EXPLAINING Contrasting Natural Trends and Progress in Achieving MDG 4

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A Paper to be presented at the 5th African Population Conference, in Arusha, Tanzania

Abstract

The trends and progress in achieving Millennium Development Goal number Four has been experiencing steady improvement in the last seven years of its declaration. The goal is aimed at reducing child mortality with set target to reduce by two thirds, between 1990 and 2015. Most countries in the sub-Sahara Africa are still trailing far behind. A lot of factors militate against their move to achieve remarkable low child mortality rate. This paper engages cursory examinations into the policies and programmes of the international communities, donors, agencies and Nigerian government and her agencies on achieving the set goal in the remaining *eight* years to the end of the stipulated time (2015). Also, the paper discusses the trends and progress of some countries within the Africa continent (especially the Northern part of the continent) comparing with sub-Saharan countries. Reasonable remedies to some of the clog in the wheel of progress in achieving the reduction in child mortality rate are proffered in the paper.

Keywords: Millennium Development Goals, child mortality, sub-Saharan Africa,

December 2007

Introduction

Infant and child mortality remain disturbing and confounding issues in child's health across the world. It is incredible that in an age of technological and medical marvels, child survival is so tenuous and sluggish in so many places, especially in developing countries. Since 20th century, most developed countries have been experiencing decrease in infant and child mortality and this has improved life expectancy at birth apart from sub-Saharan Africa (Franz and Fitzroy 2006).

An estimated 11 million children die every year (Ogunjuyigbe 2004, Mutunga 2004; Mukelabai, 2005, United Nations 2006), with large variation in under-five mortality rates and trends, across regions and countries. The deaths mostly caused by preventable and treatable ailments such as, pneumonia, diarrhea, malnutrition, malaria, measles and HIV/AID. The astonishing fact remains that out of 11 million deaths annually recorded globally, most of them occurred in developing countries. Sometimes the cause could be attributed to non-availability of antibiotics for treating pneumonia or oral rehydration salts for diarrhea. Malnutrition contributes to over half of these deaths. Ninety per cent of these occur mostly in sub-Saharan African countries as well as in South Asia (Black, Morris and Bryce 2003).

Under- five child mortality rates in other regions of the world have been decreasing drastically while that of sub-Saharan Africa has experienced slight decrease. The global under-five mortality rates between 1990 and 2003 experienced a decline from 95 deaths per 1,000 lives births in 1990 to 80 deaths per 1,000 live births in 2003. By and large, the under-five mortality rates in both developed and developing regions experienced decline from 11 and 105 deaths per 1,000 lives births in 1990 to 7 and 88 deaths per 1,000 live births in 2003 respectively but sub regionally, the rates are still on increase in sub-Saharan Africa (UNICEF and WHO 2005).

Mutunga (2004) submitted that childhood mortality rates were declining all over the world in the last fifty-five years that is between the end of World War II and early 1970's. He attributed the achievement to the intervention targeted at the communicable diseases such as diarrhea, measles, malaria, respiratory infections and other immunizable childhood infection. But later, the worldwide low mortality in 1970's started to rise due to ineptitude of national government in developing countries generally and Africa in particular. The retrogression in childhood morbidity and mortality could be attributed to poor maternal health, environment degradation and poor socio-economic backgrounds of Africans (Franz and Fitzroy 2006).

In 2002, in adopting the Millennium Development Goals (MDGs), world government committed themselves to reduce the under-five mortality rate by two-third. This means reducing the under-five mortality rate from 93 deaths per 1000 live births to 31 deaths per 1000 live births between 1990 and 2015. To achieve this ambitious target, an average annual reduction of 4.4 per cent in the under-five mortality rate will be needed between 1990 and 2015 (UNICEF 2004a). However, the current estimates by UNICEF (2004) show that under-five child mortality will be reduced by 23 per cent globally between 1990 and 2015 period, that is, by the end of 2015, the child mortality rate globally will be approximately reduced to 68 deaths per 1000 live births. With this estimate, it is well below the MDG4 of a two-thirds reduction (Mukelabai 2005).

This paper therefore takes a cursory look on the global, regional and national trends with emphasis on sub-Saharan Africa viz-a-viz other developing regions' achievements in meeting with MDG4. Also, this paper expounds on some contrasting natural factors that are making achieving the goal in sub-Saharan Africa region a nightmare. Policies and programmes of the global and international agencies, donors, and non-governmental organizations in collaboration with the sub-Saharan countries in order to meet up with MDG4 are critically examined.

Global and Regional Trends

Despite the global broad approach towards child's health and achieving the Millennium Development Goal4 which aimed at reducing child mortality with set target to reduce by two-thirds, between 1990 and 2015; only developed regions have met the standard (Table 1). Individually, almost 50 developed countries have met the target of the goal. Mukelabai (2005) quoted the UNICEF report that apart from the developed countries that have achieved the reduction, 90 countries were on track to meet the target; while 78 countries had failed and could not achieve by average just two per cent progress per year in reducing child mortality. Also, 39 countries were to reduce child mortality by more than 8 per cent every year in, on average, for the next eight years in order to reach the goal on reducing child mortality but unfortunately, 98 countries were considerably off tracks. By and large, the global pace of progress is far too slow.

Table 1. Under-five mortality rate, 1990-2003

	Child deaths per 1,000 live births	
	1990	**2003**
World	95	80

Developed regions	11	7
Commonwealth of Independent States	46	46
Developing regions	105	88
Northern Africa	87	38
Sub-Saharan Africa	185	172
Latin America and the Caribbean	54	32
Eastern Asia	48	37
Southern Asia	126	90
South-Eastern Asia	78	46
Western Asia	68	60
Oceania	86	77

Source: United Nations Statistics Division, "World and Regional Trends", Millennium Indicators Database, (accessed June 2005); based on data provided by United Nations Children's Fund and the

In 2002, for instance, the United Nation Children's Funds (UNICEF) comprehensive data showed that industrialized countries had an average child mortality rate of 7 deaths per 1000 live births while the least developed countries had a rate of 158 deaths per 1000 live births (UNICEF 2004a). Millennium Development Goal 4 aims to cut child mortality by two thirds by 2015; substantial progress towards this goal has been made since 1990 in northern Africa, Latin America/Caribbean and south-eastern Asia, much less in eastern, south-central and western Asia and Oceania. The under-five mortality rate actually increased in 14 countries, nine of which were in sub-Saharan Africa (UNICEF 2004). Though survival prospects have improved in every region (United Nations 2006), yet sub-Saharan Africa has been unanimously agreed by different authors and reports to be trailing behind other regions of the world. Of 11 million children that died from preventable and treatable infections annually across the globe, 94 per cent of these children live in 60 countries in sub-Saharan Africa, (a region with 20 per cent of the world's young children) but accounted for half of the total under-five deaths. Sub-Saharan Africa region recorded estimates of 185 deaths per 1000 live births in 1990 and 168 deaths per 1000 live births in 2004; compared with Northern Africa region (a region within the same continent) having 88 deaths per 1000 live births in 1990 and 37 deaths per 1000 live births in 2004 (United Nations 2006).

UNICEF (1999, 2000) reported that out of thirty countries with the world's highest mortality rates, twenty-seven are in sub-Saharan Africa, whereas the region's under-five mortality rate in

1998 was173 deaths per 1000 live births. Admittedly, the rate was higher than the millennium goal of 70 child deaths per 1000 live births internationally adopted in the 1990 world summit for children. Other developing regions such as Southern Asia and Latin America and the Caribbean that were listed together with sub-Saharan Africa in 1990 at the start of the MDG4 count down, as regions with high child and infant mortality have moved up the ladder of reducing their child mortality rates (compare with Southern Asia, see table 1). In sub-Saharan Africa, 1 out of every 6 children born dies before reaching five years of age while in Latin America and the Caribbean, 1 out of every 29 children dies before reaching age five and in contrast with the industrialized countries where 1 out of every 143 children dies before fifth year birthday (UNICEF 2004a).

Global and Regional Trends in Expectation of Life

Table 2: Life expectancy at birth for both sexes in selected regions and countries, 1950-2005

	1950-1955	1955-1960	1960-1965	1965-1970	1970-1975	1975-1980	1980-1985	1985-1990	1990-1995	1995-2000	2000-2005
World	46.6	49.7	52.5	56.2	58.1	59.9	61.4	62.9	63.7	64.6	65.4
Region/classification											
Asia (excluding Middle East)	42.2	45.7	49.2	54.8	57.6	59.9	61.6	63.1	64.7	66.3	67.8
Central America & Caribbean	50.6	54.4	57.4	59.6	61.9	64.2	66.1	68.0	69.5	71.4	72.5
Europe	65.6	68.1	69.5	70.5	71.0	71.5	72.0	73.1	72.8	73.5	74.2
Middle East & North Africa	42.8	45.7	48.4	51.1	53.8	56.7	59.4	62.7	64.8	66.6	67.8
Sub-Saharan Africa	37.7	39.7	41.7	43.7	45.7	47.6	49.1	50.0	49.2	47.6	46.6

Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, 2005. World Population Prospect: New York: United Nations.

Table 2 shows disparities in life expectancy between sub-Saharan Africa and other regions of the world. Other regions' life expectancy at birth increases periodically but that of sub-Saharan Africa started decreasing from 1990 through 2005. This reflects the high child mortality rates recorded by the region since the beginning of the MDG4 count down.

Mukelabai (2005) lamented the wide variation in the death of under-five children in sub-Saharan Africa and other regions. He wondered why the rate of children dying before five years of age decline by one third in Latin America and the Caribbean between 1990 and 2000 but that of sub-Saharan Africa recorded 40 per cent deaths increase at the same periods. This is the greatest challenge to achieving the child mortality target by 2015 (United Nations 2006).

Without mincing words, virtually all the countries in sub-Sahara Africa are having high under-five child mortality rates. Of 26 countries where more than 15 per cent of children die before age five in 2003, 25 are within sub-Saharan Africa (see Table 3).

Table 3: Countries where more than 15 per cent of children die before age five

S/N		Under-five mortality rate per 1,000 births, 2003
1	Sierra Leone	284
2	Niger	262
3	Angola	260
4	Afghanistan	257
5	Liberia	235
6	Somalia	225
7	Mali	220
8	Burkina Faso	207
9	Congo, Dem. Rep. of the	205
10	Guinea-Bissau	204
11	Rwanda	203
12	Chad	200
13	Nigeria	198
14	Côte d'Ivoire	192
15	Burundi	190
16	Mauritania	183

17	Zambia	182
18	Central African Republic	180
19	Malawi	178
20	Ethiopia	169
21	Cameroon	166
22	Tanzania, United Republic of	165
23	Guinea	160
24	Mozambique	158
25	Benin	154
26	Swaziland	153

Source: United Nations Statistics Division, "World and regional trends", Millennium Indicators Database, (accessed June 2005); based on data provided by United Nations Children's Fund and the World Health Organization.

Table 3 shows Sierra Leone leading with 284 children deaths per 1000 live births while Swaziland was the least with 153 children deaths per 1000 live births. Nigeria is among countries with high under-five mortality rates in the world. The 2003 Nigeria Demographic and Health Survey (NDHS) estimated 201 children deaths per 1000 live births which were higher than what was recorded in table 3.

Another country in the West African coast, Ghana, from her 2003 Demographic and Health Survey (DHS) recorded 177 deaths per 1000 live births (GDHS 2003). Kenya, one of the countries in central Africa has a child mortality rate of 111.5 deaths per 1000 live births (KDHS 1998).

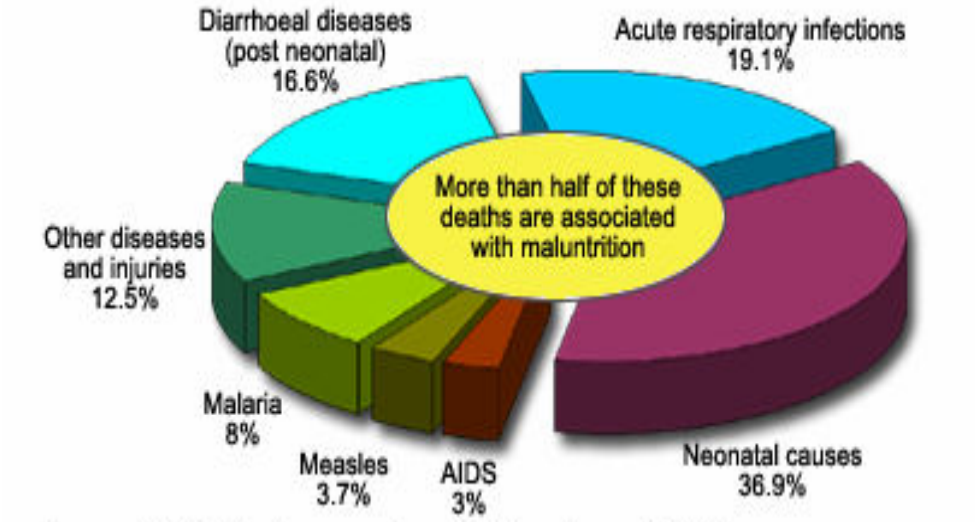
Causes of Child Mortality in Sub-Saharan Africa

Many scholars and international agencies have identified various causes of high child mortality rates in developing countries. The pathogenic (biological), socio-economic, cultural, environmental, and governmental causes have been contributing in one way or the other to the prospect of achieving the MDG4.

Pathogenic (Biological) cause

The death of a child is a tragic loss. Yet, every year, almost 11 million children die before their fifth birthday. That is 30,000 children die in one day. The pathogenic (biological) causes are the preventable and curable infections. Five diseases—pneumonia, diarrhea, malaria, measles, and HIV infection—account for over 50 per cent of the under-five deaths. Malnutrition is a contributing factor in over 60 per cent of cases (figure 1). Deaths among children under five occur mostly due to congenital malformation, low birth weights, compounded by poor antenatal care and lack of skilled birth attendants (United Nations 2006).

Figure 1: Causes of death in children under five, 2000-2003 (percent)



Source: UNICEF, Progress for Children Report, 2006

Acute respiratory infections, primarily pneumonia, kill over 2 million children under the age of five each year in developing countries. In total, they account for about 19 per cent of under-five mortality.

Malaria kills at least 1 million children annually, 90 per cent of them in sub-Saharan Africa, (Mukelabai 2005). Although, it accounts for 8 per cent (figure 1) yet, Malaria is one of the five major causes of all childhood deaths in Africa. Anaemia, low birth weight, epilepsy, and neurological problems, all frequent consequences of malaria, compromise the health and development of millions of children throughout the tropical world. In sub-Saharan Africa alone, more than 2,000 children die from malaria in one day. The rapid spread of resistance to anti-malarial drugs, coupled with widespread poverty, weak health infrastructure, and, in some

countries, civil unrest, means that mortality from malaria in Africa continues to rise. The tragedy is that the vast majority of these deaths are preventable.

Measles remains an important cause of childhood mortality, especially in developing countries. According to WHO estimates in 2000, measles accounted for approximately 777 000 deaths worldwide, of which around 60% occurred in sub-Saharan Africa. In the joint *Strategic Plan for Measles Mortality Reduction, 2001--2005*, the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) targeted 45 priority countries with high measles burden for implementation of a comprehensive strategy for accelerated and sustained measles mortality reduction. Of these countries, 33 are in sub-Saharan Africa.

Diarrhea accounts for about one-third (over 16 per cent, figure 1) of child deaths especially in developing countries (Mukelabai 2005). Studies have also revealed that dirty feeding bottles and utensils, inadequate disposal of household refuse and poor storage of drinking water are to be significantly related to the high incidence of diarrhea among under-five children (Ogunjuyigbe 2004).

AIDS is the fourth leading cause of death worldwide. UNAIDS and UNICEF (2005) revealed that the effect of AIDS on child mortality in the following five (5) sub-Saharan African countries has increased their under-five mortality rates: Lesotho with 123, Namibia 78, South Africa 74, Swaziland 143 and Zimbabwe 117. The epidemic has stalled or reversed progress in child survival and life expectancy, which are the key indicators of social and economic development (Lamptey et al, 2006). HIV/AIDS has eroded hard won gains in improving child health, and it has become one of the major causes of increasing child mortality, particularly in sub-Saharan Africa.

Socio-Economic, Cultural and Political causes

It seems nothing works out good in sub-Saharan Africa. Most studies on child mortality have the position that high under-five mortality is significantly affected by poverty and the environment (Mutunga 2004, Franz and Fitzroy 2006, Tarekegn 2007). Other regions have been improving substantially on these two factors; reduction in poverty level of their subjects resulted in the reduction of high child mortality rates and increased life expectancy at birth (see table 2). Northern Africa, Latin America and the Caribbean and South-eastern Asia maintained their rapid reduction. In these regions, economic growth, better nutrition and access to health care have helped spur improvements in child survival (UNICEF 2006). The worsening poverty situation in

African communities is preventing large groups of children from accessing basic health services and care (Mukelabai 2005). Poverty aids hunger in sub-Saharan countries, 1 child dies every 3.6 seconds in Africa because of hunger (UNESCO 2006). Poverty also influences health because it largely determines an individual's environmental risks, as well as access to resources to deal with those risks throughout the developing world.

Illiteracy is an outcome of poverty; studies have shown that maternal education is a significant cause of child survival (Ogunjuyigbe 2004). The United Nations, (2006) submitted that survival rates for children of mothers with at least a secondary education are twice as high as those children with less educated mothers.

Child mortality rates are on increase due to the effects of armed conflict, social instability and the resulting massive displacement of families and communities. Violence and sexual abuse of women and girls; harmful traditional practices such as early marriages and female genital cutting; inadequate nutrition for girls; lack of access to basic and child health care services, poor birth spacing and high rates of teenage pregnancy are other causes of high under-five mortality particularly in Africa. Politically, most sub-Saharan African states suffer from bad governance or leadership. Sometimes, it is either the political-will to faithfully execute the policies and initiatives formulated to reducing under-five child mortality is apparently lacked of or the misappropriation of grants and donations by the international agencies or community has become endemic.

Environmental cause

According to the World Bank (2000), environmental health risks fall into two broad categories. The first are the traditional hazards related to poverty and lack of development, such as lack of safe water, inadequate and poor sanitation and waste disposal, indoor air pollution, and vector-borne diseases. The second category is the modern hazards such as urban air pollution and exposure to agro-industrial chemicals and wastes that are caused by development that lacks environmental safeguards.

Environmental risk factors account for about one-fifth of the total burden of disease in low income countries according to World Bank estimates (World Bank 2001). WHO (2002) reports that among the 10 identified leading mortality risks in high-mortality developing countries, unsafe water, sanitation and hygiene ranked second, while indoor smoke from solid fuels ranked

fourth. About 3% of these deaths (1.7 million) are attributable to environmental risk factors and child deaths account for about 90% of the total.

Progress in Achieving MDG4-Global Perspective

The progress made so far globally in order to achieve MDG4 seems tenuous and slow. Globally, progress has been made in the reduction of measles mortality by 39 per cent from 873,000 deaths in 1999 to 530,000 in 2003. The largest reduction was in Africa, where estimated measles mortality decreased by 46 per cent during those periods (WHO and UNICEF, 2004).

United Nations Organizations and International Communities' Policies and Programmes in Achieving MDG4 Before 2015

UNICEF, WHO and CIDA standpoints

United Nations Children's Fund (UNICEF) being the only organization exclusively mandated to protect children has been deeply involved in championing the course for child's health globally for the past sixty years. Its functions and mechanisms have been described as means to successfully reduce child mortality and attain the MDGs by 2015. Its policy on children's right to survive and commitment to child's health brought forth the World Summit for Children in 1990 to corroborate MDGs declarations particularly, goal 4 in 1990. This has led to the global mobilization and adoption of new initiatives with clear aims and directions in different global fora; for instance, the Earth Summit in Rio de Janeiro (1992) and the Social Summit in Copenhagen (1995).

Its collaboration with other United Nations Organizations such as World Health Organization and International agencies has been shown that giving Vitamin A supplementation to children can prevent the deaths of 250,000 children every year; use of oral dehydration therapy can prevent one million deaths from acute diarrhea and dehydration, and immunization programmes can save the lives of 4 million children annually. Use of insecticide-treated bed nets (ITNs) to prevent malaria can reduce under-five mortality in malaria-endemic countries by 20 per cent; and improved breast-feeding and young child feeding practices can significantly reduce deaths from diarrhea, infections and malnutrition.

The model modification for future UNICEF work is the successful implementation and boosting of the above-mentioned high impact and cost-effective interventions. One approach to reducing

child mortality is the UNICEF Accelerated Child Survival and Development programme in 11 countries in West Africa, covering a population of 16 million people (Mukelabai 2005). This programme, which is supported by the Canadian International Development Agency (CIDA), provides high-impact packages of health interventions targeting mothers and children in communities. Their activities include strengthening routine immunization, distribution of insecticide-treated nets (ITNs) at antenatal and under-five clinics to prevent malaria, Vitamin A supplementation and treatment of diarrhea with oral rehydration therapy. This is beginning to impact positively in reducing child mortality. These interventions are combined with advocacy to empower families and communities to recognize, prevent and treat common childhood illnesses and to refer very ill children promptly to health centers. In the same way, in Eastern and Southern Africa, UNICEF is supporting the integrated management of childhood illnesses at community level, which empowers families and communities to take care of treatable diseases, such as malaria, pneumonia and diarrhea at home. Parents and caregivers are empowered with knowledge on home management of malaria and other common childhood illnesses and are trained to recognize danger signs that require urgent referral of very ill children to hospital (Mukelabai 2005).

Progress in Sub-Saharan Africa

African countries, especially those in sub-Saharan region have formulated series of policies and embarked on many projects and programmes in order to meet the set target of MDG4 before 2015. For instance, recognition of the unacceptable mortality and morbidity from malaria in Africa, and the availability of a number of evidence- based, cost-effective interventions, have led to the adoption in 1998, of the Roll Back Malaria initiative. In the Abuja Declaration of April 2000, African Heads of State resolved to support scaling-up of the following interventions- administering Artemisinnin-based Combination Therapy (ACT) and the distribution of insecticide treated nets (ITNs), which formed the core of the Roll Back Malaria strategy, aimed at halving mortality from malaria in Africa by 2010 (WHO, 2005). Also, a number of very poor countries have shown what can be accomplished through campaigns to educate families on better health practices. Other encouraging results have come from small-scale projects around the world. In two districts in the United Republic of Tanzania, for instance, social marketing directed to shop owners and the public-health sector was used to promote the distribution and use of

insecticide-treated mosquito nets. As a result, the proportion of infants reported to have slept under a treated bed net rose from 10 per cent to 50 per cent in 3 years, leading to a 27 per cent reduction in mortality among children who used the nets (United Nations 2006).

Ghanaian government, in 1994 formulated a policy on exclusive breastfeeding so as to reduce under-five mortality rate in the country, a programme which was endorsed by the World Health Organizations demographic and health survey as a means to reduce under-five mortality in children by 13 per cent (Asamankese 2004).

Nigeria, has taken several steps so as to achieve the Millennium Development Goal 4 by formulating policies and developing different programmes for execution. The remarkable step taken was the signing of the national population policy in 2004 by the then President of the Federal Republic, this policy was in recognition of the 1994 International Conference on Population and Development (ICPD). Two interested items in the policy were to 'reduce infant and child mortality and improve the health and nutritional status of Nigerian children through expanded access to high-quality promotional, preventive and curative health care services' and 'achievement of sustained economic growth, poverty eradication, protection and preservation of the environment, and provision of quality social services.' Other programmes were developed to execute action plans. Such was the formation of National programme on Immunization (NPI) in 1999 and baby-friendly regimes in 2000. These two programmes were conceptualized by the UNICEF and WHO. The vaccination of children under-five years against five major causes of children's death. Also primary health care centers were refurbished and new ones constructed where there were none. Free insecticide treated nets (ITNs) are being distributed to children under-five and pregnant women to save them from malaria pandemic, free medical care for children under-five and pregnant women to avoid inaccessibility of adequate and prompt treatment. To implement programmes on, that is poverty alleviation and environmental sustainability, policies and programmes were initiated to execute them, such as the adoption of National Economic Empowerment Development Strategy (NEEDS) by all the tiers of government in the country which has as its goals to create wealth, generate employment and reduce poverty through entrepreneurship development or promotion, Government created National Directorate of Employment (NDE), National Agency for Poverty Eradication Programme (NAPEP), and Small and Medium Enterprises Development Agency of Nigeria (SMEDAN). In the case of the environment, monthly sanitation programme was introduced and 'Operation Make Nigeria Clean' was initiated by government. Projects like the provision of bore

holes was intensified, afforestation, decreasing carbon elements that deplete ozone layer and provision of affordable housing for the masses in suburbs of the major cities were adopted according to the global recommendations. Moreover, increasing the numbers of girl-child enrolment for primary education and promoting women education and empowerment were embraced.

However, the above efforts by the government of Nigeria are still inadequate to meet-up with the standard of goal 4. Going by the NDHS (2003), it was recorded that only 13 per cent of Nigerian children aged 12-23 months can be considered fully vaccinated, that is, have received BCG, measles, and three doses each of DPT and polio vaccine. This is said to be the lowest vaccination rate among African countries. Less than half of children have received each of the recommended vaccinations. There was disparity in the number of vaccinated children in the urban areas and that of the rural areas. In addition, only 6 per cent of children slept under ordinary mosquito net while just 1 per cent slept under insecticide treated net (ITN), (NDHS 2003). Meanwhile, problems still exist. Most Nigerians are still earning less than US$1 a day. Slums are still prominent in most major cities in the country, whereby children under-five are exposed to different kinds of diseases. If something drastic is not done about these, achieving MDG4 will become an illusion.

Remedies to Emergent Constraints in Achieving MDG 4

Families and communities need to be empowered to obtain basic health care services, to have knowledge about sound child care and nutrition practices, and to have access to knowledge and services to prevent, detect, and treat common childhood diseases, and refer severely ill children to the nearest health facility.

The world has the means and know-how to prevent child deaths and improve child survival, growth and development. This can be attained by scaling up the implementation of low cost but effective interventions such as immunization, use of common antibiotics to treat pneumonia, use of the new oral dehydration solution and zinc supplementation to treat diarrhea, prevention and early treatment of HIV/AIDS, treatment and prevention of malaria using insecticide-treated nets (ITNs) have been shown to reduce mortality among children under-five years by approximately 20%. This translates to the prevention of almost 0.5 million deaths each year in Africa south of the Sahara. ITNs also protect against the development of anaemia in both pregnant women and

young children, the groups at highest risk from malaria and malarial anaemia. Giving micronutrient supplementation such as Vitamin A, promotion of exclusive breastfeeding and appropriate young child feeding practices, and provision of clean water and improved sanitation.

The remedies above can not come to reality and be sustained if the subsequent challenges are not met by each national government in order to achieving the MDG goal 4 on the reduction of under-five mortality. Thus, the following are the recommendations:

- Poverty reduction among the less developed and developing countries should be speedily addressed; women are to be empowered economically, socially and politically and improving of their health status should given serious attention.
- Also, resource mobilization to ensure adequate resources for health care should be canvassed for while sustained political commitment to implement enabling policies and translate knowledge into action should be the priority of the African leaders.
- National health systems and capacity building at all levels of health care should be strengthened in order to improve quality of care services rendering to the populace especially the infant and children.
- Disparities in the provision of health services should be removed while equal health services should be encouraged by all tiers of government.
- Adequate implementation and support for scaling up of cost effective interventions to all children in sub-Saharan Africa according to the declarations in different children-based conferences are highly demanded.
- Proper machinery for monitoring and evaluation to appraise coverage and extent of implementation of child's health policies should be strategically put in place

Conclusion

Among the life-saving interventions are breastfeeding, oral rehydration therapy, use of insecticide-treated mosquito nets to prevent malaria, use of complementary foods, use of antibiotics for the treatment of antenatal sepsis and for childhood pneumonias, and prevention of zinc deficiency. Levels of coverage for these interventions are still unacceptably low in most low-income and middle-income countries. Worse still, coverage for some interventions, such as

immunizations and attended delivery, are stagnant or even falling in several of the poorest countries. Comprehensive immunization against measles could have saved the lives of 2.3 million African children in the last decade, according to WHO and UNICEF estimates. Indeed, countries that have adopted well-known strategies, including Botswana, Malawi, Namibia and South Africa, have nearly eliminated measles since 2000. Diarrhea disease kills almost 2 million children in developing countries each year, but it is well understood that protected drinking-water; basic hygiene in the home and inexpensive oral rehydration solutions could reduce these numbers to a fraction of their present rates. Acute respiratory infections are another big killer, yet they too can be effectively treated with antibiotics. Breastfeeding all babies would save an additional 1.5 million lives each year, according to UNICEF. Improving the nutrition of mothers and basic health services, such as antenatal care and the availability of skilled birth attendants, would reduce infant deaths in the first week of life, which, in 2000, represented more than 20 per cent of under-five mortality. Increasing the ability of the poor to access health services to the same degree as the wealthier segments of society can provide major impetus toward achieving the MDG for child survival. In fact, if the under-five mortality rate in developing countries could be reduced to the under-five mortality rate for the richest 20 per cent of the population of those countries, the overall under-five mortality rate could be reduced by as much as 40 per cent.

Finally, sustaining progress for children survival, then, is an essential element in sustaining global momentum towards a better and more just world for all (United Nations 1997).

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