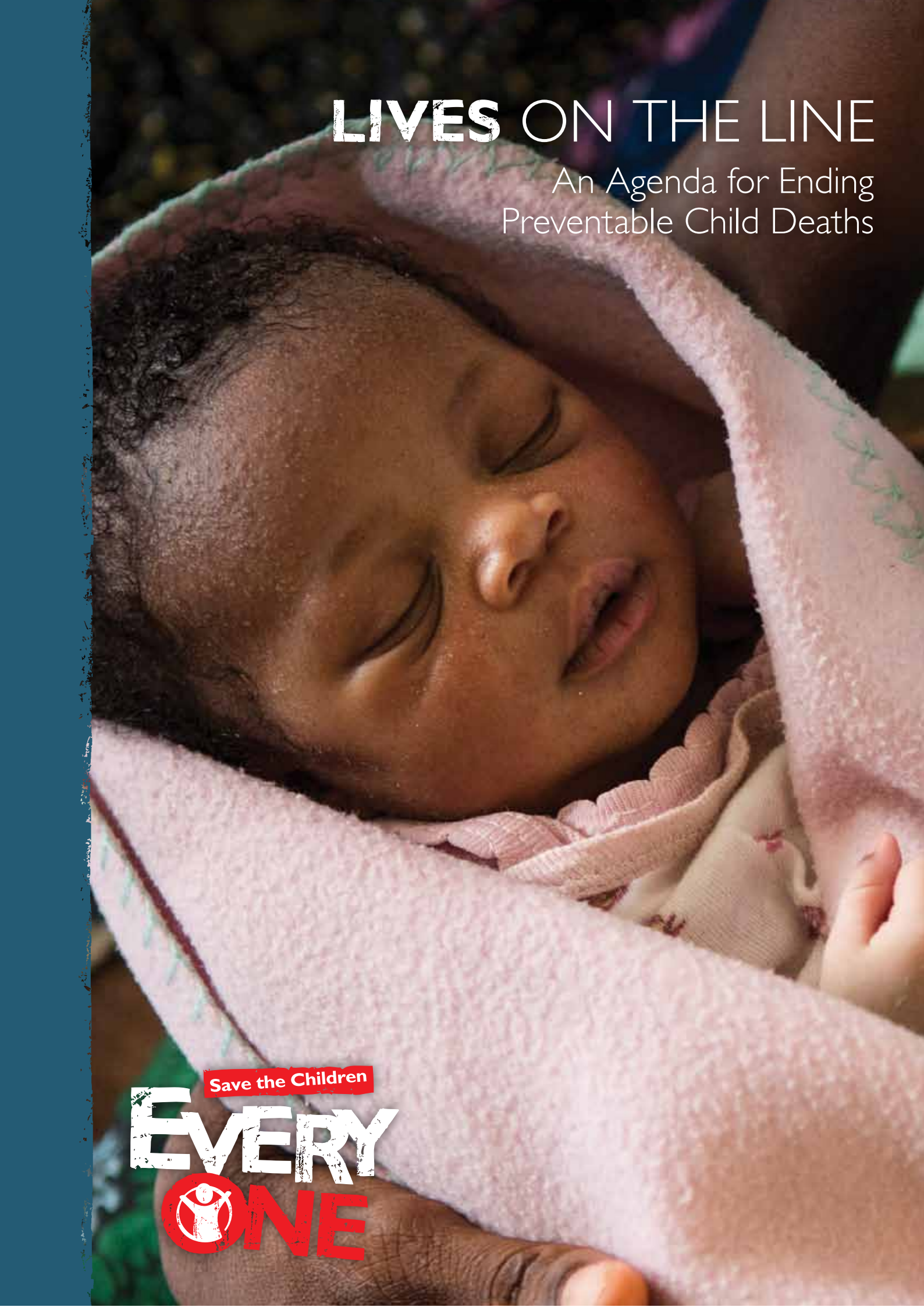

LIVES ON THE LINE

An Agenda for Ending Preventable Child Deaths

Save the Children

EVERY ONE

Cover photo: Babygirl, twenty one, sat with her three day old baby Margaret on her bed in a new Maternal Waiting Home built by Save the Children at Worhn clinic, Margibi county, Liberia. Pregnant women and mothers in rural areas have to walk up to eight hours to reach the nearest health clinic. The Maternal Waiting Home provides pregnant women with a place to stay at the clinic in their final week before delivery to ensure they get the proper professional care they need.
(Photo: Jonathan Hyams/Save the Children)

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Save the Children works in more than 120 countries.
We save children's lives. We fight for their rights.
We help them fulfil their potential.

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PHOTO: AMERTI LEMMA/SAVE THE CHILDREN

FOREWORD

In the last two years, there has been a profound change amongst people and organisations working to achieve the UN Millennium Development Goal of a two-thirds reduction in child mortality. In my role, I have the privilege of meeting with some of the diverse people working on this challenge—from frontline health workers to civil society campaigners, and private sector CEOs to heads of UN agencies. When the MDGs were adopted in 2000, the child survival community hoped for change. Today, we know that change is possible. The scale of ambition has shifted: we can end preventable child deaths within a generation.

Recent progress in saving children's lives is unprecedented. Mortality has halved since 1990, and in the last decade the rate of reduction has surged. Some of the poorest countries, such as Ethiopia and Niger, are on track to achieve the child mortality MDG by 2015. The goals have brought a focus and visibility to national and global efforts to improve child health and nutrition. New partnerships have marshalled evidence of what works, spurred policy change and mobilised resources. By working together, we have achieved far more than we could have done individually. But we know that the MDGs have started the job, rather than finished it. As a child rights organisation we cannot be satisfied with a two-thirds reduction in saving lives. Every child has the right to survive, no matter where, or to whom they are born. That is why we're joining the call for an end to preventable child deaths by 2030, and are campaigning to have this adopted as an explicit target in the UN post-2015 framework.

Earlier this year, on a visit to the Democratic Republic of Congo, I encountered this challenge at first hand. The country accounts for 6% of the world's under-five deaths, and has made less than a quarter of the progress needed to achieve the child mortality MDG. In the province of Kasai Oriental, I met heroic midwives in dilapidated health facilities battling against the odds to help mothers give birth safely. I also saw some of the barriers to progress—from a lack of essential equipment and frontline health workers to poverty and crumbling infrastructure. If we want to end preventable child deaths, we have to make it happen in places like Kasai Oriental.

This report will kick-start the final phase of our priority global campaign, EVERY ONE, which will take us to the MDG deadline of 2015. With just 800 days left before the target, we want to generate a renewed sense of urgency and ensure that governments, international institutions, business and civil society redouble their efforts to achieve the child mortality goal. If we can do this then we will know that something really has changed. We will have built the foundation for a world in which every child's potential can be fulfilled.

—Jasmine Whitbread, CEO Save the Children International

Fatuma, 20, in her family hut with her son Mohammed, 7 months. Mohammed was sick and weak and taken to the nearby OTP (Out Patient Therapeutic Programme) located in the Wuha Limat village in the Afar region. Fatuma was given high nutrient peanut paste that lasts one week for her son as well as amoxicillin syrup for his cold.

PHOTO: JANE HAHN FOR SAVE THE CHILDREN

EXECUTIVE SUMMARY

In 2000, the world adopted a series of bold and ambitious goals–the United Nations Millennium Development Goals (MDGs)–including commitments to cut poverty by half, get every child into school, and dramatically reduce child and maternal deaths by 2015. With two years to go before the target date, extraordinary progress has been made towards achieving the MDGs. Today, millions fewer people live in extreme poverty than a generation ago, most children complete a primary education, and hunger has been cut by over a third. Perhaps the single most powerful testament of progress is the fact that there are 90 million people living today whose lives would have been cut short, had child mortality rates remained at 1990 levels, the baseline year for the goals.

Recent improvements in child health have been remarkable. Twenty-five countries have already met the goal of a two-thirds reduction in child mortality rates by 2015, including many of the poorest, high-burden countries such as Bangladesh, Ethiopia, Liberia, Malawi, Nepal and Tanzania. For many other countries, including Cambodia, Guinea, Mozambique, Niger and Rwanda, achieving the goal in the remaining period is within their grasp.[1] Many middle-income countries, from Brazil to China, have already reduced child mortality to below 2 percent or 20 births per 1,000, which is the threshold for ending preventable child deaths.[2]

These gains are unprecedented. In 1960, Africa's child mortality rate was 27 percent, today it is less than 10 percent.[3] Moreover, this progress is accelerating. Sub-Saharan Africa has reduced child mortality since 2005 at five times the rate it achieved from 1990 to 1995.[4] Even in countries that are lagging behind the MDG4 target, especially those in West and Central Africa, mortality rates have been reduced by 40 percent since 1990.[5] For the first time in history, there is a realistic prospect of ending preventable child deaths within a generation.

Yet while these gains demonstrate that progress is possible, even in the poorest countries, there is no room for complacency. Each day, 18,000 children under the age of 5 years die from preventable causes, and since 1990, 216 million children have died in developing countries.[6] Reductions in newborn mortality rates continue to lag behind overall reductions in child mortality.

The world as a whole remains off-track towards meeting the fourth Millennium Development Goal of a two-thirds reduction in child mortality by 2015, and an intensified global push is needed now to maximize progress in the period up to the target date. As governments and United Nations institutions work towards agreeing on a post-2015 framework, it is equally imperative that they commit explicitly to completing the job started by the MDGs, by adopting a target to end preventable child deaths.

Opposite: Tutu Girl, four, is suffering from malnourishment and is being treated at Wohrn health Clinic with RFU (high nutrient peanut paste). Her mother told us about how Save the Children was teaching her to add a simple but nutritious seed (Benniseed) to every meal in order to add nutritional value.

Future progress in reducing child deaths will require new and different strategies from those used to get the world to this point. In many countries that are on track towards achieving the child mortality target, or that have made significant gains, there is a risk that progress will not be sustained unless there is a shift in approach, supported by adequate investment and political commitment over an extended period.

The extraordinary reductions in mortality rates have re-shaped the child mortality challenge in two key ways. Firstly, as mortality rates have been cut, the proportion of child deaths in the first month after birth—the newborn period—is increasing. Currently, in 2013, the child mortality rate among newborn babies stands at 44 percent, up from 37 percent in 1990.[7] Reducing the newborn mortality rate will require a massive increase in care for mothers and babies as part of a drive to achieve universal health coverage for all children and their families.

Secondly, child mortality is increasingly concentrated in particular regions and among the poorest and most structurally disadvantaged groups, including remote rural populations and urban slum dwellers. Whereas in 1990 West and Central Africa accounted for 17 percent of child mortality, in 2013 that figure has risen to 30 percent in the region, much of it in conflict-affected and fragile states. Africa and South Asia now account for 80 percent of all child deaths globally.[8] Within these regions, many more children are dying in poor households than in rich ones, with inequalities actually increasing in Africa in the 13 years since the MDGs were adopted. Reducing child mortality will depend on strategies to improve equity, including removing barriers to health and nutrition for the poorest families and expanding access to health care in contexts where state capacity is weak and conflict and insecurity is widespread.

While progress has presented new challenges, one persistently tough challenge that also requires stepped up attention is malnutrition. Progress in reducing malnutrition, an underlying cause of 45 percent of child deaths, remains stagnant and threatens to jeopardize overall progress. Stunting, which is caused by chronic malnutrition, has been cut by just one-third since 1990.[9]

An intensified global effort to sustain progress and complete the unfinished business of the MDGs will require increased resources focused on all these challenges. At the moment, many of the countries with a high burden of child mortality are under-investing in health and nutrition, and failing to deliver against existing commitments. Increased funding for essential health care and nutrition needs to be matched by adequate investment in health workers, without whom many key interventions cannot be delivered. It is estimated that 46 million women give birth each year without the support of a skilled health worker, and 57 countries fall below the World Health Organization's recommended minimum ratio of 23 doctors, nurses and midwives for every 10,000 people.[10]

PHOTO: AUBREY WADE/SAVE THE CHILDREN

Newborn baby Grace, six-months-old, sleeps while her mother, Agnes, arranges around her a new mosquito net in Malamu, Liberia. Malamu is one of Kingsville's neighbouring communities where one in nine children die before they're five. A dirty water supply threatens lives and an under equipped clinic makes treatable diseases deadly.

However, the experience of countries that have made major inroads into child mortality demonstrates that resources alone are not enough. There is new and compelling evidence that catalyzing action often plays a critical role. For example, a *Lancet* analysis of high-impact nutrition interventions helped to lay the foundation for commitments to prevent 20 million cases of stunting and to double the aid for nutrition at this year's *Nutrition for Growth* conference. An enabling environment for change usually underpins evidence of progress towards MDG4. This includes high-level political champions taking action in response to public demand led by civil society organizations including NGOs, religious groups and professional associations. The experience of Sierra Leone, where a popular mobilization helped secure a commitment to free health care for mothers and children in 2010, is a case in point.

Finally, progress often rests on broad based partnerships. Child mortality is not simply a health challenge, but also a political, economic and social challenge. Reducing child mortality rates requires broad coalitions for change that marshal knowledge, resources, political commitment and accountability for results. This was the insight that drove the creation of the UN Secretary General's strategy for women's and children's health, *Every Woman, Every Child*, in 2010. New and innovative partnerships at global, national and local levels are needed to build an unstoppable movement in every country and community where children continue to die from preventable causes.

The Save the Children global campaign, EVERY ONE, is one part of that wider movement for change. It is rooted in our experience of working to protect and promote children's health and nutrition, over 90 years and in more than 100 countries, and in the partnerships we have forged. We believe that this can be the generation to end preventable child deaths, and ensure that every child's right to survive is realized, no matter where they are born. This report sets out that agenda.

By the end of 2015 governments, actively supported by other stakeholders and donors, should publicly take the following four steps to end preventable child deaths:

1. Publish and implement comprehensive, costed national health plans in high-burden countries that respond to the key causes of child mortality and ensure quality essential health care for every child and mother. The plans must include:
   - The proven interventions and care needed for newborns to survive the crucial first month of life;
   - Programmes to reach every child with routine immunization and plans to include pneumococcal and rotavirus vaccines in routine coverage;
   - A properly trained, supported and equipped health worker in reach of every child and every birth attended by a skilled birth attendant;
   - Investment in direct nutritional interventions to tackle stunting and micronutrient deficiency.
2. Launch a national campaign in every high-burden country to reduce stunting, make sure every child has access to a nutritious diet and that this is an aim of social and agricultural policies and programmes, and ensure access to safe water and sanitation.
3. Publicly commit the levels of public spending required to guarantee equal access to essential health care for all children, no matter where they are born, linked to a transparent process whereby civil society can actively track budgets and spending.
4. Commit to ending preventable child deaths and health care for all in the post-2015 agenda, as part of a single framework that includes a robust accountability framework.

INTRODUCTION

Today, in a district clinic in the town of Jinja in Uganda, Florence, a midwife, is using simple procedures and resuscitation equipment to save the lives of newborn babies every day. With the right equipment and the right training Florence can save many more lives.

The challenge facing Uganda, and many other low-income countries, is that there are not enough Florences. Late last year the Ugandan Parliamentary Committee on Health declared "a crisis in human resources for health". The country employs around half the health workforce it needs.[11]

Trained health workers employed in the system often face long hours and work without the right equipment in dilapidated facilities. For millions of people, access to quality health care remains a distant dream and pregnant mothers still often turn to traditional birth attendants to help deliver their babies. In Uganda and around the world, a lack of access to quality health care is made worse by the challenge of malnutrition, which increases vulnerability to disease and has long term effects on children's ability to grow and develop.

The loss of life of mothers and children is a daily tragedy for thousands of families but this does not make the headlines.

Around the world, millions of people have a story to tell about a family member, relative or friend who has died in childbirth, or a baby's life that should never have been lost. These stories take us beyond the statistics, and show the need for a sustained campaign, building the case for investing in health care and nutrition for every child—no matter where they live or to whom they are born.

So where do we start? We need more health workers on the frontline, trained and equipped to save lives. We also need champions for child survival, in governments and parliaments, in the media, in academia, business and civil society, who can help drive decisions and implementation. We need a movement that can support those advocates and create a climate of expectation and accountability. We need the solid evidence of what works to make the case and inspire action. And we need to continue to communicate the real progress that can be made, and is being made, around the world to save children's lives.

Uganda has a bold vision of becoming a prosperous country by 2030. A healthy mother and a healthy child are the very bedrock of a productive society. Safely delivered children, healthy mothers, protection from disease and adequate nutrition all add up to a healthy population that can drive this vision. Like many countries in Africa, Uganda has already made impressive inroads into child mortality, reducing it by more than 60 percent since

1990. Yet the job is far from complete—in 2012, over 100,000 children in Uganda, and 6.6 million around the world, died from preventable causes.[12]

In 2009, Save the Children launched its most ambitious global campaign, EVERY ONE, to catalyse accelerated progress towards the fourth United Nations Millennium Development Goal, a two-thirds reduction in child mortality. With two years remaining to the MDGs target date of 2015, this campaign report takes stock of the progress the world has made towards the Goal, and identifies the steps needed to finish the job the MDGs have started.

Despite an unprecedented level of political attention, and dramatic overall reductions in child mortality, three major challenges stand out. Firstly, as mortality levels fall, a growing share of the remaining burden of deaths occurs during the first month of life, when a child is most vulnerable.

Secondly, reductions in mortality have not been shared equally, so that the challenge is increasingly concentrated amongst children in hard to reach settings, and amongst disadvantaged groups. In a special interview at the end of this report Kul Gautam, former UNICEF officer responsible for drafting the Declaration and Plan of Action of the 1990 World Summit for Children, says, "In public health, as in other basic services, it is often easier to reach the first 50 percent of the population than the last 10 percent. That is because many of the 'low-hanging fruits' are plucked first and we are left with the hardest-to-reach populations."

Finally, malnutrition remains a persistent challenge. Unless the world addresses the need for more and better newborn health care, and removes the barriers preventing the poorest children from getting access to essential health services and adequate nutrition, the recent progress towards MDG 4 will not be sustained.

In this report, we present a new ranking of countries. It is based not only on how quickly they are making progress towards achieving MDG4, but also on the extent to which progress is equitable and sustainable. This "triple bottom line" demonstrates that many countries that have achieved major reductions in child mortality will need to shift their strategies going forward in order to continue building on the gains they have already made. We also include a series of more detailed case studies of trends within high burden countries—Afghanistan, Bangladesh, Ethiopia, India, Indonesia, Kenya, Nigeria, Pakistan and Sierra Leone—that tell the story of how policy and political choices have driven reductions in child mortality. This report goes on to recommend the steps needed to end preventable child deaths, drawing on the experience of countries that have already reached this target, or are on a trajectory to achieve it.

PHOTO: SAVE THE CHILDREN

CHILD SURVIVAL: PROGRESS AND CHALLENGES

In 2009, Save the Children's EVERY ONE campaign was launched with a report calling for "the next revolution" to realise children's rights to health and to massively reduce child mortality. The report emphasized the need to finish the job started by James Grant, UNICEF's visionary executive director, who catalyzed the first child survival revolution that began in the early 1980s.

The world has taken dramatic strides towards turning this vision into reality. In 1990, over 12 million children died each year before their fifth birthday. Today, even though the world population has since grown by more than 1.5 billion, the number of child deaths each year is 6.6 million. This means that each day, 17,000 fewer children die than in 1990.[13]

Put in a historical context, these gains are extraordinary. In 1900, infant mortality in Europe was higher than it is today in Sierra Leone. Even in 1960, more than one quarter of children in Africa died before the age of five.[14] Today, that has been reduced to less than 10 percent. Many middle-income countries have now reduced mortality to below 2 percent, or 20 deaths per 1,000 births—defined as the threshold for ending preventable child deaths. In 1990, Brazil had a mortality rate of 62 deaths per 1,000 live births, higher than India's current rate. In a generation, it has lowered child mortality by more than three-quarters, to 14 deaths per 1,000.[15]

Progress has been uneven, both between and within countries. Nonetheless, there have been substantial reductions in every part of the world. Even in West and Central Africa, the region that has lagged furthest behind, child mortality has been cut by almost 40 percent since 1990. In East Asia, Latin America and Eastern Europe and Central Asia, child mortality has been reduced by 60 percent or more while East and Southern Africa and South Asia have more than halved the mortality rate over the MDGs period.[16]

Moreover, this progress is accelerating. Today the world is reducing child mortality at a faster rate than at any point since 1990. Between 1990 and 1995, mortality was cut by an annual average of 1.2 percent. In the last seven years, this rate of reduction has more than tripled, to 3.9 percent. Africa has doubled the rate of reduction over the past decade, compared with the 1990s.[17]

The success of many low-income, high-burden countries shows that there is scope to accelerate progress further. Bangladesh, Bolivia, East Timor, Ethiopia, Liberia, Malawi, Nepal and Tanzania have all reached MDG4 ahead of the 2015 target date. In 1990, all these countries had mortality rates of over 13 percent, and in the case of Liberia, a mortality rate of 25 percent.[18] A further group of countries, including Bolivia, Cambodia, Cape Verde, Eritrea, Niger, Madagascar, Mozambique, Rwanda and Uganda, have reduced child mortality by over 60 percent in the MDG period. In total, 28 of the

Opposite: Dora Luna Galeano, age 28, was trained by Save the Children to serve her community as a brigadista, or volunteer health worker. She is counseling Edixia de los Angeles Lopéz Bravo, age 21, about how to care for her daughter, 21-month-old Jannea Criceyda Lopéz.

75 high burden "Countdown"[19] countries—which together account for 98 percent of child mortality—are on track to achieve the goal, and only one country, Zimbabwe, has seen mortality rates rise in the period.[20]

Behind this progress lie some major changes in the causes of child mortality. Pneumonia remains the biggest single killer of children, accounting for 17 percent of all deaths, or 1.1 million children, each year. Diarrhoea remains one of the leading global causes of death among children under 5, accounting for 9 percent of all under-5 deaths—a loss of more than 580,000 child lives in 2012. Since 2000, however, deaths from diarrhoea have more than halved, to 600,000 in 2012, as access to simple oral rehydration salts and zinc, and more recently the rotavirus vaccine has expanded.[21] The reduction in deaths from malaria has been similarly dramatic. While it still accounts for 14 percent of all child deaths in Africa, over 1 million lives have been saved through malaria interventions. Niger is a case in point: in 2013, 64 percent of children sleep under bed nets, up from just 1 percent in 2000. Over the same period, child mortality in Niger has almost halved.[22]

Malnutrition remains the greatest single underlying cause of child mortality, being a factor in almost half of all child deaths, as well as being a major brake on children's physical and mental development. Some 800,000 child deaths each year are linked to poor breastfeeding practice, with children who are exclusively breastfed for the first 6 months being 14 times more likely to survive than children who are not breastfed.[23]

Experience from countries that have made the greatest progress, points to some common lessons. Firstly, there are relatively simple and affordable solutions to the leading causes of child survival. These include routine immunization, oral rehydration, support for exclusive breastfeeding, family planning (to plan and space births), insecticide treated bed nets, and quality maternal care and nutrition during pregnancy, childbirth and the newborn period. Secondly, countries that have delivered health care at the community level and invested in training and equipping frontline health workers have been able to roll out these solutions. For example, Ethiopia's health extension programme, which was launched in 2004 and employs 40,000 health extension workers, has been an important factor in that country's success in expanding coverage of health care interventions, and reducing child mortality.[24]

Finally, countries that have progressed most rapidly towards the goal have also put resources and political commitment behind the goal, with investment in health budgets, and high level monitoring of progress. In Zambia, the government's recently adopted target to prevent a further 100,000 child deaths in the next four years, and the drive in Bangladesh to expand routine immunisation across the country, are cases in point.[25]

Consolidating these gains and building momentum beyond 2015, towards the goal of ending preventable child deaths, will depend on countries investing in health care systems that guarantee essential services for every child and their families. Health outcomes depend on more than just health care, but without strong, fully functioning health systems as a platform for progress, meeting the three major challenges on newborn survival, inequality and malnutrition will be impossible to achieve.

TABLE 1 COUNTRIES WITH HIGH CHILD MORTALITY THAT HAVE MET OR ARE MAKING SIGNIFICANT PROGRESS TOWARD MDG 4.

Country	Percent Reduction in Child Mortality	
Bangladesh	72	MET
Malawi	71	
Nepal	71	
Liberia	70	
United Republic of Tanzania	68	
Timor-Leste	67	
Ethiopia	67	
Bolivia	66	MAKING SIGNIFICANT PROGRESS TOWARD MEETING
Bhutan	66	
Eritrea	65	
Niger	65	
Rwanda	64	
Madagascar	63	
Mozambique	61	
Uganda	61	
South Sudan	59	
Senegal	58	
Guinea	58	
The Gambia	57	
Lao People's Democratic Republic	56	
India	55	
Zambia	54	
Yemen	52	
Myanmar	51	
Benin	50	

*Countries with an under-five mortality rate of 40 or more deaths per 1,000 live births in 2012.

Table is adapted from UNICEF 2013. Committing to Child Survival: A Promise Renewed 2013 Progress Report. Online. http://www.unicef.org/publications/files/APR_Progress_Report_2013_9_Sept_2013.pdf. Accessed September 2013.

CHILD SURVIVAL PROFILE

ETHIOPIA

POPULATION: 93.9 MILLION

EVERY ONE INDEX RANKING:
11 / 34

EVERY ONE INDEX SCORE:
1.92 / 3.0

UNDER 5 MORTALITY SCORE:
1.0 / 1.0

EQUITY SCORE:
0.17 / 1.0

SUSTAINABILITY SCORE:
0.75 / 1.0

Child survival is a national health policy priority in Ethiopia. Under 5 mortality decreased by 53 percent between 2000 and 2012, from 146 to 68 deaths per 1,000 live births, making Ethiopia one of the few countries in Africa to achieve MDG 4 before the deadline.[27] The Government of Ethiopia led the African Leaders Call to Child Survival in January 2013, and also co-hosted the June 2012 Child Survival Call to Action, which galvanized global commitments for child survival. The government has committed to increasing the national nutrition budget by US$15 million annually to 2020,[28] reduce stunting by 20 percent by 2020, and improve governance and coordination.[29]

Ethiopia's Health Sector Development Plan (HSDP) started in 1996/97 and since 2009 Ethiopia has been implementing HSDP IV. The government established the Health Development Army in 2010 to be the key vehicle for achieving the plan's goals. The health plan identifies six priority areas, including a focus on newborn health, and delivering health services to traditionally under-served pastoralist regions. The Government of Ethiopia is implementing community case management, community-based nutrition programmes, and community-based newborn health initiatives to expand access to essential health services, and it launched a revised National Nutrition Programme in June 2013.

ETHIOPIA AND THE EVERY ONE INDEX

Ethiopia ranks fairly high in the EVERY ONE Index, due both to its dramatic progress in reducing child mortality, and a strong score on sustainability. However, if Ethiopia were to be scored just on equity, it would place low in the ranking. Although Ethiopia has achieved MDG 4, many sections of the population continue to experience very high rates of child mortality. Children in the poorest 40 percent of the population are twice as likely to die than children in the top 10 percent, girls are 25 percent more likely to die than boys, and children living in rural areas are 37 percent more likely to die than children living in urban areas.58 Unless the government delivers health services more equitably, mortality among structurally disadvantaged groups will be reduced too slowly, and frustrate progress towards the longer-term goal of ending preventable child deaths.

Sustaining Ethiopia's Progress

Tackling newborn mortality, malnutrition and inequity will be key to sustaining progress in Ethiopia. Newborn deaths decreased from 45.5 per 1,000 live births in 2000 to 29 deaths per 1,000 live births in 2012. Meanwhile, 44.2 percent of children in Ethiopia were stunted in 2011.

CHILD & INFANT MORTALITY TRENDS

Indicator	2012	2000	% change	% of US deaths that are newborns
Under-five mortality (per 1000)	68	146	-53	42
Neonatal mortality (per 1000)	29	45.5	-36	—

SUSTAINABILITY MEASURES

Indicator	2011	2000	% change
Improved Sanitation Facilities (% of population with access)	20.7	8.1	155
Stunting (all children under 5)	44.2	57.4	23
Government Health Expenditure	14.64	8.96	—
Governance	-.40	-.91	—

EQUITY MEASURES

Indicator	2000	2011	% change
Wealth (Top 10% vs. Bottom 40%)	2.49	2.04	—
Gender (Male vs. Female)	1.11	1.25	—
Geography (Urban vs. Rural)	1.30	1.37	—

CHILD SURVIVAL PROFILE

INDONESIA

POPULATION: 251 MILLION

EVERY ONE INDEX RANKING:
3 / 34

EVERY ONE INDEX SCORE:
2.17 / 3.0

UNDER 5 MORTALITY SCORE:
1.0 / 1.0

EQUITY SCORE:
0.67 / 1.0

SUSTAINABILITY SCORE:
0.5 / 1.0

Indonesia's child mortality rate has been reduced by 40 percent over the last decade, while the rate of newborn deaths has fallen by almost a third. The Government of Indonesia has made significant commitments, especially on nutrition within Indonesia's National Medium Term Development Plan, and in the 2011-2015 National Food and Nutrition Action Plan. Indonesia has joined the SUN Movement and committed to reducing stunting in children by 40 percent by 2025.

INDONESIA AND THE EVERY ONE INDEX

The Government of Indonesia is progressing both equitably – inequalities in mortality have narrowed since the late 1990s—and sustainably according to the EVERY ONE Index, which ranks it at 5 out of 75 countries. Indonesia has increased access to basic health services for children and to water and sanitation, and has significantly increased its national budget for health—although at 5 percent of public expenditure it remains low by international standards.

However, disparities persist. In 2007[30], the latest year when data was collected, children in the poorest 20 percent were more than twice as likely to die as children born into the wealthiest 20 percent, while children living in rural areas are almost 60 percent more likely to die before the age of five than children living in urban areas. Equity between boys and girls showed no improvement over that time, with girls still 20 percent more likely to die than boys.

Sustaining Indonesia's Progress

The Government of Indonesia must do more to address inequities, especially gender and regional disparities in order to sustain reductions in child mortality. The presidential election in 2014 will provide opportunities to position child survival on the agendas of the candidates. More high profile champions for child survival are needed at the national level to help drive progress, including in national legislature. Due to the government's decentralized system, stronger civil society campaigning at the sub-national level and commitment of local stakeholders are also critical to catalyze progress on maternal, newborn and child health. Efforts to support exclusive breastfeeding need to be scaled up and national politics need to be effectively implemented. There also needs to be increased efforts to address neonatal mortality which has actually stagnated over the last several years. Latest country level data shows that the neonatal mortality is currently at 19 per 1,000 live births.[31]

CHILD & INFANT MORTALITY TRENDS

Indicator	2012	2000	% change	% of US deaths that are newborns
Under-five mortality (per 1000)	31	52	-40	48
Neonatal mortality (per 1000)	15	22	-32	—

SUSTAINABILITY MEASURES

Indicator	2011	2000	% change
Improved Sanitation Facilities (% of pop with access)	58.7	47.4	24
Stunting (all children under 5)	36.8	41.6	-4
Government Health Expenditure	5.32	4.47	—
Governance	-.24	-.27	—

EQUITY MEASURES

Indicator	1997	2007	% change
Wealth (Top 10% vs. Bottom 40%)	3.71	2.42	—
Gender (Male vs. Female)	1.21	1.21	—
Geography (Urban vs. Rural)	1.65	1.59	—

FINISHING THE JOB: THREE MAJOR CHALLENGES

The next child survival revolution is unfolding, but sustaining progress will depend on three major challenges being addressed: the growing proportion of child deaths taking place in the newborn period, the large number of children being bypassed by recent gains in child survival, and malnutrition.

NEWBORN MORTALITY

As child mortality rates reduce, the challenge is increasingly concentrated in the first 28 days of life. This can be seen in a comparison between high burden countries, such as Mali or Sierra Leone, where newborn deaths account for less than 30 percent of the total, and a low burden country such as Brazil, where 66 percent of all child deaths happen in the first month of life. This newborn period is when the risks to children are greatest and the health care needs most complex, with one third of all newborn deaths happening in the first day of life.[32]

The current annual rate of reduction in newborn mortality is significantly lower than for children under 5 years overall—current trends indicate that would take 140 years for a newborn child in sub-Saharan Africa to have the same chance of survival as a child born in the United Kingdom. Whereas child mortality has halved since 1990, newborn deaths have reduced by one-third, with progress slowest in low-income countries. As a result the share of newborn deaths in the global total has increased since 1990, from 37 percent to 44 percent in 2013, or 2.9 million of the 6.6 million deaths worldwide.[33] In every region outside Africa, newborn deaths now account for a majority of child mortality, with almost 60 percent of child deaths in Bangladesh and Nepal taking place in the first 28 days.

Sustaining reductions in child mortality will increasingly depend on reductions in neonatal mortality, especially in South Asia where the burden of child death remains relatively high for many countries but a majority of those deaths now occur in the newborn period. Yet despite the relatively slow progress in this area many countries have been able to achieve substantial improvements, Bangladesh, Cambodia, Indonesia, Nepal and Vietnam have all reduced neonatal mortality rates by over 47 percent since 1990, while Brazil, China, Egypt and Peru have achieved reductions of over 60 percent.[34] These countries have invested in proven and affordable health care for mothers and babies.

The causes of newborn mortality are well known. Most deaths are caused by infections, complications during labour and birth such as asphyxia, prematurity and low birth weight, and pneumonia and diarrhoea. An estimated two-thirds of these deaths could be prevented through relatively low-cost solutions, including clean cutting of the umbilical cord, good breastfeeding practices, antibiotics for infections, and "kangaroo mother care"—keeping newborn babies warm through continuous skin-to-skin contact with the mother. Ensuring that skilled birth attendants are present to provide immediate care to

PHOTO: JOHN AHERN/BILL & MELINDA GATES FOUNDATION

A premature baby is cared for in the pediatric ward at Yekatit Hospital in Addis Ababa.

mothers, and that health workers are accessible to mothers and newborn babies in the periods before and after child birth, is critical to delivering these and other services. Yet at the moment, 48 million women give birth each year without the support of someone with recognized midwifery skills, and 2 million women give birth completely alone.[35]

At a national level, a growing number of countries are recognizing the need to invest in maternal and newborn care as part of a broader strategy to expand access to essential health-care services. Ethiopia's recent commitment to quadruple the number of midwives, and increase the proportion of births attended by a skilled professional, from 18 percent to 60 percent is a case in point. Measures to improve the nutrition of mothers and newborns, which is critical both to a healthy birth weight and to good breastfeeding practices, are also increasingly recognized as a policy priority by governments, especially in plans developed through the Scaling Up Nutrition (SUN) movement.[36]

At the global level, the development of an "Every Newborn Action Plan"—which is expected to be launched at the 2014 World Health Assembly—is helping to galvanize national commitments to reducing newborn mortality, and to hold governments and other stakeholders accountable for progress in the context of the Every Woman, Every Child strategy.[37]

CHILD SURVIVAL PROFILE

SIERRA LEONE

POPULATION: 5.61 MILLION

EVERY ONE INDEX RANKING:

—

EVERY ONE INDEX SCORE:

1.33 / 3.0

UNDER 5 MORTALITY SCORE:

0.5 / 1.0

EQUITY SCORE:

—

SUSTAINABILITY SCORE:

0.5 / 1.0

Although Sierra Leone has the world's highest child mortality rate and is off track towards MDG 4, the child mortality rate has fallen by more than a fifth over the last decade, and the newborn mortality rate is down by 12 percent. Because of a lack of data, it is not possible to identify disparities in child mortality, or comment on the extent to which Sierra Leone is addressing inequity. The government has taken some important steps toward addressing child health. Sierra Leone has joined the SUN Movement, and a civil society platform is now tracking the government's commitments to nutrition. The government has also launched a strategy to reduce teenage pregnancy as part of a larger effort to reduce maternal mortality, and recently it incorporated plans to reduce newborn mortality into its national maternal and child health strategy.

SIERRA LEONE AND THE EVERY ONE INDEX

Sierra Leone, in part due to the rate of improvement in child mortality, ranks higher than a number of other countries in Africa, including Botswana, Kenya and South Africa.

Sustaining Sierra Leone's Progress

The Government of Sierra Leone faces major challenges to make significant progress on maternal, newborn and child health. Health expenditure as a percentage of the national budget has declined over the last decade, from 14 percent in 2000 to 11.7 percent in 2011, falling further to 10.5 percent in the 2013 national budget. Some recent programmatic developments could help improve MNCH, if implemented effectively. MNCH is a specific pillar within the Agenda for Prosperity, the country's five-year development plan.

The health workforce suffers from low capacity, both in terms of quantity and quality of workers. The weakness of the health commodities supply chain makes it difficult to reach people with quality products. While there are important champions for child survival within government, corruption remains a barrier to progress. An empowered, cohesive civil society will be critical if Sierra Leone is to see significant gains in child survival, including the media, which are important ambassadors for MDG4 in the country but often have weak capacity. Civil society organizations and the media need to collaborate to mobilize the public to demand government accountability for ensuring children's rights and delivering essential services. The Agenda for Prosperity provides an entry point for organizations to advocate for better policy implementation and greater investment in maternal, newborn and child health.

CHILD & INFANT MORTALITY TRENDS

Indicator	2012	2000	% change	% of US deaths that are newborns
Under-five mortality (per 1000)	182	234	-22	27
Neonatal mortality (per 1000)	49.5	56	-12	—

SUSTAINABILITY MEASURES

Indicator	2011	2000	% change
Improved Sanitation Facilities (% of pop with access)	12.9	11.9	8
Stunting (all children under 5)	37.4	—	—
Government Health Expenditure	11.69	14.20	—
Governance	-1.16	-1.46	—

INEQUITY

Despite the achievements, millions of the poorest children have been bypassed by progress towards MDG 4. Disparities between children in the richest and poorest countries have narrowed, but remain gaping. A child in Sierra Leone is 90 times more likely to die before his/her fifth birthday than a child in Luxemburg, where the child mortality rate is just 0.2 percent. Within developing countries, children in lower income groups and rural areas—the two overlap significantly—face a far higher risk of dying in the first five years than children in higher income groups and those living in urban areas. For example, 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 5 than the richest.

In sub-Saharan Africa, the region with the highest mortality rate (accounting for half of all child deaths) these gaps widened rather than narrowed between 1998 and 2008, and in extreme cases, child mortality has actually risen for some groups in the context of overall progress—for example, in Burkina Faso, child mortality rose among the poorest 20 percent of the population between 1993 and 2003.[38] Alongside these wealth-based gaps, disparities between boys and girls are also worsening across regions, by an average of one percentage point annually.[39]

These inequities matter both because every child has an equal right to survive, and because of the evidence that more equitable progress towards MDG4 can be both faster and more sustainable. An estimated 4 million additional lives could have been saved over a 10-year period in 40 high-burden countries, had progress for all income groups matched the rate of reduction in child mortality in the fastest improving quintile.[40]

EQUITY GAPS

- **The equity gap** is a measure of the difference in child mortality rates between one group of children and another. Mortality rates are measured as the number of children who die per 1,000 children who are born alive.
- **The wealth equity gap** is the difference in the mortality rates between children born into the wealthiest 10 percent of families and children born into the poorest 40 percent of families.
- **The gender equity gap** is the difference in the mortality rates between boys and girls.
- **The geographic equity gap** is the difference in the mortality rates between children in urban areas and children in rural areas.

As the world moves towards MDG4 and high mortality rates are concentrated in regional and social groups, continued success will increasingly depend on gauging progress against a "triple bottom line"—the overall reduction in mortality, equity and sustainability. In our new EVERY ONE index for this report, we have produced a composite ranking that does this, taking account of how much progress is being made toward reducing child mortality rates among groups typically lacking access to health (children in poor households, girls and children living in rural areas) and groups that have typically had better access (children in wealthier households, boys, and children in urban areas). For each pair of groups, we measured whether the equity gap has been closing or widening each year over time. The index also factors in the political sustainability of progress, gauged by the level of political commitment of a country and political stability.

In the 34 countries for which this data is available, we have measured progress by the average annual percentage change in the equity gap. The index shows that despite dramatic progress in reducing child mortality, gender and geographical disparities have persisted, with gender disparities widening by one percentage point in the African countries for which data was available. The wealth gap in mortality rates between the wealthiest 10 percent of families and the poorest 40 percent of families has narrowed at the global level, but only very slowly, by an annual average of just 1 percentage point. On average, individual countries are improving on only one of the index's three measures of equity.

At the country level, Niger scores highest. Although it still has very high child mortality (114 deaths for every 1,000 live births in 2012) it has reduced that rate rapidly, from 326 in 1990, in an equitable and sustainable way. The Government of Niger's policies in support of universal access, provision of free health care for pregnant women and children, and strong nutrition programmes have enabled the country to decrease child mortality at a pace that exceeds that needed to meet MDG4.[41]

Some countries that have made dramatic reductions in child mortality, such as Bangladesh and Cambodia, score relatively low on the index. They will need a much stronger policy focus on equity going forward, if they are to consolidate the progress they have already made.

Bangladesh scored 0.17 for equity, meaning that despite progress in reducing disparities in child mortality[42] there are still inequalities in mortality rates between boys and girls, wealthy and poor children, and children living in rural and urban areas.

Bangladesh also scored low on sustainability, highlighting the need to ensure that political statements are translated into policy implementation, and for pointing to a need for ongoing civil society advocacy to protect and build on recent gains.

In contrast, countries such as Senegal are likely to fall short of the MDG 4 target, but have nonetheless scored relatively well in terms of equity and sustainability—potentially laying the foundation for continued and accelerated reductions in child mortality beyond 2015.

CHILD SURVIVAL PROFILE

BANGLADESH

POPULATION: 164 MILLION

EVERY ONE INDEX RANKING:
21 / 34

EVERY ONE INDEX SCORE:
1.54 / 3.0

UNDER 5 MORTALITY SCORE:
1.0 / 1.0

EQUITY SCORE:
0.17 / 1.0

SUSTAINABILITY SCORE:
0.38 / 1.0

Child mortality rates in Bangladesh have more than halved over the last decade, driven in large part by expanded coverage of a limited number of high-impact interventions, especially routine immunization for children, oral rehydration therapy and Vitamin A supplementation. The latest country health survey shows that among children aged 12-23 months, 98 percent now have access to routine immunizations, as evidenced by coverage of BCG (TB vaccine). Coverage rates of completed course of pantavelent vaccines (including DPT-dipdiphtheria, pertussis and tetanus—are 93 percent and coverage of measles is 84 percent.[43] According to UNICEF, an expansion of community health workers has enabled improvements in health care quality and has led to an increased use of health facilities.

Progress has been backed by strong demonstrations of political will. In June 2012 Bangladesh Minister of Health joined India, Ethiopia and others in the A Promise Renewed initiative, with a pledge to end preventable child deaths. In July 2013, Bangladesh launched its Child Survival Call to Action, which includes six strategic interventions and identifies seven ways to implement these interventions. This is leading to Bangladesh updating its National Neonatal Health Strategy. Recognizing that child malnutrition is a barrier to achieving progress in child survival, the Government of Bangladesh has adopted a Nutrition Plan (2011-2016) within its National Health Strategy. The government will also soon roll out new pneumococcal vaccines within its routine immunization programme.

BANGLADESH AND THE EVERY ONE INDEX

In spite of dramatic progress towards achieving MDG 4, Bangladesh scored poorly for both equity and sustainability. Bangladesh has a long way to go to reduce inequality between rich and poor: a child born into a family in the poorest 40 percent of the population is twice as likely to die as a child born into the top 10 percent.

Drawing on lessons from successful advocacy around respiratory infections and the introduction of the pneumococcal vaccine, civil society mobilization has an important role to play in advancing newborn mortality and health inequalities in the political agenda.

CHILD & INFANT MORTALITY TRENDS

Indicator	2012	2000	% change	% of US deaths that are newborns
Under-five mortality (per 1000)	41	88	-53	58
Neonatal mortality (per 1000)	24.4	40.7	-40	—

SUSTAINABILITY MEASURES

Indicator	2011	2000	% change
Improved Sanitation Facilities (% of population with access)	54.7	45.3	21
Stunting (all children under 5)	41	57.2	28
Government Health Expenditure	8.93	7.56	—
Governance	-.85	-.56	—

EQUITY MEASURES

Indicator	1994	2011	% change
Wealth (Top 10% vs. Bottom 40%)	2.03	2.72	—
Gender (Male vs. Female)	1	1.10	—
Geography (Urban vs. Rural)	1.34	1.19	—

Sustaining Bangladesh's Progress

To sustain progress towards the goal of ending preventable child deaths, the Government of Bangladesh must successfully implement its Child Survival Call to Action plan, including accelerating progress on neonatal health. It must also continue to strengthen its health system, particularly by increasing access to skilled birth attendants, which remains at very low levels. After national elections scheduled for October 2013 through January 2014, it is crucial that the new government endorses and fully adopts Bangladesh's plan to end preventable child deaths.

PHOTO: JEFF HOLT

Jasmine is a community health volunteer trained by Save the Children. She diagnosed Nadim with severe pneumonia and referred him to the hospital for treatment. Working in the community, Jasmine records information about each child that she diagnosis and treats into a log book, times the respiratory health using a timer, and councils parents about pneumonia.

Countries at the bottom of the index have been affected by conflict and fragility, either in the past or currently. They have weak health systems and require intensified domestic efforts, supported by donors, to get on track towards achieving MDG4.

In no region are all three measures of inequity improving. For instance the wealth and geographic equity gaps are slowly worsening by two percentage points annually in the Latin American countries for which data was available, while the gender equity gap has remained the same. In the African countries for which data was available, both the wealth and the gender equity gaps widened, with the geographic equity gap showing no improvement.

Achieving progress that is both equitable and sustainable implies a much more comprehensive approach to child mortality that tackles inequities in the underlying social determinants of child health. Such an approach would include 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 MDG4, reflected in a more efficient distribution of public resources for child survival; and government transparency and accountability, which can help generate public demand for action on child mortality and ensure commitments are met.

ADDRESSING MALNUTRITION

Tackling child malnutrition—particularly by focusing on the first 1,000 days—is critical to reaching MDG 4 and achieving the long-term goal of ending preventable child deaths.

Nutrition is key to a child surviving and thriving to the age of 5 and beyond. According to the Copenhagen Consensus—a body of eminent economists—every dollar spent to reduce chronic child nutrition yields at least US$30 in economic benefits.[44]

Well-nourished children are better equipped to fight disease, learn and contribute to societies. Girls with good nutrition become healthy, strong women and have healthier children and more prosperous families. Under-nutrition during pregnancy can lead to fetal growth restrictions and undernourishment in newborns. One-third of newborns are malnourished.[45]

Even as child mortality has fallen in recent years, stunting rates have remained persistently high, and malnutrition now underlies nearly half of all under-5 deaths. Stunted children often experience physical and cognitive disabilities that last their whole lives.[46]

In 2013, 165 million children in the world are stunted.[47] While this is a decline from 253 million in 1990, the average annual 2.1 percent rate of reduction at is low. In May 2012, the World Health Assembly passed a resolution with a target of reducing stunting globally by 40 percent by 2025. To reach this goal, the annual rate of reduction must accelerate to 3.9 percent a year.[48] The stunting rate is less than 1 percent in a number of countries including Nigeria.[49] Despite being a middle-income country, Nigeria has the highest level of stunting in sub-Saharan Africa and the third highest in the world; 41 percent of Nigerian children under 5 are stunted with 23 percent being severely stunted.[50]

Countries must make it a priority to ensure proper nutrition in the first 1,000 days from pregnancy to a child's second birthday and to accelerate rates of reduction in stunting. Continued progress in child survival will not be possible without tackling this challenge.

THE WINDOW OF OPPORTUNITY

Responding to these challenges and completing the unfinished business of MDG 4, will place major demands on everyone involved in the movement to end preventable child deaths—from frontline health workers to policymakers and politicians to international institutions and donor agencies. There is an encouraging window of opportunity in which to make accelerated progress, with three key developments creating an enabling environment for change:

New Consensus—An international political consensus is emerging that high levels of child mortality are avoidable and unacceptable, and warrant a sustained global response. This is reflected in a growing commitment from decision-makers around the world to invest in health care and nutrition as a springboard for economic and social development —an agenda set out by World Bank President Jim Kim at the World Health Organization in May 2013, when he identified health as both the measure and means of poverty reduction. One recent study found that reducing child deaths can result in an 8 percent increase in GDP per capita 10 years later. [51] Countries are taking different paths specific to their contexts, but there have been some common features of each success story: better access to quality health care; improved nutrition; a concerted effort to addressed inequities; especially those faced by women and girls; and improved governance and

THE **EVERY ONE** INDEX

Each of the 75 countries is ranked according to its total score for reduction in under-5 mortality, equity and sustainability. Countries with missing data on equity or sustainability have been assigned an average score and their position in the Index takes into account this average score.

Country Name	**Reduction in US Mortality score** (out of 1)[52]	**Equity score** (out of 1)[53]	**Sustainability score** (out of 1)[54]	**Total score** (out of 3)	**Ranking**
Niger	1.0	0.67	0.88	2.54	1
Liberia	1.0	—	0.88	2.21	-
Rwanda	1.0	0.17	1.00	2.17	2
Indonesia	1.0	0.67	0.50	2.17	3
Madagascar	1.0	0.67	0.50	2.17	4
India	1.0	0.33	0.75	2.08	5
China	1.0	—	0.75	2.08	-
Egypt, Arab Rep.	1.0	0.67	0.38	2.04	6
Tanzania	1.0	0.67	0.38	2.04	7
Mozambique	1.0	0.50	0.50	2.00	8
Nepal	1.0	0.50	0.50	2.00	9
Zambia	1.0	0.33	0.63	1.96	10
Lao PDR	1.0	—	0.63	1.96	-
Ethiopia	1.0	0.17	0.75	1.92	11
Vietnam	0.5	0.67	0.75	1.92	12
South Sudan	1.0	—	—	1.85	-
Benin	1.0	0.33	0.50	1.83	13
Malawi	1.0	0.33	0.50	1.83	14
Senegal	1.0	0.33	0.50	1.83	15
Azerbaijan	1.0	—	0.50	1.83	-
Brazil	1.0	—	0.50	1.83	-
Korea, Dem. Rep.	1.0	—	0.50	1.83	-
South Africa	1.0	—	0.50	1.83	-
Congo, Dem. Rep.	0.5	—	1.00	1.83	-
Ghana	0.5	0.67	0.63	1.79	16
Burkina Faso	1.0	0.00	0.75	1.75	17
Bolivia	1.0	0.33	0.38	1.71	18
Eritrea	1.0	—	0.38	1.71	-
Afghanistan	0.5	—	0.88	1.71	-
Angola	0.5	—	0.88	1.71	-
Guinea Bissau	0.5	—	0.88	1.71	-
Iraq	0.5	—	0.88	1.71	-
Cambodia	1.0	0.00	0.63	1.63	19
Mali	1.0	0.00	0.63	1.63	20
Sao Tome and Principe	1.0	—	0.25	1.58	-
Bangladesh	1.0	0.17	0.38	1.54	21
Peru	1.0	0.00	0.50	1.50	22
Uganda	1.0	0.00	0.50	1.50	23
Nigeria	0.5	0.50	0.50	1.50	24
Pakistan	0.5	0.50	0.50	1.50	25
Kyrgyz Republic	1.0	—	0.13	1.46	-
Botswana	0.5	—	0.63	1.46	-
Burundi	0.5	—	0.63	1.46	-
Central African Republic	0.5	—	0.63	1.46	-
Tajikistan	0.5	—	0.63	1.46	-

Notes: The average equity score is 0.333 The average sustainability score is 0.512

Country Name	Reduction in US Mortality score (out of 1)	Equity score (out of 1)	Sustainability score (out of 1)	Total score (out of 3)	Ranking
Togo	0.5	—	0.63	1.46	-
Uzbekistan	0.5	—	0.63	1.46	-
Guinea	1.0	0.00	0.38	1.38	26
Cameroon	0.5	0.33	0.50	1.33	27
Congo, Rep.	0.5	—	0.50	1.33	-
Djibouti	0.5	—	0.50	1.33	-
Gambia, The	0.5	—	0.50	1.33	-
Mauritania	0.5	—	0.50	1.33	-
Mexico	0.5	—	0.50	1.33	-
Sierra Leone	0.5	—	0.50	1.33	-
Sudan	0.5	—	0.50	1.33	-
Kenya	0.5	0.50	0.25	1.25	28
Zimbabwe	0.5	0.50	0.25	1.25	29
Chad	0.5	0.33	0.38	1.21	30
Gabon	0.5	—	0.38	1.21	-
Solomon Islands	0.5	—	0.38	1.21	-
Somalia	0.5	—	0.38	1.21	-
Swaziland	0.5	—	0.38	1.21	-
Yemen, Rep.	0.5	—	0.38	1.21	-
Cote d'Ivoire	0.5	—	0.38	1.21	-
Comoros	0.5	—	0.25	1.08	-
Guatemala	0.5	—	0.25	1.08	-
Myanmar	0.5	—	0.25	1.08	-
Turkmenistan	0.5	—	0.25	1.08	-
Philippines	0.5	0.17	0.38	1.04	31
Lesotho	0.5	0.00	0.50	1.00	32
Morocco	0.5	0.00	0.50	1.00	33
Haiti	0.5	0.33	0.13	0.96	34
Equatorial Guinea	0.5	—	0.13	0.96	-
Papua New Guinea	0.5	—	0.13	0.96	-

TABLE 2 REGIONAL COMPARISONS OF EQUITY IN CHILD MORTALITY

Region	Average Annual Change in Equity Gap (Wealth)	Average Annual Change in Equity Gap (Gender)	Average Annual Change in Equity Gap (Urban/Rural)
Eastern Mediterranean Region [3 countries]	-1	+1	-1
African Region [21 countries]	-1	+1	0
Region of the Americas [3 countries]	+2	0	+2
South-East Asia Region [4 countries]	-3	0	-1
Western Pacific Region [3 countries]	0	-1	+9
Total [34 countries]	-1	0	0

Note: A negative change indicates a decline in the Equity Gap, and therefore an increase in equity between the groups indicated. A positive change indicates an increase in the Equity Gap, and therefore a decline in equity.

accountability. Bold political leadership at the highest levels often delivers a leap forward in national commitments to saving lives. Some examples are: the announcements of free health care in Sierra Leone and free maternity services in government health facilities in Kenya; the Indian state of Rajasthan's provision of free generic medicine and diagnostic services; China's commitment to national health improvements for all; Brazil's focus on tackling nutrition; Nigeria's Saving One Million Lives initiative; and Ethiopia's National Nutrition Strategy.

New Evidence—A growing body of evidence is demonstrating the feasibility of achieving dramatic reductions in child deaths by addressing the leading drivers of mortality. The number of children who die annually fell from 8.1 million in 2009[55] to 6.6 million in 2012—a decrease of nearly 20 percent in just three years—based in part on the increased availability of data to decision-makers and policymakers.[56] In 2012, the Copenhagen Consensus identified nutrition as a global priority for governments and the private sector, with each dollar spent on tackling malnutrition generating a US$30 return. A series of studies in recent years in the medical journal The Lancet showed that by implementing known, affordable solutions the lives of millions more children could be saved. The Lancet studies helped to underpin the commitments to doubling aid for nutrition at the Nutrition for Growth conference in London in 2013, the Commission on Information and Accountability that is tracking progress on maternal, newborn and child health in the wake of the Canadian G8 in 2010, and the renewed momentum around tackling newborn mortality.

New Partnerships—the number and the scope of partnerships promoting child survival has risen dramatically in recent years. In 2010 the UN Secretary General launched a strategy for women and children's health, Every Woman, Every Child, which is rooted in the recognition that just as there is no one solution to child mortality, no one actor can achieve the MDGs. In the two years after it was launched, 260 partners—including Save the Children—had together committed US$57.7 billion for initiatives through Every Woman, Every Child. In 2010, the G8 also launched the Muskoka Initiative for Maternal, Newborn and Child Health, through which donors pledged an additional

PHOTO LEFT: CAROLINE TRUTMANN MARCONI PHOTO RIGHT: FREDERIC COURBET/PANOS

Left: Hadija helps Josephine, two, drink tea from a cup outside their home in Kilolambwani village, Lindi Rural District, Tanzania.

Right: A mother and her child waiting to be treated at a therapeutic feeding centre in Warakaye Kebelle, Meket Woreda, North Wollo Zone, Amhara Region, Ethiopia. The clinic is part of a Community Managed Acute Malnutrition Programme set up by the Government and implemented with support by Save the Children.

Mothers and their children at Ramada Health Post. Ramada Health Post, southern Ethiopia, provides health care to people from remote communities.

US$5 billion towards achieving MDG4. In 2012, the Governments of Ethiopia, India and the United States, together with UNICEF, mobilized more than 100 countries around the initiative, A Promise Renewed: A Call to Action, a vision for ending preventable child deaths by 2035.[57] Strategies focused on nutrition have also galvanized new commitments and political energy. The 1,000 days initiative, launched by the US and Irish governments in 2010, helped to raise the visibility of malnutrition amongst governments and other stakeholders, while the Scaling Up Nutrition (SUN) Movement, launched at the 2010 UN General Assembly, is working to ensure the fundamental rights of all people to adequate nutrition. At the time of this writing, 41 countries have joined the SUN Movement and are now calculating the costs of scaling up access to adequate nutrition in their countries. Partnerships on specific drivers of child mortality have also emerged, such as the Global Vaccine Action Plan, the Global Action Plan for Pneumonia and Diarrhoea, and Family Planning 2020, which are bringing together governments, business, civil society and international institutions around collective health challenges.

Whether or not the world capitalizes on these three developments in child survival depends in large part on political will. This will be reflected in governments and other stakeholders giving visibility to the issue in their public statements and policy, creating alliances of committed institutions and individuals to work around a common agenda, and delivering resources that help drive policy implementation. It will also rely on new and existing civil society coalitions—bringing together nongovernmental organizations, professional associations, academia, business and religious groups—creating a climate in which stakeholders are held to account for their contribution to progress.

CHILD SURVIVAL PROFILE

KENYA

POPULATION: 43.2 MILLION

EVERY ONE INDEX RANKING:
28 / 34

EVERY ONE INDEX SCORE:
1.25 / 3.0

UNDER 5 MORTALITY SCORE:
0.5 / 1.0

EQUITY SCORE:
0.5 / 1.0

SUSTAINABILITY SCORE:
0.25 / 1.0

The child mortality rate has declined by a third in Kenya over the last decade, while the newborn death rate has declined by 18 percent. New leadership in government has taken positive steps toward improving child survival. The government recently introduced the pneumococcal vaccine and is making it available, free of cost, in public hospitals. In the first 100 days after being elected, the new government made primary health care and maternity services free for all Kenyans within public hospitals—a significant step toward achieving Universal Health Coverage in Kenya. The government has also finalized a training curriculum for community health workers, which redefines their roles and responsibilities. While abolishing user fees is in the ruling party's policy manifesto, it has not yet acted to remove them.

Malnutrition is a significant obstacle to reducing mortality, with more than a third of children stunted. The Government of Kenya joined the SUN movement in 2010 and committed to increasing resources available for high-impact nutrition interventions through the National Nutrition Action Plan. The government adopted a new policy late last year, which will promote exclusive breastfeeding and establishes guidelines for marketing and promoting breast milk substitute. Facing high rates of micronutrient deficiencies, the Government of Kenya launched a food fortification campaign last year in partnership with industry. This partnership has led to an increase in the availability of fortified maize and wheat flours as well as cooking oils and fats.

KENYA AND THE EVERY ONE INDEX

Kenya ranks low on the index: it is off track towards MDG 4, and is making below average progress in reducing disparities in child mortality. Children born into the poorest 40 percent of households are 50 percent more likely to die as children born into the wealthiest 10 percent of households. Gender inequality, in terms of differences in mortality rates between boys and girls, increased between 1993 and 2009, with girls now 16 percent more likely to die than boys. Children in rural households are 15 percent more likely to die than children living in urban households. It also scores low on the EVERY ONE Index's sustainability measures.

Funding for health in Kenya remains very low, and the percentage of government spending that is allocated to health has actually decreased in recent years. In 2011 the health budget made up less than 6 percent of the national budget—far less than Kenya's Abuja Declaration commitment to invest 15 percent of its national budget in health.

CHILD & INFANT MORTALITY TRENDS

Indicator	2012	2000	% change	% of US deaths that are newborns
Under-five mortality (per 1000)	73	110	-34	36.7
Neonatal mortality (per 1000)	26.8	32.5	-18	—

SUSTAINABILITY MEASURES

Indicator	2011	2000	% change
Improved Sanitation Facilities (% of pop with access)	29.4	26.9	9
Stunting (all children under 5)	35.2	35.8	-2
Government Health Expenditure	5.94	10.54	—
Governance	-.54	-.54	—

EQUITY MEASURES

Indicator	1993	2009	% change
Wealth (Top 10% vs. Bottom 40%)	2.32	1.49	—
Gender (Male vs. Female)	1.09	1.16	—
Geography (Urban vs. Rural)	1.27	1.15	—

Sustaining Kenya's Progress

The Government of Kenya, since being elected in May 2013, has decentralized spending, and it now provides budgets to counties that have some autonomy over how resources are spent. This increases the importance of advocacy at the county level to see that a portion of these funds is allocated to maternal, newborn and child health—especially as some counties question the need to invest public resources in immunization. Health and nutrition spending is also competing with other priorities, such as free primary education, which also have potential spillover benefits for health. With health spending already a small part of the national budget, it is important that existing spending levels are protected.

CHILD SURVIVAL PROFILE

NIGERIA

POPULATION: 174.5 MILLION

EVERY ONE INDEX RANKING:
24 / 34

EVERY ONE INDEX SCORE:
1.5 / 3.0

UNDER 5 MORTALITY SCORE:
0.5 / 1.0

EQUITY SCORE:
0.5 / 1.0

SUSTAINABILITY SCORE:
0.5 / 1.0

Child mortality in Nigeria has halved over the last decade, but newborn mortality has declined by only 20 percent. The Government of Nigeria has recently taken important steps to reduce child mortality. Under the Every Woman, Every Child strategic framework, Nigeria committed to fully funding its health programme by 2015, pledging to increase spending at the federal, state and local levels from less than 5 percent of the national budget to 15 percent, a per capita investment of US$31.63. In 2012, as a part of its commitment to end preventable child deaths, Nigeria launched the Saving One Million Lives initiative, which includes a costed plan for improving nutrition nationwide. The government has established a newborn health desk within the Federal Ministry of Health and has introduced a subsidy re-investment empowerment fund to administer maternal, newborn and child health funds. The government has also introduced new pentavalent and pneumococcal vaccines, while two states have introduced separate budget lines for nutrition and four states have established nutrition partners' forums.

NIGERIA AND THE EVERY ONE INDEX

Nigeria has moved backwards on important measures that impact child mortality, reflected in a much lower rate of decline than other countries. A smaller percentage of the population has access to proper sanitation facilities now than 10 years ago, and the percentage of children who receive treatment for diarrhoea and the rate of exclusive breastfeeding have both fallen.

Nigeria has made very little progress in improving equity. A child born in the poorest 20 percent of the population is two-and-a-half times more likely to die before the age of five than a child born in the wealthiest 20 percent. A child born in a rural area is 60 percent more likely to die before the age of 5 than a child born in an urban area and girls have a higher likelihood than boys of dying before the age of 5.

Sustaining Nigeria's Progress

Nigeria's investment in health recently increased from 4 percent to 7.5 percent of the national budget. But this is still only half of the 15 percent target set by the African Union Abuja Declaration in 2001. The Government of Nigeria has made numerous commitments to maternal, newborn and child health. But the government faces daunting challenges in efforts to improve and sustain reductions in child mortality including insecurity, weak governance, inequity, and a weak primary health-care system. The Open Budget Index measure for the Nigeria federal budget process declined from a score of 20 in 2006 to 16 in 2012.

CHILD & INFANT MORTALITY TRENDS

Indicator	2012	2000	% change	% of US deaths that are newborns
Under-five mortality (per 1000)	124	188	-34	32
Neonatal mortality (per 1000)	39.2	48.9	-20	—

SUSTAINABILITY MEASURES

Indicator	2011	2000	% change
Improved Sanitation Facilities (% of pop with access)	30.6	34.5	-1
Stunting (all children under 5)	41	43	-5
Government Health Expenditure	7.51	4.22	—
Governance	-1.12	-0.96	—

EQUITY MEASURES

Indicator	1990	2008	% change
Wealth (Top 10% vs. Bottom 40%)	2.59	2.54	—
Gender (Male vs. Female)	1.10	1.05	—
Geography (Urban vs. Rural)	1.60	1.57	—

The constitutional review process currently underway provides an important opportunity to advocate for universal health coverage in Nigeria, as health is not a priority of any arm of the government in the current constitution. Campaigning for the Presidential election, scheduled for early 2014, is also underway, providing opportunities to make child survival an election issue and help to spur further progress.

The passage of the National Health Bill which is now awaiting the 3rd and final senate reading will provide a breakthrough deal for mothers and children if signed into law. If the bill is fully funded and implemented, it could potentially lead to scaling up the coverage of basic life-saving health care services to 90 percent coverage. Achieving a 90 percent coverage means a near universal coverage, which could improve healthcare for numerous Nigerians and help Nigeria achieve its MDG 4 and 5 goals.

CHILD SURVIVAL PROFILE

INDIA

POPULATION: 1.2 BILLION

EVERY ONE INDEX RANKING:
5 / 34

EVERY ONE INDEX SCORE:
2.08 / 3.0

UNDER 5 MORTALITY SCORE:
1.0 / 1.0

EQUITY SCORE:
0.33 / 1.0

SUSTAINABILITY SCORE:
0.75 / 1.0

India accounts for more than one-fifth of all child deaths worldwide, and is off track to achieve MDG 4. Over the last decade, the child mortality rate in India has declined by 39 percent, but the newborn mortality rate has declined by only 27 percent, and more than half of deaths among children under 5 occur among newborns. More than half of its children are stunted, the outcome of chronic malnutrition.

Over the past year especially, the Government of India has made some significant demonstrations of political will to improve child survival. In June 2012, the government co-led the Child Survival Call to Action with the Governments of the US and Ethiopia, where it committed to ending preventable child deaths by 2035. It followed this by organizing its own national call to action in February 2013 and launching a reproductive, maternal, newborn, child health and adolescents strategy, designed to tackle the leading causes of child mortality, including chronic malnutrition and newborn complications and infections. The Government of India has increased its budgetary allocation towards health and nutrition in the last two years, more than doubling its health budget from 1 percent to 2.5 percent of its GDP, although it remains low by international standards.

INDIA AND THE EVERY ONE INDEX

India scores high on the EVERY ONE Index, with a rank of 7 out of 34 countries for which equity data are available. It scores relatively high for political commitment and a steady decline in child mortality rates, but poorly on equity. A child born in the poorest fifth of the population in India is three times more likely to die than a child born in the top 10 percent.

Sustaining India's Progress

Continuing to increase resources will be critical to eliminating preventable child deaths in India. While the Government of India recently doubled its health expenditures, it is still allocating 8% of its annual national budget, compared with 14 percent in Ethiopia. New commitments to child survival must be sustained through any potential change of government during elections in 2014.

India must translate new policies into action by tackling child malnutrition, newborn health and broad health inequalities. The multiyear strategy must include collecting disaggregated data that shows impacts on the poorest people and among girls.

CHILD & INFANT MORTALITY TRENDS

Indicator	2012	2000	% change	% of US deaths that are newborns
Under-five mortality (per 1000)	56	92	-39	55
Neonatal mortality (per 1000)	30.9	42.2	-27	—

SUSTAINABILITY MEASURES

Indicator	2011	2000	% change
Improved Sanitation Facilities (% of pop with access)	35.1	25.5	37
Stunting (all children under 5)	51	57.1	-11
Government Health Expenditure	8.05	7.39	—
Governance	-.03	-.14	—

EQUITY MEASURES

Indicator	1992	2006	% change
Wealth (Top 10% vs. Bottom 40%)	3.74	3.40	—
Gender (Male vs. Female)	1.06	1.08	—
Geography (Urban vs. Rural)	1.67	1.55	—

Given that over 50 percent of India's under 5 child mortality rates are due to neonatal mortality, India's plan to release the newborn action plan and State of India's Newborns report is an important step forward. Efforts to address newborn health need to be integrated into, and implemented as part of the reproductive, maternal, newborn, child health and adolescents strategy. The government also needs to urgently accelerate efforts against malnutrition.

PHOTO: CAROLINE TRUTMANN MARCONI

AN AGENDA FOR **ACTION**

Achieving MDG4 and building momentum towards ending preventable child deaths in a generation will depend on action at three levels. Firstly, the direct causes of child mortality need to be tackled through the interventions that have a proven impact. Secondly, the underlying causes of death, lack of access to health care and malnutrition, must be addressed through provision of essential health care and adequate nutrition for every child. Finally, the structural reasons why children are dying, from poverty to gender inequality to poor governance, need to be confronted in order to create an enabling environment for sustainable progress.

1. HEALTH CARE FOR EVERY CHILD

The experience of countries that have reduced child mortality to below the threshold of 20 deaths per 1,000 live births shows that sustained progress towards ending preventable child deaths depends on the building of health systems that guarantee quality, accessible health care to every section of society, including communities in hard-to-reach areas, vulnerable groups and disadvantaged populations. Brazil is a case in point, where increasingly systematic provision of routine immunization, community-level health care and improved sanitation has enabled steady improvements in child survival. Yet, in most developing countries, major inequalities in access to health care persist, which in turn contributes to disparities in health outcomes. The poorest families face high direct, indirect and opportunity costs in accessing health care, and they lack access to information and the political voice to demand better services. An estimated 40 million children, in 25 high-burden countries, lack access to essential health care.[58] Many of these children face particular challenges in dispersed rural populations, urban slum communities, and conflict-affected and fragile states.[59 60 61]

Wealth, education, location, ethnicity, age and gender can all have a major influence on who gets access to health care, and on the quality of that care.[62] In Bangladesh, a woman from a wealthy household is 10 times more likely to have a skilled attendant when giving birth, compared to a woman from a poorer family. For women living in urban versus rural areas of Bangladesh, the difference is three to one. In both Bangladesh and India, a woman from a wealthy household is six times more likely than a woman from a low-income household to have at least four antenatal visits.

Ensuring access to essential services for children and mothers should be part of a wider effort to achieve universal health coverage (UHC) that guarantees everyone, starting with the most vulnerable, has access to high quality care without facing any financial hardship. The success of UHC needs to be judged by health outcomes—many of the 18,000 daily

Opposite: A child is weighed by Midwife Meckytildis Amlima in order to monitor his growth development at the Health Centre in Kilolambwani village, Lindi Rural District, Tanzania.

CHILD SURVIVAL PROFILE

AFGHANISTAN

POPULATION: 31.1 MILLION

EVERY ONE INDEX RANKING:
—

EVERY ONE INDEX SCORE:
1.71 / 3.0

UNDER 5 MORTALITY SCORE:
0.5 / 1.0

EQUITY SCORE:
—

SUSTAINABILITY SCORE:
0.88 / 1.0

Despite a volatile political and security environment, child mortality in Afghanistan has declined 26 percent over the last decade. In 2013, more than one in 10 Afghan children will die before the age of 5. One in every 50 women in Afghanistan will die from pregnancy-related causes—a dramatic improvement from the rate in 2000, when one in every 11 women died during pregnancy and childbirth.

However, Afghanistan still has a very high burden of maternal, newborn and child deaths, with an under 5 mortality rate of 99 out of 1,000, approximately one-third of which occur during the newborn period.[63]

AFGHANISTAN AND THE EVERY ONE INDEX

Afghanistan is ranked in the middle of the EVERY ONE index, ahead of countries such as Nigeria and Uganda. Lack of data on equity in child mortality in Afghanistan makes it impossible to say whether or not the country is making equitable progress. However, Afghanistan is showing signs that its progress is likely to be sustainable. The Ministry of Health has plans to restructure the health sector, and in 2012 Afghanistan launched the Health for All Afghans initiative, which could help strengthen the governance capacity of the Ministry of Public Health. A National Gender Strategy is in place with the aim of improving gender equity, along with a National Reproductive Policy and Strategy. Afghanistan is also in the process of revising a strategy on child and adolescent health, which will include newborn care as a critical intervention for reducing child mortality.

Efforts to strengthen the health system have contributed to progress in maternal, newborn and child health. Growth in the number of midwives has played an important role. The Afghan Midwifery Project helped increase the number of trained midwives from 500 in 2002 to 3,500 in 2013. According to the World Health Organization, midwife training contributed to an increase in life expectancy for women from 47-50 years to 63-64 years.

Sustaining Afghanistan's Progress

The size of the health budget as a share of the total national budget increased from 1.7 percent in 2002 to 3.3 percent in 2011. External donors fund 75 percent of total public health expenditures, which is unlikely to be sustained over the long-term.

Increasing domestic resources will be critical to achieving the goals and objectives under the various health policies and strategies. The government should also focus more on strengthening health workforce capacity, especially at the community level. Despite important progress in training additional midwives, there continues to be a critical

CHILD & INFANT MORTALITY TRENDS

Indicator	2012	2000	% change	% of US deaths that are newborns
Under-five mortality (per 1000)	99	134	-26	36
Neonatal mortality (per 1000)	36	43	-16	—

SUSTAINABILITY MEASURES

Indicator	2011	2000	% change
Improved Sanitation Facilities (% of population with access)	28.5	23.2	23
Government Health Expenditure	3.34	1.70 (2002)	—
Governance	-1.46	-2.32 (2002)	—

shortage of health workers in many contexts. The National Health Workforce Plan would help increase the numbers only marginally, to 9.12 doctors, nurses, and midwives per 10,000 population over the next five years. There needs to be a sharper focus on increasing knowledge and training of health workers in reproductive and child health.

Behaviour change communication efforts will be key to increasing the demand for maternal, newborn and child health services. There is a significant lack of knowledge and appropriate care of children at home, including improper care of newborns and feeding practices, and delays in seeking care. Mass media can play an important role in raising awareness and in educating communities about effective newborn and child care practices.

child deaths do not occur because health systems are absent, but because they are poor quality and high cost, lacking the staff, equipment and resource needed to save lives. [64]

In most high-burden countries, more funding is urgently needed for better facilities, effective logistics systems for drugs and other life-saving commodities, health workers who are trained, supported and given the incentives to do their jobs well, and effective monitoring and accountability systems that enable progress to be tracked. Thirty-five years after the Alma Ata Declaration articulated a vision of "health for all", public investment in health care remains inadequate. Only three African countries commit more than 15 percent of public spending to health care, and two thirds of countries in the region spend less than 10 percent.[65] Wherever a strong public health system is lacking, poor families end up paying for services, usually through regressive official or unofficial out-of-pocket charges, such as user fees, that push 100 million people into poverty each year.[66] The World Health Organization estimates that impoverishment from out-of-pocket spending is minimized only when out-of-pocket spending is limited to 15-20 percent of total health expenditures.[67]

Where governments are committed to achieving UHC, there are necessary debates about how to best fund and provide services. While each context is specific, and some cost-sharing exists in most health systems, out-of-pocket charges at the point of use should be eliminated for essential reproductive, maternal, newborn and child health services, and where necessary cross-subsidies created within health systems between wealthier users and the poorest families. For low-income countries in particular, the road to UHC is often long, so governments should prioritize access to quality essential services for the poorest and most vulnerable.

Increased public funding is a necessary, but insufficient means of achieving UHC. Other barriers that often block access to health services, such as lack of transport and social customs that make it difficult for women and girls to seek health care outside the home, also need to be tackled. For example, public outreach campaigns that promote health-seeking behaviour should be part of a comprehensive effort to expand access and reduce inequities.

As access increases, quality of care must also improve. Facing a lack of options, poor people are commonly left to purchase health care wherever they can get it. This often means paying cash to local facilities that fail to meet the most basic quality standards. For example, Uganda's Ministry of Health closed 250 facilities in the capitol city of Kampala in 2013 because they lacked basic equipment including doors, wash basins and taps, and locks on the cabinets where medicines were stored.[68]

To provide affordable, quality health care to every child, national strategies toward achieving universal health care should also include three priority components: investment in ensuring that a health worker is within reach of every child; increased attention on providing essential newborn care; and expanded access to life-saving commodities.

GENDER DISPARITIES AND CHILD SURVIVAL

In most high-burden countries, girls face higher risks of mortality than boys. Addressing gender inequality is critical both as a means to improving health outcomes for children and as an end in itself:

- **Increasing girls' access to education** means healthier children. Educated girls tend to marry later and begin having children when their bodies are fully developed. They are also likely to earn more and therefore have more to invested in the health and well-being of their children.
- **Proper nutrition for women and girls** means proper nutrition for infants and children. Gender inequality impacts women's access to nutritious foods in the household. Where women have a low social status, they eat least and eat last. This also can be true for girls. Girls who are chronically malnourished and become stunted are at higher risk of birth complications and of giving birth to underweight babies in adulthood.
- **Unequal relationships between men and women** impact on women's ability to access health services, including family planning. This can have negative knock-on effects on the ability to space births and delay the age at which mothers first give birth. Unequal relationships can also increase the likelihood of early marriage, which can substantially increase the risks at birth both to mothers and children.

A Health Worker In Reach of Every Child

No child will receive health-care interventions or commodities without the support of a health worker who is appropriately trained, supported, equipped, motivated and within reach of every child, including the most poor and vulnerable. Children are five times more likely to live to reach their fifth birthday when they are in a country that has enough doctors, nurses and midwives to serve the population.[69] Yet worldwide, there is a shortfall of 3.5 million community health workers, midwives, nurses and doctors.

In 2006, the World Health Report drew attention to this crisis, identifying 57 countries where there were fewer than 23 doctors, nurses and midwives per 10,000 people—the minimum number identified by the World Health Organization as necessary to deliver essential health care. Seven years on, and despite some important progress on recruiting additional staff and improving the existing skills base (44 of these countries have now developed national plans to build their human resources for health) none of these 57 countries has reached the WHO threshold.

More health workers are urgently needed in rural, underserved areas and among the urban poor, who often face a double threat of being at increased risk of infectious disease, and being least likely to be within reach of a health worker. "Frontline" health workers provide health care in many of the areas that are hardest to reach, often being the first and only point of contact with the health system for millions of people. Frontline health workers with midwifery skills have a critical role to play in tackling newborn and maternal mortality—if midwives and skilled birth attendants, with the right training and support, routinely attended births, the lives of 1.3 million newborn babies a year could be saved. Yet there is an estimated global shortfall of 350,000 midwives globally.[70] Frontline health workers also play a key role in community case management of serious childhood illnesses such as malaria, diarrhoea, and pneumonia, and in antenatal home visits, birth preparedness and newborn care preparedness.

Solving the health-worker crisis is not only about increasing the number of workers. Many countries also need to dramatically improve the distribution of health workers to make sure they are reaching populations with the greatest need. It is also necessary to provide health workers with better training and supervision, improve their working conditions and provide incentives to retain them in the public health system. In addition to building the capacity of frontline health workers, governments also need to invest in the supervisory, support and referral systems needed to address more complicated health issues.

Essential Newborn Care

There are three major causes of children dying in the first 28 days: complications associated with premature birth (being born too soon), complications that arise during the birth process, most commonly birth asphyxia (not getting enough oxygen), and succumbing to infections. By addressing these conditions, it is possible to reduce newborn deaths by more than two-thirds.[71] These complications can be reduced with proper spacing between births and appropriate maternal nutrition, but they can also be treated. One key part of the solution is ensuring that skilled birth attendants are on hand to support mothers giving birth. Action in the following areas will also have a high impact:

- **Reduce complications associated with premature birth:** When a baby is going to be born early, administering corticosteroid medication to the mother before childbirth significantly improves the infant's chances of survival. Once the premature child has been born, exclusive breastfeeding, coupled with "kangaroo mother care" (holding the baby skin-to-skin) further increases the chance of survival.
- **Reduce complications that arise during birth:** Providing basic pregnancy and obstetric care for pregnant women, essential newborn care, and resuscitation when needed, prevents birth complications and helps keep complications that do arise from being fatal. Essential newborn care includes hygienic practices during the birth process (clean surfaces and tools such as a clean blade when cutting the umbilical cord), drying the baby to warm and stimulate his or her body immediately after birth, checking to see if the baby is breathing and providing resuscitation where necessary,

providing immediate skin-to-skin contact with mother for the first hour, and initiating early and exclusive breast feeding.

- Reduce the threat of infection after birth: Starting on day one, and continuing throughout the first month, babies require essential newborn care that reduces the risk from infections. Exclusive breastfeeding is one key way to prevent infections. Applying chlorhexidine, a widely available antiseptic, to the umbilical cord can also prevent many infections. Where newborns do develop infections, families and health workers must be able to identify the early danger signs, and receive antibiotics promptly from qualified health-care providers.

Life Saving Commodities

Making sure that health workers have the commodities they need to prevent and treat the causes of child and maternal deaths is a critical component of efforts to end preventable child deaths. Expanding access to 13 high-impact, yet currently neglected, commodities for women's and children's health could save more than 6 million lives over the next five years.[72] Four products alone—steroid injections for women in pre-term labour, resuscitation devices that trigger breathing in newborns, chlorhexidine to clean umbilical chords and injectable antibiotics to treat sepsis and pneumonia—could save the lives of more than 1 million babies each year, at a cost of between 13 cents and US$6 each. [73]

A growing number of partnerships have been established in recent years to accelerate the distribution of life-saving commodities. In 2010, Every Woman, Every Child challenged the global community to increase access to essential medicines and health supplies. In the same year, the UN Secretary General established the UN Commission on Life-Saving Commodities for Women and Children to improve access to 13 key commodities for maternal, newborn and child health in 50 of the world's poorest countries (Table 3). The Commission identified organizational partners who are now leading worldwide efforts to scale-up access to each of the commodities.[74]

Similarly, there has been growing momentum behind immunization following the success of the measles vaccine, which led to a 92 percent reduction in measles-related deaths in Africa between 2000 and 2008, and the introduction of new pneumococcal and rotavirus vaccines with the potential to dramatically reduce deaths from pneumonia and diarrhoea. These developments have spurred new investment and political commitment, especially through the Global Alliance for Vaccines and Immunisation (GAVI). The World Health Organization estimates that the lives of 2 million more children could be saved each year through a comprehensive package of available vaccines, and at the World Health Assembly in 2012, 194 countries endorsed the Global Vaccines Action Plan (GVAP) at, as part of a "decade of vaccines", with the goal of reaching every person with the vaccines they need by 2020.[75] While countries are implementing individual multi-year plans to achieve the GVAP's objectives, they have agreed to measure their progress annually based on a single accountability framework.

TABLE 3 COMMODITIES RECOMMENDED BY THE UN COMMISSION ON LIFESAVING **Commodities for Women and Children**

Product	Purpose
Oxytocin	Controls bleeding after childbirth
Misoprostol	Prevents postpartum hemorrhage
Magnesium sulfate	Treats preeclampsia and eclampsia (a preventible fatal condition) in pregnant women
Injectable antibiotics	Treats sepsis and pneumonia
Antenatal corticosteroids	Prevents death in pre-term newborns
Chlorhexidine	Prevents life-threatening infections in newborns
Newborn resuscitation equipment	Triggers breathing in newborns
Amoxicillin	Treats infections
Oral rehydration salts (ORS)	Treats dehydration
Zinc	Treats acute diarrhoea in children; essential for child
Female condoms	Family planning, STD prevention
Contraceptive implants	Family planning
Emergency contraception	Family planning

Achieving universal access to essential health commodities requires a diverse set of solutions:

- **Governments must be more accountable** for ensuring reliable supplies, with communities empowered to express demand for commodities and services to which they have a right—and to hold governments and service providers accountable for supplying them.
- **Wholesale price barriers must come down.** Countries must be able to reliably procure enough commodities to meet the health needs of the whole population. Each country needs a suitable range of suppliers so competition can drive prices down

and keep them low—including by enhancing and enforcing the capacity of emerging-market producers to make large quantities of quality products. Greater availability of off-patent medicines can help provide cheaper and more sustainable options for governments in low-income countries. Increasing the expression of demand would also help bring prices down.

- **The cost of products must come down at the point of care.** Commodities and the health services that deliver them must be free at the point of use, so that poor people are not excluded, or others pushed into poverty as the price of access.
- **The quality of health commodities must be safeguarded through effective regulation**—substandard medicines and vaccines cause harm to patients, result in extended illness or death, and even cause drug resistance.
- **Health workers must be in the right places, with the right training, with access to the commodities so that they reach the most vulnerable children and families**—including in hard-to-reach rural areas.

2. EVERY CHILD HAS THE NECESSARY NUTRITION TO SURVIVE AND THRIVE

Malnutrition is the underlying cause of 45 percent of deaths of children under 5, leading to over 3 million deaths each year, 800,000 of which occur among newborn babies.[76] [77] During the critical period from conception to 2 years of age – the first 1,000 days of life—chronic malnutrition can have irreversible effects on mental and physical development, exposing children to a lifetime of increased risk of ill health and reduced productivity. Stunting, which is caused by chronic malnutrition, can start during pregnancy as a result of poor maternal nutrition, poor feeding practices, low food quality and frequent infections, all of which can slow a child's growth.[78]

MALNUTRITION

Malnutrition results from lack of adequate nutrition for healthy growth and development and leads to various disorders including stunting, wasting, and micronutrient deficiency. A child is stunted when malnutrition causes him or her to be significantly shorter than a healthy child of the same age.[79] Stunting is a visible indicator of chronic malnutrition, and the presence of stunting suggests that a child's cognitive and biological development has been compromised. A child suffers wasting when malnutrition causes him or her to weigh less than a healthy child of the same height. Micronutrient deficiency occurs when a child has not received enough essential vitamins and nutrients to sustain their health. Micronutrient deficiency causes physical and cognitive disability and can be deadly.

Given the importance of nutrition to child survival, the slow rate of reduction in stunting poses a real threat to future progress towards the goal of ending preventable child deaths. Globally, the proportion of children who are stunted has been reduced slowly since 1990, from 40 percent to 27 percent. Six high-burden countries that are on track towards, or have already achieved MDG4—Bangladesh, Ethiopia, Malawi, Nepal, Niger, Rwanda—remain among the 34 countries with the highest burden of child malnutrition, raising questions about their ability to maintain current rates of reduction in child mortality.[80]

Well-nourished children are not only better equipped to fend off disease but also better able to learn and to contribute to their societies in the future. A recent study shows that malnourished children earn as much as 22 percent less than children who are well nourished.[82] When malnutrition is widespread, the cumulative impact is great enough to be a drag on entire economies. Research shows that malnutrition can reduce a country's gross domestic product by 2 to 3 percent.[83]

Ensuring that every child has an adequate level of nutritional intake to survive and thrive depends on a multi-pronged approach that goes beyond health care, to include social protection, food and agriculture policy, and water and sanitation. The actions in this approach include:

- **Make malnutrition visible** Chronic malnutrition needs to be made visible to policymakers and politicians as a cause of child mortality. An agreed global target needs to be enshrined in the MDGs post-2015 framework, with similar targets adopted at the national level in countries with the highest burden.
- **Invest in direct interventions** Scaling up the package of 13 high-impact interventions identified in The Lancet, including fortification, into ambitious national nutrition plans could save 2 million lives and would cost US$10-12 billion a year.
- **Protect families from poverty** Countries should work towards establishing social protection systems, with a guaranteed minimal nutritional floor, that reach pregnant and lactating women, and children under two.
- **Harness agriculture and food production to help tackle malnutrition** Governments must support small-scale farmers and women farmers, and ensure that making a positive impact on nutrition is an explicit objective of food and agriculture policies by focusing on policies designed to improve children's diets.

3. CREATE NEW AND INNOVATIVE PARTNERSHIPS

Securing the promise of the next child survival revolution is as much a political challenge as it is a technical one. Ensuring that child survival is a political priority in every country will require innovative partnerships that marshal knowledge, resources and political leverage to continually drive change. Countries have a responsibility to guarantee access to health care, but they will need to harness the capacity of civil society, including faith-based

organizations, the private sector and others to create an unstoppable movement to end preventable child deaths.

Overall progress in child survival has accelerated in recent years as saving children's lives has become a greater political priority. But just as political priorities ascend, they can also descend. The "U-shaped curve of concern" describes a situation where a global health issue is identified as a political priority, programmes are created, resources are invested and, as a result, cases and deaths decline. Over time, however, officials and policymakers interpret this success to mean that resources are no longer needed. They shift funding to other areas, and political attention wanes. As a consequence, illnesses or even deaths rise again, and progress is lost.[84]

As countries achieve MDG4, and the target date of 2015 is reached, there is a risk that the policy and political focus on saving children's lives will weaken and progress will slow. Accelerating annual declines in preventable child deaths until they are eliminated requires strong, sustained advocacy within countries and at the global level. No single individual or organization can keep child survival high on the political agenda. New and innovative partnerships that bring together diverse organizations and interests are needed to demonstrate a constituency of concern, create a climate of public expectation, demand change and ensure accountability. Fortunately, consensus across a range of critical areas in child survival has enabled the growth of effective and even visionary child survival partnerships. For example, we know that keeping newborns alive past their first day, then the first month, by delivering essential newborn care will reduce child deaths dramatically and that ensuring good nutrition in the critical window of a child's first 1,000 days will save even more lives, and foster healthy physical and cognitive development. We have even seen a recent resurgence of the idea that universal health coverage is an essential right to be fulfilled everywhere.

What makes today's child-survival partnerships so promising is that they are not merely centralized global initiatives. Through A Promise Renewed, 174 governments have committed to ending preventable child deaths in a generation, and are working with donor governments and UN agencies, as well with local actors in civil society and the private sector to achieve this goal. As part of Every Woman, Every Child and A Promise Renewed, countries are also currently contributing to the development of an Every Newborn Action Plan to be launched at the 2014 World Health Assembly. This plan is intended to provide a roadmap that all partners can follow in their efforts to reduce preventable newborn deaths.[85] Initiatives such as these are involving the participation of local actors from every sector. Their participation is essential, because if we are to eliminate preventable child deaths in the next generation, the child survival agenda must be carried out aggressively within countries, at the local level.

In order to ensure active stakeholder participation, governments need to ensure that public institutions allow all segments of the population, including the most marginalized, to impact the policymaking process. In many cases this will require organizing civil

CHILD SURVIVAL PROFILE

PAKISTAN

POPULATION: 193.2 MILLION

EVERY ONE INDEX RANKING:
25 / 34

EVERY ONE INDEX SCORE:
1.5 / 3.0

UNDER 5 MORTALITY SCORE:
0.5 / 1.0

EQUITY SCORE:
0.5 / 1.0

SUSTAINABILITY SCORE:
0.5 / 1.0

Pakistan is off track towards MDG 4. The child mortality rate in Pakistan declined by 23 percent over the last decade, while the newborn mortality rate declined by 15 percent. Pakistan continues to experience high child mortality rates, and almost half of under 5 child deaths occur among newborns.

Governments at both the national and provincial levels have recently taken some significant steps with the potential to improve maternal, newborn and child health (MNCH) across the country. The caretaker government established a Ministry of Health Services, Regulation and Coordination, and the current government has appointed a full-time Minister for Health Services at the federal level. The Ministry has formed a national MNCH task force, which is chaired by the federal secretary for health and includes all provincial health directors general. The provincial directors general have formed a provincial MNCH task force, which has the mandate to develop an accelerated plan for achieving MDG 4, and to support the activities led by the federal government and development partners. Provincial governments are also adapting the Global Action Plan for Pneumonia and Diarrhea for implementation at provincial level. Two provinces, Punjab and Sindh, have recently enacted a Protection of Breastfeeding Law, and provincial-level consultations are taking place on the country's Every Newborn Action Plan. A member of the SUN Movement, Pakistan has increased some funding for child health and nutrition and is also developing provincial policies, strategies and plans to improve nutrition. The political parties' manifestos include commitments to increase the national health budget and to improve immunization coverage.

PAKISTAN AND THE EVERY ONE INDEX

Like Nigeria, Pakistan's score falls in the middle of the index. Child mortality rates are declining more slowly than average in Pakistan and equity gaps are narrowing more slowly than average. A child born in the poorest 40 percent of households is more than twice as likely to die as a child born in the wealthiest 10 percent of households. While the government has made numerous MNCH policy commitments implementation remains weak.

Sustaining Pakistan's Progress

To accelerate progress on child survival, Pakistan must aggressively address its health workforce crisis, tackle child malnutrition and improve newborn health. To expand the coverage of proven interventions for the prevention and control of most common childhood illnesses, Pakistan needs a larger network of skilled and equipped community-based workers supported with supervision and monitoring. Routine immunization is weak, in part due to the lack of health-care workers. The government should enact legislation to remove barriers in the way of health workforce training.

Pakistan should also increase its focus on addressing nutrition in the first 1,000 days of life and neonatal mortality. Stunting in Pakistan rose from 41 percent in 2001 to 43 percent

CHILD & INFANT MORTALITY TRENDS

Indicator	2012	2000	% change	% of US deaths that are newborns
Under-five mortality (per 1000)	86	112	-23	49
Neonatal mortality (per 1000)	42.2	49.4	-15	—

SUSTAINABILITY MEASURES

Indicator	2011	2000	% change
Improved Sanitation Facilities (% of pop with access)	47.4	37.4	27
Stunting (all children under 5)	43.7	41.6 (2002)	—
Government Health Expenditure	3.58	2.46	—
Governance	-.82	-.58	—

EQUITY MEASURES

Indicator	1991	2006	% change
Wealth (Top 10% vs. Bottom 40%)	2.58	2.23	—
Gender (Male vs. Female)	1.03	1.03	—
Geography (Urban vs. Rural)	1.41	1.27	—

in 2011. The SUN plan must be translated into concrete action and increased budget allocation. Instead of tackling each of these issues independently, the population and the health system would benefit from an improved integrated approach to MNCH.

Furthermore, while the globally available data showed a decline, Pakistan has the world's third highest national number of newborn deaths.[85] The neonatal mortality rate of reduction of 0.9 percent has been less than the global average of 2.1% and less than the national maternal and child mortality rate of reduction.[86]

There is an urgent need for a strong civil society in Pakistan to monitor progress on child survival, build accountability and increase public influence in setting national priorities. As a first step, the process for creating budgets and policies needs to be made more open and transparent. Efforts should be made to improve communication between civil society and the national Planning Commission and finance departments, in order to increase public access to information.

society and building the capacity of individuals and organizations to participate, raise their voices and influence change.

Participation in the context of under-5 mortality means that parents, communities and civil society organizations are able to claim their right, and that of their children, to health. Participation also requires parents to be able to help shape policy discussions and processes that allow them to hold service providers and decision-makers to account on their commitments. Accessible, transparent and effective mechanisms of accountability for child health need to be in place at all levels in order to ensure that commitments are monitored, reviewed and acted upon.[87]

4. FINISHING THE JOB—ENDING PREVENTABLE CHILD DEATHS

The child survival movement stands at a historic moment. On the one hand, the MDGs have spurred unprecedented progress in child survival. On the other hand, fresh approaches are needed in order to sustain progress into the future. In the next two years, governments, international institutions, civil society and business will help to shape the post-2015 framework for poverty reduction and development, culminating in a UN international summit in late 2015. This framework will be a critical part of the architecture for child survival. A strong set of goals, focused on further progress in reducing child and maternal deaths, is essential to maintain political pressure and accountability for ending preventable child deaths.

Save the Children has identified five critical challenges that the post-2015 development agenda must address if we are to make the idea of ending preventable child deaths a reality.

1. **Equity** It is impossible to achieve MDG4 without significant improvements to health care, or health outcomes, among the poorest sections of society. The post-2015 framework needs to put a premium on reaching the world's poorest and hardest to reach, and address gender disparities.

2. **Accountability** The MDGs lack a robust accountability framework, so where political will has been weakest, progress has been slowest. Data is the foundation for accountability. As this report has shown, disaggregated data that enables tracking of progress for different social and economic groups is not possible in many countries.

3. **Synergies** The MDGs, while creating clear areas of focus, did not emphasize the ways in which one area of development, such as gender-based violence, can impact any other area, for example, newborn survival. The next framework must foster more holistic solutions to child survival by building linkages between health and other human development outcomes, and by promoting whole health-care systems that can deliver quality health care to all.

4. **Outcomes** The post-2015 framework must retain the MDGs' focus on outcomes for children's health, and not only measure inputs.

5. **Sustainability** Everyone's health depends on the environment in which we all live. As the world's population increases and as countries industrialize further, ensuring the health and sustainability of the environment will be even more critical to ensuring the health of children and adults alike.

To address these overarching challenges, we are calling for the post-2015 framework to establish 10 goals to be met by the year 2030. Every one of these goals is relevant to child survival (bold text denotes those directly focused on child health and wellbeing):

Goal 1: Eradicate extreme poverty and reduce relative poverty through inclusive growth and decent work.

Goal 2: Eradicate hunger, halve stunting, and ensure universal access to sustainable food, water and sanitation.

Goal 3: End preventable child and maternal mortality and provide basic health care for all.

Goal 4: Ensure children everywhere receive quality education and have good learning outcomes.

Goal 5: Ensure all children live a life free from all forms of violence, are protected in conflict and thrive in a safe family environment.

Goal 6: Make governance more open, accountable and inclusive. To provide a supportive environment for the goals above, Save the Children proposes four more:

Goal 7: Establish effective global partnerships for development.

Goal 8: Build disaster-resilient societies.

Goal 9: Ensure a sustainable, healthy and resilient environment for all.

Goal 10: Deliver sustainable energy to all.

PHOTO: JONATHAN HYAMS/SAVE THE CHILDREN

RECOMMENDATIONS

1. **Publish and implement comprehensive, costed national health plans in high-burden countries,** that respond to the key causes of child mortality and ensure quality essential health care for every child and mother. The plans must include:
   - The proven interventions and care needed for newborns to survive the crucial first month of life;
   - Programmes to reach every child with routine immunization and plans to include pneumococcal and rotavirus vaccines in routine coverage;
   - A properly trained, supported and equipped health worker in reach of every child and a skilled birth attendant present at every birth;
   - Investment in direct nutritional interventions aimed at tackling stunting and micronutrient deficiency.
2. **Launch a national campaign in every high-burden country** to reduce stunting, give every child access to a nutritious diet and make this an aim of social and agricultural policies and programmes, and ensure access to safe water and sanitation.
3. **Publicly commit the appropriate levels of public spending** to guarantee equal access to essential health care for all children, no matter where they are born, linked to a transparent process whereby civil society can actively track budgets and spending.
4. **Commit to ending preventable child deaths and to health care for all** in the post-2015 agenda, as part of a single framework that includes a robust accountability framework.

Babygirl, twenty one, sat with her three day old baby Margaret on her bed in a new Maternal Waiting Home built by Save the Children at Worhn clinic, Margibi county, Liberia.

ANNEX 1: **EVERY ONE** INDEX METHODOLOGY

The EVERY ONE Index uses data collected by the UN Inter-agency Group for Child Mortality and Countdown to 2015, as well as Save the Children analysis of nationally-representative household surveys.

Focusing on the 75 countries with the highest burden of maternal and child mortality, we assigned each country with a ranking based on the speed at which it is improving performance across three important dimensions—reducing the number of children under 5 who die each year (under-5 mortality), equity and sustainability. Our overall approach was to score countries more highly if their rate of progress was above average, while recognizing countries that are making progress but at a slower rate. Each country could score a maximum of three points, with one point available for each of the dimensions.

Reduction in Under-5 Mortality

We calculated the average annual rate of reduction in under-5 mortality between 2000 and 2012. Countries with a decline in under-5 mortality that was faster than the average scored a maximum of 1 point. Countries with a decline in under-5 mortality that was slower than the average scored 0.5 points. Countries that experienced no decline in under-5 mortality received 0 points.

Equity

We measured equity by looking at differences in the average change in under-5 mortality at three levels: between the richest 10 percent of the population and poorest 40 percent (wealth equity); between girls and boys (gender equity); and between children in rural and urban settings (geographical equity). A 1:1 mortality rate ratio is assumed to represent equity.

Again, we calculated the average rate of progress towards equity for each of the three levels. If a country was making above average progress in improving equity for one level, it received a score of 0.333. If progress was below average, it scored 0.167 and if equity levels were not improving then they scored 0. For example, India scored 0.167 for wealth equity, 0 for gender equity (because it is moving away from gender equity) and 1.67 for geographical equity, giving it a total equity score of 0.33 out of 1.

Sustainability

We selected four indicators to act as proxy measures for a country's likelihood of sustaining progress on child mortality: the existence of a costed national strategy for maternal, newborn, and child health; whether performance on Government Effectiveness Indicators had been improved; increased public expenditure on health as a proportion of total annual budgets; and increases in the proportion of the population with access to improved sanitation facilities.

In the case of costed MNCH strategies, a country scored 0.25 if it had a strategy and 0.125 if there was a partial strategy. For the other three indicators, we again calculated an average. If a country was making above average progress in improving performance, it received a score of 0.25. If progress was below average, it scored 0.125 and if performance declined then it scored 0. For example, Nigeria scored 0.25 for having a costed MNCH strategy, 0 for lack of progress on government effectiveness, 0.25 for increased public expenditure on health and 0 for no progress on access to improved sanitation, making its total sustainability score 0.5 out of 1.

Data Availability

Sufficient data on equity were not available for 41 of the 75 countries, so we assigned them with an average score to differentiate them from countries for which data were available. We assigned these countries an average score so as not to unfairly disadvantage them in the absence of available data. Recognizing the limitations of applying average scores—which undoubtedly resulted in some countries being assigned higher or lower scores than they deserve—this was the fairest way to assess their performance from a statistical perspective. We urge all countries to collect child mortality data that can be disaggregated by income, sex, geography (urban versus rural) and other important factors, such as ethnicity, so that inequity can be monitored and addressed.

ANNEX 2: **ADVOCACY** TIMELINE

2013

- October 30: GAVI meeting in Stockholm, Sweden on Mutual Accountability to assess progress towards immunizing 250 million children in the world's poorest regions by 2015
- November 10-13: Third Global Forum on Human Resources for Health
- November 12: World Pneumonia Day
- November 17: Every Newborn Action Plan on World Prematurity Day

2014

- April 7: World Health Day and World Health Worker Week
- May 19-May 23: World Health Assembly
- Global Launch: Every Newborn: An Action Plan to End Preventable Deaths
- Report series release: New neonatal series to be published in The Lancet
- June 16: Day of the African child
- June: Two year anniversary of A Promise Renewed
- June: One year anniversary of Nutrition for Growth Summit
- July 11: Two year anniversary of Family Planning 2020 London, England, to increase access to contraceptives to 150 million more women and girls by the year 2020
- August 1-7: World Breastfeeding Week to promote breastfeeding for better child nutrition, each year has a different theme, a chance to disseminate advocacy materials in support of breastfeeding and complementary feeding
- August 18: 500 days before MDGs deadline
- September: One year before MDGs deadline
- November 15-16: Brisbane, Australia, G20
- November 20: Universal Children's Day

2015

- April 7: World Health Day and World Health Worker Week
- May: World Health Assembly
- June 16: Day of the African Child
- June: Three year anniversary of A Promise Renewed
- June: Two year anniversary of Nutrition for Growth Summit
- July 11: Three year anniversary of Family Planning 2020
- August 1-7: World Breastfeeding Week
- September: High level UN summit on the MDGs
- November: GAVI pledging conference

AN **INTERVIEW** WITH KUL GAUTAM

"THE TIME FOR CHILD SURVIVAL HAS COME."

Kul Chandra Gautam is former Deputy Director of UNICEF and Assistant Secretary General of the United Nations. He was the key senior UNICEF officer responsible for drafting the Declaration and Plan of Action of the 1990 World Summit for Children.

Q. Since you began your career at UNICEF, child deaths have dropped from 45 thousand children per day to 19 thousand per day. The deadline for reaching MDG4 is looming, and we have also seen a new movement arise to eliminate preventable child deaths in the next generation. How hopeful are you that we can build on this momentum and actually eliminate preventable child deaths?

In public health, as in other basic services, it is often easier to reach the first 50 percent of the population than the last 10 percent. That is because many of the "low-hanging fruits" are plucked first and we are left with the hardest-to-reach populations and more expensive interventions. In child survival, too, we made great and quick progress in implementing many low-cost, high impact interventions. For example, oral rehydration therapy against diarrhoea and mass immunization against vaccine-preventable diseases, which reduced child mortality dramatically. Now, most of the child deaths in the world are concentrated in the neonatal period, which means during the first days and weeks of an infant's life. These deaths are closely linked to maternal health and nutrition and require interventions before and during pregnancy and immediately after delivery. And there are no quick fixes.

However, we have now acquired valuable experience in offering reproductive, maternal, newborn and child health services following a "continuum of care" approach. The Save the Children-led "Saving Newborn Lives" initiative has made a huge impact. Targeted nutrition interventions during the first thousand days, from conception to twenty-four months, and the UN-led Every Woman, Every Child campaign have generated great momentum for reducing mortality among newborns. I am, therefore, quite optimistic that dramatic further progress can be made in ending preventable child deaths in the coming decade.

Equity, disparity reduction and "leaving no child behind" are likely to be key strategies of the post-2015 global development agenda. Since the greatest gaps between the rich and poor countries of the world, and even inside national borders, are in terms of maternal and child deaths, I expect this issue to command high priority, and result in great success.

Q. Why are you optimistic that tackling childhood malnutrition is more feasible now than ever before?

When we started the first child survival revolution in the 1980s, we already knew that malnutrition was a major underlying cause of child mortality. But we weren't able to

tackle it at that time, because we didn't have ready solutions. We had immunization, and it was cheap. We had oral rehydration therapy. And while malnutrition was known to be a problem, we had no ready solution. Part of it was that we had no agreement among nutrition experts. Should we focus on feeding? On agriculture? Should we measure height? Weight? Should we provide this enzyme? That enzyme? As a result, we didn't make a big effort. The wonderful news is that after three decades we finally have agreement on what should be done.

Q. And what is that?

Today we have consensus that we need to focus on the first one thousand days, starting in pregnancy and to the second year of age. Why is that 1,000 days so important? Because some of the damage that is caused to the body and mind in those days is irreversible. But on the positive side, if you have well-nourished children at that age and in early childhood, then a whole positive cycle begins. Children who are well nourished don't get sick as often, they go to school more often, they concentrate better in school, and when they graduate they will get better jobs. This leads to better income and better development for themselves and for society.

Q. How can national policymakers take the lead in improving child survival?

They should put child survival at the centre of national development. Why? All the other things they want—to grow the economy, to have a productive workforce, to build an educated society—these all rely on having a healthy population. Malnutrition, especially, harms development because children suffer long-term cognitive disabilities that then hold them back. Whatever your agenda is—economic, social, human development—we need to start with ensuring healthy, well-nourished infants and children. If we miss our chance to fulfill these basic rights for children when they're young, we cannot fully make up for it later.

Q. Despite being a poor country that has experienced civil war relatively recently, your country of Nepal has still made significant progress towards improving child survival. What is one thing that the government did to really accelerate progress?

I grew up in a village. Our village was similar to other villages in that we could see lots of people had goiters in their neck. As a child, I wasn't sure what this meant. What caused this? Was it just cosmetic, or were people with goiters suffering something profound? Later we all learned that it was caused by iron deficiency, and it was actually the most prevalent form of brain damage. When the government learned this, it required salt to be iodized. It was such a simple solution. You need less than half teaspoon of iodine

throughout your whole life to prevent goiters and the underlying cognitive damage. How much does that cost? Pennies, not even dollars. Today you go to Nepal and you don't see many people with goiters anymore. There may be some elderly people who survived from those times, but my children and grandchildren don't know anyone with goiters. In my childhood they were everywhere. This is one example of how the whole landscape has changed.

Q. What would you say to national leaders who might need some constructive encouragement to invest more resources in child survival?

Leaders of emerging countries that wish to be bigger actors geopolitically must realize that they are viewed not only in terms of the sizes of their economies or their militaries, but also in terms of how their people are thriving — or not thriving. Just look at how much progress on child survival we have made in the last two decades. It is astounding. But to continue making progress, we are going to have to work harder at reaching children who have not yet been reached. Leaders cannot afford to delay. In fact, I am reminded of an old proverb. When is the best time to plant a tree? The answer: 20 years ago. When is the second-best time? The answer is today. The time for a renewed focus on child survival has come.

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LIVES ON THE LINE

An Agenda for Ending Preventable Child Deaths

"THERE CAN BE NO KEENER REVELATION OF A SOCIETY'S SOUL THAN THE WAY IN WHICH IT TREATS ITS CHILDREN."

— Nelson Mandela, former president of South Africa

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