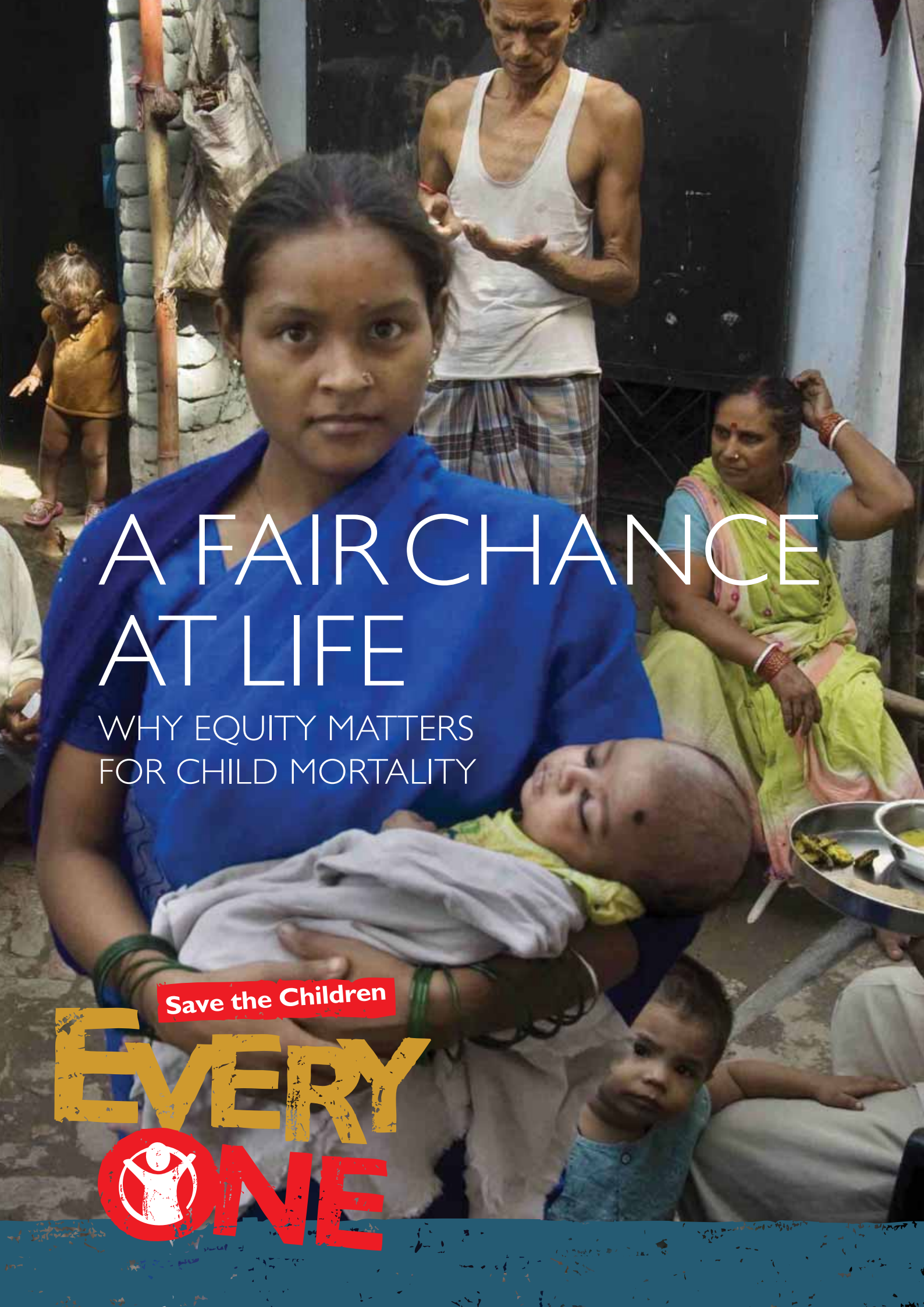

A FAIR CHANCE AT LIFE

WHY EQUITY MATTERS FOR CHILD MORTALITY

Save the Children

EVERY ONE

A FAIR CHANCE AT LIFE

WHY EQUITY MATTERS FOR CHILD MORTALITY

A SAVE THE CHILDREN REPORT
FOR THE 2010 SUMMIT ON THE
MILLENNIUM DEVELOPMENT GOALS

Save the Children is the world's leading independent children's rights organisation, with members in 29 countries and operational programmes in more than 120. We fight for children's rights and deliver lasting improvements to children's lives worldwide.

Published by
Save the Children
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London EC1M 4AR
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savethechildren.org.uk

First published 2010

Registered Charity No. 1076822

Cover photo: Sarita successfully gave birth to her first child in Delhi, India, after losing a baby in a miscarriage. Save the Children is working to ensure that the Government of India invests more to recruit, train, equip and deploy health workers to meet the needs of India's poorest and most marginalised communities. (Photo: Raghu Rai/Magnum for Save the Children)

Typeset by Grasshopper Design Company
Printed by Park Communications

CONTENTS

FOREWORD

This new report from Save the Children, *A Fair Chance at Life*, draws attention to one of the most pressing development challenges of our age – the toll of preventable child deaths in the world's poorest countries, which in 2008 claimed nearly 9 million lives. This is a scandalous waste of human potential, and a cause of enormous suffering to the families and communities that are affected.

Progress towards the fourth Millennium Development Goal (MDG) – a two-thirds reduction in child mortality by 2015 – is also one of the best measures of wider social and economic development. The fact we are collectively off track to meet this goal should therefore be an urgent concern. The forthcoming UN summit in New York to review the eight MDGs is the last major opportunity before the target date to reach international agreement on actions to accelerate progress.

The report shows that an intensified effort to reduce child mortality can succeed only if equity is put front and centre. Ensuring that every child has a fair chance at life is a moral imperative. But there is also – as Save the Children's research demonstrates – a compelling instrumental case for prioritising equitable progress in order to achieve MDG 4. The challenge – and opportunity – is to draw on the policy lessons of poor countries that have succeeded in reducing child mortality for all sections of their societies.

Since they were adopted in 2000, the Millennium Development Goals have been a powerful spur to national and international efforts to improve the lives of millions of people. Despite the slow and uneven progress, many more children are reaching their fifth birthday than was the case a decade ago. These gains have been driven in part by civil society organisations like Save the Children, who have played an invaluable role in holding governments to account for the pledges enshrined in the MDGs.

As we approach the target date of 2015, it's essential that governments and international institutions, working with civil society, redouble their commitment to achieving MDG 4. The test of success will not simply be whether it is met as an aggregate global target. The real measure of progress will be the extent to which we achieve lasting change in children's lives within every country and community, regardless of their status. This is the vision that should be animating world leaders as they gather in New York, and underpinning policy choices over the coming five years.

Lord Mark Malloch-Brown
Former Administrator of the United Nations Development Programme (1999–2005)

ACKNOWLEDGEMENTS

This report was researched and written by Alison Holder, with Maricar Garde and Jessica Espey, in Save the Children's Development Policy team. It was edited by Patrick Watt, Frances Ellery and Kitty Arie.

The report received the support and input of a large number of colleagues and partners. Particular acknowledgements are due to Eitan Felner and Fernando Bazán Torres, Saiffudin Ahmed, Dan Seymour, Jan Vandemoortele, Kevin Watkins, Nicola Jones, Marek Tuszynski and the team at Tactical Tech.

Thank you to Save the Children colleagues who provided comments on the report including David Mepham, Nadja Dolata, Delphine Valette, George Graham, Maria Pizzini, Amelia B Kyazze, Lydia Baker, Eliot Whittington, Kerry Smith, Jennifer Grant, Nicola Hypher, Lara Brearley, Nouria Brikci, Simon Wright, Louise Fulford, Anna Ford and colleagues in the UK media team, Sue Rooks, Gorel Bogarde, Michael Klosson, Ryan Quinn, Anne Tinker, David Oot, Ben Hewitt, Shireen Miller, Munir Ahmed and Sanna Johnson.

EXECUTIVE SUMMARY

The number of children who die before their fifth birthday is one of the best barometers of global social and economic progress. In 2000, the world's governments committed themselves to make a two-thirds reduction in the child mortality rate by 2015 – the fourth of eight United Nations Millennium Development Goals (MDGs). But with five years to go before the target date, the world is collectively off track to reach MDG 4. Just 40% of the necessary progress has been achieved so far, and in three-quarters of countries the goal will be missed on current trends.

Yet past performance need not dictate future progress. When world leaders gather this September in New York to take stock of the MDGs, they have a make or break opportunity to agree the steps needed to accelerate reductions in child mortality, and achieve MDG 4 by 2015. A Global Strategy for Women's and Children's Health, led by the UN Secretary-General, is being tabled at the September summit. This plan represents the last best chance to make a decisive dent by 2015 in the annual toll of nearly 9 million preventable child deaths.

However, this plan will succeed only if it places equity at the heart of national and global efforts to tackle child mortality. Children do not die randomly: 99% of child deaths take place in developing countries, and within these countries children from the poorest backgrounds are least likely to survive. Yet the MDGs are currently blind to issues of equity: like most of the other eight goals, MDG 4 is an aggregate target and says nothing about which children die, where, and from which causes. Some argue that the MDGs in their current form encourage a focus on 'low hanging fruit' – interventions that target the better-off in society – which in turn sharpen inequalities and prolong injustice.

Yet achieving MDG 4 while leaving the poorest children behind violates the spirit, if not the letter, of the goal. It is also an ineffective long-term strategy for reducing child mortality. Research by Save the Children shows that prioritising the poor is one of the surest ways to make progress towards MDG 4: many of the countries that are most successfully reducing child mortality are doing so equitably, with progress concentrated among the poorest and most disadvantaged sections of their populations. Conversely, those countries making slow progress or no progress towards MDG 4 tend to be characterised by extreme disparities in life chances between children from the poorest and richest backgrounds.

Crucially, equitable reductions in child mortality have often happened in very poor countries – for example, Ghana, Mozambique and Bolivia – and during periods of relatively low economic growth. This underscores the central role of policy choices. Successful countries have tended to base policy and budget allocations on a clear-eyed analysis of the direct and indirect causes of child mortality, and have sought to identify structural barriers – from income to discrimination against girls and women – that prevent the poorest households from getting access to healthcare, an adequate diet and other key determinants of child survival.

At a global level, the benefits of such an approach are potentially enormous. If the 42 developing countries that account for over 90% of child deaths all took an egalitarian approach to cutting under-five mortality, and made progress across all income groups at the same rate as for the fastest-improving income group, an additional 4 million child deaths could be averted over a ten-year period.

Individual countries must vary their approach to reducing under-five mortality, depending on the distribution of child deaths. In most cases, making equitable progress is not simply a matter of targeting disadvantaged groups. In the countries that are off track towards achieving MDG 4, child mortality is usually high not just among the poorest fifth of the population, but across the poorest 60–80%. In these contexts, governments must adopt an explicit goal of **universal access** to a minimum package of good-quality essential services.

A commitment to equitable access to healthcare needs to be coupled with an effort to **reduce inequities in the indirect causes** of under-five mortality, including nutrition – which by itself contributes to more than a third of child deaths – and water and sanitation. Across all areas of policy, a commitment to equity means little unless it is reflected in a **more equitable allocation of public spending**. Experience shows that public spending is more likely to be equitable where there is **transparent and accountable government**, which helps to generate popular demand for action on child mortality and to ensure that commitments are met.

In sum, Save the Children is calling on the international community to use the forthcoming MDG summit to bring about a revolution in efforts to cut child mortality. The UN Global Strategy for Women's and Children's Health must put equity front and centre in the following three ways:

- **Localise MDG 4** – governments, donors and international institutions must commit to achieving a two-thirds reduction in child mortality for all income groups and in every community, and take the necessary policy and budgetary steps to achieve this objective.
- **Monitor progress against equity objectives** – governments, donors and international institutions must start to gather and report routinely on progress towards MDG 4, disaggregated by wealth, gender and other locally relevant sources of inequity. Donor countries will need to provide both capacity building and funding to enable governments to strengthen their data in this way.
- **Foster demand for action on equity** – the UN institutions, working with civil society, can actively support popular demand for more equitable progress towards the goals, and ensure that the needs and priorities of the poorest and most vulnerable children are emphasised in policy decisions.

INTRODUCTION

In September 2010, world leaders meet in New York for the UN Summit on the Millennium Development Goals (MDGs). Contained in these eight goals are the aspirations for a more equitable and just world – aspirations that political leaders committed to fulfil when they signed the Millennium Declaration in the year 2000.

Important progress has been made against many of the goals, but much more needs to be done. A decade on, and five years from the deadline, 2010 is a decisive year. At the Summit, the goals could be jeopardised by inaction, and the fight against poverty derailed for a generation. Alternatively, world leaders can seize the opportunity to rescue the goals from failure, with lasting benefits for millions of the world's poorest children.

Save the Children believes that 2010 must mark a radical shift in effort. We are particularly concerned that the fourth goal – a two-thirds reduction in child mortality by 2015 (MDG 4) – remains off track. The child mortality rate at a global level has fallen by just 28% since the MDG baseline year of 1990,[1] far short of the 67% reduction required to meet the goal. And the closely related goal of reducing maternal mortality by three-quarters (MDG 5) is deemed to be the most off track of all the MDGs.[2]

Although the trend in child mortality rates is moving in the right direction for most countries, nearly three-quarters of the countries with the highest child mortality burden will not reach the goal on current trends.[3] Moreover, progress at the global level masks significant disparities between and within countries and regions.

This is because the MDGs – despite the principles of equality and solidarity that were the foundation of the Millennium Declaration, and on which the goals were based – neglect issues of equity. Perversely, progress towards MDG 4 could be achieved in some cases by improving health services for higher income groups, leaving the poorest and most in need of care no better or even worse off.[4]

INEQUITY AND CHILD MORTALITY

To better understand the disparities that lie behind the headline figures on child mortality and the role that inequity plays in hampering progress towards MDG 4, Save the Children undertook research to unpack the statistics on child mortality in the 32 countries for which data was available.[5]

As this report will show, there are significant disparities in child mortality between and within countries. Child deaths do not, on the whole, strike randomly. Ninety-nine per cent happen in the developing world, and within every society children in the poorest households are significantly more likely to die before their fifth birthday.[6] Behind each avoidable child death is a complex story of disadvantage, exclusion and discrimination.

Many people assume that the differing child survival rates between and within countries are purely related to the wealth of a country, and are somehow inevitable. But, as our analysis shows, countries have very different records of translating wealth into survival prospects for children. Countries with comparable levels of per capita

income show considerable variation in child mortality rates. There is also no visible pattern between per capita income growth and the rate of reduction in child mortality rates.

Not only are poor children more likely to die than rich children, in most countries the gap is widening. Our analysis shows that less than 30% of countries are making equitable progress towards MDG 4. This means that in many countries – even some of those most successful in reducing the overall numbers of children dying – the reductions are being made more swiftly among the rich than the poor.

Taking an equitable approach to improving child survival matters in and of itself; the principles of equity and freedom from discrimination underpin all children's rights, including the right to survival. But our analysis shows that addressing inequity can also accelerate overall progress towards MDG 4: the deaths of 4 million children could have been prevented (across 42 countries over a ten-year period) if countries had made more equitable reductions in child mortality.

Our analysis also shows that it is possible for countries to make equitable progress in reducing child mortality. From studying seven countries that we identified as making both significant and equitable progress in reducing child mortality – Ghana, Mozambique, Niger, Egypt, Indonesia, Bolivia and Zambia – we have developed four broad policy lessons about how countries can equitably improve child survival.

Without the political will to prioritise the health and wellbeing of *every* mother and child at the Summit on the Millennium Development Goals, the lives of millions more children will continue to be at risk.

THE GLOBAL COMMITMENT TO CUT CHILD DEATHS

The UN Millennium Declaration, ratified by world leaders in 2000, was designed to improve the wellbeing of millions of people by 2015.

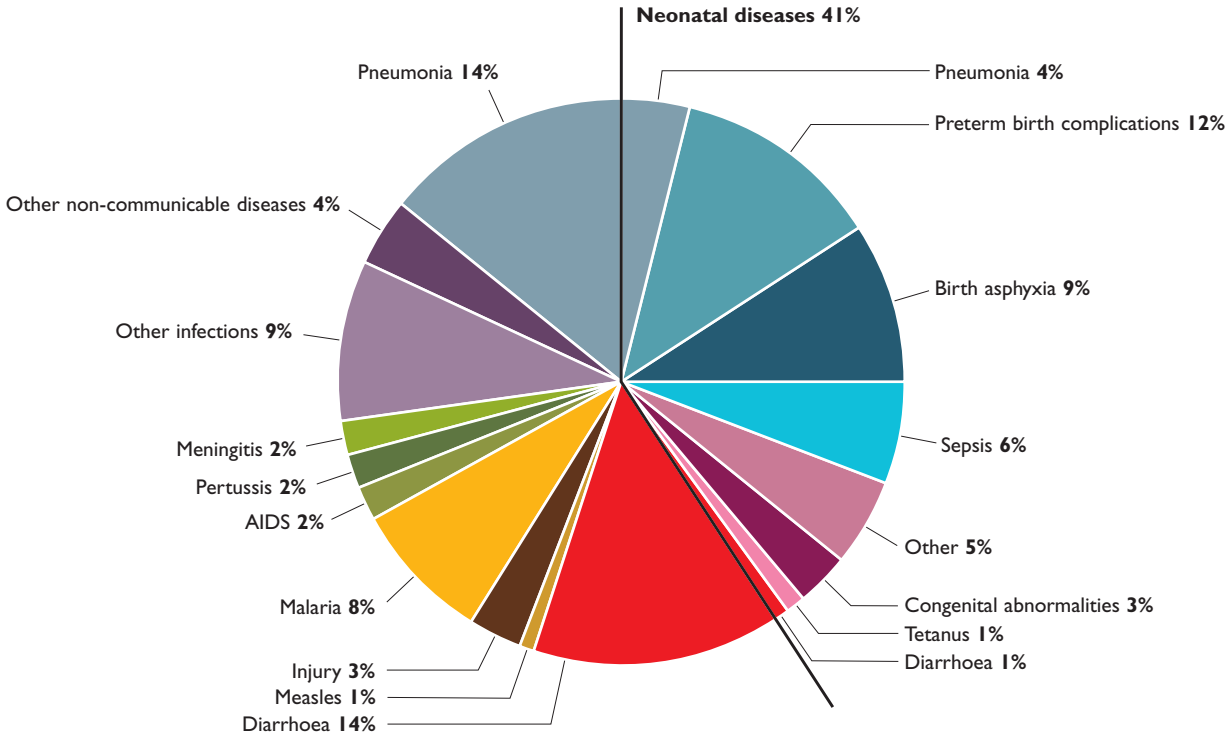
Ten years on, and with five years to go before the 2015 deadline, what progress has been made against the fourth Millennium Development Goal – to reduce child mortality by two-thirds by 2015?

MDG 4: THE STORY SO FAR

Although the child mortality rate at a global level has fallen, progress has been far too slow. On the positive side, of the 68 'Countdown to 2015' countries (which together account for 97% of maternal and child deaths worldwide), 60 have reduced child mortality since 1990.[7] And a recent study found that the rate of reduction has accelerated since 2000, compared with the period from 1990 to 2000.[8]

However, the rate of reduction – 28% since the baseline year of 1990[9] – is well below the 67% reduction required to meet the goal. This failure can be measured in the millions of children's lives lost, largely to preventable causes (see Figure 1).

Figure 1: Causes of child deaths



Source: R E Black et al (2010) 'Global, regional, and national causes of child mortality in 2008: a systematic analysis', *The Lancet*, Vol. 375, No. 9730, pp 1969–1987

Nearly three-quarters of the countries with the highest child mortality burden will not reach MDG 4.[10] Of the 68 'Countdown to 2015' priority countries, only 19 are on-track to reach MDG 4. Eleven more are making faster-than-average progress,[11] but still not enough progress to achieve MDG 4 by 2015. This leaves 33 countries that are making slow or no progress, and a further five countries – Chad, Congo, Kenya, South Africa and Zimbabwe – that have actually seen increases in their child mortality rates since 1990.

The challenge of meeting MDG 4 is greatest in sub-Saharan Africa, where close to one child in seven still dies before their fifth birthday.[12] Although the mortality rate in sub-Saharan Africa has fallen, high fertility levels mean that the absolute number of child deaths in the region has increased since 1990, from 4.2 to 4.6 million.[13] Yet even some very poor African countries, with limited state capacity and high mortality rates, have managed to make significant and equitable progress in reducing under-five deaths.

Equity and child survival within countries

Because the MDGs were conceived as global targets, they are measured in global figures. Yet this obscures differences between countries and inequities within them.

Closer examination of the statistics on child mortality rates in several countries shows that, where progress is being made, it is often being concentrated among the better-off. The poorest groups are often left as badly or even worse off (see Chapter 2).

The neglect of equity in the MDGs matters both because children have a right to health, and because in the long run it will stymie gains in child survival. The New York summit is the final high-level political opportunity before 2015 to agree on a global action plan to achieve MDG 4. No such plan can succeed unless it places equitable progress at the heart of its agenda.

REASONS TO PRIORITISE CHILD SURVIVAL

The fact that millions of young children continue to die of largely preventable causes is reason enough for the international community to prioritise MDG 4. But there are at least four more reasons why child survival should be the focus of global efforts in the run up to the 2015 MDG deadline.

Survival is every child's right

States have a binding obligation, enshrined in international law, to respect, protect and realise every child's right to survival. All of the world's governments (except the USA) have ratified, accepted, or acceded to the UN Convention on the Rights of the Child (CRC), which includes clear rights to life, health and nutrition.[14] Indeed, given its centrality to human rights agreements, child mortality has been described as an indicator of social justice. We know that the majority of the 8.8 million children who die each year would survive in a world in which resources and benefits were distributed more equitably.[15]

High child mortality and under-nutrition block wider development

High child mortality, illness and malnutrition can be a brake on economic and social development. Children who are sick and undernourished, especially in the first two years of life, often pay a life-long and irreversible price in terms of physical stunting and reduced cognitive ability.[16] The direct, indirect, and opportunity costs for households and societies of illness and death are also heavy, and can reinforce a vicious cycle of poverty and vulnerability.

Child mortality is a barometer of a country's wellbeing

Child mortality has been described as the best barometer of social and economic progress, not only because the health of a country's children determines the future prospects of that society, but also because child mortality is a snapshot indicator for development.[17]

New pressures on child survival and health

The context in which child mortality is being tackled is changing, placing new pressures on child health and making MDG 4 more urgent than ever. It is estimated that children under five make up 85%[18] of those who die as a result of climate change; 44% of child deaths happen in countries considered fragile[19]; and nearly 70% of the countries with the highest child mortality burden are currently experiencing or have experienced armed violence in the last two decades.[20]

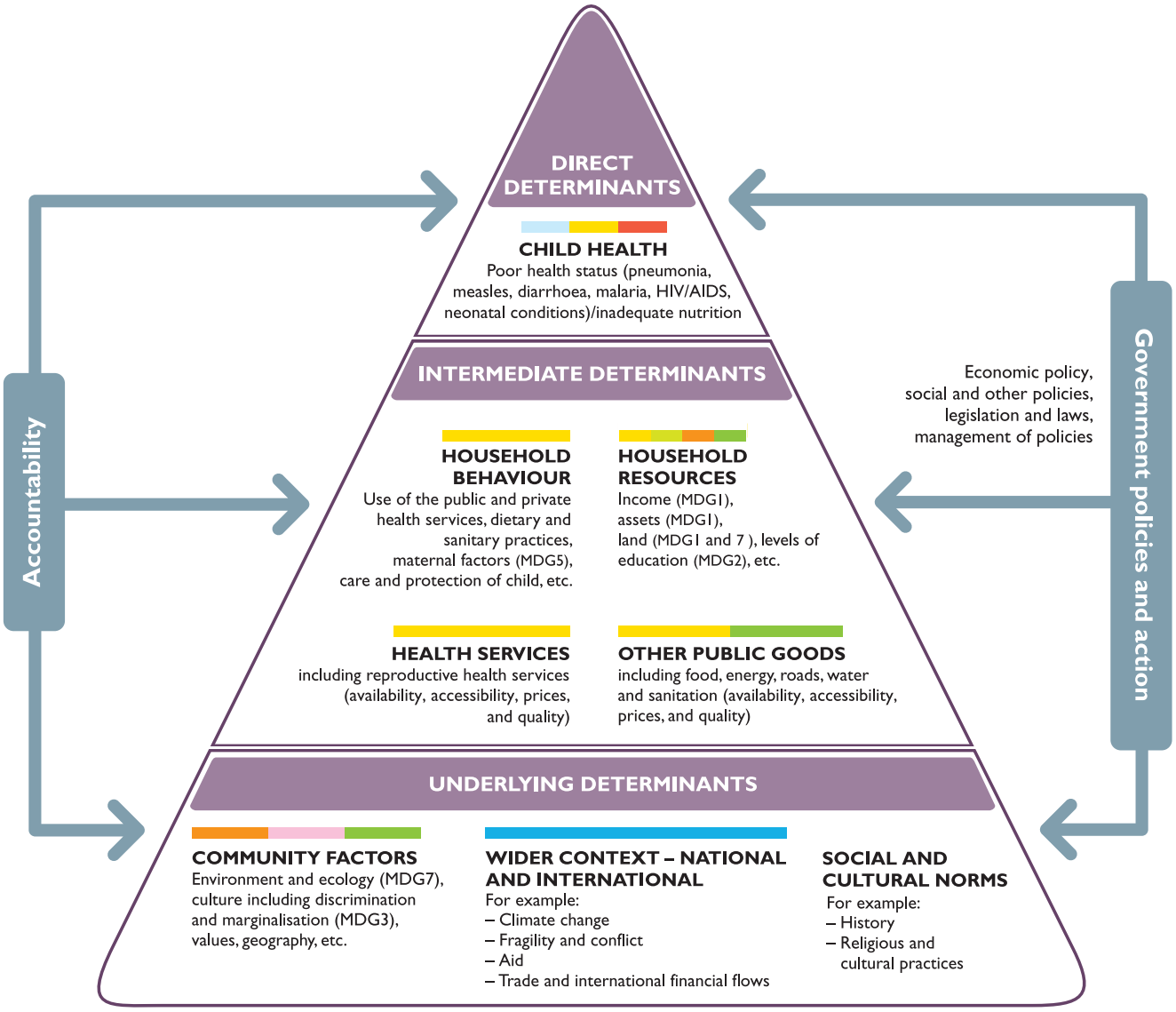
LINKS BETWEEN MDG 4 AND THE OTHER MDGs

Just as progress on MDG 4 can unlock improvements in other social and economic indicators, progress on child survival in turn is heavily influenced by whether other goals are met.

MDG 4 and MDG 5 (to reduce maternal mortality), for example, are intrinsically linked: inadequate care before birth and during delivery contributes to 40% of child deaths. Even babies who survive the neonatal period (up to 28 days) have greatly reduced chances of surviving beyond the age of five if their mothers die, in part because they are less likely to receive adequate nutrition and healthcare. One study in Bangladesh found that a child whose mother dies has only a 24% chance of surviving to the age of ten, but an 89% chance of living to ten if the mother remains alive.[21] Another study in Haiti found that where a mother dies, there is a 55% increased risk of one or more children in the family dying before the age of 12.[22] It is because of the links between MDGs 4 and 5 that Save the Children has elsewhere proposed the need for a joint Global Action Plan on MDGs 4 and 5.[23]

Reducing child mortality is also closely linked to progress on nutrition (MDG 1), education (MDG 2), water and sanitation (MDG 7), and gender equality and empowerment of women (MDG 3). And, of course, progress towards MDG 4 is also influenced by factors beyond the scope of the MDGs, including governance and accountability, armed violence and climate change. The interlocking nature of the MDGs highlights the need to approach MDG 4 with a broad lens that recognises the complexity of factors that influence a child's chances of survival (see Figure 2 overleaf).

Figure 2: Factors influencing child mortality and links to the MDGs



Key

MDG 1 MDG 2 MDG 3 MDG 4 MDG 5 MDG 6 MDG 7 MDG 8

2

WHY EQUITY MATTERS IN TACKLING CHILD MORTALITY

Global figures on progress towards achieving MDG 4 mask significant disparities between and within countries and regions. Despite the commitment to equity, equality and human rights in the UN Millennium Declaration, the MDGs can inadvertently encourage countries to focus on interventions that achieve progress among relatively easy-to-reach groups, thereby sharpening inequalities.

MDG 4 highlights the danger of relying on aggregate statistics alone. Roughly nine in every ten of the 68 developing countries covered in the *Countdown to 2015 report*[24] are making some progress towards reducing child mortality. But Save the Children's analysis[25] shows that, on average, disparities in child mortality between rich and poor have increased. In short, while there has been some progress towards MDG 4, this has often been concentrated in the wealthiest fifth of the population (the top quintile), in some cases leaving the poorest fifth of the population (the bottom quintile) no better or even worse off.

Overall, this pattern held in almost two-thirds of the countries for which data was available. In Burkina Faso, an overall reduction in child mortality rates at the aggregate level masks an actual *increase* in child mortality among the poorest 20% of the population.

INEQUALITY AND INEQUITY

The pattern of child mortality in most countries – and of underlying access to healthcare and other determinants of children's wellbeing – is not only unequal, it is also unfair. Some inequalities are the result of physiological factors. For example, boys are typically less likely than girls to survive early childhood for reasons unrelated to the care and attention they receive.

But most health disparities are inequitable – they reflect structural disadvantage based on income, gender, ethnicity and other factors.

'Equity' implies not just fairness, but also recourse to justice. Public policy choices often reflect and entrench disparities, by allocating resources and prioritising interventions that are of greatest benefit to better-off sections of society.

Addressing inequities in child survival is, therefore, not just a matter of identifying technical policy fixes. It also requires political changes, including more responsive and accountable government.

MORAL, LEGAL AND PRACTICAL REASONS TO ACT

There are moral, legal and practical reasons for tackling the inequities that exist in child mortality. Ensuring that all children benefit from gains in health and wellbeing matters as an end in itself: the principles of equity and freedom from discrimination underpin all rights. Under the CRC, states are obliged by law to respect, protect and fulfil the rights of every child.[26]

There are also good instrumental reasons for taking an equitable approach to MDG 4, because a focus on equity can unlock faster and more sustainable progress towards MDG 4:

1. Monitoring progress on MDG 4 across all sections of a society can act as an **early warning system** that draws attention to fault lines in a country's social fabric[27] and highlights key barriers that need to be overcome if the MDGs are going to be met.
2. Combating extreme inequities is good for **economic development**, because redistribution can both raise growth rates and make growth more efficient in reducing poverty.[28]
3. Reducing disparities, including gender disparities, can help to address the root causes of poverty and vulnerability, and improve people's ability to assert their rights, thereby creating a virtuous circle of **accountable government and equitable public policy**.[29]

INEQUITIES IN CHILD MORTALITY REFLECT POLITICAL PRIORITIES

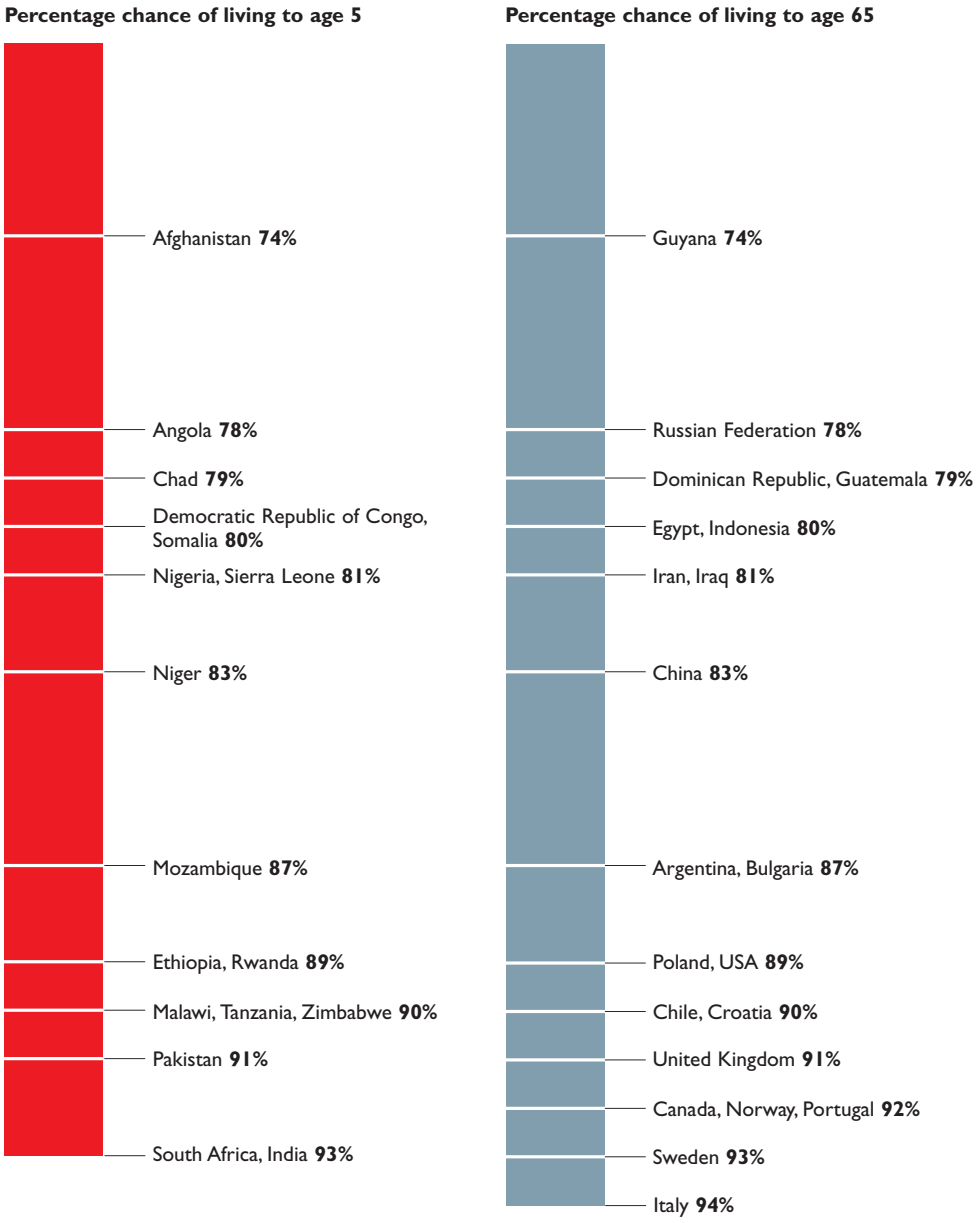
The modern world is characterised by stark inequalities, including in the life chances of children. Almost all child deaths – 99% – happen in the developing world. A person born in sub-Saharan Africa can expect to live, on average, 52 years.[30] In western Europe, life expectancy is 80 years.[31] The life expectancy rates in sub-Saharan Africa today have not been seen in Europe since the beginning of the 20th century.[32] In 40 developing countries, children have less chance of living to the age of five than a person in the UK has of living to the age of 65 (see Figure 3 opposite).[33]

These differences in child mortality in part mirror the enormous differences in economic development between countries. Economic growth can be a powerful tool for reducing income poverty, which is one of the underlying determinants of child mortality. But differences in both income levels (GDP/capita) and economic growth (changes in GDP over time) have a less direct relationship with child mortality rates than is often assumed.

Countries at the same level of income perform very differently in terms of how well they convert wealth into improved survival prospects for children (see Figure 4 on page 10), and especially for the most disadvantaged children. For example, Sri Lanka – with a per capita income of $1,790 – has a child mortality rate of 13, less than half the level in Guatemala, which has a per capita income of $2,680. Gabon has an equivalent per capita income to Argentina, but a child mortality rate of 57, almost four times higher.[34]

There is also no visible pattern between per capita income *growth* and the rate of reduction of child mortality rates. Comparing economic growth with changes in child mortality for 196 countries reveals no obvious correlation. Child mortality rates declined in countries with high, low or even negative growth (see Figure 5 on page 11). Previous studies have found the same pattern.[35]

Figure 3: Gaps in life chances between developing and developed countries

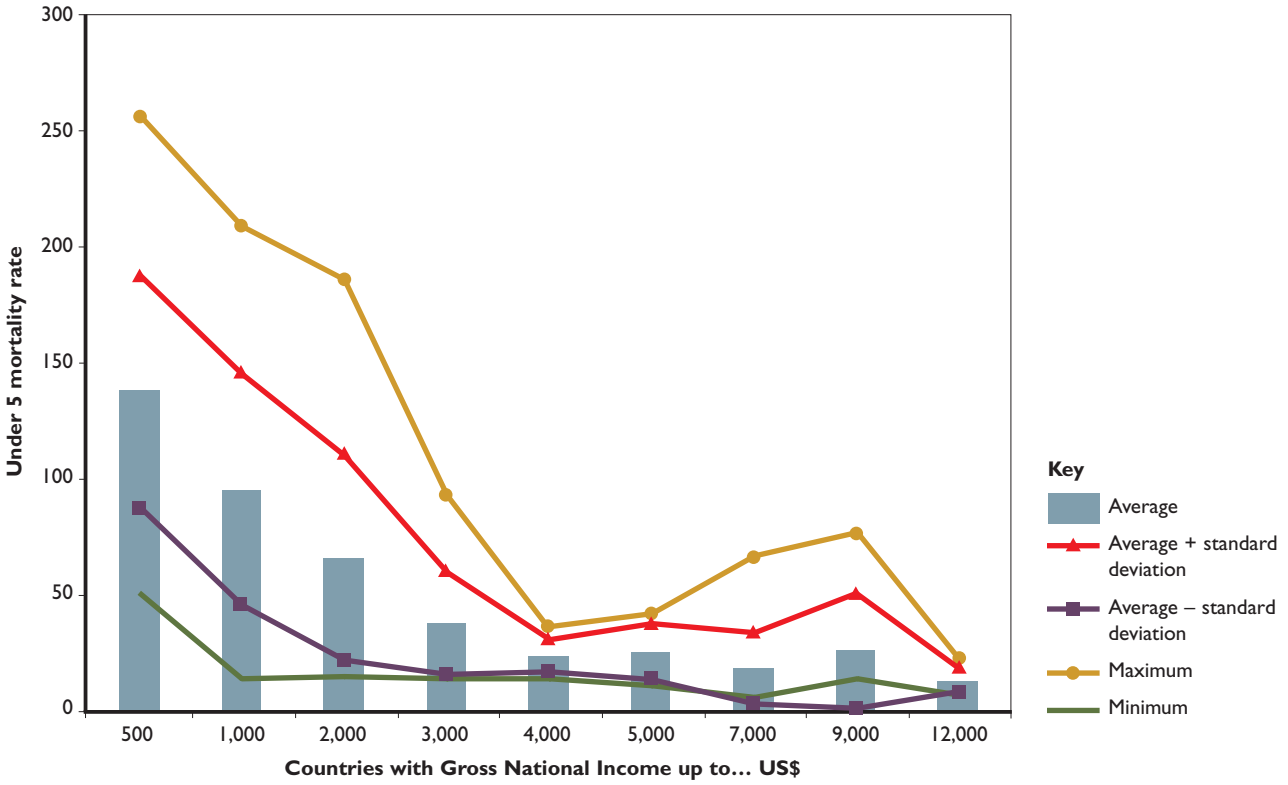


Source: Save the Children analysis based on data from the World Development Indicators and UNICEF, *The State of the World's Children 2010*

The contrasting experiences of Egypt and Equatorial Guinea are a case in point. Between 1990 and 2005, Egypt's economy grew by an average of 2.6% a year, while child mortality came down by 7% a year.[36] During the same period, Equatorial Guinea achieved an annual average growth rate of almost 17%, but experienced only a 2% average annual reduction in child mortality.[37]

Similarly, India has struggled to translate gains in income into improved life chances for children. Despite recent average economic growth of almost 8% a year, India's current rate of reduction in under-five mortality is just 40% of what's needed to achieve MDG 4 by 2015.[38]

Figure 4: Child mortality rates in countries clustered by GNI per capita, 2008



Source: Save the Children analysis using data from UNICEF, *The State of the World's Children 2010*

In sum, wealth does not straightforwardly equal health. Economic growth and rising per capita incomes do not automatically translate into reductions in child mortality. Equally, low-levels of economic development do not preclude countries from making progress towards MDG 4. Clearly, how wealth is distributed, and the accompanying policy choices that are made, have a significant bearing on progress towards MDG 4, and on the extent to which that progress benefits the most disadvantaged children.

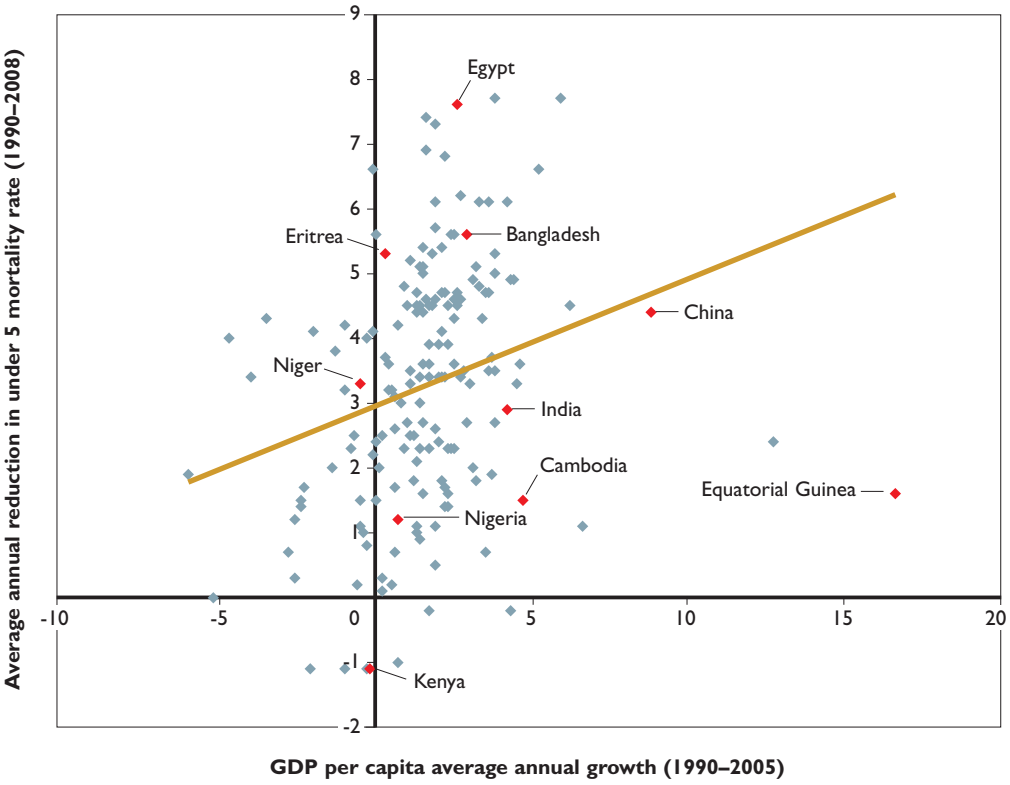
Inequity within countries

Within every society, the chance of surviving to your fifth birthday depends on where you happen to be born, how rich your parents are, whether your mother is educated, whether you are a girl or a boy, your ethnicity and your religion.

The result is that in many countries the child mortality indicators for the poorest, least educated and most marginalised groups are several times worse than those for better-off sections of the population. For example, whereas in Zambia the poorest 20% of children are 1.1 times more likely to die before their fifth birthday, in Peru the child mortality rate in the poorest quintile is 5.3 times higher than in the richest quintile. In India, child mortality in the poorest quintile is almost three times higher than in the richest quintile, and in Nigeria the poorest children are two-and-a-half times more likely to die before the age of five than the richest.[39]

On average, these disparities are widening, rather than narrowing. Data showing progress towards MDG 4 across income groups is available in Demographic and Health Surveys (DHS) for 32 of the 68 'Countdown to 2015' priority countries. It reveals that while there has been an average

Figure 5: Relationship between economic growth and reductions in under five mortality



Source: Save the Children analysis using data from UNICEF, *The State of the World's Children 2010* (for child mortality rates) and UNICEF, *The State of the World's Children 2007* (for economic growth rates)

reduction in the child mortality rate of nearly 3% per year across these countries, this has been accompanied by an average rise in the ratio of child mortality between the richest and poorest of 0.5%.[40] In total, 20 of these 32 countries have seen an increase in inequity between top and bottom wealth quintiles (see Figure 6 overleaf). In short, in over 60% of countries, progress towards MDG 4 has typically been concentrated among better-off groups, at the expense of the poorest children.

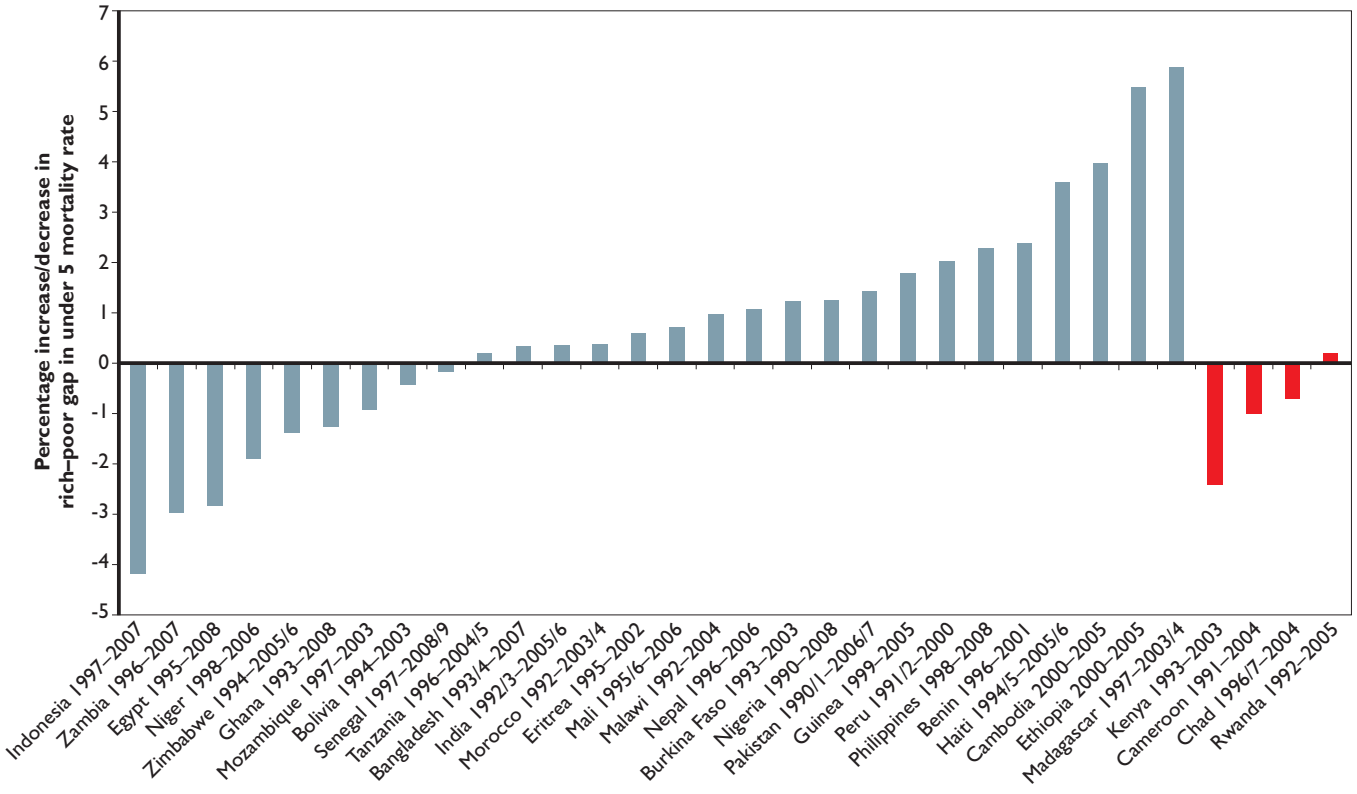
In an additional three countries – Cameroon, Chad, and Kenya – disparities in child mortality have narrowed but this has been accompanied by an increase in the overall number of children that die before the age of five. Just nine countries – less than one-third of the total for which the data is available – have experienced equitable progress in which child mortality rates improve faster in the poorest quintile of the population than in the richest quintile.

Inequities beyond income

Inequities in child mortality, however, do not simply arise from differences in income. Instead, disparities in income both reflect and interact with group inequities, such as those based on gender. The unequal status of men and women in almost every society is perhaps the most pervasive and entrenched inequity, and this has both a direct and indirect impact on child mortality.

In India, for example, high levels of selective abortion contribute to skewed male-to-female birth ratios. Son preference in India and China can result in high mortality among girls because they are not adequately breastfed or given the same access to medical treatment.[41] A study of 4,000 children aged between one and two in India found that the likelihood of girls being fully vaccinated was five percentage points lower than that for boys.[42]

Figure 6: Inequality in child mortality by socio-economic group



Key

Countries with diminishing under 5 mortality rate between two Demographic and Health Surveys

Countries with increasing under 5 mortality rate between two Demographic and Health Surveys

Note: The rich–poor gap is the difference between the under 5 mortality rate of the poorest and richest wealth quintiles.

Source: Save the Children analysis using data from Demographic and Health Surveys (DHS)

In many poor countries with high child mortality, women have little influence over their own healthcare and little control over household finances. In Gujarat, India, for example, 50% of women feel they need the permission of their husband or parent-in-law before taking their sick child to a doctor.[43] Similar findings have been obtained for other parts of the world.[44] Teenage girls – forced into marriage and early pregnancy – also have a higher risk of dying or losing their babies in pregnancy or childbirth.

Gains in women's education and relative power – both within and outside the household – strongly influence children's chances of survival. According to a study of 25 developing countries, all else being equal, one to three years of maternal schooling would reduce child mortality by about 15%.[45] And in south Asia, if women and men had equal status, it is estimated that there would be 13.4 million fewer malnourished children.[46]

Discrimination based on ethnicity also means that there are high levels of child mortality in certain ethnic groups. One recent study showed that in India and Vietnam, despite significant overall reductions in income poverty, people from minority ethnic groups are more likely to suffer from health problems, and are less likely to be covered by health programmes or to receive vital vaccinations.[47]

Inequities operate in clusters, not silos. Being poor, female and born to an uneducated mother, for example, carries a cumulative risk that a child will not survive until their fifth birthday.

ELIMINATING INEQUITY

Despite these unequal starting points, it is possible to reduce child deaths as quickly among the poor and disadvantaged as it is among the rich and privileged, even in low-income countries with high child mortality rates. And failing to do so brings with it a range of costs, not least the number of lives lost.

One way of calculating the opportunity cost of not taking a more equitable approach to MDG 4 is to model what has been described as an 'egalitarian approach'[48] – where the rate of reduction in child mortality in each quintile matches the rate of reduction in the fastest-improving quintile. For most countries this involves extrapolating from the rate of reduction for the richest quintile to other quintiles, and estimating the number of additional child deaths that could be prevented. As this analysis is based on *observed* rates of reduction in a given country, it is difficult to argue that this level of progress is not feasible because of financial, technological or other context-specific constraints. Modelling the egalitarian approach gives a more conservative view of the number of lives that could be saved than an 'equitable approach', which assumes faster rates of reduction in child mortality for the poorest quintile than for other quintiles.

Save the Children's analysis found that if countries had taken an egalitarian approach to child mortality, there would have been dramatic benefits for the poorest children and a massive increase in the number of lives saved: **four million child deaths** could have been prevented across 42 countries over a ten-year period.

The poorest children in some countries would have especially benefited from an egalitarian approach to reducing child mortality. For example:

- Pakistan would have prevented an additional 323,000 deaths
- Ethiopia would have prevented an additional 260,000 child deaths
- Nigeria would have prevented an additional 892,000 child deaths

In countries where under-five mortality worsened between the two survey periods, raising progress towards MDG 4 to the rate of the fastest-improving quintile would instead have led to an *improvement* in child survival. For example, in Kenya, where there was an increase of nearly 150,000 under-five deaths between 1993 and 2003, an egalitarian approach would have actually prevented 214,000 deaths. Perhaps the most important implication is that an egalitarian approach would have led four more Countdown countries – Benin, Cambodia, Ethiopia and Madagascar – to be on track to meet MDG 4.

EQUITABLE PROGRESS TOWARDS MDG 4 IS POSSIBLE

While many countries have combined reductions in child mortality with widening disparities between income groups,[49] there is nothing inevitable about this relationship. Countries as diverse as Egypt, Indonesia, Bolivia and Ghana show that it is possible to make equitable gains in child survival. All of these countries have reduced child mortality substantially, while at the same time making faster progress among poor people than among the better-off.

Looking at the change in both child mortality rates and in inequity between wealth quintiles in child mortality in 32 countries for which data was available, Save the Children identified the following five possible paths towards achieving MDG 4 (see also Table 1 overleaf and Appendix 1, page 32):

- **Equitable progress** – countries making above-average progress towards MDG 4, while also concentrating progress among children from the poorest households (measured by a reduction in the ratio of child mortality rates between top and bottom wealth quintiles)
- **Equity-neutral progress** – countries that made above average progress towards MDG 4 overall without any significant change in inequity
- **Inequitable progress** – countries that made above-average progress towards MDG 4 with an above-average increase in inequity, because progress was faster in the richest quintile

- **Slow or no progress** – countries that made little or no progress towards MDG 4, largely combined with increases in inequity[50]
- **Reversal** – countries that experienced rising child mortality regardless of changes in inequity.

It is clear that national averages tell us relatively little about progress towards MDG 4 for the poorest children (see Table 2 opposite). For example, Ethiopia, Madagascar, Cambodia and Haiti have all made large reductions in child mortality among the richest fifth of their populations, but the poorest fifth have seen much smaller reductions. Both Rwanda and Burkina Faso have seen decreases in child mortality in the top quintile, while child mortality *increased* among the poorest quintile.

Table 1: Countries by progress on child mortality rate and inequity (32 countries with data available)

Category	Categories	Countries
1	Equitable progress	Ghana, Mozambique, Niger, Egypt, Indonesia, Bolivia, Zambia
2	Equity-neutral progress	Bangladesh, Morocco, Eritrea
3	Inequitable progress	Malawi, Nepal, Ethiopia, Madagascar, Peru, Philippines, Haiti
4	Slow or no progress	India, Benin, Burkina Faso, Cambodia, Guinea, Mali, Nigeria, Senegal, Tanzania, Zimbabwe, Pakistan
5	Reversal	Cameroon, Chad, Kenya, Rwanda

Table 2: The change in child mortality rates between the richest and poorest quintiles

Country	Change in under-five mortality rate among poorest 20%	Change in under-five mortality rate among richest 20%
1: Equitable progress		
Bolivia	-32%	-30%
Egypt	-49%	-36%
Ghana	-34%	-20%
Indonesia	-29%	9%
Mozambique	-29%	-25%
Niger	-27%	-15%
Zambia	-42%	-19%
2: Equity-neutral progress		
Bangladesh	-54%	-55%
Eritrea	-35%	-37%
Morocco	-30%	-33%
3: Inequitable progress		
Ethiopia	-18%	-37%
Haiti	-23%	-48%
Madagascar	-27%	-51%
Malawi	-28%	-35%
Nepal	-37%	-44%
Peru	-32%	-42%
Philippines	-17%	-29%
4: Slow reduction		
Benin	-5%	-15%
Burkina Faso	4%	-8%
Cambodia	-18%	-32%
Guinea	-6%	-15%
India	-24%	-27%
Mali	-22%	-27%
Nigeria	-9%	-27%
Pakistan	-3%	-19%
Senegal	-21%	-20%
Tanzania	-2%	-4%
Zimbabwe	-15%	1%
5: Worsening		
Cameroon	-6%	7%
Chad	3%	8%
Kenya	15%	47%
Rwanda	46%	-11%

Note: Changes in mortality rates in the richest and poorest quintiles are based on earliest and latest DHS rounds for each country (see appendix).

HOW TO MAKE EQUITABLE PROGRESS ON CHILD SURVIVAL – FOUR KEY LESSONS

Drawing on the experience of the seven Countdown to 2015 countries that have made equitable progress towards MDG 4 – Ghana, Mozambique, Niger, Egypt, Indonesia, Bolivia and Zambia – it is possible to identify four broad policy lessons that drive success. Strategies to tackle child and maternal mortality equitably must:

- be comprehensive, focusing on nutrition, clean water and sanitation, women's empowerment and social protection, as well as on healthcare
- provide universal essential services, including to the poorest children and families.
- ensure that resources are distributed equitably
- include transparent and accountable budgeting and public expenditure management.

These lessons should form the basis of an action plan on child and maternal survival at the MDG review summit in September 2010, and drive national efforts to get back on track towards MDG 4.

POLICY LESSONS FOR EQUITABLE REDUCTIONS IN UNDER-FIVE MORTALITY

Lesson 1 – MDG 4 requires comprehensive strategies to tackle inequities in the wider determinants of child survival

Those countries that have made progress towards MDG 4 attest to the value of simple and cost-effective healthcare interventions. In Niger, an immunisation drive led to a 99% decrease in deaths from measles between 2004 and 2006 (see Niger case study opposite).[51] In Bangladesh, measles vaccination coverage rose from 69% to 83% between 1993 and 2007, with corresponding improvements in child survival across all sections of society.[52] And in Nepal substantial gains in child mortality have in part been achieved by providing treatment for diarrhoea and acute respiratory infections through a network of community health workers.[53]

However, expanding access to health services will only have limited impact unless it is coupled with measures to reduce disparities in the wider determinants of child survival. Tanzania is an example of a country that is often lauded for its health investments, but that has seen relatively modest improvements in child mortality. Between 1996 and 2004/05, child mortality fell annually by an average of just 0.7%, accompanied by a rise in inequity over the same period (see Tanzania case study).[54]

CASE STUDY: NIGER – A STORY OF FRAGILE PROGRESS

Niger's position on a list of 'high achievers' seems improbable. Economic stagnation, famine and chronic undernutrition, natural disaster, internal conflict and political instability have all affected Niger in recent years. The country is currently in the throes of a catastrophic food crisis, with half of the population – approximately 7 million people – experiencing severe food deprivation.[55]

Yet against this fragile backdrop, between 1998 and 2006 there were significant and equitable gains in child survival. Over this period Niger's under-five mortality rate declined by 28%, alongside a large reduction in inequity: under-five mortality declined by 27% for the poorest 20% of the population, as compared with a reduction of 15% in the richest 20%.

Niger's improvement (in absolute terms) must be seen relative to its starting point. In 1990, the MDG baseline year, Niger had the highest under-five mortality rate in the world, and even today it is ranked 13th from the bottom.[56] Nonetheless, its policy choices hold important lessons for how to make progress even in the poorest and most challenging contexts.

- Since 2002, a variety of strategic plans have been set, including the health development plan, the National AIDS Control Strategic Framework, and the water and sanitation policy and strategy.
- Specific health interventions have included a successful drive to improve child immunisation, particularly for measles and poliomyelitis.
- Interventions have been scaled up to tackle malaria, HIV and AIDS and cholera, which threaten more than 80% of the population.[57]
- Between 1992 and 2006 the percentage of children with acute respiratory infections taken to a health facility increased at annual average of 9%.[58] This can partly be attributed to the introduction of health charge exemptions.
- Between November 2005 and April 2006, Niger adopted legislation that provides free healthcare for caesareans and uterine ruptures, free contraception, and exemption of payment for antenatal visits and for care for children aged 0 to 5 years.[59]
- The numbers and capacity of health workers have increased, with the number of doctors doubling from 2002 to 2008.[60]

In early 2010 the 'Fifth Republic' was deposed in a political coup, ending a decade of relative political stability. Many official donors responded by cutting or freezing aid. Given Niger's dependence on international aid this raises fundamental questions about whether these fragile gains in child health can be sustained and consolidated.

CASE STUDY: TANZANIA – HEALTH INVESTMENTS WITH UNEVEN RETURNS

Tanzania is commonly heralded as a bright star in terms of health investments and social sector spending. But looking at the period 1996–2005, despite increasing investments in the health sector, the gains have been disproportionately concentrated in the top wealth quintile. In 1996 the child mortality rate in the poorest quintile was 140 per 1,000 live births. In 2004–05, this had only moderately decreased to 137. Meanwhile, the richest quintile saw child mortality fall from 135 in the late 1990s to 90 in 2004.[61]

High-quality essential services for children such as IMCI (integrated management of childhood illnesses), treated bed nets, vitamin A supplementation, effective anti-malarial treatment and breastfeeding promotion lay behind this improvement for better-off sections of the population.

The 2005 National Strategy for Growth and Reduction of Poverty (NSGRP)[62] recognised the need for more equitable improvements in child mortality and made this a priority for its five-year plan, stating that health services should be accessible to poor members of the population and that quality should be improved.

The NSGRP attributed lack of progress to seven factors – the high cost of drugs; the lack of rural health services and long distances to health facilities; inadequate and unaffordable transport systems; poor quality of care; a weak exemption and waiver system for the poorest households;[63] shortage of skilled providers; and poor governance and accountability mechanisms.

Tanzania's health budget also focused too exclusively on disease targeting and immunisation, with little attention given to equity of coverage and improvements in general health systems (the budget for which declined between 2001 and 2005). The government also neglected undernutrition over this period, despite 44% of children being moderately to severely stunted.[64]

In contrast to Tanzania, those countries that have made equitable progress towards MDG 4 have tackled wider disparities in three key areas – nutrition, sanitation and women's empowerment – and made effective use of social protection programmes to overcome many of the demand-side barriers to healthcare and adequate nutrition.

Nutrition

Undernutrition is a factor in more than one-third of child deaths and remains an urgent development challenge in its own right.[65] One-quarter of children under five years of age are underweight, a level that has declined since 1990 by only five percentage points – just one-third of the reduction needed to achieve the target under MDG 1.[66] And although the percentage of stunted children decreased globally from 40% to 27% between 1990 and 2010, the *number* of stunted children is projected to increase in many areas.[67] In Africa, the number of stunted children is estimated to have increased from 45 million in 1990 to 60 million in 2010.[68] Undernutrition among pregnant women in developing countries leads to one in six infants

being born with low birth weight, which not only carries a high risk of neonatal death, but can also permanently damage long-term cognitive and physical development.[69]

Those countries that have made equitable progress or equity-neutral progress on MDG 4 (category 1 and 2 countries) have a strong track record of complementary nutrition programmes as part of their maternal and child health strategies. These have focused on low cost and relatively simple measures such as breastfeeding promotion, complementary feeding and micronutrient supplementation. Countries in these two categories have also made extensive use of indirect interventions such as cash and commodity transfers to help the poorest families to access nutritious food.

Sanitation

Clean water, sanitation and basic hygiene practices play a critical role in reducing preventable child mortality. Infectious diseases accounted for an estimated 68% of the 8.8 million child deaths in 2008,[70] with pneumonia accounting for 18% and diarrhoea for 15% of the global total.[71] More than 40% of deaths from pneumonia and diarrhoea take place in sub-Saharan Africa, where 42% of people lack access to an improved water source, and almost 70% are without adequate sanitation.[72] In the future increasing water stress due to climate change and population growth is likely to make delivering clean water even more difficult and important.[73]

Improved drinking water sources and proper sanitation are crucial to reducing child deaths from diarrhoea, while an estimated 45% of cases could be prevented by simple hand washing with soap.[74] Hand washing can also significantly reduce the risk of pneumonia, combined with early detection systems and treatment with antibiotics.[75]

Again, the evidence from those countries that have made equitable progress towards MDG 4 suggests that improved sanitation has played an important role. Our analysis found that countries in category 1 reduced the proportion of households without sanitation facilities at an average annual rate of 4.5%, compared with average annual reductions of only 2.3% among category 4 and 5 countries (those that have made no progress, slow progress or gone backwards against MDG 4).[76]

In Bolivia, there was an 8% improvement in the number of people without a sanitation facility from 1994 to 2003, while in Egypt there was a 9% improvement between 1992 and 2005.[77] By comparison, many of the countries in categories 3 and 4 witnessed only marginal change, or rates remained static. In Guinea, Nigeria and Senegal, access to adequate sanitation actually fell between 1990 and 2006 – in the case of Nigeria from 57% to 30%.[78]

There is also evidence that unequal access to sanitation is itself closely linked to inequities in child mortality. In Bangladesh, households in the wealthiest quintile are three times more likely to have access to a latrine than households in the poorest quintile. The data from Bangladesh suggests that disparities in access to sanitation have an impact on inequalities in child mortality, independently of other factors such as income.[79] Similar results are seen in more comprehensive studies across other countries.[80]

Empowering women

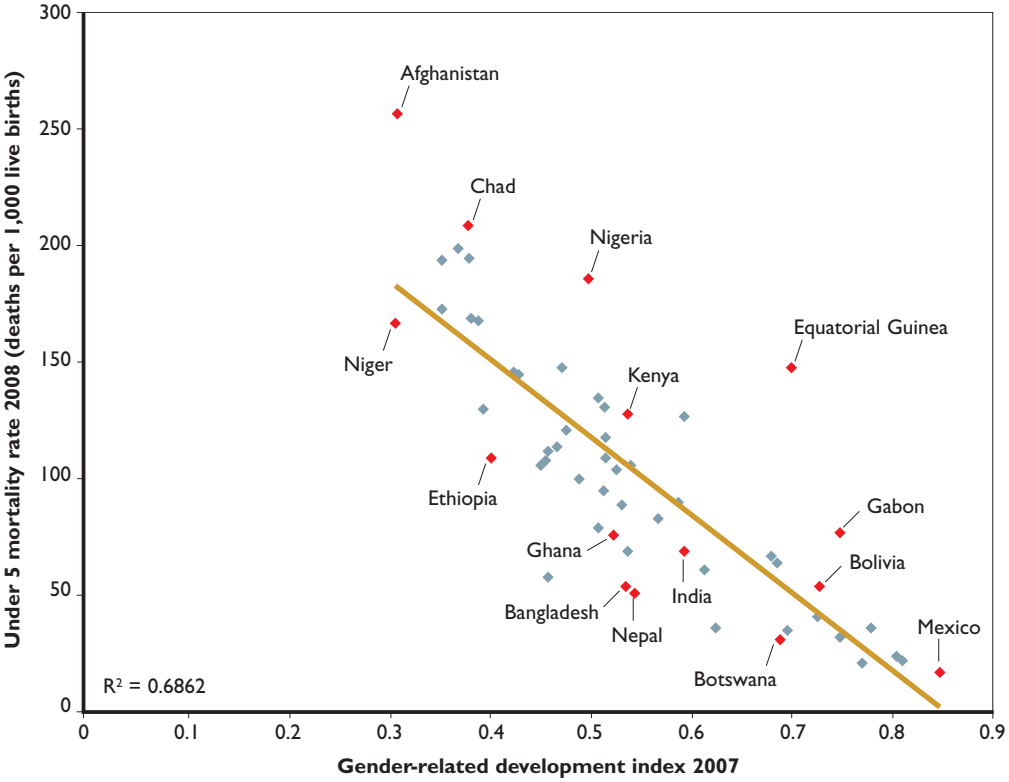
Tackling the extremes of gender inequity is a necessary condition for making sustained progress in reducing child deaths. Discriminatory practices against women and girls are a violation of rights. They also have a devastating effect on children's survival, health and development. Conversely, empowering women to make choices about their own lives can have the knock-on effect of saving children's lives. If women and men had equal status, it is estimated that the proportion of underweight children below the age of three years would fall by 13 percentage points globally.[81]

Comparing countries using the UN Development Programme's Gender-related Development Index[82]

– which, among other things, captures women's political participation and labour market status – with child mortality rates shows a strong relationship between progress towards MDG 4 and women's empowerment (see Figure 7 below). Bolivia is a case in point. Legal reform and policy change has helped to contribute to an increase of 70% in women's participation in economic decision making in the public and private sectors since the early 1990s.[83] During the same period, the number of women represented in national and local politics increased by 16%.[84]

Women in category 1 countries that have made equitable progress towards MDG 4 are also more likely to make decisions about their own health. Whereas 63% of women in countries in this category participated in decisions to seek healthcare for themselves, only 40% of women did so in category 4 and 5 countries.[85] Similarly, whereas an average of 39% of women in category 1 countries have access to contraceptive services, this figure falls to 29% for countries in categories 4 and 5.[86]

Figure 7: Countries with empowered women have lower child mortality rates



Source: UNICEF, *State of the World's Children 2010* (under 5 mortality rate) and *UNDP Human Development Indices: A statistical update 2009* (gender-related development index)

CASE STUDY: OVERCOMING GENDER INEQUITY IN BANGLADESH

Historically, a cultural tradition of son preference[87] has meant that Bangladeshi boys were more likely to receive lifesaving interventions than girls.[88] However, in the last ten years, sex differentials in the coverage of measles vaccination have largely disappeared[89] and child mortality rates have significantly improved. From 1993 to 2007, the child mortality rate fell by on average 5.3% annually,[90] and the gap between boys' and girls' prospects of survival closed.

Improved equity in health service coverage cannot be attributed to any single initiative, but to a series of steps aimed at empowering women and improving health service access. Microcredit schemes, improved female education (driven partly by increased use of stipends for girls' secondary schooling), the growth of vibrant women's civil society organisations and networks, falls in the fertility rate over the past three decades and expanding job opportunities for women have all contributed to a narrowing of disparities between the sexes.

Since 2001, progress towards equitable access to health services has been assisted by the training of community health workers under the Integrated Management of Childhood Illnesses programme (IMCI). The IMCI has placed increasing emphasis on the major causes of child mortality – especially measles, malaria, pneumonia, diarrhoea and malnutrition – and on improving community care of children. An evaluation of the programme showed that the quality of care for a sick child at first-level government health facilities is substantially improved by the IMCI strategy.[91] Between 1999 and 2007 there was a three-fold increase in the use of these facilities, exclusive breastfeeding in children younger than six months increased, and prevalence of stunted growth reduced.[92] Research in the Matlab area of the country showed that IMCI-trained community health workers contributed to reduced sex inequities in immunisation coverage.[93]

Social protection

Child survival for the poorest and most marginalised groups is often threatened most immediately by financial and other barriers, which prevent households from securing an adequate diet and access to essential services. Increasingly, developing countries are making effective use of social protection policies, such as cash transfers, to reduce poverty and vulnerability, and to improve the health and wellbeing of children.

The social protection programmes with the greatest direct impact on inequity in child survival are those that have sought to reduce the cost of accessing health services for the poorest families – by introducing social health insurance, for example – and those that have sought to address other key determinants of child mortality, especially nutrition.

Many of the countries that have equitably reduced child mortality have also implemented cash transfer programmes, although there are significant variations in the coverage and effectiveness of these schemes. Indonesia has established the largest cash transfer programme in East Asia, and since the introduction of the National Safety Net Programme in response to the economic crisis in 1998, cash

and in-kind transfers have been an integral part of the country's poverty reduction strategy. The programme currently includes a combination of subsidised rice, employment creation, scholarships, healthcare and nutrition supplements, and a community fund.

In 2000, Ghana, another country that has succeeded in making equitable progress towards MDG 4, extended social protection programmes focused on the poorest, mainly rural, households with the aim of improving access to healthcare, education and nutrition. Examples of the measures implemented in Ghana include an education capitation grant paid to schools to ensure fee-free access, a free maternal healthcare policy, a school feeding programme, a pilot cash-transfer programme and the National Health Insurance Scheme (see case study below).

Lesson 2 – the need for a universal approach to service delivery

The tension between universalism – where the entire population is the intended beneficiary of a service – and selectivity, where eligibility is restricted, plays out in many debates on how best to achieve social outcomes, both in developed and developing countries. In practice, differences

CASE STUDY: GHANA'S NATIONAL HEALTH INSURANCE SCHEME

In 2003, Ghana took bold steps to improve the coverage of its health service by implementing a universal health insurance scheme (NHIS), replacing the previous forms of community-based health insurance, which had limited coverage, and imposed out-of-pocket payments at the point of use. The NHIS was partly a response to evidence that out-of-pocket costs were the major reason for poor health service access (according to 2003 DHS data, 54% of women cited it as the main constraint to using healthcare).

Whereas private insurance is often unaffordable for the poorest households in low-income countries, social health insurance (SHI) is a compulsory scheme based on pooled contributions and covering a specified benefit package, typically contracted from public and private providers. At the district level, the NHIS is partly administered through District Mutual Health Schemes. These schemes seek to enrol Ghanaians outside the formal sector and to target the 'underprivileged segment of society'.[94]

By the end of 2007, 55% of the population was registered with the NHIS, and 44% had received their membership cards.[95]

There have been criticisms of the NHIS roll-out: for example, at present only 29% of people in the bottom quintile are in the scheme, compared to 67% of the top quintile;[96] most people cited affordability as the main reason for non-enrolment.[97] And the scheme has been criticised from a children's rights perspective, because children whose parents or guardians do not register with the scheme are unable to access healthcare, and because the scheme excludes children who come into conflict or contact with the law.

However, Ghana is now taking steps to rectify these biases to better address the needs of the poorest households.

between the two approaches are often not clear-cut, especially as universal service provision may be rolled out step-by-step, often with a focus on universal access to particular high-impact interventions in the early stages of implementation. This is complicated further by the fact that targeting can be used as an instrument to make universalism more effective – targeting within universalism – in which extra benefits are directed to certain groups within the context of a generalised service.

In reality, most countries mix universal and targeted approaches, and lie somewhere on a continuum between the two extremes.[98] But where countries sit on this continuum matters, and countries that have managed to reduce child mortality equitably have tended to promote a universal package of essential services.

Bolivia's progressive roll-out of a universal package of basic healthcare is a case in point (see Bolivia case study below). And, since 2006, Ghana has adopted the High Impact Rapid Delivery (HIRD) approach as a national strategy to reduce child mortality. The HIRD scheme aims to provide essential health and nutrition services to rural communities unable to register with the National Health Insurance Scheme. The government has also

CASE STUDY: HEALTHCARE IN BOLIVIA

An example of a step-wise approach towards universal coverage has taken place in Bolivia, where the government has been moving towards a policy of universal healthcare provision since 1996. Given the scale of unmet need and the scarcity of resources, the government initiated these reforms in phases, initially prioritising maternal health and child survival through their National Insurance Scheme for Maternity and Childhood. This scheme included 32 service packages, providing medical assistance to mothers and to children below the age of five years. It covered maternity care, including caesarean sections for obstetric emergencies, and paediatric care for cases of diarrhoea and respiratory infections.

In 1998, this scheme was changed to the Basic Health Insurance Scheme (SBS) and a complementary indigenous insurance scheme, which together covered services for 92 health problems. In addition to the previous scheme, the SBS included obstetric emergency transport, newborn care, child nutrition and development screening, vaccination and care for infectious diseases other than diarrhoea and pneumonia, such as sepsis and meningitis.

In November 2002, the Universal Mother and Child Insurance Scheme (SUMI) was launched, covering approximately 500 health problems for children from birth to five years. SUMI services were extended in April 2006 to incorporate 27 additional sexual and reproductive health service packages, including family planning and cervical cancer screening, protecting women up to 60 years of age.

SUMI is intended to be a universal, comprehensive healthcare package, which the population can access through all public health services whatever the level, as well as through services provided by the social security system.

invested in scaling up the Community-based Health Planning and Services initiative, which complements the HIRD by placing community health nurses closer to communities and allows community members to become more active participants in the provision of their own healthcare.

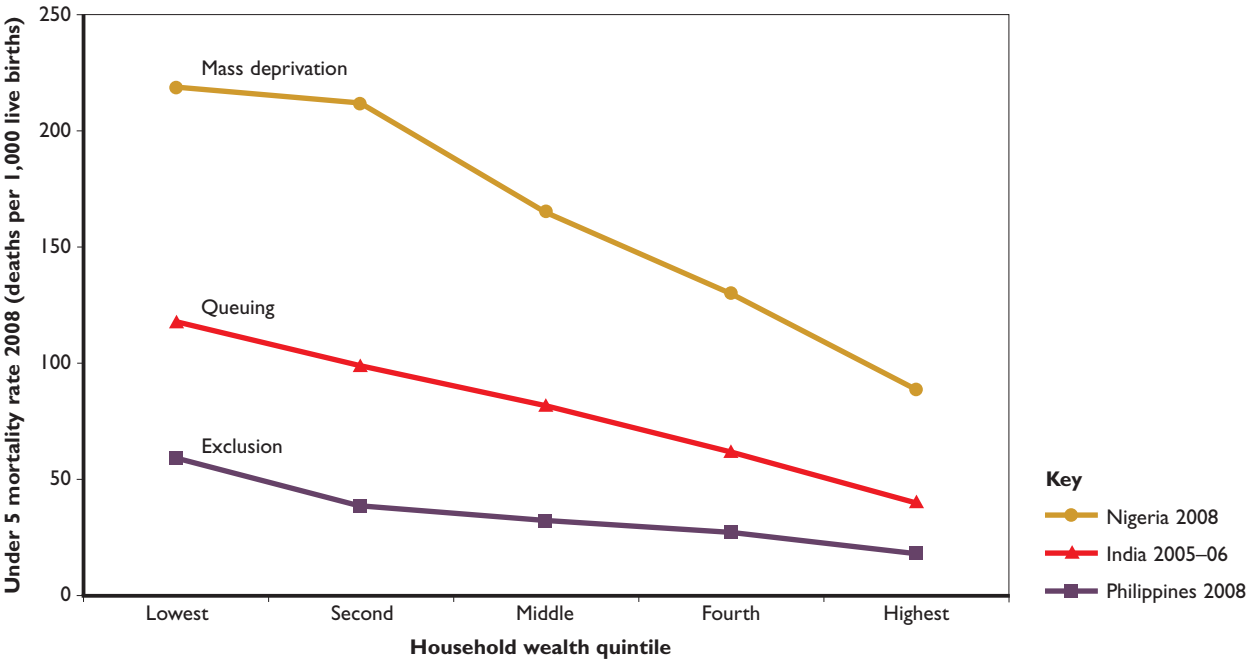
Universal access to essential services is a corollary of treating child survival as a right – under international human rights law, states are obliged to take the appropriate legislative, administrative, and other measures to implement the rights of *all children* to the maximum extent of their available resources. But there is also a practical case for universal access to healthcare and other social benefits.

First, the patterns of inequity in access to health systems in the countries with the highest child mortality rates – where unmet needs are spread across a larger share of the population, rather than being concentrated among a small disadvantaged minority – lend themselves to more universal approaches. Second, the targeting of services carries its own costs and assumes administrative capacity that many poor countries with high child mortality rates do not have. Finally, universal provision of essential services can help to cement the contract between citizens and the state and, by reducing inequities, contribute to political stability – a key challenge in many of the countries that have the highest child mortality rates.

1 Patterns of inequity in most countries with high child mortality point to universal provision

While inequities in child mortality exist in virtually all countries, the nature of inequity varies and tends to follow three broad patterns – 'exclusion', 'mass deprivation', and 'queuing' (see Figure 8 below).

Figure 8: Different patterns of inequity in child mortality



Source: Save the Children analysis based on data from Demographic and Health Surveys, adapted from UN/DESA, *Implementing the Millennium Development Goals: Health Inequality and the Role of Global Health Partnerships*, 2009

At one extreme are countries where a large part of the population enjoys a wide range of benefits but a minority is excluded. This pattern of *exclusion* is often found in middle-income countries such as Brazil, where average child mortality rates are relatively low and child deaths are concentrated in the poorest fifth of the population. The policy challenge in these circumstances is to extend the benefits enjoyed by the majority, often with a targeted strategy that removes the particular barriers preventing the poorest households from uptake of health benefits, and which creates tailored provision for structurally disadvantaged groups, while building up the ability of the poorest households to cope with the economic shocks of illness and death.[99]

Other countries – especially those lower middle-income countries that are making progress towards MDG 4 but where average child mortality rates remain relatively high – follow a middle pattern of *queuing*, where there is a level of generalised access to health services, but the wealthier sections of the population still benefit disproportionately and the poorest groups remain neglected.

At the other extreme are the poorest countries – which tend to have very high levels of child mortality and where child deaths are spread more evenly across income groups. In these situations, households outside the wealthiest 10–20% of the population face *mass deprivation*, lacking access to the necessary range of health and other related benefits. These countries – Niger, Nigeria and Ethiopia are examples – typically have fragile health systems with limited coverage, and suffer from endemic and deep poverty and chronic emergencies, often including armed violence.

Countries with patterns of *mass deprivation* account for a majority of the countries with the highest child mortality burden; the main policy challenge in these countries is to build a primary healthcare system that tackles the major causes of child death and reaches under-served poor and rural communities.[100] In the context of *mass deprivation*, narrow, targeted approaches to services are unlikely to meet the needs of the 40–60% of the population that is income poor, or of households that are vulnerable to poverty.

In sum, most countries with high levels of child mortality, many of which are off track towards achieving MDG 4, should adopt an explicit goal of universal access to primary healthcare, coupled with increased investments in other critical areas, especially nutrition, water and sanitation, and education.

2 Universal approaches are more suited to countries with low levels of development and administrative capacity

The argument often advanced in favour of targeted social benefits is that this is all poor countries can afford. But this ignores the fact that there are significant financial and administrative costs associated with selecting beneficiaries on the basis of poverty. This is especially the case in low-income countries where poverty is dynamic, where many individuals and communities are not legally registered, and where cash income is only loosely correlated with deprivation. Countries that are off track towards MDG 4, or have high levels of child mortality, typically lack the capacity, systems and resources to administer a complex targeted system of social benefits. In short, contrary to the widespread belief that a universal approach to social benefits is beyond the reach of poor countries, there is evidence that universalism in many countries was in fact *dictated* by underdevelopment.[101]

One study that looked at the impact of targeted anti-poverty interventions in 48 countries found that 25% of programmes were regressive, meaning that the better-off benefited disproportionately. The case of India, with its long history of interventions targeted towards the poor, illustrates the challenges even in a country that is relatively prosperous

and has significant state capacity. The impacts of targeted programmes in India have been "very disappointing"[102] because many of the poor are missed and many of the benefits "leak" to better-off people.

3 Universal approaches can contribute to political stability

Universal access to services can have wider political benefits, as well as having a positive impact on child mortality. Forty per cent of countries making slow or no progress on MDG 4, or going backwards against the goal, can be considered fragile,[103] and nearly 70% are currently suffering or have suffered armed conflict since 1990.[104] Universal approaches to social benefits may actually help to stabilise the fragile political situation in these countries. While the relationship between social policy and political stability is complex, inclusive service provision can help to reduce the inequities that often feed conflict, normalise post-conflict societies, and legitimise the state, thereby contributing to peace and stability.[105]

Lesson 3 – the need for an equitable distribution of resources

Countries that have made equitable reductions in child mortality have done so in the context of high-level political commitment to child and maternal health, reflected in a more equitable distribution of resources.

Egypt, which achieved MDG 4 in 2006, is an example of how political commitment can drive success. The government launched a major initiative in 1992 called 'healthy mother, healthy child' to improve health conditions in poor areas. The effort focused on improving care for pregnant women, providing skilled assistance during childbirth and increasing access to family planning information and services.

Likewise, in 1996 Indonesia launched a programme called the 'Mother Friendly Movement'. This initiative is coordinated by the State Ministry for Women's Empowerment alongside a number of other national ministries, which collaborate with grassroots groups to make childbirth safer. The Movement has used mass media and other communication channels to raise public awareness of the 'three delays' that threaten women giving birth: delay in identifying the signs of obstetric emergency; delay in reaching service delivery facilities; and delay in receiving assistance at the delivery points.[106] The programme has two additional components – mother-friendly hospitals, and the mother-friendly sub-district. In the mother-friendly sub-district, the community has been encouraged to join local saving schemes. Savings can be used to cover the cost of childbirth, and to get necessary services in the event of an obstetric emergency.[107]

In many of the category 1 countries making equitable progress towards MDG 4, governments have also taken a public stance on equity, recognising that certain groups are disadvantaged and taking direct steps to address these inequities. Bolivia, for example, voted for a new constitution in 2009 that sought to address the rights of indigenous people.

These policies have been underpinned by a more equitable distribution of resources. Our analysis found that in category 1 countries a much greater percentage of health expenditures are covered by social security than in countries making slow or no progress. In category 1 countries, 23% of health expenditures are covered by social security schemes, whereas in countries where child mortality rates are static or in reverse, less than 3% is covered by social security.[108]

Those countries that have made greater use of social security schemes also tend to rely less on out-of-pocket payments, including user fees, as a source of health financing. The negative impact of user fees on access to healthcare and health outcomes, particularly for children in poor households, has been widely documented,[109] and there is now a consensus on the need to remove

user fees.[110] Countries making slow or no progress towards MDG 4 rely on out-of-pocket payments for 84% of health financing, against 75% for countries making equitable progress.[111] Moreover, between 2000 and 2007, countries in category 1 reduced their dependence on out-of-pocket payments at twice the rate of category 4 and 5 countries.[112]

Kenya – which had the highest *increase* in under-five mortality in the period Save the Children examined – is an example of how not to allocate public resources if equitable progress is going to be achieved. The wealthiest fifth of the population claim *twice* as much public spending for health as the poorest fifth of the population.[113]

Countries that are making weak progress against MDG 4 tend not only to spend inequitably within the health budget, but also under-invest in public health overall. Public health expenditure accounted for 2.6% of GDP on average in category 1 countries between 2001 and 2005, compared to 1.9% of GDP in category 4 countries. Some of the countries with very high burdens of under-five deaths commit even less funding. Over the same period, public health spending averaged 0.9% of GDP in India, 0.5% in Pakistan and 0.8% in the Democratic Republic of Congo.[114]

Lesson 4 – the need for governments to be transparent and accountable

Budget allocations do not, by themselves, ensure that resources will reach the worst-off children. Save the Children's analysis has shown that countries making slow or no progress on MDG 4 are also characterised by weak public expenditure management – from budget preparation and execution to reporting and legislative oversight. This reduces further the already scarce resources available for spending on social benefits (such as free healthcare and improved nutrition), the timeliness with which those resources are delivered, and the extent to which resources are distributed equitably.

Kenya, which is one of the few countries to have seen *increases* in child mortality in the period we studied, is a case in point. According to an assessment by the World Bank,[115] lack of transparency in Kenya's budget makes it impossible to discern provincial budget allocations. The lack of proper accountability mechanisms at the health facility level has contributed to widespread abuses and inconsistencies in the application of programmes that are meant to benefit the poor, with actual benefits often being captured by better-off households.[116] Cameroon, which has also gone backwards against MDG 4, illustrates the problem of breaks between budget allocation and actual resource transfers to frontline services (see Cameroon case study overleaf).

The correlation between transparency and accountability and progress on MDG 4 can be illustrated with the 2008 Open Budget Index.[117] The record of budget transparency in most category 4 and 5 countries is extremely poor. The 11 countries in these two categories that were included in the Index have an average overall score of 21% in terms of budget openness.[118] Category 1 countries that are making equitable progress towards MDG 4, on the other hand, scored an average of 38%.[119] The lack of budget transparency in many countries that are off track towards MDG 4 makes it especially difficult for citizens to hold their governments accountable for the management of public money, thereby creating opportunities for governments to hide unpopular and wasteful policies; this ultimately reduces the resources available to tackle under-five mortality and to fight poverty.

A lack of transparency and accountability can also fuel corruption, with particularly damaging consequences for children in poverty, who are often reliant on essential services, have limited recourse, and usually do not have the power to hold government to account. Where corruption means that allocated resources are not spent for their stated purpose, the effect can often be

CASE STUDY: BREAKS IN THE CHAIN BETWEEN BUDGET ALLOCATION AND SOCIAL SERVICES – THE CASE OF CAMEROON

In Cameroon, weak public financial management creates several breaks in the chain from budget approval to actual spending in health services. These include:

- *Delays in execution of the budget:* Budget execution is cumbersome, with numerous agencies – often with unclear and overlapping mandates – involved in administrative control. The number of approvals required for a single expenditure, from commitment to payment, is estimated to be 22.
- *Low execution rates for social priority sectors:* The rate at which budget commitments get turned into disbursements is lower for priority sectors than other sectors, including sovereignty, defence and general administration. High budget allocations therefore do not necessarily translate to high levels of spending.
- *Weak oversight of budget and poor audit capacity:* Cameroon's parliament has neither the capacity nor the information required to adequately fulfil its mandate to control and provide oversight of government expenditure. For example, parliament is provided with a huge volume of documents and very limited time to discuss and adopt the budget bill. The independence of Cameroon's Supreme Audit Institution (SAI) is also severely limited. The head of the SAI may be removed by the executive without the final consent of the judiciary or legislature. In addition, the SAI has almost no discretion to decide which audits to undertake.
- *Ministers have discretion to change the composition of the budget:* Ministers are accountable only to the President and are therefore very powerful within their ministries. Ministers can shift resources between activities and even into activities that may not be in the budget approved by the legislature.
- *Lack of formal processes for the prioritisation of the budget according to nationally agreed development policy framework:* Cameroon's poverty reduction strategy (PRS), developed in 2003 through a wide consultative process, identified a number of development priorities, including good governance and diversification and growth of the economy and related social policies deemed necessary for Cameroon to achieve the MDGs. But the PRS has not been used as a credible policy framework to anchor the national budget.
- *Lack of transparency:* Cameroon's score on the Open Budget Index shows that the public is given scant information on the central government's budget and financial activities. This makes it very difficult for citizens to hold government accountable for its management of public money.[120]

Sources: World Bank, *Cameroon Public Expenditure Management and Financial Accountability Review*, Open Budget Initiative: Country Summary (Cameroon), 2006

that the poorest households are required to pay disproportionately to secure access to services.[121]

In general terms, corruption in the health sector takes three main forms: mismanagement and embezzlement of funds, including in procurement; the distribution of medical supplies, which can be counterfeited, out of date, or diverted; and in illicit payments to health workers by patients.[122] As the case study below shows, Chad – which has seen an increase in child mortality – presents a vivid illustration of the devastating effects that corruption and mismanagement of health spending can have on poor households' access to healthcare.

CASE STUDY: LEAKAGES IN HEALTH SPENDING IN CHAD

The case of Chad graphically illustrates the impact of leaky financial management on frontline health services. Despite a 24% increase in the health budget in 2003, building on significant growth of health spending in the past decade, the incidence of malaria, diarrhoea, respiratory infections, parasites, meningitis and cholera has remained high.

Part of the problem is that most of the funding allocated to the regional level never reaches its intended destination. A 2004 World Bank study found that regional delegations receive about one quarter of the material and financial resources that are officially allocated to them, with regional and district administration capturing most of the remainder. In 2004, primary health centres received less than 1% of the Ministry of Health budget officially allocated to the regions.

As a result, although the government officially allocates 680 CFAF ($1.17) in health expenditures for the average Chadian, people actually receive less than 10 CFAF ($0.02). Because of this massive leakage, government transfers account for only 2% of health centres' revenues (excluding salaries) and for one-quarter of their revenues when salaries are included. User fees have become the single most important source of financing for primary health centres, as health workers respond to the shortage of resources by increasing the prices they charge patients for drugs, effectively barring many people from basic healthcare.

A lack of supervision and control of resources and ineffective and arbitrary planning explain much of the gap between stated allocations and actual expenditures. For example, once resources are allocated by the Ministry of Health to regional administrators, those administrators are responsible for allocating resources to the various district heads or health centres in their areas. The Ministry of Health does not provide any guidelines for how to do this.

Source: B Gauthier and W Wane, 'Leakage of public resources in the health sector: an empirical investigation of Chad', *Journal of African Economies*, 18, 1, 2009, pp 52–83

CONCLUSION AND RECOMMENDATIONS

The inequalities in the life chances of children examined in this report are not the result of random chance, but the logical outcome of policy choices. As such, they are deeply inequitable. These inequities are also one of the greatest brakes on progress towards the goal of a two thirds reduction in child mortality by 2015. Justice demands action to narrow global and national disparities in child mortality. But the weight of evidence also recommends it as one of the best routes to getting the world on track to achieve MDG 4.

The good news is that, despite the overall picture of insufficient progress, there are enough examples of countries making rapid and equitable reductions in child mortality to point the international community towards a new set of equity-focused policies. With the world having made just 40% of the necessary progress towards MDG 4, a radical shift of approach is needed. More of the same will not get us to the target. The enormous potential benefits of adopting a more equitable approach to reducing child mortality puts the onus on governments, donors and international institutions to apply the lessons of countries that are combining rapid and equitable improvements in child survival.

When world leaders gather in New York for the MDG review summit in September 2010, a Global Strategy for maternal and child health will be put on the table by the UN Secretary General. This action plan reflects a recognition both of the urgent need to address MDGs 4 and 5 together, and of the fact that these two goals are the furthest off track of the eight MDGs. To have a lasting and significant impact on child mortality, the action plan must catalyse policy change and implementation at the national level, especially in those 68 Countdown to 2015 countries that are off track on MDG 4 or have a high burden of child death. It must be backed by new resources from developing countries and donors, and monitored through a robust accountability framework.

But the action plan risks being thwarted in its aims unless it puts equity at the front and centre of its efforts. This should happen as a point of principle. Achieving the MDGs in the aggregate while leaving the poorest people behind may comply with the letter of the goals, but not their spirit. At the same time, countries that have taken an equity-blind approach to the goals have also tended to make slower progress towards the goals, and in the worst cases have gone backwards. In contrast, the experience of countries such as Mozambique, Indonesia, Bolivia and Ghana highlights four key policy lessons explored in this report. These demonstrate the need for:

- a **comprehensive approach** to child mortality, which tackles inequities in the underlying social determinants of child health.
- a commitment to providing **universal access** to a minimum set of essential services, rather than solely targeting disadvantaged groups
- a strong political commitment to making equitable progress towards MDG 4, reflected in a more **equitable distribution** of public resources for child survival
- government **transparency and accountability**, which can help generate public demand for equitable action on child mortality and ensure commitments are met.

Using the UN Convention on the Rights of the Child and other human rights conventions to place equity at the heart of public policy can help to ensure that all of these dimensions are covered in national plans. These same principles must also be applied beyond the Global Strategy for Women's and Children's Health, to the wider MDG agenda. Agreement on three specific measures in New York will help to make both faster and more equitable progress towards MDG 4.

Localising MDG 4
Governments, donors and international institutions must commit to achieving the MDGs for all income groups and in every community, and take the necessary policy steps to achieve this objective.

Monitoring progress against equity objectives
Governments, donors and international institutions must start to gather and report routinely on MDG progress disaggregated by wealth, gender and other locally relevant sources of inequity. Donors will need to provide both capacity building and funding to enable countries to strengthen their data in this way.

Fostering demand for action on equity
The UN institutions, working with civil society, can actively support popular demand for more equitable progress towards the goals, and ensure that the needs and priorities of the poorest and most vulnerable children and their families are emphasised in policy debates and decisions.

There is still time not only to accelerate progress towards the MDGs before 2015, but to make changes to the way we think about the goals by bringing concerns about equity and justice to the fore. In doing so, we can ensure that we stay true to the original spirit of the Millennium Declaration, unlock faster and more sustainable progress, and ensure that millions of the poorest and most vulnerable children are given a fair chance at life.

APPENDIX 1

COUNTRIES BY PROGRESS ON CHILD MORTALITY RATE AND INEQUITY

	Under-five mortality rate (Poorest 20%)	Under-five mortality rate (Richest 20%)	Overall U5MR	Ratio of the U5MR between the richest 20% and poorest 20% (relative gap)	Change in the U5MR (%)	Change in the relative gap (%)	Average annual change in U5MR (%)	Average annual change in relative gap (%)
1: Equitable progress								
Ghana 2008	103.1	59.9	84.8	1.7	-36.1	-17.4	-2.95	-1.26
Ghana 1993	156.2	75	132.8	2.1				
Mozambique 2003	196.2	108.1	178.2	1.8	-18.5	-5.4	-3.36	-0.93
Mozambique 1997	277.5	144.6	218.7	1.9				
Niger 2006	206.1	156.7	217.7	1.3	-28.1	-14.3	-4.03	-1.90
Niger 1998	281.8	183.7	302.6	1.5				
Egypt 2008	49	18.9	33.4	2.6	-65.2	-31.1	-7.79	-2.83
Egypt 1995	147.2	39.1	95.9	3.8				
Indonesia 2007	77.3	31.8	51	2.4	-27.8	-34.9	-3.20	-4.20
Indonesia 1997	109	29.2	70.6	3.7				
Bolivia 2003	119.2	37.1	92.7	3.2	-29.8	-3.8	-3.86	-0.43
Bolivia 1994	176.3	52.8	132.1	3.3				
Zambia 2007	123.8	110.2	136.8	1.1	-28.8	-28.2	-3.04	-2.97
Zambia 1996	212.3	135.6	192.1	1.6				
2: Equity-neutral progress								
Bangladesh 2007	86.3	43.3	73.9	2.0	-50.6	4.4	-5.29	0.33
Bangladesh 1993–94	185.7	97.3	149.7	1.9				
Morocco 2003–04	77.6	26.1	53.6	3.0	-36.1	4.4	-3.67	0.36
Morocco 1992	111.6	39.2	83.9	2.8				
Eritrea 2002	99.6	65	107	1.5	-29.8	4.2	-4.94	0.59
Eritrea 1995	152.2	103.5	152.5	1.5				
3: Inequitable progress								
Malawi 2004	183	111.2	157.6	1.6	-34.3	12.1	-3.43	0.96
Malawi 1992	253.1	172.4	239.7	1.5				
Nepal 2006	98.1	46.7	79.1	2.1	-43.2	11.1	-5.50	1.06
Nepal 1996	156.3	82.7	139.2	1.9				
Ethiopia 2005	130	92	132	1.4	-29.7	30.6	-6.81	5.48
Ethiopia 2000	159.2	147.1	187.8	1.1				
Madagascar 2003–04	141.8	49.4	111.3	2.9	-32.1	49.3	-5.38	5.89
Madagascar 1997	195	101.4	163.9	1.9				
Peru 2000	92.6	17.6	60.4	5.3	-34.0	17.4	-5.06	2.03
Peru 1991–92	136.2	30.4	91.5	4.5				
Philippines 2008	58.5	17.1	37.3	3.4	-32.1	25.2	-3.79	2.27
Philippines 1998	79.8	29.2	54.9	2.7				
Haiti 2005–06	125	54.9	102.3	2.3	-27.2	47.2	-2.85	3.58
Haiti 1994–95	163.3	105.6	140.6	1.5				

	Under-five mortality rate (Poorest 20%)	Under-five mortality rate (Richest 20%)	Overall U5MR	Ratio of the U5MR between the richest 20% and poorest 20% (relative gap)	Change in the U5MR (%)	Change in the relative gap (%)	Average annual change in U5MR (%)	Average annual change in relative gap (%)
4: Slow reduction								
India 2005–06	117.6	39.4	85.3	3.0	-28.2	4.8	-2.52	0.36
India 1992–93	154.7	54.3	118.8	2.8				
Benin 2001	198.2	93.1	162.7	2.1	-11.5	12.5	-2.42	2.39
Benin 1996	208.3	110.1	183.9	1.9				
Burkina Faso 2003	206.3	144.1	193.2	1.4	-5.5	12.8	-0.57	1.21
Burkina Faso 1993	199.1	156.9	204.5	1.3				
Cambodia 2005	127.1	43	106.3	3.0	-12.6	21.4	-2.65	3.96
Cambodia 2000	154.8	63.6	121.6	2.4				
Guinea 2005	216.7	112.8	187.8	1.9	-3.7	11.1	-0.63	1.78
Guinea 1999	229.9	133	195.1	1.7				
Mali 2006	233.3	123.6	214.8	1.9	-14.8	7.1	-1.59	0.69
Mali 1995–96	297.9	169.1	252.2	1.8				
Nigeria 2008	218.5	87.4	171	2.5	-10.6	25	-0.62	1.25
Nigeria 1990	239.6	119.8	191.3	2				
Senegal 2008–09	142.5	56	99.6	2.5	-28.6	-2.2	-2.76	-0.18
Senegal 1997	181	69.6	139.4	2.6				
Tanzania 2004–05	137.3	93.3	132.2	1.5	-8.7	2.4	-0.70	0.18
Tanzania 1996	140.1	97.5	144.8	1.4				
Zimbabwe 2005–06	71.9	56.7	69.3	1.3	-8.7	-15.5	-0.76	-1.39
Zimbabwe 1994	84.5	56.3	75.9	1.5				
Pakistan 2006–07	120.8	60	93.3	2.0	-22.5	19.3	-1.58	1.11
Pakistan 1990–91	124.5	73.8	120.4	1.7				
5: Worsening								
Cameroon 2004	188.7	87.6	147.6	2.2	2.5	-12.3	0.19	-1.01
Cameroon 1991	200.7	81.7	144	2.5				
Chad 2004	176	186.5	202.5	0.9	0.7	-4.9	0.10	-0.71
Chad 1996–97	170.6	172	201.1	1.0				
Kenya 2003	148.9	91.1	112.7	1.6	20.9	-21.8	1.92	-2.42
Kenya 1993	129.3	61.9	93.2	2.1				
Rwanda 2005	211.1	121.7	182.3	1.7	12.1	64.0	0.96	4.21
Rwanda 1992	144.4	136.5	162.6	1.1				
Average							-2.77	0.61

1: Equitable progress – Reduction of more than/equal to average yearly change in U5M (-2.77% per year) and any decrease in the relative gap

2: Equity-neutral progress – Reduction of more than/equal to average yearly change in U5M (-2.77% per year) and increase in the relative gap of less than or equal to 0.61% per year

3: Inequitable progress – Reduction of more than/equal to average yearly change in U5M (-2.77% per year) and increase in the relative gap of more than 0.61% per year

4: Slow reduction – Less reduction than average yearly change in U5M (-2.77% per year) and any change in the relative gap (i.e. increase or decrease)

5: Worsening – Increase in yearly average of U5M and any change in the relative gap (i.e. increase or decrease)

ENDNOTES

Introduction

[1] Save the Children analysis based on data from UNICEF, *The State of the World's Children 2010*

[2] Statement by Ban Ki-moon at the 2008 G8 Summit, see UNFPA, 'G-8 Commitment to Maternal and Reproductive Health is a Welcome Boost to Poor Women Worldwide, says UNFPA', press release 9 July 2008

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[20] Based on the UCDP/PRIO Armed Conflict Dataset, taking all of the Countdown to 2015 countries that have experienced armed conflict between 1990 and 2008 (latest data available)

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2 Why equity matters in tackling child mortality

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3 How to make equitable progress on child survival – four key lessons

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[102] See note 101.

[103] Based on a list of 29 countries made up of those countries that appeared on at least three of five externally-generated lists of fragile and failed states between 2005 and 2007: Top 32 countries in the Failed States Index (The Fund for Peace); DFID Proxy List of Fragile States; Bottom Quintile of the Index of State Weakness (Brookings Institution); World Bank List of Fragile States; and CIFP Top 40 Fragile States

[104] Based on the UCDP/PRIO Armed Conflict Dataset, counting those of our Category 4 and 5 countries that experienced armed conflict between 1990 and 2008 (latest data available)

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[110] For example, the UNGA side event 'Healthy women, healthy children', held in 2009, elicited commitments from major donors, including the World Bank and DFID, to making primary healthcare free at the point of use. The EU has issued clear Council conclusions to this effect.

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[113] World Bank, *Kenya Poverty and Inequality Assessment: Volume I: Synthesis Report*, Report No. 44190-KE, 2008

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[116] See note 115.

[117] The Open Budget Index is put together by the International Budget Project (IBP), as part of the Open Budget Initiative. The index is based on a comprehensive analysis and survey that evaluates whether governments give the public access to budget information and opportunities to participate in the budget process at the national level. The IBP works with civil society partners in 85 countries to collect the data for the Survey.

[118] The countries included in categories 4 and 5 that are included in the Open Budget Index 2008 survey are: India, Burkina Faso, Cambodia, Nigeria, Senegal, Tanzania, Pakistan, Cameroon, Chad, Rwanda and Kenya.

[119] The countries in category 1 for which information was available within the Open Budget Index 2008 were: Ghana, Niger, Egypt, Indonesia, Bolivia, and Zambia.

[120] Open Budget Index, *Open Budget Index 2008 Rankings*, http://openbudgetindex.org/files/Rankings2008-Revised.pdf (accessed 26.7.10)

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A FAIR CHANCE AT LIFE

WHY EQUITY MATTERS FOR CHILD MORTALITY

A SAVE THE CHILDREN REPORT FOR THE 2010 SUMMIT ON THE MILLENNIUM DEVELOPMENT GOALS

In September 2010 world leaders have a make-or-break opportunity to agree the steps needed to accelerate reductions in child mortality – and achieve Millennium Development Goal 4 (MDG 4) by 2015. *A Fair Chance at Life* argues powerfully that equity must be placed at the heart of efforts to tackle child mortality.

This new research compares the mortality rates of poor children and rich children in 32 countries. It then categorises countries according to their progress – or lack of it – in reducing inequity in child mortality.

In many countries that are successfully reducing child mortality, progress is concentrated among the poorest and most disadvantaged children. Conversely, in countries making slow or no progress towards MDG 4, disparities in life chances between children from the poorest and richest backgrounds tend to be extreme.

The evidence is clear. Prioritising poor children is one of the surest ways to make the progress towards MDG 4 that is so urgently needed. This report identifies four key lessons for policy-makers in developing countries, and highlights what the international community must do to put equity front and centre in efforts to cut child mortality.

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