

However, seven countries (Cameroon, Congo Republic, Egypt, Equatorial Guinea, The Gambia, Guinea-Bissau, and São Tomé and Príncipe) recorded a decline in the number of women in parliament between 1990 and 2010. Furthermore, in 2010 there were 17 countries³⁷ with less than 10 percent of women's representation, with Egypt and Comoros as the worst performers (1.8 and 3.0 percent representation respectively). Women's participation in the executive, judicial, traditional, and other public spheres is low across the majority of the countries, with only 29 percent of women holding positions as senior officials or senior managers.³⁸ Overall though, Africa's progress toward achieving gender parity in the national parliaments is very encouraging. In order to ensure continued gains in this and other public spheres, governments should institutionalize a minimum quota of women parliamentarians, while also addressing challenges such as cultural norms and traditional institutions. This will ensure that governments continue to strive for gender parity in public life beyond 2015.

GOAL 4: REDUCE CHILD MORTALITY

According to the World Health Organization (WHO), almost 90 percent of all child deaths are attributable to just six conditions: neonatal causes, pneumonia, diarrhea, malaria, measles, and HIV/AIDS. Progress to reach MDG 4 (reducing under-five mortality by two-thirds from 1990 to 2015), will require universal coverage with the following key effective and affordable interventions: care for newborns and their mothers; infant and young child feeding programs; vaccines; prevention and case management of diarrhea, pneumonia and sepsis; malaria control; and prevention and care of HIV and AIDS. It is believed

37 Algeria, Botswana, CAR, Chad, Comoros, Congo Republic, Côte d'Ivoire, DRC, Egypt, The Gambia, Ghana, Kenya, Libya, Niger, Nigeria, São Tomé and Príncipe, and Somalia.

38 UN (2010).

that these interventions could reduce the number of child deaths by more than half, particularly in countries where child mortality is high.³⁹

Generating accurate estimates of under-five mortality poses a considerable challenge because of the limited availability of high-quality data for many developing countries. New estimates at the global level, by the United Nations Inter-agency Group for Child Mortality Estimation (IGME), show that of the 31 countries recording an under-five mortality rate (U5MR) of at least 100 deaths per 1,000 live births in 2009, 30 were in Africa. The global U5MR has declined by almost one-third over 20 years, from 89 deaths per 1,000 live births in 1990 to 60 deaths per 1,000 live births in 2009. However, progress in some regions – notably Africa (excluding North Africa), Southern Asia, and Oceania – is insufficient to meet the Goal (IGME, 2010).

Overall there has been some progress in the three indicators tracking the achievements of countries towards MDG 4. Despite these achievements, and due to the fact that most child deaths are preventable or treatable, African countries should revitalize comprehensive and integrated efforts against the main diseases that cause child mortality within the framework of strengthening health systems and ensuring a quality continuum of care.

Target 4.A: – Reduce by two-thirds between 1990 and 2015, the mortality rate among children under five years old

Indicator 4.1 – Under-five mortality rate (U5MR)

Africa recorded a decline in U5MR from 165 deaths per 1,000 live births in 1990 to 118 deaths per

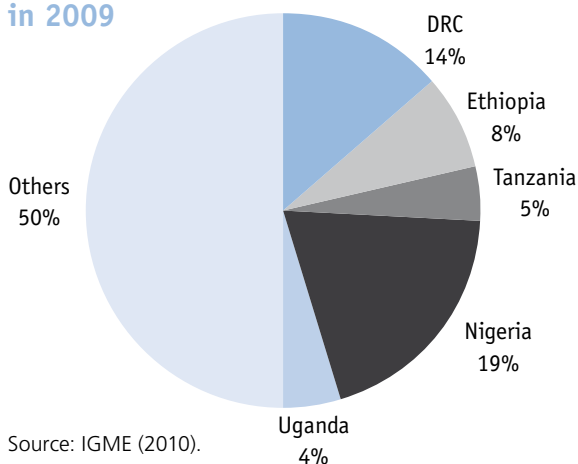
39 UN (2010).

1,000 live births in 2009 – a 28 percent reduction over a period of 20 years. This reduction translates into an annual average reduction of 1.8 percent, which is considered to be insufficient to enable the continent as a whole to reach the target (IGME, 2010). In terms of the number of infant deaths, there has been a slight decline of 4 percent from 4.2 million in 1990 to 4.1 million in 2009.

DRC, Ethiopia, Tanzania, Nigeria, and Uganda accounted for about 50 percent (2.0 million) of the deaths in 2009 (*Figure 23*). Nigeria has identified some factors contributing to the elevated U5MR, including a decline in resource allocation and inequality in access to healthcare facilities. In the case of Tanzania, constraints include inadequate financial and human resources in the health sector and the lack of a management information system for monitoring and evaluation (M&E) purposes. Certain countries, such as Sierra Leone, have initiated various public interventions to improve child and maternal health (see *Box 4* under MDG 5). Nevertheless, the U5MR continues to be high in the majority of countries, with 30⁴⁰ out of 53 countries registering rates of more than 100 deaths per 1,000 live births in 2009 (*Figure 24*). The slow progress toward a reduction in child mortality is exacerbated by the high levels of population growth.

40 Angola, Benin, Burkina Faso, Burundi, Cameroon, CAR, Chad, Comoros, Congo, Côte d'Ivoire, DRC, Equatorial Guinea, Ethiopia, The Gambia, Guinea, Guinea-Bissau, Liberia, Malawi, Mali, Mauritania, Mozambique, Niger, Nigeria, Rwanda, Sierra Leone, Somalia, The Sudan, Tanzania, Uganda, and Zambia.

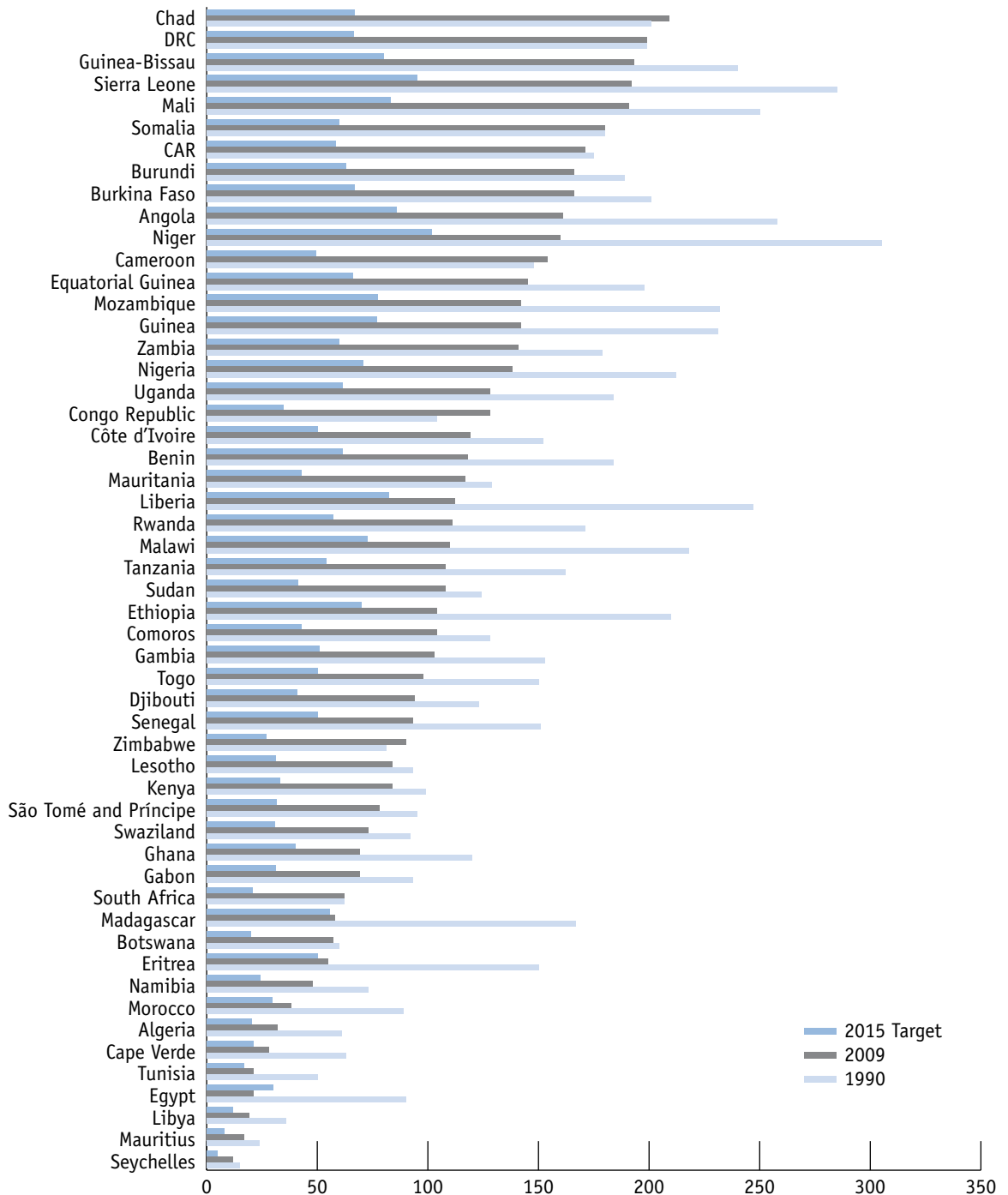
Figure 23: Countries with the highest prevalence of under-five deaths in Africa in 2009



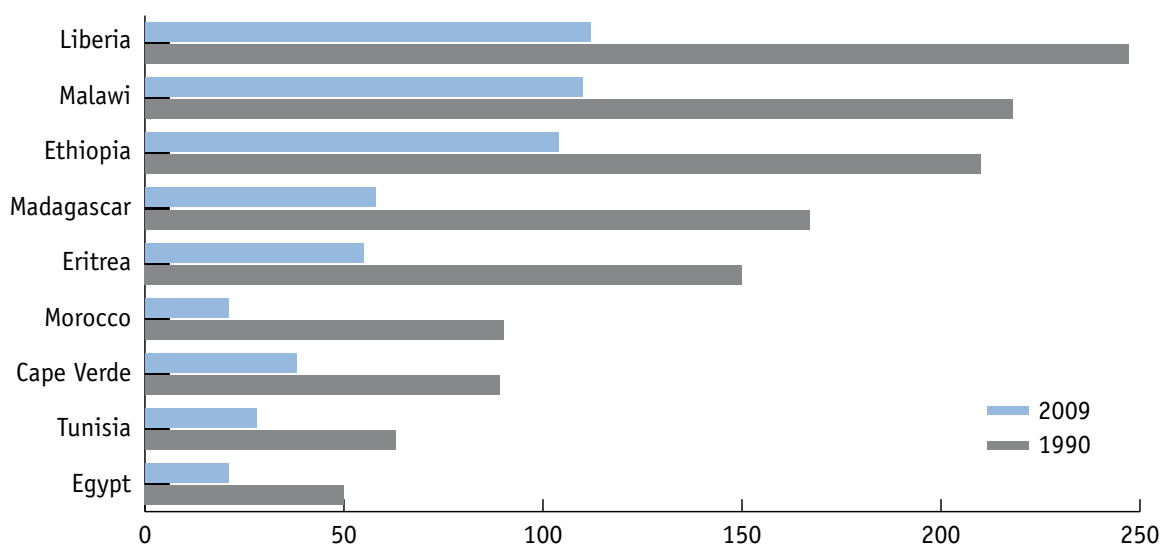
Source: IGME (2010).

As with the other MDGs, the regional average for this indicator conceals disparate rates of progress among individual countries. Based on the pace of progress achieved from 1990 to 2009, six countries (Algeria, Cape Verde, Eritrea, Libya, Morocco, and Tunisia) are definitely on course to achieve the target, having reduced their under-five mortality rates by more than 45 percent. This has been largely attributable to improvements in the mothers' level of education; the strengthening of health systems through policies that provide a balance between curative and preventative interventions; increased access to health facilities; and the implementation of robust monitoring and evaluation (M&E) systems. Furthermore, among the countries that have managed to reduce U5MR by at least 33 percent, five countries (Ghana, Madagascar, Namibia, Senegal, and Togo) are classified as being on track to achieve the target of MDG 4. However, the majority of countries have failed to make sufficient headway in reducing U5MR. Chad and DRC have displayed tendencies of either stalling or regressing in their U5MR since 1990, mainly due to insufficient funding, low-skilled professionals in their health sectors, and the failure of government policies to effectively address the situation.

Figure 24: Progress toward reducing the U5MR rate, 1990, 2009, and 2015 (target)



Source: Compiled from IGME (2010).

Figure 25: The nine best U5MR-performing countries, 1990 and 2009

Source: Compiled from IGME (2010).

It is noteworthy that Ethiopia features in the best-performing countries' list, with a 50 percent reduction between 1990 and 2009 (*Figure 25*). This achievement should be viewed in the context of the very high population levels in Ethiopia and Nigeria. For both these countries, a very high initial U5MR has created a greater challenge for the achievement of a two-thirds reduction.

Figure 25 reveals that nine countries have made the most progress by reducing their U5MR by 50 percent or more from 1990 to 2009. Egypt has already met the target and other countries are likely to do so by 2015 if the current trend is maintained. The number of countries with an U5MR below 100 deaths per 1,000 live births

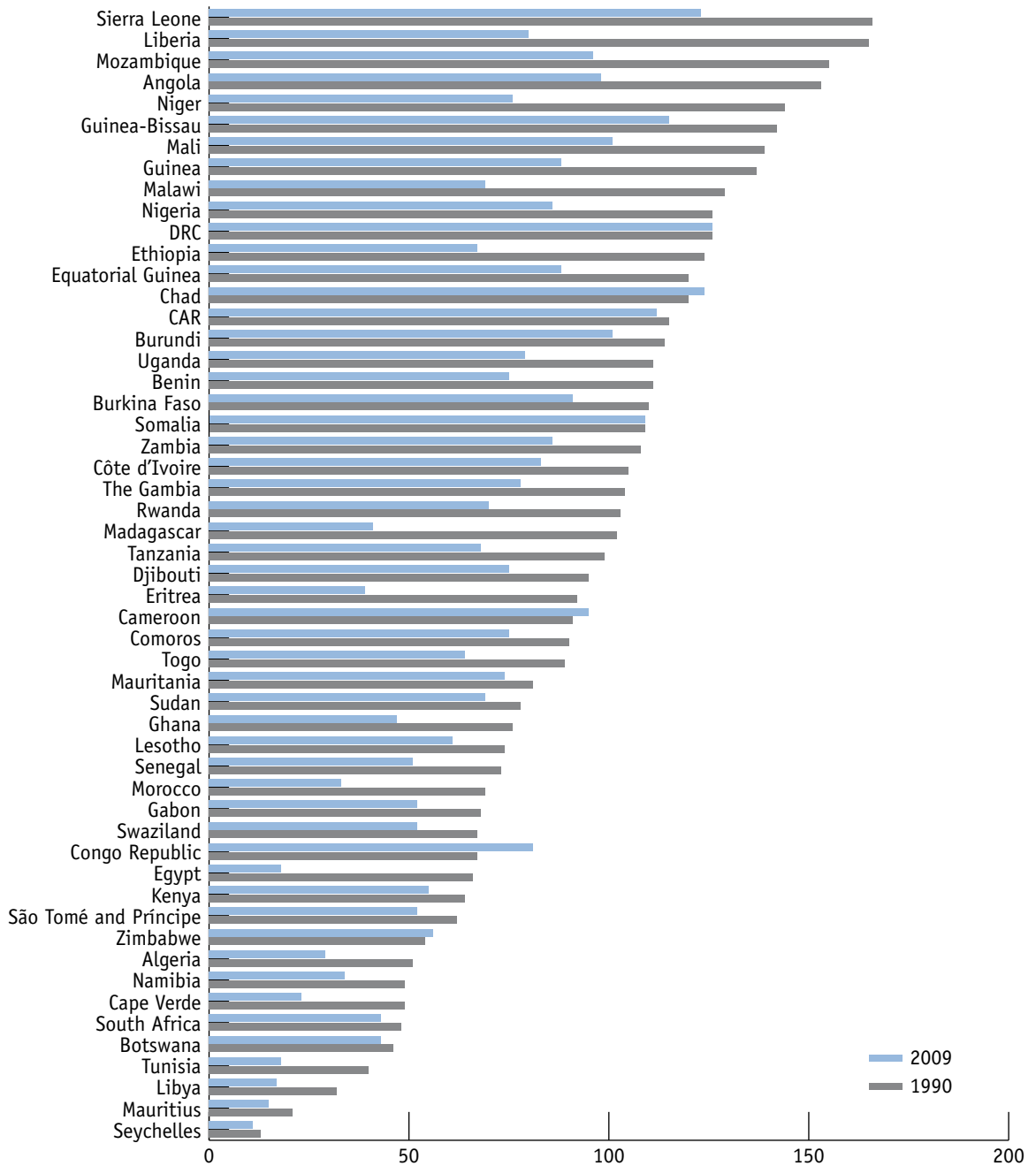
increased from 17 countries⁴¹ in 1990 to 23 countries⁴² in 2009.

The policy interventions that resulted in a high reduction in the U5MR are country-specific but certain commonalities exist. The political will to reduce child mortality is crucial to success, and this is the bedrock for prioritized budget allocations and for more focused interventions. For example, Ethiopia has expanded the supply of health workers in rural areas to provide information and advocacy on nutritional and vaccination information, and general child medical advice to mothers. Malawi has implemented an integrated management of

41 Algeria, Botswana, Cape Verde, Egypt, Gabon, Kenya, Lesotho, Libya, Mauritius, Morocco, Namibia, São Tomé & Príncipe, Seychelles, South Africa, Swaziland, Tunisia, and Zimbabwe.

42 The 23 countries included the 17 countries above plus Djibouti, Eritrea, Ghana, Madagascar, Senegal, and Togo.

Figure 26: Progress in reducing the Infant Mortality Ratio (per 1,000 live births), 1990 and 2009



Source: Compiled from IGME (2010).

its childhood illness program, which focuses on leveraging synergies across different state and non-state implementing agencies, to increase coordination and effectiveness (WHO, 2009).

What is particularly commendable is that among these top-performing countries, we find the post-conflict states of Liberia and Eritrea, which managed to reduce their U5MR by 55 percent and 63 percent, respectively. In the case of Liberia, key ingredients in its robust performance include: leadership commitment, strong partnerships, and enhanced service delivery, as well as secondary factors such as infrastructure development, improvements to formal education, increased domestic food production, and successful development of the private sector. Indeed, the private sector can play a key role by providing better wages, thereby increasing the amount households have to spend on health services. The reported reductions in the child mortality ratio for Eritrea are attributed to increased use of targeted health interventions, such as immunizations, (including measles vaccinations), the use of insecticide-treated bed-nets to prevent malaria, and Vitamin A and food supplements.

Accelerating progress on this indicator will require targeted interventions to address its root causes. Four diseases – pneumonia, diarrhea, malaria, and AIDS – accounted for 43 percent of all deaths in children under five worldwide in 2008. Most of these lives could have been saved through low-cost preventive and curative measures, including antibiotics for acute respiratory infections, oral rehydration for diarrhea, immunization, the use of insecticide-treated mosquito nets and appropriate drugs for malaria. There is an urgent need to refocus attention on pneumonia and diarrhea, which are two of the three leading killers of children.

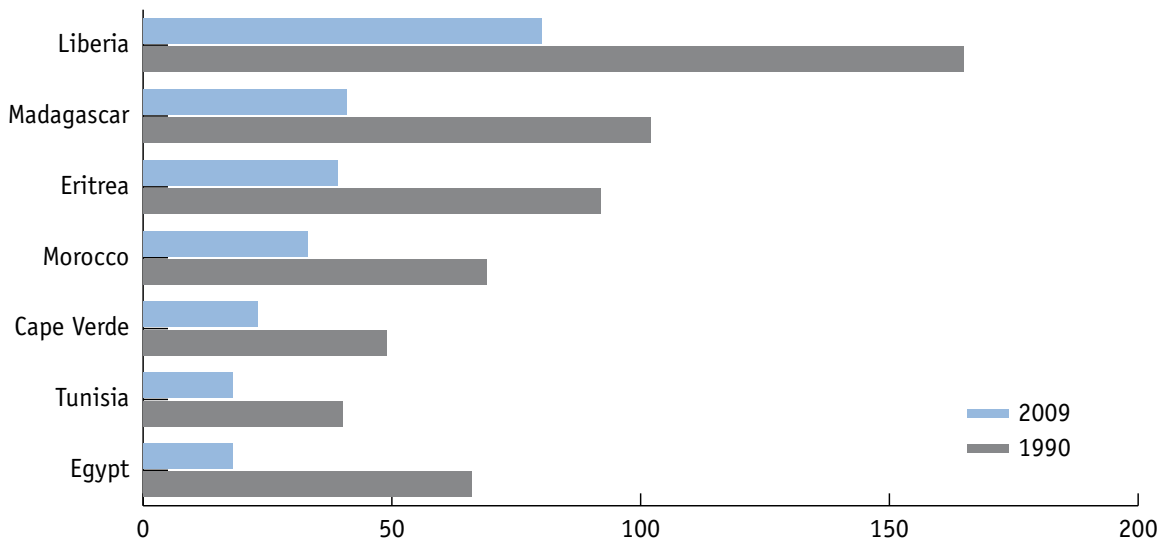
The use of new tools, such as vaccines against pneumococcal pneumonia and rotaviral diarrhea, could add momentum to the fight against these common yet deadly diseases. Combined with a renewed focus on adequate nutrition, such tools provide an entry point for the revitalization of comprehensive programming.

Indicator 4.2 – Infant Mortality Rate (IMR)

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 (*Figure 26*).

Figure 27 shows the seven best-performing countries in reducing IMR by at least 50 percent between 1990 and 2009. Three of these seven top performers are in North Africa (Egypt, Morocco, and Tunisia); two in West Africa (Cape Verde and Liberia), while East Africa is represented by

Figure 27: The seven best IMR-performing countries, 1990 and 2009

Source: Compiled from IGME (2010).

Madagascar and Eritrea. It should be noted that Liberia and Eritrea, which are both included in this list, are postconflict 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 subregions are not represented in this list. Furthermore, of the three countries (Cameroon, Chad, and Zimbabwe) where IMR has increased, two are in Central Africa (Figure 28). This may be an indication of the high prevalence rates of diseases such as malaria that are major causes of infant deaths in the subregion, combined with weak capacity to respond to the threats.

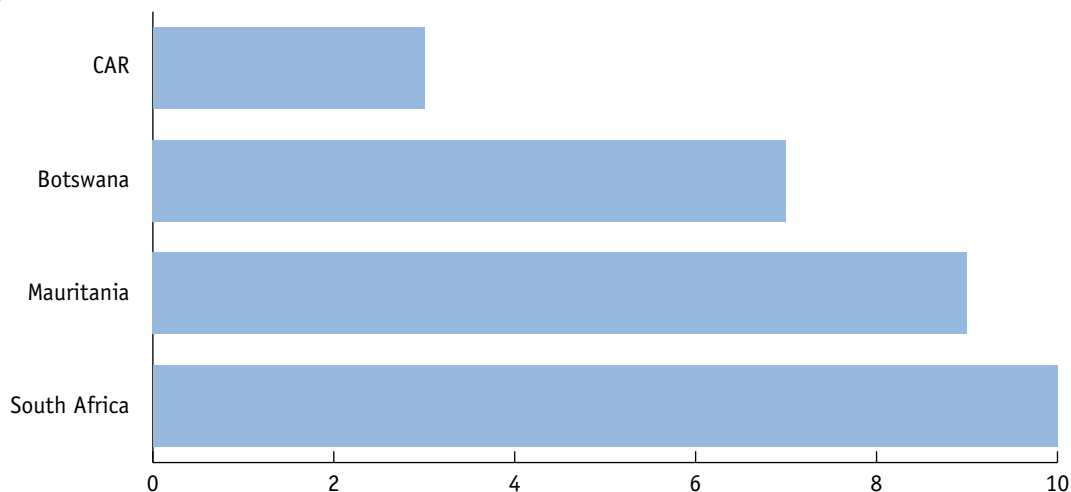
Overall, tackling infant and under-five mortality will require integrated maternal and child care

systems, improved infant nutrition, and a scaling-up of immunization coverage.

Indicator 4.3 – Proportion of one-year-old children immunized against measles

In view of the potential of the measles vaccination to reduce child mortality, routine measles vaccination coverage has been selected as an indicator of progress toward achieving MDG 4. In addition, measles vaccination coverage is often used as a proxy for a country's level of access to child health services. Measles is the leading cause of death in children in Africa ahead of AIDS, tuberculosis, and malaria (WHO, 2009).

Figure 28: Four worst IMR-performing countries, 1990–2009 (reductions of 10% or less)



Source: Compiled from IGME (2010).

While vaccination coverage against measles registered an improvement in Africa from 54 percent in 1990 to 84 percent in 2009, this is not considered adequate to effectively ensure the survival of children. The rates of immunization against measles across the continent vary from one country to the next and a number of countries have made great efforts to increase coverage. For example, 17 countries⁴³ reported a 90 percent and above coverage rate, with only three countries (Nigeria, Somalia, and Chad) below 50 percent immunization coverage in 2009. There was, however, a reversal in immunization coverage rates for some countries between 1990 and 2009 (*Figure 29*).⁴⁴ The decrease

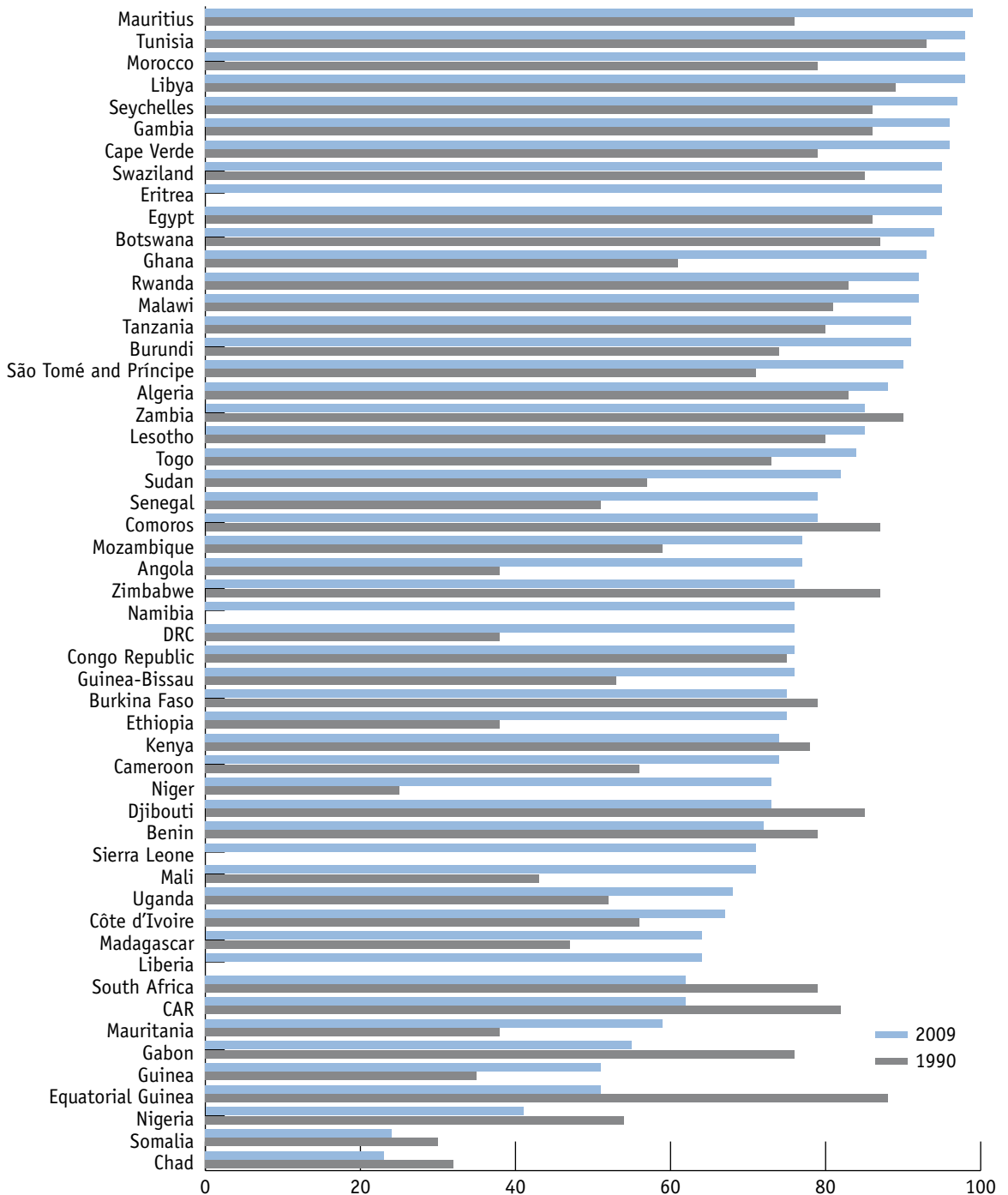
in coverage rates in some of these countries has been variously attributed to conflicts, traditional practices, and inadequate access to healthcare.

A single-dose vaccine strategy is insufficient to prevent measles outbreaks. In countries with weak health systems, the second dose is offered during campaigns to ensure high coverage. Between 2000 and 2008, the combination of improved routine immunization coverage and the provision of a second-dose opportunity led to a substantial reduction in measles mortality. Projections show that without supplementary immunization activities in these countries, mortality will quickly rebound, resulting in approximately 1.7 million measles-related deaths between 2010 and 2013. However, with sufficient funding, political commitment, and high-quality implementation of the second-dose measles strategy in priority countries, it should be possible to maintain the exceptional gains made so far.

43 A coverage of 90 percent or over was attained by Botswana, Burundi, Cape Verde, Egypt, Eritrea, The Gambia, Ghana, Libya, Malawi, Mauritius, Morocco, Rwanda, São Tomé & Príncipe, Seychelles, Swaziland, Tanzania, and Tunisia.

44 Reversals were recorded over the 1990–2009 period for Benin, Burkina Faso, CAR, Comoros, Djibouti, Equatorial Guinea, Gabon, Kenya, South Africa, and Zambia.

Figure 29: Progress on measles vaccination in African countries, 1990–2009 (%)



Source: WHO (2010).

Overall, there has been some progress in the three indicators tracking the achievements of countries toward MDG 4. Despite these achievements, and due to the fact that most child deaths are preventable or treatable, African countries should revitalize a comprehensive and integrated effort against the main diseases that cause child mortality such as measles, pneumonia, diarrhea, malaria, and AIDS. This should be done within the framework of strengthening health systems and ensuring a continuum of care.

GOAL 5: IMPROVE MATERNAL HEALTH

At the September 2010 High Level Meeting on the MDGs, world leaders expressed grave concern over the slow progress in improving maternal and reproductive health and reducing maternal mortality. Nonetheless, they commended regional efforts made to address the challenge.

A notable initiative is the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA), which was successfully launched by the African Union in partnership with the UNFPA and other UN agencies in May 2009 and began to be implemented at the national level in 26 countries⁴⁵ over the period 2010/11 under the slogan "*Africa Cares: No Woman Should Die While Giving Life.*" All these countries have instituted follow-up maternal, newborn and child health interventions to reduce morbidity and mortality.

45 Benin, Botswana, Cameroon, CAR, Chad, Congo Republic, Eritrea, Ethiopia, The Gambia, Ghana, Guinea-Bissau, Kenya, Lesotho, Malawi, Mauritania, Mozambique, Namibia, Nigeria, Rwanda, Senegal, Sierra Leone, Swaziland, Togo, Uganda, Zambia, and Zimbabwe. Eight of these countries launched the campaign in 2009, namely Chad, Ghana, Malawi, Mozambique, Namibia, Nigeria, Rwanda, and Swaziland.

African leaders have also committed to enhancing budgetary allocations to the health sector. Several countries have dedicated themselves to the implementation of the 2001 Abuja Declaration, whereby African Heads of State and Government agreed to allocate a minimum of 15 percent of their budget to the health sector in an effort to fast-track progress on health-related MDGs. By the end of 2010, six countries (Botswana, Burkina Faso, Liberia, Madagascar, Rwanda, and Tanzania) had fulfilled their commitments while many others remain on track.⁴⁶ In this regard, certain countries (notably Burundi, Ghana, and Sierra Leone) have made significant commitments to abolish user fees in the provision of maternal healthcare services, and many other countries provide subsidies or protection schemes. These initiatives echo the sentiments of the Fifteenth AU Summit held in Kampala, Uganda, which reaffirmed the need for increased budgetary allocations to maternal and child health services. Several countries in Africa, including Ghana and Uganda, have adopted MDGs Acceleration Frameworks (MAFs) that identify bottlenecks to implementation for specific prioritized interventions (see *Box 4*).

Although the lack of data on maternal health continues to be a major challenge to tracking progress, the available information suggests that while some progress has been made, it is not sufficient to achieve this Goal by the target date.

46 As of year-end 2009, government expenditure on health as a percentage of total government expenditure for Botswana, Burkina Faso, Liberia, Madagascar, Rwanda, and Tanzania was 16.7, 16.3, 17.2, 15.1, 16.8, and 18.1 percent respectively. In four more countries (Chad, Djibouti, Namibia, and São Tomé & Príncipe), this percentage has increased steadily and is expected to reach the 15 percent target. In 2009, these countries respectively spent 13.8, 13.9, 14.5 and 13.2 percent of their budget on the health sector (WHO, 2010b).