of at least 90 per 1,000 live births. In 2005, these 60 countries accounted for 93 per cent of all deaths of children under five worldwide. Of these, only seven – Bangladesh, Brazil, Egypt, Indonesia, Mexico, Nepal and the Philippines – are considered to be on track to meet MDG 4. In contrast, 19 of the priority countries will need to achieve annual reductions of 10 per cent or more per year to achieve the 2015 target.

Priority 2: Providing a continuum of care by packaging and delivering them at key points in the life cycle

Astonishing results have been achieved by some child health programmes that target specific diseases and conditions. These ‘vertical’ interventions, as they are known, are usually one-time events or disease-specific in nature, such as immunization campaigns covering one disease. Lessons from the past, explored in greater detail in Chapter 2, show that such programmes are ill-suited to providing the more comprehensive and sustained care that mothers, newborns and children need. More recent experience suggests that even greater progress is possible if these life-saving interventions were combined into ‘packages’ of care and administered at key points in the life cycle.

Meeting the health needs of children, women and families poses considerable challenges in peacetime. These challenges are compounded many times during emergencies, natural or human-made. Yet delivery of health services to populations in general and to children in particular is critical in these contexts. In effect, a significant proportion of the children who are not currently being reached through existing interventions live in countries where the delivery of health services has been severely disrupted. Between 1989 and 2000, 110 recorded conflicts took place; 103 of them were civil wars, many of them protracted, accompanied by institutional collapse and violence directed against civilians. At present, more than 40 countries, 90 per cent of them low-income nations, are dealing with armed conflict. UNICEF’s Humanitarian Action Report 2008 highlighted 29 emergency situations affecting children and women.

A complex emergency is defined broadly as a situation of armed conflict, population displacement and/or food insecurity with associated increases in mortality and malnutrition. Most of the major causes of child mortality in complex emergencies are the same as the top killers of children in general. They include measles, malaria, diarrhoeal diseases, acute respiratory infections and malnutrition. These are often compounded by outbreaks of other communicable diseases, such as meningitis, and nutrition-deficiencies that can contribute substantially to child morbidity and mortality. The highest mortality rates in refugee populations, for example, tend to occur among children under five.

Child mortality rates are usually highest during the acute early phase of a complex emergency. By contrast, in post-emergency settings, where children have remained in stable refugee camps for prolonged periods, child mortality might be lower in the refugee population than among neighbouring resident children. Obstacles to the provision of health care to children in complex emergencies include limited access, cultural barriers, insecurity, limitations in resources such as drugs and supplies, and a lack of communication among the various organizations providing relief.

Community leadership and engagement is especially critical in these contexts. Contrary to the assumption that communities in situations of crisis are fragile and tend to fragment under the stress of war, famine or mass displacement, research increasingly suggests that some form of community mobilization is almost always possible and that important elements of community remain intact and even gain in importance under conditions of stress. Evidence from Ethiopia, Malawi and Southern Sudan focusing on the challenges of treating severe malnutrition in complex emergencies suggests that the success of an intervention depends critically on involving key community figures (such as traditional leaders, teachers and community health workers), as well as community organizations, volunteer networks and women’s organizations. In addition, involving traditional health practitioners can be equally important, because in many cases they are the first to be consulted in health-seeking behaviour and can therefore play a critical role in identifying severely malnourished children at an early stage.

An effective continuum of care also addresses the gaps in care, whether in the home, community, health centre or hospital. Babies with birth asphyxia, sepsis or complications from a preterm birth can die within hours or even minutes if appropriate care is not provided. Because more than 60 million women in the developing world deliver at home, it is critical that a skilled attendant be present at birth with strong backup by a local health clinic or other first-level facility and the hospital, should complications arise. Quality of care at all of these levels is crucial.

Priority 3: Strengthening health systems and community partnerships

Delivering comprehensive health care for children requires preventive measures, as well as treatment of illness. Prevention typically requires behavioural changes that start in the house and continue to gain support through the community. Improvements in nutrition, for example, are often the result of better infant feeding practices by mothers or other caregivers, whether through breastfeeding or, later, by providing a diversified diet through kitchen or community gardens. Such practices must be learned by an individual and reinforced by the community. Wells, pumps and toilets are important to good hygiene. But their effectiveness depends on a community primed to maintain them and use them. Children must learn to wash their hands and practise good hygiene, habits that are cultivated in the home, in school and among neighbours and friends.

As an integral part of the larger health system, community partnerships in primary health care can serve a dual function: actively engaging community members as health workers and mobilizing the community in support of improved health practices. They can also stimulate demand for quality health services from governments. Community involvement fosters community ownership. It can also add vitality to a bureaucracy-laden health system and is essential in reaching those who are the most isolated or excluded. As the following chapters in this report will show, many countries, including some of the poorest in the world, have implemented successful community-based health programmes. The challenge now will be to learn from their experiences, take the programmes to scale and reach the millions of children whom the health system, so far, has passed by.

Creating a supportive environment for child survival strategies

Prospects for child survival are shaped by the institutional and environmental context in which children and their families live. It comes as no surprise, for example, that infant and child mortality rates are highest in the poorest countries, among the most impoverished, isolated, uneducated and marginalized districts and communities, and in countries ravaged by civil strife, weak governance and chronic underinvestment in public health systems and physical infrastructure. Of the 11 countries where 20 per cent or more of children die before age five – Afghanistan, Angola, Burkina Faso, Chad, the Democratic Republic of the Congo, Equatorial Guinea, Guinea-