

NO CHILD **BORN TO DIE**

CLOSING THE GAPS

Save the Children





A slum in Delhi, India

NO CHILD **BORN TO DIE**

CLOSING THE GAPS



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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Cover photo: Zainabu gave birth to her son, Yasini, at the district hospital in Mtwara, Tanzania.
(Photo: Colin Crowley/Save the Children)

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THE STORY IN NUMBERS

4,000,000

In **1990**, more than **12 million** children a year died before their fifth birthday. By **2009**, that toll had been cut to **8 million** – a reduction of **4 million** child deaths a year.

4

The world needs to reduce child mortality at **four times** the current rate to reach the Millennium Development Goal of a two-thirds reduction by **2015**.

1 in 7

One in seven young children in the poorest countries lives in a healthcare desert, without access to essential health services.

$\frac{3}{4}$

Over **three quarters** of all deaths among children under five are caused by complications and infections during and shortly after birth, and by pneumonia, diarrhoea and malaria.

33:3:1

Africa accounts for one-third of the global disease burden¹ among mothers and children, but just **3%** of the world's health workers, and **1%** of global health spending.

6

Two million people in the Sierra Leonean capital, Freetown, are served by **six** obstetricians and gynaecologists, in a country where women face a one-in-seven lifetime risk of death during childbirth.

3

The poorest children in these countries are **three times** more likely to live in a healthcare desert than children from families in the highest income group.

9½

A child in the highest income group in Nigeria is **nine and a half times** more likely to receive the vaccine against diphtheria, whooping cough and tetanus than the poorest children.

\$3.7 billion

There is a **US\$3.7bn** funding shortfall for vaccine funding up to 2015.

\$17.5 billion

Healthcare for every mother and child requires an additional **US\$17.5bn** a year – less than one-quarter of what Europeans spend on cosmetics annually.

7,000

7,000 children's lives are saved each day by immunisation. A further **4.2 million** could be saved by **2015** through comprehensive coverage of new and existing vaccines.

4.5

Only **4.5 US cents** in every dollar of global aid spending goes to maternal and child health.

100 million

100 million people a year are pushed into poverty by being charged for healthcare.

55%

When health fees were removed for mothers and children in rural Zambia, there was a **55%** increase in people using health services.

NO CHILD BORN TO DIE



PETER CATON

8 MILLION
children under five die every year

EXECUTIVE SUMMARY

In 2000, world leaders committed themselves to a dramatic reduction in child deaths by 2015.

There has been extraordinary progress. Today, more than 4 million fewer children die each year than in 1990, the baseline year for the Millennium Development Goals (MDGs). Some of the poorest countries – from Malawi and Nepal to Bolivia and Bangladesh – are on track to achieving the MDG of a two-thirds reduction in child mortality, demonstrating what's possible even where resources are scarce and the needs are great.

But with five years to go to the target date for the MDGs, there is also a huge unfinished agenda, with more than 8 million children a year dying before their fifth birthday. The challenge is clear: a fourfold acceleration of progress is needed to achieve the target of a two-thirds reduction in child mortality. The potential prize is enormous: an additional 15 million children's lives can be saved between now and 2015 if the right choices are made.

The causes of most of these deaths – pneumonia, diarrhoea and malaria, and complications and infections during and immediately after birth – rarely lead to early mortality among children in rich countries. Children are continuing to die in huge numbers in the poorest countries not because the solutions are unknown, but because the known solutions are not reaching them. Ninety nine per cent of children's deaths are in developing countries, half of them in sub-Saharan Africa. A child born today in Angola is 37 times less likely to reach their fifth birthday than a child in the European Union.

These deaths are a scandal because they are largely preventable. Tried and tested solutions, such as routine immunisation and skilled birth attendants, can make a life and death difference to millions of children. Yet if saving children's lives does not demand a technological breakthrough, it does require a political breakthrough. Just as there has been progress, the history of efforts to tackle child mortality is also littered with broken promises and missed opportunities. Less than one-third of the countries with high child mortality will achieve the MDG on their current trajectory. In too many cases, governments in the poorest countries are failing to meet their commitments: for example, just five African governments are spending 15% of their revenues on health, as African governments pledged to do in an African Union summit in 2001. Equally, donor countries are falling short. Current levels of aid for maternal and child health are roughly one-third of what's needed to provide every woman and child with essential healthcare.

99%

of children's deaths
are in developing
countries, half
of them in
sub-Saharan Africa

Opposite: Nishi and her newborn daughter at a clinic in Bangladesh. The number of children dying in Bangladesh has been cut dramatically in recent years.

40 MILLION

children under five live in a 'healthcare desert'

The UK is well placed to be at the forefront of this effort to end the scandal of preventable deaths among young children in the poorest countries. The UK government's decision to protect its aid budget gives it the authority to lead a global effort in this area, and it is already one of the largest investors in healthcare for mothers and children in the poorest countries, and in the main global partnership for immunisation. It must now use this position to leverage commitments from other donor and developing countries alike, and ensure that resources are directed to where the need is greatest.

Children's lives will not be saved by healthcare alone. But without access to the most basic health services that are taken for granted in wealthy countries, the goals the world has set itself cannot be met. At the moment, millions of children in the poorest countries are falling ill and dying because health services are unaffordable, physically inaccessible or low quality. In the most extreme cases, children lack any access to even a skeletal health service. Save the Children estimates that 40 million children under the age of five in countries with high child mortality live in a 'healthcare desert', measured by lack of immunisation coverage or access to treatment for diarrhoea.

Ensuring that every child receives essential healthcare, irrespective of the conditions into which they are born, requires three resource gaps to be closed:

- The immunisation gap – 2 million more children a year could be saved in 2015 if 90% of children in the poorest countries were immunised with new and existing vaccines. But just when we are on the brink of a breakthrough with new vaccines for pneumonia and diarrhoea, the partnership created to fund immunisations in the poorest countries faces a funding crisis. The Global Alliance for Vaccines and Immunisation (GAVI) needs to mobilise an additional \$3.7 billion over five years to bridge the funding shortfall. GAVI partners, including the pharmaceutical industry, also need to work to bring down prices for the new vaccines as low as possible.
- The health worker gap – the World Health Organization estimates that there is a critical shortage of 3.5 million health workers in the poorest countries, without whom millions of children will face illness and early death. Doctors, midwives, nurses and community health workers are the backbone of health services. Without them, life-saving measures cannot be put in place. Millions of existing health workers also lack the training and support they need to do their jobs effectively, or are used inefficiently. Financial and policy barriers to addressing these problems of quantity and quality among health workers urgently need to be addressed, not least by implementing the commitments already made in the UN's Every Woman, Every Child strategy.

- The financing gap – children cannot be immunised, and health workers recruited, trained and used effectively, without sufficient and efficient investment in essential healthcare that is free at the point of use. It has been estimated that an extra \$17.5 billion a year is required, between now and 2015, for the MDGs for children's and mothers' health to be achieved. The poorest countries need to increase their own funding for health, but donors also need to do more, both by giving more and by giving aid in ways that enable countries to plan for the long term. Failure to address the financing gap will push the costs of healthcare on to the poorest families. For millions of children, the result is that they forgo life-saving treatment, or are pushed further into poverty.

Underlying all three of these resource gaps is an injustice, in which the poorest and most marginalised children are consistently less likely to receive the life-saving healthcare they need. The poorest children are most at risk from life-threatening illness, yet are least likely to be immunised or have access to a skilled and equipped health worker, and their families are most likely to have to meet healthcare costs from their own income. The net result is a gaping disparity in life chances: in most developing countries, children from the poorest families are several times less likely to reach their fifth birthday than children in the top income bracket. In India, for example, a child in the poorest fifth of the population is three times less likely to reach their fifth birthday than a child in the richest fifth. The fact that this equity gap is widening in a majority of countries with high mortality rates should be of urgent concern.

Save the Children's campaign – *No Child Born To Die* – will focus on closing these gaps. We believe that no child is born to die: every child is born to fulfil their potential. For this to happen, we must make sure that governments, the private sector and civil society work together to create a world in which every child, wherever they are born, has the chance to reach their fifth birthday and to thrive.



40%

of child deaths happen during birth and in the first month of life

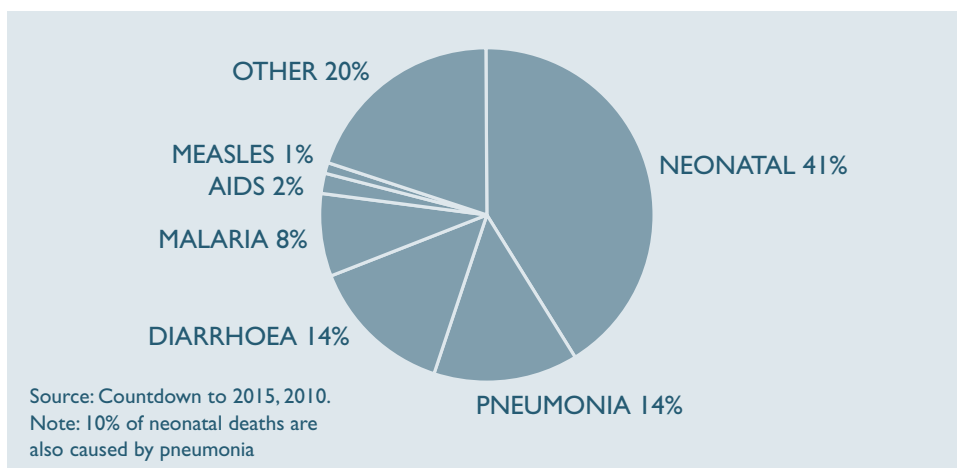
I. THE CHALLENGE

There are two sides to the story of the global effort to cut the toll of avoidable child deaths in the world's poorest countries. Both are true.

The first story is one of remarkable progress. In 1990, more than 12 million children failed to reach their fifth birthday. Twenty years later, that number has been reduced to 8 million, despite 1.3 billion people being added to the global population during that period.² Crucially, some very poor countries – often with poorly performing economies – have succeeded in making major gains in child health: Malawi, Bangladesh, Nepal and Bolivia are all on track to meet the MDGs of a two-thirds reduction in child mortality by the target date of 2015.³ In many countries, children who a generation ago would have died from simple problems and preventable diseases can now expect to survive. This success often goes unrecognised, but is critically important, because it challenges the assumption that nothing changes for the better in the poorest countries, and because it holds lessons for how to make greater progress in the future.

The second story is one of missed opportunities and broken promises. While millions of children now have a better future than their parents' generation, at the present rate of progress the global target for 2015 will be missed by a wide margin: child mortality needs to be reduced at four times the current rate in order to deliver on the promises made in the MDGs. Only 19 of the 68 'Countdown' group of developing countries with high child mortality are on track to achieve the MDG.⁴ Progress is especially slow in Africa. Whereas the region accounted for one-third of child deaths in 1990, it now accounts for half of the global total. Millions of children in Africa and south Asia continue to die from complications and infections during and shortly after childbirth; and from pneumonia, diarrhoea and malaria (see chart 1).

GLOBAL CAUSES OF DEATH AMONG CHILDREN UNDER FIVE YEARS OF AGE



Opposite: One-month-old Macervens is examined at a health centre in Léogâne, Haiti.

1
3

of child deaths
are the result of
pneumonia and
diarrhoea

These deaths are a scandal, because there is nothing inevitable about them: the causes and solutions are well understood. Forty per cent of child deaths happen during birth and in the first 28 days. Most of these deaths can be prevented through the presence of skilled attendants during delivery, access to emergency obstetric care, and care during pregnancy and in the early weeks of life. Another third of child deaths are the result of pneumonia and diarrhoea, which can be prevented through a combination of clean water and sanitation, adequate nutrition and a new generation of vaccines. Most cases of pneumonia can be treated effectively through timely diagnosis and antibiotics, and most diarrhoea through a simple formula of salts. Bed-nets treated with insecticides, routine immunisation for measles, tuberculosis and other diseases, and adequate nutrition for children all have a critical role to play in preventing early death.

Yet in the absence of a health service, most of these interventions are difficult, and often impossible, to make. Without health workers to diagnose and treat illnesses, deliver vaccines and attend births, and without health facilities that are stocked, equipped, staffed and genuinely accessible, children will not receive the care they need. Health services require policies that govern their day-to-day running, and sufficient and efficient funding to ensure that policy commitments are met.

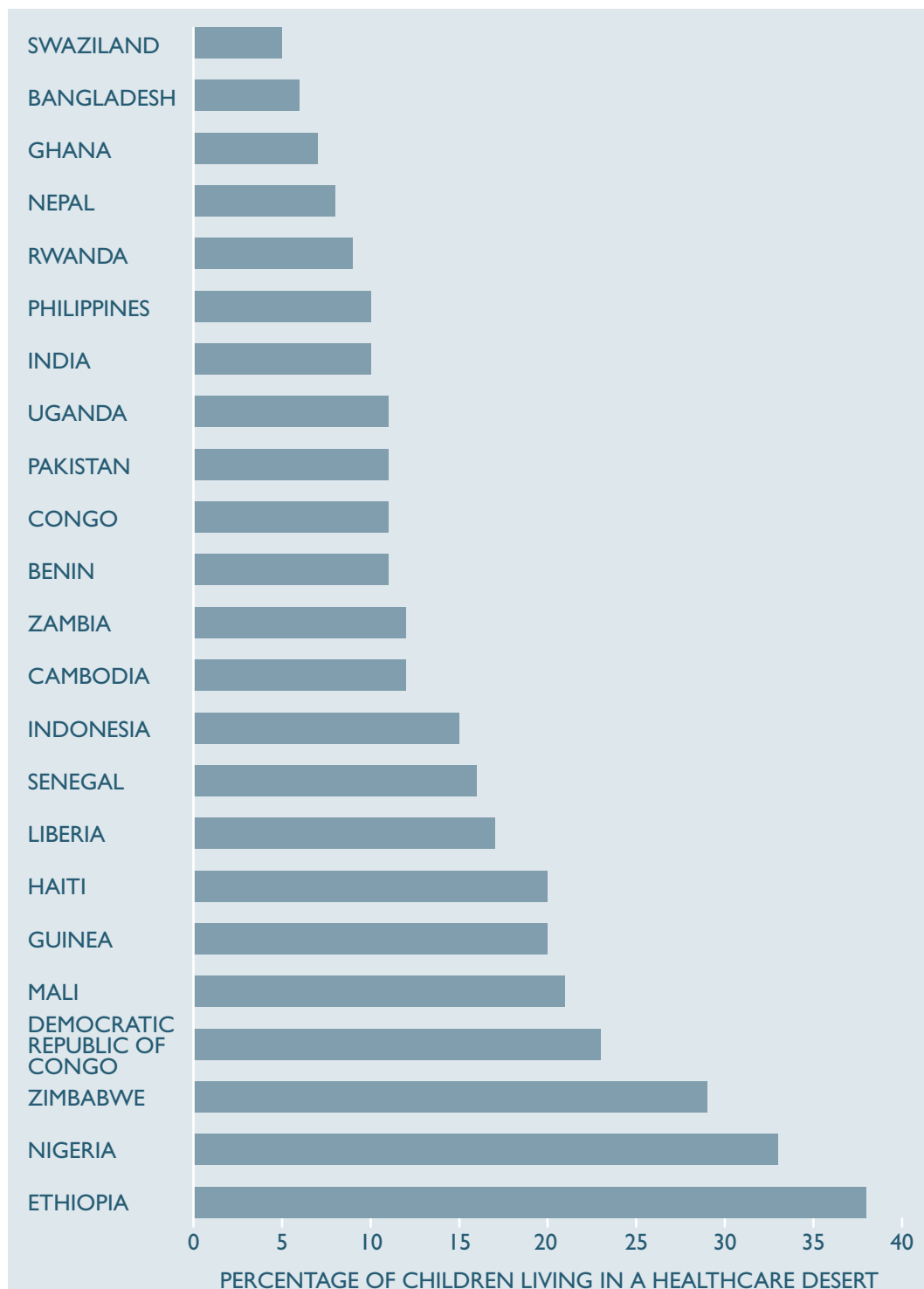
Many of the countries that have cut child mortality dramatically have rolled out a minimum package of healthcare for every child, irrespective of the situation they are born into. Bolivia, for example, has followed these principles of a comprehensive *and* universal service under its Universal Mother and Child Insurance Scheme, which covers 500 health problems for children below five years of age. Similarly, since 2006 Ghana has adopted a High Impact Rapid Delivery scheme designed to give essential health and nutrition services to rural communities not registered with the national health insurance programme.⁵

Yet at the moment, millions of children lack access to such a health service. For most children, the issue is not a complete absence of healthcare. Rather, it is a case of the healthcare that exists being financially or physically inaccessible, or of such low quality that it is of limited practical help. Typically, the children with the least access are from the poorest communities, living in remote rural areas or in slums, and often in a legally unregistered limbo where states don't recognise their need.⁶

The most disadvantaged among these children live in a *de facto* healthcare desert, where even the most basic treatment and care is not accessible. By our estimate, 40 million children under the age of five – one in seven children in 25 countries with high child mortality – can be classed as severely deprived in terms of healthcare, measured by coverage of routine immunisations, and treatment of diarrhoea.⁷

Two-thirds of these children live in just three countries: 13 million in India, 8 million in Nigeria and 5 million in Ethiopia. Overwhelmingly they come from the poorest families: on average a child in the poorest fifth of the population is three times more likely to lack access to healthcare than a child in the wealthiest fifth.

PROPORTION OF CHILDREN LIVING IN A HEALTHCARE DESERT



Source: Demographic and Health Surveys, 2005 onwards.

A healthcare desert is a situation where a child does not receive routine immunisations or treatment for diarrhoea.

NO CHILD BORN TO DIE

THE POOREST CHILDREN ARE AT THE HIGHEST RISK OF DISEASE, BUT ARE LEAST LIKELY TO HAVE ACCESS TO HEALTH SERVICES OR TO BE IMMUNISED

CLOSING THE THREE RESOURCE GAPS

Meeting the healthcare needs of these children, and of the millions more who have patchy and poor quality access, will involve closing three critical resource gaps, without which a major reduction in child deaths cannot be achieved. First, child mortality goals will not be met without a dramatic scaling up of immunisation. There are two dimensions to this challenge: there is an urgent need to expand access to existing vaccines, with one-fifth of children born each year currently lacking access to the standard set of vaccines recommended by the World Health Organization (WHO). This leaves millions of children – who are usually from the poorest backgrounds and therefore most at risk of illness – doubly vulnerable to such readily preventable diseases as tuberculosis and measles. There is also an opportunity to prevent many more deaths by rolling out a new set of vaccines, including for the most common cause of pneumonia and for diarrhoea, which have recently come onto the market. This will require a substantial increase in funding from governments and international institutions, coupled with a commitment to bringing down prices for life-saving vaccines in the poorest countries.

Second, health services cannot function without health workers who are well trained, deployed in the right places, paid a living wage and supported to do their jobs effectively. At the moment, most of the countries that are off track towards meeting the MDG on child mortality face a critical shortage of doctors, nurses, midwives and community health workers, and often struggle to make effective use of the health workers who already exist.

Third, the funding shortfall for immunisations and health workers is part of a wider financing gap that is currently jeopardising the provision of healthcare for every child. Estimates of the price tag for the child mortality MDG vary, but all of them would require a significant scaling up of financial commitments to healthcare by governments in the poorest countries and by donor governments in rich countries. The sums involved are affordable when set against existing spending priorities, and could be met if existing developing country pledges on health spending and donor aid commitments were met. In the absence of more and better quality funding for health, millions of children will continue to have access to life-saving care rationed by price. Making healthcare free at the point at which it is needed is central to ensuring that every child is able to survive and thrive.

Closing these gaps depends on a wider challenge being met: of ending the injustice that puts the poorest children at a massively increased risk of early death. Child mortality does not strike randomly: a child in India from the poorest fifth of the population is three times less likely to survive to five years than a child in the top income group. In Nigeria, a child in the poorest fifth of the population is 2.5 times more likely to die in early childhood; in Peru, over five times more likely. As recent research from Save the Children found, this gap is widening for a majority of countries with a high burden of child mortality.⁸ This disparity in life chances reflects entrenched inequalities in each of



RAGHU RAIMAGNUM FOR SAVE THE CHILDREN

In India, a child from the poorest fifth of the population is three times more likely to die than a child in the top income group. Here, Kamar is supported during her pregnancy by Sangeeta, a community worker from one of Save the Children's partner organisations in Delhi, India.

the three priority areas identified in this report. The poorest children are typically at the highest risk of disease, but are also the least likely to have access to a functioning health service, are least likely to be immunised, and will usually be expected to meet a disproportionate share of healthcare costs from their own family's income. Ensuring that every child has a fair start in life will require a much stronger policy emphasis on removing the barriers that stand between the poorest and most disadvantaged children and essential healthcare.

Implementing this agenda will transform the lives of millions of children, and with it the futures of their families, communities and countries. Ensuring that every child's right to essential health services is realised is a moral imperative worth pursuing in itself: Save the Children believes that no child is born to die. But it is also a smart investment in economic and social development. Governments, international institutions, the private sector and civil society organisations must rise to this urgent challenge over the next five years. Just as the cost of failure is prohibitive, in children's lives lost and futures blighted, so the potential prize is enormous. By taking the right action now, 15 million children's lives can be saved between now and 2015.



CAROLINE TRUTHMANN/SAVE THE CHILDREN

2 MILLION
more children could be saved each year by 2015
through a comprehensive package of vaccines

2. THE IMMUNISATION GAP

Immunisation is one of the best ways of ensuring children survive and thrive in early childhood. An estimated 7,000 children's lives are saved by vaccines every day, and many more people are protected from debilitating illness and disability.⁹

The remarkable success of the measles vaccine is a case in point. In 2000, 750,000 children died from the condition. In 2008 that number had been reduced to just over 160,000. A major push in Africa led to a 92% reduction in measles-related deaths during this period.¹⁰ Likewise, the decision by the Gambia to introduce the Hib (*Haemophilus influenzae* type B) vaccine in 1997 has virtually eliminated a major cause of pneumonia and bacterial meningitis.¹¹ And whereas in 1980 just one in five children worldwide was vaccinated against diphtheria, pertussis (whooping cough) and tetanus (DPT), in 2007 that coverage had quadrupled to 80%.¹² These and other successes – including the global eradication of smallpox, and near-eradication of polio – mirror the experience of the UK, which has used routine immunisation to help cut child mortality (see box).

Many vaccines also confirm the adage that prevention is cheaper than cure: it costs US\$0.72 to deliver the DPT vaccine, and \$1.80 to vaccinate against measles, mumps and rubella.¹³ It has been estimated, for example, that an upfront investment of \$100 million in eradicating smallpox during the ten years up to 1977 has since saved about \$1.3 billion a year globally in treatment and prevention costs.¹⁴ The potential gains from comprehensive immunisation are huge: the WHO's own estimate is that a comprehensive package of available vaccines could save an additional 2 million children's

VACCINES IN THE UK AND THE POOREST COUNTRIES

The UK, like many developing countries, has been able to use routine immunisation to help achieve major advances in children's health. The eradication of smallpox and polio from the UK, and the massive reduction in measles, mumps and rubella are the result of routine immunisation. More recently, the Hib vaccine – introduced by the NHS in 1992 – cut cases of bacterial meningitis by 99%.¹⁷

But rich countries like the UK have some major advantages over poorer countries. First, vaccines are usually expensive when they first appear on the market, meaning that there's a time lag between rich countries introducing them and poorer countries following suit. Although initiatives such as the Global Alliance on Vaccines and Immunisation (GAVI) have started to reduce this time lag, cost remains a barrier for millions of the world's poorest children. Second, rich countries have the health services and infrastructure to rapidly expand vaccine coverage, including for the poorest children. Often, this is absent in the poorest countries, meaning that where vaccines are introduced, the children at greatest risk of illness are often the last to be vaccinated.¹⁸

Opposite: A newborn baby receives their first inoculation at a health clinic in Huambo Province, Angola.

7,000

children's lives are saved by vaccines every day

lives a year by 2015.¹⁵ Yet at the present time, the world must bridge a funding shortfall of \$3.7 billion for the work of the major international vaccine partnership if it is to seize this opportunity.¹⁶ A pledging meeting in London in June of the Global Alliance on Vaccines and Immunisation (GAVI) will be a critical moment to deliver on this agenda.

AN UNFINISHED AGENDA

The flip side to immunisation's successful track record is a major, unfinished agenda in reaching children with life-saving vaccines. While in rich countries immunisation is a routine part of infancy and early childhood, 23 million children worldwide – about

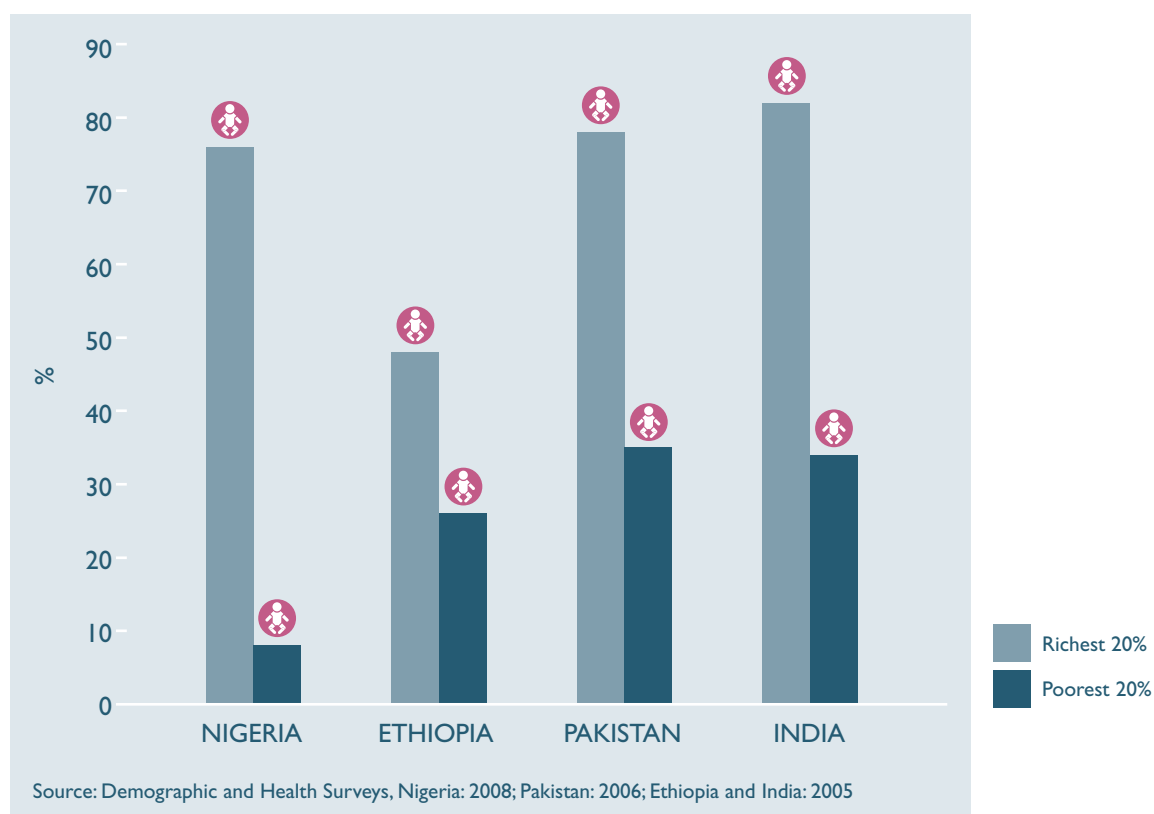
KEY CHILD IMMUNISATIONS

Vaccine	What does it prevent?	When is it given?	What does it cost? (US\$)	Coverage in Africa %
DPT	Diphtheria, pertussis (whooping cough), tetanus	6, 10, 14 weeks	0.72	71
BCG	Tuberculosis	At birth	0.11	79
Measles/ MMR	Measles/ measles, mumps, rubella	Low risk – 12 months, 15–18 months High risk – 9 months, 12–18 months	1.86	71
Yellow fever	Yellow fever	9 months	0.90	
Hepatitis B	Hepatitis B	At birth, 6 and 14 weeks	1.08	70
Hib (Haemophilus Influenza type B)	Pneumonia, bacterial meningitis	6, 10, 14 weeks	13.60	62
Pentavalent (DPT-HepB-Hib)	Diphtheria, pertussis, tetanus, hepatitis B, pneumonia, bacterial meningitis	2, 4, 6 months	11.76	–
Pneumococcal	Pneumonia	6, 10, 14 weeks	21.00	–
Rotavirus	Diarrhoea	6, 10, 14 weeks	15.00*	–

Source: UNICEF, WHO, GAVI. Unit costs through GAVI/UNICEF procurement

* not yet procured by UNICEF/GAVI

COVERAGE OF DPT VACCINE FOR THE RICHEST AND POOREST INCOME GROUPS



IN 2000, MEASLES KILLED 750,000 CHILDREN. IN 2008 THAT NUMBER HAD BEEN REDUCED TO JUST OVER 160,000.

23 MILLION CHILDREN – ONE CHILD IN FIVE BORN EVERY YEAR – GOES WITHOUT THE LIFE-SAVING DPT VACCINE, WHICH COSTS 72 US CENTS PER CHILD

one in five of all children born each year – go without the three combined doses of DPT – against diphtheria, pertussis (whooping cough) and tetanus.¹⁹ Seventy per cent of these children live in just ten countries: Chad, China, the Democratic Republic of Congo (DRC), Ethiopia, India, Indonesia, Iraq, Nigeria, Pakistan and Uganda.²⁰ A similar picture exists for other crucial vaccines: 29% of one-year-old children in Africa go without the measles vaccine, while 38% of children in Africa have not been immunised against Hib, which prevents the second largest cause of pneumonia among children.

Overwhelmingly, the children missing out on vaccines are from poor families, often living in the countryside or in slum areas. In Pakistan, two-thirds of children from the richest 20% of the population receive DPT. Among the poorest 20%, barely one in five children gets immunised.²¹ Some countries have marked regional inequalities. Whereas 85% of infants in the wealthier Indian state of Maharashtra are fully immunised, in poorer Bihar just 10% of infants are covered.²² The bitter irony is that, in many cases, the children most at risk from the conditions vaccines are designed to prevent are also the children least likely to be immunised. Eliminating gaps in immunisation coverage based on wealth should be an urgent priority for donors and governments as they meet in June 2011 to discuss funding for the Global Alliance on Vaccines and Immunisations (GAVI) – a partnership founded in 2000 between governments, the private sector and international institutions to expand access to vaccines in the poorest countries.

Low coverage of vaccines usually reflects the fact that children do not have access to healthcare. Some vaccines – against measles, for example – can be provided through periodic campaigns, even in the absence of a functioning healthcare system. But it is extremely difficult to sustain coverage levels without:

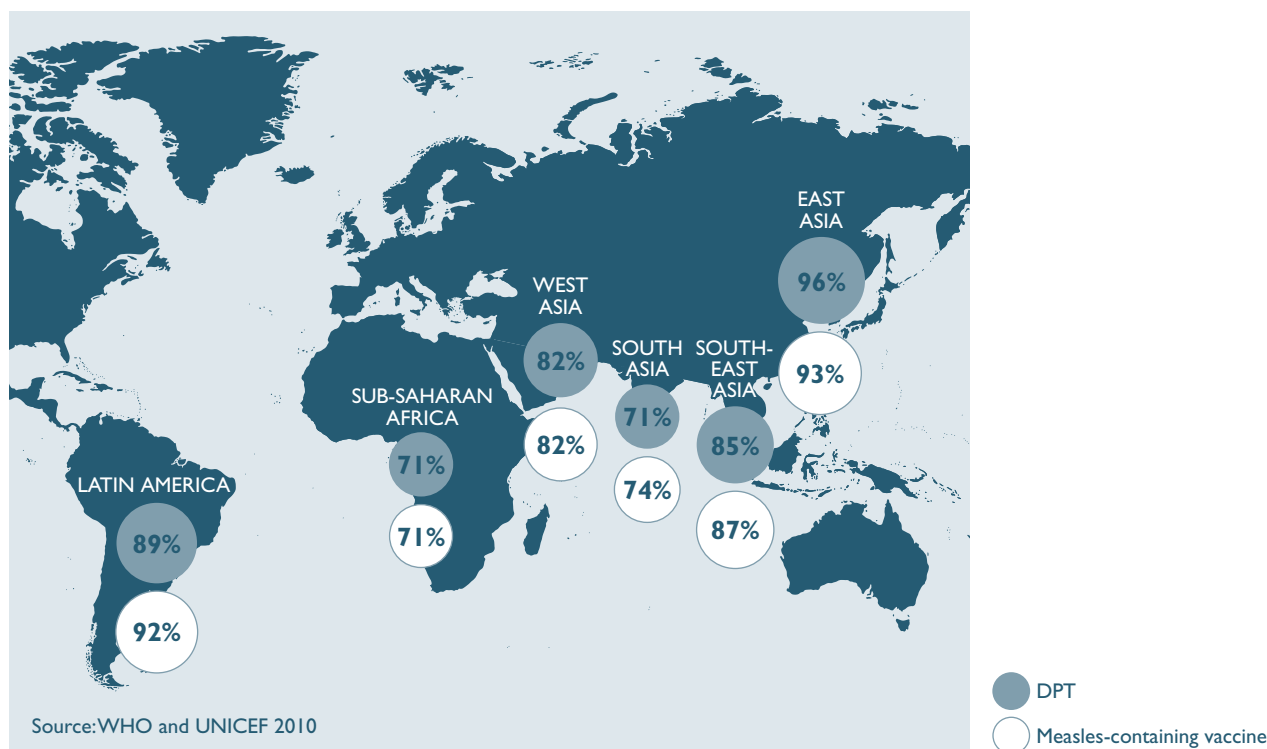
- a system in which attended births are the norm, underpinned by a network of health facilities and health workers
- a procurement, distribution and storage system
- systems for birth registration and record-keeping.

For vaccines such as the DPT and hepatitis B vaccines, which require several doses over a period of months, access to some form of structured healthcare is critical. Indeed, in countries where immunisation coverage is high, vaccines are often a child's introduction to the healthcare system. Immunisation sessions can also be an effective way of providing health services to mothers and older children. The challenge is clear – giving every child access to life-saving vaccines depends on every child getting access to healthcare.

This gap is often greatest in countries that are affected by conflict: 18 of the 25 countries with DPT coverage below 70% are fragile or conflict-affected states where healthcare systems are often weak or non-existent.²³ Although GAVI's eligibility threshold for donor funding for new vaccines has been temporarily lowered, from 70% DPT coverage to 50% (together with a national income threshold of less than US\$1,500 per person), there remains a risk that some of the countries in greatest need of increased support for immunisation fail to qualify for donor assistance.

THE CHILDREN MISSING OUT ON VACCINES ARE OVERWHELMINGLY FROM POOR FAMILIES

COVERAGE FOR TWO KEY VACCINES BY REGION



NEW VACCINES: NEW OPPORTUNITIES, NEW CHALLENGES

Since 2000, major new vaccines have appeared on the market. Much of this expansion has happened in rich countries like the UK, which together account for over half of the US\$17 billion annual sales of vaccines. But the real potential of immunisation to transform children's lives lies in the poorest countries. Three new vaccines in particular have the potential to help meet the challenge of ending preventable deaths among young children:

- pneumococcal, which tackles the most common cause of pneumonia among children. The vaccine could prevent between 250,000 and 550,000 child deaths a year
- rotavirus, which addresses the infection that lies behind about one-third of diarrhoeal deaths and could prevent between 250,000 and 500,000 child deaths a year
- pentavalent, a combined vaccine for the DPT, Hep B and Hib vaccines, which has a proven track record of preventing diphtheria, whooping cough, tetanus, hepatitis B, bacterial meningitis and pneumonia.

These new vaccines have great potential, but should not be treated as magic bullets. Where coverage for existing vaccines is low or highly unequal, they will have limited

THE WORLD'S
MAJOR VACCINE
PARTNERSHIP
– KNOWN AS
GAVI – FACES A
SHORTFALL OF
\$3.7 BILLION

impact unless the underlying issue of access to healthcare is addressed. Other measures are at least as important in terms of reducing deaths among young children: most diarrhoea-related deaths can be prevented through clean water, adequate sanitation and by hand washing with soap, which by itself could prevent an estimated 45% of cases.²⁴ Improved nutrition and hygiene, early detection and treatment with antibiotics could prevent up to 85% of pneumonia-related deaths.²⁵

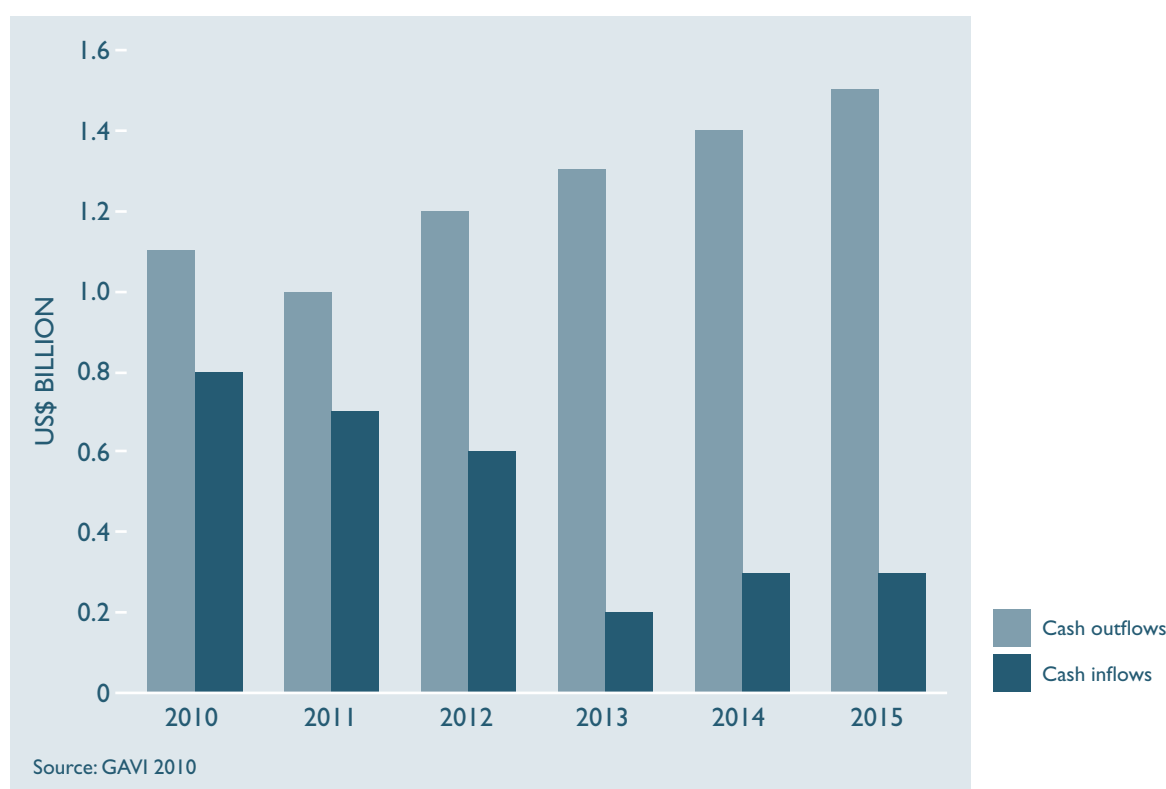
However, vaccines are a proven and vital part of a wider effort to prevent child deaths. GAVI estimates that 90% coverage of new and existing vaccines could prevent an additional 2 million child deaths a year by 2015, and save 4.2 million children's lives in total over the next five years.²⁶ But at the moment, the poorest countries are largely missing out. Only five out of 43 low-income countries and 11 out of 52 lower-middle income countries have introduced both the pneumococcal and rotavirus vaccines.²⁷

Price is an important part of the explanation for this slow uptake. Significant progress has been made in recent years in bringing down the cost of life-saving drugs in the poorest countries, most notably for HIV and AIDS.²⁸ Despite important differences between drugs and vaccines, a similar story can be told for many vaccines. The projected average weighted price for pentavalent, for example, is expected to reduce by \$0.50 in 2010 to below \$3 a dose.²⁹ However, despite this progress, providing a child with all three new vaccines still costs over \$45 at current prices, which is more than annual per capita public spending on health in at least 39 developing countries.³⁰ For countries that qualify for GAVI funding, most of this cost will be covered externally, arguably making price more of a factor for donors, than it is for most low-income country governments. Nevertheless, at the end of 2008, 30 of the 72 GAVI-eligible countries were co-financing the introduction of pentavalent, rotavirus and pneumococcal vaccines.³¹ And for other countries that narrowly fail to qualify for GAVI, prices – which are often much higher than those negotiated through GAVI – can be a serious challenge to health budgets.

Two important issues that keep prices high and reduce competition are the small number of pharmaceutical companies developing and producing new vaccines, and the barriers to market entry. For example, just two companies – GlaxoSmithKline (GSK) and Merck – produce the rotavirus vaccine. Similarly, GSK and Pfizer are the two principal manufacturers of the pneumococcal vaccine. Vaccine prices are also influenced by the fact that, unlike most drugs, they are normally only administered in one or two doses, meaning that manufacturers need to get the return on investment from a single use. This helps to explain why manufacturers are especially keen to protect patents that give a monopoly on vaccine production. Manufacturers also cite research and development (R&D) costs as a key reason for the high unit cost of vaccines, although without a clearer breakdown of costs it is difficult to judge whether or not the R&D costs of the new vaccines have already been recovered.

Whatever the precise combination of factors driving current prices on new vaccines, the fact that they remain relatively high is one reason for the large funding gap that has opened up for GAVI, which works to reduce the period between the development of

GAVI – FUNDING NEEDS AND INCOME FOR IMMUNISATION



new vaccines and their adoption by the poorest countries. GAVI currently purchases vaccines, mostly through UNICEF, for 72 low- and lower-middle-income countries. It has been instrumental in expanding access to hepatitis B and Hib vaccines, and its interventions have so far prevented an estimated 5.4 million children's deaths.³²

But just as funding demands are increasing, so the income for GAVI is falling. Spending on the pentavalent, pneumococcal and rotavirus vaccines, which accounts for two-thirds of total projected GAVI spending between 2010 and 2015, is expected to lead to annual spending of US\$1.3 billion in 2013, while annual resources are projected to drop from a peak of over \$0.8 billion in 2010 to \$0.3 billion in 2015.³³ This widening funding gap is down to three main causes:

- a tailing off in income from the International Financing Facility for Immunisation (IFFIm), a UK government-led initiative to front-load spending generated through bond issues
- a reduction in funding through the Advance Market Commitment Scheme, which is designed to create incentives for the development and production of new vaccines
- direct contributions by donor governments, which are under pressure as aid budgets get squeezed.

Direct contributions by donors to GAVI are under particular pressure. Less than half of all GAVI funding comes from direct bilateral contributions, and fell in absolute terms between 2007 and 2009. Although some new bilateral commitments were announced at the G8 in Canada in 2010, including by Canada and France, without a major new funding drive around the June 2011 pledging conference, roll out of the new vaccines will be in question.

In short, more funds are urgently needed to expand access to life-saving vaccines to millions of the world's poorest children. But lower prices for the new vaccines are also necessary. Without them, the current GAVI model cannot easily be sustained – let alone extended to millions of children in middle-income countries that are currently not covered by the initiative.

GAVI: CASH RECEIVED BY YEAR, AND TOTAL CUMULATIVE DONOR COMMITMENTS (US\$ MILLIONS)

	2006	2007	2008	2009	Cumulative contribution 1999–2009*
Australia	5.0	5.0	5.0	5.0	28.6
Canada	5.2				348.7
Germany	5.3	5.9		5.7	22.0
France	12.6				1,768.9
Netherlands		33.5	38.9	31.2	332.7
Norway	64.9	86.2	65.4	82.8	517.8
Sweden	14.6	15.5	19.1	13.8	130.9
UK	23.2	48.1			3,438.6
USA	69.3	69.3	71.9	75.0	568.7
EC		4.8	23.1	28.6	71.5

Source: GAVI 2010

* including IFFIm and AMC commitments

CHILDREN MOST AT RISK FROM THE CONDITIONS
VACCINES ARE DESIGNED TO PREVENT ARE THE
LEAST LIKELY TO BE IMMUNISED

RECOMMENDATIONS TO HELP CLOSE THE IMMUNISATION GAP

- **Mobilise additional funds** – the 2011 London pledging meeting must help to bridge the \$3.7 billion five year funding gap. The UK currently provides about one-quarter of GAVI funding, and should use this leadership position to leverage further commitments from other rich countries. At a minimum, other donor countries should match any further increases in UK support for GAVI.
- **Bring down prices** – the GAVI pledging meeting in June 2011 should be used to agree a review of vaccine pricing, leading to a new architecture for prices in the poorest countries. In particular, GAVI members, including the pharmaceutical industry, should reduce the price further for pentavalent, pneumococcal and rotavirus vaccines.
- **Front-load spending** – donor countries should explore innovative financing mechanisms, in collaboration with the French government ahead of the 2011 G8 and G20 summits, to generate front-loaded resources for immunisation.
- **Deliver vaccines through better healthcare for every child** – the UK and other donors should work with national governments and international institutions to ensure that every child has access to a minimum standard of healthcare (which expanded immunisation coverage depends on), with a particular focus on immunising the children at greatest risk of life-threatening diseases.



3.5 MILLION
more health workers are needed by 2015

3. THE HEALTH WORKER GAP

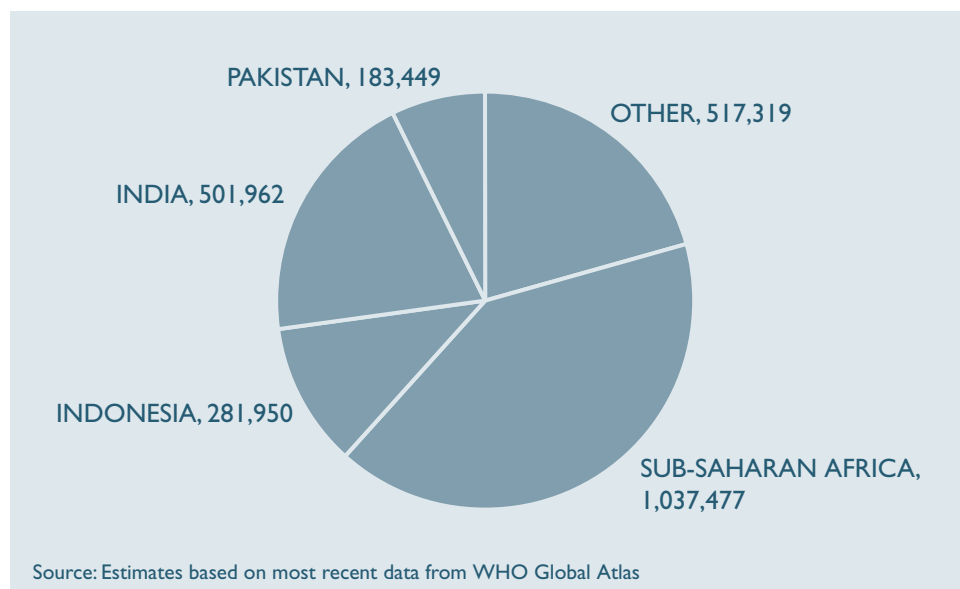
Health workers are the backbone of healthcare. Without doctors, midwives, nurses and community health workers, there is no one to diagnose illnesses, dispense treatment, assist at births or immunise children.

All too often, the major barrier to children receiving the care they need is not a lack of know-how or technology. Rather, children are missing out on life-saving healthcare because the staff needed to do the job are missing. Globally, the best estimate is that another 3.5 million health workers need to be recruited, trained and deployed by 2015 in order to achieve the MDGs of a two-thirds reduction in child mortality, and a reduction by three-quarters in maternal mortality. The challenge does not stop there. Millions of existing health workers need to be better trained and managed, deployed in the right places, and given the incentives and equipment they need to do their jobs effectively.

TOO FEW HEALTH WORKERS

The UN Secretary General's strategy for maternal and child health puts the minimum threshold for delivering essential health services at 2.3 doctors, nurses and midwives for every 1,000 people. This number is a floor, not a ceiling – it does not include community health workers (who are often the first line of prevention and treatment for children) or support staff such as managers and administrators. According to this measure, 61 countries – 41 of them in Africa – face critical shortages of health workers.

THE GLOBAL HEALTH WORKER SHORTFALL



Opposite: The labour ward in the federal medical centre in Katsina, northern Nigeria. A million children under five die in Nigeria every year.

THE UK HAS **40 TIMES** MORE HEALTH WORKERS THAN SIERRA LEONE, RELATIVE TO ITS POPULATION

THE SHORTAGE OF HEALTH WORKERS IN SIERRA LEONE

Sierra Leone currently has less than 10% of the health workers it needs to meet the UN's minimum threshold – a shortfall of over 11,000 nurses, midwives and doctors. Two million people in the capital, Freetown, are served by just six obstetricians and gynaecologists – in a country where women face a one in seven risk of death during childbirth over their lifetimes.³⁴ The contrast with the UK is stark. In Britain, there are approximately 120,000 doctors and 380,000 nurses, or eight health professionals for every 1,000 people. If the UK had the same ratio of health workers as Sierra Leone, it would have just 12,500 doctors and nurses – one fortieth of the current number.

Globally, the shortfall using the most recent data totals 2.5 million doctors, nurses and midwives. The WHO estimates that, in order to achieve the health MDGs by 2015, an additional 3.5 million health workers, including one million community health workers, need to be recruited, trained and deployed in 42 of the poorest countries. As the graph shows, a shortage of health workers tends to go hand in hand with high levels of child mortality. Over 40% of the global health worker gap is in sub-Saharan Africa, which has one-third of the global disease burden among mothers and children and just 3% of the world's doctors, nurses and midwives.³⁵ India accounts for another 20% of the global health worker gap.

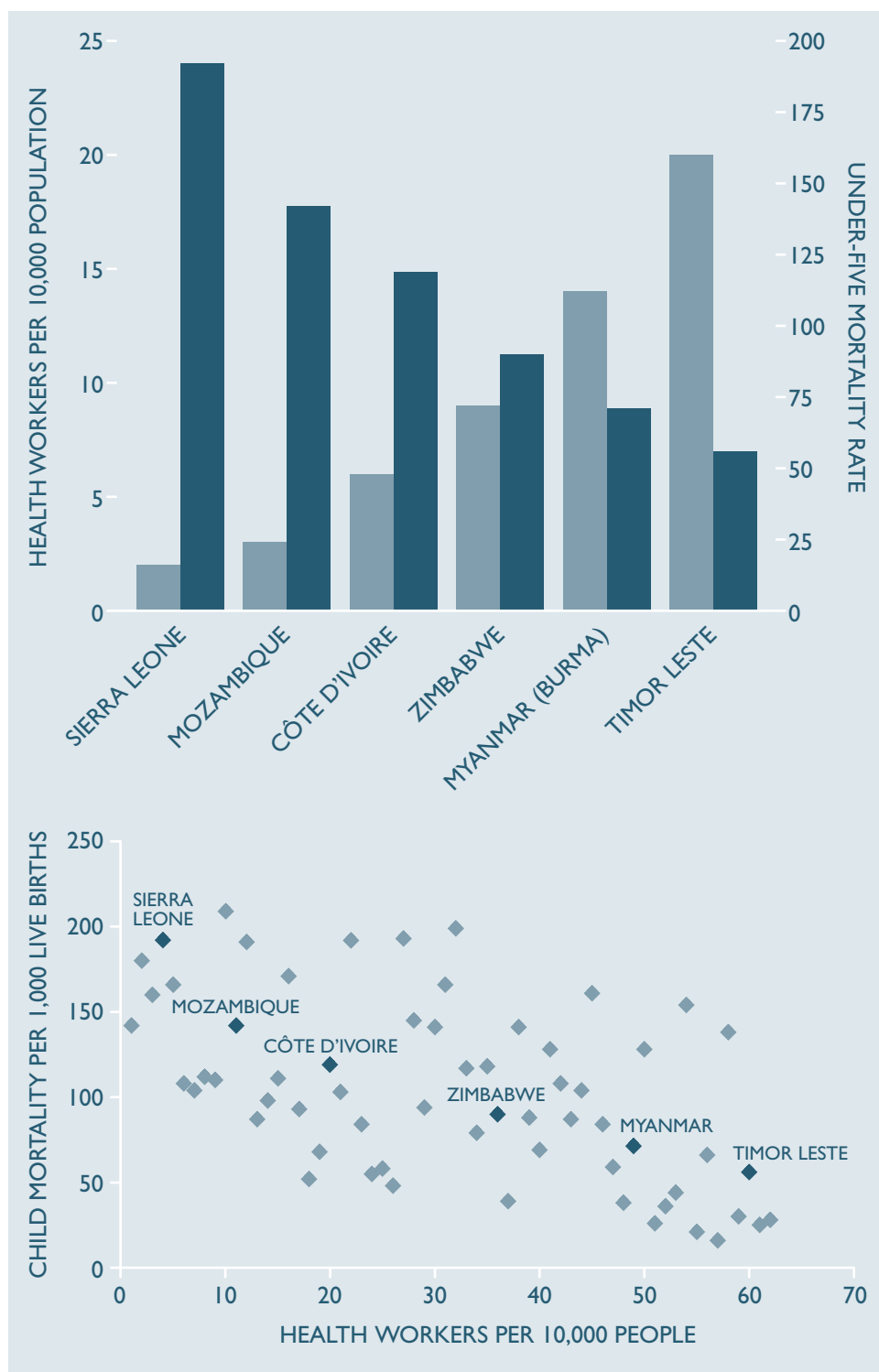
Over one-third of Africa's health worker shortfall exists in just four countries: Ethiopia, the DRC, Nigeria and Sudan. At the moment, far too little is being done to meet this



AUBREYWADE

Mabinti, in her eighth month of pregnancy, is examined by Bintu, a health worker at a Save the Children-supported clinic in Freetown, Sierra Leone.

COUNTRIES WITH HIGH CHILD MORTALITY FACE CRITICAL SHORTAGES OF HEALTH WORKERS



The scatter graph plots child mortality rates against health worker ratios in 62 developing countries.

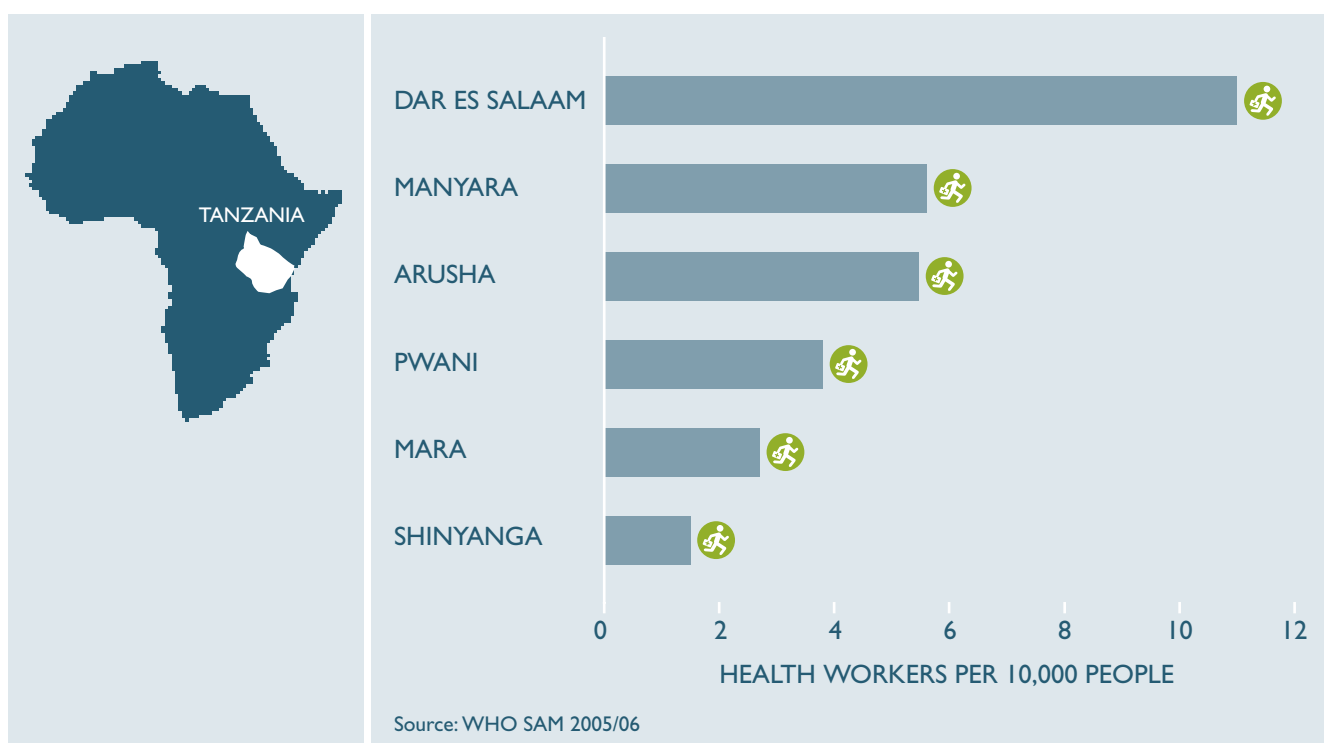
SUB-SAHARAN AFRICA HAS ONE-THIRD OF THE GLOBAL DISEASE BURDEN AMONG MOTHERS AND CHILDREN, BUT JUST 3% OF THE WORLD'S DOCTORS, NURSES AND MIDWIVES

need. One recent study of 12 African countries found that current levels of recruitment and training are insufficient even to maintain existing health worker ratios.³⁶ The challenge for governments and international donors is clear: without a concerted recruitment push in the critical shortfall countries, there is little prospect of making accelerated progress towards the global goal of cutting child mortality by two-thirds.

MAXIMISING HEALTH WORKERS' IMPACT – DEPLOYMENT AND SUPPORT

The challenge of bridging the health worker gap goes beyond a shortfall in numbers. In countries with high child mortality, existing staff are rarely deployed in a way that responds effectively to the major health challenges. There are two dimensions to this problem. First, health workers tend to be concentrated in urban centres where health facilities are often based, and away from the remote villages, informal settlements on the fringes of cities and slum areas where the poorest and most vulnerable children typically live. For example, in Tanzania urbanised Arusha has a child mortality rate of 83 per 1,000 births, and 5.5 health workers for every 10,000 people. In contrast,

UNEQUAL DISTRIBUTION OF HEALTH WORKERS: SELECTED URBAN AND RURAL DISTRICTS IN TANZANIA



HEALTH WORKERS TEND TO BE CONCENTRATED IN URBAN CENTRES WHERE HEALTH FACILITIES ARE BASED AND AWAY FROM THE VILLAGES AND SLUM AREAS WHERE THE POOREST AND MOST VULNERABLE CHILDREN LIVE



PIERS BENANTAR

A rural health clinic in Lindi district, Tanzania

mainly rural Shinyanga has a child mortality rate of 130, and a health worker ratio of just 1.5. A similar picture exists elsewhere. In Nigeria, Osun state has a child mortality rate of 89 and 4.2 health workers for every 10,000 people. In contrast, Yobe state has a mortality rate of 222 and a health worker ratio of just 1.1.³⁷

Second, this disparity also reflects an often understandable reluctance by doctors, nurses and midwives to work in remote or insecure places where they will receive limited practical support and where equipment and essential drugs are often lacking. One survey in Malawi found that just 10% of health facilities were resourced to deliver a package of essential healthcare,³⁸ while another survey among nurses reported widespread frustration at a lack of basic equipment including beds, linen, surgical gloves and detergent.³⁹ Ensuring that facilities in poor and remote areas are equipped and that health workers are supported is critical to getting health services out to where they are needed. In some cases, a premium needs to be paid to create incentives for health workers to be based in rural and disadvantaged areas. In many cases, this will require an increase in resources for health, and a reallocation towards poor and under-served communities.

The experience of Mariana Jossefa Augusto, a nurse in Gujia district, in Mozambique's Gaza province, is typical of the challenges facing health workers in many poor countries. Talking to Save the Children, she explains that she is responsible for maternal and child health in a district with 15,000 children under the age of five and 35,000 women of reproductive age, spread over a 40km radius. There are four fewer nurses working on maternal and child health in the district than the official allocation, and a chronic

ROGIERO JOSÉ SARDINIA, A COMMUNITY HEALTH WORKER IN RURAL MOZAMBIQUE, SERVES 17,000 PEOPLE ACROSS NINE VILLAGES. HE IS PAID A MONTHLY STIPEND OF US\$30

shortage of medicines, delivery kits and beds. Experiences like this are repeated across many low-income countries, and point to a second problem. Existing health workers are often not being trained and supported to do the things that will have the greatest impact on child mortality. A lot of in-service training tends to be short term, disease-specific and poorly coordinated.⁴⁰ In contrast, where relevant training is provided it can have a dramatic impact: community health workers in Nepal, trained in basic newborn care and with only limited additional equipment, were able to achieve a 30% reduction in deaths among newborn babies in the communities where they were operating, compared to areas covered by community health workers outside the programme.⁴¹

For millions of health workers, the lack of equipment and effective support to do the job is compounded by unrealistic workloads, poor pay and limited management. The working conditions for Rogiero José Sardinia, a community health worker in rural Nampula province, Mozambique, illustrate the point. Based at a small village health post made of wood and thatch, he serves 17,000 people scattered across nine villages, the furthest 18km away. Each month, he travels 47km by bicycle to the district capital to submit reports and receive medicines, although these are often unavailable, leaving local families dependent on private pharmacies. For this work, he is paid a monthly stipend of about US\$30. In many of the poorest countries, levels of pay for health workers are often below what is needed to meet even basic needs. In Ethiopia, a junior nurse's monthly salary is 884 birr – about \$50.⁴² In Burkina Faso, a certified nurse can expect \$150 a month.⁴³

Poor working conditions drive many health workers to take their skills elsewhere or to leave healthcare behind altogether. In either case, the effect on child survival and the prospects of making progress towards meeting the health MDGs are similarly negative. One-quarter of all doctors trained in Africa work in the industrialised countries of the OECD, and there are more Ghanaian doctors outside Ghana than in the country.⁴⁴ In some cases, including in the UK, rich countries have become heavily dependent on foreign health workers, with more than 75,000 nurses from overseas working in the National Health Service.⁴⁵ While the causes and consequences of health worker migration are complex, and many health workers are better able to use their skills outside their countries of origin, the poorest countries are currently losers in a system where scarce doctors, nurses and midwives, often trained at public expense, end up contributing to already well-resourced health systems in the richest countries.

Donor countries need to provide support to countries with critical health worker shortages, by reducing 'push factors' such as poor pay and working conditions, and at the same time minimising 'pull factors' by stopping active recruitment to their own health services from countries with critical shortages. The WHO international code of conduct on health worker migration is a starting point for addressing these issues, and in ensuring that countries with critical shortages of health workers are able to start to meet their needs.

THERE ARE MORE GHANAIAN DOCTORS OUTSIDE GHANA THAN INSIDE THE COUNTRY

The struggle to hold on to existing health workers is often exacerbated by constraints on the ability of health ministries to recruit new health workers or to give them a living wage. Personnel often account for the bulk of health spending, and in many countries health workers account for a large proportion of the public sector workforce. Conditions attached to International Monetary Fund (IMF) lending, which low-income countries must usually comply with in order to release funds from aid donors such as the UK, often place restrictions on the public sector wage bill, and on the ability of countries to expand the number of public sector employees.⁴⁶ This can have a significant, if indirect impact on the ability of governments to address health worker critical shortages, and in countries such as Zambia has had the effect of undermining wider commitments by the IMF and other donors to protect priority social expenditures. A more flexible approach by the IMF, minimising the use of public sector wage and recruitment ceilings and freezes, is needed to create more space for the poorest countries to address chronic health worker needs.

MORE THAN
75,000 NURSES
FROM OVERSEAS
WORK IN THE
UK NATIONAL
HEALTH SERVICE

RECOMMENDATIONS TO HELP CLOSE THE HEALTH WORKER GAP

- **Support critical shortage countries** – donors should increase long-term aid to countries that lack the minimum number of health workers needed to do the job, and ensure that they are trained, supported and deployed to have the greatest impact on child mortality.
- **Remove international barriers to progress** – donor countries should use their influence in the IMF to ensure that countries have the flexibility to increase health worker numbers and pay.
- **Stop active recruitment of health workers from critical shortage countries** – donor countries should end active recruitment of health workers to their own health services from countries below the WHO threshold, and implement the international code of conduct on health worker migration.



TERI PENGILLEY

\$17.5 BILLION

is needed a year to bridge the funding gap for healthcare for mothers and children

4. THE FINANCING GAP

Universal access to healthcare is not an unaffordable pipe dream. Some of the poorest countries in the world have made dramatic strides towards ensuring that every child – regardless of where they live, and their family’s level of income – can get the prevention, care and treatment needed to lead healthy lives.

However, many more countries continue to fund healthcare from fees charged at the point of use, which often forces children either to forgo essential care or drives their families into poverty. Meeting the challenge of free healthcare for every child demands a collective financial effort: more money is needed, both from governments in developing countries, and from rich countries like the UK. But it also demands a collective political and policy effort, which generates more healthcare for the money, with much greater emphasis placed on spending on the right priorities, channelled in the right ways. At the moment, neither governments nor donors are rising to this challenge.

THE COST OF HEALTHCARE FOR EVERY CHILD

Calculations vary of the funding needed to achieve the goals the world has set itself, of sharply reducing child and maternal deaths, and tackling some of the major killer diseases, especially AIDS, TB and malaria. But the UN’s current best estimate is that on average an additional \$34 billion a year is needed annually between now and 2015, from countries’ own resources and from aid, for the poorest 49 countries in the world in order to meet the Millennium Development Goals. The estimates of the funding gap just for healthcare for mothers and children are smaller, at an average of \$17.5bn a year.⁴⁷

Although these total sums sound large, they need to be put into perspective – \$17.5bn is ten weeks of US spending on the war in Afghanistan, or about one-quarter of what Europeans spend each year on cosmetics.⁴⁸ In per capita terms, the additional costs are modest: the funding gap for the world’s poorest 49 countries in 2011 is \$19 per person using the high end scenario, and \$10 using the lower end – compared to per capita spending in the UK’s National Health Service of £1,953 a year.⁴⁹

Much of this additional funding can and must be generated by poor countries themselves. The 49 poorest countries are currently projected to spend \$6.7bn on health for mothers and children in 2015, or just 16% of the additional resources needed in that year to achieve a comprehensive scaling up of healthcare. Existing efforts are inadequate. For example, although African governments committed to the target of spending 15% of revenues on health at the African Union summit in Abuja, Nigeria in 2001, in 2008 just five African countries had met this target.⁵⁰

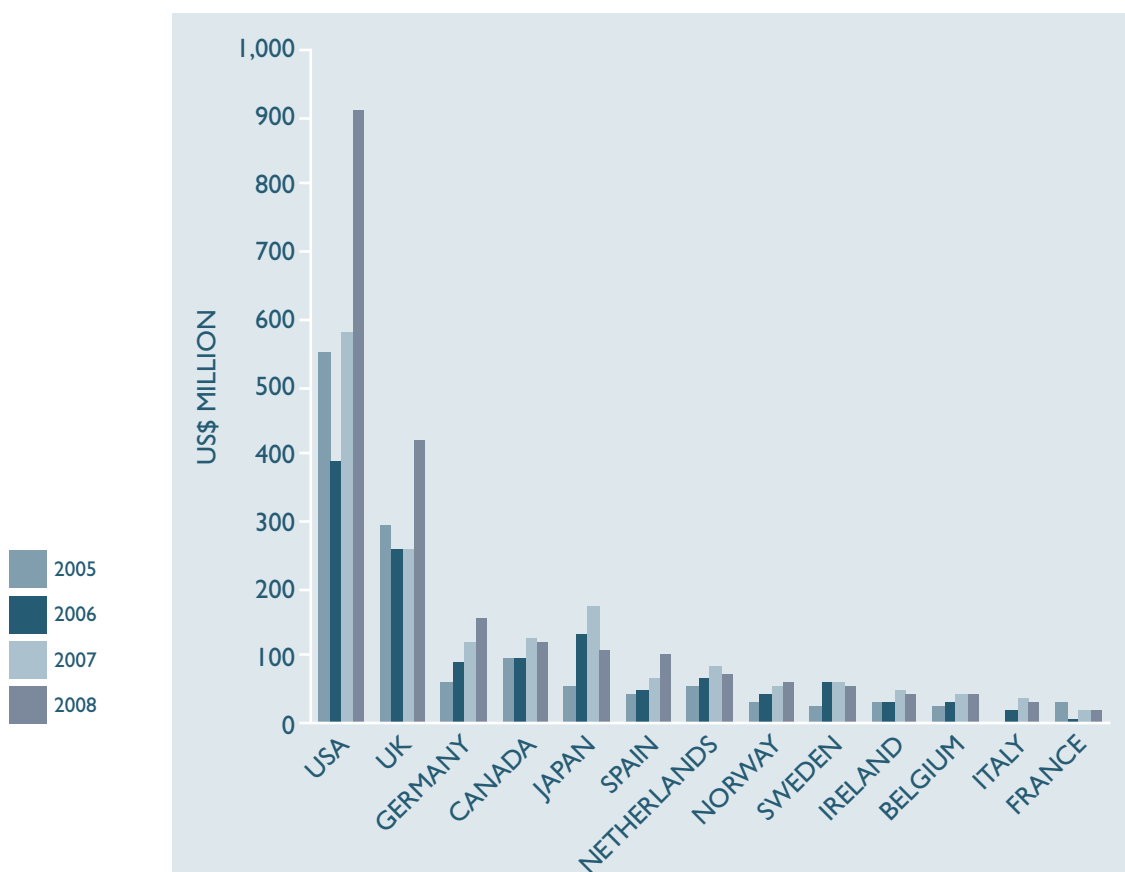
Opposite: At a hospital in Zambezia, Mozambique, Davide holds his sister, Amelia, while their sisters, Marta and Alice sit together. Both the younger girls are very sick with malaria, and were brought to the hospital by Save the Children staff. Both the children’s parents are dead.

THE HEALTH FUNDING GAP FOR THE WORLD'S POOREST 49 COUNTRIES IS BETWEEN \$10 AND \$19 PER PERSON

THE UK SPENDS £1,953 PER PERSON A YEAR THROUGH THE NATIONAL HEALTH SERVICE.

Yet it is equally clear that even with substantial increases in government revenues and reallocation of resources, the poorest countries will continue to depend heavily on donor support in order to provide healthcare. At present, donors are not providing the level of funding, for the right things and channelled in the right way, needed to deliver on their commitments. There has been some progress, driven mainly by the USA and UK, which together account for almost 60% of aid for maternal, newborn and child health: aid in this area has doubled since 2003, to \$5.4bn in 2008 – equivalent to \$5.80 for every child in the 68 countries that together account for 98% of child mortality.⁵¹ Yet this still only represents 4.5 cents in every dollar of global aid spending, and is about one-third of the level of need identified in the UN Secretary-General's strategy. Many donors are giving substantially less than their fair share. France, for example, contributed \$19 million to maternal, newborn and child health in 2008 – one-third of the sum given by Norway, which has a population 15 times smaller.⁵²

AID TO MATERNAL, NEWBORN AND CHILD HEALTH FOR THE 68 COUNTDOWN COUNTRIES, BY LEADING DONOR



Source: Countdown 2010

THE FUNDING GAP FOR HEALTHCARE FOR MOTHERS AND CHILDREN IS **\$17.5 BILLION A YEAR** – OR TEN WEEKS OF US SPENDING ON THE WAR IN AFGHANISTAN



A health clinic in Freetown, Sierra Leone

The aid that is allocated to health for mothers and children is poorly targeted, as well as insufficient: for example, whereas Botswana – with a child mortality rate of 3.1% – received \$152 per child in aid in 2008, Sierra Leone – with a rate of 19.4% – received \$15 per child.⁵³ Countries with large populations and high levels of need, such as Pakistan, the DRC and Nigeria, are often the biggest losers, receiving roughly \$5 per child on average in recent years for health.

The ways in which aid is provided also limits its impact on child survival. When governments expand healthcare, they need to make long-term funding commitments that are difficult to reverse, such as recruiting health workers. Yet aid for health tends to be short term, unpredictable and fragmented.⁵⁴ One study by the UK government's Department for International Development, comparing the quality of aid for water, education and health in Uganda, Ethiopia and Bangladesh, found that aid for health was least likely to be aligned with a country's own plans, or harmonised with what other donors are doing.⁵⁵ In Nepal, despite a strong plan and significant progress towards cutting child deaths, just 20% of the aid for health is pooled into a central fund, with promised aid often arriving late or not at all.⁵⁶

The UK's track record on the effectiveness of its aid for health is significantly better than for many donors. Funding for countries' health sector budgets has increased from £5m to £133m since 2002, with the proportion of funding aligned with countries' own plans increasing from one-quarter to one-third of the total.⁵⁷ The UK is also doing more to make aid more predictable, with a ten-year funding partnership with Zambia, to 2017, and a five-year partnership with Mozambique.⁵⁸ Donors need to build on this progress, and make more use of long-term funding arrangements, and show greater willingness to fund recurrent costs, both of which are critical to closing the health worker and immunisation gaps in the world's poorest countries.

A SAVE THE CHILDREN STUDY IN EAST AND CENTRAL AFRICA FOUND THAT 30% OF POOR HOUSEHOLDS DON'T GET ANY HEALTHCARE BECAUSE OF THE COST

MAKING HEALTHCARE FREE AT THE POINT OF USE

If the cost of providing every child with access to healthcare in the poorest countries is affordable, the cost of inaction is not. Where governments and donors fail to meet the cost of basic healthcare, the burden often falls on the poorest households to pay for services at the point at which they need it. Charging people in this way is the main source of health funding in 33 countries, and accounts for over a quarter of healthcare funding in a further 75 countries.⁵⁹

Demands for payment at the point of use are most common in poorer countries. Because episodes of illness are often difficult to anticipate and can involve large one-off costs which poor households are least able to meet, user charges can have a life-and-death impact. Children are often the first and worst affected, not least because children account for a large proportion of healthcare needs. In Nepal, for example, one study found that 80% of all health spending by households was on children.⁶⁰

In some cases, a family's willingness to pay doesn't denote an ability to pay, and comes at a long-term cost: within two years of Burundi introducing fees in 2002, 80% of patients had either gone into debt or sold assets.⁶¹ A study from the Indian state of West Bengal found that in a quarter of cases of hospital admissions, the cost exceeded 40% of household spending, other than for food, in a given year. One effect of hospital admissions was that families cut back on other necessities, including food and schooling.⁶² Globally, an estimated 100 million people each year are pushed into poverty by meeting the costs of healthcare.⁶³

'CATASTROPHIC' HEALTH COSTS – WHAT THEY WOULD MEAN IN THE UK

The World Health Organization has defined any household spending more than 40% of their non-food budget on healthcare as experiencing a 'financial catastrophe', which is likely to lead to spending on education, food and rent being reduced and families being plunged into poverty. Often, girls lose out most where a family is forced to cut back on essentials. Big, unanticipated medical bills can also force families deeper into poverty, by leading to 'distress sales' of assets like land and livestock that make it difficult to recover financially. The greater the proportion of healthcare funding met through direct payments, the greater the likelihood of financial catastrophe. In health systems where over 70% of funding comes from payments at the point of use, an average 4% of households will face financial catastrophe in a given year. To put this in context, average non-food household expenditure in the UK is £20,945 a year. Catastrophic medical bills in Africa are therefore the equivalent of an average British family being hit by health charges in excess of £8,400.⁶⁴

In other cases, families forgo urgent treatment – one Save the Children study in East and Central Africa found that 30% of poor households were simply unable to receive healthcare because of the cost.⁶⁵ Charging a fixed price for a service punishes the poorest families: in Ghana, whereas haemorrhage during childbirth cost the equivalent of between 5–8% of average household annual spending, it costs more than double that as a share of the income of the poorest families.⁶⁶ Even small charges can deter people from using health services, especially where the treatment is preventive or does not address an immediate and highly visible need. For example, a programme in Kenya that moved from providing deworming tablets free of charge to charging an average of US\$0.30 saw uptake fall from 75% to 19%.⁶⁷

Conversely, when fees are lifted, there's often a dramatic increase in the number of children receiving essential healthcare. In rural Zambia, for example, the decision to use savings from debt relief to bankroll the removal of health fees in 2006 and 2007 led to a 55% increase in the use of government health facilities. Perhaps unsurprisingly, districts with the highest levels of poverty saw the largest jump. In Sierra Leone, the government's decision in 2010 to remove healthcare charges for young children and pregnant and breastfeeding women, partly made possible by the UK's political and financial backing, led to a doubling in the numbers of hospital-based births.⁶⁸ Niger, Nepal and Burundi have had similar positive experiences with removal of charges.⁶⁹

The challenge of making healthcare available for every child does not stop with the lifting of formal charges. Many of the barriers that stand between children and life-saving treatment arise from unofficial charges, indirect costs such as transport to reach health facilities, and the 'opportunity cost' of income that's foregone because of time spent getting healthcare and caring for sick family members. To be successful, any decision to make healthcare free has to reduce these unofficial and indirect costs, as well as formal charges, and also offset the income lost from payments. Encouragingly, the UN Secretary-General's strategy on maternal and child health has led to 15 countries committing to making healthcare free, laying the foundation for decisive action to close the health financing gap in many of the world's poorest countries.

RECOMMENDATIONS TO HELP CLOSE THE FUNDING GAP

- **Make healthcare free for every child** – donors should work with national governments in those countries that have committed to free healthcare, to deliver on that promise and make basic healthcare genuinely accessible regardless of income.
- **Give more and better aid for child health** – donors should provide more long-term aid that enables the poorest countries to recruit the health workers they need, increase vaccine coverage and remove charges, as part of national plans to provide every child with healthcare.

5. CONCLUSION AND RECOMMENDATIONS

The world cannot meet the goal of dramatically improving children's chances of survival unless every child is guaranteed access to healthcare, regardless of the situation in to which they have been born.

Save the Children believes that no child is born to die, and that every child should be able to fulfil their potential. But ensuring that no child is left behind is not only the right thing to do. It is also the smart choice: the biggest returns on investment by governments and donors lie in getting healthcare to the 40 million children who currently live in a healthcare desert. The life-saving interventions that can make a lasting difference to children are well-established and affordable, from malaria prevention to attended births, and from supplements of vitamins and minerals to treatment of fever with antibiotics. But without a health service, staffed by health workers who are well trained, properly equipped and supported, and deployed in the right places, these interventions can only ever be delivered in a piecemeal way. Bridging the health worker gap in the poorest countries is a critical first step to accelerating progress towards the fourth Millennium Development Goal.

Immunisation tells a similar story. Experience shows that vaccines can make a major dent in child mortality. They are already preventing 2.5 million child deaths each year, and could prevent a further 2 million a year by 2015. But the immunisation gap can only be bridged if vaccines are delivered as part of a package of essential healthcare, by health workers. At the moment, vaccines are often not reaching the children most at risk of the diseases being immunised against. The new generation of vaccines pose a further challenge of under-funding. The Global Alliance for Vaccines and Immunisations faces a widening funding shortfall in the coming years, which urgently needs to be filled through a combination of increased investment by governments and a reduction in prices.

The funding crunch for vaccines points to a wider financing gap that must be bridged if every child is to have access to essential healthcare. At the moment, governments in the poorest countries are under-investing in children's health and need to step up on their own commitments, such as the Abuja targets adopted by the African Union. But healthcare for every child cannot happen in the poorest countries without more and better support from rich countries like the UK. At the moment, donors are collectively giving about one third of what's needed, and what they do give is often channelled in ways that make it difficult for the poorest countries to make long-term spending commitments in areas such as health worker recruitment and immunisations.

AT THE
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THE POOREST
COUNTRIES

The upshot of insufficient and inconsistent funding for child health is that many of the poorest households in the poorest countries are left to foot the bill. Often the costs are punitive, forcing parents to choose between healthcare and other essentials such as food and schooling, and leading many children to forgo urgent treatment. Expecting families to pay for healthcare at the point they need it is bad for child health, and also for the fight against poverty. Healthcare for children will only be accessible if it is free at the point at which it is used. As a first step, rich country governments need to support those countries that have committed to providing free healthcare.

Bridging these three gaps, and providing every child with the health services they need, requires a renewed political commitment from governments, and much greater accountability for the pledges that have already been made. The potential prize should add urgency to this effort. Implementing this agenda would help to save the lives of 15 million children by the MDG target date of 2015, and radically transform the lives of millions more.

BY TAKING
THE RIGHT
ACTION NOW,
15 MILLION
CHILDREN'S
LIVES CAN BE
SAVED BY 2015

RECOMMENDATIONS

- Close the immunisation gap, by mobilising additional funds, bringing down prices, front loading spending and delivering vaccines through health systems.
- Close the health worker gap, by supporting countries to recruit, train and deploy an additional 3.5 million health workers, through long-term aid and changes in the international financial institutions.
- Close the financing gap, by providing more and better aid for child health and supporting governments to make healthcare free for every child.
- Close the equity gap, by setting national and donor targets to improve healthcare coverage for the poorest children, and to reduce disparities in access based on wealth.

APPENDIX: IMMUNISATION COVERAGE BY COUNTRY

(FOR THE COUNTDOWN GROUP OF COUNTRIES WITH
A HIGH BURDEN OF CHILD AND MATERNAL MORTALITY)

	Diphtheria tetanus toxoid and pertussis (DTP3) immunisation coverage among 1-year-olds (%)	Measles (MCV) immunisation coverage among 1-year-olds (%)	Hepatitis B (HepB3) immunisation coverage among 1-year-olds (%)	Hib (Hib3) immunisation coverage among 1-year-olds (%)	BCG immunisation coverage among 1-year-olds (%)	Polio (Pol3) immunisation coverage among 1-year-olds (%)
Somalia	31	24	N/A	N/A	29	28
Equatorial Guinea	33	51	N/A	N/A	73	39
Nigeria	42	41	41	N/A	53	54
Gabon	45	55	45	N/A	89	44
Central African Republic	54	62	54	54	74	47
Lao PDR	57	59	67	N/A	67	67
Guinea	57	51	58	58	81	53
Haiti	59	59	N/A	N/A	75	59
Papua New Guinea	64	58	64	64	80	70
Mauritania	64	59	64	64	81	63
Uganda	64	68	64	64	90	59
Liberia	64	64	64	64	80	74
Iraq	65	69	58	N/A	92	69
Yemen	66	58	66	67	58	65
India	66	71	21	N/A	87	67
Guinea-Bissau	68	76	68	68	89	72
South Africa	69	62	67	67	81	70
Niger	70	73	70	70	78	71
Angola	73	77	73	73	83	73
Azerbaijan	73	67	46	N/A	81	79
Zimbabwe	73	76	73	73	91	69
Mali	74	71	75	74	86	74
Kenya	75	74	75	75	75	71
Sierra Leone	75	71	75	75	95	74
Mozambique	76	77	72	74	87	75
Democratic Republic of Congo	77	76	77	77	80	74
Madagascar	78	64	78	78	73	76
Ethiopia	79	75	79	79	76	76
Cameroon	80	74	80	80	90	79
Zambia	81	85	80	81	92	83
Côte d'Ivoire	81	67	81	81	95	77
Indonesia	82	82	82	N/A	93	89
Burkina Faso	82	75	81	81	92	84
Nepal	82	79	82	N/A	87	82

	Diphtheria tetanus toxoid and pertussis (DTP3) immunisation coverage among 1-year-olds (%)	Measles (MCV) immunisation coverage among 1-year-olds (%)	Hepatitis B (HepB3) immunisation coverage among 1-year-olds (%)	Hib (Hib3) immunisation coverage among 1-year-olds (%)	BCG immunisation coverage among 1-year-olds (%)	Polio (Pol3) immunisation coverage among 1-year-olds (%)
Lesotho	83	85	83	83	96	80
Afghanistan	83	76	83	83	82	83
Sudan	84	82	76	76	82	84
Bolivia	85	86	85	85	88	84
Tanzania	85	91	85	85	93	88
Pakistan	85	80	85	85	90	85
Senegal	86	79	86	86	97	83
Philippines	87	88	85	N/A	90	86
Mexico	89	95	71	89	90	89
Djibouti	89	73	89	89	90	89
Togo	89	84	89	89	91	89
Myanmar	90	87	90	N/A	93	90
Congo	91	76	91	91	90	91
Guatemala	92	92	92	92	93	92
Burundi	92	91	92	92	98	96
Peru	93	91	93	93	99	92
Democratic People's Republic of Korea	93	98	92	N/A	98	98
Malawi	93	92	93	93	95	93
Tajikistan	93	89	93	93	82	93
Ghana	94	93	94	94	99	94
Cambodia	94	92	91	N/A	98	95
Bangladesh	94	89	95	N/A	99	94
Swaziland	95	95	95	95	99	96
Botswana	96	94	93	N/A	99	96
Turkmenistan	96	99	97	N/A	99	97
Egypt	97	95	97	N/A	98	97
China	97	94	95	N/A	97	99
Rwanda	97	92	97	97	93	97
Gambia	98	96	98	98	94	97
Brazil	99	99	98	99	99	99
Morocco	99	98	98	99	99	99
Eritrea	99	95	99	99	99	99
Chad	N/A	N/A	N/A	N/A	N/A	N/A

Source: WHO 2009

ENDNOTES

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Opposite: A newborn baby at the general hospital in Katsina, northern Nigeria.



THE WORLD CANNOT DRAMATICALLY IMPROVE CHILDREN'S CHANCES OF SURVIVAL UNLESS EVERY CHILD IS GUARANTEED ACCESS TO HEALTHCARE.

NO CHILD BORN TO DIE

CLOSING THE GAPS

Despite major progress in reducing deaths among children, 8 million children died in 2009 in poor countries. It's a scandal because these deaths are largely preventable. Children are dying not because the solutions are unknown, but because the known solutions are not reaching them.

Children's lives will not be saved by healthcare alone. But without access to the most basic health services that are taken for granted in wealthy countries, the goal the world has set itself – to reduce child mortality by two-thirds by 2015 – cannot be met. Save the Children estimates that 40 million children under the age of five in countries with high child mortality live in a 'healthcare desert'.

This report analyses three fundamental gaps in healthcare services in poor countries – the millions of who children miss out on immunisations each year; the shortage of health workers, and the severe shortfall in financing for basic healthcare. It puts forward recommendations for what needs to be done to close these gaps.

Every child is born with the right to survive – and yet thousands die needlessly every day. Save the Children's global campaign, EVERY ONE, is determined to end this injustice. We are tackling the most common causes of newborn and child deaths, such as diarrhoea, pneumonia and malaria, by ensuring proven solutions are within reach of every child. Working with others, we believe we can succeed. We are building a movement in over sixty countries to support action to save children's lives and urge leaders to live up to their promises to children. EVERY ONE of us has a part to play.

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