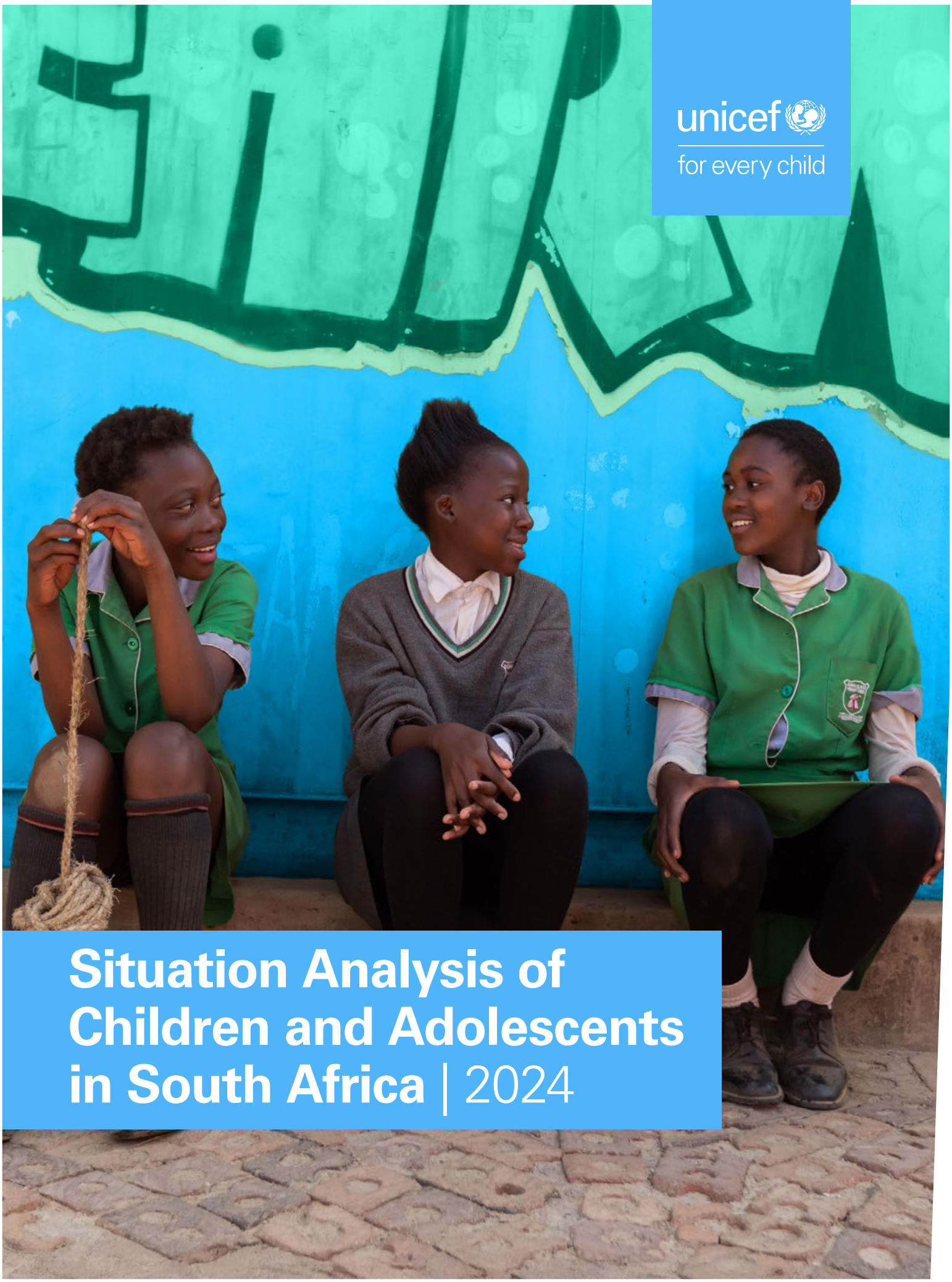
unicef
for every child



Situation Analysis of Children and Adolescents in South Africa | 2024

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Acronyms

ACRWC	African Charter on the Rights and Welfare of the Child
ANC	African National Congress
APP	Annual Performance Plan
ART	Antiretroviral Therapy
AU	African Union
BELA	Basic Education Laws Amendment
BMI	Body Mass Index
CCA	Common Country Analysis
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CEELAC	Climate, Energy and Environment Landscape Analysis for Children
CEM	Council of Education Ministers
CO	Country Office
COSATU	Congress of South African Trade Unions
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
CGD	Child Dependency Grant
CGE	Commission for Gender Equality
CSG	Child Support Grant
CSO	Civil Society Organization
DA	Democratic Alliance
DALY	Disability-Adjusted Life Year
DBE	Department of Basic Education
DBST	District-Based Support Team
DEVAW	Declaration on the Elimination of Violence Against Women
DHA	Department of Home Affairs
DHET	Department of Higher Education and Training
DHS	Demographic and Health Survey
DPL	Development Policy Loan
DoH	Department of Health
DoHA	Department of Home Affairs
DSD	Department of Social Development
DPSA	Disabled People of South Africa
DRRM	Disaster Risk Reduction and Management
DSRAC	Department of Sport and Recreation, Arts and Culture
DWS	Department of Water and Sanitation
ECCE	Early Child Care and Education
ECD	Early Childhood Development
ECDI	Early Childhood Development Index
ECE	Early Childhood Education
EFF	Economic Freedom Fighters
EMIS	Education Management Information System
ERRP	Economic Reconstruction and Recovery Plan
FCG	Foster Child Grant
FET	Further Education Training
FY	Fiscal Year
GBV	Gender-Based Violence
GDI	Gender Development Index
GDP	Gross Domestic Product
GED	General Education Certificate
GGPI	Global Gender Parity Index
GII	Gender Inequality Index

GIR	Gross Intake Rate
GNI	Gross National Income
GoSA	Government of Republic of South Africa
GPSJS	Governance, Public Safety and Justice Survey
HDI	Human Development Index
HMIS	Health Management Information System
IBST	Institution-Based Support Team
ICT	Information and Communication Technology
IDD	Iodine Deficiency Disorders
IE	Inclusive Education
IHDI	Inequality Human Development Index
ILO	International Labour Organization
IMF	International Monetary Fund
IPV	Intimate Partner Violence
JMP	Joint Monitoring Programme
LCS	Living Conditions Survey
MCH	Mother and Child Health
MHM	Menstrual Hygiene Management
MICS	Multiple Indicator Cluster Survey
MODA	Multiple Overlapping Deprivation Analysis
MTBBE	Mother Tongue-Based Bilingual Education
MTCT	Mother-to-Child Transmission
NCD	Non-Communicable Disease
NDC	Nationally Determined Contributions
NDMC	National Disaster Management Centre
ND-GAIN	University of Notre Dame Global Adaptation Index
NEET	Not in Education, Employment or Training
NER	Net Enrolment Rate
NHI	National Health Insurance
NIR	Net Intake Rate
NPAC	National Plan of Action for Children
NPR	National Population Register
NSNP	National School Nutrition Programme
NSC	National Senior Certificate
NSP	National Strategic Plan
OHCHR	Office of the High Commissioner for Human Rights
PED	Provincial Education Department
PEIR	Public Expenditure and Institutional Review
PIRLS	Progress in International Reading Literacy Study
PLSD	Project on Statistics on Living Standard and Development
PMTCT	Prevention of Mother-to-Child Transmission
PNC	Postnatal Care
PSET	Post-school Education and Training
RCCE	Risk Communication and Community Engagement
SACE	South African Council of Education
SACP	South African Communist Party
SACU	Southern African Customs Union
SADEL	South African Department of Employment and Labour
SADHS	South African Demographic and Health Survey
SADC	Southern African Development Committee
SANHDR	South Africa National Human Development Report
SANS	South African National Standards
SAPS	South African Police Services
SASSA	South African Social Security Agency
SBC	Social and Behaviour Change

SDG	Sustainable Development Goal
SDGEA	Solemn Declaration on Gender Equality in Africa
SEN	Special Education Need
SGBV	Sexual and Gender-Based Violence
SitAn	Situation Analysis
SMEs	Small and Medium-sized Enterprises
SNI	Social Norms Index
SQ-LNS	Small Quantity Lipid Nutrient Supplements
SPED	Special Education
SRH	Sexual and Reproductive Health
Stats SA	Statistics South Africa
STEM	Science, Technology, Engineering and Mathematics
STI	Sexually Transmitted Infections
TB	Tuberculosis
TVET	Technical and Vocational Education and Training
UDHR	Universal Declaration of Human Rights
UN	United Nations
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UNGASS	United Nations General Assembly Special Session
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFCCC	United Nations Framework Convention on Climate Change
UNICEF	United Nations Children's Fund
USA	United State of America
USD	United State Dollar
UNSDCF	United Nations Sustainable Development Cooperation Framework
VAC	Violence Against Children
VACS	Violence Against Children Survey
VAS	Vitamin A Supplementation
VAW	Violence Against Women
VAWG	Violence Against Women and Girls
WASH	Water, Sanitation and Hygiene
WEI	Women's Empowerment Index
WHO	World Health Organization
ZAR	South African Rand

MESSAGE FROM THE UNICEF REPRESENTATIVE

This 2024 Situation Analysis of Children and Adolescents in the Republic of South Africa brings together extensive recent data and research on areas pertaining to the mandate of UNICEF. It is also the culmination of consultative efforts with Government, civil society, academia and UN partners to assess the progress made towards improving child rights in the country.

As we mark 30 years of democracy, the insights and data contained here help us understand the challenges and inequities that are still faced by too many children and young people in this country, despite the notable progress made over the past three decades.

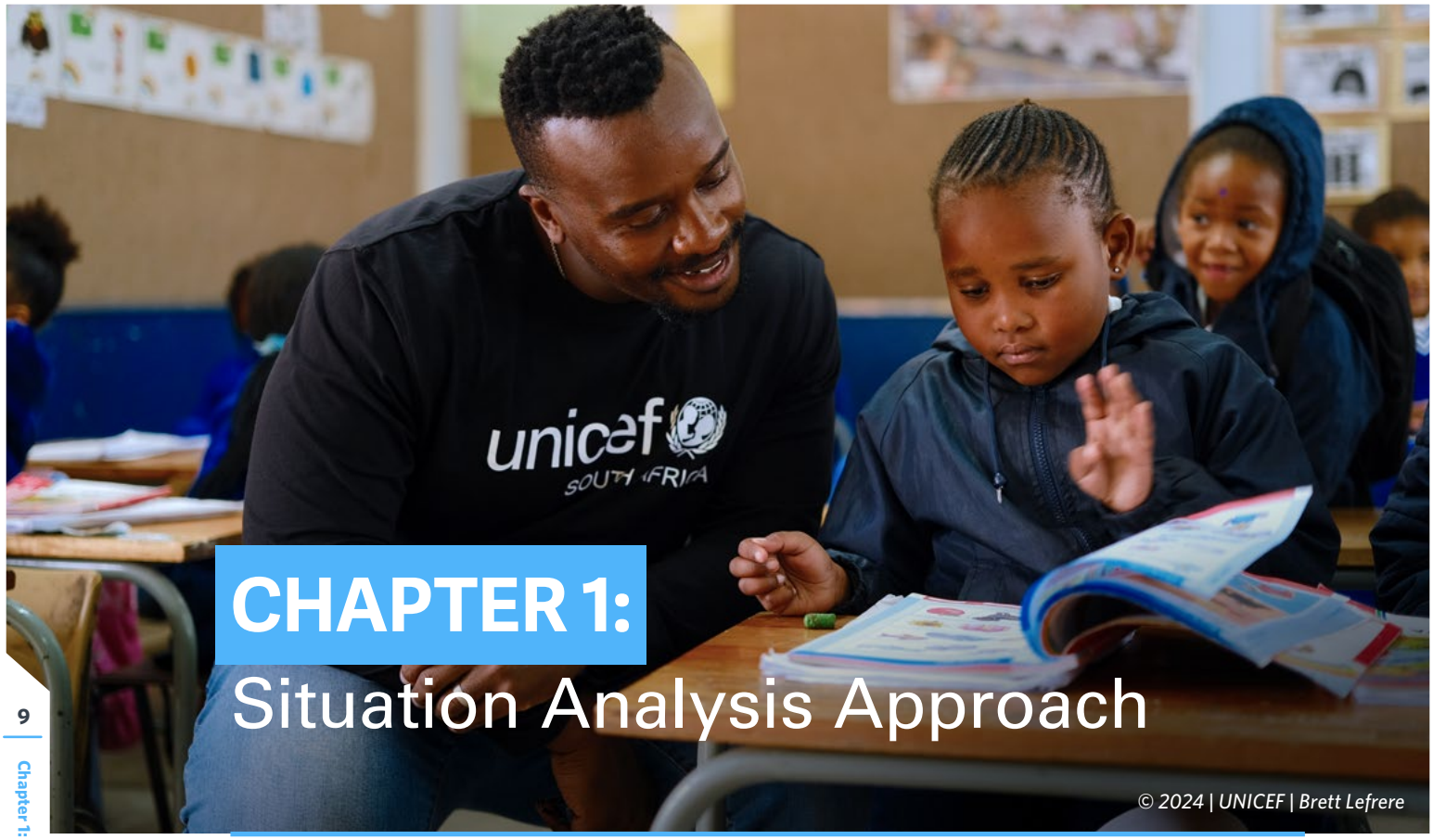
This analysis comes at an opportune time as the Republic of South Africa solidifies its Medium-Term Development Plan and the United Nations embarks on planning for the new five-year United Nations Sustainable Development Cooperation Framework. In addition, the content from this report will help shape the upcoming Country Programme Document of UNICEF South Africa.

The common thread that runs through all these plans is a shared commitment to ensure that child rights are promoted and that the well-being of South Africa's children and adolescents are realized as envisaged by the Convention on the Rights of the Child and this country's globally admired Constitution.

The following pages present an informed and timely snapshot of the status of children and adolescents, because behind each statistic is the story of South Africa's difficult past, its complex present and most importantly, its hopeful future.

Christine Muhigana

REPRESENTATIVE, UNICEF SOUTH AFRICA



CHAPTER 1:
Situation Analysis Approach

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The United Nations Children's Fund (UNICEF) in South Africa, in collaboration with the Government of South Africa (GoSA), has conducted research and evaluations that have provided data and evidence used over time, along with national statistical data, to strengthen and broaden evidence on the situation of children and adolescents in the country. Such research and evaluations have revealed that although progress has been made in addressing children's rights in a number of areas, more effort is needed to contribute to an inclusive, equitable, and prosperous country that ensures the provision of quality services and support for all children and adolescents to advance their rights.

This situation analysis (SitAn) will help to document the current situation of children and adolescents in South Africa and monitor progress made to advance their rights. This SitAn will also focus on bottlenecks and knowledge gaps related to inequities and deprivations. Findings from this SitAn will help to inform child-focused policy dialogue and advocacy to improve the lives of children and adolescents in South Africa, with a focus on accelerating the achievement of child-related SDGs with equity. This SitAn can also be used to guide strategic financial and programmatic choices at national and sub-national levels and inform programme interventions in the next programme cycle that will be planned in consultation with the GoSA.

South Africa Country Programme

The last time that UNICEF South Africa conducted a SitAn of children and adolescents in South Africa was in 2016. Findings of this 2016 SitAn informed the development of the current 2020-2025 Government and UNICEF South Africa Country Programme.[1] The SitAn also informed the 2020 UN South Africa Common Country Analysis (CCA) and an updated CCA in 2022, as well as served as a basis for the development of the 2020-2025 United Nations Sustainable Development Cooperation Framework (UNSDCF).

Since the 2016 SitAn on children in South Africa, there have been changes in the country's socio-economic and political contexts and programming environment. Thus, there is a need to assess and update the 2016 SitAn and to consider the impact of the COVID-19 pandemic and other key events

(both national and international) that have impacted the development trajectory of the country. There is a need to update the 2016 SitAn and provide UNICEF and its partners with new and robust evidence on the situation of children and adolescents in the country, including the situation of the most vulnerable and disadvantaged children and adolescents.

This SitAn captures data from a wide range of sources, including surveys, research studies, thematic area analyses, and evaluations that have recently been conducted in South Africa, providing new data and findings that can be used to strengthen and broaden evidence on the situation of children and adolescents in the country. The SitAn also pays due consideration to the 2030 Agenda for Sustainable Development and child-related Sustainable Development Goal (SDG) indicators, as well as UNICEF's Strategic Plan 2022-2025 and Gender Action Plan 2022-2025, both of which are aligned with the SDGs and various thematic strategic frameworks.

Purpose and Scope

The SitAn offers a comprehensive and robust analysis that compiles and interprets the most recent data and information, including trend data where relevant, as it relates to children and adolescents in South Africa. The analysis focuses on UNICEF global priority areas, including: rights to survive and thrive; rights to education and learning; rights to be protected from violence and exploitation; rights to live in a safe and clean environment; and rights to have an equitable chance in life.[2] These global priority areas align with UNICEF South Africa's priority areas outlined in the Country Programme 2020-2025.[3]

In keeping with UNICEF's mandate to safeguard the rights of all children, this SitAn adopts human rights-based and equity-focused approaches, along with disability, gender, and humanitarian action lenses. The focus is on documenting achievements and progress made toward SDGs, coupled with bottlenecks, challenges, and barriers that exist across sectors that prevent children and adolescents, especially the most vulnerable and disadvantaged, from benefiting from interventions and services, and enjoying their rights enshrined in the Convention on the Rights of the Child (CRC), as well as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the Convention on the Rights of Persons with Disabilities (CRPD), and other international and regional obligations of the country.

In keeping with the purpose of the SitAn, the aim is that it:

- Provides comprehensive and robust data, information, and evidence from multiple sources to further the understanding of the situation of children and adolescents in South Africa.
- Examines progress made and opportunities that exist, alongside bottlenecks, challenges, and barriers that remain (e.g., patterns of inequity and deprivation) when it comes to achieving children's and women's rights.
- Examines the progress that policy and programme interventions have made towards inclusive social services, and the adequacy of budget and policy delivery for 'leaving no child behind'.
- Examines key issues and deprivations that affect girls and boys of different ages, including threats and risk factors, as well as negative impacts and outcomes.
- Builds upon existing strategic priorities for the country and teases out upcoming areas of consideration to reduce disparities and address deprivations and vulnerabilities, thereby making a contribution to shaping the national development agenda, and to accelerate the achievements related to national and international development goals relevant to children and adolescents.
- Raises awareness among policymakers and practitioners about the situation of children and adolescents in South Africa, including vulnerabilities, deprivations and barriers faced by children and adolescents, particularly those most at risk and who have been left behind in the country.

This SitAn unpacks national and sub-national data and examines disaggregated data to reveal inequalities based upon demographics (e.g., sex, age, wealth index quintile), location (e.g., region, urban/

rural areas) and other dimensions. Such analysis will inform contextualised strategic thinking on what can be done by duty-bearers and key stakeholders to attain and sustain inclusive social development that guarantees equal inclusion and participation of all groups of children and adolescents.

This SitAn supports UNICEF South Africa and its partners to prioritise and address key issues and challenges preventing children and adolescents, especially the most vulnerable and disadvantaged, from enjoying their rights as defined in the CRC and other international and regional legal frameworks to which the country is party. This SitAn serves to inform evidence-based planning and programming, and guide policy advocacy and partnership efforts. Data and findings from this SitAn can also be used to inform social and behaviour change (SBC) initiatives, including messaging and content for social and behaviour change communication (SBCC). These SBC initiatives can be disseminated on UNICEF and partners' websites to inform collective action.

Objectives

The main objectives of this SitAn were to:

- Develop a deep understanding of the situation of children and adolescents by analysing the policies and strategies, and social and economic trends affecting them.
- Identify and analyse barriers and bottlenecks that prevent children, and especially the most vulnerable and disadvantaged children and families, from benefiting from social services across sectors and enjoying their rights.
- Provide national government partners with a comprehensive equity-sensitive and evidence-based analysis of the situation of children and adolescents.
- Provide essential information to non-government partners (e.g., civil society, non-governmental and community-based organisations, media, and businesses) to be used in their planning and interventions to address the most urgent issues affecting children and adolescents, and that can contribute to the (re)formulation of key national strategies, so that the priorities for the most vulnerable and disadvantaged children and adolescents are integrated into the socio-economic development agenda.

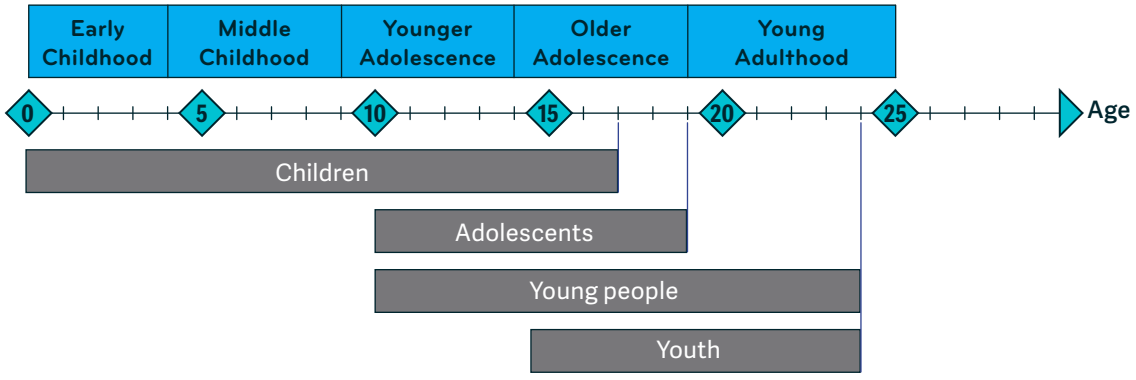
- Identify critical data gaps and contribute to the generation of evidence that can improve the monitoring of the rights of children and adolescents, especially the most vulnerable.
- Assess the current or potential presence of emergency risks (i.e., disaster risks and other potential shocks), the likelihood of their occurrence, underlying vulnerabilities, and the capacities and coping mechanisms of families, communities, and local and national institutions.
- Analyse to what extent there is an enabling environment for the realisation of the rights of all children and adolescents, and analyse how evidence-based interventions and services needed to address deprivations are prioritised in national policies, laws, strategies, plans, and budgets.
- Capture new or emerging areas of concern regarding children and adolescents, such as environmental issues affecting them, mental health issues, the digital divide and online safety, and more.
- Analyse the role/impact of the business sector on the fulfilment of children and adolescents' rights and public financial management.

Subgroups of Children, Adolescents and Youth

UNICEF recognises that individual diversity makes it difficult to define a universal age for the start and end of the critical period of physical growth and development for children, adolescents and youth; yet, defining a specific age span is essential for monitoring progress across contexts and time. The second decade of life is a period of substantial neurological development, second only to early childhood. Thus, UNICEF follows the World Health Organization (WHO) definition of childhood, adolescents and youth, which allows UNICEF to align its programming with other global data, policy and programme frameworks.[4]

Figure 1.1 shows that children aged 0-17 include a number of distinct subgroups, including: early childhood (0-4 years), middle childhood (5-9 years), younger adolescents (10-14 years) and older adolescents (15-19 years). In addition, adolescents aged 10-19 years include younger adolescents (10-14 years) and older adolescents (15-19 years). Young people aged 10-24 years include adolescents (10-19 years) and youth (15-24 years).

FIGURE 1.1. Different stages of child, adolescent and youth in terms of physical growth and development



SOURCE: *UNICEF Programme Guidance for the Second Decade: Programming with and for Adolescents, 2018, p. 9*

There is growing recognition of the importance of investing not only in children aged 0-17, but also in adolescents aged 10-19 years and youth aged 15-24 years (which includes adolescents), particularly since adolescents and youth face many economic, social and cultural challenges. The second decade of life is a period of substantial neurological development, second only to early childhood. For instance, the types of skills needed in the labour market are changing, technological changes are making many jobs vulnerable to automation, and many educational systems are struggling to prepare adolescents and youth with the skills they need to meet employers' expectations. In addition, a large proportion of job creation is driven by entrepreneurs and small businesses, leaving a growing

pool of young job-seekers with an insufficient number of jobs.[5] These challenges are more acute for adolescents and youth in disadvantaged communities, and those who lack opportunities because of their gender, ethnicity, disability, socio-economic status and more.[6]

It is often during childhood and adolescence that inequities become particularly apparent. Economic, social and structural disadvantages, coupled with bias and discrimination, can prevent poor and marginalised adolescents from successfully completing their education and progressing onto post-secondary and tertiary education programmes; in turn, restricting their entry into the labour market and their ability to earn a quality wage.[7] Interventions that target adolescents and youth can effectively prevent inequities from passing on to future generations. The first step, however, is addressing inequities, which requires understanding how they relate to issues of poverty, academic achievement, school dropout, unemployment, exploitation, violence and criminal offending.

Conceptual Framework

The conceptual framework for this SitAn was guided by UNICEF's *Core Guidance: New Generation Situation Analysis*.[8] The focus was on developing a narrative and understanding of children and adolescents in South Africa, including the realisation (or non-realisation) of their rights in the country. In doing so, this SitAn adopts a human rights-based approach that focuses on those who are most marginalised, excluded or discriminated against, which often requires an analysis of gender norms, different forms of discrimination and power imbalances to ensure that interventions reach the most marginalised segments of the population. This requires investigating the unequal realisation of children's and adolescents' rights to: survive and thrive; learn and acquire skills for the future; protection from violence, exploitation, abuse, neglect and harmful practices; use safe and equitable water, sanitation and hygiene (WASH) services; live in a safe and sustainable climate and environment; and have access to inclusive social protection and to live free of poverty (see Annex B: Conceptual Framework and Questions).[9]

This analysis fosters an understanding of the drivers of deprivations and inequities across each of these different dimensions (e.g., inequities based upon sex, age, gender, socio-economic status, ethnicity, disability) and establishes linkages between the underlying and structural causes, and critical bottlenecks and barriers to achieving children's and adolescents' rights and well-being.[10] **Box 1.1** highlights some of the possible determinants of underlying and structural causes, and bottlenecks and barriers that this SitAn aims to understand.

BOX 1.1. Determinants of underlying and structural causes, and bottlenecks and barriers

- **Social norms** – widely followed social rules of behaviour that generate barriers
- **Legislation and policy** – adequacy of laws and policies to reduce/avoid barriers
- **Budget and expenditures** – allocation and disbursement of required resources
- **Management and coordination** – roles and accountability, coordination and partnership
- **Availability of essential commodities and inputs** – essential commodities and inputs required to deliver a service
- **Access to adequate services and information** – physical access (e.g., services, facilities and information, including access to digital tools and information)
- **Financial access** – direct and indirect costs for services and practices
- **Social and cultural practices and beliefs** – individual and community beliefs, behaviour, practices and attitudes
- **Continuity of use** – completion and continuity in service, practice
- **Quality** – adherence to quality standards (national or international)

SOURCE: Terms of Reference for Situation Analysis of Children and Adolescents in South Africa, p. 4.

The conceptual framework situates the analysis in the country context, with a clear recognition of regional and global issues that impact the lives of children and adolescents at the country level.[11] The focus was also on identifying data gaps that exist at the country level and should be addressed to generate a better picture of the situation of children and adolescents in South Africa.[12] This includes "an absence of data on vulnerable groups or 'invisible' or 'unaccounted' children."[13] Illustrating critical data gaps can create opportunities for UNICEF to engage in dialogue and advocate with the GoSA and other national partners to fill these gaps with improved administrative data collection, issue-specific surveys, studies and research, and enhanced data analysis of existing data. This can feed into national planning, budgeting, and/or legislative and policy processes.[14]

Methodology

The conceptual framework situates the analysis in the country context with a clear recognition of regional and global issues that impact the lives of children and adolescents at the national level. The focus was also on identifying data gaps that exist at this level and should be addressed to generate a better picture of the situation of children and adolescents in South Africa. This includes "an absence of data on vulnerable groups or 'invisible' or 'unaccounted' children." Illustrating critical data gaps can create opportunities for UNICEF to engage in dialogue and advocate with the Government of South Africa and other national partners to fill these gaps through improved administrative data collection, issue-specific surveys, studies and research, and enhanced data analysis of existing data. This can inform national planning, budgeting and/or legislative and policy processes.

Desk Review

The primary methodology for this SitAn was a comprehensive desk review of data and information from recognised and credible global, regional, national and sub-national data sources that are widely accepted and used, as well as data and findings from studies, research and evaluations (see Annex A: References).[15]

National data sources will include housing and population surveys, national household income and vulnerability surveys, labour force surveys, and other population-based surveys, such as the General Household Survey (GHS) and special surveys (e.g., violence against children surveys, vulnerability assessment studies, and HIV prevalence, incidence and behaviour surveys).

In addition, administrative data sources, such as national health management information systems (HMIS), education management information systems (EMIS) and civil registration and vital statistics (CRVS), were valuable sources of data and information when available. Economic data sources included national budget and expenditure data, and country-specific data from international data sources, such as the World Bank and the United Nations Educational, Scientific and Cultural Organization (UNESCO).[16] The World Bank is a good source for data and information related to a wide range of economic, health and education-related indicators, including SDG-related indicators. These are important data sources that provide current and trend data and information.[17]

In situations where there is a lack of official data, alternative data and information sources were used at times as substitutes for official data and to triangulate information or complement official statistics to deepen the analysis. Alternative data sources came from organisations working with vulnerable and/or marginalised persons and national human rights institutions. Alternative sources of information also include findings from specialised studies and evaluations, journal articles, book chapters and newspaper articles.[18]

Equity Analysis

Based on data from national and alternative data sources, an equity analysis was undertaken related to each of the dimensions covered in this SitAn, including gender-relevant and child-related SDG indicators. This included indicators related to the following SDGs: no poverty (SDG 1); zero hunger (SDG 2); good health (SDG 3); quality education (SDG 4); gender equality (SDG 5); clean water and sanitation (SDG 6); renewable energy (SDG 7); good jobs and economic growth (SDG 8); reduced

inequalities (SDG 10); sustainable cities and communities (SDG 11); responsible consumption (SDG 12); climate action (SDG 13); peace and justice (SDG 16); and partnerships for the goals (SDG 17) (see Annex C: Child-Related SDG Indicators).

The equity analysis focused on inequities based on the characteristics of children and adolescents, as well as households (e.g., wealth quintile). Most important were comparisons based on gender, age, and vulnerability status (e.g., children without parental care, children living in economically vulnerable households, disabled children, victims of violence, female-headed households). Such an analysis is important for understanding the multiple forms of discrimination and exclusion experienced by children and adolescents.

The equity analysis allows for an examination of the strengths and weaknesses of national institutions that influence the realisation of children's and women's rights, including rights set out in the CRC, CEDAW, CRPD, and other core international and regional human rights instruments. The measurement of progress against these formal obligations is a central benchmark by which to assess the situation of children and adolescents in South Africa.

Trend Analysis

Based on data from national sources and alternative data sources, trend analysis was undertaken when relevant data were available for multiple time periods. Trend analysis and horizontal data plots are particularly useful for analysing changes over time in child poverty, maternal and child health, school enrolment and completion rates, and child protection, among others. Trend analysis can help reveal changes over time in the realisation of children's rights by fostering greater social inclusion, especially for the most disadvantaged and excluded children and families, reducing disparities and inequality, and strengthening inclusiveness.

Causal Analysis

Data sources and consultations inform the understanding of current patterns and trends regarding inequities and their causes, as well as the structural gaps that perpetuate disparities, exclusion, and deprivation for children and adolescents. Where data and information were available, efforts were made to focus on documented determinants that are either immediate or underlying, along with the structural causes of patterns, trends, and observed outcomes among children. The causal analysis took into consideration macro-level determinants, such as legislation, policies, strategies, plans, and public expenditure that contribute to the realisation of rights and the reduction of inequities among children and adolescents in South Africa.

As part of the causal analysis, constraining factors and possible drivers of inequities for particular population groups and/or geographic regions were explored. The causal analysis helped to identify appropriate strategies and approaches that could be employed to address existing bottlenecks and barriers relative to achieving the rights of children and adolescents, while ensuring equity. The causal analysis is presented alongside data and is included in the interpretation of data and literature on contributing factors or causal determinants.

Sector-Specific Consultations

Sector-specific consultations were conducted with UNICEF Country Office (CO) staff, national partners, and key stakeholders to allow for their inputs on the SitAn Report regarding content, existing data, data sources, and documents relevant to the desk review and the SitAn. Sector-specific consultations were used to understand general changes in trends and the situation in the programming environment, with a focus on the situation of the key results for children and adolescents (see Annex C: List of Participants in Sector-Specific Consultations).

Key Stakeholder Interviews

Key stakeholder interviews were conducted with government and civil society partners across sectors. These interviews focused on priorities and issues facing children and adolescents, including the most disadvantaged and vulnerable, as well as challenges and barriers to addressing the needs of children and women. Key stakeholder interviews were semi-structured conversations informed by data and information gathered, trends and patterns identified, and gaps in data and information, which helped to fill gaps in the SitAn. UNICEF CO staff identified key stakeholders who should be interviewed (see Annex D: List of Participants in Key Stakeholder Interviews).

Consultations with Children and Young People[19]

Consultations will be conducted with children and young people aged 10-24 under the aegis of a UNICEF Innocenti research project, in cooperation with another group of consultants. Data and findings from the UNICEF Innocenti research project will complement this SitAn but will result in a separate, standalone report.

Validation of Key Findings

Findings from this report were presented in a validation meeting involving UNICEF CO staff, national partners, and key stakeholders. The validation meeting took place in July 2024 in Pretoria, South Africa.

CHAPTER 2:
Overview of South Africa

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South Africa, officially the Republic of South Africa, is the southernmost country in Africa, with 2,798 kilometres (km) of coastline that stretches along the South Atlantic and Indian Oceans. In the north, neighbouring countries include Namibia, Botswana, and Zimbabwe, while to the east and northeast are Mozambique and Eswatini. South Africa also completely enclaves the country of Lesotho.

South Africa is classified as an upper-middle-income country[20] with one of the most diversified and financially integrated economies in Africa.[21] In 2022, South Africa had a gross domestic product (GDP) of USD 405.9 billion[22] (ZAR 7.1 trillion) and a gross national income (GNI) of USD 397.4 billion[23] (ZAR 6.9 trillion). With good infrastructure, South Africa is the second most favoured investment destination on the African continent (after Egypt).[24]

Despite being classified as an upper-middle-income country, inequality in South Africa has long been recognised as one of the most salient features of society, as the country has consistently ranked as one of the most unequal countries in the world.[25] Income inequality has been extremely high in South Africa and has remained so since 1993. From 1993 to the most recent Living Conditions Survey in 2014/15, the Gini coefficient of household per capita income has been well above 0.6;[26] in 2014, the Gini Index[27] was 63 (up from 57.8 in 2000).[28] This placed South Africa in the 'top five' most unequal countries on a global scale.[29] More recently, in 2022, the World Bank reported that between 2008 and 2018, South Africa's Gini coefficient changed very little, declining from 68 to only 67, or just 0.21 points per year. This is the slowest decline among Southern African Customs Union (SACU) countries, even though the country has the highest level of inequality in the region.[30]

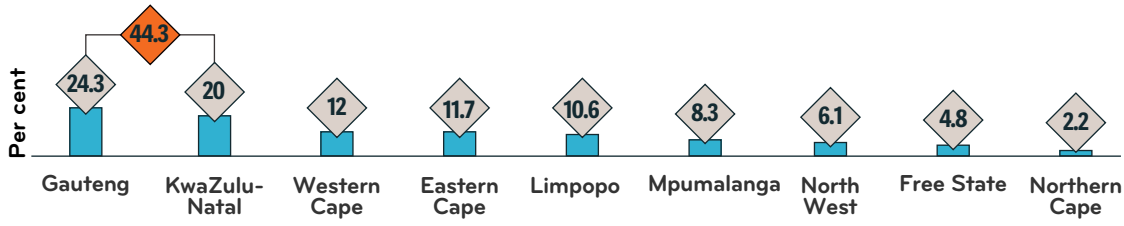
South Africa is divided into nine provinces – Eastern Cape, Free State, Gauteng, KwaZulu-Natal, Limpopo, Mpumalanga, North West, Northern Cape, and Western Cape – which vary in size and population. The smallest and most densely populated province is Gauteng, a highly urbanised region, while the largest province is Northern Cape, which is a vast, arid, and relatively unpopulated region that makes up nearly a third of the country's total land area.[31] It is notable that South Africa has three capitals:[32]

- **Cape Town**, in the City of Cape Town Metropolitan Municipality, Western Cape, is the legislative capital, where the country's Parliament is situated.
- **Bloemfontein**, in Mangaung Metropolitan Municipality, Free State, is the judicial capital, where the country's Supreme Court of Appeal is located.
- **Pretoria**, in the City of Tshwane Metropolitan Municipality, Gauteng, is the administrative capital and the capital of the country. It is also home to the Union Buildings, which serve as the official seat of the GoSA, as well as a large proportion of the public service.

Demographic Profile

According to the 2022 South Africa Population and Housing Census, South Africa's population has steadily increased over the past three decades, with an average annual growth rate of 1.2 per cent.[33] In 2022, the population was 62,027,503, representing a 19.8 per cent increase from 51,770,560 in the 2011 census, and a 52.8 per cent increase from 40,583,573 in the 1996 census. **Chart 2.1** shows that 44.3 per cent of the population lives in the two most populated provinces – Gauteng and KwaZulu-Natal – with nearly one-quarter (24.3 per cent) concentrated in Gauteng, which includes Johannesburg and the capital city of Pretoria.

CHART 2.1. Proportion of population by region (%), 2022



SOURCE: Census 2022: Statistical Release. Department of Statistics South Africa, pp. 3-4. Retrieved on 12 December 2023 from: Statistics South Africa | Census Dissemination (statssa.gov.za); see Annex Table 1.

The majority of the population are Black African (81.4 per cent); only 8.2 per cent are categorised as coloured, 7.3 per cent are White, 2.7 per cent are Indian/Asian, and less than one per cent are 'other' (0.4 per cent).[34] Languages most often spoken in households include IsiZulu (24.4 per cent), IsiXhosa (16.3 per cent), Afrikaans (10.6 per cent) and Sepedi (10.0 per cent); a wide range of other languages are often spoken in households, but to a lesser extent.[35] Population group remains a strong predictor of poverty in South Africa, with Black Africans being at the highest risk of being poor.[36] In 2015, 47 per cent of households headed by Black Africans were poor, compared to 23 per cent of households headed by a person of mixed race (coloured), little more than one per cent of households headed by Indian/Asian South Africans, and less than one per cent of households headed by White South Africans.[37] From 2006 to 2015, White South Africans had the highest annual mean and median expenditures compared to other population groups, whereas Black Africans had the lowest expenditures; annual median expenditures for White South Africans were more than 10 times higher than that of Black Africans.[38]

In terms of religion, the majority of the population are Christians (85.3 per cent); only 14.7 per cent of the population are non-Christians, including 7.8 per cent who are Traditional African, 1.6 per cent who are Muslim, 1.1 per cent who are Hindu and fewer than one per cent are 'other'.[39]

Over time, the rural population has declined from 53 per cent in 1960 to 32 per cent in 2022;[40] whereas the urban population increased from 47 per cent in 1960 to 68 per cent in 2022.[41] In 2022, only 13.8 per cent of households were categorised as agricultural households, down from 19.9 per cent in 2011. Most agricultural households were in KwaZulu-Natal (22.9 per cent), Limpopo (21.1 per cent) and Eastern Cape (19.6 per cent). Black African households (90.8 per cent) constitute the largest proportion of agricultural households, compared to White African households (5.1 per cent). Livestock and poultry production are the leading agricultural activities, followed by fruit or vegetable production, and grains, food crops and industrial crops.[42]

Table 2.1 shows that in 2022, 33.6 per cent of the population were children aged 0-17, whereas 42.9 per cent could be categorised as children and youth aged 0-24. More specifically, 9.4 per cent were under the age of five (early childhood), 8.2 per cent were aged 5-9 years (middle childhood), 8.7 per cent were aged 10-14 years (young adolescents), 8.0 per cent were aged 15-19 years (older adolescents), and 8.6 per cent were aged 20-24 years (young adulthood). More generally, 17.6 per cent of the population were aged 0-9 years (young children), 16.7 per cent were aged 10-19 years (adolescents), and 16.6 per cent were aged 15-24 years (youth). In comparison, 57.1 per cent of the population were aged 25 years or older; in particular, 33.4 per cent were aged 25-44 years (young working adults), 17.2 per cent were aged 45-64 years (older working adults), and 6.5 per cent were aged 65 years or older (elderly).

TABLE 2.1. Population by age group, 2022 | 2022 Census Data

Age Groups (Years)	Description	n	%
0 - 4	Early childhood	5,833,515	9.4
5 - 9	Middle childhood	5,109,104	8.2
10 - 14	Young adolescent	5,404,124	8.7
15 - 19	Older adolescent	4,975,309	8.0
20 - 24	Young adulthood	5,309,738	8.6
25 - 44	Young working adults	20,733,885	33.4
45 - 64	Older working adults	10,654,769	17.2
65+	Elderly	4,007,056	6.5
Total	**All ages**	**62,027,503**	**100**
0 - 9	Young children	10,942,619	17.6
10 - 19	Adolescents	10,379,433	16.7
15 - 24	Youth	10,285,047	16.6
10 - 24	Young people	15,689,171	25.3
Subtotal	**0-17 years (children)**	**20,866,875**	**33.6**
Subtotal	**0-19 years (children & adolescents)**	**21,322,052**	**34.4**
Subtotal	**0-24 years (children & youth)**	**26,631,790**	**42.9**

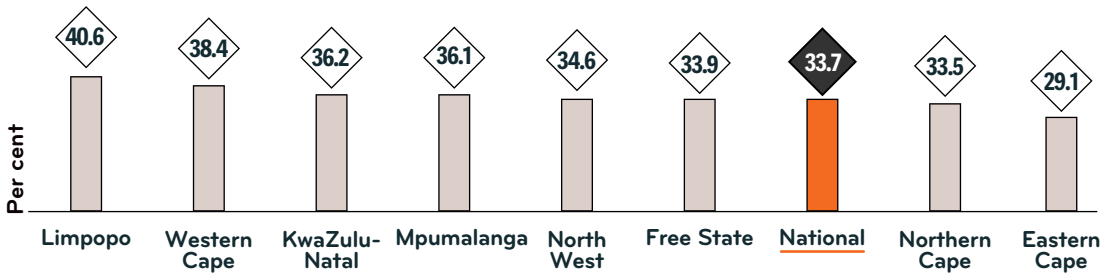
Note: 0 equates to birth.

Note: 0 equates to birth.

SOURCE: Census 2022: Statistical Release. Department of Statistics South Africa, pp. 3-4. Retrieved on 12 December 2023 from: Statistics South Africa | Census Dissemination (statssa.gov.za)

Chart 2.2 shows that according to the 2023 GHS, children aged 0-17 years represented 33.7 per cent of the population. Most provinces have a proportion of children larger than the national average. Limpopo (40.6 per cent) has the largest proportion of children under the age of 18, whereas the Eastern Cape has the smallest proportion of children (29.1 per cent).

CHART 2.2. Children (0-17 years) as a percentage of the population by province (%), 2023



SOURCE: 2023 GHS (UNICEF South Africa's own calculations)

Living Arrangements of Children

In 2023, 39 per cent of households were classified as nuclear (i.e., couples or one or more parents with children), 32 per cent were classified as extended households (i.e., a nuclear core combined with other family members, such as parents or siblings) and 27 per cent were single-person households. Extended households were more common in rural areas compared to urban areas, whereas nuclear families were more common in urban areas than in rural areas.[43]

Household membership is often based on an inter-generational configuration. In 2023, 39 per cent of households were classified as double-generation households (comprising parents and children) and 14 per cent had three generations; only 13 per cent of households were single-generation households (partners or siblings living together) and 4 per cent were skip-generation households, in which

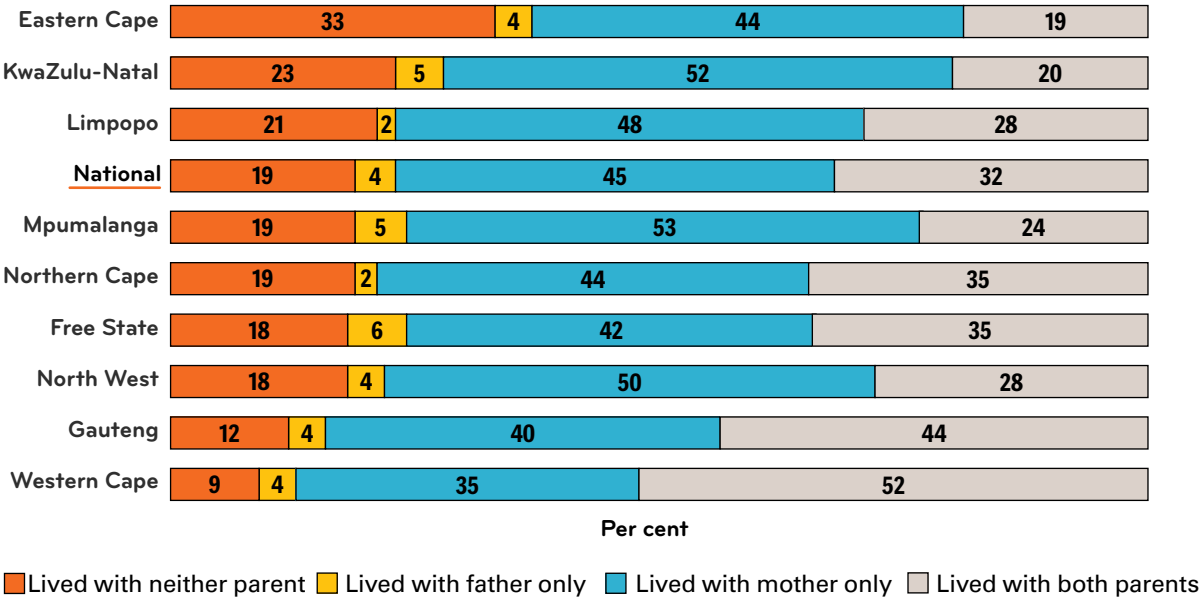
grandparents lived with grandchildren. The highest proportion of skip-generation households was found in Eastern Cape and Limpopo (7 per cent each), and Free State (6 per cent). Skip-generation households were also more common in rural areas (8 per cent) compared to urban areas (3 per cent).[44]

In 2023, 12 per cent of children were classified as orphans (i.e., children under the age of 18 who lost one or both parents to death); 2 per cent lost both parents, 3 per cent lost their mothers and 8 per cent lost their fathers. The proportion of orphaned children was highest in Free State (15 per cent), KwaZulu-Natal (14 per cent) and Eastern Cape (14 per cent), and lowest in Western Cape (8 per cent).[45]

Chart 2.3 shows that in 2023, only 32 per cent of children lived with both parents, whereas 45 per cent lived only with their mothers, 4 per cent lived only with their fathers, and 19 per cent lived with neither parent. Children who did not live with either parent were most common in Eastern Cape (33 per cent), KwaZulu-Natal (23 per cent) and Limpopo (21 per cent), and least common in Western Cape (9 per cent) and Gauteng (12 per cent).[46]

According to the Joint Estimates and Action Global Reference Group on Children Affected by COVID-19 and Crisis, as of December 2022, in South Africa, more than 285,000 children lost a parent/caregiver due to COVID-19. The largest numbers of children who lost a parent/caregiver due to COVID-19 were in KwaZulu-Natal (60,000), Eastern Cape (51,000) and Gauteng (50,000).[47]

CHART 2.3. Children's living arrangements by province (%), 2023



SOURCE: 2023 GHS

Governance

South Africa has a long and rich cultural history that includes hundreds of years of Dutch and British colonisation, as well as decades of apartheid. For much of the 20th century, apartheid policy governed relations between South Africa's white minority and non-white majority, sanctioning racial segregation and political and economic discrimination against non-white citizens of South Africa.[48] Although the legislation that formed the foundation of apartheid was repealed in 1994, the social and economic repercussions of this discriminatory policy have persisted into the 21st century. One of the most devastating aspects of apartheid was the government's forcible removal of Black Africans from rural areas designated as "White", with their land sold at low prices to white farmers. From 1961 to 1994, more than 3.5 million Black Africans were forcibly removed from their homes and relocated to the Bantustans,[49] where a large proportion of the population fell into poverty and experienced hardship.[50]

South Africa's apartheid policies were met with resistance, including non-violent demonstrations, protests and strikes, as well as political action and armed resistance.[51]

In 1994, South Africa held its first democratic elections, in which South African citizens of all races were allowed to participate. South Africa's transition to democracy was subsequently guaranteed by the 1996 Constitution of the Republic of South Africa (hereinafter referred to as the 1996 Constitution).[52] The 1996 Constitution includes a Bill of Rights, which enshrines the rights of all people in the country and affirms the democratic values of human dignity, equality, and freedom. The Bill of Rights guarantees fundamental rights, including equality before the law and the right to equal protection and benefit of the law, which are the cornerstones of democracy.[53]

The 1996 Constitution established the Republic of South Africa as a constitutional democracy with three spheres of national, provincial, and local levels of government,[54] each of which has legislative and executive authority in its own sphere and is defined as "distinctive, interdependent, and interrelated."[55] The Constitution combines aspects of parliamentary and presidential systems. Legislative authority is held by Parliament, which consists of the National Assembly and the National Council of Provinces. Executive authority is vested in the President, who is Head of State and Head of Government, along with the Cabinet. The President is elected from Parliament to serve a fixed term of five years. The Constitution also establishes an independent judiciary, including the Constitutional Court, the Supreme Court of Appeal, High Courts, Magistrates' Courts, and Special Courts.[56]

Since 1994, the African National Congress (ANC), South Africa's governing party, has led the country's democratic transformation under the leadership of former Presidents, including H.E. Nelson Mandela (1994-1999), H.E. Thabo Mbeki (1999-2008), H.E. Kgalema Motlanthe (2008-2009), and H.E. Jacob Zuma (2009-2018). In August 2016, South Africa experienced one of the most competitive local government elections, in which the ANC lost majority support in four metropolitan cities. As a result, political parties negotiated coalition deals that left the ANC unseated in Johannesburg, Pretoria, and Nelson Mandela Bay.[57] These developments marked South Africa's first experience of a large-scale coalition government, which has proven difficult to manage for the respective cities.[58] The volatility of these coalitions has often affected the efficient functioning of the jurisdictions in which they exist, compromising the ability of local governments to optimally deliver services to their communities.[59]

Although the Government of South Africa (GoSA) has promoted commendable social developmental changes, the ANC has been accused of embracing policies that are not far-reaching enough to address high unemployment, poor service delivery, and inequalities between the rich and the poor. In fact, under former President H.E. Jacob Zuma, the ANC was embroiled in allegations of corruption and failing state-owned enterprises. This led to an erosion of the ANC's popularity and credibility with the people of South Africa and global investors.[60] As a result, in 2018, President Jacob Zuma was pressured to resign amidst mounting corruption allegations.[61]

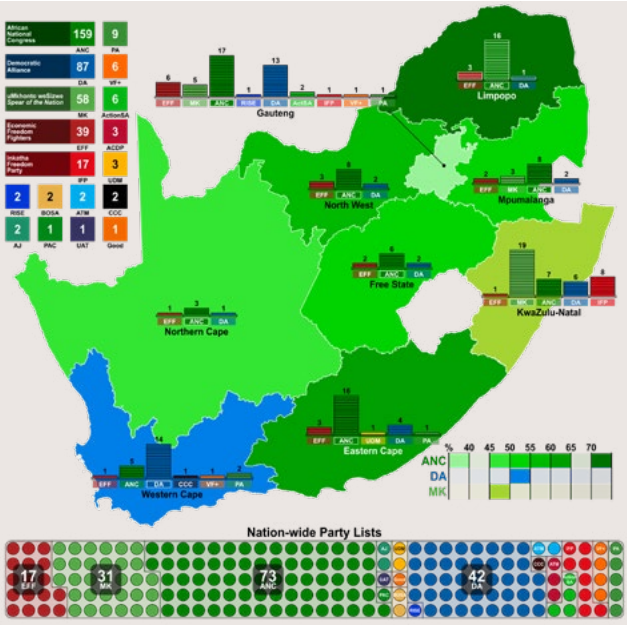
Subsequently, in February 2018, H.E. Cyril Ramaphosa, leader of the ANC, was elected President of South Africa. In May 2019, national and provincial general elections were held, and the ANC continued to hold the majority of seats in Parliament; however, their share of the votes decreased to 58 per cent (down from 62 per cent in 2014). This was the first time that the ANC's support fell below 60 per cent. The political parties with the second and third largest representation in the National Assembly were the Democratic Alliance (DA) and the Economic Freedom Fighters (EFF).[62]

In 2021, South Africa experienced unrest in the KwaZulu-Natal and Gauteng provinces, including Johannesburg. The unrest was sparked by the imprisonment of former President Zuma for contempt of court and for defying a constitutional court order to give evidence at an inquiry investigating high-level corruption during his nine years in office.[63] This led to claims that former President Zuma's allies were seeking to overthrow South Africa's democracy. Some community members of Indian origin expressed concerns that racial tensions had been deliberately inflamed by those orchestrating the violence, particularly in one of the worst-affected provinces and communities, and that security forces had failed to protect them. Others argued that systematic poverty, which has shaped the lives of Black Africans,

was the catalyst for the riots.[64] In 2020 and 2021, poverty was exacerbated by severe social and economic restrictions aimed at slowing the spread of COVID-19.[65] The riots, which included violence, looting, and the burning of buildings and homes, left at least 72 dead and 1,234 arrested.

The Judicial Commission of Inquiry into Allegations of State Capture, Corruption, and Fraud in the Public Sector, including Organs of the State, better known as the Zondo Commission, was a public inquiry established in January 2018 by former President Jacob Zuma to investigate allegations of state capture, corruption, and fraud in the public sector. In 2022, the Zondo Commission Report was published, revealing "how almost every arm of the State was suffocated and left bankrupt by leaders of the ANC." The report was an indictment of the ANC.[66]

In 2022, President H.E. Cyril Ramaphosa was re-elected as leader of the governing ANC.[67] This was despite the fact that the ANC's support fell below 50 per cent in local government elections in November 2021. This result reinforced a new era of coalition politics, particularly in metropolitan areas. Today, the ANC leads the government in a tripartite alliance with the Congress of South African Trade Unions (COSATU) and the South African Communist Party (SACP). The political parties with the second and third largest representations in the National Assembly are the DA and EFF.[68]



SOURCE: Public Domain, https://commons.wikimedia.org/w/index.php?curid=148988453

On 29 May 2024, general elections were held. The result was that South Africa's ruling ANC lost the majority for the first time. The ANC has dominated South African politics since winning in the first post-apartheid election 30 years ago. As a result, the ANC has formed a coalition government of 11 parties, including seven different parties in the Cabinet, in an unprecedented power-sharing agreement.[69] In recent years, the World Bank has described South Africa's political transition as "one of the most remarkable political feats of the past century.[70]

"In recent years, the GoSA has recognised the negative impact of corruption on development, particularly regarding the attainment of Sustainable Development Goals (SDGs) in the 2030 Agenda for Sustainable Development. Corruption has adversely affected progress made toward achieving SDG 1, ending poverty in all its forms everywhere; SDG 3, ensuring healthy lives and promoting well-being for all at all ages; SDG 4, ensuring inclusive and equitable quality education and promoting lifelong learning opportunities for all; SDG 5, achieving gender equality and empowering all women and girls; SDG 10, reducing inequality; and SDG 16, promoting a peaceful and inclusive society for sustainable development, providing access to justice for all, and building effective, accountable and inclusive institutions at all levels.[71] In response, President H.E. Cyril Ramaphosa intensified efforts to fight corruption by establishing a Judicial Commission of Inquiry to investigate incidents of state

corruption over the past decade, as well as other commissions to investigate the effectiveness of state-owned enterprises to improve service delivery.[72]

Since the 1990s, South Africa has emerged as a new migration hub, attracting hundreds of thousands of migrants from Central, East and West Africa, as well as Bangladesh, China, Eastern Europe and Pakistan.[73] This increased migration has led to a host of challenges, including: a higher prevalence of irregular migration, including women and unaccompanied minors; inadequate migration management policies and border management processes; rising xenophobic sentiments and increased incidents of violence against migrants; a high prevalence of communicable diseases (e.g., HIV, AIDS, tuberculosis); and a brain drain of skilled nationals.[74]

Since 2008, South Africa has experienced periodic xenophobic crimes that resulted in loss of life, looting and destruction of businesses belonging to African foreign nationals. Xenophobic incidents have undermined South Africa's standing as a continental and global leader and eroded the President's efforts to attract and promote investment, as well as to create employment, social cohesion and regional peace.[75]

International and Regional Commitments

South Africa is a member of the United Nations (UN) and the African Union (AU).[76] South Africa has ratified many UN conventions and made binding international commitments to adhere to the standards laid down in these universal human rights documents, including the Universal Declaration of Human Rights (UDHR) and the International Covenant on Economic, Social and Cultural Rights.[77] South Africa is also a member of regional economic communities, including the Southern African Development Community (SADC)[78] and the Southern African Customs Union (SACU).[79]

South Africa has signed and ratified international and regional conventions that promote gender equality, including CEDAW[80] and the Optional Protocol to CEDAW.[81] South Africa also ratified the African Charter on Human and People's Rights and the Protocol on the Rights of Women in Africa (often referred to as the Maputo Protocol), the Solemn Declaration on Gender Equality in Africa (SDGEA), and the SADC Protocol on Gender and Development and Post-2015 Agenda.

In an effort to translate international and regional commitments to promote gender equality into national policy, in 2010, the Government adopted its first National Policy Framework for Women's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Empowerment and Gender Equality, which has yet to be updated.[82] South Africa also officially recognises women's rights and gender equality in the 1996 Constitution, which provides for equality before the law and non-discrimination on several protected grounds.[83] More recently, the National Development Plan: Vision 2030, which serves as a blueprint for development in the country, recognises the importance of a gender equality and women's empowerment agenda. In recent years, the President of South Africa has also signalled his support for a gender equality agenda by approving the establishment of a Presidential Review Committee on Women's Emancipation and Gender Equality. The President also hosted a National Summit on Gender-Based Violence (GBV) and Femicide in 2018, which led to the establishment of the Presidential Task Team to address issues of GBV and femicide in a comprehensive and concerted manner.[84] In 2020, the Government of South Africa also adopted a National Strategic Plan on GBV and Femicide.[85]

The Government of South Africa and its partners have also prioritised several interventions and programmes to advance women's empowerment. The most important include:[86]

- Job creation and sustainable growth.
- Women's economic empowerment through work with small and medium-sized enterprises, informal businesses, and women's cooperatives.
- Increasing women's and girls' access to education, especially in science, technology, engineering, and mathematics (STEM) fields.
- Improving women's health by focusing on reducing maternal mortality rates and addressing high levels of HIV and AIDS among young women.
- Addressing GBV against women and children, including femicide and intimate partner violence (IPV).

Despite such legal and policy frameworks, programmes, and interventions, women and girls continue to experience gender inequalities and discrimination that shape their life experiences and opportunities, placing them at increased risk of GBV.[87]

South Africa ratified the Convention on the Rights of the Child on 16 June 1995, marking the first international treaty ratified under the new democracy,[88] and the Optional Protocol to the Convention on the Rights of the Child concerning the involvement of children in armed conflict.[89] On 30 June 2023, South Africa also acceded to the Optional Protocol to the Convention on the Rights of the Child regarding the sale of child prostitution and child pornography. South Africa has yet to sign or ratify the Optional Protocol to the Convention on the Rights of the Child on a communications procedure. On 7 January 2000, South Africa ratified the African Charter on the Rights and Welfare of the Child (ACRWC), and on 7 June 2000, ratified the Worst Forms of Child Labour Convention (ILO No. 182).

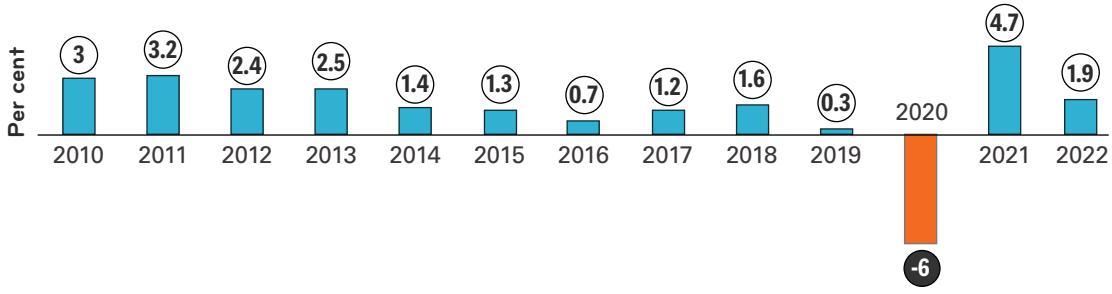
South Africa ratified the UN Convention on the Rights of Persons with Disabilities[90] and the Optional Protocol to the Convention on the Rights of Persons with Disabilities, as well as the 1951 Convention relating to the Status of Refugees. South Africa also signed the 2030 Agenda for Sustainable Development and Africa 2030, both of which promote women's and children's rights and advance gender equality.

Political Economy

The World Bank classifies South Africa as an upper middle-income country.[91] In 2022, South Africa had a GDP of USD 405.3 billion[92] and a GNI of USD 396.8 billion.[93] Despite this classification, inequality in South Africa has long been recognised as one of the most salient features of society, and the country has consistently ranked as one of the most unequal nations in the world.[94] In 2022, the World Bank reported that between 2008 and 2018, South Africa's Gini coefficient changed very little, declining from 68 to only 67, or just 0.21 points per year. This is the slowest decline among Southern African Customs Union (SACU) countries, even though the country has the highest level of inequality in the region.[95] This Gini coefficient places South Africa among the 'top five' most unequal countries on a global scale.[96]

Chart 2.4 shows that South Africa had a GDP growth rate of 3.0 per cent in 2010, but it subsequently declined to 0.3 per cent in 2019. In 2020, South Africa's GDP contracted by 6.0 per cent due to the COVID-19 pandemic.[97] By 2021, the GDP rebounded to 4.7 per cent, but then fell to 1.9 per cent in 2022 due to persistent electricity shortages and constraints in the transport sector, coupled with the global downturn following Russia's invasion of Ukraine.[98]

CHART 2.4. South Africa's annual GDP growth (%), 2010-2022



SOURCE: Retrieved on 3 January 2024 from: GDP growth (annual %) - South Africa | Data (worldbank.org)

Since 2020, Statistics South Africa (Stats SA) reported that the real GDP (measured by production) contracted by 16.9 per cent in the 2nd quarter of 2022 due to the COVID-19 pandemic. More recently, following a decrease of 1.1 per cent in the 4th quarter of 2022, real GDP increased by 0.4 per cent in the 1st quarter of 2023 (**Chart 2.5**).

CHART 2.5. South Africa's real gross GDP (%), 1st Quarter 2020 – 1st Quarter 2023

SOURCE: Statistics South Africa (2023). Gross domestic product (First quarter 2023). Statistics South Africa: Pretoria, South Africa, p. 2. Retrieved on 2 February 2024 from: P04411stQuarter2023.pdf (statssa.gov.za)

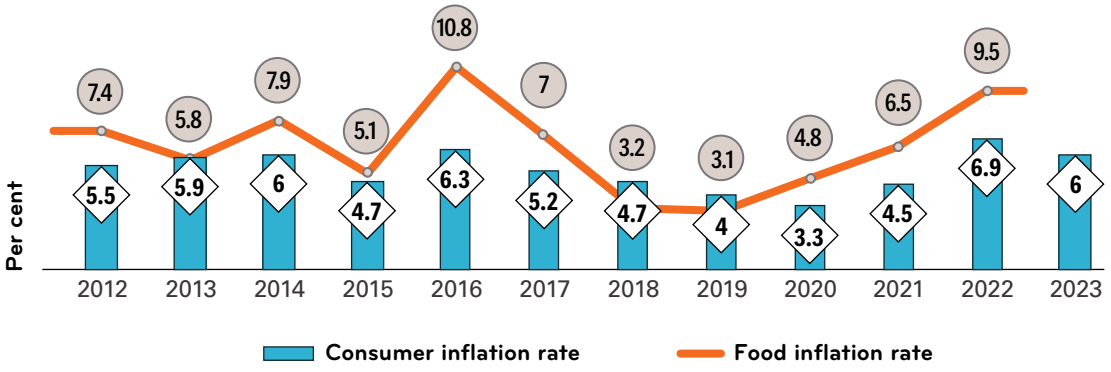
Since 2007, electricity supply shortages have constrained South Africa's growth; these shortages intensified in 2021 and 2022. Severe electricity shortfalls have disrupted economic activity and increased operating costs for businesses, many of which rely on costly diesel generators. Electricity shortages have also negatively affected water infrastructure and distribution, health and education service delivery, and information and communications technology (ICT). Although new reforms and investments are underway,[99] load shedding is expected to continue for a few more years.[100]

Both the COVID-19 pandemic and weak structural growth have exacerbated the socio-economic challenges facing South Africa.[101] Although the services sectors and domestic trade are key drivers of growth, the labour market remains weak. Despite the fact that the employment rate increased to 40.1

per cent in the 2nd Quarter of 2023, from a pandemic low of 35.9 per cent in September 2021, there were still about 74,000 fewer jobs at the end of the 2nd Quarter of 2023 than at the end of 2019, with women and youth persistently more impacted.[102] In 2023, South Africa's economy was projected to grow marginally by 0.2 per cent, but is projected to grow by 1.5 per cent in 2024, largely as a result of growth in trade, tourism, mining, and manufacturing.[103]

Chart 2.6 shows that consumer and food inflation rates have fluctuated from 2012 to 2023. In 2023, the annual consumer inflation rate was 6.0 per cent (down from 6.9 per cent in 2022); whereas in 2022, the food inflation rate was 9.5 per cent (up from 6.5 per cent in 2021). Inflation rates have been impacted largely by the COVID-19 pandemic, global supply chain issues, and global inflation, including price increases for energy, food, and transport. In 2022, the South African Rand (ZAR) also depreciated by 9.5 per cent against the United States Dollar (USD), due largely to weak investor sentiment in South Africa stemming from its persistent energy crisis.[104]

CHART 2.6. Annual consumer and food inflations rate (%), 2010-2022



SOURCES: Provided by UNICEF, based upon Statistics South Africa data

In 2023, across the African continent, local currencies weakened against global trading currencies, including the USD and pound sterling (£), resulting in a loss of value and purchasing power of these local currencies.[105] The significant gap between supply and demand for foreign currencies in African countries is a major issue.[106]

The International Monetary Fund (IMF) attributed the depreciation of African currencies to external factors, including a lower risk appetite in global markets and interest rate hikes in the United States of America (USA), which drove investors away from Africa toward safer, higher-paying US Treasury bonds. As a result, foreign exchange earnings were adversely affected in many countries, as demand for the region's exports dropped due to the economic slowdown in major economies. At the same time, high oil and food prices, partly due to Russia's war in Ukraine, pushed up import costs.[107] A heavy reliance on imports is another common factor; African countries import more finished goods than they export. Consequently, African countries require foreign currencies, such as USD or Chinese RMB, to pay international suppliers, increasing the demand for foreign exchange and reducing reliance on local currencies.[108] Many African governments, including the Government of South Africa (GoSA), have accumulated substantial debts that need to be serviced, consuming foreign currency reserves. Vast amounts of money have also been allocated to pay heavily subsidised local fuel and energy prices.[109]

In managing rising inflation, the Reserve Bank of South Africa raised the base interest rate to 6.25 per cent in September 2022, up from 5.5 per cent in July 2022. Inflationary pressures were projected to remain elevated in 2023 but cooled to 5.5 per cent in November 2023.[110]

In 2020, the IMF approved USD 4.3 billion in emergency financial assistance under the Rapid Financing Instrument to support the GoSA's efforts to address the challenging health situation and severe economic impacts of the COVID-19 pandemic. IMF funding was provided in the form of a low-interest loan that contributed to the government's fiscal relief package and paved the way for the GoSA to provide the necessary financial relief required to foster new economic growth and mitigate further harm to the economy.[111] The IMF's emergency financial support served as a catalyst for additional financing from other international financial institutions, including the African Development Bank, New Development Bank, and the World Bank.[112]

In January 2022, the World Bank approved South Africa's request for a USD 750 million low-interest development policy loan (DPL) to support the Government's fiscal relief package and efforts to accelerate its COVID-19 response aimed at protecting the poor and vulnerable from the adverse socio-economic impacts of the COVID-19 pandemic. This DPL is part of the GoSA's broader financing strategy to access external financing from international financial institutions to support the implementation of South Africa's Economic Reconstruction and Recovery Plan (ERRP) and to build a resilient and sustainable economic recovery. The DPL is also aligned with priorities to modernise the country's social protection and health services and improve delivery systems that will continue to be relevant beyond the COVID-19 pandemic. The DPL aligns with the World Bank's Crisis Response Approach aimed at protecting lives and livelihoods and supporting a more inclusive and resilient growth path.[113]

In June 2022, the World Bank approved an additional USD 480 million for South Africa's COVID-19 Emergency Response Project. The loan followed a request by the GoSA for assistance in financing vaccine procurement contracts. The loan financed the procurement of 47 million COVID-19 vaccine doses by the GoSA. By supporting the country's COVID-19 vaccination programme, the project is helping the GoSA to cope with the COVID-19 pandemic and creates the fiscal space needed to strengthen its health system and ensure financial and institutional sustainability.[114]

Labour Force Participation

In 2022, 61 per cent of persons aged 15-64 were employed in the labour force (up from 57 per cent in 2010; see Annex Chart 1). In the third quarter of 2023, the labour force participation rate was 60 per cent; the number of employed persons increased by 399,000 to 16.7 million in the third quarter of 2023, compared to 16.3 million in the second quarter of 2023.[115] Males have been more likely than females to participate in the labour force (see Annex Chart 2). In 2019, prior to the COVID-19 pandemic, 68 per cent of men aged 15-64 participated in the labour force, compared to 57 per cent of women aged 15-64. During the pandemic, men's labour force participation rate decreased to 64 per cent in 2020 and 65 per cent in 2021, whereas women's labour force participation rate decreased to 53 per cent in 2020 and 54 per cent in 2021. Gender inequalities in labour force participation contribute to gender inequalities in the family and community, as women lack economic independence.

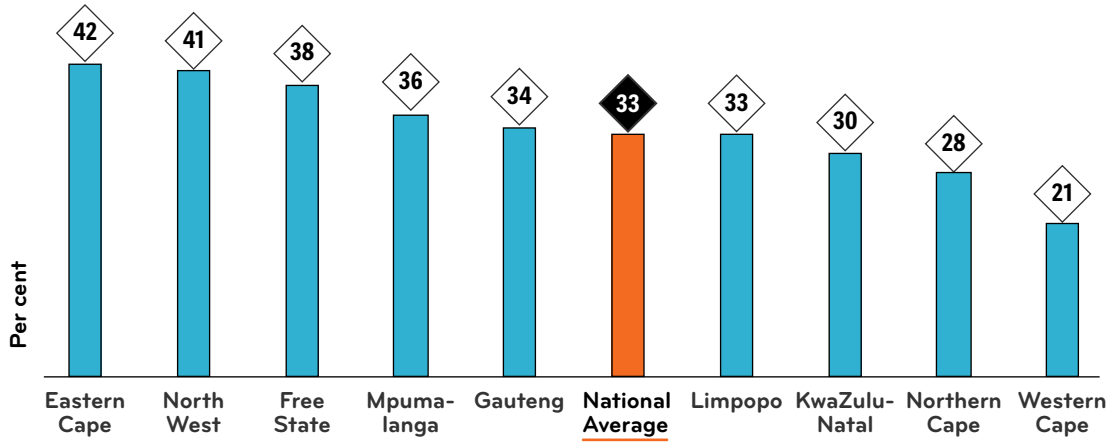
Unemployment

The unemployment rate[116] is the most widely used indicator for unemployment and is a designated SDG Indicator (8.5.2). Over the past decade, unemployment has remained a structural challenge for South Africa, which has one of the highest unemployment rates in the world.[117] Joblessness in South Africa has continued to hinder human and economic development compared to other countries in the global context.[118]

Chart 2.7 shows that the unemployment rate was 33 per cent in the 1st Quarter of 2024.[119] Unemployment rates varied from a low of 21 per cent in the Western Cape to a high of 42 per cent in the Eastern Cape. Five provinces had higher unemployment rates than the national average of 33

per cent, indicating that more than one in three people in these provinces were unemployed in the 1st Quarter of 2024.

CHART 2.7. Unemployment rate by region (% total labour force, national estimates), 1st Quarter 2024



SOURCE: Presentation Quarterly Labour Force Survey Q1: 2024. Retrieved on 2 July 2024 from: PowerPoint Presentation (statssa.gov.za).

Human Development

The *Human Development Report 2023/2024*[120] presents Human Development Index (HDI) values[121] for 193 countries and territories. The HDI is a summary measure of average achievement in key dimensions of human development, including the ability to lead a long and healthy life, measured by life expectancy at birth; the ability to acquire knowledge, measured by mean years of schooling for adults aged 25 years and older, and expected years of schooling; and the ability to achieve a decent standard of living, measured by gross national income per capita. The scores for the three HDI dimension indices are aggregated into a composite index using a geometric mean, and a ranking is provided.[122]

Table 2.2 shows the 2022 HDI values[123] for South Africa.[124] The scores for the three HDI dimension indices are aggregated into a composite index using a geometric mean, and a ranking is provided.[125] In 2022, South Africa's HDI value was 0.716, which classifies the country as 'high' on the HDI, positioning it at 105 out of 193 countries and territories (up from a rank of 109 out of 191 countries and territories in 2021). For comparison purposes, similar data are presented for sub-Saharan Africa and countries with high human development.

TABLE 2.2. South Africa Human Development Index (HDI) Indicators, 2022

Country	Human Development Index (HDI)		Life expectancy at birth[126] (SDG 3)	Expected years of schooling (SDG 4.3)	Mean years of schooling (SDG 4.4)	GNI per capita (2017 PPP$) (SDG 8.5)
	Rank	Value				
South Africa	105	0.716	61.5	14.3	11.6	13,186
Sub-Saharan Africa	---	0.549	60.6	10.3	6.0	3,666
High human development	---	0.764	75.2	14.5	8.6	15,484

SOURCE: UNDP (2023). Human Development Report 2023/2024: Breaking the gridlock. UNDP: New York, NY, USA.

South Africa's HDI value is based on the following data. In 2022, South Africa's life expectancy at birth was 61.5 years (up from a low of 54 years in 2004)[127]; this is lower than the average life expectancy at birth for high human development countries (75.2 years). In South Africa, the expected

mean years of schooling were 14.3 years, which is higher than the average for sub-Saharan Africa (10.3 years) but lower than for high human development countries (14.5 years). In comparison, mean years of schooling in South Africa were 11.6 years, which is much higher than the mean years of schooling in sub-Saharan Africa (6.0 years) and high human development countries (8.6 years). Finally, South Africa's GNI per capita was $13,186 in 2022 (up from $10,680 in 2004),[128] which is notably higher than the average for sub-Saharan Africa ($3,699) but lower than for high human development countries ($15,484).

To measure human development more comprehensively, the Human Development Report 2023/2024 presents the Gender Development Index (GDI), which compares female and male achievements based on HDI values, and the Gender Inequality Index (GII), which highlights women's empowerment as it relates to reproductive health, education, political representation, and the labour market.[129] In South Africa, the HDI value for females was 0.710, compared to 0.721 for males, resulting in a 2022 GDI value of 0.985, placing the country in Group 1 (i.e., countries with high equality in HDI achievements between women and men). South Africa's GDI value of 0.985 is above the GDI value of 0.915 for sub-Saharan Africa but lower than the GDI value of 0.962 for high development countries (see Annex Table 2). South Africa also has a 2022 GII value of 0.401, ranking it 99 out of 193 countries (see Annex Table 3).[130]

To measure inequality, the Human Development Report presents the Inequality-adjusted Human Development Index (IHDI), which takes into account inequality in all three dimensions of the HDI by 'discounting' each dimension's average value according to its level of inequality. The IHDI is the HDI discounted for inequalities. The 'loss' in human development due to inequality is the difference between the HDI and the IHDI and can be expressed as a percentage. The IHDI is calculated based on the premise that as inequality increases in a country, the loss in human development also increases.

South Africa's 2021 HDI value was 0.713; however, when the value is discounted for inequality, the IHDI value falls to 0.471. South Africa's IHDI value is higher than the IHDI value of 0.627 for high human development countries and the value of 0.383 for sub-Saharan Africa.[131] South Africa's overall loss due to inequality is 33.9 per cent, which is higher than the average overall losses due to inequality for sub-Saharan Africa (30.0 per cent) and lower than for high human development countries (16.8 per cent) (see Annex Table 4).[132]

Indices on Women's Empowerment and Gender Equality

In 2023, the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women) and UNDP launched *The Paths to Equal: Twin Indices on Women's Empowerment and Gender Equality*,[133] which highlights global challenges faced by women and provides a roadmap for targeted interventions and policy reforms. The report introduces two new indices: the Women's Empowerment Index (WEI), which measures women's power and freedoms to make choices, and the Global Gender Parity Index (GGPI), which assesses gender disparities in key dimensions of human development. Combined, these two indices offer a comprehensive assessment of countries' progress in achieving gender equality.[134] The WEI and GGPI complement UNDP's existing composite gender indices – the Gender Development Index (GDI), the Gender Inequality Index (GII), and the Gender Social Norms Index (SNI) – which are powerful tools in the pursuit of measuring gender equality.[135]

The WEI and GGPI are summary measures of average achievements on key dimensions of human development (i.e., capabilities that are universally valued as important human goals and that require a gender-sensitive agenda and policy interventions to be achieved).[136] The WEI measures women's empowerment across five dimensions of human development, including life and good health; education, skills-building, and knowledge; labour and financial inclusion; participation in decision-making; and freedom from violence. The GGPI assesses the status of women relative to that of men on the first four dimensions, with some variation in indicators and variable treatment.[137] Together, the WEI and GGPI

answer two questions that are at the core of women's rights and human development: Are women and girls more empowered to make their own choices and seize opportunities in life? And has gender parity been achieved? These two questions are linked but should not be conflated.

The WEI and GGPI are calculated for 114 countries. In 2022, South Africa's WEI value was 0.680, classifying the country as 'lower middle' on women's empowerment, while South Africa's GGPI value was 0.823, classifying the country as 'high' on the GGPI. For comparison purposes, similar data are presented for sub-Saharan Africa and high human development countries in Annex Tables 5 and 6.

Both the WEI and GGPI serve as quick and useful tools for policymakers to examine how they are faring in meeting their obligations towards achieving women's empowerment and gender equality. The indices also allow policymakers to track and compare their progress with that of other countries facing similar challenges and constraints. Eliminating inequality in outcomes between women and men is crucial to redistributing power, including the power of women to claim their rights and realise their full potential.[138]

Persons With Disabilities

Table 2.3 shows that the national disability prevalence rate was 6 per cent in 2022 (down from 7 per cent in 2011).[139] In both 2011 and 2022, the national disability prevalence rate was slightly higher among females than males. Among children and youth aged 5-24, the proportion of children aged 5-9 with disabilities decreased from 11 per cent in 2011 to 2 per cent in 2022. The proportion of adolescents aged 10-14 and 15-19 years with disabilities also decreased, but to a lesser extent.

In terms of population group, it is notable that the proportion of White South Africans with a disability increased from 7 per cent in 2011 to 10 per cent in 2022. In terms of region, in 2011 and 2022, the Northern Cape, Free State, and Eastern Cape had a larger proportion of persons with disabilities, while the Western Cape and Gauteng had the smallest proportion. There has been a decrease in the proportion of persons with disabilities in each of the provinces, except for the Western Cape and Gauteng, where the proportion remained unchanged.

TABLE 2.3. Persons aged five years and older with disability in South Africa (%), 2011 and 2022

	2011	2022
National	7%	6%
Sex		
Male	6%	5%
Female	8%	7%
Age group		
5-9 years	11%	2%
10-14 years	4%	2%
15-19 years	3%	2%
20-24 years	2%	2%
Population group		
Black African	8%	6%
White	7%	10%
Coloured	6%	6%
Indian/Asian	6%	7%
Other	6%	6%

	2011	2022
Province		
Northern Cape	11%	8%
Free State	11%	8%
Eastern Cape	10%	9%
North West	10%	7%
KwaZulu-Natal	8%	6%
Limpopo	7%	5%
Mpumalanga	7%	5%
Western Cape	5%	5%
Gauteng	5%	5%

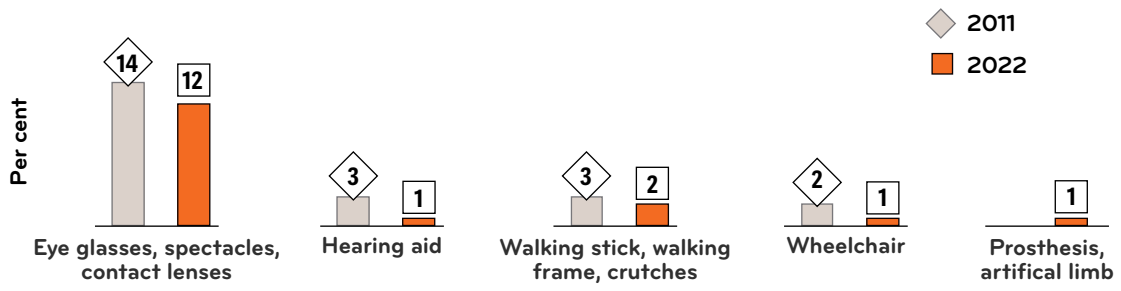
SOURCE: Census 2022: Statistical Release (P0301.4). Department of Statistics South Africa: Pretoria, South Africa, pp. 52-57.

Chart 2.12 shows the proportion of the population aged five years and older by type of assistance device. The proportion of persons using eyeglasses, spectacles, and contact lenses was 14 per cent in 2011 and 12 per cent in 2022. The proportion of the population using each of the other assistive devices was much lower and minimal. For instance, only 2 per cent of the population used a wheelchair in 2011 and 1 per cent in 2022.

Disabled People of South Africa (DPSA) is the non-profit disability body that mobilises and advocates for the rights and attainment of equal opportunities for persons with disabilities. DPSA is recognised as the national assembly of persons with disabilities for Disabled People International, which has UN observer status. There are other non-governmental, faith-based, and community-based organisations that work to advance the rights of persons with disabilities in South Africa; some of these are run and managed by persons with disabilities.[140]

In 2018, facilitated by litigation, a landmark settlement agreement between the South African National Council for the Blind, the National Braille Authorities, the School Governing Bodies of Schools for Visually Impaired Learners, and the Department of Basic Education compelled the State to provide braille textbooks for all visually impaired learners.[141]

CHART 2.12. Persons aged five years and older by type of assistive device (%), 2011 and 2022



SOURCE: Census 2022: Statistical Release (P0301.4). Department of Statistics South Africa: Pretoria, South Africa, pp. 52-57.

In 2018, the Committee on the Rights of Persons with Disabilities recognised that South Africa has made steady progress towards the realisation of the rights of persons with disabilities, including updating the national disability policy with the White Paper on the Rights of Persons with Disabilities, which emphasised embedding disability inclusion within government-wide regulatory, planning, resourcing, programming, and reporting systems. The Committee also recognised that more children with disabilities were enrolled in ordinary schools than in special schools, and in 2015, sign language was introduced as a language of instruction in all schools for deaf learners.[142] Measures were also adopted to address the unacceptable levels of violence, abuse, and periodic neglect that learners with disabilities were exposed to in some boarding facilities at special schools. In addition, a robust and inclusive public dialogue on assisted decision-making began with the conclusion of a report on the issue by the South African Law Reform Commission.[143]

However, the Committee on the Rights of Persons with Disabilities raised some concerns, including: the situation of women and girls with disabilities, particularly black women and girls, who regularly face double discrimination and violence; and the fact that children with disabilities formed the majority of children in institutions and special school hostels, and were left out of the basic education system, especially in rural areas. Concerns were also raised in relation to the 2015 Life Esidimeni tragedy, which involved the death of 144 persons with intellectual disabilities (at psychiatric facilities) in Gauteng province due to neglect, lack of care, and the absence of a system to monitor such institutions. The Committee recommended that South Africa take immediate measures to address violence and abuse of women and children with disabilities, and adopt a national strategy for the deinstitutionalisation of children with disabilities.[144]

The Committee noted that the Mental Health Care Act 17 of 2002 denied legal capacity to persons with disabilities, particularly persons with intellectual disabilities. In response, the Committee encouraged socio-economic development programmes and initiatives to address disability issues, and that persons with disabilities know their rights and how to speak for themselves. The Committee recommended that the Government of South Africa adopts a strict timeline for the development of a national strategy and legislation on independent living.[145]

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Humanitarian Risks

In South Africa, there is a humanitarian-development-peace nexus in which development work has been affected by climate shocks, including three consecutive seasons of drought, recurring floods in parts of the country, declining economic growth, and the COVID-19 pandemic. Accordingly, in 2022, the UN CCA recommended that the UNSDCF should include an emergency preparedness component and establish or integrate more formal arrangements with the South African National Disaster Management Centre (NDMC) and corresponding sub-national entities in preparation for future emergencies, humanitarian disasters, and/or new disease outbreaks.[146]

That same year, UNICEF documented that the health and well-being of children remain at risk as the COVID-19 pandemic continues to unfold alongside a deepening energy crisis and fallout from the war in Ukraine, including food security issues and rising food prices. It has been estimated that half of households in South Africa struggle to meet basic food needs and are vulnerable to malnutrition and negative long-term health and educational effects. In 2022, the number of people in need (living below the poverty line) was 14 million, of which 4.8 million, or 34.3 per cent, were children in need.[147] According to UNICEF, only 35.7 per cent of the 14 million people in need were reached, including 1.7 million, or 35.4 per cent, of children in need.[148]

In 2021 and 2022, UNICEF scaled up its COVID-19 vaccination rollout response through technical cold chain support to the National and Provincial Departments of Health, as well as risk communication and community engagement (RCCE) work. As a result, about 12.8 million people were provided with

lifesaving information about COVID-19 vaccinations and child health services. In June 2022, South Africa reached 50 per cent COVID-19 vaccine coverage among the adult population. In late 2022, a measles outbreak was declared, as immunisation rates in some areas failed to reach the 95 per cent coverage needed to stop community transmission, partly as a result of reduced vaccination rates due to the COVID-19 pandemic.[149] These situations have eroded people's resilience by weakening their livelihoods and have forced shifts in focus from development to humanitarian interventions.[150]

In 2022, UNICEF documented that emergency education and early childhood development (ECD) programmes provided about 470,000 children with improved access to quality education services to mitigate the long-term impact of COVID-19 learning disruptions. In late 2022, flooding in KwaZulu-Natal also disrupted schooling for many children.[151] As the floods hit, President Ramaphosa declared a national state of disaster for a coordinated response across all spheres of government, and state entities activated contingency arrangements in keeping with their mandates. The Government of South Africa developed a multisectoral National Integrated Flood Response and Recovery Plan, which included a three-pronged approach: Phase 1 focused on immediate humanitarian relief to secure the safety and basic needs of all affected persons; Phase 2 focused on stabilisation and recovery, including rehousing people who lost their homes and restoration of services; and Phase 3 focused on reconstruction and rehabilitation.[152] It was against this backdrop that the UN in South Africa launched a coordinated humanitarian response through its agencies, funds, and programmes, in an effort to provide prompt disaster support to the government and rally personnel and resources to meet urgent humanitarian needs.[153] This included support to intervene in health, education, agriculture, disaster risk management and coordination, and economic recovery.[154]

In 2022, following the KwaZulu-Natal floods, multi-purpose cash grants were provided to 725 families, and WASH programming was activated to alleviate the impact of the KwaZulu-Natal floods on vulnerable households. In addition, broader psychosocial support was provided to help improve the mental health and well-being of approximately 230,250 children.[155]

In February 2023, President Ramaphosa declared a national "state of disaster" over the country's crippling power shortages, stating that it poses an existential threat to the economic and social fabric of South Africa; this declaration was quickly walked back after legal threats. Electricity shortages are the product of delays in building new coal-fired power stations, corruption in coal-supply contracts, criminal sabotage and failures to ease regulation that would enable private providers to swiftly bring renewable energy online.[156]

Climate-related events, such as the devastating floods in KwaZulu-Natal and droughts in other provinces, coupled with crippling power shortages, indicate South Africa must urgently build resilience to withstand future shocks, whether socio-economic, political, climate-related, or environmental.[157]

Climate Change Risks

South Africa's topography and location make it highly vulnerable to the impacts of climate variability and change, as does the country's high dependence on rain-fed agriculture and natural resources, high levels of poverty, and low adaptive capacity.[158] In 2021, the University of Notre Dame Global Adaptation Index (ND-GAIN Index) ranked South Africa among the most vulnerable countries (i.e., 95 out of 185 countries),[159] given the country's high vulnerability score of 0.390 and low readiness score of 0.356. South Africa is the 111th most vulnerable country and the 120th most ready country out of 185 countries.

This is despite the fact that South Africa is statistically a negligible net emitter of greenhouse gases. In 2020, South Africa's net emissions amounted to 501,521 total greenhouse gas emissions (kt of CO2 equivalent),[160] accounting for only 1.1 per cent of the world's total greenhouse gas emissions of 46,120,921.[161] At the same time, however, South Africa emits 8.6 tonnes per person of greenhouse gases, including carbon dioxide, methane and nitrous oxide, which is higher than the world average of 6.8 tonnes per person.[162]

People living in South Africa are on the front lines of climate change impacts. South Africa's topography and location influence its temperate climate and increase its vulnerability to climate variability, extreme weather events, and natural hazards.[163] South Africa already experiences a high degree of risk from natural hazards and disasters, including droughts, floods, wildfires, and storm-related events (e.g., high winds, coastal storm surges, and hail), all of which are likely to be exacerbated by climate change. These events are expected to increase in frequency and intensity and contribute to desertification, land degradation, and loss of biodiversity, including the country's unique wildlife populations.[164]

Other challenges posed by climate change include those related to water resource availability, changing population patterns, and increasing population demands. The climatic and socio-economic environments in semi-arid areas of South Africa promote unsustainable agro-ecological systems that suffer from crop failures and reduce the productivity of rangelands; this renders many communities vulnerable to food insecurity and unstable livelihoods.[165]

South Africa has already experienced the negative impacts of climate change and extreme weather events. These vary largely by province and district and include increasing temperatures, prolonged dry spells and recurrent droughts, intense rainfall, and flooding. Water scarcity and drought conditions are expected to increase the risks of food insecurity and may exacerbate conflict situations over scarce resources, which may force additional population displacement. Sea level rise and increasing coastal storm surges will also impact much of the country's coastline. These climate-related events are already becoming more commonplace than in the past and are predicted to persist and worsen in the future.[166] This is expected to negatively impact children's health, nutritional status, and access to education and protection systems.[167]

South Africa's key economic sectors – agriculture, water, energy, and health – are highly vulnerable to climate variability and change; each of these is briefly discussed in the subsections that follow.

Agricultural Sector: The agriculture sector is critical to the country's economy; it employs over 860,000 people and contributes significantly to food security and export revenues. The sector is diverse and includes both commercial and subsistence farming systems. Local livelihoods depend heavily on agriculture, which comprises maize, wheat, sugar cane, and sunflower seed production. Livestock production is also a significant part of agriculture.[168] Climate change is expected to have adverse impacts on cereal crop production, high-value export agriculture, and animal husbandry practices. Although climate change trends are likely to positively impact the production of key tropical crops, such as sugar cane, these gains for the economy might negatively affect children's nutrition and could be offset by increased pest diversity and distribution.[169] For these reasons, agricultural production and food security in South Africa are significant national policy concerns.170

Water Sector: South Africa is a water-stressed country, and the impacts of climate change on the water sector could exacerbate existing conflicts, further increase inequalities, and limit access to potable

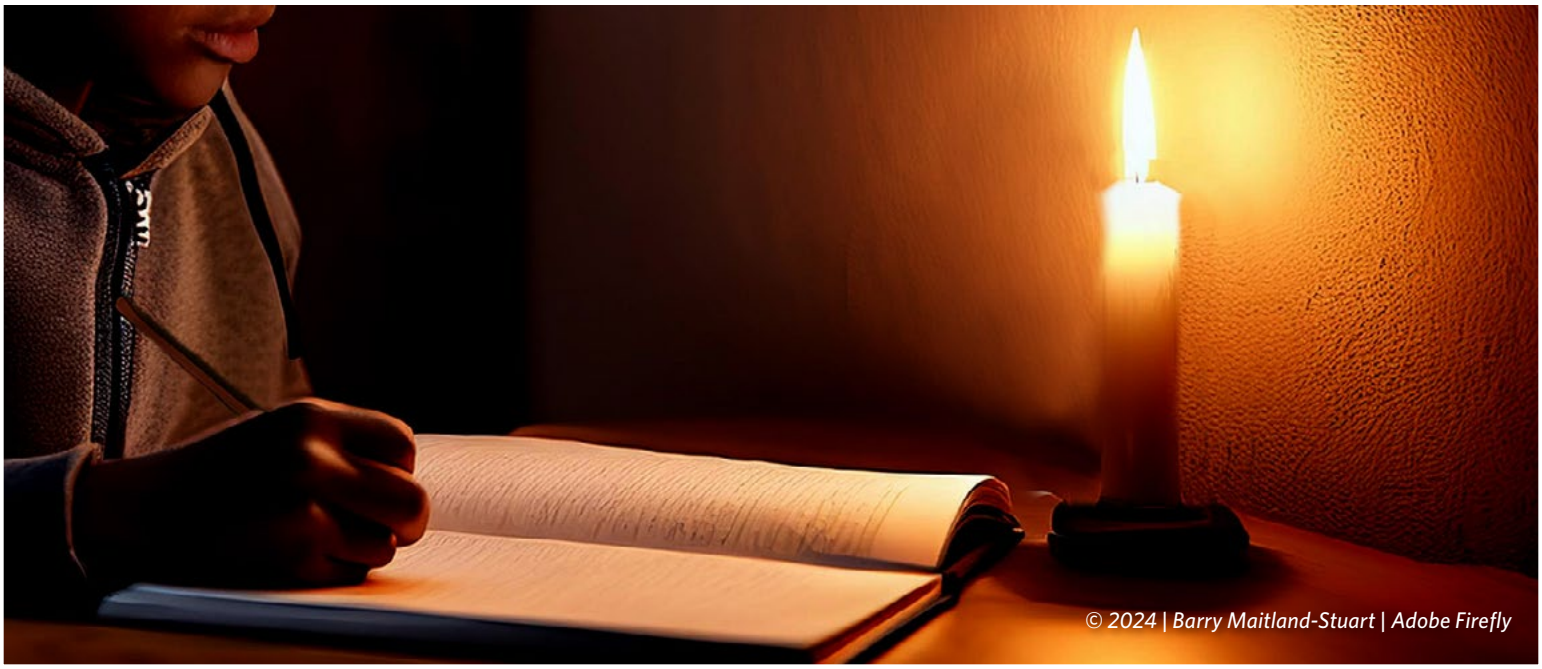
water and safely managed drinking water. Changes in the quality and availability of water will become the dominant challenge in the country, as more variable rainfall is likely to increase disasters associated with droughts, floods, and waterborne diseases. A majority of the population already faces water supply deficits for at least part of the year. In addition, rising water demand and increased pollution across shared water resources are critical problems.[171]

At this time, South Africa does not have the capacity to expand its water storage or increase its generation of hydropower. In the future, the challenge will be that rising temperatures are expected to decrease water availability, and changes in rainfall and evaporation are likely to alter water infiltration and groundwater recharge rates, further decreasing the reliability of unimproved groundwater and surface water sources during droughts and prolonged dry periods. Thus, the sustainable and reliable storage and use of water resources is a top priority for the Government of South Africa; this requires a robust water resources management policy that promotes the efficient, equitable, and optimal utilisation of water resources.[172] Since 2023, the Department of Water and Sanitation has been working on the water sector climate strategy, which will be finalised in 2024.[173]

Energy Sector: South African energy production is highly dependent on the country's cheap and abundantly available coal, which comprises approximately 80 per cent of the total system load.174 Coal energy175 is supplemented by crude oil imports and enriched uranium imports for South Africa's nuclear power plants; a limited quantity of natural gas is available for energy production. Hydropower is one source of renewable energy for the country, followed by biomass and solar energy; yet, in 2017, hydropower comprised only one per cent of energy generation.176

In recent years, South Africa's population and economic growth, along with an expanding tourism sector, have placed greater demands on energy production and are expected to continue to do so over the long term.[177] Regarding climate change, rising temperatures have already posed limitations on the cooling capacities of power-generating stations, resulting in reduced outputs. Future demands for electricity and increasing peak load requirements during hotter summers will put further strain on power-generating stations and lead to disruptions in energy supply and transmission. There are also expected to be increased costs related to the maintenance and repair of power and energy infrastructure.[178]

Ultimately, energy generation, transmission, and expanded use are critical to the national development agenda and economic growth. South Africa is also a major energy supplier for other countries in the region; thus, a reduction in energy generation could have adverse trickle-down effects for these nations. For these reasons, the Government of South Africa is focused on supporting the country's transition to a low-carbon economy (i.e., renewable energy and high-efficiency coal-fired power stations), which are expected to have major implications for its energy sector.[179]



Health Sector: Climate change is expected to impact public health, including increased exposure to heat-related illnesses (i.e., dehydration, heat exhaustion, heat stroke), vector-borne diseases (i.e., malaria, dengue fever, yellow fever), air pollution and associated respiratory illnesses, water-borne illnesses (i.e., cholera, diarrhoeal diseases), and communicable diseases (i.e., HIV/AIDS).[180]

To reduce the impacts of climate change on public health, context-specific actions need to be implemented that are aligned with locally relevant health vulnerabilities (e.g., reducing certain pollutants, developing heat-health action plans, improving biosafety, and more). South Africa's health infrastructure needs to be upgraded to support more systematic climate change resilience, and health workers need to be capacitated to identify diseases as they emerge.[181]

To mitigate and adapt to climate change, the GoSA has developed a range of legislation, policies, strategies, and plans, including:

- National Climate Change Adaptation Strategy, 2020[182]
- National Climate Change Response: White Paper, 2017[183]
- National Climate Change Response Policy, 2011[184]
- National Energy Act 34 of 2008[185]
- National Climate Change Response Strategy, 2004[186]

These national legal and policy frameworks provide a common vision of climate change adaptation and climate resilience for the country and outline priority areas, strategic objectives, interventions, and outcomes to achieve this vision. This includes pursuing a low-carbon growth strategy and a low-emission development strategy.[187]

In 2016, South Africa signed the Paris Agreement on climate change under the aegis of the UN Framework Convention on Climate Change (UNFCCC), which was adopted on 12 December 2014 at the 21st session of the Conference of the Parties of the UNFCCC CoP21, held in Paris, France.[188] In keeping with Paris Agreement commitments, the National Climate Change Adaptation Strategy 2020 identified four strategic objectives:[189]

- Build climate resilience and adaptive capacity to respond to climate change risks and vulnerabilities.
- Promote the integration of climate change adaptation responses into development objectives, policy planning, and implementation.
- Improve understanding of climate change impacts and capacity to respond to these impacts.
- Ensure resources and systems are in place to enable the implementation of climate change responses.

In 2016, South Africa submitted its Nationally Determined Contribution (NDC) to the UNFCCC, with updates in 2021,[190] and submitted its 4th Biennial Update Report to the UNFCCC in 2021.[191] The NDC sets out climate mitigation and adaptation objectives, along with financing and capacity-building requirements.[192] The current NDC, which will be revised by 2025, does not include child-sensitive commitments in most crucial areas, including health, energy, social protection, education, water, and sanitation; this is a significant gap that should be addressed in the revised NDC.[193]

In May 2024, the South African Parliament unanimously passed the Climate Change Bill, which sets ambitious goals to achieve the country's low-carbon and climate-resilient future. The Climate Change Bill enables the development of an effective climate change response and a long-term transition to a low-carbon and climate-resilient economy and society in the context of sustainable development. The Bill includes essential mitigation and adaptation measures against climate change, representing a major step forward for South Africa in implementing a strong national climate change response and heralding a new era of accountability and engagement in the fight against climate change for businesses. The Bill also mandates that the Ministry of Forestry, Fisheries and the Environment allocate carbon budgets to businesses engaging in listed climate-impacting activities, necessitating the development and submission of greenhouse gas emission plans.[194]

South Africa has made significant progress in refining its policy and legal framework for disaster risk reduction and management (DRRM) through adaptation, prevention, and mitigation. This includes the Disaster Management Act 57 of 2002 and the Amendment Bill, along with the National Disaster Management Framework (2005), which provides guidelines and recommendations for more effective disaster prevention, mitigation, and preparedness. The Act makes provision for national, provincial, and municipal disaster management centres to enable coordination of disaster risk management activities.[195]

Climate resilience is key to sustainable development and to achieving the SDGs, and achieving the SDGs will facilitate South Africa's efforts to mitigate and adapt to climate change. The fiscal deficit and high public debt are likely to limit the government's ability to invest in climate change mitigation, resilience building, and capacity building across the country to address the negative impacts of climate change.

Children are the least responsible for climate change, yet they will bear the greatest burden of its impact.

Impact of Climate Change on Children

UNICEF recognises that climate change is a direct threat to children's ability to survive, grow, and thrive. This is the first time a generation of children will grow up in a world made significantly more dangerous as a result of climate change and environmental degradation.[196] As extreme weather events increase in frequency and intensity, they threaten children's lives and destroy infrastructure critical to their well-being, including homes and schools. Floods compromise water and sanitation facilities, which leads to diseases, such as cholera, to which children are particularly vulnerable. Children are the most susceptible to diseases that will become more widespread as a result of climate change, including malaria and dengue fever.[197]

In 2023, the Department of Water and Sanitation (DWS) supported UNICEF's climate, energy, and environment landscape analysis for children (CEELAC), which concluded that South Africa's climate change policies do not consider or address children's unique needs and vulnerabilities; consequently, these policy frameworks are not sufficiently child-responsive.[198]

The CEELAC also documented that children of all ages are vulnerable to environmental exposures related to climate change; however, exposure to and impacts of various environmental hazards vary by age and stage of development, as well as geography and socio-economic circumstances.[199] In particular, rising temperatures and extreme events (e.g., floods and droughts) are exacerbating the impacts of environmental hazards on children, especially in rural and impoverished communities, and in cities that tend to rely on effective stormwater drainage as a flood management solution.[200] Given that an estimated 55.5 per cent of the population lives below the national poverty line[201] and 62.1 per cent of children are multidimensionally poor, with higher concentrations of child multidimensional poverty in Limpopo (82.8 per cent), Eastern Cape (78.7 per cent), KwaZulu-Natal (75.8 per cent), Mpumalanga (69.2 per cent), and North West (64.1 per cent),[202] the impact of climate change on socio-economic vulnerability is expected to be significant in South Africa. The effects of climate change will be further compounded by the high unemployment rate and limited capacity of the Government of South Africa to provide social assistance, basic services, and readiness to respond to environmental disasters.[203]

Food insecurity related to climate change is a serious issue, particularly in South Africa, where less than 21 per cent of young children receive adequate nutrition or a minimum acceptable diet, which is critical to their health and development. Poor nutrition in childhood, including in early childhood and adolescence, can have far-reaching consequences, including child mortality, stunting and wasting, and reduced learning and cognitive development, which can lead to lower employment opportunities in adulthood.[204] Heat stress is also among the most significant climate-related hazards facing South

Africa's children. It is expected to negatively affect their health and well-being, as well as their education and ability to play outside. Additionally, heat stress is likely to lead to an increase in child abuse, which is already high in South Africa.[205]

Extreme weather events, such as flooding and drought, can result in families being displaced and forced to live in crowded spaces and informal settings (e.g., community halls), where children, particularly adolescent girls and young women, are vulnerable to violence and exploitation. Households with assets and skilled labour are in a better position to move from vulnerable areas and adapt to environmental disasters when they occur, whereas poor households, with few resources, lower levels of education, and a lack of marketable skills, are more likely to find themselves living in marginalised communities and climate-vulnerable situations (e.g., informal settlements facing a heightened risk of fire and/or located on wetlands or in floodplains). Poor households are more likely to be both directly and indirectly affected by the negative effects of climate change, including climate-related food insecurity, lack of access to safe drinking water, heightened risk of disease, and failing basic education and health services.[206]

Climate change also poses significant challenges to the WASH sector, which will further exacerbate health and social disparities. WASH is vital for children. In recent years, municipalities across the country have faced increasing water outages due to inadequate infrastructure investments, which include ageing WASH infrastructure, power outages, and climate change impacts. Functional drainage and wastewater treatment systems are severely lacking, especially in many rural areas and informal settlements in South Africa.[207]

Children are most at risk when WASH services fail or are impacted by flooding. Flooding often destroys or damages WASH infrastructure, leads to the overflow of poorly built latrines and pit latrines, and contaminates surface and drinking water sources with sewage, particularly in rural areas and informal settlements. Frequently, flooding leads to outbreaks of waterborne diseases, such as cholera and other diarrhoeal diseases, especially among children under five.

In South Africa, the rising costs of electricity, along with power outages, have heightened the focus on 'energy poverty', which disproportionately affects marginalised households (up to half of South African households are estimated to need more energy than they use). Energy poverty directly impacts children in multiple ways. For instance, children require consistent access to modern energy services to study and access the internet. They also need modern energy services to support healthcare (e.g., access to medicines that require refrigeration). Children who are unable to access sufficient modern energy services are more likely to be heavily exposed to health and life risks associated with cheap fossil fuel-based alternatives.[208]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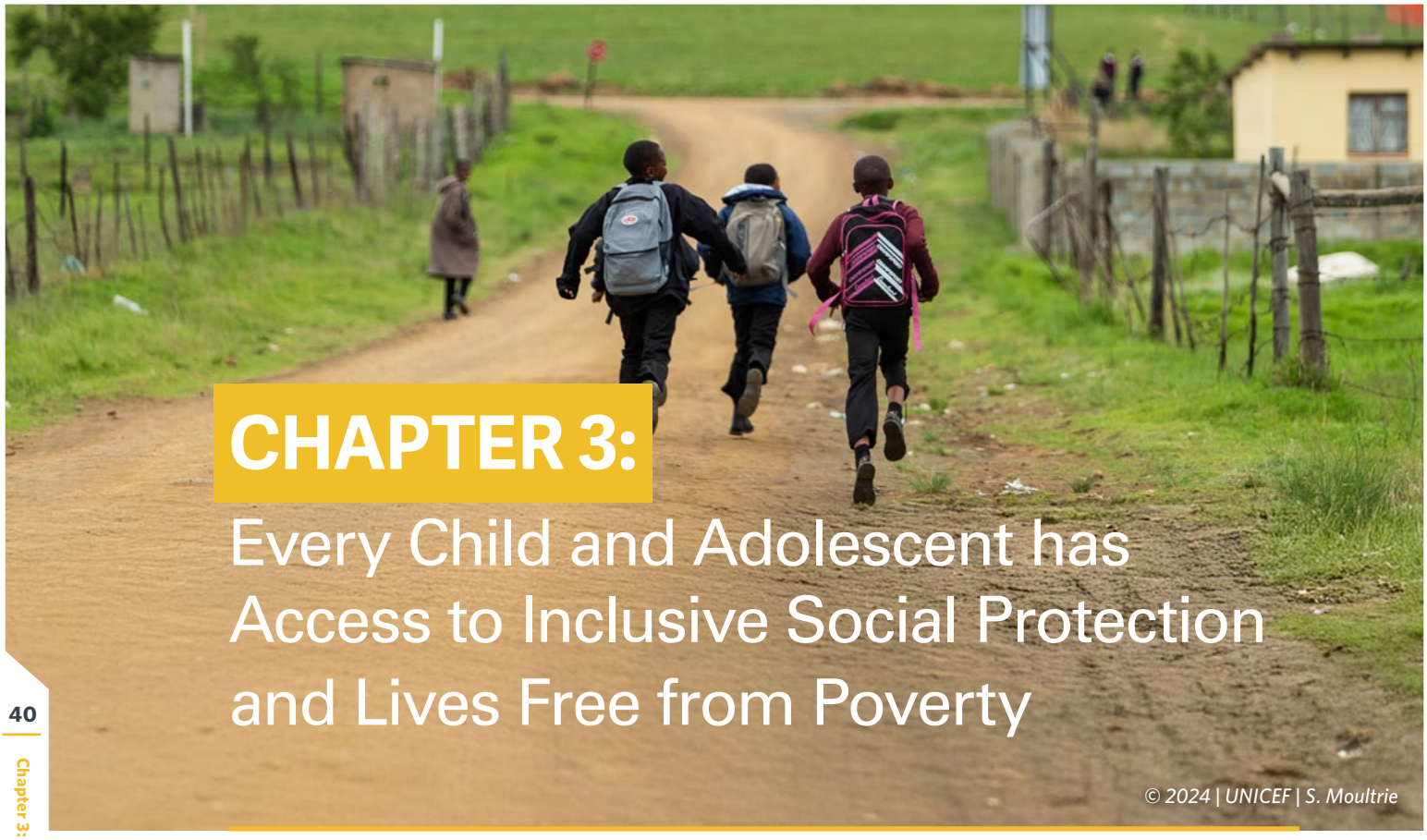

CHAPTER 3:
Every Child and Adolescent has Access to Inclusive Social Protection and Lives Free from Poverty

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Every child has a right to fulfil his or her full potential. However, when a child lives with social or economic deprivations, and experiences discrimination, these experiences can have negative life-time consequences for a child and impede his or her opportunities and abilities to achieve their full potential.

Children are more likely than adults to live in poverty and are more vulnerable to its effects; in other words, growing up in poverty has detrimental impacts on their physical, emotional, and social development, which threatens their life chances and increases their risk of inter-generational poverty.[209] SDG 1 focuses on ending poverty in all forms everywhere.[210]

Poverty

Poverty has persistently been high in South Africa. In 2016, the national monetary poverty rate was 55.5 per cent.[211] Poverty is at the heart of a considerable amount of vulnerability, social discrimination, and exclusion. Households with inadequate income are especially vulnerable to changing economic, social, and environmental circumstances and experience reduced income-earning potential. People who live in poverty also tend to reside in rural and remote areas, less desirable neighbourhoods, and inadequate housing, which are particularly susceptible to weather-related damage. The poor are also more likely to live in communities that can be unsafe environments for children and adolescents, with higher rates of crime and violence.

Child Poverty

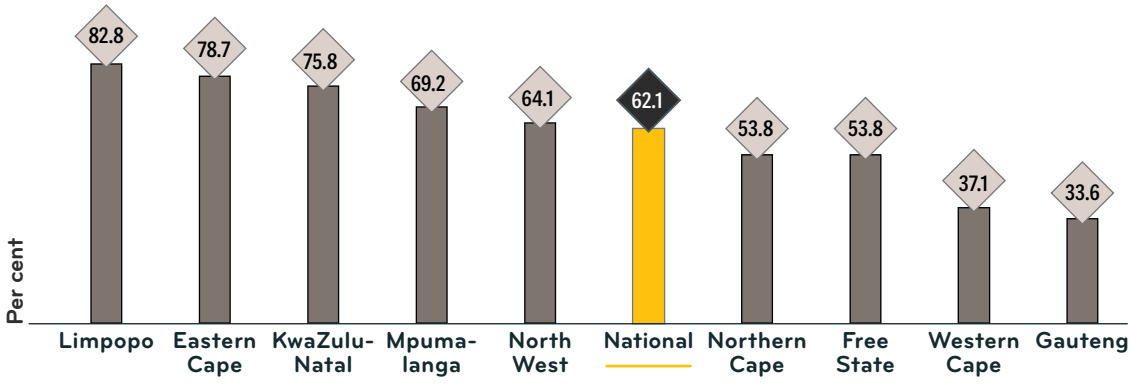
Children often bear the burden of poverty, and poor children are frequently left behind when fulfilling their rights. Child poverty limits children's access to vital resources, including nutrition, health care, education, learning and skills development, social services, and WASH, preventing them from achieving their full potential. Families living below the poverty line are not typically provided with adequate safety nets and social services to ensure their children have the same opportunities as wealthier children. Ultimately, child poverty threatens the future of national economic and social development.

In 2020, UNICEF and Stats SA conducted a multiple overlapping deprivation analysis (MODA) of child poverty in South Africa. Using data from the 2014/2015 Living Conditions Survey (LCS), the MODA revealed that 62.1 per cent of children aged 0-17 years were multidimensionally poor (Chart 3.1). Specifically, 59.9 per cent of children aged 0-4, 63.4 per cent aged 5-12, and 62.5 per cent aged 13-17 were multidimensionally poor.

Knowing which children are poor, where they live, and the make-up of their households is important to understanding the situation of child poverty in South Africa. This information is needed to design the right policies and programmes to address and reduce poverty for every child.[212]

Chart 3.1 shows that multidimensional child poverty is higher than the national average in Limpopo (82.8 per cent), Eastern Cape (78.7 per cent), KwaZulu-Natal (75.8 per cent), Mpumalanga (69.2 per cent), and North West (64.1 per cent), while it is lowest in Western Cape (37.1 per cent) and Gauteng (33.6 per cent). There are also notable urban versus rural differences, as children in rural areas (88.4 per cent) are twice as likely to be multidimensionally poor as children in urban areas (41.3 per cent). Additionally, children in non-metropolitan municipalities (73.7 per cent) are nearly twice as likely to be multidimensionally poor as children in metropolitan municipalities (39.6 per cent).[213]

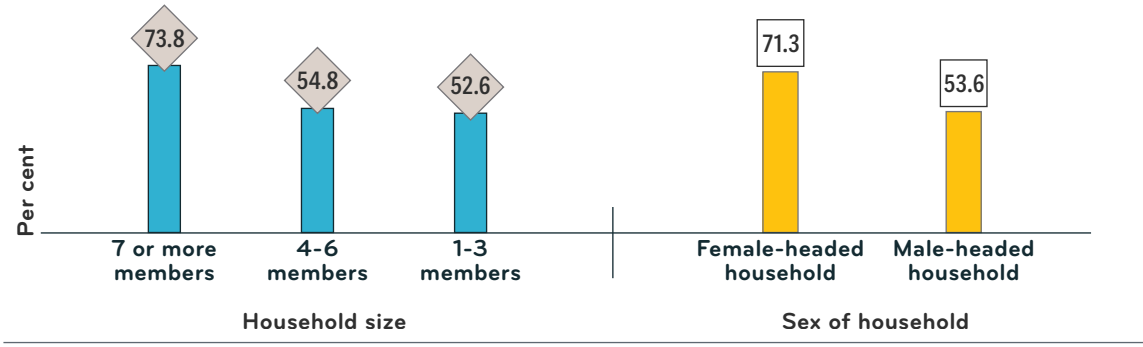
CHART 3.1. Multidimensional child poverty rates (ages 0-17) by region (%), 2020



SOURCE: Department of Statistics South Africa (2020). *Child Poverty in South Africa: A Multiple Overlapping Deprivation Analysis*. Department of Statistics South Africa: Pretoria, South Africa, p. 17

Chart 3.2 shows that multidimensional child poverty is higher in households with more members and among female-headed households. In particular, multidimensional child poverty is highest in households with seven or more members (73.8 per cent), yet remains quite high in households with four to six members (54.8 per cent) and one to three members (52.6 per cent). Multidimensional child poverty is also higher in female-headed households (71.3 per cent) compared to male-headed households (53.6 per cent). It is also notable that orphaned children (77.3 per cent) and children living in single-parent households are more likely to be multidimensionally poor, whether the parent is male (67.7 per cent) or female (75.0 per cent), compared to non-orphaned children (59.5 per cent).[214]

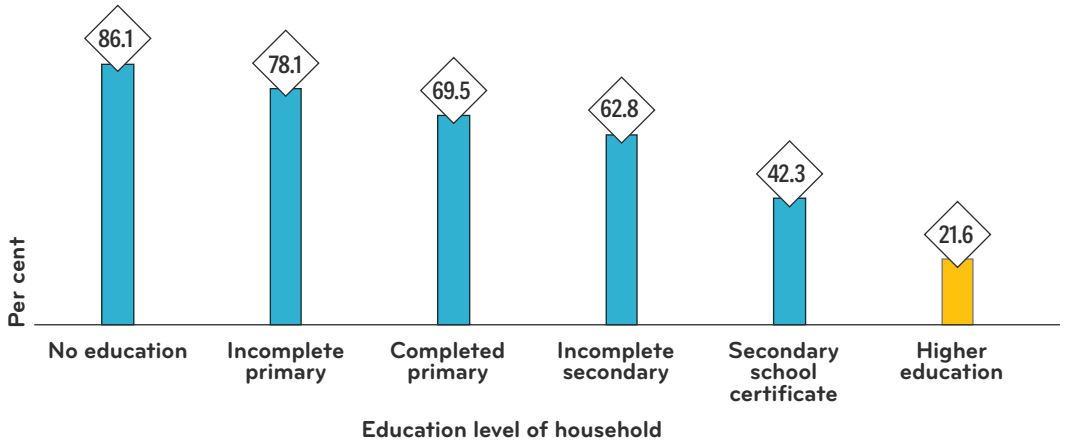
CHART 3.2. Multidimensional child poverty rates (ages 0-17) by household demographics (%), 2020



SOURCE: Department of Statistics South Africa (2020). Child Poverty in South Africa: A Multiple Overlapping Deprivation Analysis. Department of Statistics South Africa: Pretoria, South Africa, p. 19.

Chart 3.3 shows that multidimensional child poverty is also closely associated with the socio-economic characteristics of households. Children in households with a head of household (HoH) who has no education (86.1 per cent) or an incomplete primary education (78.1 per cent) are most likely to be multidimensionally poor. In fact, children in households where the HoH has no education are twice as likely to be multidimensionally poor as children in households with a HoH who has a secondary school certificate (42.3 per cent), and four times more likely to be multidimensionally poor than children in households with a HoH who has higher education (21.6 per cent).

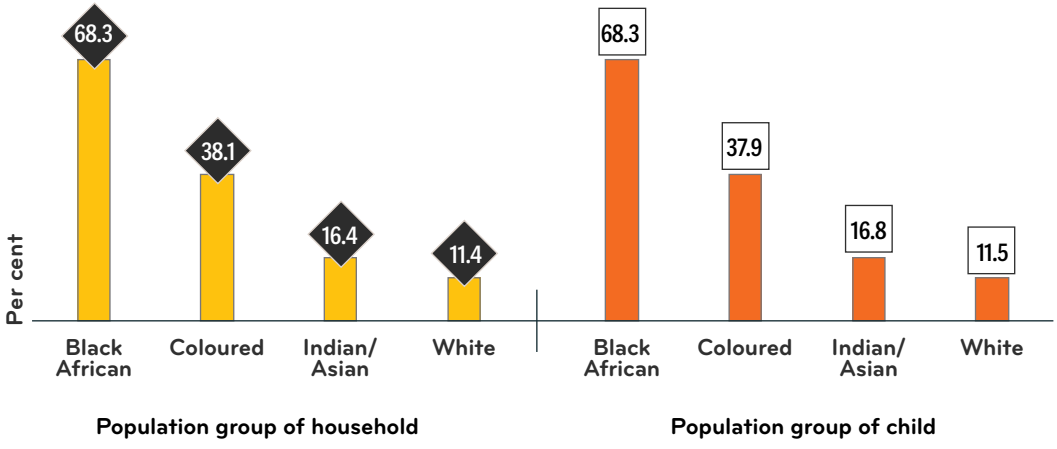
CHART 3.3. Multidimensional child poverty rates (ages 0-17) by household education level (%), 2020



SOURCE: Department of Statistics South Africa (2020). Child Poverty in South Africa: A Multiple Overlapping Deprivation Analysis. Department of Statistics South Africa: Pretoria, South Africa., p. 19.

Chart 3.4 shows a clear correlation between multidimensional child poverty and population group, reflecting the legacy of decades of apartheid. Children living in households where the head of household (HoH) is Black African were most likely to be multidimensionally poor (68.3 per cent), i.e., six times more likely than children living in households where the HoH is White (11.4 per cent) and four times more likely than in households where the HoH is Indian/Asian (11.4 per cent). In contrast, children living in households where the HoH is Coloured (38.1 per cent) were three times more likely to be multidimensionally poor than children living in households where the HoH is White. Similar patterns of multidimensional poverty emerged concerning the population group of children.

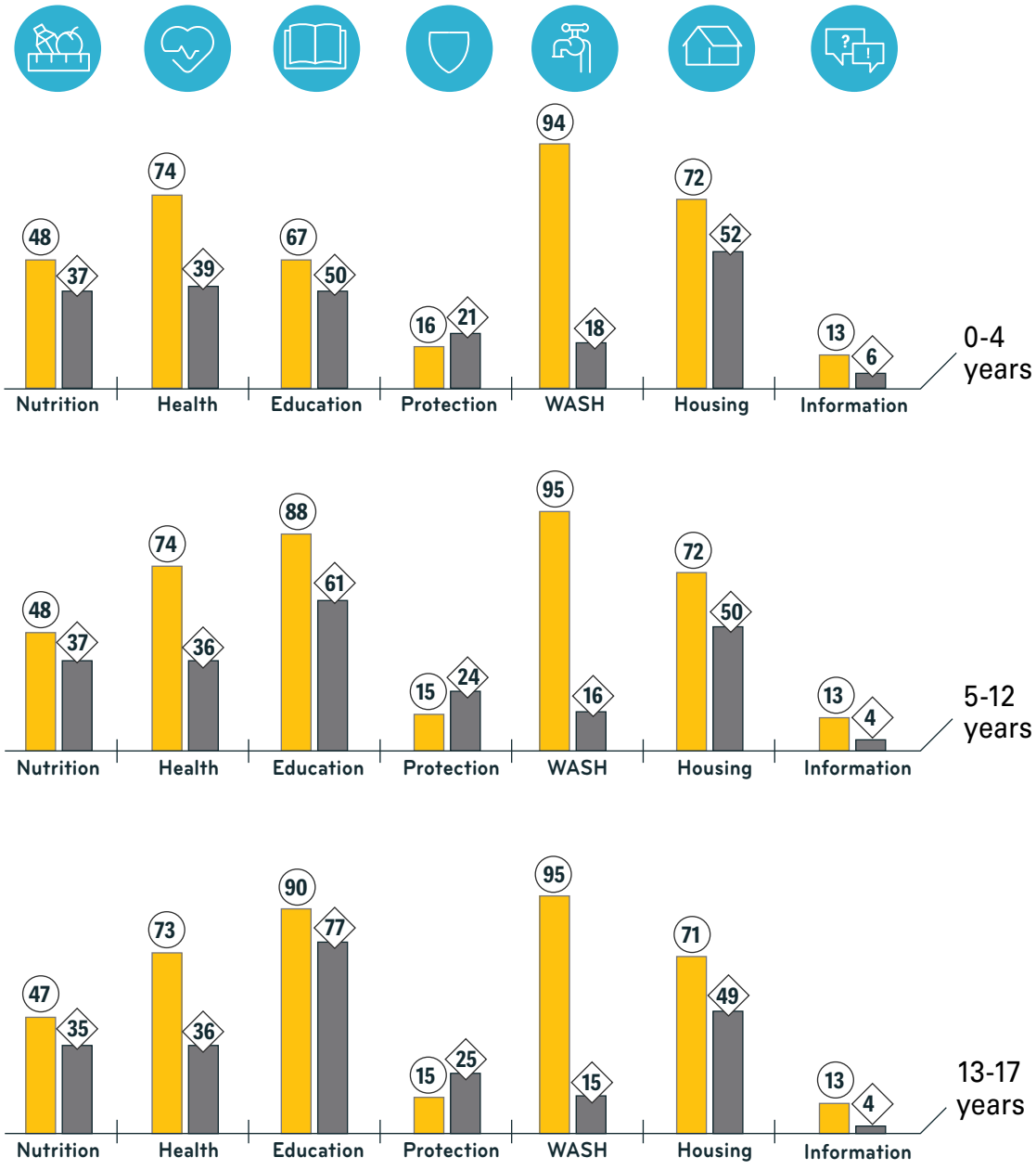
CHART 3.4. Multidimensional child poverty rates (ages 0-17) by household and child population (%), 2020



SOURCE: Department of Statistics South Africa (2020). Child Poverty in South Africa: A Multiple Overlapping Deprivation Analysis. Department of Statistics South Africa: Pretoria, South Africa., p. 19.

Knowing which dimensions contribute to multidimensional poverty for children is important; these dimensions may vary by age. For comparison purposes, the MODA analysed the impact of seven dimensions on multidimensional poverty in children aged 0-4, 5-12, and 13-17 years (**Figure 3.1**).

FIGURE 3.1. Deprivation head count child poverty rate by dimension and areas (%), 2020



SOURCE: UNICEF (2020). Child Poverty in South Africa: A Multiple Overlapping Deprivation Analysis – Summary. UNICEF: Pretoria, South Africa, p. 11; see Annex Table 7.

Among children aged 0-4, deprivation rates were related to:

- **Housing:** 61.3 per cent
- **Education/child development:** 57.9 per cent
- **Health:** 54.4 per cent
- **WASH:** 51.5 per cent
- **Nutrition:** 42.5 per cent
- **Protection:** 18.8 per cent
- **Information:** 9.0 per cent

Among children aged 5-12, deprivation rates were related to:

- **Education/child development:** 73.0 per cent
- **Housing:** 59.7 per cent
- **Health:** 53.1 per cent
- **WASH:** 50.9 per cent
- **Nutrition:** 41.4 per cent
- **Protection:** 19.8 per cent
- **Information:** 8.2 per cent

Among children aged 13-17, deprivation rates were related to:

- **Education/child development:** 74.4 per cent
- **Housing:** 58.5 per cent
- **Health:** 52.1 per cent
- **WASH:** 50.2 per cent
- **Nutrition:** 40.4 per cent
- **Protection:** 20.3 per cent
- **Information:** 7.7 per cent

Poverty is at the heart of vulnerability, social discrimination and exclusion, including limited access to education, healthcare and other basic essential services. Households with inadequate incomes are more vulnerable to changing economic and social circumstances and to reduced income-earning potential. During the COVID-19 pandemic, many households experienced unemployment and a rapid income decline, which likely increased their vulnerability to poverty. From February to April 2020, the country saw a 40 per cent drop in employment, leading to widespread job losses. Estimates indicated that 20 per cent to 33 per cent of those who lost their jobs during the lockdown period lost the majority of their income.[215] It was further projected that the bottom 10 per cent of households lost nearly 45 per cent of their income during nationwide shutdowns, highlighting the pandemic's devastating impact on the most vulnerable.[216] Given this context, the World Bank projected that 23 million South Africans would be pushed into poverty in 2020.[217] Despite attempts to implement relief programmes, 80 per cent of newly unemployed individuals did not receive any support whatsoever.[218]

In recent years, research focused specifically on poverty rates among children under 6 years of age in South Africa has revealed that in 2019, 56 per cent of children under 6 years lived in households with incomes below the upper-bound poverty line, which equated to ZAR 1,558 per person, per month in 2023. In 2020, the upper-bound poverty rate among children under 6 years of age increased to 64 per cent due to the COVID-19 pandemic and then further increased to 70 per cent in 2022. This means that more than two-thirds, or nearly 5 million children under 6 years of age, lived in households that cannot provide for their basic needs.

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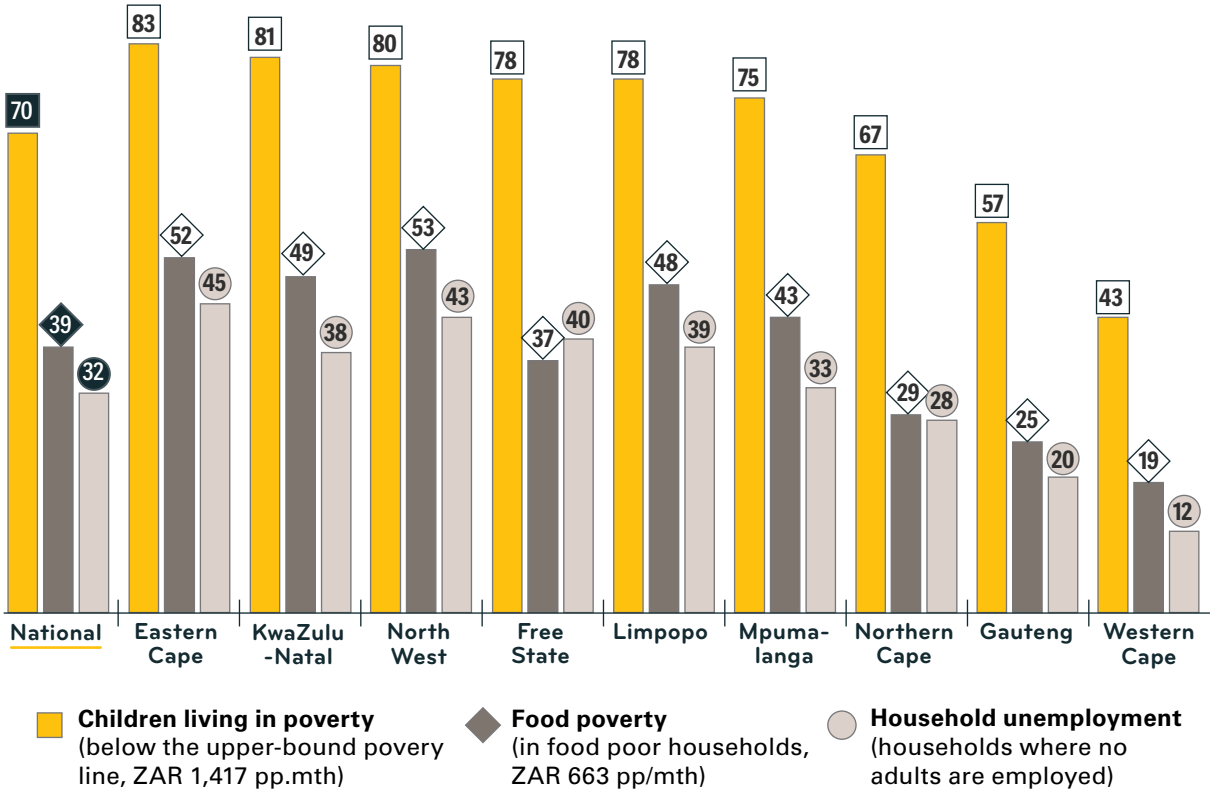
Chart 3.5 shows that there is substantial provincial variation in poverty rates among children under 6 years of age. In 2022, 70 per cent of South African children under 6 years of age were living in poverty and 39 per cent were in food poverty. The Eastern Cape (83 per cent), KwaZulu-Natal (81 per cent), North West (80 per cent), Free State and Limpopo (78 per cent each), and Mpumalanga (75 per cent) had larger proportions of children under 6 years of age living in poverty than the national average; whereas Gauteng (57 per cent) and Western Cape (43 per cent) had the lowest proportions of children under 6 years of age living in poverty. Similar geographic differences emerged in terms of the proportion of children in food poverty, except that far fewer children in the Free State were in food poverty (37 per cent) than would be expected, given that 78 per cent of children under 6 years were living in poverty.

CHART 3.5. Status of children under 6 years in poverty (%), 2022



SOURCE: Hall, K. et al. (2024). South African Early Childhood Review 2024. Children's Institute, University of Cape Town and Ilifa Labantwana: Cape Town, South Africa, p. 14.

Although poverty was expected to increase across the whole country as a result of the pandemic, the most significant rise in poverty was anticipated among the most vulnerable populations, particularly children and families in rural areas, as well as women. Lessons learned from the pandemic indicated that building resilience against shocks can be achieved through responsive social protection and minimising exposure to shocks.

Social Protection and Assistance

Social protection is a right enshrined in the UDHR and recognised in Article 26 of the CRC (every child has a right to social security). Social protection is concerned with preventing, managing, and overcoming situations that adversely affect people's well-being. It consists of policies and programmes designed to reduce poverty and vulnerability by promoting efficient labour markets, diminishing exposure to risks, and enhancing capacities to manage economic and social risks (e.g., unemployment, exclusion, illness, disability, and old age). Social protection includes social assistance

(e.g., cash transfers), social insurance (e.g., health insurance), and employment and educational support. Such programmes and policies can reduce multidimensional child poverty and improve families' and children's access to nutritious and sufficient food, health care, and education, as well as enhance the overall physical, emotional, and social development of children.[219]

Efforts to expand social protection coverage to children and families are key to upholding children's right to a decent standard of living. Moreover, well-designed social protection and assistance systems contribute to the principles of 'leave no one behind' and 'reach the furthest behind'.[220] South Africa's social grants, along with its tax policies and social spending, have been credited with being strongly progressive, helping to raise the income of the poorest by ten times and to reduce income inequality by a quarter.[221]

The South African Social Security Agency (SASSA) administers three social protection and assistance programmes that specifically benefit children: Child Support Grant (CSG), Care Dependency Grant (CDG), and Foster Child Grant (FCG).[222] There is also the National School Nutrition Programme (NSNP), which is a government programme administered by the Department of Basic Education (DBE). Individuals can also apply for social relief of distress assistance, which is a temporary provision of help intended for those in such dire material need that they are unable to meet their families' most basic needs.[223] These grants and programmes are briefly described in the sections below.

The most common barriers to take-up of social assistance grants were:

- Lack of documentation needed to complete the application process (e.g., caregiver ID, birth certificate)
- Income eligibility
- Lack of information or knowledge of the social assistance programmes and grants
- Application barriers

Migrant Children 2023: *Among the 13,147,954 children receiving CSGs, only 17,091 beneficiaries were migrant children.*

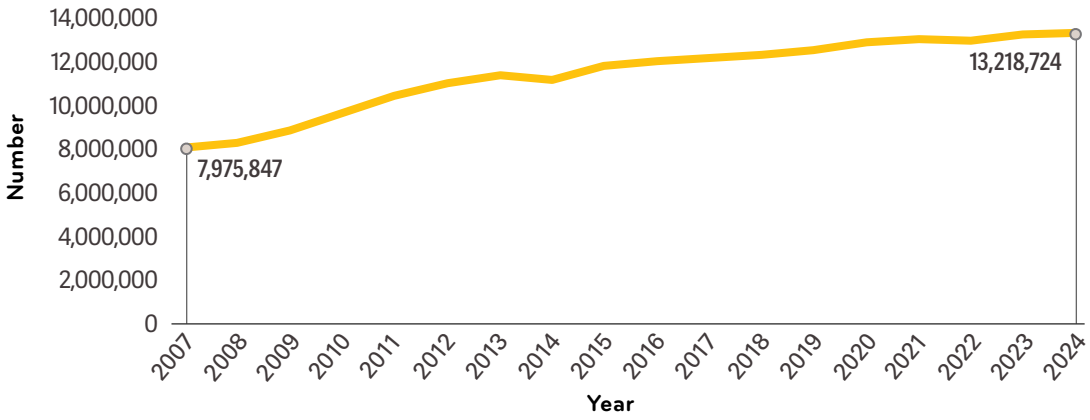
SOURCE: Department of Statistics South Africa (2024). Migration Profile Report for South Africa. A Country Profile 2023. Stats SA: Pretoria, South Africa.

Child Support Grant (CSG)

In 1998, the GoSA introduced the CSG, which provides income support to poor children. Since its launch, the CSG has evolved into one of the most comprehensive social protection programmes. The CSG is for residents from lower-income households who need financial assistance to help care for a child or children; an unconditional payment is made to a primary caregiver[224] of a child under the age of 18 years.[225] As of 1 April 2024, the value of the basic CSG was ZAR 530 per child, per month. In recent years, SASSA introduced the CSG top-up to assist relatives or primary caregivers in providing for an orphan's basic needs; the CSG top-up amount is ZAR 520 per child, per month. Thus, the total CSG (basic + top-up) is ZAR 780 per child, per month. Each primary caregiver may receive a CSG for up to six children who are not their legal or biological children.[226]

Chart 3.6 shows that the number of children receiving CSGs has increased by 66 per cent, from 7,975,847 children in 2007 to 13,218,724 in 2024. This increase can be attributed to policy reforms that expanded the reach and impact of the CSG by raising the age limit for eligibility from 7 to 18 years old, raising the income threshold to more effectively reach all poor children, and adjusting benefit levels to respond to inflation and improve both social equity and economic impacts. In 2014, there was a slight dip in the number of children receiving CSGs due to the introduction of a biometric system, which led to the identification and suspension of CSGs for beneficiaries who were not verified biometrically; however, most of these CSGs were reinstated the following year, but without back-pay.[227]

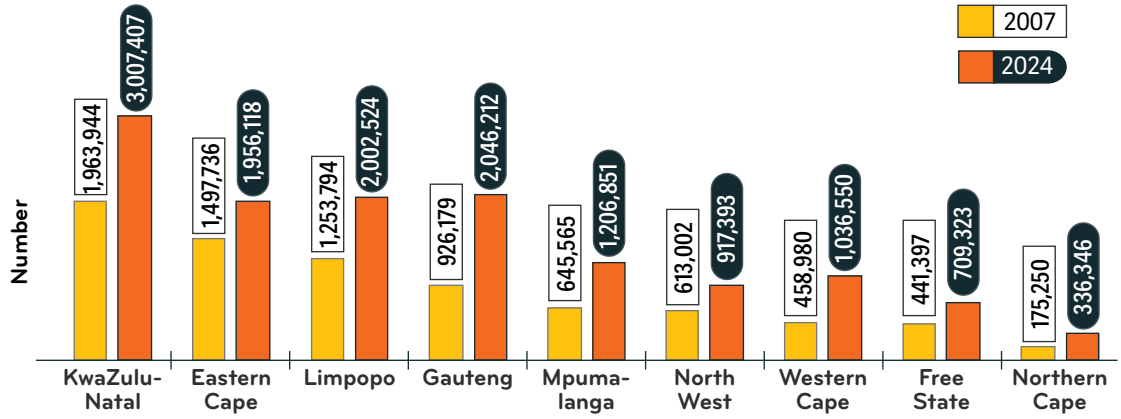
CHART 3.6. Number of children receiving the CSG, 2007-2024



Note: Data provided by the SASSA 2007-2024 Social Grant Statistics; **SOURCE:** Retrieved on 13 May 2024 from: Children Count (uct.ac.za)

Chart 3.7 shows that in 2007 and 2024, the number of children receiving CSGs was highest in KwaZulu-Natal and lowest in Northern Cape. The number of children receiving CSGs increased in all provinces from 2007 to 2004; the largest increases were in Western Cape and Gauteng.

CHART 3.7. Number of children receiving the CSG by region, 2007 and 2024



Note: Data provided by the SASSA 2007-2024 Social Grant Statistics; **SOURCE:** Retrieved on 13 May 2024 from: Children Count (uct.ac.za)


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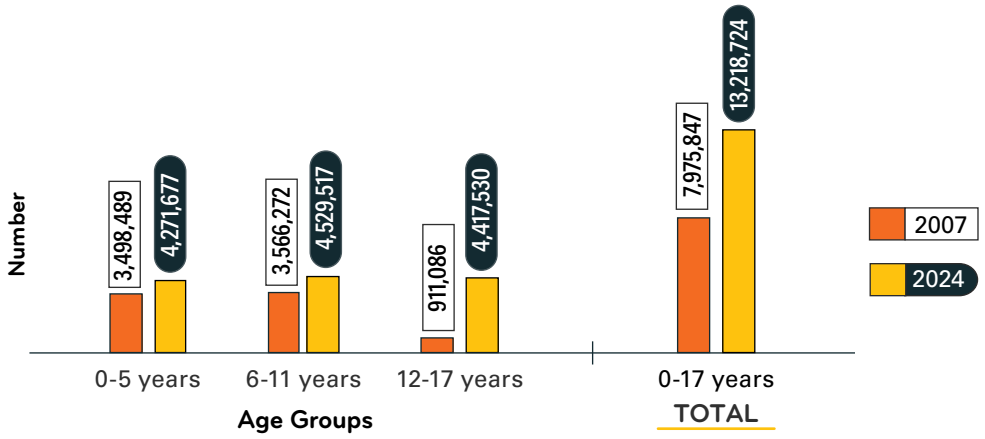
Chart 3.8 shows that children aged birth-5 years and 6-11 years were far more likely to receive a CSG in 2007. Since 2007, policy reforms led to an increase in the number of children over 7 years of age who were provided with a CSG; thus, there is a notable increase from 2007-2024 in the number of children ages 6-11 and 12-17 years who were able to receive the CSG.

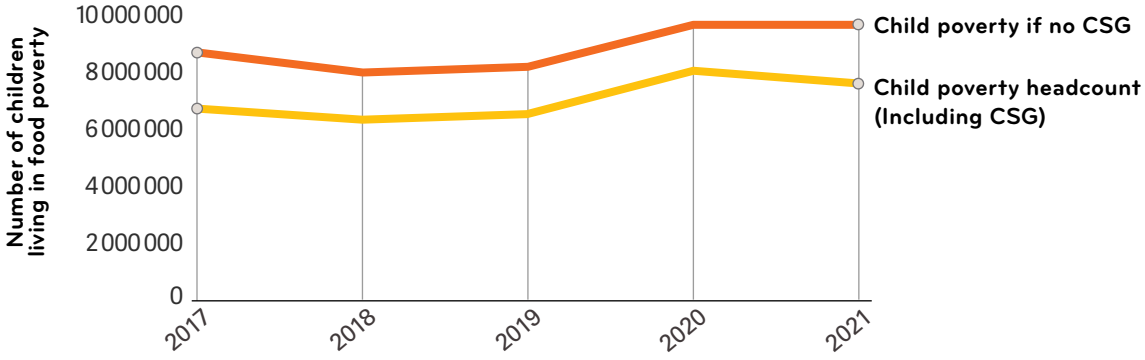
CHART 3.8. Number of children receiving the CSG by age group, 2007 and 2024



Note: Data provided by the SASSA 2007-2024 Social Grant Statistics; **SOURCE:** Retrieved on 13 May 2024 from: Children Count (uct.ac.za)

Since 2013, once the planned extensions of eligibility to children under 18 was complete, child food poverty rates declined more slowly, alongside a more gradual growth in uptake of CSGs. **Figure 3.2** illustrates the effectiveness of the CSG in reducing the child poverty headcount. It shows that in the years leading up to the COVID-19 pandemic, an estimated one-third of more than 6 million South African children were living in food poverty. In the absence of the CSG, this number would have been more than 8 million children. Thus, the CSG had a protective effect in the aftermath of the lockdowns related to the COVID-19 pandemic, yet where poverty rates remained higher than in previous years, the CSG effectively kept 2 million children from falling into food poverty.[228]

FIGURE 3.2. The impact of CSG on child food poverty headcounts



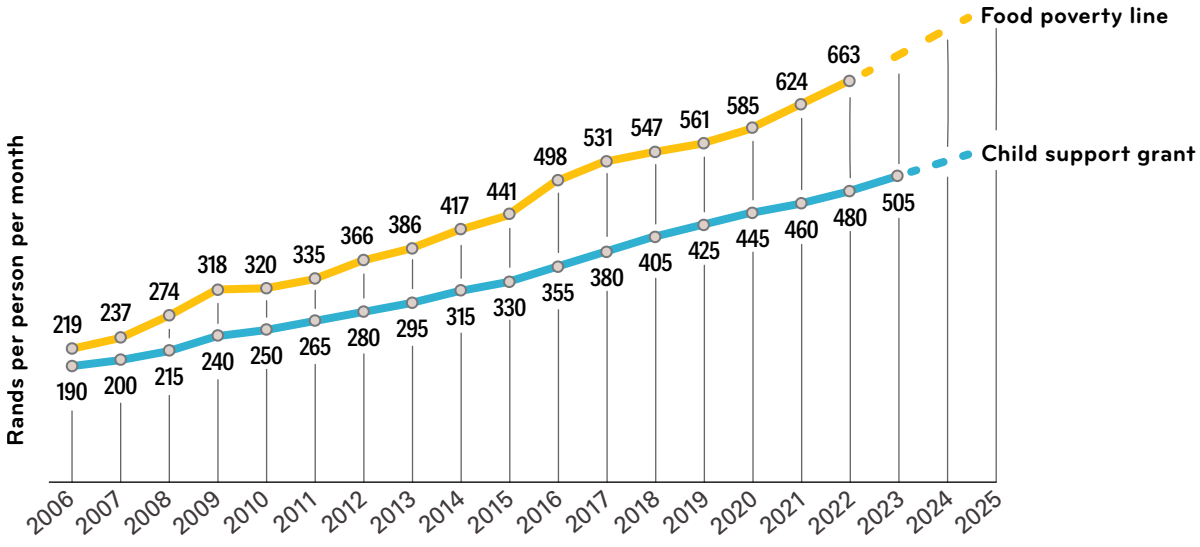
SOURCE: Hall, K., P. Proudlock & D. Budlender (2023). Reducing Child Poverty: A review of child poverty and the value of the Child Support Grant. Children's Institute & DSD: Pretoria, South Africa, p. 86.

The CSG has had an even greater effect on the depth and severity of child poverty in South Africa. In 2021, 37 per cent of children were living below the food poverty line, but in the absence of the CSG, that figure would have been 47 per cent. Thus, the CSG, which was received by nearly 13 million children in 2021, reduced the child food poverty headcount by 21 per cent, the depth of child food poverty by 4 per cent, and the severity of child food poverty by 66 per cent, bringing child food poverty closer to zero.[229]

The CSG has been successful in reaching large numbers of poor children with relative ease and has one of the best pro-poor targeting records of all the existing social grants in South Africa,[230] and there

is evidence that the CSG is spent on food, education, and basic goods and services.[231] Yet, the CSG can bring children out of poverty only if they are not living very far below the poverty line to start with. For children living in deeper poverty, the CSG is very useful but will not necessarily lift the poorest children above the poverty line if the value of the grant is not increased.[232] Thus, the main weakness is that the value of the CSG at ZAR 520 per child, per month in 2024, is too small to protect the poorest children from hunger, malnutrition, and stunting (**Figure 3.3**).[233] For this reason, the UN Committee on the Rights of the Child, the UN Committee on Economic, Social and Cultural Rights, and the African Committee of Experts on the Rights and Welfare of the Child have all recommended that the CSG amount be increased. In 2020, the DSD acknowledged that the CSG amount should be reviewed because it is below the food poverty line and commissioned a study to assess the impact of the CSG on reducing child poverty.[234]

FIGURE 3.3. Widening gap between the value of the food poverty line and the CSG, 2006-2025



SOURCE: Hall, K., P. Proudlock & D. Budlender (2023). Reducing Child Poverty: A review of child poverty and the value of the Child Support Grant. Children's Institute & DSD: Pretoria, South Africa, p. 16.

There is evidence that the CSG not only realises children's rights to social assistance but also helps to alleviate income poverty and is associated with improved nutrition, health, and education outcomes, especially if the grant is accessed soon after birth and is continuously received. Given the positive and cumulative effects of the CSG, it is important that parents and caregivers can access the CSG for their children as early as possible.[235]

To improve take-up, however, there are barriers that need to be addressed, including confusion about eligibility requirements and the means test; lack of documentation, mainly identity books or birth certificates, and proof of school enrolment, although the latter is not an eligibility requirement; and problems of institutional access, including the time and cost of reaching SASSA offices, long queues, and lack of baby-friendly facilities.[236]

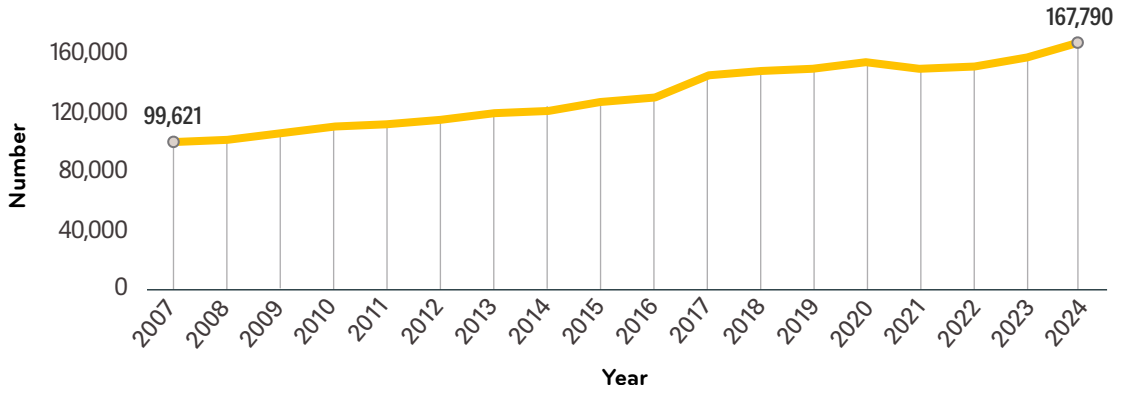
Care Dependency Grant (CDG)

The CDG is a non-contributory monthly cash transfer from SASSA to parents, foster parents, or primary caregivers of a child under the age of 18 who requires full-time care due to a physical or mental disability. The CDG excludes children who are cared for in state institutions because the purpose of the grant is to cover the additional costs, including opportunity costs, that the parent or caregiver may incur as a result of the child's disability.[237] Applicants who foster a care-dependent child may be eligible to receive a CDG and a CSG for the same child. As of 1 April 2024, the value of the CDG is ZAR 2,180 per month, and an increase of ZAR 10 is expected on 1 October 2024.[238]

Although the CDG targets children with disabilities, children with chronic illnesses are also eligible for the grant once the illness becomes disabling (e.g., children who are severely ill with AIDS-related illnesses). Children with disabilities and chronic illnesses require substantial care and attention, and parents may need to stay at home or employ a caregiver to look after the child. Children with health conditions may also need medications, equipment, or frequent hospital visits; these extra costs can put a strain on families that are already struggling to make ends meet. There is often a relationship between poverty and chronic health conditions.[239]

Chart 3.9 shows the number of children receiving CDGs increased by 68 per cent from 99,621 children in 2007 to 167,790 in 2024.

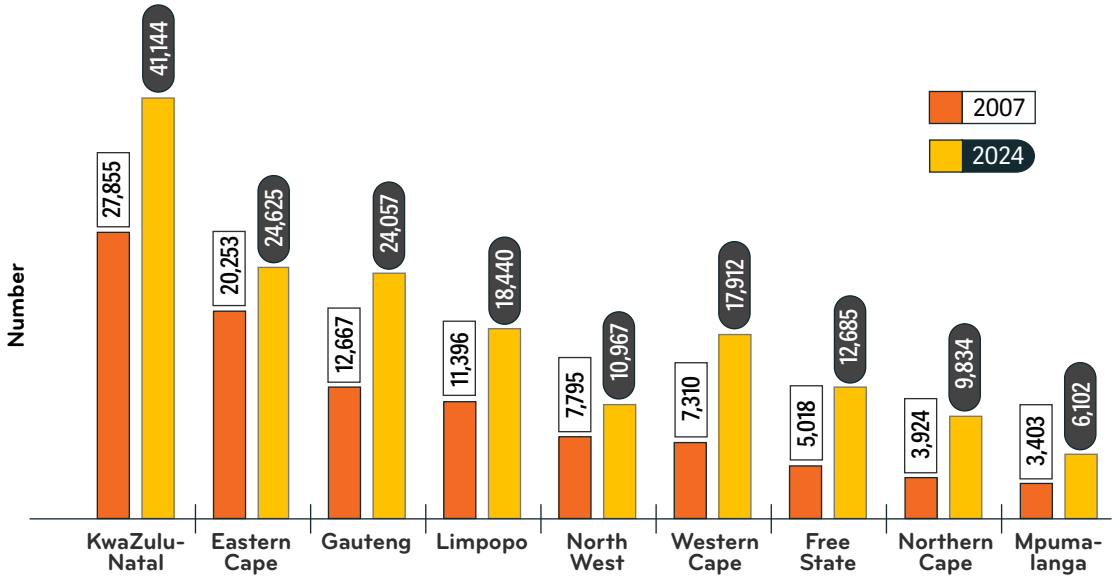
CHART 3.9. Number of children receiving the CDG, 2007-2024



Note: Data provided by the SASSA 2007-2024 Social Grant Statistics; **SOURCE:** Retrieved on 13 May 2024 from: Children Count (uct.ac.za)

Chart 3.10 shows that in 2007 and 2024, the number of children receiving CDGs was highest in KwaZulu-Natal and lowest in Northern Cape. While the number of children receiving CDGs has increased in all provinces from 2007 to 2004, the largest increase was seen in Mpumalanga, Free State, and Western Cape.

CHART 3.10. Number of children receiving the CDG by region, 2007 and 2024



Note: Data provided by the SASSA 2007-2024 Social Grant Statistics; **SOURCE:** Retrieved on 13 May 2024 from: Children Count (uct.ac.za)

Foster Child Grant (FCG)

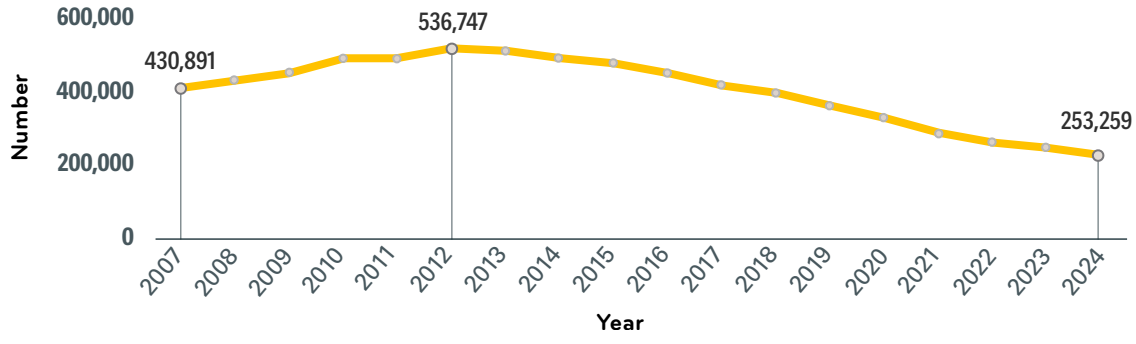
The Foster Child Grant (FCG) is administered under the Social Assistance Act 13 of 2004 by the South African Social Security Agency (SASSA) for children found to be in need of care and protection under the provisions of the Children's Act 38 of 2005 by a children's court, who need to be placed in the alternative care of a person who is not the parent or guardian of the child (foster parents) following statutory intervention. The FCG is paid to foster parents providing care to a child under the age of 18 years. As a statutory grant, the FCG is not subjected to a means test and is automatically paid to foster parents for the children placed in their care. As of 1 April 2024, the value of the FCG is ZAR 1,180 per child.

The absence of a means test and the relatively large value of the grant, compared to the CSG, is justified on the basis that the child is a ward of the State and has been placed in alternative care, in which case the State is directly responsible for ensuring that all of the child's needs are provided for. Since 2003, the number of HIV-related orphans has risen sharply; as a result, the Department of Social Development (DSD) and its social workers have started encouraging grandparents to apply for foster care placements and to apply for the FCG because the value of the FCG is nearly three times that of the CSG.[240]

Chart 3.11 shows that the number of children receiving FCGs increased by 25 per cent, from 430,891 in 2007 to 536,747 in 2012. By 2010, more than 500,000 children were receiving FCGs, and the foster care system was struggling to keep pace with these numbers due to the strict checks and balances required by law (i.e., initial investigations and reports by social workers, newspaper advertisements, court-ordered placements, and additional two-yearly social worker reviews and court-ordered extensions of placements).[241] SASSA is not allowed to pay the FCG without a valid court order or extension order; thus, from 2009 to 2011, SASSA stopped paying more than 110,000 FCGs because of a backlog in the extension of court orders. In 2011, a High Court order stipulated that foster care court orders that had expired or were set to expire in the next two years must be extended until June 2013; this placed a moratorium on the lapsing of FCGs.[242]

Because there was no legal policy solution for this temporary issue, DSD received an urgent High Court order that extended the date to the end of 2017, which was then extended until the end of 2019, and subsequently extended from year to year until November 2023.[243]

CHART 3.11. Number of children receiving the FCG, 2007-2024



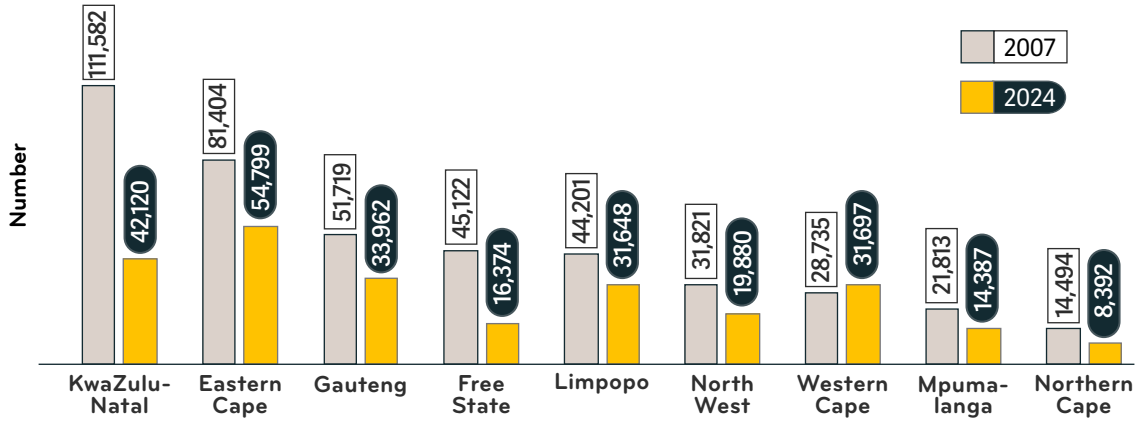
Note: Data provided by the SASSA 2007-2024 Social Grant Statistics; **SOURCE:** Retrieved on 13 May 2024 from: Children Count (uct.ac.za)

Since 2012, the number of children receiving FCGs has steadily declined by 53 per cent to 253,259 in 2024. This decline reflects the fact that a Directorate at DSD was unwilling to use the foster care system for orphans in kinship care. Thus, in 2020, the Social Assistance Act was amended to allow for a new CSG top-up for orphaned children living with relatives (as opposed to providing them with the FCG).[244] The CSG top-up is more easily accessible than the FCG (caregivers can apply directly to SASSA without first having to go through a social worker investigation and court placement) and does not expire every two years as the FCG does; however, the CSG top-up is a smaller grant than the FCG.

The CSG top-up payment is close to the food poverty line – enough to cover basic food needs for a child. By mid-2022, the CSG top-up was being implemented, and by February 2024, there were 65,000 orphaned children in kinship care receiving the CSG top-up. Nevertheless, the CSG top-up has not been received quickly enough to offset the declining numbers of FCGs, and it is likely that many more orphans are excluded from the higher grant amounts.[245]

In 2022, the Children's Amendment Bill was passed by Parliament and signed into law by the President on 22 December 2022. The Children's Amendment Act 17 of 2022 amended the Children's Act 38 of 2005 in that it clarifies that the majority of orphaned children in kinship care should be referred to the CSG top-up; only those children in need of supervised care and protection should be placed in foster care. This Amendment Act came into effect on 08 November 2023. Thus, all new cases of orphans in kinship care should go directly to SASSA to apply for the CSG top-up; however, orphans in kinship care who were already in foster care and receiving the FCG in December 2023 were exempt from this change and can remain on the FCG until they are 18 years old or 21 years old if still in education. The Amendment Act also devolves jurisdiction for guardianship orders to the Children's Court to make it easier for relatives caring for orphans to secure parental responsibilities and rights orders; previously, this was only accessible at the High Court.[246]

CHART 3.12. Number of children receiving the FCG by region, 2007 and 2024



Note: Data provided by the SASSA 2007-2024 Social Grant Statistics; **SOURCE:** Retrieved on 13 May 2024 from: Children Count (uct.ac.za)

Chart 3.12 shows that in 2007 and 2024, the number of children receiving FCGs was highest in KwaZulu-Natal and lowest in Northern Cape. The number of children receiving FCGs decreased in nearly all provinces from 2007 to 2024, except in Western Cape, where there was a 10 per cent increase in the number of children receiving FCGs. The largest decrease was seen in Free State and KwaZulu-Natal.

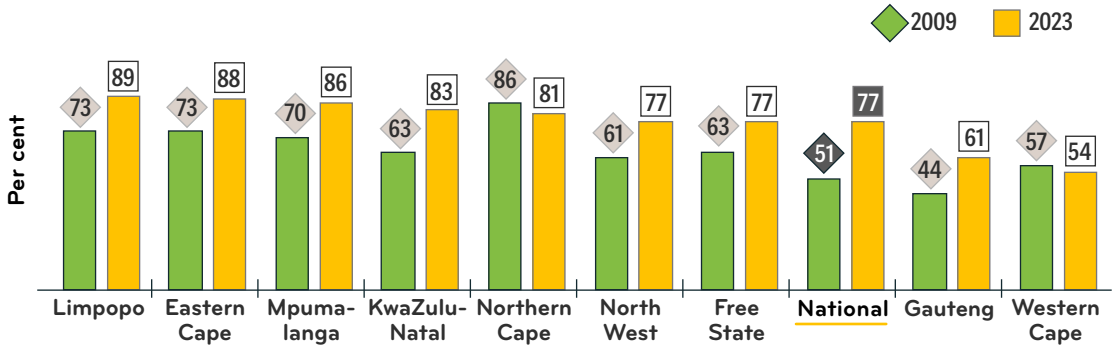
National School Nutrition Programme (NSNP)

In 1994, the NSNP was established as a government programme that provides one nutritious meal to all learners in primary and secondary schools. The NSNP also includes an educational component that focuses on teaching children to establish and maintain good eating and lifestyle habits. To support this initiative, educators are provided with resource materials to enhance the curriculum and to make every school a healthy environment. Schools are also encouraged to establish food gardens from which they can obtain fresh produce (e.g., fruits and vegetables) to supplement the school food menu, in keeping with the South African Food-Based Dietary Guidelines. The overall aim of the NSNP is to enhance the learning capacity of learners through the provision of healthy meals at schools. Where the NSNP is implemented, there is evidence that it has helped improve punctuality, regular school attendance, concentration, and the general well-being of participating learners.

Chart 3.13 shows that in 2023, 77 per cent of learners attending public schools benefited from the NSNP (up from 63 per cent in 2009). Learners attending public schools in Limpopo (89 per cent), Eastern Cape (88 per cent), and Mpumalanga (86 per cent) were most likely to benefit from the NSNP. The proportion of learners attending schools who benefited from the NSNP in KwaZulu-Natal (83 per cent) and Northern Cape (81 per cent) was also higher than the national average. In comparison, learners attending public schools in Gauteng (61 per cent) and Western Cape (54 per cent) were least likely to benefit from the NSNP. The proportion of learners attending public schools who benefited from the NSNP increased in most provinces from 2009 to 2022, except in Northern Cape and Western Cape, where there was a decrease in the number of learners who benefited from the NSNP.

In 2023, the GoSA reported that nutritious meals were provided to 9.6 million learners on school days, which was funded through a conditional grant and the FY 2023/24 budget of $9.8 billion, along with an additional budget over the 2023-2025 Medium-Term Expenditure Framework of R1.5 billion to mitigate increased food inflation, spikes in petrol prices, higher learner numbers, and improved menu options and plans to extend the provision of breakfast.

CHART 3.13. Learners attending public schools who benefited from NSNP by province (%), 2009-2023



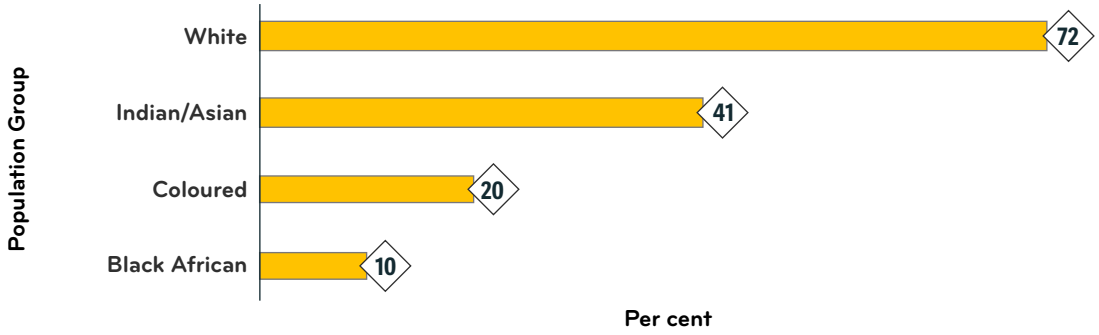
Note: Schools are classified by quintile, so schools classified as quintiles 1, 2 and 3 will have the NSNP; **SOURCE:** 2023 GHS

Health Insurance Coverage

In 2023, only 16 per cent of South Africans were covered by a medical aid scheme, of which 24 per cent were individuals in metropolitan areas.[247] **Chart 3.14** shows that White South Africans were most likely to be covered by a medical aid scheme (72 per cent), whereas Coloured South Africans (20 per cent) and Black Africans (10 per cent) were least likely to be covered. It is notable that White South

Africans were seven times more likely than Black Africans to be covered by a medical aid scheme and nearly four times more likely than Coloured South Africans.

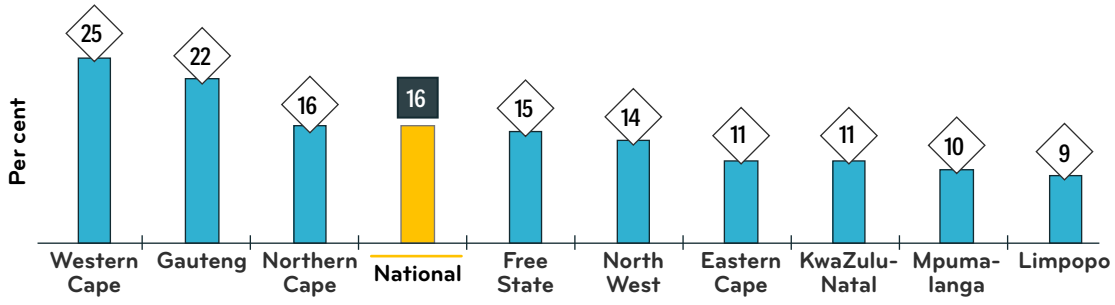
CHART 3.14. Distribution of individuals who are members of medical aid schemes by population group (%), 2023



SOURCE: 2023 GHS

Chart 3.15 shows that in 2023, individuals in the Western Cape (25 per cent) and Gauteng (22 per cent) were most likely to be covered by a medical aid scheme, higher than the national average of 16 per cent. In contrast, individuals in KwaZulu-Natal and the Eastern Cape (11 per cent each), Mpumalanga (10 per cent), and Limpopo (9 per cent) were least likely to be covered by a medical aid scheme.

CHART 3.15. Medical aid scheme coverage rates by province (%), 2023



SOURCE: 2023 GHS

In 2013, a National Health Insurance (NHI) Bill was passed by Parliament. The NHI Act aims to achieve universal access to quality health care services in South Africa, in accordance with Section 27 of the 1996 Constitution. The Act also establishes an NHI Fund and sets out its powers, functions, and governance structures, providing a framework for the strategic purchasing of health care services by the Fund on behalf of users. Additionally, the Act creates mechanisms for the equitable, effective, and efficient utilisation of the NHI Fund's resources to meet the health needs of the population and precludes or limits undesirable, unethical, and unlawful practices in relation to the Fund and its users.[248]

As it relates to children, the NHI Act ensures that all children are entitled to basic health care services, as provided for in Section 28(1) of the 1996 Constitution. Adolescents aged 12 to 18 can also apply for registration as users of the NHI Fund if they are not registered as children of a user. The Bill also establishes that school health services will be provided to improve the physical and mental health, and general well-being of school-going children, including those in pre-Grade R and from Grade R up to Grade 12.[249]

Human rights advocates contend the newly passed NHI Act excludes asylum seekers, except in emergency situations, but includes children of asylum-seekers, which ensures that all children have access to health care. The concern is that because asylum seekers are excluded, they may not be aware that their children are eligible for health care under the aegis of the NHI. There is also concern that asylum-seeking pregnant women are entitled to health care under the NHI, except in the event of an emergency or life-threatening pregnancy. Human rights activists are concerned that this will lead to increased maternal and neonatal morbidity and mortality, and disabilities among asylum-seeking women and their newborns, and limit their access to ANC and PNC. Human rights activists are also concerned that the exclusion of asylum-seeking pregnant women from health care will contribute to declines in birth registration, as birth registration typically occurs in hospitals at the time of birth.

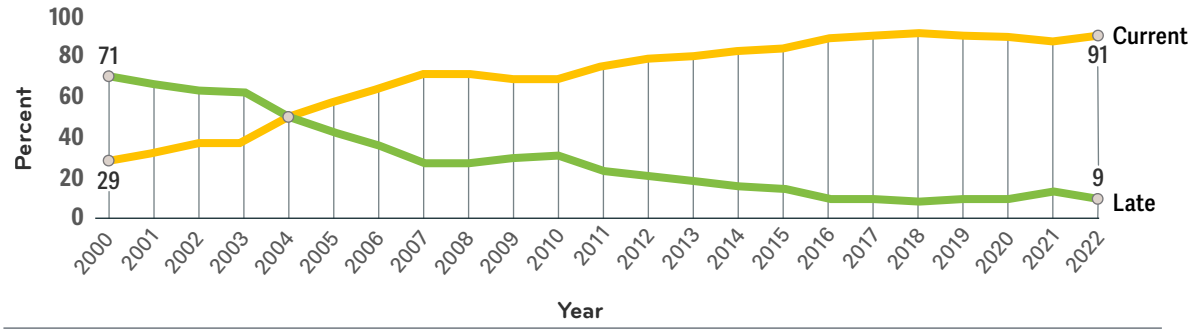
Birth Registration

Article 7 of the CRC provides that a child shall be registered immediately after birth and shall have the right from birth to a name and nationality. Birth registration establishes the existence of a person before the law and lays the foundation for the protection of children's rights. Birth certificates are proof of registration and the first form of legal identity. For these reasons, birth registration is an SDG target and indicator. SDG Target 16.9 aims to provide legal identity for all, including birth registration, by 2030, and SDG Indicator 16.9.1 is the proportion of children under five years of age whose births have been registered with a civil authority.[250]

In South Africa, birth registration is governed by the Births and Deaths Registration Act 51 of 1992, which was amended in 2010 (Amendment Act 18 of 2010).[251] The Department of Home Affairs (DHA) is the official authority responsible for registering births. Parents, guardians, and any other person legally responsible for the child have a legal obligation to register the birth of a child within 30 days of birth. While there is no fee for birth registration, there is a penalty for late registration.[252] Late birth registration is classified into three categories: births within 30 days; births after 30 days but before 365 days; and births after one year but before age 15 years, as well as births for those aged 15 years and older. Once birth registration is completed, a birth certificate is issued to the applicant, and information is captured on the National Population Register.[253]

Over the past two decades, the GoSA has made great strides in eliminating late registration of births through concerted efforts to actively reach those who are hard to reach. **Chart 3.16** shows that current birth registration in South Africa increased from 29 per cent in 2000 to 91 per cent in 2022, whereas late birth registration decreased from 71 per cent in 2000 to 9 per cent in 2022. To achieve this remarkable improvement, South Africa has had to overcome several obstacles. This has been accomplished by creating several mobile programmes that bring social services (including birth registration) to rural communities, along with establishing on-site registration facilities in hospitals with maternity units; the result has been an impressive improvement in the registration of births.[254]

CHART 3.16. Birth registrations by status of registration (%), 2000-2022



SOURCE: Statistics South Africa (2023). Recorded live births 2022. Statistics South Africa: Pretoria, South Africa. Retrieved on 24 February 2024 from: P03052022.pdf (statssa.gov.za)

"A birth certificate is crucial because it is a proof of who you are, who your family is, where you are from and how old you are. Without legal proof of identity, children are left uncounted and invisible."

Still, however, migrant children and undocumented South African children face challenges in obtaining the necessary documents required to obtain a birth certificate, which increases their risk of statelessness; this situation has worsened since the COVID-19 pandemic. It is also important to note that the NPR only covers its citizens by design, and children without birth certificates are not entered into the National Population Register (NPR) administered by the DHA.[255] Numerous public service institutions rely on the official birth-registration figures contained in the NPR for planning purposes.

Without birth registration and a certificate, children cannot access essential services and programmes, such as social welfare, child protection, healthcare, and education that help to secure children's most fundamental rights. Children without a birth certificate can also be cut off from routine vaccinations and are more vulnerable to violence, abuse, and exploitation because they are unable to prove their age and formalise their immigration status. Children and adolescents without a birth certificate are also more likely to find their future prospects extremely limited, which renders them more likely to live in poverty. In young adulthood, official identification is needed for important transactions, such as opening a bank account, registering to vote, entering the formal job market, and inheriting property.[256]

Public Finance for Children and Adolescents

Mobilising national resources for children and adolescents is critical to ensuring sustainable and equitable impact on their lives; this includes influencing national budget processes. To understand how best to leverage resources for children and adolescents, it is important to take a closer look at spending across sectors. Globally, UNICEF works directly with government agencies and the private sector to ensure that governments uphold their commitments as signatories of the CRC and supports governments where needed. For the rights of children and adolescents to be fully achieved, sustainable resources that yield sustainable results for them are important.

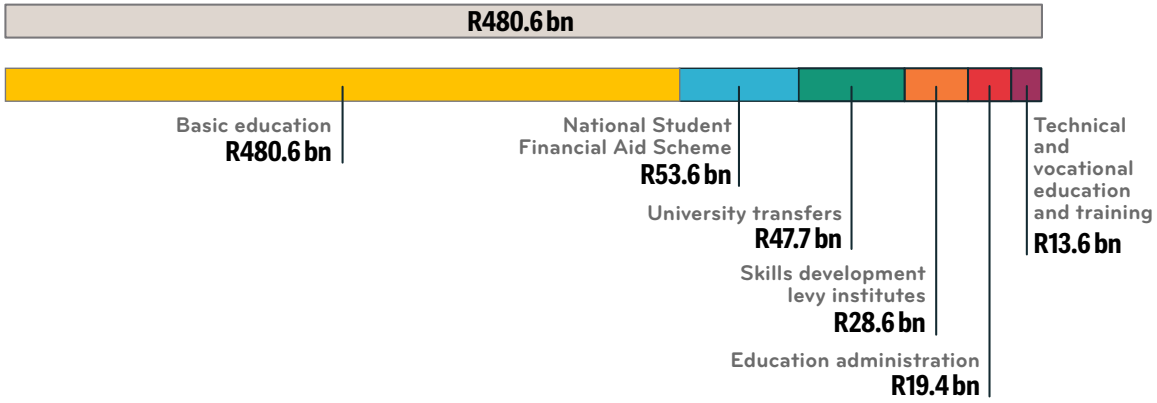
UNICEF often analyses social sector expenditures to enable and empower governments to make better-informed decisions to strengthen policy and programme implementation for children and adolescents, which is critical during times of economic setback, such as during the COVID-19 pandemic. Social sector expenditures refer to the use of government funds to support the well-being of the population, which impacts the lives of children and adolescents.

Financial data presented in this section are drawn from publicly available data sources, including expenditure estimates for three spending categories – health, education and social protection. In the national budget for the fiscal year (FY) 2024/25, a total of ZAR 1.41 trillion was allocated to social services, which included ZAR 480.6 billion for learning and culture (education), ZAR 271.9 billion for health, ZAR 387.3 billion for social development (social protection), and ZAR 265.3 billion for community development.[257]

Education Public Expenditures

In FY 2024/25, consolidated spending for basic education was ZAR 324.5 billion (up from ZAR 309.5 billion in FY 2023/24), and ZAR 144.0 billion was allocated to post-school education and training (up from ZAR 135.6 billion in 2023/24).[258] **Figure 3.4** shows that for FY 2024/2025, ZAR 480.6 billion was allocated to learning and culture (education) expenditures. This included ZAR 303.0 billion for basic education, ZAR 53.6 billion for the National Student Financial Aid Scheme, ZAR 47.7 billion for university transfers, ZAR 28.6 billion for skills development levy institutions, ZAR 19.4 billion for education administration, and ZAR 13.6 billion for technical and vocational education and training (TVET).[259]

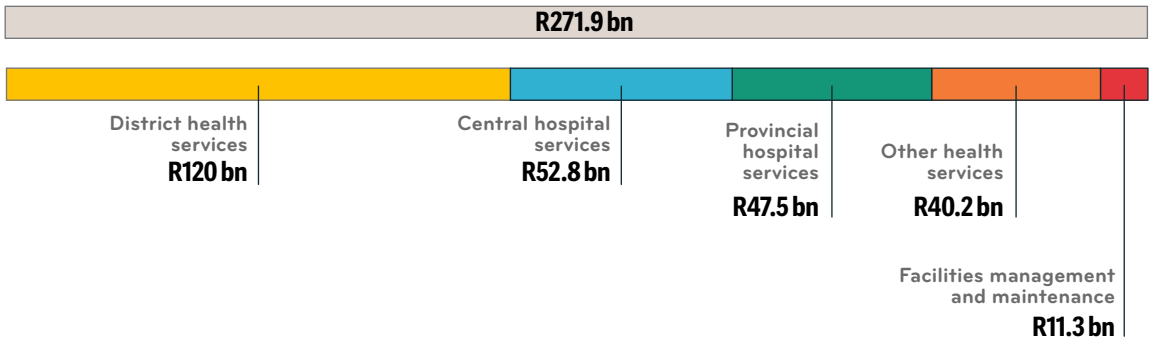
FIGURE 3.4. Budget 2024/25 expenditures for education



Health Public Expenditures

In FY 2024/25, consolidated spending for health was ZAR 271.9 billion (up from ZAR 259.2 billion in FY 2023/24).[260] **Figure 3.5** shows that, in FY 2024/25, ZAR 271.9 billion was allocated for health expenditures. This included ZAR 120.0 billion for district health services, ZAR 52.8 billion for central hospital services, ZAR 47.5 billion for other health services, ZAR 40.2 billion for provincial hospital services, and ZAR 11.3 billion for facilities management and maintenance.[261]

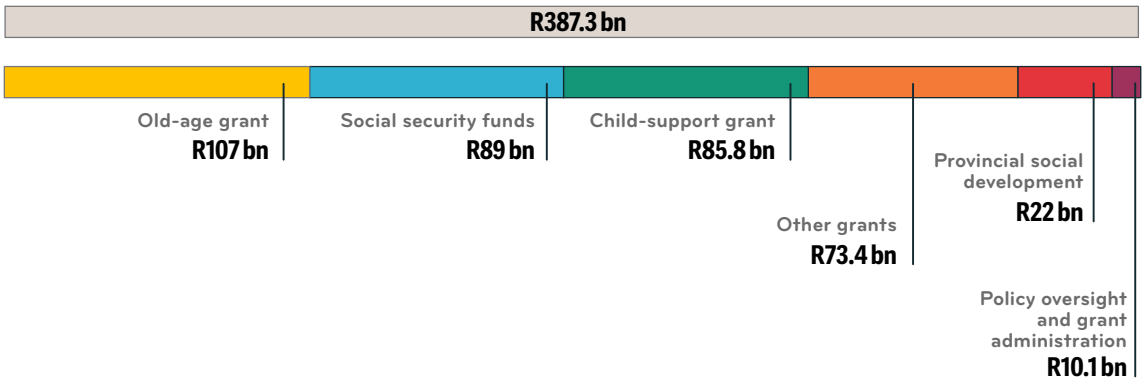
FIGURE 3.5. Budget 2024/25 expenditures for health



Social Protection Expenditures

In FY 2024/25, consolidated spending on social protection was ZAR 298.3 billion, with ZAR 89.0 billion allocated to social security funds (up from ZAR 286.2 billion and ZAR 92.4 billion in FY 2023/24, respectively).[262] **Figure 3.6** shows that for FY 2024/25, ZAR 387.3 billion was allocated to social development (social protection). This included ZAR 107.0 billion for the old-age grant, ZAR 89.0 billion for social security funds, ZAR 85.8 billion for the CSG, ZAR 73.4 billion for other grants, ZAR 22.0 billion for provincial social development, and ZAR 10.2 billion for policy oversight and grant administration.

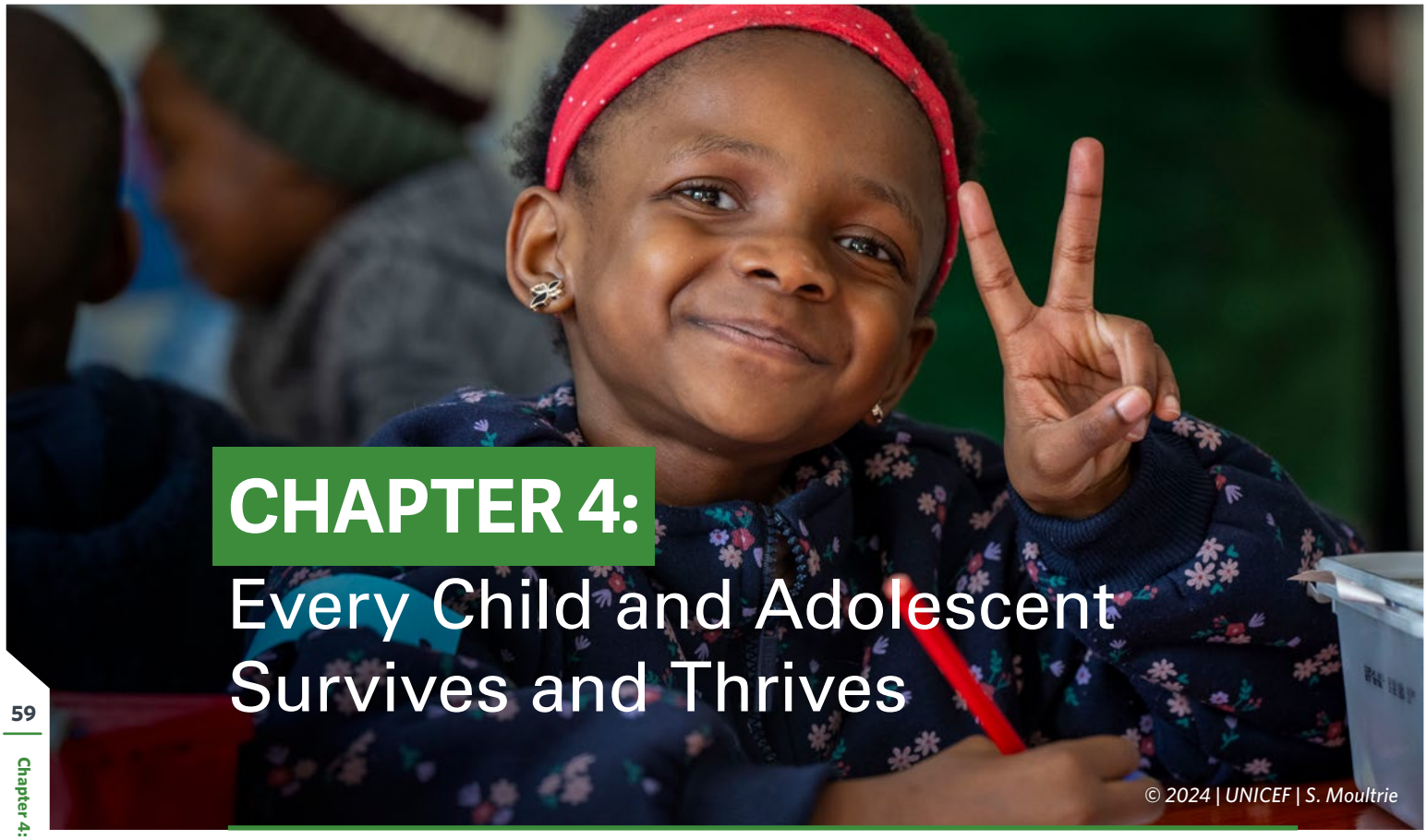
FIGURE 3.6. Budget 2024/25 expenditures for social protection



Summary of Data Gaps

This chapter focused on data related to every child's right to access inclusive social protection and live free from poverty, and there were notable data gaps.

- There is a need for more detailed disaggregated data related to social assistance grants so that more can be learned about the children receiving these grants and their impact on child poverty. For instance, it would be beneficial to have more detailed data and information on the benefits and impact of early uptake of the CSG, particularly for children aged 0-1 years.
- There is a need for more detailed disaggregated data related to the NSNP so that more can be learned about the children who benefit from the NSNP and the impact of the NSNP on their lives. For instance, this includes a need for data related to the number of children benefiting from the NSNP by sex, age, and grade.



CHAPTER 4:
Every Child and Adolescent Survives and Thrives

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The COVID-19 pandemic interrupted progress made on key measures of child survival, growth, and development. Decades of progress in addressing every child's right to survive and thrive are being threatened by a complex and changing global context. The survival of children and adolescents, especially the most vulnerable and marginalised, will have the best chance in life if certain critical and quality health interventions and services are made available to them at specific times throughout their lives. This marks a holistic approach to ensuring that children and adolescents have all the life-saving and life-changing interventions they need to grow into healthy adulthood.[263]

Ending preventable maternal and child mortality, and promoting maternal and child health (MCH) and development, are fundamental goals of the 2030 Agenda for Sustainable Development, particularly SDG 3, which aims to ensure healthy lives and promote well-being for all at all ages. Key SDG 3 indicators include: maternal mortality (3.1.1); under-five mortality (3.2.1); neonatal mortality (3.2.2); stunting, wasting, and overweight (2.2.1 and 2.2.2); early childhood development (4.2.1); reducing premature suicide mortality by promoting mental health and well-being (3.4.2); strengthening the prevention and treatment of substance abuse, including narcotic drug abuse (3.5.1) and harmful use of alcohol (3.5.2); improving access to sexual and reproductive health services, including family planning, information, and education (3.7.1); reducing the adolescent birth rate (3.7.2); and reducing the number of new HIV infections (3.8.1 and 3.3.1). This chapter synthesises available data and information on each of these topics.

Health System in South Africa

The Department of Health (DoH) is mandated by the National Health Act 61 of 2003 to provide a framework for a structured and uniform health system, setting the responsibilities of the three levels of government in the provision of health services. The mission of the DoH is to improve health by preventing illness and disease and promoting healthy lifestyles; thus, the DoH consistently aims to enhance the healthcare delivery system by focusing on access, equity, efficiency, quality and sustainability.[264] There are numerous other legal frameworks that have been enacted in South Africa and are pertinent to the health system and the provision of health services.[265]

The National Development Plan: Vision 2030 outlines nine goals for the health system, including: **1)** improvements in evidence-based preventative and therapeutic interventions for HIV; **2)** progressive improvement of TB prevention and cure; **3)** reductions in maternal and child mortality, including infant mortality; **4)** reductions in the prevalence of non-communicable diseases by 28 per cent; **5)** reductions in injuries, accidents and violence by 50 per cent from 2010 levels; **6)** completing health system reforms to strengthen the district health system; **7)** strengthening primary healthcare teams to provide care to families and communities; **8)** achieving universal health care coverage; and **9)** filling posts with skilled, committed and competent individuals. The overarching goal that measures impact is for the average male and female life expectancy at birth to increase to at least 70 years. These goals align with SDG 3, which aims to ensure healthy lives and promote well-being for all at all ages, along with related targets.[266]

The most recent National Department of Health Strategic Plan 2020/21-2024/25 aims to improve health status through the prevention of illness and disease and the promotion of healthy lifestyles. The Health Strategic Plan also seeks to consistently enhance the healthcare delivery system by focusing on access, equity, efficiency, quality and sustainability.[267] The Health Strategic Plan is aligned with the National Development Plan: Vision 2030, the Medium-Term Strategic Framework 2019-2024, and the National Development Implementation Plan 2019-2024. These policies aim to: eliminate avoidable and preventable deaths (survive); promote wellness and prevent and manage illness (thrive); and transform the health system, improve patient experiences of care, and mitigate social factors determining ill health. These objectives are aligned with the 2030 Agenda for Sustainable Development.[268]

The GoSA has enacted other health-related strategic plans, including the South African Maternal, Perinatal and Neonatal Health Policy (MPNH); the National Strategic Plan (NSP) for the Prevention and Control of Non-Communicable Diseases (NCDs); the National NCD Campaign; and the National Adolescent and Youth Health Policy 2017, among others. In 2023, South Africa's Parliament passed the NHI Bill. The NHI Bill paves the way for universal health coverage and will have considerable implications for how healthcare is funded and organised in South Africa.[269] In recent years, steps have also been taken to subsidise highly specialised health services at the country's tertiary and central hospitals, which are generally located in urban areas, yet are unevenly distributed across the provinces; as a result, a large number of referrals are made from rural provinces to those with better tertiary health service capacities.[270]

South Africa has public and private health systems that exist in parallel and operate in tandem; the public health system serves the majority of the population. The public health system includes more than 400 public hospitals, comprising large regional hospitals managed by provincial health departments, as well as small hospitals and primary care clinics managed at the municipal level. Johannesburg and Cape Town are both well known for having good public hospitals. Public hospitals associated with major universities are also recognised for their quality health services; however, wait times at university hospitals can be long.[271]

South Africa's public health infrastructure has numerous shortcomings, including old and often poorly maintained health facilities that are in need of repair, refurbishment, and, in some cases, replacement. There is also a need to invest in new infrastructure where gaps in service delivery exist.[272] Although the public health system is funded by the government and through point-of-care spending from patients, it remains largely underfunded and understaffed, and has been described as poorly managed. Patients are often frustrated by long wait times, a lack of privacy, and serious overcrowding.[273]

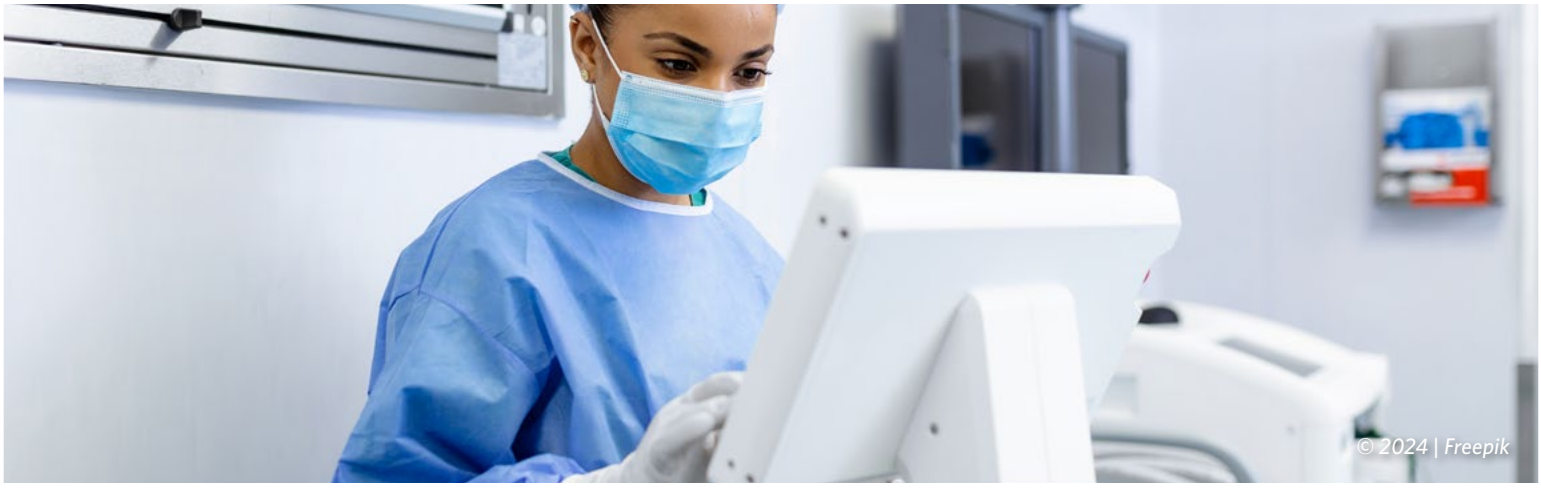
In comparison, the private health sector in South Africa, which serves predominantly middle- and upper-class families and expatriates, is well funded and staffed. Patients who use the private healthcare system can expect short wait times, modern facilities, adequate medical equipment and supplies, and greater privacy. The quality of healthcare professionals in private hospitals is often among the country's best, as private health facilities offer higher wages and better benefits compared to public hospitals and clinics.[274]

South Africa has a shortage of medical doctors, specialists, and nurses. To improve the country's doctor-to-patient ratio, the GoSA has increased the number of doctors trained at domestic medical schools through a combination of bursary schemes targeting students from underprivileged areas and has increased the general intake at medical schools.[275]

In 2022, the DoH recognised the impact of loadshedding on the provision of health services and intervention measures, as health workers called upon the government to exempt health facilities from loadshedding to mitigate the impact on their effective functioning.[276] Loadshedding is a risk to efforts to deliver quality health care to patients and to ensure quality pharmaceutical services. Although the majority of public health facilities have backup power supply systems (e.g., generators and uninterrupted power supplies), these alternative energy sources are not designed to provide backup electricity for long periods. Some generators are old, and others lack the capacity to power an entire health facility; thus, health facilities are not adequately equipped to meet the increasing demands during loadshedding and have, at times, been forced to shut down critical areas, which compromises patient care. Additionally, persistent power outages contribute to the reduced lifespan of some critical medical machinery and equipment, including the backup generators. Unpredictable and prolonged power outages also pose a threat to the safety and efficacy of various medications and vaccines that need to be stored within specific temperature ranges. Security in health facilities can also be compromised during blackouts, especially in the evening.[277]

To address these issues, the DoH is engaging with the National Treasury to discuss additional budget implementation to sustain loadshedding contingency plans, including unbudgeted increases in diesel and oil expenditures to run generators and maintenance costs. The DoH is also considering a phased approach to investment in renewable energy through solar power installations at health facilities; this, however, requires a feasibility study before such an investment can be made.[278]

For data and information related to health public expenditures, see Chapter 3, Public Finance for Children and Adolescents, Health Public Expenditures.



Child Survival

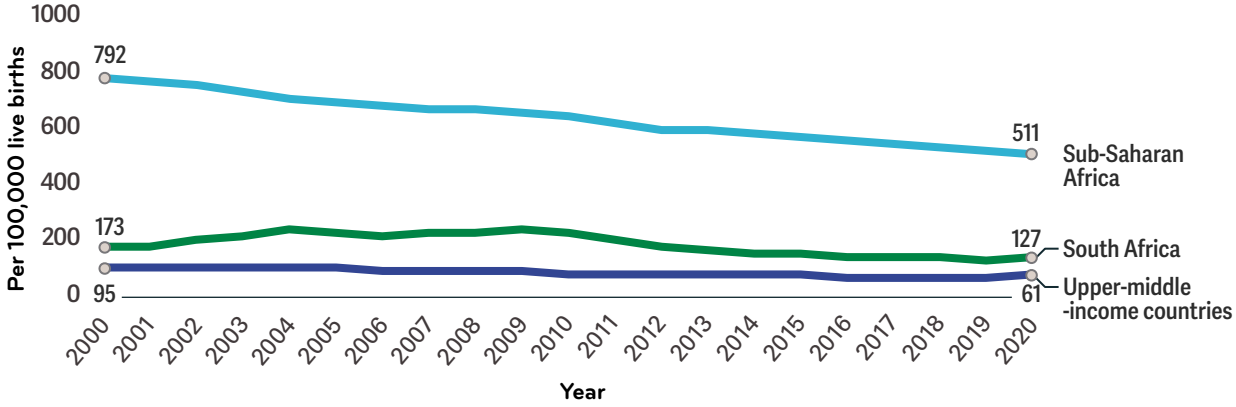
Efforts to improve maternal and neonatal survival have translated into commitments to accelerate the scale-up of an essential package of maternal and newborn care services, including quality antenatal care (ANC) and postnatal care (PNC) for pregnant women.[279] ANC and PNC are essential for maternal health and neonatal survival, and cover critical evidence-based interventions, including immediate assessment of babies, early and exclusive breastfeeding, umbilical cord care, and the reinforcement of PNC care and messaging among families and caregivers.[280] The presence of skilled birth attendants at birth is also critical to averting maternal and neonatal mortality, morbidity, and disabilities.[281]

Maternal Mortality

Maternal mortality refers to deaths due to complications from pregnancy or childbirth.[282] Complications leading to maternal death can occur without warning at any time during pregnancy and childbirth, although some complications can be screened for and prevented. Thus, it is crucial that every pregnant woman is monitored and identified as at-risk for a high-risk pregnancy through ANC.[283] Most maternal deaths can also be prevented if births are attended by skilled healthcare professionals (i.e., doctors, nurses, or midwives) who are regularly supervised, have the proper equipment and supplies, and can refer women in a timely manner to emergency obstetric care when complications are diagnosed. Complications require prompt access to quality obstetric services equipped with life-saving drugs, including antibiotics, and the ability to provide blood transfusions needed to perform Caesarean sections or other surgical interventions.[284]

Chart 4.1 shows trends in maternal mortality ratios per 100,000 live births for South Africa, alongside averages for sub-Saharan Africa (excluding high-income countries) and upper-middle-income countries for comparison purposes. Over the past two decades, South Africa has seen a 27 per cent reduction in the maternal mortality ratio, from 173 deaths per 100,000 live births in 2000 to 127 deaths per 100,000 live births in 2020. From 2000 to 2009, South Africa's maternal mortality ratio was notably lower than the average for sub-Saharan Africa, yet higher than the average for upper-middle-income countries. In 2020, South Africa's maternal mortality ratio was 127 deaths per 100,000 live births, compared to 61 deaths per 100,000 live births for upper-middle-income countries and 511 deaths per 100,000 live births for sub-Saharan Africa (excluding high-income).

CHART 4.1 Maternal mortality ratio (modelled estimate, per 100,000 live births), 2000-2020



SOURCE: Retrieved on 10 February 2024 from: Maternal mortality ratio (modelled estimate, per 100,000 live births) - South Africa | Data (worldbank.org); Maternal mortality ratio (modelled estimate, per 100,000 live births) – Sub-Saharan Africa (excluding high income) | Data (worldbank.org); Maternal mortality ratio (modelled estimate, per 100,000 live births) - Upper middle income | Data (worldbank.org)

From 2020 to 2022, there were notable differences of in-facility maternal mortality ratios by province, with the highest rates in the Free State (180.9) and the lowest in the Western Cape (89.2).[285]

The *Saving Mothers, Saving Babies* Report covers the period from 2020 to 2022 and identifies the main causes of maternal deaths as follows:[286]

- Non-pregnancy-related infections (29 per cent)
- Obstetric haemorrhage (16 per cent)
- Hypertensive disorders of pregnancy (15 per cent)
- Medical and surgical disorders (14 per cent)
- Pregnancy-related sepsis (5 per cent)
- Miscarriage (5 per cent)
- Other (16 per cent)

See Annex Figure 1 for the top four underlying causes of maternal mortality for all provinces.

Maternal deaths related to such complications were attributed to:[287]

- Administrative weaknesses, such as inadequate transport facilities
- Lack of healthcare facilities and appropriately trained staff
- Patient-oriented issues, such as infrequent ANC attendance and delays in seeking medical help
- Health worker issues, such as healthcare providers' failure to follow protocols, delays in referring patients, and poor initial assessment and recognition/diagnosis
- Communication issues

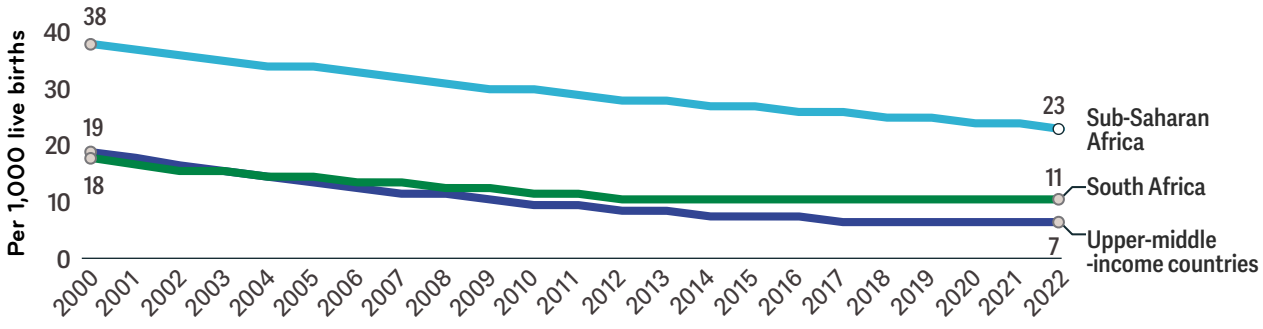
In 2020, 68 per cent of women had their first ANC visit before they were 20 weeks into their pregnancy (down from 70 per cent in 2019). All regions observed a decline in the percentage of women seeking their first ANC visit before 20 weeks, except KwaZulu-Natal, which recorded a slight increase from 74 per cent in 2019 to 75 per cent in 2020.[288]

Neonatal Mortality

The neonatal period – the first 28 days of life – is the most vulnerable time for a child's survival. **Chart 4.2** shows trends in neonatal mortality rates (per 1,000 live births) for South Africa, alongside averages for Eastern and Southern Africa and upper-middle-income countries for comparison purposes. Over the past two decades, the neonatal mortality rate in South Africa has declined by 39 per cent, from 18 deaths per 1,000 live births in 2000 to 11 deaths per 1,000 live births in 2022. This pattern is similar to the 40 per cent decline in neonatal mortality rates for Eastern and Southern Africa over the same period, whereas average neonatal mortality rates for upper-middle-income countries declined by 63 per cent.

From 2000 to 2021, South Africa's neonatal mortality rates have been consistently lower than the average for Eastern and Southern Africa, but since 2003 have been higher than the average for upper-middle-income countries. In 2021, South Africa's neonatal mortality rate was 11 deaths per 1,000 live births, compared to 23 deaths per 1,000 live births for Eastern and Southern Africa and 7 deaths per 1,000 live births for upper-middle-income countries.

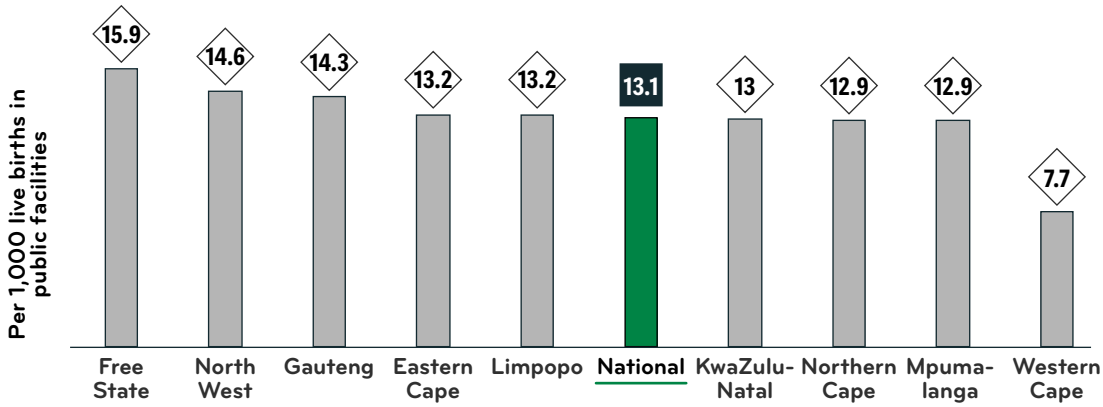
CHART 4.2. Neonatal mortality rate (per 1,000 live births), 2000-2022



SOURCE: Retrieved on 11 February 2024 from: CME Info - Child Mortality Estimates

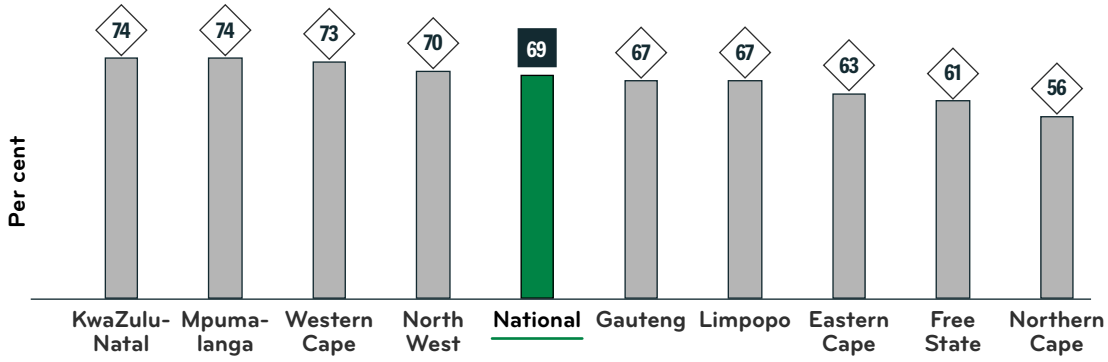
Chart 4.3 shows notable differences across provinces in the rate of neonatal deaths in facilities. In 2021/22, the rate of neonatal deaths in facilities was highest in Free State (15.9 per 1,000 live births in public facilities) and North West (14.6 per 1,000 live births in public facilities), and lowest in Western Cape (7.7 per 1,000 live births in public facilities).

CHART 4.3. Neonatal death in facility rate by province (per 1,000 live births in public facilities), 2021/22



SOURCE: Hall, K. et al. (2024). South African Early Childhood Review 2024. Children's Institute, University of Cape Town and Ilifa Labantwana: Cape Town, South Africa, p. 24.

CHART 4.4. First ANC visit before 20 weeks of pregnancy (%), 2021/22



SOURCE: Hall, K. et al. (2024). South African Early Childhood Review 2024. Children's Institute, University of Cape Town and Ilifa Labantwana: Cape Town, South Africa, p. 22.

Chart 4.4 shows that nationally, 69 per cent of ANC first visits occurred before 20 weeks. Early ANC bookings were highest in KwaZulu-Natal (74 per cent), Mpumalanga (74 per cent), and Western Cape (73 per cent), and lowest in Free State (61 per cent) and Northern Cape (56 per cent). It is notable that early ANC bookings and visits appear to align to some extent with lower neonatal mortality rates by province.

In 2018, the leading causes of neonatal deaths were:[289]

- Prematurity (49 per cent)
- Intrapartum-related injuries (28 per cent)
- Congenital abnormalities (9 per cent)
- Infection (8 per cent)
- Other (6 per cent)

This study concluded that an estimated 25 per cent of all neonatal deaths were modifiable. This, however, requires reducing deaths through prevention (i.e., reducing prematurity and improving ANC), managing complications during delivery (e.g., preventing asphyxia), and improving the quality of newborn care, especially the management of infections. It also requires improving health workers' skills, health facilities, and equipment in neonatal units at all referral hospitals to ensure high coverage and quality of ANC.[290]

About half of perinatal deaths can also potentially be modified through interventions targeted at women before pregnancy and during ANC visits. For instance, by providing nutritional supplements and prompt treatment of sexually transmitted infections (STIs), and through the provision of advanced ANC to detect and manage high-risk obstetric conditions, including timely caesarean sections and induction of labour when required. The DoH has recognised, however, that the health system is unable to adequately detect high-risk pregnancies early on and to institute interventions for at-risk pregnancies.[291]

In 2020, the ratio of stillbirths to early neonatal deaths was about 2:1, indicating in-utero deaths.[292] The stillbirth rate declined from 21 per 1,000 births in 2018 to 19 per 1,000 births in 2020, with a sharp decline in Mpumalanga from 21 per 1,000 births in 2018 to 7 per 1,000 births in 2020; in comparison, there was an increase in stillbirths in the Eastern Cape, KwaZulu-Natal, and North West.[293] Most causes of stillbirth are understood to be treatable or preventable, including probable foetal compromise, pathological placental conditions, and foetal invasive bacterial infections.[294]

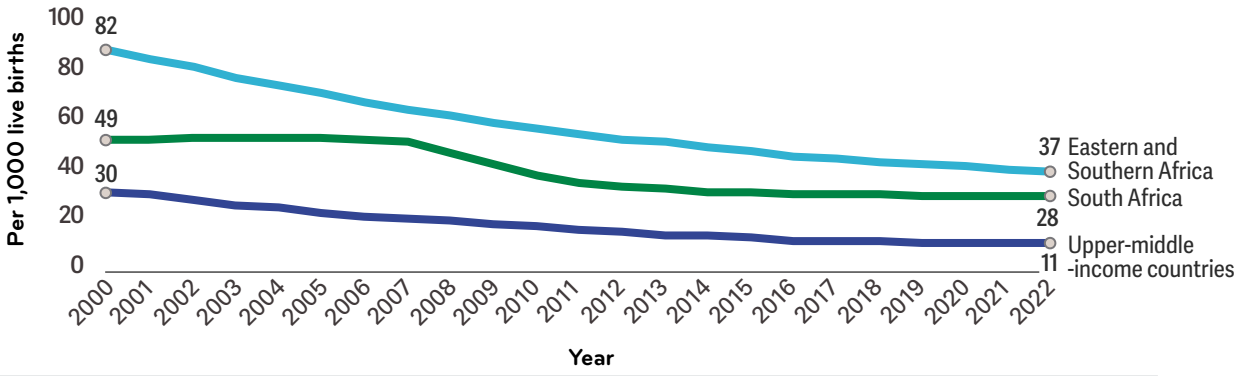
In 2021, the MPNH was introduced to reduce maternal, perinatal, and neonatal morbidity and mortality rates by 50 per cent by 2030, in line with the 2030 Agenda for Sustainable Development. Consequently, this Policy aims to improve the delivery of a range of maternal, perinatal, and neonatal health services that are comprehensive, high-quality, integrated, accessible, respectful, effective, and safe, and provided equitably to individuals, couples, and communities across the nation.[295]

Infant Mortality

Infant mortality is the death of children under one year of age. **Chart 4.5** shows that over the past two decades, the infant mortality rate in South Africa has decreased by 43 per cent, from 49 deaths per 1,000 live births in 2000 to 28 deaths per 1,000 live births in 2022. In comparison, Eastern and

Southern Africa experienced a 55 per cent decrease in the infant mortality rate, from 82 deaths per 1,000 live births in 2000 to 37 deaths per 1,000 live births in 2022. Meanwhile, upper-middle-income countries experienced a 63 per cent decrease, from 30 deaths per 1,000 live births in 2000 to 11 deaths per 1,000 live births in 2022. Since 2000, South Africa's infant mortality rate has been lower than the average for Eastern and Southern Africa, but higher than the average for upper-middle-income countries.

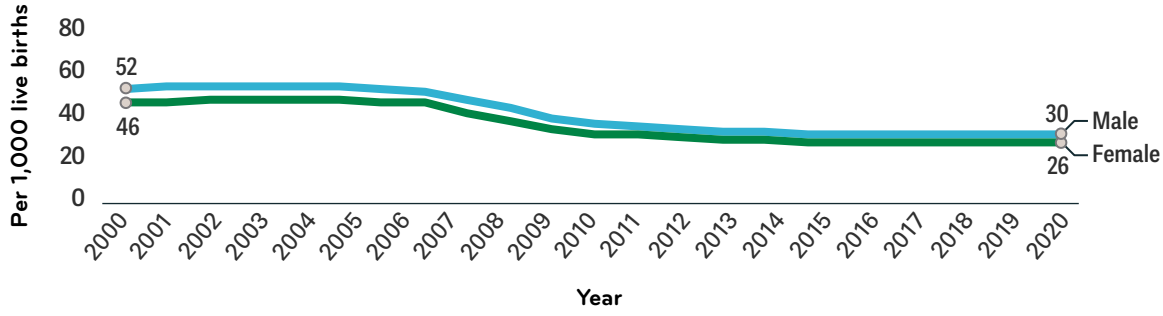
CHART 4.5. Infant mortality rate (per 1,000 live births), 2000-2022



SOURCE: Retrieved on 11 February 2024 from: CME Info - Child Mortality Estimates

Over the past two decades, the infant mortality rate has consistently been slightly higher for males; however, since 2012, that gap has been closing. While the male infant mortality rate decreased by 42 per cent from 52 deaths per 1,000 live births in 2000 to 30 deaths per 1,000 live births in 2022, the female infant mortality rate decreased by 43 per cent from 46 deaths per 1,000 live births in 2000 to 26 deaths per 1,000 live births in 2022 (**Chart 4.6**).

CHART 4.6. Infant mortality rate (per 1,000 live births) by sex, 2000-2022

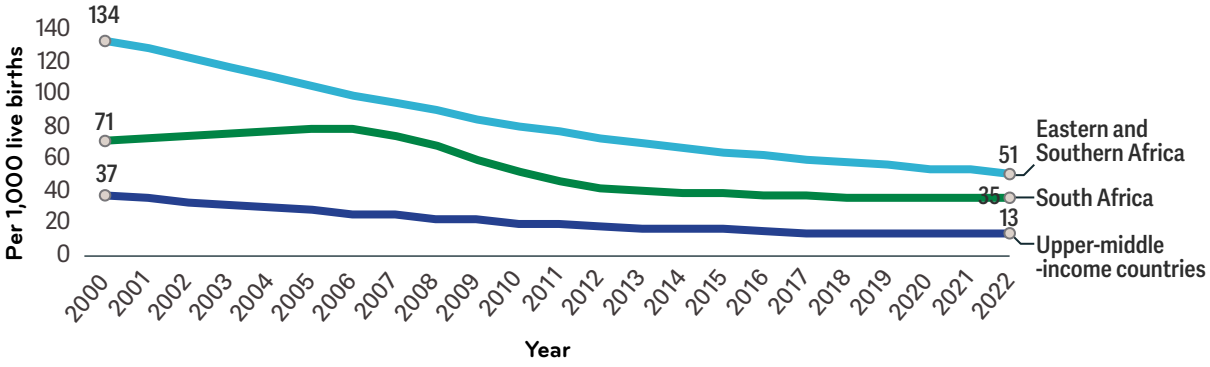


SOURCES: Retrieved on 11 February 2024 from: CME Info - Child Mortality Estimates

Under-Five Mortality

Chart 4.7 reveals trends in under-five mortality rates per 1,000 live births for 2000-2022. Over the past two decades, South Africa has experienced a 51 per cent decrease in the under-five mortality rate, from 71 deaths per 1,000 live births in 2000 to 35 deaths per 1,000 live births in 2022. From 2000 to 2021, South Africa's under-five mortality rate has remained lower than the average under-five mortality rate for Eastern and Southern Africa, yet higher than the average for upper-middle-income countries. In 2022, the average under-five mortality rate for Eastern and Southern Africa was 51 deaths per 1,000 live births, whereas the average for upper-middle-income countries was 13 deaths per 1,000 live births, compared to 35 deaths per 1,000 live births for South Africa. The minimum SDG target of at least 25 under-five deaths per 1,000 live births has yet to be achieved in South Africa; thus, there is still more work to be done to reduce the number of under-five deaths by 2030.

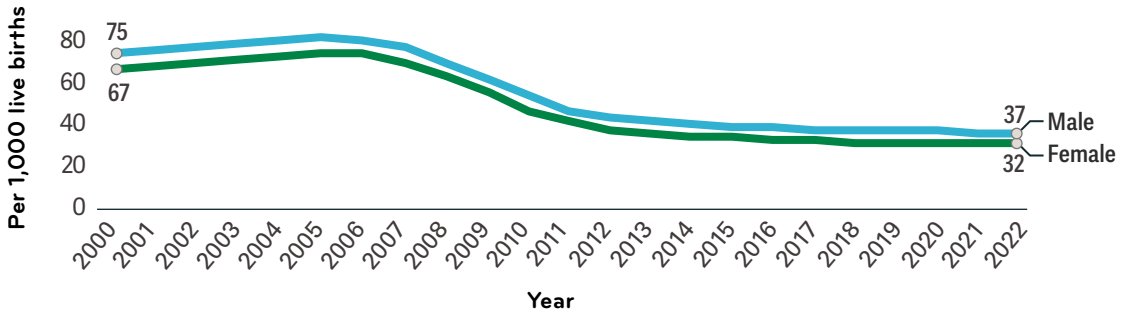
CHART 4.7. **Under-five mortality rate (per 1,000 live births), 2000-2021**



SOURCE: Retrieved on 11 February 2024 from: CME Info - Child Mortality Estimates

Chart 4.8 shows that over the past two decades, the under-five mortality rate has been consistently higher for males than for females in South Africa. The male under-five mortality rate decreased by 51 per cent, from 75 deaths per 1,000 live births in 2000 to 37 deaths per 1,000 live births in 2022, whereas the female under-five mortality rate decreased by 52 per cent, from 67 deaths per 1,000 live births in 2000 to 32 deaths per 1,000 live births in 2022.

CHART 4.8. **Under-five mortality rate (per 1,000 live births) by sex, 2000-2022**

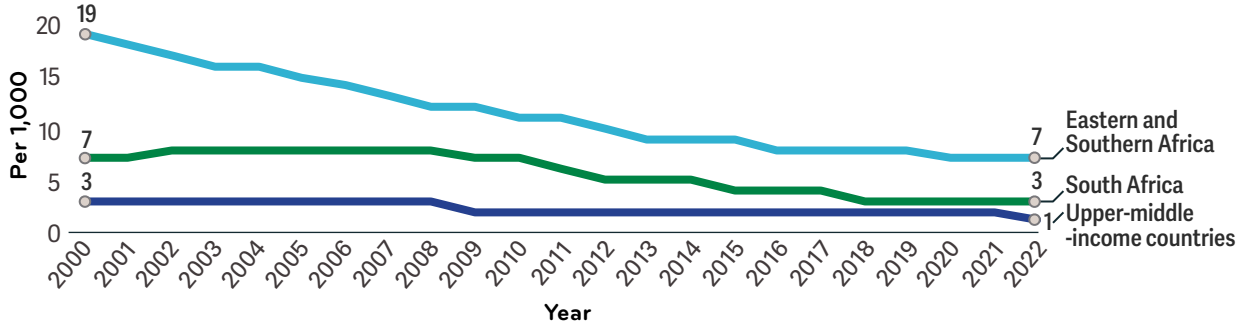


SOURCES: Retrieved on 11 February 2024 from: CME Info – Child Mortality Estimates

Child Mortality (Ages 5-9)

Chart 4.9 shows that in South Africa, the mortality rate for children aged 5-9 decreased by 57 per cent, from 7 per 1,000 in 2000 to 3 per 1,000 in 2022. From 2000 to 2022, South Africa's mortality rate for children aged 5-9 was consistently lower than the average for Eastern and Southern Africa, and higher than the average for upper-middle-income countries, although the gap has closed in recent years. In 2022, the mortality rate for children aged 5-9 was 7 per 1,000 for Eastern and Southern Africa and 1 per 1,000 for upper-middle-income countries, compared to 3 per 1,000 for South Africa.

CHART 4.9. **Mortality rate for children aged 5-9 (per 1,000), 2000-2022**



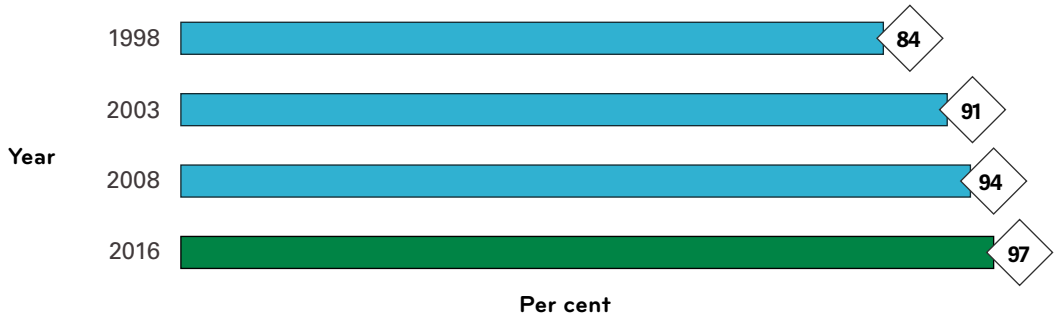
SOURCE: Retrieved on 11 February 2024 from: CME Info – Child Mortality Estimates

Presence of Skilled Birth Attendants

One important strategy for reducing newborn and child morbidity and mortality is ensuring that every baby is delivered with the assistance of a skilled birth attendant (i.e., medical doctor, nurse, or midwife). Skilled birth attendants should be competent maternal and newborn health professionals who are educated, trained, and regulated to national and international standards. Skilled health staff are capable of facilitating physiological processes during labour to ensure clean and safe births, and they can identify, manage, and refer women and newborns with complications to emergency care.

Chart 4.10 shows that there has been a steady increase in the proportion of births attended by skilled health staff over the past two decades, from 84 per cent in 1998 to 97 per cent in 2016; more recent data are not available. Given the importance of skilled birth attendants in reducing maternal morbidity and mortality, the proportion of births attended by skilled health staff was included as an SDG indicator (3.1.2), related to SDG Target 3.1, which aims to reduce the global maternal mortality ratio to less than 70 per 100,000 live births by 2030.

CHART 4.10. Births attended by skilled health staff (% of total), 1998-2016



SOURCE: Retrieved on 11 February 2024 from: Births attended by skilled health staff (% of total) - South Africa | Data (worldbank.org)

In 2021, the MPNH was introduced to reduce maternal, perinatal and neonatal morbidity and mortality rates by 50 per cent by 2030, in line with the 2030 Agenda for Sustainable Development. Accordingly, the Policy aims to ensure that all health staff providing maternal, perinatal and neonatal services are trained, competent, certified and registered with a regulated professional health body, to guarantee quality, safe and effective maternal, perinatal and neonatal health services and deliveries. The Policy also aims to improve clinical governance mechanisms to ensure that health workers exercise their skills at the appropriate level of care, as defined in the relevant scopes of practice of professional councils and regulatory bodies (see Annex Figure 1 for basic data on improving coverage and quality of care).[296]

Infant and Young Child Feeding and Nutrition

The CRC recognises that every child has a right to nutrition, from birth to 18 years of age. To realise this right, children and their families need access to nutritious diets, essential services, and positive practices that set them on the path to *survive and thrive*.[297] SDG Target 2.2 aims to end all forms of malnutrition by 2030, to reduce the prevalence of stunting and wasting in children under five by 40 per cent by 2025, and to address the nutritional needs of adolescent girls and pregnant and lactating women.

According to UNICEF, 23 per cent of South Africa's children are classified as food poor and are at risk of life-threatening malnutrition and related health complications. As a result, South Africa is one of 20 countries that account for 65 per cent of all children living in severe child food poverty globally.[298] Using data from the GHS, Stats SA reported in 2023 that the majority of households had adequate access to food (77 per cent), whereas 23 per cent considered their access inadequate (14 per cent) or severely inadequate (9 per cent).[299] Moreover, 20 per cent of metropolitan households experienced inadequate or severely inadequate access to food during the preceding year, with food access problems most common in Mangaung (26 per cent) and Johannesburg (25 per cent).[300]

Several factors are fuelling the child food poverty crisis in South Africa, including food systems that fail to provide children with nutritious, safe, and accessible food options. Given the high rates of unemployment and poverty, parents and caregivers are unable to afford nutrient-rich foods, as recommended by infant and young child feeding guidelines, and they are not always able to adopt and sustain positive child feeding practices.[301] Child nutrition is also negatively impacted by easy access to cheap, nutrient-poor, and unhealthy ultra-processed foods and sugar-sweetened beverages that are aggressively marketed. These unhealthy foods and beverages are consumed by an alarming proportion of young children experiencing food poverty, displacing more nutritious and healthier food options from their daily diets. Given these realities, efforts to tackle severe child food poverty require a commitment to transforming food systems so that nutritious, diverse, and healthy foods are readily accessible, affordable, and desirable options for feeding young children.[302]

BOX 4.1. UNICEF's guidance on transforming food systems to support improved child nutrition

Food systems require public and private sector actors to take full responsibility for their unique roles in shaping children's diets. Governments have primary accountability for upholding children's right to food and nutrition. They must set standards that align with children's best interests and create a level playing field for food producers and suppliers, ensuring their actions (i.e., food production, transformation, distribution, labelling, marketing, and retailing) are consistent with these standards. Food systems must deliver nutritious, safe, affordable, and sustainable food options for children, and the private sector has a key role to play as providers of food and essential goods and services for children and adolescents; a source of employment and livelihoods for women and families; a shaper of food markets, food prices, and consumer demand; and a driver of climate and environmental change.

SOURCE: UNICEF (2024). *Child Food Poverty. Nutrition Deprivation in Early Childhood. Child Nutrition Report.* UNICEF: New York City, NY, USA.

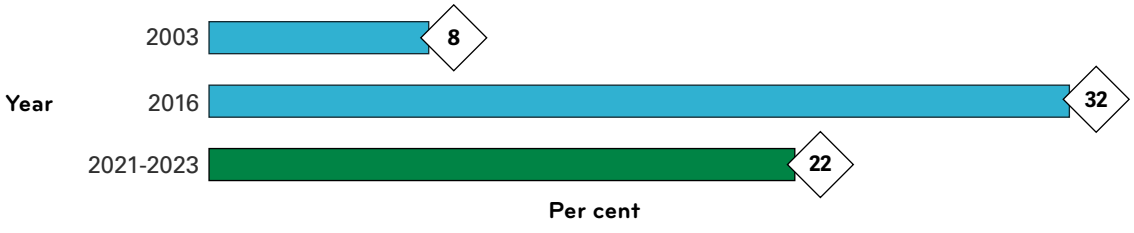
Breastfeeding

Infant feeding practices can increase child survival and promote healthy growth and development. Breastfeeding is the best source of nutrition for most infants and can lead to better health and growth outcomes, with the potential to reduce stunting during the first two years of life. It can also lower the risk of certain health conditions for both infants and mothers, and protect children from infection. Breastfeeding is both economical and safe.[303]

Exclusive breastfeeding is recommended for the first six months of age, with continued breastfeeding alongside complementary foods up to two years of age or beyond.[304] Despite the critical benefits of breastfeeding, practices are still far from optimal in many parts of the world. Many children do not start breastfeeding early enough – within the first hour of life – and do not exclusively breastfeed for the recommended first six months. Many children stop breastfeeding too soon.[305]

In South Africa, the proportion of infants under six months of age who were exclusively breastfed increased from 8 per cent in 2003 to 32 per cent in 2016, and reportedly decreased to 22 per cent in 2021-2023 (**Chart 4.11**).[306]

CHART 4.11. Exclusive breastfeeding (% of children under 6 months), 2003 and 2023



SOURCE: Data for 2023 and 2016 retrieved on 11 February 2024 from: Exclusive breastfeeding (% of children under 6 months) - South Africa | Data (worldbank.org); Data for 2021-2023 retrieved from: Hall, K. et al. (2024). South African Early Childhood Review 2024. Children's Institute, University of Cape Town and Ilifa Labantwana: Cape Town, South Africa, p. 33.

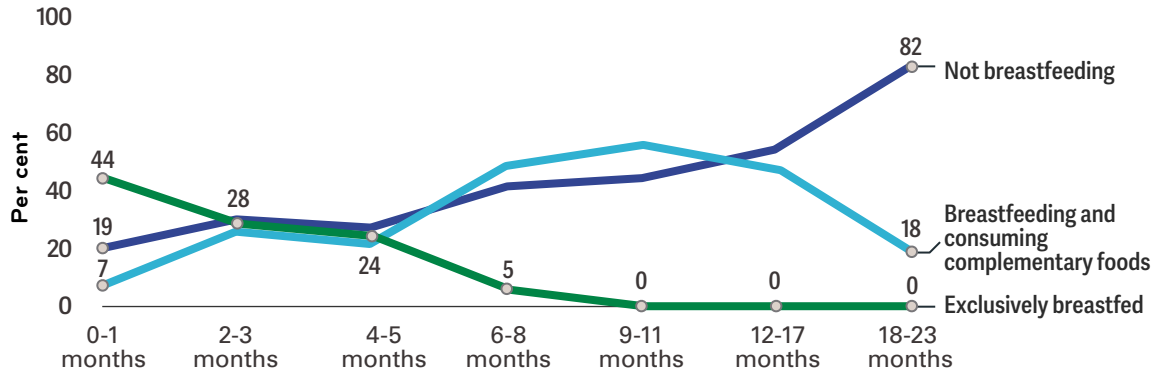
UNICEF and the WHO recommend that infants be breastfed within one hour of birth, exclusively for the first six months of life and up to two years and beyond.

In keeping with WHO recommendations, South Africa has committed to promoting exclusive breastfeeding for infants under six months for all mothers, regardless of HIV status.[307] However, South Africa's exclusive breastfeeding rate still lags behind the WHO's global target of 50 per cent, which countries should reach by 2025.[308]

In 2016, 67 per cent of children were first breastfed within one hour of birth and 80 per cent within one day of birth. The median duration of exclusive breastfeeding was only 2.9 months, and predominant breastfeeding continued to 3.8 months. It is also notable that 51 per cent of children continued to receive breast milk at one year, and 13 per cent at two years (see Annex Table 8 for data related to key infant and young child feeding indicators on breastfeeding status and the introduction of solid or semi-solid foods).

Chart 4.12 shows that the percentage of exclusive breastfeeding declines with age, from 44 per cent among children aged 0-1 month, 28 per cent among children aged 2-3 months, 24 per cent among children aged 4-5 months, and only 5 per cent among children aged 6-8 months. Contrary to the recommendation that children under six months should be exclusively breastfed, many infants also receive other liquids before reaching six months of age, such as water (10 per cent), other milks (11 per cent), and non-milk liquids (1 per cent). Moreover, 18 per cent of children begin consuming complementary foods before six months, and 21 per cent begin consuming complementary foods at four to five months of age.

CHART 4.12. Breastfeeding practices among children under the age of 2 (%), 2016



SOURCE: SADHS, 2016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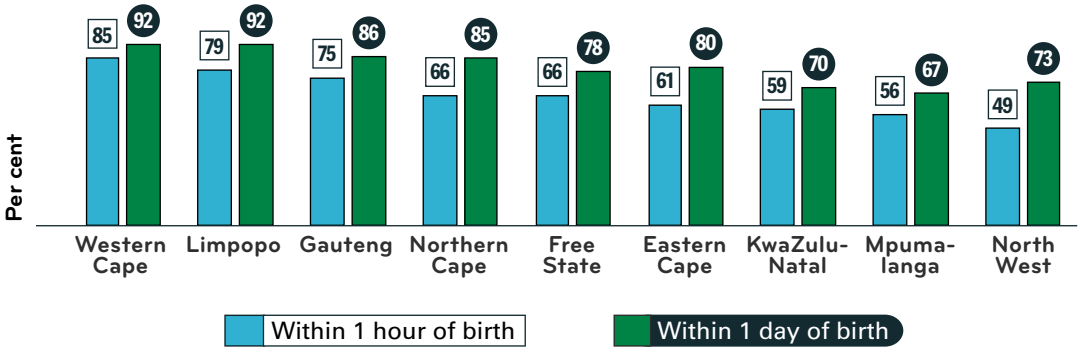
There are notable regional differences in breastfeeding practices within one hour and one day of birth. **Chart 4.13** shows that in 2016, newborns in the Western Cape (85 per cent) were most likely to start breastfeeding within one hour of birth, whereas newborns in Mpumalanga (56 per cent) and North West (49 per cent) were least likely to breastfeed within one hour of birth. In addition, newborns in the Western Cape (92 per cent) and Limpopo (92 per cent) were most likely to be breastfed within one day of birth, whereas newborns in KwaZulu-Natal (70 per cent) and Mpumalanga (67 per cent) were least likely to be breastfed within one day of birth.

CHART 4.13. Newborns who started breastfeeding within one-hour and one-day of birth (%), 2016



SOURCE: SADHS, 2016

More than half of South Africa's children are not exclusively breastfed, largely due to sophisticated and aggressive marketing of breastmilk substitutes, which continues to undermine confidence in breastfeeding, putting the health of mothers and children at risk.[309] Despite policies aimed at containing aggressive marketing of breastmilk substitutes, the market for infant formula remains widespread and is quite powerful and successful. Infant formula marketing often misuses and distorts information to influence mothers' decisions and feeding practices, which undermines breastfeeding and child health.[310]

It is also notable that during the COVID-19 pandemic, misguided fears that COVID-19 could be transmitted through breastfeeding resulted in some breastfeeding mothers denying their infants breast milk; despite the fact that UNICEF and the WHO instructed mothers suspected or known to have COVID-19 to continue breastfeeding, as it is safe for infants and young children, and the benefits of breastfeeding substantially outweigh the potential risks of illness associated with COVID-19.[311]

Recent civil unrest in South Africa also demonstrated the need to create an enabling environment and to strengthen the chain of support for breastfeeding mothers in different settings.[312] It is also important to ensure that the use of breastmilk substitutes occurs within the context of current regulations to avoid unnecessary donations that undermine breastfeeding. Calling for donations of breastmilk substitutes and providing inaccurate information to breastfeeding and non-breastfeeding mothers may lead to a drastic decline in breastfeeding, with damaging consequences for the survival, growth, and development of children.[313]

Child Undernutrition

Children's nutritional status reflects their overall health. Children who have access to an adequate food supply are not typically exposed to repeated illness, are well cared for, and are more likely to reach their growth potential and be considered well-nourished. Children who do not receive the nutrition they need are at risk of micronutrient deficiencies, diet-related non-communicable diseases, stunting (low height-for-age),[314] wasting (low weight-for-height),[315] and poor cognitive development.[316] Children who suffer from undernutrition are more likely to die from common childhood ailments, and those who survive often endure recurring illness. Government investment in nutrition programmes that aim to prevent and treat malnutrition, as well as set children on the path to grow and develop properly throughout childhood and into adulthood, is important.

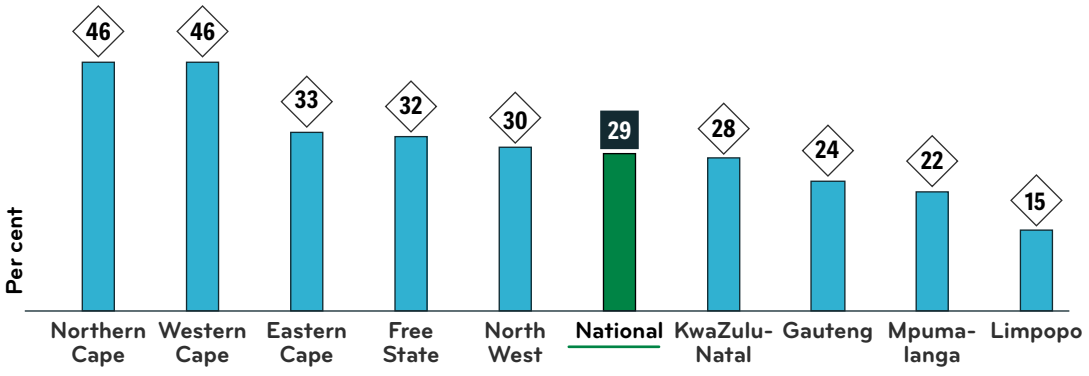
Chart 4.14 shows the proportion of children under five with nutritional deficiencies, including underweight, stunting, wasting, and severe wasting. In 2022, 8 per cent of children under five were underweight (up from 6 per cent in 2016), 29 per cent were stunted (up from 27 per cent in 2016), and 5 per cent were wasted (up from 2 per cent in 2016). In 2016, 2 per cent of children under five were severely wasted. In 2016, boys (30 per cent) were more likely than girls (25 per cent) to experience stunting.[317] More recently, in 2022, UNICEF ranked South Africa among the top 10 countries for severe wasting among children under five years of age.[318]

CHART 4.14. Children under-five with nutritional deficiencies (%), 2008-2016

SOURCE: Data for 2008 and 2016 were retrieved on 11 February 2024 from: Prevalence of underweight, weight for age (% of children under 5) - South Africa | Data (worldbank.org); Prevalence of stunting, height for age (% of children under 5) - South Africa | Data (worldbank.org) Prevalence of stunting, height for age (% of children under 5) - South Africa | Data (worldbank.org) Prevalence of stunting, height for age (% of children under 5) - South Africa | Data (worldbank.org); Prevalence of wasting, weight for height (% of children under 5) - South Africa | Data (worldbank.org); Prevalence of severe wasting, weight for height (% of children under 5) - South Africa | Data (worldbank.org); Data for 2021-2023 retrieved from: Hall, K. et al. (2024). South African Early Childhood Review 2024. Children's Institute, University of Cape Town and Ilifa Labantwana: Cape Town, South Africa, p. 33.

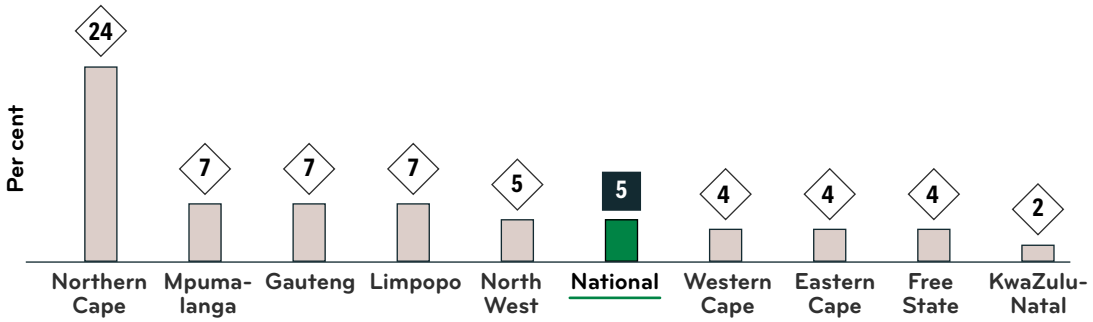
Charts 4.15 and **4.16** show provincial differences in the prevalence of stunting and wasting among children under five. In 2021-2023, Northern Cape and Western Cape (46 per cent each) had the highest proportion of children under five who were stunted. Similarly, Northern Cape had the highest proportion of children under five who were wasted (24 per cent). In comparison, Limpopo had the lowest proportion of children under five who were stunted (15 per cent), and KwaZulu-Natal had the lowest proportion of children who were wasted (2 per cent).

CHART 4.15. Stunting in children under-5 (%), 2021-23



SOURCE: Hall, K. et al. (2024). South African Early Childhood Review 2024. Children's Institute, University of Cape Town and Ilifa Labantwana: Cape Town, South Africa, p. 33.

CHART 4.16. Wasting in children under-5 (%), 2021-23



SOURCE: Hall, K. et al. (2024). South African Early Childhood Review 2024. Children's Institute, University of Cape Town and Ilifa Labantwana: Cape Town, South Africa, p. 33.

The four main causes of stunting in South Africa are inadequate dietary intake, repeated infections, social and cognitive under-stimulation, and air pollution.[319] To reduce the occurrence of stunting, there are two evidence-based interventions: nutrition education for caregivers and the wider community, focusing on appropriate complementary feeding practices, and ensuring that food systems can deliver safe, nutritious, affordable, and sustainable foods for young children in South Africa.

Malnutrition is difficult to reverse and has lifelong consequences, and it can be fatal. In 2022/23, a staggering 15,000 South African children required hospitalisation due to severe acute malnutrition, representing a 25 per cent increase in just over the past five years.[320] Children who recover from early stunting still perform more poorly in cognitive tests than their peers who do not experience early malnutrition. They also perform nearly as poorly as children who remain stunted.[321] In fact, the 2021 Thrive by Five Index found that stunted children aged 50-59 months were, on average, 5-6 months behind their peers in developmental assessments.[322] In 2022/23, an estimated 1,000 South African children per year lost their lives to preventable acute malnutrition.[323]

In South Africa, among the best ways to reach mothers and children aged 6-24 months is via primary health care clinics. Challenges that exist, however, relate to logistics, poor ICT infrastructure, a shortage of managerial skills, weak coordination, and a lack of trained nutritionists, which remain challenges for any national initiative delivered through the national network of primary health clinics.[324] To overcome these challenges, community-based approaches, such as community health worker home visits and mother-to-mother peer groups, can be used to widen and deepen the reach

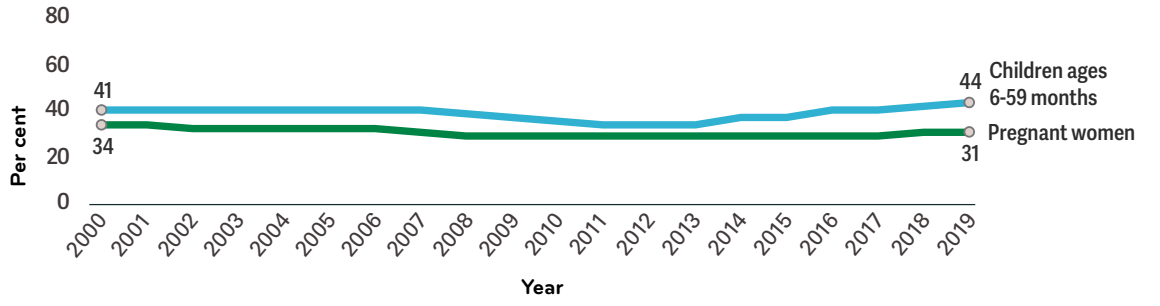
of efforts to scale up nutrition interventions, including identifying and reaching zero-dose children who, in addition to not being immunised, are likely to experience nutritional deficiencies and other deprivations. Partnerships with early learning programmes are also important and can expand coverage of programmes aimed at eliminating stunting. Policies are also crucial, particularly those related to health and WASH, as well as regulations that curtail advertisements promoting unhealthy foods for young children, and policies and programmes that promote access to nutritious foods and optimise the nutrient content of foods. Early learning programmes have an important role to play in supporting these policies.[325]

Mother and Child Anaemia

Anaemia, especially iron-deficiency anaemia, is common during pregnancy and can affect a baby's growth in the uterus. Because all women are at risk for anaemia during pregnancy, pregnant women often need more iron and other nutrients. Anaemia in pregnancy is preventable and treatable with prenatal vitamins. Serious and untreated anaemia in pregnancy can cause complications, including pre-term labour, increased blood loss during delivery, low birth weight, and anaemia and/or developmental delays in the baby.

Chart 4.17 shows that the proportion of pregnant women with anaemia declined by only three percentage points from 34 per cent in 2000 to 31 per cent in 2019, whereas the proportion of children aged 6-59 months who were anaemic increased by three percentage points from 41 per cent in 2000 to 44 per cent in 2019.

CHART 4.17. Anaemia among pregnant women and children ages 6-59 months (%), 2000-2019



SOURCE: Retrieved on 11 February 2024 from: Prevalence of anaemia among pregnant women (%) - South Africa | Data (worldbank.org) and Prevalence of anaemia among children (% of children ages 6-59 months) - South Africa | Data (worldbank.org)

Overweight and Obesity in Children

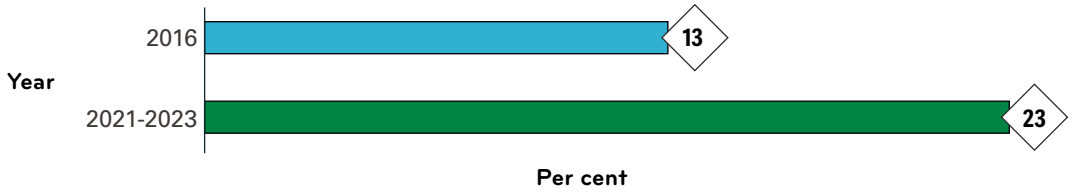
Child obesity is associated with a range of physical, emotional and social problems for children that can affect a child's development and social prospects in life. Obesity in childhood is an important risk factor for adult non-communicable diseases. Major factors contributing to the global rise in obesity include:

- Increased food processing and trade liberalisation, which has made cheap, highly processed foods readily available.
- Increased consumption of energy-dense foods that are high in fat and sugars.
- Reduction in the availability of plant-based foods.
- Decline in activity energy expenditures, largely due to motorised transport and less demanding manual tasks.

This nutritional transition has been taking place over the past several decades, as unprocessed food from the land has been replaced by processed food.

In South Africa, the proportion of children under five who were overweight was 23 per cent in 2021-2023 (up from 13 per cent in 2016). In 2016, boys (16 per cent) were more likely than girls (11 per cent) to be overweight;[326] gender differences are not available for 2021-2023 (**Chart 4.18**).

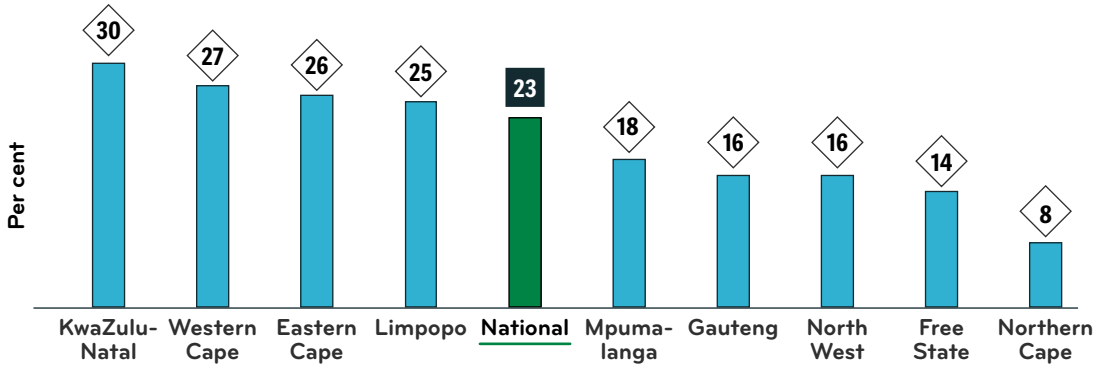
CHART 4.18. Overweight children under-five (%), 2016 & 2021-23



SOURCE: Data from 2016 retrieved on 11 February 2024 from: Prevalence of overweight, weight for height (% of children under 5) - South Africa | Data (worldbank.org); Data from 2021-2023 retrieved from: Hall, K. et al. (2024). South African Early Childhood Review 2024. Children's Institute, University of Cape Town and Ilifa Labantwana: Cape Town, South Africa, p. 33.

Chart **4.19** shows that in 2021-2023, KwaZulu-Natal (30 per cent), Western Cape (27 per cent), Eastern Cape (26 per cent) and Limpopo (25 per cent) had a larger proportion of overweight children compared to the national average of 23 per cent, whereas Northern Cape (8 per cent) had the smallest proportion of overweight children.

CHART 4.19. Overweight children under-five (%), 2021-23



SOURCE: Hall, K. et al. (2024). South African Early Childhood Review 2024. Children's Institute, University of Cape Town and Ilifa Labantwana: Cape Town, South Africa, p. 33.

In 2023, the DoH launched the Strategy for the Prevention and Management of Obesity in South Africa 2023-2028, which aims to reduce obesity and prevent NCDs. This strategy builds on gains made in recent years with the 2015-2020 Strategy for the Prevention and Management of Obesity in South Africa, including the health promotion levy on sugar-sweetened beverages, salt reduction regulations, and current efforts to implement front-of-pack labels to enable consumers to make informed decisions. The Strategy for the Prevention and Management of Obesity in South Africa 2023-2028 aims to empower South Africans to make healthy choices by ensuring equitable access to healthy food, physical activity opportunities, and a capacitated healthcare system that supports the prevention and management of obesity. The goal is that these strategic objectives will reduce the prevalence of obesity and diet-related NCDs among South Africans.[327] This strategy complements the National Strategic Plan for the Prevention and Control of NCDs 2022-2027, which also aims to strengthen the capacity of individuals and populations to adopt healthier behaviours and lifestyles, including promoting healthy food options and nutrition in prioritised settings, such as ECD centres, schools, and workplaces. The plan also aims to provide regular screening for and promote awareness of obesity in both adults and children.[328]

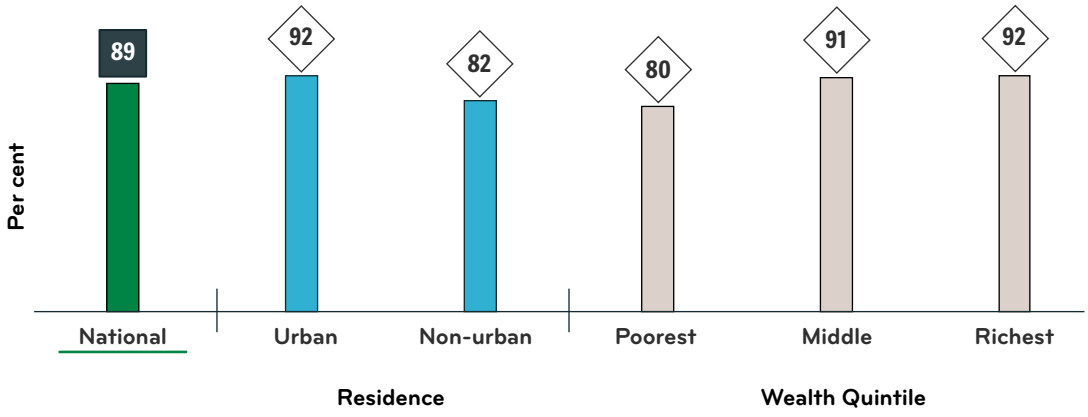
Salt Iodisation

Iodine deficiency can lead to a variety of health and developmental consequences known as iodine deficiency disorders (IDD). Iodine deficiency is a major cause of preventable brain damage and mental retardation, including impaired psycho-motor development in young children. IDD is most commonly and visibly associated with an abnormal enlargement of the thyroid gland (goitre) and increases the risks of stillbirth and miscarriage in pregnant women.[329] In its most extreme form, IDD

causes cretinism – a congenital condition marked by physical stunting and intellectual disability. IDD takes its greatest toll in impaired mental growth and development, contributing to poor learning outcomes, reduced intellectual ability, and impaired work performance.[330]

Chart 4.20 shows that in 2016, 89 per cent of South African households had adequately iodised salt of ≥ 15 parts per million (ppm). South Africa had nearly reached the universal salt iodisation target of 90 per cent of households having salt tested at 15 ppm. Urban households (92 per cent) were more likely than non-urban households (82 per cent) to have adequate iodised salt. In addition, the richest households (92 per cent) and middle-income households (91 per cent) were far more likely to have adequate iodised salt compared to the poorest households (80 per cent); thus, children in non-urban and the poorest households are at increased risk of IDD.

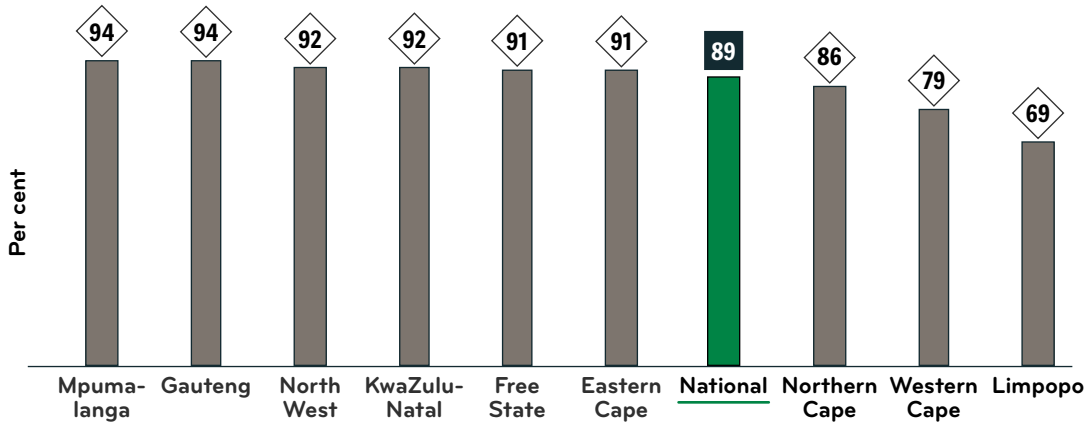
CHART 4.20. Consumption of adequate iodized salt by residence and wealth quintile (% of households), 2016



SOURCE: SADHS, 2016, p. 198

Chart 4.21 shows that while nearly all households in Gauteng, Mpumalanga, KwaZulu-Natal, North West, Eastern Cape, and Free State consumed adequate iodised salt, households in Western Cape (79 per cent) and Limpopo (69 per cent) were the least likely to have adequate iodised salt. Thus, children in Western Cape and Limpopo are at increased risk of IDD.

CHART 4.21. Consumption of adequate iodized salt by province (% of households), 2016

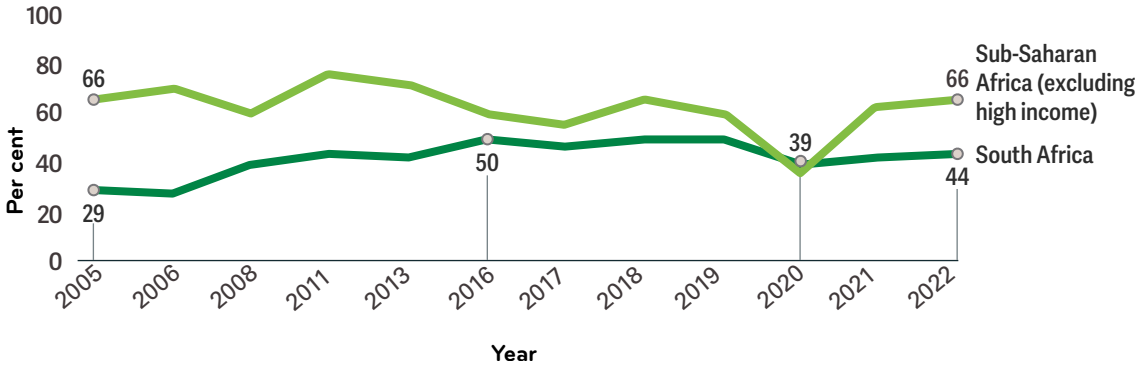


SOURCE: SADHS, 2016, p. 198

Vitamin A Supplementation

Research has found that vitamin A supplementation (VAS) can improve a child's chance of survival by 12 to 24 per cent. Recent food-based approaches, such as food fortification and the consumption of foods rich in vitamin A, are essential to ending vitamin A deficiency in the long term. However, until such programmes are sustained at a large scale, the delivery of high-dose VAS remains the principal strategy for controlling vitamin A deficiency in children aged 6–59 months. VAS has been proven safe and cost-effective and is an equitable way of reaching the most vulnerable children. Ensuring universal VAS coverage or at least effective coverage (≥ 80 per cent) is important for improving child survival.

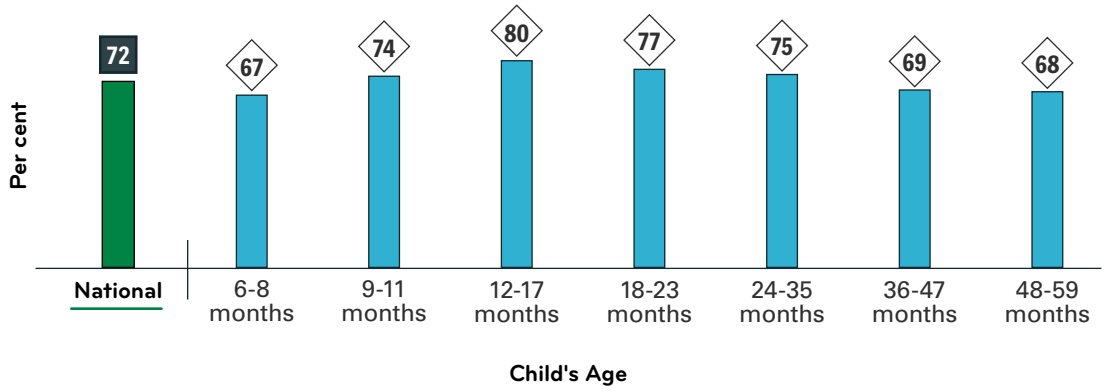
CHART 4.22. VAS coverage rate (% of children ages 6-59 months), 2005-2022



SOURCE: Retrieved on 23 February 2024 from: Vitamin A supplementation coverage rate (% of children ages 6-59 months) - South Africa | Data (worldbank.org) and Vitamin A supplementation coverage rate (% of children ages 6-59 months) – Sub-Saharan Africa (excluding high income) | Data (worldbank.org)

Chart 4.22 shows that the VAS coverage rate has fluctuated in South Africa, from a low of 29 per cent in 2005 to a high of 50 per cent in 2016, followed by a decline to 39 per cent in 2020 and then an increase to 44 per cent in 2022. Similarly, average VAS coverage rates have fluctuated in sub-Saharan Africa (excluding high-income countries), yet stood at 66 per cent in 2022; this is higher than the VAS coverage rate in South Africa.

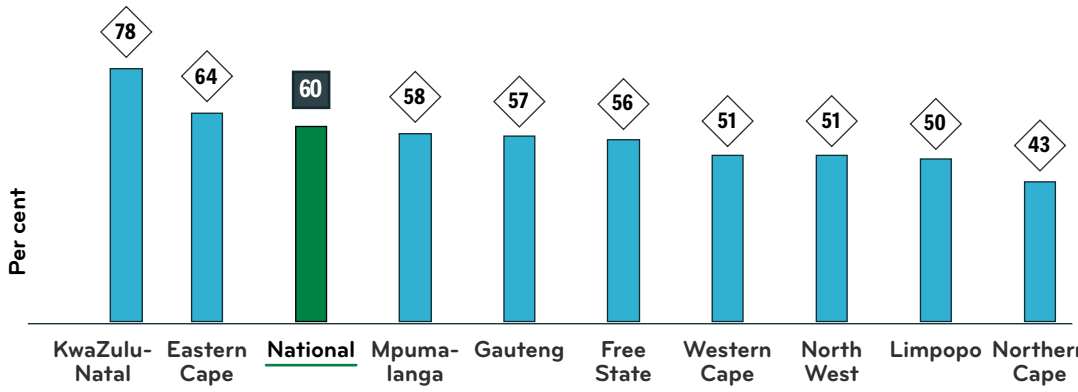
CHART 4.23. Children given VAS in past 6 months (% of children ages 6-59 months) by child's age, 2016



SOURCE: SADHS, 2016, p. 199.

In 2016, the proportion of children ages 6-59 months who received VAS in the six months prior to the survey was 72 per cent, with variation by children's age and region. **Chart 4.23** shows the proportion of children who received VAS steadily increased from 6-8 to 12-17 months, but then steadily declined from 18-23 to 48-59 months.

CHART 4.24. Vitamin A coverage (% of children ages 12-59 months) by province, 2021-2023



SOURCE: Hall, K. et al. (2024). South African Early Childhood Review 2024. Children's Institute, University of Cape Town and Ilifa Labantwana: Cape Town, South Africa, p. 33.

In South Africa, the public health system provides children aged 12-59 months with VAS. Following gradual improvements in Vitamin A coverage over the past decade, it dropped in all provinces during 2020/21 because of the COVID-19 pandemic, falling just below the 50 per cent mark. In 2021/22, however, coverage rates bounced back to 60 per cent nationally, exceeding previous levels.[331]

Chart 4.24 shows that in 2021-2023, Vitamin A coverage among children aged 12-59 months was 60 per cent nationally. Vitamin A coverage was highest in KwaZulu-Natal (78 per cent) and lowest in the Northern Cape (43 per cent).

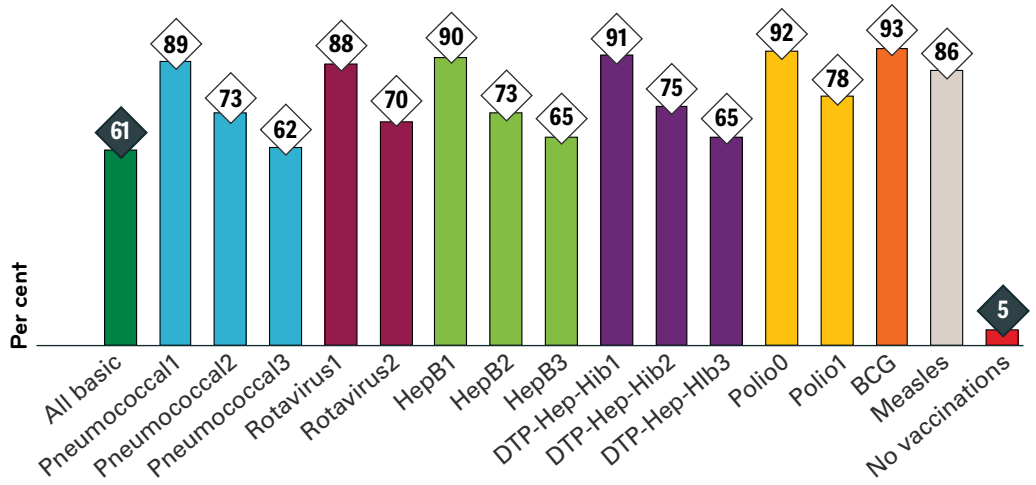
Childhood Immunisations

Vaccines are one of the most cost-effective public health interventions, with proven strategies that make them accessible even to the most hard-to-reach and vulnerable populations. Vaccines are a proven tool for controlling and eliminating life-threatening infectious diseases and are estimated to avert two to three million deaths each year. For these reasons, vaccination coverage is one of the indicators used to monitor progress towards reductions in child morbidity and mortality. At the global level, SDG Indicator 3.b.1 is used to monitor the progress of child vaccination at the national level.

The WHO recommends that all children be vaccinated against tuberculosis, diphtheria, pertussis, tetanus, polio, measles, Haemophilus influenzae type b (Hib), pneumococcal bacteria/disease, rotavirus, and rubella. Likewise, the Department of Health's Expanded Programme on Immunisations in South Africa (EPI-SA) aims to ensure that 90 per cent of all children are fully immunised by the age of one year.[332] The EPI-SA has established the following routine childhood immunisation schedule:[333]

- BCG and polio vaccines (at birth)
- 2 doses of oral polio vaccine
- 3 doses of pneumococcal conjugate vaccine (PVC)
- 4 doses of Hexavalent vaccine, containing DPT, Hepatitis B, and Haemophilus influenzae type b (Hib) and inactivated polio antigens
- 2 doses of rotavirus vaccine
- 2 doses of Measles-Rubella
- TdaP

CHART 4.25. Children aged 12-23 months vaccinated at any time before the survey (%), 2016



SOURCE: SADHS, 2016

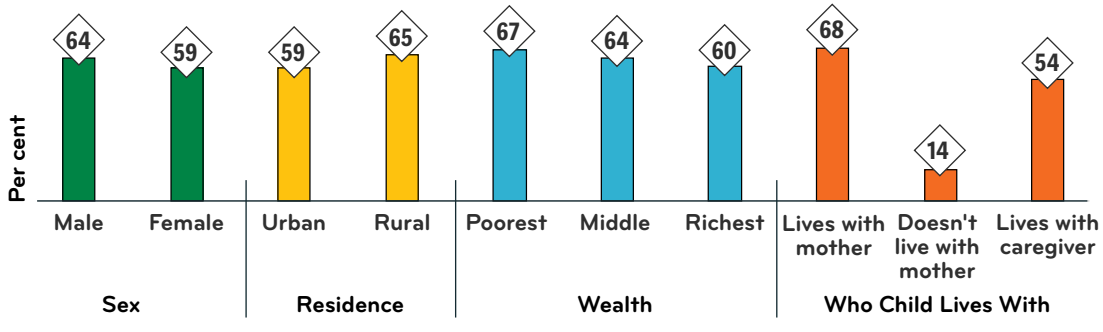
Chart 4.25 shows that in 2016, prior to the COVID-19 pandemic, basic vaccination coverage was 61 per cent among children aged 12-23 months; only 5 per cent of children in this age group had not received any vaccinations. More specifically, 93 per cent of children received the BCG vaccine, and 86 per cent received the measles vaccine. For multi-dose vaccines, coverage was typically highest for the first dose and declined in subsequent doses, as is the case with the pneumococcal, rotavirus, Hep B, DTP-Hep-Hib, and polio vaccines.

More recently, in 2020, the Department of Health reported that 84 per cent of children had received all basic vaccinations up to one year of age (i.e., up to the first dose of measles), and vaccination coverage was 81 per cent for children vaccinated with doses scheduled up to 12 months (i.e., up to the second dose of measles). The proportion of children fully vaccinated (i.e., having received all age-appropriate vaccinations from birth to 18 months) was 77 per cent; only 4 per cent of children were unvaccinated.[334]

Despite significant drops in coverage during the COVID-19 pandemic and concerns about recovery, immunisation coverage rates rebounded and increased to 86 per cent in 2021/2022, bringing the rate closer to the Global Vaccine Action Plan target of 90 per cent.[335]

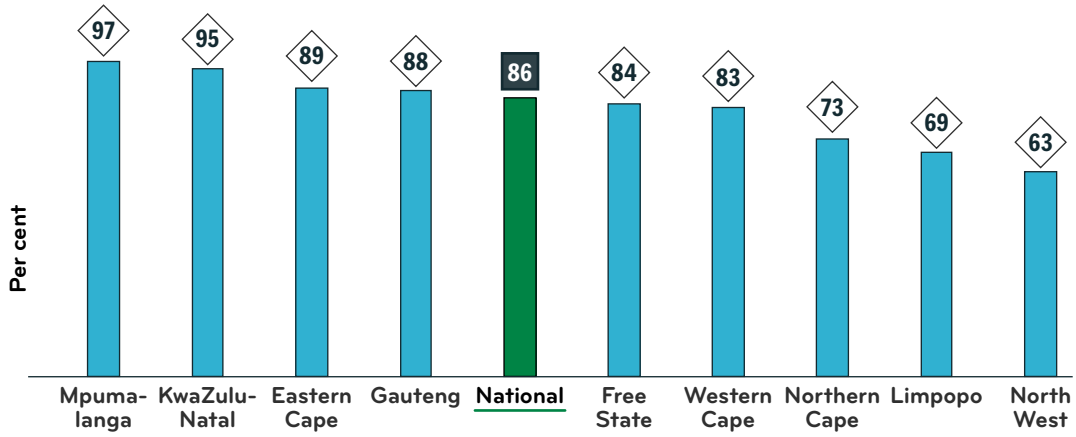
Chart 4.26 shows that in 2016, basic vaccination coverage was higher among males (64 per cent) than females (59 per cent), and higher in rural areas (65 per cent) than in urban areas (59 per cent). Vaccination coverage was also highest among children living in the poorest households (67 per cent) and lowest among children in the richest households (60 per cent). Children who lived with their mothers (68 per cent) were more likely to have all basic vaccinations compared to children who lived with caregivers (54 per cent), and were nearly five times more likely to have all basic vaccinations than children who did not live with their mothers (14 per cent).

CHART 4.26. Basic vaccine coverage among children ages 12-23 months by demographics (%), 2016



SOURCE: SADHS, 2016

CHART 4.27. Basic vaccination coverage among children ages 12-23 months by region (%), 2016



SOURCE: Hall, K. et al. (2024). South African Early Childhood Review 2024. Children's Institute, University of Cape Town and Ilifa Labantwana: Cape Town, South Africa, p. 24.

Chart 4.27 shows that more recently, in 2021/22, basic vaccination coverage was highest in Mpumalanga (97 per cent) and KwaZulu-Natal (95 per cent) and lowest in the Northern Cape (73 per cent), Limpopo (69 per cent), and North West (63 per cent).

Ongoing challenges, including vaccine hesitancy, have further contributed to global declines in essential childhood immunisation coverage rates, and decreases in essential immunisation levels have led to rising outbreaks of measles, diphtheria, polio, and yellow fever.[336]

In South Africa, perceptions regarding the importance of vaccines for children have declined by 30 per cent in recent years; as a result, children are under-immunised.[337] Over the past decade, South Africa has reported more than 100,000 zero-dose children annually (103,000 in 2021 and 148,000 in 2022). The increase in the number of zero-dose children has been observed in all provinces, as well as in both urban and rural areas; however, zero-dose children have been primarily concentrated in densely populated districts and eight metropolitan municipalities. The number of zero-dose children in rural districts are also quite high and should not be ignored, as rural populations are likely to live in poverty and face many health-related challenges and context-specific structural barriers that impact immunisation uptake.

Regardless of province, there are multiple factors that impact vaccine uptake, including:

- Sporadic vaccine stock-outs at lower levels
- Sub-optimal demand generation activities
- Vaccine hesitancy among specific population groups
- Suboptimal vaccination outreach services
- Poor defaulter tracking mechanisms

Adolescent Sexual and Reproductive Health

Adolescence is often considered the healthiest period of the lifespan because it is the point of lowest mortality and a time when many attributes of good health are at their highest. At the same time, adolescence is a period of physical, emotional and cognitive development that can be marked by engagement in risky behaviours, which can increase one's risk of poor health and death.

Based on their stage of brain development, adolescents are more likely to act on impulse, misread or misinterpret social cues and emotions, get into accidents, become involved in fights, and engage in dangerous or risky behaviours. Adolescents are less likely to think before they act or pause to consider the consequences of their actions or change their dangerous and/or inappropriate behaviours. This

does not mean that adolescents cannot make good decisions or tell the difference between right and wrong, nor does it mean that they should not be held responsible for their actions.[338] Rather, it means that adolescents are more likely to engage in risky behaviours, including risky sexual behaviours that can lead to early pregnancy and childbirth, as well as exposure to STIs, including HIV/AIDS. Adolescents are also more likely to experiment with alcohol, tobacco and drugs, and to experience mental health issues, including depression, suicide and self-harming behaviours. They are also at risk of unintentional injuries and violence-related deaths.

Given these realities, adolescence is an opportune time for health services and interventions that aim to promote improved lifelong health and well-being. This includes measures that improve sexual and reproductive health (SRH), such as increased access to SRH education and services, and condom use to protect against STIs and pregnancy; introduce early mental health screening for depression, suicidal tendencies, and other mental health conditions; improve access to prevention and treatment programmes for substance abuse; and reduce the risk of engaging in anti-social behaviours. Accurate health information, psychosocial support and services can improve adolescent health, well-being and decision-making, and contribute to overall health improvements.

Menstrual Hygiene Management

There has been increased attention to menstrual hygiene as part of a comprehensive SRH programme[339] and menstrual hygiene management (MHM). MHM and the potential link between lack of access to sanitary products and school absenteeism is an issue for many girls in South Africa.[340] In 2018, a study was undertaken to explore the extent of access to modern sanitary products among female high school students in Gauteng, as well as the needs and challenges they face in managing their menstruation in school settings. This study collected data from ten schools in the Sedibeng district between June and August 2018.[341]

The study found that 86 per cent of female learners reported preferring or exclusively using disposable sanitary pads. Very few learners used tampons (2 per cent) due to discomfort, fear of use, and cultural resistance to their use. The majority of female learners (85 per cent) had enough sanitary products to last for every period in the past three months, and 67 per cent indicated that their family could always afford to buy sanitary materials. In contrast, 15 per cent of female learners did not have enough sanitary products in the past three months, and 32 per cent reported that their family could only sometimes afford to buy these materials. Only 1 per cent of female learners reported that their families could never afford MHM products.[342]

Female learners obtained sanitary products from a number of different sources; 83 per cent obtained sanitary products from family members, 21 per cent sometimes purchased MHM products themselves, and 3 per cent sometimes obtained MHM products through their boyfriends. One in three, or 34 per cent, of female learners reported that schools were an important site for accessing sanitary products, whereas 22 per cent of female learners were unable to manage their menstrual flow.[343]

While most schools in the study had received disposable pads at some point, not all learners at these schools had been reached, and supply sustainability emerged as an issue, with many schools and learners reporting that sanitary pads had not been distributed for up to three months prior to the study. In some schools, limited supplies resulted in inequitable distribution of pads among learners. In schools with limited supplies or lacking a guiding policy on MHM, learners were required to request pads from a designated educator, which was viewed as embarrassing for female students; thus, they often sent a friend on their behalf or avoided the school supply and borrowed a pad from a friend. In some schools, educators reported contributing personal funds so that the school could purchase pads for emergency situations or for female learners from financially constrained backgrounds.[344]

While access to MHM products was a critically important challenge facing some female learners, the most widely reported challenge faced by girls during their menses was lower abdominal pain before and/or during menstruation (57 per cent), and some reported feeling distracted and unable to concentrate in class (22 per cent). Girls also felt anxiety around having soiled themselves, which

negatively affected their classroom participation. Educators identified younger female learners who were still learning to manage their menses as struggling more with these challenges than older learners. Some educators also refused to allow female learners to go to the bathroom during their classes, which increased feelings of anxiety and distraction.[345]

It is crucial for MHM that schools have clean, functional, and private toilet facilities, with the availability of soap and water, and appropriate methods of waste disposal for used sanitary products. Despite the fact that 68 per cent of female learners reported throwing soiled MHM products in the bin or bucket provided, some schools had inadequate sanitation and waste disposal facilities. As a result, 41 per cent of female learners stored their used sanitary pads in their bags to throw them away at home. Less common disposal methods included throwing sanitary pads in the toilet or pit latrine, and burning or burying them. Lack of cleanliness and poor conditions of learner toilets was clearly a major issue in schools.[346]

Due to MHM issues, 26 per cent of female learners reported missing school because of their period. Female learners who did not have enough MHM products in the past three months (46 per cent) were twice as likely to miss school due to their period compared to female learners who had enough MHM products (23%).[347]

In 2017, the Department of Women, Youth and Persons with Disabilities launched the Sanitary Dignity Programme, which aims to provide free sanitary products to girls and women in need and seeks to reduce the number of girls missing school and to create a positive future for learners. The Programme encompasses the entire value chain from procurement and production to storage, distribution, and disposal of sanitary products. From 2019 to 2023, the Programme benefited 4.3 million female learners.[348]

Sexual Behaviours

Healthy sexuality is an important part of adolescent development. Parents play a crucial role in helping young people develop healthy routines, behaviours, and relationships that they can carry into their adult lives. Many adolescents find it difficult to navigate this transition, including understanding that risky sexual behaviours can jeopardise their health during these formative years and contribute to poor health outcomes in adulthood.[349]

Data on the sexual behaviours of young people in South Africa are limited. **Table 4.2** shows that in 2016, males aged 15-19 (15 per cent) and 20-24 years (15 per cent) were more than twice as likely as females in the same age groups (6 per cent and 7 per cent respectively) to have had sexual intercourse before the age of 15.

TABLE 4.2. Youth ages 15-24 year who had sexual intercourse before the age of 15 (%), 2016

	Male	Female
Ages 15-19	15%	6%
Ages 20-24	15%	7%

SOURCE: SADHS 2016

Table 4.3 shows that in 2017, 36 per cent of females aged 15-19 had ever had sex. Among those who had ever had sex, only 13 per cent had their sexual debut by age 15, and 71 per cent had sex in the past year. Females who were HIV positive (57 per cent) were far more likely to have ever had sex compared to those who were HIV negative (35 per cent). Additionally, females who were HIV positive (82 per cent) were more likely to have had sex in the past year compared to their HIV negative counterparts. The difference in their sexual debut by age 15 was not as pronounced.

TABLE 4.3. Female adolescents aged 15-19 by HIV status and sexual behaviours (%), 2017

	Female, HIV negative 15-19 years	Female, HIV positive 15-19 years	All females 15-19 years
Ever had sex	35%	57%	36%
Among those who ever had sex			
Had sex in the past year	70%	82%	71%
Sexual debut by age 15	13%	14%	13%
Among those who had sex in the past year			
Used a condom at last sex	61%	48%	59%
Two or more partners in the past year	12%	16%	13%
Most recent partner was 5 years older	33%	47%	34%

SOURCE: SABSSM Survey 2017, p. 25.

Table 4.3 also shows that among females aged 15-19 who had sex in the past year, 59 per cent used a condom the last time they had sex. Only 13 per cent had two or more partners in the past year, and 34 per cent reported that their most recent partner was five years older than themselves. Females who were HIV negative (61 per cent) were far more likely to use a condom the last time they had sex than females who were HIV positive (48 per cent). Additionally, females who were HIV positive (16

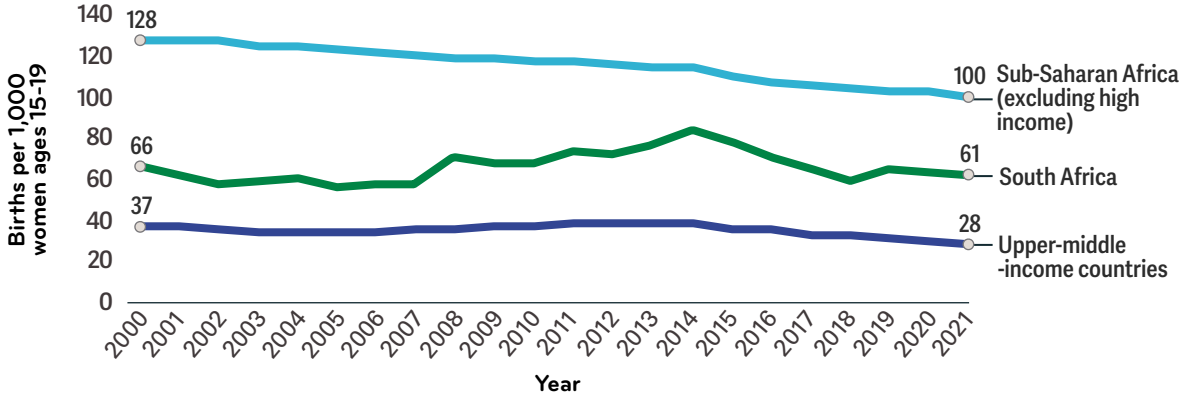
per cent) were more likely to report that they had two or more partners in the past year compared to females who were HIV negative (12 per cent). Furthermore, females who were HIV positive (47 per cent) were far more likely to report that their most recent partner was five years older than themselves compared to females who were HIV negative (33 per cent). Such data were not available for male adolescents aged 15-19.

In 2019, the DoH implemented the revised National Contraception Clinical Guidelines and an associated South African Handbook for Contraceptive Method Provision, which build on previous guidelines (i.e., National Contraception and Fertility Planning Policy and Service Delivery Guidelines and National Contraception Clinical Guidelines) and support women's agency and choice in a rights-based approach to SRHR.[350] In 2019, the DoH also implemented the National Integrated SRHR Policy, which consolidates various service guidelines and provides an opportunity to define a package of service benefits for women throughout their reproductive lifecycle. The package of services forms the basis for implementation in the NHI and demonstrates the DoH's commitment to providing comprehensive SRH services with a rights-based approach.[351]

Adolescent Fertility

Globally, the problem of teenage pregnancy continues to be a focus, as complications from pregnancy and childbirth are the leading cause of death among adolescent girls. **Chart 4.28** shows that from 2000 to 2021, South Africa experienced only an 8 per cent decrease in the adolescent fertility rate, from 66 births per 1,000 in 2000 to 61 births per 1,000 in 2021. In comparison, the average for sub-Saharan Africa (excluding high-income countries) decreased by 22 per cent, from 128 births per 1,000 in 2000 to 100 births per 1,000 in 2021. Similarly, the average for upper-middle-income countries decreased by 24 per cent, from 37 births per 1,000 in 2000 to 28 births per 1,000 in 2021. From 2000 to 2021, South Africa had a higher adolescent fertility rate than upper-middle-income countries but lower than the average for sub-Saharan Africa.

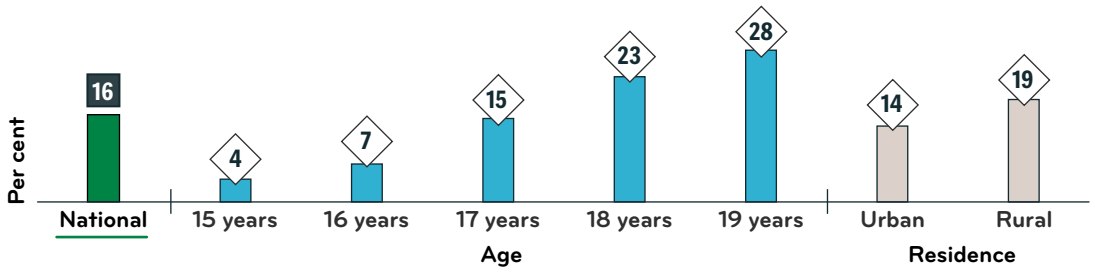
CHART 4.28. Adolescent fertility rate (births per 1,000 women ages 15-19), 2000-2021



SOURCE: Retrieved on 16 February 2024 from: Adolescent fertility rate (births per 1,000 women ages 15-19) - South Africa | Data (worldbank.org); Adolescent fertility rate (births per 1,000 women ages 15-19) - Sub-Saharan Africa (excluding high income) | Data (worldbank.org);

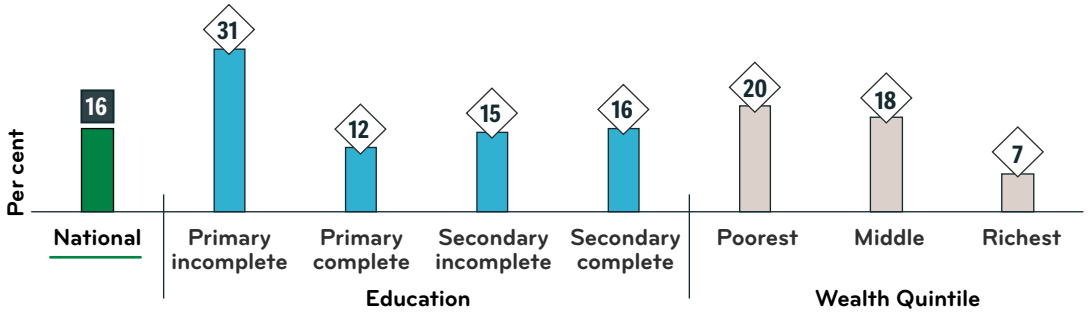
Chart 4.29 shows that in 2016, in South Africa, 16 per cent of girls aged 15-19 had a live birth or were pregnant with their first child (12 per cent had a live birth and 3 per cent were pregnant with their first child). This includes only live births and does not account for girls who gave birth to a child that did not survive at birth or girls who sought to terminate their pregnancy. As girls increase in age from 15 to 19 years, they were more likely to have had a live birth or to be pregnant with their first child. Girls who were 19 years old (28 per cent) were seven times more likely to have had a live birth or to be pregnant with their first child than 15-year-olds (4 per cent), and four times more likely than 16-year-olds (7 per cent). Additionally, girls in rural areas (19 per cent) were more likely than girls in urban areas (14 per cent) to have had a live birth or to be pregnant with their first child.

CHART 4.29. **Teenage pregnancy and motherhood by age and residence (%), 2016**



SOURCE: SADHS, 2016

CHART 4.30. **Teenage pregnancy and motherhood by level of education and wealth (%), 2016**

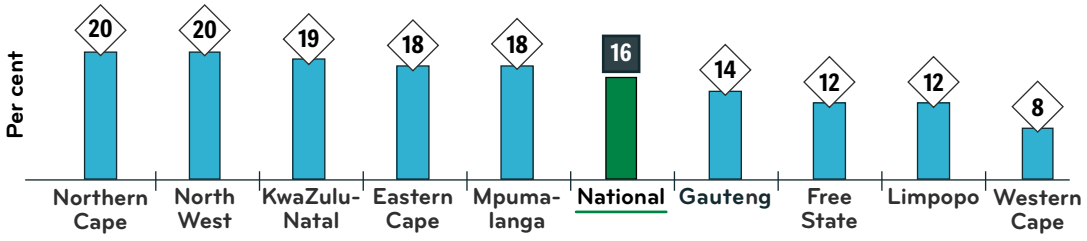


SOURCE: SADHS, 2016

Chart 4.30 shows that girls aged 15-19 with an incomplete primary education (31 per cent) were twice as likely to have had a live birth or to be pregnant with their first child compared to girls with a primary education (12 per cent). Girls with no education were seven times more likely to have had a live birth or to be pregnant than girls with a primary education (12 per cent), incomplete secondary education (15 per cent), and completed secondary education (16 per cent). Poverty is also a strong predictor of early childbearing, as girls from the poorest households (20 per cent) and middle-income households (18 per cent) were two to three times more likely to have had a live birth or be pregnant with their first child compared to girls from the richest households (7 per cent).

Chart 4.31 shows that teenage pregnancy and motherhood rates were highest in Northern Cape (20 per cent), North West (20 per cent), and KwaZulu-Natal (19 per cent), and lowest in Western Cape (8 per cent). It is also notable that Gauteng (14 per cent), Free State (12 per cent), and Limpopo (12 per cent) had lower teenage pregnancy and motherhood rates than the national average of 16 per cent.

CHART 4.31. **Teenage pregnancy and motherhood by region (%), 2016**

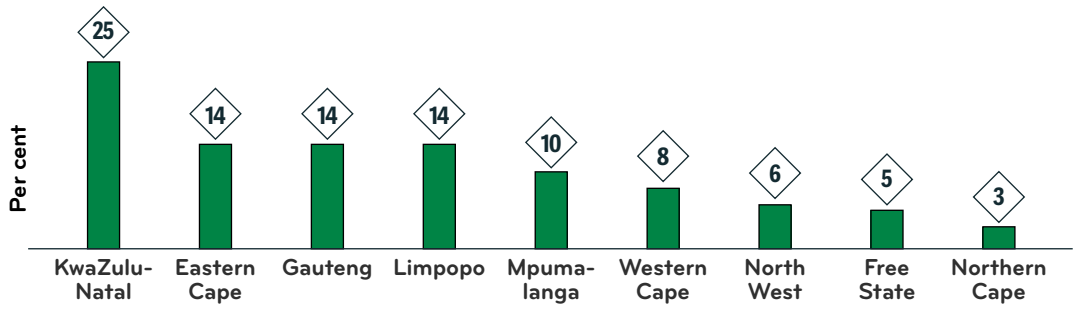


SOURCE: SADHS, 2016, p. 82.

In 2019, a total of 106,383 live births among adolescents were registered at the Department of Home Affairs (DoHA). Live births registered by DoHA are administrative data that capture the number of live births during a one-year period, whereas South African Demographic and Health Survey (SADHS) data are population-based survey data that capture the prevalence of teenage pregnancy among adolescent girls aged 15-19. Thus, DoHA and SADHS data are not comparable and need to be interpreted differently.

Chart 4.32 shows that in 2019, among the 106,383 DoHA-registered live births among adolescents, the largest proportion were in KwaZulu-Natal (25 per cent), followed by Eastern Cape, Gauteng, and Limpopo (14 per cent each). The fewest live births among adolescents were registered in Free State (5 per cent) and Northern Cape (3 per cent). It is not clear from the data what is driving these provincial differences.

CHART 4.32. Registered live births among adolescents by DoHA by region (%), 2019



SOURCE:

Contributing factors to teenage pregnancy include:

- Child marriage, especially in rural areas
- Lack of access to contraceptives, particularly when SRH services are not youth-friendly
- Sexual abuse of girls, which can lead to unwanted pregnancies

During the pandemic, adolescents had decreased access to health care and schools, which likely led to an increase in adolescent pregnancies. It is also notable that in 2022, the South African Council of Educators (SACE) identified *blessers* and teachers as responsible for impregnating 11,000 learners in Limpopo.[352]

Teenage pregnancy is a pressing issue in South Africa. In 2021, the DBE enacted a Policy on the Prevention and Management of Learner Pregnancy in Schools. This Policy aims to reduce the increasing number of learner pregnancies by providing SRH services to teenagers, ensuring that pregnant learners have access to ANC, and that pregnant learners and their babies have access to a stigma-free, non-discriminatory, and non-judgemental environment. The Policy also aims to provide a positive and supportive atmosphere where learners can access professional advice, information referrals, counselling, treatment, care, and support.[353]

HIV/AIDS Among Children and Adolescents

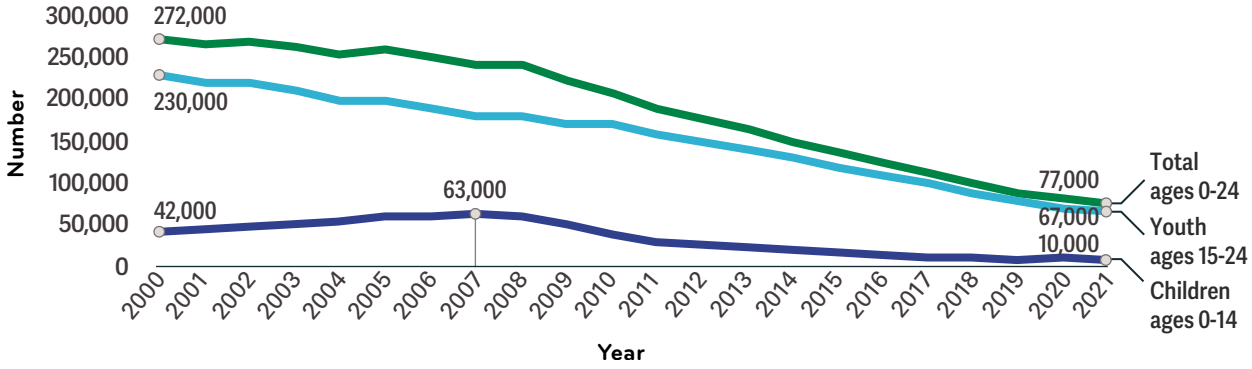
HIV/AIDS is a global public health threat. Every new HIV infection in a child, every child death from AIDS, and every child orphaned by HIV highlights the need to safeguard children's rights to health, survival, and development, all of which the global community has pledged to uphold in the CRC.[354] Children living with and affected by HIV are among the most vulnerable individuals in any society; thus, improving HIV outcomes for them is essential for children's rights throughout the 2030 Agenda for Sustainable Development.[355] Accordingly, SDG target 3.3 aims to end the AIDS epidemic by 2030. In line with this, the UN General Assembly Special Session (UNGASS) on HIV/AIDS called on governments to improve the knowledge and skills of young people to better protect themselves from HIV; this is especially important since young people represent a growing share of people living with HIV worldwide.

Globally, in 2021, on average, 1.2 million adults aged 15-49 were newly infected with HIV.[356] More specifically, 560,000 children and youth aged 0-24 years were newly infected with HIV, including 160,000 children aged 0-14 and 400,000 youth aged 15-24.[357] In 2020, 88 per cent of children aged 0-19 living with HIV resided in sub-Saharan Africa. Among those in sub-Saharan Africa, three out of four, or 75 per cent, resided in Eastern and Southern Africa.[358] According to the most recent data for Eastern and Southern Africa, only 25 per cent of girls aged 15-19 and 17 per cent of boys aged 15-19 had been tested for HIV in the past 12 months and received the results of their last test. If this trend continues, hundreds of thousands of adolescents will become HIV-positive in the coming years, and without knowing their status, these adolescents will miss out on life-saving treatment. In addition, over the past decade, a large population of children infected with HIV perinatally are growing into adolescence.[359]

In South Africa, in 2022, the Sixth South African National HIV Prevalence, Incidence and Behaviour Survey (SABSSM VI) found that an estimated 13 per cent of the population was living with HIV (translating to 7.8 million persons), down from 14 per cent in 2017.[360] More specifically, 17 per cent of the population aged 15-49 had HIV (down from 21 per cent in 2017), 5 per cent of youth aged 15-24 had HIV (down from 8 per cent in 2017), and 2 per cent of children aged 0-14 were HIV-positive (down from 3 per cent in 2017). Among children aged 0-14, females (2 per cent) and males (3 per cent) were equally likely to be living with HIV, but among youth aged 15-24, females (7 per cent) were nearly twice as likely as male youth (3 per cent) to be living with HIV.[361]

Chart 4.33 shows that over the past two decades, there has been an estimated 72 per cent decrease in the number of children and youth aged 0-24 newly infected with HIV in South Africa, from an estimated 272,000 in 2000 to 77,000 in 2021. This includes a 76 per cent decrease in the number of children aged 0-14 newly infected with HIV (from an estimated 42,000 in 2000 to 10,000 in 2021), and a 71 per cent decrease in the number of youth aged 15-24 newly infected with HIV (from an estimated 230,000 in 2000 to 67,000 in 2021). The number of new HIV infections among children aged 0-14 peaked at 63,000 in 2007.

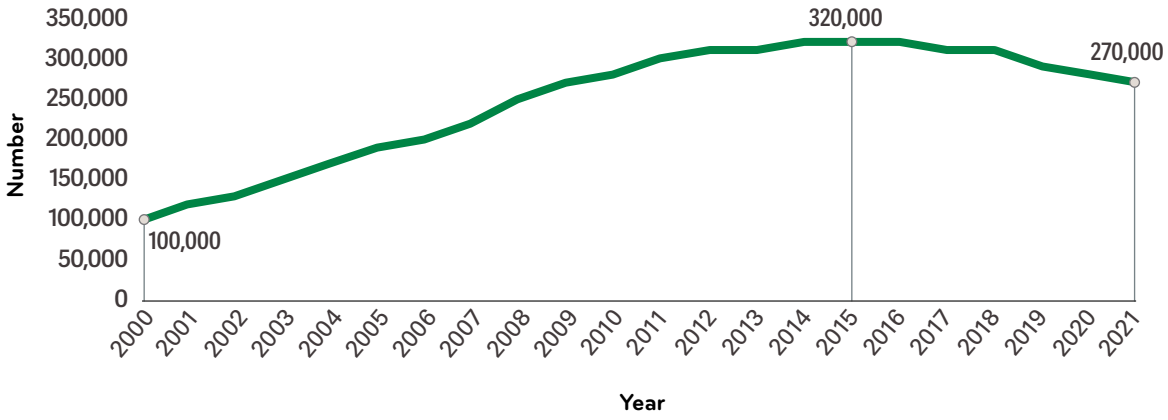
CHART 4.33. Number of children and youth aged 0-24 newly infected with HIV, 2000-2021



SOURCE: Retrieved on 24 February 2024 from: Children (ages 0-14) newly infected with HIV - South Africa | Data (worldbank.org) and Young people (ages 15-24) newly infected with HIV - South Africa | Data (worldbank.org)

Chart 4.34 shows that from 2000 to 2011, there was a 220 per cent increase in the number of children aged 0-14 living with HIV in South Africa, rising from 100,000 in 2000 to 320,000 in 2011. Following this peak, there has been a 16 per cent decrease in the number of children living with HIV, from 320,000 in 2016 to 270,000 in 2021. Thus, the proportion of children living with HIV is 170 per cent higher in 2021 than in 2000. According to SABSSM VI, it was estimated that 12,651 children aged 0-14 were living with HIV in 2022.[362]

CHART 4.34. Number of children (ages 0-14) living with HIV, 2000-2021



SOURCE: Retrieved on 24 February 2024 from: Children (0-14) living with HIV - South Africa | Data (worldbank.org)

Over the past several decades, South Africa has made significant strides in reducing vertical transmission of HIV. This success can be attributed to improved access to HIV testing and antiretroviral therapy (ART), especially for pregnant women, infants and children, as well as offering nutrition and health counselling for mothers and children affected by HIV/AIDS. Bear in mind, however, that HIV prevention and treatment services are dependent on effective health systems.[363]

In 2019, the South African National Guideline for the Prevention of Mother-to-Child Transmission of Communicable Infections was introduced. This National Guideline outlines three major strategies for programme improvement, including:[364]

1. **Prevention of primary HIV infection and unintended pregnancies in women of childbearing potential**
2. **Improvement of maternal viral suppression rates at delivery and in the post-delivery period through potent, well-tolerated ART, strategic use of maternal viral load monitoring, linking mothers to post-delivery HIV care, and integration of mother-infant health care**
3. **Provision of enhanced prophylaxis to infants of mothers with elevated HIV viral loads during the breastfeeding period**

Experts maintain that rigorous implementation of the South African National Guideline for the Prevention of Mother-to-Child Transmission of Communicable Infections has the potential to effectively move South Africa closer to the goal of eliminating vertical transmission of HIV, particularly mother-to-child transmission, and making an HIV-free generation a reality.[365] In 2023, the DoH also introduced Guidelines for Vertical Transmission Prevention of Communicable Infections.[366]

In partnership with the GoSA, the United States Agency for International Development (USAID) has funded South African DREAMS, a core package of evidence-based prevention interventions implemented in 24 districts across eight provinces of South Africa. DREAMS includes a range of evidence-based behavioural, bio-medical, and structural interventions that target adolescent girls and young women, as well as their parents/caregivers, male sex partners, and communities.[367]

Due to these initiatives, South Africa has seen a reduction in the vertical transmission of HIV in the first two months of life from 23 per cent in 2003 to 0.7 per cent in 2019, despite a persistently high antenatal HIV prevalence rate of around 30 per cent in 2019.[368] In 2022, 28 per cent of pregnant women were HIV positive (antenatal clients testing HIV+) and 95 per cent of pregnant women initiated antiretroviral therapy (ART).[369] It is notable that the Northern Cape and Western Cape had the lowest HIV prevalence rates among pregnant women (15 per cent and 16 per cent respectively), and HIV-positive pregnant women in the Western Cape were least likely to initiate ART during the antenatal period (69 per cent).[370] Improving access to ART during ANC has significantly contributed to this success but has led to an increase in the relative proportion of vertical transmission due to breastfeeding in the first six months post-delivery.[371]

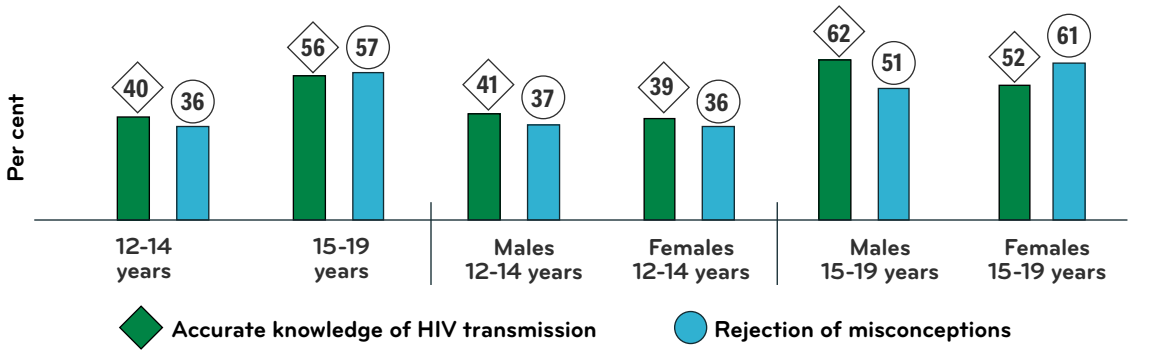
The COVID-19 pandemic exposed, and in some cases exacerbated, inequities in HIV responses, including increasing the number of marginalised people who are at greater risk of HIV, reducing the number of people tested for HIV, and interrupting access to ART due to the closure of health facilities. Most notably, women and girls were disproportionately affected by the COVID-19 pandemic, as well as by the multiple and often cascading vulnerabilities associated with it. The pandemic also caused a steep increase in poverty, which is a major risk factor for HIV.[372]

Correct information is the first step toward raising awareness and giving adolescents and youth the tools to protect themselves from HIV infection. Yet misconceptions about HIV/AIDS are common and can confuse young people, thereby hindering prevention efforts.[373] A major shortcoming in reaching and supporting young people at one of the most vulnerable periods in their lives underscores the importance of strengthening linkages across all aspects of adolescent health and well-being, as well as their ability to survive and thrive. Reductions in HIV risk and susceptibility can be best achieved through closer integration with programmes and initiatives focused on adolescent health, nutrition, and safety, among other areas.[374]

Adolescents' Knowledge of HIV

Adolescents living with HIV include those who acquired HIV perinatally or through sexual intercourse. Girls are at increased risk of acquiring HIV due to biological and social vulnerabilities that make them more susceptible to HIV infections through sexual intercourse.

CHART 4.35. Adolescents living with HIV ages 12-19 with knowledge of HIV transmission (%), 2017



SOURCE: SABSSM 2017

Chart 4.35 shows the proportion of adolescents aged 12-19 living with HIV who had correct knowledge about the virus in 2017. Correct knowledge was measured by correctly answering either two questions on HIV prevention (i.e., Can a person reduce the risk of getting HIV by using a condom every time you have sex? Can a person reduce the risk of getting HIV by using a condom every time you have had sex?) or three questions related to misconceptions about HIV (i.e., Can AIDS be cured? Can a healthy-looking person have HIV? Can a person get HIV by sharing food with someone who is infected?).

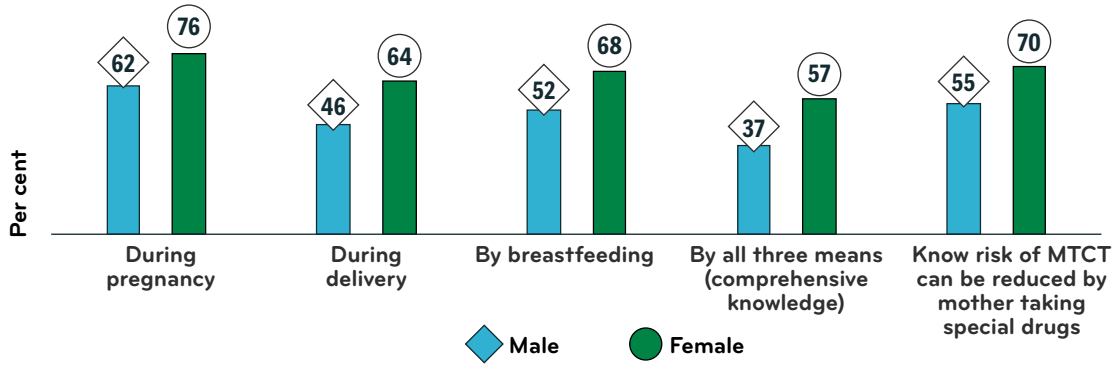
Among adolescents living with HIV, only 40 per cent of those aged 12-14 and 56 per cent of those aged 15-19 had accurate knowledge of HIV transmission. Among adolescents aged 12-14 living with HIV, only 41 per cent of males and 39 per cent of females had knowledge of HIV transmission. In addition, only 37 per cent of males and 36 per cent of females rejected misconceptions about HIV. In comparison, among adolescents aged 15-19 living with HIV, males (62 per cent) were far more likely than females (52 per cent) to have accurate knowledge of HIV transmission; yet, females (61 per cent) were more likely than males (51 per cent) to reject misconceptions about the virus.

There were also notable locality differences in knowledge of HIV transmission and the rejection of misconceptions about HIV among adolescents aged 12-19 living with HIV. Among adolescents living with HIV, those in rural areas were more likely to have accurate knowledge about HIV transmission (54 per cent) and to reject misconceptions about HIV (54 per cent), compared to adolescents living in urban areas (49 per cent and 48 per cent respectively).[375]

Adolescent Knowledge of Mother-to-Child HIV Transmission

The 2016 SADHS also measured youth knowledge of mother-to-child HIV transmission and prevention. **Chart 4.36** shows that there were no notable differences between male and female adolescents aged 15-19 in their knowledge that HIV can be transmitted during pregnancy (62% and 76% respectively), during delivery (46% and 64% respectively), or by breastfeeding (52% and 68% respectively). Females (57%), however, were far more likely than males (37%) to know that HIV can be transmitted from mother to child by all three means – during pregnancy, during delivery, and by breastfeeding (comprehensive knowledge). It is also noteworthy that 70 per cent of females and 55 per cent of males were aware that the risk of mother-to-child transmission (MTCT) can be reduced by mothers taking special drugs.

CHART 4.36. Adolescents aged 15-19 with knowledge of mother-to-child HIV transmission by sex (%), 2016



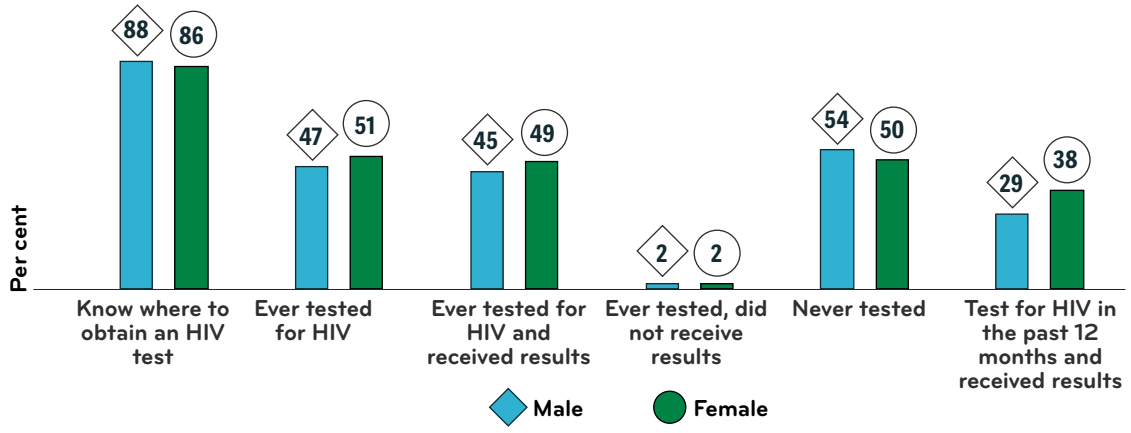
SOURCE: SADHS 2016

In South Africa, Let's Talk is one programme that aims to improve knowledge of HIV. Let's Talk is a 10-week group support programme that employs a family-centred approach to enhance well-being, build HIV prevention knowledge and skills, and strengthen the mental health of adolescents and their parents/caregivers. This innovative programme seeks to reduce young people's risk of HIV infection by combining HIV education and behavioural skills-building with support for effective parenting and adolescent psychological health.[376]

Adolescent Knowledge of HIV Testing

Chart 4.37 shows that the majority of adolescents aged 15-19 knew where to obtain an HIV test. While females (86 per cent) were as likely as males (85 per cent) to know where to obtain an HIV test, females were slightly more likely to have ever been tested (51 per cent) and to have received the results (49 per cent) compared to males (47 per cent and 45 per cent respectively). Only two per cent of females and males reported that they were tested for HIV but did not receive results. It is also notable that 38 per cent of females and 29 per cent of males tested for HIV in the 12 months prior to the survey and received results.

CHART 4.37. Adolescents ages 15-19 knowledge of HIV testing and HIV testing practices by sex (%), 2016



SOURCE: SADHS 2016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Adolescent Mental Health

In 2021, the WHO reported that globally, 14 per cent of adolescents aged 10-19 experienced a mental disorder, accounting for 13 per cent of the global burden of disease in this age group. Depression, anxiety and behavioural disorders are among the leading causes of illness and disability among adolescents. Additionally, suicide is the fourth leading cause of death among young people aged 15-29. Risk factors for suicide are multifaceted and include childhood abuse, stigma against help-seeking, barriers to accessing care and support for suicide, and harmful use of alcohol. Digital media, like any other form of media, can also play a significant role in either enhancing or hindering suicide prevention efforts.[377]

Multiple factors can affect the mental health of adolescents. The more common risk factors that adolescents face, which have a greater potential to impact their mental health, include exposure to adversity, pressure to conform to peers, and exploration of gender or sexual identity. Media influences and gender norms can also exacerbate disparities between an adolescent's lived reality and their perceptions or aspirations for the future. Other important determinants of stress and poor mental health include the quality of one's home life; relationships with peers; exposure to violence, especially sexual violence and bullying; harsh parenting practices; poor living conditions; and experiences of stigmatization, discrimination and/or exclusion, particularly when there is a lack of access to quality support and services.[378]

For some adolescents, living in emergency, humanitarian and fragile settings can increase their risk of poor mental health. Other risk factors include chronic illness, intellectual disabilities or other neurological conditions, being orphaned, being a teenage mother, and being in an early or forced marriage.[379]

Emotional disorders common among adolescents include anxiety disorders (which may involve panic or excessive worry). It is estimated that globally, four per cent of adolescents aged 10-14 and five per cent aged 15-19 experience anxiety disorders. Depression is estimated to occur in one per cent of adolescents aged 10–14 and three per cent aged 15–19.[380] Depression and anxiety share some symptoms, including rapid and unexpected mood changes. Anxiety and depressive disorders can profoundly affect school attendance and performance. Social withdrawal can exacerbate feelings of isolation and loneliness. Depression can lead to suicide.[381]

In South Africa, data related to adolescent mental health and suicide are limited, especially for nationally representative data. Data that do exist include 2019-2020 statistics from the District Health Information System (DHIS), which estimated that 20 per cent of teenagers below 18 years

of age had a detected or untreated mental health disorder that resulted in anxiety, mood, and stress disorders, and were associated with an increased risk of suicide.[382] In addition, about 6 per cent of children below 18 years of age visited a mental health facility in 2019 and 2020.[383]

The South African National Youth Risk Behaviour Survey (SANYRBS) also found that 24 per cent of youth between Grades 8 and 11 had experienced feelings of depression, hopelessness, and sadness, and 21 per cent attempted suicide at least once.[384] Another study of school children aged 14-15 in Cape Town found that 41 per cent of adolescents experienced depression, 21 per cent experienced post-traumatic stress disorder (PTSD), and 16 per cent experienced anxiety.[385]

Behavioural disorders are also common among adolescents, but they tend to be more prevalent among younger compared to older adolescents. Globally, attention deficit hyperactivity disorder (ADHD), characterised by difficulty paying attention, excessive activity, and acting without regard to consequences, occurs in three per cent of adolescents aged 10–14 and two per cent of those aged 15–19. Research has also found that conduct disorders, which involve symptoms of destructive or challenging behaviours, occur in four per cent of adolescents aged 10–14 and two per cent of those aged 15–19. Behavioural disorders can affect adolescents' education, and conduct disorders may result in criminal behaviour.[386] Data on behavioural disorders among adolescents in South Africa are lacking.

Failure to address adolescent mental health and well-being can have long-term consequences that extend into adulthood, including impaired physical and mental health that limits opportunities to lead a fulfilling life as an adult.[387]

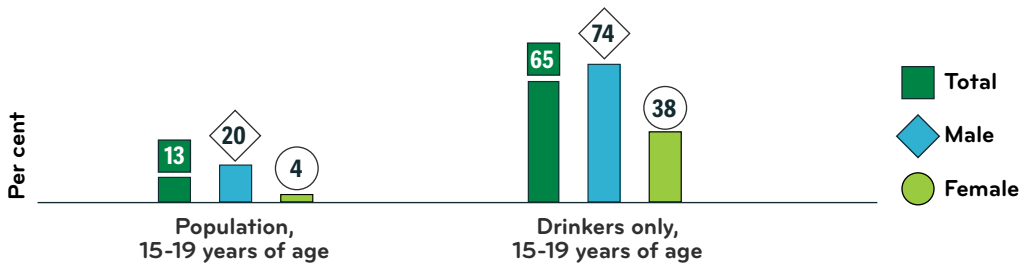
Adolescent Alcohol and Substance Use

Alcohol use typically begins in adolescence and young adulthood and is a major risk factor for adverse health and social outcomes, as well as non-communicable diseases later in life.[388] Adolescents are less able to anticipate the negative effects of alcohol on their health and well-being, including the risks of abusing alcohol and developing addictions.[389]

From 2000 to 2019, alcohol consumption per capita remained steady in South Africa, at 9 litres of pure alcohol per capita in both 2000 and 2019. In 2019, males aged 15 years and older consumed five times more alcohol (15 litres of pure alcohol per capita) than their female counterparts (3 litres of pure alcohol per capita; see Annex Chart 3).

Chart 4.38 shows that in 2016, 13 per cent of adolescents aged 15-19 in South Africa had one or more episodes of heavy drinking (consuming at least 60 grams or more of pure alcohol on at least one occasion in the past 30 days). Males (20 per cent) were five times more likely than females (4 per cent) to engage in heavy episodic drinking. More specifically, among adolescents who reported drinking alcohol, 65 per cent had episodes of heavy drinking; adolescent males who were drinkers (65 per cent) were nearly twice as likely as female drinkers (38 per cent) to engage in heavy drinking. In South Africa, the legal minimum age for the purchase and consumption of alcoholic beverages is 18 years.[390]

CHART 4.38. Adolescents aged 15-19 with heavy episodic drinking by sex (%), 2016



SOURCE: Retrieved on 24 February 2024 from: 19089_South Africa.pdf (who.int)

South Africa is also known for a high rate of substance abuse. The South Africa Community Epidemiology Network on Drug Use (SACENDU) collects data from treatment centres across nine provinces. The latest data shows that cannabis remained the leading primary substance of use nationally (31%) and for the Central Region, Gauteng, KZN, and the Northern Region. Among individuals aged under 20 years, cannabis (54%) was reported as the predominant primary substance of use across regions. In the Western Cape, 84% of persons under 10 years reported cannabis as their main substance of use at the time of admission.[391]

Treatment admissions for methamphetamine (MA, known as '*tik*') as a primary substance of use were highest in the Eastern Cape (38%) and Western Cape (35%). However, national MA use rates reduced notably from 35% in the previous period to 21% in 2021.

Adolescent Nutrition

Adolescence is a period of development that begins at puberty and ends in early adulthood, characterised by a rapid pace of growth that is second only to that of infancy.[392] Rapid physical growth during adolescence creates a high demand for energy and certain nutrients; both energy (calories) and protein are essential for pubertal development.[393] Adolescent girls require approximately 2,200 calories per day, whereas adolescent boys require 2,500 to 3,000 calories per day. Additional intake requirements include fat, calcium, iron, zinc, vitamins, and fibre. Nutritional guidance for adolescents is important for supporting the development of healthy lifestyles, preventing weight-related problems, reducing disease risk, and ensuring that all needs are met for growth and development. In balance with adequate physical activity, healthy dietary choices help to prevent excess weight gain, iron deficiency anaemia, and poor bone mineralisation, among other health problems.[394]

Nutrition is a critical factor for appropriate adolescent development and an important element in the prevention of disease development, especially chronic diseases. A balanced, varied diet provides adequate calories and nutrition to meet the needs of most adolescents, but many adolescents live in environments that do not promote optimum nutrition.[395] Nutrition and adolescent transition are closely related because eating patterns and behaviours are influenced by many factors, including peer influences, parental modelling, food availability and costs, food preferences, personal and cultural beliefs, mass media, and body image.[396] Families must work to provide improved food environments to encourage optimum nutrition; after all, dietary habits established early in life may be carried into adult life.[397]

Over the past decade, nutrition has been identified as a major global priority, and the increase in worldwide overweight and obesity has been highlighted. The World Health Assembly declared 2016-2025 as the 'decade of nutrition' and set global targets that have since been integrated into SDG 2, which is focused on ending hunger, achieving food security, improving nutrition, and promoting sustainable agriculture. SDG 2 aims to end all forms of malnutrition by 2030 and address the nutritional needs of adolescents, particularly girls.[398]

Research conducted in South Africa from 1994-2018 on adolescents' nutritional status, dietary intakes, practices, and their determinants has revealed that dietary intake among adolescents was transitioning to energy-dense, processed foods that are high in sugar and fat but low in micronutrients.[399] Some of the factors contributing to adolescents being overweight and obese were irregular breakfast consumption, increased snacking, fewer family meals, and low levels of physical activity. These studies also found, among secondary students, gender differences in eating habits.[400]

Underweight and Overweight Adolescents

The WHO defines underweight as a body mass index (BMI) below the fifth percentile for age and gender. Among adolescents, underweight status has been associated with higher rates of morbidity and mortality, though to a lesser extent than obesity. It has also been linked to higher rates of asthma, scoliosis, intestinal problems, and emotional disorders. The onset of puberty may be delayed in male and female adolescents with a low BMI, and underweight females are more likely to experience

abnormal menstruation and sub-fertility. Underweight adolescents who become pregnant may be at increased risk for pregnancy complications and poor foetal and maternal outcomes, including prematurity and low birth weight.[401]

Underweight status may be related to genetics, acute or chronic undernutrition, and/or illness. Adolescents with low BMI may develop a negative body image, particularly among males who desire a muscular physique. They may also suffer from eating disorders, such as anorexia or bulimia. Furthermore, adolescents with a low BMI may experience fatigue, lack of energy, and increased susceptibility to infections. Notably, some adolescents may be genetically lean, possessing an efficient metabolism and a low propensity to store body fat.[402]

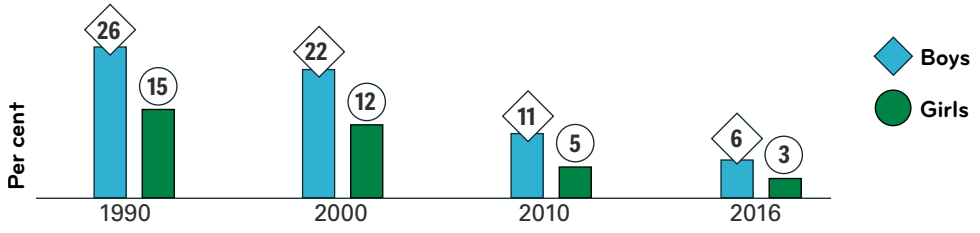
In comparison, obesity is a multifaceted chronic condition with several contributing causes, including biological risk factors, socioeconomic status, health literacy, and numerous environmental influences. Of particular concern are the increasing rates of overweight and obesity among adolescents, as global rates of obesity have risen significantly over the past three decades.[403] Two major contributing factors to the global rise in obesity are increases in food processing and trade liberalisation, which have made cheap, highly processed foods readily available. Additionally, the nutritional transition towards increased consumption of energy-dense foods high in fat and sugars, coupled with a reduction in the availability of plant-based fibres, has contributed to this global rise. There has also been a decline in energy expenditure from physical activity, largely due to motorised transport and less demanding manual tasks.

Adolescents often do not meet the daily intake recommendations for certain food groups and nutrients, which may contribute to a heightened risk of obesity. With obesity disproportionately affecting adolescents, the negative effects of excess adiposity may be particularly salient during this critical period of development. The presentation of chronic cardiometabolic disease symptoms, typically observed in adults, such as hypertension, hyperglycaemia, dyslipidaemia and inflammation, is becoming increasingly common in adolescents with obesity. In adolescence, obesity increases the risk for Type 2 diabetes, which is likely to persist into adulthood. Eating patterns formed during adolescence are also frequently carried into adulthood and affect future risk for the development of chronic diseases, such as heart disease, osteoporosis and cancer.[404] In addition, there is a dynamic interplay between obesity and psychosocial health, as adolescents with obesity may experience increased levels of stress, depressive symptoms and reduced resilience.[405]

Overweight and obesity among adolescents is a global problem and, in recent years, has been identified as a major issue among school-going adolescents in South Africa. In the past, the most frequent form of malnutrition in Africa was under-nutrition; however, in recent years, there has been an increase in reported cases of adolescent overweight and obesity in South Africa, as well as in other African countries.[406] This may be a result of unhealthy eating habits and/or poor dietary practices among adolescents.

In South Africa, data related to patterns of underweight and overweight adolescents are limited. **Chart 4.39** shows that the proportion of underweight adolescent boys decreased by 20 percentage points from 26 per cent in 1990 to 6 per cent in 2016, whereas the proportion of underweight adolescent girls decreased by only 12 percentage points from 15 per cent in 1990 to 3 per cent in 2016. Over time, adolescent boys have been nearly twice as likely as girls to be underweight.

CHART 4.39. Underweight adolescents aged 10-19 by sex (%), 1990-2016



SOURCE: Retrieved on 18 February 2024 from: Adolescent health dashboards country profiles - UNICEF DATA

In comparison, **Table 4.4** shows a dramatic increase in the proportion of adolescent girls and boys aged 10-19 who are overweight and obese. The proportion of overweight girls increased fivefold from 6 per cent in 1990 to 32 per cent in 2016, while the proportion of overweight boys increased tenfold from 2 per cent in 1990 to 20 per cent in 2016. Additionally, the proportion of obese girls rose from 1 per cent in 1990 to 13 per cent in 2016, whereas the proportion of obese boys increased from 0 per cent in 1990 to 9 per cent in 2016.

TABLE 4.4. Overweight and obese adolescents aged 10-19 by gender (%), 1990-2016

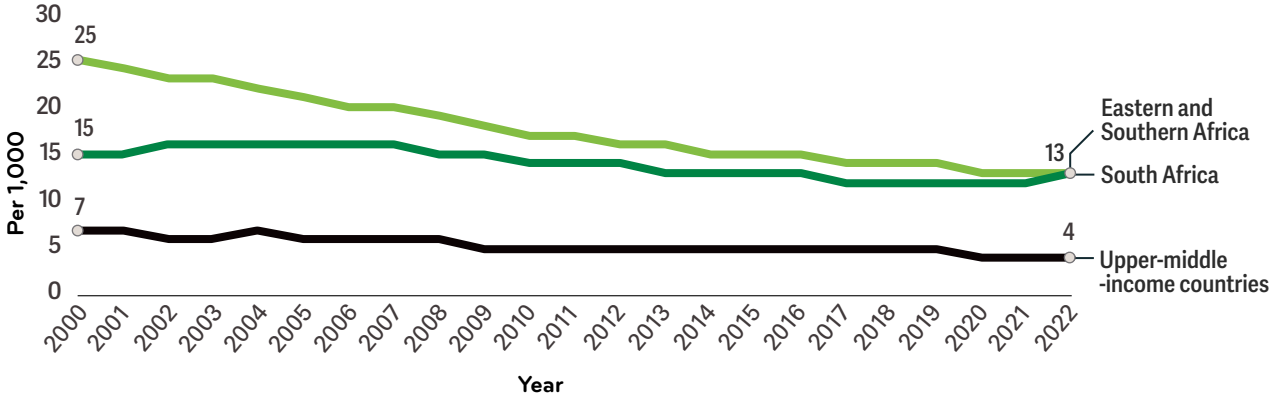
Year	Boys		Girls	
	Overweight	Obese	Overweight	Obese
1990	2%	0%	6%	1%
2000	3%	1%	10%	2%
2010	11%	4%	22%	8%
2016	20%	9%	32%	13%

SOURCE: Retrieved on 18 February 2024 from: Adolescent health dashboards country profiles – UNICEF DATA; see also NCD Risk Factor Collaboration, based on worldwide trends in body-mass index, underweight, overweight and obesity from 1975-2016.

Adolescent Mortality (Ages 10-19)

Chart 4.40 shows trends in adolescent (ages 10-19) mortality rates per 1,000 for South Africa, alongside averages for Eastern and Southern Africa and upper-middle-income countries for comparison. Over the past two decades, South Africa has experienced a 13 per cent decrease in the adolescent mortality rate, from 15 deaths per 1,000 adolescents in 2000 to 13 deaths per 1,000 adolescents in 2022. South Africa's adolescent mortality rate has been notably lower than the average for Eastern and Southern Africa, yet higher than the average for upper-middle-income countries. In 2022, the adolescent mortality rate was 13 per 1,000 adolescents in South Africa and Eastern and Southern Africa, which was significantly higher than the adolescent mortality rate of 4 per 1,000 adolescents in upper-middle-income countries.

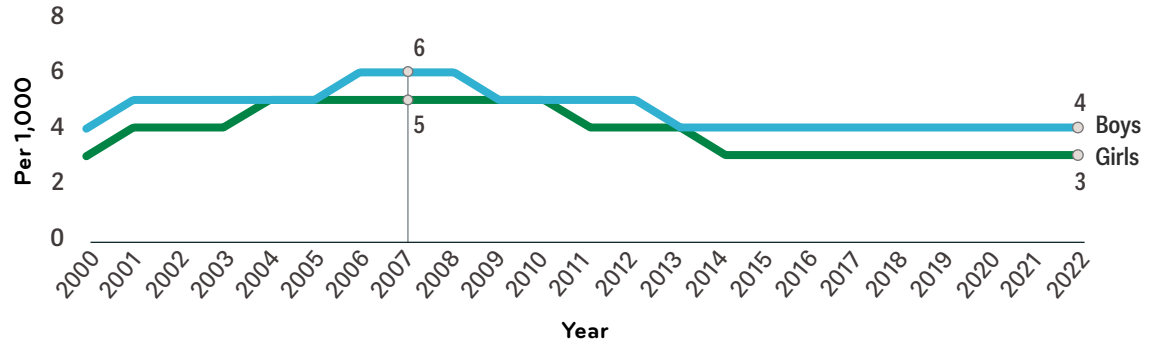
CHART 4.40. Adolescent mortality rates aged 10-19 (per 1,000), 2000-2021



SOURCES: Retrieved on 24 February 2024 from: CME Info - Child Mortality Estimates

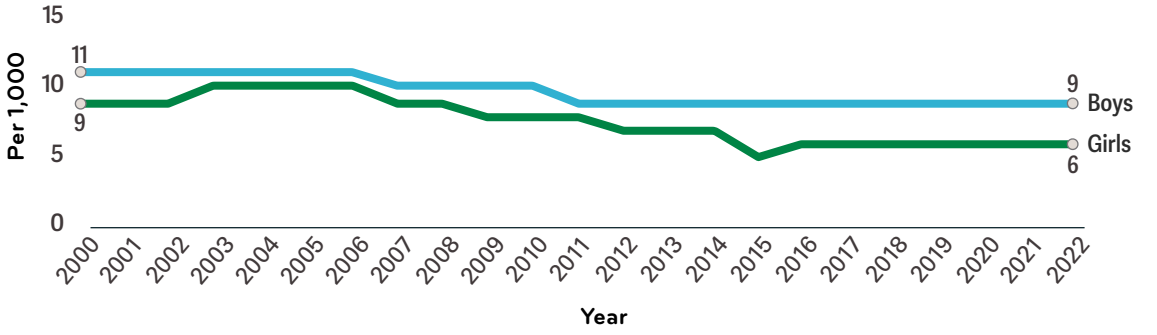
Chart 4.41 shows that from 2000 to 2022, in South Africa, adolescent girls and boys aged 10-14 had similar mortality rates. In comparison, **Chart 4.42** shows that among adolescents aged 15-19, boys had slightly higher mortality rates than girls. It is also notable that adolescents aged 15-19 (8 per 1,000 adolescents) had mortality rates that were twice as high as those of adolescents aged 10-14 (3 per 1,000 adolescents).

CHART 4.41. Adolescent mortality rates aged 10-14 (per 1,000) by sex, 2000-2022



SOURCES: Retrieved on 24 February 2024 from: CME Info - Child Mortality Estimates

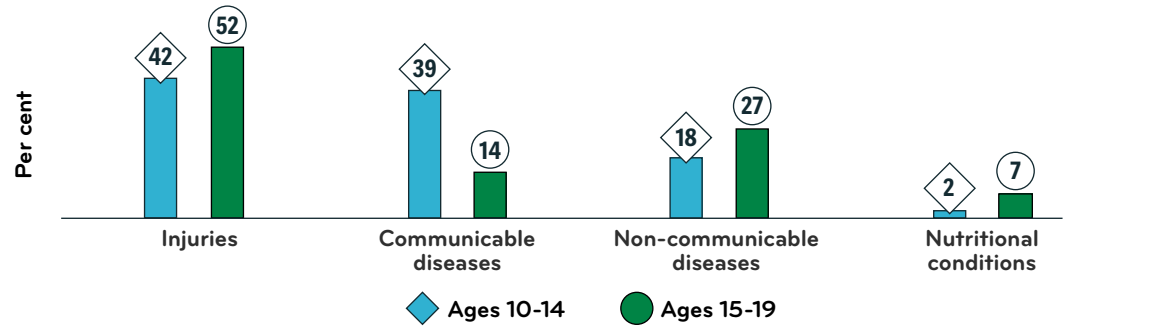
CHART 4.42. Adolescent mortality rates aged 15-19 (per 1,000) by sex, 2000-2022



SOURCES: Retrieved on 24 February 2024 from: CME Info - Child Mortality Estimates

Little is known in South Africa about the leading causes of death among adolescents aged 10-19; however, the available data shows that the leading causes of death among boys aged 10-14 were injuries (42 per cent), communicable diseases (39 per cent), non-communicable diseases (27 per cent), and nutritional conditions (7 per cent). In comparison, the leading causes of death among boys aged 15-19 were injuries (52 per cent), non-communicable diseases (27 per cent), communicable diseases (14 per cent), and nutritional conditions (7 per cent) (**Chart 4.43**).

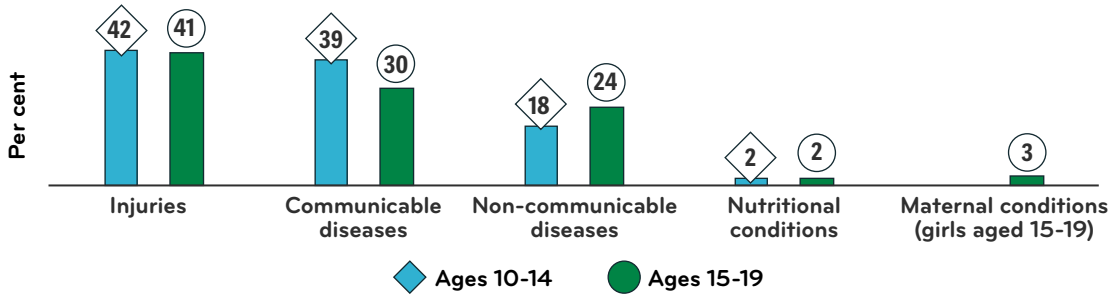
CHART 4.43. Leading causes of death among boys aged 10-19 by age group (%), 2019



SOURCE: Retrieved on 24 February 2024 from: Adolescent health dashboards country profiles – UNICEF DATA; see also WHO Global Health Estimates, 2019.

In comparison, **Chart 4.44** shows that the leading causes of death among adolescent girls aged 10-14 were injuries (42 per cent), communicable diseases (39 per cent), non-communicable diseases (18 per cent), and nutritional conditions (2 per cent). In contrast, the leading causes of death among girls aged 15-19 were injuries (41 per cent), non-communicable diseases (24 per cent), communicable diseases (30 per cent), maternal conditions related to pregnancy (3 per cent), and nutritional conditions (2 per cent).

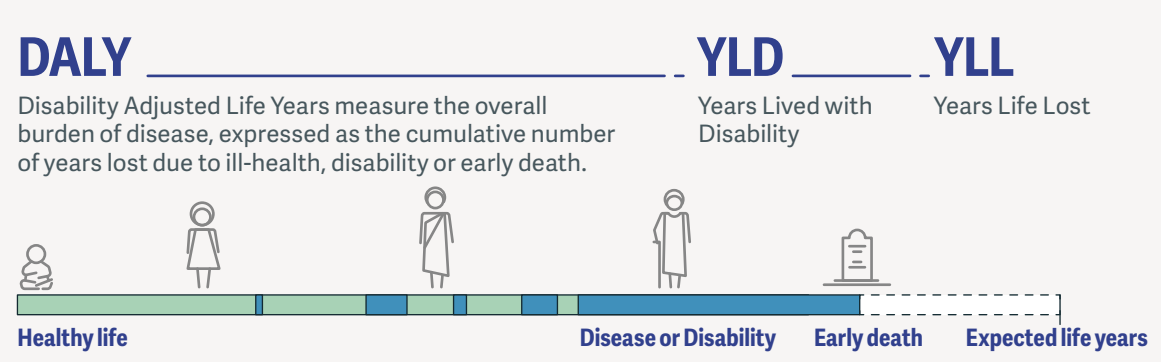
CHART 4.44. **Leading causes of death among girls aged 10-19 by age group (%), 2019**



SOURCE: Retrieved on 24 February 2024 from: Adolescent health dashboards country profiles – UNICEF DATA; see also WHO Global Health Estimates, 2019.

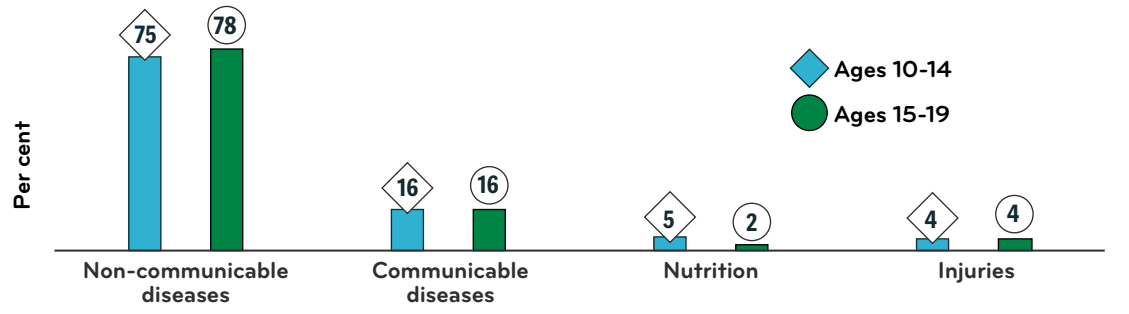
Adolescent Disability-Adjusted Life Years

The disability-adjusted life year (DALY) is a summary measure of overall disease burden, expressed as the number of years lost due to ill health, disability, or early death. In the 1990s, DALYs were developed by the World Bank and WHO as a measure of the global impact of disease on individual health status, i.e., a method of quantifying the global burden of disease and comparing overall health and life expectancy across countries. The DALY combines information about morbidity and mortality and is expressed in terms of the number of healthy years lost.



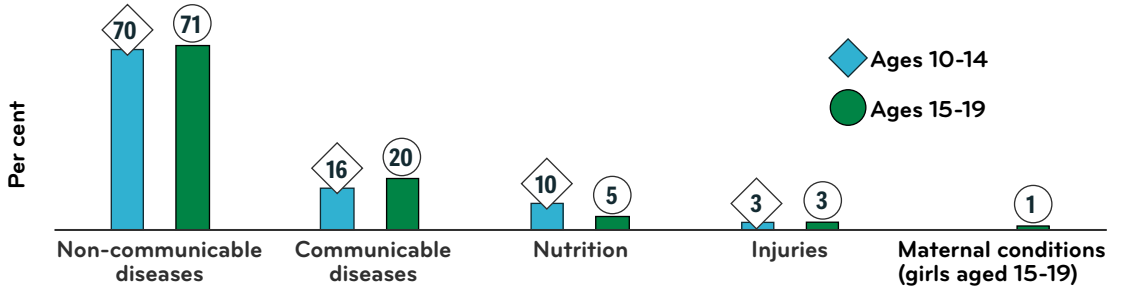
nutrition was twice as likely to be the cause of DALY for boys aged 10-14 (5 per cent) compared to boys aged 15-19 (2 per cent). Similarly, **Chart 4.46** shows that non-communicable diseases were the main cause of DALY for adolescent girls aged 10-14 (70 per cent) and 15-19 years (71 per cent). Nutrition was twice as likely to be the cause of DALY for girls aged 10-14 (10 per cent) compared to girls aged 15-19 (5 per cent), whereas communicable diseases were more often the cause of DALY for girls aged 15-19 (20 per cent) than for girls aged 10-14 (16 per cent). Among girls aged 15-19, maternal conditions were also a cause of DALY, but to a lesser extent (1 per cent).

CHART 4.45. DALY by cause among adolescent boys aged 10-19 (%), 2019



SOURCE: Retrieved on 24 February 2024 from: Adolescent health dashboards country profiles - UNICEF DATA; see also WHO Global Health Estimates, 2019.

CHART 4.46. DALY by cause among adolescent girls aged 10-19 (%), 2019



SOURCE: Retrieved on 24 February 2024 from: Adolescent health dashboards country profiles - UNICEF DATA; see also WHO Global Health Estimates, 2019.

Table 4.6 shows the leading causes of DALYs among adolescent boys and girls aged 10 to 19 in South Africa. These data correspond to the leading causes of DALYs presented in Charts 4.42 and 4.43.

TABLE 4.6. Leading causes of DALYs among adolescents aged 10-19 by sex, 2019

Boys (10-14 years)	Girls (10-14 years)
Childhood behavioural disorders Asthma Anxiety disorders Other hearing loss Skin diseases	Iron-deficiency anaemia Anxiety disorders Childhood behavioural disorders Asthma Migraine
Boys (15-19 years)	**Girls (15-19 years)**
Depressive disorders Childhood behavioural disorders Anxiety disorders Migraine Other hearing loss	Depressive disorders HIV/AIDS Anxiety disorders Migraine Gynaecological diseases

SOURCE: Retrieved on 24 February 2024 from: Adolescent health dashboards country profiles - UNICEF DATA

National Policies and Plans on Child and Adolescent Health

Table 4.7 highlights national policies and programmes on child and adolescent health adopted by the GoSA, including: the national adolescent health programme; a national policy to prohibit the sale of unhealthy food and sweetened beverages in or near schools; a national policy/law on the minimum age for the purchase or consumption of alcoholic beverages; a national policy/law to prohibit the sale of tobacco products to minors; and a plan or strategy for child and adolescent mental health. The GoSA has yet to establish an operational, multi-sectoral national non-communicable diseases policy, strategy, or action plan, or an operational policy, strategy, or action plan to reduce physical inactivity.

TABLE 4.7 National policies and programmes on child and adolescent health

Operational, multi-sectoral national non-communicable diseases policy, strategy or action plan that integrates several non-communicable diseases and their risk factors	✗
Operational policy, strategy, action plan to reduce physical inactivity	✗
National adolescent health programme	✓
National policy to prohibit selling of unhealthy food and sweetened beverages in or close to schools	✓
National policy/law designating an appropriate minimum age for purchase or consumption of alcoholic beverages	✓
National policy/law to prohibit sale of tobacco products to minors	✓
Plan or strategy for adolescent mental health	✓
Plan or strategy for child mental health	✓

SOURCE: Retrieved on 24 February 2024 from: Adolescent health dashboards country profiles – UNICEF DATA; see also, WHO Policies, Strategies and Action Plans (WHO Global Health Observatory); Mental Health Atlas, 2020; Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health Policy Survey, 2018-2020.

Table 4.8 shows that the GoSA has yet to establish that there are no legal age limits for unmarried adolescents to access contraceptive services (except sterilization), HIV testing and counselling, and/or mental health services without parental/legal consent.

TABLE 4.8. No legal age limit for unmarried adolescents to access services without parental/legal consent

Contraceptive services (except sterilization)	✗
HIV testing and counselling	✗
Mental health services	✗

SOURCE: Retrieved on 24 February 2024 from: Adolescent health dashboards country profiles – UNICEF DATA; see also, Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health Policy Survey, 2018-2019.

Table 4.9 shows that the GoSA has exempted user fees for adolescents for contraceptives, HIV testing and counselling, mental health care, and testing and treatment of STIs. The GoSA also has user fee exemptions for rehabilitation for substance abuse and vaccination for HPV for selected population groups.

TABLE 4.9. User fee exemptions for adolescents

Contraceptives	✓
HIV testing and counselling	✓
Mental health care	✓
Rehabilitation for substance abuse	✓
Testing and treatment of STIs	✓
Vaccination for HPV	✓

Yes (selected population groups)

SOURCE: Retrieved on 24 February 2024 from: Adolescent health dashboards country profiles – UNICEF DATA; see also, Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health Policy Survey, 2018-2019.

Yes (selected population groups)

Finally, **Table 4.10** shows that the GoSA imposes taxation on sugar-sweetened beverages, beer, spirits, and wine.

TABLE 4.10. Taxation of sugar-sweetened beverages and alcohol

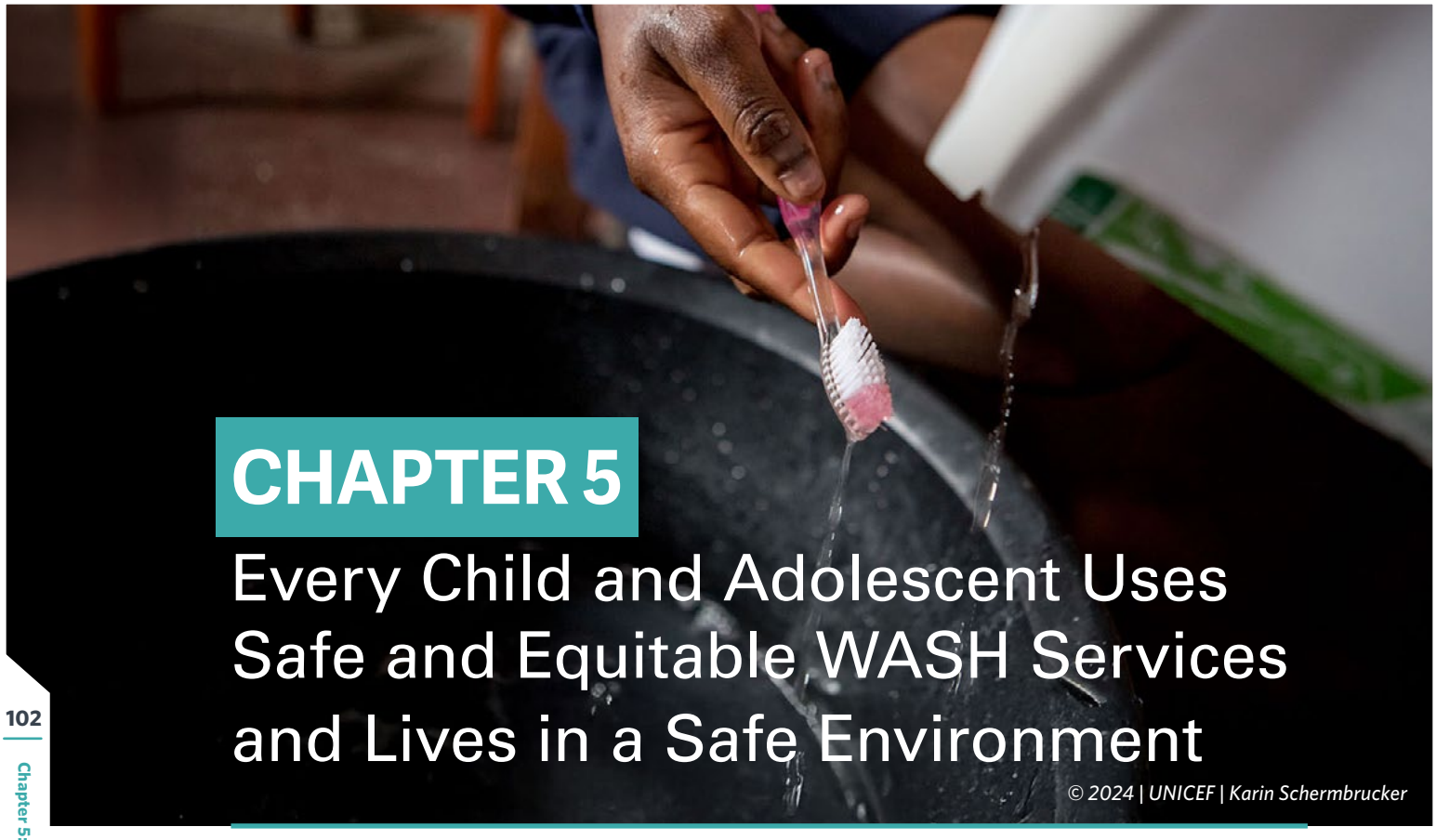
Sugar-sweetened beverages	✓
Beer	✓
Spirits	✓
Wine	✓

SOURCE: Retrieved on 24 February 2024 from: Adolescent health dashboards country profiles – UNICEF DATA; see also, Global Survey on Alcohol and Health, 2016; Non-Communicable Country Capacity Survey, 2019.

Summary of data gaps

This chapter focused on data related to every child's right to survive and thrive, and there were notable data gaps.

- Data related to practices of breastfeeding, including exclusive breastfeeding, are available, but more data and information are needed to understand what support and accommodations mothers need to inform their decisions to breastfeed and to ensure exclusive breastfeeding up to 6 months.
- Data related to teenage pregnancy are limited to adolescent fertility rates. Qualitative data related to adolescents girls' experiences around pregnancy and motherhood are lacking. Such data are needed and important to: reduce teenage pregnancy; develop and evaluate social and behaviour change initiatives; developing and evaluating SRH programmes and policies to reduce teenage pregnancy; develop programmes and policies that support teenage mothers to continue their education, learning and skills development, and to be able to access employment; and to strengthen much needed social protection services to reduce teenage mothers' risks of falling into and/or living their lives in poverty, along with their child(ren).
- Data related to HIV testing, treatment and prevention among young people aged 10-24 years are lacking, as is data related to their knowledge and practices regarding pre-exposure prophylaxis (PrEP).
- Data related to alcohol, tobacco and drug use among adolescents are lacking and limited in scope, although it is important to understand the risky behaviours of adolescents. This data should be collected and further disaggregated by sex, age, residence (urban vs. rural) and region.
- Data related to adolescent mental health and well-being, including suicidal tendencies, are lacking in South Africa. Such data are important, particularly given the fact that international research has found that anxiety and depressive disorders have increased among adolescents as a result of stressors and strains related to the COVID-19 pandemic, conflict and climate change. Such data and information are needed to improve mental health services for young people, and social and behaviour change interventions to strengthen demand for services. This data should be disaggregated by sex and age, at the least.
- Data related to nutrition and physical (in)activity among adolescents are lacking. Such data are important for better understanding adolescents' health and the potential risks of being underweight, overweight, or obese. It would be beneficial to invest in research focusing on the perspectives of children and adolescents and their lived experiences in accessing food, particularly healthy options. Using human-centred design to identify the food options they seek, as well as their experiences of being physically active, is essential. This research should examine differences between (and among) girls and boys as not all children are the same. There are lessons learned from engaging with children and adolescents regarding the support and assistance they need in relation to knowledge, attitudes, and practices concerning nutrition and physical activities to support their health and development. Such information will help to inform social and behaviour change interventions aimed at improving nutrition and physical activity among adolescents.



CHAPTER 5

Every Child and Adolescent Uses Safe and Equitable WASH Services and Lives in a Safe Environment

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Children need a safe and clean environment to survive, grow, and thrive (Article 24, CRC). The availability of safe and clean WASH services and the quality of the physical environment in which children live are important determinants of their health and well-being, learning, safety, and ability to take advantage of opportunities to reach their full potential.[407] Inadequate WASH is primarily responsible for the transmission of diseases such as cholera, diarrhoea, dysentery, hepatitis A, typhoid, and polio. Diarrhoeal diseases exacerbate malnutrition and remain a leading global cause of child deaths. The COVID-19 pandemic highlighted the importance of WASH for children and the fragility of the systems and services upon which they rely for WASH.[408]

Given the global trend of the disproportionate burden of unsafe water on children, they must be prioritised in national WASH strategies. WASH-related policies and plans must be climate-resilient, supported by accelerated financing and capacity development, and complemented by robust data collection and monitoring systems. Securing the fundamental right to access water and sanitation is closely linked to many aspects of the SDGs.[409]

In South Africa, the 1996 Constitution provides the right of all people in South Africa to dignity and access to an environment that is not harmful to their health or well-being, and is sustainable and protected from pollution or degradation.[410] South Africa's environment, however, is increasingly under threat, in part from the impacts of climate change, disasters, and hazards; these and other deteriorating environmental conditions threaten the services on which children rely in the areas of WASH. Thus, strengthening the capacity and resilience of communities and governmental systems to maintain safe and clean environments is critical to the environmental and resilience components of the 2030 Agenda for Sustainable Development. This includes: SDG 6 on clean water and sanitation; SDG 11 on sustainable cities and communities; SDG 13 on climate action; and SDG 5 on gender equality.[411] An even greater challenge is to ensure that new and existing WASH systems are resilient to climate change and the growing threat of water scarcity.[412]

Water, Sanitation and Hygiene (WASH)

Access to safely managed drinking water, sanitation services, and good hygiene practices are considered core socio-economic and health determinants, and are key for maternal, newborn, and child health and survival. Thus, SDG indicators focus on the proportion of the population with safely managed drinking water (6.1.1) and sanitation services (6.2.1), as well as on mortality rates attributed to exposure to unsafe WASH services (3.9.2). The WHO-UNICEF Joint Monitoring Programme (JMP) for Water Supply, Sanitation and Hygiene defines safely managed WASH services as meeting three criteria – accessible on premises, available when needed, and free from contamination (**Figure 5.1**). The JMP also offers WASH data related to households, schools, and healthcare facilities.[413]

FIGURE 5.1. SDG service ladders for WASH

	Water	Sanitation	Hygiene	Waste Management	Environmental Cleaning
Higher levels of service	To be defined at a national level	To be defined at a national level	To be defined at a national level	To be defined at a national level	To be defined at a national level
Basic service	Water is available from an improved source on the premises	Improved sanitation facilities are usable, with at least one toilet dedicated for staff, at least one sex-separated toilet with menstrual hygiene facilities, and at least one toilet accessible for people with limited mobility.	Functional hand hygiene facilities (with water and soap and/or alcohol-based hand rub) anr available at points of care, and within five metres of toilets.	Waste safely segregated into at least three bins, and sharps and infectious waste are treated and disposed of safely.	Basic protocols for cleaning are available, and staff with cleaning responsibilities have all received training.
Limited service	An improved water source is within500 metres of the premises, but not all requirements for basic service are met.	At least one improved sanitation facility is available, but not all requirements for basic service are met.	Functional hand hygiene facilities are available either at points of care or toilets but not both	There is limited separation and/or treatment and disposal of sharps and infectious waste, but not all requirements for basic service are met.	There are cleaning protocols and/or at least some staff have received training on cleaning.
No service	Water is taken from unprotected dug wells or springs, or surface water sources; or an improved source that is more than 500 metres from the premises; or there is no water source.	Toilet facilities are unimproved (e.g. pit latrines without a slab or platform, hanging latrines, bucket latrines) or there are no toilets.	No functional hand hygiene facilities are available at either points of care or toilets.	There are no separate bins for sharps or infectious waste, and sharps and/or infectious waste are not treated/ disposed of safely.	No cleaning protocols are available and no staff have received training on cleaning.

In accordance with SDG 6, the GoSA has committed to achieving, by 2030, universal and equitable access to safe and affordable water for all, access to adequate and equitable sanitation and hygiene for all, and an end to open defecation. The challenge is that South Africa has structural deficiencies in WASH in households, schools,[414] and health facilities; thus, achieving universal access to safe drinking water and sanitation by 2030 will be challenging for the GoSA, given current levels of investment and climate variability. In addition, influencing national behaviour change towards good hygiene practices remains a challenge in South Africa, particularly where hygiene washing facilities are limited. There are also notable gaps in access to safely managed WASH practices[415] between urban and rural communities and in informal settlements.[416]

Safe Water

Everyone has the human right to safe drinking water during times of stability and crisis, in both urban and rural contexts. In South Africa, the human right to basic water is enshrined in Chapter 2 of the 1996 Constitution and has been introduced in 'Free Basic Water and Sanitation' policies.

In South Africa, the sustainability of safe water supplies is one of the most serious challenges, particularly given that water scarcity is a recurring phenomenon and is expected to worsen with climate change. When children do not have access to clean water, it negatively impacts all aspects of their lives, including their health, nutrition, and education.

South Africa is a water-scarce country with an average annual rainfall of 464 mm (compared to the global average of 786 mm), with some seasonal and regional differences. Water-related problems regularly occur as a result of decreased rainfall and droughts; flooding also arises from excessive rainfall.[417] In the future, climate change is predicted to worsen water-related problems in South Africa. Decreases in rainfall and increases in drought will lead to a reduction in the availability of fresh water for drinking purposes.[418] Water scarcity is further exacerbated by high levels of poverty and inequality, which make it difficult for many people to access safe and sustainable water services.[419]

***Safe Water:** In 2010, the United Nations General Assembly recognized the right of every human being to have access to enough water for personal and domestic uses, meaning between 50 and 100 litres of water per person per day. The water must be safe, acceptable and affordable. The water costs should exceed 3 percent of households income. Moreover, the water source has be within 1,000 meters of the home and collection time should not exceed 30 minutes.*

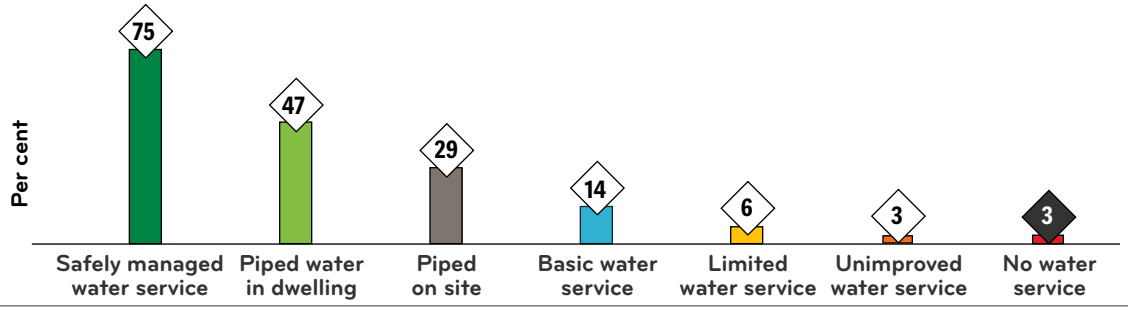
SOURCE: Retrieved on 6 March 2024 from: Water | United Nations

Safe water supplies are also impacted by an ageing infrastructure and increased demand related to population growth, particularly in urban areas, as well as increased demands for water from agricultural and industrial sectors. The result is an unequal distribution of water resources and service provision for domestic water.

Service Level	Definition
Safely managed	Drinking water from an improved water source that is located on premises, available when needed and free from faecal and priority chemical contamination.
Basic	Drinking water from an improved source, provided collection time is not more than 30 minutes for a round trip, including queuing.
Limited	Drinking water from an improved source for which collection time exceeds 30 minutes for a round trip, including queuing.
Unimproved	Drinking water from an unprotected dug well or unprotected spring.
Surface water	Drinking water directly from a river, dam, lake pond, stream, canal or irrigation canal.
Note: Improved sources include: piped water, boreholes or tubewells, protected dug wells, protected springs, and packaged or delivered water.	

Households: **Chart 5.1** shows that in 2022, 75 per cent of households had access to safely managed drinking water, of which 47 per cent had piped water in their dwelling and 29 per cent had piped water on site. In addition, 14 per cent of households had basic water service, 6 per cent had limited water service, and 3 per cent had unimproved water service. Only 3 per cent of households had no water service.[420] Based on these data, Stats SA estimated that 75 per cent of persons used safely managed drinking water; yet, 13 per cent of households rely on a communal or neighbour's tap for drinking water.[421] In 2023, the percentage of households with piped water in their dwelling was 30 per cent, with piped water in on-site/yard.[422]

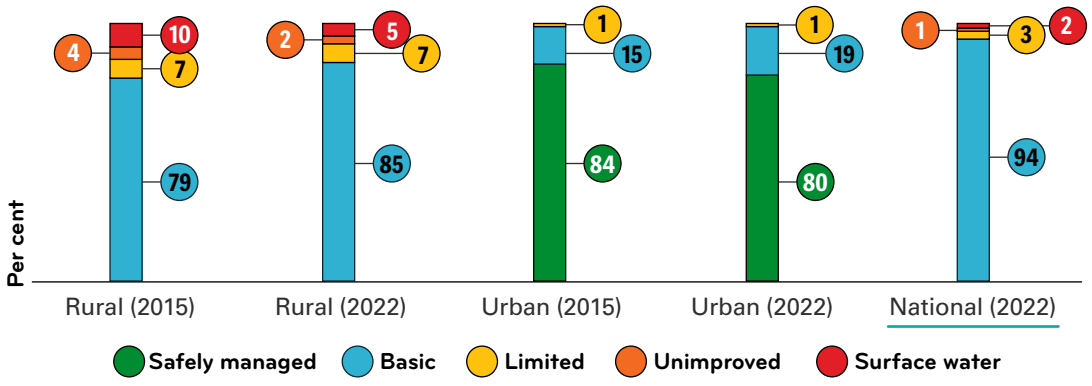
CHART 5.1. Household access to water services (%), 2022



SOURCE: 2022 GHS; see also UNICEF South Africa WASH Fact Sheet.

Chart 5.2 shows that from 2015 to 2022, there have been some improvements in access to safely managed drinking water in South Africa. Based on WHO-UNICEF JMP data, 94 per cent of households had basic drinking water in 2022. More specifically, 80 per cent of urban households had safely managed drinking water (down from 84 per cent in 2015), while no rural households had safely managed drinking water in either 2015 or 2022. Instead, 85 per cent of rural households had basic drinking water (up from 79 per cent in 2002), compared to only 19 per cent of urban households. In 2022, 7 per cent of rural households still relied on limited water sources, 3 per cent had unimproved water sources, and 5 per cent relied on surface water (down from 10 per cent in 2015).

CHART 5.2. Households using safely managed drinking water by area and year (%), 2015 and 2022

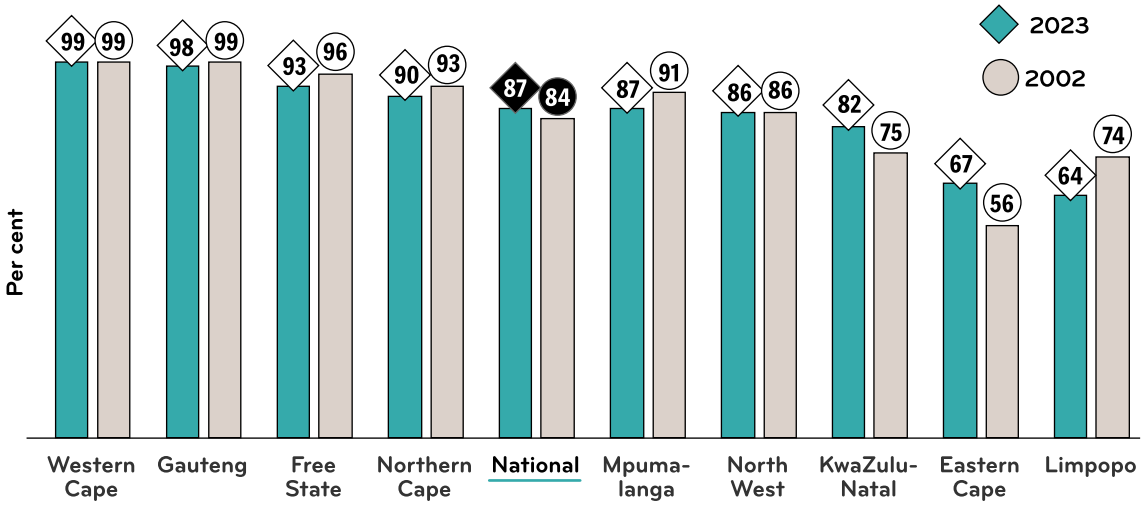


SOURCE: WHO-UNICEF JMP. Retrieved on 23 March 2024 from: JMP (washdata.org)

Chart 5.3 shows that in 2023, households in the Western Cape (99 per cent), Gauteng (98 per cent), Free State (93 per cent), and Northern Cape (90 per cent) were most likely to have access to piped or tap water in their dwelling, whereas households in the Eastern Cape (67 per cent) and Limpopo (64 per cent) were least likely to have access to piped or tap water in their dwelling.

Nationally, there was a three-percentage point increase in the proportion of households with piped or tap water in their dwelling, from 84 per cent in 2002 to 87 per cent in 2023. The most notable increases were in Eastern Cape and KwaZulu-Natal, whereas there were notable decreases in the proportion of households with piped or tap water in their dwellings in Limpopo and Mpumalanga.

CHART 5.3. Households with access to piped or tap water in dwelling by province (%), 2002 and 2022



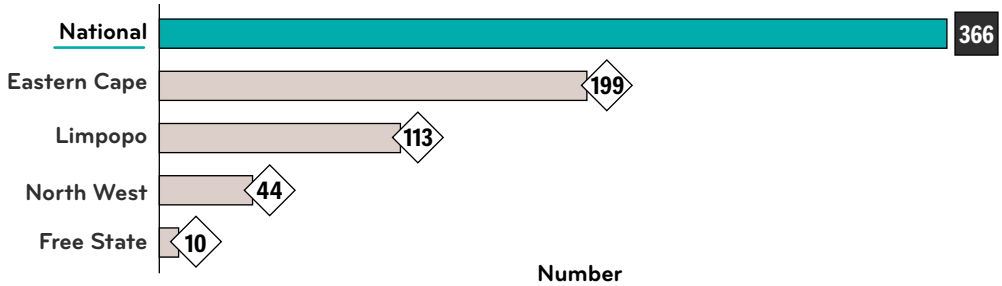
SOURCE: 2023 GHS

Schools: According to the Strategic Framework for Water Services, all schools must have adequate and safe water supplies. However, access to safely managed water sources and safe drinking water remains a problem in schools.

In 2021, the South African Human Rights Commission reported that 366 schools in four regions had no water services. This included 199 schools in the Eastern Cape, 113 schools in Limpopo, 44 schools in North West, and 10 schools in the Free State (**Chart 5.4**). Given these numbers, it was predicted that the lack of water for sanitation and hygiene affected a total of 5,429 teachers and 144,255 students.[423]

More recently, in 2023, the DBE reported that there were 1,306 water supply projects in schools, of which 1,292 were completed, while the remaining 14 water supply projects were scheduled to be completed in 2023/24, thus reducing the number of schools without water supplies.[424]

CHART 5.4. Schools with no water, 2021



SOURCE: July 2021 Report on Water and Sanitation in Schools by the South African Human Rights Commission, 2021. Retrieved on 7 March 2024 from: Water And Sanitation Report - 28 SeptemberPM.pdf (sahrc.org.za)

Water quality in schools is threatened by inadequate waste disposal, such as a lack of menstrual hygiene bins and incinerators, and poor wastewater management, compromising surface and groundwater.[425]

Water Quality: Water quality is a serious concern in South Africa. In 2023, the Department of Water and Sanitation (DWS) released the 2023 Blue Drop Report, which provides an assessment of drinking water quality. The Blue Drop Report is a comprehensive assessment of the state of all 958 water supply systems in each of the 144 water services authorities in South Africa.

In 2023, 26 water supply systems scored more than 95 per cent and qualified for the prestigious Blue Drop Certification (44 systems received Blue Drop status in 2013), indicating an overall decline in excellence from 2014 to 2023. Among the 958 water supply systems, 277 (29 per cent) were identified as being in a critical state of performance (up from 174 in 2014), showing an increase in critically performing systems from 2014 to 2023.[426]

Overall, drinking water systems in major metropolitan areas are performing well in Blue Drop key performance areas. Gauteng has the highest percentage of systems with excellent or good performance (62 per cent), followed by Western Cape (50 per cent). Northern Cape has the highest percentage of drinking water systems with poor or critical performance (87 per cent, from 48 per cent in 2014)..

The percentage of drinking water systems with poor or critical performance in Free State has also deteriorated from 31 per cent in 2014 to 59 per cent in 2023.[427]

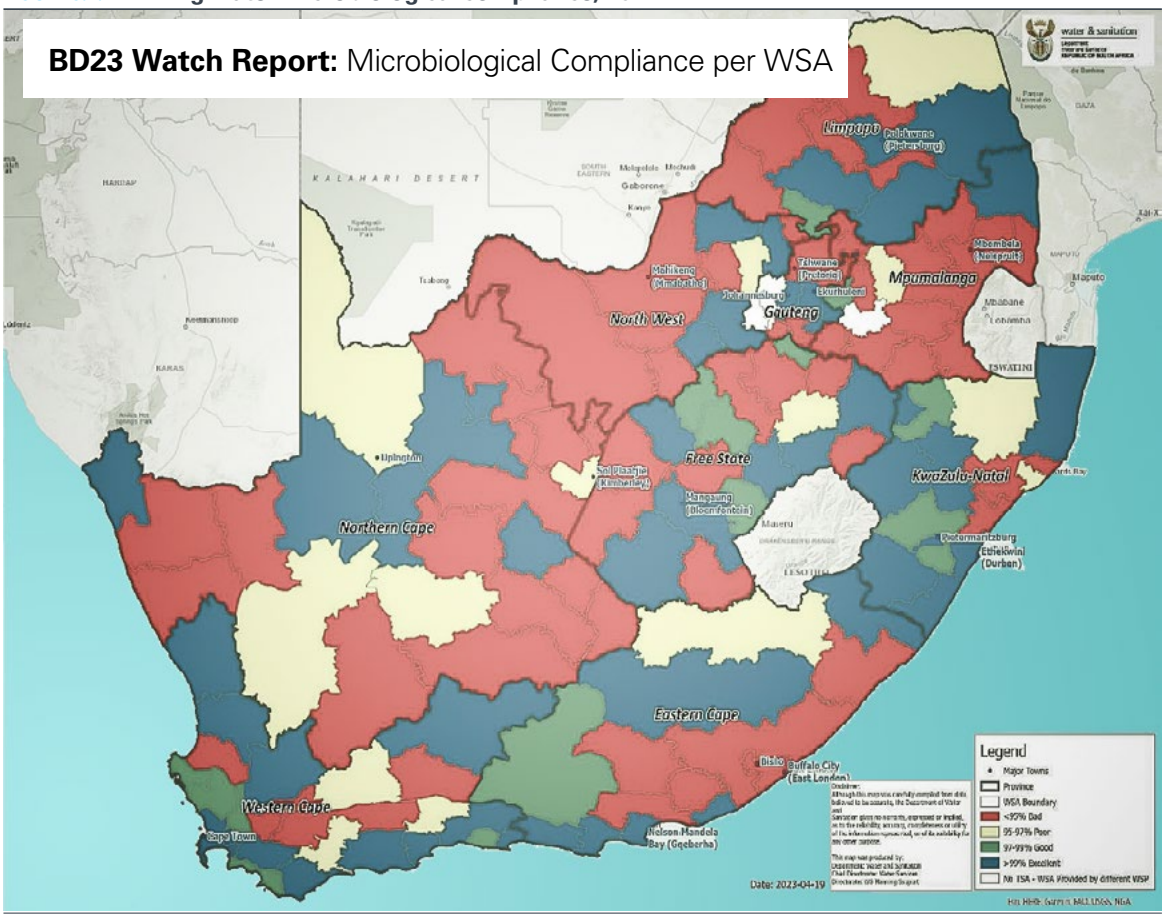
According to South African National Standards (SANS) 241, municipalities are required to monitor the microbiological and chemical quality of the water provided to residents.[428] An assessment of water quality tests carried out by municipalities during the 2021/22 municipal financial year found the following regarding microbiological water quality compliance (**Figure 5.2**):[429]

- 39 per cent of systems achieved excellent (> 99 per cent of water quality tests met SANS 241 standards)
- 11 per cent of systems achieved good (97-99 per cent of water quality tests met SANS 241 standards)
- 9 per cent of systems achieved poor (95-97 per cent of water quality tests met SANS 241 standards)
- 41 per cent achieved bad (< 95 per cent of water quality tests met SANS 241 standards)

With regard to chemical water quality compliance (**Figure 5.3**):[430]

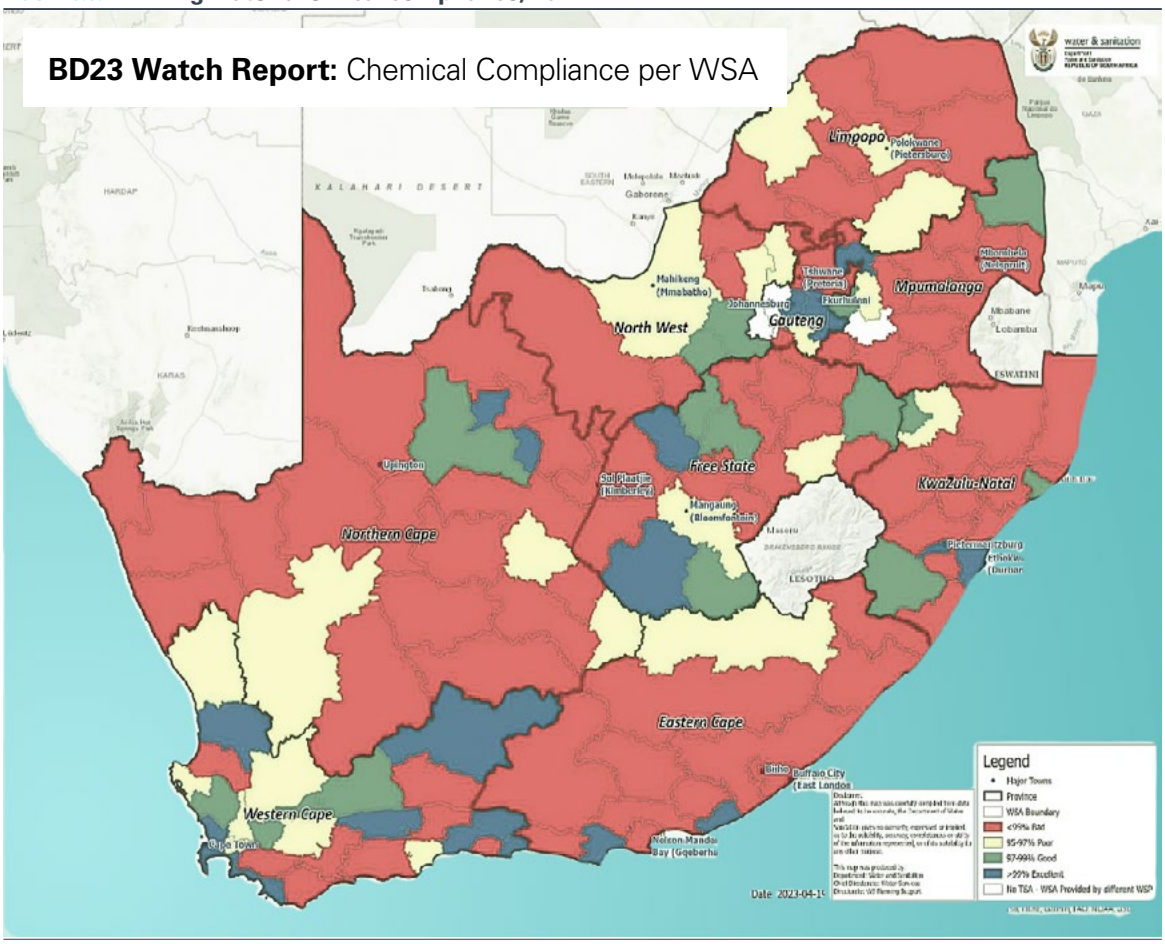
- 17 per cent of systems achieved excellent (> 99 per cent of water quality tests met SANS 241 standards)
- 13 per cent of systems achieved good (97-99 per cent of water quality tests met SANS 241 standards)
- 15 per cent of systems achieved poor (95-97 per cent of quality tests met SANS 241 standards)
- 55 per cent achieved bad (< 95 per cent of water quality tests met SANS 241 standards)

FIGURE 5.2. Drinking water microbiological compliance, 2021/22



SOURCE: Retrieved on 6 March 2024 from: DWS Home

FIGURE 5.3. **Drinking water chemical compliance, 2021/22**



SOURCE: Retrieved on 6 March 2024 from: DWS Home

In May and June 2023, contaminated drinking water was blamed for a lethal cholera outbreak in some parts of the country. More than 600 people with suspected cholera symptoms were seen, especially in Gauteng and Free State hospitals. Regarding confirmed cases, South Africa recorded a total of 166 laboratory-confirmed cases and 202 suspected cases of cholera in five provinces between 1 February and 6 June 2023. The majority of cases were recorded in Gauteng (92 per cent), specifically in the Hammanskraal area, and 5 per cent in Free State – in Parys and Vredefort. Other provinces that recorded positive cases included Limpopo, Mpumalanga, and North West. The death toll from the cholera outbreak was 31 persons as of 1 June 2023.[431]

Improving water quality is critical for preventing disease and enhancing the accessibility and availability of safe drinking water, both equally important, particularly for women and girls who are often tasked with carrying water. Recognising this, the GoSA has integrated SDG 6 into its National Development Plan and the National Water and Sanitation Master Plan, along with other relevant policies and plans. The government has also launched campaigns to raise awareness and promote water conservation. However, gaps remain in existing policies and strategies, limited financing for water, and inadequate investment in infrastructure. There is a need for greater emphasis on the social and environmental aspects of water management, particularly concerning climate change. Another deficit is the lack of attention to the linkages between water and energy, which are essential for sustainable development.[432]

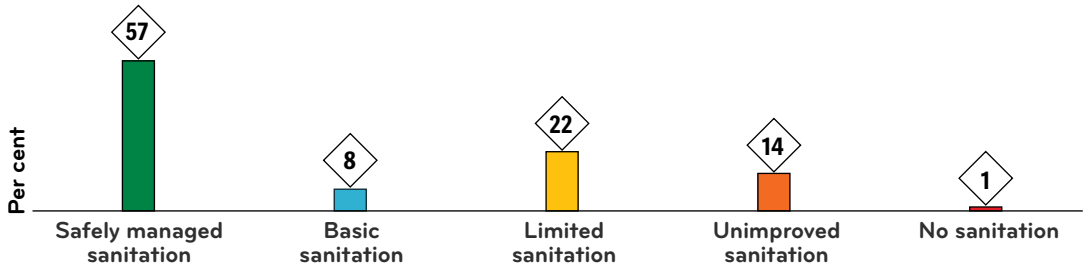
Sanitation

Sanitation is about the coupling of behaviours, facilities, and services that provide the hygienic environment that children need to fight disease and grow up healthy. Adequate sanitation is essential to childhood survival and development, whereas poor sanitation puts children at risk of childhood diseases and malnutrition that can impact their overall development and learning.[433]

In South Africa, the DWS is responsible for implementing the National Sanitation Policy of 2016 and regulating the sanitation sector.[434] The National Sanitation Policy is a cross-sectoral policy that recognises sanitation services will contribute to public health, and that aspects of the sustainable provision of sanitation services are linked with the sustainable management of water, waste, environment, health, and other related sectors.[435] The Policy also recognises the need for sanitation services to be sensitive to people with special needs, as well as women, children, and the elderly.[436]

Households: **Chart 5.5** shows that in 2022, 57 per cent of households had access to safely managed sanitation services, whereas 8 per cent had basic sanitation, 22 per cent had limited sanitation, and 14 per cent had unimproved sanitation services. Only one per cent of households had no sanitation services. An estimated 83 per cent of households used improved sanitation services, such as a flush toilet connected to a public sewage system or septic tank or a pit toilet with a ventilation pipe (up from 62 per cent in 2002).[437]

CHART 5.5. Household access to safely managed sanitation services (%), 2022

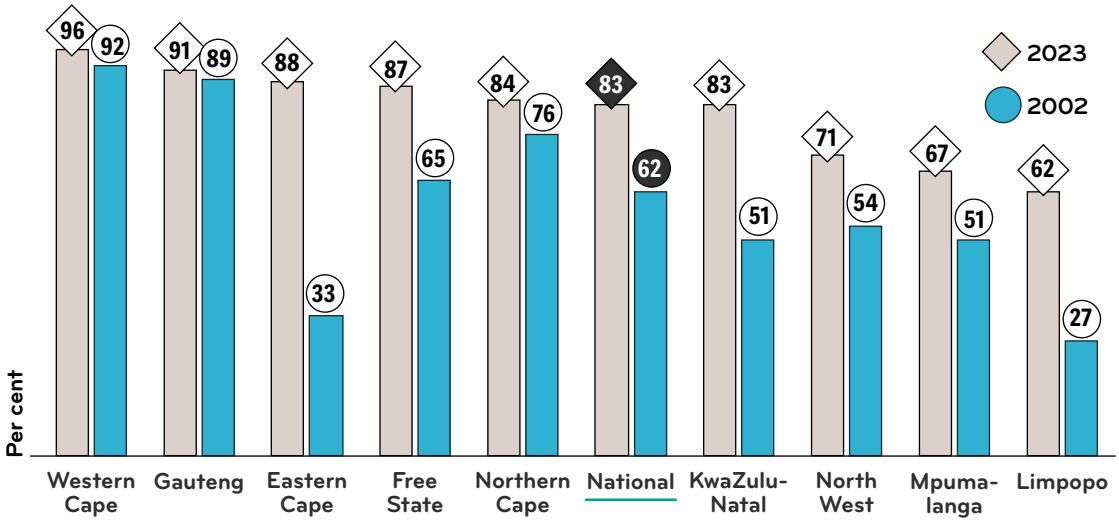


SOURCE: 2022 GHS

Chart 5.6 shows that in 2023, 83 per cent of households had access to improved sanitation services, defined as flush toilets connected to a public sewerage system or a septic tank, or a pit toilet with a ventilation pipe. Households in the Western Cape (96 per cent), Gauteng (91 per cent), Eastern Cape (88 per cent), and Free State (87 per cent) were more likely to have access to improved sanitation services, whereas households in North West (71 per cent), Mpumalanga (67 per cent), and Limpopo (62 per cent) were least likely to have access to improved sanitation services.

Nationally, there was a 57-percentage point increase in the proportion of households with improved sanitation services, from 62 per cent in 2002 to 83 per cent in 2023. The most notable increases were in the Eastern Cape and Limpopo.

CHART 5.6. Households that have access to improved sanitation by province (%), 2023



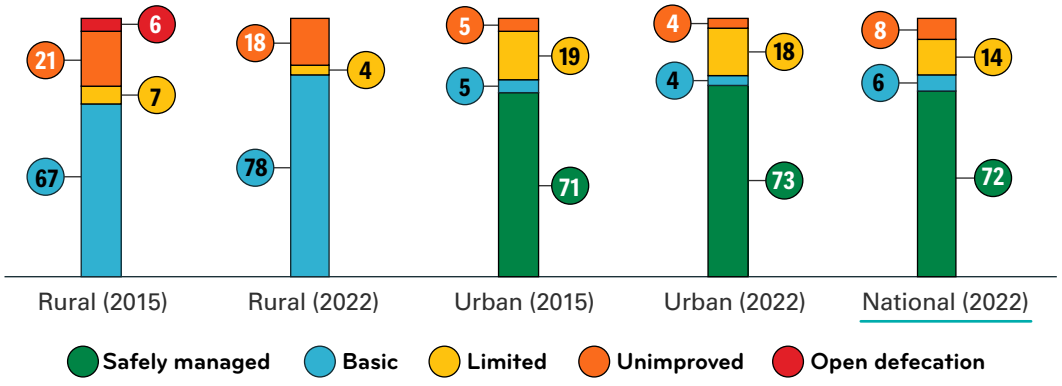
SOURCE: 2023 GHS

According to the WHO-UNICEF JMP, in 2022, 72 per cent of households in South Africa had safely managed sanitation services, whereas 6 per cent had basic sanitation services, 14 per cent had limited sanitation services, and 8 per cent had unimproved sanitation services (**Chart 5.6**). Without basic sanitation services, people have no choice but to use inadequate communal latrines or to practise open defecation, which poses risks to their health and livelihoods.

Service Level	Definition
Safely managed	Use of improved facilities that are not shared with other households and where excreta are safely disposed of in situ or transported and treated offsite.
Basic	Use of improved facilities that are not shared with other households
Limited	Use of improved facilities shared between two or more households
Unimproved	Use of pit latrines without slab or platform, hanging latrines or bucket latrines.
Open defecation	Disposal of human faeces in fields, forests, bushes, open bodies of water, beaches or other open spaces, or with solid waste.
Note: Improved facilities include: flush/pour flush to piped sewer systems, septic tanks or pit latrines; ventilated improved pit latrines, composting toilets or pit latrines with slabs.	

Chart 5.7 shows that in 2022, 73 per cent of urban households had safely managed sanitation services (up from 71 per cent in 2015); whereas no rural households had safely managed sanitation services in either 2015 or 2022. Instead, 78 per cent of rural households had basic sanitation services (up from 67 per cent in 2015). Without basic sanitation services, 18 per cent of urban households and 4 per cent of rural households had limited sanitation services (compared to 19 per cent and 7 per cent respectively in 2015). In addition, 4 per cent of urban households and 18 per cent of rural households had unimproved sanitation services (compared to 5 per cent and 21 per cent in 2015). In 2022, no rural or urban households practised open defecation (down from 6 per cent and 1 per cent respectively in 2015).

CHART 5.7. Households using safely managed sanitation services by area and year (%), 2015 and 2022



SOURCE: WHO-UNICEF JMP. Retrieved on 6 March 2024 from: JMP (washdata.org)

Even in communities with toilets, waste containment may not be adequate. If toilets are difficult to clean or waste containment is not designed or maintained to safely contain, transport, and treat excreta, waste might come into contact with people and the environment. These factors make sustainable development nearly impossible.[438]

Schools: The Strategic Framework for Water Services 2003 indicates that all schools must have adequate sanitation services. Thus, there are norms and standards for school infrastructure that guide the provision of sanitation services in schools. In 2016, the Water Research Commission introduced Guidelines for School Sanitation to improve schools' ability to build and manage school toilets to protect learners' rights to safety, health, and dignity.[439]

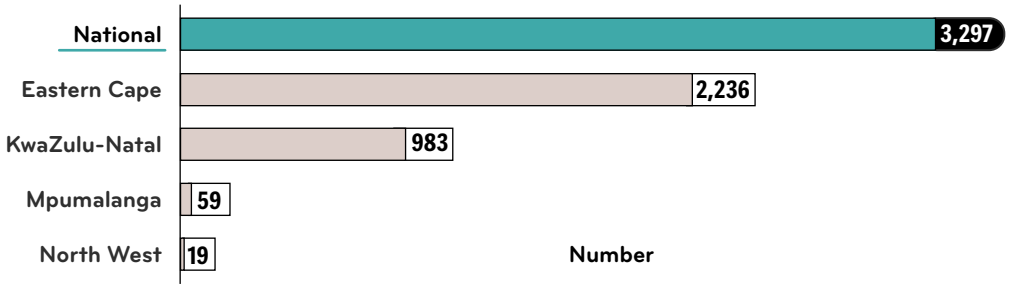
Access to safely managed sanitation services is also a problem in schools. In 2021, the South African Human Rights Commission reported that 3,297 schools in four regions used pit latrines. This included

2,236 schools in the Eastern Cape, 983 schools in KwaZulu-Natal, 59 schools in Mpumalanga, and 19 schools in North West (**Chart 5.8**). Thus, it was predicted that the number of schools using pit latrines affected a total of 37,858 teachers and 1,039,117 students.[440]

In 2023, the DBE reported that there were 1,087 sanitation projects in schools, all of which were completed as part of the ASIDI programme.[441]

Sanitation Quality: In 2023, the Green Drop Progress Assessment report, which focuses on wastewater quality management and regulation of wastewater treatment works, found that 64 per cent of wastewater treatment works are at high or critical risk of discharging treated or untreated water into rivers and the environment. The number of wastewater treatment works in the high and critical risk categories has increased since 2013. This has negative environmental implications and poses risks to human health (e.g., cholera outbreaks are often associated with wastewater pollution of water resources).[442]

CHART 5.8. Schools with no safely managed sanitation services, 2021



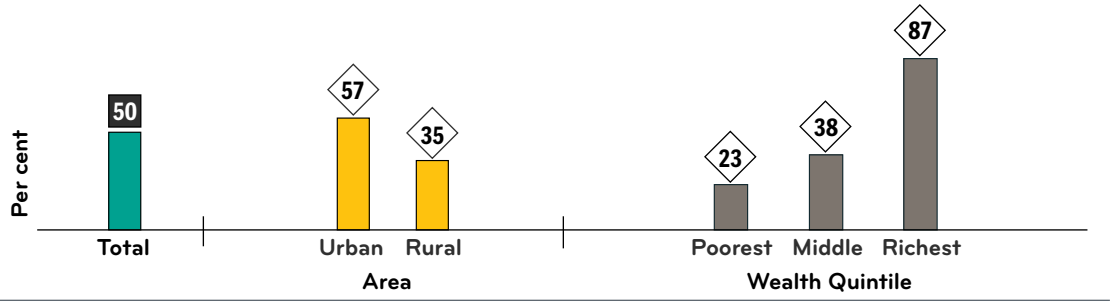
SOURCE: July 2021 Report on Water and Sanitation in Schools by the South African Human Rights Commission, 2021. Retrieved on 7 March 2024 from: Water And Sanitation Report - 28 SeptemberPM.pdf (sahrc.org.za)

Hygiene

Good hygiene is critical for preventing the spread of infectious disease and helping children lead long and healthy lives. Good hygiene can help prevent children from missing school, resulting in better learning outcomes. For families, good hygiene means avoiding illness and spending less money on healthcare. In some contexts, good hygiene can also secure a family's social status and help individuals maintain their self-confidence. However, good hygiene is difficult to practice without the right knowledge and skills, adequate community support, and the belief that one's own behaviours can make a difference.[443]

Households: In South Africa, there are families and children who live in conditions that make it difficult to maintain good hygiene; this can be a challenge when water and soap for handwashing are unavailable. **Chart 5.9** shows that in 2016, only 50 per cent of households had a place for washing hands (either a fixed or mobile location) with soap and water. Households in urban areas (57 per cent) were more likely to have handwashing facilities than those in rural areas (35 per cent). The richest households (87 per cent) were more than twice as likely to have handwashing facilities as middle-income households (38 per cent) and nearly four times more likely than the poorest households (23 per cent).

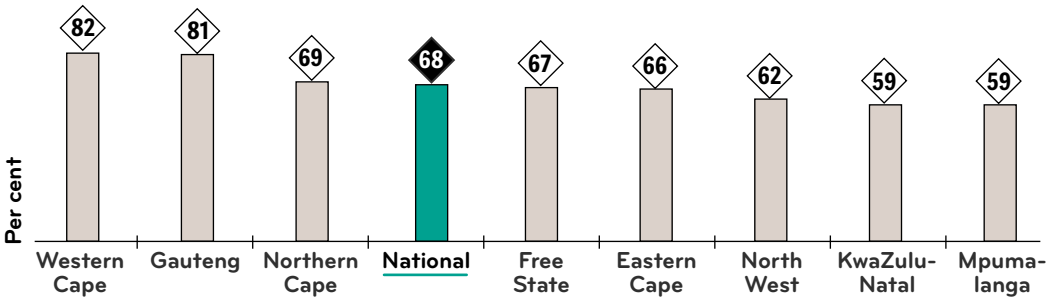
CHART 5.9. Households with handwashing facilities with soap and water by area and wealth (%), 2016



SOURCE: SADHS, 2016

Chart 5.10 shows that in 2016, 68 per cent of households in South Africa had access to handwashing facilities with soap and water. Households in the Western Cape (82 per cent) and Gauteng (81 per cent) were the most likely to have these facilities, whereas those in North West (62 per cent), KwaZulu-Natal (59 per cent), and Mpumalanga (59 per cent) were the least likely to have access to handwashing facilities with soap and water.

CHART 5.10. Households with handwashing facilities with soap and water by region (%), 2023



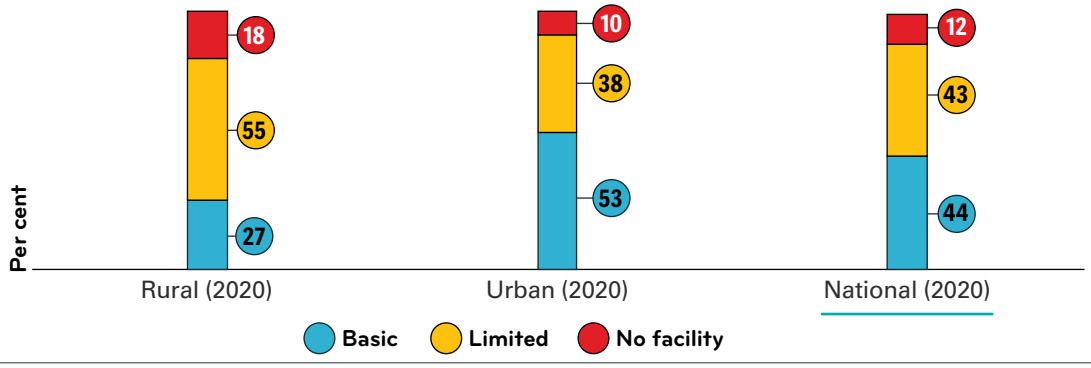
SOURCE: 2023 GHS

According to the WHO-UNICEF JMP, in 2020, 44 per cent of households in South Africa had basic hygiene services (handwashing facilities with water and soap available), 43 per cent had limited hygiene facilities (with water but no soap), and 12 per cent had no hygiene facilities (no water or soap). Urban households (53 per cent) were twice as likely as rural households (27 per cent) to have basic hygiene services, whereas 55 per cent of rural households and 38 per cent of urban households had limited hygiene facilities. Rural households (18 per cent) were also nearly twice as likely as urban households (10 per cent) to have no handwashing facilities (**Chart 5.11**).

Service Level	Definition
Basic	Availability of a handwashing facility on premises with soap and water.
Limited	Availability of a handwashing facility on premises without soap and water.
No facility	No handwashing facility on premises.

Note: Handwashing facilities may be fixed or mobile and include a sink with tap water, buckets with taps, tippy-taps, and jugs or basins designated for handwashing. Soap includes bar soap, liquid soap, powder detergent, and soapy water but does not include ash, soil, sand or other handwashing agents.

CHART 5.11. Households using safely managed hygiene services by area (%), 2020



SOURCE: WHO-UNICEF JMP. Retrieved on 7 March 2024 from: JMP (washdata.org)

Schools: Proper handwashing practices are also an issue in schools, particularly in rural areas due to the absence of regular water supplies. The combination of inadequate handwashing facilities and water scarcity in schools can negatively impact school attendance for girls during their menstruation.[444] It is notable that the Strategic Framework for Water Services 2003 establishes that hygiene education and wise use of water must be taught in all schools.

Mortality Attributed to Unsafe WASH Services

Inadequate WASH are important risks to health, particularly in low- and middle-income countries. The impact of unsafe WASH on death rates of children under-five and mothers in the year after childbirth is important to understand; unfortunately, that data are not available. Data that are available relates to SDG 3.9.2, which is the mortality rate attributed to exposure to unsafe WASH.

Table 5.2 shows that, on average, South Africa has a low mortality rate attributed to exposure to unsafe WASH, at 28 per 100,000 population. This is much lower than the average of 48 per 100,000 population for sub-Saharan Africa (excluding high-income countries) but higher than the average of 6 per 100,000 population for upper middle-income countries.

TABLE 5.2. Mortality rate attributed to unsafe WASH (per 100,000 population), 2019

South Africa	28
Sub-Saharan Africa (excl. high income)	48
Upper middle-income countries	6

SOURCE: Retrieved on 6 March 2024 from: Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (per 100,000 population) - South Africa | Data (worldbank.org)

Climate Change and WASH

Children and young people, including adolescent girls and young women, in South Africa are among the most at risk from the impacts of climate change, threatening their health, education and protection. In 2021, in UNICEF's first comprehensive analysis of climate risk from a child's perspective, South Africa ranked 72nd among 163 countries in terms of risk, with water scarcity and soil and water pollution having a particular impact on children affected by poverty and poor nutrition. Thus, climate change is likely to deepen the vulnerability of children in South Africa.[445]

In South Africa, climate change poses significant challenges to the WASH sector. It threatens national water security, with major implications for WASH services that will exacerbate health and social disparities. WASH is ranked as the second highest risk for children under five and those aged 5-14 years, as it is vital for children's health. WASH also plays a crucial role in maintaining hygienic living conditions and in preventing waterborne diseases to which children are highly susceptible.

Climate change impacts water availability and quality through altered precipitation patterns, leading to more intense and prolonged droughts in some regions and increased rainfall and flooding in others. These changes can affect the availability of freshwater sources, with droughts reducing surface and groundwater levels, and floods damaging WASH infrastructure, such as latrines and septic systems, leading to the flooding of pit toilets and contamination of water sources with pollutants and pathogens. This can result in outbreaks of cholera and other diarrhoeal diseases.[446]

Extreme heat events also tend to exacerbate sanitation issues by increasing water demand for personal hygiene while putting a strain on water resources. WASH infrastructure is also vulnerable to climate-related hazards, such as hurricanes, storms, and sea-level rise. Severe weather events often damage water supply and treatment systems, disrupting services and causing water shortages; this was evident during the recent KwaZulu-Natal floods, which resulted in negative economic and social impacts. Coastal communities also face the risk of inundation and saltwater intrusion into freshwater sources and sanitation facilities.[447]

Reduced access to clean water can lead to increased healthcare costs and lost productivity due to waterborne diseases. In addition, women and girls, who are often responsible for water collection,

may face longer and more dangerous journeys to find water during droughts. Furthermore, climate-induced displacement and migration can strain existing WASH services in host communities, as well as schools and health facilities.[448]

To prepare for the effects of climate change on WASH, it is essential that the Government of South Africa focus on strengthening the climate resilience of WASH infrastructure and services, including: enhancing water storage and management systems to cope with changing rainfall patterns; improving water-use efficiency; developing climate-resilient sanitation infrastructure; involving local people in the monitoring of water quality at points of use; and promoting safe water treatment and purification technologies.[449]

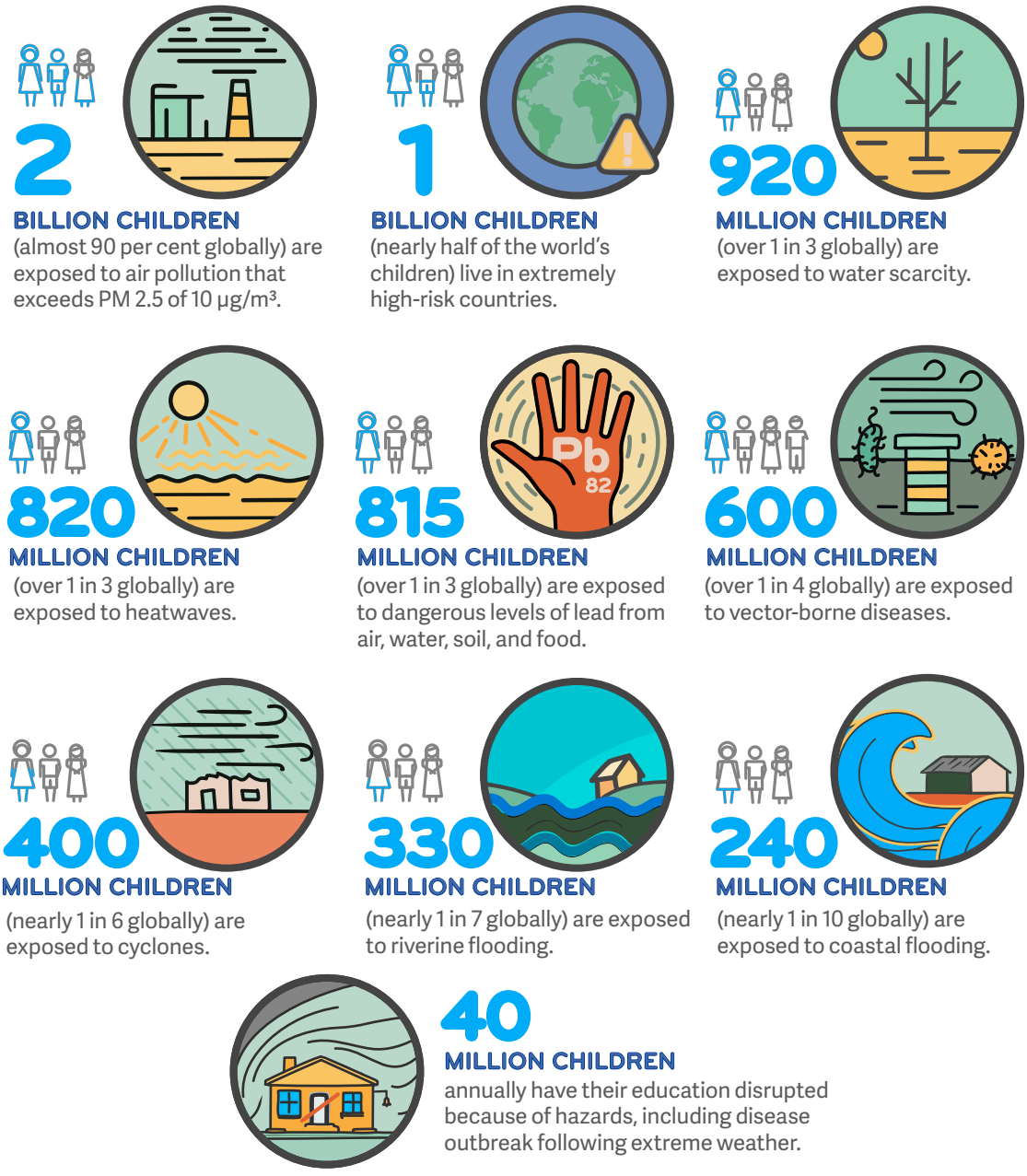
Right to a Healthy Environment

The right to a healthy environment is a powerful tool to protect children from the impact of environmental degradation and climate change.[450] In a historic move, the UN General Assembly declared a healthy environment a human right. In a resolution passed in July 2022, the UN General Assembly stated that climate change and environmental degradation were among the most pressing threats to humanity's future; thus, it called on UN Member States to step up efforts to ensure that their people have access to a "clean, healthy and sustainable environment."[451] The resolution comes as the planet grapples with what has been described as a 'triple planetary crisis' of climate change, nature and biodiversity loss, and pollution and waste. If left unchecked, these problems could have disastrous consequences for people around the world, especially the poor, women and girls, and children in general.[452]

Globally, more than one million premature deaths among children under the age of 5 are caused by pollution and toxic substances annually. This is because:

- Children are physically and economically more vulnerable and less able to survive shocks from floods, droughts, severe weather, and heatwaves.
- Children are more vulnerable physiologically to toxic substances, such as lead and other forms of pollution, affecting them even at low levels of exposure.
- Children are at greater risk of death compared to adults from diseases that are likely to be exacerbated by pollution and climate change, such as pneumonia, malaria, and diarrhoea.
- Any deprivation caused by climate and environmental degradation at a young age can result in a lifetime of lost opportunity.
- All children are at risk from environmental hazards and climate change, but children living in poverty, internally displaced children, children with disabilities, and girls and women are the most vulnerable.[453]

In South Africa, the 1996 Constitution provides the right of all people in South Africa, including children and adolescents, to dignity and the right of access to an environment that is not harmful to their health or well-being, and is sustainable and protected from pollution and degradation. Since 1994, South Africa has adopted normative frameworks governing chemicals and waste, including the National Environmental Management Act 107 of 1998; the National Environmental Management: Air Quality Act 39 of 2004; and the National Environmental Management: Waste Act 59 of 2008. Other measures in progress include the Climate Action Bill and efforts to ban certain hazardous pesticides, such as chlorpyrifos.[454] At the same time, there are outdated laws that still exist, resulting in harms and human rights infringements (e.g., the Hazardous Substance Act 15 of 1973 and the Fertilizers, Farm Feeds, Seeds and Remedies Act 36 of 1947, which allow for the import of hazardous pesticides that are banned in their country of origin). The result is the legalized poisoning of agricultural workers in the fields and neighbouring communities.[455] Despite efforts by the government to establish institutions and laws that address environmental racism (i.e., institutionalised discrimination based on race or colour), pervasive air, water, and chemical pollution still imposes a heavy toll, especially on disadvantaged communities.[456]



Air pollution related to the mining and burning of coal is also a public health concern in South Africa. Nearly 90 per cent of the country's electricity is generated from coal.[457] The mining and burning of coal are the largest contributors to South Africa's emissions of greenhouse gases and air pollution, which result in the release of pollutants that lead to respiratory and cardiovascular diseases. One study estimated that 2,239 human deaths in South Africa and more than 9,500 cases of bronchitis could be attributed to air pollution (i.e., tiny airborne particles) small enough to penetrate the lungs and pass into the bloodstream.[458] Dust and ash around coal mines also negatively affect air quality. The challenge in South Africa is that data on air pollution is lacking, and monitoring equipment is often non-functional. It is also notable that South Africa's National Air Quality Standards are far less protective than the air quality standards of the WHO, indicating a need for more stringent regulations.[459]

Exposure to hazardous chemicals is also a public health concern in South Africa. Hazardous chemicals and waste of concern include mercury, asbestos, polychlorinated biphenyls (PCBs), lead and pesticides.[460] There is a lack of data, however, on the environmental health risks facing South African children exposed to these hazardous chemicals. Lead is one known environmental health risk facing children in South Africa. In 2005, it was estimated that 20 per cent of houses in certain areas of the country may have been painted with lead-based paint.[461] Children living in

homes with lead-based paint may be exposed to lead in indoor dust and play areas. Lead exposure is associated with reductions in intelligence quotients (IQ), learning difficulties, poor school performance, and aggressive or violent behaviour later in life. In 2010, regulations to control the use of lead-based paints were introduced in South Africa, but there is a lack of certainty regarding the extent of compliance among paint manufacturers, and old lead-based paints applied to houses and schools remain a public health concern. Elevated lead levels have been found in paint applied to school buildings, playground equipment and children's toys.[462] In 2013, research also found that 74 per cent of children living in the country's fishing villages, where subsistence fishers regularly melt lead to craft fishing sinkers, had lead poisoning.[463] Without a national blood lead surveillance programme and lead poisoning prevention strategy, lead poisoning of children remains a public health concern in South Africa.[464]

BOX 5.1. African Climate Alliance et al. vs. Ministry of Mineral Resource & Energy et al. (#CancelCoal case)

On 10 November 2021, three South African NGOs – African Climate Alliance, Vukani Environmental Justice Movement in Action, and groundWork – initiated a constitutional challenge against the South African government's plans to augment its coal-fired electricity capacity (African Climate Alliance et al. vs. Minister of Mineral Resources & Energy et al., also known as the #CancelCoal case). The #CancelCoal case is a constitutional challenge against the South African government's plans to develop 1,500 megawatts of new coal-fired electricity generation.

They argue that the government's plans to develop new coal plants threaten not only the rights to an environment that is not harmful to the health or well-being of present and future generations in South Africa but also the rights to life, dignity, equality, and the best interests of the child. This is because the carbon dioxide emissions and pollution from coal-fired power pose unjustifiable harms and risks of harm to human health, the environment, and, importantly, our climate. Expert evidence supporting the case shows that South Africa does not need coal power to meet the country's electricity needs, now or in the future, and that it adds significant costs and emissions to South Africa's electricity system. South Africa's electricity needs can be met by available and less harmful renewable energy alternatives, which are also cheaper than the proposed new coal-fired power.

Noting that South Africa is one of the top 15 current global greenhouse gas emitters, the plaintiffs argue that the procurement of 1,500 megawatts of new coal-fired power stations threatens the rights of present and future generations in South Africa, who will be left to deal with the consequences of extreme weather events, heat waves, droughts, coastal flooding, famine, cyclones, and social upheavals. They also argue that the constitutional rights violations caused by the new coal plants will disproportionately impact the poor and vulnerable, including women, children, and young people.

SOURCE: Retrieved on 17 May 2024 from: Cancel Coal: Legal Challenge of Government's Plan for New Coal-fired Power Capacity – Centre for Environmental Rights (cer.org.za)

Children's exposure to pesticides in both urban and rural settings is a significant public health concern. Children's unique vulnerabilities to pesticides are well documented.[465] In South Africa, research has found that babies with birth defects are more likely to be born to women exposed to garden and agricultural pesticides, as well as to DDT indoor residual spraying (IRS), women engaged in livestock dipping for ticks, and those who re-use pesticide containers for collecting water.[466] In 2012, research found levels of DDT and DDE in the breast milk of South African women living in IRS areas for malaria were five times higher than the Food and Agricultural Organization's (FAO) defined allowable daily intake.[467] Accurate pesticide poisoning statistics for children are lacking in South Africa, despite pesticide poisoning being a notifiable medical condition.[468]

There is a significant lack of data and information related to the status of children's environmental health in South Africa. In addition, there are no clear national targets to mitigate environmental degradation and climate change, nor are there policies and programmes aimed at protecting children from the impacts already being felt. For instance, in May 2024, the South African

Parliament unanimously passed the Climate Change Bill, which sets ambitious goals to achieve the country's low-carbon and climate-resilient future. The Bill includes essential mitigation and adaptation measures against climate change, representing a major step forward for South Africa in putting into practice a strong national climate change response. While the Bill heralds a new era of accountability and engagement in the fight against climate change for businesses, it is unclear to what extent the health and future of children are being given primary consideration in environmental and health decision-making.

What is lacking, however, is a cohesive national agenda to ensure that the rights of children to a clean and safe environment are met. Thus, attention needs to be directed to a range of environmental health risks facing children in their home and school environments, particularly in settings of poverty where children are often exposed to multiple environmental health hazards.[469] In 2020, the South African Medical Research Council (SAMRC) reported that children in low-income communities face more risks from indoor air pollution, inadequate sanitation, and contaminated water, compared to those living in higher-income communities; this inequality illustrates that there are notable health disparities among South Africa's children, which impact their overall health and well-being.[470]

Mortality Attributed to Air Pollution

Drivers of air pollution are closely related to those of climate change. Approximately two billion children live in areas where air pollution levels exceed standards set by the WHO, causing them to breathe toxic air that is putting their health and potentially their brain development at risk. As part of a broader project to assess major risk factors to health, mortality resulting from exposure to household (indoor) air pollution[471] and ambient (outdoor) air pollution[472] is evaluated. Of all these pollutants, fine particulate matter has the greatest effect on human health due to its ability to penetrate the lungs and bloodstream, which can lead to cardiovascular and respiratory diseases, and have negative neurological effects on children. In 2018, the WHO reported that globally, exposure to fine particulate matter is responsible for an estimated 4.2 million deaths annually.[473]

Air pollution affects all regions of the world, but populations in low and middle-income urban areas are most impacted. According to the latest air quality database, 99 per cent of the world population lives in places where air pollution levels exceed WHO guideline limits.[474] More specifically, in 2019, it was reported that 97 per cent of cities in low and middle-income countries with more than 100,000 inhabitants do not meet WHO air quality guidelines; in high-income countries, this percentage decreases to 40 per cent.[475] Globally, poor air quality has been linked to morbidity, including premature deaths; as air quality declines, the risk of stroke, heart disease, lung cancer, and chronic and acute respiratory diseases, including asthma, increases for individuals.[476] Mortality attributed to household and ambient air pollution has costs for the healthcare system and results in economic loss.[477]

Table 5.3 shows that the mortality rate attributed to household and ambient air pollution was 75 per 100,000 population in South Africa, which was slightly lower than the average of 75 per 100,000 population for upper middle-income countries, and far lower than the average of 169 per 100,000 population for sub-Saharan Africa (excluding high-income countries).

TABLE 5.3. Mortality rate attributed to household and ambient air pollution (per 100,000 population), 2019

South Africa	75
Sub-Saharan Africa (excl. high income)	169
Upper middle-income countries	78

SOURCE: Retrieved on 6 March 2024 from: Mortality rate attributed to household and ambient air pollution, age-standardized (per 100,000 population) - South Africa | Data (worldbank.org)

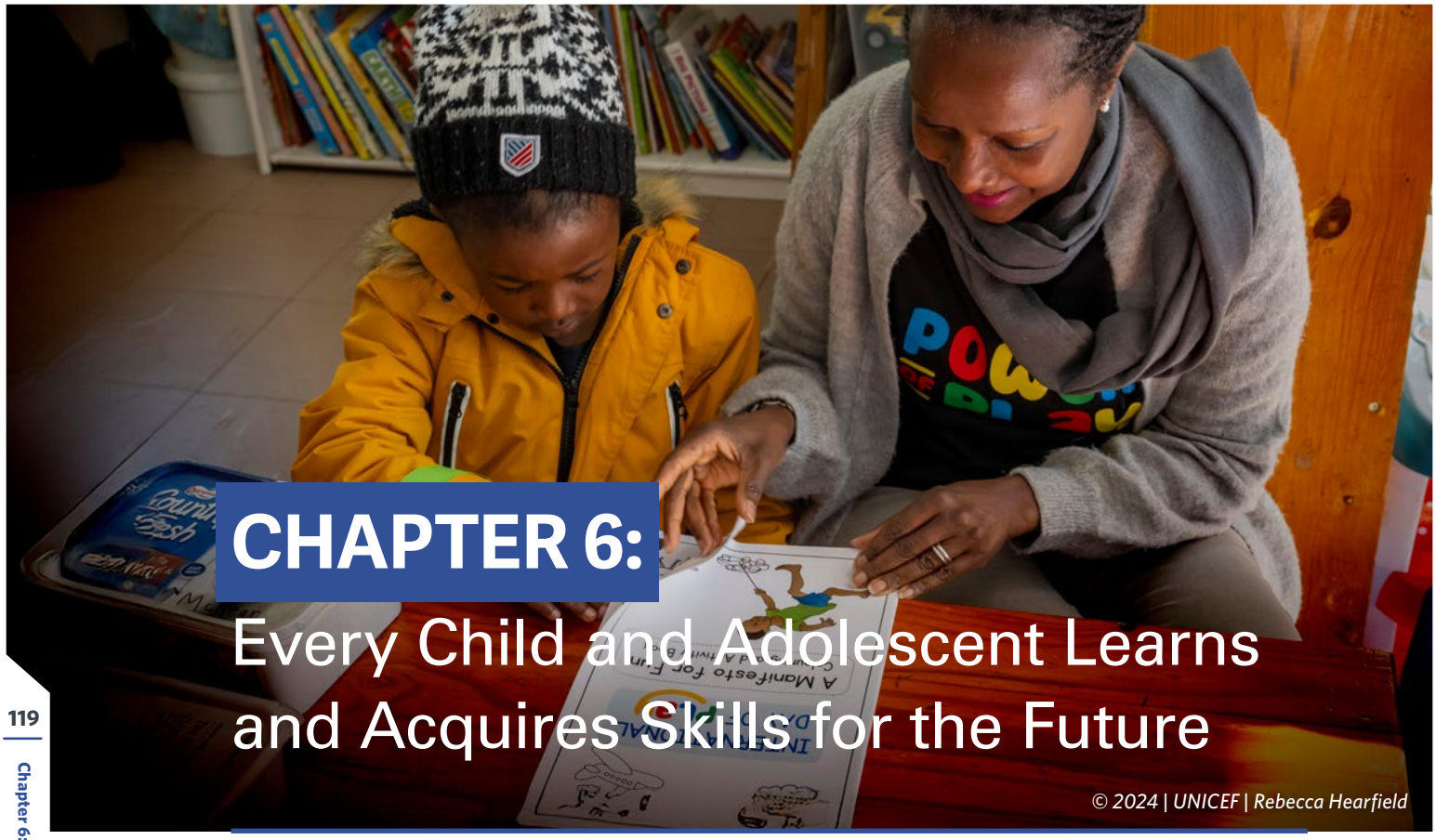
In 2021, it was estimated that more than 34,000 deaths in South Africa were linked to air pollution-related causes across all ages. More specifically, in 2021, air pollution accounted for some 3,365

deaths of children under five, of which 80 per cent occurred within 28 days of birth, with ambient particulate matter, primarily from vehicle fumes, coal-burning power plants, and industrial activities, being the main contributor.[478] The health effects of exposure to air pollution include premature birth, low birth weight, asthma, and lung diseases, all of which can be especially deadly for newborns and young children. Given these numbers, South Africa has the eighth largest number of children dying before their fifth birthdays from ambient particulate matter, with fossil fuel combustion being a key contributor.[479] Beyond these deaths, many more children and people live with debilitating chronic diseases, putting tremendous strain on healthcare systems, economies, and society at large.[480]

Summary of Data Gaps

This chapter focused on data related to every child and adolescent's right to live in a safe and clean environment. It revealed data gaps, including:

- Data and information are lacking regarding the availability of safely managed WASH and WASH-related infrastructure in early learning centres, schools, and health facilities.[481]
- Data and information are needed on the steps being taken to ensure that new and existing WASH systems are resilient to climate change and the growing threat of water scarcity.
- Data and information are needed on the number of schools and health facilities whose services are disrupted due to disasters, as well as the nature and extent to which WASH facilities at schools and health facilities are at risk, particularly due to climate-related events and disasters.
- Data and information on the impacts of air pollution and hazardous chemicals on children and adolescents in South Africa are also needed.



CHAPTER 6:
Every Child and Adolescent Learns and Acquires Skills for the Future

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"All children and adolescents need access to quality education and learning that develops the skills, knowledge, attitudes and values that will enable them to navigate a complex world and succeed in school, work and life. Secondary education has the potential to be a key platform for adolescents to enter the world of work, start a business and have a positive impact in their communities, but only if they have the skills needed to break cycles of intergenerational poverty. Education and skills development can contribute to broad-based economic and social growth by equipping children and adolescents with the tools for lifelong learning, allowing them to fully participate in society and the economy."[482]

Education is a key determinant of individual and social mobility and an effective remedy for unemployment and chronic poverty.[483] Prior to the COVID-19 pandemic, the world was already facing a learning crisis; however, the pandemic brought education systems across the world to a halt, with school closures affecting more than 1.6 billion learners at their peak, including 167 million young children who lost access to early childhood education (ECE).[484] Globally, it was estimated that nearly 147 million children missed more than half of their in-person schooling from 2020 to 2022, and many, especially the most vulnerable, were at risk of dropping out of school. Even when children remained in school, the amount of learning time lost due to the pandemic resulted in what UNICEF described as "a desperately poor level of learning" in 32 low-income countries. Even where schools tried to keep teaching using remote learning, the socio-economic divide was perpetuated.[485]

With the adoption of the SDGs, the GoSA committed to achieving SDG 4, to ensure inclusive and equitable quality education and promote lifelong learning opportunities for all, along with its ten related targets, including ensuring by 2030 that: all girls and boys complete free, equitable and quality primary and secondary education leading to relevant and effective learning outcomes (SDG 4.1); all girls and boys have access to quality early childhood development (ECD), care and pre-primary education so that they are ready for primary education (SDG 4.2); equal access for all women and men to affordable and quality technical, vocational and tertiary education, including university (SDG 4.3); increased numbers of youth and adults who have relevant skills, including technical and vocational skills, for employment, decent jobs

and entrepreneurship (SDG 4.4); and more. South Africa has also committed to the goals and targets of the Continental Education Strategy for Africa, which are aligned with SDG 4. Quality education is crucial for securing a successful transition to work, yet there are still significant deficits in the education system in South Africa that translate into poor learning outcomes for children and adolescents.

Educational System in South Africa

The 1996 Constitution guarantees the right of all South Africans to a basic education (Grades 1-9) and binds the GoSA to progressively improve access to further education and training (Grades 10-12). The South African Schools Act 84 of 1996 establishes the legal foundation for schools and makes schooling compulsory for all learners aged 7-15 years. In 2022, both the National Education Policy Act 27 of 1996 and the South African Schools Act 84 of 1996 were amended to improve the national curriculum related to Grade R and Grades 1-12. Other key pieces of legislation related to education have also been enacted.[486]

In 2020, the GoSA adopted a National Action Plan to 2024 towards the realisation of Schooling 2030[487] and the Department of Basic Education Strategic Plan 2020-2025,[488] which outlines ongoing priorities and strategies for the education sector to provide quality basic education for all. These plans complement other education policies related to access to schools, school management, school funding, and curriculum and assessment.[489]

The National Development Plan (NDP) 2030 also envisions that the education system provides high-quality education, including universal early childhood education (ECE), with globally competitive literacy and numeracy standards, along with further and higher education and training that enables all children and young people to achieve their full potential.[490] This includes high-quality education for learners with special educational needs or disabilities. The NDP 2030 also identifies adult basic education, training, and skills development as a priority for building national capabilities in the country.

South Africa's basic educational system is managed, regulated, and financed by two national departments:

- Basic education is provided by the DBE and nine provincial Departments of Education (DoEs). The DBE is mandated by law to develop and monitor national standards for the provision, delivery, and performance of basic education, including early learning and Grades R to 12, while the nine DoEs are responsible for implementing and funding basic education.[491]
- The Department of Higher Education and Training (DHET) is mandated to provide a unified national system of post-secondary education and training, including higher education and vocational training institutions, adult basic education and training, and further education and training colleges.[492]

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TABLE 6.1. Structure of South Africa's basic education system

Age	0	1	2	3	4	5	6	7[746]	8	9	10	11	12	13	14	15	16	17	18
Type	**Preschool**						**Primary school**								**Secondary school**				
Grade	Early learning programmes						R	1	2	3	4	5	6	7	8	9	10	11	12
Law	Non-compulsory						Compulsory										Further Education and Training		
Structure	Early Learning						Foundation Phase				Intermediate Phase			Senior Phase					
	Includes children with special early learning needs, but not systemically in all early learning programmes						Special needs education												

Table 6.1 shows that South Africa's formal educational system consists of:

- One year of non-compulsory preschool (Grade R) for children aged 5 years or older, as prescribed
- Eight years of compulsory primary (basic) education for children aged 6-13 years (Grades 1-7)
  - Four years of foundational phase education for children aged 6-9 years (Grade R and Grades 1-3)
  - Three years of intermediate phase education for children aged 10-12 years (Grades 4-6)
  - One year of senior phase education for children aged 13 years (Grade 7)
- Two years of compulsory lower secondary education (high school) for children aged 14-15 years (Grades 8-9)
- Three years of upper secondary education (high school), further education, and training for adolescents aged 16-18 years (Grades 10-12)
- The National Senior Certificate (NSC) examination signifies the culmination of 12 years of formal schooling
- Four years of post-secondary or higher (superior) education for youth aged 18-24 years

Special needs education for children with special educational needs (SENs) that cannot be accommodated in ordinary public schools.

Over the past three decades, there have been improvements in the country's basic education system, at times with the support of development partners.[493] For instance, in 2023, the World Bank and South Africa's DBE jointly launched the Public Expenditure and Institutional Review for Early Childhood Development (ECD-PEIR).[494] The purpose of ECD-PEIR is to inform planning and programming to ensure that all young children in South Africa receive a comprehensive package of integrated ECD services to build the foundations to thrive later in life. Thus, ECD-PEIR focuses on opportunities to increase and improve public investment and expenditure in ECD, including further expansion and quality improvements to ECD services, as well as strengthening inter-departmental and cross-government collaboration to ensure improved delivery of ECD services.[495] ECD-PEIR is grounded in the recognition that investment in ECD is one of the most important tools available to ensure that children benefit from formal schooling, improve academic performance, decrease the probability of premature school dropout, and, later in life, lead to improved health, social and economic outcomes, as well as help reduce intergenerational transmission of poverty.[496]

In 2023, recognising the need for greater coordination, cooperation, and collaboration around ECD, the DBE announced South Africa's 2030 Strategy for ECD Programmes. This 2030 Strategy for ECD Programmes serves as a roadmap for achieving universal access to ECD, including two years of quality preschool, by 2030, as set forth in the NDP 2030. Ultimately, the 2030 Strategy for ECD Programmes provides the basis for a new social compact between all ECD role-players, ensuring that efforts and resources are aligned behind a common strategy informed by the DBE's six social justice principles: access, redress, equity, quality, inclusivity, and efficiency.[497]

Beyond ECD, the DBE has focused on other educational reforms, such as curriculum strengthening and reading and language policies (referred to as the Three Stream Model). The Stream Model defines three separate curriculum streams for learners, including an academic stream, a technical

stream and an occupational stream.[498] The focus on curriculum strengthening includes incorporating subject-based competencies into the national curriculum. To determine which subject-based competencies should be stipulated and at what levels of education, the DBE developed a National Competency Framework, which was approved by the Council of Ministers in 2023.[499] In addition, the DBE's Reading Literacy Strategy for 2023-2030 states that the Reading Policy aims to address the national reading crisis by enabling a literacy policy environment that is age-appropriate and culturally relevant, with agile teachers and parental and community involvement. Among the shifts is support for extending the use of mother tongue-based bilingual education in all schools by 2025, which will enable the home language of learners beyond Grade 3 to be used for all subjects up until Grade 6.[500]

Building upon the progress made, the DBE aims to continue providing permanent solutions to the architecture of the education and training systems in the country. In 2024/25, the continued focus is on:[501]

- Improving foundational skills of numeracy and literacy, especially reading
- Immediate implementation of a curriculum with skills and competencies and standardised assessments to reduce failure, repetition and dropout rates, and introduce multiple qualifications, such as the General Education Certificate (GED) before the Grade 12 exit qualifications
- Urgent implementation of two years of ECD before Grade 1, and support for the transfer of the responsibility for children aged 0 to 4 years from the DSD to the DBE
- Completing an integrated Infrastructure Development Plan, informed by infrastructure delivery and regular maintenance, which is resource-based
- Working with the Department of Sport and Recreation, Arts and Culture (DSRAC), DoH and the South African Police Services (SAPS) to teach and promote social cohesion, health, psychosocial support, and school safety.

In 2024/25, the DBE also plans to continue initiating Mother Tongue-Based Bilingual Education (MTBBE) for African languages to be utilised as languages of learning and teaching beyond Grade 3, entering the space previously enjoyed by English and Afrikaans. The DBE firmly believes that through the MTBBE, learning outcomes will improve as learners learn best in their home languages.[502]

For data and information related to education public expenditures, see Chapter 3, Public Finance for Children and Adolescents, Education Public Expenditures.

Access to Education

Access to quality education is one of the most effective interventions to empower children, adolescents, and youth, ensuring they have the knowledge and skills needed to function in and contribute to society. Access to education has broad effects on children's learning and skills development, health and well-being, civic engagement, and protection from hazardous and exploitative practices. Access to quality education is a vital prerequisite for combating poverty.[503]

South Africa's education system, however, faces a number of challenges in providing quality education, such as:

- Weak learning outcomes, despite relatively high levels of public spending on education.
- A shortage of teachers, especially qualified teachers, at all levels (an estimated 428,000 educators are needed by 2030).
- Low retention rates at the upper secondary school level.
- Although enrolment at the secondary level has been expanding, there are learning deficits in secondary education, which make transitioning from secondary to tertiary education difficult.
- Enrolment in tertiary education is lagging.
- While lack of funding may not be the primary cause of poor performance, the distribution of resources may not be equal or efficient.
- Historical factors explain a significant part of the current status quo (e.g., population groups that the

apartheid government denied quality education are the groups that have the poorest educational outcomes).

In 2019, the IMF documented that progress had been made in improving the poorest and lowest performing schools, but there was still a need for further improvement, as 80 per cent of South Africa's poorly performing schools were in townships and rural communities. Management in these schools tends to have limited capacity, and teachers from these schools tend to have lower subject content knowledge, with few systems holding them accountable. This challenge is further exacerbated by the political influence that teacher unions have in the education system.[504]

BOX 6.1. South African court hands down judgement on undocumented children's rights to a basic education

In December 2019, a Division of South Africa's High Court handed down a ground-breaking judgement upholding the right to education of undocumented children. The case was brought by the Centre for Child Law, the Legal Resources Centre, and 37 affected children. In this ruling, the Court confirmed that everyone has the right to basic education, regardless of their status or ability to provide proof of identity through the production of a birth certificate or other official documentation. It is within this context that the Court scrutinized Clauses 15 and 21 of the Admission Policy and found that these clauses unjustifiably limit numerous constitutional rights, including the right to equality and dignity, the right of children to have their best interests considered, and the right to basic education, by excluding undocumented learners from public schools. As a result, Clauses 15 and 21 were declared unconstitutional. It was further held that these clauses were not justifiable limitations under Section 36 of the Constitution because constitutional rights may only be limited by law of general application. The Admission Policy is not a law of general application, but merely a policy, and accordingly incapable of sanctioning the limitation of any right contained in the Bill of Rights.

The Court noted that all children have their own dignity and are individuals with distinctive personalities not reliant on or measured in the light of the actions of their parents/guardians; therefore, learners (many of whom have no choice in being brought to South Africa or who have been abandoned by parents and left in the care of others) should not have to bear the negative consequences of their parents' actions of either entering the country illegally, failing to obtain their own documentation, or perhaps failing to apply to have their children documented.

The Court adopted the SAHRC's suggested approach to interpreting Sections 39 and 42 of the Immigration Act 13 of 2002. It found that when properly interpreted through the prism of the Bill of Rights, as is required by Section 39(2) of the Constitution, the reference to 'learning institution' and 'training' in Section 39 of the Immigration Act should be construed not to include the provision of basic education by schools to children. Such an interpretation was consistent with Section 29 and Section 28(2) of the Constitution and international conventions. Considering this interpretation, it accordingly found it unnecessary to declare these provisions to be unconstitutional.

The Court also held that the decision not to fund undocumented learners was unconstitutional. The State was directed to admit all children not in possession of an official birth certificate into public schools in the Eastern Cape and where a learner is unable to provide a birth certificate, the principal of the relevant school is directed to accept alternative proof of identity (i.e., an affidavit or sworn statement deposed to by the learner's guardian/parent/care-giver that fully identifies them). It further interdicted/restrained the State from removing or excluding children from schools (including illegal foreign children already admitted) for the sole reason of not being in possession of an identity document/number, permit or passport or if they are unable to produce any identity documentation. This landmark judgment provided much needed protection to millions of undocumented and vulnerable children in South Africa.

SOURCE: Retrieved on 22 May 2024 from: South African court hands down ground-breaking judgment on undocumented children's right to a basic education | International Bar Association (ibanet.org)

During the COVID-19 pandemic, school closures caused more than just disruption to education and significant learning losses, as nearly 370 million children in 150 countries missed out on school meals. In South Africa, school closures and strict lockdown measures interrupted the learning of an estimated 17 million learners from pre-school to secondary school, alongside 2.3 million students enrolled in post-school education and training.[505] Recognising the impact of the COVID-19 pandemic on children, adolescents, and youth—particularly the most vulnerable and disadvantaged—the DBE developed new educational policies and regulations (e.g., Learning Recovery Programme), trimmed the curriculum, adjusted the academic timetable, and implemented new teaching programmes and modes of delivery, catch-up curriculum, health and safety measures, and financial relief packages. Such efforts, however, did not guarantee that children, adolescents, and youth participated in instruction equally.[506]

After nearly two years of school closures, schools reopened in January 2022, but children attended school in rotational shifts, meaning they only attended school on certain days. This had both short- and long-term consequences for children, as pandemic-related learning disruptions took a huge toll on South Africa's students. Data from UNICEF and UNESCO showed that school children in South Africa were between 75 per cent to a full school year behind where they should have been, and 400,000 to 500,000 students dropped out of school between March 2020 and July 2021.[507]

Globally, and in South Africa, the COVID-19 pandemic exposed the vulnerabilities and inequities that exist in the education system. The GoSA has recognised that unequal access to education, which was further underscored by the COVID-19 pandemic, risked magnifying deep inequalities in access to quality learning for all children and adolescents and amplifies the effects of poverty with significant intergenerational implications for vulnerable families.[508] The COVID-19 pandemic further highlighted the importance of administrative processes and protocols, including those needed to ensure flexibility in teaching and learning disruptions. The GoSA recognised that accountability within the schooling system needs to be strengthened to ensure learning improves within the context of a pandemic.[509]

Number of Schools

In 2023, there are a total of 24,871 schools in South Africa, of which 90.6 per cent are public and 9.4 per cent are independent. KwaZulu-Natal (24.2 per cent) and Eastern Cape (21.3 per cent) have the largest proportion of schools compared to Free State (4.1 per cent) and Northern Cape (2.4 per cent; see Annex Table 9).

In 2021, there was also a total of 42,420 early learning programmes, of which 60 per cent were in urban areas and 40 per cent in rural areas, including 24 per cent in Gauteng and 19 per cent in KwaZulu-Natal.[510]

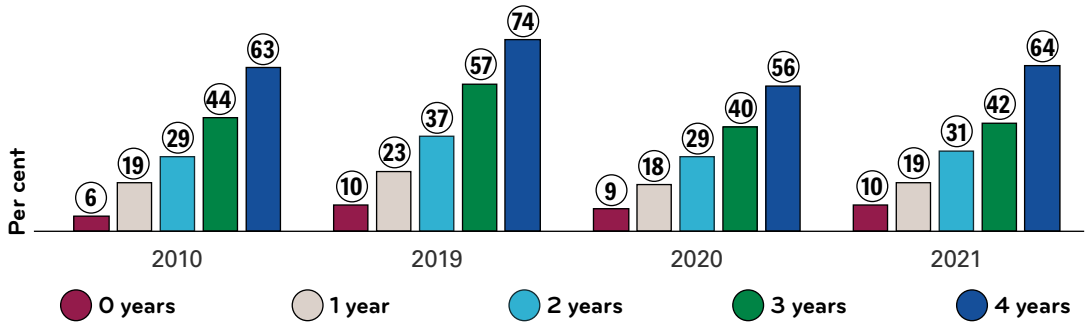
Pre-Primary School Enrolment

Investing in expanding access to quality early learning programmes is a core strategy to improve learning outcomes.[511] In 2015, ECD became part of SDG 4, which aims to ensure inclusive and equitable quality education and promote lifelong learning opportunities for all. In particular, SDG Target 4.2 aims to, 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. SDG Target 4.2 includes two key indicators: the proportion of children aged 24–59 months who are developmentally on track in health, learning, and psychosocial well-being, by sex (4.2.1); and the participation rate in organised learning, one year before the official primary entry age, by sex (4.2.2).

The GoSA has prioritised ECD and developed ECD-related policies. In April 2022, the DBE took over the ECD function from the DSD, including funding for early learning programmes and infrastructure support for ECE providers, as well as piloting the construction of low-cost ECD centres.[512]

Chart 6.1 shows that the proportion of children aged 0–4 years who attended ECD facilities increased from 2010 to 2019, followed by subsequent declines in 2020 and 2021 during the COVID-19 pandemic.

CHART 6.1. Children ages 0-4 years who attended ECD facilities (%), 2010-2021

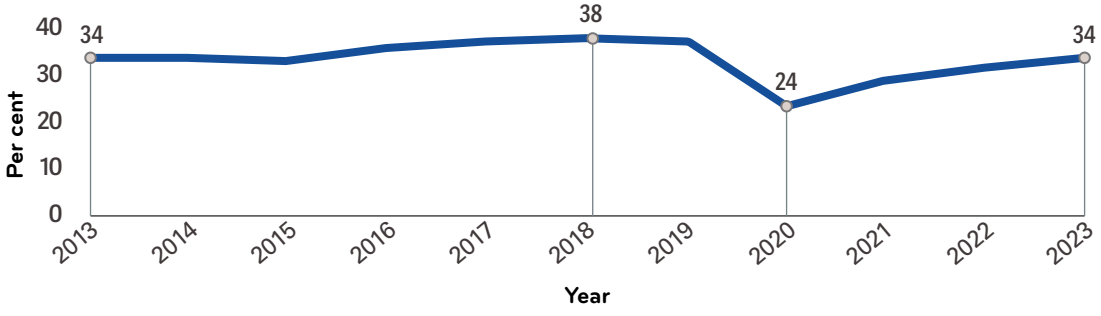


SOURCE: Department of Basic Education Annual Performance Plan 2024/25. Department of Basic Education: Pretoria, South Africa.

Pre-primary school is considered the formal Grade R for children aged 5-6 years; however, some children also attend early learning programmes prior to Grade R, mostly in community-based sites.[513] In 2022, it was estimated that 2.9 million children from birth to 6 years of age accessed early learning programmes, including Grade R.[514] That same year, it was estimated that 88 per cent of children in Grade 1 participated in Grade R in the year before entering Grade 1.[515] In 2023, 34 per cent of children up to 4 years old accessed early learning programmes provided through a crèche, educare centre, pre-school, nursery school, Grade R, or similar.[516]

More recently, the 2023 GHS revealed that 34 per cent of children aged 0-4 years attended an ECD programme (i.e., including ECD centres, pre-schools, nursery schools, crèches, educare centres, and Grade R). It is notable that in 2019, prior to the COVID-19 pandemic, 37 per cent of children aged 0-4 years attended an ECD programme, but this fell to 24 per cent in 2022 during the COVID-19 pandemic. There has been a steady increase in the proportion of children attending an ECD programme; however, the proportion has not yet returned to pre-pandemic levels (**Chart 6.2**).[517]

CHART 6.2. Children aged 0-4 years in an ECD programme (%), 2013-2023

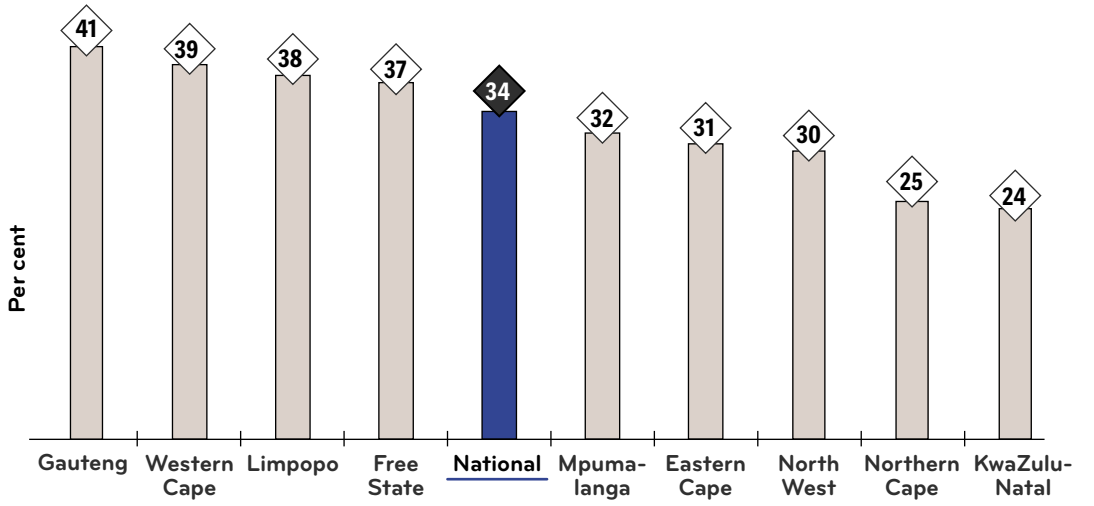


SOURCE: 20213-2023 GHS

More specifically, **Chart 6.3** shows that in 2023, children aged 0-4 years in Gauteng (41 per cent), Western Cape (39 per cent), Limpopo (38 per cent), and Free State (37 per cent) were more likely to attend an ECD programme, whereas children in Northern Cape (25 per cent) and KwaZulu-Natal (24 per cent) were least likely to attend an ECD programme in 2023.

It is also notable that in 2023, 25,545 children were enrolled in Grade R (although Grade R is not compulsory), of which 50.5 per cent were female and 49.5 per cent were male.[518] However, these data are not meaningful, as they do not reflect the gross or net enrolment rates for children aged 5-6 in Grade R.

CHART 6.3. Children aged 0-4-years in an ECD programme by province (%), 2023



SOURCE: 2023 GHS

Early Childhood Development

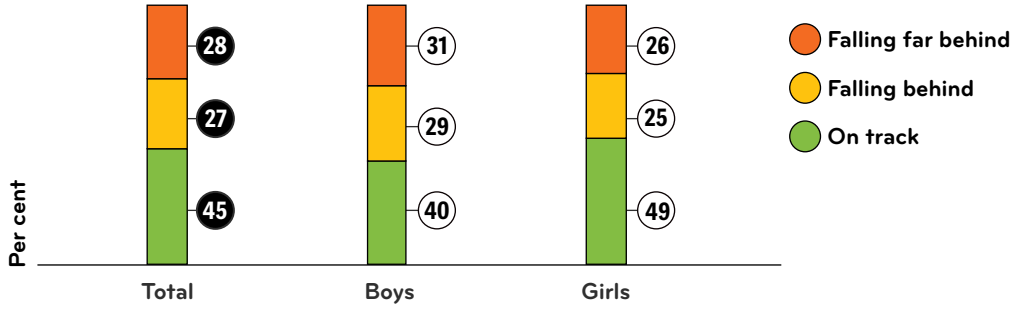
Early childhood is the most crucial period for children's holistic development, given the profound, lifelong impact of early experiences on children's future learning, health, and earning potential.[519] Nurturing care – nutrition, health, protection, early learning, and responsive caregiving – is essential for all children, especially within the first four years of a child's life, to achieve their full developmental potential.

The COVID-19 pandemic caused disruptions to early childhood services, as children were confined to their homes without normal access to play, learning, health and nutrition.[520] The pandemic highlighted a crisis of care and early learning for children under five, especially where childcare and early learning services were disrupted. The pandemic also compounded pre-existing inequalities and exclusion, as the most disadvantaged parents/caregivers and children struggled to cope.[521] For many parents, the added responsibilities of childcare and learning for children led to increased social, emotional and economic stressors, which may have impacted their mental health and well-being, in turn affecting their ability to provide nurturing and responsive care for their young children.[522]

UNICEF recognises that ECD has many dimensions and unfolds at a 'breathtaking pace'; thus, measuring ECD in the early years is a complex undertaking and a specialised field of study, but it is crucial to understanding children's development to their full potential.[523] The Early Childhood Development Index (ECDI) 2030 was designed to capture the achievements of key developmental milestones among children aged 2-4 years and addresses the need for nationally representative and internationally comparable data on ECD.[524] South Africa has yet to implement the ECDI 2030, but the Thrive by Five Index 2021 is used to monitor trends over time in the proportion of children aged 4-5 years who attend early learning programmes and are on track for their age in key areas of development. This is the largest survey of preschool child outcomes ever attempted in South Africa. The Thrive by Five Index provides population-level data on how well preschool children in South Africa (aged 50-59 months) are doing in three developmental domains known to be associated with long-term outcomes: early learning, physical growth, and social-emotional functioning.[525]

In 2022, the Thrive by Five Index 2021 revealed that only 43 per cent of children aged 4-5 enrolled in early learning programmes in South Africa were on track to thrive by five, particularly in the areas of physical growth and early learning. Conversely, 57 per cent of children enrolled in early learning programmes failed to thrive by five (53 per cent of children faced barriers to thriving in only one of either physical growth or early learning, and 4 per cent faced significant barriers to thriving and were at high risk of falling short in both physical growth and early learning).[526] It is important to note that these data do not reflect children who are not enrolled in early learning programmes.

CHART 6.4. Learning Total Scores for children (aged 4-5) enrolled in early learning programmes by sex (%), 2022

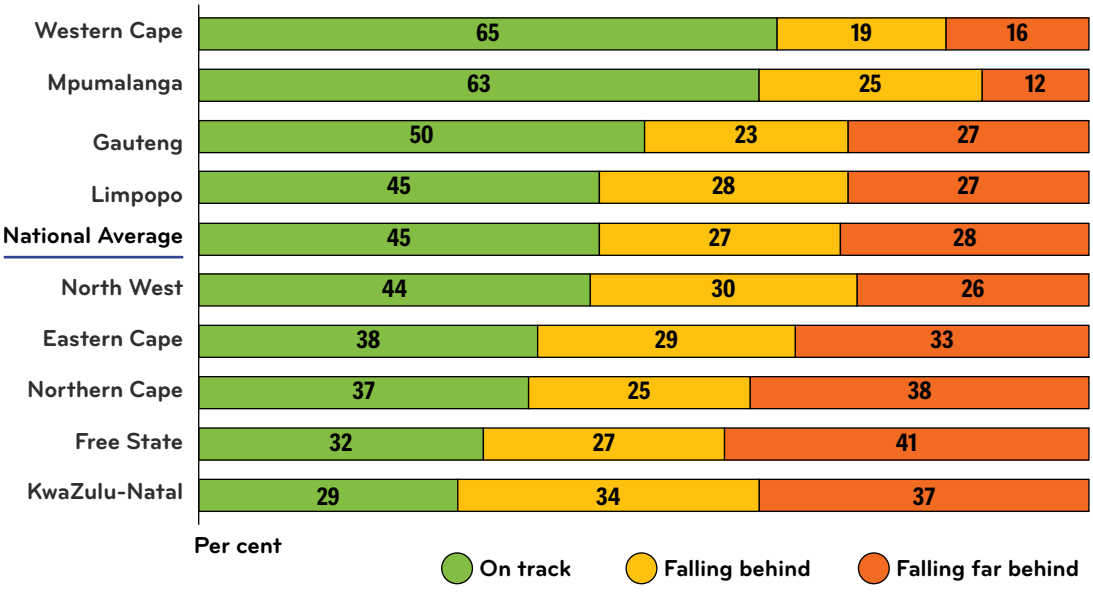


SOURCE: Giese et al. (2022). Thrive by Five Index Report Revised August 2022. Innovative Edge: Cape Town, South Africa.

Chart 6.4 shows that only 45 per cent of children aged 4-5 years who were enrolled in early learning programmes were on track for the Learning Total Score, whereas 27 per cent were falling behind and 28 per cent were falling far behind. The Learning Total Score combines all five of the learning domains that were assessed, including gross motor development; fine motor coordination and visual motor integration; emergent numeracy and mathematics; cognition and executive functioning; and emergent literacy and language. These particular domains were selected because performance in these areas is known to be associated with longer-term outcomes. There are notable sex differences: girls (49 per cent) were more likely to be on track for the Learning Total Score compared to boys (40 per cent), whereas boys were more likely to be falling behind (29 per cent) and falling far behind (31 per cent) compared to girls (25 per cent and 26 per cent respectively).

Chart 6.5 shows that there are provincial differences in attendance in early learning programmes in terms of the Learning Total Score. Children aged 4-5 who were enrolled in early learning programmes in the Western Cape and Mpumalanga (65 per cent and 63 per cent) were most likely to be on track for learning totals related to the five learning domains, whereas children in the Free State and KwaZulu-Natal were least likely to be on track for learning totals. It is notable that the Northwest (44 per cent), Eastern Cape (38 per cent), and Northern Cape (37 per cent) are also below the national average of 45 per cent for being on track for learning totals. These data also reveal that children in the Free State (41 per cent), Northern Cape (38 per cent), and KwaZulu-Natal (37 per cent) are most likely to be falling far behind.

CHART 6.5. Learning Total Scores for children (aged 4-5) enrolled in early learning programmes by region (%), 2022

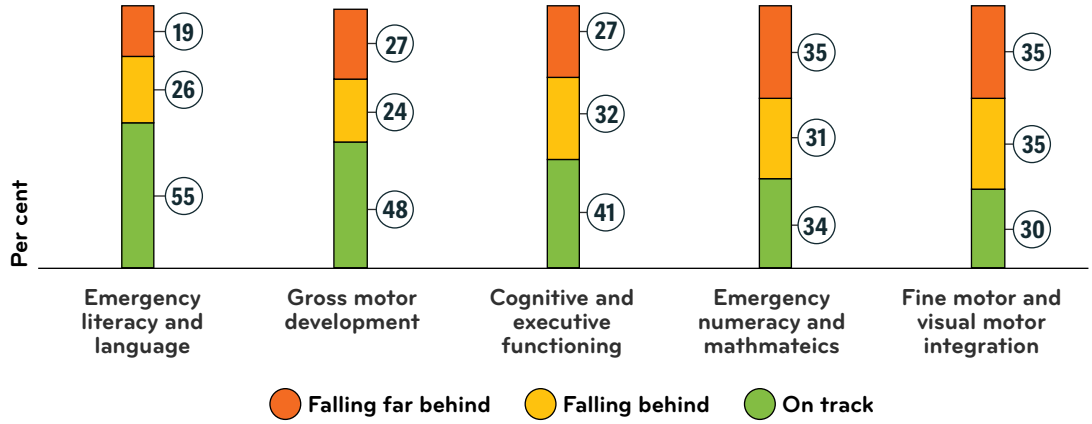


SOURCE: Giese et al. (2022). Thrive by Five Index Report Revised August 2022. Innovative Edge: Cape Town, South Africa.

Finally, **Chart 6.6** shows the proportion of children on track, falling behind and falling far behind by learning domain. These data show that 55 per cent of children aged 4-5 who were enrolled in early learning programmes were most likely to be on track with emergent literacy and language, followed by gross motor development (48 per cent), cognitive and executive functioning (41 per cent); and least likely to be on track with emergent numeracy and mathematics (34 per cent), and fine motor and visual motor integration (30 per cent).

The most notable sex differences are that girls are far more likely to be on track with cognitive and executive functioning (44 per cent) and fine motor coordination and visual motor integration (35 per cent), compared to boys (39 per cent and 26 per cent respectively). Additionally, girls are more likely to be on track with literacy and language (57 per cent), and numeracy and mathematics (36 per cent), compared to boys (52 per cent and 32 per cent respectively). There were no notable differences between boys (49 per cent) and girls (48 per cent) when it comes to being on track for gross motor development.[527]

CHART 6.6. Children (aged 4-5) in early learning programmes by learning domain (%), 2022



SOURCE: Giese et al. (2022). Thrive by Five Index Report Revised August 2022. Innovative Edge: Cape Town, South Africa.

In recognition of the importance of early years for human development and the need to invest resources to support and promote optimal child development, in 2015, the GoSA adopted a National Integrated ECD Policy.[528] This Policy is aimed at transforming ECD service delivery in South Africa, with a focus on addressing critical gaps to ensure the provision of comprehensive, universally available, and equitable ECD services. The Policy covers the period from conception until the year before children enter formal school, or in the case of children with developmental difficulties or disabilities, covers until the year before they turn seven years old, which marks the age of compulsory schooling or special education.[529]

In general, the purpose of the National Integrated ECD Policy is to: provide an overarching, multi-sectoral enabling framework of ECD services aimed at the survival, protection, and development of young children; define a national comprehensive ECD programme and support, with identified essential components; identify relevant players and their roles and responsibilities for the provision of the various components of ECD services; and establish a national integrated ECD leadership and coordinating structure. The Government has also prioritised ECD in the National Development Plan 2030.[530]

The challenge, however, is that the ECD sector is underfunded, with only 5 per cent of national expenditures or 1.5 per cent of GDP allocated to ECD. Using this information, the DBE is developing a new service delivery model for early learning to achieve the government's vision of universal access to quality early learning and development while prioritising the most vulnerable children.[531] The DBE also aims to enhance the efficiency of resource allocation and increase funding to early learning programmes for children from birth to five years old. To further improve access to early learning opportunities, the DBE aims to streamline the requirements of early learning programmes to access

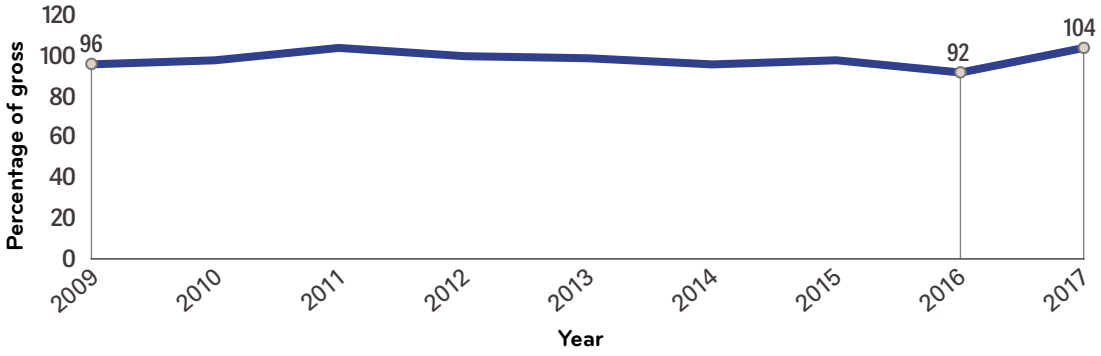
subsidies, and the DBE has partnered with the Presidency's Red Tape Reduction team to identify areas for streamlining registration processes and enable greater collaboration with local governments.[532]

It is also notable that early learning programmes are not attached to schools (public or independent), but are operated primarily by non-governmental entities, which include both for-profit and not-for-profit providers, and these are regulated by the Children's Act 38 of 2005.[533]

Primary School Enrolment

Primary education includes seven years of education for children aged 6-13 (Grades 1-7). **Chart 6.7** shows gross intake rates (GIR) for 2000-2020. The GIR reflects the general level of access to primary education and the capacity of the education system to provide access to grade 1 for the official school entrance age population. There was an increase in the GIR from 96 per cent in 2009 to 104 per cent in 2011, after which it declined to 92 per cent in 2016, then increased to 104 per cent in 2017. Data were not available for 2018-2023. Because the GIR includes students of all ages, including those whose age exceeds the official age group, the GIR can exceed the population of the age group that officially corresponds to the age at which children enter grade 1.

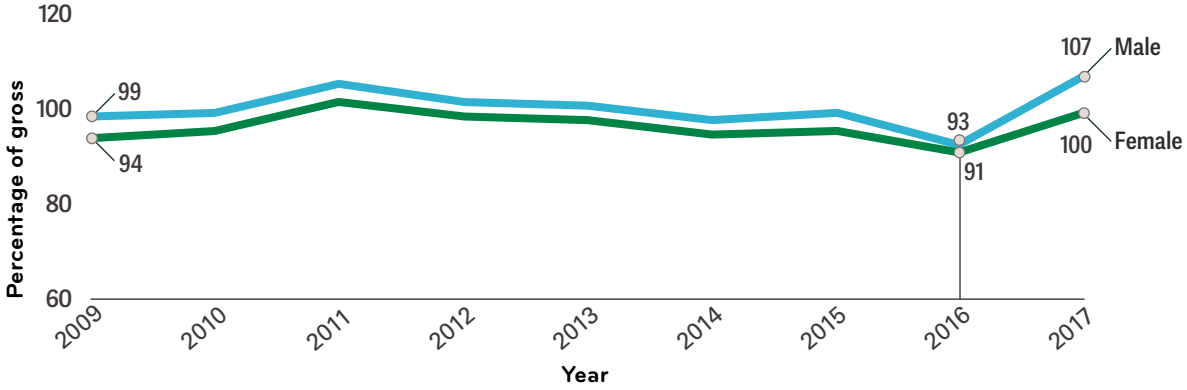
CHART 6.7. GIR for primary education (%), 2009-2017



SOURCE: Retrieved on 18 March 2024 from: Gross intake ratio in first grade of primary education, total (% of relevant age group) - South Africa | Data (worldbank.org)

Chart 6.8 shows sex differences in GIRs for primary education from 2009 to 2017. Over time, boys have had a slightly higher GIR for primary education than girls; however, in 2017, the gender gap widened to the point that boys (107 per cent) had a GIR that was 7 percentage points higher than girls (100 per cent). This finding may be linked to the fact that boys are more likely to enter primary education a year or two late (one to two years older than the typical primary education intake age). It will be important to analyse this trend from 2018 to 2023 and to monitor it further to determine if this gender gap continues to exist or grows larger.

CHART 6.8. GIR for primary education by sex (%), 2009-2017



SOURCE: Retrieved on 18 March 2024 from: Gross intake ratio in first grade of primary education, male (% of relevant age group) - South Africa | Data (worldbank.org) and Gross intake ratio in first grade of primary education, female (% of relevant age group) - South Africa | Data (worldbank.org)

Compared to the GIR, the net intake rate (NIR) is the proportion of new entrants to the first grade of primary education who are of the official primary school entrance age, expressed as a percentage of the population of that age. **Table 6.4** shows that in 2017, the NIR for primary education was only 40 per cent, including 43 per cent for boys and 38 per cent for girls. It is notable that the NIR is significantly lower than the GIR, by 64 percentage points. Since the NIR excludes overage and underage students, it more accurately captures the education system's coverage and internal efficiency than the GIR; nevertheless, it is useful to examine the differences between the GIR and NIR for understanding the incidence of overage and underage access to grade 1. Both the GIR and NIR are important to policymakers and planners because they specify the degree of accessibility to primary education.

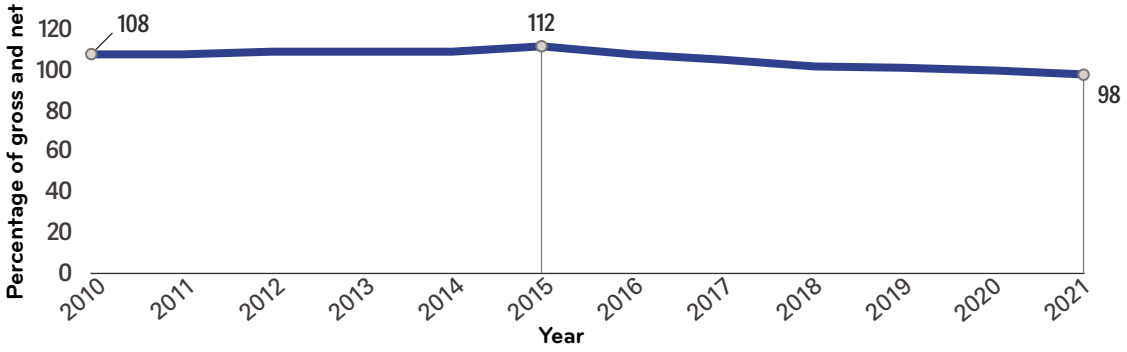
TABLE 6.4. GIR and NIR for primary education by sex (%), 2017

	GIR	NIR
Total	104	40
Male	107	43
Female	100	38

Note: Data are not available for 2006-2016 or 2018-2023. **SOURCE:** Retrieved on 18 March 2024 from: Net intake rate in grade 1 (% of official school-age population) - South Africa | Data (worldbank.org); Net intake rate in grade 1, male (% of official school-age population) - South Africa | Data (worldbank.org) and Net intake rate in grade 1, female (% of official school-age population) - South Africa | Data (worldbank.org)

Chart 6.9 shows the GER for primary education from 2010 to 2021. There was an increase in the GER for primary school-age children from 108 per cent in 2010 to 112 per cent in 2015, but this was followed by a steady decrease to 98 per cent in 2021.

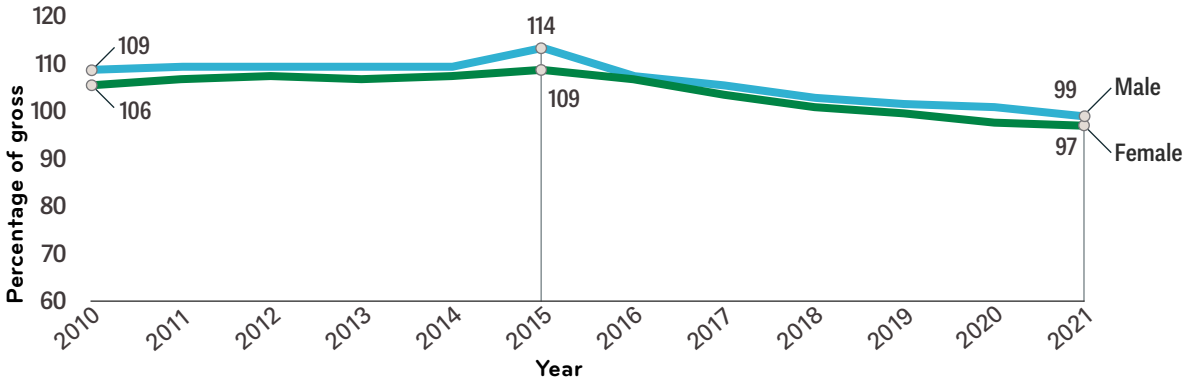
CHART 6.9. GER for primary education (%), 2010-2021



SOURCE: Retrieved on 18 March 2024 from: School enrolment, primary (% gross) - South Africa | Data (worldbank.org)

Chart 6.10 shows that the GERs for boys and girls were in parity from 2010 to 2021; however, in 2015, the GER for boys surpassed that of girls. In 2021, the GER for boys was 99 per cent (up from 92 per cent in 2001) and 97 per cent for girls (up from 90 per cent in 2001).

CHART 6.10. GER for primary education by sex (%), 2010-2021



SOURCE: Retrieved on 18 March 2024 from: School enrolment, primary, male (% gross) - South Africa | Data (worldbank.org) and School enrolment, primary, female (% gross) - South Africa | Data (worldbank.org)

Secondary School Enrolment

Secondary education includes five years of schooling for adolescents aged 13-18, comprising two years of lower secondary education for children aged 13-15 (grades 8-9) and three years of upper secondary education and training for adolescents aged 15-18 (grades 10-12). Upper secondary education (grades 10-12) is not part of the basic education system in South Africa, which provides general education, but includes TVET and college preparatory curricula. Upon successful completion of Grade 12, students are expected to pass the NSC examination, referred to as '*matric*', which signifies the culmination of 12 years of formal schooling.

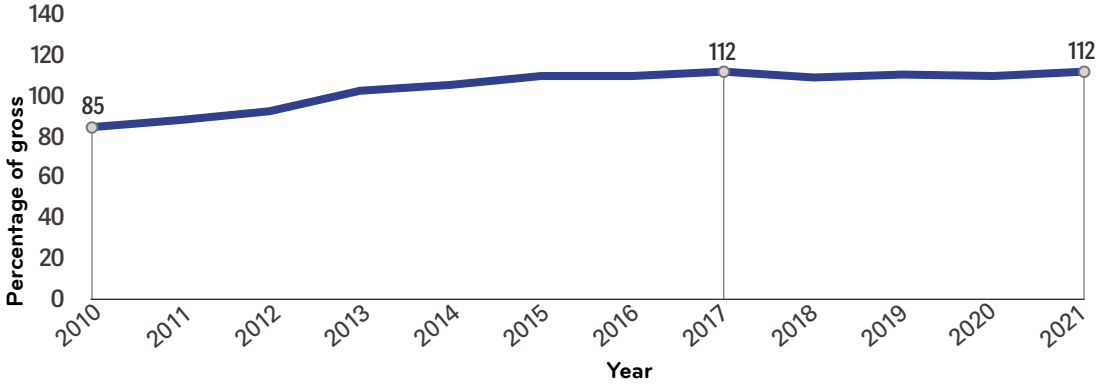
BOX 6.2. Three Stream Model for secondary education

In 2017, the DBE piloted a Three Stream Model for secondary education that features separate academic, technical, and occupational streams for secondary schools. There has been progress in introducing the Three Stream curriculum model, leading to a fundamental shift in focus towards greater TVET. As of 2024, various technical vocational specialisations have been introduced in 550 schools, and 67 schools are piloting the occupational stream. The aim is also to expand access to 'niche subjects' with an engineering or computing focus at the secondary level. Although a wider range of technical subjects has been introduced in the past few years, there has been little progress in the number of learners taking the core technological subjects. For example, the percentage of Black African or Coloured Grade 12 candidates taking at least one niche technology-focused subject in matric has remained unchanged at 9 per cent from 2018 to 2021, compared to 50 per cent for White African and Indian/Asian learners combined. There is clearly a need for greater and more equitable participation in technical and vocational subjects to improve youth preparedness for life after school; yet this has significant budget and staffing implications, which must be addressed properly in the coming years if curriculum diversification on the desired scale is to be realised.

SOURCE: Department of Basic Education Annual Performance 2024/25, p. 32.

Chart 6.11 shows GERs for secondary education from 2010 to 2021. Secondary education GERs steadily increased from 85 per cent in 2010 to 112 per cent in 2021.

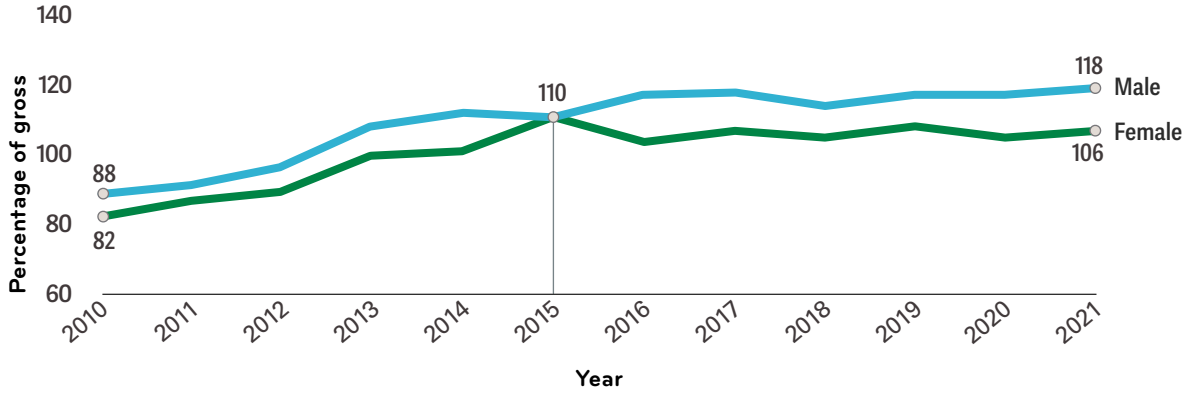
CHART 6.11. GER for secondary education (%), 2001-2021



SOURCE: Retrieved on 18 March 2024 from: School enrolment, secondary (% gross) - South Africa | Data (worldbank.org)

Chart 6.12 shows that GERs for secondary education have varied by gender; girls' enrolment in secondary education has surpassed that of boys since 2001, and the gender gap has widened over time, as GERs have steadily increased. In 2010, the GER for girls was 88 per cent, compared to 82 per cent for boys (a 6 percentage point difference); by 2021, the GER for girls increased to 118 per cent, compared to 106 per cent for boys (a 12 percentage point difference).

CHART 6.12. GER for secondary education by sex (%), 2001-2021



SOURCE: Retrieved on 18 March 2024 from: School enrolment, secondary, female (% gross) - South Africa | Data (worldbank.org) and School enrolment, secondary, male (% gross) - South Africa | Data (worldbank.org)

Table 6.6 shows that in 2017, the NER was 72 per cent (down from 91 per cent in 2015). The NER for girls (79 per cent) was 14 percentage points higher than that of boys (65 per cent). This gender difference in the NER did not exist in 2015. Similarly, in 2017, there was a notable gender difference in the GER, with girls (117 per cent) having a GER that was 11 percentage points higher than that of boys (106 per cent). Data from 2017 are presented because the NER data for 2017 are the most recent data available.

TABLE 6.6. GER and NER for secondary education by sex (%), 2015 and 2017

	GER		NER	
	2015	2017	2015	2017
Total	110	112	91	72
Male	110	106	91	65
Female	110	117	90	79

Note: Data are not available for 2001-2014, 2016 or 2018-2023. **SOURCE:** Retrieved on 18 March 2024 from: School enrolment, secondary (% net) - South Africa | Data (worldbank.org); School enrolment, secondary, male (% net) - South Africa | Data (worldbank.org) and School enrolment, secondary, female (% net) - South Africa | Data (worldbank.org);

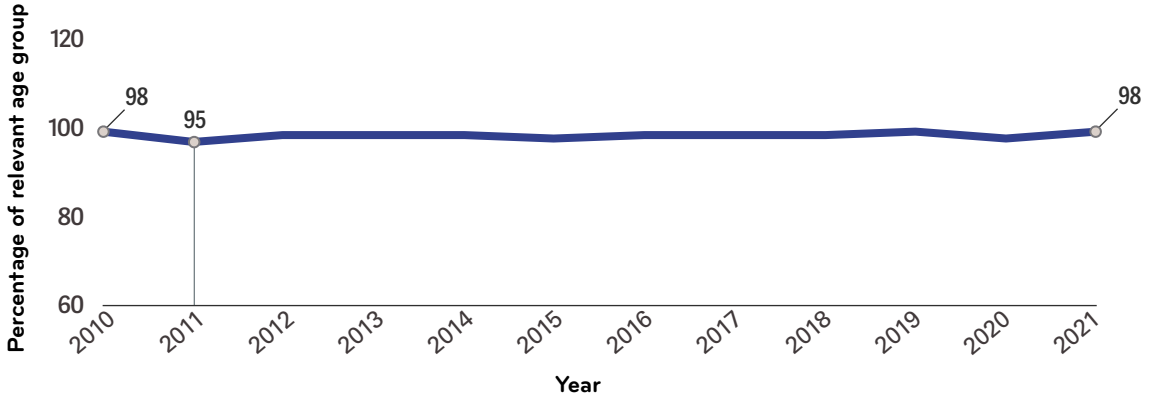
Completion Rates

Ensuring that all girls and boys complete primary and secondary education is a target of the 2030 Agenda for Sustainable Development. Education is a vital prerequisite for reducing poverty, empowering women, increasing economic growth, protecting children from hazardous and exploitative labour and sexual exploitation, promoting human rights and democracy, protecting the environment, and influencing population growth.

Primary Education Completion

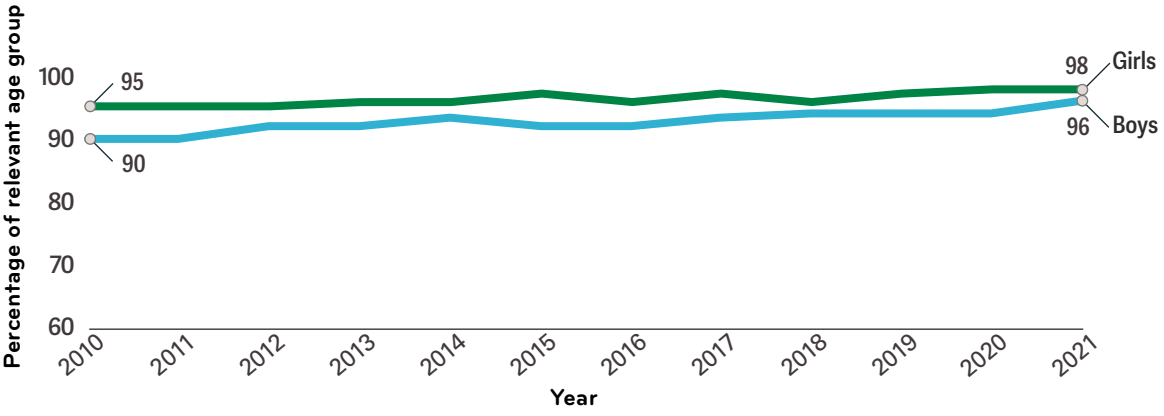
UNESCO defines the completion rate as the percentage of a cohort of children or young people aged three to five years above the intended age for the last grade of each level of education who completed that grade. **Chart 6.13** shows that primary education completion rates remained largely unchanged from 98 per cent in 2010 to 98 per cent in 2021; data were not available for 2022-2023. **Chart 6.14** shows that during this same period, primary education completion rates were slightly higher for girls than for boys. In 2010, the completion rate for girls (95 per cent) was 5 percentage points higher than that of boys (90 per cent); this pattern has continued to varying degrees over time. By 2021, there was greater gender parity in primary school completion rates, with only a two-percentage point difference between girls (98 per cent) and boys (96 per cent).

CHART 6.13. Primary education completion rate (% of relevant age group), 2015-2021



Note: Data are not available for 2022-2023. **SOURCE:** Statistics South Africa (2023). Sustainable Development Goals Country Report 2023 South Africa. Statistics South Africa: Pretoria, South Africa, p. 68.

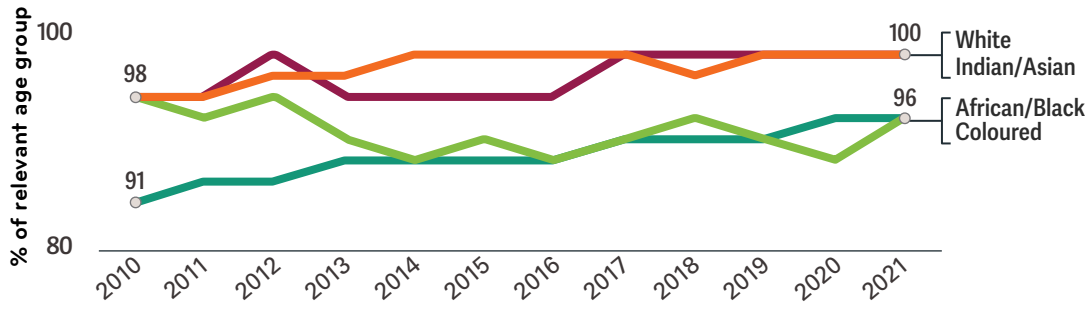
CHART 6.14. Primary education completion rate by sex (% of relevant age group), 2010-2021



Note: Data are not available for 2022-2023. **SOURCE:** Statistics South Africa (2023). Sustainable Development Goals Country Report 2023 South Africa. Statistics South Africa: Pretoria, South Africa, p. 68.

Chart 6.15 shows that from 2010 to 2021, primary education completion rates were higher for White Africans and Indians/Asians. In 2010, White Africans (98 per cent), Indians/Asians (98 per cent), and Coloured Africans (97 per cent) were more likely to complete primary education than Africans/Blacks (91 per cent). By 2021, White Africans (100 per cent) and Indians/Asians (100 per cent) were slightly more likely to complete primary education than Coloured Africans (96 per cent) and Africans/Blacks (96 per cent).

CHART 6.15. Primary education completion rate by population group (% of relevant age group), 2010-2021



Note: Data are not available for 2022-2023. **SOURCE:** Statistics South Africa (2023). Sustainable Development Goals Country Report 2023 South Africa. Statistics South Africa: Pretoria, South Africa, p. 68.

Table 6.7 shows some variation in primary education completion rates by province in 2010 and 2021. In 2010, the national primary education completion rate was 92 per cent. The Western Cape (98 per cent) and Gauteng (96 per cent) had the highest completion rates, while the Eastern Cape (83 per cent) had the lowest. By 2021, the national primary education completion rate had increased to 97 per cent (up from 92 per cent in 2010). Again, completion rates were highest in the Western Cape (98 per cent) and Gauteng (98 per cent), and lowest in the Free State (91 per cent) and Northern Cape (91 per cent).

TABLE 6.7. Primary education completion rate by province (% of relevant age group), 2010 & 2021

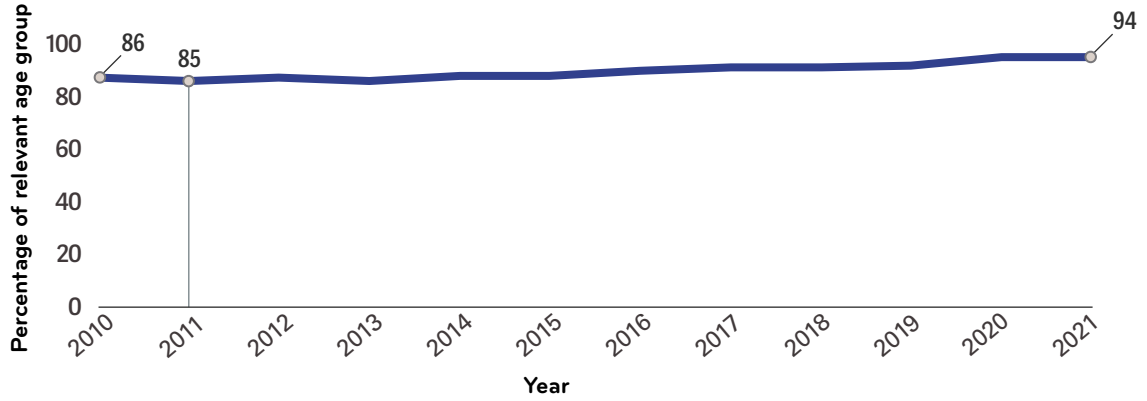
	2010	2021
National	92	97
Western Cape	98	98
Gauteng	96	98
Free State	94	91
Limpopo	93	97
KwaZulu-Natal	93	96
Northern Cape	93	91
Mpumalanga	92	96
North West	91	95
Eastern Cape	83	97

Note: Data are not available for 2022-2023. **SOURCE:** Statistics South Africa (2023). Sustainable Development Goals Country Report 2023 South Africa. Statistics South Africa: Pretoria, South Africa, p. 68.

Secondary Education Completion Rates

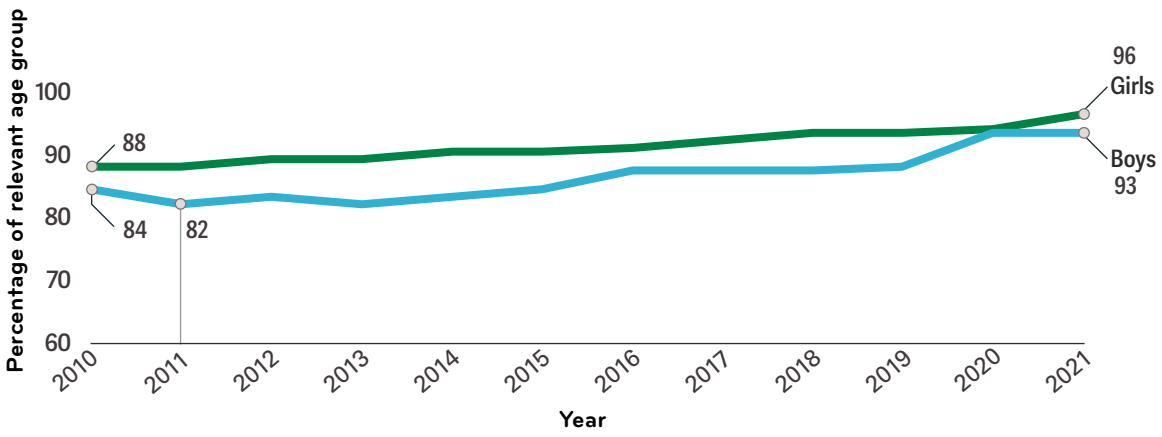
Chart 6.16 shows that lower secondary education completion rates have steadily increased from 86 per cent in 2010 to 94 per cent in 2021; data were not available for 2022-2023. **Chart 6.17** shows that from 2010 to 2021, lower secondary education completion rates have been higher for girls than for boys; however, the gender gap began to close in 2020. The lower secondary education completion rate for girls increased from 88 per cent in 2010 to 96 per cent in 2021, whereas for boys the completion rate increased from 84 per cent in 2010 to 93 per cent in 2021.

CHART 6.16. Lower secondary education completion rate (% of relevant age group), 2010-2021



Note: Data are not available for 2022-2023. **SOURCE:** Statistics South Africa (2023). Sustainable Development Goals Country Report 2023 South Africa. Statistics South Africa: Pretoria, South Africa, pp. 68-69.

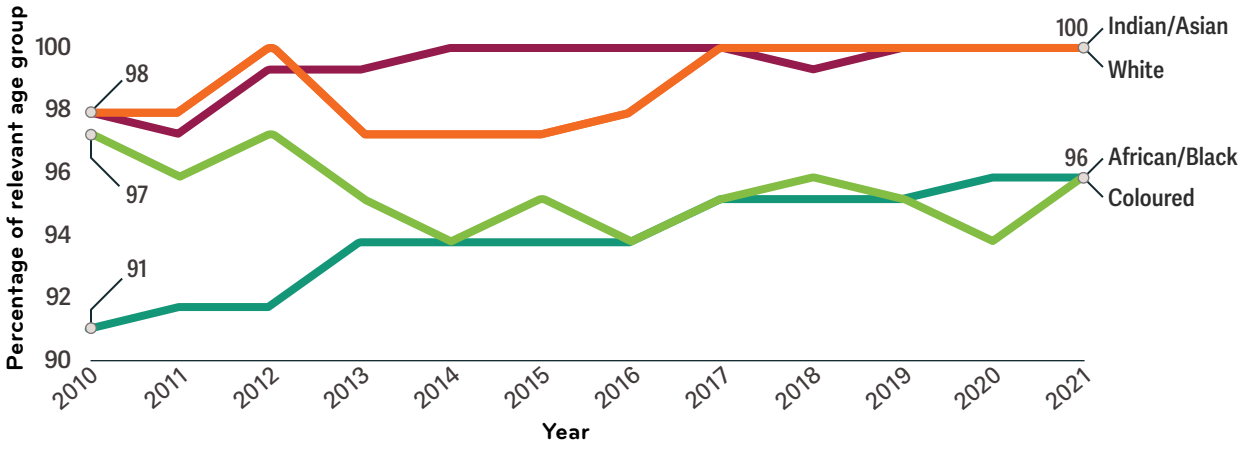
CHART 6.17. Lower secondary education completion rate (% of relevant age group), 2010-2021



Note: Data are not available for 2022-2023. **SOURCE:** Statistics South Africa (2023). Sustainable Development Goals Country Report 2023 South Africa. Statistics South Africa: Pretoria, South Africa, pp. 68-69.

Chart 6.18 shows that from 2010 to 2021, lower secondary education completion rates were higher for White Africans and Indians/Asians. In 2010, White Africans (100 per cent) and Indians/Asians (98 per cent) were far more likely to complete lower secondary education than Coloured (85 per cent) and Africans/Blacks (84 per cent). By 2021, the racial disparities continued to exist, with White Africans (100 per cent) and Coloured (97 per cent) more likely to complete lower secondary education than Indians/Asians (94 per cent) and Africans/Blacks (94 per cent).

CHART 6.18. Lower secondary education completion rate by population group (% of relevant age group), 2010-2021



Note: Data are not available for 2022-2023. **SOURCE:** Statistics South Africa (2023). Sustainable Development Goals Country Report 2023 South Africa. Statistics South Africa: Pretoria, South Africa, p. 68.

Table 6.8 shows variations in lower secondary education completion rates by province for 2010 and 2021. In 2010, the national lower secondary education completion rate was 86 per cent. Completion rates were highest in Mpumalanga (94 per cent) and lowest in Gauteng (75 per cent). By 2021, the national completion rate increased to 94 per cent (up from 86 per cent in 2010). In this year, completion rates were highest in the Western Cape (99 per cent) and Mpumalanga (98 per cent), and lowest in the Free State (87 per cent) and Northern Cape (86 per cent). This finding is likely linked to the fact that the Free State and Northern Cape had the lowest completion rates for primary education.

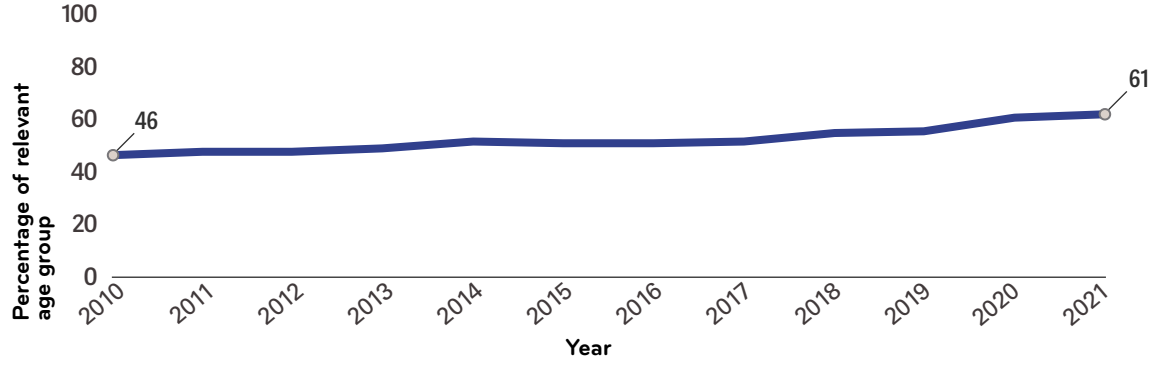
TABLE 6.8. Lower secondary education completion rate by province (% of relevant age group), 2010 and 2021

	2010	2021
National	86	94
Mpumalanga	94	98
Western Cape	88	99
Limpopo	87	96
North West	87	94
Eastern Cape	86	92
KwaZulu-Natal	85	94
Northern Cape	81	86
Free State	80	87
Gauteng	75	90

Note: Data are not available for 2022-2023. **SOURCE:** Statistics South Africa (2023). Sustainable Development Goals Country Report 2023 South Africa. Statistics South Africa: Pretoria, South Africa, p. 68

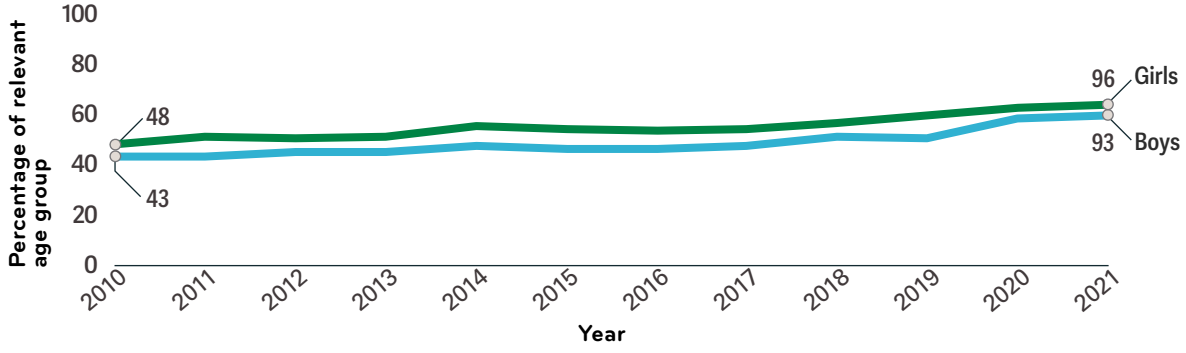
Chart 6.19 shows that upper secondary education completion rates were quite low from 2010 to 2021; however, they steadily increased from a low of 46 per cent in 2010 to 61 per cent in 2021; data were not available for 2022-2023. In addition, **Chart 6.20** shows that from 2010 to 2021, upper secondary education completion rates have been higher for girls than for boys; however, the gender gap began to close in 2020 and 2021. The upper secondary education completion rate for girls increased from 43 per cent in 2010 to 63 per cent in 2021, whereas the completion rate for boys increased from 43 per cent in 2010 to 59 per cent in 2021 (Box 8.1).

CHART 6.19. Upper secondary education completion rate (% of relevant age group), 2010-2021



Note: Data are not available for 2022-2023. **SOURCE:** Statistics South Africa (2023). Sustainable Development Goals Country Report 2023 South Africa. Statistics South Africa: Pretoria, South Africa, p. 69.

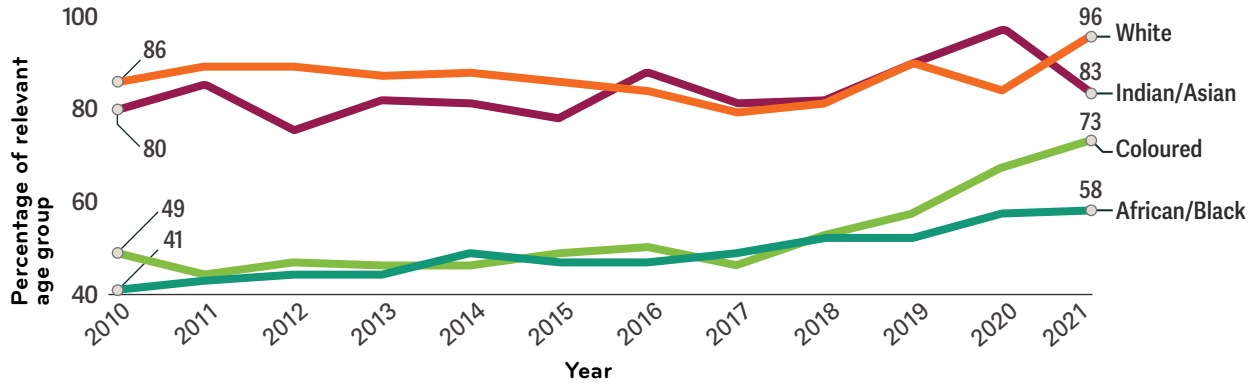
CHART 6.20. Upper secondary education completion rate (% of relevant age group), 2010-2021



Note: Data are not available for 2022-2023. **SOURCE:** Statistics South Africa (2023). Sustainable Development Goals Country Report 2023 South Africa. Statistics South Africa: Pretoria, South Africa, p. 69.

Chart 6.21 shows that from 2010 to 2021, upper secondary education completion rates were far higher for White Africans and Indians/Asians than for African/Blacks and Coloured Africans. In 2010, White Africans (86 per cent) and Indians/Asians (80 per cent) were twice as likely to complete upper secondary education as African/Blacks (41 per cent) and Coloured Africans (49 per cent). By 2021, racial disparities continued to exist, with White Africans (96 per cent) more likely to complete upper secondary education than Indians/Asians (83 per cent) and significantly more likely than African/Blacks (58 per cent) and Coloured Africans (73 per cent).

CHART 6.21. Upper secondary education completion rate by population group (% of relevant age group), 2010-2021



Note: Data are not available for 2022-2023. **SOURCE:** Statistics South Africa (2023). Sustainable Development Goals Country Report 2023 South Africa. Statistics South Africa: Pretoria, South Africa, p. 69.

Table 6.9 shows differences in upper secondary education completion rates by province in 2010 and 2021. In 2010, the national upper secondary education completion rate was 46 per cent. Completion rates were highest in Gauteng (58 per cent) and the Western Cape (50 per cent), and lowest in Limpopo and the Eastern Cape (33 per cent each). This finding is surprising, given that Gauteng had the lowest lower secondary education completion rates. In 2021, the national upper secondary education completion rate increased to 61 per cent (up from 46 per cent in 2010). Completion rates were highest in the Western Cape (74 per cent) and Gauteng (67 per cent), and lowest in the Eastern Cape (46 per cent), Northern Cape (51 per cent) and Limpopo (51 per cent).

TABLE 6.9. Upper secondary education completion rate by province (% of relevant age group), 2010 and 2021

	2010	2021
National	46	61
Gauteng	58	67
Western Cape	50	74
Free State	47	59
KwaZulu-Natal	46	61
Mpumalanga	43	63
North West	41	64
Northern Cape	38	51
Limpopo	33	51
Eastern Cape	33	46

Note: Data are not available for 2022-2023. **SOURCE:** Statistics South Africa (2023). Sustainable Development Goals Country Report 2023 South Africa. Statistics South Africa: Pretoria, South Africa, p. 69

What explains these increases in secondary education completion rates is not clear from the data. UNICEF, however, attributes the improvements seen in primary and secondary education completion rates to enhanced policies, programmes and funding for education, as well as targeted programmes aimed at retaining students until they complete secondary education.[534]

Grade Repetition

Grade repetition rates represent the proportion of students from a cohort enrolled in a given grade in a given school year who study in the same grade in the following school year.[535] Repeating a grade reflects the internal efficiency of educational systems. Repetition is one of the key indicators for analysing and projecting pupil flows from grade to grade within educational systems. Grade repetition data are lacking in South Africa, although it would be useful to have repetition rates at both the primary and secondary school levels, disaggregated by sex and grade.

Despite the lack of grade repetition data, it is important to note that grade repetition policies were relaxed in South Africa in 2020 in response to education disruptions due to the COVID-19 pandemic. As a result, in 2020, there was a notable increase in learners advancing to the next grade, especially at the upper secondary school level. Grade promotion rates were 88 per cent for Grade 9 (up from 80 per cent in 2019), 75 per cent for Grade 10 (up from 60 per cent in 2019), and 80 per cent for Grade 11 (up from 68 per cent in 2019).[536]

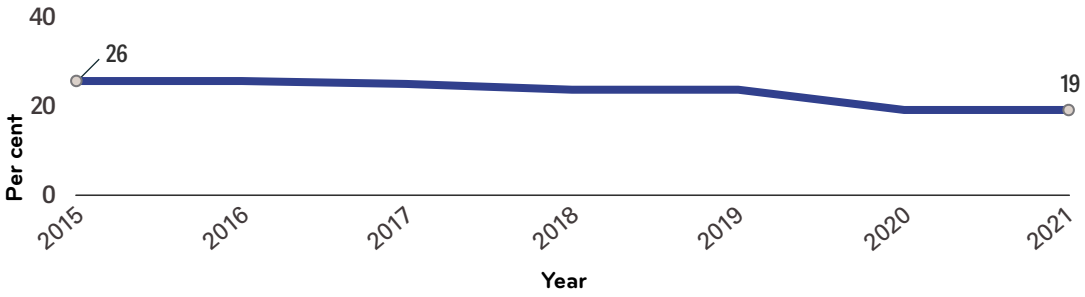
School Dropout

School dropout rates reflect the proportion of pupils from a cohort enrolled in a given grade in a given school year who are no longer enrolled the following school year. Premature exiting measures the phenomenon of pupils from a cohort leaving school without completion and its effect on the internal efficiency of educational systems. School dropout is a key indicator for analysing and projecting pupil flows from grade to grade within the educational cycle. Grade-by-grade dropout data are collected in South Africa and disaggregated by sex, but it would be useful to have such data and statistics available to the public.

Chart 6.22 shows that the proportion of youth aged 15-24 who dropped out of school without completing Grade 12 decreased from 26 per cent in 2015 to 19 per cent in 2019; there were no notable gender differences, except that male youth were 2 percentage points more likely to drop out of school without completing Grade 12 than female youth. These data are somewhat deceiving because they conceal the proportion of dropouts by grade, sex and population group. For comparison purposes, it would be better to show the school dropout rate from Grade 1 to 12, as well as the proportion of youth who dropped out of school without completing lower and/or upper secondary education by age group (youth aged 15-17 years versus 18-24 years).

The school dropout rate is of particular concern because students who drop out of school prematurely will experience a lack of access to higher education, fewer job opportunities, and lower wages than their peers who complete their schooling.[537]

CHART 6.22. Youth aged 15-24 years who dropped out-of-school without completing Grade 12 (%), 2015-2021

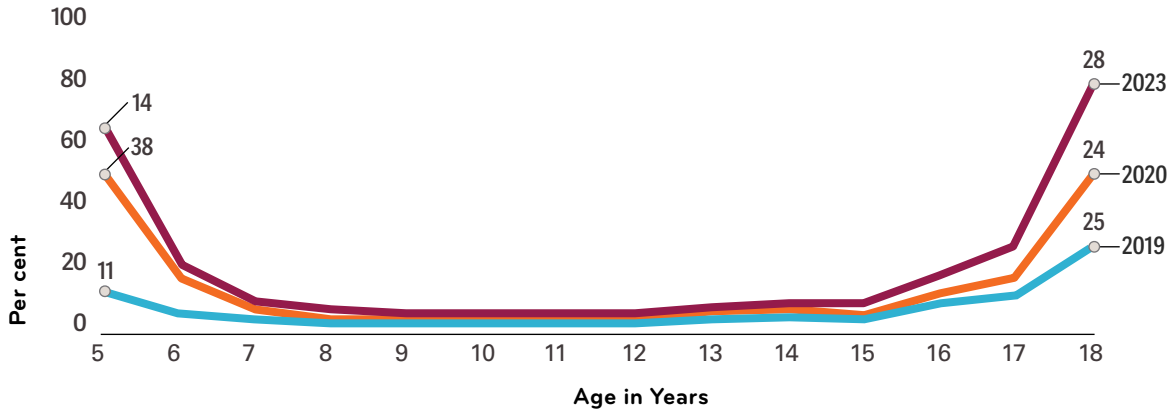


Note: Data are not available for 2022-2023. **SOURCE:** Statistics South Africa (2023). Sustainable Development Goals Country Report 2023 South Africa. Statistics South Africa: Pretoria, South Africa, p. 70

Out-of-School Children

Chart 6.23 shows that from 2019 to 2021, there has been a notable increase in the proportion of out-of-school children, particularly among those aged 5-8 and 15-18. In 2020, there was a rapid rise in the number of out-of-school children and youth, mainly due to school closures during the COVID-19 pandemic. Distance learning was not an effective response to these closures in South Africa, as access to digital learning was limited. In 2021, when schools still could not fully reopen, most opted for in-school learning with some form of hybrid model, including rotational attendance combined with distance learning. The percentage of out-of-school children aged 5-18 remained high in 2021 compared to 2019.[538]

CHART 6.23. Out-of-school children ages 5-18 years by age in years (%), 2019-2023



SOURCE: 2023 GHS

In 2023, an estimated 3 per cent of 15-year-olds and 10 per cent of 17-year-olds were out of school. Although most 18- and 19-year-olds were still attending secondary school, as many as 28 per cent of 18-year-olds and 51 per cent of 19-year-olds were out of school. The main reasons provided by males and females aged 7 to 18 for not attending school in 2023 were:[539]

- Poor academic performance (29 per cent, up from 21 per cent in 2022)
- No money for school fees (20 per cent, the same as in 2022)
- Disability and illness (10 per cent, down from 23 per cent in 2022)
- Other reasons (14 per cent)

There were also gender-specific reasons for being out of school. In 2023, 24 per cent of females dropped out of school due to lack of funds for school fees (compared to 15 per cent for males) and 14 per cent due to family commitments (compared to < 1 per cent for males). In comparison, males (6 per cent) were twice as likely as females (3 per cent) to stop attending school because they had no interest in education.[540] Although inadequate access to financial resources to pay for fees remains a hurdle for learners, two-thirds of learners aged 5 years and older do not pay school fees, and almost 70 per cent receive social grants.[541]

Inclusive Education

South Africa has a broad definition of inclusive education that espouses education for all, including children who are often marginalised, including, but not limited to, children with disabilities, ethnic minorities, rural populations, and those affected by HIV/AIDS.[542] The focus in this section is on inclusive education for children with disabilities.

Since 2001, South Africa has focused on strengthening inclusive education in the education system through a White Paper.[543] The White Paper, however, only articulates policy aspirations, not

requirements; as a result, resources deployed to support inclusive education have been limited, resulting in slow progress.[544] Inclusive education is the responsibility of DBE, DSD, DoH, and the Department of Public Works. To support inclusive education, the DBE established a National Commission on Special Needs in Education and Training, and a National Committee on Education Support Services, which are tasked with conducting research and providing evidence-based recommendations to improve support services and access for children with disabilities to education.[545]

In 2023, Section 6 of the 1996 Constitution was amended to recognise sign language as the 12th official language in South Africa.[546] This amendment was important for the rights of persons who are deaf and hard of hearing, and it triggered subsequent actions, including the promotion of sign language and the allocation of resources for teaching and learning sign language at all levels of the educational system.

Children with Disabilities

Children with disabilities and special educational needs (SEN) are vulnerable to being excluded from the educational system. South Africa strongly supports children's rights to inclusive education, as evident in national laws and policies (e.g., South African Schools Act 84 of 1996, Policy on Disability, Policy on Inclusive Education) that address special education, integration or mainstreaming, and inclusive education.[547] Education centred on children with disabilities is also clearly defined within different levels of governance; for instance, the DBE's Directorate of Inclusive Education is responsible for managing the development, monitoring and evaluation of policies, programmes and systems for the education of children with disabilities. At the provincial level, DoEs are mandated to ensure access for all learners to facilitate learning environments, and district-based support teams (DBSTs) support teaching and learning at the school level.[548]

> *South Africa defines disability as "imposed by society when a person with a physical, psychosocial, intellectual, neurological and/or sensory impairment is defined access to full participation in all aspects of life, and when society fails to uphold the rights and specific needs of individuals and impairments."*

SOURCE: White Paper on the Rights of Persons with Disabilities, 2015

However, in 2018, the Committee on the Rights of Persons with Disabilities concluded that South Africa needs to fully effect the rights of inclusion for all children with disabilities, including young children. The inclusion of young children with disabilities in early learning and development opportunities remains a challenge in South Africa, as such children are typically not accommodated in mainstream early learning programmes.[549]

South Africa also has special education schools that offer specialised educational services for children with special educational needs (SEN), including those living with disabilities, such as visual, hearing, physical, communication, intellectual, and multiple disabilities.[550] In 2018, the GoSA declared all special needs schools as no-fee schools, resulting in these schools being fully funded by the government. However, issues have been raised regarding the poor conditions of special education schools (e.g., inadequate accommodations and facilities, lack of assistive devices, and insufficient staff).[551] The country also has inclusive and special education programmes in universities and teacher training institutes, such as the University Special Education (SPED) Programme, University Inclusive Education (IE) Programme, and embedded approaches for IE/SPED (which is compulsory for all teachers), as well as separate modules on IE.[552]

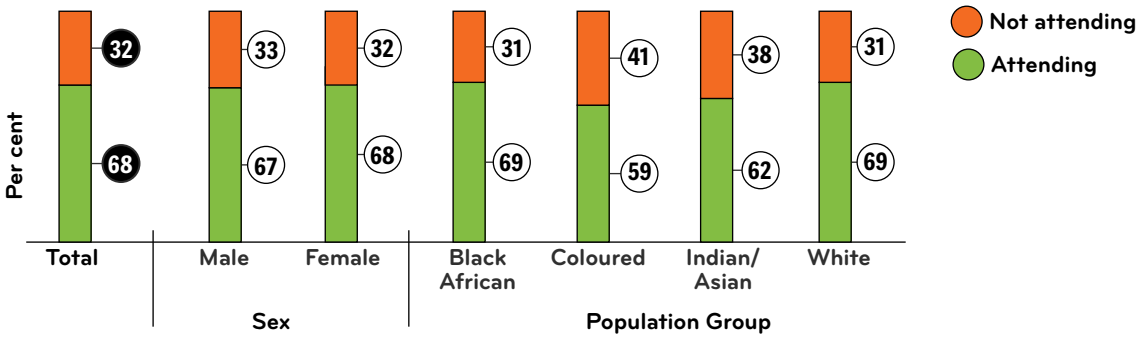
South Africa's White Paper on the Rights of Persons with Disabilities 2015 outlines directives on universal access and the design of school buildings and facilities, which are grounded in the principles of universal design for building construction to make them more accessible. The directive also

includes provisions for tertiary education on universal design, and training for decision-makers, implementers, and service providers (e.g., design and construction firms), as well as accreditation and/or licensure procedures.[553]

In 2022, there were 489 special schools in South Africa, of which 435 were public schools and 54 were independent schools; these special schools accommodated 139,343 learners. There were also 832 full-service public schools, which accommodated 121,461 learners with disabilities. Additionally, there were 8,641 children with severe to profound intellectual disabilities supported in special care centres.[554] However, children with disabilities still remain disproportionately disadvantaged in accessing learning opportunities in South Africa.

Chart 6.24 shows that among children and youth aged 5-24 living with disabilities, 68 per cent were attending educational institutions. Black and White Africans (69 per cent) with disabilities were more likely to attend an educational institution than Coloured Africans (59 per cent). It is important to note that attendance proportions may be influenced, in part, by the fact that children under the age of 18 are more likely to attend schools and special schools than youths aged 18-24.

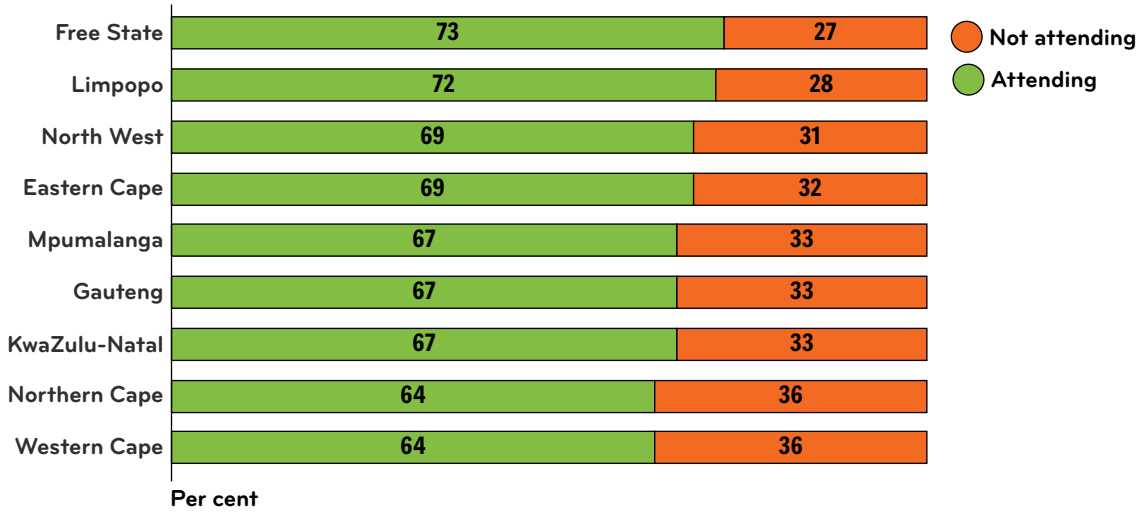
CHART 6.24. Persons with disability (aged 5-24) attending educational institutions (%), 2022



SOURCE: Statistics South Africa (2024). Census 2022: A profile of education enrolment, attainment and progression in South Africa. Statistics South Africa: Pretoria, South Africa.

Chart 6.25 shows that there are provincial differences in the proportion of children and youth aged 5-24 with disabilities attending educational institutions. Children and youth with disabilities in Free State were most likely to attend educational institutions, whereas children and youth in Northern Cape (64 per cent) and Western Cape (64 per cent) were less likely to be enrolled in educational institutions.

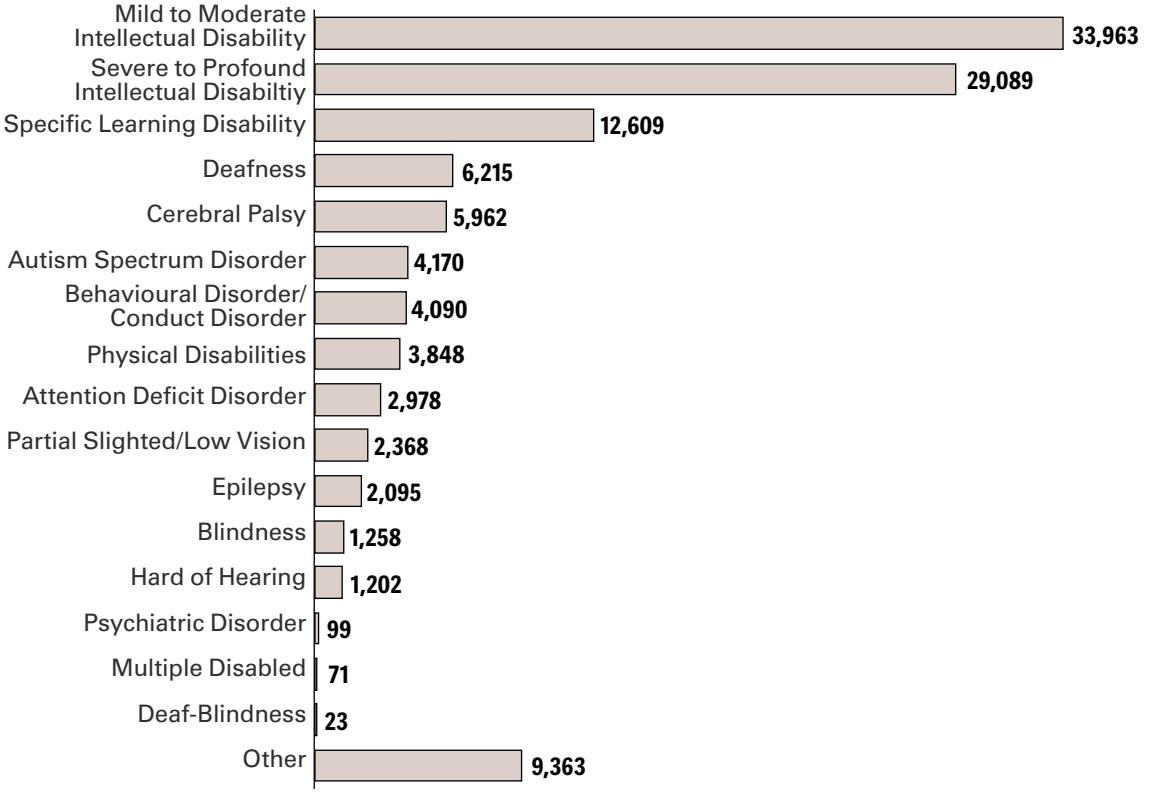
CHART 6.25. Persons with disability (aged 5-24) attending educational institutions by province (%), 2022



SOURCE: Statistics South Africa (2024). Census 2022: A profile of education enrolment, attainment and progression in South Africa. Statistics South Africa: Pretoria, South Africa.

More recent data are lacking on children with disabilities and SEN learners in educational institutions. **Chart 6.26**, however, shows that the available data are from the Education Statistics in South Africa 2016, which was published by the DBE in 2018. In 2016, among the 119,403 SEN learners, an estimated 28 per cent had a mild to moderate intellectual disability, 24 per cent had severe to profound intellectual disabilities, and 11 per cent had a specific learning disability. In addition, 5 per cent were deaf, 5 per cent had cerebral palsy, and 4 per cent had an autism spectrum disorder. Eight per cent had 'other' primary disabilities than those listed.

CHART 6.26. Number of SEN learners by type of primary disability, 2016

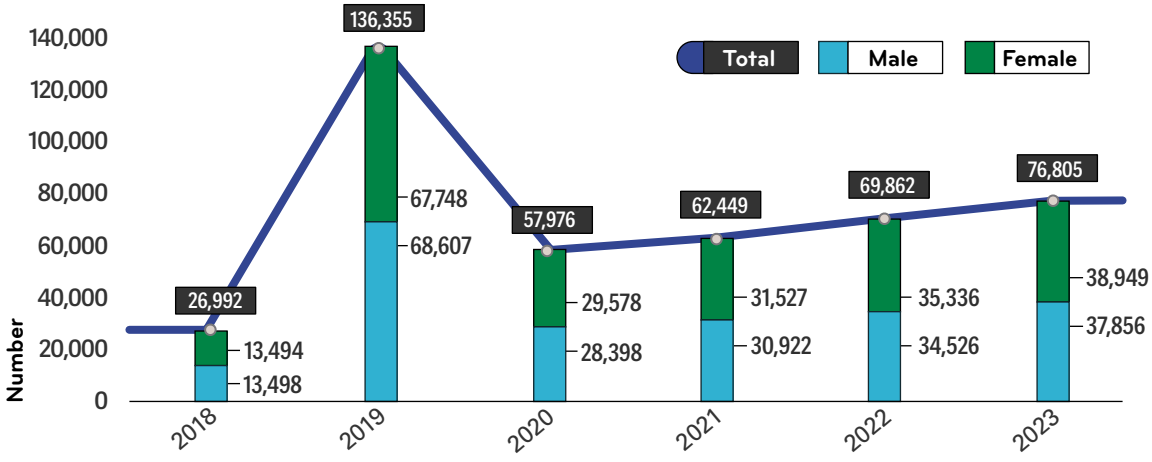


SOURCE: Education Statistics in South Africa 2016, p. 29.

Migrant Children

There is limited data on migrant children in the educational system, and the data are not disaggregated by age, grade, or level of education.[555] **Chart 6.27** illustrates the distribution of immigrant children in basic education from 2018 to 2023. In 2018, there were 26,992 immigrant learners in basic education, including 13,498 males and 13,494 females. Over the subsequent years, the number of immigrant learners increased for both sexes. By 2019, the number of immigrant learners had dramatically risen to 136,355, including 68,607 males and 67,748 females. However, in 2020, the number of immigrant learners declined significantly to 57,976. What accounted for the dramatic increase in immigrant learners in 2019 and the sudden decline in 2020 is unclear. Since 2020, the number of immigrant learners in basic education has slowly increased to 37,856 in 2023, including 37,856 males and 38,949 females.

CHART 6.27. Immigrant learners within basic education, 2018-2023



SOURCE: Department of Statistics South Africa (2024). Migration Profile Report for South Africa. A Country Profile 2023. Stats SA: Pretoria, South Africa, p. 37.

Trained Teacher

According to international standards, a trained teacher is one who has received at least the minimum organised pre-service pedagogical training and in-service training required for teaching at the relevant level. The training of teachers can significantly impact student learning outcomes; however, this only occurs when teachers apply new knowledge and skills in their classrooms. Data related to the proportion of trained teachers in primary, lower secondary, and upper secondary education, in line with international standards, is lacking in South Africa.

In 2023, there were an estimated 454,000 teachers in the public basic education system, with a national average learner-educator ratio of 30:1.[556] In South Africa, minimum requirements for teachers are defined in the 2015 Revised Policy on Minimum Requirements for Teacher Education Qualifications. As of 2021, only 66 per cent of teachers possessed a Relative Equivalent Qualification Value of 14, the minimum required level of education to be registered as a fully professionally qualified teacher with the South African Council of Educators, while 10 per cent of teachers were either unqualified or under-qualified.[557]

Regarding ECD practitioners and educators, in 2021, there were 165,059 practitioners and educators working primarily in the non-governmental sector (including for-profit and not-for-profit), of which 48 per cent lacked qualifications in early learning and development. Only 42 per cent had a NQF Level 4 or 5 qualification (although the majority held a Level 4 qualification), and 10 per cent had a NQF Level 6 to 9 qualification.[558] This data reconfirms the challenge identified in the NDP Vision 2030, which pointed out that an overwhelming number of ECD practitioners do not have the required knowledge and skills to implement quality early learning and development programmes.[559]

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In 2021, Stellenbosch University estimated that 50 per cent of in-service teachers were over the age of 50 years, and 70 per cent were female. Age is a risk factor for teacher supply in the coming decades, as this cohort of teachers will retire. Coupled with a high attrition rate, half of those who leave public teaching every year are below the official retirement age. The reasons for leaving teaching vary from transferring to private schools and shifting to higher-paying jobs, to female teachers leaving to start a family, among others.[560] To address these issues, the GoSA developed a Human Resource Development Strategy to tackle teacher supply issues; however,[561] it is unclear whether this strategy is effective.

Skills and Learning Outcomes

The DBE is working to improve teaching quality to ensure that students learn basic literacy and numeracy skills in the early grades, which, in turn, will limit the number of repeaters and make the overall educational system more efficient.[562] Data, however, are lacking in South Africa regarding literacy and numeracy skills among students in primary and secondary schools.

In March 2024, the DBE launched a new report providing evidence-based insights and analysis of foundational learning in South Africa. It is one of four country reports produced in partnership with UNESCO's Global Education Monitoring Report, the Association for the Development of Education in Africa, and the AU, as part of the spotlight report series on foundational learning in Africa.[563] This report documents that learners' outcomes in South Africa are well below target.[564]

Literacy Skills:

In 2016, an estimated 78 per cent of Grade 4 learners were below grade level and could not read a text for meaning in any language. In 2021, South Africa also scored lowest among countries participating in the Progress in International Reading Literacy Study (PIRLS) examination. The performance of South African learners significantly decreased by 10 per cent, from 320 in 2016 to 288 in 2021. The share of learners who did not reach minimum proficiency levels by the time they reached Grade 4 also increased from 78 per cent in 2016 to 81 per cent in 2021.[565] Only 19 per cent of children reached the minimum proficiency level in reading. It is notable that girls scored higher than boys on average (almost 0.5 standard deviations higher); the proportion of girls not reaching minimum proficiency levels in reading was lower by almost 10 percentage points compared to 2016.[566] More specifically, in the Western Cape, a language assessment of Grades 3 and 6 in 2022 found that only 59 per cent of Grade 3 learners and 76 per cent of Grade 6 learners could pass at the lowest level (scoring at least 30 per cent on the exam). Low foundational learning skills are a reality faced by the DBE.[567]

The PIRLS data also revealed a sharp urban-rural divide. Children from rural areas scored significantly lower than children from urban areas (0.5 standard deviations lower); a higher proportion of children from rural areas did not reach the minimum proficiency levels (20 per cent). The impact of

socioeconomic background on children's learning is also strong. Children from lower socioeconomic backgrounds scored lower and were less likely to reach minimum performance levels in reading compared to children from higher socioeconomic backgrounds.[568]

South Africa's reading performance in the PIRLS worsened from 2016 to 2021, with the average score decreasing by 0.3 standard deviations and the share of children not reaching the minimum performance levels in reading increasing by 3 percentage points. These findings are concerning given South Africa's commitment to improving education quality.[569] In recent years, the DBE has coordinated several initiatives aimed at improving reading outcomes. For instance, a newly revised Reading Literacy Strategy is being developed, which will place a greater focus on ECD as preparation for learning to read, including in one's home language, and using pedagogical approaches appropriate for indigenous languages, while also extending the use of mother-tongue-based bilingual education beyond Grade 3.[570] The DBE has also developed early-grade reading benchmarks for the Nguni and Sesotho-Setswana language groups, Afrikaans and English as a first additional language, and Xitsonga and Tshivenda home languages. The benchmarks outline how many words or letters learners should be able to sound out or read by the end of their present grade to be on track to read with meaning.[571]

Mathematics and Science Skills:

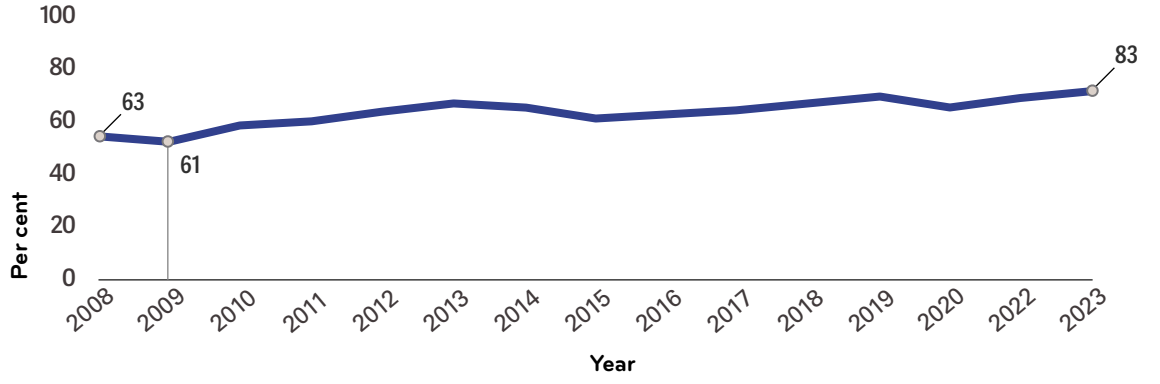
In 2019, the Trends in International Mathematics and Science Study (TIMSS) ranked South Africa as one of three countries with the lowest achievements, although it continues to make progress in improving mathematics achievement. This study found that only 41 per cent of mathematics learners and 36 per cent of science learners had acquired the foundational subject knowledge and skills measured by TIMSS. This is equivalent to a fourfold increase for mathematics (from 11 per cent to 41 per cent) and a threefold increase for science (from 13 per cent to 37 per cent) over a 20-year period.[572]

These data demonstrate a real need for reforms to the educational system to improve the quality of teaching and learning outcomes. This requires a shift from the traditional approach of teaching fundamentals to developing a competency-based education and curriculum that focuses on children's development of foundational reading and numeracy skills, along with other subjects. Given the situation, UNICEF recognises the DBE's ongoing efforts toward competency-based learning in each subject as a promising approach for the education sector; however, time will tell.

Examination Results

In 2008, the GoSA introduced the NSC, an examination and assessment test at the end of Grade 12, which reflects the proportion of adolescents who pass Grade 12. **Chart 6.28** shows the proportion of students who passed Grade 12 from 2008 to 2023. The proportion of students who passed the NSC increased from 63 per cent in 2008 to 78 per cent in 2013, but then decreased to 71 per cent in 2015. After that, NSC passes steadily increased to 81 per cent in 2019, before decreasing to 76 per cent in 2020, most likely as a result of school closures related to the COVID-19 pandemic. By 2023, 83 per cent of students passed the NSC, a notable increase from 63 per cent in 2008.

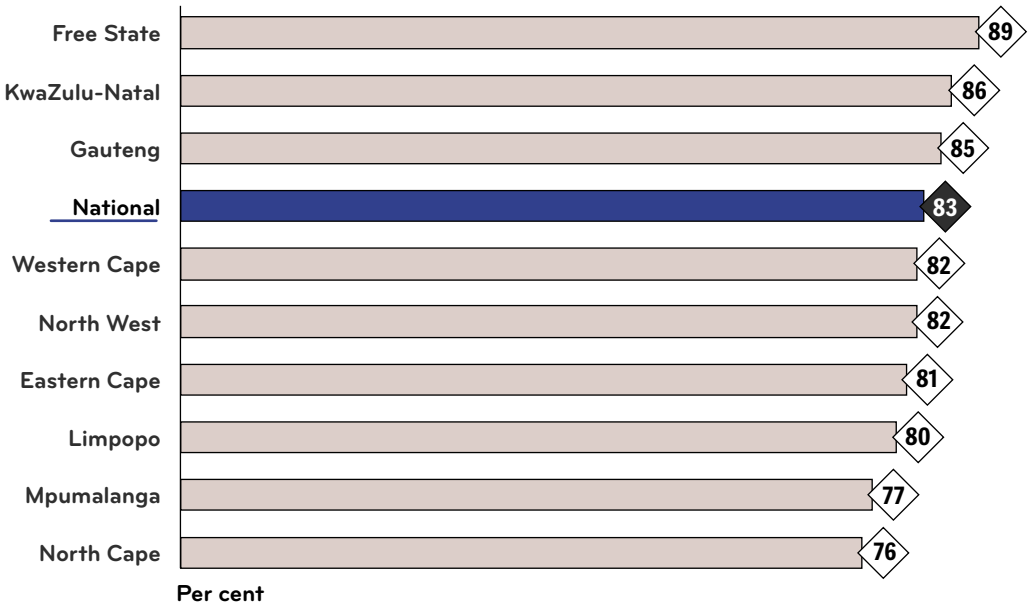
CHART 6.28. NSC passes (%), 2008-2023



SOURCE: Department of Basic Education Republic of South Africa (2021). National Senior Certificate Examination Report 2020 Examination Report. Department of Basic Education: Pretoria, South Africa, p. 6. Retrieved on 19 March 2024 from: 2020NSCREPORT.pdf (education.gov.za); NSC Examination Results. Retrieved on 21 May 2024 from: 2023 NSC Reports (education.gov.za)

Chart 6.29 shows that in 2023, the proportion of students who passed the NSC was highest in Free State (89 per cent), KwaZulu-Natal (86 per cent), and Gauteng (85 per cent), which were higher than the national average of 83 per cent. In contrast, NSC pass rates were lowest in North Cape (76 per cent) and Mpumalanga (77 per cent).

CHART 6.29. NSC passes by province (%), 2023

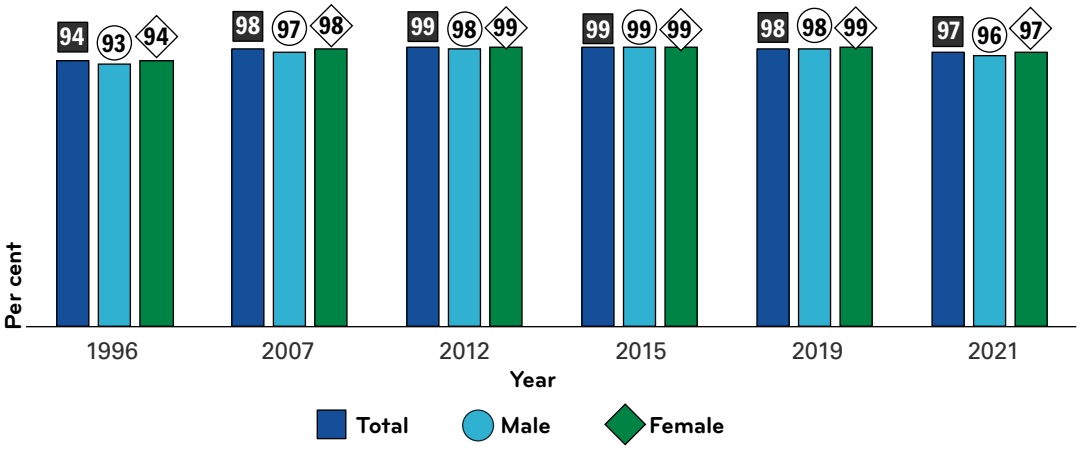


SOURCE: 2023 NSC Exam Results Technical Report. Retrieved on 21 May 2024 from: NSC23 Technical Report.pdf (education.gov.za)

Literacy Rates

In South Africa, from 1996 to 2021, literacy rates among youth aged 15-24 remained high at 94 per cent in 1996 and 97 per cent in 2021 (**Chart 6.30**). Among persons aged 15 years and older, the adult literacy rate increased from 84 per cent in 1996 to 90 per cent in 2021. For males aged 15 years and older, the adult male literacy rate rose from 84 per cent in 1996 to 91 per cent in 2021, whereas the adult female literacy rate increased from 81 per cent in 1996 to 89 per cent in 2021. While there is gender parity in the youth literacy rate, the gender gap appears to be closing over time.

CHART 6.30. Literacy rates among youth (ages 15-24) by gender (%), 1996-2021



SOURCE: Retrieved on 18 March 2024 from: Literacy rate, youth total (% of people ages 15-24) - South Africa | Data (worldbank.org); Literacy rate, youth male (% of males ages 15-24) - South Africa | Data (worldbank.org) and Literacy rate, youth female (% of females ages 15-24) - South Africa | Data (worldbank.org)

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Use of Information and Communication Technology

The DBE recognises that transformation of the education system into a 21st-century learning environment that provides learners with the skills they need to succeed in today's information-age economy is essential. The 2004 White Paper on e-Education aimed to transform learning and teaching through the use of ICT and to produce ICT-capable learners; however, the DBE is long overdue in achieving this transformation.[573]

According to the SMS, the proportion of schools with internet connectivity increased from 35 per cent in 2011 to 67 per cent in 2022, but progress has been uneven across provinces. The more affluent provinces, such as Western Cape and Gauteng, have made considerable progress in providing some of their schools with ICT infrastructure. Provinces that are lagging behind cite competing priorities and a lack of adequate resources as reasons for not implementing ICT in education.[574]

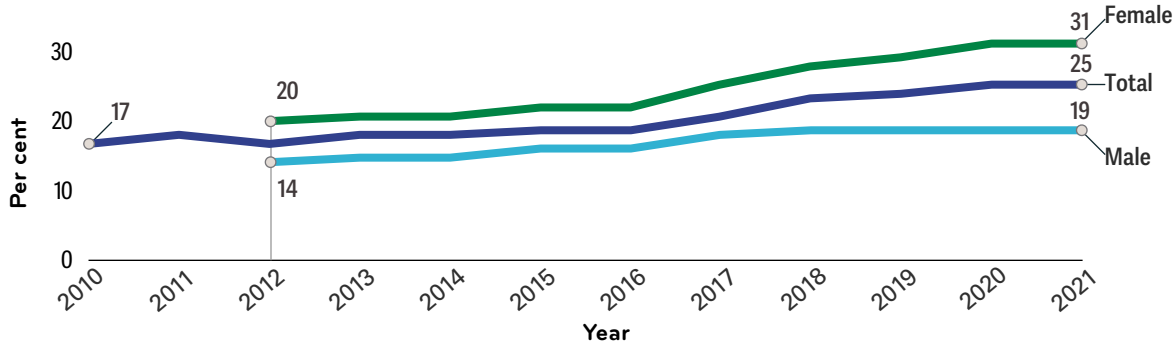
Data related to children and adolescents' use of ICT, however, are lacking. In 2016, it was reported that only 22 per cent of households owned a computer, including 28 per cent of urban households and 9 per cent of rural households.[575] Data related to the proportion of adolescents (ages 15-19) and youth (ages 15-24) who have ever used a computer, used a computer in the past 3 months, owned a mobile phone, ever used the internet, and used the internet in the past 3 months would be extremely beneficial.

Tertiary Education

SDG Target 4.3 aims to by 2030, ensure equal access for all women and men to affordable and quality technical, vocational, and tertiary education, including university, by 2030. In addition, SDG Target 4.4 aims to by 2030, substantially increased the number of youth and adults who have relevant skills, including technical and vocational skills, for employment, decent jobs, and entrepreneurship by 2030. In South Africa, however, tertiary education is rather exclusive.

In South Africa, higher education is quite exclusive. **Chart 6.31** shows that the proportion of youth who were enrolled in tertiary education increased from 17 per cent in 2010 to 25 per cent in 2021. Over time, more females have been enrolled in tertiary education than males. In 2021, 31 per cent of those enrolled in tertiary education were female (up from 20 per cent in 2012), compared to 19 per cent of males (up from 14 per cent). The rate of female enrolment in higher education increased at a rate (11 percentage points) twice that of males (5 percentage points).

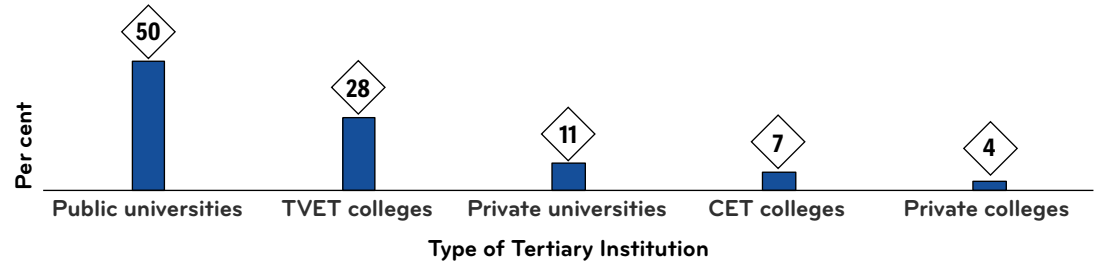
CHART 6.31. Tertiary enrolment by sex (% gross), 2012-2021



SOURCE: Retrieved on 20 March 2024 from: School enrolment, tertiary (% gross) - South Africa | Data (worldbank.org); School enrolment, tertiary, male (% gross) - South Africa | Data (worldbank.org) and School enrolment, tertiary, female (% gross) - South Africa | Data (worldbank.org)

Chart 6.32 shows that 50 per cent of students enrolled in tertiary education were in public universities, while 28 per cent were in TVET colleges in 2021. Fewer students were enrolled in private universities (11 per cent), CET colleges (7 per cent), and private colleges (4 per cent). The majority of these students were enrolled in undergraduate degree programmes (55 per cent) and undergraduate certificates and diplomas (27 per cent). Far fewer students were enrolled in postgraduate studies, such as those below Master's level (7 per cent), Master's degrees (6 per cent), and Doctoral degrees (2 per cent).[576]

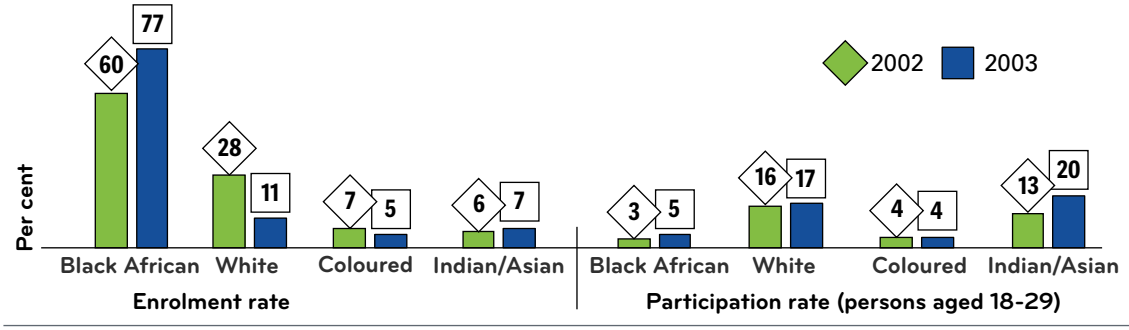
CHART 6.32. Student enrolments in tertiary education by type of institution (%), 2021



SOURCE: Department of Higher Education and Training (2023). Statistics on Post-School Education and Training in South Africa 2021. Department of Higher Education and Training: Pretoria, South Africa. Retrieved on 22 May 2024 from: Statistics on Post-School Education and Training in South Africa 2021.pdf (dhet.gov.za)

Chart 6.33 shows enrolment and participation rates in higher education institutions by population group. From 2002 to 2023, the total number of students enrolled in higher education institutions increased by 57 per cent, growing to 962,000 students. In 2023, 77 per cent were Black African, 11 per cent were White, 7 per cent were Indian/Asian, and 5 per cent were Coloured. Although most students enrolled in higher education institutions were Black African, the education participation rate of Black Africans remained proportionally low at 5 per cent, compared to 17 per cent for White Africans and 20 per cent for Indians/Asians.

CHART 6.33. Higher education enrolment and participation rates by population group (%), 2002 & 2022



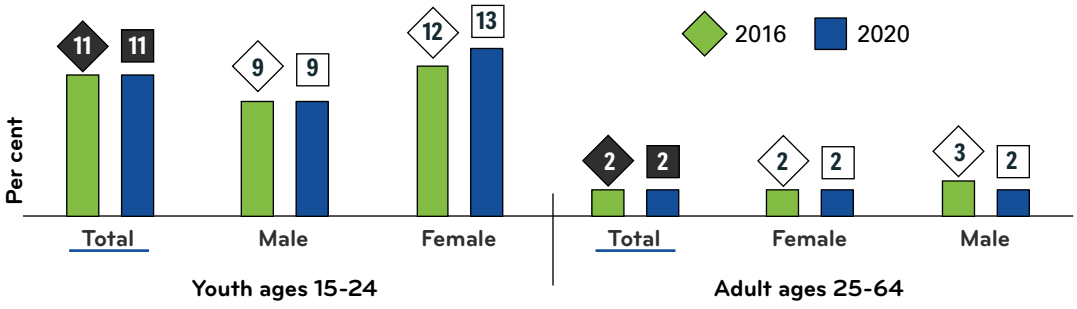
SOURCE: 2023 GHS

TVET, also known as Further Education and Training (FET) in South Africa, is an occupation- and employment-based education. TVET is typically facilitated through formal schools, centres, and institutions that are publicly or privately owned, and through informal, traditional apprenticeship or non-formal semi-structured training. The nature of TVET content is to prepare learners for specific trades, crafts, and careers, largely through practice-based learning and complementary theory to equip learners with the practical competencies and know-how needed to perform in their respective occupations within the labour market.

In South Africa, there are 50 accredited and registered public TVET colleges operating around 364 campuses that are distributed across the country's rural and metropolitan areas. Public TVET colleges are founded and maintained by DHET under the jurisdiction of the Continuing Education and Training Act 16 of 2006. TVET colleges play an important role in developing South Africa's workforce by offering hands-on, practical education and training that prepare individuals with the skills and information required for diverse sectors. South African TVET colleges offer a diverse range of programmes and courses through which individuals can be awarded certificates and diplomas.[577]

Chart 6.34 shows that in 2016 and 2020, 11 per cent of youth aged 15-24 and 2 per cent of adults aged 25-64 participated in formal and non-formal education and training. In both years, female youth were slightly more likely than male youth to participate in formal and non-formal education. This gender difference was not as evident among adults aged 25-64 years.

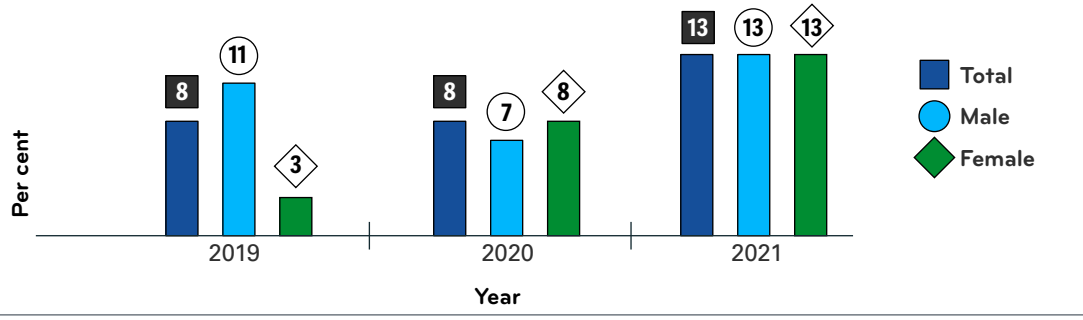
CHART 6.34. Youth and adults in formal and non-formal education and training by age group (%), 2020



Note: Data are not available for 2021-2023. **SOURCE:** Statistics South Africa (2023). Sustainable Development Goals Country Report 2023 South Africa. Statistics South Africa: Pretoria, South Africa, p. 71

Chart 6.35 shows that among adults aged 25 years and older, in 2021, 13 per cent attained at least a Bachelor's Degree or equivalent (up from 8 per cent in 2019). In 2019, males (11 per cent) were nearly four times more likely to attain at least a Bachelor's Degree or equivalent than females (3 per cent). In 2021, however, males (13 per cent) and females (13 per cent) were equally likely to attain at least a Bachelor's Degree or equivalent. In 2021, even fewer adults aged 25 years and older had earned a Master's Degree or equivalent (2 per cent)[578] or a Doctoral Degree or equivalent (0.2 per cent).[579]

CHART 6.35. Educational attainment of at least a Bachelor's Degree or equivalent, aged 25+ (%), 2019-2021



SOURCE: Retrieved on 20 March 2024 from: Educational attainment, at least Bachelor's or equivalent, population 25+, total (%) (cumulative) - South Africa | Data (worldbank.org); Educational attainment, at least Bachelor's or equivalent, population 25+, male (%) (cumulative) - South Africa | Data (worldbank.org) and Educational attainment, at least Bachelor's or equivalent, population 25+, female (%) (cumulative) - South Africa | Data (worldbank.org)

It is well documented that well-performing TVET lecturers, and by implication, TVET colleges, are an integral component of national economic growth and development.[580] In 2024, research undertaken by JET Education Services found that the existing national performance management system for TVET lecturers in South Africa lacks systematic integration. Although the current policy basket contains the necessary instruments and processes, it requires better coordination and renewal. A key weakness is that the appraisal gives greater prominence to the pedagogy of theory subjects than to the pedagogy of skills-based instruction. In addition, a lack of access to work-integrated learning, low accountability, and overly manual systems and processes are further characteristics of South Africa's current system that is in dire need of renewal. It is also notable that the Integrated Quality Management System (IQMS) is perceived as time-consuming, overly bureaucratic, and characterised by limited induction, preparation, and poor communication. On a positive note, the research identified several leverage points within the current system that provide a grounding for the work ahead. There are also examples of specific TVET colleges that have taken the current system, with its limitations, and built supportive organisational cultures that enable TVET lecturer professional development and wellness programmes for lecturing staff, encouraging a culture of growth.[581]

Climate Change and Education

Climate change and environmental issues are linked to children's access to education and academic performance. Without quality education, including education on climate change and environmental issues, children will not be equipped to prepare themselves for climate and environmental hazards, to serve as climate change champions and agents of change, or to become part of a functioning workforce for economic growth.[582]

Climate change-related events are likely to worsen children's access to education and negatively impact the quality of education and learning outcomes, particularly in rural and remote areas, and among vulnerable and disadvantaged children and families.[583]

- **Heavy rains –** Heavy rainfall impacts access to safe water and sanitation. During heavy rains, harvested water often becomes dirty and undrinkable, and tap water can become contaminated and unsafe to use, in which case people need to fetch water from wells and springs, which are unprotected water sources. During rainy seasons, toilets can overflow and become unusable, leading to an increased likelihood of open defecation, which can result in human faeces contaminating water sources. Animal faeces can also wash into water sources and affect wells and spring water. Despite the various ways in which water is contaminated, during heavy rains, many people have to use and drink dirty and contaminated water, which causes waterborne illnesses and leads to diarrhoea.

  For households that rely on firewood to heat their homes and cook, they often struggle to find dry wood during heavy rainfall. Without enough firewood to boil water, people tend to use the water as is, which causes waterborne diseases. Heavy rainfall also causes damage to agriculture and leads to an increase in pests; as a result, agricultural and food production declines, contributing to food insecurity.

  Heavy rainfall also leads to flooding, which results in damage to roads, bridges, and infrastructure, and contributes to soil erosion. For people who rely on solar energy, their ability to harness or collect solar energy is negatively impacted.

  Heavy rains can also cause the flooding of streams and rivers, putting people's lives at risk. Children are at increased risk of drowning in floods, particularly where there are no bridges; thus, some children and adolescents are unable to attend school during heavy rains and flooding because they cannot cross the river, as footbridges are often washed away. For children with disabilities, particularly those with limited mobility who use wheelchairs, attending school during heavy rains becomes impossible due to slippery roads.

- **Drought –** Dirty water and lack of water are serious issues during droughts. During droughts, when there is no water in the taps, women and girls often have to walk long distances to fetch water, and they are more likely to collect water from rivers. When girls have to travel long distances to fetch water, they may stop attending school and are at an increased risk of experiencing sexual violence while doing so.
- When there is a lack of water, it is not easy for people to wash their hands after using the toilet or to wash their hands before eating; this contributes to the spread of disease and illness. People are also at increased risk of heat-related illnesses and flu during droughts, which limits children's attendance at school.
- **Extreme heat and cold –** Extreme heat during the summer months and extreme cold during the winter months may lead many children to avoid attending school and/or have difficulty travelling to and from school and concentrating on their education during these extremes. Colder temperatures in winter disproportionately impact children and young people from poor households that cannot afford warm clothing.
- **Food insecurity –** Climate change is contributing to food insecurity and hunger. Crops are being negatively affected by drought, heavy rains, and extreme temperatures. Climate change is leading to decreased agricultural production and increased food insecurity and hunger, which negatively impacts children's ability to study and learn.
- **Migration –** Persons affected by climate change will migrate as a result of these conditions. When children move, especially vulnerable ones, they are likely to face various social, economic, and legal challenges. Changes in the education system, including curriculum and language of learning, particularly for non-native learners, can pose additional difficulties. Migrant children who lack the legal documents required for school registration and/or face financial barriers will encounter challenges accessing education. South Africa may even experience an increase in internal migration due to climate change, which can affect children's access to schooling and learning. Moreover, the student-to-teacher ratio, which is already a concern in South Africa, is likely to worsen as more migrant children enrol in schools and classrooms, negatively affecting the teaching and learning experience for both teachers and students.

An income shock from deteriorating agricultural conditions due to climate change often leads households to reduce current expenditures on food and/or education, contributing to decreased school enrolment and educational attainment for children. Some households may seek additional income streams, resulting in older children being removed from school to work as agricultural and non-agricultural labourers.[584] Some families will also migrate to urban areas seeking new opportunities but may be forced to settle in informal settlements, where access to basic services is poor. In these environments, the risk of child labour and abuse can be higher than in rural areas.

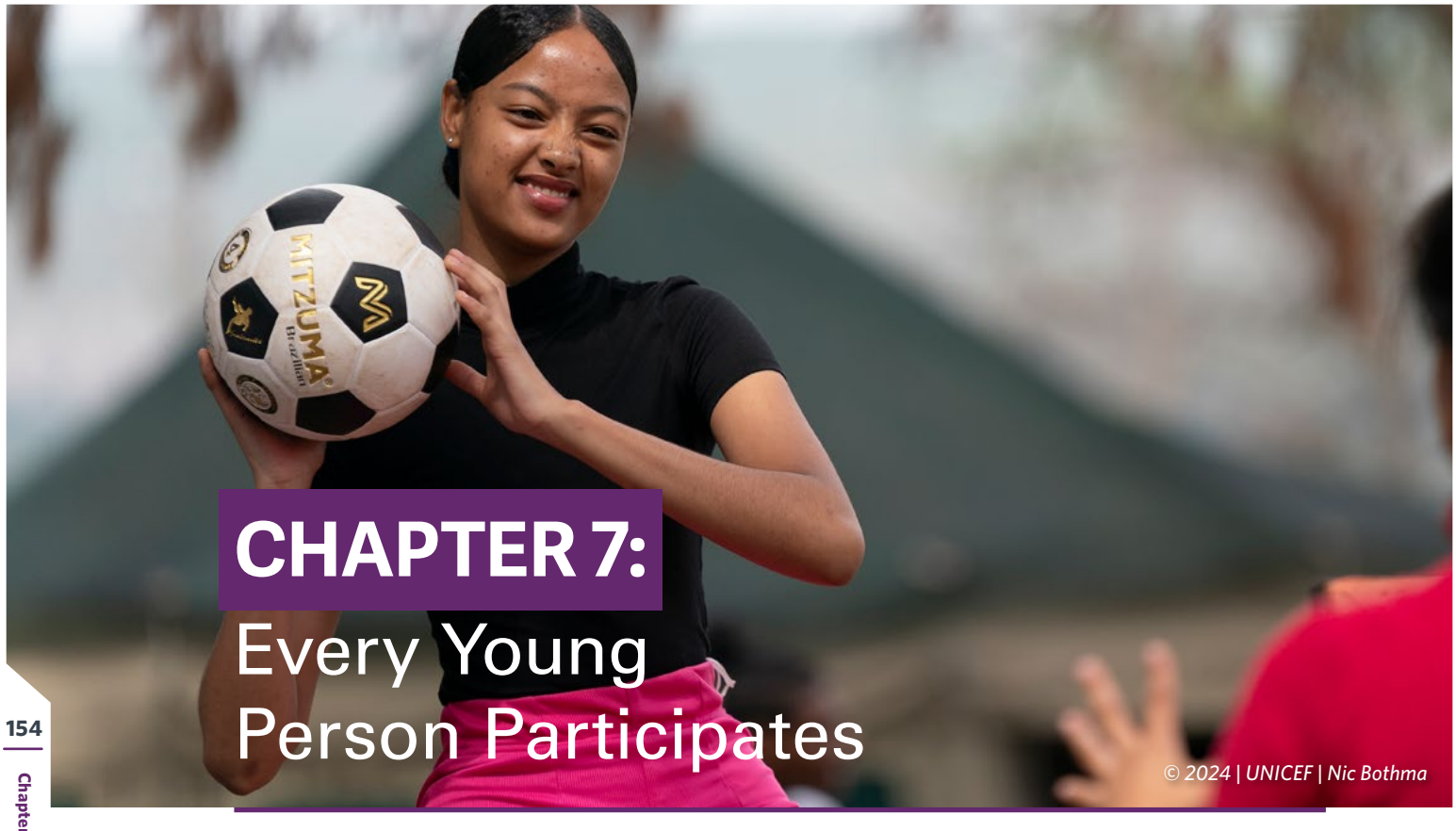
Summary of Data Gaps

This chapter focused on data related to every child's right to learn and acquire skills for the future. There were notable data gaps, including:There is a lack of available and timely data to report on some key indicators related to SDG 4, which aims to ensure inclusive and equitable quality education and promote lifelong learning opportunities for all. This includes: the proportion of children and young people in grades 2/3, at the end of primary education, and at the end of lower secondary achieving at least a minimum proficiency level in reading and mathematics by sex (4.1.1); the proportion of youth and adults with ICT skills, by type of skill (4.4.1); parity indices (female/male, rural/urban, bottom/top wealth quintile, and others, e.g., disability status) for all education indicators (4.5.1); and the proportion of the population in a given age group achieving at least a fixed level of proficiency in functional literacy and numeracy skills, by sex (4.6.1). Data may be available, in part, for some of these indicators, but not for full reporting.

- Raw numbers are often reported, and percentages are not always calculated, which makes data interpretation and comparisons difficult. From year to year, the data reported can vary, which makes comparisons challenging at times.
- NERs are lacking for pre-school and Grade R. Additionally, gross and net intake rates, as well as gross and net enrolment rates, are lacking for primary education, along with transition rates from Grades 7 to 8. Furthermore, gross and net enrolment rates for lower and upper secondary education are lacking. These data should be disaggregated by sex, province, wealth quintile, and other vulnerabilities (e.g., orphaned status, children with disabilities).
- Grade repetition rate data are lacking. It would be beneficial to calculate grade repetition rates as a proportion of pupils from a cohort enrolled in a given grade in a given school year who study in the same grade in the following school year; this data should be further disaggregated by grade and gender.
- The proportion of youth aged 15-24 who dropped out of school without completing Grade 12 is available; yet these data obscure the proportion of dropouts by age in years and by age group. For comparison purposes, it would be better to show the school dropout rate by age in years and school grade (grades 1-12), with disaggregation by sex, province, and wealth quintile. It would also be beneficial to report the proportion of non-transitioners from the last grade of one education level to a higher level, such as from primary to lower secondary and from lower to upper secondary. A qualitative study of the situation of out-of-school children, including girls and boys, is also lacking; such a study would reveal the reasons why girls and boys drop out of school, the barriers and challenges that limit their ability to re-enter school, and the support needed to address their vulnerabilities, change their life course, and improve their future social and economic well-being. It would also be beneficial to gather qualitative data on the perspectives of adolescents and youth regarding preventing school dropout.
- Data on children with disabilities are available; however, data related to equitable access to education for orphaned children and migrant children are lacking. It would be beneficial to report the proportion of students with disabilities enrolled in pre-schools, primary schools, and lower and upper secondary schools, with disaggregation by province and type of disability. It would also be beneficial to conduct a qualitative study of the situation of orphaned children, children with disabilities, and migrant children in the educational system, to understand the various barriers and challenges they face in accessing education and the ability of educators to meet their specific needs, as well as learning challenges that they may encounter.
- Data related to the proportion of trained teachers in pre-school, primary, and lower and upper secondary education are lacking in South Africa. UNESCO defines trained teachers as those "who have fulfilled at least the minimum organised teacher-training requirements (pre-service or in-service) to teach a specific level of education according to the relevant national policy or law. These requirements usually include pedagogical knowledge (broad principles and strategies of classroom management and organisation that transcend the subject matter being taught, as well as approaches, methods, and techniques of teaching) and professional knowledge (knowledge

of statutory instruments and other legal frameworks that govern the teaching profession). Some programmes may also cover content knowledge (understanding of the curriculum and the subject matter to be taught and the use of relevant materials)."[585]

- Data and statistics related to skills and learning outcomes are limited; thus, it would be beneficial to collect and report on learning outcomes, in keeping with SDG indicator 4.1.1.Data related to the proportion of adolescents (ages 15-19) and youth (ages 15-24) using ICT, disaggregated by sex, age group, level of education, area (urban vs. rural), and wealth index quintile, are lacking. Useful data would include the proportion of adolescents and youth who have: ever used a computer; used a computer in the past 3 months; own a mobile phone; ever used the internet; and used the internet in the past 3 months.
- Data related to child and early marriage, levels of education, and child labour and education are also lacking. It is important to understand the levels of educational attainment among girls who were married before the ages of 15 and 18, as well as among children involved in child labour and working in hazardous conditions.
- National TVET/FTE data are lacking. TVET/FTE enrolment and graduation rate data should be regularly collected and analysed, disaggregated by type of TVET/FTE and province, as well as by sex and age. Such data can inform the education reforms needed to develop a demand-driven TVET system that supports young people in obtaining the skills required for a successful transition from basic and secondary education to employment. TVET can play a central role in developing the skills of adolescents and youth and preparing them for employment; however, this requires partnerships with the private sector.
- National tertiary/higher education data are lacking. Tertiary/higher education data should be regularly collected and analysed, and disaggregated. It would be beneficial to have data and statistics on enrolment in institutions of higher education by sex and type of institution, programme of study, and levels of study (e.g., certificate, diploma, degree, postgraduate, Masters, and PhD/Doctorate).



CHAPTER 7: Every Young Person Participates

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"For young people, the path to a successful future goes through quality education that equips them – and empowers them – with the skills they need to thrive into today's work for."[586]

Between the ages of 15 and 24, most youth complete their education and enter the labour force. The majority of youth transition successfully into the labour force, but the shift from school to work is not as straightforward for all. There are young people who complete their schooling but are unable to obtain employment, finding the job search to be a long and arduous process characterised by cycles of unemployment, zero-hour contracts, unpaid internships, apprenticeships or traineeships, and low-quality jobs with few legal rights or social protection. This has profound social and economic impacts in terms of lost productivity.[587]

For youth who find themselves out of school and unemployed, the social and economic impacts can be significant regarding lost productivity and the effect on mental health and well-being.[588] Mental health is a vital factor in a young person's ability to successfully move from school to work. Research has shown that mental health issues are the primary reason why youth may find themselves with a 'not in employment, education or training' (NEET) status.[589]

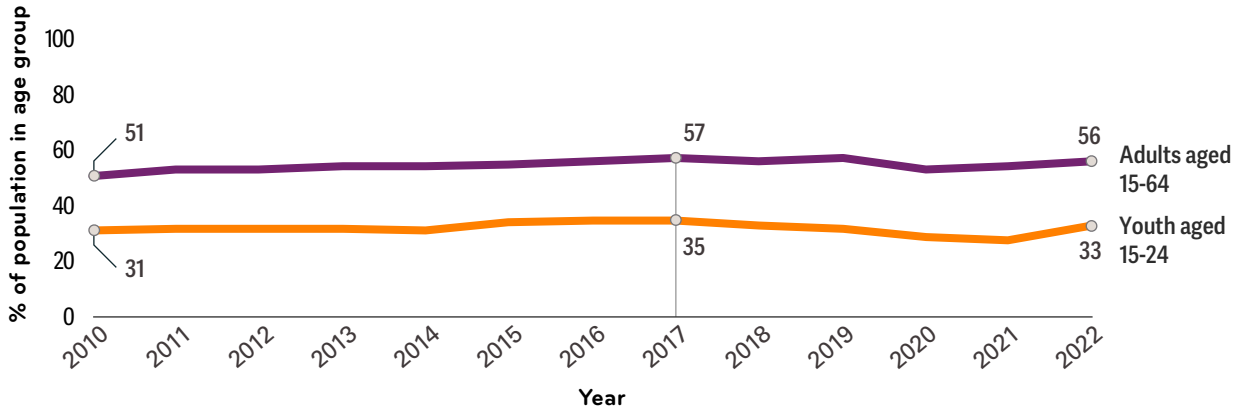
In low-, middle-, and high-income countries, youth mental health and well-being have often been overlooked, yet they play an important role in the success of job searches and whether young people secure decent work.[590] A youth's sense of self-worth and self-esteem may also suffer, particularly if the time taken to obtain gainful employment extends into months or years; in such situations, a young person may not achieve their full labour market potential and may experience reduced incomes over their lifetime. For wider society, the potential for loss of productivity should be a concern.

Globally, investments in quality wage jobs and self-employment fall short of youth aspirations, leaving a growing pool of young people with an insufficient number of decent jobs. Moreover, many educational systems struggle to equip youth with the skills needed to meet employers' expectations. The COVID-19 pandemic and the related global recession have further exacerbated the socio-economic challenges facing youth, putting at risk many of the gains made in recent years to advance opportunities for young people.[591]

Youth Labour Force Participation

Chart 7.1 shows labour force participation among working-age populations in South Africa, comparing youth aged 15-24 to adults aged 15-64. In 2021, the total youth population (aged 15-24) was estimated at 10,285,047, or 16.6 per cent of the population, of which only 30 per cent were employed in the labour force (up from 28 per cent in 2010). This compares to 59 per cent of adults aged 15-64 who were employed in the labour force in 2022 (up from 57 per cent in 2010). Historically, the labour force participation rate for adults aged 15-64 has been higher than that for youth aged 15-24. According to the 2023 3rd Quarter Labour Force Participation Survey, the labour force participation rate was 60 per cent; the number of employed persons increased by 399,000 to 16.7 million in the 3rd Quarter of 2023, compared to 16.3 million in the 2nd Quarter of 2023.[592]

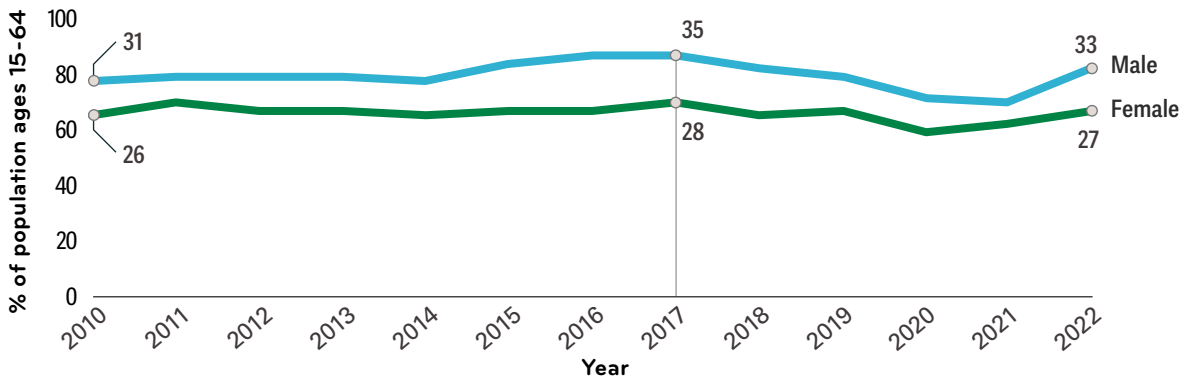
CHART 7.1. Labour force participation rate by age group (%, modelled ILO estimate), 2010-2022



SOURCE: Retrieved on 19 March 2024 from: Labor force participation rate, total (% of total population ages 15-64) (modelled ILO estimate) - South Africa | Data (worldbank.org) and Labor force participation rate for ages 15-24, total (%) (modelled ILO estimate) - South Africa | Data (worldbank.org),

Chart 7.2 shows that from 2010 to 2021, among youth aged 15-24, males were more likely than females to participate in the labour force. In 2019, prior to the COVID-19 pandemic, 32 per cent of male youth participated in the labour force, compared to 27 per cent of female youth. In 2020 and 2021, during the COVID-19 pandemic, the youth employment rate dipped for both males and females. By 2022, the youth labour force participation rate rebounded to 33 per cent for male youth and 26 per cent for female youth.

CHART 7.2. Youth labour force participation rate by sex (% pop. ages 15-24, modelled ILO estimates), 2010-2022



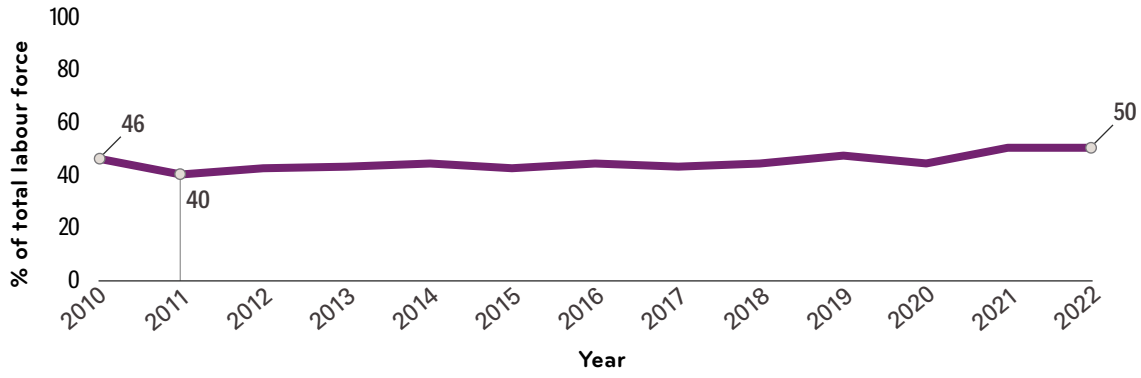
SOURCE: Retrieved on 19 March 2024 from: Labor force participation rate for ages 15-24, female (%) (modelled ILO estimate) - South Africa | Data (worldbank.org) and Labor force participation rate for ages 15-24, male (%) (modelled ILO estimate) - South Africa | Data (worldbank.org)

Youth Unemployment

The unemployment rate[593] is the most widely used indicator for unemployment and is a designated SDG Indicator (8.5.2). Over the past decade, unemployment has remained a structural challenge for South Africa; the unemployment rate has never been 20 per cent or lower. In 2022, the United Nations Development Programme (UNDP) highlighted joblessness in South Africa as a barrier to human and economic development, compared to other countries in the global context.[594]

Chart 7.3 shows that from 2010 to 2022, the youth unemployment rate in South Africa fluctuated slightly, from 46 per cent in 2010 to a low of 40 per cent in 2011, before increasing to 47 per cent in 2019. In 2021 and 2022, the youth unemployment rate was as high as 50 per cent, partly due to the COVID-19 pandemic. In 2023, the youth unemployment rate was estimated to be 61 per cent, according to official statistics, and a staggering 71 per cent if you count those youth who are no longer trying to find employment.[595]

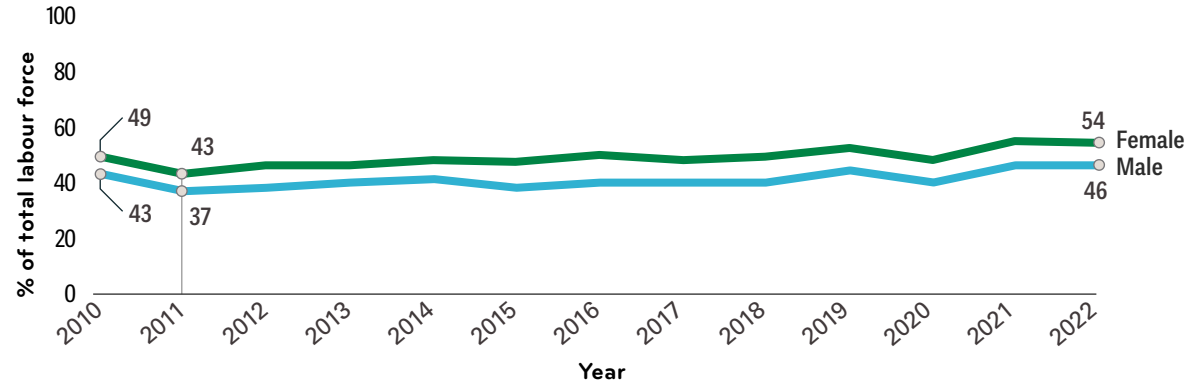
CHART 7.3. Youth unemployment rate (% of labour force ages 15-24, modelled ILO estimate), 2010-2022



SOURCE: Retrieved on 19 March 2024 from: Unemployment, youth total (% of total labor force ages 15-24) (modelled ILO estimate) - South Africa | Data (worldbank.org)

Chart 7.4 shows that from 2010 to 2022, the female youth unemployment rate has consistently been higher than the male youth unemployment rate. In 2020, during the COVID-19 pandemic, both the female and male youth unemployment rates decreased by four percentage points, reaching 48 per cent and 40 per cent respectively. Subsequently, in 2021 and 2022, both the female and male youth unemployment rates significantly increased. By 2022, the female youth unemployment rate had climbed to 54 per cent, while the male youth unemployment rate had risen to 46 per cent.

CHART 7.4. Youth Unemployment rate by sex (% of labour force ages 15-24, modelled ILO estimate), 2010-2022



SOURCE: Retrieved on 19 March 2024 from: Unemployment, youth male (% of male labor force ages 15-24) (modelled ILO estimate) - South Africa | Data (worldbank.org) and Unemployment, youth female (% of female labor force ages 15-24) (modelled ILO estimate) - South Africa | Data (worldbank.org)

As a consequence of higher youth unemployment rates, youth account for a disproportionate share of total unemployment. These patterns reflect the difficulties that young people encounter when they enter the labour market and either do not have or are perceived as not having the qualifications or experience required to ensure access to many job opportunities. Given that unemployed youth tend to live with their families, this can further exacerbate the financial situation of families and households, increasing the risk of volatile family situations. In South Africa, the lack of safety nets, including unemployment insurance, has intensified the impact of the COVID-19 pandemic on the health and economic well-being of the more than 2 million South Africans who fell out of employment as a result of the pandemic.[596] Further analysis is needed to understand the long-term impact of the COVID-19 pandemic on youth unemployment and labour force participation.

Globally, one of the issues facing both policymakers and employers is that traditional approaches to education and TVET have not kept pace with the knowledge and skills demands of the labour market, which has contributed to a skills gap across global regions. The modern world of work requires individuals to have foundational academic qualifications, coupled with a range of soft and social skills essential for navigating the challenges of an ever-changing labour market, fluctuating employer demands, and a volatile macroeconomic context. In addition to having a formal education, young people need the opportunity to explore options beyond their immediate school environment, such as developing entrepreneurial skills and exploring routes to sustainable self-employment. In this respect, policymakers and researchers have become increasingly interested in how young people's social capital and networks can be leveraged to help them move into decent work.[597]

For these reasons, youth unemployment is a major policy concern. Globally, governments are aware of these issues and are addressing them through the formulation and implementation of a wide variety of policies and programmes. The relevance and importance of these programmes will become even more pronounced as the negative impacts of the COVID-19 pandemic on employment and national economies become clearer. In South Africa, there have been warnings that unemployment threatens the country's stability, as evidenced by the week of riots and looting in 2021, which left more than 350 people dead in the country.[598]

Youth Not in Employment, Education Or Training (Neet)

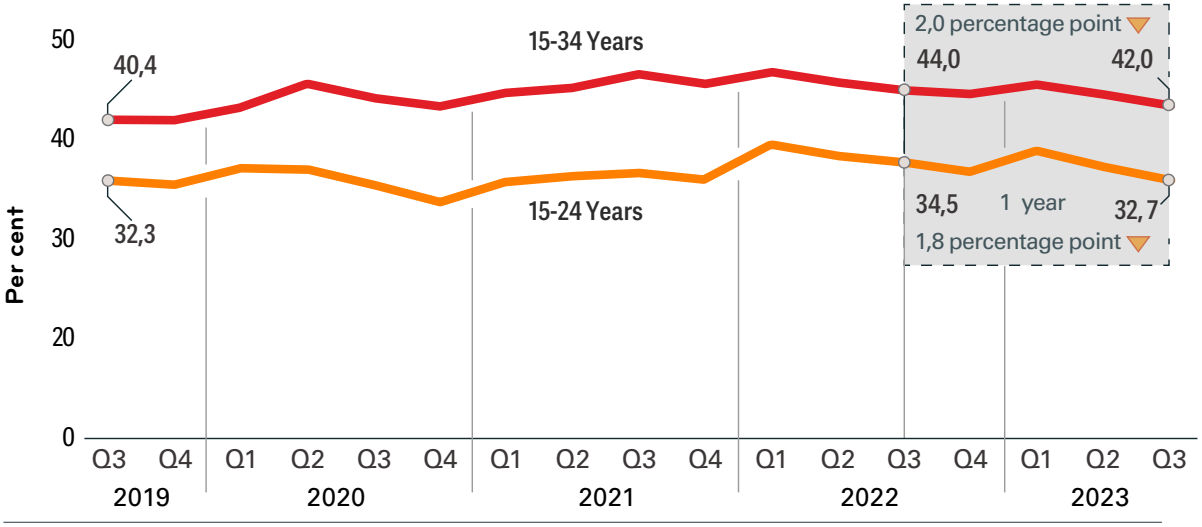
The proportion of youth (ages 15-24) NEET is an SDG indicator (8.6.1). Youth NEET is the percentage of the youth population that are neither working nor in education or training; it includes youth who are unemployed as well as those who are inactive for other reasons. This SDG indicator arises from the recognition that unemployment is strictly defined as those who are not in employment and are actively seeking work and available for work. Consequently, the definition of unemployment excludes a potentially significant proportion of the youth population who are not working but are not actively seeking employment for a variety of reasons.

Education is a key determinant of individual social mobility and an effective remedy for unemployment and chronic poverty.[599] Globally, young people with no more than a lower primary education account for more than 30 per cent of youth NEETs and are three times more likely to be NEET than youth with a university degree.[600] Youth NEETs are more likely to be at risk from the adverse impacts of unemployment, including marginalisation, exclusion and engagement in anti-social behaviours. The need to incorporate this group of youth into the analysis of youth issues led to the NEET indicator becoming the sole youth-specific target for the post-2015 SDGs. The youth NEET rate can be directly compared to the unemployment-to-population ratio, as both are derived as percentages of the overall youth population.

For statistical purposes, the UN defines youth as those persons aged 15-24 years; as is the case with SDG indicator 8.6.1, the proportion of youth (ages 15-24) NEET. In Africa, however, the African

Youth Charter defines youth as those persons aged 15-35 years. These different definitions of youth significantly impact the youth NEET rate. For instance, in 2021, 46 per cent of youth aged 15-34 fell into the youth NEET category in South Africa, compared to 34 per cent of youth aged 15-24 years.[601] In addition, in the 2023 3rd Quarter Labour Force Survey (LFS), it was reported that 42 per cent of youth aged 15-34 fell into the youth NEET category in South Africa, compared to 33 per cent of youth aged 15-24.[602] Chart 7.5 shows that the youth NEET rate (ages 15-24) decreased by 1.8 percentage points from the 3rd Quarter 2022 to the 3rd Quarter 2023, whereas the 15-34 years youth NEET rate decreased by 2.0 percentage points.[603]

CHART 7.5. Youth NEET Rates for youth aged 15-24 and 15-34 from 3rd Qtr. 2019 to 3rd Qtr. 2023



SOURCE: Department of Statistics South Africa (2023). Quarterly Labour Force Survey (QLFS) Q3:2023. Department of Statistics South Africa: Pretoria, South Africa. Retrieved on 2 February 2024 from: PowerPoint Presentation (statssa.gov.za)

In 2022, an analysis of youth NEET in South Africa, particularly among persons aged 15-34, found that most youth NEET were from poor, grant-dependent households or financially stretched and indebted extended families of single low-wage earners. Youth NEET were also predominantly urban or moved between urban and rural areas. In addition, at least 50 per cent of youth NEET had young children. Most youth NEET also lived in households where there was no adult who had at least a matric certificate, and a significant proportion were the only adult in the household.[604]

Given that youth NEET included persons aged 15-34, it was found that most youth NEET were not in or eligible to be in post-school education and training (PSET) institutions. Many had attended some form of tertiary education but dropped out before graduating, usually for financial or other socio-economic reasons. Although most youth NEET had some form of education, they had mostly attended poor-quality schools where the quality of education did not lead to the acquisition of basic communication, literacy, and/or numeracy skills that many employers require. They were also unlikely to find jobs through social networks.[605]

Among females, two factors are highly associated with increased youth NEET status. On the one hand, married or cohabiting women between 15-19 years of age have an 11.3 times greater probability of being NEET than their unmarried counterparts. Between 20-24 years of age, married or cohabiting women were twice as likely to be NEET.[606] For women aged 20-24 years, attaining secondary school is associated with a 50 per cent reduction in the probability of being NEET.[607] In addition, a social grant of any kind in the household decreases the probability of females aged 15-19 being NEET by 82 per cent, and 20-24-year-old women by 67 per cent.[608] Participation of women aged 20-24 years in government employment programmes in the past year was also associated with a reduction in the probability of being NEET by 48 per cent; although only one per cent of women aged 20-24 had participated in a government employment programme, it appears that these initiatives assist young women in finding employment in the long term.[609]

In South Africa, youth unemployment is a challenge, which "limits the earning potential of youth, stymies business growth, threatens social cohesion, and puts pressure on public resources."[610] Thus, the high youth unemployment rate has been described as a so-called 'ticking time bomb.[611]

'Globally, it is well documented that youth can often encounter difficulties when they enter the labour market, as they may not possess or may be perceived as not possessing the necessary qualifications or experience required to ensure access to many job opportunities. Thus, one of the issues facing both policymakers and employers is that traditional approaches to education and TVET have not been able to keep up with the knowledge and skills demands of the new labour market, contributing to the development of a skills gap across global regions. The modern world of work requires individuals to have foundational academic qualifications, coupled with a range of soft and social skills essential for navigating the challenges of an ever-changing labour market, fluctuating employer demands, and a volatile macroeconomic context. In addition to having a formal education, young people need the opportunity to explore options beyond their immediate school environment, such as developing entrepreneurial skills and exploring routes to sustainable self-employment. In this respect, policymakers and researchers have become increasingly interested in how young people's social capital and networks can be used to help them move into decent work.[612]

For these reasons, youth unemployment is a major policy concern. Globally, governments are aware of these issues and are addressing them through the formulation and implementation of a wide variety of policies and programmes. The relevance and importance of these programmes have become even more pronounced as the negative impacts of the COVID-19 pandemic on employment and national economies have become clear.

To address South Africa's youth unemployment challenge, the South African National Human Development Report (SANHDR) 2022: Harnessing the Employability of South Africa's Youth provides a five-pronged strategy:[613]

- A strategic approach to youth transition pathways to sustainable livelihoods
- Creating and seizing job opportunities and the demographic dividend
- Capturing the opportunities in the new world of work
- Revitalising the National Youth Service Schemes
- Creating alliances of different actors

To further address youth NEET, particularly among young women, it is important to:[614]

- Reduce early marriage and adolescent motherhood
- Improve the quality of education and educational attainment, particularly among poorer youth who often do not acquire the skills and competencies needed to enter the labour market
- Increase employment opportunities for young women

Adolescent Participation and Civic Engagement

Adolescent participation and civic engagement are important because adolescents are directly affected by decisions made by national and community leaders in areas of education, health, and employment. Adolescents often have strong views on policies and programmes that shape their lives and communities, but they are frequently excluded from public dialogue and decision-making processes on issues that affect their lives.[615] In keeping with the CRC, adolescents have the right to be heard, to engage with governments and businesses, and to influence matters that affect them. When adolescents are provided opportunities to contribute to social change, they build better futures for themselves and contribute to the prosperity of entire communities.[616]

Globally, UNICEF works to promote adolescent participation and civic engagement, empowering adolescents to become drivers of social change through a variety of actions:[617]

- Promote policies and laws that encourage adolescent participation.
- Strengthen platforms for adolescent participation.
- Help adolescents develop the skills needed to form and voice their opinions.
- Assist communities in supporting adolescents to create solutions and lead change.
- Focus on adolescents most likely to be excluded.

Youth Parliament

In 2013, the Youth Parliament was launched. The Youth Parliament is a national discussion platform provided by Parliament to encourage young people, through active debates, to take part in shaping the country and democracy. The Youth Parliament aims to recognise the valuable contributions made by youth to the country's liberation and development. Parliament established the Youth Parliament to ensure that youth continue to play a critical role in social transformation, reconstruction, and development in post-apartheid South Africa.[618]

The Youth Parliament serves as a mechanism to involve youth in debating the pressing issues faced by young people and creates an opportunity for youth to engage with Parliament and Provincial Legislatures, as well as with the national government and youth structures, encouraging them to take part in decision-making and legislative processes.[619]

The theme of the Youth Parliament in 2013 was "Youth at the centre of economic opportunities."[620] More recently, in 2020, the Youth Parliament focused on youth economic issues exacerbated by the COVID-19 pandemic.[621]

UNICEF's U-Report

In 2021, UNICEF South Africa launched UNICEF's U-Report to strengthen the involvement and participation of young people aged 10–24 in South Africa, and it now has 400,456 registered U-Reporters. https://sa.ureport.in/engagement/ UNICEF's U-Report is an online platform and social monitoring tool designed to increase opportunities for young people and other community members to share their opinions and speak out on a range of topics, as well as access lifesaving and life-enhancing information. The U-Report also aims to increase opportunities for young people to participate in decisions that impact their lives and their communities, and to change and influence social norms.

The U-Report platform serves to strengthen community-led development and citizen engagement, providing stakeholders, service providers and decision-makers with real-time public opinion and viewpoints on issues being addressed in communities. The platform also provides useful information to U-Report participants so that they can work to change and improve their localities. Information gathered through the U-Report can also be used to inform UNICEF programming and GoSA policy-making.

While not representative, U-Report also allows for repeated polling on a subject to provide an indication of behavioural and social trends. In 2021, U-Report polling focused on improving mental health support for young people in South Africa. According to findings from the UNICEF South Africa U-Report poll, approximately 65 per cent of respondents stated that they had experienced a mental health issue but did not seek help, with 20 per cent not knowing where to find assistance and 18 per cent being afraid of what people would think if they sought help for a mental health issue. Increased poverty and a lack of hope for the future topped the reasons given for children and young people's anxiety, showing a shift from violence as the leading reason in a poll conducted earlier in 2021.[622]

More recently, in August 2023, ahead of International Youth Day, a new 2023 U-Report was conducted that focused on issues that matter to young people, from mental health to climate change, sexual health and discrimination. This U-Report found that 23 per cent of respondents cited life skills as the most useful to develop in helping them find work, 19 per cent identified vocational training,

and 18 per cent identified the development of entrepreneurship skills. In addition, 28 per cent of respondents noted that paid mentorship opportunities are important.[623]

In October 2023, ahead of World Mental Health Day, UNICEF released findings from the latest U-Report polls which revealed that 60 per cent of youth needed mental health support over the past year. The need for support was 5 per cent higher among females than males. This poll found that only 63 per cent of respondents who needed support actively sought help, with the primary reason for not seeking assistance being a lack of knowledge about where to go. Additionally, 22 per cent of respondents cited family as an outlet for support, but only 36 per cent ever spoke with their caregivers about their mental health. This U-Report also highlighted that 48 per cent of respondents were most anxious about the need to build their skills and secure future employment, as well as concerns over rising poverty due to increasing living costs and educational success.[624] More recently, in March 2024, another U-Report was launched that focused on issues of sexual and reproductive health (SRH), sexual and gender-based violence (SGBV), and HIV.[625]

Young People and Climate Change

Young people in South Africa have become active in taking action to address climate change. In 2023, they were called upon to participate in a photography project entitled 'The Green Rising: Climate Impact and Response – Through a Fresh Lens'.[626] This project encourages young people to use photography to document and share how their lives are being affected by climate and environmental issues, and how they are adapting and fighting back. The aim is to amplify the voices and images of children and young people impacted by climate change in communities across South Africa.[627]

Under the auspices of the project, young people will learn to use photography and storytelling techniques to produce a photo book and exhibit. The goal is to empower young people to share their stories about the realities of climate and environmental shocks, and to practice ways in which they are adapting and minimising the impact. The content generated from this project will serve as a documentation of history and increase the visibility of young people who are on the frontline of combating the climate and environmental crisis.[628]

In South Africa, 'The Green Rising' photo project was launched by UNICEF South Africa, the Office of the High Commissioner for Human Rights (OHCHR) Southern Africa, Maverick Citizen, and EPA Images.[629]

Young People and the Media

South African media are guided by a number of legal and ethical frameworks related to reporting on children, such as section 28.2 of the Bill of Rights of the Constitution and the Criminal Procedure Act 51 of 1977. Ethically, media are also bound by the Press Code of Ethics and Conduct for South African Print and Online Media, as well as their own media's press codes and other accepted standards of journalistic practice when reporting on children. South Africa is also a signatory to the CRC and ACRWC, which promote children's rights to freedom of expression, dignity, and privacy, among other rights.[630]

In 2022, Media Monitoring Africa (MMA) monitored coverage of children in the media and found that children's representation in the media is very low, at 6 per cent of all reported stories during the monitoring period. In addition, children's voices are under-represented in news media coverage at 8 per cent. This means that issues affecting children are receiving less coverage in the media, and that children are not provided an opportunity to express their views. If children's issues are not adequately reported, people remain unaware of the challenges and problems faced by children. This can lead to a lack of public support for policies and programmes that benefit children.[631]

When children are covered in the media, the topics most frequently addressed include: crime (19 per cent); disasters and accidents (15 per cent); the justice system (14 per cent); education (11 per cent); child abuse (7 per cent); and health (7 per cent). Less frequently, children are covered in topics such as: conflict and political violence (4 per cent); personalities and profiles (3 per cent); economics (2 per cent); media and the arts (2 per cent each); substance abuse (1 per cent); gender (1 per cent); and poverty (0 per cent).[632]

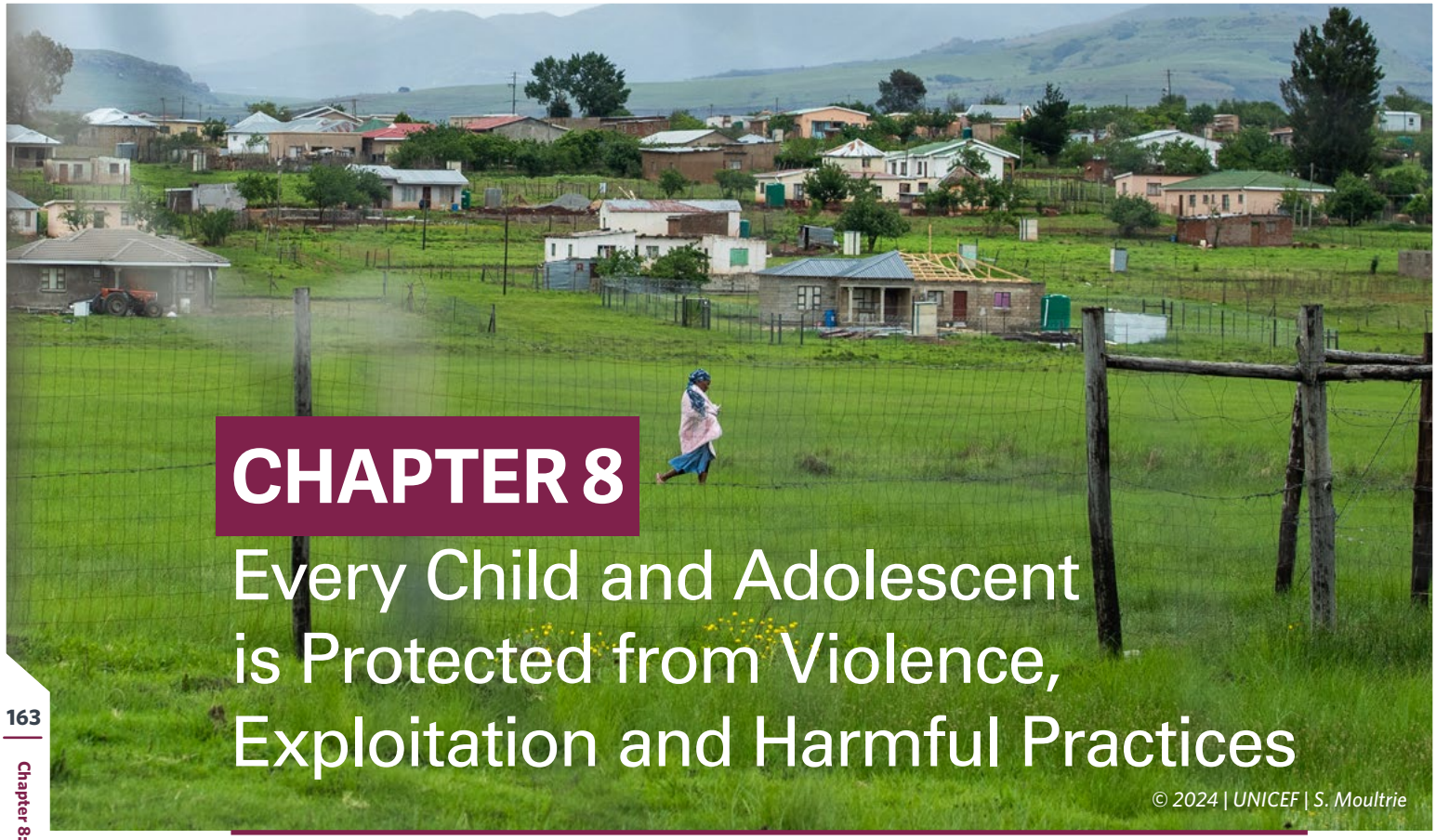
Given these findings, it was recommended that the media make a deliberate effort to increase the number of children's stories, which will help to bring children's issues to the national agenda and to the attention of policy makers. There also needs to be an increased effort to ensure that children are given opportunities to contribute their voices to the coverage, particularly when it is in their best interest.[633] Adding children's voices to media coverage enables them to contribute to the discourse and provides society with an understanding of how children think about various issues in their communities and society.[634]

In 2023, UNICEF released research produced with Media Monitoring Africa examining how children engage with news on social media. The research revealed that children's social media use is primarily entertainment-based and focused on connecting with friends. Despite this, hard news is often consumed alongside celebrity news or through content shared by friends. The young participants also noted that news content could be more engaging by incorporating more audio-visual elements, shorter text, and younger voices to present news stories. In addition, the research revealed that news received through family and traditional media is still regarded as more trustworthy. The learners indicated that political news is important for staying informed about current affairs, with some expressing feelings of encouragement and awareness, while others felt sad and angry due to corruption and crime.

Summary of Data Gaps

This chapter focused on data related to every young person's participation and civic engagement. There were notable data gaps, including:

- Data related to youth labour force participation and unemployment rates are limited, and qualitative data are missing to understand the experiences of adolescents and youth concerning labour force participation and unemployment.
- Youth NEET data are scarce. It is important to collect youth NEET data and to disaggregate this information by sex and age groups (15-19 years and 20-24 years). Qualitative data are also lacking to understand the experiences of youth who are NEET and the support that these young people need to address their vulnerabilities, change their life course, and improve their future social and economic well-being.
- Data are lacking on the impact of COVID-19 on youth labour force participation, unemployment, and NEET status. This data gap can likely be filled by analysing existing information, particularly data collected by the government and development partners both during and after the pandemic, especially data that focused on measuring the impact of COVID-19 on the population. Since the COVID-19 pandemic led to job losses and interruptions to education, it disproportionately impacted already vulnerable populations; thus, understanding the effects of the COVID-19 pandemic on youth labour force participation, unemployment, and NEET status is critical. Such data can be used to inform the development of TVET/FTE and employment programmes that engage youth, build their knowledge and skills, foster innovation, and create jobs that can sustain stability and prosperity in the lives of youth and their families.[635]
- Data and information are limited on children in the media, particularly to address the question: What is the potential role of traditional media, social media, and social movements in advancing child rights?



CHAPTER 8

Every Child and Adolescent is Protected from Violence, Exploitation and Harmful Practices

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"Child protection is the prevention of, and response to, exploitation, abuse, neglect, harmful practices, and violence against children (VAC) and adolescents. Despite advancements in child rights over the past two decades, strengthening child protection remains a priority. The COVID-19 pandemic has further intensified threats to children's rights to protection, as services to manage these risks were reduced, and countries continue to feel the social and economic impacts of the pandemic. School closures during the pandemic, caregiver deaths caused by the pandemic and other diseases, and disruptions in child protection and other services have placed the most vulnerable at an increased risk of multiple rights violations, such as violence and abuse, child marriage, child labour, child trafficking, and family separation."[636]

Experiencing violence in childhood impacts lifelong health and well-being.[637] It is well-documented that children exposed to violence, abuse, and exploitation, either directly or indirectly, are at increased risk of being physically injured or harmed, experiencing impaired brain and nervous system development, and developing negative coping strategies, such as alcohol and/or drug use and abuse, and engagement in high-risk sexual behaviours.[638] They are also more likely to experience low self-esteem and suffer from anxiety, depression, and other mental health problems that can lead to self-harming and suicidal behaviours.[639] Children exposed to violence, abuse, and exploitation are also at increased risk of learning difficulties, performing poorly at school, dropping out of school, and facing difficulties finding and keeping a job.[640] They are also at heightened risk for later victimisation and/or perpetration of interpersonal and self-directed violence, which can affect the next generation of children.[641] The social and economic costs of VAC, in terms of lost potential and future social and economic well-being, are well documented.[642]

Globally, there has been increased attention and recognition of the pervasive nature and impacts of VAC and sexual and gender-based violence (SGBV) on children and adolescents. There has also been important progress made in documenting the prevalence of VAC and SGBV in the home and family, schools and institutions, and communities. Steps have also been taken to improve the ability of child

protection and justice systems to identify and respond to VAC and SGBV. Nevertheless, incidents of VAC and SGBV remain largely hidden, as most incidents are undocumented and under-reported. In addition, some forms of VAC are socially accepted and condoned as discipline and are not perceived as abusive; as a result, many children do not realise that what they experience is a form of violence or abuse. There are also stigmas that surround SGBV, and in some countries, SGBV is considered taboo.[643]

In many countries, when children disclose experiences of violence or abuse, they often find that educators, social workers, child protection officials, police, and justice officials are ill-equipped to respond. Accountability for violations of children's rights, including those committed in families, schools, and other institutions, is important, as is the way that children are treated by national systems and duty-bearers.

Violence, abuse, and exploitation of children can be prevented, but it requires systematic efforts to address risk and protective factors at the four interrelated levels of risk – individual, relationship, community, and society. The evidence-based technical package, INSPIRE: Seven Strategies for Ending Violence Against Children, identifies seven strategies and related approaches that have shown success in reducing VAC. These seven strategies include: implementation and enforcement of laws; norms and values change; safe environments; parental and caregiver support; income and economic strengthening; response services provision; and education and life skills.[644] South Africa is a pathfinding country committed to INSPIRE and to ending violence against children, sending a letter of commitment in 2017.[645]

Child Protection System

Child protection is "the prevention of, and response to, violence, abuse, exploitation, neglect and harmful practices affecting children and adolescents."[646] Child protection systems connect children to vital social services and a fair justice system – starting at birth – and they provide care to the most vulnerable children, including those affected by conflict and in humanitarian situations.[647] In many countries, governmental and non-governmental institutions make up the child protection system, which provides services to vulnerable children and families.

In South Africa, the key policy and legal frameworks that guide the child protection system include the Bill of Rights in the 1996 Constitution, the Children's Act 38 of 2005, the National Child Care and Protection Policy (NCCPP) of 2019, and the Child Justice Act. In the 1996 Constitution, there are six rights directly related to crime and maltreatment of children, including the right to:

1. be protected from maltreatment, neglect, abuse and degradation;
2. be protected from exploitative labour practices;
3. be protected from performing work or services that are not appropriate for their age, would impact their well-being, and/or affect their physical, mental, spiritual and moral development, or their educational participation;
4. be treated as a child when in conflict with the law;
5. be represented by a legal practitioner assigned by the state; and
6. be protected in cases of armed conflict and not used for ulterior causes.

The Bill of Rights also suggests that all decisions concerning the child should be made with their best interests in mind.[648]

The Children's Act 38 of 2005 provides a standard for the best interests of a child and outlines guiding factors for applying this principle, which takes into account aspects related to crime and maltreatment, including the need to: protect children from any physical or psychological harm that could subject or expose them to maltreatment, abuse, degradation, ill-treatment, violence, or harmful behaviours towards others; protect children from family violence; and opt for actions or decisions that would avoid or minimise further legal or administrative proceedings in relation to the child.[649] The Act also establishes service standards for children in need of care and protection.

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In addition, the NCCPP provides a framework of roles and responsibilities, coordination mechanisms, and a package of services for child care and protection. This package of services includes: promotive enabling services, prevention and early intervention services, and responsive protective services.[650]

The DSD is responsible for leading and coordinating efforts for the care and protection of children and addresses issues of social safety and child labour that fall under the jurisdiction of other line departments, such as DBE, DoH and SADEL. DSD is also responsible for coordinating planning, providing technical support for implementation, and monitoring and reporting on the realisation of policy goals and objectives. DSD has a regular coordination mechanism, such as the National Child Care and Protection Forum, as defined in the policy as the national mechanism for coordinated planning, provision of technical support for implementation, and monitoring the realisation of policy goals and objectives. Meanwhile, the South African Council of Social Service Professions regulates the accreditation of the profession, licensing and registration of social service professionals, as well as education, development and training of social service professionals.[651]

In 2023, DSD employed 13,269 social service professionals, including social workers, social auxiliary workers, and child and youth care workers; however, there is a high turnover among social service professionals.[652] As a result, more social service professionals are needed, although the current budget may not permit an increase in workforce.

In 2019, the Office of the Rights of the Child (ORC) was re-established under the DSD. The main objective of the ORC is to ensure the effective mainstreaming of child rights at national, provincial and local levels. The ORC was mandated to develop and oversee the implementation of the National Plan of Action for Children (NPAC) and is responsible for all reporting on obligations to children. The NPAC has a direct bearing on the rights and well-being of children and ensures that domestic legislation is in harmony with international legal frameworks.[653]

For data and information related to social protection expenditures, see Chapter 3, Public Finance for Children and Adolescents, Social Protection Expenditures.

Bans on Corporal Punishment

In South Africa, corporal punishment is unlawful in the home (**Table 8.9**). In September 2019, the Constitutional Court confirmed a 2017 decision by the High Court of Gauteng, which found the common law defence of "reasonable or moderate chastisement" to be unconstitutional under Articles 10 and 12(1)(c) of the Constitution. Under South Africa's common law system, this decision from the Constitutional Court repealed the defence that "parents have the power to inflict moderate and

reasonable chastisement on a child for misconduct, provided that this was not done in a manner offensive to good morals or for objects other than correction and admonition." With this decision, the Constitutional Court effectively banned the use of all corporal punishment in the home, meaning that criminal provisions against assault now apply equally to children. In light of this Constitutional Court ruling, in 2024, the GoSA reported to the UN Committee on the Rights of the Child that corporal punishment is not permitted in the home.[654]

TABLE 8.9. Status of legal abolition of corporal punishment in South Africa

Setting	Status
Home	Abolished in law ✓
Alternative care settings	Abolished in law ✓
Day care	Abolished in law ✓
Schools	Abolished in law ✓
Penal institutions	Abolished in law ✓
Sentencing	Abolished in law ✓

The Children's Act 38 of 2005 defines abuse in relation to a child as "any form of harm or ill-treatment deliberately inflicted on a child," including "assaulting a child or inflicting any other form of deliberate injury on a child" and "exposing or subjecting a child to behaviour that may harm the child psychologically or emotionally." In 2007, the Children's Act was amended to provide for prevention and early intervention programmes which must focus, among other things, on "developing appropriate parenting skills and the capacity of parents and caregivers to safeguard the well-being and best interests of their children, including the promotion of positive, non-violent forms of discipline."[655]

General Regulations under the Children's Act 38 of 2005 also explicitly prohibit corporal punishment and other forms of humiliating and degrading punishment in alternative care settings, including foster care, cluster foster care schemes, and child and youth care centres. National Norms and Standards for Drop-In Centres also clearly state that corporal punishment should not be used.[656] National Norms and Standards for ECD programmes also state that corporal punishment should not be used and is prohibited in preschool and educational day care provision.[657]

Corporal punishment is also prohibited in schools in accordance with Section 10 of the South African Schools Act of 1996, Article 3 of the National Education Policy Act, and Article 16 of the Further Education and Training Colleges Act. In 2000, the Constitutional Court dismissed a bid by 196 Christian schools to make an exception to the prohibition of corporal punishment on grounds of religious conviction. In 2024, the government reported to the Committee on the Rights of the Child that it had trained 141 schools on alternatives to corporal punishment during the previous year (2023).[658]

Corporal punishment is also unlawful as a disciplinary measure in penal institutions. The Correctional Services Second Amendment Act of 1996 abolished disciplinary corporal punishment in prisons in respect of civil debtors, although there is no explicit prohibition of corporal punishment in the Correctional Services Act of 1998. Regulations under the Children's Act of 2005, however, explicitly prohibit corporal punishment in child and youth care centres and place a duty on management and staff of such centres to promote positive discipline.[659]

Corporal punishment is also prohibited as a sentence for crime under the Abolition of Corporal Punishment Act of 1997, which was enacted following a 1995 Constitutional Court decision that ruled whipping unconstitutional. In addition, there is no provision for corporal punishment in the Child Justice Act of 2008.[660]

Violence Against Children

Children and adolescents are often exposed to violence, either directly or indirectly, which includes witnessing or hearing violent interpersonal events, being directly involved by trying to prevent a violent encounter or by calling for outside help, and/or experiencing the visible or emotional consequences of witnessing or encountering violence.[661] Exposure to violence both inside and outside the home during childhood has also been associated with feelings of stress and anxiety, including anxiety about the loss of one's caregiver or their love, anxiety about physical harm to oneself, and anxiety about not meeting standards that can lead to feelings of shame and guilt. Exposure to violence, particularly in the home, has also been associated with the development of aggression in children.[662] Exposure to physical violence can begin to affect a child as early as infancy and negatively impact young children's ability to develop trust in their parent(s)/caregiver(s), leading to insecurities in their attachments and other relationships in their lives.[663]

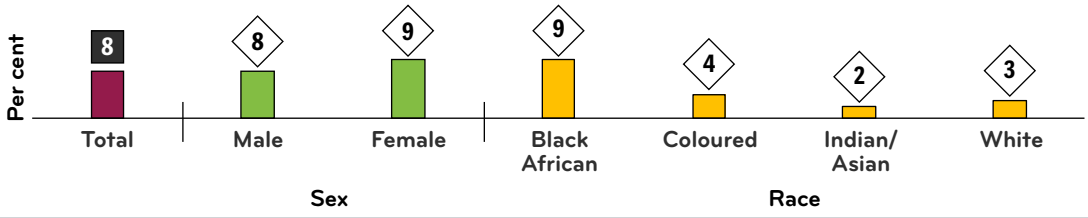
Violence against children (VAC) can occur in any setting but most often takes place in the home and family, schools, and public spaces (i.e., communities). In South Africa, VAC prevalence data at the national level are limited because the country does not periodically conduct the MICS[664] and has not yet conducted a Violence Against Children and Youth Survey (VACS), as other countries in the region have done. As a result, there is a serious gap in data on VAC, particularly in the home and family, in schools, and in public spaces. Available VAC prevalence data are limited to the annual GHS (2009-2023) and the 2019/2020 Governance, Public Safety and Justice Survey (GPSJS), along with some independent studies.

From 2013 to 2015, a nationally representative cross-sectional study of sexual abuse of children aged 5-16 years in South Africa (n=5,631) found that 58 per cent of children experienced direct victimisation and 52 per cent experienced indirect victimisation. More specifically, 25 per cent of children aged 5-16 experienced family violence, 18 per cent experienced physical abuse, 13 per cent experienced emotional abuse, and 12 per cent experienced neglect.[665]

In 2019, the GHS found that 8 per cent of children aged 5-17 experienced some form of violence at school (down from 19 per cent in 2009). Among children who experienced violence in schools, 84 per cent experienced corporal punishment, 11 per cent experienced physical violence by a teacher, 14 per cent experienced verbal abuse (i.e., being insulted, teased, or harassed) by a teacher, 5 per cent experienced physical abuse (i.e., being hit or punched) by another learner(s), and 4 per cent experienced verbal abuse (i.e., being insulted, teased, or harassed) by another learner(s).[666]

Chart 8.1 shows that girls (9 per cent) and boys (8 per cent) were equally likely to experience violence at school. Black Africans (9 per cent) were twice as likely to experience violence in schools as coloured children (4 per cent) and three times more likely to experience violence in schools than white children (3 per cent), and nearly five times more likely than Indian/Asian children (2 per cent).

CHART 8.1. Children aged 5-17 who experiences violence in schools by demographics (%), 2019



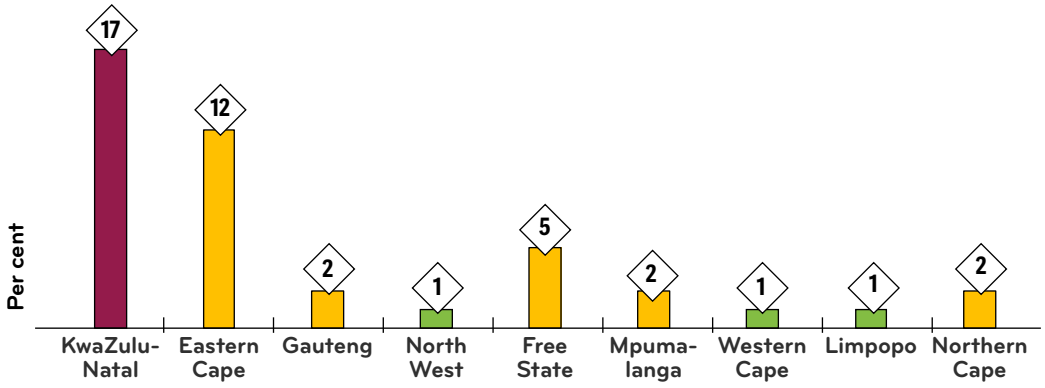
SOURCE: 2019 GHS

Among children exposed to violence in schools, 71 per cent were exposed to violence in primary school and 29 per cent in secondary school. It is likely that some children were exposed to violence in both primary and secondary schools; however, the data were either unavailable or were not analysed to explore this reality.[667] It is also notable that children from the poorest households (21 per cent) were far more likely to experience violence in schools than children from the richest households (14 per cent).[668]

Chart 8.2 shows the proportion of children aged 5-17 who experienced corporal punishment at school by province. In 2023, children from KwaZulu-Natal (17 per cent) were most likely to experience violence in schools, followed by 12 per cent in the Eastern Cape and 5 per cent in the Free State. This is followed by two per cent of children in Gauteng, Mpumalanga, and Northern Cape who experienced violence in schools.

Children in North-West, Western Cape, and Limpopo were least likely to experience violence in schools, with a one per cent rate recorded in each of these provinces.

CHART 8.2. Children aged 5-17 who experienced corporal punishment at school by province (%), 2023



SOURCE: 2023 GHS

Corporal Punishment

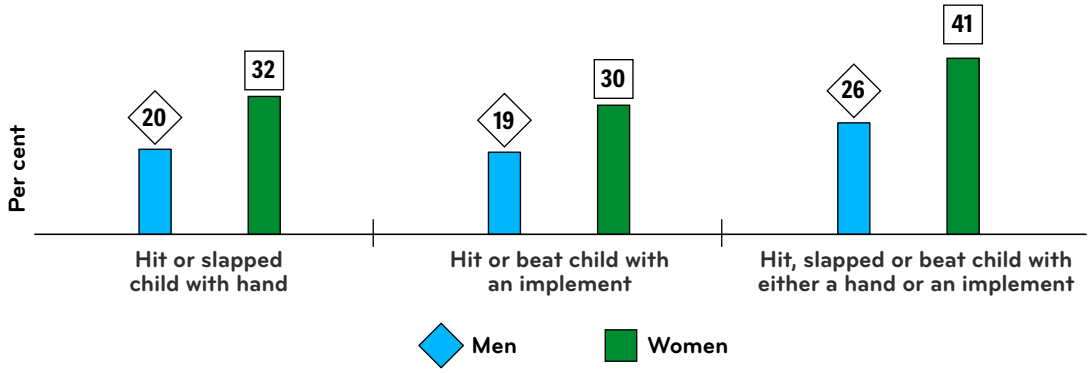
Discipline is a part of childrearing that teaches children self-control and acceptable behaviour. Too often, however, parents, caregivers, and educators use methods of discipline that rely on corporal (physical) punishment, intimidation, and emotional and verbal abuse to punish unwanted behaviours and encourage desired behaviours in children.

Corporal punishment is defined as any punishment in which physical force is used and intended to cause some degree of pain or discomfort. Most forms of corporal punishment involve hitting, slapping, and spanking children with the hand or an object (e.g., whip, stick, belt, shoe, wooden spoon), but can also involve kicking, shaking, and throwing children, as well as scratching, pinching, biting, pulling hair, boxing ears, and caning. Corporal punishment also includes forcing children to stay in uncomfortable positions or forced ingestion (e.g., soap, hot peppers). In severe cases, corporal punishment can involve burning or scalding a child.

While parents, caregivers, and even educators often use corporal punishment to enforce children's compliance with desired behaviours, research has found that corporal punishment is likely to have opposite and undesirable effects and can be harmful to children, leading to anti-social and aggressive behaviours and negative impacts on children's mental health, well-being, and social development. Rather than reducing inappropriate behaviours, corporal punishment teaches children that the use of physical aggression is normal and an appropriate means of solving conflicts. The negative consequences of corporal punishment can carry over into adulthood.[669]

The proportion of children in South Africa who experience violent discipline in the home and family is limited to 2016 SADHS data. **Chart 8.3** shows that in 2016, 41 per cent of women aged 15-49 with one or more children under the age of 18 living with them hit, slapped, or beat their child with either their hand or an implement (32 per cent hit or slapped their child with their hand, and 30 per cent hit or beat their child with an implement). In addition, 26 per cent of men aged 15-49 with one or more children under the age of 18 living with them hit, slapped, or beat their child with either their hand or an implement (20 per cent hit or slapped their child with their hand, and 19 per cent hit or beat their child with an implement).

CHART 8.3. Parents/caregivers use of corporal punishment to discipline children by sex (%), 2016

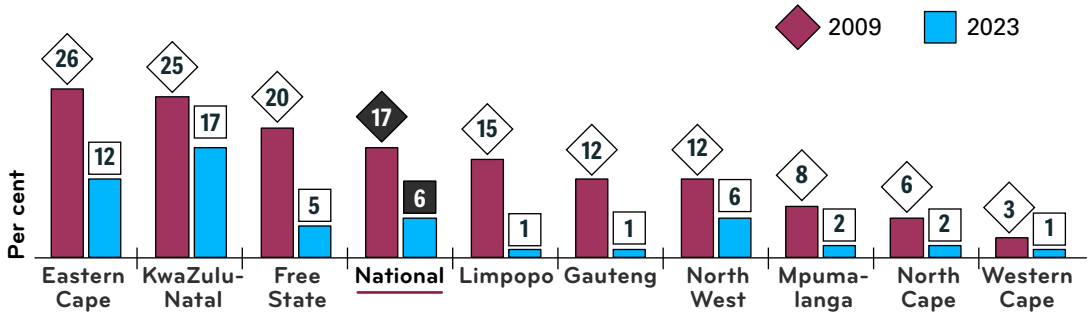


SOURCE: SAHDS, 2016

The GHS measures children's experiences of corporal punishment in schools. **Chart 8.4** shows that in 2023, 6 per cent of learners experienced corporal punishment in schools (down from 17 per cent in 2009). Corporal punishment in schools was most prevalent among children in KwaZulu-Natal (17 per cent, down from 25 per cent in 2009) and the Eastern Cape (12 per cent, down from 26 per cent in 2009), and lowest among children in the Northern Cape (2 per cent, down from 6 per cent in 2009), Limpopo (1 per cent, down from 15 per cent in 2009), Gauteng (1 per cent, down from 12 per cent in 2009), and the Western Cape (1 per cent, down from 3 per cent in 2009).

In 2019, it was reported that among children aged 5-17 who experienced corporal punishment by teachers in schools, 53 per cent were girls and 47 per cent were boys. In addition, 60 per cent attended schools in rural areas and 40 per cent in urban areas.

CHART 8.4. Children who experienced corporal punishment at school by province (%), 2009 & 2022



SOURCE: 2023 GHS

Public Acceptance of Corporal Punishment

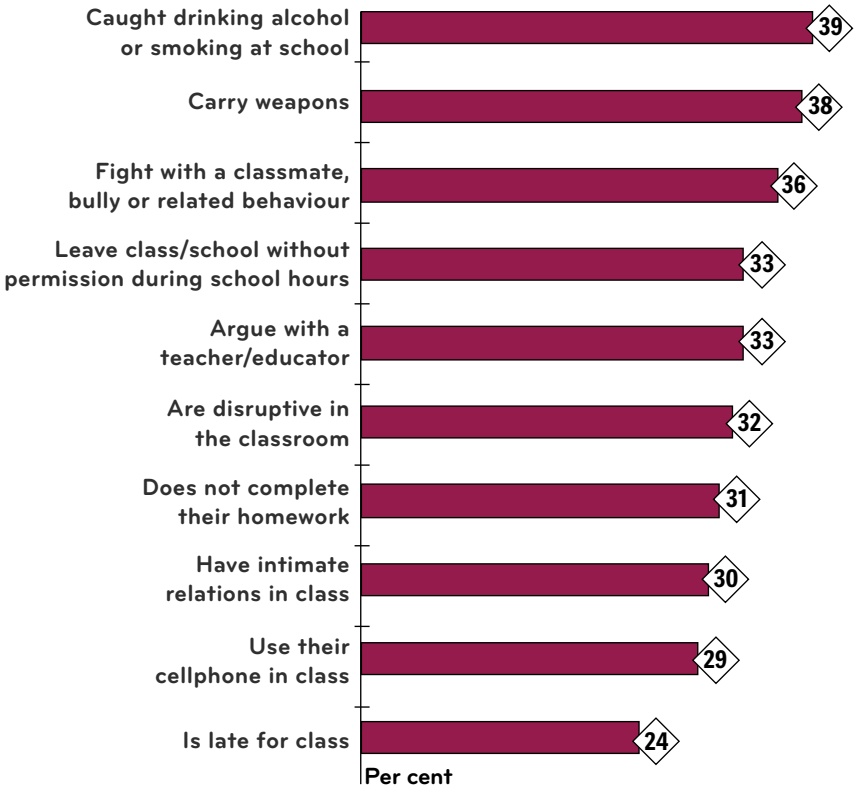
Understanding children's risks of experiencing violent discipline in the home and schools requires understanding the extent to which such violence is tolerated in families and the wider community (social norms). Social norms are widely held beliefs about what is typical and appropriate within a reference group. They represent a rule of behaviour that some individuals in a group conform to because they believe most others in the group do as well (it is typical behaviour), and because most others in the group believe they ought to conform (it is appropriate behaviour).[670] Some individuals may face pressure to conform to the social norms of a group, particularly if the group sanctions members who deviate from its social norms and standards.[671]

In some parts of the world, corporal punishment is socially accepted and common.[672] In South Africa, there is limited data on public support for the use of corporal punishment to discipline and control

children in the home and family, as well as in schools. The 2019-2020 GPSJS did find, however, that while 91 per cent of persons aged 16 years and older were aware that corporal punishment is illegal in South Africa, there were perceived justifiable reasons for parents and teachers/educators to use corporal punishment to discipline children.[673]

Chart 8.5 shows that more than one in three individuals believed that teachers/educators are justified in using corporal punishment to discipline and control children in the classroom if they: are caught drinking alcohol or smoking at school (39 per cent); carry weapons (38 per cent); fight with a classmate, bully, or engage in related behaviours (36 per cent); leave class/school without permission during school hours (33 per cent); and argue with a teacher/educator (33 per cent). A notable proportion of the public also believed that teachers/educators can use corporal punishment in the classroom if students are disruptive (32 per cent), do not complete their homework (31 per cent), have intimate relations in class (30 per cent), use their cell phones in class (29 per cent), or are late for class (24 per cent).

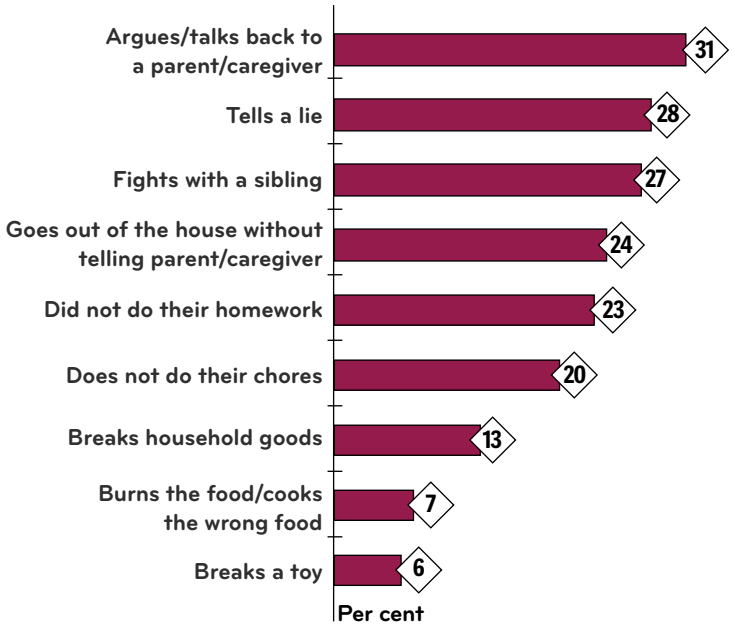
CHART 8.5. Public acceptance of teachers/educators' use of corporal punishment in the classroom (%), 2019/2020



SOURCE: GPSJS, 2019/2020

Chart 8.6 shows that the public also believes that parents/caregivers are justified in using corporal punishment if a child argues or talks back to parents/caregivers (31 per cent); tells a lie (28 per cent); fights with a sibling (27 per cent); goes out of the house without informing their parent/caregiver (24 per cent); fails to do their homework (23 per cent); does not complete their chores (20 per cent); breaks household items (13 per cent); burns the food or cooks the wrong dish (7 per cent); or breaks a toy (6 per cent).

CHART 8.6. Public acceptance of parents/caregivers use of corporal punishment in the home (%), 2019/2020



SOURCE: GPSJS, 2019/2020

Emotional Violence

According to the WHO, emotional or psychological violence includes restricting a child's movements, denigration, ridicule, threats and intimidation, discrimination, rejection, or non-physical forms of hostile treatment. It encompasses intentional conduct that seriously impairs a person's psychological integrity through coercion or threats. This includes any act that causes psychological harm to an individual, such as coercion, defamation, verbal insults, or harassment.[674] Acts of emotional violence can stem from uncontrolled frustration on the part of a parent or caregiver, or may serve a similar purpose to that of corporal punishment – to intimidate or scare a child into obedience and compel them to "refrain" from unruly behaviour.[675]

Research has found that children who experience emotional violence are likely to internalise the negative name-calling, insults, ridicule, and humiliating words, particularly when directed at them by a parent, caregiver, or authority figure (e.g., teacher or educator). Emotional violence can instil fear and anxiety in children and lead to long-term negative consequences and behaviours, as well as adversely impact their social and emotional development, and performance in school and academic success.[676] The negative effects are likely to differ greatly depending on the context and age of the child, but for many children who experience violence in the family, such violence often begins in early childhood and continues into adolescence.[677]

In South Africa, data related to children's experiences of emotional violence in the home, schools, and online is limited and not nationally representative.

Sexual Violence

Sexual violence is any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, acts to traffic, or other acts directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.[678] Sexual violence is also defined as engaging in non-consensual vaginal, anal, or oral penetration of a sexual nature of the body of another person with any bodily part or object, engaging in other non-consensual acts of a sexual nature with a person, and causing another person to engage in non-consensual acts of a sexual nature with a third person.

Sexual violence includes a range of acts, including completed non-consensual sexual acts, attempted non-consensual sexual acts, non-physically pressured sexual acts, and unwanted sexual contact.

- **Unwanted sexual touching –** Anyone touched them in a sexual way against their will, but did not attempt or force them to have sex.[679] Touching in a sexual way against their will included fondling, pinching, grabbing, or touching on or around their sexual body parts.
- **Attempted forced sex –** Anyone tried to make them have sex against their will, but the act did not occur. They might have tried to physically force them to have sex or might have attempted to pressure them through harassment or threats.
- **Pressured sex –** Anyone pressured them to have sex against their will through harassment or threats, and the act occurred.
- **Physically forced sex –** Anyone physically forced them to have sex against their will.

Every year, millions of girls and boys around the world face sexual violence and abuse. Children are subjected to sexual violence at home, at school and in their communities, and are increasingly at risk of online sexual abuse and exploitation. Most often, however, sexual abuse occurs at the hands of someone a child knows and trusts.[680]

It is important to understand the prevalence of sexual violence against children and adolescents in South Africa, because it results in severe physical, psychological and social harm to the victims. Victims are also at increased risk of HIV and other STIs and illnesses, as well as unwanted pregnancy, psychological trauma and social stigmatization that can result in social isolation. Some victims of sexual violence resort to risky behaviours, such as substance use or abuse, to cope with the trauma. As child victims reach adulthood, sexual violence can reduce their ability to care for themselves and others.[681] Children who experience sexual abuse are also at increased risk of sexual victimisation in adulthood.[682] It is crucial to understand these dynamics and trends related to sexual violence against children and among children and youth, particularly when designing prevention and protection programmes and interventions. While the data related to sexual violence against children is limited, the administrative data for sexual offences against children by SAPS is available. Please refer to Chart 8.10: Sexual offences for children aged ≤ 17 years reported to the police by sex, 2015/16 – 2019/20.

Online Child Sexual Exploitation and Abuse

Online child sexual exploitation and abuse is a real concern given the increased use of digital technology among children and adolescents in South Africa. The COVID-19 pandemic brought with it heightened emotional vulnerabilities, economic hardship, and surges in children's unsupervised time online, which likely magnified their vulnerabilities to sexual exploitation and abuse, particularly online. In addition, widespread disruptions in child protection services left vulnerable children without adequate access to protection.[683]

In South Africa, among 1,639 internet-using children aged 9-17 who participated in the Disrupting Harm household survey, 58 per cent went online at least once a day, and the majority accessed the internet using smartphones (97 per cent), followed by computers (39 per cent). Among these children, 9 per cent reported being offered money or gifts in return for sexual images or videos, 9 per cent were asked to meet in person to engage in sexual activities, and 7 per cent said that their sexual images had been shared without their permission. In addition, 7 per cent of internet-using children reported being threatened or blackmailed to engage in sexual activities. This form of sexual extortion is not explicitly criminalised in South African legislation, which represents a crucial gap in the national response to online child sexual exploitation and abuse.[684]

In 2018, 46,730 child sexual exploitation and abuse cases were investigated in South Africa, leading to 40,807 arrests and 13,082 convictions. In contrast, only 89 online child sexual exploitation and abuse cases were investigated, resulting in 58 arrests and 28 convictions.[685] In 2019, 38,031 'CyberTips' were made concerning suspected child sexual exploitation and abuse in South Africa.[686]

Disclosure of Violence and Help-Seeking Behaviours

Data on disclosure and help-seeking behaviours, and the use of services among children and youth who experience violence are extremely important for understanding why and where child and youth victims seek help and protection from the violence in their lives, as well as how many child victims do not speak out or seek help or protection from the violence they face, and the reasons why. Help-seeking behaviours and service use data can be used to improve the availability of essential services for child victims of violence and abuse, and to inform programme and social and behaviour change initiatives aimed at ending VAC. In South Africa, data on disclosure and help-seeking behaviours for violence, as well as knowledge of available services and their usage, are limited, and the data is not available from a nationally representative sample.

It is notable, however, that the Disrupting Harm household survey found that children who were subjected to online child sexual exploitation and abuse were generally reluctant to disclose their experiences to anyone. In fact, half of these children did not tell anyone the last time they were subjected to such exploitation or abuse. If children did choose to disclose, a friend was the most common confidant. Only one to two per cent of children reported the situation to the police, social workers, or a helpline.[687]

Exposure to Community Violence

Community violence is a public health concern because it is well documented that exposure to community violence may be a direct source of stress for children, adolescents, and youth, even if they are not the victims of such violence. Children and adolescents often experience indirect stress simply by hearing about a violent incident in their community from their parents, neighbours, or the media. Even observing a heavy police presence and the use of force in the area after an incident of community violence can be especially stressful for children and youth.[688] Both direct exposure (victimisation or witnessing an incident of violence) and indirect exposure to community violence can increase one's fear of future victimisation.[689]

Research has also shown that proximal or chronic exposure to community violence, including witnessing such violence, can compromise children's and adolescents' functioning and contribute to anxiety, sleep disruption, depression, impaired emotional processing and regulation, avoidance behaviours, substance use, and risk of suicide, among other mental health and functioning issues.[690] Exposure to community violence can also have negative effects on children's educational outcomes, particularly when they are exposed to violence on the way to and from school, as community violence, such as gang violence and gun violence, spills over into schools.[691] Adverse childhood experiences, such as direct and indirect exposure to community violence, can have a tremendous impact on future violence-related victimisation and perpetration, as well as lifelong health and opportunities.[692]

Data related to children and adolescents' exposure to community violence is limited, and national prevalence data is not available from a nationally representative sample in South Africa.

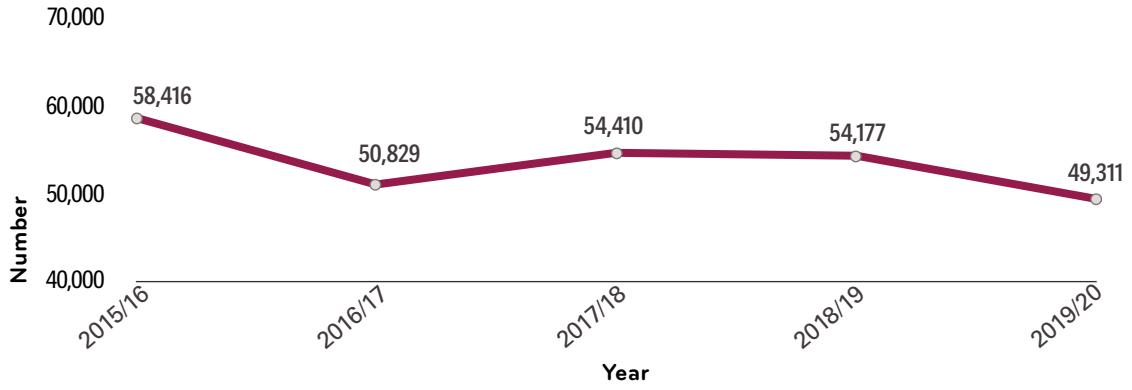
Child Protection Administrative Data

To facilitate evidence-based decision-making and to advocate for strengthening the national child protection system, the GoSA and child protection service providers require accurate, regular, and up-to-date data and information on how child protection and social services systems are functioning, including the number of children and families served (e.g., by sex, age, region, and population group) and the type and quality of services accessed and delivered. Such data can inform policy and programme planning and improve service delivery; however, this administrative data is not digitised and publicly available in South Africa. It would also be useful to have data and information on the

behavioural and social barriers to accessing services; however, this data would most likely come from a survey or qualitative study.

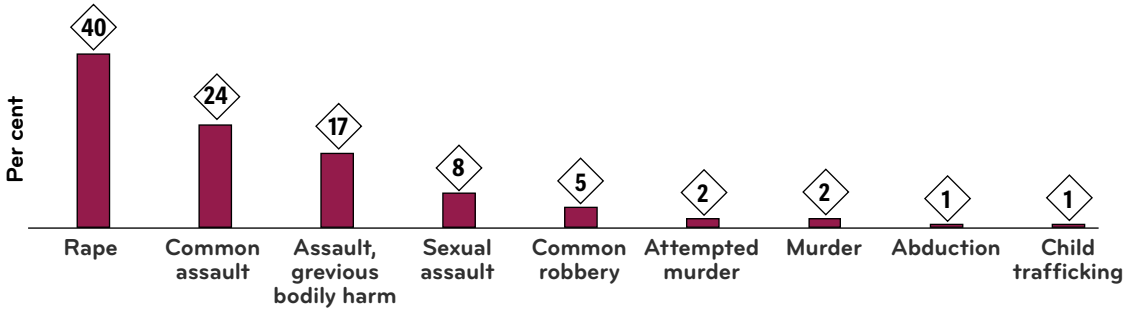
The available data consists of administrative records from the police related to crimes against children aged 17 years and younger. Chart 8.7 shows that the number of crimes against children aged 17 years and younger reported to the police decreased by 16 per cent, from 58,416 in 2015/16 to 49,311 in 2019/20.

CHART 8.7. Number of offences against children aged 17 years and younger reported to police, 2015/16-2019/20



SOURCE: SAPS 2015/16 and 2019/20; see Statistics South Africa (2024). Child Series Volume II: Crimes against children. Statistics South Africa: Pretoria, South Africa, p. 50.

CHART 8.8. Offenses against children aged 17 years and younger reported to police by crime, 2019/20

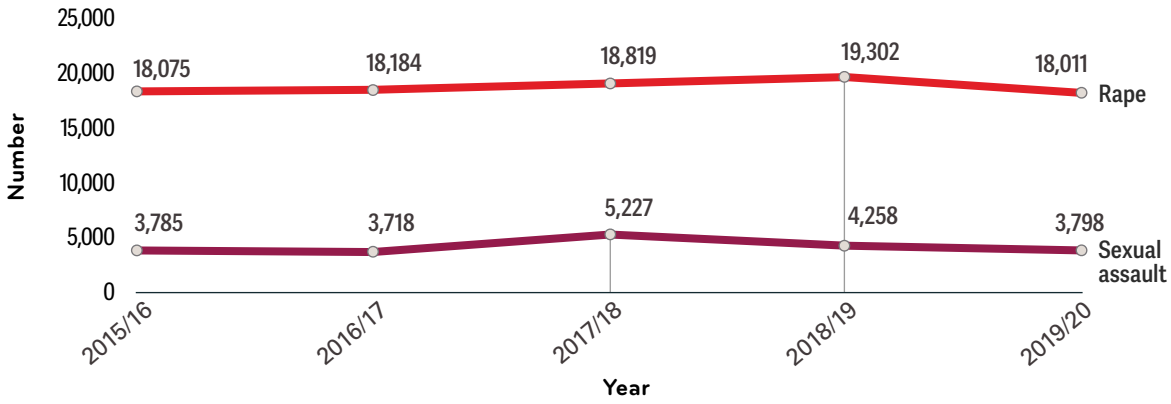


SOURCE: SAPS 2015/16 and 2019/20; see Statistics South Africa (2024). Child Series Volume II: Crimes against children. Statistics South Africa: Pretoria, South Africa, p. 5.

Chart 8.8 shows that among the total number of offences against children aged 17 years and younger reported to the police in 2019/20, the largest proportion were for rape (40 per cent) and common sexual assault (24 per cent), followed by assault with grievous bodily harm (17 per cent). Far fewer were crimes of sexual assault (8 per cent), common robbery (5 per cent), attempted murder (2 per cent), murder (2 per cent), abduction (1 per cent), and child trafficking (1 per cent).

Chart 8.9 shows that the number of sexual assault cases against children aged 17 years and younger increased from 3,785 in 2015/16 to a high of 5,227 in 2017/18, after which the number of sexual assault cases against children dropped to 3,798 in 2019/20. The number of rape cases is far greater. In 2015/16, the number of rapes against children aged 17 years and younger was 18,075 and increased to a high of 19,302 in 2018/19, before declining to 18,011 in 2019/20.

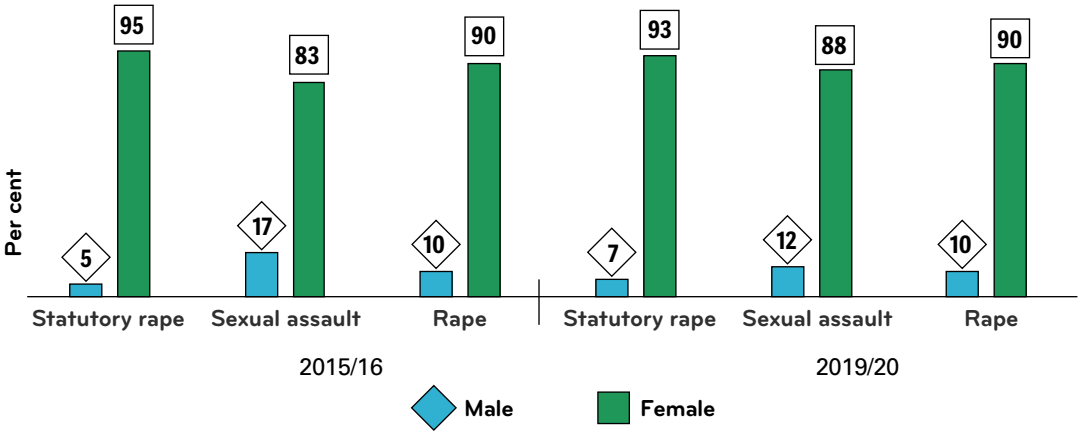
CHART 8.9. Number of crimes against children aged ≤ 17 years reported to the police, 2015/16-2019/202



SOURCE: SAPS 2015/16-2019/20; see Statis SA (2024). Child Series Volume II: Crimes against children. Statis SA: Pretoria, South Africa, p. 50.

Chart 8.10 shows that in 2015/16, among the total number of statutory rape cases against children aged 17 years and younger that were reported to the police, 95 per cent involved female victims. Similarly, among the total number of sexual assault and rape cases against children aged 17 years and younger that were reported to the police, 83 per cent of sexual assault cases and 90 per cent of rape cases involved female victims. A similar pattern emerged in 2019/20, where victims of statutory rape, sexual assault and rape were victims 17 years and younger.

CHART 8.10. Sexual offences for children aged ≤ 17 years reported to the police by sex, 2015/16 – 2019/20



SOURCE: SAPS 2015/16 and 2019/20; see Statistics South Africa (2024). Child Series Volume II: Crimes against children. Statistics South Africa: Pretoria, South Africa, p. 18.

In contrast to the data above, the INTERPOL National Central Bureau Pretoria reported that 68,512 cases of sexual offences against children were recorded by law enforcement in South Africa from 2017 to 2019, with 325 cases having an online component. During the same three-year period, law enforcement launched 169 investigations into online child sexual exploitation and abuse cases; however, only 51 people suspected of online child sexual exploitation and abuse crimes were arrested in 2017, 60 in 2018, and 58 in 2019.[693]

Violence Against Women and Girls

The 2030 Agenda for Sustainable Development identifies the elimination of violence against women and girls (VAWG) as a crucial priority for achieving gender equality and sustainable development.[694] After all, VAWG is both a cause and consequence of gender inequality and a major obstacle to women and girls' enjoyment of all human rights and their full participation in society and the

economy. Ending VAWG is a cross-cutting priority across the SDGs and vital to achieving several goals, including: ending poverty (SDG 1); improving health (SDG 3); enhancing quality education (SDG 4); establishing sustainable cities and communities (SDG 11); and promoting peace, justice, and strong institutions (SDG 16).[695] The 2030 Agenda builds on existing international frameworks that address VAWG, particularly CEDAW and the agreed conclusions of the Commission on the Status of Women at its fifty-seventh session.[696]

> *Violence against women (VAW) is defined as "all acts of gender-based violence that result in, or are likely to result in, physical, sexual, psychological or economic harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life."*

International instruments, including CEDAW and the Declaration on the Elimination of Violence Against Women (DEVAW), along with general recommendations provided by the Committee on the Elimination of Discrimination against Women, provide the most comprehensive understanding of VAWG at the international level and define the legal obligations of States to end VAWG. Regional human rights instruments that address VAWG include the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (known as the Maputo Protocol), which South Africa ratified in 2004.[697]

Table 8.1 highlights national laws that exist in South Africa related to VAWG and the legislative gaps that need to be addressed. South Africa has a sexual offences act within the criminal law (i.e., Sexual Offences and Related Matters Amendment Act 32 of 2007), a domestic violence act (i.e., Domestic Violence Act 116 of 1998), and a law on sexual harassment (i.e., Protection from Harassment Act 17 of 2011). South Africa has yet to enact a violence against women act or a law on stalking.

TABLE 8.1. National laws on VAWG in South Africa

National law	Year	Status
Sexual offences act	2007 (amended 2021)	Passed, taken effect ✓
Domestic violence act	1998 (amended 2023)	Passed, taken effect ✓
Law on sexual harassment	1998 (amended 2005)	Passed, taken effect ✓
Violence against women act		Not passed ✗
Law on stalking		Not passed ✗

There are many challenges to ending VAWG in South Africa, including a greater commitment on the part of the State's bodies, particularly the police and justice systems, to protect VAWG survivors and prosecute perpetrators of VAWG. Police and justice officials tend to lack the specialised training and staffing needed to properly handle VAWG cases, and there are legal issues and funding gaps that limit police and justice system responses to VAWG and ensure that VAWG survivors have access to quality essential services.[698]

In 2021, the UN Women Rights Committee acknowledged that South Africa's low levels of prosecution and conviction in domestic violence cases, in particular, and the frequent failures by the police to serve and enforce protection orders, exposed domestic violence survivors to repeated abuse, which has resulted in the violation of women's fundamental rights. According to official statistics, in 2018-2019, there were 143,824 requests for protection orders, yet only 15 per cent, or 22,211, were granted, and in many cases, the protection order merely instructed the abuser to sleep in another room in the same

house.[699] Given this context, the UN Women Rights Committee concluded that South Africa failed to comply with its obligation to effectively investigate, prosecute, and punish cases of domestic violence and to provide systematic and effective capacity building for the judiciary and law enforcement bodies, thereby violating the right of South African women to live free from domestic violence.[700]

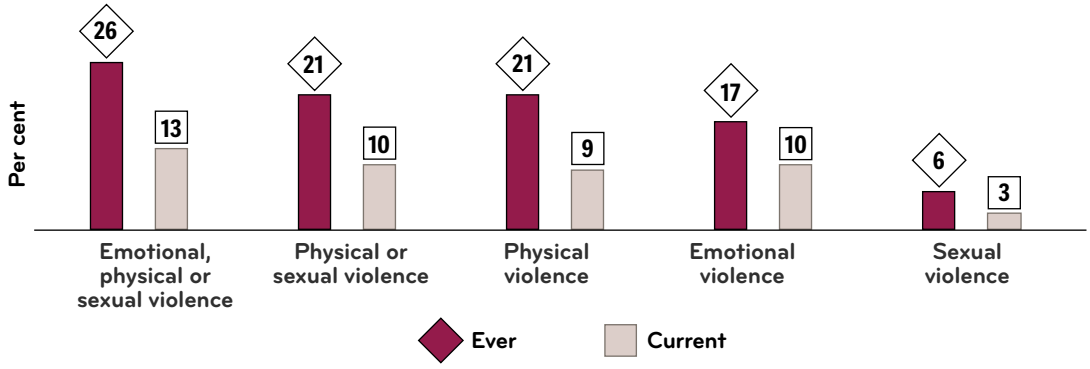
There is also a lack of essential services for VAWG survivors across South Africa, particularly in rural areas. Essential services are those provided to VAWG survivors and their children by health and social services sectors (including shelter, counselling, and legal aid) and police and justice sectors. This includes a shortage of shelters or safe houses where women and their children can seek emergency shelter and longer-term accommodation when needed. Thus, more often than not, perpetrators are able to access VAWG survivors and witnesses, harassing, intimidating, and threatening them.[701]

To improve responses to VAWG, the UN Women Rights Committee made 34 recommendations for action, including, but not limited to: improving the law enforcement response to VAWG cases; policies ensuring that VAWG survivors have adequate access to justice, protection, and victim support services; and measures aimed at dismantling patriarchal attitudes and discriminatory stereotypes that legitimise VAWG, particularly domestic violence. In 2022, South Africa accepted at least 20 of these recommendations.[702]

VAWG Prevalence Data

In South Africa, there is a notable lack of national statistics on VAWG, including a lack of population-based VAWG prevalence data. The existing VAWG data comes from the 2016 SADHS and focuses on IPV experienced by women aged 18 years and older. **Chart 8.11** shows the proportion of women aged 18 years and older who have ever experienced IPV by a current or former husband/partner, as well as those who experienced IPV in the 12 months prior to the survey (current). In 2016, 26 per cent of women had ever experienced emotional, physical or sexual IPV, and 21 per cent had ever experienced physical or sexual IPV. More specifically, 21 per cent of women had ever experienced physical violence, 17 per cent had experienced emotional violence, and 6 per cent had experienced sexual violence. A notable proportion of women were also currently experiencing emotional, physical or sexual IPV (13 per cent), and physical or sexual IPV (10 per cent). More specifically, 9 per cent of women had current experiences of physical violence, 10 per cent had current experiences of emotional violence, and 3 per cent had current experiences of sexual violence.

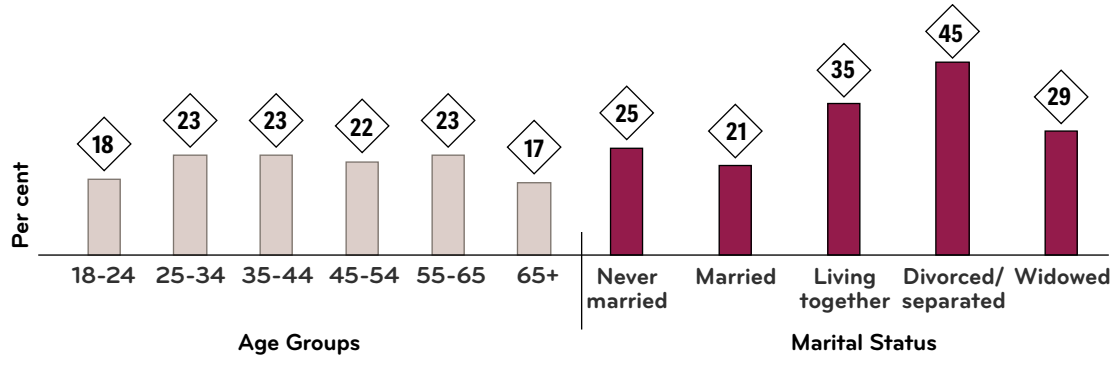
CHART 8.11. Women (18+ years) who ever experienced of IPV by type of IPV (%), 2016



SOURCE: SADHS, 2016

Chart 8.12 shows that women of all ages were nearly equally likely to ever experience physical or sexual violence by an intimate partner (current/former husband/partner). It is notable, however, that divorced/separated women (45 per cent) and women living with their partner but not married (35 per cent) were most likely to experience physical or sexual violence at the hands of their current/former husband/partner. It is also notable that one in five, or 21 per cent, of married women have ever experienced physical or sexual IPV, and one in four, or 25 per cent, of women who were never married have ever experienced physical or sexual IPV (dating violence).

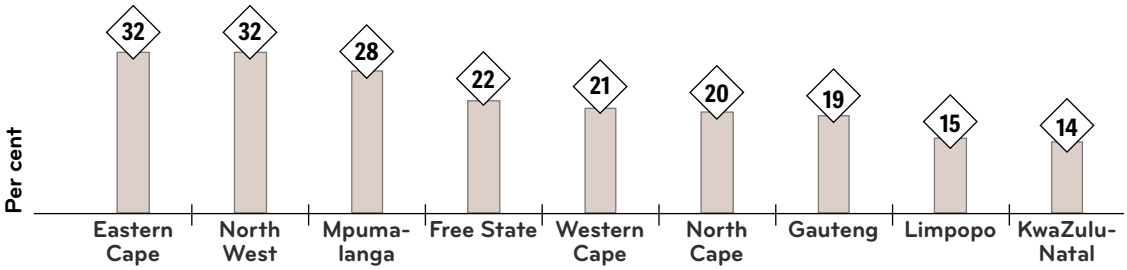
CHART 8.12. Women (18+ years) who ever experienced physical or sexual IPV by age and marital status (%), 2016



SOURCE: SADHS, 2016

Chart 8.13 shows that the prevalence of physical or sexual IPV varies by province. Women in the Eastern Cape (32 per cent), North West (32 per cent), and Mpumalanga (28 per cent) were most likely to experience physical or sexual IPV, whereas those in Limpopo (15 per cent) and KwaZulu-Natal (14 per cent) were least likely to do so. There were no significant differences in experiences of physical or sexual IPV among women in urban (21 per cent) and non-urban (22 per cent) areas.

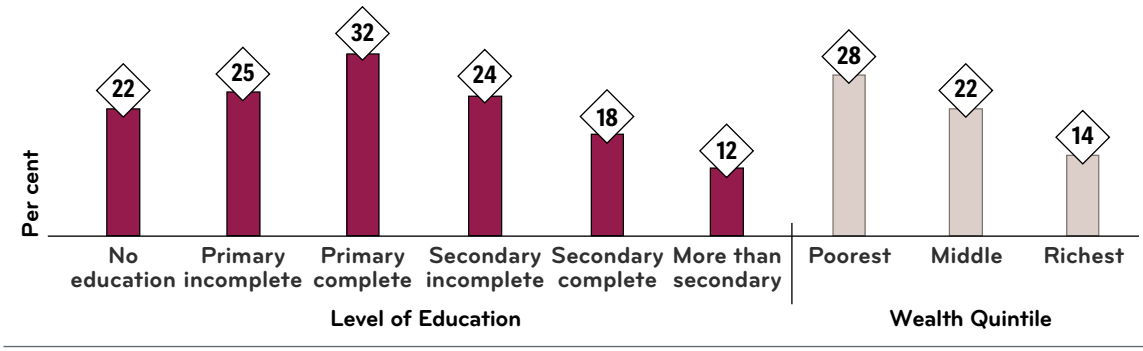
CHART 8.13. Women (18+ years) who ever experienced physical or sexual IPV by province (%), 2016



SOURCE: SADHS, 2016

Chart 8.14 also shows that women with lower levels of education were far more likely to experience physical or sexual IPV than women with a completed secondary education or more; in other words, as women's level of education increases, their risk of experiencing physical or sexual IPV decreases. It is also notable that women from the poorest households (28 per cent) were twice as likely as women from the richest households (14 per cent) to experience physical or sexual IPV, and more likely than women from middle-income households (22 per cent). It should be recognised that higher levels of education and increased wealth do not make women immune to experiencing physical or sexual IPV, as 18 per cent of women with a completed secondary education, 12 per cent with more than a secondary education, and 14 per cent of women from the richest households have ever experienced physical or sexual IPV.

CHART 8.14. Women (18+ years) who ever experienced physical or sexual IPV by education and wealth (%), 2016



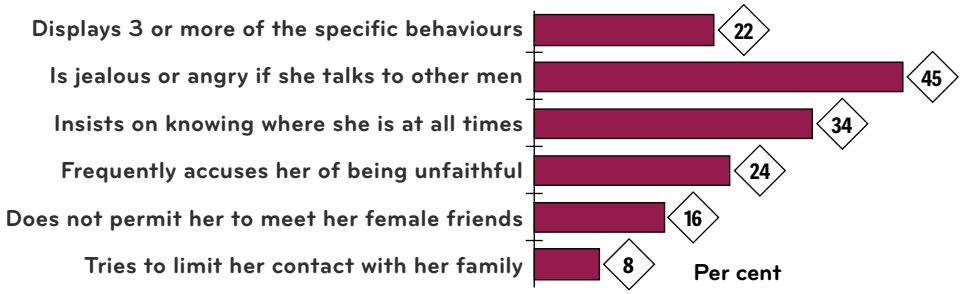
SOURCE: SADHS, 2016

Controlling Behaviours of Husbands/Partners

IPV is closely linked to controlling behaviours, such as persistent jealousy and accusations of infidelity, acts that restrain access to friends and family, and monitoring communications with others. Research has shown that women who report controlling behaviours by their husbands or partners are more likely to experience IPV.[703]

The 2016 SADHS asked women about the types of controlling behaviours, if any, displayed by their husbands or partners. Chart 8.15 shows that more than one in five, or 22 per cent, of women aged 15-49 had husbands or partners who displayed three or more specific controlling behaviours. More specifically, 45 per cent of women reported their husbands or partners getting jealous or angry if they talked to other men, and 34 per cent of women reported their husbands or partners insisting on knowing where they are at all times. In addition, as many as 24 per cent of women reported their husbands or partners frequently accusing them of being unfaithful, 16 per cent reported their husbands or partners not permitting them to meet with their female friends, and 8 per cent reported their husbands or partners trying to limit their contact with family.

CHART 8.15. Controlling behaviours of husbands/partners among women aged 15-49 (%), 2016



SOURCE: SADHS, 2016

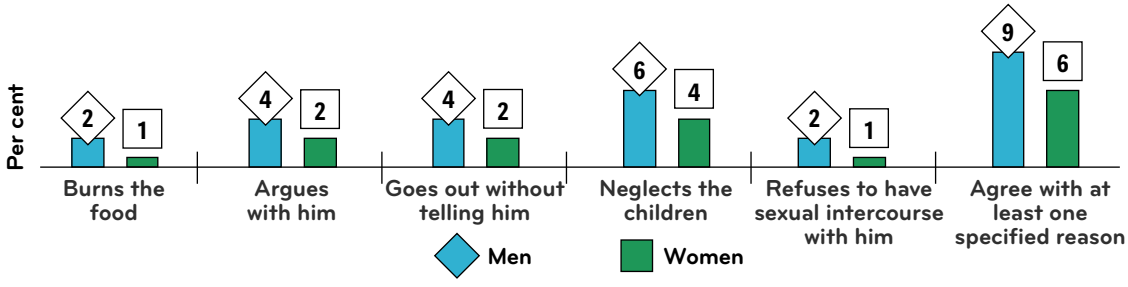
It is notable that 60 per cent of women who reported their husband/partner displayed three or more of the specific controlling behaviours in Chart 8.15 indicated they were afraid of their husband/partner most of the time. Moreover, they were six times more likely to be afraid of their husbands most of the time compared to women whose husbands did not display controlling behaviours (10 per cent).[704]

Attitudes Toward Wife Beating

The 2016 SADHS found that among women and men aged 15-49, 9 per cent of men and 6 per cent of women indicated that it was acceptable for a husband to beat his wife under one or more circumstances (**Chart 8.16**).

These attitudes were more often held by boys aged 15-19 (14 per cent) and young males aged 20-24 (13 per cent), compared to men aged 25 years and older. Men in non-urban areas (15 per cent) were also twice as likely to hold attitudes supportive of wife beating compared to men in urban areas (7 per cent). Men in Limpopo (19 per cent), KwaZulu-Natal (13 per cent), Free State (13 per cent), and North West (11 per cent) were more likely to hold attitudes supportive of wife beating compared to men in Gauteng (6 per cent), Western Cape (5 per cent), and Mpumalanga (3 per cent).

CHART 8.16. Attitudes toward wife beating by sex (ages 15-49, %), 2016



SOURCE: SADHS, 2016

Men with no education (11 per cent), incomplete primary education (12 per cent), complete primary education (10 per cent), and incomplete secondary education (12 per cent) were nearly twice as likely as men with secondary education (5 per cent) or more than secondary education (6 per cent) to hold attitudes supportive of wife beating. In terms of wealth, men from the poorest households (15 per cent) were five times more likely to believe a husband is justified in beating his wife compared to men from the richest households (3 per cent), and more likely than men from middle-income households (8 per cent).[705]

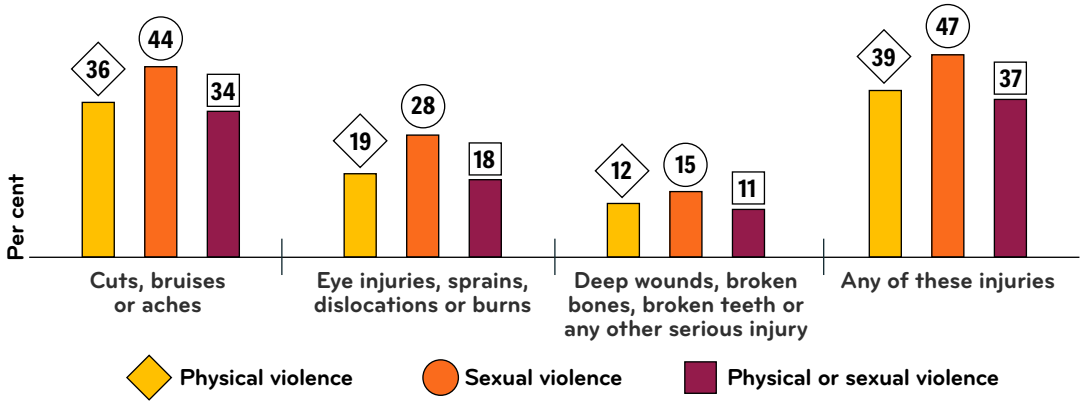
IPV-Related Injuries

Many women who experience IPV suffer various physical health effects, including physical injuries. **Chart 8.17** shows that among ever-partnered women who have experienced physical or sexual IPV, 37 per cent sustained injuries. More specifically,

- 44 per cent experienced cuts, bruises, or aches,
- 18 per cent experienced eye injuries, sprains, dislocations, or burns,
- 11 per cent experienced deep wounds, broken bones, broken teeth, or any other serious injury.

It is notable that women who experienced sexual violence were slightly more likely to sustain each of these different types of injuries compared to women who experienced physical violence.

CHART 8.17. Women's (18+ years) experiences with IPV-related physical injuries (%), 2016



SOURCE: SADHS, 2016

VAWG Survivors Disclosure and Help-Seeking Behaviours

Typically, the DHS collects data on the disclosure and help-seeking behaviours of VAWG survivors; however, the 2016 SADHS did not include questions related to these behaviours for women who experienced IPV. The lack of data on disclosure and help-seeking behaviours creates a notable data gap because such information is extremely important for understanding why and where VAWG survivors seek help for the violence in their lives. Such data are needed to improve the availability of essential services for VAWG survivors. Data related to disclosure and help-seeking behaviours also helps us understand how many VAWG survivors do not speak out or seek help or protection from the violence they experience, and the reasons why. This information can help to inform programming and social and behaviour change initiatives aimed at increasing awareness of VAWG and the rights of survivors to access essential services.

Impact of COVID-19 on Domestic Violence

Globally, the COVID-19 pandemic brought a combination of economic and social stresses and strains for women and their families, and measures to restrict contact and movement placed women and girls at increased risk of SGBV. Domestic violence became more pervasive during the COVID-19 lockdown as many people lost their jobs and means of economic survival. Women bore the brunt of

this situation because they tend to rely on their partners to provide for the family. In addition, crowded homes, substance abuse, limited access to services, and reduced peer support exacerbated these conditions. During the pandemic, many women were trapped in their homes with their abusers, without access to private spaces, making it difficult for them to make a call or seek help online.[706]

VAWG took on new complexities as exposure to COVID-19 was used as a threat; abusers exploited the inability of women to call for help or escape, while women risked being thrown out onto the street with nowhere to go.[707] At the same time, support services struggled to provide assistance to VAWG survivors, and health workers, police, and justice officials—who are typically the first responders to VAWG—were at times overwhelmed by shifting priorities, making them unable to help survivors effectively. In addition, civil society groups were affected by lockdowns and resource reallocation, with some domestic violence shelters full and others having to close during the pandemic.[708]

In South Africa, official reports showed that within the first weeks of lockdown measures being implemented, the SAPS received 2,320 complaints of GBV, with only 148 related charges made. These statistics represent a 37 per cent increase from the weekly average of GBV cases reported to SAPS in 2019. Furthermore, from 27 March to 16 April 2020, the GBV Command Centre in South Africa recorded a spike in reported GBV cases, including a total of 10,660 reports via phone, 1,503 through unstructured supplementary services data, and 616 via SMS. On one day, 16 April 2020, the GBV Command Centre received 674 reported GBV cases.[709]

Prior to the spread of COVID-19, accessing social services was challenging for VAWG survivors in South Africa; however, lockdown measures related to the pandemic made it even harder for survivors to obtain services and rendered women dependent on their place of residence.[710]

Child Marriage

Child marriage refers to any formal marriage or informal union between a child under the age of 18 and an adult or another child. While the prevalence of child marriage has decreased worldwide, the practice remains widespread – one in five girls are married.[711] The right to 'free and full' consent to a marriage is recognised in the UDHR, with the understanding that consent cannot be 'free and full' when one of the parties involved is not sufficiently mature to make an informed decision about a life partner. CEDAW also addresses the right to protection from child marriage. Although marriage is not directly addressed in the CRC, child marriage is linked to other rights, such as the right of children to express their views freely and to be protected from harmful traditional practices. Child marriage is also frequently addressed by the Committee on the Rights of the Child.

Child marriage is more common among girls, but does occur among children of both sexes. In many parts of the world, parents encourage the marriage of their daughters while they are still children in the hope that the marriage will benefit them both financially and socially, while also relieving financial burdens on the family. Child marriage robs girls of their childhood and threatens their lives and health.[712]

Girls who marry before the age of 18 often experience disruptions to their education and their ability to enter the labour market, may experience separation from family and friends, and have fewer freedoms to participate in community activities, which often takes a heavy toll on girls' physical and psychological well-being. Girls who marry as children often become pregnant during adolescence, when the risk of complications during pregnancy and childbirth increases for both themselves and their infants. Girls who marry before the age of 18 are also more likely to experience domestic violence.

Girls who marry before the age of 18 have worse economic and health outcomes than their unmarried peers, which are eventually passed down to their children. Child marriage also has substantial economic costs at the national level, with major implications for development and prosperity.[713] For

these reasons, child marriage is identified as a harmful practice in the 2030 Agenda for Sustainable Development. SDG 5 includes a target aimed at eliminating all harmful practices, including child, early, and forced marriage by 2030, and SDG Indicator 5.3.1 monitors the proportion of women aged 20-24 who were married or in a union before the ages of 15 and 18.In 1995, South Africa ratified the CRC, which sets a minimum age of marriage of 18 years, as well as ratified CEDAW, which obligates states to ensure 'free and full consent' to marriage. In 2019, South Africa also ratified the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, which provides for the protection of women from harmful practices; in particular, Article 6 sets the minimum age for marriage at 18 years. That same year, South Africa ratified the African Charter on the Rights and Welfare of the Child; in particular, Article 21 prohibits child marriage.

South Africa has a 'hybrid' or 'mixed' legal system, formed by the interweaving of several distinct legal traditions, including a civil law system inherited from the Dutch, a common law system inherited from the British, and a customary law system inherited from indigenous African communities (often referred to as African Customary Law, of which there are many variations depending on tribal origin). As a general rule, however, South Africa follows English law in both criminal and civil procedure, constitutional law, and laws of evidence.

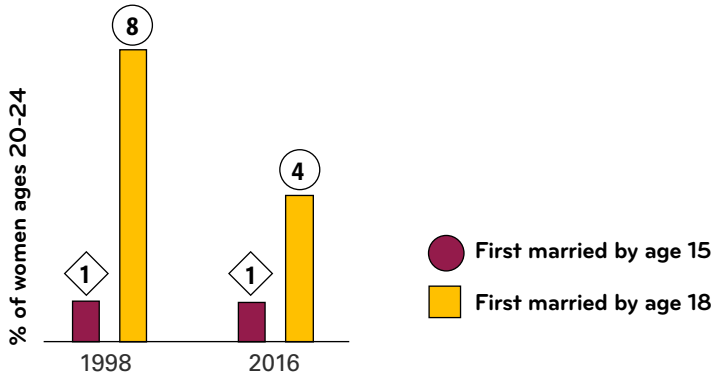
Under South African law, there are three types of marriages – civil marriages, customary marriages, and civil unions. A customary marriage is one that is "negotiated, celebrated or concluded according to any of the systems of indigenous African customary law."[714] Under the Children's Act 38 of 2005, the minimum legal age of marriage is 18 years for both girls and boys. Similarly, the Civil Union Act 16 of 2006 prohibits any civil union of persons below the age of 18 years. There are, however, inconsistencies and loopholes in legislation. In particular, the Marriage Act 25 of 1961 allows girls to be married at the age of 15 with parental consent but maintains the minimum age of 18 years for boys. It is noteworthy that the draft Marriage Bill was gazetted in 2023, which states a person should be 18 years and older to marry, thereby harmonising the existing fragmented marriage legislation regardless of religion, culture, sex, and age. The Recognition of Customary Marriages Act 120 of 1998 further allows minors to enter into customary marriage with parental consent, without specifying a minimum age limit for boys or girls.

In 2015, former President Zuma promulgated the Prevention and Combating of Trafficking in Persons Bill, which prohibits non-consensual ukuthwala and classifies it as a trafficking offence.[715] Ukuthwala is a cultural practice deriving from the Xhosa marriage custom and involves the 'pretend abduction' of the bride-to-be as part of negotiations between the two families.[716] In recent years, the practice of ukuthwala has been invoked to justify the abduction of girls as young as 12 years to be married off to older men. Although ukuthwala is legally prohibited, it still occurs in the Western Cape, Eastern Cape, and KwaZulu-Natal provinces. In some cases, money or gifts are also given to parents in a distortion of traditional ilobolo (dowry) practices.[717]

During its 2016 review, the UN Child Rights Committee expressed deep concerns about the persistence of child marriage, virginity testing, and ukuthwala. The Committee also raised concerns that the Children's Act 38 of 2005, the Marriage Act of 25 of 1961, and the Recognition of Customary Marriages Act 120 of 1998 set different conditions for the marriage of girls under the age of 18. The Committee urged the Government of South Africa (GoSA) to harmonise legislation to ensure the minimum age of marriage is 18 years for both girls and boys.[718] During its 2017 Universal Periodic Review (UPR), South Africa agreed to review recommendations to harmonise legislation to ensure that the minimum age of marriage is 18 years for both girls and boys and to develop specific measures to educate society on customary practices leading to forced and child marriage.[719]

Data related to child marriage in South Africa are limited. UNICEF estimates that 1.6 million girls and women of all ages were first married or in a union before the age of 18 in South Africa.[720] **Chart 8.18** shows that in South Africa, very few women aged 20-24 were first married or in a union before the age of 15. In addition, the proportion of women aged 20-24 who were married or in a union before the age of 18 decreased from 8 per cent in 1998 to 4 per cent in 2016.

CHART 8.18. Women aged 20-24 who first married before the age of 15 and 18 (%), 1998 and 2016

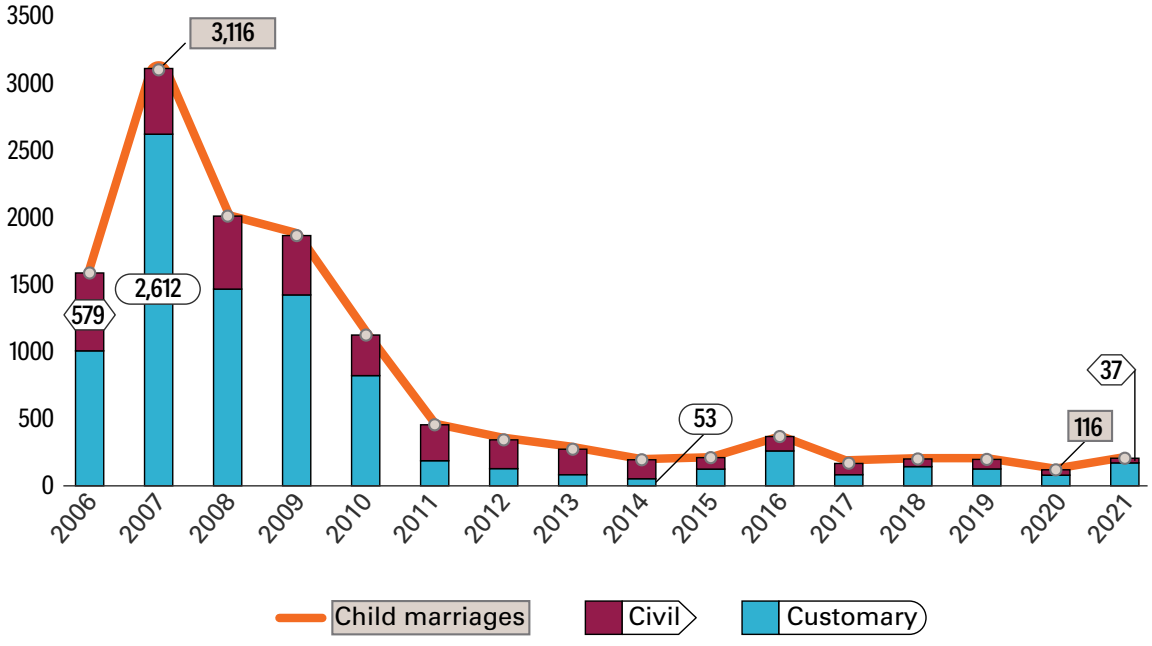


SOURCE: Retrieved on 28 March 2024 from: Women who were first married by age 15 (% of women ages 20-24) - South Africa | Data (worldbank.org); Women who were first married by age 18 (% of women ages 20-24) - South Africa | Data (worldbank.org)

More specifically, in 2018, the Commission for Gender Equality (CGE) informed the Portfolio Committee on Social Development in Parliament that 91,000 underage children, as young as 14 years old, had been forced into marriage in South Africa. They reported that the number was highest in KwaZulu-Natal (n=25,000), followed by Gauteng (n=15,000) and the Eastern Cape (n=9,000).[721]

Chart 8.19 shows the number of child marriages for children aged 17 years and younger from 2006 to 2021. Most notable is that the number of child marriages peaked at 3,116 in 2007 and decreased by 93 per cent to 207 in 2021. Year-on-year, customary child marriages are typically more common than civil child marriages; however, there has been a notable decrease over time in both the number of customary and civil child marriages.

CHART 8.19. Number of child marriages for children aged 17 years and younger, 2006-2021



SOURCE: Marriages and divorces, 2006-2021; see Statistics South Africa (2024). Child Series Volume II: Crimes against children. Statistics South Africa: Pretoria, South Africa, p. 15.

Child Labour and Trafficking

Globally, children are engaged in paid and unpaid work that is not harmful to them. Children engaged in paid and unpaid work are classified as child labourers; however, this classification applies when they are either too young to work or involved in hazardous activities that may compromise their physical, mental, social and/or educational development. The CRC recognises the rights of children to be protected from economic exploitation and from performing work that is likely to be hazardous or that interferes with their education, and/or is harmful to their health or physical, mental, spiritual, moral or social well-being and development.

In South Africa, children are subjected to child labour, including the worst forms of child labour, such as in commercial sexual exploitation and forced begging, sometimes as a result of human trafficking, and are used in illicit activities. The 2019 Survey of Activities of Young People found that 5 per cent of children were engaged in child labour (Table 8.2). Data related to the proportion of children working in hazardous conditions are limited.

2022: South Africa's National Trafficking Hotline received 2,408 trafficking reports, of which 20 percent concerned cases of child trafficking.

Table 8.2 shows that adolescents aged 16-17 (7 per cent) and those aged 10-15 years (6 per cent) were twice as likely to be engaged in child labour as children aged 7-9 years (3 per cent). Black Africans (6 per cent) were twice as likely to be engaged in child labour compared to White South Africans (3 per cent); in comparison, only one per cent of Indian/Asian and Coloured children were engaged in child labour.

The proportion of children in child labour was highest in KwaZulu-Natal, Mpumalanga and Eastern Cape (8 per cent each), and lowest in Free State, Northern Cape and Western Cape (1 per cent each). It is also notable that the proportion of children in child labour was three times higher in rural areas (9 per cent) than in urban areas (3 per cent).

TABLE 8.2. Child labour in South Africa (%), 2019

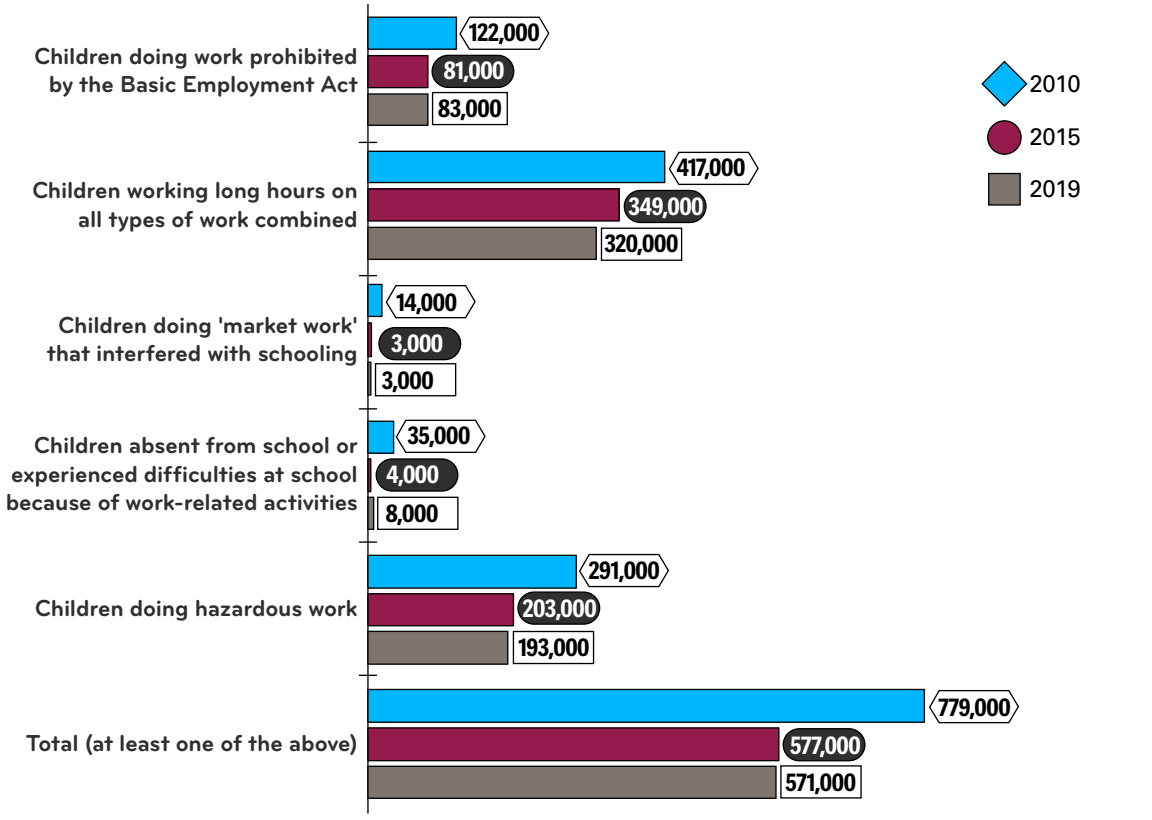
Total	5%
Age groups	
7-9 years	3%
10-15 years	6%
16-17 years	7%
Sex	
Male	5%
Female	5%
Population group	
Black African	6%
White	3%
Indian/Asian	1%
Coloured	1%

Total	5%
Province	
KwaZulu-Natal	8%
Mpumalanga	8%
Eastern Cape	8%
Gauteng	4%
Limpopo	3%
North West	2%
Free State	1%
Northern Cape	1%
Western Cape	1%
Geographic area	
Rural	9%
Urban	3%

SOURCE: Statistics South Africa (2021). Survey of Activities of Young People 2019. Statistics South Africa: Pretoria, South Africa Retrieved on 30 March 2024 from: P02122019.pdf (statssa.gov.za)

Chart 8.20 also shows that from 2010-2019, the number of children who reported doing work prohibited by the Basic Conditions of Employment Act 75 of 1997 decreased by 39 per cent (from 122,000 in 2010 to 83,000 in 2019). In addition, the number of children working long hours across all types of work combined decreased by 97 per cent (from 417,000 in 2010 to 320,000 in 2019). There was also a 10 per cent decline in the number of children engaged in 'market work' that interfered with schooling (from 14,000 in 2010 to 3,000 in 2019), and a 27 per cent decline in the number of children who were absent from school or experienced difficulties at school due to work-related activities (from 35,000 in 2010 to 8,000 in 2019). Furthermore, there was a 99 per cent decline in the number of children involved in hazardous work from 2010 to 2019 (from 291,000 in 2010 to 193,000 in 2019).

CHART 8.20. Child labour composite indicator, 2010-2019



SOURCE: Statistics South Africa (2021). Survey of Activities of Young People 2019. Statistics South Africa: Pretoria, South Africa Retrieved on 30 March 2024 from: P02122019.pdf (statssa.gov.za)

Table 8.3 offers an overview of children's work by sector and activity in South Africa.

TABLE 8.3. Children's work by sector and activity

Sector/Industry	Activity
Agriculture	Farming, including the production of corn and fruit
Industry	Factor work, including processing cotton to make blankets
Services	Food service
	Domestic work
	Street work, including vending
Worst forms of child labour	Commercial sexual exploitation, sometimes as a result of human trafficking
	Use in illicit activities, including in gang-related activity
	Use in the production of pornography
	Forced labour in domestic work, agriculture, street vending, cell phone repair shops and begging

SOURCE: South Africa: 2022 Findings on the Worst Forms of Child Labor. Bureau of International Labor Affairs. Retrieved on 28 March 2024 from: 2022 Findings on the Worst Forms of Child Labor: South Africa (dol.gov)

There is evidence that South Africa is a destination country for child trafficking from Southern Africa and Africa as a whole. Young children within South Africa, mostly girls aged 10-14 from socio-economically disadvantaged and rural areas, are subject to commercial sexual exploitation in major cities, including Cape Town and Johannesburg. Traffickers often recruit domestic and foreign victims with promises of jobs and economic opportunity in urban areas.

Government officials indicated that child trafficking, primarily for commercial sexual exploitation, increased significantly during the COVID-19 pandemic. South Africa is also considered a major destination for child sex tourism. In addition, children with disabilities, both girls and boys, are subjected to forced begging.[722]

In South Africa, children are also subjected to the worst forms of child labour through recruitment and use in criminal activities. For instance, gangs use child recruits, known as *springbokkies*, to watch for police, transport guns, deliver illicit drugs, and commit acts of violence, including murder. In recent years, there has been a significant rise in murders committed by children affiliated with gangs, some as young as 8 years old. The gang use of child recruits is particularly prevalent around Cape Town in the Western Cape. Gangs tend to recruit children to reduce the risk of criminal prosecution for their activities, as children under the age of 10 do not have criminal responsibility under South African law.[723]

South Africa has ratified most key international conventions related to child labour, including ILO Convention 138 on Minimum Age and ILO Convention 182 on the Worst Forms of Child Labour. South Africa has also established national laws and regulations related to child labour and the worst forms of child labour. Still, however, gaps exist in South Africa's legal framework to adequately protect children from the worst forms of child labour (**Table 8.4**).

TABLE 8.4. National laws and regulations on child labour

Standard	Meets International Standards	Age	Legislation
Minimum age of work	Yes	15	Basic Conditions of Employment Act 75 of 1997, Section 43
Minimum age for hazardous work	Yes	18	Regulations on Hazardous Work by Children in South Africa; Basic Conditions of Employment Act 75 of 1997, Sections 4-10
Identification of hazardous occupations or activities prohibited for children	Yes		Regulations on Hazardous Work by Children in South Africa; Basic Conditions of Employment Act 75 of 1997, Sections 4-10; Children's Act 38 of 2005, Section 150(2)(a)
Prohibition of forced labour	Yes		Basic Conditions of Employment Act 75 of 1997, Section 48; Constitution of the Republic of South Africa, Section 13; Children's Act 38 of 2005, Section 141 and 150(2)(a); Prevention and Combating of Trafficking in Persons Act 7 of 2013, Sections 4 and 5
Prohibition of child trafficking	Yes		Children's Act 38 of 2005, Section 141; Prevention and Combating of Trafficking in Persons Act 7 of 2013, Section 4
Prohibition of commercial sexual exploitation of children	Yes		Children's Act 38 of 2005, Section 141; Criminal Law Amendment Act 32, Chapter 3
Prohibition of using children in illicit activities	Yes		Children's Act 38 of 2005, Section 141
Minimum age for voluntary state military recruit	Yes	18	Defence Act 42 of 2002, Section 52
Prohibition of compulsory recruitment of children by (State) military	N/A		Defence Act 42 of 2002, Section 52

Prohibition of military recruitment of non-state armed groups	No		
Compulsory education age	Yes	15	South African Schools Act 84 of 1996 Chapters 1 and 2, Sections 1-5
Free public education	No		South African Schools Act 84 of 1996, Chapter 2, Section 5, and Chapter 4, Section 39

SOURCE: South Africa: 2022 Findings on the Worst Forms of Child Labor. Bureau of International Labor Affairs. Retrieved on 28 March 2024 from: 2022 Findings on the Worst Forms of Child Labor: South Africa (dol.gov)

GoSA has also established two policies related to child labour, including the National Child Labour Programme of Action for South Africa, Phase IV, 2017-2024, and the Prevention and Combating of Trafficking in Persons National Policy Framework. However, the implementation of these policies remains a challenge, and policy gaps exist that limit efforts to address child labour. For instance, the GoSA has yet to include child labour elimination and prevention strategies in the South African Education Action Plan or the National Development Plan.[724]

In 2022, South Africa hosted the 5th Global Conference on the Elimination of Child Labour. Delegates at the Conference adopted the Durban Call to Action, which included commitments to: promote decent work; end child labour in agriculture; adopt data-driven and survivor-informed policy and programmatic responses; expand access to education and universal social protections; and increase financing and international cooperation for the elimination of child labour.[725]

In 2023, the Department of Employment and Labour, in collaboration with IO, launched an EU-funded child labour project that aims to strengthen the prevention and elimination of child labour in South Africa's agricultural sector. The project is being piloted in two provinces – KwaZulu-Natal and Western Cape – due to the fact that KwaZulu-Natal has among the highest prevalence of child labour in the country, and Western Cape has the highest number of children not attending school.[726]

The GoSA has established institutional mechanisms for the enforcement of laws and regulations on child labour, including the South African Department of Employment and Labour (SADEL), the South African Police Service (SAPS), and the South African Department of Justice and Constitutional Development. However, gaps remain in the operations of enforcement agencies, which hinder adequate enforcement of child labour laws.[727]

Labour law enforcement agencies in South Africa have taken action to address child labour; however, gaps exist in the operations of the SADEL that may hinder adequate labour law enforcement, including the inadequate allocation of financial resources. South African law treats child labour as a criminal offence; therefore, labour inspectors can refer child labour cases for criminal prosecution.[728]

In recent years, criminal law enforcement agencies in South Africa have taken actions to address child labour. For instance, training has been provided to criminal investigators, penalties for violations related to the worst forms of child labour have been imposed, and referral mechanisms exist between criminal authorities and social services. Nevertheless, gaps remain within the operations of the criminal enforcement agencies that may hinder adequate criminal law enforcement, including insufficient training for criminal investigators to identify and investigate child trafficking.[729]

There is also evidence that the SAPS lacks sufficient resources to investigate all suspected cases of child trafficking and forced child labour. In fact, in recent years, there has been a steady decline in the number of SAPS officers.[730] Despite assistance from NGOs with the operation of call centres, which are part of the complaint mechanism, it has been reported that the SAPS has difficulty following up on reported cases and identifying victims of human trafficking during law enforcement activities; as a result, victim identification and referral procedures are not uniformly implemented. In some provinces, the Department of Social Development only coordinates victim services upon receiving confirmation from the SAPS that the individual has been subjected to human trafficking; as a result, when the

SAPS does not pursue investigations of a case, human trafficking survivors face obstacles accessing essential protection and support services.[731]

The GoSA has also established a key mechanism to coordinate its efforts to address child labour (**Table 8.5**). The Implementing Committee on the Child Labour Programme of Action is led by SADEL and supports the implementation of the Child Labour Programme of Action. The National Intersectoral Committee on Trafficking in Persons also coordinates the government's anti-human trafficking efforts, including efforts to eliminate child trafficking. Gaps still exist, however, that hinder effective coordination of efforts to address child labour, including inadequate participation of all relevant agencies in the National Intersectoral Committee on Trafficking in Persons.[732]

TABLE 8.5. Key mechanisms to coordinate government efforts on child labour

Coordinating Body	Role & Description
Implementation Committee on the Child Labour Programme of Action	Supports the implementation of the Child Labour Programme of Action. Led by SADEL, the Implementation Committee includes representatives from government agencies, organized labour, commercial agriculture, and the ILO. In 2022, the Implementation Committee reconvened for the first time since the start of the COVID-19 pandemic.
National Intersectoral Committee on Trafficking in Persons	Coordinates the government's anti-human trafficking efforts, including efforts to eliminate child trafficking. Several member agencies, including SAPS, the Department of Human Affairs and SADEL send representatives to meetings of the National Intersectoral Committee on Trafficking in Persons or the Provincial Task Teams, but engagement on key issues remains limited.

SOURCE: South Africa: 2022 Findings on the Worst Forms of Child Labor. Bureau of International Labor Affairs. Retrieved on 28 March 2024 from: 2022 Findings on the Worst Forms of Child Labor: South Africa (dol.gov)

In 2022, the GoSA funded and participated in programmes aimed at eliminating or preventing child labour, including Thuthuzela Care Centres, the Direct Cash Transfer Programme, and the National School Nutrition Programme, which can prevent and respond to survivors (**Table 8.6**). Although South Africa has programmes that target child trafficking and poverty alleviation, it does not have social programmes with a mandate to address other worst forms of child labour, including forced begging and the use of children in illicit activities. There remain inadequacies and gaps in social programmes; thus, the government is unable to address the full scope of the problem.[733]

TABLE 8.6. Key social programmes to address child labour

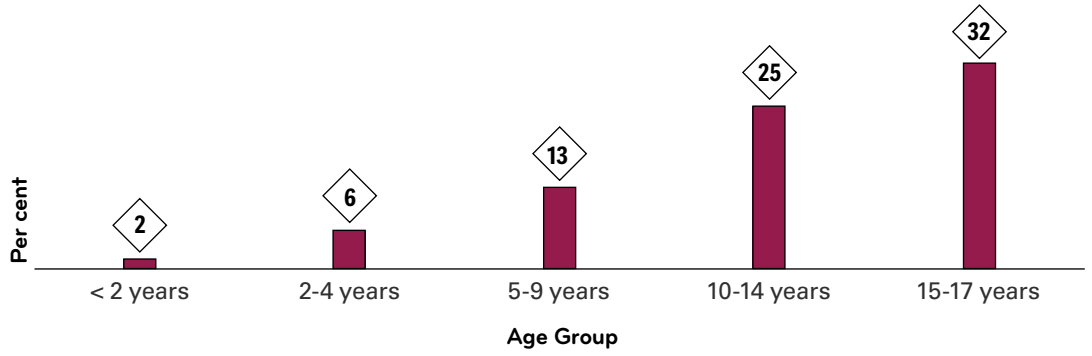
Programme	Role & Description
Thuthuzela Care Centres	Government-run crisis centres are mandated to provide services to GBV survivors, including child trafficking survivors. The centres continued providing services in 2022.
Direct Cash Transfer Programmes	Include the CSG, which provides monthly unconditional direct cash transfers to help low-income parents and guardians meet the basic needs of their children, and the FCG, which provides monthly payments of approximately USD 65 (R 1,050) to caretakers of foster children. In 2022, the government continued both programmes, increasing the Foster Care Grant benefit by 1.9 per cent, and the CSG by 4.3 per cent.
National School Nutrition Programme	Provides one to two meals every school day to about 9.5 million school children. As of 2020, 77 per cent of public-school students received meals from this school feeding scheme. This programme remained active in 2022.

SOURCE: South Africa: 2022 Findings on the Worst Forms of Child Labor. Bureau of International Labor Affairs. Retrieved on 28 March 2024 from: 2022 Findings on the Worst Forms of Child Labor: South Africa (dol.gov)

Children in Alternative Care

In 2016, the SAHDS found that 22 per cent of households in South Africa were caring for foster or orphaned children, and 23 per cent of children under the age of 18 were not living with a biological parent. More specifically, 16 per cent of children under the age of 18 were orphans, meaning that one or both parents had died. Chart 8.21 shows that the percentage of children who are orphans rises rapidly with age, from 2 per cent among children under the age of 2, to 13 per cent among children aged 5-9 years, and 32 per cent among children aged 15-17.

CHART 8.21. Orphaned children (with one or both parents dead) by age group (%), 2016

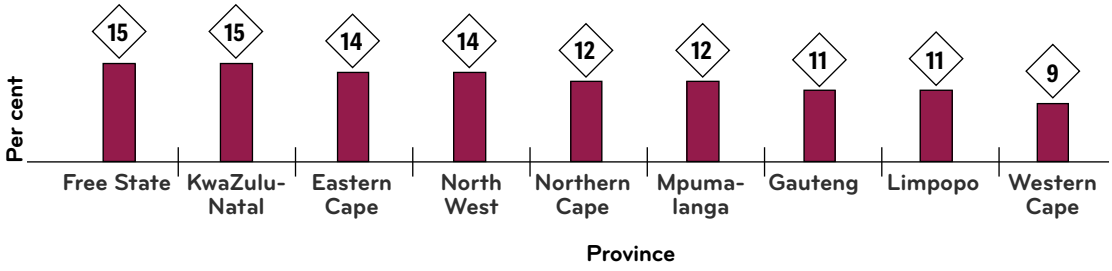


SOURCE: SADHS, 2016

It is notable that the percentage of children under the age of 15 living with both parents decreased by 4 percentage points, from 33 per cent in 1998 to 29 per cent in 2016. In addition, the percentage of children not living with a biological parent decreased by 3 percentage points, from 25 per cent in 1998 to 22 per cent in 2016. Conversely, the percentage of children under 15 who were orphans increased by 4 percentage points, from 10 per cent in 1998 to 14 per cent in 2016.[734]

More recently, the 2023 GHS found that 12 per cent of children in South Africa could be classified as orphans, i.e., children who had lost either one or both of their parents. More specifically, 2 per cent of children lost both parents, 3 per cent lost their mothers, and 8 per cent lost their fathers. Chart 8.22 shows that the proportion of orphaned children is highest in Free State and KwaZulu-Natal (15 per cent each) and lowest in Western Cape (9 per cent).

CHART 8.22. Orphaned children (with one or both parents dead) by province (%), 2022



SOURCE: 2023 GHS

The latest data and information about children in alternative care settings are not publicly available. There is also a lack of data on the proportion of children orphaned by HIV/AIDS and living in alternative care settings.

Children on the Move

South Africa attracts economic and social migrants seeking better socio-economic opportunities, peace, and security. Many migrants include children who are travelling alone or with their parents/ caregivers and families, and in some cases, individuals they may encounter along the way. Migrant children, especially unaccompanied migrant children, are particularly vulnerable and face a multitude of difficulties regarding health, education, and welfare services in South Africa.

In 2017, UNICEF estimated there were 642,000 migrant and refugee children in South Africa, making it the largest child migrant population on the African continent.[735] More recently, in 2022, it was reported that there were an estimated 2.4 million migrants in the country; however, the number of children among them is not reported.[736]

The lack of data on migrant children in South Africa is a significant challenge. This includes a lack of child protection-related data on migrant children, despite the fact that migrant children are among the most vulnerable and at increased risk of violence, abuse, and exploitation, particularly if they are unaccompanied. The UNCRC reports that migrant children, particularly girls, are at increased risk of harmful practices, including child marriage and female genital mutilation, especially if they are migrating from countries where these practices are common.

While data on violence against migrant children is not available, incident monitoring by the University shows that there was a significant rise in violent attacks against the migrant population in 2008, with a total of 150 reported incidents and 72 fatalities. During the last decade, the average number of reported incidents per year is 61 across the country, with the highest incidences occurring in Gauteng, KZN, and the Western Cape.[737]

Data that are available related to the number of social grants provided to migrant children are presented in Chapter 3, in the section on Social Protection and relevant social grants.

Justice For Children

The Child Justice Act 75 of 2008 aims to:[738]

- Establish a criminal justice system for children who are in conflict with the law and accused of committing offences.
- Provide for the minimum age of criminal capacity for children and address justice for children.
- Provide a mechanism for dealing with children who lack criminal capacity outside the criminal justice system.
- Make special provision for securing attendance at court and for the release or detention and placement of children.
- Make provisions for the assessment of children.
- Provide for the holding of a preliminary inquiry and incorporate, as a central feature, the possibility of diverting matters away from the formal criminal justice system in appropriate circumstances.
- Make provisions for child justice courts to hear all trials of children whose matters are not diverted.
- Extend the sentencing options available in respect of children who have been convicted.
- Entrench the notion of restorative justice in the criminal justice system as it pertains to children in conflict with the law.

There are also policies and guidelines that access justice for children, include:

- Policy Framework for the Accreditation of Diversion Services in South Africa (2010)
- Department of Justice and Constitutional Development National Policy Framework (2010)
- National Policy Guidelines on Pre-Sentence Evaluation Committees (2011)`
- Anti-Gangsterism Strategy for Children and Youth At-at Risk, and Children in Conflict with the Law (2017)

In 2009, guidelines were introduced for home-based supervision, and in 2010, guidelines were established for probation officers and child and youth care workers to provide appropriate services to children in conflict with the law. It is also important to note that South Africa's minimum age of criminal capacity was raised from 10 to 12 years, following the amendment of the Act effective from 2022.

According to section 94 of the Child Justice Act 75 of 2008, multiple coordination mechanisms have been established for Child Justice. The Director-General Intersectoral Committee for Child Justice is chaired by the Department of Justice and Constitutional Development and includes participation from the National Prosecution Authority (NPA), SAPS, the Department of Correctional Services, DSD, DBE, and DoH. The Committee is supported by the National Technical Intersectoral Committee for Child Justice, which meets bi-monthly. There are also Provincial Child Justice Fora that report to the National Technical Intersectoral Committee.

The Preliminary Inquiry (PI) is a mechanism to facilitate the disposal of cases in the best interest of children, and the inquiry magistrate can take into account the individual needs and circumstances of each child appearing at the inquiry through the assessment report compiled by the probation officer. Among the total number of children registered for the preliminary inquiry (10,623 in the fiscal year 2022/23), over 85% of the cases involve children above the age of 15.[739] Following the PI, 49.8% of the children were referred to the Child Justice Court for further management, while 30.5% of the children were diverted.

The top crimes allegedly committed by children include Assault (Grievous Bodily Harm) at 22%, Assault at 13%, Rape at 12%, and Theft at 10%. It is also noteworthy that Murder ranks among the ten crimes with 4% (436 cases).[740]

Child Protection and Climate Change

Child protection is a cross-cutting issue when it comes to the impacts of climate change on households, families, and communities. For instance, incidents of child abandonment are likely to increase if families are displaced, separated, or forced to relocate following climate change-related events, such as severe floods. Children are also vulnerable to emotional distress and trauma if they experience climate change-related events and disasters, such as floods or droughts, especially if they result in the loss of life, housing, livelihoods, livestock, and the destruction of agricultural crops.[741]

Decreased agricultural production may also lead to increased rural-to-urban migration, which can expose children to heightened vulnerabilities and harm. For instance, displaced children living in informal settlements are at increased risk of being abused or exploited and falling victim to human traffickers. Extreme temperatures can also cause heat stress, leading to mental health disturbances and an increased risk of abuse for children. In addition, in the aftermath of extreme weather events, such as floods, families may be displaced and forced to live in crowded spaces, such as community halls.[742]

Summary of Data Gaps

This chapter focused on data related to child protection from violence, abuse, exploitation, and harmful practices, as well as protection and justice for children. It revealed numerous data gaps, including:

- There is a lack of national prevalence data on children's exposure to physical, sexual and emotional violence in the home and family, in schools and in communities. This requires measuring the prevalence of experiences of violence in childhood (before the age of 18), including direct experiences of physical, sexual and emotional violence, and witnessing such violence, whether in the home, schools or the community. This data should be disaggregated by sex, age and place where the violence occurred, as well as data related to both victims and perpetrators.
- Data are also limited on peer violence, including peer bullying and physical fighting, particularly among adolescents aged 10-17, in schools, public spaces and online. The available data is not a nationally representative sample and would be difficult to use for policy or programme design at country level. This data should be disaggregated by gender, age, disability and place where the violence occurred, as well as data related to both victims and perpetrators.
- Data related to child marriage and child labour are available but limited. Moreover, data related to children working in hazardous conditions and the worst forms of child labour are not available. More data are needed, including qualitative data related to child marriage and child labour, as well as the experiences of children working in hazardous conditions and the worst forms of child labour. Qualitative data is needed to develop a more accurate picture and understanding of child marriage and children who are working, including those in hazardous conditions, which can inform prevention and protection initiatives.
- Data related to children on the move is a notable gap. Data is required for the total number of children on the move by gender, age and nationality. The missing data includes the number of children on the move accessing different types of public services, and how many are not accessing public services. While the child protection data itself is significantly limited, disaggregation by migration status is not available, which is necessary for better policy-making and programming.
- Harmful cultural practices are serious acts of child rights violations as constitutionally defined in South Africa, yet data on these practices is not available. Children are abducted and forced to undergo activities that violate human rights and compromise their dignity, such as customary male circumcision, virginity testing and child marriage, including Ukuthwala, where age restrictions and limitations by law are not upheld. Data should be generated and disaggregated according to the nature of unlawful practice, gender, age and geographic area to facilitate programming and interventions. It is also important to collect geographic data to further understand the cultural and traditional aspects of harmful practices.
- To facilitate evidence-based decision-making and advocate for strengthening national child protection and social services provisions, the government and its partners require accurate, reliable and timely data and information. This includes data and information on how the child protection system and social service providers are functioning, including the number of children served by these systems by gender and age, as well as the quality of services provided. In South Africa, the lack of nationally representative child protection data is a notable gap that needs to be addressed by strengthening administrative data systems across sectors responsible for child protection, as well as the capacities of institutions to analyse and disseminate this data in a meaningful and useful way for data users (e.g., policy-makers and development partners). Ministry/agency personnel often require technical assistance and capacity building to strengthen their abilities to collect, analyse and utilise administrative data on child protection.

CONCLUSIONS

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This SitAn on children and adolescents in South Africa identified several priority areas in which concerted and sustained action is needed to ensure their rights are realised. These general observations are made with the acknowledgment that a complete equity-based analysis of the situation of children and adolescents in South Africa depends on the availability of data, including timely data and data disaggregated by gender, age, wealth status, and other vulnerabilities, as well as area, district, and region. Such data, however, are not always readily available. Data that are available are not always timely or real-time, and in some cases, nearly a decade old. Outdated data make it difficult to analyse the current situation of children and adolescents and to document or analyse changes over time. Each chapter in this report includes a summary of data gaps related to the realisation of children's rights.

Although the government produces meaningful and relevant data related to the rights of children and adolescents, including data made available for this report, existing data do not always capture the full range of issues that allow for an in-depth assessment of the situation of children and adolescents.

Data are crucial for evidence-based planning, programme and policy formulation, and proper monitoring and analysis of the situation of children and adolescents. Data also impact the ability to effectively and efficiently allocate resources to advance the needs and rights of children, adolescents, and youth. Trend data are also needed to determine whether the situation of children and adolescents has improved over time. In some situations, the lack of timely data is an ongoing challenge. For instance, despite the central role of poverty in determining the realisation of children's rights, there is a lack of timely child poverty and indigence data. Given the lack of trend data related to child poverty, it is not possible to analyse whether the socio-economic situation of children and adolescents, and other vulnerable groups, is better, worse, or the same as it was five to ten years ago. In addition, some families may not be characterised as poor but are still vulnerable in different ways that negatively impact children, adolescents, and youth.

Way Forward

The idea behind the SDGs is to create a global movement to advance work on the 2030 Agenda for Sustainable Development; therefore, governments should frame their development plans and policies for the coming years based on this globally agreed-upon development agenda. To maintain an enabling environment conducive to delivering equitable social and economic growth and effective poverty reduction, certain capacities must be established or strengthened. These include:

- **Mobilising and channelling resources** to the appropriate sectors at the right time for optimal effect, and improving efficiency for the best use of limited resources (e.g., evidence-based and results-based budgeting and financial efficiency).

- **Enforcing standards and regulations**, and operationalising laws, policies, and action plans, including those in draft form.

- **Establishing a mix of social partnerships with key actors**, including central, regional, and local authorities, civil society groups, research institutions, and the private sector, along with international and non-governmental development partners.

- **Improving systems for generating, collating, and managing data and information** so that it is easily accessible on a timely basis and shared across ministries/agencies and sectors to better support the needs of children, adolescents, young people, and their families.

This SitAn revealed a real need to strengthen cooperation around children's rights and the needs of adolescents and youth. Findings from this SitAn indicated areas where the government and development partners would benefit from a much deeper understanding[743] of how to **build better partnerships for smart planning, problem-solving and innovation** to accelerate results for children and adolescents in the following areas:

- **Education**, with a focus on strengthening the quality of pre-school, primary and secondary education, which requires building the capacity of teachers, improving teaching and learning materials, and enhancing school infrastructure, as well as expanding coverage of ICT and the human capital[744] of school personnel.

- **TVET**, with a focus on partnering with the private sector to identify and develop market-driven TVET opportunities for young people.

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- **Health and well-being**, with a focus on: improving maternal and child health and reducing maternal and child morbidity and mortality; encouraging and supporting women to exclusively breastfeed; improving access to nutritious, safe, affordable, and sustainable foods during childhood and adolescence; increasing access to sexual and reproductive health education and uptake of services for all young people aged 10-24, not just those who are victims of sexual and gender-based violence or those infected with HIV/AIDS; increasing access to HIV/AIDS prevention initiatives for young people; and reducing teenage pregnancy.

- **Social protection**, with a focus on multidimensional child poverty[745] and the impact of COVID-19 on this issue, so that the GoSA and development partners can more effectively concentrate on policy efforts to alleviate children's deprivations and achieve sustainable poverty eradication through social safety net programmes.

- **Child protection**, with a focus on strengthening multi-sectoral coordination for child protection and effective prevention, early intervention, and response to violence, abuse, and exploitation of children and adolescents, including sexual and gender-based violence against girls and harmful practices. There is also a need to enhance social services and child protection services that support vulnerable children and adolescents, ensuring access to protection services in rural and remote areas, where child protection systems and services are few and far between.

- **WASH**, with a focus on improving access to safely managed WASH in households, schools, and health facilities, and ensuring that new and existing WASH systems are resilient to climate change over time, including the growing threat of water scarcity.

- **Climate change**, with a focus on strengthening the capacities of the government to respond to climate change and climate crises, aims to bring together specialised expertise to enhance disaster risk reduction (DRR) and ensure that hazards do not become disasters. This requires devoting greater attention and resources to shielding children, adolescents, and youth from these risks and enhancing their resilience. As a cross-cutting priority, particular attention must be paid to addressing the heightened risks faced by the most vulnerable children, adolescents, and youth. They should also be engaged as change agents for the future of climate resilience and environmental protection to ensure that climate action plans meet their specific needs and uphold their rights.

- **Strengthening public-private partnerships should be a key intervention.** Developing a strategic business-for-results agenda and framework that engages the private sector is crucial; however, it must be coordinated and conducted in cooperation with both private and public sectors, including government and non-governmental partners. Business-for-results initiatives and engagement with the private sector should also align with public policies and national agendas, including national action planning for children's rights and the rights of young people.

As the Government of South Africa (GoSA) continues with post-pandemic recovery and plans for the future, it is important for the government to seize the opportunity to **'build back better' by creating a more sustainable, resilient, and inclusive society**. This requires risk-informed programming and smart planning, problem-solving, and innovation to address the challenges facing children, adolescents, and youth, who represent more than 50 per cent of South Africa's population.

ANNEX A:

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ANNEX B:

CONCEPTUAL FRAMEWORK AND QUESTIONS

Framework	Questions
Country Overview (Scene Setting)	What population groups are affected by: national/sub-national laws and policies, including budgets; conflict; and economic, social and environmental factors that lead to inequities?
	How does the broader country context contribute to child rights and the well-being of children and adolescents?
	What macro factors exacerbate inequities? What innovative solutions are accelerating inclusive development?
	How are institutions – regional, national, sub-national, private, public, faith-based, community, etc. – systematically achieving their obligations on inclusive services and enabling opportunities for children and adolescents?
Causes, Challenges and Risks	What specific factors have contributed to the realization of child rights and well- being? What are the main child rights violations in the country?
	What are the top factors, including risks (prioritization is key here), that prevent the realization of child rights and well-being?
	What are the key factors that drive inequities in the realization of child rights and well-being? How are children and adolescents engaged as active agents in decisions?
	Do children and adolescents, especially the most vulnerable, enjoy their rights to (available, access, use, adequate and effective) coverage of commodities, services and opportunities?
Child Rights and Well-Being: Progress and Inequities	What progress has been made in achieving children's rights and well-being across relevant age groups, such as neonatal, children under five years, young children, older children and adolescents, as defined within the national context, literature, and evidence?
	Has progress been unequal? How large or deep are the deprivations faced by marginalized groups, such as girls and women, those living in poverty, children with disabilities, minorities and refugee children, among others?
	Who are the groups left behind, where, and why? Who, among the children who are left behind, face severe and/or intersecting deprivations and disadvantages, or multiple forms of discrimination that make them likely to be furthest behind?
	How resilient are children and adolescents to shocks and stressors?
Global and Regional Issues	What are the global and regional issues that impact child rights and well-being?
	Has there been country progress in addressing the concluding observations of the periodic reports of the UN CRC and related human rights treaties?
	How are cross-border issues and openings (migrations, trafficking, digitalization, etc.) being addressed/harnessed at scale?
	How does the realization of child rights and well-being contribute towards achieving the SDGs in the country, and addressing emerging issues?

SOURCE: UNICEF (2019). Core Guidance: New Generation Situation Analysis. UNICEF: New York, NY, USA, p. 16.

ANNEX C:

LIST OF PARTICIPANTS IN SECTOR-SPECIFIC CONSULTATIONS

Thematic Area Consultations	Organisation	Name(s)	Title
Child protection: 16 April 2024	UNICEF	Robin Haarr	UNICEF Consultant
	UNICEF	Fulufhedzani Nelufule	PME Officer
	UNICEF	Allister Pillay	PME Officer
	UNICEF	Tshiamo Mariti	Child Protection UNV
	UNICEF	Makiba Yamano	Chief of Child Protection
	Save the Children	Megan Briede	Programme Director
	Scalabrini Centre	James Chapman	Head of Advocacy & Legal Advisor
	UNICEF	Sinah Moraue	Child Protection Specialist
	UNICEF	Gloria Khoza	Child Protection Officer
	REPSSI	Celeste Matross	Country Director
	UNICEF	Tashana Ntuli	Child Protection Officer
	REPSSI	Lilly Magodi	Project Assistant
	Clowns without borders	Lulu Ngcobo	Co-Director
	REPSSI	Vunda Joy Demula	Regional M&E Officer
	UNICEF	Caroline Dlamini	Child Protection UNV
	Save the children	Margaret Zulu	Team Lead for Migration & Displacement /Child Protection
	UN	Maria Vittoria Azzarello	JPO in Human Rights
	University of Cape Town Refugee Rights Unit	Sally Gandar	Head of Strategic Litigation & Advocacy
	Scalabrini	Rachel	
	UNICEF	Helen North	UNICEF D4C Consultant
	UNICEF	Hellen Moerane	Programme Assistant Officer
	Save The Children	Gugu Xaba	
	IOM	Maria Moreriane	Regional Migration Health Project Officer
	UNICEF	Mandla Dube	ICT Officer

Thematic Area Consultations	Organisation	Name(s)	Title
Education: 17 April 2024	UNICEF	Robin Haar	UNICEF Consultant
	DBE	Kulula Manona	Chief Director for Foundations for Learning
	NECT	Godwin Nhauro	Assistant National Education Programme Manager
	University of Pretoria	Alex Antonines	Professor in Entrepreneurship
	UNICEF	Andile Dube	Education Manager
	MIET AFRICA	Dawn Jones	Director of Programmes
	MIET AFRICA	Ntokozo Mokhethu	Team Lead Manager - MIET AFRICA
	UNICEF	Nokuthula Prusent	Youth & Adolescent Development Specialist
	UNICEF	Lungile Mdluli	Early Childhood Development Officer
	UNICEF	Nduvho Ramulongo	Education Specialist
	UNICEF	Hana Yoshimoto	Chief of Education
	UNICEF	Andre Viviers	Education Manager
	UNICEF	Fulufhedzani Nelufule	PME Officer
	UNICEF	Allister Pillay	PME Officer
	NECT	Lebogang Maphelela	Assistant National Programme Manager · National Education Collaboration Trust
	UNICEF	Helen North	UNICEF D4C Consultant
		Fatima	
	Cotlands	Nozizwe Dladla-Qwabe	Chief Operations Officer
	UN	Shanelle Van Der Berg	Human Rights Officer
		Alex's OtterPilot	
	UNESCO	Shawa, Remmy	
	NECT	G2 Nhauro	
	MIET AFRICA	Nontu	
	UNICEF	Mandla Dube	ICT Officer
	Department of Education	Geyer, Simoné	DDG, Planning and Delivery Oversight
	UN	Maria Vittoria Azzarello	JPO in Human Rights
	NECT	John Thurlow	Director of Programmes
		Fatima Adam Zenex	Programme Director
	UNICEF	Lucky Howard	Programme Assistant Officer

Thematic Area Consultations	Organisation	Name(s)	Title
Health and Nutrition: 18 April 2024	UNICEF	Robin Haar	UNICEF Consultant
	UNICEF	Fulufhedzani Nelufule	PME Officer
	UNICEF	Allister Pillay	PME Officer
	UNICEF	Boitumelo Marakile	HIV/AIDS Officer
	UNICEF	Lea castro	Programmes Officer
	UNICEF	Lebogang Schultz	SRH/HIV manager
	UNICEF	Bontle Motloung	Health Officer
	UNICEF	Sufang Guo	Chief Health and Nutrition
	UNICEF	HELEN NORTH	UNICEF D4C Consultant
	UN	Maria Vittoria Azzarello	JPO in Human Rights
	SANAC	Nozuko	
	WHO	Qekeko Dlamini	
	Department of Health	Gertrude Mbhaliti	Deputy Director: HIV Youth Manager
	Department of Health	Hannelie Meyer	HOD: SAVIC
	Department of Health	Joyce Mahuntsi	Deputy Director: Maternal and Neonatal Health
	SANAC	Nthabiseng	
Wash: 23 April 2024	UNICEF	Robin Haar	UNICEF Consultant
	UNICEF	Fulufhedzani Nelufule	PME Officer
	WRC	Nonhlanhla Kalebaila	Research Manager - Water Quality
	WRC	Sudhir Pillay	Research Manager: Sanitation
	UNICEF	Lea castro	Programme Officer
	PILO	Jonathan Godden	
	UNICEF	Mandla Dube	ICT Officer
	UN	Brian Mubiwa	Technical Focal Point
	WRC	Eunice Ubomba-Jaswa	Research Manager: Water Resources Quality
	Department of Water and Sanitation	Kevin Roussel	Regional Coordinator
	NDMC	Pumeza Tyali	Deputy Director · National Disaster Management Centre
	UN	Maria Vittoria Azzarello	
	GIZ	Noxolo Thabatha,	Technical Advisor for WASH in Schools
	UNILIVER	Sihlobo, Ponds	Technical Lead
	UN	Shanelle Van Der Berg	Human Rights Officer
	UNICEF	Khumbuzile Zuma	WASH Specialist
	Water aid	Charity Nshimbi	Programme Manager - WaterAid
	UN	Mkhwanazi Ntombizethu	Programme Management Associate

SitAN workshop validation **30th July 2024**		
Name	**Organization**	**Job Title**
Christine Muhigana	UNICEF	Representative
Irfan Akhtar	UNICEF	Deputy Representative
Chrislene Naidoo	UNICEF	Snr. Executive Associate

SitAN workshop validation **30th July 2024**		
Name	**Organization**	**Job Title**
Makiba Yamano	UNICEF	Chief Child Protection
Gloria Khoza	UNICEF	Child Protection Officer
Sinah Moruane	UNICEF	Child Protection Specialist
Janine Joy Simon-Meyer	UNICEF	SBC Manager
Mandisa Philile Mathobela	UNICEF	Partnerships Manager
Drooti Kala	UNICEF	Partnership Officer
Hana Yoshimoto	UNICEF	Chief Education
Engenas Senona	UNICEF	Education Specialist
Lungile Mdluli	UNICEF	Education Officer
Andile Dube	UNICEF	Education Manager
Sufang Guo	UNICEF	Chief Health / Senior Health Specialist
Khumbuzile Zuma	UNICEF	WASH Specialist
Bontle Rosa Motloung	UNICEF	Health Officer
Mandla Dube	UNICEF	ICT Officer
Ilona Milner	UNICEF	PMER Manager
Allister Pillay	UNICEF	Monitoring & Evaluation Officer
Russell Wildeman	UNICEF	Social Policy Manager
Thobile Adrian Mthiyane	Social Policy	Social Policy Specialist
Celetse Matross	REPISSI	Country Director
Vunda Joy Demula	REPISSI	Regional M&E Officer
Busi Sambo	NDSD	Social Work Policy Manager
Nkhensani Baloyi	Jet Education	ECD Research Officer
David Harrison	DGMT	CEO
Catherine Weihs	ILO	Project Coordinator
Mastoera Sadan	DPME	Chief Sector Expert
Rachel Naille	Jet Education	
Kefiloe Masiteng	RCO	Head of the Resident Coordinator's Office
Melissa Maseko	Presidency	Project support administrator
Nkele Ntuli	Presidency	
Nthabiseng Malefane	DIRCO	Senior Manager
Mariette Strydom	UNICEF	Programme Assistant
Nomaswazi Sibanyoni	UNICEF	Chief of Operations
Mbali Mushatama		
Ndlovu Stanley		
Jonathan Godden		
Hlamalani Nenzhelele		
Christinah Lekoelea	UNICEF	HR Manager
Vusumuzi Duncan Mnisi		
Mbonisi Nyathi		
Lynn van der Elst		
MTHETHWA, Simangele		
Jennifer Norins		
Janet Du Preez		
Mashadi Kekana	IOM	Assistant to the Representative
Liz-Marie Basson		

SitAN workshop validation **30th July 2024**		
Name	**Organization**	**Job Title**
Wilmi Dippenaar	South African Parenting Programme Implementers Network	Director
Dawn Jones	MEIT Africa	Director of Programmes
Sithembile Nqeketo		
Lea Castro	UNICEF	
Dr. Rose September		
Nthabiseng Mogowe		
Ayanda Ndlovu	UNICEF	
Nokuthula Prusent	UNICEF	
KHOSA-LESOLA, Ester		
Feni Motshwane		
James Chapman	Scalabrini	Head of Advocacy & Legal Advisor
Tashana Nomazwe Ntuli	UNICEF	Child Protection Officer
Nontu		
Pfarelo P. Mudau		
Kaathima		
Boitumelo Morakile	UNICEF	HIV/AIDS Officer
Penny Campbell		
David Moretsele	UNICEF	Senior Finance/Accounts Associate
Tabisa Silere-Maqetseba		
Lulu Ngcobo	Clowns without borders	Co-Director
Gilbert Tshitaudzi	UNICEF	
Bontle Motloung	UNICEF	Health Officer
Sudeshan Reddy	UNICEF	Communication Specialist
Lucy Jamieson	Children's Institute,	senior researcher
Emmanuel Modikwane	Save the children	Child Righst Governance Programme Manager
Thulani Mbatha	UNFPA	Assistant Representative/Head of Programs
Mokoena, Sibongile Petunia		
Jody van der Heyde	Independent Consultant	Research Consultant, Justice and Violence Prevention
Carmel le Roux	UNICEF	Procurement Assistant
Yumi Bae	UNICEF	Regional Chief of Programme & Planning
Siwakhe Ndamase	DPME	Chief Sector Expert
Nokulunga Lady-fair Zamisa	UNICEF	Operations Associate
Nicholas Dowdall	Lego Foundation	Senior Programme Specialist
Sigida, Salome Thilivhali	Department of Basic Education	Provincial Program Manager
Sufang Guo	UNICEF	Chief of Health and Nutrition
phakamile Madonsela	MMA	Public and Media Skills Development Manager
Watson, Patricia	Department of Basic Education	Chief Director
Sally Gandar	University of Cape Town Refugee Rights Unit	Head of Strategic Litigation & Advocacy
Lucky Howard	UNICEF	Programme Associate
Xolisa Dodo	National Treasury of South Africa	Communication Specialist

SitAN workshop validation **30th July 2024**		
Name	**Organization**	**Job Title**
Ntsakisi Ramunasi		
Ntokozo Mokhethu	MIET Africa	Team Lead Manager -
Hellen Moerane	UNICEF	Programme Associate
Zandile MZ. Kubeka		
Dlamini-Nqeketo, Sithembile	WHO	Technical Medical Officer and Adviser to the National TB and HIV programs of the Ministry of Health
Paula Proudlock	Children's Institute	Senior Researcher
Mark Blecher	Department of water and sanitation	Chief Engineer Water Services & Local Water Management
Vunda Demula	REPSSI	Regional M&E Officer
Neo Thabisile Mofokeng		
Makiba Yamano	UNICEF	Chief of Child Protection
Renjini Devaki	Red Cross	Planning, managing, implementing and monitoring
Khumbuzile Zuma	UNICEF	WASH Specialist
Nkhensani Baloyi	JET Education	ECD Research Officer
Malibongwe Gwele	Children's Institute, University of Cape Town	Research Officer
Cleopatra Mosana	National Treasury	Head of Communications
Kerileng Motsamai	UNODC	One Stop Centre Manager

ANNEX D:

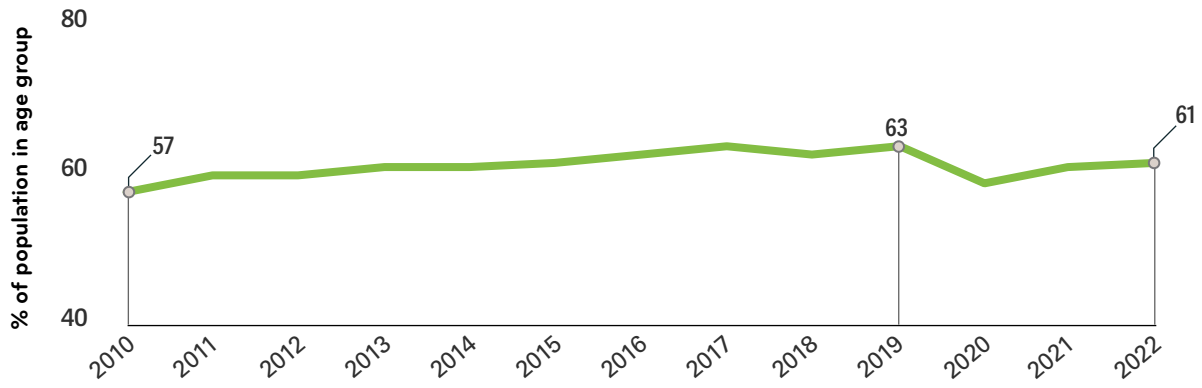
List of Participants in Key Stakeholder Interviews

Thematic Area	Organization	Name(s)	Title
Health & Nutrition	National Department of Health (NDOH)	Dr. Lesley Bamford & Dudu Shiba	Child Health Specialist
WASH	National Department of Water & Sanitation (NDWS)	Mark Bannister	Chief Engineer Water Services & Local Water Management
	OneWorld	Belynda Petrie	Director
Social Protection	National Treasury	Mark Blecher & 2 colleagues	Health & Education
	National Planning Commission of South Africa	Mastoera Sadan	Chief Sector Expert
	Statistics South Africa (SSA)	Patricia Koka & Seble Worku	Chief Director, Multidimensional Poverty Statistics
	WC Office of the Commissioner for Children	Cameron Cyster	
	Social Policy Initiative	Isobel Frye	Director
	International Labour Organization (ILO)	Catherine Weihs	
Education	Department of Basic Education (DBE)	Sandrini Moodley	School Safety
	NECT	Godwin Khosa	Chief Executive Officer
	JET Education Services	James Keevy	Chief Executive Officer
Climate Change	Presidential Climate Commission	Mbali Baduza	Chief Executive Office, Presidential Climate Commission
Child Protection	United States Agency for International Development	Anita Sampson	Director, Bilateral Health Programme
	Institute for Security Studies, Justice and Violence Prevention Programme	Dr. Chandre Gould	Senior Research Fellow
	University Pretoria, Centre for Child Law	Karabo Ozah	Director
	University of Cape Town, Children's Institute	Lucy Jamieson	Senior Researcher
	Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)	Luxolo Matomela	
Cross-Sectoral	UNICEF	Helen North	Data for Children Consultant
	Wits School of Public Health	Dr. Sara Nieuwoudt	Co-ordinator, MPH Social and Behaviour Change Communication

ANNEX E:

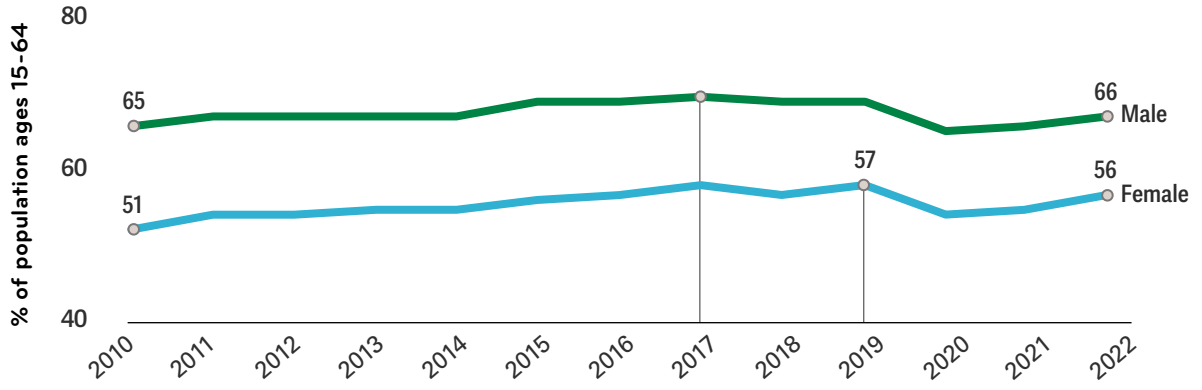
Annex Tables

Annex Chart 1. Labour force participation rate, ages 15-64 (%, modelled ILO estimate), 2010-2022



SOURCE: Retrieved on 13 May 2024 from: Labor force participation rate, total (% of total population ages 15-64) (modelled ILO estimate) - South Africa | Data (worldbank.org)

Annex Chart 2. Labour force participation rate by sex (% pop. ages 15-64, modelled ILO estimates), 2010-2022



SOURCE: Retrieved on 13 May 2024 from: Labor force participation rate, female (% of female population ages 15-64) (modelled ILO estimate) - South Africa | Data (worldbank.org) and Labor force participation rate, male (% of male population ages 15-64) (modelled ILO estimate) - South Africa | Data (worldbank.org)

Annex Table 1. Distribution of population by province, 2022		
Province	**2022 population**	**% of the population**
Gauteng	15,099,422	24.3
KwaZulu-Natal	12,423,907	20.0
Western Cape	7,433,019	12.0
Limpopo	6,572,720	10.6
Eastern Cape	7,230,204	11.7
Mpumalanga	5,143,324	8.3
North West	3,804,548	6.1
Free State	2,964,412	4.8

Annex Table 1. Distribution of population by province, 2022		
Province	**2022 population**	**% of the population**
Northern Cape	1,355,946	2.2
South Africa	62,027,503	100.0

SOURCE: Census 2022: Statistical Release. Department of Statistics South Africa, pp. 3-4. Retrieved on 12 December 2023 from: Statistics South Africa | Census Dissemination (statssa.gov.za)

Annex Table 2. Gender Development Index (GDI) for South Africa, 2021												
Country	**GDI**		**HDI values**		**Life expectancy at birth (SDG 3)**		**Expected year of schooling (SDG 4.3)**		**Mean years of schooling (SDG 4.4)**		**Estimated GNI per capita (2017 PPP$)**	
	Value	**Group**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**
South Africa	0.985	1	0.710	0.721	64.2	58.6	14.8	13.7	11.5	11.7	10,423	16,095
Sub-Saharan Africa	0.915	---	0.525	0.574	62.6	58.7	10.2	10.5	5.2	6.9	3,025	4,388
High human development	0.962	---	0.747	0.777	78.0	72.5	14.8	14.2	8.3	9.0	10,904	20,011

SOURCE: UNDP (2023). Human Development Report 2023/2024: Breaking the gridlock. UNDP: New York, NY, USA.

Annex Table 3. Gender Inequality Index (GII) for South Africa, 2021									
Country	**GII**		**Maternal mortality ratio** *(deaths per 100,000 live births) (SDG 3.1)*	**Adolescent birth rate** *(births per 1,000 women ages 15-19) (SDG 3.7)*	**Female seats in parliament** *(%) (SDG 5.5)*	**Population with at least some secondary education** *(% ages 25+ years) (SDG 4.4)*		**Labour force participation rate** *(% ages 15+ years)*	
	Value	**Rank**				**Female**	**Male**	**Female**	**Male**
South Africa	0.401	99	127	60.9	45.4	83.0	84.9	50.8	63.5
Sub-Saharan Africa	0.565	---	516	99.3	26.4	30.9	42.0	63.9	76.4
High human development	0.339	---	65	28.7	26.0	74.0	78.4	49.8	74.2

SOURCE: UNDP (2023). Human Development Report 2023/2024: Breaking the gridlock. UNDP: New York, NY, USA.

Annex Table 4. Inequity-adjusted Human Development Index (IHDI) for South Africa, 2021						
Country	**IHDI value**	**Overall loss (%)**	**Coefficient of human inequality (%)**	**Inequality in life expectancy (%)**	**Inequality in education (%)**	**Inequality in income (%)**
South Africa	0.462	35.6	32.2	19.5	17.3	59.9
Sub-Saharan Africa	0.363	33.9	33.6	27.9	33.6	39.4
High human development	0.628	17.8	17.3	8.3	14.0	29.6

SOURCE: UNDP (2023). Human Development Report 2023/2024: Breaking the gridlock. UNDP: New York, NY, USA.

Annex Table 5. Women's Empowerment Index (WEI) for South Africa, 2022					
Components	**SDG**	**Value and Indicators**	**South Africa**	**Sub-Saharan Africa**	**High Human Development**
		WEI value	0.680	0.498	0.641
Life and good health	3.7	Women of reproductive age whose need for family planning is satisfied with modern methods (% ages 15-49)	81.8	53.5	85.7
		Adolescent birth rate (births per 1,000 women ages 15-19)	60.9	99.4	27.6

Annex Table 5. Women's Empowerment Index (WEI) for South Africa, 2022					
Components	**SDG**	**Value and Indicators**	**South Africa**	**Sub-Saharan Africa**	**High Human Development**
Education, skills-building and knowledge		Population with completed secondary education or higher, female (% ages 25 and older)	52.8	20.2	40.4
	8.6	Youth not in education, employment or training (NEET), female (%ages 15-24)	32.4	33.9	24.7
Labour and financial institution		Labour force participation rate among working-age individuals living in a household comprising a couple and at least one child under age 6, female (% ages 25-54)	75.9	70.9	62.2
	8.10	Account ownership at financial institution or with a mobile-money-service provider, female (% of population ages 15 and older)	86.2	40.8	72.7
Participation in decision-making	5.5	Share of seats held by women in parliament (%)	46.1	26.5	26.0
		Share of seats held by women in the local government (%)	40.7	---	30.3
		Share of managerial positions held by women (%)	31.6	38.0	32.9
Freedom from violence	5.2	Ever-partnered women and girls subjected to physical and/or sexual violence by a current or former intimate partner in the previous 12 months (% ages 15-49)	13.0	20.6	6.6

SOURCE: UNDP & UN Women (2023). The Paths to Equal: Twin indices on women's empowerment and gender equality. UNDP & UN Women: New York, NY, USA.

Annex Table 6. Global Gender Parity Index (GGPI) for South Africa, 2022						
Components	**SDG**	**Value and Indicators**	**Sex**	**South Africa**	**Sub-Saharan Africa**	**High Human Development**
		GGPI Value		0.823	0.697	0.733
Life and good health		Fraction of life expectancy at birth spent in good health (%)	Female	84.5	85.8	86.5
			Male	87.8	88.3	89.3
Education, skills-building and knowledge		Population with completed secondary education or higher (% ages 25 and older)	Female	52.8	20.2	40.4
			Male	79.2	31.5	43.4
	8.6	Youth not in education, employment or training (NEET), female (% ages 15-24)	Female	32.4	33.9	24.7
			Male	28.8	22.5	15.0
Labour and financial institution		Labour force participation rate among working-age individuals living in a household comprising a couple and at least one child under age 6, female (% ages 25-54)	Female	75.9	70.9	62.2
			Male	90.4	93.0	96.7
	8.10	Account ownership at financial institution or with a mobile-money-service provider, female (% of population ages 15 and older)	Female	86.2	40.8	72.7
			Male	84.6	51.7	76.9
Participation in decision-making	5.5	Share of seats held by women in parliament (%)	Female	46.1	26.5	26.0
		Share of seats held by women in the local government (%)	Female	40.7	---	30.3
		Share of managerial positions held by women (%)	Female	31.6	38.0	32.9

SOURCE: UNDP & UN Women (2023). The Paths to Equal: Twin indices on women's empowerment and gender equality. UNDP & UN Women: New York, NY, USA.

Annex Table 7. National child deprivation headcount ratio by dimensions and age groupings (%), 2020			
Dimension	0-4 years (%)	5-12 years (%)	13-17 years (%)
Information	9.0	8.2	7.7
Access to information devices	9.0	8.2	7.7
Housing	61.3	59.7	58.5
Energy	23.2	23.7	23.1
Shelter	53.3	51.7	50.6
WASH	51.5	50.9	50.2
Waste disposal	46.9	46.6	45.7
Sanitation	24.6	23.6	23.1
Drinking water source	11.8	12.7	12.2
Protection	18.8	19.8	20.3
Safely	18.8	19.8	20.3
Education/Child development	57.9	73.0	74.4
Child development	57.9	n/a	n/a
Lateness in schooling	n/a	11.6	33.4
School facilities	n/a	76.8	70.8
Health	54.4	53.1	52.1
Availability of RTHC	12.5	n/a	n/a
Distance of health care centre	53.4	53.1	52.1
Nutrition	42.5	41.4	40.4
Food security	42.5	41.4	40.4

n/a = not applicable; **SOURCE:** Department of Statistics South Africa (2020). Child Poverty in South Africa: A Multiple Overlapping Deprivation Analysis. Department of Statistics South Africa: Pretoria, South Africa.

Annex Figure 1. Top four underlying causes of maternal mortality by province (%), 2020-2022 triennium

	EC	FS	GP	KZN	LP	MP	NW	NC	WC	SA
MSS	17.64	28.30	17.20	17.23	15.71	15.92	19.07	14.99	11.69	16.99
NPRI	47.97	34.52	27.26	39.89	26.68	35.92	40.33	38.97	36.74	35.21
Ec	2.48	6.21	3.79	3.10	4.49	2.59	3.27	5.99	1.67	3.41
Miscarriage	5.88	2.76	7.14	4.81	5.24	7.04	9.26	4.50	1.00	5.50
PRS	6.50	10.35	5.83	4.81	7.98	8.52	4.90	5.99	4.01	6.19
OH	17.02	31.06	19.97	14.74	22.69	30.36	28.34	20.98	9.35	19.84
HDP	20.73	35.90	17.49	9.78	21.69	20.00	25.07	26.98	10.69	17.85
AR	3.40	3.45	1.02	1.86	4.74	5.18	2.72	1.50	1.00	2.55
ADR	0.62	1.38	1.02	0.78	1.99	0.74	0.00	0.00	0.00	0.86
Emb	6.19	5.52	2.33	2.95	4.24	4.81	2.18	5.99	5.01	3.84
AC	1.86	0.00	3.94	2.02	0.75	1.85	3.81	1.50	3.34	2.38
Miscellaneous	0.31	1.38	0.00	0.47	0.50	0.74	0.00	1.50	1.34	0.50
Unknown	0.93	17.26	8.02	6.52	2.99	5.18	6.54	8.99	3.34	5.93

Top 4 most common underlying causes

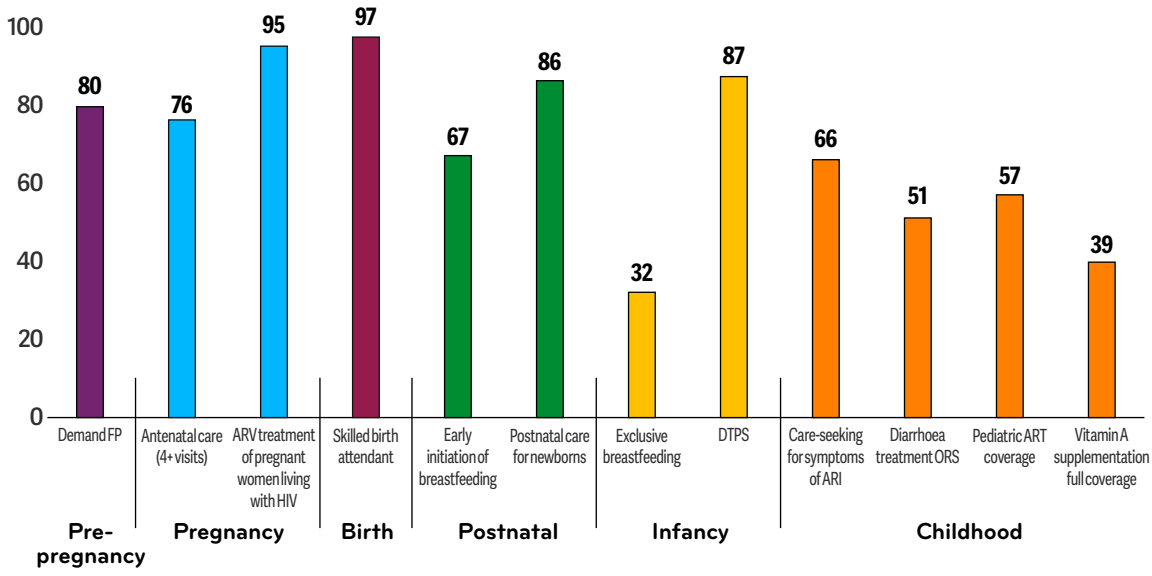
Most common | 2nd most common | 3rd most common | 4th most common

SOURCE: South African National Department of Health (2024). Saving Mothers – Executive Summary 2020-2022: Inclusive data for COVID-19 pandemic. South African National Department of Health: Pretoria, South Africa

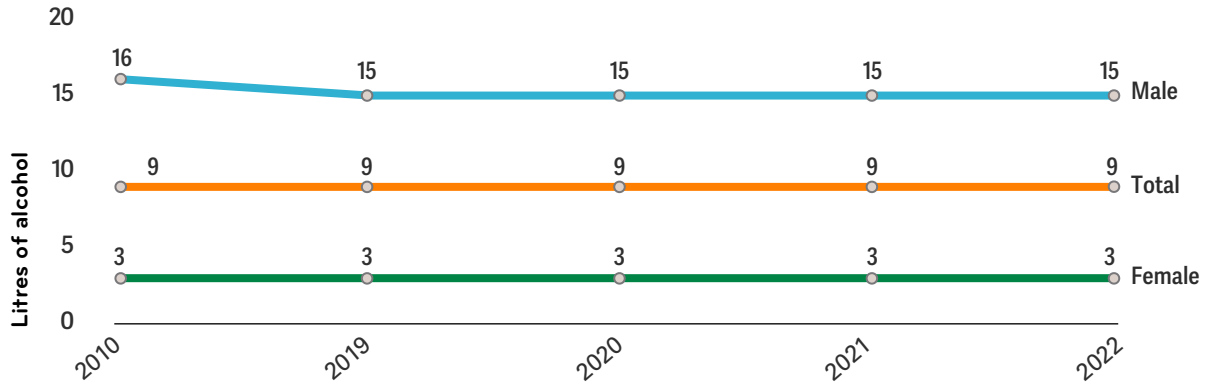
Annex Table 8. Infant and young child feeding (IYCF) indicators on breastfeeding status (%), 2016	
	%
Initial breastfeeding	
Started breastfeeding within 1 hour of birth	67
Started breastfeeding within 1 day of birth	80
Exclusive breastfeeding	
Exclusive breastfeeding (under 6 months)	32
Exclusive breastfeeding (4-5 months)	24
Predominant breastfeeding	
Predominant breastfeeding (0-5 months)	46
Continued breastfeeding	
Continued breastfeeding at 1 year	51
Continued breastfeeding at 2 years	13
Age-appropriate breastfeeding (0-23 months)	37
Liquids	
Bottle feeding (0-23 months)	47
Solid or semisolid foods	
Introduction of solid, semisolid or soft foods (6-8 months)	83

SOURCE: SADHS, 2016

Annex Figure 1. Improving coverage and quality of care (%)



Annex Chart 3. Total alcohol consumption per capita by sex (litres of pure alcohol, 15+ years), 2000-2019



SOURCE: Retrieved on 24 February 2024 from: Total alcohol consumption per capita (litres of pure alcohol, projected estimates, 15+ years of age) - South Africa | Data (worldbank.org); Total alcohol consumption per capita, male (litres of pure alcohol, projected estimates, male 15+ years of age) - South Africa | Data (worldbank.org); Total alcohol consumption per capita, female (litres of pure alcohol, projected estimates, female 15+ years of age) - South Africa | Data (worldbank.org)

Annex Table 9. Number of schools by province and type of school, 2022

Province	Public	Independent	Total	
	n	n	N	%
Eastern Cape	5,016	269	5,285	21.3
Free State	937	84	1,021	4.1
Gauteng	2,061	918	2,979	12.0
KwaZulu-Natal	5,790	230	6,020	24.2
Limpopo	3,622	217	3,839	15.5
Mpumalanga	1,632	139	1,771	7.1
Northern Cape	543	43	586	2.4
North West	1,443	106	1,549	6.2
Western Cape	1,467	319	1,786	7.2
Total	22,511	2,325	24,836	100.0

SOURCE: School Realities 2023.

ANNEX F:

CHILD-RELATED SDG INDICATORS

Number	Indicator	Tier
Goal 1: No Poverty		
1.1.1	Proportion of population below the international poverty line, by sex, age, employment status and geographical location (urban/rural)	I
1.2.1	Proportion of population living below the national poverty line, by sex and age	I
1.2.2	Proportion of men, women and children of all ages living in poverty in all its dimensions according to national definitions	II
1.3.1	Proportion of population covered by social protection floors/systems, by sex, distinguishing children, unemployed persons, older persons, persons with disabilities, pregnant women, newborns, work-injury victims and the poor and the vulnerable	II
1.4.1	Proportion of population living in households with access to basic services	II
1.a.2	Proportion of total government spending on essential services (education, health and social protection)	II
Goal 2: Zero Hunger		
2.2.1	Prevalence of stunting (height for age <-2 standard deviation from the median of the World Health Organization (WHO) Child Growth Standards) among children under 5 years of age	I
2.2.2	Prevalence of malnutrition (weight for height >+2 or <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age, by type (wasting and overweight)	I
Goal 3: Good Health		
3.1.1	Maternal mortality ratio	I
3.1.2	Proportion of births attended by skilled health personnel	I
3.2.1	Under-5 mortality rate	I
3.2.2	Neonatal mortality rate	I
3.3.1	Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations	I
3.3.2	Tuberculosis incidence per 100,000 population	I
3.4.2	Suicide mortality rate	I
3.6.1	Death rate due to road traffic injuries	I
3.7.1	Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods	I
3.7.2	Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1,000 women in that age group	I
3.8.1	Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)	I
3.9.1	Mortality rate attributed to household and ambient air pollution	I
3.9.2	Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services)	I
3.b.1	Proportion of the target population covered by all vaccines included in their national programme	I
Goal 4: Quality Education		
4.1.1	Proportion of children and young people (a) in grades 2/3; (b) at the end of primary; and (c) at the end of lower secondary achieving at least a minimum proficiency level in (i) reading and (ii) mathematics, by sex	II
4.2.1	Proportion of children under 5 years of age who are developmentally on track in health, learning and psychosocial well-being, by sex	III
4.2.2	Participation rate in organized learning (one year before the official primary entry age), by sex	I
4.5.1	Parity indices (female/male, rural/urban, bottom/top wealth quintile and others such as disability status, indigenous peoples and conflict-affected, as data become available) for all education indicators on this list that can be disaggregated	I/II/III

Number	Indicator	Tier
4.6.1	Proportion of population in a given age group achieving at least a fixed level of proficiency in functional (a) literacy and (b) numeracy skills, by sex	II
4.a.1	Proportion of schools with access to (a) electricity; (b) the Internet for pedagogical l purposes; (c) computers for pedagogical purposes; (d) adapted infrastructure and materials for students with disabilities; (e) basic drinking water; (f) single-sex basic sanitation facilities; and (g) basic handwashing facilities (as per the WASH indicator definitions)	II
Goal 5: Gender Equality		
5.2.1	Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age	II
5.2.2	Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence	II
5.3.1	Proportion of women aged 20–24 years who were married or in a union before age 15 and before age 18	II
5.4.1	Proportion of time spent on unpaid domestic and care work, by sex, age and location	II
5.6.1	Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care	II
Goal 6: Clean Water and Sanitation		
6.1.1	Proportion of population using safely managed drinking water services	II
6.2.1	Proportion of population using (a) safely managed sanitation services and (b) a hand-washing facility with soap and water	II
Goal 7: Renewable Energy		
7.1.2	Proportion of population with primary reliance on clean fuels and technology	I
Goal 8: Good Jobs and Economic Growth		
8.7.1	Proportion and number of children aged 5–17 years engaged in child labour, by sex and age	II
Goal 10: Reduced Equalities		
10.1.1	Growth rates of household expenditure or income per capita among the bottom 40 per cent of the population and the total population	II
Goal 11: Sustainable Cities and Communities		
11.1.1	Proportion of urban population living in slums, informal settlements or inadequate housing	I
Goal 12: Responsible Consumption		
12.8.1	Extent to which (i) global citizenship education and (ii) education for sustainable development (including climate change education) are mainstreamed in (a) national education policies; (b) curricula; (c) teacher education; and (d) student assessment	III
Goal 13: Climate Action		
13.1.1	Number of deaths, missing persons and directly affected persons attributed to disasters per 100,000 population	II
13.1.2	Number of countries that adopt and implement national disaster risk reduction strategies in line with the Sendai Framework for Disaster Risk Reduction 2015–2030	I
Goal 16: Peace and Justice		
16.1.1	Number of victims of intentional homicide per 100,000 population, by sex and age	I
16.2.1	Proportion of children aged 1–17 years who experienced any physical punishment and/or psychological aggression by caregivers in the past month	I
16.2.3	Proportion of young women and men aged 18–29 years who experienced sexual violence by age 18	II
16.9.1	Proportion of children under 5 years of age whose births have been registered with a civil authority, by age	I
Goal 17: Partnerships for the Goals		
17.18.1	Proportion of sustainable development indicators produced at the national level with full disaggregation when relevant to the target, in accordance with the Fundamental Principles of Official Statistics	III
17.19.2	Proportion of countries that (a) have conducted at least one population and housing census in the last 10 years; and (b) have achieved 100 per cent birth registration and 80 per cent death registration	I

ENDNOTES

1 UNICEF South Africa's Country Programme Document (CPD) 2020-2025, budgeted at USD 48.3 million, has five outcome areas: 1) child health and well-being; 2) early childhood education, and primary and secondary education; 3) adolescent development and participation; 4) child protection; and 5) social policy and child rights.

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19 The Focus Group Discussion Guide for use with consultations of young people that was developed by Dr. Robin Haarr (PhD), Professor and UNICEF Senior Consultant, to support the design of this SitAn, shall not be duplicated, used or disclosed, in whole or in part, by UNICEF or other UNICEF consultants without Dr. Robin Haarr's permission, coupled with proper citation and acknowledgement.

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743 A deep dive is a more thorough or comprehensive assessment and analysis of a subject or issue.

744 Human capital includes the preparation, recruitment and retention of highly talented and effective school teachers and administrators.

745 Multidimensional child poverty defines children who experience a state of poverty that is more complex than that defined by a unidimensional measure of poverty, but encompasses child material needs

746 Although children may be admitted to school earlier than age 7, age 7 is the year where compulsory school attendance start. This figure uses the latter as the year when a child is Grade 1 as a simplified model.

unicef

for every child

Physical address:
Equity House
659 Pienaar street
Brooklyn
Pretoria

Postal address:
PO Box 4884
Pretoria
0001

Author
Dr. Robin Haarr,
PhD, Professor
UNICEF Senior Consultant