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OPPORTUNITY

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Build simple, loving connections for every child



EARLY IDENTIFICATION, EARLY ACCESS

WHY UNIVERSAL EARLY HEARING SCREENING MAKES SENSE FOR SOUTH AFRICA

International guidelines recommend that all newborns should have their hearing tested within one month of birth. If they have hearing loss, they should be formally diagnosed by three months of age and receive appropriate intervention by the time they are six months old. But South Africa doesn't have a national policy for universal newborn hearing screening, and many of the almost 6 000 babies born deaf in South Africa every year only get diagnosed sometime after their second birthday. By that time a critical window for brain development has been missed, which compromises their ability to learn, do well at school and interact with the world around them.

In this learning brief, we look at how the Hold My Hand Accelerator, a public–private collaboration between DGMT and the Presidency, worked with subject specialists to propose a new policy and set in motion a trial project to support universal newborn hearing screening in South Africa.

The National Strategy to Accelerate Action for Children (NSAAC), led by the Presidency and the Department of Social Development, identifies 10 key priorities to shape South African children's future and calls for broad partnerships across government, civil society, trade unions and the private sector. Hold My Hand is the Accelerator for Children and Teens, established through a partnership between the Presidency and DGMT. It contributes to fast-tracking critical strategies that require public–private collaboration, including the provision of early hearing and vision screenings and referrals for young children.

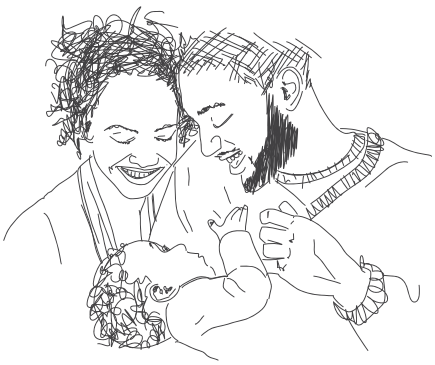
A CHILD'S FIRST CONNECTIONS

Up to six out of every 1 000 babies born in South Africa can't hear the world around them,[1] about three times the rate in developed countries.[2] Although hearing loss is one of the most prevalent congenital disabilities in the world, it is often missed because the signs aren't obvious early on. In fact, in South Africa, a child's hearing loss is often only diagnosed sometime between their second and third birthdays,[3] which is much later than the global benchmark for diagnosis at the age of three months.[4]

But it needn't be so. It is a quick process to test whether a newborn can hear using a painless and non-invasive technique, and international guidelines recommend that all babies should be screened for hearing ability within one month of their birth. If they fail the initial screening and follow-up tests confirm hearing loss, they should be formally diagnosed by three months of age so that appropriate intervention can start by the time they are six months old.[5]

However, failing to diagnose a baby's hearing loss early and subsequently provide them the right support means that a critical early brain development window can be missed. This is because the neural connections that help a child's brain make sense of the sounds in their world develop rapidly in the first three months after birth (even though the ears and their associated structures and neural paths are already functional by around the 25th week of foetal development).[6] Every time the brain picks up on sound, another connection is sparked. A strong, sprawling network soon develops, which sets the foundation for early language and speech development.

But if a child's brain doesn't get stimulated by sound because their ears can't pick up on the stimuli, the cells in the area dedicated to processing auditory information won't make extensive connections with others. If these cells lie fallow for too long, without input and stimulation by signed language, the brain areas dedicated to language development and communication skills don't get enough stimulation either and so won't develop to their full potential, which can compromise a child's ability to learn and interact with the world around them. That said, it is not deafness itself that limits a child's potential, but the barriers that arise when children lack early access to language, communication and environments that enable full participation.



1 Tombe-Mdewa, W. et al. 2026. The economic costs of congenital hearing loss in a South African cohort. ***Health Services Insights***. 19:11786329251401414. https://doi.org/10.1177/11786329251401414

2 Olusanya, B.O. and Newton, V.E. 2007. Global burden of childhood hearing impairment and disease control priorities for developing countries. ***Lancet***. 369(9569):1314-1317.

3 Phanguphangu, M., Kgare, K. and Ross, A.J. 2025. Age of detection of congenital hearing loss in South Africa: A systematic review. ***Journal of Public Health in Africa***. 16(1): 777. https://doi.org/10.4102/jphia.v16i1.777

4 Joint Committee on Infant Hearing. 2007. Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs.

5 The timeframe is often referred to as the 1-3-6 principle. See: Joint Committee on Infant Hearing. 2007. Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs.

6 Graven, S.N. and Brown, J.V. 2008. Auditory development in the fetus and infant. ***Newborn and Infant Nursing Reviews*** 8(4): 187–193.

THE CONNECTION BETWEEN HEALTHY PREGNANCIES AND NEWBORN HEARING LOSS

Research shows that babies born too early or at a low birth weight have a greater risk of hearing impairment than those delivered at full term and normal birth weight.[7] We also know that one in seven babies in South Africa is born underweight,[8] often because of poor maternal health fuelled by poverty. But by helping mothers eat better, providing social protection through a Maternal Support Grant, improving antenatal care, avoiding exposure to toxins such as alcohol and medication that could impair auditory development, and encouraging mothers to get regular health checks during their pregnancy,[9] we can help more babies grow well before birth — and lower the chance of preventable disabilities.

THE COST OF INACTION

Close to a million babies were born in South Africa in 2022. With the prevalence of hearing loss estimated at six per 1 000, roughly 6 000 children would have been born without hearing. Research shows that, based on that year's figures, inaction could cost South Africa around R16.4 billion over their lifetime, with productivity losses due to either unemployment or limited ability to work accounting for almost three-quarters of that.[10] In addition, special schooling, social assistance and direct healthcare expenses would amount to about R1.7 million per person over their lifetime.[11]

But the consequences of late detection and diagnosis are far from just monetary. When babies gurgle, gesture or make sounds, their brains are primed to receive and return responses in order to elicit another round of interactions. This back-and-forth not only builds the foundations for communication but also shapes the development of social and emotional skills. However, if a caregiver's response is not received, the so-called serve-and-return loop breaks and building optimal brain architecture is compromised. Since a baby's brain is highly receptive to such interactions during the first two years after birth, not making the most of stimulation during this period is a lost opportunity for the country to build a caring, inclusive and productive society.

CAN YOUR BABY HEAR?

Testing a newborn's hearing can be done through recording either otoacoustic emissions (OAE) or automated auditory brainstem responses (AABR). Both techniques are quick, safe and non-invasive. OAE testing is generally cheaper and simpler to implement, but it's sensitive to noise and prone to giving false positives. AABR testing is less sensitive to background noise and so rarely gives false positives, but the initial costs to implement are higher.

The most commonly used technique, OAE, involves inserting a bud-like earphone connected to a handheld signal generator into the baby's ear. The device creates a sound signal that travels through the baby's ear canal, across the middle ear and then reaches the inner ear (cochlea). The sound wave generated by the stimulating device travels through the fluid in the inner ear, exits through the middle ear and travels back along the ear canal to reach the earpiece with a built-in microphone. It picks up the signal and relays it to the operator device, which registers a successful signal loop and tells the screener that the child's inner ear works correctly.

In the case of an AABR test: small, painless electrodes are placed on a baby's head and connected to a handheld stimulating device, about the size of a smartphone. From here a signal travels to the cochlea. When picked up by the nerve cells at the base of the cochlea, the cochlear nerve running through the brainstem is activated and relays the message to the hearing centre in the brain. When the hearing area in the brain is activated, a wave trace shows on the operator device, confirming that the sound was successfully perceived.

7 Van Dommelen, P. et al. 2015. Hearing loss by week of gestation and birth weight in very preterm neonates. ***Journal of Pediatrics***. 166(4): 840–843. doi: 10.1016/j.jpeds.2014.12.041

8 Health Systems Trust. District Health Barometer, 2024. https://dhb.hst.org.za/reproductive-maternal-child-health

9 Issue 34 of ***Hands-on Learning*** focused on what can be done to improve maternal health and reduce stunting in South Africa. https://dgmt.co.za/hands-on-learning-issue-34/

10 Tombe-Mdewa et al. 2026. Economic costs of congenital hearing loss. ***Health Services Insights***.

11 Ibid.

MAKING SOUND DECISIONS

In South Africa, most babies — especially if they're born seemingly healthy — go home without getting their hearing tested,[12] and despite guidelines for universal newborn hearing screening having been drawn up in 2018,[13] a state-run national programme has not yet been implemented. Failure to roll out large-scale, policy-mandated screening is said to be linked mostly to resource constraints in the public healthcare sector. For example, recent analyses show that South Africa only has about 2 600 registered audiologists[14] — about half as many as are ideally needed to serve everyone in South Africa.[15] Moreover, only about 20% of them work in the public sector,[16] despite about 85% of the population relying on public healthcare.[17]

According to a recent global survey, about a third of the world's population lives in countries where near-universal early hearing screening programmes are in place.[18] However, although GDP was generally about 10 times higher in countries with extensive screening programmes than in those without, the analysis showed that high screening coverage was not seen only in high-income countries; several middle-income countries also had extensive programmes in place. This suggests that rolling out a wide-reaching initiative doesn't depend only on national wealth, but that factors such as awareness and political will are also important policy drivers.[19]

This is where the Hold My Hand Accelerator comes in.[20] It has been working closely with the Presidency and government on 10 priorities aligned with the goals set out in the National Strategy to Accelerate Action for Children (NSAAC).[21] One of them is to prevent disability, explains Noxolo Gqada, who leads strategic design and integration at the Accelerator. The NSAAC identifies a national universal newborn hearing screening programme as a catalytic intervention to help change the future of South Africa's children.

TWO VIEWS, ONE GOAL

Although the Accelerator entered the disability space as a relative outsider, it played an important role in bringing together early hearing detection and intervention partners across the public, private and civil society sectors to come up with a united approach to getting a national screening programme off the ground. This, says Gqada, has been a turning point, as specialists working in this field have long been approaching intervention from two different perspectives.

One favours integrating children with hearing loss into a world of sound through the use of amplifying technology such as hearing aids or cochlear implants to support language development and communication skills. The other advocates for children reaching their full potential as part of the Deaf community, where communication relies on sign language and dedicated education approaches. Both approaches have their merits and are grounded in the desire to give children with hearing loss the best chance at cognitive, academic and social development — ultimately rooted in supporting connection and belonging.

However, in the past, childhood hearing advocates were focusing on points of divergence, particularly the ***type*** of intervention required. Sometimes this meant that sight was lost of the primary gap in the system, namely that children with hearing loss simply are not identified and diagnosed early enough,



12 For example, see: Meyer, M.E. and Swanepoel, DeW. 2011. Newborn hearing screening in the private health care sector – a national survey. ***South African Medical Journal.*** 101(9):665–667; Maluleke, N.P., Chiwutsi, R. and Khoza-Shangase, K. 2021. In: Khoza-Shangase, K. & Kanji, A. Early detection and intervention in audiology: An African perspective (pp. 196-218). Wits University Press, 2021. https://library.oapen.org/handle/20.500.12657/46214

13 HPCSA guidelines.

14 Mothemela, B., Ramma, L. and Swanepoel, D. 2025. Update on the state of audiology in South Africa. ***International Journal of Audiology***. 64(3):286–289. doi: 10.1080/14992027.2024.2354511

15 Pillay, M., Tiwari, R., Kathard, H. and Chikte, U. 2020. Sustainable workforce: South African audiologists and speech therapists. ***Human Resources for Health***. 18 (1): 47. https://doi.org/10.1186/s12960-020-00488-6

16 Ibid.

17 Statistics SA. 2026. General Household Survey 2025. Pretoria: Statistics SA

18 Of the 196 countries surveyed, 158 responded. Among these, about a third reported to have a near-universal early hearing screening programme in place. However, as the participating countries represent about 95% of the world's population, the authors regard the results as "a reasonable approximation of the global situation". See: Neumann, K., Euler, H.A., Chadha, S. and White, K.R. 2020. A survey on the global status of newborn and infant hearing screening. ***Journal of Early Hearing Detection and Intervention***. 5(2):63-84. https://doi.org/10.26077/a221-cc28

19 Ibid.

20 https://www.holdmyhand.org.za/10-key-priorities/prevent-disability

21 Department of Social Development. 2026. The National Strategy to Accelerate Action for Children. Pretoria: https://www.dsd.gov.za/index.php/documents?task=download.send&id=701&catid=7&m=0

which delayed getting them the right support, says Gqada. "So, we brought a group of specialist practitioners and committed hearing activists into the same room, under the whole-of-society approach of the NSAAC, to create a community of practice." The idea behind convening this group of 30–40 role players who meet quarterly was to focus on points of convergence and intentionally curate a space for alignment and real-time coaching of critical sector leaders to build consensus — not on everything but on the things that mattered.

Two key issues emerged. One was to focus on impact, by coming together for screening so that children with hearing loss could be identified in good time, born from the perspective that families are best placed to choose the intervention that would be most appropriate for their child, rather than promoting one intervention over the other. The second issue was to rally around common and shared principles such as task shifting. This meant moving away from audiologist-led screening and instead training designated lay screeners, enabling audiologists to focus on specialist skills such as diagnostics and intervention.

"Then we approached government to discuss how we could implement this," Gqada explains. "Uniting the two schools of thought was important, because if the National Department of Health (NDoH) were to put a countrywide screening programme in place while the advocacy agents weren't on the same side, it would yield little benefit; innovative service delivery models need to be generated from the bottom up, from grassroots to policy. So, to create unity among thought leaders in the sector and align that unity with the government's outlook, we wrote up a policy brief,[22] which puts forward specific implementation options for the country. It maps out what's happening in different parts of the country and what should be leveraged to make universal rollout happen."

Serendipity had a hand in the process, too. Sensory screening had been a matter of concern for the NDoH for a while but hadn't yet become an area of proactive focus. Then, a new deputy director for non-communicable diseases was appointed in the department — after the post had been vacant for almost two years. She happened to be an audiologist. It was a unique window of opportunity, says Gqada, "because not only was there now someone in the department with a special interest in newborn hearing screening, but she was also open to engaging with the sector to shape her strategy". This brought a sense of urgency to move things forward, but with an openness to lean on the support of a community of experts — from clinicians to academics and civil society.

CONCEPTUALISING A PRACTICAL PLAN

Doing the background work that informed the policy brief enabled the community-of-practice group to build consensus and shared value that enabled them to move beyond policy. Testing every newborn, regardless of their health status or the facility in which they're born, makes the most sense. This would require additional investment and training more health workers than the country is getting by with at the moment. But a modelling study showed that screening represents only 2% of the total lifetime healthcare costs of a child with hearing loss and that the "long-term societal costs of late detection far outweigh the upfront investment for early screening and intervention".[23]

Regardless of the sound economic reasoning behind putting a universal newborn hearing screening initiative in place, the practicalities are challenging.[24] Insights from the group's collaborative work in shaping the policy brief allowed them to put forward a workable plan for what implementation could look like in real life — from how to task-shift screening to the type of training and equipment that would be needed and how data would have to be managed.

The National Health Insurance (NHI) scheme, positioned as a vehicle to roll out universal health coverage, could offer a practical funding and delivery mechanism for integrating hearing screening into routine maternal and child health services. In addition, training lay health workers to serve as dedicated screeners, supervised by a qualified audiologist, could help to scale the reach of screening programmes, the group proposed, as the limited number of audiologists available would no longer be a constraining factor.[25]

"We then approached the Western Cape Department of Health, as they are currently the only province working on provincial newborn hearing screening guidelines, and they agreed to run a trial with us," explains Gqada.

22 Every child heard: Why South Africa must implement universal newborn hearing screening now. 2025. (Hold My Hand Policy Brief 05). Cape Town: Hold My Hand. https://holdmyhand.org.za

23 Ibid.

24 Kanji, A. 2022. Newborn and infant hearing screening at primary healthcare clinics in South Africa designated as National Health Insurance pilot sites: An exploratory study. ***South African Journal of Communication Disorders***. 69(1): e1–e7. doi: https://doi.org/10.4102/sajcd.v69i1.840

25 Every child heard: Why South Africa must implement universal newborn hearing screening now. 2025. (Hold My Hand Policy Brief 05). Cape Town: Hold My Hand. https://holdmyhand.org.za

PUTTING THE PLAN INTO PRACTICE

The trial for universal newborn hearing screening is planned at six public-sector primary healthcare facilities — one each in Oudtshoorn and George (in the Garden Route district) and four in the Khayelitsha subdistrict.

All newborns seen at the facilities before they're 14 weeks old — whether at a mother's postnatal check-up or when they arrive for their 6-, 10- or 14-week immunisation — will be screened. The initiative introduces two shifts in thinking: (i) moving screening to the primary healthcare level and (ii) leveraging private providers. "The Garden Route district (where Oudtshoorn and George are located) is an existing NHI site," explains Gqada, "and so they're already leveraging and are familiar with public–private partnerships."

WHAT IS AN NHI SITE?

South Africa's plan for the NHI scheme is set to be rolled out in phases. A pilot project meant to see how the NHI could work was launched in 11 districts across all nine provinces in 2012 and focused on strengthening healthcare infrastructure in line with what would be needed for universal health coverage. Part of this was getting facilities to "ideal" status, which meant that they'd have suitable infrastructure, enough staff, supplies and equipment, and sound administrative systems in place to run in a way that would support the NHI.

In the model followed in the trial programme, the private provider will offer clinical oversight by supporting screeners, both remotely and at the primary healthcare facility, and also conduct a middle ear test to rule out the presence of fluid in the ear if the initial screening test indicates hearing impairment.[26] This is an important step, explains Gqada, because fluid in the ear is a common cause of a baby failing a screening test.[27] "In public facilities, children often get referred to a waiting list for a diagnostic test if they fail their initial screening. And if the failed test was indeed due to hearing loss and not an infection or residual fluid, this burdens the health system by extending delays during a critical time for a life-changing intervention."

Children who are confirmed to have failed their screening will then be fast-tracked to the Red Cross War Memorial Children's Hospital or Tygerberg Hospital in Cape Town. So, even though diagnosis and treatment will be handled by the public system, partnering with private-sector audiologists to support screeners at primary health facilities means that screening can happen (i) soon after birth and at the facility where a baby is born, to ensure integrated service delivery and reduce loss to follow-up; and (ii) at scale to extend coverage, by having a diverse screening team at facilities.

This integrated primary healthcare approach also brings community health workers into the trial programme, which will help to increase coverage through raising awareness, reduce the risk of people not turning up for their follow-up test, and ensure timely and appropriate linkages to services.

Gqada explains that the trial programme seeks to leverage the strengths of each sector for the benefit of children. The combination of private-sector skills and capacity and the scale and reach of the public sector, together with the model being implemented in both rural and urban settings, will allow the team to assess whether the approach yields adequate coverage and diagnostic success.

LESSONS LEARNT

The nearly two years of working on plans to get every newborn's hearing tested have brought valuable lessons:

1 NETWORKS ARE AN UNTAPPED ASSET

As the incubator of the Hold My Hand Accelerator, DGMT has access to an extensive number of experts, enabling the organisation to bring people together to build networks. "But a network is not just a list of contacts. It's an organic, dynamic entity that grows and develops, and we were able to tap into the expertise of implementing partners already funded by DGMT to help us build a community of practice," says Gqada. By leveraging the collaborative work of the group as well as

26 The presence of fluid can be due to amniotic fluid being trapped in a newborn's ear after birth or a possible ear infection.

27 Schwarz, Y. et al. 2023. Newborn hearing screening: Early ear examination improves the pass rate. ***Journal of International advanced Otology***. 19(5):402–406. doi: https://doi.org/10.5152/iao.2023.22987

DGMT's position in the policy space, getting buy-in for an evidence-based trial was possible. "It's the networks that are the change agents, not the funding organisation."

2 WORK ON MORE THAN ONE LEVER OF CHANGE SIMULTANEOUSLY

Over the past two years, the team learnt that focusing only on one aspect of change won't shift the needle fast enough. However, "starting many small fires at the same time" can get things going and then develop over time. "Our community of practice worked at building the evidence base and preparing the background for the policy brief while at the same time also working to create awareness about hearing loss and the need for screening. Simultaneously, the community engaged with provincial and national government as thought partners, not adversaries. Having a solid foundation of research and programmatic evidence from earlier studies, together with demand for screening and appropriate communication channels, created critical mass when we brought all the levers together," explains Gqada.

3 NEUTRALITY IS A VALUABLE FACILITATOR

The Accelerator's relative inexperience in the field created a space where experts with different views on intervention were able to come together in a neutral setting. More than that: because the Accelerator team was not made up of sector experts, specialists were willing to talk through widely accepted ideas and rethink what they really mean. In this way, the team's neutrality facilitated a reframing of preconceived ideas, encouraged critical evaluation and promoted problem-solving born from working towards a shared goal.

4 NAVIGATE BOTH TOP-DOWN AND BOTTOM-UP RELATIONSHIPS

Driving change in a policy space that has been idling for a long time requires being both a strategic partner to decision-makers and a trusted ally to those implementing programmes on the ground. It's not a quick thing, though. Newborn hearing screening is just a starting point for addressing disability under the NSAAC, and although it's not the only thing to be done, it's a place to start. "Making the Accelerator an orchestrator of relationships rather than a holder of relationships required building trust, and that can be achieved only through building deep, meaningful connections."

WHAT'S NEXT?

The trial programme in the Western Cape will gather data on implementation and feasibility. Findings will be tested against theory as they emerge, building a realistic picture of what a large-scale newborn hearing screening programme in South Africa requires. This would also inform what realistic programmatic and outcome targets would be for the country compared to international and local benchmarks. Although there's still a long way to go to reach the global benchmark of 95% coverage for universal screening, South Africa has committed to increasing universal coverage to 30% by 2029/30 (up from 10%), in line with World Health Organization global targets for ear and hearing care. By 2029/30, the Accelerator aims to move beyond concept to practice. It plans to present to national policymakers, programme implementers and Treasury a robust, informed and costed service delivery model that leverages cross-sectoral partnerships in line with the principles of the NHI.

This brief was written by Linda Pretorius and edited by Rahima Essop, with contributions from Noxolo Gqada.

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