Addressing inequalities in child health: opportunities and challenges

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Outline

• What is the status of child health in South Africa?
• How do poverty and inequality impact on children’s health?
• What interventions are needed to promote health equity?
• How is government attempting to improve access and quality of care?
• What are the key challenges?
Health vs wealth: SA in the world

http://www.gapminder.org/downloads/gapminder-world-map/
Goal 4: Reduce child mortality

Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate
MDG4: global progress

Progress has been seen in every part of the world:

• Malawi: from 225 to 100 [1990 – 2008] ➔ on track
• Nepal, Bangladesh, Eritrea, Mongolia, Bolivia:
  – All reducing U-5MR by at least 4.5% per year: all on track
• Niger, Mozambique, Ethiopia:
  – Improving but not fully on track

In some countries, progress is slow or non-existent
In South Africa U-5MR had, until recently, gone up since 1990

Global child mortality continues to drop. UNICEF 10 September 2009
MDG4: SA progress

U-5MR projections from various sources

Goal for U-5MR: 20 by 2015

Department of Health (2012)
Child mortality in South Africa

The range of U5MR

Gauteng: 45

Sources: Lagerdien K. Reviewing child deaths in South Africa – a rights perspective. [CI] 2005
Causes of under-five deaths in South Africa

Neonatal causes; pneumonia, diarrhoea and other child illness; and HIV/AIDS each account for 30% of U5 deaths.

According to Child PIP 60% of children were underweight and a third were severely malnourished.

Based on SA Burden of Disease estimates for 2000
Figure 4: Leading causes of death among older children, by age group and by sex, 2007

Male deaths 5 – 9 years, 2007
- Number = 2,004
- Injuries: 21.7%
- Ill-defined natural: 13.7%
- Tuberculosis: 11.5%
- Lower respiratory infection: 9.3%
- Diarrhoeal diseases: 9.1%
- Other endocrine & metabolic conditions: 4.5%
- Other infectious & parasitic disease: 3.7%
- Bacterial meningitis: 2.5%
- HIV/AIDS: 2.2%
- Other nervous system: 1.4%

Female deaths 5 – 9 years, 2007
- Number = 2,009
- Injuries: 16.8%
- Ill-defined natural: 15.3%
- Tuberculosis: 11.7%
- Lower respiratory infection: 11.1%
- Diarrhoeal diseases: 10.0%
- Other endocrine & metabolic conditions: 4.9%
- Other infectious & parasitic disease: 3.2%
- Bacterial meningitis: 3.3%
- HIV/AIDS: 3.0%
- Other nervous system: 1.5%

Male deaths 10 – 14 years, 2007
- Number = 2,233
- Injuries: 29.2%
- Ill-defined natural: 12.2%
- Tuberculosis: 9.2%
- Lower respiratory infection: 7.9%
- Diarrhoeal diseases: 5.6%
- Bacterial meningitis: 3.8%
- Other endocrine & metabolic conditions: 3.6%
- Other infectious & parasitic disease: 2.7%
- HIV/AIDS: 1.7%
- Epilepsy: 1.7%

Female deaths 10 – 14 years, 2007
- Number = 1,802
- Injuries: 19.1%
- Ill-defined natural: 11.3%
- Tuberculosis: 12.3%
- Lower respiratory infection: 9.4%
- Diarrhoeal diseases: 7.5%
- Other endocrine & metabolic conditions: 3.9%
- Other infectious & parasitic disease: 3.1%
- Bacterial meningitis: 2.9%
- Other nervous system: 2.4%
- HIV/AIDS: 1.7%
- Epilepsy: 1.7%

Male deaths 15 – 17 years, 2007
- Number = 2,334
- Injuries: 50.5%
- Ill-defined natural: 9.3%
- Tuberculosis: 4.9%
- Lower respiratory infection: 4.0%
- Bacterial meningitis: 2.3%
- Epilepsy: 1.9%
- Other endocrine & metabolic conditions: 1.7%
- Other nervous system: 1.6%
- Diarrhoeal diseases: 1.5%
- Other respiratory: 0.9%

Female deaths 15 – 17 years, 2007
- Number = 1,947
- Injuries: 21.5%
- Ill-defined natural: 12.7%
- Tuberculosis: 12.4%
- Lower respiratory infection: 8.0%
- Diarrhoeal diseases: 5.0%
- Other endocrine & metabolic conditions: 3.2%
- Other infectious & parasitic disease: 3.1%
- HIV/AIDS: 2.6%
- Bacterial meningitis: 2.5%
- Epilepsy: 1.7%

Figure 5: Key interventions to address the determinants of child illness and injury

**Determinants**
- Social determinants
  - Poverty
  - Poor maternal education
  - Heavy and poorly paid physical labour of women
  - Racial and gender inequalities

**Interventions**
- Intersectoral action
  - Policies, programmes and community action to address social determinants, limit exposure and strengthen immunity

**Increased exposure**
- Poor diets
- Poor sanitation
- Unclean and/or meagre water supplies
- Poor hygiene
- Smoky living environment
- Substance abuse
- Unsafe environment
- Unsafe roads and vehicles

**Impaired immunity**
- Low birth weight
- Undernutrition
- HIV infection
- Parasites
- Other infections

**Health services**
- Primary health care including prevention, health promotion, curative and rehabilitative services

**Illness and injury**
SOCIAL DETERMINANTS
Figure XX: Factors influencing infant mortality in South Africa

Child poverty in South Africa remains extremely high. In 2010, six out of every 10 children lived in households with an income of less than R575 per person per month. Stark racial disparities persist, with 67% of African children living in poor households compared to only 4% of White children.
Table XX: Dimensions of deprivation and inequality in South Africa

<table>
<thead>
<tr>
<th>Dimensions of deprivation</th>
<th>Children in poorest 20% of households</th>
<th>Children in richest 20% of households</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income poverty</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Child hunger</td>
<td>28%</td>
<td>3%</td>
</tr>
<tr>
<td>Inadequate water</td>
<td>54%</td>
<td>9%</td>
</tr>
<tr>
<td>Inadequate sanitation</td>
<td>47%</td>
<td>9%</td>
</tr>
<tr>
<td>Overcrowding</td>
<td>28%</td>
<td>5%</td>
</tr>
<tr>
<td>Educational throughput†</td>
<td>46%</td>
<td>17%</td>
</tr>
<tr>
<td>Clinic far from home</td>
<td>46%</td>
<td>25%</td>
</tr>
</tbody>
</table>


* See Part 3: Children Count – The numbers for more information on these indicators.

† Proportion of children aged 16 – 17 who have completed compulsory schooling (grade 9).
HEALTH SECTOR DETERMINANTS
Figure XX: Inequalities between public and private health care – usage and per capita expenditure.

<table>
<thead>
<tr>
<th>Medical scheme members using private sector services</th>
<th>Use private primary health care services and public hospitals</th>
<th>Use only public sector services</th>
</tr>
</thead>
<tbody>
<tr>
<td>![Calculator with R 11,300 per person]</td>
<td>![Calculator with R 2,500 per person]</td>
<td>![Calculator with R 1,900 per person]</td>
</tr>
<tr>
<td>8 million people</td>
<td>8 million people</td>
<td>35 million people</td>
</tr>
</tbody>
</table>

Map XX: Immunisation coverage for children under one year, 2011/2012

Source: District Health Information System (DHIS) data in District Health Barometer 2011/12. (in press)
Table XX: Key interventions to address child morbidity and mortality

<table>
<thead>
<tr>
<th>Category</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>Ensure universal coverage of prevention of mother-to-child transmission (PMTCT)</td>
</tr>
<tr>
<td>Neonatal deaths</td>
<td>Improve maternal nutrition; reduce smoking and drinking alcohol during pregnancy; improve early antenatal care and maternal care at health facilities, promote exclusive breastfeeding</td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>Increase coverage of community-based integrated management of childhood illness. Improve access to safe drinking water and sanitation.</td>
</tr>
<tr>
<td>Lower respiratory tract infection</td>
<td>Improve immunity (through PMTCT, nutrition and immunisation) and improve housing. Community treatment with antibiotics</td>
</tr>
<tr>
<td>Malnutrition</td>
<td>Improve pregnant mothers’ nutrition; promote exclusive breastfeeding, growth monitoring, improve complementary foods; improve treatment of diarrhoea and severe malnutrition. Work with other government departments to address household food security:</td>
</tr>
<tr>
<td>Injury</td>
<td>Integrate injury prevention within primary health care programmes and work with other departments to reduce burns, drowning, road traffic injuries and violence.</td>
</tr>
</tbody>
</table>
Poor Coverage of Key Child Health Interventions

Currently, both the **coverage** and **quality** of these priority interventions are **inadequate**, especially at community and primary levels and at first-level hospitals in rural and peri-urban settings. Only 35% of young children (12 – 59 months) received vitamin A supplements, 38% of pregnant women received antenatal care in the first 20 weeks of pregnancy, and only 26% of babies were exclusively breastfed for the first six months.


Actions to improve access and quality of child health services

- a priority **focus on poorest districts** and communities with most malnutrition and HIV infection
- a well-functioning, standardised **community health worker programme** to deliver priority child care interventions at community level;
- a rapid **improvement in staffing ratios and performance in child care in clinics and health centres**, with support for mid-level workers and nurses;
- greatly **improved clinical care for sick children in district hospitals**
- rapid expansion in the training and recruitment of **community paediatricians**
TWO MAJOR NEW HEALTH POLICIES

- National Health Insurance (NHI)
- Re-Engineering Primary Health Care
National Health Insurance
Health care financing and rationale for NHI

Mechanism for addressing:

• Existing health system challenges

Ensuring whole population is:

• Able to get care when needed - 16.6% experience difficulty in accessing health care (Shisana et al 2007)

• Financially protected from the costs of care (currently 13% of health care spending is out-of-pocket)
Funding of NHI

Increase funding of health services through:

• Increased allocations from general tax revenue
• Mandatory health care contributions by employees and employers
• Removal of tax subsidies to medical aids
• Pool these funds
How is NHI planning to improve access?

Purchase from accredited providers (public and private):

Medical schemes will remain:

  Likely that membership will decline

  Fewer schemes
‘Re-engineering PHC’
The three **key recommendations** are essentially:

1. Strengthen the district health system (DHS).

2. Place much greater emphasis on population based health and outcomes, which includes a new strategy for community-based services through a PHC outreach team based on community health workers (CHWs) and mobilising communities.

3. Pay greater attention to those factors outside of the health sector that impact on health, the social determinants of health ("upstream factors")
Three streams for Re-engineering PHC

(a) a ward based PHC outreach team for each electoral ward;
(b) strengthening school health services; and
(c) district based clinical specialist teams with an initial focus on improving maternal and child health.
Figure 1 Proposed PHC model

- District/Sub-district Management Team
- Specialist Support Teams
- Contracted Private Providers
- District Hospital
- Community Health Centres
- PHC Clinic
  - Doctor
  - PHC Nurse
  - Nurse
  - Pharmacy assistant
  - Counsellor
- Schools
  - School Health
- Health Services
  - Community
  - Local Government
  - Environmental health
  - Refuse removal
  - Pest and vector control
- Households
  - PHC Outreach Teams
  - Epidemics
  - Schools
  - Households
  - Crèches
  - Environmental health
  - Health
PHC outreach team

– Professional nurse,
– staff nurse and
– community health care workers

The PHC outreach team will provide comprehensive PHC health care services to a defined number of families. Each PHC outreach team will operate out of a PHC clinic which is based within the community that it serves. A PHC clinic may accommodate more than one PHC outreach team with a recommended maximum of three PHC teams per clinic.
Figure 2 Ward Based PHC Outreach Services

WARD BASED PHC OUTREACH TEAM

PHC Team Responsible for providing: Primary Health care to 1620 Families/households; Community Outreach Services; preventative, promotive, curative and rehabilitative services;

Professional Nurse
(Team leader)
Health Promoter
Environmental Health Practitioner

CHW 270 Families

CHW 270 Families

CHW 270 Families

CHW 270 families
Key Challenges

- partnering with the private sector;
- improving governance and accountability,
- investing in human resource development
  numbers
  competences
NHI? Yes, but......

NHI COULD be a mechanism to redistribute health care resources BUT some key challenges need to be addressed

- Definition of an acceptable ‘package’ of services
- Development of sufficient CAPACITY and ENSURING ACCOUNTABILITY in administration of NHI fund
- Regulation of private sector and rapid strengthening of public sector, especially in rural areas – to ensure that inequities are not aggravated
Some key challenges need to be addressed

- Reconsider ratio of CHWs to households. Several countries have two tiers of CBWs – full-time CHWs and part-time CBWs in a ratio of 1:10. This could generate >400,000 jobs
- Definition of an acceptable ‘package’ of services including CHWs being allowed to undertake treatment
- Development of sufficient CAPACITY and ENSURING ACCOUNTABILITY
Key interventions required

- Rapidly increase investment in training: re-open nursing colleges, increase output and appropriate training by medical schools and other HEIs
  - Brazil has more than 2.5 million workers formally employed in the health sector, which represents about 1.3% of the country’s population. South Africa has only 150,509 health professionals in a population of 51 million (constituting 0.3% of the population) in 2010.

- Rapidly increase output of MLWs

- Reorientate health professionals to be able to address local social determinants

- Reorientate specialists in District Specialist Teams
Key interventions required

- Reduce power of conservative professional bodies; enlarge ‘scope of practice’ of non-doctors
- Improve incentives and support in rural areas
- Upgrade infrastructure in rural/peri-urban areas
- REBUILD AND STRENGTHEN CIVIL SOCIETY
THANK YOU