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**Article:**

https://doi.org/10.1016/S0140-6736(14)60497-9

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Global, regional, and national levels of neonatal, infant, and under-5 mortality 1990-2013: a systematic analysis

Authors
The Global Burden of Disease 2013 Child Mortality Collaboration

Abstract

Background
Remarkable financial and political efforts have been focused on reducing child mortality for the past a few decades. Timely measurements of levels and trends in under-5 mortality are important for assessing progress towards the Millennium Development Goal 4 (MDG 4) target of reducing child mortality by two-thirds from 1990 to 2015, and identifying success models.

Methods
We generated updated estimates of child mortality in early neonatal (0-6 days), late neonatal (7-28 days), post-neonatal (29-364 days), childhood (1 – 4 years) and under-5 (0 – 4 years) age groups for 188 countries from 1970 to 2013 using more than 29,000 survey, census, vital registration and sample registration data points. Gaussian process regression with adjustments for bias and non-sampling error was used to synthesize the data on under-5 mortality for each country. A separate model was used to estimate mortality for more detailed age groups. Explanatory mixed effects regression models were used to examine the relationship between under-five mortality and income per capita, maternal education, HIV child death rates, secular shifts, and other factors. Shapley decomposition was used to quantify the contribution of these different factors and birth numbers to the change in numbers of deaths in under-5 age groups from 1990 to 2013. Under-5 mortality rate scenarios were constructed from 2013 to 2030 using observed rates of change between 2000 and 2013.

Findings
We estimate that 6.3 million (5.8, 6.9) children died in 2013 under-5, a 65% reduction from 18.0 million (17.5, 18.6) in 1970. In 2013, child mortality rates range from a high of 152.1 per 1000 (130.0-177.0) in Guinea-Bissau to 2.3 (1.8-2.9) per 1000 in Singapore. From 1990 to 2013, annual rates of change ranged from -6.5% to 0.9%. 101 out of 188 countries, including 43 out of 48 countries in Sub-Saharan Africa, have seen faster decline in child mortality rate from 2000-2013 comparing to 1990-2000. In 2013, neonatal deaths account for 41.6% of under-five deaths up from 37.3% in 1990. Comparing 2013 with 1990, rising numbers of births, particularly in sub-Saharan Africa, led to 1.4 million more child deaths, rising income per capita and maternal education led to 859 thousand and 2.4 million fewer deaths, respectively. Changes in secular trend led to 4.1 million fewer deaths. Unexplained factors only accounted for -4% of the change in child deaths. In 23 developing countries, there is evidence that declines since 2000 have been faster than predicted on the basis of income, education and secular shift alone.
Interpretation

Only 29 developing countries are expected to achieve MDG 4. Declines since 2000 are accelerating in many developing countries particularly in sub-Saharan Africa. It is plausible but not definitive that the Millennium Declaration and increased development assistance for health have been a factor in faster declines in some developing countries. Without further accelerated progress many countries in West and Central Africa will still have high levels of under-five mortality in 2030.

Funding

Bill & Melinda Gates Foundation. United States Agency for International Development

Introduction

Over the past few decades there has been substantial political, donor, and country focus on reducing child mortality. The Millennium Development Goal 4 (MDG 4) target of reducing child mortality by two-thirds from 1990 to 2015 has captured high-level leaders’ attention. The UN Commission for Accountability for Women’s and Children’s Health is a further reminder of intensified interest, along with numerous initiatives from donor organizations. Global interest in child mortality reduction is not new; the child survival revolution, Jim Grant’s pioneering work at UNICEF on child interventions, and the Health for All by the Year 2000 campaign are indicative of the global focus on improving child survival that began more than three decades ago. Key actors such as the governments of the United States, Ethiopia, and India, together with UNICEF, are arguing for a continued post-2015 focus on further reductions in child mortality to eliminate all child deaths from preventable causes in our lifetime. This global goal is primarily motivated not only by the huge disparities between and within nations in child mortality rates, but also by compelling evidence that child mortality can be reduced even in low-resource settings.

Child mortality worldwide is declining and has been in many countries for many decades. The declines achieved in high-, middle-, and low-income countries surely count among the more important achievements for humanity over the last 60 years. Four types of interconnected explanations have been advanced for the sustained but heterogeneous declines in child mortality. Demographers and other social scientists have identified long-term relationships between child mortality and maternal education, income per capita, and technology change. Health system researchers have explained why some health systems are able to achieve faster rates of decline or lower levels of child mortality at similar levels of income and health expenditure. More recently, detailed analyses by the Countdown to 2015 and other groups have sought to explain levels and trends in child mortality through the coverage of a short list of proven technologies. Political scientists have called attention to the potential role of global collective action, such as the Millennium Declaration itself, as a key contributor to social phenomenon and health development. All of these explanations have merit; understanding the balance and interconnection between them may provide important insights for future global and national action to accelerate declines in child mortality.
Timely, local, and valid assessments of trends in child mortality rates along with the associated drivers of these trends can provide an important input to national, regional, and global debates on next steps. While the long-term trend in child mortality has been downward, there is important heterogeneity across countries and age-groups. Understanding this heterogeneity can help to catalyse and optimise a process of shared learning from success stories as well as identify critical areas requiring more attention.

The Global Burden of Diseases, Injuries, and Risk Factors Study 2013 (GBD 2013) provides an opportunity to examine the levels and trends of child mortality, and to explore key factors associated with progress. In this paper, we use the GBD 2013 to report on three interrelated themes: 1) estimate the levels and trends in early neonatal (0 – 6 days), late neonatal (7 – 28 days), postneonatal (29 – 364 days), childhood (1 – 4 years) and under-5 (0 – 4 years) mortality from 1990 to 2013 for 188 countries (we have added one additional country to GBD2013 as we have included both Sudan and South Sudan in this analysis) using the most up-to-date data and methods; 2) explore the contribution of broad drivers of child mortality over the past few decades and whether there have been accelerated reductions beyond what might have been expected post 2000; and 3) forecast child mortality to 2030 in order to identify populations that are likely to be the main challenges to further global progress with child survival strategies in the mid-term.

Methods

Estimating child, infant, and neonatal mortality by country 1990-2013

We use the broad data analysis strategy from the Global Burden of Diseases, Injuries and Risk Factors Study 2010 (GBD 2010) for measuring national trends in child mortality. The accompanying appendix summarises the methods that have been used in multiple previous studies, including further refinements based on critical feedback for the GBD 2010. Figure 1 shows the analytical steps in generating estimates of under-5 mortality. There are three components in this process. We begin with an analysis of the raw data on child mortality where we employ improved formal demographic methods to analyse empirical data on child deaths reported from censuses, vital registration systems, sample registration systems, disease surveillance systems and various surveys with different birth history modules. Demographic techniques applied to major sources of data collectively generate over 29,000 child mortality point estimates for countries in various years given that there might be multiple mortality estimates from different sources for a specific country in a given year. Next, we synthesise child mortality data for each country following a three-step process. First, we apply a non-linear mixed effects model to examine the relationship between child mortality, lagged distributed income per capita (LDI), maternal education, and the crude death rate from HIV/AIDS in the under-5 age group. In the second stage, spatial-temporal regression is applied to the residuals from the first stage regression where we effectively “borrow strength” over time and across countries within the same GBD region. Results from the second step are then used as priors in the third stage where we apply a Gaussian process regression (GPR) to generate best estimates of child mortality with a 95% uncertainty interval. In the final component, we apply an age and sex model to estimate age-specific and sex-specific mortality for early neonatal, late neonatal, postneonatal, and childhood age groups. The age and sex
model improves upon the GBD 2010\textsuperscript{18} by applying a mixed effects model that accounts for the differential effect of the HIV/AIDS epidemic on age-specific mortality among the neonatal age groups and post-neonatal deaths under age 5. Detailed descriptions of each of these components are provided in the appendix.

Data and estimates for under-5 mortality, as well as visualization of model fits, are shown in the appendix for 188 countries.

**Factors associated with child mortality trends**

We explore the correlates of child mortality to elucidate the contribution of different factors to recent changes in under-5 mortality rates. We estimate the following equation using mixed effects linear regression,

\[
\ln(5q0) = \beta_0 + \beta_1 \times \ln(LDI_{cy}) + \beta_2 \times \text{maternal education}_{cy} + \beta_3 \times HIV_{cy} \\
+ \sum_{s=1}^{308} \alpha_s \times \text{year_GBD super region}_s + \gamma_c + \epsilon_{cy}
\]

Equation 1

where \(c\) is country, \(y\) is year, \(\gamma_c\) is a random effect on country, \(LDI\) is lagged distributed income per capita\textsuperscript{38} for country \(c\) in year \(y\), \text{maternal education} is the average years of education earned by women in the age group 15 to 49, \(HIV_{cy}\) is HIV-related child crude death rate\textsuperscript{39,40} for country \(c\) in year \(y\) as estimated using Spectrum\textsuperscript{41,42} and \(5q0\) is the probability of death before the age of five estimated from this study. We also added combined year and GBD super region fixed effects, \text{year_GBD super region}, to capture the differential secular trends of child mortality by geographic units. Following Preston\textsuperscript{32} we use time (year) as a proxy for changes in availability and use of technologies designed to improve child health that are correlated with time – here we use the term “secular trend” to more broadly encompass the availability of specific child health technologies, as well as changes in our understanding of how to more effectively deliver health interventions, and the interaction of health programs with other technological change such as the expansion of roads or other related infrastructure.

We tested alternative model specifications including within and between estimators\textsuperscript{43} country fixed effects, and mixed effects models with different auto-regressive terms; the general magnitude of the effects for income, education, and time were robust to specification. We use the specification above because it is the simplest to explain, and there was no qualitative difference in our results across model specifications. We applied Shapley decomposition to this regression equation\textsuperscript{44,45} to quantify the contribution of changes in income per capita, maternal education, HIV, secular trend, births, and a collective of “other” factors to the change in under-5 mortality from 1990 to 2013. Shapley decomposition is a method with a game theoretical foundation that allows for decomposition of changes in a variable due to different contributory factors. Specifically, to examine the impact of these six factors on changes in under-5 deaths from 1990 to 2013, 64 scenarios were constructed where all six factors take on values from either 1990 or 2013 in each specific scenario. To compute the impact of any
one factor, we examine 32 pairs of scenarios where all five remaining factors are kept constant. For each pair, we then calculate the change in under-5 deaths, where only the factor of interest changes value, and use this as a measure of the contribution of this specific factor to the change in under-5 deaths. The average of the changes in all 32 pairs of scenarios is the contribution of one factor when all other factors remain constant. The same process is repeated for all six factors. We used Equation 1 to predict annual rates of change for each country from 2000 to 2013 using observed changes in income per capita and maternal education and counterfactual levels of HIV in the absence of intervention. Counterfactual HIV death rates were generated using the UNAIDS Spectrum models by setting prevention of mother-to-child transmission (PMTCT), co-trimoxazole prophylaxis, and antiretroviral therapy (ART) to zero for all years. These predicted rates provide an estimate of the impact of changes in income per capita, education, and the long-term secular trend by GBD super-region based on a comparison with observed rates of change.

**Scenarios for under-5 mortality in 2030**

We develop four scenarios to forecast the under-5 mortality rate in 2030 based on the distribution of observed annualised rates of change from 2000 to 2013. Scenario 1 uses the observed rate of change from 2000 to 2013 for each country to project to 2030. Child mortality rates in any country with an observed increase in mortality over this period are assumed to stay at a constant level over the projection period. In scenario 2, all countries experience the best 75\textsuperscript{th} percentile rate of change measured across all countries from 2000 to 2013. In scenario 3, all countries experience a rate of change corresponding to the best 90\textsuperscript{th} percentile, and in scenario 4, to the best 95\textsuperscript{th} percentile rate of change. We use observed rates of change for all-cause mortality by detailed age groups: early neonatal, late neonatal, post-neonatal, and child deaths at ages 1-4, to also generate scenarios for the age composition of under-5 deaths. Forecasts of the number of deaths are based on these predicted rates and UN Population Division fertility forecasts. Forecasted age-specific and sex-specific mortality were then rescaled to match the forecasted all-cause under-5 mortality rate in 2030.

Analyses were done using Stata 13.1, R versions 2.15.2, 3.0.1, and 3.0.2, and Python 2.7.3.

**Results**

Figures 2a and 2b show the trend in the global under-5 mortality rate and the annualised rate of change from 1970 to 2013. Worldwide, under-5 mortality has declined by slightly more than two-thirds (-69.5%), from 146 per 1000 in 1970 to 85 per 1000 in 1990 and to 45 per 1000 in 2013. The global number of under-5 deaths declined from 18.0 million in 1970 to 12.2 million in 1990 and to 6.3 million in 2013. Child mortality fell at an annual rate of between -2.5 and -3.0% from 1970 until 1985 but slowed beginning in 1985, and was at its lowest (-1.2%) in 1994. Progress in reducing child mortality has steadily accelerated since 1997. Indeed, since 2003, the global child mortality rate has declined at a faster rate than in the 1970s and 1980s. Tables 1a and 1b show early neonatal, late neonatal, post-neonatal, childhood (1-4 years), and under-5 mortality rates and number of deaths for 1970, 1980, 1990, 2000, 2010, and 2013. In 2013, 31.9% of under-5 deaths worldwide occurred in the early neonatal period, 9.7% in the late neonatal period, 29.1% in the post-neonatal period and 29.1% between the ages of 1 – 4
years. The age composition of global child deaths has progressively changed over the last 43 years; the proportion of child deaths in the neonatal (early and late) period increased from 33·1% in 1970 to 37·3% in 1990 and to 41·6% in 2013. Annual rates of change over the period 1970 to 2013 have been very similar (close to -3%) for late neonatal, postneonatal, and ages 1 – 4 years, but slower, -1·9%, for the early neonatal period. In the period 2000 to 2013, the annual rate of change for the early neonatal period was 1·2 to 1·4 percentage points slower than for other under-5 age-groups, albeit faster than the early neonatal rate of decline in previous decades. Trends for super-regions and annualized rates of change are shown in Web figure 2 in the appendix.

Table 2 provides estimates and uncertainty intervals for early neonatal, late neonatal, postneonatal, childhood, and under-5 mortality rate by country for 2013, as well as under-5 deaths and the annualised rates of change in under-5 mortality rate from 1990 to 2000, 2000 to 2013, and 1990 to 2013 for 188 countries and 21 GBD regions. Under-5 mortality rates range 66·9-fold from 152.1 per thousand in Guinea-Bissau to 2·3 per thousand in Singapore in 2013. The 10 countries with the highest under-5 mortality rate in 2013 are all in sub-Saharan Africa. 56 countries have achieved under-5 mortality rates below 10 per 1000 in 2013; 10 of them are developing countries. 25 countries in 2013 account for 80% of child deaths in the world (Afghanistan, Angola, Bangladesh, Brazil, Burkina Faso, Cameroon, Chad, China, Cote d’Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, India, Indonesia, Kenya, Malawi, Mali, Mozambique, Niger, Nigeria, Pakistan, Philippines, Sudan, Tanzania, and Uganda). Neonatal mortality rates range from 42·4 per thousand in Mali to 1·2 in Singapore in 2013. Based on the observed rates of change from 1990 to 2013, 29 out of 138 developing countries are likely to achieve the MDG 4 target of a two-thirds reduction in child mortality from 1990 levels by 2015 (Armenia, Bahrain, Bangladesh, Benin, Bhutan, Brazil, Burma, China, Egypt, El Salvador, Ethiopia, Federated States of Micronesia, Grenada, Iran, Lebanon, Liberia, Libya, Maldives, Nepal, Nicaragua, Oman, Peru, Saudi Arabia, Sri Lanka, Thailand, Timor-Leste, Tunisia, Turkey, and United Arab Emirates).

Figure 3 compares annualised rates of change over the period from 2000 to 2013 with the period 1990 to 2000. Countries plotted under the equivalence line experienced faster rate of change from 2000 to 2013 comparing to 1990 to 2000. The MDG 4 target rate of -4·4% per year is shown for reference. 101 of 188 countries had faster rates of decline between 2000 and 2013 than for the period 1990 to 2000. Of note, 90% (43 out of 48) of countries in sub-Saharan Africa had an acceleration in the rate of decline. 21 of 29 countries in Central Europe, Eastern Europe, and Central Asia have also had accelerated declines. Conversely, 22 of 29 countries in Latin America and the Caribbean had slower rates of decline post 2000 than before. In addition, slower rates of change were observed, on average, in nine regions. Large differences in the rate of change of child mortality are apparent in several small island nations, most likely due to larger random fluctuations over time. For convenience, Figure 3 excludes North Korea and The Bahamas due to substantially higher rates of change in these two countries that distort the scales in the figure. The speed of decline in child mortality has been fastest in southern sub-Saharan Africa where child mortality increased in the 1990s likely due to the HIV epidemic, and then subsequently declined with the scale-up of PMTCT and ART. 48–53 Bangladesh has maintained a consistently higher rate of change of around -4·7 to -5·5% since 1970, slightly higher than in neighbouring India (-3·0 to -4·2%), although the pace of child mortality change in India has picked up over the last 13 years, reaching -4·5%
in 2013. Timor-Leste had one of the fastest rates of change (-7.6% per year) since 2000. Nine countries account for two thirds of the global decrease of 3.0 million child deaths in 2013 compared with 2000 (in order of magnitude): India, China, Ethiopia, Bangladesh, Indonesia, Pakistan, Brazil, Afghanistan, and South Africa.

Summary results for four regression model specifications examining the broad determinants of change in under-5 mortality rates are shown in Table 3. These models account for a very large share of the observed variation in under-5 mortality rates – R-squared values range from 0.84 to 0.98. For the mixed effects regression model, the impact of a 10% increase in income per capita corresponds to a 1.4% decrease in under-5 mortality. A one year increase in maternal education corresponds to an 8.6% percent decrease in under-5 deaths. Our findings thus confirm and quantify the findings of other researchers that improving levels of maternal education in low- and middle-income countries will have a far greater and impact on reducing child mortality compared with any other intervention. The year fixed effects for each super-region that capture the secular trend unobserved by income, maternal education, or HIV were essentially linear for all regions, even though the slope and level of these regional time trends were quite heterogeneous across regions. The average annual change explained by the secular trend was -2.3% overall, ranging from -1.4% to -3.3% across regions.

We have also estimated the contribution of changes in income, education, birth numbers, time as a proxy for technological progress, HIV, and other (unobserved) factors to changes in the number of child deaths in each country, comparing 1990 with 2013. At the global level, higher numbers of births in countries with higher under-5 mortality rates contributed to 1.4 million (1.39, 1.42) more child deaths in 2013 compared to 1990. Similarly, the HIV/AIDS epidemic has resulted in a 39.3 thousand (36.1, 42.6) increase in under-5 deaths from 1990 to 2013. Rising levels of income, on the other hand, particularly after 2000, led to more than three-quarters of a million fewer deaths in 2013 while higher maternal education led to 2.4 (2.2, 2.6) million fewer deaths. The secular trend, which we posit to likely represent technological changes and their diffusion, accounted for 4.1 (3.4, 4.8) million fewer deaths in 2013 than in 1990. Changes in other factors not accounted for in this simple model led to an increase of 246.9 (-388.5, 870.2) thousand deaths in 2013 compared with 1990. Figure 4 provides the results of the Shapley decomposition of changes in under-5 mortality for the seven GBD super-regions. The largest decrease in the number of under-5 deaths occurred in south Asia where the secular shift contributed the most, followed by maternal education, and then income. Other factors actually led to an increase in the number of child deaths; in other words, overall, south Asia has had less progress than expected in reducing child deaths because of unobserved other factors. Child deaths in south-east Asia, east Asia, and Oceania have also declined, with most factors except HIV making important contributions to observed changes. In sub-Saharan Africa, increasing birth numbers in the absence of other change would have led to an increase in under-5 deaths. The main contributors to lower child mortality were secular factors and maternal education. More detail on the Shapley decomposition of changes in the number of under-5 deaths for the 21 GBD regions is provided in Table 4.

To quantify the potential contribution of global and national action following the Millennium Declaration on trends in under-5 mortality, Figure 5 shows which countries had a significantly faster rate of decline than expected. Expected trends are based on observed income per capita, maternal
education, secular trends, and HIV child deaths in the absence of intervention (what would happen were not for the global effort in scaling up ART and PMTCT). Twelve countries in sub-Saharan Africa (Botswana, Burkina Faso, Burundi, Ethiopia, Liberia, Mozambique, Niger, Rwanda, Senegal, Sao Tome and Principe, South Africa, and Zambia) had faster than expected declines. In Asia, child mortality in China, Cambodia, Maldives, Timor-Leste, and Turkey has declined faster than predicted, as it has in six countries in Latin America (Bolivia, Brazil, El Salvador, Guatemala, Nicaragua, and Peru). Countries with slower than expected declines include five in Africa and four in Central Asia, as well as Pakistan and Malaysia.

**World in 2030**

Figure 6 shows possible global trends in under-5 mortality through to 2030 based on the four scenarios for change in child mortality defined earlier. Even under the most ambitious scenario for reducing child mortality, the global number of child deaths in 2030 would still be around 2·4 million, about 4 million less than the current number, but still substantial. Continuing current rates of change would lead to an expected 3·8 million deaths in 2030. These scenarios assume the UN Population Division forecasts of fertility; faster rates of fertility decline than projected by the UN, which might be achieved through scale-up of family planning services, are not factored into these scenarios, but would lead to fewer deaths. Figure 7 shows the expected level of child mortality in various countries in 2030 if rates of change continue as currently observed. Several countries, under this scenario of “business as usual”, would still be expected to have comparatively high levels of under-5 mortality in 2030. Under-5 mortality rates in excess of 100 per 1000 live births would still prevail in the Central African Republic, Guinea-Bissau, and Chad; those with expected rates above 70 per 1000 include Nigeria, Democratic Republic of the Congo, and Mali. Our projections suggest that the global age composition of under-5 deaths would continue to shift towards a younger structure. In 2013, neonatal deaths account for 41·6% of under-5 deaths globally. Under this scenario of no acceleration in observed rates of decline, this would increase only marginally to 44·7% in 2030, by which time postneonatal deaths and those at ages 1-4 years would account, respectively, for 28·0% and 27·3% of under-5 deaths worldwide.

**Discussion**

The dominant global health focus on improving child survival over the past four decades or so has been extremely successful, although more remains to be done. Child mortality levels declined, on average, by 2·7% per year from 1970 to 1985, then slowed down for a decade until 1997, began to accelerate, and since 2005, have declined by an average of 3·5% per year. Accelerated declines have occurred in India, nearly all countries in sub-Saharan Africa, and eastern Europe. Conversely, the rate of decline in child mortality has decelerated in many Latin America countries as shown in Web figure 2. As a result, 48 (29 out of which are developing) countries are expected to achieve the MDG 4 target rate of 4·4% per year by 2015. The annual number of under-5 deaths has declined by about two-thirds since 1970, falling below 7 million for the first time in 2010 and, based on patterns of change since 2000, should reach 5 million in 2021 and 4 million in 2029. If current trends persist, more than 120 countries would be expected to have child mortality levels below 20 per 1000 in 2030. By our projection, 18 countries will have under-5 mortality rate that is higher than 50 per 1000 in 2030, and among them, 8 countries
(Central African Republic, Chad, Democratic Republic of the Congo, Guinea-Bissau, Lesotho, Mali, Nigeria, and Somalia) would, however, still have under-5 mortality rates in excess of 70 per 1000. Walker et al.\textsuperscript{54} have projected under-5 mortality rate to 2035 based on the observed rate of change in the coverage of interventions. Their analysis suggests that 37 countries will likely still have child mortality rates over 50 per 1,000 live births in year 2035 if country level trends in coverage continue unchanged.

Our analysis confirms the findings of previous studies that the majority of countries will not achieve the MDG 4 target. In our view, that ought not to be the standard by which country progress is measured. Indeed, our analysis of observed and expected rates of change since the Millennium Declaration suggests that accelerated declines in child mortality observed since then cannot be explained by income, education, or the secular trend (including technological interventions) alone. In fact, in 23 developing countries, under-5 mortality rates have declined significantly faster than expected, including in a number of southern African countries that experienced increases in the 1990s related to the HIV epidemic and which have subsequently benefited from the scale-up of ART and PMTCT. It is entirely possible that the commendable progress in this group of countries, over and above what might have been expected, is largely attributable to global action following the MDGs that led to increased funding for HIV control programs. In Niger, this has been carefully documented.\textsuperscript{31} The case could also be made that accelerated declines in Cambodia, Timor-Leste, Guatemala, and El Salvador post the MDGs are linked both to government policy change and increased development assistance for health.\textsuperscript{55} Changes in Turkey and China, both of which have received relatively little development assistance per capita, are more likely related to national policy change and health system strengthening.\textsuperscript{56–59} Rudan and colleagues\textsuperscript{58} have documented the rapid decline in child mortality in China and analyses by Feng et al.\textsuperscript{59} have demonstrated the important role that socioeconomic and health system determinants have played in reducing child mortality in China.

The reasons underlying these faster than expected declines in child mortality are undoubtedly multifactorial and complex, and deserve further study, but prominent among them is surely the adoption of national policies that promote development and greater access to essential child care services among the worst off as well as increased investments in health and related sectors. It is also possible that the MDG declaration and subsequent political momentum influenced the health investment landscape, stimulating a more effective and comprehensive response by bilateral donors, GAVI, PEPFAR, GFATM, the World Bank, and other development partners to ensure the more widespread dissemination of new technologies and the remarkable progress against HIV. Indeed, the attention that has been paid to achieving the MDGs more broadly, and not merely those directly concerned with health, has undoubtedly aided progress in reducing child mortality by improving broader development indicators such as education, income and the environment, all of which are likely to lead to improved child survival. In contrast, 17 countries had rates of change in under-5 mortality significantly slower than expected. A more detailed case study analysis of these countries compared to those with faster than expected declines could provide further insights into bottlenecks and circumstances that hinder progress.
Our analysis of long-term trends in child mortality provides some insight into the comparative contribution of different factors. Globally, income growth over the period 1990 to 2013 accounted for only about 14.9% (13.5, 16.3) of the change in the number of child deaths. Although correlated (correlation coefficient of 0.72) with income, maternal education had a much larger impact on declines in child mortality (42.3% (39.2, 45.1)), a finding that is consistent with previous research, but now provides a quantitative assessment of just how important mothers education is in reducing child mortality. These findings reinforce the continued importance of investments in primary and secondary schooling for girls in particular. Continued high total fertility rates, especially in sub-Saharan Africa, have led to increased numbers of births, which, all other things being equal, has led to nearly one million more child deaths in 2013 compared to 2000. The renewed focus on contraceptive programs for low-income countries is thus very timely and a critical component of national strategies to assist countries in reducing the number of child deaths.

Preston and others have noted in a series of analyses spanning four decades that the relationship between life expectancy, income, and education has been shifting upwards over time; that is, the same level of income and education today is associated with much lower levels of age-specific mortality and higher life expectancy than before. They attribute this shift correlated with time to the advancement of technology and the diffusion of such advancement; technology is defined in this case very broadly to encompass both new tools but also new ways in which societies are organised to deliver programs and interventions. We find the same major shift in the relationship in our analysis of child mortality. The way that the secular trend is estimated would also capture systematic improvements in the average efficiency of societies’ ability to convert improvements in income and education into child mortality reductions, such as improved efficiency of production. Overall, the secular trend accounts for the largest share (72.1% (60.4%-82.5%)) of the change in child deaths from 1990 with 2013. New drugs, vaccines, diagnostics, procedures, and public health campaigns are part of this shift. In the last 23 years, this would include innovations such as insecticide treated bednets (ITNs), technologies to prevent mother-to-child transmission of HIV (PMTCT), antiretroviral therapy (ART), rotavirus vaccine, pneumococcal and other vaccines, and many other life-saving technologies. The dominant role of new technologies and more efficient ways of diffusing them in poor countries emphasises the importance of continued innovation in drugs, vaccines, public health programs, and the delivery of healthcare for continued declines in under-5 mortality. Indeed, our assessment of the comparative role of health technologies in bringing about the massive declines in child mortality over the past few decades provides indirect evidence for donors, researchers, and countries alike of the critical impact that these investments have had.

The variation in child mortality around the income and education curve at a given moment in time has been interpreted as variation in country performance in producing better child health, a component of which may be related to health systems. In our study, we control for time invariant differences between countries that may be related to the environment or other fixed attributes. We find that unobserved factors beyond income, maternal education, time, HIV, birth and time-invariant country factors account for only about 4.3% (-6.7, 15.2) of the global change in under-5 deaths between 1990 and 2013. Although other factors quantitatively have a much greater role in reductions in child
deaths since 1990, understanding the local policy factors correlated with this unobserved change could provide important insights and opportunities for shared learning. Nevertheless, the fact that our model can explain 97.2% of the observed variation in under-5 mortality rates provides strong evidence to support the continued investment in the primary determinants of lower child mortality, namely maternal education, income growth and the development and application of new technologies.

While substantial progress has been made in reducing child mortality worldwide, our scenario analysis of projected under-5 mortality in 2030 provides a sobering reminder about the magnitude of the task ahead. Even if current, relatively rapid declines in mortality in low-income countries of sub-Saharan Africa persist, along with declines observed elsewhere, over 3.8 million children will still die before their fifth birthday in 2030 unless the speed of decline can be accelerated. Progress is being hindered in part by fertility patterns where the fraction of births worldwide is likely to increasingly shift towards sub-Saharan Africa where mortality rates are highest. This shift in the distribution of births means that global progress in reducing child mortality, even if every country maintains the same rate of decline, will slow. The countries that will have the highest rates of child mortality in 2030 based on current trends are concentrated in West and Central Africa. Ambitious goals to reduce under-5 mortality to 20 per 1000 as proposed by the US, Ethiopia, and India, will need to strategically focus on countries in these regions.

Anticipating the pace of these declines implies that donors may want to prioritize funding for some countries based on their likely future under-5 mortality rate. Conversely, the pace of child mortality decline in some countries such as India for example, is accelerating, such that by 2030, according to our base scenario, India will have an under-5 mortality rate below 25 per 1000.

Over the past 6 years, multiple studies have been released on country levels and trends in child mortality. At the global level, the UN and our (the GBD collaboration) estimates of the number of child deaths have largely converged. Appendix table 3 shows estimates from UNICEF and independent academic studies, including the GBD 2010 and this analysis. In their latest iteration, the UN Inter-agency Group for Child Mortality Estimation (IGME) has modified their methods, resulting in higher mortality estimates for 1990. In some cases, this has substantially changed their estimates of annualised rates of decline. In some cases they now estimate that high-income countries such as Spain are under-reporting child deaths, despite the lack of direct evidence of under-reporting. Overall, the correlation between their estimates of the annualised rate of change from 1990 to 2007, published in 2012 and 2013, is 0.93. Likewise, the GBD effort has modified some methods such that the correlation of the annualised rate of change for the same period is 0.87 between GBD iterations. However, the uncertainty intervals on annualized rates of change between 2000 and 2010 generated as part of the GBD collaboration appear to be relatively robust, not over-lapping in only 8 cases out of 188. Continued improvements in methods and data availability, particularly for recent years, make the assessment of trends comparatively unstable. The correlation between UNICEF annual rates of change from 1990 to 2007 published in 2009 and in 2013 is 0.81. The correlation between this study and Rajaratnam et al. is 0.84. Improvements in methods and data are to be encouraged, but these perhaps surprisingly modest correlations mean that the public health community must be cautious in over-interpreting trends.

This analysis has many limitations. First, in this study we attempt to explicitly model the non-sampling error that affects different surveys in each country. This approach avoids estimating false trends due to
compositional bias in the data available for a given year but depends on the validity of the estimates of
non-sampling error. Unfortunately, there is no way to externally validate this process except in countries
with complete vital registration systems—but most of these countries do not collect summary or
complete birth history data. Second, the trend for the most recent years is a short-term forecast for
many countries. Our estimates may be too high or too low in these cases and the GPR process
appropriately generates widening uncertainty intervals for them. However, time lags between data
collection and inclusion in our synthesis are shortening for many countries. For example, we include
results from the Sample Registration System in India and also data for China through to 2012. Third, in
our analysis of the factors contributing to under-5 mortality change in each region we include country
random effects and fixed effects on year interacted with region. We may be underestimating the
contribution of local policy and health system organization if these changes are correlated overtime
within a region. Fourth, while we have systematically searched and identified sources of data on under-
5 mortality, there are likely data sources that have not been identified. The large set of collaborators
from 82 countries involved in this analysis has helped identify new sources and evaluate the quality of
existing data, but there is more scope to expand the information base in the future. Fifth, we employed
the Shapley decomposition method to parse out the contribution of different factors to changes in
under-5 deaths. This method, although computationally intensive, is intuitive. Although other methods
have been proposed to decompose impacts of different factors on indicators of interest, Shapley value
decomposition, to our knowledge, is most suitable in our application.\textsuperscript{86,87}

The vigorous debate on setting development goals for the post-2015 era is predicated on the belief that
global goal setting and quantitative monitoring can catalyse change. This may well be the case. The
acceleration of declines in under-5 mortality beyond that expected on the basis of income, education
and the secular trend, particularly in a number of sub-Saharan African countries, coincides with the
MDG era and increased investments in these countries in health and social development programs by a
range of donors. As the end of the MDG era rapidly approaches, the global public health community
might better serve the needs of countries by focusing on the accelerated declines post-2000 that we
have reported here, rather than on which countries will achieve the arbitrary but seemingly useful
targets set by the MDGs. Galvanising political commitment to ensuring life-saving technologies are
implemented will be critical. The essential health intelligence that comes from large global monitoring
efforts such as the GBD study will better focus attention on countries where progress has been
disappointing. The consequences of not doing so—more than 3 million avoidable child deaths in 2030—
would be a scathing indictment of the failure of the donor, research, and international development
community to collectively build on the impressive reductions in child mortality that we have come to
expect.

\textbf{Research in Context Panel: changes in methodology on mortality estimation
for children under age 5}

Continuous efforts have been made in improving child mortality estimation since the publication of GBD
2010.\textsuperscript{18} In this study, significant improvements have been made on several fronts. First, we employ a
mixed effects model to adjust non-sampling data biases using source-type specific fixed effects across all
countries and source-specific random effects within country. One specific data source is selected in each
country as the reference source, and the difference in the summed fixed and random effects between
other sources and the reference is subtracted from each non-reference source to adjust for data bias. In
the case that multiple sources are selected as the reference, we take the average value of the selected
sources. Over 200 all-cause mortality experts from around world have contributed to the selection of
the reference data sources. Second, we use a nonlinear mixed effects model to more accurately capture
the functional form between child mortality rate and other factors including HIV/AIDS. This has
significant implications for the estimation of child mortality in the most recent time period where data
are sparse and covariates have more pronounced impact on final estimates. Third, we have improved
our mortality estimation strategy for neonatal deaths. The new strategy we employ accounts for the fact
that few children die from HIV in the neonatal age group, and helps improve our estimated age
distribution of deaths in ages under five.

Tables and figures
Figure 1. Child mortality estimation process for the Global Burden of Diseases, Injuries, and Risk Factors
2013 Study

VR = Vital registration. Cov = covariates.

Figure 2a. Global under-5 mortality rate, 1970 - 2013

Figure 2b. Annualised rate of change in global child mortality rate, 1970 – 2013

Table 1a. Global mortality rate (deaths per 1000 livebirths) for early neonatal, late neonatal,

Table 1.b. Global number of deaths (thousands) for early neonatal, late neonatal, postneonatal, child

Table 2. Early neonatal, late neonatal, postneonatal, childhood and under-5 mortality in 2013 for 188
countries and 21 Global Burden of Disease regions.

Global Burden of Disease regions are sorted alphabetically; countries within a region are sorted
from most negative to most positive rate of change 2000-2013

Figure 3. Global annualised rate of change in under-5 mortality rate (%) from 1990-2000 and 2000-2013.
Solid line shows the equivalence line between the two periods. Dashed lines show the MDG 4 target
rate of 4-4% per year. Figure excludes The Bahamas and North Korea to make the axes more readable.

Solid line shows the equivalence line between the two periods. Dashed lines show the MDG 4
target rate of 4-4% per year. Figure excludes The Bahamas and North Korea to make the axes

Table 3. Regression models for the log of the under-5 mortality rate for different model specifications for 188 countries 1970-2013.

*Within-between estimator with AR(1) autocorrelation specification

** Within-between estimator without AR(1) autocorrelation specification

†Significant at 0·001 level

# Combined GBD super-region and year fixed effects, as well as country level random effects, when included, not shown here

Table 4. Shapley decomposition analysis of the change in the number of deaths comparing 2013 to 1990 related to changes in income per capita, maternal education, HIV child death rate, births, secular shift measured by time, and unobserved factors for the world and 21 GBD regions.

Figure 4. Change in the number of deaths comparing 2013 to 1990 due to income per capita, maternal education, HIV child death rate, shift in secular trend, births and unobserved factors for seven GBD super-regions.

Figure 5. Countries with statistically significant differences between the observed rate of change in under-5 mortality 2000 to 2013 compared with the expected rate of change based on income, education, shift in secular trend and HIV death rates in the absence of intervention.


Figure 6. Projected global under-5 deaths for four scenarios, 2013-2030. Scenarios have been defined by the distribution of observed rates of change 2000 to 2013.

Figure 7. Projected under-5 mortality rate in 2030 based on the observed rate of change for each country 2000 to 2013.
Appendix
Overview of methodology and updates since the GBD 2010 to all-cause mortality estimation

Web table 1. Source types used in child mortality bias correction.


Web table 3. Global under-5 mortality rates from several studies.


Web table 5. Shapely decomposition analysis of the change in the number of deaths comparing 2013 to 1990 related to changes in income per capita, maternal education, HIV child death rate, births, secular trend, and unexplained factors for 188 GBD countries.

Web table 6. Number of years with data in each decade by country.

Web figure 1. Under-5 mortality rate for 188 countries.

Web figure 2. Regional rate of change in under-5 mortality rate, 1970-2013.

References

2 UN. Secretary-General. Integrated and coordinated implementation of and follow-up to the outcomes of the major United Nations conferences and summits in the economic, social and related fields: report of the Secretary-General. New York, USA, United Nations, 2004.


4 GAVI Alliance. Investing in immunisation through the GAVI Alliance. , 2010.


Vital registration, sample registration

Complete birth histories

Summary birth histories

Assessment of completeness

Nonlinear mixed effects model

Bias correction (excluding incomplete VR)

VR completeness correction

Spatio-temporal regression and Gaussian Process Regression

Conflict and disaster shocks (child)

Deaths and mortality rates by sex and age

Age/sex model

Covariates

Summary birth history method

Complete birth histories

Vital registration, sample registration

Figure 1. Child mortality estimation process for the Global Burden of Diseases, Injuries, and Risk Factors 2013 Study
Figure 2a. Global under-5 mortality rate, 1970–2013.

Figure 2b. Annualised rate of change in global under-5 mortality rate, 1970–2013.
Figure 3. Global annualised rate of change in under-5 mortality rate (%) from 1990–2000 and 2000–2013. Solid line shows the equivalence line between the two periods. Dashed lines show the MDG4 target rate of 4.4% per year. Figure excludes The Bahamas and North Korea to make the axes more readable.
Figure 4. Change in the number of deaths comparing 2013 to 1990 due to income per capita, maternal education, HIV child death rate, shift in secular trend births and unexplained factors for seven GBD super-regions.
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Figure 6. Projected global under−5 deaths for four scenarios, 2013−2030.
Scenarios have been defined by the distribution of observed rates of change 2000 to 2013.

Year | Projected global under−5 deaths [in millions]
--- | ---
0 | 6.2
1 | 5.8
2 | 5.4
3 | 5.0
4 | 4.6
5 | 4.2
6 | 3.8
7 | 3.4
8 | 3.0
9 | 2.6
10 | 2.2
11 | 1.8
12 | 1.4
13 | 1.0
14 | 0.6
15 | 0.2

Scenario 1: Observed country−level rates
Scenario 2: Best 75th percentile
Scenario 3: Best 90th percentile
Scenario 4: Best 95th percentile
Figure 7. Projected under–5 mortality rate in 2030 based on the observed rate of change for each country 2000 to 2013
### Table 1a. Global mortality rate (deaths per 1000 livebirths) for early neonatal, late neonatal, postneonatal, child and under-5 age groups for 1970, 1980, 1990, 2000, and 2013.

<table>
<thead>
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<th></th>
<th></th>
<th></th>
<th></th>
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<td>Under 5 (0-4 years)</td>
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<td>111.7</td>
<td>84.7</td>
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### Table 1b. Global number of deaths (thousands) for early neonatal, late neonatal, postneonatal, child and under-5 age groups for 1970, 1980, 1990, 2000, and 2013.

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Table 1b. Global number of deaths (thousands) for early neonatal, late neonatal, postneonatal, child and under-5 age groups for 1970, 1980, 1990, 2000, and 2013.
<table>
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<th>Post-Neonatal (29-364 days)</th>
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Table 2. Early neonatal, late neonatal, postneonatal, childhood and under-5 mortality rate and under-5 deaths in 2013, and annualised rates of change in mortality rates for 1990-2000, 2000-2013, and 1990-2013 for 188 countries and 21 Global Burden of Disease regions.
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Syria
Tunisia
Turkey
United Arab Emirates
Yemen
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High-income
Canada
USA
Oceania
Federated States of
Micronesia
Fiji
Kiribati
Marshall Islands
Papua New Guinea
Samoa
Solomon Islands
Tonga
Vanuatu
sub-Saharan Africa,
Central
Angola
Central African Republic
Congo
Democratic Republic of th
Equatorial Guinea
Gabon
sub-Saharan Africa,
Eastern
Burundi
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Djibouti
Eritrea
Ethiopia
Kenya
Madagascar

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<th>Std. Error</th>
<th>95% Conf. Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lagged distributed income</td>
<td>Mixed effects regression</td>
<td>-0.15†</td>
<td>0.008</td>
<td>(-0.17, -0.14)</td>
</tr>
<tr>
<td>(logarithmic scale)</td>
<td>Within-between regression*</td>
<td>-0.14†</td>
<td>0.014</td>
<td>(-0.17, -0.11)</td>
</tr>
<tr>
<td></td>
<td>Generalized linear model</td>
<td>-0.14†</td>
<td>0.007</td>
<td>(-0.16, -0.13)</td>
</tr>
<tr>
<td></td>
<td>Within-between regression**</td>
<td>-0.14†</td>
<td>0.008</td>
<td>(-0.16, -0.13)</td>
</tr>
<tr>
<td>Maternal education</td>
<td>Mixed effects regression</td>
<td>-0.09†</td>
<td>0.004</td>
<td>(-0.10, -0.08)</td>
</tr>
<tr>
<td></td>
<td>Within-between regression*</td>
<td>-0.09†</td>
<td>0.009</td>
<td>(-0.11, -0.08)</td>
</tr>
<tr>
<td></td>
<td>Generalized linear model</td>
<td>-0.09†</td>
<td>0.004</td>
<td>(-0.10, -0.08)</td>
</tr>
<tr>
<td></td>
<td>Within-between regression**</td>
<td>-0.09†</td>
<td>0.004</td>
<td>(-0.10, -0.08)</td>
</tr>
<tr>
<td>Crude death rate from HIV</td>
<td>Mixed effects regression</td>
<td>99.46†</td>
<td>4.253</td>
<td>(91.12, 107.80)</td>
</tr>
<tr>
<td>HIV</td>
<td>Within-between regression*</td>
<td>68.17†</td>
<td>4.978</td>
<td>(58.41, 77.92)</td>
</tr>
<tr>
<td></td>
<td>Generalized linear model</td>
<td>98.20†</td>
<td>4.214</td>
<td>(89.94, 106.45)</td>
</tr>
<tr>
<td></td>
<td>Within-between regression**</td>
<td>98.20†</td>
<td>4.263</td>
<td>(89.84, 106.55)</td>
</tr>
</tbody>
</table>

*Within-between estimator with AR(1) autocorrelation specification
**Within-between estimator without AR(1) autocorrelation specification
†Significant at 0.001 level
# Combined GBD Super-region and year fixed effects, as well as country level random effects, when included, not shown here
Table 4. Shapley decomposition analysis of the change in the number of deaths comparing 2013 to 1990 related to changes in income per capita, maternal education, HIV child death rate, births, secular trend, and unexplained factors for the world and 21 GBD regions

| Region                          | Fertility | Maternal Education | HIV/AIDS | Income | Unexplained | Secular Trend | Total      |
|--------------------------------|-----------|--------------------|----------|--------|-------------|---------------|-------------|------------|
|                                | 1401.9    | -2430              | 39.3     | -858.5 | 246.9       | -415.1        | -5745.4     |
| Global                         |           |                    |          |        |             |               | (1390.6-1415.3) | (2616.4-2339.1) | (36.1-142.6) | (-945.1-1772.8) | (388.5-870.2) | (-475.2-3449.4) | (-5800.4-5709.4) |
| Asia Pacific, High-income      | -2.6      | 2                  | 0        | -1     | 0           | -5.8          | -11.3       |
|                                | (-2.6-2.6) | (-2.1-1.8)        | (0.0)    | (-1.1-9) | (-6.8)       | (-6.6-5.1)    | (-11.4-11.3) |
| Asia, Central                  | -6.6      | -22.3              | 0        | -2.8   | 32.4         | -68.9         | -68.2       |
|                                | (-6.8-6.4) | (-24.1-20.7)      | (0.0)    | (-3.1-2.5) | (24.1-41.4)  | (-78.1-61)    | (69.67-61)  |
| Asia, East                     | -265.7    | -231.8             | 4        | -216.4 | -205         | -310.7        | -1229.3     |
|                                | (-267.5-264.8) | (-249.6-215)      | (3.4)    | (-237.8-195.2) | (264.4-142.7) | (374.5-248.5) | (1323.2-1227.7) |
| Asia, South                    | -79.5     | -897.5             | 2.1      | -377.5 | 496.4        | -1576.9       | -2432.9     |
|                                | (-83.6-76.6) | (-974.1-820.7)    | (1.9-2.3) | (-420.7-338.3) | (51.1067.7)  | (2139.1-1034) | (2487.6-2396.6) |
| Australasia                    | 4         | -4                 | 0        | -2     | 1           | -1.4          | 1.4         |
|                                | (-4.4-4.3) | (0.0)              | (-2.1-1) | (-1.3) | (-1.6-1.2)  | (-1.4-1.4)    |             |
| Caribbean                      | -1.2      | -13.5              | 1.9      | 2      | 1.7          | -17.3         | -32.3       |
|                                | (-1.2-1.2) | (-14.5-12.5)      | (-2.1-1.8) | (-5.4) | (-1.5-1.4)  | (-20.6-13.9)  | (-32.5-32.2) |
| Europe, Central                | -6.9      | -3.7               | 0        | 1.2    | -3           | -12.9         | -28.1       |
|                                | (-7.6-9)  | (-4.3-4.1)        | (0.0)    | (-1.4-1.1) | (-4.9-1.8)  | (-14-11.5)    | (-29.3-28)  |
| Europe, Eastern                | -10.8     | -8.9               | 0        | 7      | -33          | -66           | 530.2       |
|                                | (-11-10.7) | (-9.7-8.3)        | (0.0)    | (-8-6) | (-41.123)    | (-37.9-29.8)  | (-14.5-45.7) |
| Latin America, Andean          | 5         | -17.7              | 0        | -3.5   | 12.9         | -24           | 58          |
|                                | (-5.5)    | (-19.16-4)        | (0.0)    | (-3.9-3.2) | (-17.2-8.5) | (-23.9-19.7)  | (-58.1-58)  |
| Latin America, Central         | -9        | -37.9              | -1       | 16     | -21.4        | -58           | -123.1      |
|                                | (9.9)     | (-40.4-35.1)      | (-1-1)   | (6-6-5.4) | (-31.9-10.8) | (-69.5-47.2)  | (-123.4-122.9) |
| Latin America, Southern        | -1.2      | 4.7                | 0        | 1.8    | 3.4          | -11           | -15.5       |
|                                | (-1.2-1.2) | (-5.1-4.4)        | (0.0)    | (-2-1.6) | (2-1.4-9)    | (-12-7.9)     | (-15.6-15.4) |
| Latin America, Tropical        | -19.4     | -33.5              | 2        | 4.8    | -30.1        | -46           | -134.5      |
|                                | (-19.4-19.3) | (-36.31)         | (-2-2)   | (5-3-4.3) | (-38.3-21.8) | (-55.3-76)    | (-134.7-134.3) |
| North Africa/Middle East       | 58.8      | -147.7             | 3        | 33.7   | 24           | -307          | -453.2      |
|                                | (57.7-61) | (-158-156-2)       | (3-4)    | (-37-2-30.4) | (-70-21-2) | (-353-260-8)  | (-454-542-2) |
| North America, High-income     | 1.8       | -2.2               | -1       | -2.2   | 7.1          | -23           | -19.1       |
|                                | (1.8-1.8) | (-2.3-2.3)        | (-1-1)   | (-2.4-1.9) | (4-2-10.2) | (-26-8-20.6)  | (-19.2-19.1) |
| Oceania                        | 4.9       | -4.3               | 0        | -6     | 3.9          | 6.2           | 3.3         |
|                                | (4.8-4.9) | (-4.6-3.9)        | (0.0)    | (-7-6) | (1-7.4-2)    | (-7-6)        | (3-4-3)     |
| sub-Saharan Africa, Central    | 244.6     | -107.6             | 4.7      | 29.5   | 38.1         | -182          | 27          |
|                                | (243.246) | (-115.8-99.9)     | (4.3-5.1) | (26-5.32-4) | (5.8-70.6) | (214-1-149.9) | (25.9-28-4) |
| sub-Saharan Africa, Eastern    | 559.5     | -260.5             | 31.7     | -72.6  | 181.4        | -487          | 474.3       |
|                                | (557-4562) | (-280-5-240-7)    | (34-4.2-9) | (-79-6-65.3) | (-262-4-99.3) | (-570-7-402-2) | (-474-9.473-4) |
| sub-Saharan Africa, Southern   | 5.4       | -31.4              | 2.5      | -1.1   | 14           | -37           | -47.6       |
|                                | (5.3-5.5) | (-33-8.29)        | (2-3.2-7) | (-1-2-1) | (7-5.20-8) | (-43-7-30-5)  | (-47-8.47-5) |
| sub-Saharan Africa, Western    | 938.8     | -442.9             | 62.6     | -91.2  | 186.9        | -693          | 39.3        |
|                                | (932-4467) | (-477-2-409-1)    | (57-5.67-9) | (-100-2-82) | (68-6.310-7) | (815-4-570-5) | (-41-9-36)  |
Web Appendix to Global, regional, and national levels of neonatal, infant and under-5 mortality 1990-2013: a systematic analysis

Authors
Global Burden of Disease 2013 Child Mortality Collaboration

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Appendix

In analyzing child mortality rates for the Global Burden of Diseases, Injuries, and Risk Factors Study 2013 (GBD 2013) we employ a methodology based on that of Rajaratnam et al.,1 Lozano et al.,2 and Wang et al.3 We have made the following important improvements:

1. Incorporation of data bias adjustment into the modeling process. We estimate source specific bias based on data type specific fixed effects and random effects by source as explained in detail below. By estimating and removing such biases from raw child mortality data, we are able to avoid implausible estimated levels and trends due to sources for different periods with different levels of non-sampling variance.

2. Improvement in estimating the empirical relationships between child mortality rate, income, maternal education and HIV/AIDS. The empirical relationship between child mortality rate and other covariates is a crucial component in generating the mean trend, or prior, for the Gaussian process regression (GPR). In GBD 2013, we employ a nonlinear hierarchical mixed effects model that reflects the theoretical and demographic relationship between child mortality and other covariates, especially the crude death rate from HIV/AIDS in children under-5.

3. Improving estimates of child mortality rate in neonatal periods under the impact of HIV/AIDS. As HIV/AIDS has little impact on the child mortality rate in early neonatal and late neonatal age groups, we improve on the methodology used by GBD 2010 to reflect the changing fraction of under-5 mortality occurring in the neonatal age group.

The steps in generating mortality rate and numbers of death by child age groups are illustrated in Figure 1. We provide a short description here regarding data synthesis using raw child mortality rate estimates from censuses, vital registration systems, sample registration systems, complete and summary birth histories from survey sources and the age and sex model where we estimate mortality rate for early neonatal, late neonatal, postneonatal, and childhood mortality rates using the estimated child mortality rate from data synthesis step.

1. Data synthesis for child mortality rate analysis: completeness assessment, non-linear hierarchical mixed effects model, spatial-temporal regression and Gaussian Process regression

1.1 Under-5 vital registration completeness assessment

Vital registration (VR) systems often do not capture all deaths in a country. We use a simple linear regression of \( \log_{10}(s_{q_0}) \) on year, with a binary indicator variable for \( s_{q_0} \) estimates derived from VR systems (as described in Equation 1) to assess whether a vital registration system is significantly different from estimates provided by survey sources. If the coefficient for the VR indicator variable is statistically significant at the .05 \( \alpha \)-level, we deem the VR system to be biased. Biased VR systems are adjusted upward in a later step.

\[
\log_{10}(s_{q_0})_t = \alpha + \beta_1 \cdot t + \beta_2 \cdot 1_{VR} + \xi_t
\]

where: \( t \) is time (a continuous variable);
I_{VR} is an indicator for child mortality rate (m_{0}) estimates derived from VR systems; 
\xi_t is an error term.

1.2 First stage – Nonlinear hierarchical mixed effects model

In this stage, we use a nonlinear mixed effects regression to estimate data bias of non-VR child mortality data and provide first stage predictions.

The nonlinear mixed effects regression model is

\[ \log y_{cst} = \log \left( \exp \left( \beta_1 + \gamma_1 c + \beta_2 + \gamma_2 s + \beta_3 + \beta_4 + \beta_5 + \alpha_c + \epsilon_{cst} \right) \right) \]

where \( c \) is country, \( y \) is year, \( s \) is source, and \( t \) is source type; each source was categorized into one of 16 source types across all countries, as listed in Table 1. This formulation is used because the relationship between \( m_{0cys} \) and income and education is linear in log space but linear with HIV mortality in normal space.

Additionally,

- \( \beta_1 \) is central mortality rate in the under-5 age group
- \( \gamma_1 \) is lagged distributed income per capita
- \( \gamma_2 \) is mean years of education for women of reproductive age (15-49 years)
- \( \gamma_3 \) is the estimated death rate due to HIV in age group 0-4
- \( \gamma_4 \) and \( \gamma_5 \) are random slope by country
- \( \gamma_6 \) is a random effect by country
- \( \gamma_{cs} \) is a random effect by source nested within country
- \( \alpha \) is a source type fixed effects across countries
- \( \beta_i \) is a fixed covariate coefficient
- \( \epsilon \) is the residual
Web table 1. Source types used in child mortality bias correction

<table>
<thead>
<tr>
<th>Data Source Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete Birth History-Demographic and Health Survey</td>
<td></td>
</tr>
<tr>
<td>Complete Birth History-AIDS Indicator Survey and Malaria Indicators Survey</td>
<td></td>
</tr>
<tr>
<td>Complete Birth History-World Fertility Survey</td>
<td></td>
</tr>
<tr>
<td>Complete Birth History-Multiple Indicator Cluster Survey</td>
<td></td>
</tr>
<tr>
<td>Complete Birth History-Other survey Series</td>
<td></td>
</tr>
<tr>
<td>Summary Birth History-Demographic and Health Survey</td>
<td></td>
</tr>
<tr>
<td>Summary Birth History-Multiple Indicator Cluster Survey</td>
<td></td>
</tr>
<tr>
<td>Summary Birth History-Other survey series</td>
<td></td>
</tr>
<tr>
<td>Summary Birth History-AIDS Indicator Survey and Malaria Indicators Survey</td>
<td></td>
</tr>
<tr>
<td>Summary Birth History-Census</td>
<td></td>
</tr>
<tr>
<td>Summary Birth History-World Fertility Survey</td>
<td></td>
</tr>
<tr>
<td>Vital Registration/Sample Registration/Surveillance- complete</td>
<td></td>
</tr>
<tr>
<td>Vital Registration/Sample Registration/Surveillance- incomplete</td>
<td></td>
</tr>
<tr>
<td>Household Death Recall-Other survey series</td>
<td></td>
</tr>
<tr>
<td>Household Death Recall-Census</td>
<td></td>
</tr>
</tbody>
</table>

For each country, we choose a source, or combination of sources, which are believed to be the least biased. If a country has a complete vital registration system, this is the reference source. If a country does not have complete vital registration, but has Demographic and Health Surveys (DHS) estimates from complete birth histories, these are chosen as the reference source. If a country has neither of these types of data, or DHS surveys are unreliable based on published assessments, we assign the surveys conducted after 1980, in combination, as the reference (incomplete vital registration data is not included). Additionally, in some countries we choose other surveys as the reference. In certain cases, in-country all-cause mortality experts draw from their familiarity with data quality to help us to choose the reference category. The broad set of collaborators in this study contributed local knowledge to the selection of the least biased survey or set of surveys.

1.3 Data adjustment:

Each data source has an associated random effect as well as a source type fixed effect. The sum of these random and fixed effects for the reference sources is the estimated true deviation from the baseline modelled mortality level. In countries with multiple high-quality sources, the mean of the random and fixed effects from these sources is taken as this true deviation. We adjusted all other sources by including these reference values for the random and fixed effects values instead of those estimated for each individual source, as shown below.

\[
\text{adjusted}_5 m_{0,cys} = \exp\left(\beta_1 + \gamma_{1c} \right) \cdot \log(\text{LDI}_{cy}) + \beta_2 + \gamma_{2c} \cdot \text{education}_{cy} + \gamma_c + \gamma_{ref,c} \cdot 3 + \alpha_{ref,c} + \beta_3 \cdot \text{HIV}_{cy} + \varepsilon_{cys}
\]

The exception to the above adjustment is incomplete vital registration data, which is adjusted upwards using a five year rolling mean of the difference between incomplete vital regression and a LOESS of the already-adjusted survey data.
1.4 Spatial-temporal regression for residual smoothing:
The spatial-temporal stage captures the correlation structure in the residuals over time and across countries in the same GBD region. As described by equations 4 and 5 below, these residuals are computed based on the adjusted data from the previous steps and the predicted child mortality. The predicted time series was obtained from the equation below; no random effects or survey type fixed effects are included. This computation is done in logit($q_0$) space.

\[
predicted_m_{0,cy} = \exp[\beta_1 \log(LDI_{cy}) + \beta_2 \cdot \text{education}_{cy} + \alpha_{\text{interception}}] + \beta_3 \cdot HIV_{cy}
\]

\[
\text{residual} = \logit(\text{adjusted}_m q_{0,cys}) - \logit(\text{predicted}_m q_{0,cy})
\]

For this spatial-temporal component, residuals are weighted based on their proximity to the prediction year in space and time. Ninety-nine percent of the weight is on in-country residuals; one percent is on other residuals in the same GBD region. A modified tricube kernel is used to give more weight to data points closer in time. To capture rapid change in countries with major accelerations or decelerations, we compute the spatial-temporal component two ways.

First, we estimate the smoothed residuals using a linear fit to this weighted data in every country-year; this is similar to a LOESS fit to the spatial and temporal residuals. Second, we compute the smoothed residuals using only the space and time weights applied to the residuals. A combination of these two estimates series gives a final estimate of the smoothed residuals. Equation 6 shows that more weight was given to the local linear fit in data-dense countries while in data sparse countries, more weight was given to the weighted average.

\[
\text{final smoothed residual} = k \cdot \text{linear estimate} + (1 - k) \cdot \text{weighted average}
\]

where 
\[
k = \frac{\text{number of in country data points}}{\text{number of in country data points} + \text{number of country years with no data}}
\]

The effect of this weighting function is to follow the data much more closely including accelerations and decelerations when the data is dense.

Finally, the smoothed residuals are added back to predictions using the non-linear mixed effects model without random effects as discussed in the earlier section.

In Web Table 6, we list by country the number of years within each decade for which we have empirical estimates of under-5 mortality rates. The impact of spatio-temporal regression is most pronounced in places where there is no empirical data for an extend time period. In such situation, results from spatio-temporal regression largely determine our final estimates of under-5 mortality for the period.
1.5 Gaussian Process Regression

The output of the spatial-temporal step is used as the mean function, or prior, for the Gaussian process regression (GPR), which produces a final time series of point estimates, as well as uncertainty intervals.

1.5a. Mean, Covariance, and Likelihood

The model for the Gaussian process regression is shown below, where \( \mu_t \) is the true \( \logit q_0 \) at time \( t \), \( f(t) \) is the baseline mortality risk, in logit space, and \( S_t \) captures excess mortality due to war and disasters. \( S_t \) is estimated independently of \( f(t) \). \( M \) and \( C \) describe the Gaussian process, giving the mean and covariance, respectively.

\[
\mu_t = \logit^{-1} f(t) + S_t \\
\tag{1}
\]

The prior distribution of \( f(t) \) can be described in terms of the mean prior—the prior for \( M \)—and the covariance prior—the prior for \( C \). We utilize the second stage predictions as the mean prior and used a Matern function to describe the covariance prior. The Matern covariance function is uniquely flexible; its equation is

\[
M(t, t') = \sigma^2 \frac{2^{1-v} \Gamma(v)}{\Gamma(v)} \frac{(d(t, t') \sqrt{2v})^v}{l^v} K_v \left( \frac{d(t, t') \sqrt{2v}}{l} \right) \\
\tag{2}
\]

where \( t \) is time, \( d(\cdot; \cdot) \) is a distance function, and \( \sigma^2, v, l, \) and \( K_v \) are hyperparameters that allow the covariance to model trends with a variety of smoothness characteristics. \( v \) is the differentiability of the estimates, \( l \) corresponds to how correlated the estimates are over time, \( K_v \) is the Bessel function, and \( \sigma^2 \) is the marginal variance. In this application, we set \( v \) to 2 for most countries, and to 0.8 for countries with only vital registration data that are not in the Caribbean or Oceania. We use cross-validation, described in detail below, to choose values of \( \sigma^2 \) and \( l \) specific to each region.

The likelihood describes the probability of observing the data given a particular set of parameters. As shown in equation 8, we use a normal model for describing the probability of observing a particular value of \( \logit(\logit q_0) \) where the mean is given by \( f(t) \) and the variance by \( V_t \), the data variance.

\[
\logit(\logit q_0) \sim \text{Normal}(f(t), V_t) \\
\tag{3}
\]

1.5b. Hyperparameter selection through cross-validation

For cross-validation to select GPR hyperparameters \( \sigma^2 \) and \( l \), data are divided as follows: for each region, a number \( X \) between 10 and 20 was sampled and the most recent \( X \) years of data in that region are assigned to the testing set. Then a number \( X \) between 5 and 10 is sampled, a country from within the region is sampled, and a year where there is data in that country is sampled. All data within \( X \) years of the selected year in the selected country are assigned to the testing set. This is repeated as many times as there are countries in the region; because iterations of this procedure are independent, the data selected for the testing set may overlap. Any data that are not selected for the testing set are included in the training set.

For each testing and training division, the second stage model is fit on the bias-adjusted training data. Then, the third stage model is also fit on the bias-adjusted training data using each combination of scale and squared amplitude values tested for a total of 25 sets of predictions. The testing data are matched to the predictions in the
corresponding country and year for each of the 25 sets of predictions. For each match we calculate the absolute relative error of the prediction compared to the empirical estimate in the testing set. We also classify each bias-adjusted estimate in the testing set as being covered or not covered by each corresponding prediction uncertainty interval.

Once this procedure has been carried out for all 100 testing and training divisions of the data we calculate the mean absolute relative error and the mean coverage for each combination of GPR parameters across all 100 sets of predictions. The ideal set of parameters would produce estimates with low mean absolute relative error and mean coverage close to 0.95. We use the function described in equation 8 to calculate a loss metric which incorporates both the coverage and the absolute relative error into a single measure to assess performance. Parameter combinations with lower values of this loss metric are considered preferable.

\[
\text{Loss} = \begin{cases} 
(0.95 - \text{coverage})/5 + \text{(absolute relative error)} & \text{if coverage} \leq 0.95; \\
(\text{coverage} - 0.95)/1 + \text{(absolute relative error)} & \text{if coverage} > 0.95.
\end{cases}
\]

The optimal parameters may differ from country to country. To allow for this, we calculated the loss function described in equation 8 separately for each of the 21 GBD geographic regions.

1.5c. Final estimates and confidence intervals
Given the mean, covariance, and likelihood above, we use GPR to obtain a posterior distribution of the time series of \(\logit(q_0)\) for each country. We draw 1000 samples from this distribution, and take the mean, 2.5\text{th}, and 97.5\text{th} percentile as our best estimate, upper, and lower confidence intervals, respectively. The Gaussian process regression is implemented in Python’s PyMC package.

1.6 Variance calculations
As mentioned in the previous section, data variance is a key factor in generating the uncertainty interval of child mortality rate. Data variance is calculated for each empirical observation of \(q_0\) and incorporated both sampling and non-sampling biases. The method for calculating the data variance depends on the type of data:

1. For estimates derived from complete vital registration data we assume that there is no non-sampling variance and include only sampling variance as computed from a binomial model. We set \(N\) equal to the national population aged 0 to 5 years and \(p\) equal to the mortality rate, \(q_0\). We calculate the variance of \(q_0\) from \(p(1-p)/N\) and then transform this to the variance of \(\log_{10}(q_0)\) using the delta method.\text{4}

2. For estimates derived from incomplete vital registration data, we want to include not only sampling variance but also the non-sampling variance that arises from uncertainty in the completeness estimate. For these data, the total data variance is given by the sum of the sampling variance (calculated as for complete vital registration data) and the variance of the completeness estimate;

3. For estimates derived from complete birth histories we generate 1000 simulations of \(q_0\), convert these estimates into \(\log_{10}\) space and calculate the sampling variance from these 1,000 simulations;

4. For estimates derived from summary birth histories, we use the standard error from the mean residuals;

5. For estimates not covered under the above four calculations the missing data variance is determined as the maximum standard error from non-VR points in the country, if the data variance is still missing it is calculated as the maximum standard error from non-VR data in the GBD region.
Finally, for each source type, we calculate the within-source-type variance of the source-specific random effect. This additional non-sampling variance is then converted to log_{10} space and added to the variance as calculated above for all data points not classified as complete vital registration.

1.7. Shocks
We compile a database of child deaths due to conflict and natural disaster from three sources: the Uppsala Conflict Data Program (UCDP), the International Institute for Strategic Studies (IISS), and the EM-DAT database published by The Center for Research on the Epidemiology of Disasters. The conflicts we analyze include both domestic and international as largely defined by the two main data sources we are using: UCDP and IISS. For natural disasters, we include major forces of nature: earthquake, hurricane, and flood.

After compiling a database of all-age war and disaster deaths, we use the methods described by Lozano et al.\(^4\) to split deaths into age groups, creating 1000 simulations. For countries with shocks, the calculated shocks under-five mortality rate are added to the GPR estimates, which are “shock-free” by definition, at the simulation level. Here we employ the simple mathematical relationship between all-cause mortality rate and cause specific mortality rate, that is, the sum of mortality rate due to shocks and from non-shock causes are all-cause mortality rate. The mean, 2.5th, and 97.5th percentiles of the simulations are then used as final estimates and confidence intervals. In countries without shocks, GPR results are presented as final estimates.

2. Age and sex model to generate mortality
The process used to break down under-5 mortality into age- and sex- specific groups has been previously described.\(^2\) The current process is largely similar but has been modified to improve the accuracy of predictions for countries affected by HIV/AIDS. As pointed out by Bradshaw et al., neonatal mortality tends to be overestimated if the all-cause child mortality rate is used as the only predictor.\(^5\) We use a two-stage modeling process to generate sex-specific estimates of early neonatal (days 0 to 6), late neonatal (days 7 to 27), post-neonatal (the remainder of the first year), and childhood (ages 1 to 4) mortality. First, the ratio of male to female under-5 probability of death is estimated, then age- and sex-specific mortality estimates are generated using this ratio. To fit models to obtain estimates, data from vital registration, sample vital registration, and complete birth histories are converted to mortality risks for specific age groups. Sources have differing levels of age specificity and at least include infant (composed of early neonatal, late neonatal, and post-neonatal) and child mortality, but can include all 4 smaller age groups. The two models – first the sex model, then the age-specific and sex specific model – are fit on the data.

The sex model predicts the ratio of male probability of death under age 5 (\(s_{q0}\)) to female \(s_{q0}\) for each country \(i\) in region \(j\) in year \(t\). The data are ordered by observed \(s_{q0}\), and categorized into 20 evenly sized bins. Then, the model is fit to the data as described in the equation below.

\[
\left( \frac{\text{Male } s_{q0}}{\text{Female } s_{q0}} \right)_{\text{jit}} = \beta + \gamma_{s_{q0} \text{ bin}} + \gamma_j + \gamma_{t} + \epsilon_{\text{jit}}
\]

The ratio is predicted by nested country and region random effects \(\gamma\) and \(\gamma_t\), a random effect on the \(s_{q0}\) bin, and an intercept term, \(\beta\). A Loess regression is then used to smooth the estimated \(\gamma_{s_{q0} \text{ bin}}\) on \(s_{q0}\), creating a continuous \(\gamma'_{s_{q0} \text{ bin}}\). Then, the equation below is used to predict the ratio of male to female \(s_{q0}\):
\[
\left(\frac{\text{Male } s_{q_0}}{\text{Female } s_{q_0}}\right)_{jit} = \hat{\beta} + \gamma'_{s_{q_0} \text{ bin }}(s_{q_0}^{\text{jit}}) + \gamma_j + \gamma_i \quad 10
\]

The male and female \( s_{q_0} \) values are found using the system of equations that includes the model above and equation below, where \( r_{\text{birth}} \) is the sex-ratio at birth.

\[
s_{q_0} = \left(\frac{1}{1+ r_{\text{birth}}}\right) \cdot (\text{female } s_{q_0}) + \left(\frac{r_{\text{birth}}}{1+ r_{\text{birth}}}\right) \cdot (\text{male } s_{q_0}) \quad 11
\]

Age-specific models are then fit for each age group on sex-specific data. A separate model is fit for each age group yielding five models for each sex: early neonatal, late neonatal, postneonatal, infant, and child. The log of the probability that an under-5 death occurs in a given age group is modeled instead of the mortality risk, simplifying the scaling process and restricting risks to be between 0 and 1. Because evidence suggests HIV has differential effects on different under-5 age groups,\(^5,6\) the crude death rates from HIV/AIDS in the under-5 age group were included in the model. We used crude death rates due to HIV based on the 2013 UNAIDS estimates,\(^7\) updated using Spectrum software.\(^8\) The inclusion of this covariate improves both the fit and prediction of the model in countries with HIV. The functional form of the model is below.

\[
\log(\Pr(\text{death at age } y|u5 \text{ death})_{jit}) = \beta_1 + \beta_2 \cdot HIV_{it} + \gamma_{s_{q_0} \text{ bin }} + \gamma_j + \gamma_i + \varepsilon_{jit} \quad 12
\]

Once the sex and age models are fit, they are applied to the \( s_{q_0} \) estimates derived from our \( s_{q_0} \) modeling process to estimate death risks for each age and sex. Uncertainty is accounted for in two ways. Uncertainty in \( s_{q_0} \) is carried through from the GPR process by making predictions on the 1000 simulations produced by GPR for each country-year. Further, the predictions are made by simulations of this model which are generated using uncertainty around each term of the sex and age models.

The predictions of the log of the conditional probability of death are then transformed to mortality risks and scaled to create consistency between the age and sex predictions and the \( s_{q_0} \) predictions from GPR.
3. References


### 4. Additional tables and figures


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Note: The data represents various economic indicators for different countries and regions, spanning the years 2001-2006.
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**North America, High-income**

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**Oceania**

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### Web table 2b. Numbers of under-5 deaths for five-year intervals from 1970 to 2013 for 188 countries and 21 Global Burden of Disease regions.

#### Under 5 Deaths per 1000 live births

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### Web Table 3. Global under-5 mortality deaths from several studies.

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Web table 4: Data source list of child mortality data sources used in the GBD 2013.

VR/SRS/DSP = Vital registration, sample registration system, and disease surveillance points. HH = Household deaths. CBH = Complete birth history. SBH = Summary birth history.

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Web figure 1. Under-5 mortality rate for 188 countries.
Asia Pacific, High–income
Japan (JPN)
Asia, Central
Turkmenistan (TKM)

Year

Number of deaths per 1000

GPR
GPR with shocks
Stage 1: Regression
Stage 2: Space–time
VR/SRS/DSP
CBH

GPR with shocks
Stage 1: Regression
Stage 2: Space–time
VR/SRS/DSP
CBH

Transparent points are mixed effects adjusted
Hollow = outlier or shock
Asia, East
Taiwan (TWN)
Asia, South
Bangladesh (BGD)
Asia, Southeast Cambodia (KHM)

Number of deaths per 1000

Year

GPR
GPR with shocks
Stage 1: Regression
Stage 2: Space−time
VR/SRS/DSP
CBH

Hollow = outlier or shock
Transparent points are mixed effects adjusted
Reference category

Standard DHS
Other DHS
Census
Other

Asia, Southeast Cambodia (KHM)


50
100
150
200
250
Asia, Southeast Maldives (MDV)

Number of deaths per 1000

Year

GPR
GPR with shocks
Stage 1: Regression
Stage 2: Space−time
VR/SRS/DSP
CBH

VR
Standard DHS
Census

Transparent points are mixed effects adjusted
Hollow = outlier or shock

Reference category
Asia, Southeast Philippines (PHL)

Number of deaths per 1000

Year


Stage 1: Regression
Stage 2: Space–time
GPR
GPR with shocks
VR/SRS/DSP
CBH

VR Standard DHS Census WFS

VR
Standard DHS
Census
WFS
Asia, Southeast
Seychelles (SYC)

Number of deaths per 1000

Year


Stage 1: Regression
Stage 2: Space−time
GPR with shocks
SBH
HH
Transparent points are mixed effects adjusted
Hollow = outlier or shock

GPR
GPR with shocks
Stage 1: Regression
Stage 2: Space−time
VR/SRS/DSP
CBH
Australasia
New Zealand (NZL)

Year

Number of deaths per 1000
Caribbean
The Bahamas (BHS)
Caribbean
Barbados (BRB)

Number of deaths per 1000

Year

GPR
GPR with shocks
Stage 1: Regression
Stage 2: Space-time
VR/SRS/DSP
CBH
SBH
HH

Transparent points are mixed effects adjusted
Hollow = outlier or shock
Caribbean
Grenada (GRD)

Year
Number of deaths per 1000

Stage 1: Regression
Stage 2: Space–time

VR/SRS/DSP
CBH

GPR with shocks
SBH
HH
Reference category
Transparent points are mixed effects adjusted
Hollow = outlier or shock
Caribbean
Saint Lucia (LCA)

Number of deaths per 1000

Year

GPR
GPR with shocks
Stage 1: Regression
Stage 2: Space−time
VR/SRS/DSP
SBI
CBH

Transparent points are mixed effects adjusted
Hollow = outlier or shock

GPR
GPR with shocks
SBH
HH
Reference category

Staple Points are mixed effects adjusted
Hollow = outlier or shock
Europe, Central Bulgaria (BGR)

Year vs. Number of deaths per 1000

- GPR
- GPR with shocks
- Stage 1: Regression
- Stage 2: Space-time
- VR/SRS/DSP
- CBH

Transparent points are mixed effects adjusted
Hollow = outlier or shock

VR Census LSMS Europe, Central Bulgaria (BGR)
Europe, Central
Hungary (HUN)

Year
Number of deaths per 1000

GPR
GPR with shocks
Stage 1: Regression
Stage 2: Space-time
VR/SRS/DSP
CBH

Transparent points are mixed effects adjusted
Hollow = outlier or shock
Europe, Central
Montenegro (MNE)

Stage 1: Regression
Stage 2: Space−time
CBH

GPR
GPR with shocks
SBH
HH
Reference category
Transparent points are mixed effects adjusted
Hollow = outlier or shock

GPR Census
Europe, Central
Montenegro (MNE)
Europe, Central
Poland (POL)

Year

Number of deaths per 1000

GPR
GPR with shocks
Stage 1: Regression
Stage 2: Space–time
VR/SRS/DSP
CBH

VR

Europe, Central
Poland (POL)

GPR
GPR with shocks
Stage 1: Regression
Stage 2: Space–time
VR/SRS/DSP
CBH

Transparent points are mixed effects adjusted
Hollow = outlier or shock

Europe, Central Slovakia (SVK)

Number of deaths per 1000

Year

Europe, Central Slovenia (SVN)
Europe, Eastern
Latvia (LVA)

Number of deaths per 1000

Year


GPR
GPR with shocks
Stage 1: Regression
Stage 2: Space−time
VR/SRS/DSP
CBH

Transparent points are mixed effects adjusted
Hollow = outlier or shock
Europe, Western Switzerland (CHE)

Number of deaths per 1000

Year


Stage 1: Regression
Stage 2: Space−time
VR/SRS/DSP
CBH

GPR
GPR with shocks
SBH
HH
Reference category
Transparent points are mixed effects adjusted
Hollow = outlier or shock
Europe, Western Germany (DEU)

![Graph showing the trend of number of deaths per 1000 from 1970 to 2010. The graph illustrates the decline in deaths over time, with different lines representing various stages of regression and space-time analysis.]

- **GPR**: Generalized Proportional Risk
- **GPR with shocks**: Generalized Proportional Risk with shocks
- **Stage 1: Regression**: Initial regression analysis
- **Stage 2: Space-time**: Space-time analysis
- **VR/SRS/DSP**: Virtual, Surveys, Random Samples, Designated Survey
- **CBH**: Case-Based Homicide

**Legend**:
- Transparent points are mixed effects adjusted
- Hollow = outlier or shock
Europe, Western
United Kingdom (GBR)

Year
Number of deaths per 1000
Europe, Western
greece (GRC)

Year

Number of deaths per 1000


5 10 15 20 25 30 35

Stage 1: Regression
Stage 2: Space−time
GPR/SRS/DSP
CBH

GPR with shocks
SBH
HH
Reference category
Transparent points are mixed effects adjusted
Hollow = outlier or shock

GRC: Greece
Europe, Western
Malta (MLT)

Year
Number of deaths per 1000

GPR
GPR with shocks
Stage 1: Regression
Stage 2: Space-time
VR/SRS/DSP
CBH

Hollow = outlier or shock
Transparent points are mixed effects adjusted
Reference category

Europe, Western Netherlands (NLD)

Number of deaths per 1000

Year

Europe, Western Norway (NOR)

Number of deaths per 1000

Year


GPR
GPR with shocks
Stage 1: Regression
Stage 2: Space−time
VR/SRS/DSP
CBH

GPR with shocks
SBH
HH
Reference category
Transparent points are mixed effects adjusted
Hollow = outlier or shock

Europe, Western Norway (NOR)

Number of deaths per 1000

Year


GPR
GPR with shocks
Stage 1: Regression
Stage 2: Space−time
VR/SRS/DSP
CBH

GPR with shocks
SBH
HH
Reference category
Transparent points are mixed effects adjusted
Hollow = outlier or shock
Europe, Western Portugal (PRT)

Year Number of deaths per 1000

GPR with shocks
Stage 1: Regression
Stage 2: Space–time
VR/SRS/DSP
CBH

Transparent points are mixed effects adjusted
Hollow = outlier or shock

GPR
GPR with shocks
SBH
HH
Reference category
Latin America, Central Mexico (MEX)

- GPR
- GPR with shocks
- Stage 1: Regression
- Stage 2: Space-time
- Transparent points are mixed effects adjusted
- Hollow = outlier or shock

Year

Number of deaths per 1000

GPR Standard DHS Census Other WFS
North Africa/Middle East
Iraq (IRQ)

Number of deaths per 1000

Year


VR SRS Census Other MICS

GPR GPR with shocks
Stage 1: Regression
Stage 2: Space−time
VR/SRS/DSP
CBH

SBH

Hollow = outlier or shock
Transparent points are mixed effects adjusted
Reference category

GPR with shocks
Stage 1: Regression
Stage 2: Space−time
VR/SRS/DSP
CBH

SBH

Hollow = outlier or shock
Transparent points are mixed effects adjusted
Reference category
North Africa/Middle East
Oman (OMN)

Year
Number of deaths per 1000
0 50 100 150 200
250

Stage 1: Regression
Stage 2: Space−time VR/SRS/DSP CBH
Reference category
Transparent points are mixed effects adjusted
Hollow = outlier or shock

GPR GPR with shocks SBH HH

VR Census Other
North Africa/Middle East
Oman (OMN)
North Africa/Middle East
Tunisia (TUN)

Year
Number of deaths per 1000


GPR
GPR with shocks
Stage 1: Regression
Stage 2: Space–time
VR/SRS/DSP
CBH

Transparent points are mixed effects adjusted
Hollow = outlier or shock

VR Standard DHS PAPFAM PAPCHILD Census Other MICS WFS

North Africa/Middle East
Tunisia (TUN)
sub-Saharan Africa, Central Angola (AGO)

Number of deaths per 1000

Stage 1: Regression
Stage 2: Space-time
VR/SRS/DSP
CBH

GPR
GPR with shocks
Stage 1: Regression
Stage 2: Space-time
VR/SRS/DSP
CBH

Transparent points are mixed effects adjusted
Hollow = outlier or shock

Other MICS MIS

Reference category

Other MICS MIS

sub-Saharan Africa, Central Angola (AGO)
sub-Saharan Africa, Central Democratic Republic of the Congo (COD)

Number of deaths per 1000

- Standard DHS
- Census
- MICS

Year


GPR
GPR with shocks
Stage 1: Regression
Stage 2: Space−time
VR/SRS/DSP
CBH

SBH
HH
Reference category
Transparent points are mixed effects adjusted
Hollow = outlier or shock

Standard DHS Census MICS
sub-Saharan Africa, Central Democratic Republic of the Congo (COD)
sub-Saharan Africa, Eastern Eritrea (ERI)

Number of deaths per 1000

Year
sub–Saharan Africa, Eastern South Sudan (SSD)

Number of deaths per 1000

Year

GPR
GPR with shocks
Stage 1: Regression
Stage 2: Space−time
VR/SRS/DSP
CBH

Census Other

Transparent points are mixed effects adjusted
Hollow = outlier or shock
sub-Saharan Africa, Eastern Tanzania (TZA)

Number of deaths per 1000

Year


50

100

150

200

GPR

GPR with shocks

Stage 1: Regression

Stage 2: Space-time

VR/SRS/DSP

CBH

Standard DHS

Census

Other

LSMS

AIS

Transparent points are mixed effects adjusted

Hollow = outlier or shock

GPR with shocks

Stage 1: Regression

Stage 2: Space−time VR/SRS/DSP CBH

Standard DHS Census Other LSMS AIS

sub−Saharan Africa, Eastern Tanzania (TZA)
sub-Saharan Africa, Southern Zimbabwe (ZWE)

Year
Number of deaths per 1000

Stage 1: Regression
Stage 2: Space−time
VR/SRS/DSP
CBH
GPR
GPR with shocks
SBH
HH
Reference category
Transparent points are mixed effects adjusted
Hollow = outlier or shock

VR Standard DHS Census Other MICS
sub-Saharan Africa, Western Burkina Faso (BFA)

![Graph showing trends in Number of deaths per 1000 over years.]

- **Number of deaths per 1000**: 100 to 350

**Reference category**: Transparent points are mixed effects adjusted. Hollow = outlier or shock.
sub-Saharan Africa, Western
Cote d'Ivoire (CIV)

Year
Number of deaths per 1000


100
150
200
250

Stage 1: Regression
Stage 2: Space−time
VR/SRS/DSP
CBH

GPR
GPR with shocks
Stage 1: Regression
Stage 2: Space−time
VR/SRS/DSP
CBH

Standard DHS
Census
Other
WFS
AIS

GPR with shocks
SBH
HH
Reference category
Transparent points are mixed effects adjusted
Hollow = outlier or shock

T ransparent points are
mixed effects adjusted

sub-Saharan Africa, Western Ghana (GHA)

Number of deaths per 1000

Year


GPR with shocks
Stage 1: Regression
Stage 2: Space–time
VR/SRS/DSP
CBH

Standard DHS
Other DHS
Census
MICS
WFS
LSMS

Transparent points are mixed effects adjusted
Hollow = outlier or shock

GPR
SBH
HH
Reference category

Standard DHS
Other DHS
Census
MICS
WFS
LSMS

sub-Saharan Africa, Western Ghana (GHA)
sub-Saharan Africa, Western Guinea (GIN)

- Standard DHS
- Other DHS
- Census

GPR
GPR with shocks
Stage 1: Regression
Stage 2: Space−time
VR/SRS/DSP
CBH

Transparent points are
mixed effects adjusted
Hollow = outlier or shock

Year
Number of deaths per 1000
sub-Saharan Africa, Western
Mali (MLI)

Year
Number of deaths per 1000

G
GPR with shocks
Stage 1: Regression
Stage 2: Space-time
VR/SRS/DSP
CBH

Standard DHS
Other DHS
Census

Transparent points are mixed effects adjusted
Hollow = outlier or shock

GPR
SBH
HH
Reference category

100 150 200 250 300 350 400

Standard DHS Other DHS Census
sub-Saharan Africa, Western
Mali (MLI)
sub-Saharan Africa, Western Mauritania (MRT)
sub-Saharan Africa, Western Niger (NER)
sub-Saharan Africa, Western Senegal (SEN)

Number of deaths per 1000

Stage 1: Regression
Stage 2: Space-time

Transparent points are mixed effects adjusted
Hollow = outlier or shock

GPR
GPR with shocks
Standard DHS
Other DHS
Census
MICS
WFS
MIS

Year
sub-Saharan Africa, Western Sierra Leone (SLE)

Year

Number of deaths per 1000

GPR

GPR with shocks

Stage 1: Regression

Stage 2: Space−time

VR/SRS/DSP

CBH

Hollow = outlier or shock

Transparent points are mixed effects adjusted

Reference category

Standard DHS

Census

MICS

GPR with shocks

H

SBH

HH

Stage 1: Regression

Stage 2: Space−time

VR/SRS/DSP

CBH

Standard DHS

Census

MICS
Web figure 2. Regional rate of change in under-5 mortality rate, 1970-2013.
Rate of change in under-5 mortality rate: Asia Pacific, High-income, 1970-2013
Rate of change in under−5 mortality rate: Asia, Central, 1970–2013

Year

Annualised Rate of Change (%)
Rate of change in under-5 mortality rate: Asia, East, 1970–2013

Year

Annualised Rate of Change (%)
Rate of change in under-5 mortality rate: Asia, South, 1970–2013

Annualised Rate of Change (%)

Year

Rate of change in under-5 mortality rate: Asia, Southeast, 1970–2013
Rate of change in under-5 mortality rate: Caribbean, 1970–2013

Annualised Rate of Change (%)
Rate of change in under–5 mortality rate: Europe, Central, 1970–2013
Rate of change in under-5 mortality rate: Europe, Eastern, 1970–2013
Rate of change in under-5 mortality rate: Europe, Western, 1970–2013
Rate of change in under-5 mortality rate: Latin America, Andean, 1970–2013
Rate of change in under-5 mortality rate: Latin America, Central, 1970–2013
Rate of change in under-5 mortality rate: Latin America, Southern, 1970–2013
Rate of change in under-5 mortality rate: Latin America, Tropical, 1970–2013
Rate of change in under-5 mortality rate: North Africa/Middle East, 1970−2013
Rate of change in under-5 mortality rate: North America, High-income, 1970-2013
Rate of change in under-5 mortality rate: Oceania, 1970–2013
Rate of change in under-5 mortality rate: sub-Saharan Africa, Central, 1970-2013
Rate of change in under-5 mortality rate: sub-Saharan Africa, Eastern, 1970–2013
Rate of change in under-5 mortality rate: sub-Saharan Africa, Southern, 1970-2013

![Graph showing the rate of change in under-5 mortality rate from 1970 to 2013 for sub-Saharan Africa, Southern region. The graph indicates a general decline in mortality rates over this period, with a significant reduction in the late 2000s and early 2010s.](chart.png)
Rate of change in under-5 mortality rate: sub-Saharan Africa, Western, 1970–2013

Annualised Rate of Change (%) vs Year