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# List of Acronyms and Abbreviations

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<th>Description</th>
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<tbody>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
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<tr>
<td>ART</td>
<td>Antiretroviral</td>
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<tr>
<td>ARV</td>
<td>Antiretroviral</td>
</tr>
<tr>
<td>AU</td>
<td>African Union</td>
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<tr>
<td>AUC</td>
<td>African Union Commission</td>
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<tr>
<td>CARMMA</td>
<td>Campaign on Accelerated Reduction of Maternal, Newborn and Child Mortality in Africa</td>
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<tr>
<td>CPRs</td>
<td>Contraceptive Prevalence Rates</td>
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<tr>
<td>DPT</td>
<td>Diphtheria, Pertussis and Tetanus</td>
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<tr>
<td>EAC</td>
<td>East African Community</td>
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<tr>
<td>ECOWAS</td>
<td>Economic Community of West African States</td>
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<tr>
<td>EID</td>
<td>Early Infant Diagnosis</td>
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<tr>
<td>EPI</td>
<td>Environmental Performance Index</td>
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<td>FP</td>
<td>Family Planning</td>
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<tr>
<td>FGM</td>
<td>Female Genital Mutilation</td>
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<tr>
<td>GAVI</td>
<td>Global Alliance for Vaccines and Immunization</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>HPV</td>
<td>Human Papilloma Virus</td>
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<tr>
<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<td>MDGs</td>
<td>Millennium Development Goals</td>
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<tr>
<td>MMR</td>
<td>Maternal Mortality Ratio</td>
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<tr>
<td>MNCH</td>
<td>Maternal Newborn and Child Health</td>
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<tr>
<td>MPoA</td>
<td>Maputo Plan of Action</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Preventing Mother-to-child Transmission of HIV</td>
</tr>
<tr>
<td>SADC</td>
<td>Southern African Development Community</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<tr>
<td>SRHR</td>
<td>Sexual and Reproductive Health and Rights</td>
</tr>
<tr>
<td>RECs</td>
<td>Regional Economic Communities</td>
</tr>
<tr>
<td>SBA</td>
<td>Skilled Birth Attendant</td>
</tr>
<tr>
<td>SIAs</td>
<td>Supplementary Immunisation Activities</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>UNGASS</td>
<td>United Nations General Assembly Special Session</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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Despite the progress recorded, Africa is still confronted with formidable challenges as the continent strives towards attaining the Millennium Development Goals (MDGs), especially MDGs 4 and 5, by 2015. The substantial progress made in most African Union (AU) Member States in improving maternal, newborn and child health (MNCH) is a clear testimony that the factors underpinning the challenges are as well-known as the interventions that should be undertaken as counter measures. What remains is the political will to galvanize our efforts for a sustained and accelerated push to achieve success.

The Continental Policy Framework on Sexual and Reproductive Health and Rights and the Maputo Plan of Action (MPoA) for its implementation, remain key tools for Africa to attain MDGs 4 and 5. The Campaign on Accelerated Reduction of Maternal, Newborn and Child Mortality in Africa (CARMMA) serves as a critical advocacy platform for improvement of maternal, newborn and child health. CARMMA has motivated significant national ownership, having been launched by 37 AU Member States. It is our sincere hope that within the next 18 months, all AU Member states will have successfully launched CARMMA.

Maternal, newborn and child health issues have also engaged the attention of the African Union Heads of State and Governments who, following their Kampala 2010 summit, focused on maternal, newborn and child health, identified key actions that need to be undertaken, including the directive that the status of maternal, newborn and child health in African states be reported annually up to the year 2015, corresponding to the time we shall report on the MDGs.

This first report, therefore, seeks to facilitate the presentation of progress thus far while highlighting persistent challenges and recommending remedial action. Through the CARMMA, the African Union also advocates for the recognition that preventable maternal mortality and morbidity are pressing human-rights issues that violate a woman’s rights to health, life, education, dignity, and information. Our response to maternal morbidity and mortality should include implementation of specific legal and ethical obligations by Member States, such as the establishment of effective mechanisms of accountability (i.e., maternal death audits or reviews). Monitoring progress should not just focus on data. We should also realize that there are faces behind all those numbers. We should monitor and reinforce equity by insisting on disaggregated data on maternal mortality and morbidity to assess whether vulnerable groups are equally benefiting from health programmes.

I wish to express appreciation to all the development partners that have continued to support MNCH programmes and interventions on the continent, especially those partners that have contributed to the development of this report.

Maternal, newborn and child mortality and morbidity are limiting Africa’s development. Let’s act now to improve MNCH in Africa. I look forward to the day when No Woman in Africa will Die while Giving Life! and No Child will Die of Hunger, Disease and Neglect!

H.E. Advocate Bience Gawanas
Commissioner for Social Affairs
African Union Commission
Executive Summary

The African Union Summit of Heads of State and Government, in Kampala in 2010, adopted key actions to improve maternal, neonatal and child health, and directed that annual status reports be submitted to the Assembly. This document is the first of those reports. The African Union Commission (AUC) has continued to promote the implementation of the Continental Policy Framework on Sexual and Reproductive Health as well as the Maputo Plan of Action (MPoA). The Campaign for Accelerated Reduction in Maternal (Newborn and Child) Mortality in Africa (CARMMA) has continued to be adopted and implemented by Member States. The total number of Member States that have launched the Campaign has reached 37, surpassing the targets set for 7 Member States per year in 2009. Nevertheless, the status of maternal, neonatal and child health in Africa falls short of the targets of the Millennium Development Goals (MDGs) to reduce child mortality (Goal 4) and improve maternal health (Goal 5).

Africa still has the highest proportion of under-five deaths, with 1 in 9 children dying before their fifth birthday. The leading causes of under-five mortality include preventable illnesses such as pneumonia, diarrhoea and malaria, as well as neonatal complications. These health problems are exacerbated by conditions such as under-nutrition and HIV/AIDS. An important opportunity exists for decreasing the child survival gap between Africa and more developed regions by giving priority to investments in preventable causes of child mortality and employing underutilized, low-cost interventions. These include prevention and timely recognition and treatment of pneumonia, diarrhoea and malaria, as well as prevention of birth complications, expansion of immunisations, and
Executive Summary

prevention and treatment of HIV infections and under-nutrition among pregnant women and children.

Newborns in Africa, south of the Sahara have the highest risk of death, globally. Approximately, 33 percent of under-five deaths occur in the first month of life² and over 70 percent within the first year. The causes of neonatal deaths include complications related to premature birth, birth asphyxia, sepsis and pneumonia. We must give priority to reducing neonatal mortality by implementing proven strategies, including high quality antenatal care and skilled birth attendance. We must especially scale up and extend these services to underserved, difficult to reach and poor communities where the most vulnerable infants often live.

Under-nutrition is an indirect cause of death for children and leaves millions more with lifelong physical and mental impairments that lessen productivity. Progress in reducing under-nutrition has been slow during the past 20 years, and the greatest gaps exist in unstable AU Member States experiencing political crisis or natural disasters. However, a number of relatively poor countries are doing an admirable job of tackling this problem, underscoring the importance of political will and effective strategies.

Through increased routine immunisation coverage and large-scale immunisation campaigns, Africa, south of the Sahara made significant progress in reducing measles deaths, with an 85 percent decrease between 2000 and 2010. Despite this increase in coverage, more than 20 percent of African children are still not protected against preventable life-threatening illnesses. The burden of vaccine preventable deaths is borne largely by the African continent, which accounts for almost half of the global burden. Increasing the coverage of six vaccines to 90 percent can reduce treatment costs and also prevent lost productivity of parents and caregivers.³ Increasing the coverage of pneumococcal and rotavirus vaccine can protect against pneumonia and diarrhoea, two leading causes of child mortality in Africa. The successful expansion of sustainable immunisation programmes in Africa will require strong political will and financial commitment from African leaders to build on existing programmes in their countries.

Africa is still home to a significant proportion of HIV-positive women of reproductive age, pregnant women with HIV, and HIV-positive children. Nevertheless, access to prevention of mother-to-child transmission (PMTCT) services is less than 50 percent, on average, for priority countries on the continent. Additionally, only 26 percent of HIV-positive children have access to antiretroviral therapy (ART) services. Global data present Africa as the continent with both the highest HIV burden and the greatest gaps in access to care. Significant challenges remain to scaling up the provision of diagnostic and treatment services for pregnant women, as well as prevention, early diagnosis and treatment for children.

Maternal deaths have been reduced globally, including on the African continent, but not sufficiently to make a significant improvement towards the MDG targets for maternal mortality. This demonstrates a significant gap in meeting the MDG of universal access to reproductive health care. A woman in Africa, south of the Sahara has a 1 in 39 chance of dying in pregnancy or childbirth, compared to a 1 in 3,800 risk in developed countries.⁴ Leading causes of maternal deaths are related to obstetric complications around the time of childbirth, and three-quarters of those deaths and significant morbidity can be prevented by access to a full continuum of quality reproductive health services. Nevertheless, access to and utilization of services such as family planning, antenatal care and skilled delivery at birth is still low. Integration of HIV and reproductive health services is largely weak across the continent, losing additional benefits that could be gained through a continuum of care.

Family planning is a proven, cost-effective method for saving the lives of women and children, preventing unwanted pregnancies, slowing population growth and alleviating poverty at household and national levels. There are huge disparities in contraceptive use between African regions, ranging from less than 10 percent to 42 percent. To achieve maternal health goals, it is critical to address unmet family planning needs, providing service to families who want to space births or limit their family size. Clearly, renewed and increased commitments are needed to ensure universal access for women and their partners so they can make informed decisions about family planning. Comparable attention is needed to the sexual and reproductive health of adolescents, as they are the key to future economic and social development in their countries.
Executive Summary

Inadequate financial resources and investment are key factors undermining progress towards universal access to a full range of newborn and child health services, as well as reproductive and maternal health services in Africa. Resource allocation to the health sector remains inadequate to support the delivery of quality services that would promote good health. As good health is fundamental to the development of the critical human capital required to stimulate economic development, the impact of under-financing health care is multi-dimensional. The current level of financing is not sufficient to guarantee high quality or equitable service delivery, but is a precondition for achieving MDGs 4 and 5 and, indeed, the goals that African Union Member States have for their countries.

Poor linkages and collaboration between the ministries of health and the social determinants ministries, such as the ministries of water resources, environment and agriculture, is a crucial factor that, if not addressed, will weaken Africa’s progress towards meeting the MDG targets. Synergy and collaboration between these ministries in areas of overlapping responsibility will maximize available resources and, thus, enable greater availability of quality health services, particularly for the most at-risk who live in rural communities where services are most lacking.

Concrete steps must be taken to scale up evidence-based, cost-effective interventions to address the primary causes of child and maternal mortality and morbidity. Recommendations include health workforce capacity building, with special emphasis on skilled birth attendants and community health workers. Member States also need to address equity issues and ensure that women, children and the most vulnerable populations, have access to an integrated package of high quality essential services, covering a continuum of care at all levels. Partnerships should be fostered among multiple governmental offices, nongovernmental partners and civil society to implement a coordinated, national response to the sexual and reproductive health needs of young people. Lastly, the Regional Economic Communities of Africa should play a key role in mobilizing their Member States to renew and strengthen their commitments to maternal, neonatal and child health, and to achieving MDGs 4 and 5.
Background

Globally, approximately 287,000 women died from causes related to pregnancy and childbirth in 2010. Africa, south of the Sahara accounts for 56 percent of these maternal deaths and 49 percent of deaths among children under age five. In 2010/2011, nearly 4.5 million mothers, newborns, and children under five died in Africa, south of the Sahara:

- 162,000 mothers died as a result of complications of pregnancy and childbirth.
- 1,122,000 babies died before reaching one month of age.
- 2,248,000 children who survived their first month died before their fifth birthday.
- In addition, an estimated 880,000 babies were stillborn.

For every death, at least 20 women suffer illnesses or injuries related to childbirth or pregnancy that often lead to long term disabilities. The lifetime risk of dying during pregnancy and childbirth in Africa, south of the Sahara is 1 in 39 women, compared with 1 in 3,800 for women in the developed world. Eighty percent of those deaths could be prevented by simple, low-cost treatments and quality obstetrical care.

The African Union Commission (AUC) recognizes fully that the status of women, of which maternal health is a potent proximate indicator, is central to social and human development, and a key determinant of equitable and sustainable economic growth and development. The AUC firmly believes that sustained economic growth, peace and stability cannot be realized without addressing persistent gender inequalities, social exclusion and poor health outcomes on the continent.

The Sexual and Reproductive Health and Rights (SRHR) Policy Framework was adopted by the AU under decision no. EX.CL/225 (VIII) in 2005 in response to the call for the reduction of maternal and infant morbidity and mortality in Africa. It was developed as Africa’s contribution to the implementation of the Programme of Action of the International Conference on Population and Development (ICPD), because reproductive health and the rights of women as well as men are among the key priority objectives of the ICPD. The continental SRHR policy framework was aimed at accelerating action on the implementation of the MDGs, particularly those related to health, MDGs 4, 5 and 6. In 2006, the AU, under Executive Council declaration no; EX.CL/Dec.516 (XV), adopted the Maputo Plan of Action (MPoA) for the implementation of the SRHR Policy Framework.

Following a successful review of the implementation of the Maputo Plan of Action in 2010, the 15th Session of the Ordinary AU Assembly, whose Summit was held in Kampala, mandated the AUC (under declaration Assembly/AU/Decl.1(XV)) to report annually on the status of MNCH in Africa until 2015. In furtherance of this mandate, the AUC, in collaboration with partners, has developed this first report on the status of MNCH in Africa.
The following sections provide an overview of child mortality in Africa, south of the Sahara, including a special focus on neonatal mortality, and how the problems can be addressed. Childhood under-nutrition, a major contributor to mortality and morbidity, and immunization, a cost-effective and efficient preventive intervention, are also discussed. These sections are followed by a detailed discussion of pediatric HIV.
CHILD MORTALITY

Substantial, but insufficient progress has been made in Africa towards achieving the MDG 4 target, a two-thirds’ reduction in under-five mortality, from 178 deaths per 1,000 live births in 1990, to 59 by 2015. Data for 2011 indicate a 39 percent reduction, to approximately 109 deaths per 1,000 live births. Over the same period, the total number of under-five deaths in the world declined from nearly 12 million to approximately 7 million. Despite this, progress has been insufficient for reaching MDG 4, and over 9,000 African children under five, died every day in 2011. About half of the global child deaths occur in five countries, two of which are AU Member States: Nigeria and Democratic Republic of the Congo. (The others are India, Pakistan and China.)

In Africa, south of the Sahara the average annual rate of reduction in under-five mortality has accelerated, doubling from 1.5 percent per year between 1990 and 2000, to 3.1 percent between 2000 and 2010. The six AU Member States that achieved the greatest reductions in child mortality include Democratic Republic of Congo, Madagascar, Niger, Malawi, Liberia, and Sierra Leone. While North Africa reduced its under-five mortality rate by 67 percent, Africa, south of the Sahara’s rate fell by only 30 percent, less than half of what is required to achieve MDG 4. Africa, south of the Sahara registers the highest rates of child mortality, with 1 in 9 children dying before age five—more than 16 times the average for developed regions (1 in 152), and higher than Southern Asia (1 in 16). Although there has been progress in reducing under-five mortality, the disparity between Africa and other regions has magnified.

Children living in rural and poorer households remain disproportionately at risk. In rural areas, children are approximately 1.7 times more likely to die before their fifth birthday than those in urban areas. Children from the poorest 20 percent of households are nearly twice as likely to die before age five as the richest 20 percent. Mother’s education is a powerful determinant of inequity. Children whose mothers have had at least a primary school education are at reduced risk, compared to children of mothers without any education.

Globally, the major killers of children under age five are pneumonia (18 percent), diarrhoeal diseases (14 percent), preterm birth complications (14 percent), birth asphyxia (9 percent), and AIDS (2 percent). Under-nutrition is an underlying cause in more than one-third of under-five deaths. In Africa, the leading causes of under-five mortality are pneumonia (17 percent), Malaria (15 percent), and diarrhoeal disease (12 percent).

In impoverished communities and most high-mortality countries, facility-based services are not sufficient to prevent these conditions or to address them within a critical window after onset of symptoms. Doctors and hospitals are often unavailable, too far away, or too expensive. Community health workers (CHWs) have a critical role to play. When appropriately trained and supervised, and with an uninterrupted supply of medicines and equipment, they can meet critical needs by identifying and correctly treating most children and making referrals to higher levels of care when necessary. CHWs can screen children for under-nutrition, treat diarrhoea and pneumonia, promote breastfeeding, distribute vitamins and micronutrients, and counsel mothers about proper nutrition, hygiene and sanitation.

In 2004, WHO and UNICEF issued a joint statement on the management of pneumonia in community settings and the clinical management of acute diarrhoea, which highlighted the importance of community-based treatment. Community management of all cases of childhood pneumonia could result in a 70 percent reduction in mortality from pneumonia among children under five. Community case management of malaria could reduce overall and malaria-specific under-five mortality by 40 percent and 60 percent, respectively, and severe malaria morbidity by 53 percent. In some countries, such as Malawi, CHWs have contributed to broad-scale success in saving lives by providing essential diagnoses and treatment for malaria, diarrhoea, and pneumonia, and fighting under-nutrition.
An important opportunity exists for decreasing the child survival gap between Africa and more developed regions by prioritizing these largely preventable causes of mortality and utilizing proven low-cost strategies and interventions, which include the following:

- Vaccination against pneumonia

- Timely recognition of pneumonia symptoms, followed by seeking and receiving appropriate care and antibiotic treatment. Currently, less than one-third of children with suspected pneumonia receive antibiotics worldwide.

- Vaccination against rotavirus.

- Timely treatment of diarrhoea with oral rehydration solution, zinc and continued feeding. Only 39 percent of children with diarrhoea receive that treatment worldwide. The poorest children are least likely to receive treatment, and zinc remains unavailable in many high-mortality countries.

- Prevention of malaria by using long lasting insecticide treated bed nets and medications for prevention and treatment

- Addressing the rights of women to be educated, as well as, to choose health and social services

- Interventions to prevent neonatal mortality, as described in the section below

- Adequate nutrition during the first 1000 days of life and beyond

- Routine immunisations, as described in the section on immunisations

- Prevention and treatment of HIV infection, as discussed in subsequent sections
More than one-third of global neonatal deaths occur in Africa, which has the highest neonatal mortality rate globally; 34 deaths per 1,000 live births in 2011. In almost all regions of the world neonatal mortality has declined more slowly than under-five mortality, and consequently, the proportion of under-five deaths that occur in the neonatal period has increased to more than 40 percent. Globally, neonatal mortality declined by 32 percent, from 32 deaths per 1,000 live births in 1990, to 22 in 2011. Between 1990 and 2010, the average annual rate of reduction for neonatal mortality was 1.7 percent, while under-five mortality declined by 2.3 percent annually. The fastest reduction in Africa was in Northern Africa (55 percent).

Children in Africa, south of the Sahara have the highest risk of death in the first month of life, but progress addressing this risk has lagged. In Africa, the proportion of under-five deaths that occur within the first month of life has increased by approximately 7 percent since 1990, from 27 percent to 33 percent. Lowering neonatal deaths is a priority for achieving MDG targets for under-five mortality in Africa. The leading causes of neonatal deaths in Africa include complications related to premature birth, birth asphyxia, sepsis, pneumonia, congenital abnormalities, diarrhoea, and tetanus.

**SUMMARY RECOMMENDATIONS**

Many of the causes of neonatal mortality are intertwined with the health, nutrition, economic and social status of the mother during and after pregnancy. They could be easily avoided through the use of proven, low cost interventions at the community and facility levels, including the following:

- High quality antenatal care
- Adequate maternal nutrition before and during pregnancy
- Skilled birth attendance
- Postpartum health care visits within 48 hours after birth
- Good hygiene during and after delivery to prevent infections
- Detecting and treating infections in a timely manner
- Providing warmth immediately after birth
- Feeding within the first hour after birth
- Using resuscitation to treat birth asphyxia
CHILDHOOD UNDER-NUTRITION

Under-nutrition is an indirect cause of one-third of under-five deaths, approximately 2.3 million each year, and leaves millions more with lifelong physical and mental impairments. Worldwide, more than 170 million children do not have the opportunity to reach their full potential because of poor nutrition in the earliest months of life.

Much of a child’s future is determined by the quality of nutrition in the first 1,000 days of life. The period from the start of a mother’s pregnancy through a child’s second birthday is a critical window for development of the brain and body, which require good nutrition. Childhood under-nutrition can lessen productivity in adulthood due to diminished physical and mental development. Children with stunted growth are predicted to earn an average of 20 percent less during adulthood.

Progress in reducing under-nutrition has been slow during the past 20 years, and a combination of global trends – climate change, volatile food prices, economic uncertainty and demographic shifts – are putting future progress at even greater risk. Stunting is prevalent even in countries that are making progress in reducing child mortality. Addressing child under-nutrition, especially among children under age two, must be a priority for all governments and their partners.

The reduction of malnutrition is most challenging in unstable AU Member States experiencing political crisis or natural disasters. The Horn of Africa crisis continues to highlight how vulnerable children are in such disasters and how this situation contributes to slowing progress and reversing previous gains in child survival and maternal health. A food crisis is currently unfolding in the Sahel, threatening the survival of children and women already weakened by under-nutrition as a result of recurrent and frequent droughts in the region.

Poverty and political instability are not the only obstacles to improving childhood nutrition. A number of relatively poor countries are doing an admirable job of tackling this problem, while other countries with greater resources are not doing as well. Malawi and Madagascar are the two top AU Member states where the majority of children under age two are being fed according to recommended standards. This indicates that economic growth is not a pre-requisite for fighting under-nutrition. Rather, it underscores the importance of political will and effective strategies.
Child Health

CHILD NUTRITION STATISTICS

300
Every hour of every day, 300 children die because of malnutrition. It’s an underlying cause of more than a third of children’s deaths – 2.6 million every year. But it is not recorded on death certificates and, as a result, it is not effectively addressed.

27%
171 million children – 27 percent of all children globally – are stunted, meaning their bodies and minds have suffered permanent, irreversible damage due to under-nutrition.

20%
Adults who were malnourished as children earn an estimated 20 percent less on average than those who weren’t.

2-3%
The effects of malnutrition in developing countries can translate into losses in GDP of up to 2-3 percent annually.

$20b - $30b
Globally, the direct cost of malnutrition is estimated at $20 to $30 billion per year.

6x
In developing countries, breastfed children are at least 6 times more likely to survive in the early months than non-breastfed children.

20%
If all children in the developing world received adequate complementary feeding, stunting rates at 12 months could be cut by 20 percent.

SUMMARY RECOMMENDATIONS

Addressing this critical issue will require the following actions:

➤ Prioritizing the nutritional needs of children below age two and pregnant women

➤ Promoting exclusive breastfeeding for the first six months and continued breastfeeding with complementary foods up to age two

➤ Counseling mothers on proper nutrition during antenatal care and during well child care visits, as well as, in the community

➤ Introducing appropriate complementary feeding practices, together with interventions to identify and manage children at risk of under-nutrition

➤ Placing special attention on and making resources available to regions experiencing economic, political and environmental situations that place their populations at great risk of under-nutrition
CHILDHOOD IMMUNISATION

Each year 1.7 million children, globally, die from vaccine-preventable diseases. Preventive health interventions are the most cost effective and efficient method to sustainably improve and protect the health of populations. Since 2000, African countries successfully immunised 207 million children, and during the period 2012-2015 it is projected that an additional 95 million children in Africa will be immunised. The huge increase in spending on immunisation and related improvements in programme performance can be tracked predominantly to donor and national funding increases: 38 African countries established line items for immunisation in their national budgets, 12 countries bought all of their own vaccines, and 19 countries that received support from the Global Alliance for Vaccines and Immunisation (GAVI) developed financial sustainability plans. The projected immunisation coverage rates that are needed to meet the MDG are 90 percent coverage nationwide and 80 percent coverage in all districts. However, in 2010, most African countries were still in the 50 percent to 79 percent range for nationwide coverage.

Through increased routine immunisation coverage and large-scale immunisation campaigns, Africa, south of the Sahara made the most progress in reducing measles deaths, with an 85 percent decrease between 2000 and 2010, close to the global goal of 90 percent. However, some previously polio-free countries in west and central Africa experienced a resurgence of poliovirus transmission in 2008-2009. Contributing factors include the inability to achieve optimal coverage during supplementary immunisation activities against a background of low routine immunisation coverage, disconnection between required activities and available resources, and limited ownership, financing and accountability by national and sub-national authorities.

While immunisation coverage in Africa is on the rise, more than 20 percent of African children are still not protected against preventable life-threatening illnesses. Generally, the poorest households are also those with the lowest DPT3 coverage rates. For example, in Somalia, for every child vaccinated against DPT3 in the poorest households, five children from the richest households are immunised; in Sudan, the Democratic Republic of the Congo and the Central African Republic, the ratio is about 1 to 3.27. Mother’s educational attainment is also closely linked with immunisation rates. Figures 1 and 2 illustrate that, while vaccine coverage rates are increasing, the greatest burden of vaccine preventable deaths continues to be borne by the African continent, which accounts for almost half of the global burden.

Immunisation and vaccines are considered to be one of public health’s “best buys,” reducing morbidity and mortality and providing important long-term individual- and population-level benefits, such as healthcare savings, gains in productivity and improved cognitive development. For example, increasing the coverage of six vaccines to 90 percent can reduce treatment costs and also prevent lost productivity of parents or caregivers. Vaccination of children with DPT3, polio, tuberculosis and measles vaccines by the age of two contributes to improved cognition, leading to increased test scores and higher future productivity and increased earnings.

By the end of 2011, 13 African countries had introduced the pneumococcal vaccine for pneumonia and 2 countries had rolled out the rotavirus vaccine which protects against the most deadly forms of diarrhoea. By 2015, an additional 15 African countries will have introduced the pneumococcal vaccine and 17 more will have introduced the rotavirus vaccine. These vaccines have the potential to significantly impact under-five mortality.

Human papillomavirus (HPV) causes virtually all cervical cancer. In 2008, 275,000 women died of cervical cancer, globally; 88 percent of these deaths occurred in developing countries. The new HPV vaccine can prevent approximately 70 percent of cervical cancer cases. Following a 2008 impact assessment of 18 vaccines, the Global Alliance for Vaccines and Immunization (GAVI) began supporting the introduction of HPV vaccine in developing countries. Introducing the HPV vaccine to the 9 to 13-year old girls whom WHO recommends be immunized, is challenging since they...
Child Health

FIGURE 1: HISTORIC TRENDS IN DPT3 COVERAGE BY WHO REGION

![Graph showing historic trends in DPT3 coverage by WHO region from 1980 to 2010.]


FIGURE 2: AFRICA’S VACCINE PREVENTABLE DISEASE BURDEN

DEATHS BY CAUSE AMONG CHILDREN UNDER FIVE (ROUNDED TO THOUSAND), BY WHO REGION, 2008

<table>
<thead>
<tr>
<th>WHO REGION</th>
<th>ALL CAUSES</th>
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<th>PERTUSSIS</th>
<th>MEASLES</th>
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<tr>
<td>American</td>
<td>284,000</td>
<td>13,000</td>
<td>8,000</td>
<td>1,000</td>
<td>2,000</td>
<td>--</td>
<td>1,000</td>
</tr>
<tr>
<td>Eastern Mediterranean</td>
<td>1,237,000</td>
<td>68,000</td>
<td>90,000</td>
<td>32,000</td>
<td>19,000</td>
<td>7,000</td>
<td>14,000</td>
</tr>
<tr>
<td>Europe</td>
<td>148,000</td>
<td>7,000</td>
<td>3,000</td>
<td>3,000</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>South East Asian</td>
<td>2,390,000</td>
<td>107,000</td>
<td>127,000</td>
<td>52,000</td>
<td>90,000</td>
<td>84,000</td>
<td>17,000</td>
</tr>
<tr>
<td>Western Pacific</td>
<td>534,000</td>
<td>33,000</td>
<td>8,000</td>
<td>17,000</td>
<td>1,000</td>
<td>2,000</td>
<td>4,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>8,795,000</strong></td>
<td><strong>476,000</strong></td>
<td><strong>453,000</strong></td>
<td><strong>199,000</strong></td>
<td><strong>195,000</strong></td>
<td><strong>118,000</strong></td>
<td><strong>63,000</strong></td>
</tr>
</tbody>
</table>

usually do not have routine contact with health services. To minimize missed opportunities, HPV vaccine delivery can be integrated with other health interventions, such as HIV prevention, family planning, nutrition, and maternal health. Countries are being invited by GAVI to apply for support for introducing the HPV vaccine.32
Child Health

SUMMARY RECOMMENDATIONS

The successful expansion of sustainable immunisation programmes in Africa over the next decade will require strong political will and financial commitment from African leaders to build on existing immunisation platforms in their countries. They will need to do the following:

- Work in partnership with regional and in-country stakeholders, including civil society.
- Develop immunisation systems that rely on evidence generated by improved surveillance systems.
- Monitor programme performance and impact over time.
- Strengthen national health regulatory authorities.
- Deploy an adequate number of trained and supported human resources, guided by sound management.
- Integrate across EPI schedules and other health interventions.
- Develop capacity to assess and forecast needs.
- Build, maintain and sustain systems for regular procurement, delivery and effective supply of vaccines. (Stock-outs of traditional vaccines in key countries in West and Central Africa in 2011, have demonstrated that weaknesses in the system can threaten gains in immunisation coverage.)
- Ensure the availability of HPV vaccine by continuing or beginning integration of the vaccine with health interventions utilized by girls. Countries should also take advantage of support offered by GAVI.
Pediatric HIV

In 2010, there were 1.36 million pregnant women and 3.1 million children (aged 0–14 years) living with HIV in Africa, of which 360,000 were newly infected. Children account for 1 in 6 new infections globally. In December 2009, 90 percent of children with HIV lived in Africa. Figure 3 illustrates that the largest burden of pediatric HIV borne is by Africa, south of the Sahara.
Pediatric HIV

FIGURE 3: CHILDREN UNDER 15 YEARS LIVING WITH HIV, GLOBALLY, 2010

PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV

Africa, south of the Sahara is the region with the largest number of pregnant women living with HIV. Children primarily acquire HIV in utero, during birth and through breastfeeding. Without appropriate interventions, it is estimated that the rate of Mother-to-Child Transmission (MTCT) of HIV would be 40 percent. With efficacious interventions, the risk of mother-to-child transmission can be reduced to 5 percent. Providing ARV prophylaxis to pregnant women living with HIV has prevented more than 350,000 children globally from acquiring HIV since 1995; 86 percent of these children live in Africa, south of the Sahara. However, such interventions are still not widely accessible or available in many resource-limited settings where the burden of HIV is highest.

Most countries in the region support the following goals, which are outlined by WHO’s The Global Plan to Eliminate New HIV Infections in Children by 2015 and Keep their Mothers Alive:

- Reduction of HIV incidence among women
- Reduction of unmet need for family planning to zero among all women
- Reduction of the vertical transmission rate to less than 5 percent
- Ninety-percent reduction in HIV-related maternal deaths up to 12 months post-partum
- Ninety percent reduction in HIV attributable deaths among infants and children under age five

Among the major challenges in preventing the vertical transmission of HIV is the lack of ability to follow women through the continuum of care. The most effective Prevention of Mother-to-Child Transmission (PMTCT) services are those that interact with the pregnant mother throughout her pregnancy and continue for
Pediatric HIV

In 2010, only 28 percent of infants born to HIV positive mothers were tested for HIV within the first two months of life. Improved follow-up of women in PMTCT programmes, particularly in the post-natal period, is vital to ensure that all infants are tested for HIV and linked to treatment service, if needed. When infants and young children go to the health facilities for immunisations and other services, the HIV status of their mothers is usually not checked, and the HIV exposure status of the child remains unknown. Referrals from other child health services (such as immunisation programmes) can help ensure that children are tested, and if diagnosed as HIV-positive, that they receive appropriate ARV treatment.

However, many health facilities lack the appropriate tools to identify HIV exposed infants and healthcare providers are insufficiently trained in diagnosing pediatric HIV.

The turn-around time from blood collection to the return of HIV test results to the health facility and sharing with parents/caregiver is often too long and

In 2010, only 28 percent of infants born to HIV positive mothers were tested for HIV within the first two months of life. Improved follow-up of women in PMTCT programmes, particularly in the post-natal period, is vital to ensure that all infants are tested for HIV and linked to treatment service, if needed. When infants and young children go to the health facilities for immunisations and other services, the HIV status of their mothers is usually not checked, and the HIV exposure status of the child remains unknown. Referrals from other child health services (such as immunisation programmes) can help ensure that children are tested, and if diagnosed as HIV-positive, that they receive appropriate ARV treatment.

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The turn-around time from blood collection to the return of HIV test results to the health facility and sharing with parents/caregiver is often too long and
### Pediatric HIV

**Figure 5: Number of Children 0–14 Years Receiving ARV Therapy Compared to Estimated Need and Percentage Coverage Among Children in Low and Middle Income Countries, by Region**

<table>
<thead>
<tr>
<th>Region</th>
<th>Number of Children Receiving ARV Therapy, December 2010</th>
<th>Estimated Number of Children Needing ARV Therapy, 2012 [Range]</th>
<th>ARV Therapy Coverage Among Children, December 2012 [Range]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa, south of the Sahara</td>
<td>387,500</td>
<td>1,840,000 [1,600,000 – 2,100,000]</td>
<td>21% [19 – 24%]</td>
</tr>
<tr>
<td>Eastern and Southern Africa</td>
<td>337,200</td>
<td>1,290,000 [1,100,000 – 1,400,000]</td>
<td>26% [23 – 29%]</td>
</tr>
<tr>
<td>Western and Central Africa</td>
<td>50,200</td>
<td>550,000 [480,000 – 630,000]</td>
<td>9% [8 – 11%]</td>
</tr>
<tr>
<td>Latin America and the Caribbean</td>
<td>16,300</td>
<td>41,400 [34,000 – 50,000]</td>
<td>39% [32 – 48%]</td>
</tr>
<tr>
<td>Latin America</td>
<td>13,600</td>
<td>30,600 [25,000 – 38,000]</td>
<td>44% [36 – 55%]</td>
</tr>
<tr>
<td>Caribbean</td>
<td>2,700</td>
<td>10,800 [8,700 – 13,000]</td>
<td>25% [21 – 31%]</td>
</tr>
<tr>
<td>East, South and South-East Asia</td>
<td>43,800</td>
<td>113,000 [84,000 – 140,000]</td>
<td>39% [30 – 52%]</td>
</tr>
<tr>
<td>Europe and Central Asia</td>
<td>7,500</td>
<td>11,400 [10,000 – 13,000]</td>
<td>65% [55 – 71%]</td>
</tr>
<tr>
<td>North Africa and the Middle East</td>
<td>840</td>
<td>18,500 [12,000 – 25,000]</td>
<td>5% [3 – 7%]</td>
</tr>
<tr>
<td>All low- and middle income countries</td>
<td>456,000</td>
<td>2,020,000 [1,800,000 – 2,300,000]</td>
<td>23% [20 – 25%]</td>
</tr>
</tbody>
</table>

**Note:** Some numbers do not add up because of rounding.

A. For an explanation of the methods used, see the explanatory notes for Annex 4 and 5, and Box 5.9.

B. The coverage estimate is based on the unrounded numbers of people receiving and needing antiretroviral therapy.

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leads to delays in initiating treatment. A number of countries have put systems in place to reduce turn-around time for infant diagnosis, but access to early infant testing with appropriate follow-up is still low. Stock-outs of HIV test kits and materials used in Early Infant Diagnosis (EID) are still reported in several African countries. Equipment is also often broken and the repair process takes too long. This seriously handicaps EID and delays timely initiation of lifesaving treatment for infants and young children.
**Pediatric HIV**

**PEDIATRIC CARE AND TREATMENT FOR PEDIATRIC HIV**

Among the estimated 1.49 million infants born to mothers living with HIV globally, only 42 percent received antiretroviral therapy (ART) to prevent HIV transmission from their mothers in 2010. Without diagnosis and treatment, half of them will die before their second birthday. Only 26 percent of HIV-infected children in Africa, south of the Sahara were receiving antiretroviral (ARV) treatment, far lower than the 51 percent coverage of ART among adults. While the number of HIV-positive children receiving ART increased from about 75,000 in 2005 to 450,000 in 2010, more than 2 million still needed treatment.38 Figure 5 shows the estimated number of HIV-positive children in Africa, south of the Sahara receiving ART compared to the need and in comparison to other regions of the world. It also compares the proportion of HIV-positive children under 15 receiving ART in Africa, south of the Sahara to the proportion in other regions of the world. These data demonstrate that insufficient progress has been made in scaling-up pediatric HIV diagnosis, care, support and treatment.

HIV-infected infants have an exceptionally high mortality risk – approximately 30 percent will die by their first birthday without access to HIV care and treatment. Unfortunately, access to treatment among infants is even lower than that among older children. Pediatric formulations of ART drugs are not always available. This leads to inaccurate dosing which further compromises the health of these vulnerable populations.

An HIV-infected infant or young child always needs an adult to administer the ART. This can be challenging because many of these children are orphans and live with relatives who have their own children to take of or other duties which inhibit their abilities to provide appropriate care. Regular, high quality counseling is needed to support caregivers and families in providing treatment for children.

**SUMMARY RECOMMENDATIONS**

The scaling up of prevention and treatment for pediatric HIV must become a priority and will require the following actions:

- Ensure there are no missed opportunities for prevention, treatment and care by providing an uninterrupted continuum of care for women during pregnancy and after childbirth.
- Improve follow up of women, especially during the postpartum period to ensure that the HIV status of mothers and children is monitored.
- Test all infants born to HIV-positive mothers within the first two months of life.
- Ensure that health care providers and facilities have the training and tools needed to test infants for HIV.
- Ensure that facilities do not experience stock-outs of test kits and materials for EID.
- Ensure the availability of pediatric formulations of ART for infants and children.
Maternal Health

A woman in Africa, south of the Sahara has a 1 in 39 chance of dying in pregnancy or childbirth, compared to a 1 in 3,800 risk in developed countries. This is the largest disparity between poor and rich countries of any health indicator and emphasizes the need to focus on maternal health. In addition to the threat of death, there are obstetric-related injuries and disabilities that have long term affects, such as injuries to pelvic muscles, internal organs and the spinal cord, and those which can lead to fistulas.

At least 20 percent of the burden of disease in children below the age of five is related to poor maternal health and nutrition and poor quality of care at delivery. Nutritional deficiencies such as anaemia contribute to low birth weight, prematurity and birth defects. Malaria is an important risk to maternal health, potentially leading to anaemia, increased risk for maternal and infant mortality and developmental problems for infants. HIV infection is a continuing threat, not only because it has become a major cause of maternal mortality, related to more than 10 percent of maternal deaths in Africa, but also because of the risk of mother-to-child transmission. A majority of maternal deaths and injuries are preventable with high quality care during pregnancy, delivery and the post-partum period.
Maternal Health

LEVELS AND TRENDS OF MATERNAL DEATHS

The Maternal Mortality Ratio (MMR), which estimates the number of maternal deaths per 100,000 live births, is a key indicator of the mortality burden associated with pregnancy and childbirth. The MDG 5a target is to reduce the maternal mortality ratio by three-quarters by 2015. However, across Africa, the MMR has changed little since 1990 and Africa currently falls far short of its MDG for maternal mortality, 235 deaths per 100,000 live births. Africa, south of the Sahara accounts for 59 percent of global maternal deaths, with MMR substantially higher than for other regions of the world, as follows:

- Global: 210/100,000 live births
- South Asia: 220/100,000 live births
- Africa, south of the Sahara: 500/100,000 live births

Figures 6a and 6b illustrate progress towards reducing maternal mortality in African regions and East African Countries. Regional variations in the rates of maternal mortality across Africa are similar to the pattern for family planning which is discussed in a subsequent section of this report. In the EAC region, the maternal mortality burden is 450 per 100,000 live births, trailing behind the SADC ratio of 300, but ahead of the ECOWAS rate of 550. The EAC region’s progress on maternal mortality nearly stalled in the 1990s but regained momentum in the 2000s.

Data for 2008 indicate a 1 in 35 lifetime risk of maternal death in the East African Community (EAC) region, 1 out of 28 in the Economic Community of West African States (ECOWAS) region, and 1 out of 44 for women in the Southern Africa Development Community (SADC).

Overall, the EAC and ECOWAS regions’ progress towards achieving the MDG 5a is rated “reasonable,” having registered a 45 and 44 percent declines, respectively. However, none of the ECOWAS countries is on track to achieve MDG 5a; only Cape Verde has made good progress towards that objective. This highlights the importance of making significant and sustainable investments in maternal health before member countries come close to meeting MDG 5a.

FIGURE 6A: PROGRESS TOWARD REDUCTION OF MATERNAL MORTALITY RATIOS: 1990–2010, AFRICA MDG REGIONS44

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa, south of the Sahara</td>
<td>850</td>
<td>500</td>
<td>39</td>
<td>213</td>
<td>-23</td>
<td>-41</td>
<td>-2.6</td>
<td>Reasonable</td>
</tr>
<tr>
<td>Eastern Africa</td>
<td>800</td>
<td>450</td>
<td>n/a</td>
<td>200</td>
<td>n/a</td>
<td>-45</td>
<td>-2.9</td>
<td>Reasonable</td>
</tr>
<tr>
<td>Middle Africa</td>
<td>910</td>
<td>600</td>
<td>n/a</td>
<td>228</td>
<td>n/a</td>
<td>-34</td>
<td>-2.1</td>
<td>Reasonable</td>
</tr>
<tr>
<td>Southern Africa</td>
<td>260</td>
<td>300</td>
<td>n/a</td>
<td>65</td>
<td>n/a</td>
<td>19</td>
<td>0.9</td>
<td>No Progress</td>
</tr>
<tr>
<td>Western Sahara</td>
<td>970</td>
<td>550</td>
<td>n/a</td>
<td>243</td>
<td>n/a</td>
<td>-44</td>
<td>-2.8</td>
<td>Reasonable</td>
</tr>
</tbody>
</table>

*The progress marker is categorized as follows: 0% No Progress; 1-12% Insignificant; 13-24% Reasonable, 50-69% Good Progress; 70+% = on track
Maternal Health

**FIGURE 6B: PROGRESS TOWARD REDUCTION OF MATERNAL MORTALITY RATIOS: 1990–2008, EAST AFRICAN COUNTRIES**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Eritrea</td>
<td>930</td>
<td>280</td>
<td>72</td>
<td>-28</td>
<td>-70</td>
<td>-36</td>
<td>On Track</td>
</tr>
<tr>
<td>Djibouti</td>
<td>370</td>
<td>300</td>
<td>93</td>
<td>-11</td>
<td>-19</td>
<td>-4</td>
<td>Reasonable</td>
</tr>
<tr>
<td>Uganda</td>
<td>670</td>
<td>430</td>
<td>35</td>
<td>-20</td>
<td>-36</td>
<td>-13</td>
<td>Reasonable</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>990</td>
<td>470</td>
<td>40</td>
<td>-30</td>
<td>-53</td>
<td>-29</td>
<td>Good</td>
</tr>
<tr>
<td>Kenya</td>
<td>380</td>
<td>530</td>
<td>38</td>
<td>-11</td>
<td>39</td>
<td>8</td>
<td>No Progress</td>
</tr>
<tr>
<td>Rwanda</td>
<td>1100</td>
<td>540</td>
<td>35</td>
<td>-33</td>
<td>-51</td>
<td>-31</td>
<td>Good</td>
</tr>
<tr>
<td>Sudan</td>
<td>830</td>
<td>750</td>
<td>32</td>
<td>-25</td>
<td>-10</td>
<td>-4</td>
<td>Insignificant</td>
</tr>
<tr>
<td>Tanzania</td>
<td>880</td>
<td>790</td>
<td>23</td>
<td>-26</td>
<td>-10</td>
<td>-5</td>
<td>Insignificant</td>
</tr>
<tr>
<td>Burundi</td>
<td>1200</td>
<td>970</td>
<td>25</td>
<td>-36</td>
<td>-19</td>
<td>-13</td>
<td>Reasonable</td>
</tr>
<tr>
<td>Somalia</td>
<td>1100</td>
<td>1200</td>
<td>14</td>
<td>-33</td>
<td>9</td>
<td>6</td>
<td>No Progress</td>
</tr>
</tbody>
</table>

*The progress marker is categorized as follows: 0% No Progress; 1-12% Insignificant; 13-24% Reasonable, 50-69% Good Progress; 70+% = on track

Figure 6b shows that with an overall MMR decline of 70 percent, Eritrea is the only country in the wider Eastern Africa region that is on track for achieving MDG 5a. Rwanda and Ethiopia have made good progress that could lead to achieving MDG 5a by 2015. Four Eastern Africa Member States (Kenya, Sudan, Tanzania, and Somalia) made no progress or insignificant progress between 1990 and 2008.

Mauritius has the lowest MMR in the SADC region, as well as in Africa, south of the Sahara, overall, with 36 maternal deaths per 100,000 live births. None of the countries in the SADC region is considered to be on track to achieving MDG 5a. However, the good progress of Mauritius is followed by Namibia, with a maternal death rate of 180 per 100,000 live births, and Botswana, with a rate of 190. Overall, the SADC region’s reduction in MMR is 19 percent, and if this trend continues it is unlikely that countries in the region will get close to the MDG target by 2015. The MMR increases in countries that had previously achieved relatively lower rates of increase, Kenya and Somalia, raises concerns about the sustainability of progress toward improving women’s health. It likewise, calls for concerted efforts to identify the factors contributing the increases and to ensure sustained programme support.
CAUSES OF MATERNAL MORTALITY

WHO estimates that the leading causes of maternal mortality in Africa, south of the Sahara are related to obstetric complications around the time of childbirth—maternal haemorrhage (34 percent), pre-eclampsia/eclampsia (19 percent), abortion (9 percent), and maternal sepsis (9 percent). Another 11 percent are from indirect and other direct causes which include HIV/AIDS, malaria, anaemia and parasites. HIV/AIDS is associated with up to 21 percent of maternal deaths, as HIV-positive pregnant women are at increased risk of suffering both direct pregnancy-related complications and indirect causes of mortality from opportunistic infections such as tuberculosis. Malnutrition, including associated maternal anaemia, also contributes to maternal mortality and the high incidence of stillbirths.

The 2008 WHO data indicate that unsafe abortions accounted for 12 percent of maternal deaths in Southern Africa and Western Africa and 18 percent in Eastern Africa. It is estimated that there were 2.4 million unsafe abortions in Eastern Africa in 2008, and that unsafe abortions account for 13,000 maternal deaths in the region every year. In the same period, there were about 1.8 million abortions in Western Africa, with about 28 unsafe abortions out of every 1,000 women of reproductive age. In comparison, there were about 120,000 unsafe abortions in Southern Africa in 2008. Unsafe abortions also cause other long-term maternal disabilities, which are not even documented.

REducing Maternal Mortality

It is estimated that almost three-quarters of maternal deaths can be prevented by increasing women’s access to comprehensive reproductive health services, including antenatal care, skilled attendants at childbirth, emergency obstetric care, post abortion care, maternal nutrition, early postpartum care for mothers, and family planning. Early and continued ARV treatment for HIV-positive pregnant women is essential for ensuring health during pregnancy and beyond and for preventing mother-to-child transmission. Option B+, the provision of ARV treatment for all HIV-positive pregnant women regardless of CD4 level and continuing beyond childbirth, eliminates the need for CD4 testing and can be implemented by nurses. It, therefore, can be a cost-effective approach in low resource settings.

The proportion of births assisted by skilled birth attendants (SBAs) is considered a measure of a country’s readiness to prevent maternal deaths. The data present a very worrying image of the SBA situation in the EAC and ECOWAS regions, showing that just over half of the deliveries (50.6 percent in the EAC region and 51.3 percent in ECOWAS) were assisted by SBAs, compared with 61.5 percent in SADC. Two of the three EAC countries that have consistently had good coverage of antenatal care and SBA interventions (Rwanda and Uganda) also rank highest in progress towards lowering MMRs. The two SADC countries that have consistently had good coverage of these two interventions (Botswana and Namibia) are among the three countries with the lowest estimated MMRs in the region. Similarly, the ECOWAS countries that have consistently had good coverage of these two interventions (Cape Verde, Ghana, and Gambia) also have the lowest estimated MMRs in the region.

One opportunity for reducing maternal mortality is increasing the proportion of births that occur in health facilities that provide high quality care. Several AU Member States—Malawi, Uganda, Rwanda, and Ghana—have experienced major increases in facility-based births in the last few years and substantial decreases in their rates of maternal mortality. However, coverage by skilled birth attendants alone is not sufficient to assure good care. The qualifications for
Maternal Health

SBAs must be supported by training in evidence-based best practices, adoption of high standards of care, routine supervision and monitoring to maintain standards, and referral linkages to a broader range of obstetric care, including emergency services. The services of SBAs must be embedded in a continuum of care that follows a woman from routine reproductive health services, through antenatal care, childbirth, postpartum care, and postpartum family planning.

There are huge disparities in access to safe motherhood services between different socio-economic groups. These disparities should be monitored closely and addressed urgently. Analysis shows that, overall, progress was most notable in countries that are doing better in increasing access to SBA-aided deliveries for people of relatively low socio-economic status (the less educated, poor, and rural-based). Similarly, gender discrimination and low levels of female education deter women from seeking care and from making decisions and accessing the best available services.

ANTENATAL CARE

Antenatal care (ANC) provides an opportunity for monitoring pregnancies, detecting potential problems, and determining the remedial measures necessary during pregnancy and delivery. High quality ANC involves educating women about proper nutrition and danger signs of obstetric complications that warrant medical attention, monitoring the woman’s health and evidence of pregnancy complications, discussing plans for birth, monitoring nutritional status, identifying problems that may require caesarian section and making recommendations, administering or referring women for HIV testing in order to facilitate treatment for PMTCT, and providing malaria prevention through Intermittent Preventive Treatment and long-lasting insecticide-treated bed-nets.

WHO recommends that women receive four antenatal visits in order to ensure the provision of the full spectrum of monitoring and follow-up services, such as for pre-eclampsia and prevention of malaria. The proportion of women having four ANC visits is considerably lower than for those attending at least once; only 48.8 percent of women received four ANC visits in the ECOWAS region, 45 percent in the EAC and 60 percent in the SADC.

Rates of attending at least one ANC visit are higher. The EAC region has the highest rates, with more than 9 out of 10 pregnant women having one ANC visit (97.7 percent), compared with 91.5 percent for SADC and 84.1 percent for ECOWAS. Tanzania recorded a near-universal level for at least one visit (97.7 percent). The remaining EAC countries also had impressive coverage rates for one visit, more than 90 percent.

It is important to determine whether the lower rates of attendance for four visits are a reflection of programme inefficiencies or of deliberate programmatic actions to de-emphasize the number of times women should attend ANC in favor of focusing on the quality of care during the few visits they make. In any event, it is important that women attend the four visits to ensure adequate monitoring, timely attention to complications that may arise and appropriately timed preventive treatment for malaria. Near-universal attendance of at least one ANC visit in most countries shows that women generally understand the importance of having at least one medical check-up during pregnancy. The main challenge is identifying how programmes can build on this success so that more women increase their attendance to at least four antenatal visits. This will help to ensure they are connected with skilled birth attendants, encouraged to deliver in appropriate facilities and receive or are referred to other reproductive health services.
Except for South Africa, which has liberalized its abortion laws, all SADC countries had restrictive abortion laws. Considering that the removal of legal restrictions paves the way for the provision of safe abortion services that would save many women’s lives, it is important for SADC countries to continue reforming their abortion laws.

In Eastern Africa, unsafe abortions are estimated to account for almost 1 out of 5 of all maternal deaths (18 percent), the highest rate, while the Southern Africa region has the lowest rate, being almost 1 out of 10 maternal deaths (9 percent). The reasons for the region’s poorer abortion indicators could be partly explained by its restrictive abortion laws compared with the other regions. The EAC countries only allow abortion in two instances: to save a woman’s life, and based on a woman’s physical and mental health. In Western Africa, unsafe abortions are estimated to account for almost 1 out of 8 of all maternal deaths (12 percent).

Considering that removing legal restrictions to abortion facilitates the provision and uptake of post-abortion care, and that safe abortion services can significantly reduce maternal deaths, countries that have very restrictive abortion laws should explore the possibilities of reforming their relevant policies. But having safe abortion services is not just about removing or relaxing legal barriers. It also entails addressing service-level challenges as well as stigma to ensure that women who legally qualify for safe abortion can access this service. Increasing access to FP is also cost-effective in reducing unplanned pregnancies, which drive many women to have unsafe abortions in circumstances where they cannot access safe abortion.

**SUMMARY RECOMMENDATIONS FOR REDUCING MATERNAL MORTALITY**

The majority of maternal mortality could be eliminated with expanded availability and use of comprehensive reproductive health services that are accessible to all women, including those with limited ability to pay and those living in geographically remote areas. These services include the following:

- Attendance of four antenatal care visits that include the full spectrum of educational, monitoring and follow-up services
- Skilled attendance at childbirth
- Childbirth in well-staffed and equipped health facilities
- Emergency obstetric care
- Post abortion care
- Good maternal nutrition
- Early screening and treatment for HIV
- Two or more doses of Intermittent Preventive Therapy for Malaria
- A continuum of services for HIV-positive women that begin during pregnancy and continue beyond the postpartum period
- Interventions that ensure cost and ability-to-pay are not barriers to maternity care

**ADDRESSING UNSAFE ABORTION**

Maternal Health

Addressing Unsafe Abortion

The majority of maternal mortality could be eliminated with expanded availability and use of comprehensive reproductive health services that are accessible to all women, including those with limited ability to pay and those living in geographically remote areas. These services include the following:

- Attendance of four antenatal care visits that include the full spectrum of educational, monitoring and follow-up services
- Skilled attendance at childbirth
- Childbirth in well-staffed and equipped health facilities
- Emergency obstetric care
- Post abortion care
- Good maternal nutrition
- Early screening and treatment for HIV
- Two or more doses of Intermittent Preventive Therapy for Malaria
- A continuum of services for HIV-positive women that begin during pregnancy and continue beyond the postpartum period
- Interventions that ensure cost and ability-to-pay are not barriers to maternity care

Summary Recommendations for Reducing Maternal Mortality

Except for South Africa, which has liberalized its abortion laws, all SADC countries had restrictive abortion laws. Considering that the removal of legal restrictions paves the way for the provision of safe abortion services that would save many women’s lives, it is important for SADC countries to continue reforming their abortion laws.

In Eastern Africa, unsafe abortions are estimated to account for almost 1 out of 5 of all maternal deaths (18 percent), the highest rate, while the Southern Africa region has the lowest rate, being almost 1 out of 10 maternal deaths (9 percent). The reasons for the region’s poorer abortion indicators could be partly explained by its restrictive abortion laws compared with the other regions. The EAC countries only allow abortion in two instances: to save a woman’s life, and based on a woman’s physical and mental health. In Western Africa, unsafe abortions are estimated to account for almost 1 out of 8 of all maternal deaths (12 percent).

Considering that removing legal restrictions to abortion facilitates the provision and uptake of post-abortion care, and that safe abortion services can significantly reduce maternal deaths, countries that have very restrictive abortion laws should explore the possibilities of reforming their relevant policies. But having safe abortion services is not just about removing or relaxing legal barriers. It also entails addressing service-level challenges as well as stigma to ensure that women who legally qualify for safe abortion can access this service. Increasing access to FP is also cost-effective in reducing unplanned pregnancies, which drive many women to have unsafe abortions in circumstances where they cannot access safe abortion.
Maternal Morbidity

In Africa, for every woman who dies during childbirth, another 20 are estimated to suffer from debilitating diseases. Maternal morbidity is broadly defined as medical complications caused by pregnancy, labour or delivery. These include obstetric fistula, anaemia, infertility, damaged pelvic structure, chronic infection, depression and impaired productivity. Women who suffer from maternal morbidity may face long-term physical, psychological, social and economic consequences that can lead to household and marital problems, social isolation, shortened life spans and suicide.

Maternal morbidities are a result of several complex and often synergistic factors linked to, among many others, age at first marriage and subsequent pregnancy before full maturity of female reproductive organs and completion of growth. This increases the risk for complications during labour, which can result in fistula and rupture of the uterus. Obstetric fistula occurs as a result of damage to internal organs caused by prolonged or obstructed labor. Obstetric fistula disproportionately affects young and poor women, as well as, women living in rural areas and those whose growth is stunted due to poor nutrition or childhood illness. Women who have undergone female genital mutilation are also more likely to experience prolonged or obstructed labor and to develop obstetric fistula. Women with fistulas experience uncontrollable passage of urine and faeces into the vagina. They are often deserted by their families and friends, and are unable to undertake their daily activities.

Measuring maternal morbidity is difficult, yet a necessary component of monitoring the progress of maternal health in Africa. The exact number of women living with obstetric fistula is unknown, but is estimated by UNFPA to be over 2 million worldwide, with 100,000 women at risk of obstetric fistula each year. Surveys show that 1 percent of women in Ethiopia who have ever given birth and 4.7 percent in Malawi have experienced obstetric fistula. However, because of underreporting and social stigma, these numbers are believed to be an underestimate of the true extent of the problem.

**SUMMARY RECOMMENDATIONS**

- National policies should address age of marriage and existing policies need to be enforced.
- Awareness about the risk factors for obstetric complications, including obstetric fistula, needs to be increased at the community level.
- Services for the prevention and repair of obstetric fistula need to be expanded and made accessible for those with limited financial resources.
- Antenatal care should include monitoring for risks associated with maternal morbidities, as well as, treatment and/or referral as appropriate.
- Maternity and postpartum care should address and ensure follow up and referral for women suffering from obstetric morbidities such as fistula.
Despite the increasing commitment of the African Union leadership to enhancing investment and strengthening capacity, interventions to address exceptionally high levels of unmet needs Sexual and Reproductive Health (SRH) services and safe motherhood, progress in addressing these challenges in Africa, south of the Sahara remains limited. Statistics suggest that the EAC region is trailing behind the SADC with regard to indicators of family planning and adolescent SRH, but is ahead of the ECOWAS. The EAC region’s progress on family planning nearly stalled in the 1990s but regained momentum in the 2000s. In general, the countries in the region made progress towards universal access to SRH, and efforts to revitalize SRH programmes appear to be paying off, as evidenced by faster progress in the last decade. While the proportion of married women using modern contraception is 55 percent globally and 45 percent in South/Central Asia, it is still only 23 percent in Africa as a whole and 17 percent for Africa, south of the Sahara.

Clearly, much remains to be done. However, the work already begun by African regional organizations can provide a valuable platform for supporting the identification, enhancement, dissemination, and scaling-up of the drivers of progress towards universal access to SRH. Addressing SRH throughout the lifecycle is essential for achieving all of our goals in MNCH, as family planning, adolescent care and antenatal care are part of a continuum of care that ultimately is expected to lead to better health outcomes for women and children.
**IMPROVING ACCESS AND UPTAKE OF FAMILY PLANNING**

The 1994 International Conference on Population and Development (ICPD) Programme of Action has served as the cornerstone for ensuring universal access to the information and services women and their partners need for making informed and voluntary decisions about their sexuality and for planning the number and timing of their pregnancies. Family planning is at the heart of achieving both MDG 5b and ICPD objectives. Family planning is a proven, cost-effective measure for saving the lives of women and children, preventing unwanted pregnancies, and slowing rapid population growth. A recently released study by the Guttmacher Institute and UNFPA projected that filling the current unmet need for modern contraceptive methods in Africa, south of the Sahara would reduce pregnancy-related deaths by 48,000.48

Worldwide, fulfilling the unmet need and subsequently reducing the number of births, would result in 1.1 million fewer infant deaths, most of which would be in Africa, south of the Sahara. Family planning also contributes to the alleviation of poverty at the household and national levels, preservation of the environment, and adaptation to the effects of climatic change.

The SADC region led in modern contraceptive use, with 42.2 percent of married women using modern methods. There are huge disparities in contraceptive use among different socio-economic groups, but countries in the region that are making relatively good overall progress (Malawi, Madagascar, Zimbabwe, and Namibia) showed considerable increases in contraceptive use among the poor, the rural-based, and the least educated.

Fewer than 3 out of 10 married women (27.4 percent) in the EAC region use modern contraceptives, placing that region behind SADC, where the use of modern contraceptives is about 4 out of 10 (42.2 percent). The leading country in the EAC is Rwanda, which experienced a decline in the 1990s and then an unprecedented increase in the 2000s, from 4.3 percent to 45.1 percent.

Compared with SADC and the EAC, ECOWAS countries have persistently had much lower Contraceptive Prevalence Rates (CPRs), less equitable distribution of contraceptive use, and greater reliance on the largely ineffective traditional methods. Use of modern contraceptives in Western Africa more than doubled from 3.9 percent to 8.9 percent between 1993 and 2006. However, the latest CPRs for modern methods were less than 10 percent in 8 of the 15 ECOWAS member states. Cape Verde’s CPR of 57.1 percent is exceptional in a region where the second-best level was 16.6 percent (Ghana) and the third was 13.3 percent (Burkina Faso).

The level of unmet needs for family planning (FP) shows the extent to which women who want to avoid or delay pregnancy are not using contraception and are, therefore, at risk of having unwanted or unplanned pregnancies. In the SADC region, Mauritius had the lowest level of unmet needs for FP (3.5 percent in 2002), followed by Namibia (6.7 percent), Zimbabwe (12.8 percent) and South Africa (13.8 percent). The highest level of unmet needs during the 2000s was recorded in Malawi (27.6 percent) in 2004. The other African countries had unmet need levels of between 18 percent and 27 percent (Mozambique 18.4 percent, Ethiopia 25 percent, Lesotho 23 percent, Swaziland 24 percent, DRC 24.4 percent, Tanzania 25.3 percent, and Zambia 26.5 percent). Botswana had the highest level of unmet needs at 44.7 percent in 1988, followed by Uganda at 40.6 percent in 2006-2007 (the most recent data available).

High levels of unmet demand for family planning reveal that countries can make considerable progress towards universal access to reproductive health by enabling women with unmet needs to access and use contraception. High unmet need for family planning is a missed opportunity and provides low hanging fruit for AU Member States to rapidly increase contraceptive prevalence rates, lower fertility, reduce the dependency ratio and spur economic growth and, thus, benefit from a demographic dividend. This is a priority for Africa’s development.
Sexual and Reproductive Health

ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH

Young people’s SRH is a key determinant of the economic and social development of their communities and countries. Early engagement in sex, early marriage, and low use of contraceptives are key precursors to early childbearing, high fertility, high child mortality, and low levels of female education.

In the EAC region, the highest age at first sexual experience was 17.8, highest age at marriage was 19.4, and the lowest adolescent fertility rate was 1 birth per 10 adolescent women. The average level of contraceptive use among young people in the EAC region was 15.4 percent, which trailed SADC’s 24.6 percent but was better than ECOWAS with 7.6 percent. The average age at first sexual experience in the ECOWAS region decreased slightly from 16.4 to 16.2 between 1993 and 2006, and ranged from 15.6 in Niger to 18.4 in both Ghana and Senegal. There was a slight increase in age at first marriage, from 17.4 to 18.3, over that period, with country averages ranging between 15.5 in Niger to 19.8 in Ghana. The average ages at first sexual experience and marriage are lower in ECOWAS compared with the EAC and SADC regions.

Contrary to conventional thinking, the average age at first sexual experience in the SADC region increased slightly from 17.2 to 17.4 between 1992 and 2007, and ranged from a low of 16.1 in Mozambique to a high of 19.3 in Namibia. SADC recorded slightly less improvement in age at first sexual experience between the 1990s and 2000s, compared with the EAC and ECOWAS. There had also been a slight increase in the average age at first marriage in the SADC region, from 18.2 in 1992 to 18.9 in 2007, with country averages ranging from 17.5 in Mozambique to an exceptionally high 27 in South Africa. Botswana’s and Namibia’s average age at first marriage, 24, was also high. The average age at first marriage for ECOWAS was 18.3 years and for EAC was 19.4 years.

The introduction of Human Papilloma Virus (HPV) vaccine in the last decade represents an important opportunity to deliver services to adolescents girls. HPV vaccines target the papilloma virus that causes cervical cancer and is transmitted during sexual contact. To ensure that adolescent women receive this vaccine,

INTEGRATION OF SRH AND HIV

SRH and HIV/AIDS are closely related, and there are important potential benefits for both the client and health system associated with linking and integrating the provision of these services. These benefits include improved access to and uptake of SRH and HIV/AIDS interventions, more effective use of limited resources, increased focus on prevention, improved quality of care and effectiveness through reduced duplication, as well as, convenience and cost savings for clients.

Vast opportunities for reducing the vertical silos of SRH and HIV policies and programmes continue to exist in the African Union Member States. However, it is evident that programmes are not taking full advantage of SRH and HIV services to integrate prevention and treatment. HIV prevalence rates in the EAC are quite high, making it especially critical for the region to integrate SRH and HIV services to extend the reach of both types of services. Yet, only about one in five women (21.5 percent) in Eastern Africa receive HIV counseling and testing during ANC, which is comparable to Southern Africa’s 22.6 percent, but higher than Western Africa’s 7.75 percent.

AU Member States should collaborate with a wide variety of stakeholders in reproductive and adolescent health, education, women’s empowerment, gender equity, and cancer services. This will help to ensure the advancement of women’s, adolescent girls’, and mothers’ health on the continent.
A much smaller proportion of women in ECOWAS countries (7.8 percent) receive HIV counseling and testing during ANC, compared with those living in the SADC (22.6 percent) and the EAC (25.7 percent). This matches the relatively low rates of utilization of ANC. The small proportion of HIV-positive women receiving ARVs to prevent mother-to-child transmission is another indication of missed opportunities for integrating SRH and HIV. The average coverage for the ECOWAS region was 27.9 percent, ranging from 14.2 percent in Guinea, to 54.7 percent in Niger and 57 percent in Cape Verde. The average coverage for the SADC region was 59.5 percent, although it ranged from 1.2 percent in Madagascar to 100 percent in the Seychelles.

Although country-level efforts to integrate SRH and HIV services are ongoing (albeit at different levels), integration is generally less than optimal because of a number of challenges that need to be addressed before countries and clients can take full advantage of the potential benefits of integration. These challenges include the following:

- Lack of strong coordination mechanisms
- Lack of clear integration strategies and policies
- Shortages, and high depletion of the health workforce
- Imbalances in financial and other resources between SRH and HIV
- Lack of integrated financial, procurement, and monitoring and evaluation systems

### SUMMARY RECOMMENDATIONS FOR SEXUAL AND REPRODUCTIVE HEALTH

When progress is made in family planning and antenatal care coverage, it is largely attributable to several policy and programme features, including advances in:

- Government commitment, demonstrated by clear strategies and obligation of funding
- Improvements in health care infrastructure and systems, focusing on enhanced availability of and access to services for disadvantaged groups and adolescents through innovative approaches to service delivery and service integration
- Community outreach activities that take services closer to vulnerable and hard-to-reach communities and adolescents
- Provision of low-cost or free antenatal and family planning services
- Training of health care personnel and task-sharing, where lower cadre personnel are trained to provide some of the services formerly provided by doctors
- Public-private partnerships that promote and support innovation and help to ensure incorporation of appropriate new technologies.
Impact of Conflict and Political Instability

Research in the last decade has increased understanding that conflict and political instability impede a country’s ability to maintain security and order and to provide goods and services, including health services, to its citizens. These factors often increase the burden of disease and contribute to high mortality levels. For example:

- More than one-third of maternal deaths worldwide occur in politically unstable countries
- One-third of people living with HIV/AIDS live in politically unstable states
- One-third of the population of politically unstable states is malnourished
- Malaria deaths are 13 times higher in politically unstable states than in other developing countries

Gender-based violence often occurs within the context of broader conflict and political instability, as described in the recent work of Nicholas D. Kristof and Sheryl WuDunn and in news reports of rape being used as a weapon in political conflicts. In addition, it is increasingly recognized that violence per se, irrespective of the social or political context, is a major cause of ill health among women and girls. The reproductive health consequences of sexual violence include unintended pregnancies and reproductive tract infections. Female survivors of violence are reported to be more likely to have multiple sexual partners and less likely to use condoms and other contraceptives. The implications of sexual violence adding to rates of HIV infection are very clear and must increasingly be addressed in both reproductive health and AIDS prevention programs.

When the increased burden of disease and higher mortality in areas of political conflict and instability are combined with disruptions in health service delivery, it is not a coincidence that countries in Africa, south of the Sahara, experiencing conflicts and other emergencies often have high rates of maternal, newborn and child deaths and morbidities. This has been evident in countries such as Angola, the Democratic Republic of the Congo (DRC), Liberia and Sierra Leone. For example, a 2006 study in the DRC found that maternal deaths were higher in the conflict-ridden east (1,175 maternal deaths per 100,000 live births) than in the western part of the country (811 per 100,000).

MNCH data often are not available for fragile countries, but the broader picture is suggestive of the impact. Southern Sudan, provides a vivid example. In 2006, the patchwork of international and local NGOs working in the region were able to provide basic health services to only about 25 percent of the population, due to poor service infrastructure, lack of roads, inadequate communications, and supplies being frequently disrupted by marauders.

Addressing higher levels of mortality and morbidity in these countries can require dealing with some or all of the following:

- Security
- Government reform
- Serious logistical challenges
- Significant capacity building
- Impediments to health service delivery that are also found in more stable regions
Impact of Conflict and Political Instability

However, acting to save lives in a crisis and then to establish accessible, high-quality sustainable health services also addresses the need to establish public authority and foster good management practices within government. Donors and other international partners, therefore, recognize many important reasons to provide assistance to restore, repair and build health systems in these situations. Tools such as the Conflict Assessment Framework are available for countries to use when starting this process. These tools can facilitate analyses of the situation and preparedness for development in an objective manner during a politically charged situation. Critical MNCH services should be prioritized during both the emergency response and later phases, when a permanent package of basic health services and the systems to deliver them are being restored or developed.

With an eye towards development, short-term programming must be consistent with a long-term vision to develop a human resource base for the management and delivery of health services. For example, in DRC, family planning services had disappeared during the war and then were reintroduced and integrated into restored primary health care services. After improvements in provider capacity, supervision, management and advocacy, within 22 months of implementation the number of new users was 86,938: 57 percent condoms, 23 percent injectables, 15 percent oral contraceptives, 3 percent traditional methods, 1 percent IUD, and 1 percent mini-laparatomy. That 14 percent of eligible women were new users of family planning with a broad method mix shows a substantial shift from earlier contraceptive patterns in DRC, which were strongly traditional and included very little modern method use. This example illustrates that rapid and substantial increases in modern contraceptive use can be achieved in an African post-conflict country, and integration of family planning, or another new programme, within a broader and permanent health service initiative can succeed in a post-conflict situation.

An additional concern is introduced when conflicts or internal instability leads to international sanctions, such as economic sanctions and restrictions on foreign visitors. Despite efforts to avoid impacting humanitarian assistance, disruption of some health services can occur. In particular, when internal instability creates an environment that permits a lack of fiscal discipline or less than prudent management, multilateral and bilateral partners may postpone funding. This can directly impact needed services, including health services.
Analyses of African Union Member States’ general expenditures on health and per capita government expenditures show that by 2010 only six Member States had achieved, or nearly achieved, their commitments to spend 15 percent of their national budgets on health, in line with the Abuja Declaration. Health spending in Africa, south of the Sahara averaged $25 - $27 per capita, with 32 of the 53 AU Members investing less than $20 per capita, including 4 of the countries that have met the 15 percent benchmark.

In an effort to review progress towards attaining the 2001 Abuja Declaration of African Heads of States goal of allocating 15 percent of national budgets for health, a comparison of health financing in 2011 against 2010 was undertaken in 2012. The comparison was carried out in partnership with the Africa 15 Percent-Plus Campaign and focused on any increase or decrease in percentage allocation to health, as well as, actual per capita investment in health in the 15 Member States that have come closest to or actually allocated 15 percent or more since the 2001 Abuja commitments. The comparison also outlined broad trends in health financing across all Member States and included the following findings:

- The number of countries meeting/surpassing the 15 percent commitment increased from six in 2009-2010 to eight in 2010-2011.
- Forty-two out of the 54 AU Member States increased actual per capita investment in 2010-2011. However, 23 of these countries invested under $30USD.
- Seven AU Member States decreased actual per capita investment in health.
- Twenty-six AU Member States increased overall percentage allocated to health.
- Twenty-two AU Member States decreased overall percentage allocated to health.
- A few countries decreased the percentage allocated to health, but simultaneously increased per capita spending because the size of their overall national budgets increased.
- There is overall progress based on dual analysis of the percentage allocated to health and per capita investment in health.
- The allocation to health in many cases includes external support of between 0.9 percent and 59 percent.

Health Financing

Inadequate financial resources and investment are key factors undermining progress towards universal access to SRH, safe motherhood, newborn and child health services in Africa. However, assessment of the amount of money spent on MDG’s 4, 5a and 5b is hampered by a lack of data, as only a few countries have the capacity for reporting or have undertaken detailed studies of the subaccounts within their national health accounts to examine and track these budget lines. Reliable estimates of current spending on MNCH are a precondition for sound policy and decision making on health financing. There is also a need to improve both the tracking of MNCH financing flows and the estimation of additional MNCH resources needed to reach MDGs 4 and 5.
Impact of Conflict and Political Instability

There is a broad correlation between increased government allocation to health and better health outcomes. However, mere allocation of more money to health does not necessarily result in sustainable funding of SRH, safe motherhood, newborn and child health, nor does it guarantee quality or equitable access to services. For example, in many African countries outside North Africa, external donors provide most of the funding for family planning and other SRH programmes and commodities, which places these critical services at risk should donors shift priorities. Moreover, monitoring how much money is invested in MDGs 4 and 5 reveals that the countries making the most progress have demonstrated sustained commitment to increasing allocations of domestic budgets and donor funding to these programmes.
Recommendations

OVERALL

- Health system strengthening initiatives should be implemented to enhance the function of the health system, with due attention paid to the upgrading of facilities when needed, ensuring adequate supplies and referral systems between levels of care, improvement of the quality of care, and the collection and use of local data to adequately inform decision making about health care delivery.

- Health workforce capacity building should be given special attention in order to address critical shortages of health workers at all levels and the lack of adequately trained personnel. Member States need to enhance the training, recruitment, deployment and retention of various categories of health workers.

- Synergy and collaboration should be addressed between the ministries of health and the social determinants ministries, such as the ministries of water resources, environment and agriculture. Doing so, in areas of responsibility that overlap, will maximize available resources and provide for better health of the population.

- Community participation and partnerships with non-governmental entities and civil society need to be strengthened and institutionalized to create necessary synergies and efficiencies in the provision of care and the promotion of health.

- Community-based care initiatives must be developed and scaled up, with task shifting to community-based health workers, where feasible, for essential services. This involves the development and utilization of educational materials, training curricula and guidelines, and the implementation of high standards of care with appropriate supervision.

- Member States should ensure that women and children have access to an integrated package of essential services covering a full continuum of care, including family planning, antenatal care, skilled care during childbirth at appropriate facilities, newborn and postnatal care, emergency obstetric services, prevention and treatment of HIV and other infectious diseases, immunisations, treatment of childhood diseases and nutritional supplements.

- Member States should address equity issues that impact access to essential health services for women, poor populations, people living in rural areas, and populations that are disadvantaged, hard to reach or marginalized for other reasons. Some equity issues cross sectors, such as the need to increase women’s educational opportunities, since they can lead to increased use of health services and improve reproductive and maternal health outcomes.

- Information sharing across the region on good practices and low cost, high impact interventions should be institutionalized to facilitate appropriate adaptation.

CHILD HEALTH

- Strategies to improve child health and nutrition must focus on addressing the barriers to utilizing cost-effective interventions focused on the primary causes of child illness and mortality. Special attention is required to improve quality of care and to address the need for trained personnel at all levels, from the community to referral hospitals. AU Member States must consistently develop, evaluate and scale up the interventions for which there is evidence demonstrating a high impact on child health and survival.

- Special attention should be focused on interventions to prevent and treat diarrhoea, pneumonia and malaria at the facility and community levels, including ORS, zinc and antibiotics, as well as malaria prevention and treatment.

- Focus on the critical issue of neonatal mortality by advocating and increasing Safe Motherhood interventions and other reproductive health and child health interventions at the community and facility levels (below).

- Member States should work to achieve sustainable and high levels of immunisation coverage focused on effective routine immunisations, and the successful introduction of new vaccines against the biggest
**Recommendations**

Killers of children, diarrhoea and pneumonia. Scaling up of immunisation efforts will require awareness-raising and information campaigns, as well as support for the financing and technical aspects.

- Member States should promote implementation of the African Plan for Elimination of Mother-to-Child Transmission (EMTCT) of HIV.

- Improve pediatric HIV diagnosis, care and treatment by the use of quality parent and caregiver counseling, integration of HIV, SRH and child health services, and the use of community health workers to improve linkages between facilities and communities, which can ensure retention and continuity of care.

- Implement solutions for children at risk of under-nutrition and their families, including iron folate, breastfeeding, complementary feeding when necessary, vitamin A, zinc, good hygiene and other cost-effective solutions that have been proven to have an impact on the nutrition and health of children.

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**MATERNAL HEALTH**

- Prioritize development and implementation of innovative policies and interventions that address barriers to access of basic MH and SRH services among under-served and marginalized sub-populations, such as vouchers and the use of community-based health workers.

- Reinforce efforts to prioritize and champion SRH by mobilizing political will and support (at the national, sub-national, and community levels), matched with committed and sustained financial input to implement supportive MH and FP policies. Member States that have launched CARMMA should be faithful to the execution of Country Implementation Plans.

- Member States should ensure that SRH programmes are well-funded and that they increasingly take over the funding responsibility of SRH commodities and related services from donors. National Health Accounts (NHAs) should contain sub-accounts for SRH and other major maternal health costs in order to facilitate assessment of the extent to which financial resources are allocated and used to address key priorities.

- Institutionalize maternal death audits to strengthen the evidence base for programme and policy development and implementation as well as to motivate adequate attention to quality of care.

- Enhance access to FP to reduce unplanned pregnancies and unsafe abortions.

- Ensure adequate provision of, and access to, antenatal care and skilled birth attendants to address the major causes of maternal mortality and morbidity, including maternal eclampsia and post-partum haemorrhage and to improve child survival.

- Abortion laws should be reviewed appropriately to prevent maternal deaths resulting from unsafe abortions and to provide post-abortion care.

- Gender issues and the empowerment of women should be consciously addressed, including efforts to engage men, youth and community participation.

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**ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH**

- Member States should promote young people’s access to information, services and care. This includes promoting the integration and prioritization of young people into national policy planning and budgeting processes, such as poverty reduction strategies, social equality policies and frameworks, sector plans and budgets.

- Partnerships should be fostered among multiple government ministries (e.g., finance, education, health, youth and sports, culture), development partners and civil society (including youth groups) at multiple levels to implement a coordinated, national response to the SRH needs of young people.

- Adolescents should be recognized as agents of change. Policies and programmes should consider the capacities and contributions of adolescents while ensuring their protection as children simultaneously.
**Recommendations**

- Efforts must be made to reach the most vulnerable groups of adolescents including those out of school, with disabilities, or living in indigenous, migrant and minority households, on the streets or in other hazardous conditions.

- Institutional capacity should be built and supported to ensure sustainable and effective programmes including sexuality education and youth-friendly training curricula, as well as appropriate pre-service and in-service training of teachers, administrators, and health workers. These could facilitate youth friendly/focused services across sectors.

- Member States should seek to rapidly scale up programmes that provide information and implement cost-effective interventions such as immunisation with HPV vaccine to young adolescents.

**HEALTH FINANCING**

- Member States should strive to achieve 15 percent allocation for the health sector, with emphasis on using domestic resources, wherever possible, as opposed to donor funds.

- Efforts to increase health financing in Member States should aim to increase per capita allocation to health.

- Governance and accountability systems need to be strengthened within the health sector to minimize waste, improve efficiency, decrease corruption, and deliver “more health for the money.”

- In response to current challenges of international resource mobilization, Member States should explore alternative and sustainable sources of health financing, including opportunities to engage private employers, where feasible.

- There should be corresponding investment in prevention and broader determinants of public health, such as clean water, sanitation and an adequate and nutritious food supply.

- The Regional Economic Communities should play a key role in mobilizing their Member States to strengthen commitments to (1) increase expenditures on health in general, (2) ensure that governments have specific budget line items on SRH and safe motherhood, and (3) commit to taking primary responsibility to fund and manage these programmes in due course.
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