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2. Subject for discussion (DA) (Ms B S Masango): Solutions to address severe malnutrition crisis, confronting past failures to coordinate and implement critical interventions to protect children from hunger (114)

Speech by Dr Karl le Roux MP

Honourable House Chair,

Today's debate about malnutrition is important because when infants die of starvation, it is clear that as a country we are failing the most vulnerable and most precious members of our society - our children.

The fact that 155 children have died of severe malnutrition in the first four months of 2025 is simply heartbreaking. I can remember the helplessness I felt as a young doctor in the Eastern Cape when terribly ill babies with kwashiorkor or marasmus – the severest forms of malnutrition - arrived at the hospital I was working at. Despite following excellent malnutrition protocols, it was usually too late, with up to 1/3 of these children dying.

However, there is a much bigger problem lurking just under the surface which most parents and healthcare workers are completely unaware of: namely chronic mild to moderate malnutrition. Because mild to moderate cases of malnutrition are far more common, they actually represent a much greater share of the tragedy of malnutrition

IN FACT -mild to moderate malnutrition is the underlying cause of half of South Africa's under 5 deaths – meaning nearly **20 000** deaths in SA in 2023.

Further, chronic mild malnutrition results in children not growing as tall as they should be – which is called stunting – which harms their intellectual development and undermines school achievement and future earning capacity. And although malnutrition rates have decreased in South Africa over the past twenty years, stunting remains remarkably high at about 28%. Which means that more than a quarter of South African children will not reach **their full potential** because of an inadequate intake of the right quantity, but more importantly – the right **quality** of food.

The problem with mild to moderate malnutrition is that unless we look for it - it remains invisible—quiet, persistent, and devastating to millions of children across South Africa - shaping lives, limiting potential, and undermining national progress.

Honourable members, it also important recognise that malnutrition is not confined to childhood. Its repercussions stretch across the **entire life course**—and indeed across generations.

Starting at birth, children born with low birth weight begin life at a significant disadvantage. LBW is often a consequence of hypertension, infection, inadequate maternal nutrition, smoking, alcohol use and inadequate maternal care. LBW is strong predictor of later malnutrition and stunting, poor learning outcomes and even adult diseases such as obesity, type 2 diabetes and hypertension. This **intergenerational** pattern of malnutrition is well recognised. A girl who is undernourished in childhood is likely to become a shorter adult, who is more vulnerable in pregnancy and more likely to deliver a low-birth-weight infant, and thus the cycle begins again.

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Understanding malnutrition in this way—spanning generations and shaping lifelong outcomes—has important implications for public policy and the way we respond to and fight malnutrition.

The causes of malnutrition are complex and operate at interconnected levels.

At the **societal level**, poverty, inequality, corruption, geographical barriers and environmental degradation all have an impact. Where women lack autonomy, where criminals run amok, where there are no jobs or where essential services are lacking, malnutrition inevitably follows.

At the **household level**, the key factors include access to nutritious food, knowledge of good feeding and caring practices, sanitation, and access to good quality primary healthcare. Even in households where food is present, poor feeding practices including the use of formula instead of breastfeeding, or lack of support for young mothers can compromise a child's growth.

Clearly, for us to deal with the scourge of malnutrition as a country - we need to a **whole-of society-approach**.

Firstly, we need to fight poverty by doing all we can to encourage economic growth, through stable fiscal policies, and also by removing red tape and job-killing policies like BEE. We need better policies to make sure that we reduce food waste, and that excess food from restaurants and retailers can get to the poor and the hungry.

Further, we need to educate all South Africans about nutrition and healthy eating, the importance of protein, healthy fats and vegetables. Clearly eating amagwingya and polony washed down with Twizza is not good nutritious food for either children or adults!

We need to relentlessly **promote exclusive breastfeeding for the first six months** and educate all South Africans about the incredible benefits of breastfeeding as a way to cement the foundations of child's health and wellbeing, and also practically support working women who want to continue breastfeeding even when they return from maternity leave. As I used to say to new mothers in the maternity ward: Ubalulekile kakhulu unkuncanicsa iinyanga ezithandathu ngebele lodwa - ubisi lwebhele lwanele, limnandi, liyakhusela umtwana ngezifo.

How can the Department of Health intervene in the crisis of malnutrition? Well - DOH has access to an incredible resource in the form of 45 000 Community Health workers that look after 250 households each - covering nearly 2/3 of all households in South Africa. Imagine if we used these Community Health workers effectively to fight malnutrition at the household level?

A South African NGO called Philani, which is based in Khayelitsha and the in rural Eastern Cape, provides a model that could easily be adopted by the DoH. In a cluster-randomised controlled trial based in Khayelitsha, its Mentor Mother programme decreased the incidence of children who are underweight for age by 60% and who were stunted by 30%, and found that 75% of children who were born with LBW, which is the greatest risk factor for later malnutrition, had a normal weight for age by 1 year.

Philani uses CHW called Mentor Mothers, who perform daily home visits in their communities - to support pregnant mothers and to identify any children under 6 who are malnourished. These CHWs are given simple, robust electric scales and trained about how to plot the weights of children on growth charts over time and identify children whose growth is faltering, and therefore are able to identify mild and moderate malnutrition EARLY. By contrast, CHW employed by provincial departments of health

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only have access to a Mid-Upper-Arm-Circumference Tape, which only identifies severely malnourished children, when it is often already too late to help them.

The Philani CHW support pregnant mothers throughout their pregnancies and up to when their children are 6 years old, encouraging mothers to enrol into antenatal care early, eat well, get onto ARVS and stop drinking and smoking. Mothers are visited within a few days of delivering and supported in their breastfeeding, while babies are regularly weighed to ensure that they are thriving. Babies who are born with low birth weight are followed up especially closely.

This proven model would require training and investment - and every community health worker would need to be provided with a simple electronic scale – but could dramatically impact the incidence of malnutrition in South Africa.

If we use a whole of society approach, as well as the specific interventions mentioned above, we can banish malnutrition from our society.

Failure to act will be costly—morally, socially and economically. But with prioritisation of malnutrition and strategies to use our vast army of CHWs, we can break the cycle of malnutrition and ensure that every child—regardless of where they are born— can grow to their full potential and have the chance to lead a healthy, productive life.