Annual Status Report on Maternal Newborn and Child Health in Africa

2013

“Low-cost, high-impact MNCH interventions in Africa”
Acknowledgement

This status report focuses on specific themes that promote “low-cost, high-impact MNCH interventions in Africa - Family planning, immunization, nutrition, integration of health services and health financing. The report reviews their situation with regards to MNCH on the continent and makes concrete, targeted recommendations. The status is presented against the background of selected and relevant (integrated) indicators of the MPoA”.

The support and critical contribution of key partners to this publication is hereby acknowledged and appreciated. Specifically the support of the UNFPA, PMNCH, AfriDev, GAVI, AAI, USAID and AusAID is recognized and commended.
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List of Acronyms and Abbreviations

AIDS – Acquired Immunodeficiency Syndrome
AMC – Advanced Market Commitment
ANC - Antenatal Care
ART – Antiretroviral therapy
AU – African Union
AUC - African Union Commission
CARMMA - Campaign on Accelerated Reduction of Maternal, Newborn and Child Mortality in Africa
CMR – Child Mortality Rate
CRS – Congenital Rubella Syndrome
CSOs – Civil Society Organizations
DTP - Diphtheria, Pertussis and Tetanus
FP - Family Planning
GAVI – Global Alliance for Vaccines and Immunization
HIV - Human Immunodeficiency Virus
HPV - Human Papilloma Virus
ICPD - International Conference on Population and Development
IFFIm – International Finance Facility for Immunization
M&E - Monitoring and Evaluation
MDGs - Millennium Development Goals
MMR - Maternal Mortality Ratio
MNCH - Maternal Newborn and Child Health
MPoA - Maputo Plan of Action
NGO – Non-governmental Organization
ORS – Oral Rehydration Salts
PCV – Pneumococcal Conjugate Vaccine
RCV – Rubella Containing Vaccine
RECs – Regional Economic Communities
SAMMM – Severe Acute Maternal Morbidity
SRH - Sexual and Reproductive Health
SRHR - Sexual and Reproductive Health and Rights
UNAIDS – Joint United Nations Programme on HIV/AIDS
UNFPA - United Nations Population Fund
UNICEF – United Nations Children’s Fund
USD – United States of America Dollar
WFMC – well family Midwife Clinic
WHO - World Health Organization
Foreword

The African Union Heads of State and Government at their 15th Ordinary Assembly mandated the African Union Commission to report annually on the state of Maternal Newborn and Child in Africa, until 2015. I am therefore, pleased to present this second Africa MNCH Status Report.

Healthy women are the foundation of a strong community, and healthy newborns are the future and yet we encounter a lot of deaths each year in Africa. This tragic loss of so many lives and disability can be prevented or managed through high-impact, low-cost interventions that are proven to save lives.

I am therefore pleased that this status report focuses on specific themes that promote “low-cost, high-impact MNCH interventions in Africa - Family planning, immunization, nutrition, integration of health services and health financing. The report reviews their situation with regards to MNCH on the continent and makes concrete, targeted recommendations. The status is presented against the background of selected and relevant (integrated) indicators of the MPoA”.

Furthermore the 20th Ordinary Assembly of AU Heads of State and Government requested the Conference of African Union Ministers of Health to review the status of MNCH on the continent and report back (to the Assembly). This report will therefore serve as a vehicle through which that directive is implemented.

I therefore, call upon all stakeholders to utilize the findings and recommendations of this report to improve the state of MNCH in Africa.

H.E. Dr. Mustafa S. Kaloko
Commissioner for Social Affairs
Executive Summary

The Continental Policy Framework on Sexual and Reproductive Health and Rights and the Maputo Plan of Action for its implementation, remain key tools for Africa to attain MDGs 4 and 5 in the period running up to 2015. 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 in Africa. CARMMA has motivated significant national ownership, having been launched by 37 AU Member States.

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 the foregoing, the AUC in collaboration with partners developed and submitted Annual Status of MNCH in Africa report 2012 to 19th Ordinary AU Assembly.

The 20th AU Assembly, January 2013 directed the Conference of African Union Ministers of Health to review the situation of MNCH in Africa and report back to the Assembly, underscoring the outcomes of the High-Level Event on “Reinforcing the Campaign on Accelerated Reduction of Maternal Mortality in Africa”, a side event where Heads of State and Government reaffirmed their commitment to the health of women and children. Consequently the AUC and partners have prepared the 2nd annual report on the status of Maternal, Newborn and Child Health in Africa (2013).

The report is presented in six main chapters including the background section; these chapters are; child health, maternal health, integration of services, financing MNCH interventions and recommendations for action.

Globally, over 20,000 children die each day, the majority of them from preventable causes. Worldwide, the four major killers of children under age 5 are pneumonia (18 percent), diarrheal diseases (15 percent), preterm birth complications (12 percent) and birth asphyxia (9 percent). Under nutrition is an underlying cause in more than a third of under-five deaths. Malaria is still a major killer in Africa (outside northern Africa), causing about 16 percent of under-five deaths.

While there has been a significant reduction in child deaths, the world is still only half way towards reaching the target of cutting the child mortality rate by two-thirds by 2015 (MDG 4). African children carry a disproportionately high proportion of deaths as compared to their counterparts in other parts of the world. Twenty three of the twenty four countries with child mortality rates of over 100 per 1000 live births are in Africa. Of particular concern is the slower rate at which the neonatal mortality rate is falling compared to child mortality rates. Preterm births are increasing in most countries with 60 percent of preterm births occurring in Africa and Asia.

Five of the nine developing regions have attained a decline of over 50 percent child mortality over the last 22 years with North African countries having achieved a 68 percent decline over
the same period. Countries in Africa South of the Sahara achieved a reduction of 39 percent but more importantly the countries have doubled their annual rate of reduction from 1.5 percent to 3.1 percent in the last 22 years.

Eight countries with a child mortality rate in excess of 150 deaths per 1,000 live births are less likely to meet the MDG 4 target and therefore may need to redouble their efforts in reducing child mortality. Whereas most African countries have recorded tremendous reductions in child mortality rates since 1990 to date, only one country, Egypt, has been able to achieve the MDG 4 target and five other countries are on track to achieving the MDG 4 targets.

The unacceptably high level of under-nutrition among children not only reduces their immunity to diseases but also affects their longer term physical and cognitive developments. Accelerating the reduction of under-five mortality is possible by expanding effective preventive and curative interventions that target the main causes of post-neonatal deaths (pneumonia, diarrhoea, malaria and under-nutrition) and the most vulnerable newborn babies and children. Efforts to expand coverage of vaccinations including pneumococcal and rota virus vaccines as supported by international alliances like GAVI and country governments needs to be intensified.

Every day in 2010, about 800 women died due to complications of pregnancy and child birth, including severe bleeding after childbirth, infections, hypertensive disorders, and unsafe abortions. Out of the 800, 440 deaths occurred in Africa (outside north Africa) and 230 in Southern Asia, compared to five in high-income countries. The risk of a woman in a developing country dying from a pregnancy-related cause during her lifetime is about 25 times higher compared to a woman living in a developed country. Maternal mortality is a health indicator that shows very wide gaps between rich and poor, both between countries and within them.

Most countries in Africa (over 60%) had high maternal mortality ratios of more than 300 maternal deaths per 100,000 live births whereas two African countries namely Chad and Somalia exhibit extremely high MMR of greater than 1,000 maternal deaths per 100,000 live births. African countries with the highest burden of maternal deaths are Nigeria (40,000), the Democratic Republic of Congo (15,000), Sudan¹ (10,000), Ethiopia (9,000) and the United Republic of Tanzania (8,500), each contributing to between 3% to 14% of the global toll.

Whereas levels of maternal mortality have declined by 41% since 1990, progress had been variable, not satisfactory but possible. Skilled birth attendance and contraceptive prevalence rates which directly affect maternal deaths remain low in many member states and concerted efforts are required if the Continent is to achieve MDG 5.

The number of African women using contraceptives has increased from 69 to 75 million during the five years period between 2008 and 2012. The bulk of this increase comes from Eastern Africa (6million), whereas actual number of users declined in North Africa by 13 million. Whereas the Southern African region has seen an increase in 6 million users over the same period, there was very little or no change in Western and Middle Africa respectively. Meeting women’s needs for family planning would prevent 53 million unintended pregnancies each

¹ Figures for Sudan reflect MMR estimates before the July 2011. The republic of South Sudan is estimated to have one of the highest MMR in the world
In many African countries, adolescents make up to a third of the population and continue to face a range of health and social challenges. African countries constitute 20 of the 25 countries with the highest adolescent fertility globally. Adolescents are exposed to a wide range of sexual and reproductive risks including early marriage, unwanted pregnancy and unsafe abortion and high rates of HIV and maternal deaths. This huge segment of the population, the largest ever, could play its due place in national growth and development should its sexual and reproductive health needs be properly addressed along with educational and employment opportunities.

African leaders have committed to the wellbeing women and children. Among others, these commitments have been expressed through the Maputo Plan of Action, CARMMA and at the 15th and 20th Ordinary Assembly of the AU. The Heads of States and Governments which deliberated on CARMMA at the Summit and at a high level event hosted by the Republic of Benin passed a number of decisions and communiqués to further bolster actions to improve maternal, newborn and child health in Africa. One among the many decisions “requests the ministers of Health of the African Union to examine the progress made regarding the state of maternal, newborn and child health; map out concrete and innovative strategies at a larger scale in order to adequately address the health needs of African women and children and submit a report to the 21st Ordinary Session of the Assembly.

The report also addresses integration of MNCH services and discusses the potentials of the continuum of care approach to expand universal access to services.

Financing MNCH interventions is one of the key challenges across the continent. The report highlights some of the innovative strategies to meet the financial shortfalls, commitments from the international community and the percentage of health expenditures from the national budgets of African Countries. While there are encouraging developments in domestic and other funding mechanisms, challenges remain to raise additional resources and making best use of those at the disposals of member states.

A set of recommendations are also forwarded that focus on the key areas that the report focused. These recommendations include, but not limited to ensuring universal access to high impact low cost maternal, newborn and child health interventions and strengthening health systems with focus on human resources for health and ensuring availability of essential and life saving commodities for women and children.
1. Background

The Continental Policy Framework on Sexual and Reproductive Health and Rights and the Maputo Plan of Action for its implementation, remain key tools for Africa to attain MDGs 4 and 5 in the period running up to 2015. 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 in Africa. CARMMA has motivated significant national ownership, having been launched by 37 AU Member States.

The 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 Programmes of Action of the International Conference on Population and Development (ICPD) as the centrality of sexual and reproductive health and rights to human development received recognition by the international community and country governments. Furthermore, the continental SRHR policy framework was aimed at accelerating action on the implementation of the MDGs, particularly those related to health, including 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 the foregoing, the AUC in collaboration with partners developed and submitted Annual Status of MNCH in Africa report 2012 to 19th Ordinary AU Assembly.

The 20th AU Assembly, January 2013 directed the Conference of African Union Ministers of Health to review the situation of MNCH in Africa and report back to the Assembly, underscoring the outcomes of the High-Level Event on “Reinforcing the Campaign on Accelerated Reduction of Maternal Mortality in Africa”, a side event where Heads of State and Government reaffirmed their commitment to the health of women and children.

Consequently the AUC and partners have prepared the 2nd annual report on the status of Maternal, Newborn and Child Health in Africa (2013).

The report is presented in six main sections; following this background is a chapter on Child Health that examines the status of child, infant and neonatal mortality in the Continent. Nutrition and immunization are discussed further as contributors to child mortality and morbidity and in consideration of the high impact and low cost interventions to address major causes of mortality and morbidity.

Maternal health is addressed from a number of perspectives; levels and trends in mortality, maternal morbidity, adolescent sexual and reproductive health, nutrition and immunization.
Under the section in family planning are discussed levels and trends in fertility, contraceptive prevalence rates, unmet needs and repositioning family planning.

Integration of services has been treated as a spate chapter to demonstrate the importance of the fact that one way to ensure universal access to high impact low cost intervention is integration across the continuum of pregnancy, childhood and adolescence. The final two chapters discuss financing of MNCH intervention and a set of recommendations to scale up low-cost high impact MNCH interventions in Africa.
2 CHILD HEALTH

2.1. Under Five Mortality

While there has been a significant reduction in child deaths, the world is still only half way towards reaching the target of cutting the child mortality rate (CMR) by two-thirds by 2015 (MDG 4). Of particular concern is the slower rate at which the neonatal mortality rate is falling compared to CMR\(^2\). Globally, over 20,000 children die each day, the majority of them from preventable causes\(^3\). Though substantial progress has been made in reducing under-five mortality which stood at 51 deaths per 1,000 live births at the end of 2011, more still need to be done if the global millennium development goal target of 29 deaths per 1,000 live deaths is to be achieved by 2015\(^4\).

Five of the nine developing regions have attained a decline of over 50 percent child mortality over the last 22 years with North African countries having achieved a 68 percent decline over the same period. Countries in Africa South of the Sahara achieved a reduction of 39 percent but more importantly the countries have doubled their annual rate of reduction from 1.5 percent to 3.1 percent in the last 22 years.

Most of the under-five deaths occur in Africa south of the Sahara and Southern Asia countries. For example in 2011, all the countries with an under five mortality rate over 100 deaths per 1,000 live births were from these two regions with 23 out of the 24 countries from Africa south of the Sahara\(^5\). By 2011, 28 countries (59 percent) in Africa South of the Sahara had managed to reduce their child mortality rate below 100 deaths per 1,000 live births whereas 20 (41 percent) countries had child mortality rates above 100 deaths per 1,000 live births. Six of the 28 countries with child mortality rates below 100 deaths per 1,000 live births have achieved child mortality rates below 40 deaths per 1,000 live births and are showing promising trend towards achieving MDG 4 target by 2015.

Eight (17 percent) countries with a child mortality rate in excess of 150 deaths per 1,000 live births are less likely to meet the MDG 4 target and therefore may need to redouble their efforts in reducing child mortality (Figure 1). Whereas most African countries have recorded tremendous reductions in child mortality rates since 1990 to date, only one country (Egypt) has been able to achieve the MDG 4 target and five other countries are on track to achieving the MDG 4 targets (figure 2)\(^6\).

The leading global causes of death among children aged below five years are pneumonia (18%); preterm birth complications (14%); diarrhoea (11%); intrapartum related complications (9%);

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\(^3\) WHO and UNICEF (2012) Count down 2015: building a future for women and children


\(^5\) Ibid

\(^6\) Ibid
and malaria (7%). Under nutrition is the underlying factor in more than a third of under-five deaths.

Preterm births are increasing in most countries with preterm birth complications being the main cause of newborn deaths – 60 percent of preterm births occur in Africa and Asia. Of the 11 countries with preterm birth rates above 15%, 9 are in Africa south of the Sahara.

**Figure 1. Countries With the Highest Prevalence of Under Five Mortality, 2009**

![Chart showing countries with highest under-five mortality rates, with a large portion for DRC (14%), Nigeria (19%), Tanzania (5%) and Ethiopia (8%) with others (50%) combined.]

Pneumonia and diarrhea, the leading killers of children under 5 are ‘diseases of poverty’ because they are closely associated with factors such as poor home environments, under-nutrition and lack of access to health services. Efforts to tackle childhood pneumonia have had mixed results, with both impressive successes and lost opportunities.

Globally, major progress has been made in providing access to improved drinking water sources and promoting exclusive breastfeeding in the first six months of life. New vaccines against major causes of pneumonia have become available and most low-income countries have introduced the Haemophilus influenzae type b (Hib) vaccine. Pneumococcal conjugate vaccines (PCV) are also increasingly available, but gaps in vaccine uptake within countries could greatly reduce impact.

Effective treatment of diarrhoeal disease rests on administration of oral rehydration salt (ORS) solutions to prevent life-threatening dehydration, continued feeding and zinc supplementation. Unfortunately, these inexpensive life-saving treatments remain inaccessible for the vast majority of children in the poorest countries, and those in the poorest groups within countries. Even more worrisome is the lack of any real progress in expanding treatment coverage since 2000. Globally, less than one-third of children with diarrhoea receive ORS and Zinc use is also

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8 UNICEF (2012) Committing to child survival; A promise renewed
low. In addition, through support from GAVI, rotavirus vaccine is becoming available in developing countries and plans to roll it out to more deserving countries are on course.

Accelerating the reduction of under-five mortality is possible by expanding effective preventive and curative interventions that target the main causes of post-neonatal deaths (pneumonia, diarrhoea, malaria and under-nutrition) and the most vulnerable newborn babies and children.

Figure 2: Child Mortality Rates in Africa
2.2. Infant Mortality Rate

The Infant Mortality Rate (IMR) – deaths of infants under one-year-old per 1,000 live births in the same year – also registered a downward trend in Africa, from 102 deaths per 1,000 live births in 1990 to 75 deaths per 1,000 live births in 2009. This represents a decrease of 26 percent over a period of 20 years. In terms of the actual number of infant deaths, there was a marginal 2 percent reduction from 2.64 million in 1990 to 2.59 million in 2009 for the
continent as a whole. The total number of infant deaths in Africa, excluding North Africa, amounted to 2.5 million. This represents a staggering 97 percent of infant deaths that occurred in 2009 on the continent as a whole. The continental aggregate figure for IMR exhibits wide variations among countries. The majority of African countries have registered positive, albeit slow, progress for this indicator. A total of 47 countries registered reductions in IMR between 1990 and 2009 that ranged from 3 to 73 percent.

Six member states - Liberia, Eritrea, Madagascar, Cape Verde, Tunisia and Egypt-are best performers by reducing IMR by at least 50% between 1990 and 2009. Note that these countries are the same as those who have shown the same progress in under five mortality rate excepting Ethiopia and Malawi. Three of these six top performers are in North Africa (Egypt, and Tunisia); two in West Africa (Cape Verde and Liberia), while East Africa is represented by Madagascar and Eritrea. It should be noted that Liberia and Eritrea, which are both included in this list, are post conflict countries. This demonstrates not only that conflict is a cause of high child and infant mortality, but that political will and pertinent policy interventions can translate into significant positive change.

The Central Africa and Southern Africa sub-regions are not represented in this list of top performers. Furthermore, of the three countries (Cameroon, Chad, and Zimbabwe) where IMR has increased, two are in Central Africa. This may be an indication of the high prevalence rates of diseases such as malaria that are major causes of infant deaths in the sub-region, combined with weak capacity to respond to the threats.

2.3. Neonatal Mortality
Although the over-all under-five mortality has been declining, deaths occurring during the neonatal period has been increasing. Therefore reducing the proportion of under-five deaths that occur during the neonatal period is important. Neonatal mortality, covering deaths in the first month after birth, is of interest because the health interventions needed to address the major causes of neonatal deaths generally differ from those needed to address other under-five deaths. Over the last 22 years all regions have seen slower reductions in neonatal mortality than in under-five mortality; whereas neonatal mortality has declined by 32 percent, from 32 deaths per 1,000 live births in 1990 to 22 in 2011 representing an average annual reduction of 1.8 percent a year, under-five mortality has registered a much higher annual reduction of 2.5 percent.

Countries in Africa south of the Sahara account for 38 percent of global neonatal deaths, have the highest neonatal mortality rate of 34 deaths per 1,000 live births in 2011 and are among the countries showing the least progress in reduction of neonatal mortality. Neonatal mortality rates in Africa ranges from 7 deaths per 1,000 live births in Egypt to 50 deaths per 1,000 live births in Somalia. Nine countries in Africa namely; Mauritius (9), Seychelles (9), Republic of cape Verde (10), Botswana (11), Namibia (18), Algeria (16),South Africa (14), Eritrea (21), Rwanda (22) and Congo (22) have recorded neonatal mortality rates below 22 deaths per 1,000 deaths; The country specific neonatal mortality rates are shown in figure 4.

Figure 4: Neonatal Mortality Rates in African Countries
Around 40% of all under-five deaths occurred in the neonatal period, the majority from preterm birth complications and complications during delivery. Many mothers in the world’s poorest countries deliver their babies at home rather than in a health facility thereby putting themselves and their babies at greater risk if complications occur. Coverage of institutional deliveries averages only 60% worldwide. Another significant cause of neonatal death is infection, including sepsis, meningitis, tetanus, pneumonia and diarrhoea. Low birth weight (less than 2,500 grams) greatly increases children’s risk of dying during their early months and years and those who survive may have impaired immune function, increased risk of disease, and are likely to have cognitive disabilities and to remain undernourished throughout their lives.

Postnatal care visits on issues such as “early and exclusive breastfeeding, keeping the baby warm, increasing hand washing and providing hygienic umbilical cord and skin care, identifying conditions requiring additional care and counseling on when to take a newborn to a health facility from a skilled health worker can be very effective in encouraging proper care to prevent neonatal deaths. Community health workers can play a critical role in providing care to families who do not have easy access to a health facility.

A growing body of evidence confirms the significant impact of early initiation of breastfeeding, preferably within the first hour after birth. Since fewer than half of all newborns are put to the breast within one hour, much more needs to be done to promote this practice and reduce overall neonatal mortality.

To make sure that the causes of newborn deaths can be addressed, efforts to invest in the key interventions must include investment in key commodities needed to reduce these deaths. The commission on lifesaving commodities for instance has identified antibiotics, chlorohexidine, antenatal corticosteroids and resuscitation devices as key commodities that need to be procured more regularly.

2.4. Nutrition and Child Health

The bulk of the world’s chronic under-nutrition (more than 80 per cent) is borne by twenty-four countries of which half are from Africa10 (Table1). In Africa, stunting rates are particularly high at 40 per cent and due to chronic under-nutrition, about 165 million children are stunted and around 51 million children suffer from wasting.

For children growing up in Africa the link between poor nutrition and infectious disease has always been a particularly vicious cycle. Lack of vital nutrients, such as vitamin A or zinc, can weaken the immune system making children more vulnerable to infections. Undernourished children are at far greater risk of death and severe illness due to pneumonia and diarrhoea than are well-nourished children. Under-nutrition weakens the overall immune system, which needs adequate protein, energy, vitamins and minerals to function properly. For pneumonia, under-nutrition also weakens the respiratory muscles needed to clear secretions in the respiratory tract. Whereas for diarrhoea, under-nutrition places children at higher risk of more severe, frequent and prolonged illness11.

10 UNICEF (2009) Tracking progress on child and maternal nutrition: A survival and development priority
11 UNICEF (2012) Pneumonia and diarrhoea: Tackling the deadliest diseases for the world’s poorest children
Simple, inexpensive interventions applied during the critical window of opportunity; during pregnancy and during the child’s first two years of life can prevent under-nutrition, decrease mortality, support growth and promote child health and well-being. Interventions such as early initiation of breastfeeding, exclusive breastfeeding, complementary feeding and micronutrients supplements can greatly reduce under nutrition and improve children’s chances of survival. For instance, a non-breastfed child is 14 times more likely to die of all causes in the first six months of life than an exclusively breastfed child. Vitamin A supplementation reduces mortality from all causes among children aged 6-59 months. Improving child nutrition is not only entirely feasible but also affordable and cost-effective. Nutrition interventions are among the best investments in development that African countries can undertake.

While improvements in nutrition are clearly needed, there is a growing body of evidence to suggest that another effective and lasting way to help break this cycle is through immunization. Since 1987 the World Health Organization (WHO) has advocated that vitamin A supplements be given with the measles vaccine, as well as leveraging national immunization days as a platform to reach undernourished children with micronutrients as part of a package of integrated, cost-effective health interventions (ref).

With Africa’s population projected to reach 2 billion by 2050, the unprecedented challenge of feeding the continent’s children looms large. In light of this, the role that vaccines can play in helping to address the issue of undernourishment is likely to become ever more critical. There is therefore much opportunity afforded by approaching nutrition and immunization as critical in collectively advancing the health of populations, and integration of health interventions.

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12 UNICEF (2012) Committing to child survival; A promise renewed
Table 1: The Global Burden of Chronic Under-nutrition\(^{13}\)

<table>
<thead>
<tr>
<th>Ranking</th>
<th>Country</th>
<th>Stunting prevalence (%)</th>
<th>Number of children who are stunted (thousands, 2008)</th>
<th>Percentage of developing world total (199.1 millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>India</td>
<td>48</td>
<td>66,788</td>
<td>31.3%</td>
</tr>
<tr>
<td>2</td>
<td>China</td>
<td>15</td>
<td>12,685</td>
<td>0.5%</td>
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<tr>
<td>3</td>
<td>Nigeria</td>
<td>41</td>
<td>10,176</td>
<td>5.2%</td>
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<tr>
<td>4</td>
<td>Pakistan</td>
<td>42</td>
<td>9,000</td>
<td>5.1%</td>
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<td>5</td>
<td>Indonesia</td>
<td>37</td>
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<td>6</td>
<td>Bangladesh</td>
<td>63</td>
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<td>Ethiopia</td>
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<td>Democratic Republic of the Congo</td>
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<td>5,382</td>
<td>2.8%</td>
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<td>Philippines</td>
<td>54</td>
<td>3,617</td>
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<td>United Republic of Tanzania</td>
<td>44</td>
<td>3,359</td>
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<td>Afghanistan</td>
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</tr>
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<td>16</td>
<td>Kenya</td>
<td>25</td>
<td>2,154</td>
<td>1.1%</td>
</tr>
<tr>
<td>17</td>
<td>Yemen</td>
<td>56</td>
<td>1,890</td>
<td>1.0%</td>
</tr>
<tr>
<td>18</td>
<td>Myanmar</td>
<td>41</td>
<td>1,763</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>19</td>
<td>Nepal</td>
<td>49</td>
<td>1,670</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>20</td>
<td>Mozambique</td>
<td>64</td>
<td>1,626</td>
<td>&lt;1%</td>
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<tr>
<td>21</td>
<td>Madagascar</td>
<td>53</td>
<td>1,622</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>22</td>
<td>Mexico</td>
<td>10</td>
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<tr>
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<td>47</td>
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<tr>
<td>24</td>
<td>South Africa</td>
<td>27</td>
<td>1,425</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>

Due to the long latency period before the effects of chronic under-nutrition can be felt in a country, nutrition continues to remain a low priority on the national development agendas of many countries. By not recognizing the urgency to deal with under-nutrition, many countries continue to place under-nourished children at higher risks of serious infection and death from common childhood illnesses\(^{14}\). For instance, more than one-third of the global under-five deaths are attributable to under-nutrition\(^{15}\). More importantly, undernourished children who survive may become locked in a cycle of recurring illness and faltering growth, with irreversible damage to their development and cognitive abilities\(^{16}\).

### 2.5. Immunization and Child Health

Africa has made enormous progress in protecting children against major childhood diseases. Immunization coverage in Africa is at its highest level in history but over 20% of African

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\(^{13}\) UNICEF (2009) Tracking progress on child and maternal nutrition: A survival and development priority


\(^{15}\) Black, Robert E., et al., ‘Maternal and Child Under-nutrition: Global and regional exposures and health consequences’, *The Lancet*, vol. 371, no. 9608, 19 January 2008, pp. 243–260. Note that earlier estimates of more than 50 per cent of deaths being caused by under-nutrition relate to the age group 6–59 months, whereas the latest estimate extends to all children under 5 years old.

children, approximately 8.45 million as measured by DTP3 coverage are still not protected against life-threatening illnesses through vaccines\textsuperscript{17}. Additionally, only 12 out of 54 African countries finance between 50\% of their Expanded Program on Immunization\textsuperscript{18}, a fact which underlines how much more can be achieved with improved investment in immunization. With the support of partners, African countries are accelerating the roll-out of new vaccines against the major killers of children, such as pneumonia and diarrhea (Figure 4). Nearly 90 per cent of deaths from pneumonia and diarrhoea occur in the poorest regions of the world in Africa South of the Sahara and South Asia. Over 75\% of the global under-five deaths occur in fifteen countries of which ten are from Africa south of the Sahara (Figure 5).

**Figure 5: Deaths among Children Under age 5 due to Pneumonia and Diarrhea by Region, 2010\textsuperscript{19}**

![Pie chart showing deaths among children under age 5 due to pneumonia and diarrhoea by region, 2010](image)

<table>
<thead>
<tr>
<th>Region</th>
<th>Deaths 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-Saharan Africa</td>
<td>1,078,000</td>
</tr>
<tr>
<td>South Asia</td>
<td>651,000</td>
</tr>
<tr>
<td>Other regions</td>
<td>268,000</td>
</tr>
<tr>
<td>Total</td>
<td>1,997,000</td>
</tr>
</tbody>
</table>

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**Figure 6: Countries with Highest Under Five Mortality due to Pneumonia and Diarrhoea**

\[17\] http://www.who.int/immunization_monitoring/data/SlidesGlobalImmunization.pdf
Efforts to tackle childhood pneumonia, the leading killer of children under 5, causing 18% of all child deaths worldwide through the introduction of new vaccines against pneumonia are gaining ground in developing countries. Nearly all AU member states have introduced this vaccine and most of the countries have recorded coverage of over 50% (Figure 6). Coverage of pneumococcal conjugate vaccines (PCV) is low with only 23 member states having introduced the vaccine by 2011 (Figure 7); however, with support from partners, efforts are underway to roll out the vaccine to countries with the highest pneumonia burden. By the end of 2013, more than 25 African countries are projected to have introduced the pneumococcal vaccine.

Rotavirus, the leading cause of severe childhood diarrhoea and responsible for an estimated 40 per cent of all hospital admissions among children under age 5 worldwide continues to cause deaths in Africa where the rotavirus vaccine remains largely unavailable. A recent study found that the impact as measured by deaths averted per 1,000 children vaccinated of introducing rotavirus vaccination was up to five times greater for children from the poorest households than from the richest. It is estimated that equitable coverage of rotavirus vaccination in Nigeria would increase health benefits 400 per cent for the poorest children and double them at the national level. In Africa, only eight AU member states (Malawi, Rwanda, South Africa, Sudan, Tanzania, Ethiopia, and Ghana) have rolled out the rotavirus vaccine. By 2013, more than 10 countries are projected to have rolled out the rotavirus vaccine.

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21 Ibid
Africa’s fight against the deadly diseases that affect its children and young adults reached a historic landmark in December 2012, with the 100 millionth individual vaccinated against meningitis A on Africa’s “meningitis belt,’ a region through 26 countries from Gambia in the west to Eritrea in the east. This strong political will, implementation and financial commitment by African leadership, finance and health ministers, is critical for ensuring continued progress and sustainability, as is working in partnership with regional and in-country stakeholders such as civil society and the private sector.

In addition to their direct impact on Africa’s mortality rates, vaccines contribute significantly to population health through the opportunity to integrate MNCH and SRH interventions across the continuum of care to maximize synergy and sustain the benefits to all vulnerable populations. Higher coverage rates also mean that everybody, even those who are not immunized, can benefit from the miracle of vaccines through the phenomenon of herd immunity - for example, the more children are immunized in a population, the lower the disease rate will be for all. Furthermore, immunization also contributes to the reduction of illness and long-term disability in children and adults. Health workers are freed up and parents spend less time looking after sick children. This brings added value by reducing the burden of disease on families, health systems and societies.

Investing in, and providing, equal access to immunization by Africa’s leaders represents a tried and tested way of accelerating progress toward the three health-related Millennium Development Goals (MDG) 4, 5 and 6. Immunization saves lives and prevents illness, avoiding sometimes catastrophic health expenditures for both individuals and societies and improving productivity. Yet millions of children are not receiving the life-changing vaccines recommended by the World Health Organization (WHO) as part of a routine immunization programme. The number of children receiving three doses of the vaccine against diphtheria, tetanus and pertussis (DTP3) is the traditional measure for the strength of a routine immunization.

WHO recommends that infants receive 11 antigens as part of routine immunization programmes. These include vaccines against diarrhoea and pneumonia, the two biggest killers of children under 5. There is a moral imperative to reset Africa’s ambition so that the measure of success is that all African children are fully immunized. A fully immunized African child has a better shot at living up to their full potential both intellectually and physically. The opportunity offered by the ‘fully immunised child’ would also continue to bring attention and opportunities to re-energize and strengthen integrated interventions, such as Vitamin A supplementation, bed net distribution, and family planning information; and to advance commitments to improve child and maternal health more broadly, such as the 2010 Kampala Declaration, the 2006 Maputo Plan of Action and the Campaign on Accelerated Reduction of Maternal, Neonatal, and Childhood Mortality (CARMMA).

Overwhelming evidence demonstrates the benefits of immunization as one of the most successful and cost-effective public health interventions known. Over the past few decades, immunization has achieved many things, including the eradication of smallpox, lowered the global incidence of polio by 99 percent and dramatically reduced illness, disability and death from diseases such as diphtheria, tetanus, whooping cough, pneumonia, meningitis A, diarrhoea and measles. However, inequities in immunization still exist, both between and
within countries. Household wealth, geographic location and gender-related factors, such as the mother’s education, all have an impact on whether an African child is immunized or not. In many African contexts there are also additional challenges in reaching discrete population groups that may include: documented or undocumented migrants; displaced or mobile populations; certain tribal or ethnic groups; and people from some religious communities.

By empowering people stay healthy as part of a package of cost-effective health interventions, vaccines remove a major barrier to Africa’s development. Undoubtedly, immunizing children is one of Africa’s best buys. By investing in immunization, African countries can collectively make a lasting contribution to the MDGs and advance the health and development commitments of African leaders and governments to their children and people to lead productive, prosperous, and healthy lives.
Figure 7: Hib Vaccine coverage in Africa
Figure 8: Coverage of Pneumococcal Conjugate Vaccines in African Countries

PCV Coverage in Africa

- Full vaccine coverage: 12 countries
- Partial vaccine coverage: 11 countries
- Vaccine not provided: 23 countries

Number of countries
3 MATERNAL HEALTH

Maternal health in Africa has witnessed tremendous attention by the African Union, other African intergovernmental organizations, national governments, and international health organizations. African countries are increasingly exacting efforts to ensure a drastic reduction in the mortality figures in line with the health MDGs, come 2015. Increasing numbers of women are now seeking care during childbirth in health facilities and therefore it is important to ensure that quality of care provided is optimal.

With only three years to go until 2015, the world is not even half way to reaching MDG 5, the goal of reducing the maternal mortality ratio (MMR) by three quarters\(^22\). Globally, over 10% of all women do not have access to or are not using an effective method of contraception. It is estimated that satisfying the unmet need for family planning alone could cut the number of maternal deaths by almost a third\(^23\). At the London Family Planning Summit in July 2012, $2.6 billion was pledged to sustain current access to family planning services for 260 million girls and women around the world, and to reach 120 million more women by 2020.

The UN Commission on Life-Saving Commodities for Women and Children launched in 2012, highlights the inequitable access to life-saving medicines and health supplies suffered by women and children around the world and calls the global community to work together to save 16 million lives by 2015\(^24\). Evidence shows that an estimated 1.4 USD is saved on maternal and newborn health care for every dollar invested in family planning and another 4 USD is saved on treating complications from unplanned pregnancies\(^25\).

Limited access to sexual and reproductive health information and services leaves many African women and girls of all ages, nationalities and social circumstances powerless to prevent pregnancies that they do not want and cannot afford to carry to term. Unsafe abortion is often their last, desperate resort. Estimates indicate that 6.2 million unsafe abortions took place in Africa in 2008, contributing to 29% of the global total\(^26\). Unsafe abortion imposes significant costs on families and on national health systems already struggling with scarce resources. Preventing unwanted pregnancies and complications from unsafe abortions – through improved access to contraception and safe abortion – thus has the potential to save lives as well as significant resources.

3.1. Maternal Mortality

3.1.1. Levels and Trends in Maternal Mortality

Every day in 2010, about 800 women died due to complications of pregnancy and child birth, including severe bleeding after childbirth, infections, hypertensive disorders, and unsafe abortions. Out of the 800, 440 deaths occurred in Africa (outside north Africa) and 230 in Southern Asia, compared to five in high-income countries. The risk of a woman in a developing country dying from a pregnancy-related cause during her lifetime is about 25 times higher compared to a woman living in a developed country. Maternal mortality is a health indicator that shows very wide gaps between rich and poor, both between countries and within them.²⁷

Most countries in Africa (over 60%) had high maternal mortality ratios of more than 300 maternal deaths per 100,000 live births whereas two African countries namely Chad and Somalia exhibit extremely high MMR of greater than 1,000 maternal deaths per 100,000 live births. African countries with the highest burden of maternal deaths are Nigeria (40,000), the Democratic Republic of Congo (15,000), Sudan²⁸ (10,000), Ethiopia (9,000) and the United Republic of Tanzania (8,500), each contributing to between 3% to 14% of the global toll.

Despite these high figures, some African countries like Tunisia (56), Egypt (66), Mauritius (60), Sao Tome and Principe (70) and Cape Verde (79), Algeria (81) had low MMR (defined as 20–99 maternal deaths per 100 000 live births). Other countries like, Botswana (160), Djibouti (200), Namibia (200), Gabon (230), Eritrea (240), Madagascar (240) and Equatorial Guinea had moderate MMR (defined as 100–299 maternal deaths per 100 000 live births)²⁹ (Figure 9).

Five countries in Africa – Botswana, Lesotho, Namibia, South Africa and Swaziland, showed an increase in maternal deaths from 2000 to 2005 on account of HIV, but their maternal mortality rates are currently dropping as antiretroviral treatments become more available.

Among the more prominent success stories for Africa, Equatorial Guinea has achieved MDG 5, one of the 10 countries worldwide that did so during the period. Its maternal death rate dropped by 81 per cent, from 1200 to 240 per 100,000 live births. Other African countries showing promising trends in achieving MDG 5 are; Egypt, Sao Tome and Principe, Madagascar and Eritrea (Figure 9). While substantive progress has been achieved in almost all regions, many African countries will be particularly encouraged by this report in their efforts to reach the MDG target of reducing maternal deaths by 75 per cent by 2015.

Figure 9: Comparison of MMR and MDG 5 targets in African Countries

²⁸ Figures for Sudan reflect MMR estimates before the July 2011. The republic of South Sudan is estimated to have one of the highest MMR in the world
3.1.2. Causes of and Factors Underlining Maternal Deaths
Maternal deaths are caused by a wide range of complications in pregnancy, childbirth or the postpartum period. Most of these complications develop because of the pregnancy itself, and some occur where pregnancy has aggravated an existing disease. The four major killers are: severe bleeding (mostly bleeding postpartum), infections (also mostly soon after delivery), hypertensive disorders in pregnancy (eclampsia) and obstructed labour. Complications after unsafe abortion cause 13 per cent of maternal deaths. Globally, about 80 per cent of maternal deaths are due to these direct causes.30

Among the indirect causes of maternal death (20 per cent) are diseases that complicate or are aggravated by pregnancy, such as malaria, anaemia and HIV. Women also die because of poor health at conception and a lack of adequate care needed for the healthy outcome of the pregnancy for themselves and their babies.

Figure 10. Major Causes of Maternal Deaths in Africa31

Absence of skilled health personnel at birth is a key underlying factor in high maternal mortality. In the 10 countries with the highest mortality, only 21% to 59% of births had a skilled attendant present, compared to 63% to 100% in the 10 countries with lowest maternal mortality.32 There are birth-related disabilities that affect many more women and go untreated like injuries to pelvic muscles, organs or the spinal cord. At least 20% of the burden of disease in

30 Maternal mortality Fact sheet N°348 May 2012
children below the age of 5 is related to poor maternal health and nutrition, as well as quality of care at delivery and during the newborn period. And yearly 8 million babies die before or during delivery or in the first week of life.

Whilst skilled birth attendance is key to reducing maternal deaths, other elements (antenatal care and postnatal care) are required for continuum of care throughout and following pregnancy. ANC coverage for the first visit is close to 80% for most countries in Africa however this drops to less than 50% for the 4 ANC visits. This drop is also true for postnatal care coverage which is even lower.

Across the African continent, unsafe abortion claims the lives of at least 29,000 African women and girls each year – most in the prime of their lives. Hundreds of thousands more suffer serious, often life-altering injuries, including infertility. Additionally, Africa bears the brunt of the burden of maternal deaths from unsafe abortion, accounting for 62% of the global total. South Africa for example has been able to reduce much of its maternal morbidity thanks to liberal abortion legislation and relatively high rates of skilled attendance at birth.

The underlying factors that prevent women from accessing services and eventually exposes them to deaths and disabilities are described in the “Three Delays Model”, a) delay in decision to seek care, b) delay in reaching care, and c) delay in receiving adequate health care.33

Women’s status in the community and the family are key determinants of their ability to decide and timely access services in addressing the three delays. Among other interventions, educating young girls is arguably the best bet as a lasting solution in not only addressing maternal health but also ensure child health and familial wellbeing. Educated girls lead demographic change. An educated girl marries later, has less children, more evenly spaced, seeks medical care sooner for self and children, increases the probability of her children’s survival improves her children’s learning and education and reduces overall fertility rates.34

3.2. Maternal Morbidity

For every maternal death, there are approximately 20 other women who suffer pregnancy-related disability. That is equivalent to an estimated 10 million women each year who survive pregnancy, yet experience some type of severe negative health consequence.35 Obstetric fistula is the most well-known of these conditions, disabling tens of thousands of women in Africa each year.36 Survival after obstetric hemorrhage on a background of chronic under nutrition and malaria also leaves countless women chronically debilitated, and survival after septic abortion or puerperal sepsis may come at a cost of chronic pelvic pain and infertility.37

33 http://www.maternityworldwide.org/what-we-do/three-delays-model/
34 Human Development Report, UNDP, 2003
Severe acute maternal morbidity (SAMM), often termed ‘near-miss’, has attracted interest in recent years because of its potential value as a supplementary maternal outcome measure to maternal death. Cases of SAMM serve as markers of severe illness and can be used as audit triggers to initiate discussion, education and facility improvement. Health care facilities may measure their burden of maternal illness by their numbers or rates of SAMM. Better still, they can track their effectiveness in preventing maternal deaths by calculating a ‘mortality index’ – maternal deaths divided by the sum of cases of SAMM. The lower the mortality index, the more effective is the facility in preventing maternal deaths.

There is currently no national or provincial surveillance system for SAMM in Africa, south of the Sahara and the burden of maternal mortality and morbidity remains unacceptably high. However, SAMM notification or reporting will become more frequent, and provide useful information to clinicians and facility managers.

3.3. Family Planning

Family planning along with emergency obstetric and newborn care and adolescent reproductive health constitute one the three pillars of maternal and newborn health. Family planning improves maternal health, reduces unintended pregnancies and abortions, prevents the spread of HIV/AIDS, and promotes responsible development and environmental sustainability. Furthermore a recent study has concluded that the use of modern contraception enhances women’s educational attainment, workforce participation and economic stability.

Around the world, 222 million women have an unmet need for modern contraception. In 39 African countries contraceptive prevalence among women married or cohabiting that report at least use of one form of contraception - is less than 50%. Meeting women's needs for family planning would prevent 53 million unintended pregnancies each year, resulting in 14.5 million fewer abortions and 250,000 fewer women dying in pregnancy or childbirth annually.

*Increasing contraceptive use in developing countries has cut the number of maternal deaths by 40% in the past 20 years, merely by reducing unintended pregnancies. By preventing high-risk pregnancies, especially in women with many repeated and un-spaced pregnancies, and those that would have ended in unsafe abortion, increased contraceptive use has reduced maternal mortality ratio by about 26% in little more than a decade. A further 30% of maternal deaths could be avoided by fulfilling the unmet need for family planning.*

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40 2012 Africa Women and Children’s Scorecard Focusing on Maternal and Reproductive Health, by Africa Public Health. Info (now Afri-Dev.Info) and Africa Coalition on Maternal, Newborn and Child Health
41 Population Action International - [http://populationaction.org/topics/family-planning/](http://populationaction.org/topics/family-planning/)
3.3.1. Levels and trends in fertility

Fertility in Africa (outside north Africa) stood at 5.1 births per woman in 2005–10, more than double the replacement level. This high fertility combined with declining mortality has resulted in rapid population growth—2.5 percent per year—and the UN projects the African (outside north Africa) population to grow from 0.86 billion in 2010 to 1.96 billion in 2050 and 3.36 billion in 2100. Such unprecedented expansion of human numbers creates a range of social, economic, and environmental challenges and makes it more difficult for the continent to raise living standards. Hence the growing interest in demographic trends in Africa among policymakers. According to conventional demographic theory, high fertility in the early stages of the demographic transition is the consequence of high desired family size. Couples want many children to assist with family enterprises such as farming and for security in old age. In addition, high child mortality leads parents to have additional children to protect against loss or to replace losses. Fertility decline occurs once rising levels of urbanization and education, changes in the economy, and declining mortality lead parents to desire a smaller number of births.43

Figure 11. Total Fertility Rate, African Countries44

As shown in fig 11, more than 36 (70%) African countries are currently having a total fertility rate of more than four. Whereas a number of northern African countries are getting closer to the replacement level fertility of two, Mauritius is the only country that has attained that level to date.

A study based on DHS data from 40 countries, shows that on average, fertility levels were lower among countries with better social settings or stronger family planning programs than among

43 Fertility Transition: Is sub-Saharan Africa Different? John Bongaarts, John Casterline
44 http://wwwr.worldbank.org/.../FertilityFamilyPlanning_all.xlsx
those with poorer settings or weaker programs; they were lowest in the presence of both good social settings and strong programs. In addition, fertility was positively associated with infant mortality and negatively associated with female education, but not associated with poverty. About half of the 2.3-birth difference in fertility between countries in Africa (outside north Africa) and those elsewhere can be attributed to differences in program efforts and social settings\(^{45}\).

Fertility declines lead to a boost in income per head caused by decreased youth dependency rates, and also change the social and economic position of women, reducing gender inequality and allowing women more opportunity to enter formal employment than before the fertility decline. In addition to these immediate economic benefits, fertility decline will have long-term effects on economic growth when the next generation of healthier and better educated children enter the labour force\(^{46}\).

### 3.3.2. Contraceptive Prevalence Rates

In Africa, south of the Sahara, only 17 percent of married women are using contraceptives, compared to 50 per cent in North Africa and the Middle East, 39 per cent in South Asia, 68 per cent in Latin America and the Caribbean and 76 per cent in East Asia and the Pacific. Contraceptive prevalence rates in over 80% of African countries are below 50% (figure 9). Only in a few countries in Africa, south of the Sahara, such as South Africa, Zimbabwe, Botswana, and Kenya, have family planning programs been successful enough to increase contraceptive use to much higher levels.

<table>
<thead>
<tr>
<th>Table 2. Progress in Number of Women using Modern Contraceptive methods in the African Region, 2008-2012(^{47})</th>
</tr>
</thead>
<tbody>
<tr>
<td>Among all women aged 15-49, number using modern</td>
</tr>
</tbody>
</table>

\(^{45}\) Anrudh K. Jain and John A. Ross  *Fertility Differences Among Developing Countries: Are They Still Related to Family Planning Program Efforts and Social Settings?*

\(^{46}\) David Canning, T Paul Schultz  *The economic consequences of reproductive health and family planning* Published Online July 10, 2012 [http://dx.doi.org/10.1016/S0140-6736(12)60827-7](http://dx.doi.org/10.1016/S0140-6736(12)60827-7)

### Table 1. Modern Contraceptive Methods in Africa

<table>
<thead>
<tr>
<th>Region and sub region</th>
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<th>methods, (millions)</th>
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<td></td>
<td>2008</td>
<td>2012</td>
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<tr>
<td>Africa</td>
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<td>51</td>
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<td>23</td>
</tr>
<tr>
<td>(outside northern Africa)</td>
<td>31</td>
<td>36</td>
<td>4.2</td>
<td>17</td>
</tr>
<tr>
<td>• Eastern Africa</td>
<td>12</td>
<td>17</td>
<td>11.7</td>
<td>20</td>
</tr>
<tr>
<td>• Middle Africa</td>
<td>2</td>
<td>2</td>
<td>1.9</td>
<td>7</td>
</tr>
<tr>
<td>• Southern Africa</td>
<td>7</td>
<td>9</td>
<td>5.8</td>
<td>54</td>
</tr>
<tr>
<td>• Western Africa</td>
<td>6</td>
<td>7</td>
<td>2.8</td>
<td>9</td>
</tr>
<tr>
<td>Northern Africa</td>
<td>19</td>
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</tr>
<tr>
<td>69 Poorest Countries</td>
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<td>252</td>
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<td>645</td>
<td>1.7</td>
<td>56</td>
</tr>
</tbody>
</table>

Between 2008 and 2012, the number of modern method users increased by 42 million in the developing world as a whole, an average annual increase of roughly 10 million users.\(^{27,28}\) In comparison, between 2003 and 2008, the number of modern method users rose by almost 100 million in developing countries, from 504 million to 603 million, an annual increase of 20 million users. The increase between 2008 and 2012 was partly due to population growth (52%), and partly to the small increase in the contraceptive prevalence rate (48%). For example, the proportion of currently married women in the developing world using modern methods barely changed between 2008 (56%) and 2012 (57%).

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Figure 12. Contraceptive Prevalence Rates in African Countries
More substantial increases in modern method prevalence rates among married women were seen in Eastern Africa (from 20% in 2008 to 27% in 2012) and in Southeast Asia (from 50% to 56%). Notably, there was no increase in Western Africa and Middle Africa, areas where modern contraceptive use continues to be very low. In these sub-regions, health systems are especially weak and mortality rates very high, and the need for comprehensive care that includes contraceptive, maternal, infant and child health services—relevant for all countries—is particularly great.

A case study in Eastern and Southern Africa states a promising progress in contraceptive use from many countries including Botswana, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Namibia,
Rwanda, South Africa, Swaziland, and Zimbabwe. Among the nine drivers of change that the report outlines are political will, sustained financing, health system strengthening and commodity security. While there is much work to be done to further increase access to and utilization of contraceptive services in these countries, those with very low contraceptive prevalence rates, such as Sudan (9%), Somalia (15%) and Djibouti (18%) face a formidable challenge to increase their relative contraceptive prevalence rates.

African governments are now also worrying more specifically about the implications of high population growth rates: in fact, three-quarters of Africans now live in the 24 countries with governments that view their population growth rates as too high. In most African countries, over half the population is under the age of 15, which means there is a vast pent-up demographic momentum throughout the continent.

### 3.3.3. Unmet Needs for Contraceptives

Unmet need for family planning refers to the condition of wanting to avoid or postpone childbearing but not using any method of contraception. The number of women in developing countries who want to avoid pregnancy but are not using modern contraception declined only slightly between 2008 and 2012, from 226 to 222 million. However, in the 69 poorest countries, where 73% of all women with unmet need for modern contraceptives reside, the number actually increased, from 153 to 162 million women.

All African countries have an unmet need for family planning; while countries have an overall larger need for birth spacing, the majority of countries have at least 5 percent of women who do not wish to have any more children. On the basis of their unmet needs, African countries can broadly be categorized in to two groups: the first group represents two countries with a large unmet need for limiting childbearing (Lesotho and Swaziland), where more than 15 percent of women want to stop childbearing altogether. The second group counts 18 countries with a greater unmet need for spacing (more than 15 percent), namely Benin, Burkina Faso, Chad, Côte d’Ivoire, DRC, Eritrea, Ethiopia, Gabon, Ghana, Liberia, Malawi, Mali, Mauritania, Rwanda, Senegal, Sierra Leone, Uganda, and Zambia.

The use of family planning methods depends not just on users’ preferences but also on health system characteristics. Strong family planning programs rely on effective family planning service delivery strategies, such as those that offer methods tailored to the needs of users, provide family planning counseling and medical expertise for administering methods, and follow up on users’ response to the method. Countries in the region with frail health systems are faced with the challenge of improving contraceptive method choice within existing constraints.

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48 Assessment of Drivers of Progress in Increasing Contraceptive use in sub-Saharan Africa; Case Studies from Eastern and Southern Africa. Preliminary report 1 March 2012 African Institute for Development Policy

49 [http://www.guttmacher.org/media/nr/2012/06/19/index.html](http://www.guttmacher.org/media/nr/2012/06/19/index.html)

50 Family Planning Trends in Sub-Saharan Africa: Progress, Prospects, and Lessons Learned Mona Sharan, Saifuddin Ahmed, John May, and Agnes Soucat
3.3.4. Repositioning Family Planning

Because family planning and reproductive health programs are so important for both health and demographic reasons, it is essential that more, resources be invested in this area. Many new programs will need substantial funding as they expand. The numbers of women in the reproductive age groups are increasing, as are the proportions of those women who want to use contraception: today there are over 1.2 billion women of reproductive age in the developing world.

Family planning programs in many countries have successfully used mass media communication campaigns to raise awareness of the benefits of family planning, legitimize small families, and change reproductive preferences\(^{51}\). Programs can use these same communication channels to address many of the reasons why women with unmet needs do not use family planning methods and encourage them to change their behavior. Effectively crafted, evidence-based messages can explain the true risk of pregnancy for women who are breastfeeding or have sex infrequently, address concerns about contraceptive side effects and health risks, publicize sources of different family planning commodities, and address religious or other opposition to modern contraceptives.

The integration of services as part of health sector reform offers another, complementary way to reach women and reduce missed opportunities to provide family planning services. Any time people seek health care represents an opportunity to identify their unmet need. Health clients may be especially receptive to and in need of family planning information and services when they are seeking an abortion, have just delivered a baby, or are diagnosed with HIV\(^{52}\). Offering integrated services at these moments is convenient for clients and can also address other health problems.

**The London Family Planning Summit of July 2012 was a landmark event that brought together governments, UN agencies and foundations with the aim of revitalizing global commitments to family planning and access to contraceptives as a cost-effective and transformational development priority.**

**Family Planning 2020 (FP2020)** builds on the partnerships launched at the London Summit on Family Planning. It will sustain the momentum from London and ensure all partners are working together to achieve and support the goals and commitments announced at the Summit\(^{53}\).

3.4. Adolescent SRH and Maternal Health

African countries constitute 20 of the 25 countries with the highest adolescent fertility globally.\(^{54}\) In many African countries, adolescents make up to a third of the population and

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\(^{53}\) [http://www.londonfamilyplanningsummit.co.uk/index.php](http://www.londonfamilyplanningsummit.co.uk/index.php)
continue to face a range of health and social challenges. For instance, initiation of sexual activity while they lack adequate knowledge and skills for protection places adolescents at a higher risk of unwanted pregnancy, unsafe abortion and sexually transmitted infections including HIV&AIDS. Consequently adolescent fertility is growing, as well as the number of young girls exposed to HIV.

Globally (ref),

- About 16 million adolescent girls give birth every year – most are in low- and middle-income countries.
- An estimated three million girls aged 15-19 undergo unsafe abortions every year.
- In low- and middle-income countries, complications from pregnancy and childbirth are a leading cause of death among girls aged 15-19 years.
- Stillbirths and new-born deaths are 50% higher among infants of adolescent mothers than among infants of women aged 20-29 years.
- Infants of adolescent mothers are more likely to have low birth weight.

High prevalence of underage ‘marriage’ and childbearing in some AU Member States is associated with higher maternal mortality and morbidity as well as neonatal and infant mortality. The 30 African countries where 30% to 75% of underage girls are forced into marriage also include 22 of the 30 countries with the highest maternal mortality. Similarly, the 30 African countries where between 30% to 75% of underage girls are forced into marriage also include 23 of the 30 countries with the highest child mortality, showing a correlation between child marriage and maternal & child mortality.

It is important to highlight that child marriage undermines the health, human and social development of African youths and Africa as a whole by placing at risk the lives of an estimated 37.4 million young girls - through maternal mortality; HIV; lack of access to reproductive and sexual health; social, psychological and physical violence; and by excluding them from education; thus removing them forcibly from the human and social development capacity pool of the continent. Ending child marriage practice is one important measure to ensure that the sexual and reproductive health, rights, aspirations of young girls, and their capacity to contribute to the development of Africa are defended.

In the developing world, one in seven girls is married before her 15th birthday and some child brides are as young as eight or nine. Pregnancy during adolescence is associated with higher risk of health problems like anemia, sexually transmitted infections, unsafe abortion, postpartum hemorrhage, and mental disorders (like depression). Pregnant adolescents also bear negative social consequences and often have to leave school reducing their employability leading to long-term economic implications. Unmet needs for family planning especially for spacing are high among adolescents. AU Member States and the RECs with support from CSOs continue to play a major role in addressing adolescent SRH to meet these challenges through

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54 2012 Africa Reproductive and Sexual Health Scorecard, by Africa Public Health. Info (now Afri-Dev.Info) and Africa Coalition on Maternal, Newborn and Child Health
55 2013 Africa Scorecard on Multi-Faceted Violence Against Young Girls & Women produced by Afri-Dev. Info & the Africa Coalition on Maternal, Newborn and Child Health
56 On Youth Development, from just health – to health, human and social development: Transition document of the Africa Public Health Alliance to the Africa Health, Human and Social Development Alliance.
technical support in strengthening and improving health care system for providing adolescent friendly health services.

For many adolescents who need sexual and reproductive health services, such as appropriate information, contraception and treatment for sexually transmitted infections, these are either not available or are provided in a way that makes adolescents feel unwelcome and embarrassed. A lot still needs to be done in the area of sensitizing health service providers in their ability to address the needs and developmental attributes of adolescents to be able to attract them.

3.5. Skilled Birth Attendance

Skilled birth attendant is an accredited health professional such as a midwife, nurse or doctor who has been educated and trained to proficiency in the skills necessary to manage normal deliveries and diagnose, manage, or refer obstetric complications. Skilled attendants must be able to manage normal labor and delivery, perform essential interventions, start treatment and supervise the referral of mother and baby for interventions that are beyond their competence or not possible in a particular setting.

The proportion of births attended by skilled health personnel is currently lower in Africa (excluding North Africa) than in all other developing regions worldwide. In the six worst-performing countries (Burundi, Chad, Eritrea, Ethiopia, Niger, and Somalia), only one-third of women delivered with a skilled healthcare worker present. Other countries (e.g. Kenya, Lesotho, Liberia, Madagascar, Somalia, and Zambia) recorded no progress on this indicator or even a regression. The Sudan saw a drastic drop from 86.3 percent in the period 1990–1999 to 49.2 percent in the period 2000–2009, which is most likely due to the ongoing conflicts in the country. The top-performing countries in the 2000–2009 survey (with 75 percent or higher of women who received skilled assistance during delivery) were (in order of achievement): Mauritius, Algeria, Tunisia, Botswana, South Africa, São Tomé and Príncipe, Namibia, Zimbabwe, Egypt, and Cape Verde.

Research demonstrate that between 13% - 33% of maternal deaths could be averted by the presence of a skilled birth attendant. However, the gap between evidence based standards for skilled management of basic and emergency obstetrics and actual practice among skilled birth attendants is a subject of debate. International standards and operational definitions do not automatically lead to the education and/or training of SBAs who demonstrate competency in their midwifery and obstetric care practices. It is suggested that a great deal of stagnation of maternal health programs has been the result of confusion and careless choices between scaling up truly skilled birth attendants or multipurpose workers in large quantities and with short training, fewer skills, limited authority and no career pathways.

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3.6. Nutrition and Maternal Health

Key indicators of maternal nutrition are maternal stature, body mass index and micronutrient deficiency. Poor maternal nutrition contributes to at least 20% of maternal deaths, and increases the probability of other poor pregnancy outcomes, including newborn deaths. Short maternal stature, often a result of childhood stunting, is also a risk factor for obstructed labour and caesarean delivery due to a disproportion between the baby’s head and the maternal pelvis. Prolonged obstructed labour combined with no or delayed access to caesarean delivery can result in maternal mortality, debilitating long-term health consequences such as obstetric fistula and neonatal mortality due to birth asphyxia. Many countries with high maternal undernutrition also lack readily available emergency caesarean sections.

Limited information is available on maternal micronutrient deficiencies. A WHO review of nationally representative surveys from 1993 to 2005 found that 42% of pregnant women worldwide are anaemic, more than half of them due to iron deficiency. Prenatal folic acid deficiency, also widespread, is associated with increased risk of neural tube defects. Further research is needed to understand the relationships between maternal undernutrition and short- and long-term maternal and child health outcomes.

The cycle from the mother’s pregnancy to the child’s second birthday provides a critical window of opportunity in which interventions to improve maternal and child under-nutrition can have a positive impact on young children’s prospects for survival, growth and development, especially in countries with a high burden of under-nutrition. A package of effective nutrition interventions has widely been agreed upon by experts and programme partners. It includes interventions in three key areas:

- Maternal nutrition during pregnancy and lactation particularly Iron and Folic acid supplements during pregnancy
- Initiation of breastfeeding within the first hour after birth, exclusive breastfeeding for the first 6 months, and continued breastfeeding up to at least 24 months of age.
- Adequate complementary feeding from 6 months onward, and micronutrient interventions as needed.

There is growing evidence of the benefits to mother and child of early initiation of breastfeeding, preferably within the first hour after birth. Early initiation of breastfeeding contributes to reducing overall neonatal mortality. It also reduces a mother’s risk of post-partum haemorrhage, one of the leading causes of maternal mortality. Colostrum provides protective antibodies and essential nutrients, acting as a first immunization for newborns, strengthening their immune system and reducing the chances of death in the neonatal period.

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3.7. Immunization and Maternal Health

Rubella infection just before conception or during pregnancy can cause miscarriage and stillbirth, and babies born with Congenital Rubella Syndrome (CRS), most commonly heart problems, deafness or blindness. The human and economic toll of rubella is staggering. For instance, WHO estimates that in 1996, 22,000 children were born with CRS in Africa. Given that few countries in Africa had introduced rubella-containing vaccine (RCV), current estimates are believed to be in line with these figures.

Africa has one of the highest number of estimated CRS cases and the lowest uptake of rubella-containing vaccines. Among WHO member states, more than one-third of countries, mostly in Africa, were not using rubella vaccine in the national immunisation schedule as of 2010. The Rubella vaccine gives long-term protection, and is often given in combination with measles vaccine as a measles-rubella (MR) or measles-mumps-rubella (MMR) vaccine. The MR vaccine is considered safe and cost-effective at around US$ 0.50 cents per dose.

New WHO guidelines in 2011 supported a paradigm shift in vaccination strategy for the introduction of rubella-containing vaccines. Earlier thinking in the rubella disease community placed an emphasis on immunising adolescent girls and women of child-bearing age to decrease the risk of CRS. However, in many settings, barriers to access resulted in limited vaccine coverage and the rubella virus continued to circulate. The new approach focuses on interrupting transmission of rubella virus, thereby eliminating rubella as well as CRS over the long term.

Accelerating the introduction of a combined measles-rubella vaccine in Africa will spread its protection to those in most need, and builds on efforts to control measles. From 2013, African countries are launching large-scale ‘catch up’ campaigns in measles-rubella, and countries are self-financing the introduction of the vaccine in their routine immunization programmes. One cost-effective vaccine which prevents two life-threatening diseases is a major step in accelerating progress in controlling measles and rubella.

Cancer is an emerging health issue across Africa. In 2008, 542,000 deaths were attributed to cancer on the continent, a number that is expected to rise to 970,000 by 2030. Among these cancers, cervical cancer is the leading cause of cancer deaths among women in many African countries. Immunizing girls before the initiation of sexual activity (that is, before first exposure to HPV infection), is a key strategy to prevent cervical cancer. Safe and effective HPV vaccines against HPV types 16 and 18, which cause about 70% of cervical cancer cases, provide a tremendous opportunity to put girls at the center of Africa’s development. It is recommended (WHO) that HPV vaccination of girls aged 9-13 years through national immunization programmes in African countries where cervical cancer constitutes a public health priority and where vaccine introduction is feasible.

The year 2013 is a landmark year for Africa’s girls, with the first African countries piloting the best ways to deliver HPV vaccine. Seven African countries will be piloting the best ways to

deliver HPV vaccine to girls together with other interventions that benefit their lives. These demonstration projects will pave the way for countries to build capacity and infrastructure needed to vaccinate girls nationwide.
3.8. Reinforcing CARMMA

The Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) is an African Union Commission (AUC) initiative to promote and advocate for renewed and intensified implementation of the Maputo Plan of Action for Reduction of Maternal Mortality in Africa to attain the MDG 5. Although the principal focus of CARMMA is maternal mortality, it is also about child mortality because of the impact of maternal mortality on children and families.

CARMMA was launched at the continental level during the Africa Union Conference of Ministers of Health in May 2009 in Addis Ababa, with the theme: “Universal Access to Quality Services: Improve Maternal, Neonatal and Child Health”. CARMMA derives its significance and authority from previous commitments made by African Heads of States on Maternal Health and the achievement of health-related Millennium Development Goals (MDGs).

A review of progress in implementation of the Maputo Plan of Action noted that an unprecedented effort is ongoing in Africa to revise, update and develop policies, strategies and plans related to the different components of SRHR. The main challenges and lessons highlighted by almost all countries who participated in the assessment under each priority area in the Maputo PoA relate to inadequate resources, weak health systems, inequities in access, weak multi-sector response, low priority accorded to health in national development plans, and inadequate data.

CARMMA was informed by the slow progress in and the recognition of the daunting challenges in reducing maternal mortality in most African countries by 75 per cent in comparison with 1990’s figures by 2015, as recommended in the MDG5. There was also growing concern that social development in general and women’s health in particularly faces new threats from the global financial crisis and economic meltdown, unpredictable aid future, compounded by climate change and food crises, among other challenges.

With the leadership of the African Union and the support of African Governments, CARMMA has been launched in 37 African countries. Because of the urge to speed-up the achievement of the Millennium Development Goal 5 (MDG5A & 5B), a number of initiatives that link with CARMMA have been put in place by the global community. Some of these initiatives are; a) The UN Secretary General’s Global Strategy on Women’s and Children’s Health; b) The UN Commission Life-saving Commodities for Women and Children; c) Commission on Information and Accountability for Women’s and Children’s Health; d) the Global and Regional Partnerships on Reproductive, Maternal, Newborn and Child Health; e) the Save the Mother and Save the Child Initiative of the Prevention and Elimination of Mother to Child Transmission of HIV.

64 http://au.int/pages/carmma/whatis
The 15th Ordinary Summit of the AU Heads of States and Governments held in Kampala further strengthened CARMMA and reaffirmed commitments to MNCH in the continent. One among key decisions that the Summit passed on includes “Strengthen the health system to provide comprehensive, integrated, maternal, newborn and child health care services, in particular through primary health care, repositioning of family planning including reproductive health commodities security, infrastructure development and skilled human resources for health in particular to train Community Health Workers to mitigate the human resource crisis in the Health sector”. Government stewardship, partnership, sustainable financing and call on the Global Fund for Fight against HIV/AIDS, Malaria and TB to create a new window to fund maternal, Newborn and Child Health were also part of the decision

At the 20th AU Summit in January 2013 AU Heads of States and Governments deliberated on MNCH status in Africa, another landmark that provided further impetus to CARMMA. The Assembly reaffirmed its previous commitments underscoring those contained in the Maputo Plan of Action, CARMMA, the Abuja Declaration on HIV/AIDS, Tuberculosis, Malaria and other infectious diseases and the universal access to prevention, treatment and support services as well as its commitment to redouble efforts to improve the health of African women and children as spelt out in the “Actions on Maternal, Newborn and Child health and development in Africa (Assembly/AU/Decl.1(XI)).

The High Level Event on CARMMA at the 20th AU Summit in January 2013 AU Heads of States and Governments was another important forum that was attended by over 30 Heads of States and Governments. Hosted by the President of the Republic of Benin who was the then Chair of the AU.

The Summit also requested AU Ministers of Health to examine progress made regarding the state of maternal, newborn and child health; map out concrete and innovative strategies at a larger scale in order to adequately address the health needs of African women and children and submit a report to the 21st Ordinary Session of the Assembly.

To respond to this call from Heads of State and Governments, Ministers of Health have mapped out the following concrete and innovative strategies based on the outcomes of the High Level Event, the best practices from various African countries and the findings from international bodies working in the field of maternal health:

a) Collectively and individually redouble efforts to improve maternal, newborn and child health and thereby reduce maternal and child mortality to accelerate progress towards MDGs 4 and 5;

b) Request the Africa Union Commission (AUC) in collaboration with the United Nations Population Fund (UNFPA), serving as the secretariat for CARMMA, to establish a continental structure to monitor and follow up on progress and facilitate the sharing of best practices among member states;

c) Encourage member states that have not yet done so to launch CARMMA and invite all member states to explore innovative and sustainable approaches to channel
additional human and financial, domestic and external resources to reinforce action on maternal, newborn and child health;

d) Request the Africa Development Bank in collaboration with the AUC and UNFPA to develop a framework for the establishment of a mechanism to source, pool and manage resources in support of Maternal Newborn and Child Health including through the promotion of inter-continental cooperation on best practices;

e) Foster and strengthen global and country level partnership with development partners including civil society, professional associations, private sector and women’s and youth groups;

f) Expand access to family planning and other reproductive health services and reduce the huge unmet needs for contraception;

g) Take concrete measures to strengthen health systems with a particular focus on improving health infrastructure and ensuring effective supply chain management for life-saving commodities to support universal access to high impact maternal and newborn health interventions, especially under the Every Woman Every Child Global Strategy and its Commissions;

h) Invest in human resources for health, building skilled and motivated health workforces, including midwives in particular, to increase access to skilled birth attendance and strengthen emergency referral;

i) Scale-up coverage of more effective antiretroviral (ARV) interventions and safer infant feeding practices to eliminate mother to child transmission, while implementing other measures to prevent new HIV infections among women in reproductive age;

j) Recognize the need for an international conference on maternal health to be held in 2013 as an opportunity to share best practices and enhance south-south cooperation;

k) Mainstream women’s and children’s health and overall wellbeing in line ministries—mainly education, food, housing and employment—and national development plans;

l) Develop a costed and evidence based plans, where this is not done, to address priorities and implement high impact maternal, newborn and child health interventions indicating gaps in funding to meet the targets of MDG 4 and 5 (with support from HHA partners);

m) Improve quality of care across the continuum of care and ensure that services are organized and delivered in an integrated and comprehensive manner;

n) Build country capacity for operations research in MNCH and strengthen health information systems including vital events registration;

o) Address inequities in maternal, newborn and child health service coverage; and

p) Establish CARMMA Councils at national and sub-national levels involving key stakeholders to provide oversight to evidence based planning and monitoring of services and tracking availability and utilization of domestic and external resources.

The decision of the Assembly and the Communiqué from the High Level Event are based on a thorough examination of the continental challenges in achieving MDG 4, 5 and 6 and a reiteration of previous commitments by African Leaders. With actions matched on the ground, these decisions will no doubt accelerate the status of the MNCH in the continent. By raising additional resources and effectively using those at the disposal of countries, strengthening
health systems with focus on human resources for health and essential and life saving commodities, fostering partnership and through evidence based planning and monitoring most African countries are in much better standing today to improve the health of mothers, newborns and children.
4. INTEGRATION OF SERVICES

Integrated delivery of services means the management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system. The idea of integrated health services is not new. Indeed it was the basis for the focus on primary health care in the 1980s.

The "Continuum of Care" for reproductive, maternal, newborn and child health includes integrated service delivery for mothers and children from pre-pregnancy to delivery, the immediate postnatal period, and childhood. Such care is provided by families and communities, through outpatient services, clinics and other health facilities. The Continuum of Care recognizes that safe childbirth is critical to the health of both the woman and the newborn child—and that a healthy start in life is an essential step towards a sound childhood and a productive life.

Global scorecard on MNCH has indicated slow progress on MDGs 4 and 5, attributed to low coverage with key preventive and therapeutic MNCH interventions. The need for intensified action on MNCH goals has prompted the global health community to consider innovative ways to dramatically increase intervention coverage including the integrated delivery of multiple HIV and MNCH interventions in a single delivery setting.

Integrating programs for HIV, family planning (FP), and maternal, neonatal, and child health would address patients’ multiple needs at once, and may enhance program effectiveness and efficiency. This will no doubt go a long way in expanding access to both HIV and maternal, newborn and child health, thereby contributing significantly to the achievement of the health-related Millennium Development Goals (MDGs)

Across the African continent, most HIV, MNCH and FP services are offered in isolation. In recent years program managers and policymakers have begun to recognize the missed opportunities and inefficiencies created by these vertical approaches. Experiences in some countries in Africa south of the Sahara suggest that integrating reproductive health and HIV services may improve access to contraception for HIV-infected individuals, increase uptake of prevention of mother-to-child transmission services and cervical cancer screening, and lead to earlier initiation and sustained use of anti-retroviral therapy.

65 INTEGRATED HEALTH SERVICES – WHAT AND WHY?

66 PMNCH Fact Sheet: RMNCH Continuum of care Reproductive, maternal, newborn and child health. Updated September 2011
In South Africa, evaluation of an intervention that brought ART staff to ANCs for ART provision were associated with a significantly shorter time from HIV diagnosis to ART initiation when compared to pre-integrated care (before integration, the median time was 56 days, and after integration it was 37 days). Integration was also associated with a significantly shorter time to receiving a CD4 result (the median was 50 days before integration, compared with 29 days after). Other similar evaluations in Malawi, Zambia and Tanzania have all pointed at the potential health benefits of integration of MNCH/FP/HIV services.

National estimates of intervention coverage often mask important sub-national inequities. Country reports should include a profile of socioeconomic inequities in coverage for a set of key interventions across the continuum of care. Intervention coverage in many countries is substantially higher among women and children from richer households, but inequities in coverage vary by intervention. Interventions that require a functional health system, such as skilled attendant at birth, are particularly inequitable, while interventions that do not, such as vaccines are more equitable. Integrated delivery of services along the continuum of care is one potential strategy to address inequities in service availability and utilization.

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70 Rasch V, et al. Post-abortion care and voluntary HIV counseling and testing—an example of integrating HIV prevention into reproductive health services *Trop Med Int Health* 2006; 11:697–704

5. FINANCING OF MNCH INTERVENTION

Governments can increase access and reduce financial barriers for reproductive, maternal, newborn and child health services through pro-poor legislation (for example, expanding fully or partially subsidized prepayment schemes, removing user fees and other financial barriers to access, instituting conditional cash transfer schemes, creating universal health systems and the like) and adequate funding for reproductive, maternal, newborn and child health, including from domestic resources\(^2\).

5.1. Status of MNCH Financing

AU Member States have made great strides in health financing, particularly towards meeting the Abuja target of allocating at least 15% of their national budgets to health. Over 55% of African countries have allocated over 10% of their total government expenditure to health. More encouraging, five countries (Madagascar, Togo, Zambia, Botswana and Rwanda) have attained the Abuja target (Figure 1\(^3\)). Despite this remarkable achievement, countries such as Guinea, Chad, Eritrea, Guinea Bissau, Somalia, Sudan and Nigeria commit less than 5% of their national budget to health. In most countries the proportion of health budget allocated to MNCH services has not been determined.

The support from partners towards MNCH in Africa has been tremendous. It is estimated that donor disbursements for MNCH increased by 64% between 2003 and 2006, from US$2.12 billion to $3.48 billion. This is separate from child health financing from maternal and neonatal health financing. Of the $3.48 billion disbursed in 2006, 66% ($2.31 billion) was spent on child and 34% ($1.17 billion) on maternal and neonatal health. In 2006, 54% of donor assistance to MNCH was from bilateral agencies, 31% from multilateral financers (World Bank, UNFPA, UNICEF, and the European Commission), and 15% from the Global Fund and GAVI Alliance. The two leading MNCH financers were the World Bank ($725m) and the US government ($692m). World Bank financing to MNCH, however, may be overinflated because up until 2008 the World Bank was the only organization that reported commitments (not disbursements).

5.2. Innovative Financing of MNCH intervention

In order to speed up progress in MNCH, Africa may need to move away from the traditional forms of funding. Innovative sources of funding, such as the International Finance Facility for immunization, which uses long-term legally binding commitments by donors to issue bonds on the international capital markets, provide cash that can be used by organizations such as the Global Alliance for Vaccines and immunization (GAVI) to partner with African countries to fund immunization programmes. Another innovative financing mechanism, the Advance Market Commitment, has accelerated the development and manufacture of pneumococcal vaccines, many of which are now being introduced in many African countries. Finally, African businesses are showing increasing interest in providing financial resources, advocacy, and core business skills to advance routine immunization coverage in Africa.

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Figure 13: Allocations to Health as percentage of National Budgets

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MNCH programme may also learn from innovating financing mechanisms of other disease programmes such as HIV/AIDS and malaria. The air ticket (solidarity) levy, a small contribution
added to outbound air tickets, is one of the most successful innovative financing mechanisms in Africa today. Several African countries have already implemented the levy to support UNITAID and have increased access to the best medicines and diagnostic products for vulnerable populations. With the air ticket levy, African economies can use their vibrant growth to support international solidarity as well as generate additional domestic resources for health and the fight against HIV/AIDS, malaria and tuberculosis.

There are also some good practices that have been learnt at national level. For example, Ghana utilizes a national health insurance levy to finance 70% of its National Health Insurance Scheme. Taxes on profitable sectors or big corporations have also been used, as in Gabon where the government had since 2008 implemented a 10% tax on mobile phone companies’ turnover to cover those not able to contribute to national health insurance. Excise tax on products that pose risks to health, such as tobacco, are considered a “win-win” strategy since they can lead to reduction in risky behavior while at the same time increase domestic revenues. Other taxes that have been utilized by countries to raise revenue are financial transactions-related tax, tourism tax, and luxury tax.

5.3. Domestic Financing of MNCH
High level political commitment of African governments towards improving the health of women and children has been demonstrated at the 15th Ordinary Session of the AU Assembly whose theme was on MNCH, the launch of CARMMA in 37 Member States and removal of user fees at facilities for women and children by member states. Countries that have recently removed user fees for maternal and child health services include Benin, Burkina Faso, Chad, Congo, Mali, Sierra Leone and Liberia. In spite of these developments, more financing, ownership and commitment is still required in other areas. For example, only 12 out of Africa’s 54 countries finance between 50% to 100% of their expanded programme on immunization. How about funding for maternal health family planning and other Rh services?

6. RECOMMENDATIONS TO SCALE UP LOW COST-HIGH IMPACT MNCH INTERVENTIONS IN AFRICA

6.1. Political will/Investment
a. Need to move from spending more time in talking to actions in implementing various policy and financing recommendations. There is need to have a mechanism of implementing and monitoring all political commitments.

6.2. Nutrition
a. An investment in nutrition including food fortification is an investment in children and an investment in children is an investment in Africa; therefore fortification should be considered as a high impact and relatively low strategy.
b. Food and nutrition security should become the real engine of equitable and sustainable economic growth.
c. There is need for establishing Bureaus of standards to ensure cross sectoral policy on food fortification that ensures that processed and packaged food items are fortified with essential micro-nutrients and vitamins
d. Increased budgetary allocations and cross-sectoral planning and action is needed for adequate nutrition interventions, strengthen strategic food reserves, improved distribution, and ensure synergy of plans and action, coordination and collaboration by the relevant ministries – health, agriculture, water resources, industries e.tc.
e. Child stunting, child hunger poverty are further major moral and developmental challenges that must be decisively resolved by all societies beyond 2015. Need to put in place a High Level Political Championship Mechanism on Nutrition at the AU to boost continent efforts to improve nutrition development and security in Africa.

6.3. Immunization
a. Strengthen immunization programmes within the context of health systems strengthening
   • Ensure effective and sustainable introduction of new vaccines and prioritized technologies as part of a package of integrated, cost-effective health interventions.
   • Broaden and deepen ambition, effort, and advocacy for a ‘fully immunized child’.

b. Ensure adequate and sustainable domestic financing of national immunization systems. Countries under investing in their expanded program on immunization to increase investment.

c. Strengthen the management, analysis, interpretation, use and exchange of immunisation data and information at all levels
d. Integrate immunisation with other MNCH/SRH interventions to maximise synergy and sustain the benefits to all vulnerable populations

e. Increase community demand for and access to immunization through behavior change communication and social mobilization activities, vaccination campaigns and increased routine immunization services

f. Increase vaccination coverage and decrease the number of unimmunized children through programmes tailored to overcome geographic, income and gender-related barriers to immunization

g. Develop strategies to address inequalities in immunization that are integrated into national health plans and that strengthen health systems.

h. Improve vaccine and injection safety and improve and strengthen vaccine cold chain management systems

i. Work in partnership with regional and in-country stakeholders such as civil society and the private sector.

6.4. Maternal Health and Family Planning

a. Develop country and regional mechanism to monitor progress in fulfillment of commitments by partners and national governments to finance maternal health and family planning programs.

b. Identify the gaps in reducing maternal mortality at country level including obstacles to reach services and develop evidence based planning and monitoring mechanisms.

c. Strengthen and expand family planning programmes to accelerate provision and universal access to family planning services as an entry point to improving maternal health.

d. Increase the numbers of skilled birth attendants, particularly midwives to ensure the availability of and universal access to quality emergency obstetric and newborn care services.

e. Ensure availability at all times of essential MNCH interventions at facility level.

f. Improve nutrition of women in pregnancy and during lactation

g. Introduce maternal death audits at facility and community levels

h. Prioritize the education of the girl child and young women, providing enabling environment for them to stay and complete schooling
i. Uphold the African Charter on Welfare and Protection of the Child and abolish child ‘marriage’ which contributes greatly to maternal mortality through pregnancy related death of underage girls.

6.5. Health System Strengthening

a. Strengthen human resources for health to ensure safe delivery in EmONC facilities including trained obstetricians, anesthetists and other essential cadres

b. Ensure the availability of essential medicines and equipment for safe delivery including for example oxytocin and misoprostol to reduce bleeding, magnesium sulfate and its antidote for eclampsia (high blood pressure of pregnancy), equipment for blood transfusion, etc..
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