

Inadequate living conditions, extreme poverty and socioeconomic factors affect the health of mothers and newborns. However, effective health systems can greatly limit the number of infant deaths, particularly by addressing life-threatening issues during the neonatal period. Around two-thirds of deaths during the first year of life occur before an infant reaches 28 days (neonatal mortality), primarily from congenital anomalies, prematurity and other conditions arising during pregnancy. For deaths beyond these first critical weeks (post-neonatal mortality), there tends to be a greater range of causes – the most common being Sudden Infant Death Syndrome (SIDS), birth defects, infections and accidents.

Infant mortality rates are low in most OECD countries, at less than five deaths per 1 000 live births in all countries except Mexico, Turkey and Chile (Figure 3.18). Within OECD countries, though, infant mortality rates are often higher among indigenous populations and other vulnerable groups – as observed in Australia, Canada, New Zealand and the United States (Smylie et al., 2010[1]). In partner countries, infant mortality remains above 20 deaths per 1 000 live births in India, South Africa and Indonesia, and above ten deaths in Colombia and Brazil. Infant mortality rates have fallen in all OECD and partner countries since 2000, with reductions generally largest in countries with historically the highest rates.

Despite this progress in reducing infant deaths, the increasing numbers of low birthweight infants are a concern in some OECD countries. On average, one in 15 babies born in OECD countries (6.5% of all births) weighed less than 2 500 grammes at birth in 2017 (Figure 3.19). Low birthweight infants have a greater risk of poor health or death, require a longer period of hospitalisation after birth, and are more likely to develop significant disabilities later in life. Risk factors for low birthweight include maternal smoking, alcohol consumption and poor nutrition during pregnancy, low body mass index, lower socio-economic status, having had in-vitro fertilisation treatment and multiple births, and a higher maternal age. The increased use of delivery management techniques such as induction of labour and caesarean delivery, which have contributed to increased survival rates of low birthweight infants, may also explain the rise in their numbers.

Japan, Greece and Portugal have the greatest share of low birthweight infants among OECD countries. There are fewer low birthweight infants in the Nordic (Iceland, Finland, Sweden, Norway, Denmark) and Baltic (Estonia, Latvia, Lithuania) countries. In 23 of the 36 OECD countries, the proportion of low birthweight infants has increased since

2000, most markedly in Korea. Among partner countries, Indonesia and Colombia have a high share.

### Definition and comparability

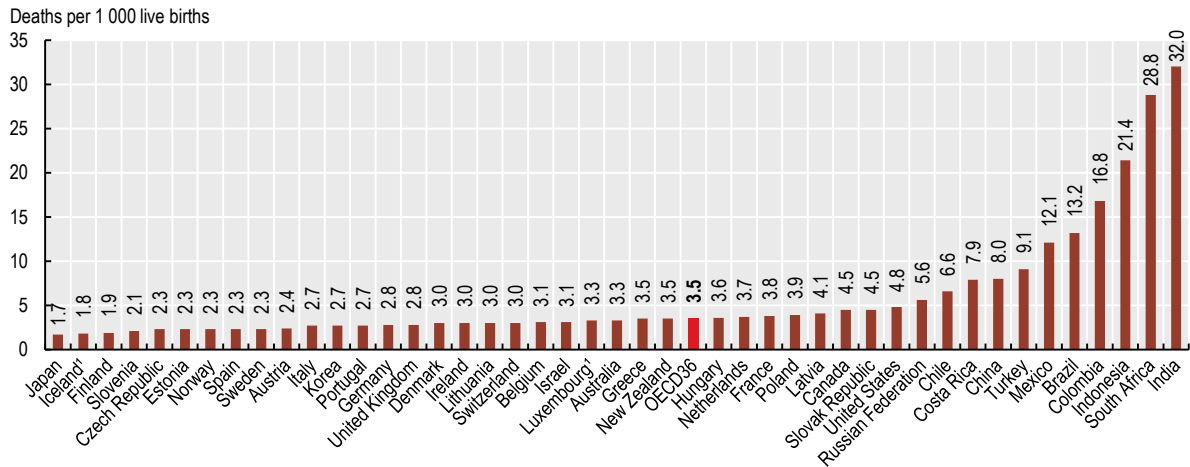
The infant mortality rate is the number of deaths of children under one year of age per 1 000 live births. Some of the international variation in infant mortality rates may be due to variations in registering practices for very premature infants. While some countries register all live births including very small babies with low odds of survival, several countries apply a minimum threshold of a gestation period of 22 weeks (or a birth weight threshold of 500 grammes) for babies to be registered as live births (Euro-Peristat, 2018[2]). To remove this data comparability limitation, data presented in this section are based on a minimum threshold of 22 weeks' gestation period (or 500 g birth weight) for a majority of OECD countries that have provided these data. However, the data for ten countries (Australia, Canada, Greece, Ireland, Italy, Lithuania, Luxembourg, Mexico, Norway and Portugal) continue to be based on all registered live births (i.e. with no minimum threshold of gestation period or birthweight), resulting in potential over-estimation.

Low birth weight is defined by WHO as the weight of an infant at birth of less than 2 500 g (5.5 pounds) irrespective of the gestational age. This threshold is based on epidemiological observations regarding the increased risk of death to the infant. Despite the widespread use of this 2 500 g limit for low birth weight, physiological variations in size occur across different countries and population groups, and these need to be taken into account when interpreting differences (Euro-Peristat, 2018[2]). The number of low weight births is expressed as a percentage of total live births.

### References

- [2] Euro-Peristat (2018), *European Perinatal Health Report: Core indicators of the health and care of pregnant women and babies in Europe in 2015*.
- [1] Smylie, J. et al. (2010), "Indigenous birth outcomes in Australia, Canada, New Zealand and the United States – an overview", *Open Womens Health*, Vol. 4, pp. 7-17.

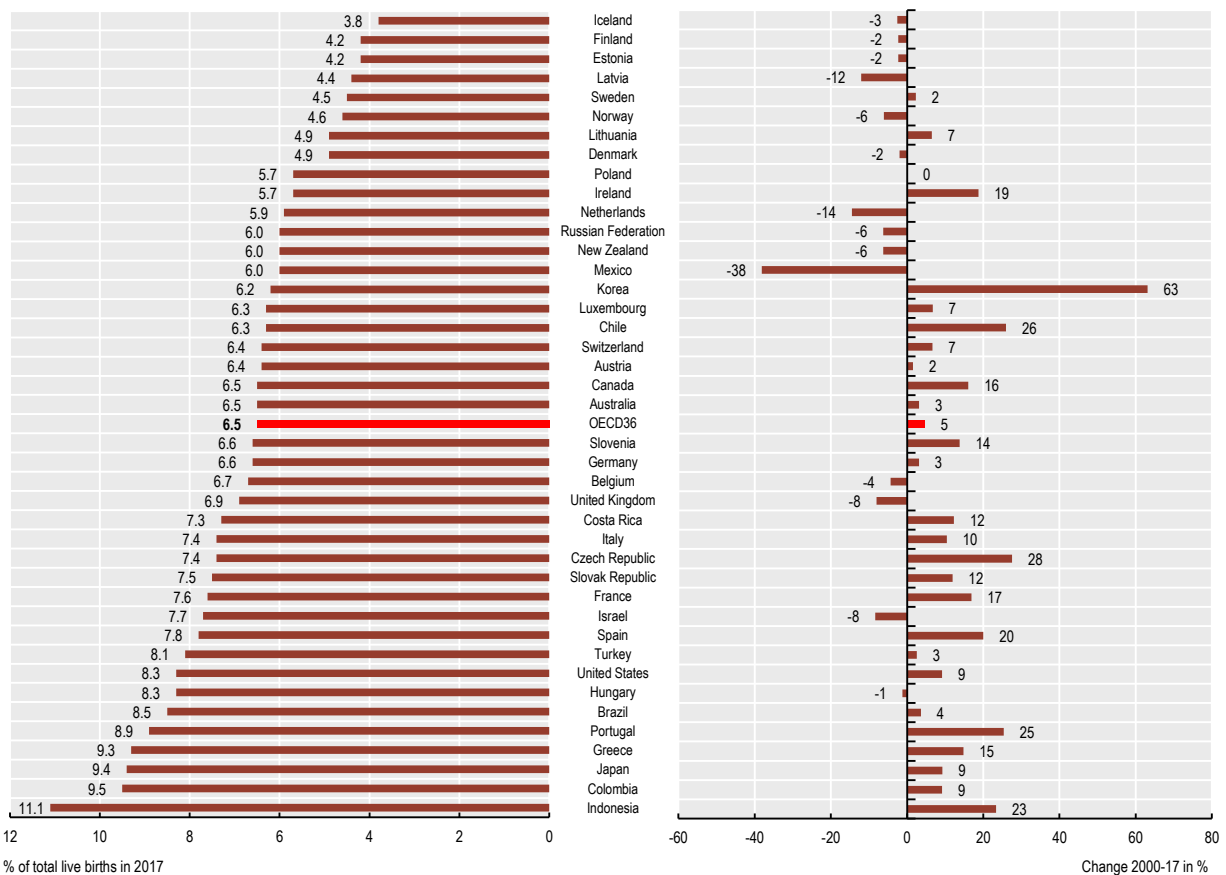
Figure 3.18. Infant mortality, 2017 (or nearest year)



1. Three-year average (2015-17).  
Source: OECD Health Statistics 2019.

StatLink <https://doi.org/10.1787/888934015144>

Figure 3.19. Low birthweight infants, 2017 and change 2000-17 (or nearest year)



Source: OECD Health Statistics 2019.

StatLink <https://doi.org/10.1787/888934015163>



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