People's Health Movement South Africa

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Children's right to health: Do they get what was promised?

Maylene Shung King, Children's Institute, University of Cape Town

Children have been given significant political recognition in our democratic dispensation. The South African government has signed and ratified the UN Convention on the Rights of the child, promising to put children first and take concerted steps towards realizing their civil, political and socio-economic rights. In terms of a child's right to health, Article 24 of the Convention obliges us to accord children the right to the "highest attainable standard of health". In addition, we need to ensure the fulfillment of a number of other indivisible rights that directly impact on their health such as their right to a safe and clean environment and their right to food and shelter.

Children's rights to health were further entrenched in the Constitution which grants them a Right to basic health care services, the Right of access to health services and the Right to emergency services in Sections 27 and 28 of the Bill of rights.

Interventions to improve children's health were prioritized in the Reconstruction and Development Programme, introducing free health care for children under 6 and pregnant mothers and a primary school nutrition programme. Free health care has since been extended to include all children at public sector primary care facilities and those with moderate and severe disabilities at secondary and tertiary health facilities.

A number of structural, policy and programmatic strategies were also put in place. South Africa has a National Programme of Action for children (that includes child health) co-ordinated through the Office on the Rights of the Child in the president's office. Dedicated Maternal child and woman's health directorates were formed at a national and provincial level, along with several parallel programmes that address child health issues. Efforts to improve the delivery of services to children include the IMCI programme, PMTCT, a policy on school health services, Youth and Adolescent health, mental health and others.

Government also aligned itself with international processes and goals for children. The most recent was the adoption of the Millennium Development Goals that require us to reduce infant and child mortality by two thirds before 2015 and reduce infant and child malnutrition by half.

Despite these commitments, policies and interventions, child health indices have systematically worsened over the past few years.

What is the current health status of children in South Africa?

The short answer is that we do not know for sure. Current national level information on children's health is outdated and is not very accurate where it does exist. The 2004 StatsSa report on mortality recognizes their deficiency of good data on children. Closer examination of the data reveals that their report underestimates child deaths by at least 30-40%. The most accurate data we have is still the 7 years out of date 1998 Demographic and Health survey data updated for 2000 by the MRC Burden of Disease unit. This means that the most basic indicators of child health status, namely mortality indicators, are simply not available on an ongoing basis and where they do exist, are inaccurate.

Little national and provincial level information is available on child morbidity. Child-specific information on the status and impact of epidemics such as HIV on children is simply not available. Even less is available on children's utilization of health services, with the exception of some data on immunization coverage. Coverage of crucial programmes such as PMTCT is simply not known. Little is known about the quality of care that children receive through health services. Where information does exist, it shows that significant inequities exist across geographic boundaries in terms of children's access to basic health services. The 1998 South African Demographic and Health survey showed almost a 30% difference in immunization coverage between the province with the best coverage and the province with the poorest coverage.

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Internationally trends are afoot to move away from just measuring indicators of child survival to also focus on issues of child well-being and positive health indicators, and herein lies the rub...

With such poor information, what do we know about children and their health?

Children constitute almost half of the South African population. Given the direct relationship between health and poverty it is important to note that, depending on the definition of poverty, up to seven out of ten children in South Africa live in poverty. The health statistics bear testimony to this.

We are regressing in terms of child survival. In 1998 our infant and under-5 mortality rates were 45 and 59 respectively. The MRC burden of disease study of 2000 shows a significant increase in infant and under-5 mortality rates to 59 and 95 respectively. These worsening survival trends are of great concern and make the Millennium Development Goal of reducing the infant mortality rate to 17 by 2015 appear unattainable.

Children still die largely from preventable causes directly linked to poverty and poor health service provision. Most deaths in the first year of life relate to neonatal causes, many of which are preventable by good antenatal, obstetric and postnatal services. Despite free health care to pregnant women and children, universal access to good quality antenatal services has not yet been attained. The primary causes of deaths in children under 5 are now HIV-related, but close on its heels is diarrhoeal disease and acute respiratory infections, with malnutrition a very important but often unrecognised underlying cause.

A "silent" epidemic in older children is that of trauma and violence, the leading causes of death in children aged 5-18. Firearm injuries are increasing and so are motor vehicle accidents involving children. Again, this requires active intervention by the Departments of Safety and security and transport in their policies, programmes and plans.

We know little of morbidity patterns in children, except that the age-old companions of malnutrition, diarrhoeal diseases and acute respiratory infections are still the major conditions affecting children. We know that roughly one in every four children suffer with malnutrition and at least a fifth of all TB cases are children. These are now compounded by the HIV epidemic that has about a quarter of a million children living with HIV-infection and many more affected by the consequences of the epidemic. On the positive side, important childhood infections such as measles, polio and tetanus are virtually eradicated with very few cases on an annual basis. Little is known about chronic diseases in children and even less about their mental health.

Why is the health of our children so poor, in spite of all the efforts to address this?

One of the overriding factors is that the health sector is seen as the primary custodian of children's health, when in fact the majority of the factors that impact on child health lies beyond the domain of the formal health sector.

There is little or no child-specific focus or prioritization when central budgets, and non-health sector plans are developed, quite contrary to the spirit and letter of the Convention on the Rights of the Child and the Constitution that urges us to "put children first" and "in every matter concerning the child to consider the best interest of the child". Despite the strong link between illness and lack of basic amenities such as water and sanitation, none of the local government integrated development plans, nor those of the Departments of water affairs, housing and transport, take indicators of child health into account when planning the distribution of resources and services. Yet the tools required to factor child health indicators into local government resource allocation exist and have been tested by the Equity Gauge project at the University of Western Cape, School of Public Health.

Even within the health sector children are not duly prioritised in all matters concerning the health system. For example, there is no piece of legislation that comprehensively addresses legal child health issues. The new Health Act has a sentence or two about children and the drafters

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chose to defer child health issues in anticipation that these would be addressed in the upcoming Children's Bill. Given current progress with the Bill, it is not likely to be the case.

There is no clear strategic plan for child health at a national level that ensures the integration and coordination of child health issues throughout the health system. Policies and programmes are developed in piecemeal fashion with each component of child health services competing for attention with many others. Systemic health policies and plans often do not consider children's issues in a systematic and child-orientated fashion. The government plan released in 2003 for the comprehensive care and treatment of HIV/AIDS is a case in point where many gaps in the conceptualization of comprehensive care for children infected with HIV exist.

In the quest for comprehensive primary health care, the very fundamentals of the Primary Health Care approach as it pertains to children have been undermined. A mass of anecdotal evidence suggests that crucial prevention and health promotion interventions for children are neglected in lieu of curative and adult health activities. Important programmes for children such as developmental screening, nutrition programmes, EPI and the PMTCT are not adequately implemented. Only one province in the country has a programme for developmental screening of children. Research in the Mount Frere area reveals a serious lack of knowledge among frontline health workers concerning the management of malnourished children in hospital. A rapid situational analysis of clinics in 2002 that looked at key interventions for children with HIV, gave a picture that is probably true for many other child health interventions. The study showed that only 35% of clinics reported administering Vitamin A, only 20% of clinics knew what the correct protocols were for prophylactic and support programmes for children with HIV, and only 4% of clinic respondents knew the correct dosage for Cotrimoxazole. This points to a potentially huge knowledge gap around child health issues at primary level, as well as an inability to deliver the most basic child health interventions.

Tracking resource allocation through expenditures and budgets for child health services is impossible, as child health interventions are not reflected as line items in the national and provincial financial systems. The budgetary commitment to facilitate the realization of children's right to health is thus unclear.

Conclusion

Much work still needs to be done to improve the health of South African children.

As a start, a clear integrated child health strategy within the Department of Health is required as a matter of urgency. Coupled with this, a clear integrated intersectoral plan to address better outcomes for children must be developed. In addition, mechanisms to ensure and track adequate budgetary commitments to children's health service and interventions must be put in place.

At the implementation level serious consideration must be given to the current status of preventive health interventions for children. In addition, the staffing, both numbers and skills, to ensure delivery of timely effective and good quality child health services is essential.

Among those working in the Children's Policy Institute, passion for children's issues runs high, but elsewhere, despite the rhetoric, we have found no consistent advocacy voice for child health. Civil society, except around HIV, has been silent on issues of child health and the current draft patient health charter does not even mention the word "child".

Given the many issues that need to be addressed, it has become clear that a concerted effort is needed by colleagues within all sectors of government and civil society to ensure child health achieves much greater recognition, and that the rhetorical promises and rights translate into real health gain for our children.

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