Save the Children®

State of the **WORLD'S MOTHERS 2008**

Closing the Survival Gap for Children Under 5

Save the Children®

CONTENTS

Front cover:
In Bangladesh, Meena and her 7-day-old baby girl Barsha are both healthy after a safe delivery in their home. They were assisted by a traditional birth attendant trained by Save the Children to give essential care to mothers and newborns. Meena and Barsha also benefited from prenatal care and postnatal counseling provided by Save the Children.

ISBN 1-888393-20-3

Closing the Survival Gap for Children Under 5

IN COMMEMORATION OF MOTHER'S DAY, SAVE THE CHILDREN is publishing its ninth annual *State of the World's Mothers report*. The focus is on the 200 million children under age 5 who do not get basic health care, with poorest children most frequently left out and most at risk of dying. This report shows which countries are doing the best – and which are doing the worst – at reaching children with basic health measures. It also looks at the survival gaps between the poorest and best-off children in developing countries, and shows how millions of lives can be saved if children, especially the poorest, receive essential, low-cost health care.

Foreword

BANGLADESH

If flowers and a sentimental card are all that interest you on Mother's Day, stop reading now. The presents that would bring tears of joy to most of the world's mothers are not chocolates or flowers. Instead those mothers want health care that could save their children's lives – remarkably simple, inexpensive tools such as vaccines, vitamin A, antibiotics and a trained community health worker.

Last summer I helped deliver this care to babies in Bangladesh. During my work, I encountered a young mother named Tahmina, who had received prenatal counseling and infant care education from Save the Children. As a result of that assistance, her son was thriving, and easy access to a health worker in the village greatly improves the chances he'll become a healthy, productive adult.

Tahmina's child is fortunate. He escaped the unthinkable fate of the 2 million children who die the day they are born – or the 2 million more who die during their first month of life. In total, nearly 10 million children under age 5 die each year – more than 26,000 *every day*.

To put those statistics in perspective, global child mortality equates to the 2004 Asian tsunami striking every 40 days and killing only children – nearly all of them among the poorest of our world's 6.5 billion people.

Generous hearts opened throughout the world in the aftermath of the tsunami, and millions of dollars in aid flowed to the victims and their families. But in the ongoing disaster that strikes thousands of the world's mothers every day – the deaths of their children – available resources do not equal the need.

Most of these children die from birth complications, diarrhea, pneumonia, measles and malnutrition – afflictions that are rarely fatal in developed countries. We know how to prevent most of these deaths, and the tools necessary to save these children are simple, inexpensive and readily available. So why aren't we doing it?

Much of the reason lies in common misperceptions. According to recent polls, most Americans believe the leading cause of child deaths worldwide is AIDS. In truth, the disease accounts only for 3 percent. We must better educate ourselves about the underlying causes of these senseless deaths – and the key to that process lies within this report.

Save the Children's 2008 *State of the World's Mothers* report ranks 55 developing countries on their effectiveness in reaching the poorest children with lifesaving measures that are often taken for granted in the developed world: antibiotics, vaccines, oral rehydration therapy, prenatal care and trained assistance during childbirth. We can save more than 6 million children each year by responsibly increasing funding to improve community-level health services in the developing world, where 99 percent of child deaths occur.

One in every six children in sub-Saharan Africa still dies before age 5. In some countries, parents don't name a child during the first six weeks of life because they fear the baby will not survive even its earliest days. We have the power to help calm those mothers' fears and provide hope for their children's future.

I believe medicine can serve as a currency for peace. I've seen those who once took up arms against one another unify and lay down their weapons to build health clinics. I've seen medicine inject hope where once there was only despair. Harnessing that power is true to the moral principles that have guided our nation since its founding and allows America to forge new alliances across the globe.

A U.S. Coalition for Child Survival survey conducted last fall shows 93 percent of all Americans believe saving these children should be a national priority. We cannot afford to let this opportunity to save millions of young lives pass, and I can think of no better time than Mother's Day to raise our voices to address this challenge.

William H. Frist, MD
Former U.S. Senate Majority Leader
Chairman, Save the Children's *Survive to 5* campaign

Introduction

ETHIOPIA

Every year, our *State of the World's Mothers* report reminds us of the inextricable link between the well-being of mothers and their children. More than 75 years of experience on the ground have shown us that when mothers have health care, education and economic opportunity, both they and their children have the best chance to survive and thrive.

But many are not so fortunate. Every year, more than 500,000 women die during pregnancy or childbirth, and nearly 10 million children die before reaching their fifth birthday. Almost all these deaths occur in developing countries where mothers, children and newborns lack access to basic health care services. It is especially tragic since most of these deaths could be prevented at a modest cost.

While child mortality rates in the developing world have declined in recent decades, it is of no solace to the 26,000 mothers who must mourn the loss of a child each and every day. To address the global challenge of saving mothers' and children's lives, Save the Children is working on four fronts:

First, Save the Children is increasing awareness of the challenges and solutions to maternal, newborn and child survival. As part of our *Survive to 5* campaign, this report calls attention to areas where greater investments are needed and shows that effective strategies are working, even in some of the poorest places on Earth.

Second, Save the Children is encouraging action by mobilizing citizens in the United States and around the world to support programs to reduce maternal, newborn and child mortality, and to advocate for increased leadership, commitment and funding for programs we know work.

Third, we are making a major difference on the ground. Save the Children works in partnership with national health ministries and local organizations to deliver high-quality health services throughout the developing world. Working together to improve pregnancy and delivery care, vaccinate children, treat diarrhea, pneumonia and malaria, as well as to improve children's nutrition, we have saved millions of children's lives. The tragedy is that so many more could be saved, if only more resources were available to ensure that these lifesaving programs reach all those who need them.

Fourth, within our programs that deliver services, we are leading the way in research about what works best to save the lives of babies in the first month of life, who account for close to 40 percent of deaths among children under age 5. Our groundbreaking *Saving Newborn Lives* program, launched in 2000 with a grant from the Bill & Melinda Gates Foundation, has identified better care practices and improved interventions to save newborn lives. The benefits of these efforts have reached over 20 million women and babies in a dozen countries and now are being extended to new mothers in additional countries, ensuring that even more babies receive needed care, especially during the critical first week of life.

We count on the world's leaders to take stock of how mothers and children are faring in every country. Investing in this most basic partnership of all – between a mother and her child – is the first and best step in ensuring healthy children, prosperous families and strong communities.

Every one of us has a role to play. Please read the *Take Action* section of this report, and visit www.savethechildren.org on a regular basis to find out what you can do to make a difference.

Charles F. MacCormack
President and CEO
Save the Children

Executive Summary

Worldwide, more than 200 million children under age 5 do not get the basic health care they need. This contributes to nearly 10 million children dying needlessly every year from highly preventable or treatable ailments such as diarrhea and pneumonia.

A disproportionate number of the children without health care come from the poorest and most marginalized families in developing countries. While there has been significant progress in reducing the overall death toll among children under 5 in recent decades, death rates among the poorest of the poor have not improved nearly so well, and in some countries they have gotten worse. These widening health care inequities unfairly condemn millions of the world's poorest children to early death or a lifetime of ill health.

This year's *State of the World's Mothers* report shows which countries are succeeding – and which are failing – to deliver basic health care to the mothers and children who need it most. It examines where the health care gaps between the poorest and best-off children are widest, and where they are smallest. It also looks at the survival gaps between the rich and poor children in developing countries, and shows how millions of children's lives could be saved by ensuring all children get essential, low-cost health care.

KEY FINDINGS

1) An alarming number of countries are failing to provide the most basic health care that would save children's lives. In each of 55 developing countries – which together account for 83 percent of child deaths – more than 30 percent of children do not get basic health care when they need it. Our *Basic Health Care Report Card* shows that nearly 200 million children under 5 in these countries are missing out on lifesaving interventions such as prenatal care, skilled assistance during birth, immunizations, and treatment for diarrhea and pneumonia. In 30 of the 55 countries, more than half the children do not get basic health care. And in Ethiopia and Somalia – the two lowest ranked countries on the *Report Card* – more than 80 percent of children do not receive basic lifesaving health care. *(To read more, turn to pages 15-21)*

2) The poorest children are least likely to get lifesaving health care. The *Report Card* shows large inequities in health care provided to the poorest children compared to the best-off children in almost every country. This is true for highest ranked countries, as well as for the lowest ranked countries on the *Report Card*. In the Philippines and Peru, for example, the poorest children are 3.2 times more likely to go without essential health care. In the Philippines, 46 percent of the poorest children lack health care, and in Peru that number is 48 percent. In Mali and Nigeria, the poorest children are 2.5 times more likely to go without health care. In Mali, 67 percent of the poorest children do not get health care and in Nigeria, 83 percent do not. *(To read more, turn to page 21)*

3) Child death rates are highest in the poorest, most disadvantaged places. Nearly all under-5 deaths (99 percent) occur in the developing world. Within countries, death rates among the poorest children are higher. On average, a child in the poorest fifth of a population faces a risk of dying that is more than twice that of a child from the richest fifth. In many countries, the under-5 mortality rate among the poorest children is 3 times higher or more. Latin American countries such as Brazil, Bolivia and Peru have some of the world's widest survival gaps. Of all the countries on the *Report Card*, Peru has the largest child survival gap – the poorest Peruvian children are 7.4 times more likely to die than the richest Peruvian children. In Asia, large disparities are seen in Indonesia, the Philippines and India. In the Middle East, Egypt and Morocco have large inequities. And in Africa, Nigeria and South Africa have the greatest survival gaps between rich and poor children. *(To read more, turn to pages 9-21)*

4) The funding for child survival does not match the need. Worldwide spending on health care disproportionately benefits people living in high-income countries with expensive problems to treat, while most of the disease and almost all of the preventable child deaths occur in developing countries. The overall shortfall between the funds needed and funds committed to save children's lives is very large. Also, the causes that kill the most children do not receive a corresponding share of the funding that does exist. *(To read more, turn to pages 12-13)*

5) Closing health care coverage gaps could save more than 6 million children each year. It is estimated that 3.9 million more children would survive to age 5 every year if the world were to close existing child survival equity gaps. And if all children – rich and poor alike – were to receive a full package of essential health care, 6.1 million children's lives would be saved each year. Closing the survival gaps in India and Nigeria alone would prevent nearly 20 percent of global child deaths – this would mean 1.1 million Indian children and 660,000 Nigerian children would be saved each year. *(To read more, turn to page 13)*

◂ NEPAL

A SNAPSHOT: SAVING THE LIVES OF MOTHERS AND CHILDREN

Worldwide, more than 200 million children under age 5 do not get basic health care when they need it.[1]

Each year, 9.7 million children die worldwide before reaching their fifth birthday. That's more than 26,000 children every day.[2]

More than 1 death in every 6 in the world is the death of a child under the age of 5.[3]

Every minute, a woman meets her death during pregnancy or childbirth.[4]

Every year, 2 million newborn babies die on the day they are born.[5]

The biggest killers of children worldwide are newborn complications, pneumonia, diarrhea and malaria.[6]

Using existing, low-cost tools and knowledge, we could save more than 6 million of the 9.7 million children who die every year from easily preventable or treatable causes.[7]

ANGOLA

RECOMMENDATIONS

1) Design health care programs to better target the poorest and most marginalized mothers and children. If we are to solve the child survival problem once and for all, we need to close the coverage gap for all children, but especially the gap between rich and poor. Health outreach strategies and funding allocations must target the hardest-to-reach mothers and children who are most in need. *(To read more, turn to pages 23-29)*

2) Strengthen basic health systems. Thousands of children die every day in developing countries because health systems are grossly under-funded and cannot meet the needs of the people. More funding is needed for staffing, transport, equipment, medicine, health worker training, and the day-to-day costs of operating these systems.

3) Deliver a basic package of maternal, newborn and child health care that takes into account the realities for poor people in developing countries. The tools to save mothers' and children's lives work best when they are delivered together as a package and along a "continuum of care" that links communities, local health facilities and hospitals. This means starting with good care for children in the home to prevent and treat the simplest ailments, then providing services in local clinics for more serious problems, and finally providing hospital care for the most severe conditions. Most health systems invest in the opposite order, devoting significant resources to hospital-based care. The reality is that most sick children in the developing world never make it to a hospital.

4) Invest in community health care workers to reach the poorest of the poor with essential lifesaving care. Millions of poor and marginalized families do not get basic health care because it is simply unavailable, too far away or too expensive. Many children die from causes that do not require doctors or hospitals, and could be saved by training, equipping and deploying more community health care workers who can deliver this basic health care. These health workers – who would live in or near the communities that need help most – could serve as a powerful first line of defense against the most common killers of children. *(To read more, turn to pages 23-29)*

5) Increase government support for proven solutions that save children's lives. In order to meet internationally agreed-upon development goals to reduce child deaths and improve mothers' health, lifesaving services must be increased for the children and newborns who need help most. The United States should demonstrate leadership toward these goals by passing the *U.S. Commitment to Global Child Survival Act* (HR 2266 and S1418) and fully fund programs to save children's lives. This bill renews U.S. leadership for child and newborn health programs in developing countries while ensuring greater coordination and accountability in the delivery of these services. *(To read more, turn to page 35)*

Executive Summary

THE 2008 MOTHERS' INDEX: SWEDEN TOPS LIST, NIGER RANKS LAST, UNITED STATES RANKS 27TH

Save the Children's ninth annual Mothers' Index *compares the well-being of mothers and children in 146 countries – more than in any previous year. The* Mothers' Index *also provides information on an additional 27 countries, 22 of which report sufficient data to present findings on children's indicators. When these are included, the total comes to 173 countries.*

Sweden, Norway 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. Niger ranks last among the 146 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 27th this year. Last year it was 26th.

Conditions for mothers and their children in the bottom countries are grim. On average, 1 in 21 mothers will die from pregnancy-related causes. More than 1 child in 6 dies before his or her fifth birthday, and roughly 1 child in 3 suffers from malnutrition. About 50 percent of the population lack access to safe water and only 3 girls for every 4 boys are enrolled in primary school.

The gap in availability of maternal and child health services is especially dramatic when comparing Sweden and Niger. Skilled health personnel are present at virtually every birth in Sweden, while only 33 percent of births are attended in Niger. A typical Swedish woman has nearly 17 years of formal education and will live to be 83 years old, 72 percent are using some modern method of contraception, and only 1 in 185 will lose a child before his or her fifth birthday. At the opposite end of the spectrum, in Niger, a typical woman has less than 3 years of education and will live to be 45. Only 4 percent of women are using modern contraception, and 1 child in 4 dies before his or her fifth birthday. At this rate, every mother in Niger is likely to suffer the loss of a child and 9 out of 10 mothers are likely to lose two children in their lifetime.

Zeroing in on the children's well-being portion of the Mothers' Index, *Italy finishes first and Niger is last out of 168 countries. While nearly every Italian child – girl and boy alike – enjoys good health and education, children in Niger face a 1 in 4 risk of dying before age 5. Forty-four percent of Niger's children are malnourished and 54 percent lack access to safe water. Only 47 percent of children in Niger are enrolled in primary school, and within that meager enrollment, boys outnumber girls 4 to 3.*

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.

NIGER

200 Million Children Do Not Get Their Fair Share of Health Care

Worldwide, more than 200 million children under age 5 do not get basic health care when they need it.[8] As a result, more than 26,000 children die needlessly every day from easily preventable or treatable ailments such as diarrhea and pneumonia.[9]

Who are these children? They tend to be the poorest of the poor in developing countries. They live in communities where there are few health clinics and even fewer health personnel. They often belong to ethnic or religious minority groups who have faced generations of neglect and discrimination. And more often than not, they are girls.

The so-called "child survival" problem has been around for decades – it is one of the most stubborn and longstanding challenges facing the world. The tragic irony is that affordable solutions have also existed for decades, and these solutions are being steadily refined and improved. What has been lacking is political will and funding needed to deliver these proven solutions to the children who need them most.

In the early 1980s, the international community joined together to launch the "child survival revolution," which promoted the use of low-cost, basic health care interventions to prevent and treat the major causes of infant and child mortality. Since then, the number of children under 5 who die worldwide each year has steadily declined – it is now below 10 million for the first time in recorded history.

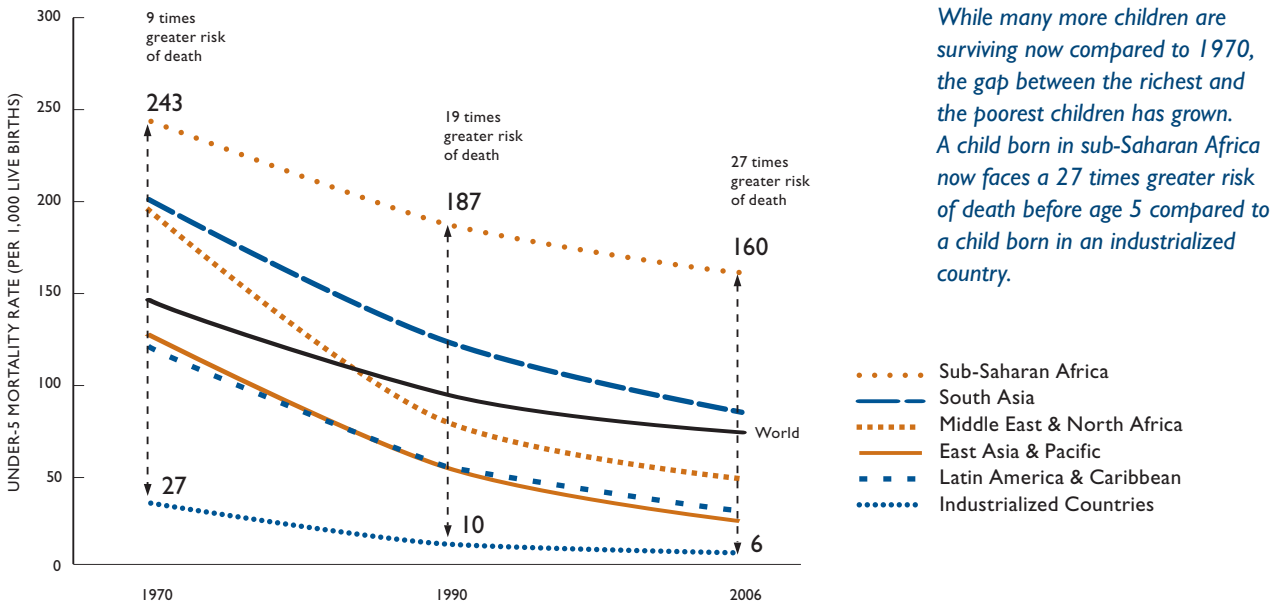
But the majority of children whose lives have been saved were the ones who were easiest to save. Better-off segments of countries and societies have benefited most.[10] Advances in child survival have come more slowly in poor countries, and to the poorest people within those countries. The child survival revolution, for all its accomplishments, has left large inequalities between rich and poor.

GROWING INEQUITIES FOR THE POOREST CHILDREN

A child's chance of making it to his or her fifth birthday depends to a great extent on the country or community where the child is born. At the heart of the child survival problem is a widening gap between the health of the world's rich and poor. Virtually all child deaths (99 percent)[11] occur in developing countries in settings of poverty.[12] And the gap in child death rates between the richest and poorest regions of the world has increased in recent decades.

Within countries, death rates among the poorest children are higher. On average, a child in the poorest fifth of a population faces a risk of dying that is more than twice that of a child from the richest fifth.[13] Among babies in the first month of life (who account for 37 percent of deaths among

PROGRESS SLOWS AS THE SURVIVAL GAP GROWS, 1970-2006



While many more children are surviving now compared to 1970, the gap between the richest and the poorest children has grown. A child born in sub-Saharan Africa now faces a 27 times greater risk of death before age 5 compared to a child born in an industrialized country.

Source: UNICEF. *State of the World's Children 2008*. Table 10, p.153

200 Million Children Do Not Get Their Fair Share of Health Care

children under age 5), those born to mothers in the poorest fifth of a population are almost 30 percent more likely to die compared to those in the richest fifth.[14] These aggregate statistics mask much larger differences in many countries.

In many countries, the under-5 mortality rate among the poorest children is 3 times higher or more than among the richest children. Latin American countries such as Brazil, Bolivia and Peru have some the world's widest survival gaps. In Asia, large disparities are seen in India, Indonesia and the Philippines. In the Middle East, Egypt and Morocco have large inequities. And in Africa, Nigeria and South Africa have the greatest survival gaps between rich and poor children.

A mother in sub-Saharan Africa is 83 times as likely as a mother in an industrialized country to lose her child in the first 5 years of life.[15] Four out of 5 mothers in sub-Saharan Africa are likely to lose a child during their lifetime[16] – a commonplace but largely untold tale of grief.

In almost every developing country, the disparities in health and health care are large and growing. Children of the poorest, most marginalized families are considerably less likely to have access to lifesaving interventions compared to children from the best-off families.

The poorest children are more vulnerable to death and disease because of greater exposure to unclean water, poor sanitation, indoor pollution and inadequate housing conditions. They are more likely to be born at a low birthweight, to become malnourished and to contract recurring common diseases. These factors make the poorest children more susceptible to life-threatening infectious diseases.[17]

The poorest children also face greater risks because their parents often lack knowledge of healthy practices and lifesaving services. The most impoverished mothers and families are the least likely to use the services that can do the most to save children and safeguard their health.

Not surprisingly, the quality of services for the poorest communities is usually inferior to the quality of services for wealthier communities. Staffing, supervision and supply logistics are more difficult in remote, impoverished areas. Roads may be impassible in certain seasons. And even in settings with better infrastructure, disadvantaged ethnic groups sometimes face unsympathetic or even hostile health providers, which deters them from seeking prompt care.

SURVIVAL GAPS FOR GIRLS IN INDIA AND CHINA

In most countries, girls survive at somewhat higher rates than boys. But in India and China – the two most populous countries in the world – girls die at much higher rates than boys, and the gender gaps are widening.

India has the world's largest gender survival gap. Indian girls are 61 percent more likely than boys to die between the ages of 1 and 5. This means that for every 5 boys who die, 8 girls die.[18] While India has cut its overall child mortality rate by 34 percent since 1990, the survival gap between girls and boys has widened. The gap is widest in rural areas, but this is by no means a strictly rural phenomenon.[19]

In China, girls are 30 percent more likely than boys to die before reaching their fifth birthday. That is, for every 7 boys who die, 9 girls die.[20] Recent research concludes not only that the female-male gap is widening, but that it reflects rising infant and under-5 mortality rates among girls in China.[21]

The main reason for the gender gaps in India and China is inequity of health care for female and male children. Son preference is deeply rooted in Indian and Chinese traditional culture, which results in discrimination against girls in nutrition as well as in preventive and curative health care. Girls in India are often brought to health facilities in more advanced states of illness than boys, and taken to less qualified doctors when ill.[22] In both countries, less money is spent on girls' health compared to boys.[23, 24] As a result, girls are less likely to receive the medicines and treatments they need. In India's Punjab state, results of one study showed that expenditure on health care during the first two years of life was 2.3 times greater for sons than for daughters.[25]

Even where progress is being made in child survival, reductions in female mortality have been counterbalanced by female infanticide and sex-selective abortions. Researchers estimate there are as many as 500,000 "missing girls" each year in India due to sex-selective abortion and infanticide.[26] These practices could amount to 10 million missing girls over the last 20 years.[27] The corresponding figure for China is estimated at 35 to 41 million missing girls, or more than 6 percent of the Chinese population.[28]

INDIA

THE CRITICAL LINK BETWEEN MOTHER AND CHILD

Numerous studies have documented the inextricable link between the well-being of mothers and that of their children. When mothers are poor, uneducated and unable to access health care, the risks to themselves and their children multiply.

Poor women often do not get adequate care during pregnancy and childbirth. They are far more likely than rich women to die from common complications of childbirth. Women who become pregnant in developing countries face a risk of maternal death 6 to 600 times higher than women in developed counties.[29] A woman's lifetime risk of dying due to maternal causes is:

- in Africa, 1 in 26;
- in Asia, 1 in 120;
- in Latin America, 1 in 290;
- in more-developed countries, 1 in 7,300.[30]

It is estimated that every year, 50 million women in developing countries give birth at home with no professional care whatsoever,[31] and about 533,000 women die in childbirth or from complications of pregnancy.[32]

A mother's death is more than a personal tragedy. It can have severe consequences, not only for her family, but also for the community and the economy. When mothers die, their young children are 3 to 10 times more likely to die.[33] Every year, nearly 4 million newborn babies die in the first month of life, mostly from preventable causes. The majority of these deaths occur in settings where there are also very high rates of maternal death.[34]

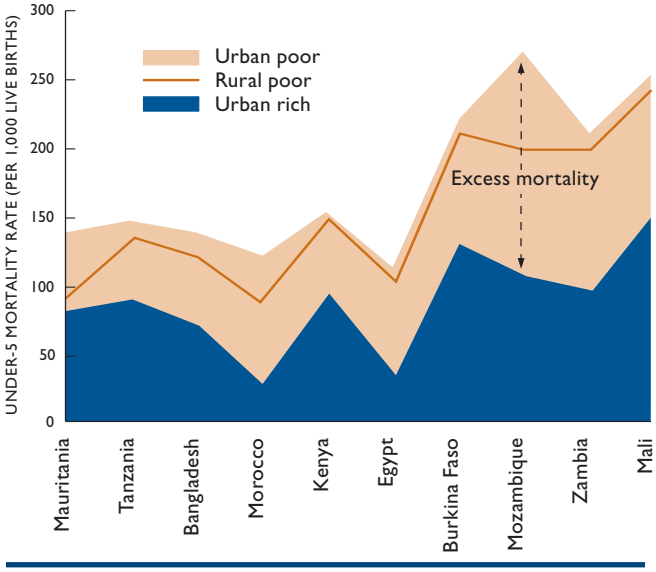
URBAN-RURAL DISPARITIES IN CHILD SURVIVAL

In general, urban children in the developing world enjoy better health than their rural counterparts and face a lower risk of dying before age 5. On average, urban children are better nourished. They are less likely to suffer chronic malnourishment (stunting) and to be severely underweight.[35]

In some countries, however, the rural environment is healthier than the urban one. In Bangladesh, stunting rates are higher in urban areas.[36] In Mauritania, Morocco and Mozambique, children of the urban poor are 40 to 60 percent more likely to die before their fifth birthday compared to even their poorest rural counterparts. And in the slums of Rio de Janeiro, Brazil, infant mortality rates are up to 10 times higher than those in neighboring wealthy suburbs.[37] Children in these slums lack access to health care and many other basic services.

High levels of overcrowding in urban areas make poor children vulnerable to communicable diseases such as diarrhea, acute respiratory infections and meningitis. Vaccine-preventable diseases such as measles, diphtheria and whooping cough also spread more rapidly in overcrowded urban areas. And inadequate sanitation and drainage magnifies risk of communicable disease.[38]

10 Countries Where Children of the Urban Poor Fare Worse Than Their Rural Peers



Source: Davidson R.Gwatkin, et al. *Socio-Economic Differences in Health, Nutrition, and Population (2007).*

200 Million Children Do Not Get Their Fair Share of Health Care

THE RURAL POOR FACE THE GREATEST RISKS

Children born to poor mothers in rural areas face great challenges to survival. Babies born in rural areas are 21 percent more likely to die in the first month of life compared to those in urban areas.[39] These babies are often born at home, without any contact with the health system. The mother might be aided at delivery by a neighbor or family member or by no one at all. In sub-Saharan Africa and South Asia, for example, just over 40 percent of women deliver with a skilled attendant.[40]

Rural mothers in Burundi, Eritrea, Nepal and Pakistan are 80 percent less likely to give birth with a skilled attendant compared to urban mothers.[41] In Chad and Niger, for every 100 urban births assisted by skilled health personnel, fewer than 15 rural births are.[42] And in Ethiopia, less than 3 percent of rural births are attended, compared to 45 percent of urban ones.[43]

The poorest mothers and newborns in some countries fare even worse. In Bangladesh, Chad and Nepal, less than 4 percent of births to poor mothers are attended by skilled personnel.[44] In Ethiopia, less than 1 percent of poor mothers give birth with a skilled attendant and best-off mothers are 38 times more likely to give birth with assistance.[45]

Poor mothers are generally less educated and less likely to ensure their children are immunized or to recognize danger signs when their children are sick and in need of professional care.

In sub-Saharan Africa, the poorest children are over 5 times more likely to be without any basic immunization coverage than the wealthiest children.[46] In South and East Asia, children in the poorest households are over 6.5 times more likely to receive no immunizations.[47] In Niger, less than 5 percent of the poorest children are fully immunized, compared to more than 50 percent of the wealthiest children.[48] In Chad, Nigeria and Yemen, the poorest children are 78 percent less likely to be immunized against measles.[49]

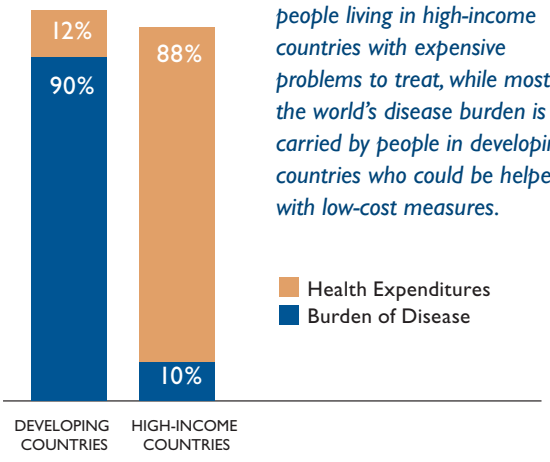
Rural children, poor children and children of poorly educated mothers are about 25 percent less likely than others to be taken to an appropriate health care provider when they show signs of pneumonia.[50] And the poorest children are 20 and 40 percent less likely to be treated for diarrhea and fever.[51]

FUNDING FOR CHILD SURVIVAL DOES NOT MATCH UP WITH NEED

Global support for the child survival agenda in the 1980s dramatically increased the availability of lifesaving measures and helped save millions of young lives. But support for child survival programs has not kept pace with increasing needs, and funding for child survival programs by major international donors has been stagnant or declining since the 1990s.

Diseases such as AIDS and tuberculosis – which have high profiles and vocal activists – are attracting more interest and money from big donors and governments today, based partly on the mistaken belief that they kill the most children. But the truth is that most children in the developing world are dying today from the same preventable killers that have stalked them for decades: diarrhea, pneumonia, measles, malaria and newborn infections such as tetanus.

DEVELOPING COUNTRIES HAVE THE MOST DISEASE YET THE LEAST MONEY FOR HEALTH CARE



Worldwide spending on health care disproportionately benefits people living in high-income countries with expensive problems to treat, while most of the world's disease burden is carried by people in developing countries who could be helped with low-cost measures.

Source: WHO. *World Health Statistics 2007*.

An analysis of the health funding priorities of 42 major donors shows that much of the money being granted today for the health of the world's poor does not target the needs of the mothers and children who are most at risk. First of all, the overall shortfall between the funds needed and funds committed is very large. Second, the diseases that kill the most children do not receive a corresponding share of the funding.[52]

ETHIOPIA

The study looked at donor funding for 20 communicable diseases from 1996 to 2003 and found that tetanus, measles and acute respiratory infections (such as pneumonia) are the three diseases where needs and funding are most out of sync.[53] For example, pneumonia represents more than a quarter of what is referred to as the "disease burden" in developing countries – nearly as high as that of AIDS – yet pneumonia receives less than 2.5 percent of direct funding, while AIDS receives 46.2 percent of direct donor assistance. Measles represents 9 percent of the burden but receives only 1.7 percent of funds. And tetanus represents 3.3 percent of the burden but receives less than 1 percent of funds.[54]

Since 1960, the United States has provided significant support for programs to save the lives of children and their mothers, yet funding for maternal and child health programs has stagnated over the past decade. When adjusted for inflation, U.S. funds for child and maternal health have declined by nearly 20 percent, a significant drop in light of the increasing numbers of children under 5 in high-mortality countries.

In 2008, the U.S. Congress began to reverse this trend and made a significant commitment to the world's children. For the first time in a decade, U.S. funding for child and maternal health received a critical boost of almost $100 million, bringing the total U.S. investment in programs funded by the U.S. Agency for International Development (USAID) to $446 million.

THE LIFESAVING POTENTIAL OF EQUITY

If we are to solve the child survival problem once and for all, the world will have to close the gap between rich and poor and target health outreach efforts to the hardest-to-reach children. It is estimated that 3.9 million more children would survive to age 5 every year if we were to close existing equity gaps. And if all children – rich and poor alike – were to receive a full package of essential health care, 6.1 million children's lives would be saved each year.

- **3.9 million children saved** – If every country in the world were to close its own survival gap, 40 percent of all under-5 deaths would be prevented. In other words, if within each country all children survived at the same rate as the best-off 20 percent of the population, 3.9 million lives would be saved.[55]

  Nearly 20 percent of global child deaths could be prevented by closing the survival gaps in India and Nigeria alone – two of the world's most inequitable countries that also have very large populations. This would mean 1.1 million children's lives would be saved in India and 660,000 would be saved in Nigeria each year.

- **6.1 million children saved** – If all children – rich and poor alike – received universal coverage of lifesaving interventions, 63 percent of all under-5 deaths would be prevented.[56] That is, if all children in high-mortality countries were to benefit from preventive and curative interventions such as skilled birth attendance, immunizations and treatment for pneumonia, diarrhea and malaria, 6.1 million lives would be saved each year.

Targeting health care to the poor will maximize the number of children's lives we can save. The child survival success stories of the past several decades have clearly shown this is possible. The challenge now is to extend proven, lifesaving health care to the rest of the world's children – the ones who need it most.

Report Card: How Well Are Countries Providing Children With Basic Health Care?

Save the Children presents a first-ever *Basic Health Care Report Card* showing which developing countries are doing the best and the worst at reaching children with basic health care. This analysis clearly shows that in order to solve the child survival problem once and for all, we will have to close the gap between rich and poor and target our efforts to the hardest-to-reach children.

The *Report Card* examines 55 countries that together account for 59 percent of the world's under-5 population and 83 percent of the deaths among children under age 5. It looks at how many children in these countries do not get basic health care when they need it, and how conditions differ among the poorest and wealthiest children within each country. It finds alarming numbers of children not receiving even the most basic health services, as well as inequities in health coverage and death rates for the poorest children in every country.

Countries are ranked based on the total percentage of children who do not get basic health care when they need it. We define "basic health care" as a package of lifesaving interventions that includes: prenatal care, skilled care at childbirth, immunizations, and treatment for diarrhea and pneumonia.

In every country on the *Report Card*, more than 30 percent of children lack these essential health care services. In more than half of these countries, 50 percent or more of children do not get health care. In Ethiopia and Chad – the two lowest ranked countries on the *Report Card* – more than 80 percent of children do not receive basic lifesaving health care.

The Philippines, with 31 percent of children under 5 missing out on basic health care, is the highest ranked country in this analysis. Ethiopia, with 84 percent of children not getting basic health care, ranks the lowest.

Within countries, there are alarming gaps in survival rates between the poorest and best-off children. South Africa and Peru have the largest survival gaps between rich and poor. In South Africa, the poorest children are 4 times more likely to die before reaching age 5. In Peru, the poorest children are 7.4 times more likely to die. In Brazil, Egypt and India, meanwhile, a poor child is 3 times more likely to die than a rich child.

There are also alarming inequities in whether health services reach the poorest children compared to the best-off children. This is true for countries where the national averages are relatively good, such as the Philippines (where 46 percent of the poorest children do not get health care, compared to 14 percent of the best-off children), Indonesia (48 percent of poorest versus 23 percent of best-off) and Bolivia (58 versus 24 percent). It is also true in countries where the national health care averages are bleakest, such as Cameroon, Mali and Nigeria, where the poorest children are 2.3, 2.5 and 2.5 times more likely than the best-off to get the health care they need. In Mali, 67 percent of the poorest children do not get basic health care. In Cameroon, 76 percent do not; and in Nigeria, 83 percent of the poorest children go without basic health care.

WHERE THE MOST CHILDREN GET HEALTH CARE

PHILIPPINES

The PHILIPPINES is making good progress in improving health care for children and has achieved a 48 percent reduction in its under-5 death rate since 1990.[57] But progress has favored the nation's best-off children – between 1998 and 2003, the child survival gap grew by 18 percent.[58] With support from USAID, the Philippine Department of Health launched a number of initiatives in 1989 promoting immunizations to prevent disease, oral rehydration therapy to treat life-threatening diarrhea, and breastfeeding to improve early childhood nutrition.[59] Today more than three-quarters of children with diarrhea receive oral rehydration therapy (the highest percentage of any country in this analysis) and 92 percent of 1-year-olds are vaccinated against measles.[60] The Philippines has one of the lowest newborn mortality rates in the developing world (15 per 1,000 live births).[61] Sixty percent of births in the Philippines are assisted by trained

◂ MOZAMBIQUE

personnel, but the disparity between rich and poor is wide, with 92 percent of births among the wealthiest assisted by skilled health professionals, compared to 25 percent among the poorest.[62] Nearly half of the poorest children under 5 in the Philippines (46 percent) do not get health care when they need it, and a poor child is 3.2 times more likely than a rich child to die before reaching age 5. The Philippines could save many more children's lives by targeting health care to the poor. If all children survived at the same rates as the wealthiest children, 35 percent of the Philippines' under-5 deaths could be averted. That means 26,000 Philippine children would be saved each year.

PERU appears to have relatively high standards of health care for children based on national averages. However, it has the most glaring inequities between rich and poor children of all countries analyzed for this report. On average, 68 percent of Peruvian children get health care when they need it, but among the wealthiest families, 85 percent of children receive care while half of the children in the poorest families miss out on essential health services. As a result, the poorest children in Peru have a 7.4 times higher risk of death compared to the best-off children, and this gap has widened in the past decade. Approximately 95 percent of Peruvian children are immunized to prevent measles, polio and other diseases, but only 57 percent of children with diarrhea receive oral rehydration therapy. Nearly a third of children with pneumonia do not see a skilled health care provider.[63] The poorest mothers in Peru are 65 percent less likely to give birth with skilled assistance and the newborn mortality rate is 11.5 times higher among the poorest.[64] Closing the child survival gap could save 69 percent of the children who die every year in Peru before their fifth birthday.

SOUTH AFRICA also has better-than-average health care compared to other developing countries, but the inequity in survival rates of the poorest and the wealthiest children is stark, and overall under-5 mortality rates are worsening, not improving. More than a third of South African children (34 percent) do not get health care when they need it, and a poor child is 4 times more likely to die than a rich child. Since 1990, the child mortality rate in South Africa has risen 15 percent,[65] and AIDS is associated with 57 percent of child deaths.[66] It is estimated that 29 percent of pregnant women are infected with HIV,[67] and 1.2 million children under the age of 17 had been orphaned by AIDS.[68] Preventing mother-to-child transmission of HIV is critical to saving the lives of children under 5.[69] After AIDS, newborn complications comprise the second most frequent killer of children – accounting for 35 percent of under-5 deaths[70] – and this is the area where there is the greatest disparity between rich and poor. Nearly all of the wealthiest mothers in South Africa benefit from skilled assistance during childbirth, while about a third of the poorest mothers do not.[71] Improving delivery care for the poorest mothers could do a lot to prevent newborn deaths. If under-5 survival rates among the poorest South African children were raised to those of the richest, 68 percent of child deaths could be prevented. That means 52,000 South African children would be saved each year.

INDONESIA

INDONESIA is making remarkable progress in saving children's lives, having cut its under-5 mortality rate by 63 percent since 1990.[72] Still, more than 7.5 million Indonesian children (35 percent) do not get the health care they need.

Report Card: How Well Are Countries Providing Children With Basic Health Care?

With support from international donors, Indonesia has made substantial investments in public health in recent years. The majority (92 percent) of pregnant women in Indonesia receive prenatal care, 87 percent are vaccinated against tetanus and 72 percent of births are attended by skilled personnel.[73] Oral rehydration therapy, which is promoted through health education and mass media campaigns,[74] is received by 56 percent of children with diarrhea.[75] Immunization rates are over 70 percent[76] but have been dropping. Newborn diseases account for 38 percent of all under-5 deaths,[77] and the situation is most precarious among the nation's poorest families, where 60 percent of women give birth without a skilled attendant (compared to 6 percent in the most affluent households). Indonesia is one of the few countries in which recent progress in child survival has been equitably shared. Between 1997 and 2003, the under-5 mortality rate among the poorest fell by 30 percent, compared to 25 percent among the richest.[78] Yet despite this progress in closing the child survival gap, the poorest Indonesian children are still 3.5 times more likely to die before their fifth birthday compared to their best-off peers, and the poorest infants have an 8 times greater risk of dying between the first day of life and their first birthday.[79] If all children instead experienced the same rates of survival as the wealthiest, 36 percent of child deaths in Indonesia could be prevented. That means 54,000 Indonesian children would be saved each year.

TURKMENISTAN has achieved a 48 percent reduction in its under-5 death rate since 1990[80] and many health care advances have been equitably shared between the poorest and richest segments of society. The government has launched a nationwide effort to certify hospitals as "baby-friendly" and nearly all mothers and newborns (98 percent or more) now receive prenatal care and skilled assistance during childbirth. Turkmenistan also does a good job of ensuring that children are vaccinated – rates for immunization against the most common childhood diseases are 98 percent or above. Still, more than a third of Turkmenistan's children (35 percent) do not get essential basic health care when they need it. Only half the children with pneumonia receive treatment with antibiotics and only 25 percent of children with diarrhea receive oral rehydration therapy.[81] For every 2 children from the wealthiest families who die, 3 children from the poorest families perish. This is perhaps due to higher prevalence of diarrhea in rural areas and low rates of treatment. Only 54 percent of children in rural areas have access to safe drinking water (compared to 93 percent of urban residents)[82] and the poorest children are 25 percent less likely to receive oral rehydration therapy compared to the best-off children.[83]

Malnutrition is another concern. The poorest children are nearly 50 percent more likely to be moderately stunted.[84]

10 COUNTRIES WITH THE HIGHEST NUMBER OF CHILDREN WHO ARE NOT GETTING ADEQUATE HEALTH CARE

		Children without basic health care	
	Country	Percent (%)	Absolute number
1	India	53	67,127,000
2	Nigeria	66	16,090,000
3	Bangladesh	62	11,656,000
4	Ethiopia	84	11,317,000
5	Pakistan	55	10,478,000
6	Brazil	44	7,929,000
7	Indonesia	35	7,599,000
8	DR Congo	61	7,229,000
9	Egypt	48	4,117,000
10	Kenya	56	3,423,000
			Total: 146,965,000

WHERE THE FEWEST CHILDREN GET HEALTH CARE

In NIGERIA, 66 percent of the children under 5 (more than 16 million children) do not get the health care they need. The gap between the wealthiest and the poorest is pronounced: While 33 percent of the best-off children go without health care, that figure climbs to 83 percent among the poorest. As a result, poor children in Nigeria are 3.2 times more likely to die than their best-off peers, and the data suggest the survival gap between rich and poor is widening.[85] With its large population and high under-5 mortality rate, Nigeria accounts for more than 1 million of the nearly 10 million child deaths each year. Currently, 65 percent of births take place at home with no skilled assistance,[86] 67 percent of children with pneumonia do not receive care, and 72 percent of children with diarrhea do not get oral rehydration therapy.[87] And the poorest children are more than twice as likely to go without care as the wealthiest. For example, 84 percent of the poorest children with diarrhea do not get oral rehydration therapy (compared to 47 percent of the wealthiest). These children are up to 9 times more likely to go without immunizations and mothers are 5.6 times more likely to give birth without skilled assistance.[88] Nigeria could save

Report Card: How Well Are Countries Providing Children With Basic Health Care?

millions of children's lives by improving basic health care for the poorest families and closing the survival gap. If all children in Nigeria survived at the same rate as the best-off 20 percent of the population, 59 percent of child deaths could be prevented. That means 660,000 Nigerian children's lives would be saved each year.

In YEMEN, 71 percent of the children (more than 2.5 million children) do not get health care when they need it. About two-thirds of Yemen's population, including 80 percent of the country's poor people, live in rural areas with little access to health care, electricity and other services.[89] Nearly three-quarters of births (73 percent) take place at home with no skilled assistance and more than one-third of child deaths occur within the first month of life.[90] Pneumonia and diarrhea are leading causes of death among children under 5, yet only 47 percent of children with suspected pneumonia are taken to a health care provider. Only 18 percent of children with diarrhea receive oral rehydration therapy.[91] Among Yemen's poorest families, 87 percent of children go without basic health care, and a poor child is 2.2 times more likely to die than a child from the best-off segment of the population. The poorest children are 3 to 5 times more likely to go without basic immunizations and are half as likely to be taken for care when they are sick with pneumonia.[92] The poorest mothers in Yemen are even more disadvantaged. They are 75 and 86 percent less likely to receive prenatal and delivery care than the best-off mothers.[93]

In CHAD, 78 percent of the children do not get health care when they need it. Chad has been overwhelmed by hundreds of thousands of refugees – the majority of whom are children – fleeing conflicts in neighboring countries. As a result, under-5 mortality rates are worsening, and 1 child in 5 dies before his or her fifth birthday.[94] Only 39 percent of pregnant women in Chad receive prenatal care and 86 percent of births take place at home with no skilled assistance.[95] Acute respiratory infections, malaria and diarrheal diseases are the most common killers of children, yet only 12 percent of children with suspected pneumonia receive care, only 32 percent of children with malaria get anti-malarial drugs, and 27 percent of children with diarrhea receive oral rehydration therapy. Immunization rates for children are between 20 and 40 percent overall, but only 1 percent of the poorest children

COUNTRIES WHERE CLOSING THE SURVIVAL GAP WOULD SAVE THE MOST LIVES

Country	Under-5 mortality rate (per 1,000 live births)		Annual no. of births (thousands)	Lifesaving potential of closing the survival gap	
	National average (2006)	Best-off 20%	2006	Number of lives saved (thousands)	% under-5 deaths prevented
India	76	34	27,195	**1,142**	55
Nigeria	191	79	5,909	**660**	59
DR Congo	205	119	3,026	**260**	42
Pakistan	97	74	4,358	**101**	24
Ethiopia	123	92	3,159	**98**	25
Niger	253	157	683	**66**	38
Indonesia	34	22	4,427	**54**	36
South Africa	69	22	1,102	**52**	68
Madagascar	115	49	714	**47**	57
Angola	260	205	792	**44**	21

If all children in just these 10 countries enjoyed the same survival rates as the best-off 20 percent in their own country, more than 2.5 million children's lives would be saved each year.

Sources: 2006 national under-5 mortality rates and number of births: UNICEF. *State of the World's Children 2008*. Under-5 mortality rates of the best-off 20 percent of households: Davidson R. Gwatkin, et al. *Socio-Economic Differences in Health, Nutrition, and Population: An Overview*, supplemented with results from recent DHS and MICS surveys.

CHAD

are fully immunized.[96] The poorest mothers in Chad face horrendous odds: Only 9 percent receive prenatal care (compared to 77 percent of the best-off) and less than 2 percent give birth with the benefit of skilled assistance (compared to 51 percent of the best-off).[97] As a result, one woman in 11 will die in pregnancy or childbirth.

In SOMALIA, 82 percent of the children do not get the health care they need. Somalia is one of the poorest and most volatile countries in the world, and many families have been internally displaced by conflict and extreme poverty. Women have particularly low status in Somalia. Many are illiterate or poorly educated, and do not receive adequate care during pregnancy and childbirth. Female genital mutilation is widespread (98 percent)[98] and the country has one of the highest maternal mortality ratios in the world (1 in 12 women will die from a pregnancy-related cause).[99] A third of under-5 deaths occur among newborns in the first month of life.[100] Pneumonia and diarrhea are leading causes of death among children, yet only 13 percent of children sick with pneumonia are taken to a health care provider and only 7 percent of

Report Card: How Well Are Countries Providing Children With Basic Health Care?

children with diarrhea receive oral rehydration therapy (the lowest rate in the world).[101] Coverage of lifesaving interventions is lowest among the poorest children. Only 5 percent of the poorest children with diarrhea receive oral rehydration therapy. Poor children with suspected pneumonia are more than 80 percent less likely to be taken for treatment. And only 5 percent of the poorest children are fully immunized against diphtheria, pertussis (whooping cough) and tetanus, compared to 29 percent of the best-off children.[102] The poorest mothers are similarly disadvantaged. Whereas over 50 percent of best-off expecting mothers receive prenatal care, only 8 percent of poorest mothers do. The poorest mothers are nearly 4 times more likely to give birth without a skilled attendant – 89 percent of the poorest mothers give birth at home with no skilled assistance.[103]

In ETHIOPIA, 84 percent of children (more than 11 million) do not get health care when they need it. The vast majority of births (94 percent) take place at home with no skilled assistance (the highest rate in the world), maternal mortality rates are very high, and nearly a third of under-5 deaths occur among newborn babies within the first month of life.[104] Ethiopia is home to over 5.4 million orphans, more than 800, 000 of whom have lost parents as a result of AIDS.[105] Pneumonia and diarrhea are leading causes of death among children, yet only 19 percent of children sick with pneumonia are taken to a health care provider and 15 percent of children with diarrhea receive oral rehydration therapy.[106] The poorest children are roughly 60 percent less likely to receive lifesaving interventions. Less than 10 percent of the poorest children receive oral rehydration treatment for diarrhea, compared to 30 percent of the best-off[107]. Only 1 in 4 of the poorest children are fully immunized against measles, diphtheria, pertussis and tetanus, compared to 1 in 2 of the best-off children.[108] Coverage gaps are greatest in maternal and newborn care. Whereas 58 percent of best-off mothers receive prenatal care, less than 13 percent of the poorest mothers do.[109] Less than 1 percent of the poorest mothers receive skilled assistance at delivery, compared with 27 percent of the best-off mothers.[110] These grim statistics do not tell the whole story, however. Despite its many challenges, Ethiopia has made remarkable progress in improving health care for children and has cut its under-5 mortality rate by 40 percent since 1990.[111] This progress has favored the best-off children, unfortunately, and the survival gap is widening. If Ethiopia could close its child survival gap – that is, if all children experienced the same child survival rates as the best-off 20 percent – one-quarter of Ethiopia's child deaths could be prevented. That means 98,400 Ethiopian children's lives would be saved each year. (*See page 28 for more on how Ethiopia is working to ensure better health care for children in the future.*)

ETHIOPIA

BASIC HEALTH CARE REPORT CARD

Priority country	Population under age 5 (thousands) (2006*)	Children under age 5 without basic health care (2006*)		Rank	Coverage Gap		Survival Gap		
					Children under age 5 without basic health care*		Under-5 mortality rate* (per 1,000 live births)		
		percent (%)	absolute no. (thousands)		poorest (%)	best-off (%)	poorest	best-off	poorest children's higher risk of death
Philippines	11,027	31	3,391	1	46	14	66	21	3.2
Peru	2,815	32	912	2	48	15	59	8	7.4
South Africa	5,254	34	1,807	3	44	40	87	22	4.0
Indonesia	21,720	35	7,599	4	48	23	77	22	3.5
Turkmenistan	491	35	173	4	32	32	106	70	1.5
Azerbaijan	547	39	215	6	51	55	133	41	3.2
Gabon	158	39	61	6	51	34	93	55	1.7
Bolivia	1,243	40	493	8	58	24	119	37	3.2
Lesotho	272	41	112	9	51	31	114	82	1.4
Congo	587	42	245	10	52	32	135	85	1.6
Benin	1,488	44	647	11	56	32	151	83	1.8
Brazil	18,092	44	7,929	11	56	38	99	33	3.0
Gambia	261	44	116	11	54	38	158	72	2.2
Zambia	2,012	45	904	14	55	27	192	92	2.1
Cambodia	1,690	46	772	15	55	36	127	43	3.0
Tanzania, United Republic of	6,953	46	3,167	15	51	26	137	93	1.5
Morocco	2,978	47	1,406	17	66	31	78	26	3.0
Mozambique	3,670	47	1,733	17	61	27	196	108	1.8
Tajikistan**	858	47	401	17	50	39	98	57	1.7
Egypt	8,634	48	4,117	20	54	39	75	25	3.0
Madagascar	3,142	48	1,521	20	61	25	142	49	2.9
Côte d'Ivoire	2,849	49	1,395	22	62	23	150	100	1.5
Senegal	1,913	49	931	22	63	36	183	64	2.9
Swaziland	147	49	71	22	57	41	-	-	-
Burkina Faso	2,605	50	1,300	25	65	29	206	144	1.4
Central African Republic	668	52	347	26	66	34	223	112	2.0
Eritrea	808	53	428	27	80	41	100	65	1.5
Ghana	3,195	53	1,686	27	65	44	118	100	1.2
India	126,843	53	67,127	27	66	31	101	34	3.0
Malawi	2,425	54	1,311	30	60	43	183	111	1.6
Uganda	5,840	54	3,133	30	56	40	172	108	1.6
Pakistan	19,012	55	10,478	32	81	45	125	74	1.7
Angola	3,082	56	1,738	33	68	43	288	205	1.4
Guinea	1,544	56	872	33	71	37	217	113	1.9
Kenya	6,161	56	3,423	33	66	40	149	91	1.6
Mali	2,247	56	1,247	33	67	27	248	148	1.7
Cameroon	2,851	57	1,632	37	76	33	189	88	2.1
Sierra Leone	999	57	572	37	62	45	268	179	1.5
Guatemala	2,066	58	1,202	39	79	45	78	39	2.0
Togo	1,045	59	619	40	73	45	150	62	2.4
Guinea-Bissau**	322	60	192	41	70	39	253	166	1.5
Haiti	1,244	60	744	41	77	46	125	55	2.3
Congo, Democratic Republic of the	11,843	61	7,229	43	69	50	248	119	2.1
Bangladesh	18,951	62	11,656	44	76	39	121	71	1.7
Nepal	3,626	62	2,265	44	75	38	98	47	2.1
Niger	2,713	62	1,688	44	71	41	206	157	1.3
Rwanda	1,617	63	1,017	47	69	50	211	122	1.7
Burundi	1,461	64	933	48	77	60	-	-	-
Mauritania	456	65	298	49	84	48	98	79	1.2
Nigeria	24,503	66	16,090	50	83	33	257	79	3.2
Lao People's Democratic Republic	715	69	491	51	76	67	-	-	-
Yemen	3,639	71	2,573	52	87	61	163	73	2.2
Chad	1,943	78	1,521	53	93	58	176	187	0.9
Somalia**	1,507	82	1,236	54	93	63	140	128	1.1
Ethiopia	13,439	84	11,317	55	90	68	130	92	1.4
TOTAL:	**368,171**		**196,485**	**Over half the children in these countries go without basic health care**					

Methodology: The percent of children under age 5 without basic health care is calculated as a weighted average of seven key lifesaving interventions in three coverage areas: maternal and newborn care, immunization and treatment of sick children. For complete methodology see Methodology and Research Notes.

Note: Coverage and survival data are from the most recently available DHS and MICS reports. In some cases, figures do not reflect more recent gains in child survival and may differ considerably from national-level estimates as reported by UNICEF.

Sources: 2006 national-level coverage estimates: UNICEF. *State of the World's Children 2008*; Coverage gap data: *Demographic and Health Surveys* (DHS) and *Multiple Indicator Cluster Surveys* (MICS) from 1991-2006, compiled by the Countdown 2008 Equity Analysis Group; Survival gap data: D.R. Gwatkin, et al. *Socio-Economic Differences in Health, Nutrition, and Population*, supplemented with data from recent DHS and MICS reports.

Evaluating the Survival Gap:

small gap = low inequity in child survival

moderate gap = moderate inequity in child survival

large gap = high inequity in child survival

- No data

* Data are for 2006 or the most recent year available. "Poorest" and "best-off" refer to the bottom 20% and top 20% of households respectively.

** Under-5 mortality rates refer to the poorest 60% and best-off 40% of households respectively.

Reaching the Poorest of the Poor and Closing Child Survival Gaps

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 9.7 million children under 5 die every year from preventable or treatable causes.

Millions of children's lives could be saved by a coordinated global effort to train, equip and supply more community health workers who can reach the poorest, most marginalized communities. Each year, such an endeavor could spare the lives of up to 3 million children and improve the health and well-being of countless millions more. A continuum of care from pregnancy through childhood, linking community-based health workers to strengthened health systems in developing countries could prevent 6 million child deaths each year.[112]

PROVEN SOLUTIONS TO SAVE CHILDREN'S LIVES

Saving children's lives in developing countries, where millions die each year of ailments such as pneumonia, diarrhea or measles, is simple and inexpensive. Proven, low-cost solutions exist, but tragically they are not reaching the 200 million children whose lives are at risk every day because their families do not get basic health care.

Pneumonia care – Pneumonia kills more children under 5 than any other illness – more than AIDS, malaria and measles combined.[113] Up to 3 million children die from pneumonia each year, accounting for as many as a third of under-5 deaths worldwide.[114] Antibiotics to treat pneumonia can cost less than 30 cents.[115] Yet it is estimated that only 25 percent of caregivers know the danger signs of pneumonia;[116] only about half of the children who are sick with pneumonia receive appropriate medical care,[117] and less than 20 percent of children with pneumonia receive the recommended antibiotics.[118]

Oral rehydration therapy for diarrhea – Diarrhea kills nearly 2 million young children each year.[119] That's nearly 5,500 children every day. The oral rehydration salts needed to prevent a child from dying of diarrheal dehydration cost less than 50 cents.[120] This simplest of solutions is estimated to have saved 40 million children's lives since it was first put to the test in India in 1971.[121] Yet it remains tragically underused. Worldwide, only 38 percent of children with diarrhea receive oral rehydration therapy.[122]

Malaria prevention and treatment – Malaria, a disease transmitted by mosquitoes to humans, kills 800,000 children under 5 each year in sub-Saharan Africa alone,[123] where 1 out of 6 childhood deaths is caused by malaria.[124] The key to malaria control and preventing future childhood deaths from malaria is a combination of traditional low-cost methods and promising new drugs. Programs to promote indoor spraying with insecticide and sleeping under insecticide-treated bed nets cost about $2.80 to $4 per child per year.[125] Yet only 8 percent of children under 5 in sub-Saharan Africa sleep under treated nets[126] and only 1 in 3 children with fever are treated with anti-malarial drugs, with far fewer receiving the most effective combination therapy.[127]

A SIMPLE FORMULA SAVES LIVES IN MALI

In Mali, a 16-month-old boy named Yaya has not learned yet that he was part of one of the great public health success stories of our time. When Yaya got diarrhea last year, his mother took him to the village health volunteer, who gave him oral rehydration salts to prevent death by dehydration. This simple solution of salt, sugar, potassium and other nutrients is estimated to have saved 40 million children's lives since the 1970s.

Karim, the health volunteer in the village of Toula, was trained by Save the Children to treat diarrhea and other common illnesses that affect children. He advised Yaya's mother to continue to breastfeed her baby and to avoid certain traditional medications that would be harmful. Yaya's mother followed the advice, and Yaya recovered in 3 days.

Yaya was one of the lucky ones. In Mali, 47 percent of children do not get even this most basic health care.

Toula's chief has been monitoring the registry of child deaths in his village since Karim began treating children and organizing immunization sessions. He says the infant mortality rate in Toula has decreased by 90 percent.

Measles immunization – Measles causes more than 240,000 children's deaths every year, and is one of the world's leading causes of childhood vaccine-preventable death.[128] As one of the most highly contagious diseases known, measles can spread quickly within a household or urban community causing permanent disabilities for many of its survivors, including blindness, hearing impairment, brain damage and other deadly complications such as pneumonia. At around 33 cents per dose, measles vaccination is one of the most cost-effective public health interventions available for saving children's lives.[129] Worldwide, measles immunization coverage has increased steadily since 1990, but in the 47 countries accounting for 95 percent of measles deaths, nearly one-third of all 1-year-olds are not immunized against measles.[130]

Breastfeeding and Vitamin A – Malnutrition is an underlying cause of up to half of all deaths among children under 5.[131] Undernourished children have lowered resistance to infection and are more likely to die from common childhood ailments like diarrhea and pneumonia. The problem often starts when mothers who are themselves in poor health and undernourished give birth to underweight babies. Babies who are not exclusively breastfed for the first 6 months are at heightened risk for undernutrition and disease. Older children often do not get enough food, or the right kind of food, because their families cannot afford it. Severe poverty and chronic food shortages are complex problems, but a number of low-cost solutions can make a big difference and save lives. Exclusive breastfeeding for the first six months of life has the potential to prevent 13 percent of all under-5 deaths in developing countries, making it the most effective preventive method of saving children's lives.[132] It costs no money for a mother to breastfeed her infant, but worldwide almost two-thirds of babies are not exclusively breastfed.[133] Vitamin A, given two to three times per year, can prevent blindness and lower a child's risk of death from diarrhea, malaria and measles – at a cost of only 2 cents per capsule.[134] Vitamin A supplementation has saved an estimated 2.3 million lives since 1998,[135] but 28 percent of young children in poor countries are still not receiving this treatment.[136]

PROTECTING MOTHERS AND BABIES WHEN THEY ARE MOST VULNERABLE

Every year, 60 million mothers in the developing world give birth at home with no professional care whatsoever,[137] and around 4 million newborn babies die in the first month of life.[138] Pregnant women and newborn babies are especially vulnerable to deadly infections and complications. The most serious cases require comprehensive emergency care in a fully equipped medical facility, but most deaths could be prevented with basic care for new mothers and their babies before, during and after childbirth.

Prenatal care – Caring for newborn babies starts with caring for pregnant mothers, ensuring that they are adequately nourished, free from infections and exposure to harmful substances, and monitored for complications during pregnancy. Immunization against tetanus and sleeping under a mosquito net in malaria areas should be part of prenatal care packages. For babies born at home, good prenatal care also includes counseling to encourage a clean birth, awareness of danger signs, a plan for going to a skilled attendant, and immediate and exclusive breastfeeding.

BREATHING LIFE INTO NEWBORNS IN GUATEMALA

As part of the Mayan tradition, Doña Teresa received a divine calling when she was 16 to serve her people as a comadrona*, or traditional birth attendant. Now 55, she has helped deliver hundreds of babies in her village in the western highlands region of Guatemala, including 16 children of her own, eight of whom survived.*

Doña Teresa – who now has 15 grandchildren – recently received training from Save the Children to improve her knowledge and skills. Before her training, one of her daughters-in-law had two stillbirths. After Doña Teresa was trained, her daughter-in-law became pregnant for the third time. She encouraged her to eat well during the pregnancy. "I gave her V-8 juice, eggs and bananas. I sent her to the hospital [in the city] for her prenatal check-ups."

Doña Teresa also learned how to resuscitate newborns who are not breathing at birth. She tells of several times she has had the opportunity to apply her knowledge to save newborn lives. Most recently, in January of this year, Doña Teresa resuscitated a baby boy born following a complicated delivery. It was impossible to get the mother to the local hospital, but Doña Teresa knew the steps to give the baby his best chance at survival. She cleaned his mouth with a sterile towel, wiped and wrapped him and then patted his back. She then blew air into his mouth, breathing life into his limp body. The baby boy survived.

Reaching the Poorest of the Poor and Closing Child Survival Gaps

Skilled care during childbirth – Skilled birth attendants are people with midwifery skills who have been trained to manage normal deliveries and to diagnose and manage or refer complicated cases. They provide for a clean delivery, ensure the newborn is dried and kept warm, recognize and immediately resuscitate non-breathing babies, and identify other danger signs in both mother and baby to avoid delay in seeking additional care when needed. Skilled care providers may practice in a health facility or a household setting, but they need a functioning referral system for the management of complications. In settings where skilled providers are not yet available and births are attended by informal health workers, they should be trained to promote clean deliveries and proper newborn care, and to recognize and immediately refer complications.

Postnatal care – Since many deaths occur in the first hours and days after birth, early postnatal care is key to improving newborn health and survival. The early postnatal period is a highly vulnerable time for mothers as well – 61 percent of maternal deaths occur in the first six weeks after birth, and nearly half those deaths occur in the first day after delivery.[139] Postnatal care providers can offer counseling on newborn care practices, help ensure immediate and exclusive breastfeeding, and recognize health problems (such as infections) among mothers and newborns that require immediate attention. Postnatal care costs about half the amount of skilled care during childbirth and has the potential to save 20 to 40 percent of newborn lives.[140] But to date, postnatal care for mothers and newborns has received relatively little emphasis in public health programs, with only a tiny minority of mothers and babies in high-mortality settings receiving postnatal care in the first hours, days and weeks.

COMMUNITY HEALTH WORKERS ARE KEY TO PROGRESS

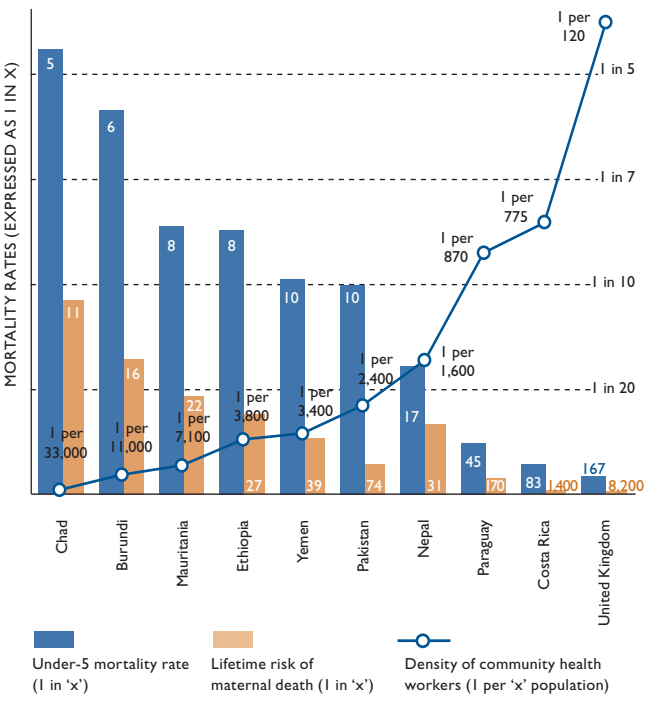
Throughout the developing world, there is a shortage of health care professionals and health care delivery systems cannot meet the needs of the people. In Malawi, Niger and Tanzania, for example, there is just one doctor for every 50,000 people. Compare this to one for every 391 in the United States.[141] The World Health Organization recommends a ratio of one doctor for every 1,000 people, yet almost every country in sub-Saharan Africa and South Asia fails to meet this goal, usually by a very wide margin.

In many rural communities, taking a sick child or a pregnant woman to the nearest health care provider requires a journey on foot of several hours or even a day. Dirt roads are often in poor condition and become even more treacherous at night or during the rainy season. If parents successfully make it to a clinic with their child still alive, they often find there are no staff or medications available. And so another child dies, usually from a condition that could have been easily treated. This scenario is all too common in the developing world.

In remote places where the majority of under-5 deaths occur, there is an urgent need for more health workers who live in or near the communities that need help most. These health workers – carefully selected, trained and equipped to deliver basic care – can serve as a powerful first line of defense against the most common killers of children.

Community health workers educate their neighbors about healthy behaviors and treat common illnesses such as diarrhea, pneumonia and malaria. They counsel pregnant women about good nutrition, clean delivery and proper care

WHERE THERE ARE MORE HEALTH WORKERS, MORE MOTHERS AND CHILDREN SURVIVE



Sources: Community health worker density: WHO. *World Health Statistics 2007*; Under-5 mortality rate and lifetime risk of maternal death data: UNICEF. *State of the World's Children 2008*. Tables 1 and 8

Reaching the Poorest of the Poor and Closing Child Survival Gaps

HOW COMMUNITY HEALTH WORKERS HELP CHILDREN SURVIVE TO 5

PRENATAL CARE

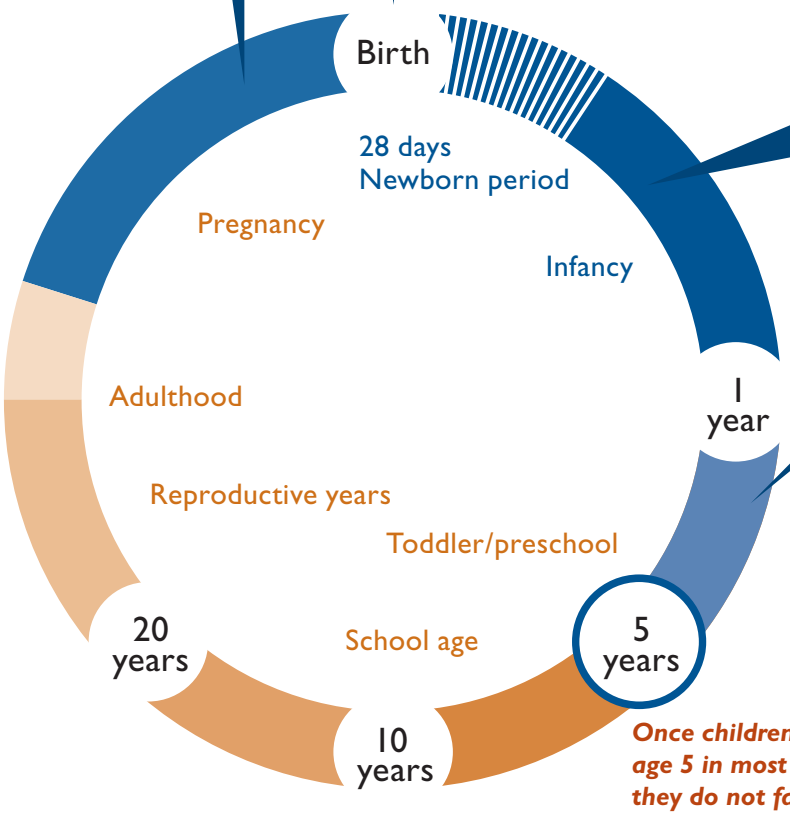
- Vaccinate women to protect mother and baby from tetanus
- Promote use of mosquito nets to prevent malaria
- Treat malaria
- Prevent transmission of HIV from mothers to babies
- Promote a plan for emergency obstetric care if needed during childbirth

LABOR AND DELIVERY CARE

- Promote use of a professional birth attendant
- Provide clean delivery kits if delivering at home
- Refer complications in mother and newborn to emergency obstetric care if needed
- Prevent transmission of HIV from mothers to babies

KEEPING BABY HEALTHY AND WELL-NOURISHED

- Promote immediate breastfeeding and keeping baby warm
- Reduce chances of infection through proper hygiene and hand washing
- Encourage exclusive breastfeeding for 6 months
- Add new healthy foods at 6 months in addition to continued breastfeeding
- Promote vitamin A use and diet diversity
- Promote vaccination and remind moms to get babies vaccinated
- Provide and promote insecticide-treated bed nets for mother and baby to sleep under



CARING FOR SICK CHILDREN

- Support care at home including early recognition of illness and compliance with recommended treatments
- Provide care for infections such as pneumonia, malaria, newborn infections and diarrhea
- Support care of low-birthweight and malnourished children
- Refer children with severe malnutrition, infant and childhood illness to clinic if necessary

Once children reach age 5 in most countries, they do not face the same risk of death again until they are 70[142]

FIGHTING PNEUMONIA IN BANGLADESH

Respiratory illnesses are common among children in Bangladesh – so common that they are the number-one killer of children under 5. Still, when 3-year-old Rashed fell ill with a fever and had difficulty breathing, his parents thought he just had a cold. "We didn't understand he was ill at first," said his father, Kamrul. "We took him to a hospital, but two days later he died."

So when daughter Sweety, age 2, developed similar symptoms three years later, Kamrul took her to the home of Momtaj, a trained volunteer village health worker. "I used my timer to count her breath rate, diagnosed her with pneumonia and treated her with an antibiotic called Cotrimoxazole," said Momtaj.

Momtaj is one of 7,000 volunteer health workers living in some of the most remote and underserved areas of Bangladesh. Over the last five years, they have been trained to diagnose and treat childhood pneumonia and diarrhea, two of the top killers of young children in Bangladesh. This is part of a pioneering effort by Save the Children, several national non-governmental organizations and the government of Bangladesh to reduce the country's 277,000 child deaths each year.

The morning after being treated, Sweety's health had improved dramatically. Momtaj visited Sweety at home to check on her progress and counsel the family on follow-up treatment.

Momtaj says she feels empowered by her new knowledge and skills. She travels throughout her village telling people how to recognize the difference between a common cold and pneumonia. "Before, the people in my village were not aware of pneumonia," said Momtaj. "But once I was trained, I told them to look for danger signs like rapid breathing."

"I'm not a big doctor. I have just a few years of schooling," adds Momtaj. "But, as you can see, with my treatment, children are smiling and healthy."

Sweety's father agrees. "Now I feel that if Momtaj had been trained earlier, my son's life could have been saved," said Kamrul.

for babies in their vulnerable first hours of life. By providing services close to home, community health workers increase access to lifesaving measures and reduce the burden of time and money on both families and health care systems.

Community health workers have varying degrees of education and training, but do not need to be highly educated to be successful. Experience in many countries has now shown that these workers can successfully master the skills needed to deliver basic health interventions, including diagnosing and treating common illnesses, mobilizing demand for immunization services and vitamin A, and promoting critical newborn health and nutrition practices. Large-scale community health worker programs are typically supported by the Ministry of Health, which provides medical supplies, training and clinical back-up when the health worker identifies a problem in need of more specialized care.

In some communities, it matters if the health worker is male or female. In parts of South Asia for example – where cultural traditions discourage women from going to male health care providers – efforts to recruit and train female health workers have increased the percentages of women and children receiving immunizations and other services. In many parts of Africa, Latin America and Southeast Asia, however, both male and female health workers are providing welcome and much-needed care.

It is estimated that over 60 percent of the nearly 10 million children who die every year could be saved simply by delivering basic services through health facilities and community health workers. With support from international donors, a number of developing countries have achieved remarkable success by investing in community health workers. For example:

In INDIA, doctors for the wealthy are plentiful, but poor people often do not get the care they need. Over 1 million deaths of children under 5 occur each year in the first month of life in India.[143] Most of these newborns are born and die at home. But thousands of health workers are being trained to fill the void in rural and tribal areas, as well as in urban slums. Community health workers have been trained to treat infections, resuscitate asphyxiated newborns and care for low-birthweight babies. As a result, newborn mortality rates in targeted areas declined by 50-60 percent.[144] The government of India now plans to replicate home-based newborn care throughout the country.

In BANGLADESH, there is just 1 doctor for every 3,800 people. Most of the people (75 percent) live in rural areas, but only 20 percent of the health workforce is based in these areas.[145] But a group of 4,000 local women have received training to treat childhood illnesses. This has substantially

Reaching the Poorest of the Poor and Closing Child Survival Gaps

increased access to care for diarrhea and pneumonia among families who could not afford health services. In a recent two-and-a-half-year period, these health workers treated over 2 million cases of diarrhea and respiratory infection.[146]

IMPROVING IMMUNIZATION COVERAGE IN AFGHANISTAN

Shakila and Rahmutullah, a young couple in the northern Afghanistan town of Andkhoy, know the pain of losing children. Two of their children died from tetanus, a common infection that can be easily prevented by vaccinating women before they become mothers.

Shakila was not vaccinated because the local health clinic was staffed by men, and Rahmutullah would not allow her to go there. When the clinic employed a female vaccinator, Rahmutullah took Shakila to the clinic to be immunized. They now have two children, a boy and a girl, and both are healthy.

Now that Shakila can visit a female health worker, she takes her children to the clinic for regular health care, and she has ensured that they are immunized too.

In Afghanistan, 58 percent of children do not get basic health care. Only 24 percent of Afghan women and 27 percent of Afghan children are fully immunized.[147] Research shows that when a female vaccinator is available, twice as many women will be immunized against tetanus and children's vaccination coverage improves by 50 percent.[148]

NEPAL has just one doctor for every 4,800 people, yet Nepal has cut its under-5 death rate by almost 60 percent since 1990,[149] in part by investing in health workers at the village level. A national cadre of Female Community Health Volunteers (FCHVs) has helped increase immunization coverage from 43 to 83 percent since 1996. More than 95 percent of children under 5 now receive vitamin A supplements, nearly all of which are distributed by FCHVs.[150] Female Community Health Volunteers have made Nepal the first country to deliver vitamin A supplements every six months to 3.5 million children nationwide (ages 6 months to 5 years). This effort alone prevents at least 12,000 child deaths annually in Nepal.[151]

In ETHIOPIA, there is only one doctor for every 33,000 people and most of these doctors are located in urban centers, while 85 percent of the population lives in rural areas.[152] Health systems and infrastructure are seriously underdeveloped, and transportation problems are severe, especially during the rainy season. Almost all births take place at home (94 percent), 1 child in 8 dies before reaching age 5, and most mothers and children who need care live too far from a road, let alone a health facility. In the southern part of the country – where pastoralist families live in widely scattered households – community health workers were trained to treat children for diarrhea, pneumonia and malaria, to provide health education and to refer serious cases to health facilities. As a result, access to care more than tripled and mothers' home-care for ill children dramatically improved.[153] With the support of several external donors, the government of Ethiopia is now working to train and deploy 30,000 professional health extension workers to villages by 2009. Each will receive one year of training to provide basic curative and preventive health services, including diarrhea treatment, malaria prevention and treatment, health education, and clean, safe childbirth.[154]

NEPAL

TO SAVE CHILDREN, EDUCATE GIRLS

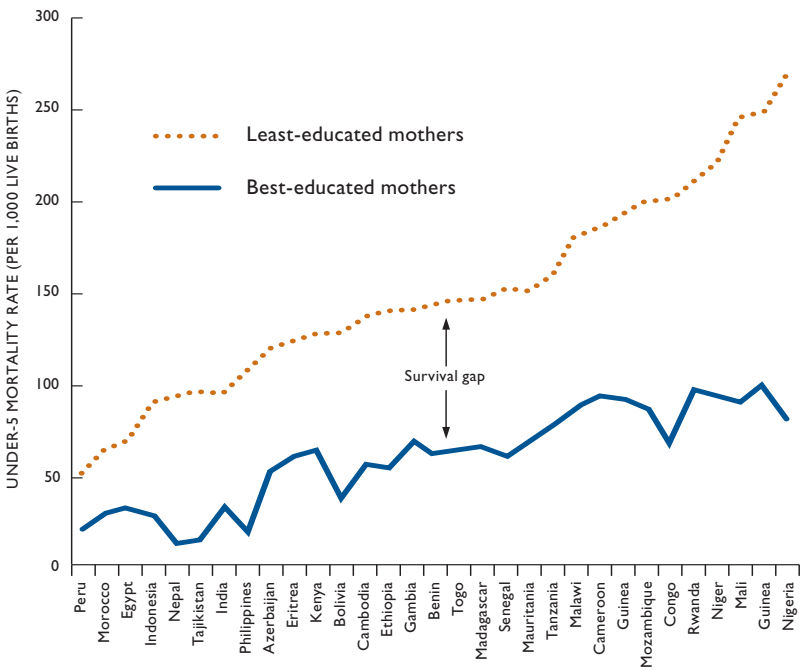
One of the most effective ways to lower the risk of death for mothers and children is to ensure that girls go to school. The more time girls spend in school, the later they marry and begin childbearing. Educated girls are more likely to grow up to be mothers who are healthy, well-nourished, economically empowered and knowledgeable about how to care for themselves and their children.

Data from developing countries in Africa, Asia and Latin America demonstrate that as mothers' education levels rise, under-5 mortality declines.[155] The tendency of poor women to be less educated is one of the chief reasons why poorer children die earlier. In many countries, a mother's education level has more of an influence on her child's survival prospects than does her level of wealth or poverty.[156]

Educated mothers are more likely to get prenatal care, to have a safe delivery and to get postnatal care.[157] They are also more likely to ensure their children are immunized, to take them for treatment when they are sick, to teach good hygiene, and to provide a healthy diet.[158]

One study, using data from 65 countries, estimated that doubling the proportion of girls educated at the secondary level (from 19 to 38 percent) would result in a 53 percent drop in infant mortality (from 81 to 38 deaths per 1,000 births).[159]

WHEN MOTHERS ARE EDUCATED, MORE CHILDREN SURVIVE



In each of these countries, rates of under-5 mortality among children of the least-educated mothers are at least twice as high as those of children of the best-educated mothers. The greatest education-related survival gaps are in Nepal, Nigeria and Tajikistan.

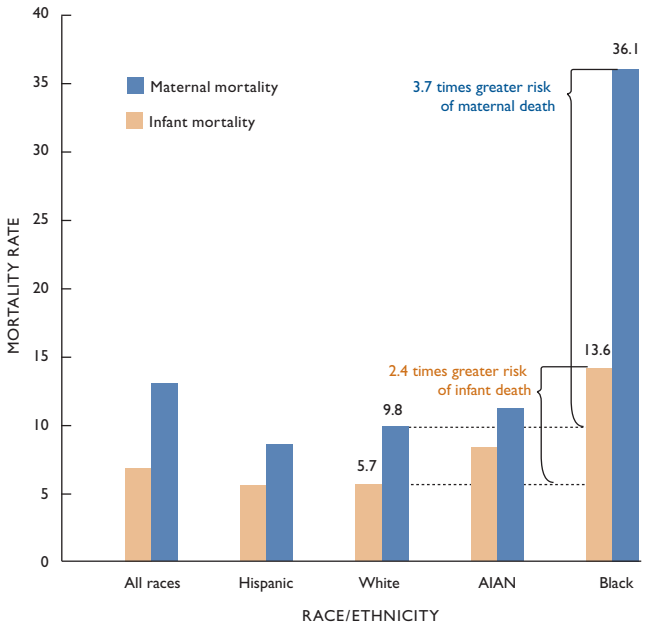
Sources: *Multiple Indicator Cluster Surveys* (MICS) and *Demographic and Health Surveys* (DHS) in 31 countries, 2000-2006

Child Survival Inequities in the Industrialized World

In more developed countries, as in less developed countries, it is the poorest, most marginalized children who suffer the most from inadequate health care and early death. The children who die before reaching age 5 in industrialized countries tend to be from low-income, ethnic minority groups, and their rates of death are often many times higher than those of the majority.

In the United States, African-American, American-Indian and Alaska-Native children have the highest rates of death. In much of Europe, the risk of child death is greatest among the Roma people. And in Australia, the Aboriginal children are most likely to die before reaching age 5.

IN THE UNITED STATES, BLACK MOTHERS AND BABIES HAVE THE HIGHEST DEATH RATES



In the United States, infant mortality rates among blacks are 2.4 times higher than those of whites, and maternal mortality rates are 3.7 times higher. Note: Infant mortality is reported per 1,000 live births, maternal mortality per 100,000 live births. AIAN = American Indian/Alaskan Native.

Sources: AIAN infant mortality data: *Infant Mortality Statistics from the 2004 Period Linked Birth/Infant Death Data Set.* National Vital Statistics Reports. Vol.55, No.14; AIAN Maternal mortality data: U.S. Department of Health and Human Services: Indian Health Service. *Indian Health Disparities*; All others: National Center for Health Statistics. *Health, United States, 2007 With Chartbook on Trends in the Health of Americans*.

- In the United States, America-Indian and Alaska-Native infants are 1.5 to 2 times more likely to die than white infants,[160] and African-American infants are 2.4 times more likely to die than white infants.[161]
- In the Czech Republic, Slovakia and Hungary, infant mortality rates among the Roma are about double that of the non-Roma population.[162] In Italy, infant mortality rates among the Roma are 3 times higher than those of other Italians.[163]
- In Romania, Roma children die at rates comparable to infants in Madagascar and Tanzania. Roma children are almost 4 times more likely to die as infants compared to the most socially advantaged Romanians.[164]
- Among the Māori of New Zealand, infant mortality rates are more than twice as high as the general population.[165]
- In Australia, Aboriginal infants die at rates 3 times higher than the national average.[166]

WIDENING CHILD HEALTH AND SURVIVAL GAPS IN THE UNITED STATES

The United States spends more money on health care per capita than nearly any other country in the world,[167] yet has the highest rates of child poverty and the lowest levels of child health and safety of the rich countries.[168] As a result, infant and child mortality rates in the United States are higher than in any other industrialized country, the only exceptions being Latvia, Lithuania and Slovakia.[169]

Despite substantial reductions in U.S. infant mortality during the past several decades, the black-white infant survival gap has widened. From 1980-2000, even as overall infant mortality rates declined, the black-white ratio of infant mortality increased 25 percent.[170]

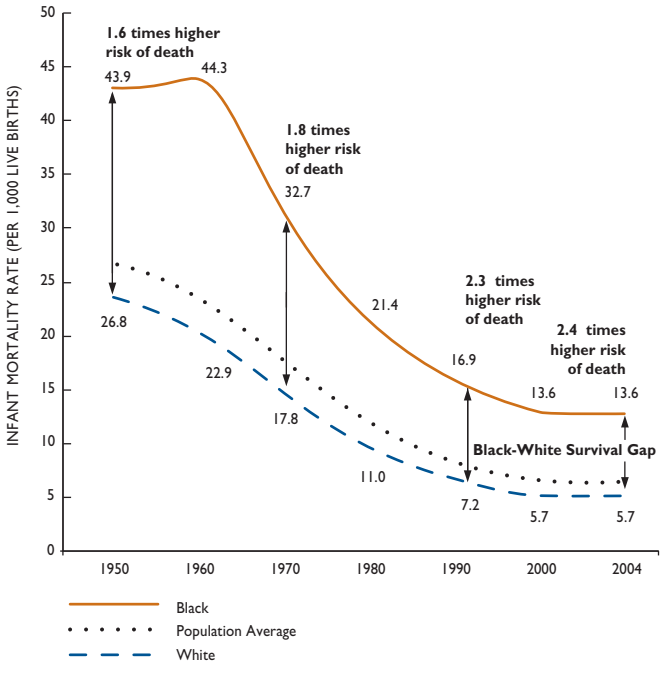
From the mid-1960s through 1980, the poor in the United States made health gains and their infant death rates declined as the survival gap shrank. Since 1980, however, disparities between rich and poor in the U.S. have widened and infant death rates among the poor remain higher than among the rich.[171]

One recent study found that if – between 1965 and 2002 – all families in the U.S. had enjoyed the same improvement in infant mortality rates as the highest income quintile, 20 percent of all infant deaths could have been averted and an estimated 460,000 people might still be alive.[172] And if all infants had experienced the same yearly infant death rates as the richest white infants, 20 percent of all white infant deaths and 25 percent of deaths among infants of color could have been prevented in 2000 alone.[173]

Here are some additional facts about child mortality and health care inequities in the United States:

- In the United States, 21 percent of children under age 5 live below the poverty line – that is 1 child in 5.[174] Poverty rates are highest among children of color. Forty percent of all African-American children, 39 percent of American-Indian/Alaska-Native children, 30 percent of Hispanic children and 16 percent of white children live in poverty.[175]
- The United States' under-5 mortality rate (8 per 1,000 live births) is twice that of Belgium, Czech Republic, Finland, France, Italy, Japan and Norway (4 per 1,000 live births) and more than twice that of Iceland and Sweden (3 per 1,000 live births).[176]
- Approximately 11 percent of American children under age 6 do not have health insurance.[177]

THE BLACK-WHITE INFANT SURVIVAL GAP IS WIDENING



Sources: Post-1980 data: National Center for Health Statistics. *Health, United States, 2007 With Chartbook on Trends in the Health of Americans*; 1950-1980 data: H.C. Kung, D.L. Hoyert, J.Q. Xu and S.L. Murphy. *Deaths: Final Data for 2005. National Vital Statistics Reports*. Vol. 56, No 10. (National Center for Health Statistics: Hyattsville, MD: 2008). Note: Up until 1980, data for black and white ethnic groups included persons of Hispanic and non-Hispanic origin and were reported by the race of the child and not of the mother.

HOW SWEDEN BATTLED INEQUITY AND SAVED LIVES

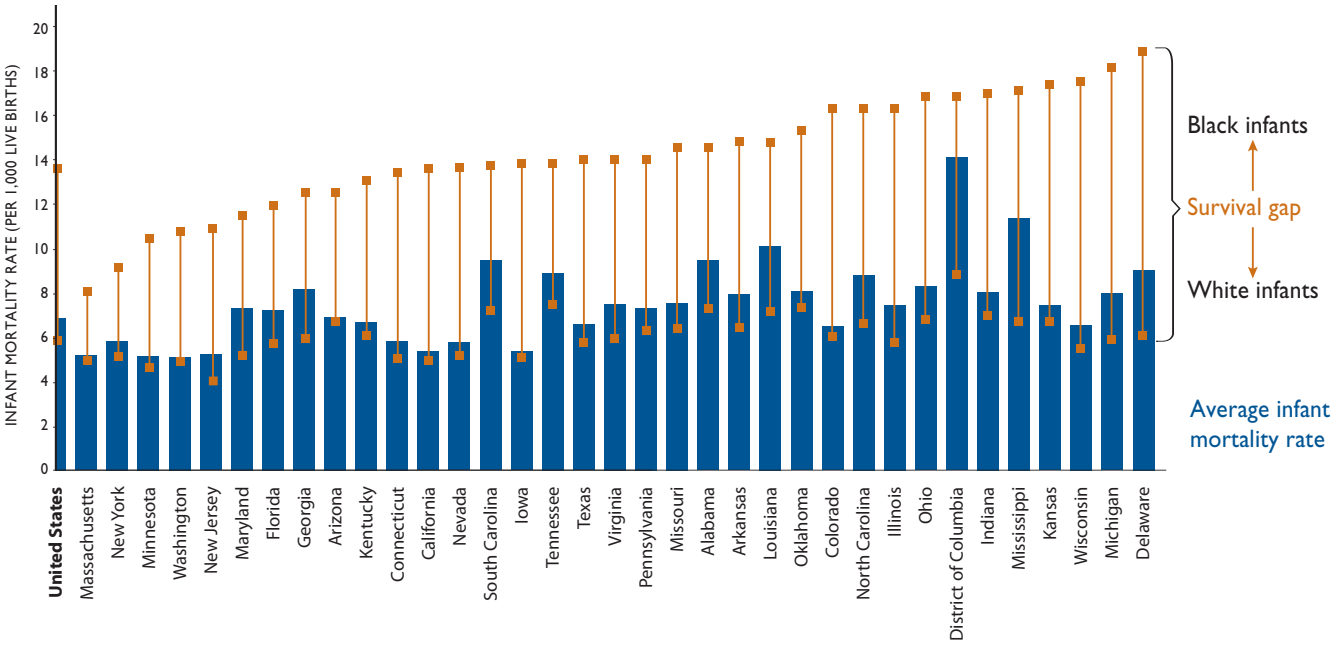
Sweden is one of the best places in the world to be a mother or a child, no matter one's level of income – but it was not always so. In the 1920s, the poorest babies were up to 3.5 times more likely to die before reaching their first birthday,[191] and the child survival gap was a source of political concern.

In the 1930s, the Swedish government introduced a series of new policies, including free maternal and child health services, financial support to low-income families and general welfare and housing reforms. The preventive maternal and child health services rapidly achieved extensive coverage and particularly benefited the poor. By 1950, maternal health services covered about 60 percent of all pregnant women and child health services covered more than 80 percent of infants.[192]

These reforms led to significant reductions in social inequity and infant mortality.[193] Today in Sweden, inequity in infant mortality has been almost eliminated[194] and Swedish children – rich and poor alike – enjoy one of the lowest rates of child mortality in the world.[195]

- Hispanic children are over 3 times more likely to be uninsured than their white peers – 20 percent of Hispanic children have no health insurance coverage. More than 40 percent of uninsured Hispanic children do not receive any medical care.[178] Roughly 9 percent of African-American children are uninsured, of which 15 percent do not receive medical care.[179] Among white children, 6 percent are uninsured.[180] White children see physicians at twice the rate of minority children.[181]
- The poorest children in the United States are 20 percent more likely to go without preventive care.[182] More than 30 percent of children living below the poverty line do not receive even one preventive medical (or "well-child") visit per year.[183]
- Maternal mortality rates in the United States outstrip those of all other developed countries largely due to the mortality rates among women of color.[184] The maternal mortality rate among black women (36.1 per 100,000 live births) is about 4 times the rate among white women (9.8 per 100,000 live births). This gap has widened since 2000.[185]
- Women of color in the United States, especially low-income women, are less likely to receive prenatal care that is vital to healthy birth.[186] Early prenatal care among minority groups has increased by at least 20 percent since 1990, but disparities still exist.[187] Hispanic and black women are more than twice as likely as white women to receive no prenatal care or late prenatal care. American-Indian/Alaska-Native mothers are more than 3 times as likely as white mothers to receive inadequate prenatal care.[188]
- Immunization rates show similar disparities. Black children and American-Indian/Alaska-Native children have the lowest vaccination rates, while whites have the highest rates.[189] Even greater coverage gaps are seen between rich and poor. Nearly one-quarter of poor children are not fully immunized, compared to 13 percent of children from high-income families.[190]

BLACK-WHITE INFANT SURVIVAL GAPS IN U.S. STATES



Infant mortality rates among black infants are at least twice as high as white mortality rates in nearly every U.S. state with available data. In Wisconsin, Delaware and Michigan, a black baby is over 3 times more likely to die compared to a white baby. Survival gaps of this magnitude are comparable to those in Bolivia, Nigeria and the Philippines – some of the most inequitable countries in the world.

Source: National Center for Health Statistics. *Deaths: Final Data for 2005. National Vital Statistics Report* (2008)

USA

Take Action Now! Make a World of Difference for Children

Every year, nearly 10 million die before reaching age 5. Two-thirds of these lives could be saved by delivering basic, low-cost services to the mothers, children and newborns who need help most. Help us help children survive to 5.

Now is the time for governments, corporations, humanitarian organizations and private citizens to take joint responsibility to reduce these needless deaths. By ensuring that mothers and children everywhere have access to basic health care, the world community can provide a more promising future for families, communities and society as a whole.

HELP US SAVE THE LIVES OF CHILDREN AROUND THE WORLD:

- **Tell Congress to approve the *U.S. Commitment to Global Child Survival Act*** (HR 2266 and S1418) and fully fund programs to save children's lives. As a member of the U.S. Coalition for Child Survival, Save the Children is working with members of Congress to build support for bipartisan legislation that renews U.S. leadership for child and newborn health programs in developing countries while ensuring greater coordination and accountability in the delivery of these services. It was introduced by Representatives Betty McCollum (D-MN) and Chris Shays (R-CT) in the House and Senators Chris Dodd (D-CT) and Gordon Smith (R-OR) in the Senate and is cosponsored by more than 80 House members and more than 20 Senators. The Senate Foreign Relations Committee approved it unanimously in February and sent it to the full Senate for consideration. Go to www.savethechildren.org/action to send a note of support to your member of Congress.
- **Participate in Save the Children's Annual Advocacy Day in Washington, June 11-12.**
  We will hold our sixth annual Advocacy Day program in Washington, DC June 11-12 to encourage the President and Congress to take bold action to meet challenges children face both at home and abroad. This year, Save the Children staff, trustees, supporters and interested students will join together to press for American leadership to save the millions of children who die from preventable causes through adoption of the *U.S. Commitment to Global Child Survival Act.* Visit www.savethechildren.org, and click on the Advocacy Day link.
- **Join Save the Children's *Survive to 5* campaign.**
  Survive to 5 is a 5-year effort to encourage Americans to become more aware of and engaged in action for child survival. By 2010, we are trying to mobilize 10 million actions for the 10 million children who die each year. Visit www.savethechildren.org/surviveto5 to find out how you can do more!
- **Help Save the Children train 50,000 health care workers.** Children's health is priceless but health care comes down to dollars and cents. $100 can help Save the Children train one community health care worker to treat children with diarrhea, pneumonia and malaria and serve as a promoter of health practices for children such as breastfeeding and vaccination. For $25, Save the Children can provide a toolkit with the basics a health worker needs to care for a community's children, including: a respiration timer, thermometer, flashlight, key medicines and carrying bag.
  Visit www.savethechildren.org/surviveto5 to support this work.
- **Join the Save the Children Action Network**
  to receive monthly e-mail updates on legislative issues regarding child survival as well as other critical policy issues affecting children. Learn about ways that you can get involved and make your voice heard. To sign up, visit www.savethechildren.org/action.

www.savethechildren.org

SIERRA LEONE

◂ ETHIOPIA

Appendix: The Mothers' Index and Country Rankings

The ninth annual *Mothers' Index* helps document conditions for mothers and children in 146 countries – 41 developed nations[196] and 105 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.

SIERRA LEONE

MOTHERS' INDEX RANKINGS

European countries – along with New Zealand and Australia – dominate the top positions, while countries in sub-Saharan Africa dominate the lowest tier. The United States places 27th 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.

2008 MOTHERS' INDEX RANKINGS

TOP 10: **Best places to be a mother**		BOTTOM 10: **Worst places to be a mother**	
RANK	COUNTRY	RANK	COUNTRY
1	Sweden	**137**	Ethiopia
2	Norway	**138**	Mali
3	Iceland	**139**	Djibouti
4	New Zealand	**140**	Eritrea
5	Denmark	**141**	Guinea-Bissau
6	Australia	**142**	Angola
7	Finland	**143**	Sierra Leone
8	Ireland	**144**	Yemen
9	Germany	**145**	Chad
10	France	**146**	Niger

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.

- Two-thirds of all births are not attended by skilled health personnel.
- On average, 1 in 21 mothers will die from pregnancy-related causes.
- 1 child in 6 dies before his or her fifth birthday.
- 1 child in 3 suffers from malnutrition.
- Nearly 1 child in 3 is not attending primary school.
- Only 3 girls are enrolled in primary school for every 4 boys.
- On average, females have only 5 years of formal education.
- Women earn only half what men do for equal work.
- Every woman is likely to suffer the loss of a child at some point in her lifetime.

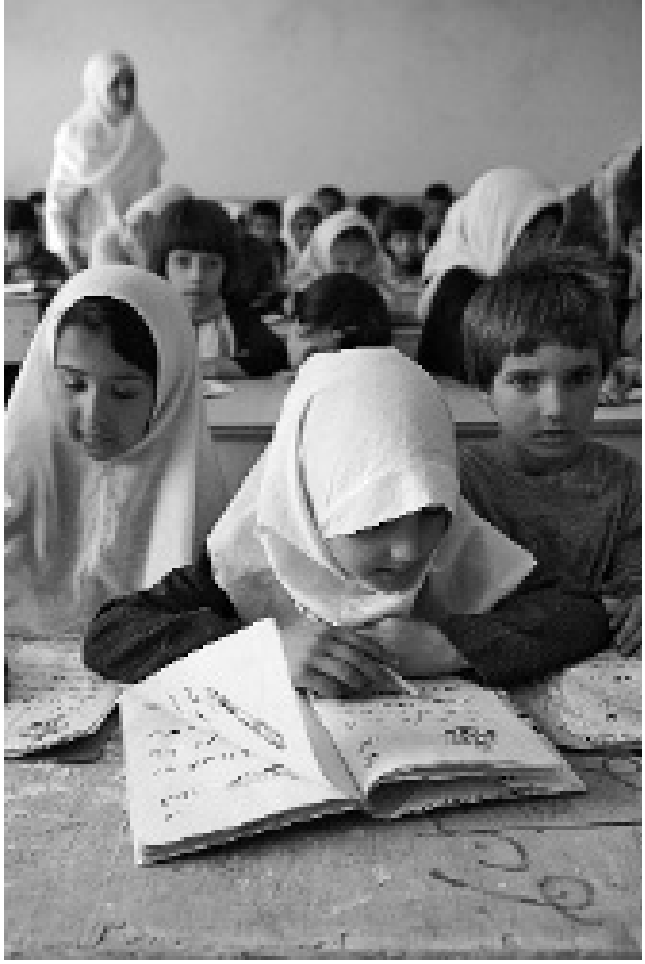
◂ EGYPT

The contrast between the top-ranked country, Sweden, and the lowest-ranked country, Niger, is striking. Skilled health personnel are present at virtually every birth in Sweden, while only 33 percent of births are attended in Niger. A typical Swedish woman has nearly 17 years of formal education and will live to be 83 years old, 72 percent are using some modern method of contraception, and only one in 185 will lose a child before his or her fifth birthday. At the opposite end of the spectrum, in Niger, a typical woman has less than 3 years of education and will live to be 45. Only 4 percent of women are using modern contraception, and 1 child in 4 dies before his or her fifth birthday. At this rate, every mother in Niger is likely to suffer the loss of a child and 9 out of 10 mothers are likely to lose two children in their lifetime.

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. That region also accounts for 17 of the 20 lowest-ranking countries.

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 Afghanistan and Chad. In Ethiopia only 6 percent of births are attended. Compare that to 96 percent in Sri Lanka and 94 percent in Botswana.
- 1 woman in 7 dies in pregnancy or childbirth in Niger. The risk is 1 in 8 in Afghanistan and Sierra Leone. In Ireland, the risk of maternal death is 1 in 47,600.
- A typical women will die before the age of 40 in Central African Republic, Zambia and Zimbabwe. Life expectancy for women is only 34 in Lesotho and 32 in Botswana. In Swaziland, the average woman will not live to see her 30th birthday while in Japan, women live to 86 on average.
- Fewer than 5 percent of women use modern contraception in Afghanistan, Angola, Chad, Democratic Republic of the Congo, Guinea, Guinea-Bissau, Niger, Rwanda and Sierra Leone. Over 80 percent of women in China and the United Kingdom use some form of modern contraception.
- In Egypt, Morocco, Oman, Qatar, Sudan and the United Arab Emirates, women earn 25 cents or less for every dollar men earn. In Saudi Arabia, women earn only 16 cents to the male dollar. In Kenya and Sweden, women earn over 80 cents for every dollar men earn.



AFGHANISTAN

- In Belize, Oman, Qatar and Saudi Arabia, not one seat in parliament is occupied by a woman. Compare that to Sweden and Rwanda, where 47 and 49 percent of seats are held by women respectively – almost the same percentage of seats as held by men.
- In Djibouti and Niger, a typical female has less than 4 years of schooling and more than half of all children are not enrolled in primary school. In Australia and New Zealand, the average woman receives over 20 years of formal education.
- In Afghanistan, Central African Republic, Chad and Guinea-Bissau, only 2 girls for every 3 boys are in primary school.
- 1 child in 4 does not reach his or her fifth birthday in Afghanistan, Angola, Niger and Sierra Leone. In Iceland and Sweden, only 1 child in 333 dies before age 5.
- Over 40 percent of children under age 5 suffer from moderate or severe malnutrition in India, Madagascar, Niger, Sudan, Timor-Leste and Yemen. In Bangladesh, nearly 50 percent of children suffer from malnutrition.
- More than 60 percent of the population of Afghanistan and Papua New Guinea lack access to safe drinking water and more than 70 percent lack access to safe water in Ethiopia and Somalia.

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.

Appendix: The Mothers' Index and Country Rankings

FREQUENTLY ASKED QUESTIONS ABOUT THE MOTHERS' INDEX

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

The United States ranked 27th 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 4,800 – one of the highest in the developed world. Thirty-five out of 43 countries performed better than the United States on this indicator, including nearly all the Western, Northern and Southern European countries and Australia, Bulgaria, Canada, Czech Republic, Hungary, Japan, New Zealand, Poland, Slovakia and Ukraine.*
- *Similarly, the United States did not do as well as many other countries with regard to under-5 mortality. The U.S. under-5 mortality rate is 8 per 1,000 births – up from 7 in last year's Index. Twenty-nine countries performed better than the U.S. on this indicator.*
- *Only 61 percent of children in the United States are enrolled in preschool – making it the ninth lowest country in the developed world on this indicator.*
- *Next to Australia, the United States has the least generous maternity leave policies of any wealthy nation.*
- *The United States is also lagging behind with regard to the political status of women. Only 17 percent of seats in the U.S. Congress are held by women, compared to 47 percent in Sweden and 42 percent in Finland.*

Why is Sweden number one?

Sweden performed as well as or better than other countries in the rankings on all the indicators. It has the highest ratio of female-to-male earned income, the highest percentage of women with seats in the national government and – along with Iceland – the lowest under-5 mortality rate 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 146 countries for which published information regarding performance on these indicators existed. All 146 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.*

USA

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.*

2008 MOTHERS' INDEX RANKINGS

Country	Mothers' Index Rank*	Women's Index Rank	Children's Index Rank**
TIER I: More Developed Countries			
Sweden	1	1	4
Norway	2	5	12
Iceland	3	3	18
New Zealand	4	2	20
Denmark	5	6	19
Australia	6	4	27
Finland	7	7	24
Ireland	8	8	21
Germany	9	15	2
France	10	12	3
Netherlands	11	9	28
Spain	12	16	10
Belgium	13	18	5
United Kingdom	14	10	25
Switzerland	15	17	13
Slovenia	16	14	11
Greece	17	13	15
Estonia	18	20	14
Italy	19	24	1
Canada	20	11	32
Austria	21	26	7
Portugal	22	25	17
Lithuania	23	19	30
Latvia	24	21	26
Hungary	25	23	23
Czech Republic	26	30	9
United States	27	22	33
Slovakia	28	31	22
Poland	29	28	29
Malta	30	32	8
Japan	31	36	6
Belarus	32	29	31
Luxembourg	33	35	16
Croatia	34	27	35
Bulgaria	35	34	34
Russian Federation	36	37	37
Romania	37	33	39
Macedonia, the Former Yugoslav Rep. of	38	38	42
Moldova	39	39	41
Ukraine	40	40	40
Albania	41	41	43
TIER II: Less Developed Countries			
Israel	1	1	3
Cuba	2	3	9
Argentina	3	2	14
Cyprus	4	4	1
Uruguay	5	5	4
Barbados	6	7	8
Kazakhstan	7	6	26
Korea, Republic of	8	8	7
Costa Rica	9	10	13
Bahamas	10	9	6
Chile	11	19	2
Panama	12	13	35
Thailand	13	15	20
Kyrgyzstan	14	14	40
China	15	12	48
Peru	16	17	38
Brazil	17	11	49
Colombia	18	18	29
Mauritius	19	21	21
Uzbekistan	20	20	32
Jamaica	21	22	23
Dominican Republic	22	24	30
Trinidad and Tobago	23	31	28
Vietnam	24	16	58
Armenia	25	29	22
Kuwait	26	28	16
Mexico	27	32	24
Tunisia	28	36	19
Venezuela, Bolivarian Republic of	29	23	41
South Africa	30	30	46
Bahrain	31	37	11
Libyan Arab Jamahiriya	32	33	33

Country	Mothers' Index Rank*	Women's Index Rank	Children's Index Rank**
TIER II: Less Developed Countries (continued)			
Lebanon	33	44	10
Suriname	34	34	51
Malaysia	35	42	16
Guyana	36	27	66
Mongolia	37	26	57
Philippines	38	25	65
Qatar	39	51	5
Jordan	40	50	12
Honduras	41	41	50
Azerbaijan	42	35	59
Iran, Islamic Republic of	43	45	37
El Salvador	44	43	53
Algeria	45	49	36
Belize	46	46	42
Namibia	47	39	67
Georgia	48	52	34
Paraguay	49	53	31
Gabon	50	38	69
United Arab Emirates	51	57	43
Turkey	52	58	25
Nicaragua	53	55	55
Tajikistan	54	47	68
Indonesia	55	48	70
Saudi Arabia	56	61	39
Kenya	57	40	74
Zimbabwe	58	56	71
Botswana	59	59	61
Ghana	60	54	72
Morocco	61	66	54
Oman	62	65	60
Guatemala	63	67	64
Cameroon	64	60	79
Congo	65	62	77
India	66	64	76
Swaziland	67	68	73
Papua New Guinea	68	63	81
Pakistan	69	70	75
Nigeria	70	69	80
Côte d'Ivoire	71	71	78
TIER III: Least Developed Countries			
Maldives	1	1	2
Cape Verde	2	5	1
Uganda	3	2	15
Rwanda	4	6	13
Malawi	5	7	8
Lesotho	6	8	9
Mozambique	7	4	21
Cambodia	8	3	32
Solomon Islands	9	10	4
Tanzania, United Republic of	10	11	12
Nepal	11	16	11
Comoros	12	17	3
Bangladesh	13	12	17
Burundi	14	9	22
Gambia	15	18	5
Lao People's Democratic Republic	16	13	25
Guinea	17	15	27
Mauritania	18	19	20
Madagascar	19	14	35
Zambia	20	21	18
Equatorial Guinea	21	20	23
Togo	22	25	19
Benin	23	26	16
Burkina Faso	24	23	37
Ethiopia	25	24	36
Mali	26	22	38
Djibouti	27	29	24
Eritrea	28	30	28
Guinea-Bissau	29	32	31
Angola	30	27	40
Sierra Leone	31	31	39
Yemen	32	34	29
Chad	33	28	42
Niger	34	33	44

* 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, 81 and 44 countries respectively for which sufficient data existed to calculate the *Children's Index*.

The Complete Mothers' Index 2008

TIER I	Women's Index								Children's Index			Rankings		
Development Group	Health Status			Educational Status	Economic Status			Political Status	Children's Status			SOWM 2008		
MORE DEVELOPED COUNTRIES	Lifetime risk of maternal mortality (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 (2006)		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 41 countries)+	Women's Index Rank (out of 41 countries)+	Children's Index Rank (out of 43 countries)+
	2005	2005	2007	2005	length	% wages paid	2005	2008	2006	2005	2005			
Albania	490	8	77	12	365 days[1]	80/50 (a,z)	0.54	7	17	50	78	41	41	43
Australia	13,300	72	83	20	6* weeks	0	0.70	27	6	104	148	6	4	27
Austria	21,500	47	82	16	16* weeks	100	0.46	33	5	91	102	21	26	7
Belarus	4,800	42	74	15	126 days	100 (z)	0.63	29	13	105	95	32	29	31
Belgium	7,800	74 (f)	83	16	15* weeks	82/75 (b)	0.55	35	4	121	110	13	18	5
Bosnia and Herzegovina	29,000	16	77	—	1 year	100 (z)	—	12	15	—	—	—	—	—
Bulgaria	7,400	26	76	13	135 days	90 (z)	0.65	22	14	79	103	35	34	34
Canada	11,000	73	83	17	17* weeks	55	0.64	21	6	68 (z)	117 (z)	20	11	32
Croatia	10,500	—	79	13	1+ year	100 (z)	0.67	21	6	47	88	34	27	35
Czech Republic	18,100	63	79	15	28* weeks	69	0.51	16	4	109	96	26	30	9
Denmark	17,800	72	80	18	18* weeks	100	0.73	38	5	93	124	5	6	19
Estonia	2,900	56	78	17	140 days[1]	100 (z)	0.62	21	7	111	101	18	20	14
Finland	8,500	75	82	18	18* weeks	65	0.71	42	4	59	111	7	7	24
France	6,900	69	83	17	16* weeks	100	0.64	18	4	118	116	10	12	3
Germany	19,200	72	82	16 (z)	14* weeks	100	0.58	32	4	98	100	9	15	2
Greece	25,900	—	81	17	17* weeks	100	0.55	15	4	67	102	17	13	15
Hungary	13,300	68	78	16	24* weeks	70	0.64	11	7	83	96	25	23	23
Iceland	12,700	—	83	19	13* weeks	80	0.72	33	3	94	108	3	3	18
Ireland	47,600	—	81	18	18 (8)* weeks	80 (c)	0.53	13	5	101 (z)	113	8	8	21
Italy	26,600	39	84	17	21* weeks	80	0.47	17	4	104	99	19	24	1
Japan	11,600	51	86	15	14 weeks	60	0.45	9	4	85	102	31	36	6
Latvia	8,500	39	78	17	112 days[1]	100 (z)	0.65	20	9	84	98	24	21	26
Lithuania	7,800	31	79	17	126 days[1]	100 (z)	0.69	23	8	68	97	23	19	30
Luxembourg	5,000	—	82	14	16* weeks	100	0.51	23	4	86	94	33	35	16
Macedonia, the former Yugoslav Republic of	6,500	—	77	12	9 months	— (d,z)	0.48	29	17	33	84	36	38	42
Malta	8,300	—	81	15	14 weeks	100 (z)	0.50	9	6	101	99	30	32	8
Moldova, Republic of	3,700	43	73	12	126 days[1]	100 (z)	0.63	22	19	62	82	39	39	41
Montenegro ‡	4,500	33	77 (z)	13 (z)	—	—	—	11	10	44 (z)	89	—	—	38
Netherlands	10,200	76	82	17	16* weeks	100	0.64	39	5	90	119	11	9	28
New Zealand	5,900	72	82	21	12 weeks	50	0.70	33	6	93	123	4	2	20
Norway	7,700	69	83	18	9* weeks	80	0.77	36	4	88	114	2	5	12
Poland	10,600	19	79	16	16* weeks	100	0.60	20	7	54	99	29	28	29
Portugal	6,400	33 (y)	81	16	17* weeks	100	0.59	28	5	77	99	22	25	17
Romania	3,200	30	76	14	126 days	85 (z)	0.69	9	18	75	85	37	33	39
Russian Federation	2,700	47 (z)	72	14	140 days[1]	100 (z)	0.62	14	16	84	92	36	37	37
Serbia ‡	4,500	33	75 (z)	13 (z)	—	—	—	20	8	44 (z)	89	—	—	36
Slovakia	13,800	41	79	15	28* weeks	55	0.58	19	8	95	95	28	31	22
Slovenia	14,200	59	81	18	105 days	100 (z)	0.61	12	4	79	100	16	14	11
Spain	16,400	67	84	17	16* weeks	100	0.50	37	4	114	124	12	16	10
Sweden	17,400	72 (y)	83	17	15* weeks	80	0.81	47	3	89	103	1	1	4
Switzerland	13,800	78	84	15	16 weeks	100	0.63	29	5	99	95	15	17	13
Ukraine	5,200	38	73	14	126 days	100 (z)	0.55	8	24	86	89	40	40	40
United Kingdom	8,200	81 (g)	81	17	26 (26)* weeks	90 (e)	0.66	20	6	59	105	14	10	25
United States	4,800	71	81	17	12 weeks	0	0.63	17	8	61	95	27	22	33

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

TIER II	Women's Index							Children's Index					Rankings		
Development Group	Health Status				Educational Status	Economic Status	Political Status	Children's Status					SOWM 2008		
LESS DEVELOPED COUNTRIES and TERRITORIES (minus least developed countries)	Lifetime risk of maternal mortality (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 71 countries)+	Women's Index Rank (out of 71 countries)+	Children's Index Rank (out of 81 countries)+
	2005	2006	2005	2007	2005	2005	2008	2006	2006	2005	2005	2004			
Algeria	220	95	50	74	13	0.34	8	38	4	112	83	85	45	49	36
Argentina	530	99	—	79	16	0.54	40	16	4	113	86	96	3	2	14
Armenia	980	98	22	75	12	0.63	9	24	4	94	88	92	25	29	22
Azerbaijan	670	100	12	71	11	0.65	11	88	7	96	83	77	42	35	59
Bahamas	2,700	99	60	75	12	0.70	12	14	—	101	90	97	10	9	6
Bahrain	1,300	98	31	77	15	0.35	3	10	9	104	99	—	31	37	11
Barbados	4,400	100	53	79	14 (z)	0.63	10	12	6 (y)	108	113	100	6	7	8
Belize	560	84	42	74	13	0.40	0	16	7	127	84	91	46	46	42
Bolivia	89	67	35	68	—	0.57	17	61	8	113	89	85	—	—	52
Botswana	130	94	39	32	12	0.31	11	124	13	106	75	95	59	59	61
Brazil	370	88	70	76	15	0.58	9	20	6	140	106	90	17	11	49
Brunei Darussalam	2,900	99	—	80	14	0.42	—	9	—	108	96	—	—	—	—
Cameroon	24	63	13	47	10	0.49	14	149	19	117	44	66	64	60	79
Chile	3,200	100	—	82	14	0.40	15	9	1	104	91	95	11	19	2
China	1,300	98	83	74	11	0.64	21	24	7	112	76	77	15	12	48
Colombia	290	96	64	76	12	0.63	8	21	7	112	78	93	18	18	29
Congo	22	83	—	55	7	0.50	7	126	14	88	39	58	65	62	77
Costa Rica	1,400	99	71	81	12	0.53	37	12	5	110	79	97	9	10	13
Côte d'Ivoire	27	57	7	47	5 (z)	0.32	9	127	20	72	25 (z)	84	71	71	78
Cuba	1,400	100	72	80	16	0.45	43	7	4	102	94	91	2	3	9
Cyprus	6,400	100 (y)	—	82	14	0.60	14	4	—	101	97	100	4	4	1
Dominican Republic	230	96	66	72	13	0.43	20	29	5	113	71	95	22	24	30
Ecuador	170	99	50	78	—	0.56	25	24	9	117	61	94	—	—	44
Egypt	230	74	57	73	—	0.23	2	35	6	101	86	98	—	—	15
El Salvador	190	92	61	75	12	0.40	17	25	10	113	63	84	44	43	53
Fiji	160	99	—	71	14	0.48	—	18	8 (y)	106	88	47	—	—	62
Gabon	53	86	12	54	13 (z)	0.57	17	91	12	130	55 (z)	88	50	38	69
Georgia	1,100	99	20	75	13	0.33	9	32	3	94	83	82	48	52	34
Ghana	45	50	19	58	8	0.71	11	120	18	94	45	75	60	54	72
Guatemala	71	41	34	72	9	0.32	12	41	23	114	51	95	63	67	64
Guyana	90	94	36	68	14	0.41	29	62	14	132	102	83	36	27	66
Honduras	93	67	51	71	12	0.46	23	27	11	113	66	87	41	41	50
India	70	47	43	67	10	0.31	9	76	43	125	59	86	66	64	76
Indonesia	97	72	57	70	11	0.46	12	34	28	117	63	77	55	48	70
Iran, Islamic Republic of	300	90	56	73	13	0.39	4	34	11	111	81	94	43	45	37
Iraq	72	89	10	62	8	—	26	46	8	99	45	81	—	—	56
Israel	7,800	99 (y)	52 (h)	83	16	0.65	14	5	—	109	92	100	1	1	3
Jamaica	240	97	63	73	12	0.56	13	31	4	95	87	93	21	22	23
Jordan	450	100	41	74	13	0.31	6	25	4	96	87	97	40	50	12
Kazakhstan	360	100	53	70	16	0.63	16	29	4	109	99	86	7	6	26
Kenya	39	42	32	49	10	0.83	7	121	20	112	49	61	57	40	74
Korea, Democratic People's Republic of	140	97	53	67	—	—	20	55	23	—	—	100	—	—	—
Korea, Republic of	6,100	100	67	82	15	0.40	14	5	—	105	96	92	8	8	7
Kuwait	9,600	98	41	80	13	0.35	2	11	10	98	95	—	26	28	16

The Complete Mothers' Index 2008

TIER II continued	Women's Index							Children's Index					Rankings		
Development Group	Health Status				Educational Status	Economic Status	Political Status	Children's Status					SOWM 2008		
LESS DEVELOPED COUNTRIES and TERRITORIES (minus least developed countries)	Lifetime risk of maternal mortality (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 71 countries)+	Women's Index Rank (out of 71 countries)+	Children's Index Rank (out of 81 countries)+
	2005	2006	2005	2007	2005	2005	2008	2006	2006	2005	2005	2004			
Kyrgyzstan	240	98	49	72	13	0.58	26	41	3	98	86	77	14	14	40
Lebanon	290	98	37	75	15	0.31	5	30	4	106	89	100	33	44	10
Libyan Arab Jamahiriya	350	94	26	77	17	0.30	8	18	5	106	105	72 (y)	32	33	33
Malaysia	560	98	30	76	14	0.36	10	12	8	96	76	99	35	42	16
Mauritius	3,300	98	49	76	13	0.41	17	14	15	102	88	100	19	21	21
Mexico	670	86	60	79	13	0.39	23	35	5	109	80	97	27	32	24
Micronesia, Federated States of	—	88	—	74	—	—	0	41	15	115	85	94	—	—	47
Mongolia	840	99	54	68	13	0.50	7	43	6	93	92	62	37	26	57
Morocco	150	63	55	73	9	0.25	11	37	10	105	50	81	61	66	54
Namibia	170	76	43	45	11	0.57	27	61	24	99	56	87	47	39	67
Nicaragua	150	67	66	73	11	0.32	19	36	10	112	66	79	53	55	55
Nigeria	18	35	8	44	8	0.41	7	191	29	103	34	48	70	69	80
Occupied Palestinian Territory	—	99	—	75	14	—	—	22	3	89	99	92	—	—	18
Oman	420	95	18	77	11	0.19	0	12	18	82	88	79 (y)	62	65	60
Pakistan	74	31	20	65	6	0.29	23	97	38	87	27	91	69	70	75
Panama	270	93	54 (y)	78	14	0.57	17	23	8	111	70	90	12	13	35
Papua New Guinea	55	41	20	58	5 (z)	0.72	1	73	35 (y)	75	26	39	68	63	81
Paraguay	170	77	61	74	12	0.34	10	22	5	104	64	86	49	53	31
Peru	140	73	50	74	13	0.55	29	25	8	112	92	83	16	17	38
Philippines	140	60	33	74	12	0.61	21	32	28	113	85	85	38	25	65
Qatar	2,700	99	32	77	14	0.24	0	21	6	106	100	100	39	51	5
Saudi Arabia	1,400	91	29	75	13	0.16	0	25	14	91	88	95 (y)	56	61	39
Singapore	6,200	100	53	81	—	0.51	25	3	3	78	63	100	—	—	27
South Africa	110	92	55	44	13	0.45	33	69	12	104	93	88	30	30	46
Sri Lanka	850	96	50	78	—	0.41	6	13	29	98	83	79	—	—	63
Suriname	530	85	41	73	13 (z)	0.40	26	39	13	120	87	92	34	34	51
Swaziland	120	74	26	29	10	0.29	11	164	10	107	45	62	67	68	73
Syrian Arab Republic	210	93	28	76	—	0.34	12	14	10	124	68	93	—	—	45
Tajikistan	160	83	27	67	10	0.57	18	68	17	101	82	59	54	47	68
Thailand	500	97	70	75	12	0.62	12	8	9	96	71	99	13	15	20
Trinidad and Tobago	1,400	98	33	73	12	0.46	27	38	6	100	81	91	23	31	28
Tunisia	500	90	53	76	14	0.29	23	23	4	109	84	93	28	36	19
Turkey	880	83	38	72	10	0.35	9	26	4	93	75	96	52	58	25
Turkmenistan	290	100	53	67	—	0.64	16	51	11	—	—	72	—	—	—
United Arab Emirates	1,000	99	24	82	11	0.25	23	8	14	83	64	100	51	57	43
Uruguay	2,100	100	—	80	16	0.56	12	12	5	109	105	100	5	5	4
Uzbekistan	1,400	100	63	70	11	0.60	18	43	5	100	95	82	20	20	32
Venezuela, Bolivarian Republic of	610	95	—	77	12 (z)	0.53	19	21	5	105	75	83	29	23	41
Vietnam	280	88	57	74	10	0.70	26	17	25	95	76	85	24	16	58
Zimbabwe	43 (z)	80	50	36	9	0.58	16	105	17	96	36	81	58	56	71

Note: Data refer to the year specified in the column heading or the most recently available.

+ The *Mothers' Index* ranks and *Women's Index* ranks are out of the number of countries for which sufficient data were available, as specified for each tier in the column headings. The *Children's Index* ranks include additional countries for which adequate data were available to present findings on children's indicators, but not on women's indicators.

‡ Due to the cession in June 2006 of Montenegro from the State Union of Serbia and Montenegro, disaggregated data for Montenegro and Serbia are not yet available for all indicators. With the exception of female life expectancy at birth, the participation of women in national government and the under-5 mortality rate, data presented are pre-cession aggregates.

** The parliament of Bangladesh was dissolved on 27 October 2006, in view of elections that are yet to take place. Women held 15 % of the seats in the outgoing parliament.

— No data [1]calendar days (all other days unspecified)

(a) 80% prior to birth and for 150 days + 50% for the rest of the leave period; (b) 4 weeks at 82% of pay + 11 weeks at 75% of pay; (c) 80% for first 18 weeks, additional 18 weeks unpaid; (d) Paid, amount not specified; (e) 90% for the first 6 weeks + flat rate (approximately 33% of average wage) for 20 weeks, additional 26 weeks is unpaid; (f) Data pertain to the Flemish population; (g) Data excludes Northern Ireland; (h) Data pertain to the Jewish population; (y) Data are from an earlier publication of the same source (z) Data are from a secondary source

* These countries also offer generous parental leave which often follows maternity leave and can be taken by either parent, usually one at a time. Payment may be equal to or less than the maternity leave allowance rate. For further information on parental leave in OECD countries, 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 2008		
LEAST DEVELOPED COUNTRIES	Lifetime risk of maternal mortality (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 34 countries)+	Women's Index Rank (out of 34 countries)+	Children's Index Rank (out of 44 countries)+
	2005	2006	2005	2007	2005	2005	2008	2006	2006	2005	2005	2004			
Afghanistan	8	14	4	48	4	—	28	257	39	87	0.59	39	—	—	43
Angola	12	45	5	43	3 (z)	0.62	15	260	31	64 (z)	0.86 (z)	53	30	27	40
Bangladesh	51	20	47	66	9	0.46	15**	69	48	109	1.03	74	13	12	17
Benin	20	78	7	56	6 (z)	0.47	11	148	23	96	0.80	67	23	26	16
Bhutan	55	56	19	66	7 (z)	—	3	70	19	97 (z)	0.97 (z)	62	—	—	6
Burkina Faso	22	54	9	50	4	0.66	15	204	37	58	0.80	61	24	23	37
Burundi	16	34	10	46	6	0.77	31	181	39	85	0.86	79	14	9	22
Cambodia	48	44	19	61	9	0.74	20	82	36	134	0.92	41	8	3	32
Cape Verde	120	89	46	74	11	0.35	18	34	14 (y)	108	0.95	80	2	5	1
Central African Republic	25	53	7	40	—	0.61	11	175	29	56	0.66	75	—	—	33
Chad	11	14	2	45	4	0.65	5	209	37	77	0.67	42	33	28	42
Comoros	52	62	19	67	7	0.51	3	68	25	86	0.88	86	12	17	3
Congo, Democratic Republic of the	13	61	4	46	—	0.52	8	205	31	62	0.78	46	—	—	41
Djibouti	35	61	—	55	4	0.48	14	130	29	40	0.82	73	27	29	24
Equatorial Guinea	28	65	—	42	9 (z)	0.43	18	206	19	114	0.95	43	21	20	23
Eritrea	44	28	5	58	5	0.45	22	74	40	64	0.81	60	28	30	28
Ethiopia	27	6	6	49	6	0.60	22	123	38	100	0.88	22	25	24	36
Gambia	32	57	9	59	8	0.53	9	113	20	81	1.06	82	15	18	5
Guinea	19	38	4	55	6	0.69	19	161	26	81	0.84	50	17	15	27
Guinea-Bissau	13	39	4	47	4 (z)	0.51	14	200	19	70 (z)	0.67 (z)	59	29	32	31
Haiti	44	26	22	54	—	0.52	4	80	22	—	0.95 (z)	54	—	—	14
Lao People's Democratic Republic	33	19	29	58	9	0.51	25	75	40	116	0.88	51	16	13	25
Lesotho	45	55	30	34	11	0.52	25	132	20	132	1.00	79	6	8	9
Liberia	12	51	6	43	8 (z)	—	13	235	26	100 (z)	0.73	61	—	—	30
Madagascar	38	51	17	57	6 (z)	0.70	8	115	42	139	0.96	50	19	14	35
Malawi	18	54	26	40	10	0.73	13	120	19	122	1.02	73	5	7	8
Maldives	200	84	33	68	11	0.50	12	30	30	94	0.98	83	1	1	2
Mali	15	41	6	50	5	0.68	10	217	33	66	0.80	50	26	22	38
Mauritania	22	57	5	56	7	0.50	22	125	32	93	1.01	53	18	19	20
Mozambique	45	48	12	42	7	0.81	35	138	24	103	0.85	43	7	4	21
Myanmar	110	57	33	65	8 (z)	—	—	104	32	100	1.02	78	—	—	10
Nepal	31	19	35	64	8	0.50	17	59	39	126	0.95	90	11	16	11
Niger	7	33	4	45	3	0.57	12	253	44	47	0.73	46	34	33	44
Rwanda	16	39	4	46	8	0.74	49	160	23	120	1.02	74	4	6	13
Senegal	21	52	8	58	—	0.54	22	116	17	78	0.97	76	—	—	7
Sierra Leone	8	43	4	43	6 (z)	0.45	13	270	30	79 (z)	0.71 (z)	57	31	31	39
Solomon Islands	100	85	—	64	8	0.50	0	73	21 (y)	97	0.95	70	9	10	4
Somalia	12	33	—	50	—	—	8	145	36	—	—	29	—	—	—
Sudan	53	87	7	58	—	0.25	18	89	41	60	0.87	70	—	—	25
Tanzania, United Republic of	24	43	17	47	5 (z)	0.73	30	118	22	111	0.97	62	10	11	12
Timor-Leste	35	18	9	59	—	—	29	55	46	151	0.92	58	—	—	34
Togo	38	62	9	57	7 (z)	0.43	11	108	26	100	0.85	52	22	25	19
Uganda	25	42	18	52	10	0.70	31	134	20	119	1.00	60	3	2	15
Yemen	39	27	10	64	7	0.30	0	100	46	89	0.74	67	32	34	29
Zambia	27	43	23	38	7 (z)	0.55	15	182	20	111	0.95	58	20	21	18

Methodology and Research Notes

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. Last year (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' 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 6). 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 March 1, 2008.

Sources: 2007 Population: United Nations Population Fund. *State of World Population 2007*. (UNFPA: 2007), supplemental data from: United Nations Population Division. *World Population Prospects: The 2006 revision*. Population Database available online at: esa.un.org/unpp/ ; Definition of development regions: United Nations Population Division. *World Population Prospects: The 2006 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 mortality

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. Calculations are based on maternal mortality and fertility rates in a country. Some country estimates are derived using a WHO/UNICEF methodology. Data are for 2005.

Source: *Maternal Mortality in 2005: Estimates Developed by WHO, UNICEF, UNFPA and the World Bank*. (WHO: 2007)
www.who.int/whosis/mme_2005.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 (including 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 October 1, 2005.

Source: United Nations Population Division.
World Contraceptive Use 2005 (wall chart).
www.un.org/esa/population/publications/contraceptive2005/WCU2005.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 2000-2006. 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) 2008.
State of the World's Children 2008. Table 8, pp.142-145
www.unicef.org/sowc08/docs/sowc08_table_8.pdf

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 2007.

Source: United Nations Population Fund (UNFPA) 2007. *State of World Population 2007*. pp. 86-89. www.unfpa.org/swp/swpmain.htm

Methodology and Research Notes

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. Data are from 2005 or the most recent year available.

Source: United Nations Educational, Scientific and Cultural Organization (UNESCO) 2007. *Education for All Global Monitoring Report 2008*. Table 4, pp.276-283. www.efareport.unesco.org.

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 during 1996-2005.

Source: United Nations Development Programme (UNDP) 2007. *Human Development Report 2007/2008*. Table 29, pp.330-333. hdrstats.undp.org/indicators/284.html

Maternity leave benefits

The maternity leave indicator includes both the length of time for which benefits are provided as well the extent of compensation. The data are compiled by the Organisation for Economic Co-operation and Development (OECD) and the International Labour Organisation (ILO) based on information provided by countries from 2005-2006 and 2004-2006 respectively. Data on maternity leave benefits are reported for Tier I countries only, 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.

Sources: OECD Family Database. Key characteristics of parental leave systems. Table PF7.1 Updated January 18, 2007. Available online at: www.oecd.org/dataoecd/45/26/37864482.pdf, supplemented by data from: United Nations Statistics Division. Statistics and indicators on women and men. Table 5g. Updated 28 August 2006. 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 the lower or single-house of national legislatures or parliaments occupied by women. Data are as of February 29, 2008.

Source: Inter-Parliamentary Union (IPU). Women in National Parliaments. Situation as of February 29, 2008. 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 5 years of age, expressed per 1,000 live births. Data are from 2006.

Source: UNICEF 2008. *The State of the World's Children 2008*. Table 1, pp.114-117. www.unicef.org/sowc08/docs/sowc08_table_1.pdf

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 reference population respectively. Data are from 2000-2006. This indicator is included in Tier II and Tier III only, as few more developed countries report these statistics.

Source: UNICEF 2008. *State of the World's Children 2008*. Table 2, pp. 118-121. www.unicef.org/sowc08/docs/sowc08_table_2.pdf

Gross pre-primary enrollment ratio

Early childhood care and education (ECCE), 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 (GER) 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. GERs 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 2005 or the most recently available. Pre-primary enrollment is analyzed across Tier I countries only.

Source: United Nations Educational, Scientific and Cultural Organization (UNESCO) 2007. *Education for All Global Monitoring Report 2008*. Table 3b, pp. 268-275. www.efareport.unesco.org.

Gross primary enrollment ratio

The gross primary enrollment ratio 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. Data are for the school year ending in 2005 or the most recently available. This indicator is not tracked in Tier I, where nearly all children complete primary school.

Source: United Nations Educational, Scientific and Cultural Organization (UNESCO) 2007. *Education for All Global Monitoring Report 2008*. Table 5, pp.284-291. www.efareport.unesco.org.

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. Data are for the school year ending in 2005 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: United Nations Educational, Scientific and Cultural Organization (UNESCO) 2007. *Education for All Global Monitoring Report 2008*. Table 5, pp.284-291. www.efareport.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 2005 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.

Source: United Nations Educational, Scientific and Cultural Organization (UNESCO) 2007. *Education for All Global Monitoring Report 2008.* Table 8, pp.308-315. www.efareport.unesco.org.

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 (.62 miles) of the user's dwelling. Data are from 2004.

Source: United Nations Children's Fund (UNICEF) 2008. *The State of the World's Children 2008.* Table 3, pp.122-125. www.unicef.org/sowc08/docs/sowc08_table_3.pdf

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, with the exception of educational data which were supplemented by data from the UNESCO Institute for Statistics' online database, available at: stats.uis.unesco.org

4. Standard scores, or Z-scores, were created for each of the indicators using the following formula:

$$Z = \frac{X - \overline{X}}{S}$$

where Z = The standard, or Z-score
X = The score to be converted
$\overline{X}$ = The mean of the distribution
S = The standard deviation of the distribution

5. 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.

Methodology and Research Notes

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 avoid rewarding school systems where pupils do not start on time or fail to progress through the system at expected rates, gross enrollment ratios (GERs) between 100 and 105 percent were discounted to 100 percent. Gross enrollment ratios over 105 percent were discounted to 100 and any amount over 105 percent was subtracted from 100 (for example, a country with a gross enrollment rate of 107 percent would be discounted to 100-(107-105), or 98). In Tier I, GERs over 105 percent were instead discounted to their respective country's net enrollment ratio if available.
- 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.

6. 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. A *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).

7. 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.

8. Data analysis was conducted using Microsoft Excel software.

BASIC HEALTH CARE REPORT CARD

The *Basic Health Care Report Card* analyzes coverage rates of a key set of effective and affordable child survival interventions available to prevent or treat the main causes of under-5 deaths in 55 of the 68 priority countries for maternal and child survival. Countries were ranked based on a national coverage index calculated as a weighted average of seven indicators in three intervention areas: maternal and newborn care, immunization and treatment of sick children (see the following table for indicator definitions). Average coverage levels for these interventions were similarly calculated for the poorest and richest children (bottom and top wealth quintile respectively) in each country. Only priority countries for which sufficient data were available for an analysis of the poor-rich coverage gap were included in this study. All national estimates used to compute the coverage index are from UNICEF's *State of the World's Children 2008* (www.unicef.org/sowc08/index.php). Wealth quintile data is from *Demographic and Health Surveys* (DHS) and *Multiple Indicator Cluster Surveys* from 1991-2006 as compiled by the Countdown 2008 Equity Analysis Group, courtesy of Dr. Ties Boerma (WHO: Geneva).

Note: Save the Children's basic health care coverage analysis was inspired by and modeled after that conducted by the Countdown 2008 Equity Analysis Group (see Countdown 2008 Equity Analysis Group. "Mind the Gap: Equity and Trends in Coverage of Maternal, Newborn, and Child Health Services in 54 Countdown Countries." *The Lancet.* Vol. 371. April 12, 2008. pp.1259–1267). However, findings from the Countdown and those reported in the *Basic Health Care Report Card* differ given variations in national-level data sources, selected interventions and weighting schemes used to calculate the coverage index.

INTERVENTIONS ANALYZED AS PART OF THE BASIC HEALTH CARE PACKAGE, BY INTERVENTION AREA

	Indicator Definition
Maternal and newborn care indicators	
Prenatal care coverage (ANC)	Percentage of women 15-49 years old attended at least once during pregnancy by skilled health personnel (doctors, nurses or midwives).
Skilled care at childbirth (SBA)	Percentage of births attended by skilled health personnel (doctors, nurses or midwives).
Immunization indicators	
Measles vaccination (MSL)	Percentage of infants who are immunized against measles.
Diphtheria, pertussis, and tetanus vaccination (DPT3)	Percentage of infants who received three doses of DPT vaccine.
BCG vaccination	Percentage of infants currently vaccinated against tuberculosis.
Treatment of sick children indicators	
Oral rehydration therapy for diarrhea (ORT)	Percentage of children (aged 0-4) with diarrhea (in the two weeks preceding the survey) receiving oral rehydration therapy (oral rehydration salts, recommended home solution or increased fluids) and continued feeding.
Treatment of pneumonia (ARI)	Percentage of children (aged 0-4) with suspected pneumonia (in the two weeks preceding the survey) who were taken to an appropriate health care provider.

Source: UNICEF. *State of the World's Children 2008*

These 7 indicators were weighted according to their mortality-reducing potential (see Jones et al. "How Many Child Deaths Can We Prevent This Year?" *The Lancet*. Vol. 362. July 2003, pp.65-71 for the estimated percent of under-5 deaths that could be prevented if universal coverage of individual interventions were achieved in just 42 of the child survival priority countries in 2000). Assuming interventions that promise to save the most children's lives should be those most widely available, curative interventions were weighted more heavily than preventive in calculating the coverage index. The formula used to calculate the percent of children without basic health care coverage was:

$$100\% - \left[\frac{15}{35}\text{ORT} + \frac{6}{35}\text{ARI} + \frac{3}{35}\text{ANC} + \frac{10}{35}\text{SBA} + \frac{1}{35}\left(\frac{\text{MSL} + 2\text{DPT3} + \text{BCG}}{4}\right)\right]$$

The indicator weights represent the normalized mortality-reducing potential of each intervention. For example, if nearly all children under 5 sick with diarrhea received oral rehydration therapy, 15 percent of under-5 deaths could be prevented.

Note: Universal immunization against measles could prevent 1 percent of global under-5 deaths. Rather than use only measles vaccination coverage in this analysis – as it is often over-estimated – we calculated a weighted vaccination score to better reflect actual coverage levels. Moreover, the estimate of preventable under-5 deaths resulting from skilled care at birth was calculated as the mortality-reducing potential of several of its components taken together: clean delivery (4 percent), resuscitation (4 percent) and newborn temperature management (2 percent).

Under-5 mortality rates observed among the poorest and richest children and the ratio between them – the survival gap – were also analyzed for 52 of the 55 priority countries included in the *Basic Health Care Report Card* for which data were available. This data was sourced from an analysis conducted by Gwatkin and colleagues (Davidson R. Gwatkin, et al. *Socio-Economic Differences in Health, Nutrition, and Population: An Overview*. World Bank: Washington: 2007) and supplemented by data from recent *Demographic and Health Surveys* (DHS) and *Multiple Indicator Cluster Surveys* (MICS) available online at www.measuredhs.com and www.childinfo.org respectively.

Endnotes

[1] Calculations derived from national-level estimates of the percentage and absolute number of children under age 5 without basic health care for all developing countries for which sufficient data points were available. When taken together, the absolute number of children under 5 in these 81 developing countries totaled more than 200 million. Please see Methodology and Research Notes for data sources and complete methodology.

[2] UNICEF. *State of the World's Children 2008.* (New York: 2008) Table 1, p.117

[3] Calculations based on global population and death rate estimates from the Central Intelligence Agency. *The World Factbook.* www.cia.gov/library/publications/the-world-factbook/

[4] Calculations based on the estimated 536,000 maternal deaths worldwide in 2005. Source: *Maternal Mortality in 2005: Estimates Developed by WHO, UNICEF, UNFPA and the World Bank.* (WHO: 2007), p.1

[5] UNICEF. *State of the World's Children 2008.* p.4

[6] Ibid, p.8

[7] Calculations based on the estimated 63 percent of global under-5 deaths that could be prevented if universal coverage of a package of lifesaving interventions were achieved in just 42 child survival priority countries accounting for 90 percent of annual child deaths. Source: Jones, Gareth, Richard W. Steketee, Robert E. Black, Zulfiqar A Bhutta, Saul S. Morris and the Bellagio Child Survival Study Group. "How Many Child Deaths Can We Prevent This Year?" *The Lancet.* Vol.362. July 2003, pp.65-71

[8] Calculations derived from national-level estimates of the percentage and absolute number of children under age 5 without basic health care for all developing countries for which sufficient data points were available. When taken together, the absolute number of children under 5 in these 81 developing countries totaled more than 200 million. Please see Methodology and Research Notes for data sources and complete methodology.

[9] UNICEF. *State of the World's Children 2008.* p.1

[10] Cornia, Giovanni Andrea and Leonardo Menchini. *The Pace and Distribution of Health Improvements During the Last 40 Years: Some Preliminary Results.* UNDP-French Government Forum on Human Development, Paris, January 17-19, 2005, pp.1-33

[11] UNICEF. *State of the World's Children 2008.* p.117

[12] The Bellagio Study Group on Child Survival. "Knowledge into Action for Child Survival," *The Lancet.* Vol.362. July 26, 2003. (Lynhurst Press Ltd.: London) p.325

[13] WHO. *World Health Statistics 2007.* (Geneva: 2007) pp.74-76

[14] Lawn, Joy, 2004. Unpublished analysis of Measure/DHS Demographic and Health Survey data for 50 developing countries. Survey years: 1994-2002, data referring to a 10-year period prior to survey.

[15] UNICEF classifications were used for "industrialized" countries (North America and Western Europe, including Israel and Cyprus and excluding most Central and Eastern European countries).

[16] Calculations based on comparative rates of under-5 mortality and total fertility published in UNICEF's *State of the World's Children 2008.* Table 10.

[17] Victora, Cesar G., Adam Wagstaff, Joanna Armstrong Schellenberg, Davidson Gwatkin, Mariam Claeson, Jean-Pierre Habicht. "Applying an Equity Lens to Child Health and Mortality: More of the Same Is Not Enough," *The Lancet.* Vol.362. July 19, 2003. (Lynhurst Press Ltd.: London) p.234

[18] International Institute for Population Sciences (IIPS) and Macro International. *National Family Health Survey (NFHS-3), 2005-06: India: Volume I.* (Mumbai: 2007) p.183

[19] Cesar G.Victora, et al. "Applying an Equity Lens to Child Health and Mortality: More of the Same Is Not Enough." *The Lancet.*

[20] WHO. *World Health Report 2006.* p.168

[21] World Bank. "China's Progress Towards the Health MDGs." *Rural Health in China: Briefing Note Series.* Briefing Note No.2. (March 2005) p.3

[22] IIPS and Macro International. *National Family Health Survey, 2005-06: India: Volume I.* p.183

[23] Zia, Helen. "A Great Leap Forward for Girls." *Ford Foundation Report.* Winter 2000.

[24] Cesar G.Victora, et al. "Applying an Equity Lens to Child Health and Mortality: More of the Same Is Not Enough." *The Lancet.*

[25] Ibid.

[26] Jha, Prabhat, Rajesh Kumar, Priya Vasa, Neeraj Dhingra, Deva Thiruchelvam and Rahim Moineddin. "Low Male-to-Female Sex Ratio of Children Born in India: National Survey of 1.1 Million Households." *The Lancet.* Vol. 367, No. 9506. January 21, 2006. pp.211-218

[27] Ibid.

[28] Li, S., C. Zhu, M. Feldman. "Gender Differences in Child Survival in Contemporary Rural China: A County Study." *Journal of Biosocial Science.* Vol.36 (2004) pp.83-109

[28] *Maternal Mortality in 2005: Estimates Developed by WHO, UNICEF, UNFPA and the World Bank.* (WHO: 2007) p.16, 23-27

[29] Ibid, p.16

[30] Calculation based on the total number of births and average rate of skilled birth attendance in developing countries in 2006 as published in UNICEF's *State of the World's Children 2008.* p.117

[31] *Maternal Mortality in 2005: Estimates Developed by WHO, UNICEF, UNFPA and the World Bank.* p.1

[32] Strong, M.A. *The Effects of Adult Mortality on Infant and Child Mortality.* Paper presented at USAID Committee on Population Workshop on the Consequences of Pregnancy, Maternal Morbidity and Mortality for Women, their Families and Societies, Nairobi, Kenya. October 19-20, 1998.

[33] Lawn, Joy, Simon Cousens, and Jelka Zupan. "4 Million Neonatal Deaths: When? Where? Why?" *The Lancet.* Vol. 365, No. 9462. (Lynhurst Press, Ltd.: London: March 3, 2005) pp.891-900

[34] Lawn, Joy, 2004. Unpublished analysis of Measure/DHS Demographic and Health Survey data for 50 developing countries. Survey years: 1994-2002, data referring to a 10-year period prior to survey.

[35] UNICEF. *Progress for Children: A World Fit for Children Statistical Review.* No.6. December 2007. p.18

[36] van de Poel, Ellen, Owen A. O'Donnell and Eddy van Doorslaer. "Are Urban Children Really Healthier?" *Tinbergen Institute Discussion Paper No. 2007-035/3* (Tinbergen Institute: April 10, 2007)

[37] Loewenberg, Samuel. "Tackling the Causes of Ill Health in Rio's Slums." *The Lancet.* Vol. 365, No. 9463, March 12, 2005. pp. 925-926

[38] Sclar, Elliott D, Pietro Garau and Gabriella Carolini. "The 21st Century Health Challenge of Slums and Cities." *The Lancet.* Vol. 365, No. 9462. pp.901-903

[39] Lawn, Joy, 2004. Unpublished analysis of Measure/DHS Demographic and Health Survey data for 50 developing countries. Survey years: 1994-2002, data referring to a 10-year period prior to survey.

[40] UNICEF. *State of the World's Children 2008.* p.145

[41] WHO. *World Health Statistics 2007.* pp.75-77

[42] Ibid.

[43] WHO. *World Health Statistics 2007.* p.75

[44] Ibid.

[45] Ibid.

[46] Gwatkin, Davidson R, Shea Rutstein, Kiersten Johnson, Eldaw Suliman, Adam Wagstaff, and Agbessi Amouzou. *Socio-Economic Differences in Health, Nutrition, and Population: An Overview.* (World Bank: Washington: 2007) pp.83-84

[47] Ibid.

[48] Ibid, p.82

[49] Ibid, pp.77-78

[50] UNICEF and WHO. *Pneumonia: The Forgotten Killer of Children.* p.18

[51] Gwatkin, et al. *Socio-Economic Differences in Health, Nutrition, and Population: An Overview.* pp.90, 102

[52] Shiffman, Jeremy. "Donor Funding Priorities for Communicable Disease Control in the Developing World." *Health Policy and Planning.* Vol.21, No.6. September 18, 2006. pp.411-420

[53] Ibid.

[54] Ibid.

[55] Cesar G.Victora, et al. "Applying an Equity Lens to Child Health and Mortality: More of the Same Is Not Enough." *The Lancet.*

[56] Gareth Jones, et al. "How Many Child Deaths Can We Prevent This Year?" *The Lancet.*

[57] UNICEF. *State of the World's Children 2008.* p.152

[58] Gwatkin, Davidson R., Shea Rutstein, Kiersten Johnson, Eldaw Suliman, Adam Wagstaff and Agbessi Amouzou. *Socio-Economic Differences in Health, Nutrition, and Population in the Philippines.* (World Bank: Washington: 2007)

[59] Manuel-Santana, R. "Philippine Campaign Boosts Child Immunizations," *FrontLines.* (USAID: Washington: March, 1993) pp.9-10

[60] UNICEF. *State of the World's Children 2008.* p.124

[61] Ibid, p.116

[62] Davidson R. Gwatkin, et al. *Socio-Economic Differences in Health, Nutrition, and Population in the Philippines.*

[63] UNICEF. *State of the World's Children 2008.* p.124

[64] Instituto Nacional de Estadística e Informática (INEI) y ORC Macro. *Perú Encuesta Demográfica y de Salud FamiliarENDES Continua 2004-2006.* (INEI y ORC Macro: Calverton, Maryland: 2007) p.118 (Spanish)

[65] UNICEF. *State of the World's Children 2008.* p.152

[66] WHO. *World Health Statistics 2007.* p.29

[67] Joint United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization (WHO). *2007 AIDS Epidemic Update.* (Geneva: December 2007) p.16

[68] UNAIDS. *Report on the Global AIDS Epidemic.* (Geneva: 2006) p.455

[69] Bradshaw, Debbie, David Bourne and Nadine Nannan. "What are the Leading Causes of Death Among South African Children?" *MRC Policy Brief.* No.3 (Medical Research Council: South Africa: December 2003)

[70] WHO. *World Health Statistics 2007.* p.29

[71] Gwatkin, Davidson R., Shea Rutstein, Kiersten Johnson, Eldaw Suliman, Adam Wagstaff and Agbessi Amouzou. *Socio-Economic Differences in Health, Nutrition, and Population in South Africa.* (World Bank: Washington: 2007)

[72] UNICEF. *State of the World's Children 2008.* p.151

[73] Ibid, pp.123, 143

[74] ORC Macro. *Indonesia Demographic and Health Survey 2002/2003.* (Calverton, MD: December 2003)

[75] UNICEF. *State of the World's Children 2008.* p.123

[76] Ibid.

[77] WHO. *World Health Statistics 2007.* p.25

[78] Gwatkin, Davidson R., Shea Rutstein, Kiersten Johnson, Eldaw Suliman, Adam Wagstaff and Agbessi Amouzou. *Socio-Economic Differences in Health, Nutrition, and Population in Indonesia* (World Bank: Washington: 2007)

[79] Badan Pusat Statistik-Statistics Indonesia (BPS) and ORC Macro. *Indonesia Demographic and Health Survey 2002-2003.* (BPS and ORC Macro: Calverton, Maryland: 2003) p.111

[80] UNICEF. *State of the World's Children 2008.* p.153

[81] Ibid, p.124

[82] Ibid.

[83] Countdown 2008 Equity Analysis Group, courtesy of Dr. Ties Boerma. (WHO, 20 Avenue Appia, 1211 Geneva 27, Switzerland)

[84] Gwatkin, Davidson R., Shea Rutstein, Kiersten Johnson, Eldaw Suliman, Adam Wagstaff and Agbessi Amouzou. *Socio-Economic Differences in Health, Nutrition, and Population in Turkmenistan* (World Bank: Washington: 2007)

[85] Gwatkin, Davidson R., Shea Rutstein, Kiersten Johnson, Eldaw Suliman, Adam Wagstaff and Agbessi Amouzou. *Socio-Economic Differences in Health, Nutrition, and Population in Nigeria* (World Bank: Washington: 2007)

[86] UNICEF. *State of the World's Children 2008.* p.144

[87] Ibid, p.124

[88] Davidson R. Gwatkin, et al. *Socio-Economic Differences in Health, Nutrition, and Population in Nigeria*

[89] IFAD. *Rural Poverty in Yemen.* www.ruralpovertyportal.org/english/regions/asia/yem/index.htm

[90] UNICEF. *State of the World's Children 2008.* p.117

[91] Ibid, p.125

[92] Gwatkin, Davidson R., Shea Rutstein, Kiersten Johnson, Eldaw Suliman, Adam Wagstaff and Agbessi Amouzou. *Socio-Economic Differences in Health, Nutrition, and Population in Yemen* (World Bank: Washington: 2007)

[93] Ibid.

[94] UNICEF. *State of the World's Children 2008.* p.114

[95] Ibid, p.142

[96] Gwatkin, Davidson R., Shea Rutstein, Kiersten Johnson, Eldaw Suliman, Adam Wagstaff and Agbessi Amouzou. *Socio-Economic Differences in Health, Nutrition, and Population in Chad* (World Bank: Washington: 2007)

[97] Ibid.

[98] UNICEF. *State of the World's Children 2008.* p.147

[99] *Maternal Mortality in 2005: Estimates Developed by WHO, UNICEF, UNFPA and the World Bank.* p.26

[100] UNICEF. *State of the World's Children 2008.* p.116

[101] Ibid, p.124

[102] UNICEF. *Somalia Multiple Indicator Cluster Survey 2006 Report.* (New York: 2007) p.88

[103] Ibid, p.120

[104] WHO. *World Health Statistics 2007.* p.25

[105] Ethiopia Ministry of Health and the Federal HIV/AIDS Control Office (FHAPCO). *Single Point HIV Prevalence Estimate.* June 2007. p.7

[106] UNICEF. *State of the World's Children 2008.* p.122

[107] Countdown 2008 Equity Analysis Group, courtesy of Dr. Ties Boerma. (WHO, 20 Avenue Appia, 1211 Geneva 27, Switzerland)

[108] Central Statistical Agency [Ethiopia] and ORC Macro. *Ethiopia Demographic and Health Survey 2005.* (Addis Ababa, Ethiopia and Calverton, MD: 2006) p.131

[109] Ibid, p.112

[110] Ibid, p.118

[111] UNICEF. *State of the World's Children 2008.* p.150

[112] Gareth Jones, et al. "How Many Child Deaths Can We Prevent This Year?" *The Lancet.*

[113] UNICEF and WHO. *Pneumonia: The Forgotten Killer of Children.* (New York and Geneva: 2006) p.4

[114] Ibid, p.5

[115] Ibid, p.28

[116] UNICEF. *Progress for Children: A World Fit for Children Statistical Review.* p.22

[117] Ibid.

[118] UNICEF and WHO. *Pneumonia: The Forgotten Killer of Children.* p.4

[119] UNICEF. *Progress for Children: A World Fit for Children Statistical Review.* p.23

[120] Bryce, Jennifer, Robert E. Black, Neff Walker, Zulfiqar A. Bhutta, Joy E. Lawn, Richard W. Steketee. "Can the World Afford to Save the Lives of 6 Million Children Each Year?" *The Lancet.* Vol. 365. June 25, 2005. pp.2193-2200

[121] Harvard School of Public Health. "Cholera: A Not-So-Simple Solution," *Harvard Public Health Review.* www.hsph.harvard.edu/review/summer_solution.shtml

[122] UNICEF, *State of the World's Children 2008.* p.125

[123] UNICEF. *Progress for Children: A World Fit for Children Statistical Review.* p.36

[124] WHO. *World Health Statistics 2007.* p.31

[125] Breman, Joel G., Anne Mills, Robert W. Snow, Jo-Ann Mulligan, Christian Lengeler, Kamini Mendis, Brian Sharp, Chantal Morel, Paola Marchesini, Nicholas J. White, Richard W. Steketee and Ogobara K. Doumbo. "Conquering Malaria." *Disease Control Priorities in Developing Countries,* 2nd edition. (New York: Oxford University Press: 2006) pp.413-32

[126] UNICEF. *State of the World's Children 2008.* p.125

[127] UNICEF. *Progress for Children: A World Fit for Children Statistical Review.* p.36

[128] WHO. *Measles Fact Sheet.* http://www.who.int/mediacentre/factsheets/fs286/en/index.html

[129] Ibid.

[130] UNICEF. *Progress for Children: A World Fit for Children Statistical Review.* p.20

[131] Ibid, p.19

[132] UNICEF. *State of the World's Children 2008.* p.10

[133] Ibid, p.121

[134] UNICEF. *Vitamin A Supplementation: A Decade of Progress.* (New York: 2007) p.v

[135] UNICEF. *Vitamin A Supplementation: Progress for Child Survival.* Working Paper (New York: 2006) p.2

[136] UNICEF. *State of the World's Children 2008.* p.66

[137] Ibid, p.19

[138] UNICEF. *Progress for Children: A World Fit for Children Statistical Review.* p.24

[139] X.F. Li, et al "The Postpartum Period: The Key to Maternal Mortality," *International Journal of Gynecology & Obstetrics* 54 (1996) pp.1-10

[140] Darmstadt, Gary, Neff Walker, Joy Lawn, Zulfiqar Bhutta, Rachel Haws and Simon Cousens. "Saving Newborn Lives in Asia and Africa: Cost and Impact of Phased Scale-Up of Interventions within the Continuum of Care." *Health Policy and Planning 2008,* Vol.23, No.2. pp.101-117

[141] WHO. *World Health Statistics 2007.* pp.56-62

[142] Figures are world aggregates. Sources: Under-5 mortality rate: UNICEF. *State of the World's Children 2008.* p.117; Death rates by age group: C.D. Mathers, D. Loncar. "Projections of Global Mortality and Burden of Disease from 2002 to 2030." *PLoS Medicine.* Vol. 3, No.11, Dataset S1. pp.2011-2030

[143] UNICEF. *State of the World's Children 2008.* p.115

Endnotes

[144] Bang, Abhay T., Rani A. Bang, Sanjay B. Baitule, M. Hamini Reddy and Maheesh D. Deshmukh. "Effect of Home-Based Neonatal Care and Management of Sepsis on Neonatal Mortality: A Field Trial in Rural India." *The Lancet.* Vol. 354. (Lynhurst Press, Ltd.: London: December 4, 1999) pp.1955-1961

[145] Mabud, M.A. *Demographic Implications for Health Human Resources for Bangladesh.* (Asia-Pacific Action Alliance on Human Resources for Health, Independent University: 2005) p.6

[146] Marsh, David, Eric Starbuck, Eric Swedberg, Kathryn Bolles, Steve Wall, Nizam Ahmed, Dixmer Rivera, Carolina Hilari, Tedbab Degefie, Naida Pasion, et al. *Community Case Management: Overview and Update.* (Save the Children: December 20, 2006) (unpublished document)

[147] Ministry of Health. *Afghanistan Health Survey 2006: Estimates of Priority Health Indicators for Rural Afghanistan.* pp.42, 48

[148] See, for example: Save the Children. *Provincial Strengthening in Northern Afghanistan: Capacity Building and Innovation to Support the Basic Package of Health Services and Sustainably Improve Access, Quality and Use of Essential MCH Services through Jawzjan Province.* (Westport, CT: 2005) p.6 and U.S. Fund for UNICEF. *MNT Monitor: The Campaign to Save Mothers and Babies from Tetanus*. Fall 2004. No.8. www.who.int/immunization_monitoring/diseases/06_fall_2004.pdf

[149] UNICEF. *State of the World's Children 2008.* p.115

[150] Ibid, p.120 and Ministry of Health and Population (MOHP) [Nepal], New ERA and Macro International Inc. *Nepal Demographic and Health Survey 2006.* (Kathmandu: 2007) p.260

[151] USAID. *Empowering Female Community Health Volunteers.* www.usaid.gov/stories/nepal/fp_nepal_female.html

[152] Kebbede, G. *Living with Urban Environmental Health Risks: The Case of Ethiopia.* (Ashgate Publishing, Ltd: Aldershot, England: 2004) p.181

[153] Marsh, David, Eric Starbuck, Eric Swedberg, Kathryn Bolles, Steve Wall, Nizam Ahmed, Dixmer Rivera, Carolina Hilari, Tedbab Degefie, Naida Pasion, et al. *Community Case Management: Overview and Update.* (Save the Children: December 20, 2006) (unpublished document)

[154] Chaya, Nada. *Poor Access to Health Services: Ways Ethiopia is Overcoming It.* (Population Action International: April 23, 2007) and UN Office for the Coordination of Humanitarian Affairs/IRIN. *Ethiopia: New Programme Boosts Village Based Health Service Delivery.* May 26, 2007 www.irinnews.org/Report.aspx?ReportId=72371

[155] See, for example: Giovanni Andrea Cornia and Leonardo Menchini. *The Pace and Distribution of Health Improvements During the Last 40 Years: Some Preliminary Results* and Michael Marmot on behalf of the Commission on Social Determinants of Health. "Achieving Health Equity: From Root Causes to Fair Outcomes." *The Lancet.* Vol. 370, No.9593. September 29, 2007. pp.1153-1163

[156] Wirth, Meg, Deborah Balk, Enrique Delamonica, Adam Storeygard, Emma Sacks and Alberto Minujinc. "Setting the Stage for Equity-Sensitive Monitoring of the Maternal and Child Health MDGs." *Bulletin of the World Health Organization.* Vol.84, No.7. July 2006. pp.505-588

[157] Gill, Kirrin, Rohini Pande and Anju Malhotra. "Women Deliver for Development." *The Lancet.* Vol. 370, No.9595. October 13, 2007. pp.1347-1357

[158] Marmot, Michael. "Health in an Unequal World." *The Lancet.* Vol.368. December 5, 2006. pp.2081-2094.

[159] Grown, Caren, Geeta Rao Gupta and Rohini Pande. "Taking Action to Improve Women's Health through Gender Equality and Women's Empowerment." *The Lancet.* Vol. 365, No. 9458. February 5, 2005. pp.541-543

[160] The range of values results from discrepencies between reported and revised rates of American Indian and Alaskan Native (AIAN) infant mortality. Rates are adjusted to compensate for misreporting of AIAN race on state death certificates. Sources: Reported IMR (2004): *Health, United States, 2007 With Chartbook on Trends in the Health of Americans.* National Center for Health Statistics. (Hyattsville, MD: November 2007) Table 19, p.159; Adjusted IMR (2002-2004): U.S. Department of Health and Human Services: Indian Health Service. *Indian Health Disparities.* http://info.ihs.gov/Disparities.asp

[161] Data are for Non-Hispanic African Americans. Source: National Center for Health Statistics. *Health, United States, 2007 With Chartbook on Trends in the Health of Americans.* Table 19. p.159

[162] Sepkowitz, Kent A. "Health of the World's Roma Population." *The Lancet.* Vol 367, No.9524. May 27, 2006. pp.1707-1708

[163] Ibid.

[164] Ibid.

[165] Anderson, Ian, Sue Crengle, Martina Leialoha Kamaka, Tai-Ho Chen, Neal Palafox and Lisa Jackson-Pulver. "Indigenous Health in Australia, New Zealand, and the Pacific." *The Lancet.* Vol. 367, No. 9524. May 27, 2006. pp.1775-1785

[166] Ibid.

[167] WHO. *World Health Statistics 2007.* pp.64-72

[168] UNICEF. *Child Poverty in Perspective: An Overview of Child Well-Being in Rich Countries.* Innocenti Report Card 7. (UNICEF Innocenti Research Centre: Florence: 2007) pp.6,12

[169] UNICEF. *State of the World's Children 2008.* pp.114-117

[170] UN Committee on the Elimination of Racial Discrimination. Working Group on Health and Environmental Health. *Unequal Health Outcomes in the United States: Racial and Ethnic Disparities in Health Care Treatment and Access, the Role of Social and Environmental Determinants of Health, and the Responsibility of the State.* (January 2008) p.10

[171] Kreiger, Nancy, David Rehkopf, Jarvis Chen, Pamela Wtareman, Enrico Marcelli and Malinda Kennedy. "The Fall and Rise of US Inequities in Premature Mortality: 1960-2002," *PLoS Medicine.* February 26, 2008. pp.0227-0241

[172] Ibid, p.0234

[173] Ibid, p.0235

[174] U.S. Census Bureau. *2006 American Community Survey.* www.census.gov/acs/www/index.html

[175] Ibid.

[176] UNICEF. *State of the World's Children 2008.* pp.114-117

[177] DeNavas-Walt, Carmen, Bernadette Proctor and Jessica Smith. *Income, Poverty, and Health Insurance Coverage in the United States:* 2006. (U.S. Census Bureau: August 2007) p.27

[178] Robert Wood Johnson Foundation. *Going Without: America's Uninsured Children.* (Washington: August 2005) p.11

[179] Ibid.

[180] Ibid.

[181] Chu, Susan Y., Lawrence E. Barker and Philip J. Smith. "Racial/Ethnic Disparities in Preschool Immunizations: United States, 1996-2001." *American Journal of Public Health.* Vol. 94, No. 6. June 2004. pp.973-977

[182] U.S. Department of Health and Human Services. *Child Health USA 2006.*

[183] Ibid.

[184] National Center for Health Statistics, Centers for Disease Control. *Maternal Mortality and Related Concepts, Vital Health Statistics.* Vol.33. February 2007 pp.1-13

[185] Miniño A.M., M.P. Heron, S.L. Murphy, K.D. Kochankek, *Deaths: Final Data for 2004.* National Vital Statistics Reports. Vol 55, No 19. (National Center for Health Statistics: Hyattsville, MD: August 2007.) Table 34, p.103

[186] Agency for Health Care Research and Quality. *National Healthcare Disparities Report, 2006.* www.ahrq.gov/qual/nhdr06/nhdr06.htm.

[187] U.S. Department of Health and Human Services. *Child Health USA 2006.*

[188] Ibid.

[189] Susan Y. Chu, et al. "Racial/Ethnic Disparities in Preschool Immunizations: United States, 1996-2001." *American Journal of Public Health.*

[190] Agency for Healthcare Research and Quality. *2007 National Healthcare Disparities Report.* (U.S. Department of Health and Human Services: Rockville, MD: February 2008) p.198

[191] Burström, B. "Social Differentials in the Decline of Infant Mortality in Sweden in the Twentieth Century: The Impact of Politics and Policy." *International Journal of Health Services.* Vol. 33, No 4. (2003) pp.723–741

[192] Ibid.

[193] Ibid.

[194] Dahlgren, Göran and Margaret Whitehead. *European Strategies for Tackling Social Inequities in Health: Levelling Up Part 2.* (WHO Regional Office for Europe: Copenhagen: 2006) p.10

[195] UNICEF. *State of the World's Children 2008.* Table 1, pp.14-17

[196] The category "more developed" nations includes countries in all regions of Europe, including Central and Eastern European countries as well as the Baltic States, plus Northern America, Australia, New Zealand and Japan.

Credits

Managing Editor/Writer
Tracy Geoghegan

Principal Advisers
David Oot, Mary Beth Powers, Eric Swedberg

Research Directors
Beryl Levinger, Nikki Gillette

Research Assistants
Maureen Daniel, Marianne Taflinger, Jessica Shanks

Contributors
Lubana Ahmed, Elizabeth Bocaletti, Ties Boerma, Kathryn Bolles, Jennifer Bryce, Eileen Burke, Wendy Christian, Kate Conradt, Giusy De Loiro, Tedbabe Degefie, Waleed El-Bashir, Abel Galvez, Dunni Goodman, Christen Grasso, Kristina Grear, Davidson Gwatkin, Sharyn Hanly, Jesse Hartness, Tariq Ihsan, Negin Janati, Lois Jensen, Sanna Johnson, Kate Kerber, Tom Krift, Sharon Lake-Post, Mike Kiernan, Suzanna Klaucke, Michael Klosson, Vivica Kraak, Joy Lawn, Matt Lehigh, Dinah Lord, David Marsh, Hiwot Mengistu, Carolyn Miles, Carol Miller, Marc Nosbach, Patricia O'Connor, Joanne Omang, Veronica Pollard, Samson Radeny, Christie Scott, La Rue Seims, Mark Shriver, Stephanie Sison, Eric Starbuck, Allyson Stollenwerck, Michael Taurus, Anne Tinker, Souleymane Toure, Sarah Tyler, Cesar Victoria, Steve Wall, Leslie Wilson, Michelle Zelsman, Betsy Zorio

Administrative Coordinator
Jon Aley

Design
Spirals, Inc.

Photo Editor
Susan Warner

Photo Credits
Cover – David Greedy. *Bangladesh. Meena and her 7-day-old baby girl Barsha were assisted by a traditional birth attendant trained by Save the Children.*

Page 1 – Michael Bisceglie. *Bolivia. A teenage mother participates in a Save the Children workshop on health and education.*

Page 2 – David Greedy. *Bangladesh. Former U.S. Senator Bill Frist visits children in a Dhaka slum where Save the Children supports health programs.*

Page 3 – Jenny Matthews. *Ethiopia. Save the Children President Charles MacCormack visits a 4-month-old boy in a health facility supported by Save the Children in Awassa.*

Page 4 – Michael Bisceglie. *Nepal. A mother uses the "kangaroo care" technique to provide warmth for her underweight 6-day-old baby.*

Page 6 – Boris Heger. *Angola. A nurse trained by Save the Children examines 19-month-old Berta. There is not one doctor in the municipality – an area of 17,500 square miles with a population of 277,000.*

Page 7 – Anna Kari. *Niger. Harisa walked for two hours with her 3-year-old boy to get special therapeutic food at an emergency feeding program run by Save the Children.*

Page 8 – Anna Kari. *Sierra Leone. Aminata with her two children, Fatmata and James. Her three other children died of malaria and diarrhea. Aminata now goes to a Save the Children clinic where she learned the benefits of breastfeeding and sleeping under a mosquito net.*

Page 11 – Peter Caton. *India. Children in a Bhagwanpura slum that is home to 25,000 people and has no medical facility.*

Page 13 – Kelley Lynch. *Ethiopia. Kebele plays with her child in southern Ethiopia.*

Page 14 – Michael Bisceglie. *Mozambique. Josefina and her 2-year-old son Junior.*

Page 15 – Michael Bisceglie. *Philippines. Women attend Save the Children's prenatal counseling sessions.*

Page 16 – Andrew Caballero-Reynolds. *Indonesia. A midwife trained by Save the Children bathes 5-day-old Aisyah.*

Page 19 – Amadou Mbodj. *Chad. Abdulah is carried by his mother to his daily weighing. He was admitted to the hospital two weeks earlier due to severe malnutrition. Through a program that is run by Save the Children, he was treated with antibiotics and therapeutic milk and has now recovered his normal weight.*

Page 20 – Jenny Matthews. *Ethiopia. Worke holds her 2-month-old daughter Tsegereda at a health center in Tulla that is supported by Save the Children.*

Page 22 – Linda Cullen. *Afghanistan. Masuma gets his measles vaccination.*

Page 23 – Boubacar Sidibe. *Mali. 16-month-old Yaya is healthy now after being treated with oral rehydration solution for diarrhea.*

Page 24 – Elena Ceto de Pol. *Guatemala. Doña Teresa (right), a traditional birth attendant trained by Save the Children, helped her daughter-in-law Ana (left) give birth to a healthy baby boy after suffering two stillbirths.*

Page 27 – David Greedy. *Bangladesh. Health worker Momtaj holds 2-year-old Sweety, who is healthy now after being treated for pneumonia.*

Page 28 – Michael Bisceglie. *Nepal. Health worker Prembati helps a new mother to feed her underweight baby with expressed breast milk.*

Page 30 – Susan Warner. *USA. 3-year-old Zoe plays doctor at a daycare center in Alabama supported by Save the Children.*

Page 33 – Reed Saxon. *USA. Parents and children wait for medical examinations in Los Angeles.*

Page 34 – Jenny Matthews. *Ethiopia. Milkias, a 4-month-old boy, waits for a vaccination at a health center in Tulla that is supported by Save the Children.*

Page 35 – Aubrey Wade. *Sierra Leone. Alisan, a 15-month-old boy, is weighed as part of his one-month check-up following vaccinations at a clinic supported by Save the Children.*

Page 36 – Ahmad El-Nemr. *Egypt. Fatma and her 2-week-old daughter Gihad attend classes on newborn care supported by Save the Children in the village of Minya.*

Page 37 – Anna Kari. *Sierra Leone. Sitta with two of her children at home in Bayama. Three other children died of malaria and diarrhea. Her children now sleep under a mosquito net provided by Save the Children and have not had malaria since.*

Page 38 – Jean Chung. *Afghanistan. Girls attend a school supported by Save the Children in Panjshir Valley.*

Page 39 – Mike Kiernan. *USA. Melissa, her 2-year-old daughter Hanna, and infant Charity receive a home visit every two weeks as part of a Save the Children early childhood development program in Kentucky.*

Back Cover – Tom Pietrasik. *Bangladesh. 9-year-old Tanjeela holds her malnourished 6-month-old brother Shohag at a Save the Children-supported hospital in Dhaka that provides services to all patients, regardless of income.*

BANGLADESH

Worldwide, more than 200 million children under age 5 do not get the basic health care they need. This contributes to nearly 10 million children dying needlessly every year from highly preventable or treatable ailments such as diarrhea and pneumonia.

A disproportionate number of the children without health care come from the poorest and most marginalized families in developing countries. While there has been significant progress in reducing the overall death toll among children under 5 in recent decades, death rates among the poorest of the poor have not improved nearly so well, and in some countries they have gotten worse. These widening health care inequities unfairly condemn millions of the world's poorest children to early death or a lifetime of ill health.

State of the World's Mothers 2008 shows which countries are succeeding – and which are failing – to deliver basic health care to the mothers and children who need it most. It examines where the health care gaps between the poorest and best-off children are widest, and where they are smallest. It also looks at the survival gaps between the rich and poor children in developing countries, and shows how millions of children's lives could be saved by ensuring all children get essential, low-cost health care.

As in previous years, *State of the World's Mothers* presents a *Mothers' Index*. Using the latest data on health, nutrition, education and political participation, the *Index* ranks 146 countries – both in the industrialized and developing world – to show where mothers and children fare best and where they face the greatest hardship.

Save the Children®

54 Wilton Road
Westport, Connecticut 06880
1.800.728.3843

Save the Children is the leading independent organization creating lasting change for children in need in the United States and around the world. Save the Children USA is a member of the International Save the Children Alliance, a global network of 28 independent Save the Children organizations working to ensure the well-being and protection of children in more than 120 countries.

To learn more about our programs to help children in need around the world, go to: **www.savethechildren.org**