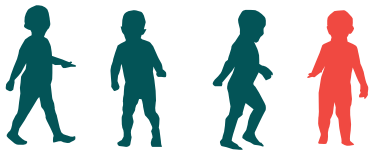
PRIORITISING THE FIGHT AGAINST **STUNTING IN SOUTH AFRICA**

Evidence, gaps, and implications: a synthesis of ten papers from a special issue of *Development Southern Africa* (Volume 42, Issue 6, 2025)

This special issue brings together policymakers, practitioners, and researchers from seven institutions across 10 articles spanning measurement, determinants, interventions, monitoring tools, and governance. Together, they paint a comprehensive picture of why South Africa's stunting rate has remained stubbornly high, and what it will take to shift the trajectory.



ABOUT 1 IN 4

children under 5 is stunted in South Africa

South Africa has one of the highest rates of stunting among upper-middle-income countries globally. Additionally, there is little change despite large improvements in the expansion of child grants and the dramatic shifts over the last three decades in improved housing and access to sanitation and water.*

Stunting means a child is too short for their age, a sign of long-term, chronic undernutrition and other deficiencies in the early environment. A stunted child is not just small; their brain development, school performance, and lifetime earning potential are all affected. Stunting harms in the first 1,000 days of life (from conception to age two) can last a lifetime; and be passed on to the next generation.

This document summarises what the special issue papers contribute to our understanding of stunting and what can be done to address it. We highlight key research gaps — particularly the need for local evidence on the role of in utero alcohol exposure, maternal health, environmental health and gut health — to match important international findings. As the recommendations are grounded in the evidence presented in this special issue, these gaps necessarily limit the scope of the recommendations.

Suggested citation

Burger, R., Du Plessis, L., Rich, K., Ruder, T., Sadan, M., Slemming, W. & Wills, G. (2026). Prioritising the Fight against Stunting in South Africa: Evidence, Gaps and Implications. Synthesis of ten papers from a special issue of Development Southern Africa, 42(6), 2025.

1. WHAT HAVE WE LEARNT

Our numbers may be wrong, and that matters

One of the most important contributions of this special issue is a forensic look at how stunting is measured in South Africa. Rich and Engelbrecht[1] show that nationally representative surveys have produced wildly different stunting estimates, ranging from around 20% to over 30%, for a similar period. The culprit is not just data scarcity, but poor data quality: missing height measurements, inconsistent survey methods, and sampling biases that distort results. National stunting averages hide geographic and demographic variation. Moreover, wealthier urban children are disproportionately represented in missing data, which may inflate stunting estimates in urban areas while understating the relative burden in rural settings. **This finding is foundational: if we cannot reliably track if stunting is rising or falling, we cannot hold programmes or policies accountable.** Standardised, nationally representative surveys and improved data collection with quality control is not a technical nicety, it is the precondition for scope clarity.

* See Said-Mohamed, R., Micklesfield, LK., Pettifor, JM. & Norris, SA. (2015). Has the prevalence of stunting in South African children changed in 40 years? A systematic review. BMC Public Health 15,534; Devereux, S, 2017. Why South Africa's social grants aren't eradicating malnutrition. https://foodsecurity.ac.za/news/why-south-africas-social-grants-arent-eradicating-malnutrition/; National Department of Health (NDoH), Statistics South Africa (Stats SA), South African MedicalResearch Council (SAMRC) & ICF, 2019. South Africa demographic and health survey 2016. NDoH, Stats SA, SAMRC and ICF, Pretoria and Rockville, MD.

Parental death leaves children extremely vulnerable

Leach and von Fintel[2] make an important distinction that policy has often overlooked: the death of a parent has a different and more severe impact on stunting than parental absence alone. This distinction matters in South Africa, where more than half of children under five do not live with their fathers, either because of death or absence, and who may not be adequately reached by standard, broadly targeted nutrition programmes. **Their findings show that paternal orphans are at particularly high risk of stunting**, partly due to lower household resources following the loss of a father. In addition, paternal orphans and children with absent fathers are more likely to experience hunger than those living with their fathers, regardless of household income.

Risk factors are multifactorial, context-specific, and compounded by a double burden

Senekal and co-authors[3] Western Cape analysis reinforces a central theme of this issue: that **the determinants of stunting are multifactorial and context-specific,** spanning household food insecurity, poverty, low parental education, precarious employment, low birth weight, and higher birth order. The Western Cape stunting prevalence (17.5%) is substantially lower than national estimates, underscoring the limitations of nationally aggregated analyses and the need for subnational research to inform local responses. The study also documents a double burden of malnutrition: overweight and stunting peaking in the same age group (one- to two-year-olds), complicating intervention design.

Civil society can work together to limit commercial drivers of child malnutrition

Grimbeek and co-authors[4] bring a civil society lens to the commercial determinants of stunting, using the 2021 'Not Today Nestlé' campaign to show how **infant formula and ultra-processed food marketing undermines breastfeeding and optimal nutrition**. This is not simply a matter of parental choice: aggressive marketing, combined with poverty that makes cheap, calorie-dense but nutrient-poor foods the default, creates a food environment that is structurally hostile to child nutrition. Poor breastfeeding practices reflect inadequate maternal support, contradictory advice from health workers, and avid formula marketing. Meanwhile, complementary foods are often nutritionally inadequate, introduced too early, and lack dietary diversity.

South Africa has one of the lowest exclusive breastfeeding rates in Africa, with less than one third of infants under six months exclusively breastfed, far below the WHO target of 50% by 2025.*

Growth monitoring is failing children

Williams and co-authors[5] assessed how consistently the Road to Health Book, South Africa's universal child health record, captures length-for-age measurements. The findings are sobering: **length is one of the least reliably recorded indicators, despite being the core marker of stunting.** This is not merely an administrative gap. Growth faltering is fastest in the first two years of life, and without regular length measurement, red flags can go undetected until it is too late.

Müller and co-authors[6] assess mHealth (mobile health) tools for community-based growth monitoring. Across three case studies in South African settings, **digital tools showed promise in improving measurement accuracy and enabling real-time data flow.** The technology exists; the challenge is scaling it. The authors emphasise that successful implementation depends on investing in training, infrastructure, community engagement, and health system integration.

* Koray, MH., Wanjiru, JN., Kerkula, JS., Dushimirimana, T., Mieh, SE., Curry, T., Mugisha, J., Kanu, LK. (2025). Factors influencing exclusive breastfeeding in Sub-Saharan Africa: analysis of demographic and health surveys. BMC Public Health. 15;25(1):1790.

Effective interventions exist but are hard to scale

Burger and co-authors[7] evidence review identifies two interventions with the strongest short-term evidence for reducing stunting in children aged 6–24 months: 1) nutrition education for caregivers (especially around complementary feeding) and 2) small-quantity lipid-based nutrient supplements (SQ-LNS), affordable, nutrient-dense pastes that can improve linear growth when provided at scale. Evidence suggests nutrition education is most effective in food-insecure contexts, where it is paired with food access; **information alone does not change diets households cannot afford**.

Contextualising these international findings to South Africa, Smuts, Faber and Havemann-Nel[8] show that simply providing point-of-use fortification (e.g. SQ-LNSs) or the provision of single nutrient-rich foods (e.g. eggs) was insufficient to improve linear growth in two South African studies. **Stand-alone strategies should not replace helping caregivers improve children's overall dietary diversity**, including foods like eggs, milk, and other animal products. To make this successful, programmes also need clear nutrition education and must be designed to fit local conditions.

90% of stunted children reside in only 34 countries

South Africa is one of only 34 countries responsible for 90% of the world's stunted children — despite being an upper-middle-income country.*

Cross-departmental collaboration and coordination is crucial

Du Plessis and co-authors[9] conducted a qualitative study with provincial officials in the Western Cape, Gauteng, and Bulawayo, Zimbabwe, to map what data and action levers exist at provincial level. Their finding is revealing: **most of the relevant data exists, but is siloed across departments, not routinely shared, and not used to drive action.** Du Plessis and colleagues show that South Africa already has much of the data needed to inform efforts to address stunting, but it is not being used effectively. Responsibility for reducing stunting is shared across sectors like health, education, and social development, meaning no single department is clearly accountable. For policy, the message is clear: better data usage, stronger coordination across departments, and local accountability are essential to drive progress.

Food environment policies are poorly implemented

Delobelle and co-authors[10] used the Food-EPI: an internationally standardised benchmarking tool, to score South Africa's food environment policies against best practice. **Eight of 12 undernutrition indicators were rated at low or very low implementation**, including access to water, sanitation and hygiene (WASH) in public areas (the lowest-rated indicator), provisions for breastfeeding in work and public spaces, food safety support for informal retailers, complementary feeding policy, breastfeeding and complementary feeding targets, growth monitoring, and political support for addressing malnutrition across the life course. Only food fortification (mandatory since 2003) was rated high.

Stunting crisis originates in structural inequality

Stunting in South Africa is a development challenge, not just a nutrition issue. Poverty, inequality, high rates of orphanhood, poor sanitation, dysfunctional food systems, and weak governance converge to undermine child growth. **Interventions treating stunting as purely a dietary deficiency will have limited impact;** only multi-sectoral, coherent policies, intentionally funded interventions and structurally aware approaches will drive lasting change.

* Galasso, E., Wagstaff, A. (2019). The aggregate income losses from childhood stunting and the returns to a nutrition intervention aimed at reducing stunting. Econ Hum Biol. 34:225-238. doi: 10.1016/j.ehb.2019.01.010. Epub 2019 Mar 18. PMID: 31003858.

2. PRIORITY KNOWLEDGE GAPS: WHAT WE NEED TO UNDERSTAND BETTER

This special issue also maps what we do not yet know. Several urgent knowledge gaps emerge:

Measurement and surveillance

- Due to varied approaches in survey sampling, inconsistent anthropometric measurements, inaccurate recording, and systematic biases in non-response, **it is not clear that we have a firm hold on the prevalence of or trends in stunting** in South Africa. We can do better with harmonised approaches, more representative samples, and more robust strategies to guard against bias in non-response. Improving routine growth monitoring is also vital.
- How do we **build a community-level surveillance system** that identifies where stunting burdens are highest? And track breastfeeding rates, dietary diversity, and micronutrient status in real time; not just once every five years?
- Can the **digitisation of the Road to Health Book be accelerated** in a way that generates reliable population-level data without losing the caregiver-held record that is central to its value?
- **A deeper understanding of how stunting relates to cognitive development** in our context would be essential to ensure efforts remain focused on the outcomes that matter most.

Determinants and mechanisms

- What is the **relative contribution of the determinants that are often missing from our surveys** such as air quality and gut health? International evidence suggests a large potential role for such factors but due to a lack of local evidence it is not yet clear how these factors may impair child growth in South Africa.
- How do we better understand and address **the compounded disadvantage faced by double orphans and other structurally vulnerable groups**?
- Given international evidence, more research is needed on how **in utero experiences affect child growth and development** in South Africa.

Interventions

- Caregiver stress, depression, and trauma affect feeding and caregiving practices, but **evidence on affordable, feasible and scalable interventions is lacking.**
- What is the **most cost-effective delivery model to disseminate nutrition education and distribute essential nutrition commodities** such as SQ-LNS in South Africa? Which platform (clinic, community health worker, ECD centres) will achieve the best mix of implementation depth and coverage that is reliable, standardised, and affordable?
- Does **combining the Child Support Grant with nutritional support**, such as supplements and nutritional education, produce better child growth outcomes than cash alone? The existing evidence base is thin.
- Given current food prices, what is the **most effective, sustainable and affordable way to improve the quality and quantity of food** consumed by low-income households?

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Governance and systems

- How do we create **meaningful accountability for stunting outcomes at district and provincial level,** across multiple government departments?
- What **governance structures successfully coordinate multi-sectoral stunting responses in comparable settings,** and what can South Africa learn from them?
- How do we **better regulate the marketing of commercial milk formula for infants and ultra-processed foods** in ways that are enforceable and effective?

3. RECOMMENDATIONS AND NEXT STEPS

POLICYMAKERS

The evidence is clear enough to act; what is needed to address stunting is political will, clear ownership, and cross-departmental accountability and resources.

Establish clear accountability for stunting outcomes

Stunting falls between departmental mandates with no clear ownership. A dedicated, cross-departmental and cross-sectoral policy, with responsible officials, district-level targets, and regular reporting, is the most important structural change needed. The National Food and Nutrition Security Plan has lapsed, and it is a serious concern that we are now in 2026 without a successor in place.

Invest in improved data infrastructure

Commission a high-quality, nationally representative child anthropometry survey within the medium-term. In the meantime, standardise measurement protocols and skills training across all existing surveys and data platforms. Begin the phased digitisation of the Road to Health Book, linking it to the National Health Information System. Mandate the routine collection of infant and young child feeding indicators such as exclusive breastfeeding under six months at every primary healthcare facility.

Complement social security with targeted nutrition support

The Child Support Grant currently falls below the food poverty line.* Review evidence suggests that piloting the addition of SQ-LNS with a comprehensive approach to nutrition education could improve child growth and development outcomes at relatively low cost. Social protection and nutrition policies must be aligned.

Prioritise the first 1,000 days: from conception to age two

Most funding flows towards Early Childhood Development (ECD) efforts that begin too late.** Maternal nutrition, breastfeeding support, complementary feeding, and growth monitoring must reach children in the 0–2 year window. Scaled-up community health worker programmes, supported by digital tools, may offer a practical delivery mechanism.

Stronger enforcement of the infant food and commercial milk formula environment

South Africa regulates the marketing of commercial milk formula and unhealthy foods, but enforcement remains weak. Delobelle and colleagues' Food-EPI benchmarking confirms this: although regulations on commercial milk formula marketing have been in place since 2012, experts rated enforcement as inadequate. Most restrictions on unhealthy food marketing to children remain voluntary, relying on industry self-regulation rather than mandatory legislation; a gap the expert panel identified as a top ten priority action. Strengthening monitoring, compliance, and accountability is critical to protect infant nutrition and improve the food environment.

Target the most vulnerable populations

National averages conceal extreme geographic and demographic variation. Orphans, children in informal settlements, children in the poorest municipalities, and children of migrant or absent fathers face compounded disadvantages that average programmes will not reach. Targeting mechanisms, informed by district-level data, need to be built into programme design from the outset.

* Hall, K. & Hendricks, S. (2025). Income poverty, unemployment and social grants. In: Jamieson, L., Mathews, S., Machisa, M. & Lake, L. (eds) *South African Child Gauge 2025*. Cape Town: Children's Institute, University of Cape Town. pp. 184–191; Pietermaritzburg Economic Justice & Dignity Group. *Household Affordability Index, February 2026*. Pietermaritzburg: PMBEJD.

** South Africa's ECD investments remain chronically underfunded and skewed towards older children (Slemming, Biersteker & Lake 2024). Only 6.5% of public ECD spending goes towards early learning, nutrition support and caregiver support (Ilifa Labantwana n.d.), with the formal subsidy system predominantly serving children aged 3–5 in registered centres rather than those in the first 1,000 days (Real Reform for ECD Campaign 2024). See: Slemming, W., Biersteker, L. & Lake, L. (2024). *South African Child Gauge 2024*, Children's Institute, University of Cape Town, Cape Town; Ilifa Labantwana, n.d., *Funding*, viewed 13 April 2026, https://ilifalabantwana.co.za/reviewing-our-work/our-story-of-change/funding/; Children's Institute & Ilifa Labantwana, 2024, *South African Early Childhood Review 2024*, Children's Institute, University of Cape Town, Cape Town.

B. NGO AND THE SOCIAL DEVELOPMENT SECTOR

Civil society and NGOs are often the last mile of delivery for the most vulnerable children. This research reinforces their critical role and the importance of building the evidence base for what works.

Adopt and advocate for mHealth-supported growth monitoring

Müller and colleagues show that mobile-based tools can improve the accuracy and coverage of community-based growth monitoring. NGOs running ECD, health, or community development programmes should pilot and scale these approaches, building the evidence base for national adoption. This is particularly important in areas where primary healthcare capacity is weakest.

Champion integrated, multi-sector programming

Single-sector programmes, nutrition education, WASH, psycho-social support and even supplementation, alone are insufficient. The evidence points clearly to the need for combinations: comprehensive nutrition education and support plus caregiving support plus social protection plus access to health services. NGOs with the relationships and flexibility to work across these domains are uniquely positioned to demonstrate and advocate for integrated approaches.

Invest in broader civil society platforms to strengthen advocacy

The 'Not Today Nestlé' case study demonstrates the power of civil society to create public accountability for commercial actors and push for regulatory enforcement and change. NGOs working in nutrition, food systems, and consumer rights should build coalitions to sustain this advocacy, including the marketing of commercial milk formula for infants, the labelling of ultra-processed foods, and the pricing of nutritious foods.

Disseminate research to frontline workers

A striking finding from the subnational governance study is that even officials responsible for implementing child welfare policies do not always understand the long-term and intergenerational consequences of stunting. NGOs can play a critical role in translating this evidence into training, advocacy, and community mobilisation; building demand for action from communities and government.

Ensure programmes reach the most marginalised

Organisations working with orphans and vulnerable children, communities affected by HIV/AIDS, and households living in extreme poverty should recognise that these populations face the highest stunting risk, and that standard programme designs may not reach them. Deliberate outreach, stigma reduction, and case-finding approaches are needed for the most invisible children.

C. PRIVATE SECTOR

The private sector is implicated in stunting in multiple ways, as part of the problem, and as an essential part of the solution. Both realities require honest engagement.

Nutritious, affordable foods are a core responsibility

The South African food industry must provide affordable, accessible, nutritious complementary foods for low-income markets. Food pricing, placement, and availability in lower-income communities shape what households feed their children. Diets in low-income households are constrained by the affordability and availability of nutritious foods, limiting the impact of information or individual choice. Voluntary and regulatory commitments on product mix, pricing, and marketing in lower-income areas are needed.

Corporate social investment (CSI) should focus on the first 1,000 days

South Africa's CSI landscape invests heavily in education and youth development, but these interventions come too late. A child stunted by age two enters school already disadvantaged. CSI that funds ECD nutrition, community health worker support, and caregiver education in the first 1,000 days will produce larger and more durable returns to human capital than equivalent investments at school age.

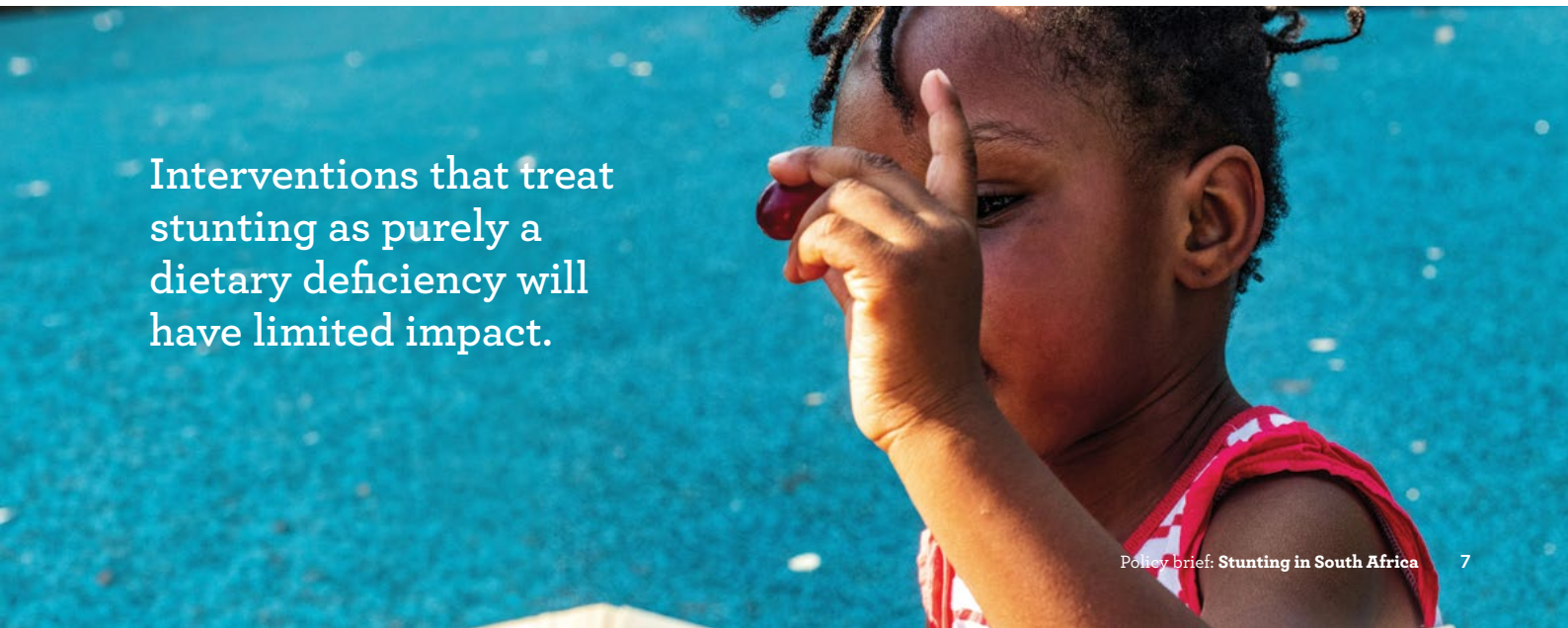
Employers: support working mothers' ability to breastfeed

An 32% exclusive breastfeeding rate* reflects not only a knowledge gap but a structural failure to support mothers who want to breastfeed but cannot within their working conditions. Paid maternity leave, breastfeeding breaks, and lactation facilities are practical interventions that employers can implement and advocate for through worker unions, including in the informal sector.

Food industry must accept responsibility for marketing practices

The 'Not Today Nestlé' case study illustrates that companies operating in the infant food space must comply with World Health Organization (WHO) International Code. Voluntary compliance, third-party auditing, and transparency in marketing practices are the minimum standard. Companies that position themselves as partners in addressing stunting while marketing breast milk substitutes aggressively, face a fundamental credibility and ethical problem.

* National Department of Health (NDoH), Statistics South Africa (Stats SA), South African Medical Research Council (SAMRC) & ICF. 2019. South Africa Demographic and Health Survey 2016. Pretoria, South Africa & Rockville, Maryland: NDoH, Stats SA, SAMRC & ICF.



CONCLUSION

South Africa has many prerequisites for addressing childhood stunting: sufficient aggregate food supply, a functioning social protection system, a large cadre of community-level workers reaching millions of households, and a research community that understands the drivers of stunting.

What has been insufficient, until recently, is the political commitment, governance architecture, and multi-sectoral coordination needed to align these assets around a clear objective. President Ramaphosa's 2026 State of the Nation Address (SONA) commitment to end child stunting by 2030, with its emphasis on the first 1,000 days and targeted nutritional interventions for pregnant women and low-birth-weight children, signals that stunting has finally been elevated to a national priority.

The evidence in this special issue offers **grounds for cautious optimism** about breaking the intergenerational cycles of poverty, poor health and stunting. This collection has advanced the evidence base, and the process of producing it has itself been generative, fostering dialogue across disciplines and between researchers, policymakers, and practitioners who too often work in parallel. **Sustaining and deepening that collaboration will be essential** if the political commitment expressed in the SONA is to be matched by the leadership, financing, and implementation discipline needed to translate it into a measurable decline in stunting.

Endnotes

Prioritising the Fight Against Stunting in South Africa: *Special Issue of Development Southern Africa* (Volume 42, 2025)

1 Kate Rich, Liezel Engelbrecht. Measuring stunting and tracking trends in prevalence in South Africa: Conceptual and methodological considerations. Pp 750-770

2 Grace Leach, Dieter von Fintel. Parental death, parental absence and stunting. Pp 791-810

3 Marjanne Senekal, Nelia Steyn, Fatima Hoosen, Sonia Malczyk, Janetta Harbron, Anna-Marie Müller, Hilary Goeiman, Johanna Helena Nel. Prevalence and socio-demographic predictors of malnutrition in under 5-year-olds in the Western Cape. Pp 771-790f

4 Angelika Grimbeek, Eunice Motha, Petronell Kruger Civil society perspectives on commercial determinants of stunting: A case study of the "Not Today Nestlé" campaign. Pp 855-869

5 Maggie Williams, Benedict Raphael Oamen, Maryke Rademeyer, Jessica Ronaasen, Thea Wynne. Appraising the completeness of Road-to-Health Booklets at ECD Centres in Nelson Mandela Bay, South Africa. Pp 823-836

6 Anna-Marie Müller, Helen Donkin, Emma Chademana, Phiwe Dauwa. mHealth for community-based growth monitoring and promotion: Three case studies from South African settings. Pp 837-854

7 Ronelle Burger, Lisanne du Plessis, Trust Gangaidzo, Mastoera Sadan, Wiedaad Slemming, Gabrielle Wills. Priority interventions for reducing stunting in the complementary feeding age group in South Africa. Pp 885-903

8 Marius Smuts, Mieke Faber, Lize Havemann-Nel. Food-based approaches to improve the nutritional quality of the complementary diet to address stunting. Pp 811-822

9 Lisanne du Plessis, Marna Smuts, Romeo Bhebhe, Angela Coetzee, Joyce Kinabo, Scott Drimie. Indicators and actions to address stunting across multiple sectors relevant at subnational level. Pp 904-926

10 Peter Delobelle, Nicole Holliday, Carmen Klinger, Zandile June-Rose Mchiza, Peter von Philipsborn, Karin Geffert, Olufunke Alaba. Early and young child feeding in South Africa: Expert assessment of public policy using food-EPI. Pp 870-884

About the project
This project was funded by the DG Murray Trust. Its aim was to address the fragmentation and siloed nature of research, programme development and policy on stunting by producing a special issue of the journal Development Southern Africa that bridges these divides — drawing together contributions that span disciplines, sectors and the research-policy-practice interface.

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