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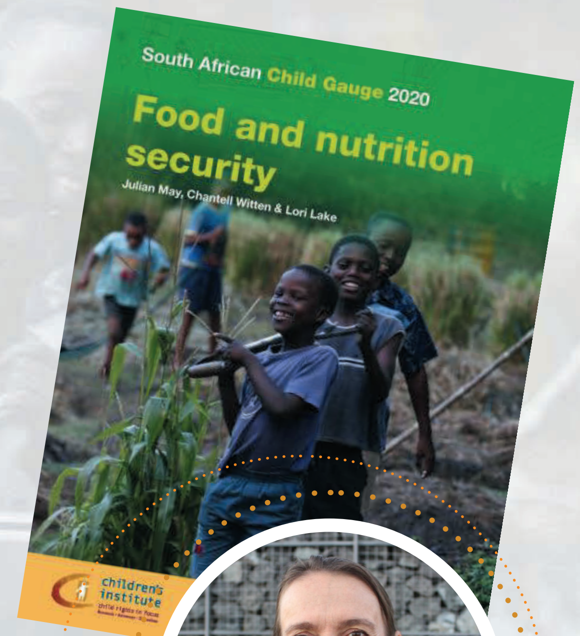


2020 South African Child Gauge

The slow violence of child hunger

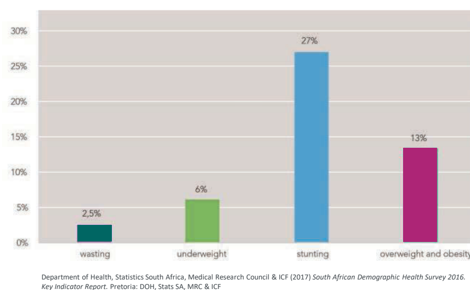
Julian May, Chantell Witten & Lori Lake

Thank you. It's a real pleasure to be here and to be part of the NACCW conference. I'm a huge fan of your work in the life space of children. I am going to be sharing findings from the 2020 issue of the South African Child Gauge which was led by Professor Julian May of the University of the Western Cape and Chantal Witten who is a dietitian and lecturer in health science education at the University of the Free State. This presentation is the fruit of a collaboration with over 60 authors from universities around the country bringing together many different disciplines to develop a holistic understanding of what is happening in relation to nutrition and food security for South Africa's children.

Why should we care about child malnutrition?

In South Africa we are experiencing what is called the double burden of malnutrition. We can distinguish between undernutrition, where children are not getting enough nutrients to thrive and grow, and overnutrition where children are getting too much of the wrong kinds of food to grow and thrive. Data from the 2016 South African Demographic Health Survey show that wasting and underweight are not a public health concern in South Africa, but we are very worried about the one in four young children who are stunted or short for their age. These very high rates of stunting have remained stubbornly unchanged for over 20 years so there's a real question about why we are doing so badly and what needs to change. At the same time, we're equally concerned about the growing problem of overweight and obesity which is affecting one in eight of our young children. We also know that these early experiences of either under or over nutrition cast a long shadow across the life course. A mother who is undernourished is more likely to have a low-birth-weight baby and those low-birth-weight babies are more likely to become stunted children and stunted adolescents. This is an intergenerational cycle where the

The double burden of malnutrition



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

- 1 in 4 young children are stunted or short for age
- **1 in 8** young children are **overweight or obese**

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health and nutrition of the mother starts to impact on the health and nutrition of her children and her grandchildren.

We also know that stunted children are at greater risk of becoming overweight or obese as adolescents and of developing what we call diet-related non-communicable diseases (NCDs), such as diabetes and heart disease. And these very same NCDs are increasing the risk for severe COVID infection and hospitalization.

If we want to break this cycle of poor nutrition and poor health, we need to intervene very early on in childhood. Children who are undernourished, who are stunted, are not simply short for their age, the undernutrition is stunting both their physical growth and their developing brains in ways that makes it difficult for children to learn, and this has implications for education and their employment prospects.

Obesity is increasing rapidly with age and over time. Girls are far more affected by overweight than boys and rates have escalated from below 10% to close to 30% from 2000 to 2015. Over 60% of adult women are overweight in South Africa and that's a real concern when we understand the link with NCDs. Obesity affects close to 40% of adult women leading to very high and increasing rates of diabetes. This is a concern not just for the individual woman and child, it places a significant cost burden on the health care system.

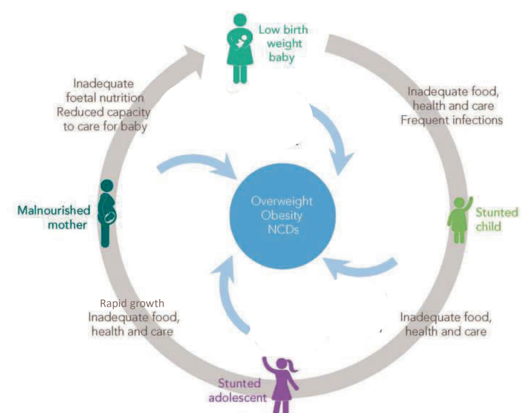
We chose to focus in the issue of the *South African Child Gauge* on the 'slow violence of malnutrition'. This concept was first developed to describe what's been happening with climate change and how the impacts of climate change often happen really slowly on the very edges of society, and affect communities who don't have a very powerful voice in in political and economic decision-making. So, when we talk about slow violence and malnutrition we're looking at the way in which it is causing often permanent damage to the developing body and the developing brain, very slowly in ways that are largely invisible and this delayed destruction is very often not being recognized as violence at all. We wanted our audience and policy makers to understand the very real damage that malnutrition is doing to our children's bodies and brains.

What are the drivers of child malnutrition in South Africa?

In 2010 UNICEF developed a conceptual framework to help us understand some of the key drivers of malnutrition. The two most immediate causes are inadequate dietary intake (not having sufficient food or the right kinds of food or a diverse enough diet for optimal growth and development) and infection (For example, a child who experiences diarrhoea is likely to lose a significant amount of weight and it is

A long shadow across the life course

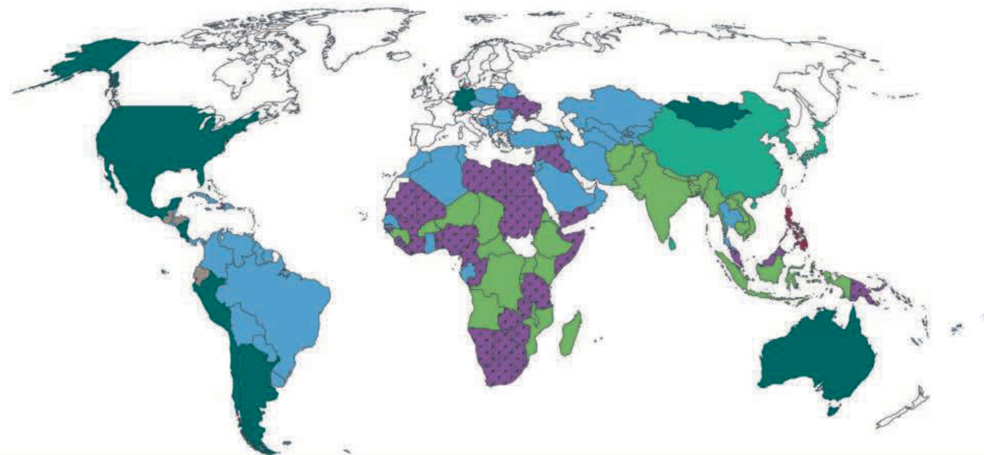
- Undernourished mothers are more likely to have low-birth-weight babies and stunted children.
- Stunted children are at a greater risk of becoming over-weight or obese as adolescents – and developing diet-related NCDs such as diabetes and heart disease.
- In other words, we need to intervene early in childhood to break this intergenerational cycle of ill-health and poverty.



Adapted from: Branca F, Piwoz E, Schultink W, Sullivan LM. Nutrition and health in women, children, and adolescent girls *British Medical Journal*, 2015; 351: h4173

Map of childhood stunting and anaemia and overweight in adult women, 2017 and 2018

Insufficient data
Overweight only
Anaemia only
Stunting only
Overweight and anaemia
Overweight and stunting
Anaemia and stunting
Overweight, anaemia and stunting



South Africa is performing poorly relative to other middle-income countries.

Source: UNICEF/WHO/World Bank Group. Joint child malnutrition estimates. NCD Risk Factor Collaboration. WHO Global Health Observatory.
Notes: Stunting in children aged under 5 years ≥ 20%; anaemia in women of reproductive age ≥ 20%; overweight (body mass index ≥ 25) in adult women aged ≥ 18 years ≥ 20%. Based on data for 141 countries.

quite difficult to help that child catch up the weight that they have lost). We also know that disease makes children more vulnerable to malnutrition, and malnutrition itself makes children more vulnerable to disease. We start to see a cycling of malnutrition and infection. At the level of the household or the community, we are concerned about inadequate access to food and inadequate access to care, and so responsive caregiving is an important element – recognizing when a child needs to be fed, particularly with early infant feeding, and responding to that need. The care element is really important and maternal depression can make it very difficult for mothers to respond appropriately or feed appropriately. Insufficient access to health care services and unhealthy living conditions cluster in certain communities and are rooted in political and economic and historical inequalities. So, we also need to look at the structural drivers that underpin the patterns of underweight and obesity. In South Africa 60% of children are living below the poverty line and roughly 30% of children do not have water on site. One in ten children live without electricity, which is a problem in terms of refrigeration and keeping foods safe and to prevent diseases like diarrhoea. One in five children live far from their health facility. These kinds of challenges, again, tend to cluster in particular communities or groups of children and they create a knock-on effect or cumulative pattern of disadvantage over time.

We also know that individual food choices are shaped in very powerful ways by the local food environment. In spaza shops many products are highly processed foods and they're very high in salt, sugar and trans and saturated fats – all of which are bad for children and are obesogenic. But these are the foods that are widely available, cheap, convenient and are flooding our local markets. So, we need to also interrogate the role of this broader global food system and big multinational corporations that dominate that system who are producing these unhealthy ultra-processed foods. Such companies are very explicitly expanding their markets in the global South and are also targeting children as an emerging market. For example, the first introduction to very sweet, salty food sets that taste for those kind of foods across the life course.

We also need to pay attention to the impact of the COVID-19. There has been a significant rise in food prices together with rising unemployment, affecting up to nearly 50% of work seekers with women far more likely to have lost their jobs than men. At the same time, we saw the closure of schools and ECD programs which removed an essential daily meal or source of nutrition support. As a result, we saw a rise in child hunger affecting 15% of households in April/May 2021. One in seven households reported a child had gone hungry in the week preceding this survey. Globally there have been projections of a 14%

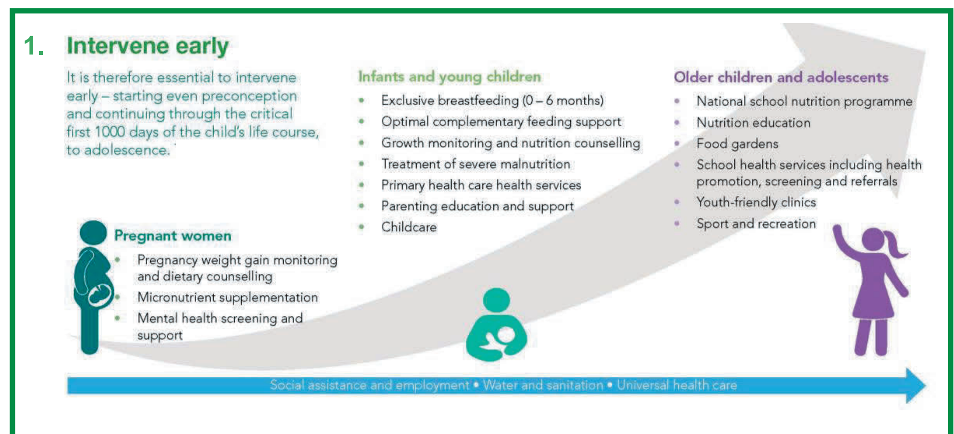
increase in wasting, and wasting is a particularly severe form of acute malnutrition. It is a key driver of under-five mortality in South Africa, and 50% of all child deaths in hospital in South Africa are associated with either severe or moderate acute malnutrition.

Poor families have tried to shield their children from the effects of the pandemic by shifting the kinds of foods that they buy. More families are buying starch and doing away with fruits, vegetables, proteins that contain the macro and micronutrients that children need to thrive. We have also seen a significant disruption in children's access to healthcare services.

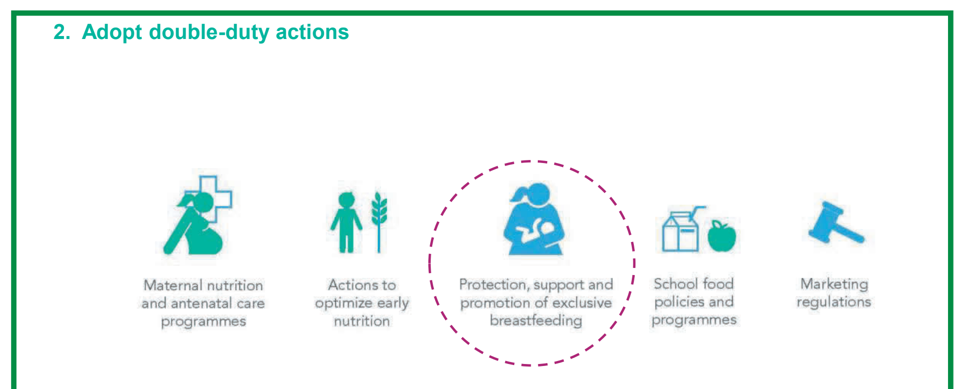
There is also a concern that those children who are hungry and malnourished are not accessing health care services and are therefore not being counted and are not receiving the kind of support that they need. So a key call coming through this issue of the Child Gauge is a call to strengthen surveillance systems to ensure that those children are identified at community level and linked up to support.

Three guiding principles

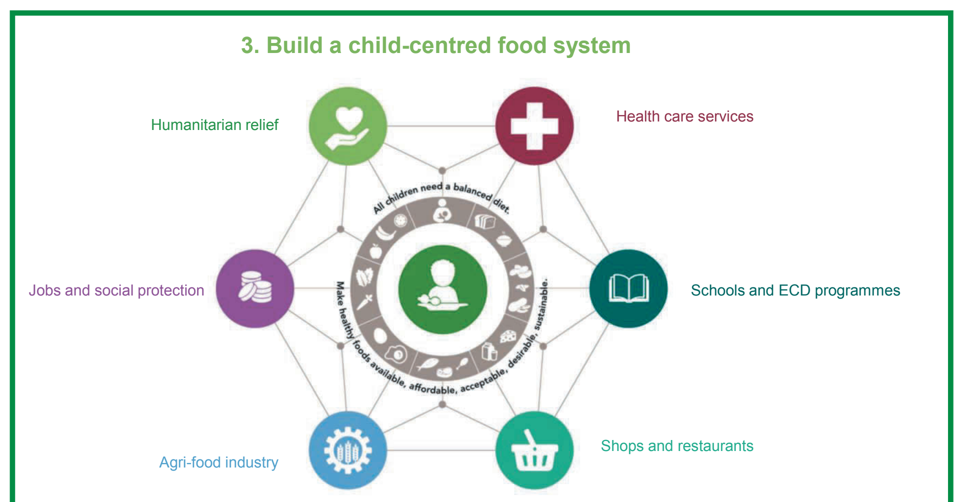
We identified three guiding principles for action, for moving forward and taking on this this very complex challenge.



The first is a strong call to intervene early. This means intervening even preconception in order to improve the health of adolescent girls and women so that we have a strong foundation for pregnancy and fetal development – and then to continue that support through pregnancy and the first 1000 days of life. There is a clear package of services and interventions that should be developed, delivered primarily through health care but also looking at mental health screening and support, parenting education and access to Child & Youth Care.



The second guiding principle is to adopt a double duty action approach. Every intervention that we put in place should not only address undernutrition but also protect children from overnutrition. So, for example, we know that breastfeeding is particularly effective in promoting optimal growth and development. It also prevents infection and it has been found to



lessen the risk of obesity later in life. This would be a good example of a double duty action. Equally important if we're thinking about school feeding, we need to make sure that the meals we offer are healthy meals, that are not full of sweet, salty, fatty foods that may address undernutrition but may increase the burden of overweight and obesity. We need to interrogate all our different interventions to make sure that they support this double-duty action approach.

The third guiding principle is to build a child-centered food system. We need to put the child at the center of our efforts to improve nutrition and food security in South Africa. In order to achieve this we have to pull together a whole range of different role players. We need to look at the kinds of foods that are stocked in shops and restaurants, and create incentives for more healthy options or subsidies to make healthy foods more affordable. We need to engage with the agri-food industry who are responsible for developing those products, and we also need to improve access to jobs and to social protection in the form of grants, given the very high levels of child poverty in South Africa. And we need to think about the nutritional needs of children and in our humanitarian relief efforts what goes into those food parcels and are these healthy and appropriate especially for infants and young children?

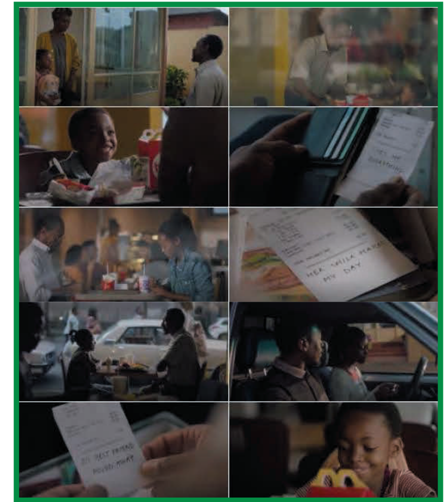
Six opportunities for intervention

The Child Gauge identifies six opportunities for intervention.

The first step it to **invest in maternal health and nutrition**. Nutritional needs increase quite dramatically during pregnancy and there's a real danger of micronutrient deficiencies, which are a threat to the health of mum and baby. But we also know that food insecurity increases the risk of maternal mental health disorders such as depression which may then undermine women's capacity to both feed and care for their children. We need to be providing micronutrient supplements, making sure that women are accessing antenatal care early within the first 20 weeks of pregnancy and we need to be also monitoring weight gain and providing appropriate dietary counseling so that women don't become overweight and obese during their pregnancy. We need to extend social assistance to pregnant women, and we need to be screening for mental health and domestic violence and making sure that women receive support, so that they're not carrying those problems forward with them once their children are born.

Step two is to **enhance infant and young children's feeding practices.** Breastfeeding gives children the best possible start in life, and yet infant breastfeeding rates in South Africa are way below the World Health Organization's target of 50%. We also know that only one in four infants from six to 23 months are being fed a minimum acceptable diet and that means that they're not getting a diverse enough diet with many

different kinds of foods to ensure that they access vitamins and minerals – and that they are not eating frequently enough during the day. One in three children under two are already eating salty snacks and sugary foods that are likely to set them up for developing overweight and obesity later on. So, we need to be increasing support for breastfeeding women within the home and in the workplace and monitoring baby growth regularly, so that we can identify exactly when children's growth starts to falter. In this way we can take action immediately and ensure that they catch up their growth and are referred to support.



Step three is to **invest in early childhood development.** The ECD subsidy is intended to promote more equitable access to ECD programmes in South Africa, and 40% of that subsidy is meant to contribute to a daily meal. But because the registration requirements are so challenging, the subsidy is only reaching 10% of preschool children (whereas the national school nutrition programme (NSNP), supports 77% of school children). In addition to the challenges of registration, there's a means test, so individual children and their families need to provide evidence that they qualify for this subsidy and that means this is not aligned with the CSG. There is a real need to iron out those challenges and particularly to align the means test with the CSG, to allow grant recipients to automatically qualify for the ECD subsidy.

Step four is to **improve school nutrition for older children and adolescents.** The NSNP provides a daily meal to over 9 million learners and it's been found to improve punctuality, attendance and concentration. But it was suspended during the lockdown and it was only reinstated following court action. We also need to look at the quality of school meals and there are guidelines in place both for the NSNP and for school tuck-shops. But these are just guidelines and they really need to be monitored and enforced if they're going to start to have an impact on child health and nutrition.

There is also a concern that children are becoming increasingly sedentary. Less than half of learners get sufficient daily exercise, and 1 in 3 schools are without sporting facilities. So, there is a need to create safe and healthy school environments that promote sport and physical exercise, particularly for adolescent girls who may have safety concerns about exercising out in their communities.

Step five is to **protect children from harmful business practices.** International fast food companies spend over five million dollars a day globally on marketing unhealthy foods to children. These companies use sophisticated marketing techniques to exploit children's fantasies and build brand loyalty. For this reason, the World Health Assembly has called on states to protect children from the marketing of unhealthy food and beverages and in 2014 the National Department of Health introduced Regulation 429 that aimed to restrict the marketing of unhealthy food to children. However, due to resistance and pushback from the food industry this has not been implemented.

Lastly, we need to **strengthen social protection** – particularly in the context of rising unemployment and food prices. The ECD subsidy is one example of social protection, but that reaches a very small proportion of young children, whereas the CSG has much broader reach. But even the CSG is only reaching four out of five young children in poor households, so we need to close this gap in coverage. The other source of support is social relief of distress and this includes DSD's zero hunger campaign that enables malnourished children to access a voucher, food parcel or cash. But this social relief of distress support is an even smaller monthly amount than the CSG. So these forms of relief are entrenching stunting – as the grant amount is simply not enough to meet even the nutritional needs of the child. The sugar tax has helped limit

the consumption of sweet and sugary beverages, so we can also use taxes to limit consumption of unhealthy food and introduce subsidies to make a basket of healthy foods more affordable.

A child rights imperative

In conclusion, we are calling for a whole-of-government, whole-of-society approach to put children at the very heart of our food system. This is because children's nutrition is a child rights imperative and the state has an immediate obligation through section 28 of the Constitution to respect, protect, promote and fulfill children's rights to basic nutrition. Even in an economic crisis, the state may only introduce regressive measures as a very last resort and they must ensure that the children are the very last to be affected.

The UN Secretary-General and the UN Committee on the Rights of the Child have called on states to take active and immediate measures to ensure that children are fed nutritious food during the period of emergency, disaster or lockdown. In the words of Gabriela Mistral: "There are many things in life that can wait, but the child cannot wait, now is the time that his bones are being formed, his mind developed and to him we cannot say tomorrow, his name is today". The time to act is now.

I acknowledge the many contributors to the Child Gauge' and our partners – the Centre of Excellence in Human Development, University of the Witwatersrand; UNICEF South Africa; The Standard Bank Tutuwa Community Foundation; and the Desmond and Leah Tutu Foundation without whom the book would not have been possible. Thank you.

For more information and to access a copy of the 2020 South African Child Gauge see: *http://www.ci.uct.ac.za/cg-2020-food-and-nutrition-security*