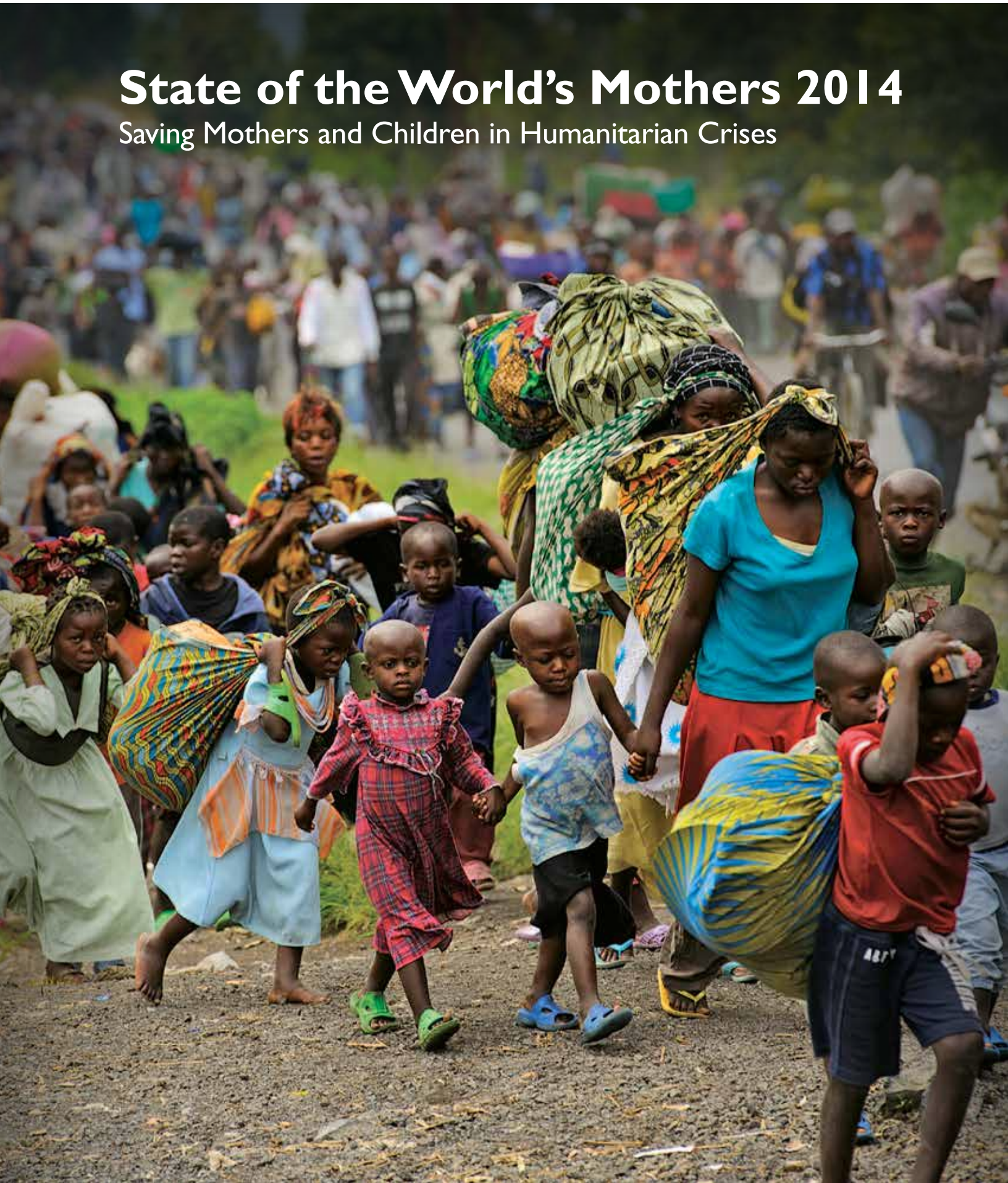
Save the Children®

State of the World's Mothers 2014

Saving Mothers and Children in Humanitarian Crises



Save the Children

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Some names of mothers and children have been changed to protect identities.

On the cover

Thousands of Congolese people flee their town in North Kivu following new fighting in the eastern Democratic Republic of the Congo in 2012.

Photo by Phil Moore

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Saving Mothers and Children in Humanitarian Crises

Save the Children's 15th annual *State of the World's Mothers* report focuses on millions of women and children living in communities affected by conflict, fragility and natural disasters, and their everyday struggle to survive.

More than 60 million women and children are in need of humanitarian assistance this year. Over half of maternal and child deaths worldwide occur in crisis-affected places; still the majority of these deaths are preventable. In this report, Save the Children examines the causes of maternal and child deaths in crisis settings, and suggests urgent actions needed to support mothers who are raising the world's future generations under some of the most difficult and horrific circumstances imaginable.

Since 2000, Save the Children's annual *Mothers' Index* has become a reliable international tool to show where mothers and children fare best, and where they face the greatest hardships, using the latest data on health, education, economics and female political participation. Looking at trends so far this century, we see how armed conflict, political instability and natural disasters have played a major role in undermining the well-being of mothers and children in the world's poorest countries. We also see that progress is possible, even in countries suffering from devastating humanitarian crises.

For more than 90 years, Save the Children has been on the frontlines of emergencies around the world, providing food, lifesaving health care and protection from harm to the most vulnerable mothers and children. This report aims to further that mission by shining a spotlight on unmet needs, effective solutions and recommended policy changes.

Syrian refugees in Jordan

Philippines

Introduction

Motherhood can be the toughest job in the world, with long hours, constant demands and no time off. But for women living in places affected by conflict and natural disasters, the challenges of being a mother are greater – and the stakes are so much higher.

Save the Children's 15th annual *State of the World's Mothers* report comes at a pivotal moment in history, when humanitarian crises have focused a spotlight as never before on the needs of mothers and children who are struggling to survive.

For the first time in history, there is a realistic prospect of ending preventable child deaths within a generation. But the world as a whole remains off-track to meet the fourth Millennium Development Goal of a two-thirds reduction in child mortality by 2015. The majority of preventable child deaths are increasingly concentrated in particular parts of the world, much of it in conflict-affected and fragile states.

Any mother, anywhere – myself included – will do anything to protect her children. From their very first breath, we promise to keep our babies safe from harm – we tell them they can count on us. And when disaster strikes, it's more difficult and more important than ever to keep that promise. Our 2014 research demonstrates how critical – and difficult – the mother-child connection is during a humanitarian crisis, when families' lives are thrown into turmoil.

It's no surprise that the 10 toughest places to be a mother in this year's *Mothers' Index* all have a recent history of armed conflict and are considered to be fragile states. Six of the bottom 10 countries suffer from recurring natural disasters. And, as usual, the poorest mothers have it the hardest: the report once again points out the disheartening disparity between mothers in rich and poor countries.

In places affected by humanitarian crises, the vast majority of children's deaths occur due to crumbling infrastructure, a lack of basic health services or a skilled heath worker during childbirth. Livelihoods are disrupted, if not totally destroyed, and mothers may find it impossible to adequately feed and support their families. They and their children also become more vulnerable to the risks of exploitation, sexual abuse and physical danger. So the tragedy of the crisis itself is compounded by fear and uncertainty, making mothers feel helpless.

Fortunately, mothers aren't alone. As part of our global campaign to save children's lives, EVERY ONE, Save the Children is campaigning for policy and political changes that will tackle the causes of child mortality. We are also delivering programs around the world that provide access to maternal and child health care services, recruit and equip skilled heath workers, protect women from human rights violations and remove financial barriers to health care.

Save the Children responded to 119 humanitarian crises in 48 different countries last year. Since our founding in 1919 to help children in war-torn Europe after World War I, we have stopped at nothing to safeguard the well-being and the future of children around the world.

On my travels I've met with mothers recovering from the devastation of ongoing conflict, mothers trying to make a refugee camp feel like home, and mothers who fled from violence with their children on their backs. Despite the horrors of the past, every mother I meet is focused on the future and how to make it brighter for her children.

Just as children depend on their mothers to keep them safe, mothers are depending on us to build a better, more secure world for their families. We must make a promise to be there for mothers – even, and especially, when times are tough.

Jasmine Whitbread
CEO of Save the Children International

Nigeria

Executive Summary: Key Findings and Recommendations

Each day, an estimated 800 mothers and 18,000 young children die from largely preventable causes. Over half of these maternal and under-5 deaths take place in fragile settings,[1] which are at high risk of conflict and are particularly vulnerable to the effects of natural disasters.[2]

The urgent task of completing the unfinished business of the Millennium Development Goals, and ending preventable child and maternal deaths, is increasingly concentrated in these contexts. Finding ways of meeting mothers' and children's health and nutrition needs in fragile states and humanitarian crises is central to this challenge.

In Save the Children's 15th annual *State of the World's Mothers* report, we examine the impact of humanitarian crises on maternal, newborn and child survival in countries consistently ranked as the most difficult places to be a mother.

Since the *Mothers' Index* was launched in 2000, the majority of the bottom 10 countries have been in the midst of, or emerging from, a recent humanitarian emergency. Of the 28 countries that have ever ranked in the bottom 10, 27 are current or former fragile states, all but four have a recent history of armed conflict, and nearly two-thirds (18 of 28) are characterized by persistent natural disasters. In addition to emergencies, many of these countries face ongoing health crises due to chronic challenges, including limited access to quality health care.

Most current and previous bottom 10 countries are among the poorest in the world, and recent crises have only exacerbated problems that have persisted for decades. Failure to address basic human needs has been both a cause and a consequence of conflict in countries like Central African Republic, Somalia and Sudan. And the hardest hit families in any disaster – be it "natural" or man-made – tend to be the poorest of the poor, mostly women and children.

Violence and conflict have uprooted more families than at any time on record.[3] By the end of 2012, more than 45 million people worldwide were forcibly displaced due to conflict or persecution.[4] In addition, natural disasters, which can be especially deadly in the world's poorest communities, displaced more than 32 million in 2012.[5]

Of the more than 80 million people projected to be in need of humanitarian assistance in 2014, the majority are deeply impoverished and over three-quarters are women and children.[6,7]

Mothers and children face the highest risks of death, and steepest roads to recovery, in crisis situations that occur in fragile settings. These countries

Mothers and Children in Crisis: Vital Statistics

More than 250 million children under age 5 live in countries affected by armed conflict.[8]

The poorest people suffer most from natural disasters – 95 percent of disaster fatalities occur in developing countries.[9]

56 percent of maternal and child deaths take place in fragile settings.[10]

Worldwide, women and children are up to 14 times more likely than men to die in a disaster.[11]

The average refugee situation lasts 17 years.[12]

For every person killed directly by armed violence, between 3 and 15 die indirectly from diseases, medical complications and malnutrition.[13, 14]

On average, countries in conflict have less than half the minimum number of recommended health workers.[15]

More than 80 percent of the high-mortality countries unlikely to achieve the Millennium Development Goals for mothers' and children's survival have suffered a recent conflict or recurring natural disasters or both.[16]

and territories (more than 50 in number) lack resilience to emergencies and face chronic underlying challenges, including extreme poverty, weak infrastructure, and poor governance. In these settings, children and mothers face an everyday emergency, whether or not a humanitarian crisis is officially recognized by the international system.

This report looks in depth at four different countries impacted by humanitarian emergencies. Two case studies examine the challenges facing mothers and children in situations of armed conflict:

- **Civil war in Democratic Republic of the Congo** has led to horrific abuses against women and children, and directly and indirectly claimed more than 5.4 million lives. But less than 10 percent of these deaths have occurred in combat, and mortality rates in areas of the DR Congo outside conflict zones are often as high as in the conflict-affected eastern provinces. Most deaths in the DR Congo have been due to preventable or treatable causes such as malaria, diarrhea, pneumonia, newborn causes and malnutrition – and almost half the country's death toll has been children under age 5. DR Congo exemplifies many of the challenges facing countries with high mortality burdens, which are also off track towards the Millennium Development Goals: it is a fragile state with a weak health infrastructure that leaves many without access to basic health care. Health facilities often lack properly trained medical staff and medical supplies – many do not even have electricity and water. Attacks on health workers also undermine the quality and availability of care by traumatizing the health workforce and forcing health facilities to suspend activities. Despite the many challenges, there are signs of hope and progress in the DR Congo. Well-established local non-governmental organizations (NGOs) provide medical care and psychological support to rape victims in conflict-affected areas. In the Kivu provinces, humanitarian agencies have been supporting the national Ministry of Health in the provision of primary and secondary health care services, vaccinations, and family planning and maternal health programs. (*To read more, turn to pages 33-41.*)

- **Syria's civil war** – now in its fourth year – has had a devastating impact on mothers and children. Almost 1.4 million children and 690,000 women have fled the conflict and become refugees in neighboring countries, while over 9 million people inside Syria are in need of lifesaving humanitarian assistance. Estimates suggest as many as 1,000 women and children a month have been killed in the conflict.[17] Hundreds – if not thousands – more have likely died due to shortages of food and medical care. A lack of data means that the impact of the conflict in Syria on maternal and child survival has yet to be fully assessed. But what is clear is that women in Syria face huge difficulties in accessing prenatal, delivery and postnatal care, including lack of ambulances, few female hospital staff and frequent checkpoints and roadblocks encountered on the way to hospitals. These problems have led to unassisted births, as well as a shift in the proportion of women opting for planned cesarean sections. Numerous assessments among refugees from Syria – in camps as well as non-camp settings across the region – have reported gaps in the availability of reproductive health services. Anecdotal evidence suggests newborn deaths are on the rise inside Syria, while babies born to refugees from Syria also face daunting odds. Three years of displacement and collapsing health services have left young children in Syria highly vulnerable to potentially fatal diseases. Children in many parts of Syria have limited or no access to vaccination, and for the first time in over a decade, there are polio and widespread measles outbreaks. Cases of measles and other preventable diseases have also been reported among refugees in Jordan, Lebanon and Turkey. In 2011, before the conflict erupted, Syria had a child mortality rate of 15 per 1,000 births – comparable to a country like Brazil – and was on track to achieve MDGs 4 and 5. The conflict has led to the collapse of what had been a functioning health system, and threatens to set back progress by a generation. (*To read more, turn to pages 43-51.*)

Natural disasters also pose special threats to a nation's poorest mothers and children, even in middle-income countries such as the Philippines and industrialized countries such as the United States:

- **The Philippines'** resiliency is being tested by more frequent and increasingly severe emergencies. Typhoon Haiyan on November 8, 2013 was one of the most destructive typhoons to ever hit land. It killed more than 6,000 people, devastated more than 2,000 hospitals and health clinics and destroyed countless health records and computer systems. While it is too soon to predict how many lives will ultimately be lost due to Haiyan, past experience suggests many more young children could die in 2014 due to deteriorating conditions than were killed outright by the storm itself. Like many middle-income countries, the Philippines is broadly on track to achieve MDGs 4 and 5, and most people have access to essential health care. It is unclear whether storms like Haiyan have the potential to erode the Philippines' progress on the MDGs for child and maternal survival, but without greater investment in disaster-proof health systems, and quicker and more effective humanitarian response, it may be increasingly challenging to keep rebuilding the country's health infrastructure – especially if the country experiences


Somalia

more typhoons on the scale of recent years. (*To read more, turn to pages 25-31.*)

- **In the United States**, when Hurricane Sandy barreled into the mid-Atlantic coast in October 2012, nearly 776,000 people were uprooted from their homes and the country was once again reminded that a disaster could devastate large swaths of a major metropolitan area, paralyzing essential services and leaving millions without electricity, transportation, homes and jobs. The hard-learned lessons of Hurricane Katrina, seven years earlier, have led to many improvements in emergency management. But many gaps remain in U.S. emergency planning and preparedness. After Katrina, mothers and children with the fewest resources often faced the most daunting challenges. This is likely to be true for future disasters as well. While the conditions facing mothers and children in a country like the United States are very different from those in the other country case studies, there are common challenges, including the resilience of health care and other essential services, and the extent to which humanitarian response reaches those mothers and children in greatest need. (*To read more, turn to pages 53-57.*)

Meeting the health and survival needs of mothers, newborns and children in humanitarian crises is challenging, but solutions do exist. In many fragile and conflict-affected countries, important progress has been made in improving care during pregnancy and childbirth. For example, Pakistan and Burkina Faso increased the proportion of births attended by a skilled health worker by 20 percent between 2000 and 2008. These improvements included communities affected by violence and conflict. However, among the dozens of fragile and conflict-affected states, Nepal is the only country to have already reached the Millennium Development Goal to reduce maternal mortality by three-quarters since 1990. Other fragile and conflict-affected states – including Afghanistan, Angola, Eritrea, Timor-Leste and Yemen – are on track to meet the MDG on maternal health, provided their current rate of progress continues.[18] In almost all fragile states, progress in saving babies less than a month old remains too slow.

The humanitarian community has been working to make maternal and child health and nutrition services a priority in emergency response. The *Minimum Initial Service Package (MISP) for Reproductive Health*, developed and used worldwide by governments and NGOs, recommends a set of priority interventions for the care of mothers and newborns in emergencies. These include providing kits to facilitate clean and safe deliveries and establishing referral systems to manage obstetric emergencies. The lifesaving potential of optimal infant and young child feeding, which is concerned with interventions to protect, promote and support safe and appropriate feeding practices for infants and young children in all emergencies, has also gained momentum globally over the last decades. Policy guidance and training materials were gathered in the *Operational Guidance on Infant and Young Child Feeding*

in Emergencies (IYCF-E) and endorsed by the World Health Assembly in 2010. The forthcoming *Every Newborn Action Plan*, to be considered for approval by the World Health Assembly in mid-May 2014, recognizes the need for special attention to emergency settings and context-specific actions for improving care at birth and care for small and sick newborns. As this report documents, there are many challenges for every country in protecting mothers and children in humanitarian crises, but these challenges increase significantly in fragile regions and states that lack resilience to emergencies and face chronic underlying challenges, including weak and unresponsive governance. Of the 10 countries at the bottom of this year's *Mothers' Index*, all are so-called fragile states.

Increasingly, mothers and children facing the greatest risks are geographically concentrated in key regions of the world. In 1990, West and Central Africa accounted for 16 percent of child deaths worldwide. Now, almost a third of the global toll of child deaths are found in that sub-region in countries with weak states and complex development challenges. Nigeria and DR Congo alone account for 20 percent of all child deaths worldwide. Approximately one third of child deaths now occur in South Asia, with high mortality rates increasingly concentrated in socially excluded communities and in *de facto* fragile contexts such as the Indian states of Bihar and Orissa and in Pakistan's Khyber Pakhtunkhwa province.

The conclusion is obvious. Besides addressing the need for every country to be better prepared to assist mothers and children in emergencies, we also must begin the difficult but urgent task of working to provide stability in the most fragile regions of the world, and identifying ways of building better access to health care in these contexts. Ending preventable deaths of mothers and children will not be possible until such countries become more stable and health care more accessible.

2014 Mothers' Index Rankings

Top 10		Bottom 10	
RANK	COUNTRY	RANK	COUNTRY
1	Finland	**169**	Côte d'Ivoire
2	Norway	**170**	Chad
3	Sweden	**171**	Nigeria
4	Iceland	**172**	Sierra Leone
5	Netherlands	**173**	Central African Republic
6	Denmark	**174**	Guinea-Bissau
7	Spain	**175***	Mali
8	Germany	**175***	Niger
9*	Australia	**177**	DR Congo
9*	Belgium	**178**	Somalia

* Countries are tied

Save the Children's 15th annual *Mothers' Index* assesses the well-being of mothers and children in 178 countries – more than in any previous year. Finland, Norway and Sweden top the rankings this year. The top 10 countries, in general, attain very high scores for mothers' and children's health, educational, economic and political status. The United States ranks 31st. Somalia scores last among the countries surveyed. The 10 bottom-ranked countries – all but one of them from West and Central Africa – are a reverse image of the top 10, performing poorly on all indicators. Conditions for mothers and their children in the bottom countries are grim. On average, 1 woman in 27 dies from pregnancy-related causes and 1 child in 7 dies before his or her fifth birthday.

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 role that armed conflict, poor governance and natural disasters play in these tragedies. All the bottom 10 countries have a recent history of armed conflict and are considered to be fragile states, which means they are failing in fundamental ways to perform functions necessary to meet their citizens' basic needs and expectations. Six of the bottom 10 countries suffer from recurring natural disasters.

See the *Complete Mothers' Index, Country Rankings* and an explanation of the methodology, beginning on page 71.

Recommendations

National governments, donor countries, international agencies, the private sector and civil society have a shared responsibility to ensure that mothers and children living in crisis-affected contexts have the best chance to survive and lead healthy lives. Doing so will require putting them at the center of national and international processes and ensuring that the necessary investments are made in their resilience, health and protection. Together we need to:

1. Ensure that every mother and newborn living in crisis has access to high quality health care: This is particularly important when mortality risk is highest – during labor, childbirth and the first week of life – as expressed in the *Every Newborn Action Plan*. National and international actors need to ensure the provision of access to quality health care for crisis-affected communities, with special attention to the particular needs of mothers and newborns. This includes eliminating any financial obstacles to accessing care and supporting an adequate number of trained and resourced frontline health workers. Governments and major donors need to support health systems, including by investing in and maintaining health infrastructure. In emergencies, humanitarians need to design health and nutrition interventions in ways that support longer term health care, and parties to conflict need to abide by the obligation not to attack health workers or health facilities.

2. Invest in women and girls and ensure their protection: Investments in women's economic and income-generating activities and in girls' education have been proven to reap positive results for maternal and newborn health and to offer protection from the harm that can result from early marriage and gender-based or sexual violence. Increasing women's and girls' access to and control over assets and resources, supporting education throughout crises, and developing gender-based violence prevention strategies have the added benefit of boosting maternal and newborn health.

3. Build longer term resilience to minimize the damaging effects of crises on health. Promoting community-based preparedness, early action, social protection, and disaster risk reduction – in particular targeting the most vulnerable, which includes mothers and newborns – can help ensure that mothers are not limited in their ability to protect and provide for their children and that local needs are met when a crisis hits.

4. Design emergency interventions with a longer term view and the specific needs of mothers and newborns in mind. This includes making reproductive health care a priority in emergency response alongside programs that include attention to the specialized needs of pregnant women and newborns to protect their health and survival, especially by providing quality care around the time of birth and special care for small and sick newborns. This also includes prioritizing a policy and response environment that protects, promotes and supports optimal infant and young child feeding, including breastfeeding.

5. Ensure political engagement and adequate financing, coordination and research around maternal and newborn health in crisis settings. Donors need to increase long-term, predictable aid for health to fragile states through funding mechanisms that are flexible and able to respond to different and changing contexts. Both the post-2015 development agenda and the 2016 World Humanitarian Summit present opportunities to discuss the unique challenges of crisis-affected states and how to ensure they are addressed in ways that can promote maternal and child survival. More immediately, the international community has the unprecedented opportunity to tackle newborn mortality and preventable stillbirths by supporting the *Every Newborn Action Plan* and the actions it will set out in May 2014 to meet ambitious targets to reduce newborn mortality and eliminate preventable stillbirths during labor.

(*To read this report's full set of recommendations, turn to pages 59-63.*)

India

Pakistan

Saving Mothers and Children in Humanitarian Crises

In a humanitarian crisis, mothers must overcome immense obstacles to provide care and safety for their children, while their own vulnerability to poverty, malnutrition, sexual violence, unplanned pregnancy and unassisted childbirth greatly increases. Humanitarian crises exacerbate economic and gender inequalities, making a bad situation even worse for the poorest mothers and their children.

The impacts of humanitarian crises on maternal and child survival vary, depending on the nature of the crisis. In armed conflict, homes, clinics and hospitals can come under attack, with health workers often fleeing or permanently migrating, food and medical supplies can be cut off, and lawlessness can become the norm. Typhoons, earthquakes and floods can destroy both communities and health infrastructure, causing families to lose everything while increasing the risk of diseases like cholera and diarrhea. A child's survival in such emergencies often depends on the strength and resourcefulness of the mother. Mothers often must take the lead in finding ways for a family to start over and rebuild, while helping their children to stay on track toward a better future.

But mothers cannot do all this alone.

Armed conflicts are now being waged in more than 20 countries around the world,[19] directly affecting over 170 million people,[20] and the majority of those who are injured, displaced, traumatized and killed are often mothers and children.[21] The majority of these conflict-affected countries are also fragile states,[22] meaning they have weak institutional capacity, poor governance and an unstable political environment.

People in fragile and conflict-affected situations are more than twice as likely to be undernourished as those in other developing countries, more than three times as likely to be unable to send their children to school, twice as likely to see their children die before age 5, and more than twice as likely to lack clean

Millennium Development Goals

The Millennium Development Goals (MDGs) are eight globally agreed upon targets to reduce extreme poverty and promote peace, human rights and security. The target for MDG 4 is to reduce the world's under-5 mortality rate by two-thirds between 1990 and 2015. The target for MDG 5 is to reduce the maternal mortality ratio by three-quarters over the same period.

Substantial progress has been made in reducing child mortality (down 47 percent from 1990 to 2012), but more rapid progress is needed to meet the 2015 target.[23] Increasingly, child deaths are concentrated in the poorest regions, and in the first month of life. Maternal mortality has also declined by 47 percent since 1990, but this too falls short of the target.[24] Seventy-five priority countries have been identified, which together account for more than 95 percent of all maternal, newborn and child deaths each year. These are known as the "Countdown" countries. With the 2015 deadline fast approaching, only 31 countries are on track to achieve the child survival goal[25] and far fewer – only 9 (of the 74 countries with available data) – are on track to achieve the maternal survival goal.[26]

Fragile and conflict-affected states are the countries most challenged in meeting the MDGs. Most of the MDG targets in fragile states will not be met,[27] and the 10 countries at the bottom of our *Mothers' Index* are all defined as conflict-affected or fragile. A growing share of child mortality is concentrated in West and Central Africa, which now accounts for almost a third of child deaths, up from 16 percent of the global total in 1990.[28] However, there are some signs of progress, with crisis-affected countries such as Afghanistan making significant progress towards the child survival MDG target, and post-conflict countries such as Nepal and Mozambique on track to achieve the goal. By May 2013, at least 20 fragile and conflict-affected states had met one or more targets and an additional six were on track to do so by the deadline of 2015.[29]

While it will be a challenge to meet MDGs 4 and 5, as well as other remaining goals, success is still possible – but only if governments do not waiver from commitments they made over a decade ago and updated as part of the *Every Woman Every Child* movement. Consolidating existing gains and building momentum beyond 2015 will depend on countries investing in health care systems that maximize long-term resiliency and guarantee essential services for all children and their families. Health outcomes depend on more than just health care, but without strong, fully functioning health systems as a platform for progress, meeting the major challenges of maternal and child survival will be impossible to achieve.

water.[30] Poor health and nutrition in these countries are in themselves a cause of fragility. But fragile states' inability to deliver effective social services is also a cause of poor health outcomes.

Many fragile and conflict-affected states are also vulnerable to disasters triggered by natural hazards, which exacerbate underlying, chronic development challenges. The poorest families suffer most, increasing inequity and trapping people in extreme poverty. In places where governance is weak and resources are scarce, women and small children are at a disadvantage competing for limited food, shelter and medical care. The breakdown of law and order that often accompanies an emergency increases the risk that women and children will experience sexual exploitation and violence.

In this report, we use the terms "humanitarian crisis," "crisis setting" and "protracted crisis" to refer to conditions created by armed conflict, fragility and major natural disasters. When a condition is more likely to occur in a specific type of setting, we use specific terms.

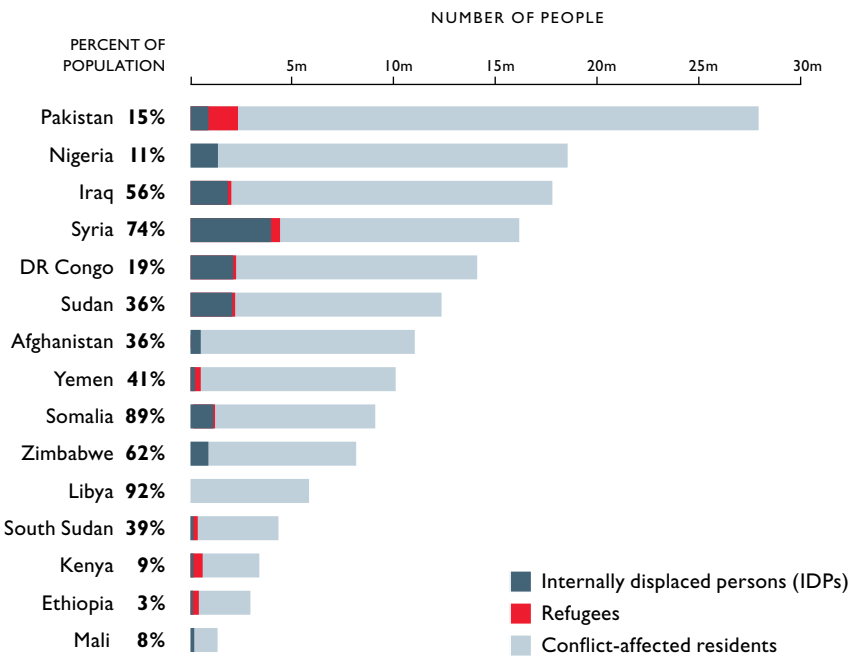
Childbirth in a crisis

More than half (59 percent) of maternal deaths worldwide occur in fragile states, many of them affected by conflict and recurring natural disasters.[31] Women die because they give birth without a skilled health provider to assist them, because they lack access to emergency obstetric services, because they cannot travel to a health facility,[32] or because service is delayed or unavailable once they reach the facility. In short, because they didn't get the care they needed when they needed it.

Women fleeing conflict may have to give birth on the run, without even the most basic items for a clean delivery. Natural disasters can destroy medical facilities and displace health workers. Distress from both types of crisis can push women into premature labor.[33]

People Affected by Conflict

According to new research by the Centre for Research on the Epidemiology of Disasters (CRED), at least 172 million people worldwide were directly affected by conflict in 2012. The overwhelming majority of them (87 percent) were residents of conflict zones rather than refugees or IDPs who fled from violence, insecurity and fear. Pakistan and Nigeria had the largest numbers of people affected by conflict – 28 million and 19 million respectively. Libya and Somalia had the largest proportions of their populations affected by violence and insecurity – around 90 percent each. Nearly three-quarters of Syrians were affected by conflict, a level almost certain to have risen since 2012.



Women who are experiencing complications of pregnancy or childbirth need emergency obstetric services to ensure their survival and the survival of their babies. The major causes of maternal death – hemorrhage, obstructed labor, infection and convulsions – are largely preventable and treatable, but in most fragile contexts, access to health services is uneven. Until recently, obstetric care was virtually nonexistent in refugee settings and a neglected part of humanitarian assistance.

Women who die in childbirth leave behind devastated families. Their babies usually do not survive[34] and those who do make it through infancy often do not live to age 5.[35] Older children, especially girls, may be forced to drop out of school to look after younger siblings, and all children who lose their mothers are more likely to be malnourished and impoverished.[36]

In many fragile and conflict-affected countries, important progress has been made in improving care during pregnancy and childbirth. For example, Pakistan and Burkina Faso increased the proportion of births attended by a skilled health worker by 20 percent between 2000 and 2008.[37]

The humanitarian community has also been working to make reproductive health care a priority in emergency response. *The Minimum Initial Service Package (MISP) for Reproductive Health* recommends a set of priority activities for the care of mothers and newborns in emergencies. These include providing kits to facilitate clean and safe deliveries and establishing referral systems to manage obstetric emergencies.[38]

"Earlier that night my wife was okay. She made dinner. After two hours the labor pains started. She gave birth to Safina at home, but the placenta was left in the womb. After two or three hours she told me she was in a lot of pain and that I needed to take her to the hospital. It was winter and snowing and we couldn't find a car. When we eventually found one, it got stuck. Hakima died in the car. She was 24. I will never forget that night. Safina was healthy when she was born but after six months she got pneumonia. We took her to the hospital and she was given some medicine but before it had finished, she died."

— **Hamidullah**, age 42
Afghanistan[44]

Risky first hours, days and weeks for a newborn

The first day of life is the most dangerous day anywhere.[39] But in a humanitarian crisis, the risks to newborn babies can multiply due to lack of skilled care, medicines and unsanitary conditions. There is too little data on newborn morbidity and mortality in crisis settings. However, it is well established that countries in conflict or experiencing other forms of instability have the most preventable newborn deaths.[40] Given the intrinsic vulnerability of newborns, the compromised quality of health care in developing countries in general, and lack of access in many fragile states and crisis settings, experts say newborn survival must be a higher priority, especially in those countries experiencing protracted crises.[41] The *Every Newborn Action Plan*, which is currently being developed by UNICEF and WHO, is one important opportunity to increase policy and budgetary support for newborn survival, including in crises.

Preterm babies – those born before 37 completed weeks of gestation – have the highest risks of complications and death. Complications of prematurity are currently the second leading cause of under-5 deaths and up to 80 percent of all newborn deaths occur among babies who are preterm, small for gestational age or both.[42] If not kept warm, fed and free from infection, these vulnerable babies can deteriorate rapidly and may die in a matter of hours. Kangaroo mother care is a simple practice that involves mothers keeping their babies warm through skin-to-skin contact. It promotes early and sustained breastfeeding, which helps build the baby's strength and resistance to disease. It is an ideal solution for preterm and low-birthweight babies, especially where high-tech treatments are impractical. In addition, a growing body of evidence shows kangaroo care can be more effective than incubator care for some preterm babies.[43]


Kenya

In very high mortality settings – such as those found in fragile states experiencing recurring emergencies – almost 50 percent of newborn deaths are due to severe infections such as sepsis, pneumonia, diarrhea and tetanus.[45] Babies born in high-risk settings are also more vulnerable to childbirth-related complications (known as "birth asphyxia") and stillbirth. More frontline health workers – and better training and equipping of existing health workers – are needed to prevent these deaths by providing skilled care at birth and emergency obstetric care. These services are also critical for saving mothers who suffer with obstructed labor or hemorrhage. In conflict settings, the country's existing health system must be supported – and not targeted – so it can keep essential services available.

As part of a growing movement to address the overlooked burden of newborn death and elevate newborn survival as a priority within humanitarian response, Save the Children and other organizations are working on a field guide for newborn health in humanitarian settings. The guide recommends that the design and implementation of emergency preparedness and response programs include attention to the specialized needs of pregnant women and newborns to protect their health and survival. It also describes ways to build long-term resilience into health systems so they are prepared to promote rapid recovery after crises occur.

The field guide recommends five solutions to save newborn lives in humanitarian settings: 1) distributing clean delivery and newborn care supplies to women who may not be able to deliver in a health facility; 2) providing quality services to the target population during pregnancy, childbirth and the postnatal period, and promoting essential newborn care; 3) providing medicines and supplies so that nurses, midwives and other health providers can help sick newborns; 4) supporting community health workers to identify pregnant women and newborns and link them to the health system; and 5) identifying and transferring sick newborns to the appropriate level of care via a functional referral system.[46] It is vital that humanitarian responses do not undermine or weaken the national health system.

The forthcoming *Every Newborn Action Plan* will focus additional attention on emergency settings and context-specific actions for improving care at birth and care of small and sick newborns.

Lifesaving benefits of breastfeeding

Infants and young children are especially vulnerable to malnutrition, illness and death during emergencies. Breast milk is the one safe and secure source of food for babies, providing active protection against illness and keeping infants warm and close to their mothers. Breastfeeding soon after birth also helps mothers by reducing the risk of post-partum hemorrhage, a leading cause of maternal mortality worldwide. But too often emergencies bring obstacles and disincentives to breastfeeding. Stress, misinformation, lack of privacy and lack of early, individual support can discourage mothers from breastfeeding and expose babies to increased risks from dirty water and inadequate nutrition.

When breast-milk substitutes are distributed where they are not needed, this can also harm breastfeeding practices and put mothers and children at risk. The

infant feeding industry may view emergencies as an "opportunity" to enter into or strengthen markets as a public relations exercise. Individuals and charities may donate breast-milk substitutes out of a genuine desire to help, and aid agencies may distribute donations without awareness of the increased risks to child health and survival. In emergencies, there is often no safe way to prepare breast-milk substitutes, with only poor quality water available. Donations are also often unsustainable and discontinued without proper planning for how to provide for mothers who may have decreased or discontinued breastfeeding. Although it is possible for mothers to re-lactate, this often takes several weeks, leaving the infant vulnerable.

During and immediately after the 2008 conflict in Gaza, there was an untargeted distribution of breast-milk substitutes and more than a quarter of mothers received infant formula, including mothers who were breastfeeding. Nearly half the mothers received other breast-milk substitutes and some received baby bottles. Roughly 50 percent of mothers reported they reduced their frequency of breastfeeding during this time.[47]

During the earthquake response in Indonesia in 2006, distribution of donated infant formula led to its increased use among previously breastfed infants. Diarrhea rates were twice as high among those who received donated infant formula compared to those who did not (25 percent vs. 12 percent).[48]

Distribution of breast-milk substitutes, if necessary, must be done in a carefully targeted way. Any donations of breast-milk substitutes and related products such as bottles and teats should be collected and stored until a designated coordinating agency, together with the government – if functional – develops a plan for their safe use or destruction.[49] If there is a need for breast-milk substitutes, it is usually far better to source them within the region to ensure labels are in the correct language.

During recent responses in Ethiopia, Haiti, Jordan, Philippines and South Sudan, humanitarian groups have set up mother-baby centers to encourage breastfeeding. These centers offer mothers a quiet, private, comfortable place to feed their babies, receive one-on-one counseling and participate in support groups dispelling myths associated with infant and young child feeding. Re-lactation counselors can also help mothers who have used formula to start breastfeeding again.

I believe in the power of breastfeeding, it can save our children and has been used throughout my family. It is natural and much better than formula, which can be dangerous if not mixed properly. Plus it's more difficult to access and costs money. I could spend that money on my children."

— **May-Joy**
Philippines[50]

Climate Change May Threaten Gains in Asia and Elsewhere

Many of the countries that have made the most progress on maternal and child survival are highly vulnerable to climate-related disasters. Bangladesh, China and Nepal have each reduced rates of child and maternal mortality by more than two-thirds since 1990, putting them "on track" to achieve Millennium Development Goals 4 and 5.[51] These three countries are also among the top 25 countries most affected by extreme weather in the last two decades, according the *Global Climate Risk Index 2014*.[52]

Bangladesh, China and Nepal have made great gains in saving women's and children's lives despite setbacks from repeated disasters. While the impact of climate change is difficult to predict and quantify, some experts in these countries worry their gains may not be sustainable if extreme weather events become more severe or more frequent.

"The threat of climate change can diminish the hard-earned beneficial impacts of years of growth and development, not just for the people in impoverished settlements along coastal belts and river banks, but for the entire nation," said Shamsul Alam, a member of Bangladesh's Planning Commission.[53]

Officials in Nepal have known how vulnerable their health facilities are to natural disasters since an assessment in 2001, but investments have been insufficient and most of the country's hospitals remain ill-prepared for a major emergency. Nepal's government recently told administrators to retrofit hospitals by strengthening beams, columns, slabs, load-bearing walls, braces and foundations within two years, or they would forfeit their licenses. It also issued a directive saying all health facilities must prepare disaster management plans and organize simulations. "The challenge is still enormous … and we have still a lot to prepare for," said Paban Sharma, director of Patan Hospital in the capital.[54]

Climate-related disasters may slow or even threaten to erode child survival gains in Guatemala, Honduras, Mongolia, Nicaragua and Thailand. Each of these countries will likely reach the MDG target for child survival, yet each is also among the ten countries that suffered most from extreme weather events between 1993 and 2012. Similarly, the Dominican Republic, Philippines and Vietnam also perform relatively well on MDG progress assessments yet are at risk of losing ground due to disasters.[55]

Surviving to age 5

We have been living on just one meal a day and it is not enough. Henri lost lots of weight and a few days ago he got very sick. He was vomiting and he wouldn't eat. He had bad diarrhea and his legs started to swell."

— **Adete**, age 16
mother of 1-year-old Henri,
Central African Republic[56]

More than half of the children who die before reaching the age of 5 live in fragile states[57] – a total of 3.7 million child deaths in 2013 – and the highest newborn and child mortality rates are found in countries currently or recently affected by conflict and insecurity. After the first month of life, the major causes of death in these settings are largely preventable and treatable: pneumonia, diarrheal diseases, malaria and measles. But in fragile and conflict-affected states, these illnesses claim more children's lives because the health care that could save them is out of reach, too far away or too expensive for people who are already vulnerable through disease, malnutrition and poverty.

On average, conflict-affected countries employ less than half the health workers they need,[58] and many work long hours without the right equipment in dilapidated facilities. Lack of access to health care is an even bigger worry in crisis contexts where children are malnourished, which increases their vulnerability to disease. Securing health worker protection, and training hundreds of thousands more, are two of the surest ways to save lives.

Disparities in access to health care are particularly stark in fragile contexts, in rural areas, and in areas where violence and insecurity make access to health care difficult. Children in these places face the highest risk of death. In Nigeria, for example, child mortality in the poorest fifth of the population – which is concentrated in the insecure north of the country – is nearly 3 times higher than in the richest quintile.[59] Closing disparities in life chances has a critical role to play in accelerating progress towards the Millennium Development Goals.

As well as being increasingly geographically concentrated in fragile contexts, under-5 mortality is more and more demographically concentrated in the newborn period, during the first 28 days of life. Further reductions in child and maternal mortality will hinge on increasing access – and improving the quality of care – around the time of birth, particularly among the poorest families who often lack access to quality health care during pregnancy, childbirth and the

Attacks on Health Workers

In some of the world's most fragile countries, health workers dedicated to saving lives are being attacked by those fighting to secure territory, resources and power. Often working in remote and dangerous areas to ensure health care reaches isolated communities, health workers' essential medicines and equipment make them easy targets for robbery and ambush. By refusing to discriminate between the patients they treat, some health workers are accused of – and punished for – being traitors.

There is little reliable data about attacks on health workers, but the UN Human Rights Council's rapporteur on the right to health has noted "intimidation, threats, kidnapping and killings, as well as arrests and prosecutions, are increasingly used as a strategy in conflict situations."[60] Groups such as Physicians for Human Rights believe health workers are in more danger now than in the past and the intensity of attacks has increased.[61]

One study found that in 2012, there were 921 violent incidents affecting health care during armed conflict and other emergencies in 22 countries.[62]

In 2013, many health workers administering polio vaccines to children were killed in Nigeria and Pakistan. Hundreds of health workers were killed in Syria. In Colombia, more than 70 violent incidents against health services were recorded, and in Afghanistan the number of security incidents was over 100.[63]

The militants were against family planning, saying women must stay at home. As a lady health visitor, I was suspected of providing family planning and therefore at risk. During the militant regime, I could not reach women, I couldn't meet my patients. If someone knew what my job was, they would have cut me to pieces."

— **Female health worker**
Pakistan[64]

newborn period. Extending maternal and newborn health services to excluded populations could yield tremendous lifesaving results. For example, if all newborn babies in Pakistan experienced the same survival rates as newborns from the richest 20 percent of the population, 48,000 more babies would survive each year.[65]

Hunger and malnutrition

Malnutrition is an underlying cause in 3.1 million child deaths each year[66] – or 45 percent of the global total – with rates of both chronic malnutrition (which causes irreversible stunting in children) and severe and acute malnutrition (which causes wasting) especially high in fragile and conflict-affected settings. For example, the five countries that have made the least progress in reducing stunting since 1990 – Côte d'Ivoire, Burundi, Afghanistan, Niger and Yemen – all have a recent history of conflict,[67] while conflict-affected populations in Djibouti, Kenya, Somalia, South Sudan and Sudan all have acute malnutrition rates at or above 15 percent (the emergency threshold).[68] Malnutrition among mothers is also a major factor in birth complications, birth weight and the health of newborn babies, who depend on breastfeeding for a healthy start in life. Yet in many parts of the developing world, women and girls are more likely to go hungry than men and boys, reinforcing an inter-generational cycle of vulnerability and deprivation.

Conditions that cause malnutrition and exacerbate gender inequality are heightened when a disaster or conflict throws families into crisis. If disasters such as prolonged drought, conflict or flooding destroy crops, cause food prices to skyrocket, disrupt food markets or force people to flee their homes and livelihoods, women and girls often find themselves at a disadvantage competing for scarce food.[69]

In the Maradi region of Niger, rates of divorce increase during food crises as heads of families see this as a way of having fewer mouths to feed.[70] In other places, food insecurity contributes to early marriages as families give away their daughters so they don't have to feed them.[71] If husbands and young men leave to find work elsewhere, mothers are left behind to lead the family and care for young children on their own.

Many children are born small because their mothers are undernourished. These small babies face a substantially increased risk of death and stunting by 2 years of age,[72] underscoring the critical importance of better nutrition for women and girls. Anemia – caused by poor diet and worsened by disease – is the most widespread nutritional problem affecting girls and women in developing countries, and its prevalence can increase during times of crisis.[73] Anemia is a significant cause of maternal mortality and can cause premature birth and low birth weight in babies. In the developing world, 40 percent of non-pregnant women and half (49 percent) of pregnant women are anemic.[74]

South Sudan

Improving nutrition is key to child and maternal survival, and to enabling people to fulfill their long-term potential. Tackling hunger and malnutrition is the smart thing to do, as well as the right thing. Better nutrition lowers costs to health care systems[75] and boosts economies, since well-nourished children are less prone to illness and are more likely to grow into productive adults.[76] Fortunately, we already know the solutions that work. First, in 2008 the *Lancet* identified 13 direct interventions – including vitamin A and zinc supplements, iodized salt, hand washing and exclusive breastfeeding – that together have the potential to prevent the deaths of almost 2 million children under the age of 5 if delivered to children in the 36 countries that account for 90 percent of malnutrition.

Secondly, social protection schemes – which provide families with regular cash transfers or food parcels – have the potential to tackle malnutrition, by boosting the ability of households to secure a nutritious diet. There is extensive experience of emergency food transfers, and more limited experience of cash transfers in humanitarian settings, but permanent social protection schemes have also been introduced with significant success in non-humanitarian contexts, with countries such as Brazil using them to substantially reduce child and maternal malnutrition.[77]

Finally, tackling malnutrition and reducing the risk of food-related emergencies depend on ensuring that the ways in which food is produced, processed, distributed and consumed better meet people's nutritional needs. Women in particular have a crucial role to play in defeating hunger and malnutrition. In developing countries, 79 percent of economically active women spend their working hours producing food through agriculture, and women are 43 percent of the farming workforce.[78] The Food and Agriculture Organization estimates that giving women farmers more resources could result in 100 to 150 million fewer hungry people in the world.[79] Research also shows that when women control increases in family income, the health and nutrition of children tend to improve.[80]


Nepal

DR Congo

Psychological and protection needs

Humanitarian emergencies can have a profound effect on mothers' and children's mental health. Abrupt life changes, family separation, worry about loved ones, and loss of community and family support are emotionally difficult for almost everyone caught up in a crisis. More serious psychological problems arise from torture, exploitation and sexual violence. Extreme feelings of fear, grief, guilt and anxiety usually cannot be treated by existing health service providers, who are often undergoing similar stress and trauma. Children are especially sensitive to the emotional states of their parents. When mothers and fathers are struggling to deal with their own stress, it can impair the ability of their traumatized children to process their own feelings.

Although much more needs to be done to understand and address the mental health needs of women and children in emergencies, humanitarian groups have pioneered approaches that are helping children and their families to cope with the upheaval of crisis and displacement. Psychosocial programs have helped adults and children in Afghanistan, Liberia, Philippines and other crisis-affected countries to cope with their traumas and return to normal family and everyday life. These programs usually do not seek to reopen and examine old wounds; instead they enhance the natural resiliency of children and the strength of the community by drawing upon traditional healing rituals.

Refugees and internally displaced persons are also at heightened risk of gender-based and sexual violence. The severity and frequency of these types of violence are compounded by the poverty, social instability and powerlessness that characterize crises, as well as the atmosphere of violence and impunity endemic to conflict settings. Rape may be used as weapon of war and a method of ethnic cleansing by forcing women and girls to bear children of different religions or ethnic groups. Women and girls may also be coerced into providing

> *I had heard about bandits raping women along the way, but I had to get to Dadaab. My children and I had gone to sleep hungry so many times, I just wanted to flee and get help…. My children just kept crying as these men raped me. I was too tired to fight back, and I let them do whatever they wanted to do. I walked around for so many miles without a cloth around my body until I got to some women in a group who gave me tattered clothes to wrap myself."*
>
> – **Fatima**, age 22
> Kenya[81]

sex to gain access to basic needs such as food, water and medicine. Women who survive may find themselves pregnant or infected with a sexually transmitted disease with limited access to care. Limited law enforcement in emergencies allows gender-based violence to take place without legal consequences for the perpetrators.

The prevalence of sexual violence against children in conflict settings is shocking. Save the Children's research and programming experience indicates that children under the age of 18 often make up the majority of victims of sexual violence in conflict-affected countries. In many of the places where Save the Children works – Afghanistan, Colombia, Côte d'Ivoire, Democratic Republic of the Congo, Jordan, Lebanon, Mali, Myanmar, the occupied Palestinian territory, Somalia, South Sudan and Syria – and in refugee camps, including those in Ethiopia and Kenya, thousands of girls and boys are subject to sexual violence.[82]

Experts say prevention of, and response to, sexual and gender-based violence should be part of a comprehensive agenda for improving reproductive health in crisis settings. Prevention strategies include: involving women in planning settlements and distributing resources, identifying at-risk individuals such as female-headed households and unaccompanied minors, educating community members to reduce social acceptance of gender-based violence, actively involving men in efforts to prevent gender-based violence, and developing a confidential reporting system. Response strategies include: emergency contraception to prevent pregnancy, prophylaxis treatment to minimize HIV transmission, counseling of victims, and referral for legal support.[83]

Yet efforts to tackle gender-based and sexual violence remain under-resourced. A recent study by CARE of donor aid to emergency appeals for 17 countries in crisis found only a tiny portion of international aid is directed towards projects that specifically target gender issues such as gender-based violence and sexual exploitation of women in humanitarian crises.[84] CARE's research in 2013 found that no donor country spent more than 5 percent of its emergency aid on targeted interventions to promote gender equality.[85] Measures to address these issues in post-conflict settings – as part of peace building and reconstruction efforts – remain similarly neglected. Recently, UN Secretary-General Ban Ki-moon set a target that the primary purpose of 15 percent of all projects established post-conflict should address women's specific needs, advance gender equality or empower women.[86]

To Reduce Disaster Risks, Educate Girls

Education of all children increases their capacity to participate socially, economically and politically, but the education of girls leads to specific benefits for the girls themselves, their families and communities. Many studies have shown that educating girls is one of the most effective investments a country can make to lift families out of poverty and build a better future. When educated girls grow up and become mothers, then tend to have fewer, healthier and better-educated children. Recent evidence suggests there is another powerful reason to educate girls – empowering women through improved education reduces vulnerability to death and injury from weather-related disasters.

"Countries that have focused on female education have suffered far fewer losses from droughts and floods than countries with lower levels of girls' education," says a World Bank report.[87] The report calculates the cost and makes the link between development and humanitarian provision, arguing that: "Educating young women may be one of the best climate change disaster prevention investments."

The analysis found a huge number of weather-related tragedies could have been prevented if more developing countries had female enrollment ratios matching the "best practice" country at their income level.[88] In a 30-year period (1970-1999), there would have been 61,500 fewer deaths during floods (40 percent fewer deaths); and in a 40-year period (1960-1999), there would have been 465 million fewer people affected by floods. The number of people affected by droughts would have been cut nearly in half, sparing 667 million people from possible drought-related poverty, food insecurity and ill-health.

"My message to the women in Congo, in the Sahel, everywhere is: send your girls to school. This is the best you can do for their future," said Kristalina Georgieva, the European Commissioner for International Cooperation, Humanitarian Aid and Crisis Response.[89]

Early marriage

Complications from pregnancy and childbirth are a leading cause of death for girls between the ages of 15 and 19 in many developing countries.[90] About 70,000 adolescents in developing countries die annually of maternal causes.[91] The youngest mothers – those aged 14 and under – face the greatest risks. Their bodies are often not physically mature enough to deliver a baby safely, so childbearing brings high risk of death or injury for both the young mother and her baby.[92] Girls who become pregnant before age 15 in low- and middle-income countries have double the risk of maternal death than older women (including older adolescents), especially in sub-Saharan Africa and South Asia.[93] Girls aged 15-19 years are also at additional risk compared to women aged 20-24 years.[94, 95]

A young mother's struggles are often passed down to her child, who starts life at a disadvantage. Children born to teen mothers are more likely to be delivered prematurely and at low birth weight than those born to women in their 20s. They are more likely to be stillborn and die in their first month of life, and are less likely to survive infancy. About 1 million children born to adolescent mothers each year do not make it to their first birthday. Infants who survive are less likely to receive adequate health care and nutritious foods. And they are more likely to be impoverished throughout life.[96, 97]


Ethiopia

Because most adolescent pregnancy in high-burden countries happens within marriage,[98] tackling child marriage is critical to reducing maternal and child mortality. Child marriage rates are often high in fragile contexts where laws on the age of marriage are weakly enforced and traditional norms often prevail. Most of the 25 countries with the highest rates of child marriage are considered fragile states or at high risk of natural disasters.[99] But child marriage can also increase during humanitarian emergencies as parents try to cope with crisis and protect their daughters as best they can.

Parents often marry off their young daughters as a survival strategy, to bring the family some income and to offer some sort of protection for the girl. But any gains that may come from these arrangements are accompanied by significant risks and disadvantages. If a girl is in school when she marries, she will usually drop out and end her education. Child brides often have less voice and influence in their new family setting than adult brides, including over issues that can be critical to maternal health, such as the timing and spacing of births and the use of contraception. Children born less than two years after a sibling are 2 times more likely to die within a year of birth than those born 3 years or more after a sibling.[100]

Strategies to prevent child marriage are not well-developed or widely implemented. Civil society organizations have had limited success with efforts that include gathering evidence, monitoring incidents, and organizing activities to empower girls and raise awareness among adults. But child marriage is not currently included in guidelines to prevent and respond to gender-based violence in emergencies,[101] and these strategies are not yet fully integrated into the humanitarian response plans of most aid groups.

> *"My father says I'm very beautiful. I'll bring him many cows when he marries me off. He says I shouldn't bother with education – just stay home and wait to be married. During last year's drought I had to drop out of school to tend my father's cattle. Sometimes I cried. I'm treated like an asset that can be disposed of at any time. Here in our village, most girls get married by age 14 to cushion their families from the effects of drought and poverty. If you're unmarried at 17, men start to shy away from you. They call you an old woman and then you may not get married at all."*
>
> — **Martha**, age 10
> South Sudan[102]

Family planning

Family planning helps save women's and children's lives – and preserves their health – by preventing untimely and unwanted pregnancies, reducing women's exposure to the health risks of childbirth and abortion, and giving women, who are often the sole caregivers, more time to care for their children and themselves.

Ethiopia

After having three days of labor pains, my mother-in-law took me to the hospital. I delivered a baby boy after heavy bleeding and the worst pain of my life. When my son was only 8 months old, I got pregnant again. I was very weak and I lost that baby. I didn't know it, but I was anemic. The doctor told me I should wait three years so I can rest and get healthy before I get pregnant again."

— **Sobia**, age 27
Pakistan[103]

A woman's ability to space and limit her pregnancies thus has a direct impact on broader global commitments, such as the Millennium Development Goals. Universal access to voluntary family planning has also been recognized by international agreements as a human right.[104]

Giving birth in many low-resource countries presents huge risks for both mother and child, but these risks are even greater during a humanitarian crisis. It is estimated that 1 in 5 women of reproductive age will be pregnant at any given time,[105] and 40 percent of these pregnancies will be unplanned.[106] In crisis contexts, access to family planning services is likely to be further undermined, and in places non-existent, as health services and supply chains are disrupted. Patriarchal attitudes and negative cultural norms can make it even more difficult for women to gain access to these services.

Many international humanitarian organizations responding to natural and man-made emergencies now include family planning materials in their emergency response toolkits. Save the Children has enhanced its focus on expanding access to family planning in emergencies and is now integrating these services as standard practice in all emergency health responses. In addition, Save the Children has partnered with UNFPA to ensure that the sexual and reproductive needs of adolescents are addressed in emergencies.

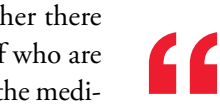
Equitable access to quality health care

When families are struggling to cope and survive, even very modest fees or other out-of-pocket expenditures cause them to delay, or fail to seek, basic health care. As a result, children may not receive health care that protects them against preventable diseases or treatment for common causes of childhood illness such as diarrhea, pneumonia and malaria. Pregnant women may give birth alone because they cannot afford a doctor or a midwife. Mothers may neglect their own health so they can buy food and medicines for their children.

Direct charges to users of health services discriminate against the poorest and most vulnerable who are least able to pay.[107] Unfortunately, unaffordable out-of-pocket payments for essential health care are most likely to be demanded in fragile and conflict-affected situations where public health systems are weak. The humanitarian principle of impartiality and the right to health should guide health systems everywhere whether in fragile contexts or emergencies, ensuring that primary health care is provided based on needs alone and affordable to all.[108]

People's utilization of health services depends not only on whether there is a fee, but also on whether they expect to find qualified health staff who are responsive, knowledgeable and friendly, and whether they can access the medicines prescribed for them. To be effective, removal of user fees in crisis settings should be accompanied by improvements in the quality of health services. This means increased drug supplies, better training and adequate salaries for health personnel, rebuilding of facilities, and support for management and supervision.

The total or partial removal of fees at public facilities must be carefully planned among the appropriate authorities, humanitarian agencies and donors, to ensure that alternative sources of revenue and additional resources are made available during a crisis so the net result is enhanced access to health services. Doing so will also contribute to the recovery of the health sector after the crisis has passed.[109]



I've given birth to six children. Three of these children died within a week of birth. They died because of lack of treatment. We can't go to a doctor because we can't afford it. Whenever a child is born and dies, we're overwhelmed with grief. It's terrible. I'm not the only one here who has lost children – there are many other mothers like me."

— **Shefali**
Habiganj District, Bangladesh[110]

Bangladesh

Tacloban, Philippines

Recurring Natural Disasters Test Philippines' Resiliency

On November 8, 2013, Typhoon Haiyan crashed into the east coast of the Philippines and swept through the central part of the island nation, causing extensive damage to life, housing, livelihoods and infrastructure across nine of the country's poorest regions.[1] The category 5 super typhoon was reportedly one of the largest and most destructive cyclones to ever hit land.[2]

Haiyan's giant waves, heavy rainfall, flash floods and landslides damaged 1.1 million homes[3] and devastated essential services in the hardest hit areas, leaving communities without sufficient access to health care, water and sanitation, and education.[4] According to official figures, 16 million people – over 16 percent of the country's population – were affected by the storm. Of these, 4.1 million were displaced, 6,293 were killed, 1,061 are still missing, and 28,689 were injured.[5] At least 10 million women and children were affected (72 percent of the affected population).[6]

The Philippines is among the world's most disaster-prone countries.[7] In recent decades, extreme weather events have increased, and experts predict this trend is likely to continue.[8] Haiyan was the third major typhoon to hit the Philippines in as many years. Typhoon Bopha was the deadliest disaster in the world in 2012, killing nearly 2,000, displacing close to 1 million and affecting more than 6 million people in Mindanao. Typhoon Washi in 2011 killed more than 1,400 and displaced 430,000 in northern Mindanao.[9, 10]

The Philippines, a middle-income country with a growing economy, has made good progress on maternal and child survival in recent decades. The country is considered to be "on track" to reach MDG 4 (with a child mortality ratio of 30 deaths per 1,000 births)[11] and "making progress" on MDG 5 (with a maternal mortality rate of 99 deaths per 100,000 births).[12] However, there are considerable inequities in health care access and outcomes between socio-economic groups, and a major driver of inequity has been the high cost of health care.

In 2010, the Philippines launched a major reform effort aimed at achieving universal coverage, increasing the number of poor families enrolled in national health insurance, providing more comprehensive benefits, and reducing or eliminating co-payments.[13] Officially, PhilHealth (the national insurance program) now has enrolled 83 percent of the population, although the covered rate (those who are actually able to go to a hospital) is estimated to be less than 75 percent.[14]

The increasing frequency and severity of disasters in recent years has led some to question whether the Philippines will be able to hold on to its MDG gains. Health experts on the ground say it is still too early to draw conclusions. So far, any short-term, localized spikes in child and maternal mortality resulting from disasters have not been severe enough to erode long-term national progress. The robust efforts of the Philippines government and the humanitarian community have by and large succeeded in preventing a full-blown humanitarian crisis after Haiyan.[15] The Philippines also has been steadily improving its disaster preparedness and ability to protect its people. But health officials do worry what might happen if typhoons the size of Haiyan and Bopha continue to pound their country. It may become increasingly challenging to keep rebuilding the health infrastructure.[16]

> *"Hours after Haiyan hit, I was called to help a young woman who was giving birth at home. She was 18 and it was her first baby. I was afraid to go. It was dark, the water was rushing in and strong lightening was crashing. The road was not passable and there was debris everywhere, but it was a call of duty. When I got there, the house was severely damaged and unsanitary. It was flooded, everything was soaked in water and the woman was unstable. The wind was howling and she was screaming every time she had a contraction. I was afraid there would be complications during the delivery. Referral to a hospital was not an option. It was a life or death situation. The woman said 'Ate Irene, I am so afraid.' I told her 'I am here helping you. Don't be afraid.' It was very high risk, but we handled it. She delivered a healthy baby boy and there were no complications."*
>
> — **Irene Cornista**, midwife[17]

Tacloban, Philippines

A lot has changed. Before I was focused on my outpatient consultations and at present I am more into signing of death certificates. It breaks my heart. Access to health care services – particularly in reproductive health – is temporarily paralyzed due to the severe destruction of typhoon Haiyan."

— Dr. Arlene Santo
Tanauan[18]

Damage to the health system

Haiyan – known locally as Yolanda – devastated thousands of hospitals and health clinics in nine provinces of the Philippines. The Department of Health estimated that 82 percent of the health facilities in the affected areas were damaged, and as a result 1.1 million people, including 163,000 children under 5, suffered from sub-optimal primary health services due to non-functioning health facilities.[19] Assessments found more than 2,250 health facilities were damaged or destroyed.[20] Hundreds of these facilities may have been barangay (village) health stations, which provide primary health and childbirth services to people in smaller communities.[21]

While it is not known how many health workers were killed or injured in typhoon Haiyan, up to 50 percent were not reporting for duty in the weeks following the storm in the severely affected areas of Leyte and Eastern Samar.[22] Many of those who survived had lost homes and loved ones and were in need of psychosocial support.[23]

"Part way through the storm one of the midwives received a call telling her that her own family's home had been completely blown away," said Dr. Greg Rolan Sumile in Estancia. "She was so upset and distracted that I told her she needed to leave to find her loved ones and look after them. We lost many staff in this manner. At the end, there were only four of us left."[24]

Despite these challenges, many health facilities were still able to function and deliver essential health care services under tarpaulins and tents.[25] Local and foreign medical teams that were deployed to the affected areas also helped keep health services available in the weeks immediately following the typhoon.

Not surprisingly, many facilities reported increases in client loads and difficulty treating all who needed help.[26] "We are seeing many more patients now than we did before the typhoon," said Judith Dalton, a nurse in Estancia. "We are coping with this by working longer hours and doing things we're not used to doing."[27]

Most of the emergency medical teams have left now, and the Philippines' health system still has not fully recovered. "The nurses look physically and emotionally exhausted," said Krista Zimmerman, a Save the Children staff member.

"The emergency has clearly taken a toll on their health and well-being. Many caregivers are in need of care themselves."

Damage to health records and computer systems is also likely to have long-term negative consequences. Many municipality registers and databases were destroyed or damaged during the storm surge, which not only makes it difficult to know just how many maternal, newborn and child deaths there were in the first days and weeks after Haiyan, but also makes it difficult to return to business as usual (for example, to ensure children get routine vaccinations).

Childbirth in a disaster zone

At the time of the typhoon, 250,000 women in affected areas were pregnant and almost 70,000 were expected to deliver in the first quarter of 2014.[28] That was more than 750 births per day expected in affected areas, with more than 100 births a day likely to involve a potentially life-threatening complication.

Before the typhoon, up to 70-80 percent of women in the areas most affected delivered their babies in health facilities[29] – this percentage is believed to have dropped considerably. Many maternity clinics were totally destroyed or heavily damaged in Eastern Visayas, limiting access to safe childbirth and placing both mothers and babies at high risk of death or injury.[30] One assessment of 52 reproductive health facilities found more than half reported severe structural damage to their buildings. A month after Haiyan, 16 of the 37 facilities (43 percent) in Eastern Visayas still had no electricity and 10 (27 percent) had no access to clean water.[31]

Midwives and doctors in Tacloban interviewed for this report said more women are giving birth at home without skilled attendance, especially those living in remote areas. "I have observed that there are mothers who are not getting enough emergency obstetric care due to the far distance of the health center and difficulty of transportation," said a midwife in San Dionisio.[32]

Midwives also describe delivering babies under very difficult conditions. In Tacloban, they said basic supplies and equipment were lacking (including a delivery table), and delivery rooms were damaged. The birthing clinic in San Dionisio had broken windows, a damaged roof and was flooded. A clinic in Concepcion was also flooded. In Carles, a midwife reported there was simply "no space for the mother's delivery." In all areas, birth attendants described assisting deliveries without electricity, using flashlights and candles to see in the dark. A doctor in Tacloban describing one especially tough delivery said "chaos made it so difficult." Lack of privacy was also cited as a challenge by midwives and doctors in Tacloban.[33]

Three months after Typhoon Haiyan, health services in many areas still had not been restored. Analyn, 18, had to give birth by the side of the road because she and her husband could not make it to a clinic in time. Fortunately, a stranger ran and got midwife Norina Malate, who delivered the baby boy safely.

> *"Having labor pains and giving birth in the middle of a natural disaster is the most challenging thing I've ever done in my life. I was so worried that I would deliver the baby in the evacuation center where there were no professionals to take care of me. My blood pressure was extremely high. One of the doctors told my husband that the baby's life and my life were both in danger."*
>
> — **Lolita**, age 34
> Tacloban[34]

A doctor from Médecins Sans Frontières who spent two months running an inflatable hospital in Tacloban says her team "saw many cases of pre-eclampsia – high blood pressure in pregnancy – which can be very dangerous. Under usual circumstances, rates of pre-eclampsia are high in the Philippines, but the stress of the typhoon seemed to have made them even higher."[35] A midwife in Pontevedra noticed something similar, telling Save the Children "there were increased cases of hypertension" in mothers.

Philippine midwives say many mothers were in a distressed emotional state when they gave birth. Recalling recent births they had assisted, midwives described the mothers as "afraid and ashamed," "stressed and fearful," "scared and nervous," "worried about her family left at home," in a "state of panic," and "depressed, confused and sad." A midwife in Pontevedra said mothers "are afraid because some of them cannot be sure when a typhoon will strike again." One midwife in Palo, near Tacloban, recalled a mother saying *"Makapoy la pirmi"* ("I am always tired").[36]

Newborn care compromised

Having a newborn in the wake of a typhoon is difficult. I worry a lot that she will get sick because the hospitals and health centers are overcrowded and inaccessible. I need to be strong not only for myself but for my family."

— **Lolita**, age 34
Tacloban[45]

In the Philippines as a whole, an increasing percentage of under-5 deaths are occurring among newborn babies in the first month of life.[37] These mostly preventable deaths are likely to have risen in number following Typhoon Haiyan.

Reliable statistics are not available, but various reports suggest lack of essential newborn care had deadly consequences in the days and weeks following the storm. An early assessment of 110 health facilities across 22 municipalities in Eastern and Western Samar and Eastern Leyte showed that only 7 percent were able to provide a clean and safe delivery, leaving both mothers and newborns at risk of infection. Newborn resuscitation for babies needing help to breathe was available at only 4 percent of health facilities.[38] The situation likely improved with the arrival of medical teams, clean delivery kits and newborn care items, but a month after the typhoon an observer in Eastern Samar noted "few of the medical teams that have come to the area are focusing on safe deliveries and only a handful of facilities can provide emergency surgery." This was especially troubling, as 75 percent of pregnant women were reportedly at high risk in at least one area of Eastern Samar.[39]

At a medical center in Eastern Visayas, several babies died from conditions that are normally treatable, such as hypothermia and hypoglycemia, often because nurses were unable to examine newborns properly at night because there was no power for lights.[40] In Concepcion, a midwife told Save the Children two newborn babies died because of severe hypothermia and prematurity.[41] A newborn also died in Central Visayas "due to lack of facilities that would attend to his condition."[42]

Four months after the typhoon, only half of affected communities had seen their health centers reopen.[43] Challenges in delivering critical childbirth and newborn care services were especially great in Tacloban and Leyte.[44]

Breastfeeding challenges

Prior to the typhoon, most mothers in affected areas breastfed their babies, and it appears there was widespread awareness about the benefits of early and exclusive breastfeeding.[46] After the typhoon, a variety of factors may have led to decreases in breastfeeding, putting infants at higher risk of disease and death.

A few weeks after the storm, some new mothers said they were not able to breastfeed as much as before due to stress brought on by the typhoon.[47]

I am worried about my twins' health. For a month I tried to breastfeed them but there was no breast milk coming out so I decided to stop. It was hard when the twins got sick after the typhoon. I wanted to give them the milk they needed. We were short of money and our problems were compounded by my difficulties in breastfeeding."

— **Mernita**, 33, Tacloban[48]

An early assessment found a decrease in breastfeeding was the number one concern related to infant and young child feeding reported at the village level, with 21 percent of communities reporting problems with insufficient breastfeeding.[49] Save the Children staff also noticed a significant number of mothers choosing to use formula rather than breast milk following the typhoon.[50] And although evidence is inconclusive, findings from a March 2014 survey suggest fewer infants in typhoon-affected areas are being breastfed (at all or exclusively) compared to regional averages before the typhoon.[51]

While lack of knowledge is one factor preventing mothers from breastfeeding, some believe poverty may play a larger role. "Livelihoods really need to take precedence for many of the families that were impacted by Typhoon Yolanda," said Cathey Delos Santos, a social welfare development officer for the municipality of Estancia. "They have nothing, and no way to earn an income, and that is first and foremost on their minds." Many mothers who have stopped breastfeeding say it is because they don't have milk anymore but many of them simply need more education about techniques that would help them keep producing milk, Delos Santos explained. Many mothers are also going to Manila (the capital city) to work, and this affects the care and feeding their children receive. "Without a source of income, families will not feel able to invest in nutrition and maternal/child health."[52]

In mid-December 2013, numerous communities reported there had been distributions of dried milk powder and infant formula (up to 28 percent of coastal areas of Eastern Visayas received donated milk powder).[53] Untargeted distribution of breast milk substitutes (BMS) can discourage new mothers from breastfeeding, undermine good breastfeeding practices, and exacerbate the risk of illness and malnutrition among infants and young children.[54] Despite early concerns and reports from the field, BMS distributions appear to have occurred on a relatively small scale. Hospitals and medical facilities, for example, maintained their strict policy against BMS distribution following Haiyan.[55]

In times of emergency, it's a big hassle to feed by bottle. You have to bring supplies, have a bottle and find clean water and a way to clean the bottle. Breastfeeding is so much simpler."

— **Abigail**, age 25
Bayas Island[56]

Staying Strong After Typhoon Haiyan

When Typhoon Haiyan hit her town, Jacqueline and her children found themselves homeless with no clothes, water or food to eat. "During the storm, I cried because my child was hit by a tree branch. I thought he was dead," she said. "There was nothing left to salvage from our house. My children went hungry and cold."

But Jacqueline, 33, refused to let her children down. She collected pieces of wood to provide a temporary roof. "I was determined because it was hard for me to see my four children suffer. I asked for wood, nails and bamboo trunks from different people. Despite the continuous rain after the storm, I was up on the roof, rebuilding. I did all this in just two days."

Upon receiving cash and carpentry training from Save the Children, she rebuilt their temporary home and made it a stronger, safer haven for her children. "I advise other women to stay strong for the sake of their children, not to panic. I am happy to have graduated from the carpentry training and would be more than willing to share what I know with other women."[57]

Threats to child survival

Prior to the typhoon, many young children in affected areas were already poorly nourished and vulnerable to disease. An estimated 5 to 11 percent were acutely malnourished; 9 to 30 percent had not been vaccinated for measles and other diseases; and 40 to 50 percent of children sick with diarrhea and pneumonia were not being treated.[58] Eastern Visayas, for example, had one of the highest rates of under-5 mortality in the Philippines, ranked below the national average in immunization coverage and had some of the worst health outcomes, including a higher than average incidence of diarrhea and fever among children.[59] The typhoon's damage to household incomes and the health system has certainly made matters worse for these children and put more at risk of death.

The assessment of 110 health facilities in Eastern and Western Samar and Eastern Leyte found most health facilities lacked lifesaving drugs and equipment. Immunization was only possible at 24 percent of facilities; management of child illness was estimated at 18 percent and treatment for acute malnutrition at 5 percent. More than 80 percent of facilities needed oral rehydration solution to treat diarrhea and 71 percent did not have enough antibiotics to treat pneumonia.[60]

Two months after the typhoon, the Department of Health had documented over 4,000 cases of acute watery diarrhea, half of which were reported among children younger than 5.[61] In focus group discussions, pregnant and lactating women across the affected areas reported that both children and adults were experiencing diarrhea because of unsafe water.[62]

Cases of pneumonia also increased after the typhoon, especially among children under 5 and the elderly. This was attributed to inadequate shelter and food,[63] as well as exhaustion, allergies and exposure to the elements.[64] A recent survey found 37 percent of children 6-59 months in affected areas had suffered from an acute respiratory infection in the previous two weeks.[65]

Research on the historic impact of typhoons in the Philippines (1979-2008) suggests almost 15 times as many infants may die in 2014 due to conditions that deteriorate in the wake of Haiyan than were killed outright by the storm itself. Depressed incomes will leave families with less to spend on health care, education and nutritious food. In past typhoons, most of the increase in deaths occurred among female infants. More males than females die in the womb immediately after typhoons, as is well established. After being born, however, a baby girl's risk of dying is higher even if she has no siblings, but it doubles if she has one or more older sisters, and quadruples if she has brothers, according to the study.[66] This suggests gender-specific competition for resources and could add thousands more to Haiyan's death toll, most of them baby girls.[67]

> *When the typhoon had passed and the storm surge was over, we took Erold directly to the hospital. We were turned away from the first hospital because it had suffered damage and didn't have any medicine. He had a fever and diarrhea and his lungs were filled with water. Three days after the typhoon, we came here. It's a terrible environment for a child. Erold falls sick a lot more than he did before. He used to be a happy baby, always smiling. But since the typhoon I've noticed that he's become more irritable and sensitive. The change was immediate."*
>
> — **Elaine**, age 22
> Tacloban[68]

Children want help to recover and prepare for the next emergency

Save the Children and other NGOs consulted 174 children and young people to learn what was most important to them after surviving Typhoon Haiyan. The children overwhelmingly said they want to play a role in planning for future emergencies and they want to be better prepared for the next disaster.

Older children said they want to take classes that teach life skills like how to build shelters, the science of the environment, and fishing. They want more friendly spaces for children to share feelings and put their minds at ease. And they want adults and the authorities to talk to them about exactly what is going on when a disaster strikes.

Fifteen-year-old Sofia from Estancia said: "We need help to rebuild and to rise from this disaster. We need education so that we are ready for when disasters come to our country. We don't just want money and gifts. We need you to help us stand again on our own feet."

When asked what they want to be prioritized in the coming months, one girl said: "More sanitary towels for girls in school kits; this will make it easier to go to child-friendly spaces, as it is embarrassing when you don't have them."

Another girl said: "The girls need more privacy in the evacuation center, there is no privacy to change clothes and it is really hard to take a bath in restrooms as there is no privacy."

And one child suggested: "The hospitals should have solar panels on them and more backup generators so that they can continue running even after a disaster and to help the wounded, sick and pregnant people."[69]

> *"Even now, when the wind blows, the children get scared because they think another typhoon is coming. Every time it rains, they cry a lot and they keep saying that it will destroy our house again. I can sense their fear and see it in their faces. Some of them have not been able to go back to school since they don't have any clothes to wear or school supplies to use."*
>
> — **Mernita**, age 33
> Tacloban[70]

Everyday Emergency in Democratic Republic of the Congo

War, hunger and disease have killed more than 5 million people in the Democratic Republic of the Congo since 1998.[1] The country has been at the center of what some observers call "Africa's world war," which has displaced millions and kept the health system in shambles. The death toll from DR Congo's war is equivalent to the 2004 Asian tsunami happening every six months, and at least 20 times greater than the 2010 Haiti earthquake.[2]

It is statistically more dangerous to be a woman or a child than it is to be a soldier in the Democratic Republic of the Congo.[3] Forced displacement, rape and abuse are commonplace. And outbreaks of measles, cholera, malaria and other viruses are frequent. One child in 7 does not survive to age 5. And 15,000 women die each year from causes related to pregnancy or childbirth.[4]

An estimated 6.3 million Congolese people are in need of humanitarian assistance. Of these, 1.3 million (21 percent of the population) are women of reproductive age and 1.2 million (18.9 percent) are children under age 5.[5] Almost a third of the DR Congo's population is affected by the nutrition crisis (22 million people) and nearly a million pregnant and lactating women are affected by acute malnutrition, which has a serious impact on the nutritional status of their children.[6]

Lack of investment in the health care system has left many health centers and hospitals completely non-functional, lacking properly trained medical staff and medical supplies.[7] Many health facilities also lack electricity and water.[8] Government salaries are low and pay is infrequent and unreliable, with health workers reportedly getting no salary for months at a time. Drug management systems are weak and there is little accountability, so drug prices vary depending on where one goes.[9] In areas affected by conflict, members of armed groups often do not distinguish between civilians and combatants, and there is little respect for the neutrality of medical facilities or humanitarian principles.[10]

Despite its many challenges, DR Congo has made some progress in saving mothers' and children's lives. It has managed to reduce maternal mortality by 42 percent since 1990 and is considered to be "making progress" toward MDG 5.[11] However, DR Congo ranks among the countries making the least progress on child survival. Its under-5 mortality rate remained largely unchanged for two decades starting in the late 1980s. Since 2005, under-5 mortality has declined by 15 percent, a positive trend, though this reduction falls far short of the target for MDG 4.[12]

> *"There are SO many women and girls who are uprooted here, without any family left or any homes… And the numbers are just going up. You can find five women living in a small room with all their children, all together. These girls or women have nothing and will often sleep with a man for a little bit of money, so they can feed their children."*
>
> **— Female police officer**
> Kitchanga[13]

SAVE THE CHILDREN

The Strength and Compassion of Congolese Mothers

"Here, in her village, the woman is something special," says Solange, a Save the Children staff member who has worked to protect women and children from sexual and gender-based violence in Masisi territory since 1996. "She does all she can do. The husband may or may not help her, so she is on her own to take care of the children. She is often on her own in the fields, and she is often on her own when she goes to the market to sell things so that her children can live. You will see her on the road – always you see her carrying the heavy loads. Without her, there is no life."

"The mother is very courageous," continued Solange. "This is also why she can fall into traps sometimes, because she is exposed to many things. When she goes to the market it can be very far – a journey she does on foot. Without other transport, this means she might need to go very, very far to get provisions. She may go from here to Pinga, there and back, she may go sell drinks locally, so that her children can survive. That's something that is very positive regarding mothers we see in these villages."

"Mothers here are also full of compassion. Often the children who are alone are welcomed into homes and mothers take care of them as if they are their own. She may not have any blood relation with the child, but the child is adopted immediately, without any money or influence. This is something we have noticed here, especially in the villages. There are many children who have been abandoned, who are orphaned, without any parents, but they find other families. And when you go into their homes you will not know that this child does not belong to that mother. You may find this out later. But to guess this kind of thing will be very difficult because the Congolese mother, she has a healthy hospitality, if we can put it that way."[14]

Childbirth in a war zone

Across sub-Saharan Africa, women have a 1 in 39 lifetime chance of dying in pregnancy or childbirth.[15] In the conflict-affected provinces of eastern Congo – where many women are in poor health and the basic care needed for a safe childbirth can be in desperately short supply – the odds are often far worse. In North Kivu, for example, the maternal mortality ratio for the first half of 2013 was 790 deaths per 100,000 live births,[16] nearly 50 percent higher than DR Congo's national average and almost 60 percent higher than the regional average for sub-Saharan Africa.[17]

Why is eastern Congo's maternal mortality rate so high? The answer can be partly explained by the four "too's," according to Djedje Lukundula, a doctor affiliated with the NGO Merlin, based in North Kivu. "Women are becoming pregnant too early (before age 16), too late (after 35), too often (the average woman has more than six pregnancies) and too close together (less than two years between deliveries)." Many deaths are also the result of what happens too late: At the time of birth, the decision to go to a clinic or hospital for care is made too late; there are delays in transporting women from home to the nearest facility, which is often very far away; and after reaching the clinic or hospital, women experience delays in receiving care.[18]

A Congolese woman with a high-risk pregnancy, or who is experiencing birth complications, often does not get the emergency obstetric care that could save her life and the life of her baby. For example, many – if not most – health facilities in conflict-affected areas lack the capacity to perform cesarean sections and treat newborn babies who need help to breathe.[19] The referral system does not work because health centers in the DR Congo generally have no transportation (ambulances, or a budget for gasoline and maintenance) and no way to communicate with other facilities.[20]

Many Congolese health workers are ill-equipped and poorly supported, and their errors can have fatal consequences, or lead to lifelong disabilities, for mothers and newborns.[21] Attacks on health workers also undermine the quality and availability of care by traumatizing the health workforce and forcing health facilities to suspend activities. There is little data on the frequency of health worker attacks in DR Congo, but they are believed to be widespread.

> *I was helping a woman in labor. We have no electricity here so it was dark, candles only. Two men arrived, both armed. They raided the clinic and stole everything I had. They tortured me for a while with a knife and then left. By the time I returned to the mother, her baby had suffocated and died. I tried to remain calm but I was totally emotional – scared, anxious and of course angry. We are trying to save lives and they are trying to kill us. Three health workers left last year to work in less insecure areas. It is hard to keep staff when things are so dangerous. Also in less remote places, health workers are more likely to be paid. Here you can be forgotten for a long time. I was last paid maybe three months ago – the first time in a long time. I got 3000 congolese francs (about $3) for two months' work."*
>
> — **Donald**, nurse[22]

"Thoughts of the past just mess up my head"

Janet, age 38, just gave birth alone in a refugee camp in Uganda. She was seven months pregnant so she wasn't expecting to go into labor. "I was on my own. I tore the umbilical cord myself. I pulled on it and it broke free," she said. "My baby died after about 30 minutes. It was a cold night and I had nothing to wrap him in."

Janet and three small children fled their home in North Kivu after armed men attacked their family's home at night. "They attacked all of us with knives. They stabbed us and cut us up. My husband and four children did not survive the attack. The three young ones survived because the men did not see them. They left us for dead. They left a knife in my head." She removes a scarf to show her scar.

"After several months here, my youngest child fell sick. We were admitted at the health center for two and a half months. The doctor said she had kwashiorkor. She died. We buried her there." Janet points to a grassy patch behind her small tent.

"Thoughts of the past just mess up my head," she said. "I do not want to think about anything."[23]

Death before age 5

I gave birth to seven babies in my life and each time I looked at the baby and thought to myself, that baby was starving inside of me and it will starve now that it is in the world. Three of my babies died because of starvation. I hope I don't have another pregnancy because that baby will starve too."

— **Congolese mother**
rural area[24]

Almost half the DR Congo's death toll since 1998 has been children under age 5.[26] DR Congo has the fifth highest child mortality rate in the world, which translated to more than 391,000 deaths among children under age 5 in 2012. Most of these deaths were not the result of armed violence, but of preventable and treatable causes like malaria, diarrhea, pneumonia and malnutrition.

In areas affected by conflict, an estimated 423,000 children are acutely malnourished, making them more vulnerable to disease and death.[27]

Under-5 mortality is estimated to be 22 percent higher among conflict-affected children compared to the national average.[28] For example, insecurity has fueled a recent malaria epidemic in North Kivu, which has been a scene of heavy fighting on and off since 1998. Families in fear of attacks will often spend the night in the bush or the fields, where the risk of exposure to malaria is very high. Malaria was blamed for 18 percent of child deaths nationwide prior to the recent upsurge.[29] In 2013, there was a three-fold increase in the number of malaria cases in parts of North Kivu compared to past years, and 80 percent of those who die from the disease are likely to be young children under 5.[30]

Measles has re-emerged as a significant public health threat for Congolese children. Vaccination rates have fallen since the 1980s and a measles epidemic has affected the entire country since 2010.[31] The disease is extremely contagious and can spread quickly in a country like DR Congo where 27 percent of 1-year-olds are not vaccinated.[32] From January through October 2013, more than 74,000 measles cases resulted in the deaths of 1,160 children.[33]

Most sick children in the DR Congo do not get lifesaving health care when they need it. According to the most recent estimates, only 42 percent of children with suspected pneumonia receive antibiotics, 39 percent of children who are ill with fever receive an anti-malarial medicine and 27 percent with diarrhea receive oral rehydration salts.[34]

Most people can't afford health care

I had to have a cesarean section even though I knew I could not pay for it. After the operation I waited in the hospital for three weeks while my husband searched for the money. My baby got many fevers during this time because she was surrounded by sickness."

— **Congolese mother**
urban area[25]

The poor are often excluded from health care in the DR Congo. With the vast majority of the population living on less than $2 a day,[35] cost is perhaps the greatest barrier most people face in accessing health services.[36]

The health system is chronically underfinanced, so costs are usually passed on to the user. The cost of emergency procedures, such as cesarean section, may be exorbitant – $60 or more[37] in areas where some women earn less than $0.50 per day.[38] According to a 2011 report by UNFPA, health facilities in the conflict-affected northeastern region of DR Congo often lack even basic supplies and

usually require expecting mothers to purchase materials like soap, gloves, a razor blade and a sheet, which are needed to ensure a clean delivery. Women who cannot afford to buy these items often end up giving birth at home or outdoors without a trained health worker.[39]

Research carried out by Médecins Sans Frontières (MSF) in Walikale, North Kivu province in 2013 found that 9 out of 10 households had had at least one person fall ill in the previous two weeks. More than 35 percent reported not seeking care, with the majority of those reporting lack of money as the reason.[40]

MSF's experience shows that when free medical services are introduced in an area, people are more likely to seek health care. In 2011, Lulimba hospital in South Kivu switched from using a cost-recovery system to operating free of charge. The number of patients soared. For example, there was a nine-fold increase in the number of deliveries, from 182 in 2010 to 1,663 in 2012, and the number of measles vaccinations went from 0 to 2,055 over the same period. This increase in the uptake of medical services can be attributed in large part to the introduction of free quality health care in the area.[41]

I still have a debt to the doctor who delivered my first child. For this pregnancy I will have to visit a traditional birth attendant because she will accept a chicken instead of money."

— **Congolese mother,** rural area[42]

Sexual violence widespread

Rape and sexual violence remain one of the most urgent challenges facing the DR Congo. Although rape existed pre-conflict, sexual and gender-based violence on such a large scale appeared as a new phenomenon, closely linked to the civil war and recurrent conflicts from 1996 to 2002.[43]

Rape has been used – and continues to be used – strategically by combatants to humiliate and dominate their enemies. In DR Congo, perpetrators have come from virtually all of the armies, militias and gangs and other groups implicated in the conflicts. A doctor at Panzi Hospital in Bukavu, South Kivu said many victims in that area reported attackers would encircle villages and publicly rape women, children and the elderly. Rape "is done to destroy completely the social, family fabric of society," said the doctor. More recently, survivors in North and South Kivu have reported being attacked on the way from the market, while looking for food in the fields or gathering firewood in the forest, in and around displaced persons camps, in villages and their own homes.[44,45,46,47]

The true extent of sexual violence in the DR Congo is not known. Rape and sexual violence are typically underreported due to the stigma and shame involved. Studies suggest one-third to two-thirds of rape victims have been children. UNFPA reported that more than 65 percent of new victims of sexual violence in 2008 were children, the majority adolescent girls. In contrast, the Special Representative of the UN Secretary-General for Children and Armed Conflict estimated that 48 percent of victims were children.[48] According to the Ministry of Gender, in conflict-affected contexts in DR Congo, the average age of survivors of sexual violence in 2012 was less than 21, with a third of all survivors falling between 12 and 17 years of age.[49]

In 2013, there was an upsurge in cases of sexual violence in North Kivu. A security vacuum allowed several armed groups to expand their military operations, which was accompanied by rape and other forms of sexual violence.[50] Between January and July 2013, UNHCR reported a 6.5-fold increase in the number of cases of sexual violence in the region compared to the same period in 2012 (705 cases vs. 108 cases), 88 percent of which were rape and 62 percent of which were perpetrated by armed elements.[51] Across the province as a whole, there were over 11,400 cases of sexual violence reported in 2013.[52] At the end of January 2014, UNHCR reported a 37.5 percent increase in protection

My twins are now 4 months old. I am having difficulty breastfeeding my babies. They are not feeding well and I'm worried that I might have to stop nursing and start feeding them solid foods. It is difficult for me to provide enough nutrition for my babies, or for myself. Because I don't have anyone to help support my children, there is not enough to eat, and not enough money. I would really like to be able to take contraception so that I don't give birth to any more children for the time being. However, I don't know of any place near me where I could get family planning services."

— **Sylvie,** age 16[53]

incidents (sexual violence and conscription of children) in the province in 2013, compared to 2012.[54]

Two well-established women's groups in North Kivu have been fighting rape and sexual violence for more than a decade. *Centre Hospitalier FEPSI* is a woman-run independent medical center providing free services in the city of Butembo in North Kivu. It serves the two districts of Lubeno and Beni (around 2 million people), providing medical and psychological help to rape victims. The FEPSI hospital has 63 beds, 57 employees and 125 "trusted persons" who spread the word in the villages about the services they offer. The FEPSI project (*Femmes Engagées pour la Promotion de la Santé Intégrale*) was founded in 2000 by 15 women who felt they had to do something to help women and children who had been raped and to prevent the spread of HIV. "We could no longer bear it that a society, the whole world, was turning the other way," said Marie Dolorose Masika-Kafanya, one of the original founders, now president.[55]

Synergie des Femmes pour les Victimes des Violences Sexuelles (Women's Synergy for Victims of Sexual Violence) is a consortium of 35 Congolese organizations that provides medical care and support to victims of sexual violence in North Kivu province. In 2002, Masika Bihamba, Synergy's founder, encountered an 80-year-old woman who'd been brutally raped. She tried to help the victim get medical treatment, but the woman was so poor that no doctor would help her, and in the end she died. "That was a turning point," said Bihamba, who has made it her mission to document rape as a war crime and provide victims with emotional, medical and legal support. "It's a war against women," she said. "When two sides fight, the one punishes the other by raping women. When I see the women come to me in search of hope, I say to myself, I must continue to fight for them." More than 1,800 women have been helped by *Synergie*. The coalition also drafted legislation to correct flaws in the country's judicial system related to punishment of rapists and violent offenders.[56]

My daughter was raped when she was 6 years old. Today my daughter cannot run. When she tries, she has pain in her stomach near her navel. She comes holding her navel and saying it hurts underneath. She must rest for 30 minutes to recover. Sometimes she has fevers – her temperature goes up suddenly. When she goes to fetch water and she sees some boys, the first look, she comes back very quickly running, especially when she is alone. Since that day until today, she fears boys."

— **Kesiya**, age 40
Mutoko[57]

Rwamwanja Health Center, Uganda

Mother-to-child transmission of HIV

An estimated 32,000 pregnant women and 32,000 adolescent girls aged 10-19 in the DR Congo are living with HIV. According to UNAIDS, HIV prevalence varies from 1.7 percent to 7.6 percent depending on the region, and may be as high as 20 percent among women who have suffered sexual violence in areas of armed conflict.[58] Infection rates nationwide are increasing among female teens and young women,[59] but HIV testing is rarely performed in health centers or maternity units.[60]

DR Congo is one of the two lowest-ranked countries in West and Central Africa in terms of prevention of mother-to-child transmission of HIV. Only 1 percent of pregnant women estimated to be HIV-positive have access to antiretroviral treatment. Without this treatment, MSF says a third of babies who are exposed to the virus will be born with HIV.[61] The official government estimate puts the mother-to-child transmission rate even higher, at 37 percent.[62]

DR Congo's weak health infrastructure is one reason for the country's high rates of mother-to-child transmission. Another is cost. Even when "free" services are offered they are rarely completely free, said Thérèse Kabale Omari, director for Kinshasa province of *Femme Plus,* an organization that works with women living with HIV in seven provinces of the DR Congo. "For example, the HIV test may be free, but you have to pay for the patient card, for the syringe they use if you need some treatment, for transport – the costs add up and few women can afford them."[63]

Lack of knowledge, minimal HIV testing and unsafe sexual practices among adolescent girls are troubling. A recent study found only 13 percent have comprehensive knowledge of HIV; 8 percent had sex with more than one partner in

> *Yesterday, I handled a case of a man whose wife was raped by the rebels in Congo. From that incident, she fell pregnant and also contracted HIV. Since she did not know that she had HIV, her husband also contracted it, and now their baby is also HIV-positive. The baby was born in Congo and since the mother's serostatus was not known, caution was not taken to prevent transmission to the baby. This couple realized their serostatus after the baby started falling sick and they brought it here for treatment."*
>
> **— Dr. Installah Franco**
> Rwamwanja refugee camp, Uganda[64]

the last 12 months and only 18 percent with multiple partners used a condom the last time they had sex. In addition, more than 20 percent of adolescent girls had sex before age 15, and only 6 percent were ever tested and received results.[65] A recent set of focus group discussions in Masisi, North Kivu found that unmarried women were the least knowledgeable about HIV or AIDS of all the groups interviewed. Most of the participants in an unmarried women focus group in Mungote Camp and half of those in the Kalinga Camp had not even heard of HIV or AIDS.[66]

Save the Children recently completed a project that helped adolescents in Goma, North Kivu to fight the spread of HIV and adopt healthy behaviors. Students aged 12-14 from two schools elected peer educators who were trained and supported by project staff and teachers. The peer educators held discussion groups and organized role-playing activities to increase awareness about sexually transmitted infections, including HIV. Teenagers painted a mural and created a theater piece to promote health messages. They also distributed brochures describing ways to recognize and prevent infections, and provided information about STI and HIV tests. Surveys in the schools afterwards showed both boys and girls reported significant improvement in their level of confidence in using a condom correctly, and girls recorded a significant change in their confidence to seek sexual and reproductive health services if needed. HIV testing was the most-accessed service over the pilot period – 35 to 45 adolescents a month went in for testing.[67]

Education of women and girls

During the war years (1996-2003), the education system was believed by some to be in even greater disrepair than the health system, creating a real risk that the next generation of Congolese would be illiterate.[68] At that time, only 35 percent of children were enrolled in primary school, and school completion rates were exceedingly low for both sexes, but especially for girls.[69] Sadly, these fears to some extent have come true. In 2007, only 53 percent of 15- to 24-year-old Congolese women were literate, compared to 63 percent in 2001.[70]

In 2012, a study by UNESCO and UNICEF found that over half (52.7 percent) of the 7.3 million children out of school in the DR Congo – some 3.8 million children – are girls.[71] Among the obstacles to girls' education are low family incomes and lack of school infrastructure in some areas. In addition, community beliefs and such harmful practices as child marriage and early pregnancy continue to tie girls to the home, doing daily chores rather than learning in school.[72] Even when they do have access to school, given the insecurity in some areas, girls and boys are at risk of being attacked on their way to or from school. Many girls also drop out of school after rape, due to ill-health, trauma, displacement or stigma. [73]

A Congolese NGO called Children's Voice is working to address some of these challenges in Goma, North Kivu. The organization provides primary schooling, vocational training and mental health assistance for children in the community, including orphans, former child soldiers and at-risk teens. For those who were not able to start primary school earlier, Children's Voice provides a free accelerated primary school program where two years of curricula are completed within one year. The program gives children who are too old to enroll in the first level of primary school the chance to complete primary school in three years as opposed to the normal six years. For older teens and young adults who have already passed the age to enter formal schooling, Children's Voice provides vocational training and literacy classes to equip teens to make a living and participate in their communities.[74]

> *"One day I was going to school from my home in Masisi. I met three boys, one of whom had a gun. They attacked me, and all three of them forced themselves on me. I feel bad that I have a baby when I am so young, but I will look after it. I just wish I could go back to school."*
>
> — **Jovia**, age 14
> mother of an 8-month-old son[75]

Syrian refugee camp, Iraq

Syrian Mothers and Children Devastated by Conflict

Syria's civil war – now in its fourth year – has had a devastating impact on mothers and children. Almost 1.4 million children and 690,000 women have fled the conflict and become refugees in neighboring countries,[1] while over 9 million people inside Syria are in need of humanitarian assistance.[2] UNFPA estimates there are more than 2.9 million Syrian women and girls of reproductive age in need of support inside and outside the country.[3] That number is expected to grow to 5 million by the end of 2014.[4]

Before the conflict started, Syria was a middle-income country with maternal and child survival statistics to match. Syria was broadly on track to reach Millennium Development Goals 4 and 5 with a child mortality rate of 15 per 1,000 births (target is 13) and a maternal mortality rate of 70 per 100,000 births (target is 60).[5] These gains had been achieved because the country had a functioning health system that provided reasonably consistent standards of care, including high vaccination coverage rates for children[6] and universal coverage of skilled birth attendance and institutional delivery.[7]

Now, the story could not be more different. Inside Syria, a shattered health system has left millions of mothers and children suffering. An estimated 64 percent of public hospitals and 38 percent of primary health centers have been damaged, destroyed or closed due to insecurity,[8] and production of drugs has fallen by 70 percent.[9] About two-thirds of Syria's doctors have fled the country.[10] In Aleppo, a city that used to have 5,000 doctors, only 36 remain.[11]

Attacks on health workers and health facilities have become common. Hospitals, field clinics, ambulances and vehicles transporting medicine and medical supplies have been targeted for destruction.[12] Doctors report being attacked for treating the wounded, including civilians.[13]

Refugees in neighboring countries have a different set of challenges. Facing one of the largest refugee exoduses in recent history, humanitarian groups and host communities in Lebanon, Jordan, Turkey, Iraq and Egypt are struggling to meet the needs of the growing refugee population. Many families fled with only what they could carry and most are now living in conditions that are drastically worse from what they knew in Syria. "Home" today is a tent, caravan, collective shelter or crowded apartment shared with up to 20 extended family members. Most have seen their finances dwindle and can no longer afford food, clothing and medical care.

> *For a whole year my children haven't eaten vegetables or fruits. My younger children have never seen fresh food in their lives. This is a pure agony for any mother. When we had the chance to leave we took it immediately. A small bus made for 24 passengers took about 100 people from my town. We were on the road for two days. We couldn't stop even for toilets. I was in my sixth month of pregnancy but I had to stand. I passed out many times. The children cried until their eyes swelled shut. They were so hungry, thirsty and exhausted. Their pants were wet and soiled because we couldn't take them off the bus to use the toilet. I really don't know how we survived that trip. Those two days on the road were as long as the year we spent under siege."*
>
> — **Zahra**, age 35
> Central Bekaa, Lebanon[14]

Childbirth under fire

I was very sick during my pregnancy but there were no doctors, no hospitals. It was not like my other pregnancies – I had no scans, no check-ups. I have always delivered in hospital before, never at home. After nightfall I told my family that I must go to hospital, but there was no way we could get through safely, shells were already falling. Men shoot at everything they see at night, and there are so many checkpoints – we would never get past. Around 4 a.m. I started to deliver. I was terrified. I was in so much pain, I thought I would die. There was a terrible complication in my birth – and I thank god some of my neighbors helped a brave midwife to get through to me. The cord was wrapped around my baby's neck – the midwife saved my baby boy's life, and mine too I think."

— Ara
Lebanon[15]

Before the conflict, 96 percent of deliveries in Syria were assisted by a skilled birth attendant.[16] While accurate figures are not available due to the conflict, UN experts suspect maternal and newborn deaths are now on the rise inside Syria.[17] A recent assessment of 121 sub-districts in Syria showed that less than a quarter had regular access to reproductive services. In some besieged areas, such as parts of Homs, there are no reproductive services at all.[18]

Women in Syria face huge difficulties in accessing prenatal, delivery and postnatal care, including lack of ambulances, few female hospital staff and frequent checkpoints and roadblocks encountered on the way to hospitals. These problems have led to unassisted births,[19] as well as a shift in the proportion of women opting for planned cesarean sections. In 2011, 19 percent of mothers in Syria delivered via cesarean section. By 2013, this had more than doubled to 45 percent.[20] A hospital in a besieged city reported delivering 75 percent of all babies via cesarean section.[21] Women are often choosing to deliver by cesarean so they can time the delivery of their baby, rather than risk being in labor in an insecure context, with no ambulance, and especially risking a terrifying journey at night.

Cesarean is by no means a woman's first choice, but many see no other option. Because a cesarean section entails major abdominal surgery, risks for the mother include infections, complications from anesthesia, hemorrhage, blood loss and dangerous clots. Consequently, women require longer recovery time. The procedure can result in premature birth if it is scheduled before the baby reaches full term. It is also linked to breathing problems and generally lower health scores for babies.[22]

According to one estimate, some 15,000 Syrian women were likely to have been pregnant in Jordan last year.[23] Because of the disruption in health services in Syria, many of these women were long overdue for medical attention when they fled their homes. If they became pregnant while still in Syria they


Syria

probably did not have adequate prenatal care[24] and many may also have been undernourished.[25] Those who now live in large camps – such as the massive Za'atari refugee camp – may have access to maternal and newborn health care, but services are not so certain for the 85 percent of refugees who live outside camps in villages, towns and cities.[26]

Numerous assessments among refugees from Syria – in camps as well as non-camp setting across the region – have reported gaps in the availability of reproductive health services.[27,28] A 2012 needs assessment in Lebanon, for example, found that 55 percent of survey respondents living in northern Lebanon reported reproductive health services were "unavailable."[29]

Unable to afford health care

As their financial resources have dwindled, Syrians' access to health care has suffered. Inside Syria, displaced families generally cannot afford out-of-pocket medical services and medicine expenses, as costs have increased substantially due to shortages.[31] In Jordan and Lebanon, the high cost of health care has forced some Syrian refugee women to forego prenatal care, well baby visits and other health services.[32] Refugees are seeking care only after health problems become critical, and are therefore more life-threatening and expensive to address. Several assessments have indicated that refugees in Lebanon are returning to Syria for treatment, as prices are considerably lower there. Doing this puts their own safety at risk and puts further pressure on the remaining and exceedingly stretched services within Syria.[33]

As a partial solution to these challenges, UNFPA has introduced vouchers to help women pay for prenatal, delivery and postnatal care inside Syria. Mobile teams visit shelters and crisis-affected areas distributing vouchers that women can use to get free maternal health and emergency obstetric services at various hospitals and clinics.[34] In Lebanon, Save the Children-supported health clinics provide free medical consultations and lab tests. Soon, they will also be starting a voucher system to cover medicine costs.

When we arrived here in the camp I was so glad that finally I could sleep without worrying about explosions and shelling. I thought that now I could feed my children and send them to school. I thought I would be able to see a doctor and get proper medical care. It took me a few days to realize that we left one hell for another. Food is available but not affordable. Medical care is also available but not affordable."

— **Zahra**, age 35
Central Bekaa, Lebanon[30]

Surviving the first hours of life

In Syria, many newborns' lives are under threat as soon as they are born. Less than half of the remaining functioning public hospitals are equipped to manage childhood illnesses or have the necessary equipment and specialist staff to treat newborn babies.[36] Frequent power cuts mean that premature babies are dying in their incubators – in one area, five newborns died this way in one day.[37] Newborn babies must be kept warm for at least four to six hours, and the lack of electricity and heating results in some children dying of cold. The unpredictability of power, cold winter months and the lack of incubators mean some hospitals wrap up babies in blankets. But in one health facility two babies died because it was too cold and the blankets did not keep them warm enough.[38]

Every day, 185 babies are born to refugees from Syria,[39] and many face daunting odds. In Lebanon, one assessment found 26 percent of women who had given birth since the beginning of the conflict reported a preterm birth.[40] Up to 5 percent of newborns in Lebanon are thought to require neonatal intensive care due to prematurity, fetal distress or congenital malformation.[41] In Za'atari camp in Jordan, more than 20 percent of all deaths from October 2012 to September 2013 were newborn deaths,[42] three times the normal share.[43] And in December 2013 alone in Za'atari, there were 13 newborn deaths, compared to four in November.[44]

My husband was killed during the fighting and I had to leave my village with my four children. I was five months pregnant and it took me two months to get to this shelter. Throughout my entire journey my children and I were bitterly cold and hungry. When I arrived I went into early labor in my seventh month. There was no hospital or medical staff nearby so the other women helped me. My baby was born so prematurely and there was no special care to help him survive. He lived just two hours."

— **Samira**, age 28
Syria[35]

Jordan

A Safe Place for Mothers and Children

Manar, a mother of two, left Syria when she was seven months pregnant with her third child. "Our neighborhood was surrounded, under siege," she said. "Our only choice was to come to Jordan." Living in a tent for 11 months in Za'atari refugee camp, she never felt safe. "We don't have any doors to lock, so people would just walk in. I do not have any privacy to breastfeed or do other things like dress or take off my scarf."

A counselor suggested Manar visit Save the Children's Infant and Young Child Feeding Center. The calm and comfortable atmosphere there immediately put Manar at ease. "I feel safer here," she said, "because there are no males entering the center." Manar quickly made visits to the center part of her routine. Counselors told Manar about the benefits of early and exclusive breastfeeding, which she had not practiced before.

"With my two older children I basically listened to the advice of my grandmother and mother but when I came to the center I was pregnant and listened to the counselor and educator and memorized everything. When I delivered the baby, they put the baby on my abdomen and I remembered what the educator said, which was how important it was for him to get the colostrum (first milk). There is no comparison as you can see, he's 8 months old and has ten teeth now and is very smart and very strong. You can see the difference in comparison with my other children.

"I followed their advice and realized what they said was true. They told us that giving the child water and sugar would cause diarrhea and that was true, I had tried that with Nabeel and it did give him diarrhea."[145]

Infant feeding challenges

In Syria, breastfeeding was not widespread prior to the conflict with only 43 percent of children under 6 months exclusively breastfed.[46] Breast-milk substitutes were widely used, with the government of Syria controlling the production and distribution of infant formula through pharmacies. Now, the conflict has broken this supply network. At the same time, with the deteriorating situation, even fewer mothers are breastfeeding and the feeding practices seem to be worsening.[47]

In all situations, children who are fed infant formula are more likely to become ill and die than those who are breastfed. In an emergency context such as the Syrian conflict, where the risk of dying is already high for children, breastfeeding saves lives, providing critical protection from infections and death.[48]

A recent needs assessment from Dara'a showed that rather than breastfeeding, people were using water and sugar for infant feeding.[49] Myths and misconceptions have proliferated about women's ability to breastfeed in a crisis, with one woman simply saying "when you run away the milk runs away."[50]

In some parts of Syria, there have been untargeted distributions of breast-milk substitutes – including to breastfeeding mothers.[51] Some of the breast-milk substitutes were labeled in German and English, which made it difficult, if not impossible, for Arabic-speaking caregivers to follow instructions and mix the formula correctly.[52]

In Lebanon, one study found that fewer than half (48.9 percent) of the women who had given birth at some point during the conflict reported any breastfeeding.[53] In Jordan – both in camps and out-of-camps – breastfeeding rates are low, especially among 6- to 12-month-olds. There are reports of families diluting infant formula to make it last longer, which lessens its nutritional value and carries a high potential to cause illness.[54]

> *"Suddenly we found ourselves in the middle of a war zone. There were clashes every day and night and we were stuck in the middle. We spent many nights out in fields with other families who were afraid just like us but didn't want to leave the village. One day… we came back to our house to find it completely destroyed and we were left with no other option but to flee to Lebanon. At that time I was breastfeeding my newborn twins Hashem and Maisam, but after those nights I spent with them out in the open and because all the fear and trauma and explosions, my milk had dried up and I couldn't continue feeding them. They were crying all the time and the roads were blocked and dangerous so we had to move at night taking very difficult roads between the fields. It took us two days to reach the Lebanese border. It was the worst two days in my life. My babies were so sick and hungry."*
>
> — **Elham**, age 29[55]

Threats to young children

Inside Syria, child casualty rates are the highest recorded in any recent conflict in the region.[57] While death and injury rates are difficult to measure, over 11,400 children are thought to have been killed,[58] and the number is rising.[59] Millions who have survived have had their healthy growth undermined, their education cut short, and their emotional development damaged by exposure to violence.

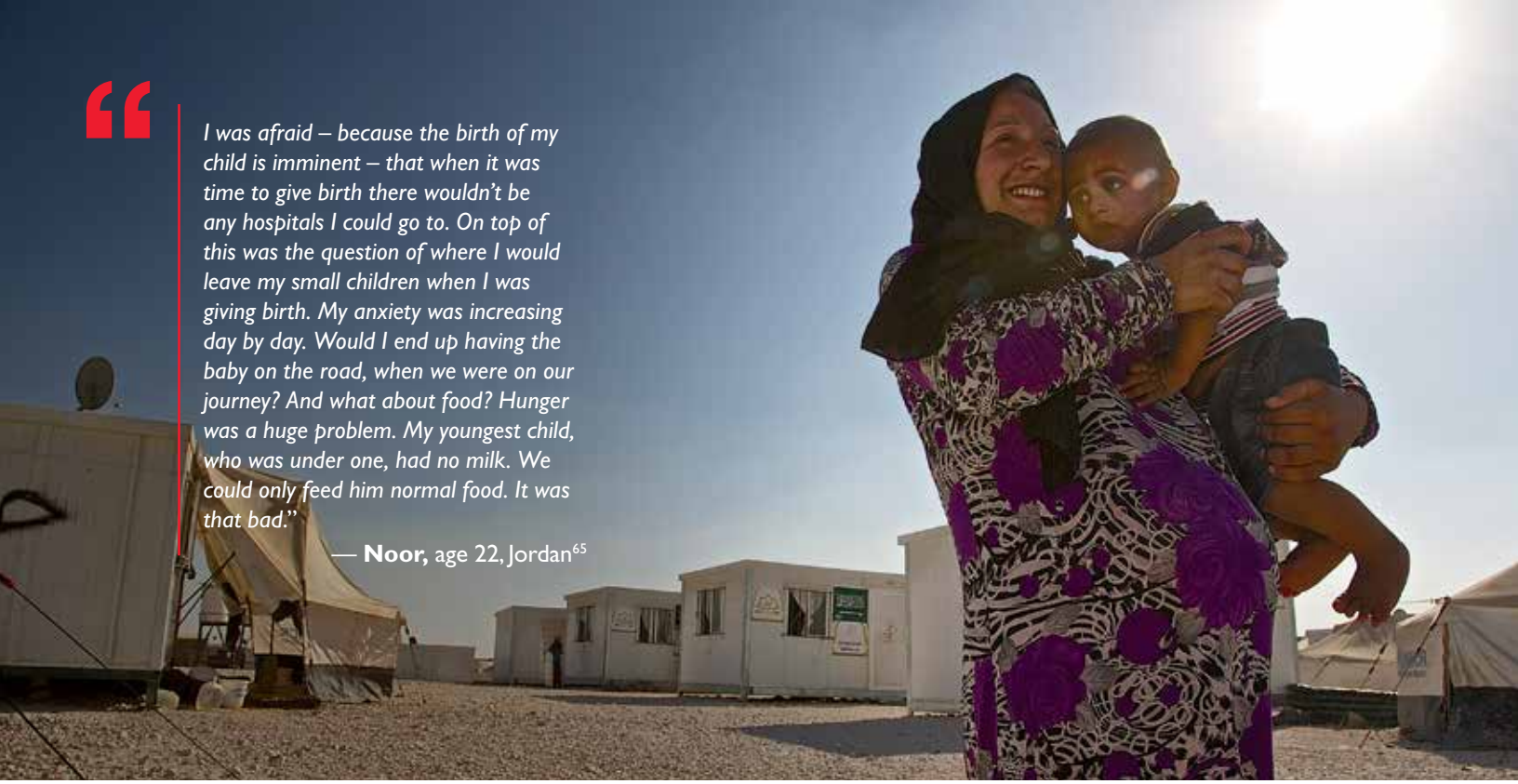
Doctors across Syria and neighboring countries are reporting an increase in the number of severely malnourished and sick children arriving for treatment. At one pediatric ward in Damascus, a doctor reported, "We used to see one child with life-threatening malnutrition less than once per month. Now there are ten cases or more every week."[60]

Three years of displacement and collapsing health services have also left Syria's children highly vulnerable to potentially fatal diseases. Children in many parts of Syria have limited or no access to vaccination, and for the first time in over a decade, there are polio and measles outbreaks.[61] Cases of measles and other preventable diseases have also been reported among refugees in Jordan, Lebanon and Turkey.[62]

Inside Syria, the number of cases of acute diarrhea among children has skyrocketed. Lack of clean water, fuel and other resources needed to prepare infant formula and sterilize bottles have been blamed for significant increases in diarrheal disease among infants.[63] An assessment in northern Syria found 23 percent of children under 5 in IDP camps had diarrhea.[64]

> *My daughter Sham, she is 1 year and 7 months. Do you know what her first word was? Explosion. Her first word! It is a tragedy."*
>
> — **Hamma**
> Lebanon[56]


Syria



I was afraid – because the birth of my child is imminent – that when it was time to give birth there wouldn't be any hospitals I could go to. On top of this was the question of where I would leave my small children when I was giving birth. My anxiety was increasing day by day. Would I end up having the baby on the road, when we were on our journey? And what about food? Hunger was a huge problem. My youngest child, who was under one, had no milk. We could only feed him normal food. It was that bad."

— **Noor,** age 22, Jordan[65]

Unmet need for family planning

Refugees from Syria frequently tell aid workers they are terrified of becoming pregnant.[66] In a recent series of interviews conducted by Save the Children staff in Lebanon and Jordan, nearly every new mother said she did not want to get pregnant and bring a child into such a difficult situation. Many were struggling to feed, clothe and house the children they already had. They said they were not physically or emotionally well enough to give birth and care for a new baby.

The same is true of internally displaced women. When aid workers speak to women inside Syria – many of them displaced from their homes and living in cramped collective shelters – they say the last thing they want is to get pregnant. "No one wants to be pregnant in the shelters… That's universal wherever we go," said Laila Baker, UNFPA representative in Syria. "There is no place to take care of the baby and it's another mouth to feed." In addition, women fear the delivery process will bring complications, as access to prenatal care, safe delivery services and emergency obstetrics is now extremely limited.[67]

Inside Syria, family planning tools are not readily available in many places. Refugees report having unwanted pregnancies because back home in Syria, villages ran out of contraceptives.[68]

I wasn't prepared and I wasn't thinking that I would bear a child, especially in these circumstances. Usually having a child would mean joy – joy for bringing a new soul to life. But in these circumstances I didn't want the baby because of the difficulties facing us."

— **Ghada**, age 26
Za'atari refugee camp, Jordan[69]

Ten months ago I got pregnant. I didn't plan to, but it happened. I hated myself for that because I don't want to bring my child into this life – the refugee life."

— **Aisha**, age 27
Central Bekaa, Lebanon[70]

Gender-based violence

Why did we leave Syria? You might think it was the bombs…but no. Although the bombing was very bad, we could live with it, we could survive. What we could not live with was the constant threat of sexual violence. In my street there was a young girl who was hurt like that in front of her father as a punishment, and then they killed him. I saw his body, and we tried to help her. She survived, but actually they both died that day, in different ways."

— **Roha**, age 23[71]

Evidence of violence against women in Syria is mounting.[72] Nearly three-quarters (74 percent) of respondents interviewed as part of a child protection assessment carried out in refugee settings in the first half of 2013 indicated an increase in sexual violence in the area they had fled.[73] The International Rescue Committee describes rape as a "significant and disturbing feature of the Syrian civil war."[74] And the UN Commission of Inquiry on Syria says "sexual violence has been a persistent feature of the conflict." UN investigators report "the threat of rape is used as a tool to terrorize and punish women, men and children."[75]

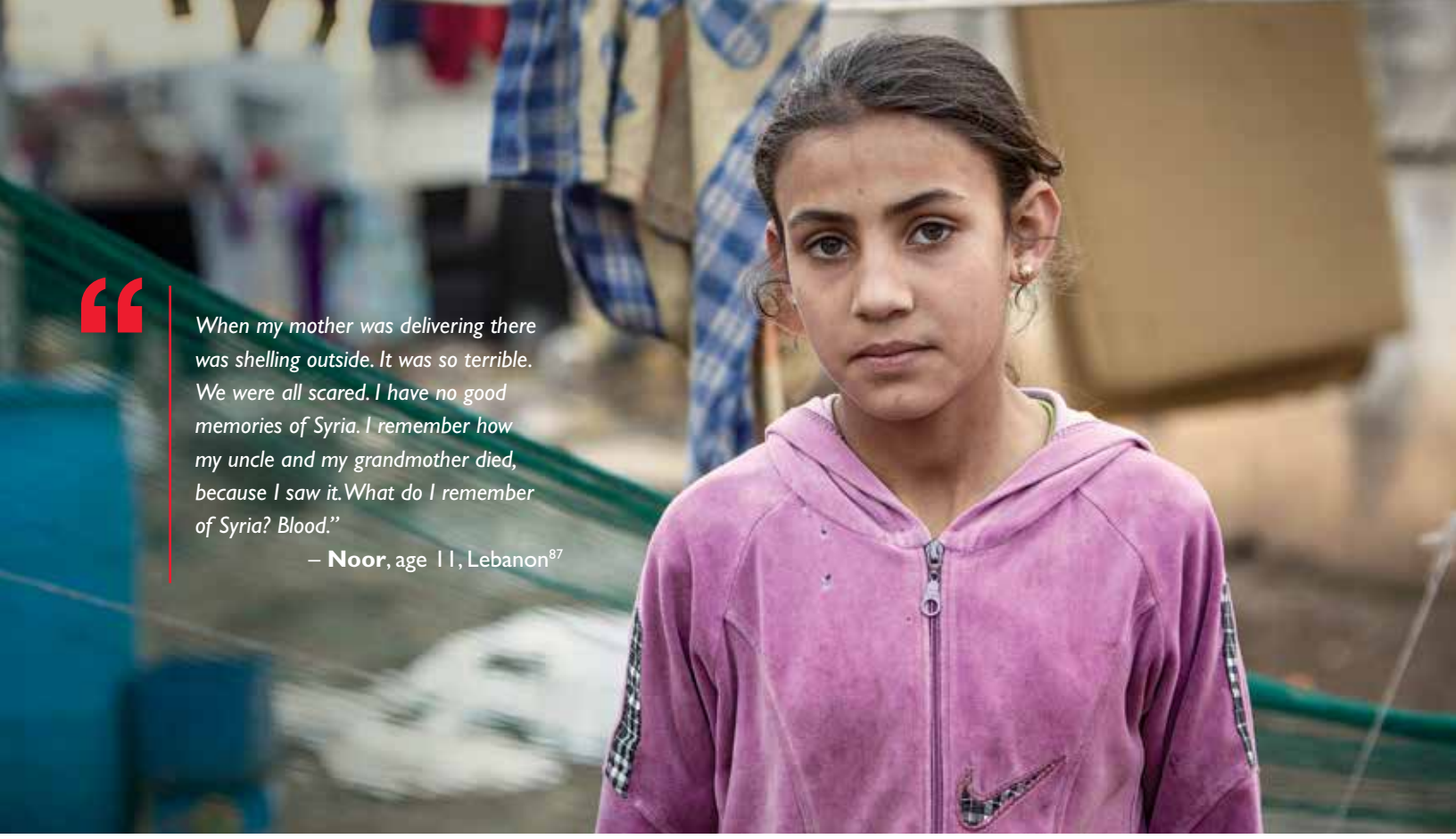
Accounts documented by UN investigators suggest sexual violence against women and girls has been committed during assaults, in detention facilities, at checkpoints and possibly during house searches.[76] Women and girls have reportedly been attacked in public and inside their homes, mainly by armed men. For many, the IRC reports, assaults occurred in front of their family members.[77] Schools have also been cited as high-risk locations.[78] In Za'atari camp, tent homes and latrines were identified as the most likely places for gender-based violence against girls. For women, the home and distribution points were the highest-risk locations.[79]

Across humanitarian aid agencies as a whole, in 2013, more than 78,655 survivors of gender-based violence within Syria were assisted with psychosocial support, psychological first aid, medical counseling and vocational skills programs.[80]

Underreporting, delayed reporting and a culture of silence make it difficult to assess the true scale of gender-based violence among refugees from Syria. UN researchers in Jordan met with a strong reluctance among refugees to speak about incidents in specific terms. Participants of both sexes confirmed that women cannot speak openly about gender-based violence, and that survivors are often afraid to discuss what has happened to them. According to a UN report, female participants added that if a woman were to come forward, she could face abuse from her brothers or male family members because such claims will disgrace the family.[81] Similarly, in Lebanon, many refugee women who were suffering from intimate partner violence said they wouldn't report being subject to violence for fear of being returned back to Syria by their husbands.[82]

Protection agencies continue to raise concerns regarding women's ability to report incidents of gender-based violence and receive quality services in Syria, particularly in areas with escalated fighting such as Aleppo, Homs and rural Damascus.[83] Lack of awareness of victim support services has been cited as a key area of concern in several assessments in and outside of Syria. A 2013 assessment in Jordan (in and outside of camps), for example, found limited availability and knowledge of clinical services for survivors of sexual violence, which was potentially hindering their use by the population.[84]

Another study last year among refugees from Syria living outside camps in Jordan found that specialized, confidential, and supportive services currently available to Syrian women and children survivors of gender-based violence are not sufficient, and when such resources are available, refugees are very often unaware of them. An alarming 83 percent of refugees surveyed did not know of any services available for survivors of gender-based violence in their community.[85] More than 80 percent of respondents in a 2013 child protection inter-agency assessment in Syria also said they did not know where child survivors of sexual violence could get professional help.[86]



When my mother was delivering there was shelling outside. It was so terrible. We were all scared. I have no good memories of Syria. I remember how my uncle and my grandmother died, because I saw it. What do I remember of Syria? Blood."

– **Noor**, age 11, Lebanon[87]

Early marriage of Syrian girls

Early marriage was not uncommon before the conflict, but some believe Syrian girls are marrying even earlier now.[88] There are reports that Syrian refugee girls in Egypt, Jordan, Lebanon, Libya and Turkey are being forced into marriages – often with much older men – under the pretext of protecting their virtue and rescuing them from the harsh life of refugee camps. In Egypt, there have reportedly been thousands of marriages between Syrian refugee women and Egyptian men.[89] In Jordan, where an average marriage can cost a groom up to $21,000, the cost is typically between $140 and $700 for a Syrian bride. "Marrying a Syrian woman is now within reach for even those down-on-their-luck Jordanian men who couldn't afford to marry before," wrote one columnist. "And for those who can afford it, marrying four refugee ladies at once could be a real boast."[90]

Women's groups are fighting back, saying these practices represent human trafficking and conflict with international human rights conventions. Syrian women activists launched a social media campaign under the name "Refugees not Captives" using Facebook and Twitter to denounce early marriages as well as those who encourage men to marry Syrian girls for "altruistic" reasons.[91] The Egyptian National Council for Women's Rights condemned the phenomenon in their country, saying these marriages are "crimes committed against women under the guise of religion."[92] And in Jordan, the interior ministry circulated an order that all courts inform couples that marriage contracts not taking place in official courts would be invalid, and the groom held legally responsible.[93]

A forced and early marriage task force was established in Jordan during the first quarter of 2014 co-chaired by UNHCR and UNFPA. Its aim is to serve as a platform to exchange information, provide technical support, develop joint actions to address the issue of forced and early marriage, build capacity of different stakeholders and develop a joint action plan to reduce the risk and mitigate the consequences of forced and early marriage in Jordan.

My daughter is 16 and she loved school. She was top of her class and wanted to become an architect. But we were too worried for her. They were attacking women. We could not protect her, so we had to marry her. She is innocent and very pretty. I know that men are hurting women – old women, single women, everyone. She did not want to get married, she wanted to study. This is happening a lot in Syria, many women I know are marrying their daughters – even younger than 16 – to protect them."

— **Um Ali**
Lebanon[94]

Moore, Oklahoma

Poorest Mothers and Children Suffer Most in U.S. Disasters

When Hurricane Sandy barreled into the U.S. mid-Atlantic coast in October 2012, the United States was once again reminded that a disaster could devastate large swaths of a major metropolitan area, paralyzing essential services and leaving millions without electricity, transportation, jobs and housing. The storm damaged an estimated 650,000 homes[1] and uprooted tens of thousands of people for months.

The hard-learned lessons of Hurricane Katrina, seven years earlier, have led to many improvements in emergency management. But to this day gaps remain in U.S. emergency planning. After Katrina, children and mothers with the fewest resources often faced the most daunting challenges. Subsequent disasters suggest this continues to be the case.

After Hurricane Sandy, Dr. Noah Nattell, an OBGYN resident physician in New York City's Beth Israel Medical Center, described how economic inequality impacted pregnant women:

> *After the winds had passed and the water retreated, there was left a dearth of health care in lower Manhattan. While private doctors escorted their privately insured patients to Mount Sinai and Lenox Hill for delivery and care, the underinsured were left with no hospital, no records, and little information. They arrived at Beth Israel Medical Center Labor and Delivery with no access to their records and some with serious complications of pregnancy. The emergency rooms were filled with the unregistered and the displaced, clamoring for care in the face of diminished resources. Outpatient clinics were overbooked 3 to 4 months in advance. Lacking a coordinated medical record system, care was compromised. Eventually the city health clinics reopened, but with no public hospital in Manhattan, these patients were instructed to travel to outer boroughs for delivery. Until the reopening of Bellevue Hospital in February 2013, our hospital became the safety net for the uninsured and underinsured in lower Manhattan. Unveiled, as I had not previously witnessed, the disparity between the classes was jarring."*[2]

Even in a developed country where the best medical technology is rarely far away, difficulty accessing prenatal care combined with the intense stress of experiencing a disaster and its aftermath put both pregnant mothers and their babies at risk. Research after Katrina showed that pregnant women with "high hurricane exposure" were three times as likely to deliver low-birth-weight infants.[3] Today, the American College of Obstetricians and Gynecologists is still calling for better disaster planning to protect women and children from increased risks such as: preterm delivery, difficulty establishing and maintaining breastfeeding, unintended pregnancy and sexual assault.[4]

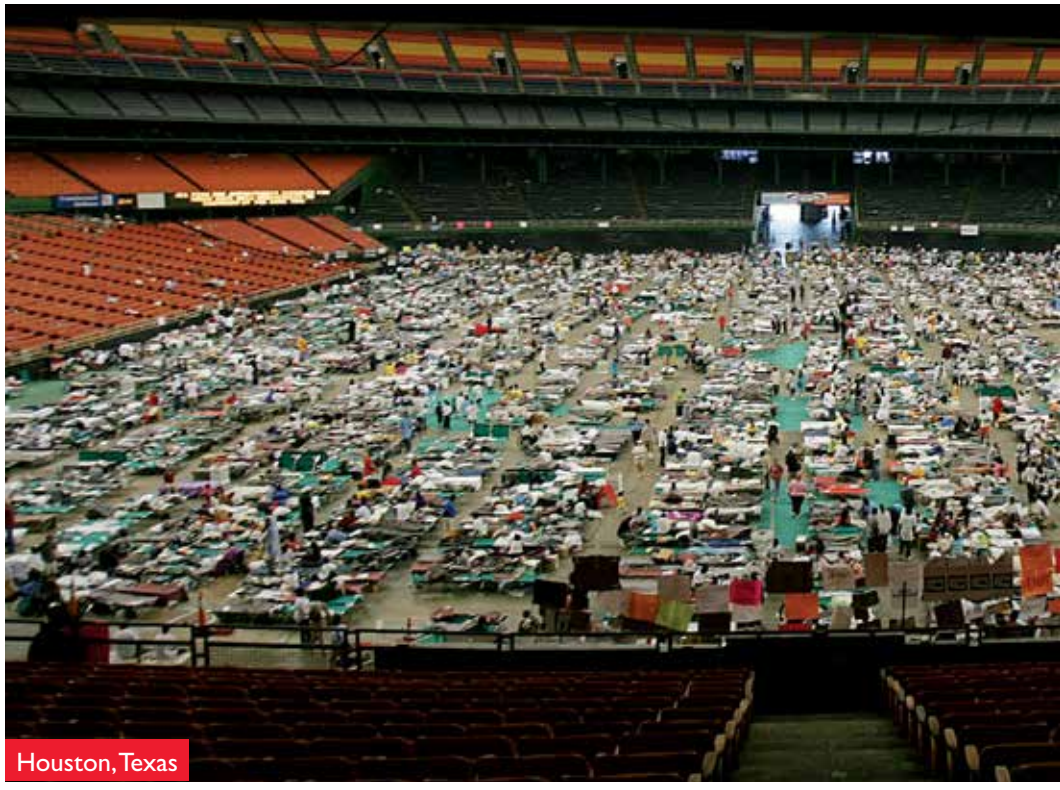
While the severe supply shortages and deplorable conditions at New Orleans Superdome after Katrina served as a wake-up call that continues to reverberate, children and families in mass shelter situations may still be vulnerable in ways that can and should be addressed. Despite the post-Katrina National Commission on Children and Disasters recommendation for a national mechanism to count children in shelters – and thereby facilitate delivery of relief meeting their unique needs – such a system has yet to be systematically implemented.[5]

> *I know a lot of people have forgotten about us in Far Rockaway. They think that because it's been over a year, we should have been past this and moved on. And it's not that we're not strong individuals, because we are. We made it through some hard times. Really hard hard times. Especially the elderly and those of us with sick babies. To be able to do that and never give up hope. It was very hard for me to stay strong for my children and not show fear. I didn't want them to be weakened by seeing me weak. I had to be strong. Sometimes when I can come here and tell my story that's when I can cry. I didn't want to cry in front of them. I wanted to show them, we can do this we're going to make it through. Mommy's happy, we're good. But inside, I was torn up. How are they going to eat? How am I going to get medicine? I didn't have a job anymore… I personally could not go into a shelter because of my children's illnesses, but someone did look out for me and let me stay a month in their home. I didn't have anything to give them back."*
>
> — **Crystal Lee**, sole caretaker for a granddaughter with cerebal palsy and epilepsy and two daughters, one with sickle-cell disease, speaking at the Rockaway Babes support and volunteer group in Far Rockaway, Queens, NY[6]

In the United States, as around the world, Save the Children works with disaster response partners to assess and close the gaps around providing child-friendly supplies, food and support for pregnant and nursing women in shelters. Additionally, the organization sets up "child-friendly spaces" where children can safely play and start to recover emotionally, while parents begin to rebuild their lives.

After Hurricane Sandy, Save the Children expressed concern that some large shelters in New Jersey did not offer children the protection of designated family living spaces and bathrooms.[7]

While shelter living can present unique stressors for children and their families, low-income families that seek refuge outside the shelter system can face more extreme challenges without the assortment of support services shelters strive to offer. Navigating bureaucratic processes to qualify for post-disaster social services presents another layer of stress and complication beyond meeting a family's daily needs under chaotic and insecure circumstances.



Houston, Texas

After Katrina, one teenage girl explained her frustration that relief efforts in Houston had only focused on hurricane refugees at the Astrodome and Convention Center, not those staying with relatives, as she, her single mother and disabled sister had.

In the chaotic aftermath of Sandy and its coastal flooding, it took weeks for official relief efforts to reach hard-hit families living in some New York City low-income housing projects, according to Aria Doe, executive director of The Action Center, in Far Rockaway, Queens. She recounted for Save the Children the struggle to mobilize resources for the many single mothers, babies and children among the thousands stranded without electricity, water, food, supplies or transportation. Many apartments lacked heat for months in the increasingly cold autumn and early winter weather, and with the elevators also out, some mothers had to climb up and down more than seven flights of stairs every time they ventured out to seek basic necessities for their families.

> *Extra police arrived to beef up security, over concerns that rival gang members were sharing the same space. Domestic violence and substance abuse were happening in public spaces, and you had incidents like people finding empty needles in the same bathroom children were using. In the aftermath of a disaster, children can be extremely vulnerable to any number of threats to their safety, including sexual exploitation, and it's critical that precautions are taken."*
>
> — **Amy Richmond**
> Save the Children
> child protection officer

> *We needed stuff for my sister. She was getting ready to die. She was on a certain formula, Peptamen Jr., and no one would give it to her even though we called the hospitals and the Astrodome. We were scared. My sister got sick and she had diarrhea, so we put her on Pedialyte water and she stayed on that until we called the 1-800 number off the can and they sent one case, which lasted six days. We would try to make appointments and no one would give us one without Texas Medicaid. But getting Medicaid would have meant we would have been in trouble once we got back here. Finally, we found our Metairie [Louisiana-based] supplier and they shipped us the milk to Houston.*
>
> – **Dariel**, age 13[8]

This community was nowhere on any maps for five weeks for services and for resources and for help. We did not receive water from the entities that we should have, from the entities that were set up to do it, hot food, clothing, diapers, diaper rash medicine. All that was privately funded from ma's and pa's and groups like yours and other groups who did not have a mandate to do that… With Katrina maybe there were excuses because something like that had never really happened before on that level. With Sandy there were no excuses, there were no excuses for poor neighborhoods to be passed by, because there was enough time to have put a plan into place."[9]


Moore, Oklahoma

Hurricane Katrina had also jolted the United States to the reality that the nation lacked a working system to reunify children who are separated from their families during a disaster. After Katrina, it took seven months before the last child was in fact reunited with her parents. After a long consultation process, the U.S. government and partner organizations in November 2013 released guidance billed as the nation's "first attempt to establish a holistic and fundamental baseline for reunifying children separated as a result of a disaster."

"It really is meant to start the discussion around reunification planning. It's not one of those things that is heavily discussed among emergency managers when it absolutely needs to be," said Sharon Hawa, program manager for emergency communications at the National Center for Missing & Exploited Children.

Ultimately, Hawa and others acknowledge, successful reunification efforts will also depend on how well families and individual organizations caring for children plan ahead. Every day, approximately 68 million children are separated from their parents while in school or child care. Yet, in 2013 most states – 28 – still failed to meet minimum standards for disaster planning in schools and child care drawn from the National Commission on Children and Disasters recommendations after Katrina.[10] On the positive side, that dropped from 46 states falling short in 2008 when Save the Children started tracking


Kentwood, Louisiana

four basic standards. The standards specify that states require: 1) all schools to have written, multi-hazard disaster plans and all child care centers to have: 2) evacuation and relocation plans, 3) family reunification plans, and 4) emergency plans for children with special needs.

After Hurricane Sandy and recent Oklahoma tornadoes destroyed and damaged hundreds of schools and child care centers, New Jersey and Oklahoma made changes to meet all four standards. New York already met all four standards.

Meanwhile, many child care centers in New York, New Jersey and Oklahoma struggled to reopen and restore supplies and services after the recent disasters. In its 2009 interim report, the National Commission on Children and Disasters cited challenges to child care recovery as a critical national gap that endangers the well-being of children as well as the economic security of families and entire communities.

It is not clear that subsequent efforts to reduce hurdles have trickled down to small providers. Family-run Agapeland Learning Center was completely destroyed in the May 20, 2013 tornado in Moore, Oklahoma. Miraculously, none of the children or staff inside at the time were seriously injured, but many lost family homes, cars and belongings. Director Memory Taylor was anxious to serve families again and to reemploy her staff – among them, a now homeless single mother who had saved one young girl from being sucked away by the tornado. But Taylor said the only official relief she could identify was a small business loan:

> *"When you're a child care center that operates on a low profit, at the end of the year there's very little money left. Then when you'll have to open up at half capacity, and you don't even know if you'll even be around at the end of the year, taking out a loan is very risky and very scary. The help that Save the Children gave us allowed us to reopen and I honestly believe that's why we're still here."*[11]

Nicki Ann Cordi in Seaside Heights, New Jersey also struggled to reopen after Hurricane Sandy devastated her child care center and her community. But when she visited her families in the shelters and heard the children ask her when they could come back, she said she knew she had no choice but to push forward. Displaced by the storm, single mom Florence Campbell and her 1-year-old son were offered temporary government in a motel room facing a busy highway. She said Cordi's reopened Ultimate Scholar II was a godsend after the months of isolation her toddler had faced:

Seaside Heights, New Jersey

> *"For my son, it messed up a lot. He wasn't able to play like he used to. He wasn't able to go to the park. He wasn't able to see the people he saw on a daily basis because we weren't able to go anywhere. We had to walk on the highway even to go to the nearest convenience store. So it stopped him from talking. It stopped him from wanting to feed himself and to play. He just pretty much stayed immobilized. [Now,] being around other children, just having a regular schedule, it's helped him a lot. He's starting to speak a little bit. He tries to explain more of what he wants. He doesn't have the tantrums he had before. He was doing at least 10 tantrums a day…. Having him here in the day care has helped me emotionally, because now I know my son is stable. My anxiety level is not so high anymore. I can breathe again.*[12]

Moore, Oklahoma

Recommendations:

State law and emergency plans: All states should meet the four minimum standards tracked in Save the Children's annual disaster report card that require child care centers and schools to have emergency plans in place. Schools and child care must regularly practice these plans and coordinate with families and emergency managers.

Shelters: National disaster coordination should require all shelters to track numbers and needs of infants, toddlers, children and pregnant women as a first critical step to ensuring child- and mom-friendly supplies and services are readily available. Additionally, all shelters should be set up to include a designated area and bathrooms for families with children.

Reunification: Emergency managers and community organizations should seek to locally adapt and apply new national family reunification guidance. To be effective, emergency managers and child care programs need to coordinate reunification planning to ensure that young children are reunited with their families as quickly as possible after emergencies.

"Whole community" emergency managment: Emergency managers should take a whole-community approach to emergency planning that ensures that all populations, including single mothers and other economically vulnerable families with young children, are accounted for in mitigation, preparedness, response and recovery efforts.

Family action: All families should have an emergency plan and kit and also make sure any schools, child care or other caregivers for their children are also prepared for disaster. See www.savethechildren.org/checklists to get started.

Child care recovery: Post-Katrina efforts to better facilitate child care recovery should be nationally evaluated and improved in order to allow children to more quickly return to high-quality, safe environments and their families and communities to more quickly bounce back economically after a disaster.

Haiti

Take Action for Mothers and Children in Crises

Around the world, dramatic progress is being made in saving women's and children's lives. We are at a tipping point, when ending preventable maternal and child deaths is within our reach. But this historic opportunity will be at risk if we fail to tackle the challenge of the women and children left behind, many of whom are living in conflict-affected and fragile states. Over half of maternal and under-5 deaths from preventable causes take place in fragile settings that are at high risk of conflict and are particularly vulnerable to the effects of natural disasters.

The last 15 years of Save the Children's *Mothers' Index* reveal:

- 67 percent of bottom 10 countries were experiencing or recovering from a humanitarian crisis the years they made the bottom 10.[1]
- Nearly 60 percent of countries ranked in the bottom 10 over the years have been experiencing or emerging from conflict.
- Of the 28 countries that have ever ranked in the bottom 10, all but four have a recent history of armed conflict.

Mothers and newborns face unprecedented challenges in these countries. In crisis settings, their vulnerability to disease, malnutrition and violence greatly increases. Many fragile and conflict-affected states are also particularly vulnerable to natural disasters that often most affect the poorest families. It is these children and mothers we must reach if we are to achieve the Millennium Development Goals for mothers' and children's survival.

The world needs to take urgent action for mothers, children and newborns in fragile states – those whose instability means they are failing to provide women, girls and boys with the basic elements needed to ensure their survival. And when disaster strikes the world must be ready to respond rapidly and ensure that the immediate health needs of women and children are met while at the same time building long-term stability.

We know that progress is possible. Countries like Nepal have significantly improved child and maternal health despite experiencing conflict. Political will backed by resources can take countries forward, even in the most difficult contexts.

What needs to be done?

National governments, donor countries, international agencies, the private sector and civil society have a shared responsibility to ensure that mothers and newborns living in crisis-affected contexts have the best chance to survive and lead healthy lives. The *Every Newborn Action Plan* will be presented to the World Health Assembly in May 2014 as part of the UN Secretary-General's *Every Woman Every Child* movement and will set out the actions needed for a two-thirds reduction in the newborn mortality rate. Achieving maternal, newborn and child survival will require putting mothers and newborns living in crisis-affected states at the center of these and other national and international efforts. Together we need to:

1) Ensure that every mother and newborn living in crises has access to high quality health care. This is imperative when mortality risk is highest – during labor, childbirth and the first week of life – as expressed in the *Every Newborn Action Plan*. Access to high-quality health care requires:

- Ensuring that primary and secondary health care is provided on the basis of need and is affordable to all by removing all financial barriers to health care in crisis settings.
- Helping women give birth safely by ensuring health workers are secure and have the medicines and supplies they need.
- Increasing the number of skilled and female health workers working in crisis situations through improved and expanded training, adequate salaries and incentives such as task sharing.
- Strengthening the overall health system by investing in its leadership and governance, infrastructure, commodities and supplies, service delivery, information systems and financing.
- Ensuring delivery of at least the minimum standard high-impact public health interventions such as vaccinations, water and sanitation.

- Meeting international obligations to protect health workers and health facilities from attack and improving data collection on attacks on health workers. Health workers and facilities in conflict settings must be supported – not targeted – so that they can continue to provide the basis for keeping essential services available.
- Strengthening maternal health care and family planning. Universal access to voluntary family planning is essential. Health information campaigns that reach mothers and fathers and support women's choices to access health care are needed, as are quality, accessible sexual violence response services.

2) Invest in women and girls and ensure their protection. Investments in women and girls have been proven to have a positive impact on maternal and newborn health. The kinds of investments that can empower and protect mothers and newborns include:

- Investing in the productive activities and safe livelihoods of women and girls, including women farmers. Investing in micro-finance initiatives targeted at women and adolescent girls can provide them with the tools, income and capacity to get involved in farming and other activities that increase their access to and control over assets and resources and enables them to build skills, awareness and access to decision-making processes.
- Promoting girls' education, ensuring that education continues in times of crisis and girls have equal access to the classroom in fragile states and emergency response settings. Greater levels of funding should be allocated for girls' education and education in emergencies. All attacks on education should be investigated with perpetrators brought to justice. Governments should support and endorse the draft *Lucens Guidelines for Protecting Schools and Universities from Military Use during Armed Conflict.*
- Including the prevention of and response to gender-based violence in a comprehensive agenda for improving reproductive health in crisis settings. In crises, women and girls are at greater risk of violence, which in turn can increase the likelihood of problematic pregnancies and births. Progress can be made by developing and investing in prevention strategies that include: involving girls and women in planning settlements and distributing resources, identifying at-risk individuals such as female-headed households and unaccompanied children, raising awareness of the way women and girls are viewed and treated in order to reduce social acceptance of gender-based violence, actively involving boys and men in efforts to prevent gender-based violence, and developing confidential reporting and investigation systems.
- Including action to prevent child marriage and other harmful practices in guidelines to prevent and respond

Kenya


Pakistan

to gender-based violence in emergencies, and integrating them into humanitarian agency response plans.

- Strengthening community-based child protection mechanisms to monitor and respond to protection threats to women and girls.

3) Build longer-term resilience to minimize the damaging effects of crises on health. This entails:

- Strengthening community-based preparedness and early response. In areas where crises are recurrent, their timing is often predictable. Contingency planning and flexible funding combined with the political will to act before, rather than after, a crisis occurs will prevent the excess mortality associated with the crisis. A proactive effort should be made to engage women in contingency planning and ensure that early warning systems take into account women's level of access to technology and their different coping strategies.
- Designing social protection policies and programs that meet the needs of the most vulnerable. Particularly in areas of chronic malnutrition, an inclusive, broad-based social protection system is needed that protects the poorest households and children from extreme deprivation and provides opportunities for the promotion of livelihoods and productive activities for both women and men. Empowering women within the household and community helps ensure mothers are not limited in their ability to protect and provide for their children.
- Prioritizing Infant and Young Child Feeding (IYCF) preparedness, including the development of comprehensive contingency and response plans, policy, strategy and guidelines for IYCF in emergencies, capacity-building, and the strengthening of IYCF programming and complementary systems.
- Investing more in disaster risk reduction (DRR). This should include more funding for DRR programs and greater integration of risk reduction into government and donor policies and programs. More support for early warning systems, and national and community preparedness planning and disaster mitigation activities can build the resilience of health systems and help avert disasters' worst effects, including acute malnutrition and the collapse of support systems for mothers and infants. Support for community initiatives – such as a community resource fund that can be managed by mother leaders for activities like food banking, or the prepositioning of stocks at the village level – can help ensure local needs are met when a crisis hits.
- Ensuring that investments are based on robust risk assessments. Activities supported by NGOs and governments need to build on robust risk assessments that

Central African Republic

identify and explore the specific vulnerabilities of different groups, including pregnant and lactating women, and mothers more broadly. These need to be monitored to take into account the changing risk context and ensure activities and interventions are appropriate.

- Building conflict sensitivity into all DRR policies and programs in areas that are vulnerable to both natural disasters and conflict. This should be based on a solid understanding of underlying tensions and conflict cleavages and the unique challenges facing newborns in these contexts. It should also include a gender analysis to identify protection risks faced by girls and women as well as boys and men, so that at a minimum those programs do not inadvertently make them worse.

4) Design emergency interventions with a longer term view and the specific needs of mothers and newborns in mind. This includes:

- Making reproductive health care an essential component of emergency response through the *Minimum Initial Service Package for Reproductive Health* priority activities for care of mothers and newborns in emergencies.
- Ensuring that vaccination programs are continued and improved at the time of crisis to prevent vaccine-preventable diseases. This could include introducing new vaccines like rotavirus or pneumococcal vaccines.
- Elevating maternal and newborn survival as a priority for humanitarian response by designing and implementing emergency preparedness and response programs that include attention to the specialized needs of women and newborns, particularly around the time of birth, with special care for small and sick newborns to protect their health and survival. These include:
  - Distributing clean delivery and newborn care supplies to women who may not be able to give birth in a health facility
  - Providing quality services to the target population during pregnancy, childbirth and the postnatal period
  - Promoting essential newborn care by implementing the eight lifesaving interventions at birth: skilled care at birth and emergency obstetric care, management of preterm births, basic newborn care, neonatal resuscitation, kangaroo mother care,

treatment of severe newborn infections, inpatient supportive care for sick and small newborns, and prevention of mother-to-child transmission of HIV

  - Providing medicines and supplies so that nurses, midwives and other health providers can help sick newborns

  - Supporting community health workers to identify pregnant women and newborns and link them to the health system

  - Identifying and transferring sick newborns to the appropriate level of care via a functional referral system

- Setting up mother-baby friendly spaces or centers to encourage breastfeeding in emergencies. These centers offer mothers a quiet, safe, private and supportive place to feed their babies, along with guidance for breastfeeding and optimal complementary feeding. Wet nursing and re-lactation counselors can also help mothers who have used formula to start exclusive breastfeeding again. Breast-milk substitutes should be distributed only when breastfeeding is impossible and then only in a carefully targeted way in hygienic conditions.

- Increasing access to skilled support for Infant and Young Child Feeding (IYCF) and care for non-breastfed infants as a core, lifesaving intervention in emergencies. National and international actors should prioritize capacity building, strengthening of coordinating bodies and availability of necessary resources.

5) Ensure adequate financing, coordination and research to guarantee the above can be accomplished. This entails:

- Ensuring that the international development and humanitarian discussions and processes at play right now put women, girls and boys at the center and are mutually reinforcing. Analysis of what is needed to improve maternal and newborn health in fragile states must be at the core of the post-2015 MDGs agenda and the 2016 World Humanitarian Summit. Coordination in both the discussions and implementation of resulting initiatives will be needed to maximize impact and prevent gaps or competing efforts.

- Donors committing to increase long-term, predictable aid for health to fragile states. Funding mechanisms for this aid must be flexible and able to respond to different and changing contexts. Donor governments must uphold the commitments they have made to improving harmonization and alignment of aid delivery, and address the disparities in aid allocated, the duplication of efforts and the neglect of fragile states.

- Reconciling short-term humanitarian/disaster assistance with long-term development financing to rebuild health systems and infrastructure and minimize future disasters. This includes ensuring health interventions in emergencies do not undermine longer-term health care, the need to build long-term domestic revenue, and the need to ensure access in financing through universal health coverage, pooled resources, and risk sharing that permit no out-of-pocket fees at the time of treatment.

- Increasing donor aid to appeals directed toward projects specifically targeting gender issues such as girls' and women's empowerment, gender-based violence and the sexual exploitation and abuse of girls, boys and women in humanitarian crises.

- Meeting the UN Secretary-General's target that the primary purpose of 15 percent of all projects established post-conflict address women's specific needs, advance gender equality or empower women.

- Addressing the data gaps related to the impact of crises on maternal and child survival, including epidemiology of main causes of mortality, coverage and utilization of health care services, and better use of data to inform programming. In emergency contexts in particular, there is a paucity of data on the type of illnesses that affect women and children, the coverage of health care services and interventions, and the levels of maternal and child mortality. Better data is also needed more generally on indicators for quality of care and information on stillbirths. It is critical that national governments, academic institutes and other stakeholders commit to the collection of data, use of data and sharing of data for global learning

Because crises and fragility have multiple causes and manifestations, no single formula will fit all contexts. Governments, donors and partners need to invest in strategies that can be adapted to different levels of government engagement, institutional capacities and country contexts. They must also address immediate priority needs, promote and implement cost-effective, high-impact interventions, and build and support health systems.

Crucially, mothers and children need to be supported to engage effectively with national and international actors; influence policies, interventions and institutions; monitor health outcomes; and hold governments, donors and development and humanitarian actors accountable toward meeting the goal of ending maternal, newborn and child deaths.

Niger

The *Mothers' Index* Turns 15

From sub-Saharan Africa to Scandinavia, mothers make a difference every day

In 2000, Save the Children created the *Mothers' Index* to document conditions for mothers around the world, showing where they do best and where they face the greatest hardships. Why was Save the Children so concerned about mothers? Because decades of program experience had taught us that the quality of children's lives depends in large part on the health, security and well-being of their mothers. As primary caretakers in virtually every society, a mother's ability to make informed decisions about her children – their health, their education and their values – affects them for life. Ending preventable maternal deaths is an urgent priority in its own right. But it's also one of the surest ways of saving the lives of children.

This year, as we publish our 15th annual *Mothers' Index*, we take a look at trends so far this century. We see where investments in mothers and children have saved lives and put countries on a path to a better future. We also see where these investments have been insufficient, where the survival and well-being of mothers and children have not progressed enough, and where countries are falling behind.

The *Mothers' Index* is constructed to measure the overall status of mothers. Because there are limited data specifically on mothers, the *Index* is a composite of elements that make up a woman's well-being and those that comprise a child's well-being. Indicators measure what matters most to a mother: her health, the health of her children, her own educational attainment and that of her children, the family's economic status, and having a voice in policies that affect them. Some of these indicators are direct measures of maternal and child survival; others are closely correlated with, and indirectly contribute to progress on maternal and child health and well-being.

As the *Index* dataset has changed over the years with two major methodology revisions and the addition of more than 70 countries (most of which have come in at the middle), this analysis focuses on broad trends and observations across the top and bottom countries. For more on the limitations of this analysis, see Methodology and Research Notes.


Sweden

Humanitarian crises in the bottom 10

The *Mothers' Index* clearly shows how conflict, fragility and natural disasters have played a major role in undermining the well-being of mothers and children over the past 15 years. The majority of the bottom 10 countries on the *Index* have been in the midst of, or emerging from, a recent humanitarian emergency. Of the 28 countries that have ranked in the bottom 10 since 2000, all but four have a recent history of armed conflict[2] and all but one are current or former fragile states.[3] Nearly two-thirds (18 of 28) are characterized by persistent natural disasters.[4]

Seven different countries have placed last on the *Index* since it was launched in 2000: Niger (9 times), Afghanistan (2 times), Burkina Faso (once) Democratic Republic of the Congo (once), Guinea-Bissau (once), Mali (once) and Somalia (once).[5] Six of the seven have a recent history of conflict and all but Guinea-Bissau suffered recurring natural disasters during this period. Five of the seven countries are in West and Central Africa, the region that is lagging most in terms of progress towards the Millennium Development Goals on maternal and child survival.

International news reports – if they focus on the bottom-ranking countries at all – often describe breakdowns in health care, education, economies and governance that are typical in a humanitarian crisis. But most of these countries were among the poorest in the world to begin with, and recent crises have only exacerbated problems that have persisted for decades. Neglected human needs have been both a cause and a consequence of conflict in countries like Central African Republic, Somalia and Sudan. And the hardest hit families in any disaster – be it "natural" or man-made – tend to be the poorest of the poor, mostly women and children.

In order to improve conditions for mothers and children in countries at the bottom of the *Index*, it is clear we must do more to end and prevent conflict, reduce vulnerability to disasters, and deliver health care, nutrition and education to refugees and internally displaced persons. Meeting these needs in crisis settings is challenging, but recent history shows progress is possible. Afghanistan and Nepal both spent multiple years in the bottom 10, with armed conflict limiting basic services and contributing to widespread death and suffering. Both have also been hit hard by recurring natural disasters – at least one a year every year for the past 15 years. Yet both countries have risen dramatically in the *Mothers' Index* rankings, with Afghanistan now 33 places from the bottom and Nepal now 63 places

Violence in the Central African Republic

"One woman who was 4 months pregnant was bleeding heavily when she arrived. She had come from the bush to see us. Sadly, she lost her baby. It was due to the stress, tiredness and pressure she was under. Her body couldn't put up with it." – Christy, midwife, Mukassa IDP camp[6]

A severe humanitarian crisis intensified in the Central African Republic following the coup in March 2013. Nearly everyone in the country is affected and an estimated 2.5 million people (over half of the population) are now in need of humanitarian assistance, including over 1 million children.[7]

Violence and fear have gripped the country, resulting in the near collapse of the state administration and public infrastructure, and a breakdown in many basic social services. Armed groups have committed indiscriminate attacks against civilians, sexual and gender-based violence, and have recruited children into combat. Many people have been forced to flee their homes, losing property and livelihoods. Diseases are spreading, and there is increased potential for epidemics.

Even before the latest upsurge in violence, the health situation in the country was precarious, with CAR having some of the worst global health indicators. CAR was already one of the hardest places in the world to be a mother or a child – with the sixth highest child mortality and the third highest maternal mortality rates in the world.[8] The CAR has consistently placed near the bottom of the *Mothers' Index*, ranking in the bottom 10 six of last 15 years (there were five years when the country could not be ranked due to lack of data).

Now, an already weak health system has virtually collapsed. Health facilities have been looted and many medical staff have fled their posts. The lack of essential medicines, supplies and health professionals has seriously affected the ability of pregnant women, newborns and mothers to receive the health care they need.[9]

Countries in the Bottom 10 (2000-2014)

COUNTRY	#YEARS IN BOTTOM 10	#YEARS IN THE INDEX	% OF YEARS SPENT IN BOTTOM 10	LAST YEAR IN BOTTOM 10
Niger†	13	13	100%	2014
Chad*	13	14	93%	2014
Mali†	13	15	87%	2014
Guinea-Bissau	12	13	92%	2014
Yemen* †	12	15	80%	2012
Ethiopia* †	9	15	60%	2008
DR Congo* †	8	8	100%	2014
Sierra Leone*	8	11	73%	2014
Burkina Faso†	8	15	53%	2007
Eritrea*	7	13	54%	2012
Central African Republic†	6	10	60%	2014
Angola* †	5	11	45%	2009
Gambia†	5	15	33%	2013
Sudan* †	4	13	31%	2012
Afghanistan* †	3	5	60%	2012
Djibouti	3	9	33%	2009
Guinea†	3	11	27%	2003
Mauritania†	3	14	21%	2005
Nepal* †	3	15	20%	2005
Somalia* †	2	2	100%	2014
Nigeria†	2	14§	14%	2014
Côte d'Ivoire	2	15§	13%	2014
Benin	2	15	13%	2002
Burundi* †	2	15	13%	2001
South Sudan	1	3	33%	2012
Equatorial Guinea	1	8	13%	2010
Liberia*	1	9	11%	2006
Cambodia†	1	13	8%	2005

Note: Countries in red were "in conflict" at some point during the period 2000-2013, apart from Guinea-Bissau, which experienced conflict 1998-1999 and so was considered "emerging from conflict" in 2000-2001. Burkina Faso and Gambia had conflicts in the 1980s, but are not considered post-conflict for the purpose of this analysis. Benin and Equatorial Guinea have no history of conflict as recorded by Uppsala Conflict Data Program. For additional details, see Methodology and Research Notes.

* Conflict (2000-2013) reached "war" intensity. Sierra Leone, which was at war 1998-1999 and experienced post-war conflict 2001-2002 was included in this set.

† Country experienced recurring natural disasters over the period 1999-2013.

§ For six of these years (2007-2012) these two countries ranked last among the group of "less developed" countries surveyed.

from the bottom (see sidebar for more on what Afghanistan and Nepal have done right).

Other conflict-affected countries have been slower to translate post-conflict reconstruction into gains for mothers and children. Sierra Leone and Liberia, for example, haven't experienced conflict for more than a decade, but Sierra Leone is still in the bottom 10 (seventh from last on the *Index*) and Liberia is only two spots removed from the bottom 10 (12th from last place). Both countries did have exceptionally high mortality rates in 2000, and have made considerable progress in improving health care and mortality rates in the past

15 years, but their progress has not been sufficient to pull them ahead of other countries on the *Index*. In both countries today, 1 woman in 24 eventually dies in pregnancy or childbirth. In 2000, Sierra Leone had the highest child death rate in the world; this is still true today, as 18 percent of children in Sierra Leone do not survive to age 5. Both countries also lag behind on the political status of women, with only 12 percent of parliamentary seats occupied by women (compared to 23 percent across the region),[10] and both remain among the poorest places in the world.[11]

Gains and losses in the middle

The number of countries in the *Mothers' Index* has grown each year as new countries have been created, more countries have begun reporting data, and indicator modifications have expanded the size of the list. In 2000, the *Index* ranked 106 countries; in 2014 it ranks 178 countries. While every country's ranking is relative to those of other countries, the growth of the *Index* makes it especially difficult to compare changes in countries in the middle of the *Index*.

Looking at individual indicators, here are a few noteworthy examples of progress:

- Since 2000, Ethiopia has reduced its lifetime risk of maternal death by nearly two-thirds (from 1 in 24 to 1 in 67) – more than every other country on the African continent. By 2010, the proportion of parliamentary seats held by women in Ethiopia had steadily increased from 3 percent to 26 percent.
- Afghanistan, Bangladesh, Bhutan and Nepal have each cut maternal death rates by 60-70 percent since 2000.
- Estonia went from having some of the highest rates of maternal and child death in the industrialized world to having some of the lowest.
- Since 2000, Singapore has cut its risk of maternal death by over 80 percent, from more than 1 in 5,000 to less than 1 in 25,000.

Progress Despite Crises in Nepal and Afghanistan

Not long ago, Nepal was one of the toughest places in the world to be a mother, ranking in the bottom 10 on the *Mothers' Index* in 2000, 2002 and 2005. Communities in many parts of Nepal suffered – and continue to suffer – from food insecurity and recurring emergencies caused by floods, landslides, droughts, earthquakes and other natural hazards. Nepal also still struggles to overcome the effects of a decade-long civil war (1996-2006) that claimed the lives of 17,000 people and displaced up to 200,000 more.[12]

Despite enormous challenges, Nepal has made impressive gains in maternal and child health. Since 1990, the country has reduced under-5 mortality by 71 percent (from 142 to 42 deaths per 1,000 live births)[13] and maternal mortality by 78 percent (from 770 to 170 deaths per 100,000 live births).[14]

How did Nepal achieve this success? The country has demonstrated sustained political and financial commitment to improving health, including substantial increases in funding for maternal health since the early 1990s. It has also made good use of data and evidence to inform decisions, adopt new ideas and swiftly scale-up proven health interventions. Removing user fees and providing cash incentives expanded access to medical services. Improvements in girls' education and incomes of the poor have also contributed to survival gains.[15]

Nepal has also invested in training and deploying more frontline health workers, especially a large cadre of female community health volunteers. These volunteers promote safe motherhood, child health, family planning, and provide both treatment and referrals. Because they come from, and live in, the communities they serve, they help create a structure that is more resilient to the impact of emergencies.

Afghanistan, another country wracked by conflict and repeated disasters – was the worst place in the world to be a mother in 2010 and 2011, but has now also risen considerably in the *Mothers' Index*. With the help of massive amounts of outside funding, and the introduction of the Basic Package of Health Services program, Afghanistan has trained midwives, improved immunization coverage and raised girls' education levels, resulting in substantial improvements to women's and children's health.

Brazil

- Malawi and Tanzania have reduced under-5 mortality by nearly 60 percent and Rwanda has reduced it by 70 percent.
- Peru and Brazil cut child mortality rates almost in half in the 1990s and kept making progress, cutting child death rates an additional 55 percent since 2000.
- Since 2000, Cambodia has managed to reduce both maternal and child mortality by 64 percent, add 3 years to children's expected years of schooling, and almost tripled the share of seats held by women in the lower house of parliament.
- Compared to just a decade ago, children in Burundi now benefit from more than twice as many years of formal schooling (from less than 5 years to 10.5 years).
- Zambia raised the average child's educational attainment to nearly 13.5 years, which is 45 percent higher than the regional average.
- The proportion of parliamentary seats held by women in Rwanda more than tripled – from 17 to 58 percent – the highest percentage in the world today.
- Kenya's progress is a mixed bag. Although the country has managed to increase school life expectancy by over 2.5 years (to 11 years – well above the regional average) and raise the share of parliamentary seats held by women more than 5-fold since 2000 (to 20 percent, which is the regional average) – both of which have improved its position on the *Index* relative to other countries – Kenya hasn't kept up with the progress other countries have made economically or in the survival of mothers and children.

Here are some countries where progress has stalled or where trends are moving in the wrong direction:

- Zimbabwe's performance on all indicators but one (political status) has deteriorated relative to other countries.
- Panama's placement relative to other countries has fallen as the health, educational and political status of women there has stagnated.
- National-level data show Somalia has made no progress in saving mothers' lives since 2000. Today, 1 Somali mother in 16 still dies from a pregnancy-related cause. Child death rates have also shown little improvement, although sub-national data from Somaliland does show some reduction in child mortality since 2006. The annual average rate of decline in under-5 mortality since 2000 nationally has been just over 1 percent.
- While many countries in sub-Saharan Africa have made good gains on female political representation, progress has stalled in the Republic of Congo. With still just under 10 percent of seats occupied by women, Republic of Congo has less than half the regional average for this indicator (23 percent).[16]
- The Dominican Republic has made no progress on maternal health status. Dominican women today still face the same risk of maternal death they did more than a decade ago – 1 in 240.
- The lifetime risk of maternal death rose by 70 percent since 2000 in Mauritius, from 1 in 1,700 to 1 in 1,000.
- While many countries in South Asia have made remarkable reductions in maternal and child death rates, progress in Pakistan has been much slower (about 25-50 percent slower).

High standards and surprising slips in the top 10


Norway

European countries – along with Australia – have dominated the top positions in the *Mothers' Index* over the past 15 years. Only four countries have ever been named the best place to be a mother: Sweden (8 times), Norway (4 times), Finland (twice) and Switzerland (once). Iceland and Sweden have been in the top 5 each of the years they've been ranked. Denmark and the Netherlands have also been consistent top performers, usually placing in the middle of the top 10. Australia's rank has been generally a bit lower, but it has made the top 10 every year for the past 15 years. These countries remain among the best in the world for mothers' and children's health and well-being.

The United States has placed in the top 10 in the past, but next to Cyprus, it has fallen the furthest from the top and evidence shows that the health of American mothers and children is falling behind. The United States is among the countries that has made the least progress since 2000 on maternal and child survival. In the U.S., the lifetime risk of maternal death has risen more than 50 percent since 2000 – from 1 in 3,700 to 1 in 2,400. Today, an American woman faces the same lifetime risk of maternal death as a woman in Iran or Romania. The United States is also among the countries making the smallest strides in saving children's lives. Thirty-four countries, both rich and poor alike, have cut their under-5 mortality rate by half or more since 2000. The U.S. under-5 mortality rate has declined from 8.4 per 1,000 live births in 2000 to 7.1 per 1,000 live births in 2012 (only a 15 percent improvement). Only 14 countries in the world made less progress than the United States on this indicator during the same time period.

Countries in the Top 10 (2000-2014)

	# YEARS IN TOP 10	LAST YEAR IN TOP 10	SOWM 2014 RANK
Finland	15	2014	1
Norway	15	2014	2
Australia	15	2014	9
Sweden	14	2014	3
Denmark	14	2014	6
Netherlands	13	2014	5
Iceland	8	2014	4
Germany	8	2014	8
United Kingdom	8	2012	26
Canada	7	2006	18
Belgium	6	2014	9
New Zealand	6	2012	16
Austria	6	2006	12
United States	4	2006	31
Switzerland	4	2003	13
Spain	3	2014	7
Ireland	3	2012	19
France	3	2011	20
Cyprus	1	2000	37

While they still enjoy some of the lowest risks of maternal death in the world, several other top 10 countries appear to have lost ground on maternal health since 2000. Switzerland's lifetime risk of maternal death increased 19 percent, Spain's increased 23 percent, New Zealand's 27 percent and Denmark's 51 percent.

Netherlands is the only top 10 country to show dramatic improvement in maternal health since 2000. The lifetime risk of maternal death in the Netherlands has declined 58 percent – from 1 in 4,400 to 1 in 10,500. Cyprus, with a 41 percent reduction, is the only other top 10 country to have cut the risk of maternal death by at least a quarter.

Why does maternal mortality appear to be on the rise in so many industrialized countries? The UN group responsible for these estimates (UNICEF, World Bank, WHO and UNFPA) does not explain these findings. National experts do not fully understand either. In the United States, many suspect increases are due to more high-risk pregnancies caused by the rising prevalence of obesity, diabetes, hypertension and cardiovascular disease, more older women having children, advancements in fertility treatments that result in multiple births, and the high rate of cesarean sections – all of which increase the risk a mother faces during pregnancy and childbirth. Recent studies in the U.S. also suggest that poor quality care and better counting of maternal deaths may play a role. These trends are also likely to be contributing factors to rising risks in other developed contexts.

The 2014 Mothers' Index and Country Rankings

Save the Children's 15th annual *Mothers' Index* assesses the well-being of mothers and children in 178 countries – 46 developed nations[17] and 132 in the developing world. All countries with populations over 100,000 and sufficient data are included in the *Index*.

The *Index* relies exclusively on information published by authoritative international data agencies. The *Complete Mothers' Index*, based on a composite score of five indicators related to maternal well-being, begins on page 77 of this report.

For an explanation of how the *Index* is calculated, see the Methodology and Research Notes.

Mothers' Index Rankings

Europe continues to dominate the top positions on the 2014 *Mothers' Index* while countries in sub-Saharan Africa fill the lowest ranks. The United States places 31st this year.

The 10 top-ranked countries, in general, are among the best countries in the world for mothers' and children's health, educational, economic and political status.

The 10 bottom-ranked countries – all but one of them in West and Central Africa – are a reverse image of the top 10, performing poorly on all indicators. Seven of these 10 toughest places to be a mother are currently experiencing a humanitarian crisis.[18] Somalia, the lowest ranked country, has experienced almost constant conflict since the collapse of its central government in 1991. Conditions for mothers and their children in these countries are devastating:

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 and the poorest families in a country may vary greatly from the national average. Remote rural areas and urban slums often have fewer services and more dire statistics. War, violence, corruption 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.

Refugees from Mali living in Niger


Afghanistan

- On average, 1 woman in 27 is likely to die from a pregnancy-related cause.
- 1 child in 7 dies before his or her fifth birthday.
- Children can expect to receive as little as 2 years but not more than 10 years of formal education.
- GNI per capita, a measure of a country's economic welfare and a mother's access to resources, is less than $650 on average.
- Women hold at most 15 percent of parliamentary seats.
- Eight out of 10 women are likely to suffer the loss of a child in their lifetime.[19]

The contrast between the top-ranked country, Finland, and the lowest-ranked country, Somalia, is striking. Although maternal death is a rare event in Finland (the lifetime chance of dying in pregnancy or childbirth is less than 1 in 12,000), one Somali woman in 16 is likely to eventually die of a maternal cause. Nearly every Finnish child – girl and boy alike – enjoys good health services and education. But children in Somalia face incredible odds. Fifteen percent of Somali children do not live to see their fifth birthday. In Finland, it's only 0.3 percent. At these rates, statistically speaking, nearly every Somali mother is likely to lose a child under age 5, whereas only 1 in 181 Finnish women are likely to suffer the loss of a young child. Children in Somalia receive less than 2.5 years of formal education, while the typical Finnish child stays in school for 17 years. Somalia is also one of the poorest countries in the world. Finland has 380 times its national wealth. And Finnish women hold three times as many parliamentary seats: 43 percent in Finland compared to 14 percent in Somalia.

But there are signs of hope in Somalia. Sub-national data suggest some parts of the country have made gains on child survival in recent years. In Somaliland, the under-5 mortality rate (estimated at 91 per 1,000 live births) has declined by 19 percent since 2006 and is significantly lower than the national average.[20] And although no new sub-national data on maternal mortality are available, small improvements on other measures of maternal health (for example, skilled birth attendance and facility births) have been noted in northern zones.[21]

The 5 Indicators of the 2014 Mothers' Index

Maternal health — **Lifetime risk of maternal death:** No mother should die giving life. A woman's risk of maternal death is a function of the number of pregnancies/births she has, the spacing of births, the conditions under which she gives birth as well as her own health and nutritional status. Maternal mortality is also a sensitive measure of health system strength, access to quality care and coverage of effective interventions to prevent maternal deaths.

Children's well-being — **Under-5 mortality rate:** A mother's well-being is intimately connected to the health and well-being of her children. U5MR is a leading indicator of child well-being, reflecting children's health and nutritional status. It is also a key indicator of coverage of child survival interventions as well as the quality of care mothers receive before, during and after pregnancy.

Educational status — **Expected years of formal schooling:** Education is a basic human right and a powerful determinant of life quality. Numerous studies show a robust relationship between years of schooling and a number of important life outcomes, including income, health and civic participation. And when a girl is educated, her children are more likely to be healthy and well schooled.

Economic status — **Gross national income per capita:** Mothers are likely to use the resources they control to promote the needs of their children. GNI per capita is the best measure available to gauge a mother's access to economic resources and, therefore, her ability to provide for her children.

Political status — **Participation of women in national government:** When women have a voice in politics, issues that are important to mothers and their children are more likely to surface on the national agenda and emerge as national priorities.

Note: For indicator definitions and data sources, see Methodology and Research Notes.

A Note on Interpreting Index Rankings

Rankings reflect a composite score derived from five different indicators related to maternal well-being (i.e. maternal health, children's well-being, educational status, economic status and political status). Consistently strong performance across the five indicators yields a higher ranking than exceptional performance on a few and somewhat lower performance on the others. In other words, all-around excellence is rewarded with higher rankings than super performance on some, but not all, indicators. Similarly, consistently poor performance across the five indicators yields a lower ranking than the worst performance on some indicators and somewhat better performance on others. This is the nature of composite scores.

It is also important to note that countries in the top and bottom 10 – particularly the top and bottom three – cluster very tightly. Consequently, while a ranking necessitates that some country will be first and another last, the differences across top and bottom performers can be very modest. This also means that the smallest change could shuffle ranks.

The *Mothers' Index* uses the most recently published internationally comparable data available as of March 13, 2014 – but there is often lag time in the reporting of data. Since indicator data are for 2010 to 2014, the numbers may not reflect current conditions in some countries. In Central African Republic and South Sudan, for example, most data are prior to recent escalations in violence. And in Spain, it may take another year or two for the data to reflect the effects of the current financial crisis, which has led to growing unemployment and reductions in welfare that have hit mothers and children especially hard.


Cambodia

Frequently Asked Questions about the Mothers' Index

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

The United States ranks 31st on this year's *Index*. Although the U.S. performs quite well on economic and educational status (8th and 14th best in the world, respectively) it lags behind all other top-ranked countries on maternal health (46th in the world) and children's well-being (40th in the world) and performs quite poorly on political status (96th in the world). To elaborate:

In the United States, women face a 1 in 2,400 risk of maternal death. Only five developed countries in the world – Albania, Latvia, Moldova, Russian Federation and Ukraine – perform worse than the United States on this indicator. A woman in the U.S. is more than 10 times as likely as a woman in Estonia, Greece or Singapore to eventually die from a pregnancy-related cause.

In the United States, the under-5 mortality rate is 7.1 per 1,000 live births. This is roughly on par with Bosnia and Herzegovina, Macedonia, Qatar and Uruguay. At this rate, children in the U.S. are three times as likely as children in Iceland to die before their 5th birthday.

Women make up 51 percent of the United States' population, but hold less than 19 percent of seats in Congress. More than half of all countries in the world perform better on this indicator than the U.S. Sixteen countries have more than double this percentage of seats occupied by women. In Finland and Sweden, for example, women hold 43 and 45 percent of parliamentary seats, respectively. In Rwanda, women hold 58 percent of seats.

Why is Finland first?

Finland has strong performance across all five dimensions of maternal and child health and well-being. Although Finland does not perform the absolute "best" overall on any one indicator, it is the only country to place in the top 15 on all five indicators. In fact, all other top 10 countries (apart from the Netherlands) perform significantly lower (i.e. they rank in the 20s or worse) on at least one indicator. Thus, it is consistently high performance that puts Finland on top.

Why is Somalia last?

Somalia's economic and educational indicators are the lowest in the world. On maternal and child mortality it ranks second and fourth from last. And although Somalia does slightly better on political status, it's not enough to compensate for poor performance across the other four indicators. It is this placement in the bottom 5 on four of the five indicators that causes Somalia to rank last on the *Index*. As discussed elsewhere in this report, Somalia's national level data mask sub-national variations.

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

The only basis for excluding a country was insufficient data or a national population below 100,000.

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 all children, provide access to maternal and child health care and advance women's economic and political 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 industrialized nations, governments and communities need to work together to improve education and health care for disadvantaged mothers and children.

Gaps between rich and poor

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 role that armed conflict and poor governance play in these tragedies. All the bottom 10 countries have a recent history of armed conflict and all 10 are considered to be fragile states,[22] which means they are failing in fundamental ways to perform functions necessary to meet their citizens' basic needs and expectations.

There are also strong regional dimensions to this tragedy. The bottom 10 countries are all in sub-Saharan Africa and that region also accounts for 26 of the 30 lowest-ranking countries. While Africa as a whole has made substantial reductions in maternal and child mortality, and gains against the other indicators, it has progressed more slowly than other regions, and on a regional level, performs worst on every indicator but one (political status). There is great

diversity within Africa, however. Some countries score relatively high against several indicators, and a number of low-income African countries – including Malawi and Ethiopia – are on track to reduce child mortality by two-thirds by 2015.

The greatest disparity across regions is found in the lifetime risk of maternal death. In West and Central Africa, 1 woman in 32 is likely to die in pregnancy or childbirth. This is nearly 5 times the risk facing women in South Asia (1 in 150) and almost 150 times the risk women in industrialized countries face (1 in 4700).[23] Children in West and Central Africa are similarly disadvantaged compared to children in other regions. Almost 1 child in 8 does not live to see his or her 5th birthday. This is twice the risk of death a child in South Asia faces and 20 times the risk in more developed countries. In 2012, an estimated 2 million children in West and Central Africa died before reaching age 5. This is nearly one-third (30 percent) of the world total.[24]

The capacity of countries to address these issues is often constrained by financial resources. Somalia, DR Congo and Burundi are the poorest countries in the world, with an estimated GNI per capita of only around $200. Compare this to the national wealth of Norway – $98,860 per capita.

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

- According to the most recent estimates, 1 woman in 15 dies in pregnancy or childbirth in Chad. The risk is 1 in 16 in Somalia and 1 in 23 in Niger and Sierra Leone. In Estonia, Greece and Singapore, by contrast, the risk of maternal death is less than 1 in 25,000.
- 1 child in 7 does not reach his or her fifth birthday in Chad, DR Congo and Somalia. In Angola and Sierra Leone it's 1 in 6. Compare this to Iceland, where only 1 child in 430 dies before reaching age 5.
- A typical child in Eritrea, Niger, South Sudan and Sudan receives only about 5 years of formal education. Somali children receive less than 2.5 years of schooling. In Australia and New Zealand, however, the average child can expect to stay in school for over 19 years.
- In Micronesia, Qatar and Vanuatu, not one parliamentary seat is occupied by a woman. In Comoros, Solomon Islands and Tonga, women have only 1 seat. Compare this to Cuba, Rwanda and Sweden, where women hold 45 percent or more of all seats in parliament.

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


Sierra Leone

2014 Mothers' Index Rankings

Country	Rank
Finland	1
Norway	2
Sweden	3
Iceland	4
Netherlands	5
Denmark	6
Spain	7
Germany	8
Australia	9*
Belgium	9*
Italy	11
Austria	12
Switzerland	13
Portugal	14
Singapore	15
New Zealand	16
Slovenia	17
Canada	18
Ireland	19
France	20*
Greece	20*
Luxembourg	22
Estonia	23
Czech Republic	24*
Lithuania	24*
Belarus	26*
United Kingdom	26*
Israel	28
Poland	29
Republic of Korea	30
United States	31
Japan	32
Croatia	33
Latvia	34
Cuba	35
Serbia	36
Cyprus	37
Saudi Arabia	38
Costa Rica	39
TfYR Macedonia	40
Malta	41
Grenada	42
Argentina	43
Bulgaria	44
Montenegro	45*
Slovakia	45*
Chile	47
Bosnia and Herzegovina	48
Barbados	49
Bahrain	50
Qatar	51
United Arab Emirates	52
Uruguay	53
Mexico	54
Hungary	55
Mauritius	56
Kuwait	57
Libya	58
Tunisia	59*

Country	Rank
Turkey	59*
China	61
Russian Federation	62
Kazakhstan	63
Ecuador	64
Romania	65*
Trinidad and Tobago	65*
Venezuela (Bolivarian Republic of)	67
Malaysia	68
Oman	69
Bahamas	70
Algeria	71
Peru	72*
Thailand	72*
Ukraine	72*
South Africa	75
Brazil	76
Lebanon	77
El Salvador	78*
Fiji	78*
Saint Lucia	80
Iran (Islamic Republic of)	81
Turkmenistan	82
Albania	83
Cape Verde	84
Colombia	85
Belize	86*
Saint Vincent and the Grenadines	86*
Mongolia	88
Sri Lanka	89
Maldives	90
Jamaica	91
Republic of Moldova	92
Bolivia (Plurinational State of)	93*
Vietnam	93*
Armenia	95*
Jordan	95*
Nicaragua	95*
Georgia	98
Azerbaijan	99*
Suriname	99*
Tonga	101
Dominican Republic	102
Namibia	103
Iraq	104
Paraguay	105*
Philippines	105*
Honduras	107
Kyrgyzstan	108
Panama	109
Timor-Leste	110
Uzbekistan	111
Guyana	112
Indonesia	113
Gabon	114
Syrian Arab Republic	115
Nepal	116
Egypt	117
Samoa	118

Country	Rank
Angola	119
Botswana	120
Morocco	121*
Rwanda	121*
Sao Tome and Principe	123
Senegal	124
Vanuatu	125
Equatorial Guinea	126*
Guatemala	126*
Bhutan	128
Lao People's Democratic Republic	129
Bangladesh	130*
Lesotho	130*
Cambodia	132
Uganda	133
Tajikistan	134
Micronesia (Federated States of)	135*
United Republic of Tanzania	135*
India	137
Mozambique	138
Swaziland	139
Solomon Islands	140
Zimbabwe	141
Cameroon	142
Kenya	143
Madagascar	144
Zambia	145
Afghanistan	146
Burundi	147*
Pakistan	147*
Ethiopia	149
Ghana	150*
Sudan	150*
Eritrea	152*
Togo	152*
Malawi	154
Mauritania	155
Comoros	156
Myanmar	157
Congo	158*
South Sudan	158*
Djibouti	160
Burkina Faso	161
Yemen	162
Guinea	163
Papua New Guinea	164
Benin	165
Gambia	166
Liberia	167
Haiti	168
Côte d'Ivoire	169
Chad	170
Nigeria	171
Sierra Leone	172
Central African Republic	173
Guinea-Bissau	174
Mali	175*
Niger	175*
Democratic Republic of the Congo	177
Somalia	178

* Countries are tied

Note: Countries in red are fragile states. Of the 51 fragile states identified by OECD, 45 are included in the *Mothers' Index* rankings. DPR Korea, Kiribati, Kosovo, Marshall Islands, occupied Palestinian territory and Tuvalu are not included due to lack of data and/or not meeting the minimum population threshold. Source: OECD, *Fragile States 2014: Domestic Revenue Mobilisation, p.83*

	MATERNAL HEALTH	CHILDREN'S WELL-BEING	EDUCATIONAL STATUS	ECONOMIC STATUS	POLITICAL STATUS	
Country or Territory	Lifetime risk of maternal death (1 in number stated) 2010	Under-5 mortality rate (per 1,000 live births) 2012	Expected number of years of formal schooling 2013	Gross national income per capita (current US$) 2012	Participation of women in national government (% seats held by women)* 2014	Mothers' Index Rank (out of 178 countries) 2014
Afghanistan	32	98.5	9.5(b)	680	27.6	**146**
Albania	2,200	16.7	10.8	4,030	20.0	**83**
Algeria	430	20.0	14.0	5,020	25.7	**71**
Angola	39	163.5	11.3	4,580	36.8	**119**
Argentina	560	14.2	16.7	5,170	37.1	**43**
Armenia	1,700	16.4	12.3	3,720	10.7	**95**
Australia	8,100	4.9	19.9(a)	59,360	31.1	**9**
Austria	18,200	4.0	15.6	47,660	32.2	**12**
Azerbaijan	1,000	35.2	11.9	6,220	15.6	**99**
Bahamas	1,100	16.9	12.6(x)	20,600	16.7	**70**
Bahrain	1,800	9.6	13.4(x,d)	14,820	18.8	**50**
Bangladesh	170	40.9	10.0	840	20.0	**130**
Barbados	1,300	18.4	15.4	15,080	21.6	**49**
Belarus	16,300	5.2	15.7	6,530	29.5	**26**
Belgium	7,500	4.2	16.2	44,660	40.7	**9**
Belize	610	18.3	13.7	4,490	13.3	**86**
Benin	53	89.5	11.0	750	8.4	**165**
Bhutan	210	44.6	12.7	2,420	8.3	**128**
Bolivia, Plurinational State of	140	41.4	13.2	2,220	30.1	**93**
Bosnia and Herzegovina	11,400	6.7	13.4(x)	4,750	19.3	**48**
Botswana	220	53.3	11.7	7,650	9.5	**120**
Brazil	910	14.4	14.2(x)	11,630	9.6	**76**
Brunei Darussalam	1,900	8.0	14.5	31,590	—	**—**
Bulgaria	5,900	12.1	14.3	6,840	24.6	**44**
Burkina Faso	55	102.4	7.5	670	18.9	**161**
Burundi	31	104.3	10.5(b)	240	34.9	**147**
Cambodia	150	39.7	10.9	880	18.5	**132**
Cameroon	31	94.9	10.4	1,170	27.1	**142**
Canada	5,200	5.3	15.8	50,970	28.5	**18**
Cape Verde	480	22.2	13.2	3,830	20.8	**84**
Central African Republic	26	128.6	7.2	510	12.5(f)	**173**
Chad	15	149.8	7.4	770	14.9	**170**
Chile	2,200	9.1	15.2	14,310	16.5	**47**
China	1,700	14.0	13.1	5,720	23.4	**61**
Colombia	430	17.6	13.2	7,020	13.6	**85**
Comoros	67	77.6	12.8	840	3.0	**156**
Congo	39	96.0	11.1	2,550	9.6	**158**
Congo, Democratic Republic of the	30	145.7	9.7	230	9.7	**177**
Costa Rica	1,300	9.9	13.7	8,820	38.6	**39**
Côte d'Ivoire	53	107.6	6.5(x)	1,220	9.4	**169**
Croatia	4,100	4.7	14.5	13,490	23.8	**33**
Cuba	1,000	5.5	14.5	5,890	48.9	**35**
Cyprus	6,300	3.2	14.0	26,110	12.5	**37**
Czech Republic	12,100	3.8	16.4	18,120	18.9	**24**
Denmark	4,500	3.7	16.9	59,850	39.1	**6**
Djibouti	140	80.9	6.6(b)	1,030	12.7	**160**
Dominican Republic	240	27.1	12.3(x)	5,470	19.1	**102**
Ecuador	350	23.3	13.7(x)	5,170	41.6	**64**
Egypt	490	21.0	13.1	2,980	2.8(f)	**117**
El Salvador	490	15.9	12.3	3,590	26.2	**78**
Equatorial Guinea	88	100.3	8.5	13,560	18.3	**126**
Eritrea	86	51.8	4.2(b)	450	22.0	**152**

Country or Territory	MATERNAL HEALTH Lifetime risk of maternal death (1 in number stated) 2010	CHILDREN'S WELL-BEING Under-5 mortality rate (per 1,000 live births) 2012	EDUCATIONAL STATUS Expected number of years of formal schooling 2013	ECONOMIC STATUS Gross national income per capita (current US$) 2012	POLITICAL STATUS Participation of women in national government (% seats held by women)* 2014	Mothers' Index Rank (out of 178 countries) 2014
Estonia	25,100	3.6	16.5	16,150	19.0	**23**
Ethiopia	67	68.3	6.6	380	25.5	**149**
Fiji	1,400	22.4	15.7	4,110	12.6(f)	**78**
Finland	12,200	2.9	17.0	46,490	42.5	**1**
France	6,200	4.1	16.0	41,750	24.8	**20**
Gabon	130	62.0	13.0(x)	10,040	15.8	**114**
Gambia	56	72.9	9.1	510	9.4	**166**
Georgia	960	19.9	13.2	3,270	12.0	**98**
Germany	10,600	4.1	16.3	44,260	35.6	**8**
Ghana	68	72.0	11.5	1,550	10.9	**150**
Greece	25,500	4.8	16.5	23,260	21.0	**20**
Grenada	1,700	13.5	15.8	7,220	25.0	**42**
Guatemala	190	32.0	10.6	3,120	13.3	**126**
Guinea	30	101.2	8.7	440	21.9	**163**
Guinea-Bissau	25	129.1	9.0	510	11.0	**174**
Guyana	150	35.2	10.3	3,410	31.3	**112**
Haiti	83	75.6	7.6(x,d)	760	3.5	**168**
Honduras	270	22.9	11.4	2,120	25.8	**107**
Hungary	3,300	6.2	15.4	12,380	9.4	**55**
Iceland	8,900	2.3	18.7	38,330	39.7	**4**
India	170	56.3	11.7	1,580	11.4	**137**
Indonesia	210	31.0	12.7	3,420	18.6	**113**
Iran, Islamic Republic of	2,400	17.6	15.2	4,290	3.1	**81**
Iraq	310	34.4	10.1	5,870	25.2	**104**
Ireland	8,100	4.0	18.6(a)	39,110	19.9	**19**
Israel	5,100	4.2	15.7	28,380	22.5	**28**
Italy	20,300	3.8	16.3	33,860	30.6	**11**
Jamaica	370	16.8	12.5	5,120	16.7	**91**
Japan	13,100	3.0	15.3	47,880	10.8	**32**
Jordan	470	19.1	13.3	4,670	12.0	**95**
Kazakhstan	770	18.7	15.0	9,780	19.8	**63**
Kenya	55	72.9	11.0	860	20.3	**143**
Kiribati	—	59.9	12.3	2,520	8.7	**—**
Korea, Democratic People's Republic of	670	28.8	—	580(x)	15.6	**—**
Korea, Republic of	4,800	3.8	17.0	22,670	15.7	**30**
Kuwait	2,900	11.0	14.6	44,100	4.6	**57**
Kyrgyzstan	480	26.6	12.5	990	23.3	**108**
Lao People's Democratic Republic	74	71.8	10.3	1,270	25.0	**129**
Latvia	2,000	8.7	15.5	14,120	25.0	**34**
Lebanon	2,100	9.3	13.2	9,190	3.1	**77**
Lesotho	53	99.6	11.1	1,380	26.8	**130**
Liberia	24	74.8	10.7	370	11.7	**167**
Libya	620	15.4	16.1	12,930	16.5	**58**
Lithuania	9,400	5.4	16.7	13,830	24.1	**24**
Luxembourg	3,200	2.2	13.9	71,620	28.3	**22**
Macedonia, The former Yugoslav Republic of	6,300	7.4	13.3	4,620	34.1	**40**
Madagascar	81	58.2	10.3	430	23.1	**144**
Malawi	36	71.0	10.8(b)	320	22.3	**154**
Malaysia	1,300	8.5	12.7	9,820	13.9	**68**
Maldives	870	10.5	12.7	5,750	6.8	**90**
Mali	28	128.0	8.6	660	9.5	**175**
Malta	8,900	6.8	14.5	19,760	14.3	**41**

Country or Territory	MATERNAL HEALTH Lifetime risk of maternal death (1 in number stated) 2010	CHILDREN'S WELL-BEING Under-5 mortality rate (per 1,000 live births) 2012	EDUCATIONAL STATUS Expected number of years of formal schooling 2013	ECONOMIC STATUS Gross national income per capita (current US$) 2012	POLITICAL STATUS Participation of women in national government (% seats held by women)* 2014	Mothers' Index Rank (out of 178 countries) 2014
Mauritania	44	84.0	8.2	1,110	22.2	**155**
Mauritius	1,000	15.1	15.6	8,570	18.8	**56**
Mexico	790	16.2	12.8	9,640	36.8	**54**
Micronesia, Federated States of	290	38.5	11.7(b)	3,230	0.0	**135**
Moldova, Republic of	1,500	17.6	11.8	2,070	18.8	**92**
Mongolia	600	27.5	15.0	3,160	14.9	**88**
Montenegro	7,400	5.9	15.2	7,220	14.8	**45**
Morocco	400	31.1	11.6	2,960	11.0	**121**
Mozambique	43	89.7	9.5	510	39.2	**138**
Myanmar	250	52.3	8.7(b)	1,130(x)	4.3	**157**
Namibia	160	38.7	11.3	5,610	26.0	**103**
Nepal	190	41.6	12.4	700	29.9	**116**
Netherlands	10,500	4.1	17.9	47,970	37.8	**5**
New Zealand	3,300	5.7	19.4(a)	30,640	33.9	**16**
Nicaragua	350	24.4	10.5	1,650	40.2	**95**
Niger	23	113.5	5.4	390	13.3	**175**
Nigeria	29	123.7	9.0	1,440	6.6	**171**
Norway	7,900	2.8	17.6	98,860	39.6	**2**
Occupied Palestinian Territory	330	22.6	13.2	1,340	—	**—**
Oman	1,200	11.6	13.6	19,110	9.6	**69**
Pakistan	110	85.9	7.7	1,260	19.7	**147**
Panama	410	18.5	12.4	8,510	8.5	**109**
Papua New Guinea	110	63.0	5.8(x,d)	1,790	2.7	**164**
Paraguay	310	22.0	12.8	3,400	16.8	**105**
Peru	570	18.2	13.1	6,060	22.3	**72**
Philippines	300	29.8	11.3	2,500	27.2	**105**
Poland	14,400	5.0	15.5	12,660	22.3	**29**
Portugal	9,200	3.6	16.3	20,620	31.3	**14**
Qatar	5,400	7.4	13.8	76,010	0.0	**51**
Romania	2,600	12.2	14.1	8,820	11.7	**65**
Russian Federation	2,000	10.3	14.0	12,700	12.1	**62**
Rwanda	54	55.0	10.2	600	57.5	**121**
Saint Lucia	1,400	17.5	12.2	6,890	17.2	**80**
Saint Vincent and the Grenadines	940	23.4	13.3	6,400	13.0	**86**
Samoa	260	17.8	12.4(b)	3,260	4.1	**118**
Sao Tome and Principe	330	53.2	11.3(b)	1,310	18.2	**123**
Saudi Arabia	1,400	8.6	15.6	21,210	19.9	**38**
Senegal	54	59.6	7.9	1,030	43.3	**124**
Serbia	4,900	6.6	13.6	5,280	33.6	**36**
Sierra Leone	23	181.6	8.8(e)	580	12.1	**172**
Singapore	25,300	2.9	14.4(x,c)	47,210	25.3	**15**
Slovakia	12,200	7.5	12.4	17,180	18.7	**45**
Slovenia	5,900	3.1	16.8	22,800	25.4	**17**
Solomon Islands	240	31.1	12.2(b)	1,130	2.0	**140**
Somalia	16	147.4	2.4(x)	120(x)	13.8	**178**
South Africa	140	44.6	13.1(x,d)	7,610	43.5(g)	**75**
South Sudan ‡	31	104.0	4.5(x)	790	24.3	**158**
Spain	12,000	4.5	17.1	29,620	37.0	**7**
Sri Lanka	1,200	9.6	13.7	2,920	5.8	**89**
Sudan ‡	31	73.1	4.5(x)	1,500	23.8	**150**
Suriname	320	20.8	13.0(b)	8,680	11.8	**99**
Swaziland	95	79.7	11.3	2,860	14.7	**139**

	MATERNAL HEALTH	CHILDREN'S WELL-BEING	EDUCATIONAL STATUS	ECONOMIC STATUS	POLITICAL STATUS	
Country or Territory	Lifetime risk of maternal death (1 in number stated) 2010	Under-5 mortality rate (per 1,000 live births) 2012	Expected number of years of formal schooling 2013	Gross national income per capita (current US$) 2012	Participation of women in national government (% seats held by women)* 2014	Mothers' Index Rank (out of 178 countries) 2014
Sweden	14,100	2.9	15.8	55,970	45.0	**3**
Switzerland	9,500	4.3	15.7	80,970	28.9	**13**
Syrian Arab Republic	460	15.1	12.0	2,610	12.0	**115**
Tajikistan	430	58.3	11.2	860	14.4	**134**
Tanzania, United Republic of	38	54.0	9.2	570	36.0	**135**
Thailand	1,400	13.2	13.1	5,210	15.7	**72**
Timor-Leste	55	56.7	11.7	3,620	38.5	**110**
Togo	80	95.5	12.2	500	16.5	**152**
Tonga	230	12.8	14.7	4,220	3.6	**101**
Trinidad and Tobago	1,300	20.7	12.3	14,710	24.7	**65**
Tunisia	860	16.1	14.6	4,150	28.1	**59**
Turkey	2,200	14.2	14.4	10,830	14.4	**59**
Turkmenistan	590	52.8	12.6(x,d)	5,410	26.4	**82**
Uganda	49	68.9	10.8	440	35.0	**133**
Ukraine	2,200	10.7	15.1	3,500	9.7	**72**
United Arab Emirates	4,000	8.4	12.0(x)	35,770	17.5	**52**
United Kingdom	4,600	4.8	16.2	38,670	23.0	**26**
United States	2,400	7.1	16.5	52,340	18.6	**31**
Uruguay	1,600	7.2	15.5	13,580	11.5	**53**
Uzbekistan	1,400	39.6	11.5	1,720	19.2	**111**
Vanuatu	230	17.9	11.7(b)	3,000	0.0	**125**
Venezuela, Bolivarian Republic of	410	15.3	14.2	12,460	17.0	**67**
Vietnam	870	23.0	11.9(x)	1,550	24.3	**93**
Yemen	90	60.0	9.2	1,270	0.7	**162**
Zambia	37	88.5	13.5	1,350	10.8	**145**
Zimbabwe	52	89.8	9.3	650	35.1	**141**
REGIONAL MEDIANS §						
Sub-Saharan Africa	53	86	10	780	19	**150**
South Asia	180	43	12	1,420	16	**129**
East Asia and the Pacific	295	28	12	3,230	15	**108**
Latin America and Caribbean	525	18	13	6,230	18	**79**
Middle East and North Africa	555	17	13	4,845	12	**77**
CEE/CIS	2,200	14	13	5,280	19	**65**
Industrialized countries	8,900	4	16	38,500	27	**19**
WORLD	180	48	12	10,140	22	

Note: Data refer to the year specified in the column heading or the most recent year available. For indicator definitions and data sources see Methodology and Research Notes.

— Data are not available.

* Figures correspond to the number of seats currently filled in parliament.

‡ Data for maternal health and educational status are pre-secession estimates.

§ UNICEF regions. For a complete list of countries and territories in these regions, see: UNICEF, *The State of the World's Children 2012*, p.124. Medians are based only on the countries included in the *Index* table.

x Data are from a secondary source.

a Discounted to 18 years prior to calculating the *Index* rank.

b Refers to primary and secondary education only.

c Calculated by the Singapore Ministry of Education.

d Based on cross-country regression.

e Estimate excludes years spent repeating grades.

f Data reflect the situation prior to parliament's dissolution.

g Figures are calculated on the basis of permanent seats only.

Methodology and Research Notes

The Complete Mothers' Index

In the first year of the *Mothers' Index* (2000), a review of literature and consultations with international experts including Save the Children staff were undertaken to identify the factors most closely linked to the well-being of mothers. Four factors were ultimately identified as the major determinants of a mother's well-being: maternal health; educational status; political status; and children's well-being. In 2007, several changes were introduced to the *Mothers' Index*. Indicators of economic status were incorporated into the *Index*. Countries were placed into one of three tiers (more, less and least developed) according to a categorization scheme established by the United Nations. The indicators used to calculate the *Index* were specific to each tier.

In 2013, the *Index* was again revised in keeping with best practice and to accommodate changes that were introduced by the international organizations that gather the data. Since that year, all countries – rich and poor alike – are evaluated against the same five indicators (outlined below), one for each of the five dimensions of maternal well-being. The specific indicators used in these comparisons were chosen on the basis of their reliability, validity, availability for the largest possible number of countries, and year-to-year variability (in order to construct a dynamic *Index*).

General note on the data

Save the Children does not collect original data for the *Mothers' Index*. Instead, it uses data from international data agencies with the mandate, resources and expertise to collect, certify and publish national data on specific indicators. International agencies sometimes harmonize data to ensure comparability across countries, and adjust for under-reporting, which can lead to discrepancies between international and national estimates. The data included in the *Index* are those most recently published as of March 13, 2014. Full source details and indicator definitions are included below.

Improvements in data collection and data reporting practices have led to an ever-growing number of countries included in the *Index* over the years. In 2000, 106 countries were ranked. Today, 178 countries are included in the *Index*. As a result, the number of countries any given country is compared to has grown.

Unless otherwise noted, regional averages and medians are for countries and territories as classified by UNICEF (see *The State of the World's Children 2012*, p.124).

Indicators, definitions and data sources

Lifetime risk of maternal death: The probability that a 15-year-old female will die eventually from a maternal cause. This indicator takes into account both the probability of becoming pregnant and the probability of dying as a result of that pregnancy, accumulated across a woman's reproductive years. Data are for 2010. *Source: United Nations Inter-agency Group (WHO, UNICEF, UNFPA and the World Bank). Trends in Maternal Mortality: 1990 to 2010. (WHO: Geneva: 2012)*

Under-5 mortality rate: The probability of dying between birth and exactly 5 years of age, expressed per 1,000 live births. Data are for 2012. *Source: United Nations Inter-agency Group for Child Mortality Estimation (UNICEF, WHO, UN Population Division, and the World Bank) 2013. Retrieved from CME Info on March 13, 2014*

Expected number of years of formal schooling: School life expectancy (SLE) is defined as the number of years a child of school entrance age can expect to spend in school and university (i.e. primary, secondary and tertiary education), including years spent on repetition, if prevailing patterns of age-specific enrollment rates persist throughout the child's life. Data are for 2013 or the most recent year available. *Sources: UNESCO Institute for Statistics (2014).Data Centre, supplemented with data from: UNDP. Expected Years of Schooling (2013).Accessed March 13, 2014*

Gross national income (GNI) per capita: Aggregate income of an economy generated by its production and its ownership of factors of production, less the incomes paid for the use of factors of production owned by the rest of the world, converted to U.S. dollars using the World Bank Atlas method, divided by midyear population. Data are for 2012 or the most recent year available. *Sources: The World Bank (2013). Data Catalog, supplemented with data from: UN SNA Main Aggregates database (2013). Accessed March 13, 2014*

Participation of women in national government: The share of seats occupied by women in a single house or,

in the case of countries with bicameral legislatures, upper and lower houses of national parliament. Data reflect the situation as of January 1, 2014. *Source: Inter-Parliamentary Union (2014). Women in National Parliaments. Accessed March 13, 2014*

Calculation methodology

1. All countries with a 2012 population over 100,000 (Source: UNDESA. World Population Prospects: The 2012 Revision. (2013)) and data available (2000 or later) for all five indicators were included in the *Mothers' Index*. Countries missing one data point were included in the *Index* table, but not in the rankings.

Notes on specific indicators:

- Where primary to secondary (gross or net of repetition) SLE estimates were higher than primary to tertiary, primary to secondary were used. Where primary to tertiary estimates were not available, primary to secondary (gross or net of repetition) or SLE estimates published by UNDP (the secondary source), whichever were highest, were used.
- To avoid rewarding school systems where pupils do not start on time or fail to progress through the system at expected rates, countries with SLEs over 18 years and gross enrollment ratios (primary to tertiary) over 105, had their school life expectancy discounted to 18 years before calculating indicator ranks.
- In countries where parliaments are no longer functioning, the most recent information before the parliament's suspension or dissolution was used.

2. Where relevant, data points were rounded to the nearest tenth for analysis purposes.
3. Countries were arrayed and ranked from 1 to 178 (1 being the best and 178 the worst) for each of the five indicators of maternal well-being.
4. Composite scores were then calculated as the average of these five indicator ranks with each indicator given equal weighting.
5. Scores were sorted from low to high and ranked from 1 to 178 to give the overall *Mothers' Index* rank.

15-Year Index Analyses

In this, the 15th year of the *Mothers' Index*, Save the Children reflects back on 15 years of progress in the rankings. Since 2000, more than 70 countries have been added to the *Index*, most coming in at the middle. The *Index* methodology has also undergone two major revisions to reflect the latest research and data availability. These changes to the *Index* dataset make country rankings in 2000 (or after) and 2014 incomparable. Nonetheless, there has been significant consistency at the top and bottom of the rankings. Therefore, this analysis focuses on observations across these top and bottom countries.

Index rankings 2000-2014 were reviewed and a list of all countries that have ever appeared in the top 10 and those that have ever appeared in the bottom 10 was compiled, counting the number of times each country made the top or bottom of the rankings, respectively.

For each top 10 country, the last year of appearance in the top 10, as well as the current *Index* rank was noted. Countries that have fallen the furthest from the top 10 were then identified. To help understand the factors that may have contributed to this fall, trend data 2000-2014 (or most recent year) for each of the five indicators currently included in the *Index*, for all countries currently included in the *Index*, were analyzed. Percentage change in the indicator value 2000-2014 as well as the relative change in country rank at the indicator-level were calculated. This 15-year retrospective was done using updated historical data for 2000 retrieved from the same sources used for *State of the World's Mothers 2014* (listed above). The results of this indicator-level analysis were also used to identify examples of survival, educational, economic and political gains and losses made by individual countries ranked in the middle of the *Index*.

A year-by-year analysis of bottom 10 countries was also done. For each year, countries experiencing or emerging from conflict or a major natural disaster were identified, using the classification rules below. The percentage of countries in the bottom 10 that experienced either or both was calculated for each *Index* year. Values were then averaged across all 15 years to give the mean share of countries that were in the midst of, or emerging from, conflict or a major natural disaster the year they were in the bottom 10.

A similar approach was used to identify the share of "Countdown" countries (75 developing countries where more than 95 percent of all maternal and child deaths occur)[25] unlikely to achieve the Millennium Development Goals for maternal (MDG 5) and child survival (MDG 4) that have suffered recent conflict, recurring natural disasters or both. Countries "unlikely to achieve" MDG4 and MDG 5 were identified as those making "no progress" or "insufficient progress" toward the respective goal's target.

Country progress assessments for MDG 5 were taken directly from the latest maternal mortality report (*Trends in Maternal Mortality: 1990 to 2010*, referenced above). Progress assessments for MDG 4 were made using the latest under-5 mortality data (from CME Info, referenced above) and according to Countdown methodology.[26]

1. Rules for classifying "conflict" countries:

- A country was considered to be "in conflict" in any given year if, during that calendar year, it experienced at least 25 fatalities (i.e. war or minor conflict) resulting from any of the three types of violent action (i.e. state-based, non-state or one-sided violence qualify) categorized by the Uppsala Conflict Data Program (UCDP).[27]
- A country was considered to be "emerging from conflict" if it experienced major conflict in the 4 years prior to the year of interest or minor conflict in the 2 years prior to the year of interest (i.e. for our purposes, the "recovery period" is the conflict year +4 years for major conflict and +2 years for minor conflict).
- A country is considered to have a "history of recent conflict" if the country was "in conflict" or "emerging from conflict" at least one year over the period 2000 to 2013 (the most recent year for which UCDP data are available).

2. Rules for classifying "natural disaster" countries:

- A country was considered to have experienced a "major natural disaster" in any given year if a disaster event recorded in the global database on natural disasters (EM-DAT) for that country-year meets at least one of the following criteria: one thousand (1,000) or more people reported killed; one million (1,000,000) or more people affected.
- A country was considered to be "emerging from a major natural disaster" in any given year if a disaster event meeting the above-mentioned criteria is recorded in EM-DAT during the year prior to the year of interest (i.e. the "recovery period" is the disaster year + 1 year).
- A country was considered to be characterized by a pattern of "persistent natural disasters" if, as recorded on EM-DAT, it experienced at least one disaster event per year for 10 out of the past 15 years of available data (i.e. 1999-2013).
- Note: For the purpose of this analysis, "natural disasters" include the following disaster sub-groups: geophysical (e.g. earthquake, volcano, landslide); meteorological(e.g. tropical cyclone, tornado); hydrological (e.g. flood, mudslide, avalanche) and climatological (e.g. heat wave, extreme winter conditions, drought, wildfire). Biological disasters (e.g. epidemics, insect infestations and animal stampedes) are not included. EM-DAT includes all disasters which fit at least one of the following criteria: 10 or more people killed; 100 or more people affected; declaration of a state of emergency; call for international assistance. *Source: The OFDA/CRED International Disaster Database – www.emdat.be – Université Catholique de Louvain – Brussels – Belgium*

This analysis has important limitations.

First, the *Mothers' Index* dataset has changed dramatically over the years (e.g. additional countries, different indicators, revised methodology). Because of these changes (and non-comparable rankings), we could not – and did not – compare changing ranks over the years. Instead, we limited our analysis to observations about the composition of the top and bottom 10, e.g. which countries have spent the most time at the top/bottom, which have climbed/fallen the furthest out of the top/bottom, etc. Then, as a supplement to this, we looked at 15-year trends across the five indicators now included in the *Index*. However, given the changing *Index* dataset, this separate analysis cannot explain why rankings have changed. It only offers insight on the changes in countries' relative position across indicators now tracked. That said, the indicators now included in the *Index* were included in some form or another in 2000, so the factors influencing a country's position on the rankings then are similar to those influencing a country's position now.

Second, historical maternal and child mortality rates are updated to account for new data. We did not, however, re-calculate *Index* rankings for 2000-2013. Instead, we used the rankings as published in *State of the World's Mothers* each year. We did, however, use updated historical data when looking at changes in indicator data and rankings 2000-2014 (or most recent year).

Countries that have never made it to the absolute top or bottom have also made noteworthy gains and losses over the past 15 years, but the changes introduced to the *Index* make it especially difficult to understand movement in the middle of the rankings. The indicator-level analysis helps identify some important trends. At the same time, there are certainly many countries that have made good advances in maternal and child health and well-being that have not been singled out, because they never appeared in either of the two groups under consideration: the absolute top and bottom of the *Index* rankings.

Endnotes

Executive Summary & Opening Chapter

1 Calculations represent the share of global maternal and under-5 deaths that occur in the 51 fragile states identified by OECD and noted in red on page 76. [*Fragile States 2014: Domestic Revenue Mobilisation.* (Paris: 2014)]. This list does not include the Philippines or India, both stable countries with pockets of fragility. Maternal and child deaths are sourced from the WHO [*Levels and Trends for Maternal Mortality: 1990 to 2010.* (Geneva: 2012)] and the UN Inter-agency Group for Child Mortality Estimation [www.childmortality.org, 2013], respectively.

2 World Bank. *World Development Report 2011: Conflict, Security, and Development.* (Washington, DC: 2011)

3 By mid-2013, the size of UNHCR's population of concern reached 38.7 million, an all-time high (since record-keeping began in 1993). With figures continuing to rise during the second half of 2013, UNHCR expected refugee and IDP year-end numbers to also be at record highs. Estimates for the total population forcibly displaced in 2013 are due out mid-2014. Source: UNHCR. *Mid-Year Trends 2013.* (Geneva: 2013)

4 UNHCR. *Global Trends Report.* (Geneva: 2013)

5 Internal Displacement Monitoring Centre. *Global Estimates 2012: People Displaced by Disasters.* (Geneva: May 2013)

6 OCHA. Overview of Global Humanitarian Response 2014. (Geneva: December 2013)

7 UNICEF. *Humanitarian Action for Children 2014.* (New York: February 2014)

8 Calculation by Save the Children. Estimate includes all children under age 5 living in Syria and the 22 countries that experienced war or minor conflict in 2013, as identified by the Uppsala Conflict Data Program (UCDP). Sources: *UCDP Conflict Encyclopedia:* www.ucdp.uu.se/database, Uppsala University [Accessed April 20, 2013]; UNICEF. *The State of the World's Children 2014 In Numbers.* (New York: 2014) Table 6

9 UNDP. *Fast Facts: Disaster Risk Reduction and Recovery.* (New York: 2012)

10 Calculations represent the share of global maternal and under-5 deaths that occur in the 51 fragile states as identified by OECD [*Fragile States 2014: Domestic Revenue Mobilisation*].This list does not include the Philippines or India, both stable countries with pockets of fragility. Maternal and child deaths are sourced from the WHO [*Levels and Trends for Maternal Mortality: 1990 to 2010.* (Geneva: 2012)] and the UN Inter-agency Group for Child Mortality Estimation [www.childmortality.org, 2013], respectively.

11 Peterson, Kristina. "From the Field: Gender Issues in Disaster Response and Recovery." *Natural Hazards Observer, Special Issue on Women and Disasters.* Volume 21, Number 5 (1997) cited in: Plan International. Because I am a Girl: *The State of the World's Girls 2013: In Double Jeopardy: Adolescent Girls and Disasters.* (Surrey, UK: 2013)

12 UNHCR. 56th Session of the Executive Committee: Report on the Annual Consultations with Non-Governmental Organizations. (UNHCR Liaison Unit: Geneva: 2005)

13 There is widespread agreement within research and humanitarian communities that, in wars in poor countries, i.e., the majority of wars today, indirect deaths far outnumber deaths from war-related violence. However, there is currently no consensus as to the extent of these deaths or the average ratio of indirect to direct deaths. As a consequence, the number of indirect deaths worldwide remains unmeasured and – except in a few high-profile conflicts such as Darfur and the DR Congo – largely unnoticed. (Source: *Human Security Report 2009/2010*)

14 Centre for Research on the Epidemiology of Disasters (CRED). *People Affected by Conflict 2013: Humanitarian Needs in Numbers.* (Brussels: 2014), Geneva Declaration Secretariat. *Global Burden of Armed Violence* (2008) and Merlin. *A Grave New World.* (London: 2010)

15 Adapted from Merlin. *A Grave New World.*

16 This analysis was limited to the set of 25 and 44 "Countdown" countries classified as making "no progress" or "insufficient progress" towards MDG 5 and MDG 4, respectively. 84 percent of each set of countries has a recent history of conflict and/or was characterized by a pattern of persistent natural disasters over the period 1999-2013. For details, see Methodology and Research Notes.

17 In August 2013, for example, at least 1,027 women and children were reported killed in Syria. According to the Violations Documentation Center in Syria, the death toll in 2013 averaged more than 700 women and children per month. Source: Violations Documentation Center. www.vdc-sy.info/index.php/en/ [Accessed March 16, 2014]

18 OECD. Fragile States 2014: *Domestic Revenue Mobilisation* and World Bank Press Release. "Twenty Fragile States Make Progress on Millennium Development Goals." May 1, 2013.

19 According to the Uppsala Conflict Data Program, in 2013, 22 countries had active state-based armed conflict within their territories; 9 countries had non-state conflicts by armed groups and 7 one-sided violence against civilians, with a total of 26 countries experiencing conflict. The most recent ACAPS Global Emergency Overview (April 8-15, 2014) documents ongoing violence in most of these, and other, countries. Sources: Uppsala Conflict Data Program (April 17, 2013) UCDP Conflict Encyclopedia: www.ucdp.uu.se/database, Uppsala University; ACAPS. *Global Emergency Overview: Snapshot 8-15 April* (2014) http://geo.acaps.org/

20 CRED. *People Affected by Conflict 2013: Humanitarian Needs in Numbers.*

21 See, for example: Dyan Mazurana, Prisca Benelli, Huma Gupta and Peter Walker. *Sex and Age Matter: Improving Humanitarian Response in Emergencies.* (Feinstein International Center, Tufts University, Medfod, MA: August 2011) and IDMC. *Briefing Paper: Girl, Disrupted.* (Geneva: March 2014)

22 See OECD. *Fragile States 2014: Domestic Revenue Mobilisation.* p.2, 83. Note: The fragile states list is used throughout this report only for the purpose of identifying trends; it is not used to define fragile states.

23 UN IGME. *Levels and Trends in Child Mortality: Report 2013.* (UNICEF: New York: 2013)

24 United Nations. *The Millennium Development Goals Report 2013.* (New York: 2013)

25 Save the Children's analysis of UN IGME 2013 data. "On track" indicates that the under-5 mortality rate for 2012 is less than 40 deaths per 1,000 live births or that it is 40 or more with an average annual rate of reduction of 4.0 percent or higher for 1990 – 2012.

26 WHO and UNICEF. *Countdown to 2015 – Building a Future for Women and Children: The 2012 Report.* (Washington: 2012)

27 World Bank. *Stop Conflict, Reduce Fragility and End Poverty: Doing Things Different in Fragile and Conflict-affected Situations.* (Washington: World Bank: 2013); OECD. *Fragile States 2014: Domestic Revenue Mobilisation.*

28 UN IGME. *Levels and Trends in Child Mortality: Report 2013.*

29 World Bank Press Release. "Twenty Fragile States Make Progress on Millennium Development Goals."

30 World Bank. *World Development Report 2011: Conflict, Security, and Development.*

31 Calculations by Save the Children. See endnote 1 for details.

32 WHO, UNFPA and Escuela Andaluza de Salud Pública. *Sexual and Reproductive Health in Protracted Crises and Recovery.* (WHO: 2011)

33 Dean, Sohni, Elizabeth Mary Mason, Christopher Howson, Zohra Lassi, Ayesha Imam and Zulfiqar Bhutta. "Born Too Soon: Care Before and Between Pregnancy to Prevent Preterm Births: From Evidence to Action." *Reproductive Health.* Volume10 (Supplement 1). November 15, 2013.

34 See, for example: Razzaque, Abdur, Akhtar Hossain, Julie DaVanzo, Mohammad Enamul Hoque, Nurul Alam, Abbas Bhuiya and Peter Kim Streatfield. (2012) "Effect of Maternal Mortality on Survival of Under-Five Children: Evidence from Matlab, Bangladesh." *Asian Population Studies.* Volume 10, Issue 1. 2014

35 See, for example: Ronsmans, Carine, Mahbub Chowdhury, Sushil Dasgupta, Anisuddin Ahmed and Marge Koblinsky. "Effect of Parent's Death on Child Survival in Rural Bangladesh: A Cohort Study." *The Lancet*. Volume 375, Issue 9730. pp.2024–2031 and Anderson, Frank, Sarah Morton, Sujata Naik and Bette Gebrian. "Maternal Mortality and the Consequences on Infant and Child Survival in Rural Haiti." *Maternal and Child Health Journal*. Volume 11, Issue 4. July 2007. pp.395-401

36 See, for example: Yamin, Alicia Ely, Vanessa Boulanger, Kathryn Falb, Jane Shuma and Jennifer Leaning. "Costs of Inaction on Maternal Mortality: Qualitative Evidence of the Impacts of Maternal Deaths on Living Children in Tanzania." *PLoS.* August 19, 2013

37 Save the Children. *Missing Midwives.* (London: 2011) p.21

38 UNFPA. *Minimum Initial Service Package (MISP).* unfpa.org/emergencies/manual/2.htm

39 Save the Children. *State of the World's Mothers 2013: Surviving the First Day.* (Westport, CT: 2013)

40 Save the Children. *Ending Newborn Deaths: Ensuring Every Baby Survives.* (London: 2014)

41 Save the Children and partners, field guide for newborn health in humanitarian settings, forthcoming.

42 Lawn, Joy, Simon Cousens and Jelka Zupan. "4 Million Neonatal Deaths: When? Where? Why?" *The Lancet.* Volume 365, Issue 9462. March 3, 2005. pp.891-900

43 Conde-Agudelo, Augustin, José Belizán and José Diaz-Rossello. "Kangaroo Mother Care to Reduce Morbidity and Mortality in Low Birthweight Infants." *Cochrane Database of Systematic Reviews 2011*: Issue 3, Article Number CD002771

44 Interview conducted for Save the Children by Anna Ford, April 2010.

45 Save the Children and partners, field guide for newborn health in humanitarian settings, forthcoming.

46 Ibid.

47 Thurstans, Susan and Vicky Sibson. "Assessing the Intervention of Infant Feeding in Gaza." *Field Exchange.* Issue 38. April 2010. pp.23-25

48 Hipgrave, David, Fitsum Assefa, Anna Winoto and Sri Sukotjo "Donated Breast Milk Substitutes and Incidence of Diarrhea among Infants and Young Children after the May 2006 Earthquake in Yogyakarta and Central Java." *Public Health Nutrition.* Volume 15, Issue 2. February 2012. pp.307-315

49 Ibid.

50 Interview conducted for Save the Children by Evan Schuurman, November 2013.

51 Save the Children's analysis of IGME and MMEIG data: The UN Inter-agency Group for Child Mortality Estimation, 2013; WHO, UNICEF, UNFPA and the World Bank. *Trends in Maternal Mortality: 1990 to 2010.*

52 Germanwatch. *Global Climate Risk Index 2014.* (Bonn and Berlin: November 2013). From 1993-2012, Bangladesh was the 5th most-affected country in terms of the impacts of weather-related loss events (storms, floods, heat waves, etc.); Nepal ranked 14th and China ranked 22nd.

53 Thomson Reuters Foundation. "Climate Change Threatens Bangladesh's MDG Achievements." July 22, 2013

54 IRIN. "Nepal's Health Sector More Earthquake-Ready." January 21, 2014.

55 Germanwatch. *Global Climate Risk Index 2014.* From 1993-2012, the 10 countries most-affected by extreme weather were: Honduras (1), Myanmar (2), Haiti (3), Nicaragua (4), Bangladesh (5), Vietnam (6), Philippines (7), Dominican Republic (8), Mongolia (8), Thailand (10) and Guatemala (10).

56 Interview conducted for Save the Children by Mark Kaye, August 2013.

57 Calculations by Save the Children. See endnote 1 for details. See also: *World Bank. World Development Report 2011: Conflict, Security, and Development.*

58 Adapted from Merlin. *A Grave New World.*

59 Save the Children. *Lives on the Line: An Agenda for Ending Preventable Child Deaths.* (London: 2013)

60 Grover, Anand. Statement to the 68th Session of the General Assembly. October 25, 2013

61 WHO. "Keeping Health Workers and Facilities Safe in War." *Bulletin of the World Health Organization*. Volume 90, Number 1. January 2012. pp.1-74

62 ICRC. *Health Care in Danger, January to December 2012: Violent Incidents Affecting Health Care.* May 15, 2013.

63 Safeguarding Health in Conflict. *Statement from World Vision on WHO's Role in Meeting the Demands of Health in Humanitarian Emergencies.* January 27, 2014

64 Merlin. *A Grave New World.*

65 Save the Children. *State of the World's Mothers 2013: Surviving the First Day.* (Westport, CT: 2013) p.20

66 Black, Robert, Cesar Victora, Susan Walker, Zulfiqar Bhutta, Parul Christian Mercedes de Onis, Majid Ezzati, Sally Grantham McGregor, Joanne Katz, Reynaldo Martorell and Ricardo Uauy. "Maternal and Child Undernutrition and Overweight in Low-Income and Middle-Income Countries." *The Lancet*. August 3, 2013; Volume 382, Issue 9890.pp.427-451

67 Data from Demographic and Health Surveys, Multiple Indicator Cluster Surveys or national nutrition surveys.

68 CRED. *People Affected by Conflict 2013: Humanitarian Needs in Numbers* and UNICEF. *The State of the World's Children 2014 In Numbers*. Table 2, pp.36-41

69 Inter-Agency Standing Committee. *Women, Girls, Boys and Men: Different Needs – Equal Opportunities.* IASC Gender Handbook for Humanitarian Action (IASC: 2006)

70 CARE. *Commonly Asked Questions About the Sahel Food Crisis*. January 21, 2014

71 Plan International. *Because I am a Girl: The State of the World's Girls 2013: In Double Jeopardy: Adolescent Girls and Disasters.* (Surrey, UK: 2013)

72 Black, Robert, Cesar Victora, Susan Walker, Zulfiqar Bhutta, Parul Christian Mercedes de Onis, Majid Ezzati, Sally Grantham McGregor, Joanne Katz, Reynaldo Martorell and Ricardo Uauy. "Maternal and Child Undernutrition and Overweight in Low-Income and Middle-Income Countries." *The Lancet*. August 3, 2013; Volume 382, Issue 9890. pp.427-451.

73 WHO, World Food Programme and UNICEF. *Preventing and Controlling Micronutrient Deficiencies in Populations Affected by an Emergency.*

74 United Nations System Standing Committee on Nutrition. *6th Report on the World Nutrition Situation*. 2010, p.38

75 Black, Robert, Lindsay Allen, Zulfiqar Bhutta, Laura Caulfield, Mercedes de Onis, Majid Ezzati, Colin Mathers and Juan Rivera. "Maternal and Child Undernutrition: Global and Regional Exposures and Health Consequences." *The Lancet*. Volume 371, Issue 9608. January 19, 2008. pp.243-260

76 Grantham-McGregor, Sally, Yin Bun Cheung, Santiago Cueto, Paul Glewwe, Linda Richter and Barbara Strupp. "Development Potential for the First 5 Years for Children in Developing Countries." *The Lancet.*Volume 369, Issue 9555. January 6, 2007. pp.60-70

77 Save the Children. *A Life Free from Hunger.* (London: 2012)

78 Food and Agriculture Organization. *The Female Face of Farming.* (FAO: 2012)

79 Food and Agriculture Organization. *Women in Agriculture: Closing the Gender Gap for Development.* (FAO: 2011)

80 Ibid.

81 UNFPA. *Women Are the Fabric: Reproductive Health for Communities in Crisis.* (New York: 2012)

82 Save the Children. *Unspeakable Crimes Against Children: Sexual Violence in Conflict.* (London: 2013)

83 Reproductive Health Access, Information and Services in Emergencies (RAISE) Initiative. *Gender-based Violence*. www.raiseinitiative.org/library/pdf/fs_gbv.pdf

84 CARE International UK. *Donor Spending on Gender in Emergencies 2013.* (London: November 2013)

85 Ibid.

86 ReliefWeb. *Donor Spending on Gender in Emergencies 2013.* November 12, 2013

87 Blankespoor, Brian, Susmita Dasgupta, Benoit Laplante and David Wheeler. *Adaptation to Climate Extremes in Developing Countries: The Role of Education.* (World Bank: Washington: June 2010)

88 Study was limited to countries identified by the World Bank as low income or lower middle income at the time of analysis

89 Plan International. *Girls' Rights Gazette*. October 11, 2012. www.plan-eu.org/content//uploads/2012/10/Girls-Rights-Gazette-text-only-version.doc

90 World Health Organization. *Adolescent Pregnancy. Fact Sheet 364.* (Geneva: 2012)

91 UNICEF. *The State of theWorld's Children 2009: Maternal and Newborn Health.* (New York: 2008) Cited in: UNFPA. *State of World Population, Motherhood in Childhood: Facing the Challenge of Adolescent Pregnancy.* (New York: 2013)

92 Dixon-Mueller, Ruth. "How Young Is 'Too Young'? Comparative Perspectives on Adolescent Sexual, Marital, and Reproductive Transitions." *Studies in Family Planning.* Volume 39, Issue 4. December 2008. pp.247-262

93 Blum, Robert, and Johns Hopkins Bloomberg School of Public Health. 2013. *A Global Look at Adolescent Pregnancy Prevention: Strategies for Success.* Office of Adolescent Health webcast. (Washington, DC: U.S. Department of Health and Human Services: May 2, 2013). Cited in: UNFPA. *State of World Population, Motherhood in Childhood: Facing the Challenge of Adolescent Pregnancy.* (New York: 2013)

94 Nove, Andrea, Zoë Matthews, Sarah Neel and Alma Virginia Camacho. "Maternal Mortality in Adolescents Compared with Women of Other Ages: Evidence from 144 Countries." *The Lancet Global Health*. Volume 2, Issue 3. March 2014. pp.155-164.

95 Blanc, Ann, William Winfrey and John Ross. "New Findings for Maternal Mortality Age Patterns: Aggregated Results for 38 Countries." *PLoS*. April 16, 2013

96 Save the Children. *State of the World's Mothers 2004: Children Having Children*. (Westport, CT: 2004)

97 UNFPA. *State of the World's Population, Motherhood in Childhood: Facing the Challenge of Adolescent Pregnancy.*

98 Ibid.

99 Plan International. *Because I am a Girl: The State of the World's Girls 2013: In Double Jeopardy: Adolescent Girls and Disasters.*

100 Cleland, John, Agustin Conde-Agudelo, Herbert Peterson, John Ross and Amy Tsui. "Contraception and Health." *The Lancet*. Volume 380. July 10, 2012. pp.149-156.

101 Inter-Agency Standing Committee. *Guidelines for Gender-based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies.* (IASC: 2005)

102 Plan International. *Because I am a Girl: The State of the World's Girls 2013: In Double Jeopardy: Adolescent Girls and Disasters.*

103 Interview conducted for Save the Children by Sadia Ijaz, September 2013.

104 IAWG. *A Statement on Family Planning for Women and Girls as a Life-saving Intervention in Humanitarian Settings.* (May 2010)

105 UNFPA. *Safe Motherhood: Protecting Mothers in Risky Situations.* www.unfpa.org/public/home/emergencies/pid/4787

106 Singh, Susheela, Gilda Sedgh and Rubina Hussain. "Unintended Pregnancy: Worldwide Levels, Trends and Outcomes." *Studies in Family Planning.* Volume 41, Issue 4. December 2010. pp.241-250

107 Xu, Ke, David Evans, Guido Carrin and Ana Mylena Aguilar-Rivera. *Designing Health Financing Systems to Reduce Catastrophic Health Expenditure.* Technical Brief for Policy-makers. (WHO: Geneva: 2005)

108 Article 12 of the International Covenant on Economic, Social and Cultural Rights, comment 14, under 'Accessibility': "Health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all."

109 Inter-Agency Standing Committee, Global Health Cluster. *Removing User Fees for Primary Health Care Services During Humanitarian Crises.* March 24, 2010

110 Interview conducted for Save the Children by Colin Crowley and Scott Clarkson, January 2012. Habiganj District, where Shefali and her children live, floods every year during monsoon and is also vulnerable to drought.

Philippines Chapter

1 *MIRA- Multi-Cluster/Sector Initial Rapid Assessment: Philippines Typhoon Haiyan.* (November 2013)

2 Ibid; *Multi-Cluster Needs Assessment: Final Report Philippines Typhoon Haiyan.* (OCHA and WFP: December 2013)

3 NDRRMC. *SitRep No. 108: Effects of Typhoon "Yolanda" (Haiyan)* (April 3, 2014)

4 *MIRA- Multi-Cluster/Sector Initial Rapid Assessment: Philippines Typhoon Haiyan.* (November 2013)

5 NDRRMC. *SitRep No. 108: Effects of Typhoon "Yolanda" (Haiyan)* (April 3, 2014)

6 UNICEF. *Philippines Humanitarian Situation Report #19.* February 7, 2014

7 Germanwatch. *Global Climate Risk Index 2014*. and Alliance Development Works. World Risk Report 2012. (Berlin: 2013)

8 World Bank. *Philippines Dashboard*. http://sdwebx.worldbank.org/climateportalb/home.cfm?page=country_profile&CCode=PHL&ThisTab=Overview

9 EM-DAT: The OFDA/CRED International Disaster Database (www.emdat.be), Université Catholique de Louvain, Brussels (Belgium) [Accessed February 3, 2014]

10 IDMC. *Comprehensive Response to Wave of Displacement Crises Needed.* (Geneva: 2013)

11 UN IGME. *Levels and Trends in Child Mortality: Report 2013*.

12 WHO, UNICEF, UNFPA and World Bank. *Trends in Maternal Mortality: 1990 to 2010.*

13 Romualdez, Alberto, Jennifer de la Rosa, Jonathan Flavier, Stella Quimbo, Kenneth Hartigan-Go, Liezel Lagrada and Lilibeth David. "The Philippines Health System Review." *Health Systems in Transition*. Volume 1, Number 2.

14 PharmaBoardroom.com. "The Philippines: Rapidly Moving Towards Universal Healthcare Coverage." March 2, 2014

15 OCHA. *Humanitarian Bulletin Philippines Typhoon Haiyan*. Issue 1. February 12, 2014

16 Consultations with Save the Children staff.

17 Interview conducted for Save the Children by Marlon Ellorimo, March 2014.

18 Ibid.

19 European Commission, Humanitarian Aid Department. *Philippines: Humanitarian Implementation Plan (HIP) Philippines (ECHO/PHL/BUD/2013/91000) Last update: 24/01/2014 Version 5.* January 29, 2014

20 Philippines Humanitarian Country Team. *Typhoon Haiyan (Yolanda) Strategic Response Plan: The Philippines.* December 27, 2013

21 UNFPA. *Humanitarian Bulletin: Typhoon Haiyan/Yolanda.* February 2014

22 *Multi-Cluster Needs Assessment: Final Report Philippines Typhoon Haiyan*. (OCHA and WFP: December 2013) and IRIN. "Maternal Healthcare Struggles for Survival after Typhoon Haiyan." Manila. December 5, 2013

23 UNICEF. *Four Months After Typhoon Haiyan, Philippines: Progress Report.* (New York: 2014)

24 Interview conducted for Save the Children by Krista Zimmerman, March 2014.

25 Plan International Philippines. *Rapid Health Facility Needs Assessment: Maternal, Newborn and Child Health.* December 19, 2013

26 USC-Office of Population Studies Foundation, Inc. *Post-Typhoon Yolanda Reproductive Health and GBV Assessment: Facility Survey.* (Cebu City, Philippines: January 2014) [Note: This was commissioned by UNFPA]

27 Interview conducted for Save the Children by Krista Zimmerman, March 2014.

28 Government of the Philippines and WHO. *Philippines Health Cluster Bulletin.* Issue 13. January 31, 2014 and UNFPA. *Humanitarian Bulletin: Typhoon Haiyan/ Yolanda.* February 2014

29 *Preliminary Results from the 2013 National Demographic and Health Survey*. March 20, 2014 www.census.gov.ph/content/ six-ten-births-are-delivered-health-facility-preliminary-results-2013-national-demographic

30 *MIRA- Multi-Cluster/Sector Initial Rapid Assessment: Philippines Typhoon Haiyan.* (November 2013)

31 USC-Office of Population Studies Foundation, Inc. *Post-Typhoon Yolanda Reproductive Health and GBV Assessment: Facility Survey*.

32 Interviews conducted for Save the Children by Marlon Ellorimo, March 2014.

33 Ibid.

34 Interview conducted for Save the Children by Hedinn Halldorsson, January 2014

35 *Médecins Sans Frontières. "Some Parts Are Still Devastated": Two Months in Tacloban, Philippines.* January 14, 2014

36 Interviews by Save the Children with health providers serving in Tacloban, Ormoc and Estancia.

37 Western Pacific Region. *Human Resources for Health Country Profiles: Philippines.* (Geneva: 2013)

38 Plan International Philippines. *Rapid Health Facility Needs Assessment: Maternal, Newborn and Child Health.*

39 Ryan, William for UNFPA. "In Typhoon's Terrible Wake, Women Continue to Give Birth Bravely." December 4, 2013

40 Agence France-Presse. "Nurses Battle Fatigue in Tide of Philippine Typhoon Births." November 21, 2013

41 Interview of a midwife serving in Tacloban conducted for Save the Children by Marlon Ellorimo, March 2014

42 IRIN. "Keeping Malnutrition on Radar After Typhoon Haiyan." December 5, 2013

43 UNICEF. *Four Months After Typhoon Haiyan, Philippines: Progress Report.* (New York: 2014)

44 Health Cluster. Response to Typhoon Haiyan (Yolanda). February 14, 2014 and OCHA. *Typhoon Haiyan (Yolanda) Consolidated Cluster Briefs.* March 10, 2014

45 Interview conducted for Save the Children by Hedinn Halldorsson, January 2014

46 Food and Nutrition Research Institute – Department of Science and Technology (FNRI-DOST). 2012. *Philippine Nutrition Facts and Figures 2011*. DOST Complex, FNRI Bldg., Bicutan, Taguig City, Metro Manila, Philippines

47 ACAPS. *Philippines: Typhoon Yolanda. Secondary Data Review.* January 2014

48 Interview conducted for Save the Children by Hedinn Halldorsson, January 2014.

49 *Multi-Cluster Needs Assessment: Final Report Philippines Typhoon Haiyan.* (OCHA and WFP: December 2013)

50 Save the Children. *Philippines Typhoon Haiyan Breast Feeding Key Messages and Q&A.* November 21, 2013

51 Government of the Philippines, World Food Programme, Action Contre la Faim and UNICEF. *Summary Findings of Nutrition Survey Using SMART Methods For Typhoon Yolanda Affected Areas of Regions VI, VII and VIII The Philippines - February-March 2014.* (March 24, 2014)

52 Interview conducted for Save the Children by Krista Zimmerman, March 2014.

53 *Multi-Cluster Needs Assessment: Final Report Philippines Typhoon Haiyan.* (OCHA and WFP: December 2013)

54 Philippines Humanitarian Country Team. *Typhoon Haiyan (Yolanda) Strategic Response Plan: The Philippines*. December 27, 2013

55 Consultations with Save the Children staff

56 Interview conducted for Save the Children by Ajla Grozdanic, January 2014

57 Interview conducted for Save the Children by Rosary Diane Maligalig, March 2014.

58 UNICEF. *Philippines: UNICEF Philippines Typhoon Haiyan Situation Report #16.* January 13, 2014

59 ACAPS. *Philippines: Typhoon Yolanda. Secondary Data Review* – January 2014

60 Plan International Philippines. *Rapid Health Facility Needs Assessment: Maternal, Newborn and Child Health*. December 19, 2013

61 UNICEF. *Philippines: UNICEF Philippines Typhoon Haiyan Situation Report #16.* January 13, 2014

62 USC-Office of Population Studies Foundation, Inc. *Post-Typhoon Yolanda Reproductive Health and GBV Assessment: Facility Survey.*

63 European Commission Humanitarian Aid department. *Philippines: Humanitarian Implementation Plan (HIP) Philippines (ECHO/PHL/BUD/2013/91000) Last update: 24/01/2014 Version 5.* January 29, 2014

64 Interview conducted for Save the Children by Krista Zimmerman, March 2014

65 Government of the Philippines, World Food Programme, Action Contre la Faim and UNICEF. *Summary Findings of Nutrition Survey Using SMART Methods For Typhoon Yolanda Affected Areas of Regions VI, VII and VIII The Philippines - February-March 2014.* (March 24, 2014)

66 Anttila-Hughes, Jesse Keith and Hsiang, Solomon. "Destruction, Disinvestment, and Death: Economic and Human Losses Following Environmental Disaster. *Social Science Research Network.* February 18, 2013.

67 MacKenzie, Debora. "Typhoon Haiyan: Baby Girl Death Toll Will Rise." *New Scientist.* November 25, 2013.

68 Interview conducted for Save the Children by Hedinn Halldorsson, January 2014.

69 Save the Children, Plan, UNICEF and World Vision. *After Yolanda: What Children Think, Need and Recommend.* (Manila: December 2013)

70 Interview conducted for Save the Children by Hedinn Halldorsson, January 2014.

DR Congo Chapter

1 Coghlan, Benjamin, Pascal Ngoy, Flavien Mulumba, Colleen Hardy, Valerie Nkamgang Bemo, Tony Stewart, Jennifer Lewis and Richard Brennan. *Mortality in the Democratic Republic of Congo: An Ongoing Crisis.* (International Rescue Committee and Burnet Institute : 2007)

2 EM-DAT: The OFDA/CRED International Disaster Database (www.emdat.be), Université Catholique de Louvain, Brussels (Belgium) [Accessed April 20, 2014]

3 In 2007, the International Rescue Committee estimated that only 0.4 percent of deaths across DR Congo that year

were directly attributed to violence. In recent years (i.e., since 2010), there have been roughly 400,000 under-5 deaths and 15,000 maternal deaths each year, compared to fewer than 1,000 battle-related deaths (some of which are civilians). And although the data are incomplete, women and children in DR Congo also appear to face a higher relative risk of death. Sources: UN Inter-agency Group for Child Mortality Estimation (IGME), The Uppsala Conflict Data Program (UCDP) Datasets and WHO, UNICEF, UNFPA and The World Bank. *Trends in Maternal Mortality: 1990 to 2010.*

4 WHO, UNICEF, UNFPA and The World Bank. *Trends in Maternal Mortality: 1990 to 2010.*

5 Save the Children's calculation using OCHA data. Source: OCHA.2014 *Plan de Reponse Strategique: République Démocratique du Congo.* (November 2013) pp. 1,58

6 OCHA. *2014 Plan de Reponse Strategique: République Démocratique du Congo.*

7 Seay, Laura. "Effective Responses: Protestants, Catholics and the Provision of Health Care in Post-War Kivus." *Review of African Political Economy.* Volume 40, Number 135. March 1, 2013. pp.83-97

8 D'Errico, Nicole, Louise Bashige Nzigire, Felicien Maisha and Luc Malemo Kalisya. "'You Say Rape, I Say Hospitals. But Whose Voice is Louder?' Health, Aid and Decision-Making in the Democratic Republic of Congo." *Review of African Political Economy.* Volume 40, Number 135. March 1, 2013. pp.51-66

9 US Global Health Initiative. *Democratic Republic of Congo Strategy 2011-2014*. November 2011.

10 Médecins Sans Frontières. *Everyday Emergency: Silent Suffering in Democratic Republic of Congo*. (Amsterdam: 2014)

11 WHO, UNICEF, UNFPA and The World Bank. *Trends in Maternal Mortality: 1990 to 2010.*

12 The UN Inter-agency Group for Child Mortality Estimation, 2013

13 Interview conducted for Save the Children by Krista Armstrong, March 2014.

14 Ibid.

15 WHO, UNICEF, UNFPA and The World Bank. *Trends in Maternal Mortality: 1990 to 2010.*

16 Division Provinciale de la Santé du Nord Kivu [Data and source provided by Merlin staff in North Kivu, DR Congo]

17 WHO, UNICEF, UNFPA and The World Bank. *Trends in Maternal Mortality: 1990 to 2010.*

18 Save the Children consultation with Merlin.

19 IAWG on Reproductive Health in Crisis. *In-depth Assessment of Reproductive Health Services in Countries Affected by Humanitarian Crises: The Democratic Republic of the Congo.* (unpublished, 2014)

20 Ibid.

21 Mbela, Kiyombo. *Analysis of the Situation of Reproductive Health Services in the DRC: Case Study of the Post-Conflict Zones of Maniema and Equateur.* Prepared for: Sexual and Reproductive Health in Protracted Crises and Recovery, Expert Consultation, Granada, Spain, September, 28-30, 2009 (unpublished)

22 Merlin. *A Grave New World*.

23 Interview conducted for Save the Children by Sylvia Nabanoba, Rwamwanja refugee resettlement camp, Uganda, February 2014.

24 Nicole D'Errico, et al. "'You Say Rape, I Say Hospitals. But Whose Voice is Louder?' Health, Aid and Decision-Making in the Democratic Republic of Congo." *Review of African Political Economy.*

25 Ibid.

26 Benjamin Coghlan, et al. *Mortality in the Democratic Republic of Congo: An Ongoing Crisis.*

27 CRED. *People Affected by Conflict 2013: Humanitarian Needs in Numbers*.

28 Ibid.

29 WHO. Global Health Observatory Data Repository. apps.who.int/gho/data [Accessed April 14, 2014]

30 IRIN. "Malaria Cases Soar in Former DRC Rebel Stronghold." November 27, 2013 and WHO Global Health Observatory Data Repository [Accessed April 14, 2014]

31 IRIN. "Measles Epidemic Affects Thousands in DRC." February 27, 2013

32 UNICEF. *The State of the World's Children 2014 In Numbers*. p.43

33 WHO. *Health Emergency Highlights*. (Geneva: October 2013)

34 UNICEF. *The State of the World's Children 2014 In Numbers*. p.43

35 The World Bank. World Development Indicators. http://data.worldbank.org/indicator/SI.POV.2DAY/countries?page=1 [Accessed January 7, 2014]

36 Measure DHS. STATCompiler [Accessed January 7, 2014]

37 Waldman, Ron. *Health in Fragile States, Country Case Study: Democratic Republic of the Congo.* (Arlington, VA: BASICS for USAID: 2006) and Mbela, Kiyombo. *Analysis of the Situation of Reproductive Health Services in the DRC: Case Study of the Post-Conflict Zones of Maniema and Equateur.* Prepared for: Sexual and Reproductive Health in Protracted Crises and Recovery, Expert Consultation, Granada, Spain, September, 28-30, 2009 (unpublished)

38 Médecins Sans Frontières. *Everyday Emergency: Silent Suffering in Democratic Republic of Congo*.

39 UNFPA. *Working Against All Odds to Improve Maternal Health in DRC.* September 19, 2011

40 Médecins Sans Frontières. *Everyday Emergency: Silent Suffering in Democratic Republic of Congo*.

41 Ibid.

42 Nicole D'Errico, et al. "'You Say Rape, I Say Hospitals. But Whose Voice is Louder?' Health, Aid and Decision-Making in the Democratic Republic of Congo." *Review of African Political Economy.*

43 UNDP, UNFPA. First regular session of the UNDP/UNFPA Executive Board, 20 to 27 January 2006. *Post-Conflict Peacebuilding in Africa: The Role of UNDP and UNFPA in Angola and the Democratic Republic of the Congo. The DRC Case Study.*

44 Susan Bartels, Michael VanRooyen, Jennifer Leaning, Jennifer Scott, and Jocelyn Kelly. *Now, The World Is Without Me: An Investigation of Sexual Violence in Eastern Democratic Republic of Congo.* (Harvard Humanitarian Initiative and Oxfam International: April 2010)

45 Médecins Sans Frontières. *Everyday Emergency: Silent Suffering in Democratic Republic of Congo*.

46 Elbert, Thomas, Harald Hinkel, Anna Maedl, Katharin Hermenau, Tobias Hecker, Maggie Schauer, Heike Riedke, Nina Winkler and Philip Lancaster. *Sexual and Gender-Based Violence in the Kivu Provinces of the DRC: Insights from Former Combatants.* (World Bank: Washington, DC: September 2013)

47 Pratt, Marion, Leah Werchick, Anaia Bewa, Marie-Louise Eagleton, Claudine Lumumba, Katherine Nichols, and Lina Piripiri. Sexual Terrorism: *Rape as a Weapon of War in Eastern Democratic Republic of Congo.* USAID/DCHA Assessment Report. March 18, 2004

48 Human Rights Watch. *Soldiers Who Rape, and Commanders Who Condone: Sexual Violence and Military Reform in the Democratic Republic of Congo.* (New York: July 2009).

49 Osotimehin, Babatunde and Zainab Bangura. *Act Now, Act Big to End Sexual Violence in the Democratic Republic of Congo.* November 6, 2013

50 Amnesty International. *Annual Report 2013: The State of the World's Human Rights. Democratic Republic of the Congo.*

51 UNHCR. "UNHCR Statistics Show Alarming Rise in Rape and Violence Against Women in North Kivu." July 30, 2013

52 Division Provinciale de la Santé du Nord Kivu [Data and source provided by Merlin staff in North Kivu, DR Congo]

53 Interview conducted for Save the Children by Colin Crowley, June 2012.

54 ACAPS. *Global Emergency Overview: Snapshot 11-18 March.* March 18, 2014

55 Welthungerhilfe. *A War Against Women: A Hospital Offers Medical and Psychological Support for Victims of Rape.* www.welthungerhilfe.de/en/get-informed/our-projects/project-en/refugee-camp-and-road-construction.html#!/b1434/

56 Wiltz, Teresa. "The Most Dangerous Woman in the World: Justine Masika Bihamba." *More*. May 24, 2010

57 Interview conducted for Save the Children by Krista Armstrong, March 2014.

58 UNAIDS. *Congo (Democratic Republic of)*. www.unaids.org/en/CountryResponses/Countries/

59 IAWG on Reproductive Health in Crisis. *In-depth Assessment of Reproductive Health Services in Countries Affected by Humanitarian Crises: The Democratic Republic of the Congo.*

60 Mbela, Kiyombo. *Analysis of the Situation of Reproductive Health Services in the DRC: Case Study of the Post-Conflict Zones of Maniema and Equateur.* Prepared for: Sexual and Reproductive Health in Protracted Crises and Recovery, Expert Consultation, Granada, Spain, September, 28-30, 2009 (unpublished)

61 Médecins Sans Frontières. *DRC: Majority of People Living with HIV Denied Treatment.* January 25, 2012.

62 IRIN. "DRC: End of Mother-to-Child HIV Transmission Still a Long Way Off." April 24, 2012

63 Ibid.

64 Interview conducted for Save the Children by Sylia Nabanoba, February 2014.

65 UNICEF. *Towards an AIDS-Free Generation – Children and AIDS: Sixth Stocktaking Report, 2013.* (New York: 2013)

66 IAWG on Reproductive Health in Crisis. *In-depth Assessment of Reproductive Health Services in Countries Affected by Humanitarian Crises: The Democratic Republic of the Congo.*

67 Women's Refugee Commission, Save the Children and UNHCR. *Case Study: Adolescent Sexual and Reproductive Health Programming in Goma, Democratic Republic of the Congo.* (New York and Washington, DC: December 2013)

68 Waldman, Ron. *Health in Fragile States, Country Case Study: Democratic Republic of the Congo.*

69 Ibid; UNESCO and UNICEF. *Children Out of School: Measuring Exclusion from Primary School.* (UNESCO Institute for Statistics: Montreal: 2005)

70 UNESCO UIS [Accessed January 7, 2014]

71 UNICEF. "Melissa Kasoke Raises Her Voice for Girls' Education in the Democratic Republic of the Congo." October 23, 2013

72 Ibid.

73 Human Rights Watch. *Soldiers Who Rape, and Commanders Who Condone: Sexual Violence and Military Reform in the Democratic Republic of Congo.*

74 Eastern Congo Initiative. *Children's Voice.* www.easterncongo.org/success-stories/cbo-success-stories/detail/182

75 Interview conducted for Save the Children by Sylia Nabanoba, February 2014.

Syria Chapter

1 Estimates include the number of registered refugees and the number of women and children awaiting registration. Source: UNHCR Syria Regional Refugee Response Information Portal: http://data.unhcr.org/syrianrefugees/regional.php [Accessed April 16, 2014]

2 Government of the Syrian Arab Republic and others. *2014 Syrian Arab Republic Humanitarian Assistance Response Plan (SHARP).* (December 2013)

3 UNFPA. *Syria Crisis Humanitarian Bulletin - Highlights of Response: February-March 2014.* (March 31, 2014)

4 UNFPA. UNFPA *Calls for More Support to Address the Special Needs of Syrian Women and Girls.* January 13, 2014

5 WHO, UNICEF, UNFPA and The World Bank. Trends in Maternal Mortality: 1990 to 2010; UN IGME. *Levels and Trends in Child Mortality: Report 2013.*

6 WHO. *Global Health Observatory Data Repository.* http://apps.who.int/gho/data [Accessed Dec 17, 2013]

7 UNICEF. *At a Glance: Syrian Arab Republic.* www.unicef.org/infobycountry/syria_statistics.html

8 *Syria Integrated Needs Assessment.* (December 2013), p.43

9 IRIN. "Syria Healthcare System Crumbling." December 2012

10 WHO. *Donor Update: Syrian Arab Republic.* September 2013

11 International Rescue Committee. *Syria: A Regional Crisis*. (New York: January 2013)

12 Physicians for Human Rights. Syria's Medical Community Under Assault. January 2014

13 International Rescue Committee. *Syria: A Regional Crisis.*

14 Interview conducted for Save the Children by Ahmad Baroudi, Lebanon, February 2014

15 Ibid.

16 UNICEF. *The State of the World's Children 2014 in Numbers*.

17 OCHA. *Humanitarian Bulletin: Syria.* Issue 39. December 3-16, 2013; IRIN. "Born into Crisis: Unwanted Pregnancies in Syria." May 29, 2013

18 Assessment Working Group for Northern Syria. *Syrian Arab Republic: Syria Integrated Needs Assessment.* December 2013. p.46

19 Supplement to Assessment Working Group for Northern Syria. *Syria Arab Republic: Syria Integrated Needs Assessment*. December 2013

20 WHO in collaboration with MOH-Syria. *Availability of Health Resources and Services at Public Hospitals in Syria.* 3rd Quarter 2013.

21 IRIN. "Born into Crisis: Unwanted Pregnancies in Syria." May 29, 2013

22 Healthy Newborn Network. "Brazilian Women Rebel Against Cesarean Births." August 2012.

23 UNFPA. *Jordanian Midwife Delivers for Syrian Refugees.* August 15, 2013. unfpa.org/public/home/news/pid/14949

24 IAWG. *Reproductive Health Services for Syrian Refugees in Zaatri Refugee Camp and Irbid City, Jordan: An Evaluation of the Minimum Initial Service Package, March 17-22, 2013* (November 14, 2013)

25 UNHCR. *2014 Syria Regional Response Plan.* (2013)

26 UNHCR. *Syria Regional Refugee Response:* Jordan. February 6, 2014

27 UNHCR. *Health Sector Bi-weekly Report Public Health and Nutrition Jordan Week 1 and 2 HIS Zaatri Report.* January 27, 2014

28 IAWG. *Reproductive Health Services for Syrian Refugees in Zaatri Refugee Camp and Irbid City, Jordan: An Evaluation of the Minimum Initial Service Package, March 17-22, 2013*

29 Usta, Jinan and Amelia Reese Masterson. *Assessment of Reproductive Health and Gender Based Violence Among Displaced Syrian Women in Lebanon, July-September 2012.*

30 Interview conducted for Save the Children by Ahmad Baroudi, February 2014

31 Government of the Syrian Arab Republic and others. *Revised Syrian Humanitarian Assistance Response Plan (SHARP), January-December 2013.* June 7, 2013. Section 3.1

32 REACH. *Informal Tented Settlements in Jordan: A Multi-sector, Baseline Assessment.* December 2013; Usta, Jinan and Amelia Reese Masterson. *Assessment of Reproductive Health and Gender Based Violence Among Displaced Syrian Women in Lebanon, July-September 2012.*

33 ACAPS. *February Regional Analysis Syria Report: Crisis Overview.* February 7, 2014

34 IRIN. "Born into Crisis: Unwanted Pregnancies in Syria." May 29, 2013

35 Save the Children. *A Devastating Toll: The Impact of Three Years of War on the Health of Syria's Children.* (London: 2014)

36 WHO in collaboration with MOH-Syria. *Availability of Health Resources and Services at Public Hospitals in Syria.* 3rd Quarter 2013.

37 Assessment Working Group for Northern Syria. *Syrian Arab Republic: Syria Integrated Needs Assessment.* December 2013.

38 Save the Children. *A Devastating Toll: The Impact of Three Years of War on the Health of Syria's Children.*

39 Calculations by Save the Children. The number of live births expected per day among Syrian refugees is estimated according to standard methodology. See: IAWG on RH in Crises. *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings.* (New York: 2010), p.77. Data sources: Total persons of concern: UNHCR, data.unhcr.org/syrianrefugees/regional.php [Accessed April 16, 2014]; Crude birth rate: World Bank, data.worldbank.org/indicator/SP.DYN.CBRT.IN [Accessed April 16, 2014]

40 Jinan Usta, et al. *Assessment of Reproductive Health and Gender Based Violence Among Displaced Syrian Women in Lebanon, July-September 2012.*

41 UNHCR. *2014 Syria Regional Response Plan.* p.23

42 Of the 193 cases for whom cause of death was identified, 39 were neonatal deaths. Source: UNHCR. *Inter-Agency Regional Response for Syrian Refugees: Health and Nutrition Bulletin: Egypt, Iraq, Jordan, and Lebanon: October 2013 - Issue No. 11.* (Amman: December 9, 2013), p.3

43 Calculations by Save the Children. Data sources: Crude death rate and total population: World Bank, data.worldbank.org [Accessed April 17, 2014]; Neonatal deaths: IGME, www.childmortality.org/ [Accessed April 17, 2014]

44 UNHCR. *Health Sector Bi-weekly Report Public Health and Nutrition Jordan Week 1 and 2 HIS Zaatri Report.* January 27, 2014

45 Interview conducted for Save the Children by Francine Uenuma, January 2014

46 PAPFAM. *Syrian Household Health Survey – Syrians Summary Report.* November 2010

47 Save the Children. *Nutrition Rapid Assessment*. January 2013

48 Global Nutrition Cluster. *Scoping Mission to Assess Nutrition Context and Potential Nutrition Information – Sharing Mechanisms within the Humanitarian Response for Northern Syria.* September 2013.

49 Syria Needs Analysis Project. *Dara'a Governorate Multi Sector Needs Assessment.* January 2014.

50 Save the Children. *Nutrition Rapid Assessment*. January 2013

51 Assessment Working Group for Northern Syria. Joint Rapid Assessment in Northern Syria II: Final Report. May 22, 2013

52 Save the Children. *Nutrition Assessment Northern Syria*. January 2013

53 Masterson, Amelia Reese, Jinan Usta, Jhumka Gupta and Adrienne Ettinger. "Assessment of Reproductive Health and Violence Against Women Among Displaced Syrians in Lebanon." *BMC Women's Health.* Volume 14, Number 25. February 20, 2014

54 UNHCR, UNICEF and WFP. *Joint Assessment Review of the Syrian Refugee Response in Jordan.* January 2014

55 Interview conducted for Save the Children by Ahmad Baroudi, Lebanon, February 2014

56 Interview conducted for Save the Children by Catherine Carter, Lebanon, February 2013.

57 UNICEF. *Under Siege: The Devastating Impact on Children of Three Years of Conflict in Syria.* (UNICEF Regional Office for the Middle East and North Africa: Amman, Jordan: March 2014)

58 *Stolen Futures: The Hidden Toll of Child Casualties in Syria.* (Oxford Research Group: London: 2013)

59 *Syria Integrated Needs Assessment.* (December 2013) p.35

60 UNICEF. *Under Siege: The Devastating Impact on Children of Three Years of Conflict in Syria.*

61 *Syria Integrated Needs Assessment.* (December 2013) p.44

62 ACAPS. *Crisis Overview: Regional Analysis Syria.* February 7, 2014

63 ReliefWeb. "WHO Warns of Increased Risk of Disease Epidemics in Syria and in Neighbouring Countries as Summer Approaches." June 4, 2013; Assessment Working Group for Northern Syria. *Joint Rapid Assessment in Northern Syria II: Final Report.* 22 May 2013; and observations by Save the Children.

64 Save the Children. *Nutrition Assessment Northern Syria.* January 2013.

65 Interview conducted for Save the Children by Dawn Trump, Za'atari refugee camp, Jordan, August 2013.

66 UNFPA." Why Isn't Family Planning Prioritized in Refugee Settings?" July 25, 2013

67 IRIN. "Born into Crisis: Unwanted Pregnancies in Syria."

68 Ibid.

69 Interview conducted for Save the Children by Francine Uenuma, January 2014.

70 Interview conducted for Save the Children by Ahmad Baroudi, Lebanon, February 2014

71 Interview conducted for Save the Children by Catherine Carter, Lebanon, June 2013.

72 *The Lancet.* "Violence Against Women in Syria." Volume 382, Issue 9908, December 7, 2013. p.1858

73 Child Protection Working Group. *Syria Child Protection Assessment 2013.*

74 International Rescue Committee. *Syria: A Regional Crisis*.

75 UN Human Rights Council. *6th Report of the Commission of Inquiry on Syria.* August 16, 2013

76 UN General Assembly. *Protection of and Assistance to Internally Displaced Persons: Situation of Internally Displaced Persons in the Syrian Arab Republic.* 67th Session. Agenda item 69 (a). July 15, 2013

77 International Rescue Committee. *Syria: A Regional Crisis*.

78 Child Protection Working Group. *Syria Child Protection Assessment 2013.*

79 Child Protection and Gender-Based Violence Sub-Working Group Jordan. *Findings from the Inter-Agency Child Protection and Gender-Based Violence Assessment in the Za'atari Refugee Camp*. 2013

80 United Nations. *How Humanitarian Funds for the Syria Crisis Were Spent – 2013 SHARP and RPP.* (2013)

81 UN Women. *Inter-Agency Assessment: Gender-Based Violence and Child Protection Among Syrian Refugees in Jordan, With a Focus on Early Marriage.* (New York: 2013)

82 Jinan Usta, et al. *Assessment of Reproductive Health and Gender Based Violence Among Displaced Syrian Women in Lebanon, July-September 2012.*

83 OCHA. *Humanitarian Bulletin: Syria*. Issue 42. February 13-26, 2014

84 IAWG. *Reproductive Health Services for Syrian Refugees in Zaatri Refugee Camp and Irbid City, Jordan: An Evaluation of the Minimum Initial Service Package, March 17-22, 2013*

85 UN Women. *Inter-Agency Assessment: Gender-Based Violence and Child Protection Among Syrian Refugees in Jordan, With a Focus on Early Marriage.*

86 Child Protection Working Group. *Syria Child Protection Assessment 2013*.

87 Interview conducted for Save the Children by Catherine Carter, Lebanon, February 2013.

88 UN Women. *Inter-Agency Assessment: Gender-Based Violence and Child Protection Among Syrian Refugees in Jordan, With a Focus on Early Marriage.*

89 Al Hayat. "Egypt: Exploitive Marriages to Syrian Refugees." April 10, 2013

90 Al Fudaylat, Mohammed. "Fleeing War, Syrian Women Find Over-Eager Embrace in Jordan." *Al Safir Al Arabi.* April 10, 2013

91 Zarzar, Anas. "Syrian Refugees: Forced into Marrying off Their Daughters." *Shoah*. September 11, 2012

92 Masriya, Aswat. "Rights Council Condemns Marriage to Syrian Refugees." *All Africa Global Media.* January 24, 2013.

93 Al Fudaylat, Mohammed. "Fleeing War, Syrian Women Find Over-Eager Embrace in Jordan." *Al Safir Al Arabi*. April 10, 2013

94 Interview conducted for Save the Children by Catherine Carter, Lebanon, February 2013.

United States Chapter

1 U.S. Department of Commerce, National Oceanic and Atmospheric Administration. *Service Assessment: Hurricane/Post-Tropical Cyclone Sandy, October 22-29, 2012.* (Silver Spring, MD: May 2013)

2 Nattel, Noah. "Emergency Care for the Haves and Have Nots – A Doctor's Story." *Every Mother Counts.* April 19, 2013 [Accessed January 31, 2014]

3 Xiong, Xu, Emily Harville, Donald Mattison, Karen Elkind-Hirsch, Gabriella Pridjian and Pierre Buekens. "Exposure to Hurricane Katrina, Post-Traumatic Stress Disorder and Birth Outcomes. *American Journal of the Medical Sciences.* Volume 336, Issue 2. August 2008. pp.111–115.

4 American College of Obstetricians and Gynecologists, Committee on Health Care for Underserved Women. "Preparing for Disasters: Perspectives on Women." *Committee Opinion.* Number 457. June 2010.

5 National Commission on Children and Disasters. *Interim Report.* October 14, 2009

6 Interview conducted for Save the Children by Tanya Weinberg, January 2014

7 Save the Children. *Unaccounted For: A National Report Card on Protecting Children in Disasters.* (Westport, CT: 2013)

8 Landry, Vi. "Awesome, Girls! A Mentoring Program at St. Mark's Community Center Helps Teenage Girls Cope with Adolescence and Post-Katrina Stresses" *Gambit*. Volume 24, Number 183. August 29, 2006

9 Interview conducted for Save the Children by Tanya Weinberg, January 2014

10 Save the Children. *Unaccounted For: A National Report Card on Protecting Children in Disasters.*

11 Interview conducted for Save the Children by Tanya Weinberg, October 2013

12 Interview conducted for Save the Children by Tanya Weinberg, January 2014

Take Action, Mothers' Index & Methodology

1 For this analysis, countries "experiencing or recovering from a humanitarian crisis" were defined as those "in conflict," "emerging from conflict," and/or those experiencing or emerging from a "major natural disaster" the year they placed in the bottom 10. For details, see Methodology and Research Notes.

2 Includes war and minor conflict that resulted in at least 25 deaths in a single year during the period 1996-2013, as reported by the Uppsala Conflict Data Program. See Appendix for full methodology.

3 Of the 28 countries that have ever made the Index bottom 10 (see page 67), 23 are currently considered fragile states by OECD (see page 76). Four others (Cambodia, Djibouti, Equatorial Guinea and the Gambia) have graduated from fragile state status since 2003, the first year a list of fragile states (then classified as "low income countries under stress") was developed. See: Independent Evaluation Group. *Engaging with Fragile States: An IEG Review of World Bank Support to Low-Income Countries Under Stress.* (World Bank: Washington, DC: 2006), pp.81-82

4 As validated and compiled by the WHO Collaborating Centre for Research on the Epidemiology of Disasters (CRED) on its International Disaster Database (EM-DAT). See Methodology and Research Notes for full explanation.

5 Burkina Faso and Mali tied for last on the *Mothers' Index* in 2005.

6 Interview conducted for Save the Children by Lizzie Moncada, Mukassa IDP camp, Central African Republic, February 2014

7 OCHA. *Central African Republic (CAR) Situation Report No.18*. March 26, 2014

8 UNICEF. The State of the World's Children 2014. p.24 and Table 8, pp.72-77

9 Consultation with Save the Children staff.

10 Inter-Parliamentary Union. *Women in National Parliaments.* www.ipu.org/wmn-e/world.htm [Accessed April 11, 2014]

11 The World Bank. "Country and Lending Groups": http://data.worldbank.org/about/country-classifications/country-and-lending-groups [Accessed March 16, 2014]

12 IDMC. *Nepal: Sustainability of IDP Returns Undermined by Lack of Assistance.* (Geneva: 2008) p.11

13 UN IGME. *Levels and Trends in Child Mortality: Report 2013.*

14 WHO/UNICEF/UNFPA/World Bank. *Trends in Maternal Mortality: 1990 to 2010.* (Geneva: WHO: 2012)

15 Engel, Jakob, Jonathan Glennie, Shiva Raj Adhikari, Sanju Wagle Bhattarai, Devi Prasad Prasai and Fiona Samuels. *Nepal's Story: Understanding Improvements in Maternal Health*. (London: Overseas Development Institute: July 2013)

16 Inter-Parliamentary Union. *Women in National Parliaments.* [Accessed April 11, 2014]

17 The category "developed" nations includes all countries not classified by UNICEF, for statistical purposes only, as "developing," so 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. This country set is consistent with the "developed regions" MDG grouping. Source: UNICEF. *The State of the World's Children 2012.* p.124

18 Humanitarian crises are taking place in Chad, Central African Republic, Mali, Niger, Nigeria, DR Congo and Somalia. In all but Nigeria, the situation is considered "severe". See: ACAPS. *Global Emergency Overview: Snapshot 8-15 April.* (April 2014) http://geo.acaps.org/ [Accessed April 17, 2014]

19 Calculations are based on prevailing rates of fertility (UNFPA. *State of World Population 2013.*) and under-5 mortality (IGME, 2013).

20 Mortality rates are difficult to estimate even in stable countries; rates may be underestimates. Sources: Somaliland Ministry of National Planning and Development (MNPD) and UNICEF. *Somaliland: Monitoring the Situation of Women and Children - Summary Preliminary Results Multiple Indicator Cluster Survey 2011.* (UNICEF: New York: 2013) and *Somalia: Monitoring the Situation of Women and Children - Multiple Indicator Cluster Survey 2006*. (UNICEF: New York: 2007)

21 Ibid; Ministry of Planning & International Cooperation and UNICEF. *Northeast Zone, Somalia: Monitoring the Situation of Women and Children - Summary Preliminary Results Multiple Indicator Cluster Survey 2011.* (UNICEF: New York: 2013).

22 OECD. *Fragile States 2014: Domestic Revenue Mobilisation.* p.2

23 UNICEF Global Databases. www.childinfo.org/maternal_mortality.html [Accessed March 14, 2014]

24 UN IGME. Levels and Trends in Child Mortality: Report 2013.

25 For a list of these countries, see the Countdown's 2013 Accountability Report, available here: www.countdown2015mnch.org/reports-and-articles/2013-report

26 "On track" to achieve MDG 4 indicates that the under-5 mortality rate for 2012 is less than 40 deaths per 1,000 live births or that it is 40 or more with an average annual rate of reduction of 4.0 percent or higher for 1990–2012. All other countries are making "insufficient progress," or "no progress" and so were included in this analysis.

27 Data were retrieved from UCDP datasets (UCDP/PRIO Armed Conflict Dataset v.4-2013; UCDP Battle-Related Deaths Dataset v.5-2013, UCDP One-sided Violence Dataset v 1.4-2013; UCDP Non-State Conflict Dataset v. 2.5-2013), available here: www.pcr.uu.se/research/ucdp/datasets/ and UCDP's Conflict Encyclopedia: www.ucdp.uu.se/database [Last Accessed April 7, 2014]

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Page 1 – Giles Duley
Jordan. *Syrian mothers with their children in Za'atari refugee camp. All these children have been born since the start of the war.*

Page 2 – Reuters / Edgar Su
Philippines. *A mother and her children walk through a flooded street after a downpour in the aftermath of super typhoon Haiyan in Tacloban city.*

Page 3 – Katie Seaborne
DR Congo. *Save the Children CEO Jasmine Whitbread visits children admitted to the stabilization center in Mwene Ditu.*

Page 4 – Pep Bonet / NOOR
Nigeria. *A mother who gave birth at home brings her sick baby to a hospital in Katsina, northern Nigeria.*

Page 7 – Colin Crowley
Somalia. *Midwife Farhiya Muse Ali examines newborn baby Zakaria in a hospital in Puntland. His mother had a difficult delivery, and Zakaria needed help to breathe at first, but both mother and baby are recovering now.*

Page 9 – Save the Children
India. *A girl goes to get water in a flooded village in Barpeta, Assam. Drinking water sources are all contaminated, so families are making do with flood water since there is little difference between the flood water and the water they draw from hand pumps.*

Page 10 – CJ Clarke
Pakistan. *Jeeran and her 2-year-old son Yousaf lost their home in the 2010 floods in Pakistan.*

Page 14 – Christena Dowsett
Kenya. *Josephine uses "kangaroo mother care" to keep her newborn daughter Claudia warm and well fed. Claudia was born prematurely at Kitui District Hospital.*

Page 16 – Tony Kaye
Central African Republic. *Adete, 16, and her 1-year-old son Henri. Both have been surviving on one meal a day, and Henri has been very sick.*

Page 17 – Amy Reed
South Sudan. *Nateyi, 2, was severely malnourished, with a fever, vomiting, diarrhea and coughing. Her mother Veronica brought her to the Save the Children stabilization center. After 5 days, Nateyi was feeling better and had regained her appetite.*

Page 18 – Kj Borja for USAID / Suaahara
Nepal. *Bishnu, her 9-month-old daughter Prinsu and mother-in-law Sapana have better nutrition with food they are growing in their home garden.*

Page 19 – Francesca Tosarelli
DR Congo. *Pamela, 17, was raped by a young man at a displacement camp. She became pregnant but lost the baby during labor. She experienced fistula as a result of the traumatic birth. She is now receiving medical and psychological care from Heal Africa.*

Page 21 – Caroline Trutmann
Ethiopia. *Mulu, 16, is 9 months pregnant. Her marriage was arranged by her parents and she was not consulted.*

Page 22 – Caroline Trutmann
Ethiopia. *A health extension worker gives a birth control injection to a 25-year-old woman.*

Page 23 – Colin Crowley
Bangladesh. *Shefali is 7 months pregnant. She has given birth to 6 children, but 3 died shortly after being born.*

Page 24 – Lynsey Addario
Philippines. *Children stand outside their flooded home.*

Page 25 – Jonathan Hyams
Philippines. *Leonida and her children Manuelle and Santiago live in a makeshift home built from a destroyed van and scraps of salvaged metal.*

Page 26 (top) – Jonathan Hyams
Philippines. *Australian and British doctors work at hospital next to Tacloban airport supported by DFID and Save the Children.*

Page 26 (bottom) – Lynsey Addario
Philippines. *A rural health clinic outside of Tacloban can no longer be used due to flood damage.*

Page 27 – Lynsey Addario
Philippines. *Midwife Norina Malate delivers the baby of Analyn, 18, by the side of the road on Leyte island.*

Page 28 – Lynsey Addario
Philippines. *Lolita and her 2-month-old daughter Princess Daniella received counseling from a Save the Children nutrition team.*

Page 29 (top) – Susan Warner
Philippines. *Abigail breastfeeds her 3-month-old daughter Kazumi.*

Page 29 (bottom) – Rosary Diane Maligalig
Philippines. *Jacqueline, a mother of four, received carpentry training from Save the Children and is rebuilding her house.*

Page 30 – Hedinn Halldorsson
Philippines. *5-month-old Erold and his family lost their home in the typhoon. They now live in a library that is serving as a shelter.*

Page 31 – Hedinn Halldorsson
Philippines. *Mernita's twins Rosel and Rodel are suffering from severe acute malnutrition, which is life threatening. They are being treated by Save the Children. Mernita's older daughters, Regine and Rose Ann, now cry whenever it rains.*

Page 32 – Paul Taggart / UNHCR
DR Congo. *Displaced Congolese women and children flee to the North Kivu provincial capital of Goma.*

Page 33 – F. Noy / UNHCR
DR Congo. *After going into labor, a pregnant refugee is carried onto a boat for the 45-minute trip to a mobile health clinic in Betou.*

Page 32 – Jodi Bieber
DR Congo. *Cilomba and her newborn baby Mbuji.*

Page 35 – Rebecca Vassie
Uganda. *Janet lost her husband and four oldest children in an attack in DR Congo. Her youngest child died of malnutrition in a refugee camp. She just lost a newborn baby after giving birth alone.*

Page 36 – Daniel McCabe
DR Congo. *Jospehine and her four sons outside their tent in a displacement camp near Goma.*

Page 37 – Colin Crowley
DR Congo. *Sylvie, 16, was kidnapped and impregnated. She escaped when she was 6 months pregnant and made the several-day journey on foot back to her family. The community welcomed her back and she soon gave birth to twins.*

Page 38 – Alessandro Pavone
DR Congo. *Kesiya and her daughter, who was raped by a young man from their village when she was just 6 years old.*

Page 39 – Rebecca Vassie
Uganda. *Families wait outside the antiretroviral therapy clinic in Rwamwanja Health Center.*

Page 40 (top) – Save the Children
DR Congo. *Poster from a Save the Children workshop on sexual and reproductive health for out-of-school teenagers.*

Page 40 (bottom) – Oliver Asselin
DR Congo. *Actors perform a street drama to raise awareness of issues related to HIV and AIDS.*

Page 41 – Rebecca Vassie
Uganda. *Jovia, 14, and her 8-month-old son John. She hopes to continue her education when John is old enough to no longer be dependent on breast milk.*

Page 42 – Sebastian Meyer / Getty Images for Save the Children
Iraq. *Domiz refugee camp in northern Iraq. The camp houses more than 50,000 people who have fled fighting in Syria.*

Page 43 – Ahmad Baroudi
Lebanon. *Zahra, 35, and her nine children. After being under siege for a year, the family left Syria in 2013.*

Page 44 – Alessio Romenzi
Syria. *Syrian women and children fleeing from Al Qsair, a small town outside of Homs.*

Page 46 (top) – Agnes Montanari
Jordan. *Mothers and children arrive at Save the Children's Infant and Young Child Feeding Center in Za'atari refugee camp.*

Page 46 (bottom) – Suzanna Klaucke
Jordan. *Manar, 30, and her three children. Manar learned about the importance of breastfeeding at Save the Children's Infant and Young Child Feeding Center in Za'atari refugee camp.*

Page 47 – Ahmad Baroudi
Lebanon. *Elham, 29, with her 2-year-old daughter Maisam. The family had to leave everything behind and move to Lebanon in search of safety.*

Page 48 – Sam Tarling
Syria. *A doctor uses a mobile phone to provide light during an operation on a baby suffering with Down syndrome.*

Page 49 (top) – Hedinn Halldorsson
Jordan. *Noor, 22, was 7 months pregnant when she walked with her husband and three small children from Syria to Jordan. She was afraid she would give birth on the side of the road.*

Page 49 (bottom) – Jonathan Hyams
Jordan. *Over 65 percent of the inhabitants of Za'atari refugee camp are children.*

Page 51 – Jonathan Hyams
Lebanon. *Noor, 11, lives in a refugee settlement near the Syrian border. "I have no good memories of Syria," she said.*

Page 52 – Justin Clemons / Getty Images for Save the Children
Oklahoma, USA. *A woman salvages what she can from her home the day after a tornado destroyed almost everything.*

Page 54 – Reuters / Carlos Barria
Texas, USA. *More than 16,000 victims of Hurricane Katrina received food and shelter at the Astrodome stadium in Houston.*

Page 55 (top) – Justin Clemons / Getty Images for Save the Children
Oklahoma, USA. *Cynthia, Brian and their 8-month-old son Braden stand with Cynthia's mother Angela and her 10-month-old baby Elijah amid tornado wreckage in Moore.*

Page 55 (bottom) – Sarah Thompson
Louisiana, USA. *One-year-old Aaliyah sleeps on a cot in a shelter for victims of Hurricane Isaac in 2012.*

Page 56 – Susan Warner
New Jersey, USA. *Florence plays with her 2-year-old son Skylar at a day care center restored with help from Save the Children after Hurricane Sandy.*

Page 57 – Brett Deering / Getty Images for Save the Children
Oklahoma, USA. *Children at a day care center in Moore have this shelter to protect them if another tornado hits their town.*

Page 58 – Lee Celano / Getty Images for Save the Children
Haiti. *Ashley and her cousin Melina see a nurse at a Save the Children medical clinic in a displaced persons camp in Petionville.*

Page 60 – Susan Warner
Kenya. *Rukia, 23, and 2-year-old Musaf lead their family's cows to a watering hole. Droughts in 2011 and 2012 devastated families and livestock, leading to increased malnutrition among children. Save the Children is helping mothers and children in the area to drink more fresh milk and improve household sanitation.*

Page 61 – Raheel Waqar
Pakistan. *Anisa reads a story aloud to her classmates.*

Page 62 – Mark Kaye
Central African Republic. *Mothers and children visit one of Save the Children's mobile health clinics.*

Page 64 – Oli Cohen
Niger. *Mother and child at a Save the Children health center that provides primary health care and treatment for acute malnutrition.*

Page 65 – Oskar Kullander
Sweden. *Rosie, 32, is on parental leave with her youngest daughter, Minou, 8 months old.*

Page 66 – Greg Funnell
Central African Republic. *Fighting and instability have intensified the humanitarian crisis.*

Page 69 – Genna Naccache
Brazil. *Elvira and Ana Cristina are practicing "kangaroo mother care" with their premature babies. Both babies will soon be discharged from the hospital.*

Page 70 – Mai Simonsen
Norway. *Elise, pregnant with her second child, gets a late ultrasound because she had complications during her first pregnancy.*

Page 71 – Helene Caux / UNHCR
Niger. *A refugee family from Mali gets minimal protection from the heat and wind from their makeshift shelter in Gaoudel.*

Page 72 – Elissa Bogos
Afghanistan. *Qamar and her two children wait to be seen by a doctor at a clinic for malnourished children in Jawzjan.*

Page 73 – Krister Jay Borja
Cambodia. *Midwife Lim Sinin measures Tuoy's tummy to assess fetal growth and development in her ninth month of pregnancy.*

Page 75 – Aubrey Wade
Sierra Leone. *Aminata watches over her severely ill 5-month-old son Daniel in the emergency ward of the Ola During Children's Hospital.*

Back Cover – Jonathan Hyams
Liberia. *Comfort carries her 9-month-old daughter Marie in an area where Save the Children provides prenatal and postnatal care, immunizations and childbirth services.*

Liberia

Each day, 800 mothers and 18,000 young children die from largely preventable causes. Over half of these maternal and under-5 deaths take place in fragile settings, which are at high risk of conflict and are particularly vulnerable to the effects of natural disasters.

The urgent task of completing the unfinished business of the Millennium Development Goals, and ending preventable child and maternal deaths, is increasingly concentrated in these contexts. Finding ways of meeting mothers' and children's health and nutrition needs in fragile states and humanitarian crises is central to this challenge.

The 15th annual *State of the World's Mothers* report examines the impact of humanitarian crises on maternal, newborn and child survival in countries consistently ranked as the most difficult places to be a mother. Since our *Mothers' Index* was launched in 2000, the majority of the bottom 10 countries have been fragile states in the midst of, or emerging from, a recent humanitarian emergency. In addition to emergencies, many of these countries face ongoing health crises due to chronic challenges, including limited access to quality health care.

State of the World's Mothers 2014 concludes that every country must be better prepared to assist mothers and children in emergencies. We also must begin the difficult but urgent work of providing stability in the most fragile regions of the world, and identify ways to build better access to health care in these contexts. Ending preventable deaths of mothers and children will not be possible until fragile countries become more stable and health care more accessible.

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