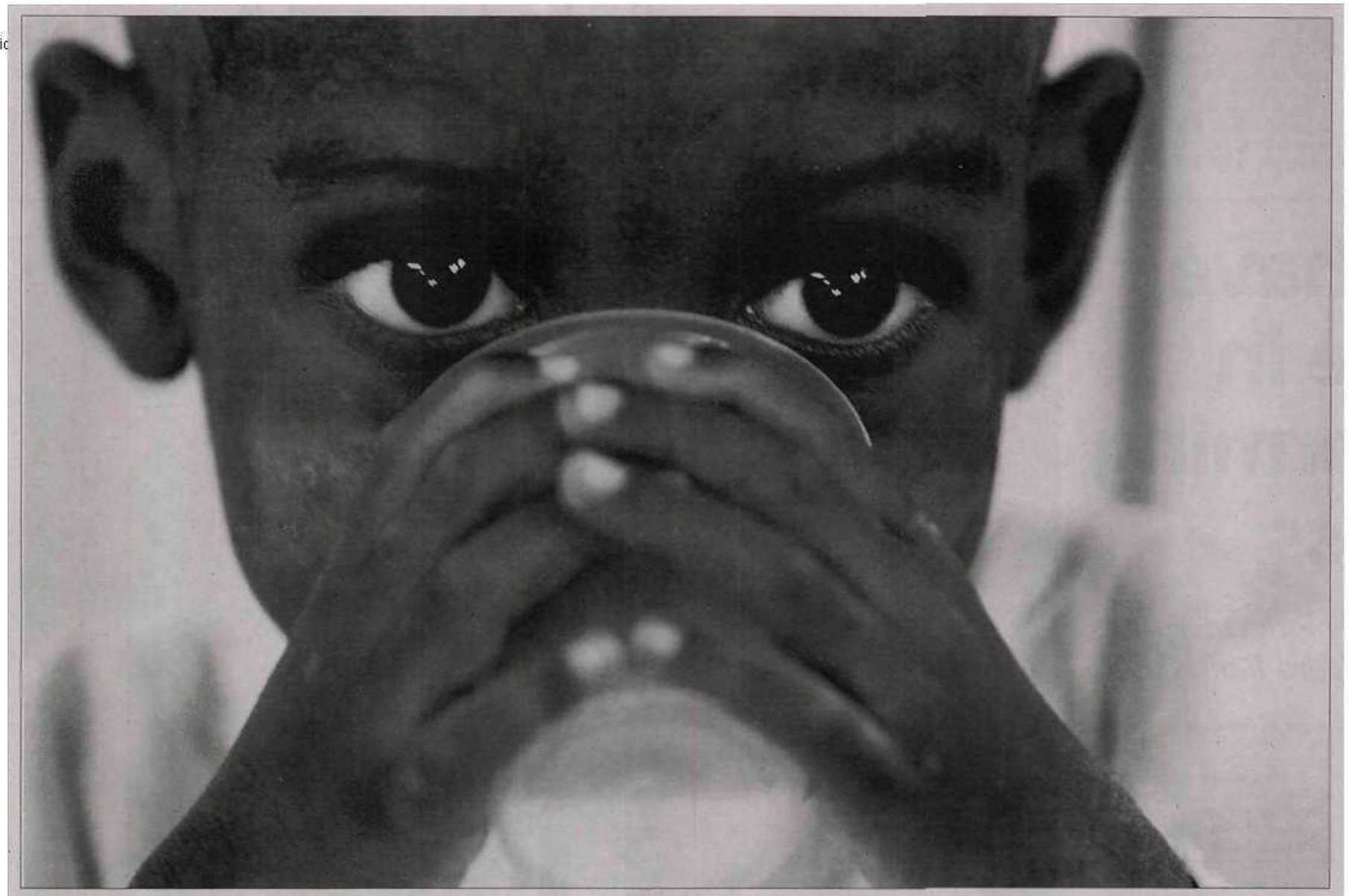
Date : September, 11 , 2010 Publication : Saturday Star Page Number : 15

OUR MOST VULNERABLE CITIZENS UNDER THE SPOTLIGHT

Date : September, 11 , 2010 Public



FAILING TO CARE: South Africa is one of only 12 countries in the world where more young children are dying now than 20 years ago. PICTURE: OBED ZILWA /AP

'Healthcare system needs a big bang'

Fed up with inefficiencies, Prof Haroon Saloojee has the spark…

SHEREE BEGA

FOR PROFESSOR Haroon Saloojee, it seems easier to save the world's babies than to save an individual child at a public hospital. That's the hard truth the neonatologist learnt after years spent fighting for bare necessities in under-equipped children's wards.

"Every day I spent fighting the system. I knew how to ventilate babies and how to be a good doctor, but as the head of the unit, I spent much of my time wondering why once again there wasn't linen or clothing for the babies, and fighting for soap."

Like many of his peers, the indefatigable bureaucracy of South Africa's public healthcare system eventually overwhelmed him – and Saloojee became a policy developer.

"I got tiring fighting the same battle again and again. The joy of being a paediatrician is caring for and healing sick children; the difficult bit is making the system work.

"Eventually I decided I couldn't spend my life saving individual babies at a hospital. I'll rather save the whole world's babies," says Saloojee, a professor in the division of community paediatrics at the department of paediatrics and child health at Wits University.

The chronic inefficiencies that plague the public health system and put the lives of children at risk make him question whether South Africa is "short-changing" mothers and their children.

South Africa is one of only 12 countries in the world where more young children are dying now than 20 years ago, ranking alongside war-torn Afghanistan and the DRC, where child deaths have risen steeply during the past decade.

The country was listed in a Save the Children report released this week which shows that 4 million children have died in the past decade globally because their governments have failed to spread major medical advances to the poor.

Getting our child-health goals on track is the subject of Saloojee's inaugural lecture at Wits next week, titled "Over 200 children die in SA every day. What can we do about it?".

He will highlight how children under five account for 80 percent of all child deaths in South Africa – these have risen from 56 deaths per 1 000 live births in 1990 to 67 in 2008 – fuelled by the HIV pandemic, poor diet and living conditions, and a deteriorating healthcare system. Most of these deaths occur in the first year of a child's life.

The recently released South African Child Gauge, compiled by the University of Cape Town's Children's Institute, to which Saloojee contributed, is evidence of how South Africa has failed to reduce child hunger, HIV and TB as the leading causes of death for children under five.

It highlights how 64 percent of children live in the 40 percent poorest households – many without access to basic sanitation and safe water, and how common childhood ailments like diarrhoea and respiratory infections persist and continue to claim lives. Poorer children are four times more likely to die than children in richer families.

That's why Saloojee believes it's time for a "big bang" that will deliver first-class healthcare to the country's children, who bear the brutal brunt of the ailing healthcare system. This turnaround demands political will, leadership, money, established norms and standards, clear targets and, most important, accountability.

Throughout his career, Saloojee has emerged as a children's rights champion who, along with the Treatment Action Campaign, orchestrated the earliest battles against former health minister Manto Tshabalala-Msimang and her department, forcing them to provide nevirapine to HIV-positive pregnant women, after thousands of babies died almost a decade ago.

He is worried South Africa is failing to reach the millennium development goals of cutting poverty, hunger and disease by 2015 and ensuring children's rights to survival, health and development.

He explains: "Children under five die mainly from infectious diseases. However, they get these because they're poor; they don't have access to clean water or sanitation, or to adequate food – or because their parents cannot ensure they get adequate healthcare."

But Saloojee points out these are the immediate causes and that the underlying causes may be more important – how much the country spends on health and what kind of health services it offers, particularly to children and their mothers.

Where has it gone so wrong? In 1990, South Africa pledged to a two-thirds reduction in child mortality by 2015 to reach the millennium goals. Saloojee will argue in his lecture that today, our under-five mortality rate is three times higher than countries with equivalent incomes per person, such as Brazil and Turkey, which have reduced their child mortalities.

"There should be no more than 20 deaths of children under five years per 1 000 babies born. At the moment, we're around 60. Basically, we're worse off than we were in 1990. But the good news is that around 2006 we took a turn for the better again, and child survival is improving."

He attributes this chiefly to improved efforts at preventing mother-to-child transmission of HIV and the provision of antiretroviral treatment.

HIV remains the biggest killer. "I have no doubt that if we didn't have HIV, even with our inefficient health management system, we'd be approaching the millennium development goal targets.

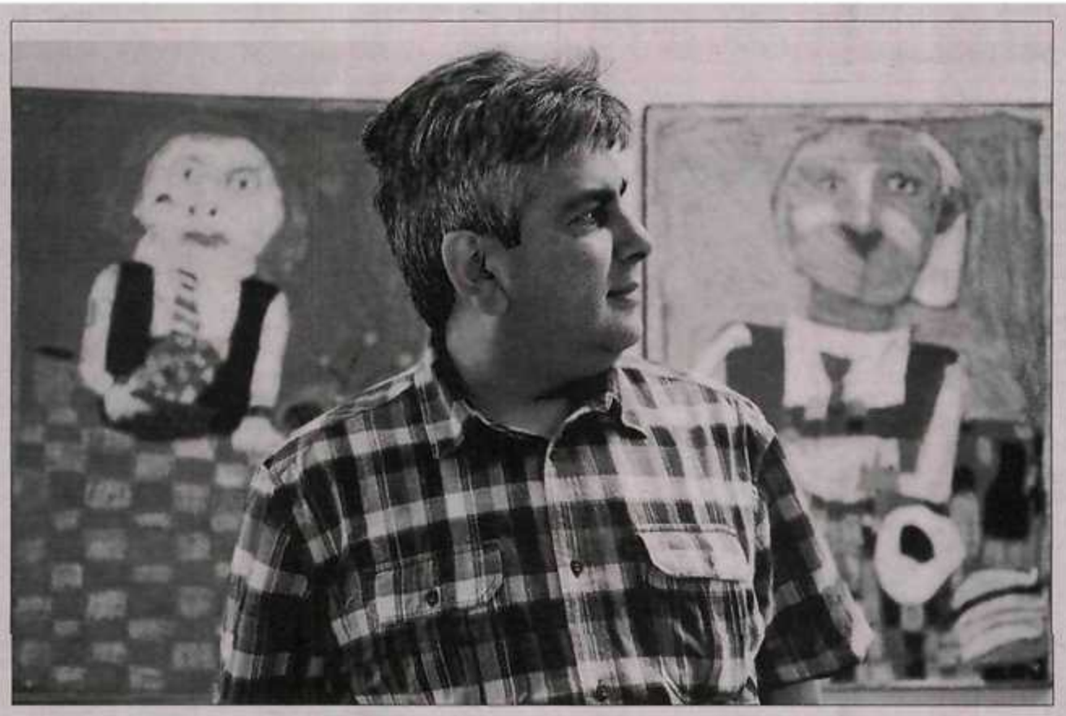
"We've got the greatest number of HIV-positive people in the world, and that's why we've had this sudden escalation in child deaths since 1995. Forty percent of our children's deaths are HIV."

He says this, coupled with ceaseless inequities – South Africa has the biggest difference in income between the richest and poorest 5 percent of the population – "it's obvious why we've gone backwards."

Saloojee is also concerned about newborn deaths – their death rates have not changed for the past 20 years, and more than a third of children who die in South Africa are severely malnourished.

He argues that South Africa's per capita income means its child mortality rates should be similar to those of Turkey and Brazil.

"We're in the same league as countries such as Niger and Malawi, whose citizens earn 10 times less than us. Our health spending is mostly in the private sector, with 60 percent of the country's health budget being spent on 15 percent of the population."



MAKING A DIFFERENCE: Professor Haroon Saloojee dreams of saving the world's babies. PICTURE: CARA VIERECKL

There are other reasons why children continue to die.

"It's about who cares for you. At least a third of deaths occur because of home factors such as caregivers delaying to seek care, not realising the severity of the child's illness, feeding the child inappropriately, or using home treatments with negative effects. These deaths can best be prevented by supporting caregivers to recognise common danger signs.

"Then it's about what kind of environment a child lives in. Ten percent of all mortalities of all children are from diarrhoeal disease, which, in a country like South Africa with over 85 percent water access, should not be the case.

The other big factor is what kind of health system is available when children get sick.

"And that's where I'm most critical, where I say that, for the amount of money we've got, we should be doing much better.

"What government is now prioritising is to spend more on district health services, which is primary healthcare.

> **They've basically taken food away from the mouths of starving babes**

"That is exactly right. But better care at this level may see more referrals to higher levels of care.

"Unfortunately, many South Africans prefer to go to academic hospitals because the quality of care is so poor at district and regional hospitals. So while budgets have moved down to the district level, the quality of services hasn't necessarily improved there and our larger hospitals continue to be flooded."

Compounding this, he says, is a lack of senior doctors, hospital beds and nurses – and inadequate assessments by health professionals and delays in referrals from clinics.

Priority national health programmes to protect children from hunger and disease, such as those preventing child malnutrition and the integrated management of childhood illnesses strategy – which attempts to provide optimal care at the clinic level – have failed because of poor leadership.

"For children who are failing to thrive we have a policy that should be offering them food supplements at clinics across the country. But you'll find it difficult to identify a district where starving children are offered food supplements.

"Budgets for that have disappeared. They've basically taken food away from the mouths of starving babes. It's an example of children in desperate need of support being offered nothing, with no one being held accountable.

The initial success of immunisation programmes for babies tapers off late in their first year of life.

"With the primary health-care immunisation programme, for some vaccines, given at six, 10 and 14 weeks, you'll see rates of coverage of 95 percent. But if you look at the measles vaccine given at nine months, the rate drops to around 85 percent.

"What that shows is that where we get caregivers to bring children to the health service for well-baby care for the first three months, after that we lose them. There is poor ongoing care and support for well children at clinics."

But child support grants, now provided to over 9 million children, have helped to save lives by attenuating the impacts of poverty.

"We know that most of the money is used to feed children and to send older children to school. There's strong evidence it does change children's lives. But for the children who aren't accessing grants, often the poorest children with access issues, or those who, despite accessing the grant, are not thriving, we're offering nothing."

Saloojee believes it would take an extra investment of R30 billion in public health – the amount the government spent on the World Cup – to save the lives of more than 100 000 children in the next five years.

In Gauteng, spending R4bn more over the next five years could save the lives of 15 000 children.

"Then we could get close to our millennium goals. But more than spending money, it's about rooting out inefficiency.

"You could probably spend at least 20 percent less if you just took away inefficiencies."

A child who doesn't have a mother has a four times higher risk of dying, he points out.

"The critical human resource we think is needed now to improve mothers' and children's lives is the community health worker. That is something sorely missing in the South African setting.

"Globally, the model has shown to dramatically reduce both mortality and improve child health; we need health workers going to homes

where there are pregnant woman and children, promoting breastfeeding, nutrition and making sure kids go to clinics if they need treatment.

"That's why Brazil, despite similar inequalities to South Africa, has reduced its child mortalities.

"It has been able to take a community focus and to get teams of doctors, nurses and community workers going out, delivering services and making sure caregivers are smarter and better equipped to care for kids."

Saloojee believes there should be one community health worker for every 250 households.

"My own view is that we need some kind of big bang (for kids' health) if we want results. I would have a national commission for children's health that would drive implementation of the many sound, but unimplemented, policies. It must have teeth and be able to eliminate bureaucratic hurdles. It can't be business as usual. It just won't deliver the kind of healthcare our children need right now."

Among his suggestions are that 50 percent more paediatricians be trained and that vacant posts for nurses be filled fast – the vacancy rate is at an alarming 30 percent now. Clinics should stay open longer to allow caregivers to bring sick kids on their way from work, and there should be clear performance targets for each clinic and district.

"The biggest problem in the past was the very poor leadership offered by the Health Department, with Tshabalala-Msimang basically ignoring HIV/Aids for 10 years.

"The new minister (of health) is articulating the right concerns but his ability to translate this into the actions that will make a difference in the lives of children is very limited because it demands leadership not only from him, but from managers at every level of the system.

"That is a fundamental problem, because the management of health systems is virtually nonexistent, both at hospital, district and clinic level. Visit individual hospitals and clinics – many of the people running them are incompetent. Clerks or nurses with limited health or financial skills have become heads of hospitals. No wonder the Health Department has been getting a qualified audit for the last five years."

This poor management hits children hardest.

"For many common conditions like pneumonia and diarrhoea, children are either misdiagnosed or diagnosed too late. The result is you either have a much more severe condition, or you die.

"For HIV, it's much more complicated. Staff at clinics are scared to start children on antiretroviral therapy, and they refer them to bigger hospitals, which are saturated and have difficulty offering care because they can't send children already started on antiretrovirals back to the clinics."

He highlights nurses leaving their posts during the recent strike.

"It is immoral and unethical for nurses to abandon premature babies and sickly children, leaving them to die.

"At this stage there's very little accountability. Whether it's 50 children who die in your clinic, district or hospital or 1 000, no one asks why. You can get away with shoddy care. This is changing, though. Hospitals are beginning to pay huge amounts of money for negligence, but at present it's just the tip of the iceberg. For one legal event there's probably a hundred events that could have ended up in court."

But Saloojee remains optimistic that SA will reduce needless child deaths. "We have some of the best-trained doctors and nurses in the world; we have enough money, and are richer than other parts of Africa. The challenge is converting our rich potential to the better health outcomes for the children of our country. They deserve this."

And it's not just about preventing children dying, he says.

"It's about our children having a reasonable quality of life. If you're a malnourished child, for instance, there's enough evidence that when you grow up, the consequences remain – lower IQ and poorer work performance. Investing in child health is really an investment in the future of the country.

"That's why we need a big bang – innovative solutions. You can chip away at the problem, but chipping away might not be enough.

"Sometimes you need a big explosion. I think we're ready for that, but someone's going to have to ignite the dynamite."