Major gaps in child survival by ethnic group

The Article by Cesar Victora and colleagues[1] in *The Lancet Global Health* is an important and timely descriptive study of ethnic differences in child mortality. The analysis included more than 2 million births among 415 ethnic groups in 36 low-income and middle-income countries (LMICs). To date, few studies have assessed ethnic differences in child mortality in multiple countries. However, consistent with the UN commitment to leave no-one behind, disaggregation of health outcomes by ethnicity is part of the Sustainable Development Goals (SDGs).

Although globally the chances of a child surviving to their fifth birthday are greater than ever before, a considerable burden of child mortality remains. In 2018, of the 680 million children aged younger than 5 years, an estimated 5 million died.[2,3] At the global level, major inequalities are clear and persistent. For a child born in sub-Saharan Africa, the risk of death before age 5 years is 14 times higher than that of a child in Europe. Within LMICs, inequalities by wealth, geographical location, sex of the child, and by mother's education are well described and tracked.[4] However, the study by Victora and colleagues takes us beyond inequalities between regions, and beyond differences stratified by wealth, residence, sex, and education, to assess inequalities between ethnic groups within individual LMICs.

As stated in SDG 10,[5] "Inequality threatens longterm social and economic development, harms poverty reduction and destroys people's sense of fulfilment and self-worth", and "we cannot achieve sustainable development and make the planet better for all if people are excluded from opportunities, services, and the chance for a better life." Inequalities are of major societal importance in both high-income and low-income settings. Moreover, a shift might be occurring towards a great new divergence in society as a result of issues associated with technological advances, education, and climate change,[6] in sharp contrast to the aspiration of a grand convergence for child survival.[7]

The results of Victora and colleagues' study strongly indicate that marked and major differences exist in child mortality by ethnic group in all countries with data available. In the 25 countries where statistically significant differences in under-5 mortality rate (U5MR) by ethnic group were identified, children in ethnic groups with the highest mortality were more than three times more likely to die than children in ethnic groups with the lowest mortality in the same country (median mortality ratio 3·3 [IQR 2·1–5·2; range 1·5–8·5]). In nearly all countries studied, these differences did not seem to be due to wealth, education, or place of residence. The reasons for these differences in child mortality are unclear, and beyond the scope of the study, but are likely to depend on national and local context. Similar to inequalities in high-income settings, research is urgently needed to identify the "causes of the causes"[8] to facilitate practical action at the national level and to enable the development of multisectoral policies that can make a difference.[9] Additionally, a need exists to track progress over time.

Abimbola stated that "sustainable progress in global health is homegrown."[10] Local multidisciplinary research teams will need to work closely with policy makers in LMICs, where there is a drive to understand and address these ethnic differences in child survival. Progress in some countries might inspire other countries to tackle the issue and overcome barriers in their own settings. To address this challenge, national policy makers will require data with direct relevance to programmes in the health sector and beyond. Research at the global level might also help to address the underlying issues driving such inequalities.

Although some ethnic groups had extremely high mortality (>150 deaths per 1000 livebirths), this issue is not only about minorities as defined by population size. The largest ethnic groups did not have the lowest child mortality in any of the countries studied, and in two countries the largest ethnic groups had the highest mortality (the Hausa in Nigeria and the combined ethnic groups that comprise the black population in South Africa).

Information on ethnicity is scarce. Of more than 90 LMICs with available data on child survival, the study was limited to just 36 countries where data on ethnicity or a proxy was available. Proxies for ethnicity included skin colour and language spoken at home. Indeed, the way in which ethnicity is defined in certain contexts might be shocking to some readers—eg, defining ethnicity by skin colour or through the use of terms such as backward. Moreover, ethnicity can be

a sensitive topic and ethnicity data are not collected in some countries, partly for political, historical, and colonial reasons. Ethnic differences in child survival in LMICs not included in the study by Victora and colleagues might be of particular interest.

To understand and address ethnic differences in child mortality, this study could represent the first step towards local, multidisciplinary research, leading to multisectoral action. To avoid a great new divergence and to ensure no one is left behind, immediate action is needed.

We declare no competing interests.

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