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DEPARTMENT: HOME AFFAIRS

Report on the Implementation Evaluation of the Birth Registration Programme

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Glossary

ACRWC	African Charter on the Rights and Welfare if the Child
BDR	Births and Deaths Registration
COGTA	Cooperative Governance and Traditional Affairs
CSG	Child support grant
DBE	Department of Basic Education
DDG	Deputy Director General
DMO	District Management Officials
DOH	Department of Health
DOJ	Department of Justice
DPME	Department of Planning, Monitoring and Evaluation
DPW	Department of Public Works
DSD	Department of Social Development
ECD	Early childhood development
ERB	Early registration of birth
FCO	Frontline clerk officials
HCF	Health care facilities
HSRC	Human Sciences Research Council
ICT	Information and communication technology
ID	Identity document
IP	Intellectual property
KII	Key informant interviews
MOU	Memorandum of Understanding
NGO	Non-governmental organisations
NPIS	National Patient Information System
NPO	Non-profit organisations
NPR	National Population Register
OVC	Orphans and vulnerable children

OVCY	Orphans, Vulnerable Children and Youth
PoB	Proof of birth
SADC	Southern Africa Development Community
SASSA	South African Social Support Agency
SLA	Service level agreements
StatsSA	Statistics South Africa
TBVC	Transkei, Bophuthatswana, Venda and Ciskei
TOR	Terms of Reference
UNCRC	United Nations Convention on the Rights of the Child
UNICEF	United Nations Children's Fund

Executive summary

1. Introduction

Genesis Analytics ("Genesis") was contracted by the Department of Planning, Monitoring and Evaluation (DPME) in September 2016 to conduct the evaluation of birth registration in South Africa. The purpose of this evaluation is to assess why births are not registered within 30 days. Recommendations have been developed to improve birth registration.

2. Methodology

The evaluation approach was informed by three pillars namely; 1) the evaluation context and systems map; 2) the theory of change; and 3) the use of the OECD DAC criteria. The evaluation design process included the development of an analysis framework, which informed the development of data collection instruments. The evaluation team prepared for fieldwork through a rigorous training workshop based on a fieldwork protocol. The fieldwork process was piloted and pilot findings were used to improve the fieldwork process.

Data collection methods for the evaluation included literature and document review, review and analysis of the Department of Home Affairs' (DHAs') Management Information System (MIS) data, key informant interviews (KIIs) with identified national and provincial stakeholders, and site visits. The site visits included interviews with parents and guardians (collectively 'clients') at DHA offices and healthcare facilities (HCFs), as well as site observations completed by the evaluation team. Over 200 individuals were interviewed during this evaluation.

3. Background to birth registration

3.1 The importance of birth registration

The importance of birth registration is reiterated and reinforced through the United Nation's (UN's) Convention on the Rights of the Child (CRC), which states that "The child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and as far as possible, the right to know and be cared for by his or her parents." (Article 7 of the 1989 UNCRC). This convention not only aims to enshrine the rights of the child but also seeks to validate the importance thereof to encourage global, universal registration.

3.2 Birth registration in South Africa

Section 28(a) of the South African Constitution (Republic of South Africa, 1996) states that: "Every child has the right to a name and a nationality from birth". Birth registration is fundamental to the efficient determination and safe-guarding of the identity and status of all born in South Africa. The birth certificate ensures access to vital government services and the full benefits of South African citizenship. The birth registration process facilitates an accurate National Population Register (NPR), towards evidence-based policy-making and improved service delivery.

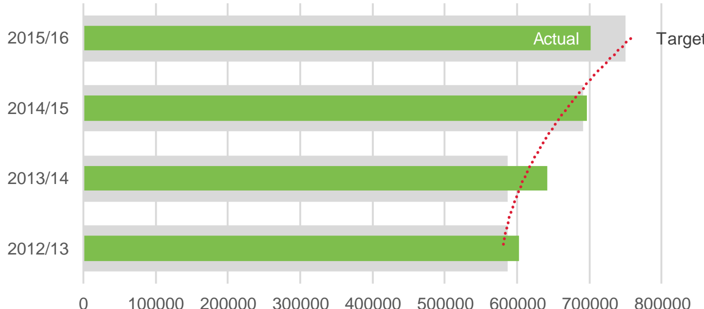
4. Findings

4.1 Promotion of the strategic vision

The overarching strategic vision is to register births as soon as they occur, thereby facilitating the early registration of births (ERBs), in other words, registration within 30 days of the birth. This vision is actualised through the connected hospital footprint programme and is **appropriate to birth registration clients and the objectives of the birth registration programme.** Two findings reinforce this conclusion:

- **86.6% of births in South Africa occur in HCFs** (Statistics South Africa, 2015), so birth registration through the connected hospital footprint programme provides the most opportune time and place.
- Registration at HCFs is shown to be the most accessible and convenient option for clients, ensuring that birth registration is timely and driving an upward trend in birth registration, as indicated in the figure that follows.

Figure 1:Total number of births registered between 2012/13-2015/16



The primary mechanism which governs this strategic vision is the Memorandum of Understanding (MOU) between DHA and Department of Health (DOH). However, this MOU is not sufficiently detailed to effectively govern implementation of the strategic vision. **The MOU leaves ambiguity around the birth registration process itself, the stakeholders responsible for various tasks therein and lines of accountability.** This was corroborated through the interview process, as illustrated in the quote below. This creates room for inconsistent interpretation, and ultimately, contributing to variation in the effectiveness of implementing the strategic vision.

"All the [applicable] departments must start working together towards a common goal (DSD, DOH, DHA, Health, South African Social Security Agency (SASSA) etc). These departments should stop working in isolation."

Official, Key informant, DOH National

There are host of pervasive social, cultural and economic factors that persist that influence a client's ability to register within 30 days after birth, irrespective of their willingness to do so. These factors are described in the table that follows.

Table 1: Factors influencing birth registration

Social factors	ID unavailability, Challenges arising from low literacy levels, Requirements for fathers' presence, DHA perceptions around negligence of parents, Incorrect informal messaging around birth registration requirements
Cultural factors	Diverse practices for naming babies, Parents' different religious affiliations, Practices to keep babies indoors to guard against 'evil spirits'
Economic factors	Transport costs

Due to these factors, while the focus on ERB has high strategic value, **the need for late registration of births (LRB) is expected to be perpetual** and, therefore, the effectiveness of LRB should not be neglected.

4.2 Implementation of the strategic vision

To affect this strategic vision, the birth registration programme has implemented a number of initiatives. However, the success of these initiatives has been varied.

The hospital footprint initiative is a notable success of the programme. However, this success is limited by gaps in the DHA-DOH MOU and subsequent ambiguity around the respective roles of DHA and DOH. The nature of the collaboration between DOH and DHA varies considerably, between extremely supportive of birth registration to unsupportive. This was reiterated through the evaluation team's on-site observations. The confusion arising from the MOU also leads to poor management of human resources, particularly unanticipated absenteeism and resultant unscheduled closure of DHA posts at HCFs.

DHA's awareness raising initiatives have had limited success. Of the parents we interviewed, **59% knew about the 30-day ERB requirement**. Principally, success is restricted by two factors: 1)

Incorrect or confusing messaging regarding the process and requirements for birth registration from Frontline clerk officials (FCOs) and HCF staff; and, 2) the inconsistent display of informational posters across DHA offices and HCFs and the inappropriate targeting of these posters.
34.71% of the South African population lives in rural areas (World Bank, 2017) which equates to over 19 million people. Outreach initiatives, including the operationalisation of mobile units, have facilitated increased access to birth registration facilities. However, many of the mobile units have not been adequately maintained, and have not continued their focus on ERB, for example focusing rather on Smart Identity Documents (IDs), which has limited the potential success of such outreach initiatives. Additionally, many units have been 'modernised', which refers to mobile units that were upgraded to provide services like issuance of smart IDs.

"We did have a mobile unit, but it has been taken to be 'modernised'."

DHA officer in Eastern Cape (DHA office)

Based on feedback received during interviews at DHA offices and HCFs, training initiatives have been rolled out to DOH and DHA officials (generally led by DHA officials) outlining the intent of the relationship between DHA and DOH and the process to be followed to register births at HCFs. However, these have been inconsistently and infrequently implemented and have therefore had **limited impact on empowering officials to drive the ERB process**.
There are successful examples of collaboration between the DHA and other state departments. However, such examples were implemented on an ad-hoc basis as they are not part of a formal policy agenda; thus, **limiting the potential of such collaboration**.
The success of each of the above-mentioned initiatives is demonstrated by this evaluation to have limited reach. A woman is only part of the ERB programme's captive audience while she is pregnant and just after giving birth. **The evaluation found that the ERB initiatives are not continuously implemented, thus limiting an individual mother's exposure to the initiatives while she is a 'captive audience member'.**

4.3 Operability of birth registration system

This evaluation finds that the best option to register births is through the connected hospital footprint. However, this option is only ideal if all required resources are available and the service point is adequately staffed. This is best evidenced by the time taken to process applications and issue birth certificates across the operability of the sites, as illustrated in the following figure, which presents the average time required to register a birth based on the resourcing available.

Figure 2: Efficiency of birth registration process differs by location and availability of resources

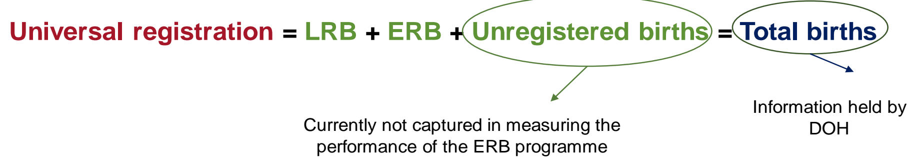
~ 15 mins	1-3 hours	1-2 days	>2 days
• At DHA service point in HCF • DHA official is present at work • All available resources (internet connection, printer, etc) are available	• At DHA office • All available resources (internet connection, printer, etc) are available	• At DHA service point in HCF or at DHA office • If required resources are not available • Clients will need to return to collect birth certificate	• At mobile unit • If required resources are not available • If mobile unit is no longer processing birth certicates

Therefore, this evaluation finds that the **efficiency and effectiveness of the operability of the birth registration system varies across provinces and facilities.** Birth registration officials tailor the implementation of the system to meet the needs of their offices, according to variable resource availability, the relative focus of on ERB as compared to other services, and their interpretation of the MOU. While tailoring the system to address the needs of clients enables the effective operationalisation at sites (and **these champions of birth registration are to be commended**); the lack of consistency in implementation compromises quality control across sites and provinces.

A contributing factor to the variance in implementation across sites is an apparent disconnect between the information from the sites and that which is required for decision making at a national level. **Target-setting is found by this evaluation to be principle weakness of the birth registration programme.** Targets are misaligned to district-level population dynamics and actual performance at sites. Assessment of performance against targets is therefore of limited value and diminishes the potential for evidence-informed decision-making.

Ultimately, the birth registration programme should aim to achieve universal birth registration, and not simply a growing rate of ERB. However, targets are not currently set with universal birth registration in mind. This requires tracking of the total number of live births at district-level, the proportion of ERB to LRB, and an estimation of unregistered births, as presented in the below figure. With these statistics, it will then be possible to create targets both for ERB and for total births registered.

Figure 3: Information required to target universal registration of births



5. Conclusions

The table below summarises the findings presented throughout this section using the Development Assistance Committee (DAC) Criteria of relevance, effectiveness, efficiency, impact and sustainability. For each criterion the evaluation team has provided an overarching impression of achievement relative to each DAC Criterion, as follows:

- Red – This is a lagging area(s)
- Amber – This is an area(s) of mixed experiences and performance
- Green – This is an area(s) of progress

Table 2: summary of findings by DAC criteria

DAC criteria	Rating	Finding
Relevance	Green	• The hospital footprint initiative provides birth registration services at the place of birth. • Hospitals are ideal places to leverage ERB as this is where 65% of births in South Africa occur.
Effectiveness	Amber	• The proportion of births registered within 30 days has increased since 2012/13. • However, this success is limited by remaining barriers within the hospital footprint initiative, specifically issues relating to the DHA-DOH collaboration.
Efficiency	Amber	• Where there are sufficient staff and resources, birth registration services are delivered efficiently, at DHA offices and within the HCF footprint. • However, this efficiency is undermined by unreliable connectivity, staff constraints and absenteeism.
Impact	Amber	• The proportion of ERB increased between 2012/13 and 2015/16. • However, there remain social, cultural and economic factors that limit the reach of the birth registration programme. • Motivation for birth registration remains strongly linked to social benefits (grants, school entry requirements, burial policies). • The birth registration programme is lagging in terms of ensuring access to birth registration services for OVCs and issuance of notices of birth to foreign nationals.
Sustainability	Red	• While the programme is contributing to improvements regarding ERB, there are concerns around the sustainability of the programme.

		• Numerous awareness campaigns were launched at the beginning of the programme, but findings indicate that, despite variations in awareness between different groups, campaigns are now ad hoc. • As new priorities for DHA arise, so resources are funnelled towards those (e.g. smart IDs) ahead of birth registration services. • Maintenance of IT equipment and services is inconsistent, resulting in declining proportions of HCF connection points remaining active following their installation. • Where understaffing and poor resources are rife, the system has been maintained through birth registration champions who go above and beyond to serve the client. • Finally, issues relating to the DHA-DOH MOU continue to pose a risk to the sustainability of the programme, as this continues to influence uncertainty around purpose, roles and responsibilities of the programme.

6. Recommendations

This evaluation aimed to assess factors influencing birth registrations. This includes factors affecting the DHAs' strategic vision to **register births as close to when they occur as possible** – in other words, the promotion of ERB.

Policies to promote the strategic vision

- R1: The DHA's strategic vision is founded on strong logic and is compelling. The value of this strategic vision should therefore be promoted:
  - Specifically, the DHA should pursue policies that support consistent understanding and buy-in amongst all stakeholders, specifically the DOH.
  - This strategic vision will be further promoted by adopting policies that enable nurses and midwives to issue temporary birth certificates. However, this policy shift is not without risks which will need to be mitigated.
- R2: The DHA should not neglect policies that create provision for LRB services. Specific to this is to:
  - R2.1 Conduct research to inform a reassessment of the 30-day cut-off for ERB; and,
  - R2.2 Not pursue a penalty for LRB as the legal basis for this is questionable at best.

Recommendations to improve implementation of the strategic vision

- R3: DHA should refine or establish MOUs with key departments to support the implementation and achievement of this strategic vision, including DOH, Department of Social Development (DSD) and the Department of Public Works (DPW).
  - R3.1: The MOU between DHA and DOH should be revised and clarified to elucidate the respective roles and responsibilities of both departments.
  - R3.2: DHA and DSD should collaborate to advance the registration of births of OVCs and children located in remote and marginalised communities.
  - R3.3: The DHA and DPW should refine facility rental agreements to ensure infrastructure is accessible and provides requisite comforts for mothers, babies and young children.
- R4: The DHA and DOH must refine the current MOU to specify each parties' roles and responsibilities to facilitate ERB specifically within connected HCFs.
- R5: DHA should invest resources to improve public awareness-raising initiatives:
  - R5.1: A complementary and comprehensive package of communications should be implemented.
  - R5.2: Visibility, design and informational content of posters should be improved.
  - R5.3: FCOs and supervisors should be trained to deliver accurate informational messaging to clients.
- R6: DHA should explore alternatives to mobile units to improve their ability to reach very remote and marginalised rural communities, specifically through mobile registration of births.
- R7: The DHA and DSD MOU should delineate the roles and responsibilities of each department to identify and support specific initiatives that promote birth registration amongst OVCs.
- R8: The DHA and DOH should identify and pursue initiatives that facilitate mothers' access to information and completion of birth registration while she is pregnant or shortly after giving birth.

Operability of birth registration system

- R9: DHA should consolidate the connected hospital footprint before continuing its expansion such that all HCFs currently connected should have active connections before new HCFs are connected.
- R10: DHA should run a campaign to celebrate the champions of birth registration in order to motivate positive behaviour and to document lessons on actions that facilitate birth registration.
- R11: DHA should improve the target-setting methodology to improve performance management and evidence-informed decision-making.

1 Introduction

1.1 Background

Genesis Analytics ('Genesis') was contracted by the Department of Planning, Monitoring and Evaluation (DPME) in September 2016 to conduct an implementation evaluation of the birth registration programme which falls under the mandate of the Department of Home Affairs (DHA). The purpose of this evaluation is to understand why births are not registered within the first 30 days after birth and systematically uncover the constraints that hinder the registration of births within this legislated period. Based on the above, and through the assessment of the range of interventions implemented by the DHA over the period 2010/11 to 2015/16, this evaluation has sought to develop evidence-based, practical and useful recommendations on how to improve the process of early birth registration (ERB) going forward.

1.2 Purpose of the report

This report constitutes the completion of the evaluation process and its purpose is to provide the key findings of the evaluation, and outline recommendations to improve the rate of ERB in South Africa. More specifically, the report presents the:

- Methodology employed to undertake the evaluation;
- Overarching findings from the literature and document review;
- Key evaluation findings;
- Conclusions from the evaluation; and,
- Recommendations for improving the birth registration system going forward.

Once this report is finalised, it will form the foundation for the DHA's improvement plan for the birth registration system.

1.3 Background to birth registration

Birth registration is fundamental to the efficient determination and safe-guarding of the identity and status of all born in South Africa. The birth certificate is a necessary document, required for citizens to access vital government services and to enjoy the full benefits of South African citizenship. Furthermore, demographic information recorded during the birth registration process is crucial for the maintenance of an accurate National Population Register (NPR), which supports evidence-based policy-making and appropriate public service delivery.

More specifically, Section 28(a) of the South African Constitution (Republic of South Africa, 1996) states that: "Every child has the right to a name and a nationality from birth". As such, parents and guardians are, under the Constitution, obliged to register the birth of their child timeously after birth. To affect this, the Amended Births and Deaths Registration (BDR) Act No. 18 of 2010 introduced the requirement that babies be registered within 30 days after birth. Together with the Constitution, the Amended BDR Act seeks to ensure that babies are registered within 30 days after birth and therefore that parents and guardians timeously fulfil their legal obligation to enshrine the rights of their child. In addition to these human rights considerations, birth registration within the 30-day window further aims to reduce fraudulent entries into the NPR by ensuring that births are registered timeously and accurately.

As a result of the country's history, South Africa has never achieved universal birth registration. The Births, Deaths and Marriages Act of 1923 was neither universal nor inclusive in its scope and only covered certain segments of the population based on location and population group. Additionally, the lack of infrastructure in rural areas and forced removals limited the means and motivations of South African citizens to register births and deaths contributing to this fact. As such, while ERB, that is, registration that takes place within 30 days of birth, is of primary importance for newborn babies, there is still a role for late registration of births (LRB) for individuals whose births were not registered within this 30-day window.

Both ERB and LRB are thus fundamental to achieving universal birth registration in South Africa. However, as elaborated on below, the focus of this evaluation has been on ERB and on developing recommendations to ensure that this is improved going forward.

1.4 Purpose of the evaluation

As noted above, the purpose of this evaluation is to understand why births are not registered within the first 30 days after birth, identify the barriers to registration with this period and develop recommendations on how to improve the process of ERB going forward. The focus on developing recommendations pertaining to ERB is important as registration within the first 30 days of birth is a legislative requirement and because improving ERB is crucial to advance universal birth registration. However, this does not negate the importance of exploring issues related to LRB within this evaluation; therefore, factors influencing LRB have also been explored.

More specifically, the evaluation aims to:

- Examine the achievement of the programme against the targets set for birth registration from 2010/11 to 2015/16
- Assess the extent to which the strategies and programmes implemented by the DHA have overcome the identified constraints to ERB
- Assess the extent of stakeholder support for the programmes implemented by the DHA
- Determine the perception of birth registration in HCFs and DHA offices among health workers, social workers, DHA officials, clients and other users
- Determine the strength and weaknesses of the legislative environment surrounding birth registration
- Provide recommendations on how systems can be strengthened to improve ERB, in line with international best practice

2 Methodology

The evaluation approach was informed by three pillars namely; 1) the evaluation context and systems map; 2) the theory of change; and 3) the use of the OECD Development Assistance Committee (DAC)[1] criteria. These pillars formed the basis of the evaluation and

[1] The Organisation for Economic Co-operation and Development (OECD) DAC criteria provides a useful framework for evaluating developmental assistance. This framework is globally recognised and is used by the majority of development assistance organisations, thus enabling comparison between programmes.

guided the development of the evaluation tools (site observation and interview guides) as well as the analysis of quantitative and qualitative data. This approach, namely a systems thinking approach combined with a theory-based approach was selected to account for the complex environment in which birth registration takes place.

Systems thinking, and through this, the systems map, presented in *Annexure A: Birth registration systems map*, captured the multifaceted environment in which birth registrations take place. It identified elements of the birth registration environment which support or hinder birth registration within 30 days, which further formed the team's contextual understanding of the birth registration system in South Africa.

In addition to the systems thinking approach, the evaluation team also drew on a theory-based evaluation approach. In doing so, the evaluation team developed a theory of change for the birth registration programme which mapped the programme's logic by linking the programme's initiatives to outputs, outcomes and intended impact of the programme. Developing a theory of change supported the evaluation approach by identifying the programme's key objectives, the steps required to achieve these and the assumptions underpinning the achievement thereof. A draft theory of change was presented to officials from the DPME, DHA, Department of Social Development (DSD) and Statistics South Africa (StatsSA) on 20 October 2016 for comment and validation. Following the workshop, the second draft of the theory of change was circulated to the Steering Committee for further comment, after which it was finalised, as presented in *Section 4: Birth registration in South Africa* below.

The theory of change and systems map informed the development of the analysis framework, the foundation of which was the OECD's DAC criteria of relevance, effectiveness, efficiency, impact, and sustainability. The application of the analysis framework ensured consistency throughout the evaluation, from the development of data collection tools, to their use when conducting fieldwork and finally to analysing the data collected.

2.1 Analysis framework and evaluation questions

As noted above, the analysis framework was foundational to the design of the data collection tools which were used to guide the implementation of all fieldwork activities, including key informant interviews (KIIs), interviews with front-line officials and the clients of the birth registration system (parents and guardians) as well as site observations. Mapping the evaluation questions onto the analysis framework ensured that all evaluation questions were answered through the course of the evaluation and findings were analysed with the objective of developing evidence-based responses to the evaluation questions. The table below lists the ten overarching evaluation questions as per the evaluation terms of reference (TOR).

Table 3: Evaluation questions

	Evaluation question
1	What are the results in terms of birth registration?
2	To what extent have the strategies and programmes[2] been communicated and implemented and what influence has this had on the results?

[2] Pertaining to birth registration.

3	Regarding the health facilities selected for connectivity, what considerations were used in selection and were they appropriate? How are the DHA facilities within health facilities operating in practice?
4	How is the birth registration service in health facilities perceived by health workers, social workers, DHA officials and other users??
5	What factors impact on the success and failure of the implementation of the various strategies listed in the TOR? What have been policy and legislation constraints?
6	What are the social and economic factors which affect the registration within 30 days?
7	To what extent are the strategies supported by key state actors?
8	To what extent are the strategies supported by key non-state actors?
9	How can systems be strengthened to improve early birth registration: what processes, procedures and policies should be introduced (including in health facilities) in order to achieve desired results?
10	How can we manage risks of late registration? Would punitive measures be effective?

The theory of change, systems map and analysis framework were approved by the Steering Committee through their acceptance of the Inception Report (October 2016) and the evaluation design report (June 2017).

2.2 Data collection tools, fieldwork training and piloting

The following section outlines the range of data collection tools developed for this evaluation and the processes employed to ensure they were consistently and rigorously implemented.

2.2.1 Data collection instruments

The data collection tools developed for this evaluation included:

- KII guides for:
  - DHA: National and Provincial
  - Other governmental departments, including the Department of Health (DOH): National and Provincial, DSD, South Africa Social Security Agency (SASSA), Department of Basic Education (DBE), Cooperative Governance and Traditional Affairs (COGTA)
  - Nongovernmental organisations (NGOs) and Non-Profit Organisations (NPOs)
- Site-level tools:
  - Interview guides for DHA front-line officials (based at offices and at healthcare facilities (HCFs), and health and social workers
  - Interview guides for parents and guardians registering births, translated into six local languages
  - Site visits observation checklists for DHA offices and HCFs (both public and private)
  - Participant consent forms and information sheets

2.2.1 Training workshop for data collectors

The evaluation team facilitated a data collection training workshop on 23 May 2017. The training provided comprehensive guidance on the practices and protocols to be followed during the evaluation's fieldwork phase. The workshop was based on a Fieldwork Protocol that was specifically developed for this evaluation. The primary purpose of this was to provide a standard procedure for the fieldwork to ensure consistency and systematic enquiry across all 54 site visits and throughout the KII process thus ensuring that the fieldwork was consistent, rigorous and that it upheld the highest degree of ethical standards.

54 sites were planned to be visited by the Genesis team who attended the Fieldwork training.

2.2.3 Piloting

The fieldwork pilot was conducted in Gauteng from 31 July to 4 August 2017.The purpose of the pilot was to test the evaluation instruments' relevance and targeting prior to full-scale fieldwork rollout. The pilot validated the tools and approach, and on the basis of the findings from the pilot exercise, the evaluation team made some minor adjustments to the tools to tailor them more specifically to the realities on the ground prior to full-scale rollout.

2.3 Data collection methods

This evaluation drew on three priority data collection methods, listed below and elaborated on in the remainder of this section.

- Literature and document review
- KIIs with national and provincial stakeholders; and,
- Site visits to DHA offices and connected HCFs which included interviews with front-line officials and the clients of the birth registration system and site observations.

2.3.1 Literature and document review

The literature and document review formed two primary purposes, firstly, it was used to inform the evaluation design phase which in turn ensured that the evaluation team developed nuanced, contextually relevant evaluation tools; and, secondly, it provided input and answers to selected evaluation questions.

In conducting the literature review, the evaluation team consulted the Steering Committee to ensure that all relevant national policy documents and associated data were included. Simultaneously, the evaluation's legal experts were consulted to ensure that the legislative and policy perspectives were accurately captured. These approaches enabled the evaluation team to collect a large set of relevant resources to inform the literature review, including: South African and international legislation, DHA policies, internal DHA documents (annual reports, strategic plans, and annual performance plans), publications of governmental and multilateral organisations, journal articles, books, and additional online resources.

Figure 4: Examples from four other countries were highlighted

The literature review informed the systems map and the theory of change, both of which were fundamental to ensuring that the analysis framework and evaluation tools were tailored to the South African context. The literature review also included a review of the South African birth registration interventions, how these have been implemented and perspectives on the relative successes thereof. Additionally, the literature review included a review of birth registration interventions which have been implemented elsewhere on the continent to understand what has been successful elsewhere and the applicability of learnings from these cases in the South African context.

2.3.2 Key informant interviews

KIIs were conducted with key stakeholders either through face-to-face interviews or telephonically[3] to collect qualitative information to answer the evaluation questions. Stakeholders contacted included:

- DHA- National and Provincial
- DOH - National and Provincial
- DSD - National
- UNICEF
- SASSA – National

A summary of the interviews by stakeholder group is provided in Table 4 below. No specific number of stakeholders was targeted. Instead, the evaluation team provided the Steering Committee with stakeholder categories and requested that suitable stakeholders be identified for each category.

It is difficult to pinpoint the precise reasons that stakeholders were unresponsive to requests for interviews. Generally, it is the evaluation team's view that the main reasons that stakeholders were unresponsive is because they did not have availability during the fieldwork phase or because they believed that they had been incorrectly identified. In other words, many stakeholders that were contacted felt they were not sufficiently involved in the birth registration process to accurately answer the questions and that there were other colleagues who were more appropriately positioned.

Table 4: Summary of KIIs contacted

Organisation	No. Contacted	No. Interviews Conducted	No. of unresponsive stakeholders
DHA National	12	6	6
DHA Provincial	9	7	2

[3] The evaluation endeavoured to control for potential respondent bias that could arise from conducting KIIs using two different formats (face to face and telephonic) by ensuring that all evaluation team members were trained on effective management of both formats. In addition, effort was made to triangulate all information collected through KIIs by ensuring that no finding was dependent on only one source of information.

DOH National	5	2	3
DOH Provincial	20	7	13
DSD	5	1	4
SASSA	3	1	2
Unicef	1	0	1
Department of Health and Welfare	1	0	1
TOTAL	**55**	**23**	**32**

2.3.3 Site visits

The purpose of site visits was to explore the current status of birth registration in South Africa and most importantly how and why birth registration processes are producing these results.

2.3.3.1 Sample selection

The sampling strategy was intended to be utility-focused, in line with this, a purposive approach to sampling was employed to meet the information needs expressed by the Steering Committee. In total, 54 sites across six provinces comprising both DHA offices and HCFs were selected for the evaluation. The site sampling considerations are briefly described below:

- **Province –** The six provinces were selected in collaboration with Steering Committee namely: Gauteng (pilot), Eastern Cape, KwaZulu-Natal, Limpopo, North West and Western Cape. These are marked on the map below:
- **Urban / rural** – This was based on a categorisation of rural/urban areas as informed by the DHA categorisation of sites. The table below illustrates the urban/rural distribution of the sample.
- **DHA / DOH sites** – The proportion of sites allocated to DHA (57,4%) versus DOH (42,6%) was agreed in conjunction with the Steering Committee.
- **Performance categories** – These were defined as actual births registered in 30 days as a percentage of the targeted number. Performance categories were:
    - Obvious outlier (greater than 120%),
    - On target (80-120%)
    - Low performance (less than 80%).
- **Distance between sites** – Sites in close proximity to each other were selected, with the objective of gaining insights into the relationships between DOH and DHA sites, the systems in place between sites, how sites within the same district function, and whether there are similar management systems used within a single district.
- **Proximity to national border** – The objective was to understand population migration dynamics on the registration of births and the process of registering of children born to foreign nationals. Three such sites were included in the sample. Two DHA offices: Musina (Limpopo) and Matatiele (Eastern Cape) and one HCF: Messina Hospital (Limpopo).

Table 5 below presents a summary of the sites selected for the evaluation, while the full list of selected DHA and DOH sites is provided in *Annexure B: Details of Methodology and Data Collection Strategy.*

Table 5: Distribution of sample sites by province

Provinces	Total DHA sites	Sampled DHA sites	Total DOH facilities	Sampled DOH facilities	TOTAL Sampled
Eastern Cape	59	5	55	3	8
Gauteng	61	6	70	5	11
KwaZulu-Natal	77	5	52	4	9
Limpopo	58	4	46	3	7
North West	22	5	34	4	9
Western Cape	28	6	41	4	10
TOTAL	**305**	**31**	**298**	**23**	**54**

At the discretion of the DHA officials consulted during site visits, the evaluation team was invited to conduct visits to six additional sites. The table of these sites is detailed in *Annexure B: Details of Methodology and Data Collection Strategy.*

2.3.3.2 Contacting the sites

18 signed permission letters were received which were used to facilitate access at selected sites.

The evaluation team contacted the DHA District Manager of Operations (DMO) responsible for each relevant district to gain permission to conduct fieldwork at the sites. The evaluation team received 18 signed permission letters, and these were used during to facilitate access at all selected sites. Via these letters, the sites were informed of the evaluation, and the approximate duration of the site visits (July – September 2017). While the approximate dates of fieldwork were shared with the sites, the exact dates allocated per site were not communicated to the sites ahead of time so as to ensure that the interviews and observations conducted were done in an environment that were reflective of the day-to-day operations at the site.

2.3.3.3 Interviews and site observations at the sites

At each DHA site, the evaluation team conducted interviews with frontline officials, supervisors and clients. These interviews were used to garner insights regarding the practicalities of implementing birth registration at site-level on a day to day basis. Similarly, at the HCFs, the evaluation team conducted interviews with the DHA official(s) responsible for birth registration at that facility, healthcare workers and, where clients were available outside of the wards, with clients. These interviews provided insights into the process of registering a birth at a HCF.

The evaluation team conducted interviews with any clients that were present at the DHA office or HCF on the day of a site visit. No particular demographic of client was targeted by the evaluation team. Instead, effort was made to interview as many clients that were identified as birth registration applicants as possible.

In addition to the interviews at each site, site observations were also conducted at DHA offices and at HCFs using the observation sheet. These captured the processes and practices taking place at the site during the time the evaluation team was present.

The evaluation team conducted visits to a total of 60 sites, of which 33 were DHA offices (31 from the initial sample and two additional sites) and 27 were HCFs (23 from the initial sample and four additional HCFs). Through these site visits a total of 217 people were interviewed. Table 6 below presents the range of interviews and site observations conducted across these sites per province by stakeholder group.

Table 6: Site interviews and observations conducted

Provinces	DHA offices			DOH facilities			
	Parents	DHA officials	Site observations	Parents	DHA officials	HCF staff	Site observations
Eastern Cape	11	7	6	0	1	0	5
Gauteng	21	5	10	0	1	0	6
KwaZulu-Natal	11	6	6	3	4	0	3
Limpopo	14	8	6	3	2	0	5
North West	7	10	9	0	3	0	7
Western Cape	14	8	5	5	1	3	1
TOTAL	**78**	**44**	**42**	**11**	**12**	**3**	**27**

Given that the evaluation team engaged parents / guardians at a sensitive time for their families, it was important for fieldwork to be intentional and appropriate to the needs of this group. This was achieved by ensuring that each interview was conducted in the preferred language for the family, using techniques to ensure that the interview was as natural and human as possible (e.g. conversational quality to questioning), and most importantly acquiring informed consent before beginning the interview. Many of the topics discussed during the interviews are sensitive (e.g. literacy rates of the parent / guardian, marital status of parents), and so all evaluators were trained on how best to manage this questioning and maintain absolute respect during the interviews.

Interview notes were captured by the evaluation team and transcribed following fieldwork into a qualitative data collation tool. Qualitative data was analysed using Atlas-ti. Site observation sheet data was analysed using a rubric, which is included in the fieldwork report.

2.4 Methodology successes and limitations

The evaluation team encountered several successes and challenges with the above detailed methodology. The details of the main success are presented in Table 7 below, along with their significance in relation to the evaluation.

Table 7: Key data collection successes

Success	Description	Significance of success
Extensive fieldwork preparation	The evaluation team underwent an extensive fieldwork preparation process, including fieldwork training and detailed logistical arrangements.	• The fieldwork was completed consistently across all sites with a high degree of rigour and adherence to ethical standards. • The evaluation team was able to complete all the site visits in the required timeframes.
Piloting in Gauteng	The pilot was conducted in Gauteng.	• The tools were tailored after the pilot, ensuing that they were appropriate to the site contexts • Gauteng proved to be the most demanding province with regards to site access and locating the relevant individuals to engage, thus presenting a rich learning experience for application to the other sites.
At the sites, DHA officials facilitated access to HCFs	Many DHA officials in the provinces coordinated with HCFs to ensure access to the HCFs. In some cases, they accompanied the evaluation teams to the respective HCFs or made calls to facilitate access.	• The team spent little time negotiating access into the sites, providing more time for substantive engagement at the sites. • In some instances, the evaluation team was able to visit additional facilities as a result of the assistance of the DHA.
60 site visits completed	The evaluation team visited 60 sites, comprising the full range of identified site characteristics	• The evaluation team was able to obtain rich data from varying sources which enabled the collection of comprehensive, meaningful data.
Language diversity	The evaluation team was comprised of individuals which met the language needs of all the areas	• Where concerns existed about the team's Venda skills, a translator was contracted. This was extremely valuable as it ensured that we were able to capture insights – particularly from parents/guardians – in their home language.

As with any research, this evaluation relied on a number of assumptions and was subject to inherent constraints. The limitations to the methodology are presented in Table 8 below. Despite these limitations, the quality of the evaluation has not been adversely affected.

Table 8: Limitations to the methodology

Challenges encountered	Details of challenges	Significance of challenges
Access to HCFs was limited in some cases	The DOH Director-General informed provincial heads of department of the evaluation. Given that the provincial heads control access to HCFs, and the evaluation team were not aware of the requirement to gain further approval from provincial heads, in some cases, the evaluation team was not granted access to the HCF or engagement was limited to the DHA official only.	• This marginally limited the evaluation team's perspectives of the programme at HCFs.
Limited awareness of the evaluation amongst DOH stakeholders	Many of the DOH KII stakeholders and site-level officials were unaware of the evaluation.	• In many cases DOH stakeholders were hesitant to contribute to the evaluation, thus limiting the DOH perspective of the birth registration programme.

Incorrect contact details provided for KIIs	In some cases, the telephone numbers and/email addresses provided were incorrect.	• Effort was made by the evaluation team to secure the correct contact details from the Steering Committee. However, this did cause further delays in securing the interviews.
Lack of responsiveness to requests for KIIs	Despite numerous attempts to set up interviews, the evaluation team was unable to secure interviews with some KII stakeholders.	• Not all stakeholder groups were included in the data collection process, thus the evaluation does not have perspectives from these groups. • The KIIs were particularly deficient in perspectives from DBE, DSD and SASSA. Therefore, the relationship between birth certificates and access to vital services as not been comprehensively assessed in this evaluation.
Individuals identified for KIIs not always appropriate	There were cases where the individuals identified by the Steering Committee for the KII process were not relevant to the evaluation.	• In these instances, there was little relevant information that could be gleaned from the interview. Where possible, effort was made to ask the individual identified if they could provide contact details for an alternative person who would have more insight. If these were forthcoming, effort was made to engage them, although again, this caused further delays in the process.
Minority groups were not included in the evaluation	Minority groups, such as parents with an adopted child and lesbian, gay, bisexual, and transgender (LGBT) parents were not consulted during this evaluation.	• Issues relating to birth registration are particularly pertinent to such minority groups seeking to adopt and foster children. However, this perspective is not included in the evaluation.
Issues concerning the legality of adoption not included in the evaluation	The effectiveness of the birth registration system has implications for the ease and legality of adoption of children in South Africa.	• Issues relating to birth registration are particularly pertinent to clients seeking to adopt children and to advance the rights of children waiting to be legally adopted. However, this evaluation did not encounter specific cases related to adoption and so these perspectives and experiences are not included in the evaluation.

3 The importance of birth registration

The importance of birth registration is reiterated and reinforced through the United Nation's (UN's) Convention on the Rights of the Child (CRC), which states that "The child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and as far as possible, the right to know and be cared for by his or her parents." (Article 7 of the 1989 UNCRC). This convention not only aims to enshrine the rights of the child but also seeks to validate the importance thereof to encourage global, universal registration.

Apart from being the first legal acknowledgement of a child's existence, the registration of births is also universally acknowledged as being fundamental to the realisation of a number of rights and practical needs including (UNICEF, 2003):

- Providing access to health care;
- Providing access to immunisation;
- Ensuring that children enroll in school at the right age;

- Enforcing laws relating to minimum age for employment, handicapping efforts to prevent child labour;
- Effectively countering the problem of girls forced into marriage before they are legally eligible, without proof of age;
- Ensuring that children in conflict with the law are given special protection, and not treated (legally and practically) as adults;
- Protecting young people from under-age military service or conscription;
- Protecting children from harassment by police or other law enforcement officials;
- Securing the child's right to a nationality, at the time of birth or at a later stage;
- Protecting children who are trafficked, and who are eventually repatriated and reunited with family members;
- Providing an enabling document to facilitate access to a passport, opening a bank account, obtaining credit, voting or finding employment.

In addition to these individual-level considerations, birth registration is also important at a national-level. Internationally, birth registration is acknowledged as a fundamental tool to a country's planning processes as it facilitates the collection of vital statistics which are then used to inform a country's population registry (UNICEF, 2003). Internationally, these population databases are considered to be the foundation of national planning for service delivery, including the delivery of education, health and other social services.

In recognising the importance of birth registration, a vast number of successful interventions have been implemented across Africa to chart a course towards universal birth registration. These are described in the subsections that follow.

3.1 Community mobilisation

Community mobilisation initiatives using community leaders and volunteers have emerged as a successful way of promoting the value of birth registrations and providing clients with information about the birth registration process. In Kenya, for example, community-based networks of volunteers (Mukembau) are trained to collect birth registration data and create awareness about the importance of birth registration. For example, Mukembau host public ceremonies when individuals receive their birth certificates to raise awareness about birth registration and generate demand for the service (Plan International, 2017). The Anglican Church in Uganda coordinates Parish Development Committees that visit households to collect data and enter it into a household register. The register is updated quarterly to include all births, deaths, and migrations in the household. This enables children to be registered while they are still infants and reduces the burden of travelling to a central location for parents (Innocenti Research Centre, 2002). The challenges and success of community-based initiatives of this nature have yet to be rigorously evaluated, but the literature available indicates that they have been successful in increasing the rate of birth registrations and awareness among parents and guardians.

3.2 Remote accessibility initiatives

Babies living in rural areas are less likely than those living in urban areas to have their births registered (UNICEF, 2013). In Africa, higher levels of birth registration can be observed around larger cities which decreases as one moves further away from the city. This is strongly related to challenges relating to the cost of travelling to the facilities to register births (Todres, 2003). Mobile registration offices and officials are a response to the challenge of providing remote communities with essential registration services. Botswana is an example

of an African country that uses house-to-house registrations, which allows births to be registered at home. Furthermore, the Botswana government has partnered with United Nations Children's Fund (UNICEF) to roll-out mobile registration units to remote areas with low registration rates such as the Okavango district where residents have to cross a river in order to reach registration offices (UNICEF, 2013).

3.3 Mobile-based systems

Mobile-phones have become an important tool in birth registrations in Africa. The use of mobile phones to register babies has been successfully used to increase the efficiency of communication between rural communities and national birth registration offices and also reduces the risk of forms being lost, damaged, or destroyed. States also face a fiscal and infrastructure constraint which means that they often are not able to invest in physical brick-and-mortar offices to serve remote populations, thus mobile-based registrations offer a cost-effective solution to this. Examples of African counties using mobile-based systems to register new births include Uganda, Kenya, and Ghana. Mobile-based systems to birth registration are typically run through public-private partnerships between the government and telecommunications companies. The available evidence suggests that mobile-based systems have a positive effect in birth registration with Ghana having registered an increase in its birth registration rate from 65 percent to 75 percent after implementing a technology-based birth registration system (GMSA Mobile Identity Team, 2013).

3.4 Non-state actor involvement

Non-state actors such as community-based organisations, civil society, and NGOs or NPOs have an important role to play in advocating for public service provision and mobilising citizens to register births so that babies can access public services. UNICEF in Uganda has been involved in lobbying the Ugandan government to allocate more resources to birth registration and adopt a comprehensive birth and death registration policy (UNICEF, 2013). The Anglican Church in Uganda also plays an important role in raising awareness of the birth registration among its members and notifying the state of babies that need to be registered (Anglican Communion Office, 2016).

3.5 Decentralised approaches

Decentralisation allows disadvantaged communities to access government services through local authorities instead of the central government. This is aimed at minimising administrative processes and reducing social inequalities through increasing efficiency in the provision of services to impoverished communities. Technology is an important driver of decentralisation, whereby local stakeholders are able to register births at a community-level through mobile systems. Uganda is an example of a country that has pursued this decentralised approach, here local birth registration agents have mobile systems to capture birth registration applications which are then sent to the relevant government department for capturing (Day of Prayer and Action Organisation, 2012).

4 Birth registration in South Africa

As elaborated in *Section 1.3: Background to birth registration,* birth registration is fundamental to extending the rights enshrined in the Constitution of South Africa (Republic of South Africa, 1996) to all children born in South Africa. The benefits of birth registration extend far beyond the initial provision of the birth certificate. Through birth registration, children are afforded a name, nationality and legal identity. The birth certificate is also the gateway to other important documents, for example a bar-coded identity document (ID)

which enables children to vote once they reach majority status and, in so doing, facilitates the renowned opening statement of the Freedom Charter – “The people shall govern”.

A birth certificate is also required to access a passport, enabling travel beyond South African borders. Further, by providing access to citizenship, birth registration enables access to basic government services and the social security net provided in South Africa. Therefore, the birth certificate is an essential document to enable children to benefit from their full rights as citizens of South Africa. Additionally, through the birth registration process, important data is captured on every citizen of South Africa, which enables better planning, better policy-making and, ultimately, better service delivery.

Given this importance, it is unsurprising that birth registration receives much attention in South Africa. This attention is mirrored in the international policy arena. South Africa is party to a number of international agreements, conventions and charters that aim to protect the rights of children Among these are The United Nations Convention on the Rights of the Child (UNCRC); the 1996 Covenant on Civil and Political Rights; the 1999 African Charter on the Rights and Welfare if the Child (ACRWC); and other SADC-specific policies, which are elaborated upon *in Annexure C: Regional birth registration policy landscape.*

4.1 History of birth registration in South Africa

Birth registration in South Africa has had a complicated history; however, initiatives led by DHA and sister departments have sought to improve the inclusivity of the birth registration process. In so doing, these initiatives aim to promote ERB and to move ever closer to universal birth registration. In the sections that follow, the history of birth registration is described as a preface to an exploration of the current policy landscape, the process of birth registration in South Africa and the factors that affect birth registration. This section concludes by providing an overview of the DHA-led initiatives to support birth registration, the intended outcomes and impact of which is described in the birth registration Theory of Change.

The first national law passed to regulate birth registration was the Births, Deaths and Marriages Act of 1923 which remained in place until it was replaced by the Amended Births and Deaths Registration (BDR) Act of 1992. The 1923 Act was neither universal nor inclusive in its scope, covering certain segments of the population based on location and population group (Joubert, et al., 2012). This geographic and population fragmentation of civil registration system prejudiced Black Africans living in rural areas. This was worsened by the Homelands Citizenship Act of 1979 which removed Black Africans from the South African citizenship roll and required them to become citizens of one of ten homelands (Joubert, et al., 2012). The four independent homelands, Transkei, Bophuthatswana, Venda and Ciskei (TBVC), were required to maintain their own vital registration systems but did not have the capacity to do so. In addition to the legal constraints facing universal civil registration, the lack of infrastructure in rural areas and forced removals and settlements limited the means and motivations of South African citizens to register births and deaths (Joubert, et al., 2012).

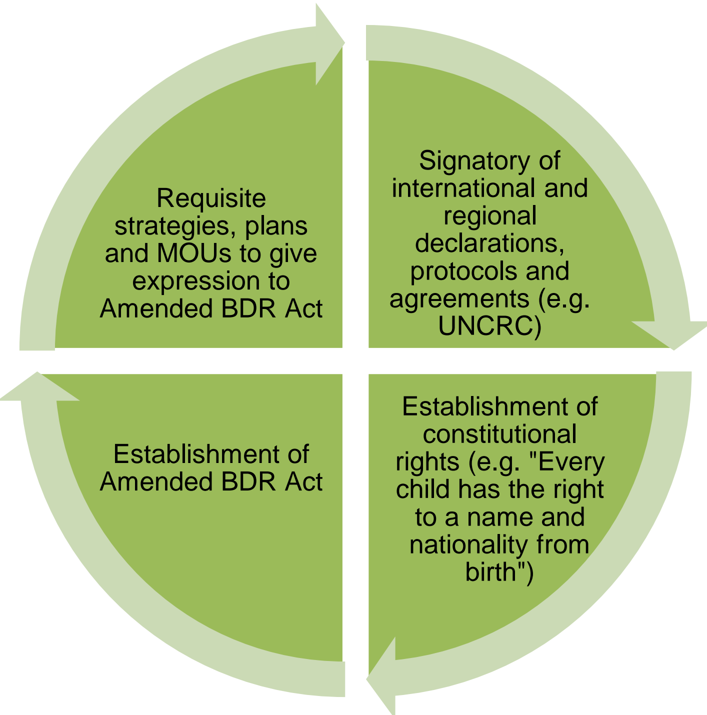
During the 1990s, several changes took place which transformed the civil registration system and started a process of correcting the negative effects of previous dispensations. The BDR Act of 1992 left no scope for optional or differential registrations and the interim Constitution of the South Africa passed in 1993 consolidated all geographic segments of the country into one unit and centralised civil registrations. Additionally, the DHA, the DOH and StatsSA established a joint technical committee to enhance civil registration and improve the quality of birth and death registration data by bringing it in line with international best practices (Joubert, et al., 2012).

4.2 The policy landscape

The South African policy landscape has evolved since 1923 towards creating an enabling environment for the advancement of universal birth registration. As a result of the evolution, the policy landscape is now appropriately comprehensive to provide the necessary legal instruments to guide key decision-makers and to protect the rights of the child, as demonstrated in Figure 5. In particular importance to this evaluation, in 2010, the BDR Act of 1992 was amended to introduce the requirement that births be registered within 30 days and created procedures for LRB in an effort to achieve universal birth registration and reduce fraud in the registration system.

The Amended BDR Act establishes a foundation for the improvement of the rate of ERB. This is important given the constitutional requirement to provide children with the right to a name and nationality from birth. By introducing the legal requirement for birth registration within 30 days, the Amended BDR shifts the South African policy landscape closer towards realising the objectives of the South African Constitution (Republic of South Africa, 1996). This is further facilitated through the current Memorandum of Understanding (MOU) between the DHA and the DOH, the objective of which is for the two departments collaborate to provide birth registration services at HCFs, identified as a key touch point for increasing ERB. The purpose of this agreement is aligned with the South African policy landscape; however, this MOU does not meet its intended purpose, for the reasons elaborated in *Section 5.5.2.1: DHA-DOH MOU* of the findings.

Figure 5: South African policy landscape enables birth registration



To support the implementation of the new requirements pertaining to birth registration, the DHA launched several interventions discussed in *Section 4.3.5: Interventions to support birth registration*

4.3 The process of birth registration

Following extensive document review and consultations with the DHA officials included in the evaluation Steering Committee, the evaluation team developed the birth registration

process map included in *Appendix D: Birth registration process map*. Close observation of this process map reveals that the correct route to be followed to complete the process is dependent on five factors:

- The place of birth (e.g. type of HCF, home or other)
- Citizenship of the parent and the availability of their identity documents
- Who is registering the birth (e.g. single mother, mother who is a minor, both parents who are unmarried or married by customary law, parents married by South African courts, etc.)
- Whether the birth occurred within or outside of South African borders
- Whether the birth is being registered within 30 days of birth or not

For ease of reference and as contextual background to this evaluation, the following diagrams are provided to illustrate the stylised registration process that is generally implemented at DHA offices and HCFs. It is important to note that the diagrams that follow represent the simplest route to register a birth and does not provide for the 'special circumstances' listed above.

Figure 6: Stylised birth registration process at DHA offices

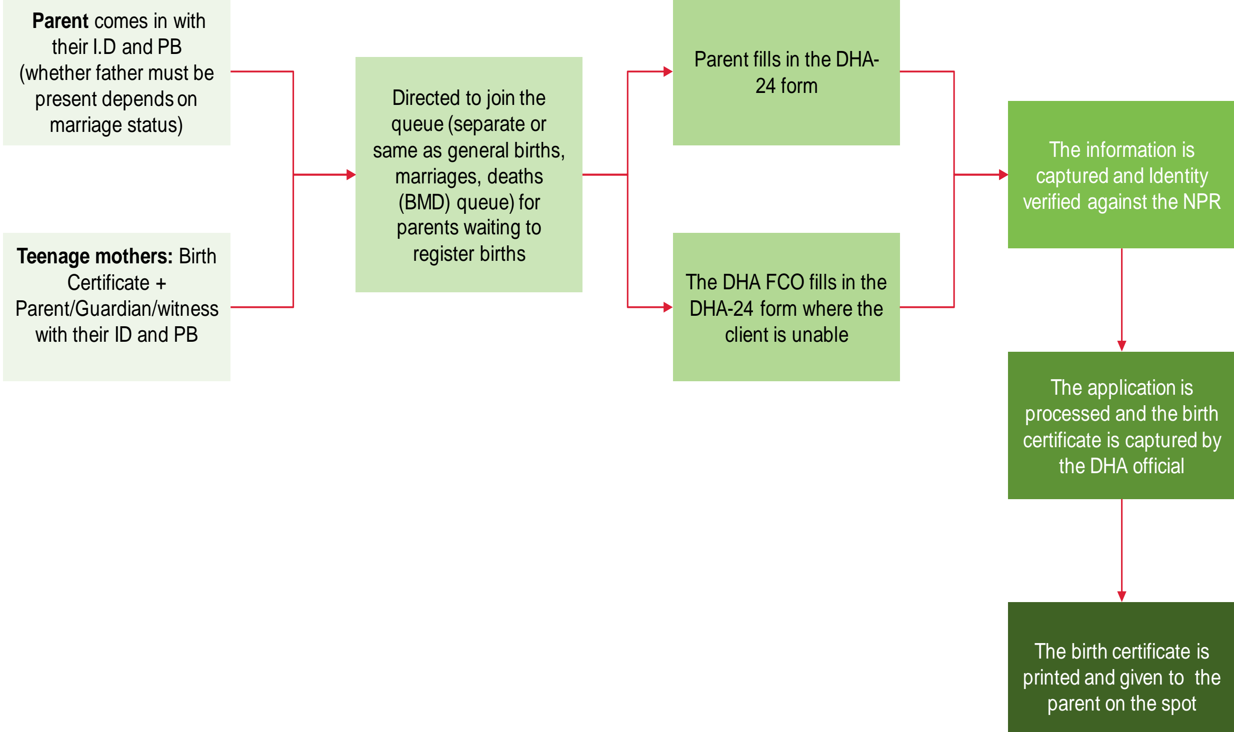
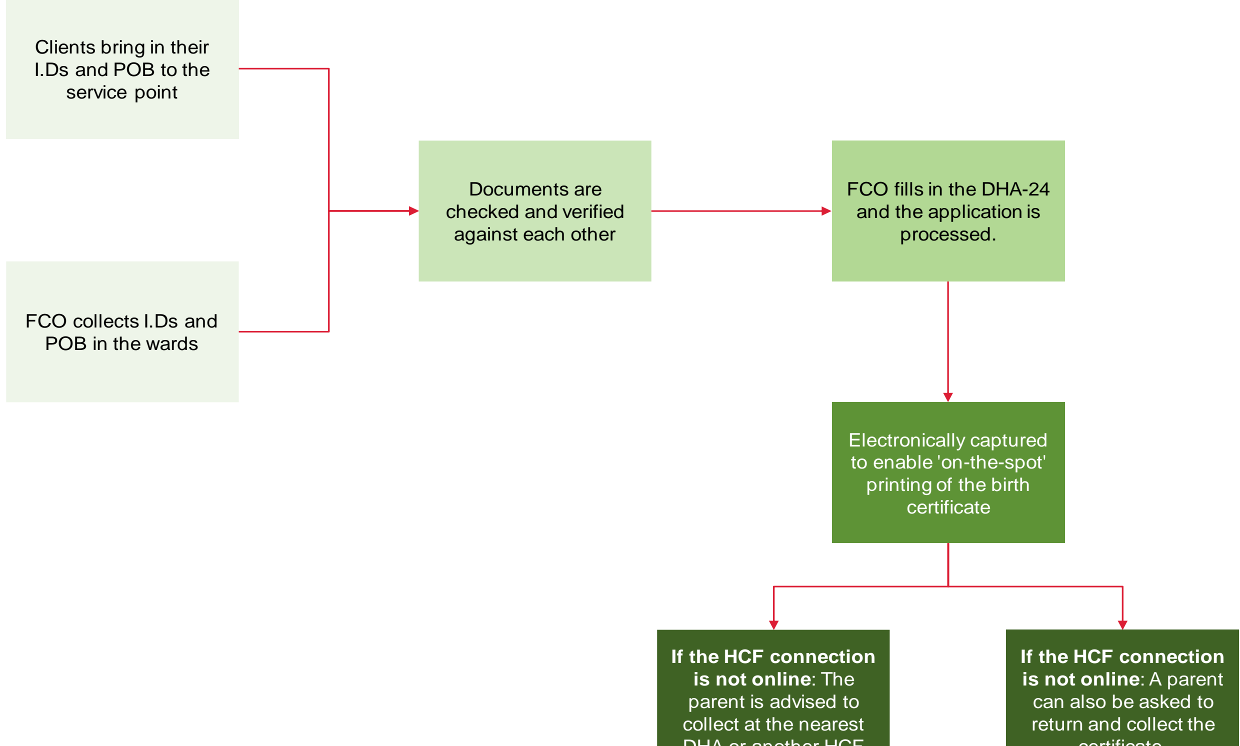


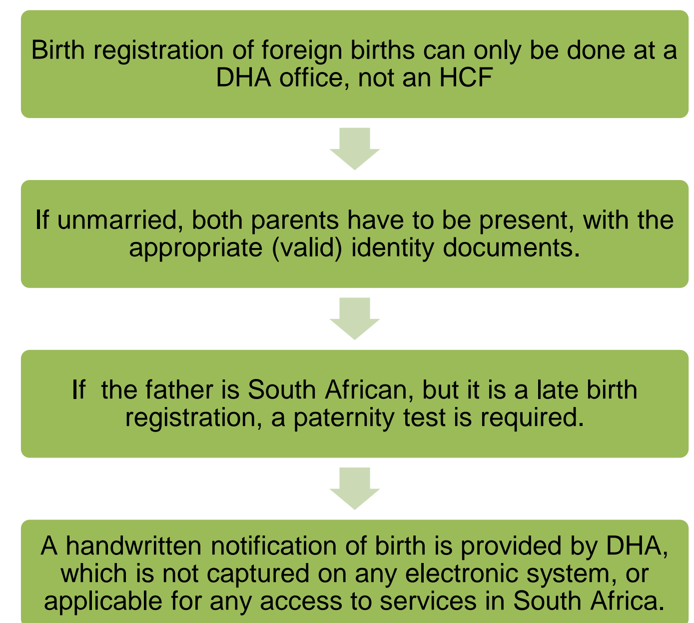
Figure 7: Stylised birth registration process at HCF



4.3.1 Birth registration of children born to foreign nationals

One of the 'special circumstances' pertains to children born to foreign nationals. The most significant departure from the stylised processes illustrated in Figure 6 and Figure 7 above is that the output of this registration process is a handwritten notification of birth that is not captured electronically. The diagram below details the other variations in the process, the risks of which are discussed in *Section 5.6.1: Registration of babies born to foreign nationals*.

Figure 8: Notification of birth for children born to foreign nationals



4.3.2 Requirements for birth registration

The documentation required for birth registration, generally, is a valid ID, the DOH provided proof of birth (PoB) form and the completed DHA-24 form. On the provision of these documents, the first issuance of an unabridged birth certificate is free.

Additional to these documents, if the birth is registered after 30 days, the DHA288/A form (affidavit) must be completed, which requires that reasons be provided for the birth being registered late. Parents are also required to submit their fingerprints and a biometric print of the child is taken.

For births outside of HCFs, a DHA24 PBA must be completed (proof of birth affidavit).

Box 1: Proof of birth form

The PoB form is branded as a DHA form. This has replaced the use of clinic cards for the purposes of birth registration. The PoB form needs to be completed by the healthcare practitioner who attended by the birth. The purpose of this form is to standardise the information captured regarding the birth particulars, which is then used when applying for a birth certificate.

In the case of unmarried parents, the father is required to provide his ID and be present for the registration of birth if the parents wish to insert his details onto the birth certificate. For those parents married by customary law, the marriage certificate needs to be provided and both parents must provide IDs and be present at the registration.

Finally, for foreign nationals, a valid passport, permanent residency permit or asylum seeker permit must be provided. As described in the diagram above, both parents have to be present with their respective documents, but if the birth registration is also LRB, the father must have a paternity test at the cost of the parents.

4.3.3 Key stakeholders in the birth registration process

Given the importance of birth registration and its relation to many State- and non-State-provided services, it is unsurprising that the DHA is joined by a number of other key stakeholders, each with important roles (or potential roles) to play in birth registration. As per the TOR for this evaluation, these stakeholders include:

- State actors:
  - DOH
  - DSD
  - DBE
  - COGTA
  - Department of Rural Development and Land Reform (DRDLR)
  - SASSA
- Non-state actors:
  - Various international and local NGOs and NPOs
  - Burial societies
  - Medical aids
  - Private clinics and hospitals

In relation to birth registration in South Africa, these stakeholders present important partnership opportunities for DHA for two reasons:

- Partner State actors and non-State actors can provide DHA with greater reach so that they are able to provide access to birth registration to a greater number of South African children.
- By sharing information between DHA and both State and non-State actors, all stakeholders might be better able to discharge their mandates, particularly because the birth certificate is necessary documentation for many of the organisations here listed.

4.3.4 Review of factors that influence birth registration

There are several factors that influence whether births are registered within the 30-day window in South Africa. While legislative frameworks mandate birth registration within 30 days, there are factors outside of the law and therefore beyond the direct influence of the State that influence, positively and negatively, whether a birth is registered within the stipulated time or not. As detailed in *Section 2: Methodology* above, this evaluation used a systems thinking approach to understand the factors that influence birth registration and how they relate to one another. The factors or systems that have been identified to this effect are the legislative system; administrative system; economic system; geographic system; political system; knowledge and education factors; and cultural factors. A graphical representation of these factors is provided in *Annexure A: Birth registration systems map***Error! Reference source not found.**.

4.3.4.1 Legislative factors

The South African Constitution states that

> *"Every child has the right to a name and nationality from birth".*
>
> Constitution of the Republic of South Africa, Chapter 2: Bill of Rights, Clause 28

To give effect to this right, the Amended BDR Act makes provision for the registration, within 30 days, of all babies born within South Africa's borders regardless of whether they have a claim to citizenship or not. It also sets out the procedure to be followed should a child need to be registered once the 30-day window has passed. Additionally, it prescribes that babies born to foreign nationals be given a hand-written birth certificate to be used when registering a birth in their home country. However, some of the procedures and regulations within the BDR Act may be an impediment to birth registration within 30 days. These include procedures relating to the registration of babies born out of wedlock; babies that are not cared for by biological parents or whose parents are deceased; and regulations regarding the documentation required register a child (George & Elphick, 2014). These inhibiting factors were confirmed through the evaluation fieldwork and are discussed further in *Section 5: Evaluation findings.*

4.3.4.2 Administrative factors

The administrative factors are those that relate to the implementation of the birth registration process by State officials. The DHA is responsible for birth registration but cooperates with other government departments that have an interest in ensuring that babies have birth certificates and are recognised as citizens by the State. These include the DBE, the DOH, and the DSD.

Interdepartmental cooperation of this nature is an enabling factor for the timely registration of births. For example, there are provisions in the agreements between the DHA and DOH for birth registrations at HCFs which eliminates the need for parents and guardians to register their baby at a DHA office. Furthermore, registration at HCFs ensures that a sizable portion of the total number of births in South Africa are exposed to the potential for

registration at the most opportune time and place for registration for the clients of the birth registration system. However, the efficacy of the cooperation between DHA and DOH in birth registration is often undermined by numerous factors including the availability of staff and infrastructure with HCFs.

Two constraining factors prominent in the literature are, firstly, the lack of client-centricity often characteristic of frontline clerk officials (FCOs); and, secondly, the accessibility of language used in the registration forms. With regards to FCOs, the literature revealed evidence that clients registering babies are routinely turned away by DHA officials for reasons that are not clear within the legislative parameters of the Amended BDR Act (George & Elphick, 2014). Attorneys, for example, have reported incidents where clients trying to register children born abroad were required "to obtain confirmation of the authenticity of the birth certificate from the country of birth" (George & Elphick, 2014). This is not a requirement of the BDR Act or the Amended BDR Act. It is important to note, however, that the frequency of such incidents has yet to be established beyond reports given to Attorneys dealing with issues of citizenship. Additionally, South Africa's Supplementary Convention on the Rights of the Child Report to the United Nations Committee notes that forms being available in only English and Afrikaans prejudices those clients with limited levels of literacy in these languages. Other limiting factors discussed in the literature, and tested in the evaluation, include long queues, poor service and inadequate and outdated infrastructure (National Child Rights Committee, 2000).

4.3.4.3 Economic factors

The economic factors that influence ERB include those facing clients registering their babies as well as fiscal constraints facing the State in the delivery of this service. While registering a child is free, clients registering children have to pay for transport if they are registering at a DHA office which compounds if they need to make multiple trips to an office (Jewkes & Wood, 1998). This problem is particularly acute in rural areas where distances between homes and DHA offices are further than in urban areas and the population is generally poorer. Another cost which clients face when registering their babies is the cost of obtaining their own IDs if they do not already have one. On a State-level, governments also face fiscal constraints that limit the availability of funds required to maintain and upgrade technology, hire staff and run awareness campaigns related to birth registration.

4.3.4.4 Geographic access

Geographic accessibility is an important driver of timeous birth registration, especially for babies living in rural areas and is also an important determinant of how the DHA plans their office footprint. International best practice states that the point of registration should be as close to the point of birth as possible, which affirms the drive to connect HCFs with birth registration services. The distance to DHA offices discourages birth registration if it is too long and too costly.

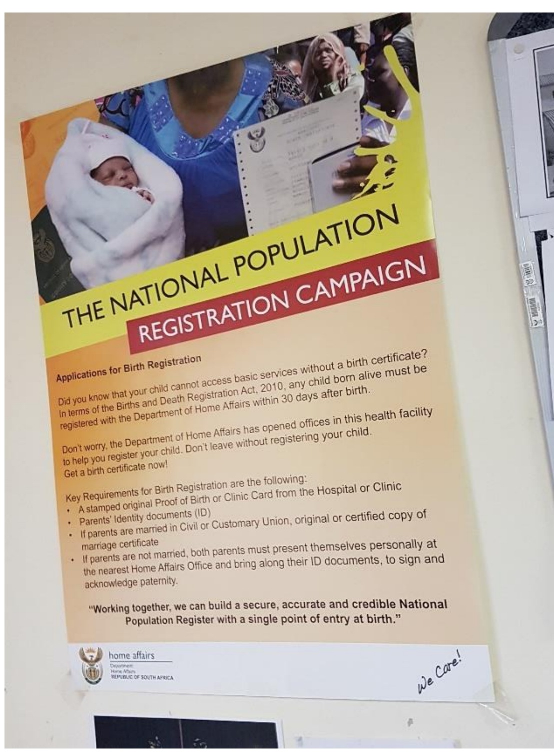
4.3.4.5 Political factors

As outlined in *Section 3.2.2: Review of factors that influence birth registration,* numerous government departments and agencies have an interest in ensuring that babies are registered on time and have a birth certificate as proof of their citizenship. This necessitates cooperation between several ministries and also makes the birth certificate inextricably linked to accessing social services such as healthcare and education.

The DOH is an important stakeholder in the birth registration process since many births take place in their facilities and babies engage with the healthcare system from early on in their lives for routine vaccinations and medical treatment. The DSD is another important

stakeholder since birth certificates are required for a qualifying child to become a social grant beneficiary. Finally, the DBE needs a birth certificate for children enrolling in schools and can assist with identifying children for late birth registration. Poor coordination between these and other departments is found to undermine the birth registration system and lead to weak enforcement of the rules. Collaboration between all government departments and agencies on birth registration, therefore, is not only important for assisting the DHA to lead the birth registration process, but also enables other government departments and agencies to execute their mandates effectively.

Figure 9: National Population Registration campaign poster



4.3.4.6 Knowledge and education factors

A lack of knowledge about the importance of ERB is an inhibiting factor for birth registrations globally. This often results in LRB when there is a need for a birth certificate such as when a child is enrolling in school for the first time. Additionally, potential clients are often discouraged by the perception that the birth registration process in complex and costly (Jewkes & Wood, 1998).The South African government launched the National Population Registration campaign in 2010 to increase awareness of the importance of ERB, publicise the 30-day requirement and correct the misconceptions held by clients about birth registration. This campaign coincided with an increase in birth registration within 30 days during 2010 and 2012.

4.3.4.7 Cultural factors

Birth registration within 30 days is closely linked to the naming of a child and other cultural practices that involve new-born babies. In South Africa, there is a great deal of variation in cultural practices across and within ethnic groups. These practices often involve delaying naming until certain rituals are performed or limiting interaction between the child and people outside of their family. Failure to recognise the ways in which cultural factors interact with the demand for birth registration can hamper demand for the service (Innocenti Research Centre, 2002).

“In some cultures, they [parents] need to take the baby home to the family for a naming ceremony. This means they can't register the baby before they leave the facility. Added to this, sometimes the culture means that the baby must stay at home for at least 3 months, so the mother can't register the baby until this time is up.”.

DHA official, Limpopo (DHA office)

4.3.5 Interventions to support birth registration

The following initiatives have been implemented by the DHA to encourage ERB.

4.3.5.1 Amended BDR Act of 2010

The BDR Act was amended in 2010 and has been in application from 1 March 2014. The amendments to the act were introduced to strengthen the regulation of the birth and death registration process and also introduced the requirement that babies must be registered within 30 days of being born. In addition to the Amended BDR Act, the Regulations on the BDR Act (2014) created the LRB process to accommodate those who had not been registered under previous acts. Additionally, the Amendment Act also makes provisions for the birth registration by parties other than a child's biological parents.

4.3.5.2 National Population Registration Campaign

The national population registration campaign was launched in 2010 to support the DHA's goal of ensuring a credible, accurate, and secure NPR with all citizens being registered at birth or within 30 days from birth. The campaign included various initiatives such as outreach programmes to rural areas, stakeholder forums including leadership from all three spheres of governments, and television appearances by senior DHA officials. While the National Population Registration campaign coincided with an increase of 11.2 percent in births registered within 30 days, there is insufficient evidence to conclude that this increase came about as a direct result of the campaign.

Between 2005 and 2006, **92 160** births were registered in HCFs.

4.3.5.3 HCFs connected to DHA

The DHA expanded their footprint to include 68 HCFs around the country between 2004 and 2005 (Department of Home Affairs, 2005). This expansion was motivated by evidence produced by the Human Sciences Research Council (HSRC) which motivated for birth registration facilitates at the place of birth. These facilities were staffed with personnel that had been trained in birth registration and birth registration IT systems. Between 2004 and 2005, 27 989 births were registered at these HCFs. Between 2005 and 2006, 50 more HCFs were connected and 92 160 births were registered in HCFs. As of November 2016, 391 HCFs have been connected to the DHA central system for birth registrations.

4.3.5.4 Upgrade and maintenance of IT systems at DHA and HCFs

The DHA has made extensive investments in the IT infrastructure in DHA offices and HCFs to enable the printing of on-the-spot birth certificates and faster connectivity. Since the 2009/10 financial year, the DHA has upgraded the connections at HCFs and added new HCFs to the network. In the 2012/13 financial year, 2 136 IT devices across a range of facilities were upgraded to deal with the problem of protracted downtimes within the DHA network.

4.3.5.5 Relationships with DOH, and other stakeholders formalised through MOUs

The MOU with the DOH outlines the partnerships between the two departments for registering newborn babies within the HCFs where they are born and allows for sharing data between departments for pre-populating the National Patient Information System (NPIS). The DHA is also supported by the COGTA and community-based organisations in holding stakeholder forums to assist with various community-based service delivery projects implemented by the DHA (Department of Home Affairs, 2013/14).

4.3.5.6 Information sharing through Izimibizo

Izimbizo are information sharing platforms targeted at rural areas that are far away from DHA offices (Department of Home Affairs, 2014/15). Izimbizo are run by the DHA's communication branch in collaboration with other directorates within the DHA and across the government. They are often covered by the media and sometimes involve senior officials such as the Minister and Deputy Minister.

4.4 Theory of change for birth registration

The theory of change for the birth registration programme presents the goals of the programme and how its interventions aim to achieve these goals. This has been informed by a comprehensive review of internal DHA documents (annual reports, strategic plan, and annual performance plans) and the inputs of the Steering Committee.

Figure 10 below presents the theory of the birth registration programme. It begins with the activities undertaken by the DHA to improve the rate of birth registrations within 30 days. These interventions include the relevant legal arrangements, investments in infrastructure and information and communication technology (ICT) systems, MOUs with other government departments, staff training, and public awareness initiatives. The activities are followed by outputs, which are the changes that are envisaged to occur as a result of the activities. The intention of the programme is that these outputs result in higher level changes, namely outcome level changes. Among these outcomes are accurate birth information; increased access to birth registration services; increased rate of birth registration within 30 days; and evidence-based planning and policy for service delivery. If the activities result in the realisation of the outputs and outcomes, the societal impact of birth registration programme is the determinant and safeguarding of the identity and status of all people (citizens and non-citizens) born within South Africa.

Through the course of the evaluation, the extent to which the theory of change holds true has been tested. Firstly, the pathways from activities to impact, shown by the arrows in the diagram, were tested through the evaluation, and, secondly, the extent to which the various activities have been implemented have been assessed.

Figure 10: Theory of change for birth registration

18 Efficient determination and safegaurding of the identity and status of all South Africans and of non-South Africans born in South Africa

16 Evidence-based planning and policy making for service delivery is enabled

15 A more reliable National Population Register

14 Expanded access and greater inclusivity in the birth registration process

12 Modernisation of the birth registration process

13 Improved accuracy of birth registration process and the capturing of information

17 Increased rate of Early Registration of Births

1 SOPs shared with provinces during training

2 South African legislation is aligned to global best practice

3 Quicker access to birth certificates through "on-the-spot" printing

4 Functional platform that connects sites for real-time registration of births

5 Expanded national DHA footprint

6 DSD system to manage registration of births of vulnerable population groups

7 DHA cooperates with stakeholders to improve rate of birth registration

9 Enriched engagement between front-line officers and the public

8 Increased knowledge amongst the front-line officers

10 Enhanced understanding of the birth registration process

11 Increased awareness about the need to register one's child within 30 days

A Birth and Death Registration Amendment Act signed into law

B Minister of Home Affairs signed the Civil Registration and Vital Statistics Declaration

C South Africa is signatory to global frameworks on birth registration

D Upgrade and maintenance of IT systems at DHA and healthcare facilities

E Healthcare facilities connected to DHA

F Investment in establishing more DHA offices

G Mobile DHA offices launched in rural areas

H Relationships with DoH DoBE, SASSA and other stakeholders formalized through MOUs

I DHA fosters relationships with other organisations: Stats SA, Cogta, DSD, Agri SA, HASA

J Moetapele Leadership Initiative launched

K Training of front-line officers

L General population awareness campaigns

M National Population Register awareness campaign launched

N Birth Registration Imbizos

O Birth Registration Indaba

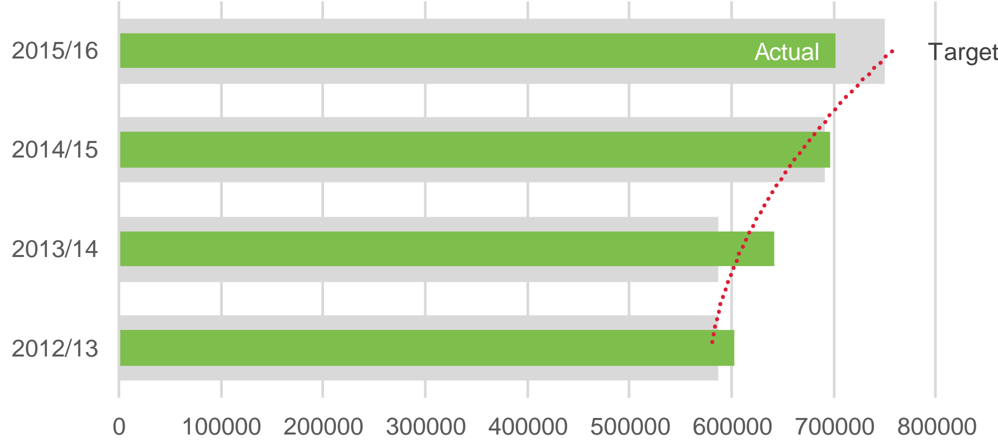
5 Evaluation findings

This section presents the findings from the evaluation, organised according to the key themes emerging from the analysis and synthesis of the quantitative and qualitative data collected. This data has been generated through literature, data and document review and, principally, the extensive fieldwork process outlined in *Section 2: Methodology* above. The discussion within each section has subsequently been used to develop cogent responses to the evaluation questions, presented in defined boxes within each section.

5.1 Analysis of trends in birth registration

Figure 11 below presents the birth registration programme's performance against targets aggregated across all sites (DHA offices and connected HCFs) nationwide, between 2012/3 and 2015/6. As this graph shows, the number of births registered has been increasing since 2012/3. This upward trend is indicative of the growing success of the birth registration programme in improving the number of births registered each year.

Figure 11:Total number of births registered between 2012/13-2015/16



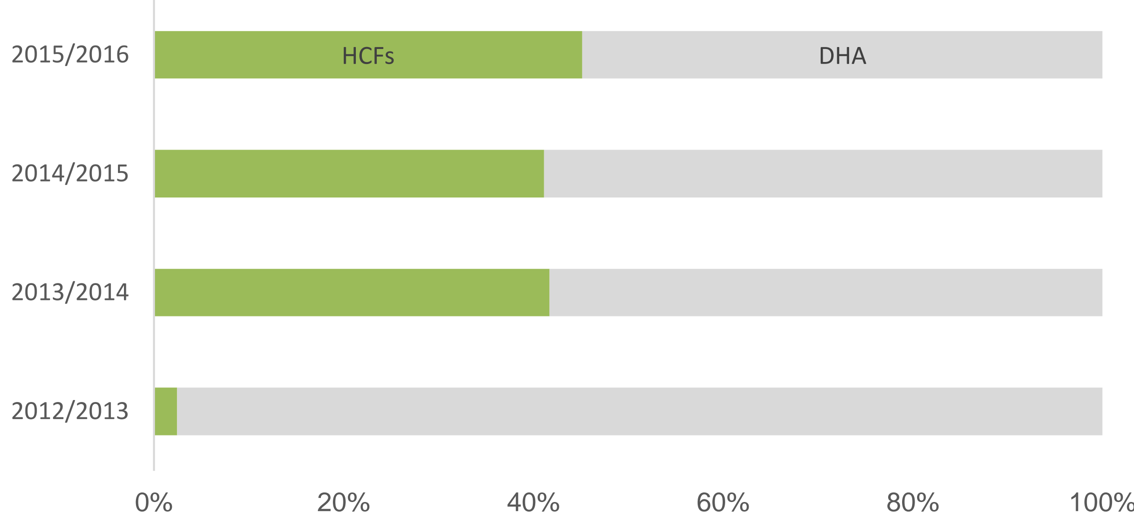
Box 2: Evaluation question 1 - What are the results in terms of birth registration?

There has been an upward trend in the number of births registered from 2012/3 to 2015/6. A key driver of this trend is the growing proportion of births being registered within 30 days at connected HCFs. However, site performance against targets is unclear because there is evidence to suggest that targets are not always appropriate given contextual factors and local population dynamics.

The evaluation team also analysed the proportion of births registered at HCFs compared to births registered at DHA offices, as depicted in Figure 12. As this analysis of the DHA data shows, birth registration at HCFs has been increasing over the years 2012/13 to 2015/16. Since births registered at HCFs are more likely to be within 30 days, this provides evidence that the hospital footprint is effective in ensuring that births are registered as early as possible. However, the growing proportion of births being registered at HCF does not negate the importance of birth registration, and LRB in particular, at DHA offices. Despite the hospital footprint, it is likely that there will continue to be parents who are unable to register

at the HCFs due to the social and cultural factors discussed in *Section 5.3: Pervasive challenges faced by clients.* For this reason, birth registration in offices remains essential.

Figure 12: Birth registration by site, DHA office compared to HCF



5.2 Effectiveness of the birth registration process

Based on site visit observations conducted during the fieldwork process at HCFs and DHA offices, it is apparent across all sites that, where the requisite resources (equipment, infrastructure, personnel) are available, the quality of services provided to the client is good, the time for processing is minimal and the overall experience on the part of the client is satisfactory. Therefore, the birth registration process, in general is considered to be effective, but this effectiveness is dependent on a number of variables, which are elaborated on in *Section 5.2.3: Limitations of effectiveness experienced at sites.*

85.6% of births in South Africa occur in a public HCF.

A key thrust of the birth registration programme is the establishment and expansion of connected HCFs through the hospital footprint initiative, which is integral to improving ERB. While birth registration falls under the DHA mandate as more than 85.6% of births in South Africa occur in public HCFs[4] (StatsSA, Millennium Development Goals 5: Improve maternal health, 2015), HCFs thus present an obvious service point for birth registration services for clients. Enabling registration at the place of birth further overcomes many of the social and economic factors which prevent parents from registering babies.

One of the greatest benefits of the hospital footprint initiative is that it reduces the distance between the client and the service. This means that no additional time or money is required to register the birth. By ensuring provision of a birth certificate before the baby is discharged,

[4] Note, this excludes births in private HCFs and thus is likely to underestimate the true figure.

many of the other external factors, outlined in *Section 4.3.4: Review of factors that influence birth registration* which hinder ERB are accounted for. This also ensures that the child's right to a name and nationality, and the associated access to government services are secured as close to the birth as possible. The hospital footprint initiative thus effectively aims to enable even greater effectiveness through connected HCFs.

> *"[The hospital footprint initiative] has reduced late birth registration. The HCF connectivity has also eased admin challenges because most of the moms register at the hospital (leaving the offices to focus on other services)"*
>
> DHA official in Limpopo (DHA office)

Connected HCFs offer the best method for improving ERB, a view shared by many stakeholders consulted during this evaluation. Since its inception, the effectiveness of the hospital footprint initiative has driven improvements in the rate of ERB. Therefore, it is important to assess the effectiveness of the hospital footprint initiative in order to identify areas for continued improvement. The subsections that follow focus on the effectiveness of the hospital footprint initiative and, in particular, identifying the areas that require attention towards the improved performance of this initiative.

5.2.1 HCF selection criteria for inclusion in hospital footprint initiative

Of the 800 hospitals in South Africa with maternity services, 391 have been connected to the DHA birth registration system, thus providing a valuable service point closest to the baby's delivery. Having a dedicated DHA service point in the HCF means that parents can be issued with a birth certificate for their baby immediately and certainly prior to leaving the hospital. This removes the need for parents to travel to the DHA office to register the child. As noted above, by providing the birth certificate so close to the place of birth, the myriad of factors which can deter parents from registering the birth are mitigated. Similarly, at the HCFs, the service is specifically for ERB which adds to the efficiency of the process.

49% of hospitals (with maternity services) have been connected to the DHA for online ERB.

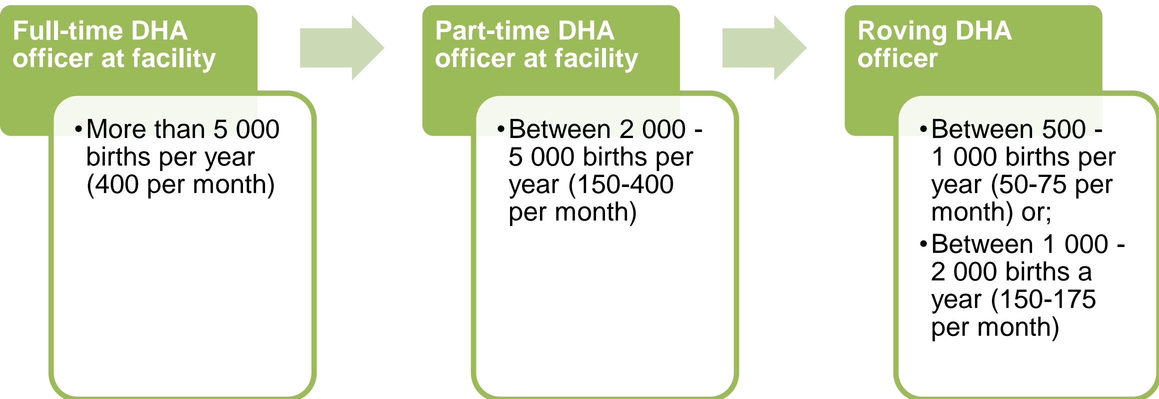
This also ensures that the child has direct access to other services – including a child support grant (CSG) – immediately following birth. Access to a CSG has a direct effect on the child's access to quality nutrition and subsequent mental and physical development (UNICEF D. a., 2012). As a birth certificate is required to apply for said grant, it is critical that the time between birth and registration is reduced as much as possible. The hospital footprint initiative is key to enabling this providing registration services at the place of birth.

Box 3: Evaluation question 3 - Regarding the health facilities selected for connectivity, what considerations were used in selection and were they appropriate? How are the DHA facilities within health facilities operating in practice?

By reducing the gap between the client and the service point through the hospital footprint initiative, the efficiency of birth registration has greatly improved. Provision of an on-the-spot birth certificate helps to enshrine the rights of the child immediately – both in terms of recognition of birth, but also in terms of access to social services. The hospital footprint is considered a successful initiative in enabling the achievement of the above. Furthermore, through ongoing maintenance and expansion, this hospital footprint can continue to improve the upward trend in ERB and a reduction in late birth registration.

The graphic below captures the requirements for full-time, part-time or roving DHA officers.

Figure 13: HCF selection process for DHA connection



Based on information provided through KIIs with National DHA staff, the method for selecting HCFs to be connected was based on birth occurrence. The type or level of service allocated was thus determined by this assumed need. This variable is endogenous (a function of the effectiveness of the birth registration system in a district) so might be misleading as to the true need given the population dynamics in the area (StatsSA, Recorded live births, 2016, 2017).

To illustrate, consider the hypothetical example of two sites that had unconnected prior to the initiative. Both areas have a hospital, but Site A has a DHA office while Site B does not. Parents living at Site B may have to travel to Site A to register births, which might be some distance. This means that the number of births registered (ERB and LRB) at Site A will be higher – and this is the variable that is used to determine which HCFs are subsequently connected. Consider too that Site B may have more young people and so, is more likely to have more pregnancies and births. Additionally, Site B might be nearer a national border and so may have more economic migrant labour, thereby also increasing the likelihood of a high number of births. By relying solely on the birth occurrence statistics to select Site A instead of Site B, the site selection criteria is very likely to be ineffective in identifying the sites with the greatest need.

5.2.2 Influence of DHA officials and HCF staff

During fieldwork, it was observed and evident from interviews with clients that DHA officials and HCF staff often provide clients with incorrect information. This information is used by clients to navigate the birth registration process. The reason for this misinformation might be that DHA FCOs or HCF staff have varying (and often incorrect) knowledge of the official process themselves. A further reason given for this – evident from interviews with DHA officials and HCT staff, as well as KIIs with provincial and national-level staff from these two departments - is that the national strategy or the official process is not being adequately communicated to staff at the office level.

> *"Yes, they wouldn't let us register the baby at the DHA office in Bronkhortspruit so we had to travel all the way to Mamelodi Hospital"*
>
> Parent in Gauteng province (DOH healthcare facility)

The inconsistency in communications by DHA officials and HCF staff is further exacerbated by the policy shift to the connected hospital network (the hospital footprint initiative). While this is a positive development, it does imply that DHA is attempting to channel clients to the most efficient route. In fact, some offices no longer provide ERB services and others do not provide LRB services. Therefore, because clients do not know the official process or where they are meant to be going for ERB and LRB respectively, clients are frequently sent from site to site.

Further, interviews with clients highlighted that they often face challenges if they deviate from the 'preferred route' – i.e. the route that is unofficially prescribed by DHA. This 'preferred route' is usually that clients that have given birth in a connected HCF complete ERB at that facility, and even in some cases are requested to return to the facility rather than being able to register at a DHA office. This is important because clients may not be able to complete ERB because they were discharged outside DHA operating hours or left the city where they gave birth in order to return to their home town. Parents may also not register right away in the HCF because of a variety of social and cultural factors (discussed further in *Section 5.3: Pervasive challenges faced by clients*).

"Yes, I knew about 30 days. I was told by the clinic staff when I was pregnant. My frustration is that I live in Orange Farm. When I registered my first child I could just go to the local DHA office (in Orange Farm). With this child I was told I have to go back to the hospital (Chris Hani) where I had my baby. This seems more chaotic. I would like it if they went back to the old system"

Parent in Gauteng province (DOH healthcare facility)

There are many opportunities for clients to misunderstand how the system functions, given the diverse needs of parents and the variety of routes they could take through the birth registration process. This means that clients need precise guidance and information to be able to navigate the process. Based on evidence collected through site observations and interviews with parents, DHA officials and HCF staff, this evaluation finds that the guidance currently provided is inconsistent and often misleading. Ultimately, this means that the birth registration process as actually experienced by clients is often ineffective (lengthy, delayed, requiring repeat attempts to register births). Further, those clients that are located in more remote areas and face issues relating to vulnerability (e.g. uncertain immigration status, low levels of literacy) are disproportionately affected by inadequate guidance, and so their experience of the birth registration process might be even less effective in meeting their specific needs.

5.2.3 Limitations of effectiveness experienced at sites

Based on site visit observations and the views shared by stakeholders (DHA officials, HCF staff and parents) consulted during the fieldwork, three key factors emerge as presenting limitations for continued effectiveness of the birth registration process through the hospital footprint initiative: 1) Operability of IT equipment; 2) Availability of staff; 3) Extent of collaboration and coordination between DOH and DHA at site-level. In addition, a particular constraint to the effectiveness of the process at DHA offices is the suitability of the infrastructure available at these premises. These are discussed in more detail in the sections below.

5.2.3.1 Operability of IT equipment

While the hospital footprint is highly regarded, based on evidence collected through site observations and interviews with parents, DHA officials and HCF staff, this evaluation finds that its effectiveness is undermined by the unreliability of the internet connection (network) and equipment which enable the service. Where there are DHA officials seconded to the HCFs, it was noted that their role is constrained if the network is down (certificates can only be issued through a live connection with the system) or if the printer or computer is broken.

"While we now have DHA staff going to the HCFs, none are operational. Hospitals are not able to print."

DHA officer in Eastern Cape (DHA office)

Based on feedback captured during the KII process with various national and provincial stakeholders, it is understood that while the hardware is the property of the DHA, for the most part they need to rely on the HCF network (internet connection). This means that in cases where the network is very busy, DOH transactions are prioritised which limits the access that the DHA has to the network. It also means that when the network is down, it is not within DHA's control to fix. This has to be requested by the facility and then actioned by their IT service provider.

At a national level, DHA monitors whether equipment is available and in use. However, based on feedback captured from the site-level DHA officials, in cases where the IT equipment at the facility is not functional, they capture the births at the local office, but still allocate it to HCF. This means that the non-functional IT equipment at HCFs is often not flagged to be repaired as it is assumed (at the national-level) to be operational. Unless it is communicated that there is a problem with the equipment it cannot be fixed and the service point remains un-operational, thereby reducing the effectiveness of birth registration at HCF.

"Facility codes are being manipulated. They are being utilised sometimes within the offices – this makes it seem like the facility is connected and working. But the reality is that the hospital does not have the equipment to be able to do registrations on site".

Key informant in Gauteng (National DHA)

Based on site observations and interviews conducted with DHA officials during the fieldwork phase, it appears that system downtime is mostly unanticipated. It is unclear from the evaluation evidence whether an early warning signal is possible or how often preventative maintenance is conducted to prevent downtime. Additionally, the main strategy employed by DHA officials to overcome downtime at connected HCFs is to travel between the HCF and the DHA office in order to complete the online application and to print the certificate. This risk mitigation strategy is similarly inefficient, as DHA officials are also expending more time and money in order to produce the desired output (the birth certificate). Therefore, overall, downtime resulting from faulty or offline equipment is costly and reduces the efficiency of the hospital footprint, and by extension, birth registration at HCFs.

"*Currently not connected online at the hospital so we have to drive to and from the hospital, and some days if we don't have the car. Then we can't take the printed certificates back on the same day.*

DHA officer in Western Cape (DHA office)

5.2.3.2 Availability of staff

The second key resource constraint is the availability of staff. There are, based on feedback gathered from DHA supervisors during on-site interviews, critical staff shortages at many offices. This limits the officials' availability to visit the local HCF. Coupled with this issue is the fact that the DHA staff only operate during office hours (exact hours vary between sites). In cases where the staff report to the DHA office before going to the facility, the actual hours that they are available in the facility are further reduced. Feedback from one DHA official indicated that they are currently in negotiations with the unions regarding overtime for Saturday hours worked. Until this negotiation is completed, DHA officials are no longer required to work on Saturday mornings – although the degree to which this is enforced varies between sites.

"We are experiencing challenges from the staff and unions. The office hours have changed to shorter hours during the week so that there is still a service on a Saturday. But at the moment it is only one Saturday a week because of issues with workers striking. We have made work on a Saturday voluntary but that is a bit tricky as people don't volunteer. At present we've created two shifts of staff to ensure there is maximum service delivery to clients."

DHA officer in Western Cape (DHA office)

There are various efforts on the part of DHA officials to ensure that the births that occur when they are not on-site are captured. Where possible, births occurring over the weekend are captured on the Monday. This is not always possible as mothers and babies are, if there are no complications, generally discharged within six hours. At some facilities, the DHA officials have requested that the nurses note down the contact information for the patients so that they can be reminded to register the birth within 30 days.

"All hospitals served in [this area] are online and all have officials posted from Mon - Fri, 07:30 - 16:00. If births are out of these hours, the official fetches the register from the nurses in the morning. Every morning starts with a presentation - information on birth registration and requirements. Some officials live in walking distance to hospitals so may go and check if there are births over the weekends."

DHA official in Western Cape (DHA office)

Figure 14: Unexpected absenteeism at DHA service point in a private HCF

Based on interviews conducted with DHA officials during the fieldwork phase, another capacity challenge is that there are insufficient DHA officials to place staff at HCFs permanently. This means that in many cases, the DHA support provided is by a roving official. While efforts are made to standardise this process to ensure the facility is visited on the same days or hours during the week, this is not always the case. Some frustrations were noted by HCF staff who indicated that as they were not sure what day the DHA official would be there, they are unable to advise their patients appropriately. In certain cases, the evaluation team also noted, through site observations, that the hours specified at the DHA service point were not upheld, in other words, the DHA official was absent during the hours they were meant to be at their desk. This erratic service appears to contribute to the negative perceptions about the DHA services reported by the HCF staff. It also means that the clients at the HCF may not be aware of the availability of DHA services in the facility thereby undermining the effectiveness of the process.

5.2.3.3 Extent of collaboration and coordination between DOH and DHA at site-level

The perception, based on the feedback captured from interviews conducted with DHA officials and HCF staff during fieldwork, was that the nature of the collaboration between DOH and DHA varies considerably, between extremely supportive of birth registration to unsupportive of birth registration. A central point of frustration appears to be related to the issues experienced with the PoB form.

According to the DHA officials operating in HCFs, the HCF staff are frustrated by having to complete a form which is, in their opinion, the responsibility of the DHA – an issue exacerbated by the fact that it is branded as a DHA form. These frustrations, on the part of the HCF staff, mean that, according to the DHA officials, they do not prioritise completing the PoB form in a timeous manner and that there is a lack of attention to detail. This results in forms which are not always correctly or completely filled in which means that they are unusable for the birth registration process, requiring the client to return to the HCF to have it corrected. This lack of collaboration between the two departments – particularly around

the requirements of the PoB form - severely hinders effectiveness of the birth registration process.

“The other issue is the PB form: the nurses assume that filling the PB form is DHA's responsibility and not theirs.”

DHA official, Gauteng (DHA office)

During interviews with DHA officials and HCF staff at sites, the evaluation team found that in an effort to combat these issues, certain DHA offices have initiated training with the nurses at their connected HCFs about how the forms should be completed and the importance of ERB. This has worked well, reducing frustrations on both sides both from the DHA perspective and the DOH perspective, which has ultimately improved the quality of service delivery to the client. This emphasises the value that inter-departmental collaboration can contribute to maximising the effectiveness of birth registration services at HCFs. Siloed responsibilities between government departments reduce the ability to facilitate birth registration effectively thus delaying or constraining the process of birth registration and, by implication, hindering the protection of the rights of the child.

“We have trained nurses on ERB and run awareness campaigns at clinics which boosted ERBs. When our DHA official was posted at the hospital, she would call the moms discharged during the weekend to make sure all births are captured. Additionally, if there was downtime at the HCF, she would drive to the DHA office, print and capture forms and then go back to the HCF to deliver the certificates.”

DHA official in KwaZulu-Natal (DHA office)

Box 4: Evaluation question 1 - What are the results in terms of birth registration?

The hospital footprint initiative is successfully improving ERB by mitigating the factors preventing parents from registering their baby once they leave the hospital. Challenges exist where there is a breakdown in the system, specifically where the implementation on the ground is not consistent with the official process planned at a national level. Further effort is needed to maximise the effectiveness of this initiative by addressing resource constraints and improving interdepartmental collaboration at site-level to ensure appropriate birth registration service delivery for all South Africans.

Box 5: Evaluation question 3 - Regarding the health facilities selected for connectivity, what considerations were used in selection and were they appropriate? How are the DHA facilities within health facilities operating in practice?

Attention must be given to the criteria used to select which HCF to connect, including whether clinics should be connected in more remote communities, and also to the factors that limit the effectiveness of birth registration at HCF. These factors are the operability of IT equipment, availability of staff, the extent of collaboration and coordination between DHA officials and HCF staff at sites.

5.2.3.4 Suitability of DHA office premises

The site observations revealed that, in general, DHA office premises are not suitable for mothers waiting with very young babies. Examples of concerns are listed below:

- Queuing time: while in most cases there are separate queues for birth registration, in other instances mothers registering babies were required to wait behind those queuing for other services. The lack of prioritisation for newborns was noted as a concern by parents interviewed at DHA offices.

- Office size: The offices are not always large enough for all those queuing to sit inside. This was cause for concern for young babies with underdeveloped immune systems who spent the queueing time outside in the cold or in the sun during the heat of the day.

The offices were not always appropriately equipped in terms of providing working toilets, feeding and changing areas for mothers with babies. This, coupled with the need to remain in the queue, often meant that mothers had to change and feed their babies while in the queue.

However, certain offices have excellent and appropriate facilities for mothers with babies, as illustrated in Figure 15 and Figure 16 below. These good examples are evidence of the potential for client-centricity at DHA sites. The availability of these facilities helps to reduce the frustrations parents might experience waiting in long queues and also helps to engender a respectful relationship between DHA and parents, thereby contributing towards more positive perceptions of the effectiveness of the birth registration process at offices.

Figure 15: Excellent feeding facilities at DHA office

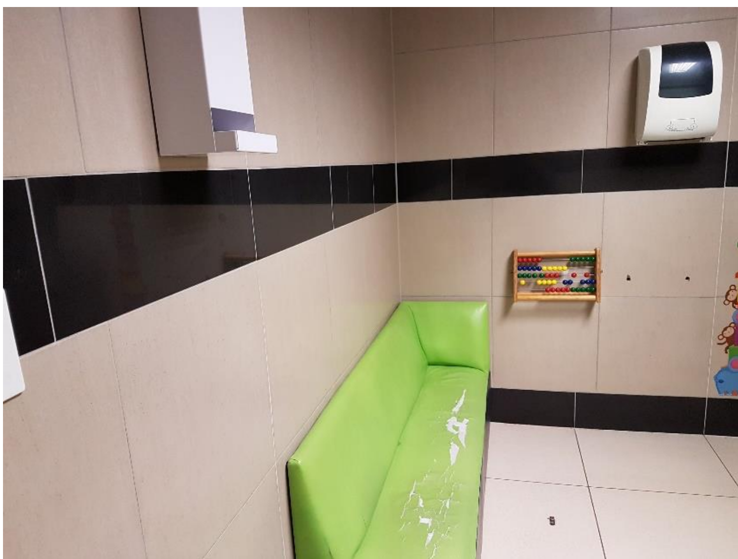


Figure 16: Excellent feeding facilities at DHA

5.3 Pervasive challenges faced by clients

While this evaluation finds that, overall, the process of birth registration is effective and its effectiveness is further enhanced by the hospital footprint initiative, there are pervasive social, cultural and economic factors which continue to influence the extent to which certain groups of the population are able to derive the full benefits of birth registration.

Data collection methods employed in this evaluation were qualitative, focusing on exploring the depth and differences in client perceptions and experiences within the birth registration system and the nuances thereof. For this reason, the evaluation does not aim to quantify the magnitude of factors constraining birth registration or to prioritise which factors are more influential or more serious. Instead, the aim was to document all factors, and to understand how and why factors affect clients' experience of birth registration. Nonetheless, since Atlas.ti was used to analyse the qualitative data according to the analysis framework, it is possible to view the frequency of responses relating to social, cultural and economic factors. Figure 17 below gives an indication of the proportion of responses that pertain to social, cultural and economic factors compared to other factors.

Figure 17: Frequency of responses relating to cultural, economic and social factors compared to other factors

	Challenges faced by clients
Cultural factors	12
Economic factors	5
Social factors	11
Other factors	29

These factors are discussed in detail in the sections that follow.

5.3.1 Social factors

The main social factors evidenced through this evaluation that have been found to affect birth registration are the unavailability of IDs, challenges resulting from low literacy levels, challenges linked to the requirements for the father's presence. and DHA perceptions around the negligence of parents. These factors are discussed in detail below.

5.3.1.1 ID unavailability

As reported by the interviewed DHA officials and observed by the evaluation team, one of the required documents for birth registration is an ID. The evaluation found that one of the social factors affecting birth registration in HCFs is the absence of a client's ID (whether the green book or a smart card ID). During interviews with both parents and DHA officials, it was reported that parents forget IDs at home when they are in labour and rushing for the hospital, or do not have IDs. In addition, in cases where parents remembered to bring IDs, they are often locked in a locker at the hospital when the DHA officials visit the maternity wards for birth registration.

This evaluation finds evidence that parents without IDs at the place of birth often leave the hospital without registering the birth of a baby. DHA officials interviewed reported that ID

unavailability is a key hinderance of birth registration in HCFs. This finding also emerged from interviews with clients seeking to register births at DHA offices. When asked why they could not register at the hospital, the clients indicated that they previously did not have their ID at the hospital and so birth registration was delayed.

'I could not register my baby's birth the first time I attempted to register at the hospital because I had forgotten my ID'

Parent, Mamelodi Hospital

'At the present moment I cannot register birth because I do not have my ID with me here at the hospital'

Parent, Klerksdorp Hospital

The DHA officials indicated that if parents do not have IDs for birth registration at the hospital, they have to either return to the hospital with IDs within 30 days or go to the nearest DHA office for birth registration. The absence of an ID, therefore, hinders ERB, particularly because many clients of the birth registration system face financial challenges and may not have money to return to the hospital or DHA office. There may be a process of 'trade-off' where the parent needs to prioritise in the case of scarcity of money. Prioritisation based on survival, for instance, having to choose between buying a pack of maize meal to feed the family for the month and using the money to catch a taxi to the DHA office, may have to be applied. Poorer clients are likely to choose food in this case. Given that the absence of an ID meant they missed the opportunity to register at the hospital, parents may default to late birth registration because they will have to wait until they have enough money to travel to a DHA office.

As reported by the DHA officials, another social factor related to IDs is birth to a minor. Minors have birth certificates and not IDs. Since an ID book / smart card is a requirement for birth registration, minors are required to be accompanied by their own parent (a mother or father) or a witness with a South African ID when seeking to register a birth. As discussed by DHA officials and DOH hospital staff consulted during KIIs, parents or witnesses of a minor are sometimes unavailable to accompany a minor for birth registration. The officials indicated that minors often have to wait on their parents/witnesses' availability in order for their baby's birth registration to take place. This often results in LRB as it may take longer than 30 days for the parents or a witness to be available.

This finding also implies that there is lack of clarity about the documents or requirements for birth registration in the case of minor mothers. The minor mothers reportedly do not know that they need to bring witnesses for birth registration. Based on sentiments expressed by parents during interviews, there is a concern that DHA officials at site level may not always tailor their advice based on the varying needs or situation of the client. By way of example, the evaluation team's impression following the fieldwork is that DHA officials in rural areas truly strive to deliver the service as tailored as possible to avoid sending a client back home, while the officials in urban areas have a larger workload and more clients to service. This means that they are often more focused on requirements and may not be able to adjust their communications to a client or how they approach a situation in a manner that is responsive to diverging client situations.

5.3.1.2 Challenges resulting from low literacy levels

As reported by some of the interviewed DHA officials, literacy is another factor affecting birth registration. DHA officials indicated that literate clients are reported to understand the importance of birth registration and how it works. These officials further added that people

with lower levels of literacy do not understand the importance of birth registration and this is one of the reasons why they do not register birth within 30 days.

The evaluation team noted that one of the reasons why illiterate people do not understand the system is that birth registration communication is not tailored to suit the understanding of illiterate people. An example made by some of the interviewed officials is a poster. As mentioned by the DHA officials and observed by the evaluation team, the DHA uses posters to communicate birth registration in HCFs, DHA offices and other public spaces. Unlike literate people who may be more inclined to reading in public, people with basic literacy, particularly senior citizens and people from rural areas, are sensitive to reading and may not be comfortable with reading in public. This implies that the messaging through posters often gets missed by people with basic literacy.

Further, during fieldwork, the evaluation team observed a difference in interacting with public services between clients from rural areas and clients from urban areas. Most of the clients from rural areas have basic levels of literacy or are illiterate and have lower levels of exposure to government services. Given this limited exposure to such services, it is unsurprising that this group of clients are often uncomplaining even though the service was slow or inefficient. This finding is also supported by the interviews with parents. When asked what could be done to improve the service, the clients in rural offices reported that the service was excellent even though it was slow, potentially because this group of clients is also grateful to be able to access the service at all.

> An unmarried mother is able to register birth alone (without the father) if she doesn't wish to include the father's details on the birth certificate. However, if the mother would like to include the father's details, the father must be present at the DHA office to acknowledge paternity and sign the birth

The evaluation team observed that while people with lower levels of literacy are intimidated by DHA offices, these people are more comfortable in HCFs. The reason for this is because there is an involvement of nurses at the HCFs. Although birth registration in HCFs is primarily facilitated by the DHA officials, the clients found comfort in the fact that these offices were within the hospital premises and there was a relationship of trust between nurses and DHA officials. This comfort and trust stems from the fact that nurses in hospitals assume a caregiver role. This caregiver role assures the client that they will be taken care of and has a positive bearing on the process of birth registration.

5.3.1.3 Requirements for father's presence

As mentioned by interviewed DHA officials and clients at DHA offices and HCFs, there are unmarried mothers who may wish to include the father's details on the child's birth certificate. This requires the father to be present to give his permission for the insert and also to verify that the father is South African. Mothers are able to register on their own if they do not have a preference to include the father's details on the birth certificate. Therefore, this challenge was only encountered by clients in instances where parents prefer that the baby assumes the father's surname, and in the case of where the parents are not married by South African Courts.

The evaluation team noted that the largest group of people affected by this requirement are unmarried couples and couples married by customary rights.[5] As mentioned by interviewed DHA officials, the married couples can have the father's details inserted into the birth certificate without the father's presence. However, if the couples are not married by South African courts, in other words, customary marriages, the procedure dictates that the father be present for the father's details to be inserted.

The interviews with both officials and parents indicated that this is one of the factors affecting birth registration. Fathers are sometimes not present at the time of birth and when registration should occur. This is because many fathers are working in a different city and not in the city where birth occurred. The evaluation found that this factor affects ERB as mothers have to wait for the father to return home for birth registration. It was mentioned in the interviews with officials that the waiting process often takes more than 30 days, because the fathers need to wait until they have money to travel back home and need to file their leave requests in advance before they can go home.

The evaluation found that in instances where mothers need to wait for the father's return, birth registration is often delayed because fathers may not be able to return home immediately or before the 30-days cut-off.

5.3.1.4 DHA perceptions around the negligence of parents

Another factor affecting birth registration as reported by the DHA officials is negligence of parents. The key informants interviewed stated that sometimes there is no valid reason why parents fail to register births within 30 days. Certain DHA officials interviewed during this evaluation indicated that mothers that do not register births within 30 days are negligent and do not value birth registration. It is important to note that this finding came through several interviews with DHA officials. However, this finding could not be validated through interviews with parents. In instances where officials assumed or concluded that parents are negligent, particularly in the case of late birth registration, an implication is that the clients may not receive good quality services if the DHA official interacting with them has a view that they are remiss in their duties as a parent.

5.3.1.5 Informal communication of the birth registration process

Most of the interviewed DHA officials cited word of mouth as one of the most effective ways of messaging birth registration, this is particularly when they asked health workers to advise patients about the birth registration services available at the health care facilities. In addition, the DHA officials were also spreading the word in the communities within which they live. This was further evidenced by the interviews with parents, with these parents indicating that they had found out about birth registration within 30 days via nurses or their friends and neighbours. While this effectively increases awareness around birth registration, by extension, word of mouth may also adversely affect birth registration in cases where a client does not receive good service and reports the experience to friends, family and neighbours. When this bad experience is communicated via word of mouth, it has the potential to scare off pregnant women or other clients, resulting in them not wanting to go to the offices to register birth with the fear that they may also experience bad service.

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[5] It is likely that this requirement also affects parents joined by civil union; however, the evaluation team did not consult any parents representative of this group.

5.3.2 Cultural factors

The evaluation found that there are various, deeply rooted cultural factors affecting birth registration, and these factors need to be taken into consideration by the DHA as the department seeks to improve the rate of ERB and clients' experiences of registering births. It is important to note that this finding did not come out strongly from interviews with clients, but mostly reported in interviews with DHA officials and the issues were more prominent in rural areas.

> *Culture affects birth registration in this province, particularly the rural areas. I took it upon myself to go educate the people of eMampondweni, the aim was to encourage them to have names ready for birth registration before the child is born. I was attacked by the whole traditional authority body and was accused of disrespecting their culture. There are certain rituals that needs to be performed when naming the children, and the baby must be born before the rituals can be performed. In addition, the elders need to be present for these rituals, so these kinds of processes take up time'*
>
> Provincial official, EC

A possible question relating to cultural factors is whether there is a correlation between the relevance of these factors to clients' experience and the age of the client. Most of the interviewed parents ranged between the ages of 21 and 40 years; however, the evaluation did not explicitly assess whether cultural factors were more relevant to specific age groups. The findings that follow should thus be interpreted to be the experience of the 21- to 40-year age group of parents / guardians. In addition, these factors are triangulated using the views shared by DHA officials interviewed.

One of the cultural factors is diverse practices around naming a baby. The interviews with DHA officials and parents indicated that sometimes parents do not register birth early because they do not have a name ready. In some cultures, there needs to be a naming ceremony which requires the presence of elders and other vital family members. These family members are often scattered across the country and may not all be immediately available for the naming ceremony. It sometimes takes more than 30 days for these members to gather together and decide on a name of a baby. In these cases, parents have to wait for the naming ceremony to take place before registering a birth.

Another cultural factor linked to naming is associated with religious beliefs. The officials indicated that in cases where parents are from two different religious affiliations, parents expressed a need to decide on which religion the baby will subscribe to before the naming the child. The officials further added that this process delays the naming procedure which can later lead to LRB.

Through the interviews with both officials and parents, the evaluation noted that another cultural factor is a belief that if the baby does not leave the house for a certain period, the baby is protected from the outside evil spirits. For this reason, mothers opt to keep their babies indoors for a month and even up to three months in some cases. In instances where mothers could not register at the HCFs for various reasons, this cultural factor leads to LRB.

The evaluation team noted during fieldwork, that in some instances, DHA officials are not sensitive to the above-mentioned cultural factors and perceive these cultural factors as an excuse made by parents when they are too lazy to go to the offices or do not want to register a birth. It is possible that the perceptions of certain DHA officials might influence the quality of service provided if cultural factors are not understood and respected. However, in a secular society, it is also important that the general requirements for State-administered services are supported through the communications provided by government and that

tactics are employed that are conscious of cultural factors but seek better solutions to yield desired outcomes (in this case ERB).

5.3.3 Economic factors

The evaluation found that there are crucial economic factors affecting birth registration which contribute towards LRB.

Through the interviews with officials and parents, it was reported that some clients of the birth registration system are faced with poverty and unemployment with limited financial means to achieve birth registration. The evaluation team noted that the financial challenges associated with transport costs affects birth registration in both urban and rural areas. However, the financial challenges were more prominent in rural areas due to long distances between rural / farming communities and DHA offices.

Additionally, for those births that occur in local clinics and unconnected hospitals, clients may not benefit from the hospital footprint initiative. This implies that these affected clients will need to travel to a DHA office, which may be in a larger district or a neighbouring second-tier town for birth registration. The interviewed parents indicated that this was often a challenge as they do not have money to travel to the offices. In instances where people could not register birth at the health care facilities because there was no DHA presence, people had to travel to the DHA offices for birth registration services. The financial burden of transport to the DHA office is often a deterrent or cause for delay (e.g. waiting until after pay day to travel).

It was noted through interviews with officials that there were some officials who visited the unconnected hospitals and clinics to provide birth registration services to the people. It is also important to note that these officials had to travel back to the DHA office to capture the applications, print the certificates, and then travel back to the clinic or unconnected hospital to deliver the birth certificates. This process required more than one day. The officials mentioned that, in these cases, parents had to travel back to the clinics and unconnected hospital to collect birth certificates. This means that even though parents could get services from unconnected health care facilities, they still incurred additional costs associated with returning to the facility to collect a birth certificate.

This implies that birth registration at the connected health care facilities is an advantage to those with limited financial resources as this means they will not have to incur additional costs by traveling to the DHA office or returning to unconnected facilities to collect a birth certificate. Conversely, one of the most cited reasons for birth registration during interviews with parents was to get a birth certificate so that they could apply for the government CSG and burial insurance for their babies. This is further evidence that many clients attempting to register a birth do require financial support to meet the needs of their babies.

Therefore, additional economic costs to registering a birth put clients at a serious disadvantage and is a barrier to ERB. The corollary is that there is a ‘natural incentive’ for birth registration given that a birth certificate is a requirement for CSG, which motivates parents to register a birth as soon as possible, particularly the financially needy parents.

5.3.4 Confirmation of the importance of challenges faced by clients

Based on the information discussed in this section, this evaluation confirms that social, cultural and economic factors continue to constrain ERB. This finding is supported by the literature review and by commonly held views of the DHA officials interviewed, at national-level, province-level and site-level. While these findings are by no means unique or unanticipated, it is important that this evaluation confirms that these cultural, social and

economic challenges have not been overcome by the interventions employed by the DHA and partner departments to date.

This confirmation is not insignificant, given the enormity of child rights and protection issues that require urgent attention. A leading international non-governmental organisation (INGO), World Vision, asserts that children are increasingly vulnerable to abduction, and unregistered children are easy targets for human trafficking and sex labour. Birth registration is thus foundational for the protection and well-being of children and a birth certificate is key to securing the link between children and their relatives to prevent child sex labour and trafficking (World Vision, 2014).

World Vision provides that these global challenges are exacerbated by birth registration systems that exclude the most marginalised and vulnerable of children. These are the children who go unregistered because their location is too remote or too rural or due to social / cultural stigmas that exclude children from the system (an example being disabled children who are not registered because of parent's fears around 'shaming' and social stigma). These children are unreachable to the State's protection because they are not aware that these children exist, and as a result, marginalised and vulnerable children suffer the consequences of:

- Poor health, as they do not have access to proper medical facilities;
- Low education levels, as they cannot be included in subsidised schooling; and,
- Insecurity, because they are not easily traceable to their relatives.

Contrarily and by way of example, in cases where governments are aware that there are children with special needs in certain communities, it is easy for them to offer supportive services to children with special needs (World Vision, 2014). Every child should be counted and able to access the systems that affect their lives. However, tailoring services based on the children's needs is impossible when a government uses inaccurate population statistics to plan its child health-care interventions. For this reason, it is important to ensure that all children are registered as early as possible (World Vision, 2014).

Box 6: Evaluation question 6 - What are the social and economic factors which affect the registration within 30 days?

Birth registration continues to be affected by various social and cultural factors. The main social factors uncovered by this evaluation are unavailability of IDs, challenging resulting from low literacy levels, requirements for the father's presence and DHA perceptions around the negligence of parents. Additionally, cultural factors relating to practices to name babies, requirements for babies to remain at home for a certain period and diverging religious beliefs of parents were also observed during this evaluation. These social and cultural factors are evidenced to constrain ERB. If not considered or catered for, these factors will continue contributing to LRB.

There are economic factors which constrain ERB in cases where clients could not register at a HCF, specifically transport costs. Financially challenged clients face difficulties in accessing sites for birth registration. This challenge contributes towards LRB, as clients have other financial obligations that might be prioritised above birth registration.
Transport costs are incurred by both urban and rural located clients but are a more substantial burden for those in rural areas. Therefore, while the connected hospital footprint has helped to alleviate this challenge to a certain degree, there is more to do.
Conversely, the birth certificate enables access to the CSG, which acts as a 'natural incentive', or a supporting economic factor, for parents that need financial support

5.4 Effectiveness of DHA interventions

The hospital footprint initiative is the primary activity deployed by the DHA to improve the rate of ERB and, in so doing, advance universal birth registration. However, there are a number of supplementary initiatives employed by the DHA which constitute the comprehensive birth registration programme. This section begins by considering whether these initiatives are appropriate in response to the contextual reality of South Africa and the enduring social, cultural and economic factors that influence birth registration, as described in *Section 5.3: Pervasive challenges faced by clients.* This section then discusses evidence relating to three specific areas that influence the effectiveness of the hospital footprint initiative and DHA initiatives; namely, 1) Public awareness of birth registration; 2) Coordination between state actors, and, 3) Coordination between non-state actors.

5.4.1 Appropriateness of DHA initiatives

This section considers whether the activities included in the theory of change, which in totality constitute the birth registration programme, are appropriate given contextual factors, policy and legislative factors and client needs (social, cultural, economic and experiential factors). The activities are highlighted below – the letters correspond to the appropriate labelling in the theory of change (Figure 10, in *Section 4.4: Theory of change for birth registration*). As such, this section discusses whether the specific activities included in the theory of change are appropriate responses to improve ERB and, by extension, universal birth registration.

5.4.1.1 Upgrade and maintenance of IT systems at DHA offices and HCFs (Theory of Change Box D)

A foundational activity in the theory of change is the upgrade and maintenance of IT systems at DHA offices and HCFs. As noted during observations both at DHA offices and DOH facilities, the provision of on-the-spot birth certificates is critical to mitigate against the factors that hinder birth registration *(see Section 5.3.1: Social factors, Section 5.3.2*: *aboveCultural factors* and *Section 5.3.3: Economic factors)*. However, the unreliability of IT systems hinders on-the-spot birth certificates and can affect the quality and consistency of the birth registration process. These inconsistencies ultimately reduce the appropriateness of the process to meet clients' needs.

"It (the birth registration process) is easy. I am going to get my son's birth certificate on the spot."

Parent in Gauteng (DOH facility)

5.4.1.2 HCFs connected to DHA (Theory of Change Box E)

For the reasons outlined in *Section 5.2: Effectiveness of the birth registration process*, it is clear that the connected hospital footprint is a highly suitable initiative and is an appropriate mechanism with which to achieve the outcomes and impact in the theory of change. The foundation of its success is that it meets the needs of the client before they leave the hospital. Based on findings from this evaluation, the hospital footprint is therefore considered the most relevant and most direct approach to improve ERB and by extension the number of total births registered each year.

"The process is perfect as it accommodates new vulnerable mothers by providing access to DHA in hospitals."

Parent, Western Cape healthcare facility

5.4.1.3 Investment in establishing more DHA offices (Theory of Change Box F)

Access to services is key - thus by increasing the number of DHA offices, it is hoped that service delivery will be further improved. However, it is important to note that in the context of the hospital footprint initiative, there is limited need for more DHA offices for birth registration services specifically, as resources were found to be better targeted if directed towards increasing DHA service points at HCFs or in the form of mobile office outreach as these are better designed to overcome the social, cultural and economic factors which influence parents' ability to register their baby. Therefore, this specific activity has limited relevance as compared to extending and improve the hospital footprint.

5.4.1.4 Mobile DHA offices launched in rural areas (Theory of Change Box G)

34.71% of the South African population lives in rural areas

34.71% of the South African population lives in rural areas (World Bank, 2017) which equates to over 19 million people. In an effort to expand reach, the DHA implemented mobile DHA offices which travel beyond the standard office catchment areas. Mobile services are extremely important to bridge the gap between DHA and rural populations who are further isolated due to distance, time and cost. These services are also a valuable approach for registering homebirths and those at clinics. However, the costs of equipment and human resources to operate these mobile units might reduce their relevance relative to other possible initiatives that have been successfully employed in other African countries. Additionally, DHA officials report that of the 117 mobile trucks nationwide, only 115 are still in service but only 45 are operational and able to print birth certificates on the spot.

Only **45 of 117** mobile trucks nationwide are operational to print birth certificates on the spot.

"There is an officer going to surrounding communities and nearby clinics to help with birth registration. This is not necessarily a truck but an individual going to communities and facilitate birth registration." DHA official in Western Cape (DHA office)

5.4.1.5 Relationships with DOH, DBE, SASSA and other stakeholders formalised (Theory of Change Box H)

The importance of collaboration between the various social services government departments is reflective of the need to reach the client, providing a holistic experience. While there is a formalised MOU with the DOH, the content of this MOU excludes a detailed breakdown of responsibilities and is not appropriate to discharge the objectives of the Amended BDR Act. As such, while in theory this MOU is a highly relevant activity, in reality its relevance is limited.

"The relationship with DOH needs to be strengthened. They are the first people that know about the birth, especially over weekends and public holidays. A weak relationship with DOH is a big risk."

DHA official in Western Cape (DHA office)

At the time of writing this report, there were no known formalised relationships with any stakeholders other than DOH in the form of an MOU. The interconnectedness between the DBE, SASSA, DSD and the birth registration process highlights a need for further formalised collaboration between departments. Further establishment and formalisation of these

relationships is, therefore, expected to improve the relevance of the birth registration programme.

"Changing to a ward-based model, where all services (prevention, health, etc) are offered holistically to patients in ward (is necessary). This will help to strengthen relationships at a service level, including coordination between DOH, DBE, DHA and DSD. Especially because Departments will have improved knowledge of the clients and how to reach them adequately and offer a full breadth of service."

Key Informant Interview, DOH (Provincial), Western Cape

5.4.1.6 DHA fosters relationships with other organisations: StatsSA, COGTA, DSD, Agri SA (Theory of Change Box I)

Similar to the discussion in the previous sub-section, collaboration with other organisations is clearly beneficial to the process of birth registration. The specific examples of potential partner organisations provided in the theory of change are; StatsSA, COGTA, DSD and Agri SA. Additionally, the services rendered by other organisations can benefit from more consistent availability of birth certificates within their various target beneficiary groups. Therefore, this remains a relevant activity within the theory of change.

5.4.1.7 General population awareness campaigns (Theory of Change Box L)

In general, improved knowledge drives better behaviour. In this case, it is expected that if clients are more knowledgeable about the process and requirements for birth registration they will adopt the desired behaviour, i.e. birth registration and possibly ERB. Therefore, campaigns to improve knowledge are appropriate to the birth registration programme.

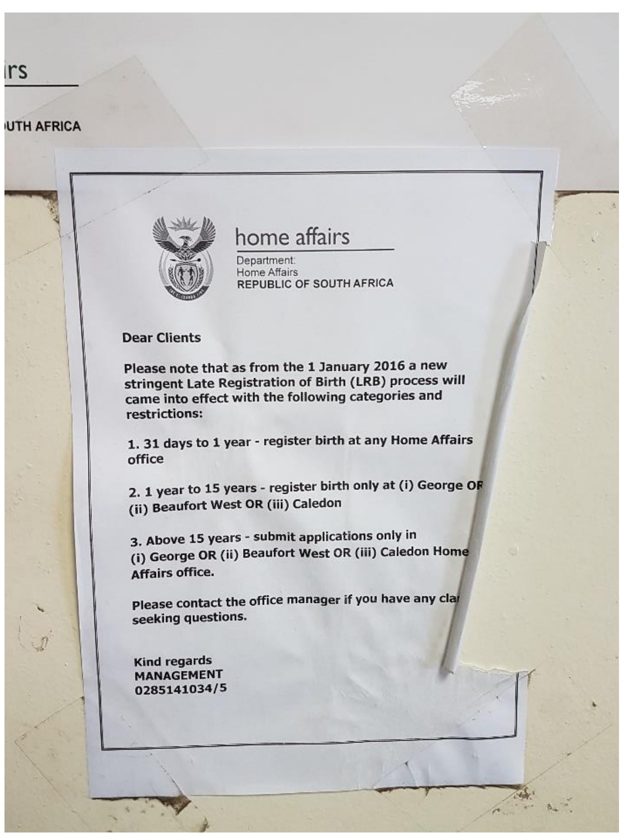
These campaigns vary greatly in terms of content, medium of delivery and stakeholder participation. Therefore, while more and further reaching awareness campaigns are appropriate to improve knowledge on ERB, the specific type of campaign is likely to have greater or lesser relevance depending on who the target audience is. This evaluation has not been able to delve into the varying types of campaigns to assess the appropriateness of each because these efforts are not coordinated and planned centrally.

As witnessed by the evaluation team during fieldwork, a common type of campaign are the posters used at DHA offices and sites. However, as discussed in *Section 5.3.1.2: Challenges resulting from low literacy levels,* these campaigns are not appropriate to clients with low literacy or illiteracy, and may be intimidating for clients with basic literacy, as illustrated in Figure 18 below. Additionally, the lack of messaging on the 'special circumstances' and clients may encounter (e.g. marriage by customary rights, not having an ID, home-based births) and confusing / low visibility messaging on LRB (Figure 19 and Figure 20) is inappropriate given the diverse needs uncovered through this evaluation.

Figure 18: Awareness raising poster 1

Figure 19: Awareness raising poster 2

Figure 20: Awareness raising poster 3



"In January 2017 we included a message on the community radio station. This is a better approach because it reaches all people - even in the rural areas. It also doesn't require the people to be able to read."

DHA official in Limpopo (DHA office)

5.4.1.8 National Population Registration awareness campaign launched (Theory of Change Box M)

The objective of the NPR campaign is to support parents' understanding of the importance of birth registration. From the findings based on interviews with DHA officials, HCF staff and parents, it is clear that where this awareness is established, parents are more likely to act on this knowledge and register their baby. The evaluation uncovered a few instances where parents noted the importance that their child is counted and that they are considered South African. This suggests that there is at least foundational understanding of the NPR in certain pockets of South Africa.

"(I need to register my baby) so that he is a real person. The baby doesn't exist to anyone but me without a legal name. He must have his birth certificate."

Parent in Western Cape (DHA office)

Some individuals (DHA officials and parents) consulted during this evaluation postulate that if parents understand the overall role of the birth registration process within the broader context of South Africa, they will be more incentivised to adhere to ERB. This finding is, however, inconclusive at best. The incentives to register to access government services and to access the CSG appear to be stronger amongst most clients. Therefore, the suitability of the NPR campaign in supporting birth registration may not be the most direct awareness-raising route to take.

> *"The communities should be more informed. Not just of the fact that births should be registered but also why it is important."*
>
> Parent in Gauteng (DHA office)

5.4.1.9 Birth registration izimbizo (Theory of Change Box N)

This initiative harnesses an existing initiative, with participation amongst many different stakeholder groups, and uses it to communicate important information about birth registration. Chaired by traditional leaders, *izimbizo* are a method of communicating the importance of birth registration to communities within traditional community structures. These were regularly cited as an outreach initiative by DHA officials, although it was acknowledged that they were more frequent in earlier years. Interestingly, fewer parents noted this as the method through which they had learned about early registration of birth. Therefore, it was difficult to test the appropriateness of reaching parents through *izimbizo* because the relevance of this awareness-raising channel and the messaging received through traditional leaders could not be probed through parent interviews.
It is possible, however, that those that attend *izimbizo* are the parents that are aware of community events, more connected to neighbours, more likely to be able to ask the right questions at clinics, and generally more capable of unearthing the information they need about birth registration. Crucially, these parents are also those that are able to attend *izimbizo*, which are often in a central community location and at times that might make getting leave from work or travel difficult. For these reasons, *izimbizo* may have limited relevance in raising awareness amongst those parents that need this knowledge the most.

5.4.2 Public awareness of birth registration

59% of interviewed parents knew about the 30-day ERB requirement.

From the data collected through KIIs with national, provincial and district DHA and DOH officials, and especially interviews conducted with clients (parents and guardians) at DHA offices and at HCFs across six provinces, this evaluation has accumulated strong evidence regarding levels of awareness about birth registration. Of the 110 parents we interviewed, 59% knew about the 30-day ERB requirement.

Box 7: Fieldwork reflections

> The parents / guardians interviewed were those who were present at sites on the day of the site visit. While it was not possible to deliberately sample parents such that they represented the demographics of the country. However, the parents that entered sites appear to be reflective of provincial demographics; age (18 – 40 years); race (predominantly Black Africans); location of residence (mostly urban or peri-urban).
> Many of the findings on public awareness are focused on clients outside of the general features of this sample – e.g. minor mothers, people in rural areas and older clients. This is because public awareness issues are particularly relevant amongst these groups and important to note in targeting universal birth registration.

Interviewed parents report that they received information on birth registration from numerous sources and this translated into their knowledge of birth registration. Good knowledge enables understanding, which is later translated into improved awareness and desired behaviour – compliance with the requirement for ERB. From the data collected, we observed four categories of awareness among clients, these are discussed further below. Also elaborated on below is from whom the client is likely to receive the information and the effect this source of information is observed to have on their level of awareness.

5.4.2.1 Clients with good levels of awareness concerning birth registration

Across the interviews conducted with parents at DHA offices and HCFs, and supported by the perceptions shared during KIIs with DHA officials, it is evident that there are many clients with good levels of awareness. The information is often received from nurses during prenatal/antenatal classes or from the DHA clerk stationed at the hospital.

> *"Yes, I knew about 30 days, my sister has a child and so she told me".*
>
> Parent in Gauteng province (DOH healthcare facility)

This statement is indicative of a more generalised observation that word of mouth is an important factor supporting birth registration awareness. However, despite the good levels of awareness, there are other factors that influence whether clients act on this knowledge. It was found that they may not take the desired action to register within 30 days, for instance, because of the perception there are long queues at offices or they become busy once they are discharged from the hospital. Therefore, other social, cultural and economic factors interact with clients' levels of awareness to determine whether clients adhere to ERB.

5.4.2.2 Clients with limited levels of awareness concerning birth registration

It was noted during the fieldwork that a second group of clients has limited awareness. These clients are those that are located in rural areas or those that are young teenage mothers. These clients do not know about the 30-day cut off. This causes late registration because they do not think the timing of registration is important. However, if they do become exposed to a big hospital network during pregnancy, it is rare these clients leave the hospital with no awareness at all. They will have some information about birth registration; however, it may not be enough to encourage or be translated into ERB.

> *"I did not know anything about registering a baby within 30 days, it was brought to my attention now when I am discharged that I could do so"*
>
> Parent in Limpopo province (DOH healthcare facility)

The below factors were found to influence the rural-located client's awareness:

- The clinics were considered too far to attend prenatal/antenatal clinics in order to hear about ERB, the *izimbizo* did not reach them, or where rural areas are vast, it was difficult for the *izimbizo* to cover the whole area.
- The timing of the *imbizo* did not allow for the clients to attend because it was scheduled when they are working or at a time of day when travel is not easy. This means clients may not have the right information on what they need to have with them (documentation) to register the birth, leading to returning to the hospital/office to the register at a later stage.
- Many young clients are dependent on the older generation's knowledge who may be passing on incorrect information or partial information as word of mouth is a strong form of awareness-raising in small or rural communities.

The third group that presented limited levels in awareness are the older clients (grandparents acting as guardians) in urban and rural areas. These clients may not have had a child in a long time, but the Amended BDR Act was applied from 2014, therefore the knowledge they have is no longer sufficient to fulfil the requirements of ERB. This may lead to older clients acting on incorrect information, passing on this information to others through word of mouth, and not registering their own babies within 30 days.

5.4.2.3 Clients that are unaware of birth registration

Lastly, it was evident through the interviews with DHA and DOH officials, that there are still clients with no awareness at all regarding ERB, for example mothers giving birth at home (and so more influenced by indigenous knowledge systems) or going to the smaller clinics (all of which are not connected to a DHA office). It is important to note the interviews conducted were limited to those clients who were at the DHA or DOH facilities. Therefore, the evaluation team were unable to interview this group of clients to directly ascertain their levels of awareness. It is unknown if at a later stage these clients may get access to other State services that would require them to register births. If they are not "in the net" and able to easily access government services, they do not receive the message or information from the nurses and they are unlikely to have the completed PoB form. The consequence is the births from these clients are unlikely to be registered within 30 days.

5.4.2.4 Effectiveness of DHA officials and HCF staff contributions to public awareness

This divergence in awareness is made worse by different levels of awareness amongst FCOs. In rare cases, FCOs also may not be aware or understand the proper requirements of ERB process regarding teenage mothers. They may communicate incorrect information to young mothers that are using birth certificates for registration. This can lead to these births not being registered until the mother has an ID.

"Today is the first time we heard about the 30-day requirement. They wouldn't let us register the baby at Home Affairs in Bronkhorstspruit near where we live. We were told we had to go back to where the baby was born, we had to travel all the way to Mamelodi."

Parent in Gauteng province (DOH healthcare facility)

5.4.2.5 Public awareness of the full scope of benefits from birth registration

Registration of birth is a fundamental, constitutional right that protects the rights of the child. The right to a name and right to citizenship is important in the South African context as these rights were not granted to the majority of the population pre-1994. To some clients, birth registration is perceived as purely administrative – they do not recognise the full benefits beyond facilitating access to government services (SASSA, school entry, and healthcare). It is unclear if the true and full benefits of birth registration is communicated by DHA and DOH or any other stakeholders to the public. This may cause late registration because clients prioritise other things that they value to be more important than the "softer" benefits that registration offers.

A few parents noted the importance that their child is 'counted' and that they are considered South African. This suggests that there is a degree of understanding of the NPR and its role in policy and planning procedures amongst certain parents. It also suggests that the 'true' benefits of birth registration do serve to motivate parents to register. It is, therefore, possible, that the more parents understand the overall role of purpose of birth registration, the more likely it is that these incentives will assert themselves and contribute to ongoing ERB efforts.

"(I need to register my baby) so that he is a real person. The baby doesn't exist to anyone but me without a legal name. He must have his birth certificate."

Parent in Western Cape (DHA office)

DHA and DOH officials (including those at the national level and those providing services at the front-line) believe there are good levels of awareness. However, the awareness that these officials are alluding to is principally knowledge of the requirements and process of ERB. The full extent of benefits transpiring from ERB was not forthcoming from KIIs at national, provincial or district level. If national and provincial officials do not have this

awareness, it is unlikely they communicate proper information to the FCOs or hospital medical staff who then pass on these awareness-raising messages to clients.

Therefore, since there are different levels of awareness amongst different groups in the population, homogenous compliance to ERB cannot be expected. These different groups behave in different ways based on the varied information and levels of awareness they have. This means the common and standard approaches employed by DHA and DOH to raise awareness have left room for improvement.

Box 8: Evaluation question 2 - To what extent have the strategies and programmes above been communicated and implemented and what influence has this had on the results?

Awareness about ERB is the key to achieving the desired behaviour amongst clients and increasing the rate of ERB. The initiatives to achieve these results are aligned to influence good public awareness. However, the initiatives are not reaching the entire population. There are gaps in information and this has led to different levels of awareness amongst clients. Therefore, this results in persistent rates of LRB or unregistered in South Africa, particularly in rural areas.

5.4.3 Coordination between State actors

The hospital footprint initiative is an exceptional example of good coordination between State actors – the DHA and the DOH. Here, effort has been made to reduce the gap between the client and birth registration services by installing DHA service points at facilities with maternity wards. This is tangible successful example of the DHA working alongside a sister department to facilitate the provision of birth registration services.

There are a number of other Departments (DSD, DBE and Department of Justice (DOJ)) whose service delivery to South African children could be greatly improved through better integration with the birth registration process conducted by the DHA. This is because a birth certificate is a document required for them to provide services, e.g. a birth certificate is needed to apply for a CSG. Unfortunately, based on feedback gathered during interviews with national and provincial stakeholders, these are rarely appropriately integrated – nor are the roles clearly defined. This breakdown in communication and collaboration causes frustration between the different stakeholders, as reported in interviews with national-level DHA, DSD and DOH stakeholders. At present, the defined mandates are entirely independent of one another. As a result of this, there is more administration required on the part of the client to ensure they can actually access all the services they need, not only in terms of birth registration but additional social services which require a birth certificate.

"All the [applicable] departments must start working together towards a common goal (DSD, DOH, DHA, Health, SASSA etc). These departments should stop working in isolation."

Official, Key informant, DOH National

Box 9: Evaluation question 7 - To what extent are the strategies supported by key state actors?

Birth registration falls directly within the DHA's mandate; however, there are a number of different departments whose roles are connected to the provision of this service. While the DHA has made an effort to collaborate with the DOH in the form of the hospital footprint initiative, there are improvements to be made to strengthen relationships. More cooperation with other partner-departments is still needed to ensure a more client-centric service can be provided which accommodates for the social, cultural and economic factors affecting birth registration in South Africa.

5.4.4 Coordination between non-State actors

A birth certificate not only fulfils the child's right to a name and a nationality from birth, but is also essential for access to key services. This is applicable to all children, but even more pertinent for children who live in remote areas and/or marginalised and vulnerable. This evaluation finds little evidence of coordination or collaboration efforts with other actors.

In the NGO sector, there are organisations whose purpose it is to facilitate access to services (such as health, nutrition, early childhood development and social welfare) to children and families, and all of these organisations must be registered with DSD to provide services and to access funding. In all such cases, NGOs and NPOs require that the children they reach (or the children's parents) have a valid identity number so that they can verify the work they do to DSD and to funders. Therefore, many NGOs and NPOs actually require a birth certificate to discharge their service.

This evaluation finds evidence that some NGOs and NPOs do, indeed, support their clients to apply for birth certificates. However, this evaluation does not find evidence that this is always coordinated with the DHA. There have been some examples revealed through the site observation but these are few and far between.

> *"The whole notion of putting government services in one precinct would really help. It gives clients the opportunity to do all services at the same time. They have already tried to go that at the moment, just needs to expand. Coordination with Home Affairs [is important] so that the services are all available at the same time".*
>
> KII, SASSA

Box 10: Evaluation question 8 - To what extent are the strategies supported by key non-state actors?

A birth certificate not only enshrines the child's right to a name and nationality but is a critical requirement to access government services. Although NGOs and NPOs often operate separately to government, they do play a key role in helping facilitate access to these government services. As a birth certificate is a requirement for many of these services, it stands to reason that such organisations can help facilitate the process of applying for a birth certificate – and should have a vested interest in doing so. The findings from this evaluation suggest that further improvements could be made by developing relationships with organisations who regularly need to use birth certificates to provide services to the most under-served citizens.

5.5 Sustaining the 'upward trend' of birth registration

Considering the successes of the birth registration programme, and in particular the hospital footprint initiative, there is a need to consider how the effectiveness of the birth registration process could be sustained into the future and the risks to this. On the balance of evaluation evidence, the sections that follow discuss the opportunities for, and risks to, the sustainability of the birth registration programme as identified by the stakeholders consulted through the course of the fieldwork.

5.5.1 Opportunities to promote sustainability

Based on the views of stakeholders (DHA officials, HCF staff and parents) uncovered during this evaluation, it is clear that there are good opportunities to promote sustainability, specifically through maintaining and eventually expanding the hospital footprint, by

improving reach to rural areas, improving awareness of birth registration and building collaborative partnerships with key stakeholders.

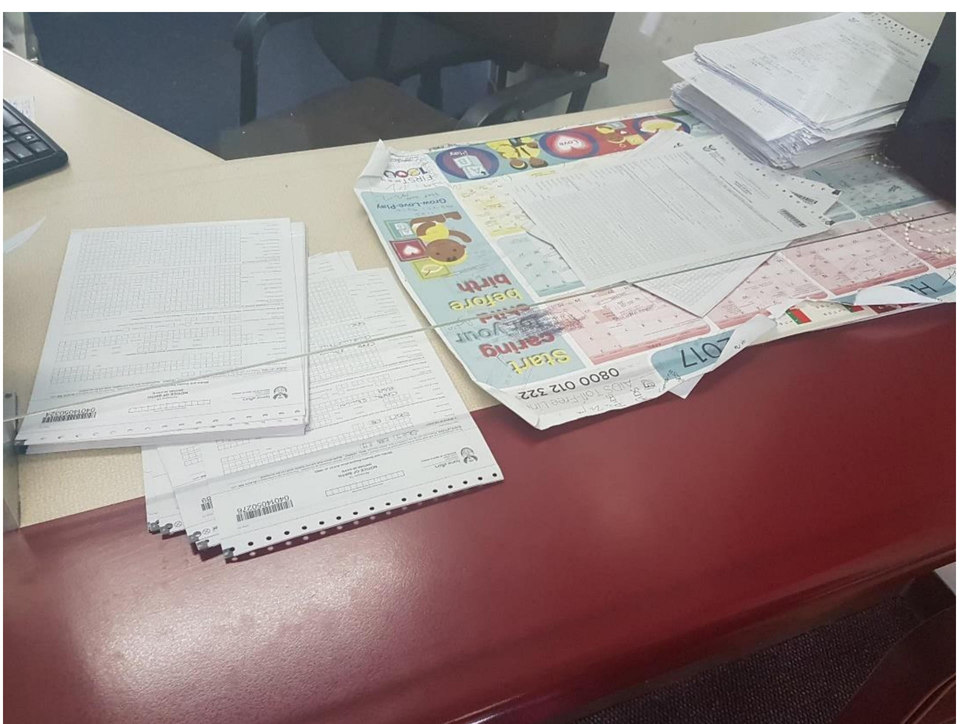
5.5.1.1 Maintaining and expanding the hospital footprint

The hospital footprint initiative is the key initiative to improve the rate of ERB as it reduces the gap between the client and the service providing a birth certificate as close to the time of birth as possible. Most stakeholders consulted agree that these service points are central to continuing the successes achieved with ERB.

Key informants in national departments emphasised that this opportunity can only be leveraged through more stringent equipment monitoring and more collaborative efforts with IT service providers. In particular, key informants noted that the infrastructure for DHA service points at HCFs need to be monitored and maintained. This includes the IT equipment – at minimum a working computer and printer – but also includes ensuring that there are the requisite available staff. HCF staff consulted during the fieldwork stage emphasised that there needs to be improvements in the allocation of DHA officers to DOH facilities to ensure that if that official is unavailable for a day, the service continues. During our site visits conducted during the fieldwork, absenteeism and the resulting unavailability of the DHA service point at HCFs was often observed. An example is one case where the official's child was sick. As such, she was not at work. Unfortunately, although her supervisor had been informed, there were not enough staff to provide a substitute.

Another example was at a large provincial HCF. The DHA official stationed at this HCF had left early, despite their office times being indicated to be until 3pm. A serious concern is that this DHA service point was left unmanned, and complete birth registration forms were left on top of the desk in a position that was easily reached by any passer-by, as depicted in Figure 21 below.

Figure 21: Completed DHA-24 forms left unattended at DHA service point in an HCF



The HCF staff said that this behaviour is not uncommon and spoke about the fact that this leads to mothers being unable to access the service and being confused as to when the DHA station would open once more. This reputational risk is claimed by the HCF staff to

lead to frustrations amongst mothers and reluctance to wait until the DHA official returns. Examples like these are evidence of instances where DHA services at a HCF is halted when DHA officials stationed at HCF are absent. This undermines the success of the hospital footprint, which is a vital ERB strategy.

5.5.1.2 Improving reach to rural areas

Often the only way in which those living in very rural or remote areas have access to the birth registration programme is via a mobile office. According to DHA officials consulted at both provincial and national levels, many mobile units have unreliable internet connections or inadequate IT provisions. As a consequence, these mobile units are not ‘fit for purpose’ to complete on-the-spot issuance of birth certificates. Therefore, while the mobile unit might be able to travel to remote communities to accept birth registration application forms, information still needs to be verified and the certificate printed at a DHA office. The client is then required to travel to that DHA office to collect the certificate, undermining the original intention of the mobile unit to avoid clients incurring transport costs.

“We did have a mobile unit, but it has been taken to be ‘modernised’.”[6]

DHA officer in Eastern Cape (DHA office)

Based on the evaluation findings, it appears that mobile units seldom concentrate on birth registration as a result of the increased focus on the nationwide roll-out of smartcard IDs. It is indisputable that limited State resources should be prioritised to the most urgent need. However, and unfortunately, this reprioritisation means that remote populations are often left underserved.

The mobile units’ reduced focus on birth registration is exacerbated by the fact that clinics are not yet connected to DHA offices, thus in most instances mobile units present the only mechanism to bring birth registration services to far-flung communities. The alternative to taking birth registration services to remote, rural communities is that clients travel long distances to access a DHA office, incurring substantial transport costs. Given the incidence of poverty in rural areas, these costs might prove insurmountable and, unless solutions are found to ensure that the marginalised rural populations have access to these services, these births will not be captured in the NPR, leading to incorrect tracking of rural population dynamics and poor information to guide service delivery plans.

5.5.1.3 Improving awareness of birth registration

While there have been numerous awareness campaigns about birth registration, the evaluation findings note that there are different levels of understanding about the processes and requirements – both on the client side and the staff side. In order to maintain and improve the upward rate of ERB, a common theme emerging from the KIIs is that there needs to be a concerted effort to improve awareness of birth registration in a manner that is conscious of the current variations in awareness and the particular social factors the limit awareness, for instance low levels of literacy. This means that these sectors of the

[6] In this context, the term ‘modernised’ seeks to explain the fact that some of the trucks were taken away from rural communities (because they were no longer in working condition). These resources were subsequently reallocated to other DHA priorities such as smart cards

population are not being reached by the main thrust of public awareness campaigns, posters and leaflets at DHA offices and HCF.

"The people in Wolmarastadt do not understand the importance of birth registration. They do not know that it is a legislation - there are cases where adults do not have IDs and birth certificates. The people think it's okay to register birth whenever and are not aware of birth registration within 30 days"

DHA official in North West (DHA office)

5.5.2 Risks to sustainability

The evaluation uncovered a variety of factors that influence the persistence of LRB. These factors are social, cultural and economic and continue to pose risks to the sustainability of continuing to increase the rate of ERB in South Africa. The evaluation included consultations with key stakeholders and a review of literature and documents, in order to assess whether the DHA-DOH MOU and the proposed penalty for LRB are viable options to mitigate risks to sustainability. The sections that follow discuss the viability of each option in turn.

5.5.2.1 DHA-DOH MOU (2010 and 2015)

The hospital footprint initiative is a core component of the birth registration programme and is thought to be supported by the MOU signed between DHA and DOH. However, the MOU as it currently reads is not aligned with this purpose and is, therefore, inappropriate to advance birth registration in South Africa. The views expressed by DHA stakeholders consulted during the course of this evaluation assert that this MOU is intended to elaborate the roles and responsibilities of each department. Further, DHA stakeholders believe that the MOU establishes a cooperative and collaborative relationship between departments for the effective implementation of the hospital footprint initiative. However, close examination of the MOU reveals that its contents are contrary to this purpose. The DHA-DOH MOU, as it currently stands, is principally to:

- Allow the DOH to access data contained with NPR
- Allow the DHA to access data contained within the NPIS

The content of the MOU, therefore, does not establish a commitment to implementation of the hospital footprint initiative nor does it provide the guiding principles that should govern the implementation of this initiative.

Further, the content of the MOU is closer in nature to a commercial contract than to a partnership agreement. It prescribes clauses relating to obligations of both parties, interpretation, confidentiality, protection of intellectual property (IP), breach and dispute resolution, which is characteristic of commercial contracts. This makes sense given that the current MOU aims to improve access to data. However, as a commercial contract, the MOU's relevance is dependent upon the annexures to the agreement:

- Annexure A of the MOU is missing. This is the implementation protocol, which was meant to have been signed between DHA and DOH but is not currently appended to the agreement. The implementation protocol is crucial because without it there is no content to the agreement with regards to the processes to follow.
- The first DHA-DOH MOU was signed in 2010 and a second MOU was signed in 2015. The second MOU refers to the first stating that:

  "5.1. The Implementation Protocol signed by DHA on 15 December 2009 and the NDoH on 18 May 2010 shall be integral to this Agreement and are incorporated as Annexure A of this agreement." (Department of Home Affairs, 2015)

However, the contents of the MOU of 2010 do not provide sufficient guidance on the specific responsibilities of both parties concerning the implementation of the hospital footprint initiative. According to a DHA national key informant consulted, it is the responsibility of particular delivery units within each national department to develop and agree the specific clauses to be added to an implementation protocol.

- Annexure B of the MOU appears to be irrelevant to the issue of birth registration as it pertains to the IDs and requirements for fingerprints.
- Annexure C of the MOU describes the obligations of DOH; however, these are described so briefly and vaguely as to have limited relevance and meaning. For example, Annexure C states that "NDoH (DOH) will cooperate with DHA to improve the civil registration process through interfacing the National Patient Registration System with the NPR but offers no guidance on 1) Who within DOH will cooperate; 2) What constitutes cooperation; 3) How cooperation will be achieved; 4) What manner of cooperation is desired; and, 5) Over what time period and how regularly should DOH cooperate.

5.5.2.2 Penalty for LRB

The DHA has proposed the introduction of a penalty for LRB as a means of mitigating the risks to sustaining the rate of birth registration. The evaluation tested the perspectives of key informants with regards to the potential implications of such a penalty and found that views were mixed.

While some DHA officials argued that it would help motivate clients to register their baby's birth early, for the most part there were concerns that this is likely to have the opposite effect and worsen late birth registration. Recognising the severity of the economic factors which play a critical role in preventing parents from registering their babies, the dominant opinion is that the additional cost for LRB in an already financially constrained context could prevent parents from even attempting to register their babies – late or at all.

> *"A penalty for LRB may help because this kind of thing spreads like wildfire and people will be more careful to register before leaving the hospital. But DHA must be careful that they then let every parent know what they need to do and what docs they need so they aren't taking advantage of the ignorant."*
>
> DHA official, Western Cape (DHA office)

One official suggested that the punitive measures are only applicable if the parent chooses not to register their baby at a DHA service point in the facility where they give birth. However, as discussed in *Section 5.3.1: Social factors* and *Section 5.3.2: Cultural factors*, there are numerous social and cultural factors which can affect whether or not the baby is named at the time of the birth. As such, if these penalties were implemented, they would discriminate against people with certain beliefs which is unconstitutional.

A legal expert consulted during the course of this evaluation stated that if the imposition of fees for late registration (in either form, i.e. 30 days to one year or after one year of age) were to result in even a few children being unable to be registered due to parental inability to pay the fee, this would infringe the child's constitutional rights to birth registration.

The legal expert also noted that the imposition of a late registration fee would weaken the process, given that first registration of birth (at whatever time in the child's early years) is currently free. Although birth registration is generally regarded as a civil right, and the concept of retrogressive measures is more usually applied to socio-economic rights, a heavy

burden rests on the State in terms of Section 36[7] of the Constitution to show why a restriction of rights currently enjoyed is necessary and desirable to achieve the purposes sought by that restriction.[8]

The imposition of late registration fees would have the effect of making birth registration for the poorest (and most vulnerable) impossible, or at least, it could delay birth registration whilst parents or caregivers find money for registration, thereby impacting the child and his or her enjoyment of rights. The motivation for such fees would presumably be justified on the basis that the threat of future fees will encourage early registration within 30 days and that this fee would be used to process the additional administration required for a LRB such as the interview board, the inspection and investigation, the assessment of additional documents provided.

Those who are most susceptible to non- or late registration include the most vulnerable categories of children – orphans, children living on the street, children of deceased parents, abandoned children, including abandoned children of migrants, and children growing up in deep rural areas, whose care-givers may also lack IDs. These children will be disproportionately affected by the introduction of late registration fees, which will exacerbate discrimination and have a multiplier effect upon their vulnerability, as it is well known that access to a range of social and health services depend on registration of birth. The constitutionality of such a step, in a context where children obviously cannot register themselves and depend on adults to do so, is questionable.

A National DHA key informant consulted indicated their agreement with this assessment and indicated that the penalty for LRB has not been progressed within national DHA internal discussions because; 1) there is no consensus that it will be effective in incentivising adherence to ERB; and, 2) there is recognition that the imposition of this penalty will disproportionately affect the most marginalised, most poor and most vulnerable children.

Box 11: Evaluation question 10 - How can we manage risks of late registration? Would punitive measures be effective?

While punitive measures may help motivate parents to register births early, there is concern that the most vulnerable will be negatively affected by this and that the additional cost will prevent parents from prioritising birth registration at all. This is expected by key informants consulted to worsen the incidence of unregistered births. Most importantly, the majority of stakeholders consulted agree that a penalty for LRB would exacerbate the marginalisation of vulnerable groups. Therefore, this evaluation concludes that punitive measures will be ineffective in driving ERB and may, indirectly, drive a growing number of unregistered births. Additionally, the State may struggle to establish the legality of a penalty for LRB

[7] Section 36 of the Constitution of the Republic of South Africa (1996) provides certain factors that must be taken into account by courts to determine whether the limitation of a right is reasonable and justifiable; 1) The nature of the right; 2) The importance of the limitation; 3) The nature and extent of the limitation; 4) The relation between the limitation and its purpose; and, 5) Whether there are less restrictive means to achieve the same purpose.

[8] This argument is supported by case law. In two decisions of the Constitutional Court involving the restriction of prisoner's right to vote (also a civil right) the State was unable to meet the various legs of the Section 36 analysis to provide for adequate justification as to why the right of prisoners to vote in national elections should be restricted.

5.6 Birth registration and expanding access and inclusion

At the highest level, the theory of change aims to achieve the impact of efficient determination and safe-guarding of the identity and status of South African and non-South Africans born in South Africa. This evaluation TOR did not contain any evaluation questions directly relating to the impact of birth registration, as this implementation evaluation is focused on assessing the performance of the programme. However, considerations relating to this highest-level impact are still pertinent, as they provide additional framing to understand how the birth registration programme can and should be improved towards the achievement of the outcomes and impact included in the theory of change.

There are numerous groups in South Africa whose experience of the birth registration process does not reflect the notable successes that have been achieved to date. These groups include:

- Orphans and Vulnerable Children (OVCs)
- Foreign nationals
- People living in very rural and remote areas

5.6.1 Registration of babies born to foreign nationals

While it is clear that the birth registration services provided to South African citizens have improved – as illustrated by the increase in numbers of births registered (*Section 5.1: Analysis of trends in birth registration*) – this evaluation finds evidence that the registration of births to foreign nationals remains an area of concern. At present, children born to two foreign national parents are not issued a birth certificate. Instead, they are issued a handwritten 'notice of birth' document. The primary purpose of the document is for it to be used by the parent to apply for the appropriate documents from the necessary consulate or embassy. This is not captured on the system, but rather is issued directly to the parent.

This creates a host of challenges – primarily that should the parent lose this document, there is no way for it to be reissued as there is no electronic record of it. The fact that the births are not captured on an online system also means that there is inadequate monitoring of the number of foreign births registered in South Africa. This is an area of risk in terms of future policy development and planning.

"The challenge with registering non-South African births is if the DHA19 needs to be reissued. The office does not keep this record so it needs the application needs to go to Pretoria. This causes confusion with the public, because they have an expectation that the office keeps the information. Another challenge is that the process for non-South Africans is not electronic and manual admin is time-consuming and difficult."

DHA officer in Western Cape (DHA office)

Based on our review of the general process for registering births for children of foreign national (see Figure 8) there are numerous factors which have been identified as challenges, which reduce the effectiveness of the birth registration process experienced by foreign nationals:

- There appears to be a lack of clarity regarding the precise process to be followed when registering foreign births – this is exacerbated by the fact that often the parents are undocumented. This can cause frustration on the part of the DHA staff (due to the fact that they lack clarity around the approach) which can negatively influence the way in which DHA staff address queries with foreign clients.
- There appears to be a lack of priority given to registering foreign births in terms of the processes and systems in place. This is, in some cases, evidenced in the negative attitude of

DHA officials to foreigners, which was evident in the tone used by officials interviewed in offices at or near border towns and was reinforced by the perspectives of parents interviewed at these offices. This was noted as a particular concern at offices that were in or near border towns.

- Even if foreign parents have all the correct documents, they cannot register their child's birth at a HCF service point. This is because their documents need to be checked by the Immigration desk at DHA. As such, it is also true that not all DHA officers can facilitate foreign birth registrations – only those that have an immigration department. This means that parents sometimes need to be directed to a different office. The siloed nature of the different departments – even within Home Affairs – undermines the effectiveness of the processes overall.

"They should really attend to cases like ours in a better way rather than just sending us from post to pillar without even explaining to us properly what they need because our children are living in danger and as illegal immigrants while they are born in South Africa with a South African father."

Parent in Limpopo (DHA Office)

- In the case of a LRB, if the father is South African and the mother is foreign a paternity test (at the client's own cost) is required. Separate to the additional inconvenience – which is often interpreted as punitive - this cost can also deter parents from continuing the process. Similarly, all social and economic factors that influence timeous birth registration are likely to be exacerbated with foreigners living in South Africa.
- The parents' documentation needs to be valid. The cost of this can also be a hindrance. The fear of retribution by the DHA for invalid immigration documentation on the part of the parents can also prevent parents from seeking a notice of birth for their child.

"My passport has expired and they only gave me a handwritten birth certificate. I told them that I am married by a South African man and so my kids are South African but they could not help me. It has been difficult going back to Zimbabwe and sorting my papers with so many responsibilities at home. So I stayed for years without proper papers and that is why I am coming now because now I have a passport."

Parent in Limpopo (DHA office)

As is clear from the discussion above, the process for foreign nationals to access a notice of birth is fraught with challenges. This is exacerbated by the fact that this document is not considered to have the same value as an electronically generated birth certificate. Furthermore, the handwritten notice of birth has a key purpose: it is required to apply for a birth certificate from the child's country of citizenship. The difficulties and delays with securing this document means that babies born in South Africa have to wait to apply for birth certificates from their own country. This has two grave implications: 1) the South African process is delaying the issuance of appropriate birth certificates for foreign nationals and; therefore, 2) the rights of the child are not being upheld.

"The main challenge in Musina is that it is close to the border and there are a lot of illegal immigrants – this is one of the reasons why births do not get registered. When the hospital reports on the number of births occurred, that number is inclusive of births to non-South African citizens which implies that it will be difficult to achieve 100% early registration of birth in Musina."

DHA officer in Limpopo (DHA office)

5.6.2 Inclusion of OVCs

When asked about the process to register the birth of OVCs the overwhelming response was that this process is managed primarily by social workers employed the DSD. This

process is also often at the direction from the courts (DOJ). A concern coming from a legal expert consulted during this evaluation is that training modules provided to social workers does not include the details and requirements of the birth registration process, including how the 'special circumstances' experienced by guardians to OVCs. As such, there appears to be a disconnect in expectations between these different stakeholders regarding the degree to which the process is understood. This reiterates the fact that the process is unclear. It should be noted that during our fieldwork, we did not have the opportunity to interview any guardians or social workers of OVCs and as such cannot describe how access to a birth certificate is affected by these factors. That said, the inconsistency or lack of clarity regarding the process is cause for concern generally as it will delay not only the issuance of a birth certificate but also the provision of affiliated social services, and more particularly as this affects an already marginalised population.

Unfortunately, the siloed nature of government operations does not lend itself to a smooth process. The requirements to register a child are very strict. In the context of South Africa and numerous social and health issues (e.g. incidence of violent death, incidence of death resulting from gender-based violence, the prevalence of HIV/AIDs, death due to drug abuse), many children experience death of one or more parent and/or are abandoned and are subsequently adopted and raised by the extended family. The current process does not allow a family member to register a baby which is not theirs, without a social worker. In cases where the death of the mother has not been reported, there is no social worker involved. This additional burden can discourage the family from pursuing a birth certificate at all.

In the South African context, a high proportion of vulnerable children are those of immigrants. In these cases, the parents are generally either economic migrants or asylum seekers – if the latter, a court order has to be issued recognising that they are indeed asylum seekers. This process can be slow and there are regularly delays. However, it is unfortunately not possible for the birth certificate to be issued without the court order. As such, further collaboration is needed between the different departments who facilitate access to services for these, the most vulnerable groups residing within South Africa.

Key informants consulted during this evaluation agree that more can be done to expand the birth registration process to those children living at the fringe of society. Further, as a signatory to the UNCRC and the African Charter on the Rights and Welfare of the Child, South Africa is mandated to work towards universal birth registration, as enshrined in the constitution (Republic of South Africa, 1996). Therefore, the achievement of this outcome is a crucial measure of the success of the birth registration programme.

This evaluation finds that the levels of awareness, amongst DHA officials, HCF staff and the clients themselves, on the requirements for birth registration in 'special circumstance' is insufficient to enable an inclusive birth registration process. Further, the myriad factors that affect OVCs, children born to foreign nationals and rurally-located children from being able to access birth registration services are intractable and cannot be overcome solely through DHA efforts.

Box 12: Evaluation question 1 - What are the results in terms of birth registration?

While there have been very effective strategies implemented to support birth registration services for South African babies, this effort is not reflected in the effectiveness of service provision to remote, marginalised and vulnerable groups, in particular children born to foreign nationals and OVCs. Here, effort needs to be made to clarify the process for registering births in 'special circumstances, given that DHA officials have inconsistent understanding of how to deal with situations and clients have limited understanding of the requirements in these situations. These is limited evidence of engagement with NGOs and DSD, and these collaborations could prove useful to reach and better serve remote,

marginalised and vulnerable groups and to consolidate efforts to reduce security risks such as child trafficking, fraud and kidnapping.

5.6.3 Birth registration as an enabler of access to other services (State and non-State)

A birth certificate is required to access many other services, and these are not limited to government. During the site observations, parents interviewed mentioned a host of benefits enabled through the birth certificate, including social grants, burial policies, medical aid and schooling. These benefits were supported by views shared by DHA officials, commenting on the reasons why their clients choose to register births. As at 30 September 2017, the total number of CSG recipients in South Africa is 12,157,809 (South African Social Security Agency, 2017). The number of CSG recipients constitutes more South Africans than receive any of the other types of grants in total (approximately, 69.9% of all grant recipients). It is unsurprising that access to CSG forms a 'natural incentive' that prompts parents to register births.[9]

"[I] need a birth certificate [for my child] to apply for a social grant and burial cover"

Parent, Gauteng, DHA office

During the fieldwork, we witnessed examples of SASSA and DHA sharing offices at HCFs. This reduces the operational cost of these service points (as expenses are shared between the two departments) and also means that the client is provided a more holistic service offering which was appreciated by the clients where this was available. While we were unable to engage with DBE, the need for a birth certificate to enrol for early childhood development (ECD) services provides another opportunity to locate a 'captive audience' for birth registration services.

Additionally, the NPOs that register with DSD are required to report on the number of project beneficiaries their work reaches. This reporting is often on the basis of children (or their parent's) ID numbers – yet another 'captive audience' that can be leveraged to promote birth registration. Overall, and supported by the views shared by key informants consulted during the course of this evaluation, close coordination of activities with State actors (e.g. SASSA, DBE and DSD) and non-State actors (e.g. NPOs, medical aids, burial societies), this evaluation finds that there is potential to unblock new channels to stimulate improvements in the rate of birth registration in South Africa.

5.7 Improving the reliability of the NPR

A key objective of birth registration is to ensure a credible NPR with only one point of entry, registration within 30 days of birth, and a population with proof of citizenship. Further, the requirement that births are registered as soon as possible and subject to all the necessary checks and balances aims to reduce fraudulent entries into the NPR. Thus, the promotion of ERB is critical for the maintenance and accuracy of the NPR, which is foundational for planning and policy-making across all government departments but especially those providing social services such as DOH, DSD and DBE. Given the performance of the birth registration programme in driving an increased number of registered births over the last five

[9] CSG can be accessed for up to three months after birth without a birth certificate. However, this incentive still appears to influence parents willingness to register births.

years and a growing proportion of births registered at HCF, it is clear that this outcome is being advanced through ERB.

However, since universal birth registration is still an ambitious objective, the key challenges to ERB uncovered by this evaluation require attention. Chief amongst these is that mothers often do not have their ID with them at the HCF when they are approached by DHA officials. The reasons for this can be loosely grouped into the following categories:

- The mother forgot to bring her ID with her when she went into labour and therefore does not have it with her in the hospital.
- Mothers are undocumented (South African or foreign) and thus do not have the appropriate ID.
- Mothers are under the age of 16 years, and thus have not yet been issued a South African ID document.

ID unavailability seems, at first glance, to be an oversimplification of barriers to birth registration. However, through interviews with DHA officials, HCF staff and parents, this evaluation finds insurmountable evidence that ID unavailability is a serious barrier resulting in the cut-off for ERB being missed. By extension, ID unavailability limits the potential to drive increases in ERB and so, does not support the achievement of a more reliable NPR.

During our fieldwork, we did experience one case where the DHA officer, based at the HCF, had recognised the issue of birth registrations being delayed due to mothers forgetting their IDs. Noting the importance of getting the mothers to register their babies before they leave the facility, this DHA official registers births so long as the mother can provide her ID number – even if she does not have the ID book/smartcard with her. While this example is by no means ideal, given the incidence of fraud in South Africa, it is illustrative of the pervasiveness of ID unavailability as a barrier to ERB. Simultaneously this example illustrates the commitment of some DHA officers to ensuring they provide the required services to those most often forgotten.

Section 5.4.2: Public awareness of birth registration discussed the effectiveness of public awareness campaigns on the public and how these contribute towards ERB. During the evaluation, it was noted that 'being counted' or being included on the population register were cited as highly valued reasons for why parents were seeking to register the birth of their baby. Based on these findings, this evaluation postulates that if more parents understand the importance of the NPR and how this affects accurate planning for service delivery, it might be possible to convince parents to register their babies within 30 days.

5.7.1 Consideration of the 30-day cut-off

72,6% of parents seeking LBR (who were interviewed) had babies of approximately 3 months old.

The quicker information is captured, the more accurate the NPR. As such, ERB facilitates a more accurate NPR than the late birth registration process. However, it is important that these births are still captured on the NPR as quickly as possible. Of the 84 parents who were consulted who had registered or were registering their babies, 61 (72,6%) of their babies were born approximately three months earlier. While these would all be considered late birth registrations (exceeding 30 days) it is important to note that none exceed a year. This finding suggests that an adjustment of the ERB cut-off of 30 days might be a solution to accommodate the social, cultural and economic factors of new parents in the South African context.

5.8 Evidence-based planning and policy-making towards improved service delivery

As discussed above, the NPR is foundational for planning and policy development. It contains information relating to the number of South Africans, what their genders are, their ages and where they are located. As such, an inaccurate NPR is a barrier to the South Africa government's ability to accurately plan resource allocation and resource targeting to meet the needs of citizens.

The NPR is also used to inform government on where new programmes or interventions are needed – this is particularly relevant in a developing economy context with a high influx of economic migrants. As such, the risk of an inaccurate NPR is huge as it prevents government from designing policies and programmes which meet the needs of a growing population.

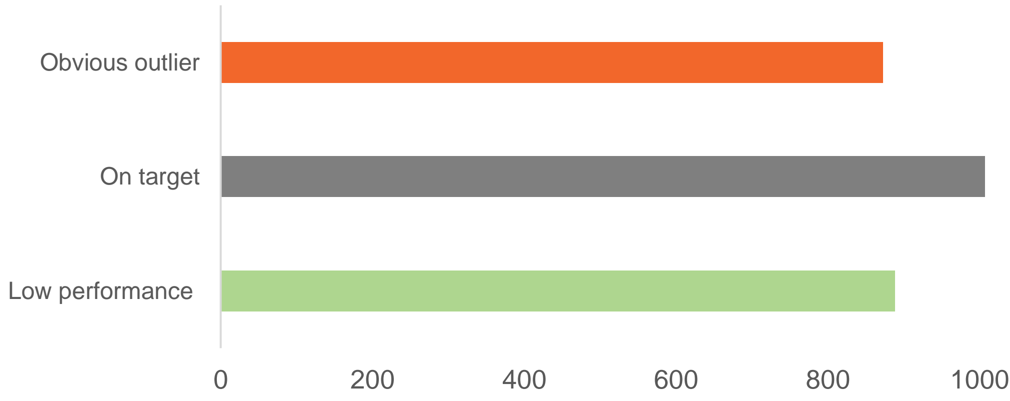
5.8.1 Site performance and target setting

The targets that are used to measure performance at site-level are crucial for evidence-based planning and policy-making. These targets enable the identification of sites that are low performing, on target and excelling, all of which are considerations that must be taken into account as the DHA and DOH jointly decide where to funnel resource, training and coordination support.

Site-level performance against targets is difficult, if not impossible, to interpret. Figure 22 below illustrates this point. Site performance against targets has been categorised as follows:

- Low performance: Less than 80% target achievement
- On target: 80% to 120% target achievement
- Obvious outlier: Greater than 120% target achievement

Figure 22: Number of sites in each performance category, cumulative from 2012/13 to 2015/16



In the graph, we calculate the total number of sites that are classified in each category over the period 2012/13 to 2015/16. As the graph shows, 701 sites are 'obvious outliers' because they exceeded targets by over 120% over the five years. At first glance, this appears to be a good news story, hinting at the success of the birth registration programme. However, closer inspection is required to really understand what the data indicates.

Table 9 provides the number of sites in each performance category but disaggregated by year. From this table, it is clear that the number of connected sites (DHA offices and HCFs) is increasing over the period. It is, therefore, unsurprising that the number of sites per performance category also increases each year. However, what is surprising is that the proportion of 'obvious outlier' sites seems to also grow proportionately. This is a concern because a site that far overshoots its target in one year, with effective target setting, should be subject to a revision in targets such that the target remains meaningful.

> In 2014/15 targets were exceeded by up to
> **105 922%.**

The last two rows in Table 9 indicate the largest deviation from target experienced at a site in each year. This data is particularly revealing – targets were exceeded by up to 105 922% in 2014/15 and the average deviation from target is ranges between 236% and 2 810% for the years 2012/13 and 2015/16. This performance might seem at the surface to indicate impressive success; however, since the incidence of targets being exceeded is so common across sites for all years, this data calls into question whether target setting is indeed appropriate and effective. This is a concern because, in the absence of being able to analyse site-level performance against targets, it is difficult to determine what the drivers of increased birth registration have been.

Table 9: Number of sites in each performance category

	2012/13	**2013/14**	**2014/15**	**2015/16**	**Total**
Low performance	27	148	200	257	632
On target	175	91	227	257	750
Obvious outlier	50	256	223	172	701
Total	252	495	650	686	2083

Notes: Low performance <80% of target | On target 80% - 120% of target | Obvious outlier >120% of target

	2012/13	**2013/14**	**2014/15**	**2015/16**
Greatest deviation from target	2 375%	88 629%	105 922%	68 881%
Average deviation from target	236%	2810%	1212%	756%

The evaluation's analysis of the appropriateness of target-setting is further supported by site-level interviews conducted with DHA officials during the fieldwork phase. Many DHA officials stated that they were not aware of the factors informing targets at site level, which they believe are decided at national-level. The DHA officials consulted found this to be a concern, emphasising that this indicates a lack of consultation with the officials on the ground and a lack of understanding of contextual factors driving performance at site-level.

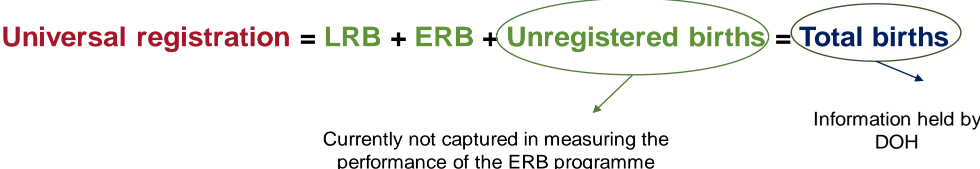
An example is useful to illustrate this point. One of the interviewed officials facilitating birth registration at a HCF stated that they had been instructed by a DHA office supervisor to register at least 15 births a day. The feasibility of this target was evidently not considered since the actual number of babies born each day could be more than, or less than, 15 births a day.

Through the interviews with officials, the evaluation finds that the targets are not appropriate given the experiences and contextual factors at site-level. These factors include the extent

to which people are able to access the sites and other social factors affecting birth registration. If targets are not realistic, the performance of officials is reportedly negatively affected as they may experience frustrations working towards unrealistic targets. Therefore, this evaluation finds that target-setting, as currently practiced, is ineffective in monitoring and managing site-level performance.

While the birth registration programme has made admirable progress in facilitating the upward trend in total births registered, this must be distinguished from the ultimate goal as expressed in the theory of change – universal birth registration. Indeed, South Africa has committed to universal registration of births as a signatory to the UNCRC. In order to set targets towards the achievement of universal birth registration, it is essential that the statistic relating to total births (information held by the DOH) be used. Without this information, it is impossible to tell whether the number of unregistered births is declining and, by extension, whether universal birth registration is advancing. Insufficient data sharing provisions within the DHA-DOH MOU are core to the ineffectiveness of target setting (discussed further in *Section 5.8.2: Implications of insufficient data sharing provisions within the DHA-DOH MOU*.

Figure 23: Information required to target universal registration of births



5.8.2 Implications of insufficient data sharing provisions within the DHA-DOH MOU

The inadequacy of target-setting is exacerbated by the fact that several key figures are unknown and thus are excluded from the methodology employed to decide targets, principally because this data is sourced across departments and requires data sharing between departments for their calculation and analysis.

The most important indicators concerning birth registration are:

- The total number of live births (actuals not registered)
- The trends in connected HCFs vs DHA offices
- Trends in national population demographics
- The proportion of ERB vs LRB

Annexure C of the DHA-DOH MOU sets a requirement for DOH to share number of live births data recorded on the NPIS with DHA. Specifically, Annexure C states that this data should be supplied by DOH within 30 days of it being requested by DHA but only for the time period requested. The number of live births is vitally important for the monitoring and management of site level performance against birth registration targets.

The wording in Annexure C suggests that this sharing of data is ad hoc and irregular. This suggests that the MOU, as currently worded, is insufficient to support evidence-based planning and performance management. Statistics on live births are crucial to understand birth trends across various localities in South Africa. Comparison of these trends to the proportion ERBs and LRBs is important to comprehensively measure the effectiveness of programme and how performance can be improved. Therefore, the MOU's establishment of an ad hoc and irregular data sharing arrangement between DHA and DOH is inappropriate given the policy needs in South Africa.

Additionally, information on the predicted number of live births per site could potentially be estimated based on the number of women who receive prenatal care at a hospital. This

estimation would be useful to plan staffing requirements for DHA officials stationed at connected HCFs. While it is understood that some women who give birth at a hospital may not have received prenatal care at that hospital, this 'pipeline' estimate will still provide more information than is currently used to determine staffing requirements at connected HCFs.

5.9 Summary findings by DAC Criteria

The table below summarises the findings presented throughout this section using the DAC Criteria – relevance, effectiveness, efficiency, impact and sustainability. For each criterion the evaluation team has provided an overarching impression of achievement relative to each DAC Criterion, using a Red, Amber, Green rating as follows:

- Red – This is a lagging area(s)
- Amber – This is an area(s) of mixed experiences and performance
- Green – This is an area(s) of progress

The findings and rating have been developed based on the evaluation team's review and synthesis of findings. This includes interrogation of both qualitative and quantitative data; however, the DAC Criteria assessment is primarily interpretative.

DAC criteria	Rating	Finding
Relevance		• The hospital footprint initiative helps to overcome many of the social, economic and cultural factors which can hinder parents applying for birth certificates through a DHA office. This is achieved by providing birth registration services at the place of birth. • Hospitals are ideal places to leverage ERB as this is where 65% of births in South Africa occur. • The hospital footprint initiative is not rolled out to all HCFs – and excludes all clinics. As such it is not a comprehensive solution for all sectors of the population but is a relevant option to address ERB in South Africa.
Effectiveness		• A myriad of awareness efforts have been implemented to maximise the effectiveness of the birth registration programme – with considerable success. • Where there are sufficient staff and resources, birth registration services are delivered effectively – both at DHA sites and particularly through the hospital footprint initiative at HCFs. • While the proportion of births registered within 30 days is increasing, this period does not accommodate those with cultural or religious beliefs that require a longer period before naming of the child can occur. • This evaluation found that there are very broad levels of awareness amongst clients. Low level of awareness – both around the 30 day cut-off, and the requirements for birth registration - undermine the effectiveness of the programme. • There continues to be a lack of clarity between the DHA and DOH regarding key requirements for birth registration (such as the PoB) as well as how these roles and responsibilities intersect. This limits the overall

		effectiveness of the programme. • Lack of IDs has been identified by this evaluation as a deterrent of birth registration through the hospital footprint initiative which undermines its effectiveness. This can be overcome by installing fingerprint verification machines in HCFs, although the initial cost and maintenance thereof could be preventative. • The limited connectedness of HCFs, especially the exclusion of clinics, reduces the effectiveness of the programme.
Efficiency		• Where there are sufficient staff and resources, birth registration services are delivered efficiently – both at DHA sites and particularly through the hospital footprint initiative at HCFs. • This evaluation has noted that the lack of staff translates to a reduction or eradication of services which severely hinders the efficiency of the programme. • Efficient delivery of birth registration services is heavily dependent on adequate equipment and connectivity. Unfortunately, as this evaluation shows, maintenance of equipment is adhoc and IT connectivity is unreliable. Both sorely undermine the efficiency of the birth registration programme.
Impact		• The proportion of ERB is increasing illustrating the positive impact of the birth registration programme. • This evaluation found that there are diverse levels of awareness amongst clients. Low level of awareness – both around the 30 day cut-off, and the requirements for birth registration – undermine the overall impact of the programme. • Motivation for birth registration remains strongly linked to social benefits (grants, school entry requirements, burial policies). The impact of the programme can be enhanced through careful consideration of these indirect benefits of birth registration, both in terms of positioning these social benefits as incentives to register births and in terms of ensuring that birth registration serves to enable access to important social benefits. • The birth registration programme is lagging in terms of ensuring access to birth registration services for OVCs • The birth registration programme is also lagging in terms of ensuring that the experience of issuing notice of births to foreign nationals is as effective and efficient as possible.
Sustainability		• While the programme is contributing to improvements regarding ERB, there are significant concerns around the sustainability of the programme. • There were numerous awareness campaigns launched at the beginning of the programme, but findings from this evaluation indicate that in many cases these are no

		longer happening. • There are significant issues with maintaining staff – exacerbated by union concerns – which highlight a key issue around the sustainability of the programme. • As new priorities for DHA arise, so resources are funneled towards those (e.g. smart IDs) ahead of birth registration services. • Maintenance of IT equipment and services is inconsistent. As such, far fewer HCT connection points remain active following their installation. This illustrates the weakness of the sustainability of the birth registration programme. • Where understaffing and poor resources are rife, the system has been maintained through birth registration champions who go above and beyond to serve the client. Unfortunately, these efforts are unsustainable. • Finally, issues relating to the DHA-DOH MOU continue to pose a risk to the sustainability of the programme, as this is entirely dependent on the nature and effectiveness of collaboration between the DHA and the DOH at all levels of government.

6 Conclusions

The importance of the birth registration programme cannot be understated. A key success of the programme is indicated by the persistent increase in the rate of ERB from 68.5% in 2013 to 76.8% in 2015 (StatsSA, 2016). However, the rate of ERB is calculated based on the total number of births registered (ERB and LRB); thus, the rate of ERB is not a proportion of all live births. Further, because the birth occurrence statistics reported by StatsSA is determined by the number of births registered and is updated to include those births that are registered late, it is difficult to say how many births go unregistered beyond a year, beyond five years and beyond 15 years. Therefore, the effectiveness of the programme in enabling universal birth registration is unknown.

The following section presents the conclusions stemming from the evaluation. This commences with an overarching assessment of the relevance of the programme at a strategic level, followed by key considerations regarding the implementation of the strategic vision and the implications of these on the implementation and operability of the ERB system.

6.1 Strategic vision

The overarching strategic vision to register births as soon as they occur, as illustrated by the option for parents to register births at the HCFs at which they occur, and reinforced by the 30-day window, is appropriate to birth registration clients and the objectives of the birth registration programme. Providing the option for registration at HCFs gives clients an accessible means by which to register the birth of their baby, and as registrations occur before or shortly after mothers are discharged, this creates the potential for the timely capturing of births. Additionally, as a large portion of births in South Africa occur at HCFs, registration at HCFs ensures that a sizable portion of the total number of births in South Africa are exposed to the potential for registration at the most opportune time and place.

The mechanism which governs this strategic decision is the MOU between the DHA and DOH. However, as outlined in *Section 5.5.2.1: DHA-DOH MOU* the MOU is not sufficiently detailed, particularly with regards to the roles and responsibilities of the respective parties, to effectively govern the implementation of this strategic vision. Without clear delineation of the respective processes to be followed by the DHA and DOH in the registration of births at HCFs, the MOU leaves ambiguity around the process itself, the stakeholders responsible for various tasks therein and lines of accountability. The evaluation find that this ambiguity creates room for inconsistent interpretation and communication relating to the requirements for birth registration, and ultimately, contributing to variation in the effectiveness of implementing the strategic vision.

While the strategy of registering births as soon after they occur was found to be relevant and appropriate to ensuring that births are accurately captured and consequently that the NPR is accurate; there are cultural and religious beliefs and structural family factors that influence a client's ability to register the births of their baby within 30 days after birth. A key factor in South Africa is the influence of migrant labour patterns on family structures and the effect of this on having both parents present to register the birth of their baby. As such certain groups of the population are unable to register the birth of their baby within the 30 day-window, irrespective of their willingness to do so. By implication, while the focus on ERB has high strategic value, the need for LRB is expected to be perpetual and, therefore, the effectiveness of LRB should not be neglected.

6.2 Implementation of the strategic vision

To affect this strategic vision, the birth registration programme has implemented a number of initiatives. As detailed below, the success of these initiatives has been varied:

- The hospital footprint initiative enables the registration of births at the source at which they occur, which facilitates the timely and accurate capturing of births. However, the success of this initiative, while notable, is limited by the gaps in the MOU and subsequent ambiguity around the implementation of the hospital footprint initiative and the respective roles of the DHA and DOH.
- The DHA's awareness initiatives have been successful in increasing awareness around the 30-day ERB window and the process that clients should follow to register the births of their babies. However, the effectiveness of this is restricted by the inconsistent display of informational posters across DHA offices and HCFs and the targeting of these posters. More specifically, not all facilities have posters on display and, where these are visible, they are dense in text, thus not catering to South Africa's illiterate population.
- Outreach initiatives, including the operationalisation of mobile units, have facilitated increased access to birth registration facilities, contributing to improved rates of ERB. However, many of the mobile units have not been adequately maintained, and have not continued their focus on ERB, for example focusing rather on Smart IDs, which has limited the potential success of such outreach initiatives.
- Training initiatives have been rolled out to DOH and DHA officials outlining the intent of the relationship between DHA and DOH and the process to be followed when implementing the birth registration programme. However, these have inconsistently and infrequently implemented and have therefore had limited impact on empowering officials to drive the ERB process.
- There are successful examples of collaboration between the DHA and other State departments, which have illustrated potential leverage for the success of the birth registration programme. The following benefits of collaborating with other State departments were identified:
  - Collaboration with DSD facilitates the inclusion of vulnerable children into the system, thus ensuring they are able to access State services.
  - Collaboration with Department of Public Works (DPW) ensures that facilities and infrastructure at DHA offices is appropriate and aligned to the needs of clients with new-born babies.
- Such examples were identified on an ad-hoc basis as they are not part of a formal policy agenda; thus limiting the potential of such collaboration and limiting the extent to which vulnerable children are included in the system and the extent to which DHA facilities are suited to the needs of clients with new born children.

The success of each of the above-mentioned initiatives is further underpinned by the context within which births occur. A woman is only part of the ERB programme's captive audience while she is pregnant and just after giving birth. As such, there is potentially a 10-month window during which the birth registration programme must target a mother, after which she is no longer part of the programme's captive audience. Any initiatives that are implemented outside of this 'captive audience window' will have lesser success in encouraging the mother to register the birth of her child. The evaluation found that the ERB initiatives are not consistently or continuously implemented, thus limiting the extent to which an individual mother will be exposed to the initiatives while she is a 'captive audience member' which limits the initiatives' potential for improving the rate of ERB.

While these initiatives have had varied success, they are complemented and reinforced by intrinsic incentives for clients to register the births of their babies:

- Access to the CSG is dependent on the child being registered. This naturally creates an incentive for clients wanting to access the grant to register their babies;
- Similarly, where parents are on medical aid, clients need to register the birth of their baby if they want their medical aid coverage to extend to their baby;
- However, while the above do incentivise clients to register their babies, they are not specifically aligned to the 30-day window.

6.3 Implementation and operability of the birth registration system

Where the birth registration system is fully operational, it is efficient and effective in enabling the timely and accurate processing of birth registrations. This is best evidenced by the time taken to process applications and issue birth certificates across the operability of the sites:

- Where a HCF is connected and fully operational, meaning it is connected to the DHA system all day and has the necessary resources to issue birth certificates on the spot, then the time taken to process the birth registration and issue the birth certificate can be as short as 15 minutes.
- Where a DHA office is fully operational, meaning it has connectivity all day and has the necessary resources to print birth certificates, birth registration and the issuance of a birth certificate typically takes one to three hours.
- Where a HCF or a DHA office is not operational, meaning it is not connected or does not have the resources to issue birth certificates on the spot, birth registration and the issuance of a birth certificate can take between one to two days. By implication, clients will need to return to the HCF or DHA office to collect the birth certificate once printed and are likely to incur costs in doing so.
- Where a mobile office is not operational, either not having the resources to issue birth certificates or no longer processing birth registrations at the mobile office, the process of registering a birth can take between one and two days.

The evaluation identified numerous examples of committed birth registration officials, displaying extreme care and perseverance to ensuring that births are registered and that clients have good experiences of registering the births of their babies. In many cases these individuals drove the success of the system in the context of limited resources, minimising the hurdles that clients would otherwise experience in registering the births of their babies. Despite this, limited resources, such as connectivity challenges, printers that are not operational and staff shortages, do limit the effectiveness of the birth registration system, as is evidenced by the time taken to process registrations at partially operational facilities compared to those that are fully operational.

The implementation of the birth registration system was found to vary across provinces and facilities. Birth registration officials tailor the implementation of the system to meet the needs of their offices and their clients, whereby variances in implementation are most notable across rural versus urban sites, small versus large offices and HCF versus DHA offices. These variances are typically as a result of differences in resource availability, the relative focus of the sites on ERB as compared to other services to clients and the interpretation of the MOU. While tailoring the system to address the needs of the officials and the clients enables the effective operationalisation of the system at sites; the lack of consistency in implementation compromises quality control across sites and provinces.

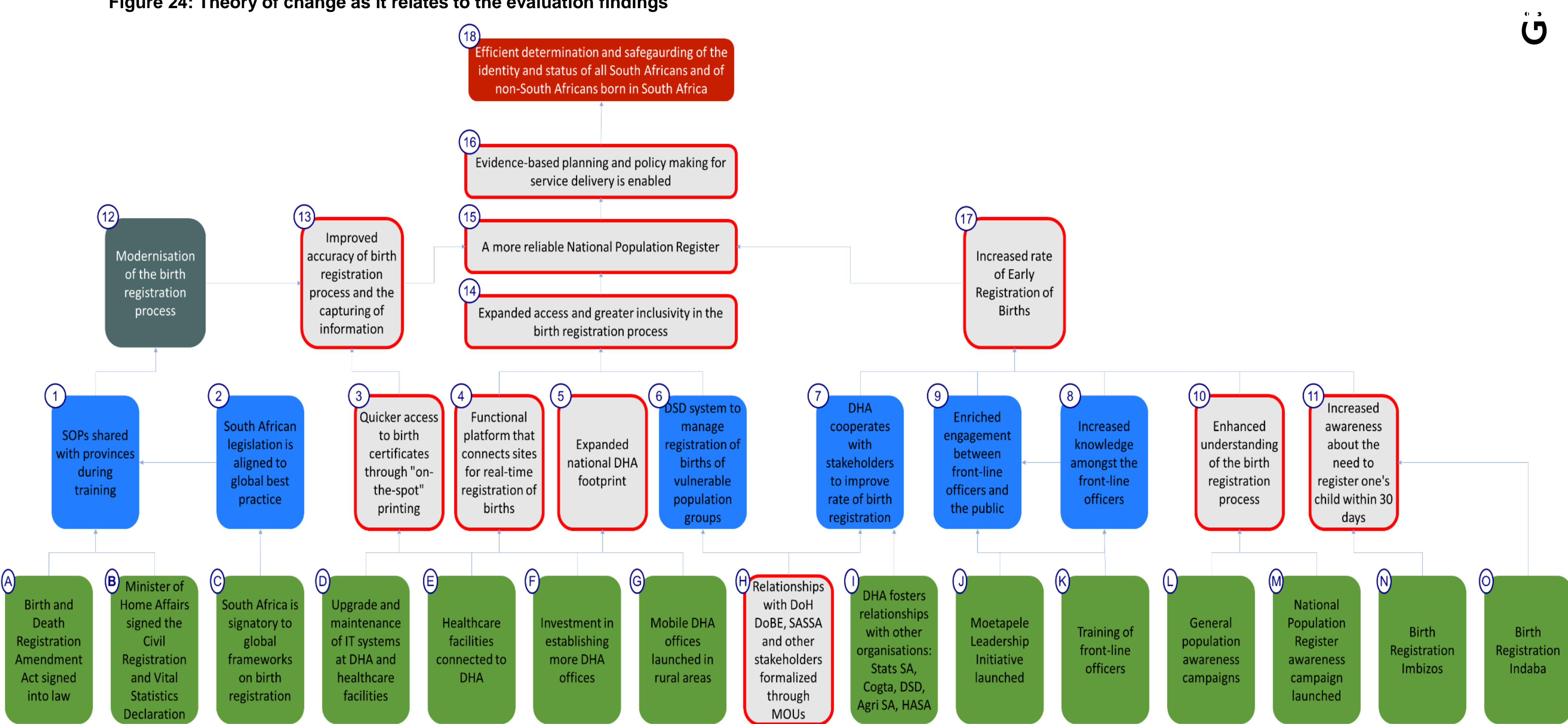
A contributing factor to the variance in implementation across sites is an apparent disconnect between the information that stems from the sites and that which is required to

inform decision making at a national level, particularly as it relates to the setting of targets. There is limited engagement between site-level officials and national-level decision makers on the factors that underpin performance, the factors that are used to determine targets and the applicability of the targets. As such, the targets are often misaligned to the actual performance at sites, and assessments of performance against targets is therefore of limited value. This thus limits the value of the monitoring information and the extent to which evidence-informed decisions can be made.

6.4 Implications for the theory of change

The evaluation found that the theory of change for the birth registration programme is a cogent reflection of the strategy and implementation of the programme. The activities, outputs and outcomes presented in the theory of change are valid and, for the most part, the linkages between them hold true. However, as outlined in the conclusions above, there are challenges to the implementation of the programme which limits the extent to which the linkages achieve their fully intended potential. Figure 24 below identifies the main areas of weakness in the theory of change in the red outlined, grey boxes. These are elaborated on below.

Figure 24: Theory of change as it relates to the evaluation findings



- **Activity/initiative level:**
  - Box H – while there is an MOU in place, this is insufficiently detailed to guide DHA and DOH in their roles and responsibilities to achieve the fully intended purpose of the MOU.
- **Outcome level:**
  - Box 3 - there are a number of resource constraints that limit the extent to which certificates are issued on the spot.
  - Box 4 – while sites have been connected, issues with connectivity limits the extent to which the platform is functional and the real-time registration of births.
  - Box 5 – as many of the mobile offices have not been maintained or no longer focus on ERB, the expanded national DHA footprint has not been fully achieved.
  - Box 10 – the awareness initiatives are implemented inconsistently and do not always cater to the illiterate population, thus limiting clients' understanding of the birth registration process.
  - Box 11 – as with the above, the *izimbizo* and *indaba* have been inconsistently implemented, thus limiting the extent to which clients appreciate the need to register the birth of their baby.
- **Outcome level:**
  - Box 13 – as certificates are not always issued on the spot, this limits the accuracy of the birth registration process and information collation.
  - Box 14 – as connectivity challenges limits the functionality of the online platform and as the mobile units are not always maintained and focused on ERB, access and inclusivity of the process is limited.
  - Box 17 – as awareness of the process and the need for registration is not fully achieved, the rate at which births are registered is not at its potential.
  - Box 15 – similarly, as access, inclusivity and the accuracy of the process is limited, the reliability of the NPR is not fully achieved.
  - Box 16 – all of the above limits the potential for evidence-based planning and policy making for effective service delivery.
- **Impact level:**
  - Box 18 – this was not directly measured through the evaluation, however, as there are breaks in the theory of change leading up to this impact level statement, the potential for achieving this is reduced.

7 Recommendations

Despite the successes of the birth registration programme, it is unquestionable that there is more to do. The recommendations provided below are based on the findings of this evaluation and have been developed to advance the goal of universal birth registration. Three sets of recommendations are provided, pertaining to:

- Promotion of the ERB programme's strategic vision
- Strengthening the implementation of the strategic vision
- Improving the implementation and operability of the birth registration system

For each set of recommendations, risks have been identified, as well as strategies to mitigate these risks.

7.1 Promotion of the strategic vision

The findings of this evaluation conclude that the best opportunity to register a birth is at the HCF of birth. Therefore, the strategic vision underpinning DHA initiatives to improve ERB, for example the connected hospital footprint programme, is essential to continue to improve the rate of birth registration in South Africa.

Achievement of this strategic vision is better enabled through the combined efforts of all stakeholders; state (partner departments and public agencies) and non-state (NPOs, community structures and the private sector[10]). These partnerships can only be unlocked if DHA makes a concerted effort to ensure that stakeholders understand and buy-in to the strategic vision, which can be achieved through consultation and discussion, joint planning sessions, partnership agreements, service level agreements (SLAs), etc. all towards mutual understanding of respective roles and responsibilities.

R1: DHA efforts to promote the strategic vision to register births as close to when they occur as possible should be reinforced and deepened. Specifically, DHA should spearhead efforts to ensure alignment, consistent understanding and buy-in to this strategic vision amongst all stakeholders through consultation and discussion, joint planning sessions, partnership agreements, service level agreements (SLAs), etc. This is especially important between DHA and DOH, but also between national, provincial and local government structures and with non-state actors.

The evaluation team has given considerable thought to who is best placed to register births. The outcome of these reflections is provided in the box that follows.

[10] The DHA has leveraged public-private partnerships to good effect in other areas of their service provision, for example issuance of IDs and passports at banks and with private service providers to modernise its systems. There is good potential to leverage partnerships with the private sector in similar ways for birth registration, particularly because private HCFs are already connected to the hospital footprint initiative and because mobile registration is already being explored by the DHA. However, this evaluation did not include consultations with private sector stakeholders; therefore, the feasibility and particulars of such initiatives remains to be tested.

Box 13: Initiative Idea 1: Who should register births?

Ultimately, the strategic vision will be further promoted by ensuring that time between giving birth and being issued a birth certificate is minimised as far as possible. This raises the question of who should ideally register the birth. DOH staff (nurses and midwives) are currently required to complete the PB-24 form. The remaining steps in the process are to complete the DHA-24 form, to verify information provided by the clients and to record this information on the system, before printing the certificate. If the information required in the PB-24 form and the DHA-24 form are combined and replaced by one form, a key inefficiency in the system could be overcome. This new form could then be submitted electronically by DOH staff, along with all supporting documents, to the DHA. This electronic submission should have simply checks to verify information. On completion of this new form, a temporary birth certificate could be provided to parents that would expire in 30 days from the birth date. The official birth certificate would then be provided to parents within 30 days subject to all remaining verifications (either by post, online or at the DHA office or HCF – as selected by the parent).

Based on the findings of this evaluation, approximately 72% the parents we spoke with at offices were registering babies that were three months old or younger. However, those babies that were two to three months old would be registered under LRB, which is a more onerous process and for which most parents are not prepared prior to visiting the office. Therefore, a 60-day or 90-day cut-off may be more appropriate in the South African context; however, more research is required to select between these options. It must be emphasised that this recommendation does not definitively state that the 30-day cut-off must be extended, but rather recommends that the rationale behind the 30-day cut-off be reassessed.

R2: Despite prioritisation of the strategic vision, the DHA should not neglect provision of LRB services because the social, cultural and economic factors delaying ERB are pervasive in South Africa.

R2.1: Furthermore, based on the findings of this evaluation, a penalty for LRB will unfairly disadvantage particularly vulnerable South Africans. Therefore, the legal basis for LRB is questionable. It is our recommendation that a penalty for LRB should not be pursued.

R2.2: Given the myriad of social, cultural and economic factors delaying ERB, those births that are not registered at HCFs or in the days following a birth are unlikely to be registered within 30 days. Therefore, it is our recommendation that the 30-day cut-off be reassessed.

7.1.1 Risks and risk mitigation

Recommendation code	**Risk**	**Mitigation**
R1	Stakeholders may continue to show limited understanding and buy-in, despite DHA's best efforts. Turnover in partner departments may limit the possibility of gaining consensus on the strategic vision. DHA may struggle to maintain momentum internally to ensure that they are able to build consensus on the strategic vision over time.	The legal departments in each partner department should advise on how best to build and maintain consensus using the guidance provided by the Intergovernmental Relations Framework Act of 2015. (Republic of South Africa, 2005)
R2.2	Revision to the 30-day cut-off is likely to be a lengthy process and may result in	Behavioural science has much guidance to provide on the heuristics and biases

	undesired outcomes. For example, client psychology might mean that their behaviour is conditioned by the number of cut-off days. So, if the cut-off day is extended, this may lead to the undesired behaviour of simply delaying birth registration further.	people display. Further behavioural research should be conducted to determine whether changing the 30-day cut-off will have any undesirable outcomes.
Initiative Idea 1	Nurses and midwives might protest against additional tasks being required.	Improve understanding that mandate for birth registration extends beyond DHA. Consult with nurse and midwife trade unions to ensure buy-in and minimise areas of conflict
	Temporary birth certificate might be vulnerable to fraud and security issues.	Checks and balances will need to be inserted into the system so that information is verified before provision of the temporary birth certificate.
	Nurses and midwives' authorisation to issue temporary birth certificates will need to be legalised.	A legal opinion should be sought before proceeding with this initiative.
	Issuance of temporary birth certificate will only be provided to children whose parents have brought all necessary information with them to the hospital, and whose mother survives childbirth.	Great care should be taken to raise awareness of requirements to facilitate the issuance of a temporary birth certificate, and to ensure that this change to the birth registration system does not disproportionately disadvantage or exclude orphans and vulnerable children.

7.2 Strengthening implementation of the strategic vision

7.2.1 DHA-specific recommendations

The promotion of this strategic vision will only be achieved through partnerships and collaboration across departments and across levels of government. This evaluation finds that ineffectiveness in the provision of birth registration services is due to a lack of recognition that effective birth registration requires coordinated efforts between stakeholders. This results in poor information sharing between stakeholders, uneven understanding of birth registration across stakeholders (and therefore inconsistent communication with clients), and, therefore, difficulty in coordinating client-centric initiatives and services.

R3: DHA should refine or establish MOUs with key departments to support the implementation and achievement of this strategic vision.

R3.1: The MOU between DHA and DOH should be revised and clarified to elucidate the respective roles and responsibilities of both departments.

R3.2: An MOU should be established between DHA and DSD to advance the registration of births of orphan and vulnerable children and children located in remote and marginalised communities.

R3.3: An MOU should be established between DHA, DOH and DPW to further elaborate on the roles and responsibilities contained within specific facility rental agreements to ensure that DHA office and HCF infrastructure is accessible and provides requisite comforts for mothers, babies and young children.

This evaluation finds that the current MOU does not enable the achievement of the strategic vision. Therefore, the current MOU must be refined to better articulate the specific roles and responsibilities of DHA and DOH to ensure that the connected hospital footprint is strengthened and maintained. In particular, the DHA-DOH MOU should enable:

- Information sharing between DHA and DOH, at two levels:

- Sharing of statistics to improve the monitoring of statistics relating to births and birth registration
- Training and capacity development to overcome the current perception that birth registration is purely a DHA process[11]

- Coordinated responses to ensure clients have good access to information on the birth registration process and requirements
- Collaboration to ensure DHA officials and HCF staff are adequately trained on the process and requirements for birth registration, possibly leveraging the existing NurseConnect platform (see Box 14).
- Facilitating bottom-up determination of birth registration targets and top-down monitoring of site performance against these targets

R4: The DHA and DOH must refine the current MOU to specify the roles and responsibilities of each department as this relates to facilitating ERB within the connected hospital footprint.

R4.1: The DHA-DOH MOU should be informed by a detailed 'stock take' exercise that documents and describes the existing 'collaboration initiatives' between DHA and DOH at national, provincial and local government levels that facilitate ERB. The most effective of these should be identified for continuation and (potentially) scale-up.

R4.2: The DHA-DOH MOU should be accompanied by implementation guidelines, an implementation roadmap and a framework to monitor the implementation of the MOU going forward.

Box 14: Initiative Idea 3: Birth registration training through NurseConnect

NurseConnect (http://www.health.gov.za/index.php/mom-connect#nurseconnect) is a platform similar to MomConnect, and is an initiative of the National DOH. NurseConnect uses mobile technology and currently, 19 254 nurses across 2 935 HCFs use the platform. This platform provides support to nurses and midwives in their daily work through targeted messages, advice and in-depth training on maternal and child health. NurseConnect offers an important opportunity to leverage an existing initiative to impart important information on birth registration to nurses and midwives. This is important because mothers at hospitals often have a good, trusting relationship with the nurse or midwife attending her, which means that HCF staff are vital sources of information for these mothers.
The DHA's role would be to work with DOH to design a training package that explains the birth registration process and requirements at HCF and that is appropriate for nurses and midwives. The training can also include simulations and examples of Frequently Asked Questions (FAQs) to prepare nurses and midwives for fielding mothers' questions from. The DHA and DOH should jointly fund the hosting of this training on NurseConnect and should collaboratively design the indicators and assessments that will be used to measure its effectiveness.

With many of those marginalised from birth registration services also having very basic literacy levels, written communication may have limited potential to reach these groups. Further, this evaluation finds that word of mouth remains a powerful mechanism for

[11] This evaluation finds that some nurses / midwives are reticent to provide information to mothers, to complete forms that have a DHA logo, or to facilitate the process of birth registration at HCF by coordinating with DHA clerks stationed at hospitals. This reticence can be overcome through clear messaging from leadership in both departments, articulating the importance of collaboration between DHA clerks and HCF staff at site-level.

awareness-raising around the process and requirements for birth registration. Therefore, a complementary and comprehensive package of audio/visual communications should be developed in a way that suits the audience and meets their information needs. Possible options are messages imparted via:

- FCOs and HCF staff (which will require holistic training of FCOs and HCF)
- Traditional leadership structures
- Community health workers (CHWs)
- Local TV shows

Importantly, messages are only relevant to parents in the nine months of pregnancy and potentially one month after the birth. Therefore, while public awareness campaigns through channels like community radio and local TV shows may be too untargeted to achieve awareness amongst those that need this information most. Instead, DHA should explore create options to reach mothers on existing platforms so that messages are not diluted in their delivery.

Poster design should be improved such that posters are eye-catching, readable and accessible to those clients with basic literacy. Posters should make good use of graphics instead of being text-heavy. The information provided on posters should include:

- The legal requirement for ERB
- Requirements to complete ERB
- Diagram explaining the process of birth registration
- Advice and contact details to contact a DHA clerk for more information

This evaluation found that many clients experience situations that require variations on the standard process for birth registration. There is uneven understanding of the requirements in these ‘special circumstances’, both amongst clients and amongst DHA clerks and HCF staff. These ‘special circumstances’ include:

- Requirements for registering babies born to foreign nationals
- Requirements for registering babies born to mother who is a minor
- Requirement for registering babies born to unmarried parents or parents within civil unions or customary marriages
- Requirements for registering adopted children

The gaps in clients’ understanding can be improved through focused informational flyers; however, this must be supported by improved and more consistent communications to clients by DHA clerks and HCF staff. Therefore, training should be provided to achieve this purpose. It is further recommended that this training includes diversity consciousness and guidance on how to navigate engagements with clients to eliminate the potential for any bias or discrimination.

R5: DHA should invest resources to improve the effectiveness of public awareness-raising initiatives relating to the birth registration process and its requirements.

R5.1: DHA should prioritise public awareness-raising initiatives through a complementary and comprehensive package of communications.

R5.2: DHA should improve the visibility, design and informational content of posters informing clients of birth registration, both at DHA offices and at HCFs.

R5.3: DHA should develop informational flyers and specific training targeted at FCOs and DHA clerks at HCFs as a supplement to posters to ensure that the requirements for 'special circumstances' experienced by clients are better understood.

This evaluation finds that mobile units are often lacking the equipment and connectivity to enable on-the-spot registration, which means that clients in far-flung locations must still travel to a DHA office to receive the birth certification, undermining the intention behind the mobile units. Additionally, the resource-intensive nature of mobile units means that these are used irregularly, which limits the effectiveness of this services. It is important that mobile units are adequately resourced to ensure that efforts to reach remote and marginalised communities are not wasted. However, the feasibility of improving resource allocation to mobile units is questionable at best, given the difficulty DHA experiences in maintaining infrastructure at certain brick-and-mortar offices.

If DHA believes that mobile units are the best mechanism to reach remote communities, it is recommended that:

- DHA works with DSD and DRDLR to identify the communities that are most at need of mobile unit services; and,
- DHA coordinates efforts with other state (for example, COGTA, DSD and DRDLR) and non-state stakeholders that conduct road shows, *izimbizo*, etc. to better leverage state resources.

However, this evaluation concludes that there are more cost-effective and sustainable means of reaching very remote populations. Principally, these mechanisms leverage technology and have been employed successfully in other African countries, most notably Mobile VRS in Uganda (http://www.mobilevrs.co.ug/home.php). A potential initiative idea is provided below. However, it should be noted, that while this idea is more cost-effective to run over time than mobile units, the start-up costs are significant. Further, this idea is likely to be more supportive of LRB than ERB. Therefore, this idea should not be pursued at the neglect of consolidating and expanding the connected hospital footprint, which is core to ERB.

This evaluation notes that the IT Department within the DHA is already exploring an alternative mechanism to reach remote and rural communities – the mobile suitcase. This initiative is being explored to improve service delivery and to facilitate multiple channels of delivery, and in recognition that access to and maintenance of mobile units is inadequate to further these aims. The mobile suitcase will be a hand-luggage size case that can be taken to clients' homes. This suitcase will contain all equipment to deliver the full spectrum of DHA services; laptop, fingerprint scanner, document scanner and a camera. It is intended that the suitcases will first be used to improve the services delivered through mobile units but the intention is that suitcases will also become handheld for 'on-foot' services, as some rural locations are difficult to reach through the road network. Each mobile suitcase will be manned by a one or two-person team and will be used on a daily basis. One hundred mobile suitcases are intended to be rolled out as part of the pilot; however, the tender process has not yet been completed for the equipment as the software needed to be finalised first.

While the mobile suitcases are intended to provide the full spectrum of DHA services, it is important to note that:

- ID issuance and birth registration is the priority; however, the tactics to be deployed to enhance ERB will need to be agreed with civic services; and,
- Late registration of birth and registration of babies born to foreign nationals require specific document checks and authorisations that will not be able to be provided through the mobile suitcase.

Therefore, the mobile suitcase offers good potential to improve the rate of ERB. There is still potential, however, that certain population groups will not benefit fully from this service, particularly those who face social factors that influence LRB and foreign nationals. It will be important to develop the strategy for the roll-out of the mobile suitcase in a manner that ensures good access for diverse population groups and recognition of pervasive social, cultural and economic factors, as described in Section *5.3: Pervasive challenges faced by clients*.

R6: DHA should explore alternatives to mobile units to improve their ability to reach very remote and marginalised rural communities.

Box 15: Initiative Idea 2: Mobile registration of births through a community-based volunteer network

Mobile technology provides an opportunity to provide more regular, less costly and easier to maintain birth registration services to remote communities in South Africa. This initiative would involve the design and deployment of a mobile platform that can be operated both web-based and through USSD. The mobile platform would be used by teams of community-based volunteers to register births door-to-door in the most difficult to reach rural communities. These teams would interface with DHA offices to verify the information that is captured on the mobile platform and to print certificates, which they would then take back to communities.

Ultimately, the successful deployment of an initiative of this nature is dependent on effective partnerships with non-state actors.

Public-private partnership to design and manage a mobile platform with both web-based and USSD capability to enable the mobile capture of information and online verification of information.

Partnership with community structures / local NGOs to recruit, train and manage teams of community-based volunteers who will use the mobile platform to register births, particularly those that are home-based and those that were not successfully captured at HCFs. Given the high levels of unemployment in rural areas, particularly youth unemployment, there is good potential to find volunteers who may be able to use their involvement in the initiative as a stepping stone to access employment opportunities.

Partnership with DSD, COGTA and Department of Rural Development and Land Reform (DRDLR) to identify rural communities that to be targeted for pilot, and upon completion of successful pilots, for scale up.

7.2.2 Recommendations requiring collaboration between DHA and other actors

The DSD, through its network of partner NPO and NGO partners, is in a better position to reach OVCs than the DHA. However, the specific tactics that would need to be deployed will vary depending on location (urban, rural, peri-urban) and the specific social dynamics in each location. Given the diversity of social challenges experienced across South Africa, the issues that affect birth registration differ greatly from location to location. Social workers that reside and/or work within local communities have the best access to information regarding which children are being excluded from the system of birth registration and how best to include them. This evaluation finds evidence that DHA officials

do consult social workers operating in their area; however, this is infrequent and inconsistent across offices. Therefore, there is an opportunity to incentivise District Management Officials (DMOs) to work with DSD and social workers within districts to find the best ideas to improve OVC's access to birth certificates.

R7: The DHA and DSD MOU should delineate the roles and responsibilities of each department to identify and support specific initiatives that promote birth registration amongst OVCs.

Box 16: Initiative Idea 4: DHA-DSD Birth Registration of OVCs competition

A potential idea is for national DHA and DSD to jointly sponsor a competition to uncover the most creative initiatives to collaborate together to improve ERB. These initiatives should be jointly proposed by DMOs and social workers. Initiatives should promote collaboration between DHA and social workers. National DHA and DSD would then select a few (perhaps one per province) of the best ideas to pilot. The champions of the idea would receive recognition and perhaps a monetary incentive. The pilots would be reviewed and findings disseminated across DHA and DSD to encourage others to pursue similar initiatives. Finally, the best pilots would be scaled for national implementation.

The 'captive audience' window is the 10-month period in which the mother is receiving prenatal care, giving birth or antenatal care at an HCF. This evaluation finds that ERB is best facilitated if information is provided to the mother during this period of time and if she is able to register the birth before the 10-month period lapses. Therefore, the 'stock take' exercise that is recommended to inform the DHA-DOH MOU should explore how existing points of contact with the mother can be leveraged to facilitate ERB.

R8: The DHA and DOH should identify and pursue initiatives that facilitate mothers' access to information and completion of birth registration while she is in the 'captive audience' window.

Box 17: Initiative Idea 5: Supplying mothers with ERB information via MomConnect

MomConnect (http://www.health.gov.za/index.php/mom-connect#momconnect) is an initiative of National DOH to support maternal health over a mobile platform. The service is free and provides mothers with access to health promotion messages and enables mothers to provide feedback on the services they receive. Interestingly, MomConnect was also introduced to enable the DOH to better track pregnancies in the public health system as early as possible. Currently, 364 860 mothers are registered on MomConnect across 4 648 HCFs.

Since many mothers already use this platform out of concern for their own health and the health of their child, MomConnect provides a very useful touchpoint to supply information concerning birth registration. However, it is important in this messaging to communicate the importance of birth registration in advancing the rights of the child and providing the child with access to government services, in order to indicate that birth registration holds importance.

Box 18: Initiative Idea 6: 'What's in your hospital bag?'

Jointly, the DHA and DOH should uncover and pursue creative ideas that are client-centric and suited to the experience of mothers who are preparing to give birth or have just given birth. This alignment is important to ensure that information reaches mothers in a manner that is appropriate and effective.

This evaluation finds that mothers may miss the opportunity to register births at HCF because they do not have their ID or their ID is locked away from the beds when the DHA clerks comes to see them. This is a missed opportunity. Mothers should be informed of the importance of having their ID with them in order to complete birth registration (and potentially the father's ID if unmarried or in a customary marriage).

Many mothers go through a 'nesting period' just before giving birth in which they prepare their homes and also for the hospital visit. An idea is to work with prenatal clinics to develop a 'What's in your hospital bag?' campaign, including a combination of informational materials, adverts, radio announcements, etc. The idea is to make the information fun and accessible, including other items that mothers may need in hospital, but reinforcing the idea that the ID should be one of these items. This could also be rolled out through MomConnect.

7.2.3 Risks and risk mitigation

Recommendation code	**Risk**	**Mitigation**
R2 *R2.1* *R2.2* *R2.3*	There may be delays concluding MOUs and accompanying implementation protocols if stakeholders struggle to align to the common vision and agree on the contents of MOUs.	R1 should be achieved / progressing before beginning activities toward R2. The development, signature and management of MOUs should be managed by a joint committee consisting of DHA, DOH, DSD and DPW stakeholders and should be guided by a roadmap to guard against delays.
R5.1	A comprehensive package of awareness-raising initiatives may be costly to develop and manage to ensure that messaging remains up-to-date and accurate.	Great effort should be made to align with existing campaigns and platforms. Cost effective mobile and internet-enabled technology should be leveraged to reach larger groups of clients.
R6	The following risks in the operationalisation of mobile birth registration are identified (Plan International, 2015): • Identity theft and fraud, because digitised data is easier to target for white collar crimes • Privacy violation – digital transmission, storage and sharing may expose personal information to individuals and use of information in ways that are against clients' wishes • Personal security violation or exploitation, since births are registered	Risk mitigation strategies for mobile registration of births should consider the system-wide risks that are not easily mitigated before moving to the more operational risks that are easier to overcome (Plan International, 2015). For instance: • Risks in the operating environment: This relates to the legal framework and institutions that support birth registration. Legal reform and the legal apparatus should be carefully reviewed and revised as necessary.

outside of the controlled environment of a DHA office or HCF • Exclusion from the benefits of birth registration, since mobile birth registration still might not reach the most excluded and marginalised children and so may deepen inequality of access to the service.	• Stakeholders: Digital registration requires significantly greater coordination and mobilisation of stakeholders. Risks are mitigated through strong contractual relationships, excellent project management and responsive tactics to adjust implementation to suit the needs of changing contexts. • Information and identity management: Strong information governance frameworks need to be in place and consequences for misuse of information should be strict and enforced. Multiple electronic and manual identity checks on all participants present good opportunities for mitigation.

7.3 Improving the implementation and operability of the birth registration system

Where all equipment and resources are working as they should at connected HCF, the system of birth registration can result in the issuance of a birth certificate within 15-20 minutes. This is world-class and indicative of what can be achieved through the connected hospital footprint. However, it is recognised that resource limitations are real. The effectiveness of the connected hospital footprint is dependent on the resources that are available. It is important to realise that, with limited resources, the reliability of currently connected HCFs should be prioritised before expanding to include more HCFs.

R9: DHA should prioritise consolidating and maintaining the connected hospital footprint before continuing its expansion.

Box 19: Initiative Idea 7: National hotline for connected HCF

This evaluation finds that, overall, the connections at HCF are modern and fit-for-purpose. However, the real challenge at sites is that connectivity can be intermittent, printers go offline, registration forms are unavailable, etc. Many of these challenges occur unexpectedly but can take a long time to resolve, particularly given that the computer platform is outsourced to a third-party service provider.

Therefore, a potential idea is to establish a national hotline to report connection and equipment challenges experienced by sites to the National DHA IT Services Directorate. This Directorate should be mandated to compile all reported incidents on a quarterly basis into a dashboard that utilises clear visuals (e.g. stoplight colours) to identify priority problem locations across the country. This dashboard should then be used to focus resources at these priority locations to improve the stability of the connected HCF footprint.

Across the provinces visited during this evaluation, it was evident that despite resource limitations, there are many DHA officials and HCF staff that take extraordinary steps to ensure that the birth registration process meets clients' needs. These champions of birth registration should be celebrated. This campaign could be run across districts but within provinces in order to ensure that it is as inclusive as possible. Therefore, provincial DHA should lead the campaign but with support and funding from national DHA.

Additionally, the campaign itself is likely to produce useful case studies that document:

- Greater specificity of the challenges experienced at sites
- Ideas and tactics DHA officials and HCF staff have undertaken to overcome challenges
- Lessons learned and key successes that have potential for replication / scaling nationwide

Finally, a 'Meet the Champions of Birth Registration' campaign can provide a useful way to reinforce positive behaviour and encourage those DHA officials and HCF staff that encounter daily challenges to persevere. In this way, it is possible that the frustrations communicated by some DHA officials and HCF staff regarding their workload and resource constraints can be overcome.

R10: DHA should run a campaign to celebrate the champions of birth registration.

This evaluation finds that target setting is a weakness of the birth registration programme. It appears that in many cases, provincial targets are proportioned to calculate district and site-level targets. This approach is lacking because population dynamics and local contextual factors are not taken into account. The recommended methodology is as follows:

- DOH should record the number of live births across all their HCFs and collate these at district-level. This statistic should be shared with DHA on a quarterly basis.
- Every three years, population demographers should be contracted by DHA to examine the trend of live births and predict a trend for the next three years.
- Additionally, DHA should track the proportions of ERB compared to LRB and the proportions of births registered at HCF and DHA offices.
- All of this information should inform the setting of targets within provinces.
- Target-setting should, thus, be bottom-up, while the monitoring of performance in relation to targets should remain top-down.

It is noted that the number of live births will include babies born to foreign nationals. However, identifying babies born to foreign nationals and using this information to proportion the number of live births for target-setting is likely to create the perverse situation where foreign nationals avoid coming to HCFs if they are not able to present identity documents. This situation should be avoided to ensure that health services do not exclude those who are in need.

It is only through improved target-setting that performance management and evidence-informed decision-making relating can be improved. This is essential to maintain the current successes of the birth registration programme and to improve the rate of birth registration in future years.

However, improved target-setting is only the foundation for improving the birth registration process. Therefore, it is further recommended that a joint DHA-DOH committee be established with the mandate to:

- Monitor and assess site level performance against targets
- Assess provincial and national trends in both ERB and LRB
- Identify issues that continue to constrain birth registration and ERB in particular

- Commission research, as necessary, to uncover particular information that will assist to overcome pervasive constraints to birth registration and ERB in particular
- Use evidence produced through site-level monitoring and additional research to design initiatives to overcome constraints
- Develop recommendations on this basis for implementation by DHA and DOH

R11: DHA should improve the methodology by which targets are set to improve performance management and evidence-informed decision-making.

R11.1: The DHA-DOH MOU should include provision for DOH to supply the DHA with the number of live births recorded at each HCF on a monthly basis, as these statistics are important inputs to calculate an appropriate target for ERB.

R11.2: The DHA and DOH should establish a joint committee with representation from both departments to review performance against targets on an annual level.

7.3.1 Risks and risk mitigation

Recommendation code	**Risk**	**Mitigation**
R11	The development of useful targets is dependent on buy-in from both DHA and DOH, and on close coordination between the two departments.	R1, R2 and R2.1 must be achieved before resources are allocated to implementing R11.
R11.1	While the DHA-DOH MOU makes provision for sharing of information contained within the NPIS, this data may be provided irregularly and in a format that does not enable easy interpretation and use of data to set targets.	The revised DHA-DOH MOU should be accompanied by an implementation protocol that clearly established what data should be provided, when (timing and frequency), to whom and what the consequences are of failing to meet these stipulations.

References

African Committee of Experts on the Rights and Welfare of the Child. (2014). *General Comment on Article 6 of the African Charter on the Rights and Welfare of the Child.*

Anglican Communion Office. (2016, November 14). *Birth Registration.* Retrieved from Anglican Communion Website: http://www.anglicancommunion.org/mission/un-presence/geneva-office/birth-registration.aspx

Assim, U. (2014). *The Dynamics of Youth Justice and the Convention on the Rights of the Child in South Africa.* Retrieved from http://www.childjustice.org.za/publications/article-40-dec-2014.pdf

Day of Prayer and Action Organisation. (2012). *A Note on Universal Birth Registration.* New York: Day of Prayer and Action Organisation.

Department of Home Affairs. (2005). *Annual Report 2004/05.* Pretoria: Department of Home Affairs.

Department of Home Affairs. (2013/14). *Annual Report.* Pretoria: Department of Home Affairs.

Department of Home Affairs. (2014/15). *Annual Report.* Pretoria: Department of Home Affairs.

Department of Home Affairs. (2015). *Memorandum of Understanding with the National Department of Health.* Pretoria: Department of Home Affairs.

George, J. P., & Elphick, R. (2014). *Promoting Citizneship and Preventing Statelessness in South Africa: A PRACTITIONER'S GUIDE.* Pretoria: Pretoria University Law Press.

GMSA Mobile Identity Team. (2013). *Mobile Birth Registration in Sub-Saharan Africa: A case study of Orange Senegal and Uganda telecoms solutions.*

Innocenti Research Centre. (2002). *Birth Registration: Right from the start.* Florence: UNICEF.

Jewkes, R., & Wood, K. (1998). Competitng discources of vital registration and personhood: Perspectives from rural South Africa. *Social Science and Medicine*, 1043 - 1056.

Joubert, J., Rao, C., Bradshaw, D., Dorrington, R. E., Vos, T., & Lopez, A. D. (2012). Characteristics, availability and uses of vital registration and other mortality data sources in post-democracy South Africa. *Global Health Action*, 1 - 17.

Lloyd, A. (2002). A theoretical analysis of the reality of children's rights in Africa: An introduction to The African Charter on the Rights and Welfare of the Child. *African Human Rights Law Journal*, 11-32.

National Child Rights Committee. (2000). *South Africa's First Supplementary CRC Report to the United Nations Committee on The Rights of The Child .*

Olowu, D. (2000). rotecting Children's Rights in Africa: A critique of the African Charter on the Rights and Welfare of the Child. . *The International Journal of Children's Rights*, 128.

Organisation of African Unity. (1990). *African Charter on the Rights and Welfare of the Child.*

Palmary, I. (2009). *For Better Implementation of Migrant Children's Rights in South Africa.* Retrieved from http://www.unicef.org/southafrica/SAF_resources_migrantchild1.pdf

Pan-African Voices for Freedom and Justice. (2007). *Regional Protection of Child Rights in Africa.* Retrieved from http://www.pambazuka.org/en/category/comment/44416

Plan International. (2015). *Identifying and addressing risks to children in digitised birth registration systems: A step-by-step guide.* Surrey: Plan International.

Plan International. (2017, November 9). *What we do.* Retrieved from Plan International Website: https://plan-international.org/birth-registration

Republic of South Africa. (1996). *Constitution of the Republic of South Africa.*

Republic of South Africa. (2005). *Intergovernmental Relations Framework Act, Act no. 13 of 2005.* Retrieved from Acts Online: https://www.acts.co.za/intergovernmental-relations-framework-act-2005/index.html

Republic of South Africa. (2012). *National Plan of Action for Children in South Africa: 2012-2017.* Pretoria: Department of Women, Children and People with Disabilities.

Republic of South Africa. (2014). *Regulations on the Registration of Births and Deaths.*

SADC. (2005). *Protocol on the Facilitation of Movement of Persons.*

SADC. (2008). *Strategic Framework and Programme of Action for Orphans, Vulnerable Children and Youth.*

SADC. (2011). *Minimum Package of Services for Orphans and Other Vulnerable Children and Youth.*

South African Alternate Report Coalition. (2015). *Alternate Report to the UN Committee on the Rights of the Child.* Retrieved from https://www.savethechildren.org.za/sites/savethechildren.org.za/files/Civil%20Society-SA%20Alternate%20Report%20Coalition%20on%20UNCRC%20Final.pdf

South African Social Security Agency. (2017). *Statistical Report.* Pretoria.

Statistics South Africa. (2015). *Millenium Development Goals 5: Improve Maternal Health.* Pretoria: Statistics South Africa.

StatsSA. (2015). *Millennium Development Goals 5: Improve maternal health.* Pretoria.

StatsSA. (2016). *Recorded Live Births: 2013-2015.* Pretoria: Statistics South Africa.

StatsSA. (2017, September 28). *Recorded live births, 2016.* Retrieved from http://www.statssa.gov.za/?p=10524

Steiner, H., & Alston, P. (2000). *International Human Rights in Context: Law, Politics, Morals.* Oxford: Oxford University Press.

Todres, J. (2003). Birth registration: An essential first step towards enabling the rights of all children. *Human Rights Brief*, 32-35.

UNICEF. (2003). *Factsheet: Birth registration.* Retrieved from https://www.unicef.org/newsline/2003/03fsbirthregistration.htm

UNICEF. (2013). *Every Child's Birth Right: Inequities and trends in birth registration.* New York: UNICEF.

UNICEF, D. a. (2012). *The South African Child Support Grant Impact Assessment: Evidence from a survey of children.*

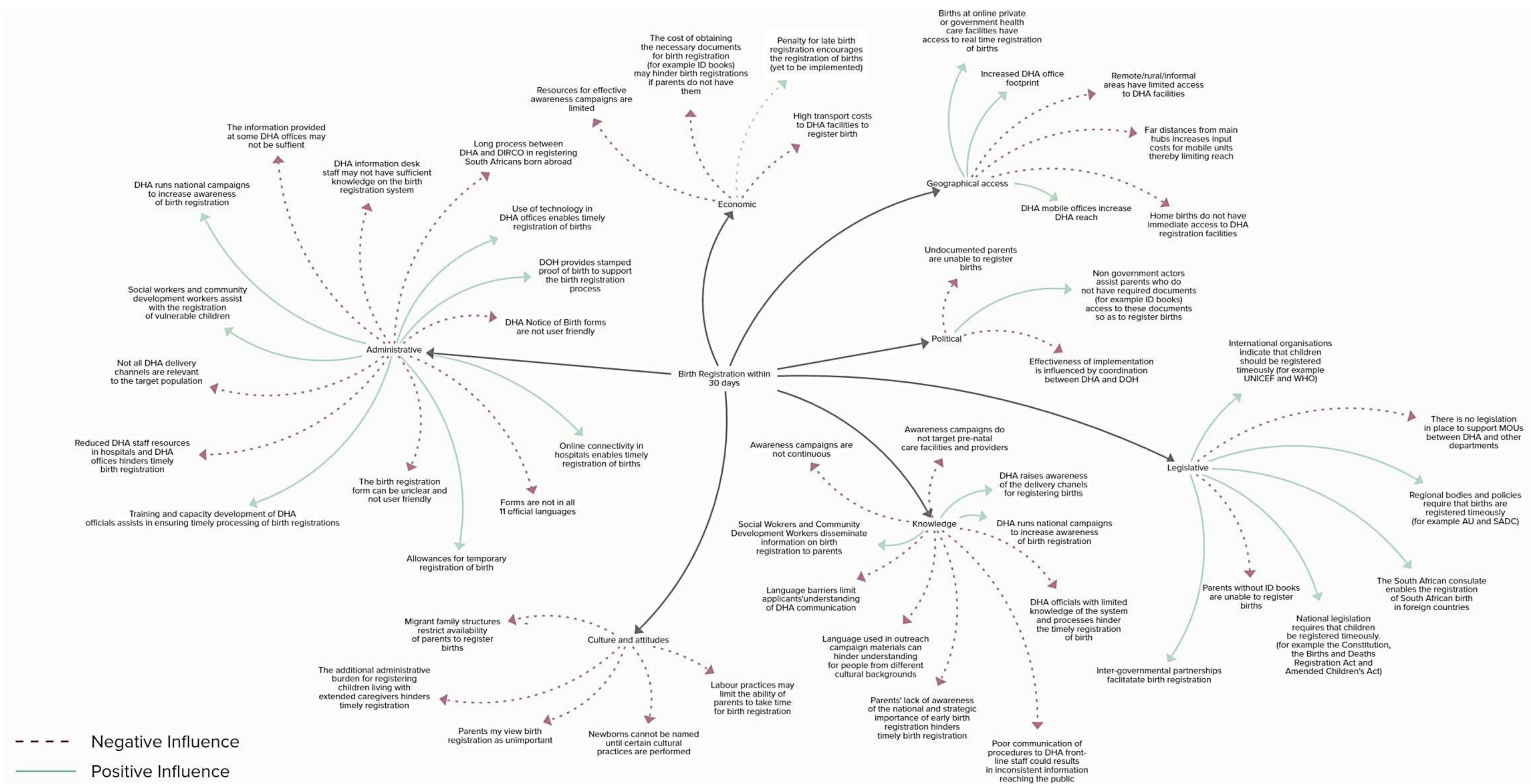
United Nations. (1989). Convention on the Rights of the Child.

World Bank. (2017). *Rural Population (% of total population)*. Retrieved from World Bank Data: https://data.worldbank.org/indicator/SP.RUR.TOTL.ZS?locations=ZA

World Vision. (2014, May 5). *Making children count and birth registration matter.* Retrieved from World Vision International: http://www.wvi.org/experts/article/making-children-count-and-birth-registration-matter

ANNEXURE A: BIRTH REGISTRATION SYSTEMS MAP

Figure 25: Birth registration systems map



ANNEXURE B: DETAILS OF METHODOLOGY AND DATA COLLECTION STRATEGY

The following tables present the details of the methodology and data collection strategy.

DHA SITE SAMPLE

Table 10: DHA site sample details

Office	Province	District	Size	Performance	Rural/urban
Mngeni	**KwaZulu-Natal**	**Ethekwini**	**Large**	**Low**	**Urban**
Bulwer	KwaZulu-Natal	Umgungundluvo	Small	On target	Urban
Tongaat	KwaZulu-Natal	Ethekwini	Medium	On target	Urban
Esikhaweni	KwaZulu-Natal	Utungulu	Small	On target	Rural
Nkandla	KwaZulu-Natal	Utungulu	Medium	Obvious outlier	Rural
Wynberg	**Gauteng**	**Johannesburg**	**Medium**	**On target**	**Urban**
Ga-Rankuwa	Gauteng	Tshwane	Medium	Obvious outlier	Urban
Carltonville	Gauteng	Westrand	Medium	On target	Rural
Randburg	Gauteng	Johannesburg	Medium	Low	Urban
Soweto	Gauteng	Johannesburg	Large	On target	Urban
Mamelodi	Gauteng	Tshwane	Small	Low	Urban
Taung	**North West**	**Dr Ruth Segomotsi Mompathi**	**Medium**	**On target**	**Rural**
Wolmeransstad	North West	Dr Kenneth Kaunda	Medium	Low	Rural
Rustenburg	North West	Bojanala	Large	On target	Urban
Potchefstroom	North West	Dr Kenneth Kaunda	Medium	On target	Urban
Ventersdorp	North West	Dr Kenneth Kaunda	Small	Low	Rural
Musina*	**Limpopo**	**Vhembe**	**Medium**	**On target**	**Rural**
Elim	Limpopo	Vhembe	Medium	Obvious outlier	Rural
Dzanani	Limpopo	Vhembe	Medium	On target	Rural
Polokwane	Limpopo	Capricorn	Large	Low	Urban
Matateila*	**Eastern Cape**	**Alfred Nzo**	**Small**	**Low**	**Rural**
Mount Ayliff	Eastern Cape	Alfred Nzo	Medium	On target	Rural
Bizana	Eastern Cape	Alfred Nzo	Medium	On target	Rural
Tsolo	Eastern Cape	OR Tambo	Small	Obvious outlier	Rural
Mthatha	Eastern Cape	OR Tambo	Large	On target	Urban
Khayalitsha	**Western Cape**	**Cape Town Metro**	**Large**	**Low**	**Urban**
Wynberg	Western Cape	Cape Town Metro	Medium	Obvious outlier	Urban
Laingsburg	Western Cape	Central Karoo	Small	Obvious outlier	Rural
Swellendam	Western Cape	Overberg	Small	On target	Rural
Worcester	Western Cape	Cape Winelands	Medium	On target	Urban
Mitchell's Plein	Western Cape	Cape Town Metro	Medium	Low	Urban

DOH SITE SAMPLE

Table 11: DOH site sample details

Healthcare facility	Province	District	Public/Private	Performance	Rural/urban
Netcare St Augustine's Hospital	KwaZulu-Natal	Ethekwini	Private	Low	Urban
Eshowe Hospital	KwaZulu-Natal	Utungulu	Public	Obvious outlier	Rural
Lower Umfolozi War Hospital	KwaZulu-Natal	Utungulu	Public	On target	Rural
Stanger Hospital	KwaZulu-Natal	Utungulu	Public	Obvious outlier	Rural
Sandton Medi-clinic	Gauteng	Johannesburg	Private	On target	Urban
Chris Hani Baragwanath	Gauteng	Johannesburg	Public	On target	Urban
Alexandra CHC	Gauteng	Johannesburg	Public	Low	Urban
Mamelodi Day Hospital	Gauteng	Tshwane	Public	Low	Urban
Dr George Mukhari Hospital	Gauteng	Tshwane	Public	On target	Urban
Potchefstroom Medi-clinic	North West	Dr Kenneth Kaunda	Private	On target	Urban
Nic Bodenstein Hospital	North West	Dr Kenneth Kaunda	Public	Low	Rural
Christiana Hospital	North West	Dr Ruth Segomotsi Mompathi	Public	Low	Rural
Klerksdorp Provincial Hospital	North West	Dr Kenneth Kaunda	Public	Obvious outlier	Urban
Medi-clinic Limpopo (Polokwane)	Limpopo	Capricorn	Private	Obvious outlier	Urban
Messina Hospital*	Limpopo	Vhembe	Public	Obvious outlier	Rural
Louis Trichardt Hospital	Limpopo	Vhembe	Public	On target	Rural
Mthatha General Hospital	Eastern Cape	Alfred Nzo	Public	On target	Urban
Nessie Knight Hospital	Eastern Cape	OR Tambo	Public	Obvious outlier	Rural
St Mary's Private Hospital	Eastern Cape	OR Tambo	Private	Low	Urban
Mitchell's Plein Maternity Obstetrics Unit (MOU)	Western Cape	Cape Town Metro	Public	Obvious outlier	Urban
Stellenbosch Hospital	Western Cape	Cape Winelands	Public	Obvious outlier	Urban
Groote Schuur Hospital	Western Cape	Cape Town Metro	Public	On target	Urban
Kingsbury Private Hospital	Western Cape	Cape Town Metro	Private	Low	Urban

ADDITIONAL SITES VISITED

Table 12: Additional sites included in the sample

Site Name	Province	Date
Job Shimankana Tabane Hospital	North West	23 August 2017
Mowbray Maternity Hospital	Western Cape	25 August 2017
Mandela Academic Hospital	Eastern Cape	28 August 2017
Qumbu Home Affairs	Eastern Cape	29 August 2017
Taylor Bequest Hospital	Eastern Cape	31 August 2017
Matatiele Home Affairs	Eastern Cape	31 August 2017

RUBRICS TO ASSESS SITE PERFORMANCE

Table 13: Rubric to assess DHA site performance against criteria

	Poor: Score = 1	**Fair: Score = 2**	**Good: Score = 3**	**Score = 0**
Information desk	There is no information desk	There is an information desk or a security guard acts as a meeter-greeter	There is an information desk and the clerk at this desk does provide guidance to clients seeking to register births	Not observed
Queuing for birth registration	There is no separate line for birth registration and there is evidence that this affects queueing time (> than 1 hour)	There is no separate line for birth registration but there is no evidence that this affects queuing time (< than 1 hour) OR There is a separate line for birth registration but queuing time is lengthy (> than 1 hour)	There is a separate line for birth registration and queuing time is reasonable (< than 1 hour)	Not observed
IT and connectivity	DHA IT system is reportedly offline, intermittent or not used for birth registration	DHA IT system is in use for birth registration and connectivity is reportedly stable for the time period observed	DHA IT system is in use for birth registration and connectivity is reportedly stable for the time period observed. IT system is reported to be modern and fit-for-purpose	Not observed
Information materials	There are no posters in the office	There are posters in the office	There are posters in the office and these posters are designed appropriately to convey information on birth registration to clients	Not observed
Accessibility for disabled persons	The office is not disabled person friendly		The office is disabled person friendly	Not observed

Table 14: Rubric to assess HCF performance against criteria

	Poor: Score = 1	Fair: Score = 2	Good: Score = 3	Score = 0
Information provided through DHA presence and HCF staff	There is a DHA presence at the HCF, but it this is irregular or infrequent and/or it is unclear whether mothers are able to access information from this source	There is regular DHA presence at the HCF, which provides information to mothers	There is regular DHA presence at the HCF, which provides information to mothers, and this is further supplemented by information provided by nurses / midwives	Not observed
Issuance of birth certificates	The registration system is offline or connectivity is intermittent	The registration system is online and connectivity is stable and reliable. Birth certificate issuance takes more than an hour.	The registration system is online and connectivity is stable and reliable. Birth certificate issuance is on the spot.	Not observed
Information materials	There are no posters in the HCF	-	There are posters in the HCF	Not observed

ANNEXURE C: REGIONAL BIRTH REGISTRATION POLICY LANDSCAPE

South Africa has ratified the following international and regional treaties, and declarations which commit to the safeguarding of children's rights (Republic of South Africa, 2012)

- UNCRC
- Optional Protocol Prohibiting the Sale of Children, Child Prostitution and Pornography
- Optional Protocol on Involvement of Children in Armed Conflict
- ACRWC
- Convention on the Elimination of All Forms of Discrimination Against Women
- Convention against Torture and other Cruel, Inhumane and Degrading Treatment or Punishment
- Convention on the Rights of Persons with Disabilities
- United Nations Millennium Declaration

Given their focus on birth registration and therefore relevance in this evaluation, the following section focuses on the UNCRC and the ACRWC.

UNITED NATIONS CONVENTION ON THE RIGHTS OF THE CHILD

The UNCRC, adopted by the United Nations General Assembly on 20 November 1989, is an international, legally-binding treaty that outlines the civil, political, economic, social and cultural rights of children (Republic of South Africa, 2012). South Africa ratified the UNCRC on 16 June 1995 and in doing so, committed to protecting and promoting the rights of children (Steiner & Alston, 2000).

With regards to birth registration, Article 7.1 of the UNCRC states that (United Nations, 1989):

> *"The child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and, as far as possible, the right to know and be cared for by his or her parents.*"

Since ratifying the convention in 1995, South Africa has proactively worked towards achieving this and has developed a comprehensive child rights protection framework in support of this objective. However, despite South Africa's obligation to report periodically on the measures adopted and progress made with regards to the above Article and the convention more broadly, South Africa's reporting has been extensively delayed (South African Alternate Report Coalition, 2015). Second, third and fourth periodic reports were only submitted in April 2013, covering the reporting periods from 1998 to 2012. Despite the reporting delays, the submitted reports indicated that South Africa has made progress in improving birth registration and increasing access to birth certificates (South African Alternate Report Coalition, 2015).

With regards to migrant children, the UNCRC indicates that States must give all children equal status regardless of their nationality (Palmary, 2009). This provides the foundation for the fair and equitable treatment of foreign migrant children, refugees and asylum seekers. Refugees and asylum seekers registered with the DHA are entitled to register the birth of

their children and obtain birth certificates as per the convention's stipulations (South African Alternate Report Coalition, 2015). However, children who are born to undocumented migrant parents and undocumented, unaccompanied foreign children face greater barriers to becoming documented and therefore are at greater risk of not being able to access basic services (South African Alternate Report Coalition, 2015).

AFRICAN CHARTER ON THE RIGHTS AND WELFARE OF THE CHILD

The ACRWC was adopted less than a year after the UNCRC with the objective of complementing the UNCRC and providing additional content on child protection laws (Pan-African Voices for Freedom and Justice, 2007). Given that the UNCRC is an international treaty, it is required to cater to culturally diverse groups with the consequence that some of the provisions do not cater for country and context specific realities (Lloyd, 2002). The ACRWC was formulated by the Organisation of African Unity in July 1990 as African member states felt that the UNCRC lacked important socio-cultural and economic nuances that the African context presents (Olowu, 2000). The ACRWC and the UNCRC are therefore intended to be complementary documents, both providing a framework for children's wellbeing in Africa. South Africa ratified the African Charter on the Rights and Welfare of the African Child in 2000 (Olowu, 2000).

With regards to birth registration, Article 6 of the ACRWC states that every child has the right to a name and nationality and should be registered immediately after birth (Organisation of African Unity, 1990). Furthermore, the ACRWC states that all children shall be given the nationality of the State in the territory in which he was born if he or she is not granted nationality by the laws of any other State. The ACRWC therefore provides a fundamental framework for birth registration in Africa and, more specifically, securing the rights of migrant children (Palmary, 2009). Furthermore, the ACRWC requires that children born to "foreigners, asylum seekers, refugees and undocumented immigrants qualify equally for birth registration in the same way as those born to citizens" (African Committee of Experts on the Rights and Welfare of the Child, 2014) and that special measures be adopted to protect those born to vulnerable parents. The extent to which this is in place for vulnerable groups will be determined in the course of this evaluation.

However, based on a review of South Africa's Regulations on the Registration of Births and Deaths, there appears to be misalignment regarding the case of births to parents in irregular migrant situations, whereby Regulation 8 provides no guarantee of confidentiality to parents to encourage registration and rather places additional administrative requirements on parents whereby they are required to have a "certified copy of a valid passport or visa or permit of the mother or father, or both parents of the child, as the case may be" (Republic of South Africa, 2014). This appears to be the case across Africa This literature review was unable to find a jurisdiction within Africa that aligns its policies and laws with the guarantee of confidentiality to those in irregular migrant situations.

As with the UNCRC, under the ACRWC, States are required to report on their progress and alignment with the charter. In October 2013, South Africa submitted its first report to the African Committee of Experts on the Rights and Welfare of the Child, covering the period from 2000-2013 (Assim, 2014). This reported the interventions run by the DHA with regards to the birth registration and the efforts made to increase access to birth registration as well as South Africa's alignment to the Charter.

There are instances of countries ratifying the ACRWC and/or the UNCRC without having the appropriate national legislation in place that requires people to register the births of their children. Additionally, in many countries the issue of birth registration is amalgamated into various, related pieces of legislation such as laws relating to the family, personal

identification or the national statistics system; however, these are often too general to provide sufficient guidance on birth registration or only address selected technical aspects of birth registration (Innocenti Research Centre, 2002). South Africa has all the required pieces of legislation in place to encourage ERB and these are easily accessible. Furthermore, South Africa's birth registration is governed by a national-level legislative framework, which overcomes many other countries challenges where there are conflicting systems of legislation across the country (Innocenti Research Centre, 2002).

SADC-SPECIFIC POLICY LANDSCAPE

The Southern Africa Development Community (SADC) has no legal requirements or policies in place that specifically relate to birth registration. While it has not been entered into force, and therefore has no legal effect, the Protocol on the Facilitation of Movement of Persons has the potential to be a key protocol in this regard, should it be entered into force. This requires that "for the purposes of identifying persons, each State Party shall establish and maintain a population register from which the status of its citizens and permanent residents can be determined accurately" (SADC, 2005). This suggests that each State should have a timely birth registration system for the purposes of ensuring an accurate population register. As noted above, this however has not been implemented and therefore, the extent to which this influences birth registration in South Africa is yet to be evidenced.

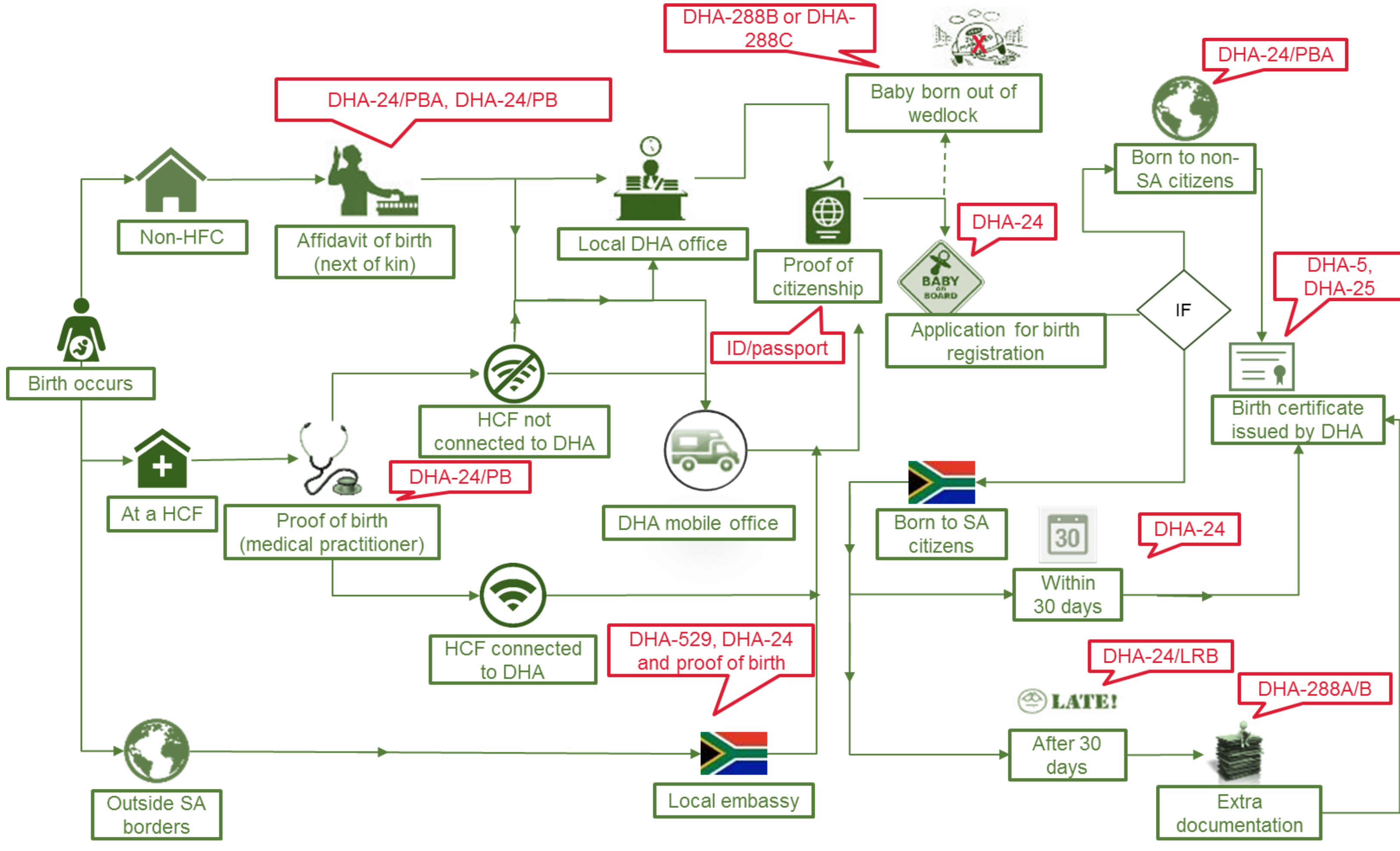
The Strategic Framework and Programme of Action for the Comprehensive Care and Support for Orphans, Vulnerable Children and Youth (OVCY) in SADC, published in 2008, emphasises the importance of registering births, particularly for the purposes of "access to inheritance and essential services such as school, health care and social assistance" (SADC, 2008). Lack of birth registration is listed as one of nine fundamental challenges for OVCY in the region and suggests that addressing the low rates of birth registration in the region and the lack of birth registration policies in SADC will be one of the strategic priorities that will be addressed in its interventions aimed at OVCY at national and regional levels. In doing so, SADC published the Minimum Package of Services for Orphans and Other Vulnerable Children and Youth in 2011 as a "guide to encourage the harmonising of service delivery to OVCY" (SADC, 2011) across the SADC region. It stipulates that SADC member states provide the following service to citizens "birth notification completed by six months and birth registration completed by two years of age for vulnerable children" (SADC, 2011). The following interventions are proposed to ensure this service:

- Policy and programmes for free and decentralised services and compulsory birth registration for all newborns and children younger than two years;
- Sensitising communities on the need children to be registered – targeting parents, child-headed households, child and youth clubs, community leaders and households in remote areas;
- Birth registration through other governmental activities and leveraging existing, ongoing service delivery programmes; and,
- Removal of penalties and fees for late registration.

South Africa has engaged with the above points, however, the effectiveness of this with regards to OVCY is yet to be determined, which is one component of this evaluation. Notably, South Africa currently does not have punitive measures in place for late registration, however, this has been given due consideration in recent times and, given the above, should be carefully considered going forward.

APPENDIX D: BIRTH REGISTRATION PROCESS MAP

Figure 26: Birth registration process map



APPENDIX E: MAPS DEPICTING SELECTED SITES