Reduce Child Mortality

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TARGET 5:

Reduce by two-thirds, between 2000 and 2015, the under-five mortality rate.

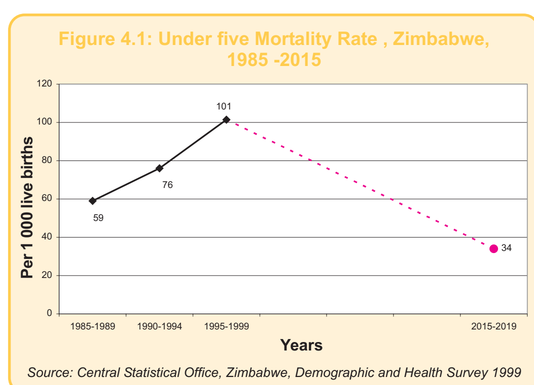
INDICATORS:

19. Under-five mortality rate[15] (deaths per 1000 live births)
20. Infant mortality rate[16] (deaths per 1000 live births)
21. Percentage of under-fives who are undernourished
22. Percentage of children vaccinated against measles

STATUS AND TRENDS

During the 1980s, infant and child mortality had declined. By the 1990s, however, overall mortality as well as infant and child mortality began to rise as shown in Figure 4.1. The rise in mortality is mainly attributed to the direct and indirect impact of the HIV and AIDS epidemic and the concomitant rise in poverty levels.

Figure 4.1: Under five Mortality Rate , Zimbabwe, 1985 -2015



Source: Central Statistical Office, Zimbabwe, Demographic and Health Survey 1999

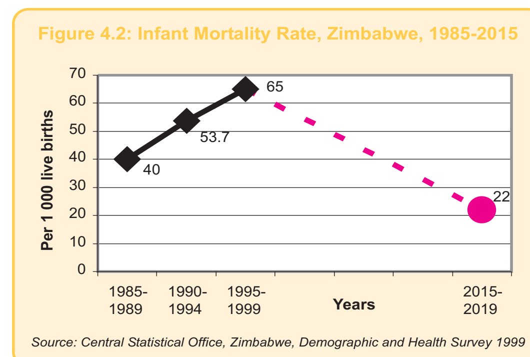
Key

- ◆ Actual
- ● Target
- —— Current rate of progress
- - - - Rate of progress required to reach goal

Infant mortality increased from 40 to 65 per 1000 live births, while under-five mortality increased from 59 to 102 per 1000 live births between 1985-89 and 1995-99 (see Figures 4.1 and 4.2). This implies that one in 15 children will die before their first birthday and that one in ten children will die before attaining the age of five years, respectively.

The Zimbabwe Demographic Health Survey (ZDHS) 1999 indicates that the infant mortality rate for the ten year period preceding the survey was 47 deaths per 1000 live births in urban areas compared to 65 deaths per 1000 live births in rural areas. The target is to reduce under-five mortality from 102 per thousand during the period 1995-99 to 34 per thousand by 2015, while infant mortality is targeted to be reduced from 65 per thousand during 1995-99 to 22 per thousand by 2015. Furthermore, the same survey also revealed that there is a strong association between a mother's level of education and a child's chances of survival. While the children of mothers with no education experienced an under-five mortality rate of 119 per 1000, those of women with higher than secondary school education experienced mortality rates as low as 21 per 1000. This illustrates that better-educated mothers are likely to have greater knowledge of nutrition, hygiene and other practices related to childcare and are more likely to use health services. Moreover, 25% of households have no access to safe water and 42% have no access to sanitation, which further exposes children to the risks of water-borne diseases.

Figure 4.2: Infant Mortality Rate, Zimbabwe, 1985-2015

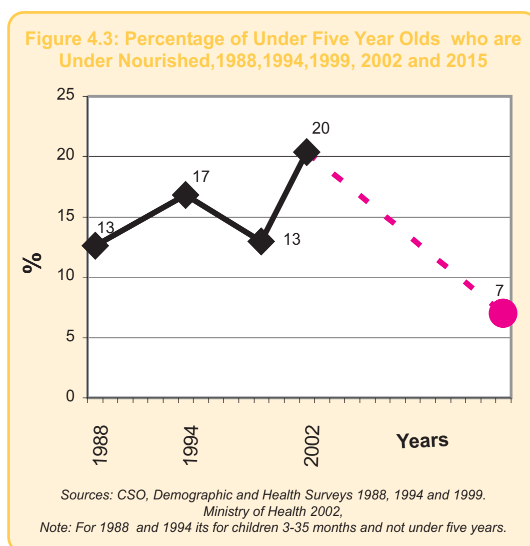


Source: Central Statistical Office, Zimbabwe, Demographic and Health Survey 1999

[16] The probability of dying between birth and the first birthday.

The proportion of under-fives who are undernourished (weight-for-age) increased in recent years, from 13% in 1999 to an estimated 20% in 2002 (see Figure 4.3). About 34% of child deaths in Zimbabwe are attributable to malnutrition. The target is to reduce under-five malnutrition from the national average of 20% in 2002 to 7% by 2015.

Figure 4.3: Percentage of Under Five Year Olds who are Under Nourished,1988,1994,1999, 2002 and 2015

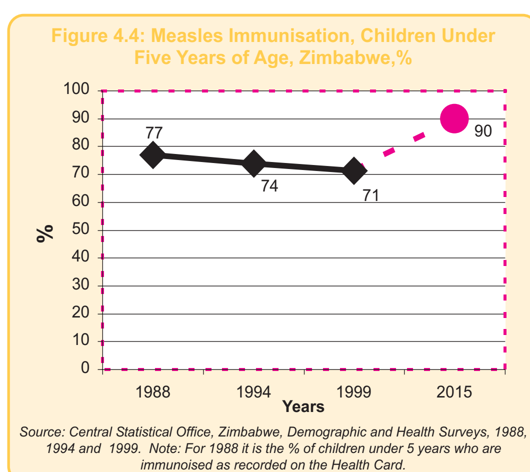


Sources: CSO, Demographic and Health Surveys 1988, 1994 and 1999. Ministry of Health 2002,
Note: For 1988 and 1994 its for children 3-35 months and not under five years.

Prevention programmes such as immunisation against childhood illness also contribute to the reduction of prenatal, neonatal and child mortality. The Zimbabwe Expanded Programme on Immunisation (ZEPI) was introduced in 1982 and the country's development objective was to increase coverage of all ZEPI vaccines to 90% by the year 2000. The completion of the Primary Course of Vaccination (PCV) is one of the criteria for the assessment of the quality of the programme and its effectiveness. There was a general rise in the trend of PCV coverage during the period 1992-1994. By 1997, the PCV coverage had risen to 96.6%.

However, measles immunization has been on the decline from 77% in 1988 to 74% in 1994, declining further to 71% in 1999 (see Figure 4.4).

Figure 4.4: Measles Immunisation, Children Under Five Years of Age, Zimbabwe,%



Source: Central Statistical Office, Zimbabwe, Demographic and Health Surveys, 1988, 1994 and 1999. Note: For 1988 it is the % of children under 5 years who are immunised as recorded on the Health Card.

The decline in measles vaccination is attributed to a weakening health delivery system, shortage of drugs, high staff shortages and the presence of child and grandparent headed households due to the HIV and AIDS epidemic. The target is to reach 90% measles immunization by 2015.

CHALLENGES

There are a number of challenges in the reduction of infant and child mortality rates by two-thirds, between 2000 and 2015.

HIV and AIDS and other diseases

The HIV and AIDS epidemic has placed children under an increased state of vulnerability. In addition, other main causes of infant and child mortality are acute respiratory infection, malnutrition, malaria and diarrhoeal diseases and pulmonary tuberculosis. The challenge is to reverse the HIV and AIDS epidemic, as well as reduce the incidence of other child killer diseases.

Parent-to-child transmission of HIV

The growing phenomenon of parent-to-child transmission at birth is largely responsible for the worsening infant and child mortality trends in Zimbabwe. The challenge is to reduce the transmission of HIV from mother to child, while at the same time reversing the prevalence of HIV infection. Interventions such as antiretroviral drugs, caesarean section and alternative infant feeding options can significantly reduce the percentage of transmission.

Poverty, Hunger and Malnutrition

The ability of households to take care of their children is affected by the magnitude of poverty. In the absence of public feeding programs, children from poor households are more prone to suffering from hunger and malnutrition. Infant and child mortality rates are higher among poor households. Thus the increase in poverty levels in both rural and urban areas impacts negatively on the mortality of children. The challenge is to stimulate broad-based sustainable economic growth and development as well as to consolidate effective child-feeding public programmes.

Weakened Health Delivery System

While the health budget has increased in nominal terms over the past years, in real terms it has decreased due to the hyperinflationary environment. This has made the procurement of essential drugs and equipment, as well as the retention of staff difficult. In addition, the impact of HIV and AIDS and brain drain on human resources in the health sector has been particularly severe. The challenge, therefore, is to protect social sector expenditure within the national budget in order to support the

strengthening and transformation of the health delivery system given the HIV and AIDS pressures.

Information, Education, and Communication (IEC) in Child care
Improved awareness in childcare by mothers has a direct positive impact on child mortality. The challenges are ensuring education of the girl child and access to information on childcare for all mothers, in particular those in the remote parts of the country.

Safe Water and Sanitation
Provision of safe drinking water and adequate sanitation are preconditions for improved child welfare. The challenge, therefore, is to provide safe drinking water and sanitation in order to combat the impact of water borne diseases, such as diarrhoea.

Universal Immunization of Children
The declining trend in measles immunization is a source of concern. The challenge is to ensure universal immunization against all child killer diseases.

Adolescent pregnancies
Children born to adolescent mothers are vulnerable to inadequate childcare due to inexperience and lack of resources. In addition, they are more likely to have low birth weight, which increases their mortality risk. Also, pregnant teenagers are more likely not to have antenatal and postnatal care when compared to mature women. The challenge is to reduce adolescent pregnancies by encouraging, among other things, the education of the girl child.

SUPPORTIVE ENVIRONMENT

Zimbabwe has various policies and programmes that are supportive to the reduction of infant and child mortality. Some of these include:

HIV and AIDS Emergency declaration
The Government has declared a state of emergency for the next five years in order to facilitate the procurement of antiretroviral and related drugs, including PMTCT to mitigate the impact of the HIV and AIDS epidemic.

Re-introduction of the village health worker
The government has reintroduced the Village Health Worker programme to strengthen communities. As a result, IEC and child-care and mothers' health will be strengthened.

Free treatment of the under five and pregnant women in public institutions
Free treatment of the under five and pregnant women in public institutions, in both rural and urban areas, has a direct positive bearing on the health of the child and the mother, particularly when the health institutions are well equipped.

Expanded Programme on Immunization:
The Expanded Programme on Immunisation (EPI) has maintained a high coverage of above 90%. Zimbabwe observes and conducts National Immunisation days and institutes effective surveillance, thus creating a conducive environment for universal immunization of children.

Child Supplementary Feeding Programmes
The Child Supplementary feeding Programme provides supplementary food for under-five children, particularly during periods of food shortages.

Orphan Care Policy
Support to orphans is a state obligation under the Convention of the Rights of the Child. The Orphan Care Policy adopted by the Cabinet in 1999 covers free health care and food subsidies/ supplements to under fives. This has created a conducive environment to protect children from hunger and malnutrition.

Supportive education policies and programmes
Child friendly programmes, such as BEAM and affirmative action, help to keep the girl child in school, thus reducing the risks of adolescent pregnancies. In addition, the educated girl child faces a better chance of becoming a good mother, with respect to child-care.

PRIORITIES FOR DEVELOPMENT

To achieve the target of reducing child mortality by 2015, the following national priorities need to be addressed:

Increase coverage of immunisation programme
There is need to sustain the high coverage of immunization against most childhood killer diseases, and particularly to increase and sustain high child immunisation against measles.

Prevention of Parent To Child Transmission (PPTCT)
Take full advantage of the extended declaration of emergency on the HIV and AIDS infection to procure and administer drugs on PPTCT to reduce child mortality.

Improved Access to Health Care facilities (particularly in the new resettlement areas)
Strengthen the health delivery system in general, given the increased demand from the HIV and AIDS epidemic. Particular attention should be given to newly resettled, rural and remote areas.

Availability of essential medicines and vaccines, especially antiretroviral drugs for PPTCT
Rationalize further priorities within the national

budget, so as to release more resources for the health sector, with an emphasis on improving working conditions for health personnel.

Access to safe water and adequate sanitation.

Consolidate and expand existing coverage of safe-water and sanitation programmes in both rural and urban areas and in particular to the newly resettled areas.

PRIORITIES FOR DEVELOPMENT ASSISTANCE

Major areas for development assistance to meet the challenges for reducing child mortality are as follows:

- Sustained increase in immunization coverage
- Procurement of Essential drugs and Health infrastructure development, including PPTCT antiretroviral drugs.
- Provision of Safe Water and Sanitation

COSTING THE CHILD MORTALITY REDUCTION GOAL

Overview: While many of the comments made under education are also applicable to this goal, the health sector has its own characteristics. The main one has to do with the kind of priority accorded by the household to healthy living and longer survival. Government, in turn, has to judge carefully how much of its health budget should be divided between preventive care and curative care. In general, allocating comparatively more funds to preventive care has a greater impact on reducing infant, Under-5 and maternal mortality. A majority of infant and child deaths are caused by not having access to clean water and, in such cases, it may be useful to spend more in the water sector. In addition, there are other preventive factors, such as better education for mothers that help to reduce child mortality. It suggests, therefore, that attaining certain health targets will require not just spending in the health sector alone, but also spending in other sectors such as water and education.

Given these related factors, it makes the projecting of unit cost for the child mortality goal a complex one. It follows, therefore, that the expenditure requirements for each of the sectors needs to be assessed carefully, and only by getting the mix of spending correctly will this target be achieved. Furthermore, as stated under primary education, it is important to know how the cost of treatment should be shared between the Government and Household. Additionally, given that the parent of the child has to pay part of this cost, an assessment on the income and affordability of the household should be made on a regular basis.

Unit cost on Child Mortality and projections

The Zimbabwe targets, in accordance with MDG, are to reduce;

- Infant mortality by 66%, from 65 per 1000 live births in 2000 to 22 per 1000 live births by 2015.
- Under-5(U-5) mortality by 66%, from 102 per 1000 in 2000 to 34 per 1000 by 2015.
- Maternal mortality by 75%, from 695 per 100000 in 2000 to 174 per 100000 by 2015.
- Additionally, Zimbabwe aims to improve on such input indicators as – doctors per patient, supplies per patient, bed per patient etc.

The average cost estimates are based on Budget Estimates of 2000 (Vote 16 – Health and Child Welfare) and Statistics on mortality indicators available for 2000. Both recurrent and development budget estimates of the health sector are used to derive average unit cost. Within the Health budget, 100% of preventive care services expenditure and 10% of all other expenditures are taken in calculating unit cost for the projections. Due to data limitations, it is assumed that all three mortality indicators are grouped in to one unit cost. With more des-aggregated data that is reliable and more frequently available, the unit costs of each mortality goal can be estimated separately.

Given these assumptions, annual real increase in expenditure to attain the above-defined goals (including 1.1% population increase), health expenditure per child/mother should increase at 3.5% per year. Average spending over the period should increase from the current level of US$ 35.4 per child/mother to US$ 46.4 per child/mother. In parallel, total health spending over the period to 2015 should be US$43.2 mn.

"As a Nation with Oneness of Purpose, Together we can Score this Goal!"