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Millennium Development Goals: Progress & prospects for meeting Child Survival targets in South Africa

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The Millennium Development Goals are eight goals that 189 United Nations Member states including South Africa are committed to achieve by 2015. This paper takes a critical look at South Africa's prospects for meeting the MDG targets for child survival.

MDG 4 commits South Africa to reduce the under-5 mortality rate (U5MR) from 1990 levels by two thirds in 2015. The U5MR trends are summarized in Figure 1.

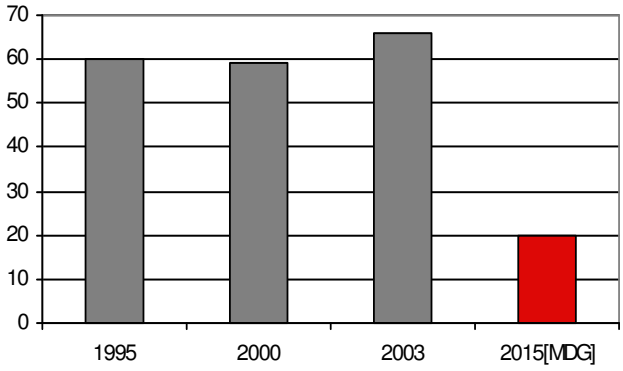

Fig.1: South Africa U5MR for 1990-2003 and 2015 MDG target (World Bank 2004)

The U5MR in South Africa in 1990 was 60, South Africa needs to achieve an U5MR of 20 by 2015 to meet the MGD 4 targets.

In contrast to most countries, the U5MR in South Africa is rising rather than declining. Based on current trends, unless urgent measures are taken to address the main causes of under 5 child death, South Africa has little hope of reaching the MDG. To develop an effective intervention strategy, a critical examination of the determinants of under-5 mortality is necessary.

Causes and trends in child mortality

The determinants of childhood mortality and morbidity remain unchanged. HIV/AIDS, diarrhoea, acute respiratory infections. low birth weight and malnutrition are the biggest killers of small children (Table 1).

Rank	Cause	No.	%
1	HIV/AIDS	42749	40.3
2	Low birth weight	11876	11.2
3	Diarrhoeal diseases	10786	10.2
4	Lower respiratory infections	6110	5.8
5	Protein-energy malnutrition	4564	4.3
6	Neonatal infections	2920	2.8
7	Birth asphyxia & trauma	2584	2.4
8	Congenital heart disease	1238	1.2
9	Road carnage	1219	1.1
10	Bacterial meningitis	1141	1.1

Table 1: Top 10 causes of death in South African children under 5 years old in 2000 (Bradshaw, Bourne & Nannan, 2003)

Most of these conditions are preventable or, when prevention fails, easily treatable. Overwhelmingly they affect children living in conditions of poverty and socio-economic exclusion.

Underlying determinants of child death

The proximal underlying risk factors for both maternal and child under-nutrition are dietary inadequacy and frequent disease (especially diarrhoea and HIV/AIDS) and, in the case of mothers, excessive physical labour.

In turn, household food insecurity, inadequate child-caring practices and poor health and environmental services underlie inadequate diets and frequent illness among children.

Underlying most common childhood infections and infestations are environmental risk factors that include inadequate sanitation and water supply,

poor hygiene practices, and poorly ventilated, crowded, smoky living spaces.

The more distal risk factors are clustered within households affected by poverty. These include "poverty", which is in effect a lack of access to a range of resources, whether financial, physical, educational or organisational. The most basic, or upstream, risk factors are structural. They operate at local, national and global levels. They include but are not limited to policies and programmes in the areas of:

- Social welfare and employment
- Housing
- Environmental health
- Land and agriculture
- Micro- and macro-economics, including trade.

At the global level, trade policies and patterns (including trade in services and intellectual property rights) play an increasingly important role in shaping diets, as well as affecting food security, the nature of work, and access to basic services. Dominant and neo-conservative macro-economic policies, which emphasise fiscal stringency above all other considerations, place a limit on the State's investment in those services important for child health.

Towards Meeting the Millennium Goals

The past few decades have seen impressive advances in our understanding and technical ability to prevent, treat and mitigate the effects of many childhood illnesses. Key examples are immunisation, treatment of diarrhoeal dehydration and prevention of mother-to-child transmission of HIV. The challenge, increasingly, is to implement successfully these efficacious interventions, especially among the poorest, and to adopt social policies that improve equity in child health.

Despite a widening gap between rich and poor, in terms of health outcomes and access to services, there are examples of successful large scale child health and nutrition programmes. Most of these examples demonstrate the successful implementation of a comprehensive primary health care approach where interventions have simultaneously addressed the immediate (proximal) and the underlying (distal) factors impacting on child survival and health. In a few low-income countries broad-based approaches have resulted in significant and sustained improvements in child and maternal health. In all of these examples – and in the past experience of industrialised rich countries – such improvements have been secured through a combination of social policies and efficacious public health interventions.

In all cases a favourable political context facilitated this comprehensive and equity-oriented approach. Such contextual factors are crucial in ensuring both investment in social services and the provision of infrastructure and community mobilization. This allowed effective technologies and interventions to be successfully promoted.

Successful programmes were characterized by participatory programme design and implementation. They also addressed key factors like coverage, targeting, intensity and resource mobilisation.

There are few examples of large-scale successful comprehensive child health programmes. This may be attributed to the dominance of conservative macroeconomic policies in the past two decades. A narrowing of the primary health care approach may also have contributed to this. Some technical interventions have been preserved and promoted while interventions to address broader social determinants (as well as participatory processes) have been denigrated or abandoned. Such 'selective', technicist approaches have been vigorously promoted as 'packages of care'.

Global economics erodes public health

Public health systems in poor countries, including South Africa, have been considerably weakened by a combination of conservative macro-economic policies and health policies that constitute 'health sector reform'. Chronic underfunding of health (and social) services has led to a serious weakening of the 'delivery' infrastructure, and especially of the human resource component. Health personnel capacity has been severely undermined as a result of a fiscal crisis and the impact of HIV/AIDS. In addition, active recruitment of personnel by rich countries experiencing a health workforce shortage has further depleted

staffing levels and seriously aggravated the dysfunctionality of health systems.

The current HIV/AIDS pandemic and the new initiatives launched to address it may already have aggravated the crisis in child health and healthcare by diverting attention and resources away from other endemic, health problems and their social determinants. There is also a strong possibility that new 'vertical' programmes and structures will be created, further delaying the long-term imperative of creating strong and sustainable 'horizontal' health systems.

A return to comprehensive PHC?

The time is long overdue for energetically translating the rhetorically rich promises of the Primary Health Care Approach to reality, turning dormant policies into action.

The main actions should centre around the development of comprehensive, well-managed programmes involving the health sector, other sectors and communities. The process needs to be structured into functioning district systems. In most countries these need to be considerably strengthened, particularly at the household, community and primary levels. Comprehensive health centres and their personnel should be the focus of these efforts and investment. The reinstatement of community health workers and other community workers (e.g. treatment and breastfeeding counsellors) should be seriously considered.

The successful development of decentralised health systems requires targeted investment in infrastructure, personnel, management and information systems. A key primary step is capacity development of district personnel through training and guided health systems research. Such human resource development must be practice-based and draw upon re-orientated educational institutions and professional bodies.

Clearly, the implementation and sustenance of comprehensive primary health care requires inputs and skills that demand resources, expertise and experience not sufficiently present in the health sectors of the Western Cape. Partnerships with non-governmental organisations with expertise in community development is crucial.

The engagement of communities in health development needs to be pursued with much more commitment and focus. The identification of functioning organs of civil society, whether or not they are presently active in the health sector, needs to be pursued.

Poor child health and nutrition impose significant and long-term economic and human development costs, especially on the poorest communities and further entrenching their status. Improving child health and nutrition is not only a moral imperative, but a rational long-term investment.