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Department:
Social Development
REPUBLIC OF SOUTH AFRICA

Rapid Assessment of Key Monitoring Indicators Measuring the Impact of COVID-19 Lockdown on Child Wellbeing in South Africa

Report on Key Findings

June 2021

unicef
for every child

Strategic Analytics & Management

WITS HEALTH CONSORTIUM

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Rapid Assessment of Key Monitoring Indicators Measuring the Impact of COVID-19 Lockdown on Child Wellbeing in South Africa

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with

Wits Health Consortium

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DRAFT

Contact: **Dr Rita Sonko**

TEL: +27 (12) 348 5251

88 Glenwood Road
Lynnwood Glen
Pretoria
0081

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Policy Summary

The South African Constitution, Section 28 states that every child has the right to family care or parental care or to appropriate alternative care, basic nutrition, shelter, health care and social services as well as the right to be protected from maltreatment, neglect, and abuse. To give effect to these rights of children as contained in the Constitution, appropriate laws such as the Children's Act (Act 38 of 2005 as amended by Act 41 of 2007) came into operation on 01 April 2010. The Children's Act is generally regarded as an important instrument towards the realization of children's constitutional rights. While the Department of Social Development (DSD) is the primary custodian of the Children's Act, there are sixteen National Departments and other institutions that are also obligated and involved in terms of the Act.

This rapid assessment which was commissioned by DSD in partnership with UNICEF aimed to gather evidence on the wellbeing of children with focus on the most vulnerable, to identify and provide support to those at high risk of hunger, violence, abuse and neglect and to determine the immediate impacts resulting from governments' response to the COVID-19 pandemic.

The Children's Act outlines several objectives which highlight the value of the data gathered through this rapid assessment. This data provides insights into the extent to which the following **objects of the Act** are being achieved for the most vulnerable children;

1. to promote the preservation and strengthening of families;
2. to give effect to the following constitutional rights of children, namely (i) family care or parental care or appropriate alternative care when removed from the family environment; (ii)social services; (iii) protection from maltreatment, neglect, abuse or degradation; and (iv) that the best interests of a child are of paramount importance in every matter concerning the child;
3. to give effect to the Republic's obligations concerning the well-being of children in terms of international instruments binding on the Republic (UN Convention on the Rights of the Child as well as the African Charter on the Rights and Welfare of the Child of which South Africa is a signatory)
4. to make provision for structures, services and means for promoting and monitoring the sound physical, psychological, intellectual, emotional and social development of children;
5. to strengthen and develop community structures which can assist in providing care and protection for children;
6. to protect children from discrimination, exploitation and any other physical, emotional or moral harm or hazards;
7. to provide care and protection to children who are in need of care and protection;
8. to recognise the special needs that children with disabilities may have;
9. and generally, to promote the protection, development and well-being of children.

As highlighted by Dawes (2009), September (2008), Proudlock and Jamieson (2008) the Children's Act 38 of 2005 shifted the emphasis of the previous Act, which was on statutory care, to one of prevention and early intervention. The current Act highlights the importance of services to vulnerable families and children which aim to reduce the probability of abuse and neglect and the need for statutory intervention.

The rapid assessment data which were gathered using the **Real Time Monitoring Tool**, address various key areas mentioned in in the above objects of the Act, and as such, provide essential information that should be used by DSD together with all the other relevant departments and institutions that are obligated by the Act to deliver on these mandates. In addition to the children's Act, this study is relevant to a number of other Acts and national policies for which the findings provide important insights and may be relevant in monitoring, evaluation and improvement of systems for delivering services and outcomes. The following as some of the most relevant Acts and National policies/programs

Legislative Framework

The Constitution of South Africa (Act No.108 of 1996)

Social Assistance Act, 1992 (Act 59 of 1992)

South African Social Security Agency Act, 2004 (Act 9 of 2004)

Social Assistance Act, 2004 (Act 13 of 2004)

White Paper for Social Welfare Service (1997)

The National Health Act (Act No. 63 of 2003)

The Mental Health Care Act (Act No. 17 of 2002)

National Policies and Programmes

The National Integrated Plan on Early Childhood Development (ECD)

Integrated School Health Policy and Programme

Child Support Grant (CSG)

The National Strategy for Prevention of Child Abuse, Neglect and Exploitation

National Strategic Plan on HIV, STIs and TB: 2017-2022.

National Integrated Social Protection Information System (NISPIS)

The Negotiated Service Delivery Agreement and restructuring of PHC

The Health Promoting Schools Initiative

The Youth and Adolescent Health Policy

Household and Community Component of the Integrated Management of Childhood Illness Strategy

The 2000 Dakar Framework for Action which aimed to achieve Education for All

Executive Summary

Study Aim and Objectives

The Department of Social Development of South Africa, in collaboration with UNICEF, commissioned the rapid assessment of the wellbeing of children to determine the immediate impacts resulting from governments' response to the COVID-19 pandemic, and to identify and provide support to those at high risk of hunger, violence, abuse and neglect.

The specific objectives of the rapid assessment are to: 1) Assess the state of wellbeing among children in targeted "hot spots" where available data indicates high risks to hunger, violence, abuse and neglect among children; 2) Assess the extent to which vulnerable children and families are coping with government's COVID-19 epidemic control measures and what they are doing to minimize risks of acquiring infections; 3) Assess the impact of COVID-19 lockdown on non-profit organisation (NPO) services targeting Vulnerable children; 4)Assess the state of readiness of NPOs to implement COVID-19 prevention guidelines and protocols during service delivery. 5) Gather evidence to support enhancement of local stakeholders' capacity to lead the identification and response to the immediate needs of vulnerable children and families; 6) Use findings from the assessment to inform the development and implementation of a viable response to curb the effect of COVID 19 and negative impact of infection mitigation measures on vulnerable children and families.

This report presents key findings with focus on the first two objectives which are informed by data from the wellbeing surveys conducted using the Real Time Monitoring Tool (RTMT) which is described in more details below.

Methods

Study Design: A multi-layered cross-sectional mixed method approach was employed to gather data from targeted communities across South Africa. The qualitative and quantitative research methods applied both used a descriptive study design. The purpose of descriptive research is to observe, describe and document aspects of a situation as it naturally occurs (Polit & Beck, 2004). For this rapid assessment, the descriptive methods focused on the status of children's wellbeing. We utilized the Real Time Monitoring Tool (RTMT), an electronic data collection and case management tool, to conduct the child wellbeing assessments. The descriptive methods also included the use of field workers' observations of the child's family context and environment.

Sampling: The primary target population for this study are parents / primary caregivers of vulnerable children and their children across South Africa. To be eligible for this study, participants were either parents / primary caregivers or children that are over 12 years old in vulnerable households identified in targeted wards. Identification of vulnerable households was based on information provided by DSD officials at local level together with the NPOs that are directly involved in supporting DSD's community outreach. The sampling frame included administrative variables such as province, district, sub-district, ward level and household. Data from Statistics SA showing geographic spread of vulnerable children as defined by DSD were used to determine the sample size allocation proportionately across provinces and districts. Using geographic information system data provided by the office of the Chief -Risk and Infrastructure Management at National DSD, "Hot spot wards" defined as areas with high HIV and TB burden coupled with high concentration of children receiving social grants, high incidents of reported cases of GBV using records from the call centre, and low coverage of services such as ECD centres, DSD service points and SAPs, were identified. For this study, the identified hot spot wards were the locations where data were collected from all identified vulnerable households. In each district, one cold spot was also identified and included in the sites where study participants were identified. Multi-level cluster sampling was applied as follows: Level 1 - Provinces (9); Level 2 - Districts -2 selected per province including one rural and one urban; Level 3 – Sub district -1 sub-district was selected per district – in total 18 sub-districts; Level 4- Wards -2 "hotspot" wards and 1 "cold spot" ward were randomly selected per sub-district. In total 54 wards were included in the sample. Selection of districts, sub-districts and wards was weighted based on poverty, GBV, HIV and TB burden. Within each of the selected 54 wards, NPOs/CBOs working with vulnerable children and funded by DSD were identified with support from the Provincial and District DSD officials. The NPOs provided the sampling frames comprising of all vulnerable children they supported. Data was then be collected from children and families identified from the registers of those selected NPOs. The total sample size estimate was just over 5000 children. While 5000 was the targeted sample size, the current findings report on just above 3500 children that have so far been enrolled as additional enrolments are planned. These children were enrolled in the study through support of NPOs that were identified in the selected districts and wards. Proportional distribution of the sample across districts depended on districts level variations in key indications of vulnerability among children.

Data Collection: The assessment of child wellbeing was undertaken using the Real Time Monitoring Tool (RTMT), an electronic application developed through a collaboration between DSD, UNICEF and SAM to gather information on wellbeing of children. The RTMT enables capturing of data including children's demographic information and their wellbeing related to seven domains namely education, economic strengthening, childcare and protection (including violence and abuse), health, nutrition, HIV/AIDS and psychosocial support. The application also enables creation of a care plan for individual children using the data that is gathered. Furthermore, the application is designed to capture data on children with disabilities and enables early screening and referral to specialised services. Therefore, outcome of the screening and care plan provides basis for tracking and following up of cases. The RTMT is also enabling the gathering of specific information pertaining to COVID-19 prevention and mitigation including the knowledge, attitudes and practices (KAP) by vulnerable households. The COVID-19 KAP questionnaire was developed based on the Centre for Disease Control and Prevention guideline on community acquired COVID-19 (Al-Hanawi et al., 2020; CDC, 2020).

Data Analysis: Descriptive analyses stratified by districts of demographic and other characteristics were performed to provide insights on the frequencies and percent distribution of the participants and events. Summary descriptions are provided by district, province, caregiver types, children's age groups, gender, disability, stakeholder type and other household characteristics. Descriptive measures such as mean (standard deviations), and medians (interquartile ranges) were calculated for all continuous measures. Normality assessments were conducted on continuous data prior to calculation of the descriptive measures of mean and standard deviation. Categorical variables are presented as frequencies and percentages. For nutritional status data, the World Health Organisation anthropometric calculator guidelines were used to determine weight-for-age, height-for-age and weight-for-length z-scores amongst others. Their distribution showing stunting, underweight and low BMI z-scores were determined.

All statistical analysis were conducted using STATA (StataCorp. 2015. Stata 14 Base Reference Manual. College Station, TX: Stata Press) and SAS Enterprise Guide 7.1 (SAS Institute, Cary, N.C).

Ethical Considerations: The protocol outlining the detailed research methods, tools, and ethical considerations/undertakings, was submitted to Pharma Ethics, a reputable ethics compliance committee for review and approval. Full approval was obtained for the study on 5th August 2020- Reference number 200823500. Furthermore, requests for authorisation to conduct the assessment was obtained from the different provincial Departments of Social Development (DSD). In compliance with good research practices, all participants were adequately informed of the purpose and methods of the assessment, risks and benefits of the assessment. Every individual's right to decline participation was accepted and respected without prejudice. Voluntary participation in the survey was only allowed and accepted after all participants had provided informed consent form and this had been captured on the RTMT app. Proper permissions were obtained in the form of assent from children before they participated in the assessment. This was in addition to the caregiver consent for the minor to participate in the survey. To preserve the confidentiality of personal data, privacy protections were built into the design and implementation of the study due to the sensitive nature of some of the data that were collected. The fieldworkers and the survey technical team signed a binding confidentiality clause to hold them to not disclose participants' information. This was done in compliance with the Protection of Personal Information (POPI) Act of 2013. Access to the database for the study is restricted to only authorised personnel (the database manager and analyst) and is password protected. In execution of the survey, the WHO and SA government COVID-19 guidelines of social distancing, wearing masks and sanitizing were strictly followed. All field workers were trained on these guidelines prior to engaging them in field activities.

Limitations: This survey shows high rates of vulnerability because participants were enrolled in known hotspot areas by design and were in most cases already identified vulnerable children and families supported by DSD funded NPOs. Nevertheless, these findings provide an opportunity for the government to enhance their efforts in reducing the impact of COVID-19 on vulnerable children. During implementation of study, preliminary findings on disability revealed that questions may not gather the highest quality data as they are not specific enough to exclude children who may have temporary impairments caused by ill-health. Furthermore, some forms of disability may not be captured with these questions. As such a decision was taken to revisit the questions and refine these after a consultation process with key stakeholders. Data collected using the initial phase of data collection was excluded from the analysis due to limited quality of responses. Another limitation is social desirability bias which is likely in this study especially on questions touching on sensitive topics such as violence, sexual abuse and HIV. In some cases, fieldworkers faced challenges in ensuring that older children were interviewed in private spaces away from hearing distance of caregivers. In such instances, social desirability bias may have been enhanced.

Key Findings

Demographics: After completion of data collection in 12 districts and 6 provinces, a total of 3508 children were assessed from 1921 households. Overall, just under 53 % of the children in the survey were female while males were 47% of the sample. The sample was split almost equally between males and females across age-groups with exception of the oldest age group where 57% were female compared to 43% male. 53% of children were from single Parent households and only 26% were from households with both parents. The majority (82.7%) of heads of households were female. 83% of the children in the survey receive social grants. This ranged from 72% of children in CT to 99% of those in JTG. The majority (82%) of these are Child Support Grants (CSGs) with only 3% receiving Foster Care Grants (FCGs). Cape Winelands stands out as the district where a substantive proportion (31%) of children receive FCGs while for all the other districts, this ranges from 0.4% (Harry Gwala District) to 7.2% (Nkangala District). Most HHs (70%) attained secondary or higher level of education, however this varied substantially across districts as shown the graph below. 77% of the HHs reported being unemployed, while just about one quarter reported being involved in either full time, part time, self-employment or doing piece jobs. Again, there are variations across districts in terms of opportunities for work and unemployment as is evident.

Care and Protection and Psychosocial Domains: Findings indicate varying levels of child safety concerns across districts. This is based on how safe children feel as well as their experience of violence (being hurt) at home, school or in their community. On the upper end of the scale, 30 percent of children in JTG and Francis Baard districts reported feeling unsafe, compared to 3% and 5% in Harry Gwala and Nkangala districts respectively. Children in Nkangala district reported the lowest rate experience of violence, which matches the rate reported for safety concerns. By contrast, three times more children in Harry Gwala (15%) and BCMM (20%) reported experiencing violence than those that were concerned about their safety in the same districts. These findings reveal that while in some cases children didn't feel unsafe, this didn't match their experience of violence. In most districts, children from single headed households had the highest exposure and experience of violence. This was highest in Francis Baard where 75% of the children that reporting being hurt were from single parent homes. It's interesting to note that where children have their parents as caregivers, they seem to experience higher rates of experience of violence compared to where grandparents or other family are the caregivers. This may suggest that nuclear families that have limited support for childcare may be more vulnerable to incidents of child abuse. This however needs further exploration. Sexual abuse was reported by 5% children overall. District data indicates that Cape Winelands (12%) and uMgungundlovu (10%) have the highest rates for reported sexual abuse among children. Risk of sexual abuse seems to increase with age, with 6% of the older children affected compared with 2.4% among the 10-11 years, 2% among the 6-9 years and 1.3% among those 5 years and less. These results indicate that children leaving with single parents report higher levels of worry and or anxiety. Findings indicate that some districts have high levels of adult violence that seems to be associated with high levels of worry and anxiety reported by children. In seven of the 12 districts, more than two thirds of children that reported being worried or anxious had also witnessed adult violence. Furthermore, in four of the same districts including Nkangala, Cape Town, Cape Winelands and Francis Baard, high proportions of children that reported being hurt also reported having witnessed adult violence. Findings indicate that just under 4% of children have considered taking their own lives. A number of districts had proportions above 5% of children including JTG (5.8%), Gert Sibande (6.1%), Mangaung (6.6%), Cape Winelands (7.1%) and Cape Town (8%). Analysis of data on reported suicidal ideations revealed that significant proportions reported being worried and or anxious.

Food Security and Anthropometric Assessments: From the findings, there are high levels if food insecurity with significant proportions of children reporting experiencing hunger. Overall, about 20% of children reported going to bed hungry, with district findings ranging from 3% in Frances Baard to 50% in JTG. Anthropometric findings indicate that overall, just over 11% of children were underweight, with large variations across districts ranging from 0% in Harry Gwala to 33% in JTG. The Height-for-Age data indicates that overall, nearly 50% of the children are stunted, again with large variations across districts from 16% in Cape Town to 70% in Gert Sibande. The anthropometric findings seem to align with the reporting of experience of hunger for most districts. However, finding for Frances Baard are mis-matched as they reflect very low reported rates of hunger, yet the district has high rates of underweight children (22%). The findings here indicate that among vulnerable children targeted by this study, the prevalence of malnutrition is much higher than the those among the general population of children in the same age bands. This is illustrated with data for children aged 5 years which show much higher rates of stunting (55%) and underweight (9.8%) that findings from the DHS(2016) which reported these to be 27% and 6% respectively, among a national sample of South African children. The data also seems to suggest that young children may be more affected by malnutrition.

Education and Economic Wellbeing: Findings from this study show that children and caregivers reported high rates (90%) as good/excellent school performance. There were minimal variations in this across districts, ranging from 78% in JTG to 95% in Thabo M. This was a positive finding despite the reported challenges children face in accessing resources

and educational support. Findings indicate that there were substantive reproportions of children that were not attending any form of schooling, ranging from 11% in Gert Sibande to 36% in both JTG and Francis Baard. Data for non-school /ECD attendance were analysed by age group and findings indicate that 73% of the five years and younger children were not attending school. This compares to 13% of the 6 to 9 years and 3 % for the older children. When compared with Data from Statistics SA's General Household Survey (GHS) 2019, findings suggest that school attendance rates among vulnerable children are lower than those from the general South African population. The GHS reported a 98% overall attendance rate across provinces for children between 7 and 17years. Our findings suggest that the 6-9 years age group may have a much lower attendance rate however further analysis is required in order to confirm this. Further work is also needed to determine how findings from this study compare with other for the 5year and young. Findings further revealed that only about 50% of children get assistance with schoolwork from someone at school, home or in their community. There is a wide variation across districts, with data from 4 districts (uMgungundlovu, JTG, Harry Gwala and BCM) showing that over 60% of children don't have access to schoolwork help. Furthermore, findings show that about 30% of children do have access to school stationery. District findings ranged from 13% in Cape Winelands to 51% in JTG. Findings from the assessments indicate that most children (over 70% in most districts) reported that they have access to basic needs. Since most (80%) children are accessing social grants, it's reasonable to attribute this positive finding to governments welfare support. However, there is a substantial proportion of children that are not able to access basic needs with the most affected district being JTG where 50% reported lacking access. It should be noted that in JGT, 99% of children are receiving social grants, however this is the sole income source for most (87%) families. Higher proportions of children from households with other income sources access basic needs compared to those that are solely dependent on social grants. These data seem to suggest that ability to provide basic needs is improved by having access to other income sources. The survey found that 16 % of girls report that they miss school and other important events because of lack of sanitary pads. This ranges from 32% of the girls in Thabo Mofutsanyane to 8% in Nkangala.

Health and HIV/AIDS Domains: Study findings revealed that overall, 7.4% of children were reported to have poor health, with substantial variation across districts ranging from 20% in Frances Baard to 1% in Nkangala. Data on recent illnesses show that reporting of these ranged from 12% of children in Nkangala to 42% of children in Mangaung, with the overall rate being 24%. The survey also assessed health seeking behaviours and overall, only 11% of children visited health facilities in the six months prior to the survey, yet 24% were reported ill in the month before the assessments. With exception of Nkangala, Cape Winelands and Frances Baard, all other districts had disproportionately higher percentages of children that fell ill than those that sought healthcare services. The largest difference between the two proportions were in Mangaung and JTG with 25 and 22 percentage point difference respectively. These same districts also had that highest proportions of children that fell ill in the month prior to the assessment. These findings indicate that poor health seeking is correlated with higher rates of recent illnesses. Health seeking data were analysed further to determine if there were any differences depending on caregivers, and how these vary across districts. A close look at these findings revealed that parents (single or both) seem to play a big role in health seeking, with the highest proportions of children that sought health services across most districts having parents as their caregivers. The exception to this is Nkangala district where the highest proportion of children that sought healthcare had grandparents as their caregivers. The survey revealed that overall, 48% of responds reported that they had ever tested for HIV. The reported rates of HIV testing among children varied substantially across districts and ranged from 30% in Thabo Mofutsanyane to 73% in Nkangala. On the other hand, the data gathered on HIV positive status (for those that reported to know their status) was limited and doesn't seem to correspond to what would be expected given the HIV prevalence in the different districts. Only 23 individuals were reported as HIV positive, and a total of 123 children were reported as being on ARV therapy across all districts. This may be indicative of the fear of stigma among respondents which may have contributed to under-reporting. While these findings are not sufficient to draw any meaningful insights about HIV positivity among the study respondents, they do reveal a need for more attention to issues around stigma and discrimination which may be hampering access to essential services. Only 45% of respondents reported that the child had been taught either at school or clubs, about HIV infection and how to protect themselves from getting infected. This ranged from just under 30% in Thabo Mofutsanyane to just over 60% in Nkangala. Furthermore, 38% of children reported that they had talked about HIV infection or AIDS with their parents /guardians. These results indicate a gap in creating awareness about HIV protective knowledge and risks among vulnerable children within their communities and families.

Only 4% of children reported being sexually active. This question was asked to only those that were 12years and older. This low reporting is indicative of potential social desirability bias.

COVID-19: Findings from these assessments show that while there seems to be fairly good levels of knowledge among caregivers regarding COVID prevention measures, the district variations reveal a need for more awareness targeting vulnerable households. These findings reveal that there are reasonably high levels (as shown by green shading) of

protective knowledge for COVID-19 prevention in most districts particularly on the importance of social distancing and wearing masks in public. Findings reveal a mixed picture regarding Knowledge about handwashing with soap and water, with only 4 districts showing high proportions of respondents with this knowledge. Furthermore, most respondents had limited knowledge about "avoiding crowded places" as being protective against spread of COVID-19. Two districts stand out as having very low levels of knowledge about COVID-19 prevention measures among respondents, namely JTG and Frances Baard. 87% of households reported that they had not had anyone in the household diagnosed with COVID-19. Six percent reported that at least one member of their household had been diagnosed with COVID-19, while another 6% said they were not sure. 82% of respondents reported being worried about COVID-19 and 94% said that they do talk to their children about how to prevent infections.

Conclusions

The findings of this survey should be consistently viewed with the lens of its objective to focus on the most impoverished communities in South Africa. The following conclusions are drawn from the findings of the study.

General observations: The responsibility to care for children predominately rest on single parents. There are variations in family dynamics and support structure in different districts with possible implications for wholesome childcare and protection. This supposition is illustrated in various findings and should be considering in developing community specific interventions. Most households are headed by unemployed females who predominantly depend on child support grants. The high burden of childcare on single parents may be an impediment to pursue opportunities to improve their material circumstances and possibly break the circle of poverty and impoverishment. Structured childcare programme may improve the status quo in several ways for the children, parents, and government.

Child Protection and Psychosocial Domains: A higher proportion of children feel unsafe even if they have never been hurt. This may be reflective of the internal and external environment they find themselves. The long-term psychosocial health implication of this may require attention and the integrated school health programme can be leveraged.

While our sample has a disproportionately more households with single parents, more children in households with single parents reported being hurt. This may signal the need for childcare support for single parents in the interest of both the child and the parents. Exposure to adult violence was high in most of the districts and children in most cases reported being hurt, highlighting child safety and protection issues. Sexual abuse rates are concerningly high and affects children of all ages, with risk increasing by age group.

The level of anxiety varied across the districts, but most children felt safe despite it. This may be indicative of other immediate needs in the homes and community and the need for continuous monitoring and support of structural and intermediary determinants of wellbeing. Considering our significantly higher proportion of single parent homes, they also had higher proportion of children reporting anxiety and sexual abuse.

Food Security and Anthropometric Findings: Rates of experience of hunger are concerning and vary considerably across districts. These variations are potentially due to prevailing socio-cultural, environmental, and economic dynamics. Anthropometric findings indicate that among vulnerable children targeted by this study, the prevalence of malnutrition is very high as reflected by the high proportions affected by stunting and underweight.

Education and Economic Wellbeing Domains: A concerning proportion of children of school going age are not attending school especially among the younger age groups. Special programmes to ensure greater school attendance are essential as a path to true self-reliance. High proportions of children reported having limited or no support with schoolwork and also many don't have access to stationery.

A portion of the household heads reported not being able to provide basic needs such as food, water, and clothing despite the grants. Higher proportions of children from households with other income sources access basic needs compared to those that are solely dependent on social grants. Families that reported being able to provide basic needs had higher proportions of children who attend school regularly and their daughters are less likely to miss school due to not having sanitary pads.

Health and HIV/AIDS Domains: There are varying levels of poor health among children across districts, with high rates of recent illness reported in the same districts that also had the lowest health seeking rates. Overall findings indicate high rates of recent illness reported among vulnerable children. Poor health seeking observed in some districts may indicate systemic challenges related to access to healthcare which require more investigation.

The low rates of HIV testing; low proportions of children that reported learning about HIV from school/clubs or from their parents/caregivers; as well as the low disclosure rates of HIV positive status, indicate that vulnerable children

remain at high risk of acquiring new HIV infections. These findings also indicate that HIV programs may not be effectively addressing underlying stigma and discrimination in these communities. All these are known impediments to accessing relevant support and access to care and may result in poor health outcomes among those infected or affected by HIV.

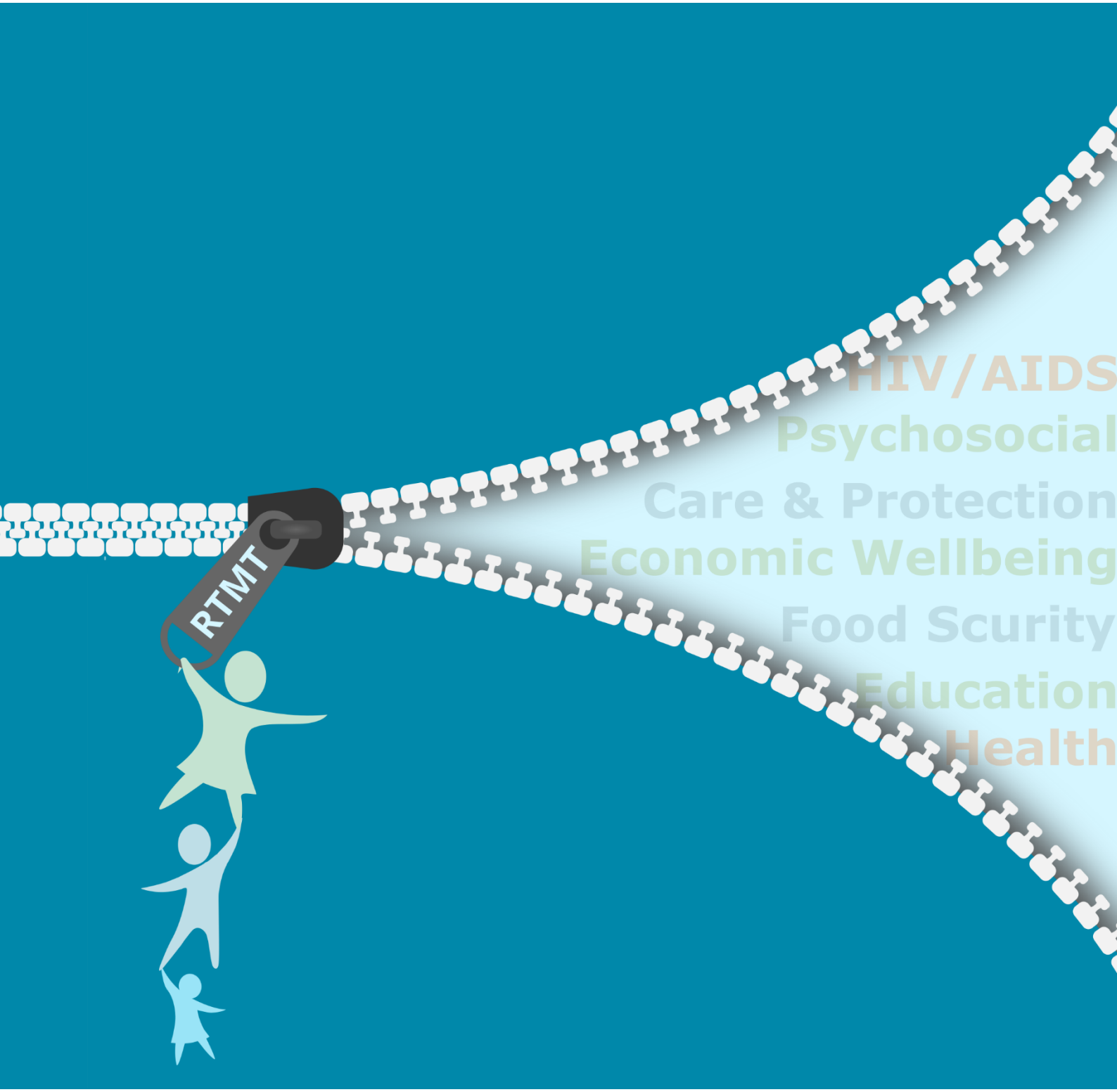
COVID-19: Unlike the situation with HIV, there are reasonably high levels of protective knowledge for COVID-19 prevention among vulnerable households in most districts. However, the mixed findings on knowledge and practices of handwashing with soap and water indicate that more efforts are needed to address these in order to abate the ongoing COVID-19 pandemic. The awareness campaigns seem to have been quite effective in getting parents to share protective knowledge about COVID-19, something that remains poor in the HIV prevention programs. Limited access to water and soap in some communities heighten risks of COVID-19 infection especially among households that report lack of basic needs.

RTMT Data Utility: Evidence from this study and the demonstrated value of the RTMT makes a strong case for institutionalising child welling monitoring including all relevant indicators, in order to inform implementation of an Integrated approach that would be required to fully respond to identified need among vulnerable children.

Recommendations

1. Strengthen systems for monitoring, evaluating and improving government programs intended to improve the wellbeing of children as mandated by the children's Act 38 of 2005 as amended by Act 41 of 2007,	by scaling up and institutionalising routine use of the Real Time Monitoring Tool at DSD service points across the country. This is a necessary step in order to provide government stakeholders at different levels (local, district, provincial and national) with immediate access to the highly valuable data as demonstrated by this study. The RTMT should be built into the routine systems for delivery of services by all NPOs supported by DSD that work with children. This will ensure that DSD service points gain a better understanding of the needs of vulnerable children in their catchment areas and as well as enhance their capability to monitor how NPOs and other actors are responding to these. The RTMT provides opportunity for DSD to implement the long overdue electronic case management system which would enable real-time tracking of how actions are implemented in response to identified needs. Furthermore, the RTMT can easily integrate with other existing government IT systems thereby providing data inputs to the Integrated Justice System (IJS) and making NISPIS a reality
2. Strengthen implementation of a multi-sectoral integrated response that addresses the needs of children as identified through the wellbeing assessments.	DSD's basic care package should be augmented through engaging other relevant departments and institutions including but not limited to Health, Education, Justice, SAPs and local municipalities, in order to streamline sharing of data about children's needs and working collaboratively to deliver efficient community driven interventions. These interventions should take into consideration the local context and address priority needs of vulnerable children and families across the domains of the wellbeing basement. Working closely with the Integrated School Health Program offers great opportunities for improving inter-sectoral coordination towards responding to needs of school going children
3. Engage broader stakeholder groups that may be required to effectively address the needs of vulnerable families that fall outside the scope of DSD.	These engagements should focus of crafting ways to strengthen systems of support and opportunities to uplift the social-economic status of women who carry the bulk of the burden of care for vulnerable children. Effectively addressing issues around food security and economic wellbeing certainly requires more stakeholders that can respond to these issues beyond what DSD can offer on its own.

4. Utilize learning gained from the effective COVID-19 awareness campaign to strengthen community outreach, awareness and participation in HIV prevention and care/support programs	including addressing stigma and discrimination. Similar efforts and support systems are required to address child protection needs, psychological wellbeing and food security
5. Invest in strengthening and testing the RTMT to collect high quality data on children with disabilities.	This will provide highly useful data on current needs for this highly vulnerable group of children, and enable development of plans that address gaps in service delivery
6. Invest in completing the outstanding components of the rapid assessment study	including data collection in outstanding provinces as well as the NPO survey and qualitative research, which together with already available data will provide a comprehensive view of the situation across country in line with the objectives of the study



1 Project Background

The Covid-19 pandemic which is affecting South Africa and the rest of the world is causing unprecedented disruption in the environments in which children grow and develop, affecting families, friendships, daily routines and the wider community. The pandemic has potential negative consequences for children's physical and psychosocial wellbeing, development and protection (The Alliance for Child Protection in Humanitarian Action, 2019). Also, measures used to prevent and control the spread such as home-based, facility-based and zonal-based quarantine and isolation exposes children to protection risks and negatively impact children and their families (Save the Children, 2018).

Food insecurity is associated with poor developmental outcomes and can cause physical and psychological harm (Golley et al., 2010; Howard, 2011; Dunn et al., 2020). Short-term consequences of missed meals include fatigue and increased risk of acquiring infectious diseases due to reduced immune response (Jacques, 2020). Undernourished children have a higher risk of mortality from conditions such as measles, malaria and pneumonia, all significant contributors to under-five mortality in Africa (Gwela et al., 2019). As we contend with Covid-19, it is crucial to ensure that the nutritional needs of vulnerable children continue to be met to avoid exacerbating disparities in health and educational attainment for years to come.

For children, stay-at-home orders mean they cannot go to school or childcare. Lack of access to Early Childhood Development (ECD) compromises the healthy developmental trajectory of many children. However, development does not pause amid all the changes to daily life; children continue to learn and grow (UNICEF, 2020). The responsibility for childcare is placed on parents and caregivers to supervise children under current pandemic context. The added burden of childcare compounded by social isolation and economic instability has created toxic home environments characterised by stress for some families (Alon et al., 2020). The initial closure of schools and childcare centres negatively impacted the provision of nurturing care essential for their physical, emotional, social and cognitive developmental needs (Martin & Sorensen, 2020). Early childhood experiences are crucial for brain development. Unsafe conditions, negative interactions and lack of educational opportunities during the early years can lead to irreversible outcomes, which can affect a child's potential for the remainder of his or her life (Van Lancker & Parolin, 2020). More than ever, it has become essential to ensure that under the current pandemic context, children have a stimulating and enriching environment, adequate nutrition, learning opportunities and social interaction with attentive caregivers (UNICEF, 2020).

The lockdown has also been associated with high incidence of violence against women and children due to high levels of anxiety and tension in households in which people are living together in the same space for prolonged periods (Usher et al., 2020; Vieira et al., 2020; Boserup et al., 2020). Unemployment, hunger, isolation and uncertainty can also be contributing factors (Li & Schwartzapfel, 2020). These are stressors that many, if not most, South African families experience. Studies on the impact of pandemics on levels of violence against women and children in South Africa are limited. The effect of the current pandemic on vulnerable children remains unknown. To our knowledge, there is currently no study of the proposed scale that has reported on the effect of the pandemic on vulnerable children in South Africa including their exposure to violence, poor health and food security.

2 Research Aim and Objectives

2.1 Study Aim

The Department of Social Development of South Africa, in collaboration with UNICEF, commissioned the rapid assessment of the wellbeing of children to determine the immediate impacts resulting from governments' response to the COVID-19 pandemic, and to identify and provide support to those at high risk of hunger, violence, abuse and neglect.

2.2 Objectives of the Study

The specific objectives of the rapid assessment are to:

1. Assess the state of wellbeing among children in targeted "hot spots" where available data indicates high risks to hunger, violence, abuse and neglect among children.
2. Assess the extent to which vulnerable children and families are coping with government's COVID-19 epidemic control measures and what they are doing to minimize risks of acquiring infections.
3. Assess the impact of COVID-19 lockdown on non-profit organisation (NPO) services targeting Vulnerable children.
4. Assess the state of readiness of NPOs to implement COVID-19 prevention guidelines and protocols during service delivery.
5. Gather evidence to support enhancement of local stakeholders' capacity to lead the identification and response to the immediate needs of vulnerable children and families.
6. Use findings from the assessment to inform the development and implementation of a viable response to curb the effect of COVID 19 and negative impact of infection mitigation measures on vulnerable children and families.

This report presents key findings with focus on the first two objectives which are informed by data from the wellbeing surveys conducted using the Real Time Monitoring Tool (RTMT) which is described in more details below.

3 Methods

3.1 Study Design

A multi-layered cross-sectional mixed method approach was employed to gather data from targeted communities across South Africa. The qualitative and quantitative research methods applied both used a descriptive study design. The purpose of descriptive research is to observe, describe and document aspects of a situation as it naturally occurs (Polit & Beck, 2004). For this rapid assessment, the descriptive methods focused on the status of children's wellbeing. We utilized the Real Time Monitoring Tool (RTMT), an electronic data collection and case management tool, to conduct the child wellbeing assessments. The descriptive methods also included the use of field workers' observations of the child's family context and environment.

3.2 Outcomes

1. **Children Outcomes:** Child wellbeing indicators; seven domains namely education, economic strengthening, childcare and protection (including violence and abuse), access to health services, nutrition, HIV/AIDS and psychosocial support. In addition, the study gathered anthropometric measurements (length-for-age, weight-for-age and BMI-for-age z-scores) and data related to coping with COVID-19.
2. **Parent / Primary Caregiver Outcomes:** responsive parenting (emotional relationship with child, caregiver child interactions, communication and stimulation), social economic status including access to government's social grants, COVID-19 support and coping mechanisms (including knowledge, attitude, and practice on COVID-19) and access to health services especially for patients on chronic treatment.

3.3 Sampling

3.3.1 Target Population and Sampling Strategy

The primary target population for this study are parents / primary caregivers of vulnerable children and their children across South Africa. The secondary target group for this study includes service providers including programme managers and frontline staff of organisations that provide services to vulnerable children. To be eligible for this study, participants were either parents / primary caregivers or children that are over 12 years old in vulnerable households identified in targeted wards. Identification of vulnerable households was based on information provided by DSD officials at local level together with the NPOs that are directly involved in supporting DSD's community outreach. Furthermore, individuals that actively participate in the provision of services within stakeholder organizations were to be also eligible to participate as key informants in the study.

The sampling frame included administrative variables such as province, district, sub-district, ward level and household. Data from Statistics SA showing geographic spread of vulnerable children as defined by DSD were used to determine the sample size allocation proportionately across provinces and districts. Using geographic information system data provided by the office of the Chief -Risk and Infrastructure Management at National DSD, "Hot spot wards" defined as areas with high HIV and TB burden coupled with high concentration of children receiving social grants, high incidents of reported cases of GBV using records from the call centre, and low coverage of services such as ECD centres, DSD service points and SAPs, were identified. For this study, the identified hot spot wards were the locations where data were collected from all identified vulnerable households. In each district, one cold spot was also identified and included in the sites where study participants were identified.

Multi-level cluster sampling was applied as follows: Level 1 - Provinces (9); Level 2 - Districts -2 selected per province including one rural and one urban; Level 3 – Sub district -1 sub-district was selected per district – in total 18 sub-districts; Level 4- Wards -2 "hotspot" wards and 1 "cold spot" ward were randomly selected per sub-district. In total 54 wards were included in the sample. Selection of districts, sub-districts and wards was weighted based on poverty, GBV, HIV and TB burden. Within each of the selected 54 wards, NPOs/CBOs working with vulnerable children and funded by DSD were identified with support from the Provincial and District DSD officials. The NPOs provided the sampling frames comprising of all vulnerable children they supported. Data was then be collected from children and families identified from the registers of those selected NPOs.

3.3.2 Sample Size

The sample size calculation was based on the assumption of an infinite population size of children, an estimated proportion of up to 50% children likely to be vulnerable, error margin of ±5%, a 95% confidence interval, an intra-class correlation coefficient (ICC) of 0.15 and a design effect of 5.5. It was further estimated that at least 36 NPOs/CBOs would be enrolled to support the identification of vulnerable children. The sample size was estimated at national level and took into consideration available data on vulnerable children including statistics of children registered to be receiving child support grants. The total sample size estimate was just over 5000 children. While 5000 was the targeted sample size, the current findings report on just above 3500 children that have so far been enrolled as additional enrolments are planned. These children were enrolled in the study through support of NPOs that were identified in the selected districts and wards. Proportional distribution of the sample across districts depended on districts level variations in key indications of vulnerability among children.

3.4 Data Collection

The assessment of child wellbeing was undertaken using the Real Time Monitoring Tool (RTMT), an electronic application developed through a collaboration between DSD, UNICEF and SAM to gather information on wellbeing of children. The RTMT enables capturing of data including children's demographic information and their wellbeing related to seven domains namely education, economic strengthening, childcare and protection (including violence and abuse), health, nutrition, HIV/AIDS and psychosocial support. The application also enables creation of a care plan for individual children using the data that is gathered. Furthermore, the application is designed to capture data on children with disabilities and enables early screening and referral to specialised services. Therefore, outcome of the screening and care plan provides basis for tracking and following up of cases. The RTMT is also enabling the gathering of specific information pertaining to COVID-19 prevention and mitigation including the knowledge, attitudes and practices (KAP)

by vulnerable households. The COVID-19 KAP questionnaire was developed based on the Centre for Disease Control and Prevention guideline on community acquired COVID-19 (Al-Hanawi et al., 2020; CDC, 2020).

In addition to the RTMT data, the study also included gathering quantitative and qualitative data from NPOs that are involved in delivery of services in the communities where the assessments of children are done. This included a survey and key informant interviews with key stakeholders involved in service delivery targeting vulnerable children. The focus of this work is to gather more insights on implementers experiences in providing services during lockdown and their knowledge, attitudes and practices related to COVID-19 disease mitigation. However, as this aspect of the study is not yet finalised, this report focuses on findings from the gathered using the RTMT.

3.5 Data Analysis

Descriptive analyses stratified by districts of demographic and other characteristics were performed to provide insights on the frequencies and percent distribution of the participants and events. Summary descriptions are provided by district, province, caregiver types, children's age groups, gender, disability, stakeholder type and other household characteristics. Descriptive measures such as mean (standard deviations), and medians (interquartile ranges) were calculated for all continuous measures. Normality assessments were conducted on continuous data prior to calculation of the descriptive measures of mean and standard deviation. Categorical variables are presented as frequencies and percentages. For nutritional status data, the World Health Organisation anthropometric calculator guidelines were used to determine weight-for-age, height-for-age and weight-for-length z-scores amongst others. Their distribution showing stunting, underweight and low BMI z-scores were determined.

All statistical analysis were conducted using STATA (StataCorp. 2015. Stata 14 Base Reference Manual. College Station, TX: Stata Press) and SAS Enterprise Guide 7.1 (SAS Institute, Cary, N.C).

3.6 Ethical Considerations

The protocol outlining the detailed research methods, tools, and ethical considerations/undertakings, was submitted to Pharma Ethics, a reputable ethics compliance committee for review and approval. Full approval was obtained for the study on 5th August 2020- Reference number 200823500. Furthermore, requests for authorisation to conduct the assessment was obtained from the different provincial Departments of Social Development (DSD). In compliance with good research practices, all participants were adequately informed of the purpose and methods of the assessment, risks and benefits of the assessment. Every individual's right to decline participation was accepted and respected without prejudice. Voluntary participation in the survey was only allowed and accepted after all participants had provided informed consent form and this had been captured on the RTMT app. Proper permissions were obtained in the form of assent from children before they participated in the assessment. This was in addition to the caregiver consent for the minor to participate in the survey.

Children have a right to equality, privacy, human dignity, safety, and freedom of expression. This assessment followed these four principles of ethics and ensured that the rights of children were adhered to. The dignity of and respect for children was always afforded to them. In this regard, the field workers were trained to collect data in an unobtrusive and sensitive manner, ensuring anonymity and confidentiality by having private interviews with the minor in a separate space that allowed for confidential discussion. The DSD-recognized NPOs participated in the data collection and were familiar with distress management protocol, support mechanisms in the community and were trained to intervene appropriately.

To preserve the confidentiality of personal data, privacy protections were built into the design and implementation of the study due to the sensitive nature of some of the data that were collected. The fieldworkers and the survey technical team signed a binding confidentiality clause to hold them to not disclose participants' information. This was done in compliance with the Protection of Personal Information (POPI) Act of 2013. Access to the database for the study is restricted to only authorised personnel (the database manager and analyst) and is password protected.

In execution of the survey, the WHO and SA government COVID-19 guidelines of social distancing, wearing masks and sanitizing were strictly followed. All field workers were trained on these guidelines prior to engaging them in field activities.

3.7 Limitations

This survey shows high rates of vulnerability because participants were enrolled in known hotspot areas by design and were in most cases already identified vulnerable children and families supported by DSD funded NPOs. Nevertheless, these findings provide an opportunity for the government to enhance their efforts in reducing the impact of COVID-19 on vulnerable children.

During implementation of study, preliminary findings on disability revealed that questions may not gather the highest quality data as they are not specific enough to exclude children who may have temporary impairments caused by ill-health. Furthermore, some forms of disability may not be captured with these questions. As such a decision was taken to revisit the questions and refine these after a consultation process with key stakeholders. Data collected using the initial phase of data collection was excluded from the analysis due to limited quality of responses.

Another limitation is social desirability bias which is likely in this study especially on questions touching on sensitive topics such as violence, sexual abuse and HIV. In some cases, fieldworkers faced challenges in ensuring that older children were interviewed in private spaces away from hearing distance of caregivers. In such instances, social desirability bias may have been enhanced.

4 Use of Data to Respond to Identified Needs of Vulnerable Children

4.1 Immediate Actions Undertaken Following Household Level Assessments

Following completion of assessments at household level, the app produced data visualizations which provided a summary of the key findings as shown in the image below. These were then used by field teams to guide the discussion with Caregivers/ parents on actions that are needed to respond to the findings.

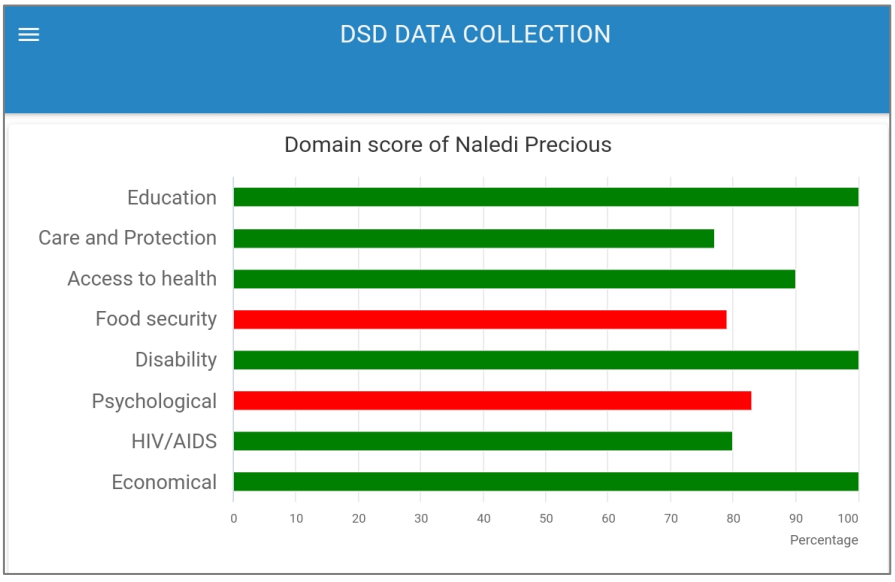


Figure 1 RTMT App Data Visualizations of the Key Findings

Actions discussed and agreed with the Caregiver/parent were captured on the app to enable documentation and follow up. In most cases where emergency needs were found, the field team immediately jumped into action by calling on help from the DSD service office managers and other relevant social service practitioners. Cases of child abuse were reported to the South African Police Services (SAPS) by the CCG working to support the affected children and their families.

4.2 Dissemination for Data Highlights Using Dashboards

Customized dashboard providing useful insights for community care providers/SSPs, NPO managers and DSD official were made available to the DSD service office managers and district officials as soon as data collection was completed. These enabled users to see key information at different levels, right from the household/child level to wards, districts and national level. Access to these dashboards during actual field work was hindered by lack of access to electronic tools by stakeholders at the ward level. Capacity strengthening needs to improve capabilities to interpret and use the data were also identified at that level as well as at district level.

4.3 Database Sharing with District and Provincial Offices

Along with sharing the dashboards, the SAM team prepared databases for each of the districts so that these could provide more detailed information on the assessments that had been done. This information was shared with each district in the form of an excel database where all variables collected in the survey were included. Providing the databases enabled the district team to implement follow-up actions for children where risks were identified. Furthermore, the data in the spreadsheet was available for uploading into available electronic databases where interventions implemented in response to finding could be captured.

4.4 Responses to findings in the field

There are numerous stories from the field about how data was used to develop immediate action plans for households and to provide support to address needs. Service office managers and social workers came on board and become really engaged in addressing emergency needs found among children and families. The one area that required more attention and resolution is standardizing systems for capturing these interventions. The SAM team found large variations in the processes, tools and skills available for enabling this to happen across sites.

5 Key Findings

5.1 Demographic characteristics of respondents

After completion of data collection in 12 districts and 6 provinces, a total of 3508 children were assessed from 1921 households. Overall, just under 53 % of the children in the survey were female while males were 47% of the sample. The sample was split almost equally between males and females across age-groups with exception of the oldest age group where 57% were female compared to 43% male.

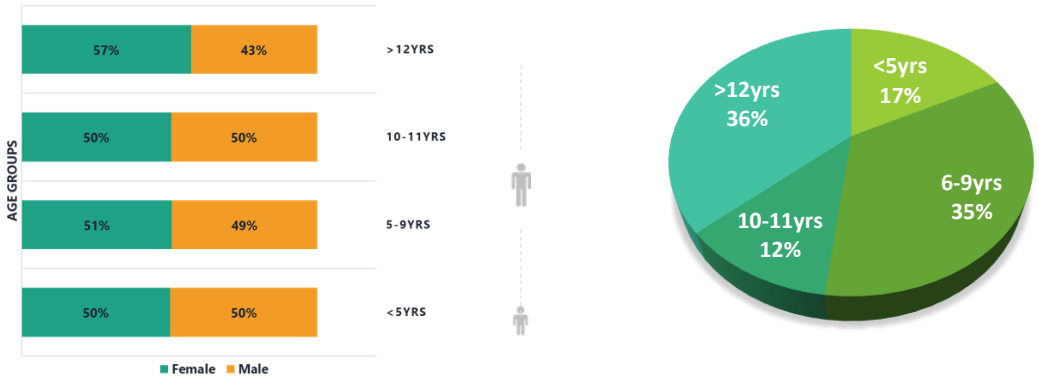


Figure 2: Age Groups of Children that were Surveyed

Over half (53%) of children were from single Parent households and only 26% were from households with both parents. The majority (82.7%) of heads of households were female. There are variations in the demographics of the head of household across districts (see table in appendix 1 for details), for example 41% of households in Cape Town (CT) had both parents compared to only 14% in John Taolo Gaetsewe (JTG). Amatole districts had the most grannie headed households at 33% while Francis Baard has the most (68%) single parent households.

83% of the children in the survey receive social grants. This ranged from 72% of children in CT to 99% of those in JTG. The majority (82%) of these are Child Support Grants (CSGs) with only 3% receiving Foster Care Grants (FCGs). Cape Winelands stands out as the district where a substantive proportion (31%) of children receive FCGs while for all the other districts, this ranges from 0.4% (Harry Gwala District) to 7.2% (Nkangala District). The Grants in Aid were unique to JTG and were received by 25% of children in the study sample.

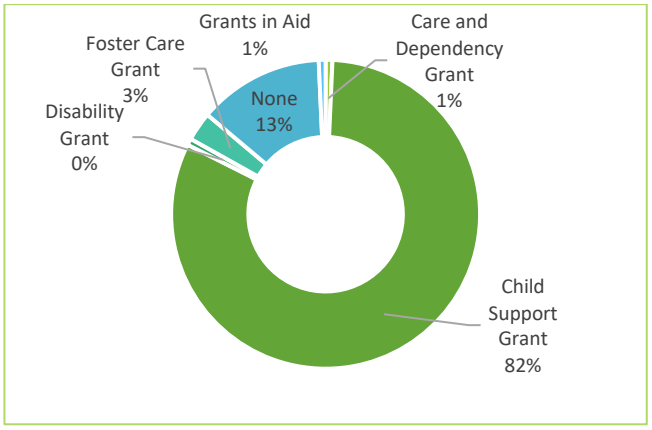


Figure 3: Types of Grants Received

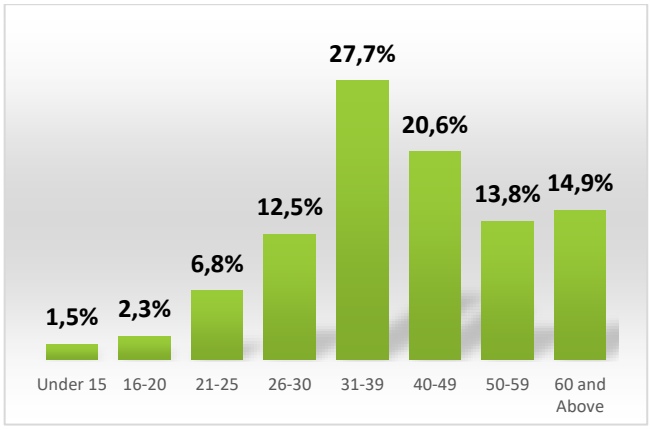
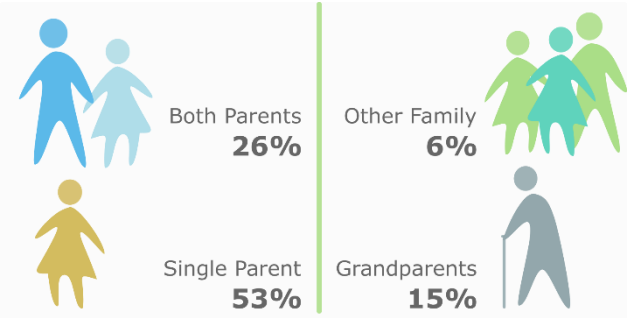


Figure 4: Heads of Households by Age-Group

80% of the Heads of Households (HH) participated as respondents in the survey and nearly half (48.2%) were between the ages of 31 and 49 years as show in Figure 4 .

Most HHs (70%) attained secondary or higher level of education, however this varied substantially across districts as shown the graph below. JTG districts has the highest proportion (22%) of HHs with no education at all followed by Amatole (14%). Figure 5 provides insights into the differences across districts.



Most (77%) of the HHs reported being unemployed, while just about one quarter reported being involved in either full time, part time, self-employment or doing piece jobs. Again, there are variations across districts in terms of opportunities for work and unemployment as is evident in Figure 6 below.

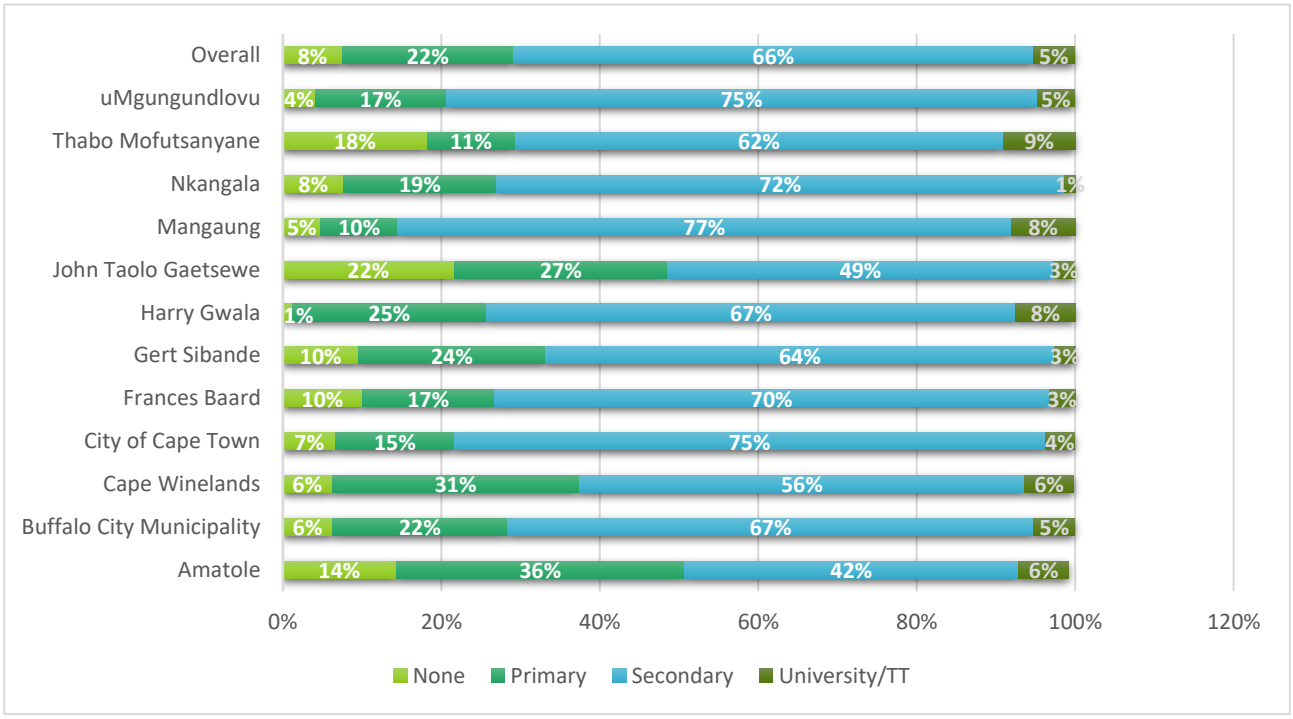


Figure 5: Education Level of Heads of Households by District

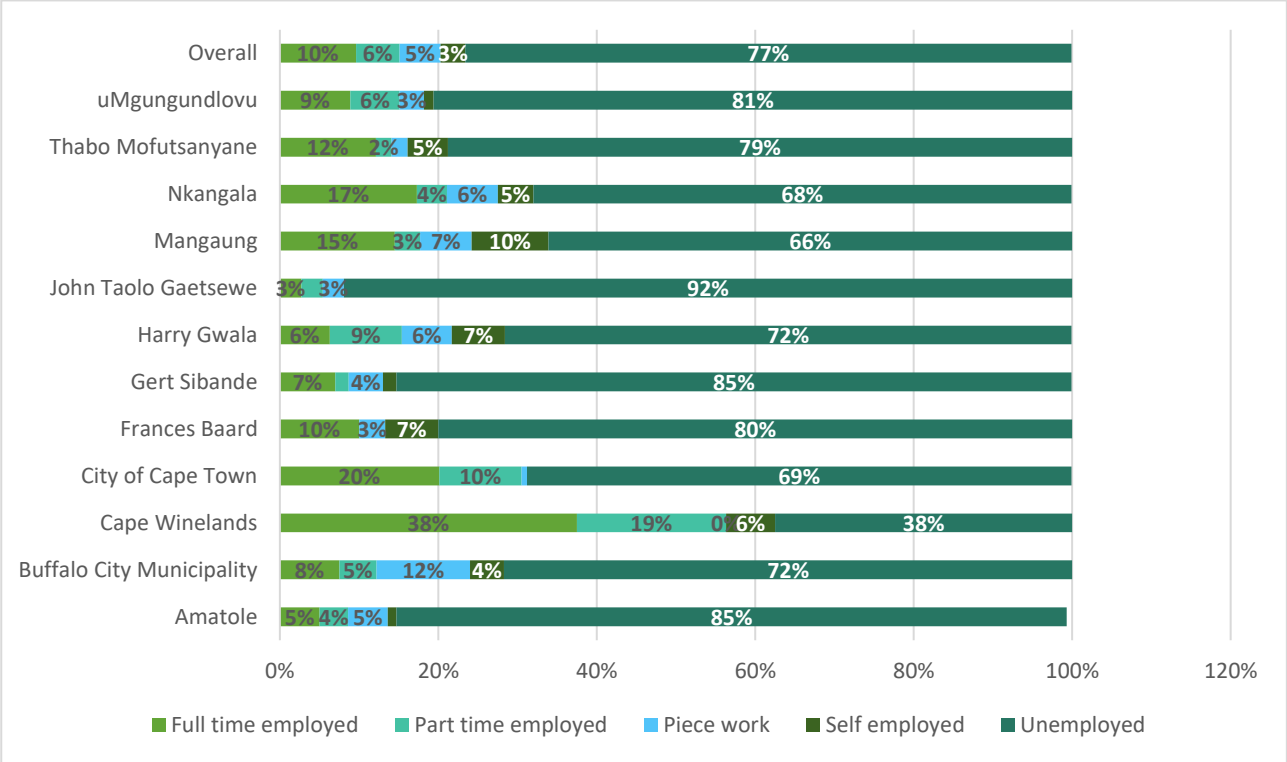


Figure 6: Employment Status of Heads of Holds by District

5.2 Care and Protection and Psychosocial Domains

Findings indicate varying levels of child safety concerns across districts. This is based on how safe children feel as well as their experience of violence (being hurt) at home, school or in their community. Data presented in Figure 7 shows that on the upper end of the scale, 30 percent of children in JTG and Francis Baard districts reported feeling unsafe, compared to 3% and 5% in Harry Gwala and Nkangala districts respectively. Buffalo City Municipality (BCM) and Thabo Mofutsanyane (Thabo M) also had low rates (6%) of children that reported feeling unsafe.

When compared to experience of violence, children in Nkangala district reported the lowest rate, which matches the rate reported for safety concerns. By contrast, three times more children in Harry Gwala (15%) and BCMM (20%) reported experiencing violence than those that were concerned about their safety in the same districts. JTG and Francis Baard have almost the same proportions of children reporting experience of violence as those that don't feel safe. These findings reveal that while in some cases children didn't feel unsafe, this didn't match their experience of violence.

Figure 8 provides more insights into this phenomenon by comparing data for those the reported feeling unsafe and also had experienced violence with those that didn't experience violence despite being concerned about safety. T The graph illustrates variations across districts, with the highest rate of those that had experienced violence and also felt unsafe being 40% for both Gert Sibande and Frances Baard. While there are widespread levels of child safety concerns among surveyed children, it's great to note that most didn't report experiencing violence.

Looking at the findings on children that reported being hurt by caregiver type (see Figure 9), it seems that in most districts, children from single headed households had the highest exposure and experience of violence. This was highest in Francis Baard where 75% of the children that reporting being hurt were from single parent homes. It's interesting to note that where children have their parents as caregivers, they seem to experience higher rates of experience of violence compared to where grandparents or other family are the caregivers. This is particularly evident in Francis Baard, Thabo M, Cape Town, BCM, Nkangala, Gert Sibande and uMgungundlovu where more than 75% of the children that reported violence and cared for by either both/and single parents. This may suggest that nuclear families that have limited support for childcare may be more vulnerable to experiencing incidents of child abuse. This however needs further exploration.

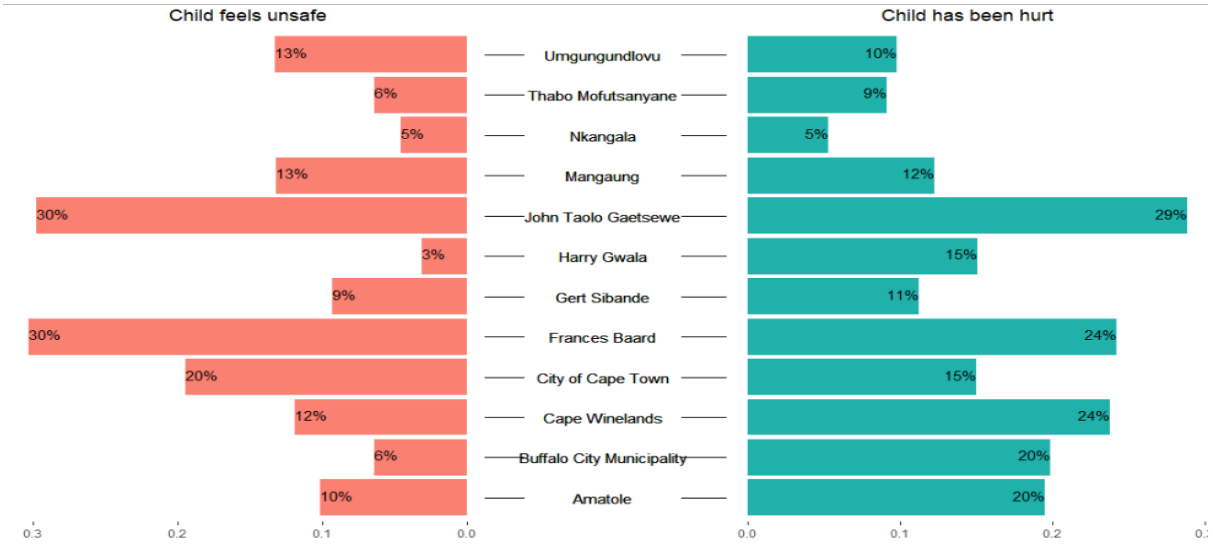


Figure 7: Proportions of Children Reporting that they Feel Unsafe versus those that Reported being Hurt by Someone in their Home, Community or School.

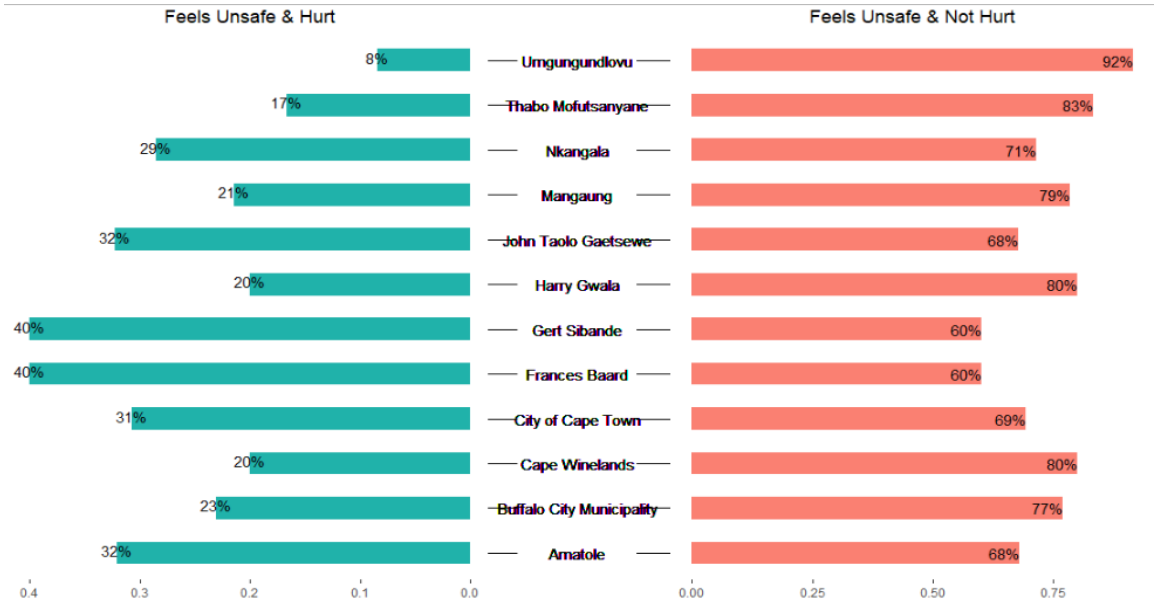


Figure 8: Experience of Violence (being Hurt) among Children that Reported Feeling Unsafe

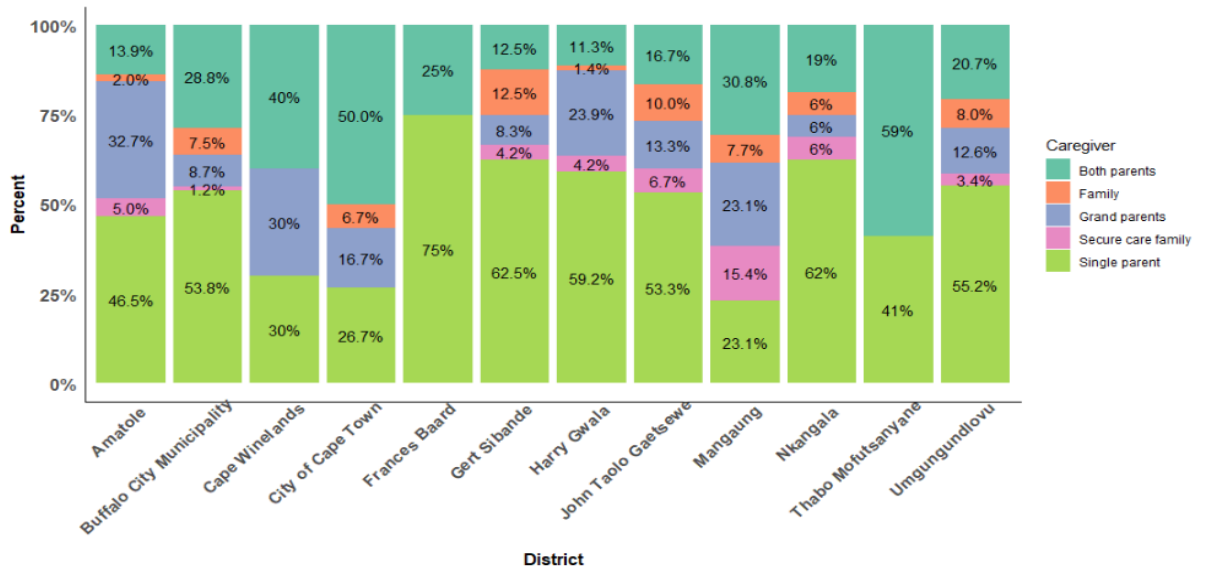


Figure 9: Percentage of Children that Reported being Hurt by Caregiver Type and District

Sexual abuse was reported by 5% children overall. District data indicates that Cape Winelands (12%) and uMgungundlovu (10%) have the highest rates for reported sexual abuse among children.

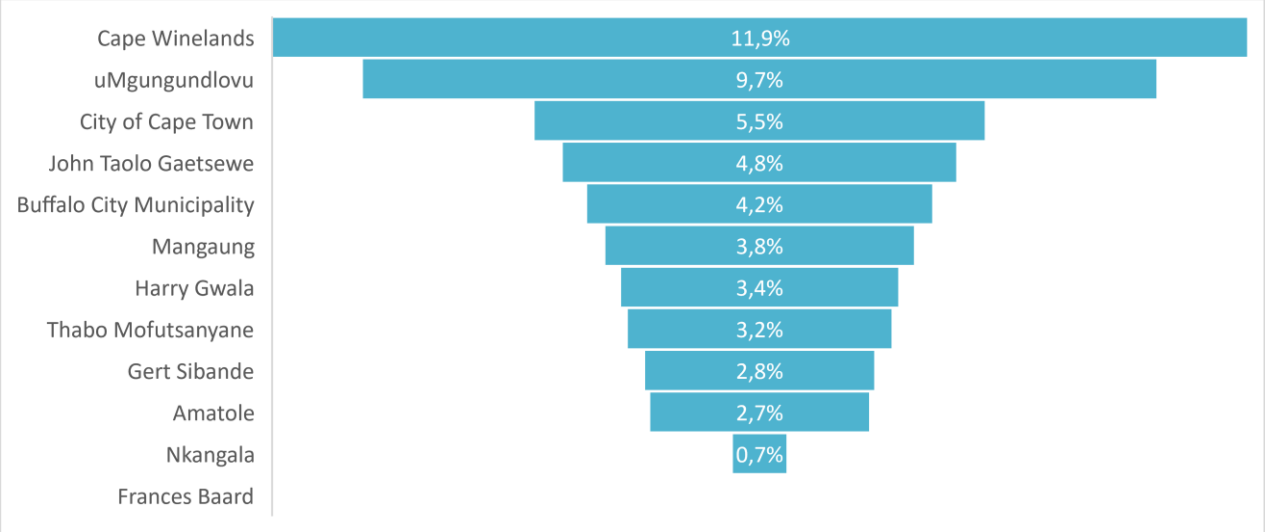


Figure 10: Percentage of Children that reported Sexual Abuse by District

75% of reported cases were by children aged 12 years and older. This may be partly because these children responded to the survey themselves, while Caregivers responded on behalf of younger children. Risk of sexual abuse seems to increase with age, with 6% of the older children affected compared with 2.4% among the 10-11 years, 2% among the 6-9 years and 1.3% among those 5 years and less.

Data in Figure 11 provides more insights into the mental health status (psychological wellbeing) of children based on their primary caregiver type. These results indicate that children leaving with single parents report higher levels of worry and or anxiety. However, in some districts like Thabo M, Mangaung, Cape winelands and Cape Town, disproportionately high numbers living with both parents report feeling worried. This could be related to high levels of violence in these communities.

Figure 12 demonstrates the link between children's worry and anxiety and witnessing adult violence in their communities. The data indicates that some districts have high levels of adult violence that seems to be associated with high levels of worry and anxiety reported by children. In seven of the 12 districts, more than two thirds of children that reported being worried or anxious had also witnessed adult violence. Furthermore, in four of the same districts including Nkangala, Cape Town, Cape Winelands and Francis Baard, high proportions of children that reported being hurt also reported having witnessed adult violence. These findings are demonstrated in Figure 13 below.

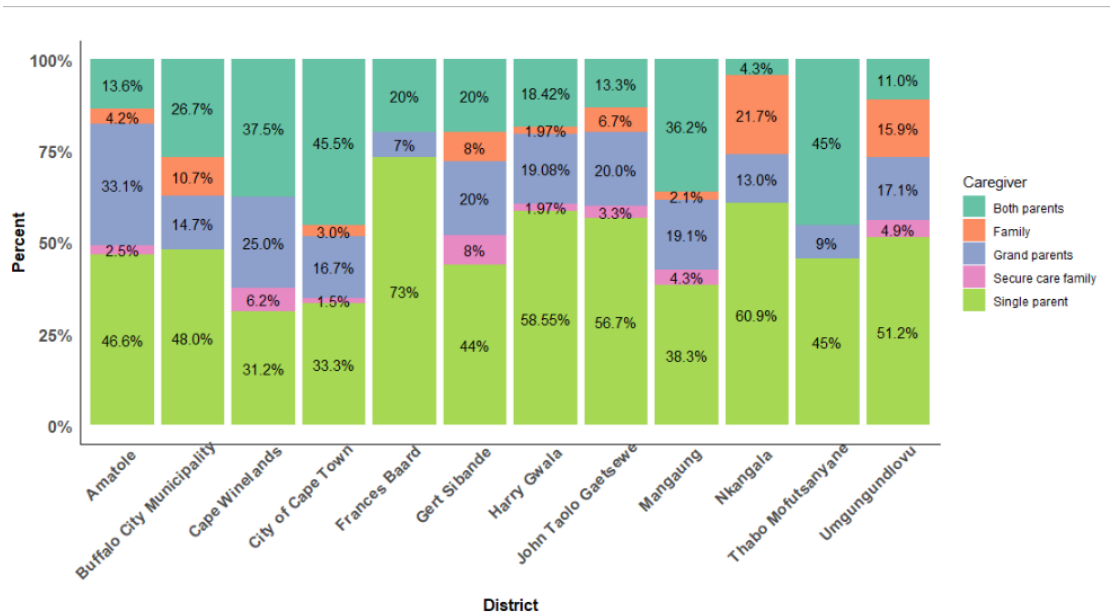


Figure 11: Percentage of Children Reporting being Worried/Anxious by Caregiver Type

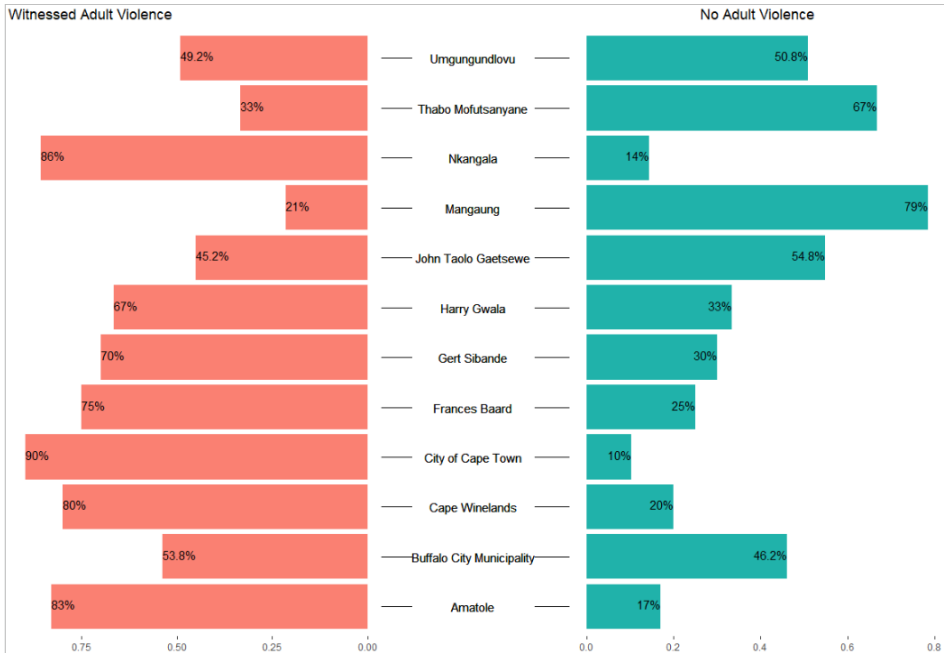


Figure 12: **Proportion of Children that Reported Feeling Unsafe by whether/not they also Reported Witnessing Adult Violence**

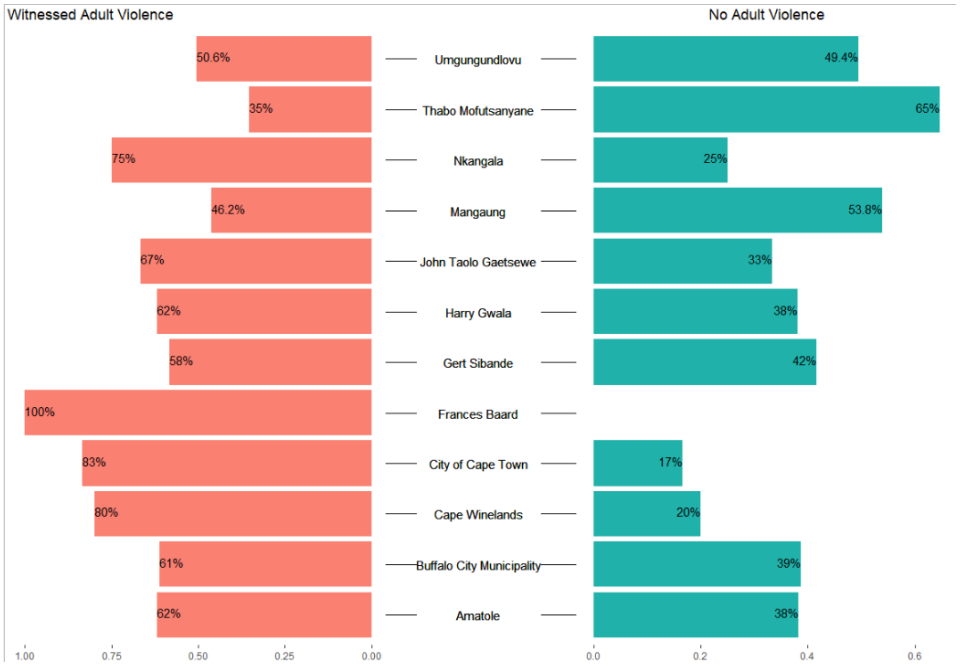


Figure 13: **Proportion of Children that Reported being Hurt by whether/not they Also Reported Witnessing Adult Violence**

Findings indicate that just under 4% of children have considered taking their own lives. A number of districts had proportions above 5% of children including JTG (5.8%), Gert Sibande (6.1%), Mangaung (6.6%), Cape Winelands (7.1%) and Cape Town (8%). Analysis of data on reported suicidal ideations revealed that significant proportions reported being worried and or anxious.

5.3 Food Security and Anthropometric Assessments

Food Security

From the findings, there are high levels of food insecurity with significant proportions of children reporting experiencing hunger. Overall, about 20% of children reported going to bed hungry, with district findings ranging from 3% in Frances Baard to 50% in JTG as shown in Figure 16.

Figure 14: Children Reporting Experiencing Hunger (Going to Bed Hungry)

Anthropometric Findings

Anthropometric findings indicate that overall, just over 11% of children were underweight, with large variations across districts ranging from 0% in Harry Gwala to 33% in JTG. Rates for four districts namely JTG, Mangaung, Frances Baard and uMgungundlovu were all above the average rate of 14% for all the districts as shown in Figure 15

The Height-for-Age data indicates that overall, nearly 50% of the children are stunted, again with large variations across districts from 16% in Cape Town to 70% in Gert Sibande. As shown in Figure 16, data for 6 districts namely Amatole, BCM, Gert Sibande, JTG, Mangaung and uMgungudlovu are above the average rate of 44%.

The anthropometric findings seem to align with the reporting of experience of hunger for most districts. However, finding for Frances Baard are mis-matched as they reflect very low reported rates of hunger yet, the district has high rates of underweight children (22%).

The findings here indicate that among vulnerable children targeted by this study, the prevalence of malnutrition is much higher than the those among the general population of children in the same age bands. This is illustrated with data for children aged 5 years which show much higher rates of stunting (55%) and underweight (9.8%) that findings from the DHS (2016) which reported these to be 27% and 6% respectively, among a national sample of South African children. The data also seems to suggest that young children may be more affected by malnutrition especially comparing the differences in the stunting rates in some districts such as Amatole, Mangaung, Thabo M and Nkangala (see Figure 17)

Furthermore, in comparing data on experience of hunger with data on ill health, we found that in some districts, a substantive proportion of children reported affirmatively for both parameters. In Amathole, 22% of children that reported ill health also said they experienced hunger, this compares to 15% of children in uMgungundlovu and 13% in three districts -BCM, JTG and Harry Gwala.

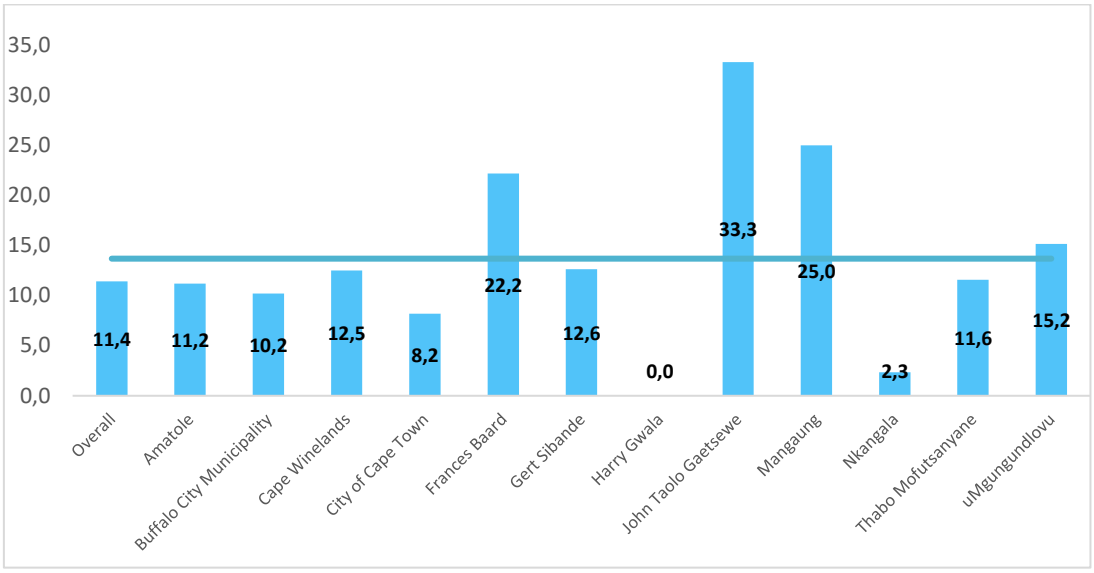


Figure 15: **Percentage of Children (All Age Groups) with Weight for Age Below -2STD (Underweight)**

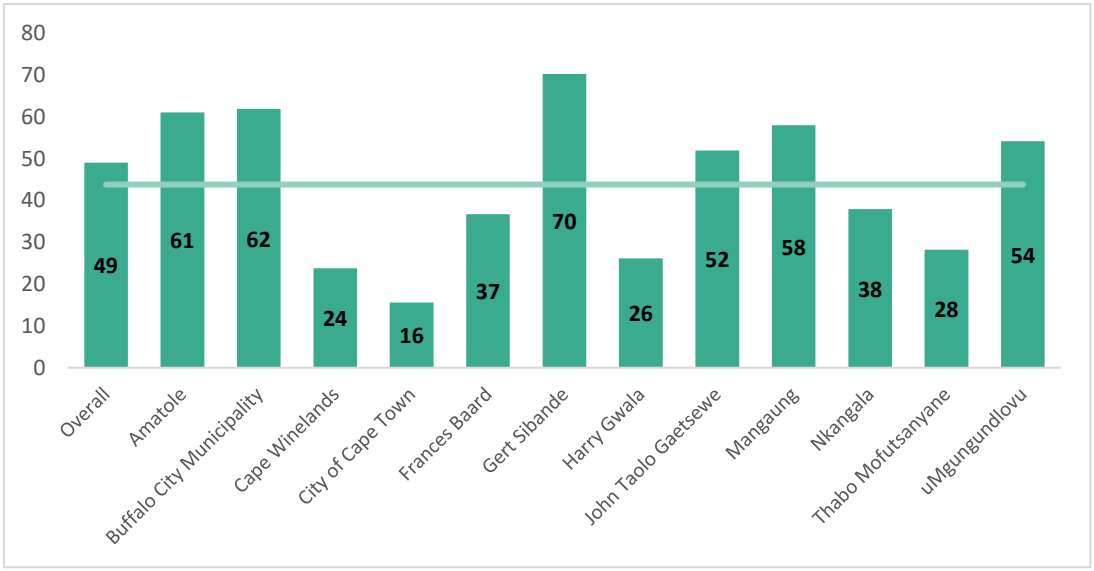


Figure 16: **Percentage of Children (All Age Groups) whose Height for Age is Below -2SD (Stunted)**

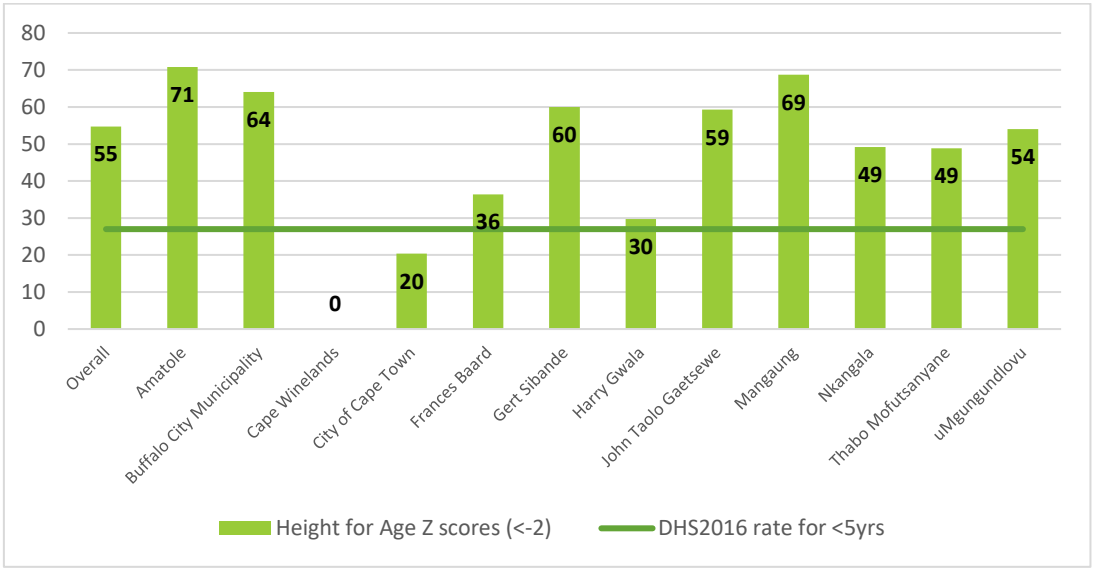


Figure 17: **Percentage of Children Aged 0 to5 yrs. whose Height for Age is Below -2SD (Stunted)**

5.4 Education and Economic Wellbeing Domains

Education:

Findings from this study found that children and caregivers reported high rates (90%) as good/excellent school performance as shown in Figure 18. There were minimal variations in this across districts, ranging from 78% in JTG to 95% in Thabo M. This was a positive finding despite the reported challenges children face in accessing resources and educational support which as discussed further below.

Findings indicate that there were substantive proproportions of children that were not attending any form of schooling, ranging from 11% in Gert Sibande to 36% in both JTG and Francis Baard. See Figure 19.

Data for non-school / ECD attendance were analysed by agegroup and findings indicate that 73% of the five years and younger children were not attending school. This compares to 13% of the 6 to 9 years and 3 % for the older children. See Figure 20. The findings vary across districts as shown in Table 5 in Appendix B which provides more information about characteristics of children that are not attending school.

When compared with Data from Statistics SA's General Household Survey (GHS) 2019, findings suggest that school attendance rates among vulnerable children are lower than those from the general South African population. The GHS reported a 98% overall attendance rate across provinces for children between 7 and 17years. Our findings suggest that the 6-9 years age group may have a much lower attendance rate however further analysis is required in order to confirm this. Further work is also needed to determine how findings from this study compare with other for the 5year and young.

Findings further revealed that only about 50% of children get assistance with schoolwork from someone at school, home or in their community. There is a wide variation across districts, with data from 4 districts (uMgungundlovu, JTG, Harry Gwala and BCM) showing that over 60% of children don't have access to schoolwork help, as shown in Figure 21.

Furthermore, findings show that about a 30% of children do have access to school stationery. District findings ranged from 13% in Cape Winelands to 51% in JTG.

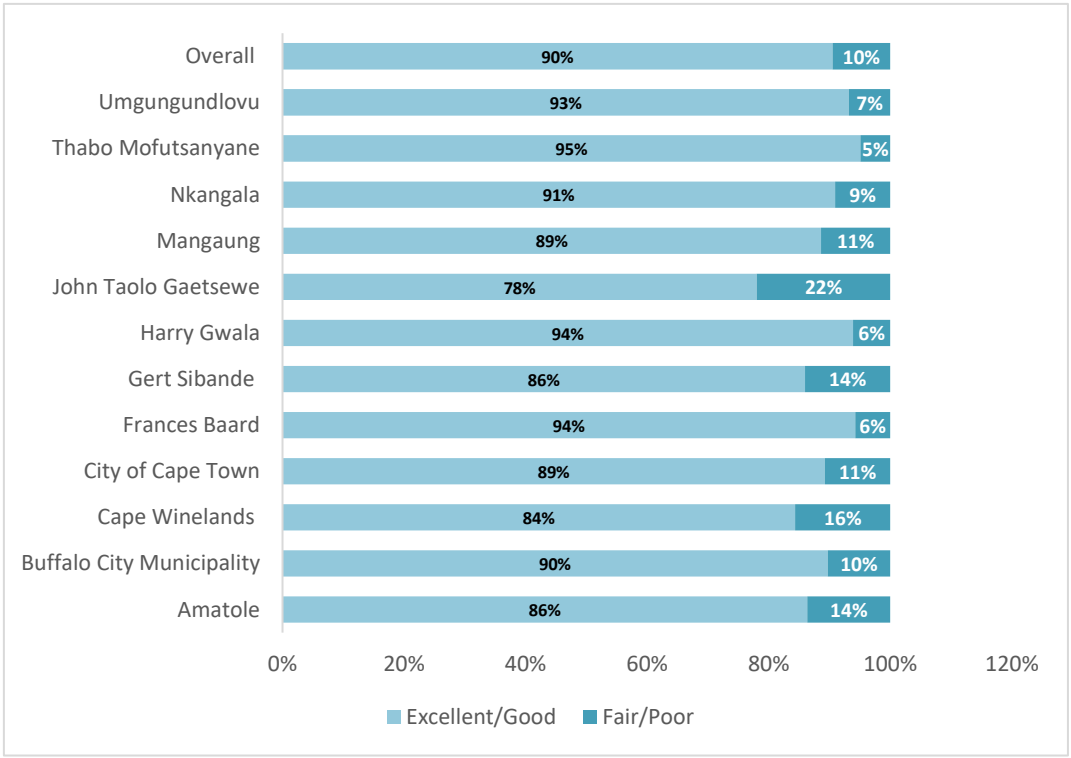


Figure 18: Reported School Performance Among Children Attending School

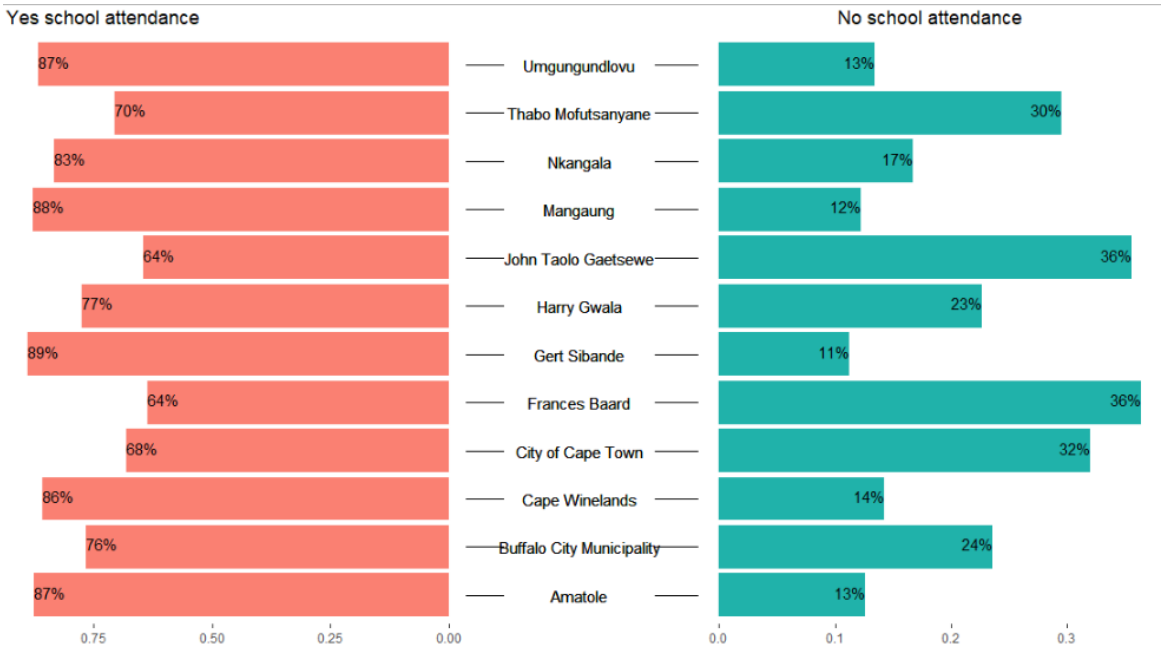


Figure 19: School Attendance Rates by Children that were Surveyed Across Districts

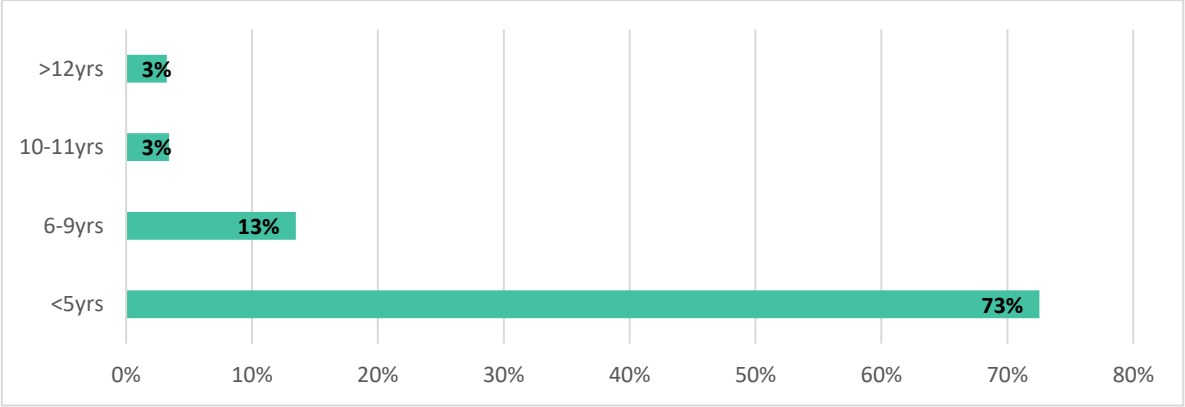


Figure 20: Percentage of Children not Attending School or ECD per Age-Group

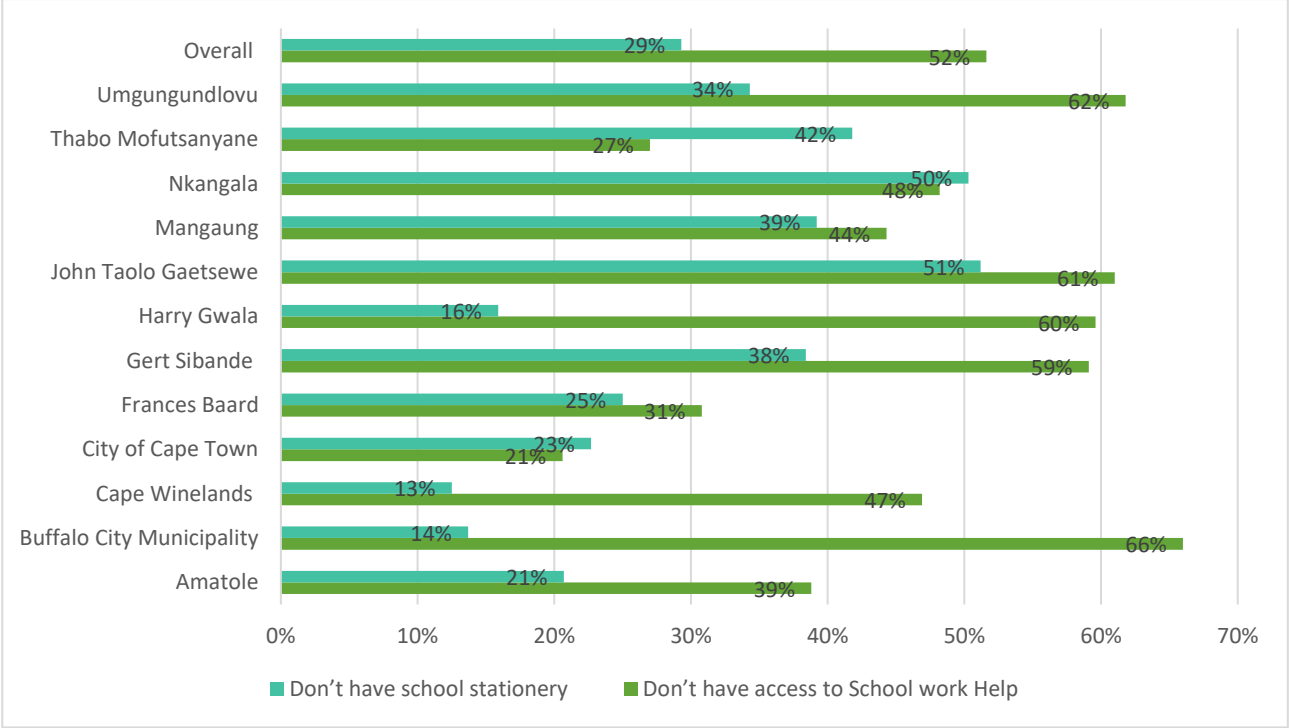


Figure 21: Proportions of Children that don't have Stationery or Access to School Work Help

Economic Wellbeing

Findings from the assessments indicate that most children (over 70% in most districts) reported that they have access to basic needs. Since most (80%) children are accessing social grants, it's reasonable to attribute this positive finding to governments welfare support. However, there is a substantial proportion of children that are not able to access basic needs as shown in Figure 22, with the most affected district being JTG where 50% reported lacking access. It should be noted that in JGT, 99% of children are receiving social grants, however this is the sole income source for most (87%) families.

Figure 23 shows proportions of children that reported access or lack of access to basic needs, based on whether their families have other sources of income besides social grants. Higher proportions of children from households with other income sources access basic needs compared to those that are solely dependent on social grants. This is especially so in Frances Baard, Thabo M, Nkangala and BCM. These data seem to suggest that ability to provide basic needs is improved by having access to other income sources.

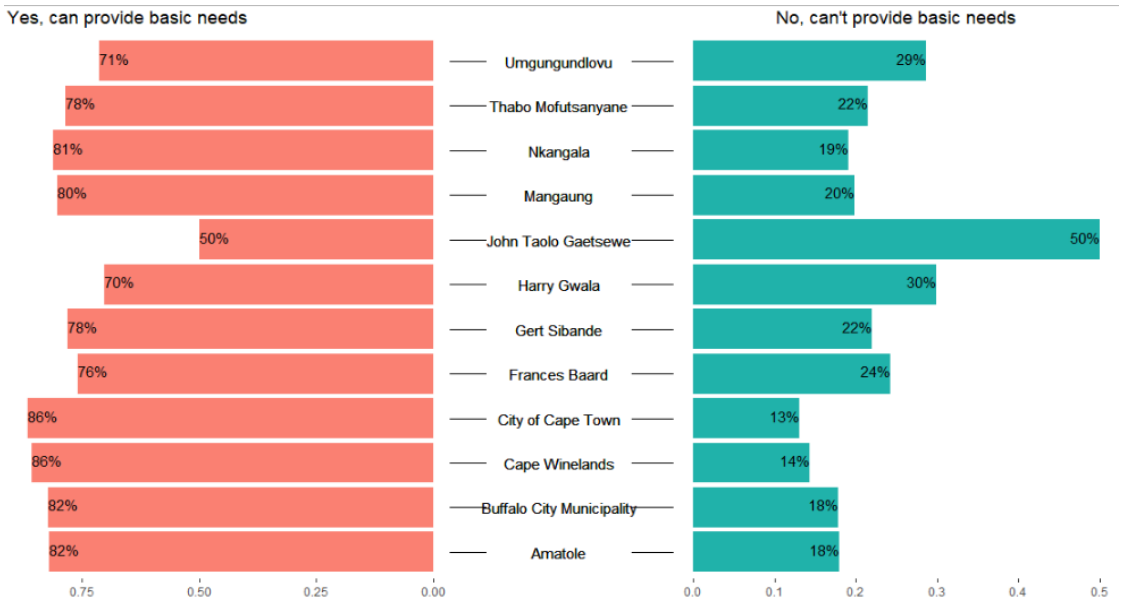


Figure 22: Proportion of Children that Reported Access or Lack of Access to Basic Needs

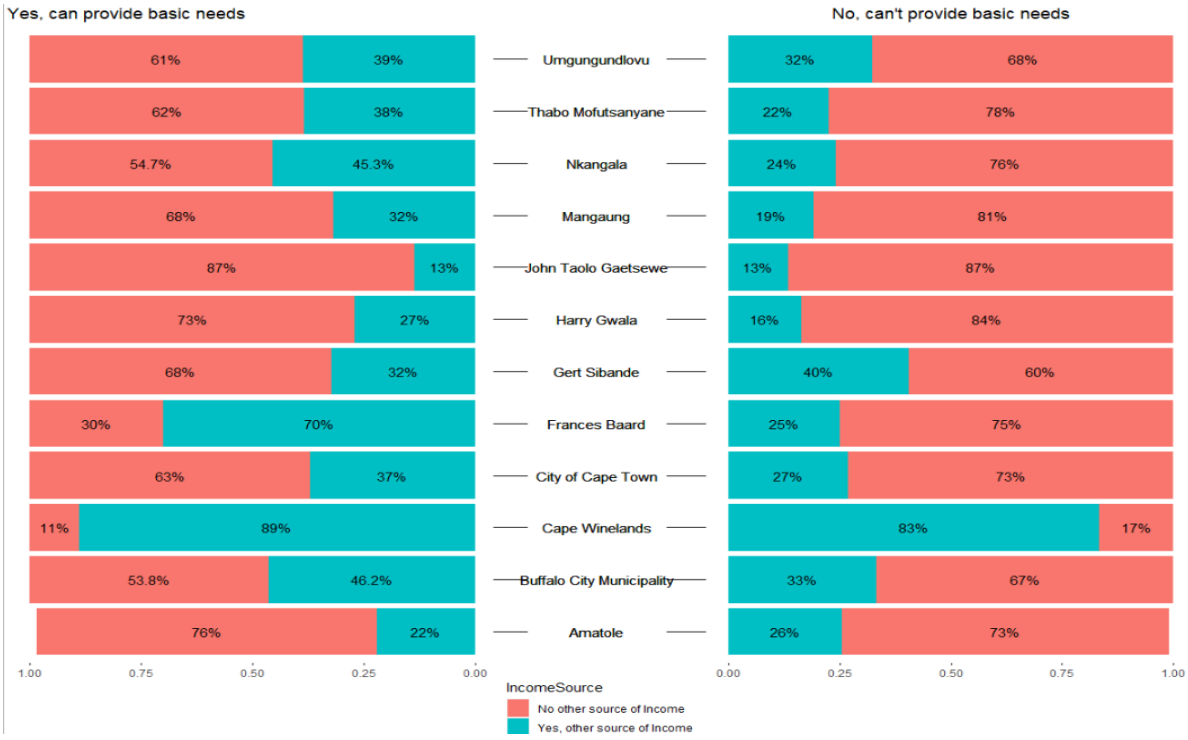


Figure 23: Access to Basic Needs Among Children Based on whether or not their HH has Access to other Income Sources Besides Grants

The survey found that 17% of girls report that they miss school and other important events because of lack of sanitary pads. Figure 24 provides more data showing variations across districts, with 32% of the girls in Thabo Mofutsanyane affected, compared to 8% in Nkangala.

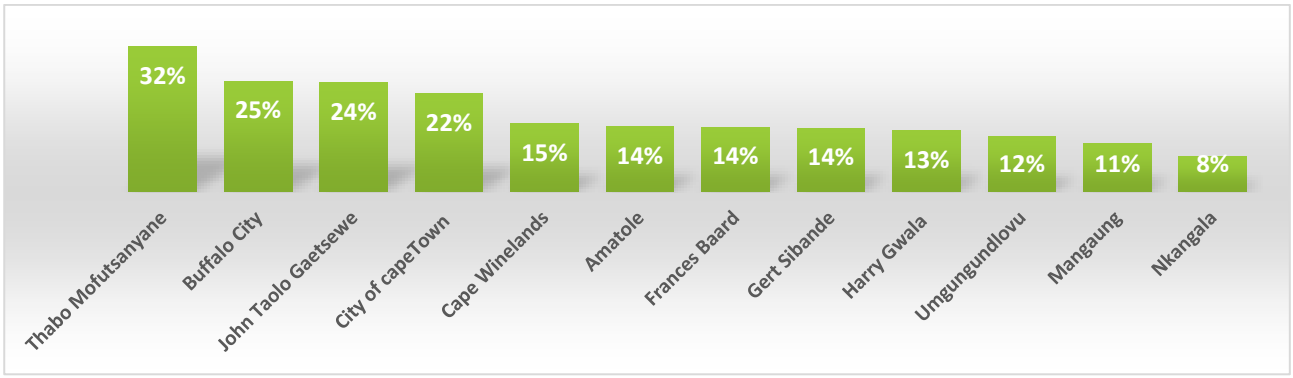


Figure 24: Proportion of Girls Reporting that they are Missing School or Important Events Due to Lack of Sanitary Pads

5.5 Health

General Health Findings

Study findings revealed that overall, 7.4% of children were reported to have ill health, with substantial variation across districts as reflected in Figure 25. Frances Baard stands out as the district that reported the highest proportion at just under 20% of children, while only 1% were reported in Nkangala.

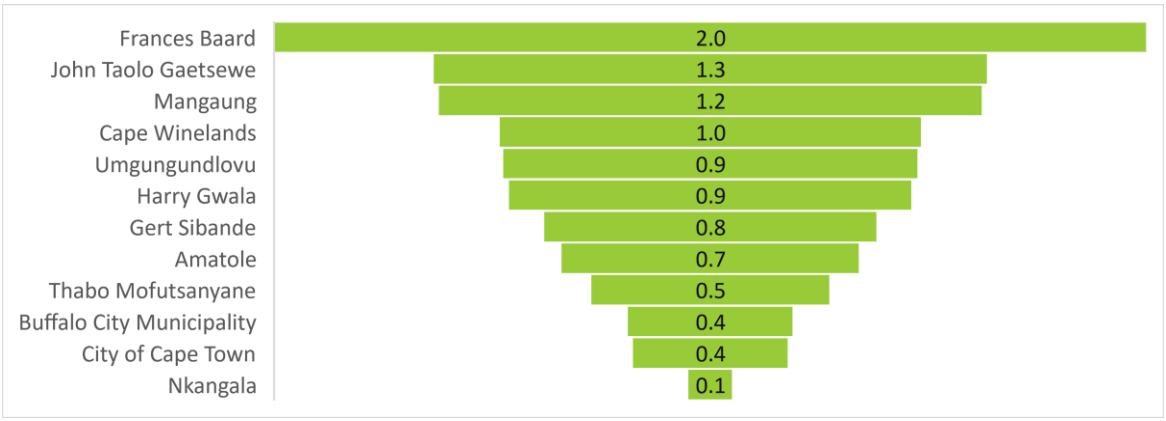


Figure 25: Percentage of Children Reported to have Poor Health which is Limiting their Participation in Day-to-Day Activities

Data on recent illnesses are presented in Figure 26 and show that reporting of these ranged from 9% of children in Nkangala to 72% of children in Mangaung.

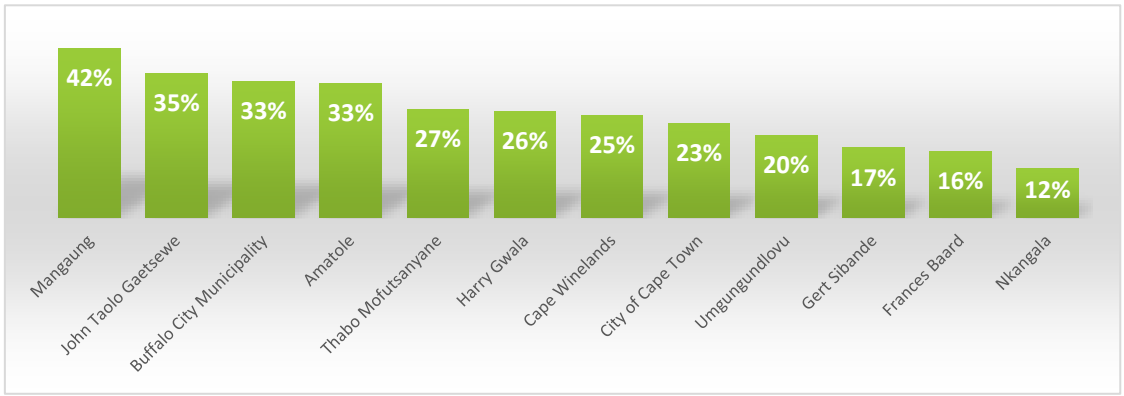


Figure 26: Percentage of Children that Fell Ill in Past Month (Running Stomach/Diarrhoea, Vomiting, Painful Cough and Difficulty Breathing)

The survey also assessed health seeking behaviours and Figure 27 shows the percentage of children that were reported to have fallen ill in the past month versus those that had visited health facilities in the past six months. overall, only 11% of children visited health facilities in the six months prior to the survey, yet 24% were reported ill in the month before the assessments. With exception of Nkangala, Cape Winelands and Frances Baard, all other districts had disproportionately higher percentages of children that fell ill than those that sought healthcare services. The largest difference between the two proportions were in Mangaung and JTG with 25 and 22 percentage point difference, respectively. These same districts also had that highest proportions of children that fell ill in the month prior to the assessment. These findings indicate that poor health seeking is correlated with higher rates of recent illnesses.

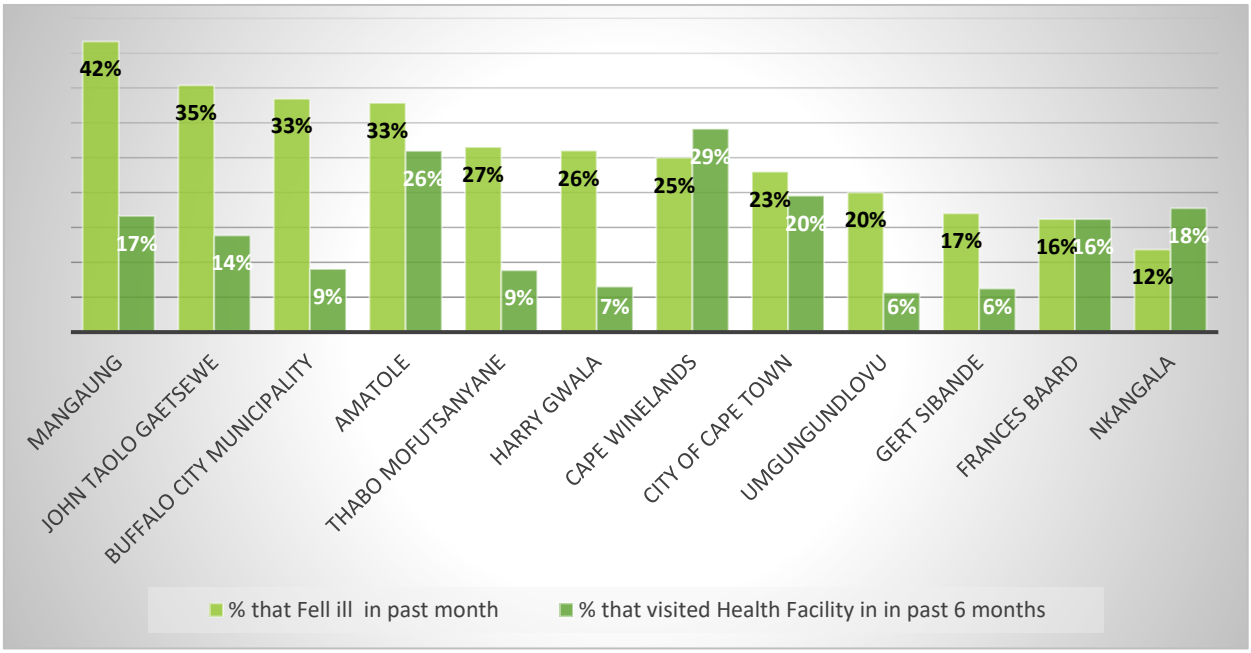


Figure 27: Proportions of Children that Fell Ill in Past Month versus those that visited Health Facilities in the Past Six Months

Health seeking data were analysed further to determine if there were any differences depending on caregivers, and how these vary across districts. A close look at these findings revealed that parents (single or both) seem to play a big role in health seeking, with the highest proportions of children that sought health services across most districts having parents as their caregivers. The exception to this is Nkangala district where the highest proportion of children that sought healthcare had grandparents as their caregivers. See Figure 28.

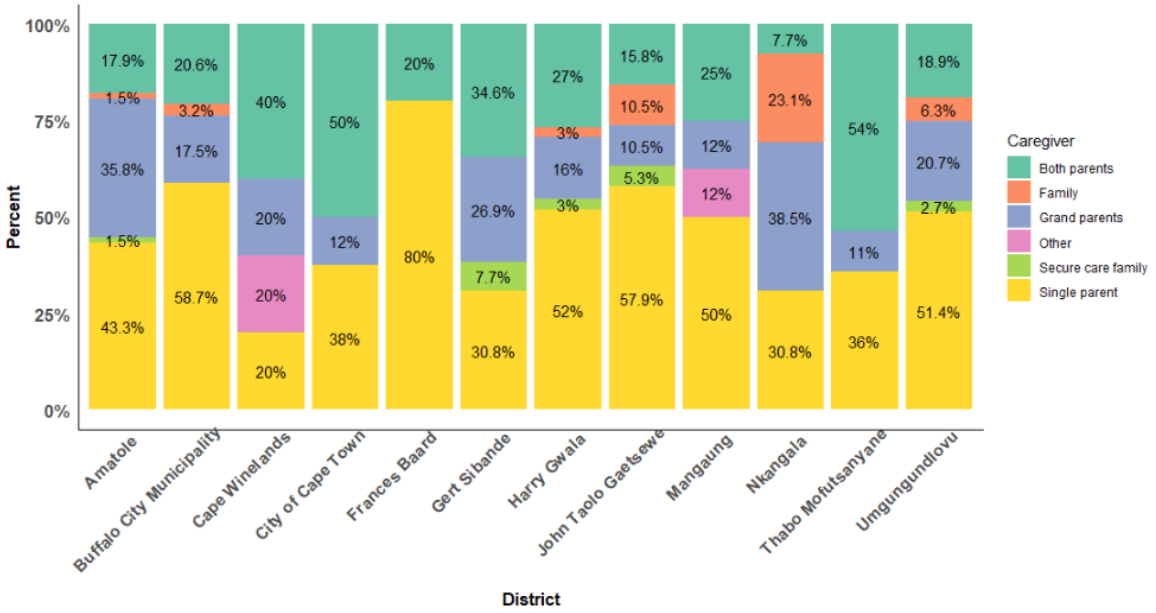


Figure 28: Percentage of Children that Visited Health Facilities During a Recent Illness by Caregiver

HIV Findings

The survey revealed that reported rates of HIV testing among children varied substantially across districts and ranged from 30% in Thabo Mofutsanyane to 73% in Nkangala as shown in Figure 29. Overall, the rate of HIV testing was reported to be just under 50%.

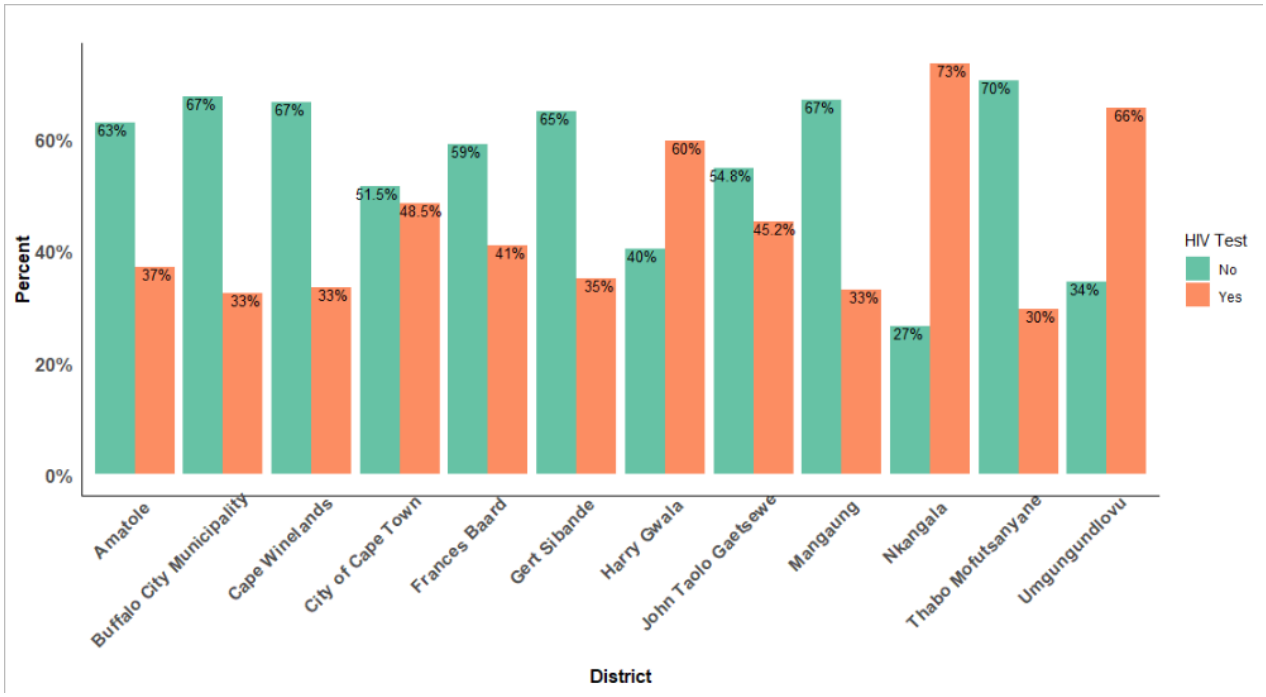


Figure 29: Percentage of Children Indicating History of HIV Testing

On the other hand, the data gathered on HIV positive status (for those that reported to know their status) was limited and doesn't seem to correspond to what would be expected given the HIV prevalence in the different districts. Only 23 individuals were reported as HIV positive, and a total of 123 children were reported as being on ARV therapy across all districts. This may be indicative of the fear of stigma among respondents which may have contributed to under-reporting. While these findings are not sufficient to draw any meaningful insights about HIV positivity among the study respondents, they do reveal a need for more attention to issues around stigma and discrimination which may be hampering access to essential services.

Only 45% of respondents reported that the child had been taught either at school or clubs, about HIV infection and how to protect themselves from getting infected. This ranged from just under 30% in Thabo Mofutsanyane to just over 60% in Nkangala. Furthermore, 38% of children reported that they had talked about HIV infection or AIDS with their parents /guardians. These results indicate a gap in creating awareness about HIV protective knowledge and risks among vulnerable children within their communities and families.

Only 4% of children reported being sexually active. This question was asked to only those that were 12years and older. This low reporting is indicative of potential social desirability bias.

5.6 Findings from COVID-19 KAP Assessment

Findings from these assessments show that while there seems to be fairly good levels of knowledge among caregivers regarding COVID prevention measures, the district variations reveal a need for more awareness targeting vulnerable households. Table 1 shows numbers and proportions of Caregivers that responded to the COVID-19 prevention knowledge assessment, with colour grading showing the proportions of respondents where Red denotes less than 50% respondents; Orange –50 to 69% and Green- 70% or more respondents.

Table 1: Protective Knowledge about Preventing COVID-19 Infections Among Caregivers

Covid Prevention Measures		Social distancing	Wearing a mask in public	Frequent washing of hands with soap and water	Avoiding being in crowded places
Amatole	(N=308)	236 (77%)	262 (85%)	196 (64%)	162 (53%)
Buffalo City Municipality	(N=288)	263 (91%)	271 (94%)	211 (73%)	138 (48%)
Cape Winelands	(N=18)	13 (72%)	14 (78%)	8 (44%)	7 (39%)
City of Cape Town	(N=147)	131 (89%)	138 (94%)	113 (77%)	86 (59%)
Frances Baard	(N=24)	11 (46%)	19 (79%)	9 (38%)	0
Gert Sibande	(N=121)	80 (66%)	94 (78%)	60 (50%)	33 (27%)
Harry Gwala	(N=233)	157 (67%)	188 (81%)	176 (76%)	94 (40%)
John Taolo Gaetsewe	(N=10)	0	3 (30%)	2 (20%)	5 (50%)
Nkangala	(N=158)	153 (97%)	105 (66%)	101 (64%)	93 (59%)
Thabo Mofutsanyane	(N=124)	113 (91%)	117 (94%)	102 (82%)	33 (27%)
uMgungundlovu	(N=258)	200 (78%)	173 (67%)	116 (45%)	40 (16%)
Overall	(N=1689)	1357 (80)	1384 (82%)	1094 (65%)	691 (41%)

These findings reveal that there are reasonably high levels (as shown by green shading) of protective knowledge for COVID-19 prevention in most districts particularly on the importance of social distancing and wearing masks in public. Findings reveal a mixed picture regarding Knowledge about handwashing with soap and water, with only 4 districts showing high proportions of respondents with this knowledge. Furthermore, most respondents had limited knowledge about "avoiding crowded places" as being protective against spread of COVID-19. Two districts stand out as having very low levels of knowledge about COVID-19 prevention measures among respondents, namely JTG and Frances Baard.

87% of households reported that they had not had anyone in the household diagnosed with COVID-19. Six percent reported that at least one member of their household had been diagnosed with COVID-19, while another 6% said they were not sure. 82% of respondents reported being worried about COVID-19 and 94% said that they do talk to their children about how to prevent infections.

6 Conclusions

The findings of this survey should be consistently viewed with the lens of its objective to focus on the most impoverished communities in South Africa. The following conclusions are drawn from the findings of the study:

General Observations: The responsibility to care for children predominately rest on single parents. There are variations in family dynamics and support structure in different districts with possible implications for wholesome childcare and protection. This supposition is illustrated in various findings and should be considering in developing community specific interventions. Most households are headed by unemployed females who predominantly depend on child support grants. The high burden of childcare on single parents may be an impediment to pursue opportunities to improve their material circumstances and possibly break the circle of poverty and impoverishment. Structured childcare programme may improve the status quo in several ways for the children, parents, and government.

Child Protection and Psychosocial Domains: A higher proportion of children feel unsafe even if they have never been hurt. This may be reflective of the internal and external environment they find themselves. The long-term psychosocial health implication of this may require attention and the integrated school health programme can be leveraged.

While our sample has a disproportionately more households with single parents, more children in households with single parents reported being hurt. This may signal the need for childcare support for single parents in the interest of both the child and the parents. Exposure to adult violence was high in most of the districts and children in most cases reported being hurt, highlighting child safety and protection issues. Sexual abuse rates are concerningly high and affects children of all ages, with risk increasing by agegroup.

The level of anxiety varied across the districts, but most children felt safe despite it. This may be indicative of other immediate needs in the homes and community and the need for continuous monitoring and support of structural and intermediary determinants of wellbeing. Considering our significantly higher proportion of single parent homes, they also had higher proportion of children reporting anxiety and sexual abuse.

Food Security and Anthropometric findings: Rates of experience of hunger are concerning and vary considerably across districts. These variations are potentially due to prevailing socio-cultural, environmental, and economic dynamics. Anthropometric findings indicate that among vulnerable children targeted by this study, the prevalence of malnutrition is very high as reflected by the high proportions affected by stunting and underweight.

Education and Economic Wellbeing Domains: A concerning proportion of children of school going age are not attending school especially among the younger age groups. Special programmes to ensure greater school attendance are essential as a path to true self-reliance. High proportions of children reported having limited or no support with schoolwork and also many don't have access to stationery.

A portion of the household heads reported not being able to provide basic needs such as food, water, and clothing despite the grants. Higher proportions of children from households with other income sources access basic needs compared to those that are solely dependent on social grants. Families that reported being able to provide basic needs had higher proportions of children who attend school regularly and their daughters are less likely to miss school due to not having sanitary pads.

Health and HIV/AIDS Domains: There are varying levels of poor health among children across districts, with high rates of recent illness reported in the same districts that also had the lowest health seeking rates. Overall findings indicate high rates of recent illness reported among vulnerable children. Poor health seeking observed in some districts may indicate systemic challenges related to access to healthcare which require more investigation.

The low rates of HIV testing; low proportions of children that reported learning about HIV from school/clubs or from their parents/caregivers; as well as the low disclosure rates of HIV positive status, indicate that vulnerable children remain at high risk of acquiring new HIV infections. These findings also indicate that HIV programs may not be effectively addressing underlying stigma and discrimination in these communities. All these are known impediments to accessing relevant support and access to care and may result in poor health outcomes among those infected or affected by HIV.

COVID-19: Unlike the situation with HIV, there are reasonably high levels of protective knowledge for COVID-19 prevention among vulnerable households in most districts. However, the mixed findings on knowledge and practices of handwashing with soap and water indicate that more efforts are needed to address these in order to abate the ongoing COVID-19 pandemic. The awareness campaigns seem to have been quite effective in getting parents to share protective knowledge about COVID-19, something that remains poor in the HIV prevention programs. Limited access to water and

soap in some communities heighten risks of COVID-19 infection especially among households that report lack of basic needs.

RTMT Data Utility: Evidence from this study and the demonstrated value of the RTMT makes a strong case for institutionalising child welling monitoring including all relevant indicators, in order to inform implementation of an Integrated approach that would be required to fully respond to identified need among vulnerable children.

7 Recommendations

1. Strengthen systems for monitoring, evaluating and improving government programs intended to improve the wellbeing of children as mandated by the children's Act 38 of 2005 as amended by Act 41 of 2007,	by scaling up and institutionalising routine use of the Real Time Monitoring Tool at DSD service points across the country. This is a necessary step in order to provide government stakeholders at different levels (local, district, provincial and national) with immediate access to the highly valuable data as demonstrated by this study. The RTMT should be built into the routine systems for delivery of services by all NPOs supported by DSD that work with children. This will ensure that DSD service points gain a better understanding of the needs of vulnerable children in their catchment areas and as well as enhance their capability to monitor how NPOs and other actors are responding to these. The RTMT provides opportunity for DSD to implement the long overdue electronic case management system which would enable real time tracking of how actions are implemented in response to identified needs. Furthermore, the RTMT can easily integrate with other existing government IT systems thereby providing data inputs to the Integrated Justice System (IJS) and making NISPIS a reality
2. Strengthen implementation of a multi-sectoral integrated response that addresses the needs of children as identified through the wellbeing assessments.	DSD's basic care package should be augmented through engaging other relevant departments and institutions including but not limited to Health, Education, Justice, SAPs and local municipalities, in order to streamline sharing of data about children's needs and working collaboratively to deliver efficient community driven interventions. These interventions should take into consideration the local context and address priority needs of vulnerable children and families across the domains of the wellbeing basement. Working closely with the Integrated School Health Program offers great opportunities for improving inter-sectoral coordination towards responding to needs of school going children
3. Engage broader stakeholder groups that may be required to effectively address the needs of vulnerable families that fall outside the scope of DSD.	These engagements should focus of crafting ways to strengthen systems of support and opportunities to uplift the social-economic status of women who carry the bulk of the burden of care for vulnerable children. Effectively addressing issues around food security and economic wellbeing certainly requires more stakeholders that can respond to these issues beyond what DSD can offer on its own.
4. Utilize learning gained from the effective COVID-19 awareness campaign to strengthen community outreach, awareness and participation in HIV prevention and care/support programs	including addressing stigma and discrimination. Similar efforts and support systems are required to address child protection needs, psychological wellbeing and food security
5. Invest in strengthening and testing the RTMT to collect high quality data on children with disabilities.	This will provide highly useful data on current needs for this highly vulnerable group of children, and enable development of plans that address gaps in service delivery
6. Invest in completing the outstanding components of the rapid assessment study	including data collection in outstanding provinces as well as the NPO survey and qualitative research, which together with already available data will provide a comprehensive view of the situation across country in line with the objectives of the study

Appendix A Demographic Data

Table 2: Demographic Data of Survey Participants

	Amatole (N=523)	Buffalo City Municipality (N=403)	Cape Winelands (N=42)	City of Cape Town (N=200)	Frances Baard (N=66)	Gert Sibande (N=214)	Harry Gwala (N=472)	John Taolo Gaetsewe (N=104)	Mangaung (N=106)	Nkangala (N=305)	Thabo Mofutsanyane (N=186)	uMgungundlovu (N=887)	Overall (N=3508)
Child Gender													
Female	256 (48.9%)	217 (53.8%)	28 (66.7%)	106 (53.0%)	34 (51.5%)	101 (47.2%)	253 (53.6%)	53 (51.0%)	66 (62.3%)	174 (57.0%)	103 (55.4%)	462 (52.1%)	1853 (52.8%)
Male	267 (51.1%)	186 (46.2%)	14 (33.3%)	94 (47.0%)	32 (48.5%)	113 (52.8%)	219 (46.4%)	51 (49.0%)	40 (37.7%)	131 (43.0%)	82 (44.1%)	425 (47.9%)	1654 (47.1%)
Child Age Group													
<5yrs	121 (23.1%)	98 (24.3%)	1 (2.4%)	44 (22.0%)	14 (21.2%)	28 (13.1%)	68 (14.4%)	26 (25.0%)	15 (14.2%)	50 (16.4%)	38 (20.4%)	109 (12.3%)	612 (17.4%)
6-9yrs	161 (30.8%)	138 (34.2%)	13 (31.0%)	72 (36.0%)	18 (27.3%)	76 (35.5%)	175 (37.1%)	30 (28.8%)	35 (33.0%)	119 (39.0%)	68 (36.6%)	304 (34.3%)	1209 (34.5%)
10-11yrs	64 (12.2%)	39 (9.7%)	5 (11.9%)	22 (11.0%)	17 (25.8%)	22 (10.3%)	65 (13.8%)	9 (8.7%)	8 (7.5%)	39 (12.8%)	28 (15.1%)	91 (10.3%)	409 (11.7%)
>12yrs	177 (33.8%)	128 (31.8%)	23 (54.8%)	62 (31.0%)	17 (25.8%)	88 (41.1%)	164 (34.7%)	39 (37.5%)	48 (45.3%)	97 (31.8%)	52 (28.0%)	383 (43.2%)	1278 (36.4%)
Child Caregivers													
Both parents	74 (14.1%)	96 (23.8%)	10 (23.8%)	83 (41.5%)	13 (19.7%)	38 (17.8%)	112 (23.7%)	15 (14.4%)	41 (38.7%)	85 (27.9%)	63 (33.9%)	146 (16.5%)	776 (22.1%)
Family	32 (6.1%)	34 (8.4%)	0 (0%)	10 (5.0%)	0 (0%)	24 (11.2%)	15 (3.2%)	9 (8.7%)	6 (5.7%)	24 (7.9%)	3 (1.6%)	72 (8.1%)	229 (6.5%)
Grand parents	176 (33.7%)	60 (14.9%)	11 (26.2%)	26 (13.0%)	4 (6.1%)	33 (15.4%)	79 (16.7%)	13 (12.5%)	23 (21.7%)	52 (17.0%)	17 (9.1%)	155 (17.5%)	649 (18.5%)
Other	3 (0.6%)	1 (0.2%)	6 (14.3%)	1 (0.5%)	1 (1.5%)	5 (2.3%)	3 (0.6%)	0 (0%)	1 (0.9%)	0 (0%)	0 (0%)	5 (0.6%)	26 (0.7%)
Secure care family	6 (1.1%)	2 (0.5%)	2 (4.8%)	2 (1.0%)	3 (4.5%)	5 (2.3%)	5 (1.1%)	4 (3.8%)	4 (3.8%)	3 (1.0%)	4 (2.2%)	24 (2.7%)	64 (1.8%)
Single parent	232 (44.4%)	210 (52.1%)	13 (31.0%)	77 (38.5%)	45 (68.2%)	109 (50.9%)	258 (54.7%)	63 (60.6%)	31 (29.2%)	141 (46.2%)	99 (53.2%)	485 (54.7%)	1763 (50.3%)
Receives Grant													
I don't know	2 (0.4%)	8 (2.0%)	0 (0%)	4 (2.0%)	0 (0%)	4 (1.9%)	3 (0.6%)	1 (1.0%)	0 (0%)	2 (0.7%)	0 (0%)	1 (0.1%)	25 (0.7%)
No	75 (14.3%)	42 (10.4%)	5 (11.9%)	51 (25.5%)	12 (18.2%)	37 (17.3%)	48 (10.2%)	4 (3.8%)	15 (14.2%)	50 (16.4%)	9 (4.8%)	101 (11.4%)	449 (12.8%)
Yes	446 (85.3%)	353 (87.6%)	37 (88.1%)	144 (72.0%)	54 (81.8%)	173 (80.8%)	421 (89.2%)	99 (95.2%)	91 (85.8%)	253 (83.0%)	177 (95.2%)	785 (88.5%)	3033 (86.5%)
chGrantType													
Care and dependency grant	1 (0.2%)	0 (0%)	0 (0%)	0 (0%)	1 (1.5%)	0 (0%)	1 (0.2%)	0 (0%)	12 (11.3%)	1 (0.3%)	5 (2.7%)	4 (0.5%)	25 (0.7%)
Child Support grant	434 (83.0%)	345 (85.6%)	24 (57.1%)	138 (69.0%)	50 (75.8%)	169 (79.0%)	419 (88.8%)	67 (64.4%)	75 (70.8%)	226 (74.1%)	170 (91.4%)	747 (84.2%)	2864 (81.6%)
Disability grant	2 (0.4%)	5 (1.2%)	0 (0%)	0 (0%)	1 (1.5%)	3 (1.4%)	0 (0%)	1 (1.0%)	0 (0%)	4 (1.3%)	0 (0%)	8 (0.9%)	24 (0.7%)
Foster care grant	9 (1.7%)	5 (1.2%)	13 (31.0%)	6 (3.0%)	2 (3.0%)	2 (0.9%)	2 (0.4%)	6 (5.8%)	4 (3.8%)	22 (7.2%)	2 (1.1%)	33 (3.7%)	106 (3.0%)
None	77 (14.7%)	48 (11.9%)	5 (11.9%)	55 (27.5%)	12 (18.2%)	40 (18.7%)	48 (10.2%)	5 (4.8%)	15 (14.2%)	52 (17.0%)	9 (4.8%)	95 (10.7%)	461 (13.1%)
Grant for older people (pension)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (0.2%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (0.0%)
Grants in aid	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	25 (24.0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	25 (0.7%)

Table 3: Demographic Data of Survey Participants - Continued

	Amatole (N=280)	Buffalo City Municipality (N=254)	Cape Winelands (N=16)	City of Cape Town (N=134)	Frances Baard (N=30)	Gert Sibande (N=115)	Harry Gwala (N=253)	John Taolo Gaetsewe (N=37)	Mangaung (N=62)	Nkangala (N=156)	Thabo Mofutsanyane (N=99)	uMgungundlovu (N=485)	Overall (N=1921)
HH respondent													
No	64 (22.9%)	87 (34.3%)	8 (50.0%)	46 (34.3%)	2 (6.7%)	21 (18.3%)	30 (11.9%)	7 (18.9%)	12 (19.4%)	32 (20.5%)	6 (6.1%)	49 (10.1%)	364 (18.9%)
Yes	214 (76.4%)	167 (65.7%)	8 (50.0%)	88 (65.7%)	28 (93.3%)	94 (81.7%)	223 (88.1%)	30 (81.1%)	50 (80.6%)	124 (79.5%)	93 (93.9%)	436 (89.9%)	1555 (80.9%)
HH Gender													
Female	225 (80.4%)	199 (78.3%)	10 (62.5%)	89 (66.4%)	24 (80.0%)	96 (83.5%)	223 (88.1%)	30 (81.1%)	51 (82.3%)	131 (84.0%)	81 (81.8%)	430 (88.7%)	1589 (82.7%)
Male	51 (18.2%)	53 (20.9%)	6 (37.5%)	45 (33.6%)	6 (20.0%)	18 (15.7%)	29 (11.5%)	7 (18.9%)	10 (16.1%)	24 (15.4%)	16 (16.2%)	47 (9.7%)	312 (16.2%)
HH Age Group													
16-20	4 (1.4%)	5 (2.0%)	1 (6.2%)	1 (0.7%)	1 (3.3%)	2 (1.7%)	8 (3.2%)	1 (2.7%)	3 (4.8%)	7 (4.5%)	0 (0%)	11 (2.3%)	44 (2.3%)
21-25	16 (5.7%)	14 (5.5%)	0 (0%)	12 (9.0%)	0 (0%)	8 (7.0%)	19 (7.5%)	4 (10.8%)	2 (3.2%)	10 (6.4%)	3 (3.0%)	43 (8.9%)	131 (6.8%)
26-30	30 (10.7%)	36 (14.2%)	1 (6.2%)	27 (20.1%)	3 (10.0%)	17 (14.8%)	28 (11.1%)	2 (5.4%)	9 (14.5%)	15 (9.6%)	12 (12.1%)	59 (12.2%)	239 (12.4%)
31-39	47 (16.8%)	67 (26.4%)	7 (43.8%)	36 (26.9%)	7 (23.3%)	37 (32.2%)	75 (29.6%)	7 (18.9%)	17 (27.4%)	46 (29.5%)	46 (46.5%)	139 (28.7%)	531 (27.6%)
40-49	49 (17.5%)	65 (25.6%)	1 (6.2%)	34 (25.4%)	10 (33.3%)	16 (13.9%)	56 (22.1%)	8 (21.6%)	10 (16.1%)	30 (19.2%)	17 (17.2%)	100 (20.6%)	396 (20.6%)
50-59	62 (22.1%)	38 (15.0%)	2 (12.5%)	15 (11.2%)	3 (10.0%)	9 (7.8%)	34 (13.4%)	8 (21.6%)	5 (8.1%)	22 (14.1%)	7 (7.1%)	59 (12.2%)	264 (13.7%)
Less than 15 years old	9 (3.2%)	8 (3.1%)	0 (0%)	1 (0.7%)	0 (0%)	5 (4.3%)	1 (0.4%)	0 (0%)	4 (6.5%)	0 (0%)	1 (1.0%)	0 (0%)	29 (1.5%)
Older than 60 years	61 (21.8%)	21 (8.3%)	4 (25.0%)	8 (6.0%)	6 (20.0%)	21 (18.3%)	32 (12.6%)	7 (18.9%)	12 (19.4%)	26 (16.7%)	13 (13.1%)	74 (15.3%)	285 (14.8%)
HH Marital Status													
Married/ Cohabiting	108 (38.6%)	98 (38.6%)	7 (43.8%)	65 (48.5%)	8 (26.7%)	23 (20.0%)	64 (25.3%)	7 (18.9%)	26 (41.9%)	43 (27.6%)	25 (25.3%)	141 (29.1%)	615 (32.0%)
Separated/ Divorced	6 (2.1%)	5 (2.0%)	1 (6.2%)	7 (5.2%)	0 (0%)	2 (1.7%)	3 (1.2%)	1 (2.7%)	4 (6.5%)	4 (2.6%)	4 (4.0%)	2 (0.4%)	39 (2.0%)
Single	119 (42.5%)	141 (55.5%)	4 (25.0%)	49 (36.6%)	18 (60.0%)	81 (70.4%)	169 (66.8%)	24 (64.9%)	22 (35.5%)	100 (64.1%)	64 (64.6%)	337 (69.5%)	1128 (58.7%)
Widowed	45 (16.1%)	10 (3.9%)	4 (25.0%)	13 (9.7%)	4 (13.3%)	9 (7.8%)	17 (6.7%)	5 (13.5%)	10 (16.1%)	9 (5.8%)	6 (6.1%)	5 (1.0%)	137 (7.1%)
HH Education Level													
None	40 (14.3%)	16 (6.3%)	1 (6.2%)	9 (6.7%)	3 (10.0%)	11 (9.6%)	3 (1.2%)	8 (21.6%)	3 (4.8%)	12 (7.7%)	18 (18.2%)	20 (4.1%)	144 (7.5%)
Primary	102 (36.4%)	56 (22.0%)	5 (31.2%)	20 (14.9%)	5 (16.7%)	27 (23.5%)	62 (24.5%)	10 (27.0%)	6 (9.7%)	30 (19.2%)	11 (11.1%)	80 (16.5%)	414 (21.6%)
Secondary	118 (42.1%)	169 (66.5%)	9 (56.2%)	100 (74.6%)	21 (70.0%)	74 (64.3%)	169 (66.8%)	18 (48.6%)	48 (77.4%)	112 (71.8%)	61 (61.6%)	362 (74.6%)	1261 (65.6%)
University/TT	18 (6.4%)	13 (5.1%)	1 (6.2%)	5 (3.7%)	1 (3.3%)	3 (2.6%)	19 (7.5%)	1 (2.7%)	5 (8.1%)	2 (1.3%)	9 (9.1%)	23 (4.7%)	100 (5.2%)
HH Employment													
Full time employed	14 (5.0%)	19 (7.5%)	6 (37.5%)	27 (20.1%)	3 (10.0%)	8 (7.0%)	16 (6.3%)	1 (2.7%)	9 (14.5%)	27 (17.3%)	12 (12.1%)	43 (8.9%)	185 (9.6%)
Part time employed	10 (3.6%)	12 (4.7%)	3 (18.8%)	14 (10.4%)	0 (0%)	2 (1.7%)	23 (9.1%)	1 (2.7%)	2 (3.2%)	6 (3.8%)	2 (2.0%)	30 (6.2%)	105 (5.5%)
Piece work	14 (5.0%)	30 (11.8%)	0 (0%)	1 (0.7%)	1 (3.3%)	5 (4.3%)	16 (6.3%)	1 (2.7%)	4 (6.5%)	10 (6.4%)	2 (2.0%)	15 (3.1%)	99 (5.2%)

	Amatole (N=280)	Buffalo City Municipality (N=254)	Cape Winelands (N=16)	City of Cape Town (N=134)	Frances Baard (N=30)	Gert Sibande (N=115)	Harry Gwala (N=253)	John Taolo Gaetsewe (N=37)	Mangaung (N=62)	Nkangala (N=156)	Thabo Mofutsanyane (N=99)	uMgungundlovu (N=485)	Overall (N=1921)
Self employed	3 (1.1%)	11 (4.3%)	1 (6.2%)	0 (0%)	2 (6.7%)	2 (1.7%)	17 (6.7%)	0 (0%)	6 (9.7%)	7 (4.5%)	5 (5.1%)	6 (1.2%)	60 (3.1%)
Unemployed	237 (84.6%)	182 (71.7%)	6 (37.5%)	92 (68.7%)	24 (80.0%)	98 (85.2%)	181 (71.5%)	34 (91.9%)	41 (66.1%)	106 (67.9%)	78 (78.8%)	391 (80.6%)	1470 (76.5%)
HH Income Source													
No other source of income	211 (75.4%)	138 (54.3%)	2 (12.5%)	84 (62.7%)	12 (40.0%)	77 (67.0%)	192 (75.9%)	31 (83.8%)	43 (69.4%)	94 (60.3%)	68 (68.7%)	305 (62.9%)	1257 (65.4%)
There is another / other source of income but is not regular	33 (11.8%)	78 (30.7%)	3 (18.8%)	11 (8.2%)	4 (13.3%)	12 (10.4%)	27 (10.7%)	2 (5.4%)	4 (6.5%)	36 (23.1%)	8 (8.1%)	128 (26.4%)	346 (18.0%)
Yes there is a regular source of income	34 (12.1%)	38 (15.0%)	11 (68.8%)	39 (29.1%)	14 (46.7%)	26 (22.6%)	34 (13.4%)	4 (10.8%)	15 (24.2%)	26 (16.7%)	23 (23.2%)	52 (10.7%)	316 (16.4%)

Appendix B : Data Tables

Table 4: Education: Performance and Access to Schooling Support

	Amatole (N=387)	Buffalo City Municipality (N=241)	Cape Winelands (N=32)	City of Cape Town (N=97)	Frances Baard (N=52)	Gert Sibande (N=159)	Harry Gwala (N=245)	John Taolo Gaetsewe (N=41)	Mangaung (N=79)	Nkangala (N=191)	Thabo Mofutsanyane (N=122)	uMgungundlovu (N=621)	Overall (N=2267)
School Performance													
Excellent/Good	317 (81.9%)	209 (86.7%)	27 (84.4%)	83 (85.6%)	49 (94.2%)	129 (81.1%)	230 (93.9%)	32 (78.0%)	70 (88.6%)	160 (83.8%)	116 (95.1%)	577 (92.9%)	1999 (88.2%)
Fair/Poor	50 (12.9%)	24 (10.0%)	5 (15.6%)	10 (10.3%)	3 (5.8%)	21 (13.2%)	15 (6.1%)	9 (22.0%)	9 (11.4%)	16 (8.4%)	6 (4.9%)	42 (6.8%)	210 (9.3%)
Not applicable	20 (5.2%)	8 (3.3%)	0 (0%)	4 (4.1%)	0 (0%)	9 (5.7%)	0 (0%)	0 (0%)	0 (0%)	15 (7.9%)	0 (0%)	2 (0.3%)	58 (2.6%)
Do Homework													
Never	83 (21.4%)	94 (39.0%)	9 (28.1%)	16 (16.5%)	5 (9.6%)	48 (30.2%)	132 (53.9%)	15 (36.6%)	27 (34.2%)	32 (16.8%)	21 (17.2%)	203 (32.7%)	685 (30.2%)
Yes	304 (78.6%)	147 (61.0%)	23 (71.9%)	81 (83.5%)	47 (90.4%)	111 (69.8%)	113 (46.1%)	26 (63.4%)	52 (65.8%)	159 (83.2%)	101 (82.8%)	418 (67.3%)	1582 (69.8%)
Have help with School													
Never	150 (38.8%)	159 (66.0%)	15 (46.9%)	20 (20.6%)	16 (30.8%)	94 (59.1%)	146 (59.6%)	25 (61.0%)	35 (44.3%)	92 (48.2%)	33 (27.0%)	384 (61.8%)	1169 (51.6%)
Yes	237 (61.2%)	82 (34.0%)	17 (53.1%)	77 (79.4%)	36 (69.2%)	65 (40.9%)	99 (40.4%)	16 (39.0%)	44 (55.7%)	99 (51.8%)	89 (73.0%)	237 (38.2%)	1098 (48.4%)
Learning Difficulty													
No difficulty	317 (81.9%)	210 (87.1%)	23 (71.9%)	72 (74.2%)	45 (86.5%)	124 (78.0%)	192 (78.4%)	21 (51.2%)	65 (82.3%)	164 (85.9%)	115 (94.3%)	546 (87.9%)	1894 (83.5%)
Yes, difficulty	70 (18.1%)	31 (12.9%)	9 (28.1%)	25 (25.8%)	7 (13.5%)	35 (22.0%)	53 (21.6%)	20 (48.8%)	14 (17.7%)	27 (14.1%)	7 (5.7%)	75 (12.1%)	373 (16.5%)
Have future study plan No	90 (23.3%)	28 (11.6%)	3 (9.4%)	9 (9.3%)	15 (28.8%)	37 (23.3%)	41 (16.7%)	9 (22.0%)	19 (24.1%)	64 (33.5%)	12 (9.8%)	140 (22.5%)	467 (20.6%)
Yes	297 (76.7%)	213 (88.4%)	29 (90.6%)	88 (90.7%)	37 (71.2%)	122 (76.7%)	204 (83.3%)	32 (78.0%)	60 (75.9%)	127 (66.5%)	110 (90.2%)	481 (77.5%)	1800 (79.4%)
Parents help													
No	52 (13.4%)	19 (7.9%)	10 (31.2%)	6 (6.2%)	4 (7.7%)	15 (9.4%)	15 (6.1%)	9 (22.0%)	3 (3.8%)	16 (8.4%)	7 (5.7%)	101 (16.3%)	257 (11.3%)
Yes	335 (86.6%)	222 (92.1%)	22 (68.8%)	91 (93.8%)	48 (92.3%)	144 (90.6%)	230 (93.9%)	32 (78.0%)	76 (96.2%)	175 (91.6%)	115 (94.3%)	520 (83.7%)	2010 (88.7%)
Have school stationery													
No	80 (20.7%)	33 (13.7%)	4 (12.5%)	22 (22.7%)	13 (25.0%)	61 (38.4%)	39 (15.9%)	21 (51.2%)	31 (39.2%)	96 (50.3%)	51 (41.8%)	213 (34.3%)	664 (29.3%)
Yes	307 (79.3%)	208 (86.3%)	28 (87.5%)	75 (77.3%)	39 (75.0%)	98 (61.6%)	206 (84.1%)	20 (48.8%)	48 (60.8%)	95 (49.7%)	71 (58.2%)	408 (65.7%)	1603 (70.7%)

Table 5: Education: Characteristics of Children not Attending School

	Amatole, N = 66	Buffalo City Municipality, N = 95	Cape Winelands , N = 6	City CT, N = 64	Frances Baard, N = 24	Gert Sibande, N = 24	Harry Gwala, N = 107	John Taolo Gaetsewe, N = 37	Mangaung, N = 13	Nkangala, N = 51	Thabo Mofutsanyane, N = 55	uMgungundlovu, N = 119	Total (Not attending school) N=661
Age Group													
<5yrs	51(42%)	69 (70%)	1 (0%)	39(88%)	13(92%)	16(57%)	68 (100%)	25 (96%)	9 (60%)	35 (70%)	37 (97%)	81 (74%)	444 (67%)
6-9yrs	10 (6%)	17 (12%)	2 (15%)	16 (22%)	5 (27%)	6 (8%)	37 (21%)	10 (33%)	3 (8.5%)	11 (9%)	18 (26%)	28 (9.2%)	163 (25%)
10-11yrs	0 (0%)	2 (5%)	0 (0%)	2 (27%)	6 (35%)	0 (0%)	2 (3%)	1 (11%)	0 (0%)	1 (3%)	0 (0%)	0 (0%)	14 (2%)
>12yrs	5 (2%)	7 (5%)	3 (13%)	7 (11%)	0 (0%)	2 (2%)	0 (0%)	1 (3%)	1 (3%)	4 (4%)	0 (0%)	10 (2.6%)	40 (6%)
HH Employment Status													
Employed	7 (5%)	18 (14%)	1 (1%)	18 (14%)	2 (2%)	2 (2%)	31 (24%)	3 (2%)	4 (3%)	8 (6%)	13 (10%)	21 (16%)	128 (3.6%)
Unemployed	59 (11%)	77 (14%)	5 (1%)	46 (9%)	22 (4%)	22 (4%)	76 (14%)	34 (6%)	9 (2%)	43 (8%)	42 (8%)	98 (18%)	533 (15%)
HH Education Level													
None	12 (18%)	5 (8%)	0 (0%)	9 (14%)	0 (0%)	1 (2%)	2 (3%)	17 (26%)	0 (0%)	8 (12%)	7 (1%)	4 (6%)	65 (1.9%)
Primary	28 (24%)	18 (15%)	1 (1%)	9 (8%)	6 (5%)	5 (4%)	19 (16%)	6 (5%)	3 (3%)	10 (9%)	2 (2%)	10 (9%)	117 (33%)
Secondary	22 (5%)	70 (15%)	5 (1%)	45 (10%)	18 (4%)	18 (4%)	78 (17%)	14 (3%)	10 (2%)	32 (7%)	40 (9%)	102 (22%)	454 (13%)
University/TT	4 (16%)	2 (8%)	0 (0%)	1 (4%)	0 (0%)	0 (0%)	8 (32%)	0 (0%)	0 (0%)	1 (4%)	6 (24%)	3 (12%)	25 (0.7%)
HH Income Source													
No other source of income	54 (12%)	69 (15%)	1 (0%)	41 (9%)	15 (3%)	8 (2%)	81 (18%)	30 (7%)	9 (2%)	36 (8%)	35 (8%)	75 (17%)	454 (13%(
There is another / other source of income but is not regular	5 (5%)	13 (12%)	4 (4%)	5 (5%)	5 (5%)	3 (3%)	15 (14%)	4 (4%)	1 (1%)	10 (9%)	2 (2%)	40 (37%)	107 (3.1%)
Yes, there is a regular source of income	7 (7%)	13 (13%)	1 (1%)	18 (18%)	4 (4%)	13 (13%)	11 (11%)	3 (3%)	3 (3%)	5 (5%)	18 (18%)	4 (4%)	100 (2.9%)

N= Total not attending school , n (%) of the total in district

Table 6: Sexual Abuse

	Amatole (N=14)	Buffalo City Municipality (N=17)	Cape Winelands (N=5)	City of Cape Town (N=11)	Gert Sibande (N=6)	Harry Gwala (N=16)	John Taolo Gaetsewe (N=5)	Mangaung (N=4)	Nkangala (N=2)	Thabo Mofutsanyane (N=6)	uMgungundlovu (N=86)	Overall (N=172)
Age Group												
<5yrs	1 (7.1%)	0 (0%)	0 (0%)	1 (9.1%)	0 (0%)	2 (12.5%)	1 (20.0%)	0 (0%)	0 (0%)	1 (16.7%)	2 (2.3%)	8 (4.7%)
6-9yrs	2 (14.3%)	5 (29.4%)	0 (0%)	1 (9.1%)	1 (16.7%)	3 (18.8%)	2 (40.0%)	0 (0%)	0 (0%)	2 (33.3%)	9 (10.5%)	25 (14.5%)
10-11yrs	1 (7.1%)	2 (11.8%)	1 (20.0%)	1 (9.1%)	0 (0%)	1 (6.2%)	0 (0%)	0 (0%)	1 (50.0%)	0 (0%)	3 (3.5%)	10 (5.8%)
>12yrs	10 (71.4%)	10 (58.8%)	4 (80.0%)	8 (72.7%)	5 (83.3%)	10 (62.5%)	2 (40.0%)	4 (100%)	1 (50.0%)	3 (50.0%)	72 (83.7%)	129 (75.0%)
Caregivers												
Both parents	2 (14.3%)	7 (41.2%)	1 (20.0%)	3 (27.3%)	1 (16.7%)	4 (25.0%)	1 (20.0%)	3 (75.0%)	0 (0%)	5 (83.3%)	16 (18.6%)	43 (25.0%)
Family	1 (7.1%)	0 (0%)	0 (0%)	1 (9.1%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	6 (7.0%)	8 (4.7%)
Grand parents	4 (28.6%)	0 (0%)	0 (0%)	4 (36.4%)	1 (16.7%)	7 (43.8%)	1 (20.0%)	0 (0%)	1 (50.0%)	1 (16.7%)	10 (11.6%)	29 (16.9%)
Single parent	7 (50.0%)	10 (58.8%)	1 (20.0%)	3 (27.3%)	4 (66.7%)	5 (31.2%)	3 (60.0%)	1 (25.0%)	1 (50.0%)	0 (0%)	51 (59.3%)	86 (50.0%)
Other	0 (0%)	0 (0%)	1 (20.0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	3 (3.5%)	4 (2.3%)
Secure care family	0 (0%)	0 (0%)	2 (40.0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	2 (1.2%)
HH Provide Basic Needs												
No	2 (14.3%)	0 (0%)	0 (0%)	1 (9.1%)	2 (33.3%)	8 (50.0%)	1 (20.0%)	1 (25.0%)	0 (0%)	2 (33.3%)	20 (23.3%)	37 (21.5%)
Yes	12 (85.7%)	17 (100%)	5 (100%)	10 (90.9%)	4 (66.7%)	8 (50.0%)	4 (80.0%)	3 (75.0%)	2 (100%)	4 (66.7%)	66 (76.7%)	135 (78.5%)
Violent Adults												
Never/not at all	4 (28.6%)	5 (29.4%)	1 (20.0%)	1 (9.1%)	3 (50.0%)	2 (12.5%)	1 (20.0%)	1 (25.0%)	0 (0%)	3 (50.0%)	65 (75.6%)	86 (50.0%)
Yes	10 (71.4%)	12 (70.6%)	4 (80.0%)	10 (90.9%)	3 (50.0%)	14 (87.5%)	4 (80.0%)	3 (75.0%)	2 (100%)	3 (50.0%)	21 (24.4%)	86 (50.0%)
Know where child is												
No	3 (21.4%)	1 (5.9%)	1 (20.0%)	0 (0%)	1 (16.7%)	2 (12.5%)	2 (40.0%)	1 (25.0%)	0 (0%)	0 (0%)	5 (5.8%)	16 (9.3%)
Yes	11 (78.6%)	16 (94.1%)	4 (80.0%)	11 (100%)	5 (83.3%)	14 (87.5%)	3 (60.0%)	3 (75.0%)	2 (100%)	6 (100%)	81 (94.2%)	156 (90.7%)
Anxious/worried												
No	6 (42.9%)	11 (64.7%)	1 (20.0%)	4 (36.4%)	5 (83.3%)	11 (68.8%)	4 (80.0%)	1 (25.0%)	2 (100%)	3 (50.0%)	75 (87.2%)	123 (71.5%)
Yes	8 (57.1%)	6 (35.3%)	4 (80.0%)	7 (63.6%)	1 (16.7%)	5 (31.2%)	1 (20.0%)	3 (75.0%)	0 (0%)	3 (50.0%)	11 (12.8%)	49 (28.5%)
Suicide Plan												
No	1 (7.1%)	0 (0%)	1 (20.0%)	1 (9.1%)	1 (16.7%)	2 (12.5%)	0 (0%)	1 (25.0%)	0 (0%)	1 (16.7%)	2 (2.3%)	10 (5.8%)
Yes	0 (0%)	1 (5.9%)	1 (20.0%)	3 (27.3%)	0 (0%)	2 (12.5%)	1 (20.0%)	2 (50.0%)	0 (0%)	0 (0%)	2 (2.3%)	12 (7.0%)

Table 7: Health: Diarrhoea

	Amatole (N=94)	Buffalo City Municipality (N=47)	Cape Winelands (N=5)	City of Cape Town (N=18)	Frances Baard (N=4)	Gert Sibande (N=19)	Harry Gwala (N=85)	John Taolo Gaetsewe (N=22)	Mangaung (N=25)	Nkangala (N=12)	Thabo Mofutsanyane (N=24)	uMgungundlovu (N=104)	Overall (N=459)
No	429 (12%)	356 (10%)	37 (1.1%)	182 (5.2%)	62 (1.8%)	195 (5.6%)	387 (11%)	82 (2.3%)	81 (2.3%)	293 (8.4%)	162 (4.6%)	783 (22%)	3,049 (87%)
Yes	94 (2.7%)	47 (1.3%)	5 (0.1%)	18 (0.5%)	4 (0.1%)	19 (0.5%)	85 (2.4%)	22 (0.6%)	25 (0.7%)	12 (0.3%)	24 (0.7%)	104 (3.0%)	459 (13%)
Gender													
Female	38 (40.4%)	32 (68.1%)	4 (80.0%)	10 (55.6%)	3 (75.0%)	11 (57.9%)	40 (47.1%)	9 (40.9%)	17 (68.0%)	7 (58.3%)	11 (45.8%)	51 (49.0%)	233 (50.8%)
Male	56 (59.6%)	15 (31.9%)	1 (20.0%)	8 (44.4%)	1 (25.0%)	8 (42.1%)	45 (52.9%)	13 (59.1%)	8 (32.0%)	5 (41.7%)	13 (54.2%)	53 (51.0%)	226 (49.2%)
Age Group													
<5yrs	25 (26.6%)	9 (19.1%)	1 (20.0%)	5 (27.8%)	0 (0%)	5 (26.3%)	13 (15.3%)	6 (27.3%)	3 (12.0%)	7 (58.3%)	6 (25.0%)	13 (12.5%)	93 (20.3%)
6-9yrs	26 (27.7%)	14 (29.8%)	1 (20.0%)	4 (22.2%)	1 (25.0%)	5 (26.3%)	27 (31.8%)	5 (22.7%)	6 (24.0%)	2 (16.7%)	10 (41.7%)	27 (26.0%)	128 (27.9%)
10-11yrs	14 (14.9%)	4 (8.5%)	1 (20.0%)	2 (11.1%)	0 (0%)	4 (21.1%)	8 (9.4%)	3 (13.6%)	2 (8.0%)	1 (8.3%)	2 (8.3%)	12 (11.5%)	53 (11.5%)
>12yrs	29 (30.9%)	20 (42.6%)	2 (40.0%)	7 (38.9%)	3 (75.0%)	5 (26.3%)	37 (43.5%)	8 (36.4%)	14 (56.0%)	2 (16.7%)	6 (25.0%)	52 (50.0%)	185 (40.3%)
Access to Clean Drinking Water													
No	6 (6.4%)	0 (0%)	0 (0%)	0 (0%)	1 (25.0%)	0 (0%)	0 (0%)	1 (4.5%)	4 (16.0%)	0 (0%)	0 (0%)	2 (1.9%)	14 (3.1%)
Yes	88 (93.6%)	47 (100%)	5 (100%)	18 (100%)	3 (75.0%)	19 (100%)	85 (100%)	21 (95.5%)	21 (84.0%)	12 (100%)	24 (100%)	102 (98.1%)	445 (96.9%)
Wash hands before eating													
No	39 (41.5%)	19 (40.4%)	4 (80.0%)	2 (11.1%)	3 (75.0%)	2 (10.5%)	5 (5.9%)	10 (45.5%)	0 (0%)	1 (8.3%)	3 (12.5%)	58 (55.8%)	146 (31.8%)
Yes	55 (58.5%)	28 (59.6%)	1 (20.0%)	16 (88.9%)	1 (25.0%)	17 (89.5%)	80 (94.1%)	12 (54.5%)	25 (100%)	11 (91.7%)	21 (87.5%)	46 (44.2%)	313 (68.2%)
Wash hands after toilet													
No	30 (31.9%)	13 (27.7%)	1 (20.0%)	3 (16.7%)	1 (25.0%)	4 (21.1%)	7 (8.2%)	15 (68.2%)	0 (0%)	1 (8.3%)	2 (8.3%)	37 (35.6%)	114 (24.8%)
Yes	64 (68.1%)	34 (72.3%)	4 (80.0%)	15 (83.3%)	3 (75.0%)	15 (78.9%)	78 (91.8%)	7 (31.8%)	25 (100%)	11 (91.7%)	22 (91.7%)	67 (64.4%)	345 (75.2%)
Visited health facility													
No	43 (45.7%)	31 (66.0%)	3 (60.0%)	9 (50.0%)	2 (50.0%)	13 (68.4%)	65 (76.5%)	17 (77.3%)	3 (12.0%)	6 (50.0%)	15 (62.5%)	81 (77.9%)	288 (62.7%)
Yes	24 (25.5%)	7 (14.9%)	1 (20.0%)	2 (11.1%)	0 (0%)	3 (15.8%)	7 (8.2%)	2 (9.1%)	0 (0%)	3 (25.0%)	2 (8.3%)	7 (6.7%)	58 (12.6%)
Didn't Respond to Question*	27 (28.7%)	9 (19.1%)	1 (20.0%)	7 (38.9%)	2 (50.0%)	3 (15.8%)	13 (15.3%)	3 (13.6%)	22 (88.0%)	3 (25.0%)	7 (29.2%)	16 (15.4%)	113 (24.6%)

Table 8: Economic Wellbeing

	Amatole (N=523)	Buffalo City Municipality (N=403)	Cape Winelands (N=42)	City of Cape Town (N=200)	Frances Baard (N=66)	Gert Sibande (N=214)	Harry Gwala (N=472)	John Taolo Gaetsewe (N=104)	Mangaung (N=106)	Nkangala (N=305)	Thabo Mofutsanyane (N=186)	uMgungundlovu (N=887)	Overall (N=3508)
Have Decent Cloth													
No	91 (17.4%)	85 (21.1%)	4 (9.5%)	26 (13.0%)	13 (19.7%)	No	91 (17.4%)	85 (21.1%)	4 (9.5%)	26 (13.0%)	13 (19.7%)	No	91 (17.4%)
Yes	432 (82.6%)	318 (78.9%)	38 (90.5%)	173 (86.5%)	53 (80.3%)	169 (79.0%)	392 (83.1%)	62 (59.6%)	81 (76.4%)	249 (81.6%)	155 (83.3%)	637 (71.8%)	2759 (78.6%)
Have Beddings													
No	118 (22.6%)	65 (16.1%)	4 (9.5%)	35 (17.5%)	4 (6.1%)	86 (40.2%)	46 (9.7%)	25 (24.0%)	15 (14.2%)	57 (18.7%)	18 (9.7%)	141 (15.9%)	614 (17.5%)
Yes	405 (77.4%)	338 (83.9%)	38 (90.5%)	164 (82.0%)	62 (93.9%)	128 (59.8%)	426 (90.3%)	79 (76.0%)	91 (85.8%)	248 (81.3%)	168 (90.3%)	746 (84.1%)	2893 (82.5%)
Electric Access													
No	136 (26.0%)	48 (11.9%)	2 (4.8%)	13 (6.5%)	12 (18.2%)	59 (27.6%)	26 (5.5%)	59 (56.7%)	24 (22.6%)	13 (4.3%)	25 (13.4%)	37 (4.2%)	454 (12.9%)
Yes	387 (74.0%)	355 (88.1%)	40 (95.2%)	186 (93.0%)	54 (81.8%)	155 (72.4%)	446 (94.5%)	45 (43.3%)	82 (77.4%)	292 (95.7%)	161 (86.6%)	850 (95.8%)	3053 (87.0%)

Table 9: Food Security & Nutrition: Children 6 years and Older

Children 6 years and Older	Amatole (N=121)	Buffalo City Municipality (N=98)	Cape Winelands (N=1)	City of Cape Town (N=44)	Frances Baard (N=14)	Gert Sibande (N=28)	Harry Gwala (N=68)	John Taolo Gaetsewe (N=26)	Mangaung (N=15)	Nkangala (N=50)	Thabo Mofutsanyane (N=38)	uMgungundlovu (N=109)	Overall (N=612)
Feed 3 times a day													
No	12 (9.9%)	21 (21.4%)	0 (0%)	7 (15.9%)	0 (0%)	3 (10.7%)	13 (19.1%)	10 (38.5%)	1 (6.7%)	0 (0%)	5 (13.2%)	35 (32.1%)	107 (17.5%)
Yes	109 (90.1%)	77 (78.6%)	1 (100%)	37 (84.1%)	14 (100%)	25 (89.3%)	55 (80.9%)	16 (61.5%)	14 (93.3%)	50 (100%)	33 (86.8%)	74 (67.9%)	505 (82.5%)
Eats Fruits													
No	65 (53.7%)	56 (57.1%)	1 (100%)	22 (50.0%)	12 (85.7%)	2 (7.1%)	31 (45.6%)	22 (84.6%)	4 (26.7%)	30 (60.0%)	17 (44.7%)	78 (71.6%)	340 (55.6%)
Yes	56 (46.3%)	42 (42.9%)	0 (0%)	22 (50.0%)	2 (14.3%)	26 (92.9%)	37 (54.4%)	4 (15.4%)	11 (73.3%)	20 (40.0%)	21 (55.3%)	31 (28.4%)	272 (44.4%)
Eats Vegetables													
No	49 (40.5%)	51 (52.0%)	1 (100%)	19 (43.2%)	11 (78.6%)	2 (7.1%)	16 (23.5%)	19 (73.1%)	3 (20.0%)	18 (36.0%)	9 (23.7%)	59 (54.1%)	257 (42.0%)
Yes	72 (59.5%)	47 (48.0%)	0 (0%)	25 (56.8%)	3 (21.4%)	26 (92.9%)	52 (76.5%)	7 (26.9%)	12 (80.0%)	32 (64.0%)	29 (76.3%)	50 (45.9%)	355 (58.0%)
Eats Meat/Proteins													
No	55 (45.5%)	49 (50.0%)	0 (0%)	15 (34.1%)	8 (57.1%)	6 (21.4%)	15 (22.1%)	20 (76.9%)	3 (20.0%)	18 (36.0%)	6 (15.8%)	40 (36.7%)	235 (38.4%)
Yes	66 (54.5%)	49 (50.0%)	1 (100%)	29 (65.9%)	6 (42.9%)	22 (78.6%)	53 (77.9%)	6 (23.1%)	12 (80.0%)	32 (64.0%)	32 (84.2%)	69 (63.3%)	377 (61.6%)
Sleeps Hungry													
No	94 (77.7%)	80 (81.6%)	1 (100%)	40 (90.9%)	14 (100%)	24 (85.7%)	57 (83.8%)	12 (46.2%)	10 (66.7%)	45 (90.0%)	32 (84.2%)	85 (78.0%)	494 (80.7%)
Yes	27 (22.3%)	18 (18.4%)	0 (0%)	4 (9.1%)	0 (0%)	4 (14.3%)	11 (16.2%)	14 (53.8%)	5 (33.3%)	5 (10.0%)	6 (15.8%)	24 (22.0%)	118 (19.3%)
Height-for-age z-scores (age <= 5 years)													
<-2	346 (54.75)	97 (70.80)	73 (64.04)	11 (68.75)	21 (48.84)	11 (29.73)	54 (54.00)	18 (60.00)	30 (49.18)	4 (36.36)	16 (59.26)	0 (0.00)	11 (20.37)
=>-2	286 (45.25)	40 (29.20)	41 (35.96)	5 (31.25)	22 (51.16)	26 (70.27)	46 (46.00)	12 (40.00)	31 (50.82)	7 (63.64)	11 (40.74)	2 (100.0)	43 (79.63)
Weight-for-age z-scores (age <= 5 years)													
<-2	48 (9.82)	13 (9.49)	6 (5.26)	4 (36.36)	7 (23.33)	0 (0.00)	0 (0.00)	4 (13.33)	3 (6.12)	3 (27.27)	4 (14.81)	0 (0.00)	4 (7.41)
=>-2	441 (90.18)	124 (90.51)	108 (94.74)	7 (63.64)	23 (76.67)	16 (100.0)	8 (100.0)	26 (86.67)	46 (93.88)	8 (72.73)	23 (85.19)	2 (100.0)	50 (92.59)
BMI-for-age z-scores (age <= 5 years)													
<-2	45 (9.20)	1 (0.73)	5 (4.39)	3 (27.27)	4 (13.33)	0 (0.00)	0 (0.00)	3 (10.00)	2 (4.08)	3 (27.27)	3 (11.11)	0 (0.00)	21 (38.89)
=>-2	444 (90.80)	136 (99.27)	109 (95.61)	8 (72.73)	26 (86.67)	16 (100.0)	8 (100.0)	27 (90.00)	47 (95.92)	8 (72.73)	24 (88.89)	2 (100.0)	33 (61.11)

Table 10: Food Security & Nutrition: Children 5years and Younger

Children 5years and Younger	Amatole (N=402)	Buffalo City Municipality (N=305)	Cape Winelands (N=41)	City of Cape Town (N=156)	Frances Baard (N=52)	Gert Sibande (N=186)	Harry Gwala (N=404)	John Taolo Gaetsewe (N=78)	Mangaung (N=91)	Nkangala (N=255)	Thabo Mofutsanyane (N=148)	uMgungundlovu (N=778)	Overall (N=2896)
Feed 3 times a day													
No	60 (14.9%)	55 (18.0%)	3 (7.3%)	23 (14.7%)	4 (7.7%)	35 (18.8%)	78 (19.3%)	47 (60.3%)	8 (8.8%)	21 (8.2%)	13 (8.8%)	188 (24.2%)	535 (18.5%)
Yes	342 (85.1%)	250 (82.0%)	38 (92.7%)	133 (85.3%)	48 (92.3%)	151 (81.2%)	326 (80.7%)	31 (39.7%)	83 (91.2%)	234 (91.8%)	135 (91.2%)	590 (75.8%)	2361 (81.5%)
Eats Fruits													
No	238 (59.2%)	152 (49.8%)	16 (39.0%)	67 (42.9%)	32 (61.5%)	82 (44.1%)	222 (55.0%)	70 (89.7%)	54 (59.3%)	152 (59.6%)	67 (45.3%)	503 (64.7%)	1655 (57.1%)
Yes	164 (40.8%)	153 (50.2%)	25 (61.0%)	89 (57.1%)	20 (38.5%)	104 (55.9%)	182 (45.0%)	8 (10.3%)	37 (40.7%)	103 (40.4%)	81 (54.7%)	275 (35.3%)	1241 (42.9%)
Eats Vegetables													
No	153 (38.1%)	125 (41.0%)	8 (19.5%)	68 (43.6%)	23 (44.2%)	35 (18.8%)	99 (24.5%)	63 (80.8%)	42 (46.2%)	82 (32.2%)	30 (20.3%)	387 (49.7%)	1115 (38.5%)
Yes	249 (61.9%)	180 (59.0%)	33 (80.5%)	88 (56.4%)	29 (55.8%)	151 (81.2%)	305 (75.5%)	15 (19.2%)	49 (53.8%)	173 (67.8%)	118 (79.7%)	391 (50.3%)	1781 (61.5%)
Eats Meat/Proteins													
No	178 (44.3%)	114 (37.4%)	2 (4.9%)	47 (30.1%)	13 (25.0%)	39 (21.0%)	93 (23.0%)	41 (52.6%)	32 (35.2%)	90 (35.3%)	36 (24.3%)	348 (44.7%)	1033 (35.7%)
Yes	224 (55.7%)	191 (62.6%)	39 (95.1%)	109 (69.9%)	39 (75.0%)	147 (79.0%)	311 (77.0%)	37 (47.4%)	59 (64.8%)	165 (64.7%)	112 (75.7%)	430 (55.3%)	1863 (64.3%)
Sleeps Hungry													
No	305 (75.9%)	248 (81.3%)	35 (85.4%)	135 (86.5%)	50 (96.2%)	153 (82.3%)	342 (84.7%)	40 (51.3%)	69 (75.8%)	230 (90.2%)	112 (75.7%)	615 (79.0%)	2334 (80.6%)
Yes	97 (24.1%)	57 (18.7%)	6 (14.6%)	21 (13.5%)	2 (3.8%)	33 (17.7%)	62 (15.3%)	38 (48.7%)	22 (24.2%)	25 (9.8%)	36 (24.3%)	163 (21.0%)	562 (19.4%)
Height-for-age z-scores (age > 5 years)													
<-2	1138 (47.54)	214 (57.53)	169 (61.01)	50 (56.18)	31 (21.99)	44 (25.43)	347 (54.22)	117 (72.22)	85 (35.12)	14 (36.84)	37 (49.33)	10 (25.00)	20 (13.79)
=>-2	1256 (52.46)	158 (42.47)	108 (38.99)	39 (43.82)	110 (78.01)	129 (74.57)	293 (45.78)	45 (27.78)	157 (64.88)	24 (63.16)	38 (50.67)	30 (75.00)	125 (86.21)
Weight-for-age z-scores (age > 5 years)													
<-2	90 (12.52)	20 (12.66)	18 (14.88)	4 (19.05)	4 (6.15)	0 (0.00)	10 (17.24)	8 (12.31)	0 (0.00)	3 (18.75)	15 (50.00)	2 (14.29)	6 (8.82)
=>-2	629 (87.48)	138 (87.34)	103 (85.12)	17 (80.95)	61 (93.85)	24 (100.0)	48 (82.76)	57 (87.69)	79 (100.0)	13 (81.25)	15 (50.00)	12 (85.71)	62 (91.18)

Table 11: COVID-19

	Amatole (N=308)	Buffalo City Municipality (N=288)	Cape Winelands (N=18)	City of Cape Town (N=147)	Frances Baard (N=24)	Gert Sibande (N=121)	Harry Gwala (N=233)	John Taolo Gaetsewe (N=10)	Nkangala (N=158)	Thabo Mofutsanyane (N=124)	uMgungundlovu (N=258)	Overall (N=1689)
Covid Family Infection												
No	267 (86.7%)	228 (79.2%)	16 (88.9%)	132 (89.8%)	22 (91.7%)	103 (85.1%)	208 (89.3%)	8 (80.0%)	139 (88.0%)	122 (98.4%)	236 (91.5%)	1481 (87.7%)
Not sure	25 (8.1%)	22 (7.6%)	0 (0%)	2 (1.4%)	0 (0%)	10 (8.3%)	11 (4.7%)	2 (20.0%)	12 (7.6%)	0 (0%)	12 (4.7%)	96 (5.7%)
Yes	16 (5.2%)	38 (13.2%)	2 (11.1%)	13 (8.8%)	2 (8.3%)	8 (6.6%)	14 (6.0%)	0 (0%)	7 (4.4%)	2 (1.6%)	10 (3.9%)	112 (6.6%)
Worry about Covid												
No	36 (11.7%)	78 (27.1%)	5 (27.8%)	69 (46.9%)	6 (25.0%)	31 (25.6%)	39 (16.7%)	3 (30.0%)	15 (9.5%)	9 (7.3%)	9 (3.5%)	300 (17.8%)
Yes	272 (88.3%)	210 (72.9%)	13 (72.2%)	78 (53.1%)	18 (75.0%)	90 (74.4%)	194 (83.3%)	7 (70.0%)	143 (90.5%)	115 (92.7%)	249 (96.5%)	1389 (82.2%)
Talk to Children about Covid												
No	17 (5.5%)	24 (8.3%)	0 (0%)	12 (8.2%)	6 (25.0%)	4 (3.3%)	24 (10.3%)	4 (40.0%)	6 (3.8%)	5 (4.0%)	6 (2.3%)	108 (6.4%)
Yes	291 (94.5%)	264 (91.7%)	18 (100%)	135 (91.8%)	18 (75.0%)	117 (96.7%)	209 (89.7%)	6 (60.0%)	152 (96.2%)	119 (96.0%)	252 (97.7%)	1581 (93.6%)

Table 12: HIV/AIDS

Variables	Overall	Amatole	Buffalo City	Mangaung	Thabo Mofutsanyane	Harry Gwala	uMgungundlovu	Gert Sibande	Nkangala	Frances Baard	John Taolo Gaetsewe	Cape Winelands	City of Cape Town
Have you ever been tested for HIV infection?													
Yes	1670 (47.65)	180 (34.55)	111 (27.54)	33 (31.13)	51 (27.42)	272 (57.51)	570 (64.26)	70 (32.86)	213 (70.07)	25 (37.88)	43 (41.35)	13 (30.95)	89 (44.50)
No	1703 (48.59)	319 (61.23)	264 (65.51)	70 (66.04)	131 (70.43)	187 (39.53)	296 (33.37)	135 (63.38)	77 (25.33)	39 (59.09)	56 (53.85)	28 (66.67)	101 (50.50)
Not sure/Don't want to answer	132 (3.77)	22 (4.22)	28 (6.95)	3 (2.83)	4 (2.15)	14 (2.96)	21 (2.37)	8 (3.76)	14 (4.61)	2 (3.03)	5 (4.81)	1 (2.38)	10 (5.00)
If Yes, what is your HIV status?													
Positive	23 (0.66)	0 (0.00)	1 (0.25)	5 (4.72)	0 (0.00)	3 (0.63)	10 (1.13)	0 (0.00)	3 (0.99)	0 (0.00)	1 (0.96)	0 (0.00)	0 (0.00)
Negative	527 (15.04)	48 (9.21)	25 (6.20)	15 (14.15)	11 (5.91)	66 (13.95)	240 (27.06)	26 (12.21)	66 (21.71)	1 (1.52)	3 (2.88)	7 (16.67)	19 (9.50)
Don't know/want to answer	56 (1.60)	5 (0.96)	5 (1.24)	0 (0.00)	0 (0.00)	18 (3.81)	9 (1.01)	4 (1.88)	7 (2.30)	4 (6.06)	1 (0.96)	0 (0.00)	3 (1.50)
Not applicable	2899 (82.71)	468 (89.83)	372 (92.31)	86 (81.13)	175 (94.09)	386 (81.61)	628 (70.80)	183 (85.92)	228 (75.00)	61 (92.42)	99 (95.19)	35 (83.33)	178 (89.00)
If HIV Positive; Are you taking your HIV treatment every day?													
Yes	125 (3.57)	20 (3.84)	4 (0.99)	5 (4.72)	0 (0.00)	46 (9.73)	34 (3.83)	7 (3.29)	6 (1.97)	0 (0.00)	2 (1.92)	0 (0.00)	1 (0.50)
No	610 (17.40)	136 (26.10)	116 (28.78)	40 (37.74)	64 (34.41)	45 (9.51)	49 (5.52)	68 (31.92)	36 (11.84)	7 (10.61)	14 (13.46)	4 (9.52)	31 (15.50)
Not applicable	2770 (79.03)	365 (70.06)	283 (70.22)	61 (57.55)	122 (65.59)	382 (80.76)	804 (90.64)	138 (64.79)	262 (86.18)	59 (89.39)	88 (84.62)	38 (90.48)	168 (84.00)
Has your child ever been taught in any of their classes or club activities, about HIV infection or AIDS and how to protect them selves from getting infected with HIV?													
Yes	1574 (44.91)	185 (35.51)	149 (36.97)	38 (35.85)	53 (28.49)	212 (44.82)	505 (56.93)	85 (39.91)	187 (61.51)	36 (54.55)	26 (25.00)	17 (40.48)	81 (40.50)
No	1642 (46.85)	259 (49.71)	217 (53.85)	67 (63.21)	129 (69.35)	237 (50.11)	327 (36.87)	111 (52.11)	97 (31.91)	27 (40.91)	54 (51.92)	23 (54.76)	94 (47.00)
Don't know/Don't remember	274 (7.82)	75 (14.40)	35 (8.68)	1 (0.94)	4 (2.15)	24 (5.07)	49 (5.52)	14 (6.57)	20 (6.58)	2 (3.03)	24 (23.08)	2 (4.76)	24 (12.00)
Not applicable	15 (0.43)	2 (0.38)	2 (0.50)	0 (0.00)	0 (0.00)	0 (0.00)	6 (0.68)	3 (1.41)	0 (0.00)	1 (1.52)	0 (0.00)	0 (0.00)	1 (0.50)
Have you ever talked about HIV infection or AIDS with your parents or guardians?													
Yes	1338 (38.17)	149 (28.60)	98 (24.32)	24 (22.64)	48 (25.81)	166 (35.10)	522 (58.85)	44 (20.66)	154 (50.66)	28 (42.42)	16 (15.38)	13 (30.95)	76 (38.00)
No	1971 (56.23)	325 (62.38)	264 (65.51)	82 (77.36)	137 (73.66)	288 (60.89)	322 (36.30)	156 (73.24)	144 (47.37)	36 (54.55)	79 (75.96)	28 (66.67)	110 (55.00)
Don't want to answer/Don't remember	196 (5.59)	47 (9.02)	41 (10.17)	0 (0.00)	1 (0.54)	19 (4.02)	43 (4.85)	13 (6.10)	6 (1.97)	2 (3.03)	9 (8.65)	1 (2.38)	14 (7.00)
To your knowledge, has your child ever been involved in sexual activity													
Yes	145 (4.14)	23 (4.41)	20 (4.96)	6 (5.66)	1 (0.54)	13 (2.75)	32 (3.61)	11 (5.16)	18 (5.92)	4 (6.06)	1 (0.96)	3 (7.14)	13 (6.50)
No	3277 (93.50)	484 (92.90)	366 (90.82)	99 (93.40)	181 (97.31)	448 (94.71)	839 (94.59)	194 (91.08)	284 (93.42)	62 (93.94)	99 (95.19)	38 (90.48)	183 (91.50)
I don't want to answer	50 (1.43)	12 (2.30)	12 (2.98)	0 (0.00)	0 (0.00)	8 (1.69)	4 (0.45)	5 (2.35)	2 (0.66)	0 (0.00)	4 (3.85)	1 (2.38)	2 (1.00)
Not applicable	33 (0.94)	2 (0.38)	5 (1.24)	1 (0.94)	4 (2.15)	4 (0.85)	12 (1.35)	3 (1.41)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	2 (1.00)

Variables	Overall	Amatole	Buffalo City	Mangaung	Thabo Mofutsanyane	Harry Gwala	uMgungundlovu	Gert Sibande	Nkangala	Frances Baard	John Taolo Gaetsewe	Cape Winelands	City of Cape Town
The last time you had a sexual activity, did you or your partner use a condom?													
Yes	73 (2.08)	14 (2.69)	7 (1.74)	5 (4.72)	1 (0.54)	5 (1.06)	10 (1.13)	7 (3.29)	17 (5.59)	0 (0.00)	1 (0.96)	0 (0.00)	6 (3.00)
No	32 (0.91)	5 (0.96)	7 (1.74)	1 (0.94)	0 (0.00)	2 (0.42)	8 (0.90)	0 (0.00)	0 (0.00)	2 (3.03)	0 (0.00)	2 (4.76)	5 (2.50)
None/Don't remember	3336 (95.18)	497 (95.39)	382 (94.79)	99 (93.40)	181 (97.31)	456 (96.41)	844 (95.15)	200 (93.90)	287 (94.41)	63 (95.45)	103 (99.04)	39 (92.86)	185 (92.50)
Not applicable	64 (1.83)	5 (0.96)	7 (1.74)	1 (0.94)	4 (2.15)	10 (2.11)	25 (2.82)	6 (2.82)	0 (0.00)	1 (1.52)	0 (0.00)	1 (2.38)	4 (2.00)
The last time you had sexual intercourse, what method did you or your partner use to prevent pregnancy?													
Birth control pills	8 (0.23)	5 (0.96)	2 (0.50)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	1 (0.47)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)
Birth control ring	1 (0.03)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	1 (0.50)
Condoms	72 (2.05)	12 (2.30)	10 (2.48)	5 (4.72)	1 (0.54)	6 (1.27)	6 (0.68)	7 (3.29)	17 (5.59)	2 (3.03)	1 (0.96)	0 (0.00)	5 (2.50)
IUD/Injection	11 (0.31)	2 (0.38)	2 (0.50)	0 (0.00)	0 (0.00)	0 (0.00)	5 (0.56)	0 (0.00)	1 (0.33)	0 (0.00)	0 (0.00)	1 (2.38)	0 (0.00)
Withdrawal	2 (0.06)	0 (0.00)	1 (0.25)	0 (0.00)	0 (0.00)	0 (0.00)	1 (0.11)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)
Some other method	2 (0.06)	1 (0.19)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	1 (0.11)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)
Nothing	9 (0.26)	0 (0.00)	3 (0.74)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	1 (2.38)	5 (2.50)
Not sure	9 (0.26)	0 (0.00)	0 (0.00)	1 (0.94)	0 (0.00)	1 (0.21)	6 (0.68)	0 (0.00)	0 (0.00)	1 (1.52)	0 (0.00)	0 (0.00)	0 (0.00)
Not applicable	3391 (96.75)	501 (96.16)	385 (95.53)	100 (94.34)	185 (99.46)	466 (98.52)	868 (97.86)	205 (96.24)	286 (94.08)	63 (95.45)	103 (99.04)	40 (95.24)	189 (94.50)
During the past 30 days, on how many days did your child have at least one drink containing alcohol? (tick only one)													
Always	11 (0.31)	1 (0.19)	0 (0.00)	0 (0.00)	0 (0.00)	3 (0.63)	4 (0.45)	0 (0.00)	1 (0.33)	0 (0.00)	1 (0.96)	0 (0.00)	1 (0.50)
Most of the time	14 (0.40)	2 (0.38)	0 (0.00)	1 (0.94)	0 (0.00)	6 (1.27)	0 (0.00)	2 (0.94)	2 (0.66)	0 (0.00)	0 (0.00)	0 (0.00)	1 (0.50)
Sometimes	166 (4.74)	27 (5.18)	26 (6.45)	6 (5.66)	1 (0.54)	13 (2.75)	22 (2.48)	18 (8.45)	22 (7.24)	9 (13.64)	4 (3.85)	7 (16.67)	11 (5.50)
Never/not at all	3314 (94.55)	491 (94.24)	377 (93.55)	99 (93.40)	185 (99.46)	451 (95.35)	861 (97.07)	193 (90.61)	279 (91.78)	57 (86.36)	99 (95.19)	35 (83.33)	187 (93.50)
During the past 30 days, how many times has your child used marijuana or dagga or any other drug (excluding those given to treat illness)													
Always	11 (0.31)	2 (0.38)	0 (0.00)	0 (0.00)	0 (0.00)	3 (0.63)	2 (0.23)	0 (0.00)	1 (0.33)	2 (3.03)	0 (0.00)	0 (0.00)	1 (0.50)
Most of the time	9 (0.26)	1 (0.19)	1 (0.25)	0 (0.00)	0 (0.00)	0 (0.00)	1 (0.11)	1 (0.47)	1 (0.33)	4 (6.06)	0 (0.00)	0 (0.00)	0 (0.00)
Sometimes	53 (1.51)	5 (0.96)	15 (3.72)	4 (3.77)	0 (0.00)	0 (0.00)	4 (0.45)	1 (0.47)	2 (0.66)	11 (16.67)	5 (4.81)	1 (2.38)	5 (2.50)
Never/not at all	3432 (97.92)	513 (98.46)	387 (96.03)	102 (96.23)	186 (100.0)	470 (99.37)	880 (99.21)	211 (99.06)	300 (98.68)	49 (74.24)	99 (95.19)	41 (97.62)	194 (97.00)

Appendix C : Additional Charts

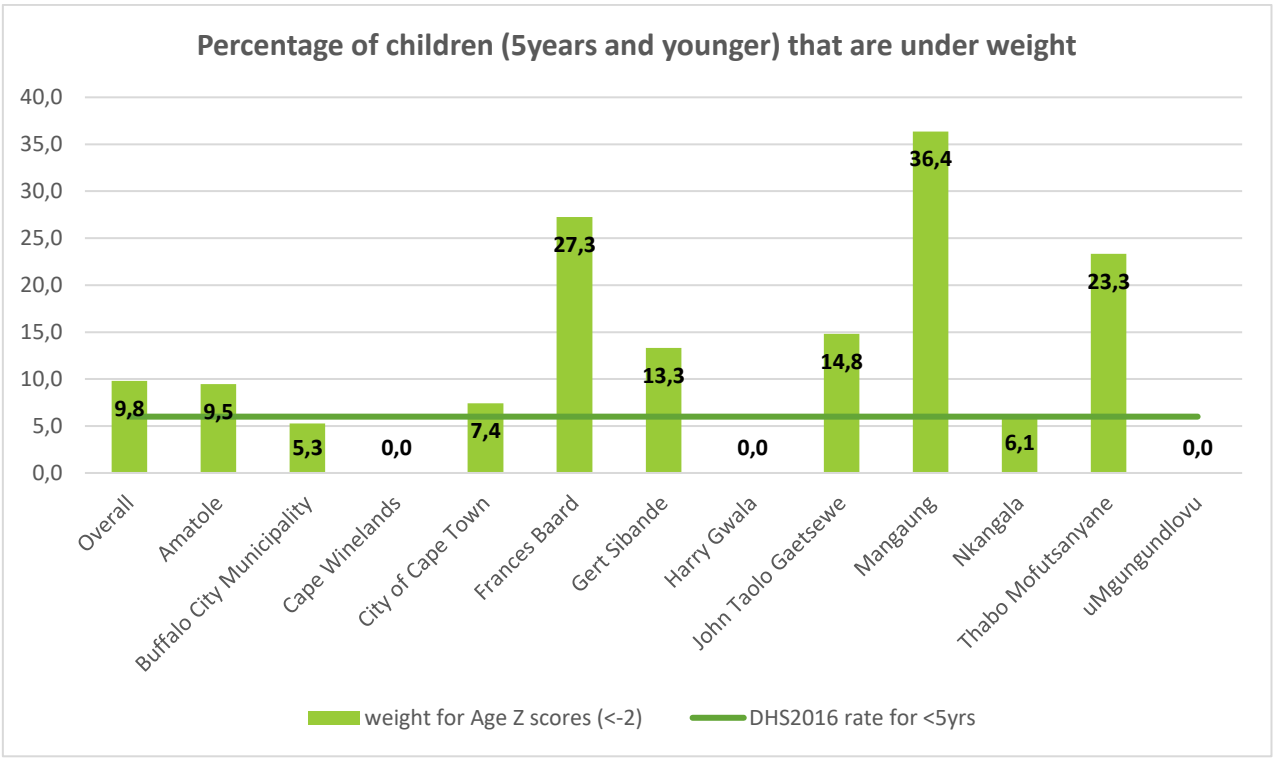


Figure 30: Percentage of Children Aged 0 o 5 yrs. whose Weight for Age is Below -2SD (Underweight)

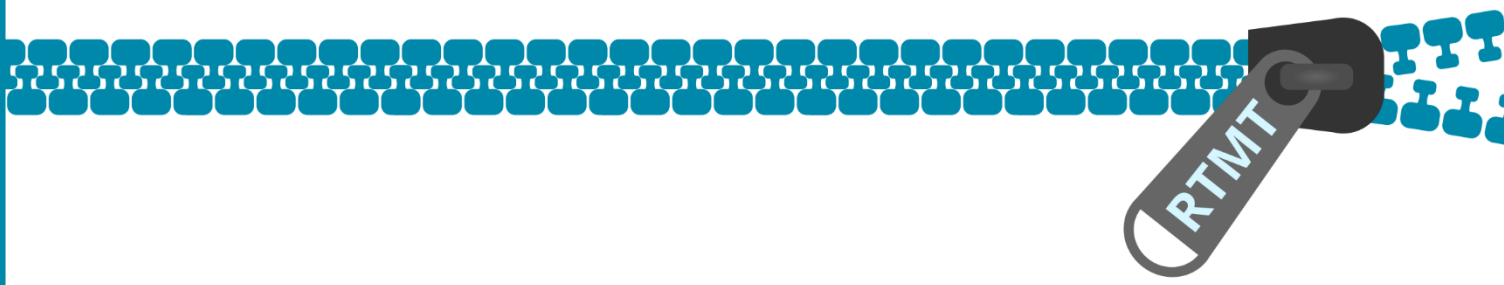
The chart below shows the percentage of girls per districts that reported missing school or other important events because they do not have sanitary pads, by whether household has other income sources (besides social grants) or not.

Figure 31: Girls Missing School Due to Lack of Sanitary Pads vs Household Income Sources

Appendix D Data collection in Districts

Table 13: Data Collection Sites, Dates, Targets and Achieved Sample

Province and Districts	Dates for field work	Target Sample size	Achieved Sample	% Assessment Achieved
KwaZulu Natal		**1340**	**1367**	**102**
uMgungundlovu district	20/12/22 – 21/02/12	850	890	105
Harry Gwala district	21/01/13 – 21/02/06	490	477	97
Northern Cape		**120**	**170**	**142**
Francis Baard	21/01/20 – 21/01/22	70	66	94
John Taolo Gaetsewe	21/01/19 - 21/01/21	50	104	208
Free State		**290**	**292**	**101**
Mangaung metro	21/02/02 – 21/02/06	140	106	76
Thabo Mofutsanyane	21/02/02 – 21/02/06	150	186	124
Eastern Cape		**855**	**956**	**112**
Buffalo City Metro	21/02/16 – 21/02/19	385	413	107
Amatole district	21/02/18 – 21/02/24	470	543	116
Mpumalanga		**495**	**522**	**105**
Gert Sibande district	21/02/22 – 21/02/26	225	116	96
Nkangala district	21/02/24 – 21/03/02	270	306	113
Western cape		**210**	**247**	**118**
City of Cape Town	21/03/16 – 21/03/18	170	202	119
Cape Winelands	21/03/17 – 21/03/18	40	42	15



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