South African Human Rights Commission

National Inquiry into the Food Systems of South Africa

A call to stop the slow violence of child malnutrition and put children at the centre of the food system[1]

Submission by the Children's Institute, University of Cape Town

Introduction

- South's Africa's burden of child malnutrition is disproportionately high for an upper middle-income country.
- The health and development of South Africa's children are compromised by a double burden of both *undernutrition* (reflected in wasting, underweight, stunting and micronutrient deficiencies) and *overnutrition* (reflected in overweight and obesity).
- Key public health concerns include the persistently high prevalence of stunting, and a dramatic increase in overweight and obesity, both of which undermine the immediate and long-term health and development of 1 in 4 young children.
- But we also focus attention on the much smaller proportion of children affected by wasting or Severe Acute Malnutrition (SAM) given the South African Human Rights Commission (SAHRC) investigation into child malnutrition deaths and the right to food in the Eastern Cape – as no child should die of hunger and malnutrition in a country that produces more than enough food to feed its people,
- This submission provides a brief overview of the forms and prevalence of different types of child malnutrition in South Africa. It then outlines some of the key drivers of malnutrition including poverty and inequality, and a predatory and unhealthy food system. It then motivates for these challenges to be addressed as a child-rights imperative, and introduces three key principles and 7 critical steps that will help ensure that child nutrition and children's best interests are placed at the centre of our efforts to reform the food system.

Focus on the double burden of child malnutrition

Wasting

- The prevalence of wasting remains below the WHO threshold of 10% and is therefore not considered of public health significance. However, recent increases in the prevalence of severe acute malnutrition (SAM) – an extreme, acute and life-threatening form of wasting – demonstrate that while the prevalence may be below the "acceptable" threshold, the severity of wasting is a concern.
- Children become wasted when they lose weight rapidly – usually due to a mix of frequent and severe infections and a poor quality diet: where repeated infections compromise children's nutritional status, while malnutrition impairs children's immunity – in ways that can drive a vicious cycle of malnutrition and disease.
- A child who is wasted is too thin for their height, and according to the 2021-23 National Food and Nutrition Security Survey 5.3% of children under five were wasted or acutely malnourished.
- In 2022/23, over 15,000 children required hospitalisation due to severe acute malnutrition (SAM) – a 25% increase over just five years, and 1,000 children died of SAM.[2]
- Wasting is also an underlying cause of death (for example, in cases where children die of diarrhoea or pneumonia) and 2022 data from the Child Health Problem Identification Programme found that 22% of child deaths in hospital were associated with SAM, and a further 23% associated with moderate acute malnutrition.
- These estimates only reflect those children with SAM who were admitted to hospital and therefore represent only a small fraction of the larger number of children who are not diagnosed, many of whom may die outside of the health system, as the Committee on Morbidity in Children under five estimates that nearly half of child deaths occur outside of the health system.[3]
- While it is important to strengthen the implementation of the WHO 10 Step Guidelines for Managing SAM in hospital to prevent children with SAM from dying, it is also critical to intervene far earlier to promote optimal health, care and nutrition and to address problems as soon as children's growth first starts to falter (or deviate from the growth curve in their Road to Health Books), and to ensure that nutritional support continues once children are discharged from hospital, so that children do not relapse and need to be readmitted.

Stunting

- Severe acute malnutrition is just the tip of the iceberg: for every child in SA that suffers from SAM, approximately 135 children are stunted – or short for their age.[4] Both the 2016 South African Demographic and Health Survey conducted by the Department of Health and the 2021-23 National Food and Nutrition Security Survey conducted by the HSRC identified under-5 stunting rates of over 25% nationally (more than 1 in 4 children under five are too short for their age).
- These rates have remained stubbornly unchanged for over two decades, and South Africa is not on track to meet the WHO/UNICEF global target of halving under-5 stunting by 2030.
- Stunting is a sign of chronic malnutrition that compromises children's physical growth and their developing brains in ways that undermine their long-term learning and development and ultimately their employment prospects. Stunting is also associated with increased risk of developing diet-related non-communicable diseases such as obesity, diabetes and hypertension in adolescence and adulthood.
- The prevalence of stunting is highest from 6 – 24 months – at a time when caregivers are starting to introduce complementary feeds and scaling back on breastfeeding. So, it is critical to intensify support and guidance during this period of heightened risk.

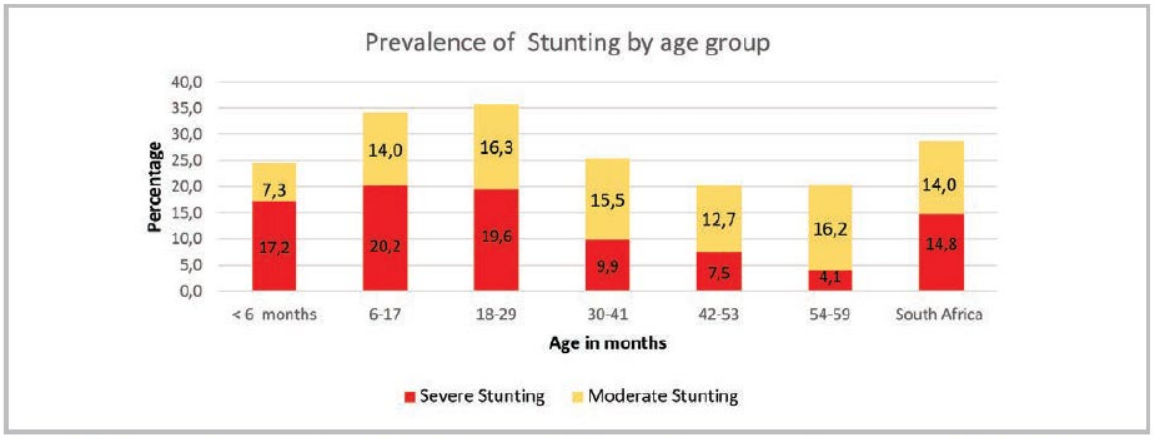
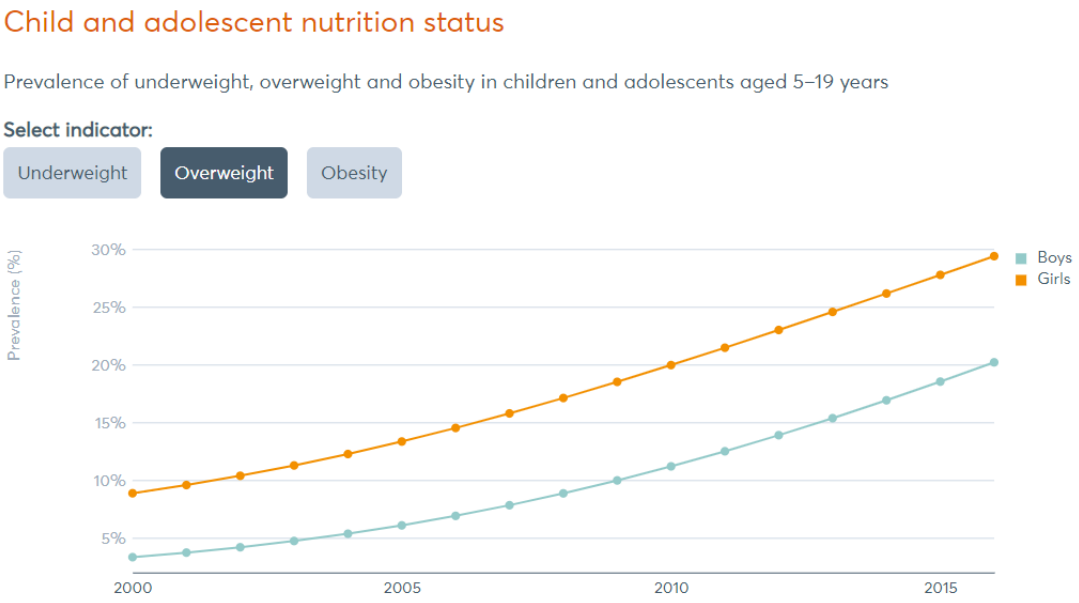


Figure 58: *The prevalence of Stunting in children under 5 years disaggregated by age group in South Africa*

Source*: Simelane T, Mutanga S, Hongoro C, Parker W, Mjimba V, Zuma K, . . . Mokhele T. National Food and Nutrition Security Survey: national report. Pretoria: Human Sciences Research Council.*

Overweight and obesity

- South African policy makers are understandably concerned by the high prevalence of stunting. But there is a risk that the focus on stunting has obscured the rapid increase in overweight and obesity in children under five – with the rate nearly doubling in less than 10 years from 13% in the 2016 South African Demographic Health Survey[5] to 23% in the 2021-23 National Food and Nutrition Security Survey.[6]
- While it is not clear if the two surveys are directly comparable, these findings echo global trends where overweight and obesity in young children has been identified as an emerging threat to public health – so it is of particular concern that South African rates are now more than four times the global average – and that the country is clearly failing to meet the SDG Target of reducing overweight and obesity in children under five to below 5%.
- Children who are overweight are at higher risk of developing obesity and other serious health problems later in life including diabetes, high blood pressure, asthma, sleep disorders, and liver disease. Being overweight can also affect self-esteem, mental health, school performance, and quality of life; especially when coupled with stigma, discrimination and bullying
- The following estimates from the *2020 Global Nutrition Report* illustrate how overweight in childhood and adolescence was increasing in South Africa even before the 2016 SADHS:

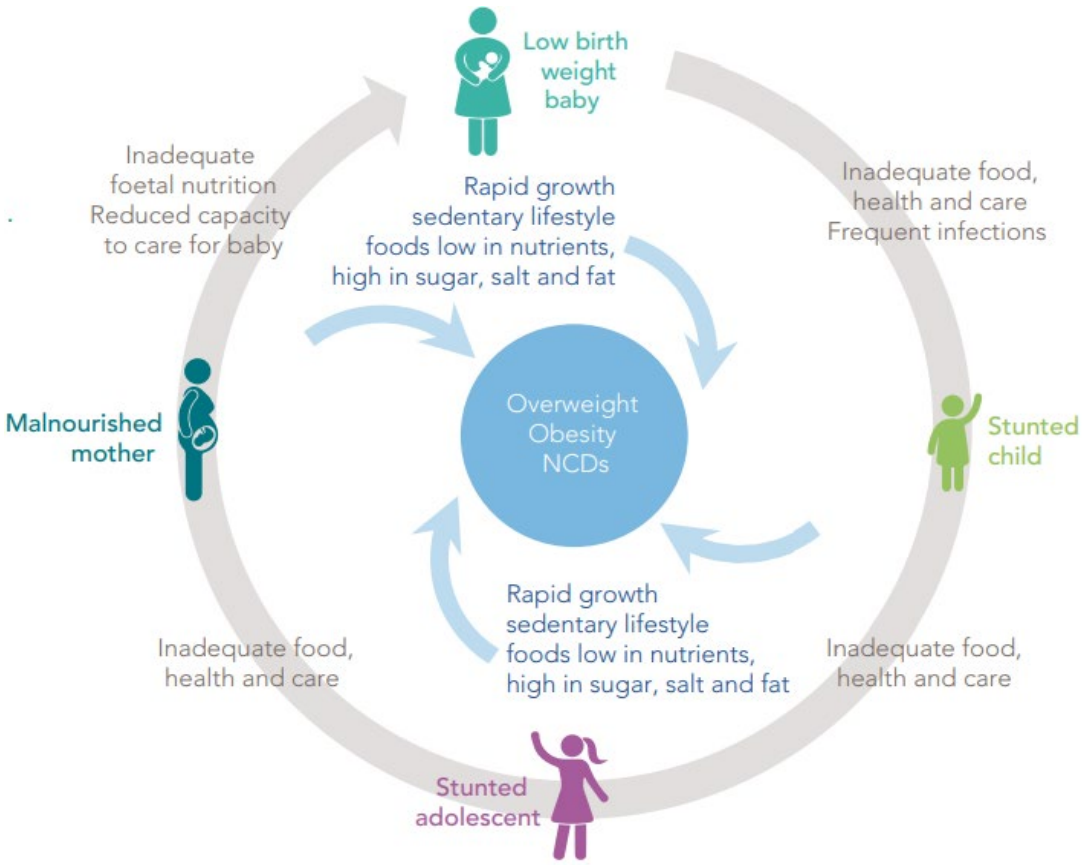


- The most recent 2024 World Obesity Atlas states that South Africa has seen the second highest increase in children with high body mass index from 2000 – 2016, and it projects that rates will continue to increase at 6.2% a year – from a baseline of 31% in 2020 to affect a staggering 71% of 5 – 19 year olds in 2035.[7]
- Overweight and obesity have also been increasing in adulthood – affecting 2 in every 3 women in South Africa – and driving an increase in Non-Communicable Diseases (NCDs) which are projected to become the leading cause of ill-health and death in sub-Saharan Africa. For example, while the prevalence of diabetes remained mostly unchanged in western Europe, from 1980 to 2014 it has more than doubled in sub-Saharan Africa to levels that are now higher than in high-income countries as thrifty phenotypes meet ultra-processed foods[i]. NCDs are occurring at younger ages and more aggressively in low- and middle-income countries.[8]

[i] The Developmental Origins of Health and Disease paradigm is helping to unpack the science behind this. When a body is starved of key nutrients and calories – in utero or in early childhood – it adapts by going into survival mode – saving energy by slowing growth and storing fat more efficiently. This early exposure to adversity can also trigger permanent changes in children's genes and metabolism that then increase their risk of becoming overweight and obese when they are suddenly exposed to energy-rich food environment later in life

Under- and over-nutrition: Two sides of the same coin

- South Africa faces a double burden of under -and overnutrition among children, evident in the prevalence of stunting, wasting and underweight alongside the rising prevalence of obesity and overweight.
- This double burden of malnutrition can occur in the same household and even the same individual. For example, undernourished mothers are more likely to have low-birth-weight babies and stunted children. Stunted children are more likely to become over-weight adolescents and to develop non-communicable diseases such as diabetes and hypertension. Stunted mothers are more likely to have stunted and overweight babies who develop into obese children, helping to drive an intergenerational cycle of malnutrition, ill health and poverty.



- Child malnutrition is difficult to reverse – and causes both immediate and lifelong harm, to the individual, their children and the country as a whole

Address the root causes

- It is important to look beyond individual behaviour in order to identify and address the systemic and structural drivers of malnutrition.
- While the immediate causes of undernutrition are a poor quality diet and frequent infections, key underlying drivers include poverty, food insecurity and inadequate access to water, sanitation and health care.[9]
- Similarly, while the immediate driver of overnutrition is an unhealthy diet (often high in carbohydrates, non-perishable and processed foods and low in dietary diversity),[10] it is equally important to address upstream determinants as caregiver and children's food choices are shaped in powerful ways by their local food environment and the national and global food system.

Rising poverty and inequality

- South Africa made significant progress in reducing the child food poverty headcount between 2003 (when it was over 50%) and 2013 (when it dropped to just over 30%).[11] This was mainly due to the expansion of the Child Support Grant (CSG) over that time period.
- Yet these early gains have been eroded: Child food poverty spiked dramatically during COVID-19 lockdown reaching a high of 39% in 2020 and rates have remained high at around 37% since 2021.[12]
- The national Food Poverty Line (FPL) represents the minimum income required for daily energy needs and was R855 per person per month in 2025. Caregivers living on income below this level do not have enough money to purchase the food needed to ensure a sufficiently nutritious and diverse diet for themselves or their children. They have to rely on food that is cheap, high in starch and fills stomachs – food likely to contribute to stunting and obesity. Children living in households below or close to this poverty line are likely to suffer from malnutrition. In 2024, 38% of all children in South Africa fell below the food poverty line – amounting to around 8 million children.[13] In the Eastern Cape, the child food poverty rate was over 50%.
- Poverty is also highly gendered: individuals in female-dominated households (without adult men) were 4 times more likely to be living in poverty than those in male dominated households.[14] This is in part due to differences in earnings, but also because of higher dependency ratios in female-dominated households (children are more likely to live with

women). Only 1 in 3 children live with their biological fathers, leaving the majority of mothers and many grandmothers to carry the burden of childcare. [15]

- Income poverty also compromises children's access to essential services such as safe drinking water, basic sanitation and health care – giving rise to frequent infections that further undermine child health and nutrition. For example, in 2024, 27% of children did not have access to safe drinking water and 21% did not have basic sanitation in their households, and 1 in 5 children had to travel more than 30 minutes to access health care services. [16]

COVID-19 further intensified these challenges

- Rising unemployment coupled with food price inflation pushed families even deeper into poverty: By November/December 2020, 1 in 6 households reported that a child went to bed hungry in the week before the NIDS-CRAM survey.
- Yet child hunger is just the tip of the iceberg. Mothers attempted to shield their children from hunger by eating less and purchasing cheaper, less nutritious meals, but these empty calories are likely to further exacerbate already high rates of stunting, micronutrient deficiencies and obesity.
- In addition, over 9 million children were denied access to school meals following the closure of schools and early childhood development (ECD) centres; and the disruption of routine health care services made it harder to identify and support children at risk of malnutrition.
- This raises concerns about how the rights of vulnerable children are sidelined in the state's responses to emergencies such as COVID, civil unrest, climate change, disasters such as the recent floods in KZN, and the current economic recession – and underscores the need to adopt a child-centred approach to the SAHRC Food Systems Inquiry.

Post COVID unemployment and food insecurity continued to rise

- A 2026 nationally representative survey by SALDRU found that food insecurity continued to rise after the pandemic as unemployment, food and fuel prices continued to soar. In 2023, 70% of households were food insecure – of these 45% were moderately food

insecure[ii], and 25% were severely food insecure[iii], with families stretching and skipping meals, selling vital assets, foregoing medicine, or taking on debt in order to survive.[17]

- Households with children and female-headed households and those relying on unstable, informal labour are particularly vulnerable with 1 in 10 female-headed households severely food insecure.
- Unemployment remains high at 31.4% (Q4: 2025) and increases to 42.1% if one includes discouraged work seekers.[18]
- While cash transfers offer a measure of protection, they are insufficient in coverage and value to buffer families from dramatic rises in food prices. The Child Support Grant (R560/child/month in 2025) continues to fall way below the Food Poverty Line (R855 in 2025) and is simply not sufficient to meet the nutritional needs of a child – let alone other essentials such as clothing, shelter, transport, airtime and electricity.
- At the same time, austerity cuts have eroded state expenditure on health services threatening to further compromise children's health and nutrition as evidenced by suboptimal immunisation coverage and measles outbreaks across the country.

Unhealthy food environments

- In many ways, children and families are stuck between a rock and a hard place as individual food choices are also shaped in powerful ways by local food environments and the broader food system which is increasingly profit-driven.
- **Global food corporations have expanded their markets in the global South, directly targeting children as consumers, and flooding local markets with cheap ultra-processed foods**.[19]
- These foods – low in micronutrients, high in sugar, salt and saturated fats – are fuelling a rapid rise in obesity and NCDs – with many of SA's children living in 'food deserts' where healthy foods are unaffordable or unavailable.
- In addition, the WHO has identified marketing of unhealthy foods and beverages to children as a key driver in the global childhood obesity pandemic.[20]
- International fast-food companies spend over $5 million a day marketing unhealthy foods to children.[21]

[ii] Households compromise on food quality and variety and begin to reduce food quantities, including skipping meals.
[iii] Households experience extreme deprivation, including hunger, going without food, and in some cases not eating for an entire day.

- Their adverts use **sophisticated marketing techniques to exploit children** – tapping into their fantasies and longing for love, home, freedom and independence to build brand loyalty.[22]
- Children are **a lucrative market,** as they are highly receptive to new tastes, exert a powerful influence on the food tastes and purchasing power of their parents and communities, and this early exposure can set a lifelong preference for sweet, salty and ultra-processed foods.
- Frequent exposure to food marketing has been found to influence children's food knowledge, preferences, consumption, diet quality and health.[23]
- For this reason the World Health Assembly adopted Resolution 63.14 in 2010 calling on states to **protect children from the marketing of food and non-alcoholic beverages** and developed a set of recommendations to guide the regulation of marketing to children[24]
- This was followed by the most recent 2023 guidance from the WHO calling on States to introduce mandatory restrictions to protect children of all ages from the harmful impact of food marketing. These restrictions should be sufficiently comprehensive to minimise the risk of industry subverting the regulations by migrating its marketing to other media.[25]

Adopt a child rights approach

- The state has a clear obligation to respect, protect, promote and fulfil children's rights – including their rights to food and basic nutrition. This includes putting in place reasonable legislative and other measures, within its available resources, to achieve **progressive realisation of everyone's Section 27 socio-economic rights** including plans, policies, laws, programmes, budgets and services which are effective, adequately resourced and make provision for the most vulnerable.
- Yet **children's Section 28 rights to basic nutrition and basic health care are not subject to progressive realisation** – and the state should therefore make these goods and services immediately available
- While families bear the primary responsibility for the care of children, Article 7 of UNCRC highlights that states have an obligation to take "appropriate measures to assist parents and others responsible for the child to implement this right, and shall, in case of need, provide material assistance and support programmes' with regard to nutrition.
- In addition, UN Committee on the Rights of the Child in its General Comment 19 on budgeting states that states **should not take deliberate regressive measures** in relation to socioeconomic rights such health care, social assistance and basic nutrition. And that even in times of economic crisis, regressive measures may only be considered after considering all other options, and ensuring that children are the last to be affected, especially those in vulnerable situations.
- These arguments have been upheld by the South African courts in *Equal Education and others vs Minister of Basic Education and others* – which called on the Department of Basic Education to reinstate the National School Nutrition Programme during COVID-19 lockdown.

Children's rights are interdependent and indivisible.

- For example, children's right to life (s11) is dependent on their right to sufficient food and water, social assistance, and health care (s27). Similarly, children's right to nutrition is dependent on children's right to know when foods are harmful to their health, and withholding this information violates their best interests. This highlights how responsibility for realising children's right to basic nutrition extends across a range of sectors and departments – including the Departments of Health, Social Development, Agriculture, Local Government, Trade and Industry, Finance, Communication, and Education – who need to work together to realise children's right to basic nutrition.

Children's best interests are of paramount importance

- Section 28 of the Constitution, and Section 9 of the Children's Act also stipulate that the best interests of the child are of paramount importance in all actions concerning children. The phrasing is intentionally broad … to allow for flexible interpretation in determining what is in the best interests of this child, in different contexts), and in S v M, the court emphasised that:

  "[s]tatutes must be interpreted and the common law developed in a manner which favours protecting and advancing the interests of children; and courts must function in a manner which at all times shows due respect for children's rights"[26]

Children have a right to protection from harmful business practices

- In addition, to fulfilling, respecting and promoting children's rights to basic nutrition, the State also has a duty to protect children from harmful business practices
- For example, every child has the right to be free from economic exploitation (UNCRC Articles 32 and 36). This includes protecting children from manipulative marketing practices that take advantage of children's vulnerabilities, including their emotions, and their limited ability to process and evaluate information, including the increasing use of children's personal data to enable brands to directly target children.
- The UNCRC's **General Comment 16** therefore issues clear guidance on the State's role to protect children from harmful business practices:

  States must take all necessary, appropriate and reasonable measures to prevent business enterprises from causing or contributing to abuses of children's rights. Such measures can encompass the passing of law and regulation, their monitoring and enforcement, and policy adoption that frame how business enterprises can impact on children's rights. States must investigate, adjudicate and redress violations of children's rights caused or contributed to by a business enterprise. A State is therefore responsible for infringements of children's rights caused or contributed to by business enterprises where it has failed to undertake necessary, appropriate and reasonable measures to prevent and remedy such infringements or otherwise collaborated with or tolerated the infringements.
- **General Comment 25** on the rights of children in the digital environment calls for similar protective measures:

  States parties should encourage the use of digital technologies to promote healthy lifestyles, including physical and social activity. They should regulate targeted or age-inappropriate advertising, marketing and other relevant digital services to prevent

children's exposure to the promotion of unhealthy products, including certain food and beverages, alcohol, drugs and tobacco and other nicotine products.

- The State must also report to the UN Committee on progress towards the realisation of children's rights in South Africa. The UN Committee's **Concluding Observations (2016)** in response to South Africa's Second Periodic Report calls on the South African government to:

  "Regulate the marketing of unhealthy foods to children in order to address the rise in child obesity and introduce strategies that enable poor households to access healthy food."

The precautionary principle

- We also urge the State to adopt the precautionary principle and to take proactive steps to protect the health and best interests of children based on the best available evidence we have at this time. Waiting for absolute and conclusive research can potentially put a generation of children at unnecessary risk – as was the case with lead poisoning and tobacco smoking where we delayed too long before taking action.[27]

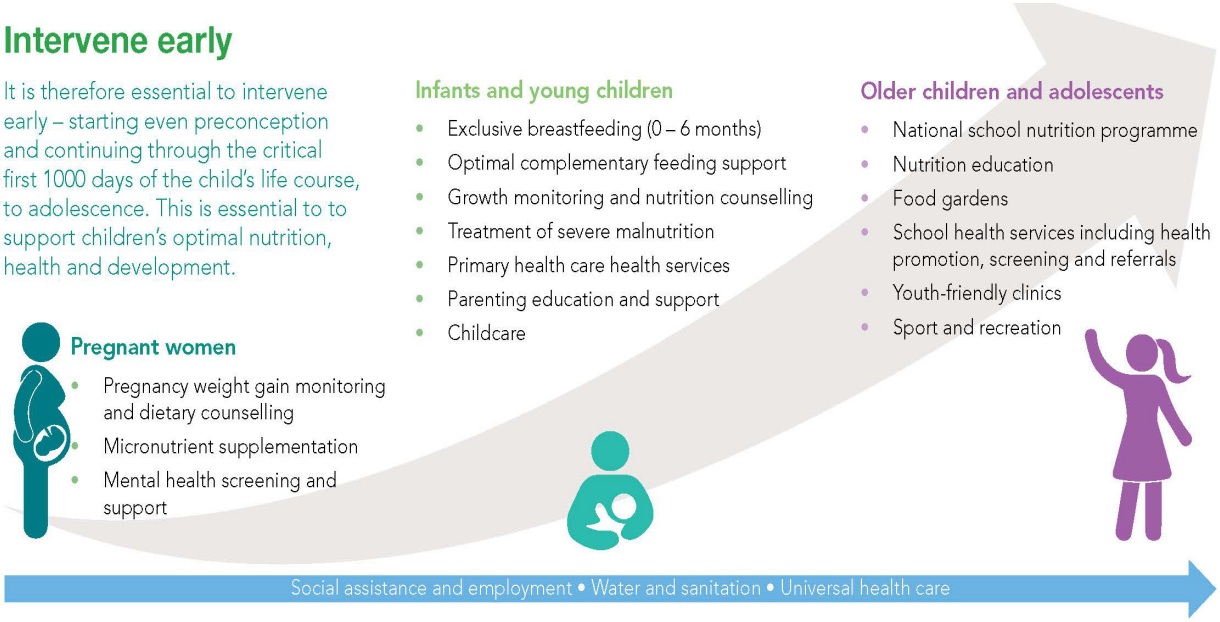
- The 1998 Wingspread Consensus Statement on the Precautionary Principle states that: "*When an activity raises threats of harm to human health or the environment, precautionary measures should be taken even if some cause and effect relationships are not fully established scientifically*."

- The precautionary principle places the burden of proof on the proponents of an activity rather than on the victims or potential victims. It upholds the public's right to informed consent, and it requires States to put anticipatory measures in place to protect people – and especially children – from unnecessary risks and potential harm.

Three key principles

1. Intervene early

- Exposure to malnutrition during sensitive periods of development can have an irreversible effect on their long-term health and development, so we need to intervene as early as possible to prevent long-term harm – starting early in the critical first 1000 days of life and continuing to adolescence.

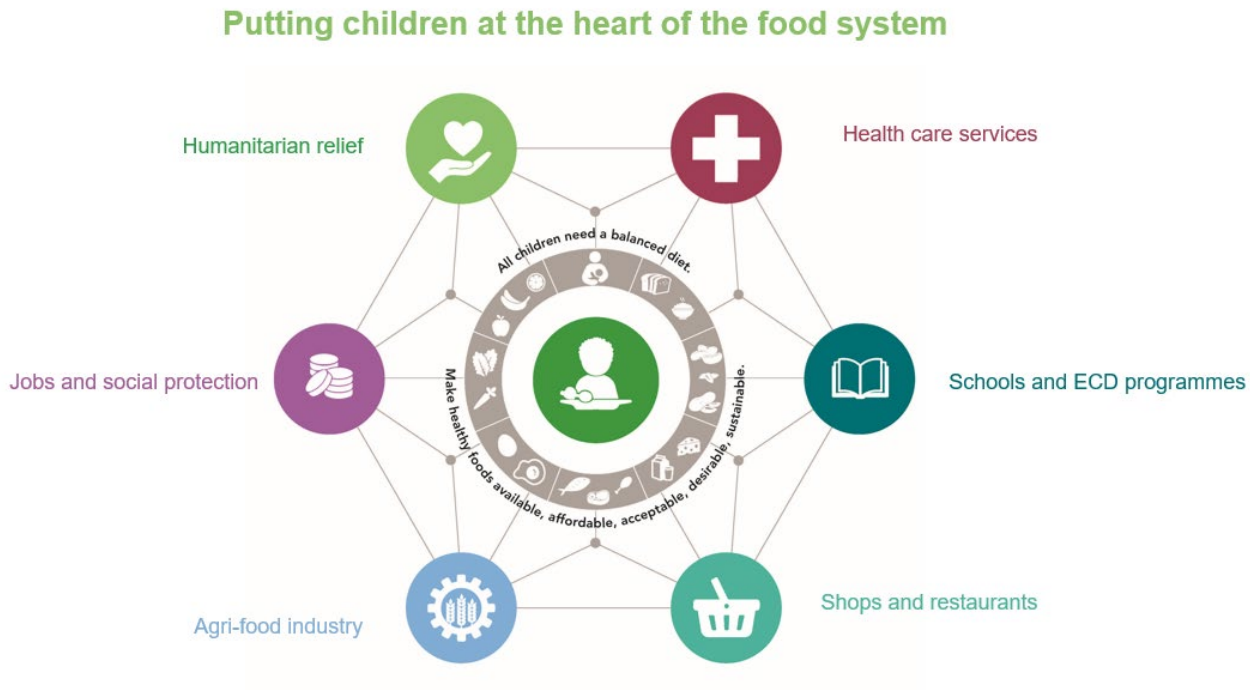


2. Adopt double-duty actions

- South Africa faces a double burden of malnutrition and therefore needs to adopt double-duty actions that address both under- and overnutrition. For example, exclusive breastfeeding for the first six months of life has been found to reduce both stunting and obesity.
- It is therefore vital to review current interventions to ensure that our efforts to reduce wasting and stunting do not inadvertently cause further harm. For example, food parcels and school meals should not only meet children's energy requirements, but they should also be rich in nutrients, and low in salt, sugar and fat.

3. Build a child-centred food system

- Child hunger and malnutrition are complex, multifaceted challenges that require a coordinated response from a range of sectors and services. Addressing this challenge will require targeted support from health services, schools and early learning programmes, greater investment in jobs and social protection, and interventions that target retail outlets such as shops and restaurants, and the agri-food industry to ensure that healthy food is available, affordable, acceptable, desirable and sustainable.



- Within each of these spheres it is essential to put in place child-specific measures to ensure that interventions are well targeted and effective so that they translate into improvements in children's food security, dietary diversity and nutritional status.

7 steps to address the burden of child malnutrition

Drawing on these core principles we have identified 7 key interventions to address the burden of child malnutrition from conception to adolescence. This includes strengthening investments in maternal health, infant and young child feeding, early childhood development, schools and social protection; tax and regulatory measures to limit children's exposure to ultra-processed foods; and strong leadership and coordination to ensure that children's best interests are centred in both policy reform and implementation.

1. Invest in maternal health and nutrition

- Women's nutritional needs increase dramatically during pregnancy, and food insecurity, micronutrient deficiencies, overweight, gestational diabetes and pre-eclampsia pose a threat to the health of both mother and unborn child. It is therefore essential to adopt a double-duty approach. This includes providing micronutrient supplements, monitoring weight gain and integrating dietary counselling into routine antenatal care with an emphasis on nutrient density and dietary diversity.
- Yet a 2024 study in 6 districts identified key bottlenecks in delivering these services: *"there still seems to be limited attention given to maternal nutrition in general, starting from the national level. This general weakness is evidenced by the fact that there is no supervision or specific technical assistance provided to the lower levels on maternal nutrition. There are no trainings specific to maternal nutrition and no national follow-up on the implementation and monitoring of maternal nutritional outputs within health facilities".*[28]
- Food insecurity also increases the risk of domestic violence, depression and anxiety that can further compromise mothers' emotional capacity to feed and care for their children.[29]
- Pregnancy and caring for a newborn are times when women often have less income – the UN Committee on Economic Social and Cultural Rights therefore recognises 'maternity' as one of the nine contingencies that a state's social security system should provide income cover for. However, it is the one contingency that South Africa's system provides no cover for if women work in the informal economy or are self-employed or unemployed. This is the gap that the proposal for a Maternity Support Grant aims to address [for more details see the submission from the MSG Coalition].

Recommendations

- **Strengthen the focus on maternal under- and overnutrition in antenatal and postnatal care – by introducing and tracking key indicators and building capacity at district and community level.**
- **Extend social assistance to pregnant women through the provision of a Maternal Support Grant (MSG) in the second semester of pregnancy to improve maternal nutrition and reduce low-birth weight babies**
- **Ensure a seamless transition from the MSG to the CSG to ensure no gap in income support and early access to the CSG**
- **Integrate violence prevention and mental health screening and support into antenatal and postnatal care**
- **Scale up efforts to prevent adolescent pregnancies and to support pregnant adolescents and extended family in caring for their infants**

2. Improve infant and young child feeding practices

Breastfeeding provides optimal nutrition. It also boosts children's immunity and protects children from both stunting and obesity – which is why the WHO recommends exclusive breastfeeding (EBF) for the first 6 months, followed by the introduction of complementary foods and continued breastfeeding until the child's second birthday.

The 2016 Demographic Health Survey found that only 32% of infants in SA are exclusively breastfed during the first six months of life, and only 23% of children 6 – 23 months are fed a minimum acceptable diet.[30] While more recent data from the 2021-23 National Food and Nutrition Security Survey suggest that EBF rates have declined to 22%.

While there are many reasons why a woman may choose not to breastfeed, the aggressive marketing of commercial milk formula (CMF) undermines caregivers' confidence and breastfeeding practices.[31]

Greater efforts are therefore needed to promote and support optimal infant and young child feeding practices as this is when children are most vulnerable to stunting and severe acute malnutrition. At the same time regulatory measures need to be strengthened to remove commercial pressures from the infant and young child feeding arena (see recommendations under the food system)

Regular growth monitoring and counselling is also essential so that health workers can intervene as early as possible to identify and support children at risk for malnutrition. It is

therefore worrying that a 2023 study by the National Department of Health and UNICEF identified key bottlenecks – including staff shortages, inadequate capacity building, and stockouts of essential commodities – needed for the screening and management of acute malnutrition in infants and young children.[32]

Recommendations

- **Scale up support for all breastfeeding women. This includes ensuring women are able to access their entitlements (to parental leave and breastfeeding breaks in the workplace) and extending this support to women working in the informal sector such as domestic workers**
- **Ensure health workers have the necessary knowledge and counselling skills to support breastfeeding women – with an emphasis on addressing mother's fears around typical infant behaviours (e.g. the sleepless or crying baby) and supporting critical transitions – including when the milk comes in, returning to work, and the transition to complementary foods**
- **Ensure health workers have the necessary knowledge and counselling skills to support appropriate complementary feeding of young children and actively promote local complementary foods that are affordable, nutrient rich and low in sugar and salt**
- **Strengthen surveillance, support and referral systems at facility and community level and ensure health workers have the equipment, knowledge and skill to identify, support and refer children at risk of under- and overnutrition**
- **Ensure caregivers with children at risk who are referred from health care facilities have access to income support and/or nutritious food parcels to enable them to feed their children the advised nutrient dense food.**

3. Invest in early childhood development

Early learning programmes offer a platform for supporting nutrition of preschool children. Registered ECD programmes currently qualify for a subsidy of R24 per child per day, 40% of which is earmarked for nutritious food, yet stringent registration requirements from multiple departments continue to exclude programmes serving those communities and children most in need.

In 2024, 68% of 3-5 year olds attended an early programme[33], yet only half of ECD programmes were registered – and of the 1.5 million poor children attending ECD programmes, only 750,000 benefitted from the ECD subsidy[34].

A further 1.2 million 3-5 year olds are not attending an ECD programme, while only 17% of children 0 – 2 attended a creche, playgroup or ECD centre.[35]

Recommendations

- **Recognise that the most vulnerable children (0 – 2 years) and those living in poverty are least likely to attend ECD centres and explore alternative strategies to identify and reach these children – for example by providing appropriate nutrition support and social assistance through the health care system**
- **Explore mechanisms to extend nutritional support to children on the weekends and during school holidays**
- **Accelerate the drive to register ECD programmes and support them to move from bronze to silver registration status so that they can access the ECD subsidy**
- **Ensure the ECD subsidy increases annually so that the quantity and quality of food is not eroded by inflation**
- **Ensure that the Nutrition Guidelines for Early Childhood Development Centres are widely disseminated and used to guide purchasing and menu planning so that all children are provided with a healthy nutritious meal**

4. Use schools to support older children and adolescents

The NSNP provides a daily meal to over 9 million learners but there are concerns that rising food prices, coupled with lack of transparency on the number of learners catered for, are eroding both the quantity and quality of school meals.

Schools (and ECD centres) should also be used as a platform for providing nutrition education and school health services.

Recommendations

- **Monitor and enforce the Department of Basic Education's guidelines for the NSNP to improve the nutritional quality of school meals**
- **Calculate the value of the food component of the NSNP and monitor the budget to ensure that the allocation for food keeps pace with food inflation.**

- **Ensure each school's allocation for the NSNP covers all the eligible children in the school, including undocumented children.**
- **Prohibit the marketing – and actively discourage the sale – of unhealthy, obesogenic foods in and around schools**

5. Create a healthy and child-centred food system

Direct intervention by the state is needed to ensure that the food system respects children's rights to health, nutrition and food that is of good quality. We therefore welcome the state's efforts to introduce regulations to: protect children from the marketing of unhealthy foods; introduce front-of-pack labelling to enable consumers to make informed choices; and taxes to limit the consumption of unhealthy foods – through the Health Promotion Levy (HPL), Audio and Audio-Visual Content Services Bill, Regulation R991 relating to Foodstuffs for Infants and Young Children, and draft Regulation R3337 relating to the Labelling and Marketing of Foodstuffs Harmful to Health.

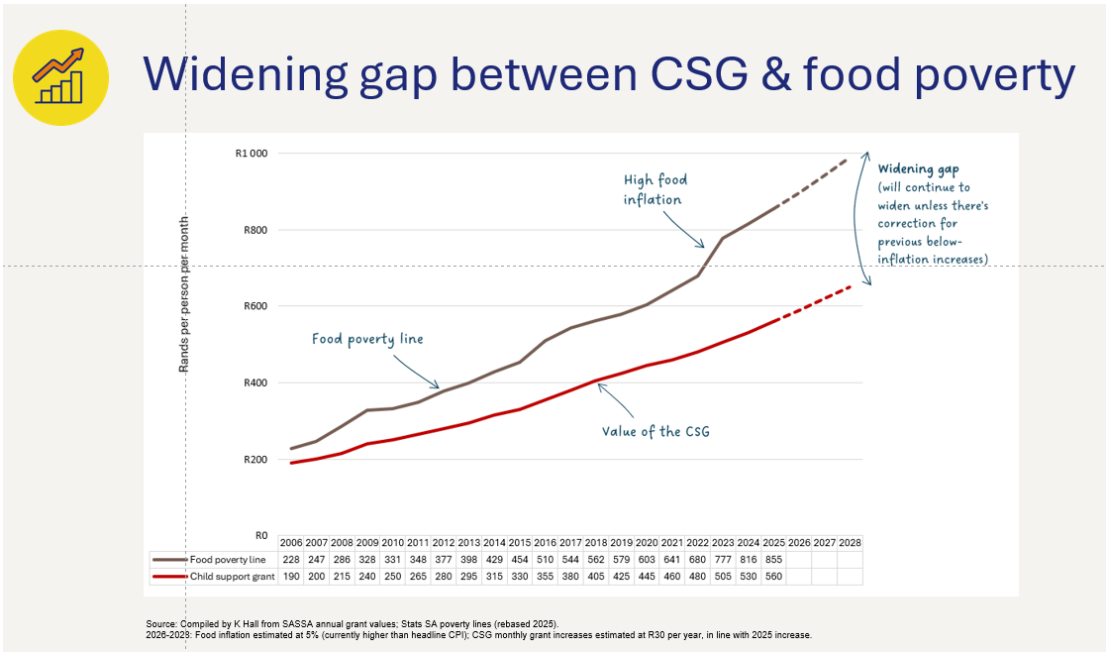
Recommendations

- **Strengthen Regulation 991 to close existing loopholes including the digital marketing of commercial formula milk through online baby clubs and influencers.**
- **Finalise draft Regulation R3337 so that consumers can easily identify foods that are harmful to health and ensure that these foods are not marketed to children.**
- **Put in place robust monitoring, enforcement and sanctions for both R991 and R3337 to ensure industry complies with marketing restrictions.**
- **Increase the HPL on sugar-sweetened beverages to 20% as recommend by the World Health Organisation[36] to curb the rise in obesity and diet-related NCDs.**
- **Subsidise the costs of a basic healthy food basket to help make healthy foods more affordable.[37]**

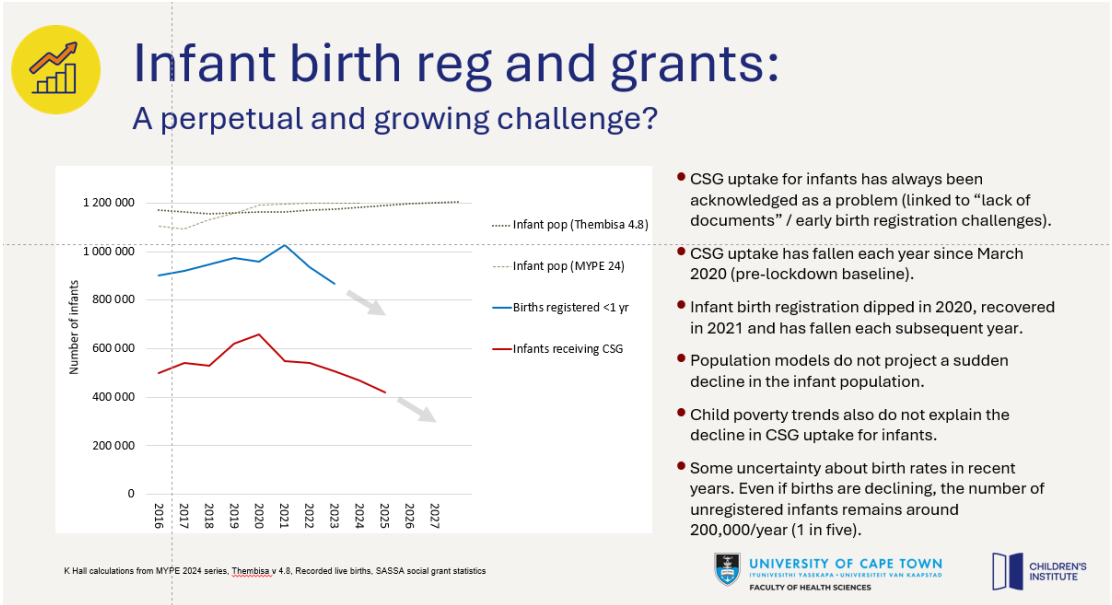
Expand social protection

- The Child Support Grant (CSG) provides a lifeline for 13 million children and over 7 million caregivers and is associated with improved nutrition and education outcomes.[38] But the grant amount (R560 a month/ R19 a day in 2025) is no longer enough to meet children's dietary needs. The State has been repeatedly advised by three international human rights committees to increase the CSG amount.[39] Yet the small incremental annual increases to the CSG have failed to keep pace with food price inflation steadily

eroding its value so that the value of grant now falls 35% below the FPL (R855 in 2025).



- Despite its impressive reach, the low value and purchasing power of the grant limits its ability to protect children from hunger and malnutrition, with many households buying foods high in starch and low in nutrients, and/or running out of food before month end.
- Restoring the value of the CSG to the FPL will significantly reduce the number of children living below the food poverty line which in turn will have a positive impact on child health and nutrition indicators.
- The CSG is well targeted, and it reaches over 80% of poor children,[40] yet early uptake of the grant for infants under 1 has continued to drop dramatically since lockdown with 238 000 fewer infants receiving the CSG in 2025 than in 2020. This 36% decrease in early uptake of the CSG coincides with a rise in child poverty and is particularly worrying given infants vulnerability to the immediate shock and long-term effects of malnutrition.
- The downward trend in early uptake of the CSG is likely caused by a similar downward trend in current year birth registration, and barriers in access to IDs for young mothers.[41]



- In 2025/26 National Treasury imposed conditions on SASSA's budget allocation, forcing SASSA to more than double the number of reviews it conducts per year on beneficiaries and to impose stricter checks on new applicant's income status at application stage. SASSA frontline services have taken on this additional burden without any additional personnel, resulting in longer queues for new grant applicants, increased transport costs to secure a grant and erroneous exclusion of the most vulnerable caregivers and children.
- The number of infants accessing the CSG will continue to decline under these conditions and we anticipate an increase in child malnutrition and stunting as a result.

Recommendations:

- **Increase the value of the CSG and the value of the Social Relief of Distress Grant for unemployed adults to the food poverty line. These are the only social grants are specifically targeted to the poorest households and individuals.**
- **As an alternative to an across-the-board immediate increase to the CSG, the existing top-up mechanism could be used to provide a higher-value grant (linked to the FPL) for eligible (poor) children under 5 years. This would reduce the budget shock of the increase while ensuring that very young children have better access to nutrition. It can be done immediately, at the touch of a button, without any revisions to the social assistance laws or regulations.**
- **Design and implement an inter-departmental strategy to ensure all pregnant women have IDs before they give birth and all babies are registered as soon as possible after birth in order to increase early uptake of the CSG**

- **In the meantime, SASSA should pro-actively promote the use of its 'alternative document' policy which allows mothers without IDs and infants without birth certificates to access the CSG as outlined in Regulation 13(1) of the Social Assistance Act. SASSA officials are however reluctant to utilise this option and the take-up is low compared to the numbers of children in need. During 2025; almost 50% of the children accessing social grants using this regulation have had their grants cancelled by SASSA.**

6. Strengthen leadership and political will

- The National Nutrition Directorate in the NDOH has lost several mid-level managers due to resignations, retirement and death crippling its capacity to address nutrition priorities
- The National Food and Nutrition Security Council which is responsible for driving the implementation of intersectoral National Food and Nutrition Security Plan has still not been appointed raising questions about a lack of political will to address these challenges.
- In contrast with this erosion of capacity and energy to address malnutrition and food security within national government institutions, the SAHRC Inquiry led by the Eastern Cape SAHRC office has shone a spotlight onto the systemic causes of SAM deaths in the Eastern Cape and has educated provincial and national departments on their constitutional obligations to children. It has created a transparent and participatory process where government has been held accountable and encouraged to engage in thinking about a cross-sectoral solution.
- While the inquiry was initiated in response to the crisis in the Eastern Cape, many of the problems identified and the recommendations made are applicable to the whole country and not just the Eastern Cape. This is important because, as this Inquiry has acknowledged, the Eastern Cape is not the only province where SAM is on concern.
- Government is legally required to implement the recommendations made by the SAHRC in its final report of the Malnutrition Inquiry and we encourage the SAHRC to continue to hold the implicated departments, both National and Provincial, accountable for implementing the SAHRC's recommendations while the broader Inquiry into Food Systems is under way.
- We are encouraged by the SAHRC's decision to hold an inquiry into Food Systems because there are many pieces to the puzzle of food insecurity in South Africa. We encourage the SAHRC to continue to hold children and their right to basic nutrition at

the centre of the broader inquiry and to ensure that recommendations and interventions to enhance food security within the broader food system translate into improved nutritional outcomes for children

Recommendations

- **Address the capacity constraints in the National Nutrition Directorate and establish the NFNS Council as a matter of urgency to strengthen leadership and drive the nutrition agenda in South Africa.**
- **Include child poverty and nutrition experts on the NFNS Council to ensure that children's needs are centred within policy, practice and food system reform.**
- **Continue to monitor and hold the state accountable to implement the recommendations in the SAHRC Report on the Child Malnutrition Inquiry**
- **Monitor and hold the state accountable to implement the recommendations that flow from this Inquiry into Food Systems.**
- **Require child impact assessments to be conducted prior to the state taking any decision on policies, laws or budgets that could have the effect of decreasing access to programmes that are central to children's basic nutrition – in particular children's social grants, the ECD subsidy and registration promotion programmes, the NSNP, basic health care services, and birth registration. This would at least protect the most important proven programmes from being eroded, particularly in times of crisis when they are most needed, yet conversely, also most at risk of neglect.**

In the words of Gabriela Mistral, Nobel Prize winner of Literature from Chile:

> "We are guilty of many errors and many faults, but our worst crime is abandoning the children, neglecting the fountain of life. Many of the things we need can wait. The child cannot. Right now is the time his bones are being formed, his blood is being made, and his senses are being developed. To him we cannot answer 'Tomorrow,' his name is today."

References

[1] This submission draws on - and updates - the findings and central arguments presented in the *2020 South African Child Gauge* on Food and Nutrition Security: https://ci.uct.ac.za/cg-2020-food-and-nutrition-security

[2] National Department of Health (30 June 2023) Response to Parliamentary Question 2501.

[3] 4th Triennial Report of the Committee on Mortality and Morbidity in Children Under Five: 2017 – 2020.

[4] Hall K, Almeleh C, Giese S, Mphaphuli E, Slemming W, Mathys R, Droomer L, Proudlock P, Kotze J and Sadan M. *South African Early Childhood Review 2024*. Cape Town: Children's Institute and Ilifa Labantwana. 2024.

[5] Department of Health, Statistics South Africa, South African Medical Research Council, ICF. South African Demographic & Health Survey 2016: Key Indicators. Pretoria and Rockville, Maryland: NDOH, Stats SA, SAMRC & ICF. 2017

[6] Simelane T, Mutanga S, Hongoro C, Parker W, Mjimba V, Zuma K, . . . Mokhele T. National Food and Nutrition Security Survey: aNtional report. Pretoria: Human Sciences Research Council. 2024.

[7] Department of Health, Statistics South Africa, South African Medical Research Council, ICF. South African Demographic & Health Survey 2016: Key Indicators. Pretoria and Rockville, Maryland: NDOH, Stats SA, SAMRC & ICF. 2017

[8] Wang H, Naghavi M, Allen C, Barber RM, Bhutta ZA, Carter A, et al. Global, regional, and national life expectancy, all-cause mortality, and cause-specific mortality for 249 causes of death, 1980–2015: A systematic analysis for the Global Burden of Disease Study 2015. *The Lancet*. 2016;388(10053):1459-544

[9] Global Nutrition Targets 2030: Stunting brief. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF). 2025.
Global Nutrition Targets 2030: Wasting brief. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF). 2025.

[10] Global Nutrition Targets 2030: Childhood overweight brief. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF). 2025.

[11] See www.childrencount.uct.ac.za

[12] See www.childrencount.uct.ac.za for a child-centred analysis of survey data over the period 2003 to 2021.

[13] See www.childrencount.uct.ac.za

[14] Posel D, Hall K & Goagoses L. Going beyond female-headed households: Household composition and gender differences in poverty. *Development Southern Africa*. 2023. DOI: 10.1080/0376835X.2023.2182760

[15] See www.childrencount.uct.ac.za

[16] See www.childrencount.uct.ac.za

[17] Southern Africa Labour and Development Research Unit. The State of Food Insecurity in South African. 2026 Report. Cape Town: SALDRU, UCT. 2026.

[18] Statistics South Africa. Quarterly Labour Force Survey. Quarter 4: 2025. Statistical Release PO211. Pretoria: Stats SA. 2026.

[19] Swart R, van der Merwe M, Spires M, Drimie S. Child-centred food systems: Ensuring health diets for children. In: J M, Witten C, Lake L, editors. *South African Child Gauge 2020*. Cape Town: Children's Institute, University of Cape Town. 2020.

[20] World Health Organization. *Report of the Commission on Ending Childhood Obesity*. Geneva: WHO. 2016.

[21] Prevention Institute. *The Facts on Junk Food Marketing and Kids* [Internet]. (undated). Accessed 20 November 2020: https://www.preventioninstitute.org/facts-junk-food-marketing-and-kids

[22] Lewis D, Bhoola S & Mafofo L. Corporate fast-food advertising targeting children in South Africa In: May J, Witten C & Lake L (eds) *South African Child Gauge 2020*. Cape Town, Children's Institute, UCT. 2020.

[23] Cairns G, Angus K, Hastings G, Caraher M. Systematic reviews of the evidence on the nature, extent and effects of food marketing to children. A retrospective summary. *Appetite*. 2013; 62:209-215.
Boyland EJ, Nolan S, Kelly B, Tudur-Smith C, Jones A, Halford JC, et al. Advertising as a cue to consume: A systematic review and meta-analysis of the effects of acute exposure to unhealthy food and non-alcoholic beverage advertising on intake in children and adults. *The American Journal of Clinical Nutrition*. 2016;103(2):519-33.

[24] World Health Organisation. *World Health Assembly Resolution 63.14 Marketing of food and non-alcoholic beverages to children.* Geneva: WHO. 2010

[25] Policies to protect children from the harmful impact of food marketing: WHO guideline. Geneva: World Health Organization. 2023.

[26] Centre for Child Law as Amicus Curiae) 2008 (3) SA 232 (CC)

[27] Martuzzi M & Tickner JA (eds). *The precautionary principle: protecting public health, the environment and the future of our children*. WHO Europe. 2004

[28] National Department of Health and UNICEF South Africa. *Evidence Based Planning using Bottleneck Analysis for Maternal Nutrition and Child Wasting Final Report.* Pretoria: NDoH & UNICEF. 2024.

[29] Abrahams Z, Boisits S, Schneider M, Prince M, Lund C. Domestic violence, food insecurity and mental health of pregnant women in the COVID-19 lockdown in Cape Town, South Africa. *Resesarch Square* [Internet]. 2020.

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

[31] How the marketing of formula milk influences our decisions on infant feeding. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF). 2022.

[32] National Department of Health and UNICEF South Africa. *Evidence Based Planning using Bottleneck Analysis for Maternal Nutrition and Child Wasting Final Report.* Pretoria: NDoH & UNICEF. 2024.

[33] Hall K, Almeleh C, Giese S, Mphaphuli E, Slemming W, Mathys R, Droomer L, Proudlock P, Kotze J and Sadan M. *South African Early Childhood Review 2024.* Cape Town: Children's Institute and Ilifa Labantwana. 2024.

[34] Real Reform. (2025) Funding for ECD. Presentation to the Standing Committee on Appropriations: Submission on the 2025 Division of Revenue Bill 4 April 2025.

[35] Hall K, Almeleh C, Giese S, Mphaphuli E, Slemming W, Mathys R, Droomer L, Proudlock P, Kotze J and Sadan M. *South African Early Childhood Review 2024.* Cape Town: Children's Institute and Ilifa Labantwana. 2024.

[36] World Health Organisation. Taxes on Sugary Drinks: Why do it? WHO: Geneva. 2017. https://iris.who.int/bitstream/handle/10665/260253/WHO-NMH-PND-16.5Rev.1-eng.pdf

[37] https://dgmt.co.za/lets-close-the-food-gap/

[38] Hall K. 2024. Income and social grants – Children receiving the Child Support Grant. *Children Count* website, Children's Institute, University of Cape Town. Accessed on 25 February 2026:

[39] UNCRC, CESCR & ACERWC

[40] Department of Social Development, South African Social Security Agency, UNICEF. *Removing Barriers to Accessing Child Grants: Progress in reducing exclusion from South Africa's Child Support Grant*. Pretoria: UNICEF South Africa. 2016.

[41] Hall K and Proudlock P in *South African Early Childhood Review 2024.* Cape Town: Children's Institute, University of Cape Town and Ilifa Labantwana. 2024.