

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 countries<sup>45</sup> 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.<sup>46</sup> 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).

#### Box 4: The MDG 5 Acceleration Framework (MAF) in Uganda and the Free Health Care Initiative (FHCI) in Sierra Leone

While the majority of African countries are failing to make sufficient advancements toward improving their Maternal Mortality Ratios, some countries are implementing innovative initiatives to accelerate progress toward MDG 5.

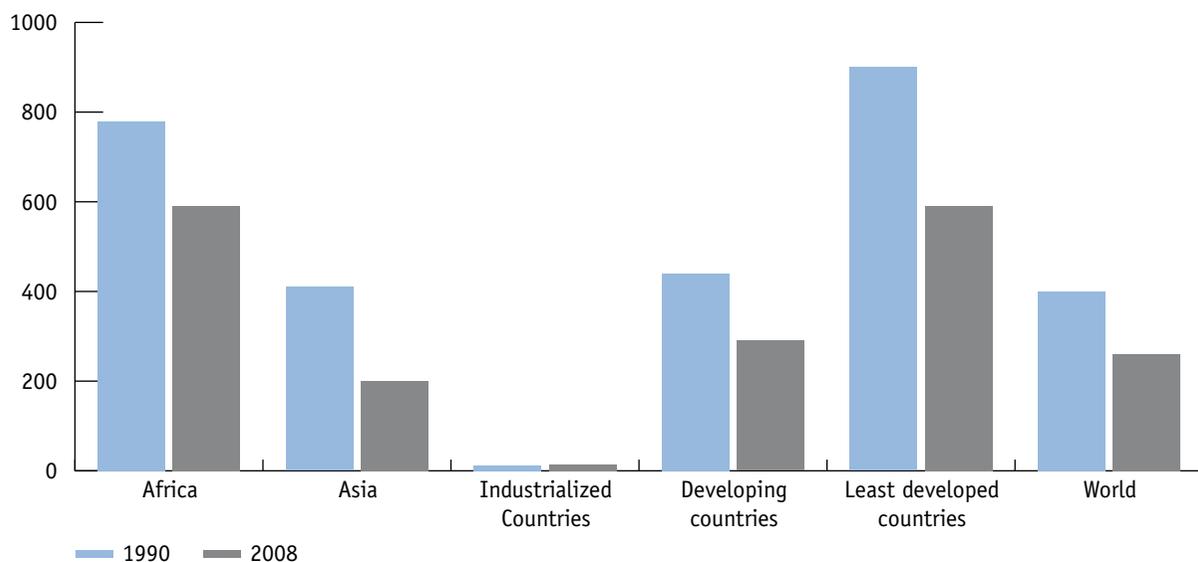
**Uganda:** In Uganda, the acceleration efforts will help operationalize the Maternal Health Roadmap, which was originally conceived in 2007. The MDGs Acceleration Framework (MAF) strikes a balance between activities that will yield immediate benefits, and those with longer-term benefits which will serve to sustain improvements in maternal health. For example, in order to address the issue of inadequate numbers of healthcare staff, a recruitment efficiency drive is being implemented in the District Service Commissions. The MAF also explores how to improve service delivery by shifting certain responsibilities from doctors to nurses or assistants. Both these actions are expected to yield results in the short-run. At the same time, for the longer-term, a strategy is being proposed to boost science education for girls in order to grow a pool of skilled midwives.

At the local level, the Soroti District in Eastern Uganda, 200 miles from Kampala, has implemented a WHO Making Pregnancy Safe (MPS) Initiative, which provides many lessons for the MDG 5 Acceleration Framework. The District is working to decrease maternal mortality through a multisector approach in order to remove all the bottlenecks in the system, not only health-related ones. In looking at the three delays of childbearing (delay in seeking care, delay in reaching care, and delay in receiving care), there are many non-health factors that contribute to safe childbirth. In this sense, efforts have been made in Soroti on a number of different fronts: (i) to educate women and health providers about the danger signs to look out for in labor; (ii) to improve roads in order to facilitate access to health units for pregnant women; and (iii) to provide standby ambulances for the transport of women in labor. According to WHO statistics, the Soroti district reduced maternal deaths through these actions by 75 percent – from 750 per 100,000 live births in 2000 to 190 deaths in 2006. Similarly, 43 percent of women living in Soroti now give birth with help from a trained health worker, as opposed to 26 percent before the MPS project started.

**Sierra Leone:** As of April 2010, Sierra Leone had introduced the Free Health Care Initiative (FHCI) for all pregnant women, lactating mothers and children under five years old. This aimed to provide a package of services, free of charge, at the point of service delivery. The government hopes to sustain the FHCI through the signing of a National Health Compact, which ensures that all existing and future investments in healthcare will be based on one validated national Health Strategy. This will safeguard partners' commitments; improve the harmonization of aid; improve coordination between governments, national stakeholders, and development partners; strengthen transparency and mutual accountability of all development partners; and reduce the complexity and transaction costs of health services delivery. In doing so, Sierra Leone is committed to driving down its MMR, which declined from 1,800 deaths per 100,000 live births in 2000 to 857 deaths per 100,000 live births in 2008.

Sources: *Uganda National MDG Report, 2010; Sierra Leone National MDG Report, 2010.*

**Figure 30: Maternal Mortality Ratio for selected global regions (per 100,000 live births), 1990 and 2008**



Sources: Compiled from WHO, UNICEF, UNFPA, and World Bank (2010).

**Target 5.A: Reduce by three-quarters, between 1990 and 2015, the Maternal Mortality Ratio**

**Indicator 5.1: Maternal Mortality Ratio (MMR)**

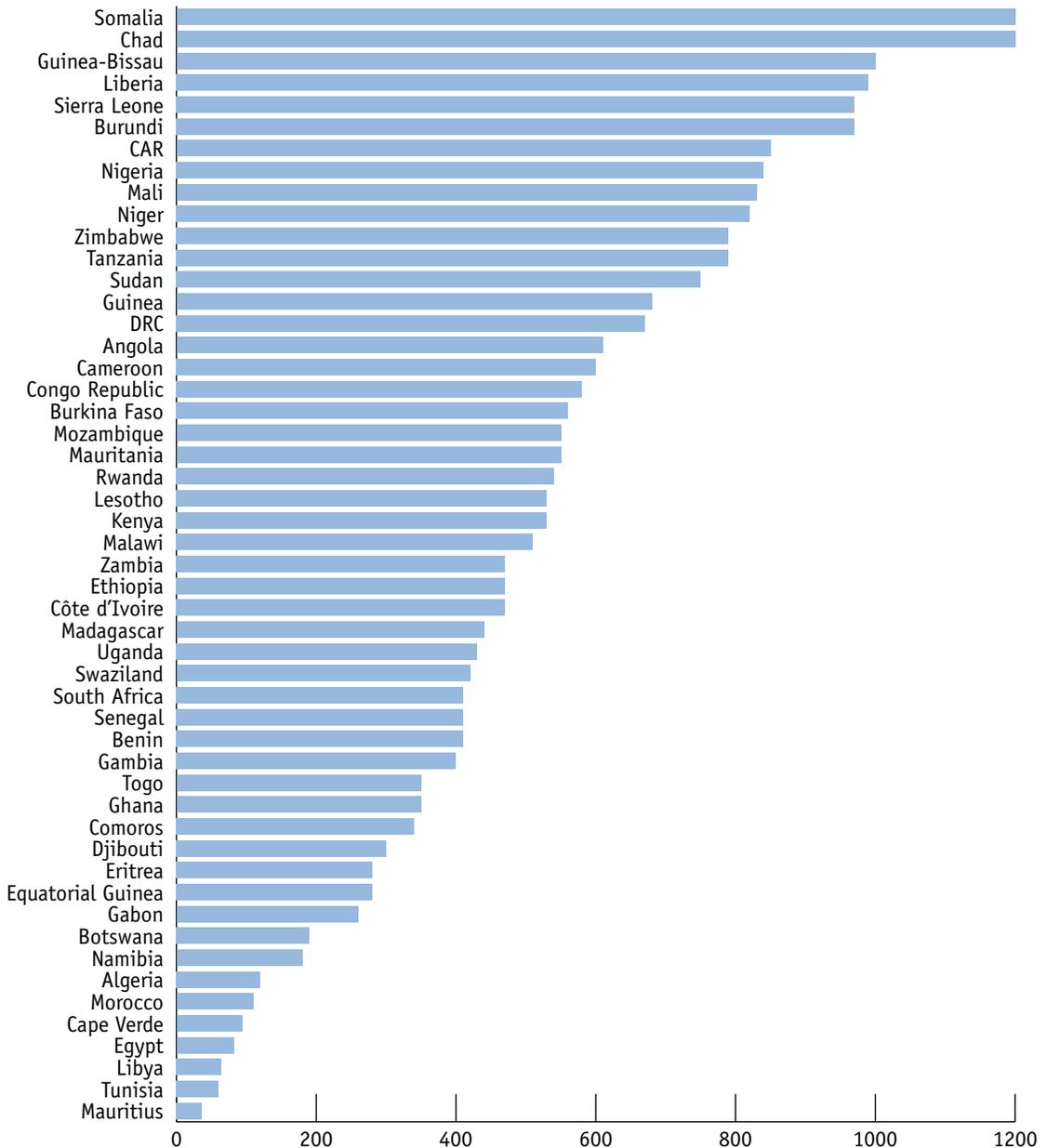
The Maternal Mortality Ratio (MMR), the most common measure of maternal health, continues to be a major challenge in Africa, particularly when compared to performance in the rest of the world. Although there was significant progress in all developing regions over the past two decades (*Figure 30*), the average annual percentage decline in the global MMR was 2.3 percent between 1990 and 2008, short of the 5.5 percent rate required to achieve the MDG target. However, when we look at the figure for Africa (excluding North Africa), the MMR declined at an average annual rate of just 1.7 percent there – worse than any other global region. However, North Africa performed much better than

the other subregions, recording between 1990 and 2008 a 59 percent decline in the MMR, compared to an average of only 26 percent in the rest of Africa.<sup>47</sup>

In 2008 three African countries (Chad, Guinea-Bissau, and Somalia), all of which have either emerged from or are in conflict, registered an exceedingly high MMR above 1,000 per 100,000 live births. In terms of the best performers for this indicator, five countries (Cape Verde, Egypt, Libya, Mauritius, and Tunisia) recorded an MMR of less than 100 per 100,000 live births for the same year. Of the remaining countries, 21 registered an MMR of between 100 and 500 per 100,000 live births, while 22 recorded a ratio of between 500 and 1,000 per 100,000 live births (*Figure 31*).

<sup>47</sup> See WHO, UNICEF, UNFPA, and the World Bank (2010).

**Figure 31: Maternal Mortality Ratio for selected African countries (per 100,000 live births), 2008<sup>48</sup>**



Sources: Compiled from WHO/UNICEF/UNFPA/ World Bank (2010).

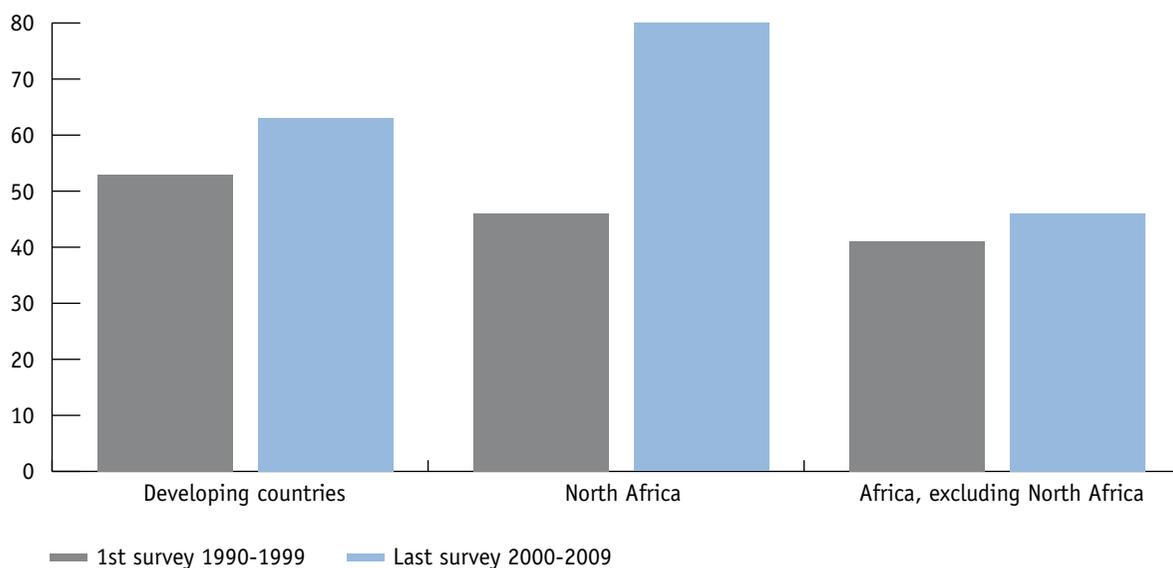
<sup>48</sup> National estimates for maternal mortality may differ from UNSD estimates. This is because the Inter-Agency Group (composed of WHO, UNICEF, UNFPA, and World Bank) adjusts these national estimates to account for flaws in some national reporting systems. For example, the national estimate for Algeria in 2008 was 81.4 per 100,000 births. After adjustment, the Inter-Agency Group estimated this to be 120.

### **Indicator 5.2: Proportion of births attended by skilled healthcare attendant**

Assistance during childbirth influences the birth outcome and health of both mother and infant during and after delivery. The skills and performance of the birth healthcare attendant determine whether or not he or she can manage complications and observe hygienic practices. The quality of the birth attendant services also influences a mother's initial decision to seek the care of a skilled healthcare worker. As shown in Figure 30, giving birth is particularly risky in Africa (excluding North Africa), where more than 50 percent of pregnant women deliver without skilled care. During the period 1990–2009, progress was very advanced in North Africa (Figure 32) but slow in the rest of the continent. The proportion of births attended by skilled health personnel is currently lower in Africa (excluding North Africa) than in all other developing regions worldwide.

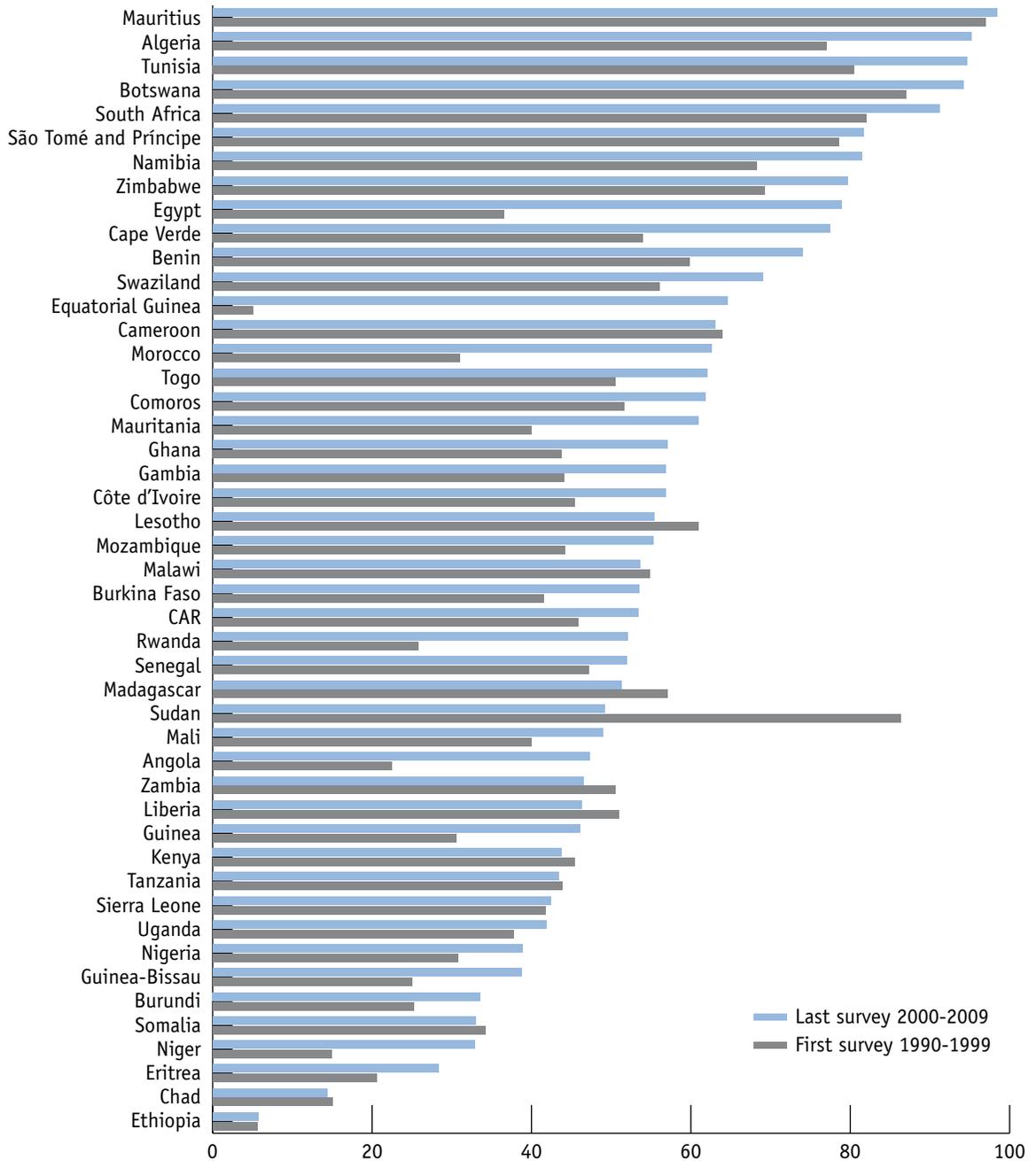
Addressing maternal health is a complex issue, as challenges lie on both the supply and demand sides of healthcare. Maternal mortality can be largely attributed to three delays in the childbearing process: delay in the decision to seek care; delay in reaching care; and delay in receiving care. The first delay – seeking care – occurs on the demand (mother's) side, while the other two delays are more supply-related. Distance to health facilities is an indicator of supply but it also affects demand for maternal care, as long distances to a health center may deter a pregnant woman from seeking care. On the supply side, the availability, quality, and cost of services clearly impact maternal mortality outcomes. On the demand side, the cost of services, the quality (both actual and perceived) of care, trust in health staff, and cultural barriers deter many women from seeking care, even when health services are available.

**Figure 32: Proportion of births attended by skilled healthcare personnel by region, 1990–1999 and 2000–2009 (%)**



Source: Compiled from UNSD data (updated in August 2010).

**Figure 33: Proportion of births attended by skilled healthcare personnel for selected African countries, 1990–1999 and 2000–2009 (%)**



Source: Compiled from UNSD data (updated in August 2010).

While most strategies to address maternal mortality focus on supplying more equipment and making services more affordable for expectant mothers, an effective strategy would be to attract more demand for such services, especially by training traditional birth attendants in rural settings in the practices of modern medicines, thereby building on the trust that already exists among them and local women.

Furthermore, there are major differences in performance for this indicator among the African countries. 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 (*Figure 33*). Of these top performers, only São Tomé and Príncipe is a Least Developed Country (LDC).

**Target 5B: Achieve universal access to reproductive health by 2015<sup>49</sup>**

Tracking and reporting on contraceptive prevalence rates, adolescent pregnancy rates, antenatal

care coverage, and unmet need for family planning is difficult in Africa. Indeed, contraceptive prevalence rates are usually recorded only for married women and do not cover all modern contraceptive methods. Moreover, a significant proportion of adolescent pregnancies are not declared, while delivery outside of health facilities is at least as common in adolescent as in adult women. Notwithstanding last year's *MDGs Progress Report for Africa 2010*, for which recent data were available, overall time-series information on these indicators remains scant and an overview of progress achieved since 1990 is not feasible. The data presented below are the same data as presented in the 2010 Report, however different aspects of progress are assessed.

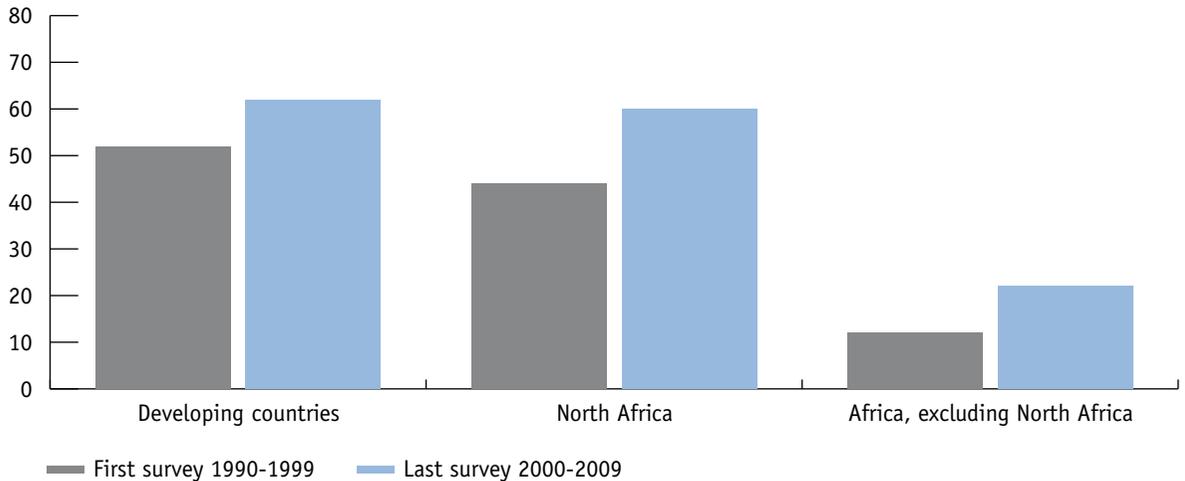
***Indicator 5.3: Contraceptive prevalence rates for married people***

The Contraceptive Prevalence Rate (CPR), which gives the percentage of married women aged 15–49 using any method of family planning, is relatively high in North Africa (60 percent) compared to the rest of Africa (22 percent) (*Figure 34*). CPR illustrates the ability of women to plan when to have children and how many children to have. During the latest survey period 1990–2009, the use of contraceptives increased among women in almost every country in Africa. The highest prevalence rates (more than 30 percent) were recorded for 12 countries: Algeria, Botswana, Egypt, Kenya, Malawi, Mauritius, Morocco, Namibia, South Africa, Swaziland, Tunisia, and Zimbabwe (*Figure 35*). Condom use is still relatively low, with the highest rate recorded in Botswana (15.5 percent). As highlighted under *Indicator 5.6: Unmet need*

49 This target was adopted at the 2005 UN World Summit and Midterm Review of progress toward the MDGs. It came

into effect in 2007, after it was operationalized by the Inter-agency Expert Group on MDGs Indicators.

**Figure 34: Percentage of married women aged 15–49 using any contraceptive method, 1990–1999 and 2000–2009**



Source: Compiled from UNSD data (updated in August 2010).

for family planning, it is critical to look at both the demand and supply side of contraceptive use. Whether a woman wishes to space her pregnancies or stop childbearing altogether has an impact on the type of contraceptive that she will choose. In order to increase use, it is important not only to make contraceptives more readily available and more affordable (supply side), but also to raise social awareness about the different types of contraceptives and how they address the different needs of women (influencing the demand side).

#### **Indicator 5.4: Adolescent birth rate**

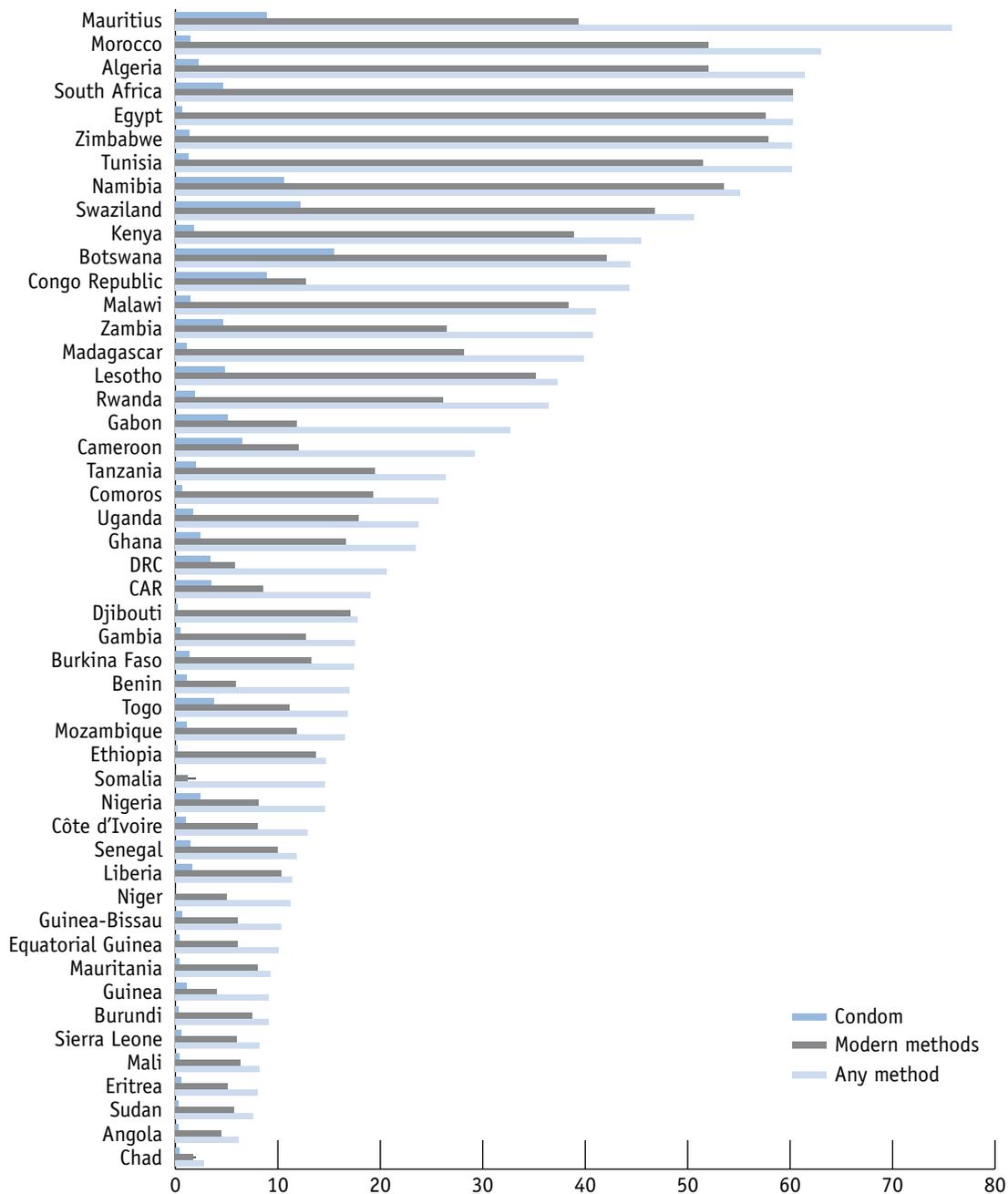
Globally, the highest birth rate among adolescents (defined as the number of births per 1,000 women aged 15–19) is observed in Africa (excluding North Africa), and there was little progress during the period 1990–2009 (Figure 36). In fact, there was no significant decrease in the adolescent birth rate from the period 1990–1999 (124 per 1,000) to 2000–2009 (121 per 1,000). The highest rates

(more than 150 per 1,000) are found in ten African countries: Angola, Chad, Guinea, Liberia, Malawi, Mali, Mozambique, Niger, Uganda, and Zambia. Adolescent birth rates of this magnitude are a contributing factor to high maternal mortality rates.

#### **Indicator 5.5: Antenatal care coverage**

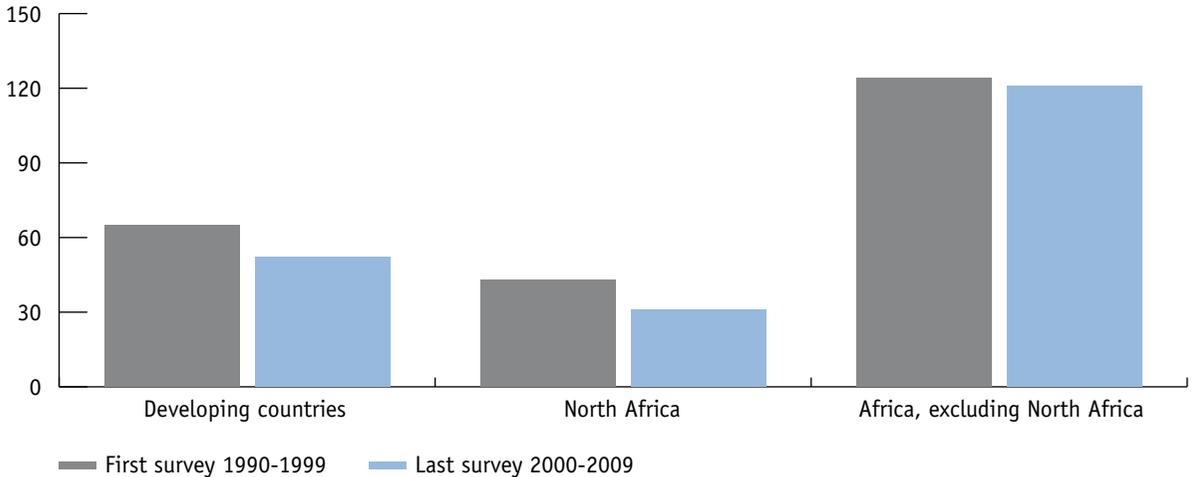
Antenatal care is more effective in preventing adverse outcomes when it is sought early on in the pregnancy and is continued through to delivery. Early detection of problems in pregnancy leads to more timely referrals in the case of women in high-risk categories or with complications. Early antenatal care also increases the chances that a woman will give birth with a skilled healthcare attendant present, which further improves outcomes. This is particularly true in Africa, where a large proportion of the population live in rural areas and where physical and cultural barriers continue to pose a challenge to healthcare delivery.

**Figure 35: Different types of contraceptive use among married women aged 15–49 years, 2000–2009**



Source: Compiled from UNSD data (updated in August 2010).

**Figure 36: Number of births per 1,000 adolescent women aged 15–19 in 1990-1999 and 2000-2009**



Source: Compiled from UNSD data (updated in August 2010).

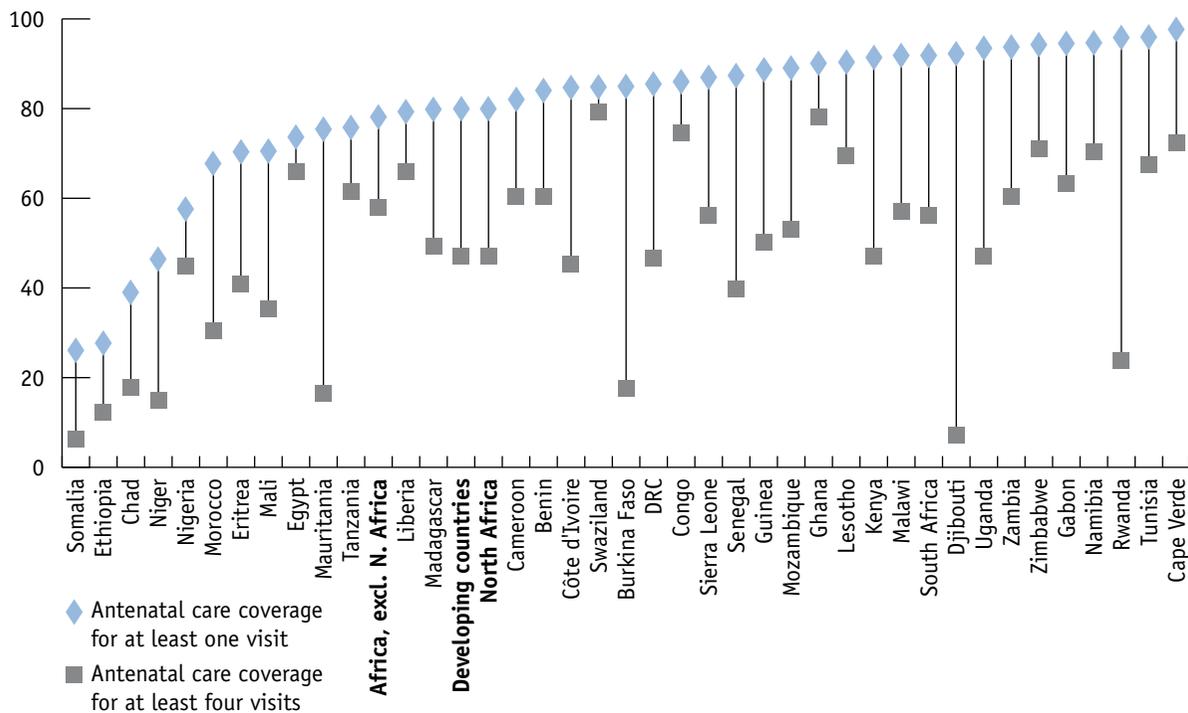
Remarkable gains in antenatal care have been recorded across the continent. The proportion of women who saw a skilled health worker at least once during pregnancy increased by 25 percent in North Africa and by 69.6 percent in the rest of Africa over the period 2000–2009. Under normal circumstances, the WHO recommends that a woman without complications should have at least four antenatal care visits, the first of which should take place during the first trimester. However, as illustrated in *Figure 37* below, only 15 countries (Benin, Cameroon, Cape Verde, Congo Republic, Egypt, Gabon, Ghana, Lesotho, Liberia, Namibia, Swaziland, Tanzania, Tunisia, Zambia, and Zimbabwe) out of a total of 38 for which data are available, recorded more than 60 percent of pregnant women who received the recommended four visits between 2000 and 2009.

**Indicator 5.6: Unmet need for family planning**

The proportion of women who would like to stop childbearing altogether or who wish to space their

next birth is a crude measure of the extent of family planning requirements. It should be noted that not all of these women are exposed to the risk of pregnancy and some of them may already be using contraception. Women who wish to delay giving birth for two or more years or who want to avoid pregnancy altogether but are not using a contraceptive method are said to have an “unmet need for family planning.” Pregnant women are considered to have an unmet need for spacing or limiting their children if their pregnancy was mistimed or unwanted. Similarly, women who are not menstruating and therefore not able to get pregnant are categorized as having an unmet need if their last birth was mistimed or unwanted. Women who are currently using family planning are said to have a met need for family planning. The total demand for family planning services comprises those who fall in both the met and the unmet need categories.

**Figure 37: Number of antenatal care visits by trained healthcare practitioner in 38 African country surveys, 2000–2009 (% of pregnant women)**

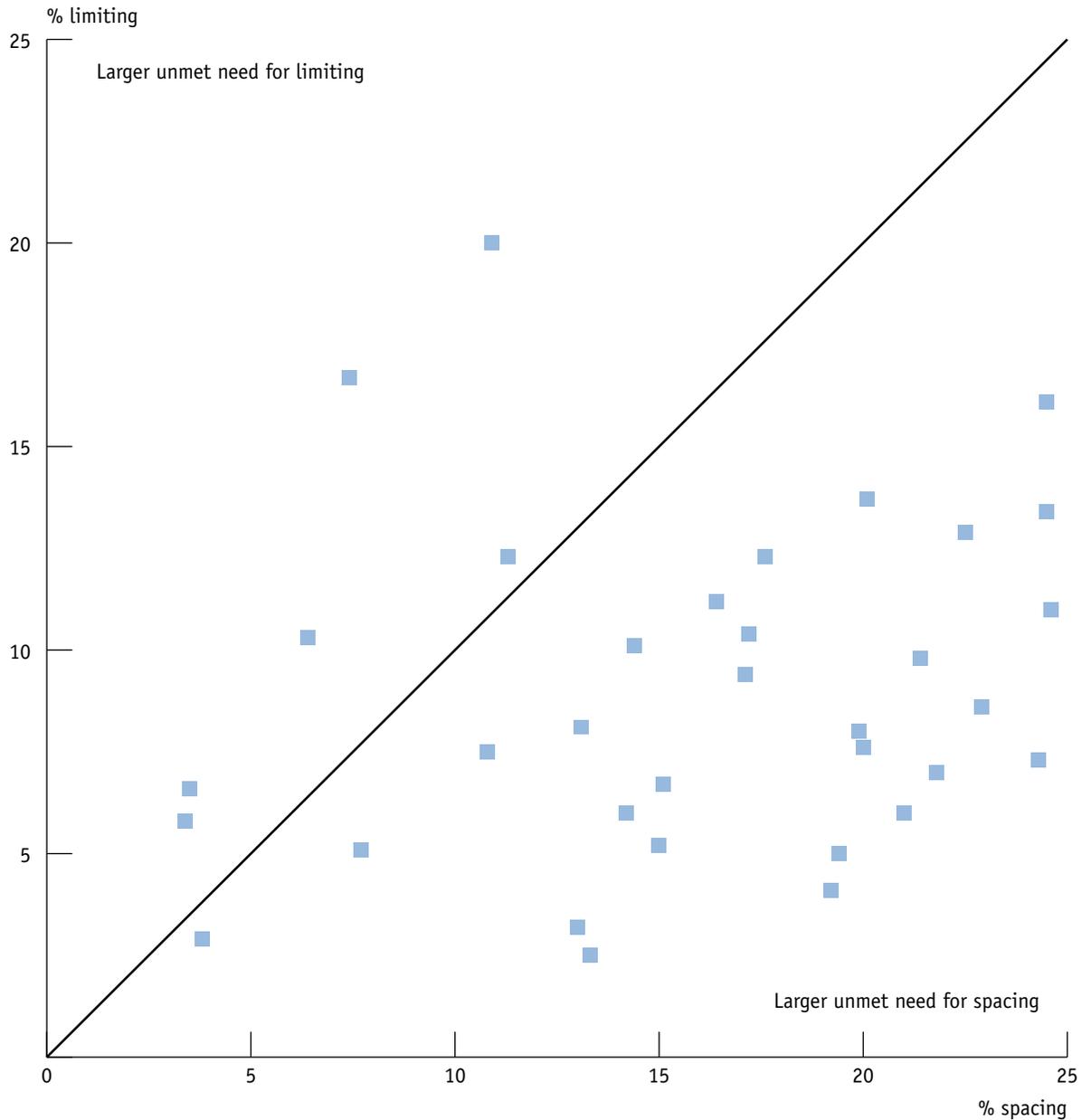


Source: Compiled from UNSD data (updated in August 2010).

All African countries have an unmet need for family planning. *Figure 38* categorizes African countries in 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 graph shows that, 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. Furthermore, the discrepancy between countries having an unmet need for limiting versus an unmet need for spacing has critical policy implications. Countries that have a greater need for limiting childbearing should focus on long-acting and permanent methods of family planning such as Intra-Uterine Devices (IUDs) and female sterilization. Those that have a greater unmet need for spacing should focus on short-term contraception methods, such as the pill and condoms. Assessing the percentage of women with each type of unmet need focuses attention on the demand-side of health services; this is crucial if countries want to effectively plan their health interventions.

**Figure 38: Unmet need for family planning in 34 African country surveys, 2000–2009**



Source: Compiled from UNSD data (updated in August 2010).

**Table 5: HIV/AIDS statistics for Africa (excluding North Africa), 2001 and 2009**

Year	People living with HIV (million)	People newly infected with HIV (million)	Children living with HIV (million)	AIDS-related deaths (million)
2009	22.5	1.8	2.3	1.3
2001	20.3	2.2	1.8	1.4

Source: UNAIDS (2010).

### GOAL 6: COMBAT HIV/AIDS, MALARIA, AND OTHER MAJOR DISEASES

Efforts to combat HIV and AIDS, tuberculosis, and malaria under MDG 6 have led to significant advances in preventing and treating these diseases. Goal 6 currently exhibits better progress than in previous years due in part to better performance of global funds, including the Global Fund to Fight AIDS, Tuberculosis and Malaria. However, this progress needs to be sustained for Targets 6.A and 6.B, and accelerated for Target 6.C in order to meet Goal 6.

#### Target 6.A: Have halted by 2015, and begun to reverse, the spread of HIV and AIDS

According to the *Report on the Global AIDS Epidemic 2010* (UNAIDS, 2010), HIV and AIDS are now more under control in Africa than ever before. Advances in stemming the HIV and AIDS pandemic have been significant in the majority of African countries, both in terms of preventing new infections and in making Anti-Retroviral Treatment (ART) more readily available to infected people.

UNAIDS estimated the HIV and AIDS prevalence rate in Africa (excluding North Africa), to have decreased to 5.0 percent in 2009, compared with 5.9 percent

in 2001.<sup>50</sup> However, this does not translate into a decrease in the actual number of people living with HIV and AIDS, due to population growth. Indeed, 22.5 million people were living with HIV and AIDS at the end of 2009, compared with 20.3 million at the end of 2001 (*Table 5*). Although the annual number of new HIV infections (incidence<sup>51</sup>) has been steadily declining since the late 1990s, this decrease is offset by the reduction in AIDS-related deaths (1.3 million in 2009 compared to 1.4 million in 2001) due to the significant scaling-up of ART over the past few years. This encouraging drop in AIDS-related deaths means that more people are surviving longer, i.e. they are classified as living with HIV.

Despite the overall positive trend toward Target 6.A, progress is mixed among countries and some of them have recorded setbacks, both in terms of prevention and treatment (*Box 5*). It is also a matter of grave concern that the number of children living with HIV is rising (500,000 more between 2001 and 2009), as this phenomenon does not

50 It is important to note that UNAIDS data aggregate North Africa with Arab countries; hence, it is not possible to provide separate figures for North Africa.

51 Incidence represents the number of new infections while prevalence represents the total number of infections. Incidence is a better indicator of the evolution of the epidemic, as it accounts only for new infections, while prevalence also accounts for deaths related to the infection.