FIFTEEN YEAR PROGRESS REVIEW OF THE IMPLEMENTATION OF THE POPULATION POLICY FOR SOUTH AFRICA (1998) AND THE INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT (ICPD) PROGRAMME OF ACTION (1994) @ 20

Building A Caring Society. Together

www.dsd.gov.za
www.population.gov.za

social development
Department:
Social Development
REPUBLIC OF SOUTH AFRICA

Table of Contents

Index of Figures

Index of Tables

Acronyms and Abbreviations

Aids	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Treatment
CARMMA	Campaign in Accelerated Reduction of Maternal and Child Mortality
CEE	Commission on Employment Equity
CRVS	Civil Registration and Vital Statistics System
CSG	Child Support Grant
DHIS	District Health Information Survey
DHS	Demographic and Health Survey
ECD	Early Childhood Development
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IEC	Information, Education and communication
IMR	Infant Mortality Rate
LGBTI	Lesbian, Gay, Bisexual, Transsexual, and Intersex
MDG	Millennium Development Goals
MMC	Medical Male Circumcision
MMR	Maternal Mortality Rate
MNCWH	Maternal Neonatal Child and Women's Health
NIDS	National Income Dynamics Study
NPU	National Population Unit
OECD	Organisation for Economic Co-operation and Development
PMTCT	Prevention of Mothers to Child Transmission
PoA	Programme of Action
RDP	Reconstruction and Development Programme
SADHS	South African Demographic and Health Survey
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
Stats SA	Statistics South Africa
STI	Sexually Transmitted Infection
TB	Tuberculosis
TFR	Total Fertility Rate
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund

Foreword

Ms. Bathabile Dlamini
Minister of Social Development:

This report on progress with the implementation of the *Population Policy for South Africa* was presented to Cabinet in February 2015. Its proposed population policy priorities were approved by Cabinet. The *Population Policy for South Africa* was adopted as a White Paper in Parliament in 1998. The National Population Unit in the Department of Social Development is responsible for promoting and monitoring the implementation of the policy. Every five years the Department produces a progress review report, to evaluate progress with the implementation of the population policy, and the Programme of Action of the International Conference on Population and Development (ICPD) of 1994.

This report incorporates Census 2011 results and other relevant data that were produced during the past five years. It also covers a broader set of themes than previous reports, including poverty and inequality; population distribution, migration and urbanisation; gender equality, equity and the empowerment of women; sexual and reproductive health and rights; HIV & Aids and health concerns with demographic implications; the changing structure and composition of families in South Africa; older persons; youth; children and persons with disabilities. The report provides a comprehensive assessment of population trends and dynamics since the adoption of the population policy in 1998, and identifies challenges and population priorities for the current term of government. These priorities are supportive of those identified in the National Development Plan.

This review report is not simply another government publication. Consultative meetings were held between 2012 and 2014 with key stakeholders, including government departments, civil society organisations and academic institutions. Thematic chapters were presented and discussed during the consultative workshops, after which they were finalised and a synthesis report compiled, reflecting the essence of the chapters and key recommendations on each theme. The synthesis report was presented and discussed at a consultative workshop in 2014, after which it was finalised.

The report concludes by identifying population priorities on which we should focus during the current term of government, to contribute to the achievement of the targets of the government's Programme of Action, particularly those identified in the National Development Plan.

Ms Bathabile Dlamini
Minister of Social Development

Executive summary

The purpose of this review was to evaluate progress with the implementation of the *White Paper on Population Policy for South Africa* (1998) and the Programme of Action (PoA) of the *International Conference on Population and Development (ICPD)* (1994) during the 2009 – 2014 period; thus following on the review that was done for the 1994 – 2009 period. This report is based on 12 thematic background papers compiled by the National Population Unit's research and policy monitoring managers.

The vision of the *Population Policy for South Africa* (1998) is the establishment of a society that provides a high and equitable quality of life to all South Africans, and in which population trends are commensurate with sustainable socio economic and environmental development. The goal is to align population trends with the achievement of sustainable human development.

Census 2011 showed that the South African population grew noticeably from 40.6 million people in 1996 to 44.8 million people in 2001, reaching 51.8 million people in 2011. Statistics South Africa estimates the mid-year population for 2014 at 54 million people (Statistics South Africa, 2014). Although the population size is still growing, the population growth rate is declining – from 2.1% (1996 – 2001) to 0.61% (2007 – 2011) per annum; this decline will continue. This decline is attributed mostly to a decline in the Total Fertility Rate (TFR) of the country from 2.9 in 1998 to 2.35 in 2011. Statistics South Africa, more recently estimated the TFR of South Africa at 2.56% in 2014, showing a slight increase since 2011 (Statistics South Africa, 2014).

South Africa has a relatively youthful population, but it is showing signs of maturing as indicated by the increase in the median age from 22 years in 1996 to 25 years in 2011. The proportion of the South African population younger than 15 years declined from 34.3% in 1996 to 32.1% in 2001, reaching 29.2% in 2011. The proportion of the population between the ages of 15 to 34 (i.e. the youth) has increased from 36. 7% in 1996 to 37.6% in 2011, whereas the proportion between the ages of 15 and 64 increased from 60.8% in 1996 to 63% in 2001, reaching 65.5% in 2011. The proportion older than 60 years increased from 7.0% in 1996 to 8.0% in 2011, and the proportion older than 65 increased from 4.8% to 5.3% during the same period. The age dependency ratio declined from 64.4 per 100 to 52.7 per 100.

More than two-thirds (68.3%) of the South Africa population are younger than 35 years old. The youth constitute 37.6% of the population and Africans constitute 83.2% of the youth. This age cohort is critical for the country's continued development and demographic transition as they represent new entrants to the labour market and will serve as the basis for future demographic growth. Access to quality education and skills development, quality and affordable health services, including modern sexual and reproductive health services as well as access to decent employment opportunities are therefore prerequisites to reaping the so-called 'demographic dividend'.

The state of the youth in South Africa is however precarious. The HIV prevalence among women aged 25 – 29 is 32.7%, and amongst men aged 30 – 34 is 25.8%. This is very high, mainly as a result of unsafe sex and having concurrent multiple partners. Teenage pregnancy, though it has declined, remains high at 56 births per 1000 live births. Unsafe and repeated abortions among the youth seem to be declining, but remains high. Youth make up 71% of the total unemployed population, with African youth aged between 15 and 24 years old constituting 53% of all the unemployed youth.

It is therefore imperative that integrated strategies are developed to address the needs of young people, with youth at the centre of developing these strategies. It is also important to improve access to quality and appropriate education and training in order to transform the youth into a productive work force. In order to unlock the developmental potential of the demographic dividend, adequate and quality job opportunities must be created. The failure or inability to integrate the youth meaningfully into society and the economy may not only result in high unemployment, but could also contribute to increased crime and ultimately social and political instability.

Despite poverty alleviation being the cornerstone of the South African government's development agenda, poverty, together with unemployment and particularly inequality, remain the most pressing socio economic challenges facing the country; poverty, inequality and unemployment still has clear race, age, sex and spatial dimensions. Evidence suggest that female headed households, African and rural households remain the worst affected by poverty and inequality. Almost half (46.6%) of Africans lived below the upper bound poverty line (R577 per person per month) compared to 24.4% of coloureds, 4.2% of Indians/Asians and only 0.6% of whites. Also, irrespective of which poverty line is used, female headed households are invariably worse off than their male counterparts – at the food poverty line (R305 per person per month) for example, female headed households were almost twice (22.7%) as likely to be poor than households headed by men (11.9%).

The many poverty alleviation programmes that address income, human capital and asset poverty resulted in more access to some form of household income, even if only in the form of a social grant, formal housing, piped water, electricity and decent sanitation. Overall South Africans are enjoying a higher standard of life, particularly in formal urban areas. Annual household income more than doubled from R48 385 to R103 204, an increase of 113% since 2001. Asset and human capital poverty also decreased significantly with 85% of households having electricity for lighting in 2011, up from 58% in 1996. The vast majority (73.4%) of households also have piped water inside the dwelling or yard – unfortunately, the provision of flush toilets has not been as successful, only increasing from 50% (1996) to 57% in 2011. Social grant recipients also increased significantly from 2.4 million in 1996 to 13 million in 2001, reaching 15.3 million in 2011.

There is increased recognition that the growth, distribution and development of the population are impacting negatively on the environment and its capacity to sustain life. The scale and complexity of human activities and impact on the environment are vastly greater today than at any other stage in human history. At any level of development, human impact on the environment is the compounded function of three interactive processes: the total number of people *(population size)*, their level of affluence *(per capita consumption)* and the environmental cost or benefit of technology *(i.e. development)* that is used to produce what is consumed, and the subsequent waste generated. Consumption has surpassed population growth as the dominant factor in increasing the population's impact on the environment.

The rapid increase in the number of households from 12.5 million in 2007 to 14.5 million in 2011 and the decrease in household size from 4.5 in 1996 to 3.6 in 2011 exerts increased pressure on the environment. Households, rather than individuals are the drivers of consumption. Smaller households generally have higher consumption rates per person than larger households, and thus a larger impact on the environment. Given the rapid increase in the number of smaller households in recent years, the impact on the environment has been significant. Wide disparities based on the relative affluence levels however lead to different patterns of consumption and waste generation. The poor tend to have a greater dependence on the immediate (natural) environment whereas the wealthy often create large, unsustainable ecological footprints. The poor are also more vulnerable to environmental degradation and will bear the brunt of climate change impacts. To minimise the negative impact on the environment, we need development that is sustainable in the long run and that will contribute towards a sustainable society. It is important that appropriate preventative and mitigating actions are taken to address the negative impact of human activities on the environment, and in particular the impact of climate change. Concerted efforts are required to change our consumption and waste generating practices.

The spatial distribution of the South African population is still reflective of apartheid planning. Internal migration is still mostly from largely under developed rural areas to the more industrial and urbanised areas. South African cities and towns offer a wider range of opportunities, including better employment opportunities. The majority (62.2%) of the South African population thus reside in urban areas. Gauteng, which has the largest share of the population (24%), is also the largest (34%) recipient of migrants. Only 56% of people in Gauteng were born there. International migrants make up 4% of the population.

Challenges caused by migration and particularly rapid urbanisation include among others, insufficient services and infrastructure for the growing urban population, contributing to a lack of formal housing and basic services (i.e. water, sanitation), resulting in an increase in homelessness and the expansion of informal settlements; limited economic opportunities, and increased urban poverty and a widening of the gap between the rich and poor; a shortage of health and educational facilities and an increase in crime.

Given the lack of opportunities and development in rural areas, rural households are still greatly dependent on remittances and social grants. What is required is a comprehensive rural policy that ensures that rural dwellers are not locked into poverty and that their life chances are improved. A comprehensive urban development policy is also needed to address rapid urbanisation and resultant challenges. Migration must be mainstreamed into development planning, and the challenges and opportunities posed by migration should form part of all sectoral strategies. Issues such as the rights, dignity and security of international migrants, including their access to Sexual and Reproductive Health and Rights (SRHR) services and protection against xenophobic and criminal attacks should also enjoy attention as per our constitution. Social cohesion initiatives should among other things cultivate mutual respect between nationals and non-nationals. Interventions are especially required at local level. Given the lack of reliable data, it is imperative that the availability of demographic information on migration on all levels is improved. Data collection, coordination and analysis of migration data as well as the capacity of planners and implementers, especially at local level need to be improved as well.

Gender mainstreaming initiatives in government programmes have contributed to an increase in, among other things, the educational level of women, their employment opportunities as well as access to social grants, free basic services and better access to sexual and reproductive health services and rights – all contributing to improving women's quality of life and that of their household members. Women's access to political power and decision making improved significantly since the 1994 elections, with women constituting 40% of Members of Parliament in 2014.

Despite the progress, poverty, unemployment and inequality disproportionately affect women and female headed households. Unemployment is much higher among women (34.6%) than men (25.6%); labour absorption is much lower for women, particularly African women (28.8%) compared to African men (40.8%) or white women (62.5%). The higher labour absorption rate for white women compared to African men is a legacy of our racist past. Women (African women in particular) are more dependent on survivalist activities in the informal sector which results in low wages, high insecurity and increased vulnerability.

Sexual and reproductive health and rights (SRHR) are vital to strengthening development and poverty alleviation efforts. Despite having a very progressive constitution and progressive legislation, including the Termination of Pregnancy Act, the country's culture remains rather conservative and patriarchal. Many women, particularly young women who want to terminate their pregnancies face discrimination and stigma at public health facilities, thus resorting to unsafe backstreet abortions, putting their lives at risk.

Data show that more women are accessing reproductive health services; women also have high levels of knowledge and access as well as usage of modern contraceptives. These factors, combined with an increase in the use of antenatal services and the use of health facilities for delivery, contributed to a reduction in illness and death among women. Despite this progress, maternal mortality remains high, with non-pregnancy related infections accounting for 40% of maternal deaths in 2012.

HIV and Aids continue to pose serious health and development challenges to South Africa, with 5.6 million people living with HIV in 2012 and 2 million children orphaned by the disease. Female youth are 3.5 times more likely to be HIV positive than their male counterparts. Male attitude and behaviour contribute significantly to the vulnerability of women. South Africa has the largest antiretroviral therapy (ART) programme in the world; given that the country also has the largest epidemic in the world, the need is immense. At the end of 2010, an estimated 55% of people who needed it were receiving treatment for HIV and the country is making good progress towards meeting its goal of 80% coverage. The decrease in the mortality rate in recent years and the increase in the life expectancy rate from 52.5 years in 2006 to 58.1 years in 2011 can be attributed to the widespread roll out of antiretroviral treatment.

Women are also exposed to high levels of violence, including sexual violence and often at the hands of their intimate partners; thus denying many women the realisation and enjoyment of full citizenship rights as set out in the constitution and the ICPD PoA. This undermines development efforts, and exacerbates women's vulnerabilities. Studies show that women with violent and or controlling partners are at a higher risk of HIV infection. These women also often lack decision making power with regard to family planning and childbearing, illustrating continued inequalities in sexual and reproductive relations.

It is imperative that the implementation of legislation and policies that promote gender equity and equality are improved. It is also important to continue with initiatives that empower women and provide them with choices through expanded access to education, health services, including sexual and reproductive health (SRH) services, skills development, employment and involvement in decision making at all levels. It is vital to continue the promotion of responsible, healthy reproductive lifestyles and behaviour among high risk groups and the youth. It is equally important to continue to promote and encourage male involvement and responsibility in family planning and other SRH services. Respect for the dignity and rights of all people, irrespective of their sexual orientation and gender identity should be cultivated, and all SRH services that people are entitled to, should be provided in a professional and non-judgmental fashion.

Despite significant progress made in addressing the rights and needs of children, the majority of children continue to live in poverty and are faced with considerable inequalities that continue to inhibit their access to better life opportunities, enhanced educational levels and improved health outcomes. The circular relationship between poverty, educational outcomes and the labour market means that many children who grow up poor are likely to become poor parents.

Persons with disabilities constitute 7.5% of the total population, but constitute only 1.4% of the workforce. Persons with disabilities are disproportionately represented among the poor and are likely to reside in rural areas. They are also among the most marginalised and neglected, and likely to experience discrimination and stigma. They are largely deprived of opportunities to participate in economic activities, lack access to health and education facilities as well as adequate home facilities. This group also struggles to access SRH services as it is often assumed that they are not sexually active or are asexual. The attitude of health care providers has also been cited as a barrier to accessing sexual and reproductive services, resulting in their SRH rights not being respected, being denied or outright ignored. It is critical that discrimination against persons with disabilities are addressed and that their SRH rights are respected, as this group is among the most likely to be exposed to HIV and other STIs as they are at a higher risk of being raped. A significant proportion (14.1%) of persons with disabilities is HIV positive.

Statistics on disabilities are often fragmented and anecdotal given the different definitions of disability and the different methods of data collection. It is therefore important to ensure that reliable and accurate demographic and socio economic data on persons with disabilities are collected. It is also important to ensure that policies and laws that entrench the rights of persons with disabilities and their access to essential services, including education, employment and SRH services are implemented. Appropriate advocacy campaigns to address negative attitudes, discrimination and stigma against persons with disabilities should be initiated and implemented.

Although good progress has been made in achieving the objectives of the population policy (1998) and the ICPD Programme of Action (1994), some of the challenges identified during the previous progress review remain and emerging ones have been identified. These existing and emerging challenges are closely linked to the following areas: Sexual and reproductive health and rights; Gender equality, equity and the empowerment of women; Dynamics of a changing population age structure; and Migration and urbanisation.

1. Introduction

1. Introduction

The *White Paper on Population Policy for South Africa,* also known as the *Population Policy,* was adopted by Parliament in April 1998. The South African population policy is guided by the *International Conference on Population and Development (ICPD) Programme of Action (PoA),* which was adopted in Cairo, Egypt in 1994. The ICPD PoA endorsed a new approach that emphasised that the links between population and development should focus on meeting the needs of individuals, rather than on achieving demographic targets, thus ushering in a shift to a sustainable human development paradigm (Department of Social Development, 2010:14).

This new population and development paradigm focused on the attainment of sustainable human development – placing the population (i.e. people) at the centre of that development. This type of development is aimed at enriching people's lives by providing them with increased options and enhanced choices that will ultimately lead to decent, quality and equitable livelihoods. Central to this approach is the recognition that the empowerment of women is not only a crucial end in itself, but also key to attaining decent, quality and equitable lives for all. Attaining gender equality, equity and the empowerment of women are therefore integral to population and development as it advocates for the provision of more choices to women through expanded access to education and health services, skills development and employment as well as full participation in policy and decision making processes at all levels.

The population policy envisioned a society that provides a high and equitable quality of life for all South Africans, in which population trends are commensurate with sustainable socio economic and environmental development. The goal of the population policy is therefore to bring about changes in the determinants of the country's population trends, so that these trends are consistent with the achievement of sustainable human development. The policy, in line with the *ICPD PoA* (1994), also demonstrates the South African government's commitment to achieving the integration of population and sustainable development, highlighting the need to integrate population factors into socio economic and development processes (Department of Social Development, 2010:14). Priority is given to issues related to families; gender equality, equity and the empowerment of women; internal and international migration and urbanisation; reproductive health and rights; HIV and Aids; population, the environment and poverty; health, morbidity and mortality; population growth and structure, including fertility and mortality trends; and children, youth, older persons and persons with disabilities (United Nations, 1994/95).

The population policy's objectives' are to enhance the quality of life of people living in the country through:

- The systematic integration of population factors into all policies, plans, programmes and strategies at all levels and within all sectors and institutions of government;
- Developing and implementing a coordinated, multi-sectoral, interdisciplinary and integrated approach in designing and executing programmes and interventions that impact on major national population concerns, and
- Making available reliable and up-to-date information on the population and human development situation in the country, in order to inform policymaking and programme design, implementation, monitoring and evaluation at all levels and in all sectors (Department of Social Development, 1998; Department of Social Development, 2010:15).

A comprehensive analysis of the available data during the formulation of the population policy, led to the identification of a number of major population concerns. These concerns covered a wide range of population, development and environment issues – all testament to the highly inequitable and race-based planning and development characteristic of South Africa at the time preceding its transition to democracy in 1994. Key among these concerns are the high incidence and severity of poverty in urban and rural areas; inequities in access to resources, infrastructure and social services, particularly in rural areas; high rates of infant and maternal mortality; high rates of premature mortality attributable to preventable causes; the pressure of population and development on the environment; the rising incidence of particularly HIV and Aids and its expected socio economic impact; marked gender inequalities in development opportunities; insecure family and community life; the nature and spatial mobility and settlement patterns, including immigration; as well as a poor knowledge base on population and population-development relationships (Department of Social Development, 2010:15). Existing and emerging issues include the precarious situation of children, the youth, persons with disabilities, older persons as well as reproductive and sexual health and rights, particularly of the youth.

Twenty four (24) strategies covering ten broad areas (major strategies) were identified to address these concerns. These ten broad areas are:

- Coordination and capacity building for integrating population and development into planning;
- Advocacy and population information, education and communication (IEC);
- Poverty reduction;
- Environmental sustainability;
- Health, mortality and fertility;
- Gender, women, youth and children;
- Education;
- Employment;
- Migration and urbanisation;
- Data collection and research (Department of Social Development, 1998; Department of Social Development, 2010:15).

The National Development Plan – Vision 2030 (NDP), which was adopted by Cabinet in 2011, effectively addresses population concerns as identified in the population policy and articulates its strategy on substantive issues such as job creation, youth, health and education very well. The NDP, which was developed following a comprehensive consultative process involving government, the private sector, civil society and ordinary South Africans aims, among other things, to eliminate poverty and reduce inequality by 2030. Chapter three of the NDP, entitled, *'Economy and Employment'* for example echoes the population policy (1998) and ICPD PoA (1994) in stressing the importance of achieving full employment, decent work and sustainable livelihoods. This chapter also highlights the high levels of inequality and the skewed ownership and control of the economy that persists; reiterating that the economic empowerment of black South Africans and women should remain top priorities. NDP objectives include:

- Raising employment through faster economic growth;
- Improving the quality of education, skills development and innovation; and
- Building the capacity of the state to play a developmental, transformative role (The Presidency/ National Planning Commission, 2011).

The National Development Plan in particular espouses to building a South Africa where '…*opportunity is not determined by birth, but by ability, education and hard work'* (The Presidency/National Planning Commission, 2011:14). The NDP, in line with the population policy (1998) and ICPD PoA (1994) strongly advocates for better educational and economic opportunities for young people and for focused efforts to eliminate gender inequality. In fact, promoting gender equality and greater opportunities for young people are integral themes throughout the NDP vision 2030 (The Presidency/National Planning Commission, 2011).

Attempts to redress disparities in wealth and access to basic resources, including basic services, remain the cornerstone of the South African government's development agenda. The many poverty alleviation programmes that address income, human capital and asset poverty resulted in more South Africans today having access to (for example) some form of household income (even if only in the form of a social grant), formal housing, piped water, electricity and decent sanitation. Overall South Africans are enjoying a higher standard of life, particularly in formal urban areas.

Despite these attempts and the progress made, poverty, inequality and high levels of unemployment remain key developmental problems in social, economic and political terms. As stated, poverty remains the single most pressing socio-economic challenge facing South Africa and its prevalence remains marked and largely defined along sex, population group and geographical location. Evidence suggest that female headed households, African and rural households remain the worst affected by poverty and inequality. Poverty, unemployment as well as inequality are also an increasing challenge in informal urban areas. Recent findings from official data sources such as the Census 2011 and other evidence based findings bear this out.

Poverty reduction initiatives are therefore still aimed at these priority target groups or vulnerable groups, including women, African and rural households, the youth and persons with disabilities.

However, in order to effect and/or continue appropriate and relevant change, regular, quality (evidence based) poverty data are needed to inform the government's planning and actions – hence this review of government's developmental attempts at addressing the problems identified and the extent to which population concerns were integrated into these developmental activities.

To that end, the National Population Unit produces a progress review report every five years, to evaluate progress with the implementation of the 1998 *White Paper on Population Policy for South Africa and the Programme of Action of the International Conference on Population and Development (ICPD)* 1994; the last report which covered the period 1994 to 2009, was published in March 2010. The current review report, strives to update that report to 2014, particularly on the basis of Census 2011 data. This report, as previous reports, is primarily concerned with the impact of development activities by partners in the field of population and development, rather than with the activities themselves. Thematic background papers (source documents) provide more information about each specific theme of the policy. In addition to evaluating progress, the report also examines shortcomings and challenges in order to improve development efforts (Department of Social Development, 2010).

Twelve thematic background papers were prepared by the NPU which outlines the extent to which objectives, strategies and concerns of the national population policy have been implemented in order to improve the quality of life of South Africans. This report provides an amalgamation (i.e. synthesis) of key findings which are analysed more comprehensively in the thematic papers and should be read in conjunction with these source documents. The thematic papers are available at www.population.gov.za.

The report is organised in 14 sections that cover the main approaches to addressing the numerous population concerns as outlined in the population policy, and that correspond with the major strategies of the population policy, the Millennium Development Goals (MDGs), the ICPD Programme of Action and the National Development Plan, where applicable. Recommendations on how to mitigate against real threats posed by observed trends as well as recommendations on how to strengthen successful interventions are made throughout the report. The first four chapters outline the relationship of population to development by considering the growth and structure of the South African population; poverty and inequality; migration and urbanisation and population and the environment. The second group of chapters addresses issues around gender and the empowerment of women; sexual and reproductive health and rights and HIV & Aids and other health concerns, as well as the demographic implications thereof. The final chapters deal with the changing structure and composition of families in South Africa with individual chapters dedicated to the youth; children; older persons; and persons with disabilities.

Although data from a variety of secondary sources were used for the present review, preference was given to official data. Data from Census 1996 was commonly used to establish a baseline for the situation in 1998. Data from Census 2001, the Community Survey 2007 and particularly Census 2011 were used to show changes where applicable in population trends over the past fifteen years.

2. Structure of the South African population

2. Structure of the South African population

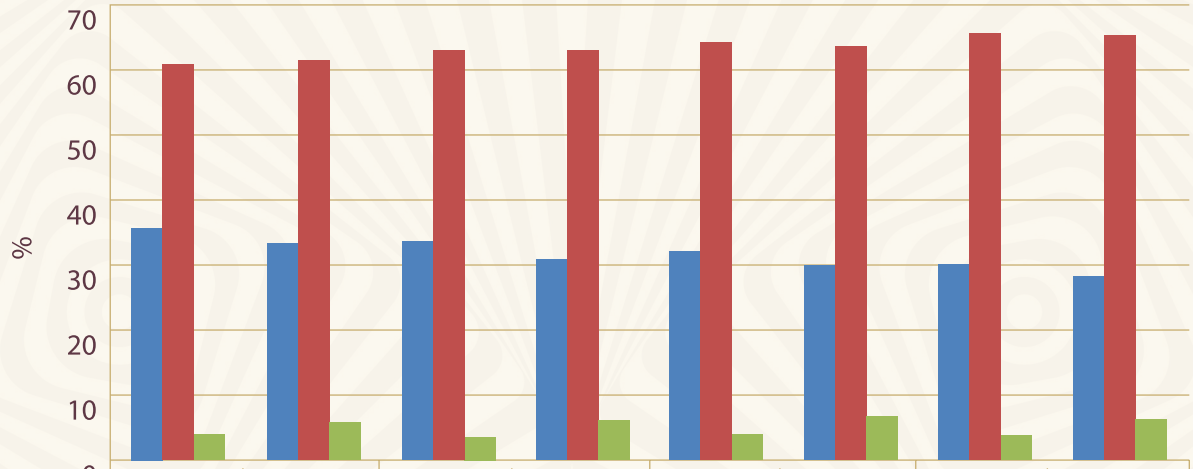
When the first ever all inclusive population census was undertaken in democratic South Africa, the total population for the country stood at 40.6 million people. Five years later, in 2001, it had increased to 44.8 million people, constituting an increase of 4.2 million people. A decade later in 2011, the total population grew to 51.8 million people, an increase of about 7 million people. In 2013, Statistics South Africa's mid term estimates showed that the country's population grew to about 52.9 million people. In 2014, Statistics South Africa's mid-year population estimates showed that the South African population stood at 54 million people (Statistics South Africa, 2014). These figures clearly show that the country's population is still growing and will do so for the foreseeable future. The Actuarial Society of South Africa (ASSA) projected that the country's population will grow to an estimated 56 million by the year 2025 (Actuarial Society of South Africa, 2011).

The total South African population will continue to increase in size over the next two decades, after which population growth may stop or become negative. The population growth rate is declining and has been declining for some time. The annual population growth rate declined from 2.1% between 1996 and 2001 to 1.3% for the period 2001 to 2007 (Department of Social Development, 2010), dropping to 1.10% for the period 2010 – 2011. The decline in population growth rates is a worldwide phenomenon, which is mostly attributed to lower fertility rates. While the overall decline in the population growth rate in South Africa is associated with decreasing fertility rates, the negative impact of HIV and Aids have also been perceived as a contributing factor to the decline.

The percentage distribution of the population (by population group) remained relatively stable between 2001 and 2014. Africans constitute the vast majority of the South African population at 80.2%, followed by coloureds at 8.8%. The white population declined from 9.5% to 8.4% and Indians/Asians showed a slight decline from 2.6% to 2.5%. Women make up about 27.6 million (51.2%) and men 26.3 million (48.8%) of the total population (Statistics South Africa, 2014).

South Africa still has a relatively youthful population with an overall median age of 25 years. The median age has however increased from 22.1 years in 1996 to 24.3 years in 2007 to the current 25 years – clear indications that the South African population is gradually ageing. Further signs that the South African population is ageing is the fact that males aged 0 - 14 years decreased from 35.6% in 1996 to 30.3% in 2011 and females decreased from 33.2% to 28.1% during that same period. Men and women aged 65 and older increased from 3.9% to 4.1% and 5.7% to 6.5% respectively during that same period (Figure 1). The so-called economically active population age group (15 - 64 years old) also increased from 60.5% (males) and 61.1% (females) in 1996 to 65.6% (males) and 65.4% (females) in 2011. The age dependency ratio declined from 64.4 per 100 to 58.7 per 100 in 2001 and was at 52.7 per 100 in 2011.

Figure 1: Distribution of the population by age-groups and sex: Censuses 1996, 2001, 2011, and CS 2007 (%)



	Male	Female	Male	Female	Male	Female	Male	Female
	1996		2001		2007		2011	
0-14	35,6	33,2	33,4	30,8	32,1	30,0	30,3	28,1
15-64	60,5	61,1	62,8	63,2	63,8	63,4	56,6	65,4
65+	3,9	5,7	3,8	6,0	4,1	6,6	4,1	6,5

Statistics South Africa, Census 2011

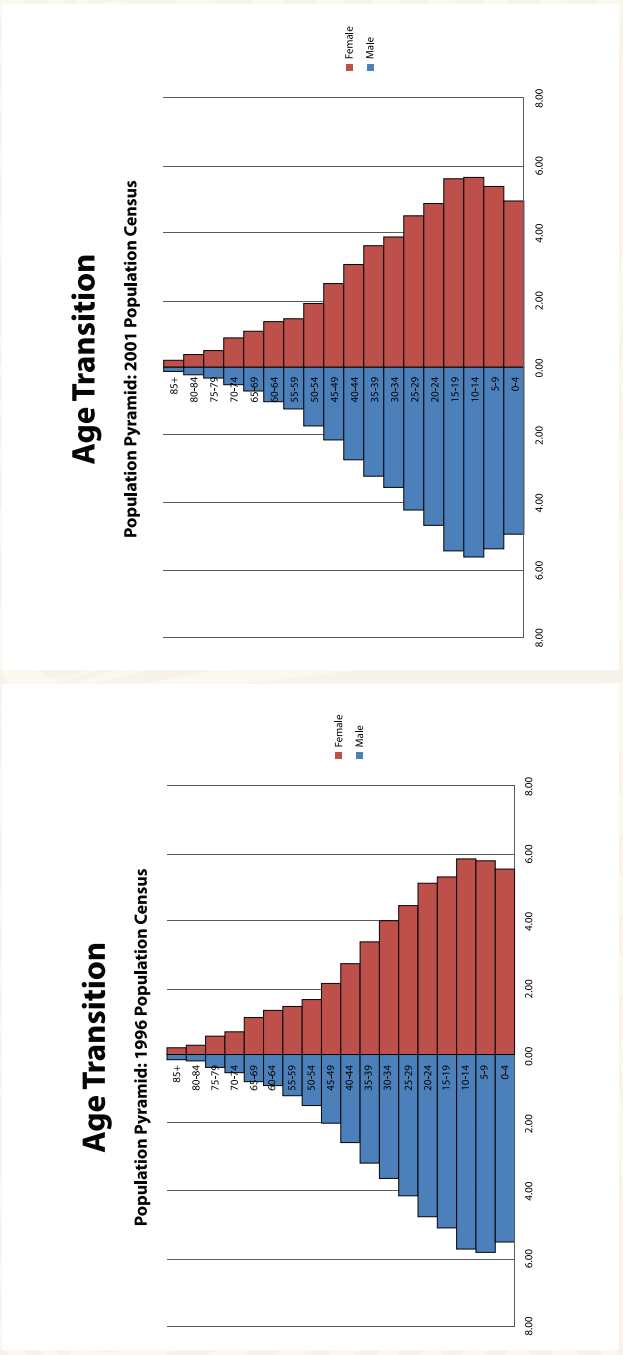
The above transition can be ascribed to declining fertility and mortality rates in recent years. The Total Fertility Rate (TFR) for example, declined from 2.92 in 2001 to 2.35 in 2011, slightly increasing to 2.56 in 2014. The mortality rate declined from 11.9 in 2001 to 11.7 in 2011. The drop in the mortality rate continued, and stood at 10.2 in 2014. In the intervening years however, the mortallity rates increased and was at 13.4 in 2003, rising to 14.4 in 2005 after which it decreased gradually to the 11.7 in 2011. The impact of HIV and Aids and the possible impact of successful interventions such as the roll out of Antiretroviral treatment (ART), could account for these fluctuations and the subsequent and gradual decrease by 2014. Coupled with that decrease in the mortality rates, life expectancy at birth, which was estimated at 52.5 years in 2006 (51.7 years for males and 56.1 for females) increased to 58.1 years in 2011 (56.8 years for males and 60.5 years for females). In 2014, life expectancy was estimated at 67.9 years (64.7 years for males and 71.0 years for females). With both fertility and mortality declining, there is no doubt that the country will increasingly experience population ageing as one of its dominant demographic characteristics.

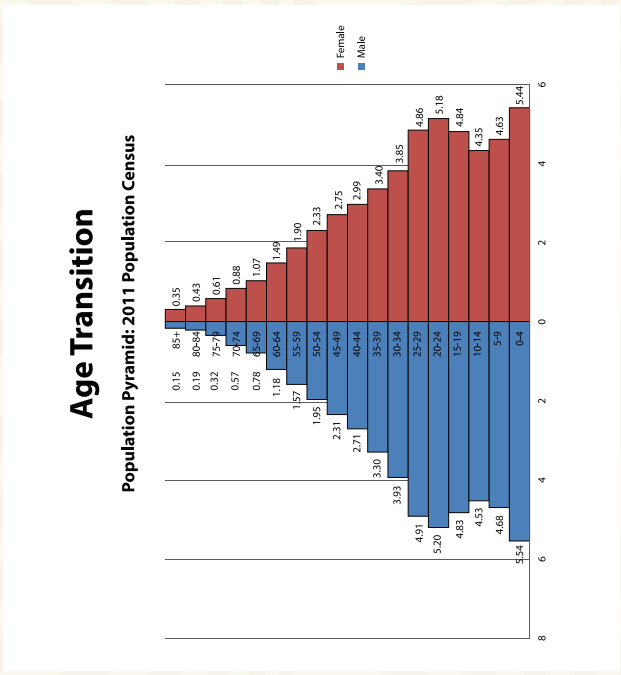
Figure 2 below represents the population-age distribution of South Africa in 1996, 2001 and 2011. The population-age structure depicted from 1996 to 2011 shows that the base population from 0-10 years shrank as a proportion of the total population, which is a clear indication that the TFR is declining. Census 2011 however indicates something of an anomaly - an increase in the 0 - 4 age group. There seems to be no clear explanation yet for this bulge in the 0 - 4 population group. Udjo (2014) explains the bulge in the 0 - 4 age

group using the indentations in the age groups 5-9 and 10-14. Udjo (2014) cites five theoretical explanations for the reduction in ages 0 - 4 in previous two censuses (1996 and 2001), namely excess childhood mortality; or an unexpected decline in the fertility of women in South Africa 10 -14 years ago; migration of parents with children or age shifting. However, by elimination, the most probable explanation argued by Udjo (2014) is the under-enumeration of the age groups 5 - 9 and 10 - 14 in Census 2011. However this does not explain the reduction in the 0 - 4 age groups in the 1996 and 2001 censuses. More research has to be conducted to derive models to estimate any undercounting or the impact of HIV and Aids on the proximate determinants.

The 2011 figures also show an increasing population of those aged 15 - 64. What is also clear from the population pyramids below is that the youth (population between the ages of 14 and 35) are increasingly forming the bulk of the South African population, particularly when one looks at the 20 – 24 age and 25 – 29 age cohorts as it appears in the census 2011 population pyramid. South Africa has an opportunity to deliver the so-called demographic 'dividend' or bonus. This 'dividend' or bonus occurs when a country experiences fertility declines in concert with declines in the population growth rate and the age dependency ratio, and refers to an upsurge in its labour force or people in their working ages relative to dependents such as children and the elderly (Department of Social Development, 2010). The demographic dividend or bonus will however only be achieved if the workforce is healthy, skilled and if there are enough job opportunities available – currently this is not the case as unemployment, in particular youth unemployment, is rife. Most of the South African youth also do not have the prerequisite skills to compete in the global economy and social ills such as teenage pregnancy and high school dropout rates are plaguing the country, jeopardising its ability to reap the benefits of this demographic 'dividend'.

Figure 2: Population distribution by age-groups and sex: Censuses 1996, 2001 and 2011



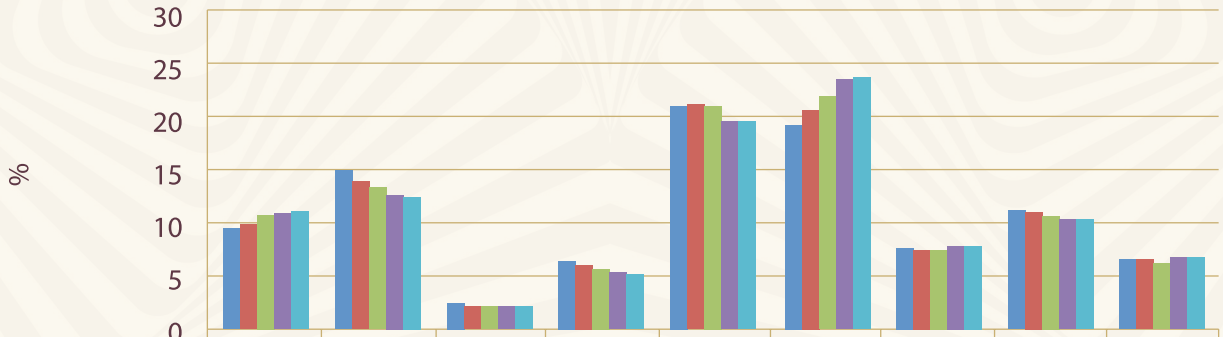


Statistics South Africa, Census 2011

After 20 years of democracy, settlement patterns in South Africa still reflect the legacy of the apartheid era, with 38.8% of the population residing in rural areas - the majority of these in the former homelands, which are areas characterised as poor and underdeveloped with limited viable commercial, industrial or agricultural activities.

Despite this apartheid legacy, South Africa is and remains the most urbanised country in southern Africa. In fact urbanisation is increasing at a rapid pace with the majority of people (62.2%) living in urban areas in 2011, up from 61.7% in 2010 and 58% in 2001. In 1996 only 55% of South Africans were urbanised. Gauteng, the economic hub of the country, is geographically the smallest province, but has the largest population, consisting of more than 12 million people (23.9%). KwaZulu Natal has the second largest population, consisting of more than 10 million people (19.8%) and is followed by the Western Cape with just over 5.8 million people (11.3%). The Northern Cape, which is geographically the largest province, has the smallest population of slightly more than 1 million people (2.2%) (Statistics South Africa, 2012; Statistics South Africa, 2014).

Figure 3: Percentage distribution of population by province, 1996 – 2014



	WC	EC	NC	FS	KZN	GP	MP	LP	NW
Census 1996	9,7	15,1	2,5	6,5	21,1	19,3	7,7	11,3	6,7
Census 2001	10,1	14	2,2	6	21,4	20,9	7,5	11,1	6,7
Cs 2007	10,9	13,5	2,2	5,7	21,2	22	7,5	10,8	6,3
Census 2011	11,2	12,7	2,2	5,3	19,8	23,7	7,5	10,4	6,8
Estimates 2014	11,3	12,6	2,2	5,2	19,8	23,9	7,8	10,4	6,8

Statistics South Africa, 2014

The number of households in the country has increased from 11.6 million in 2001 to 12.5 million in 2007, reaching 14.5 million households in 2011. Again, Gauteng, KwaZulu Natal and the Western Cape had the largest number of households and the Northern Cape the least number of households.

Census 2011 show that the majority of households in South Africa were headed by men (60.2%) compared to 38.8% headed by women. Disparities however exist across the population groups with 22.3% of white and 24.9% of Indian/ Asian households headed by women, whilst 30% of coloured and 43.8% of African households were headed by women (Statistics South Africa, 2012; Statistics South Africa, 2013:8).

The average household size decreased from 4.5 to 3.6 persons. The average household size was higher in female headed households (4.18) compared to male headed households (3.69). This trend is evident across all settlement types. The largest average household size was found to be amongst female headed households in former homeland areas, with 4.88 household members (Statistics South Africa, 2013:9). Not only were female headed households larger; they were also more intricate in their structure – for example, not all the children in

female headed households were the biological children of the head. The swift decrease in household size can be attributed to a number of interrelated factors such as a decline in fertility, an increase in urbanisation, and greater access to government subsidised housing (Department of Social Development, 2010).

The significant increase in the number of households, combined with the decrease in household size, holds significant implications for policy. In addition to an increase in the number of households demanding social services, analyses indicate that this also resulted in a significant increase in the number of households that fall under the poverty line as the 'unbundling of households' decreases the individual household's cumulative earnings (Department of Social Development, 2010).

Rural households tend to be poorer than their urban counterparts with fewer opportunities, including economic, industrial or agricultural. Rural households, in particular those in Limpopo (52.7%), the Eastern Cape (37%) and Mpumalanga (33.9%) were therefore more likely to engage in subsistence agriculture compared to their urban counterparts. However, only 4.2% of households nationally used agriculture to produce the majority of their food – the vast majority (more than 84%) of households that were engaged in agriculture did so only to produce extra food for the household. Most rural households are still dependent on urban areas for their livelihoods, mainly through remittances, and many are also dependent on social grants for their survival.

Larger towns and cities continue to show a net gain of people at the expense of rural areas. It is therefore essential that rural development initiatives create viable and sustainable livelihoods for people, thereby increasing people's options, and not forcing those who live in rural areas to migrate to urban centres simply as a means to survive.

3. Poverty and inequality

3. Poverty and inequality

Two decades after the dawn of democracy in South Africa (1994), many people in the country are still poor. Attempts to redress historical disparities in wealth and access to basic resources, including basic services such as clean water, decent sanitation and electricity, therefore remain the cornerstone of the South African government's development agenda. The population policy (1998) and ICPD Programme of Action (1994) complement this development agenda. The population policy identified poverty as, 'one of the most formidable enemies of choice'; - one of its most important objectives is to 'contribute towards the eradication of poverty and all forms of social and economic exclusion of people'. The ICPD PoA aims to 'raise the quality of life of all people by addressing human resource development; eradicating existing inequalities and barriers to women; improving options and choices for underserved members of society; and creating jobs across all sectors' (ICPD PoA, 1994:13).

The population policy proposed two major strategies that address poverty reduction. They are:

- 'Reduce poverty and socio economic inequalities through meeting peoples' basic needs for social security, employment, education, training and housing, as well as the provision of infrastructure and social facilities and services;
- Creating employment generating growth with a focus on economic opportunities for young people and women.

A number of policies, strategies and programmes exist to address these disparities through a sustainable human development approach, placing people at the centre of that development. Poverty alleviation programmes that address income, human capital and asset poverty resulted in more South Africans today having access to for example, some form of household income – even if only in the form of a social grant. More South Africans also have access to formal housing, piped water, electricity and decent sanitation. In fact, Table 1 shows that the percentage of the population that is poor decreased significantly from 57.2% in 2006 to 45.5% in 2011 and those living in extreme poverty, decreased from 26.6% in 2006 to 20.2% for the same period. This translates into a decrease from 12.6 million people living in extreme poverty in 2006 to 10.2 million living in extreme poverty in 2011 (Statistics South Africa, 2014).

Table 1: Poverty headcounts in 2006, 2009 and 2011

Poverty headcounts	2006	2009	2011
Percentage of the population that is poor	57,2%	56,8%	45,5%
Number of poor persons (millions)	27,1	27	23
Percentage of the population living in extreme poverty	26,6%	32,4%	20,2%
Number of extremely poor persons (millions)	12,6	15,8	10,2

Statistics South Africa, 2014:12

Overall South Africans are enjoying a better quality of life, particularly in urban formal areas. Despite many

interventions and the progress made, poverty, inequality and high unemployment persist. In fact, poverty remains the single most pressing socio economic challenge facing South Africa and its prevalence is still largely defined by sex, race and geographic location. Evidence continues to point to women, female headed households, African and rural households as the worst affected by poverty, inequality and unemployment. Poverty, inequality and unemployment also affect those in urban informal areas in the most adverse ways possible. Census 2011 data and other data bear this out. Poverty reduction initiatives are therefore still aimed at priority target groups including women, Africans and rural households, the youth and persons with disabilities – including those in urban informal areas.

3.1. Trends in income inequality

Severe disparities based on sex, population group, age, geographic location and settlement types are evident when looking at official unemployment figures. Census 2011 data clearly illustrate this disparity, showing that the official unemployment rate for women was higher at 34.6% than for men at 25.6%. The unemployment rate of African women was 41.2%, compared to only 5% for white men, underscoring the stark differences based on sex and population group - a legacy of our apartheid past.

Table 2: Poverty measures of adults on the three national poverty lines by sex

		Sex of adult	
Poverty line	**All adults (18+)**	**Male**	**Female**
Food poverty			
- Headcount (P_1)	21,2	18,9	23,2
- Gap (P_1)	6,7	5,9	7,4
- Severity (P_2)	3,0	2,6	3,3
Lower bound			
- Headcount (P_1)	32,3	29,1	35,1
- Gap (P_1)	21,1	10,8	13,3
- Severity (P_2)	6,0	5,3	6,6
Upper bound			
- Headcount (P_1)	45,1	41,5	48,3
- Gap (P_1)	19,6	17,7	21,3
- Severity (P_2)	10,9	9,7	11,9

Statistics South Africa, 2013

Table 2 provides an analysis of the poverty headcount by sex. It shows amongst other things, that a higher proportion of female adults was impoverished than male adults, regardless of the poverty line used (Statistics South Africa, 2013:15). Almost half (48.3%) of female adults were living under the upper bound poverty line (R577), whilst the same was true for just over four out of every ten (41.5%) male adults. This table clearly shows that female adults experienced poverty in greater depth and severity than their male counterparts, again regardless of the poverty line used (Statistics South Africa, 2013:15).

In addition to sex, population group is another factor that influenced the poverty levels of adults in South Africa. The upper bound poverty line (R577) in particular underscored the stark differences clearly. The headcount for white adults was less than one percent (0.9%), while for Indian/Asian adults it stood at 5.9%. In contrast,

almost a third (29.4%) of coloured adults were living below the upper bound poverty line as were more than half (55.4%) of African adults. To further accentuate their poverty status, about two-thirds (59.1%) of African women were below the poverty line as compared to just over half (51.1%) of African male adults (Statistics South Africa, 2013:16).

Table 3: Poverty headcount and poverty share of adults by province and sex (upper bound poverty line)

	All adults		Men		Women	
	Headcount (%)	Share (%)	Headcount (%)	Share (%)	Headcount (%)	Share (%)
Province						
Western Cape	26,7	6,9	25,3	3,1	27,9	3,7
Eastern Cape	57,9	16,3	54,5	6,9	60,7	9,4
Nothern Cape	52,8	2,8	50,2	1,2	55,0	1,6
Free State	51,0	6,8	48,2	2,9	53,4	3,9
KwaZulu-Natal	52,4	23,2	48,6	9,7	55,5	13,5
North West	50,2	7,9	45,0	3,5	55,2	4,5
Gauteng	24,6	12,9	23,1	6,0	26,1	6,9
Mpumalanga	54,6	8,3	50,0	3,6	58,6	4,7
Limpopo	69,5	14,9	65,4	6,0	72,6	8,9
Total	**45,1**	**100,0**	**41,5**	**43,0**	**48,3**	**57,0**

Statistics South Africa, 2013

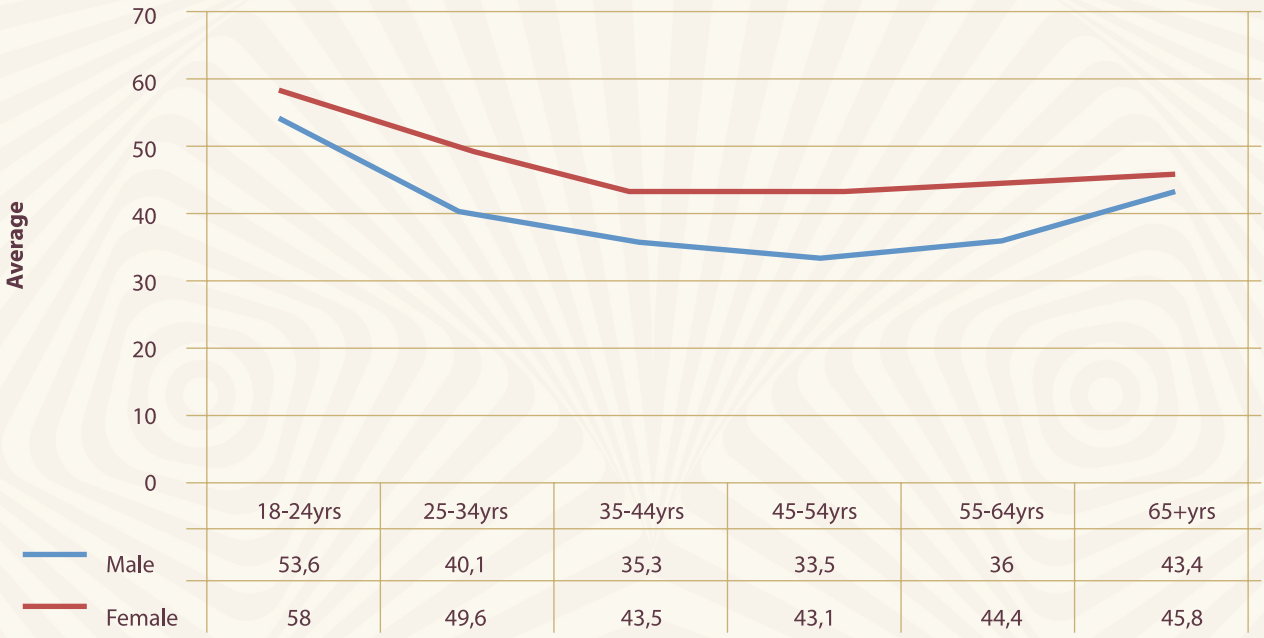
Table 3 explores the headcount of adult poverty by province and sex – showing that Limpopo had the highest at 69.5% followed by the Eastern Cape at 57.9% and Mpumalanga at 54.6%. Gauteng at 24.6% and the Western Cape at 26.7% were the provinces with the lowest headcount of adult poverty in the country. Again, women, were more likely to be poor than men and this is shown to be the case across the nine provinces (Statistics South Africa, 2013:18).

In terms of poverty share, KwaZulu Natal had the largest share with almost a quarter (23.4%) of all poor adults living in this province. This was followed by the Eastern Cape (16.3%) and Limpopo (14.9%). Gauteng, which had the lowest headcount percentage of adult poverty, had the fourth highest share (12.9%) of South Africa's poor adults – related to being the most populous province in South Africa. Again, women were more likely to be poor than men, making up 57% of the total poor adult population. Poor women in KwaZulu Natal make up almost one in seven (13.5%) of all poor adults living in South Africa (Statistics South Africa, 2013:18).

Unemployment rates declined with increasing age – the unemployment rate among the 15 – 19 age group was 64.9%, compared to 21.2% for the 40 – 44 age group; highlighting the predicament of youth unemployment for the country. Again, stark disparities exist based on population group with regard to employment with only 34% of Africans employed. The same is true for almost half (46.9%) of coloureds and 54.6% of Indians/Asians whereas most (69%) white South Africans were employed.

The labour force participation rate (official) is lowest among African women, and highest among white men. The labour absorption rate among African men was 40.8% compared to 75.7% for white men. Incidentally, the labour absorption rate is higher for white women at 62.5% than for both African men (40.8%) and African women at 28.8% - attesting to the lasting and detrimental impact of apartheid policies and the apartheid education system in particular.

Figure 4: Poverty headcount by sex and age (upper poverty line)



	18-24yrs	25-34yrs	35-44yrs	45-54yrs	55-64yrs	65+yrs
Male	53,6	40,1	35,3	33,5	36	43,4
Female	58	49,6	43,5	43,1	44,4	45,8

Statistics South Africa, 2013

As illustrated in Figure 4, poverty was at its highest level amongst the 18 to 24 year age cohort, because of the high unemployment rate of this age group. Young women in particular showed higher levels of poverty (58%) than young men (53.6%) in this cohort (Statistics South Africa, 2013:17).

Statistics South Africa used the following eight dimensions to develop an overall multidimensional deprivation index with which to measure poverty; they are: shelter, sanitation, water, energy, information, food, education and health. The Living Conditions Survey 2008/2009 discussed these dimensions individually as well as part of a collective multidimensional poverty measure (Statistics South Africa, 2013:29).

At the severe threshold of deprivation, 14% of adults were deprived at the shelter dimension, reflecting the high levels of informal housing and overcrowding. The second highest deprivation was on the energy dimension with 11.3% of adults without electricity, gas, paraffin or solar energy for lighting purposes. Health (8.7%) and education (7%) presented as the next highest deprivation on the severe threshold. Five (5%) percent of adults experienced severe sanitation and water deprivation. Women showed slightly higher levels of education and health dimensions and men showed slightly higher levels on the shelter dimensions (Statistics South Africa, 2013:29).

At the less severe threshold, deprivation was highest on the sanitation dimension, with 37.9% of adults using facilities other than a flush toilet. A further 30.6% of adults were deprived on the shelter dimension, and a quarter (25.8%) was water deprived. A fifth (20.4%) of adults were education deprived, comprising those that had not completed primary school or who had no formal education at all. Less than ten percent (6.7%) were found to be deprived on the food dimension. Levels of deprivation show women to be more deprived on the sanitation, water, education and health dimensions and men to be more deprived on the shelter and information dimensions (Statistics South Africa, 2013:29 – 30).

As expected, levels of deprivation on sanitation, water, energy and information were far higher in urban informal, traditional and rural formal areas than they were in urban formal areas. Education deprivation was also higher in these areas than in urban formal areas (Statistics South Africa, 2013:30). It is only the health dimension that shows similar levels of deprivation across the board; irrespective of the settlement type (Statistics South Africa, 2013).

In terms of poverty, a fifth of all adults were found to be living below the food poverty line (R305 per person per month). If a multidimensional approach to poverty is employed, more than two-fifths of adults were poor, while on the upper bound poverty line (R577 per person per month) almost half of all adults were found to be poor. Regardless of the line used to profile poverty, what is clear, is that women were worse off than men. This was true across all the age cohorts, educational levels, settlement types and provinces (Statistics South Africa, 2013:33). What is especially concerning, were the high levels of poverty amongst young adults – this situation places a big burden on their shoulders very early on in life. On the positive side, the potential role of education in the fight against poverty was highlighted (Statistics South Africa, 2013:33).

Clearly, the government's social services have alleviated the poverty of many South Africans. This keeps the prospect of reaping the demographic dividend alive. However, the inability of the labour market to meaningfully absorb young entrants, as reflected in the youth unemployment rate, means that we are not yet on a trajectory of sustained income poverty eradication. Due to unemployment patterns, income poverty also remains primarily defined by race and sex, with Africans and particularly African women, especially in rural areas being the poorest. This in turn resulted in continued inequality in our society.

3.2 Patterns of expenditure

The LCS 2008/2009 showed that six out of every ten households were headed by men. Those households headed by women were larger and more complex in structure. They were also more disadvantaged. Looking at expenditure levels and patterns, female headed households spent significantly less – this was found to be true across the different population groups as well as the different settlement types. Households headed by African women in particular, were shown to be especially disadvantaged (Statistics South Africa, 2013:34). Most of their expenditure also covered what could be deemed 'essential' items such as food and non-alcoholic beverages.

The average expenditure for poor households was only R23 266 per annum, more than four times less than that of non-poor households at R101 736. What is also clear is that while there were large differences between male and female headed households within the non-poor group – the average for households headed by women was R76 781 and for men, it was R113 753 – there seem to be no discernible difference between male and female headed households in the poor group. Average expenditure for poor households headed by men was R23 297 whereas it was R23 237 for those headed by women (Statistics South Africa, 2013:23). Regardless of the sex of the household head, poor households seem to be equally worse off in this regard.

The other interesting feature is the pattern of expenditure in poor households, again almost identical across male and female headed households. Slightly more than four out of ten (42.3%) poor households' expenditures were on food and non-alcoholic beverages as compared to only 16.1% in non-poor households. These findings strongly reflect the survivalist nature of poor households, which number more than one in every three households in the country across the upper bound poverty line (Statistics South Africa, 2013:23).

3.3 Poverty Alleviation: Human capital and asset poverty

Poverty as stated remains a key development problem in social, economic and political terms (Statistics South Africa, 2013:3). In order to attain both social and economic justice for all who live in South Africa, poverty alleviation remains the cornerstone of the South African government's development agenda, placing people at the centre of that development. This involves fighting the legacy of poverty, underdevelopment, unemployment, underemployment and the resultant inequality which is among the highest in the world, resulting in South Africa having a Gini Coefficient of 0.70.

Major poverty alleviation interventions include the Expanded Public Works Programme (EPWP), the Integrated Food Security Strategy and its various interventions; various Primary Healthcare initiatives and Early Childhood Development as well as the Department of Social Development's (DSD) programmes, including its Social Assistance Programme. The latter is the most effective social policy response to date and the provision of social grants makes up the largest portion of the DSD budget. In 2011/12 South Africa spent over R104 billion on social grants to assist the most vulnerable, comprising of 15.3 million people. Children constituted the majority of these beneficiaries at 10.3 million at a cost of R97 billion; followed by pensioners at 2.7 million and disability grants, which were allocated to 1.2 million people (South African Yearbook (Department of Social Development) 2011/2012). Whereas 42% of children lived in households that accessed at least one social grant, 19% lived in households that accessed the Child Support Grant (CSG) as well as an Old Age Pension grant (Statistics South Africa, 2013:60).

Studies (2011) showed that child support grants reduced the depth and severity of poverty during the economic recession in South Africa. Research also showed that the child support grant diversified income, making poor households less susceptible to the effects of the global economic crisis. The provision of social grants to vulnerable individuals and vulnerable households for example reduced the occurrence of hunger and extreme poverty. It would appear that social grants also facilitated household access to basic services and economic opportunities.

Social grants and other forms of social spending are not substitutes for job creation. The demand and the need for social grants will however only decline once the poor have decent long term employment or are gainfully self employed. For this to be realized, investment in human and physical assets are crucial – these initiatives need to be complimented by an economy that not only absorbs people, but one that provides decent jobs. For a country to grow its economy and ensure a high quality life for its citizens, it is imperative that the necessary infrastructure is in place. The South African government has already invested R330 billion in infrastructure development programmes and is currently in talks with stakeholders in the private sector to discuss funding for a R3.2 trillion infrastructure development programme.

Due to the government's continued investment in the upliftment of poor households, the share of households with access to basic services such as piped water, decent sanitation and electricity has increased significantly during the past two decades. Census 2011 data for example showed that the vast majority (77.6%) of South Africans were living in formal dwellings, an increase of 12.5% since census 1996. Fewer people lived in informal dwellings (13.6%) and even fewer lived in traditional dwellings (7.9%); the latter is down from 18.3% in 1996. This is a clear sign of the impact of social housing initiatives such as the RDP housing programme, allowing the poor to own their own houses.

Table 4: Improvement in access to services 1996 - 2011

Households	1996	2001	2007	2011
Formal housing	65.1%	68.5%	70.6%	77.6%
Electricity				
For lighting	58.2%	70.2%	80.1%	84.7%
For cooking	47.5%	52.2%	66.4%	73.9%
For heating	46.3%	49.9%	58.7%	58.8%
Water in dwelling/yard		61%	70%	73.4%
Flush toilet connected to sewerage		50%	55%	57%

Statistics South Africa, 1996, 2001, 2007 & 2011

Census 2011 data also clearly indicates that the vast majority (73.4%) of households in South Africa had access to piped water, either inside their dwelling or in their yard. A further 17.9% had access to piped water outside the yard. About 1 in 10 (8.8%) households did not have access to piped water (Statistics South Africa, 2012). As expected almost all households in provinces such as Gauteng (98.2%) and the Western Cape (99.1%) had access to piped water, either inside their dwellings or in their yards. The vast majority of households in the Free State (97.8%) also had access to piped water inside the dwelling or yard. Even though the vast majority (77.8%) of households in the Eastern Cape had access to piped water, either inside the dwelling or yard, a significant proportion (22.2%) did not have access to piped water at all.

Unfortunately, the provision of decent sanitation has not been as vigorous or successful as the provision of piped water or formal housing. Data from Census 2011 show that only 57% of households had access to a flush toilet that is connected to a sewerage system – up from 50% in 2001. Some households still made use of the bucket system (2.1% down from 3.9% in 2001) or had no access to any type of toilet facility (5% down from 13.3% in 2001) at all.

These figures show that service delivery as far as decent sanitation is concerned, is happening at a much slower pace (Statistics South Africa, 2013:26). It is imperative that the provision of decent sanitation is accelerated. Providing decent sanitation is not only a constitutional requirement with obvious health benefits, but also provides more dignity, respect and personal safety. However, rapid urbanisation and the subsequent mushrooming of informal settlements are placing further pressure on government's ability to provide this essential service.

Electricity provision has been much more prolific with the vast majority (84.7%) of households using electricity for lighting, indicating a sharp rise since 1996 when only 58.2% used electricity for lighting purposes. In contrast, the use of paraffin for lighting purposes dropped from 12.7% in 1996 to 3% and the use of candles dropped from 18.7% to 11.4% (Statistics South Africa, 2012). Similar trends are indicated when examining the use of electricity for cooking, rising sharply from 47.5% in 1996 to 73.9% in 2011. A notable increase in the use of electricity for heating also occurred during this period, from 46.3% to 58%.

The increase in the cost of electricity led to more households in South Africa using alternative sources of energy – one can only surmise that this number will increase. In 2012, slightly more that a quarter (26%) of respondents indicated that the high cost of electricity forced them to use alternative sources of energy. A further 41% have reduced their use of electricity as a strategy to cope with the increase in electricity prices whilst only 29% used the same level of electricity, paying the extra amount (Department of Energy, 2012).

Using alternative sources of energy could have other, more adverse implications and could potentially derail much of the progress made so far. Using wood or coal for cooking or heating may have negative health and environmental implications, and using candles or paraffin for lighting could pose fire and safety hazards. Using wood as an energy source also tend to have wider gender implications as women and girl children are often the ones tasked with collecting wood, a time consuming task that hinders them from embarking on other endeavours, including studying.

3.4 Education

Various studies show that a drop in adult levels of poverty (for both sexes) occurs as the level of education increases. The vast majority (77%) of women with no formal education were living below the upper bound poverty line of R577 per person per month, dropping to 53.5% for those female adults with some secondary education; dropping further to 30.4% for adult females with matric and to 10% for those with some post matric qualification. Despite a drop in those without formal schooling and an increase in those who completed grade 12 (28.5%) and even those who obtained a higher degree (12.1%); these very low figures do not bode well if South Africa wants to be globally competitive and redress existing economic and social injustices. The continued combination of unequal and a relatively poor standard of public education continues to inhibit access to higher education, and limits access to the labour market – this is particularly the case for African and coloured students who remain underrepresented in higher education and consequently in higher skilled professions.

3.5 Health

Health is an important determinant of socio-economic status and of human development. Employment and labour productivity can be seriously affected by ill health, especially when a country wants to grow its economy and establish a skilled workforce. It is therefore imperative that all citizens, in particular the most vulnerable, have access to quality, affordable and easily accessible primary health care facilities and services. Progress was made in terms of health services, for example, there are 4200 public health facilities in South Africa and the National Health Insurance (NHI) which aims to ensure that everyone in the country access appropriate, efficient and quality health services (Department of Health, 2011) will be phased in over a 14 year period and is currently being piloted in 11 health districts. The majority of children under the age of 1 year are also being immunized

and our Antiretroviral treatment (ART) rollout is among the most comprehensive in the world. Life expectancy has increased for both men and women. Despite efforts, infant-, child – and maternal mortality rates remain alarmingly high. Factors such as adverse socio economic conditions, continued maladministration and poor quality services at some public health facilities as well as the impact of HIV and Aids continue to inhibit the country's health outcomes.

3.6 Food (in) security

The right to food is a basic human right entrenched in the South African Constitution. South Africa has also committed itself to achieve MDG goals and targets, including halving the proportion of people who suffer from hunger by 2015. Even though South Africa is currently producing enough food to meet its national food requirements in sufficient quantities and of appropriate quality to consumers, large scale poverty, inequality and especially unemployment contribute to many households' inability to access a variety of nutritious foods, and be food secure. Again, households headed by Africans, female headed households, large households and those with many dependent children are most likely to experience inadequate access to food. Access to adequate food has increased from 74.9% in 2010 to 77.9% in 2011. Statistics South Africa (2014) also shows that self reported hunger dropped from 30% in 2002 to 13% in 2011. Households that access social grants were less likely to experience food insecurity.

3.7 Challenges and recommendations

Despite progress made since the dawn of democracy in South Africa nearly two decades ago, high levels of (structural) poverty, inequality and unemployment remain the key challenges facing the country. These challenges are defined along racial, sex, age and geographical dimensions, with African women, young people, persons with disabilities and those in rural and former homeland areas worst affected by the triple scourge of poverty, inequality and unemployment. Youth unemployment in particular has emerged in recent years as one of the key and most urgent challenges facing the country.

Poverty alleviation must therefore remain the cornerstone of the South African government's policies and programmes, in an attempt to improve the lives of especially the poorest and most vulnerable in society. These include the various job creation initiatives such as the Expanded Public Works Programme as well as the various social protection programmes, in particular social grants and the provision of subsidized housing and basic services such as piped water, electricity, decent sanitation facilities and refuse removal. Studies show that social grants for example reduced the occurrence of hunger and extreme poverty. Social grants also facilitated household access to basic services and economic opportunities.

Despite the identified challenges, it is obvious that the policies and programmes aimed at reducing poverty and socio-economic inequalities – through meeting people's basic needs – have had a positive effect on the development situation of the South African population. Recommendations to make progress towards poverty eradication and the reduction of inequality, and to poise our society for the demographic dividend, include:

- Economic strategies to address unemployment and poverty that will also contribute to reducing inequality;

- Economic growth that creates jobs must remain the key strategy to addressing poverty and unemployment. Special attention should be paid to addressing female and youth unemployment, and relevant skills development;
- Accelerate, expand and improve service delivery ensuring quality, affordable and easily accessible services to all, especially for vulnerable groups such as women, youth, persons with disabilities, rural dwellers and those in urban informal areas;
- Social developmental interventions that are in the pilot phase should be brought to scale;
- Expand the reach of social assistance.

4. Population distribution, migration and urbanisation

4. Population distribution, migration and urbanisation

Despite evidence of significant improvement in the South African society over the last two decades, past policies, attesting to South Africa's history of racially based government intervention in the movement and settlement patterns of its own people and those from other countries in the region still have grave effects on the wellbeing of most of its population. Even though political as well as some social and economic changes since 1994 removed the laws that forced and or restricted movement and settlement of people, particularly of Africans, the lasting effects of apartheid still linger (Wentzel and Tlabela in Kok and Collinson, 2006), especially as the spatial distribution of South Africa is still reflective of apartheid planning. It is particularly the poorest and most marginalised who still live on the periphery due to these entrenched settlement and migration patterns, resulting in many South Africans either living in poverty-stricken former homeland areas or townships, still excluded from economic and other opportunities.

Migration remains a key mechanism for people to respond to the structural imbalance that characterises our economy; economic reasons therefore remain among the main drivers of migration. Given the deep and wide inequality in income and opportunities within the country and between South Africa and its neighbours, migration and settlement patterns are not expected to abate any time soon. Also, given the far reaching impacts of migration on the social, economic and environmental conditions in both areas of origin as well as areas of destination, the process of migration is often viewed as a 'problem'. It is true that migration poses challenges for both areas of origin and destination; migration however also poses opportunities for both areas. It is therefore imperative that attention should not only be focused on the challenges posed by migration, but the opportunities it creates should be explored with vigour. Opportunities include knowledge and skills transferred by migrants, investments and remittances as well as the fostering of economic linkages and business opportunities between areas of origin and destination. The opportunities presented by migration will only be fully realised and exploited when migration information is integrated into and form part of development planning at all levels.

The ICPD PoA advocates for a more balanced spatial distribution of the population by encouraging the equitable and ecologically sustainable development of major sending and receiving areas. This type of development places particular emphasis on promoting economic, social and gender equity and reducing push factors to migration (Department of Social Development, 2010). In line with these goals, the population policy proposed a number of strategies addressing these concerns. They are:

- Increasing alternative choices to migration from rural to urban areas through the provision of social services, infrastructure and better employment opportunities in rural areas within the context of rural development programmes and strategies;
- Reducing backlogs in urban infrastructure and social services and making adequate provision for future increases in the population living in urban areas; and
- Reviewing the nature and impact of all forms of international migration on sustainable development in order to formulate and implement an appropriate strategy (Department of Social Development, 2010:34).

4.1 Population distribution

The spatial distribution of settlements reflects the relationship and interaction between the population, the environment and development, while movement between areas remain a direct response to opportunities and misfortune posed by this interaction (Department of Social Development, 2010:34). The South African population density increased from 33 persons per square kilometre (km^2) in 1996 to almost 40 persons per km^2 in 2007. In 2011, the population density stood at 43 persons per km^2. The density varies considerably by province. As expected, the largest population concentration is found in metropolitan municipalities – in 2011, the population density for Johannesburg, eThekwini (Durban), Cape Town and Tshwane (Pretoria) were 2227 people/km^2, 1526 people/ km^2, 1338 people/km^2, and 1038 people/km^2 respectively.

However former homeland areas also have relatively high population densities; in fact, over one-third of South Africa's population live in the former homelands, and a large proportion of this group is economically marginalised (National Planning Commission, 2011:37). These rural areas are also still characterised by low levels of services, infrastructure and employment opportunities. Deliberate policy interventions are required to bring rural households into the mainstream economy.

4.2 Urbanisation

Despite being the most urbanised country in southern Africa, rapid urbanisation continues. The proportion of South Africans living in urban areas increased from 55% in 1996 to 58% in 2001, rising to an estimated 60% in 2007 and reaching 62.2% in 2011. Historical restrictions limited African urbanisation to 47% in 2001 compared to 87% of coloureds, 97% of Indians/Asians and 90% of whites. The proportion of urbanised Africans has however increased at a rapid pace, making this group the largest proportion of the population in most major urban areas. Africans for example, constituted 72.3% of the population in Johannesburg, 72.2% of the population in Tshwane and 68.9% of the population in eThekwini. Cape Town is the only major urban area where Africans at 31.7% formed the second largest proportion of the population after coloureds at 45.3%.

Table 5: The population of South Africa's metros. Censuses 1996, 2001 and 2011

	Census 1996	Census 2001	Census 2011
EASTERN CAPE PROVINCE	6,147,244	6,278,651	6,562,053
-Buffalo City (East London)	685,727	704,855	755,200
-Nelson Mandela Bay (Port Elizabeth)	969,518	1,005,780	1,152,115
FREE STATE PROVINCE	2,633,504	2,706,775	2,745,590
-Mangaung (Bloemfontein)	603,528	645,440	747,431
GAUTENG PROVINCE	7,834,125	9,388,854	12,272,263
-City of Johannesburg	2,638,470	3,226,060	4,434,827
-City of Tshwane (Pretoria)	1,792,360	2,142,320	2,921,488
-Ekurhuleni (East Rand)	2,026,980	2,481,760	3,178,470
KWA-ZULU NATAL	8,572,302	9,584,129	10,267,300
-eThekwini (Durban)	2,748,300	3,090,121	3,442,361
WESTERN CAPE PROVINCE	3,956,875	4,524,335	5,822,734
-City of Cape Town	2,562,280	2,892,243	3,740,026

Statistics South Africa

The level of urbanisation varies widely by province with Gauteng and the Western Cape remaining the most urbanised provinces and provinces such as Limpopo and the Eastern Cape the least urbanised. Although most growth happened in the country's eight largest cities, population growth also took place in rural areas and other urban areas. Urban growth can largely be attributed to natural growth, yet rural – to - urban migration remains one of the most important drivers of growth in urban areas. Census 2011 show that 1 million people moved to Gauteng in the last decade – highlighting the flow of people from mostly rural to urban areas. Like urban provinces, it is also mostly larger towns and cities, specifically metropolitan areas which are generally experiencing a net gain of people as illustrated by Table 5.

Challenges caused by rapid urbanisation include among others, increased pressure to deliver services and infrastructure for the growing urban population, contributing to the continued backlog in formal housing and basic services (i.e. water, sanitation), resulting in continued homelessness and the expansion of informal settlements; limited economic opportunities, and continued urban poverty, which contributes to sustaining the gap between the rich and poor; a shortage of health and educational facilities in informal settlements, and an increase in crime and instability. A comprehensive and integrated urban development policy is needed to address rapid urbanisation and resultant challenges, and to unlock opportunities.

4.3 Internal migration

Urban provinces such as Gauteng and the Western Cape continue to show a positive net-migration between 2006 and 2011 whereas rural provinces such as Limpopo and the Eastern Cape remain the largest net losers during the same period (Statistics South Africa, 2013). Internal migration clearly continues to be mostly from largely under-developed rural areas to the more industrial and urbanised areas. South African cities and towns

offer a wider range of opportunities, including better employment opportunities. Comparing the three sets of census data (1996, 2001 and 2011), the provincial share of the total population has fallen in the Eastern Cape from 15.1% in 1996 to 12.7% in 2011 whereas Gauteng's population grew by 31% to 12.8 million people, up from 9.4 million a decade ago. Gauteng which has the largest share of the population (24%) is also the largest (34%) recipient of migrants. Only 56% of people living in Gauteng in 2011 were born there.

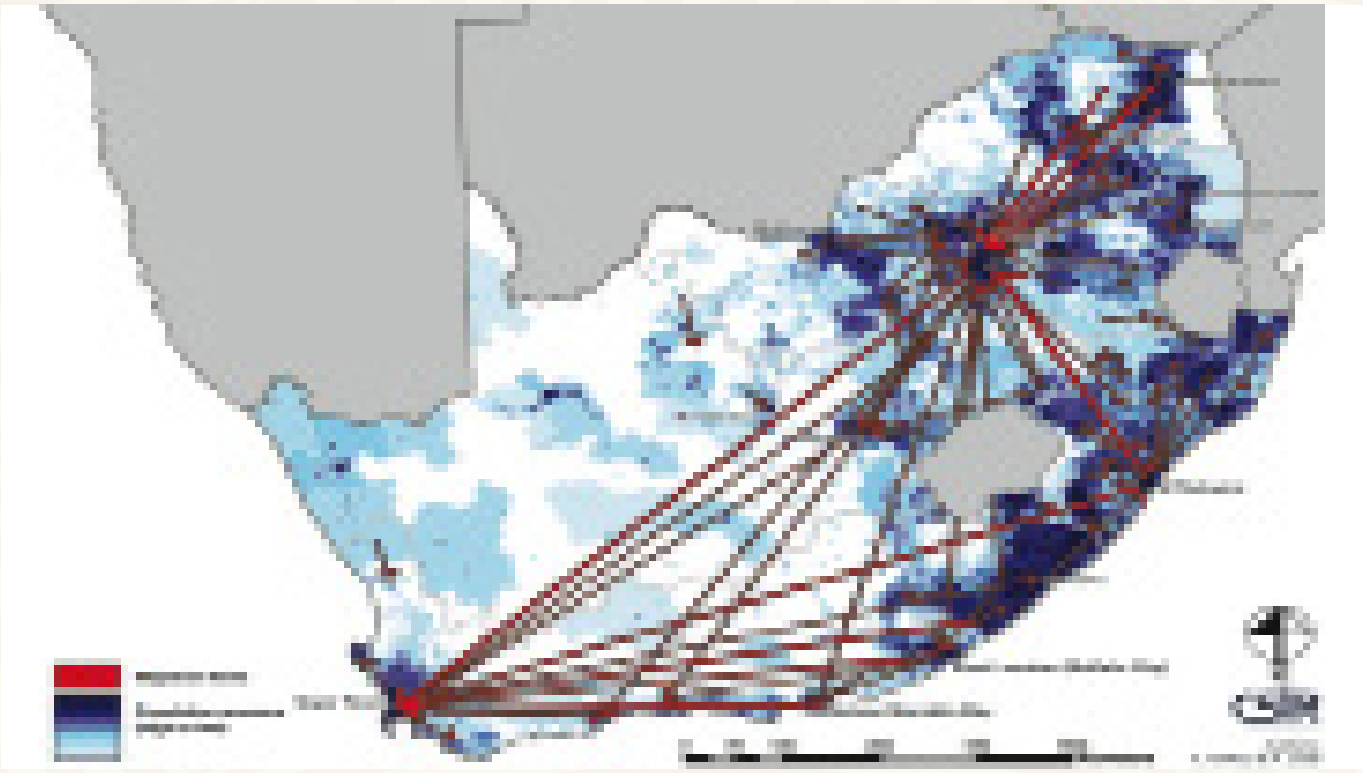
Table 6: Estimated provincial migration streams (2001 - 2006) and (2006 - 2011) and (2011 - 2016)

Provinces	Estimated provincial migration streams (2001-2006)			Estimated provincial migration streams (2006-2011)			Estimated provincial migration streams (2011-2016)		
	Out-migration	In-migration	Net-migration	Out-migration	In-migration	Net-migration	Out-migration	In-migration	Net-migration
Eastern Cape	**302 063**	**126 979**	**-175 084**	264 449	104 612	-159 837	241 758	176 821	-64 937
Free State	**81 319**	**65 370**	**-15 949**	91 340	76 742	-14 598	134 348	128 703	-5 646
Gauteng	**325 959**	**1 032 118**	**706 158**	245 650	1 046 641	800 991	624 643	1 106 375	481 732
KwaZulu-Natal	**190 455**	**172 944**	**-17 511**	181 921	165 628	-16 293	239 883	232 872	-7 012
Limpopo	**226 230**	**158 673**	**67 557**	227 919	164 991	-62 927	303 101	241 469	-61 632
Mpumalanga	**121 487**	**167 063**	**45 576**	133 003	176 142	43 139	193 562	231 381	37 818
Northern Cape	**49 441**	**46 750**	**-2 692**	50 175	47 847	-2 328	76 809	72 917	-3 892
North West	**132 629**	**207 561**	**74 932**	141 481	224 319	82 838	195 837	261 090	65 254
Western Cape	**93 376**	**299 055**	**205 680**	81 753	307 411	225 657	194 609	344 830	150 221

Statistics South Africa, 2013

Previous research, including by Statistics South Africa, clearly indicates that the economic disparities between rich and poor provinces inform the patterns and trends of migration. The largest movements thus remain between provinces with large former homeland populations and adjacent provinces with strong metropolitan economies. Whilst economic opportunities remain the driving force behind migration, it is not the only reason people move. Also, given the high unemployment rates in metropolitan areas, more people are moving to local smaller towns, dense peri-urban areas or even rural settlements that offer the promise of access to housing and services as well as easier ties with areas of origin. According to Kok and Collinson (2006), small towns are emerging as key migration nodes, and people moving to small towns typically do not return to rural villages. These new areas of destination are however also often inadequately resourced to deal with migration streams and their relatively weak economies makes finding employment nearly impossible (Department of Social Development, 2010).

Figure 5: Migration flows in South Africa



It is clear that rural areas will continue to lose migrants in the face of increased unemployment and job insecurity on commercial farms, landlessness and/or overcrowding in former homelands, failing agricultural productivity, soil erosion and drought and natural disasters such as floods. Land reform currently does not offer effective alternatives to urbanisation. In fact, rural development continues to be fragmented and lacks behind urban oriented development in terms of funding and support, making it unlikely that rural areas will retain or attract prospective migrants. Given the lack of opportunities and development in rural areas, rural households are still greatly dependent on remittances and social grants as sources of income.

Due to the above mentioned factors, rural areas are therefore bound to lose their best educated and most entrepreneurial young adults, to the detriment of development for such areas. Evidence seems to indicate that migration starts increasing sharply from the late teenage years, peaking between ages 25 and 29. A significant number of people also migrate for educational reasons. Gauteng for example received more than 140 000 learners from other provinces in 2012 and more than 80 000 moved out of the Northern Cape in the same year. Although more men than women migrate; significantly more women have been migrating over the past fifteen (15) years. Although many women continue to migrate as dependents with their partners, an increasing number are doing so independently (Department of Social Development, 2010:36). Despite the many benefits that migration can present, many women who migrate are vulnerable to a wide range of risks, and many are often restricted to unstable jobs marked by low wages and poor working conditions, and challenges to access social services.

Given the high levels of unemployment, few economic and job opportunities and limited infrastructure, the urgency of a comprehensive rural policy that ensures that rural dwellers are not locked into poverty and that

their life chances are improved is clear. The National Development Plan advocates for the creation of an inclusive and integrated rural economy that provides rural communities with greater opportunities to participate fully in the economic, social and political life of the country. These opportunities should be supported by good quality education, healthcare, transport and other basic services. Successful land reform, job creation and rising agricultural production will contribute to the development of an inclusive rural economy (National Planning Commission, 2011:34).

It is important that efforts that aim to address past and current social inequalities focus on people, not places. In areas where there are both high levels of poverty and demonstrated economic potential, development initiatives should include fixed capital investment beyond basic services and investment in appropriate infrastructure in order to exploit the potential of the area. In areas with low economic potential, development efforts should not only focus on the provision of basic services; in fact, efforts should be concentrated on the development of human capital by providing social transfers such as social grants, quality education and training and appropriate poverty alleviation programmes. These types of interventions should be seen as mechanisms aimed at addressing issues around poverty and inequality in rural areas and not as a way to stop people from migrating to urban areas (National Planning Commission, 2011).

In order to overcome the spatial distortions of our apartheid past, future settlement and economic development opportunities should also be channelled into activity corridors and nodes that are adjacent to or linked to the main growth centres. Infrastructure investment should primarily support areas that will become major growth nodes in South Africa and the Southern African Development Community (SADC) region to create regional gateways to the global economy.

4.4 International Migration

The transition to a democratic dispensation in South Africa led to significant changes in deeply entrenched regional patterns of migration. Whereas historically, labour migration was the dominant form of migration, people are now also migrating for other reasons, including accessing educational opportunities, taking up skilled occupations or to engage in trade or other business ventures (Department of Social Development, 2010:37). International migrants also increasingly include refugees and asylum seekers; it has also become more feminised and circulatory in nature. The proportion of the population in South Africa that was not born in the country rose from 2.1% in 1996 to 2.7% in 2007, reaching 4% (2.2 million people) in 2011.

Table 7: Estimates of immigration streams in South Africa by province 2011 - 2016

EASTERN CAPE	FREE STATE	GAUTENG	KWA ZULU NATAL	LIMPOPO	MPUMALANGA	NORTHERN CAPE	NORTH WEST	WESTERN CAPE	TOTAL
14 158	22 489	280 642	53 234	65 073	37 612	4 776	34 435	79 489	591 908

Statistics South Africa, 2014

International migrants are heavily concentrated in metropolitan areas, particularly in Johannesburg. Gauteng as expected is the largest recipient of immigrants at 280 642 immigrants, followed by the Western Cape with 79 489, then Kwa Zulu Natal with 53 234 immigrants, given the economic status of these provinces (Statistics South

Africa, 2014). It remains difficult to estimate the number of undocumented migrants; however deportation figures suggest that the number has increased significantly over the past decade.

Another challenge with regard to international migration and internal migration to some extent is the difficulty that migrants have in accessing health services, including sexually reproductive health and rights (SRHR) services, particularly for female migrants. Accessibility, affordability, language and sometimes culture limit their access to SRHR services. The health of undocumented migrants is also compromised as they do not have legal documents, preventing them from seeking much needed medical help in public facilities. Apartheid policies have created conditions conducive to the spread of HIV and other sexually transmitted diseases across South Africa and the region. This vulnerability is not only related to mobility, but rather to a range of interconnected circumstances, including poverty and marginalisation, and higher partner change rate (Department of Social Development, 2010:37). A further challenge is in controlling and managing the spread and prevention of communicable diseases including HIV and Aids, TB and Malaria during cross border migration and the implications these can have for the region.

Due to the migrant labour system, migrants from neighbouring countries have been living in South African communities for generations. Despite this, the South African Human Rights Commission (SAHRC), in 1997 identified xenophobia as a major source of concern to human rights and democracy in the country. Xenophobic attitudes intensified between 1997 and 2006, erupting in the xenophobic violence of 2008, and sporadic attacks since then – highlighting the urgent need to fully integrate migrants into society and address hostile and negative attitudes towards them.

Migrants, particularly international migrants, are often viewed with hostility and suspicion and the potential and real benefits they bring to the South African society in general and the economy in particular is ignored. This is particularly the case given that South Africa continues to be severely impacted by the effects of the 'brain drain'. This loss of skilled emigrants is somewhat mitigated by the reception of skilled migrants from neighbouring countries. However, this causes a 'brain drain' in their own countries of origin. For migration to play a significant role in meeting growth and development challenges, it should be linked to skills development in the country (Department of Social Development, 2010:38). In order to maximise the positive impacts of migration on development, South Africa must first of all promote the integration of migrants into South African society and communities, as integration is seen as a prerequisite for effective transnational engagement. It will also be prudent to acknowledge the association or link between xenophobia and social ills such as high unemployment, poverty, poor or non-existing service delivery, crime and the perception that migrants are 'taking our jobs'. For xenophobia to be effectively addressed and for social cohesion to prevail, including the full integration of migrants into South African communities, these real and perceived issues need to be addressed as a matter of urgency.

It is imperative that migration is mainstreamed into development planning and that the challenges and opportunities posed by migration form part of sectoral strategies (e.g. education, health, environment, housing and employment). Issues such as the rights, dignity and security of international migrants, including access to SRHR services and protection against xenophobic and criminal attack should also enjoy attention as per our constitutional obligations. Social cohesion initiatives should among other things, cultivate mutual respect between nationals and non-nationals. Interventions are required at all levels, particularly at the local level.

Due to a lack of necessary migration related data, the relative size of the contribution of urbanisation to population growth in urban areas in particular (compared to 'natural increase due to births and death') is not known (Kok and Collinson, 2006). It is also difficult to project net immigration in the future, particularly from neighbouring countries, with much depending on the political and economic circumstances in those countries. Given this lack of reliable data, it is imperative that the availability of demographic information on migration at all levels is improved. Data collection, coordination and analysis of migration data as well as the capacity of planners and implementers, especially at local level to use this data appropriately, need to be improved as well.

4.5 Conclusion

A decline in migration and urbanization tendencies is not to be expected anytime soon. It is therefore imperative that migration role players employ strategies that are more responsive to migration flows and that will enable the integration of migration into development planning, at all levels, particularly at the local government level. In fact, strategies, policies and development plans need to carefully integrate and coordinate internal and international migration and urbanization. It is also important that all three spheres of government as well as other relevant stakeholders, including civil society organizations, create an enabling environment for citizens to learn, adapt and enrich their understanding about migration issues.

4.6 Recommendations

- A strong rural policy to ensure that those who remain in rural areas are not locked into poverty and that their life chances are improved. The National Development Plan advocates for the creation of more jobs through agricultural development, based on effective land reform and the growth of irrigated agriculture and land production, and developing industries such as agri-processing, tourism, fisheries and small enterprises where potential exist;
- A strong urban development policy that caters for the increasing numbers of people by ensuring that the necessary infrastructure and services are in place for a growing urban population;
- Mainstream migration into all development planning. Challenges and opportunities posed by migration should form part of sectoral strategies (e.g. education, health, environment, housing and employment);
- Concerted efforts by all role players, including an active citizenry, the government, civil society and the private sector to engender a socially cohesive society that share common values;
- Commitment at all levels to acknowledge and address issues around social, economic, cultural and or religious exclusion, racism and discrimination and xenophobia and a commitment to promote real integration and social cohesion among all the people living in South Africa;
- Improve the availability of demographic and other information on migration at all levels, to especially inform local level planning. In this regard, we need reliable and up-to-date data, and we must improve data collection, coordination, analysis as well as the appropriate use thereof.

5. Population, environment and development

5. Population, environment and development

The South African population policy, in accordance with the South African Constitution and guided by the International Conference on Population and Development (ICPD) Programme of Action (1994) emphasises the attainment of sustainable development, placing people at the centre of that development. Development is seen as a process of enlarging people's choices and ensuring that they enjoy long, healthy and creative lives. There is recognition that the environment and development cannot be separated and that the natural resource base underpins all human, social and economic activity and in turn, human activities impact on the environment. This close interrelationship between population, the environment and development (PED nexus) is complex and interdependent.

The National Development Plan 2030, recognises that sustainable development, defined as, *'development that meets the needs of the present without compromising the ability of future generations to meet their own needs…',* is not only about maintaining economic activity and improving social welfare, but is also about ensuring that the natural resource base will not be irretrievably depleted or damaged over time (Department of Environmental Affairs, 2013). This shows recognition that unbridled economic growth cannot be sustained by the natural environment and that changes are required in the way that economic and social activities are performed. These economic and social changes should also be performed in a way that ensures fair and equal allocation of natural resources and value. This requirement is a prerequisite for sustainable development and thus environmental sustainability (Department of Environmental Affairs, 2013).

Significant improvement has been made in redressing disparities in wealth and access to basic resources and services in South Africa over the past 15 years. More South Africans are enjoying a higher standard of living; however poverty, inequality and unemployment coupled with various challenges in the provision of basic services such as regular access to clean drinking water, affordable electricity, decent sanitation facilities and regular refuse removal persist. Given the challenges facing the country, in particular the high levels of poverty and unemployment, the priorities of the government tend to veer towards economic growth and social development initiatives, which could be at the expense of the environment.

The myriad social and economic disparities and injustices facing South Africa, places the country in the inevitable position of having to reconcile the complex and often conflicting demands of poverty reduction, economic growth, housing, health and job creation (often grouped under the term 'brown agenda' issues) with also having to protect the environment and conserving the rich biodiversity of the country (often grouped under the term 'green agenda' issues), with brown agenda issues taking precedence (Department of Environmental Affairs, 2013). The South African economy is driven by a combination of continually expanding consumption and exports of primary resources, both of which have serious environmental implications as can be seen in the country's current ecological footprint (Department of Environmental Affairs, 2013).

There has however been increasing recognition that the fast pace of human-induced environmental change has and continues to have a negative impact on the physical environment itself, but also on the health and well-being of many South Africans, hampering the human development of the country as a whole. There is equally recognition for the need to (urgently) steer the country towards the attainment of greater sustainability as reflected in national policies such as the National Strategy for Sustainable Development.

5.1 Interrelationships between population and the environment

The population policy's major concerns with regard to the interrelationships of population, environment and development include:

- The cumulative pressure of the interaction of population, production and consumption on the environment;
- Inequities in access to resources, infrastructure & social services, particularly in rural areas, and implications for redistribution and growth and the alleviation of poverty (Department of Social Development, 1998).

The scale and complexity of human activities and their impact on the environment are vastly greater today than at any other stage in human history. At any level of development, human impact on the environment is the compounded function of three interactive processes: the total number of human beings (population size), their level of affluence (per capita consumption) and the environmental cost or benefit of the technology (i.e. development) that is used to produce what is consumed and the subsequent waste generated. The state of the environment and thus the state of human development are influenced by changes in the size, growth, structure and the distribution of the country's population. The impact of these variables depends on specific lifestyles and patterns of production and consumption as well as the waste generated. Despite the progress made, wide disparities remain based on the relative affluence levels, resulting in very different impacts. Notwithstanding the significant decline in the country's population growth rate, the population will continue to grow, having grown to an estimated 51.8 million people in 2011 and an estimated 54 million in 2014 already (Statistics South Africa, 2014). The country's relatively youthful population (median age of 25) has the potential to drive further population growth, and is likely to be the catalyst for increased development and household formation, and therefore increased consumption and waste (Department of Social Development, 2010:43).

The rapid increase in the number of households from 12.5 million in 2007 to 14.5 million in 2011 and the decrease in household size from 4.5 in 1996 to 3.6 in 2011 also exerts increased pressure on the environment. Households, rather than individuals are the drivers of consumption and are thus the real population units that impact on the environment. Smaller households generally have higher consumption rates per person than larger households and thus a larger impact on the environment. South African households contributed 3% to the country's total CO_2 emissions in 2000, but studies show that an increase in the number of households can have twice the impact of CO_2 emissions than an equivalent increase in population (Department of Social Development, 2010:43). Given the rapid increase in the number of smaller households in recent years, the impact on the environment has been significant. Also, the health of poor households that lack access to electricity or are reducing their electricity usage given the increasing cost in the commodity, will be further jeopardised by their use of alternative sources of energy (like firewood, coal) for cooking and heating, thus increasing indoor pollution and associated health impacts (McDaid, 2014).

5.2 Progress and disparity in human development

Consumption seems to remain the dominant factor in increasing the population's impact on the environment. Census 2011 shows that the average household income rose by 113% (in nominal terms). Real disposable income increased by 4.8% in 2010 and by 5.2% in 2011. Consumption thus continues to surpass population growth and the pressure to access resources will continue to increase.

Wide disparities based on the relative affluence levels however lead to different patterns of consumption and waste generation. The poor tends to have a greater dependence on the immediate (natural) environment whereas the wealthy often create large, unsustainable ecological footprints. Climate change is expected to increase as well as worsen existing inequalities in population and development, exacerbating existing vulnerabilities (Department of Social Development, 2010:43). Since the poor are already more vulnerable to environmental degradation; it is to be expected that they will also bear the brunt of climate change impacts. To minimise the negative impact on the environment, development that is sustainable in the long run and that will contribute towards a sustainable society, is urgently required.

Evidence show that poverty and inequality continue to be manifested along race, age, gender and geographic location, with Africans, the youth, women and those who reside in rural areas remaining among the poorest, most marginalised and vulnerable of citizens. The experience of poverty is associated with hunger, unemployment, exploitation, poor education, social and other forms of exclusion, limited choices and limited access to essential services such as proper housing, clean water, decent sanitation and adequate healthcare, thus leaving people extremely vulnerable at many levels, including high levels of morbidity and mortality due to the negative environmental health effects brought on by these adverse conditions.

Although only 2.7% of households in 2011 used coal for cooking (0.7%) and heating (2%), making them vulnerable to respiratory tract illnesses such as asthma and bronchitis; this figure is likely to increase given the increase in the cost of electricity that forced many people to use alternative sources of energy (Department of Social Development, 2010:44; Department of Energy, 2012:). Given their traditional role in the preparation of food, women and girl children are especially at high risk of exposure to smoke emitted from the burning of coal, fuel wood, animal dung and other sources of fuel. Women and especially girl children also spend large amounts of time collecting basic resources such as firewood and water. The deterioration of the natural resource base makes these activities all the more time consuming (Department of Social Development, 2010:44).

5.3 Population distribution, settlement patterns and the environment

5.3.1 Urban areas

Most (62.2%) South Africans lived in urban areas in 2011. Despite this, rapid urbanisation is not abating anytime soon. Large towns and cities are growing at the expense of rural areas, with metropolitan areas like Johannesburg, continuing to experience the highest influx rates, followed by secondary cities (Department of Social Development: 2010:44). This rapid increase in the urban growth rate coincided with a rapid increase in the number of smaller households with greater access to formal housing, electricity, piped water and decent sanitation. Providing services to an increasing number of households, places tremendous stress on the

environment as it means more water, food, energy and durable goods and less available land; thus resulting in a potential loss of biodiversity and more pollution of water, air and land. The increase in South Africa's total carbon dioxide (CO_2) emissions in metric tons per capita from 6.75 in 1994 to 7.00 in 2005 to 7.49 in 2009 is an example of the increased pressure on the environment and the negative consequences thereof, often far beyond urban boundaries (Republic of South Africa: Millennium Development Goals: Country Report, 2013).

This also puts more pressure on already struggling municipalities to deliver services, thus exacerbating the formation of informal settlements in urban areas. Informal settlements are often located in very uninhabitable areas, for example, on the banks of rivers and streams or against steep hills, thus putting those who reside there at the risk of floods or mudslides. Other challenges the urban poor face include a lack of clean water, proper housing and poor sanitation – often contributing to poor environmental hygiene and public health. The absence of clean water and decent sanitation usually contribute to a high prevalence of communicable, gastro-intestinal and food-borne and other infectious diseases. The absence of these services is also associated with accelerated environmental degradation, mostly as a consequence of the collection of local resources for energy and localized pollution (Department of Social Development, 2010:45).

Not everything is however doom and gloom – urbanization can also contribute to positive impacts on the environment. For example, increased population density is potentially beneficial as demographic concentration can make sustainability more likely. The increase in population shift from rural to urban areas can also reduce the pressure of land clearance and deforestation, thus reducing natural habitat loss. This is because urban expansion uses less land compared to land loss annually to agriculture, grazing and erosion. Urban dwellers in formal settlements tend to earn higher incomes, potentially live healthier lifestyles, have better access to basic amenities and are closer to a wider range of health facilities and other services.

5.3.2 Rural areas

The relationship between land use and its associated activities, and the natural environment or ecological systems, is complex and continually changing. Human activity in particular has contributed tremendously to these changes, which are often adverse and sometimes irreversible. The natural environment provides the basic elements that all living beings, including humans, need to survive such as water, food and shelter. Most human settlements are therefore located in areas where there are abundant natural resources, for example next to rivers, close to minerals or high potential agricultural lands (Department of Environmental Affairs, 2013).

The current and future environmental challenges for the country are associated with reliable (and clean) energy supplies, clean water, waste management and pollution control, as well as the illegal occupation of and degradation of sensitive land. Rural households in particular are and continue to be hard hit by these challenges as many of these households are typically female headed, larger, poorer, with more dependent children, and have less access to basic services. Many of these households experience food insecurity and do not have access to sufficient quantities of nutritious food. Statistics South Africa's General Household Survey (GHS, volume IV) report on food security and agriculture for the period 2001 to 2011, showed that households headed by Africans, households with female heads, large households and those with many dependent children were most likely to experience inadequate access to food.

The report also indicated that households living in rural areas were generally less likely to have adequate access to food than those in urban areas (74.3% for rural compared with 80.1% for urban areas in 2011). The report further showed that 17% of rural households moved from having inadequate access to having severely inadequate access to food (Statistics South Africa, 2012). Inadequate access to food was particularly severe in North West (32.9%) and Northern Cape (29.7%). Despite being a relatively poor and mostly rural province, households in Limpopo had better access to food than those in any other province as many households in this province engage in agricultural activities (Statistics South Africa, 2012). The same cannot be said for households in other provinces. Very few households participate in small scale agriculture; those that do, do so to supplement their access to food as they tend to be food insecure.

Subsistence farming was practiced by 18.4% of households. Households in Limpopo (49.4%), Eastern Cape (33.2%) and Mpumalanga (30.8%) were most likely to engage in subsistence farming (Statistics South Africa, 2012). Most subsistence farmers also tend to be female, highlighting the vulnerability of predominantly African women to the impacts of land and resource degradation. Unsustainable land use practices are common in overcrowded and poverty-stricken communal and tribal lands (Department of Social Development, 2010:45). The difficulty of producing sufficient food for household consumption leads to an increase in the reliance on using natural resources. This in turn, contributes to the degradation of the natural resource base on which many rural and mostly poor households depend, thus exacerbating their plight.

Rural populations are burdened by limited prospects in terms of future economic wellbeing in deteriorating environments. Although almost 40% of the country's population lives in rural areas, they are generally worse off in terms of overall socio-economic development, and have less access to services such as housing, water supply, sanitation, electricity, education and health care. The supply and maintenance of services are also made difficult and expensive by their sprawl and remoteness and many rural residents are therefore dependent on common property resources to provide subsistence, energy and income generating resources (Department of Social Development, 2010:45).

Failure to subsist often leads to labour migration and reliance on government grants, contributing to a perpetual cycle of poverty, degradation, population impact and marginalisation from which it is very difficult to escape. Land reform does not presently create viable alternative livelihoods and thereby offering an alternative to urban migration (Department of Social Development, 2010).

Investing in rural development initiatives is therefore a critical intervention, particularly in addressing severe poverty and food insecurity in these areas. Rural development should however focus on the establishment of meaningful and sustainable economic development in rural areas. It is also imperative that rural development programmes be established as measures on their own and not as a means to halt rural to urban migration and urbanisation trends. A number of rural development initiatives have been implemented, albeit with varied levels of success.

5.4 Conclusion

It is important that appropriate preventative and mitigating actions are taken to address the negative impact of human activities on the environment, and in particular the current and future impacts of climate change. Concerted efforts are required to change our consumption and waste generating practices. It is also imperative

that the demand for energy is balanced with the need to minimise the damaging impact of energy generation upon human health and the environment. This will require less dependence on energy generation using dirty energy (coal) and more focus on energy generation using clean or green energy. It is also important to strengthen and increase the human capacity required for the implementation of policy initiatives at the population, environment and development (PED) interface.

5.5 Recommendations

- Take appropriate preventative and mitigating actions to address the impact of climate change. The National Development Plan for example urges the channeling of public investment in new agricultural technologies, research and the development of adaptation strategies for the protection of rural livelihoods and expansion of commercial agriculture;
- Balance the demand for energy with the need to minimize the damaging impact of energy generation upon human health and the environment;
    * Less dependency on energy generation using dirty energy (coal)
    * More focus on energy generation using clean or green energy;
- Strengthen and increase human capacity required for the implementation of policy initiatives at the population, environment and development interface.

6. Gender equality, equity and the empowerment of women

6. Gender equality, equity and the empowerment of women

Gender equality, equity and the empowerment of women have been explicitly recognised as an important end in itself, as well as key to the achievement of sustainable human development (Department of Social Development, 2010). In fact, issues around gender equality, equity and the empowerment of women are firmly embedded in both the population policy as well as the ICPD PoA (1994) as fundamental prerequisites for sustainable human development.

The population policy articulates the following specific strategies with regard to gender, women, youth and children:

- Reducing the high incidence of crime and violence, especially violence against women and children;
- Promoting responsible and healthy reproductive and sexual behaviour among adolescents and the youth to reduce the incidence of high-risk teenage pregnancies, abortion and sexually transmitted diseases, including HIV/Aids, through the provision of life skills, sexuality and gender-sensitivity education, user-friendly health services and opportunities for engaging in social and community life;
- Advocating and facilitating measures taken in order to enable women and girls to achieve their full potential through -
  * eliminating all forms of discrimination and disparities based on gender;
  * more effective implementation of laws that protect women's rights and privileges; and
  * increasing women's representation in decision-making bodies through affirmative action;
- Promoting the equal participation of men and women in all areas of family and household responsibilities, including responsible parenthood, reproductive health, child-rearing and household work. (Department of Social Development, 1998).

The population policy notes as a major concern, the low status of women as reflected in marked gender inequalities in development opportunities, including access to productive resources. The ICPD Programme of Action (1994) advocates for the advancement of gender equality and equity and the empowerment of women, the elimination of all kinds of violence against women, and ensuring women's ability to control their own fertility as cornerstones of population and development-related programmes. In fact, the ICPD views the human rights of women and the girl-child as inalienable, integral and indivisible parts of universal human rights.

The empowerment of women refers to the action taken to overcome the obstacles of structural inequality that have previously placed women in a disadvantaged position. Gender equality is a goal to ensure equal rights, responsibility and opportunities for women and men, girls and boys, while gender equity ensures the fair and just distribution of opportunities and resources between men and women (Department of Social Development, 2010).

Two decades after the dawn of democracy, development planning and programme implementation in South Africa are still taking place in a context of the legacies of apartheid, which are still characterised by pervasive poverty, large scale structural unemployment; inequitable distribution of wealth and income; and a high incidence of crime. African women, women in rural areas and women with disabilities continue to be severely

affected and bear the brunt of this unequal legacy in all aspects of life (Department of Social Development, 2010). The continued destruction of family life, the racial dimension to the feminisation of poverty and its impact on the health and wellbeing of marginalised women also make the attainment of sustainable development and the creation of a non-sexist society so much harder (Department of Social Development, 2010).

6.1 Decision making

Women's access to political power and decision making improved significantly since the 1994 elections and the country has already surpassed many of the requirements set in the international, regional and sub-regional instruments. According to the United Nations Development Programme (UNDP), South Africa is one of the top 10 countries in the world with the highest number of women in national parliaments (United Nations Development Programme, 2013). In 1994, 111 women formed part of the 400 Members of Parliament (MPs) in the National Assembly, constituting 28% of all MPs. In 2009, the number of female MPs in the National Assembly grew to 173 or 43% of all MPs, and women were appointed to cabinet portfolios previously associated with masculinity, such as the Ministries of Defence and Military Veterans and Labour. In 2014, women made up 40% of Members of Parliament (National Assembly and National Council of Provinces combined).

Although there is a strong representation of women in the public sector, particularly in national and provincial departments, female representation is low among officials at local level and in the private sector and the media, especially at executive level. In fact, women hold only 4.4% of chief executive officer / managing director positions, only 5.3% of chairperson positions and 15.8% of all directorships in South Africa.

6.2 Education

Quality education and appropriate skills development are prerequisites for economic, social and political development and prosperity. Education creates choices and opportunities for people and communities and reduces the burdens of poverty, unemployment, and disease by creating a dynamic workforce that is able to compete and participate in the global economy (Department of Social Development, 2010). Education for women and girls is therefore fundamental to the empowerment of women and the attainment of gender equality.

Access to schooling in South Africa has been achieved equally for boy and girl children. Although there is no difference in the rate in which males and females of official school going age participate in schooling, there are more males than females in the foundation, intermediate and senior phases, whilst females outweigh males at the secondary level as well as at tertiary level. Gender parity for primary, secondary and tertiary education in South Africa was 0.99, 0.97 and 1.16 in 2007 and 1 in 2011. Girls' participation in education improved from 90.7% in 2002 to 93.9% in 2011. The female school dropout rate is also lower than that for boys. Pregnancy however remains the most common reason cited; despite the fact that education policy prohibits discrimination based on pregnancy and in fact ensures continued access to education (Department of Social Development, 2010: 50).

Although the percentage of males and females who are totally illiterate has been decreasing since 1996, gender disparities still exist. According to Census 2011 data, fewer male (7.2%) than female adults (9.9%) received no schooling. For females, the percentage decreased from 20.9% in 1996 to 20% in 2001 and 9.9% in 2011 (Statistics South Africa, 2012).

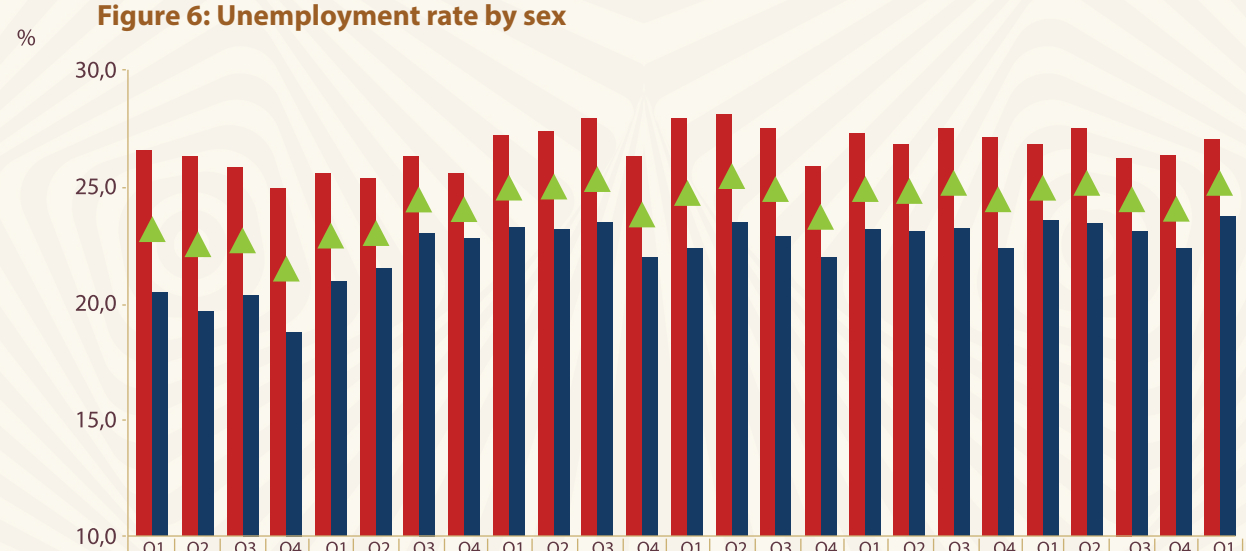
The increase in the number of women and particularly African women graduates is hailed by the education system as a significant achievement by the government over the past eighteen years towards improving access to tertiary education, encouraging equity and providing redress in education (Department of Social Development, 2010:50). Men, however continue to dominate in science, engineering and technology where they made up 57% of all enrolments in 2007. In all other fields of study, more women are enrolled than men.

6.3 Poverty and economic empowerment

Poverty continues to disproportionately affect women. In 2011, 47.1% of women compared to 43.8% of men were living in poverty (Statistics South Africa, 2014). As expected, female headed households are also much poorer than male headed households, irrespective of which poverty line is used. Individuals living in female headed households also continue to account for shares in poverty that are larger than their shares in the population (Statistics South Africa, 2013; Statistics South Africa, 2014).

Although female participation in the labour market has improved significantly over the past 18 years, unemployment remained higher for females (34.6%) than for males (25.6%) in 2011. The unemployment rate for African women is even worse at 41.5%. Female unemployment rates have constantly been higher than male rates and a similar pattern is evident in absorption and labour force participation rates. The labour force participation rate remains lowest among African women at 28.8%, compared to 62.5% for white women. The labour force participation rate of white women is however higher than that of African men (40.8%). These figures reflect the historical consequences of our apartheid past and its legacies.

Figure 6: Unemployment rate by sex



	Q1 2008	Q2 2008	Q3 2008	Q4 2008	Q1 2009	Q2 2009	Q3 2009	Q4 2009	Q1 2010	Q2 2010	Q3 2010	Q4 2010	Q1 2011	Q2 2011	Q3 2011	Q4 2011	Q1 2012	Q2 2012	Q3 2012	Q4 2012	Q1 2013	Q2 2013	Q3 2013	Q4 2013	Q1 2014
Women	26,6	26,3	25,8	24,9	25,6	25,3	26,3	25,6	27,2	27,4	27,9	26,3	27,9	28,1	27,5	25,9	27,3	26,8	27,5	27,1	26,8	27,5	26,2	26,3	27,0
Men	20,5	19,7	20,4	18,8	20,9	21,5	23,0	22,8	23,3	23,2	23,5	22,0	22,4	23,5	22,9	22,0	23,2	23,1	23,3	22,4	23,6	23,4	23,1	22,4	23,7
Both sexes	23,3	22,6	22,8	21,5	23,0	23,2	24,5	24,1	25,1	25,1	25,4	23,9	24,8	25,6	25,0	23,8	25,0	24,8	25,2	24,5	25,0	25,3	24,5	24,1	25,2

Statistics South Africa, 2014

Figure 6 clearly illustrates the vulnerability of women in the labour market. The unemployment rate of women remains higher than that of men and the national average. In Q1: 2014, the unemployment rate for women was 27.0%, 3.3% higher than the unemployment rate of men and 1.8% higher than the national average (Statistics South Africa, 2014).

Although women's share in wage employment in the non-agricultural sector has increased since 1995, large disparities in male and female wages persist. Many women also continue to be dependent on work that can be characterised as survivalist activities with low wages and huge insecurities (Department of Social Development, 2010:51). The government's poverty alleviation and skills development programmes open avenues for women to enter the labour force and to broaden opportunities for career changes. Social grants, the provision of free basic services, and the mainstreaming of gender in various government programmes has done much to improve women's quality of life (Department of Social Development, 2010:51).

6.4 Gender based violence

South Africa is beset by some of the world's highest levels of sexual and domestic violence, denying many women, including older women, the realisation and enjoyment of full citizenship rights as set out in the constitution, thus undermining development efforts, and exacerbating women's vulnerability. Studies consistently show that women with violent and or controlling partners are at a higher risk of HIV infection. In addition, perceptions as well as behaviour and practices that violate the rights of women and girls in South Africa continue despite the country's progressive human rights legislative framework, strong human rights campaigns and rights based education against harmful cultural and religious practices, and the prohibition of these under the law. The perception held by too many men (45%) and women (30%) that a man can have sex when he wants and cannot be refused if he paid lobola, is a prime example of such beliefs which ultimately translate into abusive behaviour. The apparent increase in the number and intensity of attacks against both women and children in South Africa seems to attest to this (Jewkes, RK; K Dunkle; M Nduna; N Shai: 2010).

Research by the Medical Research Council (MRC) in 2009 shows an overall reduction in the numbers of intimate femicide cases, but reported an increase in the proportion that intimate femicide makes up of all female homicide. Also, intimate femicide remains the leading cause of female homicide in South Africa. It was estimated that three women were killed by an intimate partner per day in South Africa in 2009 (Medical Research Council, 2009). According to the MRC report, this figure is likely an under-estimation as 18% of murder perpetrators were not identified. The MRC concludes that interventions to prevent intimate partner violence and gender based violence in general, is not effective, especially in light of the 1.4% increase in intimate partner violence (Medical Research Council, 2009).

6.5 Sexual and reproductive health and rights

Sexual and reproductive health and rights are vital to strengthening development and poverty alleviation efforts. Data show that more women are accessing reproductive health services; women also have high levels of knowledge and access to contraceptives. These factors, combined with an increase in the use of antenatal services and the use of health facilities during delivery, contributed to a reduction in illness and deaths among women. Very poor women in rural areas are, however, much more likely to give birth at home, exacerbating their vulnerability and undermining development potential (Department of Social Development, 2010:51).

High rates of infant, child and maternal mortality remain a serious concern. Notwithstanding a significant decline in fertility, a variation in actual and preferred family sizes highlights poor communication and a lack of female decision making power regarding family planning and childbearing.

6.6 HIV and Aids

Female youth are 3.5 times more vulnerable than men to contracting HIV. HIV prevalence has also increased from 17.4% to 19.4% for women aged 15 – 19 years old during the 2001 – 2011 period. All data on HIV and Aids clearly illustrate the fact that HIV and Aids affects women disproportionately more than men, and that the incidence of new infection is higher amongst young women than young men. The spread of the disease is closely associated with poverty and unequal power relations that increases women's vulnerability and undermine their capacity to participate equally in development (Department of Social Development, 2010:51).

6.7 Challenges and recommendations

The cumulative impact of the above challenges that women face, including a lack of decision making power regarding family planning and childbearing combined with the high levels of gender based violence, particularly intimate partner violence that many women are subjected to, illustrate the continued inequalities in sexual and reproductive relations women face. Recommendations thus include:

- Continue to empower women and provide them with choices through expanded access to education, health services, including sexual reproductive health and rights (SRHR) , skills development, employment and involvement in decision making at all levels;
- Monitoring and evaluation instruments for the empowerment of women, gender equality and equity should be improved to strengthen compliance to various instruments and to evaluate the empowerment of women in both the public and private sectors;
- Improve the implementation of legislation and policies;
- Improve female representation at decision making levels, particularly focusing on the sphere of local government as well as the private sector;
- Address the high school drop out rate among boys;
- Ensure a multi-sectoral approach to address gender based violence. Also ensure the requisite political will and leadership to address this scourge; and
- Enhance the availability, quality and accessibility of sexual and reproductive health and rights services.

7. Sexual and reproductive health and rights

7. Sexual and reproductive health and rights

Both the population policy (1998) and the ICPD PoA (1994) highlighted sexual and reproductive health and rights as a crucial population concern. In fact, reproductive health is recognised as a human right that is not only vital for improving the general health and wellbeing of a population, but is also pivotal for achieving sustainable development (Department of Social Development, 2010). This recognition is crucial as pregnancy and childbirth continue to pose significant risks for women in South Africa.

The ICPD PoA defines reproductive health as, *'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Embracing human rights, it recognises the basic right of all couples and individuals to decide freely and responsibly on the number, spacing and timing of their children and to have the information and means to do so'* (Department of Social Development, 2010: 55).

The South African population policy emphasises concerns about the high incidence of unplanned and unwanted pregnancies; the high risk of childbearing and elevated rates of infant and maternal mortality; and the rising incidence of sexually transmitted infections, particularly HIV and Aids. Other concerns include consequences of violence against women and children and the need to improve the quality and accessibility of reproductive health and rights services for underserved groups, including the youth, HIV positive youth, sex workers, persons with disabilities and Lesbian, Gay, Bisexual, Transsexual, Queer, and Intersex (LGBTI) persons.

The population policy aims to improve the quality, accessibility, availability and affordability of primary health care services, including reproductive health and rights promotion services (e.g. family planning) to all, focusing on vulnerable groups in underserved areas; and to promote responsible and healthy reproductive and sexual behaviour among adolescents and the youth.

7.1 Fertility trends in South Africa

Data suggest that the country's fertility is declining and has been declining since the 1960s. The Total Fertility Rate (TFR) has declined from 6.7 children per woman in the mid to late 1960s to 2.9 in 1998, to 2.4 in 2008 to 2.35 in 2011. The TFR increased slightly to 2.57 in 2014 (Statistics South Africa, 2014). Gauteng had the lowest fertility rate during the period 2006 – 2011, at 2.10 (which is what the population needs to replace itself), while Limpopo had the highest at 2.85. The fertility rates of the African and coloured population groups are expected to continue declining over the next 30 years, although at a slower rate. The coloured fertility rate is expected to drop to replacement level of 2.1 by 2015, while that of Africans is expected to drop to replacement level by 2035. The fertility rates of the white (1.8) and Indian/Asian (2.0) population groups, which are below replacement level, are expected to increase slightly over the next three decades.

Although Age Specific Fertility declined across all population groups, the fertility schedules for Indians and whites are characteristic of late childbearing, occurring within a narrow age range consequently resulting in lower fertility compared to African and coloured women (Statistics South Africa, 2010). The overall decline reflects improvements in the standard of living, income levels, occupational status, increased contraceptive use and the impact of urbanisation.

Women aged 20 – 24 years had the highest percentage of births at 27.4%, followed by women aged 25 – 29 years at 26.3% and those aged 30 – 34 years at 19.3% and finally young women (youth) aged 15 – 19 years at 12.2%. As expected, fewer births (3.9%) occurred after age 40 – 45 years, as fecundity decreases as women grow older (Statistics South Africa, 2013a). The median age of mothers for all births registered in 2012 was 27 years; slightly higher than the median age observed in 2011 (Statistics South Africa, 2013a). Increasing median ages observed since 2010 indicates that women are having children later in life (Statistics South Africa, 2013).

7.2 Adolescent reproductive health

The health and wellbeing of young girls (and their children) are greatly compromised by unplanned and unwanted pregnancies. The MRC (2010) survey indicated that only 45.1% of the 37.5% of learners in Grade 8 to 11 who already have had sex, reported condoms as their most commonly used method of contraception. Almost two out of every ten (17.9%) of the 37.5% who already had sex did not use any contraception at all, often resulting in negative consequences for these learners.

The negative consequences of sexual activity during adolescence (10-19 years), especially when contraceptives are not used or used incorrectly or irregularly include early pregnancy and exposure to sexually transmitted infections including HIV, curtailed personal development, increased vulnerability to exploitative sexual and coercive violence, higher risks of maternal mortality, unsafe abortions and dropping out of school.

Data from Census 2011 show that the percentage of girls aged 15 – 18 who had ever had a live birth increased from about 13% in 1996 to 14% in 2011. According to Statistics South Africa's General Household Survey for 2009 – 2011, the prevalence of teenage pregnancy increases with age, with less than one percent of 13 to 15 year olds falling pregnant in 2011 compared to those 16 years and older as illustrated in Table 8 below.

Table 8: Prevalence of teenage pregnancy for 2011

AGE	13	14	15	16	17	18	19
Prevalence (%)	0.2	0.4	0.7	3.1	7.0	8.7	11.5

Statistics South Africa: General Household Survey (2009 – 2011)

Teenage fertility has however declined, but teenage pregnancy remains high, at 56 births per 1000 women aged 15 – 19 in 2011. Again, teenage pregnancies are more prevalent among African and coloured girls than white or Indian girls. There are those who argue that the national decline in teenage fertility could be a result of an increase in the number of termination of pregnancies rather than a decline in teenage pregnancy (Makiwane, 2009). Empirical research is needed to test the veracity of this assertion.

7.3 Contraceptive use

Knowledge and use of contraceptives remain high in South Africa. According to the South African Demographic and Health Survey (SADHS), in 1998, 96.5% of women aged 15 – 49, knew of a modern method of contraception. Correct knowledge however does not always translate into behaviour as only 61.2% practiced a modern

method of contraception. In 2003, 93.6% knew of a modern method of contraceptive whilst 65.2% translated this knowledge into practice. In 2003, injections (33.2%) and pills (12.5%) were the most commonly used forms of contraceptives. Despite high knowledge and use of contraception, the 1998 and 2003 South African Demographic and Health Surveys (SADHSs) showed that as many as 9.7% and 13.8% of all South African women indicated an unmet need for family planning respectively. A significant proportion of women (10.7%) in 2010 reported an unmet need for family planning (Department of Health, 2011).

7.4 Termination of pregnancy

Termination of pregnancy is often an indication of using no (or less) efficient methods of contraceptives, or using these infrequently or incorrectly. It is also seen as a reflection of the unmet need for contraception (Department of Social Development, 2010: 56). In 2003, just over 70 000 terminations of pregnancies (ToPs) were reported in public health facilities, marking a 200% increase in the number of terminations since 1997. According to Makiwane (2009), 30% of ToPs conducted in 2003 were for adolescent girls aged 15 – 19 years old.

Table 9: Number of TOPs for 2007, 2008, 2009 and TOPs by Maternal Age

DHIS YEAR	NUMBER OF TOPs	TOPs (%) < 18 YEARS OF AGE
2007	**69 427**	12.7
2008	**72 942**	13.5
2009	**77 201**	14.6

District Health Information System (DHIS) Data

Table 9 clearly shows a notable and steady increase in the number of ToPs between 2007 and 2009. What is more worrying is the increasing ToPs among girls aged 18 years and younger. According to the 2008 National Youth Risk Behaviour Survey (NYRBS), of the 8.2% who indicated that they had a ToP, slightly more than half (51.5%) indicated that it took place at a hospital, 20.5% reported making use of a traditional doctor (healer), 10.2% indicated that the ToP took place somewhere else (place not stated) and 5.4% did not know where the ToP took place.

These figures are worrying; not only do unsafe ToPs contribute to the high maternal mortality still prevalent in South Africa; they also have the potential of causing long term poor sexual and reproductive health for many women. According to the Department of Health, unsafe ToPs accounted for 23.1% of maternal deaths (Department of Health, 2012). Despite having a very progressive constitution and liberal legislation such as the Termination of Pregnancy Act, the country remains rather conservative and patriarchal in cultural terms. Many women, particularly young women and girls who want to terminate their pregnancies face discrimination and stigma at public health facilities, forcing them to resort to unsafe ToPs, thus putting their lives at risk.

7.5 Maternal health

Complications arising from pregnancy and childbirth are among the leading causes of mortality for women of reproductive age in the developing world (United Nations Population Fund, 2005). Measures of maternal health

and deaths are important indicators of the access and usage (or lack thereof) women have to essential health care services, including reproductive health and family planning services, before, during and after pregnancy. Factors that may hinder access and usage of these services include, but are not restricted to the following:

- Obstacles to pregnancy prevention;
- Lack of information on contraception;
- Inability to use condoms and contraception consistently;
- Lack of knowledge about fertility options;
- Lack of knowledge about HIV status when pregnant;
- Inadequate access to prevention of unintended pregnancies and
- Compromised quality of antenatal care.

The Campaign in Accelerated Reduction of Maternal and Child Mortality (CARMMA) was initiated in November 2012 to tackle some of these issues. The campaign is a key strategy within the Maternal, Neonatal, Child and Women's Health 2012 – 2016 (MNCWH) plan.

7.6 Maternal mortality

Due to the lack of accurate data on maternal mortality, using Civil Registration and Vital Statistics System (CRVS) data, it would seem that the MMR increased from 150 to 299 maternal deaths per 100 000 live births between 1998 and 2007, after which it dropped to 269 per 100 000 live births in 2010. Given that the MDG target is 38 maternal deaths per 100 000 live births, South Africa is unlikely to meet it by 2015 (Republic of South Africa: Millennium Development Goals Country Report, 2013).

Non-pregnancy related infections (mainly deaths in HIV infected pregnant women complicated by tuberculosis and pneumonia) accounted for 40.5% of maternal deaths (Department of Health, 2012). Maternal deaths resulting from obstetric haemorrhage (14%) and hypertension (14%) accounted for 28% of deaths. The top three causes of maternal death (non pregnancy related infections, obstetric haemorrhage and hypertension) accounted for almost 70% of all maternal deaths (Department of Health, 2012). According to the Department of Health (2012), maternal deaths due to obstetric haemorrhage and hypertension could have possibly been prevented in 81% and 61% of cases respectively.

7.7 Ante-natal health care coverage

Ante-natal health care coverage remains high, despite the slight decline at a national level from 94.2% in 1998 to 91.7% in 2003. The proportion of births attended by trained health personnel increased from 84.4% in 1998 to 98.3% in 2008 whereas the proportion of women who have delivered in a health facility fluctuated somewhat, however increasing in recent years from 82.6% in 2004 to 86.6% in 2009. These figures are a promising indication that South Africa may be able to achieve the MDG target of 100% by 2015.

Table 10: Delivery rate in health facility – District Health Information System (DHIS)

DELIVERY RATE IN FACILITY										
DHIS 2004	89.1	72.4	84.7	83.5	86.2	70.7	101.7	76.9	81.7	*82.6*
DHIS 2005	93.3	85.6	83.8	85.3	97.5	70.2	87.9	72.7	64.7	*83.1*
DHIS 2006	65.0	80.0	79.3	77.9	84.6	81.9	91.6	72.6	92.4	*78.4*
DHIS 2009	71.3	77.4	97.5	83.3	98.2	90.6	87.5	75.0	94.6	*86.6*

District Health Information System Data

7.8 Child health

The Infant Mortality Rate (IMR), defined as the number of deaths of infants (children under the age of 1) per 1000 live births in a given year, is one of the most important health and development indicators (Department of Social Development, 2010: 57). The IMR declined from 45 per 1000 live births in 1998 to 42.5 in 2003 and rose to 53 in 2007. The MDG target is 18 per 1000 live births. Given these figures, South Africa seems unlikely to meet this target (Republic of South Africa: Millennium Development Goals Country Report, 2013).

Given the lack of accurate data on child mortality, using Civil Registration and Vital Statistics System (CRVS) data, it would seem that the IMR increased from 26 to 48 infant deaths per 1000 live births between 1998 and 2007. There has however been a decline since 2007 and by 2010; the IMR was approximately 38 deaths per 1000 live births. The introduction of the Prevention of Mother to Child Transmission (PMTCT) programme and the pneumococcus and rota virus vaccines (which were added to the Expanded Programme on Immunisation) have contributed to the decline in IMR since 2007 (Republic of South Africa: Millennium Development Goals Country Report, 2013).

The Under Five Mortality Rate showed an upward trend between 1998 and 2007 from 38 to 67 deaths per 1000 live births. Again, the introduction of PMTCT programme and the expansion of the immunisation programme reversed the upward trend and in 2010 the Under Five Mortality Rate was 53 per 1000 live births. The percentage of children under one-year in health facilities who received all vaccines increased significantly from about 70% in 2003 to about 93% in 2011 (Republic of South Africa: Millennium Development Goals Country Report, 2013).

7.9 HIV and Aids

In South Africa, HIV prevalence appears to be stabilising after alarming spikes in the 1990s and early 2000s. The burden of disease lies with women of reproductive age. According to the Statistics South Africa 2011 mid year estimates, the HIV prevalence rate was approximately 10.6% in 2011, dropping slightly to 10.2% in 2014 (Statistics South Africa, 2014). The total number of people living with HIV was estimated at approximately 5.38 million in 2011, rising to 5.6 million in 2012, dropping to 5.51 million in 2014 (Statistics South Africa, 2014).

A noticeable proportion (16.6%) of the adult population aged 15 – 49 was HIV positive in 2011 (Statistics South Africa, 2012). HIV prevalence for those aged 15 to 24 rose from 9.3% in 2002 to 10.3% in 2005, dropping to 8.7% in 2008. According to the District Health Information System (DHIS) and the National Health Laboratory Services, the percentage of babies who were HIV positive in 2009 – 2010 was 9.4%, showing a marked decline from the 15.2% in the 2008 – 2009 periods.

Preventing new infections and Aids related deaths among young women in South Africa is crucial. Existing efforts to curb the incidence and prevalence of HIV including, information, education, mass mobilisation, STI diagnosis and management and HIV counselling and testing, condom provision and promotion, medical male circumcision and Prevention of Mother to Child Transmission (PMTCT) are seemingly starting to pay off. The value of these services, in particular services such as PMTCT and ART for pregnant women cannot be underestimated.

7.10 Sexual and reproductive health and rights (SRHR) needs and services for men and boys

Involving South African men and boys in SRHR is important in itself, but also as a vehicle to protect and advance women's SRHR. The burden of taking responsibility for sexual and reproductive needs and services usually falls on women. Male reproductive health services are largely absent in public health services; men do not use health facilities as often as women, nor do many of them seem to take responsibility for sexual and reproductive issues. Medical male circumcision is currently being punted as an additional HIV prevention tool by the South African government as it has been shown to reduce the risk of STI and HIV infection. The National Medical Male Circumcision (MMC) programme was launched with the aim of reaching 80% of men aged 15 – 49 by 2015. By June 2011, 237 812 medical male circumcisions were performed; more than half (52.6%) occurred within a hospital setting whereas 41.9% were performed by traditional schools. Circumcisions performed by traditional schools present their own challenges, including botched circumcisions, and in extreme cases, the death of young men who underwent traditional circumcisions.

7.11 Challenges and recommendations

Given that the SADHS was last conducted in 2003, nationally representative data that can provide the current levels on a number of key indicators on Millennium Development Goals 4 *(Reduce child mortality)* and 5 *(Improve maternal health)* are not available, thus making it difficult to accurately monitor levels of childhood and maternal mortality in South Africa. Suffice to say, despite progress made towards improving maternal health, maternal mortality for example, remains unacceptably high, particularly due to non-pregnancy related infections. Also, despite progressive legislation that allows women access to safe termination of pregnancy facilities, illegal abortions are rife in South Africa, killing many women, including adolescent girls.

The South African Millennium Development Goals Country Report (2013) states that in the long term, the empowerment of women is important as the interplay of socio economic factors and gender inequalities exert a negative outcome on maternal health, affecting not only the extent to which healthcare services are accessed and used, but also affecting women's access to family planning services, including modern contraceptives.

Poor and marginalised women in particular are adversely affected by these challenges, ultimately limiting their choices to *'freely and responsibly decide'* whether they want children, how many and when. These women also often do not have the information, means or access to adequate SRHR services to exercise informed choices. An unmet need for family planning and access to appropriate and modern contraceptives are realities for many poor, marginalised and vulnerable adolescent girls.

SRHR are integral to attaining gender equality, equity and the full empowerment of women. Attaining gender equality, equity and the genuine empowerment of women, including their SRHR, can only be done holistically, i.e. by also ensuring that women are equal partners in the economy, as well as socially and culturally. It is in this context that the concept 'reproductive justice' should be championed. According to the Asian Communities for Reproductive Justice, *'reproductive justice exists when all people have the social, political and economic power and resources to make healthy decisions about their gender, bodies and sexualities'* (Dlamini, 2014). Attaining reproductive justice will therefore ensure that all women have full autonomy over their own fertility.

Recommendations are:

- Approach SRHR from a reproductive justice perspective as gender equality, equity and the genuine empowerment of women, including SRHR can only be realised sustainably if reproductive justice is achieved;
- Strengthen the systems of health care and services that women need during pregnancy and childbirth as a matter of urgency to address and rapidly reduce the high levels of maternal mortality, particularly due to non-pregnancy related infections;
- Ensure efficient and effective implementation as well as monitoring and evaluation of the Campaign in Accelerated Reduction of Maternal and Child Mortality (CARMMA), aimed at addressing the multitude of complications arising from pregnancy and childbirth that result in maternal death;
- Ensure efficacy in the implementation of the Department of Health's plan to scale up the basic ante-natal care programme by ensuring booking before 20 weeks, at least 4 scheduled and focused visits and the integration of the PMTCT;
- Improve women's access to and use of effective SRHR services;
- Address the unmet need for family planning through increased availability of contraception, including emergency contraception and the use of dual methods which includes condoms, but also through efforts to increase female autonomy;
- Promotion and encouragement of male involvement and responsibility in family planning and contraception usage as well as equal participation of men and women in the area of responsible parenting should be continued and strengthened;
- Undertake a SADHS as a matter of urgency and improve the country's civil registration and vital statistics system (CRVS).

8. HIV & Aids and health concerns with demographic implications

8. HIV & Aids and health concerns with demographic implications

The right to health is at the core of the Millennium Development Goals (MDGs) as improved health status leads to increased productivity, educational performance, life expectancy, savings and investments and decreased debts and expenditure on health care – ultimately leading to greater equity and socio economic stability. Improved health therefore remains a key factor for sustainable development.

Both the South African population policy (1998) and the ICPD Programme of Action (1994) identified major health concerns related to human development as well as the demographic and environmental situation in the country. These major health concerns included the rising incidence of sexually transmitted infections (STIs), especially HIV and Aids; the high rates of infant and maternal mortality, linked to high risk child bearing; and the projected socio economic impacts of Aids.

Numerous policies, strategies, programmes and projects have been developed and implemented to reduce, among other things, the incidence of HIV infections as well as infant, child and maternal mortality. Despite these attempts, HIV and Aids continue to pose serious health and development challenges to South Africa.

8.1 Levels and trends in HIV prevalence in South Africa

There has been a somewhat constant increase in the numbers of people living with HIV in South Africa since 2001 with an estimated 4.21 million people or 10.6% of the total population in South Africa infected with HIV; growing to 5.02 million people in 2008 (10.9%) and 5.38 million people in 2011. According to Statistics South Africa, the total number of people living with HIV increased to 5.6 million in 2012, dropping slightly to 5.51 million in 2014 (Statistics South Africa, 2014).

Table 11: HIV prevalence estimates and the number of people living with HIV, 2001–2011

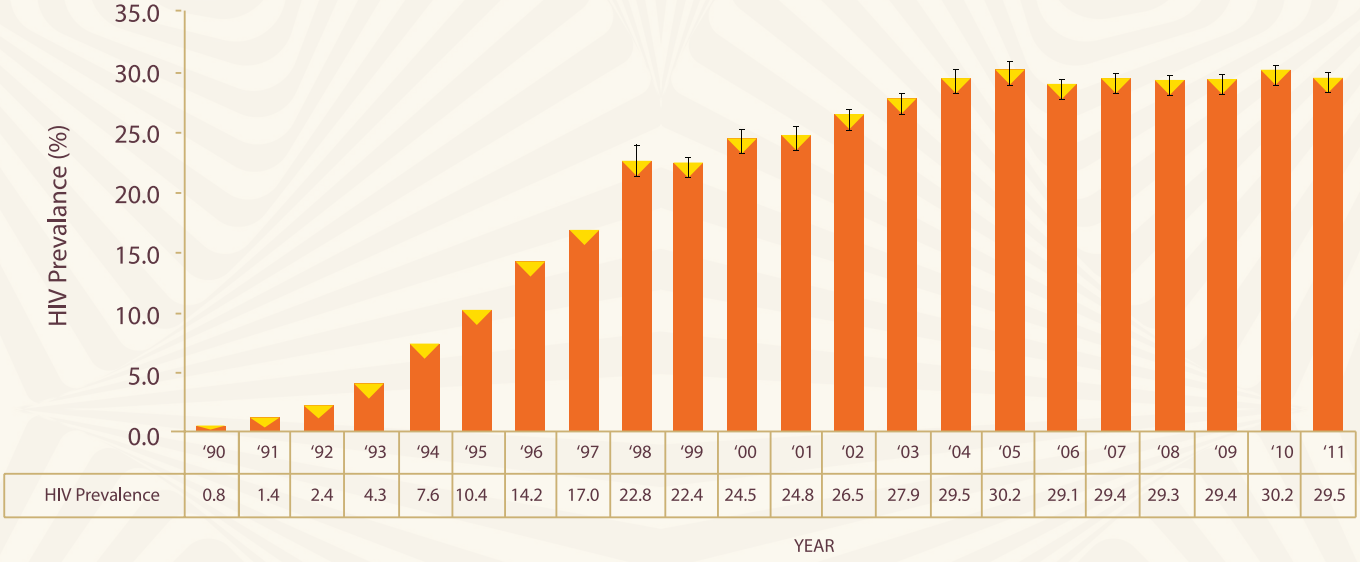
YEAR	PREVALANCE			INCIDENCE ADULT	HIV POPULATION MILLIONS
	WOMEN 15-49	ADULT 15-49	TOTAL POPULATION		
2001	17,4	16,0	9,4	1,72	4,21
2002	17,7	16,2	9,6	1,59	4,37
2003	18,0	16,2	9,7	1,58	4,49
2004	18,1	16,2	9,8	1,63	4,59
2005	18,3	16,2	9,9	1,73	4,69
2006	18,9	16,6	10,2	2,11	4,87
2007	18,9	16,5	10,2	1,54	4,95
2008	18,9	16,4	10,3	1,43	5,02
2009	19,1	16,4	10,4	1,45	5,13
2010	19,3	16,5	10,5	1,43	5,26
2011	19,4	16,6	10,6	1,38	5,38

Statistics South Africa, 2012

The data in table 11 show HIV prevalence among adults aged 15 - 49 years in South Africa from 2001 to 2011. Although there have been fluctuations in HIV prevalence since 2001, these have seemingly stabilised at around 16% to 17% (Statistics South Africa, 2012). Although the overall prevalence has stabilised, there are changes occurring in different age groups with prevalence highest among females aged 30 - 34 years (36.0%) and males aged 35 – 49 (28.8%).

It is obvious from all the data that women are more vulnerable than men to contracting HIV. In fact, female youth are 3.5 times more likely to be HIV positive than their male counterparts and approximately one-fifth of South African women in their reproductive ages are HIV positive.

Figure 7: The HIV prevalence trends among antenatal women, South Africa 1990 to 2011



Department of Health, 2011

The estimated national HIV prevalence amongst women attending antenatal clinics has remained relatively stable over recent years: 29.1% in 2006; 29.4% in 2007, 29.3% in 2008, 29.4% in 2009, 30.2% in 2010 and 29.5% in 2011. This might be indicative of the plateauing of the epidemic.

The evidence from population based HIV prevalence studies in South Africa appears to suggest that the spread of HIV among 15 - 25 year olds declined overall in the country since 2005. Trends in HIV prevalence among persons aged 15 - 24 years is a good proxy indicator of the course of new infections in the population and therefore incidence, since start of sexual activity would be recent at those young ages. Prevalence of HIV infection in the younger age groups would also be less affected by differentials in mortality and fertility between HIV infected and uninfected individuals.

In children aged 2 - 14 years, the prevalence has decreased by a difference of 3.1% from 2002 to 2008. The 2012 Human Sciences Research Council (HSRC) study confirms the decline in HIV prevalence among the 15 – 24 year olds, indicating a slight drop from 8.7% in 2008 to 7.3% in 2012. In adults aged 25 and older, the HIV prevalence increased by 1.3% from 2002 to 2008. The HSRC report (2012) also indicates that HIV infections among the adult population (25 years and older) are on the increase.

The 2008 HIV prevalence estimates show that the Western Cape Province had the lowest prevalence, followed by the Northern Cape whereas KwaZulu Natal and Mpumalanga had the highest HIV prevalence in the country. Although HIV prevalence seemed to decline among the 15 - 24 age group since 2005 in most provinces, KwaZulu Natal and Mpumalanga showed an increase. In KwaZulu Natal, HIV prevalence increased from 7.2% in 2002 to 15.3% in 2008, making it the province with the highest HIV prevalence among young people. Trends are similar for 2011 with the Western Cape and the Northern Cape having the lowest HIV prevalence rates – below 20% whereas KwaZulu Natal, followed by Mpumalanga had the highest prevalence rates – greater than 30%. As expected, the 2012 infection rates also show that KwaZulu Natal had the highest infection rates at 16.9%, followed by Mpumalanga (14.1%) and the Free State (14%) whereas the Western Cape (5.%) followed by the Northern Cape (7.4%) had the lowest infection rate (HSRC, 2012).

Recent data by the HSRC (2012) show that new HIV infections among young South Africans 15 - 24 years, continued to decline and that this decline was particularly driven by young women. Although young women still get infected at a far higher rate than the rest of the population; their rate of infection has also decreased the most (HSRC, 2012). In fact, in the early 2000s, young people represented more than 50% of new HIV infections, but represented less than a third of the number of new infections in 2012 (HSRC, 2012). Much of this can be attributed to behaviour change, particularly the increase in the use of condoms among this age group. Data show that this group has a significantly higher percentage (58.4%) of condom use than other age groups (HSRC, 2012). Higher treatment levels have also reduced the viral load in the population, making infection from unprotected sex less likely. Young women who got infected tended to have sexual relationships with older men, who have higher rates of infection and are unlikely to be on treatment. It is also harder for these young women to negotiate the use of condoms with older partners – especially if they are engaging in transactional sex (HSRC, 2012).

Observing the data on HIV incidence in South Africa during the 2001 to 2011 period, various fluctuations are evident. The data indicates a decline in HIV incidence rates among persons aged 15 - 49 from 1.72% in 2001 to 1.58% in 2003, increasing to 1.63% in 2004, 1.73% in 2005 peaking at 2.11% in 2006 where after it declined notably to 1.54% in 2007 and declining steadily to 1.38% in 2011. Again, these declines correspond with significant changes in this group's behaviour relating to increased condom use and HIV testing. In 2008, 73% of young women reported using a condom at last sex compared to 46% in 2002, and more than half had tested for HIV compared with only 13% six years earlier.

According to the HSRC (2012) study, the HIV incidence rates among women are of a particular concern. The HIV incidence rate among female youth aged 15 - 24 years was over 4 times higher than for males in this age group (2.5% vs. 0.6%). With an HIV incidence rate of 4.5% African females aged 20 - 34 years had the highest incidence of HIV among the analysed population groups (HSRC, 2012).

8.2 Factors contributing to the spread of HIV

Significant drivers contributing to the spread of HIV include male attitude and behaviours, intergenerational sex, multiple sex partners, gender and sexual violence, stigma, lack of openness, untreated viral STIs, lack of consistent condom use in long term and concurrent partnerships, mother-to-child HIV transmission, low condom use, low levels of circumcision, the spread of TB, and migration. Underlying social and structural factors that add to the impact of these drivers include high population mobility, inequalities of wealth, cultural factors

and gender inequalities – all of which significantly contribute to the vulnerability of women, particularly young women and girls and women in rural areas to contracting HIV.

Compared with the 2008 data, there were a decline in condom use in most age groups and an increase in multiple sexual partnerships among sexually active people aged 15 years and older in 2012 (HSRC, 2012). Another factor causing concern is that the majority of the respondents aged 15 years and older (76.5%) believed that they were at low risk of acquiring HIV infection. Unfortunately, approximately one in ten who believed they were at low risk for acquiring HIV infection was already infected but didn't know it. Furthermore, the overall knowledge about how HIV is transmitted and prevented also declined from about 30.3% in 2008 to 26.8% in 2012 (HSRC, 2012).

8.3 Prevention, treatment and care

South Africa has the largest antiretroviral therapy (ART) programme in the world; given that the country also has the largest epidemic in the world, the need is immense. At the end of 2010, an estimated 55% of people who needed it were receiving treatment to HIV and the country is making progress towards its goal of 80% coverage. By mid-2012, over 2 million people were on ART, again suggesting the country is on its way towards achieving universal access to treatment (HSRC, 2012). This significant increase of ART exposure in the country has had a major impact on the survival of people living with HIV. One can therefore surmise that the widespread rollout of antiretroviral treatment have contributed to the decrease in the mortality rate in recent years and the increase in the life expectancy rates from 52.5 years in 2006 to 58.1 years in 2011 and 67.9 years in 2014 (Statistics South Africa, 2014).

As a result of South Africa's successful Prevention of Mother to Child Transmission (PMTCT) programme, HIV infection levels in infants declined; this is confirmed by a further decrease in HIV infections in infants 12 months and younger from more than 2% to 1.3% in 2012 (HSRC, 2012).

8.4 Communicable and non-communicable diseases and causes of death

Tuberculosis (TB) remains the leading cause of death in South Africa, accounting for 12% of deaths annually. The risk of death due to malaria has been significantly reduced with only 4% of the population at risk of contracting and dying from the disease. Major communicable diseases resulting in annual deaths in South Africa include influenza and pneumonia (7.5%), intestinal infectious diseases (5.4%), HIV and Aids (3.1%) and other bacterial diseases (0.9%). Major non-communicable diseases which are often lifestyle related contributed to the following annual deaths: other heart diseases (4.6%), cerebrovascular diseases (4.3%), diabetes mellitus (3.6%), chronic lower respiratory diseases (2.5%) and hypertensive diseases (2.2%).

Non-communicable diseases and deaths related to injuries and violence are high in South Africa and need to be systematically tracked and addressed as burdens on health. Women in particular are increasingly exposed to high levels of violence, including sexual violence and often at the hands of their intimate partners, thus denying many women the realisation and enjoyment of full citizenship rights as set out in the Constitution and the ICPD Programme of Action. Violence against women also undermines development efforts and exacerbates women's vulnerabilities. Income inequality and poverty, high unemployment, rapid social change, high levels of drugs and particularly alcohol abuse, corruption and poor rule of law, gender inequalities and family breakdown have contributed to this climate of violence, especially the high levels of interpersonal violence.

8.5 Conclusion

Despite the challenges in the health sector, there are opportunities for significant systems improvements and progress on the major policy priorities. The Department of Health has policies, programmes and service priorities that aim to promote health and development, and to prevent or reduce risk factors for health conditions associated with tobacco, alcohol, road accidents, unhealthy diets, physical activity and unsafe sex.

Efforts to sustain adequate budget allocations for the prevention and treatment of HIV & Aids and improving service efficiency and quality of care needs to be strengthened. Most importantly, efforts to improve the quality of care need to be driven from the front, by political and health service leaders, who can inspire health workers to have the biggest possible impact on the health of the communities they serve. Credit of significant improvements should be attributed to the hard work by government, all social partners and civil society.

8.6 Challenges

- The inadequacy of human, financial and infrastructural resources;
- Weaknesses in communication and dissemination of new policies;
- Stagnation (i.e. non-decline) in HIV prevalence rates;
- Decline in overall knowledge about how HIV is transmitted and prevented;
- Lack of multi-sectoral participation in the HIV prevention response;
- Lack of monitoring and evaluation and research capacities are critical barriers that must be addressed, especially at provincial level;
- Male engagement in HIV prevention is limited, especially in the Prevention of Mother to Child Transmission (PMTCT) at programme level;
- As the burden of malaria in South Africa continues to decline, the risk of imported malaria by travelers and migrant workers from malaria endemic countries has remained a major challenge in terms of the elimination of malaria; and
- Environmental and climate changes have also contributed to shifts in the incidence of malaria in the country.

8.7 Recommendations

- Improve the social and economic status of women (particularly young women) in order to decrease their vulnerability and to increase the ability of households to deal with the impact of HIV and Aids;
- Strengthen commitment to and enhance national capacities and mechanisms for the collection, analysis, interpretation and dissemination of HIV & Aids and population research data, and the use of such data and information to inform policy making and development planning;
- Focus on emerging health issues & diseases such as lifestyle diseases and nutrition related diseases and their impacts on population dynamics and how this will impact on the attainment of sustainable human development;
- Promote and encourage the implementation of adult focused HIV prevention campaigns that focus on increasing the use of condoms as well as other protective behaviours, such as testing for HIV and getting treatment for those who need it.

9. The changing structure and composition of families in South Africa

9. The changing structure and composition of families in South Africa

The consequences of apartheid legislation had dire impacts on the overall structure of the South African society and particularly on African families. The institutionalisation of wage labour, the racist patterns of unequal development, including unequal access to quality education; the lack of adequate employment; housing and health services to Africans and the restrictions on the movement of African migrant labourers and their families, encouraged dual rural-urban homesteads and circular migration. These factors contributed to the delay of marriage, the creation of female-headed households and unstable household compositions among African families (Department of Social Development, 2010). South African families, particularly African families underwent further significant changes given the process of rapid demographic and socio-economic change experienced since the dawn of democracy, resulting in considerable change in family composition and structure (Department of Social Development, 2010). Factors that influence this rapid change in family formation and dissolution include issues around fertility, marriage, divorce and separation.

Given its multi-cultural nature, South Africa does not have a standard or single definition of family. South Africa's White Paper on Families (2012) however promotes and advocates recognition and respect for the diversity of families in South Africa. It furthermore also promotes and advocates for well functioning families that are loving, peaceful, safe, stable and economically self sustaining. Families should also provide care and physical, emotional, psychological, financial and intellectual support to their members. This description is in line with the vision as espoused in the National Family Policy (2008) and the mission expressed by the Department of Social Development that commits itself to ensure the provision of comprehensive, integrated, sustainable and high quality social development services to families, particularly those that are vulnerable, marginalised and poor. Emphasis however shifted from individual based targeting to family targeting in order to promote and strengthen families as well as the individuals within families.

The ICPD Programme of Action complements the above policies, stating that family is the basic unit of society, hence calling for comprehensive protection and support to be rendered to families. The ICPD PoA further proposes that policies and laws consider the plurality of forms, particularly the growing number of single parent families, in efforts to render support and enhance stability; and that these policies are responsive to diverse and changing needs as well as the rights of family members, particularly women and children. The South African population policy (1998) also highlights insecure family and community life, continued poverty and inequality as well as factors that inhibit women and children, particularly girls to reach their full potential.

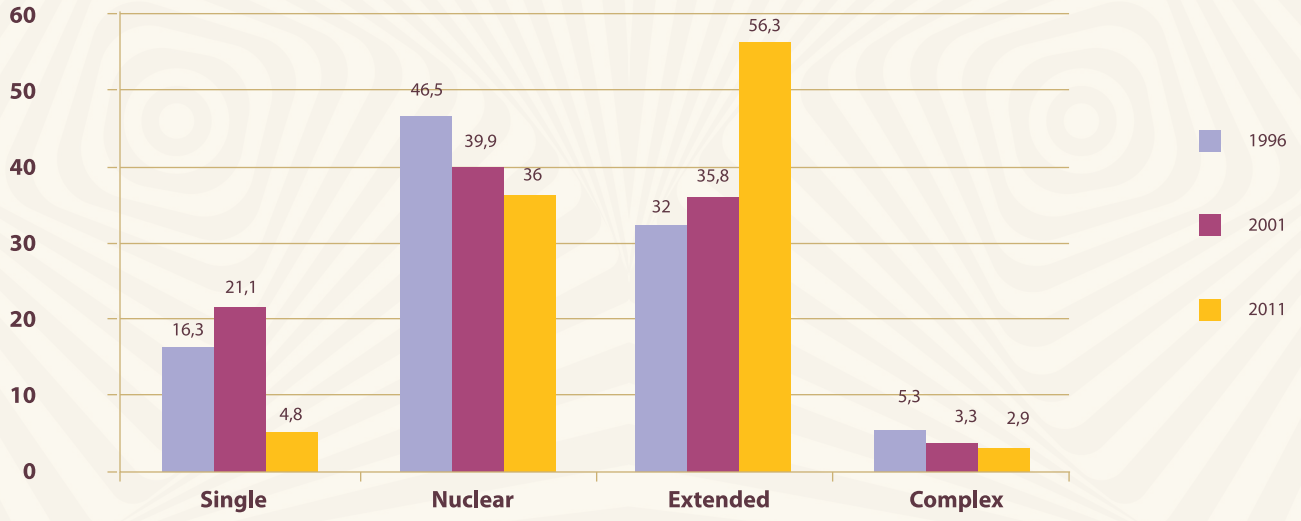
9.1 Families and households

Despite not having a single definition of families, general consensus dictates that families are, *'social groups that are related by blood (kinship), marriage, adoption, or affiliation with close emotional attachments to each other that endure over time and go beyond a particular physical residence'* (Amoateng and Richter, 2007:14). A household on the other hand, is defined as a group of persons living together in a common dwelling for at least four nights in a week and who provide themselves jointly with food and or other essentials for living, or a single person who lives alone. Whereas families are defined by some sense of kinship, household members need not be related. Families and households are conceptually distinct entities, which may overlap or not and should therefore not be used interchangeably. However, given the lack of data on families, households

are often used as units of analysis, indicating a huge limitation to our understanding of what constitute and impacts on families.

9.2 Living arrangements

Figure 8: Distribution of household types in South Africa, 1996, 2001 and 2011

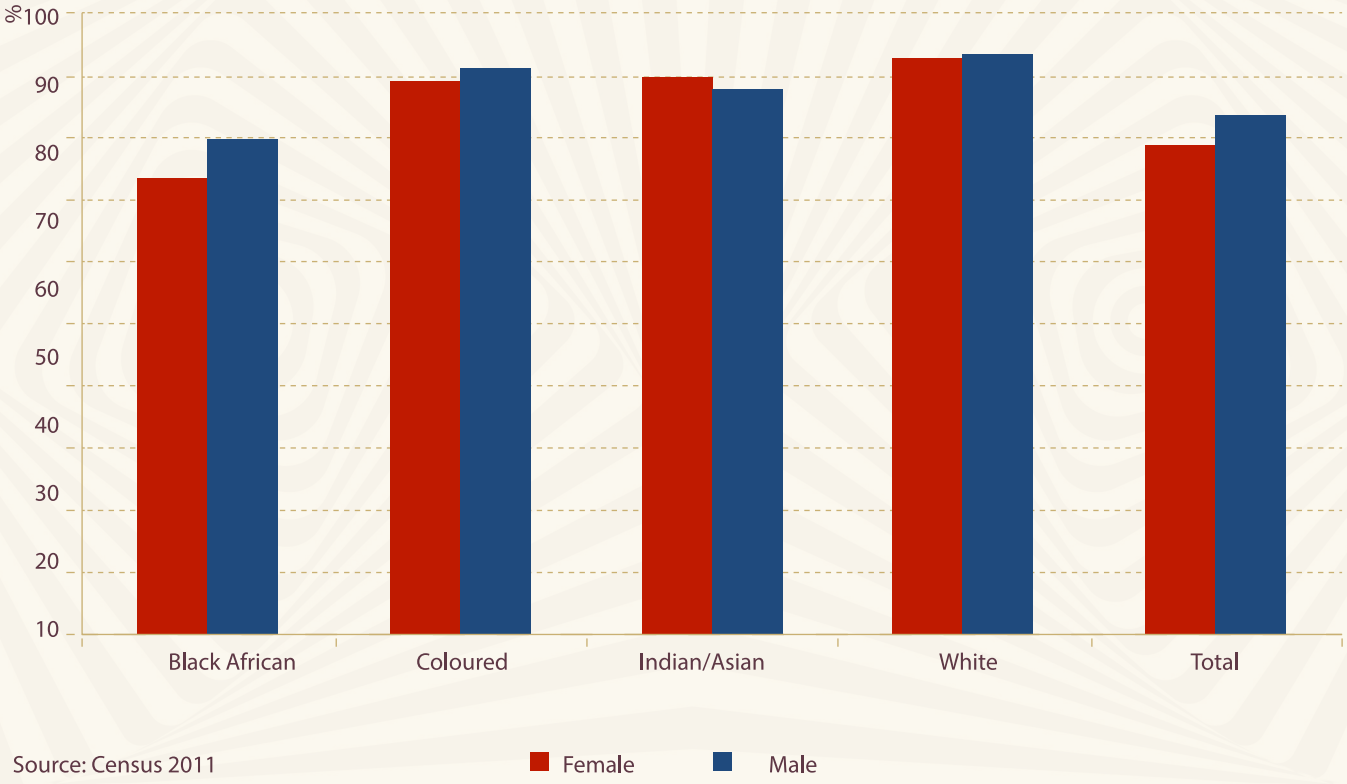


Statistics South Africa, 1996, 2001, 2011

More than half (56.3%) of South Africans form part of extended household types whereas a further 36% reside in nuclear household types. Very few South Africans form part of single (4.8%) and complex (2.9%) households. Census 2011 data shows a decline in all household types except the extended household type. Nuclear households show a decline over the past two decades from 46.5% in 1996 to 36% in 2011. Extended households on the other hand, grew from 32% in 1996 to 56.3% in 2011. Single households fluctuated during these two decades – first growing from 16.3% in 1996 to 21.1% in 2001, then declining drastically to 4.8% a decade later. Empirical studies should be conducted to shed light on why this is happening.

The majority of South Africans, both male (44.7%) and female (44.7%) tend to be part of two generation households, presumably parent (s) and children. A considerable proportion is also part of three generation household formations – this is the case for 29.8% of males and 35.3% of females in the country. Most African men (59.1%) and women (64.9%) are part of extended households whereas most White men (70.9%) and women (67.1%) are part of nuclear households.

Figure 9: Percentage of people married or living as husband and wife whose partner is a member of the same household, by sex and population group, 2011



Source: Census 2011

Census 2011

Figure 9 shows, for each population group, what percentage of women and men have their partners living in the same household. African married women and men are least likely to have their partners in the same household. Over 25% of married African women and just over 20% of married African men live apart from their partners – a legacy of the country's migrant labour system. The vast majority (more than 88%) of other population groups of all married women and men live in the same household as their partners.

9.3 Factors influencing family composition and structure

Fertility and childbearing are major drivers of family formation. Even though marriage lost its value as a determinant of fertility in South Africa, unmarried women have considerably lower fertility rates than married women, thus resulting in lower overall fertility (HSRC, 2007); thereby ensuring that marital status remains an important factor in family composition and structure. The period between 2003 and 2009 saw a decline in the annual number of registered marriages from 178 689 to 171 989 as well as an annual decline in customary marriages from 17 283 to 13 506 (Statistics South Africa, 2009; Department of Social Development, 2012). Age at first marriage (civil marriage) remained stable for both women (29 years) and men (32 years) between 2006 and 2010 (Department of Social Development, 2012). The past two decades saw an increase in family formations such as cohabitation, single parent, single adult, families and families headed by women. An estimated 92 365 South African children were living in child headed households in 2010 (Department of Social Development, 2012:20).

Despite the low fertility rate of unmarried women and the fact that South Africa already has the lowest Total Fertility Rate (2.35 in 2011) in mainland southern Africa; non-marital childbearing, especially among Africans and coloureds are among the highest in the world, accounting for 58% of all births in the country. Teenage pregnancy remains worrying high. Teenage pregnancy has major social and health implications for young mothers and their children, including, unplanned and unwanted pregnancies; curtailed personal development; increased vulnerability to sexual exploitation and exposure to STIs, including HIV and Aids.

Although family structure and parental marital status alone do not guarantee positive or negative outcomes, non-marital childbearing has been shown to have more negative implications for children's education, economic and overall wellbeing, with research indicating that stable marital unions benefit nearly every aspect of a child's wellbeing. These include greater educational opportunities, better emotional and physical health, lower incidences of risky behaviour including substance abuse, early sexual activity for girls and delinquency for boys (Wilkens, 2012:vi; Department of Social Development, 2012).

Children born to unmarried parents are also statistically more likely to end up living in single parent households than those born to married parents. Holborn and Eddy (2011:3) noted that single parents were overwhelmingly African, female and between the ages of 25 – 34. These households are also more likely to be affected by poverty and unemployment. Research bears this out showing that disparities in income correlate not only with sex, but also with population group and age with young African women on average earning far less than any other group in South Africa. Unemployment is also much higher for this group and those women who are employed earn less than their male counterparts. Women also still typically assume more household responsibilities, spend a larger portion of their time on unpaid care work than men, and form a greater proportion of discouraged work seekers.

HIV and Aids had a significant and detrimental financial, social and emotional impact on families in South Africa. Poor households, in particular female headed and those in rural areas have been worst affected. As the vast majority of HIV and Aids caregivers are women, home based care has significantly increased the burden of care of many women, and exacerbated the levels of work versus family commitments among those who are working. In cases where parents or adults die, children are sometimes forced to assume adult responsibilities including rearing their younger siblings without the prerequisite developmental or emotional experience to do so. These children have to assume these duties whilst they are still trying to deal with their own sense of loss, the anxiety of what lies ahead as well as having to deal with the stigma and shame that is unfortunately often still prevalent in the South African society.

Children are therefore amongst the most vulnerable of family and household members, especially those who are not part of a stable family unit. Due to the country's nuptiality patterns and the prevalence of female headed households, absent living fathers is a common and increasing phenomenon in contemporary South Africa (Department of Social Development, 2012). Table 12 shows that the proportion of fathers who are absent but alive increased from 41.6% in 1996 to 47.4% in 2010.

Table 12: Percentage of children with/without fathers by race, South Africa 1996-2010

Race	Presence of father	1996[b]	2002[c]	2009[c]	2010[c]
African	Deceased father	10.0	12.8	18.4	18.1
	Absent (living) father	45.5	50.2	51.5	50.6
	Father present	44.5	37.0	30.1	**31.3**
Coloured	Deceased father	7.3	7.4	6.1	7.1
	Absent (living) father	34.3	37.2	40.8	38.7
	Father present	58.4	55.4	53.1	**54.2**
Indian	Deceased father	4.8	5.0	2.4	3.6
	Absent (living) father	16.6	8.4	12.2	13.4
	Father present	78.6	86.6	85.4	**83.0**
White	Deceased father	3.4	2.4	1.7	2.3
	Absent (living) father	12.8	10.9	15.0	16.9
	Father present	83.8	86.7	83.3	**80.8**
Total	***Deceased father***	***9.2***	***11.5***	***16.1***	***16.1***
	Absent (living) father	***41.6***	***45.8***	***48.0***	***47.4***
	Father present	***49.2***	***38.7***	***35.9***	***36.5***

Department of Social Development, 2012

On the other hand, the proportion of fathers present decreased from 49.2% to 36.5% over the same period. A clear racial dimension is evident in these figures: African children have the lowest proportion (31.3%) of present fathers while Indian children have the highest (83.0%), with white children following closely behind at 80.8% and coloured children at (54,2%).

While poverty, high rates of unemployment, and financial constraints may contribute to large numbers of fathers failing to take responsibility for their children, this trend is worrying as research show the positive effect of the presence and active involvement of a father in a child's life chances; academic performance; and social, emotional and cognitive functioning (Department of Social Development, 2012).

African (28.8%) and coloured children (15.1%) also constitute the largest proportion of children not living with either their parents. Most of these children are absorbed into the households of relatives with less than 1% of all children living in child-headed or child only households between 2002 and 2011. Only 15.9% of children who lived in child headed households were double orphans – the majority of children in child headed households had at least one parent who was alive. This is because many children, again mostly African children continue to live out the effects of historical spatial planning and a migrant labour system in which adults seek work in cities and families are spread across households. A large burden falls on grandparents (mostly grandmothers) and other family members in unemployed rural households; clearly exacerbating the already dire circumstances of these households and their members.

Children are particularly susceptible to poverty. Orphans and those not living with their parents are worst affected. Again, using the food poverty line, the LCS (2008/2009) show that more than a third (34.5%) of all

children in South Africa were in poverty compared to a fifth (21.2%) of the adult population and a quarter (26.3%) of the entire population. The effect of this on children manifests in malnutrition, poor growth and increased vulnerability to diseases, all of which compromise their capacity to develop to their full potential. Child hunger has however declined from 29.7% in 2002 to 16% in 2006 to 13.7% in 2011. One could surmise that access to social assistance, particularly social grants has contributed to the decline in child hunger.

Children are also vulnerable to abuse, neglect as well as crime. Sexual offences are the most prevalent crimes committed against children. Shockingly, 60.5% of these offenses were committed against children younger than 15 years old. Even more disturbing is that almost a third (29.4%) of these sexual offences involved children between 0 -10 years old (Department of Social Development, 2012).

The abovementioned factors continue to contribute to changes in the structure and formation of families and family ties in South Africa. Other factors such as gender based violence which permeates every level of society, substance abuse, child neglect and child abuse, crime, including the increased attacks on older persons and persons with disabilities also increase the burden on families and make it more difficult to nurture and sustain their members.

9.4 Conclusion

Despite the numerous challenges that continue to face families in South Africa, one must acknowledge that much progress has been made with the development and implementation of appropriate legislation, policies and programmes to promote, support and strengthen families. In the context of high unemployment, social assistance, particularly social grants have proved to be an essential form of poverty alleviation, not only reducing the occurrence of hunger and extreme poverty, but also facilitating household access to basic services and economic opportunities. Social assistance in particular continues to be an enormous source of financial support to children in compromised and vulnerable circumstances.

9.5 Recommendations

- Undertake regular demographic research to obtain trends on all aspects of families (as oppose to only households) and of children in the country on national, provincial and local level;
- Integrate family concerns into all population, environment and development interventions;
- Promote multi-level collaboration regarding families and children between government departments, non-government organisations, other stakeholders and national and international donor organisations. The Department of Social Development and the Department of Women should take the lead in coordinating and facilitating these multi-level collaborative initiatives;
- Develop and strengthen programmes and structures that address and minimise conditions such as family disintegration, substance abuse, child abuse, neglect, exploitation, HIV and Aids, child-headed households and poverty.

10. Older persons

10. Older persons

As stated previously, the demographics of South Africa is changing. Even though the South African population is a youthful one, older persons (aged 60 years and older) make up a significant and growing proportion of it. It is therefore imperative to acknowledge the country's changing age structure and pay particular attention to older persons and their unique needs and expectations.

The population policy acknowledges the implications of increasing numbers of older persons by way of illustrating population projections through to 2020, yet it does not have specific directives or objectives specifically formulated for older persons. The ICPD PoA (1994) objectives for older persons are:

- To enhance, through appropriate mechanisms, the self reliance of elderly people and to create conditions that promote quality of life and enable them to work and live independently in their own communities as long as possible or as desired;
- To develop systems of health care as well as systems of economic and social security in old age, where appropriate, paying special attention to the needs of women; and
- To develop a social support system, both formal and informal, with a view to enhancing the ability of families to take care of elderly people within the family.

South Africa is committed to addressing the welfare needs of older persons by ensuring their dignity and respect as enshrined in the constitution and various other policies and instruments, including the Aged Persons Act, no 81 of 1967 and the Aged Persons Amendment Act, Act no. 100 of 1998; the Older Persons Act, Act no. 13 of 2006 and the South African Policy for Older Persons (2005). International instruments include the African Union Policy Framework and Plan of Action on Ageing and the United Nations' Madrid International Plan of Action on Ageing.

Census 2011 shows that older persons (aged 60 and older) comprised 8.0% of the total population in 2011, up from the 7.3% in 2001. Those aged 65 and older comprised 5.3% of the total population in 2011, up from 4.9% in 2001 with the 60 – 64 age group having the highest number and the 85+ group the lowest number. There are also more elderly females than elderly males. Africans make up most of the elderly at 63% and whites the second largest with at least 24%. Whilst Africans also make up the largest percentage distribution of the general population; the proportion of white older persons are much higher than their national percentage distribution. It is clear that the white South African population has aged more than the other population groups – at a pace that is likened to that of developed countries.

The 'near old' categories of 50 – 55 and 55 – 59 comprised approximately 4.1 million people. It is important to take note of this group and how they cope with their current social, economic and health circumstances. This group will soon transition into the 'older persons' category and it is vital to take their circumstances into account when planning for the future.

It is argued that households' living arrangements are directly related to income levels, where separate living arrangements will generally increase when there is an increase in income and vice versa. This statement proves true when household living arrangements are viewed by population group. Poorer population groups

(typically African and coloured) were most likely to reside in extended households were resources are easier accessed and shared. These households were also often skip-generation households. The following findings seem to bear this out.

Older persons (9%) were more likely to live alone than individuals in the general population (5%) and were less likely to live in nuclear households. The majority of African older persons (73.8%) however lived in extended family households compared to only 22% of white older persons who did so. More than 60% of white older persons lived in nuclear households while 13.6% lived alone (Statistics South Africa, 2011). South African households had a mean size of 3.6 in 2011 whereas the mean household size where older persons were present was approximately 4.1. Older male headed households had an average household size of 3.9 compared to the 4.0 of older female headed households. Elderly headed households that contain children had the largest average household size (5.9) in 2011. The Eastern Cape, a mostly rural province had more households headed by older persons with 27.1% and Gauteng, the least with 16.2%. The living arrangements of older persons have implications for government service delivery. Particular attention should be paid to rural households headed by older persons (mostly elderly women) that contain children as they are among the most vulnerable and marginalised people in the country (Statistics South Africa, 2011).

As part of promoting the quality of life of older persons and enhancing self reliance; ensuring economic stability is crucial. Unfortunately not all older persons have the ways and means to live independently and thus are dependent on living in multi-member households often with limited means themselves. Again, stark differences exist between the different population groups with more than half of older Africans living in households that earned below R570 per month, compared to 25% of coloureds, 20% of Indians/Asians and 3% of whites. In 2011, the majority (69%) of older persons (more women than men) indicated that social grants and pensions were their main source of income. Older women were more likely to receive social grants than older men. Limpopo, the Eastern Cape and KwaZulu Natal have higher numbers of older persons who live in low income households whereas older persons in Gauteng and the Western Cape were least likely to live in low income households.

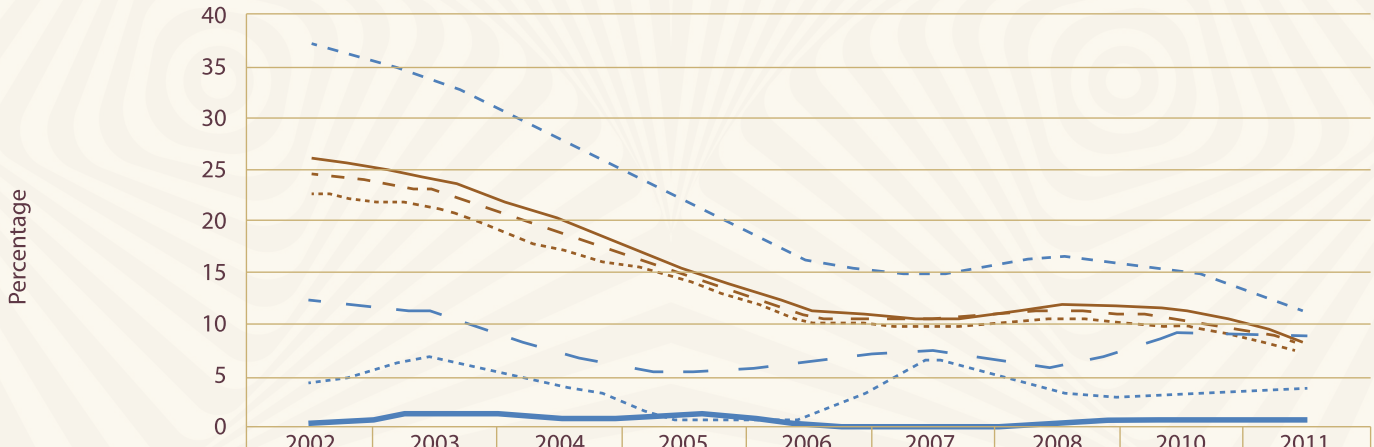
The living conditions of South Africans have improved notably over the last 15 years, more so for older persons as they perform better than the general population on the following indicators, i.e. in 2011, the vast majority (81.7%) of older persons were likely to live in dwellings that were either fully or partially owned; the majority (79.5%) also lived in formal dwellings. Older persons also had higher access to piped water (71.5%), electricity (89.6%), improved sanitation (75.3%), and surprisingly the internet (12%) (Statistics South Africa, 2011).

Older persons generally have a lower educational status and much higher illiteracy rates compared to the general population. Illiteracy amongst older persons has however decreased over the years and the percentage with no schooling decreased from 35.2% in 2002 to 25.2% in 2011. Functional illiteracy declined from 54.8% in 2002 to 43.8% for older males and declined from 59.6% in 2002 to 49.9% in 2011 for older females – clearly showing that illiteracy is highest among older women. This latter trend continues as older women in 2013 were still more likely to be illiterate than their male counterparts (47.9% compared to 39.7%) (Statistics South Africa, 2011).

Given the country's historical past, the contrast between population groups is stark. Only 0.3% of white older persons had no schooling in 2011 compared to 37.7% of African older persons. Also almost four out of every 10 older white persons (36.2%) completed secondary school compared to only 2.3% of older Africans.

10.1 Older persons and food security

Figure 10: Percentage of older persons living in households that reported hunger by sex and population group, GHS 2002 – 2008, 2010 - 2011



	2002	2003	2004	2005	2006	2007	2008	2010	2011
Male	22,8	21,5	17,7	14,6	10,2	10,0	10,5	9,8	7,8
Female	26,2	24,1	20,3	15,2	11,4	10,5	11,9	11,5	8,8
Total	24,8	23,0	19,0	14,9	10,9	10,3	11,3	10,8	8,4
Black African	37,1	33,8	28,2	22,2	16,1	14,7	16,7	15,3	11,5
Coloureds	12,5	11,3	7,3	5,0	6,5	7,5	5,8	9,3	8,9
Indian/Asian	4,4	6,8	4,2	0,6	0,7	6,8	3,2	3,0	3,8
White	0,5	1,4	0,8	1,0	0,1	0,1	0,3	0,6	0,6

Statistics South Africa: General Household Surveys 2002 – 2008; 2010 - 2011

Figure 10 shows that the percentage of older persons living in households that reported hunger decreased steadily from 24.8% in 2002 to 8.4% in 2011. There seems to be a negligible difference between older men (7.8%) and older women (8.8%) who reported hunger in 2011. The difference between the population groups however remain stark with 11.5% of Africans, 8.9% of coloureds, 3.8% of Indians/Asians and only 0.6% of white older persons reporting living in households that reported hunger. In 2011 older persons from the Northern Cape (17.6%) were more likely to live in households that experienced hunger, followed by the North West (10.9%) and KwaZulu Natal (10.8%). Older persons living in households where all household members are over 60 years are less likely to experience hunger than households where smaller proportions of the household members are over the age of 60.

10.2 Health status of older persons

Since the prevalence of acute and particularly chronic diseases increases with age, health issues and services are of vital importance to older persons. High blood pressure is the most commonly reported chronic disease among older persons with more women (44%) than men (24%) suffering from it. Arthritis is the second most common chronic condition afflicting both women (18%) and men (14%). Both conditions are more prevalent in urban than rural areas. For example, 30% of older men and 54% of older women in urban areas reported suffering from high blood pressure, compared to 16% of rural older men and 32% of rural older women. The majority of deaths among the elderly occur between the ages of 60 and 64 years. Most of these deaths are due to natural causes.

Access to medical aid has increased for those 60 years and older. In 2011 22.9% of older persons reported having access to a medical aid, up from 20.4% in 2002. This figure is also higher than the general population where only 18% have access to medical aid. More males (25.4%) than females (21.1%) have access to a medical aid and whereas the majority (73.2%) of older whites have access to a medical aid, the same is true for only 4.4% of Africans.

HIV prevalence remains higher for males over 60 years (4.6% in 2012, up from 3.5% in 2008) than females (2.4% in 2012, up from 1.8% in 2008) (HSRC, 2012). HIV prevalence among the 55 – 59 age group was 9.7% in 2012, up from 7.7% in 2008 for women and 5.5% for men, down from the 6.2% in 2008. For the 50 – 54 age group it was 10.4% for men in 2008, rising to 15.5% in 2012 whereas it stood at 10.2% for women, rising to 14.8% in 2012.

Issues around safety and security for older persons, especially in their own homes, are increasingly becoming a key factor as attacks against them are on the increase. In 2003, 4.5% of older persons reported being a victim of attack. Older women seemed more vulnerable with 5.2% reported being attacked compared to 4.2% of older men. For those older than 65 years, 71% of women and 44% of men who reported being attacked said they were attacked at home – underlying the vulnerability of this particular age group, especially in their own homes (South African Demographic and Health Survey, 2003).

10.3 Conclusion

Older persons should not be seen as static individuals who constantly need provision and help, but should be recognised as dynamic individuals who can contribute to society through their experience and wisdom. However, one should acknowledge the particular and specific needs, wants and expectations of older persons.

South Africa has done well to improve selected aspects of older persons living and health conditions. These include improving their basic living conditions, health care and access to social security. At the same time, older persons are increasingly being subjected both to physical, emotional, financial and sexual violence, particularly in their homes. Increasingly for many older persons, their sense of safety, security, and peace as well as their human rights and dignity are being violated.

10.4 Recommendations

- Greater institutional and political support to uphold the dignity and recognise the rights of older persons in South Africa;
- Up-to-date, reliable and relevant information and data, including administrative data on several aspects relating to older persons are however required in order to understand the challenges older persons face and to plan accordingly;
- With regard to health settings, geriatric wards need to be well equipped and staffed with skilled professionals who are well attuned to the needs of older patients and their particular ailments;
- Concerted efforts are needed to address issues around the safety and security as well as dignity and rights of older persons, including in their own homes.

11. Youth

11. Youth

South Africa, like many developing countries, has a relatively youthful population in which more than two-thirds (68.3%) of the population are younger than 35 years old. Youth, which is defined as those between the ages of 14 and 35 years of age, constitute 37.6% of the South African population and was estimated to number 18.7 million people (Statistics South Africa, 2011).

The youth are critical for a country's continued development and demographic change. This population represents new entrants into a country's labour force and will also serve as the basis for future demographic growth. The youth can therefore be either a major source of national development, or serious friction depending on the success with which they are incorporated into the labour market and other social structures (Xenos and Kabamalam, 1998).

11.1 The demographic dividend

The relative upsurge in the proportion of people of working age relative to the proportion of dependants such as children and older people might provide a demographic impetus for development in which fewer investments are needed to meet the needs of the youngest age groups, and resources are released for investment in the economic development and family welfare. This opportunity is known as the 'demographic 'dividend' (Bloom, Canning, Sevilla, 2002; Ross, 2004).

In order to capitalise on this opportunity, effective policies are needed in key areas. Health and sanitation interventions need to be prioritised in order to lay the foundation for a healthy workforce, while education and training should be improved in order to transform the population into a productive work force. The developmental potential can, however, only be unlocked if adequate job opportunities are created. The inability to integrate the youth meaningfully into the society and the economy might lead to high unemployment, increased crime and other social ills, which could culminate in political instability (Bloom, Canning, Fink and Finlay, 2007: 4). To reap the impending benefits and to realise the potential of youth, South Africa has been successful in developing integrated and comprehensive legislation and policies aimed at protecting and promoting the rights and development prospects of young people. Despite improvements, the marginalisation of young people persists as can be seen with unemployment, poverty, often poor education, family and community disintegration, and exposure to crime and violence (Morrow et al, 2005).

Youth development in South Africa is largely guided by the National Youth Policy, which is based on a series of legislative and policy frameworks which have been implemented since 1994. These include: the National Youth Commission Act, 1996; the White Paper for Social Welfare, 1997; the National Youth Policy (updated at five year intervals); the National Youth Development Policy Framework, 2000 – 2007; and the current (Draft) National Youth Policy 2015 – 2020 (2015).

The youth is however not a homogenous group – in fact their experiences can be characterised as 'diverse and at times paradoxical' (Morrow, 2005). The group is therefore often segmented further by age cohort and other characteristics such as sex and population group. The National Youth Policy identifies priority target groups and argues that immediate attention should be given to young women, youth with disabilities, unemployed youth,

school-age out-of-school youth and youth at risk. For purpose of comparison, the age cohort is segmented into the age group 15 – 24 and 25 – 34 years. The National Youth Policy 2009 – 2014 prioritises four policy imperatives, namely education, health and wellbeing, economic participation, and social cohesion.

11.2 Youth demographics

Census 2011 shows that the proportion of youth (14 – 35 years) to the total population has remained stable at 40% between 2002 and 2011. However, the proportion of the economically active age group to the total population has increased from 61.3% to 64.7% in 2011. The proportion of the elderly (60 years plus) has also increased from 7.3% in 2001 to 8.0% in 2011. The Age Dependency Ratio of South Africa has declined from 64.4 per 100 to 58.7 per 100 in 2001, reaching 52.7 per 100 in 2011, mainly as a result of the increased economically active age group.

African youth constituted 83.2% of South Africa's youth population and comprised the majority of youth in all provinces except for the Western Cape, where about half (52,3%) of the youth were coloured. Most of the youth in South Africa lived in the two most populous provinces, namely KwaZulu Natal (22%) and Gauteng (21%) while the smallest percentage (2.1%) was found in the province with the smallest population, namely the Northern Cape. The distribution of youth across provinces is very similar to the distribution of the general population.

Households headed by youth in the age category 15 - 24 years have been around 6% to 7% between 2002 and 2009, whilst households headed by youth between 25 – 34 years has slightly decreased from 23.1% in 2002 to 21.8% in 2009.

Vulnerability to poverty is a cause for concern as the number of young people reporting hunger showed an increase from 15.7% in 2007 to 26.6% in 2009. This is linked to limited opportunities for young people to make a living. Interventions in this regard should be holistic and should improve the ability of young people to access livelihood opportunities.

11.3 Education

Educational attainment is a critical determinant of young people's future work prospects, earnings and contributions to society (Nugent, 2006). Passing the national senior certification examination or 'matric' as it is known in South Africa, has become the minimum requirement for a better future for many young people and their families, who struggle at great expense to obtain this qualification. Due to various social and political reasons, this key to a better life becomes more elusive if learners do not succeed at their first attempt. Secondary education serves as a link between schooling and work, work-preparedness and higher education. Given that labour markets, in both South Africa and the rest of the world, have become more predisposed towards skilled workers in recent decades, there has been a corresponding requirement regarding the capacity of education systems to produce larger numbers of skilled labour market entrants.

In the past 18 years, the state has taken lengthy strides in making school education more accessible to children. Evidence of increased school participation and improved secondary schooling outcomes emerges from trend studies of the senior certificate examinations, which serve as the admission requirement for enrolment in the

higher education system. The enrolment numbers for this examination have been increasing steadily, and the pass rates climbed from 47% in 1997 to 73% in 2003. In subsequent years, this figure dropped to the 60% range, but increased again to 70% in 2011 (Naidoo 2006; Department of Basic Education, 2012). Apart from a few exceptions in recent years, the number and percentage of students sitting for the senior certificate has increased.

The numbers of those who obtain a certificate that qualifies them for university admission have however remained constant, leaving a growing number of certificated individuals who have very few options to access work or further learning. Although the number of students who fail completely has been decreasing, the students who do not qualify for degree study or 'endorsements' are not significantly better off than those who fail, as further opportunities for them are limited.

Those who do not complete their senior secondary schooling or access higher education are the most vulnerable and their chances of being employed are greatly reduced. Learner retention, especially after Grade 9 and the increasing dropout rate, especially from Grade 10 through to Grade 12 pose greater challenges and concern. Completion rates of the secondary education system can be measured in two ways: either by looking at the pass rate at the end of the schooling system (Grade 12) or by looking at the survival rates of the same cohort at the end of Grade 12. In 2010 and 2011, there was a substantial increase in the number of drop-outs in Grade 12. Reasons for this have not been researched yet, but it should be a serious concern to all involved with education in the country.

Each year, just over 1.1 million children enter the education system in Grade 1 (Department of Basic Education, 2010). Yet, almost half of these learners do not reach their matriculation year. While drop-out rates up to Grade 9 were low (cumulative percentage of 13% across the grades to Grade 8 for 2007–2008), from Grade 9 onwards the percentage of learners dropping out of the system was 6.5%, 11.5% and 11.8% for Grades 9, 10 and 11 respectively (Department of Basic Education, 2010). Thus, by Grade 12 around 40% of learners have left the education system, without a matriculation certificate. Some may go on to gain a further education and training certificate, but given the challenges in this sector the numbers are small (Perold, Cloete and Papier, 2012).

Many of the problems relating to drop-out rates during the last three years of senior secondary education are rooted in the education policy shift of 1995, which was aimed at reducing the number of over-age learners in the schooling system. Its consequence was that large groups of young people, who previously would have remained in the schooling system, were pushed into the labour market with little education and few skills that matched the needs of the economy. Black schools, which had a history of higher rates of grade repetition, were disproportionately affected by this policy (Burger & Von Fintel 2010).

11.4 Youth health and wellbeing

The health of individuals is heavily affected by social determinants such as poverty, access to housing, clean water, sanitation, clean energy and food security. The health of young people is also related to their level of education and whether they were employed or not. A high percentage of those with higher education and those who are employed report that they enjoy a high degree of good health compared to those with low levels of education and who are unemployed.

HIV and Aids and its related illnesses remain amongst the major causes of death in South Africa, with a national HIV prevalence rate of 10.6% in 2011. The prevalence was higher for the youth aged 19 - 35 years than the rest of the population, with the highest prevalence being among female youth between the ages of 25 - 29 at 32.7%. For males the highest prevalence was amongst the youth between the ages of 30 - 34 years which was 25.8%. The prevalence rates shows strong age and gender dimensions, which means that the interventions aimed at dealing with the issue should take this into account. Interventions and plans should also take cognisance of the fact that people age and move to different (older) age cohorts.

The age of sexual debut seems to have lowered as implied by the numbers of 13 year olds who are reported to have had abortions. This also implies that these young people are not using protection with only 30.7% reporting to use condoms always when they have sex. Multiple concurrent partnerships seems to be prevalent amongst the youth, with about 52% of those reporting to having had sex saying that they have had more than one partner in the past three months. The interventions should not just be about the dangers of reckless sex and the use of protection, but they should also be about behaviour change, self-esteem and not succumbing to peer pressure.

Access to medical aid amongst the youth aged 15 to 34 years has been stable at an average of just over 11% from 2002 to 2009 showing a slight improvement between 2007 and 2009 to an average of about 13%. There is no disparity between young men and young women as far as access to medical aid are concerned. Access to medical aid is important in that it increases access to health facilities and it also gives those who have access to it better medical treatment.

There are high mortality levels among different youth age groups in terms of absolute numbers. The mortality rate reached the highest at ages 30 to 34. While general fertility has come down, there is an increase in the prevalence of learner pregnancies in the country. Teenage pregnancy has been associated with increased maternal and infant mortality, increased school dropouts, poor academic performance, as well as increased poverty and economic deprivation. Just over 72% of those who fell pregnant while in school dropped out without completing their matriculation. Teenagers living in non-metros are more likely to fall pregnant than those living in the metros. Substance abuse among young people in South Africa is on the rise as suggested by the numbers of youth approaching specialist treatment centres and the numbers arrested for dealing in or using such substances.

11.5 Economic participation

Economic participation is vital to eradicate poverty, but studies suggest that young people are disproportionately affected by unemployment. Young people, particularly those in the age group 15 – 24 years, as well as those with low levels of education, women and Africans tend to be the worst affected.

Only about 41% of the adult population (aged 15 – 64 years) is employed or self-employed in the formal or informal sector. The dependency ratio (the number of people depending on one wage earner) is very high at 3.9 (National Planning Commission, 2010). This means that each employed person supports four other people. Because of the high dependency ratio, the majority of working people live near or below the poverty line of R419 per person per month.

Generally, youth unemployment levels are determined by several factors such as a lack of work experience; insufficient entry-level jobs to match the number of entrants; a mismatch of available jobs to the skills of the available entrants; and a disconnect between education and the labour market (Moleke, (2012). Youth in South Africa however, are not only hard to employ, the majority are economically inactive.

Using South Africa's official definition of youth (young people aged 15 - 34 years), the youth unemployment rate was about 34.5% in December 2010, comprising about 71% of overall unemployment. The unemployment rate for youth aged between 15 - 24 years old increased from 32.7% in 2008 to 36.1% in 2014 (Statistics South Africa, 2014). Young African people are most affected by unemployment. In 2009, 53.4% of African youth between the ages of 15 - 24 years were unemployed, compared to 14.5% of white youth (Organisation for Economic Co-operation and Development, 2010). Unemployment edged closer to 25.5% during the third quarter of 2012 and most worrying is that 71% of the working age unemployed are 35 years and younger.

What makes this situation especially unfortunate is the fact that from a demographic perspective South Africa will never have a better opportunity to eradicate its developmental deficits. The country is experiencing a 'youth bulge', which means that the proportion of young working-age people is high in comparison to the very old or the very young, i.e. those not of working age. Unemployment among young people is particularly high and more worryingly, the labour force participation is particularly low. The National Treasury (2011) estimates that only one in eight working-age adults under 25 years of age has a job. Again Africans, women, the unskilled and those in rural areas are the most likely to be unemployed. Statistics South Africa's Labour Force Survey (2014), show that approximately 3.3 million of the 10.4 million youth aged 15 – 24 years were not in employment, education or training.

A number of factors conspired to keep youth unemployment at its current levels. Firstly, economic growth has been outpaced by the growth of the labour market. While the economy expanded at an annual average of 3.2% between 1993 and 2012, it could not keep up with the rate at which new entrants added to the size of the labour force. Secondly, job entrants are not sufficiently prepared to be competitive for a global labour market. Also, while job opportunities for those with lower qualifications have decreased, demand in high skill sectors such as finance and business services have continued to increase.

11.6 Social cohesion

The number of young people registering to vote has been declining since 1999. The dwindling participation by young people in elections could weaken South Africa's democracy in the long run. It is important that a culture of civic participation is entrenched.

The high levels of poverty and inequality are a threat to long term social cohesion and civic participation. Young people have limited opportunities to improve their chances of participating in the economy. Issues of social cohesion could become secondary as young people seek ways to survive. The Victims of Crime Survey (Statistics South Africa, 2011 in Department of Social Development, 2012) shows housebreaking as the most common crime experienced by 4.5% of households at least once in 2010, followed by home robbery (2.6%). For individuals, the most common crime was assault (1.7%), followed by carjacking (1.6%). Research also shows that the majority of people involved in these types of crime were young people. The fact that young people aged between 18 and 25 years old already make up almost a quarter of those in correctional facilities, attest to

the involvement of many youth in criminal activities. There is a need to reduce the numbers of young people who are in conflict with the law. Diversion programmes need to be increased and existing programmes should be improved to offer young people a second chance. Interventions must however be holistic and the youth should be part and parcel of decision making processes.

11.7 Conclusion and recommendations

Certain measures to address the adverse effects of poverty among youth has shown to be effective. The provision of the social security scheme, in particular, the Child Support Grant, has contributed to reducing household poverty. Youth have the same rights to sexual and reproductive health services, including HIV prevention services. This has contributed to a reduction in the HIV incidence as well as an increase in condom use.

The major challenges that confront the youth include, unemployment, education, violence, teenage pregnancy and HIV and Aids. It is imperative that integrated strategies are developed to address the needs of young people, with youth at the centre of developing those interventions. Interventions should also distinguish between the subgroups 14 - 24 and 25 - 35 as experiences and aspirations differ for individuals in these different age groups. This should include adolescent and youth friendly and appropriate health services, including sexual and reproductive health and rights (SRHR) services and facilities.

It is also vitally important that access to quality and appropriate education and training be improved in order to transform the population into a productive workforce. However in order to unlock the developmental potential of the demographic dividend, adequate and quality job opportunities need to be created as a matter of urgency.

12. Children

12. Children

The status of South Africa's children (i.e. individuals under the age of 18 years), is indicative of the extent to which the country has managed to protect and develop the human potential of children over the past decades. South Africa has ratified a number of international treaties such as the United Nations Convention of the Rights of the Child (UNCRC) and its Optional Protocols Prohibiting the Sale of Children, Child Prostitution and Pornography and on the Involvement of Children in Armed Conflict as well as the African Charter on the Rights and Welfare of the Child. These international agreements aim to ensure that the rights of children are a reality in their daily lives. The guiding principles of the UNCRC for example stipulate the following:

- All children should be entitled to basic rights without discrimination;
- The best interest of the child should be the primary concern during decision making;
- Children have the right to life, survival and development;
- The views of children must be taken into account in matters affecting them (child participation).

The Bill of Rights affords all South Africans certain basic socio economic rights, including the right to have access to health care services, social security, sufficient food and water, adequate housing as well as the right to live in a safe environment. Additional protection of children includes the right to basic nutrition, education, shelter, basic health care services, social services and protection from abuse and neglect. Some of the laws that protect children and have major implications for them include the Children's Act; the Child Justice Bill; the Child Labour Programme of Action; the Integrated National Disability Strategy and the National School Nutrition Programme.

Despite significant progress made in addressing the rights and needs of children, including progressive legislation and various programmes, South African children are still faced with formidable challenges. The majority of children continue to live in poverty and are faced with considerable inequalities that continue to inhibit their access to better life opportunities, enhanced educational levels and improved health outcomes.

12.1 Demographic characteristics of children

There were 18.5 million children in South Africa in 2011, all born since the advent of democracy. According to Census 2011, the proportion that children make up of the total population declined between 2001 and 2011 (Statistics South Africa, 2012). As expected, African children comprised 84.8% of all children, constituting the largest group in all provinces, except the Western Cape where 57.7% of children were coloured. More than four-tenths of children in South Africa were found in the two most populous provinces, namely KwaZulu Natal (22.7%) and Gauteng (18%). Only 2.3% of children resided in the Northern Cape, the least populous province.

Table 13: Sex ratio of male to female children in South Africa, 1996 - 2013

	WC	EC	NC	FS	KZN	NW	GP	MP	LP	SA
1996	1.000586	1.000586	1.003526	0.985866	0.987259	0.985912	0.979775	0.974838	0.988017	0.989869
2001	0.995928	1.003277	1.001904	1.000769	0.991457	0.991913	0.980149	0.983144	0.991228	0.992026
2007	0.995352	1.020078	1.007775	0.985363	1.006311	0.991454	0.9989	0.991338	0.999868	1.002016
2011	1.016248	1.03439	1.00982	1.00982	1.018288	1.037582	1.007436	1.00993	1.223431	1.019572
2013	1.014063	1.013247	1.01143	1.003427	1.005329	1.009222	1.005323	1.006322	1.003968	1.007557

Just below one fifth (19.1%) of all children in South Africa, representing approximately 3.6 million individuals, were orphaned. The largest percentage of orphans were found in KwaZulu Natal (26.6%), followed by the Eastern Cape (24.3%) and the Free State (23%). Less than 10% of children in the Western Cape were classified as orphans. African children were significantly more likely to be orphaned than children from any other population group. More than one fifth (21.5%) of African children were classified as orphans, compared to 8.8% of coloured, 4.5% of Indian/Asian and 2.8% of white children (Statistics South Africa, 2012).

Between 2002 and 2011, the percentage of children that lived in child headed households remained consistently below 1% of all children. Although a larger percentage of children in child headed households were orphaned compared to children in the general population, only 15.9% of those children were double orphans (i.e. lost both parents). In fact, most (59.4%) had both parents alive. The majority of children who lived in child headed households were not orphans and most had at least one parent (usually the mother) who was alive.

Meintjies and Hall (2009:102) ascribe the large percentage of paternal orphans on higher male mortality rates together with the frequent absence of fathers. The proportion of absent (living) fathers increased from 41.6% in 1996 to 47.4% in 2010. Black African children had the highest proportion of absent (living) fathers at 50.6%, followed by coloured children at 38.7%. White and Indian/Asian children had the lowest proportion at 16.9% and 13.4% respectively (Department of Social Development, 2012). A large percentage of paternal orphans are found in the three provinces that are generally considered to be migration-sending provinces, namely Kwa Zulu Natal, Eastern Cape and Limpopo.

12.2 Child poverty

Given the democratic transition 21 years ago, the expectation would have been that the opportunities afforded to the children of South Africa should be much better and more equal than those of previous generations. Yet, despite the development of an array of policies and programmes specifically aimed at improving opportunities and correcting the inequities of the past, stubbornly high rates of poverty and inequality persist and are likely to be reproduced in the next generation. The critical issue underlying child poverty is the high rate of adult unemployment and the low earnings of many who do work. According to Statistics South Africa (2012), 58% of children lived in households that were poor. Of these, 90% lived in poor households with no employed adult.

The prevalence and severity of child poverty is partly a reflection of where children live. Children tend to live in households (more than 5 members per household) that are larger than the national average (of 3.6 members). Children are also under represented in urban areas, and over represented in rural areas. These arrangements reflect historic spatial and other inequalities.

Children are also over represented in the poorest 20% of households with 43% in the poorest quintile and only 8% in the top quintile. Nearly a third of these children do not live with either of their parents, but are cared for by their extended family. This is only in small part due to orphaning; a key reason for parental absence (including of mothers) is the need to find work opportunities.

Higher rates of inequality amongst children, as the general population at large, are associated with an increase in inequality within, rather than between population groups. This however does not negate the fact that disparities in poverty rates between population groups remain pronounced. The circular relationship between poverty, educational outcomes and the labour market means that children who grow up poor are likely to become poor parents. In this way, the historic and structural patterns of poverty and inequality are reproduced. The need to interrupt this cycle is widely acknowledged by policymakers, and is one of the cornerstones of the National Planning Commission's 'Vision 2030', in which there is an explicit focus on building capabilities and substantially improve life chances.

The number and the proportion of children living in poverty (measured by per capita household income) have declined over the past decade. This drop in child poverty rates corresponds with poverty trends for the population as a whole, although poverty rates for children remain higher than those for the general population.

From a money metric perspective, the LCS 2008/2009 also shows that child poverty in South Africa is much higher than poverty among the adult or general population (Statistics South Africa, 2013:68). Overwhelmingly, African children also bear the brunt of monetary poverty. Regardless of the poverty line chosen, there were more children in poverty in female headed households than male headed households. Disaggregation by settlement type reveals that children in traditional areas had the highest incidence of poverty for all poverty lines. They were nevertheless closely followed by children in rural formal and urban informal settlements. Among provinces, Gauteng and the Western Cape had substantially lower child poverty rates than the rest of the country (Statistics South Africa, 2013:68). Children in poverty had considerably less access to basic services than the non-poor – including access to water, sanitation, refuse removal, electricity and formal housing (Statistics South Africa, 2013:68).

By all three poverty lines, child poverty was highest among children with neither parent in the household. Poverty was also much lower among children with fathers present than among children whose fathers were absent (for example, lived with mother only) (Statistics South Africa, 2013:68).

12.3 Social Assistance

Social grants, particularly the Child Support Grant (CSG) are a major contributor to the reduction of child poverty. By the end of September 2012, over 16 million grants were dispersed each month. The largest, in terms of numerical reach is the Child Support Grant, introduced in 1998 with the explicit intention of alleviating child poverty. The CSG is a monthly cash grant paid to the primary caregiver of the child. Initially targeted at children

aged six years and younger, the age threshold was gradually raised through a series of phased extensions from 2003 onwards, and by 2012, the grant was available to children up to the age of 18 years who qualify for it. The CSG accounted for 31% of all expenditure on its own and is widely recognised for improving children's access to food, education and basic services (Presidency, 2009:5; Hall, 2010:107). Two other grants, namely the Foster Care Grant and the Care Dependency Grant form part of social assistance to children.

Grants are part of a basket of services to children. Beneficiaries of the CSG are automatically entitled to school fee exemptions at fee paying schools and to free health care. Just as rights are interdependent, so are children's needs. A child for example, cannot realise her right to education if she is in poor health. Health in turn, may be adversely affected by poor nutrition, a lack of access to clean water and inadequate sanitation. It is therefore imperative to address the relationship between poor living conditions and child health outcomes.

12.4 Child survival and health

Although free health services are available to pregnant women and children under the age of six, South Africa is unlikely to meet the required health targets of the 2015 Millennium Development Goals, despite considerable progress made in this area.

Less than 13% of all children had access to medical aid in 2011, compared to about 16.1% of the total population. The asymmetrical access to quality health care is further illustrated by the different health care facilities used by the different population groups. While 86.8% of African and 68.1% of coloured child-inclusive households usually went to a public clinic or hospital first, 44.9% of Indian/Asian and only 11.2% of white child-inclusive households do so. In fact, 84.8% of white and 55% of Indian/Asian child-inclusive households make use of private health care facilities such as private doctors, clinics and hospitals first. African children were also least likely to live within 30 minutes from health care facilities. This could be attributed to the fact that many African children live in rural areas.

The health and social welfare of children is as much influenced by their access to housing and basic amenities as it is influenced by their access to health care services. Many childhood diseases are related to substandard water and sanitation, and to the health risks associated with alternative fuels. The very high child mortality rate in South Africa is the most severe consequence of poverty and inequality, and is driven partly by 'diseases of poverty' such as diarrhoea and respiratory infections. Child mortality rates definitely rose between 1996 and 2001, but there is some uncertainty around the trend since then, due to data quality issues.

Data on causes of death by Statistics South Africa reveal that, after peri-natal conditions (which accounts for a quarter of deaths in children under-five years), diarrhoea (21%) and lower respiratory infections (18%) are the leading causes of death (Nannan et al, 2012). This burden of disease, and its long term impacts on children's development and on household economics, could be significantly reduced through the provision of adequate service delivery infrastructure.

As stated, access to decent housing, safe water and sanitation are among the most important basic requirements for healthy living. There have been gradual improvements in children's access to adequate housing and services over the past decade, but coverage remains far from universal. A third of children in South Africa (around 6 million) do not have easy access to a safe and reliable water supply and 5 million do not have adequate

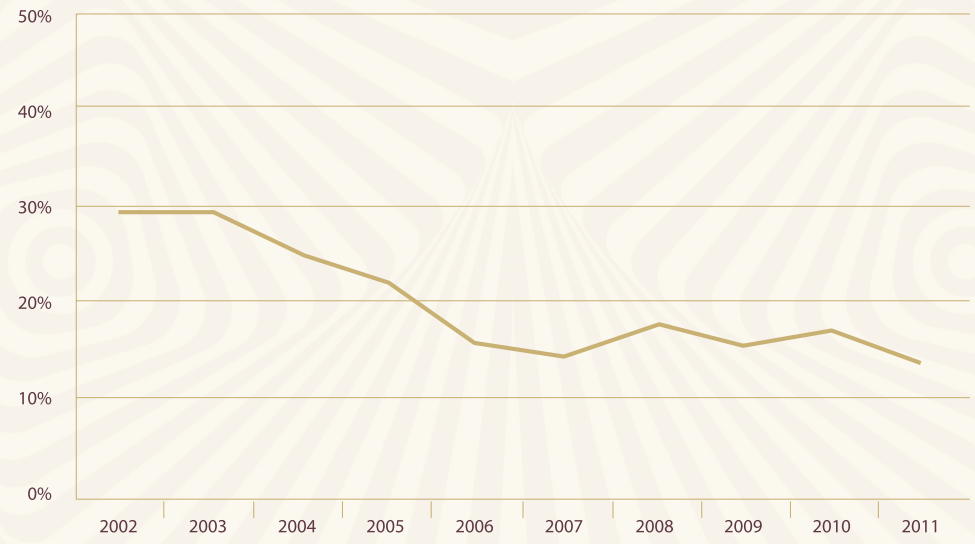
sanitation. As with many other measures of poverty, children are disproportionately worse off: they are more likely than adults to live in households without access to adequate services as most tend to live in rural areas, whereas others may reside in urban informal settlements.

12.5 Child hunger

Malnutrition is another important dimension of (chronic) poverty, linked to child survival, health outcomes and life chances. Poor nutrition is both an outcome of poverty and household food insecurity, and a contributor to intergenerational poverty. Three main anthropometric measures are commonly used to identify malnutrition in children; they are: stunting (height-for-age); underweight (weight-for-age) and wasting (weight-for-height). Stunting, which indicates prolonged malnutrition was found to be the most prevalent consequence of malnutrition among children under five. Significant differences exist in nutritional outcomes among different socio economic groups with children from the poorest and most rural provinces such as the Eastern Cape, most likely to be malnourished. The poorest 10% had rates of stunting about eight times those of the richest 10% (Zere and McIntyre, 2003).

The 2008 National Income Dynamics Study (NIDS) found similar patterns in the provincial distribution of child malnutrition. Whilst the socio economic inequalities in the distribution of stunting and underweight were still evident, they appeared to have declined considerably (May, 2012). In fact, the trend over the past decade shows a substantial drop in the number of children who go hungry 'sometimes', 'often' or 'always'. This drop can be attributed to the rapid expansion of social grants, in particular the Child Support Grant (CSG) over the last decade, which have significantly reduced hunger and malnutrition. In fact, a positive causal link between access to the CSG and children's anthropometric status has been established (Aguero, Carter and Woolard, 2007).

Figure 11: Reported Child Hunger 2002 – 2011



Katharine Hall, 2012

While the socio economic inequalities in chronic malnutrition may have declined, the disparities between rich and poor remain strong for most other non-monetary measures of poverty. In South Africa, these disparities

are also racially and geographically defined. In this way, the structural patterns of apartheid are reproduced over generations: children born into relatively wealthy households are also consistently better off in a range of other ways and, therefore, are likely to have better opportunities in life.

A number of policies are used to address inadequate household food security, including the provision of social grants, the National School Nutrition Programme, and the Integrated Food Security and Nutrition Programme (Hendricks, 2009). The five year roadmap for Nutrition for South Africa and the draft Strategic Plan for Maternal, Neonatal, Child and Women's Health (MNCWH) and Nutrition in South Africa recognises that optimal nutrition during infancy and childhood is critical to child health and development. The period during pregnancy and the child's first two years of life are considered a 'critical window of opportunity' for prevention of growth faltering. Over one third of under-five mortality is caused by under-nutrition, in which breastfeeding practices and inadequate complementary feeding play a major role.

12.6 Early Childhood Development and education

The provision of quality Early Childhood Development (ECD) can play a critical role in overcoming the effects of poverty on young children and their families. International research indicates that the early ears are critical for development, leading to higher levels of social, emotional, cognitive and physical wellbeing in young children. These in turn, translate into significant social and economic benefits to the country.

The 2000 ECD audit found 23 482 ECD sites across South Africa. Only 53% of these ECD sites had electricity, water and toilets and 8% did not have electricity, water or toilets. Forty percent of ECD centres were located in rural areas and 60% in urban areas. Only 1.36% of children with disabilities were under ECD supervision. Access to ECD services were lower than the national average in the three provinces with the greatest number of poor children – Limpopo, Eastern Cape and KwaZulu Natal. The quality of ECD training was poorest at ECD sites catering predominantly for African children. The audit showed that 88% of the 54 503 ECD practitioners required some additional training whereas 23% had no training whatsoever. A mere 12% of ECD practitioners were fully qualified.

Data from March 2012 show that 836 000 children were in 19 500 registered ECD centres nationwide with 58% of these receiving the ECD subsidy from provincial Departments of Social Development (Dlamini, 2012) and by September 2012, 767 865 children were enrolled in a Grade R class (Department of Basic Education, 2012). It is imperative that access to ECD programmes is increased, including ECD programmes that cater for the specific and unique needs of children with disabilities. It is also imperative that all ECD sites are registered and adhere to the stipulated norms and standards. The quality of ECD programmes as well as the quality of ECD teaching and the training of ECD practitioners should also be improved as a matter of urgency.

12.7 Education

The government target in Education White Paper 5 was that by the year 2010, 945 000 of all 5 year old children would have access to a Grade R year prior to entering Grade 1. Of these, 810 000 (85%) would be in public schools and 135 000 (15%) would be in independent schools and community based schools. Data from the Department of Basic Education (2012) show that at the present take-up rate, it will take at least until 2018 to reach the government target of a place in Grade R for every child before entering Grade 1.

In terms of the South African Schools Act, school attendance is compulsory for all children between the ages of 7 and 15 years or Grade 9. The percentage of children of school going age who attended any kind of educational institution remained high between 2002 and 2011, particularly for the younger ages. The percentage of children in the age group 7 to 13 years who had access to education increased from 96.6% in 2002 to about 99% in 2011. Virtually all children in this age group participated in education and it is furthermore clear that, based on the strength of a Gender Parity Index of 1, equitable access to education was achieved for boys and girls. The percentage of children between the ages of 14 and 17 who attended an educational institution increased from 91% in 2002 to 93.9% in 2011. Although the figure implies that about 6% of children in this group did not attend any institutions, it is encouraging to note that boys and girls in this age group were equally likely to attend an educational institution. Girls' participation in education improved from 90.7% in 2002 to 93.9% in 2011.

12.8 Conclusion

The Child Rights and Equity Review (2011) reveals that a child in the poorest 20% of households is two times less likely to have access to adequate sanitation and water; two times less likely to be exposed to early childhood development programmes; three times less likely to complete secondary education; seventeen times more likely to experience hunger and twenty-five times less likely to be covered by a medical scheme.

12.9 Recommendations

- Provide families, regardless of structure with parenting and relationship assistance, focusing particularly on the social and emotional side of a child's development and parental relationships;
- Encourage fathers' (especially absent living fathers) involvement in their children's upbringing.

13. Persons with Disabilities

13. Persons with Disabilities

The United Nations Convention on the Rights of Persons with Disabilities identified persons with disabilities as, *'Those who have long-term physical, mental, intellectual, or sensory impairments which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others'* (United Nations Convention on the Rights of Persons with Disabilities 2008, article1).

In South Africa, disability can be classified in six categories, namely visual, physical, hearing, emotional, and intellectual or learning and communication disabilities. Disabilities are however more than just medical conditions, but also the result of and exacerbated by social oppression and discrimination (Department of Public Service and Administration, 2001:12). Poor socio economic conditions are seen as contributing significantly to disability in developing countries, including in South Africa where persons with disabilities are disproportionately represented among the poor, as well as face stigma and discrimination (Emmett, 2006). The type and severity of the disability also has a unique impact on the ability of an individual to fully and effectively participate on an equal basis with others in society.

What cannot be disputed is the fact that persons with disabilities are among the most neglected people in society and are more likely to experience stigma and discrimination, social exclusion and negative attitudes from the wider society. Persons with disabilities have also largely been deprived of opportunities to participate in economic activities, lack access to facilities for education and health care as well as adequate home facilities.

The ICPD Programme of Action sets the following aims on how to improve the situation of persons with disabilities:

- Ensure the realization of the rights of all persons with disabilities, and their participation in all aspects of social, economic and cultural life;
- Create, improve and develop necessary conditions that will ensure equal opportunities for persons with disabilities and the valuing of their capabilities in the process of economic and social development; and
- Ensure the dignity and promote the self-reliance of persons with disabilities.

According to the 1996 population census, 2.65 million people had one or more disability, constituting 6.5% of the total population of the country. More females (6.9%) reported having a disability than males (6.1%). In South Africa, the disability prevalence rate varied widely across sex, population group, educational levels, provinces and socio-economic groups and between urban and rural populations.

Census 2001 found that people with various forms of disability accounted for 5% of the total population of the country. Africans accounted for the majority of persons with disabilities (5.2%), followed by whites (4.5%), coloureds (4.2%) and Indians/Asians (3.7%). Furthermore, African women had disproportionately higher levels of reported disabilities (5.3%) and lower education levels in comparison to other population groups in the country.

Again, Census 2001 reported that a higher percentage of persons with disabilities in South Africa lived in rural areas where access to basic services is limited. Also, one in every ten people (10.5%) with disabilities had not received any formal education; 5.2% had primary school education, 3.9% had a secondary school education and a further 3% had a higher education. Census 2001 also found that only 1% of persons with disabilities were employed.

Findings from the 2007 Community Survey seems to contradict those from the 1996 and 2001 censuses. For example, the 2007 Community Survey results showed that the total percentage of persons with disabilities in the country was 4.0%, seemingly suggesting a decrease in the percentage of persons with disabilities (from 6.5% in 1996 to 4.0% in 2007). Again, in contrast to the 1996 and 2001 censuses, the Community Survey (2007), showed that Indians/Asians constituted the highest percentage of persons with disabilities (4.6%), followed by coloureds (4.2%), then Africans (4%). White South Africans constituted the lowest percentage of persons with disabilities (3.2%). Again, in contrast to the 1996 and 2001 censuses, more males (4.2%) than females (3.7%) reported some kind of disability.

Table 14: Adapted from General Household Surveys (GHS) 2009 - 2011

CATEGORY	2009		2010		2011	
	N	%	N	%	N	%
Male	1 149 000	5.4%	1 321 000	6.1%	1 080 000	5.0%
Female	1 359 000	5.9%	1 509 000	6.5%	1 260 000	5.2%
Total	**2 508 000**	**5.7%**	**2 830 000**	**6.3%**	**2 339 000**	**5.2%**

Statistics South Africa (2009, 2010, 2011)

According to the General Household Surveys conducted in 2009, 2010 and 2011, 5.7% of the total population reported a disability with more women (5.9%) than men (5.4%) reporting a disability in 2009, whereas 6.3% of the total population reported a disability a year later in 2010, again with more women (6.5%) compared to men (6.1%) doing so. In 2011, 5.2% of the total population indicated that they had a disability, again, slightly more women (5.2%) than men (5%) reported having a disability. These figures for three consecutive years seem to either indicate a fluctuation from 5.7% to 6.3% to 5.2% or more probably the discrepancies indicate some inherent flaw with the data collection tool itself.

According to the latest report released by Statistics South Africa in 2014 on persons with disabilities, South Africa has a national disability prevalence rate of 7.5%. Provincial variations show that the Free State and Northern Cape provinces had the highest proportion of people with disabilities (11%) followed by the North West and Eastern Cape provinces (10% and 9.6% respectively). The Western Cape and Gauteng showed the lowest percentage of persons with disabilities (5%). More females (8.5%) than males (6.5%) reported having disabilities (Statistics South Africa, 2014).

The Statistics South Africa 2014 report provided statistical evidence relating to the prevalence of disability and characteristics of persons with disabilities at both the individual and household levels, based on Census 2011 data (Statistics South Africa, 2014). These results can not be compared to the results of previous censuses of 1996 and 2001 or the Community Survey of 2007 due to differences in the questions that were asked. This

report also does not include statistics on children under the age of five or on persons with psychosocial and certain neurological disabilities due to data limitations and should not be used for purposes of describing the overall disability prevalence or profile of persons with disabilities in South Africa.

Given the discrepancies above, it is impossible to draw inferences about persons with disabilities or adequately plan for their specific and unique needs. These discrepancies can be ascribed to the fact that the contents of census questions on disability were replaced by general health and functioning questions. The change in questions on disability thus makes the 2011 data on disability incomparable with the data on disability gathered from the 1996 and 2001 censuses. Irrespective of the discrepancies in the above surveys, what is clear is that persons with disabilities account for a significant proportion of the total population. It would also seem that women, rural people and the poor are disproportionately represented among those with disabilities.

13.1 Persons with disabilities in the workforce

According to the Commission on Employment Equity (CEE) Report (2012), persons with disabilities make up 0.84% of the total workforce in South Africa with slightly more persons with disabilities employed in the private sector (0.90%) than government (0.61%).

Table 15: Analysis of employment status of persons with disabilities, in different sectors

SECTOR	TOTAL WORKFORCE	NO OF PWDs EMPLOYED	% PEOPLES WITH DISABILITIES EMPLOYED
Government	1 061 809	6 516	0. 61%
Private	4 113 051	37 052	0.90 %
Total	**5 174 860**	**43 568**	**0.84 %**

Commission on Employment Equity (CEE) Report, 2012

According to the Department of Labour (2013) however, persons with disabilities accounted for 1.4% of the workforce in 2012, up from 1% in 2002 – showing a minuscule increase of 0.4% over a decade.

13.2 Access to health services

Despite the White Paper on an Integrated National Disability Strategy (Office of the Deputy President 1997:25) stating that *"appropriate, accessible and affordable health services and equal opportunities must be provided for persons with disabilities"*, which invariably includes access to sexual and reproductive health and rights services, persons with disabilities are among the most likely to be exposed to HIV (UNAids, 2012). Many interventions around the prevention, care, support and mitigation for HIV and Aids do not cater for the different, unique and specific needs and expectations when it concerns the sexual and reproductive health care services, facilities and rights of persons with disabilities. This is because it is commonly assumed that persons with disabilities are not sexually active or are asexual and therefore not at risk of sexual and reproductive ill-health, including HIV infections. This is however not the case and it has been reported that persons with disabilities are at a higher risk of sexual exploitation and rape, thus placing them at great risk of contracting sexually transmitted infections (STIs) including HIV. The HIV prevalence amongst the most vulnerable groups in South Africa attest

to this with 14.1% of people with disability being HIV positive whereas the HIV prevalence rate for the country was approximately 10.6% in 2011 (HSRC, 2008; Statistics South Africa, 2011).

The attitudes of health care providers have also been cited as a barrier to accessing sexual and reproductive health services. The combination of poverty and disability can also make it very difficult to access health care. For example, access to health care services including sexual and reproductive health services is difficult for persons with disabilities as it is often compounded by having to travel long distances to the nearest health facility whilst lacking disability-friendly public transport.

13.3 Challenges

Statistics on disability is for the most part fragmented and often anecdotal in South Africa. This lack of reliable and accurate statistics is attributed to a number of factors namely, different definitions of disability and the different methods used to collect data on disability (Office of the Deputy President 1997).

Though incomparable, the statistics show that persons with disabilities constitute a significant proportion of the population of South Africa. Persons with disabilities are among the most marginalized and vulnerable groups in many societies regardless of whether they are rich or poor. A person with a disability from a poor socio-economic background invariably faces more challenges than their wealthy counterparts as they lack resources to ameliorate their circumstances. The unreliability of information on disability prevalence in the country impacts adversely on the planning for the provision of services to persons with disabilities as well as the creation of an enabling environment for the equalisation of opportunities.

13.4 Recommendations

- Ensure reliable, up to date and accurate demographic and socio economic data on persons with disabilities;
- Continued expansion, improvement and focusing of service delivery for persons with disabilities that caters for their individual, specific and unique needs, expectations and rights, including sexual reproductive health services and facilities;
- Ensure that policies and laws that entrench the rights and dignity of persons with disabilities and their access to essential services, including education, employment, sexual and reproductive health services, etc. are implemented;
- Initiate and implement appropriate advocacy campaigns to address negative attitudes and discrimination and stigma against persons with disabilities;
- The Department of Social Development should take the lead in terms of coordinating as well as facilitating the implementation of various strategies, policies and programmes that address the needs and expectations of persons with disabilities; and crucially,
- Persons with disabilities should be central in all of the above decision making processes.

14. Conclusion and recommendations

14. Conclusion and recommendations

South Africa continues to make progress in achieving the objectives of the *ICPD Programme of Action (1994) and those espoused in the White Paper on Population Policy for South Africa* (1998). The country's continued efforts to systematically integrate population matters into development policies and plans, as well as following a coordinated, multi-sectoral, interdisciplinary and integrated approach since the adoption of the population policy paid dividends to some extent as many of the identified concerns have been addressed, albeit it with varied levels of success. Despite progress made, a myriad problems still exist, which require even more concerted efforts from all involved.

Given the country's highly inequitable and race-based planning and development under apartheid, poverty alleviation was identified as the cornerstone of the democratic government's development agenda – as it remains to this day. The myriad poverty alleviation programmes addressing income, human capital and asset poverty resulted in more South Africans today having access to some form of household income, even if only in the form of a social grant, formal housing, piped water, electricity and decent sanitation. Overall South Africans are enjoying a higher standard of life, particularly in formal urban areas. Annual household income more than doubled from R48 385 to R103 204 (in nominal terms), an increase of 113% since 2001. Asset and human capital poverty also decreased significantly with 85% of households having electricity for lighting in 2011, up from 58% in 1996. The vast majority (73.4%) of South African households also have piped water inside the dwelling or yard – unfortunately the provision of flush toilets has not been so prolific, only increasing from 50% in 1996 to 57% in 2011.

Despite the positive effect of poverty alleviation and service delivery programmes, severe disparities based on sex, population group, age and geographic location persist. These challenges were and are still compounded by the significant demographic, economic and environmental changes that have occurred since 1994, which continue to impact profoundly on the full attainment of the goal of the population policy to bring about changes to the determinants of the country's population trends, thus ensuring that these trends are commensurate with the achievement of sustainable human development.

The age structure of the South African population is changing with the proportion of children decreasing and the youth and working population increasing; the latter forming the largest cohort in South Africa. Despite the increase in those who are available for work (i.e. 15 – 64 age group) unemployment, particularly youth unemployment, is rife in South Africa and if this situation continues unabated, it will pose serious economic and social problems in future. Notwithstanding its youthful population, older persons make up a significant proportion of the South African population. Living conditions have improved for this age cohort, however older persons are increasingly becoming victims of violence and crime, including in their own homes – safety and security are therefore priority issues for this age group.

The demographic transition and resultant socio economic changes, pose interesting challenges and opportunities for South Africa. Migration, both internal and international as well as rapid urbanisation also offer opportunities for South Africa, which are however difficult to exploit given the lack of up to date and reliable migration data.

Many population concerns and related challenges were identified in this progress review report, and require focused attention in the current term of government. These matters, and proposed interventions, are organised into four priorities, which are discussed in more detail in the following section.

14.1 Proposed priorities for 2014 to 2019

Given existing and emerging challenges and population concerns, the proposed population policy priorities for the 2014 – 2019 term of government are:

14.1.1 Sexual and reproductive health and rights

Sexual and reproductive health and rights (SRHR) are vital to strengthening development and for poverty eradication efforts to succeed. Data show that more women are accessing reproductive health care services; women also have high levels of knowledge and access as well as usage of modern contraceptives. These factors, combined with an increase in the use of antenatal services and the use of health facilities during delivery, contributed to a reduction in illness and death among women. Improved access to SRHR services since 1998 have however been undermined by a decrease in life expectancy and increased Maternal Mortality Ratio, both linked to HIV and Aids. Widespread access to antiretroviral treatment is however starting to halt and reverse this trend. Maternal mortality however remains high, particularly maternal deaths due to non-pregnancy related infections - a trend that requires urgent attention.

HIV prevalence is higher among the youth than the national average. In particular, HIV prevalence among women aged 25 – 29 at 32.7% and men aged 30 – 34 at 25.8% is very high, mainly as a result of unsafe sex and having multiple partners. Teenage pregnancy, though declined, remains high at 56 per 1000 women aged 15 to 19 years of age. Unsafe and repeated abortions among the youth seem to be declining, but remains high. Despite having a very progressive constitution and progressive legislation, including the Termination of Pregnancy Act, the country's people remain rather conservative and patriarchal. Many women, particularly young women and teenage girls who want to terminate their pregnancies face discrimination and stigma at public health facilities, thus resorting to unsafe abortions, putting their lives at risk.

Persons with disabilities also struggle to access SRHR services as it is often assumed that they are not sexually active or are asexual. The attitude of health care providers has also been cited as a barrier to accessing sexual and reproductive services, resulting in their sexual and reproductive rights not being respected, being denied or outright ignored. It is critical that discrimination against persons with disabilities are addressed and that their sexual and reproductive rights are respected as this group is among the most likely to be exposed to HIV and other STIs as they are at a higher risk of being raped. A significant proportion (14.1%) of persons with disabilities is HIV positive. Appropriate advocacy campaigns to address negative attitudes and discrimination and stigma against persons with disabilities should be initiated and implemented. It is also imperative that persons with disabilities are afforded easily accessible and appropriate sexual and reproductive health services and facilities.

Respect for the dignity and rights of all people, irrespective of their sexual orientation should be cultivated and all SRHR services that people are entitled to, should be provided in a professional and non-judgmental fashion. The unmet need for family planning, not only through increased availability of contraception, including

emergency contraception, but also through efforts to increase female autonomy, must also be addressed as a matter of urgency. The use of dual methods of contraception, including condom use should be encouraged as this will not only contribute to preventing unwanted pregnancy, but also provide protection against contracting STIs, including HIV. A multi-sectoral approach is required to address gender based violence (GBV); political will and leadership at all levels are required to tackle this scourge on our society.

It is imperative to improve the social and economic status of women, particularly young women, in order to decrease their vulnerability and increase the ability of households, particularly vulnerable ones, to deal with the impact of HIV and Aids. It is equally important to continue the promotion of responsible, healthy reproductive lifestyles and behaviour among high risk groups and the youth. It is also important to continue to promote and encourage male involvement and responsibility in family planning, contraception usage and other SRH services.

These challenges can only be address adequately when reproductive justice is achieved for all in South Africa, particularly for (vulnerable) women. Reproductive justice can however only be realised when SRHR is an integral part of initiatives geared towards achieving gender equality, equity and the full empowerment of women. For this to happen all, but particularly the most marginalised and vulnerable, should also achieve economic and social justice, only then will they be able to make empowered, informed and responsible choices regarding their own fertility.

Given the above population concerns, **Sexual and Reproductive Health and Rights** is identified as one of the population policy priorities for the 2014 to 2019 period. Work in this priority area should pay particular attention to the sexual and reproductive health and rights of the youth and adolescents, including easy and affordable access to appropriate and youth friendly services and facilities.

14.1.2 Gender Equality, Equity and the Empowerment of Women

Gender equality, equity and the empowerment of women remains the cornerstone of the ICPD PoA and the population policy, because the issues of gender and the empowerment of women remain fundamental prerequisites for the attainment of sustainable human development. Gender mainstreaming initiatives in government programmes have contributed to an increase in, among other things, the educational level of women, their employment opportunities as well as access to social grants, free basic services and better access to sexual and reproductive health services and rights – all contributing to improving women's quality of life and that of their household members. Women's access to political power and decision making improved significantly since the 1994 elections, with women constituting 40% of Members of Parliament (National Assembly and National Council of Provinces Combined) in 2014.

Although great strides continue to be made towards achieving gender equality and equity, particularly as far as the adoption of legislation, policy and regulations are concerned, many identified gender inequalities persist and new ones are emerging. Poverty, unemployment and inequality continue to disproportionately affect women and female headed households. Unemployment is much higher among women (34.6%) than men (25.6%); labour absorption is much lower for women, particularly African women (28.8%) compared to African men (40.8%) or White women (62.5%). The higher labour absorption rate for white women compared to African men is a legacy of our racist past. Women, African women in particular, are more dependent on survivalist activities in the informal sector which results in low wages, high insecurity and increased vulnerability.

Women are also increasingly exposed to high levels of violence, including sexual violence and often at the hands of their intimate partners; thus denying many women the realisation and enjoyment of full citizenship rights as set out in the Constitution and the ICPD PoA. This undermines development efforts, and exacerbates women's vulnerabilities. Studies show that women with violent and or controlling partners are at an increasing risk of HIV infection. These women also often lack decision making power with regard to family planning and childbearing, illustrating continued inequalities in sexual and reproductive relations.

It is imperative that the implementation of gender related legislation and policies are improved. It is also important to continue with initiatives that empower women and provide them with choices through expanded access to education, health services, including SRHR services, skills development, employment and involvement in decision making at all levels.

Gender equality, equity and the empowerment of women therefore remain a population policy priority for the 2014 to 2019 period. Specific attention must be paid to combating gender based violence (GBV); and the unequal relationships between men and women which hinder the achievement of gender equality, equity and the genuine empowerment of women. Issues around family and family dynamics; gender and the environment; LGBTI and disabilities should also be scrutinised. This should be done from a reproductive justice perspective.

14.1.3 Dynamics of a changing population age structure: causes and consequences

Census 2011 found that the South African population grew from 40.6 million people in 1996 to 44.8 million people in 2001, reaching 51.8 million people in 2011. Females constituted slightly more than half (51%) of the population and males constituted 49% of the South African population. Africans constitute the largest percentage of South Africans at 79.8%. Although the population size is still growing, the population growth rate is declining – from 2.1% (1996 – 2001) to 0.61% (2007 – 2011) per annum; this decline will continue. This decline is attributed to the decline in the Total Fertility Rate (TFR) of the country. TFR declined from 2.9 in 1998 to 2.35 in 2011. The impact of HIV and Aids also contributed to the decline in the population growth rate.

South Africa is a relatively youthful population, but is showing signs of maturing as indicated by the increase in the median age from 22 years in 1996 to 25 years in 2011. The proportion of the South African population that is younger than 15 years declined from 34.3% in 1996 to 32.1% in 2001, reaching 29.2% in 2011. The proportion of the population between the ages of 14 to 35 (i.e. the youth) has increased from 36. 7% in 1996 to 37.6% in 2011 whereas the proportion between the ages of 15 and 64 (i.e. economically active population) increased from 60.8% in 1996 to 63% in 2001, reaching 65.5% in 2011. The proportion older than 60 years increased

from 7.0% in 1996 to 8.0% in 2011, and those older than 65 years increased from 4.8% to 5.3%. Although the living conditions of older persons improved markedly, many are victims of physical and sexual violence, including in their own homes. The age dependency ratio declined from 64.4 per 100 to 52.7 per 100. Despite this, unemployment is rife among those available for work, particularly among young South Africans; posing serious economic and social problems for the country.

More than two-thirds of the South African population are younger than 35 years old, making these age groups (children and youth) critical for the country's continued development and demographic evolution as they represent new entrants to the labour market and will serve as the basis for future demographic growth. Access to quality education and skills development, quality and affordable health services, including modern sexual and reproductive services and facilities, as well as access to decent employment opportunities are therefore crucial to reaping the so-called 'demographic dividend'. The state of the youth and children in South Africa is however precarious.

Despite significant progress made in addressing the rights and needs of children, the majority of children (58%) continue to live in poverty and are faced with considerable inequalities that continue to inhibit their access to better life opportunities, enhanced educational levels and improved health outcomes. There is a link between poverty, health, education and living conditions – for example, many childhood diseases are related to substandard water and sanitation and or a lack of nutritious food. Diarrhoea accounts for 21% of deaths for children under-5 years. Malnutrition, especially stunting is also a serious health risk for vulnerable and poor children. The circular relationship between poverty, educational outcomes and the labour market also means that children who grow up poor are likely to become poor parents in return.

Persons with disabilities constitute 7.5% of the total population, but constitute only 1.4% of the workforce. Persons with disabilities are disproportionately represented among the poor and are likely to reside in rural areas. They are also among the most marginalised and neglected and likely to experience discrimination and stigma. They are largely deprived of opportunities to participate in economic activities, lack access to health and education facilities as well as adequate home facilities. Statistics on disabilities are often fragmented and anecdotal given the different definitions of disability and the different methods of data collection. It is therefore important to ensure that reliable and accurate demographic and socio economic data on persons with disabilities are collected. It is also important to ensure that policies and laws that entrench the rights of persons with disabilities and their access to essential services, including education, employment and SRHR services are implemented.

As stated, the changing demography of South Africa and the resultant socio economic changes pose interesting challenges and opportunities for the country, and should be a population policy priority for the 2014 to 2019 period. **The Dynamics of a changing population age structure: causes and consequences** population policy priority will particularly highlight the causes and consequences of a changing population age structure, including for children and the youth; population concerns affecting people with disabilities as well as the lack of reliable demographic data concerning this group; the growing proportion of older persons; the impact of HIV and Aids; the increase in the proportion of those available for work (i.e. 15 – 64) juxtaposed with the unavailability of work and subsequent consequences, particularly as far as the realisation of the demographic dividend is concerned; as well as fertility and mortality trends.

14.1.4 Migration and Urbanisation

The spatial distribution of the South African population is still reflective of apartheid planning. Internal migration is still mostly from largely under developed rural areas to the more industrial and urbanised areas. South African cities and towns offer a wider range of opportunities, including better employment opportunities. The majority (62%) of the South African population thus reside in urban areas. Gauteng which has the largest share of the population (24%) is also the largest (34%) recipient of migrants. Only 56% of people in Gauteng were born there. International migrants make up 4% of the population.

Challenges caused by rapid urbanisation include among others, insufficient services and infrastructure for the growing urban population, which contribute to a lack of formal housing and basic services (i.e. water, sanitation), resulting in an increase in homelessness and the expansion of informal settlements; limited economic opportunities, and increased urban poverty and a widening of the gap between the rich and poor; a shortage of health and educational facilities and an increase in crime.

Given the lack of opportunities and development in rural areas, rural households are still greatly dependent on remittances and social grants. What is required is a comprehensive rural policy that ensures that rural dwellers are not locked into poverty and that their life chances are improved. A comprehensive urban development policy is also needed to address rapid urbanisation and resultant challenges.

High levels of especially internal migration and rapid urbanisation makes it imperative that migration be mainstreamed into development planning. It is equally important that the challenges and opportunities posed by migration form part of sectoral strategies (e.g. education, health, environment, housing and employment). Issues such as the rights, dignity and security of international migrants, including access to SRHR services and protection against xenophobic and criminal attacks should also enjoy attention as per our constitutional obligations. Social cohesion initiatives should among other things, cultivate mutual respect between nationals and non-nationals. Interventions are required at all levels, particularly the local level. Given the lack of reliable data, it is imperative that the availability of demographic information on migration on all levels is improved. Data collection, coordination and analysis of migration data as well as the capacity of planners and implementers, especially at local level need to be improved as well.

The Migration and Urbanisation population policy priority will therefore pay special attention to population concerns pertaining to international migration, internal migration and rapid urbanisation as well as the challenges and opportunities these pose for South Africa. The lack of migration and demographic data, the capacity of government, particularly at the local level, to integrate migration into planning which has implications for service delivery, must also be addressed.

15. Reference List

15. Reference list

1. Actuarial Society of South Africa (ASSA). (2011). ASSA AIDS and Demographic Model, 2011: Fast Facts: education, entrepreneurship, and economic growth: the three Es of real empowerment, Racial transformation. http://www.nasho.org.za/wp-content/uploads/2013/09/September_Fast_Facts_2013.pdf accessed on (01.08.2014).
2. Aguero, M., Jorge, M., Carter and Woolard, I., (2007). The Impact of Unconditional Cash Transfers on Nutrition: The South African Child Support Grant. working paper series number 06/08,University of Cape Town
3. Altman, M., Hart., T.G.B., and Jacobs, P.T., (2009). Household food security status in South Africa. Agrekon, 48(4): 345-361 available at http://www.tandfonline.com/doi/pdf/10.1080/03031853.2009.9523831.
4. Amoateng, Y., Heaton, T., and Kalule-Sabiti, I., (2007). Living arrangements in South Africa. cited in: Amoateng, Y., and Heaton, T,. (eds) Families and households in Post-Apartheid South Africa: Socio-Demographic perspectives. Pretoria: HSRC
5. Bloom, E., Canning, D., and Sevilla, j., (2003).The Demographic Dividend: A New Perspective on the Economic Consequences of Population Change. Santa Monica: RAND
6. Bradshaw, D., Dorrington, R.E., and Laubsher, R., (2014). Rapid mortality Surveillance report 2012. Capetown, South African Medical Research Council.ISBN:978-1920618-19-3.
7. Burger, R., Van der Berg, S., and Von Fintel, D., (2010). The unintended consequences of education policies on South African participation and unemployment available at http://www.econrsa.org/publications/working-papers/unintended-consequences-education-policies-south-african-participation. Accessed on (11.08.2015)
8. Commission of Employment Equity (CEE) report. (2011). Department of Labour. Available at http://www.workinfo.com/Articles/34394_cee_annual_report_2011a.pdf Accessed on (01.08.2014)
9. Commission of Employment Equity (CEE) report, . 2012). Department of Labour. Available at http://www.labour.gov.za/DOL/downloads/documents/annual-reports/employment-equity/2011-2012/12th%20CEE%20Report.2012.pdf . Accessed on (01.08.2014)
10. Community Survey. (2007). Statistics South Africa. Available at www.statssa.co.za/ accessed on (01.08.2014)
11. Department of Basic Education and Department of Statistics South Africa. (2011).Census 2011 Statistical release – P0301.4 www.statssa.co.za/ accessed on (01.08.2014)
12. Department of Energy. (2012). A survey of energy-related behavior and perceptions in South Africa. The Residential Sector. 2012.
13. Department of Environmental Affairs. (2013). 2012 South African Environmental Outlook: Chapter 3: What's affecting our environment? Draft 2: 18 January 2013.
14. Department of Environmental Affairs. (2013). 2012 South African Environmental Outlook: Chapter 2: Sustainability in South Africa: Draft 1: 31 October 2012.
15. Department of Health. (2010). Unmet need for family planning available at http://www.rmchsa.org/wp-content/uploads/2013/08/Fact-sheet-Status-of-Family-Planning-in-South-Africa.pdf accessed on (01.08.2014)
16. Department of Health. (2012). National Contraception and Fertility Planning Policy and Service Delivery Guidelines: A companion to the National Contraception Clinical Guidelines. Department of Health,

Republic of South Africa 2012. Accessed from www.doh.gov.za. on (01.08.2014)

17. Department of Public Service and Administration. (2006). The Job Access Strategy framework. 2006-2010 available at http://www.dpsa.gov.za/dpsa2g/documents/ee/JobACCESS_2006_2010_Strategic_Framework.pdf accessed on (01.08.2014)
18. Department of Public Service and Administration. (2002). Report on disability equity in the South African Public Service. South Africa: DPSA.
19. Department of Social Development, (1998). Population Policy for South Africa. Pretoria: Republic of South Africa.
20. Department of Social Development, South African Social Security Agency and United Nations Children's Fund, (2012). The South African Child Support Grant Impact: Assessment Evidence from a survey of children, adolescents and their households. Pretoria: UNICEF South Africa
21. Department of Social Development. (2010). Progress review of the implementation of the White Paper on Population Policy for South Africa (1998) and the ICPD Programme of Action (1994). March 2010.
22. Department of Social Development. (2012). White Paper on Families in South Africa. Available at http://www.dsd.gov.za/index2.php?option=com_docmanandtask=doc_viewandgid=370andItemid=3 accessed (10.08.2015)
23. District Health Information System (DHIS) and National Health Laboratory Services cited in: Statistics South Africa and United Nations Development Programme., (2010). 'Millennium Development Goals: Country Report 2010'. Statistics South Africa: Pretoria
24. Dlamini, B., (2012). Keynote address at the Early Childhood Development Conference, East London, 27 March. Available at :http://www.dsd.gov.za/index.php?option=com_contentandtask=viewandid=389andItemid=82. accessed on (10.08.2015)
25. Dlamini, B., (2014). Address by Minister Bathabile Dlamini, Minister of Social Development at the IPAS 20 year review conference of the TOP Act, 10 June 2014. Kempton Park: South Africa
26. Donald, B.,Holsinger, D., and Cowell, R., (2000). Positioning Secondary school education in developing countries: International institute for educational planning visit www.unisco.org/iipe, accessed on (01.08.2014)
27. Draft, I.Y.D.S., (2012). National Youth Development Agency, Population and Demographic Outlook of Youth, chapter1, No.35146. Johannesburg: South Africa
28. Emmett, T., (2006). Disability, Poverty, Gender and Race in Watermeyer, B.,cited in: Swartz, L., Lorenzo, T., Schneider, M. and Priestly, M. (Eds.) .2006. Disability and Social Change – A South Africa Agenda. Cape Town: HSRC Press
29. Hall, K., (2012). Review | Breaking the cycle of intergenerational poverty. Quintile distributions of households, adults and children statistics South Africa 2011. Available on http://transformationaudit.org/blog/wp-content/uploads/2013/02/Review%20Breaking%20the%20cycle%20of%20intergenerational%20poverty.pdf accessed on ((01.08.2014)
30. Hall, K., (2012). Review | Breaking the cycle of intergenerational poverty, Children access to an adequate standard of living statistics South Africa 2011, available at http://transformationaudit.org/blog/wp-content/uploads/2013/02/Review%20Breaking%20the%20cycle%20of%20intergenerational%20poverty.pdf accessed on ((01.08.2014)
31. Hall, K., (2012).Review | breaking the cycle of intergenerational poverty: Income poverty trend for children in South Africa, 2003–2011, statistics South Africa. available on http://transformationaudit.org/blog/wp-content/uploads/2013/02/Review%20Breaking%20the%20cycle%20of%20intergenerational%20poverty.pdf accessed on ((01.08.2014)

32. Hendricks and Bourne, L., (2010) An integrated approach to malnutrition in childhood. Cited In: Kibel, M, Lake, L, Pendlebury, S and Smith, C (eds).South Africa child gauge 2009/10. Cape Town: Children's Institute, University of Cape Town.
33. Holborn. L., and Eddy, G., (2011). First steps to healing the South African family. Johannesburg: South African Institute of Race Relations. Available on http://irr.org.za/reports-and-publications/occasional-reports/files/first-steps-to-healing-the-south-african-family-final-report-mar-2011.pdf accessed on ((01.08.2014)
34. Jewkes, Rache, l. K., Dunkle, Kristin, Nduna, Mzikazi., and Shai, Nwabisa. (2010). Intimate Partner Violence, Relationship Power Inequity, and Incidence of HIV Infection in Young Women in South Africa: A Cohort Study," The Lancet 376, no. 9734 (2010): 41-48
35. Kok, P., and Collinson, M., (2006). Migration and urbanization in South Africa. Report 03-04-02, Pretoria: Statistics South Africa.
36. Levy, F., and Murnane R., (2004).The New Division of Labor: How computers are creating the next job market. Princeton University Press
37. Mabizela, S., (2009) Speech: The Role of Higher Education in Society: Valuing Higher Education. Rhodes University Cape Town available at https://www.ru.ac.za/vice-chancellor/speechespresentations/name_58754_en.html accessed on (01.08.2014)
38. McDaid, L., (2014). The Health Impact of Coal The responsibility that coal-fired power stations bear for ambient air quality associated health impacts available at http://www.groundwork.org.za/special-reports/groundWork%20The%20Health%20Impact%20of%20Coal%20final%2020%20May%202014.pdf accessed (01.08.2015)
39. Medical Research Council, (2009). Every Eight Hours: Intimate femicide in South Africa 10 years later! Available on http://www.mrc.ac.za/policybriefs/everyeighthours.pdf accessed (11 April 2015)
40. Medical Research Council. (2008). Umthente Uhlaba Usamila: The Second South African National Youth Risk Behaviour Survey, Pretoria
41. Minister of Water Affairs and Forestry, South Arica National Sanitation Policy and National Sanitation Task Team, (1996). Mpumalanga http://www.dwaf.gov.za/Documents/Policies/National%20Sanitation%20Policy. pdf accessed (01.08.2014)
42. Moleke, P., (2010). Employment Experiences of Graduates: Employment and Economic Policy Research. Pretoria: HSRC
43. National Depart0ment of Transport. 2002. 2002 – 2007 National Land Transport Strategic Framework. 2nd Draft. Pretoria: National Department of Transport.
44. National Treasury. (2011). Estimates of National Expenditure 2011. Available at http://www.treasury.gov.za/documents/national%20budget/2011/ene/FullENE.pdf accessed (24 May 2011).
45. NEPI. (1992). National Education Policy Investigation: chapter 8 Curriculum. Cape Town: Oxford University Press/NECC
46. Office of the Deputy President. 1997. White paper on an integrated national disability available at http://www.gov.za/sites/www.gov.za/files/disability_2.pdf Accessed (01.08.2014).
47. Palamuleni, M., Sabiti, K., and Makiwane, M., (2007). Chapter 6: Fertility and Childbearing in South Africa in HSRC (2007). Families and Households in Post-Apartheid South Africa
48. Panday, S., Makiwane, M., Ranchod, C., and Letsoalo, T., (2009). Teenage Pregnancy in South Africa with a Specific Focus on School-Going Learners Child, Youth, Family and Social Development. Human Sciences Research Council. Department of Basic Education: Pretoria
49. Perold, H. Coeto, N., and Papier, J., (2012). Shaping the future of South Africa's youth: rethinking post

school education and skill training: African Minds. Gauteng.

50. Quarterly Labor Force Survey, Quarter 4 (October to December). (2012), Statistics South Africa, 5 February 2013. Available at http://www.statssa.gov.za. Accessed (01.08.2014).
51. Republic of South Africa. (2013). Millennium Development Goals: Country Report. 2013. Republic of South Africa. Available at http://www.undp.org/content/dam/undp/library/MDG/english/MDG%20Country%20Reports/South%20Africa accessed (10.08.2015)
52. Sheppard, C., (2009). The State of Youth in South Africa: Trends in Education Attainment. HSRC: Centre for Poverty, Employment Growth.
53. Shisana, O., et al., (2009). South African National HIV Prevalence, Incidence, Behavior and Communication Survey 2008: A turning among teenagers, Cape Town, South Africa, HSRC Press.
54. Shisana, O., Rehle, T., Simbayi, L C., Zuma, K., Jooste, S., Zungu, N., Labadarios, D.,and Onoya, D., (2014). South African National HIV Prevalence, Incidence and Behaviour Survey. (2012). Cape Town, HSRC Press
55. South African Demographic and Health Survey.(1998). key findings : contraceptive use available in www.mrc.ac.za/bod/dhsf1.pdf accessed (10.08.2015)
56. South African Demographic Health Survey. (2003). Injury and violence: Percentage distribution of adult men and women 15 years and over who reported being physically attacked in the last 12 months according to selected background available in http://dhsprogram.com/pubs/pdf/FR206/FR206.pdf accessed on (20. 04.2015)
57. South African Human Rights Commission and UNICEF. (2011). South Africa's Children – A Review. Available at http://www.unicef.org/southafrica/SAF_resources_factschildrens11.pdf of Equity and Child Rights accessed (10.08.2015)
58. Statistics South Africa, (2012). Census 2011 Key Results: Comparison of official and child-centred unemployment rates by province. Pretoria
59. Statistics South Africa. (1996). Household Survey. Available at http://www.statssa.gov.za/publications/LivingInSA/LivingInSA.pdf accessed on (01.08.2014)
60. Statistics South Africa. (1996). Population Census 1996. Available at http://www.statssa.gov.za accessed on (01.08.2014)
61. Statistics South Africa. (2001). Population distribution of people with disabilities. Pretoria: Government Printer.
62. Statistics South Africa. (2003). Census 2001: Census in Brief. Report No. 03-02-03 (2001). Pretoria. Available at www.statssa.gov.za accessed on (01.08.2014)
63. Statistics South Africa. (2005). Census 2001: Prevalence of disability in South Africa. Pretoria: Statistics South Africa. http://www.statssa.gov.za.
64. Statistics South Africa. (2011). Social Profile of Vulnerable Groups: 2003 – 2010. Report 03-19-00. Statistics South Africa: Pretoria.
65. Statistics South Africa. (2012). Census 2011 Key Results: Statistics South General Household Survey (2009). Pretoria
66. Statistics South Africa. (2012). Census in brief. Census 2011. Statistics South Africa: Pretoria.
67. Statistics South Africa. (2012). GHS Volume IV. Food security and agriculture 2002 – 2011: In-depth analysis of the General Household Survey data. Report No. 03-18-03 (2002 – 2011). Statistics South Africa: Pretoria.
68. Statistics South Africa. (2013). Men, Women and Children: Findings of the Living Conditions Survey, 2008/2009. Report No. 03-10-02 (2008/2009). Statistics South Africa: Pretoria.
69. Statistics South Africa. (2013). Millennium Development Goals, Country Report 2013. MDG 4: RE-

DUCE CHILD MORTALITY Available at http://www.statssa.gov.za/MDG/MDGR_2013.pdf accessed on (10.8.2015).

70. Statistics South Africa. (2013). Millennium Development Goals, Country Report 2013. MDG Goal 5: Improve Maternal Health Available at http://www.statssa.gov.za/MDG/MDGR_2013.pdf accessed on (10.8.2015)
71. Statistics South Africa. (2013). Recorded live births 2012. Median age of the mother by year of birth, South Africa: 1998–2012 available at http://beta2.statssa.gov.za/publications/P0305/P03052012.pdf accessed on (10.8.2015)
72. Statistics South Africa. (2014). Census 2011. Profile of People with Disability in South Africa. available at http://www.statssa.gov.za accessed on (10.8.2015)
73. Statistics South Africa. (2014). Mid-year Population Estimates available at http://beta2.statssa.gov.za/publications/P0302/P03022014.pdf accessed on (19.10.2014)
74. Statistics South Africa. (2014). National and Provincial Labour Market:Youth: Trends in the Working Age Population Among Youth and Adults 2008-2014. Available at http://beta2.statssa.gov.za/publications/P02114.2/P02114.22014.pdf accessed at (23.10.2014)
75. Statistics South Africa. (2014). Poverty Trends in South Africa: An examination of absolute poverty between 2006 and 2011. Statistics South Africa. Available at http://www.statssa.gov.za accessed on (01.08.2015)
76. Statistics South Africa. (2011). Mid-year Population Estimate. HIV prevalence available at http://www.statssa.gov.za/publications/p0302/p03022011.pdf accessed (19.10.2014)
77. Statistics South Africa.(2011).census 2011 Profile of older persons in South Africa available http://www.statssa.gov.za/publications/Report-03-01-60/Report-03-01-602011.pdf accessed on (08.08.2015)
78. Statistics South Africa.2013. Mortality and Causes of Death in South, 2010. Findings from Death Notification. Statistical release PO309.
79. Statutes of the Republic of South African Constitutional Law 1996.Constitution of the Republic of South Africa Act, SS. 26 - 28 No. 108 of1996chapter 2 bill of rights: Issue No 32)
80. The P presidency National Planning Commission. (2011). diagnostic overview report: Widespread poverty and extreme inequality. Available at www.gov.za/sites/www.gov.za/files/npc_diagnosstic_overview_1.pdf accessed on (10.8.2015)
81. The Presidency, Department of Provincial, Local Government and South African Cities Network. (2009). an overview of spatial trends and settlement characteristics. Available at http://www.sacities.net/images/stories/pdfs/national_overview_spatialtrends.pdf. Accessed on (20.04 2011).
82. The Presidency/National Planning Commission. National Development Plan.2013. Our future –make it work. Executive Summary. Available at: http://www.thepresidency.gov.za/MediaLib/Downloads/Home/Publications/AnnualReports/The%20Presidency%20Annual%20Report%202012-2013.pdf. Accessed on (20.04 2011).
83. The Presidency/National Youth Development Agency. (2015). Draft National Youth Policy 2015 – 2020. Pretoria
84. Udjo, E.O., (2014). Estimating demographic parameters from the 2011 South Africa population census. Supplement on Population Issues in South Africa. Vol.28. No.1. Available at: http://aps.journals.ac.za/pub/article/view/515 Accessed on (20.04 2011).
85. UNAIDS. (2012). Report on the global AIDS epidemic. Available at http://www.unaids.org/en/resources/publications/2012 Accessed on (19.03.2014)
86. United Nations Convention on the Rights of Persons with Disabilities. 2008 article1available on http://

www.paralympic.org/sites/default/files/document/120818093927291_2012_08+the+un+convention+on+rights+of+persons+with+disabilities_eng.pdf accessed 19 March 2014

87. United Nations Development Programme (UNDP). (2009). Beyond the Midpoint: Achieving the Millennium Development Goals January 2010, http://hdr.undp.org/sites/default/files/reports/269/hdr_2009_en_complete.pdf.New York, accessed (01.08.2014)
88. United Nations Population Fund (2004). Population and Development: Programme of Action adopted at the International Conference on Population and Development, Cairo, 5 – 13 September 1994. Available at: www.unfpa.org/webdav/site/global/shared/documents/publications/2004/icpd_eng.pdf Accessed on (01.08.2014)
89. United Nations Population Fund. (2005). "Reducing Poverty and Achieving the Millennium Development Goals: Arguments for Investing in Reproductive Health and Rights. UNFPA: New York.
90. World Bank Annual Report, 2011. Year in review: Chapter1, Education (See http://worldbank.org/education. Accessed on (01.08.2014)
91. World Health Organisation. 2013. Millennium Development Goals (MDGs). Fact Sheet No 290. Updated October (2013). Available at http://www.who.int/mediacentre/factsheets/fs290/en/. Accessed on (01.08.2014)
92. Xenos, P., and Kabamalam, M., (1998). The changing demographic and social profile of youth in Asia. In: East-West Centre, Asia-Pacific population research reports.
93. Zere, E., and McIntyre, D., (2003).Inequities in under-five child malnutrition in South Africa: Health Economics Unit, International Journal for Equity in Health (2)7 University of Cape Town, Cape Town, South Africa.

NOTES

RP364/2015
ISBN: 978-0-621-44133-8

DEPT: SOCIAL DEVELOPMENT
Chief Directorate: Communications
Private Bag X 901, Pretoria, 0001
134 Pretorius Street, HSRC Building, Pretoria, 0002

www.dsd.gov.za
www.population.gov.za