UNIVERSITY OF CAPE TOWN

DEPARTMENT OF PAEDIATRICS AND CHILD HEALTH

RED CROSS WAR MEMORIAL CHILDREN'S HOSPITAL
KLIPFONTEIN ROAD
RONDEBOSCH
7700

TEL: +27 21 658 5319/5324
FAX: +27 21 689 1287

The National Health Insurance White Paper & Child Health Comment from the Department of Paediatrics and Child Health, University of Cape Town

Endorsed by the Children's Institute, University of Cape Town, Child Health Priorities Committee, People's Health Movement, the South African Civil Society Coalition for Women, Adolescent and Child Health, and the South African Paediatric Association.

We commend government's commitment to universal health coverage and welcome the opportunity to give comment on this important policy document as there are a number of significant issues that need to be addressed to ensure that National Health Insurance (NHI) addresses children's special needs and vulnerabilities.

In particular, we commend the positive focus on maternal and child health in the strengthening primary health care (PHC) and it is important that this focus is reinforced and sustained. Two concerns, before the detailed comments, are outlined are:

1. Good child health is fundamentally dependent on preventative measures and in particular a number of social determinants of health, yet it is unclear within the NHI proposals where and how these social determinants will be addressed.
2. The NHI has introduced a number of interventions that have the potential to significantly improve child health – and the District Clinical Specialist Teams (DCSTs), in particular, are instrumental in facilitating good clinical governance for maternal and child health. Yet, we are mindful that the DCSTs in a number of sites are relatively weak and not functioning optimally. We therefore strongly appeal to the Ministry of Health to ensure that current initiatives - including the District Clinical Specialist, School Health and Ward-Based Outreach Teams – are adequately strengthened, before introducing any more new initiatives that may compromise our capacity for child health through spreading resources too thinly.

Motivation: The need to respond to children in context

The Constitution makes special provision for children in Section 28 that outlines their rights to "care" and "protection", and recognises that "a child's best interests are of paramount importance in any matter concerning a child"[1] – and this general principle should inform decisions about individual children and the design and delivery of services for groups of children.

Yet despite these entitlements, children remain disproportionately affected by **poverty** and poor access to health care services, and many experience multiple deprivations that accumulate over time creating long-lasting developmental setbacks,[2] with children in former 'homeland' areas and informal settlements continuing to experience the highest levels of deprivation.

One in five children live in overcrowded households, 1 in 3 are without water on site, 1 in 4 are without basic sanitation,[3] - so it is therefore unsurprising that diarrhoea and lower respiratory infections account for 21% and 18% respectively of under-five mortality.

More than a quarter of children 0 – 3 years are stunted[4] A further fifteen percent are overweight and 6% obese – which will increase the burden of non-communicable disease in the future. In addition, violence against children is widespread with nearly half of child homicides taking place in the context of child abuse and neglect – concentrated in children under-five.[5]

It is therefore critical that the NHI responds to these critical social determinants of child health that not only drive under-five mortality, but also compromise children's **optimal development**.

An **intersectoral approach** is therefore essential to address the complex interplay of multiple risk factors – and the Health sector including the Department of Health has a pivotal role in lobbying for improvements in children's access to services and living conditions across the life course.

This includes equitable **access to health care services**, given that nearly a quarter of children still travel more than 30 minutes to reach a health facility,[6] and transport costs and safety concerns lead to life-threatening delays in accessing treatment. Access to more sophisticated health care for children is hugely inequitable. While a lack of "positive and caring attitudes"[7] undermines uptake of both adolescent health services[8] and antenatal care[9].

It is particular pressing to address these barriers to health care, given growing evidence that **early intervention** is not only critical, but also the most **cost-effective** strategy in promoting children's optimal development and breaking the intergenerational cycle of poverty,[10] and will in turn impact significantly on the adult burden of disease. These early investments in childhood and adolescence should include not only the promotional aspects of early childhood development (as prioritized in the "first 1000 days" programmes), but also the early identification and support for those with any form of developmental disability, and programmes to promote mental health and healthy, non-violent relationships in adolescence - which if left unattended may have significant impact on our economy and social capital as a country.

In other words, childhood is a time of both risk and opportunity. It is therefore vital to make sure that **children count** and that their health and care needs are *explicitly* factored into and given priority within National Health Insurance, and that the NHI explicitly addresses these broader social determinants in order to ensure children's survival, health and optimal development.

Responses to the White Paper

Key principles

1. Given the stark inequalities impacting on children's health, we welcome the adoption of a rights-based approach and the emphasis on universal health coverage, **equity**, social solidarity and – in particular the abolition of out-of-pocket expenses and introduction of financial risk protection for the poor which offer promise in reducing the financial barriers and burden, levelling the playing fields and promoting more equitable access to health care.

2. Yet we query the failure to include any reference to:

    a. Section 28 of the Bill of Rights which specifies **children's right to basic health care services.** Unlike other socio-economic rights, children's rights to basic health care services is *not subject to progressive realisation and must therefore be implemented without delay.*

    b. Article 24(2) of the UN Convention on the Rights of the Child. This was ratified in 1995 as one of the first acts of the post-apartheid era and requires the State to prioritise child health within a broader package of care.

    These omissions suggest that children's best interests have *not* been given due consideration in the conceptualization of NHI and that their health care needs are unlikely to be given the priority required by the Constitution.

Setting standards

3. The **National Standards for Health Care Facilities** offer a potentially powerful mechanism for driving quality improvement. However children's specific health care needs are rarely addressed beyond the confines of paediatric and neonatal wards. There is a need to specify paediatric equipment, staff and child-friendly standards in other areas of the health care system such as primary health care sites, emergency services and trauma wards.[11]

4. Similarly, we welcome the vision of an **ideal clinic** which "opens on time", "is very clean", and "treats people with dignity" yet there is little focus on children and adolescent's specific needs and what is needed to develop child-, youth- and family-friendly services at clinics and community health centres despite this being the primary platform for the provision of PHC services. [See new Lancet adolescent commission.]

5. It is therefore vital that the Norms and Standards for Health Care Establishments, Ideal Clinics and other guidelines such as the proposed "comprehensive package of health services" and "essential drug list" explicitly factor in children's needs and articulate with, and give effect to, the proposed "essential package of care for children and adolescents".

6. In addition, the **Office of Health Standards Compliance** needs to put mechanisms in place to ensure that the views of children, adolescents and their caregivers are explicitly included in measures of patient satisfaction, and used to drive quality improvement plans and the provision of child- and youth-friendly services – in line with the NHI's commitment to patient-centred care.

Towards a package of care

7. Given the need for early intervention, we welcome the proposed **continuum of care** rooted in community-based services and primary health care services that extends beyond curative and specialised care to include rehabilitative and palliative care. In particular, we welcome the inclusion of **rehabilitative care** and would encourage NDoH to ensure that the proposed package of rehabilitative services extends to victims of child abuse and neglect who have an express right to "physical and psychological recovery and reintegration that fosters health, self-respect and dignity" (article 39, UNCRC).

8. We also welcome the proposed **comprehensive package of care** and the explicit inclusion of **mental health services** – a critical area of concern in child and adolescent health, given its intersection with poverty, violence and substance abuse, and the impact of maternal depression and substance abuse on the care of young children. However we are aware of the very limited access to child & adolescent mental health services and expertise, and therefore urge the minister to expand the role of the district teams to include the mental health needs of children and adolescents.

The re-engineering of primary health care

9. We welcome the **re-engineering of primary health care** and the introduction of the Ward-based Outreach Teams, Integrated School Health Programme and District Clinical Specialist Teams – all of which have the potential to improve the reach and quality of maternal and child health services when linked to an Essential Package of Care that supports children's health and optimal development from conception to adolescence.

10. We endorse the introduction of the Ward-based Outreach Teams and the central and expanding role of **Community Health Workers** (CHWs) within the NHI strategy. CHWs have the potential to extend the reach of health care services to vulnerable children and families, and significantly improve child health outcomes but this depends on the quality and duration of their training, supervision and support, and a sufficiently high ratio of CHWs to households to enable regular home visits and follow up care[12]. We therefore note with concern the relatively low CHW: household ratio proposed by NHI, and the way in which their role has been limited to identifying and referring those in need of preventative, curative or rehabilitative services to the relevant PHC facility, despite evidence that CHWs have proven effective in reducing child mortality through, for example, early recognition and treatment of pneumonia with antibiotics[13]. It is therefore essential to expand both the numbers of CHWs and their scope of practice to ensure meaningful gains for child health – and enhance their conditions of service and provide adequate mentoring and support. We also note that the therapeutic role of CHWs is critical to ensure early access to care & to reduce morbidity and mortality. This includes the provision of Vitamin A, deworming tablets and Oral Rehydration Solution as outlined in the Road to Health Book. Yet current Medicines Control Council and Pharmacy Council regulations effectively preclude CHWs in rural and peri-urban areas from dispensing these simple preventative medicines. It is therefore vital to introduce appropriate reforms to the current regulations in order to support a broader therapeutic role for CHWs.

11. It is good to see a strong emphasis on school health and efforts to identify and address barriers to learning through **Integrated School Health Programme.** The stated intentions of the ISHP have the potential to address the wide range of health needs of school-aged children, including

specific physical barriers to learning, identifying and supporting children with chronic health conditions, including those with HIV, mental health and neurodevelopmental disabilities; and the sexual and reproductive health of adolescents.

However, the suboptimal functioning of the ISHP services currently limit the benefits to a few select conditions and neglect the large numbers of children with chronic health conditions and only address adolescent health needs in limited ways. Absent or limited referral services minimise the value of screening. The huge potential of the ISHP remains untapped and as this is regarded as one of the priority streams of PHC re-engineering, more attention is required to get the ISHP up to an acceptable level of performance.

Given the paucity of school health nurses, we would like to see specific measures that enable community-based workers to work together with school bodies (teachers, parents and learners) and other sectors to improve the school environment – especially in relation to water, sanitation and food security. In addition, it is vital that partnerships with the departments of Basic Education and Social Development are strengthened as envisaged through the proposed Care and Support for Teaching and Learning (CSTL) – especially in relation to children with disabilities and long-term health conditions.

12. We welcome the **contracting in of private health providers** to address staff shortages in the public health system – in particular plans to contract in nutritionists, dental therapists, audiologists, speech and hearing therapists, psychologists, optometrists and physiotherapists and occupational therapists with the expressed intention of addressing early childhood development and physical barriers to learning. These efforts will ensure more equitable access to screening and **rehabilitation services** and should improve developmental and education outcomes**.** In addition it is important to make assistive devices such as wheelchairs and hearing aids more easily accessible at primary health care level.

    However, if private GPs are going to play a significant role in public health services, they will need to be re-orientated to child health – and in particular the prevention, promotion and rehabilitation aspects.

13. We welcome the introduction of the **District Clinical Specialist Teams** and the strong emphasis on maternal and child health which should strengthen leadership for maternal and child health at district level; enhance quality of care, and drive **intersectoral collaboration** in response to the local burden of disease. But we note that there is little reference to how the teams will engage with other departments to support intersectoral initiatives such as early childhood development, care and support for teaching and learning and child protection, nor any clarification of the respective roles and responsibilities of the DCSTS in relation to the District Health Management Offices. We also welcome the appointments of provincial paediatricians who can provide leadership, mentoring, support and oversight at provincial level. Advocacy is therefore central in ensuring that health and child's best interests are explicitly considered in all policies and administrative actions, and this advocacy function should be included in the training, job descriptions and terms of reference for the DCSTs.

    In addition we note with concern that fewer than half of DCSTs have appointed a paediatrician and are therefore reliant on family physicians who, in most cases, will not have sufficient training in paediatrics to provide leadership for child health at district level, and therefore call on the Department of Health to ensure that all DCSTs have their full staff complement.

Management, leadership and accountability

14. We support efforts to strengthen management, leadership and accountability throughout the health care system – and the renewed commitment to establishing functioning **clinic committees**. But we note the lack of clarity around the responsibilities of the **District Health Management Offices** and recommend that measures are put in place to ensure that the DCSTs, and child health interests in particular, are adequately represented on these structures – to ensure effective coordination with non-personal health services such as environmental health. Similarly, the White Paper needs to be much clearer on the role of clinic committees in general, and particularly in relation to child and adolescent health, as these committees provide a potentially powerful mechanism to not only enhance community mobilisation but also hold clinics accountable and responsive to local needs.

15. Similarly, we welcome the proposed **National Health Commission** and the intention to promote intersectoral collaboration to address the broader social determinants of health – and it is vital that child health is adequately represented on this body. It is also vital that similar structures are put in place to ensure effective **collaboration** and an integrated/transversal response to the complex drivers of childhood illness and injury at provincial and district level.

16. Similarly it is important to ensure adequate paediatric representation on the **NHI Benefits Advisory Committee** as the current prescribed minimum benefits are very adult-focused and need to be modified for paediatrics.

17. We welcome the certification and **accreditation of providers** against indicators of clinical care, health outcomes and clinical governance, but are concerned about the capacity of clinics and hospitals serving remote rural areas to meet these quality standards; this could aggravate the already wide rural-urban divide. And we therefore request NDOH to put mechanisms in place to support the poorly performing public health facilities to ensure that these meet quality standards and accreditation requirements for NHI providers.

Hospital services

18. We welcome plans to strengthen the **management and governance** of public hospitals. While centralised control has advantages in terms of equitable distribution resources and increased bargaining power, we wish to emphasise that there are differences in populations and between hospitals that would make a degree of autonomy at local level an important consideration, in order for healthcare services to be tailored more appropriately and immediately to the specific populations we serve. Some degree of autonomy will also allow for more responsive services at the local level.

19. The inter-provincial responsibility of **tertiary hospitals** is welcomed as many children in the predominantly rural provinces are currently do not have adequate access to tertiary services, especially with respect to paediatric surgery and its sub-disciplines, and child and adolescent mental health. The high incidence of congenital anomalies and complex mental health and neurodevelopmental disorders makes it especially pertinent for children that equity of access to tertiary care is improved through NHI.

20. The proposal for two specialists per discipline at **regional hospitals** is a step backwards from current norms and needs. In order to create a population focused culture, rather than an

individual focus, it is critical that facility-based doctors accept responsibility for the entire population dependent on their institution and not merely those patients able to access their institution. For specialists this includes support to all health facilities in the catchment area of the regional/tertiary institution. Two specialists per facility will struggle to do this especially when one considers that they are responsible for both paediatric and neonatal services. We therefore propose a population-based norm starting with 1 paediatrician : 25 - 40,000 children (European norms are close to 1 : 1,200) with a minimum of three specialists per facility to cater for onsite services, off site support and to ensure continuity of care during various absences.

Human resources

21. We welcome the **Human Resources for Health Strategy** and efforts to improve the quantity, quality and equitable distribution of health professionals - including incentives to attract health professionals to work in rural areas, so that the already wide rural-urban disparity in health human resources is not increased.

22. There are also very few paediatric-trained nurses outside tertiary centres, yet the majority of children and adolescents interface with the health system at primary level. It is therefore vital that all PHC nurses and CPNs working at primary level have additional training in child health and child and adolescent mental health. Currently, only 2% of registered nurses in Southern Africa are trained paediatric nurses.[14] While a re-curriculated undergraduate programme is envisaged and in the pipeline, new registered nurses entering the profession do not currently have the knowledge or skills to care for sick children. Of the children that die in South Africa, half die in hospital of conditions that are considered treatable, and half of these die in the first 24 hours after admission.[15] Being cared for by a trained paediatric nurse would make a significant difference to these numbers, and help ensure survival for the sickest children.[16]

23. Strengthening the training of paediatric nurses in South Africa is not simply a matter of increasing the numbers trained but also requires consideration of what nurses need to know and how they acquire the clinical and contextual knowledge and skills required to work efficiently with children, their families and communities. This requires that curricula are fully aligned with health service needs. The South African National Qualifications Sub-framework in 2013[17] requires that all post-basic programmes be realigned and offered at NQF level 8, a National policy shift that the White Paper does not speak to.

    Another aspect of training and service provision that the White Paper is silent on is the training and employment of the Advanced Paediatric Nurses described in the DCST policies. While austerity measures demand budget cuts, the strategy of employing less trained and junior categories of staff (auxiliary nurses and community health workers) without the support of a clear scaffolding of clinically trained and experienced registered nurses, has the potential to undermine recent gains in child health. In addition there is global evidence linking more trained nursing staff with improved health outcomes and cost saving.

24. Given the renewed focus on primary health care, prevention and health systems strengthening – there is also a need for **pre- and in-service education and training** that will marry the current focus on clinical care with the broader competencies needed to promote child health at district level – including a strong focus on public health, health systems, quality improvement, intersectoral collaboration, management and leadership.

Budgets, affordability and efficiency

25. In addition, we hope that the introduction of the NHI system will ensure more effective tracking of expenditure so that actual spending and **budgets for child health** can be disaggregated in line with the recommendation of the UN Committee on the Rights of the Child (General Comment 15 on the Right to Health) to ensure that children receive their fair share of resources.

26. We also note the potential tensions between the principle of "health care as a public good" and the principles of affordability and efficiency – which raise questions around how the NHI intends to measure "**value for money**" – and if this is intended to serve the interests of patients or the State, given that patients are already carrying the costs of current inefficiencies such as the burden of transport costs and waiting times.

27. While we welcome efforts to prevent over-servicing and plans to reimburse providers based on performance and outcomes, we question how this will be measured – through health outcomes or numbers of patients seen? We are also concerned that these systems which may lead to a focus on rapid turnover. Yet care in paediatrics and child health is more complex and time consuming. It is possible that appropriate care for children may not enable healthcare providers to claim the same re-imbursement as in other disciplines (e.g. surgery), which will lead to paediatrics becoming a less desirable speciality for young doctors and may lead to shortages in this field in the long term.

Transport for children and caregivers

28. We welcome the measures that have been put in place to eliminate out-of-pocket expenses and user fees, but note that long distances, high transport costs and safety concerns often lead to life-threatening delays in children accessing treatment and follow-up care and that this financial burden is particularly heavy for caregivers of children with complex, chronic conditions. We therefore call on the Department to put measures in place through the NHI to fund the costs of transport for children and their caregivers, given that children should not travel unaccompanied.

Neonates and children on the move

29. While we recognise the benefits of the Health Patient Registration System and its potential to track patients and improve the quality and continuity of care, we are concerned about how the health care needs of **neonates** will be addressed by the new system. The system also needs to accommodate **child mobility** and fluid household forms, as many children move repeatedly between households and across district and provincial boundaries as families juggle their needs for child care, education and employment.

Non-discrimination and the need to give priority to "vulnerable groups"

30. We welcome NHI's commitment to equity and its plans to extend **population coverage** and increase access to health services, giving priority to "vulnerable groups" – and this must be monitored and advocated for during the implementation of NHI. Yet, we note with concern the provisions that explicitly discriminate against foreign children and the failure to consider the needs of other potentially **vulnerable children**, such as adolescents, children with disabilities, chronic and rare conditions, children who have experienced child abuse and neglect, and children living in rural areas.

31. **Children with chronic and rare conditions**

It is important to make specific provision for **children with chronic conditions** - either congenital or acquired – as these children need significant inter-sectoral and multidisciplinary input throughout their lives. This should ideally emphasise care for children in the community rather than long-term hospitalisation – where parents are provided with the skills, knowledge and equipment to care for children at home – with support and guidance from the appropriate specialists (e.g. neurology, pulmonology). Intermediate care facilities are also essential to provide the necessary care in the community for children who do not have family to be cared for appropriately. In addition, we would like to know what kind of mechanisms will be put in place within NHI to safeguard the treatment of children with rare conditions, such as Gaucher's disease, which are often expensive to manage. We argue that children with severe and enduring mental health and neurodevelopmental disorders such as autism should be provided for under the same principles as those with chronic conditions.

32. **Children with disabilities**

It is good to see a stronger emphasis on screening for speech, hearing and visual impairment within the Integrated School Health Programme, and commitment to contract private providers to address the shortage of allied health professionals within the public health system. Yet it is not clear what kind of measures will be put in place to screen, prevent and treat developmental delays prior to formal schooling, and to what extent the NHI plans to address intellectual disabilities and mental illness in children.

33. **Victims of child abuse and neglect**

Given the exceptionally high levels of violence against women and children, we note with concern that there is no explicit reference to **gender-based violence and child-abuse and neglect** within the proposed "comprehensive package of care". This should include examination, treatment and counselling and mandatory reporting to social services and the criminal justice system, as well as effective coordination and collaboration with Departments of Social Development and Basic Education to strengthen the provision of prevention and early intervention services, in additional to rehabilitation services.

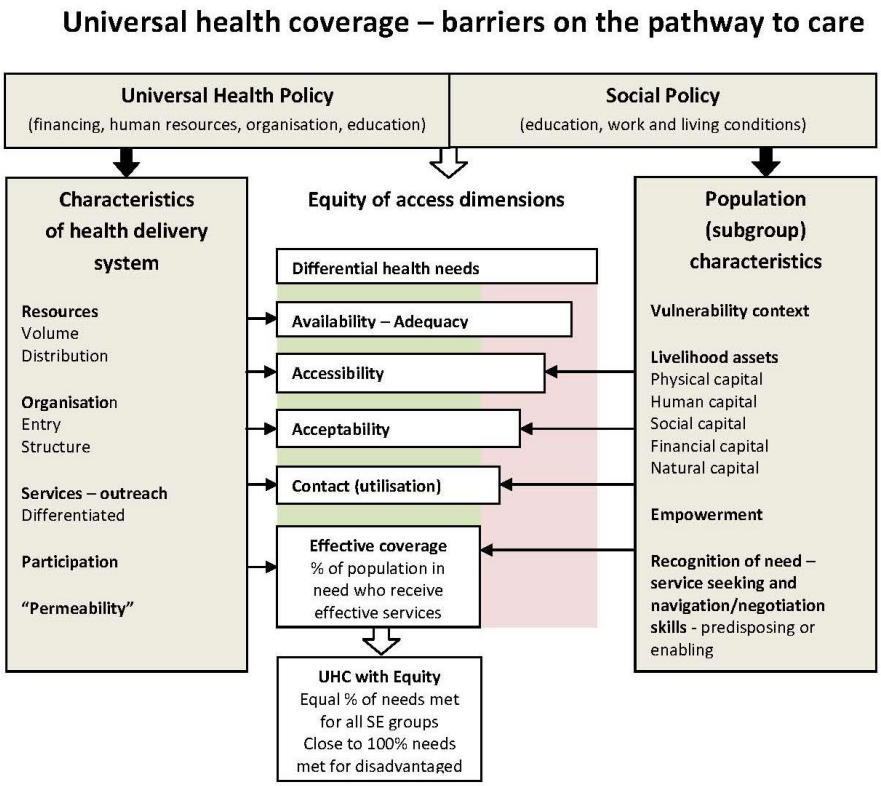
34. Adolescents seeking SRH

Young people complain of numerous barriers to health care including the negative attitudes of healthcare workers, a lack of privacy and confidentiality, and clinics that are not open after school hours,[18] all of which impact on the uptake of adolescent health services[19] and antenatal care[20]. It is therefore vital to strengthen efforts to provide youth- and adolescent-friendly services and to monitor services to ensure that these services are appropriate and acceptable.

35. Foreign children

The NHI's proposes a special contingency fund to provide 'basic health coverage" for refugees, while asylum seekers are only entitled to "emergency health care services" and treatment of "notifiable conditions", and other foreign nationals will be required to have their own health insurance or cover costs of care. These **discriminatory measures** raise concerns around equitable access for foreign children - especially refugees, asylum seekers and unaccompanied minors – who are particularly vulnerable. And these provisions violate section 6(2) (c) and (d) of the Children's Act which provides that: *"all* proceedings, actions or decisions in a matter concerning a child must – (c) treat the child fairly and equitably; and (d) protect the child from unfair discrimination on any ground."

In conclusion



Adapted from: Frenz P & Vega J (2010) *Universal health coverage with equity: what we know, don't know and need to know.* Background paper for the global symposium on health systems research, 16-19 November 2010, Montreux, Switzerland.

Frenz and Vega provide a powerful framework for conceptualising universal health coverage that recognises how the design and delivery of health care services need to create an enabling environment that is sensitive and responsive to the vulnerability contexts of particular sub-groups of the population such as pregnant teenagers or poor, rural children. Their model stresses multiple barriers on the pathway to care and the not only to make health care services available and accessible (by addressing physical and financial barriers), but also to ensure that services are acceptable (e.g. culture, language, gender and age-appropriate) and 'permeable' (i.e. welcoming) so that patients are able to navigate the health care system and negotiate access to care.

It is therefore essential that the NHI's commitment to UHC extends beyond financing, resourcing and restructuring of health to provide patient-centred care that enables children and adolescents and their caregivers to become active partners in health.

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