KiDS KNOWLEDGE INFORMATION & DATA SOLUTIONS

SOUTH AFRICAN EARLY CHILDHOOD REVIEW 2017

Acronyms

ANC	antenatal care
ARV	antiretroviral
CSG	child support grant
DHIS	District Health Information System
EC	Eastern Cape
ECD	early childhood development
ELOM	Early Learning Outcomes Measure
FAS	Foetal Alcohol Syndrome
FASD	Foetal Alcohol Spectrum Disorder
FS	Free State
GHS	General Household Survey
GT	Gauteng
HAART	highly active antiretroviral therapy
HIV	human immunodeficiency virus
KZN	KwaZulu-Natal
LCS	Living Conditions Survey
LP	Limpopo
MP	Mpumalanga
MTCT	mother-to-child transmission (of HIV)
MTSF	Medium Term Strategic Framework
NC	Northern Cape
NDoH	National Department of Health
NIDS	National Income Dynamics Study
NW	North West
PCR	polymerase chain reaction
PMTCT	prevention of mother-to-child transmission (of HIV)
RTHB	Road to Health Book
SA	South Africa
SADHS	South Africa Demographic and Health Survey
SANHANES	South African National Health and Nutrition Survey
VIP	ventilated improved pit latrine
WC	Western Cape
WHO	World Health Organisation

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Foreword

With commitment from government sectors to work together, this essential package can be delivered to all young children in South Africa.

The essential package of early childhood development (ECD) services is needed to support the overall development of children. With commitment from government sectors to work together, this essential package can be delivered to all young children in South Africa.

The Department of Social Development is in the process of finalising the National Integrated Plan for ECD, which will follow the National Integrated Early Childhood Development Policy, approved by Cabinet in 2015. The National Integrated Plan for ECD is an important step in realising these comprehensive and essential ECD services. We need to move forward with a sense of urgency to give our children a better future.

This publication presents a set of indicators to support inter-sectoral planning, delivery and monitoring of an essential package of ECD services, from conception to age six.

Many children under age six live in households facing challenges related to poverty and lack of service delivery. Young children are especially vulnerable to poor living conditions as they are still growing, have increased nutritional needs and a greater risk of infection. We need to improve the ECD services offered to these children.

While we have survey data and some administrative data, we need a management information system to support collection of routine administrative data. This is crucial for both planning and for monitoring delivery of services.

ECD services must be delivered to all children who need them. The size of the population of children who need a particular service is therefore important. Having population numbers helps with setting appropriate targets and obtaining the required budget and other resources. There will always be budget constraints, but investing in our children's future should be paramount in realising the objectives of the National Development Plan.

This *South African Early Childhood Review* is an important contribution, which assists in planning, implementation and monitoring.

Dr Kefiloe Masiteng
Deputy Secretary of Planning, Department of Planning, Monitoring and Evaluation

Introduction

Early childhood development (ECD) services are needed to support the development of young children. With commitment from government sectors to work together, an essential package of ECD services can be delivered to all South Africa's young children. This review presents a set of indicators to support inter-sectoral planning, delivery and monitoring of an essential package of ECD services, from conception to the age of six.

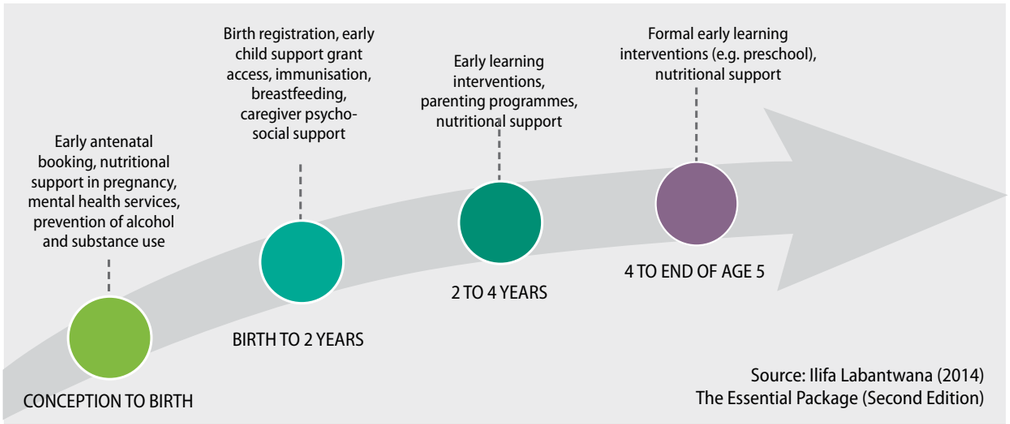
ECD services are urgent and the SA government has an obligation to provide them

More than a million children are born in South Africa every year. All of these children have rights to survival, health, protection and development. These rights are protected in the highest law of our land, the Constitution, and also in international law. To make these rights real, the Children's Act 38 (2015), as amended, says a comprehensive national strategy must be developed to enable a properly resourced, coordinated and managed ECD system. However, children cannot wait for government to realise comprehensive ECD services progressively. Early childhood, especially the first 1,000 days of life, is a particularly sensitive and rapid period of development, which lays the foundation for all future health, behaviour and learning. When children do not receive the necessary input and support to promote their development during this critical period, it is very difficult and costly to help them catch up later.

Progress at policy level

The South African government led the development of the National Integrated Early Childhood Development Policy (2015), aimed at providing a multi-sectoral enabling framework for ECD services. The policy gives effect to the provision of a comprehensive package of ECD services for young children, and prioritises the delivery of an essential package of ECD services.

The essential package of services includes those that are necessary to promote young children's survival and development and enable the realisation of their Constitutional rights, and these should be accessible with immediate effect. The essential package covers the period from conception until children start formal schooling. Because young children have a broad range of needs that are interdependent, multiple role-players should be involved in service delivery, and it is important that there is collaboration and referrals between health, education and social services. The illustration below shows examples of types of essential services needed at different ages.



Since the policy came into effect, several national structures now facilitate multi-sectoral co-ordination and planning toward implementation. Since early 2016, the national Department of Social Development has been in the process of developing an implementation plan, in collaboration with relevant national departments.

While it is promising that some provinces are in the process of developing ECD strategies aligned with the policy vision and objectives, it is unclear whether the 2018 target year for implementation, will be achieved. Actions needed to reach this goal include amending existing legislation, establishing leadership structures, allocating sufficient budget, as well as establishing communication, accountability and coordination mechanisms between all stakeholders – from national to district to municipal level.

Delivering an essential package of ECD services requires collaboration

Service delivery also requires collaboration and engagement between government departments and agencies, and civil society organisations. One way this is currently happening is through the National ECD Inter-Sectoral Forum - a platform for consultation on major developments in the ECD sector. These include policies, infrastructure development, training and curriculum, financial and human resource requirements, as well as monitoring and evaluation. One of the primary aims of the forum is to facilitate planning toward implementation of the National Policy. The forum is led by the Department for Social Development and currently has six interlinked subcommittees, performing various roles.

Information is critical

Delivery of ECD services requires an understanding of the number and distribution of young children, the conditions they live in, and the services they require. Data are also important because they tell us which areas have the highest levels of child deprivation. The *Early Childhood Review 2017* reveals striking inequalities in the welfare of young children across the country, and within provinces at district level. The data also show that there are districts that consistently perform poorly when a set of indicators are examined, showing the extent of deprivation in these areas. Regular, timely, and high quality data are needed to monitor coverage and quality of ECD services; and ultimately enable and improve planning and resourcing.

There are many challenges around data availability and accessibility currently

For many of the indicators, data are collected through national surveys, which do not allow for district level analysis. For some indicators, data are collected too infrequently, collected but not published, or not collected at all. This is particularly the case with data on nutrition, early learning and caregiver support. Another challenge is the quality of the data available. It is also difficult to measure and collect data for some of the indicators, especially those that relate to quality of services.

The ECD policy recognises the importance of proper and effective monitoring and evaluation (M&E) systems to track the implementation and impact of the policy. However, progress on the development of data systems for ECD, especially on service uptake in early learning, is very slow. In addition, the policy's M&E framework is yet to be released. Much greater emphasis and attention needs to be placed on data collection systems if service delivery is to be monitored and appropriately planned and budgeted for, and to ensure that the relevant government departments responsible for different services can be held to account.

The components of the essential package are:

Maternal and child health services	Nutritional support	Support for primary caregivers	Social services	Stimulation for early learning
Including antenatal care, PMTCT, physical & mental health screening, psychosocial support and immunisation	For pregnant women, mothers and children	Including parenting skills and psychosocial support	Including birth registration, access to social grants, responsive child protection services and psychosocial support	Including access to quality, age-appropriate early learning programmes

Children under 6 years in South Africa

Because the essential package is about early childhood services that are *essential*, these services need to reach *all* young children. There are still vast inequalities in children's circumstances and opportunities from the time they are born. Nearly two-thirds of children under 6 in South Africa live in the poorest 40% of households, where unemployment rates are high and living conditions are poor. Some children may be more difficult to reach – they may live in remote areas or may not come into regular contact with service points like clinics. By ensuring that all children get the full package of essential early services, we can help to provide them with a more equal start in life.

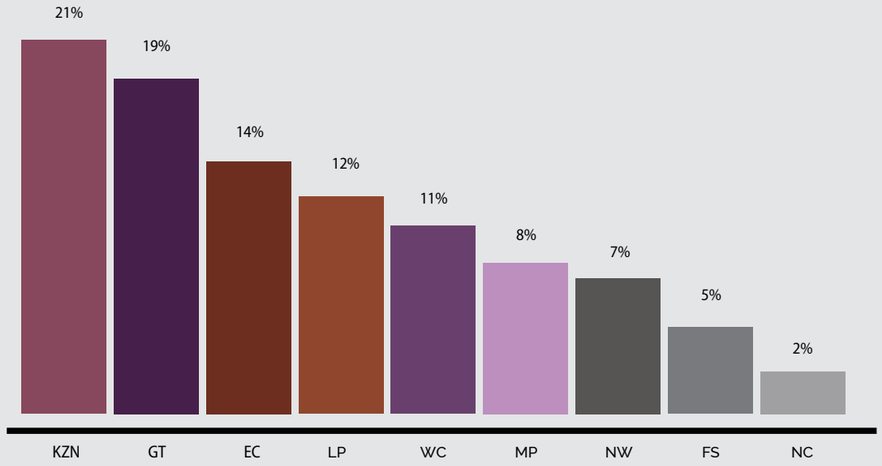
At present, it is not clear exactly how many young children live in South Africa. The last census was in 2011 and counted 6.7 million children under 6 years. The census takes place every 10 years. In between, Statistics South Africa undertakes the Community Survey, which is a similar household survey with a very big sample. The Community Survey of 2016 estimated the number of children under 6 years to be 7.1 million. In the same year, the General Household Survey (GHS), which is another big survey conducted by Statistics South Africa, produced a population of 6.2 million children under 6.

The reasons for these differences are related to the models used to determine the population weights. The Community Survey and the GHS use different models, but it seems that both are wrong. An entirely new model, which will be more closely linked to the 2011 census, is being developed and the new weights will be available in 2018. It is only then that we will know whether the current under-6 population is closer to six or seven million. The population numbers in the table at the end of this chapter are from the weighted GHS data, and are likely to be an underestimate.

Over half of South Africa's young children live in just three provinces: KwaZulu-Natal, Gauteng and the Eastern Cape. Provinces and districts face different challenges delivering services to children. In densely populated places like Gauteng, which serves over a million young children, the challenges may be about the capacity of the infrastructure and service providers to cope with demand. In the Northern Cape, a small population of only about 150,000 young children is spread over vast distances; and the challenges may relate to problems of physical access and the relatively high cost of getting services to children.

Plans for ECD infrastructure and age-appropriate services have to differentiate between the needs of urban and rural populations.

FIGURE 1: PROVINCIAL SHARE OF CHILDREN UNDER 6 YEARS IN 2015

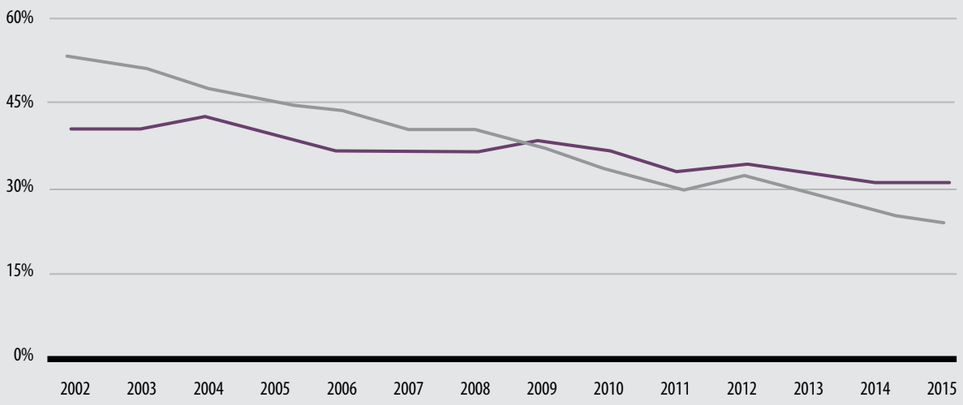


Source: GHS 2015, analysis by Children's Institute

Some provinces have growing child populations, while others are shrinking slightly. The greatest growth has been in Gauteng and the Western Cape, while the young child populations of KwaZulu-Natal, the Free State, the Eastern Cape, and Limpopo have declined.

South Africa is becoming more urban, and slightly more than half of all young children now live in urban areas. However, there are still some provinces – such as the Eastern Cape, Limpopo, KwaZulu-Natal, and Mpumalanga – where the majority of children under the age of 6 are rural. In Limpopo, well over 80% of young children live in rural households. Plans for ECD infrastructure and age-appropriate services have to differentiate between the needs of urban and rural populations. ECD services should be flexible and responsive to the needs of children, families, and communities – wherever they may be.

FIGURE 2: CHILDREN UNDER 6 YEARS LIVING IN HOUSEHOLDS WITH INADEQUATE SERVICES, 2002-2015



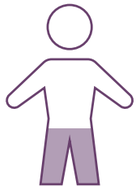
Source: GHS 2002 - 2015, analysis by Children's Institute

Young children are especially vulnerable to poor living conditions, as they are still growing and have increased nutritional needs as well as a greater risk of infection. Adequate water infrastructure is important because children are vulnerable to water-borne diseases and can also be exposed to risks when fetching water. About a third of children under 6 live in households without access to piped water on the site where they live. In the Eastern Cape, 60% of young children do not have access to adequate water.

Despite huge progress in providing sanitation, South Africa still has more than 1.5 million children under the age of 6 who do not live in a household with a toilet or ventilated improved pit latrine (VIP) on the site where they live. Poor living conditions affect hygiene, health, and food preparation in households; they can lead to the spread of diarrhoeal diseases and other infections, such as pneumonia. These diseases are among the main causes of child deaths.

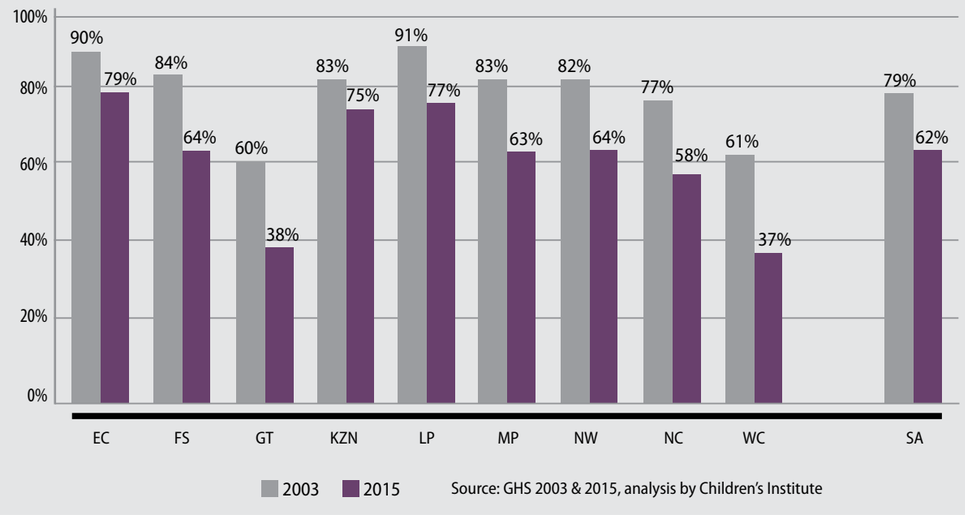
Access to adequate water and sanitation has improved over the years. Between 2002 and 2015, the number of young children living in households with poor sanitation was halved: 24% of young children lived in households with poor sanitation in 2015, down from 53% in 2002. The biggest improvement has been in the Eastern Cape, where the share of young children living in households with poor sanitation reduced from 81% in 2002 to 17% in 2015.

At a district level, there are stark inequalities across the country and within provinces. For example, only 12% of young children in the Eastern Cape district of OR Tambo have access to running water on site, compared to 94% in Nelson Mandela Bay, and 98% in the Central Karoo district in the Western Cape. In 19 out of the 52 districts in South Africa, more than half of children under 6 live in households without piped water. Districts with the greatest sanitation challenge are in Limpopo. In the province's



30% of young children fall below the food poverty line.

FIGURE 3: CHILDREN UNDER 6 YEARS LIVING BELOW THE UPPER POVERTY LINE (2003 & 2015)



Source: GHS 2003 & 2015, analysis by Children's Institute

Sekhukhune district, less than 10% of young children have an adequate toilet on site; the rates of inadequate sanitation are also high (over 70%) in Vhembe, Capricorn, Mopani, and Ehlanzeni.

Poor households have a disproportionately large burden of care for young children. About 4 million children under 6 years live in the poorest 40% of households. This is a relative poverty line, and there has been no significant change in the number of young children living in the poorest 40% of households since 2003.

Statistics South Africa has proposed three national poverty lines: an upper-bound poverty line, a lower-bound line and a food poverty line. The food poverty line is the most severe, as people living below this level of income are unable to afford sufficient food to provide adequate nutrition. The lower poverty line is based on there being enough income for people to be adequately nourished, but only if they sacrifice other essential items. The upper poverty line is the minimum required to afford both the minimum adequate food and basic non-food items. This upper-bound poverty line should be used as the line of preference for reducing child poverty. The poverty lines were set in 2011 prices, and increase each year in line with inflation. Using the headline consumer price index to inflate the poverty lines, the value of the food poverty line was equivalent to R415 per person per month in 2015, the lower line was R621 per person per month, and the upper poverty line was R965 per person per month.

About a third of children under 6 live in households without access to piped water on the site where they live.

The child poverty rates in Figure 3 are based on the upper poverty line, which allows for a minimum acceptable standard of living. Child poverty rates are compared for the years 2003 and 2015.

The majority of young children (62%) live in households that fall below the upper poverty line. The highest rates of child poverty are in the Eastern Cape, KwaZulu-Natal and Limpopo; where 79%, 75% and 77% of young children respectively lived in poor households in 2015. The number and percentage of young children living in poverty has decreased since 2003 when 4.9 million (79%) young children lived in poor households. This is due, in large part, to the expansion of social grants. This analysis is based on the GHS, which does not record very detailed information about household income. A better source, the Living Conditions Survey, suggests that poverty rates may be even higher.[1]

Thirty per cent of young children fall below the food poverty line. This is very serious, as children living in such poverty are likely to be food insecure and may become malnourished. In the Eastern Cape, almost half of young children are below the food poverty line.

Many children under the age of 6 live in households where nobody is employed or engaged in income-generating activities. Employment is important as a source of income and may come with other benefits for those employed in the formal sector; such as health insurance, unemployment insurance, and maternity leave. Regular income and other employment benefits contribute to a child's health, development, and education. While the percentage of children living in unemployed households reduced from 38% in 2003 to 29% in 2015, there are still more than 1.8 million young children living in households where nobody is working.

TABLE 1: THE STATUS OF CHILDREN UNDER 6 LIVING IN SOUTH AFRICA IN 2015, BY PROVINCE

	Indicator	SA	EC	FS	GT	KZN	LP	MP	NW	NC	WC	source
Population	**Number of children under 6 years**	**6 235 000**	884 000	304 000	1 185 000	1 316 000	756 000	528 000	463 000	144 000	655 000	a
	Households with children under 6	**4 785 000**	582 000	288 000	1 142 000	874 000	561 000	422 000	354 000	112 000	449 000	a
		30%	34%	32%	24%	32%	37%	35%	29%	35%	25%	
Area type	**Urban** Children < 6 in urban areas (formal/informal)	**3 528 000**	350 000	258 000	1 152 000	515 000	127 000	186 000	224 000	97 000	620 000	a
		57%	40%	85%	97%	39%	17%	35%	48%	67%	95%	
	Rural traditional Children < 6 in rural former homeland areas	**2 439 000**	524 000	27 000	19 000	688 000	614 000	305 000	222 000	41 000	-	a
		39%	59%	9%	2%	52%	81%	58%	48%	28%	0%	
	Rural farms Children < 6 in commercial farming areas (old RSA)	**267 000**	11 000	18 000	14 000	114 000	15 000	36 000	17 000	7 000	35 000	a
		4%	1%	6%	1%	9%	2%	7%	4%	5%	5%	
Service access	**Inadequate water** Children < 6 without piped water on site	**1 972 000**	529 000	24 000	82 000	539 000	370 000	167 000	159 000	37 000	69 000	a
		32%	60%	8%	7%	41%	49%	32%	34%	25%	11%	
	Poor sanitation Children < 6 without a toilet or VIP on site	**1 504 000**	151 000	65 000	97 000	375 000	372 000	196 000	141 000	32 000	75 000	a
		24%	17%	21%	8%	28%	49%	37%	30%	22%	11%	
Poverty	**Child poverty** Children < 6 living in poor households (< R965 in 2015)	**3 875 000**	701 000	195 000	456 000	984 000	581 000	335 000	298 000	83 000	242 000	a
		62%	79%	64%	38%	75%	77%	63%	64%	58%	37%	
	Food Poverty Children < 6 living in food poor households (< R415 in 2015)	**1 855 000**	419 000	89 000	161 000	480 000	325 000	152 000	134 000	35 000	60 000	a
		30%	47%	29%	14%	37%	43%	29%	29%	24%	9%	
	Workless households Children < 6 in households with no employed adults	**1 811 000**	405 000	99 000	143 000	444 000	331 000	141 000	140 000	42 000	66 000	a
		29%	46%	33%	12%	34%	44%	27%	30%	29%	10%	

Data gaps and challenges

We need to have reliable estimates of the young child population for the years in between censuses, which take place once every 10 years.

- The results of Census 2011 were questioned at first because it seemed to over-count young children and under-count older children.
- More recently, demographers have thought that the census may have been right – that there was an increase in fertility rates in the years preceding the census. The increase also became evident through the vital registration (births and deaths) data collected by the Department of Home Affairs.
- A new model, used to calculate population weights for surveys, will be calibrated to the census and will reflect this upswing in fertility rates (and therefore the number of infants) around 2009, after which the rates start to decline again.
- This *Early Childhood Review* could be underestimating the population and, as a result, also underestimating the extent of the challenge in reaching all young children with ECD services.

Primary level maternal and child health

Every visit by a caregiver and their child to a health facility, and every visit by a health worker to a household, is an opportunity to improve access to essential ECD services. With a well-integrated package of services, caregivers who attend clinics could receive health interventions related to pregnancy and childbirth, information about adequate nutrition, and encouragement to stimulate their children. Caregivers should also be referred to other assistance where needed, like social grants for poverty alleviation and integrated psychosocial support services for mental health. In addition to clinic visits, outreach visits to ECD centres by nurses or community health workers are important. Referrals from home visiting programmes for vulnerable households and children aged 0-2 are opportunities for young children to access critical preventative health services, and treatment when sick.

Protecting the health of a mother and her child starts with antenatal care (ANC). This is particularly important in reducing poor pregnancy outcomes and for the prevention of stunting and HIV in young children. Early ANC – before 20 weeks in pregnancy – is an important gateway to primary health and nutrition services, for both mothers and children.

There has been a steady increase in early antenatal bookings, as shown in Figure 4, with an overall increase from 54% in 2014 to 61% in 2015. However, around 40% of first antenatal visits still take place later than 20 weeks into pregnancy, and this is based only on pregnant women who do actually attend antenatal clinics. The problem is most acute in South Africa's metros: Johannesburg, Ekhurhuleni and Tshwane are three of the top four districts with the highest number of households with children under 6, yet also rank in the top four districts with the lowest rates of early ANC visits in the country (52%, 55% and 55% respectively). Only Alfred Nzo district in the Eastern Cape has a lower rate. While the increase in early antenatal visits is encouraging, at least 400,000 pregnant women each year still only visit the clinic after 20 weeks. Antenatal visits during early pregnancy are an important opportunity for physical and mental health screening, for referrals to counselling services where needed, for sharing information with pregnant women, and for signing expectant mothers up to MomConnect.

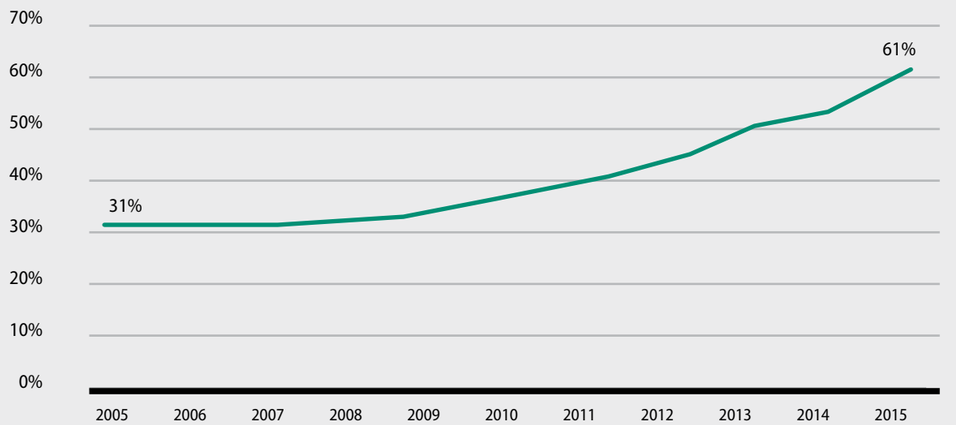
The inpatient early neonatal mortality rate indicates the quality of antenatal, intrapartum and postnatal care. Neonatal mortality rates in facilities have not changed substantially in the past 10 years, and are a key contributor to South Africa's high infant mortality rate, which was estimated to be 27 infant deaths per 1,000 live births in 2015. Capricorn district in Limpopo has the highest inpatient early neonatal death rate at 22 per 1,000 live births, with a number of Eastern Cape metros and Northern Cape districts reporting high inpatient early neonatal death rates.

The under-5 mortality rate was 40 per 1,000 in 2015. There was a marked decline in infant and under-5 mortality rates between 2008 and 2011, driven mainly by a reduction in HIV-related deaths.[2] The reduction became more gradual after 2011.

Immunisation coverage is an indicator of how well the health system is functioning. The share of children who are completely immunised by their first birthday has increased from under 70% in 2002 to 89% in 2015. It is a great achievement that the vast majority of babies are returning to clinics during their first year, or are reached by mobile services, given that many children (22% of those under 6 years) live far from their nearest facility. However, a number of provinces have experienced measles cases over the past year showing that some parents still opt out of immunisation or are not accessing it all.

Some districts have immunisation rates of over 100%. This is partly because children may be immunised in areas that are different from where they are counted in the population. It has also been suggested that immunisation rates are overestimated in the District Health Information System (DHIS), where the rates tend to be higher than those recorded in comparable surveys.

FIGURE 4: PERCENTAGE OF FIRST ANTENATAL VISITS WITHIN FIRST 20 WEEKS OF PREGNANCY



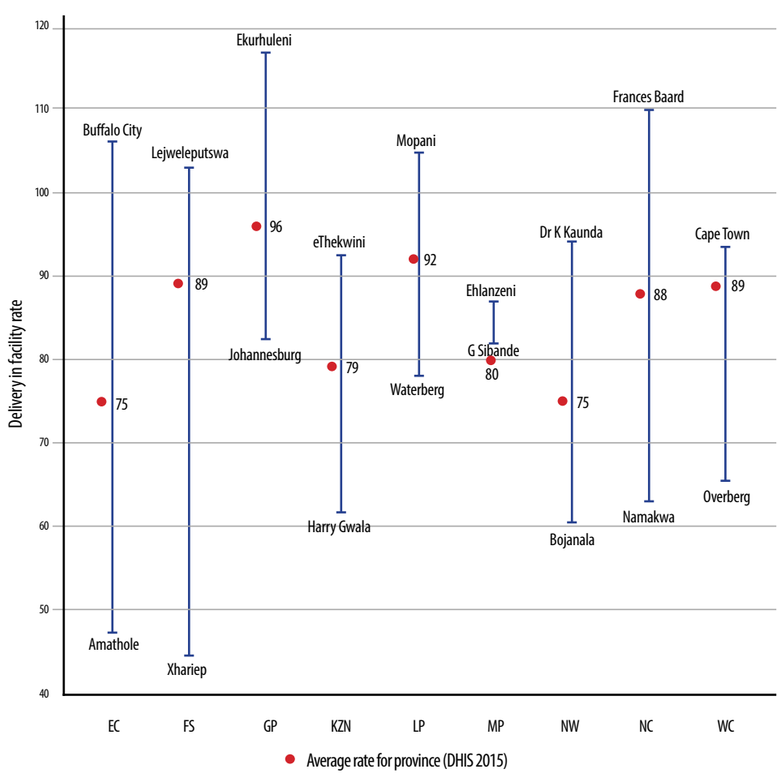
Source: DHIS 2005 - 2015

Deliveries conducted in health facilities and supervised by health personnel appear to have stabilised. Nationally, the delivery rate, which is the percentage of deliveries carried out by health personnel in public health facilities, increased from 66% in 2001 to 85% in 2015.[3] The highest facility delivery rates are in Gauteng and Limpopo provinces (97% and 91% respectively). The national average is brought down by the low rates in KZN (79%) and EC (75%) as these provinces also have some of the highest number of deliveries in the country.

However, the provincial averages mask the vast differences between districts in service access and uptake, as is shown in Figure 5. Thus, to increase the overall in-facility delivery rate, it is also important to target specific districts with very low in-facility delivery rates, for example, Amathole in the Eastern Cape, Harry Gwala in KZN and Xhariep in the Free State amongst others.

The vast majority of infants who are HIV exposed receive a PCR test within the first six weeks of their life. The *Early Childhood Review 2016* reported on results from a 2012/13 survey that covered infants (4-8 weeks old) attending public health-care clinics and community health centres for their 6-week immunisation. More recent data from the National Health Laboratory Service report a national intrauterine transmission rate of 1.1%.[4] South Africa is in the process of introducing PCR testing within six days after birth in order to identify and treat HIV early in infants. Data problems notwithstanding, these estimates indicate some major successes with South Africa's Prevention of Mother to Child Transmission (PMCT) programme.

FIGURE 5: DELIVERIES WHICH TAKE PLACE IN A PUBLIC HEALTH FACILITY, BY PROVINCE, DISAGGREGATED BY DISTRICT



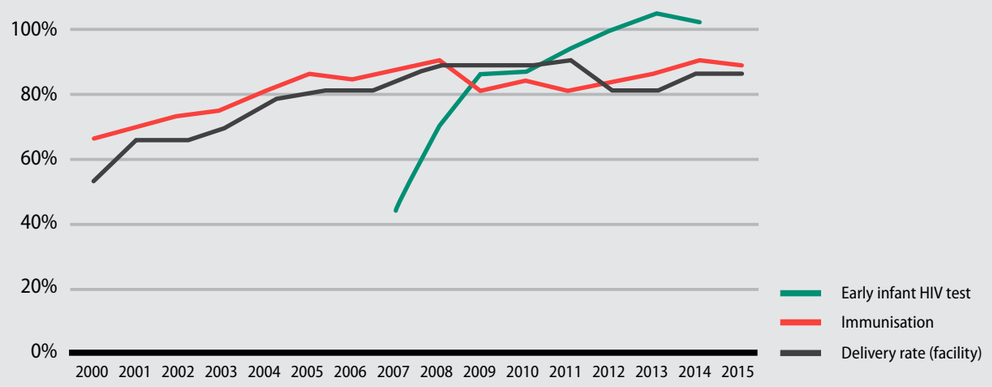
Source: DHIS 2015

ROAD TO HEALTH BOOK PRIORITY AREAS

Over a fifth of young children (1.4 million) live in households with poor access to clinics. The numbers are highest in the Eastern Cape and KwaZulu-Natal, where 33% and 30% respectively of young children live more than 30 minutes from the nearest health facility. Young children living in the largely urbanised areas, such as Gauteng and Western Cape, have better access to health facilities. This indicator only measures access (through physical distance). It tells us nothing about the quality of service at health facilities. Quality of service provision is difficult to measure, but is an important data gap.

The Road to Health Booklet (RTHB) is a vital tool that enables both caregivers and health professionals to monitor the growth of young children and identify danger signs early. All mothers who deliver babies, in both the public and private sectors, should receive a RTHB. The booklet provides health information for the caregiver, and is also their record of perinatal visits, immunisation, child growth, development, and illness events. The South Africa Demographic and Health Survey (SADHS) reports that only 66% of mothers of children aged 12-23 months had a RTHB, despite the fact that all mothers are supposed to receive one. While many caregivers might have the RTHB, it is often not fully utilised as not all health workers have been properly trained in its use. In order to increase uptake and use, the National Department of Health (NDoH) has revised the RTHB to be both more caregiver and health worker friendly and to include a much more holistic view of child development, including a comprehensive section on child development for the first time. The NDoH plans to launch the revised RTHB in late 2017 or early 2018. The RTHB now includes five priority sections, as illustrated on the facing page. These are nutrition, love, protection, healthcare, and extra care.

FIGURE 6: TRENDS IN PUBLIC FACILITY DELIVERY RATES, EARLY HIV TESTING AND IMMUNISATION



Source: DHIS 2000-2015

TABLE 2: HEALTH INDICATORS FOR PREGNANT WOMEN AND CHILDREN UNDER 6, BY PROVINCE

	Indicator	SA	EC	FS	GT	KZN	LP	MP	NW	NC	WC	source
Population	**Number of infants** Children < 1	**1 043 000**	154 000	51 000	203 000	205 000	142 000	84 000	76 000	22 000	108 000	a
	Poor access to clinics Children < 6 living more than 30 mins from nearest health facility	**1 356 000**	295 000	49 000	96 000	393 000	169 000	123 000	129 000	36 000	64 000	a
		22%	33%	16%	8%	30%	22%	23%	28%	25%	10%	
	HIV prevalence in pregnant women Antenatal clients testing HIV+	**30%**	31%	30%	29%	40%	20%	38%	28%	18%	19%	b (2013)
Service access/delivery	**Prenatal early booking** 1st visit before 20 weeks, out of all antenatal 1st visits at public facility	**61%**	60%	63%	55%	65%	61%	66%	61%	62%	68%	c
	Antenatal HAART Antenatal clients on ART as % of eligible total	**93%**	94%	87%	92%	98%	93%	96%	87%	92%	78%	c
	Early infant HIV test Infants born to HIV+ mothers who receive PCR test around 6 weeks	**101%**	95%	91%	99%	108%	94%	106%	100%	91%	97%	c (2014)
	Immunisation Children < 1 who complete the primary immunisation course	**89%**	87%	86%	106%	85%	79%	87%	83%	83%	89%	c
	Delivery rate in facility Percentage of deliveries occurring in health facilities, under trained personnel	**85%**	75%	89%	96%	79%	92%	80%	75%	88%	89%	c
Outcome	**Early neonatal mortality** Inpatient infant deaths within 7 days, per 1 000 live births	10.5	12.8	10.6	9.5	10.8	12.6	9.3	9.8	14.3	7.3	c
	Infant mortality rate Number of deaths under 1 year, per 1 000 live births in same year	27	Mortality rates not currently available at provincial level.									d

Data gaps and challenges

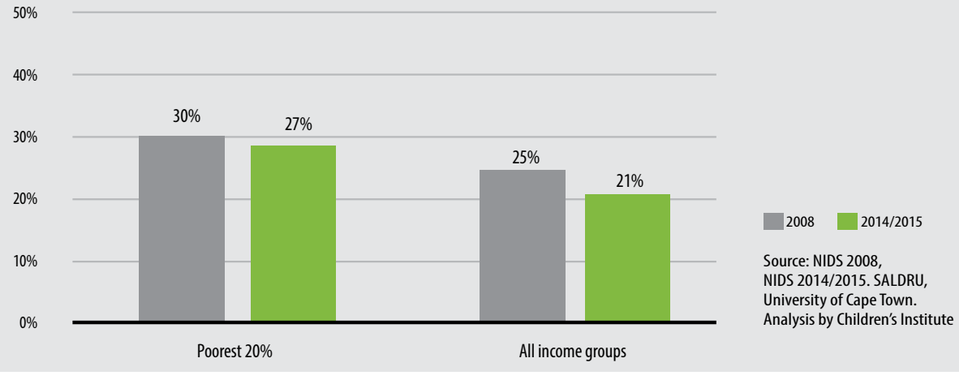
- HIV-related data are generally better than for other health domains. However, there are a number of outcome level data points that have not been updated recently. These include PMTCT transmission rates at 6 weeks, 6 months, and 18 months, which are critical for understanding the MTCT rate. HIV prevalence amongst pregnant women has also not been updated since 2013 as the DoH has not released any subsequent reports.
- There are no data on coverage of specific health interventions during pregnancy, which means we don't know whether the required interventions are actually being delivered.
- Data on maternal mental health continue to be lacking despite the increasing evidence of its impact on maternal and infant outcomes.
- We are unable to report on infant mortality rates by province.
- Quality of care data are difficult to collect, despite their importance. A focus on service quality across the board is needed.
- There is lack of data on developmental screening for infants to identify disabilities or developmental delays at 6 weeks, 9 months and 12 months.
- Data on deworming for children aged 1-5 years are currently not available.

Nutritional support

Lack of proper nutrition can result in poor health and educational outcomes for children, which in turn contribute to persistent inequality. To break this cycle, the starting point is maternal nutrition before and during pregnancy. Interventions to improve maternal and child nutritional outcomes include micronutrient supplementation, immunisation, education about breastfeeding and child nutrition, and income support through social grants. Poor nutrition affects maternal and child health. Conversely, poor health can affect food intake and result in poor nutritional status. For example, a mother who is depressed may not be able to adequately address the nutritional needs of herself or her child.

When children are chronically under-nourished they don't grow as expected. This is called "stunting", a condition where the child is too short for their age. Nationally, over a fifth of children under 5 years suffer from stunting making this condition the most prominent form of malnutrition in SA. Usually stunting is associated with long-term poverty, inadequate access to nutritious food, and prolonged exposure to infections. While Figure 7 shows that stunting rates have reduced for the poorest 20% of children under 5, much more needs to be done to combat stunting. The rates of stunting have remained high in the country, despite improvements in other aspects of child welfare, and a reduction in child poverty rates that has been attributed to the increase in number of children receiving the child support grant.

FIGURE 7: STUNTING RATES AMONGST CHILDREN UNDER 5 YEARS



Stunting is associated with long-term poverty, inadequate access to nutritious food, and prolonged exposure to infections.

In addition to high rates of undernutrition, there is an increase in overweight and obesity rates amongst children. Some of the factors that have contributed to this are inadequate diets characterised by highly processed food, fats, and sugar intake, as well as a lack of physical activity. Compared with children whose weight is in the normal range, those who are overweight are more likely to remain overweight or obese in adulthood, and are at a greater risk of suffering from cardiovascular diseases and diabetes – in childhood and adulthood. Nationally, 13% of children under the age of 5 years are overweight.

There is need for regular monitoring of children's growth and development. This will ensure that poor physical growth is identified and dealt with early, lowering the risk of children suffering from stunting and other forms of malnutrition. It is important that children are regularly measured at clinics and health facilities, and their heights and weights recorded in the Road to Health Booklet are used to monitor their development.

Anaemia in pregnant women can result in low birth weight and increase the risk of maternal illness and death. The prevalence of anaemia amongst women of reproductive age is 23% nationally, and is higher than 30% in some provinces. Anaemia is a major maternal nutritional problem caused by dietary iron deficiency, blood loss from menstruation, as well as parasitic and chronic infections. Information on anaemia is lacking from some provinces, as the survey sample is too small to draw reliable estimates. Iron deficiency anaemia is the most common form of anaemia and affects 10% of women of reproductive age in the country.

Infants with low birth weight are at risk of various health conditions that include poor physical growth. Nationally, 13% of infants born in public facilities had low birth weight in 2015. The proportion of infants born with low birth weight has remained fairly consistent since 2005.

The World Health Organisation (WHO) recommends exclusive breastfeeding for 6 months after a child is born. Breastmilk contains all the necessary nutrients for a baby's growth during this time, and protects against illness and infections. The act of breastfeeding also strengthens a mother's bond with her child. A 2012-13 survey of public health facilities that covered infants aged 4-8 weeks (irrespective of HIV status) found that only 58% of all infants were exclusively breastfed, while 11% did not receive any

FIGURE 8: FEEDING PRACTICES FOR CHILDREN AGED UNDER 6 MONTHS

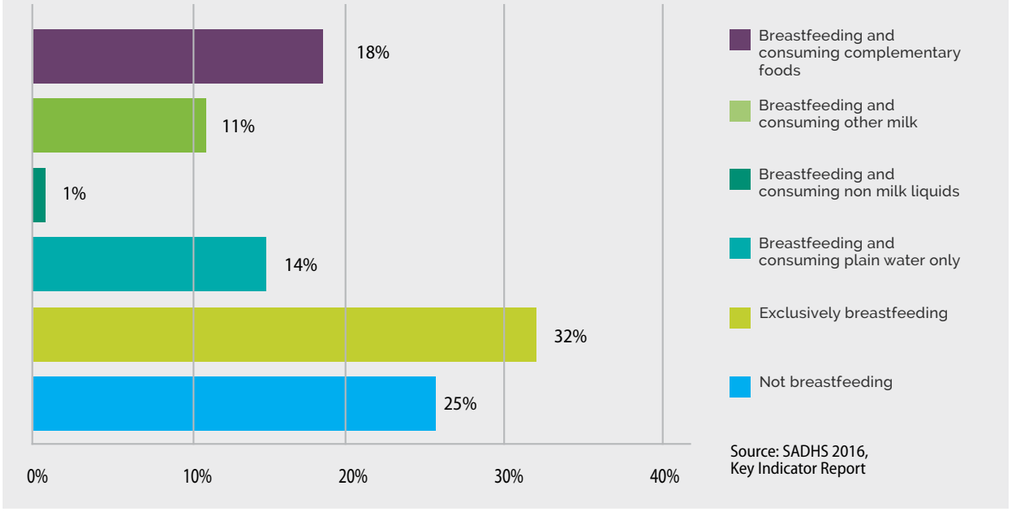
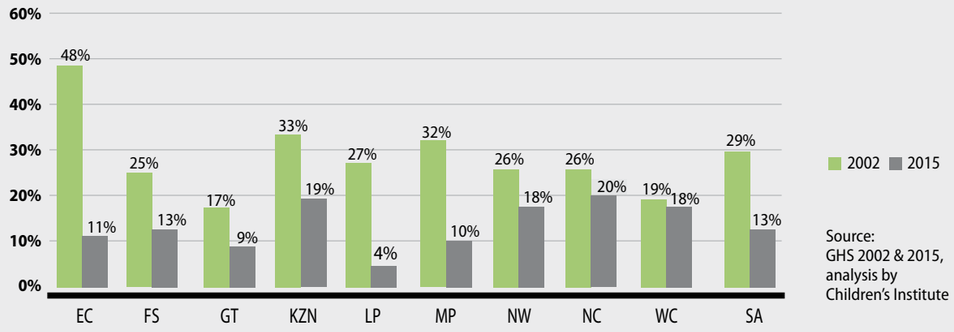


FIGURE 9: REPORTED CHILD HUNGER RATES, 2002 & 2015



Source: GHS 2002 & 2015, analysis by Children's Institute

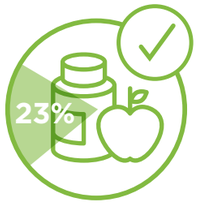
breast milk at all. Exclusive breastfeeding rates for HIV-exposed infants were slightly lower than the overall figure, at 54%. Mixed feeding practices were reported for 20% of HIV-exposed infants, placing them at risk of HIV transmission. This survey only covered infants in public health facilities and those within the 4-8 weeks age group. Initial results from the 2016 South African Demographic and Health Survey (SADHS), which used a nationally representative sample, show that 32% of infants under 6 months are exclusively breastfed (see Figure 8), up from 7% in 1998. However, 1 in 4 children aged under 6 months are not breastfed at all.

The first two years of life are especially important for child growth and development. Children need adequate diets and conducive living environments that protect against disease in order to ensure survival and optimum growth. According to the 2016 SADHS, only 23% of children aged 6–23 months are fed a minimum acceptable diet. This means that close to 80% of children in that age group are not consuming adequate diets, increasing the likelihood of malnutrition and ill-health.

Child hunger is a proxy for food insecurity and has decreased over time. While child hunger is based on subjective reporting and is not very reliable, it allows for comparisons across provinces and over time. Between 2002 and 2015, reported child hunger reduced from 29% to 13%. The Eastern Cape, Limpopo and Mpumalanga saw the biggest improvements over this 14-year period, with child hunger rates reducing by over 20 percentage points in all three provinces. The biggest change was in the Eastern Cape, where child hunger rates reduced from 48% in 2002 to 11% in 2015. It is important to note that data on child hunger do not necessarily capture the more critical aspects of nutrition, which include dietary diversity. Children can be well-fed and not hungry, but still be undernourished. Under-nutrition can lead to both stunting and wasting on the one hand, and obesity on the other hand.

Children with vitamin A deficiency have increased risk of infection and are more prone to diseases. Vitamin A deficiency has decreased since 2005; however over 40% of young children still suffer from a lack of it. Vitamin A supplementation coverage rates have improved: in 2015, over 57% of children aged 12-59 months received a vitamin A dose at a public facility; up from 52% in 2014, and a substantial improvement from a coverage rate of 35% just five years before. However, disparities across districts are striking. Some districts such as Amathole (Eastern Cape) and Xhariep (Free State) have coverage rates of over 90%, others such as Pixley ka Seme (Northen Cape) and Waterberg (Limpopo) have lower than 40% coverage rates.

A considerable number of women continue to suffer from vitamin A deficiency. Statistics from a national survey show that 13% of women of reproductive age (16-35 years) suffered from vitamin



Only 23% of children aged 6 – 23 months are fed a minimum acceptable diet.

1 in 4 children aged under 6 months are not breastfed at all.

A deficiency in 2012. Some provincial samples were too small to provide reliable estimates. The risk of vitamin A deficiency is high in pregnant women, especially in the later stages of pregnancy when there is increased demand by both the mother and the unborn child. Pregnant women should therefore have access to healthy and diverse diets, including fruits and vegetables which are rich sources of vitamin A.

The proportion of children under 5 years who are anaemic is estimated at 11%. Some of the causes of anaemia include micronutrient deficiencies (such as vitamin A), and iron deficiency, which affects 8% of children under the age of 5 years. Causes of iron deficiency include lack of sufficient iron intake and blood loss due to worm infestations. Approximately 2% of children under 5 years suffer from iron deficiency anaemia, which occurs when both iron deficiency and anaemia are present. Iron deficiency anaemia can increase children's susceptibility to infections and affect their cognitive development, which, in turn, affects their performance in school.

TABLE 3: NUTRITION INDICATORS FOR PREGNANT WOMEN AND CHILDREN UNDER 6, BY PROVINCE

	Indicator	SA	EC	FS	GT	KZN	LP	MP	NW	NC	WC	source
Population	**Vitamin A deficiency in women.** Women (16-35 yrs) below the WHO standard	**13%**	9%	8%	18%	16%	*	*	9%	*	7%	e (2012)
	Anaemia in women Women (16-35 yrs) below the WHO standard for iron-deficiency	**23%**	20%	18%	19%	36%	*	30%	17%	*	16%	e (2012)
	Low birth weight Infants born in public facilities weighing below 2.5kg (2014)	**13%**	14%	12%	13%	12%	10%	12%	14%	20%	15%	c
	Child hunger Children in households where children suffer from hunger	**13%**	11%	13%	9%	19%	4%	10%	18%	20%	18%	a
Service access	**Breastfeeding** HIV-exposed infants 4-8 weeks exclusively breastfed	**54%**	47%	56%	58%	54%	53%	52%	62%	76%	42%	g (2012/13)
	Vitamin A coverage in children 12-59 months	**57%**	64%	59%	59%	64%	50%	51%	52%	47%	47%	c
Outcome	**Vitamin A deficiency** in children under 5	**44%**	Sample too small for analysis at provincial level									e
	Anaemia in children under 5	**10.7%**	Sample too small for analysis at provincial level									e
	Stunting in children under 5	**21.3%**	Sample too small for analysis at provincial level									f
	Wasting in children under 5	**3.6%**	Sample too small for analysis at provincial level									f
	Underweight in children under 5	**5.1%**	Sample too small for analysis at provincial level									f
	Overweight in children under 5	**13.4%**	Sample too small for analysis at provincial level									f

Data gaps and challenges

- There are two main ways to look at child and maternal nutrition through survey data. One is through information about dietary intake, and the other is through information about nutritional outcomes – typically by measuring height and weight, and sometimes by testing for vitamin and mineral deficiencies. Both approaches are used in South Africa, but both also have limitations.

- Food and nutrition surveys are expensive and not carried out regularly, making it difficult to have a comprehensive up-to-date picture of dietary intake. Some surveys such as the Income and Expenditure and Living Conditions Surveys collect data on food expenditure and consumption, but this information is typically at household level. It is therefore difficult to estimate children's dietary intake (quantity and quality) from such data.

- More recent surveys that could provide in-depth data on health and nutrition, are the South African National Health and Nutrition Survey (SANHANES), the South African Demographic and Health Survey (SADHS), and the National Income Dynamics Study (NIDS). While these surveys collected data on various aspects of maternal and child health, including anthropometric measurements (heights and weights), there are limited data on food security and dietary intake. A further problem relates to the regularity of these surveys. While NIDS takes place every two years, it is a panel survey and does not remain representative of the population. SANHANES and the SADHS are both nationally representative samples, but they are not regular. SANHANES (2012) has not been repeated. The most recent SADHS was in 2016, but that was after a gap of 13 years. While in many African countries, the demographic and health surveys are conducted every five years, this is not the case in South Africa. It would be useful for the SADHS to be conducted more regularly, the sample size increased, and more data on food security and nutrition indicators collected, in order to allow for a detailed picture on the situation of child nutrition in the country.

- Disaggregated data on child nutritional outcomes are lacking, mainly due to the small sample sizes of these health and nutrition surveys that make it difficult to produce reliable estimates for provinces, across age groups, and other levels of disaggregation. It is therefore difficult to assess the extent of stunting, for example, at provincial and district level, the inequalities that may exist across geographical locations, and which areas are in urgent need of interventions. The 2014/15 Living Conditions Survey (LCS), a nationally representative survey with a large sample, collected data on household socio-economic characteristics, including income and food expenditure, as well as anthropometric measurements for children under 5 years. These kinds of data are important for understanding the contexts in which children live, especially in regards to money-metric poverty and other forms of deprivation, and how these relate to stunting and other forms of malnutrition. Anthropometric data from the 2014/15 LCS have not been made publicly available, and neither have those from the previous LCS in 2008/09.

- In some cases, data on nutrition are only available for particular child age groups, overlooking others. The 2012 SANHANES collected data on general nutrition knowledge and dietary behaviours among children aged 10-14 years. The 2016 SADHS collected data on infant and young child feeding practices, but only for children aged 6-23 months. For older children (2 years and over), it is difficult to have a picture of the quality and quantity of diets consumed. The SADHS also only collects anthropometric data for children under 5 years and 15-17 years. Children aged 6-14 years are excluded.

There are lack of regular and detailed national data on the quality and quantity of foods consumed by young children.

Support for primary caregivers

Children need caregivers who are responsive and nurturing. Since many caregivers in South Africa face extreme conditions and stressors, they require support. Support should include clear information about parenting, as well as access to psychosocial services and material support.

The National Integrated ECD Policy (2015) recognises the value of supporting primary caregivers, and views them as central to supporting early child development. It identifies parent support as an essential component of the comprehensive package of ECD services and prioritises the delivery of parenting support services. It also promotes the provision of health services and other forms of support during pregnancy, and the provision of social protection to caregivers.

Young children benefit from interventions and support services targeting mothers. The vast majority of children under 6 years live with their biological mother (85%), although there are striking inequalities between districts, with co-residence rates as low as 59% in the Amathole region of the Eastern Cape. As children get older, they are more likely to live separately from their parents due to factors like death and labour migration. Targeting mothers of young children is critical to enable access to support services for both the mother and child, and to raise awareness of the importance of responsive, nurturing care. The quality of the caregiver-child relationship impacts not only on the physiological aspects of child development, but also on socio-emotional development.[6]

Support for mothers begins with antenatal care (ANC). Antenatal visits early in pregnancy enable the identification of any problems. When problems are identified early, suitable interventions and support can be offered, preventing complications in late pregnancy. The importance of ANC, support and early intervention is evident when we consider that South Africa has the highest documented rates of Foetal Alcohol Syndrome (FAS) in the world.

> **MomConnect** is a Department of Health initiative that aims to register every pregnancy in South Africa and send each mother, through mobile technology, weekly SMS messages to support her and provide information on how to take care of her own and her baby's health. The message content is targeted based on the stage of pregnancy and continues after birth, until the child is 1 year old. For more information visit: **http://www.health.gov.za/index.php/intro**

Area-specific studies in three provinces have documented Foetal Alcohol Spectrum Disorder (FASD) rates ranging from 29 to 290 per 1,000 live births between 2001 and 2011.[7] Children born with FASD are likely to demonstrate a variety of life-long concentration and behavioural difficulties. There is evidence to suggest that levels of FAS in South Africa are increasing.[8]

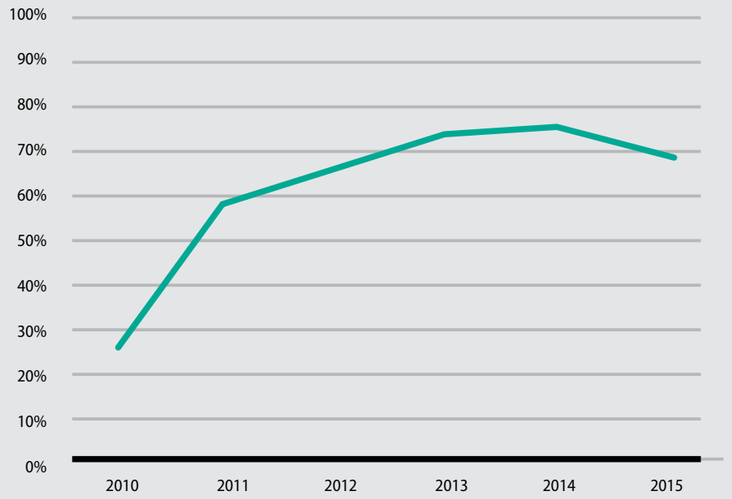
With near-universal antenatal coverage nationally, antenatal visits are a prime opportunity to share information on risks, detect harmful behaviours and adverse conditions, and offer practical support, interventions or referral. These preventative services can prevent negative child outcomes.

Repeat antenatal visits provide an opportunity to prepare pregnant women for childbirth and parenting, and to support women experiencing particular challenges, such as physical or mental health conditions or domestic violence. Visits also provide access to HIV testing. Delayed antenatal care therefore has serious consequences for both the mother and child. Women who attended public antenatal facilities in 2012 visited an average of three to four times during pregnancy.[9] The 2016 Demographic and Health Survey indicates that 76% of women surveyed attended ANC visits four or more times during their last pregnancy.[10] These figures suggest that most women are aware of the importance of regular ANC visits during pregnancy. However, there is room for improvement in early attendance – close to 40% of women are only making their first ANC visit after 20 weeks of pregnancy.

Pregnant women should be encouraged to attend antenatal services as early as possible, to gain access to the range of benefits attached to this service, and to visit at least four times during the course of their pregnancy. Non-attendance, late attendance, and infrequent attendance at ANC are among the top five avoidable factors in perinatal deaths,[11] and amongst the most common underlying causes of patient-related maternal mortality.[12]

Targeting mothers of young children is critical to enable access to support services for both the mother and child, and to raise awareness of the importance of responsive, nurturing care.

FIGURE 10: POSTNATAL FOLLOW-UPS – NATIONAL TREND



Source: DHIS 2010-2015

A qualitative study on barriers to antenatal services reports the primary challenges to be poor handling of women and girls' private and confidential information; the need for accurate and readily accessible health information; and the cost and transport implications associated with visiting clinics, particularly for those living in rural areas.[13]

The provision of infant feeding education and support to mothers is crucial to infant health. A 2012-13 survey on infants aged 4-8 weeks pointed to improvements in infant feeding education amongst HIV-positive mothers. In the majority of the provinces, more than 90% of HIV-positive mothers surveyed in public health facilities received infant feeding counselling. Given the emphasis on supporting exclusive breastfeeding amongst HIV-positive mothers, it is likely that the proportion of HIV-negative mothers who receive infant feeding counselling will be far lower. This is a data and likely service gap that needs addressing, given that a high percentage of mothers will fall within this category. Revisions to the Road to Health Booklet present an important opportunity to address this service gap, as it now aims to facilitate a more comprehensive assessment of child health, nutrition, including breastfeeding, and development. This initiative is welcomed as it is aligned with the National ECD Policy's directive for the Department of Health to adopt a more developmental approach to maternal and child health.

The postnatal period is an opportunity for service providers to pay attention to the caregiver's mood and functioning, and to provide support for issues around adjustment to motherhood, breastfeeding and bonding with the infant.

There have been substantial improvements in the coverage of postnatal care over time. Women who give birth in public health facilities are meant to have a check-up after six hours, prior to discharge, and should visit a healthcare facility for further follow-up care within six days, and again at six weeks. Checks for infection and other complications should be done during these follow-up visits. The objectives of routine postnatal care are to respond to the usual psychological and physical changes that take place post-delivery; to support, counsel and advise; and to screen for problems that threaten the mothers's and baby's health.[14] The postnatal period is also a critical period to encourage and support breastfeeding. In 2010, only 26% of women who gave birth in public facilities were recorded as having received follow-up care within six days. In 2014, this number had increased to 74%, and then declined slightly to 69% in 2015.

Both nationally and provincially, the 6-day postnatal visit rate fell below the national target of 85% in 2015.[15] The national average masks large provincial variability, with 2015 rates as low as 53% and 58% in the Northern Cape and Eastern Cape, respectively.

While there are concerns about maintaining and extending coverage, there are also important questions about the quality of care offered at postnatal visits. These concerns focus on the balance of attention between psychological and physical health within a context where maternal mental health conditions are considerably widespread.[16] Health system audits have shown that in general, maternal care services, including postnatal care, lack quality and require strengthening.[17]

Maternal mental health is important in itself, and is also important for child outcomes. A child's physical growth, immunisation, HIV testing and treatment adherence, and emotional state can be affected by the mental health of the caregiver. There are no reliable national statistics on maternal mental health but it is known that both antenatal and postnatal depression and anxiety are prevalent, affecting an estimated one third of mothers. While there have been several studies on antenatal and postnatal depression, they have been restricted to specific locations.

There are no reliable national statistics on maternal mental health but it is known that both antenatal and postnatal depression and anxiety are prevalent, affecting an estimated one third of mothers.

However, there are sufficient studies to indicate that maternal depression is common, with the prevalence of antenatal depression ranging from 18% to 47%, and 32% to 35% for postnatal depression.[18] Maternal depression is frequently not identified or treated because maternal mental health services are currently not universally integrated into the primary healthcare system.

There is little information on the provision of and access to parenting support services. Parent support programmes aim to improve parental knowledge, capacity and practices to support parents in their role as nurturing, responsive caregivers. Specialist parental support for vulnerable caregivers is especially relevant, as it addresses mental health concerns, substance abuse, and exposure to violence and abuse, among other social problems. Currently, very limited information is available on the provision or uptake of parenting programmes across the country. This is an important data gap.

Currently, MomConnect is the closest there is to a universal parenting support programmme available to new parents. With the near-universal uptake of antenatal care and well-baby clinic visits, health facilities are an ideal location for providing innovative programmes and materials in clinic waiting areas.

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

	Indicator	SA	EC	FS	GT	KZN	LP	MP	NW	NC	WC	source
Population	**Maternal care** Children < 6 who live with their biological mother	**85%**	77%	84%	91%	81%	82%	85%	86%	85%	95%	a
Service access/delivery	**Breastfeeding education** HIV+ mothers remembering receiving information during antenatal visits	**94%**	94%	85%	97%	97%	88%	95%	92%	95%	95%	g (2012)
	Postnatal follow-up Women birthing in public facilities who received follow-up care 6 days after birth	**68%**	58%	71%	77%	70%	67%	63%	69%	53%	68%	c

Data gaps and challenges

- Data on the provision of support, information, and advice to pregnant women and mothers are limited. For example, the only indicator we have for breastfeeding education is based on information provided to HIV+ mothers. We therefore have to assume that this is generalisable to the entire population of mothers, which is not necessarily the case.
- Information on the content and quality of antenatal and postnatal services is lacking.
- There are no data on maternal mental health prevalence and screening (including domestic and intimate partner violence, as well as alcohol and substance abuse) during pregnancy and postnatally.
- Data on management of primary level mental health problems for treatment are lacking.
- There are no data on the types of parent support programmes available, their identified target groups, and beneficiary access and programme reach.

Social services and income support

Early registration of births is important because birth certificates are the gateway to other services and benefits, such as the child support grant (CSG). The CSG is the main grant for children, providing income support for children living in poverty.

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 since democracy because of their positive impact and wide reach. Social assistance programmes have expanded from covering just 2.7 million people in 1994 to more than 16 million in 2014. Ten percent of South Africa's budget in 2017/18 was allocated to social grants.

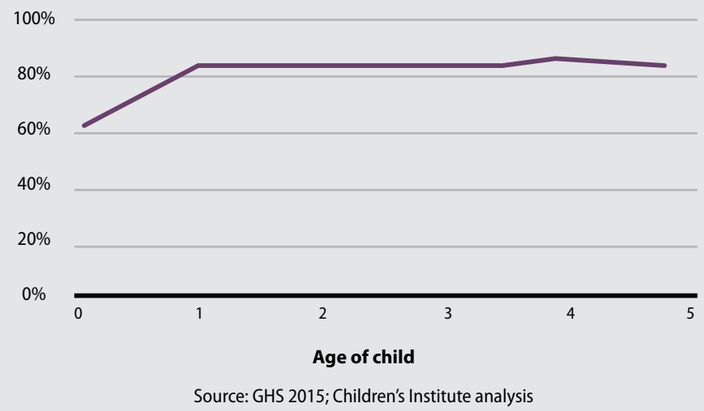
The CSG has had the highest growth of all social grants in South Africa in terms of numbers. It was introduced for poor children aged 0-7 years in 1998; it then gradually extended to all children below the age of 18 by 2012. Its reach has expanded from just under 22,000 child beneficiaries in 1998 to over 12 million in 2017. It has been shown to have a substantial developmental impact on children and their families living in poverty. However, more needs to be done to address income poverty and inequality, especially in light of new trends showing that poverty has increased since 2011, after declining in the 2000's.[19]

Using the upper-bound poverty line as a rough proxy for the means test, the CSG uptake rate among poor children under 6 years is 81%. Uptake rates are highest in the Eastern Cape, Limpopo and the North West, and lowest in the Western Cape and Gauteng. This is a known pattern, which has been reported elsewhere.[20] Possible reasons include that social security officials in wealthier provinces act as gatekeepers, making it more difficult for people to apply, or that greater population density results in long queues that deter applicants.

Figure 11 shows slow uptake of the CSG for infants under 1 year. The CSG is available to all children whose caregivers have a monthly income less than 10 times the amount of the grant (or double that if they are married). In 2015, the monthly amount of the grant was R330 per child. For children whose births are registered, the CSG application only takes about three days to process. Eligible caregivers should be able to start receiving child support grants within the first month of a child's life. This is important because early access to the CSG is associated with improved nutritional, health and education outcomes for children. CSG uptake remains the lowest for infants under a year. Amongst poor infants (below the upper-bound poverty line) only 64% receive the CSG. Once again, uptake rates are lowest in Gauteng and the Western Cape.

Early access to the CSG is associated with improved nutritional, health and education outcomes for children

FIGURE 11: CHILD SUPPORT GRANT UPTAKE AMONG POOR CHILDREN (BELOW UPPER POVERTY LINE), BY AGE

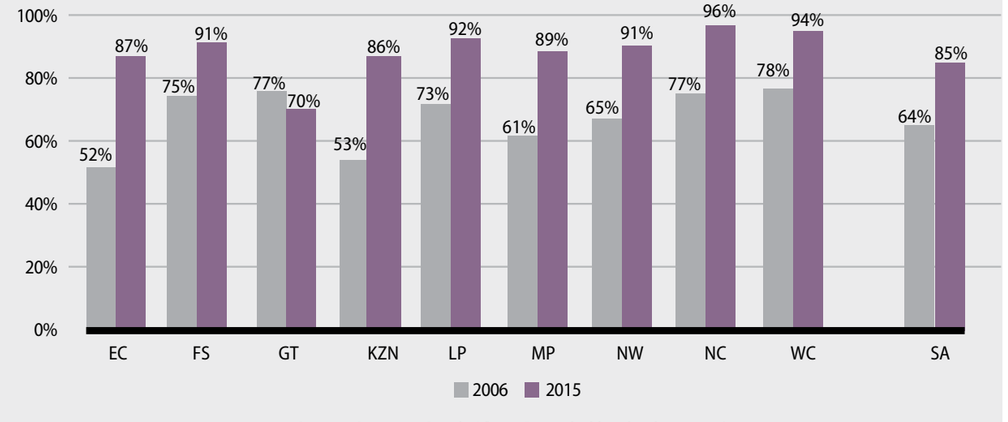


Source: GHS 2015; Children's Institute analysis

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. In 2015, 55% of poor infants (below the upper-bound poverty line) in the Western Cape and 49% in Gauteng were not receiving the CSG. Uptake rates for infants were also low in the Free State (54%). This "error of exclusion" is of concern because it tends to be the most vulnerable and needy children who do not access the grant. The highest rate of uptake for poor infants was in the Eastern Cape, where 75% of infants under the upper poverty line were reported to be receiving the CSG.

Through the Medium Term Strategic Framework (MTSF) 2014-2019, the South African government aims to ensure that at least 95% of people who qualify for social assistance benefits access these benefits by 2019. This will require ways to resolve

FIGURE 12: BIRTH REGISTRATION, BY PROVINCE



Source: Statistics South Africa: Recorded live births, 2006 & 2015

a few million exclusions. The easiest way to address exclusions for children is to ensure that they are enrolled on the grant from birth.

Birth registration has increased, but many children's births are still being registered late. Births are meant to be registered within the first 30 days, but some are not even registered within the first year. Of all the births registered in 2015, 85% were for births in current year, while 15% (165,000) were for earlier births. The provinces with the largest increases in the birth registration rates over the last ten years are Eastern Cape (52% in 2006 to 87% in 2015) and KwaZulu-Natal (53% in 2006 to 84% in 2015). Current year birth registrations in Gauteng have declined slightly over the same period.

There are no reliable data on the number of children who need social services, or on the extent of services delivered. Services for young children defined in the Children's Act (2005) include:

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

Data on child abuse, neglect, and on the service response to abuse remain very poor. The MTSF target (outcome 3) in this respect requires review, in that it calls for a 2% reduction per annum in the number of reported crimes against women, children, and other vulnerable groups (baseline 2012 was 225 430). Given the known problems of under-reporting, a more appropriate target might be one that encourages greater reporting of child abuse and improvements in prevention services as well as in services that respond to reported incidents.

The most common crimes reported against children involve sexual abuse. In 2016, a national prevalence study estimated that one in three children experience sexual violence abuse before they reach the age of 18.[21] Between 18,000 and 20,000 child sexual abuse cases are reported to the police every year. Crime statistics for 2013/14 showed that 29% of sexual offences reported to the police were children under 18 years – an average of 51 cases a day.[22] The 2015/16 crime statistics report did not include national data on crimes against children, but, in the North West, 35% of rape cases involved victims aged under 18 years.[23] Population-based studies have also found very high levels of physical abuse and physical punishment.[24] Young children are at more risk of child abuse and neglect because they are dependent on caregivers and are unable to protect themselves. In addition to sexual abuse, neglect, and physical abuse, some of the other common forms of violence affecting children under 5 years are emotional abuse and abandonment. The most severe consequence of child abuse is infanticide, which is not uncommon in South Africa.[25]

Increased efforts are needed to strengthen the child protection system. The various duty-bearers, such as the police services, Departments of Social Development and Health, and the criminal justice system, should collaborate better to improve the efficiency and effectiveness of responses. A national Child Protection Policy is currently being drafted. This policy will inform current legislative and policy frameworks to strengthen service delivery.

Only 64% of poor infants receive the Child Support Grant.

TABLE 5: SOCIAL ACCESS/DELIVERY INDICATORS FOR CHILDREN UNDER 6, BY PROVINCE

	Indicator	SA	EC	FS	GT	KZN	LP	MP	NW	NC	WC	source
Service access / delivery	**Birth registration (2015)**	**919 562**	109 210	47 473	192 439	184 225	121 973	73 686	66 254	24 310	96 626	h
	Birth registrations that are for current year births (2015)	**85%**	87%	91%	70%	86%	92%	89%	91%	95%	94%	
	Access to Child Support Grant Children < 6 receiving the CSG (March 2016)	**4 254 186**	642 954	232 159	630 872	964 979	671 328	373 174	294 040	107 512	337 168	i
	CSG uptake in children under 6 Proportion of poor children < 6 years receiving CSG	**81%**	86%	83%	67%	83%	84%	82%	79%	84%	70%	a
	CSG uptake in infants Proportion of poor children < 1 year receiving CSG	**64%**	75%	54%	49%	64%	68%	68%	57%	76%	55%	a

Data gaps and challenges

- While birth registration rates are increasing and the vital registration data are improving, it is worth noting that the number of births registered in a particular year may vary over time as the methods are revised. For example, in 2014 we reported that 76% of births were for births that occurred in that current year (based on 2015 data), but in a later report (2016) the percentage of current births recorded for 2014 was revised upwards to 83%. The *Early Childhood Review* will always attempt to source the most reliable and recent data. Trends cannot necessarily be inferred by comparing two subsequent issues of this publication.
- There is a need for regular national data on the incidence and prevalence of child abuse (including corporal punishment and sexual abuse) and neglect. These 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 records are well-kept in local offices and properly compiled at provincial and national level.
- Good administrative data on the delivery of responsive child protection services and psychosocial support for children, are needed.
- 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 – particularly the Children's Courts.

Stimulation for early learning

Babies start learning at birth. Learning takes place through their relationships with the caring adults in their lives. Programmes, such as home visiting and parenting support, designed to enrich carer engagement with young children, are therefore extremely important for a child's early development. As children grow, so their need for stimulation increases. From about the age of 3 years, young children derive great educational, social, and emotional benefits from participation in high quality group-based early learning programmes. These programmes may take different forms such as playgroups, crèches and preschools.

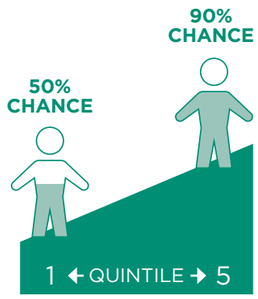
The provision of age appropriate opportunities for early learning is an essential component of the National ECD Policy's comprehensive package of services. Monitoring progress of the provision of early learning services requires us to review access, dosage, and quality.

Higher dosage of quality services is typically associated with greater cognitive gains, particularly for children from low-income communities. For optimum cognitive outcomes, the evidence suggests that two years of high quality preschool programmes are better than one; that a minimum of 15-30 hours per week is needed; and that outcomes are optimised if children are enrolled before the age of 4 years.[26]

In addition to the cognitive gains, early learning programmes provide an opportunity to link children to other services that are important at this life stage. These include sight and hearing tests, immunisation, deworming, and developmental screening to ensure early identification of learning difficulties.

Data on access to early learning programmes are gathered through the General Household Survey (GHS). The survey collects information on the number of children reported to be attending an early learning group programme. In 2015, 17% of 0-2 year olds nationally were reported to be attending such a programme. It is difficult to interpret these data meaningfully because many group learning programmes are inappropriate for children of this age. Better data are needed on the full range of early learning programmes targeting 0-2 year old children.

Of the 3.1 million children in South Africa aged 3-5 years, 63% are reported to be attending a group programme. This represents a significant increase in access over the past 15 years[27] but access seems to have stabilised between 2012 and 2015. Reasons for this 'ceiling' effect are likely to include the cost of services. Unlike health and education services, there is no provision of free group learning programmes for children of preschool age in South Africa. As a result, only those who can afford to pay for the service have access to it.



GROUP LEARNING

A 4-year-old from a poor household has a 50% chance of being enrolled in a group learning programme. A child of the same age from a wealthy household has a 90% chance of enjoying this benefit.

It is only in the North West province that access rates to early learning group programmes increased substantially for 3-5 year-olds: from 58% to 65% between 2014 and 2015. Access is lowest in KwaZulu-Natal, at 49%. This is also the province with the highest number of young children living in poverty.

Poor children are less likely than wealthier children to have access to early learning programmes. Over a million children aged 3-5 years still do not have access to group learning programmes and most of these children are found in the poorest quintiles. A four-year-old child from quintile 1 (poorest 20% of households) has a 50% chance of being enrolled in a group learning programme. In contrast, a child of the same age in quintile 5 (the wealthiest quintile) has a 90% chance of enjoying these benefits. This inequality in service access between income groups only disappears at the point where education becomes widely available, free, and compulsory – in Grade 1. At which point, many poorer children enter school with a distinct disadvantage, having missed the benefits of quality early learning programmes. Overall, 83% of 3-5 year-old children in the richest 20% of households attend a group learning programme, while only 58% in the poorest 20% of households are enrolled in a programme.

Observed increases in access to early learning services is encouraging, but the sought after early learning outcomes for children will only be realised if the programmes accessed are of good quality.

There are no reliable data that enable national monitoring of the quality of early learning programmes for children.

FIGURE 13: EARLY LEARNING PROGRAMME ATTENDANCE BY INCOME QUINTILES AND AGE

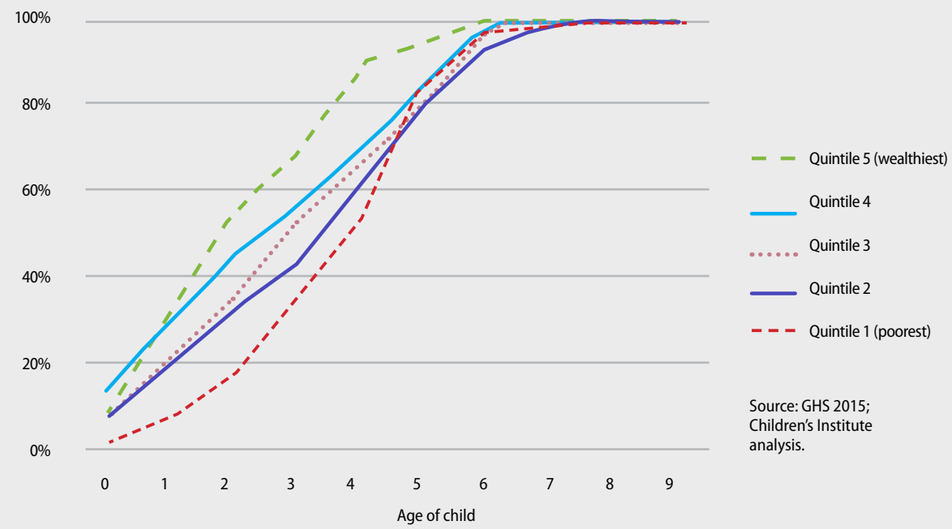
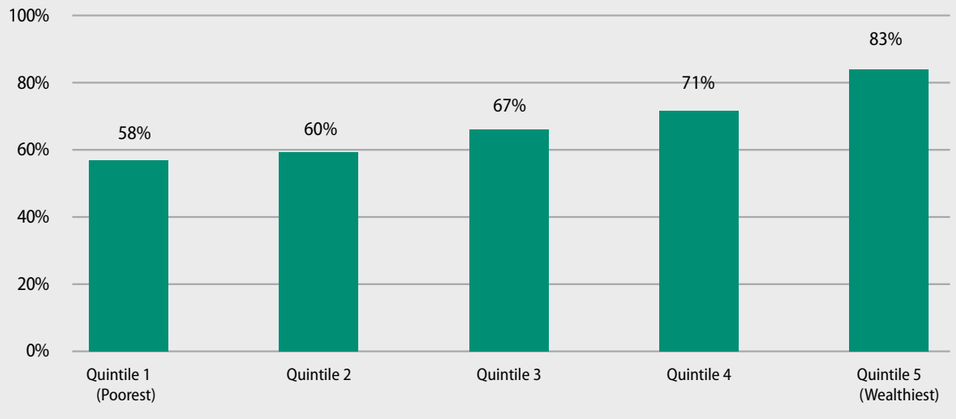


FIGURE 14: EARLY LEARNING PROGRAMME ATTENDANCE BY 3-5 YEAR OLDS, BY INCOME QUINTILES (2015)



Source: GHS 2015; Children's Institute analysis

Early Learning Outcomes Measure

To help address the gap in information on early learning programme quality, Innovation Edge commissioned the development of South Africa's first population level preschool assessment tool, the Early Learning Outcomes Measure (ELOM). ELOM is designed to assess the extent to which children aged 50-69 months are able to meet development standards in five developmental domains:

- Gross motor development
- Fine motor coordination & visual motor integration
- Emergent numeracy & mathematics
- Cognition & executive functioning
- Emergent literacy & language

Research has shown that performance in these domains predicts later school success. While learning outcomes may be impacted by many factors (including poor nutrition), you would expect to see higher ELOM scores at a population level for children attending higher quality programmes.

Currently, ELOM is being used to collect data on the effectiveness of a range of programmes designed to improve early learning outcomes in young children. These include home visiting, playgroups, toy libraries, ECD centres, and targeted add-on services. For more information on ELOM, **visit www.elom.org.za**

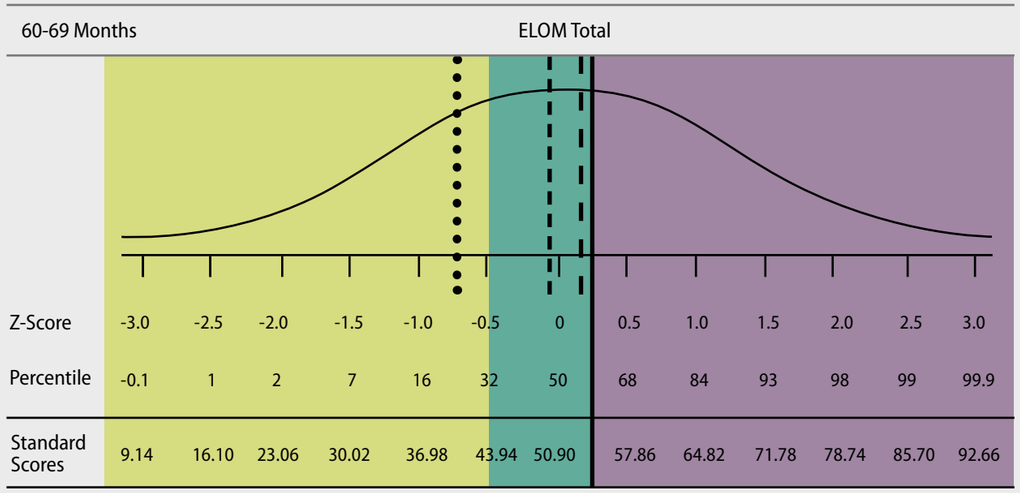
Data collected on over 1300 children across the five quintiles by ELOM clearly show that poorer children begin school at a disadvantage. In all domains, regardless of age, the performance of the poorest children tends to be lowest. The most significant delays were observed in the emergent literacy and language domain, as well as in the cognitive and executive functioning domain.

Figure 15 shows the total ELOM score for children, aged 60-69 months at the point of entry into Grade R, in quintile 1, quintiles 2 and 3 combined, and quintiles 4 and 5 combined.

Children at risk (light green:) are well below the expected performance standard (purple:) and need significant assistance to come up to the standard, while those falling behind (dark green:) are closer to the standard, and with support should be able to achieve it. These results provide a baseline against which to assess improvements in early learning programme quality over time.

The introduction, in 2017, of the first ever conditional grant for ECD in South Africa provides an opportunity to enhance the systems needed to scale high quality early learning programmes. Multiple interventions are needed to address the access, dosage, and quality gaps that affect young children within quintiles 1-3. These include greater budget allocation; better funding administration; development of routine data systems; national rollout of high quality early learning programmes; and much greater support for the ECD practitioners who engage, inspire and educate young children on a daily basis.

FIGURE 15: TOTAL ELOM SCORE FOR CHILDREN AGED 60-69 MONTHS, AT POINT OF GRADE R ENTRY



	Standard Scores	Key
Standard	54.38	
Q4/5 (Median)	53.85	
Q2/3 (Median)	49.31	
Q1 (Median)	41.99	

Source: ELOM Technical Manual, 2016

TABLE 6: EARLY LEARNING INDICATORS, BY PROVINCE

	Indicator	SA	EC	FS	GT	KZN	LP	MP	NW	NC	WC	source
Population	**Children aged 0-2**	**3 151 000**	443 000	145 000	614 000	664 000	381 000	272 000	229 000	72 000	332 000	a
	Children aged 3-5	**3 083 000**	442 000	159 000	572 000	652 000	374 000	256 000	234 000	72 000	323 000	a
Service access/delivery	**Early learning enrolment** Percentage of children 0-2 years old reported to attend an early learning group programme	**17%**	12%	25%	28%	9%	18%	13%	12%	14%	25%	a
	Percentage of children 3-5 years old reported to attend an early learning group programme	**63%**	68%	72%	72%	49%	72%	59%	65%	57%	60%	a
	No access to early learning programme Number of children 3-5 not attending any early learning group programme	**1 131 000**	143 000	44 000	158 000	333 000	105 000	106 000	82 000	31 000	130 000	a

Data gaps and challenges

- As reported in 2016's *Early Childhood Review,* South Africa does not have an administrative data system for ECD similar to those used by health and education. There are no data on the number of registered and funded ECD centres and programmes and how many children are accessing these services. As a result, all data on ECD services are drawn from survey data which are not ideal nor sustainable for robust programme monitoring and planning.
- Data on the full range of early learning programmes targeting 0-2 year old children are lacking. Currently, data are only collected on group programmes, many of which are inappropriate for children younger than 3 years.
- Lack of data on the quality of early learning programmes need to be addressed. This information is essential to inform programme enhancements and to direct resources at the most effective interventions.
- We do not know exactly how many children are receiving the per child per day early learning subsidy. The administration of the ECD conditional grant calls for vastly improved administrative data to track the number of children requiring and accessing subsidised early learning programmes.
- While we have data on service access (which usually means enrolment), we have no data on dosage i.e. how many hours of an early learning programme a child is exposed to per week. Attendance data are recorded at ECD centres and, if appropriately verified and collated, could be used as a measure of dosage. In the context of limited resources, this information is important for us to understand the minimum dosage required for improved outcomes.

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District Tables

District name	Province	District code	Households with children under 6 (CS 2016)	Inadequate water (no piped water on site) (CS 2016)	Inadequate sanitation (no flush or VIP on site) (CS 2016)	IP early neo death rate (DHIS 2015)	ANC 1st visit <20 w rate (DHIS 2015)	VitA 12-59 mm cov yy (DHIS 2015)	Imm cov <1 yy (DHIS 2015)
Alfred Nzo	EC	DC44	70 784	87.4	70.9	6.5	42.8	63.1	81.5
Amajuba	KZN	DC25	40 981	13.7	29.8	10.4	58.5	52.7	80.9
Amathole	EC	DC12	56 644	79.1	54.9	7.7	67.1	91.5	98.8
Bojanala	NW	DC37	156 986	35.3	55.2	8.6	56.3	45.4	76.6
Buffalo City	EC	BUF	62 552	29.2	24.2	12.5	59.0	58.9	92.5
Cape Town	WC	CPT	287 955	11.8	12.5	7.0	63.8	41.7	93.7
Cape Winelands	WC	DC2	60 501	11.9	13.5	8.0	73.6	54.1	79.0
Capricorn	LP	DC35	124 737	39.0	72.8	22.0	56.5	48.0	74.0
Central Karoo	WC	DC5	6 566	2.2	4.5	9.2	73.3	54.9	76.9
Chris Hani	EC	DC13	51 764	59.4	31.0	9.4	67.3	67.8	85.3
Dr K Kaunda	NW	DC40	71 241	8.1	4.7	9.0	69.5	57.4	89.8
Eden	WC	DC4	41 932	6.1	7.9	7.0	76.9	84.9	91.0
Ehlanzeni	MP	DC32	168 842	41.4	71.4	9.2	71.7	54.1	90.8
Ekurhuleni	GT	EKU	282 701	9.9	10.3	9.6	54.9	66.7	114.5
eThekwini	KZN	ETH	209 533	17.1	22.2	12.4	63.8	67.9	97.6
Fezile Dabi	KZN	DC20	50 834	6.6	19.1	14.7	58.0	55.0	71.3
Frances Baard	NC	DC9	35 207	13.4	12.4	15.8	62.9	52.8	84.1
Gert Sibande	KZN	DC30	102 382	19.2	26.1	10.3	56.0	44.1	80.2
Harry Gwala	KZN	DC43	39 152	73.1	44.1	10.9	64.6	64.2	68.5
iLembe	KZN	DC29	63 894	64.7	53.7	11.7	65.9	74.3	77.6
Joe Gqabi	EC	DC14	25 309	56.9	36.0	11.4	57.0	53.1	80.2
Johannesburg	GT	JHB	420 999	6.4	7.2	9.8	52.1	59.4	105.7
JT Gaetsewe	NC	DC45	27 853	65.6	58.5	15.6	57.3	50.9	96.7
Lejweleputswa	FS	DC18	66 441	5.9	14.5	11.9	63.5	82.0	109.1
Mangaung	FS	MAN	65 001	10.3	22.5	12.5	62.7	41.7	74.6
Mopani	LP	DC33	125 266	56.6	72.0	10.1	63.3	57.5	88.7
N Mandela Bay	EC	NMA	85 745	6.2	6.1	13.9	61.5	52.3	80.0
Namakwa	NC	DC6	9 318	3.9	11.8	9.6	73.9	45.4	61.1
Nkangala	MP	DC31	121 314	17.0	42.5	8.6	63.9	52.7	87.0
NM Molema	NW	DC38	88 539	56.1	61.0	10.8	61.2	59.0	88.7
OR Tambo	EC	DC15	102 110	88.0	46.6	18.1	60.1	59.6	88.9
Overberg	WC	DC3	22 174	9.5	10.7	10.3	78.7	54.9	86.7
Pixley ka Seme	NC	DC7	18 894	11.5	14.3	6.9	67.0	37.4	77.7
RS Mompati	NW	DC39	43 265	64.3	30.3	11.9	62.6	59.8	87.1
S Baartman	EC	DC10	33 919	12.0	12.6	10.8	69.0	58.2	80.1
Sedibeng	GT	DC42	87 739	6.6	6.7	7.1	65.3	71.4	112.5
Sekhukhune	MP	DC47	112 412	69.0	90.6	8.5	59.2	51.1	74.4
T Mofutsanyana	FS	DC19	76 828	13.4	35.0	5.5	63.0	61.1	88.8
Tshwane	GT	TSH	277 289	10.2	21.6	10.0	55.0	45.7	97.6
Ugu	KZN	DC21	51 026	78.3	60.8	8.7	65.8	58.0	82.9
uMgungundlovu	KZN	DC22	77 559	24.9	35.1	10.3	68.7	56.0	72.9
uMkhanyakude	KZN	DC27	56 450	73.7	56.9	7.3	66.4	62.4	87.5
uMzinyathi	KZN	DC24	47 391	69.7	60.5	12.0	68.4	71.2	92.2
uThukela	KZN	DC23	60 545	52.5	41.1	8.3	61.3	83.6	84.7
uThungulu	KZN	DC28	76 715	40.2	42.4	14.0	63.1	54.5	81.5
Vhembe	LP	DC34	146 683	61.5	74.7	9.4	63.5	52.2	88.3
Waterberg	LP	DC36	62 308	37.2	45.2	13.5	61.0	37.9	66.7
West Coast	WC	DC1	38 032	5.4	6.4	7.6	72.3	50.1	82.5
West Rand	GT	DC48	75 537	18.3	14.0	8.3	61.6	64.8	107.2
Xhariep	FS	DC16	12 886	8.2	8.2	2.7	75.3	94.4	123.2
ZF Mgcawu	NC	DC8	21 676	11.3	17.8	17.0	61.0	41.8	82.1
Zululand	KZN	DC26	64 969	54.3	44.3	7.3	67.0	54.7	78.1

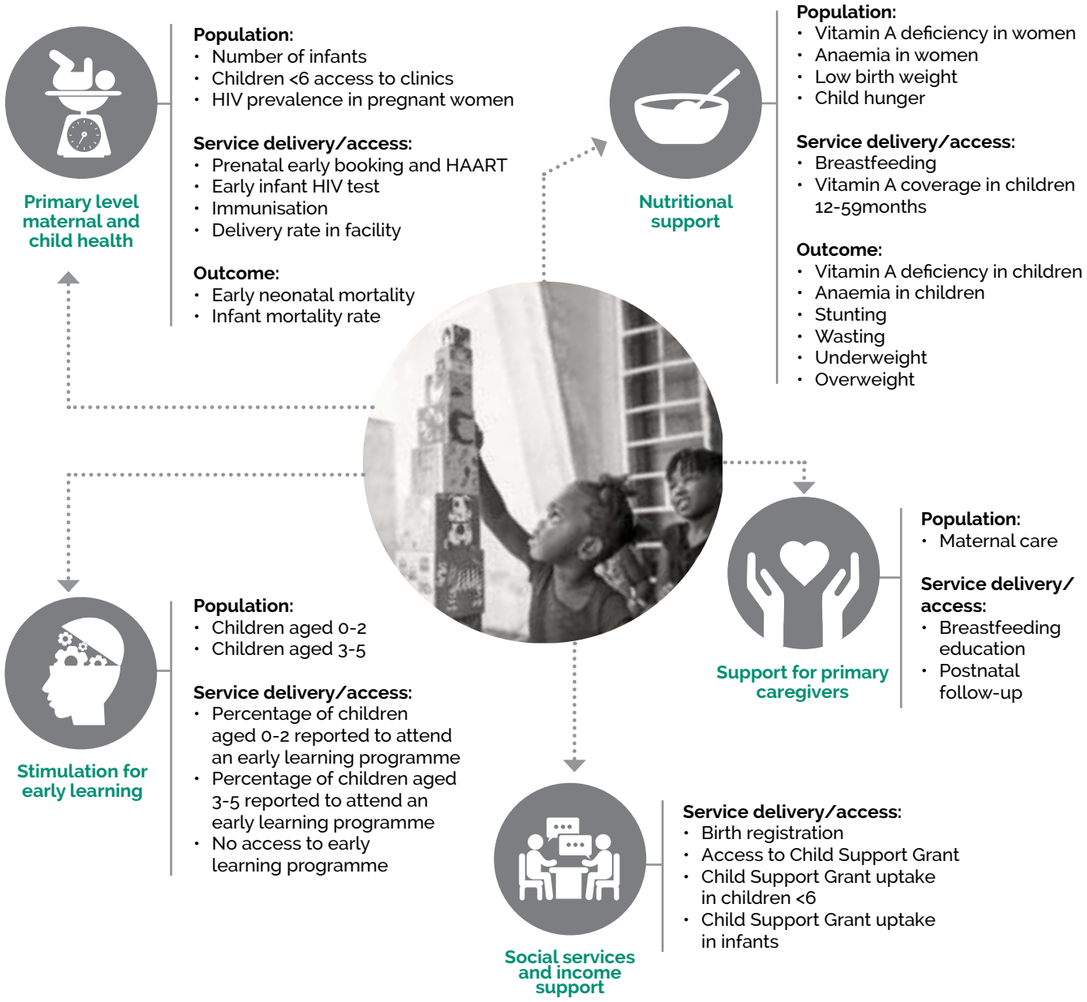
District name	Province	District code	PCR test coverage within 7 days of birth (of live births to HIV+ women) (DHIS 2015)	Delivery in facility rate (DHIS 2015)	Live birth under 2500g in facility rate (DHIS 2015)	Biological mother is co-resident (CS 2016)	Children 0-2 years attending any ECD or educational institution (CS 2016)	Children 3-5 years attending any ECD or educational institution (CS 2016)
Alfred Nzo	EC	DC44	33.8	55.6	9.7	64.7	5.4	71.4
Amajuba	KZN	DC25	84.5	69.0	14.9	76.0	11.5	65.0
Amathole	EC	DC12	63.7	47.4	9.3	58.6	14.4	76.0
Bojanala	NW	DC37	57.9	60.2	13.2	86.6	14.2	69.2
Buffalo City	EC	BUF	62.1	105.9	14.6	77.6	25.1	86.9
Cape Town	WC	CPT	30.1	93.5	14.2	90.4	24.1	72.5
Cape Winelands	WC	DC2		89.4	15.2	90.1	22.1	65.2
Capricorn	LP	DC35	65.9	84.3	12.5	75.7	22.8	85.5
Central Karoo	WC	DC5		70.6	21.1	83.9	9.5	64.4
Chris Hani	EC	DC13	53.6	66.5	13.7	62.1	15.9	75.4
Dr K Kaunda	NW	DC40	81.9	94.1	15.3	87.5	18.6	73.1
Eden	WC	DC4		85.4	16.2	89.8	24.2	77.1
Ehlanzeni	MP	DC32	58.8	87.0	12.0	80.3	12.2	71.4
Ekurhuleni	GT	EKU	66.0	116.5	12.6	89.3	25.3	75.0
eThekwini	KZN	ETH	76.6	92.4	11.5	85.0	13.1	63.3
Fezile Dabi	KZN	DC20	46.2	77.7	11.6	85.3	24.8	76.8
Frances Baard	NC	DC9	77.9	110.6	21.6	86.5	16.3	75.9
Gert Sibande	KZN	DC30	56.6	81.8	10.5	79.6	12.0	67.3
Harry Gwala	KZN	DC43	73.1	61.7	9.5	69.2	6.1	61.3
iLembe	KZN	DC29	84.6	70.7	11.6	74.2	8.0	60.0
Joe Gqabi	EC	DC14	55.0	64.3	13.1	67.1	11.7	71.8
Johannesburg	GT	JHB	70.3	82.4	13.2	89.8	24.8	76.9
JT Gaetsewe	NC	DC45	42.0	85.5	12.6	82.4	11.3	74.2
Lejweleputswa	FS	DC18	32.2	102.9	13.0	83.8	20.9	74.5
Mangaung	FS	MAN	82.2	93.0	12.6	85.6	22.7	78.2
Mopani	LP	DC33	62.2	104.7	10.2	78.3	15.5	80.2
N Mandela Bay	EC	NMA	70.0	103.5	16.9	87.1	21.5	74.1
Namakwa	NC	DC6	61.5	62.9	19.7	86.9	7.7	59.4
Nkangala	MP	DC31	69.8	84.1	13.7	83.1	15.9	71.3
NM Molema	NW	DC38	65.0	68.5	13.5	78.8	11.2	69.4
OR Tambo	EC	DC15	24.5	81.5	14.5	65.6	6.5	67.3
Overberg	WC	DC3		65.4	12.9	91.4	21.5	66.0
Pixley ka Seme	NC	DC7	65.4	71.1	24.2	81.8	9.0	61.8
RS Mompati	NW	DC39	86.2	85.5	16.5	76.4	11.1	70.2
S Baartman	EC	DC10	81.4	72.8	17.3	82.0	15.7	76.7
Sedibeng	GT	DC42	71.1	102.1	13.1	88.1	34.0	84.3
Sekhukhune	MP	DC47	45.8	95.0	9.0	77.1	12.3	79.3
T Mofutsanyana	FS	DC19	54.8	87.5	11.6	77.4	29.0	84.3
Tshwane	GT	TSH	78.8	92.1	12.8	91.9	25.2	77.2
Ugu	KZN	DC21	86.7	73.2	11.9	70.9	9.4	61.4
uMgungundlovu	KZN	DC22	96.6	83.4	14.8	77.2	13.9	69.2
uMkhanyakude	KZN	DC27	90.0	81.2	10.3	70.0	13.6	66.8
uMzinyathi	KZN	DC24	90.6	76.8	9.1	72.0	6.3	60.1
uThukela	KZN	DC23	92.1	68.3	12.3	73.3	9.7	67.2
uThungulu	KZN	DC28	73.0	79.8	13.2	68.1	8.2	61.4
Vhembe	LP	DC34	74.2	93.3	8.8	76.8	14.3	73.9
Waterberg	LP	DC36	58.3	78.0	12.1	82.1	21.1	77.9
West Coast	WC	DC1		66.2	13.6	91.9	13.3	62.2
West Rand	GT	DC48	75.4	107.6	13.4	88.0	22.9	75.0
Xhariep	FS	DC16	84.4	45.1	13.3	76.4	16.9	76.8
ZF Mgcawu	NC	DC8	48.0	82.7	19.9	87.4	8.5	50.3
Zululand	KZN	DC26	81.7	71.4	8.9	66.3	8.1	63.3

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 www.childrencount.ci.org.za for more indicators)	2015	Annual	Province
b	Department of Health: National HIV and Syphilis Prevalence Survey (http://www.health.gov.za/docs/reports/2013/report2014.pdf)	2013	Annual	Province
c	Department of Health: District Health Information System. Published by Health Systems Trust (http://www.hst.org.za/content/health-indicators)	2015/16	Annual	District
d	Medical Research Council Burden of Disease Unit (2016): Rapid Mortality Surveillance Report 2015 (http://www.mrc.ac.za/bod/RapidMortalitySurveillanceReport2015.pdf)	2015	-	National
e	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 prov)
f	SALDRU: National Income Dynamics Study (NIDS) – Wave 1, 2008 and Wave 4, 2014. Data analysed by Children's Institute, University of Cape Town (see http://www.nids.uct.ac.za/ for more about NIDS)	2008 2014/15	2-yearly (panel)	National
g	Goga, A.E., Jackson, D.J., Singh, M., Lombard, C. for the SAPMTCTE study group (2015). Early (4-8 weeks postpartum) Population-level Effectiveness of WHO PMTCT Option A, South Africa, 2012-2013. South African Medical Research Council & National Department of Health (http://www.mrc.ac.za/healthsystems/SAPMTCTEReport2012.pdf)	2012/13	-	Province
h	Statistics South Africa: Recorded Live Births (http://beta2.statssa.gov.za/publications/P0305/P03052015.pdf)	2015	Annual	National
I	South African Social Security Agency SOCPEN data extracted by special request (see http://www.childrencount.ci.org.za/social_grants.php for grant updates)	2016	-	Province

Key indicators for early childhood development in South Africa



Contributors

Lizette Berry is a senior researcher at the Children's Institute at the University of Cape Town. She holds a Master of Social Science specialising in social policy and management. Berry has more than 15 years' experience in child policy research and has a background in social work. She has an interest in the care and development of children; and contributed to a Southern African Development Community education policy framework, which promotes learner care and support. She also contributed to the Department of Social Development's White Paper on Families and the National ECD Policy and Programme. Berry was the lead editor of the *South African Child Gauge* 2013, focused on ECD services.

Colin Almeleh is the Executive Director of Ilifa Labantwana, a national programme working to secure an equal start for all children living in South Africa, through universal access to quality early childhood development. Almeleh has extensive experience working with governments and development agencies, having worked for the Children's Investment Fund Foundation and Absolute Return for Kids on maternal, newborn and child health projects throughout Sub-Saharan Africa. He holds a PhD in Sociology, a BSoSci Hons in Social Anthropology, and a BSc in Electrical Engineering. Almeleh is a past Fox Fellow at Yale University.

Sonja Giese is Executive Director of Innovation Edge, a grant and investment fund focused on unconventional ideas that find solutions to early childhood care and education challenges in under-resourced communities. Over the past 20 years, Giese has been involved in a number of successful start-up ventures in the development space, all focused on improving child outcomes through combining practical service delivery experience with policy and systems reform. She has a Bachelor of Science and Honours degrees from the University of Cape Town.

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 social policy. She co-ordinates the Institute's Children Count indicator project, which analyses national household survey data to monitor a variety of indicators related to child poverty, development and well-being. Her work has examined the targeting of poverty alleviation programmes, particularly in relation to social assistance. Hall has worked extensively on household form and care arrangements for children. She has a strong interest in housing policy and urban migration, and their implications for child care and household formation. She is a member of the standing committee of the International Society for Child Indicators and UCT's Poverty and Inequality Initiative.

Kefiloe Masiteng is the Deputy Secretary for National Planning in the Department of Planning, Monitoring and Evaluation. Prior, she served as Deputy Director General at Statistics South Africa for 11 years and was responsible for population and social statistics. Masiteng has also worked as Chief Director in the Presidency Policy Coordination and Advisory Services, where she was responsible for governance and administration, and conceptualised the government-wide monitoring and evaluation system. She has also worked in the Departments of Housing and Health, where she was responsible for monitoring and evaluation. Dr Masiteng has a PhD from the School of Governance at Wits, a Masters in Public Health from University of Pretoria, and a Batchelor of Science Honours from Wits.

Winnie Sambu is a researcher at the Children's Institute at the University of Cape Town. 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. She is an expert in data analysis, focusing on large household survey data to produce statistics for child-centred indicators used to monitor achievement of socio-economic rights for children in South Africa. These indicators are monitored through the Children Count project (www.childrencount.net) and are published in the *South African Child Gauge* on an annual basis. Sambu's research interests include poverty and inequality, food security, and household living conditions. Sambu has also been involved in other research projects within the Children's Institute, co-authoring publications on early childhood development (*South Africa Early Childhood Review*) as well as child protection.

Notes

A note on this publication

The South African Early Childhood Review 2017 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 2017 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, 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.uct.ac.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