

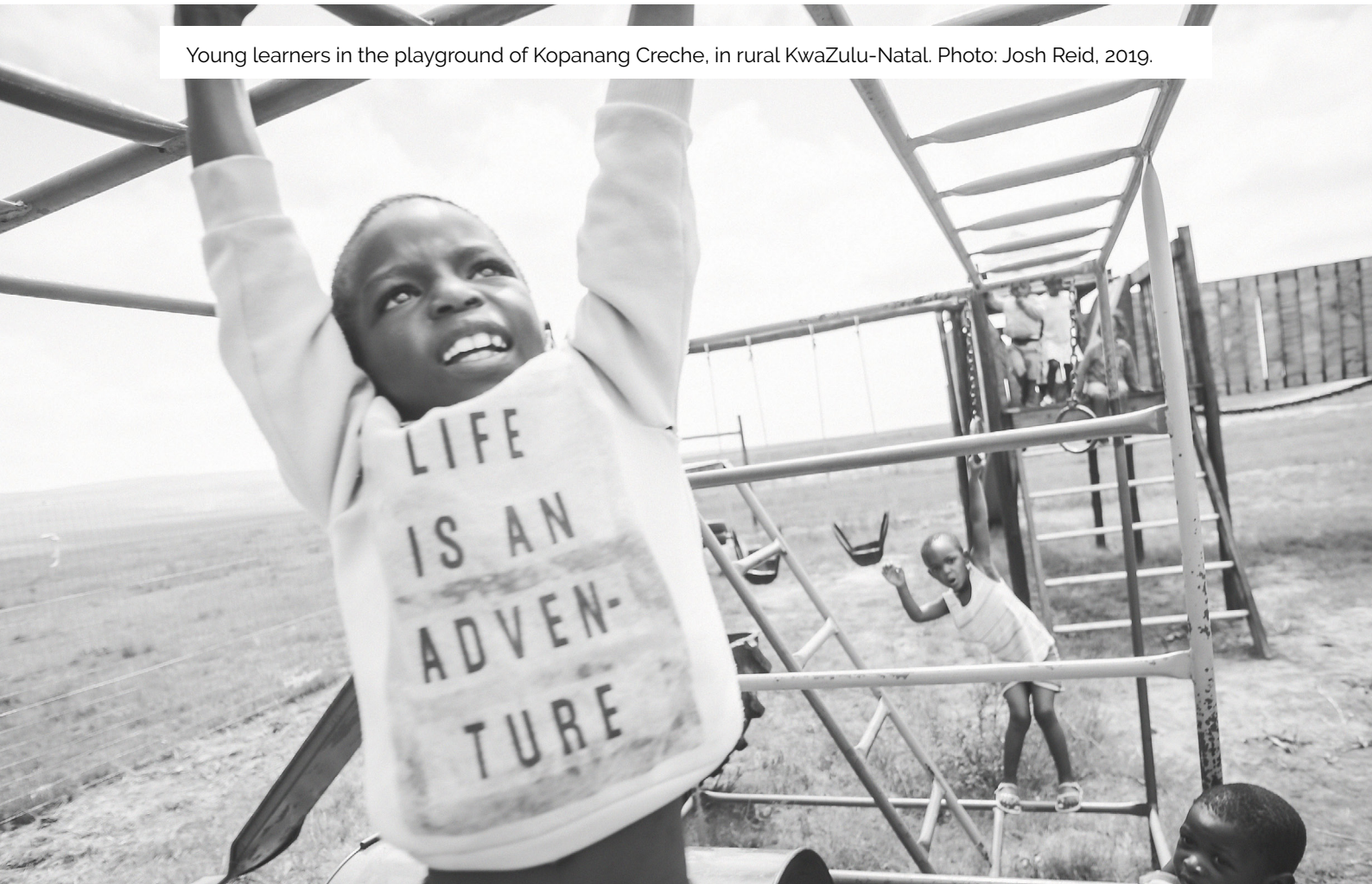


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SOUTH AFRICAN
EARLY CHILDHOOD
REVIEW 2019

Young learners in the playground of Kopanang Creche, in rural KwaZulu-Natal. Photo: Josh Reid, 2019.



Acronyms and abbreviations

ANC	antenatal care	MP	Mpumalanga
ART	antiretroviral treatment	MTCT	mother-to-child transmission (of HIV)
CHW	Community Health Worker	NC	Northern Cape
CSG	Child Support Grant	NGO	Non-Governmental Organisation
DHA	Department of Home Affairs	NW	North West
DHIS	District Health Information System	PIRLS	Progress in International Reading and Literacy Study
EC	Eastern Cape	SA	South Africa
ECD	early childhood development	SADHS	South Africa Demographic and Health Survey
ELOM	Early Learning Outcomes Measure	SAECR	South African Early Childhood Review
FS	Free State	SANHANES	South African National Health and Nutrition Examination Survey
GHS	General Household Survey	Stats SA	Statistics South Africa
GT	Gauteng	TIMSS	Trends in International Mathematics and Science Study
HAART	highly active antiretroviral therapy	VIP	ventilated improved pit-latrine
HIV	Human Immunodeficiency Virus	WC	Western Cape
KZN	KwaZulu-Natal		
LCS	Living Conditions Survey		
LP	Limpopo		
MNCH	maternal, newborn and child health		

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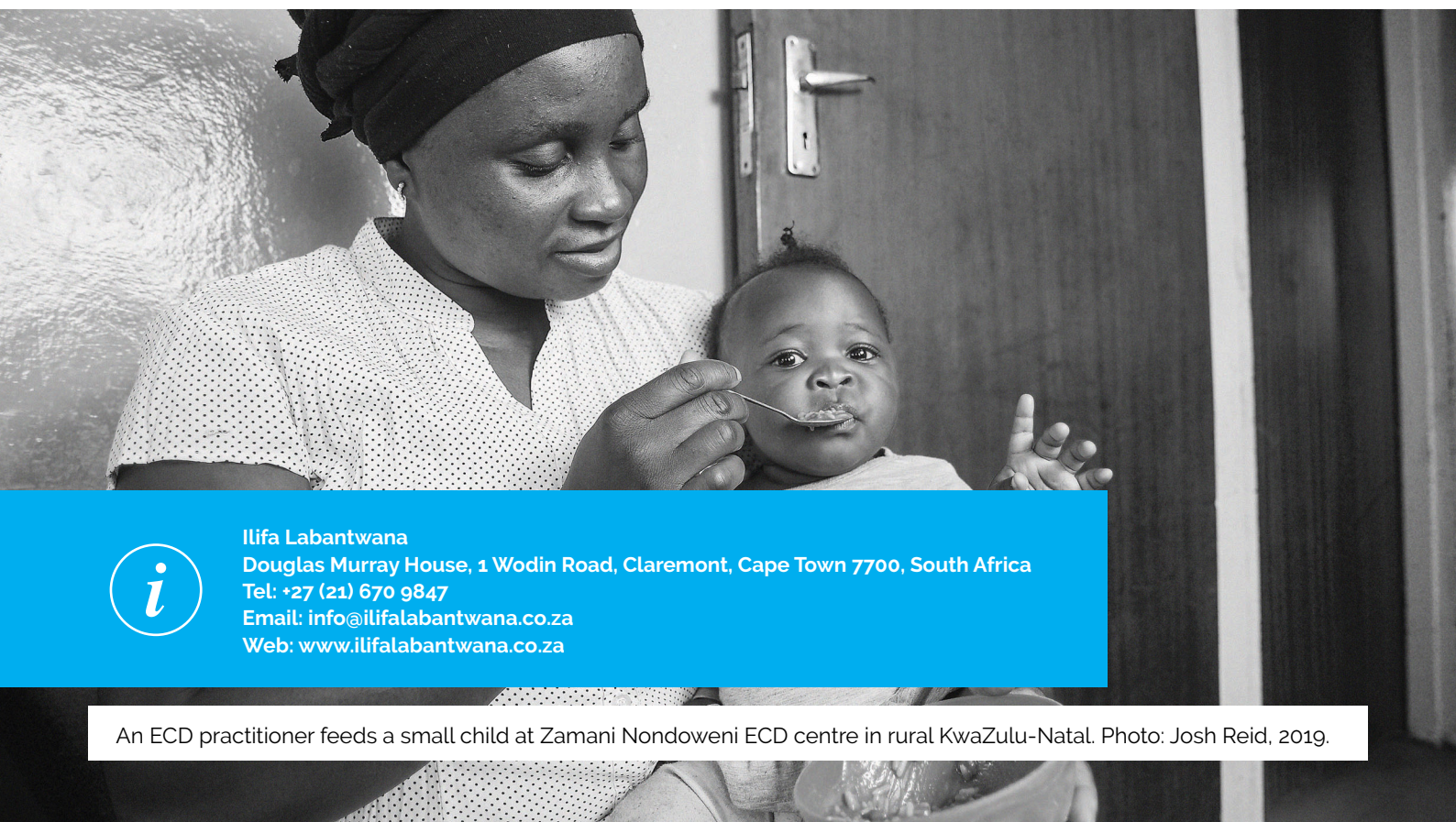
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Foreword

A hopeful future can only be realised by working together to improve the lives of children in South Africa.

The National Development Plan 2030 was adopted in 2012. After eight years we have made some progress on both the policy front and on child development outcomes. For example, the National Integrated Early Childhood Development Policy was adopted in 2015, while maternal and child mortality rates have continued on a downward trend. Many of the elements of the Essential Package of early childhood development are in place.

The South African Early Childhood Review provides us with rich data on child development and shows us that in the main we have some progress, however there are some areas where we have made little or no progress. The picture painted by this year's review is quite bleak. Despite the numerous interventions across different sectors, South Africa's stunting rate at 27% remains unacceptably high. We have to ask the question 'Why does this situation remain?'

Good quality data is vital for planning, programme implementation, and monitoring. But data on its own is meaningless unless we use it. Over the last decade we have put in place a monitoring system, however we do not seem to use data sufficiently for planning and implementation. Could this be that operational staff do not

have the requisite knowledge and skills to utilise data? Could it be that many of the interventions require more than one department or collaboration between government and NGO's? There is a dearth of research on the challenges of implementation on these types of complex interventions. If we were to have a better understanding of these implementation challenges we could plan more realistically on how to address them. The numerous evaluations undertaken by the Department of Planning, Monitoring and Evaluation (DPME) provide some evidence and point to poor co-ordination and collaboration. Calling for improved co-ordination and collaboration will not change anything, what is required is leadership at all levels and some additional resources.

In eleven years we will reach 2030, of which the NDP sketches a hopeful future. This future can only be realised by working together to improve the lives of children in South Africa. Investing in our children's future should be paramount in realising the objectives of the National Development Plan.

Dr Kefiloe Masiteng
Deputy Secretary of Planning
National Planning Commission

OPPORTUNITIES FOR INTEGRATED ECD SERVICE DELIVERY

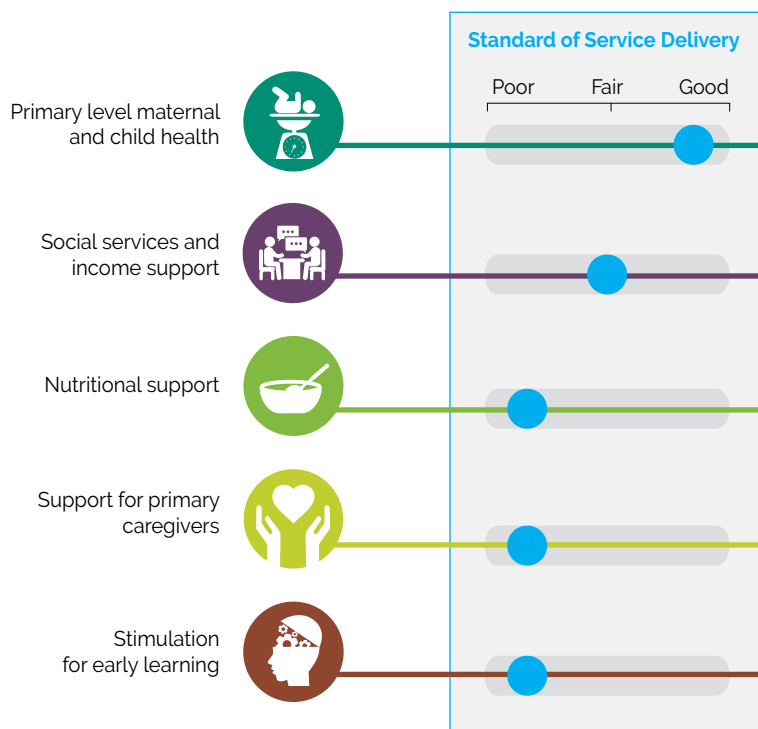
This diagram shows the essential package of ECD services at different points in the early childhood lifecycle, as well as the service touchpoints afforded by the South African health system. These health system touchpoints are an opportunity to deliver all essential ECD services in an integrated and coordinated way.

1 HEALTH SYSTEM TOUCHPOINTS

Health system touchpoints are physical points of contact between the Department of Health, caregivers and children. Health system touchpoints are also opportunities for caregivers and children to access essential services from other government departments and agencies.

2 THE ESSENTIAL PACKAGE

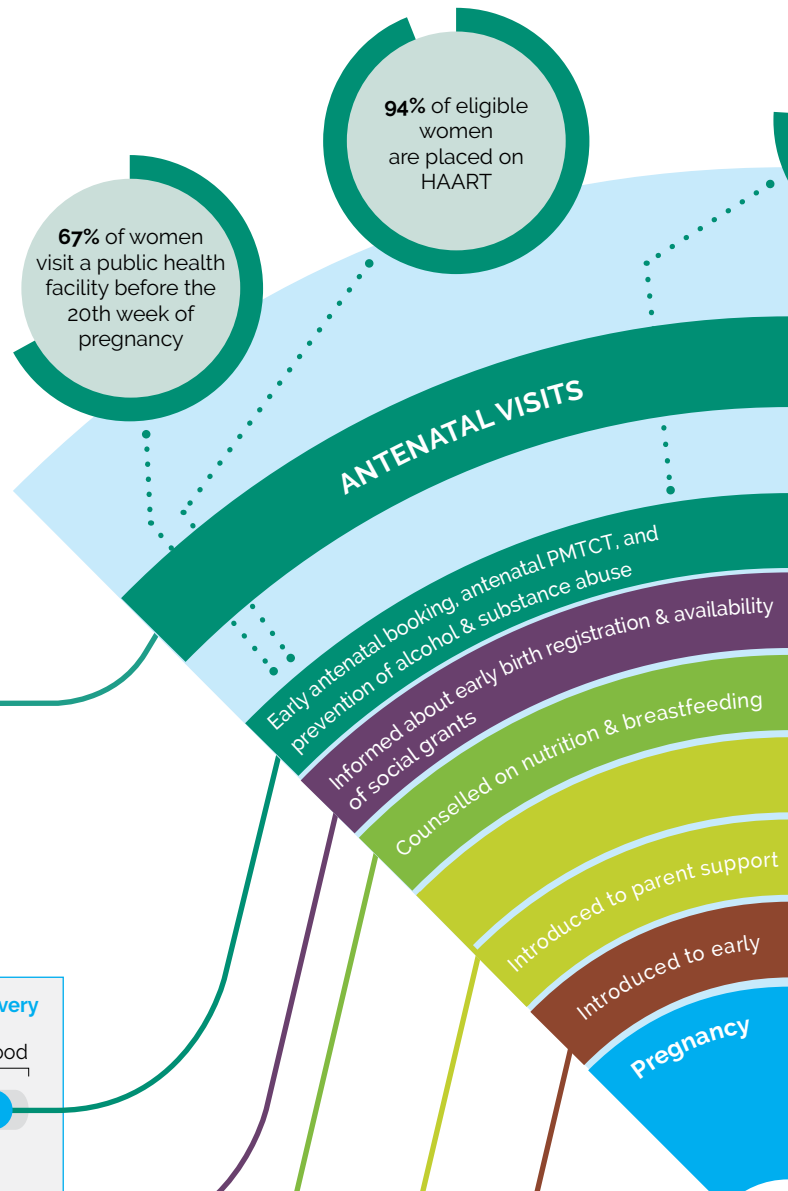
The essential package of ECD services has five domains. The standard of service delivery is indicated as: good, fair, or poor. All five components of the essential package impact on child development.

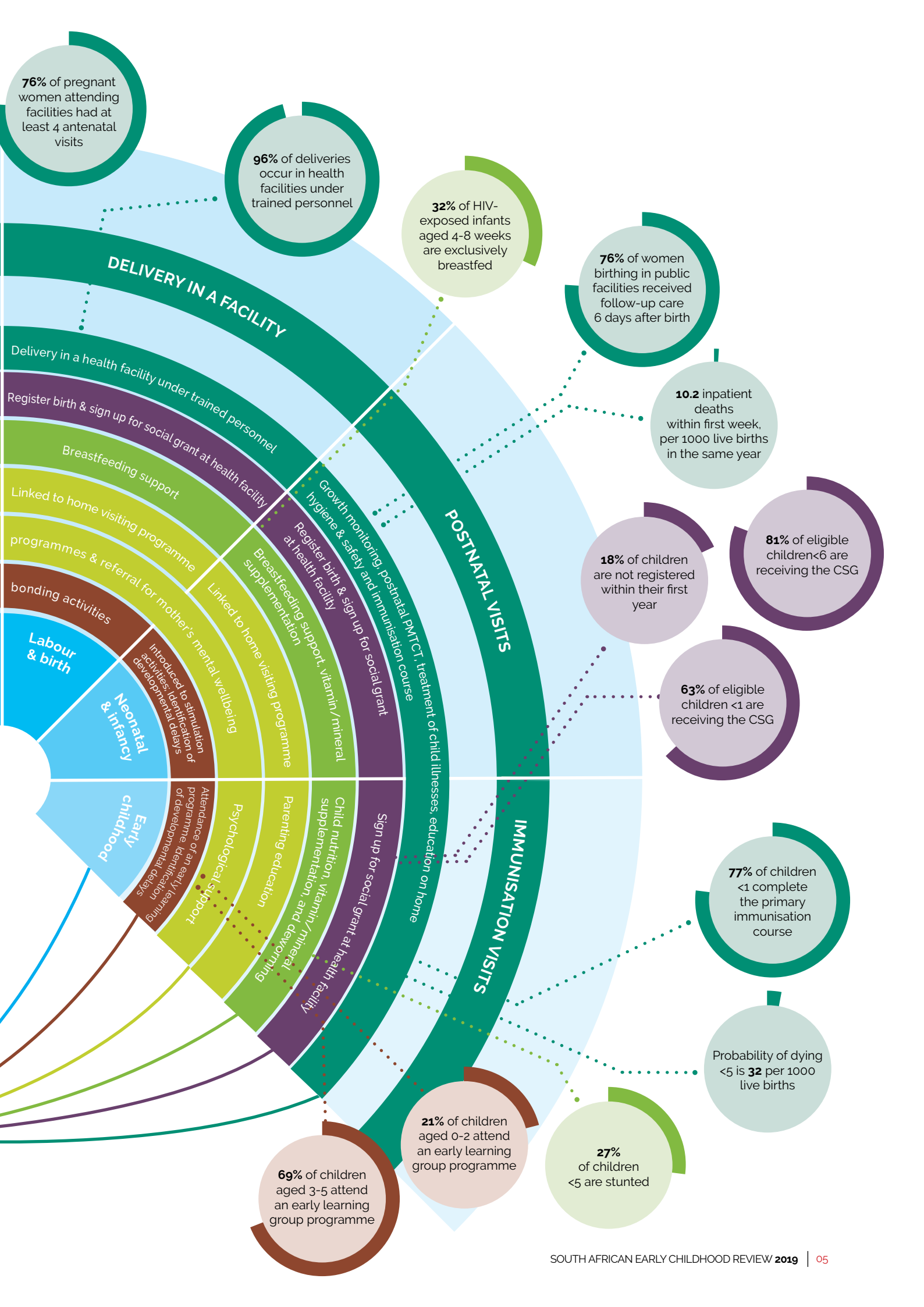


CHILD DEVELOPMENT OUTCOMES

Child development is a function of the five components of the essential package. Currently in South Africa, healthcare is the only component delivering a decent level of service. As a result, children are surviving but not thriving. Currently, there is no national data on child development outcomes*.

* Early Learning Outcomes Measure (ELOM) is a new South African population based child assessment tool that determines whether children (aged 4-6 years) are developmentally on track for age.





Introduction

The central role of early childhood development (ECD) to reduce socio-economic inequality is broadly accepted in South Africa. Yet, every year, significant numbers of poor children begin school lagging behind their wealthier peers. Half will have dropped out before finishing secondary school. The numbers are staggering when aggregated over a generation. These children are chronically underpowered to fully participate in the economy and society from the very start. Despite the many successes and achievements of the post-Apartheid period, ECD as a sector lags behind.

Children's long-term development is a function of a package of interrelated and integrated services covering the period from conception to six years of age: maternal, newborn and child health (MNCH) services; nutritional support; support for primary caregivers; social services and protection; and quality early learning programmes.¹ Collectively, these are known as the Essential Package of ECD services. In addition to these services, the development of perceptual, motor,

cognitive, language, socio-emotional, and self-regulation skills in the home through responsive caregiving is a critical component of ECD.

The majority of South Africa's children are born into environments that reduce their chances to realise their potential – typified by insufficient access to high quality MNCH services and nutrition; inadequate living environments; lack of security and social protection; and limited opportunities for quality early learning and stimulation. As a result

children experience malnutrition, toxic stress; and are at an increased risk of substance abuse, criminal behaviour, risky sexual behaviour, and reduced economic potential when they are older.¹¹

The Essential Package of services is a necessary pre-condition to realise children's constitutional rights. The annual South African Early Childhood Review (SAECR) is structured to bring together all of the available data sources on the components

The components of the essential package are:



Maternal and child health services

Including antenatal care, PMTCT, physical & mental health screening, psychosocial support and immunisation



Nutritional support

For pregnant women, mothers and children



Support for primary caregivers

Including parenting skills and psychosocial support



Social services

Including birth registration, access to social grants, responsive child protection services and psychosocial support



Stimulation for early learning

Including access to quality, age-appropriate early learning programmes

of the Essential Package, and to act as a gauge of how the country is progressing towards meeting the goals that have been defined for a number of years and in a range of programme, research, and policy documents,^{iv} most recently the National Integrated ECD Policy of 2015. These goals are aligned with the United Nations Sustainable Development Goals and the Nurturing Care Framework of the World Health Assembly (2018).

Early learning has been foregrounded in 2019 following President Cyril Ramaphosa's February announcement that the ECD mandate would shift from the Department of Social Development to the Department of Basic Education, and that the government would make an additional year of schooling (Grade RR) mandatory.

These are positive developments. The announcement confirms that ECD is recognised by government as critical; while a closer alignment with Basic Education should result in increased budget for ECD, improved workforce training, and closer alignment of the early learning curricula with the needs of foundation phase learning. However, we have more work to do

as a country to address the entire age spectrum of ECD, which begins at conception and not at age three.^v

The National Integrated ECD Policy recognises that young children have a broad range of needs that are interdependent, and multiple role-players are involved in service delivery to meet those needs. In practice, this means that effective systems are needed for co-ordination, referral and follow-up between the three key sectors that are responsible for delivering services to young children – Health, Basic Education and Social Development – as well as with other departments such as Home Affairs, the South African Police Services and Justice, and local government.

While South Africa has made good progress from a policy perspective, many of the services defined in the policy have made little or no progress over the past few years, particularly in the nutrition, early learning and caregiver-support areas. In addition to severe fiscal constraints, the lack of progress is arguably due to the inadequate institutional mechanisms required to co-ordinate, manage and monitor complex integrated ECD service delivery. South Africa lacks:

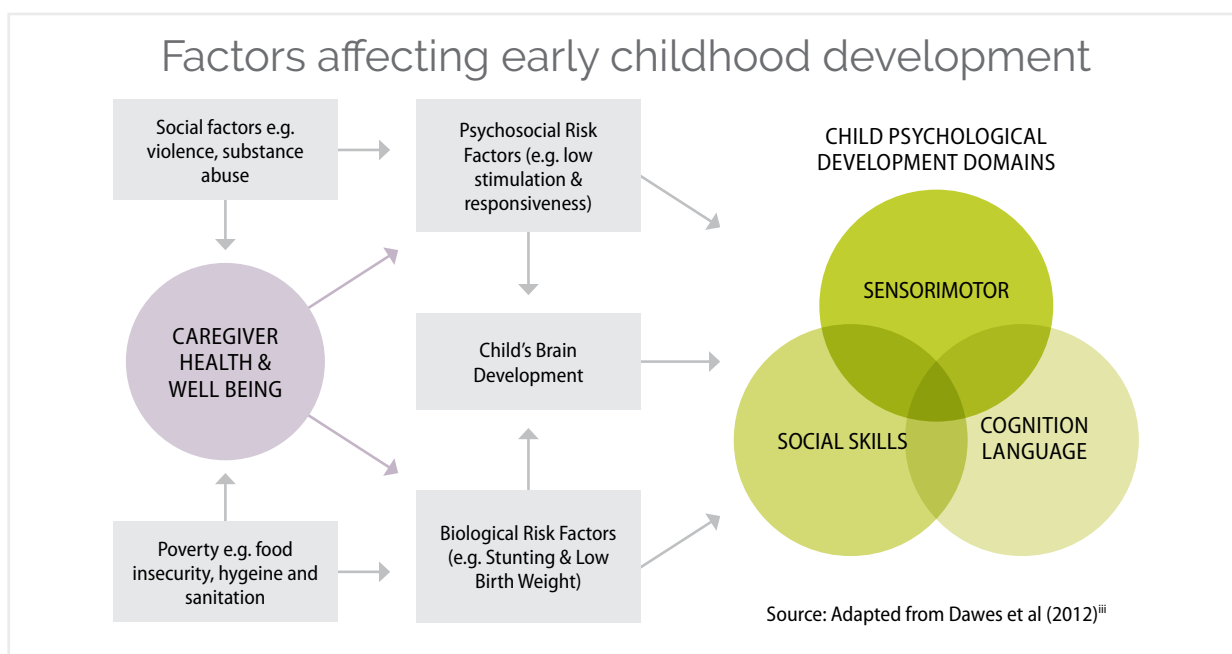
- an effective central mechanism to

mobilise and co-ordinate a national programme for young children;

- the ability and capacity to deliver quality services at scale – in particular, in implementing strategies for nutrition support, early learning, caregiver support, child protection for all children who need it, and enhanced support for children with disabilities; and

- systems to routinely monitor services and measure progress for most child outcomes.

The SAECR helps to fill some of the monitoring and measurement gap by collating indicators on early childhood. The publication estimates the extent of need (the size of the relevant population) to provide a sense of what would be required for a population-level response at scale; presents data on access to services to provide an estimate of programme reach and the number of exclusions; and where possible, includes information on outcomes as a measure of programme quality and impact. Using the Essential Package as a framework, the SAECR highlights points of intersection between different sectors and services to show the opportunities for improved integration of the service package.



Children under 6 years in South Africa

South Africa remains a highly unequal society, and there are vast inequalities in children's circumstances and opportunities from the moment they are born. The first step to giving children an equal start in life is to ensure that all young children get the full package of essential early services. We need information about the young child population to plan effectively for service delivery: the size and distribution of the population, where the child population is increasing, and the circumstances in which young children live.

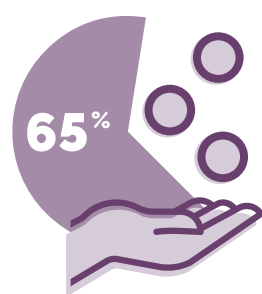
South Africa has not yet achieved complete birth registration and so the size of the child population is really an estimate, based on Statistics South Africa's mid-year population estimates. The previous issue of the South African Early Childhood Review (SAECR) 2017 gave the under-6 population of South Africa as 6.2 million. Since then, Stats SA revised its mid-year population estimates and updated the model used to calculate the population weights for its surveys, because they had been based on incorrect assumptions.

The re-weighted data reveal that there are substantially more young children than was previously thought. The under-6 population was close to 7 million children in 2017, nearly a million more than expected. This is not the result of a sudden increase in births, but due to the revised population model. As shown in Figure 1, although the young child population increased through the 2000s (from 5.6 million in 2002 to 6.8 million in 2010) the estimated number has remained quite stable since 2011.

Given that the young population is so much bigger than previously estimated, plans, strategies, and budgets will need to be reviewed and revised across all government departments that deliver services to young children in order to ensure that the additional children can be provided for.

There have been some striking changes in the distribution of young children across the provinces. Historically, the biggest child populations were in KwaZulu-Natal, Limpopo, and the Eastern Cape. However, Gauteng has a rapidly growing population, and by the end of the 2000s had the second largest population of young children. Since 2012, the under-6 population in Gauteng has grown by over 100,000, an increase of 8%, and Gauteng now has more young children than any other province. Other provinces with growing young child populations are Mpumalanga, Limpopo, and the Western Cape. The young child population is falling in the Eastern Cape and Free State.

Given that the young population is so much bigger than previously estimated, plans, strategies, and budgets will need to be reviewed and revised across all government departments that deliver services to young children.



65% of young children live in households below the upper poverty line.

The majority (57%) of young children now live in urban areas. Although adults are more likely than young children to have urban homes, the child population is gradually urbanising, through a combination of urban births and migration. Cities and towns need to keep planning and providing for larger populations of young children.

Three million children under six years still live in rural areas – mainly in the rural former homelands. This is a challenge for ECD service delivery as dispersed communities with lower population densities pose challenges to delivering services, and young children (and their caregivers) in remote areas may have to travel far to reach service points for birth registration, health care, education, and other services.

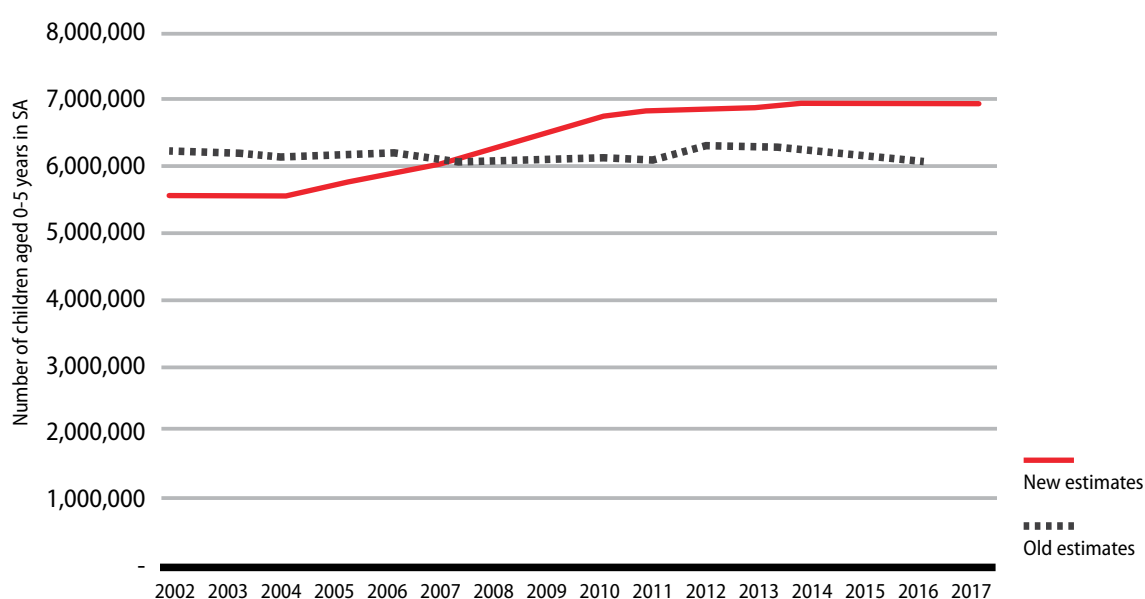
Service infrastructure for households remains a challenge, particularly in rural areas and informal settlements. Poor living conditions coupled with inadequate water, sanitation, and energy services to households put young children at risk in multiple ways. Almost a third (29%) of young children live in households without piped water on site. Adequate

infrastructure to deliver clean water is important for young children because they are particularly vulnerable to water-borne diseases. Access to water on site is important because it is risky for young children to have to leave their house to use or fetch water or to be left alone when their caregivers do so. In the Eastern Cape, over half of the young children do not have piped water to the site where they live.

Similarly, adequate sanitation is necessary for health, as poor sanitation can lead to the spread of diarrhoeal diseases and other infections that are among the main causes of malnutrition and deaths in young children. Currently, 1.5 million children do not have a flush toilet or VIP (ventilated improved pit-latrine) at home – these are the minimal forms of sanitation that are regarded by government as adequate, although a VIP can be risky for young children.

Poverty rates have been falling, but two thirds of young children (65%) still live in households that have per capita incomes below the upper poverty line. This poverty line, set by Stats SA, is equivalent to R1,138 in 2017 and is calculated as the amount of money needed to provide for minimum

FIGURE 1: NUMBER OF CHILDREN AGED 0 – 5 YEARS (2002 – 2017)



Source: Statistics South Africa (2003-2018). General Household Survey (GHS) 2002 – 2017 Previously weighted (2014) and newly weighted (2018). Analysis by Children's Institute (UCT).

nutritional needs and other basic needs such as clothing. Even though most young children receive a Child Support Grant, the amount of the grant is often not enough to bring children out of poverty.

In South Africa, 2.5 million young children are living below the food poverty line.

This is a great concern because it means that these children are in households where there is not enough money to cover even basic nutritional needs. This increases the risk of malnutrition and stunting in children, and possibly compromises the nutrition of pregnant women before their children are born (see Nutritional Support chapter on page 20). Food poverty among young children is high (30% or more) in all provinces except Gauteng and the Western Cape.

The highest poverty rates for young children are in Limpopo, KwaZulu-Natal and the Eastern Cape. These three provinces combined are home to nearly half of all young children in South Africa, and they also have the largest rural

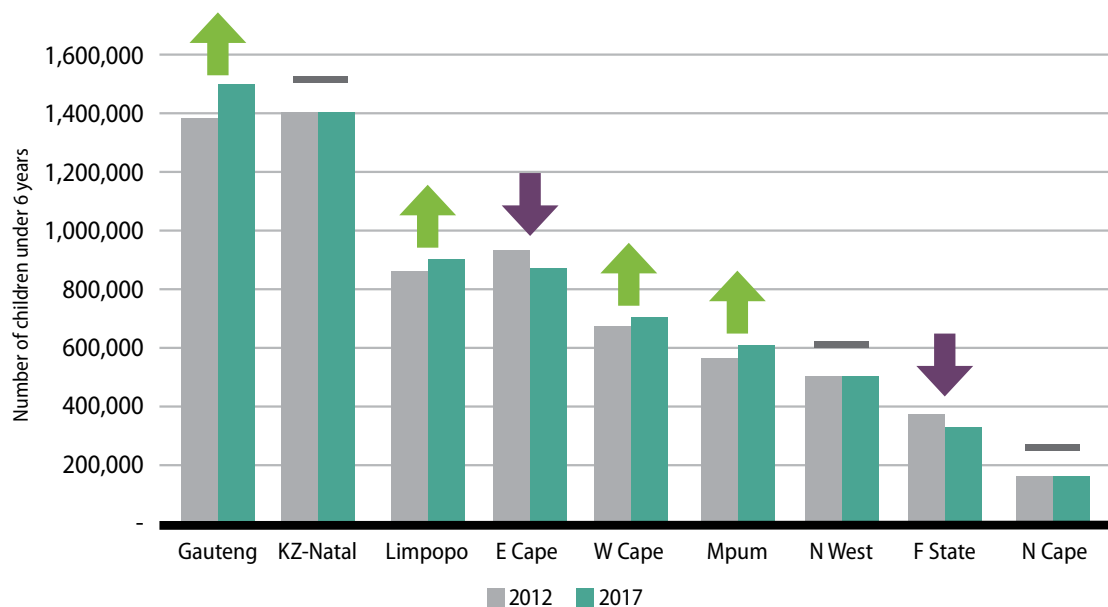
populations. The National Integrated ECD Policy, approved by Cabinet in 2015, affirms that parents and families have the first duty to care for young children and ensure that they access early childhood services, but also recognises that their ability to do so may be limited by resource and capacity constraints. Young children growing up in poor households risk exclusion from ECD services as these households are less likely to be able to afford transport to and from clinics and other government offices, or to be able to pay fees for ECD centres or crèches.

Income poverty is the result of unemployment or employment with very erratic or low income. Unemployment rates in South Africa are stubbornly high and have increased in recent years. Over 2 million children live in households where no members are working, either in the formal sector or in informal employment. These households would be entirely dependent on social grants and remittances from family members living elsewhere.



The highest poverty rates for young children are in Limpopo, KwaZulu-Natal and the Eastern Cape.

FIGURE 2: CHANGES IN THE PROVINCIAL POPULATION OF CHILDREN 0-6 YEARS (2012 AND 2017)



Source: GHS (2012, 2017). Analysis by Children's Institute (UCT)

TABLE 1: THE STATUS OF CHILDREN UNDER SIX LIVING IN SOUTH AFRICA IN 2017, BY PROVINCE

	Indicator	SA	EC	FS	GT	KZN	LP	MP	NW	NC	WC	source
Population	Number of children under 6 years	6 978 000	876 000	326 000	1 501 000	1 408 000	906 000	613 000	497 000	149 000	702 000	a
	Households with children under 6	4 667 000	496 000	239 000	1 195 000	849 000	567 000	417 000	335 000	105 000	463 000	a
		29%	30%	27%	25%	30%	37%	33%	29%	31%	25%	
Area type	Urban Children < 6 in urban areas (formal/informal)	3 974 000	336 000	278 000	1 451 000	556 000	145 000	204 000	246 000	104 000	654 000	a
		57%	38%	85%	97%	40%	16%	33%	49%	70%	93%	
	Rural traditional Children < 6 in rural former homeland areas	2 726 000	516 000	39 000	28 000	751 000	752 000	372 000	229 000	38 000	-	a
		39%	59%	12%	2%	53%	83%	61%	46%	26%	0%	
	Rural farms Children < 6 in commercial farming areas (old RSA)	278 000	24 000	10 000	22 000	101 000	9 000	36 000	22 000	7 000	48 000	a
		4%	3%	3%	1%	7%	1%	6%	4%	5%	7%	
Services	Inadequate water Children < 6 without piped water on site	2 045 000	484 000	38 000	96 000	595 000	423 000	163 000	161 000	28 000	56 000	a
		29%	55%	12%	6%	42%	47%	27%	32%	19%	8%	
	Poor sanitation Children < 6 without a toilet or VIP on site	1 557 000	138 000	64 000	142 000	343 000	398 000	211 000	175 000	19 000	65 000	a
	22%	16%	19%	9%	24%	44%	34%	35%	13%	9%		
Poverty	Child poverty Children < 6 living in poor households (< R1138 in 2017)	4 528 000	679 000	232 000	665 000	1 100 000	732 000	412 000	343 000	100 000	264 000	a
		65%	77%	71%	44%	78%	81%	67%	69%	67%	38%	
	Food Poverty Children < 6 living in food poor households (< R531 in 2017)	2 521 000	439 000	122 000	272 000	678 000	481 000	233 000	170 000	46 000	79 000	a
		35%	47%	36%	18%	46%	51%	37%	33%	30%	11%	
	Workless households Children < 6 in households with no employed adults	2 036 000	376 000	112 000	209 000	497 000	416 000	178 000	149 000	43 000	56 000	a
	29%	43%	34%	14%	35%	46%	29%	30%	29%	8%		

Data gaps and challenges

All of the indicators in this section are derived from national General Household Survey (GHS) data collected by Stats SA. It is important to have reliable estimates of the young child population across the country in order ensure that programmes are appropriately budgeted and services can reach all young children. Stats SA's previous

population models appear to have underestimated the child population. The model was revised in 2018, but it remains to be seen whether it is accurate. The next population census will only take place in 2021.

Primary level maternal and child health

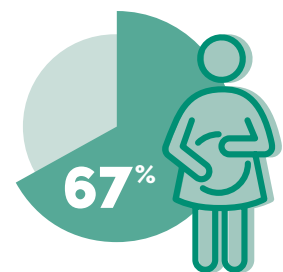


Protecting and nurturing the health of the mother and the child is the foundation on which many child development gains are built. The primary health system, through its massive network of clinic facilities and Community Health Workers, arguably offers the best infrastructure to deliver most components of the Essential Package. However, this will require coordinated service delivery and a shift in the approach of the health system from 'survive' to 'survive and thrive'.

Despite the challenges experienced by the public health system, many of South Africa's most significant post-Apartheid developmental gains especially for caregivers and children in the poorest households, have been through the health sector. This is critical for ECD because of the health sector's broad relevance to achieve the goals of the National Integrated ECD Policy.¹ As the ECD continuum of care shows (Figure 3), it is not just the maternal, newborn, and child health (MNCH) interventions that can be delivered via health system channels. Other interventions that can also be delivered via these channels, even if they are assigned to other government departments, include birth registration, parenting education and support, nutrition, early access to the Child Support Grant, identification and referrals for developmental delays, amongst others.

Antenatal care (ANC) is the first gateway to a range of health services for pregnant women and is necessary to ensure healthy births, improve nutrition for both mother and child, and provide counselling and support to pregnant women to ensure positive pregnancy experiences.² South Africa has maintained a high rate of ANC attendance in the last two decades. In the past three South Africa Demographic and Health Surveys (SADHS) since 1998, over 92% of women who have had a baby in the five years preceding each survey reported receiving antenatal services.³ However, the timing of the first ANC visit and the number of visits are also important.

Multiple visits,⁴ starting in the first trimester (0-3 months), are advised as these provide opportunities to check on the development of the foetus, to identify any physical or mental health problems in



67% of all antenatal visits in public facilities during 2017/8 occurred before 20 weeks, up from 61% during 2015/6.

Many of South Africa's most significant post-Apartheid developmental gains especially for caregivers and children in the poorest households, have been through the health sector.

the mother, and to deliver recommended interventions. It is encouraging to see that 67% of all antenatal visits in public facilities during 2017/8 occurred before 20 weeks, up from 61% during 2015/6. However, not all of these are in the first trimester, as recommended. Just under half of pregnant women book their first ANC visit in the first trimester, while the same number have their first ANC consultation in the second trimester or even later.

The quality of the service (as measured by specific interventions that are delivered during each visit)⁵ is a necessary condition to ensure good

health outcomes for mothers and their children. The SADHS data shows that when women visit facilities for ANC, a high proportion receive the key services such as blood pressure measurement, with blood and urine samples also being taken. While it is clear that the initial diagnostics are being done, we do not know whether the results were conveyed to the pregnant woman and relevant follow-ups made.

The data on antenatal antiretroviral treatment (ART) indicate some emerging service delivery challenges with ANC even in the context of significant overall progress since 2010 and South Africa's highly

FIGURE 3: CONTINUUM OF CARE DURING THE FIRST 1000 DAYS OF LIFE

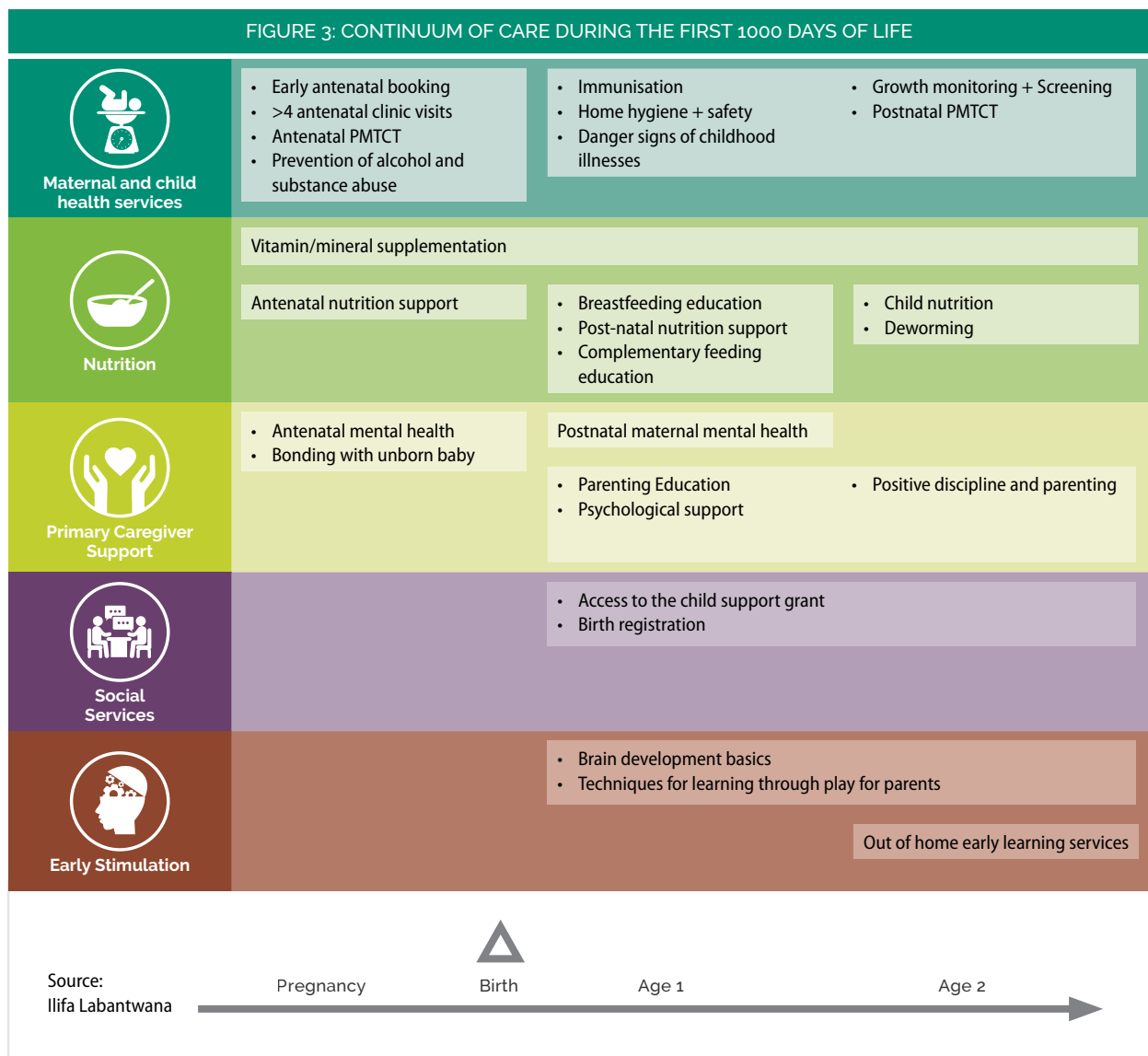
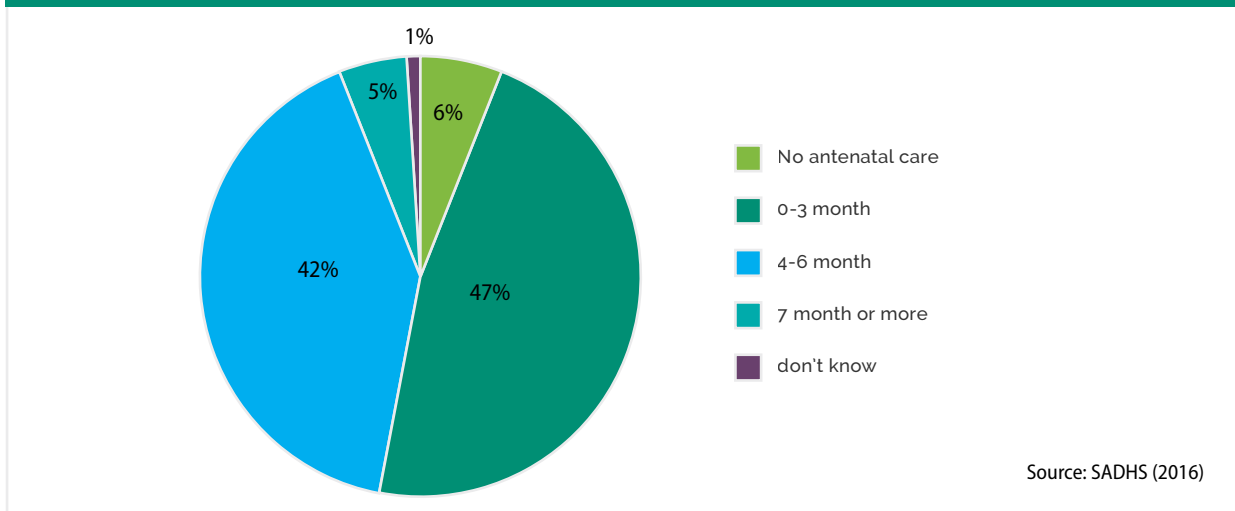


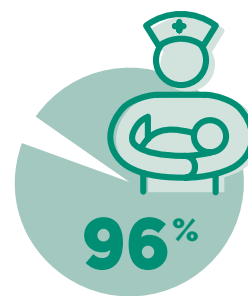
FIGURE 4 : TIME OF FIRST ANTENATAL CARE (ANC) VISIT



successful Human Immunodeficiency Virus (HIV) treatment programme. South Africa is home to the largest number of people living with HIV globally. Access to antenatal ART is critical to prevent mother-to-child transmission of HIV and reduce the incidence of paediatric infection, as well as to ensure adequate health of the mother and reduce overall HIV incidence. While improving steadily between 2010 and 2016, coverage of antenatal ART decreased from 2016 to 2017 nationally, largely in the provinces of Eastern Cape, Free State, North West and Northern Cape where coverage dropped 7%, 12%, 4% and 7% respectively.⁶ Mpumalanga, on the other hand, has made steady progress in delivering antenatal ART to pregnant women. While change over one year might not indicate a long-term trend, further

decreases in coverage over time will impact on whether South Africa can sustain its achievement of the near elimination of mother-to-child transmission of HIV. Only 0.9% of infants tested HIV-positive at 10 weeks in 2017/18.

South Africa continues to maintain a high level of facility-based deliveries (public and private) attended to by trained personnel. In 2016, 96% of all births took place in health facilities and the majority of births (85%) occurred in public facilities. These statistics are derived from the SADHS, which collects data on deliveries in public, private, and home deliveries. In the more urban and wealthier provinces like the Western Cape and Gauteng, over 15% and 10% of women respectively gave birth in private facilities. Women in these



In 2016, 96% of all births took place in health facilities

FIGURE 5: SERVICES DURING ANTENATAL CARE

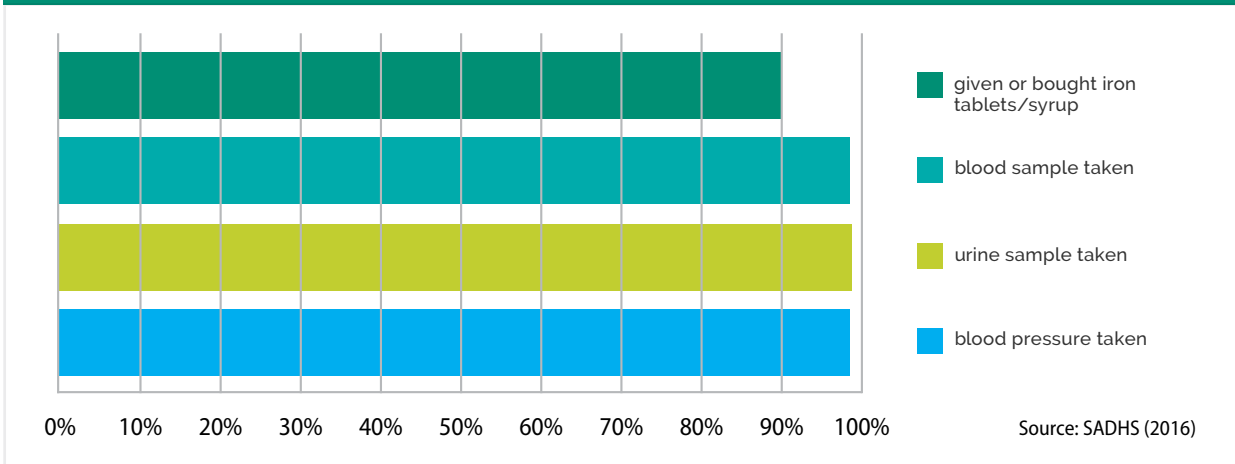
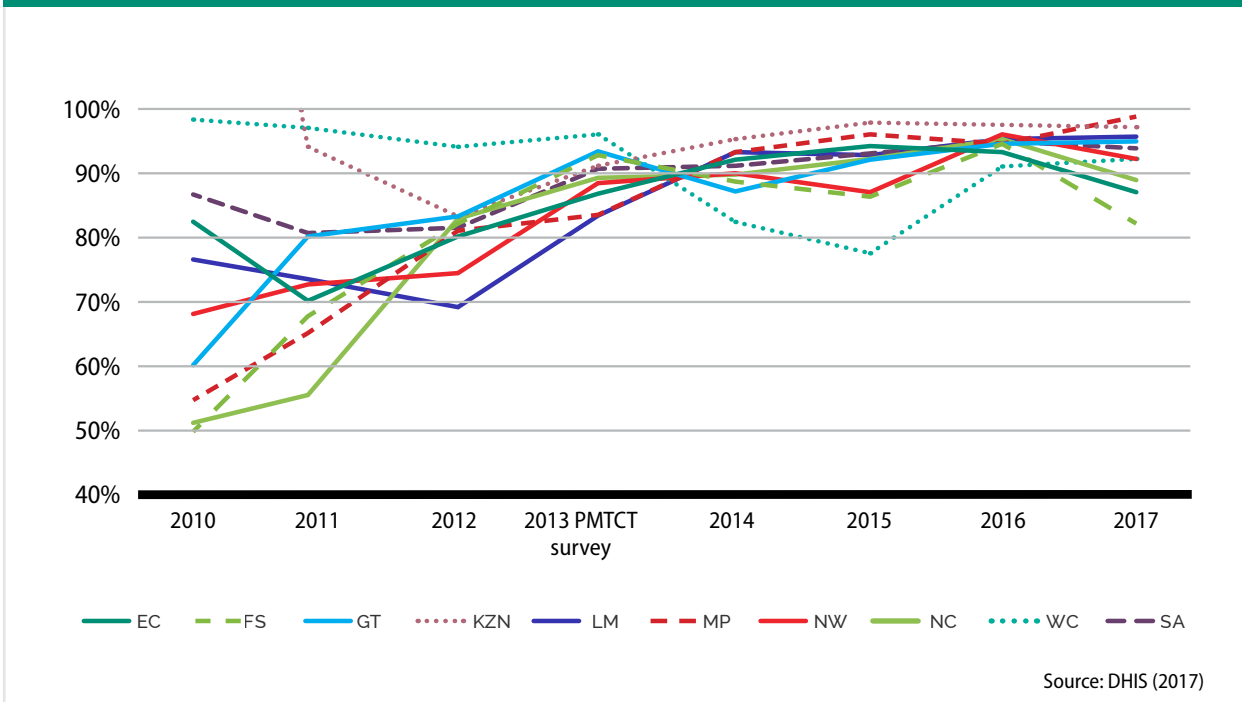


FIGURE 6: ELIGIBLE ANTENATAL CLIENTS INITIATED ON ANTI-RETROVIRAL THERAPY (2010 – 2017)



The postnatal visit and the subsequent well-child check-ups should be used to make referrals to other services.

provinces are likely to have greater access to private options through higher income levels.

In addition to the important newborn checks, postnatal visits provide additional opportunities to reinforce advice given to mothers during pregnancy and to support them to deal with childcare issues that confront them and their families soon after the birth. The postnatal visits and the subsequent well-child check-ups should be used to make referrals to other services. This is especially important for those who are poor and vulnerable. If the baby's birth was not registered before being discharged from the facility, the first postnatal visit also offers an opportunity to register, and caregivers of eligible children can begin the process of applying for the Child Support Grant. This integration of services is currently only possible at some service points where the relevant government departments have a presence, and sometimes only on certain days.

The percentage of women in South Africa visiting the clinic with their newborn within six days of birth has remained

fairly static at around 70% coverage since 2013. This means that, annually, over 300,000 newborns are not examined within six days of being born, as per the guidelines.

In 2017, the Western Cape reported the lowest coverage of postnatal visits (58%) and Limpopo reported the highest (86%). As with many of the other indicators in this review, the performance of specific provinces is inconsistent. There is also variation in the within-province trends over time suggesting that there may be reliability issues with the data. In addition to coverage of postnatal visits, it is possible to assess the quality of the visits using some key services as proxies. Over 85% of mother-baby pairs received clinical services such as checking the temperature and umbilical cord of the newborn, while less than 80% received more non-clinical interventions such as breastfeeding information, breastfeeding observation, and information on newborn dangers. Two thirds of mother-baby pairs were reported to have received all five types of services (baby's umbilical cord checked, baby's temperature taken, counselling on newborn dangers and breastfeeding, and observed breastfeeding). A further 11%

received four services, while 10% did not receive any of the five services.⁷

The newly designed Road to Health Book aims to improve the quality of postnatal services by ensuring that all baby-mother pairs receive the same broad range of essential services and placing much more emphasis on the messaging that health workers give during all postnatal visits.

Reporting immunisation coverage is important for two main reasons. Firstly, immunisation is the bedrock for addressing preventable illnesses in children. Secondly, immunisation coverage is often used as a barometer for how well a health system is functioning. The South African Early Childhood Review 2017 reported that immunisation coverage had increased from less than 70% in 2000 to almost 90% in 2015. However, when Stats SA recalibrated the mid-year population estimates in 2017, the under-1 immunisation rate was revised downwards to 79% for 2015 because the District Health Information System (DHIS) uses the population estimates as a denominator.

Immunisation rates for infants have since declined slightly across most provinces

and in 2017 only 77% of babies were estimated to be fully immunised by the age of one (Figure 8). This is a concern as it suggests that even if quality improvements in the health service are achieved with the use of the revised Road to Health Book, these will not benefit large numbers of children unless there are substantial improvements to health service access.

For many health services interventions, those in the wealthier quintiles have higher levels of coverage because they are more able to access services. In the case of immunisation, however, the richest 20% of children are less likely to be fully immunised than the poorest 20%,⁸ suggesting that failure to immunise may be partly a matter of individual choice. Despite the fact that populations in rural provinces often have to travel further to the nearest clinic than people living in urban areas, immunisation rates are mostly higher in rural areas. The government is undertaking a National Vaccination Coverage Survey in 2019 to improve understanding of immunisation perceptions and behaviour. This will help to inform better strategies to prevent any further decline in immunisation rates and improve the overall performance of the system.

FIVE MESSAGE PILLARS OF NEW ROAD TO HEALTH BOOK



NUTRITION



LOVE



PROTECTION



HEALTHCARE



EXTRA CARE

FIGURE 7: SERVICES RECEIVED AT THE POSTNATAL VISIT

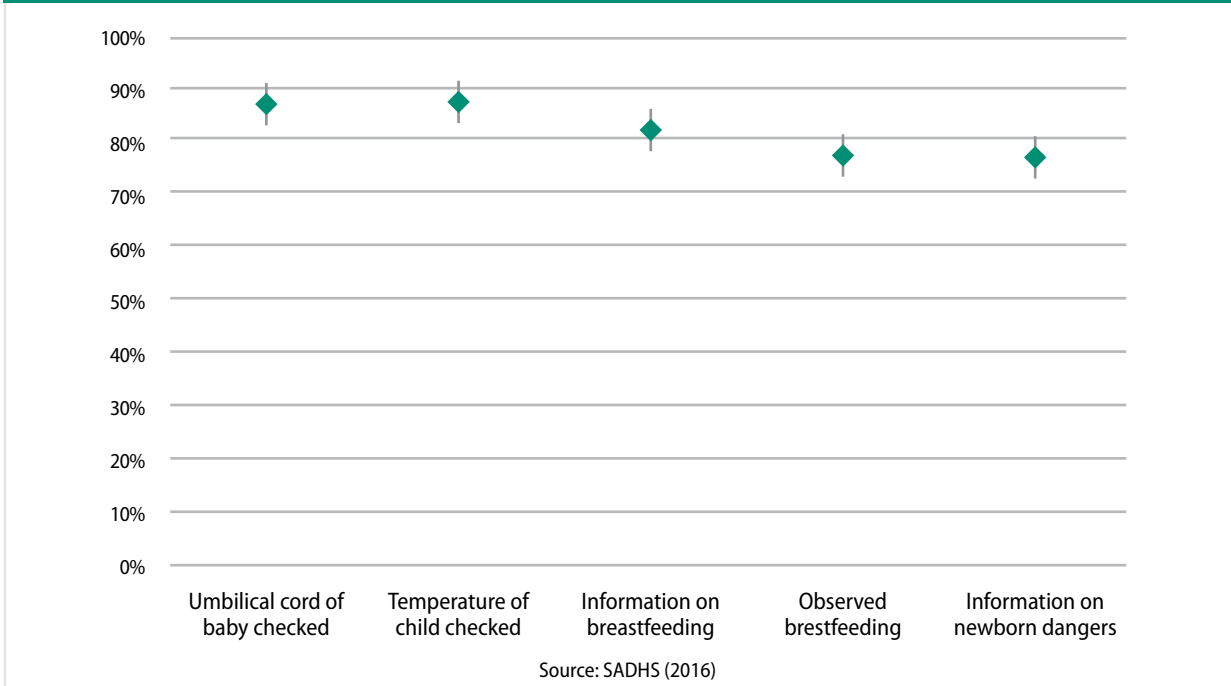
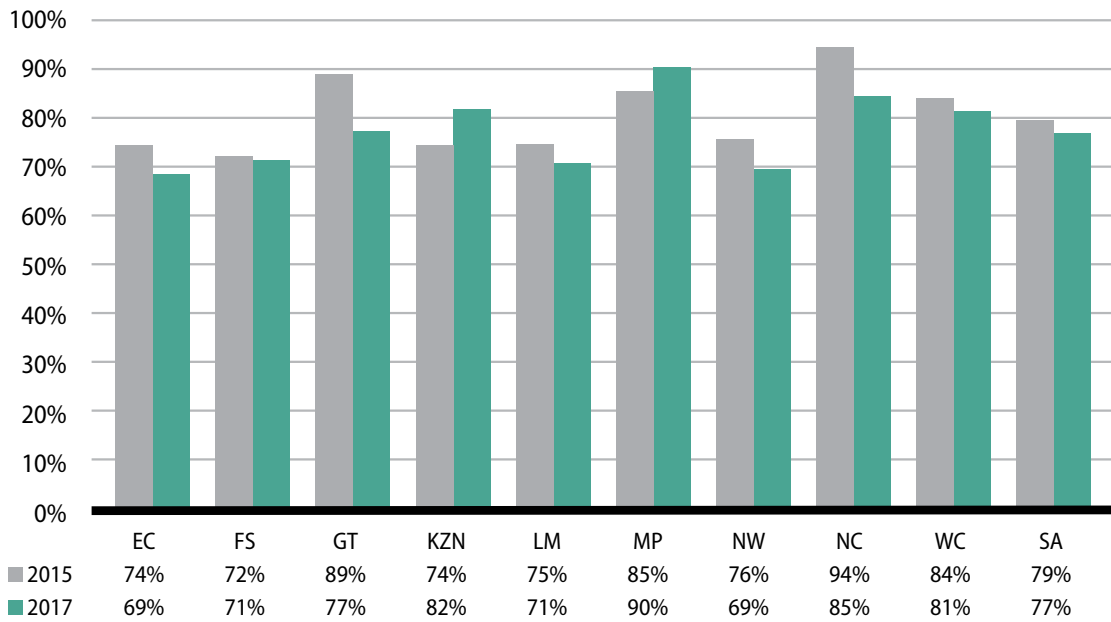


FIGURE 8: IMMUNISATION COVERAGE FOR CHILDREN UNDER-1 (2015 AND 2017)

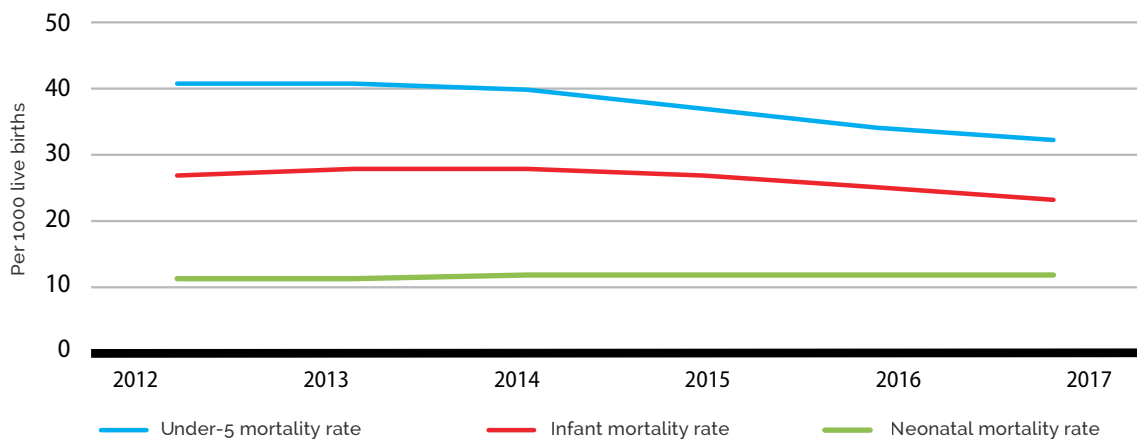


Source: DHIS (2017)

In terms of the broader service delivery context, any decline in immunisation coverage also means that there are fewer points where young children can be reached with non-clinical services such as birth registration, social grants, identification and referrals for developmental delays, support to new mothers with post-partum depression and breastfeeding, and support to caregivers with early learning and stimulation.

The ultimate markers of survival and the performance of the health system are child mortality rates. It is encouraging to see the continued decline of infant and under-5 mortality rates. However, the neonatal mortality rate has remained unchanged in recent years.

FIGURE 9: CHILD MORTALITY RATES (2012 – 2017)



Source: Bradshaw et al (2019) Rapid Mortality Surveillance Report 2017

TABLE 2: HEALTH INDICATORS FOR PREGNANT WOMEN AND CHILDREN UNDER SIX, BY PROVINCE													
	Indicator	SA	EC	FS	GT	KZN	LP	MP	NW	NC	WC	Data year	source
Population	Number of infants Children under 1 year	1,118,000	142,000	52,000	248,000	219,000	162,000	86,000	69,000	29,000	110,000	2017	a
	Poor access to clinics Children < 6 living more than 30 minutes from the nearest health facility	1,372,000	212,000	59,000	126,000	411,000	215,000	151,000	128,000	21,000	49,000	2017	a
		20%	24%	18%	8%	29%	24%	25%	26%	14%	7%		
	HIV prevalence in pregnant women Antenatal clients testing HIV+	31%	30%	30%	30%	44%	22%	35%	29%	19%	19%	2015	b
Service access/delivery	Prenatal early booking First visit before 20 weeks, out of all antenatal first visits at public facility	67%	65%	66%	61%	72%	63%	74%	66%	64%	70%	2017/18	c
	Antenatal initiation on HAART Antenatal clients on ART as % of eligible total	94%	87%	83%	95%	97%	95%	99%	92%	89%	92%	2017/18	c
	Delivery rate in facility Percentage of deliveries occurring in health facilities, under trained personnel	96%	91%	96%	97%	95%	98%	95%	95%	97%	99%	2016	d
	Postnatal visit in 6 days % mothers giving birth in public facilities who return with baby for postnatal visit within 6 days	71%	63%	64%	71%	77%	86%	63%	75%	62%	58%		c
	Immunisation coverage % of children <1 who complete the primary immunisation course	77%	69%	71%	77%	82%	71%	90%	69%	85%	81%	2017/18	c
	Paediatric HIV prevalence % infants born to HIV+ mothers who test positive in a PCR test at 10 weeks	0.9%	1.2%	1.1%	1.0%	0.7%	0.8%	1.1%	1.1%	1.4%	0.5%	2017/18	c
Outcome	Early neonatal mortality rate Number of inpatient deaths within 7 days per 1000 live births	12	Provincial estimates not available									2017	e
	Infant mortality rate Number of deaths under 1 year, per 1000 live births in same year	23	Provincial estimates not available									2017	e
	Under-5 mortality rate Probability of dying between birth and fifth birthday, per 1000 live births	32	Provincial estimates not available									2017	e

Data gaps and challenges

- Data on maternal mental health continues to be lacking despite the increasing evidence of its impact on maternal and child health, and on development outcomes.
- We are unable to report on infant and under-5 mortality rates at a provincial level.
- Quality of care data are difficult to collect, despite its importance. Focus on service quality across the board is needed.
- There are no data on children with disabilities or developmental delays. There are also no data on the numbers of children screened for disabilities and developmental delays.



Nutritional support



Breaking the inter-generational cycle of poverty and inequality must begin with improving the health and nutrition of young children. Children who receive adequate nutrition in the first 1000 days of life, and throughout childhood, are more likely to have better health and educational outcomes in childhood, and higher productivity in adulthood. The United Nations Economic Affairs Commission has shown that the costs of tackling the short and long-term negative effects of malnutrition run into billions of dollars, and these costs are borne by both households and governments.⁹ Preventing malnutrition, therefore, brings positive returns to households and society as a whole.

South Africa has high levels of child malnutrition, despite its status as a middle-income country with a relatively high per capita income compared to other countries in the region (Figure 10). However, per capita income is an average and does not reflect the very high rates of inequality and poverty in the country. Stunting occurs when a child is not growing optimally compared to the expected average growth rate and is the most common form of malnutrition in South Africa.

The prevalence of overweight and obesity is also on the rise among young children. An estimated 13% of South Africa's children aged under five years are classified as overweight. This has mainly been attributed to increased consumption of processed foods high in salt, sugar, and fats, which young children are exposed to through household diets. Statistics from the 2016 South Africa Demographic and Health Survey (SADHS) show that 35% of children aged 6-23 months consumed sugary foods

and 44% consumed salty snacks. High levels of inactivity (sedentary lifestyles) also contribute to overweight and obesity.

While good nutrition is necessary for basic survival and healthy living for both children and adults, studies have consistently shown that investments in early childhood nutrition yield significant gains in childhood and adulthood.

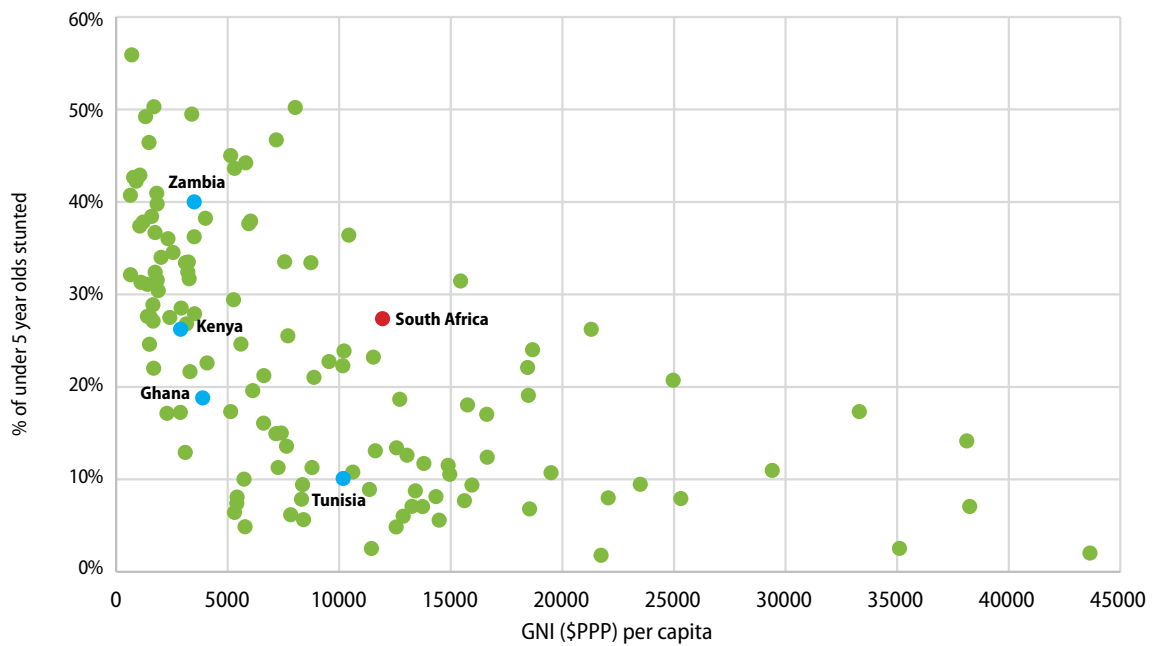
However, the nutritional status of a child is dependent on many factors, including the health and nutritional status of the mother. Pregnant women who have poor nutritional intake are at greater risk for frequent infections and low pre-pregnancy body mass index (they are stunted themselves) and are more likely to give birth to an under-weight baby.

In South Africa, about 15% of infants are born with low birth weight.¹¹ There are no significant differences in low birth weight rates across urban and rural areas, but low birth weights were found to be higher (19%) among babies born to older mothers (aged



An estimated 13% of South Africa's children aged under five years are overweight.

FIGURE 10: STUNTING RATES AND GROSS NATIONAL INCOME (GNI) PER CAPITA



Source: Adapted from Jonah C, Sambu W & May J (2018)¹⁰ Data from Human Development Report 2018.

Through early and routine ANC at public health facilities, women at risk of giving birth to low birth weight infants can be identified

35-49 years) compared to an average of 14% for babies born to mothers aged under 35 years.

Low birth weight babies are at significant risk of neonatal and infant mortality,¹² as well as other childhood illnesses like pneumonia and diarrhoea. Some studies have also found an association between low birth weight and risk for non-communicable diseases such as diabetes later in life.¹³

The risk of low birth weight can be reduced through good quality care and nutrition for pregnant women, and early uptake of antenatal care. Over 90% of women report receiving antenatal care (ANC) during pregnancy, but only 47% begin receiving this care within the first three months of pregnancy.¹⁴ Through early and routine ANC at public health facilities, women at risk of giving birth to low birth weight infants can be identified.¹⁵ provided with necessary care and dietary supplements, and the growth of the foetus can be monitored regularly.

Lack of access to adequate food for the mother during pregnancy and even

before conception results in poor intake of important nutrients that are necessary for the health of both the mother and the child. There is little information available on the diet and nutritional status of pregnant women in South Africa, but it is well established that high levels of poverty and unemployment negatively affect access to adequate food – leading to hunger, undernutrition, and micronutrient deficiencies in poor households including those with pregnant women.¹⁶

A third of women of reproductive age (15-49) suffer from anaemia, while 13% of women in the same age group are vitamin A deficient. On the extreme end, 62% of women in this age group are overweight or obese, putting them at risk of non-communicable diseases such as diabetes and hypertension. Obesity in women of reproductive age has also been found to increase the risk of them having preterm babies. Overconsumption of poor diets and lack of physical activity are some of the main leading causes of over-nutrition in adult females in South Africa. Consumption of poor diets, including those that are rich in highly processed foods, has increased among poor households partly due to low

incomes and the higher cost of healthier foods. Other structural barriers to a healthy lifestyle include lack of opportunities for physical exercise, safety concerns while exercising, as well as time poverty due to the triple burden of work, child-care, and long travel distances to work.¹⁷

Improving maternal nutrition requires policies and programmes that encourage and support consumption of healthy foods rich in micro and macro nutrients

(including calcium, iron, proteins, and vitamins) and discourage the consumption of highly processed foods. Mothers attending health facilities for ANC or for childbirth should be sensitised on the need for proper nutrition for themselves and their babies. Nutrition information can also be channelled through Community Health Workers (CHWs) who conduct home visits. This is particularly important in rural areas where mothers may have challenges accessing health services due to travel over long distances and transport costs. Provision of information on maternal nutrition, as well as infant and child feeding and regular growth monitoring, is important for nutritional outcomes. However, information alone is not enough when many children live in poor households with inadequate living conditions.

Irrespective of their birth weight, children can become stunted if they do not have access to adequate nutrition or if they suffer from frequent infections such as diarrhoea and pneumonia. Close to a third (31%) of children under two years are stunted.

Adequate nutrition in early childhood begins with exclusive breastfeeding for the first six months of a child's life. Only a third (32%) of South Africa's infants under six months are exclusively breastfed. Exclusive breastfeeding is highest among the youngest infants (0-1 months) at 44%, after which the rate begins to decline rapidly (to 23% at 4-5 months). From 6 months of age, children should be gradually introduced to complementary foods that are diverse and nutritious. However, the vast majority of young children (6-23 months) consume unvaried diets, while 77% of them do not consume a minimum acceptable diet at all.¹⁸ Food should also be sufficient in quantity,

in order to prevent children from going hungry. Child hunger rates have declined in South Africa, but 12% of children under six years live in households that report children going hungry. The percentage is highest in KwaZulu-Natal, where almost 20% of young children live in households that reported child hunger.

Eradicating stunting and other forms of malnutrition requires a multi-sectoral approach across a child's life course,

involving multiple government departments (Agriculture, Social Development, Health, and Education) and other stakeholders. The implementation of the *National Food and Nutrition Security Plan (2017-2022)* needs to be prioritised.¹⁹ The plan is based on the country's food and nutrition security policy and aims to reduce food insecurity and malnutrition through ensuring that the social protection system responds to the nutritional needs of children, improving early access to the Child Support Grant (CSG), and other methods. A further key objective is the identification and scaling up of high impact interventions that improve nutritional outcomes, for example, exclusive breastfeeding and micronutrient supplementation for pregnant women and young children. Other objectives include the development of an integrated communication plan to influence people across the life cycle to make informed food and nutrition decisions, increasing access to nutritious and affordable food, and constituting a multi-sectoral council to oversee the implementation of food and nutrition security policies and programmes.

Given the established links between poverty and malnutrition, a long-term solution would be the reduction of poverty through increased employment opportunities that generate adequate income.

But in the context of high unemployment and low wages, social assistance programmes such as the CSG should be strengthened to cater adequately to the nutritional needs of children. This can be done by increasing the value of the grant and ensuring that young children have early access to the grant.



Close to a third (31%) of children under two years are stunted

Social assistance programmes such as the CSG should be strengthened to cater adequately to the nutritional needs of children.

TABLE 3: NUTRITION INDICATORS FOR PREGNANT WOMEN AND CHILDREN UNDER SIX, BY PROVINCE

	Indicator	SA	EC	FS	GT	KZN	LP	MP	NW	NC	WC	Data year	source
Population	Vitamin A deficiency in women. Women (16-35 years) below the WHO standard	13%	9%	8%	18%	16%	*	*	9%	*	7%	2012	f
	Anaemia in women (15+ years) Women (15-49 years) below the WHO standard for iron deficient	33%	30%	28%	32%	29%	29%	39%	38%	26%	24%	2016	d
	Low birth weight % infants born with weight below 2500g	15%	14%	17%	12%	17%	11%	14%	16%	20%	18%	2016	d
	Child hunger Children under 6 years in households where children suffer hunger	823 000 12%	64 000 7%	50 000 15%	155 000 10%	271 000 19%	33 000 4%	82 000 13%	72 000 15%	32 000 21%	64 000 9%	2017	a
Service access	Breastfeeding Children aged under 6 months who are exclusively breastfed	32%	20%	28%	29%	33%	43%	15%	31%	65%	46%	2016	d
	Vitamin A coverage in children (12 - 59 months)	54%	53%	48%	51%	69%	47%	58%	42%	50%	49%	2017	c
Outcome	Vitamin A deficiency in children under 5	44%	Provincial estimates not available									2012	f
	Iron deficiency anaemia in children under 5	1.9%	Provincial estimates not available									2012	f
	Anaemia in children (6 - 59 months) Children (6-59 months) suffering from anaemia	61%	59%	54%	74%	42%	59%	70%	68%	48%	61%	2016	d
	Stunting in children under 5	27%	25%	34%	34%	29%	22%	22%	27%	21%	23%	2016	d
	Underweight in children under 5	6%	3%	8%	6%	4%	5%	5%	13%	8%	12%	2016	d
	Overweight in children under 5	13%	21%	17%	11%	18%	8%	9%	8%	5%	14%	2016	d

Data gaps and challenges

Lack of detailed individual-level data on food intake remains the biggest challenge in the assessment of dietary intake, particularly among young children and pregnant women. In addition to the fact that existing data on dietary intake is out-dated, the food consumption surveys that collect such data are carried out irregularly which makes it difficult to monitor trends and evaluate the impacts of policies and programmes designed to improve food security and nutrition.

South Africa also lacks disaggregated data on dietary intake and child nutritional outcomes, making it difficult to produce estimates across various levels of disaggregation such as geographical regions and age groups. Consequently, it is difficult to give an accurate diagnosis of the extent of inequalities in food and nutrition security. This hampers the implementation of programmes targeting the most food insecure and malnourished.



Support for primary caregivers

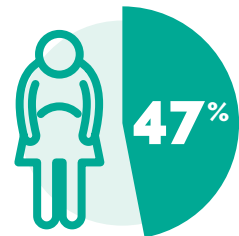
For children to thrive and reach their full potential, they require nurturing care from their caregivers. Nurturing care is care that is responsive, encourages early learning, and is emotionally supportive.²⁰ However the capacity of caregivers to offer this form of care can be undermined by the high levels of poverty, domestic violence, and perinatal depression that many of South Africa's primary caregivers experience.²¹ Caregivers need supportive services, including clear information about parenting, as well as access to psychosocial services and material support.

As many as 47% of pregnant women suffer from antenatal depression²² and up to 34% of women suffer from postnatal depression.²³ Depression not only limits a woman's capacity to offer nurturing care to her child but also has adverse outcomes for maternal-infant attachment and bonding, early infant feeding practices, maternal health seeking behaviour, infant brain development, and the mental health of the child later on in life.²⁴

Although South Africa has high rates of parental absence,²⁵ most children under six years do live with their biological mothers. This suggests that investing in educating pregnant women on positive parenting and providing them with psychosocial support throughout pregnancy and the postnatal period will continue to directly benefit the majority of children for the early years of their lives.

An example of how this kind of support could be provided is through community-based antenatal and postnatal support groups that provide positive parenting education, as well as a community of affirmation and encouragement for new mothers and their partners. At present parenting support and education programmes are not widely available in South Africa, and these programmes are particularly scarce for families living in vulnerable communities where the need for parenting support is greatest.

National evaluations have found antenatal breastfeeding education amongst HIV-positive mothers to be high, estimated at 94%.²⁶ More recent data shows that nationally, 82% of women who received postnatal care were provided with information on breastfeeding.²⁷ However, these statistics do not tell us about the quality of breastfeeding education; nor



47% of pregnant women suffer from antenatal depression and up to 34% of women suffer from postnatal depression.

Breastfeeding education alone is not enough to improve breastfeeding rates. Mothers need to be supported in their homes and communities.

do they seem to translate into improved exclusive breastfeeding rates for infants under six months which are estimated to be at around 32%²⁸ - well below the global exclusive breastfeeding target of 50%.²⁹

Clearly breastfeeding education alone is not enough to improve breastfeeding rates. Mothers need to be supported in their homes and communities with common challenges related to breastfeeding. These include mental health challenges that contribute to women losing their confidence in their ability to adequately nourish their child with breastmilk alone, as well as poor breastfeeding techniques that may result in cracked nipples and engorged breasts – resulting in the early termination of breastfeeding.³⁰

South Africa has an approximately 70,000 strong workforce of Community Health

Workers (CHWs) who if capacitated through adequate training, necessary resources, and supportive supervision, could play a critical role in providing household-based breastfeeding support to caregivers. Not only would this improve infant health and development outcomes, but it could also help to protect caregivers from postnatal depression. The literature suggests that mothers tend to base infant feeding choices on information provided to them by a healthcare worker,³¹ so an investment in training CHWs on breastfeeding education and support is likely to go a long way in improving breastfeeding rates in South Africa. There is a range of CHW programmes already in place in South Africa's vulnerable communities that could be leveraged to improve caregiver support, as well as maternal and child health outcomes.

Examples of Community Health Worker (CHW) programmes in South Africa

Mentor Mothers - The Philani Maternal, Child Health and Nutrition Trust

The Philani Maternal, Child Health and Nutrition Trust runs a CHW-led home visiting programme in the Western and Eastern Cape, with the aim of improving child health and nutrition outcomes. The programme is called Mentor Mothers and it provides support and health education to at-risk pregnant women in the communities where they live. A number of evaluations have found Philani's home visiting programme to be effective in improving the nutritional status and wellbeing of children in the communities where Philani operates. A 2015 randomised control trial found that even in the face of antenatal depression, Philani's home-visiting programme was effective in encouraging and

supporting mothers to continue positive behaviours that promote foetal and infant wellbeing. The trial found that the intervention was effective in protecting the unborn child from stunting when compared to children of depressed mothers who did not benefit from Mentor Mothers.³²

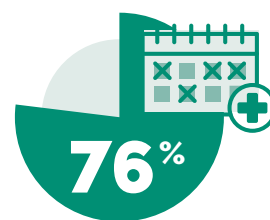
Champions for Children - Grow Great

Champions for Children is an informal community of practice that supports, empowers, and incentivises CHWs to provide evidence-based first 1000 days interventions to mothers and children through virtual and face-to-face groups in communities. Champions for Children is an example of how the presence of CHWs in communities can be leveraged to improve maternal and child health

outcomes. The CHWs participating in Champions for Children's clubs have to date established over 200 community-based, peer-supported breastfeeding groups in Limpopo and Mpumalanga. They have routinely growth monitored close to 8,000 children under two, with the aim of reaching 600,000 children under two at scale. An internal evaluation of the programme, six months into implementation, suggests that Champions for Children is statistically significantly effective in improving CHWs' confidence in their own understanding of issues related to maternal mental health, and in conducting screenings for perinatal depression. In addition, after six months of participating in Champions for Children, CHWs reported improved knowledge in supporting early antenatal bookings, improved confidence in their ability to identify at-risk babies (particularly low birth weight babies), measuring mid-upper arm circumference to screen for severe acute malnutrition, assessing the weight-for-age and height/length-for-age of children under two, and in facilitating referrals to the Department of Home Affairs for children without birth certificates.

Family Community Motivator (FCM) programme³³ - ELRU

The FCM programme is a home visiting programme, run by ELRU, targeting the most vulnerable households with pregnant women and children under two. The programme aims to provide education and support to pregnant women and caregivers through home visiting and parenting workshops with the intent to positively change their caregiving behaviours. The programme also links beneficiaries to government social and health services. In 2016, an external evaluation of the FCM programme in the North West assessed whether the programme had changed caregiver and child outcomes such as hygiene and safety in the home, caregiver coping, parenting, early learning, and access to services. The external evaluation found significant improvements in household hygiene and safety, parenting, and caregiver coping. The evaluation also found an increase in parent-child stimulation activities. Access to birth certificates and Road to Health Books had improved for children under 12 months and social grant access for children under 12 months had improved from 49% coverage to 81% over the previous year.



The majority of expectant mothers (76%) are making four or more visits to a health facility.

Exclusive breastfeeding rates can also be improved by removing structural barriers to exclusive breastfeeding. This may include extending maternity benefits to six months, legislating and enforcing paid maternity leave, as well as enabling breastfeeding in the workplace through strengthening related labour laws.³⁴ South African labour law makes provision, through the Code of Good Practice on the

Protection of Employees during Pregnancy and after the Birth of the Child, for new mothers returning to work to take two 30-minute breastfeeding or expressing breaks per day during the first six months of their child's life. However the code is not legally enforceable and employers are not obliged to provide breastfeeding or expressing rooms, thus presenting a missed opportunity to remove a significant

The mental and physical health of poor mothers could be optimised through the introduction of a maternity support grant.

structural barrier to exclusive breastfeeding in the first six months of life.

Antenatal care visits offer a window of opportunity for a range of support interventions. The majority of expectant mothers (76%) are making four or more visits to a health facility. All of these women should be screened for antenatal depression, substance abuse, and domestic violence – particularly as pregnancy is a time of increased vulnerability to domestic violence and mental illness.³⁵

In addition to the clinical care received in health facilities, the mental and physical health of poor mothers could be optimised through the introduction of a maternity support grant. Providing vulnerable women with a cash grant in pregnancy would contribute to addressing malnutrition during pregnancy which adversely impacts the growth of the foetus, as well as maternal health and maternal mental health. It was estimated that, in 2009, at least one in every four pregnant women in South Africa suffered from hunger³⁶ threatening the health and wellbeing of the mother, and the physical and cognitive development of the unborn child.³⁷

Pregnancy is often a time of reduced earning potential, increased financial pressure and vulnerability to unemployment.³⁸ The provision of income support to poor and at-risk women during this period would be aligned to the aspirations of South Africa's National Development Plan. In developing country contexts where similar strategies have been implemented, pregnancy and early childhood income support have been shown to improve a range of maternal and infant outcomes.³⁹ In addition, pregnancy income support would enable women to attend the recommended eight antenatal clinic visits and participate in community-based parenting support groups. This kind

of policy would also serve to reduce the poor uptake of the Child Support Grant (CSG) in the first year of life, as eligible women's pregnancy grants could be converted into the CSG once the baby is born.

Income support after pregnancy is crucial, given the high levels of poverty and unemployment in South African households. Statistics show that over a third (37%) of unemployed mothers with children under age one, live in households where no adult is employed.⁴⁰ The CSG is successful at reaching large numbers of children and reducing the effects of poverty, but there are delays in getting babies registered. Additionally, the CSG is not designed to support maternal nutrition as well as the basic needs of their children.

The majority of women, estimated at 71% in 2017, attend public health facilities for postnatal care six days after the birth of their child. These postnatal care visits provide a critical opportunity to support caregivers at a time of great vulnerability and link them to relevant services in their communities. Postnatal visits also offer an opportunity to reinforce breastfeeding education and provide support to mothers facing breastfeeding challenges. Research suggests that breastfeeding education and support is most effective when received both before and after the birth of the baby.⁴¹

This chapter does not address the support needed by fathers and other men who provide a social fathering role. More research is needed in this area, particularly in light of evidence pointing to the important role fathers play in the health and psychosocial development of a child during the first 1000 days and beyond.⁴² Programmes are needed that provide parental support and education to men, who are often a neglected group when caregiver support programmes and policies are developed.⁴³

TABLE 4: INDICATORS OF SUPPORT FOR PRIMARY CAREGIVERS, BY PROVINCE

	Indicator	SA	EC	FS	GT	KZN	LP	MP	NW	NC	WC	Data year	source
Population	Maternal care Children under-6 who live with their biological mother	85%	74%	82%	94%	80%	82%	84%	85%	85%	92%	2017	a
	Household education Children under-6 living with at least one adult who has passed matric	61%	47%	59%	73%	64%	49%	61%	57%	56%	63%	2017	a
Service access	Breastfeeding education % of mothers (15-49 years) who reported receiving information on breastfeeding	82%	86%	88%	72%	92%	94%	70%	79%	88%	86%	2016	d
	Follow-up antenatal visits % of pregnant women attending facilities who had at least 4 antenatal visits	76%	82%	78%	62%	77%	82%	73%	89%	75%	89%	2016	d
	Postnatal follow up Women birthing in public facilities who received follow-up care 6 days after birth	71%	63%	64%	71%	77%	86%	63%	75%	62%	58%	2017	c

Data gaps and challenges

- There is a lack of data on the provision of support, information, and advice to pregnant women and mothers.
- Information on the quality of antenatal and postnatal services is lacking.
- There are no routinely collected national data on maternal mental health challenges and screening (including domestic and intimate partner violence, as well as alcohol and substance abuse) during pregnancy and after birth.
- There are no national data on the types of parent support programmes available, their identified target groups, beneficiary access and programme reach.
- Data on the management of primary level mental health problems requiring treatment are lacking.



Young father, Mosizakhe Bottomone, comforts his newborn ahead of a routine appointment at Philani Clinic, Khayelitsha, Western Cape. Photo: Bart Love, 2018.

Social services and income support



Early registration of births is important because a birth certificate is the gateway to other services and benefits, including the Child Support Grant (CSG). The CSG provides income support for children in poverty and thus targets some of the structural causes of poor early childhood development.

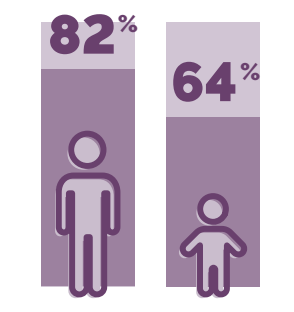
Social assistance is a way of redistributing resources to the poor through grants. Social grants are widely regarded as the most effective poverty alleviation programme in South Africa because of their positive impact, effective targeting, and wide reach. Social assistance programmes have expanded from covering just 2.7 million people in 1994 to 17.5 million in 2018.

The CSG has had the highest growth of all social grants in South Africa. It was introduced for poor children aged under seven in 1998, and then gradually extended to all children below the age of 18 by 2012. Its reach has expanded from just under 22,000 child beneficiaries in 1998 to over 12 million children in 2019.

Access to social grants for young children is lagging behind the targeted uptake levels. The Medium Term Strategic Framework 2014-2019 set a target that grants should reach at least 95% of eligible people by 2019. In 2017, this target had not been reached: 82% of poor children under six years received a grant and only 64% of poor children⁴⁴ under a year received a grant.

The relatively urbanised and wealthy provinces (Gauteng and the Western Cape) have the lowest CSG uptake rates. Poorer and more rural provinces perform better in rolling out the CSG to eligible children. This spatial patterning is strikingly different from many other indicators, where Gauteng and the Western Cape tend to outperform other provinces. Previous studies on the implementation of the CSG have suggested that in very poor provinces or districts where the population is homogenously poor, there is greater emphasis on facilitating enrolment on the grant; whereas in wealthier areas where there is greater inequality and populations are not homogenously poor, social security officials are more inclined towards "gatekeeping" and may even make applications more difficult by demanding supporting documents that are not required by law.⁴⁵

The CSG has been shown to have a substantial developmental impact on poor children's nutrition, health, and educational outcomes, and more can be done to improve its reach and impact. The value of the grant should



82% of poor children under six years receive a grant and only 64% of poor children under a year receive a grant.

For each cohort of children born in a year, around 200,000 children are not registered within the first year of their life.

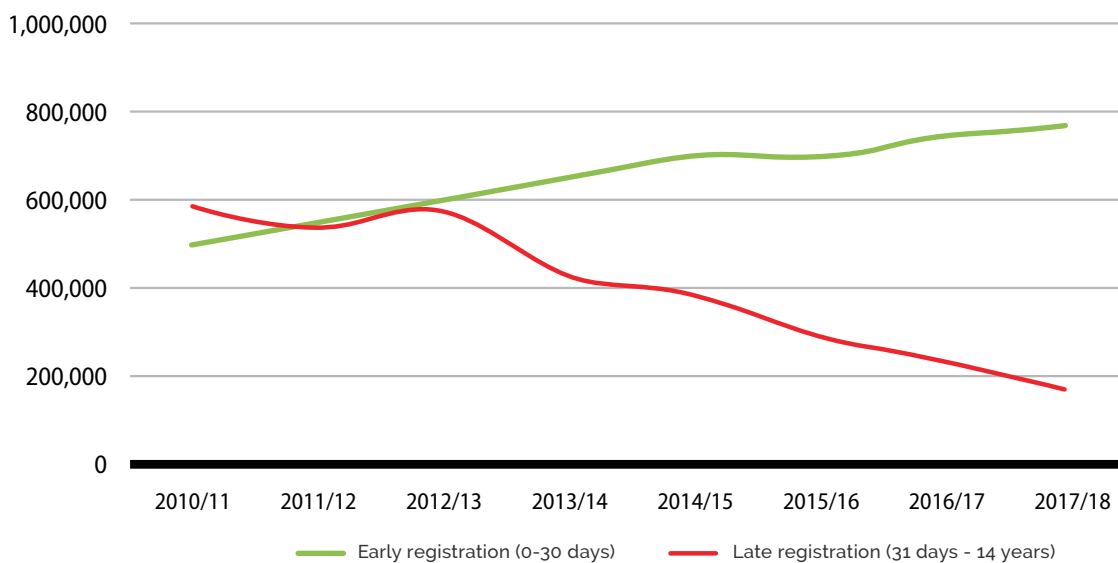
be increased. The grant amount (R400 in 2018) is considerably lower than the food poverty line (R547 in 2018). It is not enough to ensure that young children receive the minimum amount of nutrition, let alone the cost of other essentials such as clothing, bedding, transport to clinics, and fees for child care services such as crèches. The easiest way to address exclusions for children is to ensure that they are enrolled on the grant from birth. This requires greater investment in enabling birth registration at health facilities where the majority of births occur and consideration being given to expanding this model to include simultaneous CSG registration. Further, health workers should encourage eligible caregivers to apply for the CSG, if they are not already accessing it.

Early birth registration has increased over the past decade. Births are meant to be registered within the first 30 days of life and there has been a notable increase in birth registrations during this period, as shown in Figure 11. The Department of Home Affairs (DHA) attributes this achievement to a range of outreach programmes and the intensification of birth registration at health facilities.⁴⁶ There is a corresponding decline in late registrations, but calculations using a combination of birth registration data and population estimates suggest that

for each cohort of children born in a year, around 200,000 children are not registered within the first year of their life. Some are registered even later and some are never registered at all. Birth registration after one year is very much more difficult because of extra proof required and a verification process involving interviews before a panel.

Only 391 of the 1,445 health facilities where births occur in South Africa have DHA service points.⁴⁷ These service points enable caregivers to apply for birth registration of their new-born child at the health facility immediately after giving birth. Many of the service points that do exist are not yet connected digitally to the DHA mainframe, meaning that the application must be verified and processed at a DHA office. The Minister of Home Affairs has committed to ensuring that 251 priority service points, covering 84% of the births in South Africa, are digitally connected by March 2021⁴⁸. He has also committed that all health facilities where births take place will have DHA service points by 2023.⁴⁹ However, the 2019/20 Budget Vote projects that births registered within 30 days will remain at 800,000 until 2023, indicating little intention to intensify early birth registration within facilities.⁵⁰

FIGURE 11: BIRTH REGISTRATION TRENDS (2010/11 – 2017/18)



Source: DHA Annual Report (2017-2018)

The challenge of achieving complete birth registration

From the moment they are born, all children in South Africa are entitled to a name and nationality. The state confers this through birth registration and, in the case of children who are citizens, a South African identity number.

Why is it so important that children's births are registered?

Birth certificates are the gateway to a range of services that are critical for children to reach their developmental potential. Yet over half a million children aged 0-18 in South Africa do not have birth certificates and, as a result, have poorer access to a range of state services.⁵¹

- **Children without birth certificates are likely to come from poor families; yet it is difficult for caregivers to access the CSG without birth certificates.** Only 18% of young children without birth certificates receive a social grant, compared to 74% of those with birth certificates.

- **Unregistered children are more likely than registered children to be without the state-issued personal health record, the Road to Health Book (7% versus 1%),** suggesting that they are less likely to access the primary health care services necessary such as growth monitoring and immunisation.

- **Children without birth certificates are at risk of exclusion from school.** An estimated 158,000 children of compulsory school going age do not have birth certificates. Although the law⁵² does not require learners to provide a birth certificate in order to attend school, the admission policy⁵³ does; and the Department of Basic Education

has communicated a new policy of not paying schools the per learner allocation for learners without identity numbers.⁵⁴ There is growing evidence that many children without birth certificates are being excluded from school⁵⁵ even though education is a constitutional entitlement and is compulsory until a child is 15 years old.

- **There is a risk that young children without identity numbers will be excluded from funding allocations for pre-school education and services,** particularly as efforts are made to strengthen ECD administrative data systems standardised with the use of identity numbers.

What are the obstacles to birth registration?

Caregivers face a range of obstacles in birth registration. In addition to travelling distance and cost and long waiting times at DHA offices, the legal requirements, computerised systems and procedural protocols implemented by the DHA tend to be inflexible, making it difficult for some children to be registered within the required period. This is especially the case if parental and care arrangements do not conform to a nuclear family 'norm'.⁵⁶

The law, regulations and protocols governing birth registration need to be reviewed and reformed to include all children, and the systems need to be sufficiently flexible to accommodate different scenarios. Rather than being excluded from services, unregistered children should be fast-tracked into a responsive government service that pro-actively assists with their registration.

Compared to children with birth certificates, those whose births are not registered are...

- **More likely to be poor**
- **Less likely to receive a social grant**
- **Less likely to access clinics for immunisation and growth monitoring**
- **More likely to be excluded from school and from the school nutrition programme**



One in three children experiences physical violence and sexual abuse before the age of 18

There are no reliable data on the number of children who need social services, or on the extent of services delivered and service delivery gaps. Services for young children as defined in the Children's Act include:

- partial care (crèches and ECD centres) and ECD programmes
- prevention and early intervention services, such as child and family counselling, parenting skills programmes, and support for young mothers
- protection services for children who have been abused, abandoned, or neglected
- provision of alternative care, including foster care and adoption

Data on child abuse, neglect and on the related service responses remain very poor – in part because child abuse and other violent crimes against children are under-reported. The South African Police Service recorded 43,450 crimes against children in 2017/18, of which over half were sexual assault.⁵⁷ A national prevalence study estimated that one in three children experiences physical violence and sexual abuse before the age of 18.⁵⁸ The Birth to Twenty (BT20) study, a longitudinal study of children born in Soweto, Gauteng, suggests that children's exposure to violence and abuse may be even more common: 99% of children in its sample had experienced or witnessed acts of violence in childhood.⁵⁹

Young children are particularly vulnerable to child abuse and neglect because they are dependent on caregivers and cannot protect themselves. The BT20 study found that half (49.9%) of pre-school children had experienced physical punishment by a parent or care-

giver.⁶⁰ The most severe consequence of child abuse is infanticide (killing of a child under one year). A national survey of child homicides found that three quarters of homicides among young children (0-4 years) had been the result of abuse by a caregiver in their own home.⁶¹ The line between physical punishment and child abuse is blurred and it is partly for this reason that civil society organisations concerned about the rights and well-being of children have argued for a complete ban on corporal punishment.

Emerging evidence points to the links between intimate partner violence and violence against children in the home.

These forms of violence share common risk factors, and both have intergenerational dynamics – the experience of violence or even witnessing violence in childhood increases the likelihood of perpetrating violence in adulthood or entering into violent relationships.⁶² This implies the need for joint strategies to address violence against women and children.

Increased efforts are needed to strengthen the child protection system

and to ensure that the various duty-bearers, such as the police services, Department of Social Development, Department of Health and the criminal justice system, can collaborate well to improve the efficiency of responsive services and referral systems. A national Child Protection framework has been drafted and once finalised, it could inform current legislative and policy frameworks to strengthen service delivery.

TABLE 5: SOCIAL PROTECTION ACCESS/DELIVERY INDICATORS FOR CHILDREN UNDER SIX, BY PROVINCE

	Indicator	SA	EC	FS	GT	KZN	LP	MP	NW	NC	WC	source
Service access / delivery	No birth certificate Estimated number of children under 1 not registered within first year	198 000	35 000	4 000	43 000	33 000	44 000	9 000	13 000	5 000	12 000	g
		18%	25%	8%	17%	15%	27%	10%	18%	18%	11%	
	CSG uptake in children under 6 Proportion of poor children < 6 years receiving CSG	81%	86%	83%	67%	83%	84%	82%	79%	84%	70%	h
	Poor infants without grants Number and share of poor children < 1 year not receiving CSG or any grant	401 000	43 000	20 000	129 000	66 000	49 000	33 000	22 000	6 000	58 000	h
	36%	30%	39%	52%	30%	30%	38%	32%	20%	53%		

Data gaps and challenges

There is a need for regular national data on the prevalence of child abuse and neglect. The data would need to come from reported cases to the police and social services because these issues are difficult to determine in general surveys. Good systems need to be in place to ensure that reporting is encouraged and that records are accurately recorded and maintained in local offices and properly compiled at provincial and national level.

There is also a need for good administrative data on the delivery of responsive child protection services and psychosocial support for children. For example, it would be useful to track the number and proportion of child protection cases that are brought before the court within 90 days, as stipulated in the Children's Act. This would involve linked administrative data systems for the Department of Social Development and the Department of Justice and Constitutional Development.

South Africa does not have a nationally accepted tool for measuring the prevalence of disability, especially in children. The last dedicated national disability prevalence survey in South Africa

was conducted in 1999. More recently, Stats SA has included modules of disability questions in the Population Census, the Community Survey, and some of the General Household Surveys, but these cannot be used reliably to determine child disability rates as the "domains of functioning" measures are not adequately sensitive to normal development processes, particularly in young children.⁶³ Estimates of disability rates from these sources show huge discrepancies, ranging from 0.9% to 27.5% of young children under four years, and between 0.6% and 11.2% of the total child population.⁶⁴ The revised Road to Health Book includes a potential tool to identify young children at risk of disability and developmental delays. Certain screening systems for identifying disability in school-age children have been introduced through the education system in conjunction with the Department of Health, including assessments of hearing, speech, and gross motor function. The effectiveness of these tools will depend on how well and consistently they are applied by different assessors across different settings.

There is a need for regular national data on the prevalence of child abuse and neglect.



Early learning underway at the Mapukata family home in Amajingqi, Eastern Cape. Mother Nophelo Mapukata with her two young daughters. Photo: Bart Love, 2018.

Stimulation for early learning



Early childhood experiences are particularly important in shaping the development of the brain. Experiences that matter most in terms of early learning include everyday interactions between the child and their primary caregivers, as well as the child's exposure to formal and informal group-based learning opportunities with peers.

The South African National Integrated ECD Policy (2015) promotes a broad range of programmes and interventions to support parenting and to enable the delivery of group-based early learning models in a variety of contexts. These are delivered through a combination of government and non-government providers, with substantial variability in design and quality.

The influence of children's home environment and parenting practices on early development is well established.⁶⁵

Interactions between parent and child in the first few years of life are especially important for early language, cognitive, and socio-emotional development. A recent South African study has found that many caregivers never engage in key activities likely to improve early learning outcomes, such as reading, telling stories, or playing with their children.⁶⁶ The study also found that low income families have very little time available for these activities, and possess few resources such as children's books or toys.

While the first two years of life represent an important window of opportunity for

brain development, there is very little in place to support early learning for children under two years.

Just over one fifth (21%) of children aged birth to two years are enrolled in a group programme for early learning, such as a crèche or playgroup.⁶⁷ Another 9% are reported to be in the care of a day mother, childminder, or gogo. The remaining 70% are likely being cared for at home by their mothers or other family members.

Unfortunately, the General Household Survey's (GHS) questions regarding child care arrangements cannot distinguish sufficiently between care settings that include an early learning component and those that do not. This is a critical data gap. Early learning can and should happen in the full range of spaces where children spend their days. Given the fact that many children under two years are cared for at home, it is striking to note that half of children of this age are never read to by their caregivers.⁶⁸

Early learning interventions need to include well designed and contextually appropriate programmes to encourage

Many caregivers never engage in key activities likely to improve early learning outcomes, such as reading, telling stories, or playing with their children.



Over 1 million children aged three to five years still do not have access to any form of early learning programme.

responsive and interactive parenting.

These programmes may be delivered through home visiting interventions and as an extension of some group-based learning models. Another way to reach parents in the first two years is through the health system, where the child's growth monitoring and immunisation schedule enables regular contact with health workers as described in previous chapters. To maximise this opportunity, the National Department of Health has recently integrated messages which promote early learning into their mobile messaging platform, MomConnect. Early learning is also included as one of the essential care components in the revised Road to Health Book and Side-by-Side communication campaign. These are exciting examples of integrated service delivery.

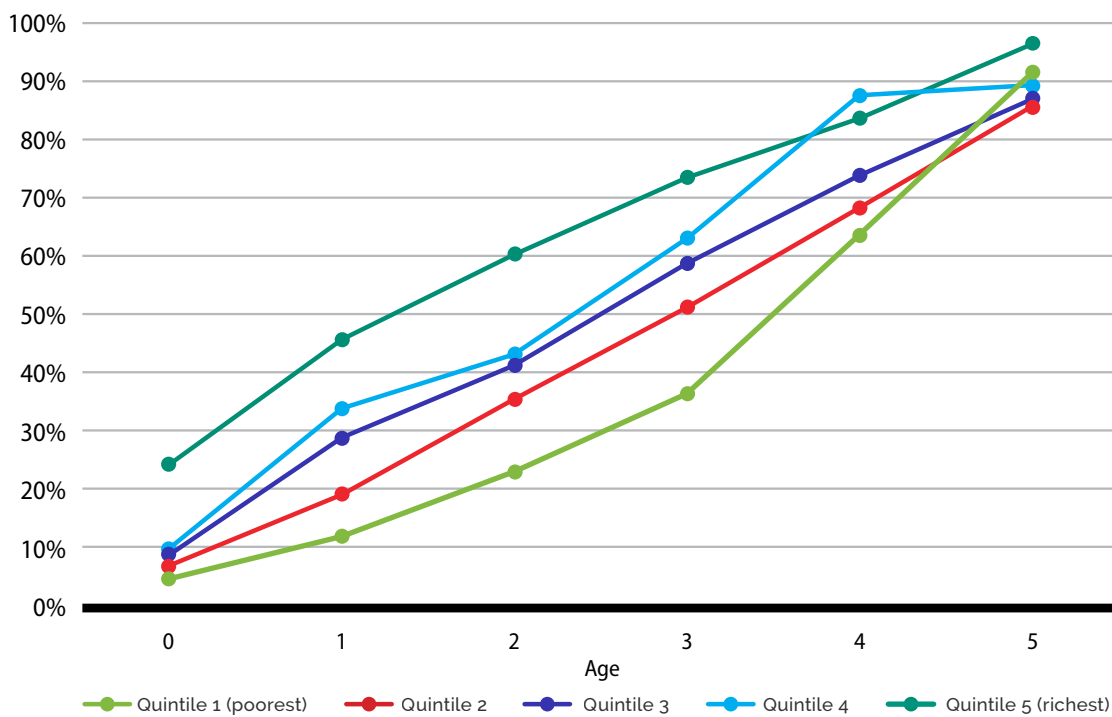
The GHS data show that 69% of children aged three to five years are enrolled in some form of early learning group programme such as a school (Grade R), preschool, nursery school, crèche, educare centre or playgroup. Access

varies substantially across provinces, from less than 60% in KwaZulu-Natal and Northern Cape to 81% in the Free State. Unfortunately, we know very little about the quality of services through the publicly available data and expect significant variability in the extent to which these various settings offer age-appropriate learning programmes.

Despite some progress, nearly 1.1 million children aged three to five years still do not have access to any form of early learning programme. Close to one third of these children live in Kwazulu-Natal. Children who do not have the benefit of an early learning programme are likely to start formal schooling at a distinct disadvantage.

Children from lower income groups are less likely to access an early learning programme, highlighting the likely role that cost plays as a barrier to access. Poor access to early learning opportunities for the poorest children is a disadvantage that will likely be carried over into their formal schooling years. Since household

FIGURE 12: ENROLMENT IN EARLY LEARNING GROUP PROGRAMME, BY INCOME QUINTILE AND AGE.



Source: GHS (2017) Analysis by Children's Institute (UCT)

income is used to derive income quintiles, the number of children is not evenly distributed across quintiles. Instead, there are more children in the lower quintiles as poor households tend to be larger: 77% of young children are in the poorest three quintiles.

The access gap between the richest (quintile 5) and poorest children (quintile 1) is widest among the children aged one to three. A three-year-old in quintile 5 is twice as likely to attend an early learning programme as a child of the same age in quintile 1. The gap between quintiles closes at the point of entry into Grade R where Quintile 1 to 3 children have access to free schooling.

While all poor⁶⁹ children of school age in South Africa can access fully subsidised (no-fee) primary and secondary education, only around 12% of poor children under six years have access to partially subsidised early learning programmes.⁷⁰ Even in subsidised programmes, the subsidy amount is not enough to cover the full costs, and parents are typically required to pay fees to cover the shortfall. With around two million children aged 0–5 living in households where nobody is employed, universal access to early learning programmes is not achievable with the current funding model and budget.

Despite the high rates of poverty and unemployment, reported rates of fee payment for ECD services are high. Of the 2.7 million children under six who attend some kind of group early learning programme (below grade R level) or are in the care of a childminder, 84% have fees paid for them. Fees range from under R100/month to over R2000/month. Nearly half (45%) pay over R200 per month⁷¹ – more than half the value of the Child Support Grant at the time of the survey.

In his 2019 State of the Nation Address, President Cyril Ramaphosa announced the shift of responsibility for early learning programmes, from the Department of Social Development to the Department of Basic Education. It remains to be seen how this function shift will play out, but the proposed change presents an opportunity

to bring funding models for early learning in line with the no-fee schools policy so as to ensure more equitable provision of early learning opportunities for all.

There are no national data on the quality of early learning programmes in South Africa, although several studies have shown that poorer children are more likely to receive poorer-quality programmes.⁷² Numerous interventions to improve the quality of early learning programme delivery are offered both by government, through its National Curriculum Framework training, and by NGOs. However, evaluation of impact of these interventions is minimal. While much emphasis has been placed on practitioner qualifications, qualifications alone are not sufficient to make a difference.⁷³ Oversight, mentoring, and on-site support from suitably qualified personnel are central to quality improvement and successful programme delivery.⁷⁴

Whether or not children realise the benefits of enrolment in a high quality early learning programme is heavily dependent on dosage – i.e. the duration and intensity of exposure to the programme. The literature suggests that two or more years' exposure to a programme is more beneficial than one, and that fifteen hours per week is the minimum recommended participation time.⁷⁵ In a recent South African study, children who had higher levels of programme exposure had significantly better learning outcomes, and children who were enrolled for at least three years showed even greater gains.⁷⁶ Efforts to support better access to high quality early learning programmes must, therefore, go hand-in-hand with efforts to ensure retention and regular attendance.

The cumulative effect of South Africa's investments in ECD services, from health and nutrition to early learning, can be determined by measuring the proportion of children who are developmentally 'on track' for age. No national data currently exist to track this important indicator.

In 2018, child outcomes data were collected on 506 children (aged 4–6 years), enrolled in ten different early learning

Several studies have shown that poorer children are more likely to receive poorer-quality programmes



78% of South African Grade 4 children were not able to reach the lowest benchmark in the reading scores (they could not read for meaning in any language), compared to 4% internationally.

Interventions that ensure adequate health and nutrition, as well as improved water and sanitation, in the early years are essential to achieving good educational and developmental outcomes.

programmes⁷⁷ across six provinces.⁷⁸ Only 29% of the children were found to be developmentally 'on track' for age, as measured by the Early Learning Outcomes Measure (ELOM).⁷⁹

The table below provides a breakdown of the 2018 ELOM data for each developmental domain. Key gaps are evident in cognitive and executive functioning, as well as in fine motor control and visual motor integration. These are foundational skills necessary for focus, self-regulation, problem solving, working memory, and hand-eye coordination. A concerted focus on these domains in early learning programmes may be helpful.

Overall, girls performed better than boys in all domains except gross motor development, where they performed equally. One third (33%) of girls achieved the expected standard on total ELOM scores, compared to 23% of boys.

A child's nutritional status is a key determinant of learning outcomes. As would be expected in line with the literature,⁸¹ children with higher height-for-age Z-scores⁸² who participated in the study performed significantly better on all ELOM domains and on the ELOM total score. This reaffirms that interventions that ensure adequate health and nutrition, as well as improved water and sanitation, in the early years are essential to achieving good educational and developmental outcomes.

Poor early learning foundations set children on a poor education trajectory. Numerous studies have pointed to South Africa's poor educational performance in the formal schooling phase. In the 2016 Progress in International Reading and

Literacy Study (PIRLS) which assessed literacy amongst Grade 4 learners, South Africa was placed last out of 50 participating countries. In the same study, 78% of South African Grade 4 children were not able to reach the lowest benchmark in the reading scores (they could not read for meaning in any language), compared to 4% internationally. As with the ELOM findings, girls scored higher than boys.

The PIRLS findings confirm the relationship between income inequality and educational outcomes – learners from poor households fare substantially worse than those from more affluent settings. A key recommendation arising from the study was the initiation of pre-primary campaigns for parents and teachers, to emphasise the importance of early literacy activities at pre-primary level.⁸³

Another international study, Trends in International Mathematics and Science Study (TIMSS),⁸⁴ which assesses numeracy, placed South Africa second last out of 49 countries and found that three out of five Grade 5 learners did not have the minimum required competencies in mathematics (they did not even have the skills to do basic addition and subtraction). Importantly, those who attended pre-school before entering primary school scored higher than those who did not attend, although this advantage was reduced for learners attending no-fee schools.

The fact that nearly 90% of learners in Grade 3 are in the correct grade for their age suggests that many children are being promoted through the foundation phase even if they do not have the basic reading and numeracy skills that would enable them to learn at higher levels.

PERCENTAGE CHILDREN ACHIEVING THE ELOM STANDARD FOR EACH DEVELOPMENTAL DOMAIN (N=506) ⁸⁰	
Gross Motor Development	37%
Fine Motor Control and Visual Motor Integration	21%
Emergent Numeracy and Mathematics	36%
Cognitive and Executive Functioning	27%
Emergent Literacy and Language	38%
ELOM Total	29%

TABLE 6: EARLY LEARNING INDICATORS, BY PROVINCE

	Indicator	SA	EC	FS	GT	KZN	LP	MP	NW	NC	WC	Data year	source
Population	Children aged 0-2 years	3 428 000	424 000	163 000	774 000	641 000	491 000	282 000	245 000	70 000	339 000	2017	a
	Children aged 3-5 years	3 550 000	452 000	164 000	727 000	768 000	415 000	331 000	252 000	78 000	363 000	2017	a
Service access/delivery	Early learning in 0-2 year olds Children 0-2 years reported to attend a preschool, nursery school, crèche, educare centre or playgroup.	21%	16%	28%	30%	14%	18%	21%	18%	8%	29%	2017	a
		726 000	67 000	45 000	233 000	88 000	90 000	59 000	44 000	6 000	97 000		
	Children 0-2 years reported to be in the care of a daymother / childminder / gogo.	9%	7%	9%	13%	4%	11%	8%	3%	17%	10%	2017	a
		298 000	30 000	14 000	103 000	26 000	52 000	22 000	6 000	12 000	35 000		
	Children 0-2 years cared for at home / not with a childminder or in a group environment.	70%	77%	64%	57%	82%	71%	72%	80%	75%	61%	2017	a
		2 404 000	328 000	104 000	438 000	527 000	349 000	202 000	195 000	53 000	206 000		
	Early learning enrolment in 3-5 year olds Children 3-5 years reported to attend an early learning group programme or Gr R	69%	70%	81%	79%	57%	79%	66%	66%	58%	66%	2017	a
	2 464 000	319 000	133 000	577 000	435 000	330 000	219 000	168 000	46 000	238 000			
Number of children 3-5 not attending any early learning group programme	1 086 000	134 000	30 000	150 000	333 000	85 000	111 000	85 000	33 000	125 000	2017	a	
ECD fees Fee payment rate for children under 6 receiving childcare or group learning prog below Gr R level.	84%	70%	87%	88%	78%	82%	94%	93%	75%	88%	2017	a	
	2 291 000	204 000	137 000	683 000	309 000	263 000	215 000	154 000	40 000	287 000			
Outcome	Foundation phase through-put Percentage of children aged 10-11 who have passed grade 3	86%	89%	90%	88%	95%	89%	88%	87%	85%	89%	2017	a
	Maths competency Gr 5 learners who have achieved minimum competence in numeracy	39%	26%	36%	57%	33%	24%	40%	29%	37%	68%	2015	i
	Reading competency Gr 4 learners with basic reading skills (low benchmark)	22%	15%	27%	32%	18%	9%	17%	22%	19%	45%	2016	j

Data gaps and challenges

- South Africa does not have an administrative data system for early learning similar to those used in the health and education sectors. There are no reliable data on the number of registered and funded ECD centres and programmes and on how many children are accessing these services. As a result, all data on ECD services is drawn from survey data which is neither ideal, nor sustainable for robust programme monitoring and planning.
- There is a lack of data on the full range of early learning programmes targeting 0-2 year old children, including coverage of parenting programmes.
- The lack of data on the quality of early learning programmes needs to be addressed. This information is essential to inform programme enhancements and to direct resources to the most effective interventions.
- We do not know exactly how many children are receiving the Department of Social Development's early learning subsidy. This is because the existing paper-based administrative system limits the accuracy and timeliness of the information. Efforts are underway by government and partners to design and build a Management Information System for ECD.
- ECD centres are required to keep a record of child attendance, but this data is typically not collected in a way that enables it to be verified and collated. Improvements to attendance tracking systems could provide a helpful measure of dosage. In the context of limited resources, this information is important for us to understand the minimum dosage required for improved child outcomes in key developmental domains.
- The Sustainable Development Goal 4.2, requires South Africa to report on the proportion of children under five years of age who are developmentally on track in health, learning and psychosocial well-being, by sex. There is currently no national data on this indicator. Several key government departments (Basic Education; Planning, Monitoring and Evaluation; and Social Development) plus partners are in the process of developing a system to address this gap.
- While the national TIMMS estimates are reliable, the provincial estimates have high standard errors.

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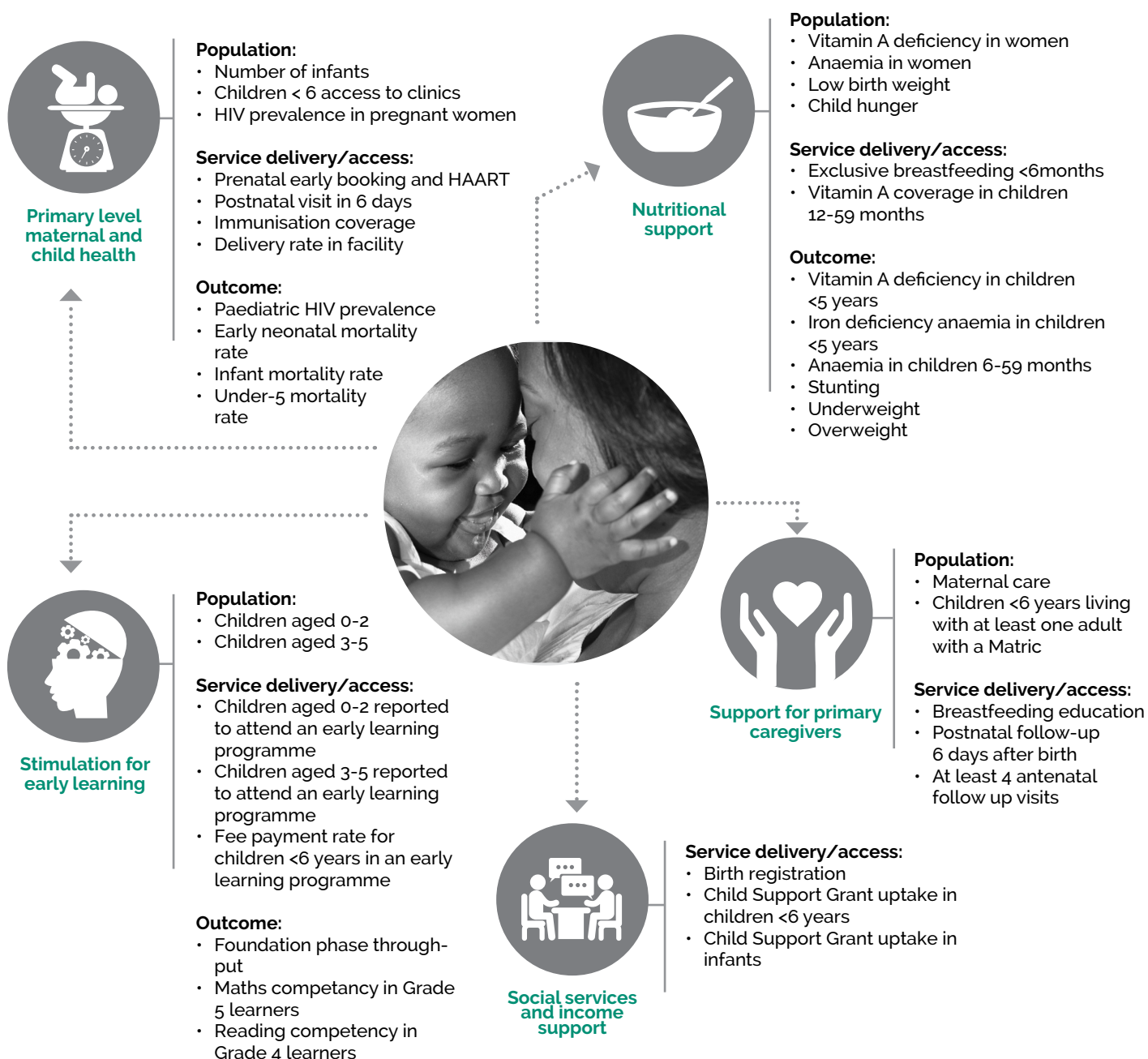
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Notes on the data and data sources

The data provided in this review are drawn from a range of sources, many of which can be updated annually. Data sources for the indicators are indicated by the letter keys to the right of the statistical tables.

Key	Data source	Year reported	Frequency	Lowest level
a	Statistics South Africa: General Household Survey (GHS). Data analysed by Children's Institute, University of Cape Town. (also see http://childrencount.uct.ac.za/ for more indicators)	2017	Annual	Province
b	Department of Health: National HIV and Syphilis Prevalence Survey (http://www.health.gov.za/index.php/shortcodes/2015-03-29-10-42-47/2015-04-30-08-18-10/2015-04-30-08-21-56?download=2584:2015-national-antenatal-hiv-prevalence-survey-final-23oct17)	2013	Annual	Province
c	Department of Health: District Health Information System. Published by Health Systems Trust (https://www.hst.org.za/healthindicators)	2017/18	Annual	District
d	Statistics South Africa: South Africa Demographic and Health Survey. Data analysed by W Sambu. (https://www.dhsprogram.com/what-we-do/survey/survey-display-390.cfm)	2016	-	Province
e	Medical Research Council Burden of Disease Unit (2019): Rapid Mortality Surveillance Report 2017 (http://www.samrc.ac.za/sites/default/files/files/2019-02-06/RapidMortalitySurveillanceReport2017.pdf)	2017	-	National
f	HSRC (2013). The South African National Health & Nutrition Examination Survey (SANHANES-1) (http://www.hsrc.ac.za/en/research-outputs/view/6493)	2012	-	National (some province)
g	Statistics South Africa (2018) Recorded Live Births 2017 (numerator), analysed with Stats SA mid-year population estimates derived from General Household Survey 2017 (denominator)	2017	-	Province
h	South African Social Security Agency SOCPEN data extracted by special request (numerator), analysed with General Household Survey 2017 (denominator) (see http://childrencount.uct.ac.za/socialgrants.php for grant updates)	2018	-	Province
i	Trends in International Mathematics and Science Study (TIMSS) (http://www.timss-sa.org.za/download/TIMSS-2015-Grade-5-National-Report.pdf)	2015	-	National
j	Progress in International Reading and Literacy Study (PIRLS) (https://www.up.ac.za/media/shared/164/ZP_Files/pirls-literacy-2016_grade-4_15-dec-2017_low-quality.zp137684.pdf)	2016	-	National

Key indicators for early childhood development in South Africa 2019



Contributors

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Sonja Giese is the founding Executive Director of Innovation Edge (IE), an investment platform with a social impact agenda. IE acts as a catalytic connector and provides financial, strategic, and programmatic support to entrepreneurs and innovators from diverse sectors, to positively transform early life experiences for young children living in poverty. Since its establishment in mid-2014, Sonja has led IE in building an exciting portfolio of investments, demonstrating its ability to take ideas from source to scale. Sonja has a degree in Science, a background in public policy, a passion for systems change, and 25 years of experience in the development sector.

Dr Katharine Hall is a senior researcher at the Children's Institute, a policy research unit at the University of Cape Town (UCT). She has a PhD in Development Theory and Policy. Her work is in the area of child poverty, inequality, and

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Dr Kopano Matlwa Mabaso is a South African medical doctor and novelist who currently leads the Grow Great Campaign - a multi-funder initiative, aimed at galvanising South Africa towards achieving zero stunting by 2030. Kopano is a Rhodes Scholar and an alumnus of the University of Oxford where she gained both her masters in Global Health Science and DPhil in Population Health. She is an elected board member of Health Systems Global, the world's first international society dedicated to health systems strengthening and knowledge translation. Kopano is the founder of Transitions Foundation, an organisation that seeks to help South Africa's youth transition from hopelessness to personal fulfillment through education. She is a published fiction writer and the winner of the European Literary Award (2007) and joint winner of the Wole Soyinka Prize for Literature in Africa (2010).

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Winnie Sambu is a researcher specialising in food security and nutrition, as well as poverty and inequality. Winnie has extensive experience working with large household survey data from various countries across Sub-Saharan Africa and has been involved in various projects examining socio-economic issues affecting children and the households they live in. She holds a Master of Economics from the University of the Western Cape and a Master of Arts, specialising in development management, from Ruhr-Universität Bochum. Winnie is currently undertaking doctoral studies at the University of Cape Town. Her Twitter handle is @wsambu.



Asandiswa Mbali, with her daughter and infant twins, at the Philani Clinic in Khayelitsha, Western Cape.
Photo: Bart Love, 2018.

A note on this publication

The South African Early Childhood Review 2019 is an annual publication, which presents information on the essential components of the comprehensive package of early childhood development services. This review includes data and commentary on over 40 carefully selected indicators on the status of children under six, as well as service delivery progress across five domains.



Primary level
maternal and child
health



Nutritional
support



Support for primary
caregivers



Social services
and income
support



Stimulation for
early learning

The South African Early Childhood Review 2019 is a joint publication between Ilifa Labantwana, the Children's Institute at the University of Cape Town, the Department of Planning, Monitoring and Evaluation in the Presidency, The Grow Great Campaign, and Innovation Edge.

About the organisations:

Ilifa Labantwana is a national ECD programme, working to secure an equal start for all children living in South Africa, through universal access to quality early childhood development.

www.ilifalabantwana.co.za

The Children's Institute aims to contribute to policies, laws, and interventions that promote equality and improve the conditions of all children in South Africa through research, education, and technical support.

www.ci.uct.ac.za

www.childrencount.org.za

The Department of Planning, Monitoring and Evaluation in the Presidency was created to facilitate, influence and support effective planning, monitoring, and evaluation of government programmes aimed at improving service delivery, outcomes and impact on society.

www.dpme.gov.za

Established mid-2014, Innovation Edge is a grant-making and investment fund. Innovation Edge focuses on unconventional ideas that find solutions to early childhood care and education challenges in under-resourced communities.

www.innovationedge.org.za

The Grow Great Campaign seeks to galvanise South Africa towards a national commitment to zero stunting by 2030. Grow Great is achieving that using data to mobilise policy makers, stories to inspire the public, communities of practice to support Community Health Workers and mom & baby classes to support parents.

www.growgreat.co.za/

