CHAMPIONS FOR CHILDREN

State of the World's Mothers 2011

Essays by Peter Singer,
Rick and Kay Warren,
Anne Mulcahy,
Jennifer Garner and others
on why investments in maternal and child health care in developing countries are good for America

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CONTENTS

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On the cover: Meena prepares her newborn baby for a check-up at home by a visiting community health worker. Infant mortality rates in this part of India have declined dramatically, thanks in part to the work of local women trained in newborn care.

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WHY INVESTMENTS IN MATERNAL AND CHILD HEALTH CARE IN DEVELOPING COUNTRIES ARE GOOD FOR AMERICA

In commemoration of Mother's Day, Save the Children is publishing its twelfth annual State of the World's Mothers report. We have assembled our *Champions for Children* – leading voices from academia, politics, religion, business and the arts – to celebrate the great progress the world has made in recent decades to reduce deaths among children under age 5. These distinguished essayists explore the many reasons why the United States, as a nation, must continue to invest in lifesaving maternal and child health programs. U.S. investment in basic health care for the world's mothers and children will impact everything from the future of national security, to economic growth for American businesses in developing countries, and even the environment.

Millions of children are alive today because of past investments in lifesaving programs. But our work is not done. Each day, 22,000 children still perish, mostly from preventable or treatable causes. While many countries are making progress, many still need our help. This report identifies countries that are lagging behind in the race to save lives. It also shows that effective solutions to this challenge are affordable – even in the world's poorest countries.

Mali

WILLIAM FRIST & JON CORZINE

FOREWORD

William H. Frist, MD, (left) is a former U.S. Senate Majority Leader. Jon Corzine (right) is a former U.S. Senator and Governor of New Jersey. They co-chair Save the Children's Newborn and Child Survival Campaign.

"Working together with developed and developing country partners, we reduced the total number of under-5 deaths worldwide by more than one-third in less than two decades."

When children in developing countries die, we all mourn this loss of life, especially when we know that most of these deaths could have been easily prevented. We are no longer Democrats or Republicans – we are members of the human family who recognize that it is simply wrong for some of our children to have access to basic services that ensure they survive, while others do not.

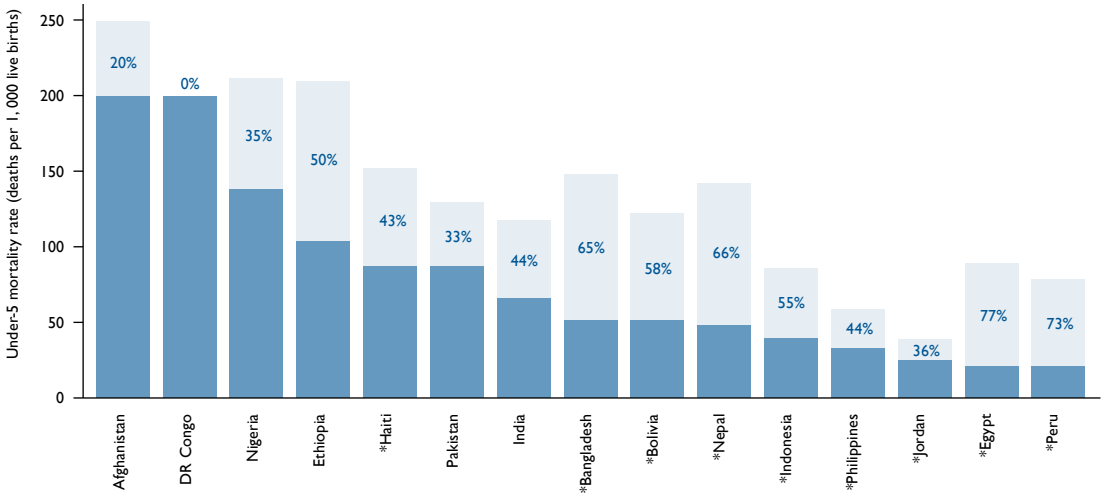
The United States has a long and proud history of leadership in the fight to save children's lives. American researchers pioneered simple solutions that have led to a remarkable decline in child mortality in recent decades (for example: oral rehydration solution to treat diarrhea, vitamin A supplements to fight malnutrition and disease, and lifesaving vaccines). Much of this success was accomplished with generous funding from the United States government.

Working together with developed and developing country partners, we reduced the total number of under-5 deaths worldwide by more than one-third – from 12.4 million per year to 8.1 million – in less than two decades. Yet tragically, 22,000 children still perish each day, mostly from preventable or treatable causes.

In the 1980s and 1990s, it was unthinkable that the United States would not be a leader in this realm. Polls have consistently shown that over 90 percent of Americans believe saving children should be a national priority. Congress and Administrations since the early 1980s have responded to the people's will and appropriated funds that enabled USAID and groups like Save the Children to deliver lifesaving services to millions of children in the poorest countries in the world.

Save the Children's 2011 *State of the World's Mothers* report assembles a distinguished group of "champions for children" to explore the many reasons why we, as a nation, must continue to invest in these lifesaving programs.

U.S. DEVELOPMENT ASSISTANCE HELPS SAVE LIVES



1990 Under-5 mortality rate
% Percent reduction in child mortality, 1990-2009
2009 Under-5 mortality rate
* Countries on track to achieve MDG4

These 15 countries were top recipients of assistance for mothers and children from USAID between 1990 and 2009. On average, these countries cut child mortality by 47 percent during that same time period. Nine of the 15 countries are on track to achieve the United Nations goal of cutting child deaths by two-thirds between 1990 and 2015 or have relatively low rates of child mortality already.

Note: These are the top 15 recipients of USAID funding for maternal and child health and family planning and reproductive health programs between 2000 and 2009. Since 2000, each of these countries received on average more than $10 million per year. Data on funding levels prior to 2000 and for 2005-2006 were not publicly available at the time of this publication, although most of these countries were likely to have been significant recipients of U.S. development assistance in the 1990s as well.

Sources: USAID funding levels by program category: Global Health and Child Survival (and its predecessor, Child Survival and Health Programs Fund) Progress Reports to Congress, 2000-2009: www.usaid.gov/our_work/global_health/home/Publications/pubarchive.html; Under-5 mortality: UNICEF. *The State of the World's Children 2011*. Table 10, pp.126-129; Progress on MDG4: WHO and UNICEF. *Countdown to 2015 Decade Report (2000-2010)*. (Geneva: 2010) Table 1, pp.8-9

Some of the messages may surprise you. For example, the President of Malawi shows that even a very poor country facing daunting health challenges can become a child survival success story by making strategic choices and working effectively with committed international partners. And Professor Peter Singer refutes the common myth that saving children is somehow at odds with protecting the environment.

Some of the solutions that could save the most lives may surprise you too. For example, did you know that a cadre of community-based health workers, given just six weeks of training and a few basic tools, can reduce child mortality by 24 percent or more? Professors Robert Black and Henry Perry from Johns Hopkins University discuss these findings in an essay revealing the great potential of community health workers to save more young lives.

There is no reason why child survival programs should not continue to receive bipartisan support. Former Xerox CEO Anne Mulcahy notes the many ways these programs help build a favorable climate for American businesses. And Col. John Agoglia reminds us that promoting the health of women and children in fragile and emerging nations is still one of the best ways for our nation to make friends and influence people around the world – which is key to America's long-term national security.

Generous American hearts go out to those who were not born into our good fortune. Actor Jennifer Garner tells how her own mother's example inspired her awareness of the critical needs of children around the world. And Rick and Kay Warren of the Saddleback Church describe how partnerships between the U.S. government and the faith-based community have improved the health of mothers and children in countless communities.

Save the Children's annual *Mothers' Index* is a powerful reminder of the many places on earth where mothers and children still need our help. Millions more lives could be saved by expanding our support for basic, low-cost health services and the frontline health workers who deliver lifesaving care. As Congress and the Administration face tough choices about future funding for international programs, let's work together to give the gift too many mothers still want most – the basic health care that will save their child's life.

THE 2011 MOTHERS' INDEX

Norway Tops List, Afghanistan Ranks Last, United States Ranks 31st

Save the Children's twelfth annual *Mothers' Index* compares the well-being of mothers and children in 164 countries – more than in any previous year. The *Mothers' Index* also provides information on an additional eight countries, four of which report sufficient data to present findings on children's indicators. When these are included, the total comes to 172 countries.

Norway, Australia and Iceland top the rankings this year. The top 10 countries, in general, attain very high scores for mothers' and children's health, educational and economic status. Afghanistan ranks last among the 164 countries surveyed. The 10 bottom-ranked countries – eight from sub-Saharan Africa – are a reverse image of the top 10, performing poorly on all indicators. The United States places 31st this year.

Conditions for mothers and their children in the bottom countries are grim. On average, 1 woman in 30 will die from pregnancy-related causes. One child in 6 dies before his or her fifth birthday, and 1 child in 3 suffers from malnutrition. Nearly 50 percent of the population lacks access to safe water and only 4 girls for every 5 boys are enrolled in primary school.

The gap in availability of maternal and child health services is especially dramatic when comparing Norway and Afghanistan. Skilled health personnel are present at virtually every birth in Norway, while only 14 percent of births are attended in Afghanistan. A typical Norwegian woman has 18 years of formal education and will live to be 83 years old; 82 percent are using some modern method of contraception, and only 1 in 175 will lose a child before his or her fifth birthday. At the opposite end of the spectrum, in Afghanistan, a typical woman has fewer than five years of education and will not live to be 45. Less than 16 percent of women are using modern contraception, and 1 child in 5 dies before reaching age 5. At this rate, every mother in Afghanistan is likely to suffer the loss of a child.

Zeroing in on the children's well-being portion of the *Mothers' Index*, Sweden finishes first and Somalia is last out of 168 countries. While nearly every Swedish child – girl and boy alike – enjoys good health and education, children in Somalia face a more than 1 in 6 risk of dying before age 5. Thirty-six percent of Somali children are malnourished and 70 percent lack access to safe water. One in 3 primary-school-aged children in Somalia is enrolled in school, and within that meager enrollment, boys outnumber girls almost 2 to 1.

These statistics go far beyond mere numbers. The human despair and lost opportunities represented in these numbers demand mothers everywhere be given the basic tools they need to break the cycle of poverty and improve the quality of life for themselves, their children, and for generations to come.

See the Appendix for the *Complete Mothers' Index* and *Country Rankings*.

◀ Afghanistan

2011 *MOTHERS' INDEX* RANKINGS

TOP 10 BEST PLACES TO BE A MOTHER		BOTTOM 10 WORST PLACES TO BE A MOTHER	
RANK	COUNTRY	RANK	COUNTRY
1	Norway	**155**	Central African Republic
2	Australia	**156**	Sudan
2	Iceland	**157**	Mali
4	Sweden	**158**	Eritrea
5	Denmark	**159**	DR Congo
6	New Zealand	**160**	Chad
7	Finland	**161**	Yemen
8	Belgium	**162**	Guinea-Bissau
9	Netherlands	**163**	Niger
10	France	**164**	Afghanistan

ANNE M. MULCAHY

A BUSINESS PLAN FOR WOMEN AND CHILDREN IN DEVELOPING COUNTRIES

Anne M. Mulcahy was CEO of Xerox Corp. from 2001-2009, retiring as its board chairman in 2010. She currently serves as chairman of the board of trustees of Save the Children.

When I became CEO of Xerox 10 years ago, the company's situation was dire. Debt was mounting, the stock was sinking and bankers were calling. People urged me to declare bankruptcy, but I felt personally responsible for tens of thousands of employees. I believed together we could put Xerox on solid financial ground.

By the time I stepped down as Xerox's CEO in 2009, and as chairman in January 2010, Xerox had become the vibrant, profitable and revitalized company it still is. What made the difference was a strong turnaround plan, dedicated people and a firm commitment from company leaders. The same smart business approach could transform the global economy – if the investment is targeted at women and children in the developing world.

Whenever an earthquake or tsunami takes thousands of innocent lives, a shocked world talks of little else. I will never forget the wrenching days I spent in Haiti last year for Save the Children just weeks after the earthquake. Such natural disasters rightly bring an outpouring of aid to the ruined families. But every day, 22,000 children under age 5 die in the developing world from treatable and even preventable conditions – principally diarrhea, pneumonia, malaria and complications of childbirth. That's more than 8 million families a year left just as devastated as if an earthquake had struck.

If there's any upside to the horror we recently witnessed in Japan, it's that the country is strong, dedicated and well-prepared to invest and recover. If we could muster the same determination and sense of responsibility that saves a company like Xerox, or a country like Japan, investing to save the women and children now dying in the developing world would be very good business.

First, we know what to do, and it involves low-cost, low-tech programs. When mothers, newborns and children have access to basic health care – skilled attendance before, during and after childbirth; vaccines and inexpensive antibiotics and anti-malarials – millions survive who would otherwise die. When parents are confident their children will live, they have fewer of them, and they invest more in each one's food, health and education. Many children then do better in school and become more prosperous. In turn, they have smaller, healthier families. It is a magic circle.

Second, the return on investment is phenomenal. The Guttmacher Institute estimates that a dollar spent to provide family planning, education and services to low-income women returns four dollars in savings on later health care. The World Bank says keeping a young girl in class raises her adult income by about 9 percent for every year of her schooling. For every year beyond fourth grade that girls attend school, an entire country's wages rise by 20 percent, according to the Women's Learning Partnership. And another recent study shows that mothers put 90 percent of their income into family and community, compared to 30 to 40 percent from men.

Third, it's in our own self-interest. Women in developing countries are the biggest emerging market in the planet's history: they number more than twice the combined populations of India and China. As the global recession eases, most new-income growth will come from

"Today, 10 of the 15 largest importers of American goods and services are countries that graduated from U.S. foreign aid programs. Let's make no mistake, investing in women and children abroad is an investment in our own economic future."

developing countries, and U.S. corporations are increasingly dependent on that fact. Today, 10 of the 15 largest importers of American goods and services are countries that graduated from U.S. foreign aid programs. Let's make no mistake, investing in women and children abroad is an investment in our own economic future. Failure to do so will limit American prosperity.

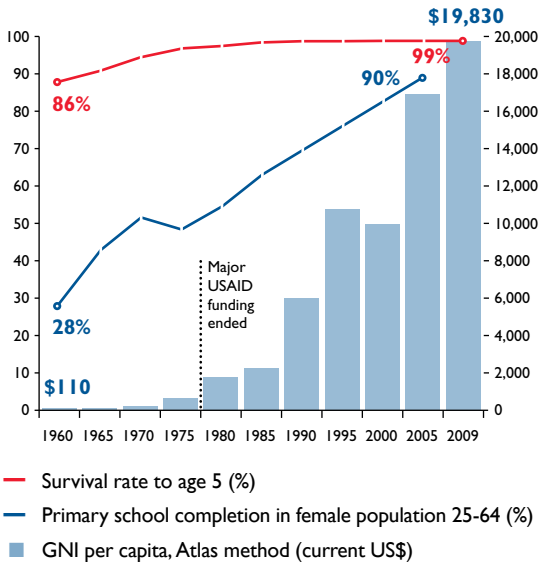
I left Xerox for the nonprofit sector because it was clear to me that only public/private partnerships can pull off a turnaround plan at the scale needed to tackle global poverty. As a businesswoman, I know that economic realities and natural disasters mean we need to make every investment count. I have seen these partnerships work firsthand.

IKEA, one of Save the Children's largest corporate supporters, works with us in countries where they source their products to keep children out of the labor force and in school. Starbucks supports school construction, teacher training and health care in coffee-growing areas from Guatemala to Indonesia. Nike supports girls' education, health care and credit services, and Proctor & Gamble teaches health and sanitation to students in Africa, Pakistan, Nepal and Southeast Asia.

These investments are smart business. When this understanding grows and creates the necessary political will, the lives of women and children in the developing world will change, and ours will too, as economies everywhere reap the benefits.

U.S. INVESTMENTS IN FOREIGN ASSISTANCE PAY OFF

CASE STUDY: SOUTH KOREA



Note: Survival rates are rounded down

In just a few decades, South Korea has been transformed from a major recipient of U.S. assistance to a major market for U.S. goods and services. Investments in health and education built the foundation for South Korea's economic growth. In the early 60s, South Korea was one of the poorest countries in the world, with a per capita GNI on par with that of Chad ($110). In 1960, South Korea was the second largest recipient in the world of U.S. development assistance. Today, South Korea is the United States' seventh largest trading partner, ahead of countries like France and Australia. Similar trends occurred in Hong Kong and Taiwan – both countries once received significant U.S. assistance and today are among the top 15 largest markets for U.S. goods and services.

Sources: World Bank. *GNI per capita, Atlas method (current US$)*: data.worldbank.org; CME Info mortality database: www.childmortality.org; Barro, Robert J. and Jong-Wha Lee, "International Comparisons of Educational Attainment," *NBER Working Paper* No.W4349, 1993. http://go.worldbank.org/HKOH13Y5D0; UNESCO UIS. *Educational Attainment of the Population Aged 25 Years and Older*: stats.uis.unesco.org; US International Trade Commission. *U.S. Trade Balance, by Partner Country 2010*: dataweb.usitc.gov; OECD-QWIDS online database: stats.oecd.org/qwids/.

COL. JOHN AGOGLIA (RET.)

TOWARD REAL U.S. NATIONAL SECURITY

Retired Army Col. John Agoglia served as Director of the Counterinsurgency Training Center-Afghanistan in Kabul from 2008-2010.

The United States military has been fighting in Afghanistan for a decade, but instability there continues to pose a critical threat to our own national security. After leading counterinsurgency training in Afghanistan for over two years, I can assure you – this threat cannot be eradicated by force alone. When communities have little hope for the future, they have little hope for peace.

Sadly, it is not surprising that Afghanistan has yet again been ranked the worst place in the world to be a mother according to Save the Children's annual analysis. It's difficult to build a stable democracy when health, education and opportunity indicators for women and children are at such low levels. Our policymakers must remember: an investment in people that improves their chances to survive and progress is an investment in our national security.

Helping the civilian population has long been a key component of the U.S. national security strategy, because encouraging economic opportunity and optimism in a community is one of the surest defenses against instability and radicalism. In Afghanistan, as elsewhere, that means listening to the concerns of women, who are half the population and affect the development of future generations.

Women in villages where U.S. troops are struggling for a foothold told our Female Engagement Teams of women soldiers that they were furious at the government and constantly anxious. Because of violence, corruption, oppression? No, they feared death in pregnancy or loss of children, families and futures for lack of simple things like midwifery care, diarrhea medicine, antibiotics and soap. As the father of five children, I shared their anger that these simple things were unavailable.

Afghan women have such poor access to health care that one in 11 will die from complications of pregnancy or childbirth compared to the lifetime risk for U.S. women, which is 1 in 2,100. Worldwide, childbirth complications kill a woman every 90 seconds, according to the latest United Nations estimates, and many more suffer illness and disability. More than 3 million newborn babies die each year, too, from preventable and treatable causes.

In Afghanistan, you get a strong sense of the long-term impact of basic solutions. When we brought in medicines and some basic food and health care for those village women, we saw an immediate effect. By saving one sick child or one pregnant woman, we saved a family. Each one then creates a growing community of gratitude and hope. Better health for a woman means more productivity and optimism, which make it more likely her children will go to school. The family income rises, and radical solutions seem less appealing.

These lessons apply around the world, including in Iraq, where I've also served. One Iraqi woman, arrested before the bomb she wore could go off, told investigators her health was bad and her family couldn't afford treatment. They sold her to an extremist who told her that if she couldn't bear children, she could find meaning by blowing herself up.

Where women are valued and fully engaged in their societies, arguments like that don't resonate. Their communities are more self-sufficient and resistant to extremism. As one officer who has served in Afghanistan put it: "The worst nightmare for Al Qaeda is to come

"An investment in people that improves their chances to survive and progress is an investment in our national security."

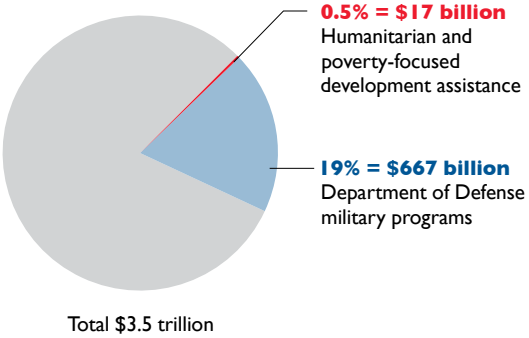
into a community that is supported and has hope." That proud Air Force reservist is also U.S. Senator from South Carolina Lindsey Graham. He is among those valiantly fighting proposed cuts to U.S. foreign assistance.

The United States spent about $667 billion on defense last year, but only $17 billion on humanitarian and poverty-focused development assistance. How much more could we have accomplished if we had invested a lot more – and much earlier – in things like hospitals and schools and midwives and medicine for the women and children of Afghanistan and other developing countries?

Investments in health and education can lead to the long-term transformation of impoverished countries. Just look at South Korea, which in 1953 looked a lot like Afghanistan does now.

In today's harsh economic climate, any proposed investment must have bipartisan support and strong arguments in its favor. Tackling the health and education problems of women and children in the developing world is relatively simple compared to other issues of global peace, and requires no further research or new technology. It is clear these investments change lives and communities to the benefit of us all. We need not wait for war to act.

U.S. GOVERNMENT SPENDING, FY 2010



Total $3.5 trillion

Sources: Office of Management and Budget. *Historical Table 4.1. Outlays by Agency: 1962–2016*. www.whitehouse.gov/omb/budget/Historicals/; InterAction. *Federal Budget Table - FY 2011 CR Extension*. (February 15, 2011) www.interaction.org/document/interaction-federal-budget-table-2011-cr-extension

PROF. BINGU WA MUTHARIKA

MALAWI'S SUCCESS IN REDUCING CHILD MORTALITY

Professor Bingu wa Mutharika is President of the Republic of Malawi.

Malawi is a success story in saving the lives of children under 5. Much of sub-Saharan Africa is not: the United Nations says most African countries will not meet the Millennium Development Goal of reducing child mortality by two-thirds by 2015. Malawi will need further help to achieve this, but we are on track.

What makes us different? Not money. Malawi is a low income country, where the poverty rate has declined but is still unacceptably high at 40 percent of the population. Malawi has learned how to make the most of what we have by focusing on interventions that make the greatest impact while tackling underlying conditions such as malnutrition which continue to cripple the healthy development of children.

Most importantly, Malawi's political leadership is dedicated to the goal of saving mothers' and children's lives. We know that commitment at the highest levels is critical.

The first key change was a "home-grown" policy blueprint that involves Malawians directly in health programs in their communities. With help from many international partners, including the U.S. Agency for International Development, we created policy and project strategies that crossed traditional bureaucratic and regional divisions. We engaged every government level and reached every home.

The second major program was intensified investment in essential health care services and civic education about their use. Fifteen percent of the Ministry of Health budget is now dedicated to children under 5. We trained Health Surveillance Assistants (HSAs) as paramedics to deliver care in rural communities and many places where doctors and nurses are unavailable. Through careful planning, we stress procurement and proper use of essential equipment, drugs and medical supplies for the tasks of every care provider.

With "Child Health Days" we educate Malawians about the health hazards facing infants and children, especially in rural areas, and offer de-worming, vaccinations, insecticide-treated mosquito nets and information about better sanitation habits. Our HSAs are ready and able to treat the biggest threats to children – diarrhea, pneumonia and malaria – and parents know where to go when these diseases strike. We focused on easy wins like immunizing infants against measles, and 81 percent of children under one were vaccinated in 2010, reducing a preventable cause of child death. We have also strengthened the integration of AIDS prevention and treatment into our health services so that seeking care is easier and more common.

While tackling the health system priorities, we worked across sectors to address the need to produce more food that ordinary people could afford, especially in rural areas. We recognized that malnutrition contributes significantly to high child mortality rates, and Malawi has recurrent droughts that devastate harvests so, for the long term, we are investing in an irrigation system to increase food security nationwide. In the short term, we provided supplementary feeding for children, vitamin and micronutrient supplements and other targeted nutrition support for children and pregnant women. Low-birthweight babies have declined from 22 percent of all births in 2004 to 13 percent in 2010 as a result.

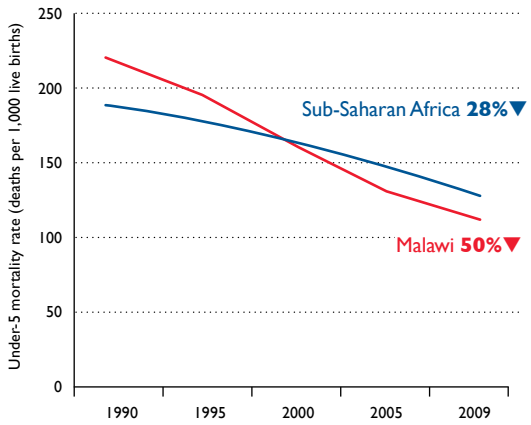
"Our results speak for themselves: the Growth and Development Strategy has helped cut our under-5 death rate by more than half, from 234 deaths per 1,000 live births in 1990 to 112 in 2010. Infant mortality showed the same decline."

Our results speak for themselves: the Growth and Development Strategy has helped cut our under-5 death rate by more than half, from 234 deaths per 1,000 live births in 1990 to 112 in 2010. Infant mortality showed the same decline, from 134 deaths per 1,000 live births in 1992 to only 66 in 2010. We are working towards another 50 percent reduction by 2015, to 32 infant deaths, which will beat our MDG target of 44.

Like all sub-Saharan countries, Malawi still faces formidable barriers. First is the chronic inadequacy of financial and human resources in relation to the need: so much to do and so little done. Second is an inadequate communications system that hampers transmission of health and nutrition data. The cost of health care can be a barrier to reduction in child mortality, and we need to find ways to reduce these costs for the most needy. Despite these challenges, we have made real strides in partnership with the health workers and communities who are increasingly demanding quality services for the health of women and children, and this partnership drives that effort.

The government of Malawi is proud of our progress for children with minimal resources, using good governance and firm commitment. Any country can learn from our experience. But much work remains before we will be satisfied.

MALAWI CUTS CHILD MORTALITY IN HALF, 1990-2009



Even very poor countries can make dramatic reductions in child mortality. Malawi – one of the poorest places in the world – is one of only three countries in sub-Saharan Africa that are on track to achieve the United Nations goal of cutting child mortality by two-thirds by 2015 (Millennium Development Goal 4). From 1990 to 2009, Malawi cut its under-5 mortality rate in half. What is the key to Malawi's success? Strong government commitment and investing in solutions that work.

Sources: WHO and UNICEF. *Countdown to 2015 Decade Report (2000-2010)*. (Geneva: 2010); Inter-agency Group for Child Mortality Estimation Database: www.childmortality.org/; UNICEF. *The State of the World's Children 2011*, Table 10.

ROBERT BLACK & HENRY PERRY

COMMUNITY HEALTH WORKERS: KEY AGENTS FOR SAVING CHILDREN

Robert Black, MD, MPH, (left) and Henry Perry, MD, PhD, MPH, are faculty members in the Department of International Health at the Bloomberg School of Public Health, Johns Hopkins University.

Millions of poor and marginalized families do not get basic health care because it is simply unavailable, too far away, or too expensive. This remains the primary reason why 8 million children under 5 die every year from preventable or treatable causes.

A growing body of evidence shows that community health workers (CHWs) can effectively reach the poorest, sickest children, with the potential to save millions of lives by providing care when and where it's needed most. With initial training of six weeks or less, these workers may serve as volunteers or for modest incentives or salaries. They can be trained to distribute vitamin A capsules and other critical micronutrients; promote sanitation (hand washing, water treatment, safe water storage, latrine construction); distribute mosquito nets to prevent bites at night that spread malaria; diagnose and treat pneumonia, diarrhea, malaria, newborn sepsis and severe malnutrition; and promote healthy behaviors such as breastfeeding, appropriate care of newborns, and immunizations of mothers and children.

There are two areas where CHWs have especially great potential to save lives and reduce overall rates of child mortality around the world: the diagnosis and treatment of childhood pneumonia and the provision of home-based newborn care.

Globally, pneumonia is the leading cause of under-5 mortality, responsible for 18 percent of deaths. An analysis of the combined results of six published studies indicates that the diagnosis and treatment of childhood pneumonia by CHWs can reduce the risk of death by 36 percent in children with this condition, and it can reduce by 24 percent the overall risk of death for all children living in geographic areas where the program exists. Only one-quarter of children in the 68 highest mortality countries (where 97 percent of child deaths occur) currently receive antibiotics when they have symptoms suggestive of pneumonia. CHWs could play a critical role in filling this treatment gap.

Newborns deaths (those that occur during the first 28 days of life) account for 41 percent of all deaths among children under age 5. The major causes of newborn mortality include pre-term birth complications, birth asphyxia and sepsis. In settings where most births take place in the home – because health facilities are not accessible or are not acceptable to the

"We now know that community health workers have the capacity to be the difference between life and death for millions of children. What is needed now is the leadership and political will."

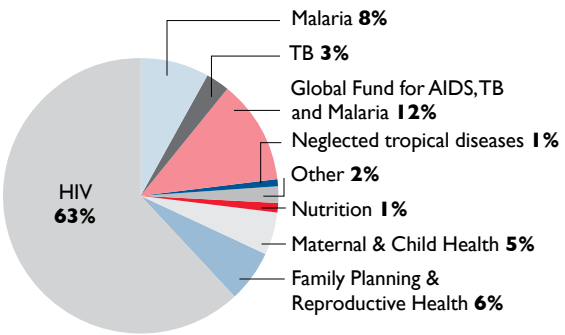
population – community health workers can provide critical services that save lives. CHWs can identify pregnant women and provide them with basic education during prenatal home visits; promote clean delivery; provide essential newborn care; manage birth asphyxia (if they attend the delivery); assist with hygienic care of the umbilical cord; diagnose and refer (or treat if referral is not possible) cases of newborn sepsis; and assist with healthy practices after birth, such as preventing hypothermia, preventing infection and promoting immediate breastfeeding. An analysis of combined results of 18 studies of home-based newborn care provided by CHWs indicates that newborn mortality can be reduced by 24 percent using this approach.

Many countries could benefit from a coordinated global effort to train, equip and supply more community health workers. Recognizing this, UN Secretary-General Ban Ki-moon has called for an additional 1 million CHWs to help close a global shortfall of 3.5 million health workers.

Of course, community health workers cannot do this job alone. They must be supported and supervised by well-managed and adequately resourced health systems. This requires political commitment; professional leadership; practical training and refresher training; and reliable logistical support for basic medicines and supplies. Donor governments and developing country governments need to plan and budget for the increased number of health workers and their support if we hope to achieve the health-related Millennium Development Goals.

The world community has a moral obligation to prevent the needless deaths of children and newborns. The late James Grant, the renowned executive director of UNICEF from 1980 to 1995 and champion of what is often referred to as the First Child Survival Revolution, repeatedly reminded us that "morality must march with capacity." We now know that community health workers have the capacity to be the difference between life and death for millions of children. What is needed now is the leadership and political will to build the health systems and grow the CHW talent pool so children born in remote, impoverished communities will have someone to give them a fighting chance to survive and thrive.

HOW IS U.S. FUNDING FOR GLOBAL HEALTH DISTRIBUTED?



Total $8.9 billion

In fiscal year 2010, the United States government spent 63 percent of its budget for global health on HIV- and AIDS-related efforts. Programs addressing the major killers of children – pneumonia, diarrhea and malaria – received significantly less funding.

Adapted from: Kaiser Family Foundation. *U.S. Global Health Initiative (GHI), Funding by Sector, FY 2009-FY 2012*. facts.kff.org/chart.aspx?ch=1315

PETER SINGER

THE CHILD YOU CAN SAVE

Peter Singer is professor of bioethics at Princeton University and the author of *The Life You Can Save*.

Right now, mothers and their children in developing countries are dying because they can't get safe drinking water, or immunization against common diseases, or basic health care. It doesn't have to be like that. It would not be difficult for us to save them.

If you live in the United States, Canada, Europe, Australia or any other industrialized nation, and are middle class or above, you are almost certainly spending money on things you do not need. Maybe it is something big, like renovating your home, which is adequate but could be nicer. Maybe it is something small, like buying bottled water when safe water flows out of the tap at no charge. Or it could be something in between those two. Whatever it is, the fact that you have more money than you require to satisfy your basic needs means that you have the ability to help mothers and children in extreme poverty. The cost of that bottle of water you buy with so little thought is more than they have to live on for an entire day.

Donating to an organization like Save the Children can help to stop these unnecessary deaths. It doesn't cost all that much, either. Is it worth $1,000 to you to save a child's life? Because that is a rough estimate of what it costs to do that, when you give to an effective organization working to extend immunization, safe water or basic health care to the world's poorest people. Think of what it would mean to you if your child died. Then you will realize how big a difference you can make, to parents and of course to their children as well, for a sum that you could give without making any really serious sacrifice.

I know that there are many different charities seeking your donation. You could give to the arts, to your college, to helping people in need closer to you, or to a thousand other charities. Many of these are, in themselves, worthwhile causes. But more than 8 million children under 5 are dying unnecessarily every year. That's about 22,000 children dying every day! We should think of that as an emergency that takes precedence over things that are merely desirable, like funding for the arts.

In terms of the difference you can make with a modest donation, nothing else comes near an effective organization working against poverty, and to improve the health and living conditions of the world's poorest people. The U.S. Environmental Protection Agency currently sets the value of a human life at $9.1 million. The Food and Drug Administration is in the same ballpark, at $7.9 million. These are the sums that the government is prepared to require corporations to spend to improve health and safety in ways that can be expected to prevent a single American death. Yet in other countries, we could save lives at a tiny fraction of that cost.

Some people think that the underlying problem is population growth: there are just too many people, they say, so saving lives will only make the situation worse. But helping more children to survive doesn't necessarily increase population. Poor parents often have large families so that at least one or two of their children will survive to take care of them in old age. If child survival programs lead parents to see that more of their children survive the early years, when child mortality is highest, they will know that they have enough surviving children to look after them. If the same health care workers who provide their children

"The fact that you have more money than you require to satisfy your basic needs means that you have the ability to help mothers and children in extreme poverty."

with basic health care also offer the parents modern contraception, family size will decline. Reducing poverty also makes it possible for families to send their children to school, and if they do that – sending their daughters as well as their sons – the next generation is likely to have smaller families. So saving the lives of children is good for the children, good for the families, and good for the environment.

Most Americans would help a hungry or sick child in front of them. Tragically, the fact that we cannot see the faces of the children dying in developing countries makes us less likely to help them. This is something that needs to change. We need to develop a culture of giving, in which giving to help those in great need becomes part of our understanding of what it is to live an ethical life.

To promote that change of culture, I've set up a website, www.thelifeyoucansave.com, to which you can go to pledge that you will give a modest percentage of your income to help reduce extreme poverty. You can't donate through the website, but once you have made your pledge, you can go to Save the Children, or to any other effective anti-poverty organization, and make your donation and begin fulfilling your pledge.

Try it. On the website you can also read comments from many people who say that giving makes them feel more fulfilled and content, because they know that they are playing their part in overcoming one of the great ethical challenges of our time.

COUNTRIES WHOSE CITIZENS GIVE THE MOST

RANK	COUNTRY	% OF POPULATION GIVING MONEY
1	Malta	83%
2	Netherlands	77%
3	Thailand	73%
3	United Kingdom	73%
5	Ireland	72%
5	Morocco	72%
7	Switzerland	71%
8	Australia	70%
8	Hong Kong	70%
10	Austria	69%
11	New Zealand	68%
12	Denmark	67%
12	Iceland	67%
14	Canada	64%
14	Lao PDR	64%
14	Qatar	64%
17	Italy	62%
18	USA	60%
19	Luxembourg	58%
19	Sri Lanka	58%
21	Sweden	52%
22	Israel	51%
23	Germany	49%
24	Chile	48%
25	Guatemala	46%

The level of giving in a country indicates something about the strength of its civil society – the extent to which individuals are willing and able to contribute towards addressing the needs of others both at home and abroad. The percentage of population giving money is defined as the proportion of the public that had, in the month prior to the survey, given financial donations to a charity/organization.

Analysis of data from: Charities Aid Foundation. *The World Giving Index 2010.*

RICK & KAY WARREN

A PURPOSE-DRIVEN MOVEMENT TO SAVE MOTHERS AND CHILDREN

Rick and Kay Warren began Saddleback Church in the living room of their condominium in 1980. Today, it is the eighth largest church in the United States, with 20,000 in attendance each week. Rick is the New York Times bestselling author of *The Purpose-Driven Life*, which has sold over 30 million copies. Kay is the author of *Say Yes to God*, a detailed account of her work as an advocate for men, women and children who are HIV positive. The Warrens have three children and four grandchildren.

We believe God designed all of us to make a difference in this world and to make an impact with our lives. There's only one way to do that: by serving others. That's why we're joining with Save the Children's See Where the Good Goes campaign to take action for mothers and children around the world who need our help.

Through Saddleback Church's PEACE Plan, we have visited some of the world's poorest, most remote villages. Most have no clinics, no doctors or health workers of any kind, but they have a church. What would happen if we could mobilize all people of faith to take on world poverty and disease – not just with words, but with action?

The Bible says "Those who shut their ears to the cries of the poor will be ignored in their own time of need" (Proverbs 21:13). It also says that our responsibility as leaders is to "Speak up for those who cannot speak for themselves, for the rights of all who are destitute" (Proverbs 31:8).

We share the vision of Save the Children and our other partners who work every day on the front lines to reduce child mortality, improve maternal health and combat HIV/AIDS, malaria and other diseases. We know that every four seconds a mother in the developing world loses her child, largely to preventable and treatable causes like pneumonia, measles, diarrhea or complications of pregnancy and childbirth.

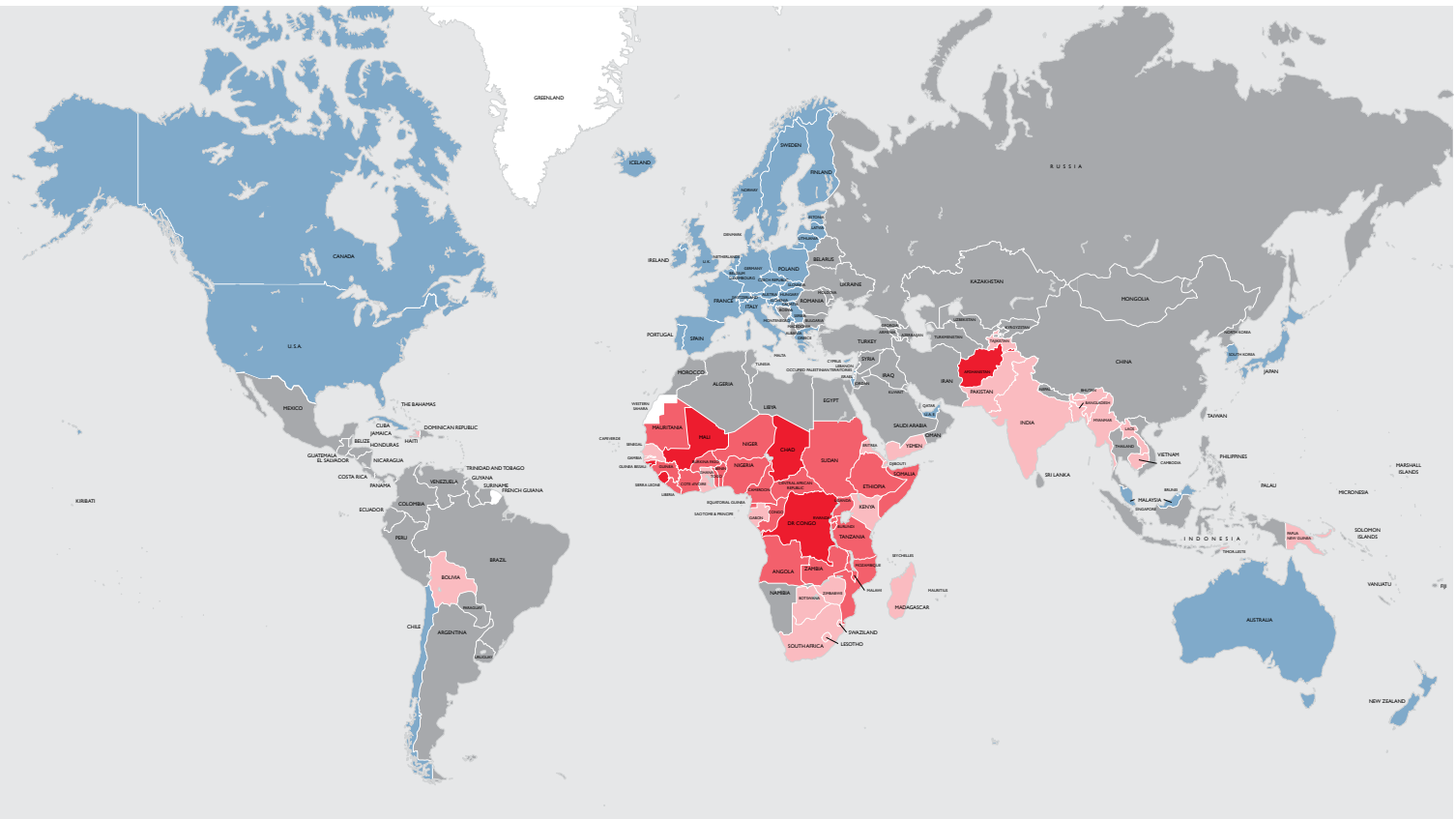
Proven, cost-effective solutions exist that can save most of these lives for just a few dollars a day. We just need the resources and the will to reach the families who need our help. Those resources come from generous individuals and are matched by investments by the U.S. government and other donor nations around the world. That partnership is making a difference as thousands more children each day survive the risky first five years of life thanks to health workers and clinics put in place by people with a purpose.

So while it might seem a daunting challenge, God never asks us to do anything without giving us the ability to do it. People of faith need to go global to take on this fight. At Saddleback, we have invested in putting the skills into the hands of local people who can make the difference in their own communities through our PEACE plan. In Rwanda for example, churches and mosques nominated 2,400 volunteers to be trained in basic health care and counseling. These purpose-filled community development volunteers took on a group of families to support, making 30,000 house calls each year! We have no doubt that small investments from donors coupled with community members empowered with knowledge, faith and determination to serve will improve health and reduce the suffering of those infected with HIV in this part of Rwanda.

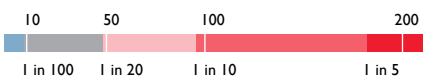
And it really is that simple – combine efforts of governments here and there, and citizens here and there, and we can do extraordinary things. Yet it only requires ordinary people with hearts willing to serve, people who want to make a difference in the world. All we need is to move from thinking "they" will do it to thinking "we" can do it. Now is the time for ordinary people empowered to make a difference together.

"Proven, cost-effective solutions exist that can save most of these lives for just a few dollars a day. People of faith need to go global to take on this fight."

WHERE DO CHILDREN FACE THE GREATEST RISK OF DEATH?



Under-5 mortality rate (deaths per 1,000 live births)



Risk of child death (1 in x)

Children in sub-Saharan Africa and Afghanistan have the highest risk of death in the world. Countries on the map are classified by a child's risk of death before reaching age 5 (expressed as 1 in x), rounded to the nearest whole number.

Calculations based on UNICEF under-5 mortality estimates.
Source: *The State of the World's Children 2011*, Table 1, pp.88-91.

DONALD PAYNE

LET'S CONTINUE TO INVEST IN AFRICA'S PROGRESS

Congressman Donald Payne represents New Jersey's 10th Congressional District. He is Ranking Member of the Subcommittee on Africa, Global Health and Human Rights.

Sometimes the American political system seems stuck in gridlock with Congress unable or unwilling to find the common ground that unites us and allows us to move forward on critical issues. But this shouldn't be the case on issues that represent our core American values – specifically our generosity as a nation and our concern for the welfare of children around the world. Over my 22 years in Congress, programs that support child survival globally have enjoyed bipartisan support and have saved millions of young lives worldwide. We must maintain that successful effort now, despite the hard choices we face in this tough fiscal environment.

I know first-hand that helping a kid at the right moment in life is crucial. My mother died when I was 8; my father was working long shifts on the Newark dockyards doing his part to respond to World War II. Growing up in a tough environment, the local Boys Club provided afterschool and Saturday activities that benefitted me and other kids. As I grew older, the Leaguers community group was formed to encourage inner city youth to go to college and become leaders in our communities. If it weren't for those important community programs, I would never have tried for and won the life-changing scholarship that helped me as I worked my way through college.

I have seen even more basic assistance work similar miracles for children around the world, especially in my travels in Africa. Every day, more than 22,000 children under the age of 5 die, mostly in developing countries and half of them in Africa. This loss in little lives is not only heartbreaking; it destabilizes families, which undermines societies. It is no coincidence that countries at the bottom of Save the Children's annual rankings of the world's best and worst places to be a child or a mother are also some of the world's most troubled and unstable nations: Afghanistan, Democratic Republic of the Congo, Niger, Somalia.

In DR Congo, for example, where child and maternal mortality rates are among the world's highest, one in every five babies will not live to see their fifth birthday. What's worse, most of these children die from conditions that are easily preventable or treatable: diarrhea, pneumonia and other infections, malaria, and diseases that occur only when children lack access to vaccines we take for granted in the United States.

Such losses are unacceptable. We know how to save these children with off-the-shelf cost-effective measures, and where we take action we see major successes. For example, President George W. Bush's best legacy is arguably PEPFAR, the President's Emergency Program for AIDS Relief, through which Congress last year sent $5.5 billion worth of medicines, training and equipment to 60 countries to combat the HIV/AIDS pandemic that is ravaging Africa. The continent has nearly 15 million AIDS orphans, but PEPFAR is providing drugs and treatments that keep people alive and prevent mother-to-child HIV transmission. These programs supported by the U.S. and other donor governments now have helped reach over 40 percent of those who have tested positive for HIV and sought treatment.

The U.S. Agency for International Development provides assistance to 47 countries in Africa. This includes maternal and child health

programs, PEPFAR, the President's Malaria Initiative and the Africa Education Initiative, which supports teacher training, textbooks and scholarships for children. Other USG-funded projects bring water and sanitation development, family planning and immunizations, school construction and scholarship support.

Millions of children are alive and thriving today because of these programs. Worldwide, an estimated 2.5 million children under 5 are saved each year as a result of immunization for vaccine-preventable diseases. In sub-Saharan Africa, two decades of improvements in health, education and incomes have saved the lives of an estimated 7 million children since 2005.

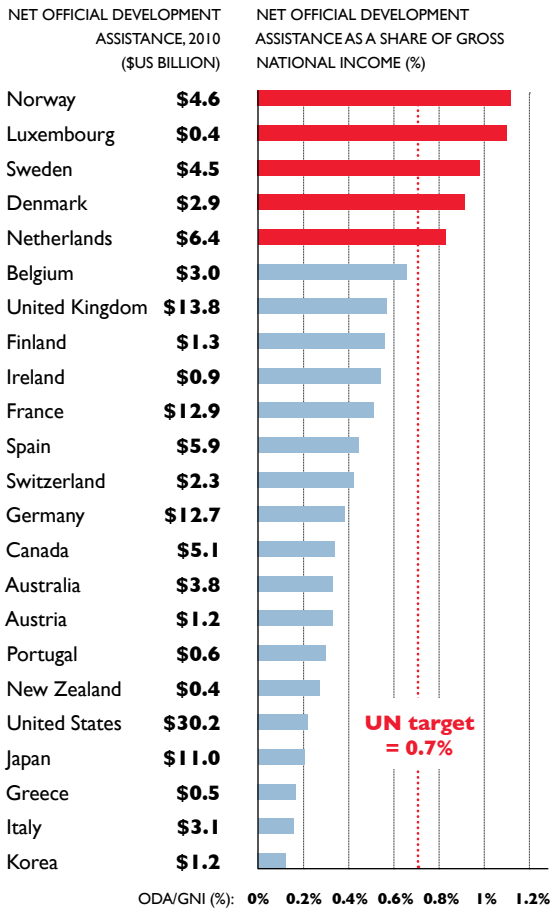
"Where health and education levels rise, democracy and good governance grow."

Where health and education levels rise, democracy and good governance grow. Ghana, for example has made remarkable progress in improving the health and well-being of its mothers and children. Between 1990 and 2009, Ghana cut its under-5 mortality rate by 43 percent. It also halved the number of people who are undernourished as well as those living in poverty. Ghana is on track to meet international targets for near universal primary school enrollment, and over the past 10 years it has added three years to the average length of schooling for girls. Ghana also earns consistently high marks on government effectiveness, political stability, civil freedoms and fighting corruption.

Taking care of children is a fundamental American value. And we know what works. But even with so much accomplished in recent decades, much remains to be done, and we have not yet invested what's necessary to meet the need. Meanwhile, current economic pressures threaten our progress. Polls show that most Americans think we spend a quarter of our budget on foreign aid, and think 10 percent would be about right. But the reality is that foreign aid spending is less than six-tenths of 1 percent of the U.S. budget. We should spend more, not less, to save children's lives. Hard economic decisions are necessary, but they must not endanger child survival.

Because of our bipartisan commitment, millions of children who would have died in the past are alive and healthy today, going to school, growing up to support their families and beginning to contribute to their societies. U.S. leadership in saving children's lives is one of our greatest success stories and proudest achievements. It would be a terrible mistake to risk the progress we have made by slowing the investment now.

THE U.S. GIVES MOST OVERALL, BUT RANKS 19TH RELATIVE TO NATIONAL WEALTH



Assistance flows from OECD Development Assistance Committee (DAC) donor countries totaled $129 billion in 2010, the highest level ever, and an increase of 6.5 percent over 2009. This represents about 0.32 percent of the combined gross national income (GNI) of DAC member countries. While the 2010 figures demonstrate a commitment to the neediest countries, they also confirm that some donors are not meeting targets they set in 2005. The United Nations has set a target contribution rate of 0.7 percent, and the average country effort in 2010 was 0.49 percent. Eighteen of these 23 countries fall short of this target. The United States spends over $30 billion a year in development assistance – more than twice the amount of any other donor country. But even though the U.S. gives the most in absolute terms, compared to some other wealthy countries, the U.S. spends considerably less on foreign aid relative to its national wealth. The best way to measure aid generosity is to look at it as a percentage of GNI. Measured this way, United States is among the least generous of countries, with only 0.2 percent of its GNI going toward foreign assistance. The most generous countries – Denmark, the Netherlands, Norway, Sweden and Luxembourg – give 0.8 to 1.1 percent of GNI to development assistance.

Source: OECD. www.oecd.org/dac/stats/analyses

JANE McCASLAND

GETTING MOTHERS EVERYWHERE THE GIFT THEY WANT MOST

Jane McCasland is a happily married mother of two living in Midlothian, Texas. Jane and her 16-year-old daughter Kate participated in Save the Children's advocacy day in Washington, DC earlier this year.

I won't lie, I love getting homemade cards from my kids, and flowers from my husband. But every mom knows, the best Mother's Day gift is healthy and happy children. More of us than you might expect have come close to losing that chance.

I was not your typical mother of a micro-preemie baby. I was 32, well-educated, and had top-flight prenatal care at Harris Methodist Hospital in Fort Worth. But in a matter of 24 hours they almost lost me and my firstborn.

Kate was born 15 weeks early and she weighed less than 1 pound 7 ounces. She was 12 inches long, about the size of a Barbie doll. She spent 112 days in the neonatal intensive care unit, and most of that was on the critical list.

It was a terrifying and very dark time. The child you've always wanted is suddenly here, and then she's struggling for life. You beat yourself up. What could I do differently? What did I do wrong? But real quickly you come to realize that doesn't matter, what matters is keeping your kid here.

More than 3 million moms lose that battle every year and watch their newborn baby die. What could be worse than that? I'll tell you what: most of these deaths are totally preventable. Too many mothers don't have access to the very basic health care and skilled attendance at birth that can make all the difference.

So, 16 years after our ordeal, my daughter and I have joined the movement to preserve U.S. funding for maternal and child health programs in developing countries, where the vast majority of these deaths occur. Our country's leadership has helped slash child mortality rates in some of the poorest places on earth. We shouldn't cut that progress short now.

We recently took that message to Washington, DC, as part of an advocacy day organized by Save the Children. Kate got to share her personal story with lawmakers, and we both got a kick out of the shocked and amazed looks on their faces that she survived all she did.

The irony is that what saved Kate is a simple technique that works well in poor countries where access to technology – like reliable incubators – is difficult to maintain. I found out about kangaroo mother care during the early weeks of Kate's hospital stay, after coming home to another sleepless night.

Channel surfing the TV, I came across a mom in Africa wrapping her itty bitty baby to her chest. It turns out this simple act can save lives because skin-to-skin contact and easy access to breastfeeding give premature babies the warmth and nutrition they need to grow bigger and stronger.

My husband and I had to argue with the doctors to give it a try, but one night a nurse trained in kangaroo care told me that Kate was having a bad night and now was the time. When the doctors saw her weight gain the next day, they gave in, and I started kangarooing Kate regularly. I'm sure it made the difference between Kate making it or not.

We got lucky. I've had a ringside seat to watch my daughter develop into one of the most amazing people I've ever known. She's smart, goofy, fun, resilient and has a really cool attitude about life. A big part of that is about giving back.

At age 11, Kate knitted 112 caps like the ones that helped keep her warm in those early days – one for each day she was in intensive

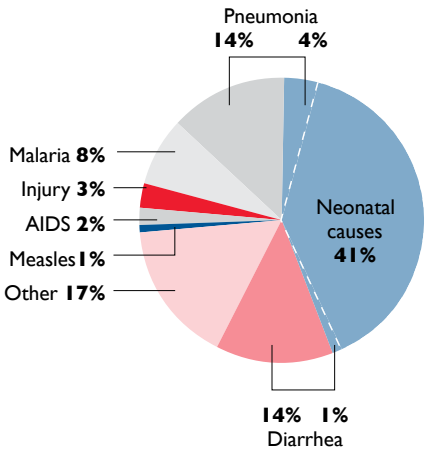
"The irony is that what saved Kate is a simple technique that works well in poor countries where access to technology – like reliable incubators – is difficult to maintain."

care. She went on to organize senior citizens to help the cause, and together they now supply nine Texas hospitals with caps for preemies.

This year Kate also gave 1,600 baby caps to Save the Children to help moms learning kangaroo care in Guatemala, Vietnam and Ethiopia. Then she asked lawmakers to do what they can, too. I was so proud. Kate is living proof that saving one life can help many more.

We made the trip to DC for kids like Kate and moms like me. It doesn't matter if you're here or in an African country, if you have every privilege or have nothing. You're a mom and you want the best for your children. You want happiness and you want survival. By speaking up for moms everywhere, we can all help deliver those gifts.

WHY DO YOUNG CHILDREN DIE?



Estimates for 2008 show that pneumonia, diarrhea and malaria remain the leading killers of children under 5 worldwide. Together they account for 41 percent of child deaths. More than 40 percent of all under-5 deaths occur in the first month of life. Most of these children could be saved by increasing coverage for known, affordable and effective interventions. Ensuring proper nutrition is a critical aspect of prevention, since malnutrition contributes to more than a third of all child deaths.

Source: Adapted from Robert E. Black et al. "Global, Regional, and National Causes of Child Mortality in 2008: A Systematic Analysis." *The Lancet.* Volume 375, Issue 9730. pp.1969-1987. June 5, 2010

JENNIFER GARNER

THE EARLY YEARS LAST A LIFETIME

Jennifer Garner is an actor, mother and artist ambassador for Save the Children's U.S. Programs.

My mother, Pat, grew up during the Depression and to say her family was poor would be an understatement. Still, you wouldn't know it hearing her talk about that part of her life. She remembers her family playing games, singing songs and reciting poetry, and my mom had an exceptional teacher who lit her up when it came to learning.

My mom was the only one in her family to graduate from college and she put herself through school working in the cafeteria. She went on to lead a very adventurous, and she would say exceptional, life.

Growing up in West Virginia, I witnessed a different kind of poverty, a more difficult kind of poverty. It was a more resigned-to-helplessness that permeated the forgotten communities in the mountains. It's the kind of poverty that we often associate with other parts of the globe.

It was thinking about this gap between my mother's hopeful, forward-looking childhood and the quiet acceptance I saw in kids a town or two away from mine that led me to work on issues affecting the youngest children and their moms.

We all love our kids and we all want to do a good job. It doesn't take money to be a good mother, but it does take someone showing you what to do. We simply aren't born with that knowledge.

That's why investing in our kids during the earliest years also means we need to make sure that their moms are prepared to motivate, read to, and raise their children. And it goes without saying that moms themselves need to be healthy and strong.

Educated and healthy kids and moms means tackling the worldwide crisis around maternal health, including in the United States.

Complications during pregnancy and at birth cause the deaths of more than 1,000 mothers and 3,000 babies every year here at home, often because struggling moms aren't getting the right care for conditions like diabetes, obesity and high blood pressure. Making sure all kids get the proper vaccines early in life would reduce preventable deaths among children as well.

Around the world, more than 350,000 women die each year from complications of pregnancy and childbirth, and millions more develop some kind of disability. When a mother dies, her children are much more likely to be poor, to drop out of school, and to die before age 5.

Simple and inexpensive solutions that are often taken for granted in the United States could save most of those women and their babies, starting with basic medical care before, during and after delivery.

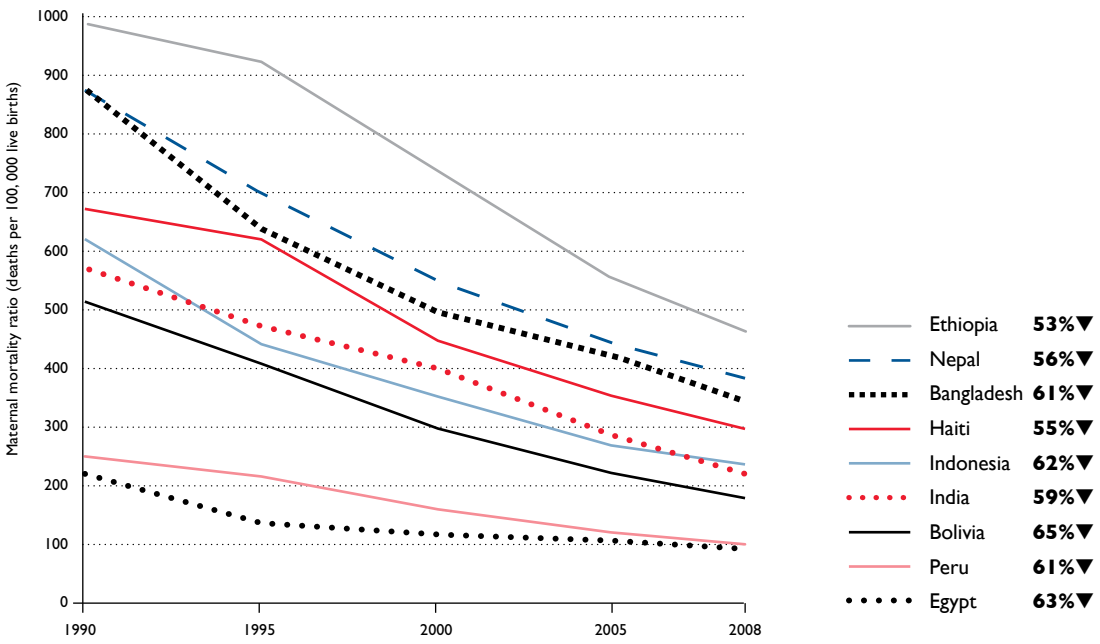
Making sure that moms are healthy and ready to be great moms will mean a generation of children in the United States and throughout the world who are ready to learn, lead and do great things. But we need to make sure this happens.

To me, everything comes back to our will as people. Education is an investment in everything that touches our lives, and we can't educate kids if they and their moms don't have basic, quality health care.

If we invest fully in all kids from cradle to cap and gown, there is no question we will have the kind of nation and world we wish to have.

"Around the world, more than 350,000 women die each year from complications of pregnancy and childbirth. When a mother dies, her children are much more likely to be poor, to drop out of school, and to die before age 5."

SUCCESS IN REDUCING MATERNAL MORTALITY IN TOP USAID-ASSISTED COUNTRIES, 1990-2009



These nine countries were among the top 15 recipients of assistance for mothers and children from USAID between 2000 and 2009. On average, these countries cut maternal mortality by 59 percent from 1990 to 2009.

Note: These are nine of the top 15 countries that received the most funds for USAID-supported maternal and child health and family planning and reproductive health programs from 2000-2009. Data on funding levels prior to 2000 and for 2005-2006 were not publicly available at the time of this publication, although most of these countries were likely to be significant recipients of U.S. development assistance in the 1990s as well.

Sources: Global Health and Child Survival (and its predecessor, Child Survival and Health Programs Fund) Progress Reports to Congress 2000-2009: www.usaid.gov/our_work/global_health/home/Publications/pubarchive.html; Maternal mortality rates: WHO. *Trends in Maternal Mortality: 1990 to 2008*. (Geneva: 2010) Annex 3.

TAKE ACTION NOW
TO SAVE MOTHERS' AND CHILDREN'S LIVES

Every year, more than 8 million children die before reaching age 5. Most of these lives could be saved by expanding support for basic, low-cost health services and the frontline health workers who deliver lifesaving care.

- U.S. citizens should urge Congress and the Administration to dramatically increase funding for maternal and child health programs in developing countries, including the training and support of frontline health workers. Visit www.savethechildren.org/action-center to send a letter to policymakers.
- Citizens everywhere should urge world leaders to fulfill the commitments their governments made to the achievement of the United Nations' Millennium Development Goals (MDGs) 4 and 5.
- Donor countries and international agencies must keep their funding commitments to achieving MDGs 4 and 5. Additionally, those countries and partners who haven't yet pledged must act to make substantial political and financial commitments to accelerate progress to achieve these goals.
- Developing country governments must commit to better support existing health workers and recruit, train, equip and support the additional health workers needed to deliver lifesaving services to mothers, newborns and young children.
- Fund health worker training at: goodgoes.org/take-action/give

Help us save the lives of mothers, children and babies around the world. To learn more about Save the Children's newborn and child survival campaign and join the movement, visit: goodgoes.org and savethechildren.net

◀ Mali India ▶

APPENDIX: THE MOTHERS' INDEX AND COUNTRY RANKINGS

The twelfth annual *Mothers' Index* helps document conditions for mothers and children in 164 countries – 43 developed nations and 121 in the developing world – and shows where mothers fare best and where they face the greatest hardships. All countries for which sufficient data are available are included in the *Index*.

Why should Save the Children be so concerned with mothers? Because more than 75 years of field experience have taught us that the quality of children's lives depends on the health, security and well-being of their mothers. In short, providing mothers with access to education, economic opportunities and maternal and child health care gives mothers and their children the best chance to survive and thrive.

The *Index* relies on information published by governments, research institutions and international agencies. *The Complete Mothers' Index*, based on a composite of separate indices for women's and children's well-being, appears in the fold-out table in this appendix. A full description of the research methodology and individual indicators appears after the fold-out.

Mothers' Index Rankings

European countries – along with Australia and New Zealand – dominate the top positions while countries in sub-Saharan Africa dominate the lowest tier. The United States places 31st this year.

While most industrialized countries cluster tightly at the top of the *Index* – with the majority of these countries performing well on all indicators – the highest ranking countries attain very high scores for mothers' and children's health, educational and economic status.

The top 10 countries this year are (from 1 to 10): Norway, Australia and Iceland (tied), Sweden, Denmark, New Zealand, Finland, Belgium, Netherlands and France.

The bottom 10 countries are (from 155 to 164): Central African Republic, Sudan, Mali, Eritrea, Democratic Republic of the Congo, Chad, Yemen, Guinea-Bissau, Niger and Afghanistan.

The 10 bottom-ranked countries in this year's *Mothers' Index* are a reverse image of the top 10, performing poorly on all indicators. Conditions for mothers and their children in these countries are devastating.

- Over half of all births are not attended by skilled health personnel.
- On average, 1 woman in 30 dies from pregnancy-related causes.
- 1 child in 6 dies before his or her fifth birthday.
- 1 child in 3 suffers from malnutrition.
- 1 child in 7 is not enrolled in primary school.
- Only 4 girls are enrolled in primary school for every 5 boys.
- On average, females have fewer than 6 years of formal education.
- Women earn only 40 percent of what men do.
- 9 out of 10 women are likely to suffer the loss of a child in their lifetime.

The contrast between the top-ranked country, Norway, and the lowest-ranked country, Afghanistan, is striking. Skilled health personnel are present at virtually every birth in Norway, while only 14 percent of births are attended in Afghanistan. A typical Norwegian woman has 18 years of formal education and will live to be 83 years old, 82 percent are using some modern method of contraception, and only one in 175 will lose a child before his or her fifth birthday. At the opposite end of the spectrum, in Afghanistan, a typical woman has fewer than 5 years of education and doesn't live to be 45. Less than 16 percent of women are using modern contraception, and 1 child in 5 dies before reaching age 5. At this rate, every mother in Afghanistan is likely to suffer the loss of a child.

The data collected for the *Mothers' Index* document the tremendous gaps between rich and poor countries and the urgent need to accelerate progress in the health and well-being of mothers and their children. The data also highlight the regional dimension of this tragedy. Eight of the bottom 10 countries are in sub-Saharan Africa. Sub-Saharan Africa also accounts for 18 of the 20 lowest-ranking countries.

WHAT THE NUMBERS DON'T TELL YOU

The national-level data presented in the *Mothers' Index* provide an overview of many countries. However, it is important to remember that the condition of geographic or ethnic sub-groups in a country may vary greatly from the national average. Remote rural areas tend to have fewer services and more dire statistics. War, violence and lawlessness also do great harm to the well-being of mothers and children, and often affect certain segments of the population disproportionately. These details are hidden when only broad national-level data are available.

◀ Mali

Individual country comparisons are especially startling when one considers the human suffering behind the statistics:

- Fewer than 15 percent of births are attended by skilled health personnel in Chad and Afghanistan. In Ethiopia, only 6 percent of births are attended. Compare that to 99 percent in Sri Lanka and 95 percent in Botswana.
- 1 woman in 11 dies in pregnancy or childbirth in Afghanistan. The risk is 1 in 14 in Chad and Somalia. In Italy and Ireland, the risk of maternal death is less than 1 in 15,000 and in Greece it's 1 in 31,800.
- A typical woman will die before the age of 50 in Central African Republic, Democratic Republic of the Congo, Mali, Mozambique, Nigeria, Sierra Leone, Zambia and Zimbabwe. Life expectancy for women is only 46 in Lesotho and Swaziland. In Afghanistan, the average woman does not live to see her 45th birthday while in Japan women on average live to almost 87 years old.
- In Somalia, only 1 percent of women use modern contraception. Rates are less than 5 percent in Angola, Chad and Guinea. And fewer than 1 in 10 women use modern contraception in 15 other developing countries. By contrast, 80 percent or more of women in China, Norway, Thailand and the United Kingdom use some form of modern contraception.
- In Afghanistan, Jordan, Lebanon, Libya, Morocco, Oman, Pakistan, Syria and Yemen women earn 25 cents or less for every dollar men earn. Saudi and Palestinian women earn only 16 and 12 cents respectively to the male dollar. In Mongolia, women earn 87 cents for every dollar men earn and in Mozambique they earn 90.
- In Qatar, Saudi Arabia and the Solomon Islands, not one seat in parliament is occupied by a woman. In Comoros and Papua New Guinea women have only 1 seat. Compare that to Rwanda, where over half of all seats are held by women.
- A typical female in Afghanistan, Angola, Djibouti, Eritrea and Guinea-Bissau receives fewer than 5 years of formal education. In Niger, it's fewer than 4 years and in Somalia, women receive less than 2 years of education. In Australia and New Zealand, the average woman stays in school for over 20 years.
- In Somalia, 2 out of 3 children are *not* enrolled in primary school. More than half (52 percent) of all children in Eritrea are not in school. In Djibouti and Papua New Guinea out-of-school rates are 45 percent. In comparison, nearly all children France, Italy, Spain and Sweden make it from preschool all the way to high school.
- In Central African Republic and Chad, 7 girls for every 10 boys are enrolled in primary school. In Afghanistan and Guinea-Bissau, it's 2 girls for every 3 boys. And in Somalia, boys outnumber girls by almost 2 to 1.
- 1 child in 5 does not reach his or her fifth birthday in Afghanistan, Chad and Democratic Republic of the Congo. In Finland, Greece, Iceland, Japan, Luxembourg, Norway, Singapore, Slovenia and Sweden, only 1 child in 333 dies before age 5.
- Over 40 percent of children under age 5 suffer from malnutrition in Bangladesh, Madagascar, Nepal, Niger and Yemen. In India and Timor-Leste, nearly half of all young children are moderately or severely underweight.
- More than half of the population of Afghanistan, DR Congo, Equatorial Guinea, Ethiopia, Fiji, Madagascar, Mauritania, Mozambique, Niger, Papua New Guinea and Sierra Leone lacks access to safe drinking water. In Somalia, 70 percent of people lack access to safe water.

Statistics are far more than numbers. It is the human despair and lost opportunities behind these numbers that call for changes to ensure that mothers everywhere have the basic tools they need to break the cycle of poverty and improve the quality of life for themselves, their children, and for generations to come.

Sierra Leone ►

Why doesn't the United States do better in the rankings?

The United States ranked 31st this year based on several factors:

- One of the key indicators used to calculate well-being for mothers is lifetime risk of maternal mortality. The United States' rate for maternal mortality is 1 in 2,100 – the highest of any industrialized nation. In fact, only three Tier I developed countries – Albania, the Russian Federation and Moldova – performed worse than the United States on this indicator. A woman in the U.S. is more than 7 times as likely as a woman in Italy or Ireland to die from pregnancy-related causes and her risk of maternal death is 15-fold that of a woman in Greece.
- Similarly, the United States does not do as well as most other developed countries with regard to under-5 mortality. The U.S. under-5 mortality rate is 8 per 1,000 births. This is on par with rates in Latvia. Forty countries performed better than the U.S. on this indicator. At this rate, a child in the U.S. is more than twice as likely as a child in Finland, Greece, Iceland, Japan, Luxembourg, Norway, Slovenia, Singapore or Sweden to die before reaching age 5.
- Only 58 percent of children in the United States are enrolled in preschool – making it the fifth lowest country in the developed world on this indicator.
- The United States has the least generous maternity leave policy – both in terms of duration and percent of wages paid – of any wealthy nation.
- The United States is also lagging behind with regard to the political status of women. Only 17 percent of congressional seats are held by women, compared to 45 percent in Sweden and 43 percent in Iceland.

Why is Norway number one?

Norway generally performed as well as or better than other countries in the rankings on all indicators. It has the highest ratio of female-to-male earned income, the highest contraceptive prevalence rate, one of the lowest under-5 mortality rates and one of the most generous maternity leave policies in the developed world.

Why is Afghanistan last?

Afghanistan has the highest lifetime risk of maternal mortality and the lowest female life expectancy in the world. It also places second to last on skilled attendance at birth, under-5 mortality and gender disparity in primary education. Performance on most other indicators also places Afghanistan among the lowest-ranking countries in the world.

Why are some countries not included in the Mothers' Index?

Rankings were based on a country's performance with respect to a defined set of indicators related primarily to health, nutrition, education, economic and political status. There were 164 countries for which published information regarding performance on these indicators existed. All 164 were included in the study. The only basis for excluding countries was insufficient or unavailable data or national populations below 250,000.

What should be done to bridge the divide between countries that meet the needs of their mothers and those that don't?

- Governments and international agencies need to increase funding to improve education levels for women and girls, provide access to maternal and child health care and advance women's economic opportunities.
- The international community also needs to improve current research and conduct new studies that focus specifically on mothers' and children's well-being.
- In the United States and other industrialized nations, governments and communities need to work together to improve education and health care for disadvantaged mothers and children.

2011 MOTHERS' INDEX RANKINGS

COUNTRY	MOTHERS' INDEX RANK*	WOMEN'S INDEX RANK**	CHILDREN'S INDEX RANK***
TIER I: MORE DEVELOPED COUNTRIES			
Norway	1	2	7
Australia	2	1	30
Iceland	2	5	7
Sweden	4	7	1
Denmark	5	4	20
New Zealand	6	3	26
Finland	7	6	19
Belgium	8	9	15
Netherlands	9	8	21
France	10	12	6
Germany	11	15	4
Spain	12	13	12
United Kingdom	13	10	23
Portugal	14	16	13
Switzerland	14	19	9
Ireland	16	11	29
Slovenia	16	17	11
Estonia	18	17	17
Greece	19	21	14
Canada	20	14	24
Italy	21	25	2
Hungary	22	21	22
Lithuania	22	20	25
Czech Republic	24	27	16
Latvia	24	23	26
Austria	26	33	5
Croatia	27	26	32
Japan	28	34	2
Poland	28	28	31
Slovakia	28	29	28
United States	31	24	34
Luxembourg	32	35	10
Belarus	33	29	33
Malta	34	41	18
Bulgaria	35	32	36
Romania	36	31	38
Serbia	37	37	35
Russian Federation	38	35	39
Ukraine	39	39	37
Moldova, Republic of	40	40	40
Bosnia and Herzegovina	41	37	42
Macedonia, TFYR	42	42	41
Albania	43	43	43
TIER II: LESS DEVELOPED COUNTRIES			
Cuba	1	1	9
Israel	2	2	3
Cyprus	3	3	1
Argentina	4	6	15
Barbados	5	5	3
Korea, Republic of	5	6	2
Uruguay	7	8	9
Kazakhstan	8	9	21
Mongolia	9	4	52
Bahamas	10	14	6
Colombia	11	10	34
Brazil	12	13	12
Costa Rica	13	22	13
Ecuador	14	12	35
Jamaica	15	14	27
Chile	16	23	5
Bahrain	17	18	22
China	18	11	43
South Africa	19	17	53
Thailand	20	20	31
Peru	21	20	42
Venezuela, Bolivarian Republic of	21	18	36
Mexico	23	29	19
Dominican Republic	24	23	40
Panama	25	25	38
Trinidad and Tobago	25	34	29
Uzbekistan	25	26	40
Kyrgyzstan	28	30	37
Tunisia	28	38	17
Armenia	30	36	16
Bolivia, Plurinational State of	30	26	51
Mauritius	32	34	30
Paraguay	33	30	39
Vietnam	34	26	55
Kuwait	35	37	23
Malaysia	36	44	23
United Arab Emirates	36	52	19
Iran, Islamic Republic of	38	41	28
Qatar	38	49	11

COUNTRY	MOTHERS' INDEX RANK*	WOMEN'S INDEX RANK**	CHILDREN'S INDEX RANK***
TIER II: LESS DEVELOPED COUNTRIES (*CONTINUED*)			
El Salvador	40	39	49
Belize	41	50	23
Guyana	41	54	32
Sri Lanka	43	33	59
Georgia	44	58	7
Namibia	44	32	67
Lebanon	46	59	7
Libyan Arab Jamahiriya	46	41	49
Cape Verde	48	45	48
Philippines	49	40	65
Suriname	49	50	46
Azerbaijan	51	52	57
Botswana	51	45	57
Algeria	53	57	43
Jordan	54	64	17
Indonesia	55	48	66
Turkey	55	65	13
Tajikistan	57	43	70
Nicaragua	58	60	54
Honduras	59	60	56
Gabon	60	45	71
Egypt	61	70	26
Swaziland	62	55	72
Fiji	63	56	68
Saudi Arabia	64	71	32
Syrian Arab Republic	65	72	45
Occupied Palestinian Territory	66	68	46
Ghana	67	62	69
Guatemala	68	67	62
Oman	69	68	62
Zimbabwe	70	66	73
Kenya	71	63	74
Morocco	72	77	60
Cameroon	73	73	78
Congo	74	74	76
India	75	76	75
Papua New Guinea	76	75	81
Pakistan	77	79	77
Nigeria	78	78	80
Côte d'Ivoire	79	80	79
TIER III: LEAST DEVELOPED COUNTRIES			
Maldives	1	1	4
Rwanda	2	2	9
Lesotho	3	3	2
Malawi	4	6	7
Uganda	5	5	9
Bhutan	6	11	2
Mozambique	7	4	26
Lao People's Democratic Republic	8	8	22
Comoros	9	12	6
Solomon Islands	9	15	1
Nepal	11	10	14
Cambodia	12	9	24
Madagascar	13	7	30
Myanmar	14	12	11
Gambia	15	18	5
Burundi	16	14	27
Tanzania, United Republic of	17	18	14
Bangladesh	18	16	16
Senegal	19	23	8
Timor-Leste	20	17	25
Mauritania	21	21	19
Liberia	22	22	17
Togo	23	27	12
Ethiopia	24	20	36
Guinea	25	24	23
Benin	26	29	12
Zambia	26	28	18
Burkina Faso	28	26	29
Djibouti	29	30	19
Angola	30	31	32
Sierra Leone	31	25	40
Equatorial Guinea	32	36	28
Central African Republic	33	33	35
Sudan	34	38	30
Mali	35	35	38
Eritrea	36	37	34
Congo, Democratic Republic of the	37	34	39
Chad	38	32	41
Yemen	39	39	33
Guinea-Bissau	40	40	36
Niger	41	41	41
Afghanistan	42	42	43

* Due to different indicator weights and rounding, it is possible for a country to rank high on the women's or children's index but not score among the very highest countries in the overall *Mothers' Index*. For a complete explanation of the indicator weighting, please see the *Methodology and Research Notes*.

** Rankings for Tiers I, II and III are out of the 43, 80 and 42 countries respectively for which sufficient data existed to calculate the *Women's Index*.

*** Rankings for Tiers I, II and III are out of the 43, 81 and 44 countries respectively for which sufficient data existed to calculate the *Children's Index*.

THE COMPLETE MOTHERS' INDEX 2011

TIER I	Women's Index								Children's Index			Rankings		
Development Group	Health Status			Educational Status	Economic Status			Political Status	Children's Status			SOWM 2011		
MORE DEVELOPED COUNTRIES	Lifetime risk of maternal death (1 in number stated)	Percent of women using modern contraception	Female life expectancy at birth (years)	Expected number of years of formal female schooling	Maternity leave benefits 2010		Ratio of estimated female to male earned income	Participation of women in national government (% seats held by women)	Under-5 mortality rate (per 1,000 live births)	Gross pre-primary enrollment ratio (% of total)	Gross secondary enrollment ratio (% of total)	Mothers' Index Rank (out of 43 countries)+	Women's Index Rank (out of 43 countries)+	Children's Index Rank (out of 43 countries)+
	2008	2008	2010	2009	length	% wages paid	2007	2011	2009	2009	2009			
Albania	1,700	22	80	11	365 days[i]	80, 50 (a)	0.54	16	15	58	72	43	43	43
Australia	7,400	71	84	21	12 months	— (b)	0.70	28	5	82	149	2	1	30
Austria	14,300	47	83	15	16* weeks	100	0.40	28	4	95	100	26	33	5
Belarus	5,100	56	76	15	126 days[i]	100	0.63	32	12	102	95	33	29	33
Belgium	10,900	73	83	16	15 weeks	82, 75 (c,d)	0.64	39	5	122	108	8	9	15
Bosnia and Herzegovina	9,300	11	78	14	1 year	50-100 (e)	0.61	16	14	15	91	41	37	42
Bulgaria	5,800	40	77	14	135 days	90	0.68	21	10	81	89	35	32	36
Canada	5,600	72	83	16	17 weeks	55 (d,e)	0.65	25	6	70	101	20	14	24
Croatia	5,200	—	80	14	1+ year	100 (f,g)	0.67	24	5	54	94	27	26	32
Czech Republic	8,500	63	80	16	28* weeks	69	0.57	21	4	111	95	24	27	16
Denmark	10,900	72	81	18	52 weeks	100 (d)	0.74	38	4	96	119	5	4	20
Estonia	5,300	56	79	17	140* days[i]	100	0.65	23	6	95	99	18	17	17
Finland	7,600	75	83	18	105* days[ii]	70 (h)	0.73	40	3	65	110	7	6	19
France	6,600	77	85	16	16* weeks	100 (d)	0.61	20	4	110	113	10	12	6
Germany	11,100	66	83	16 (z)	14* weeks	100 (d)	0.59	32	4	109	102	11	15	4
Greece	31,800	46	82	17	119 days	50+ (b,j)	0.51	17	3	69	102	19	21	14
Hungary	5,500	71	78	16	24* weeks	70	0.75	9	6	87	97	22	21	22
Iceland	9,400	—	84	20	3 months	80	0.62	43	3	98	110	2	5	7
Ireland	17,800	66	83	18	26 weeks	80 (h,d)	0.56	16	4	—	115	16	11	29
Italy	15,200	41	84	17	5 months	80	0.49	20	4	100	101	21	25	2
Japan	12,200	44	87	15	14 weeks	67 (b)	0.45	14	3	89	101	28	34	2
Latvia	3,600	56	78	17	112 days[i]	100	0.67	20	8	89	98	24	23	26
Lithuania	5,800	33	78	17	126 days[i]	100	0.70	19	6	72	99	22	20	25
Luxembourg	3,800	—	83	13	16 weeks	100	0.57	20	3	88	96	32	35	10
Macedonia, the former Yugoslav Republic of	7,300	10	77	13	9 months	— (k)	0.49	33	11	23	84	42	42	41
Malta	9,200	43	82	15	14 weeks	100 (l)	0.45	9	7	105	100	34	41	18
Moldova, Republic of	2,000	43	73	12	126 days[i]	100	0.73	19	17	74	88	40	40	40
Montenegro	4,000	17	77	—	—	—	0.58	11	9	—	—	—	—	—
Netherlands	7,100	65	82	17	16 weeks	100 (d)	0.67	39	4	100	121	9	8	21
New Zealand	3,800	72	83	20	14 weeks	100 (d)	0.69	34	6	94	119	6	3	26
Norway	7,600	82	83	18	46-56* weeks	80,100 (m)	0.77	40	3	95	112	1	2	7
Poland	13,300	28	80	16	16* weeks	100	0.59	18	7	62	100	28	28	31
Portugal	9,800	63	82	16	120 days	100	0.60	27	4	81	104	14	16	13
Romania	2,700	38	77	15	126 days[i]	85	0.68	10	12	73	92	36	31	38
Russian Federation	1,900	53	74	15	140 days[i]	100 (b,d)	0.64	12	12	90	85	38	35	39
Serbia	7,500	19	77	14	365 days	100 (n)	0.59	22	7	51	91	37	37	35
Slovakia	13,300	66	79	16	28* weeks	55	0.58	15	7	94	92	28	29	28
Slovenia	4,100	63	82	18	105 days[i]	100	0.61	11	3	83	97	16	17	11
Spain	11,400	62	84	17	16* weeks	100	0.52	34	4	126	120	12	13	12
Sweden	11,400	65	83	16	480 days[i]	80 (o,d)	0.67	45	3	102	103	4	7	1
Switzerland	7,600	78	84	15	14 weeks	80 (d,e)	0.62	28	4	102	96	14	19	9
Ukraine	3,000	48	74	15	126 days	100	0.59	8	15	101	94	39	39	37
United Kingdom	4,700	82 (r)	82	17	52 weeks	90 (p)	0.67	21	6	81	99	13	10	23
United States	2,100	68	82	17	12 weeks	— (q)	0.62	17 (i)	8	58	94	31	24	34

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TIER II	Women's Index							Children's Index					Rankings		
Development Group	Health Status				Educational Status	Economic Status	Political Status	Children's Status					SOWM 2011		
LESS DEVELOPED COUNTRIES and TERRITORIES (minus least developed countries)	Lifetime risk of maternal death (1 in number stated)	Percent of births attended by skilled health personnel	Percent of women using modern contraception	Female life expectancy at birth (years)	Expected number of years of formal female schooling	Ratio of estimated female to male earned income	Participation of women in national government (% seats held by women)	Under-5 mortality rate (per 1,000 live births)	Percent of children under 5 moderately or severely underweight for age	Gross primary enrollment ratio (% of total)	Gross secondary enrollment ratio (% of total)	Percent of population with access to safe water	Mothers' Index Rank (out of 79 countries)+	Women's Index Rank (out of 80 countries)+	Children's Index Rank (out of 81 countries)+
	2008	2009	2008	2010	2009	2007	2011	2009	2009	2009	2009	2008			
Algeria	340	95	52	74	13	0.36	7	32	4	108	83	83	53	57	43
Argentina	600	95	64	80	17	0.51	38	14	4	116	85	97	4	6	15
Armenia	1,900	100	19	77	13	0.57	9	22	4	99	93	96	30	36	16
Azerbaijan	1,200	88	13	73	13	0.44	16	34	10	116	106	80	51	52	57
Bahamas	1,000	99	60	77	12	0.72 (y)	18	12	—	103	93	97 (y)	10	14	6
Bahrain	2,200	98	31 (s)	78	15	0.51	15	12	9	107	96	94 (y)	17	18	22
Barbados	1,100	100	53	80	16 (z)	0.65	20	11	6 (y)	105 (z)	103 (z)	100	5	5	3
Belize	330	95	31	79	13	0.43	11	18	6	122	76	99	41	50	23
Bolivia	150	71	34	69	14	0.61	30	51	6	107	81	86	30	26	51
Botswana	180	95	42	55	12	0.58	8	57	14	109	82	95	51	45	57
Brazil	860	97	70	77	14	0.60	10	21	2 (z)	127	101	97	12	13	12
Brunei Darussalam	2,000	99	—	80	14	0.59	— (iv)	7	—	107	98	—	—	16	—
Cameroon	35	63	12	52	9	0.53	14	154	19	114	42	74	73	73	78
Cape Verde	350	78	46 (y)	74	12	0.49	18	28	9	98	81	84	48	45	48
Chile	2,000	100	58 (y)	82	15	0.42	14	9	1	106	90	96	16	23	5
China	1,500	99	86	75	12	0.68	21	19	7	113	76	89	18	11	43
Colombia	460	96	68	77	14	0.71	14	19	7	120	95	92	11	10	34
Congo	39	83	13	55	8	0.51	9	128	14	120	43	71	74	74	76
Costa Rica	1,100	99	72	82	12	0.46	39	11	5	110	96	97	13	22	13
Côte d'Ivoire	44	57	8	60	5	0.34	9	119	20	74	26	80	79	80	79
Cuba	1,400	100	72	81	19	0.49	43	6	4	104	90	94	1	1	9
Cyprus	6,600	100 (y)	—	82	14	0.58	13	4	—	103	98	100	3	3	1
Dominican Republic	320	98	70	76	13	0.59	19	32	4	106	77	86	24	23	40
Ecuador	270	98	58	79	14	0.51	32	24	9	117	81	94	14	12	35
Egypt	380	79	58	72	11	0.27	13	21	8	100	79	99	61	70	26
El Salvador	350	96	66	77	12	0.46	19	17	9	115	65	87	40	39	49
Fiji	1,300	99	—	72	13	0.38	— (v)	18	8 (y)	94	81	47 (y)	63	56	68
Gabon	110	86	12	63	12	0.59	16	69	12	134	53	87	60	45	71
Georgia	1,300	98	27	75	13	0.38	7	29	1 (z)	108	108	98	44	58	7
Ghana	66	57	17	58	9	0.74	8	69	17	105	57	82	67	62	69
Guatemala	210	51	34	74	10	0.42	12	40	19	114	57	94	68	67	62
Guyana	150	92	33	71	12	0.41	30	35	11 (z)	103	103	94	41	54	32
Honduras	240	67	56	75	12 (z)	0.34	18	30	11	116	65	86	59	60	56
India	140	53	49	66	10	0.32	11	66	48	117	60	88	75	76	75
Indonesia	190	75	57	74	13	0.44	18	39	18 (z)	119	74	80	55	48	66
Iran, Islamic Republic of	1,500	97	59	73	15	0.32	3	31	5	128	83	94 (y)	38	41	28
Iraq	300	80	33	72	8	—	25	44	8	103	51	79	—	—	61
Israel	5,100	99 (y)	52 (t)	83	16	0.64	19	4	—	111	90	100	2	2	3
Jamaica	450	97	66	76	14	0.58	16	31	2 (z)	93	91	94	15	14	27
Jordan	510	99	41	75	13	0.19	12	25	2 (z)	97	88	96	54	64	17
Kazakhstan	950	100	49	72	15	0.68	14	29	4	108	99	95	8	9	21
Kenya	38	44	32	56	11	0.65	10	84	20	113	59	59	71	63	74
Korea, Democratic People's Republic of	230	97	58	70	—	—	16	33	23	—	—	100	—	—	—
Korea, Republic of	4,700	100	75	83	16	0.52	15	5	—	105	97	98	5	6	2
Kuwait	4,500	98	39 (s)	80	14	0.36	8	10	10	95	90	99	35	37	23

TIER II continued	Women's Index							Children's Index					Rankings		
Development Group	Health Status				Educational Status	Economic Status	Political Status	Children's Status					SOWM 2011		
LESS DEVELOPED COUNTRIES and TERRITORIES (minus least developed countries)	Lifetime risk of maternal death (1 in number stated)	Percent of births attended by skilled health personnel	Percent of women using modern contraception	Female life expectancy at birth (years)	Expected number of years of formal female schooling	Ratio of estimated female to male earned income	Participation of women in national government (% seats held by women)	Under-5 mortality rate (per 1,000 live births)	Percent of children under 5 moderately or severely underweight for age	Gross primary enrollment ratio (% of total)	Gross secondary enrollment ratio (% of total)	Percent of population with access to safe water	Mothers' Index Rank (out of 79 countries)+	Women's Index Rank (out of 80 countries)+	Children's Index Rank (out of 81 countries)+
	2008	2009	2008	2010	2009	2007	2011	2009	2009	2009	2009	2008			
Kyrgyzstan	450	98	46	72	13	0.55	23	37	3	95	84	90	28	30	37
Lebanon	2,000	98	34	75	14	0.25	3	12	4	103	82	100	46	59	7
Libyan Arab Jamahiriya	540	94	26	77	17	0.25	8	19	5	110	93	72 (y)	46	41	49
Malaysia	1,200	99	30 (w)	77	13	0.42	14	6	8	97	68	100	36	44	23
Mauritius	1,600	98	39	76	14	0.42	19	17	15	100	87	99	32	34	30
Mexico	500	93	67	79	14	0.42	26	17	5	114	90	94	23	29	19
Mongolia	730	99	61	71	15	0.87	4	29	6	110	92	76	9	4	52
Morocco	360	63	52	74	9	0.24	7	38	10	107	56	81	72	77	60
Namibia	160	81	54	63	12	0.63	25	48	21	112	66	92	44	32	67
Nicaragua	300	74	69	77	11	0.34	21	26	7	117	68	85	58	60	54
Nigeria	23	39	9	49	8	0.42	7	138	29	93	30	58	78	78	80
Occupied Palestinian Territory	—	99	39	76	13	0.12 (y)	— (vi)	30	3	79	87	91	66	68	46
Oman	1,600	99	18 (s)	78	11	0.23	9	12	18	75	88	88	69	68	62
Pakistan	93	39	22	68	6	0.18	21	87	38	85	33	90	77	79	77
Panama	520	92	54 (y)	79	14	0.58	8	23	8 (y)	111	71	93	25	25	38
Papua New Guinea	94	53	20	64	6 (z)	0.74	1	68	26	55	—	40	76	75	81
Paraguay	310	82	70	74	12	0.64	14	23	4	102	67	86	33	30	39
Peru	370	83	47	76	14	0.59	28	21	6	109	89	82	21	20	42
Philippines	320	62	36	75	12	0.58	22	33	26	110	82	91	49	40	65
Qatar	4,400	99	32 (s)	77	14	0.28	0	11	6	106	85	100	38	49	11
Saudi Arabia	1,300	91	29 (y,s)	76	13	0.16	0	21	14	99	97	95 (y)	64	71	32
Singapore	10,000	100	53	83	—	0.53	23	3	3	—	—	100	—	—	—
South Africa	100	91	60	53	14 (z)	0.60	43 (ii)	62	12	105	95	91	19	17	53
Sri Lanka	1,100	99	53	78	13	0.56	5	15	27	101	87	90	43	33	59
Suriname	400	90	41	73	13	0.44	10	26	10	114	75	93	49	50	46
Swaziland	75	69	47	46	10	0.71	22	73	10	108	53	69	62	55	72
Syrian Arab Republic	610	93	43	77	11	0.20	12	16	10	122	75	89	65	72	45
Tajikistan	430	88	33	70	10	0.65	18	61	18	102	84	70	57	43	70
Thailand	1,200	97	80	72	13	0.63	14	14	9	91	76	100	20	20	31
Trinidad and Tobago	1,100	98	38	73	12	0.55	27	35	6	103	89	94	25	34	29
Tunisia	860	95	52	77	15	0.28	23	21	3	107	92	94	28	38	17
Turkey	1,900	91	43	75	11	0.26	9	20	3	99	82	99	55	65	13
Turkmenistan	500	100	45	69	—	0.65	17	45	11	99 (z)	84 (z)	72 (y)	—	—	64
United Arab Emirates	4,200	99	24 (s)	79	12	0.27	23	7	14	105	95	100	36	52	19
Uruguay	1,700	100	75	80	17	0.55	15	13	5	114	88	100	7	8	9
Uzbekistan	1,400	100	59	71	11	0.64	19	36	5	92	104	87	25	26	40
Venezuela, Bolivarian Republic of	540	95	62	77	15	0.48	17	18	5	103	81	83 (y)	21	18	36
Vietnam	850	88	68	77	10	0.69	26	24	20	104	67	94	34	26	55
Zimbabwe	42	60	58	47	9	0.58 (y)	18	90	16	104	41	82	70	66	73

Note: Data refer to the year specified in the column heading or the most recently available. – No data ' calendar days " working days (all other days unspecified)

+ The *Mothers' Index* rankings include only those countries for which sufficient data were available to calculate both the Women's and Children's Indexes. The *Women's Index* and *Children's Index* ranks, however, include additional countries for which adequate data were available to present findings on either women's or children's indicators, but not both. For complete methodology see *Methodology and Research Notes*.

(i) The total refers to all voting members of the House; (ii) Figures calculated on the basis of permanent seats only; (iii) The parliament was dissolved following the December 2008 coup; (iv) There is no parliament; (v) Parliament has been dissolved or suspended for an indefinite period; (vi) The legislative council has been unable to meet and govern since 2007; (vii) Figures are from the previous term; recent election results were not available at the time of publication.

(a) 80% prior to birth and for 150 days after and 50% for the rest of the leave period; (b) A lump sum grant is provided for each child; (c) 82% for the first 30 days and 75% for the remaining period; (d) Up to a ceiling; (e) Benefits vary by county or province; (f) 45 days before delivery and 1 year after; (g) 100% until the child reaches 6 months, then at a flat rate for the remaining period; (h) Benefits vary, but there is a minimum flat rate; (j) 50% plus a dependent's supplement (10% each, up to 40%); (k) Paid amount not specified; (l) Paid only the first 13 weeks; (m) Parental benefits paid at 100% for 46-week option; 80% for 56-week option; (n) 100% of earnings paid for the first 6 months; 60% from the 6th-9th month; 30% for the last 3 months; (o) 480 calendar days paid parental leave: 80% for 390 days, flat rate for remaining 90; (p) 90% for the first 6 weeks and a flat rate for the remaining weeks; (q) There is no national program. Cash benefits may be provided at the state level; (r) Data excludes Northern Ireland; (s) Data pertain to nationals of the country; (t) Data pertain to the Jewish population; (w) Data pertain to Peninsular Malaysia; (y) Data are from an earlier publication of the same source; (z) Data differ from the standard definition and/or are from a secondary source

* These countries also offer prolonged periods of parental leave (at least two years). For additional information on child-related leave entitlements see OECD Family Database www.oecd.org/els/social/family/database

To copy this table onto 8½ x 11" paper, set your photocopier reduction to 85%

TIER III	Women's Index							Children's Index					Rankings		
Development Group	Health Status				Educational Status	Economic Status	Political Status	Children's Status					SOWM 2011		
LEAST DEVELOPED COUNTRIES	Lifetime risk of maternal death (1 in number stated)	Percent of births attended by skilled health personnel	Percent of women using modern contraception	Female life expectancy at birth (years)	Expected number of years of formal female schooling	Ratio of estimated female to male earned income	Participation of women in national government (% seats held by women)	Under-5 mortality rate (per 1,000 live births)	Percent of children under 5 moderately or severely underweight for age	Gross primary enrollment ratio (% of total)	Ratio of girls to boys enrolled in primary school	Percent of population with access to safe water	Mothers' Index Rank (out of 42 countries)+	Women's Index Rank (out of 42 countries)+	Children's Index Rank (out of 44 countries)+
	2008	2009	2008	2010	2009	2007	2011	2009	2009	2009	2009	2008			
Afghanistan	11	14	16	45	5	0.24	28	199	39	106	0.66	48	42	42	43
Angola	29	47	5	50	4 (z)	0.64	39	161	16 (z)	128	0.81	50	30	31	32
Bangladesh	110	24	48	68	8	0.51	19	52	46	92	1.06	80	18	16	16
Benin	43	74	6	64	6	0.52	11	118	23	117	0.87	75	26	29	12
Bhutan	170	71	31	69	11	0.39	14	79	19	109	1.01	92	6	11	2
Burkina Faso	28	54	13	55	6	0.66	15	166	31	78	0.89	76	28	26	29
Burundi	25	34	9	53	7	0.77	36	166	35	147	0.97	72	16	14	27
Cambodia	110	44	27	64	9	0.68	19	88	36 (y)	116	0.94	61	12	9	24
Central African Republic	27	44	9	49	5	0.59	10 (vii)	171	29	89	0.71	67	33	33	35
Chad	14	14	2	51	5	0.70	5	209	37	90	0.70	50	38	32	41
Comoros	71	62	19	69	10	0.58	3	104	25	119	0.92	95	9	12	6
Congo, Democratic Republic of the	24	74	6	50	7	0.46	8	199	31	90	0.85	46	37	34	39
Djibouti	93	93	17	58	4	0.57	14	94	33	55	0.86	92	29	30	19
Equatorial Guinea	73	65	6	52	7	0.36	10	145	19	82	0.96	43 (y)	32	36	28
Eritrea	72	28	5	63	4	0.50	22	55	40	48	0.83	61	36	37	34
Ethiopia	40	6	14	58	8	0.67	26	104	38	102	0.91	38	24	20	36
Gambia	49	57	13	58	8	0.63	8	103	20	86	1.06	92	15	18	5
Guinea	26	46	4	61	7	0.68	— (iii)	142	26	90	0.85	71	25	24	23
Guinea-Bissau	18	39	6	50	5	0.46	10	193	19	120	0.67	61	40	40	36
Haiti	93	26	24	63	—	0.37	11	87	22	50 (z)	1.08 (z)	63	—	—	21
Lao People's Democratic Republic	49	20	29	67	8	0.76	25	59	37	112	0.91	57	8	8	22
Lesotho	62	62	35	46	10	0.73	23	84	13 (z)	108	0.99	85	3	3	2
Liberia	20	46	10	61	9	0.50	14	112	24	91	0.90	68	22	22	17
Madagascar	45	44	17	63	10	0.71	12	58	42 (y)	160	0.98	41	13	7	30
Malawi	36	54	38	55	9	0.74	21	110	21	119	1.03	80	4	6	7
Maldives	1,200	84	34	74	12	0.54	6	13	30	111	0.95	91	1	1	4
Mali	22	49	6	50	7	0.44	10	191	32	95	0.84	56	35	35	38
Mauritania	41	61	8	59	8	0.58	19	117	20	104	1.08	49	21	21	19
Mozambique	37	55	12	49	7	0.90	39	142	18	115	0.90	47	7	4	26
Myanmar	180	64	33	65	9	0.61	4	71	32	117	0.99	71	14	13	11
Nepal	80	19	44	68	8	0.61	33	48	45	115	0.86	88	11	10	14
Niger	16	33	5	53	4	0.34	12 (vii,y)	160	41	62	0.80	48	41	41	41
Rwanda	35	52	26	53	11	0.79	51	111	23	151	1.01	65	2	2	9
Senegal	46	52	10	58	7	0.55	30	93	17	84	1.04	69	19	23	8
Sierra Leone	21	42	6	50	6	0.74	13	192	25	158	0.88	49	31	25	40
Solomon Islands	230	70	—	68	9	0.51	0	36	12 (z)	107	0.97	70 (y)	9	15	1
Somalia	14	33	1	52	2	—	7	180	36	33	0.55	30	—	—	44
Sudan	32	49	6	60	6	0.33	24	108	31	74	0.90	57	34	38	30
Tanzania, United Republic of	23	43	20	58	5	0.74	36	108	22	105	1.00	54	17	18	14
Timor-Leste	44	18	7	63	10	0.53	29	56	49 (z)	113	0.95	69	20	17	25
Togo	67	62	11	65	8	0.45	11	98	21	115	0.94	60	23	27	12
Uganda	35	42	18	55	10	0.69	31	128	20	122	1.01	67	5	5	9
Yemen	91	36	19	66	7	0.25	1	66	46	85	0.80	62	39	39	33
Zambia	38	47	27	48	7	0.56	14	141	19	113	0.99	60	26	28	18

Complete Mothers' Index

1. In the first year of the *Mothers' Index* (2000), a review of literature and consultation with members of the Save the Children staff identified health status, educational status, political status and children's well-being as key factors related to the well-being of mothers. In 2007, the *Mothers' Index* was revised to include indicators of economic status. All countries with populations over 250,000 were placed into one of three tiers according to United Nations regional development groups: more developed countries, less developed countries and least developed countries. Indicators for each development group were selected to best represent factors of maternal well-being specific to that group and published data sources for each indicator were then identified. To facilitate international comparisons, in addition to reliability and validity, indicators were selected based on inclusivity (availability across countries) and variability (ability to differentiate between countries). To adjust for variations in data availability, when calculating the final index, indicators for maternal health and children's well-being were grouped into sub-indices (see step 7). This procedure allowed researchers to draw on the wealth of useful information on those topics without giving too little weight to the factors for which less abundant data were available. Data presented in this report includes information available through 01 March 2011.

Sources: 2010 Population: United Nations Population Fund. *The State of World Population 2010*. (New York: 2010); Classification of development regions: United Nations Population Division. World Population Prospects: The 2008 Revision. Population Database. esa.un.org/unpp/index.asp?panel=5

2. In Tier I, data were gathered for seven indicators of women's status and three indicators of children's status. Sufficient data existed to include analyses of two additional indicators of children's well-being in Tiers II and III. Indicators unique to specific development groups are noted below.

THE INDICATORS THAT REPRESENT WOMEN'S HEALTH STATUS ARE:

Lifetime risk of maternal death

A woman's risk of death in childbirth over the course of her life is a function of many factors, including the number of children she has and the spacing of births as well as the conditions under which she gives birth and her own health and nutritional status. The lifetime risk of maternal mortality is the probability that a 15-year-old female will die eventually from a maternal cause. This indicator reflects not only the risk of maternal death per pregnancy or per birth, but also the level of fertility in the population. Competing causes of maternal death are also taken into account. Estimates are periodically calculated by an inter-agency group including WHO, UNICEF, UNFPA and the World Bank. Data are for 2008 and represent the most recent of these estimates available at the time of this analysis.

Source: WHO. *Trends in Maternal Mortality: 1990 to 2008*. (Geneva: 2010). whqlibdoc.who.int/publications/2010/9789241500265_eng.pdf

Percent of women using modern contraception

Access to family planning resources, including modern contraception, allows women to plan their pregnancies. This helps ensure that a mother is physically and psychologically prepared to give birth and care for her child. Data are derived from sample survey reports and estimate the proportion of married women (including women in consensual unions) currently using modern methods of contraception, which include: male and female sterilization, IUD, the pill, injectables, hormonal implants, condoms and female barrier methods. Contraceptive prevalence data are the most recently available as of May 2009.

Source: United Nations Population Division. *World Contraceptive Use 2009 (Wall Chart)*. www.un.org/esa/population/publications/contraceptive2009/contraceptive2009.htm

Skilled attendant at delivery

The presence of a skilled attendant at birth reduces the likelihood of both maternal and infant mortality. The attendant can help create a hygienic environment and recognize complications that require urgent medical care. Skilled attendance at delivery is defined as those births attended by physicians, nurses or midwives. Data are from 2005-2009. As nearly every birth is attended in the more developed countries, this indicator is not included in Tier I.

Source: United Nations Children's Fund (UNICEF). *The State of the World's Children 2011*. (New York: 2010) Table 8, pp.116-119. www.unicef.org/sowc2011/statistics.php

Female life expectancy

Children benefit when mothers live longer, healthier lives. Life expectancy reflects the health, social and economic status of a mother and captures trends in falling life expectancy associated with the feminization of HIV/

AIDS. Female life expectancy is defined as the average number of years of life that a female can expect to live if she experiences the current mortality rate of the population at each age. Data estimates are for 2010.

Source: United Nations Population Fund (UNFPA). *The State of World Population 2010*. (New York: 2010) pp. 94-98. www.unfpa.org/swp/

The indicator that represents women's educational status is:

Expected number of years of formal female schooling

Education is singularly effective in enhancing maternal health, women's freedom of movement and decision-making power within households. Educated women are more likely to be able to earn a livelihood and support their families. They are also more likely than uneducated women to ensure that their children eat well, finish school and receive adequate health care. Female school life expectancy is defined as the number of years a female child of school entrance age is expected to spend at school or university, including years spent on repetition. It is the sum of the age-specific enrollment ratios for primary, secondary, post-secondary non-tertiary and tertiary education. Primary to secondary estimates are used where primary to tertiary are not available. Data are from 2009 or the most recent year available.

Sources: UNESCO Institute for Statistics (UIS). Data Centre. http://stats.uis.unesco.org, supplemented with data from UNESCO. *Global Education Digest 2009*. (Montreal: 2009) Table 12, pp.158-167. www.uis.unesco.org/template/pdf/ged/2009/GED_2009_EN.pdf

The indicators that represent women's economic status are:

Ratio of estimated female to male earned income

Mothers are likely to use their influence and the resources they control to promote the needs of their children. Where mothers are able to earn a decent standard of living and wield power over economic resources, children survive and thrive. The ratio of estimated female earned income to estimated male earned income – how much women earn relative to men for equal work – reveals gender inequality in the workplace. Female and male earned income are crudely estimated based on the ratio of the female nonagricultural wage to the male nonagricultural wage, the female and male shares of the economically active population, the total female and male population, and GDP per capita in purchasing power parity terms in U.S. dollars. Estimates are based on data for the most recent year available between 1996 and 2007.

Source: United Nations Development Programme (UNDP). *Human Development Report 2009*. (New York: 2009) Table K, pp.186-189. http://hdrstats.undp.org/en/indicators/130.html

Maternity leave benefits

The maternity leave indicator includes both the length of time for which benefits are provided and the extent of compensation. The data are compiled by the International Labour Office and the United States Social Security Administration from a variety of legislative and non-legislative sources from 2004 to 2009. Data on maternity leave benefits are reported only for Tier I countries, where women comprise a considerable share of the non-agricultural workforce and thus most working mothers are free to enjoy the benefits of maternity leave.

Source: United Nations Statistics Division. Statistics and indicators on women and men. Table 5g. Updated December 2010. unstats.un.org/unsd/demographic/products/indwm/tab5g.htm

The indicator that represents women's political status is:

Participation of women in national government

When women have a voice in public institutions, they can participate directly in governance processes and advocate for issues of particular importance to women and children. This indicator represents the percentage of seats in single or, in the case of bicameral legislatures, upper and lower houses of national parliaments occupied by women. Data are as of 31 January 2011.

Source: Inter-Parliamentary Union (IPU). Women in National Parliaments. www.ipu.org/wmn-e/classif.htm

The indicators that represent children's well-being are:

Under-5 mortality rate

Under-5 mortality rates are likely to increase dramatically when mothers receive little or no prenatal care and give birth under difficult circumstances, when infants are not exclusively breastfed, when few children are immunized and when fewer receive preventive or curative treatment for common childhood diseases. Under-5 mortality rate is the probability of dying between birth and exactly five years of age, expressed per 1,000 live births. Estimates are for 2009.

Source: UNICEF. *The State of the World's Children 2011*. (New York: 2010) Table 1, pp.88-91. www.unicef.org/sowc2011/statistics.php

Percentage of children under age 5 moderately or severely underweight

Poor nutrition affects children in many ways, including making them more susceptible to a variety of illnesses and impairing their physical and cognitive development. Children moderately or severely underweight are more than two and three standard deviations below median weight for age of the NCHS/WHO reference population respectively. Data are for the most recent year available between 2003 and 2009. Where NCHS/WHO data are not available, estimates based on

WHO Child Growth Standards are used. This indicator is included in Tier II and Tier III only, as few more developed countries report this data.

Source: UNICEF. *The State of the World's Children 2011*. (New York: 2010) Table 2, pp.92-95. www.unicef.org/sowc2011/statistics.php

Gross pre-primary enrollment ratio

Early childhood care and education, including pre-primary schooling, supports children's growth, development, learning and survival. It also contributes to proper health, poverty reduction and can provide essential support for working parents, particularly mothers. The pre-primary gross enrollment ratio is the total number of children enrolled in pre-primary education, regardless of age, expressed as a percentage of the total number of children of official pre-primary school age. The ratio can be higher than 100 percent when children enter school later than the official enrollment age or do not advance through the grades at expected rates. Data are for the school year ending in 2009 or the most recently available. Pre-primary enrollment is analyzed across Tier I countries only.

Source: UNESCO Institute for Statistics (UIS). Data Centre. stats.uis.unesco.org

Gross primary enrollment ratio

The gross primary enrollment ratio (GER) is the total number of children enrolled in primary school, regardless of age, expressed as a percentage of the total number of children of official primary school age. Where GERs are not available, net attendance ratios are used. Data are for the school year ending in 2009 or the most recently available. This indicator is not tracked in Tier I, where nearly all children complete primary school.

Sources: UNESCO Institute for Statistics (UIS). Data Centre. stats.uis.unesco.org, supplemented with data from UNESCO. *Global Education Digest 2009*. (Montreal: 2009) Table 3, pp.84-93. www.uis.unesco.org/template/pdf/ged/2009/GED_2009_EN.pdf and UNICEF. Primary School Participation. www.childinfo.org/education_primary.php

Gender parity index

Educating girls is one of the most effective means of improving the well-being of women and children. The ratio of gross enrollment of girls to boys in primary school – or Gender Parity Index (GPI) – measures gender disparities in primary school participation. It is calculated as the number of girls enrolled in primary school for every 100 enrolled boys, regardless of age. A score of 1 means equal numbers of girls and boys are enrolled; a score between 0 and 1 indicates a disparity in favor of boys; a score greater than 1 indicates a disparity in favor of girls. Where GERs are not available, net attendance ratios are used to calculate the GPI. Data are for the school year ending in 2009 or the most recently available. GPI is included in Tier III, where gender equity gaps disadvantaging girls in access to education are the largest in the world.

Source: UNESCO Institute for Statistics (UIS). Data Centre. stats.uis.unesco.org

Gross secondary enrollment ratio

The gross secondary enrollment ratio is the total number of children enrolled in secondary school, regardless of age, expressed as a percentage of the total number of children of official secondary school age. Data are for the school year ending in 2009 or the most recently available. This indicator is not tracked in Tier III where many children still do not attend primary school, let alone transition to higher levels.

Sources: UNESCO Institute for Statistics (UIS). Data Centre. stats.uis.unesco.org, supplemented with data from UNESCO. *Global Education Digest 2009*. (Montreal: 2009) Table 5, pp.104-113. www.uis.unesco.org/template/pdf/ged/2009/GED_2009_EN.pdf and UNICEF. Secondary School Participation. www.childinfo.org/education_secondary.php

Percent of population with access to safe water

Safe water is essential to good health. Families need an adequate supply for drinking as well as cooking and washing. Access to safe and affordable water also brings gains for gender equity, especially in rural areas where women and young girls spend considerable time collecting water. This indicator reports the percentage of the population with access to an adequate amount of water from an improved source within a convenient distance from a user's dwelling, as defined by country-level standards. "Improved" water sources include household connections, public standpipes, boreholes, protected dug wells, protected springs and rainwater collection. In general, "reasonable access" is defined as at least 20 liters (5.3 gallons) per person per day, from a source within one kilometer (0.62 miles) of the user's dwelling. Data are for 2008.

Source: UNICEF. *The State of the World's Children 2011*. (New York: 2010) Table 3, pp.96-99. www.unicef.org/sowc2011/statistics.php

3. Missing data were supplemented when possible with data from the same source published in a previous year, as noted in the fold-out table in this appendix.

4. Data points were rounded to the tenths place for analysis purposes. Data analysis was conducted using Microsoft Excel software.

5. Standard scores, or z-scores, were created for each of the indicators using the following formula: $z=(x-\bar{x})/s$ where:

z = The standard, or z-score
x = The score to be converted
$\bar{x}$ = The mean of the distribution
s = The standard deviation of the distribution

Nigeria ▲

6. The standard scores of indicators of ill-being were then multiplied by (-1) so that a higher score indicated increased well-being on all indicators.

Notes on specific indicators

- To facilitate cross-country comparisons, length of maternity leave was converted into days and allowances were averaged over the entire pay period.
- To report findings for the greatest number of countries possible, countries without a parliament, or where it has been dissolved, suspended or otherwise unable to meet, are given a "0" for political representation when calculating index scores.
- To avoid rewarding school systems where pupils do not start on time or fail to progress through the system at expected rates, gross enrollment ratios between 100 and 105 percent were discounted to 100 percent. Gross enrollment ratios over 105 percent were either discounted to 100 with any amount over 105 percent subtracted from 100 (for example, a country with a gross enrollment rate of 107 percent would be discounted to 100-(107-105), or 98) or to the respective country's net enrollment ratio, whichever was higher.
- To avoid rewarding countries in which girls' educational progress is made at the expense of boys', countries with gender parity indices greater than 1.02 (an indication of gender inequity disfavoring boys) were discounted to 1.00 with any amount over 1.02 then subtracted from 1.00.

7. The z-scores of the four indicators related to women's health were averaged to create an index score of women's health status. In Tier I, an index score of women's economic status was similarly calculated as a weighted average of the ratio of female to male earned income (75 percent), length of maternity leave (12.5 percent) and percent of wages paid (12.5 percent). An index of child well-being – the *Children's Index* – was also created by first averaging indicators of education, then averaging across all z-scores. At this stage, cases (countries) missing more than one indicator on either index were eliminated from the sample. Countries missing any one of the other indicators (that is educational, economic or political status) were also eliminated. The *Women's Index* was then calculated as a weighted average of health status (30 percent), educational status (30 percent), economic status (30 percent) and political status (10 percent).

8. The *Mothers' Index* was calculated as a weighted average of children's well-being (30 percent), women's health status (20 percent), women's educational status (20 percent), women's economic status (20), and women's political status (10 percent). The scores on the *Mothers' Index* were then ranked.

NOTE: Data exclusive to mothers are not available for many important indicators (school life expectancy and government positions held, for example). In these instances, data on women's status have been used to approximate maternal status, since all mothers are women. In areas such as health, where a broader array of indicators is available, the index emphasizes indicators that address uniquely *maternal* issues.

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Front Cover – Andy Hall
India. *Meena prepares her newborn baby for a check-up at home by a visiting community health worker. Infant mortality rates in this part of India have declined dramatically, thanks in part to the work of local women trained in newborn care.*

Page 1 – Joshua Roberts
Mali. *Salif, a community health worker trained by Save the Children, makes a home visit to check on Minta and her 4-year-old daughter Miamouna.*

Page 4 – Mats Lignell
Afghanistan. *Nazrin-Gul, age 36, has eight children – four sons and four daughters.*

Page 6 – Anne Ryan

Page 14 – Denise Applewhite / Princeton University

Page 18 – Susan Warner

Page 20 – Susan Warner

Page 24 – Joshua Roberts
Mali. *Aissata, a community health worker trained by Save the Children, measures the arm of 4-year-old Labass to determine if he is receiving adequate nutrition.*

Page 25 – Rachel Palmer
India. *Kunti brings her 6-month-old son Saklesh for a check-up with Sangeeta, a community health volunteer. Saklesh was born malnourished, weighing only 3.3 pounds. He now goes to Save the Children's mobile clinic for treatment.*

Page 26 – Colin Crowley
Tanzania. *Zainabu provides "kangaroo mother care" to her son Yasini, who was born two months early.*

Page 28 – Louise Dyring
Sierra Leone. *Soni is 2 months old and severely malnourished. She weighs only 4.4 pounds. Soni's twin sister died from fever when she was a newborn. Soni is now receiving care at a health clinic supported by Save the Children.*

Page 34 – Pep Bonet/Noor
Nigeria. *Safiya gave birth to premature quadruplets, but only two survived. She holds one of the babies against her chest, using a technique called "kangaroo mother care" that has been proven to save newborn lives.*

Back Cover – Michael Bisceglie
Malawi. *17-day-old Aisha receives regular care from a Madalitso Masa, a local health worker trained by Save the Children.*

Malawi

Every day, about 22,000 children under age 5 in the developing world die of preventable or treatable illnesses. That equates to 8 million children a year. More than 3 million of these deaths occur among newborns less than one month old.

State of the World's Mothers 2011 brings together Save the Children's *Champions for Children* – a group of leading voices from academia, politics, religion, business and the arts – to tell Americans that there is a solution to the health crisis facing mothers and children in developing countries. The *Champions for Children* include **William Frist**, former U.S. Senate Majority Leader; **Jon Corzine**, former U.S. Senator and Governor of New Jersey; **Bingu wa Mutharika**, President of Malawi; **Robert Black** and **Henry Perry**, Professors at the Bloomberg School of Public Health, Johns Hopkins University; **Anne Mulcahy**, former CEO of Xerox; **Rick** and **Kay Warren**, founders of the Saddleback Church; **Peter Singer**, author of *The Life You Can Save*, Donald Payne, Congressman from New Jersey; **Colonel John Agoglia (ret.)**, U.S. Army; and actor and mother **Jennifer Garner**. This distinguished group explores the many reasons why the United States, as a nation, must continue to invest in lifesaving maternal and child health programs. U.S. investment in basic health care for the world's mothers and children will impact everything from the future of national security, to economic growth for American businesses in developing countries, and even the environment.

State of the World's Mothers 2011 also presents the annual *Mothers' Index*. Using the latest data on health, nutrition, education and political participation, the Index ranks 164 countries – in both the developed and developing world – to show where mothers fare best and where they face the greatest hardships.

Save the Children®

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Save the Children is the leading independent organization for children in need, with programs in 120 countries, including the United States. We aim to inspire breakthroughs in the way the world treats children, and to achieve immediate and lasting change in their lives by improving their health, education and economic opportunities. In times of acute crisis, we mobilize rapid assistance to help children recover from the effects of war, conflict and natural disasters.