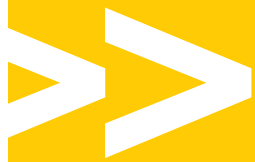


# challenges

Number 6, December 2007

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Newsletter on progress towards the Millennium Development Goals from a child rights perspective



## Reduction of infant mortality in Latin America and the Caribbean: uneven progress requiring a variety of responses



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## Infant mortality: relative progress and remaining challenges

Infant mortality has unquestionably declined throughout Latin America over the last decade, even under conditions of low and unstable economic growth and a meagre overall reduction of poverty in the region. The declines in infant mortality vary from one country to another. The persistence of high infant mortality rates is related to low income, teenage pregnancy and lack of access to basic services, as well as to the lack of appropriate health care infrastructure. At the same time, both the rural population as a whole, and the indigenous and Afro-descendent population in particular, has fallen markedly behind, with overall infant mortality rates much higher than among the rest of the population. Moreover, the cause and incidence of death in this age group have been changing according with the changes in neonatal and post-neonatal deaths.

All of the foregoing points are analysed in detail, with updated data, in the feature article of the present issue of *Challenges*. The article contains strategic information for policy planning and future intervention aimed at closing the gaps between groups and achieving a greater reduction in mortality among children under the age of five, while working to advance the corresponding Millennium Goal and the timetable set by the Programme of Action of the International Conference on Population and Development, held in Cairo in 1994.

Our editorial line-up has created space for opinions from adolescents and youth, as well as from policy experts on the problem, its causes, and approaches to dealing with infant mortality. We also offer succinct information on a broad range of programmes—utilizing various interventions—in different countries of the region regarding maternal and infant care, in an attempt to bring about a reduction in mortality.

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Economic Commission for Latin America and the Caribbean (ECLAC)  
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Regional Office for Latin America and the Caribbean (UNICEF TACRO)

Editorial Committee:  
ECLAC: Martín Hopenhayn + Sonia Montaña + Jorge Rodríguez  
UNICEF: Marcela Masnatta + Susana Sottoli + Egidio Crotti

General coordination:  
María Rebeca Yáñez

Design and layout:  
Paulo Saavedra + Rodrigo Saavedra

Contributors:  
Mariela De Jesús + Paulo Froes + Margarita Mojica +  
Francisca Palma

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Contact: [desafios@cepal.org](mailto:desafios@cepal.org), [desafios@unicef.org](mailto:desafios@unicef.org)

## Recent events

### >> Buenos Aires 30/15, International Meeting on Primary Health Care

On August 14-18, 2007, in the framework of the forthcoming Thirtieth Anniversary of the Alma Ata Declaration (1978), a meeting was held in Buenos Aires to form a consensus on, and discuss obstacles to, achieving universal health care access in the context of the 2000 Millennium Development Goals.  
<http://www.paho.org/Spanish/DD/PIN/ps070814.htm>

### >> Third World Congress on the Rights of the Child and Adolescents

The meeting was held in Barcelona, Spain, on November 14-19 and was organized by the social work foundation "La Caixa", with the support of various entities, to discuss multiple subject areas, such as child poverty, disability, juvenile justice and observatories, with emphasis on the rights of children and adolescents.  
<http://www.iiicongresomundialdeinfancia.org/index.htm>

### >> "Women Give Life: Investing in Women Produces Results" World Conference

On October 18-20, in London, the conference, convened by Women Deliver, assessed the reasons that investing in women produces multiple dividends, such as better education for girls, delayed marriage and pregnancy, reduction in maternal and child mortality, more extensive and better use of contraceptive methods, and improved levels of family nutrition.  
<http://www.womendeliver.org/spanish/index.htm>

### >> "Fiftieth Anniversary of the Latin American and Caribbean Demographic Centre—CELADE" International Seminar

In commemoration, a seminar was held at ECLAC headquarters on October 10-11, 2007, on implications for economic and social development, with the collaboration of UNFPA and the Government of France, and with the participation of prominent population specialists in the region.  
<http://www.eclac.cl/celade/default.asp>

## Key Documents



### >> UNICEF, 2007

"State of the World's Children 2007: Women and Children. The double dividend of gender equality."  
[http://www.unicef.org/spanish/publications/index\\_36602.html](http://www.unicef.org/spanish/publications/index_36602.html)



### >> ECLAC, 2007

Social Panorama of Latin America 2007  
<http://www.eclac.org/cgi-bin/getProd.asp?xml=/publicaciones/xml/5/30305/P30305.xml&txsl=/dds/tpl/p9f.xsl&base=/tpl/top-bottom.xslt>



### >> The Lancet; UNICEF; Save the Children; WHO; World Bank; BASICS; IPA; USAID; The Partnership for Maternal, Child and Newborn Health, 2005

"The countdown to 2015: child survival. Tracking progress in child survival."  
<http://www.who.int/pmnch/events/2005/countdown2015begin.pdf>

## Prevention of violence against children and protection of children and adolescents

### ● Study of the Secretary General of the United Nations on violence against children<sup>1</sup>

Preventing violence against children and adolescents is fundamental to assuring universal acknowledgement and respect for their dignity and physical integrity. A participatory debate on this subject was carried out in 17 countries of the region. In the framework of this study, and following a national consultation process, Voices of Children and Adolescents on Violence, 2006 was published, laying out strategies to deal with violence and issuing a call to several social organizations. These included the following goals:

"Design orientation programmes at schools for parents and children... Facilitate meeting space for reflection and dialogue with parents and teachers... Create family support mechanisms..." *Children of the Dominican Republic*

"Ask owners not to sell alcoholic beverages to children and adolescents... Ask authorities to stop issuing permits... Ask that hours be respected... Provide jobs..." *Children of Honduras*

"Advise parents on the subject of violence, through talks, delivering the message that it is wrong... and explaining to them that they do not have the right to abuse, mistreat or batter..." *Children of Mexico*

"Develop parental education campaigns so that, instead of hitting their children, parents will educate them... Emphasize that education is important in preventing violence..." *Female adolescents, Ecuador*

### ● Voices of Youth<sup>2</sup>

An open opinion poll on this cyber-forum (2007) examined the right to be protected and society's responsibility to respect the rights of children.

In response to the question, "Who do you think is responsible for children's security?", among the 1,349 opinions given by youngsters, the family was cited as being primarily responsible for their security (26.5%), followed by the government (11.3%), the community (3.3%), the church (1.4%) and schools (1.3%).

The vast majority of respondents indicated that two or more of the above, in combination, are responsible.

<sup>1</sup> [http://www.unicef.org/spanish/protection/index\\_27374.html](http://www.unicef.org/spanish/protection/index_27374.html)

<sup>2</sup> [http://www.unicef.org/voy/spanish/explore/cse/explore\\_poll\\_23.php?action=results&tpoll\\_ident=26](http://www.unicef.org/voy/spanish/explore/cse/explore_poll_23.php?action=results&tpoll_ident=26)



# Reduction of infant mortality in Latin America and the Caribbean: uneven progress requiring a variety of responses

Maren Jiménez, Associate Population Affairs Officer, Fabiana Del Popolo, Expert in Demography, Guiomar Bay, Expert in Demography, Dirk Jaspers-Faijer, Director

Latin American and Caribbean Demographic Centre (CELADE)- Population Division of ECLAC

## 1. The state of infant mortality in the region

Prior to 1970, one out of every 12 children born in the region died before reaching the age of one. In 6 of the 37 countries comprising Latin America and the Caribbean, the rate of infant mortality exceeded 100 deaths per 1,000 live births (Bolivia, El Salvador, Guatemala, Haiti, Honduras and Peru) and, in two countries (Bolivia and Haiti), it approached or exceeded 150 deaths per 1,000 live births<sup>1</sup>.

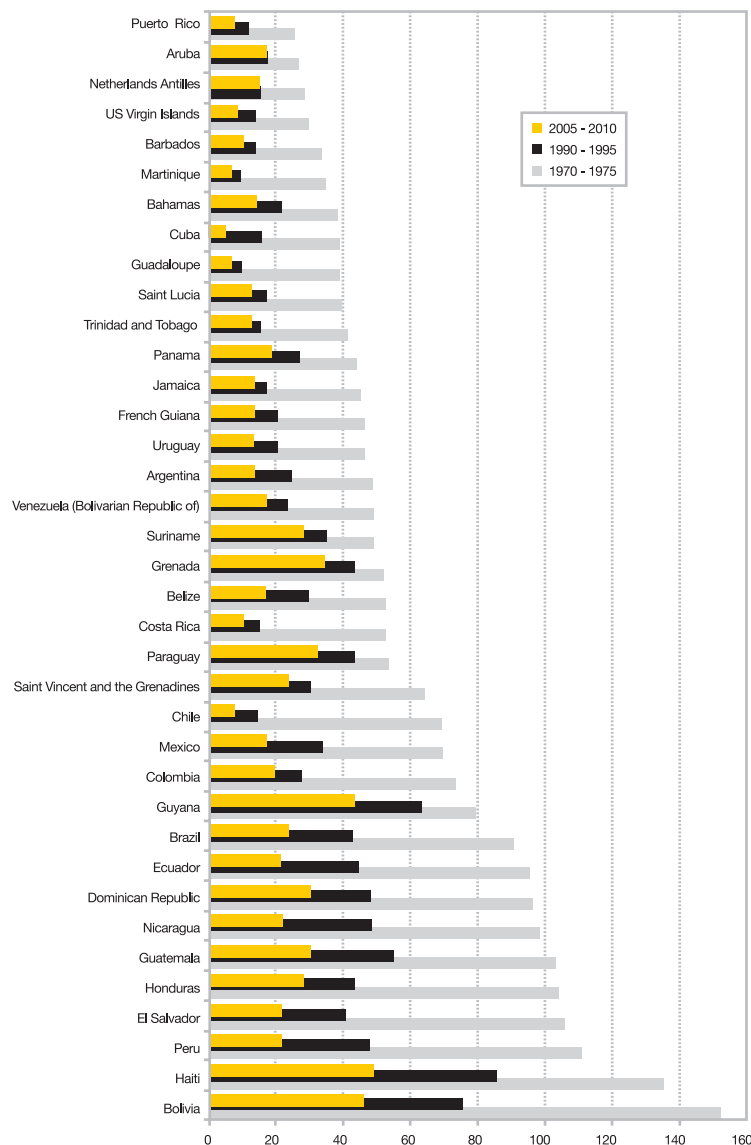
In the subsequent decades, the infant mortality rate dropped noticeably throughout the region: from 81 deaths per 1,000 live births in 1970-1975 to 38 per 1,000 in 1990-1995, and it is expected to drop to 22 per 1,000 for the 2005-2010 period. To a greater or lesser extent, all countries have experienced a significant reduction (see figure 1). Current infant mortality rates (2005-2010) in Barbados, Cuba, Chile, Costa Rica, Guadeloupe, U.S. Virgin Islands, Martinique and Puerto Rico are estimated to be 10 deaths or less per 1,000 live births, and only Haiti, Bolivia and Guyana have higher rates of around 45 per 1,000. This reduced risk of death among children occurred despite conditions of persistent poverty and inequality, as well as the recurrent economic and political crises experienced in Latin America over the last decade. In countries such as Haiti and Paraguay, very significant reductions in child mortality were achieved despite a decline in GDP between 1990 and 2005.

Indeed, the most recent decreases in infant mortality rates are not directly related to economic growth levels. Nevertheless, infant mortality remains an important indicator of social development, reflecting, in particular, access to and use of healthcare, nutritional and sanitation conditions, and social protections (principally in regard to children and adolescents), thus mirroring society's recognition and exercise of the most fundamental human right: the right to life and health.

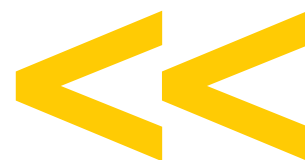
The progress achieved in this area is due to a combination of factors, including the provision of high-impact, low-cost primary care (mass vaccination programmes, oral rehydration therapy, breastfeeding, and wellness care for children), sustainable socioeconomic and demographic changes, increased coverage of basic services (particularly drinking water and sanitation services), rising educational levels and falling fertility rates.

Despite these accomplishments, many countries have faced difficulties in reducing infant mortality. The centrality and weight of this struggle are reflected in its inclusion as one of the indicators for Millennium Development Goal 4, which commits countries to reducing child mortality by two thirds between 1990 and 2015<sup>2</sup>. Given the length of the 1990-2007 period, which is approximately two thirds (68%) of the total time allotted for meeting the goal by 2015, and assuming linear progress toward the goal, the countries should already have covered at least two thirds of the distance. Thus, less than a

**FIGURE 1**  
LATIN AMERICA AND THE CARIBBEAN: INFANT MORTALITY RATES  
(Per 1,000 live births)



Source: Latin American and Caribbean Demographic Centre (CELADE)—ECLAC Population Division, *Demographic Observatory* No. 2, 2007, and Population Division of the United Nations "World Population Prospects: The 2006 Revised".

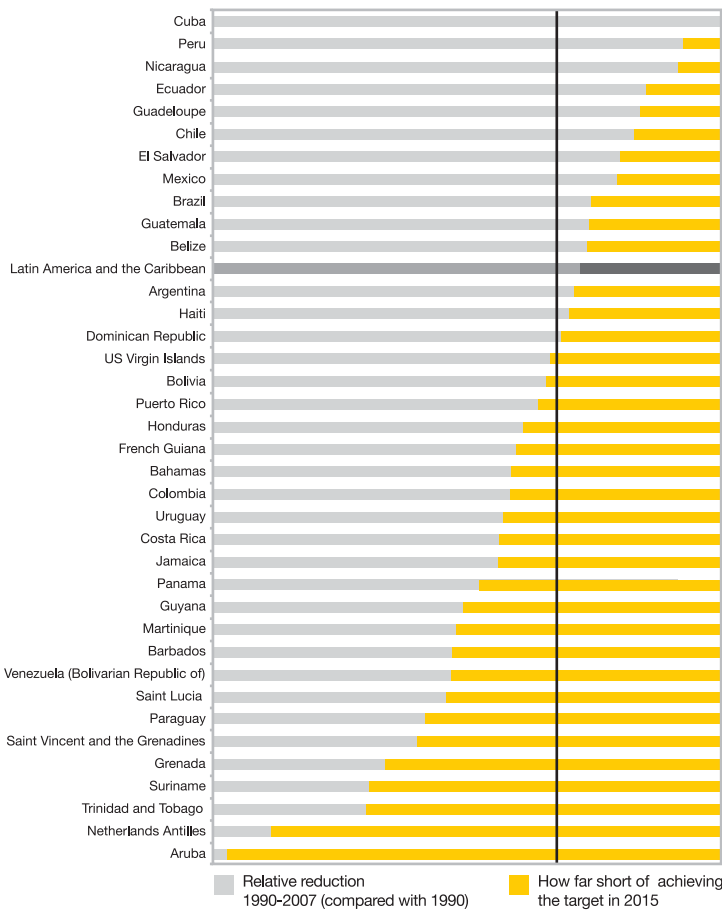


**Reductions in infant mortality in the region have been achieved despite extensive persistence of economic inequality between and within countries**

<sup>1</sup> Latin American and Caribbean Demographic Centre (CELADE)—ECLAC Population Division, *Demographic Observatory*, Year 1, no. 2, Santiago, Chile, 2007.

<sup>2</sup> Currently, there are several international agreements regarding the reduction of infant mortality in the context of Millennium Development Goal 5. The 1990 World Summit for Children (WSC) established the goal of reducing the mortality rate for children under the age of one by one third, i.e., to under 50 deaths per 1,000 live births for the 1990-2000 period, while the Programme of Action agreed upon at the 1994 International Conference on Population and Development (ICPD), in Cairo, which was ratified in 2004 (ICPD+10), extended the goal to include a reduction to 35 deaths per 1,000 live births by 2015. Although the progress of many countries has fallen short of the goals of these agreements, the existence of the agreements has helped to create health programmes that contribute to progress toward achieving the MDG targets.

**FIGURE 2**  
**LATIN AMERICA AND THE CARIBBEAN: PROGRESS IN THE REDUCTION OF INFANT MORTALITY FROM 1990 TO 2007, AND REMAINING REDUCTIONS REQUIRED BY 2015 TO MEET MDG GOAL 5 <sup>A</sup>**



Source: United Nations Population Division "World Population Prospects: The 2006 revision".  
<sup>A</sup> Millennium Development Goals.

45.3% reduction in infant mortality indicates insufficient progress towards the goal of reducing infant mortality by the timeframe given.

As figure 2 illustrates, 23 of the 35 countries in the region for which data are available show decreases of less than 45.3%, while the rates decreased by more than 45% in 14 of the countries. Although the lag in some countries may be partially attributed to the fact that they began with low child mortality rates (15 deaths or less per 1,000 live births), as is the case for Barbados, Jamaica and Puerto Rico, other countries that began with low rates have progressed in line with the goal. These include Cuba, which has already met the goal. The five countries that not only lag proportionally, but also have relatively high infant mortality rates—Guyana, Grenada, Paraguay, Suriname and St. Vincent and the Grenadines—must significantly increase their efforts if they are to achieve the goal by 2015.

## 2. The multiple causes of infant mortality

The history of public health indicates that initial declines in infant mortality are due to a reduction in deaths due to environmental factors. These deaths are considered relatively easy to prevent, and occur primarily during the post-neonatal period (from 1 to 11 months of age). Thus, during the first stages of infant mortality decline, there tends to be a proportionate increase in deaths due to low birth weight, congenital malformations and other illnesses associated with the conditions surrounding pregnancy and birth, which occur principally during the first 28 days of life (the neonatal period). Post-neonatal mortality can often be prevented by medical and sanitation measures, such as oral rehydration therapy, which reduces mortality from diarrhoea. On the other hand, a decrease in neonatal mortality requires other technologies, particularly those involved in prenatal diagnosis and specialized care during the perinatal period (i.e., prevention of fetal deaths and deaths during the first week of life).

Figure 3 shows neonatal and post-neonatal mortality at two points in time, for certain countries in the region with differing infant mortality rates. It can be seen that the number of neonatal deaths as a proportion of total infant mortality increased, while the magnitude of infant mortality in absolute terms decreased.

The number of deaths among children due to external causes is striking, considering that deaths from these causes are considered completely avoidable. Table 1 shows the situation in some of the region's countries, including the percentage of deaths due to external causes in children under the age of one, as well as in the 1-4 age bracket, which is shown for purposes of comparison. The figure highlights the relative incidence of these deaths, particularly in the 1-4 age bracket, as well as their increase, in proportional terms, for the years under analysis.

Among these deaths, those related to violence and accidents within the home, for the most recent year, can be identified, representing approximately 50% of deaths due to external causes. These deaths, being directly related to deficiencies in care, and to child abuse, are preventable. Indeed, the younger the victim of death from external causes, the higher is the probability that the death was caused by a family member.<sup>3</sup>

## 3. Geographic and socioeconomic inequalities as factors in infant mortality rates

The vital statistics registry systems of most of the region's countries do not support an analysis of social inequalities as a factor in infant mortality, since death certificates do not include family socioeconomic and educational indicators. Therefore, population census information and demographic and health surveys are essential for studying differences in infant mortality rates.

Overall, geographic differences in these countries remain an important factor in unequal child mortality rates, despite the fact that the gap between rural and urban areas has decreased slightly in some cases over the last decade (see table 2). In El Salvador, according to the 2002-2003 National Family Health Survey, rates for rural and urban infant mortality were the same during the

<sup>3</sup> United Nations, *World Report on Violence against Children and Adolescents*, Geneva, October 2006.



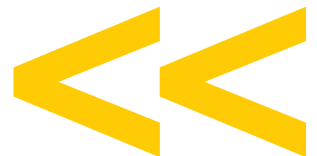
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**TABLE 1**  
**PERCENTAGE OF DEATHS DUE TO EXTERNAL CAUSES DURING CHILDHOOD, BY AGE GROUPS: COUNTRIES AND SELECTED PERIODS**

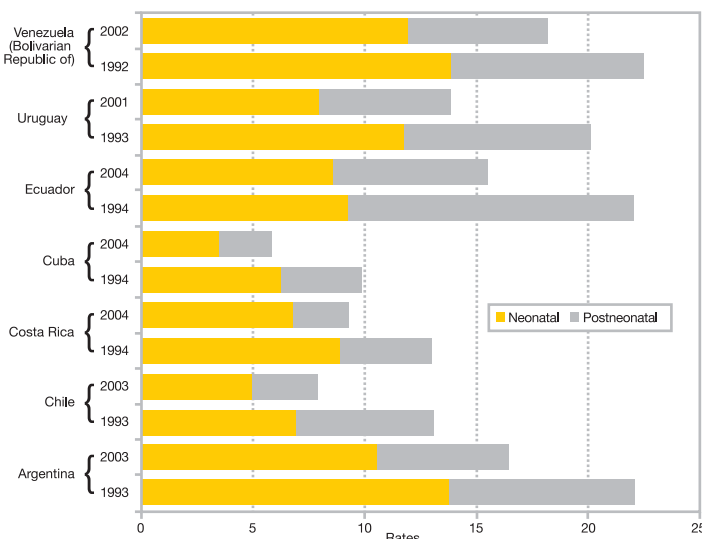
	Under 1 year	1 to 4 years
<b>Argentina</b>		
1993	5	24
2003	3	26
<b>Chile</b>		
1993	11	19
2003	1	36
<b>Costa Rica</b>		
1994	2	18
2004	2	30
<b>Cuba</b>		
1994	2	24
2004	3	27
<b>Ecuador</b>		
1994	1	10
2004	2	17
<b>Uruguay</b>		
1993	8	23
2001	7	21
<b>Venezuela (Bolivarian Republic of)</b>		
1992	4	18
2002	4	16

Source: Based on vital statistics from the World Health Organization (WHO).

## The better household conditions are and the more educated mothers are, the lower the incidence of infant mortality



**FIGURE 3**  
**NEONATAL AND POST-NEONATAL MORTALITY RATES:**  
**SELECTED YEARS AND COUNTRIES**  
*(Per 1,000 live births)*



Source: Based on vital statistics from the World Health Organization (WHO).

five years preceding the survey. In countries with high rates, however, such as Bolivia, territorial differences persist. Infant mortality in rural areas of Bolivia in 1994 was 1.5 times the urban rate, and by 2004 this ratio had declined only minimally, to 1.4. In Haiti, the rural-urban gap grew (from a ratio of 1.1 in 1995-1996 to 1.4 in 2005-2006), due to a more significant decline in urban infant mortality rates, while the rates in rural areas stagnated.<sup>4</sup>

Similarly, household conditions and the educational level of mothers continue to have a critical effect on infant mortality. The more impoverished the home and the less educated the mother, the greater is the risk of death for children under the age of one. As Demographic and Health Survey (DHS) analysis shows, children in the poorest households (first and second quintile of wealth) and those whose mothers' educational levels are low (elementary schooling or less) are more likely to die before reaching the age of one than are children in wealthier households and households with more highly educated mothers (at least secondary schooling).<sup>5</sup>

<sup>4</sup> The figures refer to the 10 years prior to the survey.

<sup>5</sup> Economic Commission for Latin America and the Caribbean (ECLAC), *The Millennium Development Goals: a Latin American and the Caribbean perspective*, Santiago, Chile, August 2005.

#### 4. Infant mortality among indigenous and Afro-descendent populations: a reflection of structural inequality and the absence of guaranteed rights

The international consensus is that meeting Millennium Development Goal 4 will be possible only if inequalities are reduced and concentrated efforts are made to reduce child mortality among the most excluded and vulnerable groups, which include indigenous and Afro-descendent populations. Although excess mortality rates in early childhood are related to poverty, especially rural poverty, the inequalities between indigenous and non-indigenous populations are still major factors influencing differential infant mortality rates.<sup>6</sup>

On average, infant mortality among indigenous children in Latin America is 60% higher than among non-indigenous children: 48 deaths per 1,000 live births compared to 30 per 1,000. The inequality in the probability of dying before the age of five is even greater, with an excess mortality rate of 70%.<sup>7</sup>

A comparison of 1990 and 2000 census figures shows a significant decrease in infant mortality among the indigenous population, though efforts have been insufficient to completely eliminate the inequality (see table 2). Two factors explain this decrease. One is an outright decline in infant mortality; the other is the presence of a lower infant mortality rate among groups that identified themselves as indigenous in the later census, but

not in the earlier one. This change was, in turn, due to two factors: changes in methodology, and the progression of a cultural revitalization that encourages more self-identification than in previous years. Although more in-depth analysis of these factors is needed, equality has certainly not been achieved. Indeed, several countries have even experienced slight increases in infant mortality in rural areas.

Meanwhile, the decrease in infant mortality in each country's indigenous population as a whole is associated with the urbanization that these populations are undergoing, and the fact that it is in urban areas that the greatest decreases, in relative terms, can be seen. Although information on the population of Afro-descendent persons is sparse, the inequalities are obvious in Brazil, Colombia and Nicaragua—unlike the cases of Costa Rica and Honduras (see table 2).

#### 5. Dealing with infant mortality in the region: a diverse phenomenon requiring a variety of responses

The heterogeneity of infant mortality in the region highlights the need for public policy that is responsive to this diversity. Because there is currently no direct relationship between economic growth and declining infant mortality, the multiple variables that affect mortality must be studied in order to create a framework for a policy dialogue that can effectively achieve goals and help ensure children's well-being and rights.

In a classic study, Mosley and Chen demonstrated the importance of how inter-sectoral strategic alliances, involving health, sanitation and housing services, can work together to reduce inequalities in infant mortality rates.<sup>8</sup> The authors proposed placing emphasis on five groups of determinants that are closely associated with infant mortality.

The first of these relates to illness control, including healthcare and basic medical intervention targeting primarily the poorest population. This involves providing access to preventive measures such as vaccines and immunizations, as well as making quality care available during pregnancy and childbirth, so as to control maternal and neonatal mortality.

The second involves maternal factors, which play an important role in children's survival. Some of the decline in infant mortality is directly related to declining fertility rates, because of the correspondingly fewer high-risk births. However, children of very young mothers (under 19 years old) children of older mothers (over 40), and those of mothers experiencing multiple childbirths with an interval of less than 24 months between births, are at high risk of death—thus highlighting the importance of education and access to family planning services to enable women to adequately plan and space their pregnancies.

Third, as might be expected, nutritional deficiencies—not only in children, but also among mothers—are markedly associated with infant mortality. Breastfeeding is very important in this connection. According to the World Health Organization (WHO), over half of deaths due to diarrhoea and respiratory

**TABLE 2**  
**LATIN AMERICA (13 COUNTRIES): INFANT MORTALITY RATES BY ETHNICITY AND AREA OF RESIDENCE 1990 AND 2000 CENSUSES**  
(Per 1,000 live births)

Country	Census Year	Country Total			Area of residence					
		Indigenous	Afro-descendent	All other	Urban			Rural		
					Indigenous	Afro-descendent	All other	Indigenous	Afro-descendent	All other
Bolivia	1992	104.0	---	65.9	82.7	---	52.9	121.0	---	93.8
	2001	77.7	---	50.5	67.8	---	48.1	87.8	---	57.1
Brazil	1990	61.1	63.9	39.4	76.7	59.7	36.1	56.7	73.1	50.5
	2000	39.7	40.2	26.7	37.2	37.6	24.7	41.8	48.1	35.0
Chile	2002	12.8	---	11.5	12.0	---	11.4	12.7	---	12.0
Colombia	2005	39.5	31.7	23.9	30.9	30.0	23.5	39.8	33.8	25.0
Costa Rica	2000	20.9	11.2	11.5	20.4	8.2	10.7	21.5	15.1	12.3
Ecuador	1990	101.8	---	53.3	61.5	---	39.6	108.0	---	69.4
	2001	72.2	---	30.5	42.9	---	24.7	76.6	---	39.1
Guatemala	1994	61.1	---	49.7	56.9	---	41.0	62.1	---	55.2
	2002	51.1	---	41.0	47.2	---	35.3	52.6	---	46.7
Honduras	2001	43.5	31.9	34.5	27.1	30.1	25.1	45.2	33.7	41.8
Mexico	1990	63.8	---	36.7	48.7	---	31.1	70.8	---	49.8
	2000	42.7	---	26.2	35.4	---	23.7	47.1	---	33.3
Nicaragua	2005	34.0	38.0	26.4	24.4	24.1	18.8	39.1	47.4	33.9
Panama	1990	72.2	---	21.6	39.9	---	17.7	75.3	---	26.0
	2000	53.5	---	17.3	31.7	---	15.7	57.5	---	19.5
Paraguay	1992	96.2	---	45.8	90.8	---	45.9	96.5	---	45.8
	2002	78.5	---	37.7	72.1	---	38.8	79.1	---	36.3
Venezuela (Bolivarian Republic of)	2001	44.4	---	19.6	31.9	---	19.1	58.1	---	22.6

Source: Latin American and Caribbean Demographic Centre (CELADE)—Population Division of ECLAC: specially processed census microdata.

Note: For the purpose of cross-census comparison, indigenous and Afro-descendent populations were defined based on self-identification, although in areas of Bolivia, Ecuador and Mexico, where indigenous languages are spoken, only the latest census used self-identification.

<sup>6</sup> Economic Commission for Latin America and the Caribbean (ECLAC), *Social Panorama of Latin America*, 2006, Santiago, Chile, February 2007.

<sup>7</sup> Del Popolo, Fabiana and Ana María Oyare, "Indigenous Population of Latin America: Socio-demographic profile in the framework of the International Conference on Population and Development and the Millennium Goals", CELADE-ECLAC Population Notes, no. 79, July 2005.

<sup>8</sup> Mosley, W. Henry and Lincoln C. Chen. "An Analytical Framework for the Study of Child Survival in Developing Countries", *Population and Development Review* 10 (Supp): pp. 25-45, 1984.



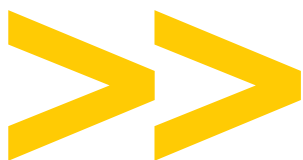
infections could have been prevented by exclusive breastfeeding during the first three months of life and partial breastfeeding during the remainder of the first year.<sup>9</sup>

The fourth involves sanitation and waste management, as well as access to drinking water, all of which are critical in controlling various infectious diseases. Children's environments are a determining factor in local mortality rates due to diarrhoea and other preventable diseases.

The fifth includes accidents and injuries leading to deaths among children and adolescents. These deaths are not always random or unexpected, and reveal serious social problems related to the environments in which children live. Attention from the public health sector is required here, along with oversight and mechanisms to protect the rights of children.

In short, the pronounced differences in infant mortality rates in Latin America and the Caribbean reflect relationships between infant mortality and various other issues addressed in the Millennium Development Goals, such as eradicating extreme poverty and hunger (Goal 1), education (Goal 2), gender equality (Goal 3), maternal health (Goal 5), and combating HIV/AIDS and other diseases (Goal 6).

The challenge for the region's countries is to undertake collective and complementary action, including inter-sectoral efforts in education, health, social protection, gender and ethnic disparities, sanitation services, environmental protection, etc., as well as geographically targeted efforts. Joint policy making to coordinate these actions will shape technical interventions, favour the most disadvantaged populations and foster the synergies necessary to reduce infant mortality. This is consistent with the ultimate goal, which is to make the right to life an accepted and universal reality for all children in the region.



**Though rural conditions and poverty are factors in high mortality in early childhood, inequalities between indigenous and non-indigenous populations persist, even when one controls for these factors**



#### BOX 1

#### POLICIES AND HEALTH PROGRAMMES FOR INDIGENOUS PEOPLE

A recent assessment by CELADE-ECLAC shows that various countries in the region already have national health policies dealing with indigenous populations (the Bolivarian Republic of Venezuela, Bolivia, Brazil, Chile, Costa Rica, Ecuador, Mexico, Nicaragua, Panama and Peru), with the majority of these translating into a range of actions. This is particularly true of those programmes that focus on specific areas, such as traditional medicine or human resource development.<sup>10</sup> Though there has been a pronounced reduction in infant and maternal mortality in a number of countries, only Brazil provides information to document this achievement. Official figures from the National Health Foundation (FUNASA) indicate that, between 2000 and 2006, indigenous infant mortality dropped from 74.6 deaths per 1,000 live births to 38.5 per 1,000.<sup>11</sup> These facts suggest that, if the political will is present, it is possible to advance significantly toward guaranteeing the right to health. At the same time, the general absence of systematic information on the health situation and epidemiological profiles of indigenous populations is a major obstacle to defining health-related goals and evaluating observance of individual and collective rights. Additional factors are the limited availability of trained human resources, meagre financing, discontinuity in allocation of funds, and relatively scant participation on the part of indigenous people.

Ensuring minimum individual and collective health rights involves promoting guarantees and protections for the following rights: improved physical and mental health through non-discriminatory access to appropriate high-quality care; comprehensive indigenous health services, including the use and strengthening of, as well as controls on, traditional medicine, along with protecting indigenous territories as vital areas; and participation in the design, implementation, management, administration and evaluation of policies and health programmes, with a focus on autonomous resources.<sup>12</sup> This poses significant public policy challenges—all the more notable in view of the recent United Nations approval of the Declaration of the Rights of Indigenous Peoples of the World.

<sup>9</sup> Betrán, Ana, Mercedes de Onis, Jeremy A. Lauer and José Villar. "Ecological Study of Effect of Breastfeeding on Infant Mortality in Latin America", *BMJ Journal*, vol. 323: pp. 303-307, 2001.

<sup>10</sup> Economic Commission for Latin America and the Caribbean (ECLAC), *Social Panorama of Latin America, 2007* (in editorial revision), Santiago, Chile.

<sup>11</sup> These estimates refer to the indigenous population in the area covered by the National Policy on Care of Indigenous Peoples in Brazil, which defined a "special indigenous health district" that is to serve as a model for locally oriented service to promote the dynamic, place- and population-specific well-being of an ethnic/cultural area with limited government interference. To date, there are 34 such "special districts", covering a total of 3,751 villages and an indigenous population of 470,000 persons (*Social Panorama of Latin America, 2007*).

<sup>12</sup> Economic Commission for Latin America and the Caribbean (ECLAC), *Social Panorama of Latin America, 2007* (in editorial revision), Santiago, Chile.



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## What global forces should be developed to strengthen health systems, and what is your experience with community participation in combating infant mortality?

Global efforts to strengthen health systems, especially those focusing on reducing maternal and infant mortality, continue to face challenges that limit coordination between advocates and organizations. Thus, the vertical approach in programmes must be re-examined, and health systems must be strengthened in a comprehensive, horizontal way, incorporating high-quality primary care systems.

In terms of community participation, PIH experiences in different countries point to strengthening alliances, especially those with health ministries and organizations such as pharmaceutical companies and religious groups, which have been key. The integrated approach includes primary care and care for chronic diseases such as HIV/AIDS and tuberculosis, as well as efforts to address exacerbating factors, ranging from precarious household conditions to lack of drinking water. Thus, “When we can count on community health care workers within the health care system as colleagues and peers, we have an enormous impact on health.”

The PIH experience could act as a guide for people who work in the public health sector, so that they are not paralysed by an “either/or” approach. For example, if we have to choose between expanding vaccination programmes or reducing maternal mortality, child survival loses out. Thus, there must be greater attention and stronger demands directed at promoting practices that serve as catalysts for comprehensive health care—i.e., care that includes treatment and social assistance in a systematic framework designed to achieve “sustainable” results, while providing high-quality care for each patient.<sup>1</sup>

To this end, we must examine the correlation between the best possible care and the greatest possible degree of community participation. The issue is not only a lack of doctors and nurses, but the need to improve levels of care and treatment for the ill, through measures that include community health promoters as a key element in these services.



### Paul Farmer

physician and anthropologist, Harvard Medical School, and cofounder of Partners In Health (PIH)

## Inter-sectoral and community participation approaches: key elements in reducing infant mortality



## How can the sectors and organizations involved in combating infant mortality strengthen their coordination, and how can one ensure that the best known practices are used?

A crucial challenge is to facilitate agreement among different organizations, with different priorities, on areas in which they can realistically cooperate and achieve results within a reasonable time frame.

Individual national/regional epidemiological characteristics and health systems must be taken into account, while a few initial priority areas for action must be identified. Once universal or nearly universal coverage is achieved, further priorities can be addressed. I have seen countries in Africa trying to get families to adopt 16 practices at the same time, with the result that none achieved universal coverage.

In regard to best practices, it is essential to identify which channels are most appropriate for providing services to accomplish each specific task. In the health sector, workers located in health facilities are frequently perceived as the main channel for providing advice or distributing tools such as antibiotics, oral rehydration therapies or vitamin A. In many places, however, access to such facilities is limited by geography, financial constraints and time factors. In my work in Africa and Asia, I have seen great success due to the involvement of civil society—NGOs, social marketing plans, mothers and various groups—in providing health interventions for the population.

Each of these sources has its own limitations, and it is important not to ignore these. For example, the private sector has its own approach and health priorities, as it zealously seeks to maximize financial gain. It is essential, for children’s survival, to involve different players in promoting key practices within the family, while acknowledging their limitations.



### Cesar G Victora

Professor, founder and coordinator of the Epidemiological Research Centre of the Federal University of Pelotas, Brazil

<sup>1</sup> Paul Farmer, *Infections and inequalities: the modern plagues*, University of California Press, 1999.

# Preventing infant mortality

In Latin America and the Caribbean, prevention of childhood infant mortality depends on a growing number, and critical mass, of successful programmes and experiences, which, in part, account for the sustained decrease of child infant mortality in recent decades. This has occurred despite the fact that the region's economies have been volatile and slow growing during this period, and that the level of poverty is as high today as it was at the beginning of the 1980s. This suggests the degree to which it is possible to intervene effectively in at-risk populations with appropriate resources.

Best practices are employed in programmes with widely varying purposes, e.g., improving childbirth care assistance during childbirth in less accessible areas, improving nutrition in the first months of life, providing easy-to-use oral rehydration systems, achieving universal vaccination against lethal diseases that plague populations of younger children, disseminating self-care information among families, and combating diseases that affect mothers and children.

The following examples illustrate this range of programmes in the countries of the region:



**Chile Grows with You. Chile**  
<http://www.gobiernodechile.cl/chile%5Fcrece/index.asp>



System of comprehensive early childhood protection to protect and support children and their families, through actions and services that are available "to all, according to need". The programme is designed to cover developmental and other needs of children up to four years of age, with the understanding that children's development is multi-dimensional and is therefore affected by biological, physical, psychological, and social factors.

**United with children and adolescents. United we shall defeat AIDS! Brazil**  
<http://www.unicef.org.br/>



This initiative includes the National STD and AIDS Program, the Ministry of Health and UNICEF, and is aimed at reducing the vertical transmission of HIV to children over the next three years.

**Maternal-Child Health Program. Cuba**  
<http://www.isis.cl/MujerySalud/Sexual/Documentos/doc/1412salusexenlasam%5E9ricas2006.pdf>



This is a high-priority programme for the health sector, and receives major emphasis from government, as well as from NGOs. It aims to maintain and improve the health of women, children and families. Its actions include an information, communication and education strategy, family planning services, measures to reduce the incidence of abortion, and provision of prenatal care.

**Pregnancy Shelters and Vertical Childbirth Care with Appropriate Intercultural Attention. Peru**  
[http://www.unicef.org/peru/spanish/survival\\_development\\_3521.htm](http://www.unicef.org/peru/spanish/survival_development_3521.htm)



These shelters, which are to be provided by the Ministry of Health, are facilities to house women, while they are waiting to give birth, who live far from health centres. The Ministry has also created and approved "technical standards for vertical childbirth care with appropriate intercultural care", designed to ensure effective, high-quality care that respects Andean and Amazonian cultures.

**Programme for the Prevention of Mother-to-Child HIV/AIDS Transmission. Jamaica**  
<http://gateway.nlm.nih.gov/MeetingAbstracts/102279470.html>



This programme is one of the priorities of Jamaica's National HIV/AIDS Control Program. Among its achievements is its provision of care to 90% of the patients in prenatal care facilities, and at over 50% of the country's clinics for the treatment of sexually transmitted diseases (STDs). In 2003, the vertical transmission rate decreased from 25% to 10%.

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■ did you know...?

**...that one out of every 12 children born in the region in the 1970s died before the age of one, and that this figure declined to 81 deaths per 1,000 live births by the 1970-1975 period and to 38 per 1,000 for 1990-1995, and that it is expected to reach 22 per 1,000 for 2005-2010?**

(Latin American and Caribbean Demographic Centre (CELADE) — ECLAC Population Division, *Demographic Observatory*, Year 1, no. 4, Santiago, Chile, 2007; *Demographic Observatory*, no. 2, and United Nations Population Division “World Population Prospects: The 2006 Revision”).

**....that in six of the region’s countries with low infant mortality, available data suggest that 30% of all deaths among children aged 1-4 are due to violent causes?**

(Based on vital statistics of the World Health Organization — WHO).

**....that on average in Latin America, infant mortality among indigenous children is 60% higher than among non-indigenous children—40 deaths per 1,000 live births versus 30 per 1,000—and that by age five the indigenous mortality rate is 70% higher than the non-indigenous rate?**

(Economic Commission for Latin America and the Caribbean —ECLAC— *Social Panorama of Latin America, 2006*, Santiago, Chile, February 2007).

**...that the major factors influencing infant mortality include lack of access to drinking water, lack of household sanitation systems and teenage pregnancy?**

(Economic Commission for Latin America and the Caribbean —ECLAC— and United Nations Children’s Fund, Regional Office for Latin America and the Caribbean (UNICEF TACRO), *Challenges*, Newsletter on progress towards the Millennium Development Goals from a child rights perspective, no. 4, Santiago, Chile, January 2007; and no. 5, July 2007. <http://www.eclac.org/desafios>).

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Av. Dag Hammarskjöld 3477,  
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