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OVERVIEW OF CHILD MORTALITY IN SOUTH AFRICA

1. INTRODUCTION

The global target set for Millennium Development Goal (MDG) 4 is to reduce the child mortality by two-thirds of the rate that it was in 1990, by 2015.

Mortality rates in Sub-Saharan Africa spiralled out of control in the 1990s due to rapidly escalating HIV and AIDS epidemic.[1]

In South Africa, the child mortality rate started to decrease, especially after 2007, with the up-scaling of HIV programmes. Programmes to combat child mortality are intrinsically linked to maternal mortality programmes as well as the fight against HIV and AIDS.

This paper will provide an overview of child mortality in South Africa, in relation to the world, and the various public programmes initiated by the Department of Health.

2. CHILD MORTALITY

The first five years are the most important in a child's life.[2] A number of critical physical, psychological, cognitive and emotional developmental milestones are rapidly achieved during this period. Indeed the first 1000 days- from pregnancy through a child's second year of life- have been identified as crucial. "Whether a child has experienced chronic nutritional deficiencies and frequent bouts of illness, early in life is best indicated by the infant's growth, in length and the child's growth in height. Day-to-day nutritional deficiencies over a period of time lead to diminished, or stunted growth. Once children are stunted, it is difficult for them to catch up in height later on..."[3] Unicef identified the first 28 days of life as being critical, with more than 40 % of under –five deaths (3.7 million) in 2004 occurring during this critical period.[4]

2.1 Definitions:

- Intrapartum – the period from the onset of labour to the third stage of labour.
- Neonatal – the period immediately succeeding birth and continuing through the first 28 days of life.
- Post-natal - occurring after birth.

[1] Nannan et al (2012)
[2] Rochat et al. (2008)
[3] Unicef (2009) p. 5
[4] Unicef (2008)

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- Peri-natal - Occurring during, or pertaining to, the periods before, during, or after the time of birth; [*i.e.,* before delivery from the 22nd week of gestation through the first 28 days after delivery.]
- Child mortality / under-5 mortality - child mortality, also known as under-5 mortality, refers to the death of infants and children under the age of five.
- Infant mortality – refers to the death of a child before the first birthday.

2.2. International Overview:

- Between 1990 and 2011, the global under-five mortality rate declined from 87 to 51 deaths per 1,000 live births.
- The highest rates of child mortality are still in Sub-Saharan Africa—where 1 in 9 children die before age five.
- The proportion of under-five deaths that occur within the first month of life (the neonatal period) has increased with 17% percent since 1990, from 36% percent to about 43%.
- About half of under-five deaths occur in only five countries: India, Nigeria, Democratic Republic of the Congo, Pakistan and China. India (24%) and Nigeria (11%) together account for more than a third of all under-five deaths.

2.3. Child Mortality in South Africa:

According to UN estimates, South Africa's under-5 mortality declined between 2000 and 2011 from 74 per to 47 per 1000 live births.[5] This figure is significantly lower than the figure recorded in the 2010 MDG Country Report, under-5 mortality at 104 per 100 000 was estimated. Sub-Saharan Africa's under-5 mortality was recorded as 109 in 2011, and the region is unlikely to meet the target of 59 per 1000 live births by 2015.

A concern though is the fact that there are disparities in the child mortality estimates for males and females in South Africa. According to UN figures child mortality for males is consistently higher than females – e.g. under-5 mortality is 50 for males and 44 per 1000 live births for females. This trend continues for infant mortality (51 and 35 respectively) and neonatal mortality rates (28 and 20 respectively).

One of the contributing factors in South Africa's poor performance is the high mortality rate among neonatal infants, which in 2011 was determined as 19 per 1000 live births. This means that in South Africa, about 40% of all child deaths occur within the first 28 days of

[5] Health (2012)

their birth.[6] Thus significant reductions in under-5 mortality rates will only be possible if deaths during the neonatal period (infant less than 1 month old) are reduced.

The most important causes of death in the early neonatal period are immaturity (45%), intrapartum hypoxia (28%), infection (10%) and congenital abnormalities (8%). Hypoxia affects mostly larger babies[7], and improvements in intrapartum monitoring and care would prevent many of these deaths. In 2010/11 one in eight babies (12.8%) was classified as having low-birth weight (≤ 2.5kg)[8]

Reducing maternal and neonatal mortality[9] and morbidity and improving women's health is a key public health goal in South Africa, and a key indicator of the MDGs[10]. However, the number of child deaths in South Africa remains high, and most of these are preventable.

The health of infants and children in South Africa is largely influenced by social and economic conditions under which they and their families live. It has been reported that approximately 66% of children in South Africa live in poverty, with a monthly household of less than R1 200 per month.

The major causes of death among infants and children in South Africa are[11]:

- Pneumonia.
- Diarrhoea.
- Birth trauma and asphyxia.
- Vaccine-preventable diseases.
- Malaria (in some areas).
- Malnutrition, and
- HIV and AIDS.

Table: Child Mortality Rates, 2009-2011

Indicator	2009	2010	2011
Under-5 Mortality Rate (U5MR). MDG Target = 20 / 1000 by 2015.	56 per 1 000 live births	53 per 1 000 live births	42 per 1 000 live Births. [Unlikely to meet MDG 4 by 2015?]

[6] Ibid
[7] Ibid
[8] DHIS data 2010/11. Extracted January 2013
[9] Definition: Neonatal mortality rate is the number of neonates dying before reaching 28 days of age, per 1,000 live births in a given year.
[10] Department of Health Strategic Plan 2010/11-2012/13
[11] Nannan et al (2012)

Infant Mortality Rate (IMR) – MDG Target = 18/1000 by 2015	40 per 1 000 live births	37 per 1 000 live births	30 per 1 000 live Births. [Unlikely to meet MDG 4 by 2015?]
Neonatal Mortality Rate (<28 days)	14 per 1 000 live births	13 per 1 000 live births	14 per 1 000 live births

Source: DOH, 2013

3. DEPARTMENT OF HEALTH'S RESPONSES

- NSDA: Strategic Output 2: Reduce maternal and child mortality rates
- Maternal, Newborn, Child and Women's Health and Nutrition Strategic Plan, 2012 – 2016 launched in May 2012:
  - Outlines package of priority services to be delivered to all women and children
  - Key strategies for improved services and outcomes
- Public Health Care: Re-engineering:
  - District Clinical Specialist Teams (DCSTs)
  - School Health Teams
  - Municipal ward based outreach PHC teams
- Campaign for the Accelerated Reduction in Maternal and Child Mortality in Africa (CARMMA) launched in May 2012:
  - Identifies priority activities to address maternal and child survival.

3.2. CARMMA Priorities

- Advancing contraception and family planning;
- Encourage early booking and improve the quality of antenatal care;
- Prevention of Mother-to-child-transmission of HIV;
- Providing obstetric ambulances;
- Maternity Waiting Homes – for better care of expecting mothers;
- Improving new born care and treatment of sick children, including Kangaroo Mother Care;
- Expanded Programme on Immunisation – at pre-schools (ECD) and schools;
- Encourage exclusive breast-feeding during pregnancy; and
- Training (essential steps in the management of obstetric emergencies, skilled birth attendants including additional midwives).

South Africa has identified six priority areas in addressing infant mortality, namely[12]:

- Promotion of early and exclusive breastfeeding including ensuring that breastfeeding is made as safe as possible for HIV-exposed infants.
- Resuscitation of newborns.
- Care for small/ill newborns according to standardised protocols.
- Provision of initiatives for Prevention of Mother to Child Transmission (PMTCT).
- Kangaroo mother care (KMC), and
- Post-natal visit within six days.

In pursuit of optimum health for children under-5, a Ministerial Committee on Perinatal Mortality was established in 2008. This Committee plays an important role in institutionalising the use of perinatal mortality[13] reviews as a mechanism for identifying and addressing deficiencies in the quality of care which mothers and their newborns receive.

The committee has published a report that identifies the following strategies to address perinatal mortality in South Africa:[14]

1. Improving access to appropriate healthcare

- Regional Clinicians should be appointed to establish, run and monitor and evaluate outreach programmes for maternal and neonatal health.
- Improve transport systems for patients and establish referral routes.
- The Government should ensure that constant health messages are conveyed to all and understood by all.

2. Improving quality of care

- Improve the training of health care professionals with regard to both undergraduate (pre-service training) and in-service training.
- National maternal and neonatal guidelines should be followed in all healthcare facilities.
- Improve provision and delivery of postnatal care.
- Normalisation of HIV infection as any chronic disease.

3.Ensuring the availability of adequate resources

- Provide adequate nursing and medical staff, adequate equipment for the health needs of both mothers and babies, especially the equipment required for emergency and critical care.

[12] Strategic Plan for Maternal, Newborn, Child and Women Health and Nutrition in South Africa 2012-2016
[13] The number of perinatal deaths per 1 000 births. The perinatal period starts as the beginning of foetal viability (28 weeks gestation or 1 000g) and ends at the end of the 7th day after delivery. Perinatal deaths are the sum of stillbirths plus early neonatal deaths. These are divided by total births (live births plus stillbirths).
[14] Strategic Plan for Maternal, Newborn, Child and Women Health and Nutrition in South Africa 2012-2016

- Provide an adequate number of hospital beds for the health needs of mothers and babies at all levels of health care, including critical care beds.

4. Auditing and monitoring

- Improve data collection and review.

4. ISSUES FOR CONSIDERATION BY PARLIAMENT IN ADDRESSING INFANT MORTALITY

In addressing infant mortality, special attention should be given to the health needs and rights of children who are socially vulnerable, including those in the poorest households, living in rural areas, and affected by HIV and AIDS.

Regulations on encouraging exclusive breastfeeding (as opposed to "mixed feeding" or combining breastfeeding with formula feeding) are being finalised by the Department of Health. Members should ensure that people's rights are maintained while also ensuring the best practices for infant's survival.

South Africa has the largest anti-retroviral (ARV) treatment programme in the world. The Prevention of Mother to Child Transmission (PMTCT) campaign is extremely successful. The PMTCT rate currently, has been reduced to 3.5%. It is likely that the next goal will be total eradication of MTCT.

The key functions of Parliaments are configured around legislation, oversight, budget scrutiny and public participation. These functions should be used to develop frameworks and measure progress aimed at reducing maternal and infant mortality. The responsibility for implementing strategies to reduce infant mortality is not only the responsibility of national sphere, but also provincial and local governments. Parliaments are encouraged to focus on the following:

- **Advocacy**

As representatives of the people, parliamentarians are the channel for voicing concerns about children's well-being. Parliamentarians are uniquely placed for this because of their direct knowledge of local realities, as well as the power to initiate action to address local problems.

- **Law making**

Law-making and policymaking are consultative processes in which parliamentarians play a determining role. Significant socio-economic policies and laws, particularly those impacting women's well-being and status, such as those prohibiting violence against women and

children, protecting women's property rights, etc. have been debated and legislated by parliaments.

- **Oversight with specific reference to the MDGs**

Parliamentary committees can exercise their oversight function to ensure the meeting of the MDG target of reducing infant mortality, with respect to the following crucial activities:

- Requesting that government ministries provide parliamentary committees with regular briefings on progress being made towards achieving the MDGs 4.
- Undertaking a Parliamentary investigation into the MDGs (or selected MDGs) and including the inputs of civil society organisations.
- Holding public consultations to gather from citizens (especially women) the impact that policies aimed at attaining the MDGs 4 is having on them.[15]
- Parliament can engage in a budget analysis to ensure that line items support the achievement of the MDGs.
- Parliaments can assure pro-poor budgeting and promote transparency and accountability in the budgeting process.[16]
- Incorporating the MDGs into regular parliamentary events is also an effective way of engaging with the goals and ensuring their success. These events include: Taking Parliament to the People, Women's Parliament, Youth Parliament and The People's Assembly.
- Developing of poverty reduction strategies and mobilising resources both locally and externally, to benefit the entire population.
- In the context of the impact of HIV and AIDS on both maternal and infant mortality, ensuring that care is provided for both parents as part of the response to mother-to-child transmission.

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[15] Ibid.
[16] Parliamentary Network on the World Bank (2010)