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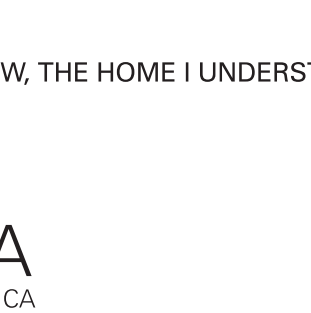
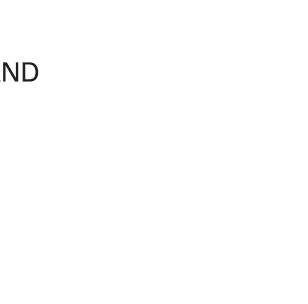
Education Series Volume IV:

Early Childhood Development in South Africa, 2016







THE SOUTH AFRICA I KNOW, THE HOME I UNDERSTAND

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Education Series Volume IV
Early Childhood Development in South Africa, 2016

Statistics South Africa

Risenga Maluleke
Statistician-General

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For technical enquiries, please contact:

Seble Worku
Tel.: 012 310 8480
Email: seblew@statssa.gov.za

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Abbreviations and acronyms

WC	Western Cape
EC	Eastern Cape
NC	Northern Cape
FS	Free State
KZN	KwaZulu-Natal
NW	North West
GP	Gauteng
MP	Mpumalanga
LP	Limpopo
RSA	South Africa
ART	Antiretroviral treatment
CRC	Convention on the Rights of the Child
CSG	Child support grant
DTaP-IPV	Diphtheria, Tetanus, Pertussis (whooping cough) and Polio vaccine
ECD	Early childhood development
GHS	General Household Survey
Hib	Haemophilus influenzae type b
HIV	Human Immunodeficiency Virus
IMR	Infant mortality rate
MDGs	Millennium Development Goals
MTSF	Medium Term Strategic Framework
NDP	National Development Plan
PCR	Polymerase chain reaction
PCV	Pneumococcal conjugate vaccine
PMTCT	Prevention of mother to child transmission treatment
NPA	National Prosecuting Authority
RDP	Reconstruction and Development Programme
RV	Rotavirus vaccine
SADHS	South African Demographic and Health Survey
SAPS	South African Police Service
SASSA	South African Social Security Agency
SD	Standard deviation
SDG	Sustainable Development Goals
STATS SA	Statistics South Africa
UMR	Under five morality rate
UNICEF	United Nations International Children's Emergency Fund
VOCS	Victims of crime survey
WHO	World Health Organisation

Foreword

South Africa‘s commitment to growth in human capital is reflected in its massive investment in education. However this could not bear the intended fruit due to various failures. Part of the quality requirement is to allow children to reach their full academic development potential by responding to good developmental paths such as adequate healthcare, good nutrition, good quality childcare and nurturing, clean and safe environment, early learning and stimulation. In recent years, the government’s pledge in investing in early childhood development (ECD) culminated in the passing of the integrated ECD policy in 2015. While the implementation of the policy requires an inter-sectoral approach, the programmes would mostly build on existing services and would only need government to set new intervention strategies for future scalable and accelerated progress in universal access to ECD. The purpose of this report is to describe the latest evidence in ECD related realisations with respect to children aged 0–6.

In 2016, according to the General Household Survey (GHS) data, the number of children aged 0–6 in South Africa was close to 7,2 million and consisted of nearly four in ten (41%) of the total child population. Close to 41% of children aged 0–6 resided either in KwaZulu-Natal or Gauteng. More than half of the children (4,1 million or 57,1% of the total children population aged 0–6) were residing in formal urban areas; yet, Eastern Cape, KwaZulu-Natal and Limpopo were the provinces facing a greater burden in supporting the young age population. Most young children aged 0–6 lived in single parent family structures, residing mostly with only their mothers (45,6%) while 12,4% of young children lived with none of their biological parents. Close to 36% of children aged six or younger belonged to large households with more than six members; close to six per cent stayed in one-roomed dwellings and close to 10% in dwellings which had no bedrooms. Furthermore, most of these children were growing in poverty as large monthly household income disparities exist between population groups with black African children being highly disadvantaged; 46% of them were confined to the lowest household income quintiles (quintiles 1 and 2). According to the South African Social Security Agency (SASSA) data, as of March 2017, 4,9 million children aged 0–6 had benefited from the child support grant (CSG); 27 498 children in the same age group received the care dependency grant (CDG); and 25 824 children aged 0–6 years received the foster child grant.

Large geographic disparities also existed in access to services. Most young children lived in households with poor access to water. Indeed, close to 35% of children in Eastern Cape and 46% in Limpopo had piped water inside their dwellings or on site. In contrast, children in Gauteng and Western Cape lived in households that have relatively higher access to piped water inside their dwellings or on site (94% and 89% respectively). Furthermore, only 57,2% of children in Limpopo had access to improved sanitation. Moreover, in total one in ten young children stayed in dwellings with poorly constructed roofs or walls. The worst cases were experienced by children in Western Cape with 17,3% of children living in dwellings with weak walls and 18,0% with weak roofs.

The ECD policy has put a lot of emphasis on the six essential ECD packages which consist of nutritional support, maternal and child health, social services, support for primary caregivers, and stimulation for early learning. There has been a large improvement in infant breastfeeding with 73% of children under one being breastfed in 2016 and among which close to 32% being exclusively breastfed. Malnutrition is a serious challenge in South Africa. Approximately a third of children in Gauteng and Free State were stunted (34,2% and 33,5% respectively). In 2016, according to the Department of Health data, South Africa also had one of the highest low birth weight rate with 13,3% occurrences of live births of babies under 2,5kg nationally. The country also had a high underweight-for-age incidence with 21,3% occurrences nationally in 2016. These disorders often led to child deaths; in 2016, the rate of deaths associated to severe acute malnutrition among children under five years of age was eight per cent. Hence inadequate pre-natal care, poor child feeding practices resulted in high early childhood mortality levels. Nationally in South Africa, the under-five mortality rate was 44 deaths and the infant mortality rate was 34 deaths per 1 000 live births.

The well-being of young children is dependent on their mothers' health from the time of conception. Mothers need to start caring for their babies from the onset of pregnancy in order to reduce the risks of complications and hence need to access antenatal care services as early as possible. However according to 2014/2015 data, only 61% of women had their first antenatal visit before the 20th week of their pregnancy whereas the WHO requirement is for all pregnant women to have their first visit at 12th week of their pregnancy. According to the GHS 2016, close to three in ten households in which pregnant women stayed had run out of money to buy food in the 12 months prior the survey.

Children in South Africa are exposed to violence, especially sexual offences. According to South African Police Service (SAPS) data, 20 254 sexual complaints concerning children less than 18 years old were reported to the police in 2015/2016.

A large percentage of children were exposed to home environments that did not provide for communication or play to stimulate learning and neither did they participate in formal learning activities. Nationally among children aged 0–6, 47% did not attend any educational centre, while 21,2% attended crèche/educare centres and 11,3% were attending pre-school. A breakdown by monthly household income quintile revealed that close to half of the children in the lower household income quintiles did not attend any educational centre while 40% of the children in the highest household income quintile attended out-of-home early learning programmes. Overall, close to 12% of children aged 0–6 did not live with either of their biological parents and only 40% lived with both biological parents. While the majority (73,2%) were cared for by their parents (either biological, adoptive or foster parents), nearly 17% were mainly cared for by their grandparents, and 5% by their aunts and uncles. Children in mostly black African families received suboptimal stimulation as 31% were never encouraged to imitate daily activities, 33,2% were never given answers when they pointed at objects and asked for explanations.

Risenga Maluleke
Statistician-General

Chapter 1: Introduction

1.1 Background

South Africa has been embarking on comprehensive reform of social programmes that affect young children with the development of the National Integrated Policy for Early Childhood Development in 2015. The policy covers most facets of early childhood development, such as nutrition, heath, protection and early learning. Although it is still unclear how the policy is going to be implemented, it is certain that social programmes for children will move away from the fragmented ways they were so far rendered and are expected to systemise the implementation of these programmes and increase integration and coordination. What is also clear is that existing child related policies will continue to serve the purpose they were intended for and existing resources would be expanded as well as new ones created, to realise the objectives of the new policy. The following section describes legal and operational frameworks that serve as national policy frameworks for planning, budgeting and implementation of programmes aimed at improving the standard of living of children in South Africa.

1.2 National legal and operational child related framework

South African laws have extensive human rights standards that should be applied to children in the country. They are crosscutting and found in various service delivery institutions relevant to child welfare and care. Although the mandate for care and protection of the child lies primarily with the Ministry of Social Development, other Ministries such as Home Affairs, Health, Presidency, Finance, Planning and Monitoring and Evaluation etc., the private sector, not-for-profit organisations, and civil society organisations all have various roles to play in the well-being and development of children in South Africa. These agencies are expected to align and coordinate their service delivery plans to result in an integrated approach to service delivery.

1.2.1 The South African Constitution

Section 28 of the Bill of Rights that constitute the second chapter of the South African Constitution (Act No 108, 1996) contains nine broad rights of children. These include the right (i) to a name and nationality from birth; (ii) to family, parental or to appropriate alternative care; (iii) to basic nutrition, shelter, healthcare services and social services; (iv) to be protected from maltreatment, neglect, abuse and degradation; (v) to be protected from exploitative labour practices; (vi) to be protected from performing work or services that are not appropriate for their age, would impact their well-being in general but also their physical, mental, spiritual and moral development; affect their educational participation; (vii) treated as a child when in conflict with the law; (viii) to be represented by a legal practitioner assigned by the state; and (iix) to be protected in case of armed conflicts and not be used for the cause. The Bill also suggests that all decisions concerning the child should be taken by looking at the best interest of the child. Various laws were subsequently enacted to give effect to these rights. The main legislation is the Children's Act (Act No. 38 of 2005) which provides a standard for the "best interests of a child".

1.2.2 The Children's Act (Act No. 38 of 2005)

The Act provides 14 guiding factors when applying the principle of the "best interests of a child" as to take account of the following features. These include (i) the nature of the relationship of the child towards its parents or caregivers; (ii) the attitude of the parents towards the child and how they exercise their parental responsibilities; (iii) the capacity of the parents or caregivers to provide for all the needs of the child; (iv) the effect on the child of any change in the child's circumstances including separation from his/her parents, caregivers, brothers or sisters; (v) the practical difficulty and expense of a child having contact with the parents on a regular basis and how it affects the child's right to maintain personal relations; (vi) the need for the child to remain in the care of his/her parents, family and maintain a connection with his/her culture or tradition; (vii) the age, sex, maturity and stage of development of the child as well as his/her background and other relevant traits; (viii) child's physical and emotional

security; (ix) child's disability status; (x) if the child suffer any chronic illness; (xii) the child to be brought up within a stable or caring family environment; (xiii) the need to protect the child from any physical or psychological harm that can subject or expose him/her to maltreatment, abuse, degradation, ill-treatment, violence or harmful behaviour towards another person; (xiv) the need to protect the child from any family violence; and (xv) the need to opt for an action or decision which would avoid or minimise further legal or administrative proceedings in relation to the child. The Children's Act further outlines parental responsibilities and rights; it elaborates on the establishment or children's courts, their proceedings and jurisdiction. The Act also provides guidelines on norms and standards for partial care; it outlines a general strategy for early childhood development; it also makes provision for child protection system and protective measures for children; for the issuing of contribution orders. The child is quite detailed and also touches on prevention and early intervention for vulnerable children, children in alternative care, children in foster care, children in child and youth care centres and drop-in centres. It also has to make new provision for the adoption of children; to prohibit child abduction; provide for surrogate motherhood; and to create certain new offences relating to children such as trafficking.

1.2.3 South African Schools Act (Act No. 84 of 1996)

The National Education Policy (Act No. 27, 1996) was enacted to redress past inequalities on access to educational institutions and guarantees the protection of individuals against unfair discrimination within the education system. It is supplemented by the South African Schools Act (Act No 84 of 1996) which prescribed the age of the child for compulsory attendance, language policy for public schools and prohibits public schools to exclude learners on the basis of non-payment of fees. The act also makes provision for prohibition of corporal punishment of learners.

1.2.4 Maintenance Act (Act No. 99 of 1998)

The Act spells out duties of parents to support their children regardless of the circumstances under which the child was born. The law expects parents to provide support that can afford the child proper living and upbringing, provision of food, clothing, accommodation, medical care and education. Although the regulation is good on paper, there are still challenges in its application.

1.2.5 Social Assistance Act (Act No. 13 of 2004)

The purpose of the Act is to provide for the rendering of social assistance to all persons in need as defined by the act and other legislations and policies and to provide for the mechanism for rendering of such assistance, amongst others. The following grants are directly relevant to children: (i) a child support grant; (ii) dependency grant; and (iii) foster child grant. The child support grant is paid to the primary care giver of a child. The care dependency grant is paid to the parent, primary care giver or foster parent of a child who requires and receives permanent care or support services due to his or her physical or mental disability. A foster child grant is paid to a foster parent who cares for a child placed in his/her custody as long as that child needs such care. All of these grants are received by application only and are subject to income thresholds, means testing, and age limits.

These national legislations concur largely with international child rights conventions South Africa is a signatory to. By becoming signatory to international laws focusing on the rights of children, South Africa is expected to abide to a full range of international rights for children. These comprise laws and conventions by the United Nations and the African Charter on the Rights and Welfare of the Child.

1.2.6 The United Nations Declaration on Human Rights (Resolution A/RES/217(III))

The Declaration was the oldest rights instrument and was adopted by the UN General Assembly in December 1948. Even though it is not legally binding, the Declaration had been adopted by many countries and has influenced most national constitutions since 1948. However most notably for our purpose, article 25 makes reference to all children being entitled to special care and assistance and equal treatment in terms of social protection regardless of being born in or out of wedlock. The

Declaration of the Rights of the Child (Resolution 1386(XIV)) also known as the Geneva Declaration of the Rights of the Child which has was subsequently adopted in November 1959 by the United Nations General Assembly, had a much more comprehensive children rights content and forms the basis for the UN Conventions on the Rights of the Child. The Declaration revolves around 10 child rights principles (i) the right to non-discrimination based on race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status; (ii) the right to special protection; (iii) the right to name and nationality from birth; (iv) the right to social security and protection including adequate pre- and post-natal care, nutrition, housing, recreation and medical services; (v) the right to special treatment for children with disability; (vi) the rights to parental care and especially to mother's care for younger children or alternative care with an atmosphere of affection, moral and material security; (vii) the right to free and equitable access to education; (viii) the right to receive protection and relief; (ix) the right to be protected against neglect, cruelty, exploitation, traffic and child labour; and (x) the right to be protected from practices which may foster racial, religious and any other form of discrimination.

1.2.7 The United Nations Conventions on the Rights of the Child (Resolution 444/25, 1989)

The Convention on the Rights of the Child (CRC) came into force in September 1990 and South Africa ratified the convention in 1995. The CRC is quite extensive and consists of 54 articles. It recognises the family set-up as the natural environment for the growth and well-being of the child and hence suggests that the latter must be provided with the necessary protection and assistance to fully assume its responsibility towards its members (particularly the children) and the community. The Convention articulates the need to create family environments that allow the child to grow in an atmosphere of happiness, love and understanding. However, the articles suggest that if the need for alternative care is necessary their care and treatment should always be based on "the best interests of the child" which is in line with South African national legislations. The CRC also pronounces that children should be raised in the spirit of peace, dignity, tolerance, freedom, equality and solidarity. The Convention declares that children have the right to a standard of living that is good enough to meet their physical and mental needs and that governments should provide access to social assistance to those in need, either through their guardians or directly. Article 28 states that all children have the right to a free primary education and that wealthy countries should help poorer countries achieve this right. The UN Convention on the Rights of the Child has two optional protocols to which South Africa also prescribes. These consist of the UN Convention on the Rights of the Child Optional Protocol Prohibiting the Sale of Children, the Child Prostitution and Pornography (Resolution A/RES/54/263); and the UN Convention on the Rights of the Child Optional Protocol on Involvement of Children in Armed Conflicts (Resolution A/RES/54/263).

1.2.8 The African Charter on the Rights and Welfare of the Child (Document CAB/LEG/24.9/49)

The Charter came into force in November 1999 and South Africa ratified the Charter in January 2000. The Charter consists of 48 articles in total; however articles 32 to 48 deal with the establishment and organisation of a committee on the rights and welfare of the child under the umbrella of the African Union. The Charter is a domesticated child rights tool of the UN Convention to suit the needs of the continent. The introduction of the Charter was also intended to allow ownership of such an instrument to countries in the continent and to guarantee effective implementation of child rights in Africa. However the Charter is mostly similar to the Convention with some nuances towards cultural and traditional values. However, some sections of the charter, such as for example the section on child labour are more protective of the child in the Convention by requiring countries to designate minimum age for admission to employment whereas the Charter has no such clause.

1.2.9 The National Integrated Policy for Early Childhood Development (2015)

The Policy was approved by Cabinet on 9 December 2015. The policy draws mostly from other existing policies and regulations that impact on mothers, infants, young children and parents. The aim of the policy is to redress the structural disadvantages that children in South Africa face and to effectively mainstream child rights issues in services delivery. The guiding principles of the policy are the universal availability of ECD services, as well as equitable access to services and the empowerment of parents or caregivers to participate in the development of children. The policy has a multi-sectoral framework approach for the provision of early childhood development and redefines early childhood services as a public good with some comprehensive packages out of which some are regarded as essential components and are prioritised by government. While the policy recognises the duty of parents and families as the main caregivers of the child, it also emphasises that implementation of early childhood rights are highly dependent on the capacity and resources available to parents and families. The purpose of the policy is to stress the leadership and coordination role of government while the policy supports both public and private delivery of early childhood. The ultimate aim of the policy is universal access for all children to ECD services from conception until the year they enter formal school or until children turn seven. According to the policy, ECD packages of services and support, are the rights to: (i) a name and nationality; (ii) family and parental care; (iii) child care and support for families to fulfil their parenting responsibilities; (iv) health care; (v) food and nutrition security; (vi) social services, including protection from abuse and neglect, psychosocial support and social assistance; (vii) basic education, including early childhood education starting from birth; (viii) information; (ix) basic services, such as water, sanitation and energy; (x) shelter and housing; and (xi) play, recreation and cultural activities. The essential package has six cross-cutting components that are considered essential for vulnerable children. These include: (i) nutritional support; (ii) maternal health care; (iii) child health care; (iv) social services; (v) support for primary caregivers; and (vi) stimulation for early learning.

1.2.10 The National Plan of Action in South Africa (2012-2017)

The National Plan of Action was developed in 1996 to integrate all child related regulations and to provide a plan of action to all entities working in child related service delivery. The national plan of action is an overarching plan with direct bearing on the rights and well-being of children. The 2012–2017 version of the plan which was approved by Cabinet in 2013 was quite detailed and centred around the following five themes: (i) child survival; (ii) child development; (iii) child care and protection; (iv) standard of living; and (v) child participation. The themes each have goals that are expected to be achieved for the period 2012–2017 with objectives to the goals; the required strategies to achieve these goals and objectives as well as lead and supporting department(s) responsible for the themes together with their roles and responsibilities. In addition, the document provides a list of national indicators that would be used to monitor progress.

1.2.11 The National Development Plan: Vision for 2030, November 2011

Investment in early learning for all children is not only a moral obligation for the country, but also a strategic imperative. The alternative is that the country will have to face the consequences of a far more divided and unequal society by 2030. Investment in all children starting from their conception is believed to give children a fair start in their life and policies related to their welfare not only levels the playing field for all, but also provides a better path to an equal future society. The National Development Plan[1] (NDP) has some quantifiable targets that affect young children and have been identified for achievement by 2030:

1. Universal access to two years of early childhood development at early development centres or access to different kinds of development interventions depending on the age of the child.
2. The NDP splits children 0–3 and 4–5 age grouping for the envisaged interventions and suggest a school readiness programme for children aged 3–5; it also suggest home and community-based early childhood development interventions for younger children.

[1] National Planning Commission, 2011

3. Develop and implement norms and standards for the funding and management of early childhood development sites.
4. Eradicate child under-nutrition by means of school feeding schemes that cover all children in need at all schools and provide highly nutritional food.
5. Design and implement a nutrition intervention for pregnant women to prevent low birth weight and put in place targeting mechanisms for women at risk.
6. Implement an 18-months postnatal support programme for vulnerable caregivers to ensure positive nutrition, micronutrient provision, immunization and care.
7. Eradicate vitamin A deficiency among children.
8. Mother to child HIV transmission rates to drop below 2 percent nationally.
9. Reduce maternal mortality from 500 to less than 100 per 100 000 live births.
10. Reduce infant mortality from 43 to below 20 per 1 000 live births.
11. Reduce under-five mortality from 104 to below 30 per 1 000 live births.
12. Reduce prevalence of chronic respiratory diseases by 28%.
13. Each household has access to well-trained community health worker.
14. Implement a strategy to improve the qualifications of early childhood development workers and develop training for new types of extension workers.

Although no targets were set for certain child wellbeing indicators, some indicators that could potentially influence the welfare of young children were included in the NDP. These include: children living arrangements, child poverty, child sexual abuse and child protection. Furthermore, the Medium Term Strategic Framework[2] (MTSF) strategic plan for the 2014–2019 electoral terms have added some targets that have major impacts on the lives of young children:

- By 2015, all learners who enroll in Grade 1 should have received Grade R education.
- By 2019, 70% of pregnant women attending primary health care facilities for antenatal care before they are 20 weeks pregnant.
- By 2019, 80% of mothers visiting a primary health care facility for postnatal care within 6 days of delivery of their babies.
- By 2019, 98% of HIV positive pregnant women initiated on ART.
- By 2019, 95% infants fully immunized.
- By 2019, 33 under 5 year deaths per 1 000 live births.
- By 2019, 8 neonate deaths per 1 000 live-births.
- By 2019, 23 infant deaths per 1 000 live births.
- By 2019, less than 100 maternal deaths per 100 000 live-births
- By 2019, 11,6% live birth under 2 500g in facility rate
- By 2018/19, the percentage of total births registered within 30 calendar days as prescribed by law must be 74% (810 000).
- By 2018/19, reduce levels of serious crime reported against children to 38 785.

1.2.12 Sustainable Development Goals (E/CN.3/2016/2/Rev.1)

Internationally, the Sustainable Development Goals (SDG) targets and indicators have an indirect focus on child well-being. However, the following 15 indicators have particular importance for measuring the well-being of young children in a country. These include:

2.1 By 2030, end hunger and ensure access by all people, in particular the poor and people in vulnerable situations, including infants, to safe, nutritious and sufficient food all year round.

2.2 By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons.

3.2 By 2030, end preventable deaths of new-borns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1 000 live births and under-5 mortality to at least as low as 25 per 1 000 live births.

[2] Department of Planning, Monitoring and Evaluation, 2014

3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

4.1 By 2030, ensure that all girls and boys complete free, equitable and quality primary and secondary education leading to relevant and effective learning outcomes.

4.2 By 2030, ensure that all girls and boys have access to quality early childhood development, care and pre-primary education so that they are ready for primary education.

4.5 By 2030, eliminate gender disparities in education and ensure equal access to all levels of education and vocational training for the vulnerable, including persons with disabilities, indigenous peoples and children in vulnerable situations.

4.8 Build and upgrade education facilities that are child, disability and gender sensitive and provide safe, non-violent, inclusive and effective learning environments for all

5.4 Recognise and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate.

8.7 Take immediate and effective measures to eradicate forced labour, end modern slavery and human trafficking and secure the prohibition and elimination of the worst forms of child labour, including recruitment and use of child soldiers, and by 2025 end child labour in all its forms.

11.2 By 2030, provide access to safe, affordable, accessible and sustainable transport systems for all, improving road safety, notably by expanding public transport, with special attention to the needs of those in vulnerable situations, women, children, persons with disabilities and older persons.

11.7 By 2030, provide universal access to safe, inclusive and accessible, green and public spaces, in particular for women and children, older persons and persons with disabilities.

16.2 End abuse, exploitation, trafficking and all forms of violence against and torture of children.

16.9 By 2030, provide legal identity for all, including birth registration.

1.3 Investment in early learning: pragmatic approach to better human capital development

Research in social sciences, neurosciences and psychology have shown the importance of early learning for later development (The Lancet series, 2016)[3]. The returns to education are increased by investments in ECD. The effects are long-lasting and largest for the most disadvantaged children (Heckman and Masterov, 2009). ECD is the foundation phase which firstly consists of the first 1 000 days (2 years) from the birth of the baby (Adair, 2014). The brain development of the baby which takes place during this period is typically faster and entails the laying down of the neurological mechanisms for future learning. Besides, the brain is easily moulded during the early years of the child. Hence the biological processes that occur have to be supplemented by stimulation. These include consistent responsive care provided that it takes place as a reaction to the child's signals and needs. Nurturing care and supportive adults' behaviour predispose the child to better later learning outcomes. Furthermore, poor childhood nutrition, poor health status, abuse and social exclusion link to poor cognitive outcomes and subsequent school attainment (Casale and Desmond, 2016). Even if the child survives from these traumas, the developmental deficit that the child experiences is hard and sometimes impossible to catch up. Furthermore, Heckman and Masterov (2009) argue that investing in young children from disadvantaged environments is more crucial since these children are more likely to commit crime, have out-of-wedlock births, and drop out of school. They argue that early interventions can potentially reverse some of the harm of disadvantage and have a high economic return. This benefit is not only for the children, but for society as a whole.

[3] The Lancet's Early Childhood Development Series 2016: Advancing Early Childhood Development: from Science to Scale, published in October 4, 2016 is a special issue led by Prof. Linda Richter (University of Witwatersrand) which brings together the work of 45 authors from various fields such as neuroscience, psychology, paediatrics, biology, global health and economics.

Young children are primarily exposed to their families and care givers who influence their day-to-day care, rearing and overall wellbeing. This is obviously not an easy area of influence for government hence a policy on early childhood development therefore serves as a tool in the provision of social services, especially for the most vulnerable children in the country. Early childhood care and education programmes are inequitable in South Africa and mostly exclude children living in poverty as well as those living in rural areas or informal settlements. Such services are mostly provided by the private sector that charge high prices and some inadequately funded not-for-profit organisations that deliver poor quality ECD services to children. In South Africa, compulsory education begins at age six. Hence before the enactment of the ECD policy, government had no obligation to provide educational services to younger children. This doesn't mean that government has not been spending on delivering services to young children. If we look at the government spending breakdown that had a direct impact on children during the period 2015/2016; of the total R1,52 trillion spent, 19% was spent on education, while 13% was spent on social protection and 11% on health. In terms of education, the highest proportion (6%) was spent on primary education; in terms of social protection, 4% was spent on families and children (Stats SA, 2017a).

1.4 Objective of the report

The introduction provided some background about the legislative and policy framework into which the ECD policy is set to be rolled out. It also summarised the targets that need to be attained by the end of 2019, which is the end of the elective period of the current government administration and for targets related to the NDP and SDGs by 2030. The report will largely be based on the General Household Survey (GHS) 2016, which contained a module on early childhood development. The module had 19 questions intended to gather information on children aged 0–6 and six questions to gather information on children in the age group 0–2. The module had questions on access to ECD interventions such as early learning, nutrition, and other well-being indicators (Stats SA, 2017b). Data sourced from administrative systems held by the Department of Home Affairs[4], South African Social Security Agency[5] and Department of Health[6] were used as supplementary sources to complete the analysis. The main purpose of the report is to provide data on child well-being and to describe the life situations of children aged 0–6 who were living in dwellings across the country in 2016. Data will as far as possible be disaggregated by age, sex, population group, geographic location and to some extent economic background of the household.

1.5 Layout of the report

The report has five chapters. The first chapter is the introduction and provides an overview of the child related policy framework in the country. It also briefly describes the purpose of the report. The second chapter presents data on the child population aged 0–6 and their living arrangements; it also provides a description of the household characteristics in which children aged 0–6 reside, their access to basic services and their proximity to health services. Chapters three and four present the components of the essential ECD packages and how children aged 0–6 fare with respect to each component. In addition, the chapters also assess whether there are child, parental, household or geographical characteristics associated with exposure to key defined components of the ECD packages. The last chapter concludes and draws key policy implications based on the findings.

[4]Birth and death registration systems used as sources for Health and Vital Statistics by Stats SA
[5] Social Grants Payment and Administration system
[6] District Health Information System

Chapter 2: Access to basic services and household characteristics

2.1 Introduction

The legislations and policies outlined in Chapter 1 are grounded in four general principles that can be summarised as: non-discriminatory; in the best interest of the child; child survival and development; and, respect for the views of the child. Furthermore, the concept of child well-being should closely relate to their social and economic conditions. In particular, socio-economic factors such as household income, community and social support, access to health care, access to housing and housing quality, overcrowding, access to basic services, access to education and child care services play prominent roles in children's physical and emotional development. Access to essential basic services such as water, sanitation and electricity by households with young children helps to eliminate structural causes of vulnerability and risks to young children. This chapter documents what is known about some of these elements and provides insights into the living circumstances of South African children aged 0–6 as measured by the General Household Survey, 2016. Child population estimates are presented with types of family living arrangements; the characteristics of the households in which these children reside; as well as access to basic services.

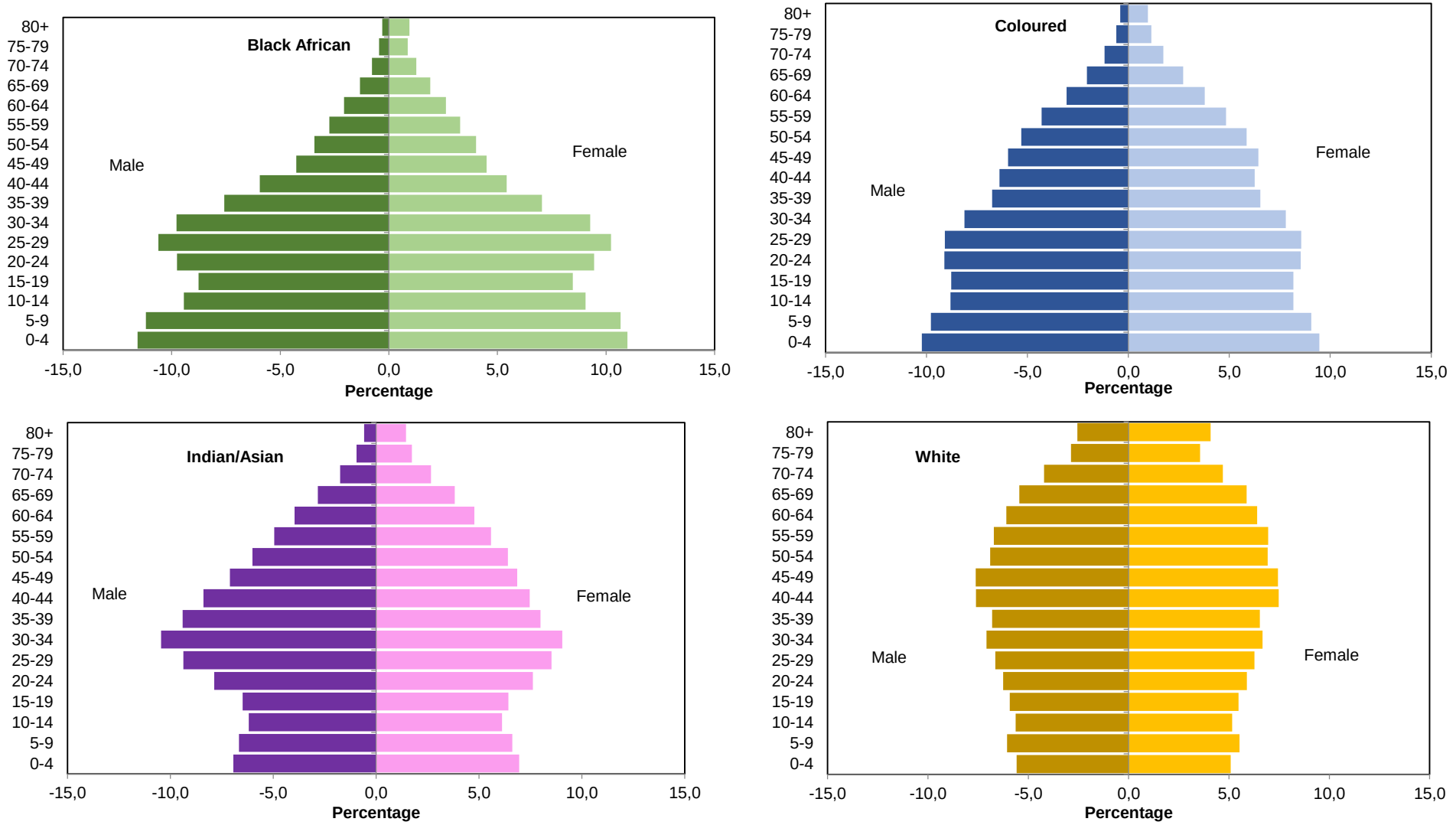
2.2 Population distribution of the country, 2016

The South African population is generally characterised by declining birth and death rates with more people having higher life expectancies than previously, and therefore resulting in a population that is living to older ages. However, there are still significant differences in life expectancies as well as in the distribution of the population by population group. In 2016, the life expectancy at birth for females was estimated at 67 years whereas for males at 61 years (Stats SA, 2017: P0302). While the black African and coloured population groups are characterised by relatively higher birth rates compared to the rest, the Indian/Asian and white populations have very low birth rates and longer life expectancies at birth. These two population groups are also showing signs of contracting. Figure 2.1 shows population pyramids that display the sex and age structure, by population group. The black African pyramid depicts a youthful population structure with a broader base whereas the white population structure, with narrowing base, depicts an aging population. Both the white and Indian/Asian populations experience a small number of births each year to replace deaths that occur in those particular population groups.

Overall in 2016, according to mid-year population estimates, children aged 0–6 constituted approximately 15% of the total population of South Africa and nearly four in ten (41%) of the total children population aged 0-18. Close to 86% of the child population in the age group 0–6 were black Africans, close to eight per cent coloureds, close to two per cent Indian/Asian and four per cent white[7]. While the total child population distribution (children aged 0–18) by population group was similar to the distribution of children population aged 0–6, it is worth noting that the total population distribution was different as approximately 81% of the total population were black African, nine per cent were coloured, two per cent were Indian/Asian and eight per cent were white. Furthermore in 2016, 64% of the total population comprised of individuals who were 18 years and older. Similarly, 62% of the total black African population were constituted by individuals who were 18 years and older; 66% of the total coloured population; three quarters (75%) of the total Indian/Asian population; and 79% of the total white population consisted of individuals who were 18 years and older.

[7] Own estimation based on 2016 mid-year population estimates using the Sprague software. Small variations exist between GHS population estimates and mid-year population estimates due to differences in methodology.

Figure 2.1: Population pyramids by population group, 2016



Source: Mid-year population estimates, 2016

2.3 Child population and living arrangements

This section provides demographic data of the child population aged 0–6 and their living arrangements. It is aimed at describing the location of these children across South Africa, their living arrangements with their biological parents and the type of family set-up they belong to.

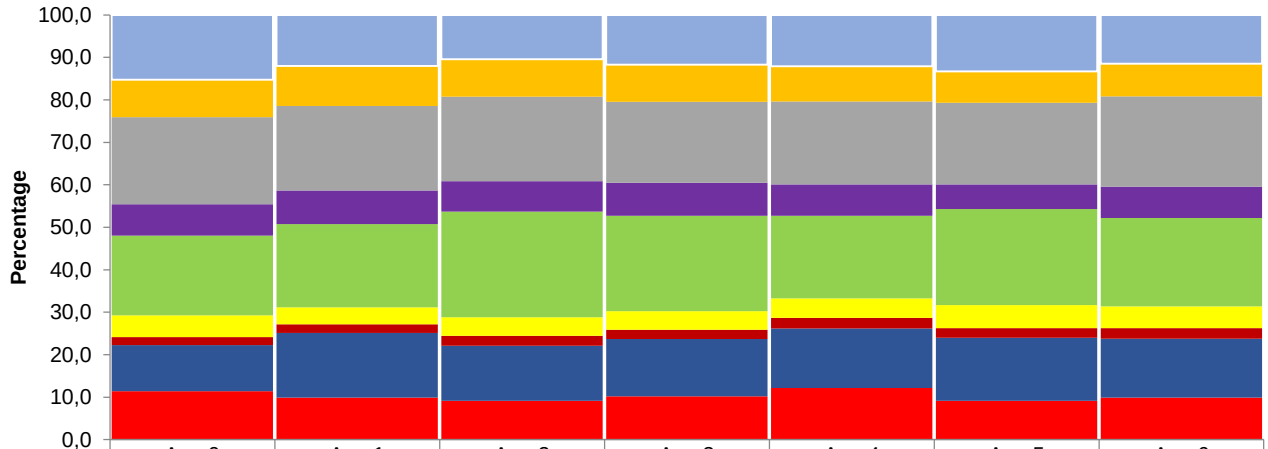
Table 2.1: Children aged 0–6 by province and sex, 2016

Province	Number in thousands	WC	EC	NC	FS	KZN	NW	GP	MP	LP	RSA
Male	Number	379	512	81	165	784	240	718	297	463	**3 639**
	Per cent	10,4	14,1	2,2	4,5	21,5	6,6	19,7	8,2	12,7	
Female	Number	359	467	80	175	746	282	711	311	421	**3 552**
	Per cent	10,1	13,2	2,3	4,9	21,0	7,9	20,0	8,8	11,9	
Total	**Number**	**738**	**979**	**161**	**340**	**1 530**	**522**	**1 429**	**608**	**884**	**7 191**
	Per cent	**10,3**	**13,6**	**2,2**	**4,7**	**21,3**	**7,3**	**19,9**	**8,5**	**12,3**	**100,0**

Source: GHS 2016

Table 2.1 presents the total number of children aged 0–6 by province and sex. According to the GHS 2016 data, there were close to 7,2 million children aged 0–6 in 2016 of which the majority (21,3%) were residing in KwaZulu-Natal, followed by close to 20% that were living in Gauteng.

Figure 2.2: Children aged 0–6 by age and province, 2016

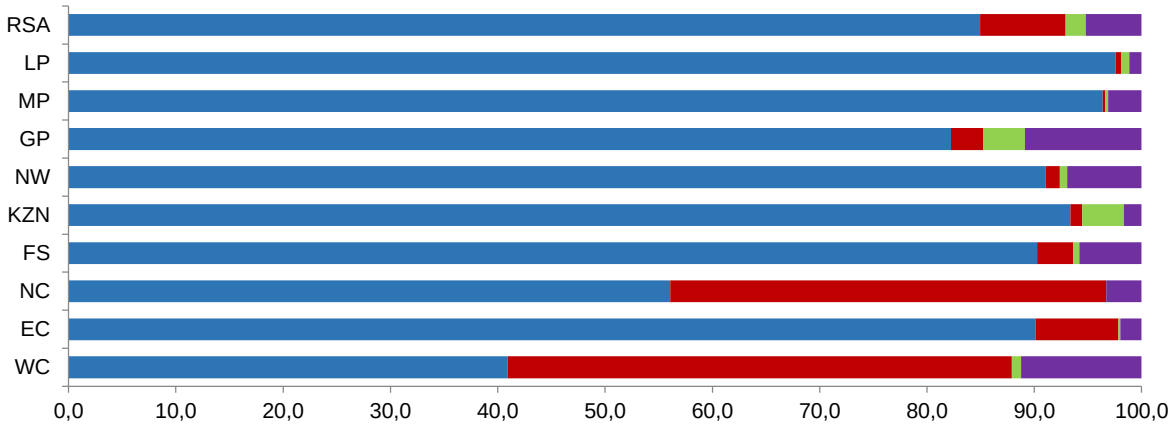


	Age 0	Age 1	Age 2	Age 3	Age 4	Age 5	Age 6
LP	15,3	12,0	10,4	11,8	12,1	13,3	11,5
MP	8,8	9,4	8,8	8,7	8,3	7,4	7,7
GP	20,5	19,9	19,9	19,0	19,5	19,2	21,2
NW	7,4	7,9	7,2	7,8	7,4	5,8	7,4
KZN	18,8	19,6	24,9	22,4	19,4	22,6	20,8
FS	5,1	4,0	4,4	4,4	4,6	5,4	5,1
NC	1,9	2,0	2,4	2,1	2,5	2,3	2,5
EC	10,9	15,2	12,9	13,5	14,0	14,8	13,8
WC	11,4	9,9	9,2	10,2	12,1	9,2	9,9

Source: GHS 2016

Figure 2.2 shows the population distribution of children aged 0–6 by age and province. Nearly two in ten babies under one year were found in Gauteng. Furthermore, KwaZulu-Natal, Gauteng and Limpopo together were accounting for more than half of the children less than one year. Mpumalanga and Limpopo had lower percentages of children aged 5 and 6 compared to the other age categories.

Figure 2.3: Children aged 0–6 by population group and province, 2016

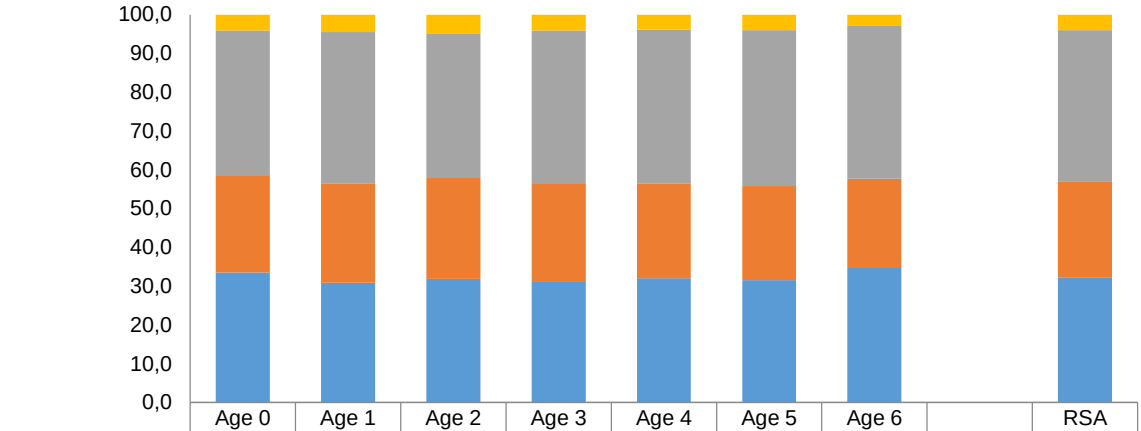


	WC	EC	NC	FS	KZN	NW	GP	MP	LP	RSA
Black African	40,9	90,1	56,1	90,3	93,4	91,1	82,3	96,4	97,6	85,0
Coloured	47,0	7,7	40,6	3,4	1,1	1,3	3,0	0,2	0,5	8,0
Indian/Asian	0,9	0,2	0,0	0,6	3,9	0,7	3,9	0,3	0,8	1,9
White	11,2	2,0	3,3	5,8	1,6	6,9	10,9	3,1	1,2	5,2

Source: GHS 2016

Figure 2.3 shows the population group distribution by province of children aged 0–6. Except for the Western Cape and Northern Cape provinces, black African children were representing the largest percentage of young children aged 0–6. Children aged 0–6 in Western Cape were predominantly coloured (47%); nearly two in five children in Western Cape were black African (41%) whereas almost one in ten children in the same province were white (11,2%).

Figure 2.4: Children aged 0–6 by age and geo type, 2016

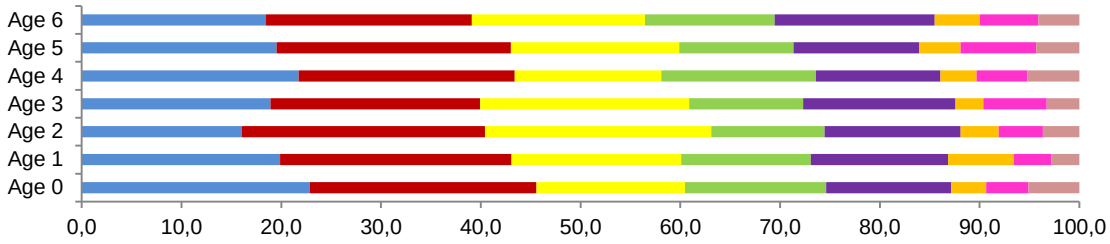


	Age 0	Age 1	Age 2	Age 3	Age 4	Age 5	Age 6		RSA
Farms	4,1	4,5	4,8	4,1	3,8	4,0	2,7		4,0
Traditional	37,3	39,1	37,3	39,4	39,8	40,2	39,6		39,0
Formal urban non-metro	25,1	25,5	26,0	25,3	24,4	24,2	23,0		24,8
Formal urban metro	33,5	30,9	31,9	31,3	32,0	31,6	34,7		32,3

Source: GHS 2016

The above graph presents data on children aged 0–6 by geographical location. Overall four out of seven children aged 0–6 lived in urban formal areas (57%), while 39% lived in traditional areas and 4% on farms. Although there is not much difference in the distribution by age, there were slightly less children residing in farm areas among the six-year-olds (2,7%).

Figure 2.5: Children aged 0–6 by age and metropolitan area, 2016

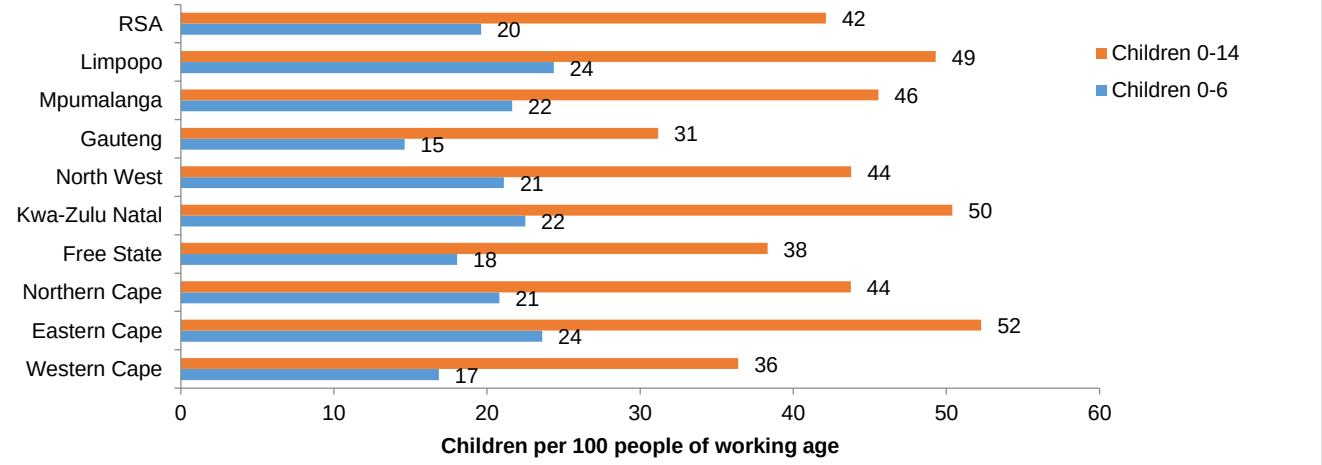


	Age 0	Age 1	Age 2	Age 3	Age 4	Age 5	Age 6
City of Cape Town	22,9	19,9	16,1	18,9	21,8	19,5	18,5
City of Johannesburg	22,7	23,2	24,3	21,0	21,6	23,5	20,6
eThekwini	14,9	17,0	22,7	21,0	14,7	16,9	17,4
Ekurhuleni	14,1	13,0	11,4	11,4	15,5	11,5	13,0
City of Tshwane	12,5	13,8	13,6	15,3	12,5	12,6	16,1
Buffalo City	3,5	6,6	3,8	2,8	3,6	4,2	4,5
Nelson Mandela Bay	4,2	3,8	4,4	6,3	5,1	7,6	5,9
Mangaung	5,1	2,8	3,7	3,3	5,2	4,3	4,1

Source: GHS 2016

Among children aged 0–6 residing in metropolitan areas, Cape Town, Johannesburg and eThekwini accounted for most of the children, while Mangaung and Buffalo City had only a small percentage of children aged 0–6.

Figure 2.6: Young age dependency ratio, 2016



Source: GHS 2016

The above graph presents the young age dependency ratio of children aged 0–6 and children aged 0–14 relative to the working age population by province. It was calculated by taking the ratio of children aged 0–6 (or children 0–14) by the total number of individuals aged 15 to 64 (number of 'young dependents' per 100 people aged 15–64 years). The young age dependency ratio is used to measure the pressure on the productive population in supporting younger children. A high ratio means those of working age bear a greater burden in supporting more children. The shortcoming of this method is that the dependency ratio only considers age when determining whether a person is economically active. However other factors, such as whether the person is a student or unemployed may determine if a person is economically active. Eastern Cape, KwaZulu-Natal and Limpopo account for a larger fraction of dependents in the country with 52, 50 and 49 children aged 0–14 respectively to every 100 people of working age.

Table 2.2: Number of children aged 0–6 living with their biological parents by age[8], 2016

Child age	Numbers in thousands	Living with father	Living with mother	Living with both parents	Living with none	Total
0	Number	7	481	391	41	**920**
	Per cent	0,8	52,3	42,5	4,4	
1	Number	13	461	370	84	**928**
	Per cent	1,4	49,7	39,8	9,1	
2	Number	23	474	378	129	**1 004**
	Per cent	2,3	47,2	37,6	12,9	
3	Number	24	454	375	132	**985**
	Per cent	2,4	46,1	38,1	13,4	
4	Number	13	406	405	125	**949**
	Per cent	1,4	42,8	42,7	13,2	
5	Number	26	383	359	152	**920**
	Per cent	2,8	41,7	39,0	16,5	
6	Number	29	348	365	155	**897**
	Per cent	3,2	38,8	40,7	17,3	
Total	**Number**	**135**	**3 007**	**2 643**	**818**	**6 603**
	Per cent	**2,0**	**45,6**	**40,0**	**12,4**	**100,0**

Source: GHS 2016

The presence and involvement of both parents are extremely important in the development of young children. Table 2.2 shows that overall most children aged 0–6 lived in single-parent families (47,6%); 45,6% lived with their mothers only and 2% lived with their fathers only. The highest percentage of children who lived with their mothers only were children under the age of one (52,3%) and children aged one (49,7%). Furthermore, while only four out of ten children aged 0–6 lived with both their parents (40%) close to 12% lived with none of their parents. However, this is mostly not the case with the smaller children aged 0–1.

Table 2.3: Living arrangement of children aged 0–6 by sex and population group, 2016

Child sex	Numbers in thousands	Nuclear	Extended	Complex	Total
Male	Number	1 675	1 904	8	**3 587**
	Per cent	46,7	53,1	0,2	
Female	Number	1 663	1 828	8	**3 499**
	Per cent	47,5	52,2	0,2	
Child population group					
Black African	Number	2 679	3 326	9	**6 014**
	Per cent	44,6	55,3	0,2	
Coloured	Number	282	280	6	**568**
	Per cent	49,7	49,3	1,0	
Indian/Asian	Number	98	39	*	**137**
	Per cent	71,8	28,3	*	
White	Number	279	87	*	**367**
	Per cent	76,0	23,9	*	
Total	**Number**	**3 338**	**3 732**	**16**	**7 086**
	Per cent	**47,1**	**52,7**	**0,2**	**100,0**

Source: GHS 2016

* Un-weighted numbers of 3 and below per cell are too small to provide reliable estimates.

[8] Note: Those with unspecified or unknown information were excluded from the analysis.

A nuclear family in this context is described as the one which consists of at least one of the two parents and the children; whereas the extended family includes grandparents and other relatives such as aunts and uncles in addition to the nuclear family. Complex households are households with members who are not related to the household head. Households' compositions differ geographically and by population group in South Africa.

The percentage of children aged 0–6 who lived in extended family units (52,7%) exceeds those living in nuclear family units (47,1%). Although there were no substantial differences by sex in the living arrangements of young children, the differences in living arrangement by population group were notable. Among black African children, 44,6% lived in nuclear families whereas the majority (55,3%) lived in extended family set up. By contrast, white children primarily stayed in nuclear family set-ups (76%); and close to 24% stayed in extended family set-ups. Indian/Asian children stayed in family arrangements similar to those of whites with a slightly larger percentage of children staying with an extended family (28%). Coloured children were equally likely to live in nuclear (49,7%) or extended family (49,3%) arrangements.

2.4 Household characteristics

This section describes the condition under which children aged 0–6 lived in South Africa. These include information on the head of the household to which these children belong, their housing conditions and economic circumstances. Household heads may sometimes not be directly involved in the care of young children, but they would most likely be the main economic providers or decision makers around important factors that affect children. Housing conditions directly impact on young children as these may influence their health status. Poor housing conditions and overcrowding also affect the safety of children. Income and asset poverty affect household food security, as well as meeting the nutritional needs of young children.

Table 2.4: Head of household's age by children's age, 2016

Child age	Numbers in thousands	Young (14–18)	Youth (19–34)	Adult (35–59)	Elderly (60+)	Total
	Number	*	265	509	189	**964**
0	Per cent	*	27,5	52,8	19,6	
	Number	*	249	545	200	**995**
1	Per cent	*	25,1	54,8	20,1	
	Number	*	253	592	215	**1 060**
2	Per cent	*	23,9	55,8	20,3	
	Number	*	230	618	224	**1 073**
3	Per cent	*	21,4	57,7	20,9	
	Number	*	216	621	206	**1 044**
4	Per cent	*	20,7	59,5	19,7	
	Number	*	176	620	224	**1 021**
5	Per cent	*	17,2	60,7	21,9	
	Number	*	179	636	214	**1 031**
6	Per cent	*	17,4	61,7	20,8	
	Number	**7**	**1 568**	**4 141**	**1 472**	**7 188**
Total	**Per cent**	**0,1**	**21,8**	**57,6**	**20,5**	**100,0**

Source: GHS 2016
* Un-weighted numbers of 3 and below per cell are too small to provide reliable estimates.

The majority of households that had children aged 0–6 were headed by adults aged 35–59. Nearly one in five (21%) children aged 0–6 belonged to households headed by elderly individuals aged 60 years or above. These would most likely include retired individuals or individuals accessing old age grants.

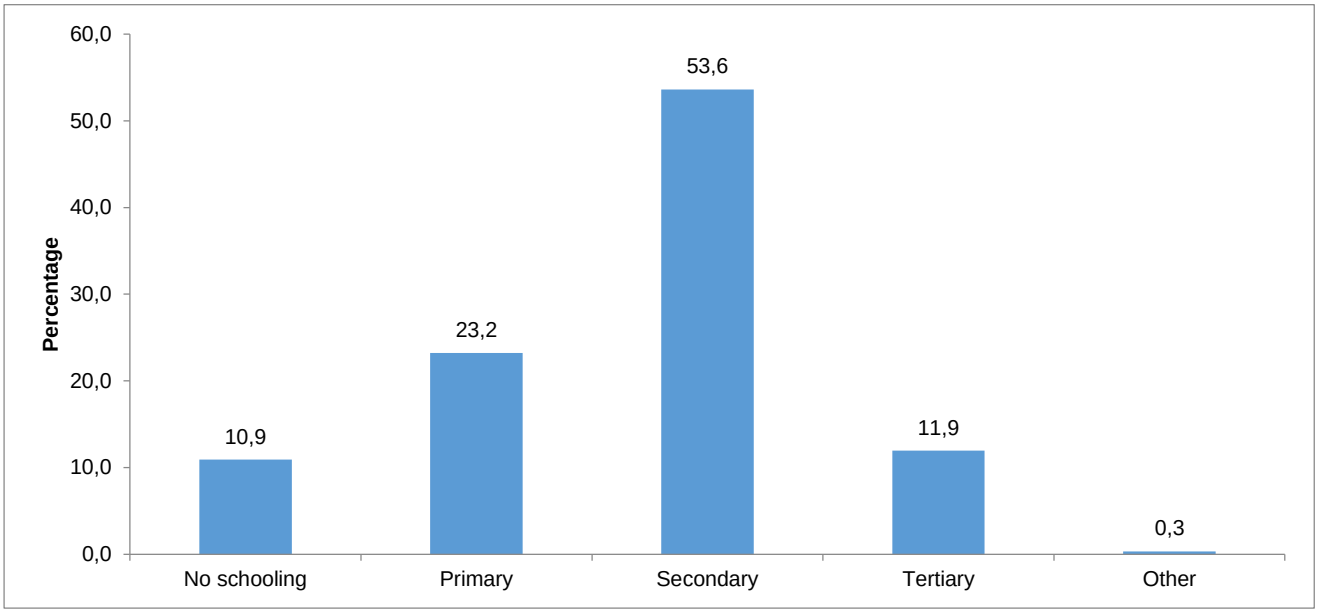
Table 2.5: Age of children by head of household's sex and population group, 2016

	Population group				Sex	
Child age	Black African	Coloured	Indian/Asian	White	Male	Female
0	84,0	8,4	2,0	5,6	55,2	44,9
1	87,1	6,7	1,2	4,9	54,5	45,5
2	85,8	7,5	2,5	4,2	51,8	48,2
3	83,7	9,1	2,0	5,2	52,8	47,2
4	84,0	8,9	2,0	5,1	55,9	44,1
5	86,0	7,9	2,2	3,9	50,2	49,8
6	84,5	6,9	1,2	7,4	54,1	45,9
RSA	**85,0**	**7,9**	**1,9**	**5,2**	**53,5**	**46,5**

Source: GHS 2016

Although a large percentage of children aged 0–6 lived in male-headed households (53,5%), it is also common in South Africa for children to be raised in female-headed households (close to 47% on average).

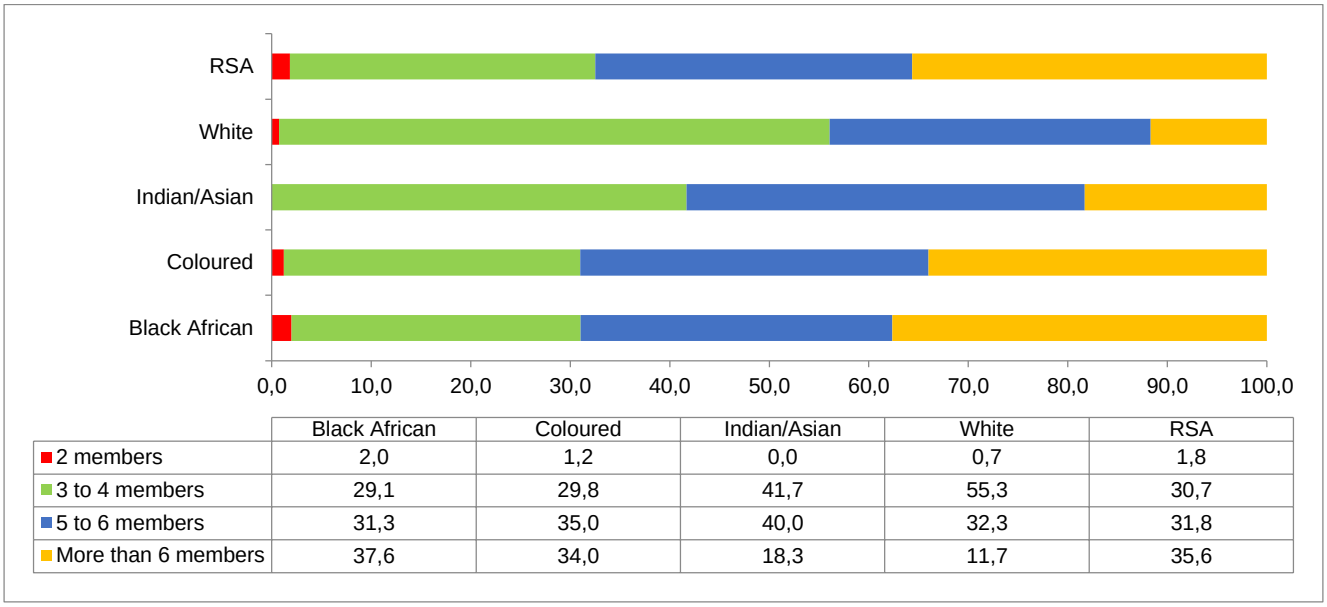
Figure 2.7: Percentage of children aged 0–6 by head of household's educational attainment, 2016



Source: GHS 2016

The majority of children (54%) aged 0–6 lived in households whose heads had attained some secondary education; while close to one-third (34%) of household heads of children in this age group had at most completed primary education. Furthermore, 11,9% of children lived in households headed by individuals who had completed some tertiary qualification. Low parental schooling proved to have an adverse effect on the cognitive stimulation received by young children.

Figure 2.8: Household size in which children aged 0–6 lived by population group of the household head, 2016

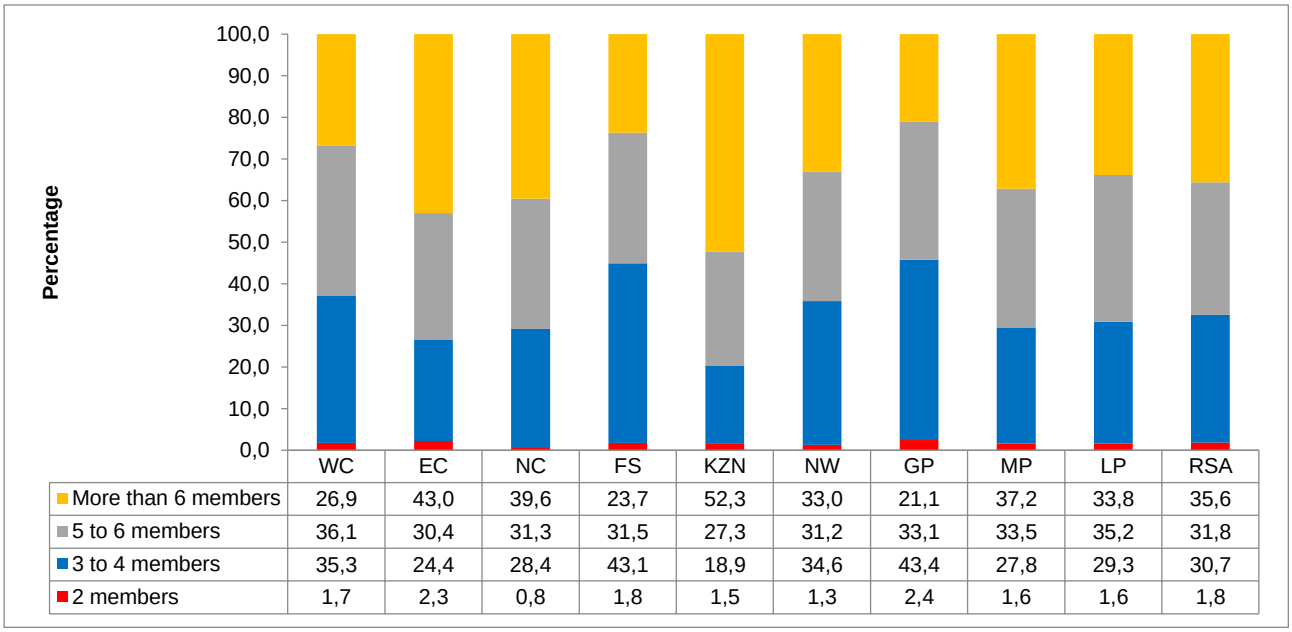


	Black African	Coloured	Indian/Asian	White	RSA
2 members	2,0	1,2	0,0	0,7	1,8
3 to 4 members	29,1	29,8	41,7	55,3	30,7
5 to 6 members	31,3	35,0	40,0	32,3	31,8
More than 6 members	37,6	34,0	18,3	11,7	35,6

Source: GHS 2016

Nationally, more than two-thirds of children aged 0–6 lived in households with household sizes consisting of five or more members (67,4%); three in ten children (30,7%) lived in households with three to four members. A breakdown by population group of the head of the household shows that 68,9% of black African and 69,0% of coloured household heads managed large households consisting of five or more members; this was also true for 58,3% of Indian/Asian household heads. Furthermore, 41,7% of Indian/Asian and 55,3% of white household heads were responsible for households that had three to four members compared to the national average of 30,7%. These amounted to 11,0 and 24,6 percentage point differences with the national average. These findings suggest that white and Indian/Asian children were more likely to reside in nuclear families compared to the other population groups.

Figure 2.9: Children aged 0–6 by household size and province, 2016



	WC	EC	NC	FS	KZN	NW	GP	MP	LP	RSA
More than 6 members	26,9	43,0	39,6	23,7	52,3	33,0	21,1	37,2	33,8	35,6
5 to 6 members	36,1	30,4	31,3	31,5	27,3	31,2	33,1	33,5	35,2	31,8
3 to 4 members	35,3	24,4	28,4	43,1	18,9	34,6	43,4	27,8	29,3	30,7
2 members	1,7	2,3	0,8	1,8	1,5	1,3	2,4	1,6	1,6	1,8

Source: GHS 2016

The percentage of children staying in households with more than six members exceeds the national average (35,6%) in Eastern Cape (43,0%) and KwaZulu-Natal (52,3%). Gauteng had the lowest percentage of children staying in such large households (21,1%). Children in Gauteng were the most likely to live in households that consisted of 3 to 4 members (43,4%). Free State had a household membership structure similar to Gauteng province.

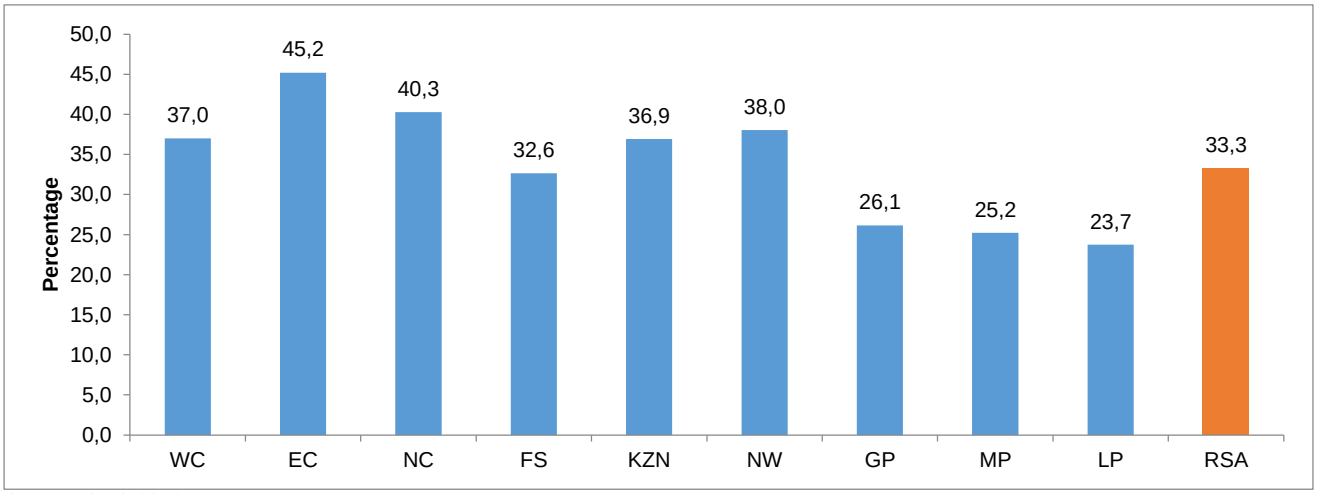
Table 2.6: Children aged 0–6 by the total number of rooms and bedrooms shared, 2016

Total number of rooms ('000)	Zero number of bedrooms	One bedroom	Two bedrooms	Three bedrooms	Four bedrooms	Five bedrooms	Six bedrooms	Seven or more bedrooms	Total
One room	379	67	*	*	*	*	*	*	**446**
Two rooms	263	223	13	*	*	*	*	*	**499**
Three rooms	58	329	116	*	*	*	*	*	**503**
Four rooms	24	182	594	29	1	*	*	*	**830**
Five rooms	7	51	920	176	2	*	*	*	**1 156**
Six rooms	9	13	371	566	73	9	*	*	**1 041**
Seven rooms	*	7	135	550	197	35	*	*	**924**
Eight rooms	*	5	65	279	192	64	8	*	**613**
Nine rooms	7	*	29	146	163	74	37	7	**463**
Ten rooms	*	2	26	95	75	51	35	7	**291**
Eleven rooms	*	*	6	36	52	32	17	16	**159**
Twelve rooms	*	*	2	23	28	33	11	6	**103**
Thirteen or more rooms	*	*	3	15	56	25	12	35	**146**
Total	**747**	**882**	**2 280**	**1 915**	**839**	**323**	**120**	**71**	**7 177**

Source: GHS 2016
* Un-weighted numbers of 3 and below per cell are too small to provide reliable estimates.

The above table shows that close to 446 000 children aged 0–6 lived in one-roomed dwellings and close to 747 000 children aged 0–6 lived in dwellings which had no bedrooms.

Figure 2.10: Children aged 0–6 living in overcrowded[9] conditions by province, 2016

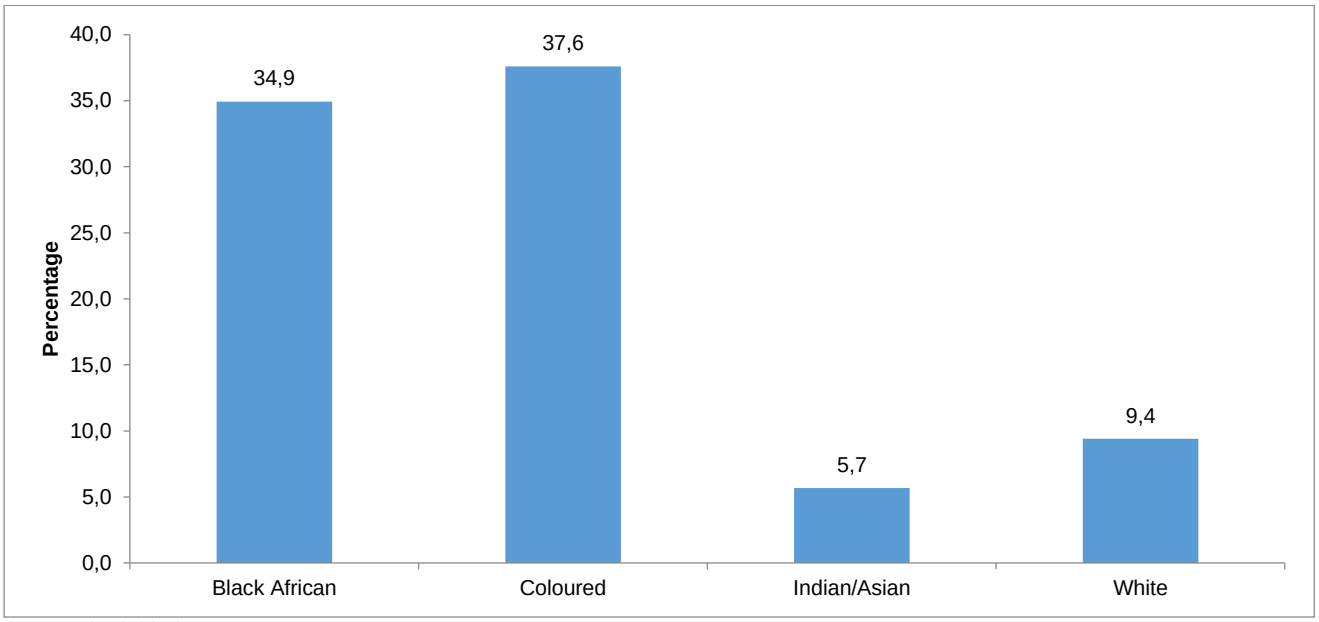


Source: GHS 2016

[9] We defined overcrowding as more than two persons-per-room in a dwelling regardless of the size of the dwelling units. In 2016, 10% of the children aged 0–6 lived in dwellings without any bedrooms, 12% with only one bedroom, 32% with two bedrooms, 27% with three bedrooms and the remaining 19% had more than three bedrooms.

According to the above graph, most children aged 0–6 lived in overcrowded conditions of more than two people per bedroom or with no bedrooms at all. Among children staying in overcrowded conditions, 45,2% resided in Eastern Cape followed by 40,3% in Northern Cape. Overcrowding was the lowest in Limpopo at just 23,7%, roughly 10 percentage points below the national average.

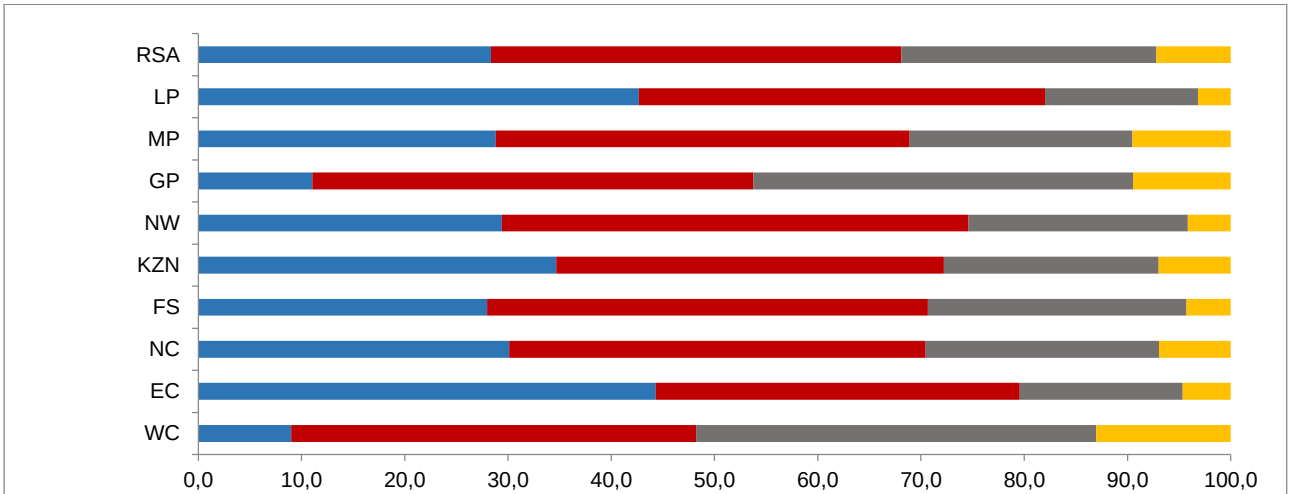
Figure 2.11: Children aged 0–6 living in overcrowded conditions by population group, 2016



Source: GHS 2016

Figure 2.11 shows the level of overcrowding by population group. Indian/Asian (5,7%) and white children (9,4%) were the least likely to live in overcrowded conditions, while coloured and black African children were subjected to notably higher overcrowding conditions.

Figure 2.12: Children aged 0–6 by the number of employed household members by province, 2016

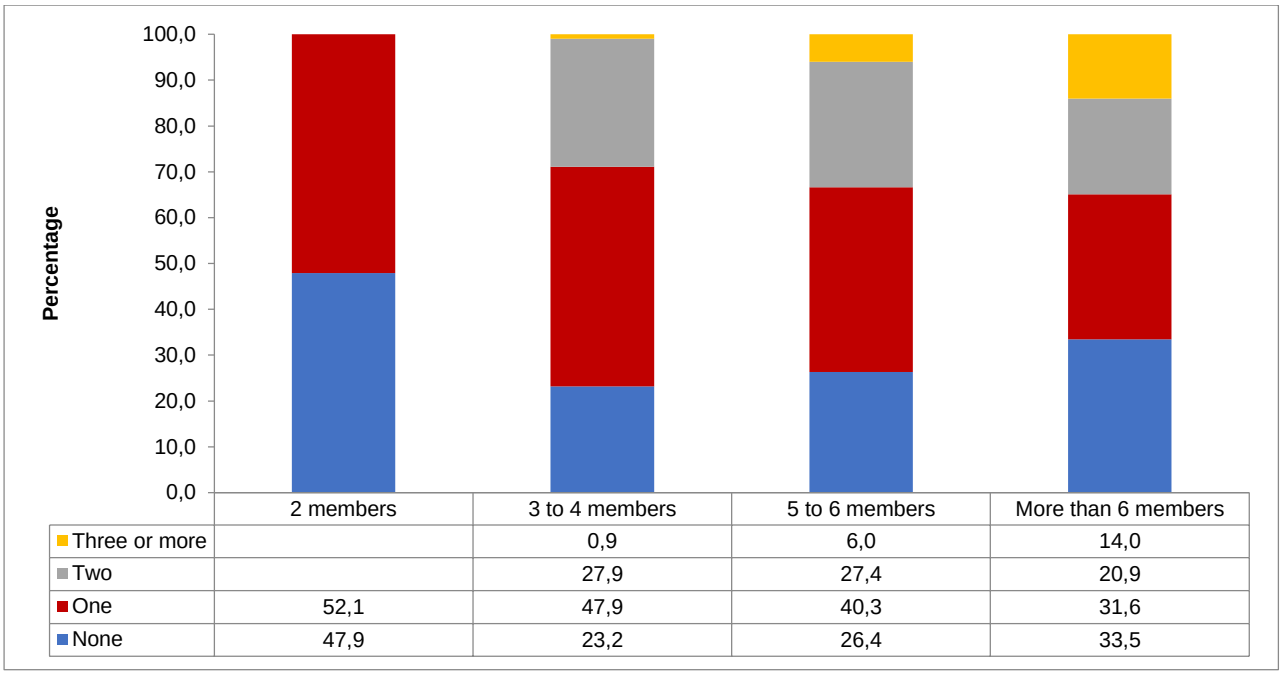


	WC	EC	NC	FS	KZN	NW	GP	MP	LP	RSA
None	9,0	44,3	30,1	28,0	34,7	29,4	11,1	28,8	42,7	28,3
One	39,2	35,3	40,3	42,7	37,6	45,2	42,7	40,1	39,4	39,7
Two	38,8	15,8	22,6	25,0	20,8	21,2	36,8	21,6	14,8	24,7
Three or more	13,0	4,7	7,0	4,3	7,0	4,2	9,4	9,5	3,2	7,2

Source: GHS 2016

The percentage of children staying in households in which none of the members were employed was the highest in Eastern Cape (44,3%), followed by Limpopo (42,7%) and KwaZulu-Natal (34,7%). These households exceeded by far the national average (28,3%). While in most provinces, children stayed in households with at least one employed member, North West, Free State and Gauteng had the largest percentage of households where at least one household member was employed with 45,2% and 42,7% respectively. Western Cape had the largest percentage of children that lived in households where at least two members were employed (51,8%); followed by Gauteng with 46,2% of children aged 0–6 years who lived in households with two or more employed household members.

Figure 2.13: Children aged 0–6 by the number of employed household members and household size, 2016



	2 members	3 to 4 members	5 to 6 members	More than 6 members
Three or more		0,9	6,0	14,0
Two		27,9	27,4	20,9
One	52,1	47,9	40,3	31,6
None	47,9	23,2	26,4	33,5

Source: GHS 2016

In 2016, close to one-third (33,5%) of large households, containing children aged 0–6 years and which consisted of six or more members did not have a single employed member; 31,6% of such households had only one employed member; 20,9% had two and 14,0% had three or more employed members.

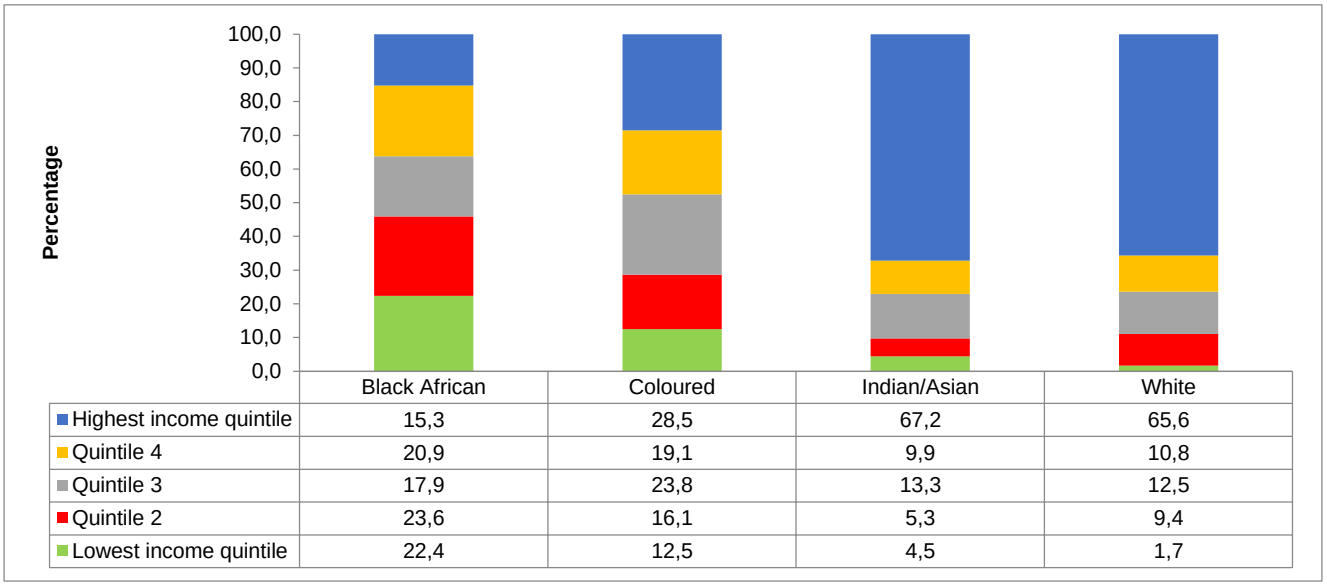
Table 2.7: Children aged 0–6 by main source of household income and geo-type, 2016

Geographical type	Number in thousands	Salaries	Remittances	Pensions	Grants	Other sources	None	Total
	Number	2 660	136	37	787	349	7	**3 977**
Urban	Per cent	66,9	3,4	0,9	19,8	8,8	0,2	
	Number	713	310	23	1 517	162	*	**2 725**
Traditional	Per cent	26,2	11,4	0,9	55,7	5,9	*	
	Number	194	15	*	68	6	1	**284**
Farm	Per cent	68,4	5,2	*	23,9	2,3	0,3	
	Number	**3 567**	**461**	**60**	**2 372**	**517**	**8**	**6 986**
RSA	**Per cent**	**51,1**	**6,6**	**0,9**	**34,0**	**7,4**	**0,1**	**100,0**

Source: GHS 2016
* Un-weighted numbers of 3 and below per cell are too small to provide reliable estimates.

According to the above table, more than half (51,1%) of the total households that had children aged 0–6 in 2016 relied on salaries/wages for their main source of household income. This is typically the case in urban and farm areas where 66,9% and 68,4% of households relied on salaries/wages as their leading source of income respectively. Nationally, grants were the second largest source of household income (34,0%) and played a predominant role as a source of household income in traditional settlement areas (55,7%).

Figure 2.14: Children aged 0–6 by household income quintile and population group, 2016



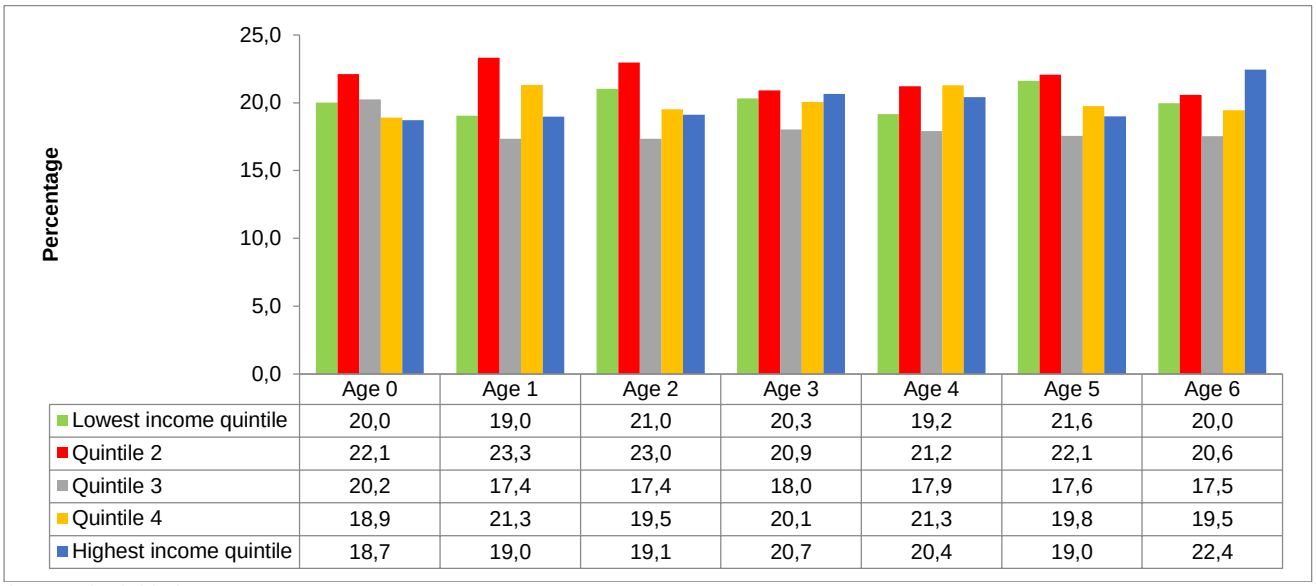
	Black African	Coloured	Indian/Asian	White
Highest income quintile	15,3	28,5	67,2	65,6
Quintile 4	20,9	19,1	9,9	10,8
Quintile 3	17,9	23,8	13,3	12,5
Quintile 2	23,6	16,1	5,3	9,4
Lowest income quintile	22,4	12,5	4,5	1,7

Source: GHS 2016

Income quintiles were calculated using total monthly household incomes based on GHS data. Where total monthly household income values were missing or were less than R1 695,34[10] monthly income values were imputed by using per capita median income multiplied by household size. Large income disparities exist by population group. Close to two-thirds of Indian/Asian children (67,2%) were found within highest income quintile households; while among white children, 65,6% lived in households classified as part of the highest income quintile. By contrast, only 15,3% of black African children lived in households from the highest income quintile which is four times less children compared to the white population. Furthermore, 22,4% of black African children lived in households classified as the lowest income quintile.

[10] Median per capita income derived using the Living Condition Survey 2014/2015 adjusted for inflation.

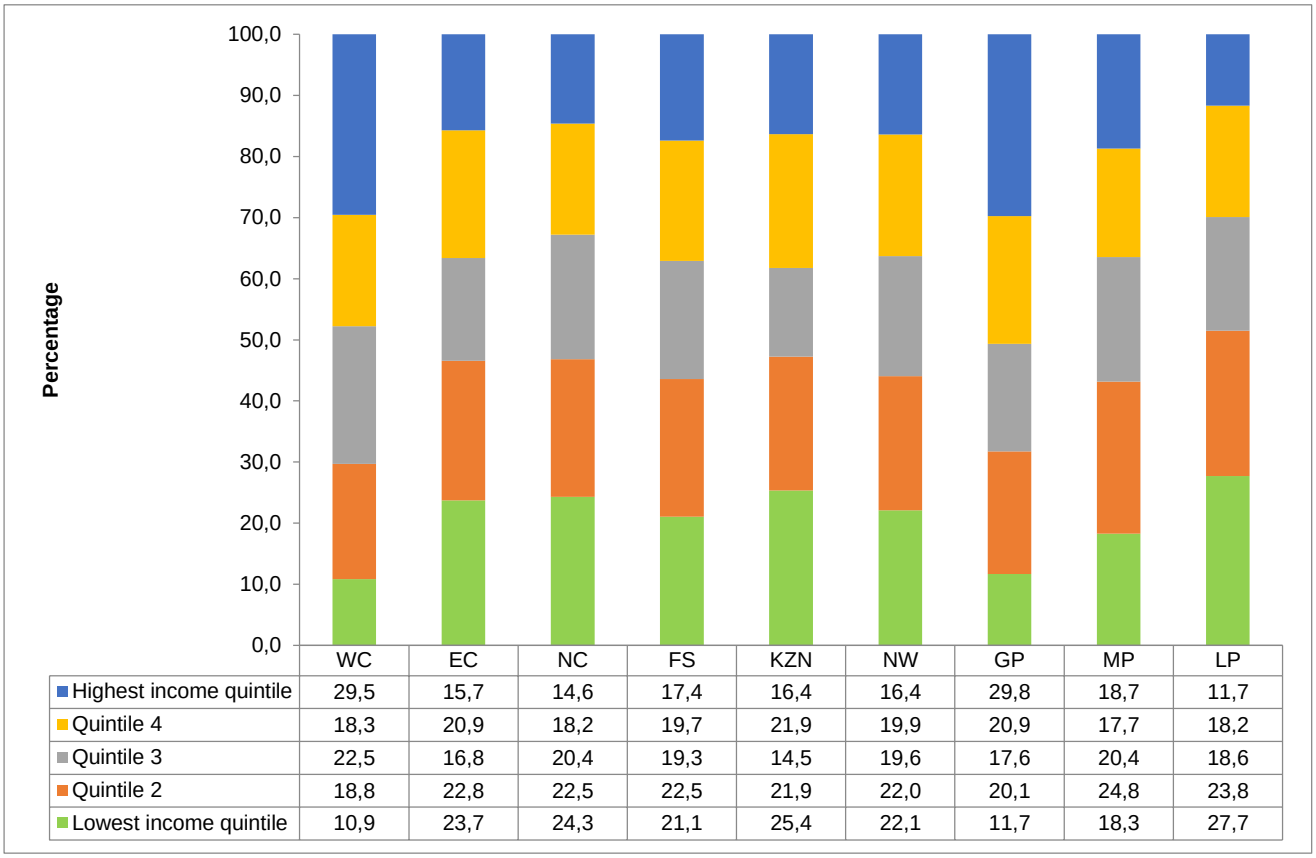
Figure 2.15: Children aged 0–6 by household income quintile and age, 2016



	Age 0	Age 1	Age 2	Age 3	Age 4	Age 5	Age 6
Lowest income quintile	20,0	19,0	21,0	20,3	19,2	21,6	20,0
Quintile 2	22,1	23,3	23,0	20,9	21,2	22,1	20,6
Quintile 3	20,2	17,4	17,4	18,0	17,9	17,6	17,5
Quintile 4	18,9	21,3	19,5	20,1	21,3	19,8	19,5
Highest income quintile	18,7	19,0	19,1	20,7	20,4	19,0	22,4

Source: GHS 2016

Figure 2.16: Children aged 0–6 by household income quintile and province, 2016

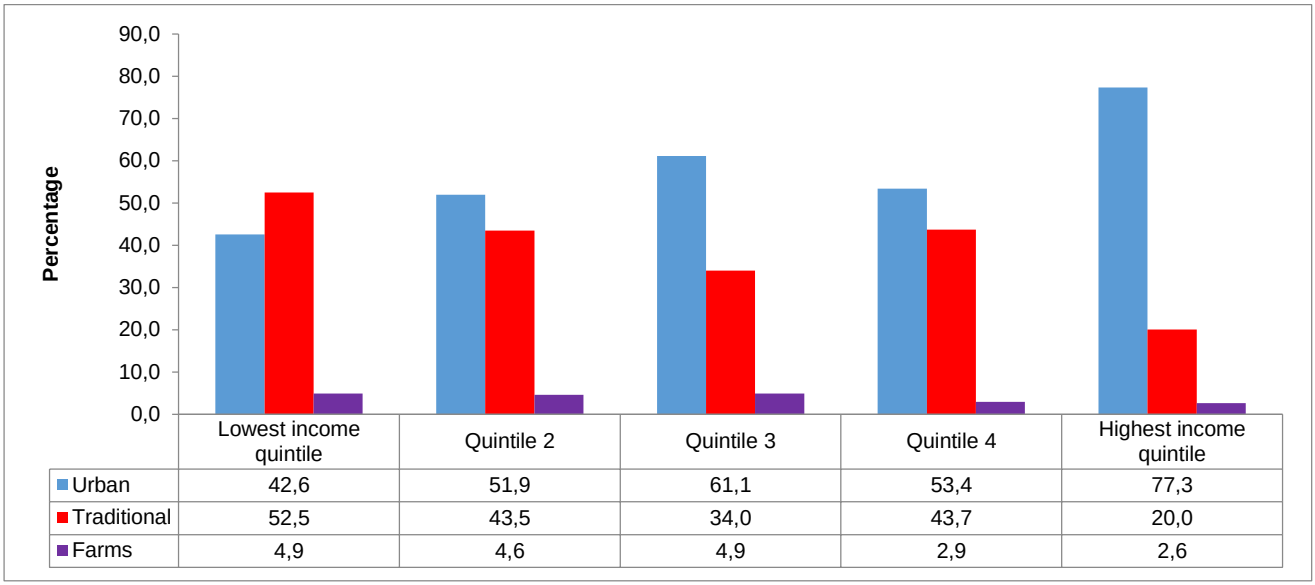


	WC	EC	NC	FS	KZN	NW	GP	MP	LP
Highest income quintile	29,5	15,7	14,6	17,4	16,4	16,4	29,8	18,7	11,7
Quintile 4	18,3	20,9	18,2	19,7	21,9	19,9	20,9	17,7	18,2
Quintile 3	22,5	16,8	20,4	19,3	14,5	19,6	17,6	20,4	18,6
Quintile 2	18,8	22,8	22,5	22,5	21,9	22,0	20,1	24,8	23,8
Lowest income quintile	10,9	23,7	24,3	21,1	25,4	22,1	11,7	18,3	27,7

Source: GHS 2016

Income inequalities were wide within provinces and this gap was conspicuous between the rich and the poor provinces. Close to 30% of young children in Western Cape and Gauteng were residing in households with the highest household income quintile while 27,7% of children in Limpopo, 25,4% of children in KwaZulu-Natal and close to 24% of children both in Eastern Cape and in Northern Cape were found in the lowest household income quintile.

Figure 2.17: Children aged 0–6 by income quintile and geo-type, 2016

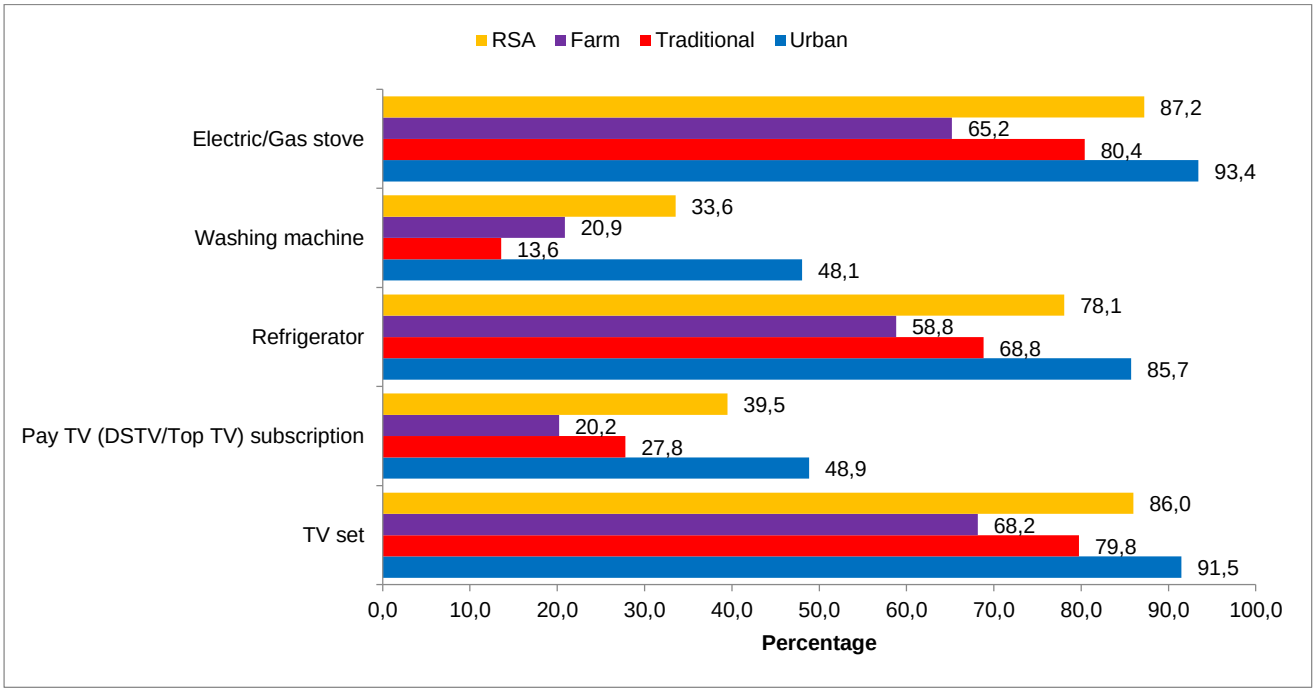


	Lowest income quintile	Quintile 2	Quintile 3	Quintile 4	Highest income quintile
Urban	42,6	51,9	61,1	53,4	77,3
Traditional	52,5	43,5	34,0	43,7	20,0
Farms	4,9	4,6	4,9	2,9	2,6

Source: GHS 2016

Major income disparities were also observed between urban and traditional settlement areas. Urban areas had by far the largest share of children in the highest household income quintile (77,3%) while more than half of the children in traditional settlement areas (52,5%) belonged to the lowest household income quintile. Children residing in farm areas were mostly classed in the lower income quintiles (quintiles 1, quintiles 2 and quintiles 3).

Figure 2.18: Children aged 0–6 by selected households' assets ownership by geo-type, 2016



Source: GHS 2016

The above graph shows selected households' assets ownership by type of geographic location of the household. Regardless of the type of asset, households with children aged 0–6 living in urban areas always had the highest percentage of asset ownership.

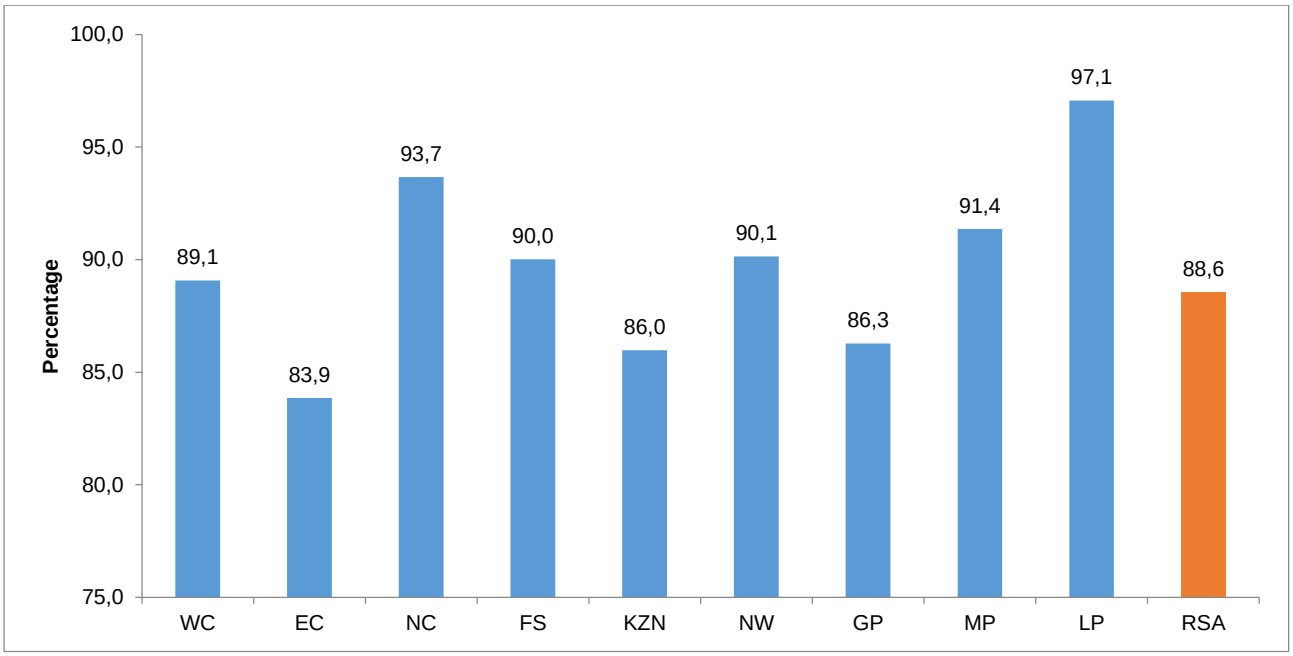
Useful assets, such as electric or gas stoves increase child well-being by providing safe and efficient means for cooking. Nationally, close to 87% of households with young children aged 0–6 use electric or gas stoves for cooking while nine in ten such households in urban areas use electric or gas stoves for cooking (93,4%). Similarly, among households with children aged 0–6 in rural areas, 80,4% use electric or gas stoves for cooking while the same is true for only 65,2% of such households in farm areas.

Access to refrigerators and washing machines relieve caregivers from prolonged household chores. In addition, refrigerators serve as storage; prevent food spoilage; keep food hygienic and away from bugs and other pests. Overall, in South Africa, among households with children aged 0–6 years, approximately 78% owned refrigerators. Similarly, 85,7% in urban areas, 68,8% in traditional areas and 58,8% in farm areas owned refrigerators. However, relatively fewer households owned washing machines, as nationally only 33,6% of households with young children owned these assets. Ownership of washing machines among households with young children was the highest for households living in urban areas (48,1%) compared to those in traditional settlement areas (13,6%) and farm areas (20,9%). TV sets and access to pay TV may not only be used as channels for caregivers to acquire more knowledge about children, but could also be used to entertain and teach the children. While TV sets were widely owned by households with young children in all geographical areas, connections to pay TV were much less common. Their prominence was also limited to households in urban areas (48,9%).

2.5 Access to basic services

The physical conditions of children's homes include their access to essential services such as electricity, water, sanitation, furnishings, space, the state of the walls and roofing. Poor housing conditions expose children to potential illness and injuries. Children's wellbeing is also impacted by how close they are to healthcare centres.

Figure 2.19: Percentage of children aged 0–6 living in households connected to the mains electricity supply by province, 2016



Source: GHS 2016

Electricity provides a vital source of energy for households, as it is used for many activities around the house from cooking, heating (including water heating), lighting, refrigeration, washing and cleaning, use of home appliances such as kettles and toasters, charging cell phones, televisions and computers. The graph above shows the percentage of households with children aged 0–6 with direct connections to the mains electricity supplied by service providers. While the national average for all households' connections to the mains electricity supply was 84,2% in 2016 (Stats SA, 2016: P0318), the national average for households with young children that were connected to the mains electricity supply was slightly higher (88,6%). The highest percentages of households connected to mains electricity were found in Limpopo (97,1%) followed by Northern Cape (93,7%) and Mpumalanga (91,4%). The percentages of households connected to the mains electricity in Eastern Cape, KwaZulu-Natal and Gauteng were below the national average with 83,9%, 86,0% and 86,3% respectively.

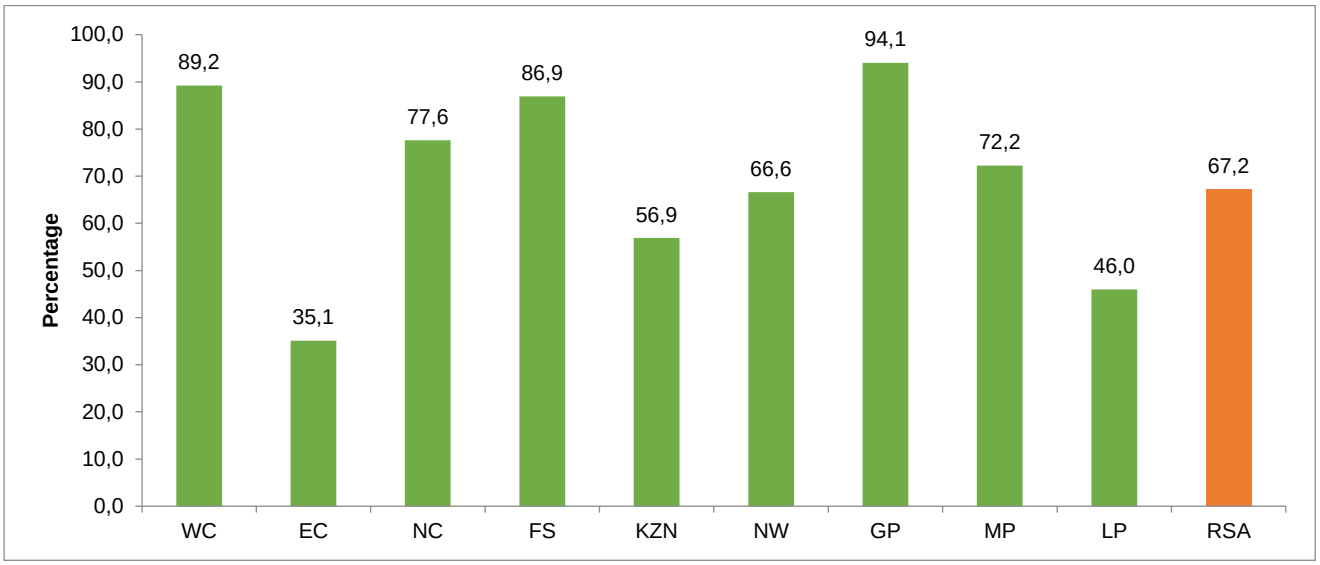
Table 2.8: Households with children aged 0–6 by main source of energy used for cooking and province, 2016

Energy used for cooking	Number in thousands	WC	EC	NC	FS	KZN	NW	GP	MP	LP	RSA
Electricity	Number	623	625	137	285	1 107	425	1 201	436	465	**5 304**
	Per cent	11,8	11,8	2,6	5,4	20,9	8,0	22,7	8,2	8,8	
Gas	Number	76	40	9	19	28	13	48	5	7	**245**
	Per cent	31,1	16,4	3,7	7,9	11,4	5,2	19,7	2,0	2,8	
Paraffin	Number	4	73	3	19	30	20	67	12	*	**229**
	Per cent	1,9	31,7	1,4	8,3	13,0	8,7	29,4	5,3	*	
Wood	Number	*	224	13	9	333	39	10	125	381	**1 136**
	Per cent	*	19,8	1,1	0,8	29,3	3,4	0,9	11,0	33,5	
Coal	Number	*	*	*	*	7	*	*	26	11	**47**
	Per cent	*	*	*	*	16,0	*	*	56,8	24,5	
Other	Number	32	16	*	7	24	25	101	4	19	**229**
	Per cent	13,9	7,0	*	3,2	10,6	11,1	44,1	1,6	8,3	
Total	**Number**	**738**	**979**	**162**	**340**	**1 530**	**522**	**1 428**	**608**	**884**	**7 191**

Source: GHS 2016
* Un-weighted numbers of 3 and below per cell are too small to provide reliable estimates.

Out of the roughly 7,2 million children aged 0–6, close to 74% (5,3 million) children lived in households that used electricity for cooking, of which approximately 23% were located in Gauteng and 21% were located in KwaZulu-Natal. Wood was the second most common type of energy used for cooking by households that accounted for 1,1 million young children and who were mostly found in Limpopo (33,5%) and KwaZulu-Natal (29,3%). Paraffin was mostly used in Eastern Cape (31,7%) and Gauteng (29,4%), while coal was mostly used in Mpumalanga (56,8%). While paraffin may be a cheaper source of energy for cooking, its detrimental attributes outweigh the advantages. They pose a danger to young children mainly because of the use of unsafe stoves; the danger of fires due to the use of these stoves; the high levels of emissions given off by these appliances in small enclosed living spaces; and the accidental ingestion of paraffin by young children.

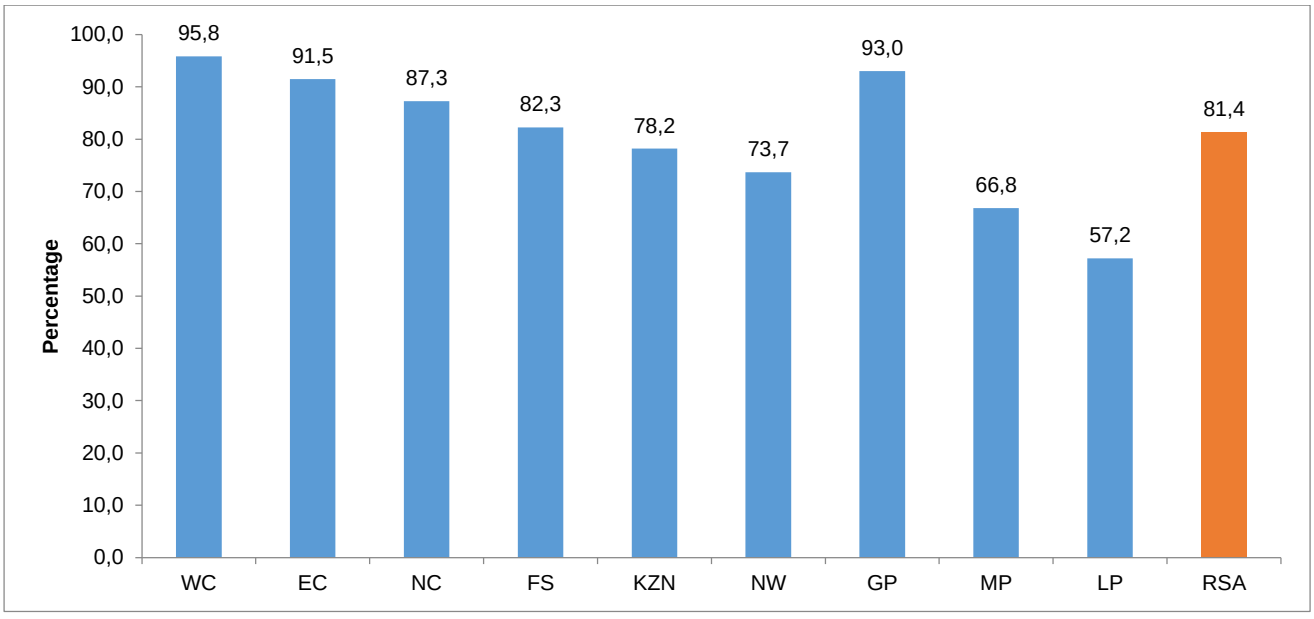
Figure 2.20: Percentage of households with children aged 0–6 by access to piped water (piped water in dwelling or on site) and province, 2016



Source: GHS 2016

Lack of water or poor water conditions create an unhealthy household environment. Moreover, lack of quality drinking water exposes individuals to diseases and young children are particularly susceptible to such outcomes. According to the GHS 2016, households in South Africa sourced water for drinking primarily from piped water in dwellings (46,4%), secondly from piped water on sites (26,8%) and thirdly from public communal taps (13,3%). The remaining approximately 14% of households either use neighbours' taps, boreholes on- or off-site, water tankers, flowing water or streams etc. (Stats SA 2016: P0318). The above graph presents households with children aged 0–6 using piped water in dwellings or piped water on sites as a main source of water for drinking. While nationally, 67,2% of households with young children used piped water in dwellings or on sites for drinking, the highest percentage of such households were located in Gauteng (94,1%) and the lowest percentage were found in Eastern Cape (35,1%).

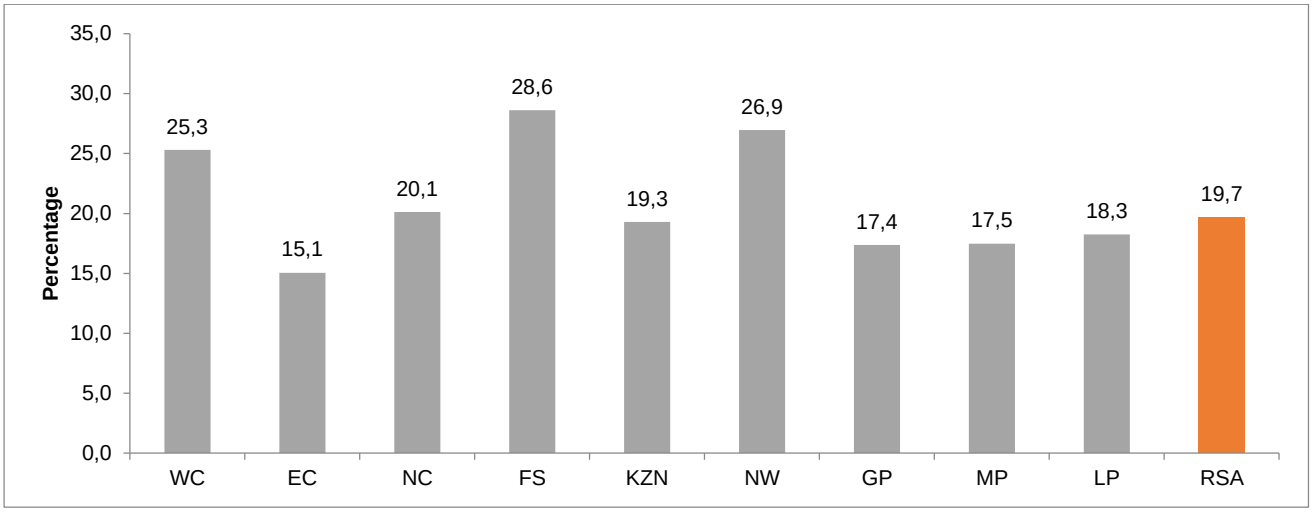
Figure 2.21: Percentage of children aged 0–6 living in households with access to improved sanitation, 2016



Source: GHS 2016

The well-being of young children also depends on access to sanitation as proper disposal of excreta is an important component of a healthy household environment. These include adequate and safe toilet facilities that do not put the safety and the health of the child at risk. Adequate toilet facilities include flush toilets that are connected to a public sewerage system or a septic tank as these guarantee proper disposal of excreta. Poor sanitation facilities include pit toilets and the use of bucket toilets. The above graph presents sanitation facilities available to children aged 0–6 in South Africa. The analysis includes (i) flush-toilets connected to public sewerage; (ii) flush-toilets connected to a septic tank; (iii) pit latrine/toilet with ventilation pipe; and (iv) ecological sanitation systems. These sanitation systems were recognised as better facilities (improved sanitation) in terms of the criteria described above. Overall in South Africa, nearly 8 children out of 10 (81,4%) aged 0–6 had access to improved sanitation. Almost universal access was observed in Western Cape (95,8%); Gauteng and Eastern Cape followed closely with 93,0% and 91,5% respectively of households with young children having access to improved sanitation. The lowest access to improved sanitation were observed in Limpopo (57,2%) and Mpumalanga (66,8%), which amounted to shortfalls of 24,2 and 14,6 percentage points respectively when compared to the national average.

Figure 2.22: Percentage of children aged 0–6 residing in households with RDP[11] or state subsidised dwellings, 2016

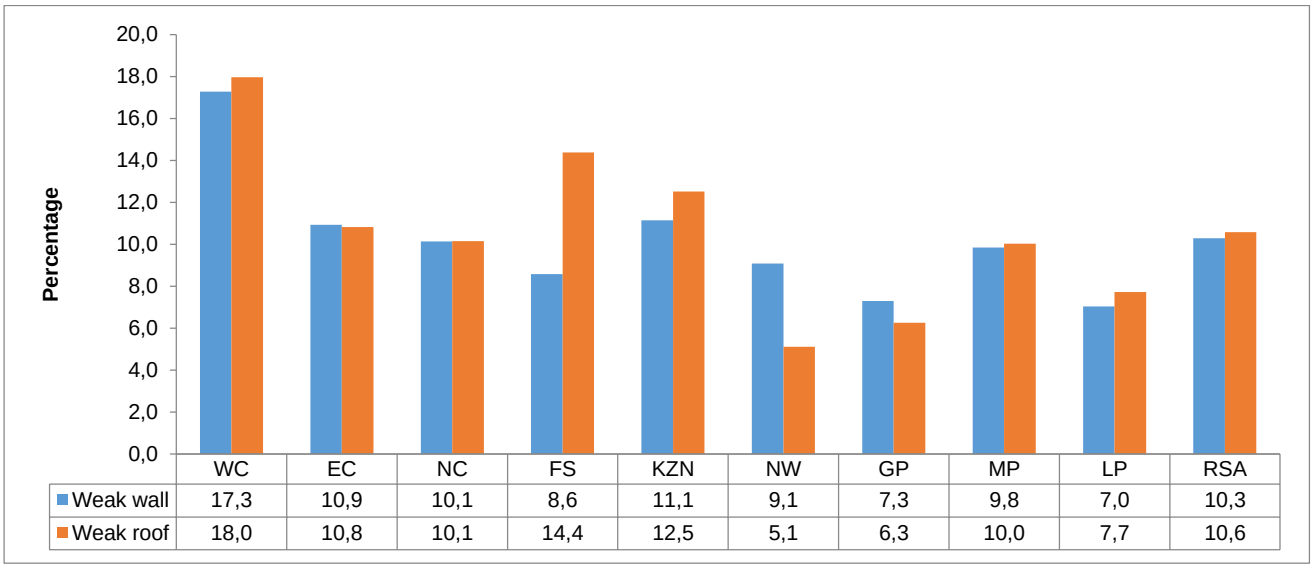


Source: GHS 2016

Reconstruction and Development Programme (RDP) houses are houses that were constructed for households with low income through the RDP, which came to an end in the early 2000s. Since then a variety of support and housing delivery mechanisms have been developed, but low cost housing has remained popularly known as RDP housing. The above analysis includes all RDP houses and state subsidised dwellings, but excludes houses owned/constructed through housing subsidies for government employees. Overall in South Africa, one in five children aged 0–6 lived in RDP or state subsidised dwellings. Households with young children resident in the Free State were the most likely to live in RDP or state subsidised houses (28,6%), followed by North West (26,9%). A quarter (25,3%) of children aged 0–6 located in Western Cape were living in RDP or state subsidised dwellings, while only 15,1% of the children in Eastern Cape had such dwellings.

[11] Reconstruction and Development Programme (RDP) is a South African socio-economic policy framework that was led by the ruling African National Congress party in 1994. It is a government programme that was designed to improve the standard of living among the underprivileged members of the population by providing low-cost housing, basic services, education, and health care.

Figure 2.23: Households with children aged 0–6 by conditions of the wall and roof of the main dwelling and by province, 2016

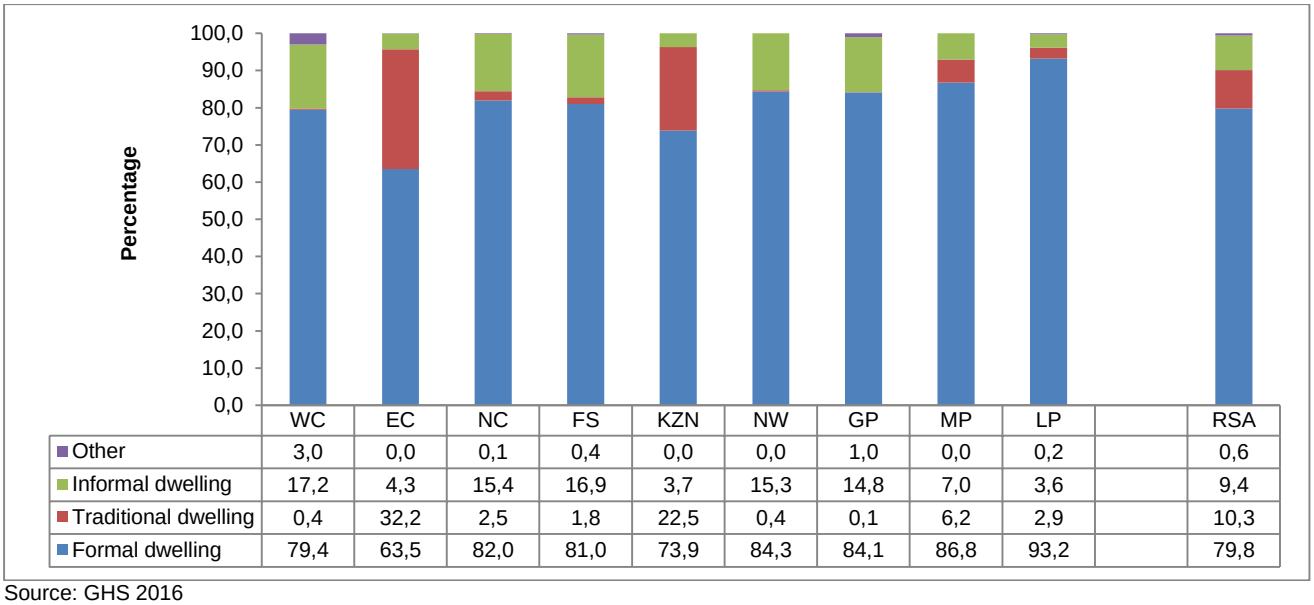


	WC	EC	NC	FS	KZN	NW	GP	MP	LP	RSA
Weak wall	17,3	10,9	10,1	8,6	11,1	9,1	7,3	9,8	7,0	10,3
Weak roof	18,0	10,8	10,1	14,4	12,5	5,1	6,3	10,0	7,7	10,6

Source: GHS 2016

Weak wall and roof conditions signal poor housing quality. In this analysis, roofing and walls that were described as very weak and weak by the respondents were combined. Poor housing conditions affect children's development as leaking roofs and bad walls produce cold and damp, resulting in a higher risk of children experiencing severe ill-health. Compared to national averages, children aged 0–6, living in Western Cape were more likely to reside in dwellings that had weak walls (17,3%) and weak roofs (18,0%). In KwaZulu-Natal, 11,1% had poor quality walls and 12,5% had poor roof quality. Gauteng and Limpopo displayed lower percentages of poor quality roofing and walls compared to the national average (weak wall: 10,3%; weak roof: 10,6%) and other provinces.

Figure 2.24: Households of children aged 0–6 by dwelling type (formal, traditional, informal, other), 2016



	WC	EC	NC	FS	KZN	NW	GP	MP	LP		RSA
Other	3,0	0,0	0,1	0,4	0,0	0,0	1,0	0,0	0,2		0,6
Informal dwelling	17,2	4,3	15,4	16,9	3,7	15,3	14,8	7,0	3,6		9,4
Traditional dwelling	0,4	32,2	2,5	1,8	22,5	0,4	0,1	6,2	2,9		10,3
Formal dwelling	79,4	63,5	82,0	81,0	73,9	84,3	84,1	86,8	93,2		79,8

Source: GHS 2016

Formal dwellings are structures built according to approved plans and consist of houses on a separate stand, flat or apartment, townhouse, room in backyard, rooms or flat-lets. Informal dwellings are makeshift structures not erected according to approved architectural plans and consist of shacks or shanties in informal settlements, serviced stands or proclaimed townships. They can also be in the backyards of other dwelling types. Traditional dwellings are dwellings made of clay, mud, reeds or other locally available materials. This is a general term that includes huts, rondavels, etc. Such dwellings can be found as single units or in clusters. Rondavels constructed with concrete blocks or stone walls are not considered traditional (Stats SA, 2016: P0318).

Overall in South Africa, 9,4% of children aged 0–6 were residing in informal dwellings. The largest percentages of informal dwellings were situated in Western Cape and Free State, each province accounting for 17% of the provincial total dwelling types. Northern Cape, North West and Gauteng also had sizeable percentages (close to 15% each) of children staying in shacks. Nationally, close to 10% of young children resided in homes of traditional dwellings type, the two largest contributors to such dwelling types were Eastern Cape (32,2%) and KwaZulu-Natal (22,5%).

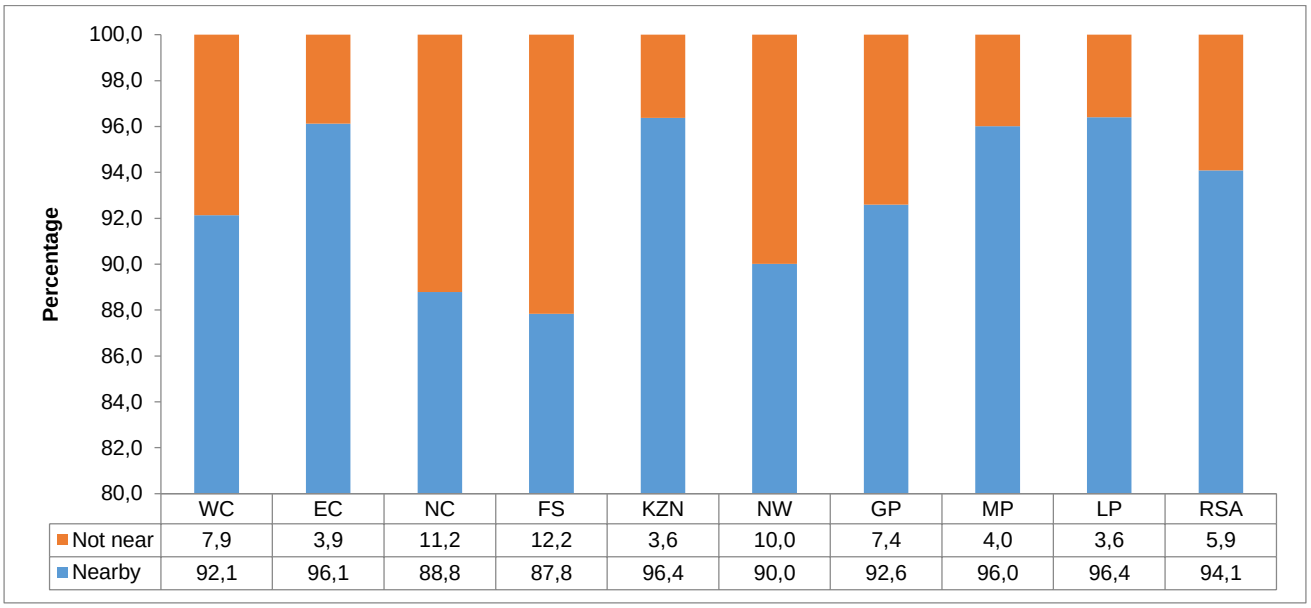
Table 2.9: Households with children aged 0–6 by type of health facility used when a member of a household is sick/ill and by population group, 2016

Population group	Public hospital	Public clinic	Other public institution	Private hospital	Private clinic	Private doctor	Traditional healer	Pharmacy	Other in private sector
Black African	5,8	79,8	0,7	0,6	1,0	11,5	0,4	0,1	0,1
Coloured	15,1	52,9	0,5	2,4	0,6	28,3	0,0	0,2	0,0
Indian/Asian	7,4	19,1	0,0	8,4	1,5	63,7	0,0	0,0	0,0
White	8,7	10,2	0,0	4,9	4,4	70,5	0,0	0,7	0,7
Total in thousands	**482**	**5 232**	**45**	**78**	**84**	**1 211**	**24**	**12**	**10**

Source: GHS 2016

The above table presents households with young children's first choice of health facilities to visit in case any member becomes ill and decides to seek medical help. The choices of health facilities varied by population group. Households with black African children would most likely visit public clinics (79,8%) as opposed to 11,5% who would visit private doctors or public hospitals (5,8%). The order of choice of households with coloured children was similar to households with black African children as the majority would most likely visit public clinics (52,9%) followed by 28,3% who would visit private doctors and 15,1% who would visit public hospitals. Similarly, households with Indian/Asians and white children would most likely have comparable choices as they would most likely visit both private doctors (63,7% and 70,5% respectively) or opt for public clinics (19,1% and 10,2% respectively). However, while 8,4% of Indian/Asian households with young children would prefer to visit private hospitals, 8,7% of white households with young children would rather visit public hospitals.

Figure 2.25: Households with children aged 0–6 by proximity of the health facility used by province, 2016

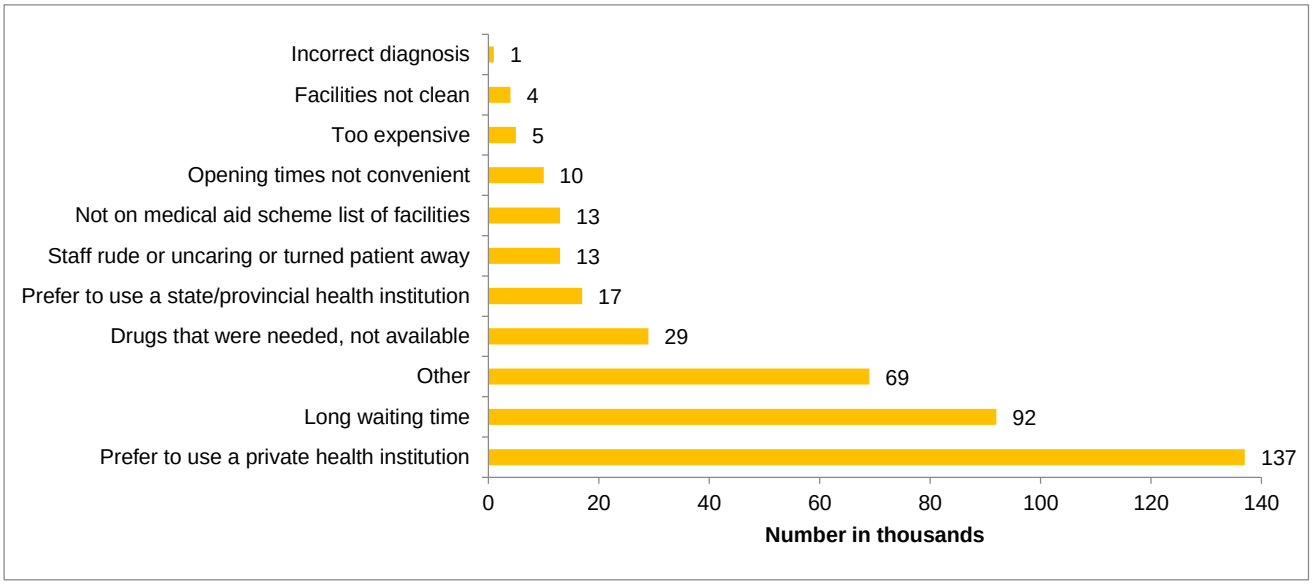


	WC	EC	NC	FS	KZN	NW	GP	MP	LP	RSA
Not near	7,9	3,9	11,2	12,2	3,6	10,0	7,4	4,0	3,6	5,9
Nearby	92,1	96,1	88,8	87,8	96,4	90,0	92,6	96,0	96,4	94,1

Source: GHS 2016

The above figure presents the proximity to the dwelling of the health facility used by households with children aged 0–6. On average, 9 out of the 10 households indicated that they visited the nearest health facility. However 11,2% of households with young children in Northern Cape and 12,2% of similar households in Free State visited health facilities that are not the nearest to their dwellings.

Figure 2.26: Households with children aged 0–6 by reasons for not using the nearby healthcare facility, 2016



Source: GHS 2016

Reasons given by households with young children for not using the closest health facilities varied from convenience to preferences for using private health facilities. Out of the 390 347 households with young children that gave reasons for not using the closest facility, 137 166 indicated that they preferred using private health institutions, while 91 808 complained about long waiting times in nearby facilities.

Table 2.10: Households with children aged 0–6 by time taken to reach health facility by means of transport used, 2017

	Time in minutes to public health facilities			
Modes of Transport	**Less than 15 minutes**	**15-29 minutes**	**30-89 minutes**	**90 minutes and more**
Walking	34,2	43,1	20,1	2,7
Minibus taxi/ bakkie taxi/ sedan taxi	23,2	53,0	21,7	2,1
Bus	12,0	56,4	29,7	1,9
Train	40,7	50,8	8,5	0,0
Own transport	54,8	40,0	4,9	0,3
Bicycle/motorcycle	0,0	100,0	0,0	0,0
Total in thousands	**1 767**	**2 622**	**1 128**	**131**
Per cent	**31,3**	**46,4**	**20,0**	**2,3**
	Time in minutes to private health facilities			
Walking	57,1	37,8	4,0	1,1
Minibus taxi/ bakkie taxi/ sedan taxi	28,4	54,5	15,8	1,3
Bus	37,6	39,6	22,8	0,0
Own transport	60,6	34,3	5,1	1,0
Bicycle/motorcycle	75,5	24,5	0,0	0,0
Total in thousands	**760**	**532**	**96**	**6**
Per cent	**54,6**	**38,2**	**6,9**	**0,4**

Source: GHS 2016

The above table presents the time taken by households with children aged 0–6 to reach the health facility of their first choice. Overall, most households with young children (46,4%) took between 15 minutes and less than 30 minutes to reach a public health facility, regardless of the type of transport used (walking, taxi, bus, or train). Close to three in ten households (31,3%) took less than 15 minutes to reach public health facilities. However, one in five households (20%) took between 30 minutes and one hour and a half, to reach public health facilities and close to two per cent took more than an hour and a half to reach public health facilities. These households would most likely be walking, using taxis, buses or train. Overall most households (54,6%) that used private health facilities would need less time (less than 15 minutes) to reach the health facilities. They would most likely be walking (57,1%) or use their own transport (60,6%).

2.6 Summary and conclusion

This chapter has shown that children aged 0–6 in South Africa live in households that vary in condition, composition and location across the country. Generally the living conditions of children aged 0–6 are best in Western Cape and Gauteng. It has also outlined the disparity in access of young children to quality and suitable housing by geography; inequality of households with young children income groupings by population group; disparity of young children's household in accessing services by population group and geography. These elements in combination or separately play a role in children's physical, emotional and mental growth.

Chapter 3: Early childhood nutrition and health

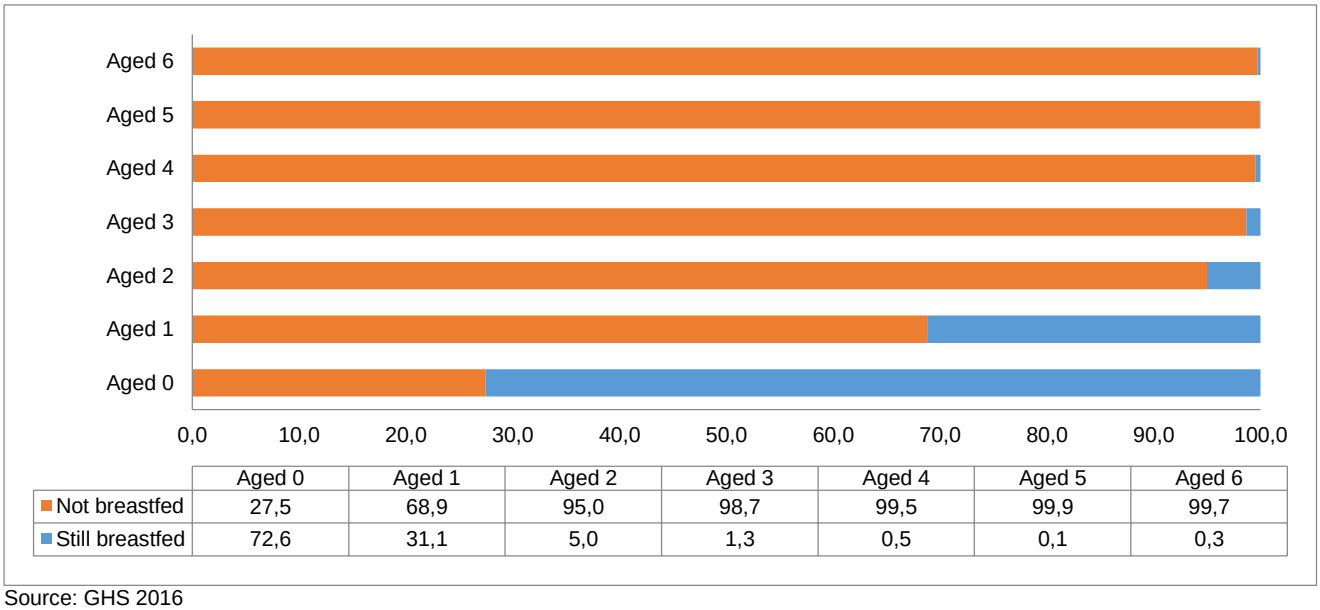
3.1 Introduction

The ECD policy was intended for children from conception until the year before they start schooling which currently stands at age six where children either attend Grade R or Grade 1. The policy was designed to function in a dual government-regulated model of public and private delivery of services with universal access for all children with prioritising of children from poor families and children with disabilities. The essential ECD components consist of nutritional support, maternal and child health care, support for primary caregivers, social services and stimulation for early learning. In this section, data on the following four components: nutritional support, maternal and child health care, support for primary caregivers are presented.

3.2 Nutritional support

Nutritional support is one of the most important tools for children to be able to achieve their full physical and intellectual potential overtime. The National Department of Health embarked on a programme called “Roadmap for Nutrition in South Africa” from 2013 to 2017. This programme envisaged optimal nutrition for all people in South Africa by 2017 and beyond, and the intention was to achieve through the provision of high quality nutrition services, for women, infants and children, throughout all levels of the health care system. According to the South African Early Childhood Review 2016, proper maternal nutrition during and after pregnancy can curb poor health outcomes of the child and can lead to improved educational outcomes for children. The policy endorses healthy feeding practices through the promotion of exclusive breastfeeding, appropriate complementary feeding, responsive feeding and strengthened fortification and supplementation mechanisms. Sustainable Development Goal number two is dedicated to “end hunger, achieve food security and improved nutrition and promote sustainable agriculture”; this shows that improved nutrition is a global concern. The WHO and UNICEF recommend that all infants be exclusively breastfed for the first six months of their lives. Thereafter, infants should receive safe and nutritionally adequate complementary foods while breastfeeding can continue for up to two years of age or beyond.

Figure 3.1: Children who are still being breastfed by age, 2016

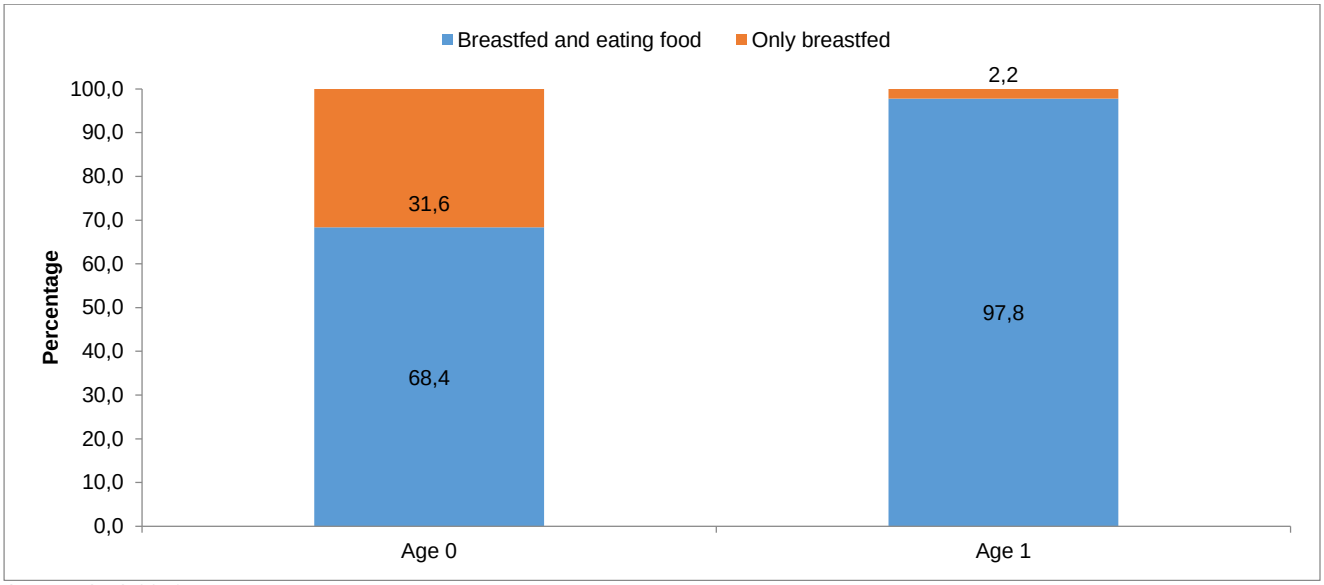


	Aged 0	Aged 1	Aged 2	Aged 3	Aged 4	Aged 5	Aged 6
Not breastfed	27,5	68,9	95,0	98,7	99,5	99,9	99,7
Still breastfed	72,6	31,1	5,0	1,3	0,5	0,1	0,3

Source: GHS 2016

The figure above shows the percentage of children breastfeeding practices by age of the child. Children aged less than one year (72,6%) were more likely to be breastfed; however, slightly more than a quarter (27,5%) of them were not breastfed. Continuous breastfeeding up to age two is recommended, however the proportion of children who were still breastfed decreased as age increased.

Figure 3.2: Percentage of children who were exclusively breasted or being breastfed while also eating other forms of food by age, 2016

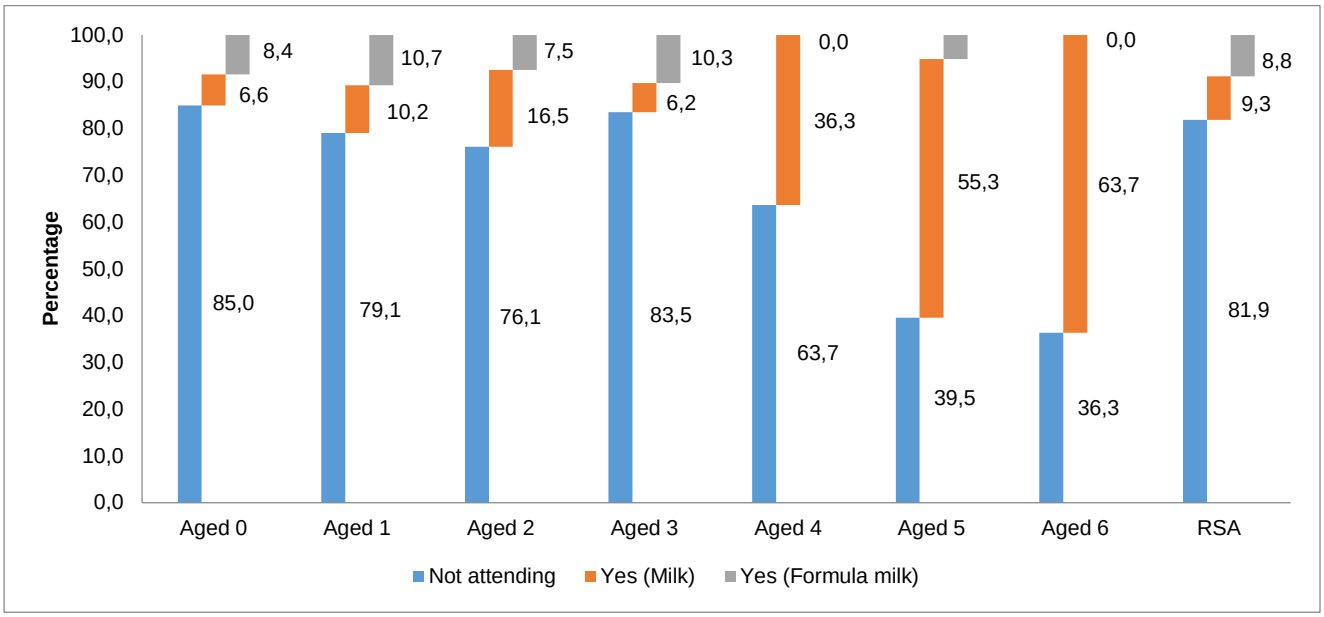


Source: GHS 2016

Breast milk is a good nutritional diet for children more especially in their first six months. According to GHS 2016, close to 32% of children less than one year were exclusively breastfed while 68% in the same age group were eating food to supplement their diet[12]. According to the SADHS 2016, exclusive breastfeeding among babies less than 6 months was 31,6% but declined sharply for children between 6 and 9 months (3,7%)[13].

[12] The question in GHS 2016 specifically asked about eating food in addition to breastmilk. The provision of liquids, such as for example water and or other kinds of milk, was not asked about and these statistics therefore refer to exclusivity in relation to other foods and not liquids.
[13] SADHS 2016 key indicators report Table 13, page 29

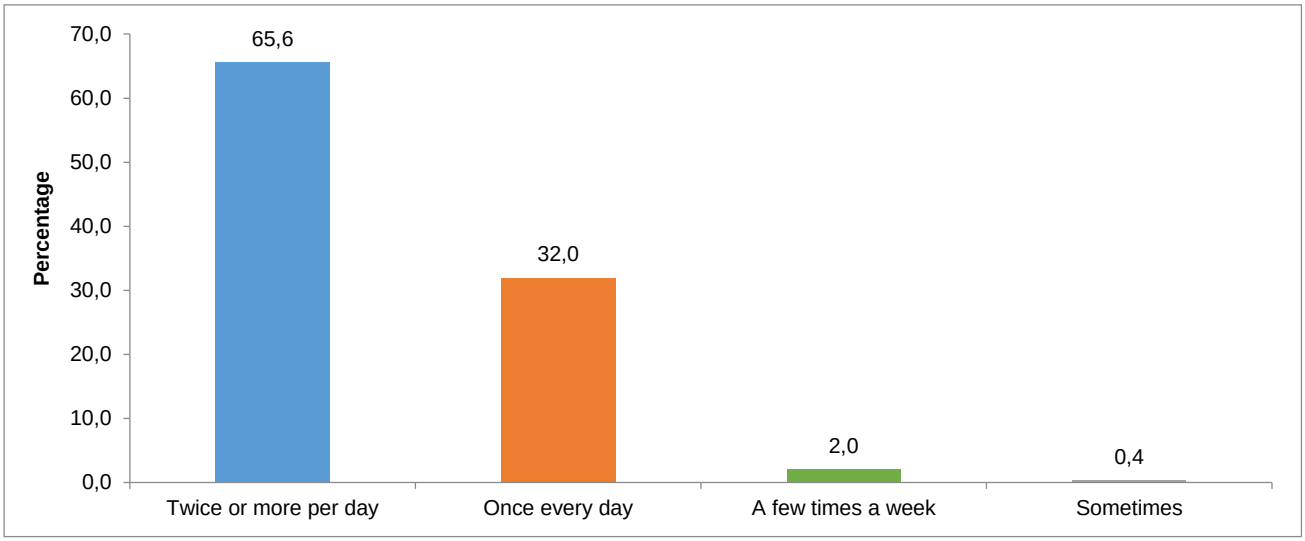
Figure 3.3: Access to milk at the place of care/ECD facility, 2016



Source: GHS 2016

The figure above displays access to milk at the ECD facilities/day care centres for children aged 0–6; this was aimed at measuring nutrition security for young children. While nationally, approximately 82% reported not attending school, the remaining proportion who reported to be attending an educational institution received milk at the place of care. Among those who reported to receive milk, 9,3% reported receiving milk (either cow milk or soya milk), and a further 8,8% received formula milk. The consumption of cow milk or soya milk was more common in the age groups, four, five and six, while the consumption of formula milk was most common amongst children aged zero to three.

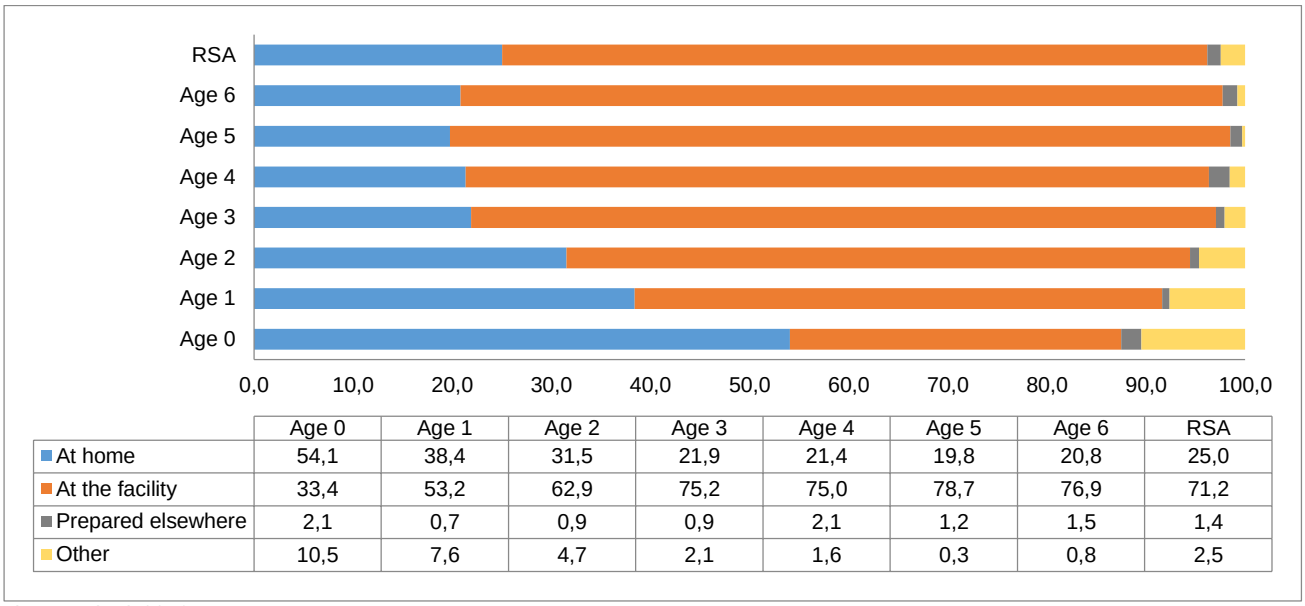
Figure 3.4: Percentage of children aged 0–6 by the timing of food consumption at the care centre, 2016



Source: GHS 2016

According to the figure above, close to two-thirds of children (65,6%) aged 0–6 were provided with food twice or more times per day, while approximately a third (32%) received food once every day. A small proportion received food a few times a week or sometimes (2,4%).

Figure 3.5: Percentage of children aged 0–6 by place of preparation of the food consumed at the care centre, 2016

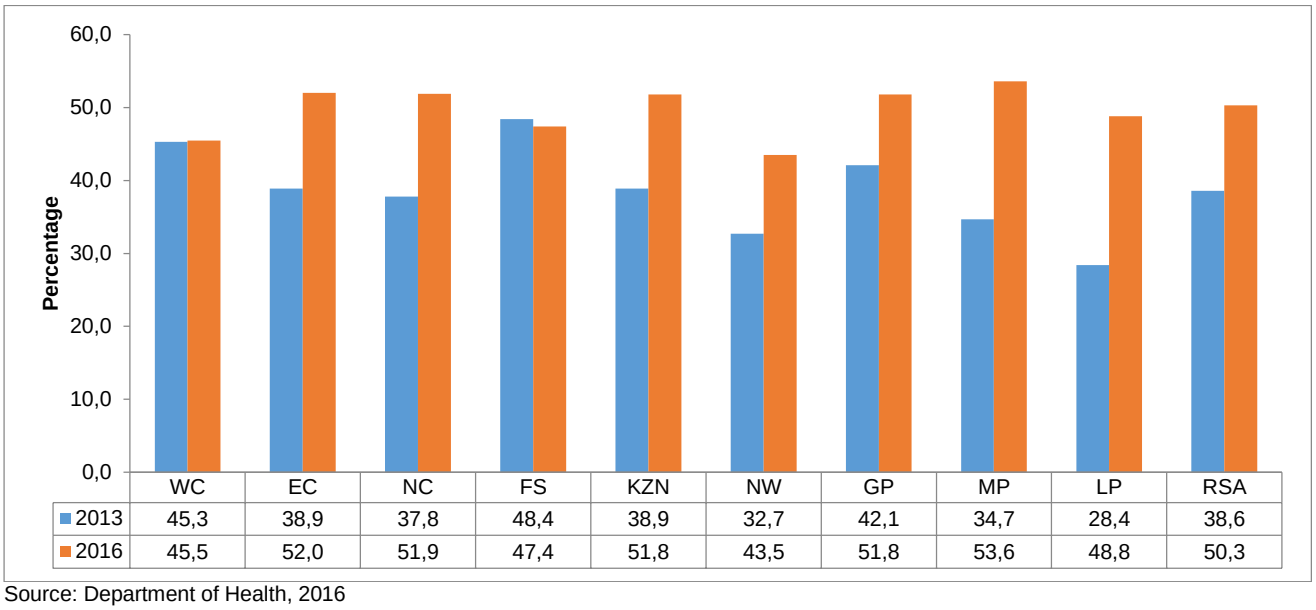


	Age 0	Age 1	Age 2	Age 3	Age 4	Age 5	Age 6	RSA
At home	54,1	38,4	31,5	21,9	21,4	19,8	20,8	25,0
At the facility	33,4	53,2	62,9	75,2	75,0	78,7	76,9	71,2
Prepared elsewhere	2,1	0,7	0,9	0,9	2,1	1,2	1,5	1,4
Other	10,5	7,6	4,7	2,1	1,6	0,3	0,8	2,5

Source: GHS 2016

Figure 3.5 above shows the distribution of children aged 0–6 by place of food preparation at the care centre they attend. It was evident that half of children aged 0 were receiving or consuming food that was prepared at home (54,1%) while a third ate food prepared at the facility (33,4%). Three-quarters of the children aged 3 and 4 ate food prepared at the facility.

Figure 3.6: Percentage of children aged 12–59 months who received vitamin A supplement, 2013–2016

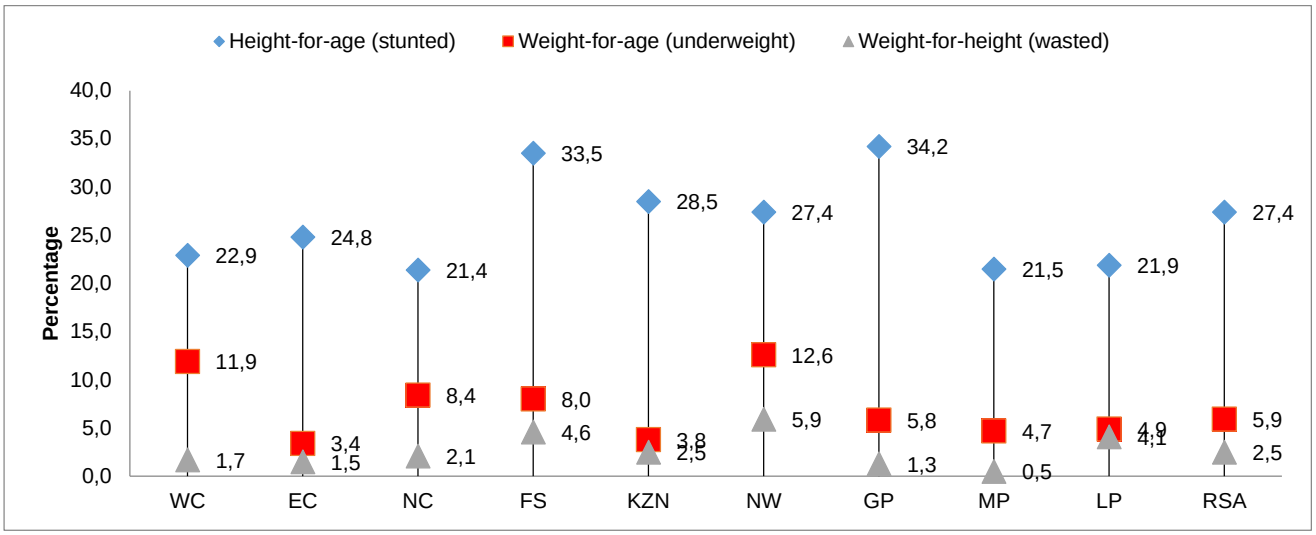


	WC	EC	NC	FS	KZN	NW	GP	MP	LP	RSA
2013	45,3	38,9	37,8	48,4	38,9	32,7	42,1	34,7	28,4	38,6
2016	45,5	52,0	51,9	47,4	51,8	43,5	51,8	53,6	48,8	50,3

Source: Department of Health, 2016

A deficit of vitamin A in infants may cause blindness and make infants susceptible to infections and life-threatening illnesses. The Department of Health provides vitamin A supplements to those in need as part of its public health policy. In 2016, overall 50,3% of children between 12 to 59 months received vitamin A supplement. Close to 54% of children in Mpumalanga and close to 52% of children in Eastern Cape, Gauteng, KwaZulu-Natal and Northern Cape each received a vitamin A supplement. The largest improvement in coverage was observed in Limpopo followed by Mpumalanga.

Figure 3.7: Nutritional status of children aged 0–59 months by province [14], 2016



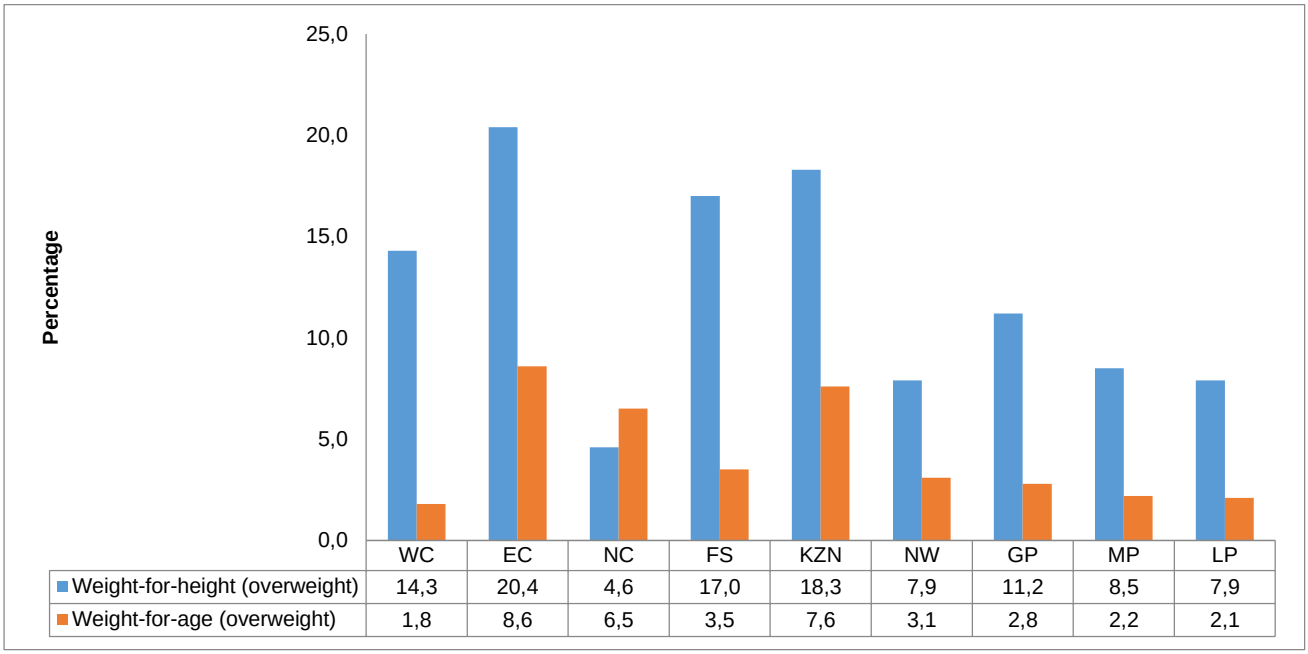
Source: SADHS 2016

The figure above shows the nutritional status of children younger than five years, as determined using three anthropometric indices. Height-for-age is a measure of linear growth. If a child is below -2 SD[2] from the reference median for height-for-age he/she is considered stunted. This condition reflects the cumulative effect of chronic malnutrition. In reference to weight-for-height, if a child is below -2 SD[2] from the reference median for weight-for-height, the child is considered wasted, a condition reflecting acute or recent nutritional deficits. The last anthropometric index is weight-for-age. This measure cannot distinguish between acute malnutrition (wasting) and chronic malnutrition (stunting). Weight-for-age is considered to be an overall indicator of a population's nutritional health.

Stunting was high in Gauteng and Free State (34,2% and 33,5% respectively), and low in Northern Cape, Mpumalanga and Limpopo (21,4%, 21,5% and 21,9% respectively). North West, Free State and Limpopo had children who were wasted as opposed to other provinces. Children who were more likely to be underweight were found in North West and Western Cape (12,6% and 11,9% in that order).

[14] Figures for weight-for height for the WC was based on 25-49 unweighted cases.

Figure 3.8: Percentage of overweight children aged 0–59 months by province[15], 2016

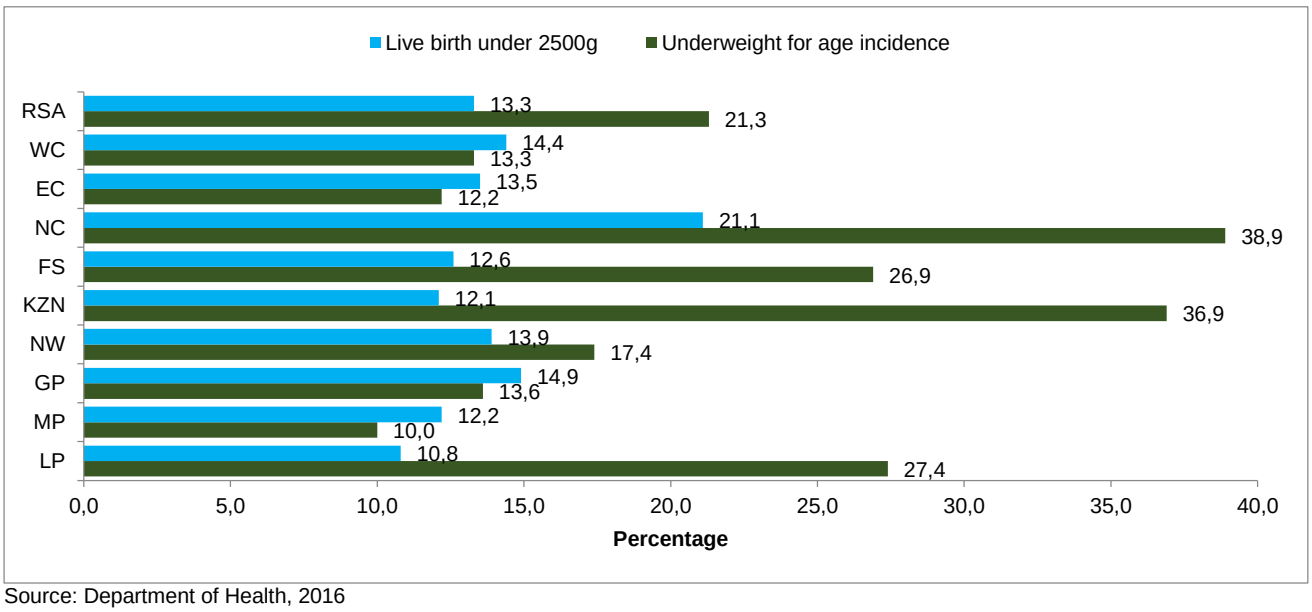


	WC	EC	NC	FS	KZN	NW	GP	MP	LP
Weight-for-height (overweight)	14,3	20,4	4,6	17,0	18,3	7,9	11,2	8,5	7,9
Weight-for-age (overweight)	1,8	8,6	6,5	3,5	7,6	3,1	2,8	2,2	2,1

Source: SADHS 2016

According to the figure above, overweight status was prevalent among children aged younger than five years in the Eastern Cape, KwaZulu-Natal and Free State provinces with close to one in five children being overweight (weight-for-height greater than +2 SD from the reference median).

Figure 3.9: Incidence of underweight for age among children under two years and live birth under 2 500g, 2016

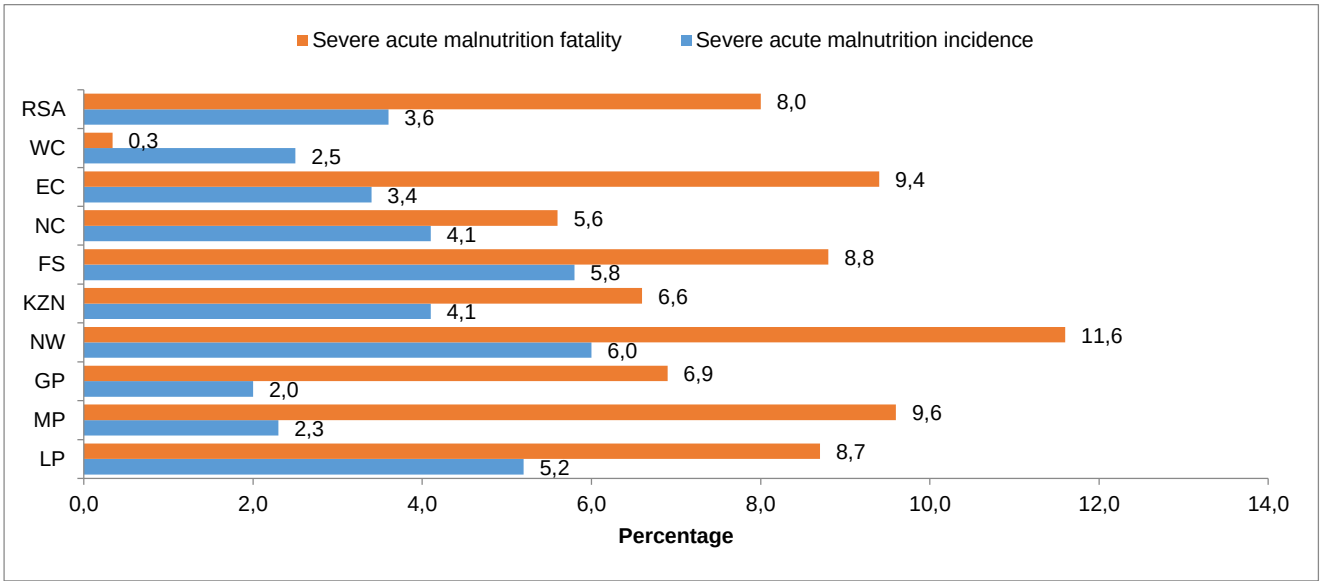


Source: Department of Health, 2016

[15] Figures for weight-for height (overweight) for the WC were based on 25-49 unweighted cases.

Among all live births that occurred in 2016 in South Africa, the incidence[16] rate of live births under a weight of 2,5 kg was 13,3%. The highest incidence was observed in Northern Cape (21,1%) followed by Gauteng (14,9%). Among all children aged under two years, the overall underweight for age incidence rate was 21,3%. The four high incidence provinces ranked from highest to lowest were Northern Cape (38,9%), KwaZulu-Natal (36,9%), Limpopo (27,4%) and Free State (26,9%).

Figure 3.10: Incidence of severe acute malnutrition rate and severe acute malnutrition fatality rate among children under five years, 2016



Source: Department of Health, 2016

The incidence of severe acute malnutrition among the under-five aged children was 3,6% in 2016 and was the highest in Free State and North West (six per cent each) and the lowest in Gauteng (two per cent). Severe acute malnutrition among young children is a potentially fatal condition. While North West and Free State which reported the highest incidence were also the provinces with the highest fatality rate (11,6% and 8,8% respectively) resulting from acute malnutrition among children aged under five, Eastern Cape, Mpumalanga and Limpopo had similarly high death rates associated with severe acute malnutrition (9,4%, 9,6% and 8,7% respectively).

[16] Incidence is the number of new cases that occurred within a year.

Table 3.1: Households with children aged 0–6 that skipped a meal or several meals in the past 12 months by age of the child, 2016

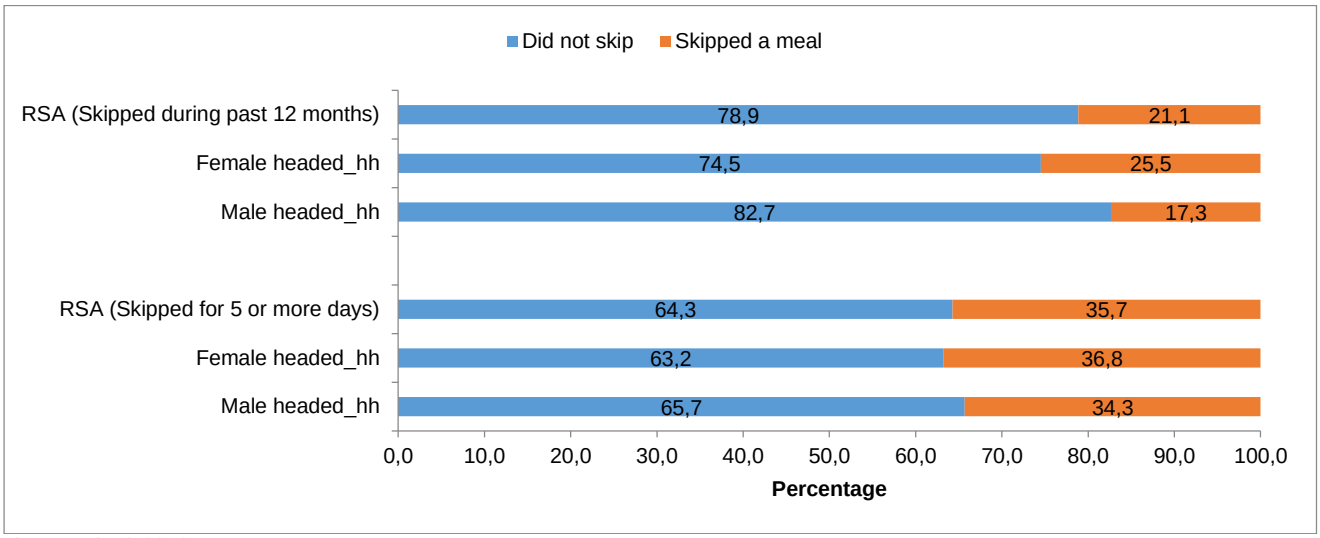
Child age	Numbers in thousands	Skipped meal (12 months prior)		Total	Skipped meal (Past 30 days)		Total
		Yes	No		Yes (5 or more days)	No	
	Number	206	758	**964**	81	112	**193**
0	Per cent	21,4	78,6		41,9	58,1	
	Number	210	784	**994**	67	130	**197**
1	Per cent	21,2	78,8		33,9	66,1	
	Number	224	837	**1 061**	68	140	**208**
2	Per cent	21,1	78,9		32,7	67,3	
	Number	242	831	**1 073**	85	150	**235**
3	Per cent	22,6	77,4		36,2	63,8	
	Number	211	834	**1 045**	83	117	**199**
4	Per cent	20,2	79,8		41,5	58,5	
	Number	224	797	**1 021**	62	145	**208**
5	Per cent	22,0	78,0		30,1	69,9	
	Number	201	830	**1 031**	65	125	**191**
6	Per cent	19,5	80,5		34,3	65,7	
	Number	**1 519**	**5 671**	**7 190**	**511**	**920**	**1 431**
Total	**Per cent**	**21,1**	**78,9**	**100,0**	**35,7**	**64,3**	**100,0**

Source: GHS 2016

Table 3.1 summarises the number of children aged 0–6 who resided in households that skipped meals[17] because there was not enough food in the house. Out of the 7,2 million children slightly more than 1,5 million (21%) of children resided in households that skipped meals in the past 12 months. Amongst those who skipped a meal in the past 12 months, roughly 511 000 skipped a meal for five or more days in the past 30 days. Skipping a meal was evenly distributed across the different ages.

[17] The GHS contains a section on households' food security: Q7.11 "Did the household skip any meals during the past 12 months because there was not enough food in the house?" A follow up question enquires if "It has happened 5 or more days in the past 30 days".

Figure 3.11: Percentage of households with children aged 0–6 that skipped any meal in the past 12 months or the past 30 days for 5 or more days, by sex of head of household, 2016



Source: GHS 2016

The figure above displays the percentages of children aged 0–6 who resided in households that skipped meals due to lack of food in the house by the sex of the household head. Amongst female-headed households with young children, a quarter skipped a meal during the past 12 months, while in male-headed households 17,3% skipped a meal. Moreover, there was not much difference between households that reported that they had skipped a meal for five or more days in the past 30 days between female (36,8%) and male (34,3%) headed households.

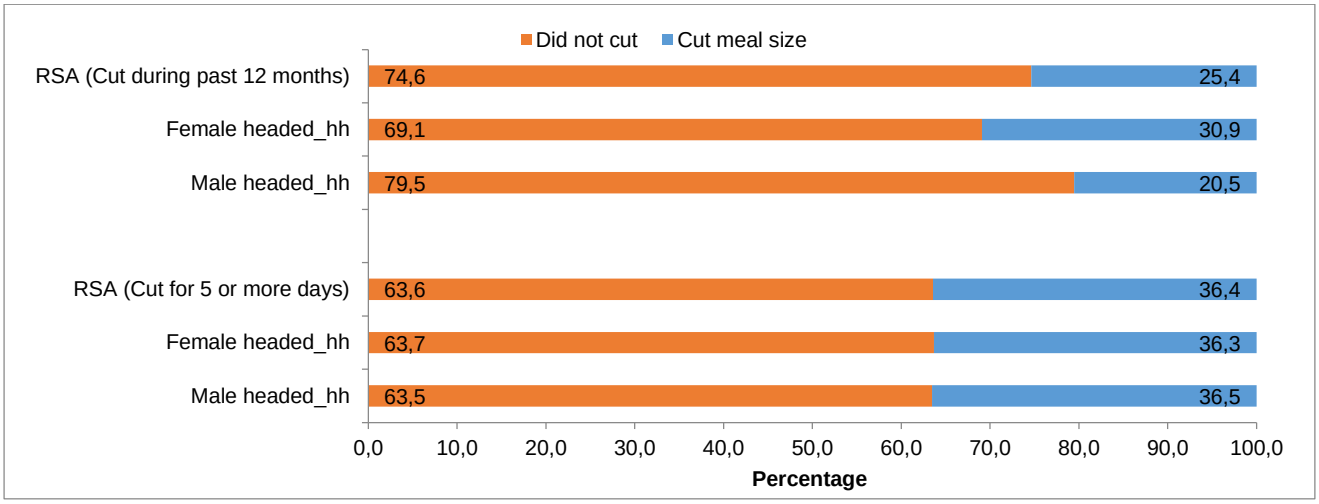
Table 3.2: Households with children aged 0–6 that reduced meal size or several meal sizes in the past 12 months, 2016

Child age	Numbers in thousands	Reduced meal size (12 months prior to the survey)		Total	Reduced meal size (Past 30 days)		Total
		Yes	No		Yes (5 or more days)	No	
0	Number	230	734	**964**	89	134	**223**
	Per cent	23,9	76,1		39,9	60,1	
1	Number	256	738	**994**	83	156	**240**
	Per cent	25,7	74,3		34,7	65,3	
2	Number	268	793	**1 061**	93	158	**251**
	Per cent	25,3	74,8		37,0	63,0	
3	Number	298	775	**1 073**	98	189	**287**
	Per cent	27,8	72,3		34,3	65,7	
4	Number	256	788	**1 045**	103	143	**246**
	Per cent	24,6	75,5		41,8	58,2	
5	Number	265	756	**1 021**	82	170	**252**
	Per cent	26,0	74,0		32,7	67,3	
6	Number	249	782	**1 031**	84	156	**240**
	Per cent	24,2	75,8		35,0	65,0	
Total	**Number**	**1 823**	**5 367**	**7 190**	**634**	**1 107**	**1 741**
	Per cent	**25,4**	**74,6**	**100,0**	**36,4**	**63,6**	**100,0**

Source: GHS 2016

The table above shows the numbers of children aged 0–6 who resided in households that reduced a meal size[18] because there was not enough food in the house. In total, 1,8 million children lived in households that reduced the size of a meal during 12 months prior to the survey. These households were evenly distributed across all ages (0 to 6 years). Approximately 634 000 children came from households that cut meal sizes for five or more days in the past 30 days.

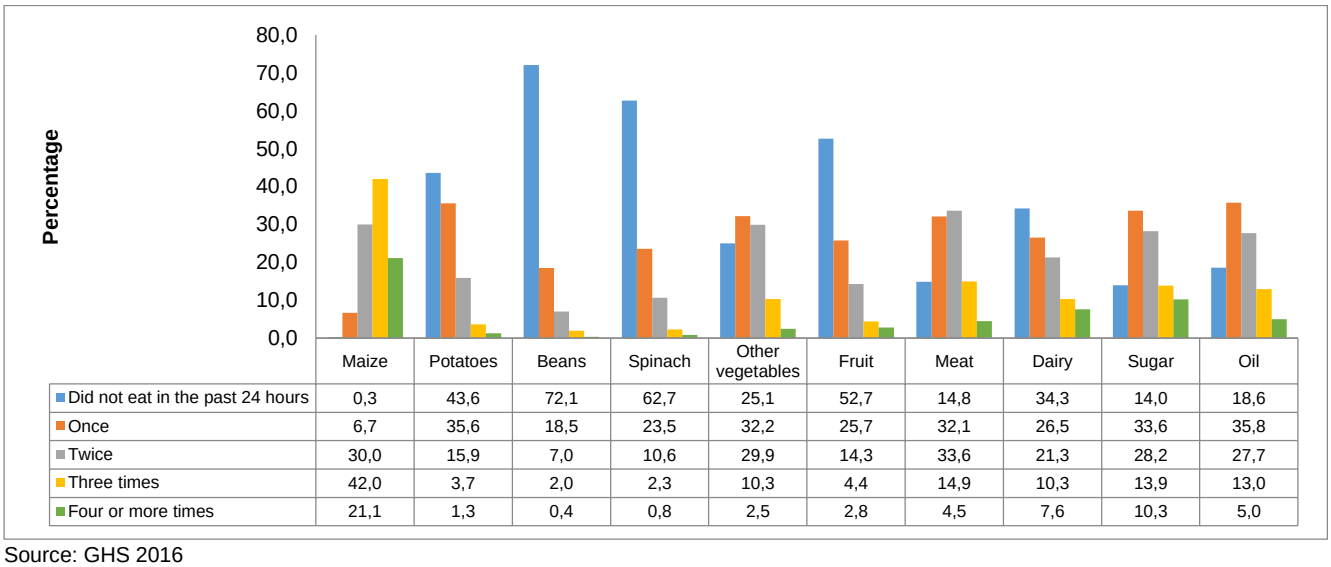
Figure 3.12: Percentage of children aged 0–6 living in households that reduced meal size in the past 12 months or past 30 days for 5 or more days, by sex of head of household, 2016



Source: GHS 2016

The figure above presents the percentages of children aged 0–6 who resided in households that cut their meal size due to lack of food in the house and the gender of the household head. Female-headed households with young children were more likely to reduce meal sizes than male-headed households.

Figure 3.13: Variety of food eaten by households with children aged 0–6 in the past 24 hours by the number of times each is eaten in a day, 2016



	Maize	Potatoes	Beans	Spinach	Other vegetables	Fruit	Meat	Dairy	Sugar	Oil
Did not eat in the past 24 hours	0,3	43,6	72,1	62,7	25,1	52,7	14,8	34,3	14,0	18,6
Once	6,7	35,6	18,5	23,5	32,2	25,7	32,1	26,5	33,6	35,8
Twice	30,0	15,9	7,0	10,6	29,9	14,3	33,6	21,3	28,2	27,7
Three times	42,0	3,7	2,0	2,3	10,3	4,4	14,9	10,3	13,9	13,0
Four or more times	21,1	1,3	0,4	0,8	2,5	2,8	4,5	7,6	10,3	5,0

Source: GHS 2016

[18] The GHS contains a section on households' food security: Q7.10 "Did the household cut the size of meals during the past 12 months because there was not enough food in the house?" A follow up question enquires if "It has happened 5 or more days in the past 30 days"

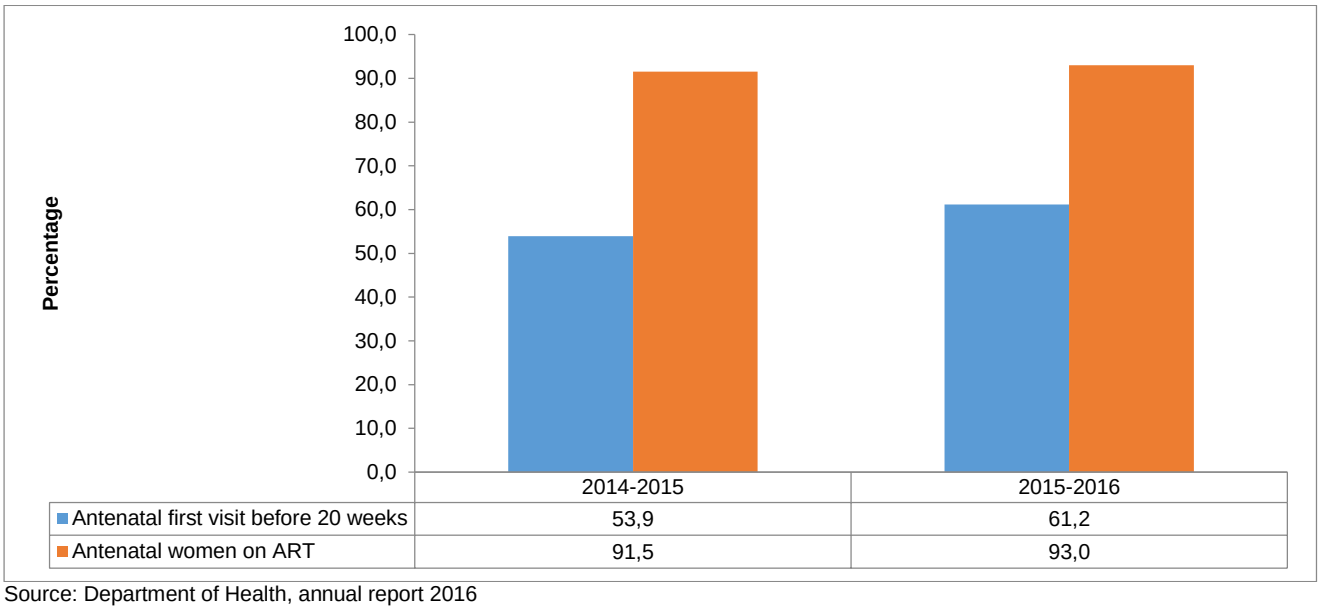
According to the figure above, it was evident that four in ten children resided in households that had eaten maize/rice/sorghum/millet/bread and other cereals three times in the past 24 hours. It was concerning that a third (34,3%) of young children did not eat dairy products in the past 24 months. It was also noticeable that slightly more than 70% of children resided in household that did not eat beans/peas/groundnuts/cashew nuts or other form of nuts. It was also concerning that 50% of children aged 0–6 lived in households that did not eat fruits in the past 24 hours, while only a quarter reported that they had consumed them once in the past 24 hours.

3.3 Maternal health care

This package provides mothers preventative and curative health care; screening for early identification, referral and support for both mental and physical maternal health, substance abuse and exposure to violence. We present data on current mothers' conditions in South Africa using data from the Department of Health and Stats SA.

One of the steps taken by government to improve maternal health was to increase access to antenatal care for pregnant women[19].

Figure 3.14: Antenatal first visit and ART intake rates among pregnant women, 2014–2016



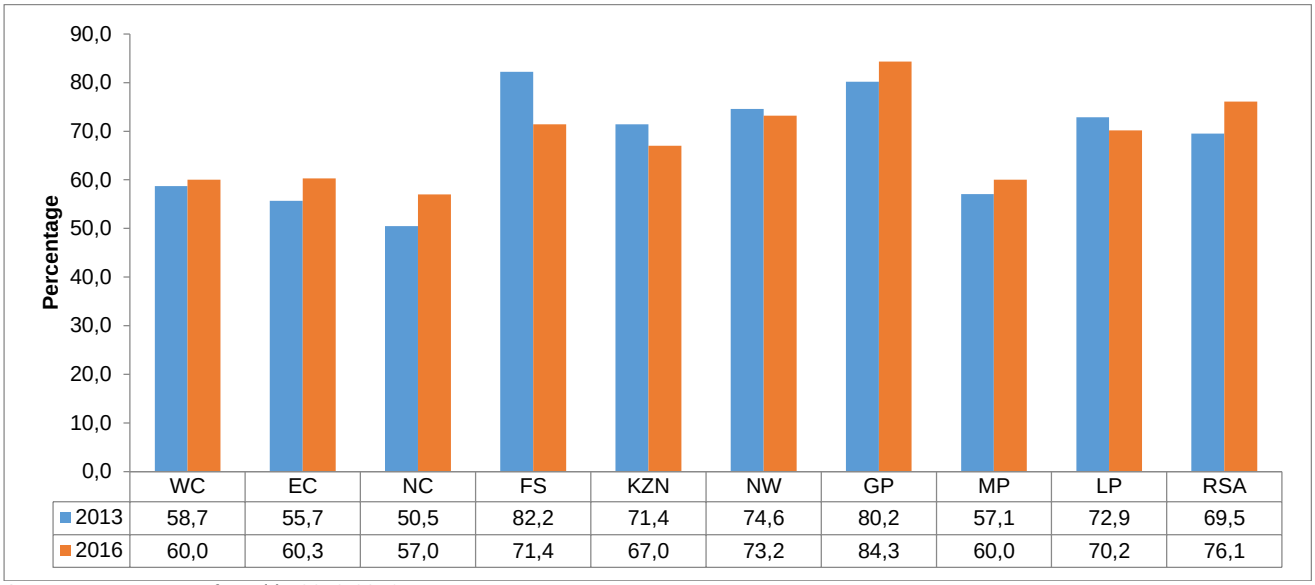
	2014-2015	2015-2016
Antenatal first visit before 20 weeks	53,9	61,2
Antenatal women on ART	91,5	93,0

Source: Department of Health, annual report 2016

The above graph shows that during the period of 2015–2016 the percentage of pregnant women who made their first antenatal visit before 20 weeks increased to 61,2% and the ART coverage for pregnant women increased to 93%. This has a big impact on ensuring that children born to HIV positive women stay negative and healthy.

[19] The WHO had issued new ANT guidelines in 2016 to improve the quality of ANT services for pregnant women. The new guidance increases the number of contacts a pregnant woman has with health providers throughout her pregnancy from four to eight. It also recommends pregnant women to have their first contact in the first 12 weeks' gestation, with subsequent contacts taking place at 20, 26, 30, 34, 36, 38 and 40 weeks' gestation.

Figure 3.15: Mother postnatal visit within 6 days rate, 2013 and 2016

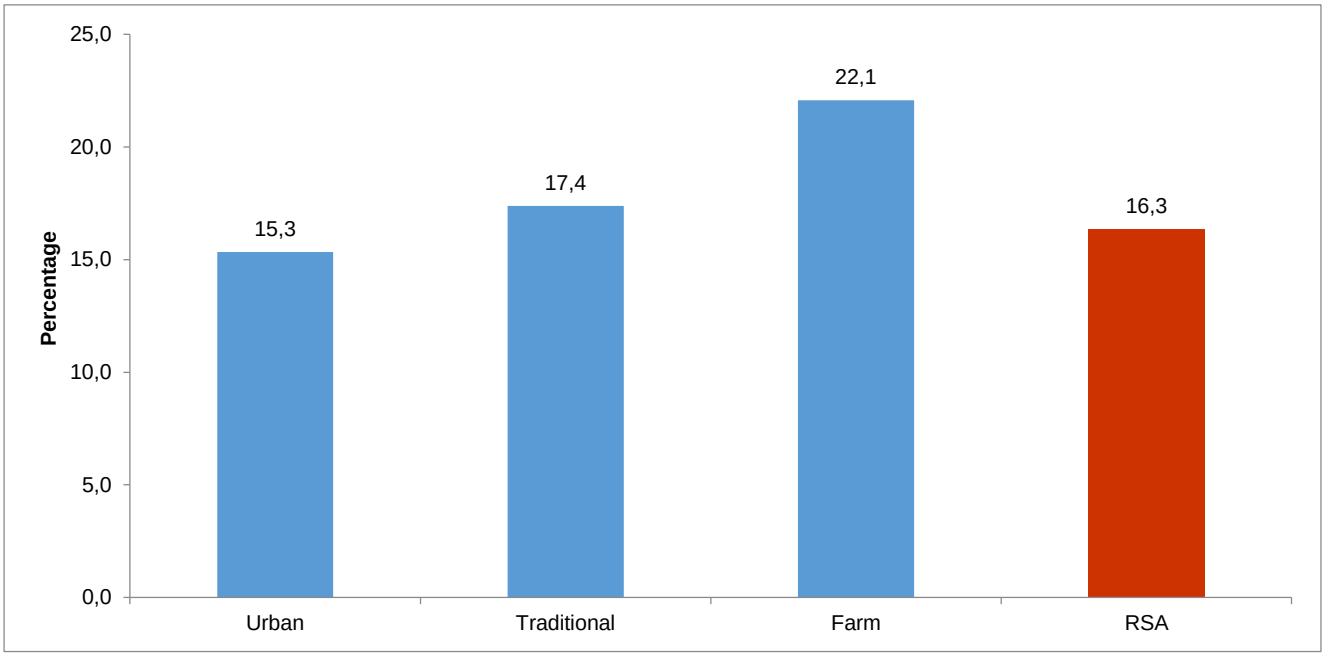


	WC	EC	NC	FS	KZN	NW	GP	MP	LP	RSA
2013	58,7	55,7	50,5	82,2	71,4	74,6	80,2	57,1	72,9	69,5
2016	60,0	60,3	57,0	71,4	67,0	73,2	84,3	60,0	70,2	76,1

Source: Department of Health, 2013-2016

Overall in 2016, close to 76% of mothers returned to the facilities for their sixth day check-up. This was a six percentage point increase from 2013. While the lowest performing provinces Mpumalanga, Eastern Cape and Northern Cape had 60% or lower coverage (mostly due to their rural health facilities that were hard to reach), the Western Cape also showed very low coverage with only 60% of mothers retuning for their check-up. Gauteng had by far the highest percentage of women returning for their follow-up examination six days after giving birth.

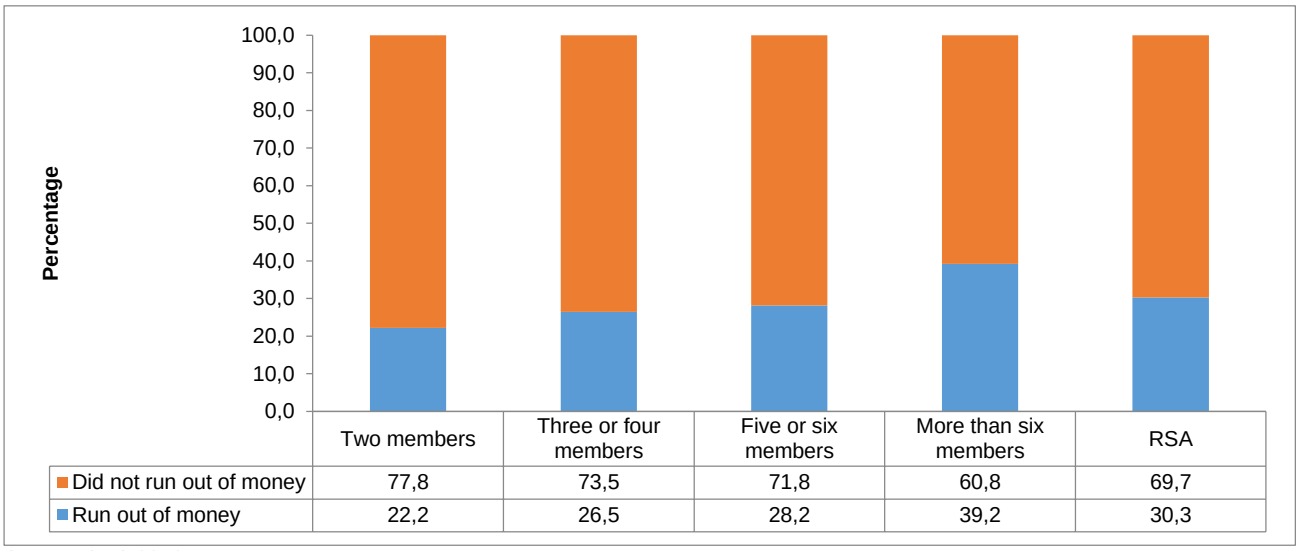
Figure 3.16: Pregnant women aged 12–50 who stayed in households where adults or children who suffered from hunger by geo-type, 2016



Source: GHS 2016

One of the main implications of the integrated ECD policy in South Africa is its emphasis on child nutrition starting from the womb of the mother. The policy outlines that improved maternal nutritional status can create a positive cycle by avoiding childhood illnesses that have dire consequences. The above graph shows that among women aged 12–50 who were pregnant during 2016, 16,3% lived in households where children or adults suffered from[20] hunger because there was not enough food.

Figure 3.17: Pregnant women aged 12–50 who stayed in households that ran out of money to buy food by household size, 2016

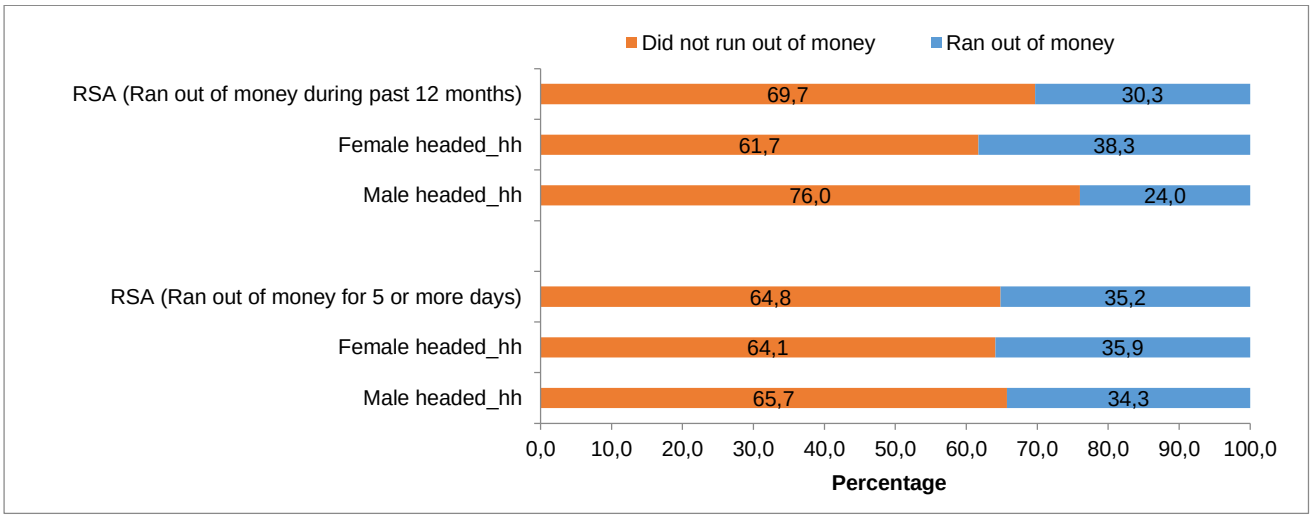


	Two members	Three or four members	Five or six members	More than six members	RSA
Did not run out of money	77,8	73,5	71,8	60,8	69,7
Run out of money	22,2	26,5	28,2	39,2	30,3

Source: GHS 2016

The graph above shows pregnant women aged 12–50 who stayed in households which ran out of money to buy food in the past 12 months prior to the survey[21], by household size. Overall, close to 30% of pregnant women indicated that they stayed in households that ran out of money to buy food. Those staying in larger households were the ones who largely bore the brunt of the situation. These women were mostly part of female-headed households (38,3%) as indicated in the graph below.

Figure 3.18: Percentage of households with pregnant women aged 12-50 that ran out of money to buy food by sex of the household head, 2016



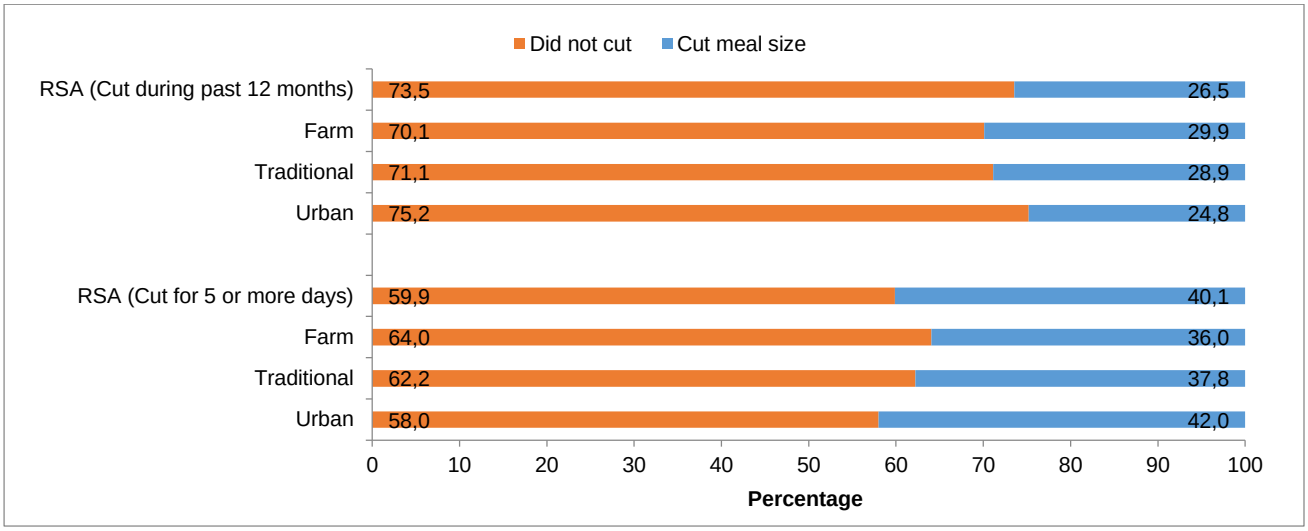
Source: GHS 2016

[20] We included in the analysis those who responded that they were sometimes, often and always hungry.

[21] The GHS contains a section on households' food security: Q7.11 "Did the household skip any meals during the past 12 months because there was not enough food in the house?" A follow up question enquires if "It has happened 5 or more days in the past 30 days"

The graph above shows pregnant women aged 12-50 who stayed in households which ran out of money to buy food in the 12 months prior to the survey and five or more days in the 30 days prior to the survey by the sex of the household head. Overall in 2016, close to 35% of pregnant women stayed in households that ran out of money to buy food for five or more days in the past 30 days prior to the survey. Close to 36% of these women stayed in households headed by women.

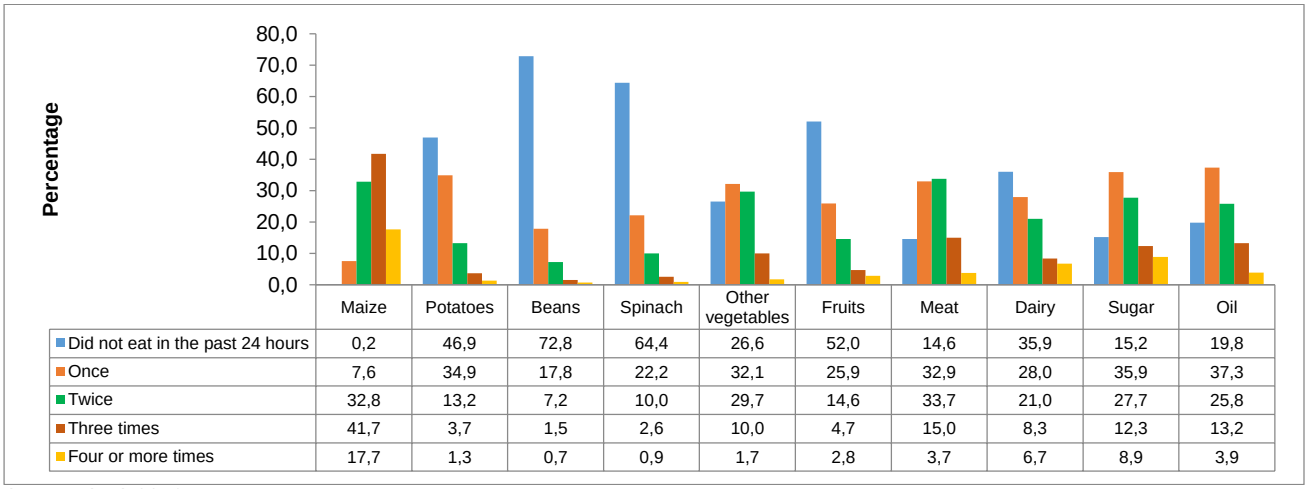
Figure 3.19: Percentage of households with pregnant women aged 12–50 that cut the size of meals, 2016



Source: GHS 2016

The above graph shows pregnant women that stayed in households that had to cut the size of their meals during the 12 months prior to the survey, because there was not enough food in the house. Overall in 2016, close to 40% of households in which pregnant women stayed had to cut the size of their meals due to lack of food for five or more days in the past 30 days prior to the survey. Most of these women were found in urban areas (42%) followed by those in traditional (37,8%) and farm areas (36,0%).

Figure 3.20: Percentage of households with pregnant women aged 12–50 by type of food consumed by household members during the past 24 hours[22], 2016



	Maize	Potatoes	Beans	Spinach	Other vegetables	Fruits	Meat	Dairy	Sugar	Oil
Did not eat in the past 24 hours	0,2	46,9	72,8	64,4	26,6	52,0	14,6	35,9	15,2	19,8
Once	7,6	34,9	17,8	22,2	32,1	25,9	32,9	28,0	35,9	37,3
Twice	32,8	13,2	7,2	10,0	29,7	14,6	33,7	21,0	27,7	25,8
Three times	41,7	3,7	1,5	2,6	10,0	4,7	15,0	8,3	12,3	13,2
Four or more times	17,7	1,3	0,7	0,9	1,7	2,8	3,7	6,7	8,9	3,9

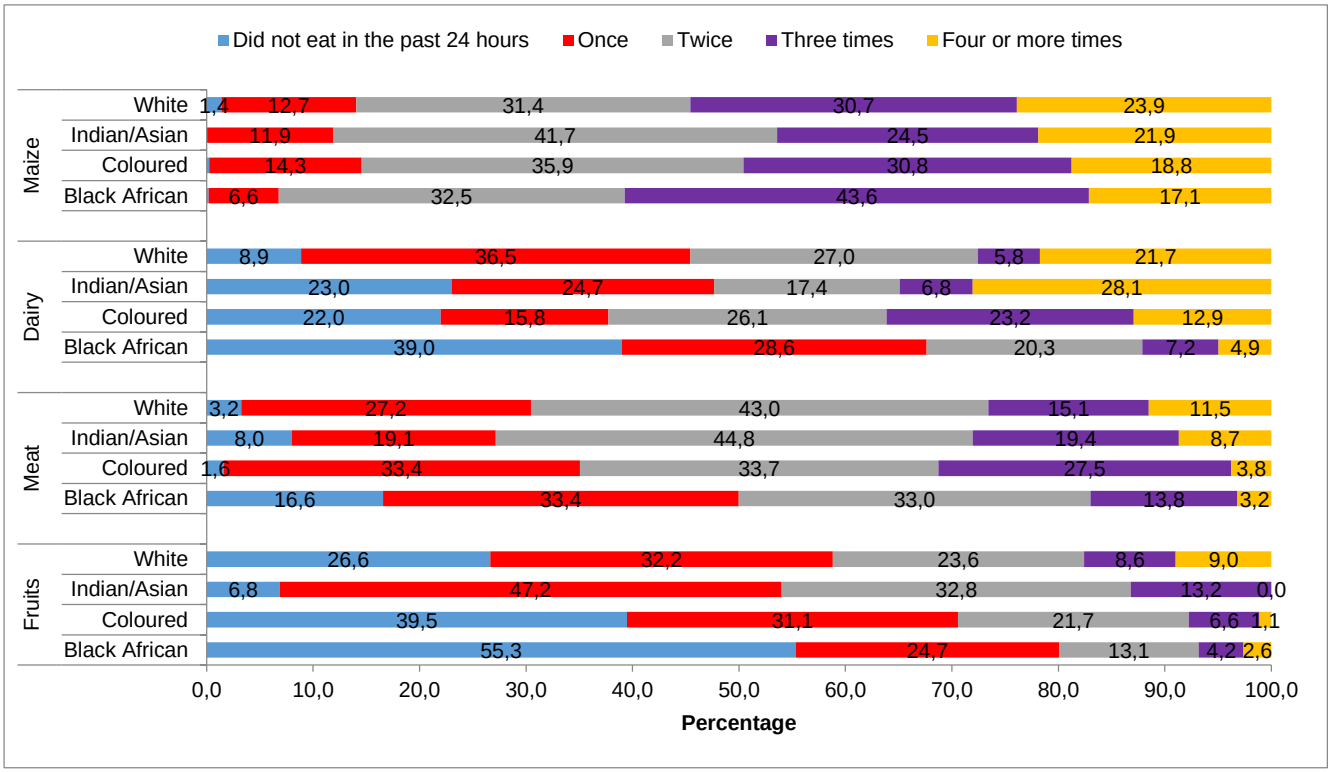
Source: GHS 2016

[22] Maize category includes rice, sorghum, millet, bread and other cereals; potatoes category includes sweet potatoes and cassava; beans category includes peas, groundnuts, cashew nuts or other nuts; spinach category includes wild green leaves; other vegetables category includes carrots, relish, tomatoes, cabbage, beetroot; meat category includes beef, goat, poultry, pork, fish and eggs; dairy category includes milk, yoghurt and other dairy products; sugar includes other sugar products; oil includes fat and butter.

The graph above shows the distribution of daily food intake of members of households in which pregnant women were residing. Although our data is not able to show us the food consumed by pregnant women within the household, we can make some inferences on possible nutrition patterns of these women by looking at the households' food consumption patterns. Most pregnant women could meet their daily need of nutrients necessary for the growth of their children by increased intake of fruits, vegetables, whole grains, and proteins. Maize, rice, bread and other cereals constituted the majority of daily sustenance consumed twice daily by 32,8%; three times daily by 41,7% and four or more times daily by 17,7% of households. Meat consumption was relatively high with more than two-thirds of households reportedly having consumed meat twice (33,7%) or once (32,9%) in the past 24 hours. The consumption of fruits and vegetables was moderate as 52% of households reported not having eaten any fruits and 64,4% not having eaten any spinach in the past 24 hours prior to the survey.

Pregnant women are expected to eat a balanced diet as their food intake is the main source of nutrients for the baby. The graph below shows pregnant women households' consumption patterns which varied by population group. Cereal consumption was very prominent among the black population group as it was consumed three times or more by more than half of the households. However this type of food was still substantial among the rest of the population groups. Conversely dairy and fruits intakes were poor among black African households as 39% of these households did not consume any dairy in the 24 hours prior to the survey; and more than half (53,3%) of black African households did not eat any fruits in the past 24 hours. Coloured-headed households were also less likely to consume fruits (39,5%) while Indian/Asian-headed households were most likely to consume fruits.

Figure 3.21: Percentage of households with pregnant women aged 12–50 by selected type of food consumed by household members during the past 24 hours by population group, 2016

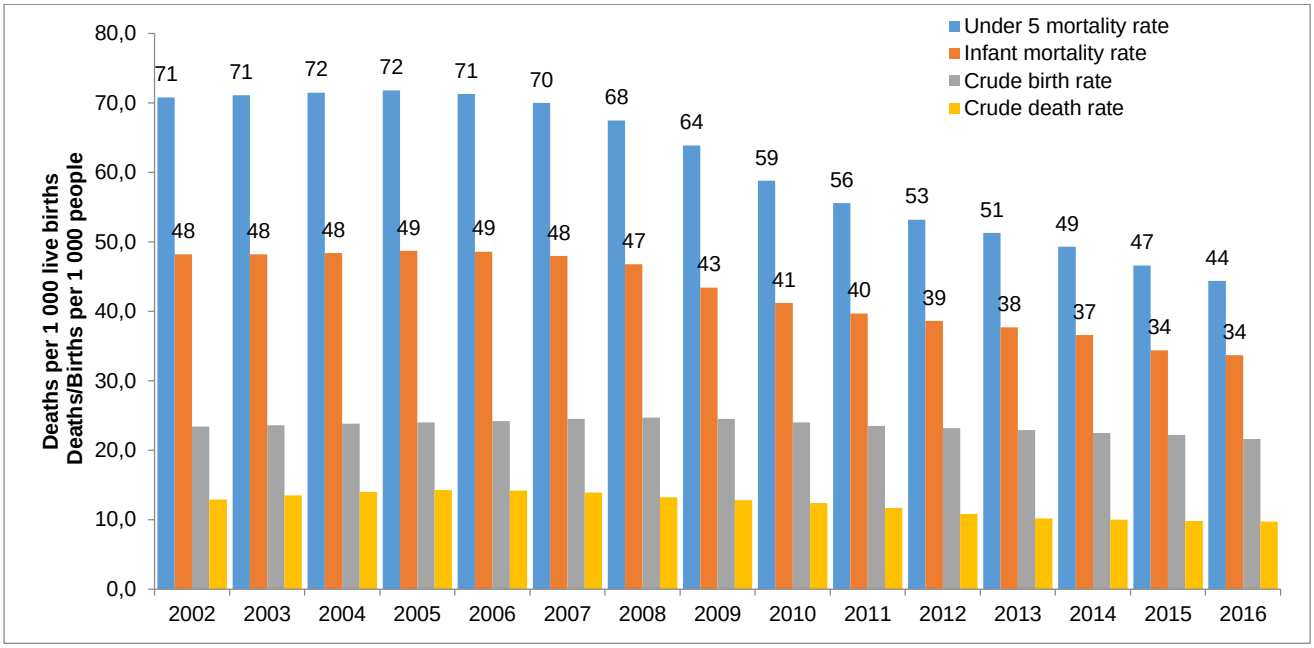


Source: GHS 2016

3.4 Child health care

This package provides preventative and curative health care for infants, and refers to access to basic health care of children. Medical care includes screening for early identification, referral and support for developmental delays and disabilities as well as immunisation. These would prevent and cure common childhood illnesses and avoid child mortality.

Figure 3.22: Child mortality rates, crude births and deaths rates, 2002–2016



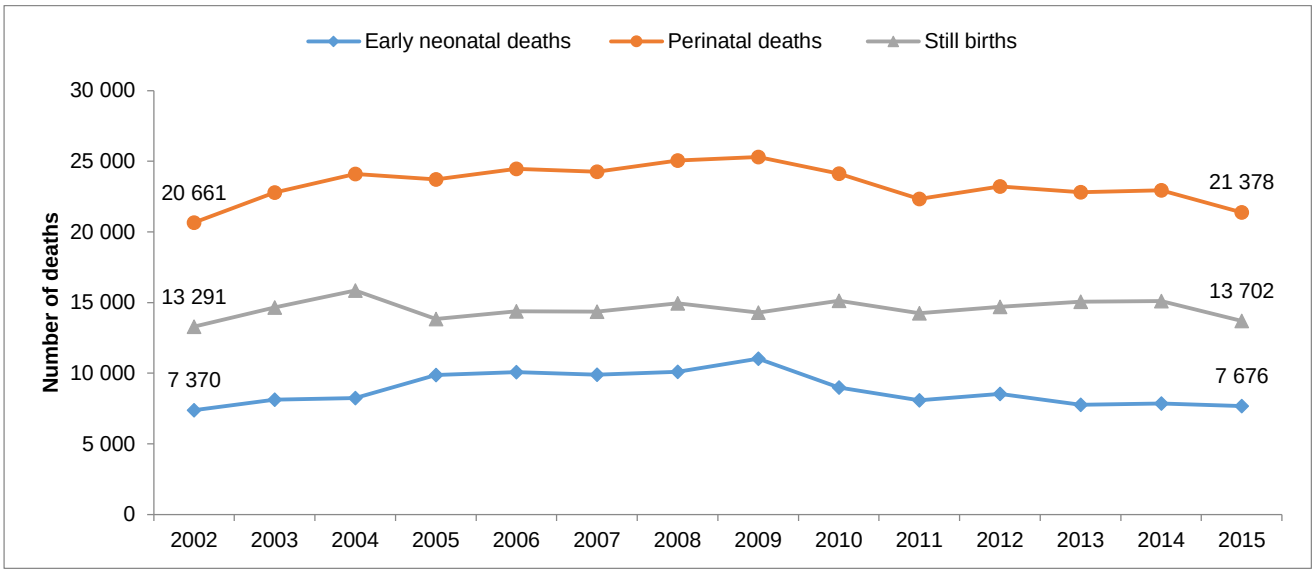
Source: Mid-year population estimates, 2016

The graph above shows mortality rates computed by using the impact of AIDS model (AIM model[23]). According to the graph above, infant mortality rate (IMR) had declined from an estimated 48 infant deaths per 1 000 live births in 2002 to 34 infant deaths per 1 000 live births in 2016. The under-five mortality rate (UMR) declined from 71 child deaths per 1 000 live births to 44 child deaths per 1 000 live births between 2002 and 2016. The annual reductions for both indicators accelerated between 2007 and 2011 compared to the other years and continued to decrease steadily; however in spite of the progress achieved in child survival both the UMR and the IMR were still very high by developed countries standard[24]. The crude death rate was down from 13 deaths per 1 000 people in 2002 to 10 deaths per 1 000 people in 2016.

[23] The AIDS Impact Model (AIM) has an inbuilt Epidemiological Projection Package for estimating HIV prevalence and incidence based on coverage of adults and children on antiretroviral treatment (ART) and Prevention of Mother to Child Transmission (PMTCT) treatment. Data inputs used were sourced from antenatal clinic data (Mid-Year population estimates, Statistics South Africa,(2017c))

[24] UNICEF estimates for Europe UMR as 5,6 and IMR as 4,7; Sub-Saharan Africa UMR as 81,9 and IMR as 55,2; Botswana UMR as 40,6 and IMR as 33,9; and Brazil UMR as 15,1 and IMR as 57,5 per 1,000 live births in 2016. (https://data.unicef.org/topic/child-survival/under-five-mortality)

Figure 3.23: Number of perinatal deaths by year of deaths, 2002–2015



Source: Perinatal death in South Africa, 2015 (Stats SA 2017d)

The above graph shows the number of perinatal deaths per category observed annually. Perinatal deaths consist of still births and early neonatal deaths. Overall, the number of deaths has remained steady over the years in all types of deaths with only a small increase between 2002 and 2015. The biggest contributor to perinatal deaths was still births.

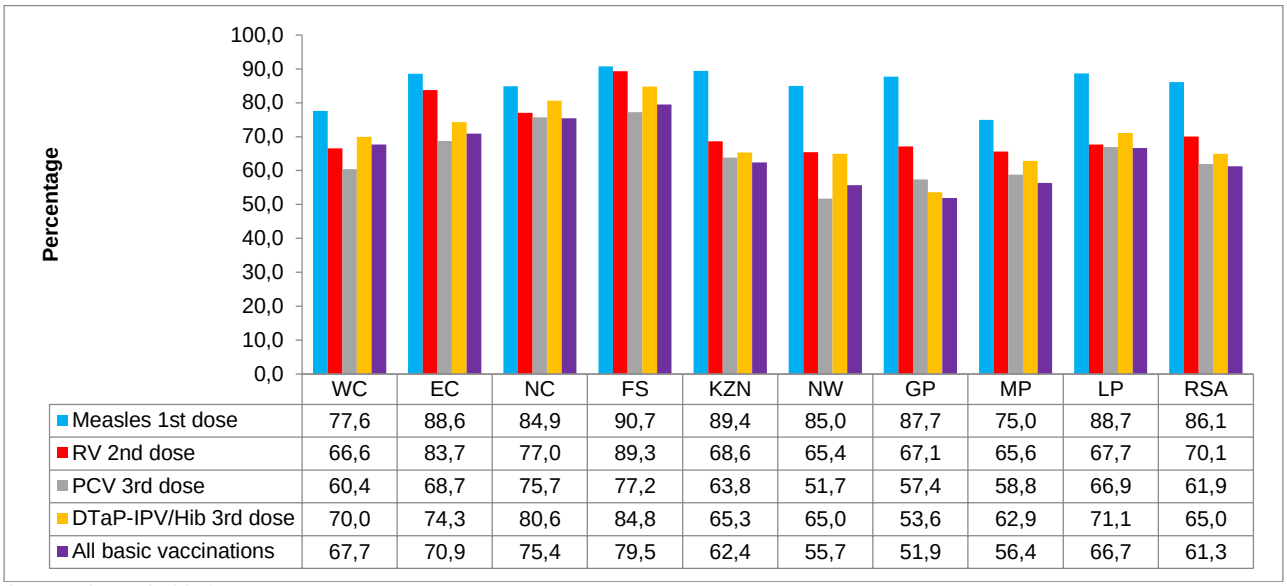
Table 3.3: Distribution of underlying causes of deaths of young children aged 0–6, 2015

Rank	Underlying causes of death	Number	%
1	Respiratory and cardiovascular disorders specific to the perinatal period (P20-P29)	3 786	11,4
2	Intestinal infectious diseases (A00-A09)	3 323	10,0
3	Influenza and pneumonia (J09-J18)	2 751	8,3
4	Malnutrition (E40-E46)	1 501	4,5
5	Disorders related to length of gestation and fetal growth (P05-P08)	1 347	4,0
6	Other disorders originating in the perinatal period (P90-P96)	1 304	3,9
7	Infections specific to the perinatal period (P35-P39)	1 169	3,5
8	Fetus and newborn affected by maternal factors and by complications of pregnancy, labour and delivery (P00-P04)	901	2,7
9	Congenital malformations of the circulatory system (Q20-Q28)	613	1,8
10	Other acute lower respiratory infections (J20-J22)	590	1,8
11	Other viral diseases (B25-B34)	561	1,7
12	Other bacterial diseases (A30-A49)	525	1,6
	Other natural causes	11 935	35,8
	Non-natural causes	3 033	9,1
Total	**All causes**	**33 339**	**100,0**

Source: Mortality and causes of death in South Africa, 2015

The table above shows the distribution of early childhood deaths for children aged 0–6. The common underlying cause of death amongst young children was respiratory and cardiovascular disorders specific to the perinatal period (11,4%), followed by intestinal infectious diseases (10%), while other bacterial diseases had the lowest occurrence (1,6%).

Figure 3.24: Immunisation coverage children aged 12-23 months, 2016[25]

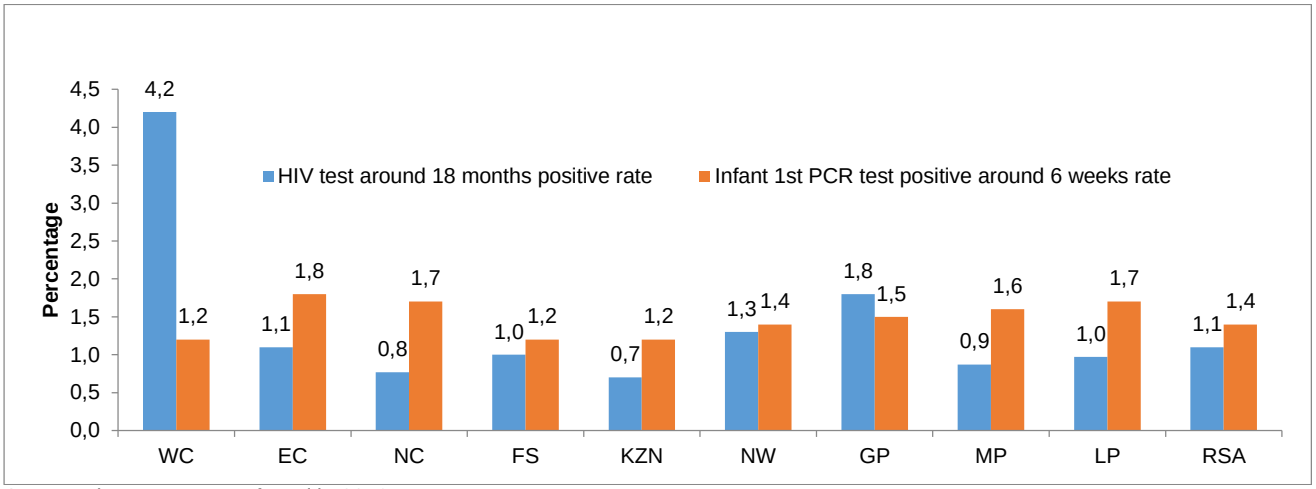


	WC	EC	NC	FS	KZN	NW	GP	MP	LP	RSA
Measles 1st dose	77,6	88,6	84,9	90,7	89,4	85,0	87,7	75,0	88,7	86,1
RV 2nd dose	66,6	83,7	77,0	89,3	68,6	65,4	67,1	65,6	67,7	70,1
PCV 3rd dose	60,4	68,7	75,7	77,2	63,8	51,7	57,4	58,8	66,9	61,9
DTaP-IPV/Hib 3rd dose	70,0	74,3	80,6	84,8	65,3	65,0	53,6	62,9	71,1	65,0
All basic vaccinations	67,7	70,9	75,4	79,5	62,4	55,7	51,9	56,4	66,7	61,3

Source: SADHS, 2016

Overall in 2016, close to 61,3% of children aged 12 to 23 months received all basic immunisations; close to 86% had received their first dose of measles vaccination. Furthermore, close to 70% of children had received a second dose of rotavirus vaccination. The PCV third dose which is a booster shot was overall administered to 62% of children 12–23 months in 2016.

Figure 3.25: HIV test positive rate among young children, 2016



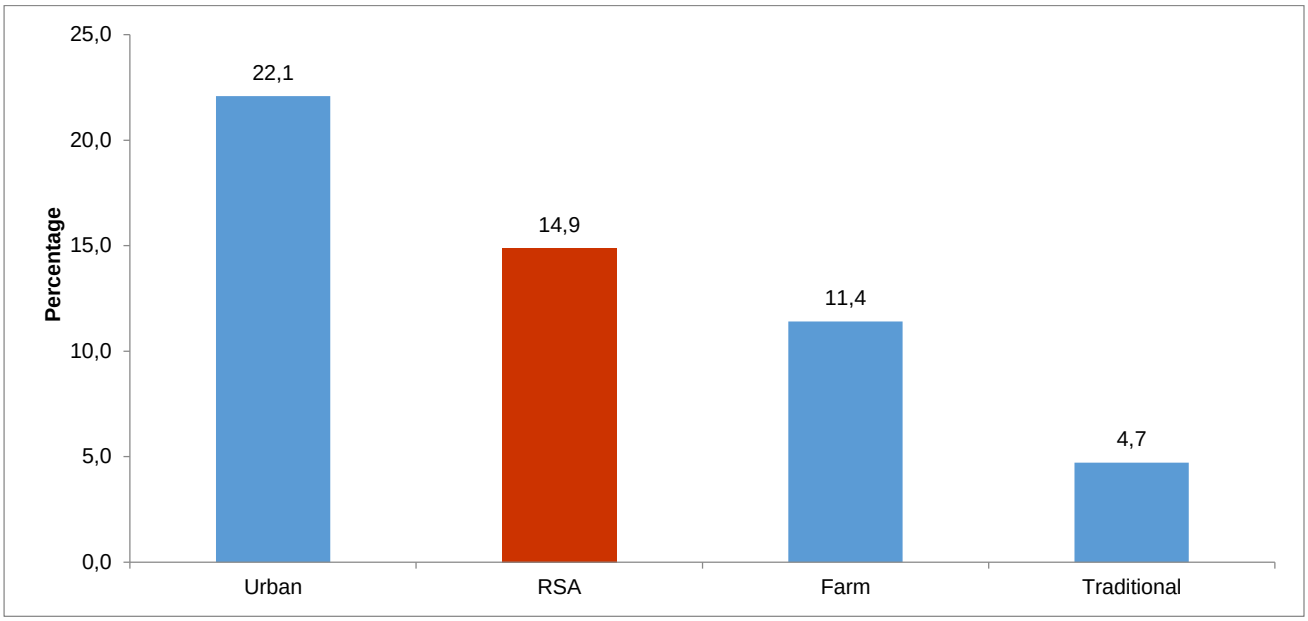
Source: The Department of Health, 2016

Overall in 2016, close to 1% of children who were tested for HIV at around 18 months turned out to be positive. The highest percentage were observed in Western Cape (4,2%) followed by Gauteng (1,8%). Similarly in 2016, close to 1% of infants who were screened for HIV the first time at around six weeks after birth were positive[26]. The highest infection rate around six weeks was observed in Eastern Cape (1,8%).

[25] RV: Rotavirus vaccine; PCV: Pneumococcal conjugate vaccine; DTaP-IPV/Hib: Diphtheria, Tetanus, Pertussis (whooping cough), Polio, and Haemophilus influenzae type b vaccines; All basic vaccinations include Bacille Calmette-Guerin (BCG), three doses of DTaP-IPV/Hib and one dose of measles vaccine. Values for WC and FS were based on 25-49 unweighted cases.

[26] Polymerase chain reaction (PCR) test or known as viral blood tests are HIV tests administered to babies born to HIV positive mothers.

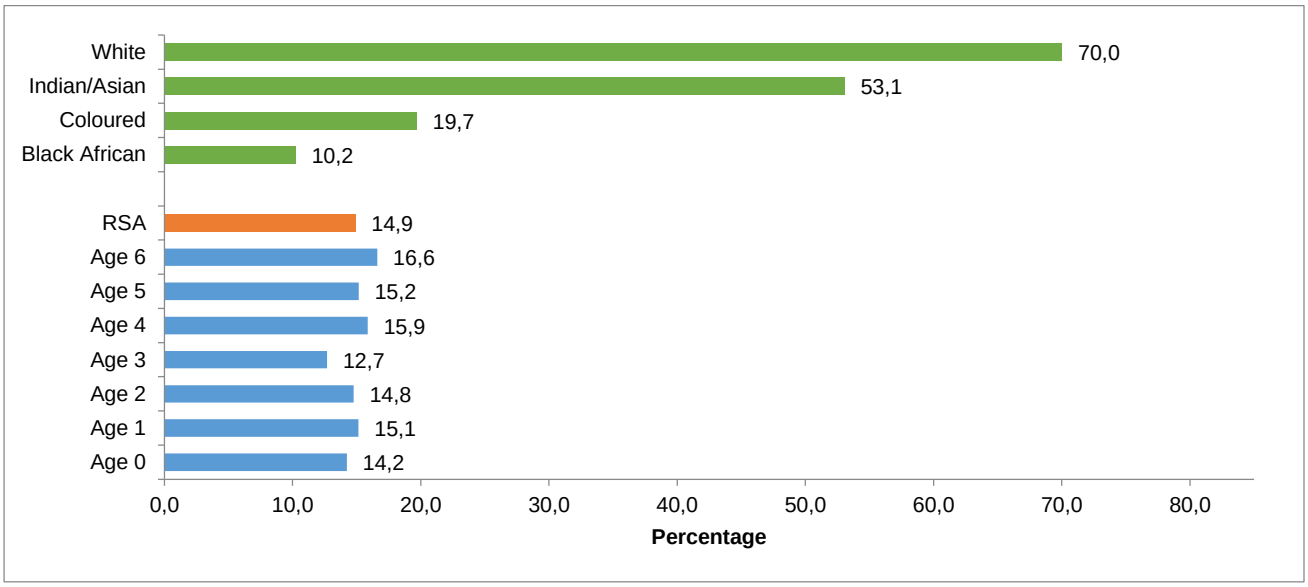
Figure 3.26: Percentage of young children aged 0–6 covered by medical aid schemes by geographical location, 2016



Source: GHS 2016

According to the figure above, 14,9% of children aged 0–6 were covered by medical aid schemes. Approximately one in five children who resided in urban areas were members of medical aid schemes (22,1%) which was above the national average for children aged 6 or less. Children in traditional areas were the least likely to be covered by medical aid schemes (4,7%).

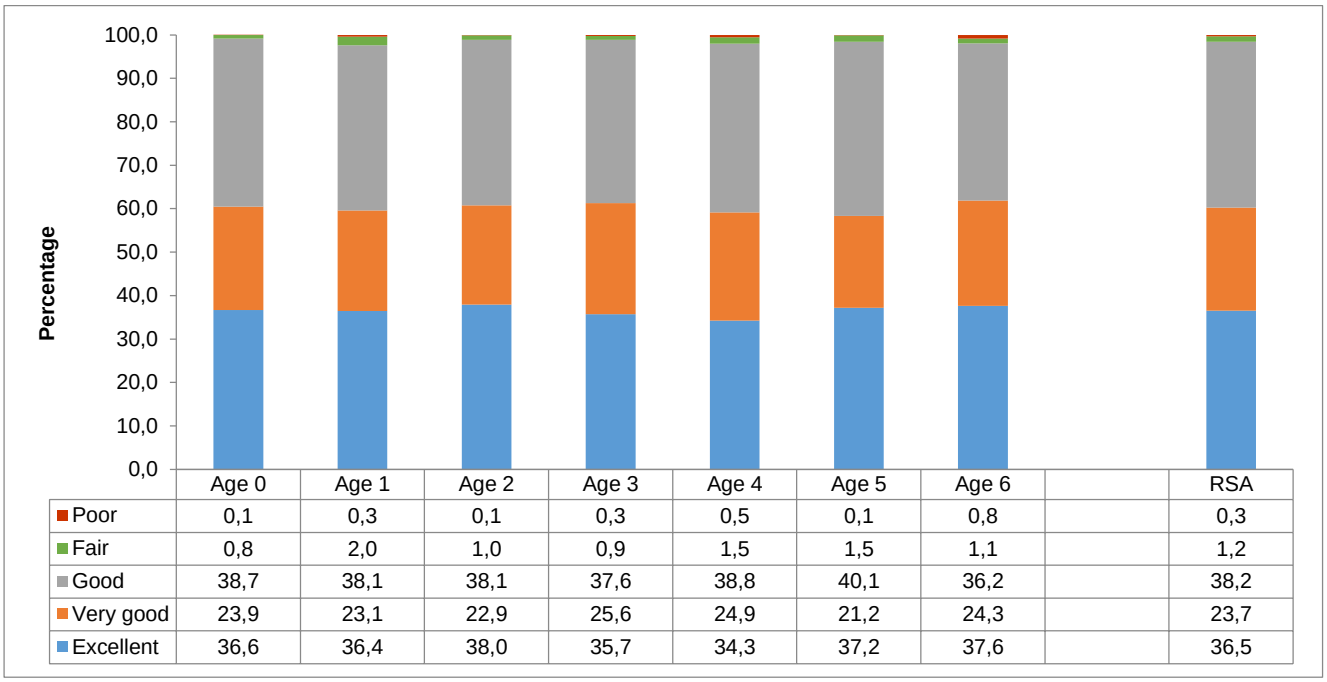
Figure 3.27: Percentage of children aged 0–6 covered by medical aid schemes by age and population group, 2016



Source: GHS 2016

The figure above shows the percentage of young children covered by medical aid schemes. Young children who were aged 6 were more likely to be covered by medical aid scheme (16,6%), while those aged 3 were less likely to be covered (12,7%). The breakdown by population group shows that seven out of ten white children were covered by medical aid while amongst black African children only one in ten benefited from medical aid.

Figure 3.28: Distribution of children's proxy reported health status by age, 2016

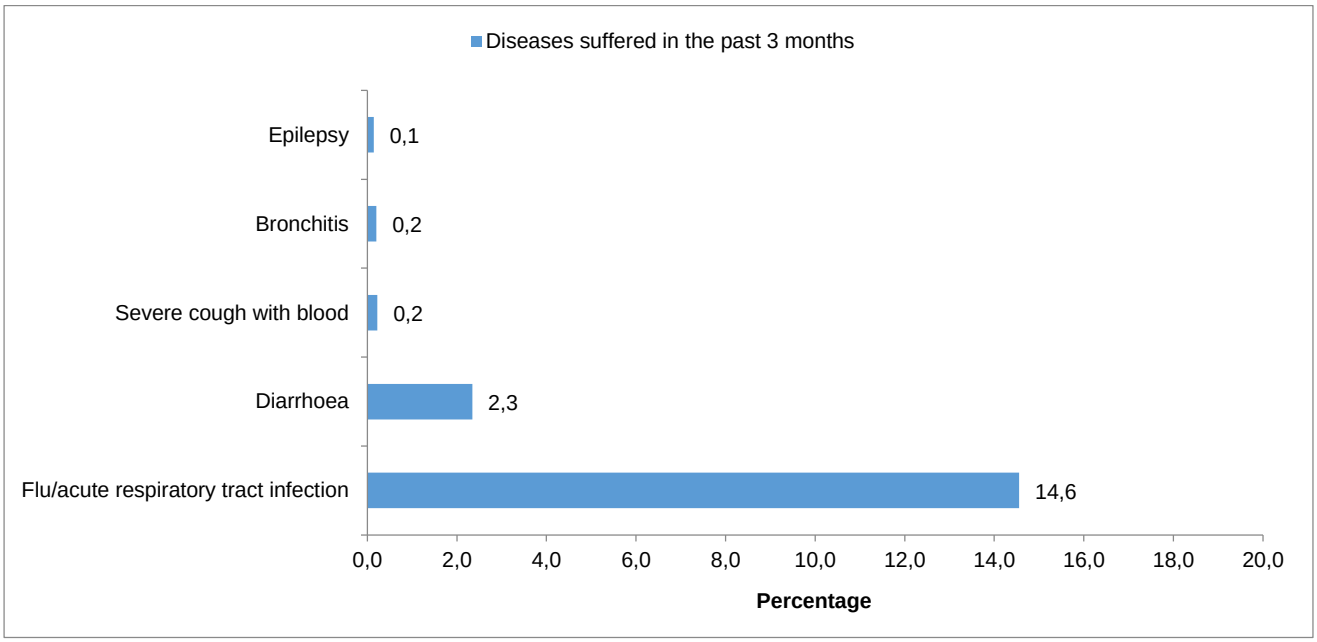


	Age 0	Age 1	Age 2	Age 3	Age 4	Age 5	Age 6		RSA
Poor	0,1	0,3	0,1	0,3	0,5	0,1	0,8		0,3
Fair	0,8	2,0	1,0	0,9	1,5	1,5	1,1		1,2
Good	38,7	38,1	38,1	37,6	38,8	40,1	36,2		38,2
Very good	23,9	23,1	22,9	25,6	24,9	21,2	24,3		23,7
Excellent	36,6	36,4	38,0	35,7	34,3	37,2	37,6		36,5

Source: GHS 2016

The figure above shows the health status of young children aged 0–6 as perceived by the respondent and his or her own definition of health. The health status of children six years or younger did not vary significantly between age groups. More than 90% of young children's health was perceived to be good, very good or excellent. Approximately 60% had very good or excellent health status. A further 38% had health status that could be described as good, whilst less than two per cent were classified as having a fair or poor health status.

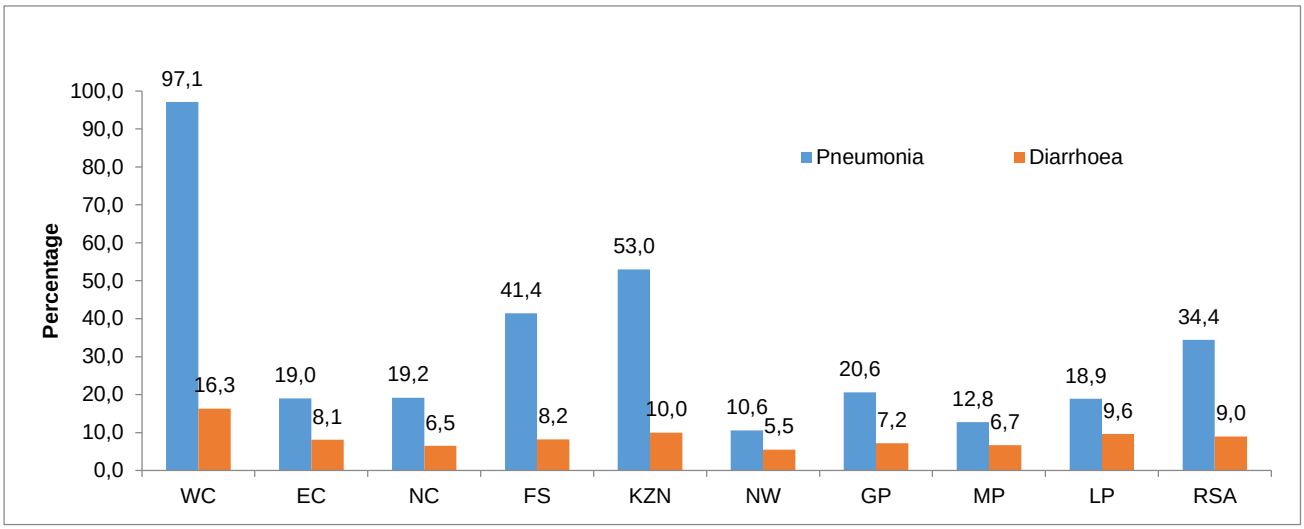
Figure 3.29: Percentage of young children aged 0–6 who suffered from any disease in the past 3 months, 2016



Source: GHS 2016

The above figure shows the percentage of young children who suffered from any disease in the past three months. Flu or acute respiratory tract infections were the most common diseases affecting young children in the three months preceding the survey (14,6%). Respiratory and cardiovascular disorders specific to the perinatal period were ranked first according to the *Mortality and causes of death 2015 report* for young children; this is clearly consistent with the GHS 2016 based on the figure above. Diarrhoea was also common with just two per cent of young children suffering from it in the past three months, this was also consistent with the *Mortality and causes of death 2015 report* which ranked intestinal infectious diseases second (Stats SA 2017e).

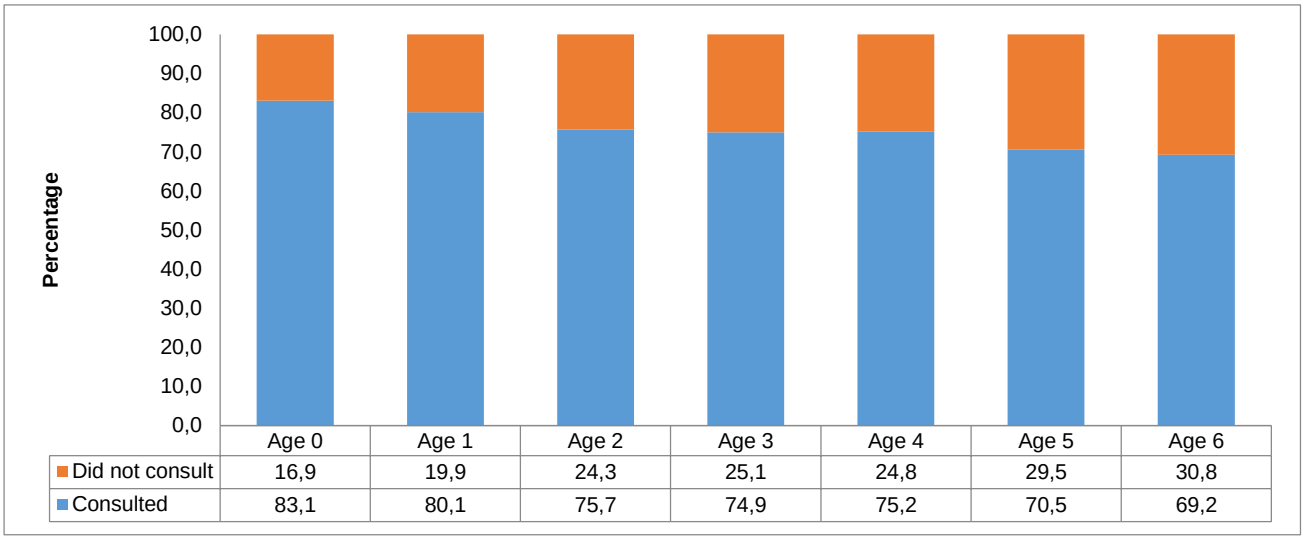
Figure 3.30: Incidence of pneumonia and diarrhoea with dehydration in children under 5 years, 2016



Source: Department of Health, 2016

According to the above graph, the incidence of pneumonia in children under five years in South Africa was the highest in Western Cape (97,1%) followed by KwaZulu-Natal (53,0%) and Free State (41,4%). While overall the incidence of diarrhoea among children under five years of age was nine per cent, Western Cape still had the highest incidence with 16,3% of children having been diagnosed as such, followed by KwaZulu-Natal (10%).

Figure 3.31: Percentage of young children aged 0–6 who consulted a health worker (nurse/doctor/traditional healer) as a result of illness, 2016

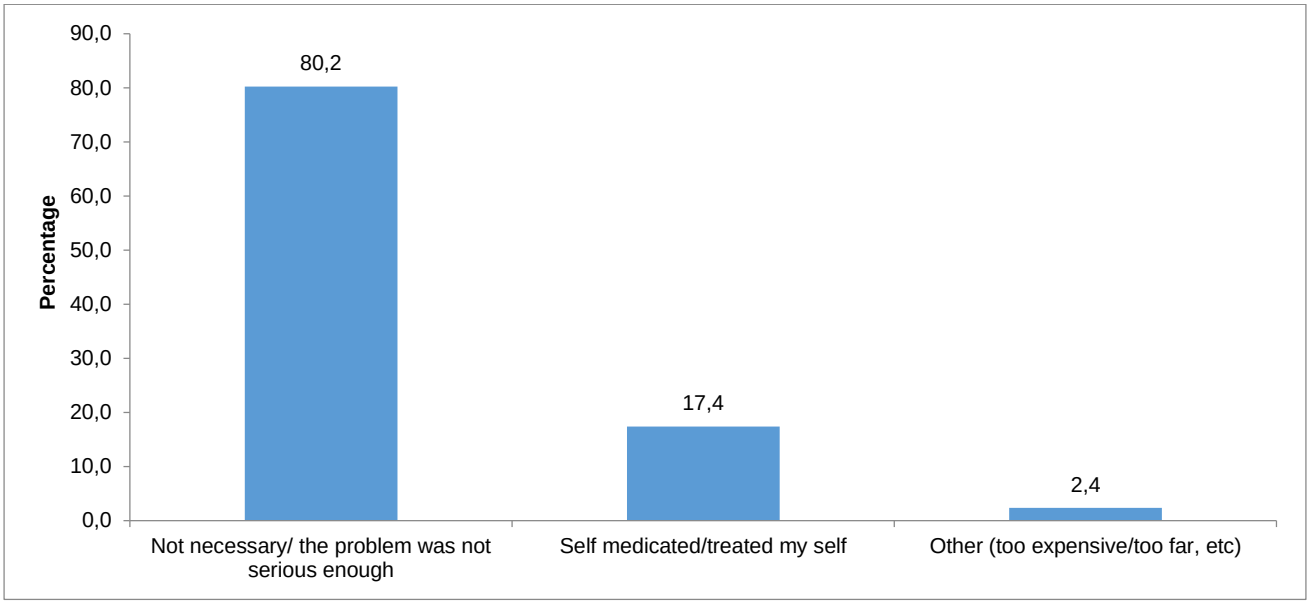


	Age 0	Age 1	Age 2	Age 3	Age 4	Age 5	Age 6
Did not consult	16,9	19,9	24,3	25,1	24,8	29,5	30,8
Consulted	83,1	80,1	75,7	74,9	75,2	70,5	69,2

Source: GHS 2016

The figure above shows the percentage of young children who consulted a health worker as a result of the illness in the three months preceding the survey. For younger children aged zero and one it was common that a health worker was consulted. However, as age increases, less children consulted for their diseases/illness.

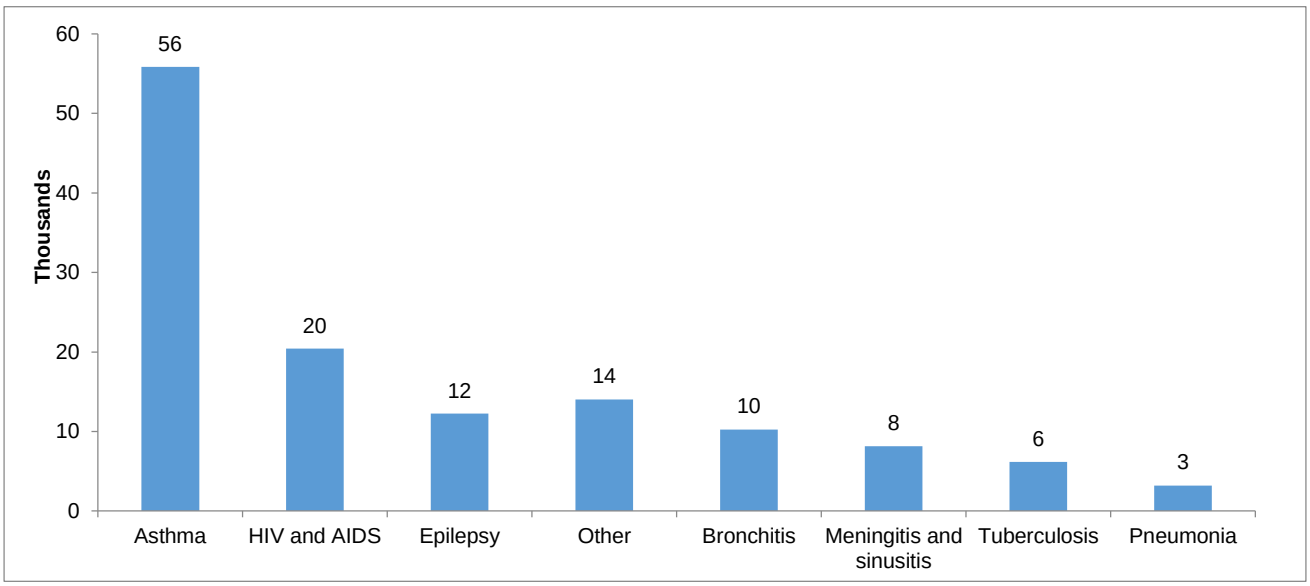
Figure 3.32: Main reasons why a health worker (nurse/doctor/traditional healer) was not consulted, 2016



Source: GHS 2016

According to the figure above, four in five children who did not consult a health worker reported that it was not necessary or the problem was not serious enough to consult a health worker, followed by those who reported that they self-medicated or treated themselves. Only few (2,4%) mentioned that it was too far/too expensive/queues were too long.

Figure 3.33: Numbers of young children aged 0–6 who have been diagnosed with the any of the following illnesses, 2016



Source: GHS 2016

The figure above shows the numbers of young children aged 0–6 who have ever been told that they had some illness or illnesses. About 56 000 of young children have been diagnosed with asthma by a healthcare worker, followed by those with HIV/AIDS, only 3 000 have been diagnosed with pneumonia.

3.5 Summary and conclusion

In 2011, the “Tshwane declaration of support for breastfeeding in South Africa” was formulated, where the country commits itself to actively promote breastfeeding. Following this historical resolution, health officials and other stakeholders were urged to support and strengthen efforts to promote breastfeeding in all aspects of their practices. One of the motives was to encourage and support HIV infected mothers to breastfeed their infants while being treated with antiretroviral drugs to prevent HIV transmission. Another major intervention was that formula feeds were no longer supplied to new-borns at public health facilities unless absolutely necessary. As a result, the GHS found in 2016 that close to 73% of children under one year old were breastfed while 5% of children aged two were still being breastfed.

While child mortality has declined over the years, under five mortality rates were still relatively high in 2016 (44,4 child deaths per 1 000 live births). These deaths mostly occurred during the perinatal periods and were caused by respiratory and cardiovascular disorders.

Chapter 4: Social services and early childhood development interventions

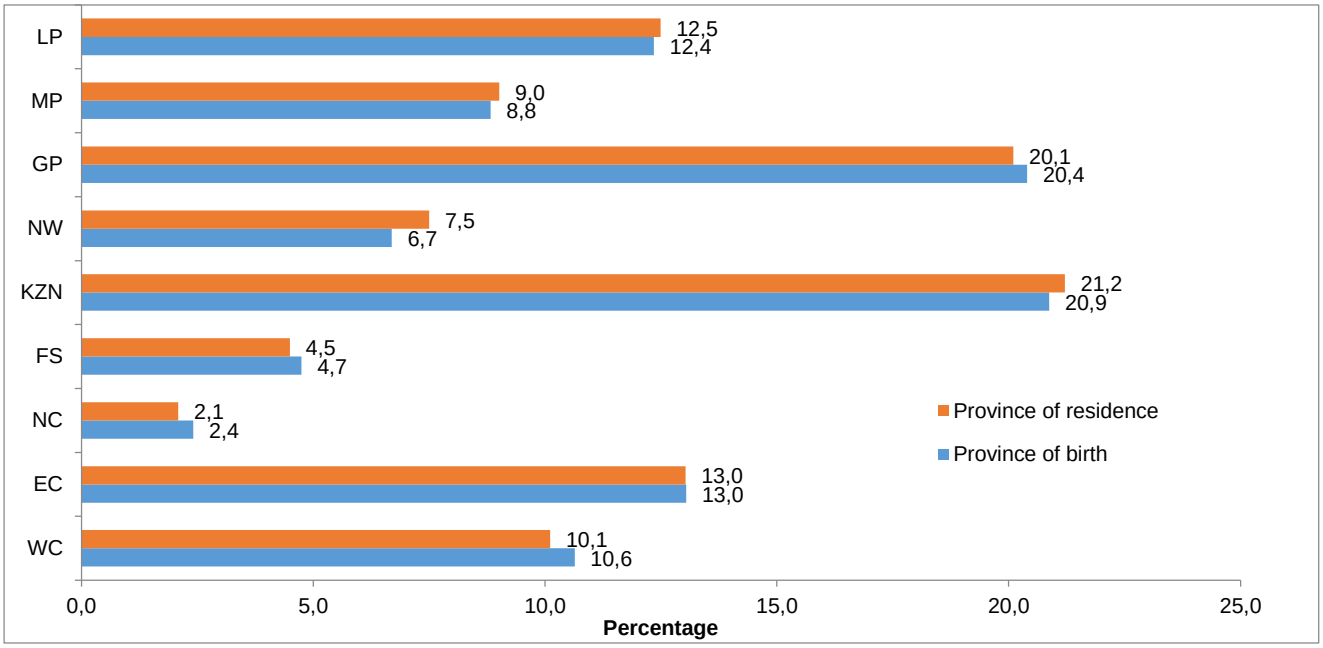
4.1 Introduction

This section covers interventions and access to the three of the essential components of the ECD packages prioritised by government. These include social services, support for primary caregivers and stimulation for early learning. The components relate to the material well-being of children, their protection from abuse, neglect and harm, and some of the support and social assistance received by their care givers.

4.2 Social services

Social services include a range of public services provided by government, private, and non-profit organisations. These public services aim to create effective access to services, build stronger communities, and promote equality and opportunity. Social services include benefits and facilities such as social grants and protection; referrals and support for abused and neglected children. Social services also ensure access to a free birth certificate within 30 days from birth; access to education, health care and social housing provided by government to improve the life and living conditions of children, the disabled, the elderly, and the poor in the community.

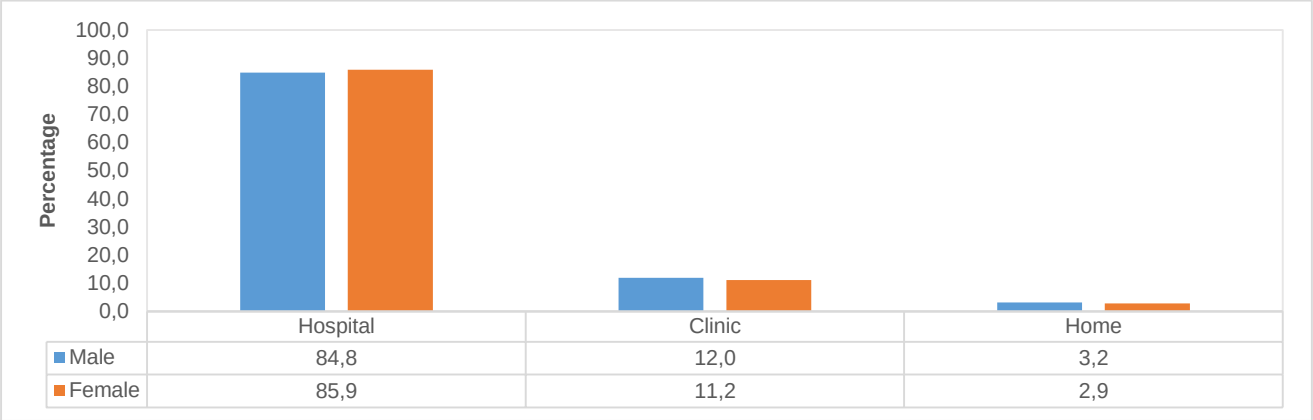
Figure 4.1: Province of birth and residence of children aged 0–2 years[23], 2016



Source: GHS 2016

As displayed in the above figure, there was generally a fairly equal distribution of children across their provinces of birth and residence.

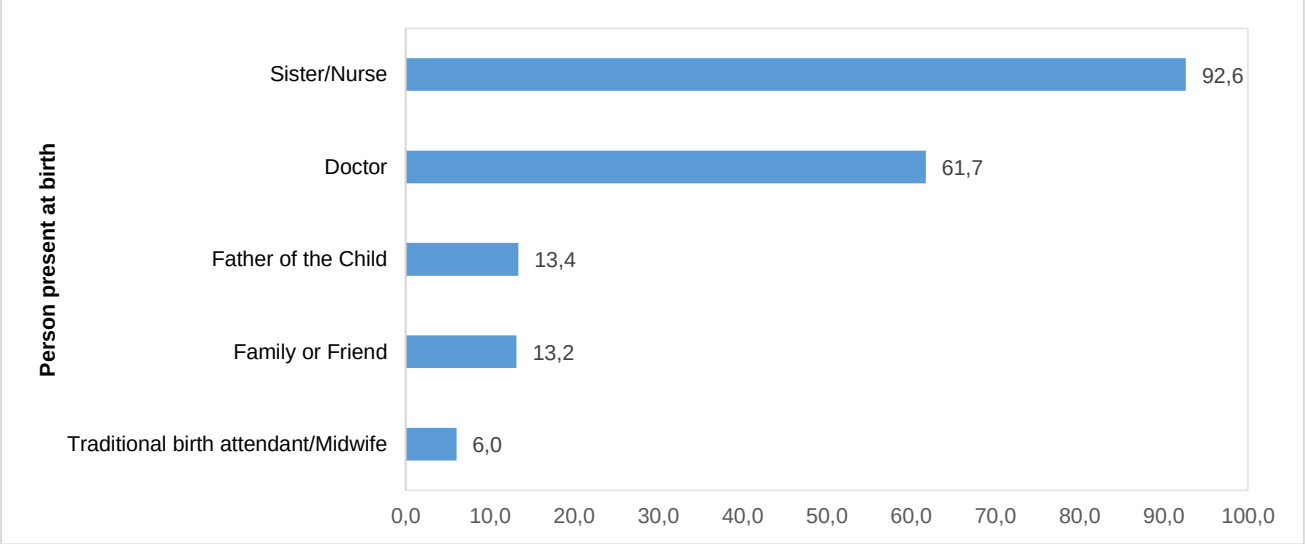
Figure 4.2: Place of birth for children aged 0–2, 2016



Source: GHS 2016

According to GHS 2016, the majority of children aged 0–2 were born in a hospital (85%) followed by those who were born in clinics (12,0%) and at home (3%).

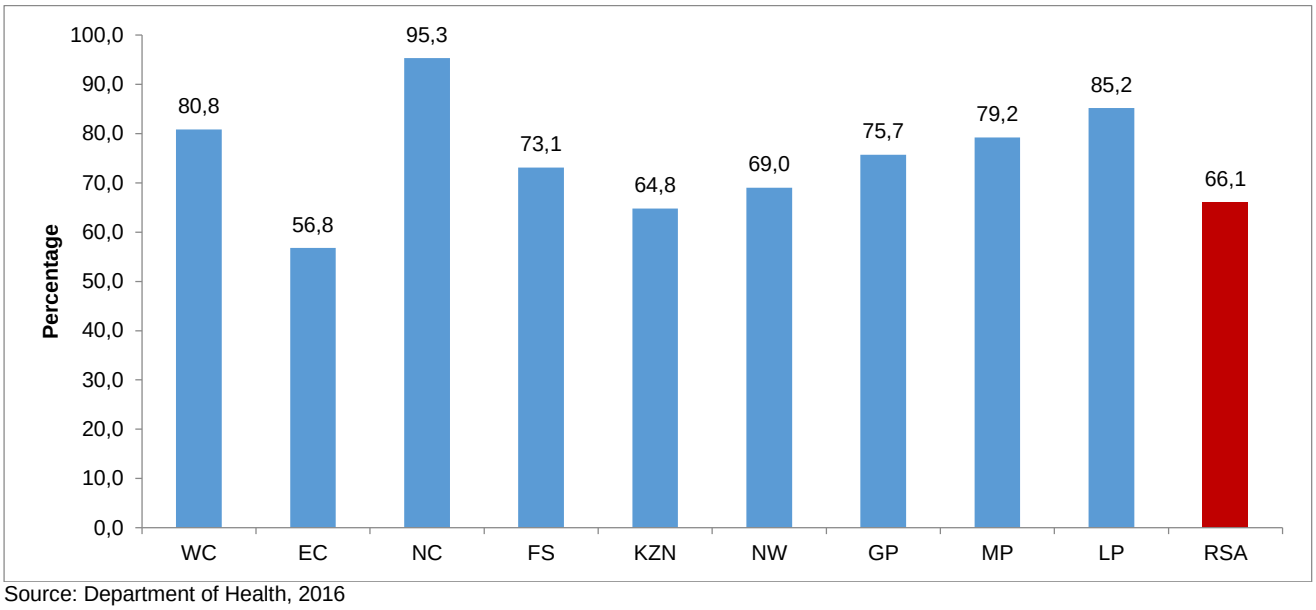
Figure 4.3: Distribution of persons present at birth of children aged 0–2, 2016



Source: GHS 2016

The figure above shows that a sister or nurse were present (92,6%) during the majority of births of children aged 0–2. Over three-fifths (61,7%) of children were born with a doctor present. A small percentage (13,4%) of fathers were also present during the birth of their children and in 13,2% of cases, a friend or family member was present. Only six per cent reported that they had a midwife or traditional birth attendant present during the birth of their child.

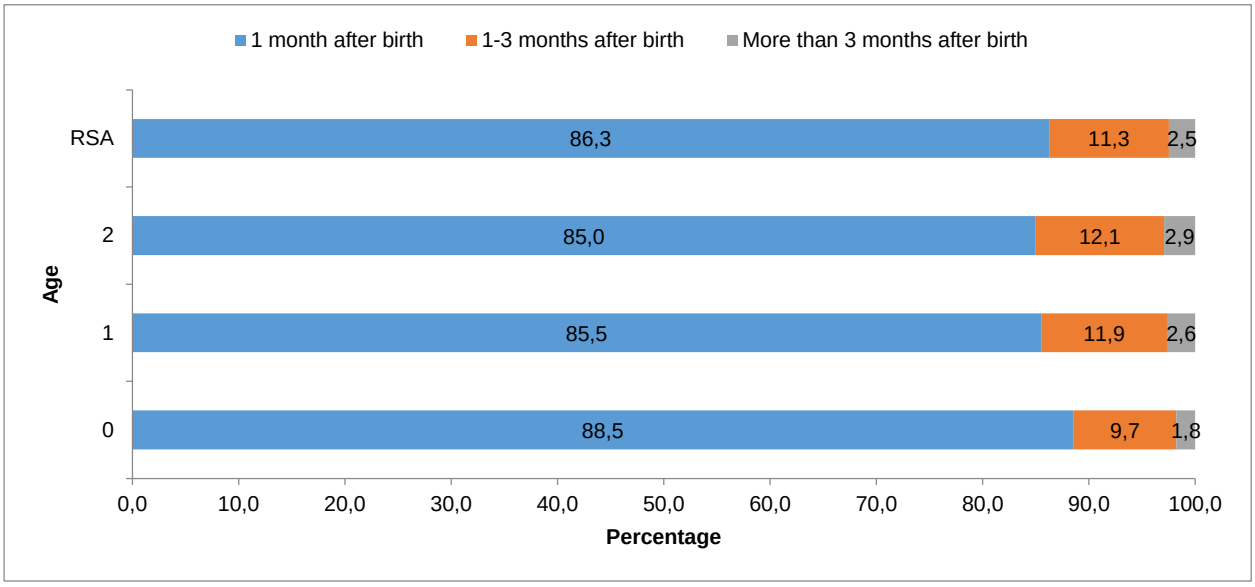
Figure 4.4: Delivery at facility rate[27], 2016



Source: Department of Health, 2016

The Department of Health[28] data shows that close to two out of three births that occurred in South Africa in 2016 took place at health facilities. While the highest occurrences were observed in Northern Cape (close to 9 out of 10), the lowest occurrences were observed in Eastern Cape (56,8%).

Figure 4.5: Time taken to receive birth certificates of children aged 0–2 years[29], 2016



Source: GHS 2016

[27] SADHS 2016: percentage delivered in a health facility among all live births in the 5 years before the survey (WC:98,8; EC: 91,3; NC: 97,3; FS:96,0; KZN: 95,4; NW: 95,4; GP: 96,9; MP: 95,3; LP: 97,5; RSA: 95,9).
[28] The denominator (estimated population of children less than 1 year) is adjusted for still births and infant deaths. Babies born before arrival at facilities are also excluded from the analysis.
[29] According to South African Births and Registration Act, 1992 all children born in South Africa must be registered within 30 days of their birth.

Early receipt of birth certificate is not only important to identify the children, but also to provide an opportunity to link children to important services such as for example the child support grant (CSG) and developmental screening. The figure above presents information on the percentage of households that indicated the time taken to receive the birth certificates for children aged 0–2 years. The figure shows that the majority of households received their birth certificates within one month after the birth of the child. Only less than three per cent across all ages indicated that they received birth certificates three months after the birth.

Table 4.1: Birth year-by-year of birth registration for children aged 0–6, 2010–2016

	Registration year							
Birth year	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**Total**
2010	889 691	80 079	21 005	12 978	8 418	6 290	2 901	**1 021 362**
2011		911 353	74 374	21 023	10 898	7 197	3 556	**1 028 401**
2012			926 726	66 775	16 147	8 882	3 771	**1 022 301**
2013				939 011	55 202	14 125	4 470	**1 012 808**
2014					954 385	46 754	7 601	**1 008 740**
2015						919 562	32 680	**952 242**
2016							876 435	**876 435**
Total	**889 691**	**991 432**	**1 022 105**	**1 039 787**	**1 045 050**	**1 002 810**	**931 414**	**6 922 289**

Source: Stats SA 2017 (P0305)

The table above shows the number of birth registrations by year of birth occurrence and year of birth registration for the period 2010 to 2016. Generally, birth registrations have been consistently above a million for the years 2010 to 2014. While birth registrations for 2015 and 2016 were below a million, there were still chances of increases as the births were continuously updated with late or delayed birth registrations. The birth registration system currently has 6,9 million children that were born and registered between 2010 and 2016.

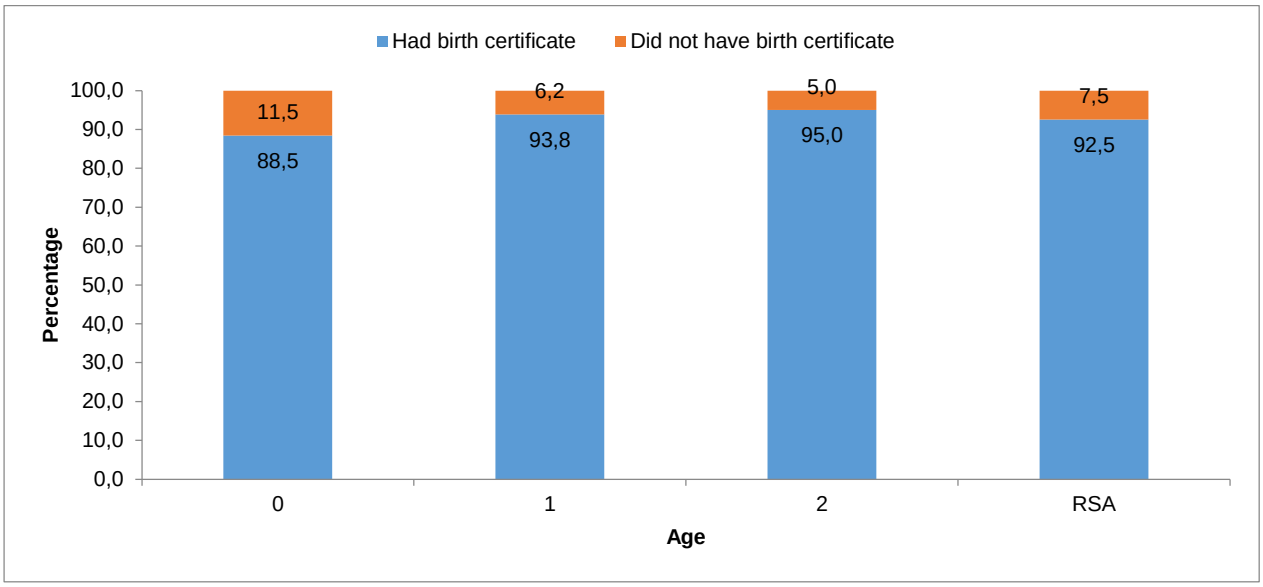
Table 4.2: Extent of late birth registration for children aged 0–6, 2010-2016

Birth year	**Total births**	**Registered within year of birth occurrence**	**Registered later than year of occurrence**	**Percentage late registrations**
2010	**1 021 362**	889 691	131 671	12,9
2011	**1 028 401**	911 353	117 048	11,4
2012	**1 022 301**	926 726	95 575	9,3
2013	**1 012 808**	939 011	73 797	7,3
2014	**1 008 740**	954 385	54 355	5,4
2015	**952 242**	919 562	32 680	3,4
2016	**876 435**	876 435	-	-

Source: Stats SA 2017 (P0305)

The table above shows that 87,1% of birth occurrences for 2010 were registered before the expiration of 2010, while 12,8% of the birth occurrences for 2010 were registered later than the year they occurred. One must note, that the year immediately following the birth year usually has more late registrations relative to later years, which in principle means that births become more complete over time. The above table also indicates that 11,4% of 2011 births, 9,3% of 2012 births, 7,3% of 2013 births, 5,4% of 2014 births and 3,4% of 2015 births were registered later than the year they occurred. These proportions are also expected to increase over time as more births for the respective years are registered. Moreover, the table has no late registrations for 2016 births as these will only start to be reported during the 2017 birth registration period.

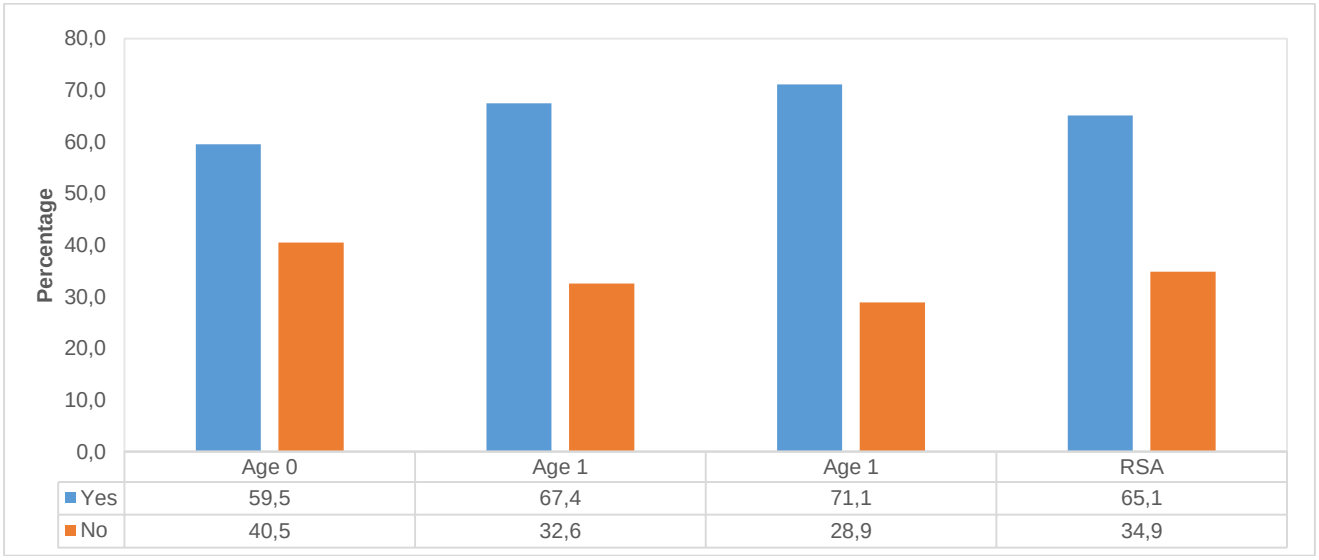
Figure 4.6: Percentage of children aged 0–2 with or without birth certificates by age, 2016



Source: GHS 2016

The figure above shows the percentage of children aged 0–2 in 2016 with or without their birth certificates. Overall close to 93% of children aged 0–2 had their birth certificates. The largest percentage of children without birth certificates was amongst those younger than one year (11,5%).

Figure 4.7: Application for birth certificate for children aged 0–2, 2016



Source: GHS 2016

Of the 461 000 total households with children aged 0–2, who indicated that their children did not have a birth certificate, over three-fifths (65,1%) of the households indicated that they applied for a birth certificate and 34,9% indicated they did not apply for a birth certificate. No reasons were given by respondents who did not apply for a birth certificate. Across the age group 0–2 years, the application for a birth certificate was the highest for children aged one (67,4%) and those aged two years (71,1%).

Table 4.3: Percentage of crime(s) (murder, attempted murder, sexual offences) committed against children younger than 18 years and conviction rate[30], 2015/2016

Crime category	Total number of complaints reported	%	Total complaints in court	%	Number conviction	%
Murder	884	2,2	1 835	6,3	248	81,1
Attempted murder	906	2,2	758	2,6	128	77,6
Sexual offences	20 254	49,8	20 048	68,9	3 007	70,5
Total	**40 689**		**29 109**		**5 348**	

Source: SAPS: annual report 2015/2016

According to the South African Police Service (SAPS) annual report 2015/2016, close to 50% of crime committed against children younger than 18 years[31] in 2015/2016 were sexual offences. In addition to sexual offences, murder and attempted murder were other forms of crimes affecting children under the age of 18 years. Although as the table above shows the conviction rate for crimes against children was the highest (81,1%) for murder, followed by attempted murder (77,6%) and sexual offences (70,5%), increased efforts are needed to strengthen the protection and safety of children in South Africa.

Table 4.4: Number of households with children aged 0–6 who experienced at least one type of crime in their households, by province of the household head and type of crime, 2015/2016

Category of crime	WC	EC	NC	FS	KZN	NW	GP	MP	LP	RSA
Theft of car	2 751	604	300	639	2 570	947	5 285	1 133	925	**15 154**
Housebreaking/ burglary	25 093	25 510	5 906	9 737	47 302	6 925	78 516	21 332	18 852	**239 174**
Home robbery	6 377	4 815	298	5 998	9 471	6 600	16 766	7 856	5 326	**63 508**
Theft of livestock/ poultry and other animals	*	20 913	2 262	2 344	19 072	5 870	2113	4 045	1 618	**58 236**
Theft of crops planted by the household	1 548	3 204	*	1 337	556	*	1508	758	1 377	**10 288**
Murder	640	*	*	565	1 484	*	*	623	*	**3 312**
Theft out of motor vehicle	4 336	1 003	776	785	2 820	*	5432	2 116	500	**17 768**
Deliberate damage of dwellings/ burning/destruction of dwellings	3 548	1 820	385	936	763	*	7256	672	564	**15 943**
Motor vehicle vandalism/ deliberate damage of vehicle	3 565	840	542	*	842	737	4372	*	*	**10 898**
Theft of bicycle	697	620	558	1 305	2 096	1 490	3613	2 353	1 609	**14 341**
Total	**486 792**	**607 183**	**121 591**	**286 356**	**847 472**	**384 269**	**1 230 837**	**441999**	**602 602**	**5 009 102**

Source: VOCS, 2015/2016

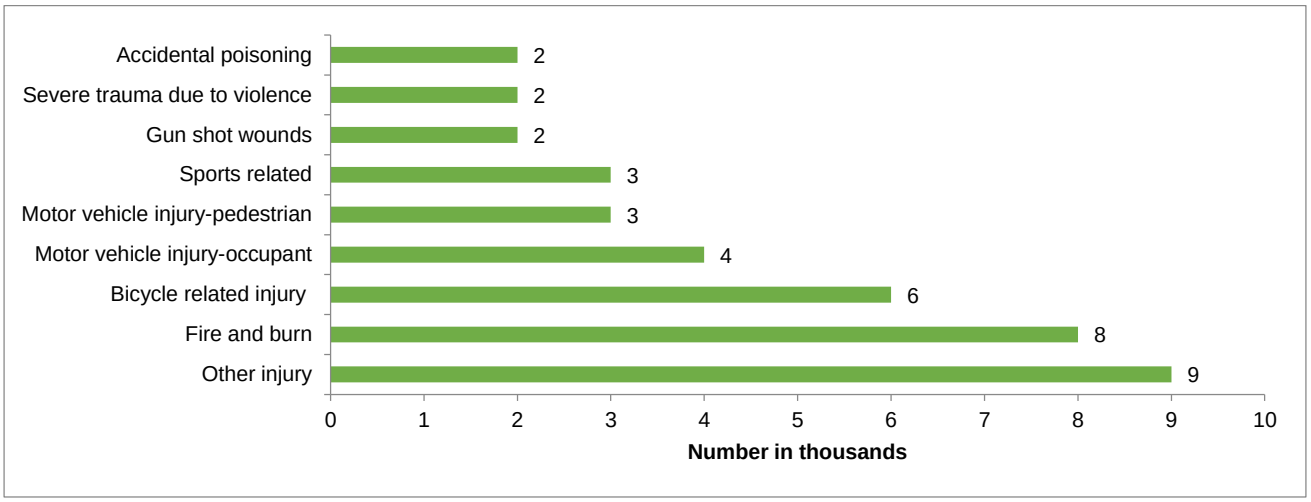
* Un-weighted numbers of 3 and below per cell are too small to provide reliable estimates.

The Victims of Crime Survey (VOCS) 2015/2016 estimated that a total of five million households with children aged 0–6, experienced crime in 2015/2016. Nationally, the majority (239 174) of these households experienced housebreaking/burglary, followed by home robbery (63 508). Home robberies are typically violent in nature and inherently put victims' life at risk. Furthermore, households with children aged 0–6 in Gauteng experienced the highest number of crimes (1 230 837) followed by KwaZulu-Natal (847 472). Households with children aged 0–6 in Northern Cape experienced the least number of crimes (121 591).

[30] The NPA defines a "conviction rate" as the "percentage of cases finalised with a guilty verdict divided by the number of cases finalised with a verdict."

[31] Data for age bracket 0–6 was not available for analysis

Figure 4.8: Injuries suffered by children aged 0–6 years, 2016



Source: GHS 2016

The above figure shows different types of injuries children aged 0–6 suffered. This finding reveals that, of all injuries, 8 000 were due to fire and burn injuries and 6 000 were bicycle accident related injuries. The figure also shows that motor vehicles related injuries were major contributors of injuries among children aged 0–6.

4.3 Support for primary caregivers

The national integrated ECD policy recognises that the family is the natural environment for the growth and well-being of children and parents bear the primary responsibility for upholding children's development and well-being. It also promotes the provision of health services and other forms of support during pregnancy to birth, and the provision of social protection to caregivers. Parenting, caregiving and family support are considered essential to the promotion of optimal early childhood development and early intervention.

Parents and caregivers are expected to ensure that children are healthy and safe; to equip them with the skills and resources needed to succeed as adults; and transmit basic cultural values to them. The policy makes provision for support in preparation for parenting and skills-building; to enhance the ability of families to cope and nurture every vulnerable child; to promote healthy pregnancy by providing maternal psycho-social support where needed; antenatal care for pregnant women; home visits and centre based supports, training and support programmes for child-minders.

Table 4.5: Number of children aged 0–6 who had access to social grant by type of grant and province, March 2017

Region	Grant type			Total
	Child dependency grand	Child support grand	Foster child grand	
Western Cape	3 529	392 205	5 064	**400 798**
Eastern Cape	3 737	740 798	5 947	**750 482**
Northern Cape	1 035	126 243	868	**128 146**
Free State	1 487	268 616	1 747	**271 850**
Kwazulu-Natal	6 936	1 107 175	3 302	**1 117 413**
North West	1 597	341 464	1 706	**344 767**
Gauteng	3 925	741 033	3 266	**748 224**
Mpumalanga	2 181	436 047	1 557	**439 785**
Limpopo	3 071	777 963	2 367	**783 401**
RSA	**27 498**	**4 931 544**	**25 824**	**4 984 866**

Source: SASSA, March 2017

The child support grant (CSG) was introduced in 1998 to help alleviate the income-poverty experienced by many children in South Africa. The CSG targets children aged between birth and 18 years. Data from the South African Social Security Agency (SASSA) of March 2017 showed that 12 million children benefited from the CSG, of which 4,9 million were children aged 0–6. It is important to note that out the approximately 5 million children aged 0–6 who received the CSG, only 9,2% were one year old or less, the other beneficiaries were aged 2–6. This may be because many children under the age of one did not have a birth certificate, which is a requirement to apply for a grant. The care dependency grant (CDG) is for children between the age of one and eighteen who have severe disabilities and require permanent care from a caregiver. Data from SASSA from March 2017, showed that CDG reached 134 264 children across all provinces. A total of 27 498 were children aged 0–6 years. The foster child grant is paid toward children aged 0–18 that were in need of care as per section 14(4) of the Child Care Act 1983, and have been placed with a foster family in terms of section 15(1) of the same Act. According to data from SASSA as of March 2017, the grant reached 466 352 children. A total of 25 824 were children aged 0–6 years.

Table 4.6: Percentage of children aged 0–6 whose biological parents were still alive[32], 2016

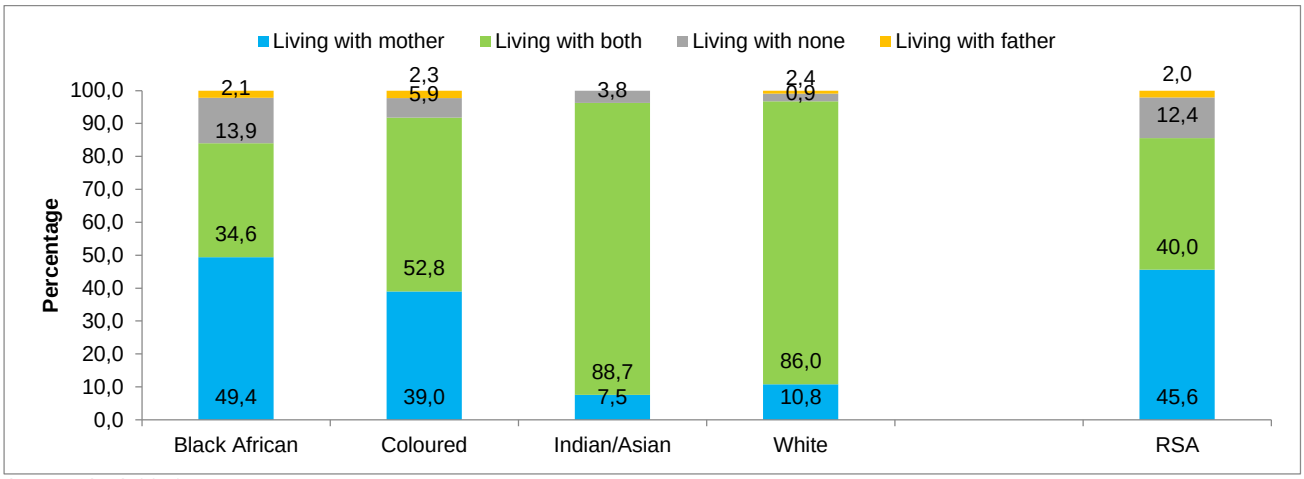
Child age	Maternal orphan	Paternal orphan	Double orphan	Not orphaned	Total
	*	7 491	*	940 195	**947 687**
0	*	0,8	*	99,2	
	3 177	13 582	*	958 625	**977 036**
1	0,3	1,4	*	98,1	
	2 898	20 093	1 986	1 020 010	**1 044 988**
2	0,3	1,9	0,2	97,6	
	8 995	30 462	*	1 010 271	**1 050 943**
3	0,9	2,9	*	96,1	
	16 682	38 482	3 964	966 858	**1 025 987**
4	1,6	3,8	0,4	94,2	
	12 230	50 848	6 208	934 258	**1 003 544**
5	1,2	5,1	0,6	93,1	
	19 141	58 388	10 496	919 512	**1 007 538**
6	1,9	5,8	1,0	91,3	
	63 123	**219 348**	**25 520**	**6 749 730**	**7 057 721**
Total	**0,9**	**3,1**	**0,4**	**95,6**	**100,0**

Source: GHS 2016
* Un-weighted numbers of 3 and below per cell are too small to provide reliable estimates.

The GHS shows that, in 2016, about 6,7 million children aged 0–6 in South Africa were not orphaned, (both their parents were still alive), whilst 25 520 were double orphans (both their parents were not alive). The table further shows that 63 123 children aged 0–6 were maternal orphans. By contrast, 219 348 children were paternal orphans (whose biological father was dead or whose living status was unknown), but whose mother was alive. The percentage of children in the age cohort 0–6 who were paternal orphans was much higher (3,1%) than the percentage of children who were maternal orphans (0,9%).

[32] A maternal orphan is a child whose mother has died but whose father is alive; maternal and paternal orphans include children who are double orphans. The General Household Survey asks, for each household member, whether their biological mother and father live in the same household. This indicator is therefore calculated by identifying single orphans (children whose mother or father is dead or whose living status is unknown), and by calculating the number and proportion of these children who are resident with their remaining parent.

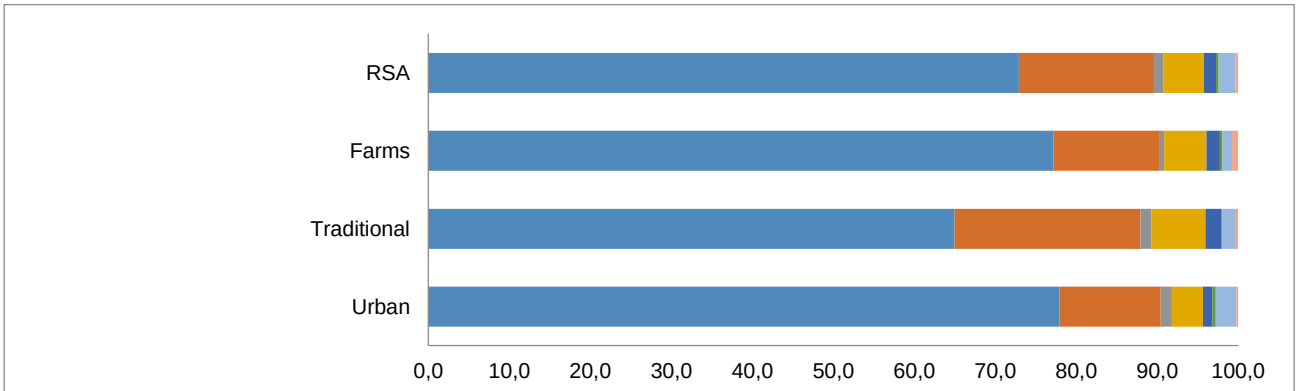
Figure 4.9: Percentage of children aged 0–6 living with their biological parents[33], 2016



Source: GHS 2016

In South Africa, both parents seldom get involved in raising children; as shown in Chapter 2. Overall, most children aged 0–6 lived in single parent-family households with mostly their mothers (45,6%). Furthermore, the above graph shows that close to 49% of black African children lived with their mothers, which was indicative of the extent of single parenthood among black African mothers. Close to 35% of black African children lived with both parents; and 14% lived with none of their parents. By contrast, while 86% of white children lived with both parents, close to 11% lived with their mothers only. These living arrangements may have an impact on childcare arrangements as children do not benefit from the care they could receive from a dual parenting system.

Figure 4.10: Main person who takes care of the child aged 0–6 by geographical location, 2016



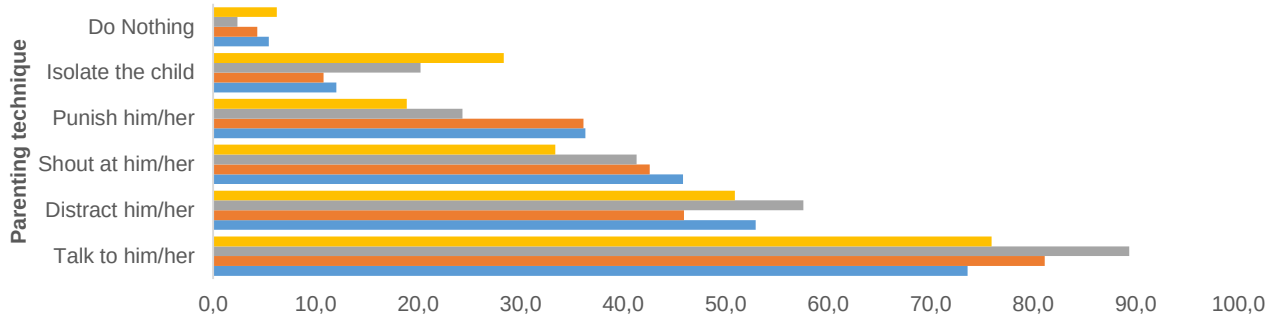
	Urban	Traditional	Farms	RSA
Biological/adoptive/foster parent	77,9	65,0	77,2	72,9
Grandparent	12,5	23,0	13,0	16,5
Sister/brother/cousin	1,3	1,4	0,6	1,3
Aunt/Uncle	3,8	6,7	5,2	5,0
Other relative	1,2	1,9	1,7	1,5
Friend /Neighbour of the family -not for pay	0,4	0,1	0,3	0,3
Paid carer/nanny	2,5	1,6	1,2	2,1
Other	0,2	0,4	0,7	0,3

Source: GHS 2016

[33] Those with unspecified or unknown information were excluded from the analysis.

The above figure presents data about the main persons who take care of the children aged 0–6. Across all geographic areas, biological/adoptive/foster parents were the main persons who were responsible for making sure that children were fed, washed and go to school/crèche. The majority of households in traditional and farms areas had a disproportionately large burden of care for young children by grandparents and other family members. This practice is common in South Africa for children to live separately from their biological parents, in the care of other relatives or friends, and this is attributable to many factors including poverty, labour migration, housing and educational opportunities. Paid care was mostly practiced in urban areas (2,5%). Children need appropriate childcare and parenting techniques to thrive; and hence a conducive environment for stimulation and learning opportunities provided by parents and caregivers have a positive and long-lasting impact on children's ability to develop their full potential. Interventions to support and develop positive parenting are mandated by Chapter 8 of the Children's Amendment Act (Act No. 41 of 2007), which deals with prevention and early intervention. Section 144 focuses on developing the capacity of parents to act in the best interests of their children by using non-violent forms of discipline (distract a child to do something else, talk to him/her and explain what is not good to do).

Figure 4.11: Parenting techniques utilised for children aged 0–6 years by population group, 2016



	Talk to him/her	Distract him/her	Shout at him/her	Punish him/her	Isolate the child	Do Nothing
White	76,0	50,9	33,4	18,9	28,4	6,2
Indian/Asian	89,4	57,6	41,3	24,3	20,2	2,4
Coloured	81,1	45,9	42,6	36,1	10,8	4,3
Black -African	73,6	52,9	45,8	36,3	12,0	5,4

Source: GHS 2016

Differences in population groups regarding the use of positive parenting techniques can be seen in the figure above. Over half of the white (50,9%), Indian/Asian (57,6%) and black African (52,9%) households reported that they talked to their children and explained why their misbehaviour was not appropriate or distracted the children as part of their parenting technique. The percentages of households that utilised physical punishment varied from 18,9% amongst the white population to 36% in both the coloured and black African population groups. Isolating the child was more prevalent amongst the white population group as compared to the other population groups.

4.4 Stimulation for early learning

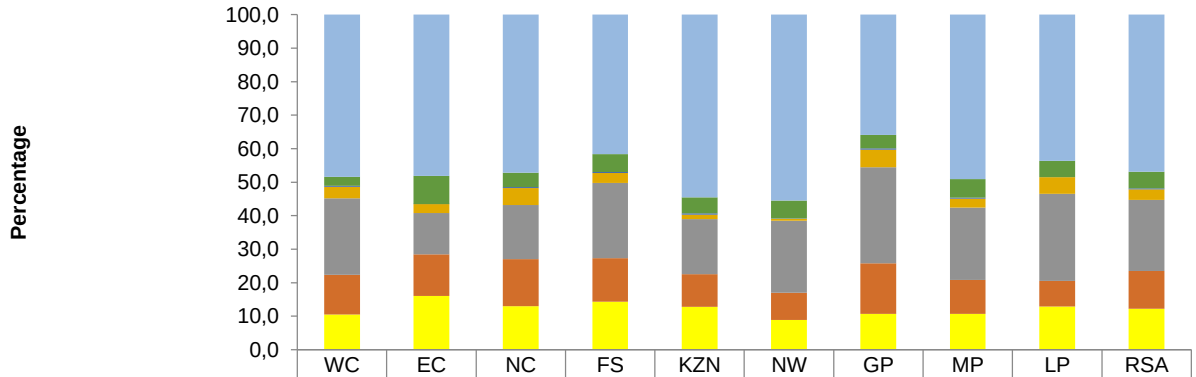
This package provides all children with the necessary foundations for early learning, socio-emotional, and language development. It includes community-based early learning, play groups or community-based early learning centres for mothers and children aged 0–2 to provide parenting support and information on early learning, socialisation and a stimulating play experience for children. Policy makers in South Africa have accepted that fair access to quality early childhood education and care can strengthen the foundations of lifelong learning for all children. Government also acknowledges the need for substantial public investment in services and the necessary infrastructure to support the broad educational and social needs of young children.

In South Africa, various types of educational child development care centres exist that include standard nursery and preschool facilities that follow formal curricula that cater mostly for children aged three or older. These schools normally have Grades 00, 000 and 0 (or Grade R), and are part of the junior school environment. Nonetheless they may also offer childcare services for younger children. Such schools create better environments for children to transition between ECD and schools. Crèches and educare centres are facilities that cater mostly for young children from infants to six years old. In some cases, these facilities may also offer Grade R classes.

Day mother or gogo services are usually offered by women in the community who use their place of residence to care for children of all ages during the day. Although such caregivers may not provide structured learning and teaching, they offer nurturing to the children by helping them learn how to form positive social attachments that are crucial to early childhood development.

The Department of Social Services policy on ECD aims to regulate day care facilities through certain ECD facilities' registration requirements (Children's Act, Act No. 38 of 2005). These include requirements for bathroom facilities; kitchens or areas used to prepare food; indoor and outdoor space requirements; and isolation rooms for sick children. According to the national norms and standards for early childhood development programmes, at least one meal per day must be provided to children at ECD facilities; all meals and snacks should meet the nutritional requirements of children; and where children are bottle-fed, a suitable facility must exist for cleaning the bottle. Requirements for staff members include skills in ECD programmes and first aid; staff-to-child ratio ranging from 1:6 for the youngest children (aged one to 18 months) to 1:30 for the older children aged 5 to 6 (Children's Act, Act No. 38 of 2005).

Figure 4.12: Attendance of ECD and school by children aged 0–6 by province, 2016



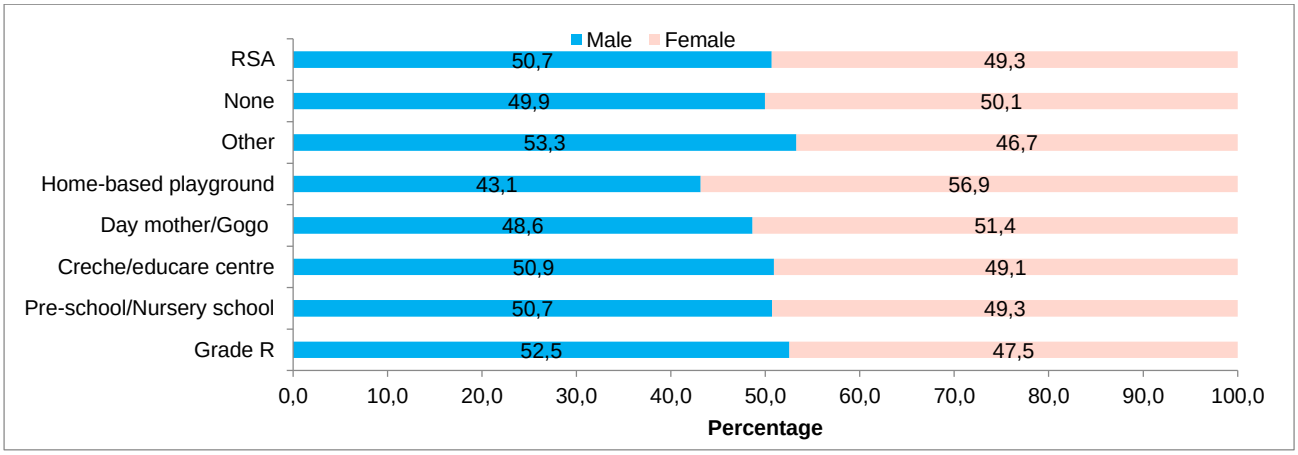
	WC	EC	NC	FS	KZN	NW	GP	MP	LP	RSA
None	48,4	48,1	47,2	41,6	54,6	55,5	35,9	49,0	43,7	46,9
Other	2,6	8,4	4,3	5,4	4,8	5,3	4,0	5,6	4,9	5,0
Home-based playgroup	0,3	0,0	0,2	0,2	0,3	0,1	0,4	0,2	0,0	0,2
Day mother/Gogo	3,4	2,7	5,1	3,0	1,4	0,6	5,3	2,7	4,9	3,2
Creche/Educare centre	22,8	12,3	16,1	22,4	16,4	21,5	28,7	21,6	26,0	21,2
Pre-school/Nursery school	11,9	12,3	14,1	13,0	9,7	8,1	15,1	10,1	7,7	11,3
Grade R	10,5	16,1	13,0	14,3	12,8	8,9	10,7	10,7	12,9	12,2

Source: GHS 2016

According to the above graph, overall among children aged 0–6, nearly 47% did not attend any educational institution and wide disparities in attendance exist across provinces. While North West and KwaZulu-Natal had proportionately lower attendance rates among this young age group compared to the national average and other provinces (55,5% and 55,6% respectively), Gauteng had the lowest proportion of children aged 0–6 who did not attend any educational institutions (35,9%) suggesting rural-urban gaps in access. On the other hand, 21,2% of the total children aged 0–6 were attending educare centres or crèches; Gauteng and Limpopo had the most children attending such facilities (28,7% and (26,0% respectively). Approximately five per cent of children in Northern Cape, five per

cent in Gauteng and five per cent in Limpopo attended day mother/ gogo types of child development arrangements. Such arrangements were less utilised by children in other provinces. One reason for this difference could be that most of the ECD facilities in South Africa are private, and thus funding to access them are difficult for some children, particularly the ones from poor families in provinces such as KwaZulu-Natal and North West.

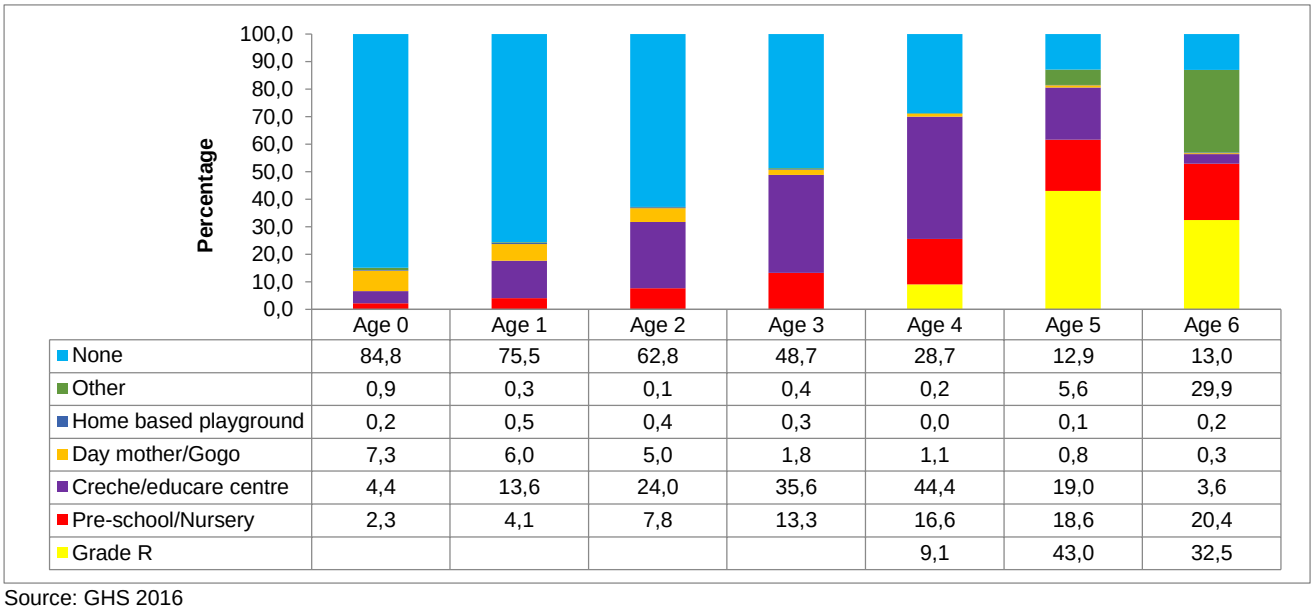
Figure 4.13: Attendance of ECD and school by children aged 0–6 by sex, 2016



Source: GHS 2016

The above graph illustrates the existence of gender uniformity in either the attendance or non-attendance of ECD programmes by young children. However, gender disparities to the disadvantage of boys exist in participation in home-based playgroups, with greater proportions of girls enrolled in these programmes compared to boys (57% and 43% respectively). Among children aged 0–6 who were attending Grade R, 52,5% were boys and 47,5% were girls.

Figure 4.14: Attendance of ECD and school by children aged 0–6 by age, 2016

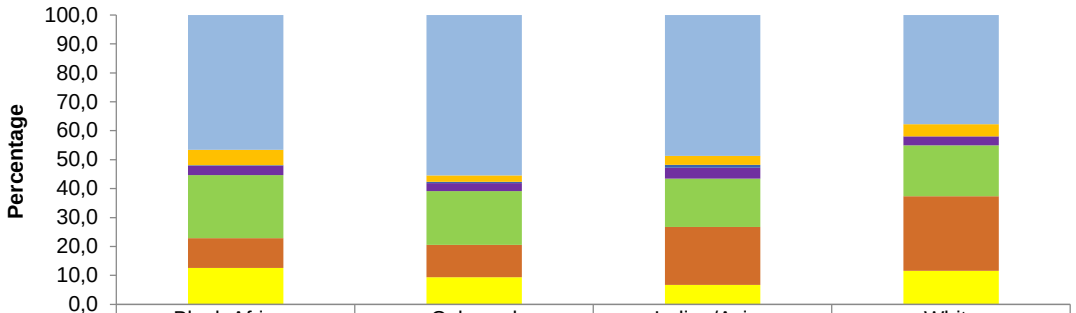


	Age 0	Age 1	Age 2	Age 3	Age 4	Age 5	Age 6
None	84,8	75,5	62,8	48,7	28,7	12,9	13,0
Other	0,9	0,3	0,1	0,4	0,2	5,6	29,9
Home based playground	0,2	0,5	0,4	0,3	0,0	0,1	0,2
Day mother/Gogo	7,3	6,0	5,0	1,8	1,1	0,8	0,3
Creche/educare centre	4,4	13,6	24,0	35,6	44,4	19,0	3,6
Pre-school/Nursery	2,3	4,1	7,8	13,3	16,6	18,6	20,4
Grade R					9,1	43,0	32,5

Source: GHS 2016

According to the above graph, 49 out of 100 children aged three years did not attend any ECD facility in 2016. Similarly, among the four year-olds, 29 out 100 did not attend an ECD facility whereas close to 13% of children aged five or six did not attend any educational facility. Even though close to one-third of the six year-olds attended Grade R, one in five children (20,4%) in this age group were still in pre-school and 3,6% were attending crèche.

Figure 4.15: Attendance of ECD and school by children aged 0–6 by population group, 2016

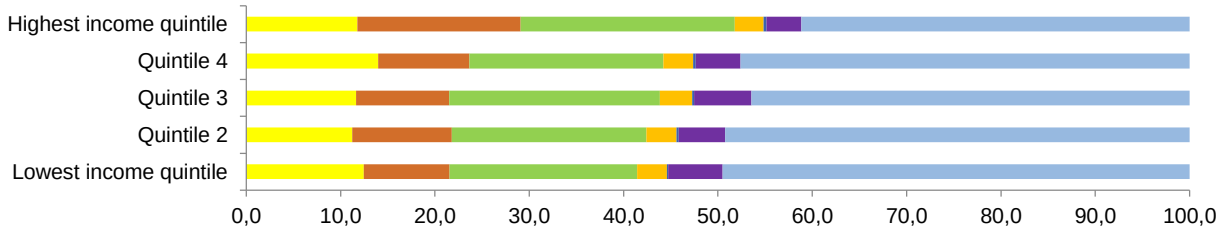


	Black African	Coloured	Indian/Asian	White
None	46,6	55,5	48,7	37,7
Other	5,4	2,1	3,1	4,2
Home-based playgroup	0,2	0,5	1,0	0,0
Day mother/Gogo	3,2	2,8	3,7	3,0
Creche/Educare centre	21,8	18,5	16,8	17,7
Pre-school/Nursery school	10,2	11,2	20,0	25,7
Grade R	12,6	9,4	6,7	11,6

Source: GHS 2016

Certain population group inequities persist in the access and attendance of educational institutions by young children. One must acknowledge in the resulting differences in the type, quality and intensity of stimulation that occur in the various places of ECD services. The above graph illustrates the demographic breakdown of the children attending the various types of ECD facilities. Among white children aged 0–6, more than a quarter (25,7%) would most likely attend pre-school or nursery schools while close to 18% would be at crèche or educare centres. This amounts to altogether 43,4% of white children attending out-of-home early learning programmes. In comparison, only 29,7% among coloureds were attending out-of-home early learning programmes. Coloureds also had high percentages of children that did not attend any type of ECD facility (55,5%). Among black/African children aged 0–6, close to 10% would most likely attend pre-school or nursery schools while close to 22% would be at crèche or educare centres. This amounts to altogether 32% of black/African children attending out-of-home early learning programmes.

Figure 4.16: Attendance of ECD centre and school by children aged 0–6 by monthly household income quintile, 2016

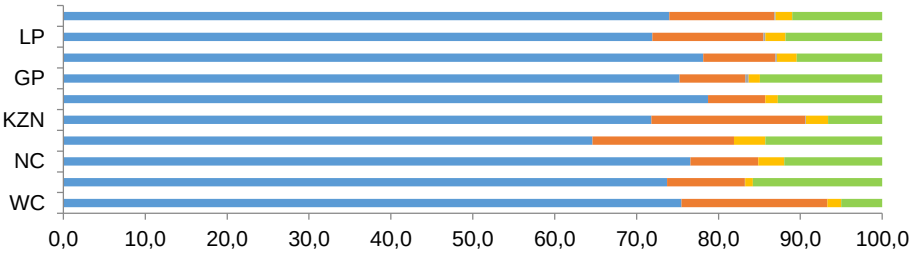


	Lowest income quintile	Quintile 2	Quintile 3	Quintile 4	Highest income quintile
Grade R	12,5	11,2	11,7	14,0	11,8
Pre-school/Nursery school	9,1	10,6	9,9	9,7	17,3
Creche/Educare centre	19,9	20,6	22,3	20,6	22,7
Day mother/Gogo	3,1	3,2	3,4	3,1	3,0
Home-based playgroup	0,2	0,2	0,2	0,3	0,3
Other	5,8	4,9	6,1	4,8	3,7
None	49,5	49,2	46,5	47,6	41,2

Source: GHS 2016

The above graph shows inequalities in early learning opportunities. Close to half of the children in the lower income quintiles households did not participate in any learning activity while one in eight children in the lowest income category attended Grade R. Among the children in the lowest income quintile households, close to 29% attended formal early learning programmes while the rest attended home based early learning programmes (9,1%). By contrast, among the children from households in the highest income quintile, 40% attended formal early learning programmes while 12% attended Grade R. However, quite large percentages among all income group households did not attend any programme.

Figure 4.17: Time spent during the day for most of the time for children not attending ECD facilities by province, 2016

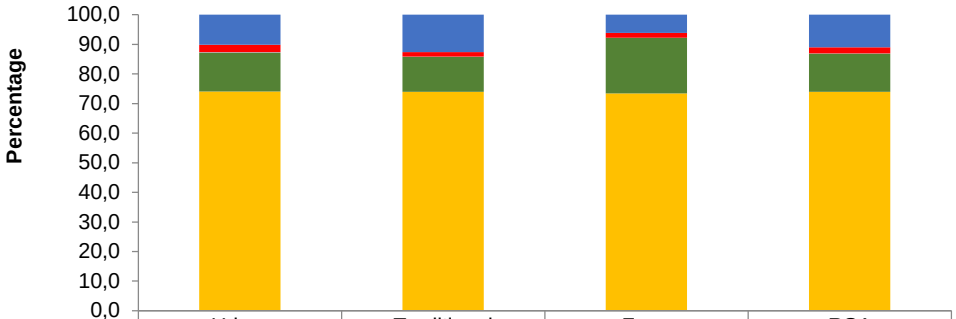


	WC	EC	NC	FS	KZN	NW	GP	MP	LP	RSA
At home with parent,foster parent or guardian	75,5	73,7	76,6	64,6	71,8	78,7	75,3	78,2	71,9	74,0
At home with another adult	17,8	9,5	8,3	17,3	18,8	7,0	8,0	8,8	13,6	12,9
At home with someone younger than 18 years	0,0	0,1	0,0	0,0	0,1	0,0	0,4	0,2	0,2	0,1
At someone else's dwelling	1,7	0,9	3,2	3,9	2,7	1,5	1,4	2,4	2,5	2,0
Other	5,0	15,8	12,0	14,3	6,6	12,8	14,9	10,4	11,8	11,0

Source: GHS 2016

Among children aged 0–6 who did not attend any educational programmes/facilities, 74% were spending most of their time at home with their parents or guardians and close to 13% were staying at home with another adult. Children who were mostly spending time at home with another adult were predominantly found in KwaZulu-Natal (18,8%) and Western Cape (17,8%). A small proportion (2,1%) were either staying at home with someone younger than 18 years or at someone else's dwelling; such arrangements were mainly practiced in provinces such as KwaZulu-Natal, Northern Cape and Limpopo (nearly 3% each) and Free State (nearly 4%) .

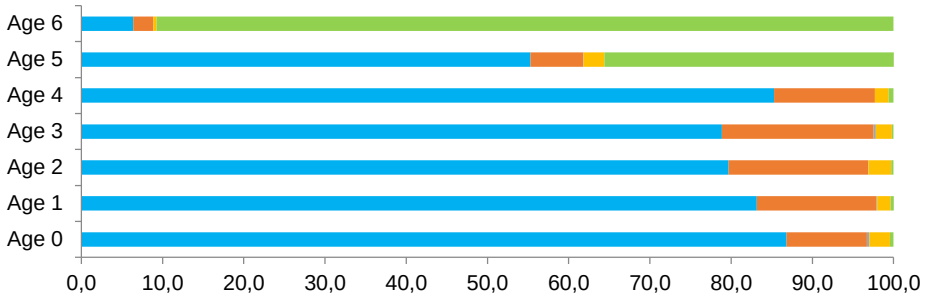
Figure 4.18: Time spent during the day for most of the time for children not attending ECD facilities by geo-type, 2016



	Urban	Traditional	Farm	RSA
Other	10,1	12,6	6,1	11,0
At someone else's dwelling	2,5	1,6	1,6	2,0
At home with someone younger than 18 years	0,2	0,1	0,0	0,1
At home with another adult	13,1	11,8	18,9	12,9
At home with parent,foster parent or guardian	74,1	73,9	73,4	74,0

Source: GHS 2016

Figure 4.19: Time spent during the day for most of the time for children not attending ECD facilities by age, 2016

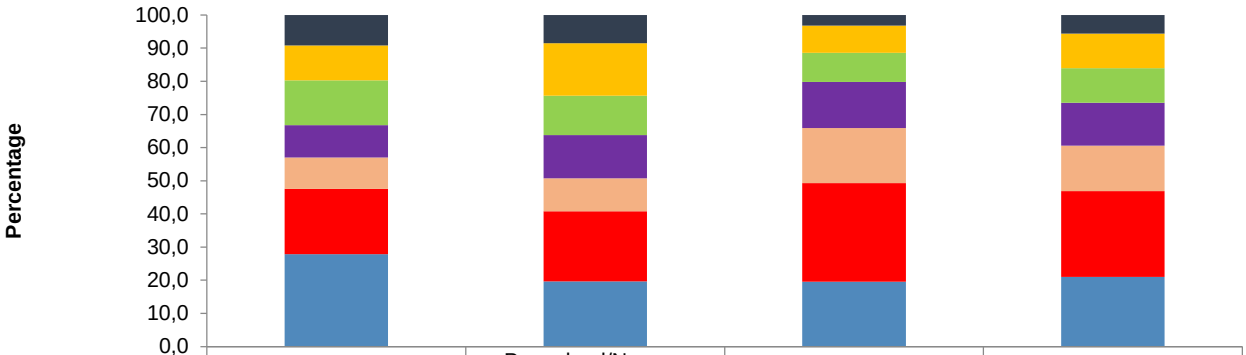


	Age 0	Age 1	Age 2	Age 3	Age 4	Age 5	Age 6
At home with parent,foster parent or guardian	86,8	83,2	79,7	78,9	85,3	55,3	6,4
At home with another adult	9,9	14,7	17,2	18,7	12,4	6,5	2,5
At home with someone younger than 18 years	0,3	0,1	0,0	0,3	0,0	0,0	0,0
At someone else's dwelling	2,5	1,7	2,8	2,0	1,7	2,6	0,4
Other	0,5	0,4	0,3	0,2	0,6	35,6	90,7

Source: GHS 2016

The type of childcare arrangement used among those who did not attend ECD facilities depends on the age of the child. While most young children aged up to four spend the day with their parents, foster parents or guardians, children aged five or six were cared for differently. Infants and children under one were mostly cared for at home by parents or guardians (86,8%). One in 10 children in this age group stayed at home with another adult and 2,5% were staying at someone else's dwelling during the day.

Figure 4.20: Monthly household expenditure on ECD, 2016



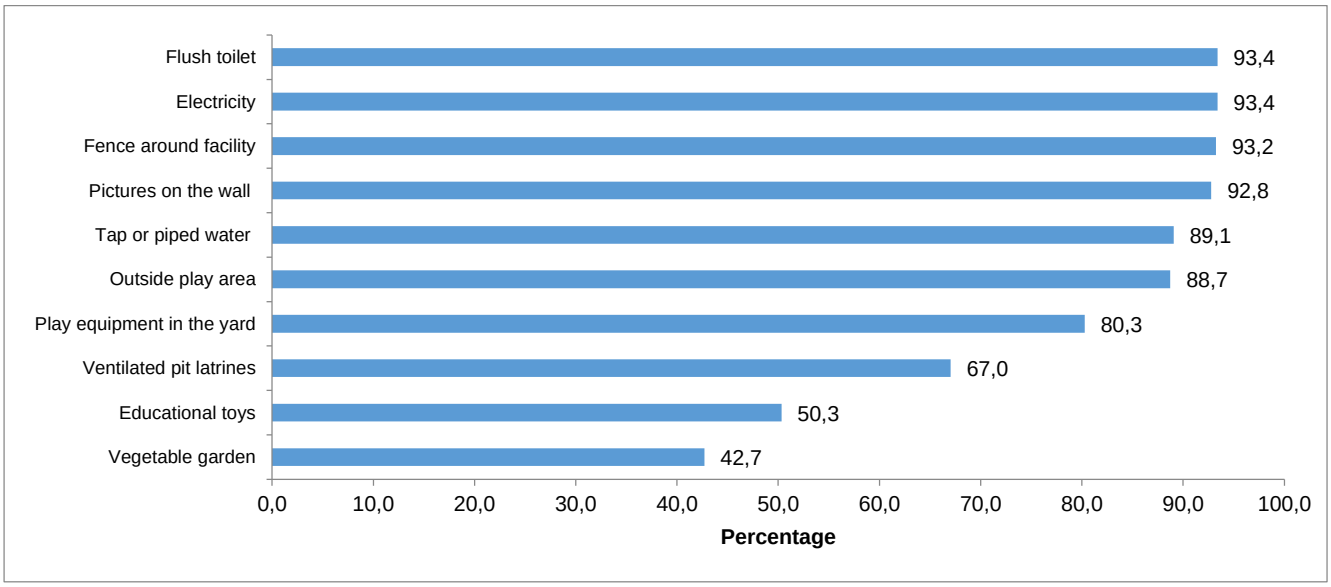
	Grade R	Pre-school/Nursery school	Creche/educare centre	Total
More than R2000	9,2	8,5	3,2	5,6
R1001-R2000	10,5	15,8	8,2	10,5
R501-R1000	13,5	11,9	8,8	10,4
R301-R500	9,8	13,0	13,9	13,0
R201-R300	9,5	10,0	16,7	13,7
R101-R200	19,6	21,2	29,7	25,8
R1-R100	27,9	19,6	19,5	21,0

Source: GHS 2016

The cost for accessing ECD facilities by children can be very expensive. The graph above depicts the monthly fees paid per child by households for their children to attend an ECD facility. While most of the cost incurred towards attending an ECD facility is paid for children to attend crèches or educare centres (1,4 million children), the majority (29,7%) reported paying R101–R200 monthly per child while 8,2% paid R1 001–R2 000 and 3,2% paid more than R2 000.

ECD facilities have to fulfil certain standard infrastructure requirements in order to be legal according to the national norms and standards for early childhood development programmes. Toilet requirements include the use of flush toilets where running water is available and the use of covered potties for younger children. Separate toilet facilities are recommended for boys and girls with a ratio of one toilet per 20 children whereas each child is expected to have a separate pottie. Similarly hand washbasins must be available with soaps and towels. The recommended ratio is one hand basin per 20 children. Furthermore, ECD facilities are expected to provide child-friendly spaces inside the structures as well as courtyards for children to play and move around; with pictures and attractive displays for children.

Figure 4.21: Type of infrastructure available at ECD centre attended by children aged 0–6, 2016



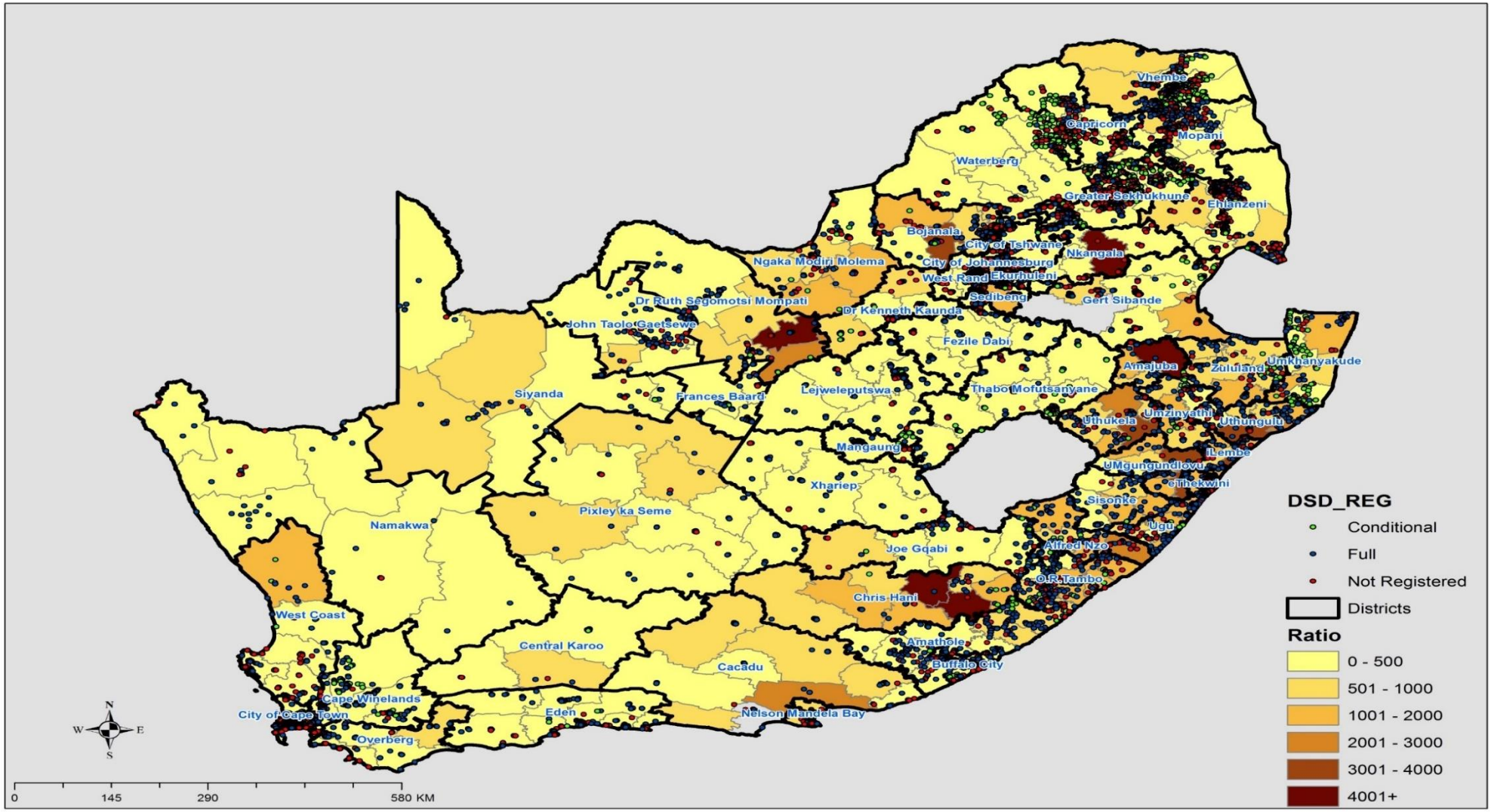
Source: GHS 2016

The above graph shows that while most ECD facilities had the required infrastructure, they lacked the basic tools that give children sensory experiences that are crucial for fine motor skills development. As such, close to 11% of the centres did not have outside play areas and 20% were without play equipment such as jungle gyms in the yard. Furthermore, half of the centres (50%) lacked educational toys.

The following map shows the ratio of the children population[34] aged 0–6 by the number of ECD centres available in the country. The map includes all centres which were fully or conditionally registered with the Department of Social Development in 2013–2014. The map also includes centres that were operating without being registered. The centres were largely concentrated in urban and metropolitan areas where the vast majority of children aged 0–6 reside. On the other hand, while the largest percentages of young children were found in KwaZulu-Natal and Gauteng, the lack of ECD centres was mostly observed in KwaZulu-Natal (in Emadlangeni, uMlalazi, uMshwathi and eThekwini). Gauteng had the largest number of non-registered ECD centres. In addition, Eastern Cape and Limpopo which were the other provinces with large portions of the young children population also lacked ECD centres in places such as Makhado in Limpopo and Mbizana in Eastern Cape[35].

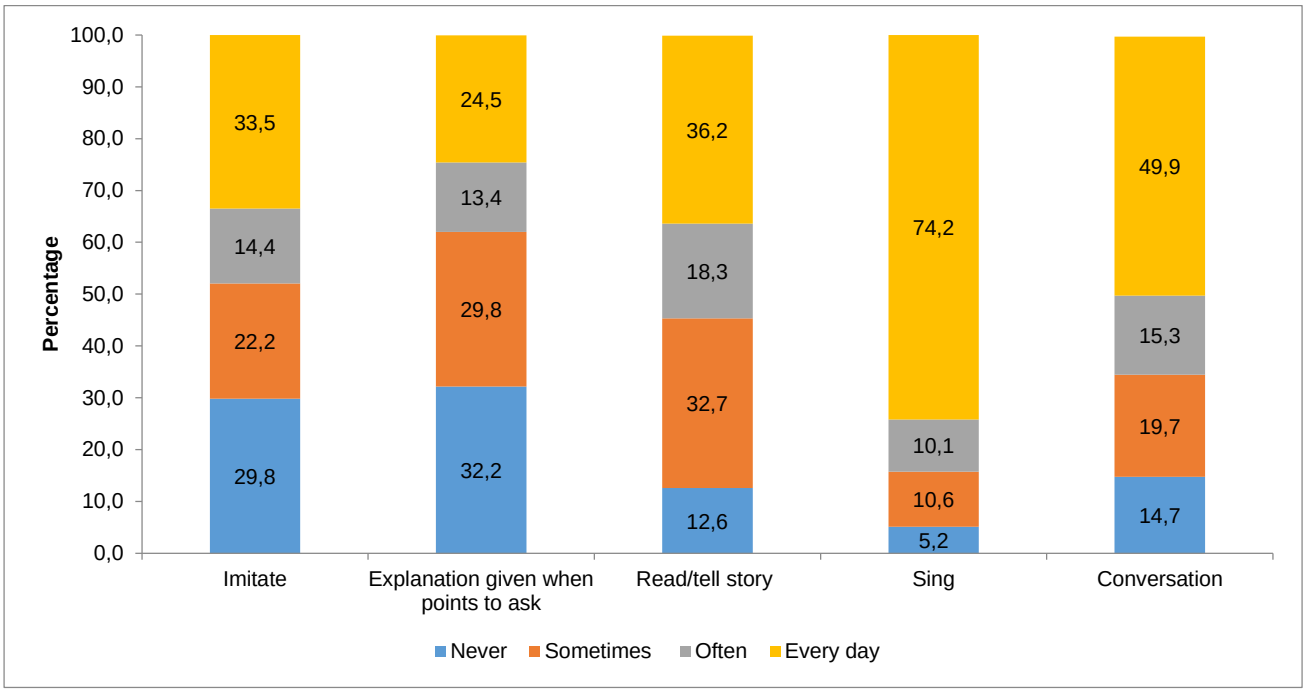
[34] Children population estimates by municipality were derived using the 2016 Community Survey data.
[35] Maps are found in the annexure of the report

Map 4.1: Distribution of the ratio of population of children aged 0–6 to ECD centres, 2013-2014



Source: Department of Social Development, ECD infrastructure audit data

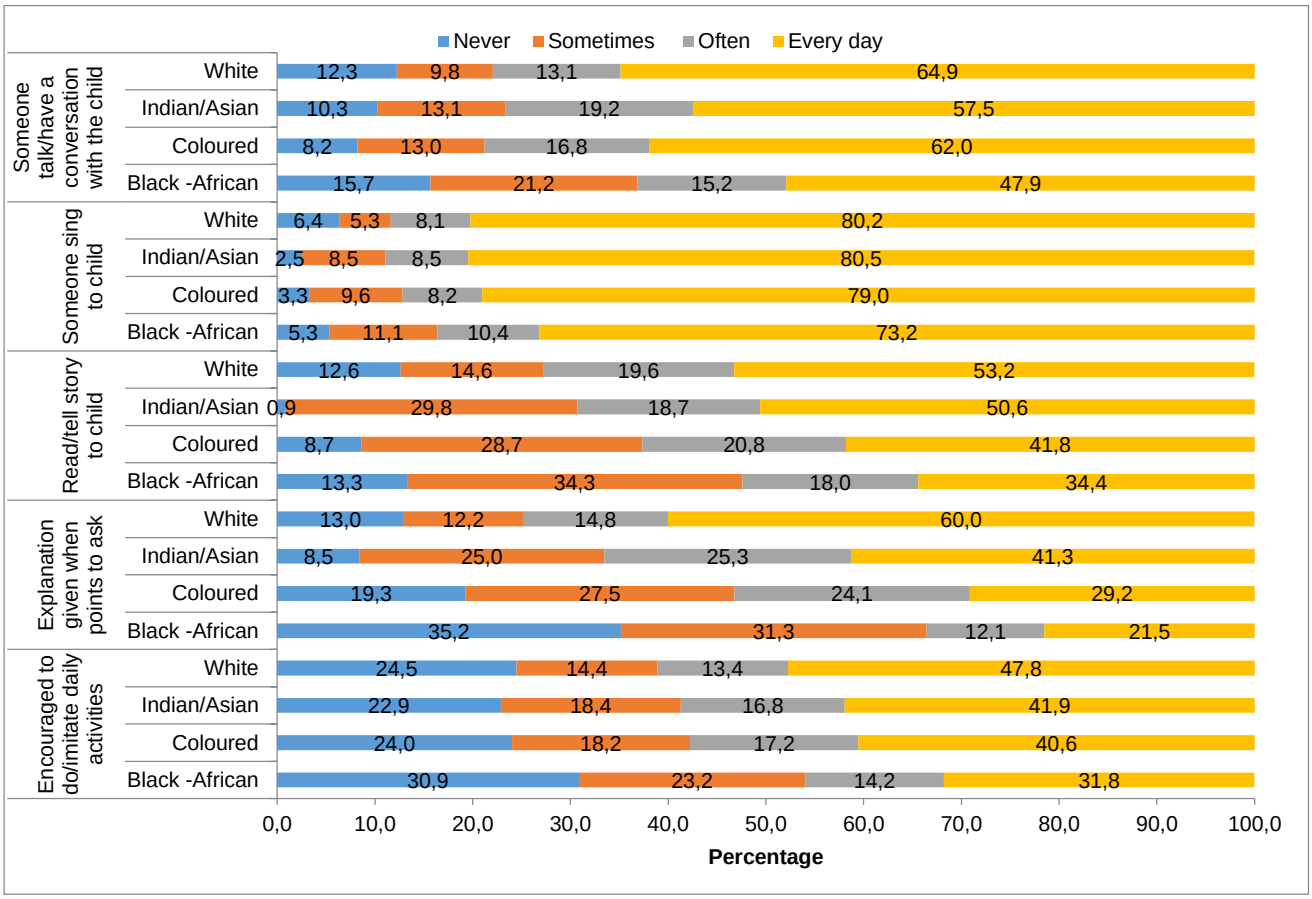
Figure 4.22: Type of stimulation received by children aged 0–6, 2016



Source: GHS 2016

The figure above shows the type of developmentally appropriate practices provided in the households and how often they are provided. The type of stimulation received by infants or pre-schoolers depends on the manner they play or interact with household members. The question was to establish how often someone in the household read or told stories to children; sang to them; encouraged them to imitate daily activities with older children or adults at home; how often the child is told what an object's name is and given an explanation of what the object does; or have conversations with the children. The results show that over two-thirds (74,2%) of children aged 0–6 years were sang to every day and half (50,1%) of parents or caregivers had conversations with the children. However, 32,2% of children were never told what an object's name was and given an explanation of what the object does. The different types of stimulations are necessary for reaching developmental milestones in motor development, language and understanding. The disproportionate acquirement of such aptitudes could lead to inequities that could persist right from infancy through the lifespan of the child (European Commission, 2011).

Figure 4.23: Type of stimulation received by children aged 0–6 by population group, 2016

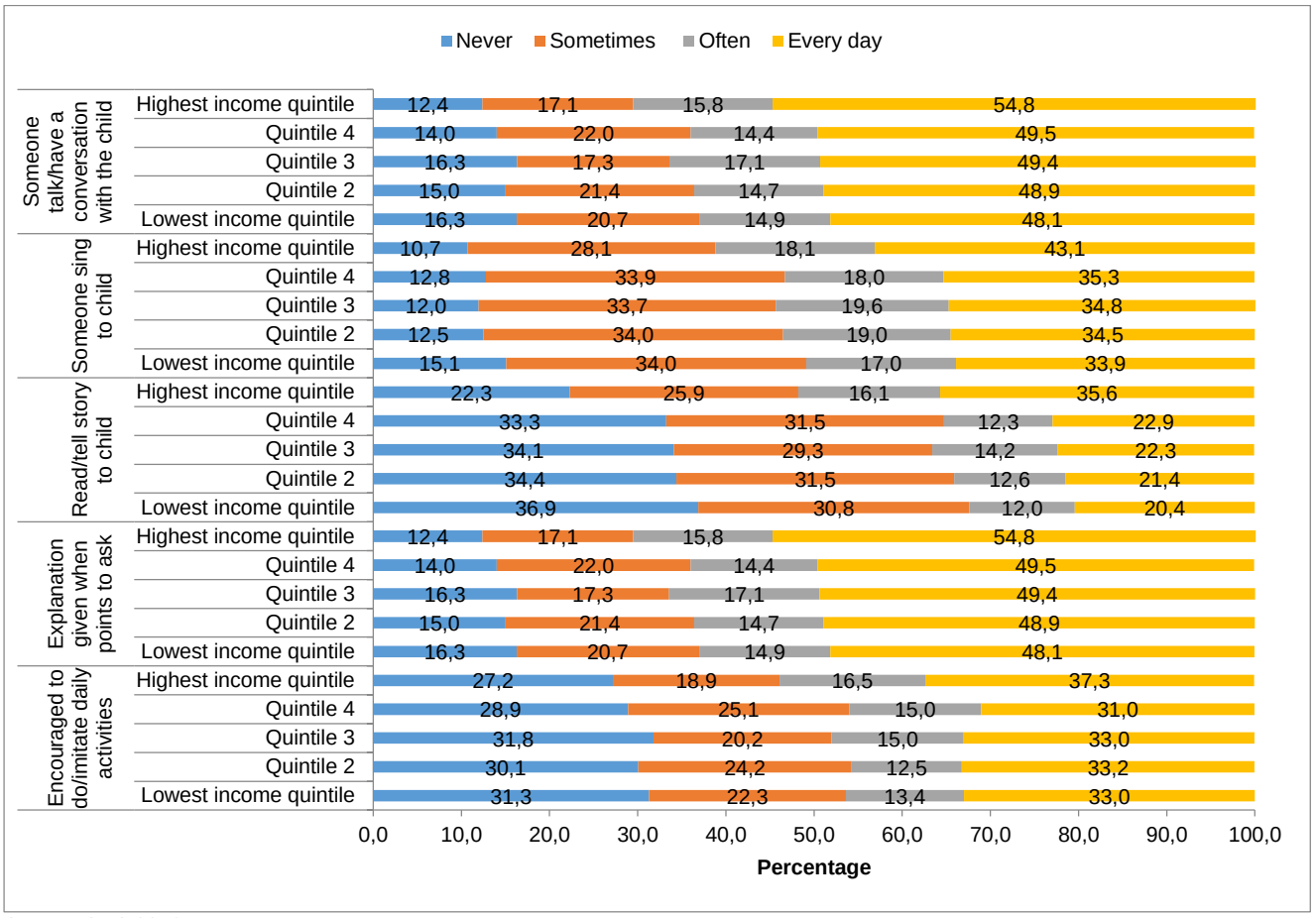


Source: GHS 2016

Differences in population groups regarding the type and frequency of stimulation received by children aged 0–6 can be observed in the graph displayed above. White children received all types of stimulation more frequently than the rest of the population groups. Among white children, 80,2% would have someone sing for them every day while among black African children the same is true for only 73,2% of the children. More than half of black African children aged 0–6 rarely received encouragement to imitate daily activities (never 30,9% and sometimes 23,2%) compared to white children in the same age group (never 24,5% and sometimes 14,4%). Similarly, close to 35% of black African children were never or only sometimes (31,3%) given any explanation when they point to ask.

The figure below shows the type of stimulation received by young children by households' income quintiles. Irrespective of their households' income quintiles, young children were having daily conversations with adults in the households and received explanations daily when they pointed at objects to ask for explanations. However, these two types of stimulation were received more commonly (54,8% every day) in the highest household income quintile compared to the other income groups. Furthermore, the chart shows that close to 36% of young children that belonged to households in the highest income quintile were told stories daily (or read to) as opposed to only 20,4% of children in the lowest households income quintile.

Figure 4.24: Type of stimulation received by children aged 0–6 by households' monthly income quintile, 2016



Source: GHS 2016

4.5 Summary and conclusion

This section described the status of social services and support received by households with young children and their primary care givers. Even though the majority of births that occurred in 2016 took place at health facilities, a large percentage of births that happened in Eastern Cape and KwaZulu-Natal were outside of health facilities. There is a delay in getting births certificates for young children as 11,5% of children under one year did not receive theirs.

Close to 53% of children aged 0–6 were attending some ECD learning facilities in 2016, but access differed by provinces. Gender did not pose any risk in lack of access to ECD services. This report also shows the types of stimulation received by young children. Population group and households income seem to be significantly limiting factors in the type of stimulation received.

According to human capital theory, "ability gaps between individuals and across socioeconomic groups open up at early ages, for both cognitive and non-cognitive skills" (Cunha and Heckman, 2010). The paper concludes that although their own ability plays a role in the development of children, the environment in which they grow up, their parental characteristics, investments and timing of interventions affect the outcomes of these children and could also potentially reduce future inequality.

Chapter 5: Recommendations and way forward

ECD is often described as laying down the foundation in human development by building the neurological mechanisms in young children necessary for future learning. As brain growth and development in infanthood is much faster than during the other periods of the human lifecycle, appropriate care during this phase is important for the development of the cognitive ability of the child. Such care can reduce the risk of diseases and create positive future outcomes for children. The integrated ECD policy in South Africa is aimed at achieving such outcomes for South African children by eliminating the seeds of learning inequalities that still persist in South Africa. Disparities in the survival and health prospects of children in South Africa also depends on their household characteristics. The purpose of the policy is consequently to effectively reach every household at risk and to provide targeted interventions. Since early intervention is key to good outcomes, these interventions start from nurturing babies right from the womb, by providing the most at risk pregnant women and families the ability to access such services. The NDP has also made provision for such interventions as stipulated in the MTSF (2014–2019). The table below describes the current status in terms of selected targets set for 2030 and 2019 respectively.

Table 5.1: Selected outcomes and targets on ECD related indicators

Outcomes	NDP targets by 2030	MTSF targets by 2019	Current status
ECD facility attendance	100%		Children aged 3 who did not attend: 51% Children aged 4 who did not attend: 31% Children aged 5 who did not attend: 14% Children aged 6 who did not attend: 14%
Child undernutrition	0%		Severe acute malnutrition incidence: 3,6% Incidence of underweight-for-age: 21,3% Severe acute malnutrition fatality rate: 8,0%
Antenatal care before 20 weeks		70,0%	61,2%
Low birth weight	0%	11,6%	13,3%
Pregnant women on ART		98,0%	93,0%
HIV transmission to infants	Drop transmission by 2%		1,4%
Post-natal care within 6 days of delivery		80,0%	76,1%
Full immunisation of infants		95,0%	71,3%
Under 5 mortality rate	30 per 1 000 live births	33 per 1 000 live births	44,4 per 1 000 live births
Infant mortality rate	20 per 1 000 live births	23 per 1 000 live births	33,7 per 1 000 live births
Births registered within 30 days		74% (810 000)	87,1%[36] (876 435[37])
Serious crimes against children		38 785	40 689

The above table provides current positive achievements in health and education; however a number of challenges need to be addressed. Malnutrition at a very young age needs immediate attention; North West, Free State and KwaZulu-Natal had most young children who were underweight and stunted. Government feeding programmes target mostly primary and secondary schools with limited service to only some ECD centres. More targeted feeding scheme interventions need to be done either through the primary health care system or through social services to reach all children at risk of malnutrition. Nutrition interventions for pregnant women at risk need to be put in place in order to prevent low birth weight.

[36] 2010 values
[37] 2016 values

Infant and under five mortality rates in 2016 were very far from the set targets for 2019 of 23 and 33 per 1 000 live births respectively, which would most likely not be achieved, unless government accelerates its intervention towards prevention and further policy adjustments that can expand to better health care. While it should be noted that birth registrations had improved considerably, some households with young children were still not able to receive their children's birth certificates within the required 30 day period.

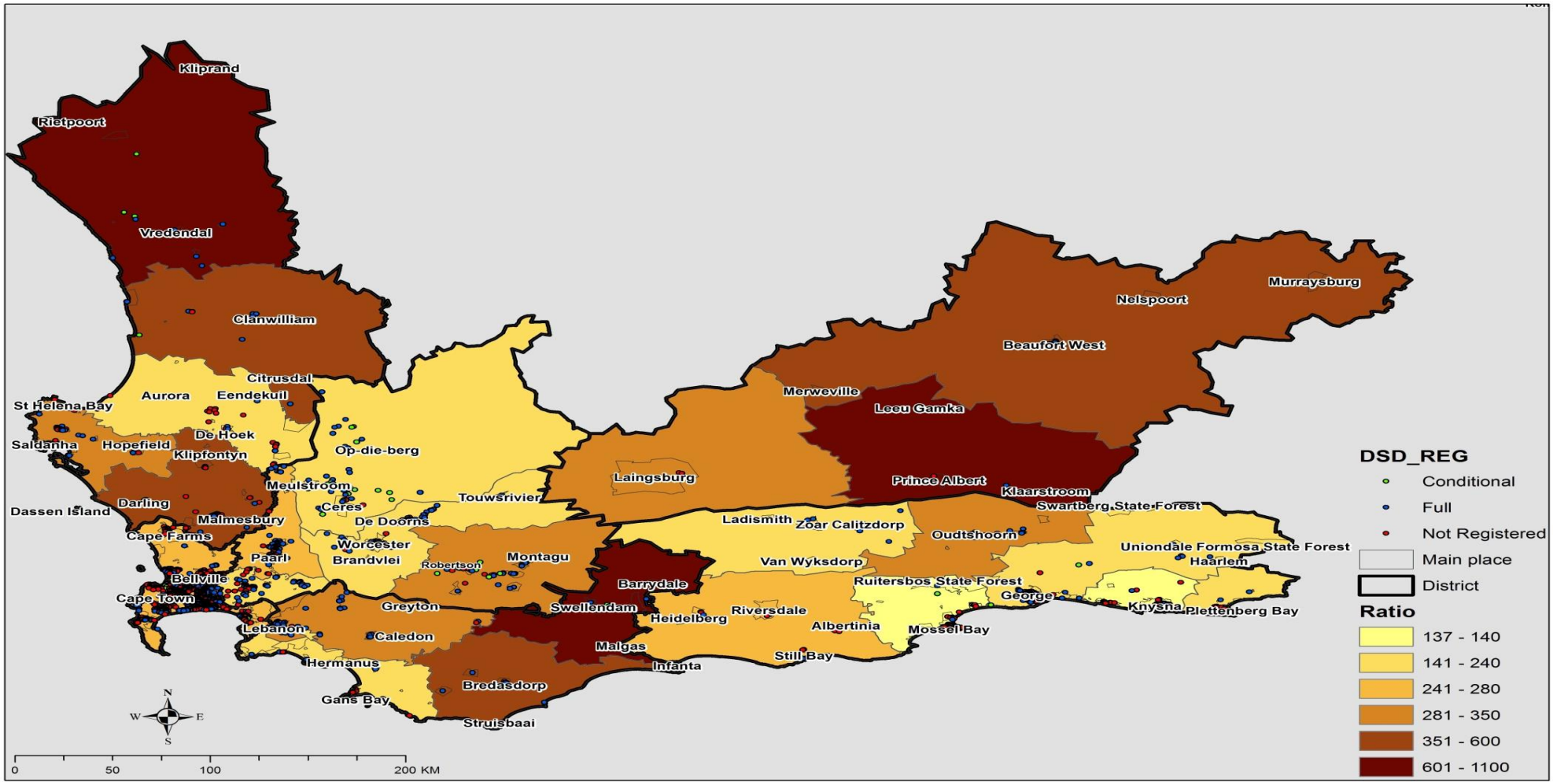
Access to basic services impacts child development. Access to electricity amongst households with young children was above 88%; however access to this service in provinces such as the Eastern Cape (83,9%), KwaZulu-Natal (86%) and Gauteng (86,3%) were below the national average and hence need improvement. This is because in these provinces, paraffin, which is an unsafe source of energy for cooking due to the poor quality of the stoves used, were mostly used in households with young children (Eastern Cape 31,7% and Gauteng 29,4% respectively). Access to piped water on site for households with young children showed clear inequalities in service delivery with Eastern Cape (35,1%) having the worst access and Gauteng the best access (94,1%). Access to improved sanitation was low in Limpopo, Mpumalanga and North West provinces. Households in these provinces rather used poor sanitation facilities that include pit toilets and bucket toilets that put young children at risk of death or diseases.

Attendance of any ECD programme for young children is necessary as part of school readiness of children by the time they have to enrol in Grade R. Unfortunately, as the above table suggests almost half of three year old children did not attend any ECD learning program (49%); close to 29% of children aged 4 did not participate in ECD learning; and among children aged 5 or 6 close to 13% each did not go to any facility or participated in ECD related learning. By way of intervention in this domain, government has created a conditional grant to provinces to realise early access to learning programmes for young children.

Investment in ECD programmes by government is pragmatic and has a strategic importance because of its ethical justification around social justice. It would also provide the means for households to escape the poverty traps through the next generation that could engage in more sustainable livelihoods due to better opportunities afforded to them. Hence government effectiveness of efforts to reach those in greatest need requires integration across sectors to address the overlapping deprivations and challenges children face.

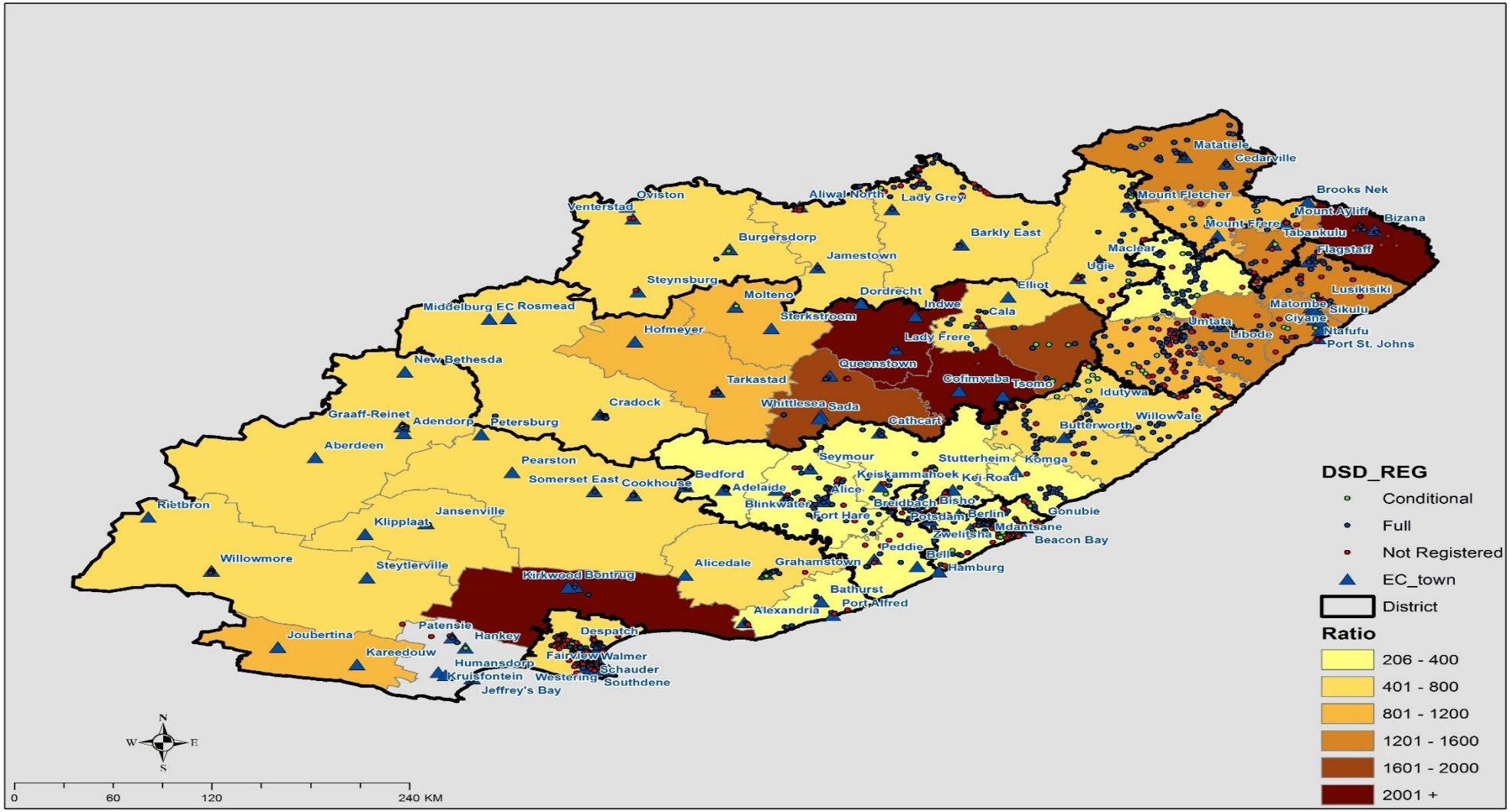
Annexure

Map A.1: Distribution of the ratio of population of children aged 0–6 to ECD centres, Western Cape, 2013–2014



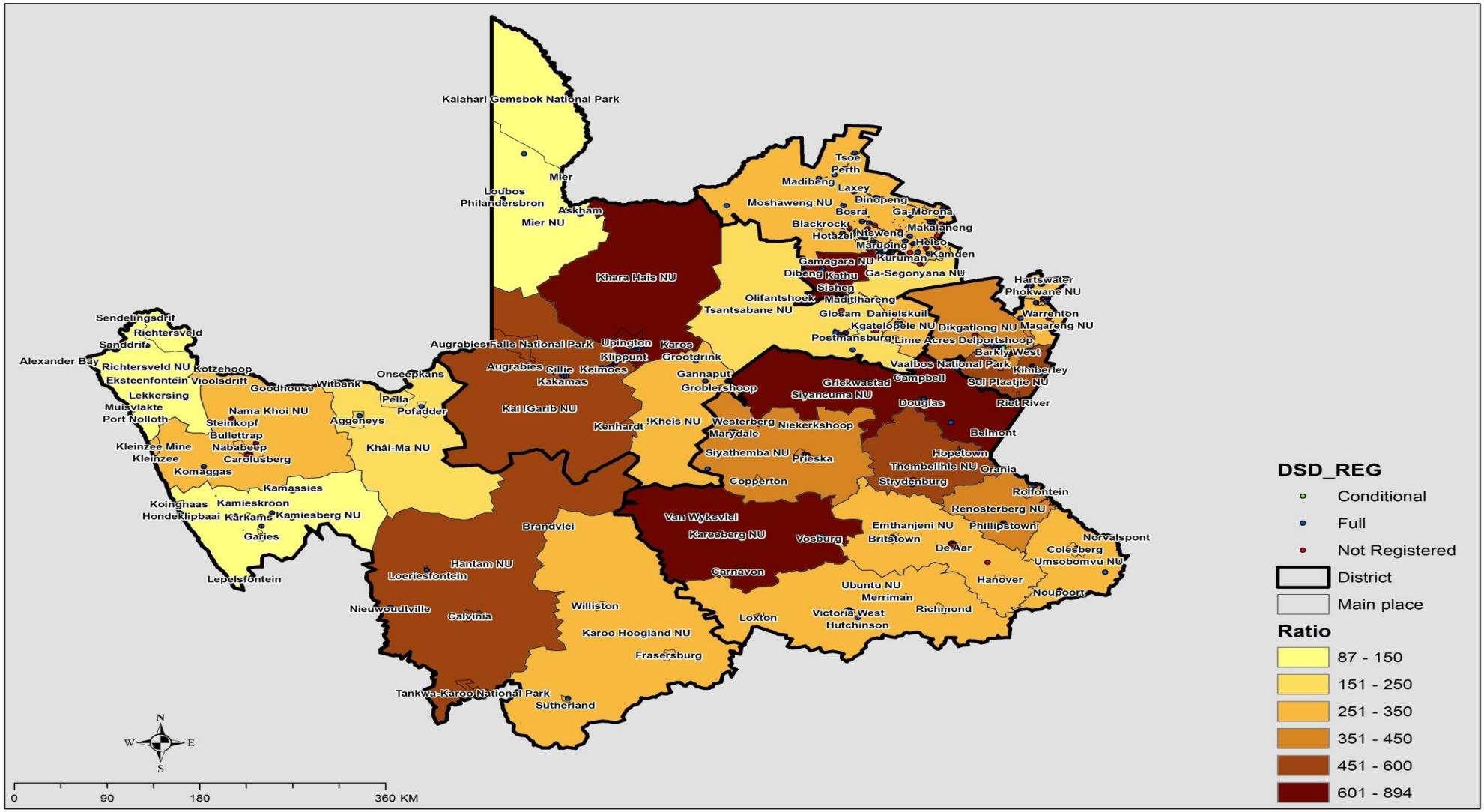
Source: Department of Social Development, ECD infrastructure audit data

Map A.2: Distribution of the ratio of population of children aged 0–6 to ECD centres, Eastern Cape, 2013–2014



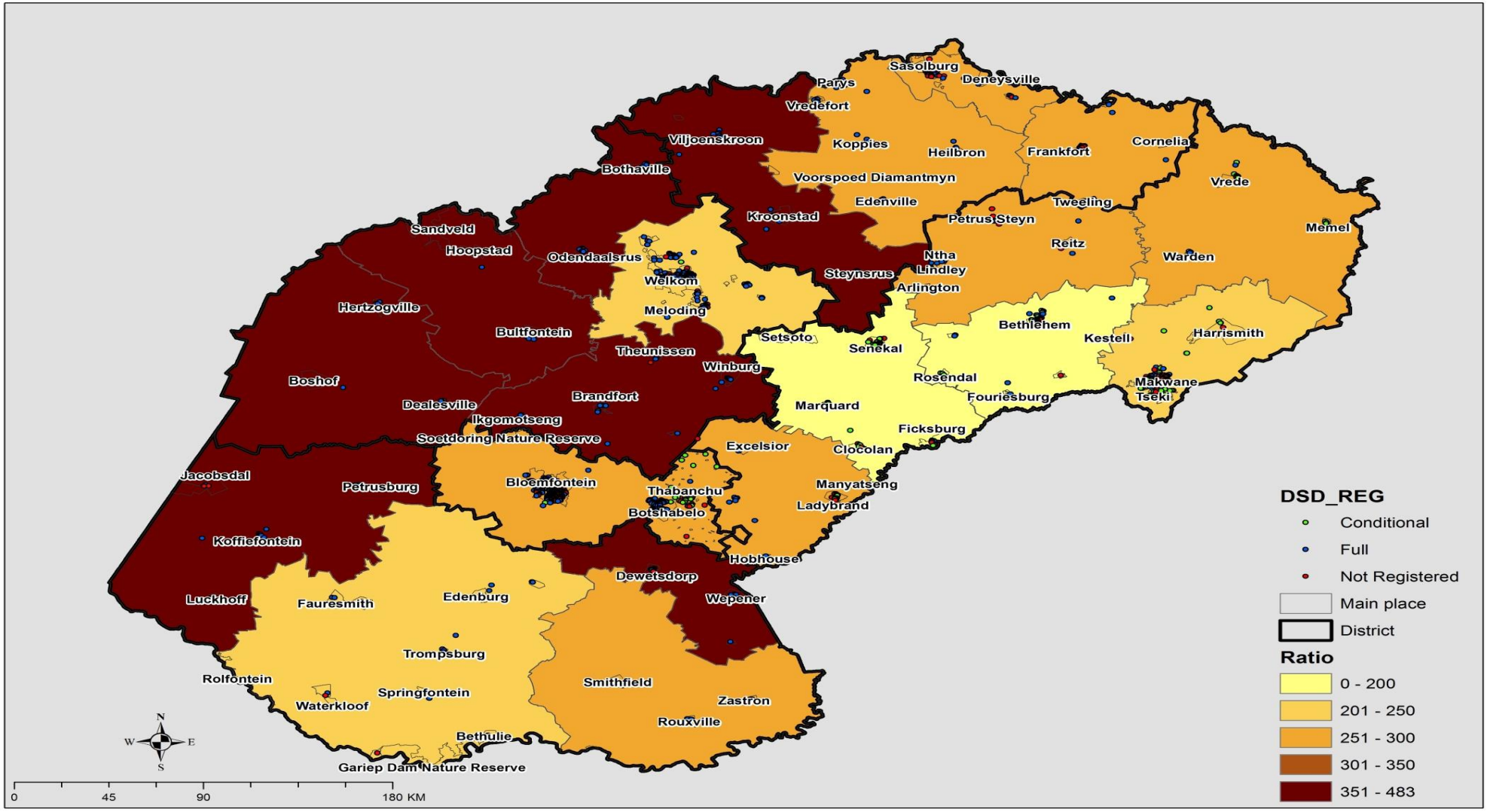
Source: Department of Social Development, ECD infrastructure audit data

Map A.3: Distribution of the ratio of population of children aged 0–6 to ECD centres, Northern Cape, 2013–2014



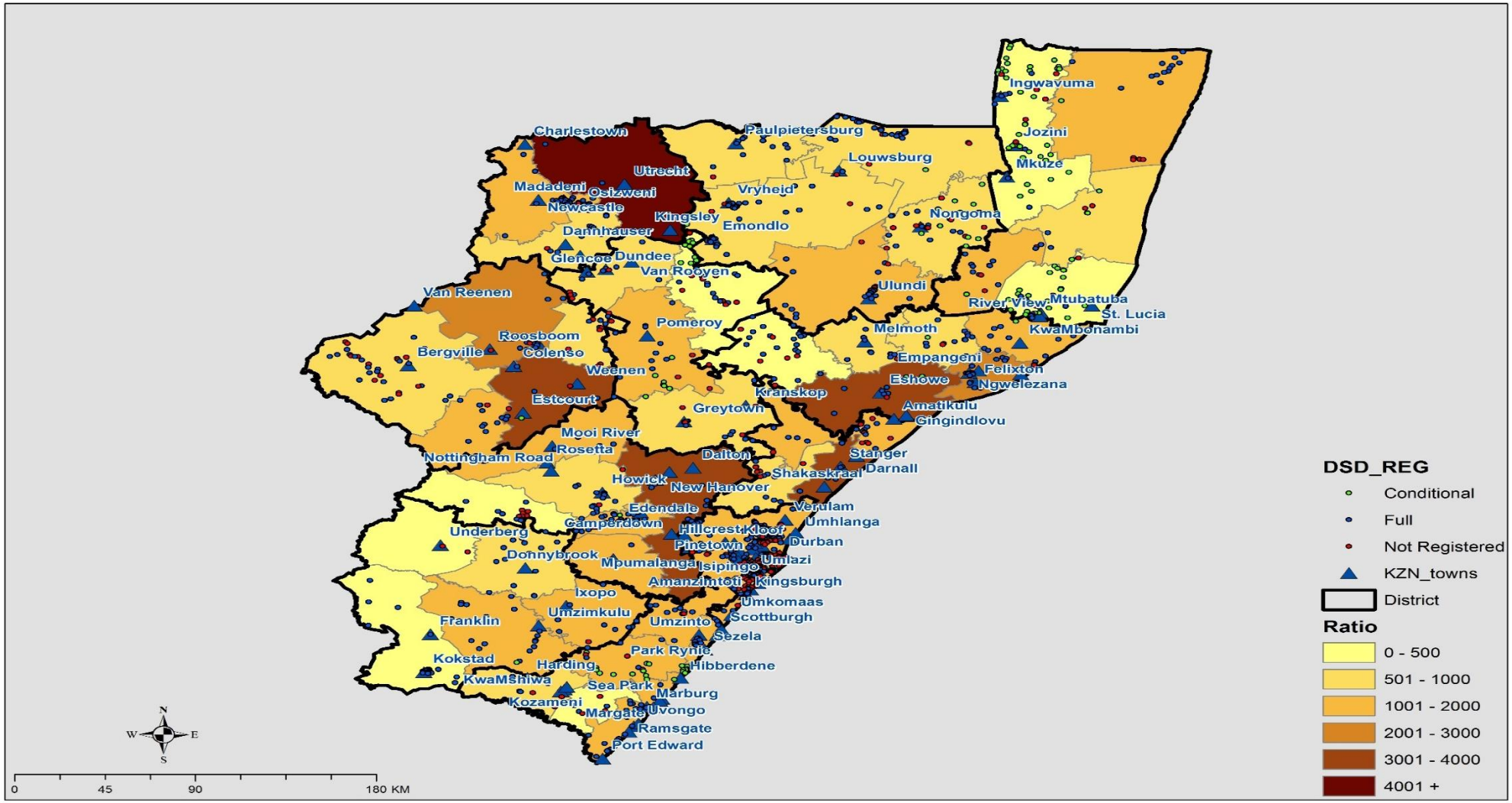
Source: Department of Social Development, ECD infrastructure audit data

Map A.4: Distribution the ratio of population of children aged 0–6 to ECD centres, Free State, 2013–2014



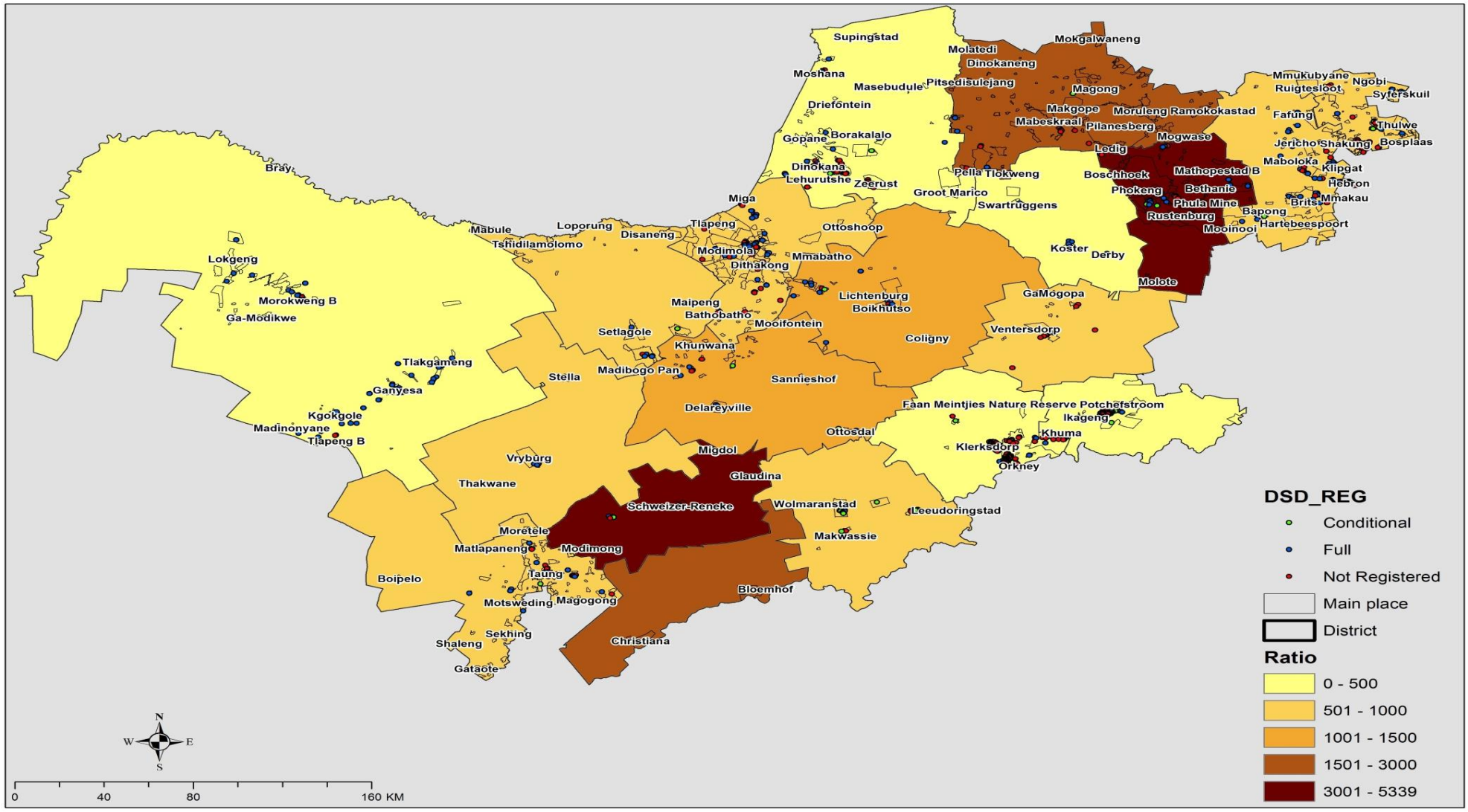
Source: Department of Social Development, ECD infrastructure audit data

Map A.5: Distribution of the ratio of population of children aged 0–6 to ECD centres, KwaZulu-Natal, 2013–2014



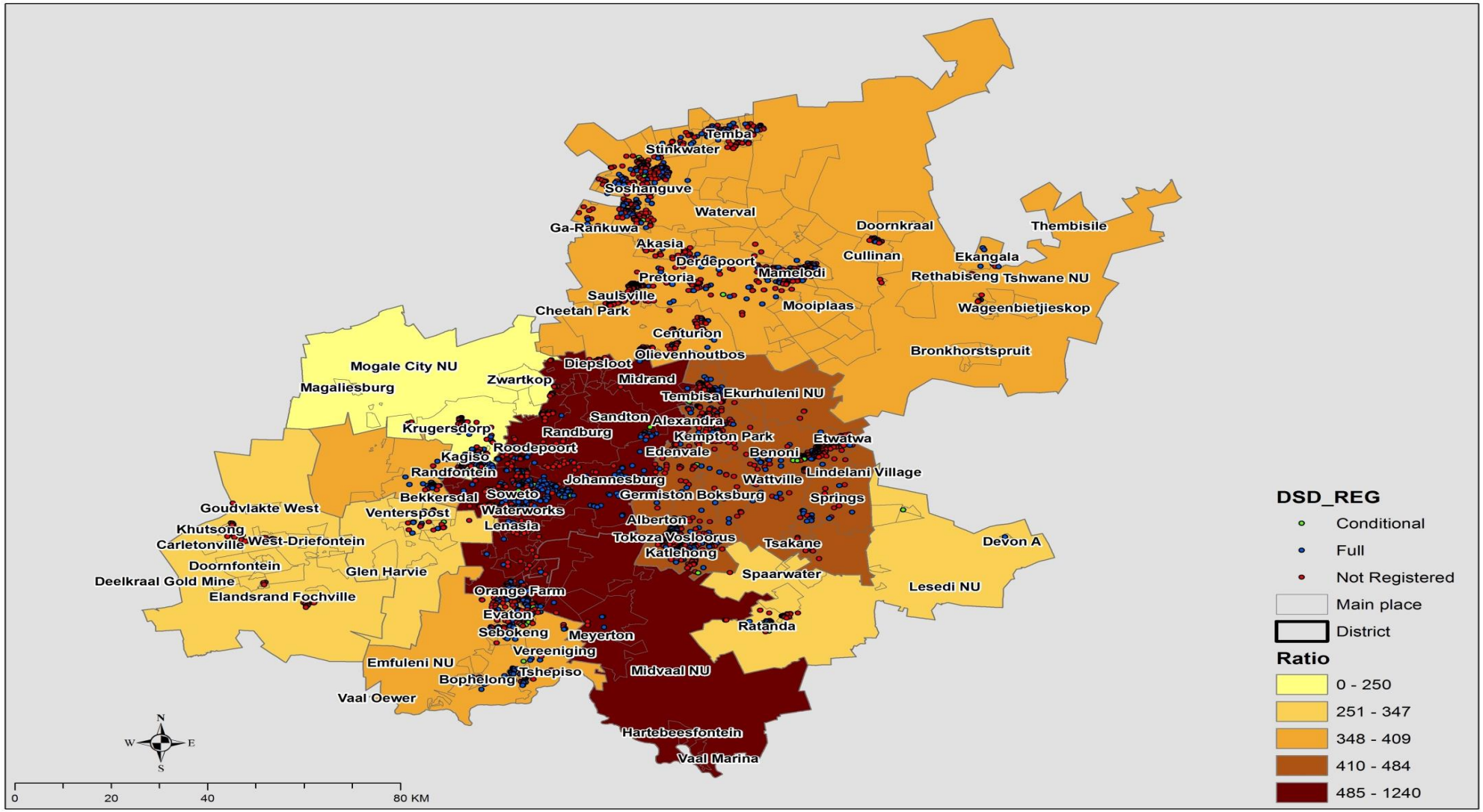
Source: Department of Social Development, ECD infrastructure audit data

Map A.6: Distribution of the ratio of population of children aged 0–6 to ECD centres, North West, 2013–2014



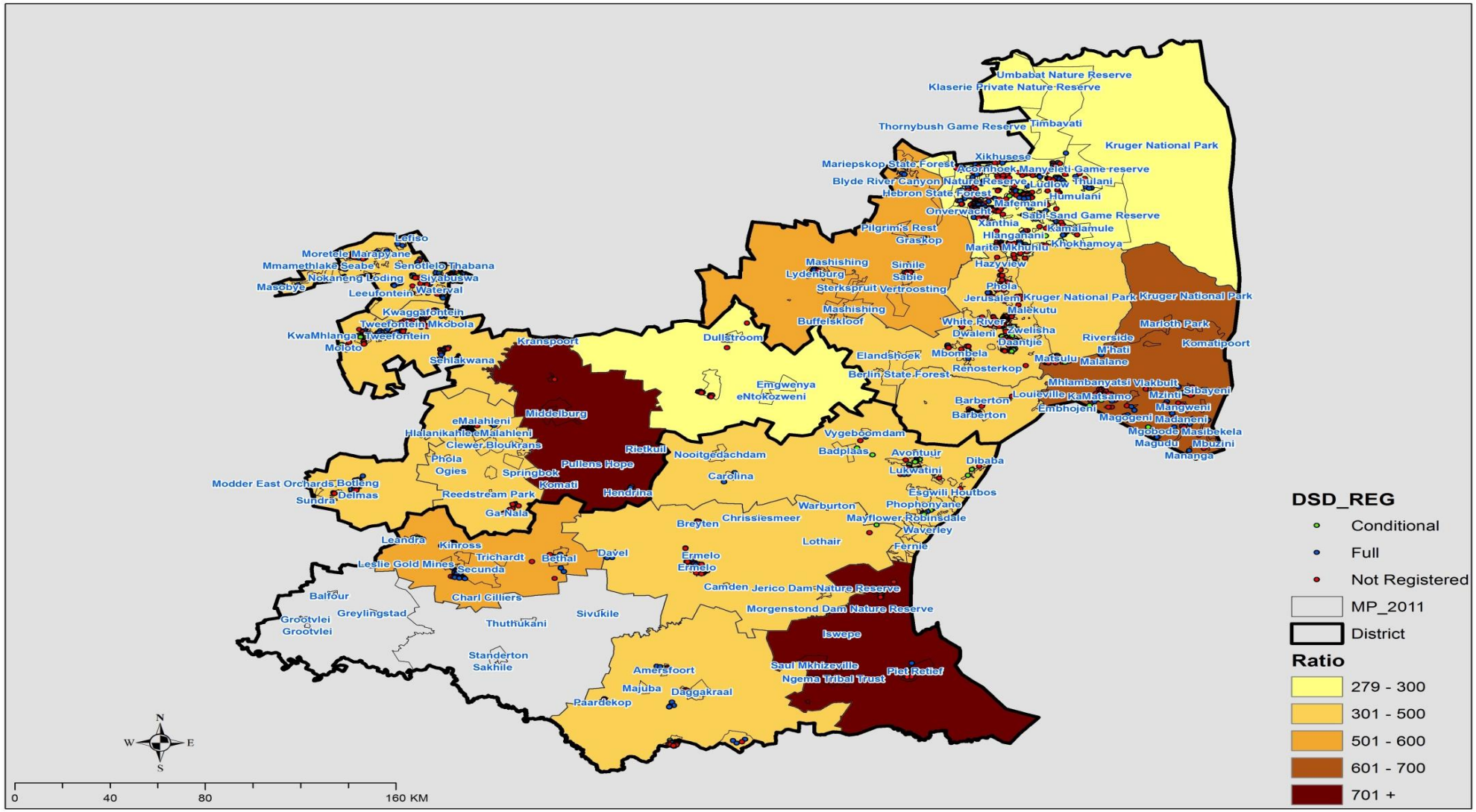
Source: Department of Social Development, ECD infrastructure audit data

Map A.7: Distribution of the ratio of population of children aged 0–6 to ECD centres, Gauteng, 2013–2014



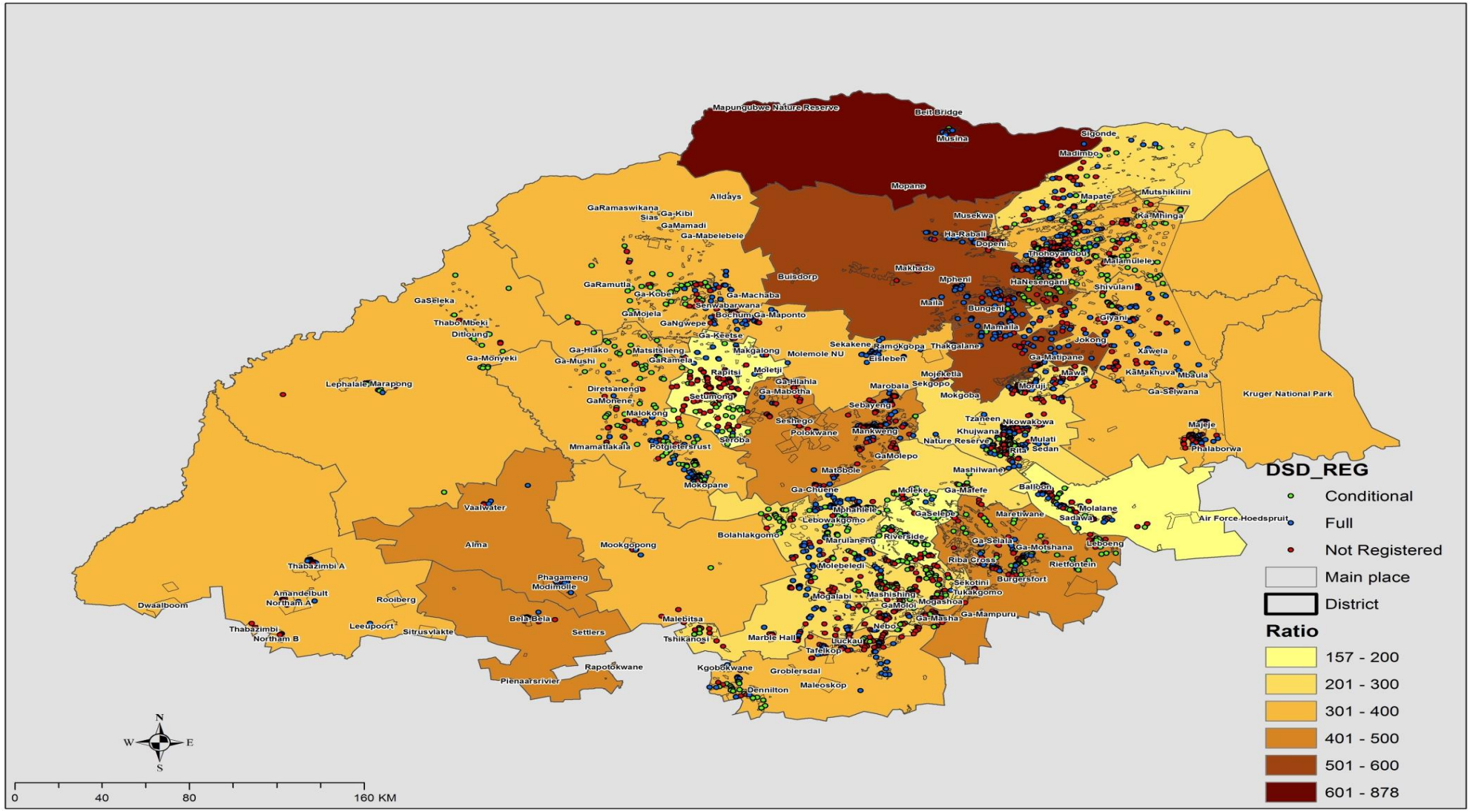
Source: Department of Social Development, ECD infrastructure audit data

Map A.8: Distribution of the ratio of population of children aged 0–6 to ECD centres, Mpumalanga, 2013–2014



Source: Department of Social Development, ECD infrastructure audit data

Map A.9: Distribution of the ratio of population of children aged 0–6 to ECD centres, Limpopo, 2013–2014



Source: Department of Social Development, ECD infrastructure audit data

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