GOAL
4

# THE 'CHILD MORTALITY GOAL'

## Goal 4 Reduce child mortality

**Target 5** **Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate**

*Indicators* *Under five mortality rate*

*Infant mortality rate*

*Proportion of one-year old children immunised against measles*

## Child survival depends on gender equality

It is easy to think of infant mortality and child survival as purely health issues which can be addressed through medical interventions such as prenatal and postnatal health care, safe childbirth, good nutrition and timely immunisation. Such a view would however be a seriously limited one. While medical factors and the state of the health infrastructure in the country are important, infant mortality and child survival are closely dependent on multiple social factors, the most critical of which is gender equality.

- **The basic foundation of child survival and health is determined during pregnancy.** Poor health (particularly anaemia and malnutrition) is a fact of life for millions of women, which is compounded during pregnancy by overwork, under-nutrition and chronic ailments that directly affect the health and survival chances of the foetus.

- **The mere existence of infrastructure and facilities for newborn care is not enough to ensure access.** In many instances, decisions around childbirth are taken by the husband and older women in the family – traditional norms, lack of faith in modern methods, misconceptions about immunisation and most of all, the low value placed on the mother's life and health often operate to deprive infants of emergency care immediately after birth.

- **Women's own understanding about safe childbirth and appropriate child care is inadequate.** Access to information is constrained not only by women's lack of freedom in decision-making, but is clearly linked to their levels of capability. Numerous studies have shown that women with even a few years of education are better equipped to locate and access health information, and have more bargaining power within the family on decisions related to her child's health.

- **Patriarchal traditions and cultural norms sanction the neglect of girl children in infancy.** As a result, baby girls are given less care and fewer months of breastfeeding, are less likely to be taken to a doctor when they are ill and may not even complete a full course of immunisation. In some regions of the world, the bias against girls is even more extreme and goes to the extent of female foeticide and female infanticide. While such practices are shrouded in secrecy, the highly imbalanced sex ratios in these countries reveal the true picture of gender inequality.
- **Women's poverty and lack of access to productive resources are a direct cause of infant mortality.** In many countries, the introduction of user charges in the public health system has reduced the access of poor women and children to basic nutrition and essential medical care.
- **Gender inequality in employment and women's dependence on low-paid and insecure jobs.** Without the assurance of minimum wages or paid leave this factor is directly linked to child survival. For poor women in many countries, taking a day off to care for a sick infant or go to a doctor for help, would mean not only the loss of a day's wage, but would put her at risk of losing her job.
- **Infrastructure is a critical factor.** Often, the distance between the home and a health facility, accessible all-weather roads and cheap transport are the factors that can save a child's life in an emergency. However, these links are not always visible to planners and policy makers who take decisions on investments in infrastructure. The vertical segmentation of government departments, with child survival being the concern of the health department and issues such as rural roads and rural transport being dealt with under other departments, acts as a barrier to gender-responsive investments in infrastructure.

## How gendered is reporting on Goal 4?

Sex-disaggregated data can provide compelling evidence of the links between gender inequality and child mortality. Unfortunately, only seven of the 78 reports reviewed present sex-disaggregated data on the indicators of infant mortality and child survival. No single report provides disaggregated data against all three indicators.

The fact that sex-disaggregated data on infant mortality is available in comparatively few countries is a reflection of the continued prevalence of a bio-medical approach to the issue – particularly unfortunate because the inadequacy of such an approach has been amply demonstrated by studies and researches across the world.

### A positive trend - sex-disaggregated data

- **Infant mortality and under-5 mortality** (Bahrain, Lebanon, Syria, Slovakia, Paraguay)
- **Age-specific death rates** (Poland)
- **Proportion of children immunised against measles** (Syria)
- **Sex ratio** (Tajikistan)

**A more encouraging trend is visible in the extent to which women's capabilities have been identified as critical determinants of child survival.** Although only seven reports make specific mention of the links between child mortality and gender inequality, as many as 25 mention the mother's health status as a major factor in child survival. The mother's level of education and access to information is mentioned in 16 reports as an important determinant of child survival. This recognition of women's health and education as important issues within the child health discourse is to be welcomed.

**However, it should be recognised that a purely instrumental concern for women's health and education – simply because they are necessary to ensure child survival - need not necessarily translate into greater gender equality.** Indeed, the majority of the references to the need for women's education and access to information are made in the specific context of equipping women to better care for their babies, rather than as a way of empowering women and strengthening their capabilities across the board.

**A positive trend - making connections visible**

- **Low status of women as a cause of infant mortality** (Kenya)
- **Inability of teenage mothers to overrule husbands and exercise choices** (Botswana)
- **Early pregnancy related to negative male attitude towards condoms** (Uganda)
- **Cultural preference for educating boys rather than girls** (Uganda)
- **Discrimination in health care for baby girls** (Egypt)
- **Interventions for women's empowerment as part of community health programme** (Ghana, Timor)
- **Son preference** (Albania, Egypt)
- **Gender equality identified as priority** (Egypt)

A more positive indication comes from the fact that reproductive health is mentioned as an important determinant of child survival in nearly one fourth of the reports (17 reports out of 78). Although this term is not defined or unpacked in all cases, it signifies a positive trend, since the reproductive health framework implies affirmation of women's right to control over their own body and fertility.

**A major missing link in reporting is the connection between poverty and infant mortality - something that would seem to be the most obviously visible issue.** Only three countries (Ghana, Cote d'Ivoire and Rwanda) have mentioned poverty and resource constraints as challenges in meeting Goal 4. Needless to add, the issue of infant mortality does not come up for discussion under Goal 1 in any of the reviewed reports.

## How can reporting on Goal 4 be strengthened?

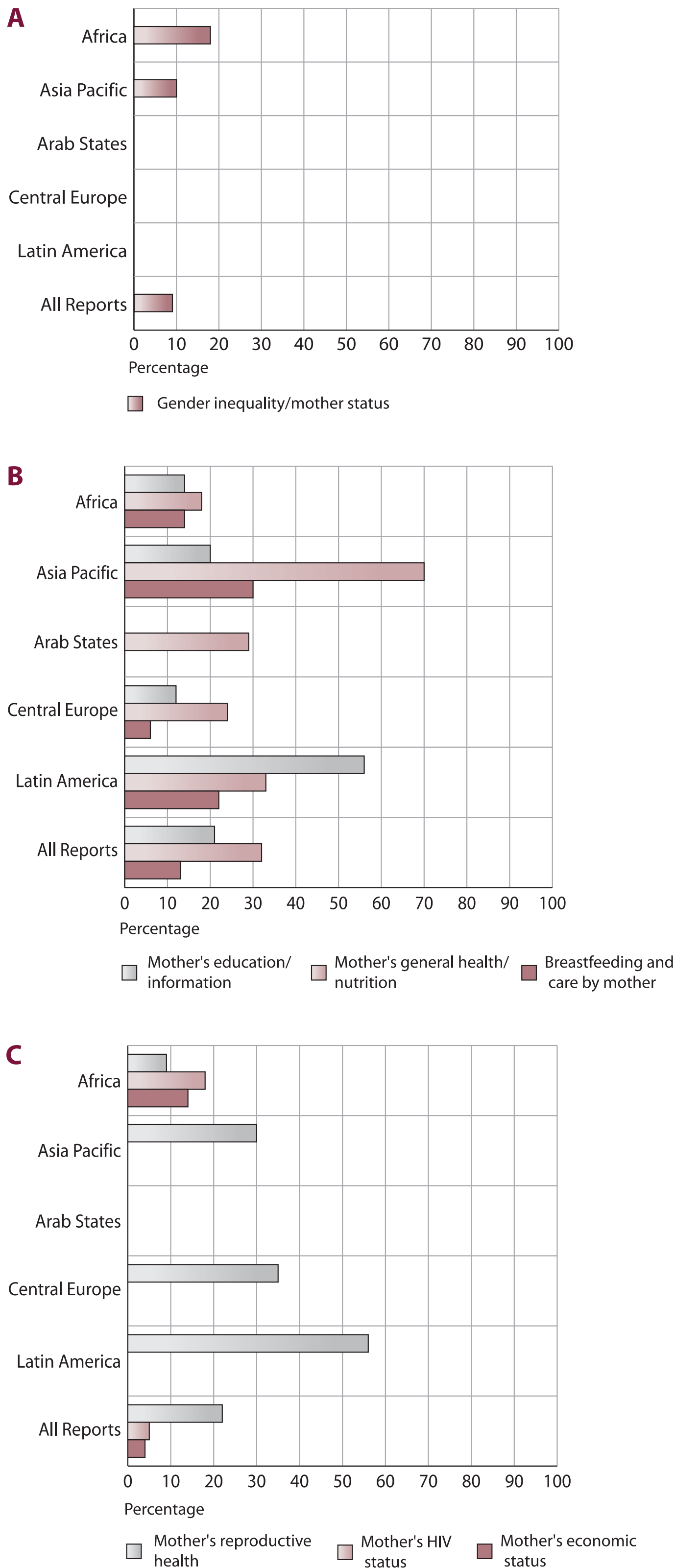
- Presenting **sex-disaggregated data** against the mandatory set of indicators.
- Collecting and presenting data on **additional contextual indicators** such as sex ratio and rates of mother-to-child transmission of HIV/AIDS.
- **Underlining the links** between gender inequality and various determinants of child mortality such as mother's education and health status.
- Using the **reproductive health approach** to make visible the linkages between child survival and women's capabilities, voice and agency.
- Making the **'money trail'** visible by reporting on spending on targeted programmes to enhance women's capabilities, make the health system more accessible to women and increase women's access to reproductive choices.

### Additional indicators

The Task Force on Child Health and Maternal Health of the UN Millennium Project has recommended that the target for Goal 4 be reworded to underline the fact that efforts to reduce child mortality must accord priority to the poor and other marginalised groups.

The Task Force also suggests the inclusion of two additional indicators to track Goal 4 – neonatal mortality rate and the prevalence of underweight children in the under-5 age group.

Figure 11 **Causes of infant mortality**




Official data on infant mortality may have inbuilt biases. The Kazakhstan report points out that data collected from women in the course of a survey on fertility history indicated higher rates of infant mortality than the official figures.

Official figures are based on registered births. In many countries, a girl infant who dies soon after birth is buried quietly and never enters the statistics.

Ten reports (13 per cent) mention insufficient or inappropriate care by mothers as a leading cause of infant mortality.

In the absence of any data to substantiate this assumption and without any explanation of the reasons underlying it, this statement appears in tune with the tendency to place the entire responsibility of child care and child survival on mothers.

On the other hand, placing this statement in context by juxtaposing it with the limited resources, support and freedom of choice available to women, would be an effective way to draw attention to the need for a sharper focus on gender equality within strategies for reduction of infant mortality.

The **Botswana** report points out how the policy of restricting the access of pregnant women to information about their HIV positive status prevents them from taking precautions to prevent mother-to-child transmission of the virus.