

SOUTH AFRICAN EARLY CHILDHOOD REVIEW 2016



Acronyms

ANA	Annual National Assessment	MTSF	Medium Term Strategic Framework
ANC	Antenatal care	NC	Northern Cape
ART	Antiretroviral Therapy	NIDS	National Income Dynamics Study
CSG	Child Support Grant	NW	North West
DSD	Department of Social Development	PCR	Polymerase Chain Reaction
EC	Eastern Cape	PMTCT	Prevention of Mother to Child Transmission (of HIV)
ECD	Early Childhood Development	PSLSD	Project for Statistics on Living Standards and Development
FASD	Foetal Alcohol Spectrum Disorder	RSA	Republic of South Africa
FS	Free State	SA	South Africa
GHS	General Household Survey	SALDRU	Southern Africa Labour and Development Research Unit
GT	Gauteng	SANHANES	South African National Health and Nutrition Survey
HAART	Highly Active Antiretroviral Therapy	SASSA	South African Social Security Agency
HIV	Human Immunodeficiency Virus	UNICEF	United Nations Children's Fund
HSRC	Human Sciences Research Council	VIP	Ventilated improved pit-latrine
KZN	KwaZulu-Natal	WC	Western Cape
LP	Limpopo	WHO	World Health Organisation
MEC	Member of the Executive Council		
MP	Mpumalanga		
MTCT	Mother to Child Transmission (of HIV)		

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The science is conclusive: investments in early childhood development yield lifetime development returns for the child, his or her family and society.

- National Integrated Early Childhood Development Policy (2015)

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Foreword

Investment in ECD is critical to ensure better performance in formal schooling which will result in improved levels of employment.

Investment in early childhood development (ECD) has been documented to be one of the most effective, long-term strategies for poverty eradication. Children learn the skills that will help them flourish, early in life, when the brain has the maximum capacity to develop. In South Africa's government policies, ECD is a national priority programme included to support the principle of investment in young children.

The National Development Plan (NDP) focuses on the capabilities of the people and of the country, and emphasises that action should be taken to improve ECD services. Investment in ECD is critical to ensure better performance in formal schooling which will result in improved levels of employment. Thus, the NDP recognises quality early childhood development as one of the measures to reduce the acute impacts of poverty.

Policy developments in the last two years provide clear direction for the scaling up of ECD provision. Government has committed to making ECD a public good and accelerating access to essential components of a comprehensive package of services from conception to formal school going age.¹

This gives impetus to ECD provisions in the NDP and the Integrated ECD Programme of Action for Moving Ahead (2013-2018) and the ECD Policy and Programme approved by Cabinet in December 2015. Key to implementation on a population based scale will be proper and effective monitoring and evaluation systems; as well as frameworks to track progress against objectives and goals, especially with regard to improving levels of access to and

the quality of ECD services for infants and young children. This is an essential part of service delivery in the implementation of the National ECD policy.

The publication of this Early Childhood Review comes at a very auspicious time. It follows the release of Development Indicators 2014 by the Department of Planning, Monitoring and Evaluation, which reflected good performance in some of the indicators of ECD services featured in this review. This publication provides more details on the indicators, making it an important product for planning. This review presents a set of indicators to support inter-sectoral planning, delivery and monitoring of the essential components of the proposed comprehensive package of ECD services from conception to the age of 6. The data provided in this review is drawn from a range of sources, many of which can be updated annually. The review also highlights a number of data gaps, which are critical in tracking progress in the future and therefore requires the development of a systematic approach to collecting information and acquiring data, particularly at a local level.

I would like to thank the authors at the Children's Institute, University of Cape Town and Ilifa Labantwana, for initiating such a useful review. In working together, I believe we will ensure that South Africa's children enjoy a better future as articulated in our Vision 2030 the National Development Plan.

Zanele Twala
Director: Sector Expert Early Childhood Development
Department of Planning, Monitoring and Evaluation

¹ Budget Vote Statement by the Minister of Social Development, Ms Bathabile Dlamini, MP to the National Assembly, Cape Town 16 July 2014

Introduction

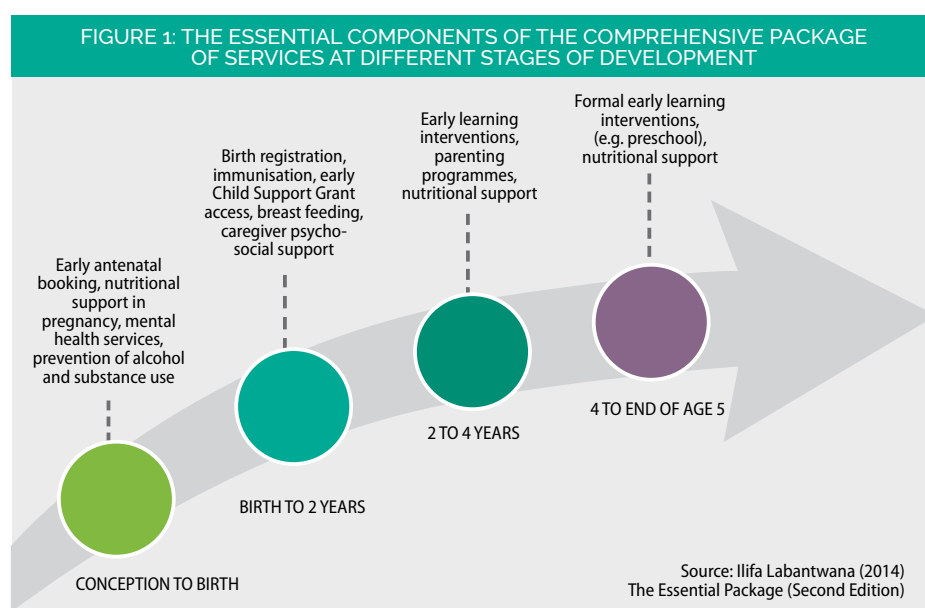
Early Childhood Development (ECD) services are needed to support the overall development of children. With commitment from government sectors to work together, a comprehensive package of ECD services with essential components can be delivered to all South Africa's young children. This review presents 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 6.

Since 2013, the South African government has led the development of the country's first national policy aimed at providing a multi-sectoral enabling framework for ECD services. The new policy, called the National Integrated Early Childhood Development Policy was approved by Cabinet in December 2015. The policy gives effect to the provision of a comprehensive package of ECD services for young children, and prioritises the delivery of essential components of the package of ECD services. The essential package consists of services that are a necessary pre-condition for the realisation of young children's Constitutional rights, and which should be realised with immediate effect. These services should be provided within the con-

text of a broader set of provisions, necessary to ensure an environment conducive to young children's development. Such services are included in the comprehensive package. The policy covers the period from conception until the year before children commence with formal education, or in the case of children with disabilities, until the year they turn 7. The policy calls for a co-ordinated approach and promotes the delivery of services across government departments, to ensure comprehensive, integrated ECD services.

Figure 1 shows examples of types of essential components of the comprehensive package of services needed at different ages. The list is not

The essential package consists of services that are a necessary pre-condition for the realisation of young children's Constitutional rights



Early childhood, especially the first 1000 days from conception to two years, is a particularly sensitive and rapid period of development.

complete but simply illustrates a range of services that comprise health, education and welfare. Each is discussed in more detail here.

The South African government has an obligation to provide ECD services

All 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 of 2015, as amended, says a comprehensive national strategy must be developed to enable a properly resourced, coordinated and managed ECD system. Provincial MECs for Social Development are tasked with developing a provincial strategy. The Act says that planning for ECD services must be led by the Department of Social Development in collaboration with the Departments of Basic Education and Health; provincial and local government, and the finance and transport sectors.

ECD services are urgent

More than a million children are born every year. They cannot wait for government to realise comprehensive ECD services progressively. Early childhood, especially the first 1000 days from conception to two years, is a particularly sensitive and rapid period of development, laying 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.

While a comprehensive package will be ideal in the long run, the immediate priority is to deliver a package of essential components of the ECD services for all young children. The new policy intends to make such a package universally available, thereby enabling the realisation of the most basic of children's rights, and giving every generation of children a good start in life.

Delivering the essential components of the comprehensive package of ECD services requires collaboration

The essential components of the comprehensive package covers the period from conception until children turn 6 years. Some services are targeted at children of a particular age or development stage, some at children who have particular risk profiles, while others are necessary for all children. 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 to have good collaboration and referrals between health, education and social services.

The essential components of the comprehensive package are:



Maternal and child primary health interventions

Including antenatal care, PMTCT, physical and mental health screening, psycho-social support and immunisation



Nutritional support

For pregnant women, mothers and children



Support for primary caregivers

Including parenting skills and psycho-social support



Social services

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



Stimulation for early learning

Including access to quality, age-appropriate early learning programmes

Children under 6 years in South Africa

The essential components of the comprehensive package of ECD services needs to reach all children under 6 years. 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.

Over half of South Africa's young children live in just three provinces: KwaZulu-Natal, Gauteng and the Eastern Cape. Slightly more than half of all young children now live in urban areas, but there are still some provinces, such as the Eastern Cape, Limpopo, KwaZulu-Natal and Mpumalanga, where more than 60% of children under the age of 6 live in rural areas.

While the population of young children has not changed substantially over the last decade, the proportion of young children living in urban areas has increased from 48% to 57%. The Free State province saw the biggest increase in the proportion of young children living in urban areas: from 62% in 2002, to 83% in 2014. Numerically, the biggest increase was in Gauteng, where the number of young children living in urban areas increased by 220 000.

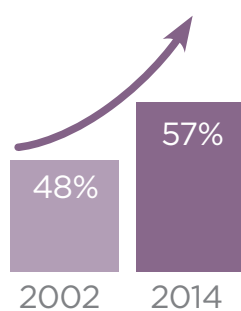
Poor households have a disproportionately large burden of care for young children. This includes situations where grandparents and other family members care for the children of parents who must migrate to find work. Four million children

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 even 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 for people to afford both the minimum adequate food and basic non-food items and should arguably be used as the line of preference for reducing child poverty.

The poverty lines were set in 2012, and increase each year in line with inflation. In 2014, the value of the food poverty line was R397 per person per month, while the lower line was R594 per month and the

Over half of South Africa's young children live in just three provinces: KwaZulu-Natal, Gauteng and the Eastern Cape.



Proportion of young children living in urban areas

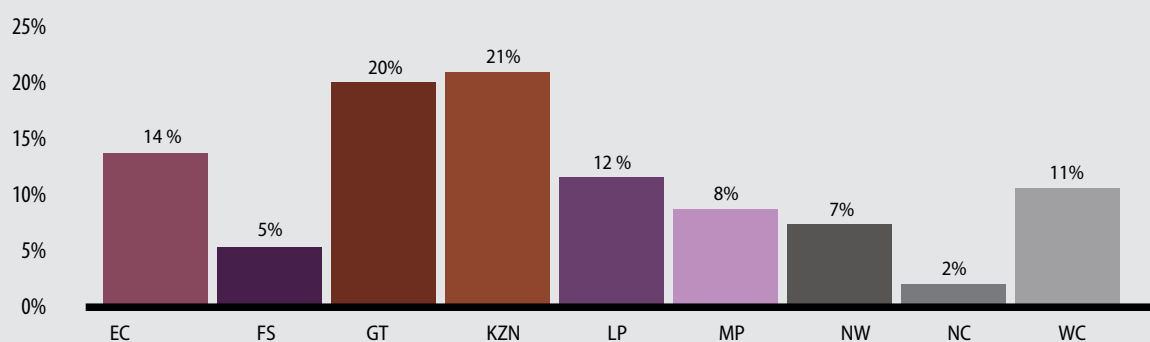
upper poverty line was R923 per month. Across all poverty lines, child poverty rates are considerably higher than adult poverty rates and the overall poverty rate. This is because children are disproportionately located in large, poor and unemployed households.² The challenge of poverty reduction is thus even more pressing in the case of children, yet there is currently no target for the reduction of child poverty in South Africa.

The child poverty rates in Figure 3 below are based on the upper poverty line (which allows for a minimum acceptable standard of living) and on the food poverty line

(which is so punitive that no child should be below it). The majority of young children (63%) 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 provinces, where 78%, 75% and 74% of young children, respectively, live in poor households.

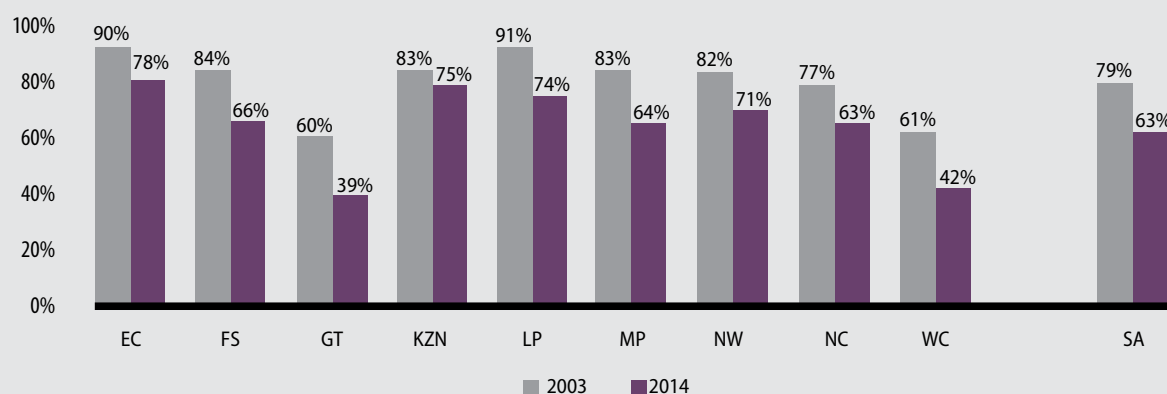
The number and percentage of young children living in poverty has decreased since 2003 when 4.9 million (79%) young children lived in poor households. This is due in large part to the introduction of social grants.

FIGURE 2: PROVINCIAL SHARE OF CHILDREN UNDER 6 YEARS IN 2014



Source: GHS 2014, analysis by Children's Institute

FIGURE 3: CHILDREN UNDER 6 YEARS LIVING BELOW THE NATIONAL UPPER POVERTY LINE (2003 & 2014)



Source: GHS 2003 & 2014, analysis by Children's Institute

² Hall & Woolard "Children and Inequality: An introduction and overview." in Hall K, Woolard I, Lake L & Smith C (2012) South African Child Gauge 2012. Cape Town, Children's Institute, University of Cape Town.

Almost a third 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.

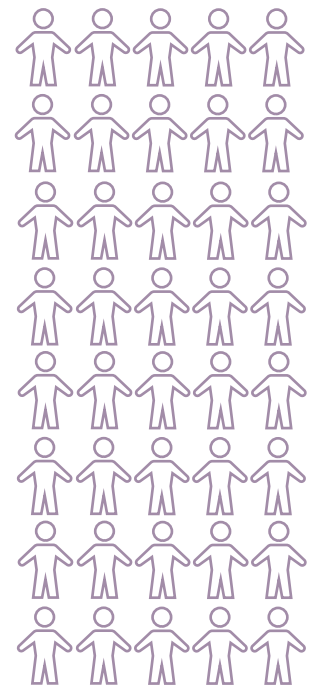
Many children under the age of 6 live in households where nobody is employed or engaged in income-generating activities. Employment is important as a source of regular income, and may come with other benefits, such as health insurance, unemployment insurance and maternity leave. Regular income and other employment benefits contribute to a child's health, development and education. While the proportion of children living in households where there is unemployment reduced from 38% in 2003 to 28% in 2014, there are still more than 1.7 million young children living in households where nobody is working.

In the future, most children will live in urban areas, but there will also be a significant number in rural areas. Plans for ECD infrastructure and services will have to differentiate between the needs of urban and rural areas. ECD services should

be flexible and responsive to the needs of children, families and communities, wherever they are. Some services need to be targeted directly at children, while others provide support to their primary caregivers.

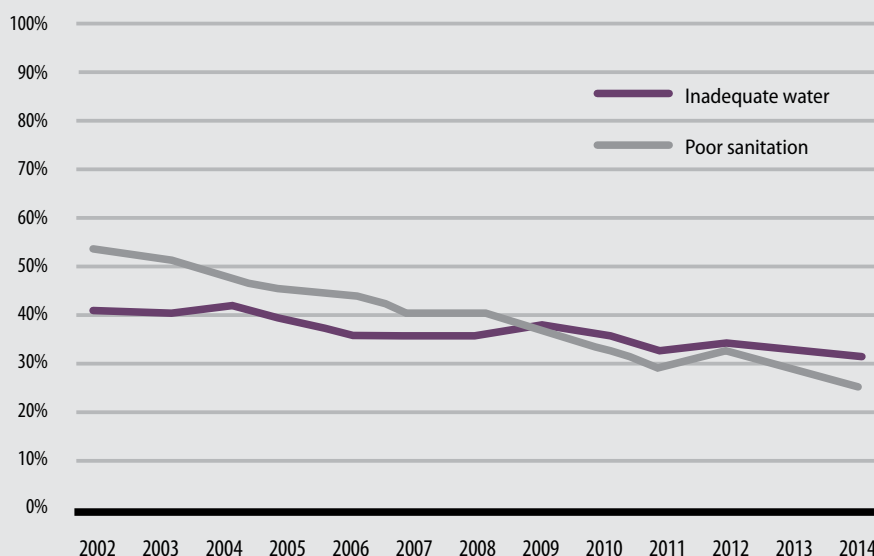
Young children are especially vulnerable to poor living conditions, as they are still growing, have increased nutritional needs and have a greater risk of infection. Adequate water infrastructure is important because children are vulnerable to water-borne diseases and can also be exposed to risks when fetching water. About a third of children under 6 live in households without access to piped water on site. In the Eastern Cape, close to two-thirds do not have access to adequate water. Despite huge progress in providing sanitation, South Africa still has more than 1.6 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, and can lead to the spread of diarrhoeal diseases and other infections, such as pneumonia. These diseases are among the main causes of child deaths.

 = 100 000 CHILDREN



4 million children under 6 years live in the poorest 40% of households

FIGURE 4: CHILDREN UNDER 6 YEARS LIVING IN HOUSEHOLDS WITH INADEQUATE SERVICES



Source: GHS 2002 - 2014, analysis by Children's Institute

Access to adequate water and sanitation has improved over the years.

Between 2002 and 2014, the number of young children living in households with poor sanitation was halved: 26% of young children lived in households with poor san-

itation in 2014, compared to 53% in 2002. The biggest improvement has been in the Eastern Cape, where the proportion of young children living in households with poor sanitation reduced from 81% in 2002 to 26% in 2014.

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

	Indicator	SA	EC	FS	GT	KZN	LP	MP	NW	NC	WC	source
Population	Number of children under 6 years	6 311 000	881 000	297 000	1 245 000	1 321 000	784 000	529 000	445 000	141 000	668 000	a
	Households with children under 6	4 870 000	581 000	284 000	1 277 000	842 000	581 000	405 000	352 000	97 000	453 000	a
		31%	34%	32%	28%	32%	39%	35%	30%	31%	26%	
Area type	Urban Children < 6 in urban areas (formal/informal)	3 592 000	347 000	245 000	1 225 000	523 000	108 000	203 000	184 000	109 000	648 000	a
		57%	39%	83%	98%	40%	14%	38%	41%	77%	97%	
	Rural traditional Children < 6 in rural former homeland areas	2 502 000	523 000	31 000	14 000	747 000	655 000	278 000	230 000	24 000	-	a
		40%	59%	11%	1%	57%	84%	52%	52%	17%	0%	
	Rural farms Children < 6 in commercial farming areas (old RSA)	217 000	11 000	20 000	7 000	51 000	21 000	48 000	30 000	8 000	20 000	a
		3%	1%	7%	1%	4%	3%	9%	7%	6%	3%	
Services	Inadequate water Children < 6 without piped water on site	1 946 000	559 000	21 000	98 000	533 000	334 000	155 000	161 000	30 000	55 000	a
		31%	63%	7%	8%	41%	44%	30%	36%	21%	8%	
	Poor sanitation Children < 6 without a toilet or VPL on site	1 651 000	225 000	54 000	107 000	420 000	368 000	221 000	165 000	27 000	65 000	a
		26%	26%	18%	9%	32%	47%	42%	37%	19%	10%	
Poverty	Child poverty Children < 6 living in poor households (< R923 in 2014)	3 969 000	691 000	196 000	483 000	992 000	583 000	341 000	314 000	89 000	80 000	a
		63%	78%	66%	39%	75%	74%	64%	71%	63%	42%	
	Food poverty Children < 6 living in food poor households (< R397 in 2014)	1 926 000	401 000	92 000	168 000	492 000	329 000	176 000	147 000	44 000	77 000	a
		31%	46%	31%	14%	37%	42%	33%	33%	31%	11%	
	Workless households Children < 6 living in households with no employed adults	1 743 000	383 000	89 000	128 000	461 000	308 000	136 000	132 000	44 000	62 000	a
		28%	43%	30%	10%	35%	39%	26%	30%	31%	9%	

Primary level maternal and child health



Protecting the health of a mother and child starts with antenatal care. This is particularly important for maternal health, and for the prevention of stunting and HIV in young children.

Across the country, more than a million children are born each year. Early antenatal care is an important gateway to primary health and nutrition services, for both mothers and children.

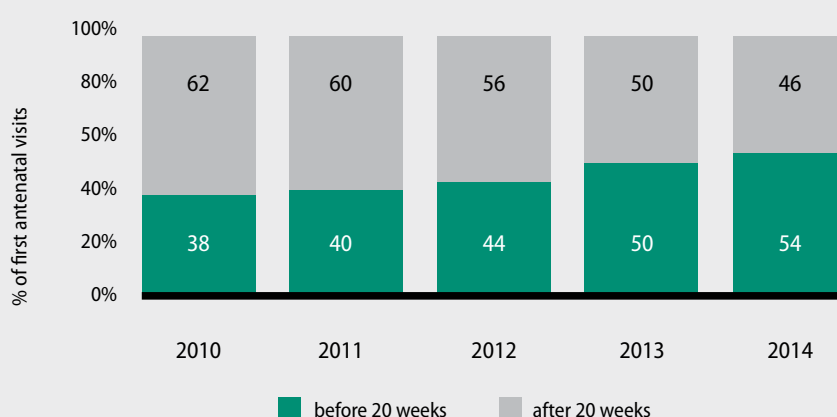
There has been a steady increase in early antenatal bookings (before 20 weeks in pregnancy), as shown in Figure 5. But 46% of first antenatal visits still take place later than 20 weeks into pregnancy. Antenatal visits during early pregnancy are a useful opportunity for physical and mental health screening. Maternal mental health is important in itself, and also important for child outcomes. Both immunisation and HIV testing and treatment adherence

are affected by the mental health of the caregiver.

With HIV prevalence rates as high as 30% among pregnant women, pregnancy is a critical time for diagnosis, treatment and prevention of HIV transmission to children. The vast majority of infants who are HIV exposed now receive a PCR test within the first six weeks of their life. Results from a 2012/2013 survey that covered infants (4-8 weeks old) attending public health care clinics and community health centres for their 6-week immunisation, showed that the risk of Mother to Child Transmission (MTCT) of HIV was 2.6% nationally, for infants less than 8 weeks of age.

There has been a steady increase in early antenatal bookings but 46% of first antenatal visits still take place later than 20 weeks into pregnancy.

FIGURE 5: PERCENTAGE OF 1ST ANTENATAL VISITS WITHIN FIRST 20 WEEKS OF PREGNANCY



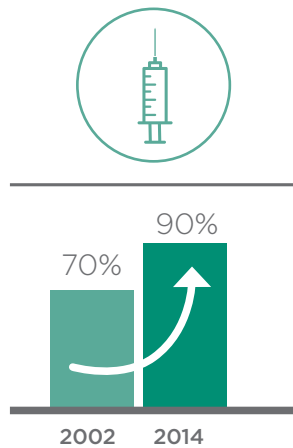
Source: DHIS 2010-2014

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 28 infant deaths per 1000 live births in 2014. The under-5 mortality rate is 39 per 1000. 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.³ The reduction became more gradual after 2011. These rates are robust estimates which adjust for bias, as the vital registration is incomplete.

Immunisation coverage is an indicator of how well the health system is functioning.

The proportion of children who are completely immunised by their first birthday has increased from under 70% in 2002 to 90% in 2014. It is a great achievement that the vast majority of babies are returning to clinics in their first year or are reached by mobile services, given that many children (21% of those under 6 years) live far from their nearest facility.



Proportion of children who are completely immunised by their first birthday has increased from under 70% in 2002 to 90% in 2014

Some districts have immunisation and HIV testing rates over 100%.

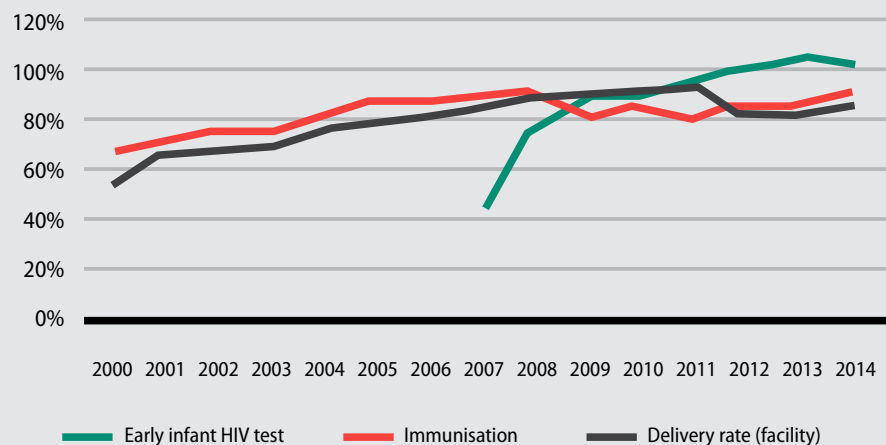
This is partly because children may be immunised in areas that are different from where they are counted in the population or because they are tested more than once. It has also been suggested that immunisation rates are over-estimated in the District Health Information System, where the rates tend to be higher than those recorded in comparable surveys.

There has been an increase in the proportion of deliveries conducted in health facilities and supervised by health personnel.

Nationally, the delivery rate, which is the percentage of deliveries carried out by health personnel in health facilities, increased from 66% in 2002 to 86% in 2014. This does not include deliveries in private hospitals. Data on deliveries in private institutions are not publicly available, making it difficult to construct a delivery rate that represents both public and private health institutions.

The highest facility delivery rates are in Gauteng and Limpopo provinces (97% and 91% respectively). The lowest rates are in the North West and Eastern Cape (75% and 77% respectively). KwaZulu-Natal has

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



Source: DHIS 2000-2014

³ Hall K, Nannan, N & Sambu, W. (2013) Child Health and Nutrition. In: Berry L, Biersteker L, Dawes A, Lake L & Smith C (eds) South African Child Gauge 2013. Cape Town: Children's Institute, University of Cape Town.

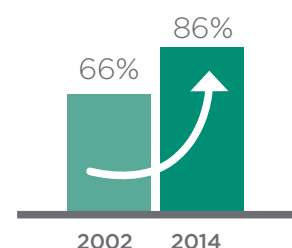
the largest population of infants in the country, but a facility delivery rate of 82%, which is below the national average.

Over a fifth of young children (1.3 million) live in households with poor access to clinics. The number is highest in the Eastern Cape, where 37% of young children live more than 30 minutes away from the nearest health facility.

Young children living in the largely urbanised areas, such as Gauteng and Western Cape provinces, 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, and is an important data gap.

Every visit by a caregiver to a health facility is an opportunity to improve access to the essential components of the package. With a well-integrated package of services, caregivers who attend clinics could receive information about adequate nutrition and child care, and encouragement to stimulate children.

Caregivers should also be referred to other assistance, like social grants, and to integrated psycho-social 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 children aged 0-2 are opportunities for young children to access critical preventative health services.



Nationally, the delivery rate, which is the percentage of deliveries carried out by health personnel in health facilities, increased from 66% in 2002 to 86% in 2014.

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	1 046 000	137 000	49 000	189 000	213 000	141 000	102 000	73 000	22 000	120 000	a
	Poor access to clinics Children < 6 living more than 30 mins from nearest health facility	1 322 000 21%	324 000 37%	55 000 19%	101 000 8%	337 000 26%	180 000 23%	115 000 22%	120 000 27%	33 000 24%	57 000 9%	a
	HIV prevalence in pregnant women Antenatal clients testing HIV+	30%	31%	30%	29%	40%	20%	38%	28%	18%	19%	b
Service access/delivery	Prenatal early booking First visit before 20 weeks, out of all antenatal first visits at public facility	54%	49%	59%	48%	57%	51%	57%	54%	58%	66%	c
	Antenatal HAART Antenatal clients on ART as % of eligible total	91%	92%	89%	87%	95%	93%	93%	90%	90%	83%	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
	Immunisation Children < 1 who complete the primary immunisation course	90%	81%	90%	108%	90%	82%	80%	82%	85%	91%	c
	Delivery rate in facility Percentage of deliveries occurring in health facilities, under trained personnel	86%	77%	88%	97%	82%	91%	81%	75%	88%	88%	c
Outcome	Early neonatal mortality Inpatient infant deaths within 7 days, per 1 000 live births	10.1	13.3	10.5	9.7	10.3	11.6	7.9	10.8	14.6	5.3	c
	Infant mortality rate Number of deaths under 1 year, per 1 000 live births in same year	29	Mortality rates not currently available at provincial level.									d



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 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. Maternal ill-health may also be affected by poor nutrition and, conversely, if a mother is depressed, she may not be able to adequately address the nutritional needs of herself or her child.

When children are chronically undernourished they don't grow as expected. This is called "stunting", a condition where the child is too short for their age. Stunting is the most prominent form of malnutrition in the country, with over a fifth of children under 5 years suffering from it. Usually stunting is associated with long-term poverty and prolonged exposure to infections. While the graphs shows that stunting rates have reduced substantially for the poorest 20% of children under 5, much more needs to be done to combat stunting.

Anaemia amongst pregnant women can result in low birth weight and increases 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 and chronic infections. Information on anaemia is lacking from some provinces, as the survey sample is too small to draw reliable estimates.

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 2014. 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. A 2012-13 survey of public health facilities that covered infants aged 4-8 weeks (irrespective of HIV status) found that 58% of all infants were exclusively breastfed, while 11% did not receive any 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.

Child hunger is a proxy for food insecurity and has decreased over time. While child hunger is based on subjective reporting, it allows for comparisons across provinces and over time. Between 2002 and 2014, reported child hunger reduced from

Stunting is the most prominent form of malnutrition in the country, with over a fifth of children under 5 years suffering from it.

29% to 13%. The Eastern Cape, Limpopo and Mpumalanga provinces saw the biggest improvements over the 12-year period, with child hunger rates reducing by over 20 percentage points in all three province. The biggest change was in the Eastern Cape, where child hunger rates reduced from 48% in 2002 to 13% in 2014. 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 can be under-nourished. And under-nourishment can lead to both stunting and wasting on the one hand, and obesity on the other hand (an increasing problem in South Africa). Future surveys should collect data on dietary intake in order to capture important information on both nutrition and hunger.

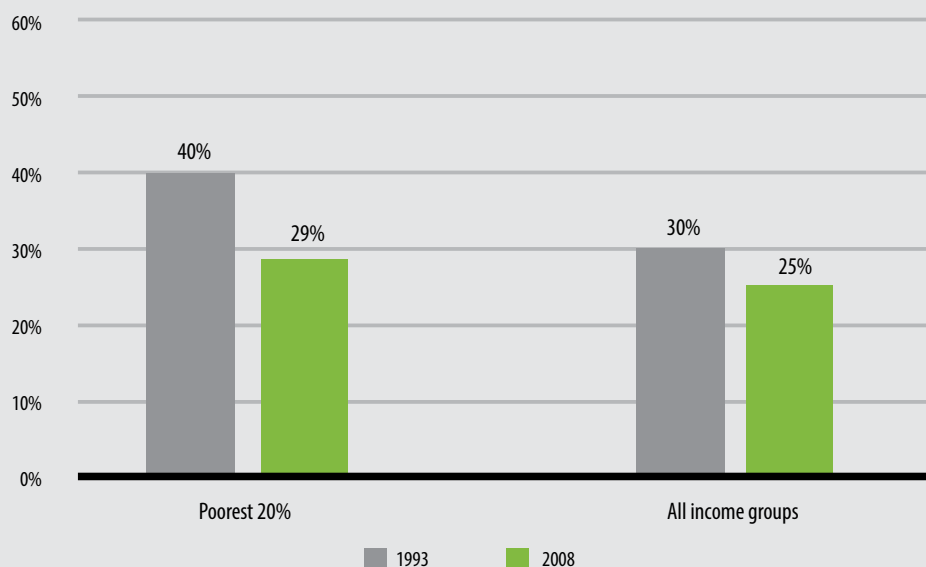
Children with vitamin A deficiency have increased risk of infection and are more prone to diseases. While vitamin A deficiency has decreased since 2005, over 40% of young children still suffer from lack of vitamin A. Vitamin A supplementation coverage rates have improved: in 2014, just over 50% of children aged 12-59 months

received a vitamin A dose at a public facility.

There are no available statistics on the vitamin A supplementation coverage among women of reproductive age.

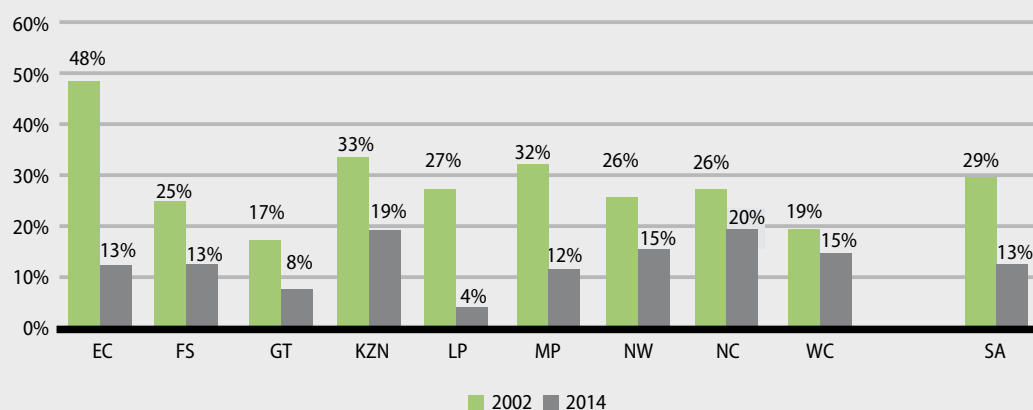
This is despite the fact that a considerable number of women continue to suffer from vitamin A deficiency. Statistics from a national survey show that 13% of women of reproductive age (16-35 years) suffered from vitamin A deficiency in 2012. Some provincial samples were too small to provide reliable estimates. 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 have 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.

FIGURE 7: STUNTING RATES AMONGST CHILDREN UNDER 5 YEARS



Source: PSLSD 1993 and NIDS Wave 1 2008 (SALDRU, University of Cape Town); Children's Institute analysis

FIGURE 8: REPORTED CHILD HUNGER RATES, 2002 & 2014



Source: GHS 2002 & 2004, analysis by Children's Institute

Some of the indicators, such as stunting rates amongst children in poor households, have been derived from relatively old data, while others, such as the quality of diet, have not been included at all, due to lack of data. Food and nutrition surveys are not carried out regularly, making it difficult to have a comprehensive up-to-date picture of the situation of child nutrition. The

South African National Health and Nutrition Survey (SANHANES) was conducted in 2012 and was expected to be a longitudinal survey. It has more in-depth data on health and nutrition, which could be used to update the statistics of some the indicators contained in this brief. The data have not yet been made publicly available, and the survey has not yet been repeated.

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
	Anaemia in women Women (16-35 yrs) below the WHO standard for iron-deficient	23%	20%	18%	19%	36%	*	30%	17%	*	16%	e
	Low birth weight Infants born in public facilities weighing below 2.5kg (2014)	13%	14%	13%	13%	12%	10%	11%	14%	19%	15%	c
	Child hunger Children in households where children suffer from hunger	13%	13%	13%	8%	19%	4%	12%	15%	20%	15%	a
Service access	Breastfeeding HIV-exposed infants 4-8 weeks exclusively breastfed	54%	47%	56%	58%	54%	53%	52%	62%	76%	42%	g
	Vitamin A coverage in children 12 - 59 months	52%	53%	59%	57%	55%	44%	50%	45%	52%	47%	c
Outcome	Vitamin A deficiency In children under 5	44%	Sample too small for analysis at provincial level									e
	Iron deficiency anaemia in children under 5	1.9%	Sample too small for analysis at provincial level									e
	Stunting in children under 5	22%	Sample too small for analysis at provincial level									e
	Wasting in children under 5	2.5%	Sample too small for analysis at provincial level									e
	Underweight in children under 5	5.5%	Sample too small for analysis at provincial level									e



Support for primary caregivers



Children need caregivers who are responsive and nurturing. Since many caregivers in South Africa face extreme conditions and stressors, caregivers require support, including clear information about parenting, as well as access to psycho-social services and material support, if they need them. Antenatal visits are a good place to start sharing information and supporting mothers.

The new national ECD policy recognises the value of supporting primary caregivers, and views parents and caregivers as central to the promotion of optimal early child development. It identifies parent support as an essential component of a 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 the antenatal period, 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, even though many older children in South Africa live separately from their parents (due to death, labour migration and other factors).

Support for mothers begins with antenatal care (ANC). Antenatal visits early in pregnancy are critical, as they can enable the early identification of any problems and suitable interventions and support can be offered at any early stage,

preventing complications in late pregnancy. The importance of maternal health care, support and early intervention is evident when we consider our rates of Foetal Alcohol Syndrome, the highest documented rate in the world: 41-46 per 1000 children in 2000, and 65-74 per 1000 children in 2005.⁴ Children born with Foetal Alcohol Spectrum Disorders (FASDs) are likely to demonstrate a variety of concentration and behavioural difficulties.⁵

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.

Women who attended public antenatal facilities in 2012 visited an average of three to four times during pregnancy. However, only 54% of women who accessed antenatal facilities made their first visit before 20 weeks of pregnancy. This is much lower than the Department of Health's target of 75% for 2016/2017.

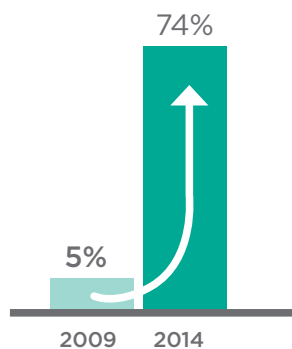
Pregnant women should be encouraged to attend antenatal facilities as early as

Non-attendance, late attendance and infrequent attendance at antenatal care is among the top 5 avoidable factors in perinatal deaths, and among the most common underlying causes of patient related maternal mortality.

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 antenatal care is among the top 5 avoidable factors in perinatal deaths,⁶ and amongst the most common underlying causes of patient related maternal mortality.⁷

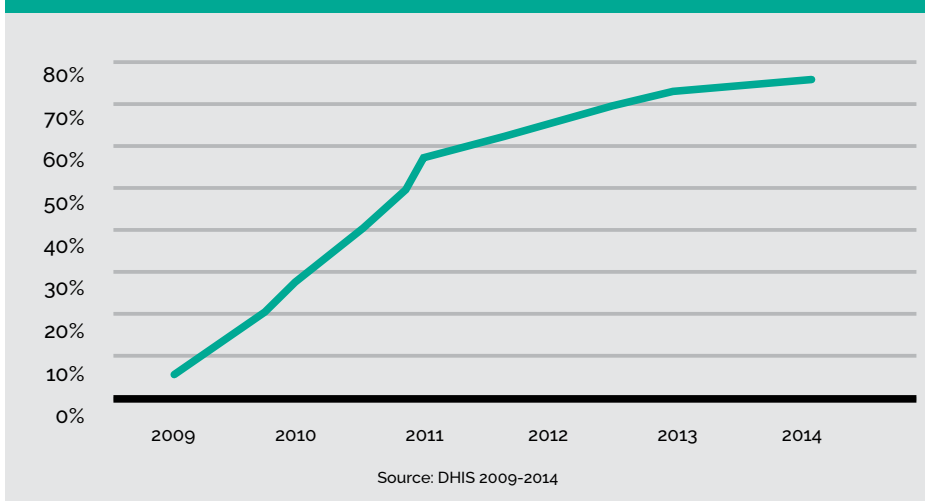
The provision of infant feeding education and support to mothers is crucial to the child's health. Available statistics from a 2012-13 survey on infants aged 4-8 weeks point to improvements in infant feeding education amongst HIV-positive mothers. In the majority of the provinces, more

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. The postnatal period is an opportunity for care 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.



In 2009, only 5% of women were recorded as having received follow-up care after 6 days. In 2014 this had increased to 74%.

FIGURE 9: POSTNATAL FOLLOW-UPS – NATIONAL TREND



There have been substantial improvements in the coverage of post-natal care.

Women who give birth in public health facilities are meant to have a check-up after six hours, and should visit a health care facility for further follow-up care after six days and again after six weeks, during which checks for infection and other complications are performed. In 2009, only 5% of women were recorded as

having received follow-up care after six days. In 2014 this had increased to 74%. This average masks large provincial variability, with 2014 rates as low as 57% and 58% in the Northern Cape and Eastern Cape, respectively.

There are no recent reliable national statistics on maternal mental health.

While there have been several studies that

⁴ May, P.A., Brooke, L., Gossage, J.P., Croxford, J., Adnams, C., Jones, K.L., Robinson, L. & Viljoen, D. (2000) Epidemiology of fetal alcohol syndrome in a South African community in the Western Cape Province. *American Journal of Public Health*, 90(12), 1905-1912; Viljoen, D.L., Gossage, J.P., Brooke, L., Adnams, C.M., Jones, K.L., Robinson, L.K., Hoyme, H.E., Snell, C., Khaole, N.C., Kodituwakku, P., Asante, K.O., Findlay, R., Quinton, B., Marais, A.S., Kalberg, W.O. & May, P.A. (2005) Fetal alcohol syndrome epidemiology in a South African community: A second study of a very high prevalence area. *Journal of Studies on Alcohol and Drugs*, 66(5): 593-604.

⁵ Viljoen et al. (2005) Ibid.

⁶ Pattinson, R.C. (2009) *Saving babies 2006-2007: Sixth perinatal care survey of South Africa*. Pretoria: Tshepesa Press.

⁷ Department of Health (2007) *Saving mothers: Third report on confidential inquiries into maternal deaths in South Africa, 2002-04*. Pretoria: National Department of Health.

A 2011 study in urban informal settlements of Cape Town found that 39% of women were depressed during pregnancy. Another study in the same year that covered a rural area in South Africa found 47% of women were depressed during pregnancy. Both antenatal and postnatal depression and anxiety are huge problems, affecting an estimated one-third of mothers.

have looked at antenatal and postnatal depression, they have been restricted to specific locations. A 2011 study in urban informal settlements of Cape Town found that 39% of women were depressed during pregnancy.⁸ Another study in the same year that covered a rural area in South Africa found 47% of women were depressed during pregnancy.⁹

Both antenatal and postnatal depression and anxiety are huge problems, affecting an estimated one-third of mothers. They are often not identified or treated because maternal mental health services are currently not part of the suite offered to

mothers in the public health 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 related to young children's optimal development. Specialist parental support of vulnerable caregivers is especially valuable, 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 such services.

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

	Indicator	SA	EC	FS	GT	KZN	LP	MP	NW	NC	WC	source
Pop	Maternal care Children < 6 who live with their biological mother	84%	72%	83%	93%	77%	83%	84%	84%	88%	95%	a
	Breastfeeding education HIV+ mothers who remember receiving information during antenatal visits	94%	94%	85%	97%	97%	88%	95%	92%	95%	95%	g
Service access/delivery	Antenatal visits Average number of antenatal visits during pregnancy	4	3	4	4	5	4	4	4	5	1	c
	Postnatal follow-up Women birthing in public facilities who received follow-up care six days after birth	74%	58%	81%	86%	66%	72%	60%	75%	57%	101%	c

⁸ Hartley, M., Tomlinson, M., Greco, E., Comulada, W. S., Stewart, J., le Roux, I., Rotheram-Borus, M. J. (2011) Depressed mood in pregnancy: Prevalence and correlates in two Cape Town peri-urban settlements. *Reproductive Health*, 8, 9.

⁹ Rochat, T. J., Tomlinson, M., Barnighausen, T., Newell, M.-L., & Stein, A. (2011) The prevalence and clinical presentation of antenatal depression in rural South Africa. *Journal of Affective Disorders*, 135(1-3), 362–373.



Social services and income support



Early registration of births is important because a birth certificate is the gateway to other services and benefits, such as the Child Support Grant (CSG). The CSG is the main grant for children and offers income support for children living in poverty.

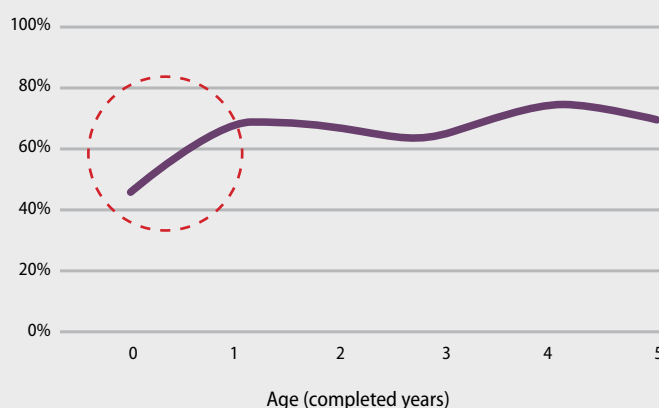
Social assistance is a way of redistributing resources to the poor through grants. Social grants are widely regarded as the most effective poverty alleviation programme since democracy because of their positive impact and wide reach. Social assistance programmes have expanded from covering just 2.7 million people in 1994 to more than 16 million in 2014. South Africa now spends close to 3.1% of GDP on social grants.

The CSG has had the highest growth of all social grants in South Africa. It was introduced for poor children under 7 years in 1998 and then gradually extended to all children below the age of 18 by 2012. It has expanded from just under 22 000 child beneficiaries in 1998 to nearly 12 million children in 2015. 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 child poverty.

Figure 10 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 month 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 lowest for infants under a year.

FIGURE 10: CHILD SUPPORT GRANT UPTAKE



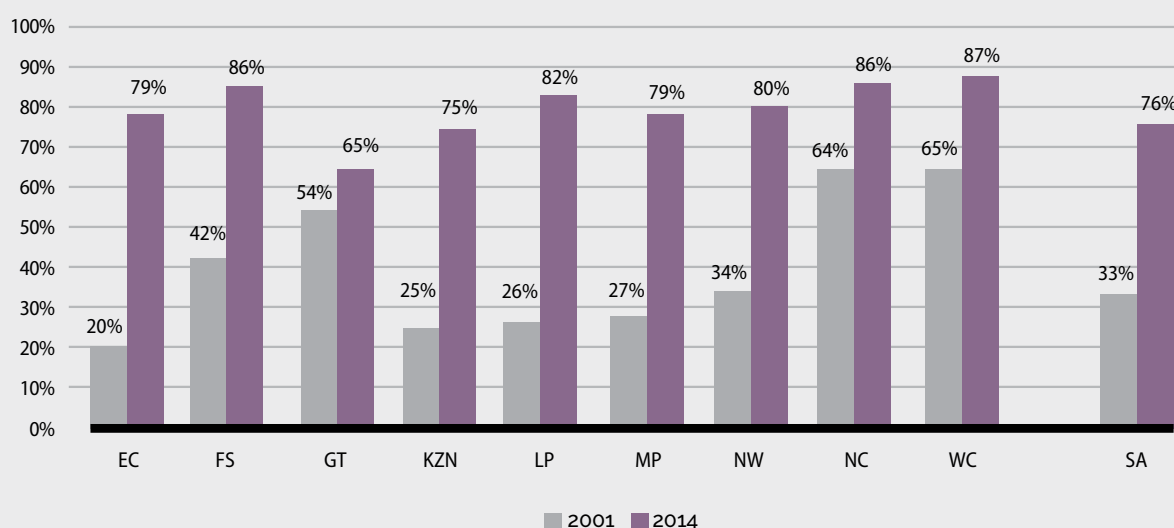
Source: SOCPEN data July 2015 by special request; GHS 2014

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 2011, 49% of eligible infants in the Western Cape and 45% in Gauteng were not receiving the CSG. This "error of exclusion" is of concern because it tends to be the most vulnerable children who do not access the grant.

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 should access these benefits by 2019. This requires finding ways to resolve a few million exclusions. The easiest way to address exclusions for children is to ensure that they are enrolled on the grant from birth.

FIGURE 11: BIRTH REGISTRATION, BY PROVINCE, 2001 & 2014



Recorded live births 2001 & 2014 (Statistics South Africa), analysis by Children's Institute

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 in the first year. Of all the births registered in 2014, 76% were for births in the preceding year, while 24% were for earlier births. The provinces with the largest increases in the birth registration rates between 2001 and 2014 include Eastern Cape (20% in 2001 to 79% in 2014), Limpopo (26% in 2001 to 82% in 2014) and KwaZulu-Natal (25% in 2001 to 75% in 2014). These rates relate to "current" live births, which refer to the births registered in the year in which they occurred.

There is an absence of reliable data on the number of children who need social services, or on the extent of services delivered.

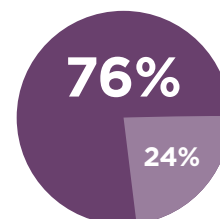
Services for young children defined in the Children's Act include partial care (crèches and centres) and ECD programmes; prevention and early intervention services, such as child and family counselling, parenting skills programmes, support for young mothers; protection services for children who have been abused, abandoned or neglected; and provision of alternative care, including foster care, adoption and child and youth 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 current under-reporting, a more appropriate target might be one that encourages greater reporting of child abuse and improvements in prevention services and in services that respond to reported incidents.

The most common crimes reported against children involve sexual abuse. Crime statistics from 2013/2014 showed that 44% of sexual offence victims (22 781) were children under the age of 18 years.¹⁰ Population-based studies have also found very high levels of physical abuse and physical punishment.¹¹ Young children

are at more risk of child abuse and neglect because they are dependent on care givers 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 include emotional abuse and abandonment. The most severe consequence of child abuse is infanticide, which is not an uncommon experience in South Africa.¹²

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



Of all the births registered in 2014, 76% were for births in the preceding year

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 (2014) Birth registrations that are for current year births (2014)	1 161 159	132 712	56 062	303 660	235 692	137 162	93 212	62 357	31 210	106 599	h
		76%	79%	86%	65%	75%	82%	79%	80%	86%	87%	
	Access to Child Support Grant Children < 6 receiving the CSG	4 289 650	655 145	237 167	629 892	975 918	667 308	372 660	289 946	108 236	344 378	i
	CSG uptake in infants Proportion of eligible children < 1 year receiving CSG		61%	69%	55%	67%	71%	51%	57%	66%	51%	j

¹⁰ South African Police Services (2014) Police Crime Statistics. Pretoria: SAPS.

¹¹ Matthews, S. & Benvenuti, P. (2014) Violence against children in South Africa: Developing a prevention agenda. In: Matthews, S., Jamieson, L., Lake, L. & Smith, C. (eds). South African Child Gauge 2014. Cape Town: Children's Institute, University of Cape Town.

¹² Mathews, S., Abrahams, N., Jewkes, R., Martin, L. & Lombard, C. (2013) The epidemiology of child homicides in South Africa. Bulletin of the World Health Organization, 91:562-568.



Stimulation for early learning



Mental stimulation in the early years is important for children's cognitive, social and emotional development. It enhances children's ability to benefit from formal education later on. While many children under 2 years are cared for at home, group learning environments (community or centre-based) may be more appropriate for children from the age of 3. Channels to promote early learning include home visiting programmes, community playgroups and centre-based programmes (such as crèches or pre-schools).

The provision of opportunities for early learning is an essential component of the national ECD policy's comprehensive package of ECD services, and is prioritised for all children from birth until they enter formal school.

programmes also provide an opportunity to link children to other services that are critical at this life stage, including sight and hearing tests, immunisation, deworming and developmental screening to ensure early identification of learning difficulties.

There is clear evidence that children who attend good quality programmes are more school ready when they enter the formal education system. Early learning

Access to early learning opportunities for children in South Africa is unequal across income levels. Children from wealthier households have greater access

FIGURE 12: CHILDREN ATTENDING ANY OUT-OF-HOME EARLY LEARNING PROGRAMME (CRÈCHE / ECD CENTRE / SCHOOL OR OTHER LEARNING INSTITUTION), BY INCOME QUINTILE

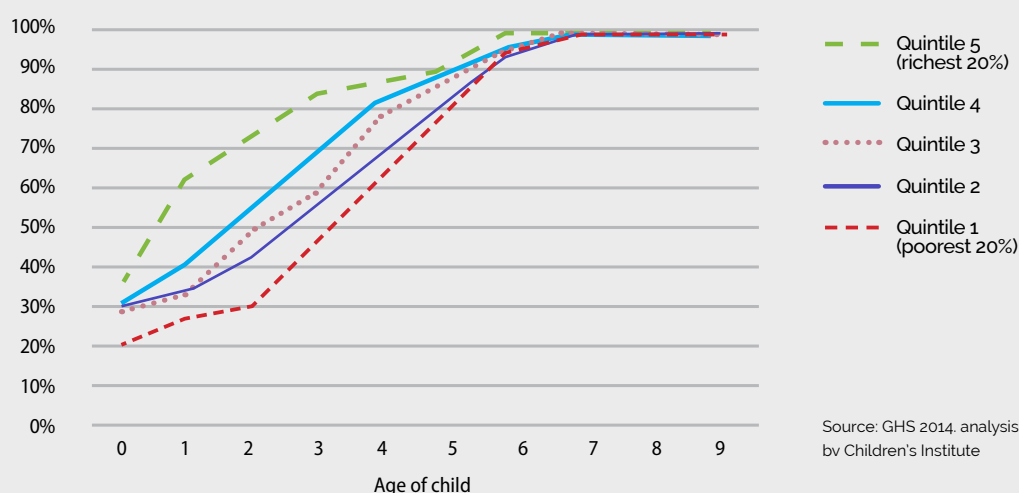
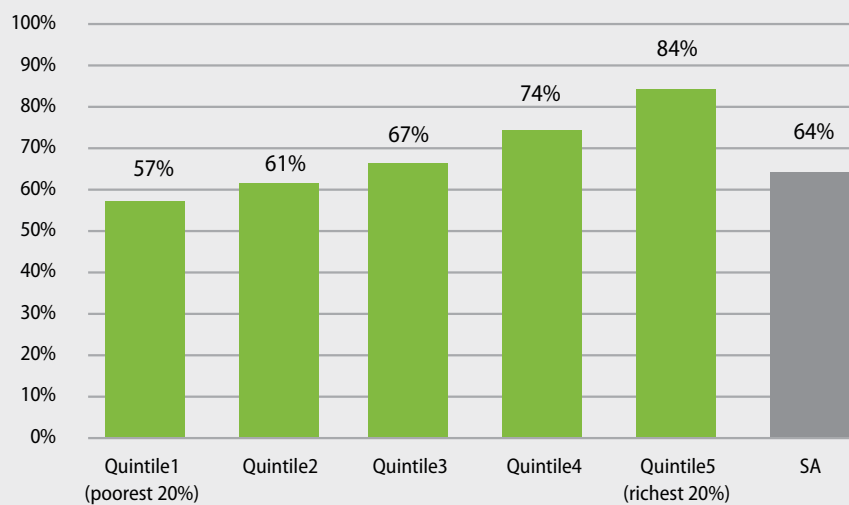


FIGURE 13: EARLY LEARNING PROGRAMME ENROLMENT ACROSS INCOME QUINTILES (3-5 YEAR OLDS) IN 2014



Source: GHS 2014, analysis by Children's Institute.

While 84% of 3-5 year-old children in the richest 20% of households attend a group learning programme, only 57% in the poorest 20% of households are enrolled in a programme.

than poorer children to early stimulation through group programmes, from earlier on in their lives. This inequality in service access between income groups only disappears at the point where education becomes widely available, free and compulsory, i.e. in Grade 1, at which point poorer children enter school with a distinct disadvantage, having not had the benefits of quality early learning programmes.

Overall, enrolment in early learning programmes has risen dramatically: of the 3.2 million children aged 3-5 years, 64% are enrolled in a group programme (this includes playgroups, community based programmes, nursery school and Grade R, but does not include children in the care of day mothers, nannies, gogos and other individual caregivers).¹³ While 84% of 3-5 year-old children in the richest 20% of households attend a group learning programme, only 57% in the poorest 20% of households are enrolled in a programme. There are clear income inequalities in access to early learning programmes, but these have reduced since 2002, when 42% of the richest quintile and only 17% of the poorest quintile were reported to be attending an early learning programme.

A million children aged 3-5 still do not attend group learning programmes. These children (most of whom are in Quintile 1-3) are missing out on a critical window of opportunity for promoting healthy development, at a time when the brain is most receptive to learning and when neural connections are being laid down for life.

Prior to 2009, enrolment in early learning programmes is likely to have been under-reported, as the General Household Survey asked a general question on attendance at educational institutions. This changed in 2009 when specific questions on ECD facilities were introduced for children aged 0-4 years. This explains the sudden jump in 2009 in Figure 14.

There has been a slight increase in attendance at group learning programmes reported for children under 2 years. It is not entirely clear that group learning environments are better than home care during these early years. The service gap for 0-2 years olds can be better addressed by strengthening models such as home visiting programmes and early learning playgroups targeting young children

¹³ Derived from the General Household Survey.

and their caregivers, as well as using the opportunities presented by the improvements we have seen in the uptake of health services, to engage parents of young children on the importance of early stimulation. The critical factor in all cases is the quality of care and stimulation. There are no reliable data that enable national monitoring of the quality of early learning programmes for children. A proxy measure for the extent to which early learning programmes are preparing children for school is the standardised tests in numeracy and literacy that are administered through public schools.

The Annual National Assessments (ANAs) indicate that many children are not able to perform at the expected level by the end of the foundation phase. Nationally, only 57% of Grade 3 learners achieved the 50% benchmark in language, and 56% obtained 50% or more in mathematics. These ANA results also reveal striking inequalities across the school quintiles, which are based on the socio-economic status of the surrounding population.

The Medium Term Strategic Framework (MTSF) target is that 75% of learners should achieve above 50% in both literacy and mathematics in Grade 3 by 2019.

Focused attention is needed to drive quality improvements in early learning – particularly for children living in quintiles 1, 2 and 3 – in order to achieve this target. Drivers for improved quality may include standardised assessments of early learning programmes with feedback loops; innovating the use of technology to enhance early learning practices; quality incentives through alternative financing mechanisms; and improvements in the planning, content and administration of ECD practitioner learnerships for both centre- and non-centre based programmes.

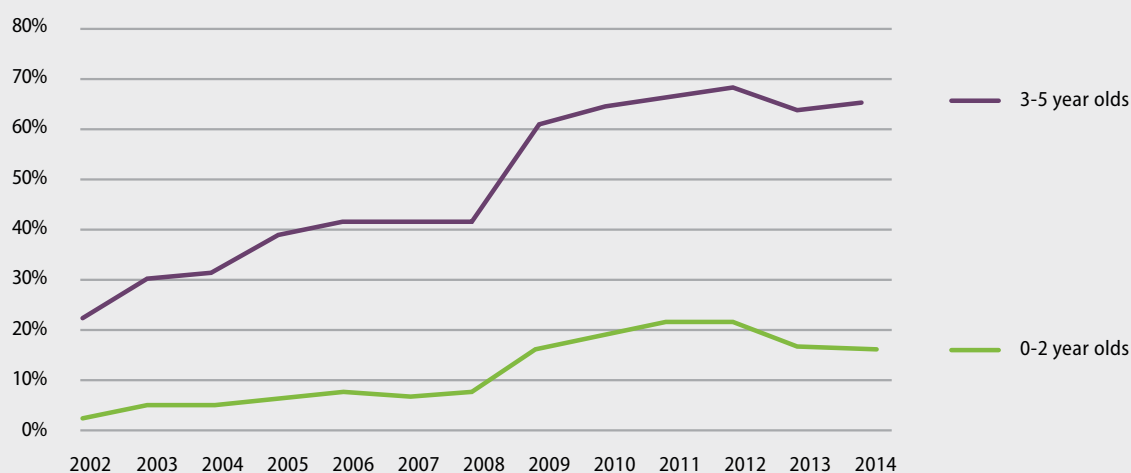
Included in the essential package is an emphasis on the importance of access to play and learning materials, for example through the establishment of community toy and book libraries. There are no reliable national data to do an assessment of children's access to these types of resources.



A million children aged 3-5 still do not attend group learning programmes.



FIGURE 14: EARLY LEARNING ENROLMENT (%) - NATIONAL TREND



Source: GHS 2014, analysis by Children's Institute

Another proxy for quality of early learning services is the extent to which ECD centres meet the required norms and standards outlined in the Children's Act.

In 2013/14, the national Department of Social Development commissioned an audit of ECD centres. Of the 17 828 sites included in the study, only 45% (8 032) were classified as having full registration (i.e. meeting the norms and standards) and 38% of these fully registered sites were recorded as requiring urgent maintenance, with rates as high as 56% in the Eastern Cape and KwaZulu-Natal. The Department of Social Development Annual Performance Plan target for ECD centre registration calls for 90% of all ECD centres in South Africa to

be fully registered and compliant with the national norms and standards by 2018. Treasury's introduction of a new conditional grant for ECD centre enhancements from 2017/18 provides an opportunity for testing interventions that bring us closer to this ambitious target.

Financing of early learning programmes has lagged well behind that of primary and secondary education. Investments in primary and secondary education will not see the intended returns if we do not ensure that young children enter school with the foundational skills needed to learn. Progressive realisation of quality early learning opportunities for all children in South Africa needs to be a top priority.

TABLE 6: EARLY LEARNING INDICATORS, BY PROVINCE

	Indicator	SA	EC	FS	GT	KZN	LP	MP	NW	NC	WC	source
Population	Children aged 0-2	3 110 000	435 000	143 000	598 000	636 000	401 000	281 000	222 000	66 000	327 000	a
	Children aged 3-5	3 200 000	446 000	153 000	647 000	684 000	383 000	247 000	223 000	75 000	341 000	a
Service access/delivery	Early learning enrolment Percentage of children 0-2 years old reported to attend an early learning group programme	16%	15%	25%	23%	8%	17%	11%	13%	10%	20%	a
	Percentage of children 3-5 years old reported to attend an early learning group programme	64%	71%	76%	73%	52%	72%	61%	58%	59%	59%	a
	No access to early learning programme Number of children 3-5 not attending any early learning group programme	1 138 000	131 000	37 000	173 000	331 000	108 000	96 000	94 000	31 000	138 000	a
Outcome	Numeracy Gr.3 learners who achieved more than 50% in maths	56%	52%	65%	74%	56%	34%	55%	39%	49%	68%	k
	Literacy Gr.3 learners who achieved more than 50% in language	57%	51%	65%	71%	57%	43%	57%	51%	45%	64%	k

Important data gaps

Many elements of the essential package cannot easily be measured through existing data. These include:

- The number of women who make at least four antenatal visits, beginning in the first trimester.
- Provision of support, information and advice to pregnant women and young mothers, and information on the quality and content of service.
- Mental health screening during pregnancy and after birth, on-site management of primary level mental health problems and referral for treatment.
- Developmental screening for infants to identify disabilities or developmental delays at 6 weeks, 9 and 12 months.
- Deworming for children aged 1-5 years.
- Access to subsidised childcare services for children whose caregivers cannot care for them during the day.
- Caregivers and young children who receive home visiting interventions to provide (and promote) early learning stimulation.
- Differentiated access to home-based and centre-based learning programmes for children under 6 years, and information on the quality of the programmes.
- Access to community learning resources for ECD (specifically toy libraries and book libraries).
- Prevalence and incidence of child abuse and neglect. This includes physical abuse (including corporal punishment), sexual abuse and non-circumstantial neglect.
- The delivery of responsive child protection services and psychosocial support for abused or neglected children.
- The number and proportion of children identified in need of care and protection brought before the court within 90 days (Department of Social Development, Department of Justice & Constitutional Development Children's Courts).
- Quality of service provision at health facilities.

Much of this information is hard to collect through standard questions in household surveys. It would be useful to address current data gaps by establishing local-level information systems that record services delivered and the numbers of mothers and children receiving services.

A population-based approach enables us to track progress toward reaching all children with the services they need.

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.

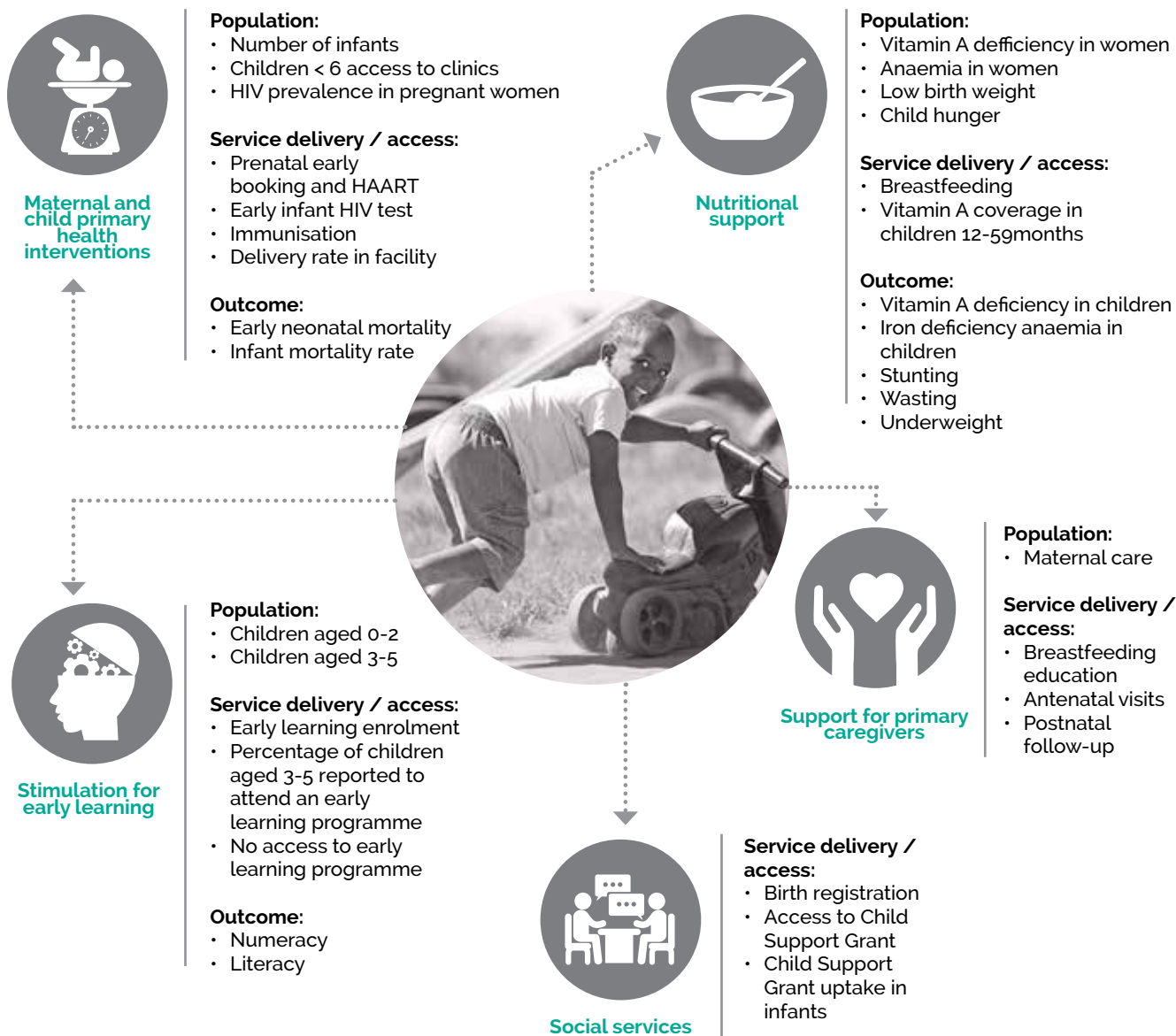
It would be useful to address current data gaps by establishing local-level information systems that record services delivered and the numbers of mothers and children receiving services.

Notes on the data and data sources

The data provided in this brief 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. Data analysed by Children's Institute, University of Cape Town. (also see www.childrencount.ci.org.za for more indicators)	2014	Annual	Province
b	Department of Health: National HIV and Syphilis Prevalence Survey (http://www.health.gov.za/index.php/2014-03-17-09-09-38/reports/category/176-reports-2015#)	2013	Annual	Province
c	Department of Health: District Health Information System. Published by Health Systems Trust (http://www.hst.org.za/content/health-indicators)	2014	Annual	District
d	Medical Research Council: Rapid Mortality Surveillance Report 2014 (http://www.mrc.ac.za/bod/RapidMortalitySurveillanceReport2014.pdf)	2013	-	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 provincial)
f	SALDRU: National Income Dynamics Study (NIDS) – Wave 1, 2008. Data analysed by Children's Institute, University of Cape Town (see http://www.nids.uct.ac.za/ for more about NIDS)	2008	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/P03052014.pdf)	2014	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)	2015	-	Province
j	SASSA & UNICEF (2013). Preventing exclusion from the Child Support Grant: A study of exclusion error in accessing CSG benefits (http://www.unicef.org/southafrica/SAF_csgexclusion.pdf)	2011	-	Province
k	Department of Basic Education: Annual National Assessments (http://www.education.gov.za/Examinations/AnnualNationalAssessmentsANA/tabid/569/Default.aspx)	2014	Annual	Province

Key indicators for early childhood development in South Africa



Contributors

Colin Almeleh is Programmes Director at Ilifa Labantwana, a donor collaborative that works with the South African government and other stakeholders to reform the systems necessary to enable the delivery of early childhood development services at scale. 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.

Lizette Berry is a senior researcher at the Children's Institute, University of Cape Town (UCT). She holds a Master's of Arts in social policy and management. She has 15 years' experience in child policy research and has a background in social work. Berry has an interest in the care and development of children and recently contributed to a SADC education policy framework that 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 and is the lead editor of the South African Child Gauge 2013.

Andrew (Andy) Dawes is a clinical and applied developmental psychologist and an Associate Professor Emeritus in the Department of Psychology at UCT. He is also a Research Associ-

ate with the Department for International Development at the University of Oxford. In 2000, he was co-founder of the Children's Institute and was Research Director in Child Youth and Family Development programme of the HSRC from 2003-2008. His expertise includes development indicators for measuring children's wellbeing, prevention of child maltreatment and violence to young children, and evaluations of early childhood interventions. Currently he is involved in three major projects: (1) an evaluation of home visiting interventions designed to improve child health, psycho-social and early learning outcomes in the first 1 000 days; (2) the development of a culturally sensitive ELDS-based instrument for assessing the outcomes of early learning programmes on the development on children entering Grade R, and (3) research in collaboration with Young Lives to support the government of Ethiopia in their roll out of programmes to improve early learning outcomes prior to Grade 1.

Sonja Giese is the Executive Director of Innovation Edge, the first social innovation fund dedicated to the promotion of early learning in South Africa, and Executive Director of Ilifa Labantwana, a donor collaborative that works with the government to reform the systems necessary to enable the delivery of early childhood development services at scale in the most marginalised 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 expe-

rience with policy reform. Prior to this, she spent nine years consulting on a range of child-rights issues and promoting the development of systems to enable service delivery at scale. Giese has a BSc and Honours degree from UCT.

Katharine Hall is a senior researcher at the Children's Institute, a policy research unit at UCT. 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 large national household survey data set to provide child-centred statistics on a variety of indicators related to child poverty, development and well-being. Her work has examined the integration of poverty alleviation programmes, and evaluated targeting mechanisms, particularly in relation to social assistance. She has worked extensively on household form, constructs of "the family" 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.

Solange Rosa is a consultant for Ilifa Labantwana. She worked for the Western Cape government for 10 years as a Senior Policy Analyst and Chief Director of the Policy and Strategy Unit, responsible for policy analysis, research, policy and strategy development and planning. She was responsible for the integrated development of the Provincial Growth and Development Strategy, OneCape 2040, the Youth Development Strategy, the Early Childhood Development Strategie-

gy, the five-year Provincial Strategic Plans, among other provincial plans, policies and strategies. Prior to that she was a Senior Legal Researcher at the Children's Institute and the Advocacy Coordinator for the Alliance for Children's Entitlement to Social Security. She has a Master's degree in Law from the UCT, and is completing a PhD at the University of Stellenbosch.

Winnie Sambu is a researcher at the Children's Institute at UCT where her current focus is on Children Count – an ongoing data and advocacy project, which monitors the wellbeing of children in South Africa. Her research interests include food and nutrition security, child nutritional outcomes, poverty & inequality, living conditions and urban environments. She has a Master's of Economics degree from the University of the Western Cape and a Master of Arts (Development Management) degree from Ruhr-Universität Bochum.

Zanele Twala is the Director/ Sector Expert Early Childhood Development at the Presidency, Department of Planning, Monitoring and Evaluation (DPME). She was previously the Executive Director of Bridge Innovation in Learning and also held the position of Country Director of ActionAid International South Africa for five years. She holds a B.Ed (Honours) Degree from the University of Wolverhampton, England, a Masters Degree in Education (International Management and Policy in Education, Education Management) from the University of Birmingham, England and also a Certificate in Education Policy Analysis from Harvard University, USA.

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