In 1960, Africa contributed to approximately 14 per cent of the global child mortality burden. Today, sub-Saharan Africa alone accounts for almost 50 per cent of child mortality, although it constitutes only 11 per cent of the world population. If Millennium Development Goal 4—reduce child mortality by two thirds—is to be achieved, Africa has the challenge of accelerating the narrowing of this gap. On average, children under-five mortality dropped from 188 per 1,000 live births in 1990 to only 171 in 2003. This corresponds to an overall decline of just 9 per cent (0.7% annually), while the MDGs target an average annual rate of reduction of 4.3 per cent. It is clear that a number of challenges needs to be overcome in Africa to reduce child mortality.

**Low coverage of interventions and weak delivery systems.** Our analysis in 13 eastern and southern African countries shows that universal coverage of scientifically proven cost-effective interventions would reduce child deaths from the current 2 million to just 650,000. Even if partial coverage of the 60-per-cent target for malaria—as agreed in the Abuja Declaration—and 70 per cent for other interventions were achieved, mortality would be reduced by almost 50 per cent. Coverage of child survival interventions remains extremely low in many countries. Of the 24 preventive and treatment interventions reviewed in 2000, only four (measles, breastfeeding, vitamin A and clean delivery) had a regional coverage of above 50 per cent. In fact, eight interventions had coverage below 5 per cent. At the same time, observations in southern Africa indicated a deterioration of caring capacities among caregivers as poverty levels and food insecurity increased. A survey of coverage of interventions in 2006 found that a number of countries are making progress in scaling up coverage, but this remains insufficient to meet MDG 4 for Africa as a continent.

**Community and household-level interventions have highest impact, but are given lowest priority.** Interventions delivered at community and household levels were found to have the highest impact (61%). Unfortunately, most health systems are set up in such a way that allocation of human, material and financial resources favours facility-based, curative care. Where community-based programmes have been set up, they tend to operate on a small scale, with little support from the formal health system. The low coverage and poor performance of the health system contribute to a high mortality rate of otherwise preventable deaths, including neonatal conditions (27%), pneumonia (21%), malaria (18%), diarrhoea (16%), HIV/AIDS (6%), measles (5%), injuries (2%) and others (5%). Malnutrition is an underlying cause of mortality in more than 54 per cent of deaths.
Gaps in continuum of care, Tanzania

Source: Countdown Profile 2005

Linkages with maternal health. Child mortality is inextricably linked with maternal mortality. In Africa, at least 25 per cent of all newborn deaths occur during the first month, 75 per cent of these during the first week. Causes include infection, asphyxia, and preterm and low birth weight. MDG 4 cannot be achieved without reducing newborn mortality. The average maternal mortality rate for Africa is as high as 1,000 for every 100,000 live births. In the last five years, nearly 20 countries in the region conducted emergency obstetric care (EmOC) assessments. While coverage of comprehensive EmOC is generally adequate, that of basic EmOC in most countries remains extremely low. Only about half of all women give birth in health facilities and less than one in three women with obstetric complications receive timely life-saving services.

Disempowering policies. Certain legal restrictions on medical practice are derived from outdated colonial rules that continue to guide clinical practices in some countries. In Malawi, the vast majority of health centres have enrolled or registered nurse-midwives. At the health-centre level, these nurse-midwives are authorized to perform four out of six basic EmOC signal functions, but are not authorized to perform the removal of retained products nor assist in vaginal child delivery. Some of these disempowering policies and legal restrictions further hamper the delivery of life-saving services even in areas where Governments have no means to assist.

Gaps in continuum of care in maternal, newborn and child health. Although nearly all women in Africa attend at least one antenatal care visit, only 40 per cent get assistance from a skilled attendant at birth. Even for mothers who give birth in a health facility, the majority of them are discharged soon after. Thus, it is hard to expect the mother to bring her baby for a routine postnatal check-up within the first week of delivery. There is enough evidence that postnatal care provided by
community health workers contributes to essential newborn care necessary for early recognition and identification of maternal and neonatal danger signs\textsuperscript{5}. However, community-based newborn care is not commonly practiced in Africa.

To reduce newborn mortality, timing of intervention is essential. Improving coverage, quality and use of skilled care, including emergency obstetric care, essential newborn care and management of preterm, low birth weight and infection in the immediate post-partum period, are likely to reduce infant mortality significantly. A community newborn-care package—including support for breastfeeding mothers, extra care for underweight babies, community-based management of pneumonia in neonates and treatment with oral antibiotic therapy—is the most cost-effective intervention to reduce newborn mortality\textsuperscript{6}. Recognizing the importance of the continuum of care, a recent publication, titled \textit{Opportunities for Africa’s Newborns}\textsuperscript{7}, studied strengths, gaps and opportunities for integrating high-impact interventions for newborn mortality reduction with existing programmes at facility and community levels.

Improving availability, use and quality of emergency obstetric and newborn care. The minimum standard coverage is four basic EmOC facilities for every 500,000 population, primarily to ensure that both urban and rural populations have timely access to life-saving services. In Africa, to make basic EmOC available requires political commitment and solid investment in the health system. Basic infrastructure, such as roads, water, electricity and telecommunications, are bare necessities. Health-care providers—mainly doctors, clinical officers, midwives, nurses, and laboratory and support staff—are only able to provide quality care in rural areas if they are supported with functional equipment, sufficient essential supplies, including drugs, regular supervision and opportunities for career development. Availability of other social services for the family, such as schooling and markets for essential supplies, is equally important. These basic conditions cannot be met by the health sector alone, but require inputs from others concerned with rural development. These are issues that the Government can take up with the private sector, faith-based organizations and development partners.

Experience shows that it is relatively easy to fix the missing functions of a hospital or health centre. Especially where skilled health-care providers are readily available, well-functioning health facilities can be upgraded through training and provision of essential supplies and equipment. Our assessments in 20 countries indicate that this is the most frequently occurring problem in Africa. In contrast, upgrading inferior health facilities involves far more extensive changes, such as connecting running water and electricity, adding new cadres of skilled attendants, Government authorization to mid-level health-care providers to perform live-saving functions, and provision of staff quarters to ensure they are available to provide 24-hour service.
Integration of maternal, newborn and child health with prevention of mother to child transmission (PMTCT) and pediatric AIDS. In many African countries, AIDS is becoming an increasingly significant contributor to child mortality. Although AIDS-related deaths constitute only about 6 per cent of child deaths in the region, in six southern African countries (Botswana, Lesotho, Namibia, South Africa, Swaziland and Zimbabwe) over 30 per cent of child deaths are AIDS-related. A significant expansion of children’s access to antiretroviral treatment and PMTCT services for mothers is therefore essential, in order to have significant impact on infant and child mortality, which has shown to be the case in Botswana.

In conclusion, opportunities exist to scale up child survival interventions through capitalizing on well-functioning and successful programmes, such as the Expanded Programmes of Immunization, relatively high antenatal care attendance and the Integrated Child Health campaigns. Other community-based interventions, including Community Integrated Management of Childhood Illnesses, have high coverage and are proven to be effective. It is also critical to ensure that Governments adopt policies to reach poor and marginalized communities. To achieve this goal, both the public and private sectors have a crucial role to play. In at least eight countries where these principles and policies have been adopted, recent demographic health surveys have indicated an over 15-per-cent reduction in mortality within five years. These success stories include Burkina Faso, Egypt, Ethiopia, Malawi, Madagascar, Mozambique, Rwanda and the United Republic of Tanzania. Although the challenges of achieving the goal of reducing child mortality are daunting, some African countries are leading the way in overcoming these challenges and thus becoming a beacon of hope for others.

Notes