Goal 4 Reduce Child Mortality

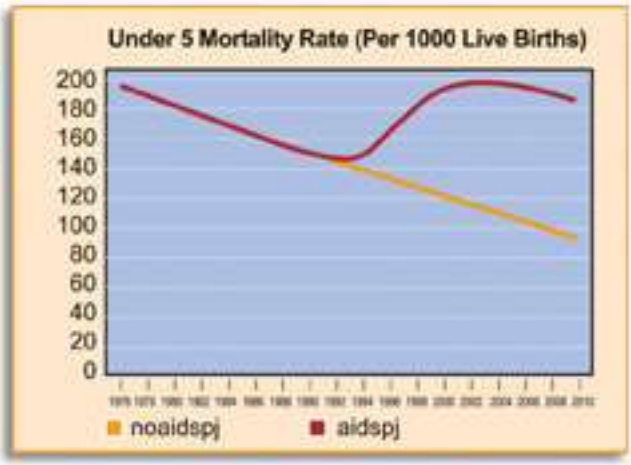
Target: Reduce under-five mortality by two thirds by 2015
Indicator: Under-five mortality rate

STATUS AT A GLANCE

Will the Goal/Target be Met	State of Supportive Environment
Potentially **Unlikely** Insufficient Data	Strong Fair **Weak but improving** Weak

Tracking Under-five Mortality Levels: Monitoring and Evaluation Environment

Elements of monitoring environment	Assessment		
Data gathering capacities	Strong	**Fair**	Weak
Quality of recent survey information	Strong	**Fair**	Weak
Statistical tracking capacities	Strong	Fair	**Weak**
Statistical analysis capacities	Strong	**Fair**	Weak
Capacity to incorporate statistical analysis into policy, planning and resource allocation mechanism	Strong	Fair	**Weak**
Monitoring and evaluation mechanisms	Strong	Fair	**Weak**



Source: World Bank and Staneck Projections.

Infant Mortality Rate per 100 000 Live Births	
1976	156
1986	99
1991	72
1997	78
2000	87

Source: CSO, report, 2000

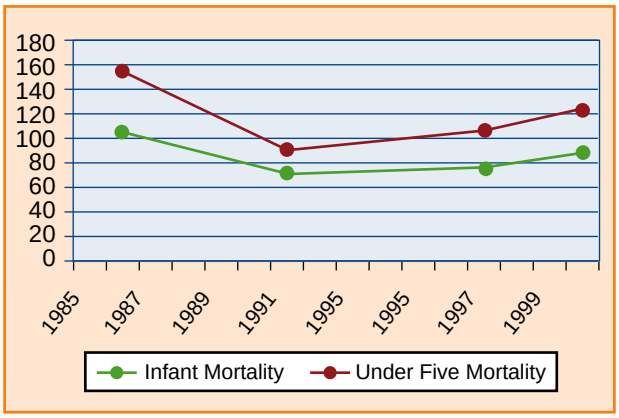
Status and Trends

In 1990 at the World Summit for Children, the government of Swaziland committed to a Declaration and Plan of Action to benefit Children. An initiative was then implemented in which the country committed to: reduce the infant and under-five mortality rate by one third between 1990 and 2000; reduce severe and moderate forms of malnutrition on children less than 5 years of age, provide universal access to safe drinking water and sanitary means of excreta disposal. By the year 2000, these goals had not been attained.

Under five mortality increased from 89 per 1000 in 1991 to 106 per 1000 in 1997 and to 122 per 1000 in 2000 (MICS, 2000). Infant mortality rate also rose from 72 per 1000 in 1991 to 78 per 1000 in 1997, rising from 87.7 per 1000 in 2000 (MICS, 2000). Underweight prevalence is 10 percent, among which the stunting prevalence is 30 percent. Access to safe drinking water is an estimated 51 percent. Sanitation is 72 percent. Birth weight below 2.5 kg is 5 percent while the exclusive breast-feeding rate is an estimated 31.2 percent (MICS, 2000). Diphtheria, pertussis and tetanus immuniza-

tion coverage is 77.2 percent. Measles immunization coverage by age 1 is 72.3 percent (CSO, Multiple Indicator Cluster Survey, 2000).

Chart 4 Infant and Under 5 Mortality



The increase in child mortality in the last decade is mainly accounted for by increased mother-to-child HIV infections, and the continued prevalence of water-borne and other infectious childhood diseases.

Major Challenges

- The advent of HIV/AIDS and its high prevalence accounts for a significant proportion of the increase in infant and child mortality. Childhood diseases such as diarrhea, water-borne disease, malnutrition and other infections also contribute to high child mortality.
- Inadequate skills to deal with major causes of morbidity and mortality among infants.
- The need to promote universal access to reproductive health care to prevent unwanted pregnancies.
- The lack of safe water and sanitation for the rural majority .

Supportive Environment

- Swaziland adopted the IMCI strategy in 1999 as a means to increase the capacity for the management of the major killer diseases in children, i.e. ARIs, diarrhea, measles, malaria, and malnutrition.
- A policy guide on the prevention of mother-to-child transmission of HIV/AIDS has been developed.

Priorities For Development Assistance

- Human resource capacities are critical; the country has few pediatricians and very few people properly trained on the IMCI strategy.
- Support is needed towards the scaling up of safe water and proper sanitation in the rural areas where there is a high prevalence of water borne diseases relating to poor sanitations.
- Support for nutrition and food security for mothers and children, particularly OVCs.
- Support for sustained immunization programmes.
- Support for the prevention of mother to child HIV/AIDS transmission.
- General support for OVCs.