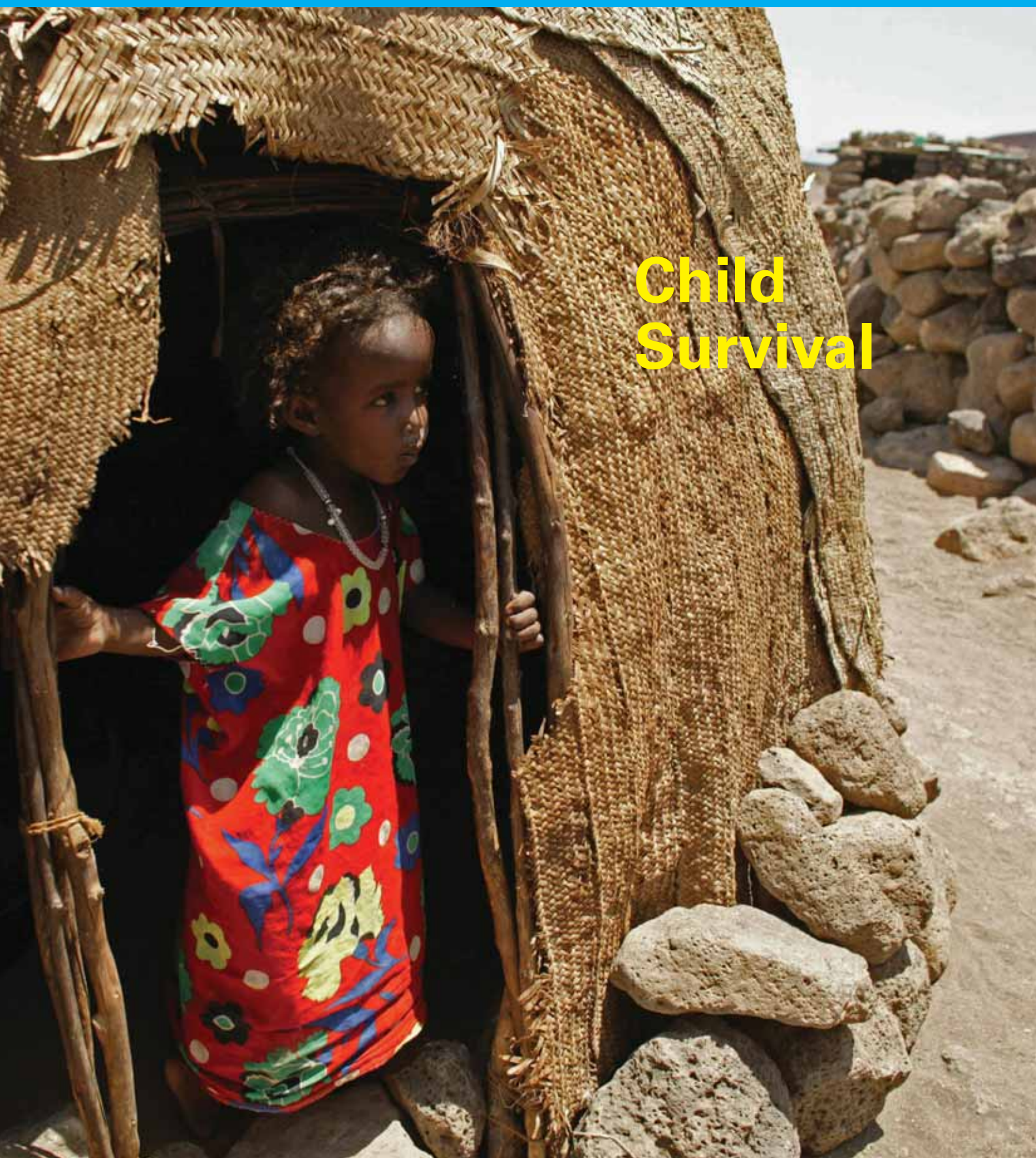


THE STATE OF AFRICA'S CHILDREN 2008: OVERVIEW



Child Survival

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'Child survival'

The world has made progress in child survival during recent decades, reducing global under-five deaths to less than 10 million in 2006 for the first time on record. But as child deaths overall have fallen, one continent – Africa* – has seen rising numbers since the 1970s. Sub-Saharan Africa now accounts for half of all under-five deaths but only has 22 per cent of the world's births. This imbalance is made all the more disturbing by the stagnation or reversals in child survival experienced by several countries in the region since 1990. Extreme poverty, conflict, AIDS, food insecurity and natural disasters, together with low health-system capacity, limited resources and governance issues, are constraints on child and maternal survival and health that require urgent and concerted action. Unless progress is rapidly accelerated, the numbers of African children who fail to reach their fifth birthday will rise well beyond the nearly 5 million who died in 2006.

To underscore the pressing need to position Africa and its children at the heart of the international development agenda, UNICEF is publishing the inaugural edition of *The State of Africa's Children*. This volume and other forthcoming regional editions complement *The State of the World's Children 2008*, sharpening from a worldwide to a regional perspective the global report's focus on trends in child survival and health, and outlining possible solutions – by means of programmes, policies and partnerships – to accelerate progress.

The report begins by examining the state of child survival and progress towards the health-related Millennium Development Goals in each of the continent's five main subregions: Central, Eastern, North, Southern and West Africa. Although much of the report concentrates on Africa south of the Sahara, cases and analysis from North Africa are examined as well.

The report outlines five broad priorities to accelerate progress and then seeks to examine each of these issues in depth, illustrating them

with side panels that provide examples from the African experience. The priorities discussed chapter by chapter are:

- Focus on the countries and communities in Africa where the burden of child mortality is highest.
- Apply the lessons learned and evidence collated over the past century.
- Provide a continuum of care for mothers, newborns and children by packaging interventions for delivery at key points during their life cycle.
- Strengthen community partnerships and health systems, with a strong emphasis on results.
- Advance the joint international agency framework for child and maternal survival and develop national health systems for outcomes.

FOCUS ON THE COMMUNITIES AND COUNTRIES WHERE CHILD MORTALITY IS HIGHEST

The African continent is divided by the Sahara, both in terms of geography and child survival. While all five countries of North Africa (Algeria, Egypt, the Libyan Arab Jamahiriya, Morocco and Tunisia) are on track to meet Millennium Development Goal 4, only a handful of the 48 countries lying south of the Sahara are in the same situation. The facts are stark and clear:

- **Sub-Saharan Africa** only managed to reduce its under-five mortality by 14 per cent between 1990 and 2006, and will need to raise its annual rate of reduction to an unprecedented 10.5 per cent for the 2007–2015 period to meet MDG 4.
- It is the only region to have experienced rising numbers of child deaths during recent decades.
- Of sub-Saharan Africa's four subregions, **Central Africa** has made the least progress in reducing its overall numbers of child deaths since 1990. Its subregional under-five mortality rate has edged upward from 187 per

* For a definition of Africa and its subregions, see p. 6.

1,000 live births in 1990 to 193 per 1,000 live births in 2006.

- **West Africa**, starting from a higher base rate of 215 per 1,000 live births, managed to reduce its under-five mortality rate by 15 per cent to 183 per 1,000 live births in 2006. Nonetheless, the subregion accounts for 2.1 million child deaths – more than 20 per cent of the global total and 42 per cent of Africa's total.
- **Eastern Africa** has seen steady progress, with a 28 per cent reduction in the under-five mortality rate between 1990 and 2006, but still accounts for 1.5 million (30 per cent) of Africa's child deaths.
- **Southern Africa** has posted a 17 per cent increase in the under-five mortality rate over the period, owing mostly to the onslaught of AIDS. But it still has absolute numbers of child deaths far below those of the other subregions, at 8 per cent of the continental total.
- The countries of the **Horn of Africa** -- notably Eritrea and Ethiopia – have made good progress on child survival, lowering this subregion's under-five mortality rate by 39 per cent since 1990. More rapid advances are possible if key issues, particularly the poor nutritional status of children under five – with nearly half moderately or severely stunted – are addressed.
- The countries of the **Sahel** have made less progress, with the under-five mortality rate declining by just 11 per cent since 1990. Raising rates of exclusive breastfeeding – only 1 in every 6 infants is exclusively breastfed during the first six months of life – would contribute to improving children's nutritional status and survival prospects.

In addition to insufficient progress in child survival, sub-Saharan Africa also lags on the other health-related MDGs. It is:

- Making insufficient progress towards eradicating extreme poverty and hunger (MDG 1).
- Displaying rates of maternal mortality (MDG 5) that are classified as very high.
- Yet to halt and begin to reverse the spread of HIV (MDG 6).
- Making no progress towards ensuring environmental sustainability through

increasing access to improved drinking-water sources and sanitation facilities (MDG 7).

Africa's children are dying of causes that are largely preventable. More than one third of child deaths are attributable to maternal and child undernutrition, and almost 30 per cent of the region's under-fives are moderately or severely underweight. With high global food prices heightening the risk of severe food shortages, the nutritional status of children and mothers has become an even more pressing issue for Africa.

Diarrhoeal diseases and pneumonia account for almost 40 per cent of child deaths in Africa. Malaria, the cause of 18 per cent of under-five deaths, is another major killer of children in this region, as are both AIDS and, to a lesser extent, measles. Although some progress has been achieved since 1990 in increasing access to improved-drinking water sources throughout Africa, it has been grossly insufficient in sanitation. In West and Central Africa combined, the number of people without access to improved water sources and basic sanitation facilities was higher in 2004 than in 1990.

Sub-Saharan Africa's lack of progress towards many of the health-related Millennium Development Goals is a cause for concern. However, faster progress during the coming years may ensue as a result of notable key gains in health outcomes and service provision. These include:

- Rapid progress in child survival in several sub-Saharan African countries since 1990.
- A remarkable 91 per cent reduction in measles deaths among children between 2000 and 2006.
- Advances in malaria prevention and treatment.
- Increased access to antiretroviral treatment for HIV-positive mothers and children.
- Rising rates of exclusive breastfeeding up to six months.
- Expanded distribution and use of micronutrient supplementation.
- A growing consensus on the framework and strategies required to accelerate progress.

The challenges facing North Africa and sub-Saharan Africa related to child survival and health

are divergent. North Africa has a firm foundation on which to push ahead – not only to reach the MDG 4 target but to go beyond it, particularly through addressing socio-economic inequities in health-care provision.

Sub-Saharan Africa will need to undergo a radical transformation of its health systems in the coming years, with several key priorities forming the basis of change. These priorities include establishing continuums of care across time and location, strengthening health systems through community partnerships, and developing health systems for outcomes.

PROVIDE A CONTINUUM OF CARE ACROSS TIME AND LOCATION

A continuum of care connects maternal, newborn and child health packages from pregnancy, childbirth, postnatal and newborn periods and into childhood and adolescence – each stage building on the last. Not only does the continuum extend across time, it also links household and community care with outpatient and outreach services and facility-based care.

A package of proven interventions has been identified that could avert the vast majority of newborn deaths: skilled attendants at delivery and newborn care; care of low birthweight infants; hygiene promotion; prevention of mother-to-child transmission of HIV (PMTCT) measures; paediatric treatment of AIDS; adequate nutrition (including exclusive breastfeeding for at least six months); immunization against the six major vaccine-preventable diseases; oral rehydration therapy and continued feeding to combat diarrhoeal diseases; antibiotics to fight pneumonia; medicine and insecticide-treated nets to treat and prevent malaria.

A number of programmes adopting a packaged approach to creating a continuum of care have been successfully scaled up in Africa, as many of the examples below attest. The **Accelerated Child Survival and Development (ACSD)** programme is a promising recent effort that has grown rapidly in West and Central Africa. ACSD concentrates on three service-delivery strategies to augment coverage for children, newborns and pregnant women and bundles them in an integrated, cost-effective package. Based on preliminary data

presented by district health teams in Ghana, this integrated approach – which includes immunization, infant and young child feeding, integrated management of childhood illnesses and antenatal care, is already having a positive impact on routine immunization coverage and under-five mortality. Subsidized insecticide-treated mosquito nets are being distributed in conjunction with immunization-plus activities.

STRENGTHEN COMMUNITY PARTNERSHIPS

Empowering African households and communities to participate in the health and nutrition of mothers, newborns and children is a logical and practical way to enhance the provision of care – especially in countries and communities where basic primary health care and environmental services are lacking. Africa provides rich examples of community-based programmes in a broad spectrum related to maternal and child health and survival.

- In **Angola**, the Ministry of Health has identified an essential package of mother and child health-care services to be delivered through three main channels: the fixed network of public health services; outreach and mobile services; and community-based activities. A cadre of community health workers is being developed to promote the package and to provide families with basic assistance.
- Community-based nutrition initiatives implemented in **Ethiopia, Malawi** and northern and southern **Sudan** between 2001 and 2005 achieved recovery rates among severely undernourished children of 78 per cent and reduced mortality rates down from 20–39 per cent to just 4.3 per cent.
- In **Ghana**, a sweeping water reform programme introduced by the Government in the early 1990s has led to a dramatic overhaul of a system that was failing to deliver, particularly in rural areas. Responsibilities for water supplies were transferred to local governments and rural communities. This participatory approach resulted in a dramatic increase in access to an improved water source, from 55 per cent in 1990 to 75 per cent in 2004, and access continues to improve.

- In 2000, the Government of **Niger** began to set up 2,000 community health posts, which supply antibiotics, oral rehydration salts and other essential elements in a basic health care package. They also offer preventive care, including micronutrient supplementation, children's growth monitoring and insecticide-treated mosquito nets. At the health posts, community health workers provide information and counselling.
- **Togo** has utilized existing infrastructure and personnel for measles immunization to deliver an integrated package of health-care interventions. The package included measles vaccine, oral polio vaccine, one treated mosquito net and one tablet of mebendazole deworming medication per child, with the aim of reaching 95 per cent of children.

Although these cases illustrate the breadth of community partnerships already in operation, much more needs to be done. Two key elements that can help sustain and support community partnerships in Africa are active support for provincial and district health systems, and the integration of community programmes into government policies and planning.

DEVELOP NATIONAL HEALTH SYSTEMS FOR OUTCOMES

To complement the key macro steps needed to create continuums of care, and to underpin the scaling up of community partnerships, other actions must be taken to strengthen national health systems in Africa. This is particularly relevant for sub-Saharan Africa.

In recent years, the 'health-systems development for outcomes' approach to service delivery has gained prominence. This new approach combines the strength of selective/vertical approaches and comprehensive/horizontal approaches to health-care provision. It emphasizes the expansion of evidence-based, high-impact health, nutrition, HIV and AIDS, and water and sanitation interventions and practices, and underlines the importance of removing system-wide bottlenecks to health-care provision and utilization.

The Strategic Framework for Reaching the Millennium Development Goals on Child Survival in Africa

The State of Africa's Children 2008 reprises the strategic framework that has been formulated by UNICEF, the World Health Organization, and the World Bank – at the invitation of the African Union – to support African countries and others in reducing the toll of maternal and child deaths. The framework addresses the bottlenecks to scaling up essential actions for 16 countries, identifies strategies to overcome these obstacles, and places a strong emphasis on using the MDGs and other indicators as the benchmark for health-system development. It calls for:

- Good data to inform policies and programmes.
- A shift to combine disease-specific and nutrition interventions in integrated packages to ensure a continuum of care.
- The mainstreaming of maternal, newborn and child health and nutrition into national strategic planning processes to scale up and strengthen health systems.
- Addressing the human resource crisis in health care in sub-Saharan Africa, which is facing a shortage of more than 850,000 health workers.
- Improved quality and increased, predictable financing for strengthening health systems.
- Political commitment to approaches that provide a continuum of care.
- The harmonization of global health programmes and partnerships.

The framework underlines the need to realign programmes through specifying intervention packages, establishing benchmarks and targets for coverage and delivery, and providing a mix of services through three key delivery modes:

- **Family-oriented, community-based services** that can be provided on a regular basis by community health and nutrition promoters, with periodic oversight from skilled professionals.
- **Population-oriented scheduled services**, including scheduled services provided by skilled or semi-skilled health workers such as auxiliary nurses or birth attendants and other

paramedical staff, through outreach or in facilities.

- **Individually-oriented clinical services** i.e., interventions requiring health workers with advanced skills, such as registered nurses and midwives or physicians, available on a permanent basis.

Scaling up services in these three areas over time could have a dramatic impact on reducing child mortality in the region. The framework outlines a three-phase approach based on a minimum package, an expanded package and a maximum package of services. Based on this framework, the investment case for child and maternal survival and health in sub-Saharan Africa is both affordable and attainable, with a maximum package of essential interventions estimated to reduce under-five and maternal mortality rates by about 60 per cent at a cost of US\$12–15 per capita, or US\$2,500 per life saved.

UNITING FOR CHILD SURVIVAL IN AFRICA

The marked progress in reducing child deaths in North Africa during recent decades, significant achievements in several sub-Saharan African countries, rapid scaling up of several key preventive interventions, and the joint international agency strategic framework for child survival in Africa provide the grounds for optimism in the ongoing struggle against death and disease on the continent. But a mighty push is required to turn sanguinity into action and rhetoric into reality.

The challenge for child survival in Africa must not be underestimated. Simply stated, sub-Saharan Africa faces an unprecedented challenge to meet MDG 4 by 2015 – to reduce its under-five mortality rate by a further 61 per cent from its 2006 figure of 160 per 1,000 live births. The outlook is particularly challenging for Central Africa and Southern Africa, which have both registered increases in their aggregate under-five mortality rates during recent years. In both of these subregions, the task is to halt, and then reverse, the rise in under-five mortality by tackling factors that affect the supportive environment – notably civil conflict in Central Africa and the AIDS

epidemic in Southern Africa. Without rapid and sustainable improvements in these areas, efforts to reduce child mortality by increasing coverage of preventive and curative treatment of childhood illness will risk foundering. Eastern Africa (including Djibouti and Sudan) and West Africa face the task of building on the moderate progress achieved in reducing child deaths since 1990.

Rapid improvement in child survival is not beyond the realm of possibility in sub-Saharan Africa. The Millennium Development Goals were not dreamed up by a group of utopians but are the result of tough thinking and hard calculations by some of the world's leading political leaders, development specialists, economists and scientists, and they represent a focal point for accelerating human development in Africa. *The State of Africa's Children 2008* describes many success stories in child and maternal health in Africa that have been made possible by combining committed leadership, sound strategies and concerted action among stakeholders.

Enhancing maternal and child survival and health in Africa will require a redoubling of efforts to scale up essential interventions in primary health care, create sustainable continuums of care and develop health systems for outcomes. It also calls for large-scale investment in all areas of the health system – from the community and household levels to outreach services and facility-based care – and especially in those countries and communities lagging furthest behind. For the goals to be met, the survival of mothers, newborns and children must become a regional imperative and be placed at the heart of the international agenda for Africa at the very highest levels.

The challenge is to shake off our lethargy and to put aside the broken promises of the past, and to unite in our efforts for maternal and child survival. The 147 million African children under age five are counting on us to ensure their health and development. The urgent need is to embrace the goal of maternal and child survival and health in Africa with renewed energy and sharper vision, both as a matter of social justice and to honour the sanctity of life.

Subregions and regions of Africa*

North Africa

Algeria; Egypt; Libyan Arab Jamahiriya; Morocco; Tunisia

Central Africa

Cameroon; Central African Republic; Chad; Congo; Democratic Republic of the Congo; Equatorial Guinea; Gabon; Sao Tome and Principe

Eastern Africa[‡]

Burundi; Comoros; Djibouti; Eritrea; Ethiopia; Kenya; Madagascar; Malawi; Mauritius; Mozambique; Rwanda; Seychelles; Somalia; Sudan; Uganda; United Republic of Tanzania

Southern Africa

Angola; Botswana; Lesotho; Namibia; South Africa; Swaziland; Zambia; Zimbabwe

West Africa

Benin; Burkina Faso; Cape Verde; Côte d'Ivoire; Gambia; Ghana; Guinea; Guinea-Bissau; Liberia; Mali; Mauritania; Niger; Nigeria; Senegal; Sierra Leone; Togo

Horn of Africa

Djibouti; Eritrea; Ethiopia; Somalia

Sahel

Burkina Faso; Cape Verde; Chad; Gambia; Guinea-Bissau; Mali; Mauritania; Niger; Senegal

Sub-Saharan Africa

Angola; Benin; Botswana; Burkina Faso; Burundi; Cameroon; Cape Verde; Central African Republic; Chad; Comoros; Congo; Côte d'Ivoire; Democratic Republic of the Congo; Equatorial Guinea; Eritrea; Ethiopia; Gabon; Gambia; Ghana; Guinea; Guinea-Bissau; Kenya; Lesotho; Liberia; Madagascar; Malawi; Mali; Mauritania; Mauritius; Mozambique; Namibia; Niger; Nigeria; Rwanda; Sao Tome and Principe; Senegal; Seychelles; Sierra Leone; Somalia; South Africa; Swaziland; Togo; Uganda; United Republic of Tanzania; Zambia; Zimbabwe

* Subregional and regional classifications have been compiled for the purposes of this report and may not strictly conform to standard UNICEF regional groupings.

[‡] UNICEF subregion plus Djibouti and Sudan.

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children

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