



POOR CHILDHOOD HEALTH CAN CONDEMN CHILDREN TO POVERTY FOR LIFE

This is the second in a series of five policy briefs published by PAN: Children drawn from a study commissioned and funded by the South African Human Rights Commission (SAHRC) and the United Nations Children's Fund (UNICEF) South Africa. The reports and policy briefs are available free of charge from the UNICEF and SAHRC websites: www.unicef.org/southafrica · www.sahrc.org.za and PAN Children – www.children.pan.org.

TITLES IN THE POVERTY TRAPS SERIES

Policy Brief 1: Education: Every child must read by age 9

Policy Brief 2: Poor childhood health can condemn children to poverty for life

Policy Brief 3: Social and family influences trap many children in poverty

Policy Brief 4: How geography can trap children in poverty

Policy Brief 5: How lack of assets affect child poverty and social exclusion

Despite progress in the policy and economic sphere since the political transition, many South African children are still caught in poverty traps and are socially excluded. Poverty traps occur where there are self-reinforcing mechanisms that cause poverty to persist. Poor children require an enabling environment in terms of health, education, assets, social and family networks, and geography to escape a poverty trap. Children caught in poverty are also potentially subject to social exclusion, the process that excludes them from full participation in society.

One manifestation of poverty traps is a high degree of chronic poverty. Recent data ¹indicate that about 41% of South African children are chronically poor, while another 32% are in households that moved into and out of poverty between 2008 and 2012. Almost all chronically poor children are also in structural poverty. That means that their households have too few assets and productive potential to allow them to break out of poverty – a real poverty trap. Children caught in structural and chronic poverty are likely to become poor adults, whose children in turn will grow up poor, illustrating that the poverty trap has an intergenerational dimension. That also makes it more likely that such children will experience social exclusion.

The persistent nature of poverty traps means that the characteristics of the poor are slow to change. Today, as before the political transition, children caught in poverty traps are most likely to be black Africans, to live in rural areas of the former homelands, and to have poorly educated parents. Weak family structures also mean that they often do not live with both parents.

This series of policy briefs has been published with support from the Programme to Support Pro-Poor Policy Development (PSPPD), a partnership between the Presidency and the European Union (EU)

INTRODUCTION

Access to health services has improved since the end of apartheid (for instance, 90% of births now take place in health facilities), but service quality still leaves much to be desired. This is part of South Africa's major service delivery problem. The maternal mortality rate – a measure of quality of health services – has increased by 80% since 1990, while under-five child mortality remains stubbornly high at 1990 levels², and the proportion of under-five children with vitamin A deficiencies doubled between 1994 and 2005³. Furthermore, HIV and AIDS has left a large imprint through many deaths and resultant loss of family earnings, orphaned children, morbidity and the need for large scale treatment of those living with HIV. Many factors affecting children's health lie outside the health sector. Good sanitation, clean water, proper housing, adequate nutrition and good nutrition practices are all essential for children's health.

The combination of poverty and poor health leaves many children unable to escape from poverty in later life. Poverty results in poor childhood health which, in turn, reduces productivity in adult life.⁴ Poverty is often linked to health deficiencies which arise from undernourishment and from exposure to disease.

How poverty affects childhood health and thereby life chances: International evidence

Poor health results have many effects on living standards. Children who are unwell are less effective learners at school, thus gaining less from education; and sick and undernourished babies are more likely to carry early health deficit with them throughout their lives.

Poor American children miss more days of school and are more often ill in adulthood than their peers. Their capacity for developing skills is thus affected, with negative implications for labour market prospects. Differences in health status between poor and wealthy children become more pronounced as they age.

Poor individuals face greater risk of contracting disease. As high levels of infectious disease may reflect an underlying institutional failure, some argue that policies that simply aim to reduce disease without addressing the underlying mechanisms will not eliminate poverty,

Thus early-life health deficiencies, whether caused by disease or malnutrition, have a lasting impact on productivity of individuals. UNICEF thus argues that improving children's health is one area where policy intervention can dramatically increase the life chances of the poor. Moreover, health outcomes are influenced by circumstances during the mother's pregnancy. This further highlights the importance of the mothers' behaviour and choices.

POOR HEALTH SERVICES

As only 17% of South African households with children are covered by medical schemes, public health care is important. Despite considerable improvement in availability of clinics after the transition, low quality of public health services remains a problem that also affects children. Half of the women interviewed at three public antenatal care clinics in Johannesburg reported that no "routine checks [blood pressure measurement, blood test, physical exam, offer to test for HIV, etc.] or screening were conducted at their first visit to the clinic", while many women were not booked upon their first visit and were rather asked to return later⁵. These are remarkable oversights given the importance of early pregnancy recognition and the prevalence of HIV/AIDS. A study in four public hospitals investigated how staff and equipment shortages and deficiencies in the skills and performance of staff interfered with HIV testing and administration of antiretroviral therapy⁶. Audits found that half of perinatal deaths in public hospitals due to intrapartum asphyxia and birth trauma could have been avoided through better health care practices and administrative efficiency⁷.

This series of policy briefs has been published with support from the Programme to Support Pro-Poor Policy Development (PSPPD), a partnership between the Presidency and the European Union (EU)

Diarrhoea

Between 1997 and 2006, deaths resulting from diarrhoea increased dramatically from 6 536 to 39 239⁸. Analysis of the 2012 GHS indicates that children in poor households are more likely (6.7%) to contract diarrhoea than non-poor children (4.8%). Its prevalence was lower where households had access to adequate sanitation (5.2% compared to 8.6%). Lack of clean water and adequate sanitation causes 90% of diarrhoea related deaths. Thus improved water and sanitation services are important for poor children. As diarrhoea sometimes induces malnutrition reduced caloric intake, malabsorption and maldigestion⁹, it may also induce stunting and underweight among children.

While children in affluent provinces have almost universal access to piped water, more than 40% of children in the Eastern Cape, Kwazulu-Natal and Limpopo do not get water from a piped source within 200 metres of their homes. Despite improvements in children's access to flush toilets between 2001 and 2007 (from 39% to 46%), there are marked inter-provincial differences, with 2007 figures of 93% in the Western Cape and 85% in Gauteng contrasting with 11% in Limpopo and 25% in the Eastern Cape.

Malnutrition

The 2012 report by the Committee on Morbidity and Mortality in Children under-five¹⁰ suggested that malnutrition was among the top five causes of child mortality. Early age malnutrition can have irreversible impacts on physical or cognitive abilities¹¹ and is associated with higher risk of cardiovascular disease¹². Early childhood malnutrition is linked to poor health and later educational performance¹³. The Box on nutrition and poverty traps presents Dasgupta's¹⁴ perspective on how under-nutrition creates poverty traps through both physical and behavioural effects.

Malnutrition is not simply over- or under-nutrition. Lack of diet diversity among children aged 1 to 9 years (as found in the National Food Consumption Survey) provides some evidence for low micronutrient intake¹⁵. This appears to be pervasive among poor South African children and often goes unnoticed owing to its effects not being immediately evident. Several other surveys have confirmed the dangerously high prevalence of, in particular, vitamin A deficiencies¹⁶, particularly among poorer groups.

Since 2003, it is mandatory to fortify certain foods. All wheat flour and maize meal products (chosen to target women, infants and young children) must be fortified with eight different vitamins and minerals. The "Roadmap for Nutrition in South Africa 2013 – 2017", a new programme of the Department of Health, emphasises nutrition of pregnant women and young children. Under-nutrition amongst pregnant women could lead to foetal growth restriction or preterm births with an increased likelihood of neonatal death, stunting and child mortality¹⁷.

FIGURE 1: Nutritional status of children 0-3 years of age (Calculations from PSLSD 1993 and NIDS 2008, and 2012 figures from the SANHANES-1 report¹, which uses only BMI for age and not weight for height as measure of wasting (BMI-for-age))

	Stunting	Under-weight	Wasting (based on weight-for-height)	Wasting (based on BMI-for-age)
1993	30.3%	20.0%	13.6%	6.8%
2008	26.3%	11.2%	7.4%	8.7%
2012	26.4%	5.9%	..	.2.7%

The table shows nutritional status for children aged 0-3 years. It combines data from three surveys. Stunting amongst young children declined between 1993 and 2008 and then stabilised at about one quarter of children in the age group. The percentage of underweight children declined substantially between 1993 and 2012.

This series of policy briefs has been published with support from the Programme to Support Pro-Poor Policy Development (PSPPD), a partnership between the Presidency and the European Union (EU)

There appears to have been some improvement in wasting, too, irrespective of measure used. Reductions in 'wasting' and 'underweight' suggests that acute child malnutrition is declining, but stubbornly high stunting shows that *chronic* malnutrition has not been affected as dramatically as *severe* malnutrition.

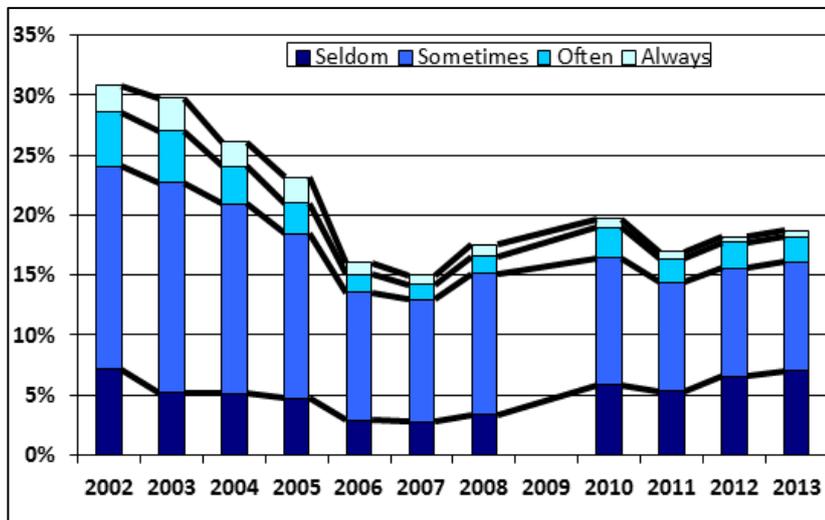


FIGURE 2: % of households with children where children went hungry at least some of the time in the past year (compiled from General Household Surveys; no data available for 2009)

The two interventions described in the Box, the Child Support Grant¹⁸ and the National School Nutritional Programme, have contributed greatly to the reduction in hunger among children as reported in the General Household Surveys (Figure 2), especially between 2002 and 2006. The world recession of 2008 reversed some of these gains. By 2013, almost 20% of households with children still reported that children experienced hunger some of the time.

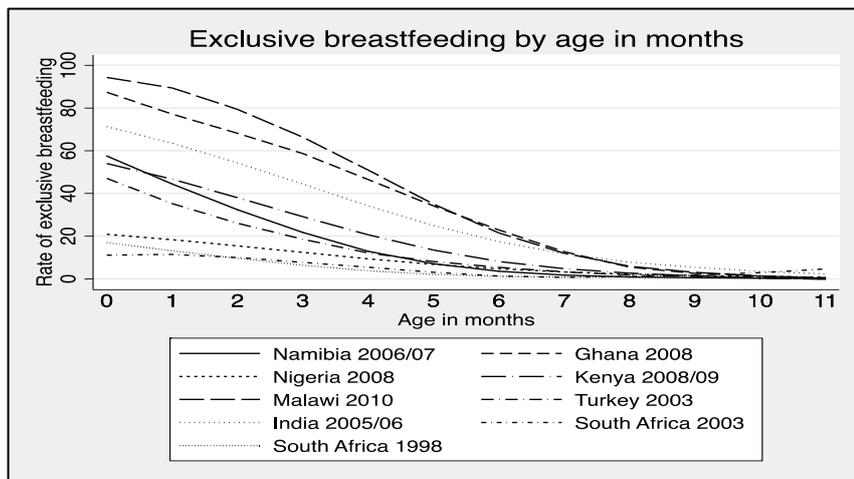


FIGURE 3: The rate of exclusive breastfeeding in some low- and middle-income countries (compiled from DHS reports)

Exclusive breastfeeding is often advocated for due to its beneficial impact on infant health. It also reduces exposure to contaminated food and water, thus decreasing diarrhoea. Exclusive breastfeeding also decreases neonatal mortality and infectious diseases. Although three-quarters of mothers breastfeed their babies, only 8% do so *exclusively* for the first six months. Most mothers follow a mixed feeding regime, combining breastfeeding with formula feeding. Figure 3 shows that the South African rate of exclusive breastfeeding is one of the lowest across some low- and middle-income countries. Travelling to work and the nature of work may contribute to low rates of breastfeeding. However, research shows that support and counselling on its benefits can significantly boost exclusive breastfeeding rates.

This series of policy briefs has been published with support from the Programme to Support Pro-Poor Policy Development (PSPPD), a partnership between the Presidency and the European Union (EU)

Nutrition and poverty traps:

Dasgupta presents an argument for the existence of a nutrition-based poverty trap that emphasises both **physical and behavioural implications of undernourishment**:

- The limited **physical** capacity for work of undernourished workers limits their ability to earn higher incomes and leaves them unable to afford improved nutrition. Thus nutritional deficiency in adulthood may instigate a cycle in which the poor stay poor. For children, the implications are even greater, as circumstances in the first three years of life have a great bearing on the mature physique – and therefore work capacity – of an individual. Reduced energy intake by poor people compels them to conserve energy and reduce effort, making them less productive, with negative consequences for incomes and finding a job. Moreover, under-nutrition has deleterious effects on learning capabilities for school-aged children by reducing energy levels and inhibiting concentration.
- The observed lethargic behaviour of children suffering from malnourishment – their children tend to be less active and less engaging with their environments than their more healthy peers – has implications for the development of their human capital (Dasgupta 1997: 20-23). Children's withdrawal from activity has a lasting impact on their **behaviour** that is difficult to reverse later in life. Further, undernourishment has even more severe impacts on cognitive ability and learning over the long term and is one of the reasons for emphasising nutritional poverty traps among children. It is at the early life stage where this mechanism is most influential.

Two successful policy interventions

Two policy interventions have strongly improved. The Child Support Grant was instituted in 1996 and gradually extended to children up to 18 years of age. By 2015 11.5 million children were recipients of these grants. There is strong evidence that they not only reduced poverty but also improved child nutritional outcomes, as measured by height-for-age and weight-for-height due to better nutrition (Coetzee, 2013; Duflo, 2000).

The National School Nutrition Programme (NSNP) was launched in 1994, initially covering only primary grades and the poorest schools. By 2012, the programme covered all grades from grade R to 12 in school quintiles 1, 2 and 3. All learners in a targeted school should receive a meal on every school day before 10 o'clock in the morning. The meal must comply with nutritional standards laid down by the Department of Health. By 2011, 73% of school learners were receiving school meals, which were well targeted at the poor.

Early Childhood Development programmes (ECD) provide another useful institutional platform for nutritional intervention, as about half of children aged three and four years are enrolled in ECD programmes. ECD facilities offer feeding schemes to children, but the food is often nutritionally deficient. It is difficult to implement nutritional interventions for young children outside ECD.

This series of policy briefs has been published with support from the Programme to Support Pro-Poor Policy Development (PSPPD), a partnership between the Presidency and the European Union (EU)

HIV/AIDS

HIV and AIDS affect children both through mother-to-child transmission and through illness or death of adult household members. Children born with HIV begin their lives at a great disadvantage, and many die before the age of five. More than half of under-five children who die in hospitals are infected with HIV¹⁹. Individuals with less education or from poorer households have a higher likelihood of contracting HIV, which also lowers the life chances of their children²⁰.

Deaths from AIDS also affect children's psychological wellbeing and socio-emotional development. AIDS infection is also associated with 'negative parenting' – infected parents are less attentive to their children, less encouraging and provide less stimulation than non-infected parents²¹. Children living with an AIDS infected caregiver often suffer physical and emotional abuse and have to bear a greater burden of household duties. Stigma around AIDS remains prevalent and children orphaned through AIDS are highly likely to suffer social exclusion, reduced concentration in school and a higher risk of contracting HIV through caring for an infected caregiver. HIV/AIDS thus holds multiple debilitating implications for children. Similar implications likely hold due to the high prevalence of tuberculosis in South Africa.

CONCLUSION

The combined effect of all these sources of poor health in childhood – such as weak health services, poor water and sanitation provision, malnutrition, and HIV/AIDS – is to create a potential poverty trap from which children may find it difficult to escape. The effect of such poor childhood health can thus be long-lasting, and early intervention is thus desirable.

This series of policy briefs has been published with support from the Programme to Support Pro-Poor Policy Development (PSPPD), a partnership between the Presidency and the European Union (EU)

Acknowledgement: This policy brief was written by the Research on Socioeconomic Policy (ReSEP) group at the University of Stellenbosch.

HEALTH: POOR HEALTH SERVICES AND OUTCOMES CAN KEEP CHILDREN CAUGHT IN A POVERTY TRAP FROM WHICH ESCAPE EVEN IN ADULTHOOD MAY BE DIFFICULT

- Most South African children are still subject to poor quality public health services
- Poor nutrition is still widespread, with one-quarter of infants being severely underweight.
- There is a very low prevalence of breastfeeding compared to other countries.
- Many children die before age five from AIDS transmitted through their mothers. Others suffer the consequences of HIV affected adults and AIDS deaths affecting their households.

The National School Nutrition Programme and the extension of the Child Support Grant are important government interventions with strongly positive outcomes for child health and nutrition. This could help many children to escape poverty in adulthood.

The South African Human Rights Commission Report:
Poverty traps and social exclusion among children in South Africa

<http://www.sahrc.org.za/home/21/files/Poverty%20Traps%20Report.pdf>

<http://www.sahrc.org.za/home/21/files/Poverty%20Traps%20Report%20Summary.pdf>

¹ South African Human Rights Commission & UNICEF. 2014. Poverty traps and social exclusion among children in South Africa. Pretoria: SAHRC, p.92.

² SAHRC and UNICEF. 2011 'South Africa's Children – A Review of Equity and Child Rights

³ Berry, L., Hall, K. and Hendricks, M. 2010. Child health: Nutrition. In Kibel, M., Lake, L., Pendlebury, S. & Smith, C. (ed.) *South African Child Gauge 2009/2010*, Cape Town: Children's Institute.

⁴ Currie, J. & Vogl, T. 2012. Early-life health and adult circumstances in developing countries. *NBER, Working Paper 18371*.

⁵ Solarin, I. & Black, V. 2013. "They told me to come back": women's antenatal care booking experience in innercity Johannesburg. *Maternal Child Health Journal* 17(2), pp. 359-67.

⁶ Sprague, C., Chersich, M.F. and Black, V. 2011. 'Health system weaknesses constrain access to PMTCT and maternal HIV services in South Africa: a qualitative enquiry'. *AIDS Research and Therapy* 8(10).

⁷ Saving Babies 2009. *Saving babies 2006-2007: sixth perinatal care survey of South Africa*. Pretoria: Tshepesa Press.

⁸ Steyn, M. 2010. Public health intervention needed to curb increase in diarrhoea-related deaths in South Africa. *CSIR Resources and the Environment*.

⁹ Nel, E.D. 2010. Diarrhoea and malnutrition. *South African Journal of Clinical Nutrition* 23(1), pp. S15-S18.

¹⁰ CoMMiC. 2012. *Interim report of the Committee on Morbidity and Mortality in Children under 5 years*. Pretoria: Dept of Health.

¹¹ Lancet 2008. Executive summary: the Lancet's series on maternal and child undernutrition. *Lancet*.

¹² Vorster, H.H. & Kruger, A. 2007. Poverty, malnutrition, underdevelopment and cardiovascular disease: a South African perspective. *Cardiovascular Journal of Africa* 18(5), pp. 321-324

¹³ Mendez, M.A. & Adair, L.S. 1999. Severity of timing of stunting in the first two years of life affect performance on cognitive tests in late childhood. *The Journal of Nutrition* 129(8), pp. 1555-1562; Glewwe, P., Jacoby, H. & King, E. 1999. *Early childhood nutrition and academic achievement: a longitudinal analysis*, Washington: International Food Policy Research Institute Discussion Paper 68.

¹⁴ Dasgupta, P. (1997. Nutritional status, the capacity for work, and poverty traps, *Journal of Econometrics*. 77, pp. 5-37.

¹⁵ Faber, M. & Wenhold, F. 2007. Nutrition in contemporary South Africa. *Water South Africa* 33(3), pp. 393-400.

¹⁶ Labadarios, D., Swart, R., Maunder, E.M.W., Kruger, H.S., Gericke, G.J., Kuzwayo, P.M.N., Ntsie, P.R., Steyn, N.P., Schloss, I., Dhansay, M.A., Jooste, P.I., Dannhauser, A., Nel, J.H., Molefe, D. & Kotze, T.J.V.W. 2008. Executive summary of the National Food Consumption Survey Fortification Baseline (NFCS-FB-I) South Africa, 2005. *South African Journal of Clinical Nutrition* 21(3), pp. 247-271.

¹⁷ Black, R.E., Victoria, C.G., Walker, S.P.B.Z.A., Christian, P., De Onis, M., Ezzati, M., Grantham-McGregor, S., Katz, J., Martorell, R. & Uauy, R. 2013. Maternal and child undernutrition and overweight in low-income and middle-income countries *The Lancet* 382(9890); Nannan, N., Norman, R., Hendricks, M., Dhansay, M.H. & Bradshaw, D. 2007. Estimating the burden of disease attributable to childhood and maternal undernutrition in South Africa in 2000. *SA Medical Journal* 97(8).

¹⁸ Coetzee, M. 2013. Finding the Benefits: Estimating the impact of the South African Child Support Grant. *SA Journal of Economics* 81(3).

¹⁹ CoMMiC. 2012. *Interim report of the Committee on Morbidity and Mortality in Children under 5 years*. Pretoria: Dept of Health.

²⁰ Ardington, C., Menendez, A. & Mutevedzi, T. 2011. Early childbearing, human capital attainment and mortality risk. *SALDRU Working Paper 56*.

²¹ Lachman, J.M., Cluver, L.D., Boyes, M.E., Kuo, C. & Casale, M. (2013) Positive parenting for positive parents: HIV/AIDS, poverty, caregiver depression, child behaviour and parenting in South Africa. *AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV*.

This series of policy briefs has been published with support from the Programme to Support Pro-Poor Policy Development (PSPPD), a partnership between the Presidency and the European Union (EU)

