

The Next Revolution: Giving every child the chance to survive

Executive Summary

Nearly 9 million children die every year before the age of five¹ – that is almost one child every three seconds. Just under 4 million of these children die within their first month, during the so-called newborn period. Almost 3 million babies die within one week of birth, including up to 2 million who die on the first day of their lives. Nearly all – 97% – of these children die in low- or middle-income countries, and disproportionately from the poorest and most marginalised communities within those countries.¹ In Afghanistan, one child in five will die before their fifth birthday;ⁱⁱ across the whole of sub-Saharan Africa, the figure is one in seven.ⁱⁱⁱ

Thirty years ago, Jim Grant, the then head of UNICEF, spearheaded a surge of global action to save millions of children's lives. Faced with the fact that many children were dying from conditions that could easily be prevented, he mounted a campaign to raise widespread awareness, money and political support for change. His efforts, and those of many others, became known as the 'child survival and development revolution'.

Now, as we enter the second decade of a new century, we can count the successes of that revolution. Millions of children have survived who would otherwise not be here today thanks to that extraordinary effort. Many of them have gone to school and grown up healthy and ready to make their own contribution to their communities. There are doctors, teachers, nurses, and small businessmen and women who are changing the world around them – because a generation knew enough to care, and cared enough to act.

Every child – no matter where or to whom they are born – has an equal right and deserves an equal chance to survive. And every one of us has a responsibility to act. It is time for the second revolution in newborn and child survival.

There is wide agreement about the actions needed to massively reduce levels of newborn and child mortality. The scandal is that governments and others with influence have failed so far to provide the leadership, resources and sense of urgency to make it happen. In the year 2000, world leaders committed themselves to Millennium Development Goal (MDG) 4, calling for a reduction by two-thirds, between 1990 and 2015, in the under-five mortality rate.

This report is published to coincide with the launch of our global campaign on newborn and child survival. Our objective for this campaign is clear: to help get the world on track to achieve MDG 4 by bringing about a substantial reduction in the preventable deaths of young children. While children are our primary focus, the health, nutritional status and broader wellbeing of a young child is linked inextricably with that of his or her mother. Therefore, the campaign will include

¹ See D You, T Wardlow, P Salama and G Jones, 'Levels and trends in under-5 mortality, 1990–2008', *The Lancet*, published online 10 September 2009. DOI:10.1016/S0140-6736(09)61601-9

efforts to address the health and wellbeing of mothers and to accelerate progress towards MDG 5 – a three-quarters reduction in maternal mortality by 2015.

High levels of child mortality can be explained at three levels.

1. There are a small number of diseases and conditions that directly cause more than 90% of deaths in under-fives. These are pneumonia, measles, diarrhoea, malaria, HIV and AIDS, and neonatal conditions that occur during pregnancy and during or immediately after birth. The latter conditions are particularly significant in respect of newborn deaths. Severe infections, asphyxia and premature births cause 86% of newborn deaths.^{iv} In nearly all cases, the diseases and conditions that are the direct causes of child death are preventable and treatable with proven interventions. But these interventions remain unavailable or inaccessible to many of the world's poorest children.

2. There are a series of intermediate factors that make some children more likely to fall prey to these diseases or medical conditions, and limit their chances of recovering from them. These factors include: the absence of essential healthcare or the inability of many mothers and their children to access it; high levels of maternal and child undernutrition and poor feeding practices; lack of access to clean water and safe sanitation; lack of maternal education; and limited access to contraception.

3. The deaths of children are not random events beyond our control. To a considerable extent, they are the outcome of policy and political choices taken by governments. They are also influenced by cultural, economic, environmental, political and social factors that governments, international institutions, the private sector and civil society could help to shape or mitigate. These are the underlying causes of newborn and child mortality.

Of these factors, poverty, inequality and discrimination are particularly important. Women and girls face pervasive discrimination in many countries – their rights and opportunities denied. This is why a commitment to equity and justice – reducing disparities, realising rights and empowering the poorest and most marginalised women – is absolutely critical for reducing child mortality rates.

Poor governance, violent conflict and worsening environmental trends like climate change are additional underlying factors that impact on the survival prospects of children. Eight of the ten countries with the worst rates of child mortality have recently experienced conflict, violence or political instability,^v and climate change is already increasing the frequency of disasters that kill poor children.^{vi}

Children's chances of survival are also influenced by global economic conditions. The World Bank estimates that child deaths could be 200,000 to 400,000 per year higher between 2009 and 2015 as a result of the financial and economic crisis.^{vii} And new global health pandemics, like the H1N1 virus (swine flu) could spread further and faster, or mutate into a more virulent form, overwhelming already fragile health systems and increasing levels of newborn and child mortality.

So what should be done?

Save the Children believes there should be a real drive to expand the coverage of proven interventions that reduce maternal, newborn and child mortality. These include: skilled personnel available to support mothers during birth; early postnatal care; preventive and curative treatment for pneumonia, diarrhoea and malaria; and support for nutrition, including breastfeeding, complementary feeding, cash transfers and wider social protection programmes. These interventions should be delivered through stronger systems, so that the poorest and most marginalised families can get the healthcare, nutrition and other services they need. Action should be matched by policies that address the underlying causes of child mortality. Policies to reduce newborn and child mortality must be flexible as they will need to be applied in fragile and conflict-affected states as well as in chronic emergencies and rapid fast-onset disaster situations.

Given the difficult economic and environmental conditions the world faces, it would be easy to be pessimistic about the prospects of achieving MDG 4. Yet we know that a really dramatic reduction in the number of child deaths is achievable. Why? Because all developed countries have already achieved huge reductions in child mortality in the course of the 20th century. In 1900, the infant mortality rate in the UK was 140 per 1,000 live births,^{viii} and in the USA, 100.^{ix} These rates are worse than in Liberia today (93 per 1,000).^x More importantly, we know it because many low- and middle-income countries have cut mortality significantly over the last few decades, and many have done so more rapidly than today's developed economies managed in the last century.^{xi} Although further progress is needed, since 1990 more than 60 countries have reduced their child mortality rate by 50%.^{xii} We do not need a major technological breakthrough to crack this problem. But we do need to:

- push the health and nutrition of mothers and young children higher up national and international agendas, building greater awareness and understanding of how widespread death and illness remains in many poor countries, and channelling anger and outrage into decisive action
- expose the false assumptions that still cloud the debate about child mortality in poor countries, creating a pretext in some quarters for inaction and cynicism
- champion what some communities and countries have achieved, the policy responses and interventions that have been shown to work, and to demonstrate how this success can be replicated elsewhere
- highlight what the world loses from high levels of child mortality and what we would all gain from saving children's lives.

Getting on the radar screen

Unlike other diseases like HIV and AIDS, or new issues like climate change, newborn and child mortality in poor countries lacks a significant public and political constituency. Our efforts and that of like-minded organisations need to find innovative ways of connecting with the public, so that this issue becomes more tangible and important to them and they begin to hold their politicians accountable for delivering on it. Save the Children's campaign is designed to do precisely this.

Debunking the myths

Many people are cynical about the possibility of doing anything about child mortality. Some believe that it would cost too much; others that reducing child mortality would further accelerate population growth on an already overcrowded planet. Many believe that attempts to improve children's health and nutrition will inevitably be thwarted by corruption and misgovernment in the poorest countries, and that there is little benefit in keeping children alive if the future ahead of them is one of desperate poverty.^{xiii}

These claims are all false. Many poor countries have cut their child mortality rates. The costs of achieving MDG 4 are small in global terms. Reductions in child mortality rates correlate with falling rates of fertility and serve to slow and stabilise population growth. While corruption and poor governance are important issues, they have not proved an insurmountable barrier to reducing child mortality in many countries. And while keeping children alive is not the end of the story – and should be complemented by policies to help them grow up healthy, well-educated, properly nourished and safe – improvements in child survival will lead to wealthier, more productive societies.

Learning from success

Several countries, including Bangladesh, Brazil, Egypt, Indonesia, China, Mexico, Nepal and the Philippines, are on track to achieve MDG4,^{xiv} and there are concrete lessons to be learned from their experience. Some of these countries have achieved cuts in mortality rates despite problems of weak or corrupt governance and in the context of deep poverty.

Sharing the benefits

We are all diminished – economically as well as morally – when children die. The influential Commission on Macroeconomics and Health estimated the global impact of maternal and newborn deaths at US\$15 billion a year in lost productivity.^{xv} It has also been estimated that 30 to 50% of Asia's economic growth between 1965 and 1990 is attributable to demographic and health improvements, including reductions in infant and child mortality, better access to reproductive health services and reductions in fertility rates.^{xvi} More recent research evidence shows that improvements in human development correlate with higher levels of economic growth, with a 5 percentage point in child mortality rates associated with a one percentage point increase in economic growth over the subsequent decade.^{xvii} At a time when governments are looking to revive their economies, there is a sound business case for investing in children's early years.

A call to action

The target date for the achieving the Millennium Development Goals, including MDGs 4 and 5, is 2015. On current trends, these targets will not be met. This coming year, 2010, is therefore an absolutely critical one for getting the world on track for meeting its promises to the world's poorest children and their mothers. This report suggests how this can be done, and why it must be done.

Save the Children, working in close cooperation with others, and using fresh evidence and new arguments, is determined to end the gross injustice of high levels of maternal, newborn and child mortality, and to champion political, policy and programme responses that will help the world achieve MDGs 4 and 5. We need nothing less than a new 'child survival revolution', that completes the job started by Jim Grant and UNICEF in the 1980s, and helps deliver massive reductions in child mortality. Our aim is that national governments and donors should become much more accountable for their performance in reducing maternal, newborn and child mortality, particularly for the poorest. This will require stronger civil society organisations – internationally, nationally and locally – that are focused on this issue, pressing and persuading governments and others to take the necessary action.

Recommendations

Make maternal, newborn and child survival the key metric in measuring success in development

Rates of mortality among the poorest communities are a much more telling indicator of development progress (or the lack of it) than per capita income. Countries should be encouraged to measure and report progress against newborn and child mortality, broken down by wealth quintile and social group, and national governments and donors should be held to account by civil society for delivering improved outcomes.

We are also making a series of concrete policy calls to donors, developing countries, international organisations and others – a seven point plan – to help save the lives of children and their mothers.

Save the Children's seven-point plan

1. Implement credible national plans. Developing countries need to implement national plans for reducing maternal, newborn and child mortality. Some of these plans exist on paper but are not being implemented effectively. In other cases, plans will need to be developed or significantly strengthened. National plans should be fully costed and set out clear benchmarks against which progress can be judged. The plans should focus on achieving universal coverage of proven interventions for reducing mortality, alongside action to strengthen systems and delivery mechanisms. Donors and international institutions should help countries to develop and implement these plans, and they should pledge that no country with a credible plan in place, and a clear commitment to implement it, should fail through lack of resources. Donors should fast-track resources to these countries.

2. Focus on newborn babies. Interventions are needed that enhance the health, nutrition and wellbeing of women and support mothers and children during and immediately after birth (the most vulnerable period for the child and the mother). Support is best provided through a 'continuum of care' – across the lifecycle, from women of reproductive age through birth to early childhood; and from care in the home through to hospitals and other health facilities.

3. Prioritise equity. This should include targets for reducing the gaps in coverage of maternal, newborn and child health, nutrition and related interventions, as well as mortality rates between rich and poor. This requires the removal of financial and non-financial barriers to care (like user

fees or informal payments) and tackling the underlying causes of high mortality, such as inequality, discrimination and the violation of rights.

4. Mobilise additional resources. It has been estimated that to reach the agreed goals on maternal and child mortality in the world's poorest countries, donors, national governments and others must more than double current annual spending on health and related interventions, from an estimated US\$31 billion in 2008 to US\$67–76 billion in 2015. This additional amount will need to come from various sources. Given the scale of the need and the urgency of a rapid increase in resources, we recommend that at least half of the additional US\$36-45 billion comes from donors, with these resources used for interventions that reduce maternal, newborn and child mortality.

5. Train and deploy more health workers. Part of the additional investment needed to reach MDGs 4 and 5 should be allocated to recruit, train, equip and deploy more health workers. Targets should be set for expanding the number of trained and properly equipped health workers in each country, particularly to meet the needs of the poorest and most marginalised communities.

6. Tackle undernutrition. Nutrition should be a much higher priority and support should be provided to proven interventions, including micronutrient supplements, exclusive breastfeeding, complementary feeding, and food fortification, as well as cash transfers and social protection programmes. Developing countries and donors should report on their performance against the internationally-agreed nutrition indicator (part of MDG 1), which many fail to do at present.

7. Increase focus on children in emergencies. Where developing countries are not able to cope with emergencies themselves, donors and others should provide lifesaving assistance for children and their families in emergency, fragile and conflict situations. They should help poor countries reduce the risks and costs of conflict and disasters by developing more resilient systems and through disaster risk reduction programmes.

Endnotes

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- ⁱⁱ *ibid*: page 118
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- ^{iv} UNICEF(2008) *op cit*: page 13
- ^v UNICEF (2008); Uppsala Conflict Database and Crisis Group, Uppsala Universitet . Accessed 3 August 2009 at www.pcr.uu.se/database.index.php
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