



# Opportunities for Africa's Newborns

## Executive Summary



THE PARTNERSHIP

For Maternal, Newborn & Child Health

IMPROVING HEALTH. SAVING LIVES.



## Messages from *Opportunities for Africa's Newborns*

- 1.** Every year in sub-Saharan Africa 1.16 million babies die in the first month of life, and another million babies are stillborn. Recently, several large African countries have reduced *child* mortality, but the number of deaths during the first month of life – especially in the first week – remains high across the continent. Up to half a million African babies die on the day they are born. Meeting Millennium Development Goal 4 for child survival in Africa depends on more attention and action to reduce *newborn* mortality.
- 2.** Up to 800,000 newborn lives could be saved each year if essential interventions already in policy reached 90 percent of African mothers and newborns. Existing programmes present opportunities to strengthen and integrate newborn health along the continuum of care – providing services both at home and health facility, at every stage of life – yet these opportunities are often missed.
- 3.** Investment to save newborn lives also saves mothers and children. The cost is affordable – an additional US\$1.39 per capita is required, and two thirds of this goes towards the health and survival of mothers and older children, too.
- 4.** Poor countries are making progress – good news from Africa! Some countries have begun to reduce both newborn and under-five mortality. Despite a gross national income per capita of under US\$400 per year, six countries – Eritrea, Malawi, Burkina Faso, Madagascar, Tanzania, and Uganda, have achieved neonatal mortality rates between 24 and 32 per 1,000 live births. These countries provide valuable examples of leadership, district-based management, focus on scaling up essential interventions, and ways to protect poor families from escalating health care costs.

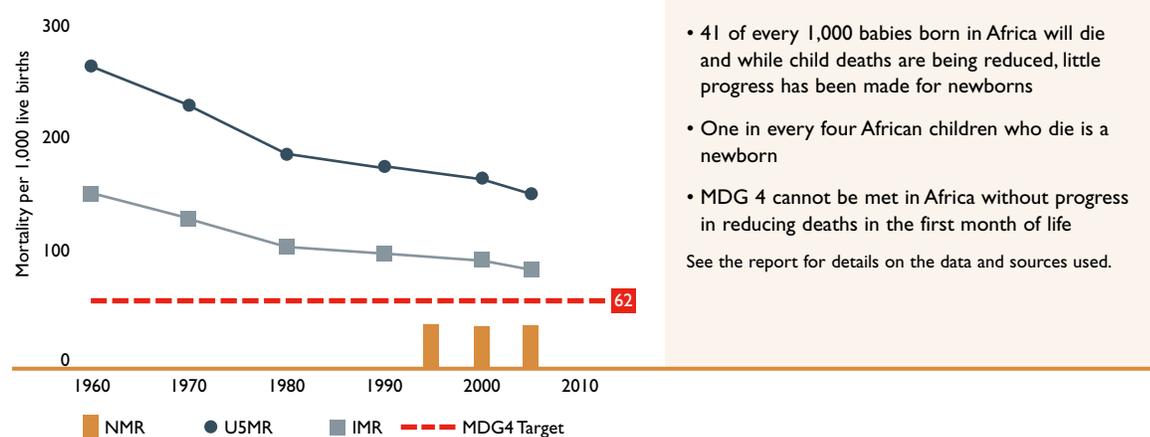
# Will Africa reach the Goal?

The Millennium Development Goals (MDGs) have galvanized much attention, but action is not happening fast enough in Africa. Political commitment to child survival programmes has saved the lives of older children, but there remains no measurable progress in slowing newborn death rates at the regional level. Forty-one of every thousand babies born in Africa die before they are one month old. This is the same as in England – more than a hundred years ago.

Addressing newborn health is a catalyst for improving both maternal and child health and accelerating progress towards MDG 4 (child survival), MDG 5 (maternal health) and MDG 6 (HIV/AIDS, tuberculosis, and malaria).

The gap is not in policy – African countries have many policy commitments. The key gap is between policy and action, and especially in reaching the poorest and most vulnerable women and babies who are most at risk.

## PANEL I: Progress to MDG 4 for child survival in sub-Saharan Africa



## Key findings

The fate of African newborns, mothers, and children is closely linked

### WHO?

Each year in Africa, 30 million women become pregnant, and 18 million give birth at home without skilled care.

#### *Each day in Africa:*

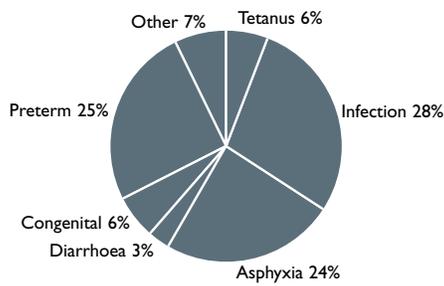
- 700 women die of pregnancy-related causes.
- 3,100 newborns die, and another 2,400 are stillborn.
- 9,600 children die after their first month of life and before their fifth birthday.

### WHERE?

The countries with the highest risk of newborn deaths are Liberia (66 per 1,000 live births), Côte d'Ivoire (65), Mali (57) and Sierra Leone (56). Three small island nations in Africa, Seychelles, Cape Verde, and Mauritius, have risks lower than 12 deaths per 1,000 live births.

Five countries account for half of Africa's newborn deaths: Nigeria, Democratic Republic of the Congo, Ethiopia, Tanzania, and Uganda. Nigeria has the largest number of newborn deaths – over quarter of a million every year. Nigeria is also among the top ten countries with the highest risk of death.

**FIGURE 1: Causes of newborn death in Africa**



**WHY?**

The top three causes of newborn death in Africa are infections, prematurity, and asphyxia. Additionally, fourteen percent of babies in Africa are born with low birthweight. These small babies account for the majority of newborn deaths and link to maternal health, nutrition and infections such as malaria and HIV.

Infections are the biggest cause of death and the most feasible to prevent and treat. Neonatal tetanus is one of the most cost-effective conditions to prevent – yet it still kills tens of thousands of African babies each year.

**WHEN?**

Birth, the first day and the first week of life are critical for survival and for long term health. What should be a time of celebration is often a time of sadness for families: Up to half a million African babies die on their birth day.

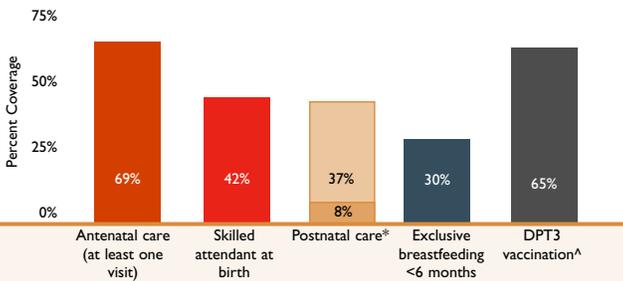
**SOLUTIONS FOR NEWBORN DEATHS? WHO BENEFITS?**

Two thirds of newborn deaths could be prevented through essential maternal, newborn, and child health (MNCH) packages already in policy, through high coverage and improved newborn care. More than 2,000 newborn lives could be saved every day.

For the most effective care, a continuum linking maternal, newborn and child health care through the lifecycle and between homes and health facilities is needed. In Africa we are successfully reaching women with at least one antenatal visit. However, coverage of care falls at the time of birth, just as the risk of death for mothers and babies peaks. Half of African women and their babies do not receive skilled care during childbirth, and even fewer receive effective postnatal care. This is also the crucial time for other interventions, especially prevention of mother-to-child transmission of HIV and initiation of breastfeeding.

Additionally, poor families who are most at risk are the least likely to have access to care, especially more complex hospital care for emergencies, such as caesarean section, as the cost of this procedure may equal a family income for one year.

**FIGURE 2: Coverage along the continuum of care**



\*Postnatal care: The Demographic and Health Survey (DHS) definition of PNC assumes that all facility births have received postnatal care, the lighter portion of the bar. The darker portion of the bar refers to women whose most recent birth was outside a health facility (63% of all births) and received a postnatal check up within 2 days using data from DHS 1998-2005.

^DPT3 refers to percentage of infants receiving three doses of diphtheria, pertussis and tetanus vaccine.

See the report for details on the data and sources used.

**THE COST OF SAVING LIVES?**

In the year 2004, sub-Saharan African countries spent an estimated US\$0.58 cents per capita on the running costs of essential MNCH care. It would cost an additional US\$1.39 per capita per year to provide essential health packages to 90 percent of women and babies in sub-Saharan Africa – a total additional cost of approximately US\$1 billion per year. Only 30 percent of this price tag is for newborn-specific interventions, so the majority of the investment also has direct benefits for mothers and older children, too.

# Actions for programme managers and professionals in Africa

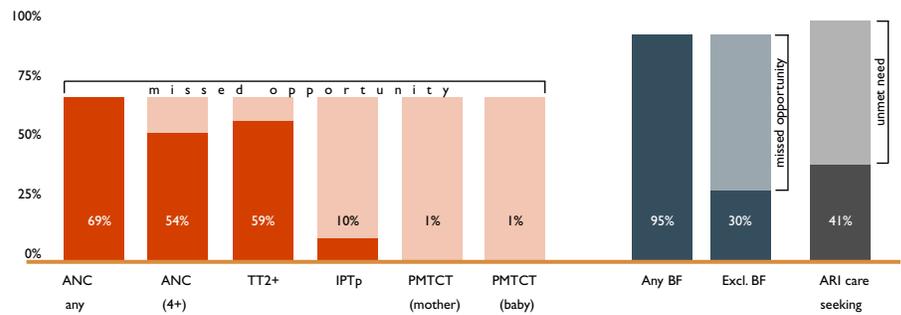
Successful plans that lead to action require good policy and good politics. Effective planning involves two parallel and interdependent processes.

- **A participatory political process** identifies and engages key stakeholders, including representatives of women’s and community groups, promotes an enabling policy environment, and results in ownership of a plan and identification of the resources needed for implementation.
- **A systematic management and prioritisation process** allows for effective allocation of scarce resources. This can be applied through the following four steps:

**STEP 1. Conduct a situation analysis for newborn health in the context of MNCH.** Where and why are newborns dying and what is the coverage of life-saving care? Which existing policies provide a platform for saving newborn lives? Are there missed opportunities? (Panel 2) For example, midwives may be present at birth but are often not trained in essential newborn care, such as ensuring warmth, breastfeeding support, and resuscitation.

**PANEL 2: Missed opportunities in existing services to provide evidence based care and save lives**

- In sub-Saharan Africa, more than two-thirds of women have at least one antenatal care visit
  - Yet few receive the recommended four visits of evidence based antenatal care
  - Only 10 per cent of those in malaria endemic areas receive preventive treatment and only one per cent who need HIV prophylaxis actually receive it
  - Almost all women breastfeed, but less than one in three African babies are exclusively breastfed up to six months, despite the fact that this behaviour alone could save around 140,000 lives a year.
- See the report for details on the data and sources used.



Are there important health care gaps, such as the lack of an effective postnatal care package? Is there a systematic approach to supporting families to practice healthy home behaviours such as breastfeeding, good hygiene, and early care seeking for illness? Are there barriers to care – such as cultural barriers, or a lack of key staff or supplies, or high costs during childbirth, especially for caesarean sections?

**STEP 2. Develop, adopt, and finance a national strategic plan** embedded in existing national policy, implementing phased approaches to maximise the number of lives saved now as well as overall health system strengthening over time. Up to one third of newborn deaths can be prevented through healthy family behaviours and home care which is feasible now, even within weak health systems. Now is the time to take part in the second primary health care revolution in Africa, with a number of governments revitalising primary care or developing new cadres of workers, to include high impact MNCH interventions. In order to succeed, however, we need to learn from the past and have a focused set of tasks, with adequate supervision, referral linkages, and incentives for staff. For example, Ghana is developing a team approach where a paid primary care nurse supervises community health workers to provide defined packages of care. A package of postnatal care for mother and newborn is being piloted.

**STEP 3. Implement interventions and strengthen the health system**, with particular attention to human resources. Africa needs an additional 180,000 midwives in the next 10 years to scale up skilled care during childbirth. To meet needs such as this, comprehensive human resource plans must focus not only on training but also on retaining and sustaining existing staff (see Panel 3 on page 9). Auditing maternal and newborn deaths as well as stillbirths has the potential to increase both quality of care and staff motivation. While staffing remains the primary challenge, lack of key supplies and drugs also contributes to lives lost. Several African countries have improved the quality of obstetric care through pre-packaged kits that provide an opportunity to include additional drugs and supplies essential for newborn health.

**STEP 4. Monitor, process, and evaluate outcomes, costs, and financial inputs.** If newborn deaths are significantly underestimated now, assessment of progress may be misleading. The quality of data, frequency of data collection and the use of data for decision making are crucial. In addition to counting deaths, tracking the coverage and quality of essential interventions and financial inputs is necessary for success.

TABLE 1:

# Evidence based interventions to save newborn lives

Packages along the continuum of care	<b>Care for girls and women before pregnancy</b>	<ul style="list-style-type: none"> <li>• Education with equal opportunities for girls</li> <li>• Nutrition promotion, especially for girls and adolescents</li> <li>• Prevention of female genital mutilation</li> <li>• Prevention and management of HIV and sexually transmitted infections (STI)</li> <li>• Family planning</li> </ul>
	<b>Care during pregnancy</b>	<ul style="list-style-type: none"> <li>• Focused antenatal care (ANC) including               <ul style="list-style-type: none"> <li>• At least 2 doses of tetanus toxoid vaccination (TT2+)</li> <li>• Management of syphilis/STIs</li> <li>• Management of pre-eclampsia</li> </ul> </li> <li>• Intermittent preventive treatment for malaria in pregnancy (IPTp) and insecticide treated bednets (ITN)</li> <li>• Prevention of mother-to-child transmission of HIV (PMTCT)</li> <li>• Birth and emergency preparedness at home, increasing demand for care</li> </ul>
	<b>Childbirth care</b>	<ul style="list-style-type: none"> <li>• Skilled attendance at birth</li> <li>• Emergency obstetric care (EmOC)</li> <li>• Improved linkages between home and health facility</li> <li>• Companion of the woman's choice at birth</li> <li>• Where there is no skilled attendant, support for clean childbirth practices and essential newborn care (drying the baby, warmth, hygiene and early and exclusive breastfeeding) at home</li> </ul>
	<b>Postnatal care</b>	<ul style="list-style-type: none"> <li>• Routine postnatal care (PNC) for early identification and referral of illness as well as preventive care:               <ul style="list-style-type: none"> <li>• For the mother: Promotion of healthy behaviours, danger sign recognition, and family planning</li> <li>• For the baby: Promotion of healthy behaviours – hygiene, warmth, breastfeeding, danger sign recognition and provision of eye prophylaxis and immunisations according to local policy</li> </ul> </li> <li>• Extra care for small babies or babies with other problems (e.g. mothers with HIV/AIDS)</li> </ul>
	<b>Integrated Management of Childhood Illness (IMCI)</b>	<ul style="list-style-type: none"> <li>• Management and care of low birthweight (LBW) babies including Kangaroo Mother Care (KMC)</li> <li>• Emergency newborn care for illness, especially sepsis</li> </ul>
Cross-cutting programmes	<b>Nutrition and breastfeeding promotion</b>	<ul style="list-style-type: none"> <li>• Nutrition promotion, especially in girls and adolescents</li> <li>• Maternal nutrition during pregnancy and lactation</li> <li>• Early and exclusive breastfeeding for babies</li> </ul>
	<b>Prevention of mother-to-child transmission of HIV</b>	<ul style="list-style-type: none"> <li>• Prevention of HIV and STIs and avoiding unintended pregnancy</li> <li>• PMTCT through antiretroviral therapy and safer infant feeding practices</li> </ul>
	<b>Malaria control</b>	<ul style="list-style-type: none"> <li>• Intermittent preventive treatment for malaria in pregnancy (IPTp) and insecticide treated bednets (ITN)</li> </ul>
	<b>Immunisation</b>	<ul style="list-style-type: none"> <li>• Tetanus toxoid vaccination (at least 2 doses) for pregnant women</li> </ul>

# Key opportunities in policy and programmes to save newborn lives

- Promote the delay of first pregnancy until after 18 years and spacing births at least 24 months apart
- Prevent and manage HIV and STIs, especially among adolescent girls

- Increase the quality of ANC, ensuring that women receive four visits and the evidence based interventions that comprise focused ANC
- Promote improved care for women in the home and look for opportunities to actively involve women and communities in analysing and meeting MNCH needs

- Increase availability of skilled care during childbirth and ensure skilled attendants are competent and equipped for essential newborn care and resuscitation
- Include emergency neonatal care when scaling up emergency obstetric care
- Promote better linkages between home and facility (e.g. emergency transportation schemes)

- Develop a global consensus regarding a PNC package
- Undertake operations research in Africa to test models of PNC, including care at the community level in order to accelerate scaling up
- Increase availability and quality of PNC

- Adapt IMCI case management algorithms to address newborn illness and implement these at scale
- Ensure hospitals can provide care for LBW babies including KMC and support for feeding
- Strengthen community practices for newborn health

- Address anaemia in pregnancy through iron and folate supplementation, hookworm treatment and malaria prevention
- Review and strengthen policy and programmes to support early and exclusive breastfeeding, adapting the Global Strategy for Infant and Young Child Feeding

- Increase coverage and improve integration of PMTCT, especially with ANC and PNC
- Use opportunities presented by expanding HIV programmes to strengthen MNCH services (e.g. better laboratory and supply management as well as tracking of women and babies, especially in the postnatal period)

- Increase coverage of ITN and IPTp to address malaria during pregnancy
- Use the current momentum of malaria programmes to strengthen MNCH services (e.g. laboratories, supplies, and social mobilisation)

- Accelerate the elimination of maternal and neonatal tetanus
- Use the solid management and wide reach of immunisation programmes to strengthen MNCH services (e.g. social mobilisation, linked interventions, and monitoring)



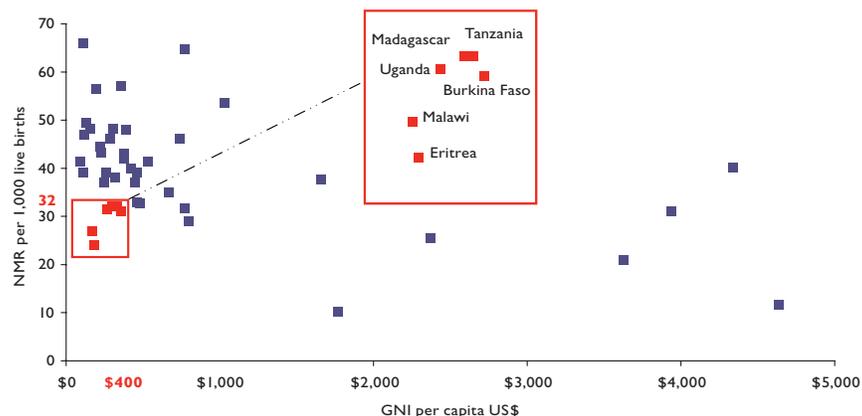


## Some low income African countries are progressing

Although no measurable progress has been made in reducing newborn mortality rates for babies during the first month of life in Africa at the regional level, a turnaround has been seen in six countries highlighted in the report, with an average decrease of 29 percent over the last 10 years. A number of strategies have been used across the six countries which have seen reductions in newborn deaths ranging from 20 to 47 percent.

- In *Malawi*, there is presidential-level commitment to maternal, newborn, and child health and greater investment by partners, especially to increase human resources for health.
- *Tanzania* has recorded a 30 percent reduction in child mortality and a 20 percent fall in newborn deaths over the last 5 years. District health managers set local budget priorities based on local patterns of death, resulting in increased spending on essential maternal and child health care.
- In *Uganda*, the performance of district health services is ranked each year and published in national newspapers.
- *Eritrea* has made consistent progress over 20 years in reducing child and newborn deaths, with an average annual reduction of around four percent over the last decade, through a focus on reaching high coverage of basic public health services, including to the poor.
- *Burkina Faso* ensures that poor women do not pay for the catastrophic cost of an emergency caesarean section which can account for more than an average family income for the year.
- Policy makers in *Madagascar* have committed to improving community-based care as well as addressing human resource constraints for skilled and emergency obstetric care.

**FIGURE 3: Low income African countries (less than US\$400 per capita GNI) with lower neonatal mortality rates (less than 32 deaths per 1,000 births)**



See the report for details on the data and sources used.

# Actions for policy makers in Africa

The opportunities and gaps are different in every country, but the following themes are consistent among the countries making progress in reducing newborn deaths, examined in this report:

**Accountable leadership:** Accountable leadership and good stewardship at all levels are important factors in setting direction and in accelerating and managing action. In several of the countries showing the most progress in reducing neonatal deaths, key leaders made regular public commitments to maternal, newborn, and child health. Good leadership maximises teamwork and the use of resources and also attracts investment from outside sources.

**Bridging national policy and district action:** Almost all of the countries that are making progress have poverty reduction strategy papers and health sector reform plans. Too often there is a gap between strategic planning at the national level and action in districts. In Tanzania, for example, policy makers have recognised this challenge, and district management teams now allocate local budget according to the burden of disease, resulting in more spending on child survival and steady increases in coverage of essential interventions.

**Community and family empowerment:** Most care for mothers and their newborns and children occurs at home. Women and families are not merely bystanders. If empowered, they can be part of the solution to save lives and promote healthy behaviours, such as breastfeeding or early care seeking for illness. Community solutions, such as emergency transport and pre-payment schemes, can also be effective.

## **Demonstrated commitment to:**

- *Making policy to support progress* towards MDGs 4 and 5 and increasing coverage of MNCH essential interventions/packages. The Road Map for reduction of maternal and newborn mortality and the WHO/UNICEF/World Bank regional child survival framework present opportunities to accelerate progress for MDGs 4 and 5 in every country in Africa and contribute to the attainment of MDG 6 on reduction of malaria and HIV/AIDS. However, this requires a consistent and high level of focus on long term plans, moving towards universal access and coverage for essential interventions and specific strategies to reach the poor.
- *Mobilising resources and increasing investment in health* and moving towards a more equitable health system involves a careful consideration of health care financing in order to meet the Abuja target for government health spending. Specific attention is required to protect the poor, particularly from the direct and indirect costs of obstetric emergencies. A number of African countries have recently removed user fees or changed policies to reduce their effect on the poor. Zambia has abolished user fees altogether, while Burundi has instituted user fee exemptions for childbirth care as well as care for children under five.
- *Measuring progress* in number of deaths and coverage of essential interventions and linking data to decision making. This involves considering equity and promoting accountability and public ownership. Some countries have employed novel approaches to use available data and promote public accountability. For example, Ugandan newspapers publish an annual league table of districts that report progress for health, education, and other key indicators. South Africa has instituted a national confidential enquiry into maternal deaths and has launched a process to examine neonatal deaths and their causes.
- *Maximising human resources.* Sustained commitment to increasing human resource capacity is particularly important for scaling up skilled attendance during childbirth. Maximising human resources also includes the use of community workers where appropriate. Meeting this challenge necessitates the involvement of governments, professional associations, and development partners. One success story comes from Uganda, where professional associations in two districts collaborated with Canadian colleagues to increase met need for EmOC through quality improvement of facilities and demand generation in communities. The government of Malawi has also been active in building capacity and strengthening quality of care (Panel 3).

## **PANEL 3: Malawi's emergency human resources programme**

Malawi has only had a medical school since the early 1990s and suffers a chronic shortage of doctors, nurses, and skilled workers. This situation is exacerbated by brain drain and HIV/AIDS. A recent survey of health facilities showed that only 10 percent of 617 health facilities in the country satisfied the requirements for delivering essential health services based on availability of services and staff levels. It became clear that improving staffing levels is the single biggest challenge to implementation of the government's Essential Health Package. An emergency human resources programme was developed by the government and partners to:

- Improve incentives for recruitment and retention of staff through salary top-ups
- Expand domestic training capacity, temporarily using international doctors and nurse tutors
- Provide international technical assistance to strengthen management capacity and skills and establish monitoring and evaluation of human resource flows



## Actions for partners to help accelerate progress in Africa

Partnership is integral to effective action. Partners have an essential role to play in saving lives through the following principles:

- PRINCIPLE 1. Increase funding for essential MNCH interventions.** These interventions, which save mothers, babies, and children, are highly cost effective. Investment is the responsibility of rich and poor countries, international donors, and leaders within countries. An increase in funding by the order of 3 to 5 fold is required.
- PRINCIPLE 2. Keep governments in the driving seat and support national priorities,** along with the principles of the Paris Declaration on aid effectiveness: one plan, one coordinating mechanism, and one monitoring system to lighten the management and reporting load.
- PRINCIPLE 3. Improve partner harmonisation.** Sometimes partners slow action in country by duplicating work or by pulling in different directions. Donor convergence allows for better decision making and more efficient use of resources at the country level. This is the founding principle of the Partnership for Maternal, Newborn & Child Health (PMNCH). This book provides an agreed platform for action by multiple partners.

*Opportunities for Africa's Newborns* represents a major milestone in the effort to save four million babies who die from preventable and treatable causes every year worldwide.

**Dr. Francisco Songane**  
Director, Partnership for Maternal,  
Newborn & Child Health

This publication helps to bridge the gap between policy and action. Newborn health is a crucial link in the continuum of care – systematic attention to strengthening and scaling up newborn care within national plans and programmes will pay off in strengthening services.

**Professor E. Oluwole Akande**  
Chair, WHO African Regional Reproductive, Maternal,  
Newborn and Child Health (RMNCH) Task Force

Now reaching every woman, baby and child in Africa with essential care will depend on us, the users of this publication. We all have a role to play.

**Hon. Amb. Gertrude I. Mongella**  
President, Pan African Parliament,  
African Union

# Africa's newborns are Africa's future

Until recently, newborn deaths in Africa have gone uncounted. New attention to Africa's newborns as the most vulnerable members of society provides opportunities to accelerate action to reduce newborn deaths but also to strengthen MNCH services and integrate more effectively with existing programmes. Increasing the coverage of essential interventions to 90 percent could save the lives of up to 800,000 newborns in Africa every year, and would also save the lives and improve the health of mothers and children. Feasible solutions to save these lives are available and require action now.

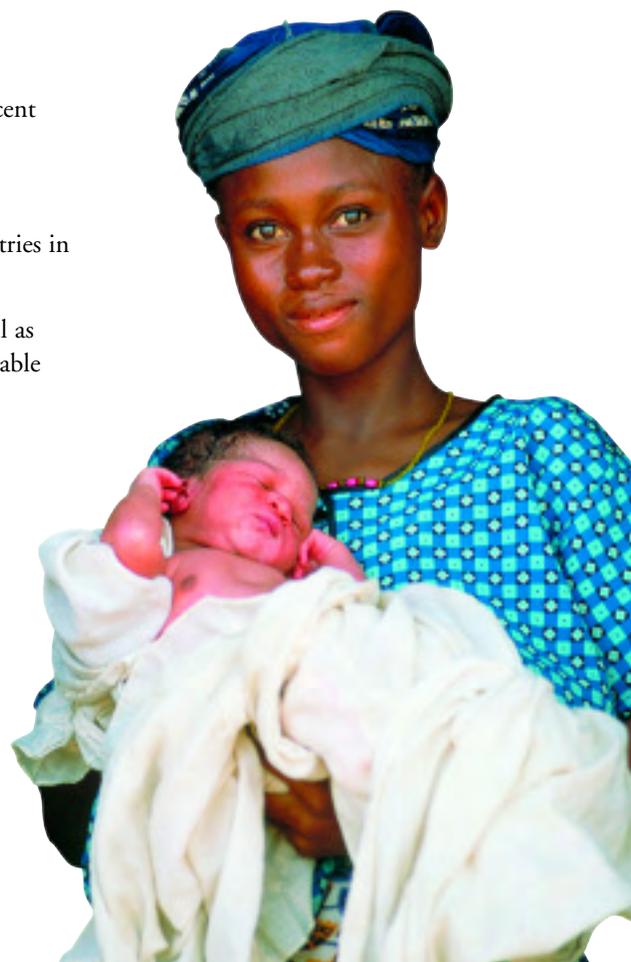
## Call for action to save Africa's newborns

### Call for action at the national level

- By the end of 2007, produce and publish a plan of action to reach national neonatal survival targets, linked to the Road Map to accelerate the reduction of maternal and newborn mortality and other relevant strategies for reproductive health and child survival. This plan should be based on situation analyses, with a baseline and target neonatal mortality rate (NMR), a foundation of evidence based interventions and specific strategies that reach the poorest families.
- Finance implementation of the plan of action by identifying and mobilising internal resources, seeking external support where necessary, and ensuring the poor are not missed in scale up efforts.
- Implement the plan within maternal health and child health programmes, with defined targets and timelines, phasing progress towards universal coverage of essential interventions.
- Monitor progress and publish results regularly. Link to existing monitoring processes such as the Road Map and health sector reviews, with the involvement of civil society. Count every newborn and make every newborn count.

### Call for action at the international level

- Include NMR as an indicator for MDG 4, with a target of 50 percent reduction between 2000 and 2015.
- Publish national NMR data in global reports on an annual basis.
- Leverage resources to meet the additional needs identified by countries in order to achieve high coverage of interventions.
- Promote integration of maternal, newborn, and child health as well as malaria, HIV/AIDS and immunisation programmes in order to enable health systems to save more lives.





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### Acronyms

ANC	Antenatal care
ARI	Acute respiratory infection
BF	Breastfeeding
CPR	Contraceptive prevalence rate
DPT3	Three doses of diphtheria, pertussis and tetanus vaccine
EmOC	Emergency obstetric care
IMCI	Integrated Management of Childhood Illness
IMR	Infant mortality rate
IPTp	Intermittent preventive treatment for malaria during pregnancy
MDG	Millennium Development Goal
MNCH	Maternal, newborn and child health
NMR	Neonatal mortality rate
PMTCT	Prevention of mother-to-child transmission of HIV
PNC	Postnatal care
U5MR	Under-five mortality rate

### The book and CD – acknowledgements and ordering information

*Opportunities for Africa's Newborns* is now available for download and the book and CD can be ordered free of charge for those working in or for Africa. The CD includes a library of over 200 programmatic and policy documents. For download, translation and ordering information, please visit [www.pmnch.org](http://www.pmnch.org).

The book has been developed by a team of 60 authors, multiple reviewers, and nine organisations working under the umbrella of the Partnership for Maternal, Newborn & Child Health. The editorial team was supported by Saving Newborn Lives/Save the Children US, through a grant from the Bill & Melinda Gates Foundation, and by BASICS, through a grant from USAID. Layout of the book and the Executive Summary by Spirals, New Jersey, USA. CD layout by World Wide Creative, Cape Town. Financial support towards the production of this publication was provided by USAID through the ACCESS programme and the Maximizing Access and Quality Initiative, as well as through the Africa Bureau of USAID; Saving Newborn Lives/Save the Children US, through a grant from the Bill & Melinda Gates Foundation; and the Department of Child and Adolescent Health and Development, WHO Geneva, through a grant from the Bill & Melinda Gates Foundation.

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