CHILD ILL HEALTH AND MORTALITY – HOW CAN WE PREVENT THE PREVENTABLE?

While significant gains in childhood mortality have been made[i], over 10 million children under-five still die every year, 99 per cent of them in developing countries. In sub-Saharan Africa, the absolute number of deaths of children under-five continues to rise. World-wide there is a worrying slowdown in improvements: the rate of decline in childhood mortality has slowed considerably – from 2.5 per cent (1960–90) to 1.1 per cent in the last decade, and this is also the case in countries that have the highest rates of mortality. A divide is emerging both within and between countries, with the poorest being left even further behind.

Early insults to the growth and development of children are partly irreversible, even with intensive interventions later in life. In many cases, the damage is done even before the child is born – small maternal size at conception produces malnourished infants and girls who will later, as malnourished mothers themselves, perpetuate poverty transmission. Child malnutrition rates are slowly rising in many countries, disturbingly in countries such as Ghana and Uganda which have been commended for their market reforms and economic growth rates, suggesting the importance of distributional issues[ii]. In 2000, over 150 million preschool children were estimated to be underweight and over 200 million children to be stunted. At current rates of improvement, by 2020 about one billion children will be growing up with impaired mental development[iii]. Childhood morbidity is especially worrying throughout sub-Saharan Africa and in entrenched pockets in many developing countries in other parts of the world, with parents unable to afford the cost of treatment for sick children.

If a representative sample were taken of 100 children born in 1990, 55 would have been born in Asia, (19 in India and 18 in China). Sixteen would have been born in sub-Saharan Africa and eight in industrialised countries. The births of 33 of these children went unregistered: as a result, they have no official existence, nor recognition of nationality. Some of them have no access to health facilities or to school without this official proof of their age and identity. Around 32 of the children would have suffered from malnutrition before the age of five, and 27 were not immunised against any diseases. Nine died before the age of five. Of the remaining 91 children, 18 do not attend school, of whom 11 are girls. Eighteen of the children have no access to safe drinking water and 39 live without sanitation. These figures provide a stark reminder of the number of children who are not born into a safe, healthy and guaranteed existence[iv].

Improving child health and nutrition is not only a moral imperative but also a rational long-term investment. The Nobel laureate economist, Robert Fogel, suggested that approximately half of the economic growth achieved by the UK and a number of western European countries by 1980 could be attributed to better nutrition and improved health and sanitation conditions – social investments made as much as a century earlier. It has been calculated that just three types of malnutrition (protein energy malnutrition, iron and iodine deficiency) are responsible for three to four per cent of GDP loss in Pakistan in any given year[v]. Tackling malnutrition in the young therefore clearly makes economic sense.

WHAT CAUSES CHILD ILLNESS AND DEATH?

The immediate causes of childhood illness and under-5 deaths are nutritional deficiencies and infectious diseases (diarrhoea, pneumonia, malaria and measles, and HIV/AIDS being particularly important in eastern and southern African countries). Neonatal causes (severe infections, birth asphyxia and complications of prematurity) claim 42 per cent of all deaths, illustrating again the importance of maternal and infant nutrition and overall health.

HIV/AIDS is estimated to infect 800,000 children annually, and in sub-Saharan Africa is responsible for 8 per cent of all childhood deaths, rising to over 20 per cent in the high prevalence countries of southern and eastern Africa. Although it is a major catastrophe, it should not overshadow the fact that even in regions with high infection rates, the other causes detailed above remain significant killers of children.

"under nutrition has remained the single leading global cause of health loss[vi]"

These diseases continue to claim lives despite the fact that the past few decades have seen impressive advances in our understanding and technical ability to prevent, treat and mitigate the effects of many childhood illnesses. The challenge is to implement successfully these interventions among the poorest. In order to do so, a range of pro-poor social and economic policies that improve equity in child health need to be adopted.

CHILD ILL HEALTH AND POVERTY

It is clear that poverty and ill health are causally related, and improved health will result from improvement and changes in sectors other than health. Poor nutrition, ill health and the inability to afford healthcare are perpetuated by low and declining real incomes, poor female education and status, unhealthy environments (housing, water and sanitation) and inadequate access to quality health services.

A child living on less than a dollar-a-day can have very different health and development outcomes depending upon which country or region he or she lives in [vii].

Incomes alone are a poor determinant of health outcomes. Measures of child health do improve with income; however, waiting for growth to 'trickle down' and improve the quality of life is not enough, especially in contexts of rising inequalities or stagnant or declining economies. Experience shows that it is possible to achieve a high level of social development (and mitigate the worst manifestations of poverty) even without a thriving economy.

Malnutrition in Latin America decreased from an estimated 21 per cent in 1970 to 7.2 per cent in 1997, while the rate of poverty (measured by income level) decreased only slightly over the last three decades – from 45 per cent in 1970 to 44 per cent in 1997 [viii]. These gains in reducing malnutrition are attributed to complementary feeding, access to basic health services and women's empowerment in terms of their education and the cash resources they control.

Therefore, a child living on less than a dollar-a-day can have very different health and development outcomes depending on which country or region he or she lives in.

KEY FACTORS THAT CONTRIBUTE TO AN INCREASE IN HEALTH STATUS

1. Government and public commitment to equitable provision of health services

The importance of a strong political and social commitment to equity (ie meeting all people's basic needs) cannot be over-emphasised.

Countries that have achieved low levels of child mortality in low-income settings have all demonstrated political commitment to equity, as well as policies and strategies to provide essential services to all. This may be achieved through a long history of egalitarian principles and democracy (eg Costa Rica), through agitation by disadvantaged political groups (eg Kerala state in India) or through social revolution (eg China).

States that have achieved good health at low cost (eg Costa Rica, China, Kerala State, India, and Sri Lanka) dramatically reduced their infant and child mortality rates and, as a result, increased their life expectancies to near those of developed countries. These reductions were accompanied by a decline in malnutrition and, in some cases, the incidence of disease.

Why some countries (such as Nigeria [ix] and Brazil in the 1990s, and the USA in the early 19th century) at various stages of their development failed to convert growth into improved life expectancy and quality of life is related to the role of public action. As Sen (1999) notes, 'the support-led process does not wait for dramatic increases in per capita levels of real income. It works through priority being given to providing social services (particularly health care and basic education) that reduce mortality and enhance the quality of life'. A commitment to social development and basic services is, in fact, an important pre-requisite for growth, when it happens, to have human development outcomes.

2. Public Health Programmes: The primary healthcare approach as part of well-planned and implemented public health programmes

The challenge is not one of lack of science or knowledge about interventions, but a lack of implementation of known efficacious interventions, especially among the poorest people.

'Amid the plethora of new and newly validated interventions there are signs that the child survival effort has lost its focus. For example, levels of attention and effort directed at preventing the small proportion of child deaths due to AIDS … Seem to be outstripping the efforts to save millions of children every year with a few cents' worth of ITMs (insect treated materials), oral rehydration therapy, or efforts to promote breastfeeding. This must change' [x].

There are a number of proven preventative interventions – antenatal care, immunisation, birth spacing, etc – but access to health services is the key factor between different socio-economic groups. Even free services are better accessed by the rich than the poor due to the poor having less knowledge, being in remote areas, being unable to cope with out-of-pocket costs and receiving inadequate and poorer quality services.

Effective large-scale implementation is the key challenge. Where public health programmes are planned, implemented and accessed well, even tackling a few diseases – eg through diarrhoea control or large-scale nutrition programmes – can significantly reduce mortality rates. The primary healthcare approach has been a huge success because it is based on an understanding that health improvements result from a reduction in both the effects (mortality and morbidity) and incidence of disease, as well as from a general increase in social wellbeing. Thus, a combination of approaches is necessary including *promotative* – operating at the level of society, *preventative* – addressing the immediate and underlying causative factors, and *curative and rehabilitative* –

dealing with the effects of health problems. Such an all-inclusive approach, which bridges sectors and incorporates social and political factors, enhances healthcare outcomes. Whilst specific actions will vary between programmes, the principle is to link up different levels. For example in a nutrition programme dietary support should be given not only in relation to nutrient value but also considering food security, and therefore cost, cultivability and or purchasability. Educational action should reinforce food habits and there should be a minimum of core health service activities managing childhood illness, the promotion of breastfeeding, support on weaning and general disease management. Coverage is also important, going beyond women and children and recognising the importance of the whole society in achieving improved health. Once broad coverage is achieved, more specific focus can be justified. Examples of successful programmes include that established in Jamkhed, India in 1971, Ceara in Brazil from 1986 and BRAC in Bangladesh in 1972[xi].

3. Synergies between services and government provision

The separate effects of different interventions, such as health, nutrition, water and sanitation and education, will only be partial. Their integration will be complementary and reinforcing so that the impact of any one intervention is increased in the presence of others.

In a Nigerian village, the equivalent gain in life expectancy at birth was 20 per cent when the sole intervention was easy access to adequate health facilities for illiterate mothers, 33 per cent when it was education without health facilities, but 87 per cent when it was both[xii].

However, integrated social and economic policy is a complex system and co-ordination is critical. For this reason, ***the role of the public sector is central*** since markets alone will not ensure universal access, which is necessary to provide the equity that is clearly critical in achieving sustainable human development gains. If the poor have to pay for services, they will not, as has been widely observed, use them. In addition, providing services to rural and remote areas needs to be a government concern since such services offer largely unprofitable prospects for the private sector. Ensuring simultaneous or well-sequenced interventions is more likely if the government is the provider of all services.

While private sector providers may have some role, they cannot be relied on for comprehensive coverage, can detract from equity provision, weaken government provision (as core staff are employed by private providers and overall resources to government providers fall) and require strong regulation by government bodies.

Decentralisation of services has been a popular response to past failures in service delivery because of its potential to respond faster to local needs, be accountable and transparent, improve information flows and make health programmes locally accountable and sustainable. Decentralisation works best where the state allows local government full control over finances and functions.

4. Education for all and gender equity and empowerment

Education is strongly correlated with improved health outcomes. One factor enabling educated women to achieve higher levels of nutrition for their children is that they are able to use their general knowledge and skills to acquire health-specific knowledge. Importantly, however, they can only act on their knowledge when they have control over resources, ability and freedom to make decisions, and freedom of movement outside the home. In countries[xiii] where sustained and improved health outcomes have been observed, women have had comparatively high literacy rates, and levels of girls and boys primary and secondary school enrolments are similar. In some of these countries, women are also employed as doctors and teachers and in the workforce are wellrepresented in non-agricultural employment. They also have their rights upheld by law in terms of maintenance, inheritance and property. However, which particular kinds of gender improvements are most closely related to improved quality of life for children requires further analysis.

Gender equity and non-discrimination is thus vital for achieving improved health outcomes.

WHAT ARE THE KEY OBSTACLES TO PROGRESS?

1. Growth First

Very poor countries can achieve profound improvements in the health of their populations by ensuring that the basic needs of all people are met. The 'growth first' development model which hopes that some of the aggregate wealth will trickle down to the poor, has not been successful in achieving improved health outcomes. Countries that have over the last 20 years improved the health status of their populations, have ensured that social policy was in place first so that growth, when it happened, could be translated into social development outcomes. They also maintained their commitments to social expenditure during periods of adjustment (eg Botswana, Zimbabwe and Mauritius) and resisted orthodox adjustment measures, using instead their own, sometimes unconventional, stabilisation processes[xiv] (eg Costa Rica, Mauritius, Malaysia and Korea).

This does not mean that growth is unimportant. Growth is important and a sustained improvement in the quality of services does require increased per capita expenditures. Stagnant or slow growing economies such as in Kerala State (India), Sri Lanka and Cuba (in the 1990s) have created problems for the social sectors. However, economic growth is not automatically translated into improvements in the social sectors. Oil rich countries such as Cameroon, Venezuela, Gabon and Nigeria have failed to turn wealth into social development outcomes; Brazil shows that the fruits of rapid economic growth (from the 1970s) is not necessarily shared equally. Growth-oriented measures which continue to relegate social development to a secondary level of importance are a primary obstacle to progress in improved health outcomes.

Equitable distribution

Encapsulated within structural adjustment programmes, and now part of development policy lending, is the tendency to ignore the importance of equitable distribution in achieving human development successes. Key donors and governments have failed to acknowledge strongly that this does matter in terms of meeting the basic needs of all people and achieving improvements in the health of entire populations.

2. Poor Health Sector Reforms

While it is well-established that the strategies for tackling health problems require a comprehensive approach (involving rehabilitative, curative, preventative and promotative components), limitations of financing and human resources have resulted in the narrow and technology-oriented approach of selective primary healthcare. This approach focuses on certain interventions – such as growth monitoring, oral rehydration therapy, breastfeeding and immunisation (GOBI) – for a variety of childhood diseases. It has at best delayed, and at worst, undermined the implementation of the comprehensive strategy codified at Alma Ata[xv]. The relative neglect of the other primary healthcare programme elements (combining the rehabilitative, curative, preventative and promotative components that also address underlying causes) and the shift away from equitable social and economic development, intersectoral collaboration, community participation and the need to set up sustainable local-level structures, suited the conservative tendencies of the 1980s and provided donors and governments with a way of avoiding the fuzzier and more radical challenges of tackling inequalities and the causes of ill health. The result was the enthusiastic initiation of selective interventions – often delivered through vertical[xvi] centrally-organised programmes – which received generous funds to the detriment of more comprehensive approaches. This is compounded by a severe lack of human resources due to the recruitment by northern countries of medical professionals, HIV/AIDS and staff attrition due to poor motivation or remuneration.

It is estimated that developing countries invest about £500 million in training health professionals who are then recruited by developed countries, equivalent to roughly 25 per cent of the total overseas development aid to these countries[xvii].

3. Financing

Many countries spend more on servicing external debt than they do on basic services. Ethiopia spends 22 per cent of its national budget on health and education but this only amounts to US$1.50 per capita on health. Even if Ethiopia were to spend its entire budget on healthcare, it would still not meet the WHO target of US$30–40 per capita. The Commission on Macroeconomics and Health (2001) estimated that a minimum of an additional $22 billion per year by 2007, and $31 billion per year by 2015, would be required to support critical health interventions in developing countries.

However, aid levels have been dropping relative to GNI since 1960 and now, at 0.22 per cent of GNP, are at their lowest ever. $600 billion in debt reduction is required to ensure that debt repayment does not impinge on essential social development funding. Compounding these shortfalls in available resources is defence expenditures, which are notably higher in countries that have low human development outcomes than those that have achieved some successes. Attempts at cost recovery through user fees have largely been unsuccessful. In Africa, the introduction of user fees increased revenues only slightly while significantly reducing the access of the poor to basic social services[xviii].

4. Donor Approaches

In a desire to achieve quick results, the inappropriate use of vertical programmes is often adopted, resulting in a widening of inequitable health outcomes and disparities in access to healthcare. The international community's response to the HIV/AIDS pandemic, while certainly commendable, comes with the caveat that an increased focus on anti-retrovirals is at the expense of other vital healthcare services. Specialists within the health sector have also perpetuated a narrow focus, ignoring other sectors and the importance of ensuring that synergies between sectors and the wider context are vital in achieving improved health outcomes.

5. Other Key Obstacles

Other key obstacles to progress include ***gender discrimination and low citizen awareness and poor political commitment to human development***.

Poor progress in women's education and rights has compounded problems in the health sector in almost all countries with poor health indicators.

The role of ideology and politics cannot be ignored as driving forces. Democracy (in the conventional sense of regular multi-party, free and fair elections) is neither a necessary nor sufficient condition, but it does help. What is crucial, however, is that there has to be a mechanism for the expression of the voice of the people. This is notably lacking in countries with poor health indicators.

Policy Pointers:

- *Growth strategies must be preceded and accompanied by social development commitments*
  Commitment to human development and the structures to enable social policy must precede or, at the very least, run parallel to economic growth strategies. This enables the products of growth to be used to achieve human development goals.

- *Equity in basic needs coverage*
  Political contexts matter and commitments to *equity*, ie meeting all peoples' basic needs, is vital. The involvement of governments to deliver core *public services* and achieve *quality coverage* is essential in this regard. *Public action* to demand equitable distribution and delivery of basic needs has proved critical.

- *Good nutrition requires a comprehensive approach*
  Key nutritional supplements and food security interventions (particularly for under-fives and pregnant women) are important in addressing the crisis in nutrition. This needs to be addressed within a comprehensive health programme tackling other diseases, health education, and aiming for comprehensive coverage. In the medium- to long-term, comprehensive primary healthcare, with sufficient numbers of trained health workers and synergies with sectors other than health are vital (as discussed below).

- *Synergies in sectors other than health*
  Improved health outcomes are also influenced by sectors other than health. Attention to incomes and assets, gender discrimination, education and healthy environments (housing, water and sanitation) are key to reducing childhood death and illness. Synergies between all these elements are critical and need to be enabled through government co-ordination.

- *Commitments to comprehensive primary healthcare*
  Comprehensive primary healthcare should not be abandoned in favour of selective approaches. Vertical programming, similarly, needs re-evaluation.

- *Financing commitments must be increased and maintained*
  Levels of spending (enhanced by increases in aid and debt relief) need to be maintained, even in times of crisis and structural adjustment.

- *Gender issues are central to achieving improved health outcomes, and anti-discrimination measures must be enhanced urgently*
  Women are agents of change and are a vital part of achieving improved health for children and young people and the wider community.

Further Reading:

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Wagstaff, A., 2003, '*Child health on a dollar a day: some tentative cross-country comparisons*', Social Science & Medicine 57(9):1529–38

Grow Up Free From Poverty (2003) *80 million lives: meeting the millennium development goals for child and maternal survival* Save the Children and CAFOD 2003

Useful websites:

The Bellagio papers first published in *The Lancet* http://www.asns.org/sinr/links.htm

i In the last decade, more than 60 countries have reduced childhood mortality by at least a third.

ii Harper, C. and Marcus, R., 2000, *Mortgaging Africa's future, the long term costs of child poverty*, SID, London: Sage.

iii James Commission, 2000, UN Report.

iv UNICEF, State of the Worlds Children, 2002.

v Horton, S. and Ross, J., 2003, *Food Policy*, Vol. 28.

vi Ezzati, M. *et al*, 2002, *The Lancet*, 360:1–14.

vii Wagstaff,A., 2003, Child health on a dollar a day, *Social Science and Medicine* 57(9)1529–38

viii UNICEF, 1998, State of the Worlds Children, UNICEF, New York.

ix It should be noted that in 1999 87% of Nigeria's GNP was used to repay debt while 10% went on defence 2% on education and 1% on health, UNICEF, 1999, The progress of nations, UNICEF, New York.

x Jones, G., et al 2003, *The Lancet*, 362:65–71

xi See CHIP report 10

xii Caldwell, J.C., 1986, Population and Development Review, Vol.12.

xiii Ten countries which exceeded the pace and scope of social progress of most other developing countries in the same time frame: Costa Rica, Cuba, Barbados, Botswana, Zimbabwe, Mauritius, Kerala State (India), Sri Lanka, Korea, Malaysia.

xiv In Korea, for example in the inflation of the 1970's, the state introduced zero based budgeting, and encouraged both capital and labour to share the costs of adjustment, restricting price increases on goods, encouraging households to save and spend less, farmers to accept fewer subsidies and wage earners to accept minimal increases.

xv Declaration adopted by the 1978 international conference on primary health care, held in Alma Ata.

xvi A specially funded programme, often focused on single issues (such as one disease) and neglecting broader elements such as systems development.

xvii Padarath, P et al, 2003, Equinet Discussion paper No.4, www.equinetafrica.org/policy

xviii Gilson, L., 1997, The lessons of user fee experience in Africa, Health Policy and Planning, 12(4):273–85

This briefing is based on Chopra, M. and Sanders, D., 2004, *Child Health and Poverty*, CHIP Report 10, CHIP: London.

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