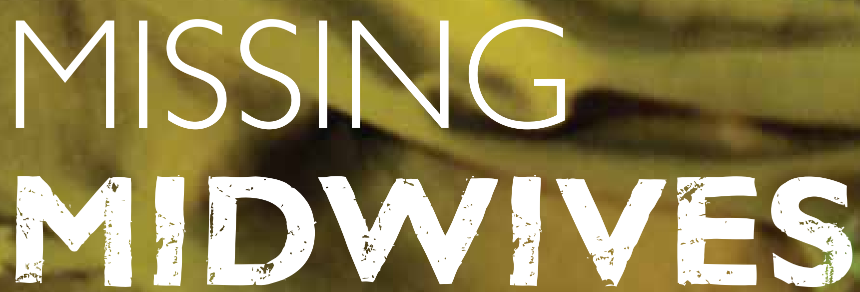

MISSING MIDWIVES

Save the Children

MISSING **MIDWIVES**

Save the Children

Save the Children works in more than 120 countries.
We save children's lives. We fight for their rights.
We help them fulfil their potential.

ACKNOWLEDGEMENTS

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Cover photo: Katsina, northern Nigeria. Uleima, holding her baby boy, has been trained by hospital staff in 'kangaroo mother care', a technique of providing warmth and comfort to premature babies through skin-to-skin contact, as an alternative to an incubator.
(Photo: Pep Bonet/Noor)

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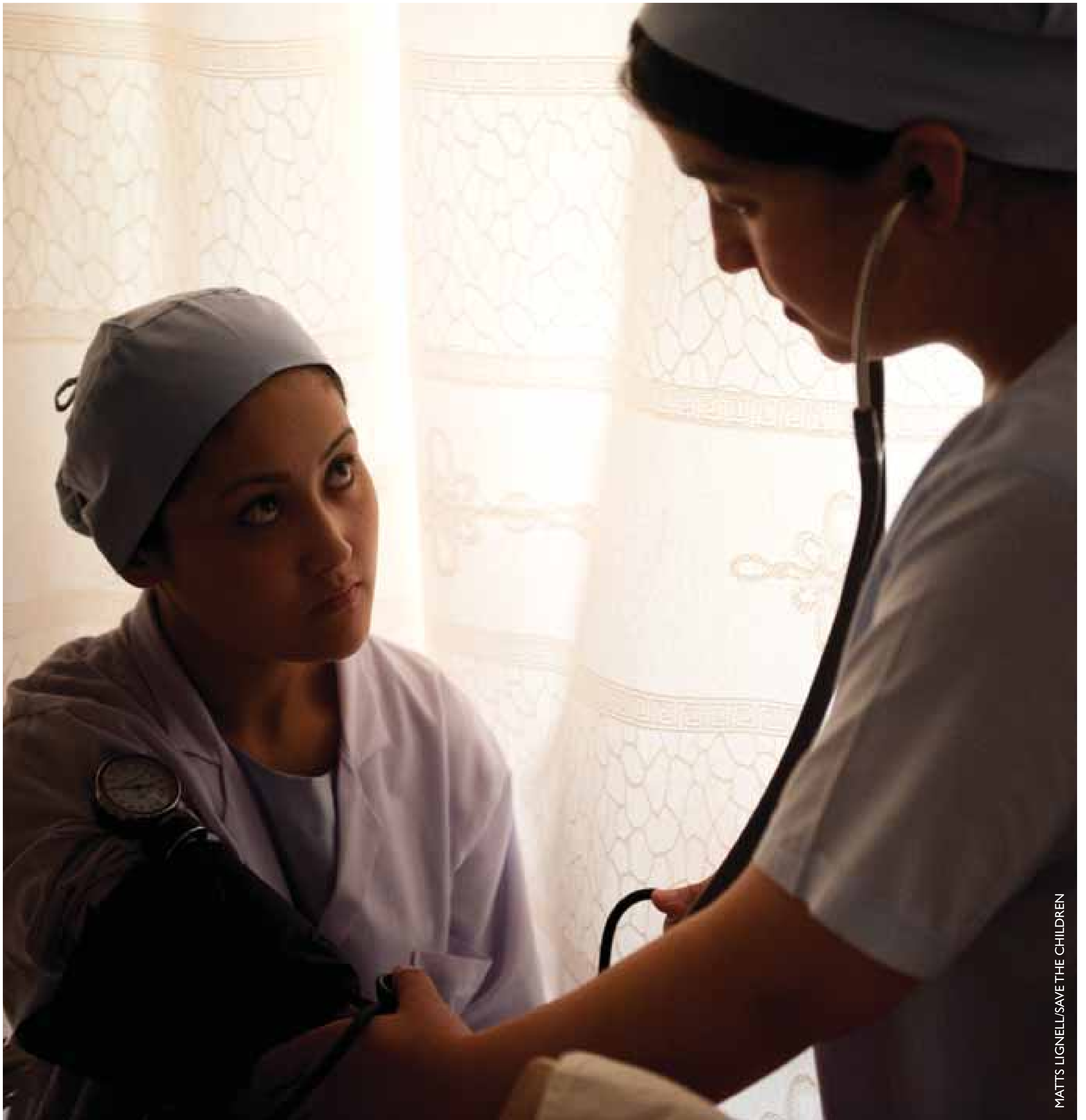


Trainee midwives in Afghanistan, where there is a drastic shortage of midwives, and the highest death rate of newborn babies in the world.

FOREWORD

Globally, we know that there is a shortage of midwives, and there is little doubt of the impact this is having on women and babies, their families and communities all over the world. The tens of thousands of women and millions of babies who die every year from childbirth-related causes are evidence of this.

This report rightly draws attention to that worldwide shortage, because midwives are vital for communities and families, and for improving a country's health, particularly in areas with high maternal and child mortality. Midwives are the key to achieving Millennium Development Goals 4 and 5 on child and maternal mortality. As we approach 2015, it is propitious that Save the Children highlights the deficit. A country is judged by the way it cares for and treats its women, and by the maternal and child health services it provides for them. World leaders need to commit investment to recruit, educate and retain midwives as a priority. We know that in countries where the government has invested in essential midwifery services, it has had a dramatic effect on the improving maternal and newborn mortality statistics.

It is unacceptable that women and their babies continue to die in childbirth in the 21st century because of lack of access to midwives and other midwifery-skilled health workers. Volumes of words have been spoken for far too long and it is now time for different actions and strategies. The solution is simple: *the world needs midwives now more than ever*, governments have to invest in midwives, and this challenge lies with world leaders. The challenge is for all of us – charities, like Save the Children, professional organizations, like the Royal College of Midwives, and civil society – to require and work with our governments, in donor or receiving countries, to act, and to deliver this change for families. What are you going to do for the women and children in your country today?

Frances Day-Stirk
Director of Learning, Research and Practice Development, Royal College of Midwives
Vice-President, International Confederation of Midwives

ALIXANDRA FAZZINA

Ratni grieves for her daughter-in-law, Keeku, who died in childbirth.

Keeku died two days after giving birth at home in her village in Pakistan. She was 25 years old. Her baby died too. Her mother-in-law, Ratni, explains what happened.

"During her pregnancy and delivery Keeku was perfectly normal and didn't show any signs of complications. She had her baby at home. There are no health facilities or doctors available in this village. We don't have any female health workers visiting this area.

"So when Keeku started shivering and complaining of terrible pain in her stomach, we rushed her to the hospital, which is an hour and a half drive from here on public transport… She was given blood, but she died immediately afterwards. Doctors said that the placenta became infected in the uterus and it spread into her body and killed her."

Keeku's baby daughter died two months later from diarrhea.

SUMMARY

"The single most critical person for effective care at the time of birth is the midwife"

The International Journal of Gynecology and Obstetrics[1]

No mother, anywhere in the world, should have to risk her life and that of her baby by going through childbirth without expert care. But every year 48 million women give birth without someone present who has recognised midwifery skills.[2] More than 2 million women give birth completely alone, without even a friend or relative present to help them, making these some of the most dangerous moments of their lives.[3]

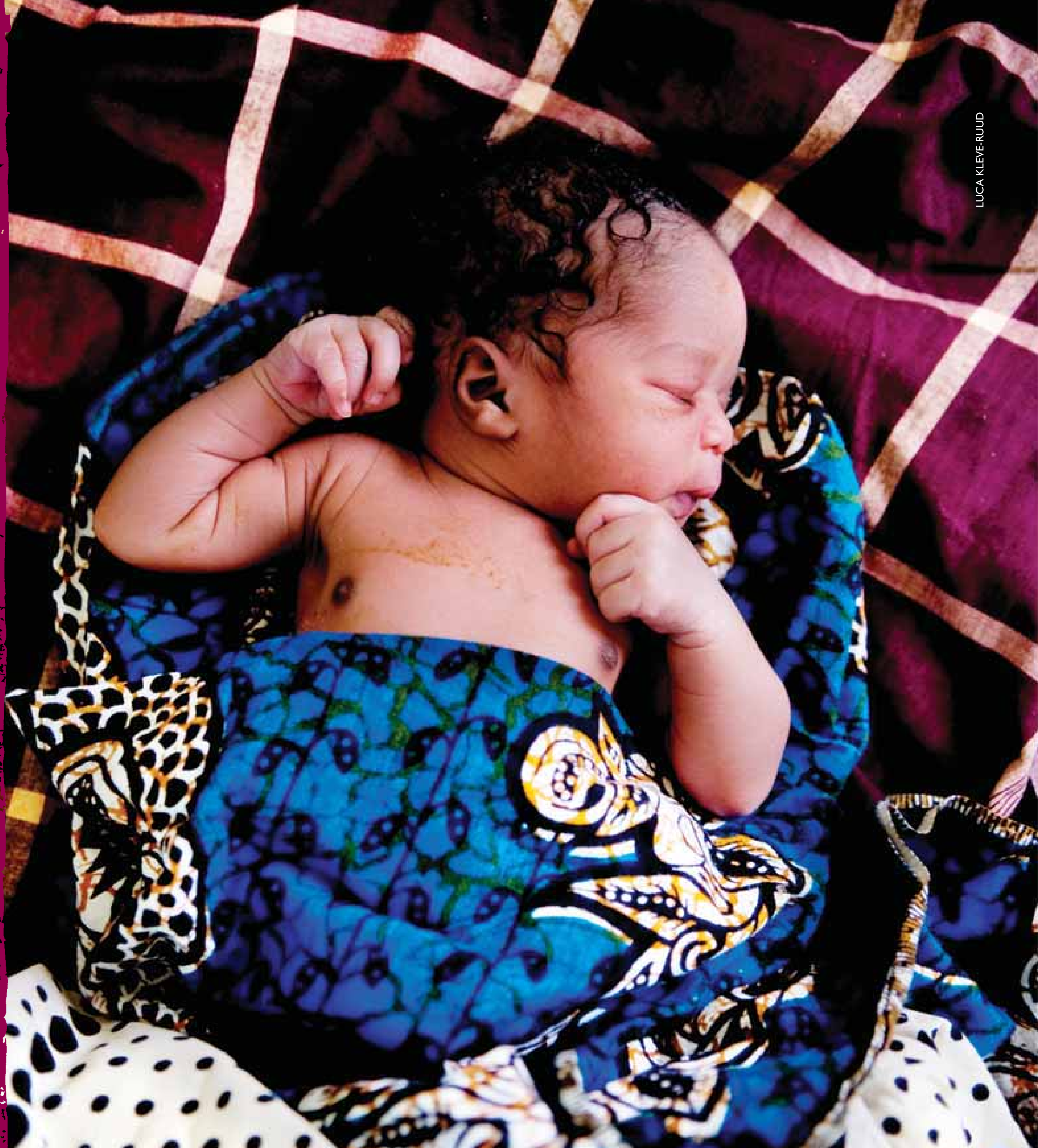
The global shortage of 350,000 midwives[4] means that many women and babies die from complications that could easily be prevented by a health worker with the right skills, the right equipment and the right support. There are 358,000 maternal deaths annually, and more than 800,000 babies die during childbirth each year. Millions more newborn lives are lost in the first month of life. If births were routinely attended by midwives and skilled birth attendants with the right training and support, the lives of 1.3 million newborn babies a year could be saved (see page 3).

Save the Children has frontline experience of the power of midwives to save lives from our work in Niger and Angola, for example, where we have trained midwives; in Afghanistan, where we run a midwife college; and in Sierra Leone, where we run clubs for pregnant women and have upgraded health centres to provide 24-hour emergency care during delivery. Our experience around the world has shown us the reasons behind the shortage of midwives and what can be done to address it on both a local level and in terms of international political action.

Stopping women and children dying in childbirth is a moral imperative. Recruiting, training and supporting midwives is also critical to the achievement of the Millennium Development Goals to reduce child deaths by two-thirds (MDG 4) and maternal mortality by three-quarters (MDG 5).

This September, world leaders will meet in New York at the United Nations General Assembly. One year on from the launch of the UN Secretary-General's global strategy on women's and children's health, they will assess progress on their commitments. Governments of rich and poor countries alike must use this meeting to build on the foundations of the global strategy and urgently take further steps to fill the global health worker shortage. Save the Children is calling on governments to make specific commitments and take concrete action towards recruiting, training, paying and deploying more midwives and health workers. With growing awareness and political support for maternal and child health, and key opportunities for change this year, now is the crucial moment to show the world why midwives matter.

EVERY YEAR MORE THAN 2 MILLION WOMEN GIVE BIRTH COMPLETELY ALONE


LUCA KLEVE-RUUD

"Nabuth wouldn't breast-feed and became weaker and weaker every day. Messalina [a health worker] has followed me both during the pregnancy and after the birth, and she was the one who insisted I go to the hospital with the baby.

"We didn't really have money for the bus ticket, but Messalina insisted. I am very thankful that she was clear and persuasive. Save the Children's health worker saved my baby's life. I am incredibly thankful."

Teresa, Mozambique

1 INTRODUCTION

Every mother will remember the feelings of anticipation, excitement, fear and joy she had before she gave birth. Everyone can imagine what a pregnant woman – a friend, a sister, a wife or partner – will go through as she approaches one of the most significant moments of her life. Now imagine giving birth without anyone in the room with any midwifery training – it can become a dangerous event.

No mother, anywhere in the world, should have to risk her life and that of her baby by going through childbirth without expert care, but every year 48 million women give birth without someone with the proper medical skills present.[5] Each year there are 358,000 maternal deaths,[6] and 814,000 newborn babies die during childbirth.[7] A million more babies are lost earlier in delivery – stillborn but having been alive in the mother's womb hours or even just minutes earlier.[8] More than 3 million babies die before they are a month old.[9]

Complications that kill hundreds of thousands of women and babies in developing countries are managed effectively in richer countries by a midwife or health worker with the right skills, the right equipment and the support of a health system. Women in the poorest countries are least likely to have a skilled attendant during birth, are much more likely to lose their newborn, and are most likely to die themselves during childbirth.

"I was in labour for almost five days, and in the end, the child came out of my womb dead. I didn't have the assistance of a birth attendant – only my family helped me."

Liknesh, Ethiopia

"At the time of the delivery the bleeding was too much. I felt dizzy and weak and I had a headache. I was very worried that I'd lose my life. I know two women who've died from bleeding too much during childbirth.

"The danger of giving birth is very real to me. If the midwife isn't there you can pass away."

Tereza with her son, Baksoro, Southern Sudan

RACHEL PALMER/SAVE THE CHILDREN

OF THE 8.1 MILLION CHILDREN WHO DIE EACH YEAR BEFORE THE AGE OF FIVE, ONE IN TEN DOES NOT EVEN LIVE TO SEE THE END OF THEIR FIRST DAY.

Within those countries women from the poorest families and those living in rural areas are much less likely to have essential midwifery services than better off women, particularly in towns and cities.

Of the 8.1 million children who die each year before the age of five, one in ten dies during their birth and does not live to see the end of their first day.[10] To stop this appalling suffering the world needs more midwives and skilled birth attendants so every woman and her baby are given the care and support they need. No child is born to die.

MIDWIVES, SKILLED BIRTH ATTENDANTS AND HEALTHCARE

Midwives and skilled birth attendants play a vital role in saving the lives of mothers and babies. The International Confederation of Midwives (ICM) defines a midwife as "a person who having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery".[11] A skilled birth attendant is an "accredited health professional, such as a midwife, doctor or nurse, who has been… trained to proficiency in the skills needed to manage normal, uncomplicated pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns".[12]

Midwives are the only people in a health service whose education and training are dedicated to the care of pregnant women, new mothers and their newborn babies. The ideal is for every birth to be attended by a certified midwife, because in an under-staffed, over-stretched health service a health worker with a wider remit is more likely to have competing demands from other patients and less time to dedicate to mothers and newborn babies. However, the significant contribution that skilled birth attendants make to saving the lives of mothers and babies must be recognised.

Midwives and skilled birth attendants cannot operate effectively in isolation. They need the support of a functioning health system to provide the necessary equipment, medicines, supervision, and a place to refer women with complications that require a higher level of care.

THE WORLD NEEDS MORE MIDWIVES

Around 1.3 million babies could be saved each year by filling the shortage in midwives in the poorest countries. New analysis by Save the Children has shown that 38% of newborn deaths could be prevented by training and supporting midwives to provide a package of eight proven interventions (see box).

AROUND 1.3 MILLION BABIES COULD BE SAVED EACH YEAR BY FILLING THE SHORTAGE OF MIDWIVES IN THE POOREST COUNTRIES.

HOW MIDWIVES SAVE LIVES

Analysis by Save the Children shows that 38% of newborn deaths could be prevented if the following eight interventions were provided by midwives to 99% of women and newborns in the 68 countries with the highest levels of maternal and child deaths. 1.3 million newborn lives could be saved through this package (from a total of 3.3 million annual newborn deaths).

1. Intermittent preventive antimalarial treatment for pregnant women in areas with high incidence of malaria – to treat and prevent malaria, which interferes with the flow of oxygen and nutrients through the placenta to the baby
2. Syphilis detection and treatment for pregnant women – to reduce the risk of syphilis, which can lead to stillbirth, prematurity and newborn death
3. Tetanus toxoid immunisation during pregnancy – to enable mothers to pass on protection to their newborn babies, who are vulnerable to contracting tetanus when their umbilical cord is cut
4. Antibiotics for preterm, premature rupture of membranes – to reduce the risk of infection if a woman's waters break prematurely
5. Antenatal corticosteroids for preterm labour – to help premature babies' lungs mature and avoid breathing problems
6. Basic emergency obstetric care – a range of interventions to help the mother and baby survive, including anticonvulsants to prevent pregnant women convulsing, antibiotics to treat infection, assisted births using forceps and/or a suction machine, drugs to make the uterus contract after birth, and manual removal of placenta
7. Immediate newborn care – to ensure babies are stimulated to breathe, kept warm and fed properly after birth
8. Neonatal resuscitation – to save the lives of babies that are not breathing when they are born.

Note: The figure of 1.3 million has been calculated using 'Lives Saved', a modelling tool developed by a consortium of academic and international organizations, that is used to model how many deaths could be averted if the coverage of selected evidence-based interventions were increased to a given level.[13] The tool accounts for country specific demographic and epidemiologic data, as well as current levels of intervention coverage to estimate lives saved. This tool has also been used to contribute to the *Lancet* Stillbirth series of 2011, which demonstrates that many stillbirths could be prevented with a functioning and effective health system.

THERE IS A GLOBAL SHORTAGE OF 350,000 MIDWIVES – PART OF A WORLDWIDE SHORTAGE OF 3.5 MILLION HEALTHCARE WORKERS.

To make further gains, the role of the wider health system in supporting the midwife is crucial. Up to two-thirds of newborn babies' lives could be saved[14] and three-quarters of maternal deaths could be prevented by comprehensive care during childbirth, including access to emergency obstetric care provided in hospitals, such as caesarean sections.[15]

TIME FOR ACTION

There is a global shortage of 350,000 midwives,[16] which is part of a worldwide shortage of 3.5 million healthcare workers. As well as the moral imperative for saving the lives of women and newborn babies, boosting the numbers of midwives would make a decisive contribution to meeting the internationally agreed Millennium Development Goals on maternal and child health (MDGs 4 and 5).

In September 2010, the UN Secretary-General launched 'Every Woman, Every Child', an ambitious global women's and children's health strategy to inspire action and speed up progress on the health-related Millennium Development Goals. As part of the strategy, eight developing-country governments made pledges to increase the number of midwives and skilled birth attendants, as did one donor country, Australia. In December 2010, the UK government pledged to support the global strategy by making strong commitments to save the lives of 50,000 women during pregnancy and childbirth and 250,000 newborn babies by 2015.

In September 2011, when world leaders will meet again in New York at the UN General Assembly, they will be held to account on their progress. Rich and poor country governments must use this meeting to build on the foundations of the global strategy and take steps towards meeting the urgent challenge of filling the health worker shortage. We call on them to make specific commitments and take concrete action towards recruiting, training, paying and deploying more midwives and health workers. With growing awareness and political support for maternal and child health and key opportunities for change this year, now is the crucial moment to show the world why midwives matter.

TRADITIONAL BIRTH ATTENDANTS AND COMMUNITY HEALTH WORKERS

In many countries the job of delivering babies falls to traditional birth attendants – respected, often older women in the community who help mothers to give birth. They are not certified or licensed and as a result their level of education, training and skills, and the quality of care they provide, can vary dramatically.

Opinion is divided over the role of the traditional birth attendant. Some traditional birth attendants use practices that can be harmful to mother and baby; for example, sitting on a woman's belly to force the baby out, using butter to attempt to turn a baby in the wrong position, or using herbs to treat infections rather than seeking medical care.[17]

A training course for community midwives in Jawzjan province, northern Afghanistan. The 18-month course, which Save the Children supports, includes extensive practice in a nearby district hospital. The session shown here is on cervical dilation.

Save the Children, through its global programmes, aims to make sure 640,000 more women have access to a trained midwife when they give birth.

MATTS LIGNELL/SAVE THE CHILDREN

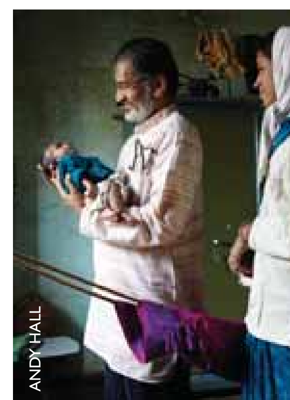
As a result, countries have at various times put bans in place to prevent traditional birth attendants from practising or being trained. Others are concerned that training them diverts attention and resources from the more important task of recruiting, training and retaining midwives and skilled birth attendants.

On the other hand, many believe traditional birth attendants can be a vital link between women and the health system, giving advice, encouraging women to go to the clinic to deliver and accompanying mothers to provide moral support. Some argue that providing even basic training can bring great benefits.

Community health workers can perform a similar life-saving role in their home villages. Training community health workers to give basic advice to pregnant women, to treat some complications, and to encourage women to go to a clinic if there are problems can make a dramatic difference.

A partner of Save the Children's, Dr Abhay Bang, pioneered home-based care for newborns in Gadchiroli district in Maharashtra, India, and made a real breakthrough in saving children's lives. The Gadchiroli trial, which included training a community health worker in each village to identify high-risk babies, and how to manage problems like hypothermia and infection, reduced newborn deaths by 70% and infant deaths by 57%. This community-based solution to the problem of newborn deaths has now been replicated in sites across India.[18] In 2010, the Indian government announced it would make this model of village-level care a key part of its newborn survival strategy. It will be rolled out across 235 districts, with a combined population of 500 million people.[19]

While a qualified, fully equipped midwife at every birth is the ideal, when they are not available the option of supporting and providing basic training to traditional birth attendants and community health workers so they can spot danger signs and refer women to health facilities can make a significant difference.[20]


ANDY HALL

Dr Abhay Bang holds a newborn baby in a village in Maharashtra, India

COLIN CROWLEY/SAVE THE CHILDREN

Rukia and her nine-day-old son, Husseinat, in Mtwara District Hospital, Tanzania.

Rukia certainly knows the value of a health worker. She had been attending regular antenatal check-ups in her local village health facility when she was told to go to the district hospital by a health worker – Rukia was showing signs of being close to giving birth, even though she was only seven months pregnant. After a scan showed that she was carrying too much fluid in her abdomen, she was operated on and her son, Hussein, was delivered by caesarean section.

After this, staff trained Rukia in 'kangaroo care' – a technique for caring for premature babies – which involves holding her son to her bare skin and wrapping him up so that she maintains body contact with him. And because she had access to a health worker she was also given advice and support in breastfeeding, and learned important hygiene techniques, such as washing her hands and cleaning her breasts before feeding.

2 MIDWIVES **SAVE LIVES**

Giving birth without a midwife or skilled birth attendant puts women and their babies at a much higher risk of death from one of the many serious complications that can happen during childbirth. So it is vital to have someone present with the right midwifery training who can identify these complications early, as they are often unpredictable and must be dealt with or referred immediately. In rich countries where almost every birth is attended by someone with the right training, equipment and supplies, many of these complications are dealt with easily. In poor countries with a serious shortage of midwives, all too often they are fatal.

Globally, one in three pregnant women (35%) gives birth without a midwife or a skilled birth attendant. In some countries rates of unattended births are much higher. On average, in the least developed countries 59% of births have no midwife or skilled health worker present; in Ethiopia the figure is 94% of births and in Bangladesh 76%.[21] By comparison, it is estimated that less then 1% of women in Canada give birth without a midwife or skilled birth attendant, with the most common cause being that the birth happens so fast that the woman cannot get to hospital in time.

Every woman should have expert care and support when she gives birth. But the reality of childbirth for many women means delivering their babies at home with no midwife, lying on a dirty bed or dirt floor in a house without running water, electricity or light.

If complications arise the woman may be miles away from the nearest health clinic or hospital. If there is an emergency the woman's family may have to urgently find transport and borrow money for fuel to take her to get help.

In Niger, many women live too far away from a health centre to walk there, so we've helped fund an ambulance and provided fuel for other district ambulances. Our efforts to improve women's access to better antenatal and postnatal care are bringing results. In 2008, 25,000 women attended antenatal consultations in the clinics we support, and more than 5,000 babies were delivered in the clinics by qualified health staff.

Dessie, four months pregnant, outside a maternity ward that Save the Children is building, and where, once construction is completed, she plans to have her baby.

Dessie from South Wollo in Ethiopia has four children but has never given birth at a health centre. "So far, all my children have been born at home with my mother-in-law's help," she says. "A blade for cutting the cord, clean cloths and her bare hands – that's all she used to deliver my children. We buy the blade in the market. We just check if it's properly packed to be sure it hasn't been used before."

The district hospital is a four-hour drive away from Wogidi so many women are unable to get there in time if there are complications. Save the Children has built a new maternity ward at the local health centre there with rooms for consultation, delivery and recovery.

The government of Ethiopia has been investing in building and upgrading health centres and has progressive policies on the practice of midwives in place to allow them to carry out a wide range of services. In its new Health Sector Development Programme launched last year, the Ethiopian government committed to training thousands more midwives and set an ambitious target to increase the number of births with a skilled attendant to 62% by 2015, but estimated that a $440 million funding gap must be filled if it is to meet the health-related MDGs.

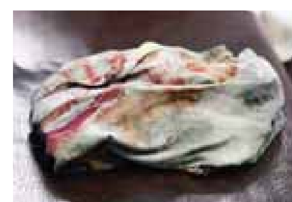
WHAT DO NEWBORN BABIES DIE FROM?

The three biggest killers of newborn babies in the first month are:

- complications arising from prematurity, eg, breathing difficulties due to under-developed lungs, or feeding difficulties due to an under-developed digestive system (28%)
- asphyxia, when a baby is deprived of oxygen during delivery and is more likely to need resuscitation when it is born (23%)
- sepsis, an infection of the blood (15%).[22]

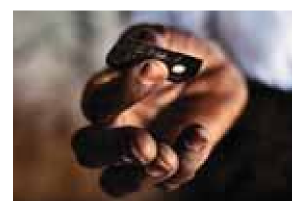
ASPHYXIA AND SEPSIS

Birth asphyxia is responsible for more deaths in children under five than malaria.[23] Asphyxia causes 814,000 newborn deaths, most of which could be prevented by midwives and skilled birth attendants. With the right training and equipment, midwives are able to monitor the unborn baby's heart rate and can detect signs of distress in a baby during birth. They are able to assess whether the baby is at greater risk of asphyxia, for example, if it is small and underweight or if it is premature. They can predict which babies are more likely to need resuscitation when they are delivered and know how to help a newborn who is not breathing. They know when to refer a woman or baby to a higher level of care at a clinic or hospital.



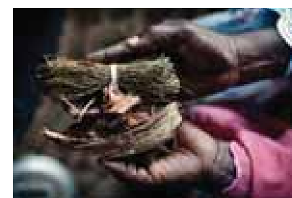
CAROLINE TRUTMANN/ SAVE THE CHILDREN

A cloth used in the delivery of a baby in rural Ethiopia.



PEP BONET/NOOR

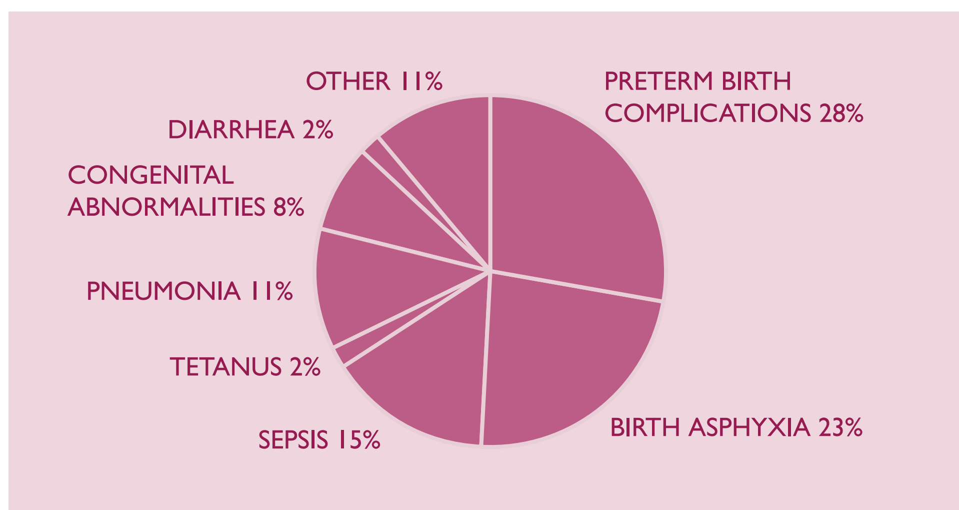
A razor blade is the only tool used by some traditional midwives, northern Nigeria.



PEP BONET/NOOR

Herbs used to treat infection in newborn babies by a traditional midwife in northern Nigeria.

WHAT DO NEWBORN BABIES DIE FROM?



SOME OF THE WAYS OF PREVENTING ASPHYXIA ARE SIMPLE – HAVING SOMEONE PRESENT WHO KNOWS TO DRY THE BABY AND STIMULATE IT TO BREATHE BY RUBBING ITS BACK OR FEET.

Some of the ways of preventing asphyxia are extremely simple. It is estimated that 42,000 lives a year could be saved simply by having someone present who knows to dry the baby and stimulate it to breathe by rubbing its back or feet.[24]

During a normal delivery, the presence of a well-trained midwife or birth attendant can prevent many cases of infection, including neonatal sepsis, which kills 521,000 newborns a year.[25] Clean delivery practices – for example, hand-washing and using sterile equipment to cut and tie the cord – can help prevent infection. The immediate care of the newborn – ensuring skin-to-skin contact with the mother and encouraging breastfeeding – is also important.

In Mvolo, Southern Sudan, the distances from women's homes to clinic and the lack of transport often prevent women from coming to a health centre. Many women will give birth at home with a traditional birth attendant. The trained midwife at the Save the Children-supported clinic in Mvolo gives women a safe delivery kit to use at home. The kit contains a pair of gloves, two ties for the umbilical cord, a razor blade, two pieces of gauze to clean the baby's face, a bar of soap and a plastic sheet to protect the mother from infection.

In richer countries deaths from asphyxia and sepsis are very rare. In Canada in 2007, 67 babies died from asphyxia and 38 died as a result of bacterial sepsis, from a total of 367,864 births. By comparison, in Burkina Faso there were 721,000 babies born in 2008, approximately double the total number of Canadian births, but 5,874 babies died from asphyxia and 3,109 babies died from sepsis. In Nepal, out of 732,000 births, 6,591 babies died from asphyxia and 5,304 died from sepsis.[26]

Save the Children is leading the way in research about what works best to save the lives of babies in their first month of life. The groundbreaking Saving Newborn Lives programme, launched in 2000 with a grant from the Bill & Melinda Gates Foundation, has identified better care practices and improved interventions to save newborn babies. The initiative helps ensure access to midwives, treatment of infections, tetanus immunisations for pregnant women, and education for pregnant women about the importance of proper hygiene, warmth and breastfeeding. The benefits of these efforts have reached more than 30 million women and babies in 18 countries and are now being extended to mothers in other countries, ensuring that more babies receive the care they need, especially during the critical first week of life.

EMERGENCY OBSTETRIC CARE

Some of the interventions that can save babies' and mothers' lives are relatively simple and can be delivered by a midwife working in the community or visiting mothers in their homes. However, to have most impact, midwives need the support of a health centre and to be able to refer the most serious complications to a hospital.

TO HAVE MOST IMPACT, MIDWIVES NEED THE SUPPORT OF A HEALTH CENTRE AND TO BE ABLE TO REFER THE MOST SERIOUS COMPLICATIONS TO A HOSPITAL.

A midwife or skilled birth attendant with the correct training, medicines and equipment can provide basic emergency obstetric care in a health centre, including administering antibiotics and anticonvulsants, assisted deliveries and manual removal of the placenta. The higher level of care for more serious complications in childbirth – known as comprehensive emergency obstetric care – cannot be performed by a midwife alone. Births requiring caesarean section or blood transfusion must be carried out in a hospital, and need the assistance of other health staff in addition to a midwife, including a surgeon to perform the operation and a laboratory technician to match blood. Referring a woman in danger to a hospital often depends on having access to a telephone to call for help or transport to go to the clinic or hospital.

Emergency obstetric care requires a functioning health system. In many developing countries providing this kind of care is a huge challenge. In the least developed countries only 35% of women give birth in a clinic or hospital, and only 3% of women deliver by caesarean section. Whereas in countries with adequate coverage of emergency obstetric care the rate of women having caesareans is expected to be 5–15%.[27] The prerequisite of a functioning health system in order to deliver emergency obstetric care explains why maternal and newborn deaths are falling at a slower rate than deaths of children under five. This underlines the need for strengthening health systems and essential midwifery services so that the diagnostic skills midwives have are matched with the infrastructure to deliver the interventions they would choose to prescribe.

ANTENATAL AND POSTNATAL CARE

A well trained, highly skilled midwife does much more than deliver babies. A midwife working at the heart of the community and within a functioning health service is able to visit women to give care, advice and support – before, during and after pregnancy. Many countries have invested in bicycles or motorbikes for midwives, enabling them to travel to remote communities more easily and to provide more frequent visits and support to more pregnant women.

Antenatal care by midwives can identify problems and prevent some complications, and means cases are referred where necessary. Midwives check the woman's blood pressure, look for signs of aneamia and give iron tablets, immunise women against tetanus, and identify signs of pre-eclampsia. The midwife can spot high-risk pregnancies – for example, if it is a multiple pregnancy, if the baby is very small or very large, or if the baby is not in a good position for delivery. A midwife can provide information and advice to women about nutrition and breastfeeding, and teach them to spot danger signs themselves. A key part of antenatal care is advising women when to go to the health centre to deliver their baby.

In Sierra Leone, Save the Children runs antenatal classes – known as 'belly woman' support groups – and emergency referral clubs, in partnership with government-employed maternal and child health aides. These antenatal groups help women prepare for childbirth,

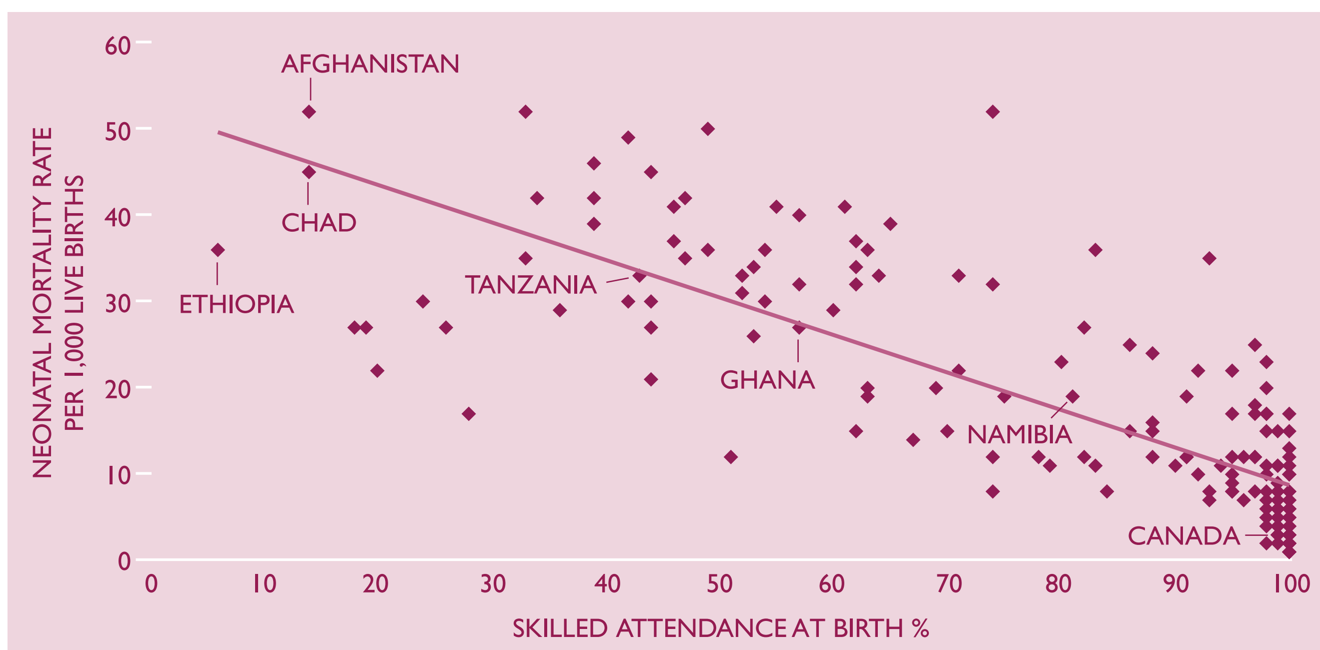
put women in contact with skilled birth attendants, and offer advice on nutrition. In a country where many traditional beliefs surrounding pregnancy still pervade – such as the belief that a pregnant woman should not eat eggs, thereby denying her an important source of protein – this kind of antenatal support is vital.

After the birth a midwife can help a new mother to feed and care for her newborn baby, and show her how to keep the baby safe and warm, and to avoid infection. Postnatal care also involves checking for signs of infection in the mother and that she is recovering well after birth.

SKILLED BIRTH ATTENDANTS AND NEWBORN DEATHS

In rich countries, having a skilled health professional present during childbirth is routine, and the rates of newborn death are very low. The opposite is true in many developing countries. As the chart below shows, there is a correlation between the percentage of births that are attended by a skilled birth attendant and the number of babies who die in their first month of life. At the right hand side of the graph there is a cluster of 41 developed countries and transition economies where 100% of births were attended by a skilled person. In most of these countries – 24 of them – the chance of a baby dying in their first month is 1 in 200 or lower.[28] This also reflects that richer countries will have stronger health systems, a greater number of health trained professionals and better provision of emergency obstetric care in health facilities.

HIGHER LEVELS OF ATTENDED BIRTH GO HAND IN HAND WITH LOWER NEONATAL MORTALITY RATES



COUNTRIES WITH THE WORST NEWBORN MORTALITY RATES[29]

	Country	Neonatal mortality rate, per 1,000 births (2009)	Percentage of births attended (2005–2009)
1	Afghanistan	52	14
2	Democratic Republic of Congo	52	74
3	Somalia	52	33
4	Mali	50	49
5	Sierra Leone	49	42
6	Guinea-Bissau	46	39
7	Central African Republic	45	44
8	Chad	45	14
9	Angola	42	47
10	Burundi	42	34

THE TEN WORST PLACES FOR BIRTH ATTENDANCE[30]

	Country	Percentage of births attended (2005–2009)	Neonatal mortality rate, per 1,000 births (2009)
1	Ethiopia	6	36
2	Afghanistan	14	52
3	Chad	14	45
4	Timor-Leste	18	27
5	Nepal	19	27
6	Lao People's Democratic Republic	20	22
7	Bangladesh	24	30
8	Haiti	26	27
9	Eritrea	28	17
10	Somalia	33	52

EVERY DAY MORE THAN 3,000 WOMEN IN NIGERIA GIVE BIRTH COMPLETELY ALONE.

GIVING BIRTH ALONE

In some countries the number of women giving birth alone, without even a relative present, let alone a midwife, is extremely high. In the 40 countries for which data is available an estimated 2.4 million women gave birth completely alone. As a result of cultural practices – such as the need to ask permission of a male relative to go out of the house – and religious beliefs, many women are not able to leave their homes to seek assistance when they go into labour. Even when a health worker is available, some women are reluctant to be seen if the health worker is a man.

The starkest example is Nigeria, where around one in five women deliver their babies alone – and this varies from 34.5% of the poorest fifth of women to 3% of the richest fifth.[31] Six million babies are born every year in Nigeria,[32] meaning every day 3,100 women in Nigeria face some of the most dangerous moments of their lives on their own. A third of women in Nigeria said that one of their reasons for not going to a health facility was because their husbands said it was unnecessary.[33] This highlights the need to make sure that efforts to tackle maternal and newborn deaths, particularly education campaigns, involve men.[34]

THE TEN LONELIEST PLACES TO GIVE BIRTH

Country (year)	Percentage of women giving birth alone[35]
Nigeria (2008)	18.6%
Niger (2006)	16.9%
Mali (2006)	13.1%
Rwanda (2007–08)	11.1%
Guinea (2005)	9.0%
Uganda (2006)	8.9%
Angola (2006–07)	8.4%
Kenya (2008–09)	6.5%
Nepal (2006)	6.3%
Ethiopia (2005)	5.4%

PEP BONET/NOOR

Aisha, from Katsina, northern Nigeria, gave birth at home without a midwife or a birth attendant. "A neighbour helped me to cut the cord with her hands and a new razor blade," she says.

Two days after the birth, Aisha's baby, Maymuna, became very ill and couldn't breathe properly. Aisha brought her to the hospital in Katsina where Maymuna was diagnosed with meningitis and other infections, possibly contracted when her umbilical cord was cut at home with a razor blade.

After three days of treatment with antibiotics, Maymuna started to recover.

3 THE MIDWIFE SHORTAGE

The 350,000 shortage of midwives[36] is part of a worldwide shortage of 4.3 million health workers.[37] Many of the factors that lead to a shortage of midwives are the same factors that contribute to a general health worker shortage in the poorest countries. Yet there are also reasons for the midwife shortage that are specific to that profession. Both these sets of reasons are explored in more detail below.

THE HEALTH WORKER SHORTAGE

The health workforce is the backbone of a health system. Without doctors, nurses, midwives and community health workers, diseases cannot be diagnosed, drugs cannot be prescribed, children cannot be vaccinated, and women and babies cannot be protected during birth. The shortage of health workers is therefore a truly global crisis and one of the biggest challenges in global development today.

The minimum number of doctors, nurses and midwives needed to deliver essential health services is 2.3 per 1,000, or one health worker for every 435 people. There are 61 countries with a critical shortage of healthcare workers – 41 of them in Africa. Niger only has one health worker for every 6,000 people, Sierra Leone has one for every 5,000.[38] By comparison, in Canada there is one health worker for every 106 people. [39] A billion people will never see a health worker.[40]

Action for Global Health outlined five causes of the health workforce crisis:[41]

1. Difficult working conditions – many health workers lack incentives. They are poorly and irregularly paid, and the shortage of staff means those who are working will have a high caseload. Many health facilities lack the basic equipment and medicines to enable them to function properly.

2. Disparities in health coverage – urbanisation has led many health workers away from rural areas in search of better working conditions and better opportunities for their families.

3. Migration of health professionals – skilled health workers may migrate in order to use their skills in rich countries where they will be better paid and better supported. In some countries, including the UK, the health service has become dependent on foreign health workers.

4. Lack of education and training opportunities – many countries lack educational facilities and educators to train enough health workers to cover the whole population, particularly in rural areas. Africa trains 5,100 doctors a year compared to 173,800 in Europe.[42]

5. Chronic under-investment in human resources – donor agencies and global health initiatives have often favoured more short-term targeted investments, such as distributing bed-nets or disease-specific vaccination drives, at the expense of longer-term commitments that would enable countries to boost the number of health workers. Many governments in poorer countries have also failed to dedicate enough of their own resources to health budgets and to health workers, with many countries lacking national human resources policies and plans.

THE MIDWIFE SHORTAGE

The World Health Organization recommends one midwife or skilled birth attendant for every 175 pregnant women[44] but this standard is far from being achieved. In Rwanda, where 400,000 babies are born in a year, there are 46 public midwives (or one midwife for every 8,600 births).[45] Uganda has 15,000 trained midwives with an estimated 1.5 million women having babies each year.[46]

Some of the reasons for the shortage of midwives mirror those listed above. A woman wishing to become a midwife faces the prospect of working in a poorly staffed, poorly

equipped health centre in a remote or even dangerous location with a huge caseload of pregnant women to look after. She may have little support or opportunity for training and may be paid relatively poorly. A midwife in Liberia is paid around $97 a month,[47] in Burkina Faso a midwife can expect around $195 a month, and in Nigeria around $470 a month.[48]

RACHEL PALMER/SAVE THE CHILDREN

"I don't have a stethoscope and my blood pressure machine doesn't work properly. I don't have a tape measure to measure the growth of the foetus in the womb – this equipment is very important for antenatal care. I'm supposed to do a urine test but I don't have any urine sticks.

"If there were two of us working here, one could work during the day and one at night, but because I'm the only one I work all day. The nightwatchman calls me if a woman goes into labour at night. As soon as labour starts I'm there. If a mother is bleeding after the delivery I keep her in for 24 hours. I stay with her during the night so I can monitor her."

Eva, a midwife in Southern Sudan

GLOBALLY, THERE IS A SHORTAGE OF 350,000 MIDWIVES.

Personal safety is a particular concern for midwives and other female health workers, in addition to poor working conditions. The International Labour Organization has noted the high risk of violence among midwives and nurses. Health facilities are often staffed by a single female health worker, which puts her in a vulnerable position and makes it impossible for that health post to provide the necessary 24-hour coverage for obstetric emergencies and complications in labour.[49]

Poor working conditions, particularly those in rural settings, drive midwives to take their skills elsewhere. Within countries, midwives tend to be concentrated in urban centres, where the better resourced health facilities are based but which are further away from the women and children who are most in need. In Sierra Leone, two-thirds of urban women said they had a midwife, doctor or health professional present when they gave birth, compared with only one-third of rural women.[50] Many midwives also migrate overseas to seek a better standard of living.

There is a shortage of opportunities for training in midwifery in the least developed countries. An additional challenge for midwifery, a traditionally female profession, is that in many countries fewer girls complete schooling than boys, so fewer women grow up with the necessary basic education. Increased investment in girls' education is essential to enlarge the pool of young women who are qualified to potentially start training as midwives.

Madame Achatou Boukar is a midwife who works at a maternity centre in the Matameye district of Niger. Here she explains how this government-funded maternity centre is grossly under-equipped and lacks basic amenities such as electricity and running water.

"With electricity, we would be able to sterilise our instruments properly and apply other techniques, but right now we cannot do any of this. Also we need more personnel. There are many patients here and there are only three of us.

"We need proper equipment, and the buildings are not in good shape. Women who have just given birth have to share the same space with sick patients. We don't have enough beds for the early stages of labour, so they end up laying on the ground."

THE FUNDING GAP

Underlying the shortage of midwives and other health workers is a lack of money available in poor countries' health budgets to pay for recruitment, training and salaries. Personnel often account for the bulk of health spending, and in many countries health workers account for a large proportion of the public sector workforce.

The cost of filling the global health worker gap of 3.5 million doctors, nurses, midwives and community health workers in 49 of the poorest countries by 2015 has been estimated at between $39 billion[51] and $53 billion.[52]

The money to pay for these additional health workers needs to come from a number of sources. First, governments in the poorest countries must increase their own spending on their health budgets. Existing efforts are inadequate. African governments committed to the target of spending 15% of revenues on health at the African Union summit in Abuja, Nigeria in 2001, but by 2008 just six had met this target – Rwanda, Botswana, Niger, Malawi, Zambia and Burkina Faso.[53]

Second, a change in the way international donors and rich country governments give money to improve health in poor countries could boost the number of health workers. Aid for health tends to be short-term, unpredictable and fragmented. However, governments in developing countries need a long-term guarantee in order to invest in recruiting and training new health workers, which can take many years, and to pay their salaries.

Third, the policies of international institutions must change. When the International Monetary Fund (IMF) lends money to a country it often includes a requirement that the country will keep inflation low and minimise the government deficit by restricting public spending, which includes the public sector wage bill. The rationale behind this is to achieve economic stability, but it can also have the effect of preventing countries from increasing the numbers of midwives and other health workers on the public payroll. A more flexible approach by the IMF that gives these countries more scope to expand the wage bill and employ health workers is needed to enable the poorest countries to fill their health worker gaps.[54]

4 FILLING THE GAPS

Recruiting, training and retaining more midwives is vital to saving children's lives, as is ensuring that existing midwives are in the right places within countries. Donors and governments must work together in developing countries to support places with a large shortage of midwives by reducing the 'push' factors like poor pay and conditions, and by improving training and addressing the unequal distribution of midwives.

At the same time, richer countries should work on minimising 'pull' factors by stopping the active recruitment of health workers from countries with critical shortages, and adhering to the WHO Global Code of Practice on the International Recruitment of Health Personnel, which sets out principles and practices of ethical recruitment.[55] This was adopted by the World Health Assembly in May 2010.

Although there has been progress globally in increasing the number of births with a skilled attendant – 65% of all births were attended in 2009,[56] compared with 56% in 2000[57] – this progress has been insufficient to meet MDGs 4 and 5. However, many of the poorest countries are successfully boosting the numbers of midwives and ensuring that more births are attended. Pakistan, Burkina Faso and Rwanda have increased the proportion of births attended by a skilled person by 20 percentage points in the period from 2000 to 2008. Although these countries are yet to reach the global average, they have pulled themselves up from the bottom of the rankings. Ten other countries have also shown improvements of more than ten percentage points since 1990.[58]

The other big challenge for these countries is to tackle inequality – ensuring that midwives and skilled birth attendants are reaching the poorest, most vulnerable and most remote women and children, and not just those that are easiest to reach. Through its global programme work, Save the Children is contributing to the efforts of the poorest countries, by aiming to make sure that 640,000 more women have access to trained midwives when they give birth, and that they get the postnatal care they need.

SOME OF THE POOREST COUNTRIES ARE SUCCESSFULLY BOOSTING THE NUMBER OF MIDWIVES.

ALIXANDRA FAZZINA

Momal, a health worker in rural Pakistan, carrying her basic healthcare kit on a visit to an expectant mother. She has been trained to advise and treat pregnant women and newborn babies.

PAKISTAN – MAKING PROGRESS, FACING CHALLENGES

Pakistan increased the proportion of births with a skilled attendant present from 18% in 1999 to 39% in 2007. The number of children dying before the age of five dropped from 112 per 1,000 births to 90 in the same period. The country's progress has been due in a large part to national initiatives to recruit and train midwives, female health visitors and skilled birth attendants to work in the community.

One such project was the Pakistan Initiative for Mothers and Newborns, which was launched in 2004. Over six years the US-funded project trained more than 10,000 health workers, 80% of whom were women; donated life-saving ambulances for emergency obstetric care; and established 24-hour service in health facilities. The scheme provided services to nearly 3 million families and half a million newborn children.[59]

More recently the government of Pakistan's new Maternal, Newborn and Child Health programme has been supported by international donors, including the UK's Department for International Development (DFID), which committed £91 million between 2008 and 2013. DFID has supported the building of community midwifery schools to train 12,000 midwives.[60]

Healthcare in Pakistan is distributed unequally, meaning that a mother and her newborn's chances of survival depend on where in the country she was born and whether she is rich or poor. The newborn mortality rate in Punjab is nearly twice that in Balochistan.[61] Tackling these inequalities must be Pakistan's foremost priority.

INDONESIA – A MIDWIFE IN EVERY VILLAGE[62]

The number of women who die in childbirth has more than halved in Indonesia over the last two years, largely as a result of the government's investment in the 'midwife in every village' programme. In 1989, as many as 19,500 women died as a result of complications during pregnancy or childbirth; now, that number is 9,600. Over seven years, Indonesia selected, trained and certified 54,000 new village midwives, bringing its total number of midwives to approximately 80,000.

The midwives provide outreach and reproductive health services, immunisations and information about proper nutrition. Many of them have a small birthing room at their home or clinic.

To keep the newly trained midwives motivated, the programme includes a feedback mechanism and the government has adapted its strategy in response by modifying the training curriculum and improving the referral system for emergency obstetric care.

Between 1991 and 2007, the percentage of Indonesian births attended by skilled personnel more than doubled, from 32% to 79%. Indonesia also lowered both its maternal and newborn mortality rates by more than 40% – from 390 maternal deaths per 100,000 live births in 1989 to an estimated 228 in 2007, and from 32 newborn deaths per 1,000 live births to 19 during the same period.[63]

Source: *Women on the Front Lines of Health Care: State of the world's mothers 2010*, Save the Children

KULLVADEE SUMNALOP/SAVE THE CHILDREN

A mother gets advice from a community healthcare volunteer and a midwife in Aceh, Indonesia.

Training is a key issue. In Canada if you want to be a midwife you can study midwifery at a university baccalaureate level. No previous diploma or degree is required. In many countries in the developing world with acute shortages of midwives, the direct entry choice does not exist. This means training takes longer and midwives who are also qualified nurses can be diverted to perform other tasks. If someone is trained solely as a midwife, all their work is focused on the mother and her baby. Allowing midwives to train directly can be viewed as a more efficient use of training budgets.

MATTS LIGNELL/SAVE THE CHILDREN

A trainee midwife in Afghanistan.

AFGHANISTAN – MIDWIFE TRAINING COLLEGES

Afghanistan is one of the riskiest places for mothers and babies, with maternal and child mortality rates among the highest in the world. Afghan women face a one in 11 lifetime risk of maternal mortality, and one child in five dies before reaching the age of five.

Since 2002, the number of midwifery schools in Afghanistan has increased from 6 to 31 after the Ministry of Public Health launched a programme to rapidly train and deploy midwives to rural areas. About 2,400 midwives have been trained and are now employed by the government and NGOs across the country, most of them in service in their own villages and communities. An additional 300 to 400 midwives are being trained each year.

The percentage of women in rural Afghanistan whose deliveries were attended by skilled personnel increased from 6% to 19% between 2003 and 2006.

Save the Children is running a midwife college in Shiberghan, Jawzjan province, in northern Afghanistan. The 18-month course gives women both theoretical and practical training, as well as extensive practice in a nearby district hospital. All the women on the course come from different villages and are required to go back to their villages to work as midwives after graduation.

Madeena graduated from the midwifery college in October 2009 and is now working in a remote community of Jawzjan, near the border with Turkmenistan. One night when she was on duty, a 40-year-old woman came to the clinic who had been bleeding heavily for several hours after giving birth. The woman's placenta had not detached completely during birth. Madeena was able to safely remove the placenta, stop the bleeding and save the new mother's life.

Source: *Women on the Front Lines of Health Care: State of the world's mothers 2010*, Save the Children

Encouraging an even distribution of midwives throughout a country is essential to make sure that the poorest, most vulnerable women and children have the support they need. The trend in most countries is that women in urban areas are much more likely to have expert support when they give birth. In 2004, Côte d'Ivoire had 2,100 midwives. Yet only 300 of them worked outside of the cities, despite the fact that half of the population live in rural areas.[64]

NIGERIA'S MIDWIVES SERVICE SCHEME – ENCOURAGING EQUAL DISTRIBUTION

To overcome the challenge of staffing primary healthcare facilities in remote rural areas, where communities have the highest risk of maternal, newborn and child death, the federal government of Nigeria launched the Midwives Service Scheme.

The initiative involves deploying newly qualified, unemployed and retired midwives to health facilities in rural communities. One year's service in a rural setting is mandatory for newly graduated basic midwives before being fully licensed to practise midwifery in Nigeria. More than 2,600 midwives have been deployed to 652 health facilities across the country, many in rural communities. The project includes plans for improving supplies and equipment, by giving each midwife a 'mama kit' containing a personal health record book and a clean and safe delivery kit. Designed initially to provide a short-term solution, the scheme has already been extended from two to three years due to its success.[65]

The programme reaches a population of more than 10.7 million people, roughly 7% of the total population.[66] In a follow-up focus group with midwives who took part in the scheme, more than half indicated that they would be happy to continue working in their rural facility even after the scheme has ended.[67]

Save the Children is working in Nigeria as part of the Partnership for Reviving Routine Immunization in Northern Nigeria, Maternal Newborn and Child Health Initiative, which aims to improve the quality and availability of maternal, newborn and child health facilities in three northern states – Yobe, Katsina and Zamfara.

PEP BONET/NOOR

The maternity ward in a medical centre in northern Nigeria.

What all these solutions have in common is that they take political will and a sensible human resources strategy with long-term vision, backed by reliable investment. The projects must put the midwives' well-being and job satisfaction at the heart of the project. These examples show that increasing the number of midwives in the world needs focused investment from the local level right up to national policy.

5 CONCLUSION AND RECOMMENDATIONS

GLOBAL SUPPORT, GLOBAL OPPORTUNITIES

The world needs more midwives and skilled birth attendants. Without them, women and newborn babies will continue to die needlessly from complications in birth that can be easily prevented by someone with the right skills.

We know the reasons for the shortage of midwives and we know what can be done to address it. There is a moral imperative to put more of those solutions to work in more places and save the lives of more women and children. Unless more midwives are recruited, trained and supported, the Millennium Development Goals to reduce child deaths by two-thirds (MDG 4) and maternal mortality by three-quarters (MDG 5) cannot be met.

Rich and poor countries have already shown their support for boosting the number of midwives. When the UN launched the Every Woman, Every Child strategy to accelerate progress towards the maternal and child health goals, several countries supported it with pledges that specifically referred to midwives. Ethiopia committed to increase the number of midwives from 2,050 to 8,635, and Rwanda has pledged to train five times more midwives. For its part, the UK government has said it will support at least 2 million safe deliveries and save the lives of 50,000 women during pregnancy and childbirth, and the lives of 250,000 newborn babies by 2015.[68]

These commitments must become a foundation for concrete action to boost the numbers of midwives and to inspire further urgently needed commitments from other governments and donors. When world leaders and donors come together again at the UN General Assembly in September 2011, it will be the ideal moment for high-level recognition of the central role that midwives and other health workers play in saving the lives of mothers and children. Rich and poor countries must work together to close the health worker gap, and we will be campaigning for key governments to make specific commitments on the recruitment and training of midwives and health workers.

Mothers will always remember the vital role that their midwife played when they gave birth. The care a midwife provides during some of the most frightening moments of a woman's life is not only reassuring – it can make the difference between life and death for the mother and her newborn baby. It is time to invest in midwives so every newborn baby survives to live a healthy, productive life and every mother can live to see her children fulfil their potential.

RECOMMENDATIONS

Save the Children is calling on governments to:

Support countries to recruit more midwives and health workers – Donor governments, especially those in the EU and G8/20, should put health workers at the heart of their ongoing development work. Every country with a critical health worker shortage should be supported to develop and implement an effective human resources plan to ensure more midwives, nurses, doctors and community health workers are recruited, trained, equipped, paid, supported and deployed to serve the poorest and most marginalised communities.

Ask the UN Secretary-General to host a health worker event at the UN General Assembly – As part of delivering on the UN Secretary-General's Every Woman, Every Child strategy, governments should call for a high-level political event in September 2011 where heads of state come together to make specific commitments to fill the 3.5 million health worker gap.

Make the International Monetary Fund support flexibility on public sector spending – Despite claims of flexibility, the International Monetary Fund is still discouraging public spending in countries with health worker shortages. All governments with seats on the IMF board must push for flexible economic policies for poor countries so they can expand their health workforce.

Respect the international recruitment code of practice – Donor governments must not actively recruit health workers from countries with critical health worker shortages. All governments must adhere to the World Health Organization Global Code of Practice on the International Recruitment of Health Personnel adopted in 2010, and support depleted countries to rebuild their health workforces.

2011 MOTHERS' INDEX RANKINGS

2011 Mothers' Index Rankings

Country	Mothers' Index Rank*	Women's Index Rank**	Children's Index Rank***
TIER I: More Developed Countries			
Norway	1	2	7
Australia	2	1	30
Iceland	2	5	7
Sweden	4	7	1
Denmark	5	4	20
New Zealand	6	3	26
Finland	7	6	19
Belgium	8	9	15
Netherlands	9	8	21
France	10	12	6
Germany	11	15	4
Spain	12	13	12
United Kingdom	13	10	23
Portugal	14	16	13
Switzerland	14	19	9
Ireland	16	11	29
Slovenia	16	17	11
Estonia	18	17	17
Greece	19	21	14
Canada	20	14	24
Italy	21	25	2
Hungary	22	21	22
Lithuania	22	20	25
Czech Republic	24	27	16
Latvia	24	23	26
Austria	26	33	5
Croatia	27	26	32
Japan	28	34	2
Poland	28	28	31
Slovakia	28	29	28
United States	31	24	34
Luxembourg	32	35	10
Belarus	33	29	33
Malta	34	41	18
Bulgaria	35	32	36
Romania	36	31	38
Serbia	37	37	35
Russian Federation	38	35	39
Ukraine	39	39	37
Moldova, Republic of	40	40	40
Bosnia and Herzegovina	41	37	42
Macedonia, TFYR	42	42	41
Albania	43	43	43
TIER II: Less Developed Countries			
Cuba	1	1	9
Israel	2	2	3
Cyprus	3	3	1
Argentina	4	6	15
Barbados	5	5	3
Korea, Republic of	5	6	2
Uruguay	7	8	9
Kazakhstan	8	9	21
Mongolia	9	4	52
Bahamas	10	14	6
Colombia	11	10	34
Brazil	12	13	12
Costa Rica	13	22	13
Ecuador	14	12	35
Jamaica	15	14	27
Chile	16	23	5
Bahrain	17	18	22
China	18	11	43
South Africa	19	17	53
Thailand	20	20	31
Peru	21	20	42
Venezuela, Bolivarian Republic of	21	18	36
Mexico	23	29	19
Dominican Republic	24	23	40
Panama	25	25	38
Trinidad and Tobago	25	34	29
Uzbekistan	25	26	40
Kyrgyzstan	28	30	37
Tunisia	28	38	17
Armenia	30	36	16
Bolivia	30	26	51
Mauritius	32	34	30
Paraguay	33	30	39
Vietnam	34	26	55
Kuwait	35	37	23
Malaysia	36	44	23
United Arab Emirates	36	52	19
Iran, Islamic Republic of	38	41	28
Qatar	38	49	11
TIER II: Less Developed Countries (continued)			
El Salvador	40	39	49
Belize	41	50	23
Guyana	41	54	32
Sri Lanka	43	33	59
Georgia	44	58	7
Namibia	44	32	67
Lebanon	46	59	7
Libyan Arab Jamahiriya	46	41	49
Cape Verde	48	45	48
Philippines	49	40	65
Suriname	49	50	46
Azerbaijan	51	52	57
Botswana	51	45	57
Algeria	53	57	43
Jordan	54	64	17
Indonesia	55	48	66
Turkey	55	65	13
Tajikistan	57	43	70
Nicaragua	58	60	54
Honduras	59	60	56
Gabon	60	45	71
Egypt	61	70	26
Swaziland	62	55	72
Fiji	63	56	68
Saudi Arabia	64	71	32
Syrian Arab Republic	65	72	45
Occupied Palestinian Territory	66	68	46
Ghana	67	62	69
Guatemala	68	67	62
Oman	69	68	62
Zimbabwe	70	66	73
Kenya	71	63	74
Morocco	72	77	60
Cameroon	73	73	78
Congo	74	74	76
India	75	76	75
Papua New Guinea	76	75	81
Pakistan	77	79	77
Nigeria	78	78	80
Côte d'Ivoire	79	80	79
TIER III: Least Developed Countries			
Maldives	1	1	4
Rwanda	2	2	9
Lesotho	3	3	2
Malawi	4	6	7
Uganda	5	5	9
Bhutan	6	11	2
Mozambique	7	4	26
Lao People's Democratic Republic	8	8	22
Comoros	9	12	6
Solomon Islands	9	15	1
Nepal	11	10	14
Cambodia	12	9	24
Madagascar	13	7	30
Myanmar	14	12	11
Gambia	15	18	5
Burundi	16	14	27
Tanzania, United Republic of	17	18	14
Bangladesh	18	16	16
Senegal	19	23	8
Timor-Leste	20	17	25
Mauritania	21	21	19
Liberia	22	22	17
Togo	23	27	12
Ethiopia	24	20	36
Guinea	25	24	23
Benin	26	29	12
Zambia	26	28	18
Burkina Faso	28	26	29
Djibouti	29	30	19
Angola	30	31	32
Sierra Leone	31	25	40
Equatorial Guinea	32	36	28
Central African Republic	33	33	35
Sudan	34	38	30
Mali	35	35	38
Eritrea	36	37	34
Congo, Democratic Republic of the	37	34	39
Chad	38	32	41
Yemen	39	39	33
Guinea-Bissau	40	40	36
Niger	41	41	41
Afghanistan	42	42	43

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

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

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

Appendix:
The Mothers' Index and Country Rankings

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

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

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

2011 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 31st this year.

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

TOP 10 best places to be a mother		**BOTTOM 10** worst places to be a mother	
RANK	Country	RANK	Country
1	Norway	155	Central African Republic
2	Australia	156	Sudan
2	Iceland	157	Mali
4	Sweden	158	Eritrea
5	Denmark	159	DR Congo
6	New Zealand	160	Chad
7	Finland	161	Yemen
8	Belgium	162	Guinea-Bissau
9	Netherlands	163	Niger
10	France	164	Afghanistan

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

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

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

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

The 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.

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

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

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

- Fewer than 15 percent of births are attended by skilled health personnel in Chad and Afghanistan. In Ethiopia, only 6 percent of births are attended. Compare that to 99 percent in Sri Lanka and 95 percent in Botswana.

- 1 woman in 11 dies in pregnancy or childbirth in Afghanistan. The risk is 1 in 14 in Chad and Somalia. In Italy and Ireland, the risk of maternal death is less than 1 in 15,000 and in Greece it's 1 in 31,800.

- A typical woman will die before the age of 50 in Central African Republic, Democratic Republic of the Congo, Mali, Mozambique, Nigeria, Sierra Leone, Zambia and Zimbabwe. Life expectancy for women is only 46 in Swaziland and Lesotho. In Afghanistan, the average woman does not live to see her 45th birthday while in Japan women on average live to almost 87 years old.

- In Somalia, only 1 percent of women use modern contraception. Rates are less than 5 percent in Angola, Chad and Guinea. And fewer than 1 in 10 women use modern contraception in 15 other developing countries. By contrast, 80 percent or more of women in Norway, Thailand and the Canada and 86 percent of women in China use some form of modern contraception.

- In Afghanistan, Jordan, Lebanon, Libya, Morocco, Oman, Pakistan, Syria and Yemen women earn 25 cents or less for every dollar men earn. Saudi and Palestinian women earn only 16 and 12 cents respectively to the male dollar. In Mongolia, women earn 87 cents for every dollar men earn and in Mozambique they earn 90.

- In Qatar, Saudi Arabia and the Solomon Islands, not one seat in parliament is occupied by a woman. In Comoros and Papua New Guinea women have only 1 seat. Compare that to Rwanda, where over half of all seats are held by women.

- A typical female in Afghanistan, Angola, Djibouti, Eritrea and Guinea-Bissau receives less than 5 years of formal education. In Niger, it's less than 4 years and in Somalia, women receive less than 2 years of education. In Australia and New Zealand, the average woman stays in school for over 20 years.

- In Somalia, 2 out of 3 children are not enrolled in primary school. Nearly half (48 percent) of all children in Eritrea are not in school. In Djibouti and Papua New Guinea out-of-school rates are 45 percent. In comparison, nearly all children France, Italy Spain and Sweden make it from preschool all the way to high school.

- In Central African Republic and Chad, fewer than 3 girls for every 4 boys are enrolled in primary school. In Afghanistan and Guinea-Bissau, it's 2 girls for every 3 boys. And in Somalia, boys outnumber girls by almost 2 to 1.

- 1 child in 5 does not reach his or her fifth birthday in Afghanistan, Chad and Democratic Republic of the Congo. In Finland, Greece, Iceland, Japan, Luxembourg, Norway, Singapore, Slovenia and Sweden, only 1 child in 333 dies before age 5.

- Over 40 percent of children under age 5 suffer from malnutrition in Bangladesh, Madagascar, Nepal, Niger and Yemen. In India and Timor-Leste, nearly half of all young children are moderately or severely underweight.

- More than half of the population of Afghanistan, DR Congo, Ethiopia, Equatorial Guinea, Fiji, Madagascar, Mauritania, Mozambique, Niger, Papua New Guinea and Sierra Leone lacks access to safe drinking water. In Somalia, 70 percent of people lack access to safe water.

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

Frequently Asked Questions about the Mothers' Index

WHY DOESN'T CANADA DO BETTER IN THE RANKINGS?

Canada ranked 20th this year based on several factors:

- One of the key indicators used to calculate well-being for mothers is lifetime risk of maternal mortality. Canada's rate for maternal mortality is 1 in 5,600[1]. A woman in Canada is almost 3 times as likely as a woman in Italy or Ireland to eventually die from pregnancy-related causes and her lifetime risk of maternal death is roughly 6-fold that of a woman in Greece.
- While other developed countries saw a decrease in under-five mortality, Canada stayed constant at 6 deaths per 1000 live births. Canada does not do as well as many other developed countries with regard to under-5 mortality. Hungary and the Netherlands, both registered gains in child survival, with rates of under-5 mortality falling from 7 to 6 and 5 to 4 (per 1,000 live births), respectively. Twenty-three countries performed better than Canada on this indicator. At this rate, a child in Canada is more than twice as likely as a child in France, Greece, Iceland, Japan, Luxembourg, Norway, Slovenia, or Sweden to die before reaching age 5.
- Approximately 70 percent of children in Canada are enrolled in preschool in line with countries like Cyprus and Greece and with lower preschool enrollment than Malta, Portugal, Japan and New Zealand
- Canada along with Serbia, Slovakia, and Greece has some of the least generous maternity leave policies – both in terms of percentage of wages paid (approximately 55%) – of wealthy nations.
- Canada is also lagging behind with regard to the political status of women. Canadian women claim a higher percentage of seats in the Senate than the House of Commons (34% compared to 22%); in fact many developing countries including Mozambique, Rwanda and Afghanistan have higher levels of female political representation in their governments.

WHY IS NORWAY NUMBER ONE?

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

WHY IS AFGHANISTAN LAST?

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

WHY ARE SOME COUNTRIES NOT INCLUDED IN THE MOTHERS' INDEX?

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

WHAT SHOULD BE DONE TO BRIDGE THE DIVIDE BETWEEN COUNTRIES THAT MEET THE NEEDS OF THEIR MOTHERS AND THOSE THAT DON'T?

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

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.

1. UNICEF's classification of industrialized countries includes all of western, northern, southern and eastern Europe (excluding CEE/CIS countries), Australia, New Zealand, North America and Japan.

The Complete Mothers' Index 2011

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

The Complete Mothers' Index 2011

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

The Complete Mothers' Index 2011

Development Group	Health Status				Educational Status	Economic Status	Political Status	Children's Status					SOWM 2011		
LESS DEVELOPED COUNTRIES and TERRITORIES (minus least developed countries)	Lifetime risk of maternal death (1 in number stated)	Percent of births attended by skilled health personnel	Percent of women using modern contraception	Female life expectancy at birth (years)	Expected number of years of formal female schooling	Ratio of estimated female to male earned income	Participation of women in national government (% seats held by women)	Under-5 mortality rate (per 1,000 live births)	Percent of children under 5 moderately or severely underweight for age	Gross primary enrollment ratio (% of total)	Gross secondary enrollment ratio (% of total)	Percent of population with access to safe water	Mothers' Index Rank (out of 79 countries)+	Women's Index Rank (out of 80 countries)+	Children's Index Rank (out of 81 countries)+
	2008	2009	2008	2010	2009	2007	2011	2009	2009	2009	2009	2008			
Kuwait	4,500	98	39 (s)	80	14	0.36	8	10	10	95	90	99	35	37	23
Kyrgyzstan	450	98	46	72	13	0.55	23	37	3	95	84	90	28	30	37
Lebanon	2,000	98	34	75	14	0.25	3	12	4	103	82	100	46	59	7
Libyan Arab Jamahiriya	540	94	26	77	17	0.25	8	19	5	110	93	72 (y)	46	41	49
Malaysia	1,200	99	30 (w)	77	13	0.42	14	6	8	97	68	100	36	44	23
Mauritius	1,600	98	39	76	14	0.42	19	17	15	100	87	99	32	34	30
Mexico	500	93	67	79	14	0.42	26	17	5	114	90	94	23	29	19
Mongolia	730	99	61	71	15	0.87	4	29	6	110	92	76	9	4	52
Morocco	360	63	52	74	9	0.24	7	38	10	107	56	81	72	77	60
Namibia	160	81	54	63	12	0.63	25	48	21	112	66	92	44	32	67
Nicaragua	300	74	69	77	11	0.34	21	26	7	117	68	85	58	60	54
Nigeria	23	39	9	49	8	0.42	7	138	29	93	30	58	78	78	80
Occupied Palestinian Territory	–	99	39	76	13	0.12 (y)	– (vi)	30	3	79	87	91	66	68	46
Oman	1,600	99	18 (s)	78	11	0.23	9	12	18	75	88	88	69	68	62
Pakistan	93	39	22	68	6	0.18	21	87	38	85	33	90	77	79	77
Panama	520	92	54 (y)	79	14	0.58	8	23	8 (y)	111	71	93	25	25	38
Papua New Guinea	94	53	20	64	6 (z)	0.74	1	68	26	55	–	40	76	75	81
Paraguay	310	82	70	74	12	0.64	14	23	4	102	67	86	33	30	39
Peru	370	83	47	76	14	0.59	28	21	6	109	89	82	21	20	42
Philippines	320	62	36	75	12	0.58	22	33	26	110	82	91	49	40	65
Qatar	4,400	99	32 (s)	77	14	0.28	0	11	6	106	85	100	38	49	11
Saudi Arabia	1,300	91	29 (y,s)	76	13	0.16	0	21	14	99	97	95 (y)	64	71	32
Singapore	10,000	100	53	83	–	0.53	23	3	3	–	–	100	–	–	–
South Africa	100	91	60	53	14 (z)	0.60	43 (ii)	62	12	105	95	91	19	17	53
Sri Lanka	1,100	99	53	78	13	0.56	5	15	27	101	87	90	43	33	59
Suriname	400	90	41	73	13	0.44	10	26	10	114	75	93	49	50	46
Swaziland	75	69	47	46	10	0.71	22	73	10	108	53	69	62	55	72
Syrian Arab Republic	610	93	43	77	11	0.20	12	16	10	122	75	89	65	72	45
Tajikistan	430	88	33	70	10	0.65	18	61	18	102	84	70	57	43	70
Thailand	1,200	97	80	72	13	0.63	14	14	9	91	76	100	20	20	31
Trinidad and Tobago	1,100	98	38	73	12	0.55	27	35	6	103	89	94	25	34	29
Tunisia	860	95	52	77	15	0.28	23	21	3	107	92	94	28	38	17
Turkey	1,900	91	43	75	11	0.26	9	20	3	99	82	99	55	65	13
Turkmenistan	500	100	45	69	–	0.65	17	45	11	99 (z)	84 (z)	72 (y)	–	–	64
United Arab Emirates	4,200	99	24 (s)	79	12	0.27	23	7	14	105	95	100	36	52	19
Uruguay	1,700	100	75	80	17	0.55	15	13	5	114	88	100	7	8	9
Uzbekistan	1,400	100	59	71	11	0.64	19	36	5	92	104	87	25	26	40
Venezuela, Bolivarian Republic of	540	95	62	77	15	0.48	17	18	5	103	81	83 (y)	21	18	36
Vietnam	850	88	68	77	10	0.69	26	24	20	104	67	94	34	26	55
Zimbabwe	42	60	58	47	9	0.58 (y)	18	90	16	104	41	82	70	66	73

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

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

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

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

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

The Complete Mothers' Index 2011

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

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MISSING MIDWIVES

"This report from Save the Children clearly demonstrates that midwives are critical to saving the lives of mothers and newborn babies. Filling the global shortage of 350,000 midwives must be a global priority if we are to reduce the terrible rates of maternal and child mortality in the world's poorest countries.

"*Missing Midwives* highlights the important role that the midwife plays within the wider health system, and lays out a range of solutions to recruit, train, support and deploy more midwives to the places where they are needed most. Save the Children tells us exactly what needs to happen both in developing countries and in terms of global political action. These recommendations cannot be ignored.

"*Missing Midwives* is essential reading for anyone concerned with reducing the burden of maternal and newborn deaths."

Dr Tony Falconer
President, Royal College of Obstetricians and Gynaecologists

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