. Due to HIV/AIDS, the numbers of orphans in care rocketed from 47,000 in 2000⁴² to 440,000 in 2017⁴³. This burgeoning demand has placed an intolerable burden on social workers who are unable to ensure that foster care orders are renewed timeously. These demands are threatening the child protection system.</p> <p>UNICEF has developed a screening tool for children at risk and trained social workers to use it. Since this is a new development, there is not yet data regarding its effectiveness.</p>
Education and life-skills	<ul style="list-style-type: none"> • Increasing enrolment in pre-school, primary and secondary schools • Establishing a safe and enabling school environment • Improving children’s knowledge about sexual abuse and how to protect themselves against it • Training in social and life-skills • Adolescent and intimate partner prevention programmes 	<p>School enrolment in South Africa is high, with 97% of school-age children attending school.⁴⁴</p> <p>The life orientation curriculum includes a focus on sexual abuse, life-skills training and relationships. However, it is not known whether increased knowledge has, or can, help children to better protect themselves from abuse.</p> <p>PREPARE is an intimate partner violence prevention programme which was tested with grade 8 learners in the Western Cape.⁴⁵</p> <p>The Department of Basic Education has recently adopted a Care and Support for Teaching and Learning (CSTL) framework and is currently upgrading and improving the curriculum to strengthen peace building.</p> <p>The National School Safety Framework is a management tool to help provincial and district officials as well as schools (teachers and learners) and school governing bodies identify and manage risk and threats of violence in and around schools.</p>

What is needed to bridge the gap between evidence and implementation?

While there is a growing evidence base and a range of prevention programmes to draw on, recent discussions between the developers and evaluators of primary prevention programmes in civil society and National Treasury have revealed a gap that may hamper efforts to prevent violence at scale.

Academics tend to focus on the development of robust, evidence-informed programmes to address risk factors, and may work closely with non-governmental organisations (NGOs) to implement these during the evaluation phase, but their job is done once the results are published.ⁱⁱⁱ In many cases the skills

and capacity to implement an intervention are quickly lost and the investment in knowledge is not realised. Scaling up is also hampered as there are very few community-based organisations or networks that have a credible national footprint in South Africa, and even fewer that can commit themselves to implementing only evidence-based programmes. It is therefore vital to bridge the gap between those who generate knowledge and those responsible for resourcing and implementing programmes.

Strengthening alignment and coordination

The Diagnostic Review of Violence Prevention against Women and Children⁴⁶ in South Africa identified an “implementation gap”

iii Three such examples include the evaluation of a gender-based violence prevention programme in Diepsloot, by Sonke Gender Justice and the University of the Witwatersrand; a project to determine whether a whole community’s approach of parenting can be shifted positively through a social activation process and the delivery of four parenting programmes, led by the University of Cape Town, the Institute for Security Studies and the Seven Passes Initiative; and the evaluation of the Sinovuyo Teen Parenting Programme in the Eastern Cape, a collaboration between Clowns Without Borders, the National Association of Child Care Workers, UNICEF and the Department of Social Development.

Child Death Reviews (CDRs) use an intersectoral approach to understand and prevent child deaths.⁴⁷ The CDR teams, led by the Children’s Institute at the University of Cape Town, facilitate a coordinated response between the police, forensic pathology services, prosecution authorities, paediatricians, and social services in the management of child deaths. The efficacy of the model in the South African setting was tested through a process evaluation in 2014 with a focus on establishing the effectiveness of the teams in strengthening the health and child protection response systems.⁴⁸

This multi-agency approach brings together evidence from medical records, autopsy reports, police and social services investigations, and enables more effective identification of child abuse and neglect. It helps identify systems failures within different departments and opportunities to strengthen

communication and coordination between them.

The CDR pilot has demonstrated how a multi-agency approach can enhance reporting and enable a real-time response to ensure children are safer in their homes. The value of making joint decisions also took the burden off the forensic pathologist and police as investigating child deaths in the home is incredibly difficult, particularly when there is a suspicion of a non-accidental injury at the hands of someone close to the child. Social services investigations have also proved crucial in identifying families in distress who require ongoing support to prevent further negative outcomes. The project has been adopted by the Western Cape Health Department as a “best practice model” and is being expanded across the province.

and the need for an oversight body to ensure better alignment and coordination between policy-makers and implementing departments. This is being addressed through an improvement plan, drafted by the Department of Planning, Monitoring and Evaluation in consultation with the affected departments. This may be good news for violence prevention efforts in South Africa. Intersectoral collaboration is also essential to strengthen service delivery at the local level, as illustrated by the child death review programme (in the above case).

Identifying what works at scale

The research community has, until now, been somewhat weak at generating information to inform scale-up including what is needed to ensure interventions are effective outside of the experimental setting and responsive to the local context.

It is important to recognise the limitations of testing programmes through small pilot studies, as these rarely reflect the conditions that interventions will encounter when taken to scale. Very often the level of motivation is high and management input by the “parent” organisation is far greater than realised. It is thus critical to identify the likely challenges of moving to scale, and to develop appropriate ways of managing them. For example, a positive evaluation of a programme through a randomised controlled trial does not necessarily mean that is suitable or ready for scale-up as it may lack the necessary systems, human and financial resources needed to go to scale.

Implementation research has the potential to address these challenges by enhancing our understanding of what is required to support the implementation of programmes with fidelity, and to inform decisions about the resourcing, selection and targeting of prevention programmes – drawing on reflections from academia, government and NGOs.⁴⁹

Building a common vision and finding a way forward

A number of factors place South Africa in a very strong position to work with the Global Partnership to End Violence Against Children and to realise comprehensive violence prevention programming. These include:

- a strong and growing body of evidence about the nature and causes of violence in South Africa;
- a significant investment in the rigorous evaluation of primary prevention programmes;^{iv}
- a growing consensus and commitment by government and civil society to violence prevention;^v and
- a strong policy framework.

This may well be sufficient grounds for South Africa to consider joining the 13 countries that have been named “Pathfinders” to fast-track the prevention of violence against children, and to take advantage of global resources and partnerships that can help translate our investments into significant gains for children.

iv The global What Works to Prevent Violence Against Women and Girls’ expenditure of £25 million over five years will provide data about the effectiveness of a wide range of interventions aimed at addressing the risk factors for gender-based violence. Yet the extent to which these interventions, if shown to be effective, can be taken up and applied outside of the context in which they have been trialled is yet to be established.

v As indicated by the National Dialogue Forum for Evidence-based Programmes to Prevent Violence Against Women and Children, which is convened by the Institute for Security Studies and supported by a multi-sectoral “driver group” including the MRC, UNICEF, Save the Children South Africa and the Department of Women.

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Ending stunting: Transforming the health system so children can thrive

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The World Health Organisation (WHO) defines health as “a state of complete physical, mental and social well-being”,¹ and affirms “the highest attainable standard of health as one of the fundamental human rights of every human being”². The South African Constitution entrenches a broad range of socio-economic rights which extend beyond the right to basic health-care services to cover key determinants of child health – such as food security, nutrition, water, housing and social assistance – all of which are essential for children to survive, thrive, and develop their full potential.

This essay focuses on undernutrition and resultant stunting,¹ identifying key interventions both within and outside the health-care system that can prevent these and enable children to not only survive, but to thrive and develop their full potential. This necessitates a strengthening of primary health care with its focus on community and primary-level health care, actions to address the social determinants of poor health,³ and an expanded role for community health workers (CHWs).

The essay addresses the following questions:

- What are the key drivers of child mortality?
- Why are South Africa’s children stunted and failing to thrive?
- What is needed to ensure that children enjoy optimal nutrition?
- What can the health-care system do to ensure children thrive?

What are the key drivers of child mortality?

The Millennium Development Goals (MDGs) aimed to reduce the under-five mortality rate (U5MR) by two thirds between 1990 and 2015. Yet, despite significant gains driven by the roll-out of the Prevention of Mother-to-Child Transmission (PMTCT) programme in South Africa, progress has slowed. In 2015 the U5MR stood at 37 deaths per 1,000 live births: nearly double the MDG target of 20 deaths per 1,000 births.⁴ Greater effort is therefore required if South Africa is to achieve the Sustainable Development Goal of 25 deaths per 1,000 live births by 2030.

Children under five years old die overwhelmingly of complications around the time of birth (such as preterm birth and low birth weight), and of preventable communicable diseases. Today the leading causes of under-five mortality are neonatal deaths (>30%), gastroenteritis (9%) and suspected pneumonia (17%); together they have surpassed HIV/AIDS (9%).⁵ Trauma and injuries, high-risk behaviour such as substance abuse and unsafe sex,⁶ and a growing epidemic of diet-related non-communicable diseases and trauma are the major causes of deaths amongst

older children and adolescents.⁷ Undernutrition due to inadequate dietary intake plays a major contributory role in all these causes of young child morbidity and mortality, and it underlies approximately 60% of all child hospital deaths.⁸ Although figures for South Africa are unavailable, the WHO estimates that undernutrition contributes to about 45% of deaths in children under five years of age globally.⁹

These conditions remain prevalent because the social determinants of health and access to good health care are unequally distributed. Young children remain disproportionately concentrated in poorer households, and in rural areas and provinces,¹⁰ where adverse environmental factors – especially poor sanitation and inadequate supplies of safe water – and poorer, less accessible health services contribute to high death rates. Children in the poorest fifth of households are four times more likely to die before their first birthday than those in the richest households.¹¹ African children, rural children, and those whose mothers lack formal education are also at greater risk.¹²

Why are South Africa’s children stunted and failing to thrive?

Stunting is a manifestation of chronic undernutrition, and prevalence remains discrepantly high in South Africa, as an upper middle-income country, with an estimated 27.4% (1.58 million)¹³ children under the age of five being stunted.¹⁴ Moreover, there is little evidence that this rate has changed significantly over the past 20 years.¹⁵

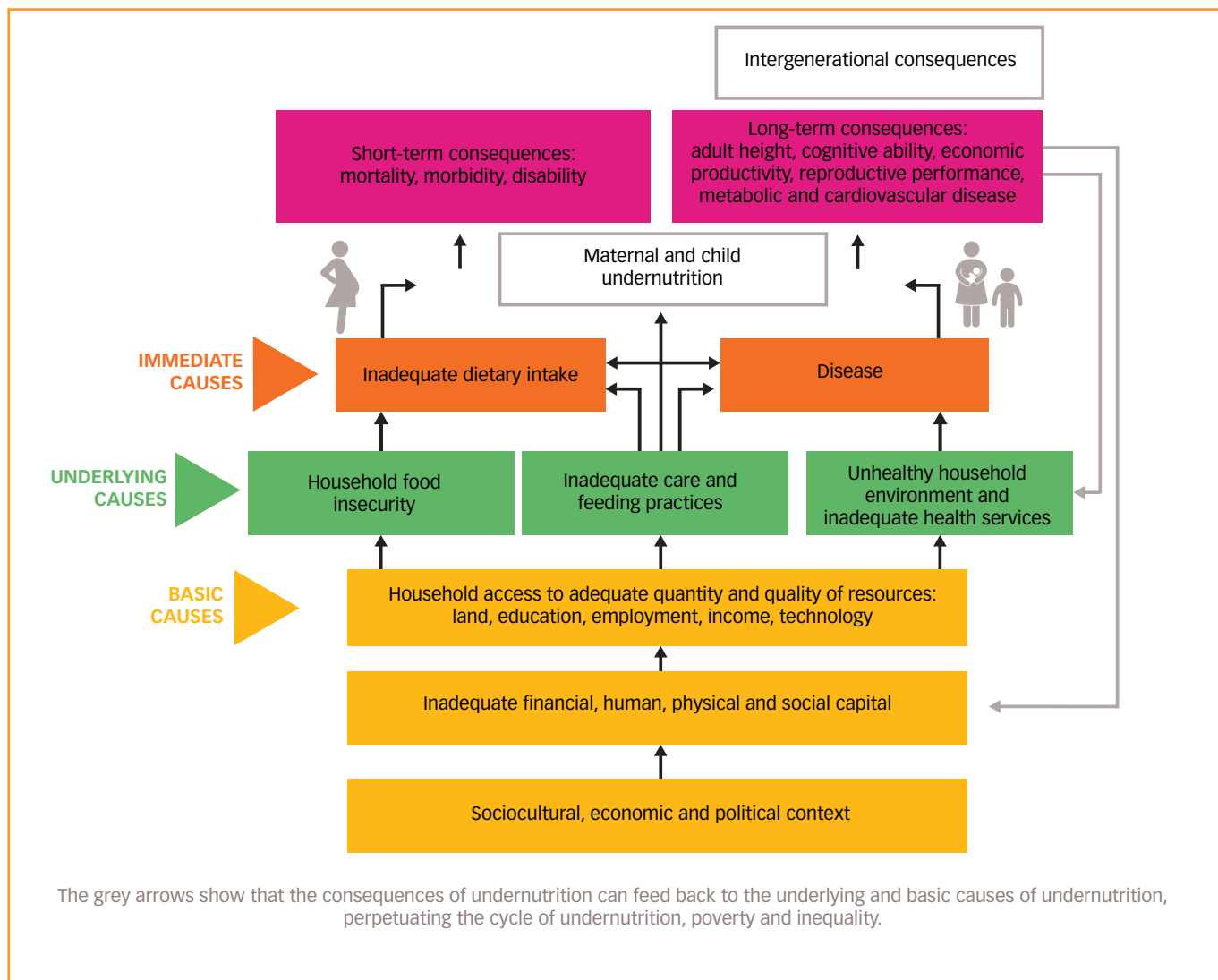
Maternal nutritional status both before and during pregnancy is a risk factor for low birth weight which predisposes to stunting in childhood.¹⁶ Stunting in the first five years is more damaging than later in life, resulting in both an increased risk of severe infection as well as intellectual impairment – compromising children’s school performance and employment prospects, and increasing the risk of obesity, heart disease and diabetes in adolescence and adulthood. Stunting during the first two years of life is particularly damaging, and may be irreversible.¹⁷ Stunting hampers the development of human capital, and of society, and results in substantial long-term health costs.

What is driving this persistently high burden of undernutrition? UNICEF’s conceptual framework for undernutrition (figure 17) identifies a range of contributory factors that operate at different levels.

The immediate causes – inadequate dietary intake and disease – mutually reinforce each other within the household.

i Stunting is defined as a height-for-age below minus two standard deviations from the median of the WHO Child Growth Standards.

Figure 17: Immediate, underlying and basic causes of maternal and child undernutrition



Source: United Nations Children's Fund (2013) *Improving Child Nutrition: The Achievable Imperative for Global Progress*. New York: UNICEF. P. 4

These immediate causes are underpinned by food insecurity, sub-optimal caring practices (such as inadequate breastfeeding), contaminated environments and unhygienic practices – especially poor handwashing. Child care and feeding practices are also closely linked to a mother's emotional state. Maternal depression, especially during the postnatal period, may compromise attachment and therefore infant feeding. While 44% of infants are exclusively breastfed in the first two months of life, this drops to only 24% of infants 4 – 5 months old.¹⁸ This is a considerable improvement on the previously documented 8%, but still well below the target of universal exclusive breastfeeding for the first six months. Moreover, given the importance of complementary feeding, it is worrying that only 23% of children aged 6 – 23 months meet the criteria for a minimum acceptable diet.¹⁹ The 2016 Demographic Health Survey indicates that stunting rates exceed 30% at birth and rise to over 40% at 18 – 27 months. This suggests that maternal factors (undernutrition, infection and substance abuse during pregnancy)

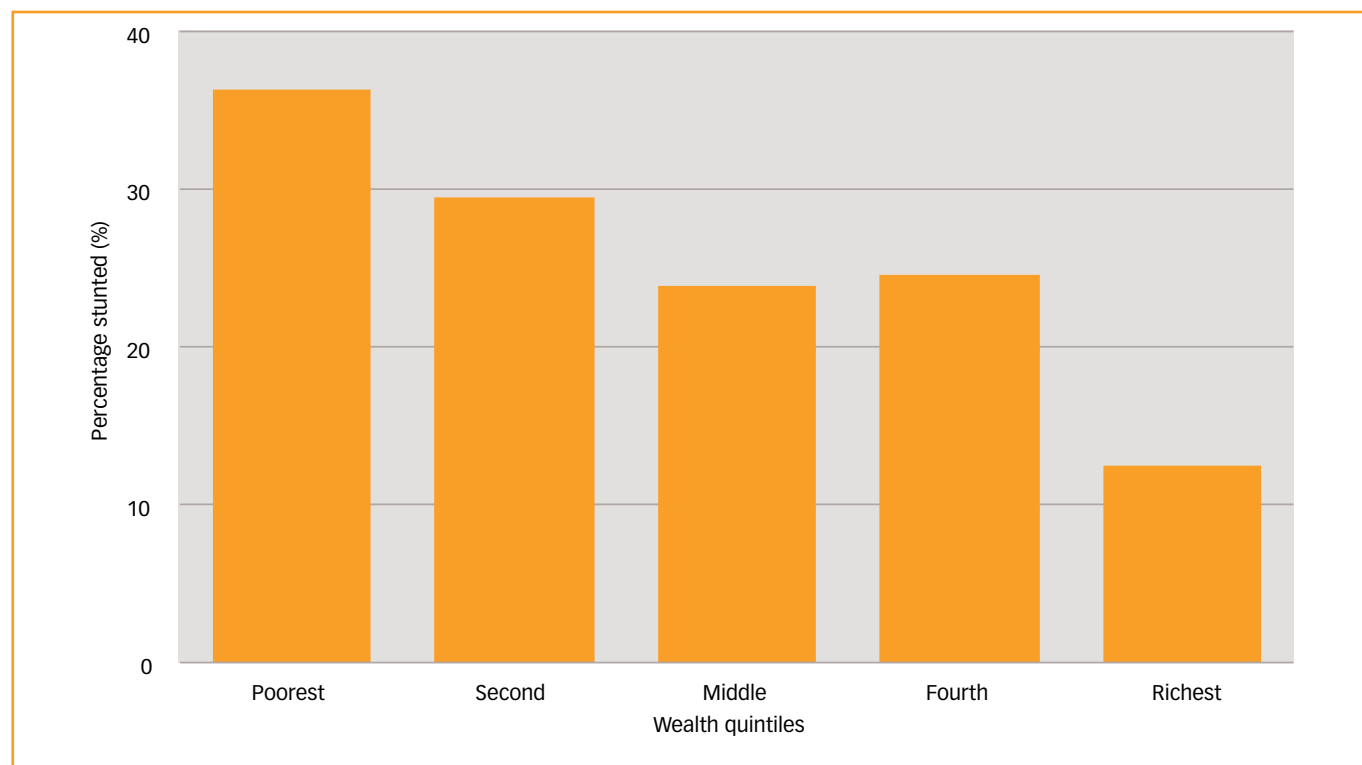
are significant for the newborn, and that the complementary diet is inadequate during late infancy and early childhood. The percentage of South African households with inadequate access to food decreased marginally from 24% in 2010 to 22% in 2016, yet it remains a source of concern that almost a quarter of all households remain food insecure in a country that normally produces a surplus of food.²⁰ This indicates slow progress in addressing household food insecurity.

Poor sanitary environments are increasingly implicated in chronic enteric inflammation,ⁱⁱ undernutrition and its consequences.²¹ Just over 30% of South Africa's children have poor access to adequate water and sanitation, with rates as high as 45% of children (8.2 million) in rural areas. Twelve percent of children live in traditional housing (2.2 million) and a further 11% (2 million) live in informal settlements or backyard shacks where access to services is limited.²² This translates into 5 – 6 million children being at risk of repeated infection and the "stunting syndrome"ⁱⁱⁱ.

ii Inflammation of the internal lining of the intestine due to repeated infection.

iii Stunting syndrome is a condition in which multiple pathological changes marked by linear growth retardation in early life are associated with increased morbidity and mortality, reduced physical, neuro-developmental and economic capacity and an elevated risk of metabolic disease in adulthood.

Figure 18: Prevalence of stunting among children under five years old, by wealth quintile,^{iv} 2016



Source: Department of Health, Statistics South Africa, Medical Research Council & ICF (2017) *South African Demographic Health Survey 2016. Key Indicator Report*. Pretoria: DOH, Stats SA, MRC & ICF.

The structural or basic causes of stunting include low levels of maternal education, inadequate household income and unemployment. Despite a decrease in the proportion of people living under the upper bound poverty line,^v from 67% to 55% between 2006 and 2015, income poverty remains widespread.²³ Children are disproportionately affected, with nearly four million children under the age of six (63%) living below this poverty line in 2014,²⁴ and prevalence of stunting is highest in the poorest households (as illustrated in figure 18).

South Africa's high rate of unemployment is the most important driver of poverty. The percentage of households with no link to the formal labour market increased dramatically from 30% in 1997 to 42% by 2008.²⁵ Unemployment stood at 27.7% in the first quarter of 2017 with an expanded unemployment rate of 36.4% if we include discouraged work seekers. Moreover, unemployment is highest amongst young adults in the reproductive age group, with 49.5% of youth 20 – 24 years old not in employment, education or training.²⁶

At a broader level climate change, resulting in increasingly frequent droughts, flooding and global warming, is undermining food security and leading to conflict and human migration on an unprecedented scale.

What action is needed to ensure that children enjoy optimal nutrition?

The first 1,000 days (from conception to the age of two years) is recognised as a particularly critical period that sets both the foundation and the trajectory of a child's development (see case 8 on p. 72). It is therefore vital to intervene early to improve outcomes and reduce inequalities.

The underlying determinants of nutrition include poverty; food insecurity; inadequate child care; and poor access to health, water, and sanitation services. Efforts to promote optimal nutrition thus need to start in the antenatal period, or even before, and extend beyond interventions in the health-care system (e.g. breastfeeding and complementary feeding, nutrient supplements and disease treatment) to include nutrition-sensitive programmes that draw on complementary sectors such as agriculture, social protection, early childhood development, education, water and sanitation.²⁷ Achieving this will require concerted action from the government, private sector and civil society to address the immediate, underlying and structural causes of undernutrition.

Adequate dietary intake

Good maternal nutrition especially during pregnancy and preferably before conception is essential. Diets should provide adequate energy and protein, together with iron and folate supplementation

iv A quintile is 20% (a fifth) of the population.

v The lowest possible poverty line (valued at R779 in 2011 prices) that allows for both minimum nutritional requirements and essential non-food expenses.

and other micronutrients and calcium to improve maternal health and birth outcomes.²⁸ Breastfeeding is recognised as the most potent of all child health interventions,²⁹ and it is urgent that the prevalence of breastfeeding – especially exclusive breastfeeding in the first six months of life – be increased.

Further interventions to improve dietary intake in the first 1,000 days include nutrition counselling, and access to nutritious weaning foods, especially in poor households. Achievement of such improvements in infant and young child feeding will require improved growth monitoring and breastfeeding support and dietary counselling by CHWs and health-centre staff. For example, studies conducted in South Africa and elsewhere have demonstrated that support by lay counsellors can significantly increase breastfeeding rates.³⁰ However, while nutrition education can have positive results in food-secure populations, it is of little benefit in food-insecure populations unless combined with food supplements.³¹

Early recognition and treatment of disease within the community

Undernourished children are at risk of infectious diseases, especially diarrhoea and pneumonia. They also take longer to recover. To break the cycle of inadequate food intake and disease it is essential to identify and treat intercurrent infections^{vi} early. Such early recognition and action are best achieved by well-trained and supported CHWs who are well placed to make good use of the Road-to-Health Book. Educating families and communities about healthy and hygienic practices, and helping caregivers to identify when an infant or young child is ill and in need of medical care are also vital to improve health and nutrition outcomes.

Improved care and feeding practices

Improved access to child-care services is closely linked to women’s empowerment. There is overwhelming evidence that improving formal female education protects against stunting in childhood and leads to improved child health outcomes. Protection increases with the level of formal education,³² as illustrated in figure 19.

Yet “[m]ost black children continue to receive an education which condemns them to the underclass of South African society, where poverty and unemployment are the norm ... children inherit the social station of their parents, irrespective of their motivation or ability”.³³ Unless the state acts effectively to address the education crisis, the risk of intergenerational undernutrition will persist.

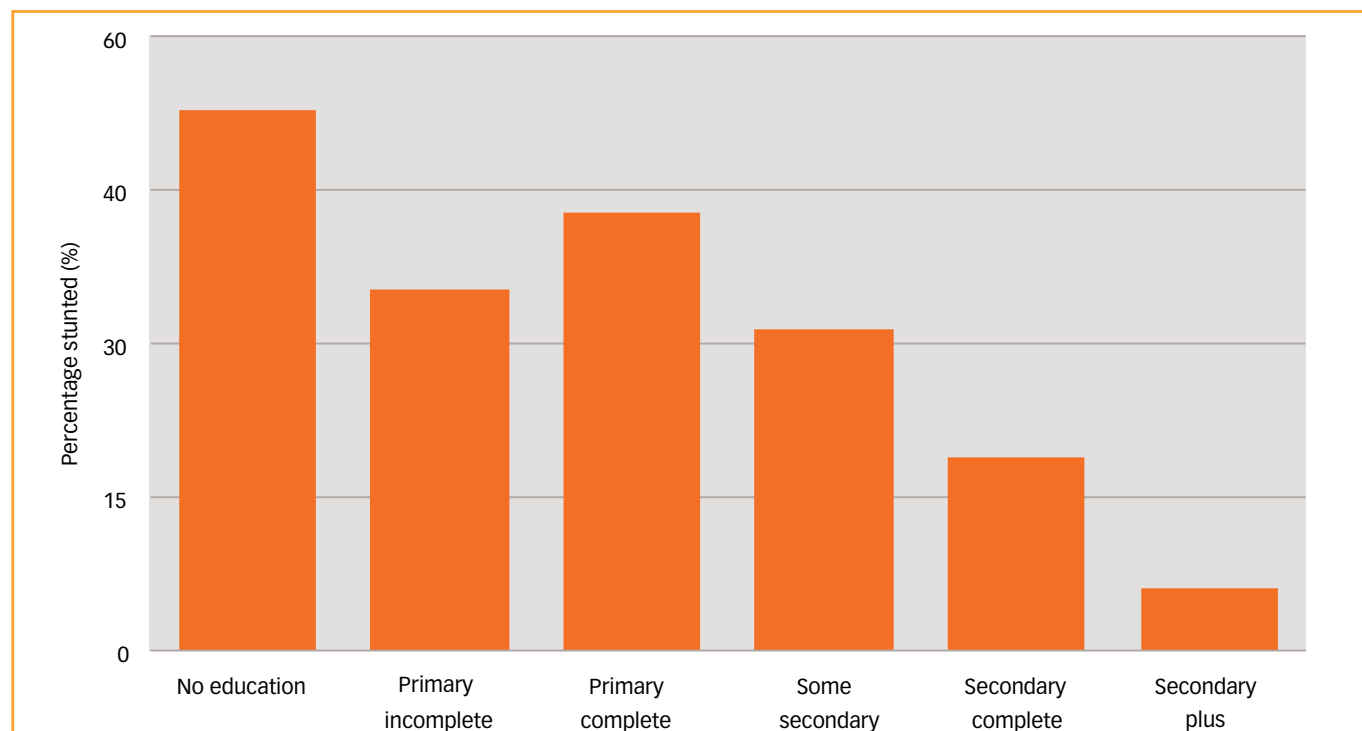
Healthy household environments and access to services

Prevention of common infections in children requires effective delivery of water and sanitation as well as adequate housing to minimise overcrowding. While considerable progress has been made in providing housing and basic services, a significant number of the most vulnerable children still live in cramped, overcrowded and unsanitary conditions.

Access to primary health-care facilities has similarly improved over the past decade, yet more than 20% of South Africa’s children still live more than 30 minutes from their health facility.³⁴ Limitations in community-based child health services threaten the PMTCT programmes,³⁵ and young children continue to die outside health facilities even in settings close to major hospitals³⁶.

Government’s plans to establish a National Health Insurance (NHI), re-engineer primary health care and invest in CHWs have the

Figure 19: Prevalence of stunting among children under five years old, by level of maternal education, 2016



Source: Department of Health, Statistics South Africa, Medical Research Council & ICF (2017) *South African Demographic Health Survey 2016. Key Indicator Report*. Pretoria: DOH, Stats SA, MRC & ICF.

vi More than one infection occurring at the same time.

Case 8: Beyond nutrition – Nurture and support in the first 1,000 days

Elmarie Malek (Department of Paediatrics and Child Health, Stellenbosch University)

The first 1,000 days of life are recognised as a particularly critical period that sets both the foundation and the trajectory of children's growth and development. While the negative impacts of poor nutrition and substance abuse are well-known, recent advances in neuroscience, neurobiology and epigenetics highlight the impact of "toxic stress" and the socio-emotional determinants of risk in the first 1,000 days. Here the stresses associated with poverty, intimate partner violence, single parenting, a lack of support, and the parent's own adverse childhood experiences are transmitted from caregiver to child, stimulating the release of cortisol and serotonin and causing long-term damage to the developing brain and immune system.³⁷ Yet support and caring relationships during pregnancy and the first two years of life can help mitigate these risks, promote resilience and protect children from the negative effects of toxic stress (see essay on care on page 51).

These scientific advances have significant implications for the design and delivery of health-care services which are the primary point of contact for children and caregivers in the first 1,000 days. To promote children's health and optimal development, key areas for intervention and systems strengthening include:

- *Support for the mother or caregiver:* Health-care services need to start by recognising the central role of the mother or caregiver in ensuring infant and child health. Psychosocial and mental health risk screening and support should therefore be incorporated into routine antenatal care, and structured opportunities should be provided to discuss parenting and infant development. For example, the WHO Care for Development package³⁸ could be incorporated into

the training of both nurses and community health workers. Home visits provide a further opportunity for reaching out and supporting vulnerable children and caregivers and facilitating their access to health care and other support services. *Multi-sectoral referral:* Health care services should adopt a multi-sectoral approach as caregivers and infants during the first 1,000 days require comprehensive interventions, extending beyond immunisation, growth monitoring and the integrated management of childhood illnesses. Referral pathways should therefore facilitate access to social and material support³⁹ including birth registration, social grants, child care and ECD services.

- *Measures and tools to promote optimal development:* We need to develop more comprehensive measures of child health and development that capture what it means for children to thrive. This extends beyond physical measures such as low birth weight, growth faltering and stunting, to include measures of cognitive, social and emotional development (see, for example, the Shanarri Child Wellness Indicators⁴⁰ on p. 57). Such measures will need to be accompanied by tools that enable health workers to identify risk and protective factors, and guide counselling and support for caregivers and families.
- *Reorientation and training of health professionals:* Health workers will require training to play a more empathetic role, and services will need to be re-orientated to allow staff time to provide supportive counseling. Growth monitoring and developmental screening need more attention, and these points of contact need to be recognised as opportunities to direct caregivers to care and support services.

potential to address these challenges and ensure more equitable access to quality care.

Household food security

In addition to the provision of meals in early childhood development (ECD) centres and the establishment of food distribution centres, social assistance – especially the Old Age Grant and Child Support Grant (CSG) – provides a crucial safety net for poor households, and plays an important role in improving child welfare and nutrition.⁴¹ Yet ECD centres currently cover a minority of young children and annual increases in the CSG have been below the rate of food price inflation, threatening its efficacy. It is essential to increase the coverage of ECD centres (and ensure that access is free) as well as coverage of other community-based nutrition programmes. The possibility of linking receipt of the CSG to a basket of subsidised healthy foods is worth considering.

In the short and medium term, improved access will require greater regulation of the prices of basic foodstuffs and implementing fiscal policies, such as taxes on unhealthy food products like

sugary beverages. The revenues generated from such taxes could then be ring-fenced to subsidise nutritious foods – such as whole grains, milk, fruit and vegetables. To address the basic causes of undernutrition and stunting requires actions to improve incomes, including raising the value of the CSG and providing employment opportunities, especially to women.

Political commitment to addressing inequality

Household food insecurity is inextricably linked to rising inequality (see the essay on p. 43), and rooted in its structural determinants including stagnant economic growth, rising unemployment, inequitable land distribution and deregulation of trade and financial flows. Addressing these basic causes of undernutrition requires political commitment by government and includes land and agrarian reform, job creation, redistribution, tax and food price controls.

Hunger and food insecurity – including calorie-rich but nutrient-poor diets – underlie both childhood stunting and the rising prevalence of obesity. While the drivers of this "double burden" of

malnutrition are complex, there is evidence that the relatively recent transition to a diet containing a significant and increasing proportion of highly processed foods is a central determinant.⁴²

This dietary transition is strongly associated with the increasing dominance of “Big Food” – large commercial entities that dominate the food and beverage environment.⁴³ The rise of Big Food in South Africa is a feature of neoliberal globalisation, where financialisation and deregulation of trade and investment are dominant features. Addressing this phenomenon will require government commitment and alignment of policies across the departments of Trade and Industry, Agriculture, and Health to promote food security. Such government commitment is unlikely to be achieved without increasing awareness and action by an active citizenry both within South Africa and globally to reform the current national (and global) food system.

These structural causes lie largely outside the immediate ambit of the health sector. But the Department of Health could, and should, take the lead in mobilising other government departments to address these broader social determinants of child health as outlined in the Global Strategy for Women’s, Children’s and Adolescents’ Health and the Sustainable Development Goals (SDGs) (as outlined on p. 25).

What can the health system do to ensure children thrive?

The planned NHI scheme aims to ensure access to quality, essential health care and financial protection for all in line with the SDG target of universal health coverage. To strengthen the public health sector in preparation for the NHI, the Health department started a programme of re-engineering primary health care which includes the introduction of Ward-based Primary Health Care Outreach Teams (WBOTs).⁴⁴ The teams include six CHWs and four home-based carers supervised by a nurse.

CHWs represent an important resource for improving coverage of primary health care and extending key health interventions to vulnerable and under-served communities. In other countries, CHWs perform a wide range of essential functions including the community management of HIV and TB. Given appropriate training, support and recognition, they can also recognise and start early treatment of life-threatening conditions like pneumonia, diarrhoea, acute undernutrition and malaria as well as promote neonatal care.⁴⁵

The success of this approach depends critically on adequate numbers of well-trained and supported CHWs with secure employment and good working conditions. Yet the majority of the 70,000 CHWs in South Africa work as volunteers or for a stipend, where payment is often erratic. Their work exposes them to the risks of violence and communicable diseases, and they have little protection or support from local health facilities. Most are currently focused on home-based care and HIV and TB treatment adherence, and will require further training and reorientation to realise their potential in maternal and child health and development.

In particular, CHWs should be empowered to promote and support breastfeeding, improve complementary feeding,

encourage household hygiene and hand washing, and recognise and respond to acute childhood infections, especially diarrhoea. Their potential role in growth promotion needs to be strengthened through focused training and increased contact with local health facilities undertaking growth monitoring.

Mortuary evidence⁴⁶ indicates that significant numbers of young children die outside health facilities of acute infections, which highlights the central role of CHWs in the prevention and treatment of potentially lethal common infections like pneumonia and diarrhoea. Yet, in South Africa, CHWs’ proposed scope of practice is mainly confined to undertaking household registration and providing information and advice.

The Department of Health should take more account of the impressive gains in child survival made in other lower- and middle-income countries that have used CHWs in the management of common childhood diseases, as well as recent local evidence that CHWs, when properly trained and supported, can successfully undertake important maternal support and child health interventions.⁴⁷

The NHI plan grossly underestimates the number of CHWs that will be needed to fulfil this meaningful role in maternal and child health. Each CHW is expected to cover 250 households. Given the large burden of disease and crowded households this ratio is likely to be ineffectual. Brazil and Rwanda have CHW-to-population ratios of 1 : 800 and 1 : 255 people respectively. In Ethiopia, a two-tier system operates: trained CHWs called health extension workers based at health outposts are supported by a volunteer cadre known as the health development army who are responsible for promoting essential family practices.⁴⁸ In South Africa, increasing the total number of generalist community-based workers to achieve a ratio of at least one CHW to 1,000 population would have the additional advantage of creating employment for women, thereby promoting improved household income and health benefits, especially for children.⁴⁹

CHWs played a key transformative role during the anti-apartheid struggle by mobilising communities for improved social and environmental conditions and medical care. Realising CHWs’ potential to address social determinants of child health today will require a radical shift in thinking as well as practical training and support in community development. This in turn will require strengthening the training of environmental health practitioners and other cadres responsible for addressing environmental and social determinants of health so that they can support CHWs in this role. Clearly, the strengthening of the district health system through WBOTs will require support from higher levels of the health system. This demands greater nutrition literacy and improved practice of health workers, especially nurses. It also necessitates enhanced management and leadership capacity, especially at the level of the District Health Management Team as well as the continuing expansion and strengthening of District Clinical Specialist Teams – with a clear mandate to reach out beyond health facilities to support community-based services and promote intersectoral collaboration to address social determinants of health at district level.

Case 9: Philani mentor mothers – Key ingredients for community-based care

Ingrid le Roux, Nokwanele Mbewu & Claudine Bell (Philani Maternal, Child Health and Nutrition Project)

Philani's mentor mothers support women through their pregnancies and the early development of their children. Each mentor mother is responsible for 400 – 500 households and promotes antenatal care, birth preparation, HIV and TB testing and adherence to treatment, maternal and child nutrition. They are also trained in mental health, basic counselling, early childhood development and stimulation.

The Mentor Mother Programme draws inspiration from the Nurse Home Visiting Programme⁵⁰ and Positive Deviant Model⁵¹ which recognises how some women in very poor communities develop coping mechanisms that enable them to raise healthy children. Philani actively seeks out these women to serve as mentors and provides them with ongoing training, supervision and support.

The mentor mother model rests on five key pillars: a careful recruitment process; appropriate training; a home-based, action-orientated health intervention; in-the-field supervision and support; monitoring and performance feedback.

Home-based interventions focus on pregnant women and children but include everyone in a household. Instead of trying to solve the family's problems during the home visits, the mentor mother shares her coping skills and knowledge and helps the family find their own solutions. Building trust and respectful relationships are important parts of the intervention.

The programme only works in a community if it has been invited and community structures help identify "positive

deviants" and these women are then carefully interviewed before being invited to attend the training.

The initial six-week training course is based on adult learning principles and alternates theory and practice. Ongoing training takes place in the field and is supplemented with monthly training sessions with coordinators and programme managers.

Support and supervision are an essential part of the mentor mother model. A staff nurse or a senior mentor mother supervises and supports small groups of mentor mothers, and further mentoring and support are provided by the coordinator (usually a nursing sister). All support staff – including the coordinator – are in the field interacting with mentor mothers and their clients every day. Time is set aside for debriefing on problem cases and feedback on performance.

Outcomes are actively monitored, including antenatal clinic attendance, HIV and TB testing, treatment and adherence, low birth weight, exclusive breastfeeding, grants up-take and nutritional rehabilitation.

The programme has proven effective. Findings from a randomised control trial show improved condom use, exclusive breastfeeding rates and height-for-age measurements: after a year, the malnutrition rates in the Philani intervention areas were half of those in the control areas.⁵²

The Mentor Mother Programme operates in the Western and Eastern Cape, and was extended to Swaziland and Ethiopia in 2012. For more information, see: www.philani.org.za

An expanded role for health services in promoting ECD

The 2015 National Integrated Early Childhood Development Policy⁵³ outlines a range of essential services for pregnant women and young children – including health care, nutrition, parent support and early stimulation – and requires the Department of Health to play an expanded role in promoting ECD, especially in the first 1,000 days of life, as outlined in case 5.

Effective ECD programmes are essential to promote optimal survival, nutrition, cognitive development, subsequent schooling performance and later employability. Yet at least 60% of children under five years old have no access to ECD services and programmes – the vast majority from disadvantaged backgrounds, where good quality ECD services are likely to have the most impact.⁵⁴ The ECD Policy therefore prioritises these children and specifies that very young children should ideally be reached at household and community level, rather than through centre-based programmes. This requires greater emphasis on home-visiting programmes led by community-based ECD workers of different kinds, including CHWs.

In South Africa, a review of home-visiting programmes in vulnerable rural communities through the Sobambisana project indicated significant changes in parenting behaviour, successful

linking of families to social grants and other services, and improved parental coping.⁵⁵ Community-based workers have been effective in mobilising communities to take up services and to demand greater government accountability for service provision. For example, in Nepal local women facilitated support groups to discuss maternal and newborn health problems and formulate strategies to address these – leading to changes in care-seeking practices and hygiene, transport schemes and child health funds, and reducing neonatal mortality by 30%.⁵⁶ Similarly, a number of South African community-based ECD interventions use community workers to raise awareness and bring together local and district government and other service providers to facilitate access to services which form an important safety net for young children and their caregivers. These community workers also provide stimulation for early learning, parenting support advice and nutrition support within a basket of ECD services.⁵⁷

In South Africa, there are a number of promising small-scale models of community-based health and ECD services, including the Philani Mentor Mothers' Programme⁵⁸ (see case 6). Pilot projects that upscale such services to district level should be established and thoroughly evaluated in representative peri-urban and rural districts to inform later roll-out in districts across the country.

Conclusion

Addressing the challenges of child ill health, undernutrition and stunting and ensuring the conditions necessary for children to thrive will ultimately involve successfully confronting their basic causes (see figure 17). These include widespread poverty, increasing inequality, and suboptimal public services. These causes are rooted in an inequitable economic system and poor governance at national, provincial and local government levels.

Effectively confronting these will require not only a public health system that is greatly strengthened for better health care delivery, especially at the district and sub-district levels, but also concerted action to improve the functioning of other state sectors. Action is needed at all levels – from primary care and service provision at the local level to land reform and trade policy at a national level, as well as global efforts to mitigate and adapt to climate change.

At the core of such transformation are good and accountable leadership and a fairer economic dispensation where social justice and the public good are valued above profit. The SDGs outline a

global commitment to address poverty, hunger, climate change and inequality. But achieving these goals in practice will require a radical change in the dominant economic paradigm at a global level, and open and transparent government at national level together with a mobilised citizenry supported by an “activist” health service that promotes citizen action towards Health for All.

South Africa needs a broad social movement for child health equity, akin to that mobilised by the Treatment Action Campaign to advocate for universal access to antiretroviral medicines and drugs needed for opportunistic infections. Similar to the TAC’s campaign, this demands a multi-pronged strategy that includes popular education and mobilisation, advocacy and litigation around children’s rights, and the building of alliances across different sectors and constituencies, including, crucially, poor communities and children themselves.

Child health professionals and advocates have a key supportive and facilitatory role to play in the establishment of such a movement.

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Getting reading right: Building firm foundations

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The Millennium Development Goals aimed to achieve universal access to primary education by 2015. Attendance rates in South Africa remain high, with 97% of children attending school,¹ yet most children are still not acquiring basic skills. While the number has been increasing in recent years, only 57% of a cohort will pass matric and about 21% will qualify to go to university.² Stark differences exist between the wealthiest 25% of schools and the vast majority of schools serving largely poor Black students, and these deficits are already entrenched early on in the foundation phase.³

The Sustainable Development Goals (SDGs) have a strong focus on reducing inequalities and aim to address issues of access and quality across the life course. This essay argues that, in order to address these deep-rooted challenges in the South African schooling system, we need a concerted prioritisation of learning to read. Drawing on the latest evidence, the essay identifies low levels of reading proficiency as one of the root causes of poor schooling outcomes, and goes on to suggest potential solutions. It makes the case by addressing the following questions:

- Why does reading matter?
- How many of South Africa's children are learning to read?
- By what age should children learn to read?
- Why are so many children not learning to read?
- What has been done to improve reading in the past?
- What reading initiatives are currently underway?
- What is the way forward?

Why does reading matter?

In the 21st century, we live in a world that is flooded with written language, or print. We see it in our newspapers, on our contracts, on the screens of our cell phones and the pages of our school books. From the policies of government to the signs on our roads, text is an essential ingredient in modern life. Print is everywhere. And this is why reading is so important.

Learning to crack the code of how we represent spoken language using symbols is a big part of why we go to school. We learn the differences between "b" and "d", or between "p" and "q". Moving from letters and syllables to words and sentences we can read about pirates, pigs and pixies or earthquakes and igloos. Once we have cracked the code the possibilities are endless. This is the joy of being initiated into the literate world.

Aside from the practical importance of reading to make our way through the world, reading – and writing – are essential for

participation in formal education as the ability to decode text, read with comprehension and learn from reading is the bedrock of most activities in institutions of learning. If reading is not mastered early on, progress in schooling is restricted.

The phenomenon of "schooling without learning" where children progress through the grades without gaining knowledge and skills can largely be attributed to the fact that many learners do not learn to read properly despite enrolling and staying in school. These learners never get a firm grasp on the first rung of the academic ladder and fall further and further behind even as they progress into higher grades. Learners that can barely decode text in their home language cannot "survive" at school, let alone thrive. For learners to reach their full potential later in life they must first learn to read fluently and with comprehension in the early years.

Learning to read also has a strong social justice imperative: the value of literacy extends beyond the classroom, and should ideally equip children with the knowledge, skills and confidence to participate actively in society.⁴ Good reading skills enable children to learn much more than their teachers might offer and it enables them to learn independently. More broadly, reading is a conduit to more abstract ways of thinking about the world. Books transcend immediate contexts, opening up possibilities for the transformation of existing realities and the discovery of new ones. They allow the reader to participate in "society's conversations about itself".⁵

How many of South Africa's children are learning to read?

Nationally representative surveys show that more than half (58%) of South Africa's children do not learn to read fluently and with comprehension in any language by the end of grade 4.⁶ The most recent and comprehensive analysis of children's reading capabilities in South Africa was the prePIRLS study of 2011.⁷ The aim was to assess the reading capabilities of grade 4 learners in whatever language their school used in grades 1 – 3. This should be the language in which they are most literate in.

In South Africa, the majority (70%) of learners learn in an African language in grades R – 3, but then switch to English in grade 4, with 90% of grade 4 learners in South Africa taught in English.⁸ The prePIRLS study assessed more than 15,000 grade 4 learners from 341 schools across the country in one of the 11 official languages.⁹ The results paint a picture of a reading crisis in our country. The 2015 prePIRLS results are expected in December 2017.

Figure 20 illustrates stark inequalities in reading outcomes between the wealthiest 10% of primary schools and the rest. While

65% of learners in the wealthiest 10% of schools reach the “high” or “advanced” benchmark, less than one in 10 learners reaches this benchmark in the poorest 70% of schools. If a learner cannot reach the “low” benchmark they can be regarded as “reading illiterate” since they cannot locate and retrieve an explicitly stated detail in a given text.¹⁰ Similarly those who cannot reach the “intermediate” benchmark in prePIRLS cannot read for meaning (or pleasure for that matter) since they cannot make straightforward inferences or interpret obvious reasons and causes.¹¹

By what age should children learn to read?

The South African curriculum, like most other curricula, sees the first three years of schooling as the “learning to read” phase during which children acquire the skills they need to navigate the world of words. From grade 4 onwards, they enter the “reading to learn” phase where they use what is assumed to be a firmly established skill to make meaning of the texts that they are reading, and encode their own ideas in their writing. Literacy is the competence upon which most formal learning depends. Without a firm foundation of reading, schooling can become an ongoing struggle.

Early reading failure leads to later learning failure.¹² While it is broadly acknowledged that reading with fluency and comprehension in at least one language should be achieved by grade 3, there are as yet no clear benchmarks for reading achievement in the South African context. Clear benchmarks could also help to establish measurable and shared definitions of what constitutes reading with fluency and comprehension in home, first and second additional languages across the grades.

Why are so many children not learning to read?

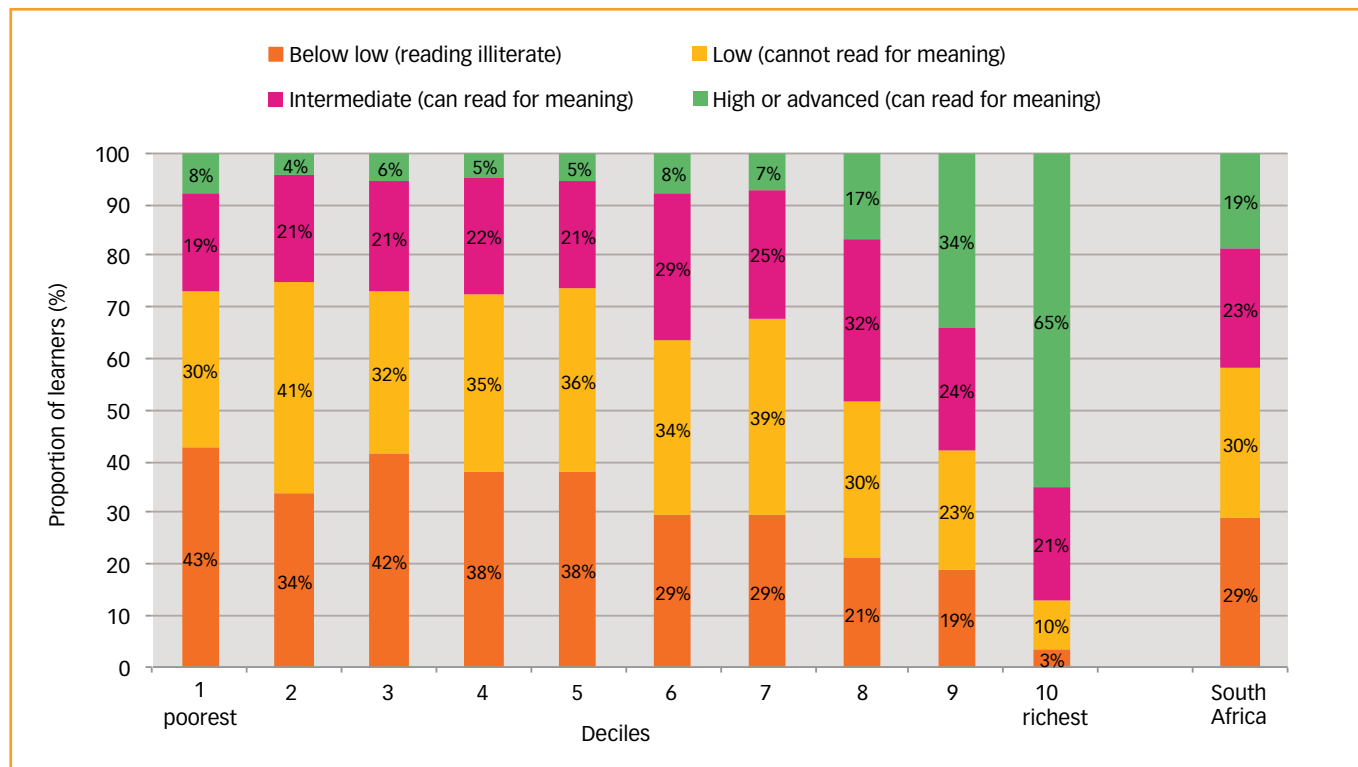
There are many reasons why children are not learning to read, and multiple factors often coincide to restrict children’s ability to acquire this essential competency. For example, extreme poverty, malnutrition and stunting compromise children’s cognitive development. Foetal alcohol syndrome and HIV may lead to developmental delays and disability, and learning disabilities are often not identified early, if they are identified at all (as noted in the inclusion essay on p. 84).

Below we list the key factors preventing children from becoming competent readers.

The early years: Reading begins in the home

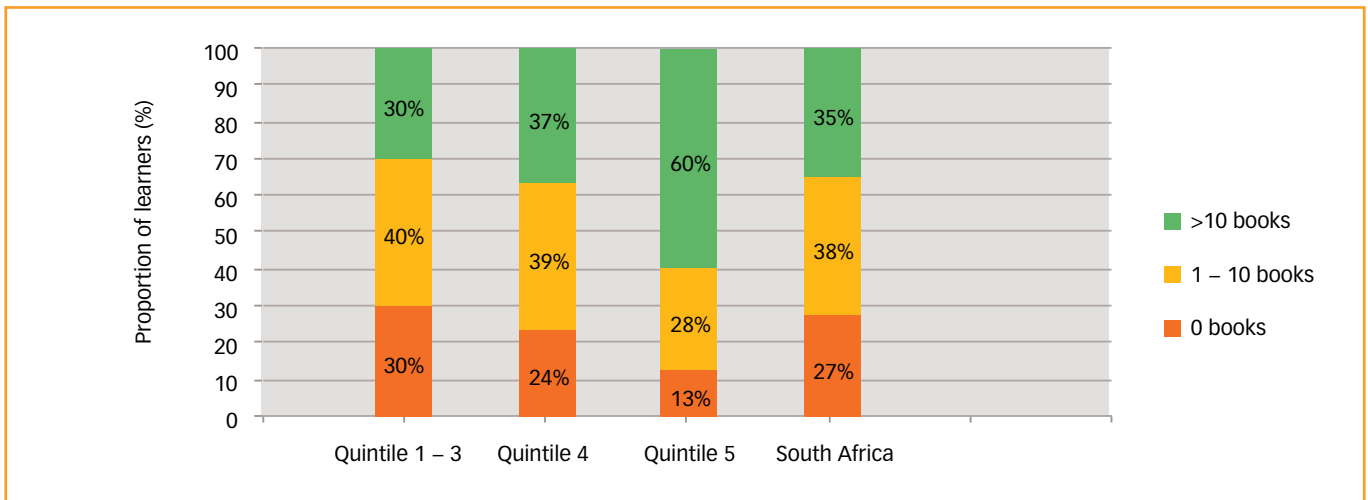
Learning to read begins in children’s earliest interactions with their families and communities, as case 4 (on p. 49) illustrates. In the early years, talk and the development of vocabulary are crucial, and strong foundations in oral language are essential to enable fluent reading with understanding. Through everyday exposure to print (especially reading stories, seeing others reading and using reading and writing for everyday tasks like writing a shopping list) children learn the pleasure and the value of the printed word. The more children interact with spoken and written language, the better readers they become. Given that spoken language differs from written language, hearing others read aloud creates an important foundation that children will then build on. As children enter school and learn to read formally ongoing support for reading in the home – especially reading for pleasure – helps children to become better readers.

Figure 20: How many learners in grade 4 can read?



Source: Author’s calculations using pre PIRLS 2011 data.

Figure 21: The prevalence of books in the home, 2013



Source: Authors' calculations using Verification ANA 2013 data.

The 2013 Verification Annual National Assessment (V-ANA) asked grade 3 learners how many books they had in their homes. Figure 21 shows that a third of children in schools in the poorest quintiles reported having no books, with an additional 40% indicating that they have 10 books or less. As many children have almost no exposure to books at home and few opportunities to read with others, the school becomes not only the primary site of learning to read, but the *only* site of learning to read for many children.

Leadership: Promoting a culture of reading in schools

In order to develop readers, a culture of reading needs to be established in the school. Principals, heads of department (HODs) and other school leaders are crucial to establishing a concerted school-wide focus on reading. Resources need to be channeled towards providing textual resources and expertise to support reading instruction and special reading programmes. Heads of departments need the time and knowledge to develop expertise in reading instruction amongst teachers. School leaders need to be able to recognise good reading instruction when they see it, facilitate sharing of good practice, and support ongoing staff development in reading instruction for those in need. Recent research has shown how principals and HODs have a very rudimentary knowledge of reading, and of when and how particular reading-related skills should be taught.¹³ In other words, expertise in reading instruction is thin amongst leaders in schools. But what about teachers?

Teachers: Instilling a love of reading

Teachers' own levels of literacy and reading practices impact on reading instruction. Pretorius and Machet identify what they call the "paradox of the primary school professional" in the South African context: "Primary school teachers are professionals who are supposedly deeply involved in developing literacy skills in their learners. Yet it is precisely in the domain of literacy that many teachers are themselves unskilled. Many primary school teachers come from communities with a strong oral culture and so they are

not inclined to be readers themselves, nor are they familiar with the traditions of storybook reading or books for young people."¹⁴

In addition to teachers' own literacy practices and resource constraints, many learners have physical, emotional and cognitive impediments to learning to read. The most obvious example are children who need spectacles but don't have them. Spectacles are a common sight in suburban schools but not in rural areas, largely because of a lack of screening, diagnosis and treatment.

Teachers require support and skills in dealing with the complexities of teaching reading, and especially in multilingual contexts. What support do teachers get in this regard?

Mixed messaging: Changing approaches to teaching reading

Teachers have been exposed to a wide range of messages on how reading should be taught and assessed in schools. Over a period of 14 years, there has been a shift from a radical "whole language" approach under Curriculum 2005 (C2005), to a highly specified "proficiency" approach in the current 2012 Curriculum Assessment Policy Statement (CAPS). The key messages on what reading instruction is, and how reading should be taught, changed radically in a relatively short time. C2005 suggested that the ability to read is "caught" while handling written texts in an integrated whole language classroom, whereas CAPS provides highly specified, procedural steps for teaching reading with a focus on developing basic skills such as aligning sounds and their written counterparts. Teacher professional development has struggled to keep pace with these changes.

There has been much contestation around the different approaches (akin to the "reading wars" elsewhere), contributing to a lack of clarity around the most appropriate way in which to teach reading. Little explicit attention is paid to reading in pre-service teacher training programmes in South Africa.¹⁵ At some universities less than 10% of the credits required to become a foundation phase teacher are about literacy or reading, despite this being the most important skill children learn in that phase. In

addition, while it is accepted that children learn to read in different ways and at different rates, the vast majority of children (90%+) can learn to read within three years. In other words, there are no clear guidelines to inform teachers what level of reading is expected at different grade levels and how this may best be assessed. Given this lack of clarity and support around how to teach reading, what do teachers do in their classrooms?

Reading instruction: Reflecting on current practice

Classroom practices during apartheid, especially in schools in poor communities, emphasised technical decoding skills and oral drill sequences in the teaching of reading. Learners in the majority of schools could often decode text (i.e. pronounce sounds and words) but had little understanding of what they had read.¹⁶ This formed part of the aversion to the teaching of phonics after 1994. The first post-apartheid curriculum policy undermined the explicit and systematic teaching of phonics, reading and writing. Findings from classroom-based studies in recent years (as outlined in box 6), indicate that classrooms are communalised with little focus on individual learners. Low level, oral discourse predominates, and the focus in reading has been on isolated words, rather than reading connected text. Opportunities to handle books, learn vocabulary and engage in writing activities have also been severely constrained.

The advent of CAPS and a number of other programmes (such as the Gauteng Primary Literacy and Mathematics Strategy) has provided teachers with greater clarity on how to teach reading and there has been a concerted attempt to shift towards a text-based pedagogy. Clear guidelines for teaching reading are stipulated in the curriculum. However, many of the practices indicated in box 6 persist, especially very slow pacing, limited exposure to extended texts in reading and writing activities, and a failure to differentiate learners according to ability for targeted instruction. In most classrooms, learners are still introduced to an extremely basic and impoverished notion of what it means to read and a limited set of resources with which to critically and pleasurably engage with text.¹⁷ The scarcity of texts is a serious obstacle to learning to read. How can learners learn to read without access to sufficient and suitable texts?

Playing football without a ball: The availability of texts

Conventional publishing models which rely on economies of scale are unable to provide texts in sufficient number or variety, especially in Africa where a multitude of languages are spoken, some by relatively small populations.¹⁸ The lack of access to books is similar to learning to play football without a ball, a “preposterous” idea but relevant to hundreds of thousands of learners in developing countries who are expected to acquire literacy skills without books.¹⁹

The National Education Evaluation and Development Unit (NEEDU) found that the importance of structured reading material was not well understood in schools and materials were not available, with only 29% of monograde and 23% of multigrade schools having an adequate supply of readers. The NEEDU

report spells out the importance of this: “Graded readers provide structured progression, guiding learners through progressively more complex texts while providing sufficient practice at each stage of the process.”²⁰

Where they are available, African language readers are often problematic in that many of them are straightforward translations of readers from English into African languages and do not take into account the structural features of African languages.²¹ What often happens in this process of translation is that the element of grading in a reader is lost. Simple English words and sentences when translated into African languages result in long, often complicated phrases, made up of many letters and syllables in the African language.

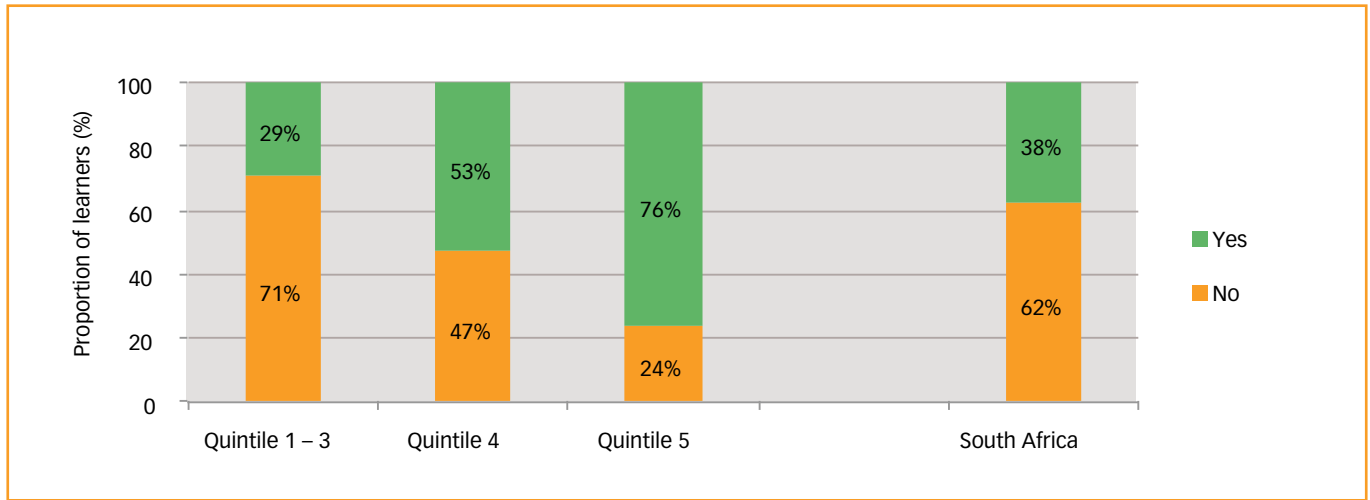
If children do not have access to books at home, the most common alternative is a school library. In 71% of schools in the poorest quintiles there was no school library available.²² The School Monitoring Survey found similar results, with only 31% of primary schools having a central school library and an additional 29% having either a mobile library or a classroom library.²³ Thus about 40% of primary schools have no library whatsoever (school, mobile or classroom).

Figure 23 shows that among those Grade 3 respondents who were in schools with no school library (62% of respondents), 30% of them indicated that they had no books at home and a further 40% indicated that they had only 1 – 10 books at home. If one takes this as a percentage of the total sample, then 19% (62% × 30%) of the children surveyed in the V-ANA 2013 had no access to any books, either at school or at home, and a further 25% (62% × 40%) had access to less than 10 books. We can therefore say that if we combine books at home and books in the school library in V-ANA 2013, 43% of all Grade 3 children have access to less than 10 books to read. Note, V-ANA did not ask about mobile libraries and classroom libraries. If we include these and use the DBE figure of

Box 6: Findings from key classroom-based studies on teaching reading in South African primary schools²⁴

- Lack of learner opportunity to handle books and bound text.
- Limited teaching of reading and writing.
- Learners mainly read isolated words rather than extended texts.
- Focus is on decoding rather than comprehension of text.
- Little or no elaboration on learner responses.
- Learning is largely communalised rather than individualised or differentiated.
- Little formal teaching of vocabulary, spelling and phonics.
- Lack of (good) print material in a range of languages in classrooms.
- Numerous complex language challenges where the majority of learners learn in an additional language which is not their home language.

Figure 22: The availability of school libraries in primary schools in South Africa, 2013



Source: Authors' own calculations, using Verification ANA 2013 data.

40% who have no library whatsoever (from the School Monitoring Survey 2011) then only 21% of all Grade 3 children have access to less than 10 books to read.

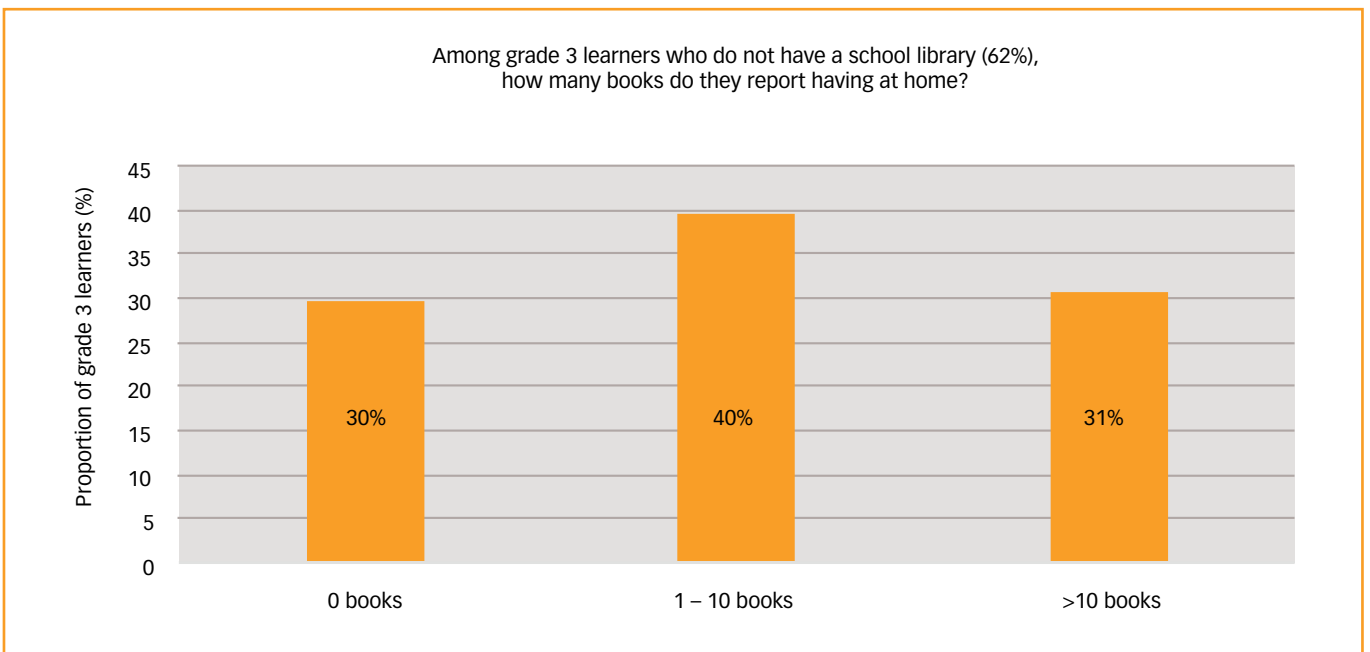
What has been done to improve reading in the past?

The finding that there is a reading crisis in South Africa is not new, and there have been several programmes to remedy the situation – some more successful than others. These include the National Reading Strategy (2008), the Foundations for Learning campaign (2008), the Systematic Method for Reading Success (2008), the Numeracy and Literacy Strategy in the Western Cape (2006), and the Gauteng Primary Literacy and Mathematics Strategy (2010), to name only the most prominent. Given the large number of literacy

interventions and reading programmes that have been launched by the national and provincial education departments, it is prudent to ask why almost all of these initiatives were not sustained for more than a few years. If anyone is to develop a new strategy to ensure all children read, it is essential to determine why previous initiatives did not stand the test of time.

Developing a new national reading strategy should not feel like *déjà vu*, with a convening of experts, a launching conference, a temporary budget and a brief discussion of how committed government is to solving the reading crisis. Reading goals must be embedded within the core activities of the Department of Basic Education (DBE) to ensure that they outlive any one particular programme or drive.

Figure 23: Children's access to books anywhere, 2013



Source: Authors' own calculations, using Verification ANA 2013 data. (Note figures sum to 101% because of rounding.)

Case 10: Rigorous evidence of what works – The Early Grade Reading Study

Stephen Taylor & Nompumelelo Mohohlwane (Department of Basic Education)

The Early Grade Reading Study (EGRS) is a large-scale evaluation led by the Department of Basic Education in collaboration with academics from the University of the Witwatersrand and Georgetown University in the United States. The project aims to build evidence about what works to improve the learning and teaching of early grade reading in typical foundation phase classrooms in South Africa.

The project began in 2015 and is working in 230 schools in the North West province, where three different home language reading interventions are being evaluated. This randomised control trial makes extensive use of mixed methods (classroom observation and detailed case studies) to provide both quantitative estimates of programme impact as well as an understanding of where, how and why different elements of the programme are working.

The intervention, which provides teachers with structured lesson plans aligned to the curriculum (CAPS), additional reading materials and on-site teacher coaching, is showing the

clearest positive impact by the end of grade 2. The other two interventions (lesson plans, materials and central training, and a parent involvement intervention) are having a small positive impact which may be larger amongst particular sub-groups.

The clearly effective coaching intervention is helping boys to catch up to girls who are substantially ahead of boys in grade 2 literacy. Programme impact is particularly large in urban township settings, but there is little impact in deep rural settings – and it may be that rural schools require a very different type of support.

This study presents arguably the most robust evidence to date of an effective reading intervention model with the potential to operate on a large scale. When supported by high quality on-site coaching, a structured learning programme can improve the teaching and learning of reading. The two teacher support interventions are continuing for a third year (grade 3) and the results will be released in 2018.

What reading initiatives are currently underway?

Existing reading initiatives are not sufficiently addressing the literacy crisis in South African schools. However, there have been some recent positive initiatives. The provision of DBE workbooks and graded readers in many schools has increased the availability and use of text. Coupled with the CAPS curriculum which specifies particular reading pedagogies, more children have the opportunity to handle books than before. Government's prioritising of reading is evident in a number of programmes. These include the proposed implementation of an improved national assessment programme and new reading campaigns such as Read to Lead and Drop All and Read. Most encouraging is that the government is taking the lead with intervention programmes to improve reading outcomes, for example the Early Grade Reading Study in the North West (case 10).

What is the way forward?

We suggest at least eight key ingredients to move from our current low levels of literacy to one where all children learn to read and thrive at school:

1. **Training:** Foundation phase teachers need meaningful opportunities to learn about reading in coherent, consistent and sustained programmes. Classrooms need knowledgeable, highly literate teachers. Teachers should be given the opportunity to develop their knowledge of well-structured learning programmes that address all the building blocks for reading (vocabulary, decoding, comprehension, etc.). Support, monitoring and feedback to teachers are crucial aspects of on-going training.
2. **Texts:** We need to improve the provision of textual resources, including the quantity, the quality and the range of languages in which these are provided. It is not possible to teach children to

read without a minimum set of graded readers in the language of learning and teaching, together with additional fiction and non-fiction books at the right level. The management and care of these resources are critical to their on-going provision.

3. **Benchmarks:** There is a need to establish reading benchmarks for different grades and for first, second and third languages. Clear benchmarks would also help to establish measurable and shared definitions of reading success.
4. **Time:** Children need plenty of opportunities to read in and outside the classroom. Reading (individually, with others, at school, at home) must become a daily routine for all South Africa's children.
5. **Tests:** Without some kind of standardised annual assessment at primary school level it is not possible to determine which schools are imparting the necessary numeracy and literacy skills to their learners. South Africa is unique in the region in that it is the only country without some kind of primary school exam. (Note these are not only used as gateway tests for promotion purposes. In many countries, they are diagnostic.)
6. **Eliminating excessive class sizes:** It is simply not possible to teach children to read in class sizes of 50 or more children. In Limpopo and the Eastern Cape, 27% of foundation phase learners are in classes with more than 50 children.²⁶
7. **Leadership for literacy:** The management of schools needs to facilitate the use of texts; the development of a culture of reading in schools; and a school-wide focus on reading instruction, its improvement and the reading outcomes of learners.

We need a consistent and system-wide focus on reading – from national assessment to district programmes. Reading needs to be consistently prioritised across the sector and across levels of government. All stakeholders need to commit to the goal that all

children must learn to read fluently and with comprehension in their home language by the end of grade 3. Literacy is the foundation for quality education and has the capacity to unlock human potential and enhance outcomes across the life course – contributing to children’s thriving; enhancing skills development, productivity and

inclusive economic development; and ensuring that they are able to exercise their rights and freedoms. Learning to read is a building block for the creation of a more equitable, peaceful and sustainable future as envisioned by the SDGs.

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Welcoming all children: The inclusion imperative

Sue Philpott (School of Education, University of KwaZulu-Natal) and Judith McKenzie (Division of Disability Studies, University of Cape Town)

The Sustainable Development Goals (SDGs) are unequivocal about the need to leave no one behind in an inclusive development process. This requires an approach in which every child – in all their diversity – is included and able to participate and thrive. In this chapter we use the example of childhood disability to explore key concepts and the current evidence base on inclusion. Disability, we argue, serves as a limit case and we assume that, if we can transform environments so that children with disabilities are able to survive and thrive, it will enable the inclusion of other vulnerable groups. A disability lens turns our gaze to those requiring the highest levels of support, providing a useful tool to explore the concept of inclusion and move from rhetoric to inclusive practice. Indeed, a focus on children with disabilities in the context of the SDGs is particularly relevant because evidence suggests that there are more children with disabilities as child survival rates improve. The challenge then is the transformation of services and approaches to ensure they are inclusive and enable all children to thrive.

In this chapter, we ask:

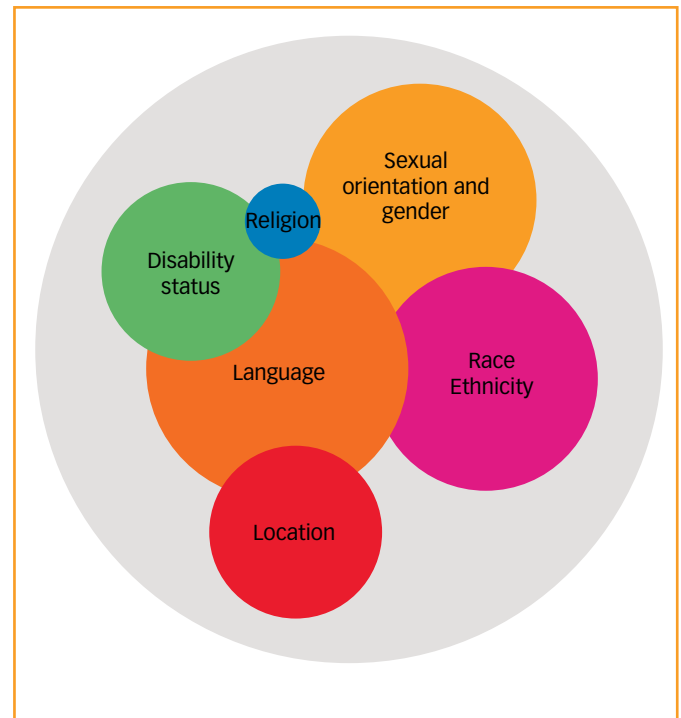
- What does inclusion mean for children with disabilities in South Africa?
- What are the state's obligations to ensure that no child is excluded from its provisions?
- How is exclusion of children with disabilities perpetuated?
- What is needed to create an enabling environment for children with disabilities to thrive?

What does inclusion mean for children with disabilities in South Africa?

Disability does not necessarily constitute vulnerability. Instead, it is the interaction of the bodily impairment with the context that determines the extent to which people are marginalised or excluded. Disability intersects with other characteristics to render a child extremely vulnerable. For example, children with disabilities who live in extreme poverty, or remote rural areas, or who are HIV positive are at high risk of exclusion from education, health and social services.¹ This is referred to as “compounded marginalisation” and protecting the rights of such groups is one of the pillars of the White Paper on the Rights of Persons with Disabilities.²

The concept of inclusion resonates with the core principle of the SDGs “that the dignity of the human person is fundamental, and that we endeavour to reach the furthest behind and the most vulnerable first”.³ While inclusion efforts specifically target those

Figure 24: Examples of diverse identities that may intersect to create compounded vulnerability

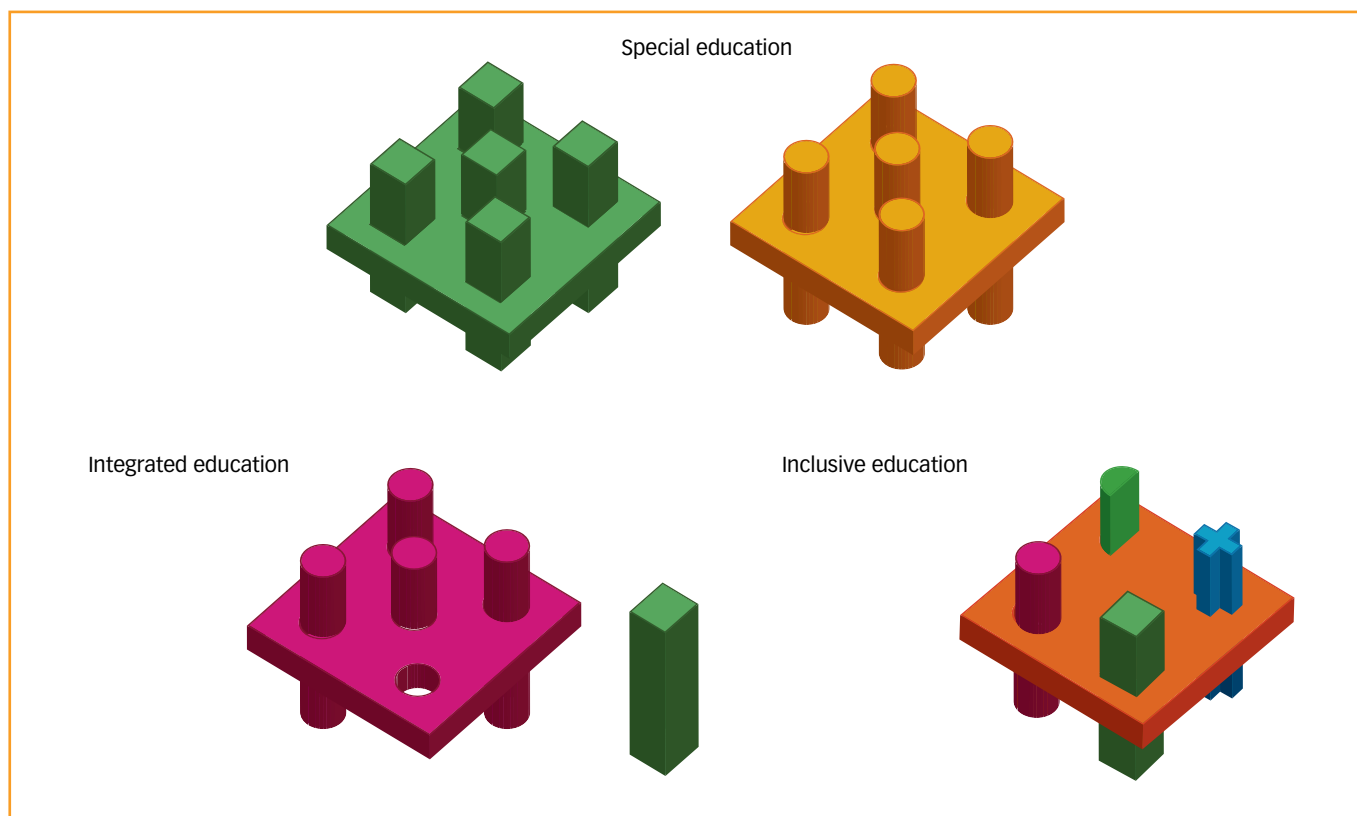


who are most vulnerable, marginalised and subject to highest risk, the premise is that everyone benefits in an inclusive approach, not just those perceived to be vulnerable.

Inclusion is understood as the process by which systems, cultures and processes accommodate a range of diversity. For children with disabilities, inclusion requires “overcoming of significant social, economic and political barriers to achieve meaningful involvement in society ... inclusion ... establishes a basis for overall well-being and is a critical component of becoming a valued and contributing member of the community”.⁴

Policies within the education sector illustrate the notion of inclusion. Education White Paper 6⁵ stresses the need to acknowledge and respect diversity among learners; affirms that every child is capable of learning and needs support; and recommends that the structures, systems and learning methodologies of education should be responsive to the needs of all learners. This may require changes in attitudes, behaviour, teaching methods and the teaching environment so that barriers to learning are removed and *all* learners are able to participate in the culture and the curricula of educational institutions.

Figure 25: Inclusion requires accommodation of diversity



Source: Inclusive Education South Africa (no date) *What is Inclusive Education? Factsheet*. Viewed 15 September 2017: www.included.org.za. Reproduced with permission from Inclusive Education South Africa.

Inclusive education policy has been further strengthened through the adoption of the Care and Support for Teaching and Learning Framework⁶. This is a multidimensional organising framework bringing together various sectors such as health, psychosocial and welfare services, safety and protection, nutrition, sports, arts and recreation, infrastructure, water and sanitation. The framework makes inclusive education everyone’s business, with the well-being of children seen as a collective effort. It supports the creation of enabling environments for teaching and learning for all children.

Such an understanding of inclusion gives life to the constitutional imperatives of equity, access and redress⁷ by recognising the rights of all children and affording them dignity while embracing their diversity. It is also a reminder that inclusion is a systemic issue and must be addressed across various social domains. Figure 25 illustrates a core tenet of inclusion: systems need to accommodate the diversity of children by being responsive and flexible, rather than children having to fit into rigid systems of mainstream provision.

What are the state’s obligations to ensure that every child is included?

The principle that every child is valued and of equal worth before the law is enshrined in the Constitution. Section 9 (the equality clause) prohibits unfair discrimination on various grounds, including disability. The right to equality is not the same as “treating all

children the same”. Indeed, the provisions for non-discrimination require that positive (or affirmative) action is taken to ensure that everyone is able to enjoy their rights.⁸ This may require the state to provide additional support for some children in order for them to enjoy the same rights as others. The Constitution also recognises the inherent worth of every human being and protects the right to dignity, which is seen as inseparable from the physical conditions within which children develop as it “secures the space for self-actualisation”.⁹

In 2007, the South African government signed and ratified the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)ⁱ which specifies what is needed to ensure the inclusion of children with disabilities in a range of sectors. For example, under this Convention the state commits to providing early identification and intervention services;¹⁰ for children with disabilities this includes encouraging stimulation and interaction with their parents soon after birth, and supporting family members to monitor children’s development and understand their children’s capabilities.¹¹

In addition, a recent court ruling – in response to the state’s failure to meet the educational needs of children’s with severe to profound intellectual disability¹² – has reaffirmed the state’s obligation to make positive and appropriate provision for all children¹³.

i The UNCRPD has been domesticated through the White Paper on the Rights of Persons with Disabilities, approved by Cabinet in 2015.

Case study 11: A lonely journey of parenting

Andileⁱⁱ is 10 years old and lives with his mother and brother in Bruntville, a township in the KwaZulu-Natal Midlands. Andile's mother reports that she had a normal delivery, but noticed that Andile did not develop at the same rate as other children as he grew up. For example, he did not try to imitate words and could not walk by the time he was 18 months old. She grew increasingly concerned about his inability to communicate and express himself until, after many visits to different doctors, he was diagnosed at age six with Autism Spectrum Disorder.ⁱⁱⁱ At the time, the doctors did not explain to his mother what autism is, and what it would mean in terms of her child's behaviour.

Nompilo,^{iv} Andile's mother, collects medicine (Ritalin) every three months from Grey's Hospital in Pietermaritzburg at a cost of R240/trip for herself and her child. However, she feels that the medicine is not working. Andile's levels of hyperactivity are still high and his aggression is a problem. She has had to stop working as a petrol attendant because she could no longer leave her mother to take care of Andile, particularly when crises occur. (For example, Andile went out of the yard, got into

a neighbour's car, and crashed it, causing R25,000 damage. His mother is still paying R1,000/month to settle the R15,000 that she owes). Nompilo experiences high levels of stress and has confessed to considering suicide at times.

Although Andile looks like any other 10-year-old (and is tall for his age), he has severe learning and behaviour challenges. He can eat by himself, but struggles with dressing. He loves singing, but cannot hold a conversation. The local primary school say they are unable to cater for Andile because he cannot sit still in the classroom to listen to the teacher. In 2015, Andile was put on a waiting list for a special school that caters for children with intellectual disabilities but he is still waiting for a space.

Andile's family did not fully understand his condition and spent a lot of money in trying to help him with traditional *muthi* (medicine). His mother has been accused by neighbours of a being a negligent parent because she can't control him. Social workers have told her that she lacks parenting skills but have not given her any advice on how to manage Andile's behaviour.

How is the exclusion of children with disabilities perpetuated?

Despite the constitutional and policy imperatives underpinning an inclusive approach, many children with disabilities do not receive the services and support that they require and are entitled to.

The 2011 census¹⁴ measured disability prevalence using the six domains of functioning: seeing, hearing, communication, remembering/concentrating, walking and self-care, using questions developed by the Washington Group. Disability was identified where there were moderate to severe limitations in a specific domain or if there were limitations across different domains. A major limitation of the census, however, is that it does not include results for children under the age of five because difficulties in functioning may be attributed to developmental delay rather than impairment. Measuring child disability is also more difficult than measuring adult disability and requires measures that are sensitive to developmental progression. Both the census and national household survey questionnaires have been criticised for lacking the necessary precision for measuring child disability.¹⁵ Internationally, use of the Washington Group disability short set of questions in data collection has been found to be an effective method for disaggregating indicators by disability status, and for monitoring the SDG objective of leaving no one behind. Recently a module to assess child functioning was developed by the Washington Group and UNICEF to specifically monitor the

status of children with disabilities.¹⁶ It is recommended that data disaggregated by disability status begin at the level of services (for example at clinics, early childhood development (ECD) centres or non-governmental organisations (NGOs), using the same tool across sectors so that comparisons can be made and progress measured).

Nevertheless, the national prevalence rate for disability was found to be 7.5%, while prevalence rates for children ranged from 11% for 5 – 9-year-olds to 4% for 10 – 14-year-olds, and 3% for 15 – 19-year-olds.¹⁷ The data indicate significant provincial variations, with the Free State and Northern Cape having the highest prevalence rates. The census gives a profile of different types of disabilities – the most common are loss of sight, cognitive difficulties and loss of hearing. There are 131,040 children with disabilities receiving Care Dependency Grants (CDGs) nationally,¹⁸ but it is not possible to assess take-up rates because prevalence data are not available.

Whilst the census gives some indication of the scale of the problem, case 11 illustrates the many challenges faced by children with disabilities and their caregivers, and their impact across the life course.

Early childhood

Although the current Road-to-Health Book contains a table of developmental milestones as a tool to monitor children's

ii Not his real name.

iii Autism is a developmental disorder, beginning in early childhood and continuing throughout adulthood. It affects three areas of development: communication, social interaction and behaviour.

iv Not her real name.

Figure 26: Levels of support for children with disabilities – an ecological system



Adapted from: Donald D, Lazarus S & Lolwana P (2002) *Educational Psychology in Social Context*. Second edition. Cape Town: Oxford University Press. P. 55.

development from birth to five years of age, research shows that this table is not systematically used at all clinics.¹⁹ This contributes to children such as Andile not being diagnosed and treated from a young age, and as a result the child’s disability and associated challenges are likely to grow in severity. Health providers’ lack of understanding of particular disabilities further results in families having unrealistic expectations of their child’s development, and being ill-equipped to provide appropriate support.

Even where a diagnosis is made, many young children with disabilities struggle to access basic rehabilitation services such as occupational therapy or assistive devices. Early childhood is a time to learn through playing and interacting with the environment and

where this is not encouraged or facilitated (as in the case of a blind child who is kept indoors) young children with disabilities are not able to develop their capabilities. Such services need to be provided on a regular basis (for example, a child who receives a buggy at age four to assist mobility is likely to require a different one at age five or six); yet there are often lengthy delays in accessing such devices, and the transport costs of reaching rehabilitation services are high. Many services for young children and their parents do not cater appropriately for children with disabilities and their families. For example, caregivers are not properly informed of the diagnosis and its impact, or given information or support to provide a stimulating home environment.

Childhood and adolescence

While all children in South Africa have the right of access to education, children with disabilities are disproportionately represented among out-of-school learners, and they get poor-quality education (and outcomes) from special schools. This has a knock-on effect of limiting access to further education and employment. A report by DeafSA²⁰ found that, in 2015, 12 schools for the deaf entered 143 learners for the national senior certificate. Of these, only 29% passed, compared to the national average of 73%. Of those who passed, only four deaf learners (10%) obtained a pass that would enable them to apply for a bachelor's degree. The report highlights the importance of addressing the specific needs of deaf learners in teacher training (including in the use of South African sign language), materials development and appropriate and effective teaching methodologies.

Difficulties in accessing services are worsened by stigma and shame associated with cultural and religious beliefs about disability as a curse or punishment for sin. A tendency to focus on the inabilities and shortcomings of the child (and parent) by both the community and service providers deepens families' sense of inadequacy. A 2012 situation analysis found children with disabilities to be particularly vulnerable to bullying and violence, resulting in trauma, social isolation and loneliness. They also experience high levels of neglect and abuse.²¹

Systemic weaknesses

A key weakness in respect of services for children with disabilities is the lack of a continuum of support between different sectors. While Andile receives a CDG, he has not yet been placed in appropriate (or any) schooling, nor benefitted from rehabilitative services or psychosocial support. Policies are in place and attempts have been made to develop tools for such coordination (such as the Department of Basic Education's Policy on Screening, Identification, Assessment and Support), but a lack of collaboration and synergy continues to prevent a seamless transition for children with disabilities from one sector to another. Consequently, many children with disabilities fall through the cracks in the system.

The absence of disaggregated data indicating the size of this population and identifying the particular support they require poses a further challenge in terms of allocating resources for children with disabilities. Such data are necessary for planning and monitoring of appropriate services, as well as enabling comparison of outcomes between disabled children and their able-bodied peers.

The impact of these different dimensions of exclusion accumulate over the life course and is often compounded by poverty, heightening children's vulnerability and increasing their risk of failure to thrive. Therefore transformation is needed to raise awareness, remove barriers and provide specific supports.

What is needed to create an enabling environment for children with disabilities to thrive?

The 2016 State of the World's Children report focused on children's right to a fair chance in life, and the United Nations noted that:

"We have a choice: invest in the most excluded children now or risk a more divided and unfair world."²² Ensuring that no child is left behind requires recognising the broader social, economic and policy contexts within which children live – what is known as the eco-systemic approach as outlined in figure 26. This foregrounds how actors at each level of the system need to work together to create an enabling environment, and identifies where barriers to inclusion may arise.

The following recommendations provide direction towards evolving practices in which the values of children's rights, equality and social justice have meaning for every child. They recognise the central importance of linkages *between* each level – families and caregivers, community-based and non-governmental organisations, and government service providers – to ensure a continuum of support. This requires transformation of the systems through which services and support for children are provided to ensure children with disabilities are included.

Awareness and visibility

In order to plan and track services for children with disabilities, it is necessary to obtain accurate prevalence data, and to disaggregate data on the basis of disability. The latter is recognised in the UNCRPD as a necessary step to realising disability rights, and is a critical element of unmasking the invisibility of children with disabilities. It is encouraging to see disability inclusion reflected in the SDGs where it is highlighted in a number of targets, including Goal 17 which underlines the importance of data collection and monitoring of the SDGs, with emphasis on disability-disaggregated data.²³ This requires putting tracking mechanisms in place to monitor increasing or decreasing discrepancies between children with disabilities and their able-bodied peers.²⁴

Reaching out and welcoming children with disabilities and their caregivers

The first level of support is to families and caregivers. In accordance with the disability rights maxim "nothing about us without us", children with disabilities and their immediate support network need to be part of determining and shaping inclusive services.²⁵ This may require outreach strategies, such as home visits by community-level workers, to identify children who are not easily able to access services.

In addition, there is a need to redesign services and to shift institutional cultures and practices to make them more inclusive, with participation of children with disabilities as a key driver. All services, including immunisation campaigns, parenting programmes and HIV/AIDS education for adolescents should ask: "How can we welcome and accommodate children with disabilities?"

Planning and providing such services require identifying and removing barriers that lead to the exclusion of children with disabilities:

Changing attitudes and behaviour: Children with disabilities are often looked upon with pity, evoking responses of charity or are treated as passive recipients of care. They become defined by what is "wrong" with them or what they are unable to do. Viewing

Case 12: Siyakwazi – Promoting inclusive ECD services in KwaZulu-Natal

Cathy Mather-Pike & Makhosi Shusha (Siyakwazi)

Siyakwazi is a community-based organisation working in rural communities of the Ugu district of KwaZulu-Natal. We believe that all children can learn. We focus on giving support to children under the age of seven who experience particular barriers to learning due to disability, learning difficulties or circumstances, such as living with an abusive father. The core focus of *Siyakwazi* is to promote inclusion of children with barriers to learning within ECD centres, schools and communities through our *siyasizas* (meaning “we support”) who are local young people committed to helping children.

We promote inclusive practices and appropriate early learning programmes to reduce developmental delays and ensure early identification of children with disabilities and/or learning difficulties. This is done by the *siyasizas* through regular site or home visits, individual support plans and laddering^v early learning activities to enhance learning for all. These activities increase early identification, inclusion and active play, and increase involvement of parents, resulting in improved early learning for all children.

In 2016, we worked with 158 children displaying varying degrees of difficulties and/or barriers to learning, of which 99 individual support plans were developed with specific goals to move each child forward in their development and learning. An ECD practitioner shared that this training was informative and “gives us more energy to do our job.”

Meeting the developmental goals of children has benefits for parents too as they gain insight into the potential of their children and realise that their own role is essential in this process. A parent describes how she felt when she found out that her child had a disability: “I felt very bad, confused with a lot of questions in my head - like how am I going to raise such a child?” After having received two years of support from *Siyakwazi* and her child being successfully included in their local ECD centre, she says: “I have noticed big changes because she is out of nappies even at night, the thing I thought would never happen. Her talking is really improving. She is playing confidently with other children. I can tell she is very happy and I am happy too.”

children with disabilities as rights-holders, entitled to dignity and equality with all other children implies a shift in thinking towards a greater recognition of agency. This requires a more appreciative asset-based approach, concentrating on maximising their capabilities, autonomy and participation.

Access to the built environment: Everyone should be able to benefit from products and places throughout their lives, with universal design aiming to accommodate diversity rather than the “average” person. South Africa has guidelines²⁶ to ensure accessibility of the built environment, but enforcement of legislative provisions must be strengthened, particularly in facilities frequented by children of different ages – such as clinics, ECD centres, playgrounds and youth centres.

Access to information and communication: Children need to be able to engage with the world around them to learn about it. Information therefore needs to be provided in ways that are meaningful for children including those who struggle to hear, see or understand. For example, the use of pictures or simple explanations may be needed to help those with intellectual disabilities learn about topics such as HIV prevention. Access to information can also be supported through use of appropriate technology or assistive devices.

Information about disability (its causes and consequences) and support services needs to be communicated with parents, community members and service providers.²⁷ Widespread disability awareness-raising and sensitisation of traditional and religious leaders as well as the general public are also needed.

An integrated and coordinated approach: Disability has been found to be both a cause and a consequence of poverty;²⁸

supporting vulnerable children with disabilities therefore cannot be separated from addressing the marginalising effects of poverty. This requires allocation of human and financial resources to ensure that children’s disabilities are identified at the earliest possible stage and that they receive the necessary medical, rehabilitation and education services. It also requires that social assistance, in the form of the CDG is provided not as an isolated response but as part of a broader basket of services and support for children and their families.

Specific interventions and supports

Children with disabilities may require specific services that are not needed by other children such as rehabilitation, assistive devices or sign language interpretation. Parents and caregivers may need specialised knowledge and skills to support their children in becoming as self-reliant and independent as possible. These are necessary to enable children with disabilities to participate on the same basis as other children and to foster a sense of feeling respected, being valued and belonging. For example, a young person with a visual impairment will need textbooks in electronic or Braille formats if he or she is to participate in a history lesson.

Conclusion

While significant progress has been made in improving child survival rates in South Africa, greater efforts are needed to ensure that every child can thrive and develop to their full potential. The inclusive development process envisaged by the SDGs will only be achieved through the transformation of systems. This includes increasing awareness and visibility of vulnerable children through

v “Laddering” is a way of choosing the right level of learning for an individual child and then gradually moving towards a higher level of achievement and mastery.

the disaggregation of data and equity targets; welcoming all children; removing the barriers that currently perpetuate their exclusion; and providing an enabling environment through a continuum of care and access to specific support that meets the individual needs of every child with a disability.

The principle of inclusion is based on the premise that society needs to change to accommodate diversity and respond to a wide range of differences and needs. Embracing inclusive practices has benefits for all children, not only those who are disabled or considered vulnerable and provides further motivation to the goal that no child is left behind.

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Transforming South Africa: A call to action

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No political democracy can survive and flourish if the mass of our people remain in poverty, without land, without tangible prospects for a better life. Attacking poverty and deprivation must therefore be the first priority of a democratic government.

The Reconstruction and Development Programme, 1994

South Africa's first democratic government enshrined an impressive array of children's rights in the Constitution and, subsequently, passed a suite of laws and policies to give effect to these rights.¹ The government also committed to meeting the Millennium Development Goals (MDGs), which ranged from halving extreme poverty rates to halting the spread of HIV/AIDS and providing universal primary education, all by 2015.

Progress toward realising children's rights has been made in some sectors.² For example, poverty was the central focus of South Africa's initial development agenda¹ and, thanks to the expansion of social assistance, over 12.6 million children currently benefit from the Child Support Grant (CSG). This has reduced extreme poverty by almost three-quarters, while the number of children living below the upper bound poverty line has fallen by a fifth³ with positive impacts on child and adolescent health, education and well-being.⁴ Reported child hunger fell from 31% of children in 2002 to 13% in 2015;⁵ whilst the percentage of children aged 5 – 6 years old attending school or early learning programmes jumped from 55% to 92%.⁶

Survival rates have improved too, and the under-five mortality rate dropped from 81 to 37 deaths per 1,000 live births between 2003 and 2015.⁷ However, we cannot just aim for children to survive, they have a right to develop to their full potential, or put simply – to thrive. If optimal development is the goal, then South Africa's progress is far too slow.

Risks and challenges to children's optimal development

Despite good policy intentions and improved service delivery in specific areas, South Africa's children remain marginalised, excluded and exposed to excessive levels of violence with significant adverse effects. In 2016, a national prevalence study estimated that one in three children are victims of sexual violence and physical abuse before they reach the age of 18 years, whilst 12% of children report neglect and 16% report emotional abuse.⁸ Poverty, gender inequality and societal norms and values are key drivers of violence.⁹

More than a quarter (27%) of children under five are stunted,¹⁰ and 56% of children cannot read fluently and with comprehension in any language by the end of grade 4 (see Spaull and Hoadley,

p. 77). Learners have little exposure to books in both their home and school environments, and teachers are not clear on how reading should be taught in schools. Poor reading and writing skills undermine learners' chances of receiving a quality education and minimise their opportunities for employment and active engagement in society. These compromised learning outcomes also have their roots in early experiences of poverty and under-stimulation, trauma, poor health and undernutrition (see Jamieson and Richter, p. 32).

The early life experiences of children in South Africa are not optimal (see Sanders and Reynolds, p. 68). Only 24% of infants 4 – 5 months of age are exclusively breastfed, and 77% of young children aged 6 – 23 months do not have an adequate diet. Close to a quarter of households are food insecure, impacting on the nutrition and well-being of pregnant women, children, and the caregivers of children. Parents and caregivers experience extreme adversity (see Berry and Malek, p. 51). South Africa's official unemployment rate is 27%; 21% of adult women experience intimate partner violence; and an estimated one in three women experience maternal depression. Alcohol and substance use are widespread, with Foetal Alcohol Syndrome Disorder rates ranging from 29 to 290 per 1,000 live births in selected areas. Facing daily stress with little support, primary caregivers are often unable to foster nurturing caregiving relationships; yet these are essential to prevent violence and to promote healthy physical, cognitive and psychosocial development. Compromised care during childhood is likely to have negative, lifelong consequences.

The challenges we face as a country are not new. But we need to be willing to do things differently. These dimensions of deprivation do not occur in isolation, rather they intersect and have a cumulative impact on children's development across the life course. An unprecedented level of cooperation between government, civil society and the corporate sector is therefore needed to address these complex challenges and drive coordinated, intersectoral action (Harrison, p. 43; Mathews and Gould, p. 61). Strong leadership is needed to drive a broad social movement and address the root causes of childhood adversity – widespread poverty, rising inequality, destructive social norms and poor and fragmented public services.

i The Reconstruction and Development Programme, sought to alleviate poverty and address the massive shortfalls in social services across South Africa. The Accelerated and Shared Growth Initiative for South Africa (AsgiSA) was launched in February 2006. Its objectives were to introduce policies, programmes and interventions that would allow the South African economy to grow enough to halve poverty and unemployment between 2004 and 2014.

Opportunities and priorities

Children maximise their potential when they are well nourished; responsively cared for; protected from disease, violence, and stress; and have opportunities to learn. Children who are poorly nourished and nurtured in the first two years of life, or those who do not receive early stimulation, are likely to learn less in school, earn less as adults, are less likely to be able to develop healthy relationships and more likely to suffer from chronic diseases during their lifetime (see Jamieson and Richter, p. 32). Harrison shows these early failures spark an intergenerational cycle of poverty and lost potential. Conversely, early investments have the potential to improve the prospects of future generations; boost national development; and reduce poverty, inequality and violence at a societal level (see p. 43). Responsive, nurturing caregivers have a protective effect and are central to reducing violence and promoting healthy, well-functioning young people and adults who can contribute meaningfully to society.

Adolescence is a dynamic period of brain development, and presents a critical opportunity to catch up developmentally.¹¹ Like their younger counterparts, adolescents need care, nutrition, health, security, quality education and opportunities to develop life skills that build their capacity and prepare them for adulthood. As children grow older it becomes more important to recognise their agency and resilience and to help them actualise their dreams of a better life rather than simply providing for them.¹²

A new approach to resolve old problems

The 2030 Global Agenda articulates a vision of a connected world in which no one is left behind, and everyone flourishes without compromising the future. It is a plan of action to end poverty, protect the planet and ensure that all people enjoy peace and prosperity and is built on a partnership to address common problems in the global North and South (see Bhardwaj, Sambu and Jamieson, p. 22). The 2030 Global Agenda incorporates a set of universal goals – the Sustainable Development Goals (SDGs) – targets and indicators that United Nations member states such as South Africa have pledged to achieve between 2016 and 2030.¹³ These obligations are not new – they derive from existing human rights instruments – but the SDGs represent a renewed commitment, set time-bound targets, and call for a coordinated approach.

Children are at the heart of the SDGs, and the 2030 Global Agenda recognises that: "When [children's] rights are respected, protected and fulfilled dividends are returned in the form of global security, sustainability and human progress".¹⁴ The SDGs are a powerful vision statement and opportunity to mobilise resources, but there are significant gaps in capacity at all levels to enforce and translate commitments into action.¹⁵ The key questions are: What is needed to translate these commitments into action,¹⁶ and how do we transform our society to ensure that these goals have real meaning for children and that no child is left behind?

The 2030 Global Agenda resonates with the National Development Plan which has a similar focus on inequality and

recognises the diverse factors that drive an intergenerational cycle of poverty,¹⁷ however its focus on children is limited and fragmented. We need to tackle this complexity and deal with the multiple causes of deprivation simultaneously; in short, a radical transformation in the ways services are delivered is required. It is not just up to government: all sectors of society – civil society, doctors, nurses, teachers, social workers, communities, parents and children themselves have a shared responsibility to ensure no one is left behind.

Where do we start?

It is urgent that poverty and household food security are addressed, and infant care and feeding practices need priority attention. Improvements in children's living conditions and better access to health care are also vital to reduce stunting (Sanders and Reynolds, p. 68).

One in five eligible children are not receiving the CSG, mainly because of a lack of information or documentation.¹⁸ These children could be considered as those left furthest behind, and expanding the coverage of the CSG to include them has the potential to eradicate extreme poverty, measured as children living on less than \$1.25 a day.¹⁹ Yet the value of the grant (R380 per capita per month) is too low to have a significant impact on the proportion of children living below the upper bound poverty line.ⁱⁱ

Given that government has rejected the possibility of increasing the value of the CSG in the medium term, South Africa needs to find other ways to reduce child poverty. Early investments in networks of care, violence prevention, nutrition, health, and education have been found to mitigate the effects of poverty and help level the playing field. In addition to promoting optimal development, it is important to identify and intervene as early as possible to address risk factors. Innovative use of health-care service platforms, for example, can facilitate access to a range of support measures for pregnant women by identifying risks at antenatal services and referring appropriately (see Berry and Malek, p. 51).

Violence against children of all ages can – and must be – interrupted through carefully designed, multi-sectoral prevention strategies drawing on evidence-based strategies and taking these to scale (see Mathews and Gould, p. 61).

Insufficient progress has been made in ensuring that the most vulnerable are reached, included and able to participate in society. Children with disabilities are a case in point, many of whom continue to be deprived of the services and support that they need, and experience stigma and multiple exclusions. Supports and systems therefore need to be tailored to meet individual needs so that the most vulnerable and excluded children can participate fully in the social and economic life of their communities on an equal footing with their peers (see Philpott and McKenzie, p. 84).

It is also important to strengthen linkages between families, community groups, government and civil society service providers to provide a continuum of support for children and their caregivers across the life course (see Philpott and McKenzie, p. 84). Local

ii Children living below the upper bound poverty line with a per capita monthly income of less than R965 in 2015 Rands as this is the only poverty line to meet children's basic needs for nutrition, clothing and shelter.

networks of care, parenting support programmes and services that address maternal mental health conditions are needed to ensure that caregivers receive support and guidance. Similarly, adolescents require mentoring and healthy peer relationships; and youth development programmes can provide adolescents with guidance, support and a sense of belonging (see Harrison, p. 43; Berry and Malek, p. 51). Home-visiting programmes are recommended to reach the most vulnerable households and could perform multiple functions – extending health-care services, promoting good nutrition, supporting parents, and assessing and referring children and caregivers in need of support (Sanders and Reynolds, p. 68; Berry and Malek, p. 51).

Getting reading right in the early stages of schooling is critical to build a firm foundation and improve children’s pathways through the education system. This requires prioritising reading at all levels of South African society: from national government to school leadership, and to the parents of school-going children and those not yet in school. Resources need to be made available to shift reading outcomes radically, including the provision of appropriate reading materials, adequate teacher training and support, and the allocation of time for reading in and outside of the formal classroom. These are essential elements to promote the enjoyment of reading and to nurture a reading culture (Spaul and Hoadley, p. 77).

Connectedness

If all children are to survive, thrive and develop to their full potential, then we must ensure that children and their families receive an integrated package of quality support services. We must build on what is working, remove barriers to quality services and strengthen the interconnections between services to ensure a seamless experience for children of all ages. For example, UNICEF South Africa is supporting government and partners to link cash, care and protection at national, provincial and community levels using the Child Well-Being Tracking Tool (case 13 below).

Care

But connectedness on its own is not enough. We need to humanise services. Public services and service providers need to shift attitudes and behaviour to create more welcoming and inclusive environments for children and their caregivers (see Philpott and McKenzie, p. 84).

Professionals should have the capacity to care and build responsive relationships with children and families. The Center on the Developing Child at Harvard University has identified three principles to improve outcomes for children and families. These are: supporting responsive relationships; strengthening core life skills; and reducing stress.²⁰ The starting point is to identify staff who are motivated and have good interpersonal skills, and they recommend using a selection process that includes observing candidates relating to others. For example, Isibindiⁱⁱⁱ has an extended probationary period that tests candidates’ suitability to be child and youth care workers before embarking on a two-year training process.²¹ Burnout and high-turnover disrupt relationships between professionals and children and families, it is therefore important to retain staff and reduce stress. Practitioners need to be supported, valued and respected, meaning they need to have adequate compensation, training, and professional development and responsive support and supervision.²² Also, organisations require consistent, adequate funding to ensure stability.

Professionals working with children and families should have enough time to develop relationships with the people they are supporting, and require manageable caseloads and class sizes. Paperwork and bureaucratic processes should be streamlined so that practitioners have more time to offer direct and meaningful support to children and their families.²³ Finally, services need to adopt a multigenerational approach, caring for parents and caregivers and supporting them to provide responsive care, and stable environments for children because when “adults are

Case 13: Child Well-being Tracking Tool

Mayke Huijbregts (UNICEF South Africa)

Identifying and supporting those furthest behind requires a structured process to help individual children and families through direct interventions to support and improve social functioning. It includes a holistic assessment of the child, development of a tailored care and action plan, support to implement the plan including referral to holistic package of services, and the review and adaptation of the plan where necessary to ensure it continues to address the child’s needs.

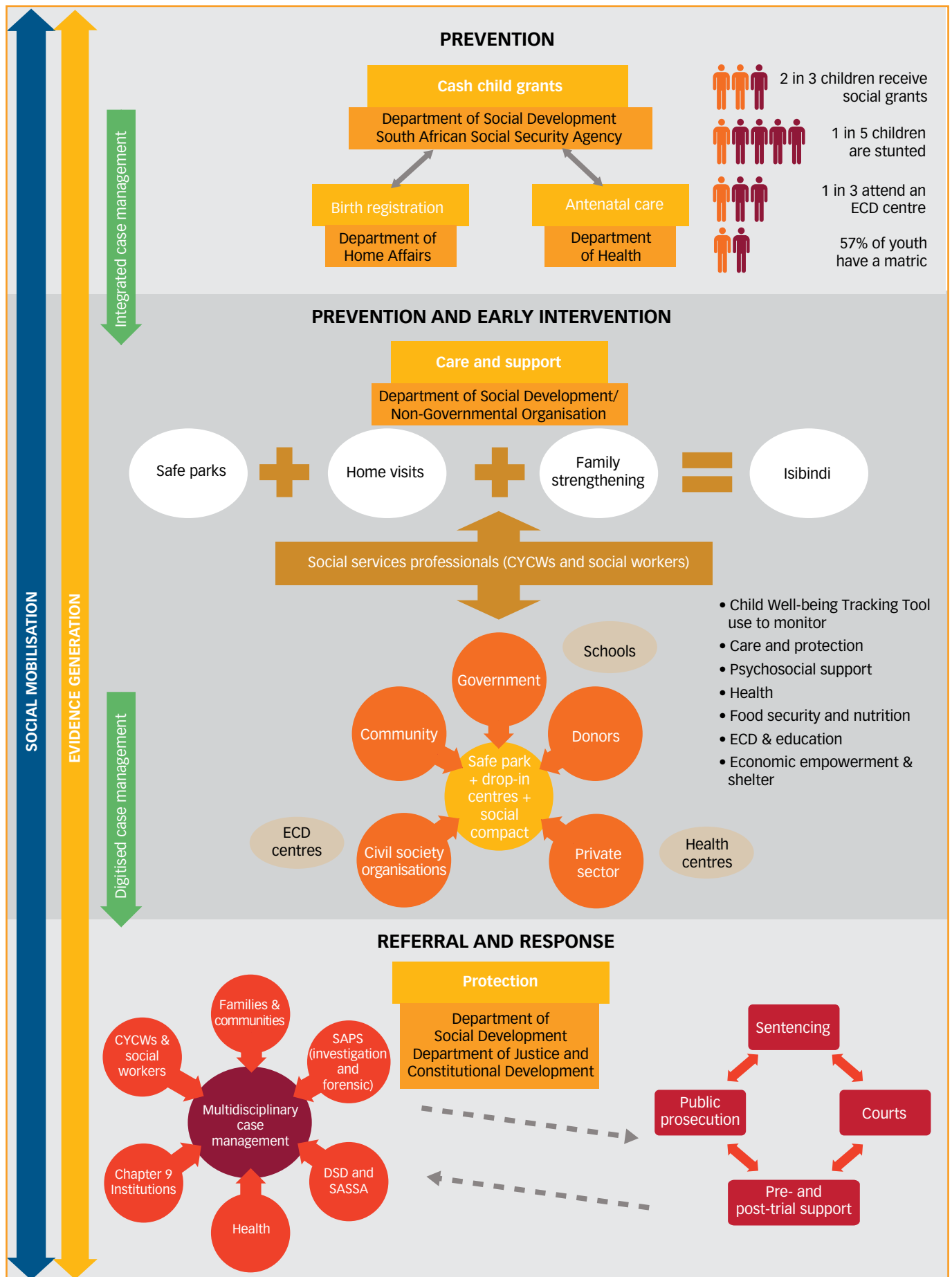
UNICEF South Africa is supporting government and partners to link cash, care and protection at national, provincial and community levels. The Child Well-Being Tracking Tool (CWBT) uses a mobile application to support integrated case management. It includes a simple dashboard to identify the needs of children and to track and analyse data regarding: care and protection;

food and nutrition; health (including HIV); psychosocial support; education and early childhood development; and economic well-being and shelter.

Social service professionals use the CWBT to assess children’s needs and vulnerabilities, make timely referrals to critical services, and track children’s well-being over time. This ensures that those who receive cash through government grants also receive holistic and tailored care and protection, for example, family visits and parenting programmes, access to other basic services and statutory child protection services for victims of violence. Case management procedures help to clarify roles and responsibilities and facilitate collaboration between the various professionals involved to ensure that the holistic needs of children are addressed more efficiently and effectively.

ⁱⁱⁱ Isibindi provides child and youth care services to children and youth in their homes, and also offers a range of services to caregivers. Their Safe Parks allow children to play under the supervision of child and youth care workers, and receive educational support.

Figure 27: Social and child protection package of services



Source: Adapted from: UNICEF South Africa (2017) *Circles of Care: Linking Cash, Care and Protection for Children in South Africa*. Pretoria: UNICEF South Africa. May 2017.

supported and can model responsive relationships with each other and with children the benefits come full circle, ultimately helping children become healthy, responsive parents themselves".²⁴

Leadership

Good leadership and management are other essential ingredients for a transformed and responsive society – this includes effective leadership within government, civil society and the corporate environment. One of the keys to doing things differently is to build capacity for leadership in every sphere of society. This is well illustrated in Metcalfe's description of leadership development among teachers, in case 2, p. 40.

A sustainable funding base

Finally, we need to secure a sustained funding base for programmes that address the intersecting challenges facing children throughout the lifecycle. Harrison argues that there are private foundations eager and willing to support, provided that the government is also committed and demonstrates leadership toward implementation of existing policies and plans (p. 43). Before we can align public and private funding government, the private sector and the civil society organisations that deliver services need to jointly develop a multisectoral strategic funding, plan to ensure that all children achieve their optimal development.

Call to action

The SDGs envision a world in which all children develop to their full potential. A review of the scientific evidence highlights how children maximise their potential when they are well nourished; responsively

cared for; have opportunities to learn; and are protected from disease, violence and stress. Yet most children in South Africa are faring badly in all these domains and action is urgently required to transform the environments that limit children's potential. Clinics, schools and other services should be attuned to the evolving needs of children and caregivers across the life course, and with strong linkages between different sectors to support children's holistic development. At a societal level, we require systems, cultures and processes that give priority to those children who are most vulnerable so that no child is excluded because of their age, ability, socio-economic status, race, gender or location. These investments in children will benefit not only the individual child, but will also propel national transformation, sowing the seeds for a more equitable society and a more sustainable future.

If we are to realise this potential demographic dividend, then we need to actively engage with the SDGs and ensure that children's optimal development is kept sharply in focus – so that it defines national priorities, informs policy and programme development, and infuses the design and delivery of local services and the ways in which we interact with children and adolescents in our homes, schools and communities.

Government, civil society, researchers, health, education and social service professionals – all have an essential role to play in promoting nurturing care and creating enabling environments in which children can thrive and reach their full potential – as do parents, caregivers and children themselves. But we cannot achieve these goals in isolation. We need to reach out, and connect and strengthen our efforts to provide children with seamless support across the life course and we should start with the most vulnerable so that no child is left behind.

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A woman with dark hair, wearing a patterned dress, is seated in front of a white door. She is looking towards the right side of the frame. The door has a classic panel design with a silver handle.

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 – 2015 and identifies the main trends over this 14-year period. A set of key indicators tracks 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
- Children's access to basic services.

A full set of indicators and detailed commentary are available on www.childrencount.uct.ac.za.

Introducing Children Count – Abantwana Babalulekile

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, the question is: 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.

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 2015, and many of the indicators in this issue compare the situation of children over this 14-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.

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.uct.ac.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 at the top of each bar (|).

Data sources and citations

Children Count – Abantwana Babalulekile uses a number of data sources. Most of the indicators draw on the General Household Survey conducted by Statistics South Africa, while some draw on administrative databases used by government departments (Health, Education, and Social Development) to record and monitor the services they deliver.

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. 132 – 133, 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.

Here are a couple of examples of how to reference Children Count data correctly: When referencing from the Demography section in this publication, for example:

Hall K & Sambu W (2017) Demography of South Africa's children. In: Jamieson L, Berry L & Lake L (eds) *South African Child Gauge 2017*. Cape Town: Children's Institute, University of Cape Town.

When referencing from the Housing and Services online domain, for example:

Hall K (2017) Housing and Services – Access to adequate water. *Children Count – Abantwana Babalulekile* website, Children's Institute, University of Cape Town. Viewed 30 November 2017: www.childrencount.uct.ac.za

Each domain is introduced below and key findings are highlighted.

Demography of South Africa's children

(pages 100 – 104)

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 18.6 million children in South Africa in 2015. Seventeen percent of children are orphans who have lost either their mother, father or both parents; 21% of children do not live with either of their biological parents; and 0.3% of children live in child-only households.

Income poverty, unemployment and social grants

(pages 105 – 110)

In 2015, over half of children (62%) lived below the "upper bound" poverty line (with a per capita income below R965 per month), and 31% 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 March 2017, just over 12 million children received the Child Support Grant; 440,000

children received the Foster Child Grant; and a further 145,000 children received the Care Dependency Grant.

Child health

(pages 111 – 118)

This section monitors child health through a range of indicators. Under-five mortality has decreased from 81 deaths per 1,000 live births in 2003 to 37 deaths per 1,000 live births in 2015. The infant mortality rate has followed a similar trend and is estimated at 28 deaths per 1,000 live births for 2015. Just over 22% of children travel far to reach their primary health care facility and 13% of children live in households that reported child hunger.

Children's access to education

(pages 119 – 125)

Many children in South Africa have to travel long distances to school. One in seven children (14%) live far from their primary school and this increases to nearly one in five children (20%) in secondary school. Despite these barriers, South Africa has made significant strides in improving access to education with a gross attendance rate of 97% in 2015. Access is also increasing in the preschool years, with 92% of 5 – 6-year-olds attending some kind of educational institution or care facility. However, this does not necessarily translate into improved educational outcomes or progress through school. In 2015, 87% of 10 – 11-year-olds had completed grade 3, and only 70% of 16 – 17-year-olds had completed grade 9.

Children's access to housing

(pages 126 – 128)

This domain presents data on children living in rural or urban areas, and in adequate housing. In 2015, 56% of children were living in urban areas, and 79% of children lived in formal housing. Just over 1.6 million children lived in backyard dwellings and shacks in informal settlements, and 18% of children lived in overcrowded households.

Children's access to basic services

(pages 129 – 131)

Without water and sanitation, children face substantial health risks. In 2015, just over two-thirds of children (68%) had access to drinking water on site, while children's access to adequate toilet facilities rose to 76% from 74% in 2014.

Demography of South Africa's children

Katharine Hall and Winnie Sambu (Children's Institute, University of Cape Town)

The UN General Guidelines for Periodic Reports on the Convention on the Rights of the Child, 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 ...”.¹

The child population in South Africa

In mid-2015, South Africa's total population was estimated at 54.4 million people, of whom 18.6 million were children under 18 years. Children therefore constitute 34% of the total population.

It is not uncommon in South Africa for children to live separately from their biological parents, in the care of other relatives. 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 and with greater proportions of adults in the largely metropolitan provinces. Together, KwaZulu-Natal, the Eastern Cape and Limpopo accommodate almost half of all children in South Africa. A further 20% of children live in Gauteng, a mainly metropolitan province, and 10% of children in the Western Cape. Despite being the smallest province in the country, Gauteng accommodates 29% of all households and 27% of adults, but only a fifth of children. This difference is because of the relatively large number of adult-only households in the province.

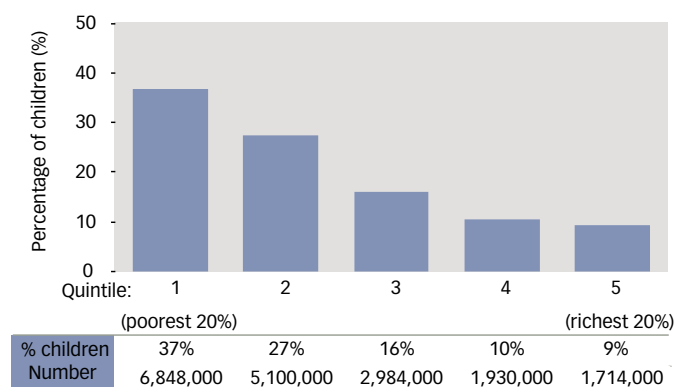
There have been striking changes in the provincial child populations over time. While there have been decreases in the number and share of children living in the Free State, Eastern Cape, Limpopo, KwaZulu-Natal, and the Northern Cape provinces, the numbers of children living in Gauteng and Western Cape have risen by 26% and 16% respectively. This is partly the result of population movement (for example, when children are part of migrant households or move to join existing urban households), and partly the result of natural population growth (new births within the province).

We can look at inequality by dividing all households into five equal groups or quintiles, based on total income to the household (including earnings and social grants) and dividing that by the number of household members, 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 (or wealthiest) 20%. Nearly two-thirds of children live in the poorest 40% of households (i.e. the poorest two quintiles).

Children are fairly equally distributed by gender and age, with on average just over one million children in each year under 18.

These population estimates are based on the General Household Survey (GHS), which is conducted annually by Statistics South Africa. The population numbers derived from the survey are weighted to the general population. Statistics South Africa revises these weights from time to time, and the estimated child population size changes as a result. Using previously weighted data, it appeared that the child population had grown by about 6% (a million children) between 2002 and 2012. However, recently revised weights, applied retrospectively, suggest that the child population has remained fairly stable, with a marginal reduction of 0.2% between 2002 and 2015. There is considerable uncertainty around the official population estimates, particularly for younger children.²

Figure 1a: Children living in South Africa, by income quintile, 2015



Source: Statistics South Africa (2016) *General Household Survey 2015*. Pretoria: Stats SA. Analysis by Katharine Hall & Winnie Sambu, Children's Institute, UCT.

Table 1a: Distribution of households, adults and children in South Africa, by province, 2015

PROVINCE	HOUSEHOLDS		ADULTS		CHILDREN		
	N	%	N	%	N	%	% change 2002 – 2015
Eastern Cape	1,727,000	11	4,049,000	11	2,644,000	14	-12.4%
Free State	906,000	6	1,877,000	5	886,000	5	-18.3%
Gauteng	4,690,000	29	9,637,000	27	3,630,000	20	26.2%
KwaZulu-Natal	2,741,000	17	6,621,000	18	4,063,000	22	-5.3%
Limpopo	1,532,000	10	3,455,000	10	2,199,000	12	-11.5%
Mpumalanga	1,211,000	8	2,677,000	7	1,559,000	8	1.6%
North West	1,215,000	8	2,412,000	7	1,291,000	7	2.4%
Northern Cape	320,000	2	774,000	2	409,000	2	-6.4%
Western Cape	1,775,000	11	4,350,000	12	1,896,000	10	15.9%
South Africa	16,117,000	100	35,852,000	100	18,576,000	100	-0.2%

Source: Statistics South Africa (2016) *General Household Survey 2015*. Pretoria: Stats SA. Analysis by Katharine Hall & Winnie Sambu, Children's Institute, UCT.

Children living with their biological parents

Many children in South Africa do not live consistently in the same household as their biological parents. This is a long-established feature of childhoods in South Africa, and international studies have shown that the country is unique in the extent of parental absence from children's daily lives.³ Parental absence is related to many factors, including historic population control, labour migration, poverty, housing and educational opportunities, low marriage and cohabitation rates, as well as customary care arrangements.⁴ 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 from their biological siblings. Parental absence does not necessarily mean parental abandonment. Many parents continue to support and see their children regularly even if they have to live elsewhere.⁵

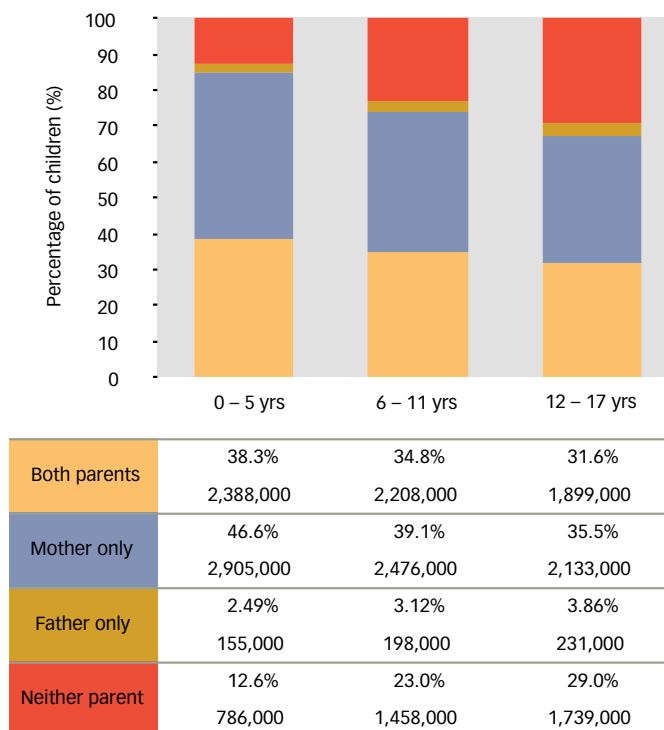
Virtually all children live with at least one adult, and the vast majority live with two or more co-resident adults. This indicator examines co-residence between children and their biological parents. Although many children live with just one of their biological parents (usually the mother), this does not mean the mother is a "single parent" as she is not necessarily the only caregiver in the household. In most cases, other adult household members such as aunts, uncles and grandparents may contribute to child care.

The share of children living with both parents decreased from 39% in 2002 to 35% in 2015. Forty percent of all children (7.5 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-one percent do not live with either of their biological parents. This does not necessarily mean that they are orphaned: most children without any co-resident parents have at least one parent living elsewhere.

There is some provincial variation in these patterns. In the Western Cape and Gauteng, the share of children living with both parents is significantly higher than the national average, with around half of children resident with both parents (54% and 51%, respectively). Similarly, the number of children living with neither parent is relatively low in these two provinces (8% and 12%). In contrast, a third of children (33%) in the Eastern Cape live with neither parent. These patterns are consistent from 2002 to 2015.

Children in the poorest 20% of households are least likely to live with both parents: only 17% have both parents living with them, compared with 75% of children in the wealthiest 20% of households. Less than one-third (30%) of African children live with both their parents, while the vast majority of Indian and White children (81%

Figure 1b: Parental co-residence by age group, 2015

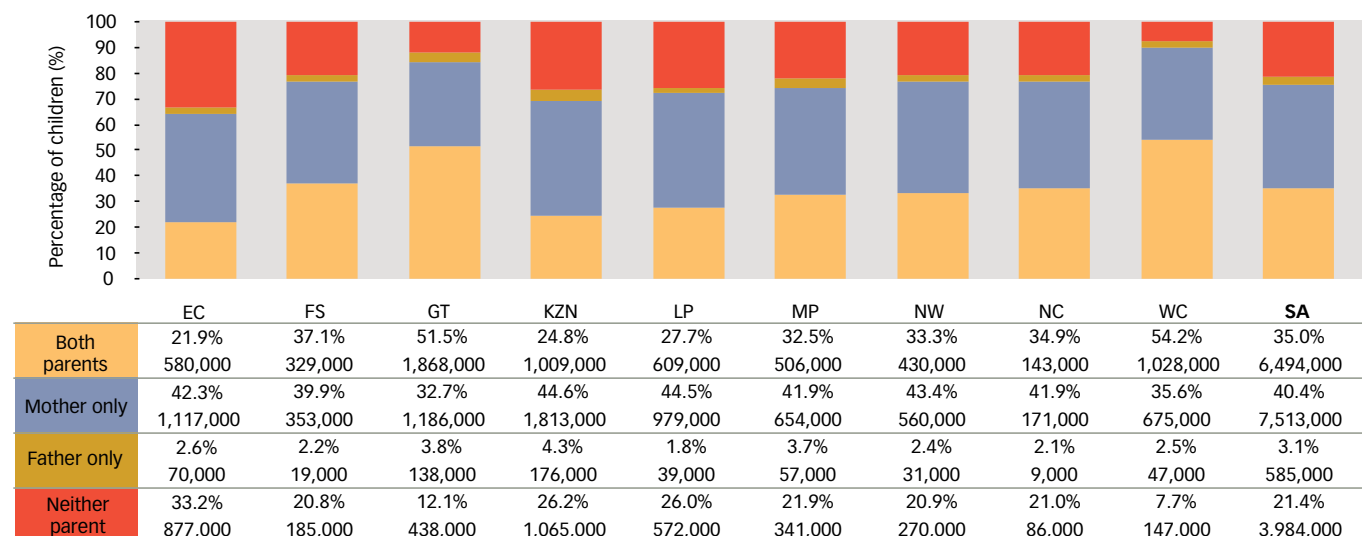


Source: Statistics South Africa (2016) *General Household Survey 2015*. Pretoria: Stats SA. Analysis by Katharine Hall & Winnie Sambu, Children's Institute, UCT.

and 78%, respectively) reside with both biological parents. Almost a quarter of African children do not live with either parent and a further 43% live with their mothers but not their fathers. These figures are striking as they suggest the limited presence of biological fathers in the home lives of many African children.

Younger children are more likely to live with their mothers, while older children are more likely to live with neither parent. While 13% of children aged 0 – 5 years (786,000) live with neither parent, this increases to 29% (1.74 million) for children aged 12 – 17 years.

Figure 1c: Children living with their biological parents, by province, 2015



Source: Statistics South Africa (2016) *General Household Survey 2015*. Pretoria: Stats SA. Analysis by Katharine Hall & Winnie Sambu, Children's Institute, UCT.

Orphaned children

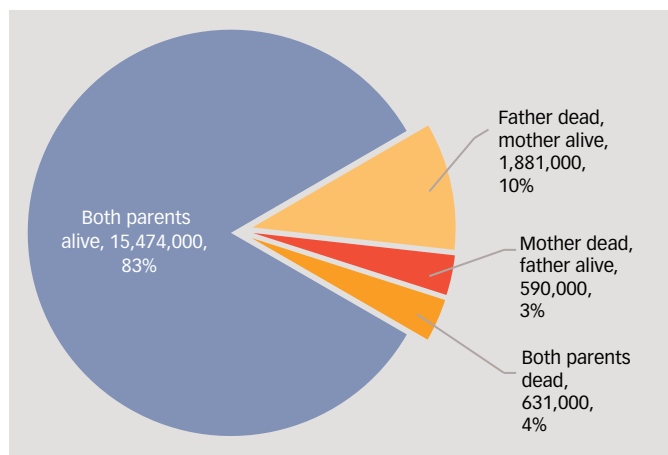
An orphan is defined as a child under the age of 18 years whose mother, father or both biological parents have died (including those whose living status is reported as unknown, but excluding those whose living status is unspecified). For the purpose of this indicator, orphans are defined in three mutually 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, where the definition of maternal and paternal orphans includes children who are double orphans.

In 2015, there were 3.1 million orphans in South Africa. This includes children without a living biological mother, father or both parents, and is equivalent to 17% of all children in South Africa.

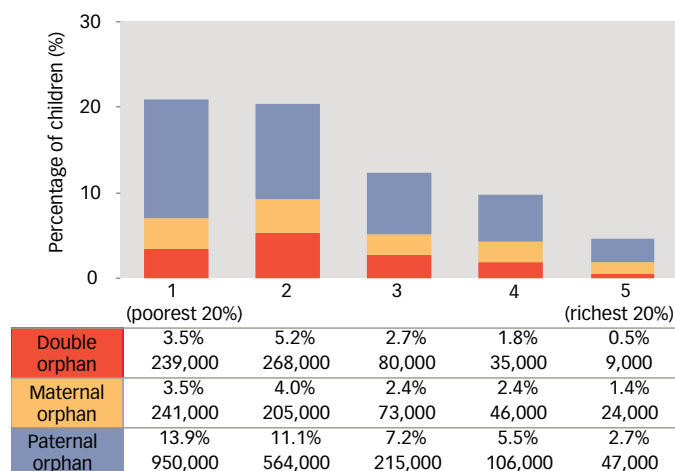
Figure 1e: Children living in South Africa, by orphanhood status, 2015



Source: Statistics South Africa (2016) *General Household Survey 2015*. Pretoria: Stats SA. Analysis by Katharine Hall & Winnie Sambu, Children's Institute, UCT.

The total number of orphans increased by 28% between 2002 and 2010, with 840,000 more orphaned children in 2010 than in 2002. However, the rate of increase in orphaning has slowed in recent years,

Figure 1d: Orphans, by income quintile, 2015



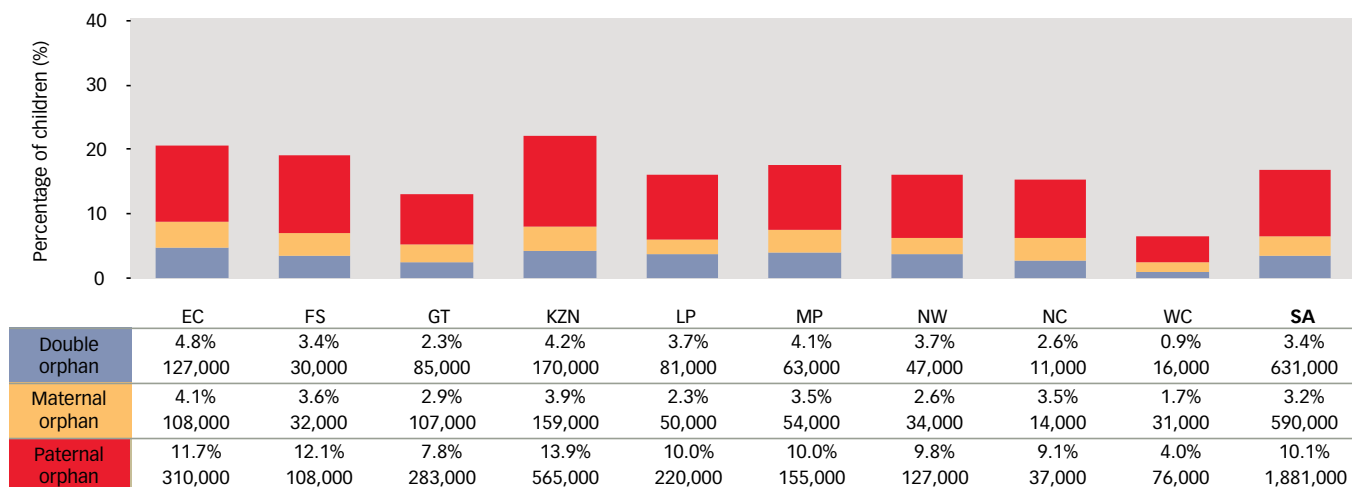
Source: Statistics South Africa (2016) *General Household Survey 2015*. Pretoria: Stats SA. Analysis by Katharine Hall & Winnie Sambu, Children's Institute, UCT.

with a drop-off in the number of orphans since 2010. By 2015, orphan numbers had almost declined to 2002 levels, largely as a result of improved access to antiretrovirals.

Orphan status is not necessarily an indicator of the quality of care that children receive. 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 maternal orphans are at risk of poorer outcomes than paternal orphans – for example, in relation to education.⁶

The majority (around 60%) of all orphans in South Africa are paternal orphans (with living mothers). In 2015, 3% of children were maternal orphans with living fathers, 10% were paternal orphans with living mothers, and a further 3% were recorded as double orphans. This means that 6% of children in South Africa did not have a living biological mother and more than double that number did not have a living biological father. 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 (1.7% or 322,000 children have fathers whose vital status is reported to be "unknown", compared with 0.4% or 78,000 children whose mothers' status is unknown).

Figure 1f: Number and percentage of orphans, by province, 2015



Source: Statistics South Africa (2016) *General Household Survey 2015*. Pretoria: Stats SA. Analysis by Katharine Hall & Winnie Sambu, Children's Institute, UCT.

The number and proportion of double orphans more than doubled between 2002 and 2011 (from approximately 361,000 to 952,000), translating to an increase of three percentage points in double orphans in South Africa. Since 2012, there has been a gradual decrease in the number of double orphans, and as at 2015, 631,000 children had lost both their parents. Orphaning rates are particularly high in provinces that contain the former homelands, as these areas bear a large burden of care for orphaned children. Sixty percent of double orphans live in the Eastern Cape, KwaZulu-Natal or Limpopo.

KwaZulu-Natal has the largest child population and the highest orphan numbers, with 22% of children in that province recorded as orphans who have lost a mother, a father or both parents. Orphaning rates in the Eastern Cape (21%) and the Free State (19%) are similarly

high. The lowest orphaning rates are in the Western Cape (7% of children have lost at least one parent) and Gauteng (13%).

The poorest households carry the greatest burden of care for orphans. Close to half (46%) of all orphans are resident in the poorest 20% of households. Around a fifth of children in the poorest 20% of households are orphans, compared with the richest 20% where total orphaning rates are around 5%.

The likelihood of orphaning increases with age. Across all age groups, the main form of orphaning is paternal orphaning, which increases from 4% among children under six years of age, to 16% among children aged 12 – 17. While 1% of children under six years have lost their mothers, this increases to 6% in children aged 12 – 17 years.

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 referred to as “child-headed households”, although this definition differs from the one contained in the Children’s Act. The Children’s Act definition of a child-headed household includes households where there are adults who may be too sick or too old to effectively head the household and a child over 16 years bears this responsibility.

While orphaning undoubtedly places a large burden on families, there is little evidence to suggest that their capacity to care for orphans has been saturated, as commentators feared in the past. Rather than seeing increasing numbers of orphaned children living on their own, the vast majority of orphans live with adult family members.

There were about 58,000 children living in a total of 35,000 child-only households across South Africa in 2015. This equates to 0.3% of all children. While children living in child-only households are rare relative to those residing in other household forms, the number of children living in this extreme situation is of concern.

Importantly, however, there has been no increase in the share of children living in child-only households in the period 2002 – 2015. If anything, the number has dropped. 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 revealed that most children in child-only households are

not orphans⁷ and 84% have a living mother. These findings suggest that social processes other than HIV-related mortality may play important roles in the formation of these households. For example, leaving teenage boys to look after a rural homestead while parents migrate to work may be a livelihood strategy for the household.

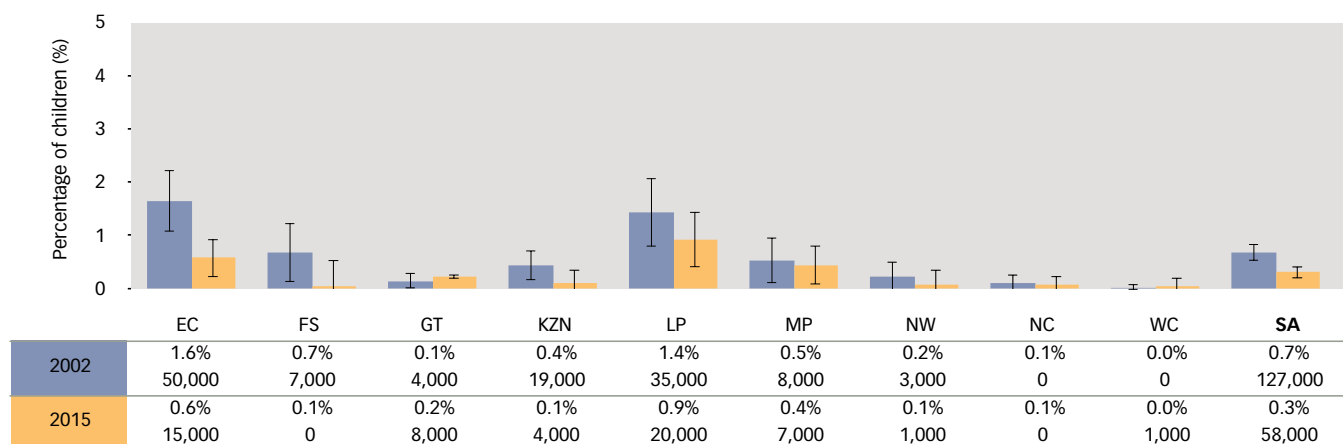
While it is not ideal for any child to live without an adult resident, it is positive that nearly three quarters (71%) of all children in child-only households are at least 15 years old. Children can work legally from the age of 15, and from 16 they can obtain an identity book and receive grants on behalf of younger children. Only five percent of children in child-headed households are under six years of age.

Research suggests that child-only households are frequently temporary arrangements, and often exist just for a short 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).⁸

Sixty percent of all children in child-only households live in two provinces: Limpopo (which accounts for 34% of children in child-only households) and Eastern Cape (26%). From 2002 to 2015, these provinces have consistently been home to the majority of children living in child-only households. The number of child-only households in KwaZulu-Natal appears to have dropped, but this may not be significant because the numbers are so small and the confidence intervals relatively wide.

Figure 1g: Children living in child-headed households, 2002 & 2015

(Y-axis reduced to 5%)



Source: Statistics South Africa (2003; 2016) *General Household Survey 2002; General Household Survey 2015*. Pretoria: Stats SA. Analysis by Katharine Hall & Winnie Sambu, Children’s Institute, UCT.

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. When comparing the overall estimates nationally, the number of children in child-headed households seems to have declined since 2002.

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Income poverty, unemployment and social grants

Katharine Hall and Winnie Sambu (Children's Institute, University of Cape Town)

The Constitution of South Africa, 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".¹

The UN Convention on the Rights of the Child, 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".²

Children living in income poverty

This indicator shows the number and share of children living in households that are income-poor. 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 affect children's rights to nutrition, education, and health care services.

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 in households with severely constrained resources.

The measure used is the Statistics South Africa "upper bound" poverty line, set at R779 per person per month in 2011 prices. The poverty line increases with inflation and was equivalent to R965 in 2015. 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.

Statistics South Africa proposed two other poverty lines:

- A "lower bound" poverty line is calculated by adding to the food line the average expenditure on essential non-food items by

households whose food expenditure is below but close to the food line. The value of the lower bound poverty line in 2011 prices was R501 per person per month. Those living below this line would not be able to pay for the minimum non-food expenses or would be sacrificing their basic nutrition in order to pay for non-food expenses.

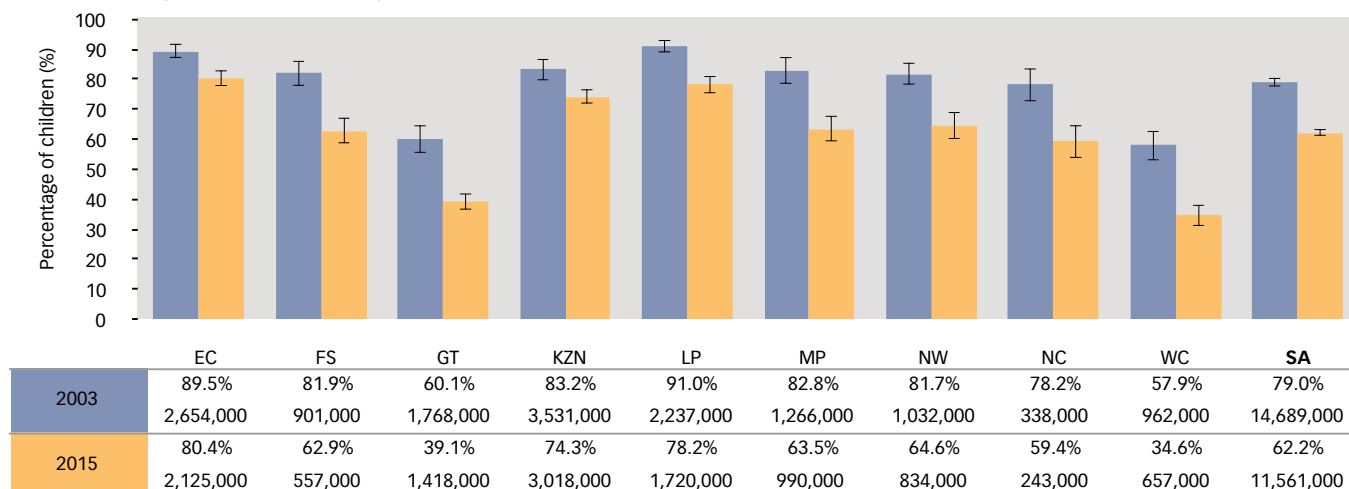
- A "food poverty" line is based on the cost of the minimum nutritional requirement of 2,100 kilocalories per person per day, without any allowance for non-food basic necessities. The value of the food poverty line in 2011 prices was R335 per person per month. Anyone living below this line will be malnourished and their health and survival may be at risk.

The Children Count website (www.childrencount.uct.ac.za) monitors child poverty using all three poverty lines. In the *Child Gauge*, where space is limited, we have focused on the upper bound poverty line as this is linked to the minimum requirement for basic nutrition as well as other basic needs such as clothing and shelter. In other words, this is the only poverty line that meets the minimum requirement for children's basic needs.

South Africa has very high rates of child poverty. In 2015, 62% of children lived below the upper bound poverty line. Income poverty rates have fallen substantially since 2003, when 79% (14.7 million) children were defined as "poor" at this income threshold. The reduction in the child poverty headcount is partly the result of a massive expansion in the reach of the Child Support Grant over the same period. Although there have been reductions in the child poverty rate, large numbers of children still live in poverty: in 2015, 11.6 million children lived below the upper bound poverty line.

Figure 2a: Children living in income poverty, by province, 2003 & 2015

("Upper bound" poverty line: Households with monthly per capita income less than R965, in 2015 Rands)



Source: Statistics South Africa (2004; 2016) *General Household Survey 2003; General Household Survey 2015*. Pretoria: Stats SA. Analysis by Katharine Hall & Winnie Sambu, Children's Institute, UCT.

There are substantial differences in poverty rates across the provinces. Using the upper bound poverty line, over three-quarters of children in Limpopo and the Eastern Cape are poor. Gauteng and the Western Cape have the lowest child poverty rates – at 39% and 35% respectively. Child poverty remains most prominent in the rural areas of the former homelands, where 83% of children are below the poverty line. The urban child poverty rate, by contrast, is 47%.

There are glaring racial disparities in income poverty: while nearly 70% of African children lived in poor households in 2015, and 39% of Coloured children were defined as poor, only 4% of White children lived below this poverty line. There are no significant differences in child poverty levels across gender or between different age groups in the child population.

Using Statistics South Africa’s lower bound poverty line (which does not provide enough for basic essentials), 46% of children were poor in 2015, and 29% (5 million children) were below the food poverty line, meaning that they were not getting enough nutrition.

The international ultra poverty line used to track progress towards the Millennium Development Goals (MDGs) was \$1.25 per person per

day. This translated to R210 per person per month in 2015, using the International Monetary Fund purchasing power parity conversion. This poverty line is extremely low – below survival level – and is not appropriate for South Africa. No child should be below it. In 2003, 43% of children (8 million) lived below the MDG poverty line. By 2015, the deadline for the MDGs, this had reduced to 12%. While this means that South Africa technically met the goal of halving the proportion of children living below the international poverty line, it still means 2.2 million children in extreme poverty.

This is now the baseline for the Sustainable Development Goals, which replaced the MDGs as a global agenda for development by 2030. Target 1.1 is to eradicate extreme poverty, using the same international poverty line of \$1.25 per person per day. Target 1.2 is that by 2030 countries should reduce at least by half the proportion of men, women and children of all ages living in poverty in all its dimensions, according to national definitions. In terms of income poverty, this would mean reducing the number of children below the upper poverty line by six million.

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 derive income from labour or income-generating activities.

Unemployment in South Africa continues to be a serious problem. The official national unemployment rate was 25.5% in the third quarter of 2015.³ This rate is based on a narrow definition of unemployment that includes only those adults who are defined as economically active (i.e. they are not studying or retired or voluntarily staying at home) and who actively looked but failed to find work in the four weeks preceding the survey. 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. The expanded unemployment rate (which includes those who are not actively looking for work) was 34.4%. Gender differences in employment rates are relevant for children, as it is mainly women who provide for children’s care and material needs. Unemployment rates (narrowly defined) remain higher for women (27.9%) than for men (23.5%).⁴

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 2015, 69% of children in South Africa lived in households with at least one working adult. The other 31% (5.7 million children) lived in households where no adults were working. The number of children living in workless households has decreased by two million since 2003, when 42% of children lived in households where there was no employment.

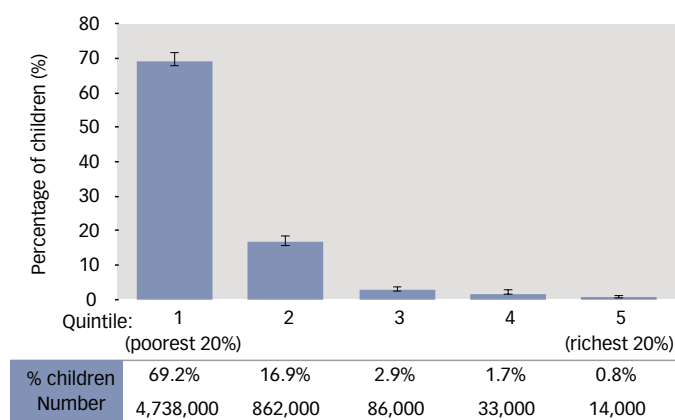
This indicator is very closely related to the income poverty indicator in that provinces with relatively high proportions of children living in unemployed households also have high rates of child poverty. Nearly 50% of children in the Eastern Cape and Limpopo live in households

without any employed adults. These two provinces are home to large numbers of children, and have the highest rates of child poverty. In contrast, Gauteng and the Western Cape have the lowest poverty rates, and the lowest unemployment rates.

Racial inequalities are striking: 35% of African children have no working adult at home, while 14% of Coloured children, 7% of Indian and 5% of White children live in these circumstances. There are no significant differences in child-centred unemployment measures when comparing girls and boys. However older children are slightly more likely than younger children to live in workless households. This may be because babies and very young children tend to live with their parents, while older children are more likely to be cared for by extended family members, especially grandparents. In the rural former homelands, 50% of children live in households where nobody works.

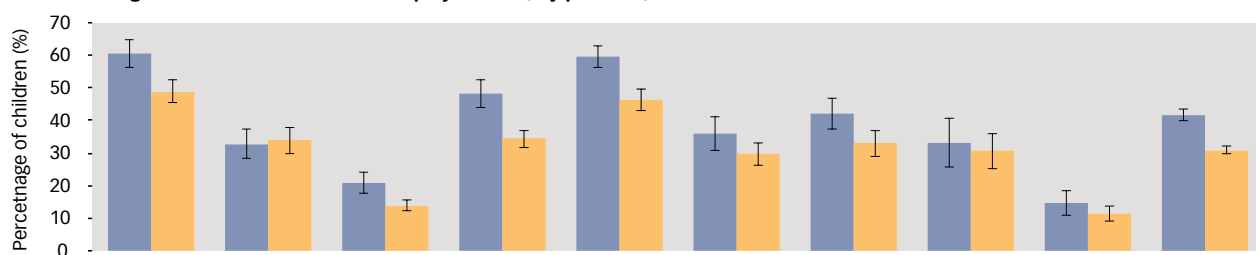
Income inequality is clearly associated with unemployment. Nearly 70% of children in the poorest income quintile (4.7 million) live in households where no adults are employed.

Figure 2b: Children living in households without an employed adult, by income quintile, 2015



Source: Statistics South Africa (2016) *General Household Survey 2015*. Pretoria: Stats SA. Analysis by Katharine Hall & Winnie Sambu, Children’s Institute, UCT.

Figure 2c: Children living in households without an employed adult, by province, 2003 & 2015



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	SA
2003	60.4%	32.7%	20.9%	48.1%	59.5%	35.9%	42.0%	33.2%	14.6%	41.6%
	1,790,000	359,000	614,000	2,041,000	1,462,000	548,000	531,000	144,000	243,000	7,733,000
2015	48.9%	33.9%	13.8%	34.3%	46.4%	29.6%	32.9%	30.5%	11.3%	30.9%
	1,292,000	300,000	502,000	1,392,000	1,020,000	462,000	425,000	125,000	215,000	5,732,000

Source: Statistics South Africa (2004; 2016) *General Household Survey 2003; General Household Survey 2015*. Pretoria: Stats SA. Analysis by Katharine Hall & Winnie Sambu, Children’s Institute, UCT.

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.

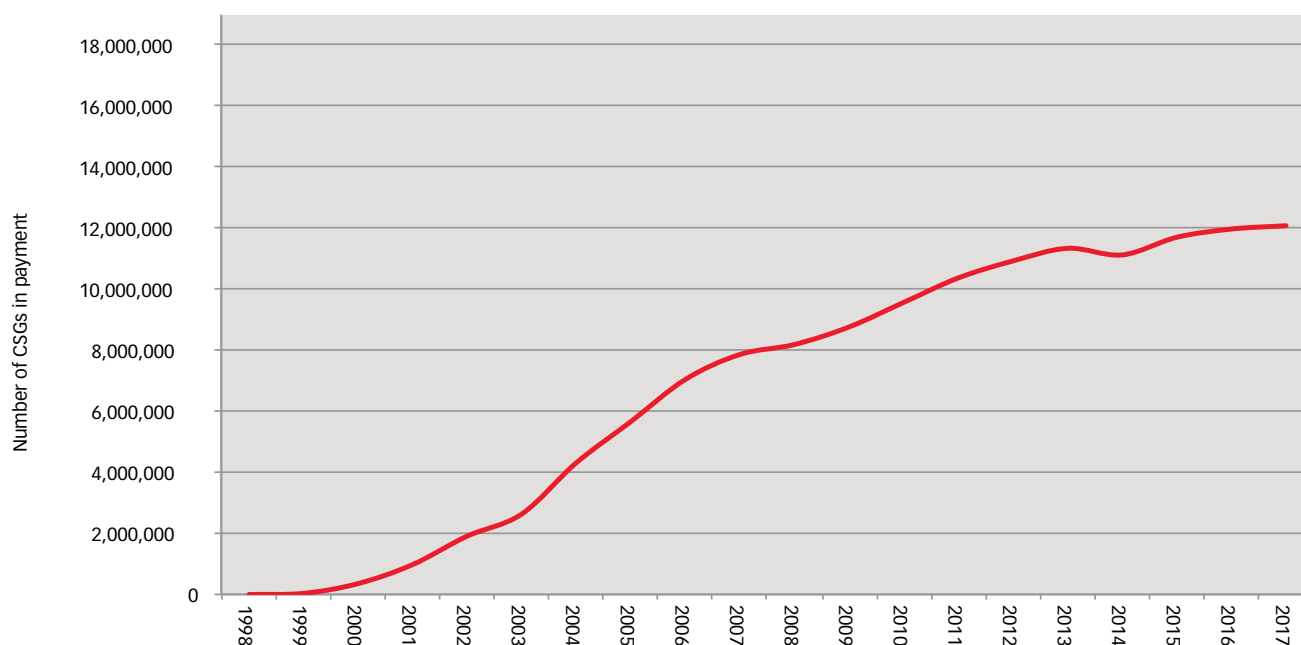
Introduced in 1998 with an initial value of R100, the CSG has become the single biggest programme for alleviating child poverty in South Africa. Take-up of the CSG has increased dramatically over the years, and the grant amount is increased slightly each year, more or less keeping pace with overall inflation. At the end of March 2017,

a monthly CSG of R360 was paid to 12,081,375 children aged 0 – 17 years. The value of the CSG increased to R380 per month from the beginning of April 2017.

There have been two important changes in eligibility criteria. The first concerns age eligibility. Initially the CSG was only available for children under seven years. From 2003 it was gradually extended to older children up to the age of 14. Since January 2012, following a second phased extension, children are eligible for the grant until they turn 18.

The second important change concerns the income threshold or means test. The income threshold remained static for 10 years until a formula was introduced – set at 10 times the amount of the grant. This means that every time the grant is increased, the means test also increases. From April 2017 the income threshold is R3,800 per month for a single caregiver and R7,600 per month for the joint income of the caregiver and spouse, if the caregiver is married.

Figure 2d: Children receiving the Child Support Grant, 1998 – 2017



Sources: 1998 – 2007: National Treasury Intergovernmental Fiscal Reviews. 2008 – 2017: South African Social Security Agency SOCPEN monthly reports, by special request.

Table 2a: Children receiving the Child Support Grant, by province and age group, 2017

Province	Number of child beneficiaries at end March 2017			
	0 – 5 years	6 – 11 years	12 – 17 years	TOTAL
Eastern Cape	636,457	698,950	540,941	1,876,348
Free State	229,649	252,914	193,557	676,120
Gauteng	636,270	658,979	480,998	1,776,247
KwaZulu-Natal	951,437	1,021,184	815,979	2,788,600
Limpopo	677,455	631,387	471,168	1,780,010
Mpumalanga	377,478	382,088	307,673	1,067,239
North West	293,951	304,087	232,139	830,177
Northern Cape	109,255	107,936	86,008	303,199
Western Cape	334,554	372,761	276,120	983,435
South Africa	4,246,506	4,430,286	3,404,583	12,081,375

Source: South African Social Security Agency (2017) SOCPEN database – special request. Pretoria: SASSA.

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 alleviate income poverty and realise children’s right to social assistance, but is also associated with improved nutritional, health and education outcomes.⁵

Given the positive and cumulative effects of the grant, it is important that caregivers are able to access it for their children as

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 R920 per month from April 2017. 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. The relatively large value of the grant, compared to the CSG, is justified on the basis that the child is technically a ward of the state, and the state is therefore directly responsible for all the child’s needs. However, the FCG has increasingly been used to provide financial support to caregivers of children who are orphaned and has effectively been used as a poverty alleviation grant for orphans in kinship care. The appropriateness and effectiveness of this approach was questioned as far back as 2003, particularly in light of the fact that many children live with kin, whether or not their parents are alive.⁸

The number of FCGs remained stable for many years while foster care was applicable mainly to children in the traditional child protection system. Its rapid expansion since 2003 coincides with the rise in HIV-related orphaning and an implied policy change by the Department of Social Development, which from 2003 started encouraging family members (particularly grandmothers) caring for orphaned children to apply for foster care and the FCG. Over the following five years the number of FCGs increased by over 50,000 per year as orphans were brought into the foster care system. The increases were greatest in provinces with large numbers of orphaned children: the Eastern Cape, KwaZulu-Natal, Limpopo and Mpumalanga.

early as possible. One of the main concerns is the slow take-up for young children. An analysis of exclusions from the CSG found that exclusion rates for eligible infants under a year were as high as 43% in 2014, up only three percentage points from 47% in 2008. Exclusion rates were found to be highest in the Western Cape and Gauteng. The total rate of exclusion for all ages is 17.5% (over 1.8 million children).⁶ Barriers to up-take include confusion about eligibility requirements and the means test in particular; lack of documentation (mainly identity books or birth certificates, and proof of school enrolment, although the latter is not an eligibility requirement) and problems of institutional access (including the time and cost of reaching SASSA offices, long queues and lack of baby-friendly facilities). It is worth noting, however, that there has been improved up-take amongst children younger than two and children older than 15 and the infant up-take rate appears to have increased from 50% in 2011 to 57% in 2014.⁷

In 2016 and early 2017 there was widespread concern that grant payments would be disrupted when SASSA’s controversial contract with Cash Paymaster Services (CPS) came to an end in March 2017. The invalid contract with CPS could not be further extended without the Constitutional Court’s permission, an alternative service provider had not been appointed, and SASSA did not yet have the capacity to take over the payment system. Civil society approached the Constitutional Court for assistance to prevent a disruption in grant payments. As a result, the Constitutional Court ordered that CPS should continue paying grants until 31 March 2018 and imposed a supervisory order to enable the Court (assisted by an independent expert committee) to monitor SASSA’s progress towards appointing an alternative service provider or developing in-house capacity.

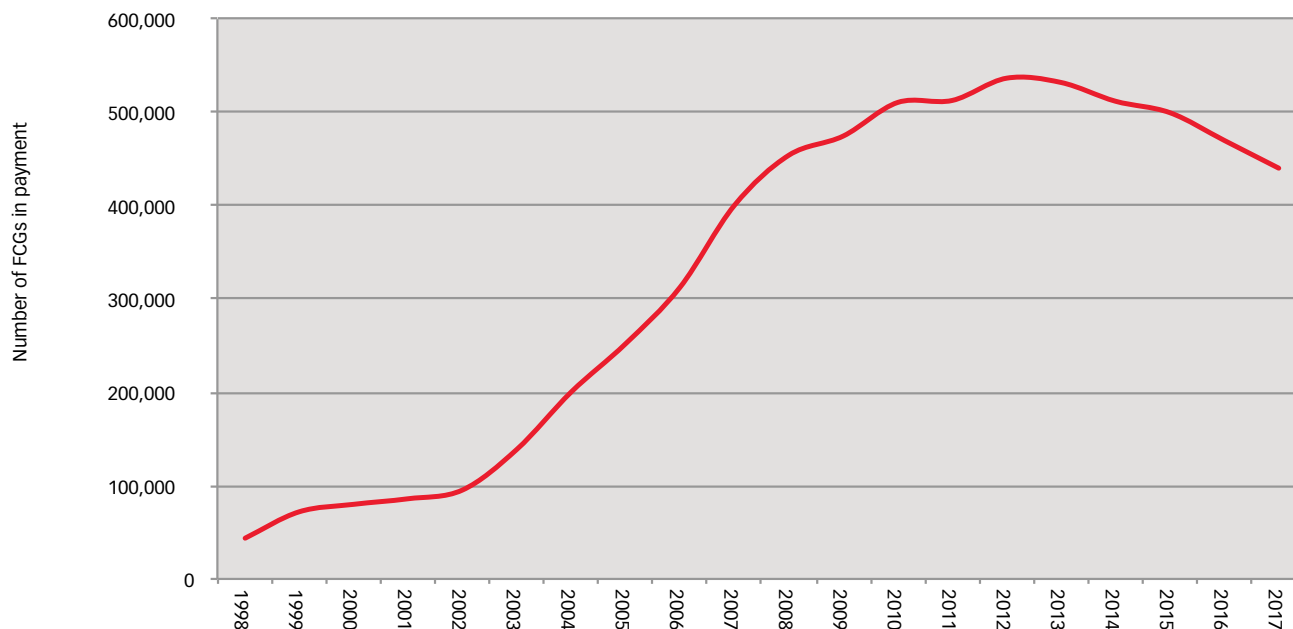
Table 2b: Children receiving the Foster Child Grant, by province, 2012 & 2017

Province	2012	2017	Difference	% difference
Eastern Cape	116,826	104,910	-11,916	-10%
Free State	43,311	33,195	-10,116	-23%
Gauteng	56,451	50,379	-6,072	-11%
KwaZulu-Natal	142,114	92,060	-50,054	-35%
Limpopo	56,066	47,921	-8,145	-15%
Mpumalanga	32,886	32,087	-799	-2%
North West	45,634	35,134	-10,500	-23%
Northern Cape	14,456	13,657	-799	-6%
Western Cape	29,003	30,945	1,942	7%
South Africa	536,747	440,288	-96,459	-18%

Source: South African Social Security Agency (2012; 2017) SOCPEN database – special request. Pretoria: SASSA.

However, by 2010 over 500,000 FCGs were in payment and the foster care system was struggling to keep pace with the numbers due to the required initial investigations and reports by social workers, court-ordered placements, and additional two-yearly social worker reviews and court-ordered extensions. SASSA is not allowed to pay the FCG without a valid court order or extension order, and over 110,000 FCGs lapsed between April 2009 and March 2011 because of backlogs in the extensions of court orders.⁹

Figure 2e: Children receiving the Foster Child Grant, 1998 – 2017



Source: South African Social Security Agency (2009 – 2017) SOCPEN database – special request. Pretoria: SASSA.

In 2011 a court-ordered settlement stipulated that the foster care court orders that had expired – or that were going to expire in the following two years – must be deemed to have been extended until 8 June 2013. This effectively placed a moratorium on the lapsing of these FCGs. As a temporary solution social workers could extend orders administratively until December 2014, by which date a comprehensive legal solution should have been found to prevent qualifying families from losing their grants in future.¹⁰ Yet no policy solution had been developed by the 2014 cut-off date. Instead the Department of Social Development sought (and received) an urgent court order extending the date to the end of 2017.

Since 2012 the number of FCGs has declined, and there has been a substantial increase in the number of grants that terminate at the end of each year, when children turn 18. At the end of 2014, 300,000 court orders had expired, representing over 60% of all foster care placements.¹¹ The grants remained in payment only because of the High Court order which prevented them from lapsing. In March 2017,

440,000 FCGs were paid each month to caregivers of children in foster care, substantially down from 2012 when 537,000 grants were in payment. The FCG is therefore now back to below 2008 levels. The most dramatic drop has been in KwaZulu-Natal, where the number of FCGs fell by 35%, from 142,000 to under 100,000.

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 high orphaning rates. The systemic problems which caused FCGs to lapse will be addressed through legislative amendment, which will need to clarify the eligibility criteria for foster care and the FCG. An option currently under consideration is to provide a larger CSG for orphaned children living with kin (colloquially called the “CSG top-up”). This would create inequalities in grant values between different categories of children living in the same levels of poverty, but may alleviate the pressure on welfare services caused by high foster care caseloads.¹²

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 disabilities who require permanent care or support services. 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. The child needs to undergo a medical assessment to determine eligibility and the parent must pass an income or "means" test.

Although the CDG targets children with 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 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.

It is not possible to calculate a take-up rate for the CDG because there is no reliable data on the number of children living with disabilities in South Africa, or who are in need of permanent care or support services. At the end of March 2017, 145,000 children were receiving the CDG, and from the beginning of April 2017, the grant was valued at R1,700 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 but very gradual increase in access to the CDG each year since 1998, when only 8,000 CDGs were disbursed.

Table 2c: Children receiving the Care Dependency Grant, by province, 2017

Province	Children
Eastern Cape	22,370
Free State	7,880
Gauteng	18,536
KwaZulu-Natal	39,871
Limpopo	14,968
Mpumalanga	10,995
North West	10,003
Northern Cape	5,987
Western Cape	14,342
South Africa	144,952

Source: South African Social Security Agency (2017) SOCPEN database – special request. Pretoria: SASSA.

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Child health

Updated by Katharine Hall (Children's Institute), Nadine Nannan (Burden of Disease Research Unit, Medical Research Council) and Winnie Sambu (Children's Institute, University of Cape Town)

Section 27 of the Constitution of South Africa 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".¹

Article 14(1) of the African Charter on the Rights and Welfare of the Child states that "every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health".²

Article 24 of the UN Convention on the Rights of a Child 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".³

The infant and under-five mortality rate

Nadine Nannan (Burden of Disease Research Unit, Medical Research Council)

The infant and under-five mortality rates are key indicators of health and development. They are associated with a broad range of bio-demographic, health and environmental factors which are not only important determinants of child health but are also informative about 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 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 a child dying between birth and the 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.

This information is ideally obtained from vital registration systems. However, like many middle- and lower-income countries the under-reporting of births and deaths renders the South African system inadequate for monitoring purposes. South Africa is therefore reliant on alternative methods, such as survey and census data, to measure child mortality. Despite several surveys which should have provided information to monitor progress, the lack of reliable data since 2000 led to considerable uncertainty around the level of childhood mortality for a prolonged period. However, the second South Africa National Burden of Disease Study has produced national and provincial infant and under-five mortality trends from 1997 up until 2012.¹

An alternative approach to monitor age-specific mortality nationally since 2009 is the rapid mortality surveillance system (RMS) based on the deaths recorded on the population register by the Department of Home Affairs.⁴ The RMS data have been recommended by the Health Data Advisory and Co-ordinating Committee because corrections have been made for known biases. In other words, the indicators shown in table 3a are nationally representative. The RMS

Table 3a: Child mortality indicators, rapid mortality surveillance 2012 – 2015

INDICATOR	2012	2013	2014	2015
Under-five mortality rate per 1,000 live births	41	41	40	37
Infant mortality rate per 1,000 live births	27	28	28	27
Neonatal mortality	12	11	12	12

Source: Dorrington RE, Bradshaw D, Laubscher R & Nannan N (2016) *Rapid Mortality Surveillance Report 2015*. Cape Town: Medical Research Council.

reports vital registration data adjusted for under-reporting which allow evaluation of annual trends. They suggest the IMR peaked in 2003 when it was 53 per 1,000 and decreased to 27 per 1,000 in 2015. During the same period the U5MR decreased from 81 per 1,000 to 37 per 1,000, which equates to a 10% annual rate of reduction up until 2011, with no further noteworthy decline since 2012.

The neonatal mortality rate (NMR) is the probability of dying within the first 28 days of life, per 1,000 live births. The NMR was 12 per 1,000 live births in 2015. Estimates of the NMR are derived directly from vital registration data (i.e. registered deaths and births without adjustment for incompleteness) up to 2013, and from 2013 onwards the estimates were derived directly from neonatal deaths and live births recorded in the District Health Information System for 2011 – 2014.

The South African Health and Demographic Survey also reports child mortality rates. After a long gap (since 2003) the SADHS was conducted in 2016. The full report and data will be released in 2018.

i These profiles can be seen at: www.mrc.ac.za/bod/reports.htm.

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 as the 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.

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.⁵ 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 medication.

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.⁶ 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. Physical inaccessibility can be related to distance, transport options and costs, or road infrastructure. Physical distance and poor roads also make it difficult for mobile clinics and emergency services to reach outlying areas. Within South Africa, patterns of health care utilisation are influenced by the distance to the health service provider: those who live further from their nearest health facility are less likely to use the facility. This "distance decay" is found even in the uptake of services that are required for all children, including immunisation and maintaining the clinic card (Road-to-Health book).⁷

Over a fifth (22%) of South Africa's children live far from the primary health care facility they normally use, and 94% attend the facility closest to their home. Within the poorest 40% of households, only 3% do not use their nearest facility, while 13% of children in upper quintile households (the richest 20%) travel beyond their nearest health facility to seek care. 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, inconvenient opening times, unavailable medicines or (in 5% of cases) rude staff.⁸

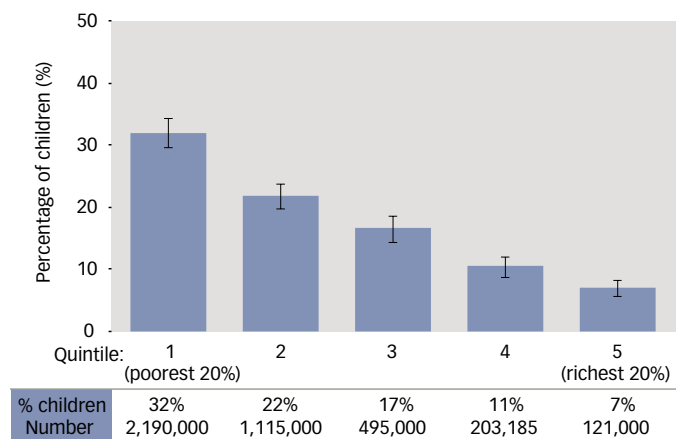
In total, 4.1 million children travel more than 30 minutes to reach their usual health-care service provider. This is a significant improvement since 2002, when 37% (or 6.9 million children) lived far from their nearest clinic.

It is encouraging that the greatest improvements in access have been made in provinces which performed worst in 2002: the Eastern Cape (where the proportion of children with poor access to health facilities dropped from 55% in 2002 to 34% in 2015), KwaZulu-Natal (down from 49% to 31%), Limpopo (from 43% to 24%) and North West (from 39% to 29%) over the 14-year period. Provinces with the highest rates of access are the largely metropolitan provinces of Gauteng (where only 8% of children live far from their usual health-care service) and the Western Cape (9%).

There are also significant differences between population groups. A quarter (25%) of African children travel far to reach a health-care facility, compared with between 5% and 10% of Indian, White and Coloured children. Racial inequalities are amplified by access to transport: if in need of medical attention, 87% of White children would be transported to their health facility in a private car, compared with only 10% of African children and 26% of Coloured children. Poor children bear the greatest burden of disease, due to undernutrition and poorer living conditions and access to services (water and sanitation). Yet health facilities are least accessible to the poor. Close to a third of children (32%) in the poorest 20% of households have to travel far to access health care, compared with 7% of children in the richest 20% of households.

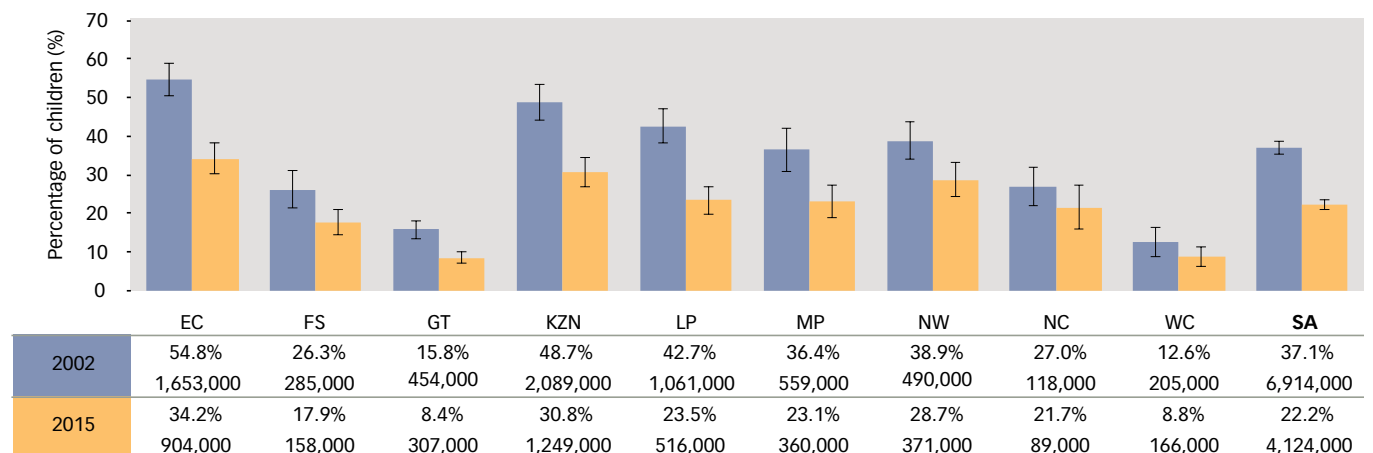
There are no significant differences in patterns of access to health facilities when comparing children of different sex and age groups.

Figure 3a: Children living far from their health facility, by income quintile, 2015



Source: Statistics South Africa (2016) *General Household Survey 2015*. Pretoria: Stats SA. Analysis by Katharine Hall & Winnie Sambu, Children's Institute, UCT.

Figure 3b: Children living far from their health facility, by province, 2002 & 2015



Source: Statistics South Africa (2003; 2016) *General Household Survey 2002; General Household Survey 2015*. Pretoria: Stats SA. Analysis by Katharine Hall & Winnie Sambu, Children's Institute, UCT.

Children living in households where there is reported child hunger

Section 28(1)(c) of the Bill of Rights in the Constitution gives every child the right to basic nutrition. The fulfilment of this right depends on children's 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 2.4 million children (13%) lived in households where child hunger was reported in 2015. There was a significant drop in reported child hunger, from 31% of children in 2002 to 16% in 2006. Since then the rate has remained fairly consistent, suggesting that despite the expansion of social grants, school feeding schemes and other efforts to combat hunger amongst children, many households remain vulnerable to food insecurity. South Africa therefore has some way to go if it is to achieve the Sustainable Development Goal target of ending hunger by 2030.⁹

There are large disparities between provinces and population groups. Provinces with relatively large numbers of children and high rates of child hunger are the Northern Cape (21%), KwaZulu-Natal (20%), North West (18%) and the Western Cape (16%). Together these provinces have over 1.4 million children living in households that report having insufficient food for children. The Eastern Cape has had the largest decrease between 2002 and 2015, with reported child hunger having reduced by 38 percentage points over the 14-year period from 49% to 11%. Limpopo has a large rural child population with high rates of unemployment and income poverty, yet child hunger has remained well below the national average, reported at 4% in 2015.

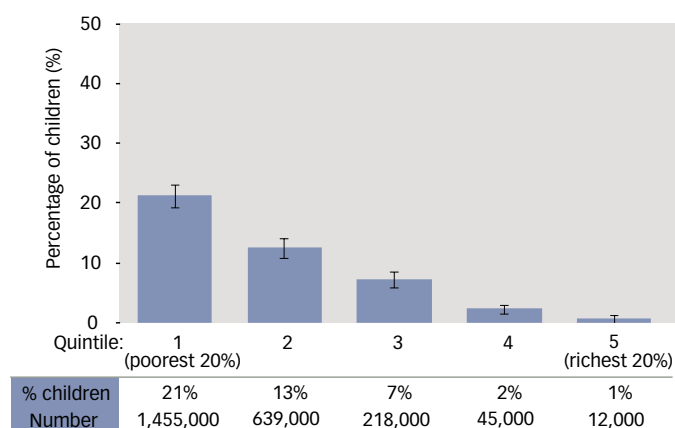
Hunger, like income poverty and household unemployment, is most likely to be found among African children. In 2015, some 2.2 million African children lived in households that reported child hunger. This equates to 14% of the total African child population. Eleven percent of Coloured children were reported to live in households where there was child hunger, while the hunger rates for Indian and White children were below 2%.

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: 21% of children in the poorest quintile go hungry sometimes, compared with less than 1% in the wealthiest quintile. The differences in child hunger rates across income quintiles are statistically significant.

There are no significant differences in reported child hunger across age groups. However, just over 800,000 children aged less than five years are reported to have experienced child hunger, signalling a risk of under-nutrition. Young children are particularly vulnerable. Inadequate food intake compromises children's growth, health and development, increases their risk of infection, and contributes to malnutrition and stunting.

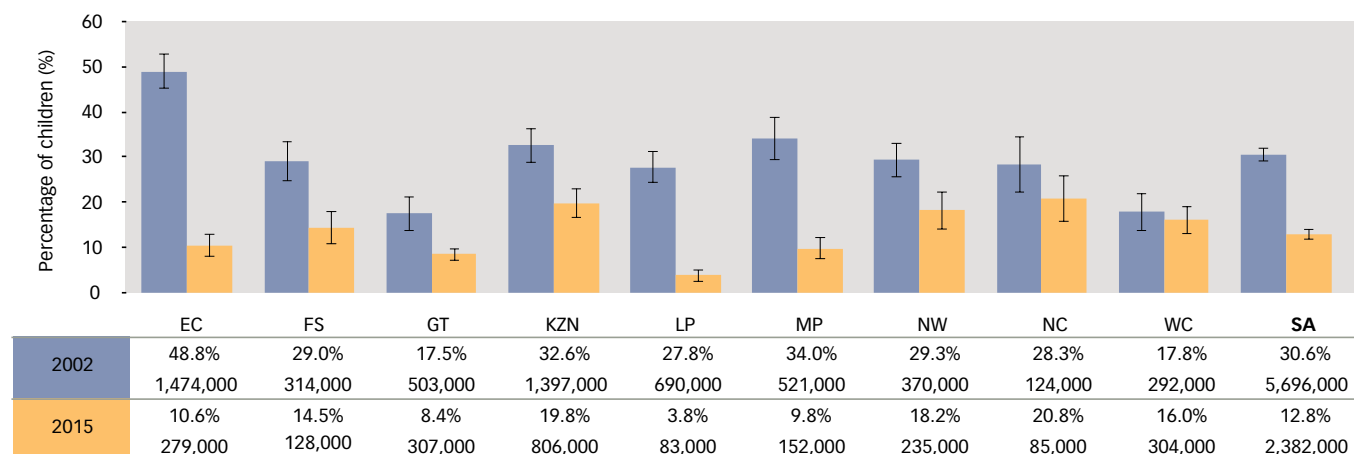
It should be remembered that this is a household-level variable, and so reflects children living in households where children are reported to go hungry often or sometimes; it does not reflect the allocation of food within households. The indicator also doesn't reflect the quality of food, including dietary diversity, which has been found to affect the nutritional status of children under five years.

Figure 3c: Children living in households where there is reported child hunger, by income quintile, 2015



Source: Statistics South Africa (2016) *General Household Survey 2015*. Pretoria: Stats SA. Analysis by Katharine Hall & Winnie Sambu, Children's Institute, UCT.

Figure 3d: Children living in households where there is reported child hunger, by province, 2002 & 2015



Source: Statistics South Africa (2003; 2016) *General Household Survey 2002; General Household Survey 2015*. Pretoria: Stats SA. Analysis by Katharine Hall & Winnie Sambu, Children's Institute, UCT.

Teenage pregnancy

This indicator shows the number and proportion of young women aged 15 – 24 who are reported to have given birth to a live child in the past year.

Teen pregnancy rates are difficult to calculate because it is hard to determine how many pregnancies end in miscarriage, stillbirth or abortion: these are not necessarily known to the respondent, or accurately reported. In the absence of reliable data on pregnancy, researchers tend to rely on child-bearing data (i.e. the percentage of women in an age group who have given birth to a live child).

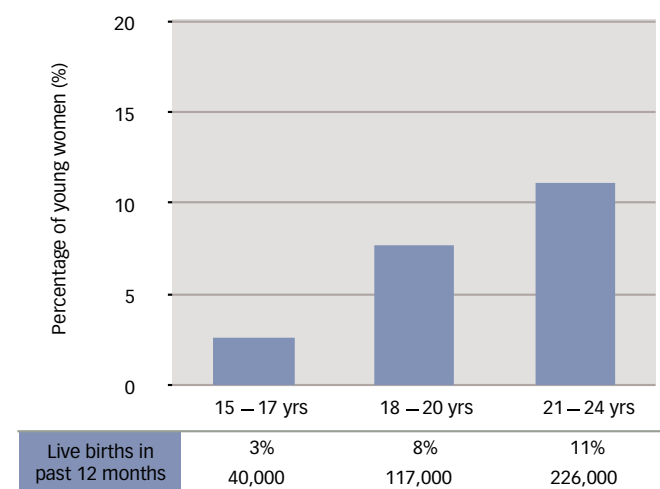
Despite widespread assumptions that teen pregnancy in South Africa is an escalating problem, the available data suggest that the percentage of teenage mothers is not increasing. A number of studies have suggested a levelling off and even a decrease in fertility rates among teenagers in South Africa.¹⁰ Teenage fertility rates declined after the 1996 Census, and Department of Health data between 2004 and 2013 showed no increase in the share of teenagers aged 15 – 19 who attended antenatal clinics.¹¹

Fertility rates are, of course, an indicator of possible exposure to HIV. HIV prevalence rates are higher among women in their late twenties and thirties, and lower among teenagers, and the prevalence rate in the 15 – 24-age group has decreased over the past 10 years. However, prevalence rates are still worryingly high: of the young pregnant women surveyed in antenatal clinics in 2013, 13% in the 15 – 19-age group and 24% of those aged 20 – 24 were HIV positive.¹² There is a strong association between early child-bearing and maternal mortality, and the majority of deaths in young mothers are caused by HIV.¹³ It is important that safe sexual behaviour is encouraged and practised.

Early child-bearing – particularly by teenagers and young women who have not completed school – has a significant impact on the education outcomes of both the mother and child, and is also associated with poorer child health and nutritional outcomes.¹⁴ For this reason it is important to delay child-bearing, and to ensure that teenagers who do fall pregnant are appropriately supported. This includes ensuring that young mothers can complete their education, and that they have access to parenting support programmes and health services. Although pregnancy is a major cause of school drop-out, some research has also suggested that teenage girls who are already falling behind at school are more likely to become pregnant than those who are progressing through school at the expected rate.¹⁵ So efforts to provide educational support for girls who are not coping at school may also help to reduce teenage pregnancies.

Poverty alleviation is important for both the mother and child, but take-up of the Child Support Grant among teenage mothers is low compared with older mothers.¹⁶ This suggests that greater effort should be made to assist young mothers to obtain birth certificates to apply for CSGs. Ideally, home affairs and social security services

Figure 3e: Child-bearing rate among young women aged 15 – 24 years, by age group, 2015



Source: Statistics South Africa (2016) *General Household Survey 2015*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

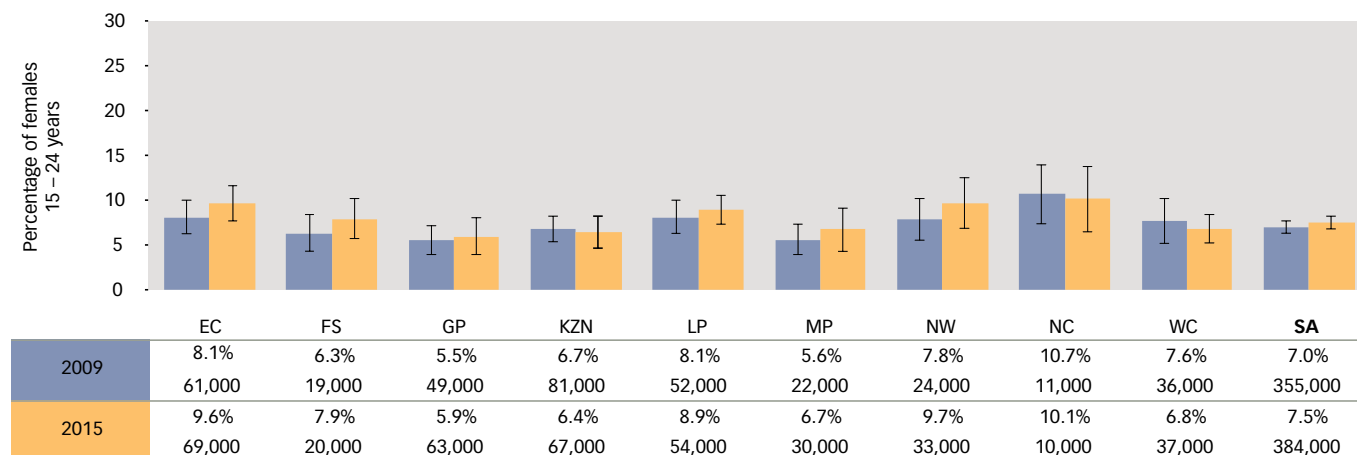
should form part of a comprehensive maternal support service at clinics and maternity hospitals.

Since 2009 the nationally representative General Household Survey (GHS) conducted by Statistics South Africa has included a question on pregnancy. The question asks the household respondent: "Has any female household member [between 12 – 50 years] been pregnant during the past 12 months?" For those reported to have been pregnant, a follow-up question asks about the current status of the pregnancy. This indicator calculates the number and proportion of young women who have given birth in the past year.

According to the GHS the national child-bearing rate for young women aged 15 – 24 was 7.5% in 2015. There has been no significant change in this rate since 2009 when the question was first asked, and the estimated number of young women giving birth in a year has remained fairly stable.

As would be expected, child-bearing rates increase with age. Less than three percent of girls aged 15 – 17 were reported to have given birth in the previous 12 months (representing 40,000 teenagers in this age group). Child-bearing rates rose to 8% among 18 – 20-year-olds (117,000 when weighted), and 11% in the 21 – 24 age group (226,000). These rates have also been stable over the seven-year period that the GHS has included this question.

Figure 3f: Annual child-bearing rates among young women aged 15 – 24 years, by province, 2009 & 2015



Source: Statistics South Africa (2010; 2016) *General Household Survey 2009; General Household Survey 2015*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

Malnutrition in children: stunting, wasting and underweight

Healthy growth in children is dependent on a number of factors, including adequate dietary intake, living conditions and health care practices. Poverty, inadequate care and feeding practices comprise children's dietary intake while unhealthy living conditions and associated infections further increase the risk of poor nutrition. The effects of poor nutrition are far reaching. Malnutrition has been found to undermine children's cognitive development¹⁷ affecting educational outcomes,¹⁸ causing a significant reduction in adult size and reducing work capacity. This can ultimately lead to lower wages and exacerbate poverty rates.¹⁹ Poor nutrition also contributes to increased health-care costs, as malnutrition in early childhood is associated with chronic diseases such as diabetes, cardiovascular disease and hypertension in adulthood.²⁰ It is therefore a drain on household resources and on the public health system.

Malnutrition is a key driver of child mortality globally and in South Africa.²¹ According to the Child Problem Identification Programme, 42% of children aged 1 – 5 years of age and 29.8% of infants who died in hospital between 2012 and 2013 were severely malnourished.²² In addition the leading causes of child deaths include diarrhoea and pneumonia,²³ diseases that cause poor health and increase the risk of under-nutrition.

The causes of malnutrition are complex. In a useful model, UNICEF differentiates between immediate, underlying and basic causes.²⁴ The immediate causes of malnutrition are inadequate dietary intake and disease, which are mutually reinforcing. Infections such as diarrhoea compromise food intake and contribute to malnutrition which further compromises children's immunity and increases the risk of infection.²⁵ Underlying causes of malnutrition include household food insecurity, inadequate care and feeding practices. Infection can occur as a result of insufficient or no breastfeeding, exposure to unhealthy environments and poor access to and utilisation of health services. On a macro scale, malnutrition can be attributed to basic or structural causes such as income inequality, unemployment and the deregulation of trade and increasing food prices.²⁶

Stunting

Stunting is defined as low height-for-age and is the most pronounced form of malnutrition. Stunting arises if a child's height-for-age measurement is less than two standard deviations from the globally accepted reference cut-off point. When the child's height-for-age measurement is less than three standard deviations from the globally accepted reference cut-off point, then the child suffers from severe stunting.

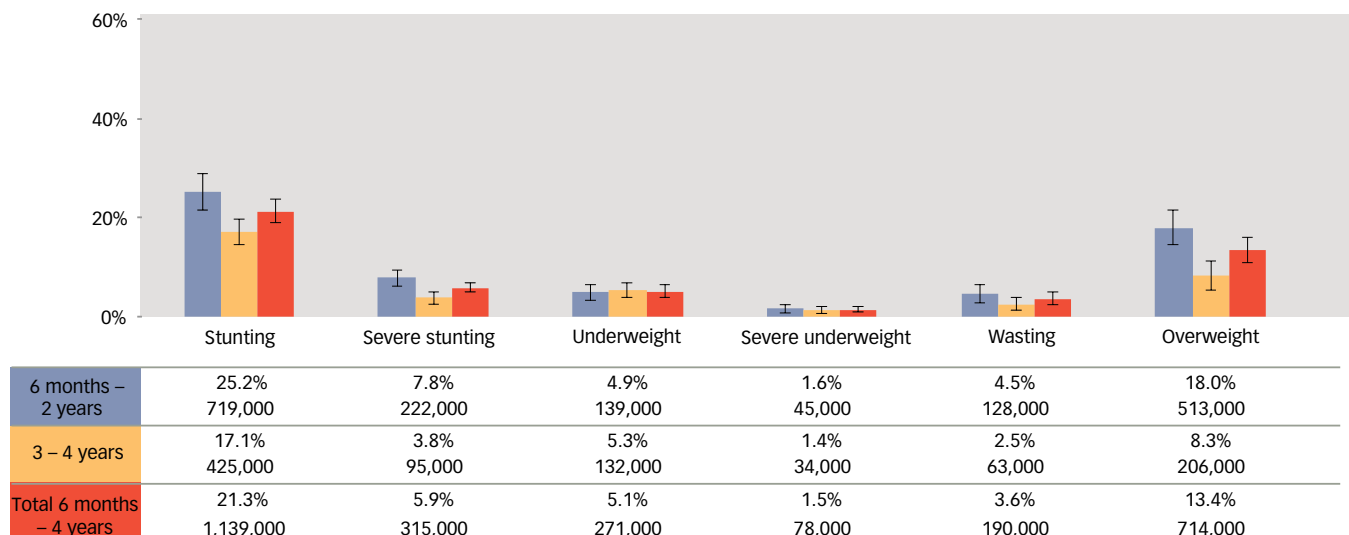
Stunting manifests over a long period, and is normally seen as an indicator of chronic undernutrition and failure to grow. Normally, a decrease in the stunting rates of a country is seen as an indicator of improvements in its socio-economic and health conditions.²⁷ Stunting is associated with poor socio-economic conditions, poor nutrition and increased risk of frequent and prolonged exposure to infectious diseases.²⁸ Poor children are at higher risk of being stunted, and if not addressed during childhood, stunting can persist into later life increasing the risk of intergenerational occurrence of malnutrition.³ Mothers who are short for age are more likely to give birth to infants with low birth weight, and their children are more likely to be stunted.²⁹ Research has also shown that stunting amongst pregnant women increases the risk of obstructed labour and birth asphyxia, thereby contributing to increased risk for perinatal mortality.³⁰

The National Income Dynamic Study (NIDS) is a panel survey that follows households over time, and collects anthropometric data for all children (0 – 17 years) unlike other surveys which focus on young children. The 1st wave of NIDS took place in 2008, while the most recent (wave 4) was conducted in 2014/15. An analysis of the anthropometric data from the 4th wave shows that 14% of children under 10 years were stunted, and, in line with other studies, stunting rates were highest amongst children aged under five years, with particularly high rates in the first two years of life. About 25% of children aged 6 months – 2 years were stunted, while 17% of 3 – 4-year-olds were stunted.

About 8% of children aged 6 months – 2 years were severely stunted. For younger children (below three years), low height-for-age is an indication of on-going failure to grow, while for older children it is an indication of children who have failed to grow in the past.³¹ Several factors may contribute to the high stunting rates amongst younger children (6 months – 2 years). Stunting could be a result of rapid growth coupled with inadequate dietary intake, including poor quality and quantity of complementary diets, and increased exposure to infection at this age.³² According to the 2016 South African Demographic Health Survey (SADHS), 77% of children aged 6 – 23 months are not fed a minimum acceptable diet, and a large proportion of children in this age group are not breastfed.³³ Due to lack of national data on dietary intake of older children, it is difficult to know the quantity and quality of diets consumed by children in other age groups.

Amongst children aged 6 months – 9 years, stunting is slightly higher among male children (16%) than females (13%) and higher in

Figure 3g: Malnutrition rates across early childhood age groups, 2014/15



Source: Southern Africa Labour and Development Research Unit (2016) *National Income Dynamics Study 2014 – 2015, Wave 4* [dataset]. Version 1.1. Cape Town: Southern Africa Labour and Development Research Unit [producer]. Cape Town: DataFirst [distributor]. Pretoria: Department of Planning Monitoring and Evaluation [commissioner]. Analysis by Winnie Sambu, Children's Institute, UCT.

rural areas than urban areas. Eighteen percent of children from rural formal areas (commercial farms) and 17% from the tribal authority areas (former homelands) are stunted, compared to 12% of those in urban areas. There are statistically significant differences in stunting across income levels. Stunting is lowest amongst children from relatively wealthy households (4%) compared to 18% of children from households in the poorest quintile.³⁴

Stunting rates have remained persistently high especially amongst young children.³⁵ Analysis of NIDS Wave 1 shows that 25% of children under five years were stunted. The recently released SADHS reported that stunting rates for children in the same age group was 27%.³⁶ The SADHS also reported very high stunting rates amongst poor households with children under five years: 36% of children living in the poorest wealth quintile are stunted, compared to 13% in the richest wealth quintile.

Underweight

A child is considered underweight if the child's weight-for-age measurement is less than two standard deviations from the globally accepted reference cut-off point, or three standard deviations in the case of severe underweight. Underweight is a composite indicator of both chronic (stunting) and acute malnutrition.³⁷

Data from NIDS Wave 4 show that nearly 6% of children 6 months – 9 years are underweight.³⁸ About 1.5% are severely underweight. No significant differences were observed across urban and rural areas, or amongst males and females. As in the case of stunting, the lowest underweight rates (2%) are found amongst children in relatively wealthy households, compared to 7% amongst children in the poorest 20% of households.

For children aged younger than 5 years (6 – 59 months), underweight rates were 5%. The 2016 SADHS found similar rates for children aged 0 – 59 months (6%). Underweight rates amongst children under five years have significantly reduced over the years and the World Health Organisation (WHO) no longer classifies it as a problem of public health significance.

Wasting

Wasting is also referred to as acute malnutrition, and is defined as low weight-for-height. A child whose weight-for-height measurement is less than two standard deviations from the globally accepted reference cut-off point is considered to be wasted. Severe wasting occurs when the child's weight-for-height measurement is less than three standard deviations from the globally accepted reference cut-off point. Wasting can change rapidly depending on the availability of food and the presence of illness, and is therefore a measure of acute (rather than chronic) malnutrition.³⁹ Due to significant and rapid weight loss, wasting increases the risk of an infant dying. Severe wasting, commonly referred to as severe acute malnutrition (SAM), is a life-threatening medical condition that requires immediate treatment and therapeutic foods.⁴⁰

South Africa's SAM case fatality rate decreased from 13.3% in 2011/2012 to 8.9% in 2015/2016.⁴¹ This means that 9% of all children under five years admitted with SAM, died of SAM (SAM was documented as cause of death).⁴² However, SAM case fatality rates are likely to be higher than reported as SAM is not always recorded on admission, and even if the child died of SAM, it will not be reflected as a SAM death if the admission diagnosis was, for example, diarrhoea. While the decline in SAM case fatality rates suggests that treatment of children diagnosed with SAM is improving, the WHO reports that case fatality rates can be reduced to less than 5% if their guidelines on SAM case management are properly implemented.⁴³ It is also important to note that malnutrition has a far greater impact on child mortality: 30% of all child deaths in facilities are associated with SAM, and a further 29% are underweight for age.

Analysis of the NIDS Wave 4 shows that 4% of children under five (6 – 59 months) were wasted, and 1% severely wasted. Wasting rates were highest in urban areas (6%) followed by the former homelands (2%). No statistically significant differences in wasting were found amongst male and female children. The SADHS reports that in 2016, 2.5% of children under five years suffered from wasting, and 1% were severely wasted. According to the WHO criteria, wasting is not a child health problem of public health significance.

Overweight

When a child's weight-for-height measurement is greater than two standard deviations from the globally acceptable reference cut-off, then that child is considered overweight. Obesity occurs when a child's weight-for-height measurement is greater than three standard deviations from the WHO Child Growth Standards median. The number and proportion of children suffering from overweight has been on the rise across the world. In Africa, the number of children aged under five years who were overweight increased by 50% between 2000 and 2016.⁴⁴ The risk factors associated with childhood overweight and obesity include poor quality diets, displaced breastfeeding with increased intake of sugary beverages and consumption of large portion sizes, and a lack of physical activity.⁴⁵ Socio-cultural factors such as household feeding practices also increase the risk of a child being overweight.⁴⁶ Children who are overweight or obese are more likely to remain obese in adulthood, and are at greater risk of non-communicable diseases in childhood and adulthood than those whose weight is within normal healthy limits.

Analysis of NIDS Wave 4 shows that 13% of children under five (6 – 59 months) were overweight. Higher rates were observed in the first two years of life, where 18% of children were overweight, compared to 8% amongst 3 – 4-year-olds. No significant differences were observed across gender, or in urban and rural areas. Similar results were seen in the 2016 SADHS which reported that 13% of children 0 – 59 months were overweight.

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Children's access to education

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Section 29(1)(a) of the South African Constitution 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".¹

Article 11(3)(a) of the African Charter on the Rights and Welfare of the Child 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".²

Article 28 of the UN Convention on the Rights of the Child recognises "the right of the child to education" and also obliges the state to "make primary education compulsory and available free to all".³

Children attending an educational institution

This indicator shows the number and percentage of children aged 7 – 17 years who are reported to be attending a school or educational facility. It is different from "enrolment rate", which reflects the number of children enrolled in educational institutions, as reported by schools to the national Department of Basic Education 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.

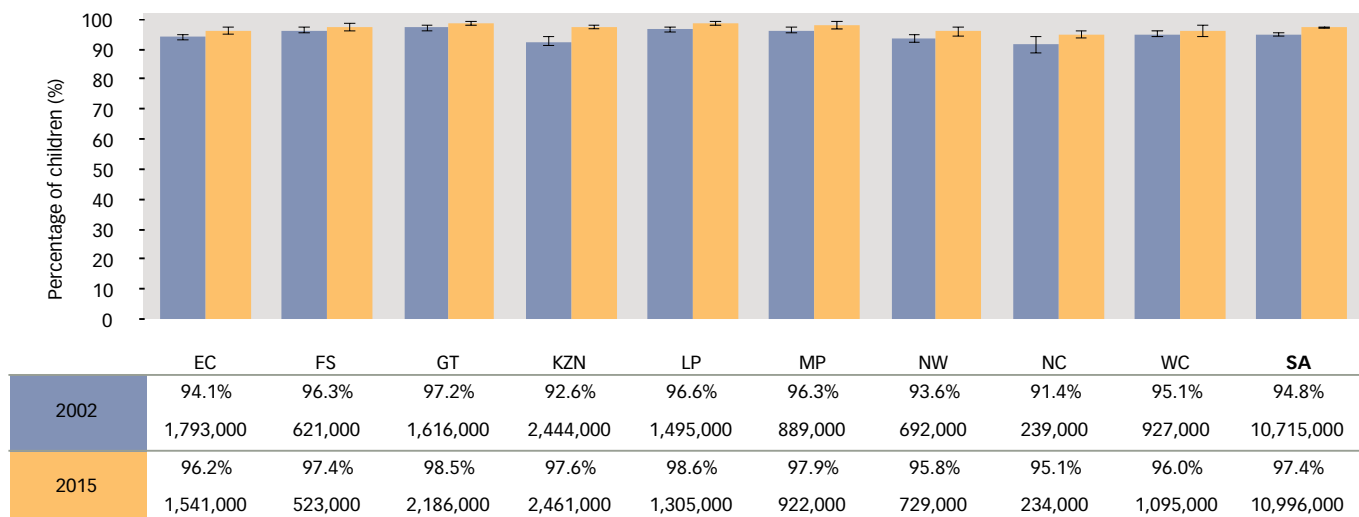
South Africa has high levels of school enrolment and attendance. Amongst children of school-going age (7 – 17 years), the vast majority (97%, or 11 million children) attended some form of educational facility in 2015. Since 2002, the national attendance rate has increased slightly. The is due mainly to a small but real increase in reported attendance rates for African and Coloured children over the 14-year period. Of a total of 11.3 million children aged 7 – 17 years, 300,000 were reported as not attending school in 2015. Attendance rates for Coloured children remained slightly below the national average in 2015, at 95%. At a provincial level, the Northern Cape and KwaZulu-Natal have

seen significant increases in attendance rates. In the Northern Cape, attendance increased by four percentage points from 91% in 2002 to 95% in 2015. In KwaZulu-Natal, the attendance increased from 93% in 2002 to 98% in 2015.

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 around 99% of children in each age year from seven to 14 are reported to be attending an educational institution, the attendance rate drops to 97% for 15-year-olds. Schooling is compulsory only until the age of 15 or the end of grade 9, and the attendance rate decreases more steeply from age 16 onwards, with 94% of 16-year-olds, 90% of 17-year-olds, and 80% of 18-year-olds reported to be attending school (based on those who have not successfully completed grade 12).⁴ No statistically significant differences exist in reported school attendance rates between boys and girls.

Amongst children of school-going age who are not attending school the main set of reasons for non-attendance relate to financial constraints. These include the cost of schooling (13%), or the opportunity costs of education, where children have family commitments such as child minding (5%) or are needed to work in a family business or elsewhere to support household income (5%). The second most common set of reasons is related to perceived learner

Figure 4a: School-age children (7 – 17-year-olds) attending an educational institution, by province, 2002 & 2015



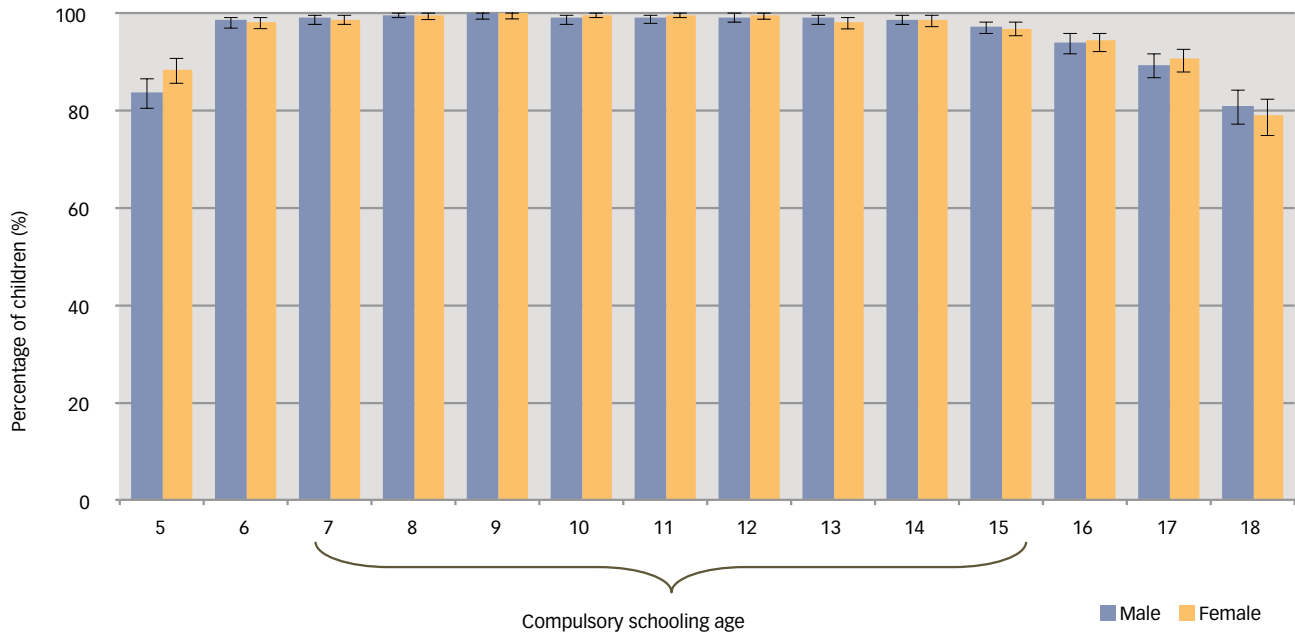
Source: Statistics South Africa (2003, 2016) *General Household Survey 2002; General Household Survey 2015*. Pretoria: Stats SA. Analysis by Katharine Hall & Winnie Sambu, Children's Institute, UCT.

or education system failures, such as a perception that “education is useless” (11%), feeling unable to perform at school (8%), or exam failure (5%). Other reasons for drop-out are illness (4%) and disability (11%). Pregnancy accounts for around 11% of drop-out amongst teenage girls not attending school (or 5% of all non-attendance).⁵ Another 5% were not in school because they were not accepted for enrolment, signifying barriers to institutional access.

There is little variation in school attendance rates across the bottom four income quintiles, where school attendance rates are between 96% and 98%. Children in the wealthiest 20% of households are most likely to be attending school (99%).

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 their mother – are less likely to enrol in school and are more prone to dropping out or progressing more slowly than their more advantaged peers. Racial inequalities in school advancement remain strong.⁶ Similarly, school attendance rates tell us nothing about the quality of teaching and learning.⁷

Figure 4b: Reported attendance at an educational institution, by age and sex, 2015



Source: Statistics South Africa (2016) *General Household Survey 2015*. Pretoria: Stats SA. Analysis by Katharine Hall & Winnie Sambu, Children’s Institute, UCT.

Access to early childhood learning programmes

This indicator shows the number and percentage of children aged 5 – 6 years who are reported to be attending an early childhood development (ECD) programme or educational institution – in other words, those attending out-of-home care and learning centres including ECD centres, pre-grade R, grade R or grade 1 in ordinary schools. While all these facilities provide care and stimulation for early learning for young children, the emphasis on providing learning opportunities through structured learning programmes differs by facility type.

Educational inequalities are strongly associated with structural socio-economic (and therefore also racial) inequalities in South Africa.⁸ These inequalities are evident from the early years, even before entry into primary school. They are exacerbated by a very unequal schooling system,⁹ and are difficult to reverse. But early inequalities can be reduced through pre-school exposure to developmentally appropriate activities and programmes that stimulate cognitive development.¹⁰ Provided that they are of good quality, early learning programmes are an important mechanism to interrupt the cycle of inequality by reducing socio-economic differences in learning potential between children before they enter the foundation phase of schooling.

The Five-year Strategic Plan¹¹ of the Department of Basic Education (DBE) includes a broad goal to improve the quality of ECD provisioning and specifically to improve access to grade R through the supply of learning materials and improving the quality of grade R educators. Evidence suggests that quality group learning programmes are beneficial for cognitive development from about three years of age¹² and the National Development Plan (NDP) priorities, cited in the DBE's Strategic Plan, include universal access to two years of early childhood development programmes. The DBE funds and monitors thousands of community-based grade R centres in addition to the school-based grade R classes. The NDP proposes the introduction of a second year of pre-school education, and that both years be made universally accessible to children.¹³ It therefore makes sense to monitor enrolment in early learning programmes of children in the 5 – 6-year pre-school age group.

In 2015, there were 288,212 learners attending 4,058 ECD centres in South Africa, according to the DBE's administrative data.¹⁴ The number of learners in the ECD centres rose by 7% between 2013 and

2014 and then declined slightly again. The DBE snap survey counts another 827,200 learners attending grade R or pre-grade R at primary schools, of whom 93% were at public (government schools) while 7%, or 55,000, were at independent schools.¹⁵

In 2015, 92% of children (1.9 million) in the pre-school age group (5 – 6-year-olds) were reported to be attending some kind of educational institution, mostly in grade 0 or grade 1. This was an increase of 38 percentage points since 2002, when 1.1 million were reported to be attending an educational institution.

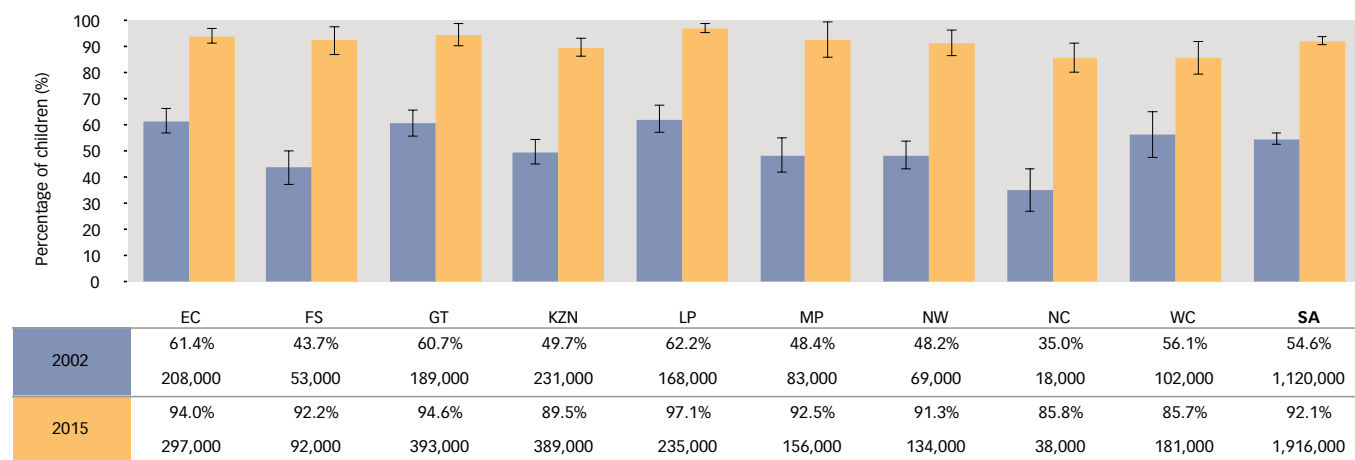
Attendance rates are high across all provinces. The highest attendance rates in 2015 were in Limpopo (97%), Gauteng (95%) and the Eastern Cape (94%), while the lowest rates were in the Western and Northern Cape (both at 86%). This pattern differs from many other indicators, where the Western Cape usually out-performs the poorer and more rural provinces like the Eastern Cape and Limpopo. Similar patterns were found in analyses of the 2007 Community Survey and the 2008 National Income Dynamics Study data.¹⁶

Given the inequities in South Africa, it is pleasing to see that there are no substantial racial differences in access to educational institutions by African and White children of pre-school age, although levels of attendance among Coloured children remain slightly below the national average, at 87%. It is also encouraging that, as with formal school attendance, there are no strong differences in pre-school enrolment across the income quintiles. There are also no significant gender differences in access to pre-school.

As with the indicator that monitors school attendance, it should be remembered that this indicator tells us nothing about the quality of care and education that young children receive. High rates of attendance provide a unique opportunity because almost all children in an age cohort can be reached at a particularly important developmental stage; but this is a lost opportunity if the service is of poor quality.

Note: Prior to 2009, enrolment in crèches, playgroups and ECD centres would have been under-reported as the survey only asked about attendance at "educational institutions". More specific questions about ECD facilities were introduced in the 2009 survey, and are likely to have resulted in higher response rates. (For a more detailed technical explanation, see www.childrencount.uct.ac.za).

Figure 4c: Children aged 5 – 6 years attending school or ECD facility, by province, 2002 & 2015



Source: Statistics South Africa (2003; 2016) *General Household Survey 2002*; *General Household Survey 2015*. Pretoria: Stats SA. Analysis by Katharine Hall and Winnie Sambu, Children's Institute, UCT.

Children living far from school

This indicator reflects the distance from a child's household to the school s/he attends. Distance is measured as the length of time travelled to reach school. The school the child attends is defined as "far" if a child has 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 a necessary condition for achieving the right to education. A school's location and distance from home can pose a barrier to education. Access to schools is also hampered by poor roads, transport that is unavailable or unaffordable, 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 who do not have schools near to their homes, the cost, risk and effort of getting to school can influence decisions about regular attendance, as well as participation in extramural activities and after-school events. Those who travel long distances to reach school 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 make it difficult to attend school regularly.

Over two-thirds (68%) of South Africa's learners walk to school, while 9% use public transport. Only 2% report using school buses or transport provided by schools or the government. The majority (77%) of White children are driven to school in private cars, compared with only 14% of African children.¹⁷ These figures illustrate pronounced disparity in child mobility and means of access to school.

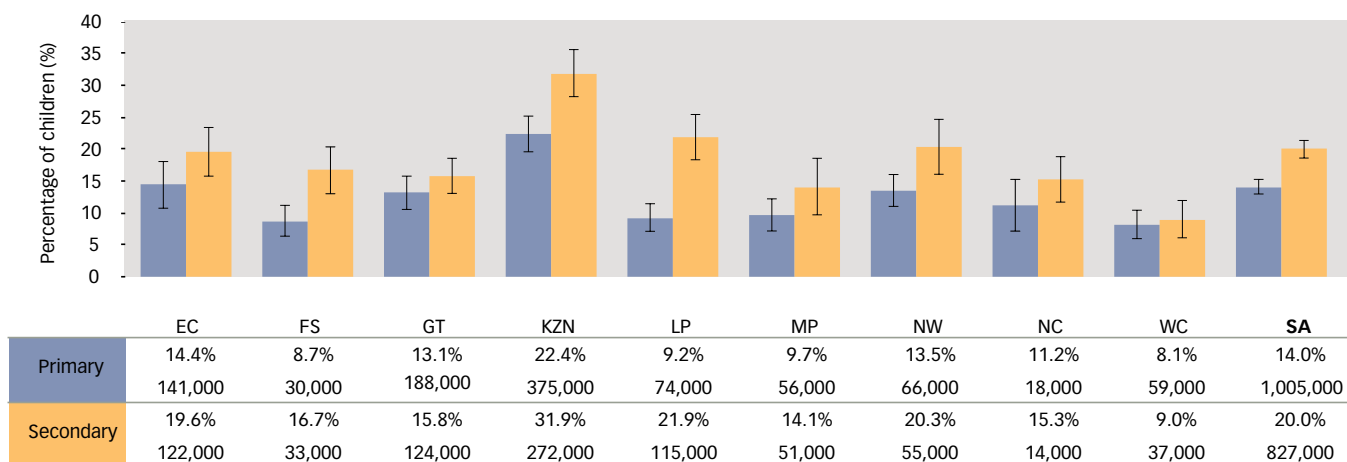
Assuming that schools primarily serve the children living in communities around them, the ideal indicator to measure physical access to school would be the distance from the child's household to the nearest school. This analysis is no longer possible due to question

changes in the General Household Survey. Instead, the indicator shows the number and percentage 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. Eighty-three percent of school-going children attend their nearest school. School-age children not attending school are therefore excluded from the analysis.

Overall, the vast majority (84%) of the 11 million children who attend school travel less than 30 minutes to reach school. Children of secondary school age are more likely than primary school learners to travel far to reach school. In mid-2015 there were over seven million children of primary school age (7 – 13 years) in South Africa. Over a million of these children (14%) travel more than 30 minutes to and from school every day. In KwaZulu-Natal this proportion is significantly higher than the national average, at 22%. Of the 4.1 million children of secondary school age (14 – 17 years), 20% travel more than 30 minutes to reach school, and again it is children in KwaZulu-Natal who are most likely to travel far (32%). The majority of these children come from poor households: 24% of secondary school age children in the poorest 20% of households travel far to school, compared to 15% of children in the richest 20% of households.

Physical access to school remains a problem for many children in South Africa, particularly those living in more remote areas where public transport to schools is lacking or inadequate and where households are unable to afford private transport for children to get to school.¹⁸ There are nearly 26,000 schools in South Africa, of which 24,000 are public and 2,000 are independent.¹⁹ A number of rural schools have closed since 2002, meaning that children in these areas may find it more difficult to access school. Nationally, the number of public schools has dropped by 10% (2,584 schools) between 2002 and 2015, with the largest decreases in the Free State, North West and Limpopo. Over the same period, the number of independent schools in the country has risen by 628 (54%).²⁰

Figure 4d: School-aged children living far from school, by province, 2015



Source: Statistics South Africa (2003; 2016) *General Household Survey 2002; General Household Survey 2015*. Pretoria: Stats SA. Analysis by Katharine Hall & Winnie Sambu, Children's Institute, UCT.

Children's progress through 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.²¹ Despite measures to address the inherited inequities in the education system through revisions to the legislative and policy frameworks, and to the school funding norms, continued disparities in the quality of education offered by schools reinforce existing socio-economic inequalities, limiting the future work opportunities and life chances of children who are born into poor households.²²

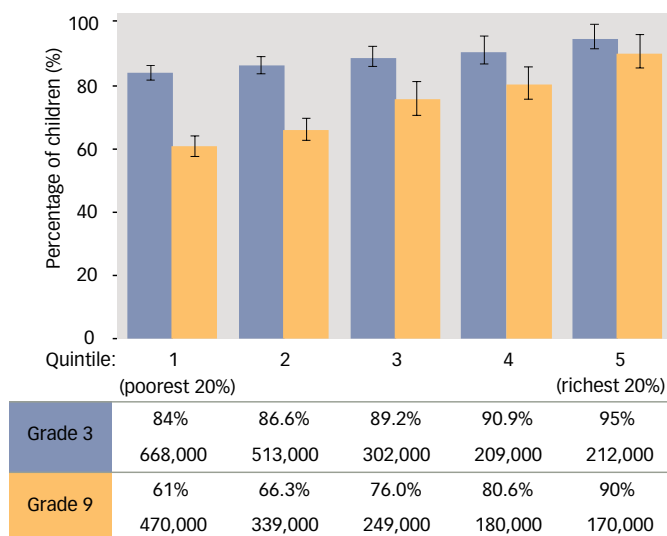
We have already seen that school attendance rates are very high during the compulsory schooling phase (grade 1 – 9). However, attendance tells us little about the quality of education that children receive, or their progress through the education system.

South Africa has poor educational outcomes by international standards and even within Africa,²³ and high rates of grade repetition have been recorded in numerous studies. For example, a study of children's progress at school found that only about 44% of young adults (aged 21 – 29) had matriculated, and of these less than half had matriculated "on time".²⁴ In South Africa, the labour market returns to education only start kicking in on successful completion of matric, not before. However it is important to monitor progress and grade repetition in the earlier grades as slow progress at school is a strong determinant of school drop-out.²⁵

Assuming that children are enrolled in primary school at the prescribed age (by the year in which they turn seven) and assuming that they do not repeat a grade or drop out of school, they would be expected to have completed the foundation phase (grade 3) by the year that they turn nine, and the general education phase (grade 9) by the year they turn 15.

This indicator allows a little more leeway: it measures the number and proportion of children aged 10 and 11 years who have completed a minimum of grade 3, and the proportion of those aged 16 and 17 years who have completed a minimum of grade 9. In other words, it allows for the older cohort in each group to have repeated one grade, or more if they started school in the year before they turned seven.

Figure 4e: Completion of grade 3 (10 – 11-year-olds) and grade 9 (16 – 17-year-olds), by income quintile, 2015

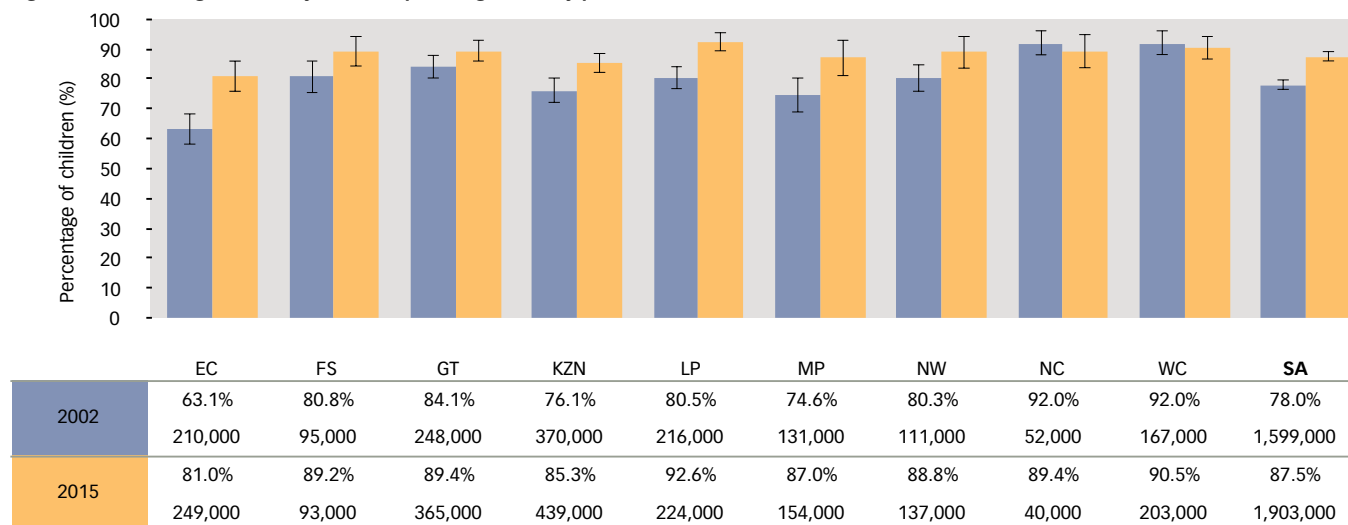


Source: Statistics South Africa (2016) *General Household Survey 2015*. Pretoria: Stats SA. Analysis by Katharine Hall & Winnie Sambu, Children's Institute, UCT.

In 2015, 87% of all children aged 10 and 11 were reported to have completed grade 3. This was up from 78% in 2002. This improvement in progress through the foundation phase was evident across most of the provinces, with significant advances in the Eastern Cape (from 63% to 81%), KwaZulu-Natal (from 76% to 85%) and Mpumalanga (from 75% to 87%). These improvements have narrowed the gap between provinces: most provinces record a progression rate of over 85% and the lowest performing province is the Eastern Cape – at 81%.

As would be expected, the rate of progression through the entire general education and training band (grades 1 – 9) is lower, as there

Figure 4f: Children aged 10 – 11 years who passed grade 3, by province, 2002 & 2015



Source: Statistics South Africa (2003; 2016) *General Household Survey 2002; General Household Survey 2015*. Pretoria: Stats SA. Analysis by Katharine Hall & Winnie Sambu, Children's Institute, UCT.

is more time for children to have repeated or dropped out by grade 9. Seventy percent of children aged 16 – 17 years had completed grade 9 in 2015. This represents an overall improvement of 21 percentage points over the 14-year period, from 48% in 2002. Provincial variation is slightly more pronounced than for progress through the foundation phase: Gauteng had the highest rate of grade 9 progression (85%), followed by the Western Cape (76%). Progress was poorest in the Northern and Eastern Cape, where around half (50% and 54% respectively) of children had completed grade 9 by the expected age.

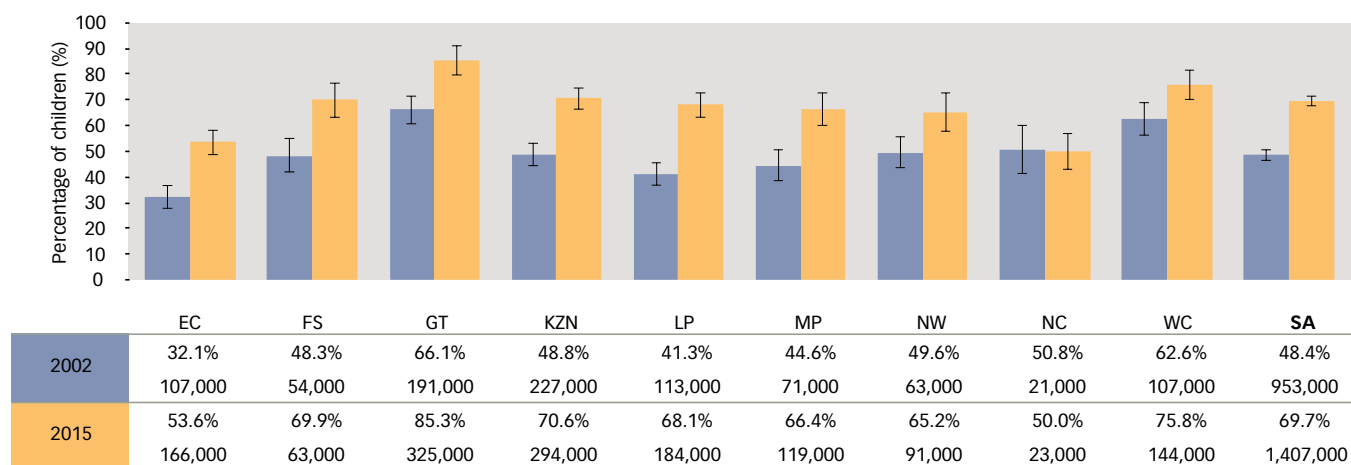
As found in other analyses of transitions through school,²⁶ educational attainment (measured by progress through school) varies along economic and racial lines. These differences become more pronounced as children advance through the grades. Gender differences in school progression, on the other hand, have remained consistent and even widened over the years: girls are more likely than boys to progress through school at the expected rate, and the difference becomes more pronounced in the higher grades. In 2015, 91% of girls aged 10 – 11 had completed grade 3, compared with 84% of boys; in the same year, 76% of 16 – 17-year-old girls had completed grade 9, compared with only 64% of boys in the same age cohort. This finding is consistent with analyses elsewhere.²⁷

There are significant differences in grade completion across income quintiles, especially for grade 9: in 2015, 61% of 16 – 17-year-olds in the poorest 20% of households completed grade 9, compared to 90% in the richest 20% of households.

Of course, grade progression and grade repetition are not easy to interpret. Prior to grade 12, the promotion of a child to the next grade is based mainly on the assessment of teachers, so the measure may be confounded by the extent of the teacher’s competence to assess the performance of the child. Analyses of the determinants of school progress and drop-out point to a range of factors, many of which are interrelated: there is huge variation in the quality of education offered by schools. These differences largely reflect the historic organisation of schools into racially defined and inequitably resourced education departments.

Household-level characteristics and family background also account for some of the variation in grade progression. For example, the level of education achieved by a child’s mother explains some of the difference in whether children are enrolled at an appropriate age and whether they go on to complete matric successfully.²⁸ This in turn suggests that improved educational outcomes for children will have a cumulative positive effect for each subsequent generation.

Figure 4g: Children aged 16 – 17 years who passed grade 9, by province, 2002 & 2015



Source: Statistics South Africa (2003; 2016) *General Household Survey 2002; General Household Survey 2015*. Pretoria: Stats SA. Analysis by Katharine Hall & Winnie Sambu, Children’s Institute, UCT.

Youth not in employment, education or training (NEETs)

“NEETs” is a term used to describe young people who are Not in Employment, Education or Training. The definition used here includes youth aged 15 – 24 who are not attending any educational institution and who are not employed or self-employed.²⁹

Widespread concerns about the large numbers of youth in this situation centre on two main issues: the perpetuation of poverty and inequality, including intergenerational poverty; and the possible implications of a large “idle” youth population for risk behaviour, social cohesion and the safety of communities.

Little is known about what NEETs actually do with their time. Young people who are neither learning nor engaged in income-generating activities may nevertheless be “productive” within their households, for example by helping maintain the home or look after children and others in need of care. However, in the absence of income, NEETs remain dependent on the earnings of other household members, and on grants that are directed to children and the elderly. The Old Age Pension in particular has been found to support job-seeking activities for young people³⁰ and it has been argued that this unvisited expenditure of the grant could be addressed by extending social security to unemployed youth³¹.

The large number of NEETs in South Africa is linked to underlying problems in the education system and the labour market. Young people in South Africa have very high participation rates in education, including at secondary level. But less than half successfully complete grade 12, and this reduces prospects for further study or employment.³² Low quality and incomplete education represent what are termed the “supply-side” drivers of youth unemployment, where young people do not have the appropriate skills or work-related capabilities to be employable or to set up successful enterprises of their own, and so struggle to make the transition from education to work.³³ The “demand-side” driver relates to a shortage of jobs or self-employment opportunities for those who are available to work.

In 2015 there were just over 10 million young people aged 15 – 24 in South Africa. Of these, 32% (3.3 million) were neither working nor enrolled in any education institution such as a school, university or college. The number of young people nationally who are

not in education, training or employment has remained remarkably consistent over the last decade, but has increased over the two decades since 1996 when only two million NEETs were recorded.³⁴ South Africa has made no progress towards what is now an explicit target of the Sustainable Development Goals, namely to substantially reduce the proportion of youth not in employment, education or training by 2020.³⁵

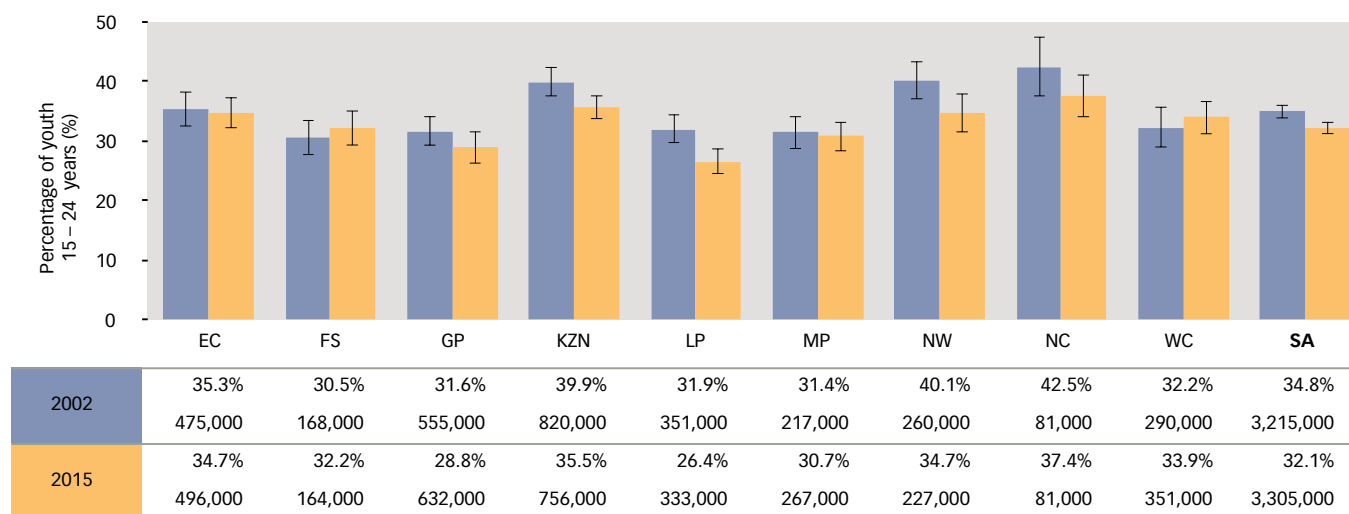
The NEET rates are fairly even across the provinces. This is hard to interpret without further analysis. Limpopo, for example, is a very poor and largely rural province. It is possible that the slightly lower-than-average proportion of NEETs in that province is partly the result of many young people migrating to cities in search of work and they are therefore counted among the NEETs in more urban provinces. It is possible that young people who are not employed in the labour market may nevertheless be employed in small-scale agriculture if their household has access to land, and this could also help to smooth the provincial inequalities that are characteristic of many other indicators.

The number and share of NEETs in KwaZulu-Natal and Limpopo have declined between 2002 and 2015. Again, this could be related to changing levels of productive activity, or to youth migration. While the proportion of NEETs has not changed substantially in Gauteng or the Western Cape, the actual number of NEETs in those provinces has increased substantially, by nearly 80,000 in Gauteng and by over 60,000 in the Western Cape. This is the result of a growing young urban population.

There is enormous variation within the broad youth group of 15 – 24 years. Only 6% of children aged 15 – 17 are classified as NEET because the vast majority are attending school. Within the 18 – 20 age band, 33% are NEETs, and half (51%) of those in the 21 – 24 age band are neither working nor in education.

While education attendance rates are fairly even for boys and girls, the gender disparity among NEETs is more pronounced. Thirty-six percent of young women are not in employment, education or training – compared with 29% of young men.

Figure 4h: Youth (15 – 24 years) not in employment, education or training (NEETs), by province, 2002 & 2015



Source: Statistics South Africa (2003; 2016) *General Household Survey 2002*; *General Household Survey 2015*. Pretoria: Stats SA. Analysis by Katharine Hall & Winnie Sambu, Children’s Institute, UCT.

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Children's access to housing

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

Section 26 of the Constitution of South Africa provides that "everyone has the right to have access to adequate housing", and section 28(1)(c) gives children "the right to ... shelter".¹

Article 27 of the UN Convention on the Rights of the Child 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".²

Distribution of children living in urban and rural areas

This indicator describes the number and proportion of children living in urban and 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 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 that 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 and adults in urban and non-urban households. Nearly half of South Africa's children (44%) lived in rural households in 2015 – equivalent to 8.2 million children. Looking back over a decade, there seems to be a slight shift in the distribution of children towards urban areas: in 2002, 47% of children were found in urban households, and this increased to 56% by 2015. A consistent pattern over the years is that children are more likely than adults to live in rural areas: In 2015, 68% of the adult population was urban, compared with 56% of children.

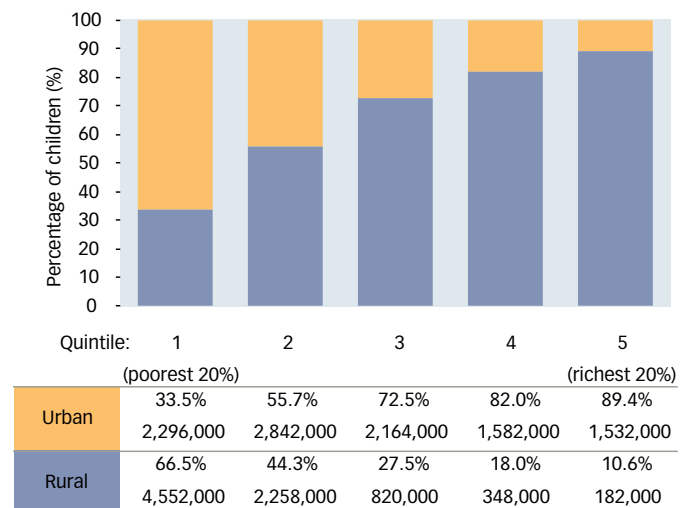
There are marked provincial differences in the rural and urban distribution of the child population. This is related to the distribution of cities in South Africa, and the legacy of apartheid's spatial arrangements where women, children and older people in particular were relegated to the former homelands. The Eastern Cape, KwaZulu-Natal and Limpopo provinces alone are home to about three-quarters (73%) of all rural children in South Africa. KwaZulu-Natal has the largest child population in numeric terms, with 2.5 million (62%) of its child population being classified as rural. The province with the highest proportion of rural children is Limpopo, where only 16% of children live in urban areas. Proportionately more children (40%) live in the former homelands, compared with adults (28%). Over 99% of children living in the former homeland areas are African.

Children living in the Gauteng and Western Cape are almost entirely urban based (97% and 95% respectively). These provinces historically

have large urban populations. The greatest provincial increase in the urban child population has been in the Free State, where the share of children living in urban areas increased from 66% of the child population in 2002 to 85% in 2015. The Eastern Cape shows signs of urbanisation too, with the urban child population increasing by 50% since 2002.

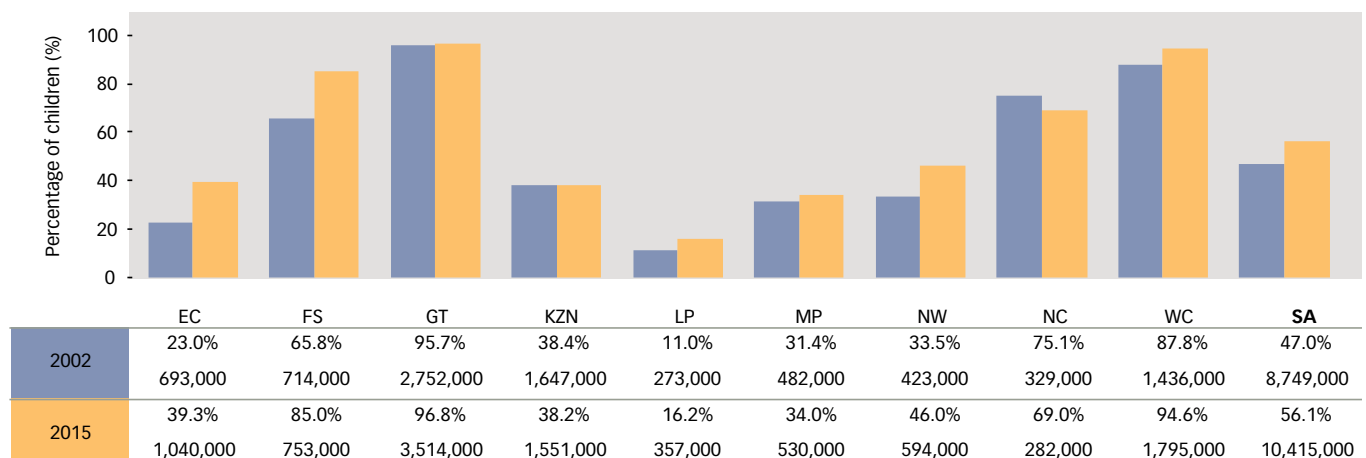
Rural areas, and particularly the former homelands, are known to have much poorer populations. Two-thirds of children in the poorest income quintile live in rural areas compared with 11% in the richest quintile. The inequalities also remain strongly racialised. Over 90% of White, Coloured and Indian children are urban, compared with 49% of African children. There are no statistically significant differences in child population in urban and rural areas across age groups.

Figure 5a: Children living in urban areas, by income quintile, 2015



Source: Statistics South Africa (2016) *General Household Survey 2015*. Pretoria: Stats SA. Analysis by Katharine Hall & Winnie Sambu, Children's Institute, UCT.

Figure 5b: Children living in urban areas, by province, 2015



Source: Statistics South Africa (2003; 2016) *General Household Survey 2002; General Household Survey 2015*. Pretoria: Stats SA. Analysis by Katharine Hall & Winnie Sambu, Children's Institute, UCT.

Children living in formal, informal and traditional 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 provided they are built with sturdy materials. “Informal” housing consists of: informal dwellings or shacks in backyards or informal settlements; dwellings or houses/flats/rooms in backyards built of iron, wood or other non-durable materials; caravans or tents. “Traditional dwelling” is defined as a “traditional dwelling/hut/structure made of traditional materials” situated in a rural area. 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 seven elements of adequate housing identified by the UN Committee on Economic, Social and Cultural Rights is that it 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 cannot necessarily be assumed to be 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

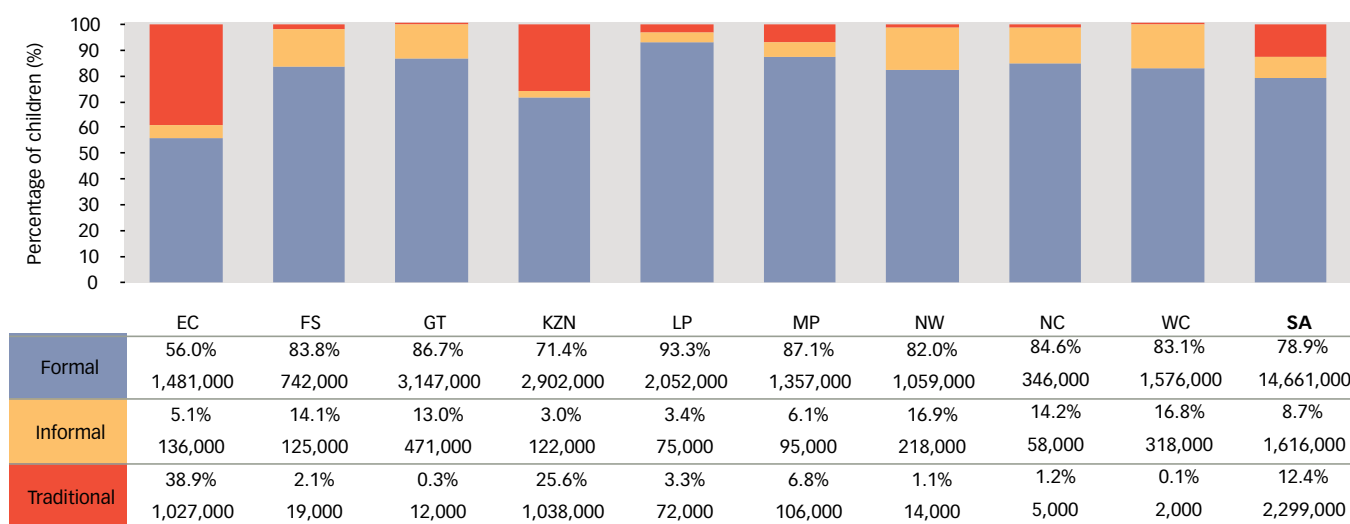
also more likely to live closer to facilities like schools, libraries, clinics and hospitals than those living in informal settlements or rural areas. Children living in informal settlements are more exposed to hazards such as shack fires and paraffin poisoning.

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: 40% of children in informal housing are in the 0 – 5-year age group. Of children aged two and under, 11% live in informal dwellings, after which the rate declines slightly with age. Given that this trend has remained consistent over a number of years, it seems likely that it is the result of child mobility or changing housing arrangements for children as they get older, rather than indicating an increase in informality over time.

In 2015, over 1.6 million children (9%) in South Africa lived in backyard dwellings or shacks in informal settlements. The number of children in informal housing has declined slightly from 2.3 million (12%) in 2002. The provinces with the highest shares of informally housed children are North West (17%), Western Cape (17%), Free State (14%) and Gauteng (13%). Limpopo has the lowest share (3%) of children in informal housing and the highest proportion (93%) in formal dwellings.

The Eastern Cape and KwaZulu-Natal have by far the largest shares of children living in traditional dwellings (39% and 26% respectively). The distribution of children in formal, informal and traditional dwellings has remained fairly constant since 2002. But racial inequalities persist. Almost all White children (99.8%) live in formal housing, compared with only 76% of African children. Access to formal housing increases with income. Ninety-nine percent of children in the wealthiest 20% of households live in formal dwellings, compared with just over two-thirds (70%) of children in the poorest income quintile.

Figure 5c: Children living in formal, informal and traditional housing, by province, 2015



Source: Statistics South Africa (2016) *General Household Survey 2015*. Pretoria: Stats SA. Analysis by Katharine Hall & Winnie Sambu, Children’s Institute, UCT.

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, and young children are particularly susceptible to the spread of disease. Overcrowding also places children at greater risk of sexual abuse, especially where boys and girls have to share beds, or children have to share with adults.

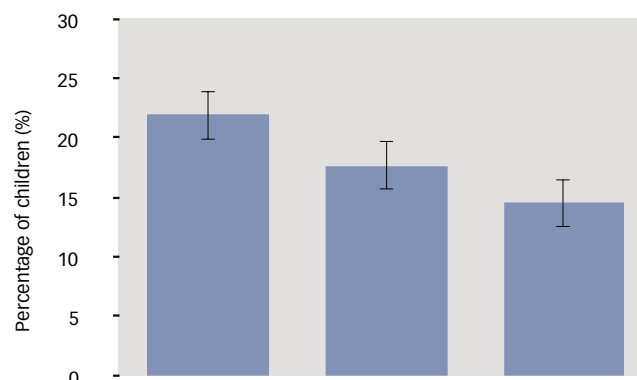
Overcrowding makes it difficult to target services and programmes to households effectively – for instance, urban households are entitled to six kilolitres of free water, but this household-level allocation discriminates against overcrowded households because it does not take account of household size.

In 2015, 3.4 million children lived in overcrowded households. This represents 18% of the child population – much higher than the proportion of adults living in crowded conditions (10%). Overcrowding is associated with housing type: 59% of children who stay in informal dwellings also live in overcrowded conditions, compared with 24% of children in traditional dwellings and 12% of children in formal housing.

Young children are significantly more likely than older children to live in overcrowded conditions. Twenty-two percent of children below six years live in crowded households, compared to 18% of children aged 6 – 11, and 15% of children over 12 years.

There is a strong racial bias in children’s housing conditions. While 19% of African and 21% of Coloured children live in crowded conditions, very few White and Indian children (less than one percent) live in overcrowded households. Children in the poorest 20% of

Figure 5d: Children living in overcrowded households, by income quintile, 2015



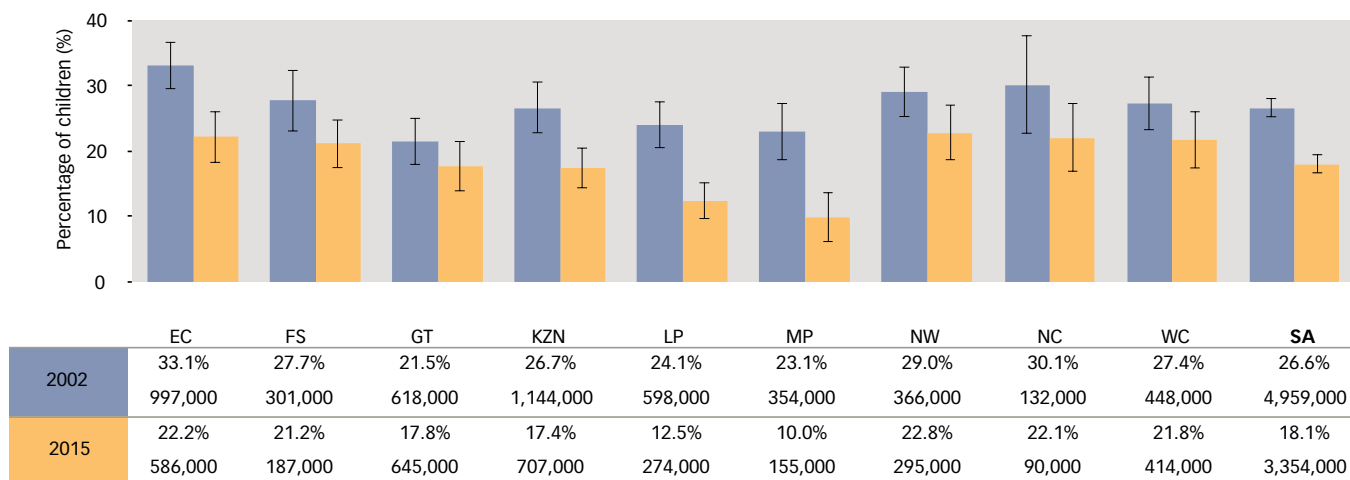
	0 – 5 yrs	6 – 11 yrs	12 – 17 yrs
% children	21.9%	17.6%	14.5%
Number	1,364,267	1,116,457	872,932

Source: Statistics South Africa (2016) *General Household Survey 2015*. Pretoria: Stats SA. Analysis by Katharine Hall & Winnie Sambu, Children’s Institute, UCT.

households are more likely to be living in overcrowded conditions (23%) than children in the richest 20% of households (1%).

The average household size has gradually decreased from 4.5 at the time of the 1996 population census, to around 3.4 in 2015, indicating a trend towards smaller households, which may in turn be linked to the provision of small subsidy houses and the splitting of households into smaller units. Households in which children live are larger than the national average. The mean household size for adult-only households is 1.7, while the mean household size for households with children is 4.9.⁶

Figure 5e: Children living in overcrowded households, 2002 & 2015, by province



Source: Statistics South Africa (2003; 2016) *General Household Survey 2002; General Household Survey 2015*. Pretoria: Stats SA. Analysis by Katharine Hall & Winnie Sambu, Children’s Institute, UCT.

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- 3 Office of the United Nations High Commissioner for Human Rights (1991) *The Right to Adequate Housing (Art.11 (1)): 13/12/91. CESCR General Comment 4*. Geneva: United Nations.
- 4 See no. 3 above.
- 5 See no. 3 above.
- 6 K Hall analysis of General Household Survey 2015, Children’s Institute, UCT.

Children's access to services

Katharine Hall and Winnie Sambu (Children's Institute, University of Cape Town)

Section 27(1)(b) of the Constitution of South Africa 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".¹

Article 14(2)(c) of the African Charter on the Rights and Welfare of the Child obliges the state to "ensure the provision of ... safe drinking water".²

Article 24(1)(c) of the UN Convention on the Rights of the Child 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".³

Children's access to basic water

This indicator shows the number and proportion of children who have access to piped 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 whether 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 "reasonable access" to water as being a minimum of 20 litres per person per day.⁴ The 20-litre minimum is linked to the estimated average consumption when people rely on communal facilities and need to carry their own water for drinking, cooking and the most basic personal hygiene. It does not allow for bathing, showering, washing clothes or any domestic cleaning.⁵ The 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 Africa,⁶ and intermittent outbreaks of cholera in some provinces pose a serious threat to children in those areas. Lack of access to adequate water is closely related to poor sanitation and hygiene. In addition, children may be responsible for fetching and carrying water to their homes from communal taps, or rivers and streams. Carrying water is a physical burden which can lead to back problems or injury from falls. It can also reduce time spent on education and other activities, and can place children at personal risk.⁷ For purposes of the child-centred indicator, therefore, adequacy is limited to a safe water source on site.

Close to six million children live in households that do not have access to clean drinking water on site. In 2015, over three-quarters (77%) of adults lived in households with drinking water on site – a significantly higher proportion than children (68%). A year-on-year comparison from 2002 – 2015 suggests that there has been little improvement in children's access to water over this period overall.

Provincial differences are striking. Over 90% of children in the Free State, Gauteng and the Western Cape provinces have an adequate water connection. However, access to water remains poor in KwaZulu-Natal (57%), Limpopo (50%) and the Eastern Cape (40%). The Eastern Cape appears to have experienced a striking improvement in water provisioning since 2002 (when only 23% of children had water on site). KwaZulu-Natal and the Free State have also recorded significant improvements: the proportion of children who had water

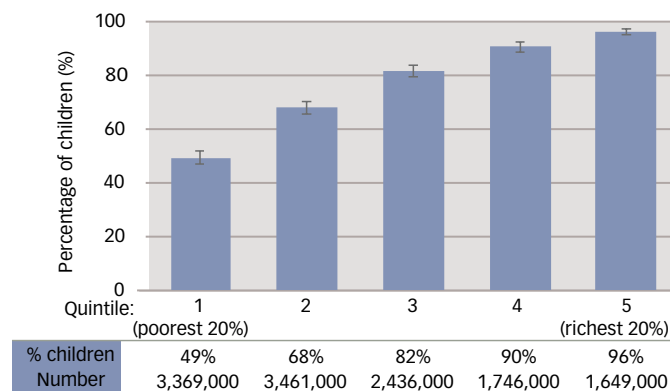
on site increased from 45% (2002) to 57% (2015) in KwaZulu-Natal, and from 81% to 93% in the Free State over the same period. The significant decline in access to water in the Northern Cape may represent a deterioration in water access, or may be the result of weighting a very small child population.

Children living in formal areas are more likely to have services on site than those living in informal settlements or in the rural former homelands. While the majority (77%) of children in formal dwellings have access, it decreases to 55% for children living in informal dwellings. Only 20% of children living in traditional housing have water available on the property.

The vast majority of children living in traditional dwellings are African, so there is also a pronounced racial inequality in access to water. Sixty-three percent of African children had water on site in 2015, while over 97% of all other population groups had drinking water at home. There are no significant differences in access to water across age groups.

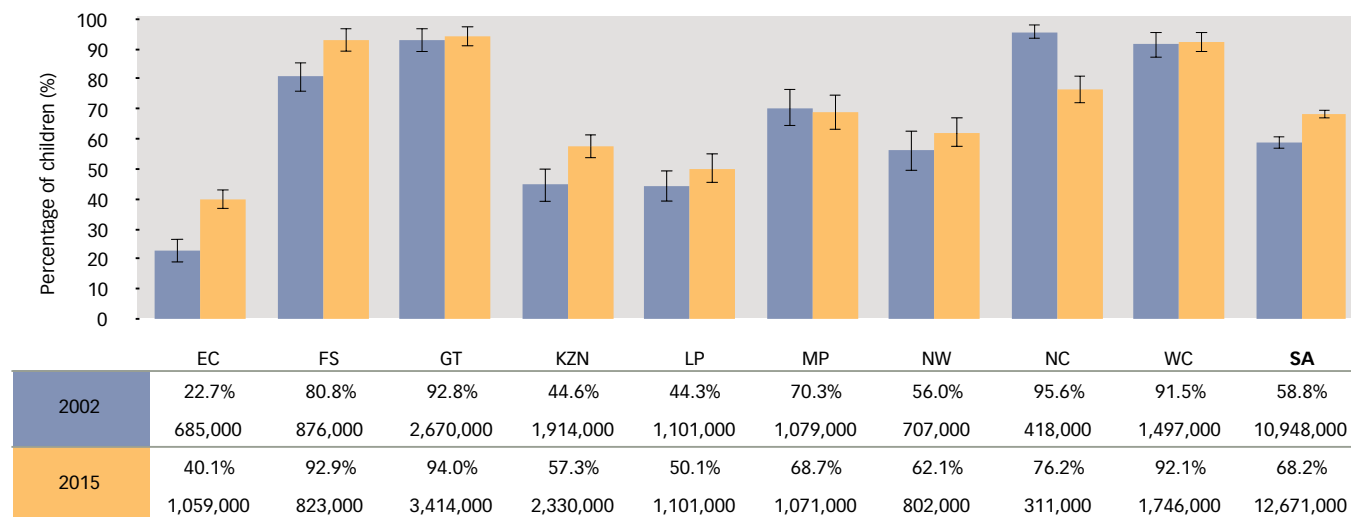
Inequality in access to safe water is also pronounced when the data are disaggregated by income category. Amongst children in the poorest 20% of households, only 49% have access to water on site, while 96% of those in the richest 20% of households have this level of service. In this way, inequalities are reinforced: the poorest children are most at risk of diseases associated with poor water quality, and the associated setbacks in their development.

Figure 6a: Children living in households with water on site, by income quintile, 2015



Source: Statistics South Africa (2016) *General Household Survey 2015*. Pretoria: Stats SA. Analysis by Katharine Hall & Winnie Sambu, Children's Institute, UCT.

Figure 6b: Children living in households with water on site, by province, 2002 & 2015



Source: Statistics South Africa (2003; 2016) *General Household Survey 2002; General Household Survey 2015*. Pretoria: Stats SA. Analysis by Katharine Hall & Winnie Sambu, Children's Institute, UCT.

Children's access to basic sanitation

This indicator shows 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 was 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".⁸

Adequate sanitation prevents 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 health and 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 compromise water quality in the area and to contribute to the spread of disease. Poor sanitation undermines children's health, safety and dignity.

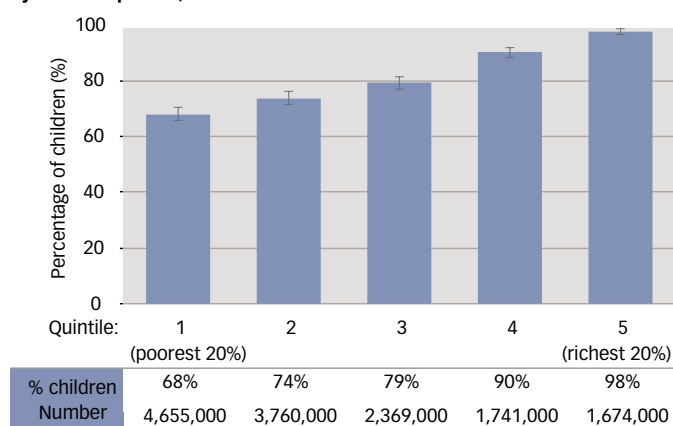
The data show a gradual and significant improvement in children's access to sanitation over the 14-year period 2002 – 2015, although the proportion of children without adequate toilet facilities remains worryingly high. In 2002 less than half of all children (45%) had access to adequate sanitation. By 2015 the share of children with adequate toilets had risen by 31 percentage points to 76%. But 4.4 million children still use unventilated pit latrines or buckets, despite the state's reiterated goals to provide adequate sanitation to all, and to

eradicate the bucket system. Children (24%) are slightly more likely than adults (20%) to live in households without adequate sanitation facilities.

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. Those with the greatest improvements in sanitation services are the Eastern Cape (where the number of children with access to adequate sanitation more than tripled from 0.6 million to 2.2 million over 14 years), KwaZulu-Natal (an increase of over 1.5 million children) and the Free State (where the share of children with sanitation improved from 51% in 2002 to 81% in 2015).

Although there have also been significant improvements in sanitation provision in Limpopo, this province still lags behind, with only 52% of children living in households with adequate sanitation in 2015. 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

Figure 6c: Children living in households with basic sanitation, by income quintile, 2015



Source: Statistics South Africa (2016) *General Household Survey 2015*. Pretoria: Stats SA. Analysis by Katharine Hall & Winnie Sambu, Children's Institute, UCT.

those in the UN-HABITAT and South Africa's National Housing Code include a minimum quality for basic services, including sanitation.

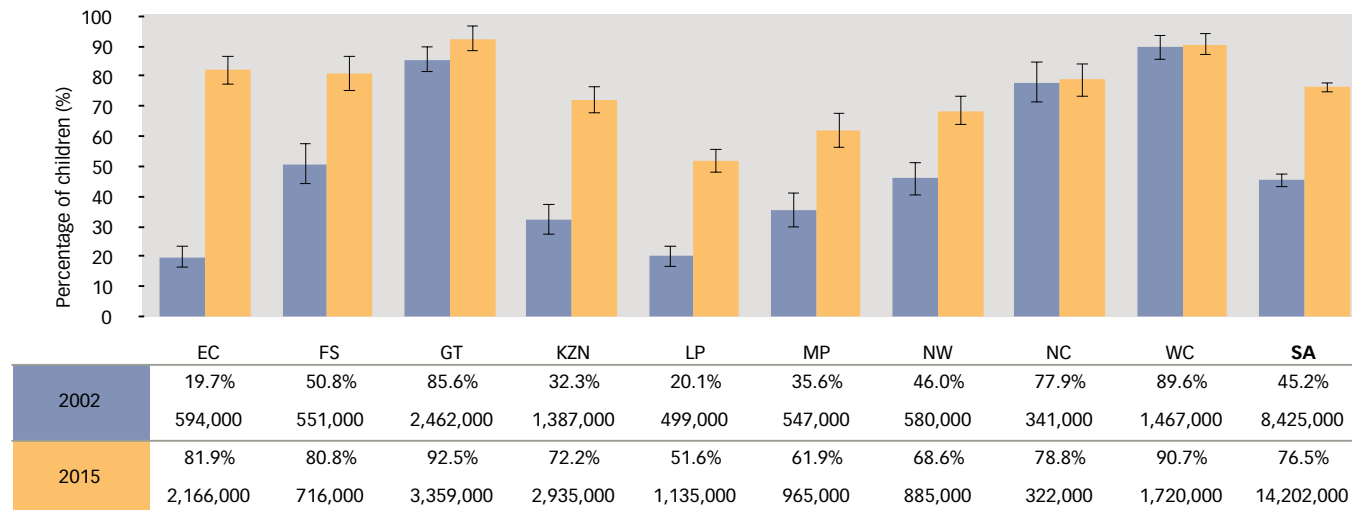
The statistics on basic sanitation provide yet another example of persistent racial inequality: over 90% of Indian, White and Coloured children had access to adequate toilets in 2015, while only 73% of African children had access to basic sanitation. This is a marked improvement from 36% of African children in 2002.

Children in relatively well-off households have better levels of

access to sanitation than poorer children. Amongst the richest 20% of households, 98% of children have adequate sanitation, while only 68% of children in the poorest 20% of households have this level of service.

Due to the different distributions of children and adults across the country, adults are more likely than children to have access to sanitation. However, there are no significant age differences in levels of access to adequate sanitation within the child population.

Figure 6d: Children living in households with basic sanitation, by province, 2002 & 2015



Source: Statistics South Africa (2003; 2016) *General Household Survey 2002; General Household Survey 2015*. Pretoria: Stats SA. Analysis by Katharine Hall & Winnie Sambu, 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 approximately 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 2015 GHS was based on a master sample that was designed in 2013 as a general purpose sampling frame to be used for all Stats SA household-based surveys. The same master sample is shared by the GHS, the Quarterly Labour Force Survey, the Living Conditions Survey and the Income and Expenditure Survey. The 2013 master sample is based on information collected during the 2011 population census. The previous master sample for the GHS was used for the first time in 2008, and the one before that in 2004. These again differed from the master sample used in the first two years of the GHS: 2002 and 2003. Thus there have been four different sampling frames during the 14-year history of the annual GHS, with the changes occurring in 2004, 2008 and 2013. 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.

Weights

Person and household weights are provided by Stats SA and are applied in Children Count analyses to give estimates at the provincial and national levels. The GHS weights are derived from Stats SA's mid-year population estimates. The population estimates are based on a model that is revised from time to time when it is possible to calibrate the population model to larger population surveys (such as the Community Survey) or to census data.

In 2013, Stats SA revised the demographic model to produce a new series of mid-year population estimates. The 2013 model drew on the 2011 census (along with vital registration, antenatal and other administrative data) but was a "smoothed" model which did not mimic the unusual shape of the age distribution found in the census. The results of the 2011 census were initially questioned because it seemed to over-count children in the 0–4 age group and under-count children in the 4–14-year group.

The 2013 model was used to adjust the benchmarking for all previous GHS data sets, which were re-released with the revised population weights by Stats SA, and was still used to calculate weights for the GHS up to and including 2015, even though it is now known that the mid-year population estimates on which the weights are based are incorrect.² All the Children Count indicators were re-analysed retrospectively, using the revised weights provided by Stats SA, based on the 2013 model. The estimates are therefore comparable over the period 2002 to 2015. The revised weights particularly affected estimates for the years 2002–2007.

Users may find that the baseline estimates reported here are different from those reported in issues of the *South African Child*

Gauge prior to 2016. The revised indicators for all the intervening years are available on the website: www.childrencount.uct.ac.za.

It is now thought that the fertility rates recorded in the 2011 population census may have been an accurate reflection of recent trends, with an unexplained upswing in fertility around 2009 after which fertility rates declined gradually. Similar patterns were found in the vital registration data as more births were reported retrospectively to the Department of Home Affairs, and in administrative data from schools, compiled by the Department of Basic Education. In effect, this means that there may be more children in South Africa than appear from the analyses presented here, where we have applied weights based on a model that it is now known to be inaccurate.

Reporting error

Error may be present due to the methodology used, i.e. 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).

National Income Dynamics Study³

NIDS is the first national panel survey to be conducted in South Africa. The baseline survey, or first "wave" of data collection, was undertaken in 2008, with subsequent waves planned at intervals of two years. In the first wave, data were obtained for every member of each sampled household, and these individuals became the permanent sample members or panel – even if they were children or babies. Subsequent waves endeavour to return not only to the original households, but also to each original household member, even if members have moved out of the household. So far, four waves of data collection have collected in 2008, 2010, 2012 and 2014/2015. The advantage of a panel survey is that it enables longitudinal analysis of the variables or outcomes under study, while effectively controlling for variation in individual characteristics. Through NIDS, individual South Africans are tracked over time to monitor changes in different aspects of their lives, including health, nutrition, education, employment and poverty.

Wave 1 data collection began in February 2008, and involved 7,305 households and 28,255 individuals. The study used a two-stage stratified and clustered sampling approach, where in the first stage, primary sampling units were selected from Stats SA's master sample.

Wave 4 data collection took place from October 2014 to August 2015 and covered 37,396 individuals; 25,266 of these were individuals who had been interviewed in wave 1.⁴ The remaining (12,128) were new individuals who had joined the households of continuing panel members.⁵

NIDS collects data on household demographics, income and expenditure patterns, living conditions, and anthropometric measurements among other indicators.

The anthropometric measurements provide the data for the nutrition analyses in Children Count. To obtain the measurements, fieldworkers record two height and two weight measurements for each child, and a third one if the one and two sets of measurements were more than one centimetre or one kilogram apart respectively. An average of the first two measurements was in each case taken for the purposes of Z-scores derivation while the third measure was used for Z-scores derivation if the first two were more than a centimetre or one kilogram apart in the height and weight measurements respectively. The weights and heights collected during the study were converted to Z-scores based on the 2006 World Health Organisation's international child growth standards for children aged up to five years.⁶ In the case of children older than five years, the WHO growth standards for school-going and adolescent children were used.

Data on height-for-age, weight-for-age and height-for-weight cover children aged up to five years. In the process of derivation, absolute Z-scores for height-for-age and weight-for-age greater than six were treated as biologically implausible and excluded from further analysis.⁷ Likewise, absolute Z-scores for weight-for-height of greater than five were also found to be implausible and excluded. While NIDS uses a national sample, further disaggregation is limited due to the relatively small sample size.

SOCPEN database⁸

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 were 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, while 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 provides grant take-up figures as at the end of March.

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Zarina Adhikari is a director in the Department of Planning, Monitoring and Evaluation. She has worked extensively in government and Parliament over the past 20 years. Her expertise relates to governance both within the state and the legislature. She is also currently completing a PhD in Rhetoric that focuses on the impact of parliamentary rhetoric on social cohesion.

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Lizette Berry is a senior researcher at the Children's Institute, University of Cape Town. She holds a Masters in Social Science, specialising in social policy and management. She has 15 years' experience in child policy research and has a background in social work. Lizette has an interest in the care and development of children and recently contributed to a Southern African Development Community education policy framework that promotes learner care and support. She also contributed to the Department of Social Development's White Paper on Families and the National Integrated Early Childhood Development Policy and Programme, and was the lead editor of the *South African Child Gauge 2013*.

Sanjana Bhardwaj is the chief of health at UNICEF Nigeria with degrees in Medicine (MD) and Public Health (MPH). Prior to this appointment, she was the chief of health and nutrition at UNICEF, South Africa, having worked in Papua New Guinea; the Caribbean region, based in Jamaica; United States and India. Increasingly, her focus is on implementation research and working on translating policy into practice, leading innovative approaches towards ensuring equity and decentralised responses with contextual solutions. Her current areas of work include optimising partnerships with a focus on health systems strengthening and leveraging technology to fast track and accelerate impact for health and development.

Carole Bloch directs the Project for the Study of Alternative Education in South Africa and has a PhD in early literacy in African settings. Focusing on story and meaning-making, she researches and supports young children's biliteracy learning, and facilitates training and storybooks with English and African languages versions. Carole currently serves as a member of the Minister of Education's reading advisory panel, on the International Board for Books on Young People and is a member of the Reading Hall of Fame. She co-initiated the Nal'ibali National Reading for Enjoyment Campaign in 2012, designing the literacy approach and led the campaign until 2015.

Chandré Gould is a senior research fellow of the Justice and Violence Prevention Programme at the Institute for Security Studies. She has a PhD in History. She is primary investigator, together with Catherine Ward, on a three-year project to assess the impact of four evidence-based parenting programmes on the parenting practices in a whole community. She is the convenor of a national dialogue forum that brings together government departments, academics and non-governmental organisations in a long-term process aimed at informing the scale-up of evidence-based violence prevention programmes nationally.

Katharine Hall is a senior researcher at the Children's Institute, University of Cape Town (UCT). Her research is mainly in the areas of child poverty, inequality and social policy. She has worked on household form and care arrangements for children, and has a strong interest in housing policy, migration, and processes of urbanisation. She co-ordinates Children Count, a project that monitors the situation of children in South Africa through child-centred analysis of national household surveys. She is a standing committee member of the International Society for Child Indicators and serves on UCT's cross-faculty Poverty and Inequality Planning Group.

David Harrison is the chief executive officer of the DG Murray Trust, a South African foundation with a strong focus on early childhood development, education and leadership for public innovation. He was the founding director of the Health Systems Trust and first editor of the *South African Health Review*. He headed the HIV-prevention campaign, loveLife, from its inception until he joined the DG Murray Trust. David studied medicine at the University of Cape Town and public policy at the University of California at Berkeley.

Ursula Hoadley is an associate professor at the School of Education at the University of Cape Town. Her work focuses on pedagogy, curriculum and school organisation in primary schooling, and she has published extensively in these areas both locally and internationally. Her most-recent book is *Pedagogy in Poverty: Lessons from 20 Years of Curriculum Reform in South Africa*, published by Routledge.

Mayke Huijbregts holds the post as chief social policy and chief child protection with UNICEF in South Africa. She has worked with UNICEF over 18 years in Mozambique, Malawi, Zambia, Zimbabwe and FYR Macedonia in the areas of social policy, child protection, management and social protection. She started her career with the European Commission in Brussels, thereafter with Human Rights Watch and OSCE. Mayke holds a LLM in Law from Amsterdam University with a specialisation in international law and human rights.

Lori Lake is a communications and education specialist at the Children's Institute (CI) University of Cape Town. She specialises in making complex ideas accessible to a wider audience of policy-makers, practitioners and children, and plays a central role in the production of the annual *South African Child Gauge*. Lori convenes the CI's child rights courses for health and allied professionals, and is currently completing her Masters in Higher Education.

Ingrid Le Roux is the founder and medical director of the Philani Maternal, Child Health and Nutrition Project that provides community-based services in the Western and Eastern Cape. She studied medicine at the Karolinska Institute in Sweden and has a Masters in Public Policy from Princeton University.

Heidi Loening-Voysey started her career as a social worker in child protection. She later moved into academia in the School of Social Work at the University of the Witwatersrand (Wits University). She left this position to study a Masters in Public and Development Management. She returned to Wits University to manage a community-university partnerships office. Her study on models of care for orphans and other vulnerable children provided the background to her move to UNICEF South Africa, where she worked in child protection for 10 years. She is currently employed by the UNICEF Office of Research in Italy, focusing on effectiveness of parenting programmes for adolescents.

Lucy Jamieson is a senior researcher at the Children's Institute, University of Cape Town. She has two roles: on the one hand she leads and contributes to a variety of Children's Institute's research projects; on the other she works to ensure that the research findings contribute to the development of laws, policies and practices that affect children. She is currently working on an international project to develop indicators for children's participation in child protection systems, and leading an action-research pilot to improve inter-sectoral coordination in the South African child protection system through multi-disciplinary case management.

Anjuli Leila Maistry is an attorney at the Centre for Child Law, University of Pretoria (UP), focusing on access to education, as well as migrant's and undocumented children's rights. Prior to this she was an attorney at Lawyers for Human Rights where she specialised in refugee law. She has a Bachelors in Arts LLB from the University of Cape Town and is currently studying towards an LLM at the UP.

Elmarie Malek is the clinical head of general paediatric and neonatal specialist services at Tygerberg Hospital and Cape Town Metro East, and a senior lecturer in the Department of Paediatrics and Child Health, Faculty of Health Care Sciences, Stellenbosch University. She is the

chairperson of the Provincial Strategic Goal 3 (PSG3) Parent, Infant and Child Wellness Working Group that advises innovations for the PSG3 Western Cape's 1st 1,000 Days Initiative. Her interests include maternal and child health and nutrition, parent–infant attachment and perinatal mental health, family and child wellness, integrated mother and child health-care services, intersectoral collaboration, partnership development, participatory learning and community engagement.

Cathy Mather-Pike is the director and founder of Siyakwazi, a community-based non-profit organisation, based in the Ugu district of KwaZulu-Natal, that supports children with a range of disabilities and barriers to their learning. She was trained as a special needs teacher at Stellenbosch University and taught in the United Kingdom in special and mainstream schools. She has an Honours degree in Early Childhood Development and is currently pursuing a Masters in Education and Development with a special focus on participatory ways of enhancing development within school readiness. She has a special interest in supporting all children in rural settings through early intervention and prevention. She envisions this model of inclusion spreading to other areas of KwaZulu-Natal.

Shanaaz Mathews is the director of the Children's Institute, University of Cape Town, and has a PhD in Public Health. Prior to this appointment she was a specialist scientist for the Gender and Health Research Unit of the Medical Research Council for 11 years. Her research interests include violence against women and children, as well as pathways to violent masculinities, using both qualitative and quantitative approaches. Her current research projects have a focus on programme evaluation and strengthening child protection systems, and she is a lead investigator with the DST-NRF Centre of Excellence on Human Development, University of the Witwatersrand.

Nonkwanele Mbewu is a senior programme manager at Philani Maternal, Child Health and Nutrition Project. She holds a Masters in Social Welfare from the University at Albany, New York; a Bachelor's degree in Education and Higher Diploma in Education, both from the University of the Western Cape; and a Certificate in Project Management, Cape Peninsula University of Technology. Nonkwanele appreciates that she can contribute to the health and well-being of the most marginalised and vulnerable groups in the society. She views Philani as a home away from home for all women and children of South Africa and embraces the cultural diversity and the connections that she makes with individuals at Philani.

Judith McKenzie is the head of the disability studies division of the Department of Health and Rehabilitation Sciences, University of Cape Town. She convenes the postgraduate diploma in disability studies and supervises masters and doctoral students. She has had a long engagement with inclusive education as an activist, teacher and researcher. Currently she is heading a teacher education project, Teacher Empowerment for Disability Inclusion, which is a partnership with the Christoffel Blinden Mission (an international disability non-governmental organisation) and housed within the division of disability studies. The project explores teacher development to promote inclusive practice in schools.

Mary Metcalfe is the director of education change at the Programme to Improve Learning Outcomes, and is a senior research associate at the University of Johannesburg. She started teaching (as an unqualified teacher) in 1974 and has held various positions in education including head of the School of Education at the University of the Witwatersrand, member of the executive council for education (Gauteng), and director general of higher education. She is currently working with a team piloting-at-scale a model for education system improvement in 6,500 schools in KwaZulu-Natal (part of the National Education Collaboration Trust).

Benyam Dawit Mezmur is an associate professor of law at the Dullah Omar Institute for Constitutional Law, Governance and Human Rights at the Faculty of Law, University of the Western Cape. He is a member, and former chairperson, of the United Nations Committee on the Rights of the Child, and current chairperson of the African Committee of Experts on the Rights and Welfare of the Child of the African Union.

Nompumelelo Mohohlwane is a deputy director in the research coordination, monitoring and evaluation directorate of the Department of Basic Education. She holds a Masters (with distinction) in Education from the University of the Witwatersrand. Her research focused on substantiating the contribution of randomised control trials to evaluating early grade reading acquisition using literature analysis and empirical data analysis of large sample data. She is currently a PhD candidate at Stellenbosch University. Her studies focus on African languages and education policy. She is a reviewer for the *South African Journal of Childhood Education*.

Nadine Nannan is a senior researcher with the burden of disease research unit at the South African Medical Research Council. She holds Masters degrees in Molecular Biology and Medical Demography. Her interests are in child mortality, inequalities in child health and the burden of disease.

Donald Nghonyama holds a B-Tech degree in Child and Youth Development from the University of South Africa, a Diploma in Education from Johannesburg College of Education, and is currently enrolled for a Masters in Organisational leadership at Eastern University, United States. Donald is a former national chairperson of the National Association of Child Care Workers in South Africa and currently the NACCW deputy director. He serves on various civil society structures and is vice president of the South African Council for Social Service Professions.

Christina Nomdo serves as a National Planning Commissioner, bringing to the table her passion for the realisation of children's rights. She is a PhD candidate in the law faculty at University of Cape Town and her thesis focuses on children's autonomy rights. She was the executive director of Resources Aimed at the Prevention of Child Abuse and Neglect (RAPCAN) for eight years.

Sue Philpott is a post-doctoral candidate in the College of Education at the University of KwaZulu-Natal. Her PhD was in Law and focused on the right of children with disabilities to early childhood development (ECD). She has worked in the disability research field for 25 years with a particular interest in action research, and is a founding member of the Disability Action Research Team (DART). Sue has been involved with a wide range of disability research and advocacy endeavours, including pilot projects for inclusion in education and in ECD, working in partnership with parent organisations, non-governmental organisations and various government departments.

Paula Proudlock is a senior legal researcher at the Children's Institute, University of Cape Town. She has an LLM in Constitutional and Administrative Law and specialises in research, advocacy and education on children's socio-economic rights. Paula has served in leadership positions for several civil society networks on law reform processes including the campaigns to extend the Child Support Grant to 18 (2001 – 2010) and the campaign to promote an evidence-based and participatory approach in the making of the Children's Bill (2002 – 2008). She is currently leading a law reform project aimed at addressing the crisis in the foster care system.

Jeff Radebe is Minister in the Presidency for Planning, Monitoring and Evaluation and chairperson of the National Planning Commission. He heads the policy unit of the African National Congress and is a member of both its national executive committee as well as its national working committee, and is the longest standing Cabinet minister. He is also a member of the central committee of the South African Communist Party. Minister Radebe is a member of the Stewardship Board of the World Economic Forum System Initiative on the Future of Education, Gender and Work, and was appointed as an ambassador for Global Citizen – a movement committed to tackling the world's biggest challenges and ending extreme poverty.

Louis Reynolds is a retired paediatrician. As a health and human rights activist he champions the Comprehensive Primary Health Care approach embodied in the Declaration of Alma Ata. He is a member of the People's Health Movement, serving as chair in 2014. From 1987 to 1994 he served on the national executive committee of the National Progressive Primary Health Care Network. His hobby is photography.

Linda Richter (PhD) is a distinguished professor and the director of the Department of Science and Technology (DST) – National Research Foundation (NRF) Centre of Excellence in Human Development at the University of the Witwatersrand. She is a research associate in the Department of Psychiatry at the University of Oxford; a faculty affiliate of the World Policy Centre at the University of California, Los Angeles; and an advisor on early child development to the World Health Organisation in Geneva. Her research interests in child, youth and family development are applied to health, education, welfare and social development.

Stefanie Röhrs holds a Doctorate in Law from the University of Würzburg (Germany) and a Masters in Public Health from the University of Cape Town (UCT). Born and raised in Germany, Stefanie first came to South Africa and UCT in 2006 to conduct research on violence against women and access to health and justice services. She returned to Germany in 2012, but came back to South Africa in 2015 and now works as a senior researcher at the Children's Institute, University of Cape Town. She is interested in women's and children's rights with a focus on violence, sexual offences, and sexual and reproductive rights.

Winnie Sambu is a researcher at the Children's Institute, University of Cape Town. She holds a Masters in Economics (Development Studies) from the University of the Western Cape and a Masters in Arts in Development Management from Ruhr-Universität Bochum/University of the Western Cape. Winnie's research interests include food security and nutrition, poverty and household living conditions. At the Children's Institute, Winnie works on Children Count, a monitoring project that provides statistics on the situation of children in South Africa. She has also been involved in other projects that have focused on early childhood development and child protection.

David Sanders, an emeritus professor and founding director of the School of Public Health at the University of the Western Cape, is a paediatrician qualified also in public health. He has over 35 years' experience of health policy and programme development, research and teaching in Zimbabwe and South Africa, having advised governments and United Nations (UN) agencies and published extensively on primary health care (PHC), child health and nutrition. He is an honorary professor in paediatrics and child health, University of Cape Town. He has received an honorary doctorate from UCT for his

contribution to the global PHC policy, received the Nutrition Society of South Africa award in 2002, and the Public Health Innovation and Lifetime Achievement Award of the Public Health Association of South Africa in 2014. He served on the UN Standing Committee on Nutrition, and the Knowledge Network on Globalisation of the World Health Organisation Commission on Social Determinants of Health. He is co-chair of the Global Steering Council of People's Health Movement, and a founding board member of Tekano, Health Equity South Africa.

Makhosi Shusha was the first Siyakwazi employee in 2011, where she is now a manager. She has a teaching diploma and is currently converting this into a degree at North-West University. She has been involved in all three services that Siyakwazi offers, namely early childhood development, non-centre based; and schools, to all children under seven and is now a mentor to the 15 Siyazisas in her care, supporting them in implementing quality programmes and services to the community of KwaNzimakwe in KwaZulu-Natal. She is passionate about parent involvement and community awareness.

Nic Spaul is currently a senior research fellow at the Research on Socio-Economic Policy (ReSEP) group at Stellenbosch University. He has spent time as a research fellow at both the Organisation for Economic Cooperation and Development in Paris and Stanford University in the United States. Nic has a PhD in Economics and has published numerous journal articles on assessment, accountability, literacy and education policy in South Africa. He is currently working on the Funda Wande project which is developing a certificate for foundation phase teachers on how to teach early grade reading in African languages.

Stephen Taylor is the director of research, coordination, monitoring and evaluation in the Department of Basic Education. The unit is responsible for system monitoring, supporting performance information management, research and evaluation of education interventions. He is a principal investigator on the Early Grade Reading Study. His academic work focuses on impact evaluation of education interventions, measuring educational performance and equity in educational outcomes. He completed a PhD in Economics at Stellenbosch University, analysing the role of education in South Africa's economic development. He is also a research associate of the Department of Economics, Stellenbosch University.

About the *South African Child Gauge*

The *South African Child Gauge* is an annual publication of the Children's Institute, University of Cape Town, that monitors progress in the realisation of children's rights. Key features include a series of essays to inform national dialogue on a particular area which impacts on South Africa's children;
a summary of new legislative and policy developments affecting children;
and quantitative data which track demographic and socio-economic statistics on children.



Previous issues of the *South African Child Gauge*:

- 2016: Children and social assistance
- 2015: Youth and the intergenerational transmission of poverty
- 2014: Preventing violence against children
- 2013: Essential services for young children
- 2012: Children and inequality: Closing the gap
- 2010/2011: Children as citizens: Participating in social dialogue
- 2009/2010: Healthy children: From survival to optimal development
- 2008/2009: Meaningful access to basic education
- 2007/2008: Children's constitutional right to social services
- 2006: Children and poverty
- 2005: Children and HIV/AIDS

All issues of the *South African Child Gauge* are available for download at www.ci.uct.ac.za

The Children's Institute, University of Cape Town, has been publishing the *South African Child Gauge*® every year since 2005 to track progress towards the realisation of children's rights.

The *South African Child Gauge 2017* is the twelfth issue and focuses on how to use the Sustainable Development Goals to create an enabling environment in which South Africa's children not only survive, but thrive and reach their full potential. It also discusses recent policy and legislative developments affecting children in the country, and provides child-centred data to monitor progress and track the realisation of their socio-economic rights.

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.

The annual *South African Child Gauge* is without question the pre-eminent national publication on the subject of children, and society owes a debt of gratitude to the Children's Institute for this evidence-led investment in the future.

Jonathan Jansen, Rector and Vice-Chancellor, University of the Free State

Within the South African context, the *Child Gauge* fulfils a three-fold purpose. First, it mobilises the resources of the university to promote engaged scholarship that seeks to better understand and address the challenges faced by South Africa's children. Second, it makes this evidence accessible to those in government who are responsible for the design and delivery of services for children. Last, but not least, it supports the efforts of civil society and an informed citizenry who can then challenge rights violations and hold government accountable.

Benyam Dawit Mezmur, Chairperson of the African Committee of Experts on the Rights and Welfare of the Child, and Associate Professor, Dullah Omar Institute for Constitutional Law, Governance and Human Rights, University of the Western Cape

We view the work of the CI, both the research and the policy engagement, as an invaluable contribution to the objective of increasing the use of research evidence in the policy-making and implementation process. The CI successfully bridges the gap in translating research into products for use in the policy community. Through the PSPPD's collaboration with the CI on the *Child Gauge*, and by supporting innovative policy relevant research, we are able to put children's issues at the forefront of the policy agenda.

Mastoera Sadan, Programme to Support Pro-poor Policy Development (PSPPD), Department of Planning, Monitoring and Evaluation

The *Child Gauge* collates and interrogates the latest research evidence from a child-centred and policy perspective. In the process of seeking to make research relevant and accessible to policy-makers and practitioners, it helps to identify blind spots, knowledge gaps and areas for further enquiry.

Linda Richter, Director of the DST-NRF Centre of Excellence in Human Development, University of the Witwatersrand

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