1. **International, African and national Instruments governing the right to equality and protection against poverty**

The rights of children to survival are guaranteed, and the correlating obligations on the state to promote, realise and protect these rights are governed by a number of international, African and national legal instruments, including:

- The United Nations Convention on the Rights of the Child (United Nations, 1990);
- The African Charter on the Rights and Welfare of the Child (African Union, 1999);
- The United Nations Millennium Development Declaration (United Nations General Assembly, 2000);
- The United Nations A World Fit For Children (United Nations General Assembly, 2002);
- The African Charter on the Rights and Welfare of the Child (African Union, 1999);

1.1 **Children’s rights to survival**

All children have a guaranteed right to survival (United Nations, 1990) (African Union, 1999). There is international, regional and national recognition that the right to survival is dependent on the realisation of a multiplicity of complimentary rights, which if neglected, contribute to infant and child morbidity and mortality. These include the rights to:

2. A standard of living adequate for the child’s physical development (United Nations, 1990, Article 27(1))
4. Basic health care services, including treatment and rehabilitation (United Nations, 1990, Article 24(1));(Republic of South Africa, Act 108, 1996, Section 27(1)(a) & 28 1(c))
5. Basic nutrition and social services (Act 108, 1996, Section 28(1)(c))
6. An environment that is not harmful to their health or well-being (Republic of South Africa, Act 108, 1996, Section 24(a)).

1.2 **The state’s obligations to ensure children’s survival**

The state is required to respect, protect and promote the realisation of children’s rights to survival through appropriate legislative, administrative and other measures (United Nations, 1990) (African Union, 1999). Given the interdependence of multiple rights to secure child survival, the obligations on the State extend beyond the provision of health care and include the obligation to address the social, economic and environmental factors that impact on child morbidity and mortality (Sanders, Reynolds, & Lake, 2012) (Blas, Sommerfeld, & Kurup, 2011).

Specific obligations that the state must fulfil include:

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1 This topical guide was prepared for PAN:Children by Patricia Martin (Advocacy Aid)

2. Intensifying proven cost-effective actions against disease and malnutrition as major causes of child mortality and child morbidity (United Nations General Assembly, 2002, paragraph 37(11)).

3. Providing high quality medical assistance and health care, with a focus on primary health care and pre-natal, post-natal, essential obstetric care and care for newborns, especially for those in areas without access to services (United Nations, 1990, Article 24(2)(B)) (African Union, 1999, Article 14(2)(b)) (United Nations General Assembly, 2002, paragraph 37(2) & (6)).


9. Ensuring full immunization of children under the age of 1 year (United Nations General Assembly, 2002, paragraph 37(7)).


12. Improving maternal health through universal access to reproductive health (United Nations General Assembly, 2000).


14. The provision of social and other forms of assistance to enable parents to provide their children with a standard of living adequate for the child's development, especially in providing for nutrition, clothing and housing (United Nations, 1990, Article 27(4)).

Whilst recognising that child survival depends on a host of interconnected rights, this guide will primarily focus on the right, and correlating obligations, to medical assistance and health care (including environmental health). This guide is one of a series. Other guides in the series deal with related and complementary rights and issues. Please refer to the following guides for further information on the link between food and nutrition, poverty and access to social assistance, child protection, early childhood development and HIV and AIDS and child survival:

- Child poverty and inequality
- Child protection
- Children and HIV and AIDS
- Early childhood development
- Food and nutrition
- The right to education for children aged 5 – 18 years
- Social protection for children.
2. National policies, laws, strategies and programme documents giving effect to the State’s obligations to ensure child survival

The White Paper for the Transformation of the Health System in South Africa commits the South African government to the transformation of the health system. It focuses on activities that will have maximum impact on the health status of the entire population which include interventions targeting those areas with the highest infant, under-five and maternal mortality rates. It further commits to achieving universal access to health services for children including infants, children under five, adolescents and women, while improving the quality of services provided (Republic of South Africa, 1997).

The Primary Health Care Package for South Africa makes provision for an integrated package of essential Primary Health Care (PHC) services and includes norms and standards for the delivery of these services by health clinics as well as community based services. Services include: Integrated management of childhood illness (IMCI), immunisation, management of communicable disease, cholera and diarrhoeal disease control, dysentery, helminths, rheumatic fever and haemolytic streptococcal infections and norms and standards for community based services such as community level water and sanitation and the integrated nutrition programme (Department of Health, 2002).

The National Health Act (No. 61 of 2003) regulates the provision of key child health programmes, including:
- Free primary health care for everyone
- Free health care for pregnant women and children under six years
- Free health care for social grant recipients (Republic of South Africa, Act No. 61 of 2003).

The Expanded Programme on Immunisation – Revised National Immunisation Schedule as at 1 April 2009 provides for the immunization of all infants and children to prevent measles, TB, tetanus, diphtheria, rotavirus and pneumococcal diseases (Department of Health, 2009).

The Delivery Agreement for Outcome 2: A Long and Healthy Life for all South Africans reflects the commitments made by the health sector to improve the health status of the entire population. The Department of Health (DOH) has undertaken, by 2014, to:
1. Increase life expectancy
2. Decreased maternal and child mortality
3. Combat HIV and AIDS and decrease the burden of disease from TB
4. Strengthen the health system effectiveness.

National targets include:
1. Decreasing the infant mortality rate to 18 deaths (or less) per 1000 live births
2. Decreasing the under-five mortality rates to 20 deaths (or less) per 1000 live births
3. Decreasing maternal mortality ratio to 100 (or less) per 100 000 live births
4. Increasing the proportion of births attended by skilled health personnel to 100%
5. Decreasing diarrhoea incidence in children under 5 years
6. Decreasing pneumonia incidence in children under 5 years.

Underlying the realisation of these goals is a commitment to re-engineer the health system to one that is based on the Primary Health Care (PHC) approach with more emphasis on promotive and preventive healthcare (Department of Health, 2010).

The National Health Insurance Green Paper introduces a revised funding and delivery model to ensure universal access to quality health care for all South Africans. The “NHI is an innovative system of healthcare

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2 There are a variety of policies and related documents that deal with child health, nutrition and HIV and AIDS, amongst others. The documents listed here do not include those pertaining to nutrition and HIV and AIDS as these are listed and dealt with extensively under the research guides dealing with Food and Nutrition and with HIV and AIDS.
financing with far reaching consequences for the health of South Africa [which] will ensure that everyone has access to appropriate, efficient and quality health services.” It aims to increase access to services for pregnant women, infants and children through enhanced access to quality district health services (Department of Health, 2011 a).

**The Policy on the Management of Hospitals** is designed to regulate and guide improved delivery of, and accountability for quality health care in hospitals. It aims to ensure that the management of hospitals is underpinned by the principles of effectiveness, efficiency and transparency to ensure improved implementation and accountability for health services (Department of Health, 2011 b).

**South Africa’s National Strategic Plan for a Campaign on Accelerated Reduction of Maternal and Child Mortality in Africa (CARMMA)** documents South Africa's plan for realisation of its CARMMA commitments. CARMMA is an African Union initiative to promote and advocate for intensified development and implementation of initiatives by Member States to reduce maternal and child mortality.

South Africa's commitments and targets are, by 2015, to reduce by two thirds the under-5 mortality rate, to reduce the maternal mortality ratio by three-quarters, and to achieve universal access to reproductive health.

Key components of the plan includes: intensified access to sexual and reproductive health services; advocacy and health promotion for early antenatal care and attendance; improved access to skilled birth attendants; strengthened human resources for maternal and child health; improved child survival through the promotion of breastfeeding, improved immunization and Vitamin A coverage and intensified case management of sick children; and intensified management of HIV positive mothers and children (Department of Health, 2012 a).

**The Strategic Plan for Maternal, Newborn, Child and Women’s health (MNCWH) and Nutrition in South Africa 2012 – 2016** documents the Departments of Health’s goals and planned interventions to reduce:

- The maternal mortality ratio from 310 per 100 000 live births in 2009, to 270 by 2014
- the under-five mortality rate (U5MR) from 56 to 50 per 1000 live births by 2014 and to 40 by 2016
- the infant mortality rate (IMR) from 40 to 36 per 1000 live births by 2014 and to 32 by 2016
- To reduce the neonatal mortality rate (NMR) from 14 to 11 by 2016.

It commits to achieving these goals through the delivery of a cost-effective package of services to every mother, new born and child in every district, including:

- Basic antenatal care (four visits for every pregnant women, starting in the first trimester)
- HIV-testing during pregnancy with initiation of ART and other PMTT services where necessary
- Improved care during labour including access to dedicated obstetric ambulances and establishment of maternity waiting homes, and numerous others (Department of Health, 2012b).

**The Human Resource for Health South Africa: HRH Strategy for the Health Sector 2012/13 – 2016/17** addresses the human resource shortage in the public health sector in South Africa. It aims, inter alia, to improve the education and deployment of health care workers to ensure universal quality coverage of essential primary health care and other health services.

The strategy proposes a rural health strategy to attract and retain health professionals and commits to drawing traditional leaders in as the first line of defence, together with community outreach health teams. The strategy further focuses on the training of both professionals and community health workers. The strategy formulates a plan for the standardisation of training and services offered by community health-care workers across the country. The medium term plan is to develop training infrastructure, plans, reimbursement and career pathways for community health workers (Department of Health, 20 January 2012).

**The National Development Plan 2030: Our future – make it work** documents South Africa’s social and economic plan for eliminating poverty and reducing inequality which incorporates a number of child-specific developmental goals. The national vision for health is that by 2030, the health system should provide quality care to all, free at the point of service, or paid for by insurance. The primary and district health care systems should provide universal access, with a focus on prevention, education, disease managements and health. Hospitals should be effective and efficient, providing quality care for those who need it. In addition, more health
care professionals should be available, especially in poorer communities. The plan identifies the priority areas of development, and these include:

- Improved management at health institutions
- More and better trained health professionals
- Greater discretion and accountability at facility level
- Better patient information systems
- More decentralised and home-based care models
- A focus on maternal and infant health care (National Planning Commission, 2012).

3. **Situation assessment and analysis of child survival in South Africa**

3.1 **Infant and child mortality rates in South Africa**

National infant, under-five and neonatal mortality rates provide a clear indication of the status of child survival as well as of the broader social and economic development status of a country. The infant mortality rate (IMR) refers to “the probability of dying between birth and exactly one year of age expressed per 1.000 live births, i.e. the number of deaths in children under one year of age during a calendar year divided by the number of children born during that year.” The under-five mortality rate (U5MR) refers to the “probability of dying between birth and exactly five years of age expressed per 1,000 live births.” Neonatal mortality rates (NMR) refer to the “number of deaths in neonates (infants 0-28 days) during a calendar year divided by the number of children born during that year” (Department of Health, April 2011).

Despite the fact that South Africa offers an extensive package of maternal, infant and child health (and related) care and support, infant, under-five and neonatal mortality rates are unacceptably high. Whilst there is widespread recognition that these rates are high, there is disparity across a number of projected estimates. Sanders points out that the most recent reliable data source for child mortality is almost 15 years old - the 1998 South African Demographic and Health Survey. Since then there have been a number of projections and estimations as to the rates of death using different data sources by inter alia, the Actuarial Society of South Africa (ASSA 2003), the Interagency Group for Child Mortality Estimation (IGME 2008), the United Nations Population Division 2006, the UN Mortality Group 2008, the US Census Bureau 2009, and the Department of Health’s Committee on Morbidity and Mortality in Children Under 5 Years (CoMMiC). A number of recent reports provide a comprehensive review of the various infant and child mortality model projections and associated data sources, and their limitations (Nannan, et al., 2012) (Department of Health, April 2011) (Sanders & Bradshaw, 2010).

The estimates and projections differ, but there is concurrence that between 1990 and 2010 child mortality rates in South Africa increased and that it is unlikely that South Africa will meet its under-five MDG of 20 deaths per 1000 live births by 2015 (Sanders, Bradshaw, & Ngongol, 2010) (Chopra, Daviaud, Pattinson, Fonn, & Levin, 2009) (Department of Health, April 2011). Whilst the under-5 mortality rate has increased, it has, since 2010, started levelling off and is showing signs of declining (Sanders, Bradshaw, & Ngongol, 2010) (Nannan, et al., 2012).

The national Department of Health (DOH) has recognised the lack of quality, reliable and consistent health data on infant and child mortality. The Health Data Advisory and Co-ordination Committee (HDACC) was established by the DOH to, inter alia, establish consensus on national indicators and baseline values and targets for future use in measuring progress towards realisation of the national Negotiated Service Delivery Agreement 2010 – 2014 goals for health on various issues, including the reduction of infant and child mortality rates (Department of Health, February 2012). The HDACC has recognised and adopted the following base line child mortality rates (as at 2009) against which progress will be measured towards attainment of the associated targets:

**U5MR**
Baseline (2009) 56 per 1,000 live births  
Target (2014): 50 per 1,000 live births (10% reduction)  
Source of data: Deaths from the national population register and birth estimates from ASSA 2008

**Infant mortality rate**

Baseline (2009): 40 per 1,000 live births  
Target (2014): 36 per 1,000 live births (10% reduction)  
Source of data: Deaths from the national population register and birth estimates from ASSA 2008

**Neonatal mortality rate**

Baseline (2009): 14 per 1,000 live births  
Target (2014): 12 per 1,000 live births (10% reduction)  
Source of data: Deaths from the national population register and birth estimates from ASSA 2008

### 3.2 Inequitable distribution of the burden of infant and child mortality

The distribution of the burden of child mortality is highly inequitable, with much higher rates recorded in the youngest infants, certain provinces, amongst African women, infants and children living in poverty in informal settlements and rural areas (Sanders, Bradshaw, & Ngongol, 2010) (Westwood, Shung-King, & Lake, 2010) (Department of Health, April 2011) (McKerrow & Mulaudzi, 2010).

A cause for concern is that the majority of child deaths occur in the youngest of infants and children. About 30% of deaths occur in the neonatal period and almost 75% occur before one year of age (Pattinson (Ed), 2009) (Department of Health, April 2011) (Department of Health, 2012 a) (Nannan, et al., 2012).

National mortality figures hide substantial provincial variations. The DOH’s CoMMiC estimated an under-5 mortality rate of 59.8 in 2008, ranging between 28.8 in the Western Cape and 110.3 in the Free State. Mortality was the highest in the Eastern Cape, KwaZulu-Natal and Free State and the lowest in the Western Cape, Gauteng and Northern Cape (Department of Health, April 2011).

In addition, there is an equally inequitable distribution of mortality between rural and urban areas and between African children and other race groups. The infant mortality rate in rural areas is 52.6 per 1000 live births compared to 32 in urban areas. It is even worse in some rural areas in the Eastern Cape where it is as high as 70 deaths per 1000 live births (Department of Health, 20 January 2012). An HSRC study confirmed that White children have a 30% greater chance of survival to the age of 5 years compared to their African counterparts (Heaton & Amoateng, 2007).

### 3.3 Causes of high infant and child mortality and morbidity

The immediate clinical causes of child morbidity and mortality in South Africa are (1) Acute Respiratory Infections (ARI), (2) Diarrhoea, (3) Infection, (4) TB, and (5) Meningitis. A very high proportion of deaths are associated with HIV and AIDS and malnutrition. 50% of child deaths between 2007 and 2009 were found to be HIV-exposed or infected. However this figure is an underestimation of the contribution of HIV infection to child mortality as the HIV status of 35% of children remained unknown (Bamford, et al. 2011,) (Department of Health, April 2011) (Statistics South Africa, 2010) (Nannan, et al., 2012). The contribution of HIV and AIDS and malnutrition to child survival and well-being is dealt with separately in two further guides in this series on (1) children and HIV and AIDS, and (2) food and nutrition. The top causes of deaths in the perinatal period are labour related complications (asphyxia and birth trauma) (17%), spontaneous pre-term birth (23%) and placental diseases (23%) (Pattinson (Ed), 2009).
A substantial number of these causes of child deaths are preventable and/or treatable and thus a substantial number of child deaths in South Africa are avoidable. 26% of child deaths recorded between 2005 and 2009 were avoidable (Bamford, 2011) (Department of Health, April 2011). 40% of the neonatal deaths caused by labour related complications in 2007 were avoidable (Pattinson (Ed), 2009).

The underlying modifiable causes of child deaths in South Africa include the following:

1. Avoidable health care system failures. Health system failures include inappropriate and incorrect behaviour and/or treatment by health care providers, insufficient numbers of qualified paediatric staff, poorly managed facilities, insufficient facilities and medicines to treat common child morbidity causes, poor implementation and coverage of preventive and therapeutic infant and child health programmes and treatment such as immunizations and Vitamin A supplementation.

2/3rds of all child deaths between 2005 and 2009 were linked to inappropriate and unsafe clinical practices, treatment and/or personnel behaviour (Bamford, et al., 2011). Chopra et al (2009) and Harrison (2009) estimate that between one quarter and one half of all maternal, neonatal and child deaths are caused by avoidable health system failures and that in 2008, 11500 infant lives could have been saved through effective implementation of neonatal care at 95% coverage (Chopra, Daviaud, Pattinson, Fonn, & Levin, 2009). 44% of neonatal deaths in 2007 linked to labour related complications were caused by avoidable inappropriate health care provider actions and/or lack of resuscitation facilities, and this was especially problematic at district and regional facility level (Pattinson (Ed), 2009).

Coverage of preventive and therapeutic treatments is not equitable and/or universal. For example, there is insufficient coverage of the Vitamin A supplementation programme. The 2005 Food Consumption survey revealed a 21% take up rate of the programme which differs provincially from 10% in Mpumalanga, to 33% in the Eastern Cape. A 2007 study found that only 29% of children under the age of 5 years in the Western Cape had received the prescribed dosage of Vitamin A supplements (Hendricks, Beardsley, Bourne, Mzamo, & Golden, 2007).

Whilst immunization coverage improved to reach 89% of children under the age of one year in 2011, coverage has yet to reach the targeted 95%. In addition, there is considerable drop-out after the age of one year. The drop-out rate between the 9-month and 18-month immunization is 20% nationally (Department of Health, 2008) (Department of Health, 2012 a).

Paediatric human resources are also insufficient to meet demand and the allocation of available resources is inequitably spread between rural and urban provinces. Saunders et al observe that while “rural areas house 47% of South Africa’s children, only 12% of doctors and 19% of nurses work there.” Similarly, in 2011, less than 50% of the 1,001 paediatricians registered with the Health Professions Council of South Africa worked in the public sector and they are concentrated in urban areas. In 2009 there was one paediatrician for every 9,600 children in the Western Cape compared to one for every one million children in Mpumalanga (Sanders, Reynolds, & Lake2012) (Department of Health, 20 January 2012).

2. Poor demand for services, caused by inter alia, low levels of caregiver knowledge and behaviour is a key modifiable factor underlying maternal, infant and child mortality in South Africa. One third of all child deaths between 2005 and 2009 were linked to behaviours of caregivers in the home and community (Bamford, et al., 2011). Delays in seeking care, lack of recognition of danger signs, the provision of insufficient food and inappropriate treatment at home are all factors that contribute to avoidable child deaths. By way of illustration, in 2008, only 49% of caregivers had knowledge of oral rehydration therapy (ORT) for diarrhoea (Department of Health, 2008) (South Africa Every Death Counts Working Group, 2008).

3. There are numerous underlying or secondary social, economic and cultural factors which contribute to
the prevalence, shape and locality of the health system failures and caregiver behaviour. These social
determinants of child survival, include poverty, access to food and nutrition and adequate housing and
basic services such as clean running water, sanitation, and refuse removal, unemployment, illiteracy or
low literacy, geographical marginalisation (in rural areas), traditional religious and cultural affiliation/
practices (Barros, Victor, Scherpbier, & Gwatkin, 2010) (Ortiz, Daniles, & Solrun, 2012) (Sanders,

4. One of the specific social determinants of child survival is accessibility, or more accurately, the
inaccessibility of health services and facilities. A reduction in child morbidity and mortality requires that
all pregnant women, infants and children enjoy access to a comprehensive continuum of services and
support covering not only the medical, but also the social, economic and cultural determinants of child
survival. In South Africa, access to the full continuum of services and support – both primary and
secondary – is inequitable, with disadvantaged children and mothers enjoying lower access to the
continuum, largely as a result of their lower social and economic status (Barros, Victor, Scherpbier, &

Their lower access to resources and basic services results in women, infants and children in the poorest
households, especially those in rural areas, bearing the highest burden of disease, yet they have the
poorest access to health services. For example, 98% of women from the richest quintile received skilled
attendance at birth, compared to 68% from the poorest quintiles (South Africa Every Death Counts
Working Group, 2008); immunization rates are 104% in the Western Cape, but 84% in the rural Eastern
Cape, and only 71% of women deliver in facilities in the Eastern Cape, compared 98% in the Western
Cape (Sanders & Bradshaw, 2010).

Similarly, children in rural areas, those living poverty and African children are substantially more likely
to live far from their closest health facility. In 2010, only 21% and 14% of children in the predominantly
urban provinces of Gauteng and the Western Cape lived more than 30 minutes from the closest health
facility, whereas in the predominantly rural provinces of the Limpopo and the Eastern Cape the
percentage jumped to 44% and 42% respectively. Similarly, there is a significant variation between
children in the poorest quintile versus the richest quintile. Almost 46% of children in quintile 1 live far
from their nearest facility, compared to 19% in quintile 5 (Hall, Lake, & Berry, 2012).

3.4 Key innovations necessary to improve child survival in South Africa

A number of recent health system diagnostics have identified the following interventions as necessary to
improve child survival in South Africa (South Africa Every Death Counts Working Group, 2008); (Saloojee,
2010); (Harrison, 2009); (Department of Health, 2008); (Chopra, Daviaud, Pattinson, Fonn, & Levin, 2009)

1. The health system must be strengthened, in terms of:

1.1 The number, qualification and equitable distribution of maternal and paediatric human resources. This
requires (a) the recruitment of health care professionals and strengthened and focussed pre-service,
post-graduate and in-service training in child health and paediatrics, and (b) the establishment of
district-level specialist teams that include paediatric doctors and nurses and district resource centres to
enable the district teams to build the broader district-level capacity and skills (Department of Health,
April 2011) (Department of Health Ministerial Task Team, 2012) (Department of Health, 20 January
2012).

1.2 Universal availability and delivery of a comprehensive, high quality package of maternal, newborn and
child preventive and therapeutic services, with a focus on preventing and treating the most common
avoidable and/or treatable causes of infant and child morbidity and mortality, such as the expanded
programme on immunization, Vitamin A supplementation, diarrhoea treatment, PMTCT, and quality neonatal care.

For example, there must be a focus on the provision of quality maternal and neonatal care at a district and regional level. As observed in the national Strategic Plan for Maternal, Newborn, Child and Women's Health and Nutrition, given that deaths in the neonatal period account for one third of all child deaths (and that many of these avoidable), the health system must focus on reducing deaths during the neonatal period through interventions aimed at remediating the avoidable underlying factors (Department of Health, 2012b). Likewise, more attention must be paid to ensuring universal availability, knowledge of, and access to prevention and treatment of diarrhoea (and other relevant diseases) (Nannan, et al., 2012).

1.3 Maternal and paediatric infrastructure and facilities must be improved, especially at regional and district health facilities.

1.4 The availability of, access to, and the quality of maternal, infant and child health services and care must be improved, especially in districts and communities with high levels of poverty, HIV infection, malnutrition, poor access to services and high child morbidity and mortality. This requires targeted spatial planning, funding, and implementation of maternal and paediatric services.

This in turn requires:

- The development of an effective primary health care system that prioritises district services and improved management and accountability for these services (Sanders, Bradshaw, & Ngongol, 2010) (Bamford, et al., 2011) (Department of Health, 2008) (Chopra, Daviaud, Pattinson, Fonn, & Levin, 2009);

- Innovative service delivery vehicles to overcome barriers preventing marginalised communities from accessing services, such as distance and user-fees (Mashiri, Maponya, Nkuna, Dube, & Chakwizia, 2008), notably a strengthened and accessible primary health care system which includes a strong community health care cadre of well qualified and motivated community health care workers (Department of Health, 2011 a) (Department of Health, April 2011) (Sanders, Reynolds, 2012) (Department of Health, 2012b).

- In addition to improving implementation of the current package of maternal, newborn and child health care, there are a number of policy gaps that also need to be filled to cover the full spectrum - from promotive to palliative services (Westwood, Shung-King, & Lake, 2010). One such gap is the lack of routine care during the postnatal period (South Africa Every Death Counts Working Group, 2008).

1.5 Leadership, management, monitoring, oversight, and accountability for the delivery of quality services must be improved in order to maximise the benefit of increased investments in human and other resources (Saloojee, 2010) (South Africa Every Death Counts Working Group, 2008) (Chopra, Daviaud, Pattinson, Fonn, & Levin, 2009) (Human Rights Watch, 2011).

1.6 Demand for maternal infant and child health services and knowledge of services and health promotive behaviour must be increased at a household and community level (Bamford, et al., 2011) (South Africa Every Death Counts Working Group, 2008) (Chopra, Daviaud, Pattinson, Fonn, & Levin, 2009). Closing the knowledge gap at a caregiver and community level is a critical step towards addressing the high maternal infant and child mortality rate in South Africa (Bamford, et al., 2011,) (South Africa Every Death Counts Working Group, 2008).

2. The social, economic and cultural determinants of child morbidity and mortality must be addressed by strengthening the broader social protection package for disadvantaged women, infants and children. For example, efforts must be made to strengthen gender equality, employment rates and laws for women,
increase education and literacy levels amongst women, improve access to basic services for vulnerable households and improve access to food and nutrition (Barros, et al, March 2012) (Ortiz, Daniles, & Solrun, 2012) (Sanders, Reynolds, & Lake, 2012).

3. Guidelines and advice on the design, implementation, monitoring and evaluation of policies and programme interventions to improve child survival

3.1 Guidelines for system-wide reform of the health-system to improve child survival

The UN’s Global Strategy for Women’s and Children’s Health provides guidance to policy makers on priority actions to enhance funding, strengthen policy and improve service delivery to ensure universal access to essential health services and proven, life-saving interventions. Targeted actions include support for country-led health plans, integrated delivery of health services and life-saving interventions so as to ensure access to essential health when and where women and children need it, stronger health systems with sufficient skilled workers, innovative approaches to financing, product development and the efficient delivery of health services, and improved monitoring and evaluation of services to ensure accountability of all actors for results (United Nations Secretary General, 2010).

Packages of Interventions for Family Planning, Safe Abortion Care, Maternal, Newborn and Child Health provides guidance on the necessary package of interventions and their essential elements that must be provided in under resourced settings so as to ensure a high quality continuum of care through pre-pregnancy, pregnancy, childbirth, postpartum, newborn care, and care of the child.

It also provides guidance on:

1. How the interventions can be used at a national and sub-national level to establish norms;
2. How they can be used to assist in implementing the principles of the Global Consensus; and
3. The resources necessary to implement the package (World Health Organisation, 2010).

Essential Interventions, Commodities and Guidelines for Reproductive, Maternal, Newborn and Child Health provides evidence based guidance to policy and programme makers on what is necessary for inclusion in an effective reproductive, maternal, newborn, and child health package of interventions across the continuum of care. It further provides guidance on how to scale up these interventions and identifies research gaps in the content of the core packages of interventions (World Health Organisation, 2011).

Saving Children 2009: Five Years of Data: A sixth survey of child healthcare in South Africa provides detailed guidance on steps to be taken to improve the management and administration of the health system and to improve clinical practice to improve child survival in South Africa. The following policy and programmatic developments to remedy the modifiable factors contributing to the high infant and child morbidity and mortality rates in South Africa are suggested:

- Develop a co-ordinated and intersectoral response to child poverty and ill health, with special emphasis on improving water supply and sanitation; improving food security; addressing barriers to accessing social grants; and providing supplementary feeding programmes.
- Develop a national plan for improving the quality of emergency care for critically ill children in South Africa.
- Define and implement a package of perinatal and post-natal care of newborn babies.
- Clarify the policy regarding infant feeding and communicate this clearly to all role players.
- Review and improve the paediatric section of the National TB Guidelines and ensure that healthcare workers have access to clear and practical guidance.
- Develop and implement a national guideline for improving the quality of care for children with severe sepsis and septic shock. The complex clinical challenges posed by the major comorbidities of malnutrition, HIV infection and tuberculosis (TB) should be considered when devising the strategy.
Child Mortality in South Africa: Using Existing Data, South African Health Review, Health System provides guidance to policy and programme developers for the improved implementation of the health programmes across all nine provinces. They emphasise the need to return to the basics, focusing on:

- The delivery of care across all levels of the health system, from the home and community, through the primary health care services, into the hospital;
- The provision of a spectrum of care that includes the mother, newborn, child and adolescent;
- A range of services that encompasses preventative, promotive and curative activities;
- The abolition of silos and the integration of services;
- The strengthening of existing, appropriate, cost effective interventions that are known to promote child survival; and
- The provision of effective support services along with improved supervision, monitoring and evaluation programmes and communication strategies.

In addition they point out that the District Health System must be supported and strengthened to ensure that every child, irrespective of where s/he lives, has equitable access to an appropriate level of care. To achieve this, the roles, responsibilities and relationships of all components within the system need to be better defined and, at each level, the focus must extend to cater for the entire population within the drainage area and not merely those individuals who are able to access the health service (McKerrow & Mulaudzi 2010).

Managing Programmes to Improve Child Health is a series of modules designed to give managers in the public health sector essential knowledge and skills to improve the management of child health interventions to reduce the under 5 mortality rate (World Health Organisation, 2009).

The Clinical Mentorship Manual for Integrated Care and Treatment Services has been developed by the national Department of Health to provide practical on-site support to enable the development of a workforce with the skills necessary to, inter alia, achieve the national goals of decreasing maternal and child mortality. It has been designed to support the development, implementation and evaluation of a clinical mentorship programme (Department of Health, January 2011).

3.2 Guidelines for strengthening newborn care

Improving Newborn Care in South Africa Lessons Learned from the Limpopo Initiative for Newborn Care (LINC) provides a set of practical tools for training and supporting newborn care at regional and district level and for the support of ongoing improvement and implementation of care through management and accreditation of programmes. The development of the tools has been based on the lessons learned from a newborn care programme developed and implemented in Limpopo regional and district facilities. It provides “a ready made and easily-adapted package to facilitate the replication of [the programme approach] in other areas.” (UNICEF South Africa, 2011).

Systematic scaling up of neonatal care in countries provides guidance to policy makers on the processes necessary to effectively scale up neonatal care. The authors stress that, in the absence of strong clinical services, innovations should start with family and community outreach services. They argue that existing opportunities within the system should be maximised through the integration of neonatal services into existing programmes. This dual approach will allow for strengthening both supply and demand, while building stronger health systems in the long term (Knippenberg, et al., for the Lancet Neonatal Survival Steering Team, 2005).

WHO and UNICEF’s Joint Statement: Home Visits for the Newborn Child: A Strategy to Improve Survival recommends home visits in the first week of life to improve newborn survival in high mortality settings. Evidence shows that this can prevent 30-60% of newborn deaths. The document provides guidance on the elements of the most effective home care programmes (WHO and UNICEF, 2009).
3.3 Guidelines for strengthening programmes to address primary causes of child mortality

New Recommendations for the Clinical Management of Diarrhoea and WHO and UNICEF’s Joint Statement: Clinical Management of Acute Diarrhoea provide prevention, treatment and management guidelines to reduce the number of deaths caused by diarrhoea. These include the provision of an oral rehydration solution (ORS) with lower glucose and salt amounts, the use of zinc in addition to rehydration therapy, and the prevention and treatment of diarrhoea in the home, breastfeeding, continued feeding and the selective use of antibiotics. In addition, they provide guidelines as to what policy makers and programme developers should do, and what health care providers and home-based carers should do to effectively implement the New Recommendations for the Clinical Management of Diarrhoea (WHO and UNICEF, 2006).

Implementing the New Recommendations on the Clinical Management of Diarrhoea: Guidelines for Policy Makers and Programme Managers is a manual for policy makers and programme managers. It provides them with the information to introduce or scale up the New Recommendations on the Clinical Management of Diarrhoea, with a focus on the new ORS formulation and zinc supplementation as part of the clinical management of diarrhoea (WHO and UNICEF, 2006a).

Diarrhoea: Why children are still dying and what can be done provides guidance on the necessary and urgent policy steps that ought to be taken to implement a 7 point comprehensive plan for diarrhoea control. It is a package of proven prevention and treatment measures, that if taken to scale, will impact on reducing child deaths. The treatment package includes ORS and zinc supplementation. The prevention package includes vaccinations, promotion of early and exclusive breastfeeding and vitamin supplementation, the promotion of handwashing with soap, improved water supply, and community-wide sanitation practices (WHO and UNICEF, 2009a).

The Global Action Plan for the Prevention and Control of Pneumonia (GAPP) provides guidance on interventions for protecting, preventing and treating pneumonia in infants and children by ensuring an environment which harbours a low risk of pneumonia, by preventing children from becoming ill, and through the treatment of ill children. It provides guidance on designing and implementing a “Complete Approach”, which is the governing framework for pneumonia control. It also provides guidance on the cost of implementation of interventions. Its target audience includes health ministries and it provides guidance on how these ministries can and should prioritise pneumonia interventions at both a policy and financial level, as well as how to integrate interventions into the health care system (WHO and UNICEF, 2009b).

Programmatic pathways to child survival: results of a multi-country evaluation of Integrated Management of Childhood Illness reviews the results of evaluations of the implementation of IMCI in developing countries. On the basis of identified blockages and barriers contributing to low survival rates, the document makes recommendations for improved and/or expanded IMCI delivery systems to overcome the IMCI blockages and improve the survival of infants and young children. Necessary improvements include a stronger community-based approach to delivery, better coverage and the need for country-level implementation guidelines based on local epidemiology (Bryce, Habicht, & Scherpbier, 2005).

3.4 Guidelines for the improvement of equitable coverage and access to quality child health care services

The comparative cost-effectiveness of an equity-focused approach to child survival, health, and nutrition: a modelling approach provides evidence, using a mathematical-modelling approach, that prioritising services for the poor and most marginalised is a more effective and cost-effective policy choice for avoiding child deaths and stunting than mainstream approaches. The study results provide evidentiary support for an equity-focused approach; that an equity focussed approach that prioritises the most deprive geographical areas is likely to reduce infant and child mortality more rapidly than mainstream policies (Carrera, et al., October 2012).
Reaching the Poor: Challenges for Child Health in the Western Pacific Region provides policy, programming, and resourcing guidance to address barriers to health for people living in rural areas and in poverty. The guidance applies to addressing barriers that are similar to those impeding access to reproductive, infant and child health for families in rural areas and living in poverty in South Africa, including distance, costs associated with access to health care, and lack of knowledge about services and programmes. It calls for, and provides input on how to prioritise underserviced areas in resource allocation, investments in Primary Health Care, addressing financial barriers through schemes such as health insurance, the prioritisation of conditions affecting poor children, targeting service delivery towards poor populations using innovations such as outreach strategies, the promotion of information, education and communication, and ensuring effective monitoring and evaluation systems (WHO: Western Pacific Region, 2008).

Infant Mortality in South Africa: Distribution, association and policy implications, 2007: an ecological spatial analysis maps the spatial distribution and prevalence of infant mortality in South Africa at a sub-district level to inform policy development. It maps high-risk clusters of infant mortality and explores the impact of a number of determinants of infant mortality. It then integrates determinant prevalence at sub-district level to estimate “high impact” factors in particular areas. Based on these findings, the paper makes policy recommendations as to where child survival interventions should focus geographically, and what specific interventions policy makers should prioritise to reduce the infant mortality rate in targeted administrative areas (Sartorius, Sartorius, Chirwa, & Fonn, 18 November 2011).

Rural-proofing the Primary Health Care Re-Engineering provides guidance on the necessary components of good Primary Health Care (PHC) as internationally prescribed, so as to improve access to quality health care for people living in rural areas. The authors provide detailed guidance as to the roles of the different components of PHC within a district setting, including district health hubs or community health centres, home carers and community health workers, and outreach services performed by nurses. The guide also provides direction on appropriate planning, resourcing, human resource planning, integration and monitoring and evaluation of PHC in rural settings (The Rural Health Advocacy Project (RHAP), 2011).

Increasing access to health workers in remote and rural areas through improved retentions: Global policy recommendations provides a comprehensive set of practical guidelines to aid countries in the development of policies and programmes to encourage health workers to live and work in rural areas. These include refining the ways students are selected and educated, as well as creating better working and living conditions (World Health Organisation, 2010b).

Achieving child survival goals: potential contribution of community health workers provides evidence in support of the positive impact community health care workers can make to improving access to services and equity in child survival. The report provides guidance on the development of appropriate community health care programmes, indicating the kinds of services that community health care workers can and should provide. The report however cautions that community health workers are not a “panacea for weak health systems and will need focussed tasks, adequate remuneration, training, supervision, and the active involvement of the communities in which they work” (Haines, et al., June 2007).

3.5 Guidelines for the increasing demand and the development of behaviour change strategies

Behaviour Change Communication Activities and Achievements: Lessons Learned, Best Practices and Promising Approaches documents the lessons learned in the course of developing and implementing various Behaviour Change Communication (BCC) initiatives to generate demand for family planning and reproductive health services among populations with low access to such services in India. The document provides insights and guidance to policymakers, programme developers and implementers on BCC actions necessary to achieving, inter alia, women and child health outcomes (USAID, 2012).
Behaviour Change Perspectives and Communication Guidelines on Six Child Survival Interventions provides guidelines for the development of communication strategies within child survival programmes, with a focus on effective communication strategies to address childcare practices contributing to child morbidity and mortality in developing countries. It draws on lessons learned about communication challenges in the child survival context. Based on these lessons, it seeks to support the public health community to move communication programmes beyond ‘demand creation’ to a systems view of behaviour change which sees communication integrated into the health system. It focuses on communication strategies for newborn/neonatal health, childhood immunization, control of acute respiratory infections, control of diarrhoeal diseases, malaria prevention and treatment, and nutrition (Seidel, 2005).

3.5 Guidelines for addressing the social determinants of child survival

The World Bank’s Environmental Health and Child Survival Epidemiology, Economics, Experiences provides policy makers with epidemiological, economic, and experiential evidence to incorporate environmental health (nutrition, water and sanitation) in the child survival agenda. It aims to aid governments to make choices about which broader social protection interventions are best suited to address their local circumstances so as to secure better child survival outcomes (World Bank, 2008).

The WHO’s Equity, Social Determinants and Public Health Programmes provides a series of essays on the social determinants of health, with a dedicated essay on Health and nutrition of children: equity and social determinants. The essay explores why child morbidity and mortality rates are much higher among children and their mothers that are subject to various forms of social and economic inequity, including poverty, gender, inequities in maternal education, and rural versus urban geography as well as the policy and programmatic interventions necessary to address the associated threats to child survival. The authors argue that lack of access to resources creates an environment which exposes poorer children to higher levels of disease-causing agents and once exposed, their lower resistance and lower access to prevention interventions increases their risk of acquiring a disease; once they are ill, their poorer access to health services, the poorer quality of the health services that they have access to means they are less likely to receive adequate treatment. The authors note that the evidence shows that whilst health systems can and have driven this inequity because of a “lack of proactive measures to address the health needs of the poor”, so too, appropriately and innovatively designed health systems can effectively promote equity in access to services and health outcomes for socially and economically disadvantaged communities. The essay provides guidance on the range of role players – both within and outside of the health sector – that must be part of the development of a holistic set of policies and interventions necessary to address the social determinants of child survival. The essay provides targeted guidance to the health sector on the interventions that ought to be taken in order to mainstream equity considerations in the child survival programme of action (Barros, Victor, Scherpibier, & Gwatkin, 2010).

The WHO’s Early child development: a powerful equalizer provides an analytical framework and guidance for spaces and opportunities for action premised on the recognition that there is fundamental link between children’s early environments and their characteristics and their survival and development. The book argues that Child Survival and Child Health agendas are “indivisible from Early Child development.” A child’s health and survival is critically determined by what they experience in their environment in the period starting at conception and continuing until the age of eight years. This document provides insight into how pregnant women’s, infant’s and children’s environments and their characteristics impact on survival and development. It further argues that the environments created by their parents, caregivers, families and communities are the most influential and provides guidance on how the state, NGOs, aid agencies and others can support these actors to create and ensure equitable access to “strong nurturant environments” (World Health Organization, 2007).
Antai’s *Social context, social position and child survival: Social Determinants of Child Health Inequities in Nigeria* documents the results of a study conducted in Nigeria into the link between high levels of child mortality (from similar poverty-linked causes as in South Africa such as malnutrition, respiratory infections, and diarrhoeal diseases) and the mother’s “social context, social stratification and social position.” The specific “objectives of the study were to assess the role of mothers’ religious affiliation, ethnicity, rural-urban migration and residence in disadvantaged urban neighbourhoods on under-five mortality in Nigeria.” The results of the nationally-representative probability sample study of 7864 households indicate that there are significant disparities in child survival among religious, ethnic, migrant groups and disadvantaged urban residents. The thesis offers a number of recommendations for the development of primary and secondary policies to address the resultant health divide. The recommendations linked to primary policies relate to the development of health policies, programmes and practices that are capable of “diminishing the effects of social stratification itself” And the implications for the development of responsive policies at a national, regional and community level. The secondary approach addresses the development of policies and programmes to equalize the social and economic status and which alleviate marginalization of socially and economically disadvantaged groups as an integral part of a broader contextual national response to child survival (Antai, 2010).

4. Case studies

4.1 Comprehensive health system revision to address child survival

Improvement of child survival in Mexico: The Diagonal Approach documents the dramatic improvement in child mortality rates in Mexico from 64 to 23 per 1000 live births in the last 25 years and the successful policies and practices behind this decline. Mexico has seen a rapid decline in diarrhoea mortality rates, a significant improvement in the nutritional status of its children, and the elimination of polio, diphtheria and measles. This case study identifies both health and non-health sector interventions as driving these changes, including a series of highly cost-effective interventions bridging clinics and homes, improved women’s education, social protection, water and sanitation, alongside investments in institutional and human resource strengthening (Sepulveda, Bustreo, Topia, Riviera, Lazano, & Olaiz, 2006).

Maternal and child health in Brazil: progress and challenges bears testimony to the impact that can be made on improving equity in child survival through a multi-faceted approach which addresses social and economic factors as well as health system and clinical factors. The U5MR has dropped by about 5% every year since 1990, underweight prevalence in children younger than 5 dropped from 5, 7% in 1990 to 1, 7% in 2006, and Brazil has attained universal coverage by skilled birth attendants. Innovations included improving broader social and economic equality and income distribution alongside geographically targeted strengthening of the health system to ensure that it reaches people living in poverty in remote areas. Interventions include the introduction of vertical health programmes (such as the promotion of breastfeeding, oral rehydration and immunization), the creation of a national tax-funded national health scheme, and many national and state-wide interventions to improve child health, child nutrition and women’s health (Victora, Aquino, Leal, Monteiro, Barios, & Szwarcwald, 2011).

How can child and maternal mortality be cut documents Malawi’s multi-faceted strengthened PHC systems approach which improved child survival significantly. Despite it having the least number of health workers per capita, a high HIV prevalence and many other disadvantages, Malawi has “bucked the trend” of reported rises in child mortality due to HIV and AIDS. It has put together an essential health package, including vaccines, treatment of childhood infections such as TB, acute respiratory infections and diarrhoeal diseases, the prevention of HIV and AIDS, and the prevention and treatment of malnutrition. Access to, and the quality of the services provided in terms of the package has been improved through the upgrading of health facilities, through trained armies of community health workers, through training of clinical assistants to perform emergency C-sections and increasing the number of nurses (Anderson, 2010).
4.2 Improved paediatric and maternal health care practices and health system management

The Limpopo Initiative for Newborn Care (LINCH) started as an initiative to improve newborn care in all hospitals in the Limpopo province through ongoing support, monitoring and training by a mobile support team. A neonatologist and a midwife visited each hospital in the province. During their visits they assessed the situation at each hospital according to a monitoring tool to determine the adequacy of facilities, equipment, support services, protocols and policies, training and services provided to newborns. Subsequent visits saw the provision of support and monitoring of improvements. The project resulted in significant changes in most hospitals with regards to attitudes to newborn care, the prioritisation of newborn care, improved in-hospital practices and improved suitability of equipment to treat newborns (Mashao, Malan, Greenfield, Mzolo, & Robertson, 2006). Further information about this initiative is provided in the preceding guide Improving Newborn Care in South Africa Lessons Learned from the Limpopo Initiative for Newborn Care (LINCH) (UNICEF South Africa, 2011).

Rural hospital beats the odds in South Africa documents a case study illustrating how strong management and a focus on effective implementation of child survival strategies at Zithulele Hospital in the Eastern Cape improved the maternal and infant mortality rates. Zithulele hospital was transformed into a best practice through strong leadership which attracted and staffed the hospital with a multi-skilled team of doctors, physiotherapists, occupational therapists, pharmacists, radiographer, dietician, dentist and social worker (compared to the initial staff contingent of 3 doctors doing compulsory community service and a radiographer), inclusive management practices, and the modification of clinical practices. This resulted in deliveries at the hospital increasing by 54% in 3 years, the perinatal mortality rate dropping from 42 to 24.6 per 1000 live births and paediatric bed availability improved from 320 to 503 (Balela, 2009).

Shaping Policy for Maternal and Newborn Health: A Compendium of Case Studies documents, inter alia, the CaliRed Accreditation Program which is a national programme to improve the quality of maternal and neonatal care services using a performance and quality improvement approach. It provides a framework and tools to implement, measure and evaluate improvements at facilities. If a facility achieves 85% of the qualifying criteria, the facility is accredited as a "quality site" for maternal and neonatal care (Sandra Crump ed., 2003).

4.3 Improving equitable coverage, and access to health care for children in marginalised communities and households

Equity in maternal, newborn, and child health interventions in Countdown to 2015: a retrospective review of survey data from 54 countries provides an overview of maternal, newborn and child health interventions that enjoy the least equitable access, especially among households living in poorer quintiles. The authors found that skilled birth attendant coverage enjoyed the least equitable coverage, followed by four or more antenatal visits, with breastfeeding being the most equitably accessed intervention. The review identifies service delivery models and other promising approaches most likely to improve access to services amongst marginalised households. These included community versus facility-based service provision, the elimination of costs, the development and deployment of services in areas of most need, task shifting, the reduction of financial barriers to access to services, and conditional cash transfers (Barros, et al., March 2012).

Methodology for optimising location of new primary health care facilities in rural communities: a case study on KwaZulu-Natal, South Africa documents a case study for optimising the location of new primary health care facilities in rural communities in the Hlabisa sub-district in the Umkhangakude district in KwaZulu-Natal. The study tested a methodology to "optimally site new primary health care facilities so as to achieve the maximum population level increase in accessibility to care." Using a geographical mapping system, a map was developed to site a clinic in the highest contiguous area of high person impedance. The result: A population-level increase in accessibility that would be achieved by constructing the clinic in the targeted site of 3.6 times higher than the accessibility achieved by the construction of the most recently built clinic in the sub-district (Tanser, 2006).
Thematic Report: Global Campaign for the Health Millennium Development Goals 2011: Innovating for Every Woman, documents the ChildColalife programme in Zambia. It is an innovative partnership using commercial supply chains reaching into the remotest of rural areas in Zambia to ensure more effective distribution of essential life-saving anti-diarrhoea kits for children under the age of 5. Working together, SABMiller, UNICEF, a pharmaceutical company and a mobile technology company worked collaboratively to ensure that “An affordable anti-diarrhoea kit, piggy-backing on the secondary Coca-Cola supply chain reached “the last mile” in underserved rural areas” (Global Campaign for the Health Millennium Development Goals, 2011).

Thematic Report: Global Campaign for the Health Millennium Development Goals 2011: Innovating for Every Woman, Every Child documents the Grameen Intel project in Bangladesh which has made use of a combination of community-based health workers and mobile communication technology to observe and assess pregnant women in remote rural locations to identify and refer those at high risk to a local clinic or specialist health care provider. Through the internet, using a user-friendly web interface, community health care workers send information about pregnant women, based on the answers provided to a number of simple questions, to rural clinics staffed by a medical team. Doctors provide immediate feedback and high risk pregnancies are referred to the formal health system for treatment (Global Campaign for the Health Millennium Development Goals, 2011).

4.4 Increasing service access and demand and child outcomes through modification of parental and health community behaviour

Best Practices in Scaling up Case Study: Egypt, Control of Diarrhoeal Diseases Goes National documents Egypt's National Control of Diarrhoeal Disease Project which was implemented with the objective of raising the visibility of oral rehydration therapy (ORT) and its use nationwide. The project focussed on designing and implementing an effective national communication strategy to communicate key ORT messages to the population of 41 million and the health community with the objective of bringing about massive changes on caretaker knowledge and behaviour. The project implemented a series of interventions, including sectoral and clinical coordination and triage management in facilities, the production and distribution of ORS, mass media campaigns, training and research and evaluation. This resulted in a dramatic reduction in the death of children under 5 due to diarrhoeal disease from 45% to 28%, a drop in the overall infant and child mortality rates, a 100% increase in caretaker knowledge of the dangers of diarrhoea, knowledge of the signs of dehydration and knowledge of the importance of ORS (Klein, 1995).

Measuring the effects of behaviour change interventions in Nepal with population-based survey results document the Sumata Initiative which was initiated in Nepal as part of a campaign to improve demand for and access to safe motherhood services. It was an integrated information, education, communication/behaviour change intervention to promote the adoption of appropriate maternal and newborn health behaviour and increase access to, and use of safe motherhood services. The strategy focussed on safe motherhood as a social, not just a medical issue and used standardized messages across multiple media and platforms. The target audience included women, husbands, community leaders and community based health workers. It succeeded in reaching 50% of its target population, increased awareness levels of the danger signs of vaginal bleeding, the danger signs in newborns, and knowledge of welfare services for women and newborns (JHPIEGO, 2004).

4.5 Addressing the social determinants of child survival

The role of social protection in achieving equitable reduction of child mortality documents evidence from a number of countries showing the role of social protection policies and programmes in reducing the child mortality by addressing the financial and other barriers preventing households from accessing food and other social services. Social protection policies included policies to support livelihoods and reduce risk and support human development such as social transfers (in cash / kind), public work schemes, livelihood measures, and measures to promote access to food and social insurance programmes. The report notes that the association
between social protection and reduced child mortality depends on the type and coverage of the programmes in question. Drawing on case studies in Brazil, Mexico, South Africa, Bolivia and Indonesia, amongst others, the authors show the positive links between the relevant programmes and child survival and distil out the common features essential to any social protection programme in order to realise the potential link between social protection programmes and improved child survival (Hypher, 2011).

**India’s Janani Suraksha Yojana scheme** recognised the need for income support to pregnant women to enable them to attend antenatal care and in-facility births. The Government of India successfully launched a conditional cash transfer scheme to incentivise pregnant women’s use of antenatal and in-facility health facilities. The programme resulted in improved use of these facilities and an associated reduction in perinatal and neonatal deaths (Lim, Dandona, Hoisington, James, Hogan, & Gakidou, 2010).

4. **References**


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