Press release – 27 July 2010

Child health – a call for action

CAPE TOWN - Children are paying the price for South Africa's failure to progress towards the Millennium Development Goals. South Africa is one of only 12 countries that has failed to reduce child mortality since 1990.

These are some of the key findings reported in the *South African Child Gauge 2009/2010*, an annual review of the situation of children in the country, which was released today <eds: Tues, 27 July> by the Children's Institute (CI), University of Cape Town (UCT). The review contains essays by child health experts from across the country.

The Millennium Development Goals (MDGs) broadly aim to reduce poverty, hunger and disease by 2015 and to ensure children's rights to survival, health and development. While South Africa is making progress towards meeting the MDG target on sustainable access to safe drinking water, this has not trickled down to children: Only 64% of children have access to safe drinking water on site. Progress has been slow for access to basic sanitation, education and gender equality. On the MDG targets for reducing child hunger, HIV, tuberculosis and child mortality, South Africa is not making any progress. South Africa has also failed to submit its reports on progress in relation to implementing the UN Convention of the Rights of the Child – the key accountability mechanism aimed at monitoring South Africa's progress in promoting the maximum survival and development of children.

The Medical Research Council (MRC) estimates that children under five account for over 80% of all child deaths in South Africa. UNICEF estimates that under-five mortality has risen from 56 deaths per 1 000 live births in 1990 to 67 in 2008. This is driven primarily by the HIV pandemic, poor diets and living conditions, and a deteriorating health care system.

The MRC estimates that nearly one third of these young children die in the first month of life. Neonatal complications (in the first 28 days of life), together with HIV and childhood infections (such as diarrhoea and lower respiratory infections) are the leading causes of death for children under five. Injuries are the leading cause of death for older children.

Why are so many children dying in South Africa?
Prof. David Sanders, founding director of the School of Public Health at the University of the Western Cape explains that "most childhood deaths are rooted in poverty, which impairs children's immunity and increases their exposure to illness and injury".

Children's Institute analysis of 2008 General Household Survey (GHS) data shows that nearly 64% of children live in the poorest 40% of households. Over one in three of children do not have access to basic sanitation or adequate drinking water on site. Nearly one in five children was stunted (chronically malnourished), according to the most recent national food consumption survey in 2005, while mortality audits by the Child Healthcare Problem Identification Programme indicate that more than 60% of children who died in hospital between 2005 and 2007 were underweight.

Inequalities persist between rich and poor, black and white, rural and urban provinces. Analysis of the 2008 GHS shows that 40% of children have to travel more than half an hour to reach their nearest clinic.

Prof. Haroon Saloojee, head of the Division of Community Paediatrics at the University of the Witwatersrand, points to systemic problems within the public health service: "The poor health status of South Africa's children is less the consequence of resource constraints, and more the result of inefficient management and use of available resources, primarily due to poor leadership, poor organisation and the absence of accountability." He says that lacklustre leadership and low morale contribute to the poor quality of basic services.

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Finance is also a problem: While the private sector accounts for nearly 60% of health care spending, it only provides care to 15% of children. Resources in the public sector are thinly stretched, with for example one paediatrician serving 9,600 children in the Western Cape, but 200,000 children in Limpopo. Failure to budget adequately leads to drug shortages and the freezing of posts – more than 36% of health professional posts in the public sector were vacant in 2008.

Coverage of key child health interventions is poor particularly in rural and peri-urban areas: According to UNICEF's *2008 State of the World's Children* report, only 29% of children (aged between 6 – 59 months) received the twice-yearly dose of vitamin A supplements (which protect against common diseases such as diarrhoea and pneumonia). The 2008/09 District Health Barometer indicates that nearly 90% of children completed a full round of immunisation during their first year of life, but this was still not enough to prevent outbreaks of measles in all nine provinces. As of April 2010, the National Institute for Communicable Diseases reported a total of 12 277 laboratory-confirmed cases of measles in South Africa. More needs to be done to improve the coverage of immunisation and other essential services.

What needs to be done?
Minister of Health, Dr Aaron Motsoaledi, who contributed a short paper to the *South African Child Gauge 2009/2010*, says that "there needs to be a renewed commitment to caring for children", and calls on "communities and health workers, researchers and policy-makers to place children first in all they say and do."

Improving child health outcomes requires concerted action from both within and outside the formal health care system.

Alleviate poverty and eliminate inequality
Prof. Louis Reynolds of UCT's School of Child and Adolescent Health calls on the Presidency to "put child health at the centre of the national development agenda" and ensure coherent action across all sectors of government.

Similarly, Minister Motsoaledi says his department is "committed to addressing the social determinants of health, especially poverty, lack of access to clean water and sanitation, poor housing and lack of household food security".

Focus on prevention
Similar collaborative efforts are required to address the problems of unsafe sex, violence, drugs and alcohol abuse, all of which have a direct impact on South Africa's children.

The roll-out of prevention of mother-to-child transmission (PMTCT) has contributed to a slow decline in under-five mortality since 2006. Increasing PMTCT coverage to 100% should effectively eliminate paediatric HIV. Priority needs to be given to the treatment and care of infants in resource-poor settings (particularly safe infant feeding). It is also important to integrate HIV/AIDS and TB programmes at all levels of the health care system, because 40% of children with HIV are infected with TB.

Nomathemba Mazaleni, director of Management Sciences for Health in South Africa, says community health workers can equip families with the knowledge and skills to prevent and treat childhood illness, and to recognise when to seek emergency care. Community-based services have proven effective in promoting immunisation and breastfeeding, improving TB treatment, and reducing child morbidity and mortality. Yet, Mazaleni says, "a lack of dedicated financial and human resources has compromised the implementation of the government's Integrated Management of Childhood Illnesses programme at community level".

Currently, policies are being developed to strengthen the delivery of community-based services for mothers and children, and to train and support community health workers. Given sufficient funding, these initiatives should have a positive impact on child health.

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Encourage participation
Recent legislative developments also impact on child health. The Children's Act, which came into full force in April 2010, outlines children's right to participate in decisions about their health care in line with their evolving capacities.

Prinslean Mahery, senior legal researcher at the CI explains that children "12 years and older can now consent to medical treatment, provided that they are mature enough to understand the risks, benefits and social implications of the test or treatment". The new law lowers the age of consent to medical treatment from 14 to 12 years but requires an additional assessment to ensure that children are mature enough to make decisions about their own. Health professionals are now responsible for ensuring children's informed consent and will need to develop the skills to communicate effectively with children and families.

Improve performance
Strong leadership is needed to improve performance in the public health care system. Saloojee recommends developing norms and standards, which should improve the quality of care and ensure that individuals and health centres are held accountable for their performance. Improved staffing ratios at clinics and community health centres should translate into shorter queues and better performance, and focused training and support from paediatricians and other health professional should improve the quality of care at district hospitals.

National, provincial and district health information systems need to be strengthened. Child-centred data are essential for setting priorities, monitoring programmes and identifying districts in need of support

Ultimately, more resources need to be allocated to child health. As Saloojee points out: "Not all of this needs to be new money – much, but not all, of the money can be obtained by reducing current inefficiencies."

The *South African Child Gauge* monitors the realisation of children's rights and is published annually by the Children's Institute, UCT. Key features include: legislative developments affecting children; child-centred data tracking children's access to social assistance, education, housing, health and other services; and a series of essays to inform, focus and sometimes direct national dialogue and debate.

The *South African Child Gauge 2009/2010* was released at a symposium on child health, hosted jointly with UNICEF South Africa. The publication is available for download on www.ci.org.za.

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