UNIVERSITY of the WESTERN CAPE

SoPH BULLETIN

The UWC School of Public Health Newsletter September 2011

Public Discussion on the National Health Insurance (NHI) Green Paper

Di McIntyre

Prof Di McIntyre asks: Can South Africa afford not to have a NHI?

Di McIntyre is a Professor in the Health Economics Unit at the University of Cape Town. Her main area of research is health care financing.

Misinformed scaremongering seems to have been the order of the day since the release of the National Health Insurance (NHI) Green Paper. South Africans have been subjected to a barrage of reports about how the proposed NHI is unaffordable, how it will increase the cost of labour and will push the economy into recession.

We need to consider some facts. What is the NHI all about? What are its likely costs?

The proposed NHI is about achieving a universal health system. That means two things: everyone enjoys financial protection from high health care costs; and everyone is able to access good health services when they really need them. South Africa is very far from this ideal; at the moment, the reality for millions of South Africans is that they simply don't get health care when they are ill. The NHI is intended to address this reality. It includes building new facilities, upgrading existing ones, introducing community-based teams of health workers to take services to people's homes, taking steps to improve the quality of care in public facilities, drawing on health professionals in the public and private sectors to provide improved health care for all. The most under-served areas will be focused on first.

This will cost money. Of course it will – but from where will that come? We need to increase public funding for health care (public funds in the sense that they are raised as taxes or other forms of mandatory solidarity payments, but most importantly that can be used for the benefit of all citizens). Some say just improve the efficiency of public health services and we can make do with current funds. But at the same time, everyone seems to agree that, among other requirements, we need more staff in public health facilities – the queues we see are because there are too few staff to cope with the current patient load. There is massive unmet health care need at the moment. If we improve access to health care, there will be even more patients. That is the idea of achieving universal coverage! Certainly, there is room to improve efficiency. But currently we do not have enough money to provide good quality, accessible services for the 84% of South Africans who are heavily dependent on publicly funded health services, and indeed as the Green Paper proposes, to provide services that all South Africans would be confident to use.

So, how much more money do we need? The Green Paper estimates that the NHI will cost about R125 billion in 2012, increasing to R256 billion in 2025. It is important to note that this is the ***total*** amount of money needed for publicly funded health services; it is not ***extra*** funding. The government is already planning to spend over R112 billion in the 2011/12 financial year on the health system and has budgeted to spend over R120 billion in 2012/13. So, to move forward with the NHI, we initially need a ***little*** bit of extra funding (R5 billion in the first year). It also needs to be recognised that government funds and

expenditure will increase over the next 14 years anyway; as the economy grows, so will public funds and spending. Using National Treasury's relatively conservative estimates of real GDP growth in future, the health budget will anyway increase to over R180 billion by 2025. At this point, with the NHI fully implemented (and providing good quality care for everyone), we will need additional public funding; but not R256 billion extra – only R76 billion more.

How can this gap be funded? The first thing we could do is apply pressure to government to devote more general tax funds to health care. After all this is a society wide issue. In 2001, African heads of state (including the South Africa president at the time) committed themselves to allocating at least 15% of general tax funding to the health sector (at the moment, we devote less than 12%). If we did this, the health budget would be nearly R230 billion by 2025. So, the gap for NHI funding would only be R26 billion. This could easily be funded by a relatively small "solidarity" health tax on personal income and a small payroll tax for employers – according to research at the University of Cape Town's Health Economics Unit, this would need to be less than 2% of income and payroll respectively.

By the time the NHI is fully implemented, public spending on health care would be about 6% of GDP. This level of public funding for health care would not be unusual. The 2010 World Health Report, devoted to the issue of universal coverage, indicated that countries that have universal health systems spend about 5-6% of GDP in the form of public funding. South Africa is thus intending to move into line with the level of public funding needed to achieve universal coverage anywhere in the world. The question really is: do we want a universal health system or not? Many stakeholders have come out in support of the goal of a universal system. But then they hasten to add that we should not expect anyone to have to pay extra towards achieving this. This is rather disingenuous.

Will wealthier individuals and employers really end up paying more for health care? At the moment, those who belong to medical schemes spend an average of 9% of their income on scheme contributions; but the richest fifth of scheme members spend an average of just over 5% of income and the poorest fifth spend about 14% of their income on scheme contributions. If the NHI achieves its goal of ensuring all South Africans receive high quality care, those who are currently members of schemes will have a real choice. If they choose not to belong to schemes, the cost to them and their employers will be far lower than at present. In fact, NHI will reduce the cost of labour, not increase it. However, it is likely that the richest will continue their medical scheme cover. Is it really unfair that this group has to contribute towards the NHI, even if they choose not to make use of their NHI service entitlements, and continue paying for medical scheme cover? Given that the richest 10% of the population has 51% of total income in South Africa, I think it would be difficult to argue that this is unfair.

But, the crunch issue is this: will the NHI deliver accessible, quality health services for all? Many question why we need a new NHI institution to achieve a universal health system. It is precisely to ensure that there is good service delivery and that we get value for money; it is precisely to address the problems of the current situation. Having an independent institution that actively purchases health services from public and private health care providers on behalf of the whole population is the route taken by countries that have successfully implemented universal health systems. It is also essential to grant public hospitals greater management authority so that they can take the steps necessary to improve their services. At the moment, hospital managers have very little authority to make decisions that would enable service quality and efficiency improvements. However, while creating these independent institutions is a pre-condition for ensuring improved service delivery, strong governance and accountability mechanisms must be put in place to prevent mismanagement.

I believe that we cannot afford ***not*** to pursue a universal health system. We cannot continue to tolerate high rates of unnecessary ill-health and death. We cannot continue to deny millions of South Africans access to health care when they need it. We cannot allow our horrendous health divide to continue.

The Green Paper lays a good foundation for addressing the health system and health challenges that face South Africa. Instead of attacking the proposed NHI, my plea is that the debate moves on. How can we all make positive contributions – yes from different perspectives - and devote our efforts to ensuring that the NHI does achieve high quality and accessible health services through well governed, accountable and independent institutions?

Article reproduced from 11.08.11 edition of Health-E News Service. Source: http://www.health-e.org.za/news/article.php?uid=20033238

Time for action in New York on non-communicable diseases

A major opportunity to advance global health is in danger of being lost. On Sept 19–20, heads of states and governments will gather in New York, NY, USA, at the UN High-Level Meeting on Non-communicable Diseases (NCDs) to approve a political statement on responding to the global NCD crisis. These diseases, principally cardiovascular diseases, cancer, diabetes, and chronic respiratory diseases, are responsible for two-thirds of the 57 million deaths worldwide each year, with four of five NCD deaths occurring in low-income and middle-income countries; at least half these deaths are readily preventable. Until now they have been neglected by countries, development agencies, and funders.

A bold and comprehensive statement from the UN High-Level Meeting will stimulate a global response commensurate with the burden of NCDs. The negotiations on the draft political statement stalled at the beginning of August because of major differences between the leading negotiating countries. The UN Resolution specifying the details of the meeting called for "an action-oriented document"; the co-facilitators are committed to producing a strong outcome statement. Lamentably, so far, the negotiations have produced a weak statement that will do little to protect vulnerable populations from the ravages of NCDs.

The preliminary paragraphs of the draft statement make many excellent points—for example, on the challenge to development posed by NCDs—and this is an important step forward. However, when it comes to proposed actions, the statement lacks vision and ambition. Crucially, it does not include a bold goal for reducing preventable mortality from NCDs—for example, the WHO goal of a 25% reduction in national mortality rates by 2025 based on 2010 rates. One of the key lessons from the Millennium Development Goals and the global response to HIV/AIDS has been the importance of time-bound goals and targets. An ambitious but achievable global NCD goal will drive change and allow for accountability on progress.

There is insufficient emphasis in the draft on the affordable, available, cost-effective, priority population-wide interventions, several of which will be cost-saving even in the short term. The two top priorities—tobacco control and salt reduction—will enable countries to reduce mortality quickly at very low cost, and achieve much of the mortality reduction goal. Nor does the draft include associated targets to assess progress in controlling these major causes of NCDs. A key measure for making progress—increased taxes on tobacco and alcohol—will not only improve health but also raise the required revenue to fund prevention and treatment programmes. The Framework Convention on Tobacco Control is a major achievement, yet the negotiations seek to downplay its implementation rather than accelerate it. The draft language on improving the availability of affordable cost-effective medicines, especially for people at high risk of cardiovascular diseases and other NCDs, is still vague.

Finally, there is little attention in the draft to the need for a flexible and efficient NCD partnership to follow through on the commitments and the appropriate accountability mechanisms. There are important precedents in both these areas from maternal and child health: the Countdown to 2015 Initiative and the proposed Accountability Commission. An independent NCD partnership, in close association with WHO, other major global institutions, and the NCD Alliance, is required to synthesise the available information on effective interventions, disseminate this evidence, monitor progress and, above all, advocate for more rapid progress. Accountability for the global and national commitments to NCD prevention, as agreed at the UN High-Level Meeting, could be incorporated into the responsibility of the Accountability Commission for Maternal and Child Health with regular reporting to the Secretary General of the UN.

The next few weeks will be crucial in determining the final political statement from the UN High-Level Meeting. *The Lancet* is deeply committed to the prevention of NCDs as part of its support for global health. We urge all concerned countries, institutions, and individuals to make their voices heard by the negotiators in New York and by their ministers, building on the advocacy shown by the NCD Alliance. This is too good an opportunity for improving global health to be missed. We will be judged harshly, and rightly so, if we fail to make a major advance in addressing this neglected aspect of the health of people worldwide. ■ *The Lancet*

Corbis

Published Online
August 30, 2011
DOI:10.1016/S0140-6736(11)61389-5

For the **UN High-Level Meeting on Non-communicable Diseases** see http://www.un.org/en/ga/president/65/issues/ncdiseases.shtml

For the **Framework Convention on Tobacco Control** see http://www.who.int/fctc/en/

For more on **Countdown to 2015** see http://www.countdown2015mnch.org

For the **Commission on Information and Accountability for Women's and Children's Health** see http://www.everywomaneverychild.org

For the **NCD Alliance** see http://www.ncdalliance.org

A Collaboration – funded by the British Council - between the UWC School of Public Health (SOPH) and the Faculty of Applied Social Sciences (FASS) at London Metropolitan University.

By Ruth Stern, Senior Researcher, SOPH

Dr Ruth Stern

Three years ago, the UWC School of Public Health (SOPH) entered into a collaboration with the Faculty of Applied Social Sciences (FASS) at London Metropolitan University in the UK, as part of the British Council's Development Partnership in Higher Education (DelPHE) initiative. The focus was our respective Masters courses, and the rationale behind the collaboration was the similarity in objectives, despite the different contexts and different teaching circumstances.

An important starting point was our shared ideology - the principles of SOPH and FASS are similar, in that both have a focus on equity, the impact of social determinants on health, and the effects of globalisation on health. We also have a significant overlap in student backgrounds. The SOPH courses, while South Africa based, have students from many countries in Sub Saharan Africa. FASS also has a significantly large African student population, along with students from various other developing countries. Some of these now live in the UK, but many come to London specifically for their studies. In addition, while there are very different socio-economic conditions within the countries as a whole, the students studying in both institutions work in resource constrained areas.

The main difference, and therefore source of interest, was the teaching approach. SOPH runs a distance learning programme, and the face to face contact we have is with students who attend summer and winter schools; while the courses at FASS are campus based taught courses, with their student body, also predominantly post graduate health workers, attending lectures and seminars throughout the duration of the module.

What we did

The main focus of the collaboration was exchange visits, where we taught on each other's courses and held discussions to share experiences and teaching materials. SOPH staff that took advantage of the exchange visits were Ruth Stern, Suraya Mohammed, Verona Mathews and Nandipha Matshanda. Other SOPH members involved in the collaboration to a varying degree were Lucy Alexander, Ehi Igumbor, David Sanders, Nikki Schaay and Vera Scott. FASS members taking part were Jo Skinner, Ruzanna Gevorgyan, Livingstone Musoro and Eileen O'Keefe, who all visited SOPH. The initial intention was to explore the integration of social determinants across modules, focusing on our respective health promotion and management courses. This was later extended to include the SOPH Primary Health Care and Epidemiology courses. In addition, specific seminars were held in both countries, to take advantage of the visitor's expertise. An example was the introduction of the concept and practice of Health Impact Assessments, now included as an example in the SOPH HP courses. Importantly, we also ended up sharing teaching methods and approaches, including the use of on-line opportunities.

The third and final year of the collaboration has been particularly productive. Staff from both Universities attended an E-Learning Africa conference in Dar es Salaam, and Nandipha Matshanda and Jo Skinner gave a joint presentation on the lessons learnt during the collaboration. The most recent activity was a virtual conference in July 2011, described in more detail in the following article. The final official activity, currently being explored, will be the development of a shared resource, building on the examples presented at the virtual conference.

A needs review of SOPH courses

In addition to the activities described above, the Delphe funding provided an opportunity for Lucy Alexander and Nandipha Matshanda to undertake a needs review of SOPH's MPH courses, interviewing past and present students in Namibia and Zambia. So far, this work has been presented as a poster at the National Public Health Association of South Africa (PHASA) conference, and it is in the process of being written up as an article (More about this in a future Bulletin).

Future opportunities

An added opportunity that has arisen as a result of the collaboration is a potential collaboration with City University of New York (CUNY) who have an existing collaboration with FASS on childhood obesity. We are currently exploring the possibilities of SOPH joining this, extending it into a three-way collaboration on the prevention of non communicable diseases.

Pedagogies and Technologies Supporting Our Curricula

Summary of a virtual conference on teaching and learning in two postgraduate programmes in Public Health based in Britain and South Africa

By Nandipha Matshanda, Education Specialist and Materials Developer, SOPH

Nandipha Matshanda

On 14 July 2011, the School of Public Health University of the Western Cape and the Centre for Primary Health & Social Care London Metropolitan University held a virtual (video) conference on teaching and learning in a Masters programme in Public Health.

Present at the conference were, from London Metropolitan University, Dr Jo Skinner, Dr Ruzanna Gevorgyan, Dr Livingstone Musoro, Dr Virginia Radcliffe and Dr Friday Adejo.

From the University of the Western Cape were Prof David Sanders, Dr Ehi Igumbor, Ms Lucy Alexander, Ms Nandipha Matshanda, (all from the School of Public Health), Dr Ruth Stern who is associated with both institutions, Ms Lorraine Fakude (from the School of Nursing) and Ms Carolynne Kies from the E-Learning Unit.

The virtual conference was held around the theme of "**PEDAGOGIES AND TECHNOLOGIES SUPPORTING OUR CURRICULA"** and was intended to allow the two institutions to share methodologies and strategies for teaching and learning in Public Health. An additional intention was to test the methodology of virtual conferencing as a possible future student support tool for Masters in Public Health students.

On both counts, the conference was counted a great success. There was very active engagement and afterwards all participants expressed enthusiastic enjoyment of the presentations. The technology allowed us to engage in lively and interesting debate and discussion. There was an element of surprise and gratification at how effectively the vehicle of the video conference itself worked.

Several very interesting presentations were made on the following topics:

- Blended learning and teaching on urban health. This presentation described how the London Metropolitan University collaborated with the City University of New York in teaching classes "across the pond" on the same topic in the same semester, using the same lecturers and with students researching the same topics in

their respective cities. Use of the same learning management system by both groups allowed the students to share and compare the results. (**Dr Livingstone Musoro**)

- In a Scholarship of Teaching and Learning vein, we were presented with the findings of an investigation into students' experiences of the blend of pedagogical approaches employed in the prescribing course offered by the London Metropolitan University; the study investigated, in particular, the effect of the blend of approaches on student achievement as well as the students' subjective responses to these approaches. (**Ms Virginia Radcliffe**)
- In a presentation on the use of e-discussion groups for teaching epidemiology at post-graduate level, we learned about the pedagogical bases for the selection of methodologies and media; we also learned about the challenges and the rewards of this approach in strengthening the pedagogical menu for teaching at post-graduate level. (**Dr Ehimario Igumbor**)
- We saw demonstrated another approach for the teaching of epidemiological concepts through the innovative use of an electronic game to foster the analysis of a case study while acquiring epidemiological skills and concepts. This presentation, as well as project, also illustrated an innovative use of collaboration across disciplines. (**Dr Ruzanna Gevorgyan**)
- We also learned about the use of case studies in extending the teaching approach in a Public Health programme. In this presentation, we also learned about the work of the School of Public Health in establishing a repository of case studies on Public Health topics for internal use as well as for sharing widely as Open Educational Resources. Another aspect of this work has been the development of case studies based on the research and project work of the School and which have been lodged in public access repositories as Open Educational Resources. (**Ms Lucy Alexander and Ms Nandipha Matshanda**)

What was most valuable was learning of the pedagogical approaches used in different Public Health Masters programmes; we discovered interesting differences that have rich possibilities for application in our contexts and programmes. Also most valuable, was discovering the possibilities of video-conferencing as a student support mechanism in a masters level course and, especially, one conducted across continents.

Quite clearly also, the conference could not have occurred without the participation of the ICT specialists from both institutions – Mr Martin Messias from London Metropolitan University, and Mr Graham Julies from the University of the Western Cape.

SOPH Research on Level and Causes of Newborn and Child Mortality in South

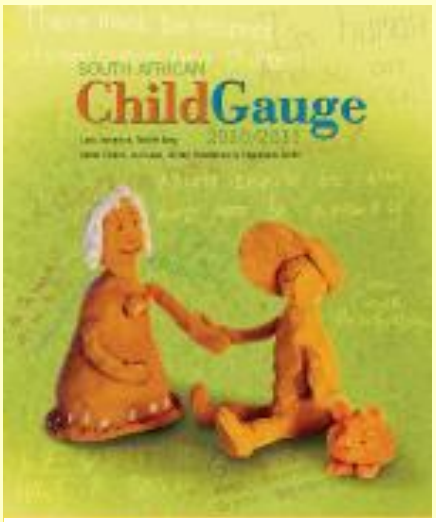
Kate Kerber

The University of Western Cape has received funding from the global Child Health Epidemiology Reference Group (CHERG) linked to World Health Organization (WHO) Geneva over the next 18 months to convene expert stakeholders to come to consensus on an ICD-compatible analysis of available data streams (e.g. vital registration, hospital mortality audit, verbal autopsy) for under-five child mortality in South Africa in order to improve on the existing UN estimates and obtain consensus around cause of death case definitions amongst the various sources of data.

Kate Kerber, a UWC PhD candidate, together with Prof Debra Jackson and Dr Joy Lawn from Save the Children will be leading this research. There will be an additional focus on the breakdown of causes of neonatal mortality and the contribution of HIV to childhood deaths in the country. This will be a collaborative, consensus-building effort with the National Department of Health, StatsSA, the Medical Research Council Burden of Disease Unit, Saving Babies and Saving Children national committees as well as global level input by WHO, UNICEF, UNAIDS, Save the Children and CHERG.

Kate Kerber is a Canadian citizen living in South Africa since 2005. She completed her master's degree in Public Health at the University of Cape Town. In 2005-6 Kate co-led the Opportunities for Africa's

Newborns publication and translations and has been involved in a number of country and regional-level policy and peer-review publications including the recently released Science in Action: Saving the Lives of Africa's mothers, newborns and children which looked at potential lives saved and costing of scaling up services across the continuum of care. In addition to her research at UWC, Kate works part time for Save the Children supporting technical and programmatic support for using maternal, newborn and child health data for policy and decision making and quality improvement in the African region.



South African Child Gauge 2010/2011

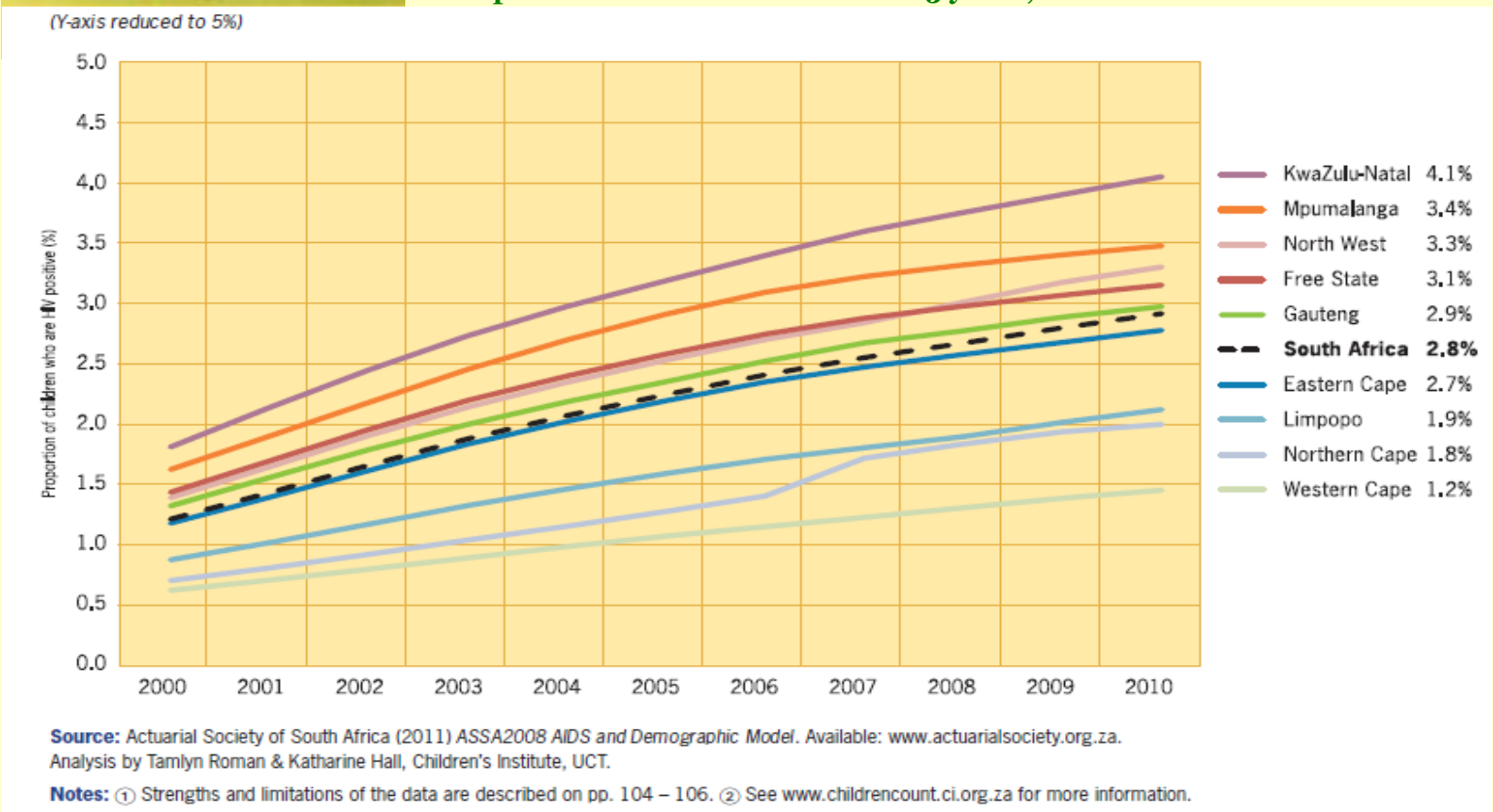
Jamieson L, Bray R, Viviers A, Lake L, Pendlebury S & Smith C (eds) 2011
Children's Institute, University of Cape Town

The South African Child Gauge is the only publication in the country that provides an annual snap-shot of the status of South Africa's children. It is published by the Children's Institute, University of Cape Town, to track South Africa's progress towards realising children's rights. The 2010/2011issue focuses on the theme 'Children as citizens: Participating in social dialogue'.

What the SACG 2010/2011 says on

Child Health…

HIV prevalence in children under 15 years, 2000 – 2010



Source: Actuarial Society of South Africa (2011) *ASSA2008 AIDS and Demographic Model*. Available: www.actuarialsociety.org.za. Analysis by Tamlyn Roman & Katharine Hall, Children's Institute, UCT.

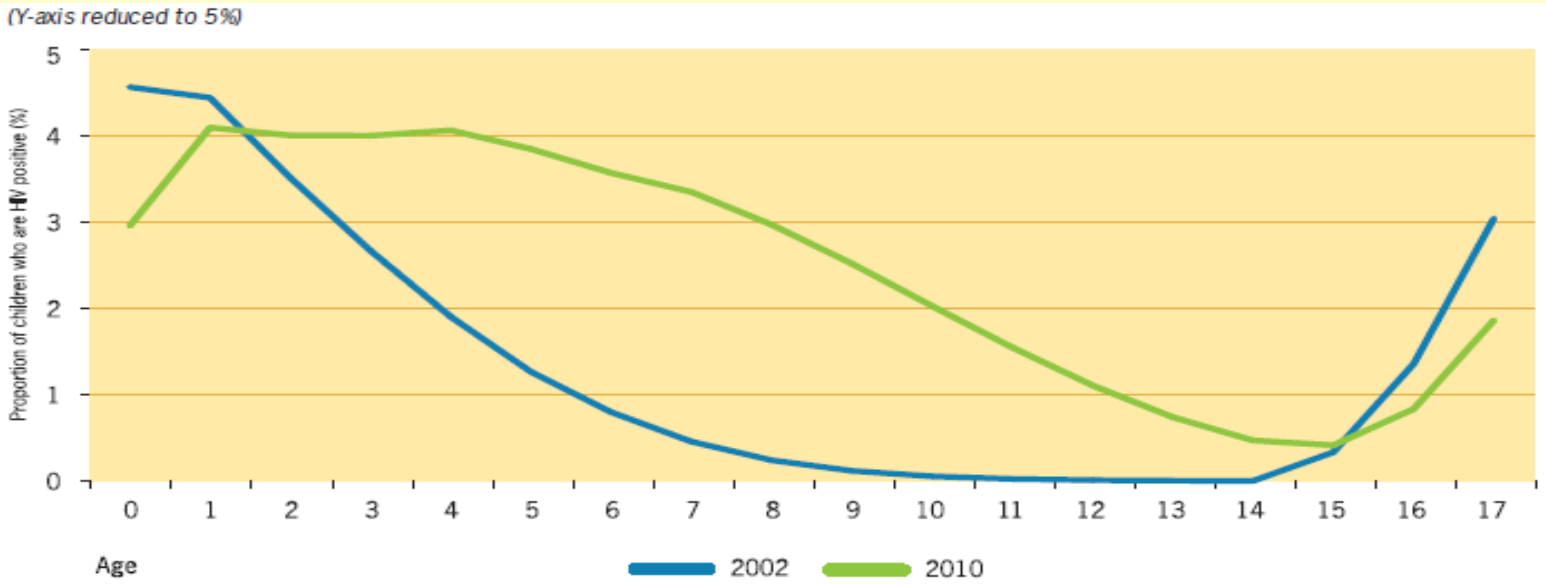
Notes: ① Strengths and limitations of the data are described on pp. 104 – 106. ② See www.childrencount.ci.org.za for more information.

Updated by Tamlyn Roman and Katharine Hall (Children's Institute)

Section 27 of the Constitution of South Africa[1] provides that everyone has the right to have access to health care services.
In addition, section 28(1)(c) gives children "the right to basic nutrition and basic health care services".
Article 14(1) of the African Charter on the Rights and Welfare of the Child[2] states that "every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health".
Article 24 of the UN Convention on the Rights of a Child[3] says that state parties should recognise "the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health".
It obliges the state to take measures "to diminish infant and child mortality" and "to combat disease and malnutrition".

HIV Prevalence in Children

HIV prevalence in children by age (0 – 17 years), 2002 & 2010



Source: Actuarial Society of South Africa (2011) *ASSA2008 AIDS and Demographic Model.* Available: www.actuarialsociety.org.za. Analysis by Tamlyn Roman & Katharine Hall, Children's Institute, UCT.

This indicator refers to the proportion of children, in a given period, who are HIV positive. South Africa is currently the country in the world with the largest number of people living with HIV. Many children are HIV positive or have become ill and died due to AIDS. The majority of children are infected before and during the birth process and some later through breastfeeding – in other words, paediatric HIV is driven by the adult epidemic. Children may also become infected through sexual intercourse, including sexual abuse. Estimates of the number of children infected with HIV are essential for planning health services to meet their needs. In addition, knowing the prevalence of paediatric HIV helps to monitor the epidemic from year to year and gives an indication of the effectiveness of the prevention of mother-to-child transmission programme (PMTCT).

The ASSA2008 AIDS and Demographic Model provides the most current estimates of paediatric HIV prevalence in South Africa and suggests that, while prevalence is increasing, the rate at which it is doing so is decreasing. The increase in prevalence could be explained by the increased survival rates for children who now have access to antiretroviral therapy (ART). However, there are significant provincial differences in prevalence, which should be investigated. The Western Cape consistently has the lowest HIV prevalence rate (1.2% in 2010), while prevalence is highest in KwaZulu-Natal (4.1%). Across South Africa, 438,000 children under 15 years (2.8%) are estimated to be HIV positive in 2010. A recent paediatric model projects the number of infected children to be slightly higher than the ASSA2008 estimates. This is partly because it includes more detailed modeling of breastfeeding rates. The probability of infection through breastfeeding is reduced by 80% if breastfeeding mothers receive highly active ART (HAART) during this period. According to this model, an estimated 3.8% of children aged 0 – 14 years old were infected with HIV in 2008, compared with 2.6% in the ASSA2008 model.

Most HIV infections in children under 14 years occur at birth or shortly thereafter. Given the rapid expansion of the PMTCT programme over the past decade, it seems surprising that prevalence should continue to increase. Figure 3a (above), derived from ASSA2008, shows prevalence by individual age for all children under 18, and compares rates for 2002 and 2010. The 2002 trend shows higher infection rates at birth, followed by a rapid decline in HIV prevalence from the age of one year. In part, this reflects the progression of the pandemic (in 2002, 10-year-olds would have been unlikely to be infected at birth), but the sudden decline in HIV prevalence (amongst living children) is also due to HIV related deaths.

Children born HIV positive need to receive ART early because, without treatment, more than 30% of children who were infected at birth would die before their first birthday. The rapid roll-out of the ART programme since 2002 has meant that increasing numbers of infected babies have received treatment and survived – as illustrated in the 2010 trend. National ART take-up amongst newly-eligible children under 15 started at a low of 2% in 2002, rising to 37% of eligible children in 2007/08. The sudden rise in prevalence rates from the age of 15 represents new infections through sexual activity amongst teenagers. In 2010, 18,522 (just under 2%) of 15-year-olds were estimated to be infected – down from 30,329 (3%) in 2002.

The infant mortality rate and under-five mortality rate

South Africa relies on survey data and modeled estimates to measure infant and child mortality because the vital registration and health information systems are not comprehensive and are inadequate for this purpose. The last reliable data on child mortality were collected from the 1998 South African Demographic and Health Survey (SADHS). In the absence of empirical child mortality estimates, the Actuarial Society of South Africa (ASSA) has developed an AIDS and Demographic model and recently released the latest version, ASSA2008. Infant and under-five mortality rates are widely used indicators of health status and socio-economic development because they reflect not only child mortality levels but also the health status of the broader population.

The infant mortality rate (IMR) is defined as the probability of dying within the first year of life and refers to the number of babies under 12 months old who die in a year, per 1,000 live births during the same year. According to ASSA2008 estimates, the IMR has gradually decreased from 52 in 2000 to 34 in 2010. The under-five mortality rate (U5MR) is defined as the probability of dying between birth and the fifth birthday. The U5MR refers to the number of children under five years old who die in a year, per 1,000 live births in the same year. According to ASSA2008 estimates, the U5MR increased gradually in the decade leading up to 2003, when it reached a high of 74, after which it steadily decreased to 50 in 2010. A child's growth and development are dependent on the family's living conditions and access to services and resources in the surrounding community. These conditions generate the biological risk factors that impact directly on the child's health through the occurrence of disease and its prognosis, of which death is the most extreme outcome.

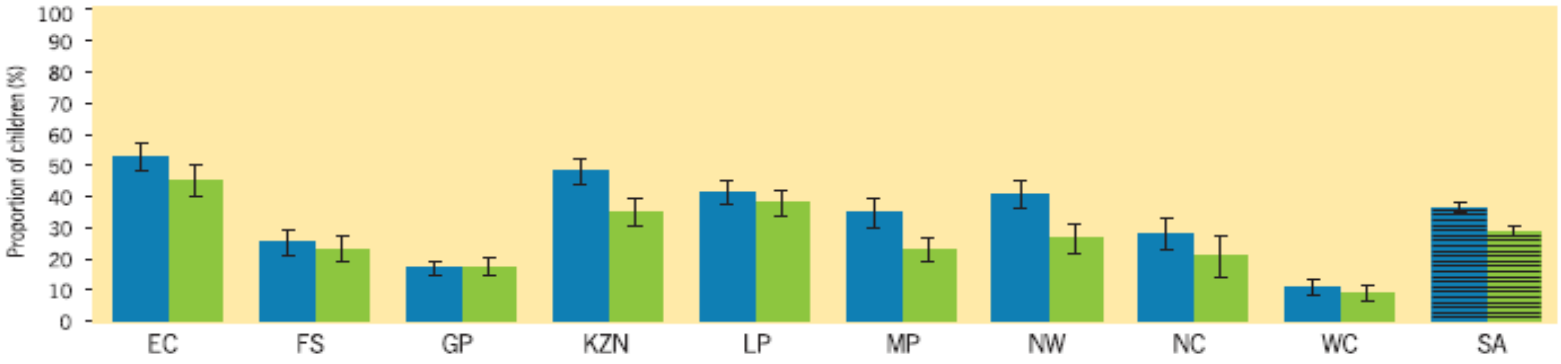
The IMR and U5MR in developing countries are therefore associated with a broad range of bio-demographic, health and social factors. These include access to maternal and child health care services such the number of antenatal care visits, maternal nutrition status, breastfeeding and infant feeding; environmental health factors such as safe drinking water, hygiene and sanitation; and socio-economic factors such as income and household conditions, women's education and household energy sources for cooking and heating. The IMR and U5MR, as indicators of health and overall societal development, are therefore intrinsically linked to the right to a healthy and safe childhood and the array of socioeconomic rights in general.

Reducing child mortality is one of the eight Millennium Development Goals (MDGs) for reducing poverty and inequality in the world. The target for MDG 4 is to reduce under-five mortality by two-thirds between 1990 and 2015. South Africa's target is to attain an U5MR of 20 deaths per 1,000 live births by 2015. Based on the 1998 SADHS and ASSA2003, it was assumed that mortality rates continued to increase during the 2000s, continuing the trend of the late 1990s. This trend correlates with an increase in HIV prevalence in pregnant women. Given the limited treatment available to HIV-positive pregnant women during the 1990s, most of the rise in infant mortality can be attributed to AIDS and AIDS-related illnesses. However the ASSA2008 estimates show that this trend was reversed around 2003. The decreasing child mortality rates correlate with the timing of the national roll-out of the prevention of mother-to-child transmission programme, and the downward trend illustrates the success of this programme in reducing child deaths.

The number and proportion of children living far from the nearest health facility

Number and proportion of children living far from the nearest health facility, 2002 & 2009

This indicator reflects the distance from a child's household to the health facility they normally attend. Distance is measured through a proxy indicator: length of time travelled to reach the health facility, by whatever form of transport is usually used. The health facility is regarded as



	EC	FS	GP	KZN	LP	MP	NW	NC	WC	SA
2002	52.7% 1,494,000	25.2% 249,000	16.9% 464,000	48.2% 1,847,000	41.5% 1,039,000	34.8% 454,000	40.5% 580,000	27.9% 84,000	10.8% 172,000	36.4% 6,382,000
2009	45.1% 1,247,000	23.2% 248,000	17.5% 565,000	34.9% 1,493,000	37.9% 878,000	22.9% 337,000	26.6% 340,000	20.8% 91,000	9.0% 160,000	28.8% 5,356,000

Source: Statistics South Africa (2003; 2010) *General Household Survey 2002; General Household Survey 2009*. Pretoria: Stats SA. Analysis by Tamlyn Roman & Katharine Hall, Children's Institute, UCT.

Notes: ① Children are defined as people aged 0 – 17 years. ② Population numbers are rounded off to the nearest thousand. ③ Strengths and limitations of the data are described on pp. 104 – 106. ④ The confidence intervals, shown on the graph as a vertical line at the top of each bar, represent the range into which the true value may fall. See p. 77 for more details on confidence intervals. ⑤ See www.childrencount.ci.org.za for more information.

"far" if a child would have to travel more than 30 minutes to reach it, irrespective of mode of transport.

The health of children is influenced by many factors, including nutrition, access to clean water, adequate housing, sanitation and a safe environment. Primary health care facilities provide important preventative and curative services, and increased access to such facilities could substantially reduce child illness and mortality. Children therefore need access to good and reliable health services to ensure that they receive life-saving interventions such as immunisation and ARVs. According to the UN Committee on Economic, Social and Cultural Rights, primary health care should be available (in sufficient supply); accessible (easily reached); affordable; and of good quality. In 1996, primary health care was made free to everyone in South Africa, but the availability and physical accessibility of public health care services remain a problem, particularly for people living in remote areas.

In South Africa, nearly 30% of children live far from the health care facility they normally use, and over 90% normally use the health care facility nearest their homes. That means 5.4 million children need to travel more than 30 minutes to reach their usual health care service provider. Nationally, access to health services remained relatively constant between 2002 and 2008 with about 40% of children living far from their health care facility. Access appears to have increased dramatically in 2009 when 29% of children were reported to live far from their health care facility. This rapid improvement is contrary to the trend over the previous seven years, and may be due partly to a change of question in the General Household Survey in 2009. For this reason, data from 2009 may not be directly comparable with that of previous years. The situation seems to have improved across the country as a whole, with an average nationwide improvement of seven percentage points.

In KwaZulu-Natal there has been an improvement of 13 percentage points in the proportion of children travelling far to their health facility (from 48% in 2002 to 35% in 2009). This may be the result of a changed question in the 2009 survey, but it may also reflect improved provisioning to a certain extent. There was a three percent increase in the number of public clinics between 2007 and 2009, from 3,077 to 3,174 clinics nationally, with the greatest number of new clinics being established in the Eastern Cape (28 clinics) and KwaZulu-Natal (20). On the other hand, there appears to be great improvement in access to health care facilities in the North West province in 2009, although only one additional clinic was established in the two-year period prior to 2009. There is considerable variation between provinces. While a large proportion of children in the Eastern Cape (45%), Limpopo (38%) and KwaZulu-Natal (35%) have to travel more than 30 minutes to reach their health facility, this proportion is much lower for other provinces, and lowest in the largely metropolitan provinces of Gauteng (18%) and the Western Cape (9%). There

are also significant differences between population groups. A third (32%) of African children would have to travel far to their health facility compared with only 7% – 12% of Coloured, Indian and White children.

The number and proportion of children living in households where there is reported child hunger

This indicator draws on data from the GHS and shows the number and proportion of children living in households where children are reported to have ever gone to bed hungry because there was not enough food, or there was not enough money to buy food. Child hunger is emotive and subjective, and this undermines the reliability of estimates on the extent and frequency of hunger, but it is assumed that variation and reporting error will be reasonably consistent so that it is possible to report trends from year to year.

The government has introduced a number of programmes to reduce hunger, malnutrition and food insecurity, yet child hunger continues to be a problem. Nearly three million children (16%) were living in households where child hunger was reported in 2009. Overall, there has been a significant drop in reported child hunger from 30% of children in 2002, and a slight drop from 18% of children in 2007. There are large disparities in reported hunger between provinces and population groups. The provinces with the highest reported child hunger rates were the Eastern Cape and Free State. Reported child hunger in the Free State increased from 13% in 2008 to 21% in 2009, but decreased overall from 2002. The Eastern Cape has particularly high rates of child poverty and unemployment, and child hunger rates have remained consistently high from 2007 to 2009 (21% – 20%), despite an overall drop in reported child hunger from 47% in 2002. Limpopo also experiences high rates of unemployment and income poverty; yet it has the lowest proportion of reported child hunger (8%). This may be related to greater food security in rural households as a result of access to land for subsistence agriculture. Hunger, like poverty and unemployment, is most likely to be found among African children. In 2009, some 2.7 million African children lived in households that reported child hunger. While this is an improvement from the 3.3 million in 2008, it still equates to 17% of the total African child population, while relatively few Coloured (13%), Indian (2%) and White (1%) children live in households where child hunger was reported.

Access the SACG at:
http://www.ci.org.za/index.php?option=com_acymailing&ctrl=archive&task=view&mailid=21&key=842422f467d92acc3a89f7ec7633156b&sub=6898-691110dcc8270cf3ddc0a2365b325087