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for every child

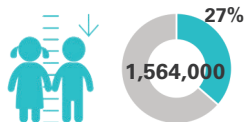


South Africa Nutrition Brief

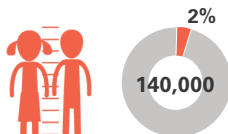
Country context

MALNUTRITION STATUS (NUMBER,%):

Child stunting (2016)



Child wasting (2016)



Child overweight (2016)



Human Development Index rating:

113 out of 189 countries (2017)

Gross Domestic Product per capita:

PPP\$ 13,730^{a/} (2018)

Poverty rate:

18.9%^{b/} (2014)

Under-five mortality:

34 per 1,000 live births (2018)

Maternal mortality:

119 per 100,000 live births (2017)

Malnutrition numbers are rounded off to the nearest whole number. PPP: Purchasing Power Parity. a/ In current international dollars b/ Population living on less than US\$1.90 a day at 2011 PPP. Source: UNICEF, WHO, WB (2018)¹, UNDP (2018)², World Bank (2018)³ and SOWC 2019⁴.

Why invest in nutrition?

Combating malnutrition in all its forms is one of the greatest global development challenges. In Africa, 56.6 million children under the age of five are stunted (have a low height-for-age or are suffering from chronic under nutrition).

In South Africa, this number stands at over 1.5 million children, meaning that almost 3 out of every 10 children in South Africa are already stunted. These children will likely not reach their full growth and developmental potential because of the irreversible physical and cognitive damage caused by persistent nutritional deprivations.

Good nutrition is the foundation of child survival, health and development; wellnourished children are better able to grow and learn, to participate in and contribute to their communities. Stunting is associated with poor brain development, which affects a child's cognitive development, educational attainment and productivity in adulthood which in turn has an effect on the development potential of a nation.

Being malnourished in early childhood elevates the risks of infant and child morbidity and mortality, increases healthcare costs and social

safety net expenditures, lowers the efficiency of investments in education, decreases lifelong income-earning potential and labour force productivity resulting in a vicious cycle of poverty, ill health and poor nutrition which is transmitted across generations.

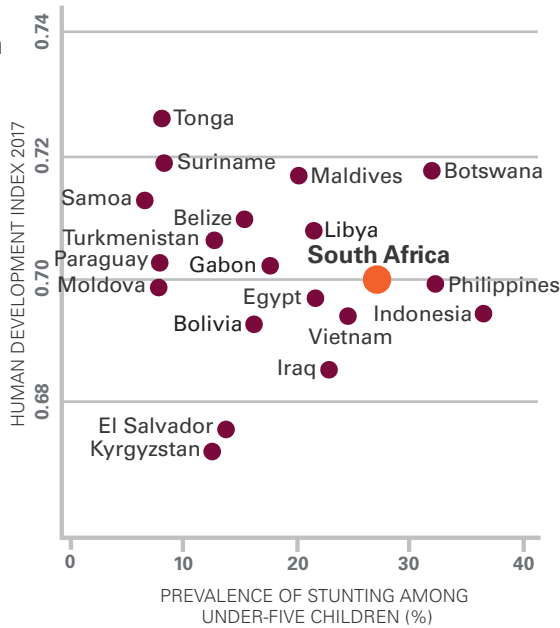
The developmental, economic and social impacts of malnutrition, especially in the early years of life, are serious and long lasting for individuals, their families, communities and countries. The costs of undernutrition in Africa and Asia are equivalent to losing 8-11 percent of GDP every year, while investments in nutrition offer a \$16 return for every \$1 invested⁵.

In the words of King Letsie III of Lesotho, the AU Nutrition Champion and FAO Ambassador, "Together we can eliminate child malnutrition in all its forms by 2030 for optimal human capital development and a more prosperous Africa!"

Nutrition profile

Stunting rates across countries

Compared to other nations in Africa with a similar Human Development Index (HDI), South Africa has a higher prevalence of stunting compared to Gabon, Libya and Egypt, and a lower prevalence of stunting compared to Botswana. South Africa's stunting prevalence of 27%¹⁰ is lower than that of many countries in the SADC region but it is still classified as high¹¹ according to international benchmarks.



Source: UNDP (2018)² and WB (2018)³ for stunting rates (most recent year available 2007-2017).

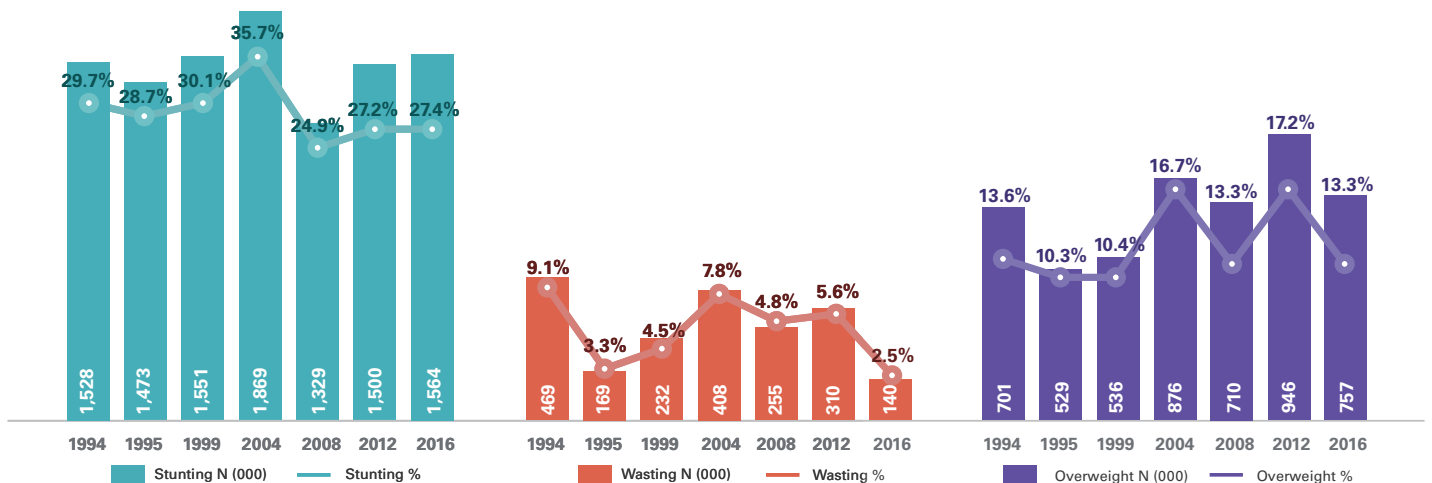
| KEY INDICATORS | VALUE | YEAR |
|--|-------|------|
| Low-birthweight (% of births <2.5kg) | 14.5% | 2016 |
| Infants exclusively breastfed (% of children under 6 months) | 31.6% | 2016 |
| Children fed 5+ food groups (% of children 6-23 months) | 39.9% | 2016 |
| Children who received a minimum acceptable diet (% of children 6-23 months) | 22.9% | 2016 |
| Anaemia in children (% of children 6-59 months) | 61.3% | 2016 |
| Anaemia in women of reproductive age (% of women age 15-49) | 25.8% | 2016 |
| Women who are thin according to BMI (<18.5 kg/m ²) (% of women age 15-49) | 3.1% | 2016 |
| Women who are overweight or obese according to BMI (≥25 kg/m ²) (% of women age 15-49) | 62.1% | 2016 |

Source: DHS 2016¹⁰, UNICEF (2019a)¹² and SOWC 2019⁴.

Child nutrition status: trends for the period 1994-2016¹

Latest available data from 2016 shows that there are 1,564 thousand children in South Africa who are already stunted and will not reach their full growth potential. Both the prevalence and the number of stunted children have increased since 2008. Stunting levels have increased 10 percent (or 2.5 percentage points) since 2008 (from 24.9% to 27.4%), while the numbers of stunted children have increased by 18 percent over the same period (from 1.3 to

1.6 million children). Child wasting has fluctuated over the years, and only in 2016 reached a level classified as very low¹¹ (<2.5%) at 2%. Child overweight has also fluctuated over the years in the range of 10-17% which is classified as high (10-<15%) and very high (>15%) according to international benchmarks¹¹. In 2016, 13% of children were overweight in South Africa.

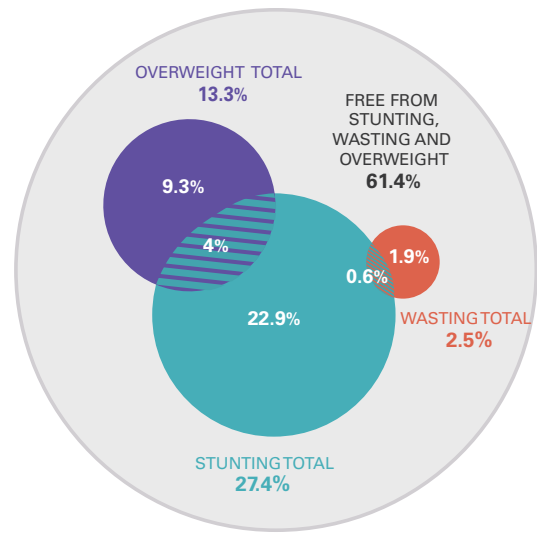


Source: UNICEF, WHO, World Bank (2018)¹

Overlapping forms of child malnutrition

2016 (%)

Different forms of malnutrition coexist within the same children: 0.6% of children under-five are both stunted and wasted, and 4% are both stunted and overweight. Children who are both wasted and stunted are 12.3-times more likely to die than their well-nourished counter-parts⁷. Children under-nourished in the first 2 years of life and who rapidly gain weight during childhood or adolescence have an increased risk of chronic disease related to nutrition⁸. There is a need for double-duty actions⁹ designed to tackle both undernutrition and obesity, and to

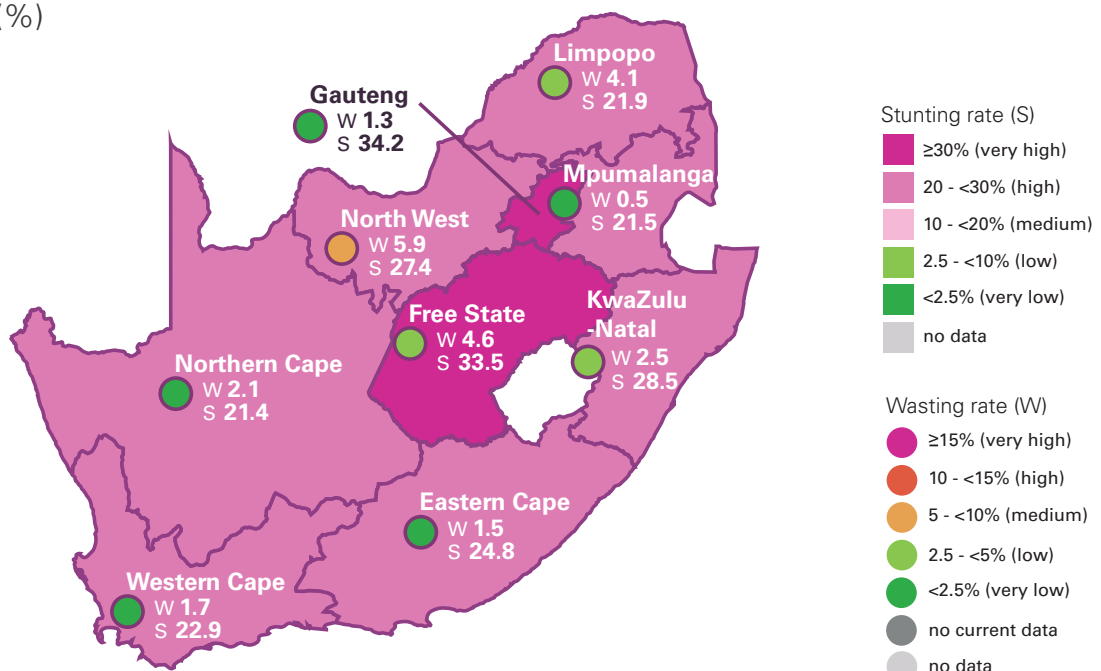


Source: UNICEF (2018)⁶.

effectively address the underlying causes of all forms of malnutrition such as poverty, lack of access to varied, nutritious and healthy foods, sub-optimal child feeding practices, etc.

Stunting and wasting by region

2016 (%)



Source: DHS 2016¹⁰

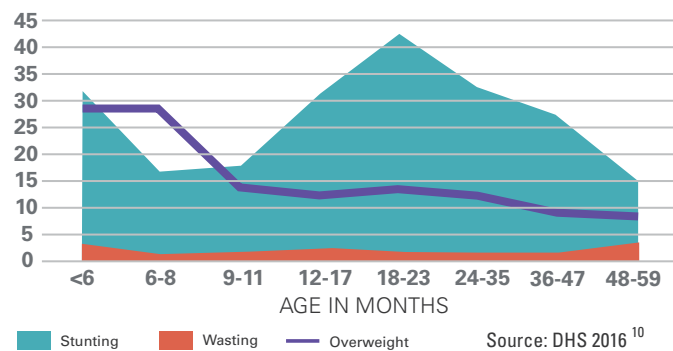
Child stunting is classified as very high ($\geq 30\%$) in Free State and Gauteng according to international benchmarks. The other provinces in South Africa have high levels (20- $<30\%$) of stunting ranging from 21% to 29%. Child wasting is generally low in South Africa, with only

1 province, North West, categorized as having a medium level (5- $<10\%$) of child wasting at 5.9%. The other provinces have low to very low levels of child wasting: 3 provinces have low levels (2.5- $<5\%$), and 5 provinces have very low levels ($<2.5\%$).

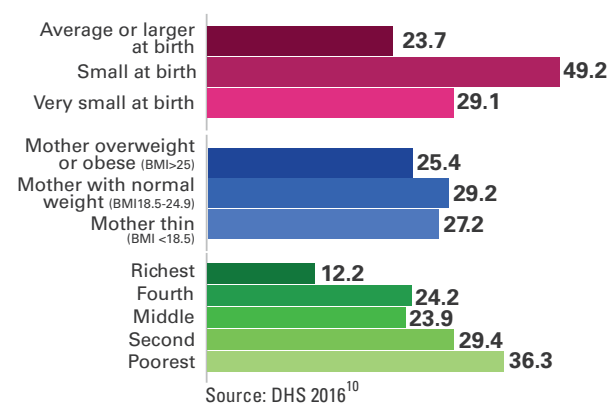
Malnutrition by age of children

2016 (%)

Stunting in children <6 months is already high ($\geq 30\%$)¹¹ at 32%. It drops to 17% in children 6-8 months but it then increases again until peaking at 43% in children 18-23 months. Stunting then slows down but remains at a medium level at 16%, demonstrating its life-long and lasting effects. Wasting is always low (2.5-<5%) or very low (<2.5%) across all ages. Overweight is lower among older children and it remains generally at high (10-<15%) levels.



Stunting rate by background characteristics 2016 (%)



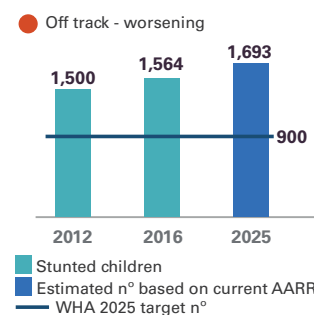
Stunting in South Africa is higher among children born small at birth. It is also high regardless of the nutrition status of mothers. This highlights the importance of tackling undernutrition starting early in life, with a focus on the 1,000 day window and continuing into adolescence and pregnancy. Higher stunting rates among the lowest wealth quintiles reflect socioeconomic inequalities.

Country progress towards World Health Assembly 2025 nutrition targets^{13,14} (%) SEE TECHNICAL NOTE

Child stunting

(THOUSANDS)

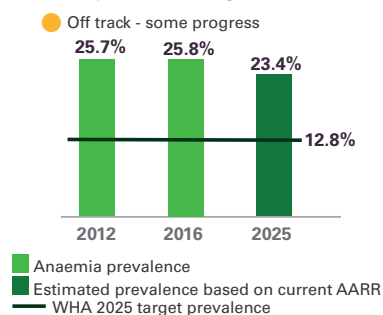
Target: 40% reduction in the number of children under-5 who are stunted



Anaemia in women

(%)

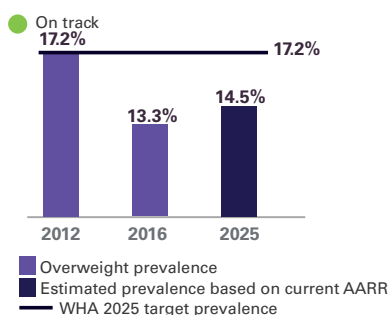
Target: 50% reduction of anaemia prevalence in women of reproductive age



Child overweight

(%)

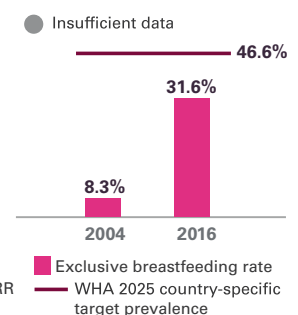
Target: no increase in childhood overweight rate



Exclusive breastfeeding

(%)

Target: increase rate up to at least 50%

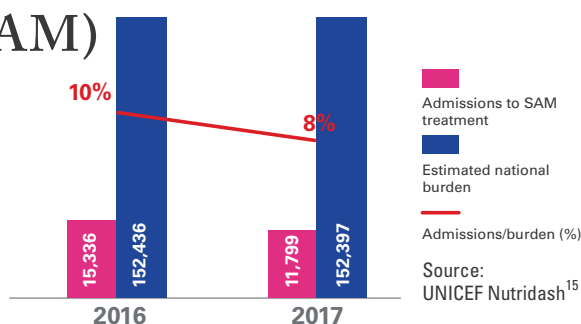


South Africa needs to accelerate actions to achieve the WHA 2025 nutrition targets for child stunting and anaemia in women. Continuing on the current trajectory for child stunting, South Africa would have 1.7 million stunted children in 2025, which is 1.9 times higher than the WHA target of 900 thousand children in 2025 (this target translates to a target prevalence of 16.2%). Continuing on the current trajectory for child overweight should keep South Africa on track. However, this is still a high level of child

overweight. This combined with an increased level of child stunting should put the focus on the need to tackle the double burden of malnutrition and to effectively start the carer support earlier before the baby is born. If anaemia in women follows the current trajectory, anaemia rate in women would have decreased to 23% in 2025. This is off track to meet the target of 13% in 2025. There is insufficient data after the WHA baseline year of 2012 to assess progress in exclusive breastfeeding.

Maternal and child nutrition intervention coverage

Children 6-59 months with Severe Acute Malnutrition (SAM)



Concerted efforts are needed to ensure pregnant women receive iron and folic acid supplementation and IYCF counselling at antenatal and postnatal care. Coordination between programmes is vital to ensure no missed opportunities when women and children go to a health facility. Despite full coverage of health facilities offering SAM, more resources should be allocated to increase the proportion of children with SAM in the population receiving treatment, which only reached 8% in 2017. Iodised salt use in households is high and needs to be maintained. Significant progress is needed to scale up Vitamin A, iron supplementation, and deworming in children from the current levels.

| | KEY INDICATORS | VALUE | YEAR |
|---------------------------|--|-------|---------|
| IYCF | Antenatal visits for pregnancy: 4+ visits (% of women who had a live birth in the five years preceding the survey) | 76% | 2016 |
| | Health facilities providing IYCF counselling | 3,957 | 2016 |
| | Health facilities providing IYCF counselling (%) | 93% | 2016-17 |
| SAM | Community-based service delivery points providing IYCF counselling (%) | n.a. | |
| | Health workers trained in SAM (%) | n.a. | |
| MICRONUTRIENTS/MEDICATION | Health facilities offering SAM treatment (%) | 100% | 2017 |
| | Children reached with MNP Programmes | n.a. | |
| | Two-dose Vitamin A supplementation coverage (% of children 6-59 months) | 47% | 2017 |
| | Children given iron supplements in past 7 days (% of children 6-59 months) | n.a. | |
| | Iron supplements for at least 90 days during pregnancy of last birth (%) | 51% | 2016 |
| | Households consuming iodized salt (%) | 91% | 2016 |
| | Districts that have a salt iodization programme (%) | n.a. | |
| | Children given deworming medication in past 6 months (% of children 6-59 months) | 63% | 2016 |

n.a = not available.
Source: DHS 2016⁴, UNICEF Nutridash¹⁵, UNICEF (2019b)¹⁶, UNICEF, ESARO (2019a)¹⁷.

Technical note on the WHA 2025 nutrition targets

The classification of progress towards achieving the nutrition targets (on track, off track-some progress, off track-no progress or worsening) can be found at the 2018 GNR¹³. The methodology is based on the rules proposed by the WHO/UNICEF Technical Expert Advisory Group on Nutrition Monitoring (TEAM). When countries have only one data point after the 2012 WHA baseline, the assessment on progress is usually reserved (insufficient data). These rules are based on a metric called average annual rate of reduction (AARR), which reflects the average percent change in prevalence over a period of time. There are two types of AARR to show recent trends: i) the current AARR, which reflects recent trends in prevalence from 2008 onwards, and ii) the pre-baseline AARR, which reflects trends before the baseline year (from 1999 to 2012). When data is available showing a linear trend, any of these metrics is used to calculate the estimated prevalence in 2025. This section in the report shows values from the WHO Global targets tracking tool¹⁴ for: 1) the WHA baseline year (the most recent time point prior to 2012), 2) the most recent available time point, 3) the estimated prevalence/number in 2025 when available, and 4) the WHA target in 2025. For all indicators except for anaemia in women the DHS is used as the main source. For anaemia in women, the WHO Global target tracking tool¹⁴ uses the anaemia estimates in the Micronutrients Database. WHO Vitamin and mineral nutrition information system, 2017.

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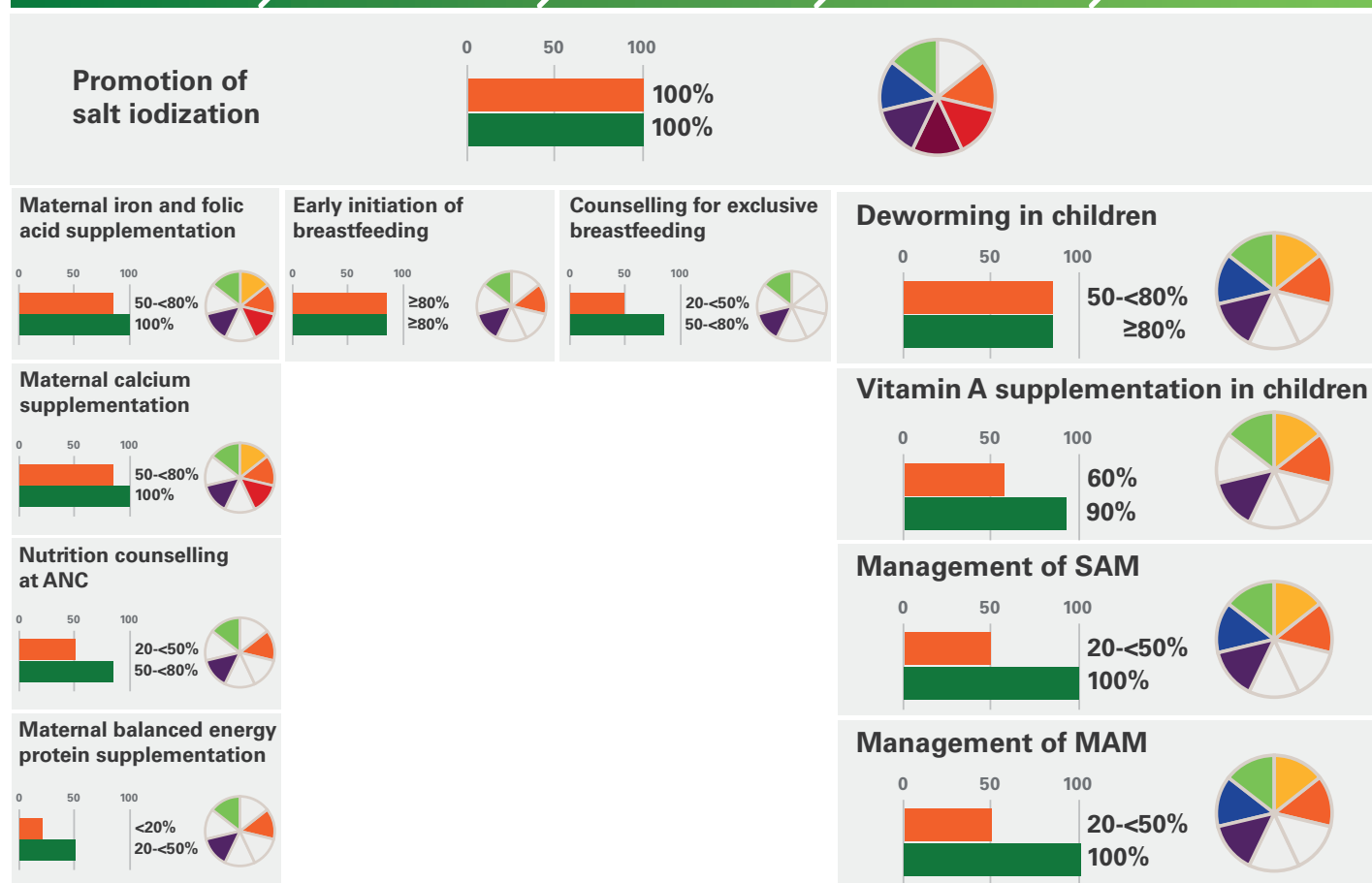
Actions for scaling up interventions^{18,19}

This section shows the estimated scale that different interventions are achieving in 2018 (current coverage), and the estimated scale which they intend to achieve by 2025 (target)

coverage) (provided by UNICEF country office)¹⁸. The presence or absence of the conditions needed to achieve scale are shown in the pie charts based on Addai and Matji¹⁹ (provided by UNICEF country

Interventions currently being implemented

NUTRITION-SPECIFIC INTERVENTIONS ACROSS THE LIFE-CYCLE



Key:



Enabling factors necessary to support successful scale-up of each intervention (Addai and Matji, 2019)¹⁹:

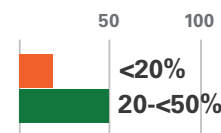


office)¹⁸. Significant progress is needed to increase the coverage of nutrition specific interventions from the current levels. This effort to increase coverage would face many challenges since many of the enabling requirements for successful scale up are not present. Existing nutrition-sensitive interventions are operating with coverage levels of 20% to 50%. These are long term resilience building interventions that have the potential to

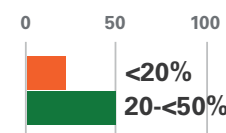
address the underlying causes of child undernutrition. Most interventions currently being implemented and those in future plans consistently have learning, partnership and political space to support growth. However, all of them are currently lacking other enabling factors to support successful scale-up such as fiscal, household economic, cultural, and capacity space.

Proposed Interventions

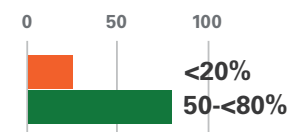
Women's empowerment



Nutrition sensitive agriculture and food security



C4D for nutrition



NUTRITION-SENSITIVE INTERVENTIONS ACROSS THE LIFE-CYCLE

