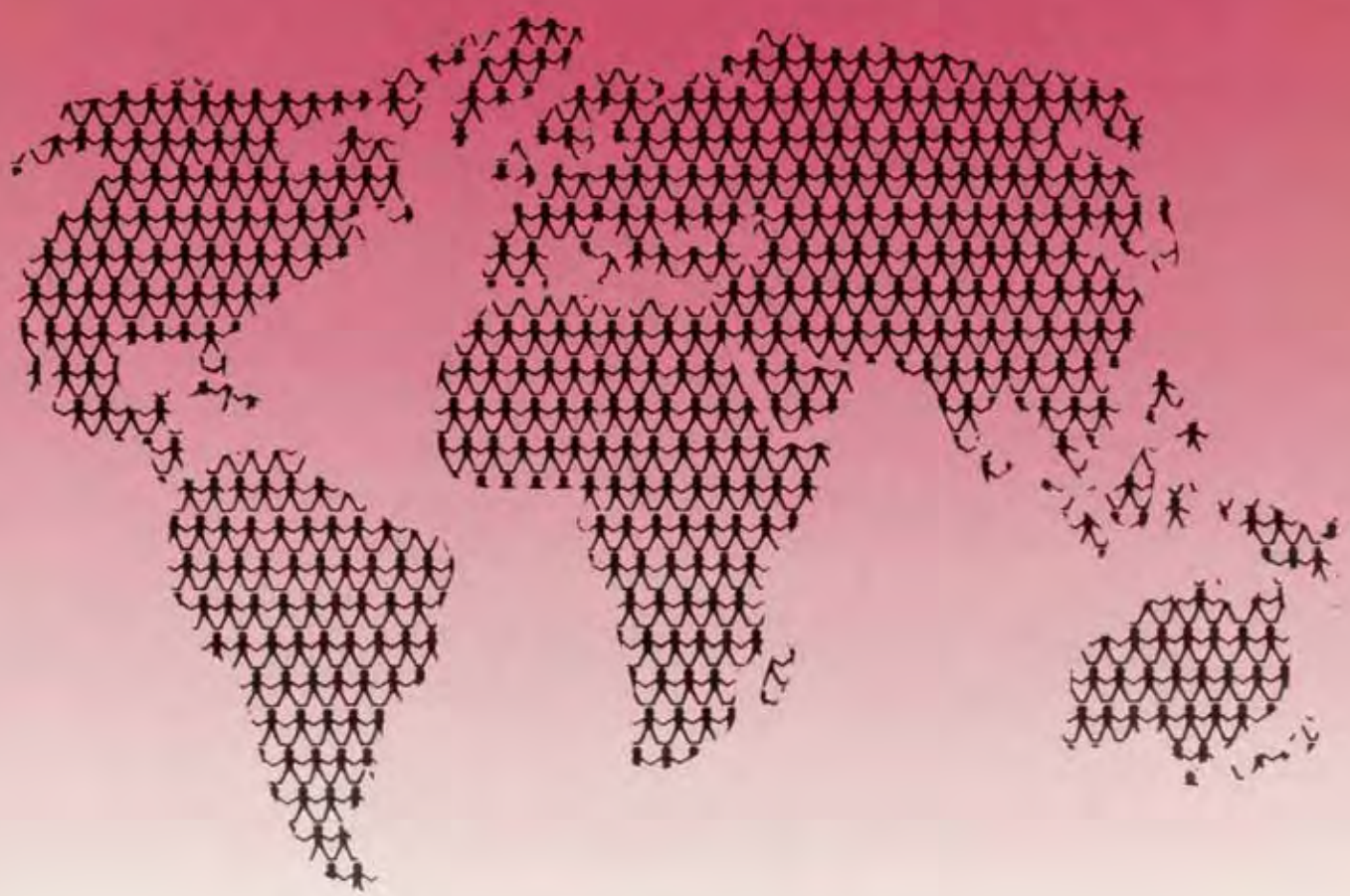
THE STATE OF THE WORLD'S CHILDREN 1989



United Nations Children's Fund
(UNICEF)

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Oxford University Press, Walton Street,
Oxford OX2 6DP
Oxford New York Toronto Delhi Bombay Calcutta Madras Karachi Pecaling Jaya Singapore Hong Kong Tokyo Nairobi Dar-es-Salaam Cape Town Melbourne Auckland and associated companies in Beirut Berlin Ibadan Nicosia

Oxford is a trade mark of Oxford University Press
Published in the United States by Oxford University Press, New York

British Library Cataloguing in Publication Data
The state of the world's children 1989
1. Children—Care and hygiene
613' 0432 RJ101
ISBN 0-19-261827-X

ISSN 0265-718X

The Library of Congress has catalogued this serial publication as follows:-
The state of the world's children—Oxford
New York: Oxford University Press for UNICEF v.:ill.; 20cm. Annual. Began publication in 1980.
1. Children—Developing countries—Periodicals. 2. Children—Care and hygiene—Developing countries—Periodicals. I. UNICEF.
HQ 792.2.S73 83-647550 362.7'1'091724

UNICEF, UNICEF House, 3 U.N. Plaza, New York, N.Y. 10017 U.S.A.
UNICEF, Palais des Nations, CH. 1211
Geneva 10, Switzerland.

Cover and design: Miller, Craig and Cocking, Woodstock, U.K.
Charts and tables: Stephen Hawkins, Oxford Illustrators, Oxford, U.K.
Typesetting and Printing: Burgess & Son (Abingdon) Ltd, U.K.

Edited and produced for UNICEF and Oxford University Press by P & L Adamson, Benson, Oxfordshire, U.K.

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Executive Director of the
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PUBLISHED FOR UNICEF

Oxford University Press

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PREFACE

This year's *State of the World's Children* report represents a departure from the tradition of recent years. Nineteen eighty-nine is the tenth anniversary of the *International Year of the Child* which, as UNICEF noted at the time, was intended to mark an inflection point in the graph of the world's concern for children. It is also the year in which the strategy for the fourth and final United Nations Development Decade of this century (1991–2000) is being formulated. In response to the request of its Executive Board, UNICEF is therefore taking this opportunity to look back on the achievements for children over the last ten years and, more importantly, to look forward to what might be achieved over the next ten.

Unfortunately, such a review is impossible without engaging the issues of debt and adjustment to economic recession – issues which have affected the lives of many millions of the world's children in the 1980s and seem likely to remain a major influence in the lives of the children of the 1990s.

UNICEF's concern for the impact of economic forces on children is a continuing one. Beginning in 1984, when this organization published the first of its two studies on the subject, our particular concern has been the advocacy of what has become known as *adjustment with a human face*. Our view is that the protection of the most vulnerable, and particularly the growing minds and bodies of young children, is both a moral imperative and a practical pre-condition for sustained economic and social progress. By attempting to monitor events and develop propositions from this standpoint, UNICEF has played a constructive, if unaccustomed, role in the evolution of thinking on these issues in the United Nations family and in the international financial institutions.

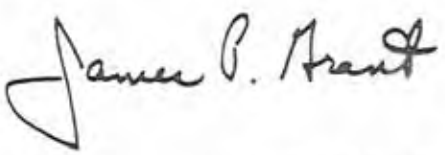
This year's report integrates these concerns with an examination of the prospects for the world's children in the decade ahead. In summary, it argues that in most nations the reacceleration of progress for children is contingent upon international action not only to resolve the debt crisis but also to allow a return to economic growth. Stronger demand in the developing world would also help in the process of restructuring the unsustainable imbalances in the economies of the industrialized nations.

Chapter III argues that even a return to economic growth, difficult as this will be to achieve, is not enough. Progress for children – and their families – also depends on learning the harsh lessons of recent years, years in which the poor have suffered most in bad economic times, just as they benefited least in good economic times. What is now required is a commitment to *real development* – a development which unequivocally puts people first, in good times and in bad, and takes as its central purpose the task of enabling all families to meet their own and their children's essential needs.

To assist in that process, and to help in the difficult task of bending priorities towards the poor, it will be necessary for the industrialized nations to review trade, aid, and financial policies in relation to the developing world. But if such changes are to command the necessary public support, they must form part of a *real development pact* by which nations would work together, case by case, to plan the eradication of the worst aspects of absolute poverty, preventable illness, widespread malnutrition, and mass illiteracy by the end of the present century. Chapters IV and V of the report look at the kind of action necessary to achieve this great goal and summarize the knowledge which has been gained over the last two decades and which now stands ready to convert relatively modest resources into major gains for humanity.

From this review of present knowledge and its recent impact, it is clear that the 1990s hold out the promise of a great breakthrough in one vital area of development – the protection of the physical and mental growth of the world's children. The last chapter of the report suggests that this potential advance is so important for future prosperity and peace in the world as to merit a special meeting of political leaders to consider how the major opportunities for protecting children might be seized over the next decade.

Finally, the report suggests that the international community as a whole, and every citizen within it, stands to gain from a renewed commitment to 'real development'. The persistence of absolute poverty on this planet is ultimately inseparable from the issues of violence, instability, and environmental deterioration which affect us all and will affect us increasingly as we move towards the opening of a new millenium.



James P. Grant
Executive Director

I

THE STATE OF THE WORLD'S CHILDREN 1989

James P. Grant

A decade of achievement threatened

Children in debt

Real aid for real development

Real development in practice

Seven sins

Today's children—tomorrow's world

Measuring real development

The under-five mortality rate (U5MR) is the number of children who die before the age of five for every 1,000 live births. It is the principal indicator used by UNICEF to measure levels of, and changes in, the well-being of children. This year's report carries a supplementary chapter – Measuring real development – which discusses the importance of the U5MR and its average annual reduction rate (in the context of a wider discussion of social indicators). It is the U5MR which governs the order in which countries are listed in the statistical tables annexed to the State of the World's Children report.

Figures given for the U5MR of particular countries, in both the text and statistical tables, are estimates prepared by the United Nations Population Division on an internationally comparable basis, using various sources. In some cases, these may differ from national estimates.

A decade of achievement threatened

For almost nine hundred million people, approximately one sixth of mankind, the march of human progress has now become a retreat. In many nations, development is being thrown into reverse. And after decades of steady economic advance, large areas of the world are sliding backwards into poverty.

Throughout most of Africa and much of Latin America, average incomes have fallen by 10% to 25% in the 1980s. The average weight-for-age of young children, a vital indicator of normal growth, is falling in many of the countries for which figures are available. In the 37 poorest nations, spending per head on health has been reduced by 50%, and on education by 25%, over the last few years. And in almost half of the 103 developing countries from which recent information is available, the proportion of 6-to-11 year-olds enrolled in primary school is now falling.

In other words, it is children who are bearing the heaviest burden of debt and recession in the 1980s. And in tragic summary, it can be estimated that at least half a million young children have died in the last twelve months as a result of the slowing down or the reversal of progress in the developing world.*

Unlike the tragedy of drought or flood or famine, this tragedy of development's reversal cannot easily be captured by the media and brought to the attention of a world-wide public. It is happening not in any one particular place, but in slums and shanties and neglected rural communities across two continents. It is happening not at any one particular time, but over long years of increasing poverty which have not been featured in the nightly news but which have changed the daily lives of many millions of people. And it is happening not because of any one visible cause, but because of an unfolding economic drama in

* This estimate does not include child deaths in countries affected by war or civil strife (such as Angola, Chad, Ethiopia, or Mozambique). It is based on an analysis of under-five deaths in those countries where the rate of reduction in under-five mortality has been less in the period 1980–87 than in the period 1970–80. Furthermore, it excludes all countries in which the rate of decline in under-five mortality was, in any case, slowing down (as evidenced by a lower rate of decline in 1970–80 than in 1960–70). This leaves only 16 countries (10 in Africa and 6 in Latin America) in which there has been a definite slowing down, running counter to recent national trends, in the rate of decline in under-five mortality. For these 16 countries alone, the number of child deaths in the last twelve months is approximately 650,000 more than would have been the case if the 1970–80 rate of decline in under-five mortality had continued, but not accelerated, in the period 1980–87. The majority of these deaths (approximately 400,000 in Africa and the remainder in Latin America) could therefore be said to be related to the slowing down or reversal of the development process during the 1980s which is a result of unprecedented borrowing, rising interest rates, falling commodity prices, inadequate investment of borrowed funds, and the domestic and international management of the resulting debt crisis.

which the industrialized nations play a leading role.

The slowing down of progress and the reversal of hard-won gains is therefore largely invisible to the industrialized world. Yet it is spreading hardship and human misery on a scale and of a severity unprecedented in the post-war era.

Mitigating this picture is the continued economic progress of China, India, Malaysia, Pakistan, the Republic of Korea, Sri Lanka, and Thailand – nations which are home to half the world's children. Asia still contains the majority of the world's absolute poor and faces enormous social problems. Yet most of its nations are continuing to see average incomes slowly rising and average living standards slowly improving.

But for most of the countries of Africa, Latin America, and the Caribbean, almost every economic signal points to the fact that development has been derailed. Per capita GNP has fallen (fig. 1), debt repayments have risen to a quarter or more of all export earnings,* share in world trade has dropped, and the productivity of labour has declined by one or two percentage points each year throughout the 1980s.

UNICEF's business is children, not the workings of the international economy. But in its everyday work in over one hundred developing nations, UNICEF is brought up against a face of today's international economic problems which is not seen in the corridors of financial power, not reflected in the statistics of debt-service ratios, not seated at the conference tables of debt renegotiation.

It is the face of the young child.

It is the young child whose growing mind and body is susceptible to permanent damage from even temporary deprivation. It is the young child whose individual development today and whose social contribution tomorrow are being shaped by the economics of *now*. It is the young child who is paying the highest of all prices, and who will bear the most recurring of all costs, for the mounting debt repayments, the drop in export earnings, the increase in food costs, the fall in family incomes, the run-down of health services, the narrowing of educational opportunities.

This year's report cannot therefore ignore the economic issues which, for so many millions of the world's poorest families, have made the 1980s into a decade of despair. But it will also emphasize the trends and the opportunities which, if the world so wills, could make the 1990s into a decade of hope.

Achievements of the 80s

It is now exactly ten years since the world celebrated the International Year of the Child. At that time, UNICEF argued that the year should mark "not a high point but an inflection point" in the graph of concern for children. But as the 1970s drew to an end, the economic problems of the developing world were already beginning to multiply. And throughout the 1980s, progress for children has had to struggle against the forces of international recession and rising debt.

Yet its achievements have still been remarkable.

As economic problems have mounted, the capacity and knowledge built up in the developing world in previous decades have begun to be exploited. And despite reversals in nations where poverty has tightened its grip, specific action for children in the 1980s has saved the lives of several million under-fives, reduced the annual child death toll by approximately two and a half million, and protected the health and growth of even larger numbers of the world's young children.

By means of a determined effort in the developing world, the proportion of children protected by immunization has been levered from under 10% to over 50% in the last eight years (fig. 2). Common illnesses like measles, tetanus, and whooping cough, which were killing 5 million

* If sub-Saharan Africa were to meet its debt and interest payments for 1988–89, then such payments would claim more than half of the region's export earnings. The difference between the amounts due and the amounts paid will be added to the region's debt.

children a year and inflicting life-long disability on several million more, are now on the retreat world-wide. Vaccines are now saving at least 1.5 million children annually (fig. 3). And the incidence of polio, the virus which has for so long crippled one child in every 200 born into the developing world, has been reduced by 25% in the last decade and could be eradicated completely in the next (panel 11).

As a result, there is now every hope that a majority of the world's nations will come close to the United Nations target of universal child immunization by 1990 (panel 1). Today, over 80 nations, including almost all of the poorest African states, are accelerating their vaccination programmes towards that goal. China, with almost 20% of the world's children, was expected to achieve 85% coverage in all provinces by the end of 1988 (panel 2). Bangladesh, Brazil, India, Indonesia, Mexico, Nigeria and Pakistan – which together contain 40% of the world's unimmunized children – are committed to universal coverage and are accelerating progress towards it.

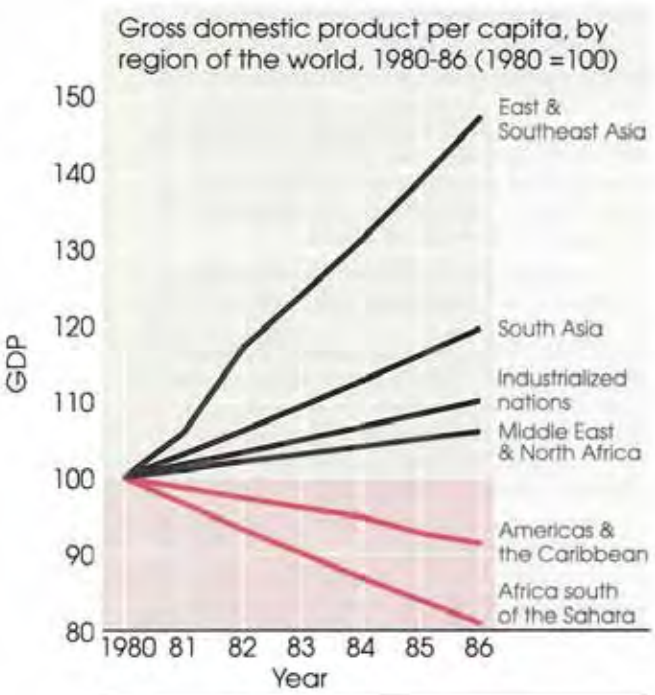
The need, in the 1990s, is to consolidate these achievements and to avoid the 'fallacy of the average' by making sure that high rates of coverage are sustained not only in every country but in every *community*. But if progress can be maintained, then the 1980 figure of almost five million child deaths a year from vaccine-preventable diseases could be reduced to perhaps a quarter of a million or less by the year 2000.

Similarly, dramatic progress has been made against the problem which remains the single most important cause of death among the world's children. In 1980, *dehydration* caused by diarrhoea was claiming almost 10,000 young lives every single day. Today, more than 25% of the developing world's families are using the low-cost technique known as oral rehydration therapy, or ORT, which enables parents themselves to prevent and treat dehydration (fig. 4). The result is the saving of an estimated 750,000 to 1 million children's lives each year (panel 3).

There is a long way still to go before dehydration is defeated, and there are many vital preventive strategies against diarrhoeal disease which urgently need to be deployed. But if the progress of the 1980s is not stalled by the effects of economic recession, then ten years from now the world might look back, as on a barbaric past, at the idea of several million dehydration deaths a year among the world's young children. In the industrialized world, where dehydration deaths are rare, it is difficult to imagine the significance of such a public health victory. Since 1945, dehydration has quietly claimed over one hundred and fifty million lives – many more than the combined civilian and military deaths of both world wars. And almost all of its victims have been children.

Fig. 1 Economic trends

The chart shows what has happened to economic development in the major regions of the world during the 1980's



Source: 'Children in a global context', Report of the Executive Director, United Nations Children's Fund, 18 Feb. 1988.

Immunization: a public health revolution

During the mid-1970s, nearly 5 million young children were dying every year of measles, tetanus, whooping cough, diptheria, tuberculosis, and polio. Millions more were permanently disabled by these six diseases, all of which can be prevented by immunization.

When the World Health Organization launched the Expanded Programme on Immunization (EPI) in 1974, fewer than 5% of children in the developing world were immunized. Three years later, the World Health Assembly resolved to make immunization against the six main vaccine-preventable diseases available to every child in the world by the end of 1990.

At the time, the goal of Universal Childhood Immunization* seemed utopian. Yet in this decade, around 80 countries have sharply accelerated their immunization programmes. And today, a majority of developing nations have a realistic chance of achieving the goal. China, with one sixth of the world's children, is expected to achieve the target two years ahead of schedule (panel 2). Countries such as Botswana, Cuba, Egypt, the Gambia, Iraq, Jordan, Oman, Rwanda, Tanzania and Saudi Arabia have reached or almost reached the target already. Others – such as Algeria, Brazil, Kenya, Mexico, Morocco, Pakistan and Turkey – are poised to reach 80%–90% coverage within the next two years.

In sum, there is now every prospect that 70%–80% of babies born during 1990 in the developing world will be immunized by the age of 12 months.

Already, almost 50% of babies born each year are vaccinated against measles, and over 55% are immunized against the other five EPI diseases. Immunization of women against tetanus (which confers immunity on the newborn baby) still lags behind at just under 25%. In total, immunization prevented, in 1987, the deaths of approximately 1.5 million infants and children from the six EPI diseases.

"In a little over a decade a public health revolution has quietly taken place", says Dr. Ralph Henderson, Director of WHO's Expanded Programme on Immunization.

In part, this remarkable progress is a result of improvements in vaccines and in the equipment used to transport and store them. But social breakthroughs have been just as important. A major boost has come from the strategy of social mobilization – the involvement of all available government institutions, teachers, religious leaders, community organizations, and the mass media to inform and support parents in using immunization services.

In addition, over 100,000 health workers have been trained to manage immunization programmes more effectively. No longer is an acute illness, for example, regarded as a valid reason for witholding vaccination. Drop-out rates have also been cut in many countries by vaccinating children brought to health clinics for the treatment of illnesses such as diarrhoea and respiratory infections.

The challenge for the 1990s is to complete the building of a permanent vaccination system which will immunize almost every child in every country before his or her first birthday (and every woman of childbearing age). Strengthened disease surveillance systems should then begin to record the elimination of diseases such as polio (see panel 11) and neonatal tetanus, and at least a 95% reduction in today's 1.8 million measles deaths each year.

As the world stands on the brink of a new era in immunization technology – with the promise of vaccines against malaria, diarrhoeal diseases, and perhaps aginst AIDS – the infrastructure of immunization now being built to deliver the present EPI vaccines may come to be seen as one of the greatest human investments ever made.

* In principle, 'universal immunization' is the level of coverage required to stop transmission of EPI diseases. In practice, different countries have set different targets for 1990. Where countries have not yet set their own targets, UNICEF uses 80% coverage for each vaccine as a minimum target.

Equally significant for the cause of maternal and child health is the rapid spread, during the 1980s, of knowledge about birth spacing. It is not yet widely enough known that births which are 'too many or too close', or to women who are 'too old or too young', are responsible for up to one quarter of all maternal and infant deaths worldwide. The promotion of birth spacing to the point where a majority of couples in the developing world now have the knowledge to decide the number and timing of their births is therefore a major *health* breakthrough. And if the momentum can be maintained in the face of today's worsening economic climate, then the spacing of births has the potential to save the lives of some 3 million children and 200,000 young women – *every year* (panel 9).

There have been many other expressions of rising concern for children in the past decade. But on a global scale these three specific interventions – immunization, ORT, and birth spacing – are perhaps the most powerful of all levers for raising the level of child well-being. And today, despite the faltering of economic development, they are beginning to fulfil the promise of the child survival and development revolution for which UNICEF and many others have campaigned and worked throughout the 1980s (fig. 5).

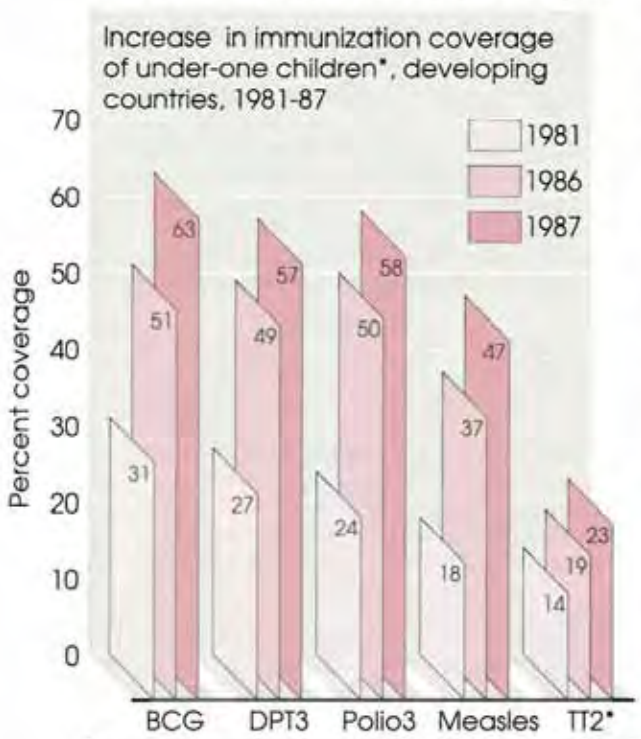
These achievements, in which many governments, United Nations agencies, voluntary organizations, dedicated individuals, and poor communities themselves have shared, deserve to be recognized. But it is important also to acknowledge that it is battles which have been won, not wars. Some fourteen million children are still dying each year from common illnesses and undernutrition, most of which could be prevented by relatively simple, relatively low-cost methods. Despite present economic difficulties, it is therefore essential to continue building the infrastructure of primary health care, to move towards *universal* immunization of infants, to inform and support *all* parents in the use of today's knowledge about oral rehydration therapy, and to make knowledge about the timing of births available to *all* families so that they can take more control over their own lives and their own health.

As the Director-General of the World Health Organization, Dr Hiroshi Nakajima, has said this year:

"*We must recognize that most of the world's major health problems and premature deaths are preventable through changes in human behaviour and at low cost. We have the know-how and technology but they have to be transformed into effective action at the community level. Parents and families, properly supported, could save two thirds of the 14 million children who die every year – if only they were properly informed. Immunization alone could save 3 million lives – and another 3 million deaths a year could be prevented by oral rehydration, a simple and cheap technology.*"

Fig. 2 Immunization increases

For each of the major vaccines, immunization coverage has increased dramatically in the 1980s.



China not included in 1981 data.

*TT2 is given to pregnant women and protects new-borns.

Source: UNICEF, September 1988.

China: a goal achieved

China is expected to achieve the goal of universal childhood immunization two years ahead of schedule. With almost 20 million babies born each year, the world's largest nation has one sixth of the world's children. China's success is therefore a major boost to achieving the United Nations goal of universal child immunization throughout the world by the year 1990.

Children have been vaccinated in China since the 1950s, but the Expanded Programme on Immunization (EPI) began only in 1979. At that time, the six main vaccine-preventable diseases still took a relatively heavy toll. In 1978, for example, there were 10,000 cases of polio, 20,000 cases of diphtheria, 600,000 cases of whooping cough, and 1 million cases of measles.

Without the benefit of a national cold-chain to store and transport vaccines, China turned to typically self-reliant ways of organizing immunization services. Vaccines produced at seven regional institutes were distributed once or twice a year to the provincial health authorities, who then rushed them to township distribution points for collection by 'barefoot doctors', who in turn relayed them by bicycle to their villages. Within three years, this 'rush and relay' system had resulted in a dramatic decline in vaccine-preventable diseases: the number of measles cases, for example, fell by more than half.

In 1982, China began to install a national cold-chain system, which has gradually been expanded to cover over 80% of the population. Then, in September 1985, President Li Xiannian gave his personal backing to a final push which has now succeeded, according to interim statistics, in immunizing 85% of children in every province of China. Final results will be announced after a nationwide assessment by the Government of China in co-operation with WHO and UNICEF, scheduled for March 1989. China's target now is to ensure that the 85% mark is reached not just in all provinces but in every individual county before the end of 1990.

An inter-ministerial 'Leading Group' has helped to mobilize a sustained effort by a broad alliance of government institutions, social organizations and communications channels, including national, provincial, and local leaders, women's organizations and schools; and the mass media of radio, television, and newspapers. April 25 is celebrated each year as Immunization Day, in many communities the programme of special events extends over a full week.

In the more remote and sparsely populated parts of the country, inhabited mainly by ethnic minorities, the support of religious, cultural, and community leaders has been enlisted to inform parents about the importance of a full course of vaccinations. It is in these regions that the most intensive efforts are now being made to drive immunization coverage beyond the 85% mark.

China's immunization triumphs are already being reflected in a dramatic decline in infant and child deaths from vaccine-preventable diseases. In 1987, China had only 439 registered deaths due to measles, diphtheria, whooping cough, and polio – a mere 8% of the level in 1982. And the total number of cases of these four diseases was only 166,000, compared with over 1.6 million in 1978.

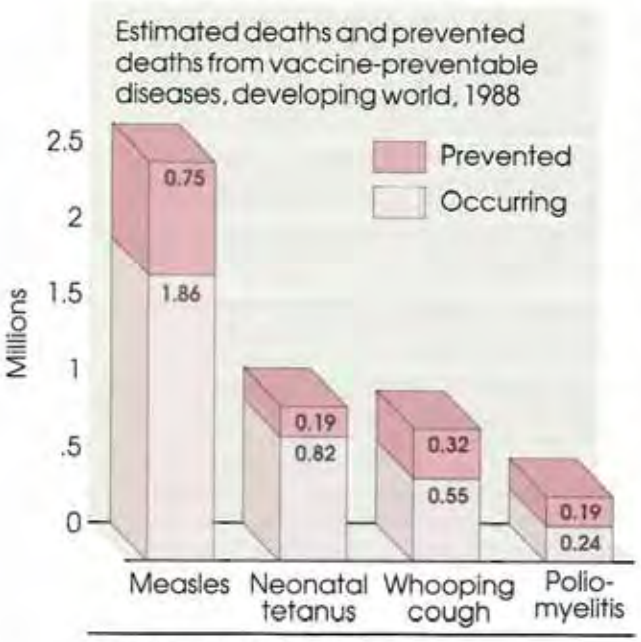
A foundation for the long-term sustainability of immunization is now being laid through the introduction, in many cases, of a simple insurance system, known as the 'EPI contract'. For a small fee at birth, parents are guaranteed immunization services for their children up to seven years of age. If a fully vaccinated child contracts a vaccine-preventable disease, parents receive a cash compensation. The funds generated by the 'EPI contract' are used to pay 'village doctors' (formerly known as 'barefoot doctors'), to maintain the cold-chain facilities, and to pay compensation when necessary. By early 1988 the scheme was in operation in one third of the country. China's immunization insurance scheme may also point the way towards sustainable immunization services in other developing countries during the 1990s.

A grand alliance

In March of 1988, the Task Force for Child Survival met in Talloires, France, to review the major child health achievements of the 1980s and the major child health problems of the 1990s (panel 12). The sponsors of the Task Force are the heads of UNICEF, the World Health Organization, the United Nations Development Programme, the World Bank, and the Rockefeller Foundation. Together with Ministers of Health from many developing countries (representing a majority of the world's children) and the leaders of most of the major aid agencies, the Task Force surveyed recent action against the main threats to the life and health of the world's children and concluded that, despite the shadow of AIDS, *"remarkable health progress has been achieved during the past decade.... Global recognition that healthy children and healthy families are essential for human and national development is steadily increasing"*.

Fig. 3 Lives saved by immunization

The chart below shows the estimated number of deaths each year and the estimated number of deaths being prevented each year from the three main vaccine-preventable diseases of childhood. The fourth column shows the number of cases of polio which are being prevented by immunization and the number of cases which are still occurring for the lack of it. All estimates exclude China.



Source: World Health Organization, 1988.

Panel 5 documents this increasing concern at the highest political levels and shows that, over the last five years, the majority of heads of State in the developing world have publicly committed their governments to achieving such goals as universal child immunization and a halving of the 1980 child death rate by the year 2000.

In some cases, these commitments are already being translated into action. Immunization coverage, for example, has been more than doubled in the last five years in such nations as Algeria, Bolivia, Burkina Faso, China, Colombia, Peru, Senegal, Syria, Togo, and Yemen and large parts of India and Pakistan. In addition, Egypt and Jordan have doubled their measles vaccination levels, and Brazil and Indonesia have more than doubled their immunization coverage against polio.

In other cases, the commitment of political leaders has so far been confined to the rhetorical. But many of the great social changes of modern history – the abolition of slavery, the ending of colonial rule, the isolation of apartheid, the increasing concern for the environment, or the growing recognition of the rights of women – have begun with the air of rhetorical commitment which has eventually swelled the sails of action.

In the 1990s, it may, at last, be the turn of the child.

For in many countries, there now appears to be a widening concern for children, a growing alliance among political leaders, the press, the professional bodies, and the private voluntary organizations in both developing and industrialized nations. Immunization, ORT, and birth spacing, for example, have advanced dramatically in the last few years partly because they have been actively promoted by hundreds of thousands of schoolteachers; by unprecedented media coverage; by trade union and co-operative leaders; by the national and local leaders of almost all major

ORT: a progress report

When the World Health Organization initiated the Diarrhoeal Diseases Control Programme in 1980, approximately 4 million children were dying each year of the dehydration caused by diarrhoea. At that time, fewer than 1% of children with diarrhoea were being treated with oral rehydration therapy (ORT), the relatively simple and low-cost method which can prevent almost all dehydration deaths. Global production of Oral Rehydration Salts (ORS) was only about 40 million litres – less than 10% of the estimated needs.

Today, the picture has changed drastically:

○ 112 developing countries now have programmes to promote the use of ORT.

○ Global production of WHO/UNICEF formula ORS has reached 300 million litres a year – two thirds of it produced in 55 developing countries.

○ Almost 60% of the developing world's under-five children now have access to a source of ORS.

○ Almost one quarter of children with diarrhoea are being treated with ORS or other appropriate fluids such as rice water, soups, gruels, fruit juices or a solution of eight level teaspoons of sugar and one of salt dissolved in one litre of water.

○ The number of deaths caused by diarrhoeal dehydration is steadily falling. According to the World Health Organization, ORT may now be preventing 750,000 to 1 million dehydration deaths a year.

These are impressive achievements. But without a major acceleration in the use of ORT within the home, the WHO goal of 50% ORT use by 1989 – preventing approximately 1.6 million child deaths from diarrhoea each year – will not be achieved.

The key is educating parents, especially mothers. First of all, parents need to know that a child with diarrhoea should be given plenty of the right fluids to replace the liquid the child is losing. They also need to know that a child with diarrhoea needs food to make a good recovery, and that a breast-fed child should continue to be given breast-milk. And they need to know that if the diarrhoea seems more serious than usual, the child needs help from a trained health worker.

In recent years radio and television have brought these basic health messages into hundreds of millions of homes. But experience has shown that the mass media, on their own, are usually not sufficient to bring about lasting changes in health behaviour. Direct, interpersonal communication is usually needed to persuade people to change long-standing attitudes and beliefs.

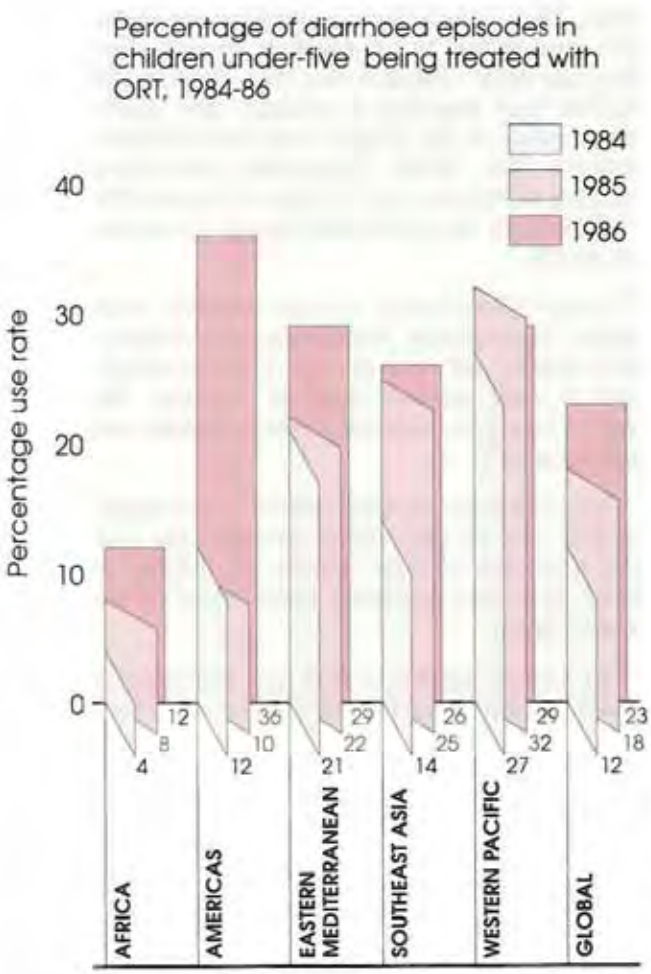
Advice about health carries special weight when it comes directly from the health services. Paradoxically, the great majority of doctors, nurses, midwives, pharmacists and other health workers have not yet received adequate training in modern methods of diarrhoea management, including the use of ORT. According to WHO, only 6% of health workers in developing countries have been trained to use ORT (including how to communicate effectively with mothers).

The health services alone cannot handle the task of educating all parents in how to deal with diarrhoea. The involvement of the mass media, schools, community leaders and non-governmental organizations is also needed to disseminate the information. But for messages about diarrhoea and ORT to be accurate, consistent and credible, the health services must take the lead in the communication effort. This means that all health personnel themselves must first be adequately trained in today's methods of diarrhoea management and control.

Fig. 4 The spread of ORT

Oral rehydration therapy (ORT) can be used to prevent or treat the dehydration, caused by diarrhoea,which is the single most common cause of death among children under five.

Almost unknown outside scientific circles at the begining of this decade, ORT is now being used by approximately one quarter of the developing world's families and is preventing 750,000 to 1 million child deaths every year.



For the purposes of this chart, ORT includes the use of both sachets of oral rehydration salts (known as ORS), recommended mainly for the *treatment* of dehydration, and also home-made solutions of salt and sugar or other fluids which are recommended for the *prevention* of dehydration.

Source : 'Programme for control of diarrhoeal diseases, sixth programme report 1986-1987', World Health Organization 15 Feb. 1988.

religions; by political parties and parliamentarians; by thousands of non-governmental groups; by major international organizations; by community organizations, women's groups, and youth movements; by employers, retailers, and public service industries; by writers, artists and entertainers; and by health services which have used not only their curative power but their *communications* power to help put today's health information at the disposal of families.

In the last five years, the *State of the World's Children* report has documented this growing involvement in some detail. In a process of infinite variation, the common thread is that the developing world is now beginning to exploit its communications revolution for social advance. In particular, it is beginning to use its growing organizational capacity to inform and support the majority of its citizens in using new knowledge. As Dr Nakajima has also said:

"*We should aim at large scale mobilization of societal forces for health development.... We must build working alliances with the mass communications sector, with educators in schools, with professional and community organizations, with business, with labour groups and unions. We must break away from our isolation and strive to win partners in our struggle for health promotion*".

This strategy of *social mobilization* – using the full range of a society's organized resources – has proved its worth in the achievements of the 80s and holds out the promise of even more significant progress in the 90s. In part, this is because there now exists an agreed body of vital health information – about birth spacing, safe motherhood, breast-feeding, weaning and child growth, immunization, diarrhoeal disease, respiratory infections, and home hygiene – which could enable families to bring about significant improvements in their own and their children's health. It is information which almost all medical authorities are agreed on, which almost all children can benefit from, and which almost all parents can act on. It is therefore information to which every family and community now has a right (panel 6).

But in part also, the present potential is based on a new capacity to put such information* at the disposal of the majority. In particular, the strategy of primary health care could support all families in knowing more, doing more, and demanding more, to improve their own and their children's health. With that support, today's health knowledge has the potential to bring about, by the end of the century, a halving of the 1980 level of child deaths and a saving of over 11 million young lives each year (fig. 5).

For all that has been achieved, therefore, the greatest potential for advance in the human condition over the next decade almost certainly lies in the further gains which could still be made in maternal and child health through the promotion of the knowledge and techniques which have proved their worth in the last decade.

Investing in children

But increasingly, social development efforts of this kind are coming under threat from the slowing down or reversal of economic progress in so many of the nations of Africa and Latin America. Too often, spending on health or education is regarded as a form of *consumption* which can only be afforded in times of plenty. It is therefore essential to stress that such efforts represent not only humanitarian improvements but also fundamental contributions to long-term economic development. Protecting the health and the education of today's children is the most basic of all *investments* in the physical and mental capacity of the next generation and therefore in the social and economic development of societies. As the Nobel Prize winning economist Theodore Schultz has written:

"*The wealth of nations has come to be predominantly the acquired abilities of people – their education, experience, skills and health... The future productivity of the economy is not foreordained by space, energy, and cropland. It will be determined by the abilities of human beings. It has been so in the past and there are no compelling reasons why it will not be so in the years to come*".

There is also a second way in which protecting child health contributes to long-term development. The record of almost every country shows that parents tend to have smaller families when they are more confident that their children will survive (and especially if reduced child deaths are a result of the parents' own well-informed actions). The World Population Conference, meeting in Mexico City in 1984, recognized this vital factor in the population issue in its closing statement:

"*Through breast-feeding, adequate nutrition, clean water, immunization programmes, oral rehydration therapy, and birth spacing, a virtual revolution in child survival could be achieved. The impact would be dramatic in humanitarian and fertility terms*".

That revolution in child survival is now beginning to play its part, acting synergistically with the expansion of birth spacing, in helping to lower birth rates in almost every region of the world (fig. 6).

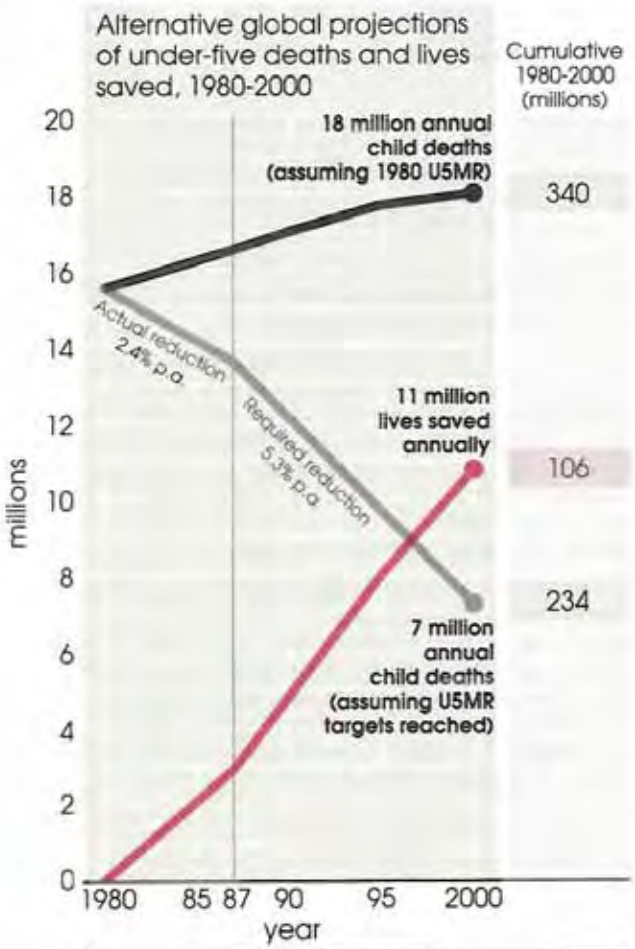
As a result, the World Bank now forecasts that world population growth will stabilize a full half-century earlier than demographers had previously thought possible and at a total of about 11 billion people – far short of the 15 or 20 billion which was widely predicted in the 1960s and early 1970s. And by the early 1990s, the world should reach the historic turning point at which the absolute annual increase in the global population begins to decline.

For these reasons, the advances of the 1980s against some of the worst *symptoms* of poverty – the ill-health, poor growth, and early deaths of so many millions of the world's children – are also advances against some of poverty's most deeply rooted *causes*.

* This information has now been brought together in *Facts for Life*, published jointly by UNICEF, WHO, and UNESCO in partnership with many of the world's best-known children's organizations and medical institutions. *Facts for Life* is an invitation to communicators of all kinds to become involved in the long-term challenge of putting today's child health information at the disposal of all parents (panel 6). For more details, please contact the Facts for Life Unit, UNICEF DIPA H-9F, UNICEF House, 3 UN Plaza, New York, NY 10017, USA.

Fig. 5 Saving children's lives 1980-2000

The top two lines on the chart show two possible trends in the annual number of child deaths from 1980 to 2000. The lower line translates the difference between these two trends into the actual number of children's lives which could be saved.



Assuming the 1980 under-five mortality rate (U5MR) remains the same

U5MR as estimated by the UN Population Division up to 1987. Thereafter the assumption is that all countries make sufficient progress to reach the U5MR target by the year 2000 (i.e. a U5MR of 70 or half the 1980 U5MR, whichever is the lower.)

Number of children's lives saved each year if U5MR reduction targets are met.

Source: UNICEF, based on United Nations Population Division estimates.

A Convention for children

This rise in concern for the well-being of children is also reflected in one other major achievement of the 1980s.

In September of 1989, the General Assembly of the United Nations should be in a position to approve the text of an *International Convention on the Rights of the Child* (panel 4). First proposed by the Government of Poland during the *International Year of the Child*, the 35 provisions of the draft Convention seek to define and defend children's political and cultural rights and to protect them from economic, sexual, and military abuse.* Significantly, the document also recognizes that ill-health and poor nutrition are violations of the child's most basic right to survive and to develop normally in mind and body.

The protection offered by the Convention may, at the moment, seem paper thin: it is sadly often the case that such international conventions are often more honoured in defiance than in deference. But the *Convention on the Rights of the Child* is a major achievement in that it has set up an agreed international standard by which nations will in future be judged. It therefore provides a 'place to stand' for all those who would exert leverage on behalf of children. And its promotion by the non-governmental organizations, by the press, and by the public in both industrialized and developing worlds, could eventually build the Convention into a moral and legal wall the breach of which will increasingly come to be regarded as a matter of international shame.

A new ethos

Despite the worst of economic times in many nations of the world, social achievements of historic importance have been recorded in the decade since the *International Year of the Child*.

* Some nations have already moved in this direction. In Brazil, children's rights have been specifically incorporated into the country's new constitution (1988). In Costa Rica, the Government has appointed a 'Defender of Children' to be responsible for research and action aimed at protecting the nation's children from mistreatment and injustice.

A Convention: on the rights of the child

Children have no political power. They do not vote, and their opinions carry little weight with governments. They are therefore totally dependent on their parents or guardians to act in their best interests and to protect their rights.

For many children in the world today, that protection is manifestly not enough. Millions of boys and girls are physically or sexually abused, or economically exploited, by the families that are supposed to provide them with security and love. In an even larger number of cases, children are denied their rights by forces beyond the family's control – by war and natural disaster, by unemployment, poverty, and their parents' lack of education. In our times, governments are still recruiting children to fight wars, employers are still exploiting the children of the desperately poor in fields and factories, and national and international economic forces are still allowed to inflict permanent mental and physical damage on young children who, no matter what the external circumstances, have a special right to protection for their growing minds and bodies.

To support families, or to compensate for their failings, there is a need for a broader social and legislative consensus on what is and what is not acceptable in the treatment of the young. And it was to help in the creation of such a consensus that the idea of an International Convention on the Rights of the Child was first proposed by the government of Poland, during the International Year of the Child (1979).

Since then, the delegates of some forty governments have been meeting regularly to try to draft such a Convention in the form of a legal agreement which will be binding on all states by which it is ratified.

Negotiating a detailed agreement across many different political and cultural systems has not always been easy, but from it all a consensus has emerged in the form of a draft text which, it is hoped, will be adopted by the General Assembly of the United Nations in the fall of 1989 – the tenth anniversary of the International Year of the Child.

The children's rights set out in the draft Convention can be broadly grouped under the headings of Survival, Protection, and Development.

Survival is a right now denied to more than 13 million under-fives who die each year, mostly from readily preventable causes. Protection includes the child's right to a name and a nationality, to be shielded from abuse – physical, mental or sexual – and from involvement in warfare. Development implies the child's right to adequate nutrition, primary health care, and basic education.

In practice, a statement of the child's rights is a statement of adult responsibilities. It is the responsibility of all adults, of governments and of the international community, to create and maintain the circumstances in which families themselves can protect the rights of the child. If families fail their children, or if circumstances such as war or disaster or absolute poverty prevent families from protecting their children's rights, then governments and the international community again have the responsibility of quickly rebuilding the essential walls of physical and mental protection around the vulnerable years of childhood.

The new Convention on the Rights of the Child provides an internationally accepted moral and legal framework for such adult action. By its very nature, it cannot be enforced in the same way as domestic laws are enforced by domestic courts. Its effectiveness therefore depends on the mobilizing of public opinion in both industrialized and developing worlds to create a new awareness of children's rights and a new sensitivity – on behalf of press and public and politicians – to violations of those rights.

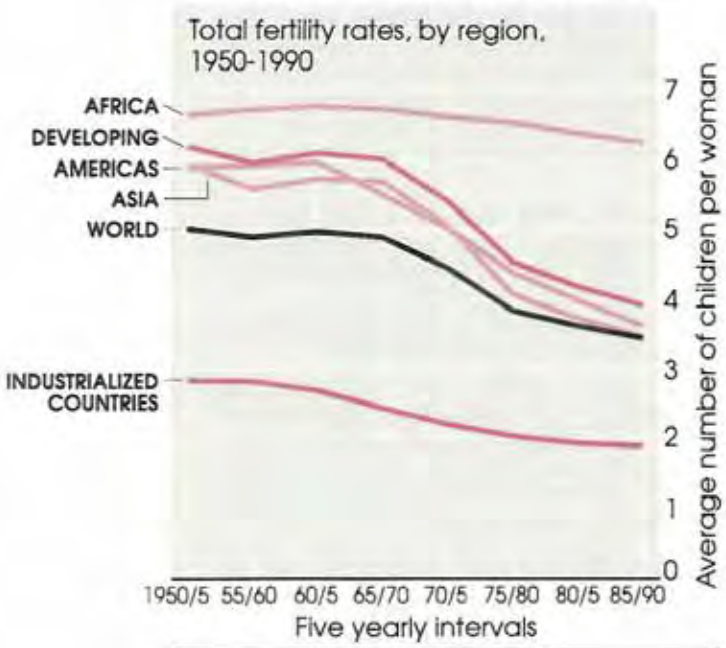
So important are these gains, so difficult their economic context, and so widespread the participation in them, that it may not be too much to hope that they represent the beginning of a new ethos for children, a new world-wide awareness and concern, a powerful 'sea-change' in what world opinion considers to be morally acceptable and what it does not.

Several times in the 1980s, a world-wide public has shown that it is not prepared to accept the sight of large numbers of children suffering and dying on its television screens in the 'loud emergencies' of drought or famine. That reaction itself reveals a fundamental change in ethos from the time when mass deaths from famine or natural disaster were accepted as inevitable because the world as a whole had neither the awareness of such tragedies nor the capacity to prevent them. Now, the time is right to seek an equivalent change, to demand that this same intolerance, this same insistence that *something be done*, should also arise in response to the less visible but far greater problem of the many millions of children who are now being killed or maimed in mind or body by the 'silent emergency' of readily preventable illness and undernutrition. That time has come because advances in communications have made most of mankind aware of this tragedy and because advances in knowledge have rendered it preventable. It is simply no longer necessary for approximately 40,000 young children to die *every day* in the developing world and for so many millions more to live on with ill-health and poor growth. Today, the world is both aware that this tragedy is happening and capable of preventing it. Ethics must march with awareness, morality with capacity.

If such a new ethos could now come of age, if the worst aspects of poverty and underdevelopment could come to be seen as being just as unacceptable as the more visible deprivations of drought or sudden disaster, then the 1980s will have seen a change which is even more important than any of its specific achievements. The question of how this might be brought about, of how a world-wide public opinion might come to raise its voice in support not just of emergency relief but of real development, will be one of the central questions examined in this year's report.

Fig. 6 Fertility falling

Fertility rates have fallen in almost all regions of the world over the last 20 years and are now beginning to turn downwards in Africa. The total fertility rate is the average number of children born per woman.



Source: United Nations Population Division.

The grand alliance: a commitment to children

Chapter one of this year's *State of the World's Children* report documents some of the main achievements for children in the 1980s. Part cause and part consequence of this new concern is the increasing number of personal and political commitments made by many of the world's political leaders in the last few years:

○ In Asia, the seven heads of state of the South Asian Association for Regional Co-operation (SAARC) have jointly stated that "the meeting of the needs of all children is the principal means of human resource development... Children should therefore be given highest priority in national development planning". The SAARC leadership has also committed itself to "achieving universal immunization by 1990 and universal access to primary education, adequate nutrition, and safe drinking water by the year 2000"

○ In Central America, the heads of state of the seven nations in the region have made an unprecedented joint television appeal for the immunization of all the region's children. The appeal is part of a joint plan aimed at halving the 1980 child death rate by 1990 – leading to the saving of approximately 50,000 young lives each year in Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama.

○ In Africa, where forty countries have sharply accelerated their immunization programmes since 1984, the personal leadership of heads of state has been the key in almost all cases. Seven sub-Saharan countries have already achieved 75% immunization coverage, and several more will reach that mark by the end of 1988. Under the aegis of the Organization for African Unity, over fifty heads of state proclaimed 1986 'African Immunization Year' and later expanded this concern to make 1988 the 'Year for the Protection, Survival, and Development of the African Child'. The OAU summit, with 31 heads of state in attendance, also endorsed the Bamako Initiative, launched by the region's health ministers in September 1987 and designed to help spread primary health care throughout sub-Saharan Africa by the mid-1990s (panel 10).

○ In the Middle East, the Council of Arab Ministers of Social Affairs have announced the target of halving the region's infant mortality rate by 1990 and proposed that reductions in infant death rates should rank alongside growth in GNP as an indicator of progress and development.

○ Many individual heads of state have also made personal and political commitments to child survival and development in the last five years. This year, to take just one example, unprecedented legislation has been introduced into the Peruvian parliament, supported by every political party in the country, which will require the reduction of infant mortality by at least 15 points before the end of the 1980s.

○ Even the 1988 Moscow Summit Meeting, convened principally to address issues of strategic arms limitation, acknowledged the new importance of the child survival and development issue. The joint communiqué issued by President Reagan and General Secretary Gorbachev stated that:

"Both leaders reaffirm their support for the WHO/UNICEF goal of reducing the scale of preventable childhood death through the most effective methods of saving children. They urged other countries and the international community to intensify efforts to achieve this goal".

Political leadership at the highest level can help to mobilize the 'Grand Alliance' necessary for the drastic reduction in child deaths and child malnutrition which today's knowledge makes possible. The major immunization successes of the 1980s, for example, have involved the participation of medical professionals and community health workers, teachers and religious leaders, mass media and government agencies, voluntary organizations and people's movements, the business community and labour unions, professional associations and conventional health services.

Children in debt

The advances already achieved during the 1980s in immunization, ORT, family spacing, and in the drafting of a *Convention on the Rights of the Child*, are among the great humanitarian achievements of our times.

But they are the jewels in a tarnished crown.

Without restoring the forward momentum of economic development, it will become increasingly difficult to sustain such progress, let alone to accelerate it by exploiting the clearly visible potential for further gains in maternal and child health. In many nations today, social advance is trying to walk up an economic escalator which has begun to travel downwards. "*Health care*," said Uganda's Minister for Health this year, "*can only be made sustainable by the lesser developed countries themselves. But if their per capita incomes continue to decline, then any progress will be eroded if not completely compromised.*"

This report therefore now turns to the impact of economic forces on the child of the 1980s and to the financial counter-currents against which progress for children will undoubtedly have to struggle in the decade ahead.

Rising debt, falling incomes

Two elements have dominated the deterioration of economic prospects over so much of the developing world in recent years. They are rising debt repayments and falling commodity prices.

The total debt of the developing world is now over US$1000 billion. In many countries, annual repayments of interest and capital amount to more than the total of all new aid and loans being received each year. On average, repayments now claim almost 25% of the developing world's export revenues.

Meanwhile, as outgoings have risen, income has declined. The developing world still depends on raw materials for the majority of its export earnings. But in the last ten years, real prices for the developing world's principal commodities – including fuels, minerals, jute, rubber, coffee, cocoa, tea, oils, fats, tobacco, and timber – have fallen by approximately 30%.*

The fall in new commercial lending and the inadequate and static levels of official aid complete the four walls of the financial prison in which so much of the developing world has been incarcerated during this decade.

Among the public in the industrialized world, it is still widely believed that money is flowing from rich nations to poor nations to assist in the struggle against poverty. Ten years ago, that was true. In 1979, a net $40 billion flowed from the northern hemisphere to the developing nations of the south. *Today that flow has been reversed.* Taking everything into account – loans, aid, repayments of interest and capital – the southern world is now transferring at least $20 billion a year to the northern hemisphere. And if we were also to take into account the effective transfer of resources implied in the reduced prices paid by the industrialized nations for the developing world's raw materials, then the annual flow from the poor to the rich might be as much as $60 billion each year.

For much of the developing world, the economic climate has therefore darkened quite dramatically in the last decade. As a result, most of the affected nations have been forced to adopt economic *adjustment policies* in an attempt to stave off balance-of-payments crises while at the same time meeting debt obligations, maintaining essential imports, and struggling to return to economic growth.

The need for adjustment is not really in question. The manner of adjustment, by contrast, is an issue which is both complex and controversial. With or without support from the International Monetary Fund (IMF), adjustment policies have usually taken the form of a dampening down of demand, a devaluation of the currency, a withdrawal of subsidies on fuel and staple foodstuffs, and deep cuts in government spending. In total, over 70 developing nations are now struggling to adjust their economies by such methods.

* Overall commodity prices recovered in the 1987–88 period after twelve years of decline which took prices to their lowest level for fifty years. That recovery now seems to be levelling out again, with real prices at approximately 30% below their 1979 levels.

And the effects, after decades of steady progress, have often been devastating to achievements of the past and to confidence in the future. All participants involved – governments, international financial organizations, private banks, and development agencies – have had to become involved in analysing the consequences, learning the lessons, and adjusting their policies to this new and unwelcome factor in the development equation.

Africa, afflicted by wars and drought and environmental deterioration as well as by debt and recession, has undoubtedly been hardest hit. "*Adjustment programmes*," said representatives of 30 African countries meeting in Khartoum early in 1988, "*are rending the fabric of African society.*" In the process, what safety nets existed for many of Africa's poor have been torn away. Of the estimated half a million child deaths in 1988 which can be related to the reversal or slowing down of development, approximately two thirds were in Africa.

The plight of Latin America, where average incomes are often 5 to 10 times higher than in Africa, may not at first seem as severe. But higher expectations, a more monetarized economy, and the grossest inequalities of any continent, have brought miseries which average incomes can conceal. In the words of a recent World Bank report:

"*Statistics fail to capture the psychological dimension of what is happening in Latin America. For several decades there has been forward movement in most countries. Even though poverty continued to be pervasive, more people were finding better jobs than ever before, and an increasing share of the population was having access to clean water, education, and medical care of some sort. At least as important, parents saw their children having a better start in life than they had had themselves. The depression has brought much of this progress to a halt. Indeed, the physical deterioration in basic infrastructure, including schools and hospitals, and the mounting excess of unemployed or underemployed persons will call for more than a weak pickup in economic growth if hopes are to be rekindled. And these pent-up needs continue to increase as investment remains depressed.*"

In the same vein, Inter-American Development Bank President Enrique Iglesias has commented (September 1988) that:

"*The per capita income of the average Latin American is 9 per cent lower today than it was in 1980. This is the average. In some countries the standard of living has slipped back to what it was 20 years ago. It does not take much imagination to realize that behind this statistic are plummeting real wage levels, soaring unemployment (some of it open, some hidden), increased levels of marginality and acute poverty – in short, an erosion of every measure of social well-being. Today, one third of Latin America's population – 130 million people – live in dire poverty*".

The effect on the poor

As the social effects of adjustment processes become more obvious, it can also be seen that the heaviest burden is falling on the shoulders of those who are least able to sustain it. It is the poor and the vulnerable who are suffering the most, and for two main reasons.

The first is that the poor have the least economic 'fat' with which to absorb the blow of recession. Often, three quarters of the income of the very poor is spent on food and much of what remains is needed for fuel and water, housing and clothes, bus fares and medical treatment. In such circumstances, a 25% cut in real incomes obviously means going without basic necessities.

The second reason is that the poor also have the least political 'muscle' to ward off that blow. Services which are of concern to the richer and more powerful sections of society – such as the major hospitals, universities, national airlines, prestige development projects, and the military – have not borne a proportionate share of the cuts in public spending (figs. 7 and 8). With some honourable exceptions, the services which have been most radically pruned are health services, free primary education, and food and fuel subsidies – the services on which the poor are most dependent and which they have least opportunity to replace by any other, private, means.

Over the last decade, for example, the proportion of government expenditure devoted to health has fallen in most countries of sub-Saharan Africa, in more than half the countries of Latin America and the Caribbean, and in one third of the nations of Asia. And the cuts have not been marginal. This report began by pointing out that in the 37 poorest nations of the world, spending per head on education has fallen by nearly 50% and on health care by nearly 25% in the last 10 years. A recent UNESCO report confirms that increasing evidence of the impact of such cuts is "*coming in from field missions of UNESCO and other organizations which are exposed first-hand to the rapidly accumulating problems of declining educational quality, stagnating enrolments, massive drop-out from primary education, inadequate teacher's pay, and similar indications of educational crisis in many countries struck by economic recession.*" The same UNESCO report also points out that government expenditure per primary school pupil is falling in 21 out of the 23 countries surveyed (fig. 9). Meanwhile, the proportion of national budgets devoted to the military is approximately 30% higher than total spending on health and education combined (fig. 8).

UNICEF's staff know from first-hand experience that in most countries the real cost of such cuts is being paid, disproportionately, by the poor and by their children. And since 1984, we have been concerned to draw world attention to the social consequences of adjustment policies and to warn that the worst was yet to come.* Today, there can no longer be any doubt about those consequences. As Michel Camdessus, the Managing Director of the IMF, has said, "*Too often in recent years it is the poorest segments of the*

* UNICEF's first special study on this topic, *The Impact of World Recession on Children*, was published in 1984. A more detailed follow-up study, *Adjustment with a Human Face*, edited by Giovanni Cornia, Richard Jolly, and Frances Stewart, has been published in English in two volumes by Oxford University Press, and includes ten country case studies – Botswana, Brazil (São Paulo), Chile, Ghana, Jamaica, Peru, the Philippines, the Republic of Korea, Sri Lanka, and Zimbabwe. Volume I is also available in French as *L'ajustement à Visage Humain* (Economica, Paris), and both volumes are available in Spanish as *Ajuste con Rostro Humano* (Siglo XXI, Madrid). The main sections of the study have also been published in German and Finnish.

Fig. 7 Decline in social spending

Adjustment to the debt crisis has forced many governments into reduced public spending. But health and education, which help to meet basic human needs now and to invest in human capacity for the future, have been cut back disproportionately.

Central government expenditure on education, health and defence, as a percentage of total government expenditure, 1972 and 1986.

	EDUCATION		HEALTH		DEFENCE	
	1972	1986	1972	1986	1972	1986
Bangladesh	14.8	9.9	5.0	5.3	5.1	11.2
Burkina Faso	20.6	17.7	8.2	6.2	11.5	19.2
Kenya	21.9	19.7	7.9	6.4	6.0	8.7
Malawi	15.8	11.0	5.5	6.9	3.1	6.0
Pakistan	1.2	3.2	1.1	1.0	39.9	33.9
Sri Lanka	13.0	8.4	6.4	4.0	3.1	8.0
Tanzania	17.3	7.2	7.2	4.9	11.9	13.8
Uganda	15.3	15.0	5.3	2.4	23.1	26.3
Zaire	15.2	0.8	2.3	1.8	11.1	5.2
Low-income developing countries						
Bolivia	31.3	11.6	6.3	1.4	18.8	5.8
Botswana	10.1	17.7	6.1	5.0	0.0	6.4
Chile	14.3	12.5	8.2	6.0	6.1	10.7
El Salvador	21.4	17.5	10.9	7.5	6.6	28.7
Morocco	19.2	16.6	4.8	2.8	12.3	16.4
Tunisia	30.5	14.3	7.4	6.5	4.9	7.9
Turkey	18.1	11.9	3.2	2.2	15.5	13.5
Lower middle-income developing countries						
Korea Rep.	15.8	18.1	1.2	1.5	25.8	29.2
Mexico	16.4	11.5	5.1	1.4	4.2	2.5
Oman	3.7	10.1	5.9	5.0	39.3	41.2
Uruguay	9.5	7.1	1.6	4.8	5.6	10.2
Upper middle-income developing countries						

Source: 'World Development Report1988', World Bank, Washington DC.

population that have carried the heaviest burden of economic adjustment".

Adjustment with a human face

The impact of this adjustment process on the *children* of the poor is not yet adequately reflected in internationally comparable statistics. But evidence of increasing malnutrition is emerging from many countries for which recent and reliable figures are available, including Burma, Burundi, Gambia, Guinea-Bissau, Jamaica, Niger, Nigeria, Paraguay, and the Philippines. It is equally clear that malnutrition has been increasing among the very poorest groups in many countries where statistics are not available or where they reveal no nation-wide decline in nutritional standards. Similarly, as has already been reported, school enrolment rates are falling and drop-out rates are rising in approximately one third of the developing nations.

In short, the social progress of decades is being brought to a halt and, in some cases, thrown into reverse.

The essence of UNICEF's position, summed up in the title of its most recent publication on the subject – *Adjustment with a Human Face* – is that policies which lead to rising malnutrition, declining health services, and falling school enrolment rates are inhuman, unnecessary, and ultimately inefficient. Conversely, policies which seek to protect the poorest families and their children – for example by maintaining well-targeted food subsidies,* expanding primary health care services, and consolidating gains in primary schooling – represent both a short-term human imperative and a long-term economic investment.

In general, we would strongly endorse the two convictions expressed by IMF Managing Director Michel Camdessus on the issuing of a recent IMF review which looked at the impact on the poorest groups of Fund-supported adjustment programmes:

"*The first is that adjustment does not have to lower basic human standards. In this context, the efforts of fellow agencies of the UN family both to protect social programmes in the face of unavoidable budget cuts and to make some programmes more efficient – delivering better services at less cost – exemplify the types of things that are essential. My second conviction is that the more adjustment efforts give proper weight to social realities – especially the implications for the poorest – the more successful they are likely to be.*"

Fig. 8 Social and military spending

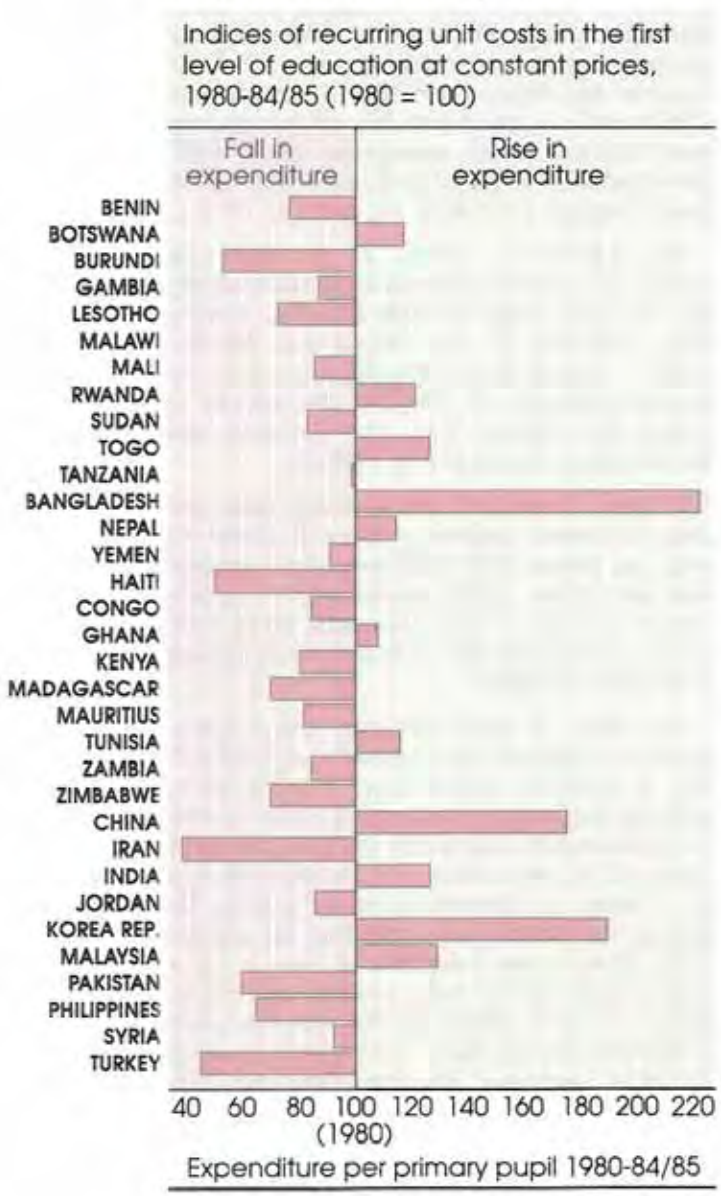
The chart shows that the developing world spends approximately 30% more on the military than on health and education combined. Recent cuts in government spending have also fallen more heavily on health and education.

Source: 'World Development Report 1988', World Bank, Washington DC.

* An early example of an 'economic adjustment programme' in which the most vulnerable were specifically protected is provided by the United Kingdom's efforts to maintain levels of child nutrition during the austere war-time years of the early 1940s. Specific attention to the need to maintain minimum standards for all meant that nutritional standards for Britain's children were actually higher in those difficult years than in the immediate pre-war period.

Fig. 9 Falls in primary school spending

The chart shows that in 21 out of 33 countries for which figures are available, expenditure per primary school pupil fell, often steeply, between 1980 and 1984/5. As costs per pupil were calculated at constant prices, these falls reveal real decreases in expenditure.



Source: 'The Educational Fallout of Adjustment' (forthcoming) by D. Berstecher, D & C Development and Co-operation, German Foundation for International Development, Bonn. All data from UNESCO Office of Statistics.

Several nations have already made important moves in this direction. Algeria, Indonesia, and Pakistan have expanded immunization and primary health care programmes by postponing the building of new hospitals. Ghana, with international support, has adopted a comprehensive strategy for protecting the vulnerable – and especially the nation's children – while struggling to adjust to recession. But in general, as the UN's Committee for Development Planning has reported in 1988:

"*There seems to be a clear bias within the political system towards a reduction of public expenditure on human development in times of distress ... many governments believed it was easier or more expedient to reduce expenditure on human development than on other items in the central government's budget.*"

In some cases, the problem may be a lack of commitment to the task of protecting the poorest and most vulnerable sections of society. In other cases, the commitment may be there but governments may be under such extreme economic or political pressure that they have very little room for manoeuvre. It is in such cases that the international community, and especially the international financial institutions and aid agencies, have an opportunity to use their resources to make it politically easier to maintain public spending on essential services for which the poor and otherwise powerless are the main constituency. On this subject, more will be said later in this report. But it should be pointed out at this stage that the task of protecting the poorest in the process of adjustment is not only humanly necessary but also practically possible and financially affordable. In introducing the IMF study already referred to, Michel Camdessus stated this case bluntly:

"*People know something about how to ensure that the very poor are spared by the adjustment effort. In financial terms, it might not cost very much. Why? Because if you look at the share of the poorest groups in the distribution of these countries' income, it is a trifling amount. Thus, to maintain their share of global income during an adjustment period, or even increase it, need not cost much, contrary to what people say. The World Bank has published social indicators of development for a long list of develop-*

ing countries which show the share of the poverty groups in national income. You will see that the poorest 40% of the population in many cases receives only 10% or less of total income. This 10% level can be maintained or even increased by 10% - making it 11% for the poor - only if everyone else makes a slight sacrifice. Unfortunately, it is generally 'everyone else', and not the poverty groups, that is represented in government".

Growth and debts

The adjustment strategies pursued in recent years, especially in relation to the middle-income developing countries, have achieved three important goals; they have prevented the collapse of the international banking and financial system; they have allowed the indebted developing countries to stay within the international economic system; and they have given the commercial banks five years to build reserves and prepare for the inevitable day when the ability of the borrowers to repay their loans was called into question.

But there is equally little doubt that adjustment strategies are failing in two major ways. First, as has already been discussed, they have placed a disproportionate burden on the poorest and most vulnerable - of whom children are the most vulnerable of all. Second, they have not succeeded in their principle aim of allowing indebted economies to escape from debt through a return to healthy economic growth.

It is this second failing - the failure to restore growth - which must now be urgently addressed. The strong arguments for 'adjustment with a human face' are not arguments for introducing more welfare programmes into stagnant economies. They are part of a wider argument for a different approach to the whole adjustment process, an approach which would not only seek to protect the poorest and most vulnerable but also contribute to a quickening of economic growth of a kind which smaller and poorer producers could both contribute to and benefit from.

For despite the hardships being visited upon the poor, present policies for coping with the debt crisis are manifestly not succeeding in restoring economic growth to most of the indebted nations. Per capita GDP in sub-Saharan Africa *declined* by 3.6% in 1980–85, by 0.5% in 1986, and by 5.1% in 1987. And the future looks equally bleak. Latest World Bank projections to the year 1995, for example, show zero per capita growth in sub-Saharan Africa (fig. 10) and only a weak rallying in most of Latin America. Similarly, the *World Economic Survey 1988* from the United Nations points out that per capita incomes in Latin America and Africa have fallen again this year (1988) and are expected to fall still further next year. In many nations, average incomes in 1995 are expected to be below the levels of 1980 and in some countries even below the levels of 1970.

For sub-Saharan Africa, in particular, the agonies of economic adjustment are self-evidently not the birth pangs of a new economic growth. With reference to the "*brutal and mindless 1980s*", Stephen Lewis, Special Adviser to the Secretary-General on the UN Programme of Action for African Economic Recovery and Development, has spoken in 1988 of:

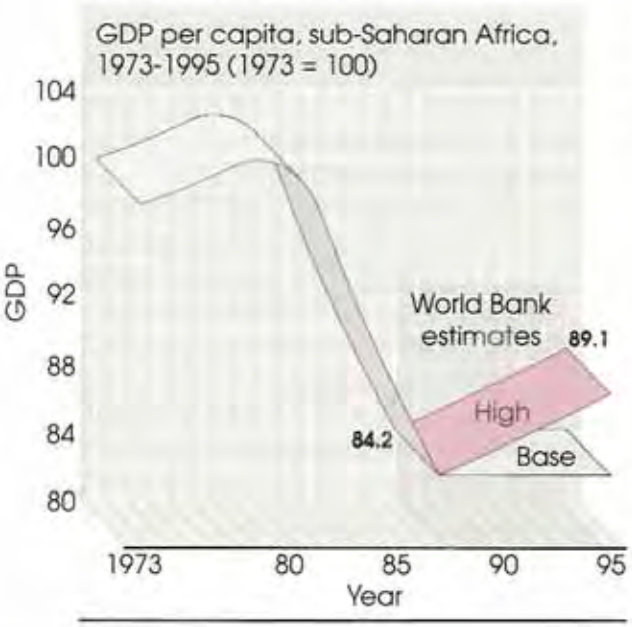
"*the litany of economic indices which haunt and shape the human condition of Africa. It matters not what you choose: GDP, GDP per capita, consumption per capita, export growth, import growth, change in terms of trade, commodity prices, debt-service ratios, foreign aid - it is, with few exceptions, a chronicle of despair*".

For most of Latin America, where unemployment, inflation, low investment, and deficiencies in economic policies have wreaked havoc with the livelihoods of not only the poor but also of a lower middle class which has been practically destroyed in some nations, there is also little sign of a return to vigorous economic growth. By cutting its imports and expanding its exports, Latin America has been able to squeeze out a surplus sufficient to make external debt repayments of $150 billion in the last five years (1983–88). But the direct consequence has been economic stagnation. As more than one Latin American spokesman has said, "*we have adjusted, but we have not grown*".

Sooner or later the fact will have to be faced that, in many countries, attempts to pay interest and capital on the full amount of present debts is fundamentally incompatible with return to eco-

Fig. 10 Africa's decline

The graph shows the decline of per capita GDP in sub-Saharan Africa during the 1970s and 1980s and the World Bank's estimates for economic growth in the region to the mid-1990s.



Source: World Bank.

nomic development. Debt repayments at present levels mean not only reduced consumption, and all the human hardship that implies, but also a reduction in investment and in future economic progress. According to Enrique Iglesias, President of the Inter-American Development Bank, speaking in September 1988:

"*The average investment rate in Latin America in the 1970s was 24.5 percent. Today it is barely 16.5 percent. I cannot stress enough how serious this is in terms of the eventual impact on the future productive capacity and erosion of human capital. In some, perhaps many cases, the real investment rate is not even enough to replace capital that is depleted. The resurgence of economic growth in our countries is impossible when investment rates are this low.*

"*Equally severe and just as important has been the erosion of investment in the region's people – its 'human capital' – as expenditures in health, education, and nutrition have been severely cut in this decade. Unfortunately this means that the costs of this economic crisis will continue to be paid by new generations of Latin Americans.*"

Inevitably, the situation in Africa is even worse. The outflow of more than a quarter of the subcontinent's earnings, for the purpose of servicing debts, means that a return to economic health is almost impossible for most of the nations of the region.

In short, the end of the present road is surely now in sight. All but one or two of the major debtor nations will again fail to keep up with their debt and interest payments in 1988 and, inexorably, the differences between the amounts due and the amounts actually paid will be added to existing debts. Between 1985 and 1986, for example, the total debt of the developing world increased by almost 10% (i.e. by approximately $70 billion) and the debts of sub-Saharan Africa increased by almost 20% (approximately $25 billion). Looking ahead to 1995, Africa's debt service obligation in that year is likely to reach $45 billion – an altogether impossible sum. Yet the unsuccessful attempt to service mounting debts is ensuring that countries cannot maintain essential social services, cannot adequately protect their rising generations, cannot invest in their future, cannot return to growth, cannot increase their imports, and cannot contribute to a healthier world economy.

By whatever means, the orderly reduction of the burden of debt is now, therefore, an essential pre-condition for breaking the log-jam of development and allowing large areas of the world to return to growth in the years ahead. Giving the fundamental issue concise expression, the Secretary-General of the United Nations has said (September 1988) that "*development in a majority of African and Latin American countries is contingent upon the resolution of the debt crisis*".

Debt relief

As this report is published, it is becoming increasingly clear that major new moves are in

Facts for Life: an alliance for children

Over 100 international organizations – from the Save the Children Alliance to the World Medical Association – are joining together as partners in the *Facts for Life* venture to be officially launched at the beginning of 1989.

The basic idea behind *Facts for Life* is simple. There exists today a body of information – old and new – which can help parents to save the lives and protect the normal growth of many millions of children in the developing world. It is information which almost all medical experts are agreed on. It is information which almost all parents can act on. It is information which almost all children can benefit from. It is therefore information to which all families now have a right.

Facts for Life, to be published jointly by UNICEF, the World Health Organization, and UNESCO, brings that information together in straightforward language. Designed as a 60-page booklet which can easily be photocopied or reproduced, it contains chapters on timing births, safe motherhood, breast-feeding, child growth, immunization, diarrhoea, coughs and colds, home hygiene, malaria, and AIDS.

Under the overall technical supervision of the World Health Organization, *Facts for Life* has been drawn up in partnership with many of the world's best-known organizations working for the health and development of children in all regions of the world. It is intended to be the simplest and most authoritative expression of today's scientific consensus on practical, low-cost, family-based ways of protecting the lives and health of children.

The most difficult part of the *Facts for Life* venture lies ahead. How can this essential health information be communicated? How can it become part of every family's basic stock of knowledge?

Experience in all countries has shown that only frequent varied repetition of new information, from all sides and over many years and from many trusted sources, can truly succeed in putting new health knowledge at the disposal of the majority. As the Director-General of the World Health Organization, Dr. Hiroshi Nakajima, has said: "An educated public is essential to the achievement of health goals. Effective education and communication are indispensable to create this educated public".

Facts for Life is therefore intended for all those who influence or control the principal channels of communication in all societies. It is presented as a long-term communications challenge to:

- heads of state and political leaders
- all branches of national and local government
- religious leaders
- educators and teachers of all kinds
- the mass media
- employers and business leaders
- trade union leaders
- community health workers and doctors
- nurses and midwives
- development workers and voluntary agencies
- youth movements and women's groups
- community organizations and traditional leaders
- artists, entertainers, and sporting personalities.

Because it demystifies health knowledge and puts it into the hands of families, and because it attempts to mobilize a wide range of social resources to promote that knowledge, it is hoped that *Facts for Life* will become a major practical contribution to primary health care in the years ahead.

Facts for Life will initially be available in Arabic, English, French, Portuguese, and Spanish. In many cases it will need to be not just translated but adapted to reflect different priorities and cultures. An accompanying booklet *All for Health* is intended as a guide and a stimulus for putting *Facts for Life* into practice. It describes the growing involvement of a wide range of communicators in health issues during the 1980s and discusses the opportunities, techniques, and difficulties for health education in the 1990s.

Any individual or organization wishing to know more about *Facts for Life* and *All for Health*, is invited to contact *Facts for Life* Unit, UNICEF, DIPA H9F, UNICEF House, 3 UN Plaza, New York, NY 10017, USA.

prospect for dealing with the developing world's debt. One significant step has already been taken by the Toronto summit at which the major industrialized nations agreed in principle on a degree of debt cancellation for some of the most affected nations in sub-Saharan Africa (on this initiative, the question now is *when* the new measures will take effect and *how* they will be translated into benefits for the poorest groups in the nations concerned).

But the basis of the consensus now beginning to take shape is that the burden of debt servicing must be lifted not only to the point where the developing countries can *cope* with debt repayment but to the point where their economies can *grow* out of their overwhelming indebtedness.

A second and more controversial element is that the commercial banks – which hold approximately 60% of the developing world's debt – must now brace themselves to bear a significant part of the losses involved in debt reduction. It is not necessary – nor would it be acceptable to the public in most industrialized nations – for large amounts of government money to be used to repay the banks or to subsidize their losses. Having had several years to prepare themselves, most European banks are now in a position to accept an immediate and significant reduction in the value of the developing world's commercial debt (the figure of a 30% reduction in the commercial bank debts of the 15 most indebted countries has been suggested by the UN Conference on Trade and Development). The North American banks, many of which have lower legally required ratios of assets to loans and some of which have recently sustained considerable losses in the domestic market, are perhaps not as firmly placed as their European counterparts to take such significant losses without flinching. But when lending policy turns out to have been unsound – often because of the comfortable assumption that 'countries can't go bankrupt' – then losses must be taken.

The third element in this incipient consensus is that the vital role of the industrialized world's governments in tackling this crisis should be to assist the essential process of promoting *growth* in the developing world by significantly increasing flows of official development assistance.

This combination of a degree of debt relief by commercial banks* and increased official aid from governments, along with measures to stabilize commodity prices and resist protectionism, is now essential to unlock the doors to growth. Without such action, today's adjustment policies will amount to little more than a rearranging of the furniture inside the debtors' prison.

Unsustainabilities

A move in this direction will require fundamental shifts in perception and policy which will not easily be achieved. But there is another element in the present crisis which could provide the impetus for the solution. That element is the threatened economic crisis in the industrialized world itself.

Today, the United States is the world's largest international debtor, owing a staggering total of approximately $500 billion – approximately equal to the total commercial debt of all the developing countries put together. It is this imbalance, and particularly the US balance-of-payments deficit, which leads this year's *World Development Report* from the World Bank to describe the state of the world economy as "*fragile*" and to conclude that "*the risk of a severe set-back for the global economy is very real*".

It is widely acknowledged that the huge United States trade deficit, presently running at approximately $150 billion a year, is unsustainable and that a restructuring of economic relationships between the major economies of the northern world, and particularly between the United States' deficits and the Japanese and West German surpluses, is also inevitable.

* Eighty-five per cent of Africa's debts are owed to governments. The debt-reduction intentions recently announced at the Toronto summit, and the cancellation by the Governments of France and Canada of significant amounts owed by the countries of sub-Saharan Africa, are welcome moves but still remain to be implemented.

There are therefore two major 'unsustainabilities' in international economic relationships. And it is clear that, from this point onwards, the world economy can go either up or down but cannot long remain on its present path. Vision and statesmanship are needed now as never before. And the vision that is required is the vision to see how the major pieces of the problem – and particularly these major 'unsustainabilities' of the global economy – might be rearranged into the shape of a potential solution.

Open discussion of United States' indebtedness and its consequences has been muted during 1988 by the exigencies of a presidential election campaign. But it is clear that the United States must itself find a way of at least halving its deficit, reducing its debts, and 'adjusting with growth' if it is not to accept the lowered standards of living which will eventually accompany the title of the world's most indebted nation.*

If the United States attempts to solve its debt and deficit problems by sharply reducing demand, devaluing the dollar, and yielding to pressure for further protectionism, then the result will be recession not only for the United States but for almost every other country as well. The Samson of the world economy will have strained at the pillars of its own problems and brought down the temple. And as in any disaster, the poorest and the most vulnerable, in both the United States and the developing world, will suffer the most. A more constructive way of restructuring the international economic edifice must be found.

The alternative approach is to attempt to redress the imbalance between the United States' deficit and Japan's surpluses (and to a lesser extent Western Europe's), by recycling those surpluses, reducing trade barriers, and adjusting through growth. This is broadly the preferred approach.

But if such an approach were widened in scope to include the developing world then it might now be possible to address both of the major 'unsustainabilities' of the world economy – resolving some of the major problems of the industrialized countries while at the same time beginning to meet the desperate needs of the southern hemisphere.

From the point of view of the industrialized world, the economic case for this global approach to the problem of restructuring economic relations is evident in the effect of the developing world's recession on the economy of the United States itself. In the first half of the 1980s, annual exports from the United States to the developing countries fell in value from $88 billion to $77 billion. Had those exports continued to rise at the same rate as in the 1970s, then their value would have doubled to approximately $150 billion by 1985. The recession in the developing world can therefore be estimated to have cost the United States tens of billions a year in lost exports, the equivalent of more than 1 million lost American jobs, and to have had a comparable impact on the economies of Europe and Japan.

Reinforcing this point, James Robinson, chief executive of the American Express Company, commented in August 1988 that:

"*... developing country debt and economic growth issues are so critical to both United States foreign policy and the domestic economy that it must be a priority item for the next President.*

"*Overcoming the debt hurdle will be crucial to improvement of the United States trade deficit. Burdened by the economic costs of trying to service their debt, the 17 most heavily indebted third world countries cut their imports of goods and services by $72 billion from 1981 to 1986. The United States*

* Throughout the 1980s, the United States has continued to serve as the main engine of the world economy, generating continued economic demand, but at the price of its own increasing indebtedness. Without the huge United States trade deficits, demand for imports from the developing world, and particularly from the middle-income countries of Latin America and Asia, would have been considerably less in recent years. At the same time, the United States has largely resisted domestic demands for sharply increased protectionism and kept its own markets relatively open to the import of goods from the developing world. Without these two factors, the economic plight of many developing and industrialized countries in the 1980s would have been very considerably worse. As against this, the need of the United States to attract funds to finance its budget deficits has meant that interest rates have had to be maintained at high levels, and this has added to the debt-servicing burden of many of the indebted developing nations, particularly in Latin America.

has been a major victim of this decline, because these countries have historically been major American export markets."

Similarly, the 1988 *Trade and Development Report*, from the United Nations Conference on Trade and Development, predicts that a reduction of 30% in the commercial debts of the fifteen most indebted developing nations would result in a 25% increase in their national incomes over the next five years and that this would in turn lead to an increase in their demand for imports of approximately $18 billion a year – one third of which would be spent on exports from the United States. Says the report:

"A permanent reduction of interest payments on the outstanding debt of highly indebted developing countries, combined with debt relief and new financial flows in assistance to sub-Saharan African countries, would contribute to raising significantly developing country demand for United States exports and thus to easing the trade imbalances among the industrialized countries."

A similar argument could also be applied to the economies of Europe and Japan. Japan, in particular, with its $80 billion trade surplus, depends heavily on the willingness of the world, and particularly of the United States, to accept a very considerable excess of Japanese exports over Japanese imports. Overall, the developing world accounts for almost 20% of the exports of the European Economic Community, over 30% of the exports of the United States of America, and over 30% of the exports of Japan. On economic grounds alone, the poor world cannot be left out of the equation.

It would therefore be in the interests of both industrialized and developing worlds if a significant part of the 25% of the third world's earnings which are now being spent on servicing debts were instead to be devoted to increased imports from the industrialized world and to increased investment in economic growth. This diversion of the massive financial outflows from the developing world – from the payment of debts to the purchase of imports – is a key step in the task of finding an upward escalator rather than a downward escalator by which to exit from the present unsustainabilities in the world economy.

Aid and debts

The case for commercial debt relief, a process in which the banks would bear a major share of the burden, is inseparable from the case for increased aid to promote growth in the developing world, a process in which the governments of the industrialized nations will have to take the major role. Debt relief without a return to growth is simply not a solution. In sum, the economic needs of the developing world can only be met, and its economic contribution can only be released, by a series of difficult changes in its relationship with the northern world. And in addition to debt-relief and increased aid, those changes would also have to include a check on protectionism and measures to stabilize the price of raw materials at remunerative levels.

In each of these areas, action has to be taken on a scale commensurate with the problem. In one way or another the developing world's debt will need to be effectively written down, case by case and in an orderly manner, by up to 50% over the next five years – including an outright cancellation, or the equivalent, of the remaining debts of many of the very poorest and most debt-burdened developing countries.

Second, something has to be done to provide a firmer and fairer platform of prices for the raw materials which provide more than half of the developing world's earnings. For in the 1980s, as rising interest payments have tightened the financial noose around the developing world's neck, falling commodity prices have opened the trapdoor under its feet.

Reduced demand for the developing world's raw materials is a result of weak economic growth in the industrialized nations and rapid advances in materials science and production processes. Both of those factors are outside the control of a developing world which is nonetheless frequently exhorted to produce and export more of its raw materials – so putting further downward pressure on world prices – in order to earn the foreign exchange to maintain imports and pay the interest on its debts. In 1986 alone, for example, falling raw materials prices wiped $19 billion from the revenues of sub-Saharan Africa – about four times the amount which the region was

South Asia: great expectations

Asia has not suffered in the same way as Latin America or Africa from the recession and debt crisis of the 1980s. Individual countries have been hard hit, but the continent as a whole has continued its steady economic advance (fig. 1). Nonetheless, South Asia still contains the majority of the world's 'absolute poor', and most of its children are being born into communities where illiteracy, preventable disease, poor growth, and early death are still common. More than one third of all the world's child deaths, for example, occur in just three South Asian countries – Bangladesh, India, and Pakistan.

But just as in the mid 1960s, when the subcontinent was poised on the edge of dramatic advances in food production, so South Asia today could be on the verge of a new generation of advances in child health. Decades of development efforts have given most countries the capacity to inform and support the majority in using new knowledge. And it is this achievement, together with today's low-cost techniques, which could bring about a child health equivalent of the green revolution in the 1990s.

The necessary catalyst, as always, is political will. And it is noticeable that children are becoming a prime concern for many of the region's political leaders. In November of 1986, seven Heads of State came together at a summit meeting of the South Asian Association for Regional Co-operation (SAARC) and announced that "the meeting of the needs of all children was the principal means of human resource development" and that "Children should therefore be given the highest priority in national development planning". The leaders of these seven nations – Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, and Sri Lanka – also committed themselves to the goals of universal child immunization by the end of 1990 and, by the year 2000, universal primary education, adequate maternal and child nutrition, and safe drinking water for all.

Vaccine preventable diseases still kill over 1.5 million children every year in the seven SAARC countries. Approximately 85,000 more are disabled every year by polio. But recent progress has been rapid. Latest official figures show that the percentage of one-year-olds receiving all three shots of DPT vaccine is approximately 80% in Sri Lanka, over 60% in Pakistan, and almost 60% in India. Lagging behind are Nepal (38%), Bhutan (16%) and Bangladesh (9%).

In all seven nations, diarrhoeal disease is one of the most important causes of child death and child malnutrition, claiming more than 1.5 million young lives a year. That figure may also be drastically reduced, over the next few years, by the spread of oral rehydration therapy (ORT) which enables parents themselves to prevent dehydration. The technique was already known to many of the region's mothers. But programmes to teach or reinforce ORT are now taking off in most of South Asia. Sri Lanka leads the way with 75% of parents using ORT, followed by Bangladesh (50%), Pakistan (33%), India (21%), Nepal (25%), the Maldives (12%) and Bhutan (11%).

If this potential for steep falls in child deaths is realised, then it will also help to lower the region's rate of population growth. As India's former Prime Minister Indira Gandhi said, "Parents are more likely to restrict their families if they have reasonable assurances of the health and survival of their children". If all seven SAARC nations had the same child death rates and birth rates as Sri Lanka, for example, then they would have a total of 3.7 million fewer child deaths each year – and almost 7 million fewer births.

promised in emergency aid during that desperate year. Action to help stabilize prices and volumes for raw material exports may therefore also be essential if the developing world is to earn its way and return to economic growth. And action of this kind can surely not be rejected on the grounds that it interferes with the laws of the market place when the industrialized world itself continues to spend between $125 billion and $150 billion a year on agricultural subsidies which deprive the developing world's exports of the right to compete for markets and are essentially commodity agreements to stabilize and guarantee the incomes of Europe's own farmers.

Third, protectionism needs to be kept in check so that the developing world can export more of its goods to the industrialized nations.

Lastly, public and private resource flows from the northern hemisphere to the south need to rise steeply. In particular, official aid for development needs to move towards the agreed target of 0.7% of the donor nations' GNPs (as opposed to the 1987 average of 0.34%) and a significant proportion, say one third, needs to be given specifically in support of policies in the developing world designed to benefit the lives, and improve the productivity, of the poorest sections of society. This theme of *real aid* for *real development* will be taken up in more detail in a moment.

But increases in the overall level of that aid are essential if the approach of adjustment through global growth is to succeed. In most cases, debt relief *alone* will not allow the poorest countries to move towards healthy economic growth and towards a permanent resolution of the development crisis.

A new Marshall Plan

Such a plan of action to break the log-jam of development and open the way to global growth will require vision and leadership of an usually high order. And perhaps its closest moral and practical precedent is the Marshall Plan by which the United States helped to restore economic growth to Europe in the years following World War II.

The spirit which inspired such solidarity is the essence of the new relationship which is now needed between the industrialized and the developing worlds. Substituting the developed world for the United States, and the developing world for Europe, the world stands in need again of the wisdom and far-sightedness which characterized Secretary of State George Marshall's words of 1947:

"*Aside from the demoralizing effect on the world at large and the possibilities of disturbances arising as a result of the desperation of the people concerned, the consequences to the economy of the United States should be apparent to all. It is logical that the United States should do whatever it is able to do to assist in the return of normal economic health in the world, without which there can be no political stability and no assured peace. Our policy is directed not against any country or doctrine but against hunger, poverty, desperation, and chaos. Its purpose should be the revival of a working economy in the world so as to permit the emergence of political and social conditions in which free institutions can exist. Such assistance, I am convinced, must not be on a piecemeal basis as various crises develop. Any assistance that this Government may render in the future should provide a cure rather than a mere palliative. Any government that is willing to assist in the task of recovery will find full co-operation, I am sure, on the part of the United States Government.*"

Soon after these words were delivered, the United States began transferring aid to Europe at an annual level amounting to 2% of its GNP. The resulting return to economic growth in Europe, soon paralleled in Japan following substantial US financial infusions, laid the foundations for more than two decades of unprecedented growth in the world economy as a whole.

Today, when America's wealth is approximately two and a half times greater, the percentage of GNP given in overseas aid is 0.22% of GNP – less than any other major industrialized country, and less than half the average of the other Western nations (fig. 11).

The United States could do more towards, and has most to gain from, a return to economic growth in the developing world. But any modern

equivalent of the Marshall Plan would also have to involve significant increases in development aid from other industrialized nations, and particularly from Japan and West Germany, which are expected to accumulate trade surpluses of, respectively, $80 billion and $40 billion in 1988–89.

Before the end of 1988, Japan is expected to become the world's largest aid donor in terms of US dollars and has announced its intention to increase aid significantly over the next four years. But these increases are in large part a reflection of changes in exchange rates: West Germany committed less money in deutschmarks in 1987 than in 1986; Japan committed less money in yen in 1986 than in 1984 (figures not yet available for 1987). It is therefore important to track aid as a percentage of donor nations' GNP and, as figure 11 shows, the record of the last 20 years is less than dynamic. The Federal Republic of Germany contributes less than 0.4% of its GNP, the United Kingdom less than 0.3%, Japan a little over 0.3%, and the United States 0.2%.

In total, only four of the industrialized nations – Norway, the Netherlands, Denmark and Sweden – have reached the 0.7% target. That target was agreed almost twenty years ago. Yet the average level of aid from the industrialized nations still stands at less than half that figure. At this time of crisis in the developing world, a crisis briefly characterized at the beginning of this report, it is essential for all industrialized countries to close on the 0.7% target and to reach it within the next five years.

Fulfilling such a target would mean an extra expenditure of some $50 billion a year. And this cannot be considered an impossible sum for an industrialized world in which military expenditures swallow that amount every four weeks.

Real aid for real development

As the 1980s come towards a close, great changes are in the air. And it is becoming clear that unprecedented opportunities are arising in world affairs.

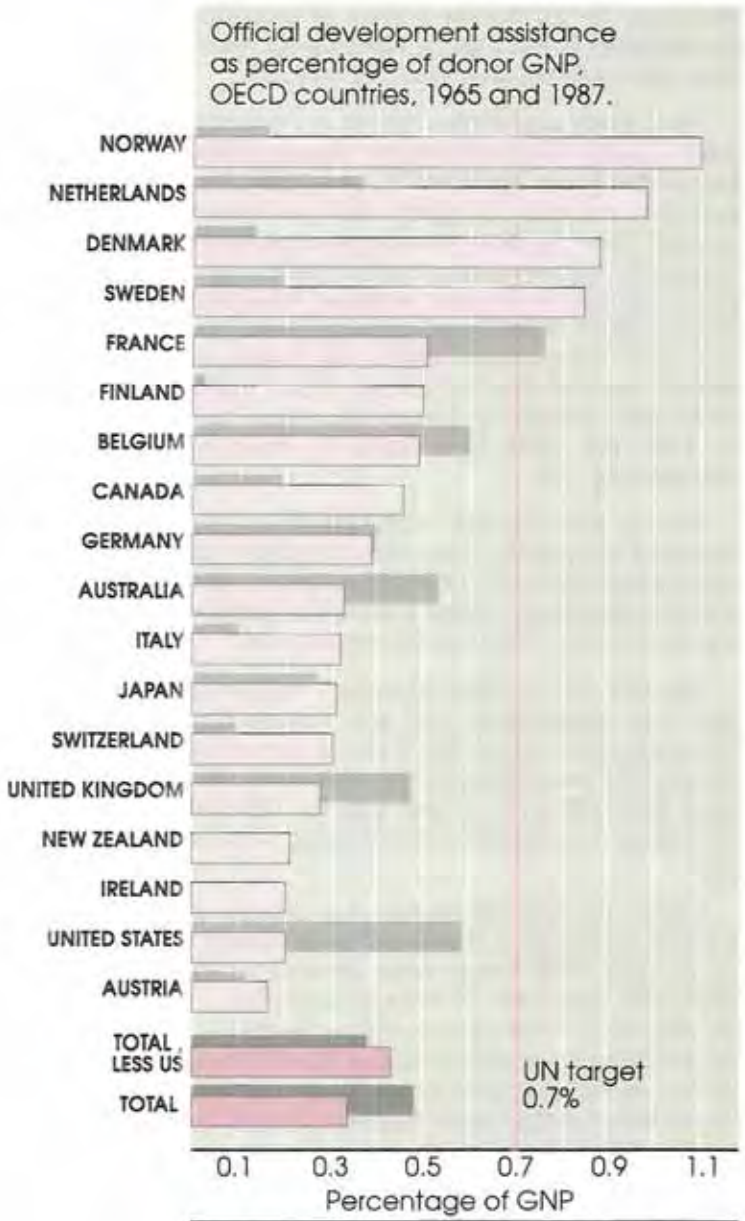
Regional tensions between the superpowers appear to be lessening; progress in peace and disarmament may at last be being made; several of the long-running armed conflicts in the world appear to be coming to an end; China is increasingly engaging in the world economy; the Soviet Union is showing more interest in working with multilateral organizations; much of Asia is making steady economic progress; world population growth is beginning to be brought under control; democracy is seen to be gaining ground in many nations; and new global economic relationships are widely accepted as inevitable.

Change is in prospect everywhere. And if at this time there is the vision to use this opportunity creatively – to see a brave new world and to dare to reach for it – then there is a real possibility over the next ten years to begin to come to grips with the triad of fundamental problems which threatens mankind in the late twentieth century: the presence and the threat of war, the deterioration of the environment, and the persistence of the worst aspects of absolute poverty.

If the developing world is ignored in the process of change and economic restructuring which is now beginning, then this opportunity will have been lost. If a significant proportion of humanity is consigned to continuing poverty, then frustration and injustice will cast a long shadow of violence and tension over the world in the years ahead. And if desperation forces large areas of the developing world to exploit the environment, its resources, its rain forests, its soils, in ways which short-term survival demands

Fig.11 The aid league

The chart below lists the aid-giving nations in order of the percentage of their GNP's given in official development aid. The shadow bar shows the percentage given in1965. Only four out of eighteen countries have reached the UN target of 0.7% of GNP.



Source: OECD, Development Assistance Committee, 'Development Cooperation: 1988 Review', Paris, December 1987.

but which long-term survival prohibits, then the environment will eventually demonstrate with an unknown severity that thinking globally and thinking long-term is now a necessity, not a luxury.*

In particular, it can be predicted that failure to seize this opportunity will mean that recent gains for democracy and stability in the developing world will quickly come under threat. As this report has already described, the economic crisis of the South has already become a social crisis. If that social crisis is allowed to deepen, then there can be little doubt that the next stage will be its translation into a political dimension with a capacity to wipe away recent political gains and introduce new instabilities in a world which, for the first time in many decades, is entertaining hopes of fundamental political progress.

For all of these reasons, political as well as economic, the exclusion of the southern world from the business of restructuring now beginning will mean not only that the northern hemisphere's attempt to solve its own economic problems will be less successful but that a great opportunity for advance on a wider front will have been missed.

Crisis or cause

But it has rarely been the case in the past that fundamental shifts in policy have followed the contours of economic and political logic alone. To bring about change of such magnitude usually requires a force of a different nature.

It requires either a great crisis or a great cause, or a combination of the two. The Marshall Plan, for example, won widespread acceptance among

* This subject is explored fully in the report of the World Commission on Environment and Development published in 1987 under the title *Our Common Future*. The report was produced under the chairmanship of the Norwegian Prime Minister, Gro Harlem Brundtland, who has commented that in their present economic situation the developing countries have *"little alternative but to tax their natural resources, often beyond the limits of recovery, to get the funds for servicing foreign debts and maintaining necessary imports"*.

the American people not just because it promoted the economic interests of the United States, but because it was also inspired by a great moral purpose.

Today, an equivalent crisis is not difficult to foresee. Failure to find a progressive answer to the unsustainabilities of the present situation will, as the World Bank has warned, almost certainly result in a recession which, while painful for the industrialized world, would have almost unthinkable social and political consequences for most of the developing countries.

But an equivalent cause is equally evident. Today, the meeting of the essential human needs of all mankind, and the eradication of the worst aspects of absolute poverty in the remaining years of this millenium, could perhaps become the galvanizing moral purpose with which to inspire change on the necessary scale.

Unfortunately, this great cause has been but dimly reflected in the international development effort of recent times. And it will be difficult to mobilize widespread and sustained public support for a renewed effort which aims no higher than the *status quo ante* and offers no more inspiring challenge than 'more of the same'.

For it is widely known that the poor have usually gained least in good times and suffered most in bad times. The return to economic growth in the developing world, hard though this will be to achieve, is therefore a necessary but certainly not a sufficient condition for progress towards the eradication of poverty.

Until this problem is addressed and until the development process is perceived to serve the poor, there will be little public support for the significant changes required in aid and trade relationships between industrialized and developing nations. And that is why it is so necessary not only to resolve the present crisis but to learn the harsh lessons of the last decade.

Children in debt

In particular, it is necessary to try to give some voice, however inadequate, to the children of the developing world who have no other say in international economic dealings but who are so profoundly and permanently affected by them.

What has been happening to the economies of so many developing nations in recent years, and the effect that this has had on so many of their most vulnerable citizens, is not just a regrettable fluctuation in the normal process of economic development. It is a tragedy which should never have happened and must never be repeated.

Three years ago, former Tanzanian President Julius Nyerere asked the question "*Must we starve our children to pay our debts?*" That question has now been answered in practice. And the answer has been 'Yes'. In those three years, hundreds of thousands of the developing world's children have given their lives to pay their countries' debts, and many millions more are still paying the interest with their malnourished minds and bodies. In Brazil's impoverished north-east alone, infant death rates increased by almost 25% in the course of 1983 and 1984 as a result of economic recession (fig. 12).

That is why the debt crisis should not be discussed too politely. For polite discussion can imply a tacit acceptance of the unacceptable. And what has happened to large areas of the developing world in the 1980s is truly unacceptable.

The fact that so much of today's staggering debt was irresponsibly lent and irresponsibly borrowed would matter less if the consequences of such folly were falling on its perpetrators. Yet now, when the party is over and the bills are coming in, it is the *poor* who are being asked to pay.

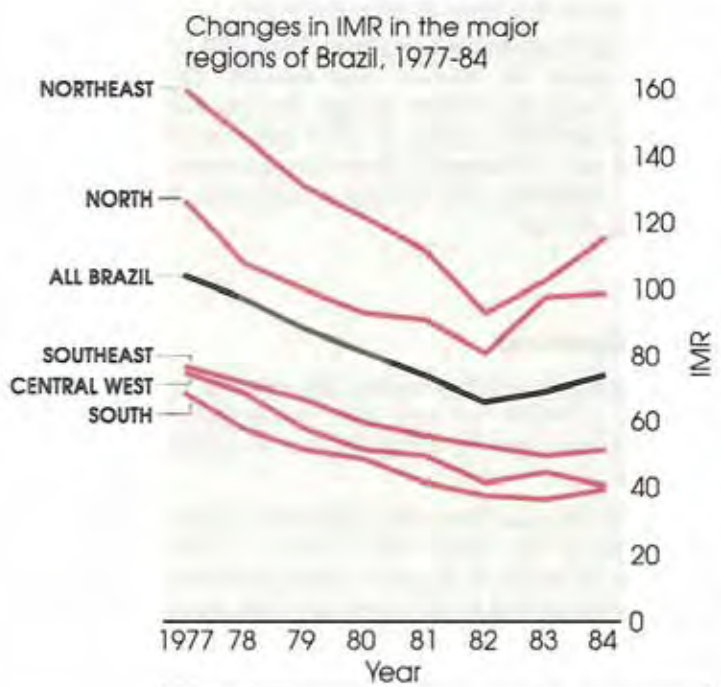
Today, the heaviest burden of a decade of frenzied borrowing is falling not on the military or on those with foreign bank accounts or on those who conceived the years of waste, but on the poor who are having to do without necessities, on the unemployed who are seeing the erosion of all that they have worked for, on the women who do not have enough food to maintain their health, on the infants whose minds and bodies are not growing properly because of untreated illnesses and malnutrition, and on the children who are being denied their only opportunity ever to go to school.

In short, it is hardly too brutal an oversimplification to say that the rich got the loans and the poor got the debts.

And when the impact becomes visible in rising death rates among children, rising percentages of low-birth-weight babies, falling figures for the average weight-for-height of the under-fives, and lower school enrolment ratios among 6-to-11 year olds, then it is essential to strip away the niceties of economic parlance and say that what has happened is simply an outrage against a large section of humanity. The developing world's debt, both in the manner in which it was incurred and in the manner in which it is being 'adjusted to', is an economic stain on the second half of the twentieth century. Allowing world economic problems to be taken out on the growing minds and bodies of young children is the antithesis of all civilized behaviour. Nothing can justify it. And it shames and diminishes us all.

Fig. 12 Rising infant deaths

The infant mortality rate (the number of deaths before the age of one per 1,000 live births) is an indicator not just of the quantity of deaths but also of the quality of life for surviving mothers and children. The chart below, showing changes in the infant mortality rate for the different regions of Brazil, shows that it is the poorest groups who are carrying the heaviest burden of the present economic crisis. The great majority of Brazil's poorest live in the northern, and especially the north-eastern, regions.



Source: Roberto A. Becker and Aaron Lechtig (UNICEF), 'Brasil: evolução da mortalidade infantil no período 1977-1984', Ministry of Health, National Division of Epidemiology.

A new direction

It is necessary to see the present debt crisis in this harsh light in order to extract the equally harsh lesson for the future.

A style of development which benefits the poor least in good economic times and penalizes the poor most in bad economic times will not receive, and does not deserve, the support of the public in either industrialized or developing worlds. And if the new ethos described earlier in this report is ever to come about, if political and public commitment to the changes now needed to put development back on the rails is ever to be mobilized into sustained pressure for an internationally co-operative development effort, then development itself, and the international development effort in particular, will have to be redefined as a process which puts the poor first, in good times and in bad. It will have to be – and be seen to be – a movement which has as its first priority the meeting of the essential needs of all human beings for adequate nutrition, clean water, safe sanitation, primary health care, adequate housing, and basic education. And in particular, it will have to be the kind of development which gives the survival and the normal healthy growth of children *first call* both on a nation's resources and on international support.

This is the kind of development which corresponds to the broad priorities of the great majority in the developing world. This is also the kind of development which could enlist the broad support of the great majority in the industrialized world. That is why the present crisis, like so many of the great crises of the past, must also be seen as

a great opportunity. For if development has come off the rails, then there could be no better time for a change in its direction.

Aid and disillusionment

If a new development effort is to enlist widespread public and political support in the industrialized world, then present disillusionments will have to be overcome.

Public idealism is not dead. In significant contrast, public support in the industrialized nations for private voluntary organizations such as Oxfam, Save the Children, CARE, the Red Cross, World Vision, Live Aid, religious aid organizations, and UNICEF's own National Committees, have more than trebled in the 1980s.

The explanation of this apparent contradiction in attitudes, between private generosity and political parsimony, is not far to seek. The truth is that there is little idealistic support for significantly increased aid and a renewed commitment to the international development effort because there is a widespread perception that such efforts are not primarily designed to meet the needs or enhance the capacities of the poorest or to make rapid progress towards the eradication of absolute poverty. In other words, there is a great deal of popular disillusionment with the intentions and the policies of both industrialized and developing country governments and it is that disillusionment which must now be addressed.

In the industrialized countries, public disillusionment with aid and development is in large part a result of using aid as an instrument of political advantage, or military strategy, or industrial subsidy. In the case of the United States, for example, over 30% of *non-military* aid now goes to just two countries – Egypt and Israel. Not one country in sub-Saharan Africa, the world's neediest region, nor India with almost half of the world's absolute poor, is even in the top ten recipients of American aid. In the case of the United Kingdom, where aid as a percentage of GNP has also declined in recent years, 75% of official bilateral aid is tied to the purchase of British goods and services. Aid from the Eastern bloc is usually even more firmly tied to the exports of the donor nations.

As a consequence of this moral dehydration of aid, development assistance today has a more and more tenuous connection with the alleviation of poverty. According to a recent report from the *Independent Group on British Aid*, for example:

"*...most of our aid programme at present is irrelevant to the real needs of the poor throughout the world....It is not concentrated on the poorest countries of the world, still less on the poorest people in the countries which we help*".

Taking the Western industrialized nations as a whole, over half of all bilateral aid is now tied to the purchase of goods and services from the donor country; less than 25% of the assistance given goes to the 40 least developed countries; less than 15% goes to the agricultural sector, which provides the livelihood for the poor majority in almost all developing countries; less than 11% goes to education; and less than 5% goes to health and birth spacing combined.

There are honourable exceptions. Over 75% of the aid given by Norway and Sweden, for example, is given without strings. But by and large, the idealistic content of aid is today in an advanced state of corrosion from the short-term political, economic, and military self-interest of the donor nations.

Donor distortion

Unfortunately, disillusionment also extends to the uses to which aid and other development resources are put by many of the recipient countries.

Because the poor have little influence on either the purposes for which aid is given or the purposes for which it is spent, donor distortion and receiver distortion often twist aid in the same direction so that aid comes to favour industry over agriculture, urban over rural, hospitals over health centres, universities over primary schools, export crops over food production, the imported over the indigenous, the capital-intensive over the

employment-creating, the construction of the new over the maintenance of the old, and, ultimately, the richer over the poorer.

In a recent health budget of one developing country, for example, $15 million was assigned to the refurbishing and extension of one city hospital while nothing whatsoever was allocated to primary health care. In another, government subsidies to a few private hospitals catering for upper-income groups amounted to five times as much as the total national budget for primary health care. And of the 11% of industrialized world aid allocated to education, the vast majority goes to secondary and university education, catering, in the main, for the better-off groups while less than 1% goes to the primary schools which are all that the majority of the developing world's children can aspire to.

So just as it could be said that much of today's debt was irresponsibly lent and irresponsibly borrowed, so much of today's aid is unwisely given and unwisely received when measured against the yardstick of its contribution to the lives of the poor. And again, there is a stark and instructive contrast with the aid funnelled through many of the private aid organizations.

Especially over the last decade, development projects funded by voluntary organizations in the industrialized world, and increasingly administered by their indigenous counterparts in the developing world, have pioneered the path towards the kind of aid-assisted development efforts which meet the needs and enhance the capacities of the poor, which encourage the participation of communities they seek to assist, which recognize the role and the needs of women in the development process, which are sensitive to environmental considerations, and which give thought to the sustainability of that which is being initiated.

Such efforts are examples of the true spirit of development aid. And the fact that their primary purpose is to alleviate poverty – by helping to empower people to improve their own lives – is the main reason for the vast public support they have received in the 1980s.

Rising quiet support, and mass participation in such events as *Live Aid*, *Band Aid*, *Sport Aid*, *First Earth Run* and many others such events in recent years have shown that there is a strong desire among large numbers of ordinary people in the industrialized and developing nations to live in a world without needless, life-denying poverty. The question now is whether that fund of human solidarity and goodwill can be enlisted in support not only of disaster relief but of long-term international development efforts – including action on the scale required in the more complex arenas of aid, trade, and debt – in order to restore the momentum of progress and renew the war on poverty.

Many would march in the cause of abolishing from our planet the worst aspects of absolute poverty – mass malnutrition, preventable illness, and illiteracy. But idealism will not respond to the corruption of that development effort, by the governments of either industrialized or developing worlds, or to its disengagement from the twin concerns of meeting basic human needs and protecting the human environment.

Support for increased aid will therefore only be forthcoming, and aid itself will only be effective, if it is first scraped cleaner so that it more clearly reflects its primary purpose. Perhaps aid which is at present devoted mainly to subsidizing the exports of donor nations should be shifted to the budgets of more relevant government departments – trade, commerce, or industry. Perhaps aid which is at present devoted mainly to furthering the military and political interests of donor nations should be reclassified under defence spending. What remains in aid budgets might then be judged against the one criterion which matters most to the majority of people in both rich and poor worlds – is aid helping to overcome the worst aspects of absolute poverty?

Once clarified in this way, the aid prism can be held up to the light of more complex questions. Is priority given where need is greatest – to the poorest countries and the poorest within countries? (fig. 13) Is a significant proportion of aid being used to assist projects in which the poor themselves participate? Is aid being used to improve the lives and lighten the work-loads of women? Is aid contributing to environmental degradation or to sustainable development? Is aid

helping to finance the recurrent costs and smaller budget items, the textbooks and essential drugs, in order to make efficient use of existing facilities? Is aid being spent on low-cost, high-impact, mass-application strategies which are of primary relevance to meeting the needs and increasing the productivity of the poor?

In sum, aid for development should be *real aid* for *real development*. And real development means people having the knowledge and the means to take more control over their own lives, to decide their own priorities, to improve their own skills, to meet their own needs, to find their own fulfilment. Above all, the test of real aid and real development is not just whether or not it leads to increases in welfare but whether or not it enhances human capacity.

Inevitably, the kind of development which liberates the contributions and the demands of so many millions of people, would also benefit the economies of both industrialized and developing nations. As the Chairman of the Development Assistance Committee (DAC), which co-ordinates the foreign aid policies of the 18 Western industrialized nations, has said:

"*Strengthen individuals in terms of education, health and nutrition and give them the right environment in terms of policy and services and you will unleash individual and group efforts favourable to economic growth*".

Finally, it is the long-term economic future, and not just the immediate and emotional appeal of children, which demands that the under-fives should occupy a special place in *real development*. For if children are deprived of the chance to grow to their full physical and mental potential, of the opportunity to go to school and learn new skills, and of the chance of a childhood in which love and security predominate over fear and instability, then future progress is constantly being undermined by present poverty. To prevent poverty from being perpetuated from one generation to the next demands that the growing minds and bodies of children be given priority protection. There could be no greater humanitarian cause. There could be no more productive investment. And there could therefore be no greater priority for real development.

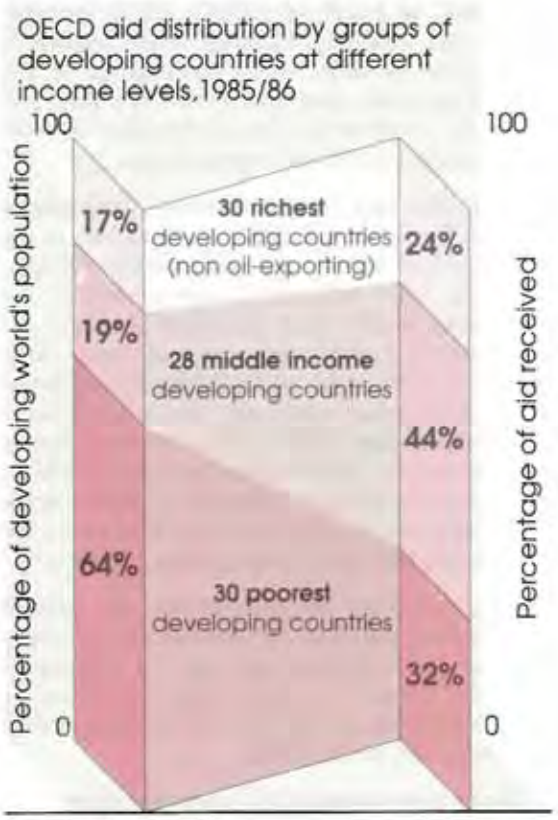
Receiver distortion

A new concern for donor distortion would need to be carried through into an equivalent concern for receiver distortion. And a new concern over the use to which aid is put may not always be unwelcome to the governments of the developing world.

Advances in democracy in recent years have made it easier for some governments to act in the interests of the poor majority. But for many governments, it is still politically difficult to shift priorities – and funds – from urban hospitals to rural clinics, from foreign scholarships to primary

Fig. 13 Where aid goes

The chart shows how the total aid of the eighteen Western industrialized countries is distributed among the richer and poorer developing countries.



Source: OECD and World Bank.

schools, from airlines to bus routes, from meeting the expectations of better-off and more politically powerful groups to meeting the needs of the poor majority dispersed in the countryside and exerting little political leverage.

In this context, real aid could play a very specific role. For it is obviously easier to allocate funds in favour of the poor if those funds come from foreign aid and if they are made available on the understanding that they will be used to improve the lives and the capacities of the poorest. Aid is only a small part – little more than 5% – of the total development effort. But especially in the poorest countries, its importance is far greater than this figure suggests. In approximately 40 developing nations, the amount of official aid received is greater than the total sum spent by the government on health or education. The criteria against which it is allocated are therefore an important point of leverage for real development.

As the 1980s draw to an end, there are some signs that aid policies may soon begin to turn in this direction. Speaking in his personal capacity, DAC Chairman Joseph Wheeler has this year (1988) provoked new thinking along these lines:

"*The poorest are often not well represented in the power structure and funding priorities frequently are assigned to the already better-off portions of the society. Aid can help bend priorities towards the poor*".

More specifically, he continues:

"*In view of India's unique position in the world, one wonders whether there is not room for an entirely new approach to working with that country in its campaign to reduce poverty. The donor community might indicate a willingness to double gross aid to India from $5 billion to $10 billion if India could put forward a proposal for a total Government effort for accelerated activity affecting the poor...*"

Making a similar proposal in relation to Latin America, he suggests:

"*... reality has left Brazil in the middle of a debt crisis which will certainly be a problem for the decade ahead, dragging down the priority Brazil can give to poverty alleviation. Is it out of the question to consider responding to a Brazilian initiative in which the problems of poverty in the north-east might be given a stepped-up priority in response to a donor willingness to provide foreign exchange which Brazil could well use in dealing with its overall development challenge?*"

In support of specific goals set by the developing countries themselves, poverty-focussed aid of this kind could become a significant force for real development in the years ahead. Specifically, aid-funded development programmes could help put into practice, on a massive scale, some of the low-cost, high-impact strategies which are now available for meeting the needs and improving the capacities of the poor. Such strategies will be discussed in more detail in the next chapter of this report.

Among the public of some industrialized countries, and among non-governmental organizations, there are also early signs of growing pressure for new patterns of development assistance. Campaigns for 'real aid' are emerging in several European countries and, in the United States, one non-governmental organization has involved thousands of citizens, and enlisted early support from over one third of the House of Representatives (including 26 members of the Foreign Affairs Committee) and one fifth of the Senate (including 7 members of the Foreign Relations Committee) behind a *Global Poverty Reduction Act** now being introduced into the United States Congress. The Act, which has also been supported by many editorials in newspapers across America, instructs the United States Government to consult with developing country governments, non-governmental organizations, and international organizations, to "*devise a plan whereby US Development Assistance would contribute measurably to eradicating the worst aspects of absolute poverty by the year 2000*". Specifically, the legislation seeks to focus US aid for the next decade on three goals: the reduction of under-five mortality rates to 70 or less (per thousand live births) in all countries; the raising of female

* The Global Poverty Reduction Act is an initiative of Results – an international lobby for world development with 130 member groups in five countries.

literacy rates to 80% or more; and the reduction of the numbers of people living in absolute poverty to less than 20% in all nations. In other words, the *Global Poverty Reduction Act* is an example of the public interest in seeing real aid used for real development.

In Europe also, there are signs that public opinion is moving in favour of increased aid and/or debt reduction to help alleviate poverty. A 1988 survey of 11,600 Europeans in 12 countries found that 89% believed that "development co-operation with the third world makes sense" and 44% agreed that "it is in our interests to write off third world debt even if this costs a lot".

Aid for the environment

Just as aid can help to "bend priorities towards the poor", it might also help to give more political weight to long-term environmental considerations. Developing country governments, often working under short-term political and financial pressures, understandably find it difficult to give priority to environmental conservation, just as they may find it difficult to give priority to the poorest groups, or to women, or to long-term preventive health. In all such cases, the costs are short-term and calculable, whereas the benefits are often either invisible or yield little in the way of political or financial advantage during the time-frame of most governments.

It is in this context that aid can begin to stand proxy for political pressure, becoming a lobby for the vulnerable and making it politically easier to take decisions of which the principal beneficiaries would be the poor, the environment, and the future.

The evidence suggests that this kind of aid – aid which is, and is seen to be, real aid for real development – would more properly deserve, and would almost certainly receive, growing support from the electorates of the industrialized nations. That public support is urgently needed if increases in aid are to play their part in restoring economic growth to the developing world.

A real development pact

In the interests of reviving their own economies, as well as in the interests of helping to put development back on the rails, the industrialized nations should therefore now give thought to a significant reduction of debts, a significant liberalization of trade, and a significant increase in real aid, in order to turn the flow of net financial transfers back in the direction of the developing world.

But the time has passed for such support to be given indiscriminately and on the comfortable assumption that it will automatically help to bring about real development. The support of press, public, and political leaders in the industrialized world – without which it will not be possible to move towards the necessary action on debt, trade, and aid – will not be forthcoming without regard for the uses to which those resources are put. The time has come when not only aid but also debt reduction and trade agreements should form part of a *real development pact* by which participating industrialized nations would make a commitment to increase resources and participating developing nations would make a corresponding commitment to a pattern of real development which unequivocally puts the poor first.

The ultimate aim and measure of that real development is the enhancement of the capacities of the poorest, their health and nutrition, their education and skills, their abilities to control their own lives, and their opportunities to earn a fair reward for their labours. This is the kind of development which the majority of people in the poor world seek, and this is the kind of development which the majority of people in the industrialized world would support. Bending development in this direction is therefore the opportunity which now arises from the present economic crisis; and this report now turns to the question of what such a commitment to real development might mean, in practice, and what it might be expected to achieve by the end of this century.

Real development in practice

If from its present doldrums, the development process did receive a fresh impetus through global growth, and if that impetus were to be in the direction of *real development*, then it is UNICEF's belief that the worst aspects of absolute poverty could almost certainly be overcome by the end of this century. In particular, we believe that it is financially and technically possible to achieve the specific goal of so improving the environment of early childhood that the shameful statistics of poor growth, frequent illness, common disability, and early death can be drastically reduced.

Resources will continue to be limited. But the crucial factor is that the ratio of resources to results can be vastly improved. And what makes that improvement possible is the new knowledge, new technology, and hard-won experience which has been built up over the last four decades. That body of knowledge provides a more solid base for the development effort to push against; and it makes accelerated progress possible during the decade ahead.

Much of that knowledge resides today in the institutions of the developing world and in the specialized agencies of the United Nations family. Decades of experience of working for real development, in almost all countries of the developing world, are now vested in organizations like the UN Development Programme (UNDP); the World Health Organization (WHO); the International Labour Organisation (ILO); the Food and Agricultural Organization (FAO); the International Fund for Agricultural Development (IFAD); the World Food Programme (WFP); the UN Population Fund (UNFPA); the UN Environment Programme (UNEP); the United Nations Educational, Scientific and Cultural Organization (UNESCO); the World Bank; UNICEF and the bilateral aid agencies of the industrialized countries. That knowledge is today one of development's most valuable resources, and it is time it was fully exploited.

Even at the level of international generalization, it is impossible to even summarize that knowledge base in these pages. What follows is therefore a brief description of only some of the most glaring and widely relevant opportunities for using today's knowledge to attack some of the worst aspects of poverty on a significant scale and at an affordable cost over the next decade. It attempts to show that meeting the basic needs of all mankind is not an impossible dream and that exploiting today's knowledge could fulfil universal aspirations for adequate food, clean water, competent health care, decent accommodation, and basic literacy and numeracy in the remaining years of this century.

Competent health care

Competent health care means giving priority to pregnant women and young children, simply because they are the most vulnerable. In the last 24 hours, over a thousand young women have died because something has gone wrong with their pregnancies or because of an attempted abortion or because of complications in giving birth. Also in the last 24 hours, approximately 40,000 children under five have died – over 80% of them from one or more of six causes – tetanus, measles, whooping cough, diarrhoea, acute respiratory infections or malaria, often in association with some degree of malnutrition. Of the survivors, many millions are prevented by poor nutritional health from fulfilling the mental and physical potential with which they were born.

The argument has already been made that protecting the lives and growing minds and bodies of young children is perhaps the most obvious of all priorities of real development. And it is here that today's knowledge still offers perhaps the greatest opportunity for dramatic advance over the next five years.

Recent achievements in immunization, based on breakthroughs in vaccine and delivery technology, were summarized at the beginning of this report. Looking back, the fact that just over half the developing world's children are now protected by immunization is a great achievement. Looking forward, the fact that almost half of the developing world's children are not protected is a great challenge. And it means that immunization is still one of the most important of all real

Immunization: a league table

The following 'league tables' list the nations of the developing world according to the percentage of their children who are immunized with DPT vaccine. Because DPT requires three separate vaccinations, it is a good indicator of how well the immunization system as a whole is working.

Americas	% children immunized (DPT)
Argentina	93
Chile	93
Costa Rica	91
Cuba	87
Jamaica	81
Dominican Rep.	80
Trinidad and Tobago	79
Panama	73
Uruguay	70
Guyana	67
Mexico	62
Colombia	58
Honduras	58
Paraguay	58
Brazil	57
Venezuela	54
El Salvador	53
Ecuador	51
Nicaragua	43
Peru	42
Bolivia	24
Haiti	20
Guatemala	16

Middle East and North Africa	% children immunized (DPT)
Kuwait	94
Lebanon	91
Jordan	89
Saudi Arabia	89
Tunisia	89
Egypt	81
Morocco	78
Oman	77
Iraq	76
United Arab Emirates	75
Iran, Islamic Rep. of	74
Turkey	71
Syrian Arab Rep.	70
Algeria	66
Libyan Arab Jamahiriya	62[c]
Yemen, Dem.	25
Yemen	14

Africa South of the Sahara	% children immunized (DPT)
Botswana	86
Mauritius	85
Tanzania, U. Rep. of	81[a]
Lesotho	77[b]
Zimbabwe	77
Kenya	75
Burundi	73
Congo	71
Côte d'Ivoire	71
Rwanda	67[a]
Zambia	66[a]
Malawi	55
Senegal	69*
Benin	52
Mozambique	51
Gabon	48
Guinea-Bissau	47
Cameroon	45
Togo	41
Uganda	39
Ghana	37
Zaire	36
Burkina Faso	34
Mauritania	32[a]
Sierra Leone	30[a]
Madagascar	30[a]
Sudan	29
Liberia	28
Somalia	25
Central African Rep.	24[c]
Nigeria	20[a]
Ethiopia	16
Guinea	15[a]
Chad	12
Mali	12
Angola	10
Niger	5[a]

Asia	% children immunized (DPT)
Singapore	98
Mongolia	79
Korea, Rep. of	76[a]
China	75
Philippines	73
Korea, Dem. Rep. of	62
Pakistan	62
Sri Lanka	61
Malaysia	59[a]
India	58
Viet Nam	51
Indonesia	48
Thailand	48
Nepal	46
Papua New Guinea	44[a]
Kampuchea	37[a]
Lao People's Dem. Rep.	28[c]
Bhutan	27
Afghanistan	25
Burma	23
Bangladesh	9

(a) 1986
(b) 1988
(c) 1985
* Two shots DPT

development opportunities. Another 3 million lives a year could be saved*; another 230,000 cases of polio per year could be prevented; and a major cause of blindness and malnutrition and mental disability could be removed.** Finance is not the only factor, but the cost of all this – of reaching all infants in all developing countries – would be an extra $500 million a year: the contribution needed from the industrialized nations would be about $100 million – the cost of two advanced fighter planes.

Reaching the unreached with today's vaccines would therefore be high on the priority list of any aid-receiving or aid-giving government which was genuinely committed to implementing large-scale, cost-efficient ways of protecting the lives of the poorest and most vulnerable. And failure to achieve universal child immunization within the next five years would be a clear statement that one of the most obvious and preventable problems of the poor is being ignored. Such a failure ought, by that time, to be seen as a matter of deep national and international shame.

Similarly, progress against diarrhoeal disease has also been referred to as one of the great health achievements of the 1980s. But here too the job is less than half complete. Today's knowledge could empower most families to prevent and treat diarrhoeal disease and protect their children against a major cause, perhaps *the* major cause, of both poor growth and early death. In particular, the breakthrough known as oral rehydration therapy, or ORT, is so simple that it can be administered by any parent, so cheap that it costs less than most poor families already spend on ineffective anti-diarrhoeal medicines, and so well-proven that it is now standard practice in the most advanced hospitals in the world.

In the 1980s, knowledge of ORT has been put at the disposal of approximately one quarter of the developing world's parents. But two and a half million children are still dying each year from dehydration, and even larger numbers are being left malnourished by frequent diarrhoeal disease. In the past, when this toll on the lives and the growth of children was largely unavoidable, it was a tragedy. In the present, when it is largely preventable, it is unacceptable.

There are difficulties, and there are costs. Preventing dehydration requires training or re-training at all levels of the health services. But given the severity and scale of the problem, and the relative cheapness and simplicity of the solution, any programme of real development would now move quickly to stop the quiet carnage of dehydration. And if this is not largely achieved five years from now, then it must be assumed that it is because the threat to children posed by diarrhoeal disease is a threat mainly to the children of the poor.

UNICEF is frequently questioned about the high priority it gives to these two specific interventions – immunization and ORT.* But real development means using today's knowledge to establish priority problems and then finding the leverage points at which to apply available resources to maximum effect. And the fact is that diarrhoeal and vaccine-preventable diseases are together responsible for almost half of all child deaths in the world and probably as much as half of all child malnutrition. And in both cases, the world has at its disposal relatively simple, relatively low-cost solutions waiting to be applied *on the necessary scale.*

That is why immunization and control of diarrhoeal disease demand such priority. As the world becomes more informed about such issues, and as perspectives change with new awareness and new capacity, it will soon become a matter of

* The ratio between the percentage of children immunized and the number of deaths prevented from vaccine-preventable diseases is not constant because deaths tend to be concentrated among the children of the poorest and those who are more difficult to reach with full immunization coverage.

** Measles and diarrhoeal disease are now known to be major causes of malnutrition and of the vitamin A deficiency which causes 250,000 children to be permanently blinded each year (many of whom subsequently die).

* Priority does not mean exclusivity. UNICEF still spends three quarters of its total programme resources on the broader aspects of primary health care, nutrition, water and sanitation, basic education, support for women, and special programmes for children in emergencies, children affected by wars, street children, and children in other specially difficult circumstances.

national disgrace, and an indictment of both national and international development efforts, if millions of children are still being killed, maimed, blinded, and brain-damaged by a group of diseases which our civilization has the overwhelming power to eliminate.

Passive atrocities

Along with immunization and ORT, other recent advances in knowledge have also made it possible to make very great gains, at very little cost, against most of the other major problems which threaten the lives and the growth of children – including acute respiratory infections, malaria, blindness, and cretinism. And in each case, the ratio of resources required to results achieved makes such actions an obvious choice for inclusion among real development's priorities.

Any development strategy which seeks to apply known low-cost solutions to the worst aspects of poverty, for example, would immediately move to eliminate the scandal of a quarter of a million children going blind each year for the lack of a 10-cent vitamin A capsule or a daily handful of green vegetables. Similarly, inexpensive capsules or injections or the iodation of salt could eliminate, at almost negligible cost, the risk of iodine deficiency disorders which lower the productivity of millions of adults and irreparably damage the mental and physical capacities of hundreds of thousands of children. It is simply unnecessary for children to be born with brain damage because their mothers lack iodine in their diets when the cost of iodating all edible salt is less than 5 cents per person per year. As UNICEF's former Regional Director for South Central Asia, David Haxton, long associated with this cause, said on his retirement this year:-

"*Permit me to suggest that it is a crime for one more child to be born a cretin. We have known the answer to prevention for over 75 years.. Must we end this century with hundreds of millions still at risk when we know the answer and can afford the price?*"

To allow these passive atrocities to continue on this scale, when the means are at hand to prevent them, makes neither economic nor human sense. Children who are denied the right to develop to their physical and mental potential can neither contribute fully to, nor benefit fully from, the development of their societies. And if real development is to mean anything at all, then the time has surely come to give priority to the obvious actions which could make so much difference to so many and for so little cost.

Maternal health

Half a million 'maternal deaths' every year (panel 9) are sad testimony to another obvious real development priority.

The roots of this problem reach deep into social soils. As long as the nutrition of girls is placed second to that of boys, and as long as women eat last and least and work hardest and longest, pregnancy will remain a greater-than-natural risk. And as long as half of all babies in the developing world are delivered with no trained person in attendance, and no system in place for calling on basic obstetric services when something goes wrong, then child-bearing will remain up to 150 times as dangerous as it is in Europe or North America.

But it should also be pointed out that over one third of the 140 million women in the developing world who have become pregnant in the last twelve months *did not want to have another baby*. And an estimated 200,000 of them died in the desperate attempt to terminate those pregnancies by means of illegal abortion.

Enabling those women to exercise their preferences, by safe means, would have brought benefits to both parents and children out of all proportion to the costs involved. According to some studies, for example, as many as a quarter of all infant deaths and a quarter of all maternal deaths could be prevented by the well-informed timing of births (fig. 14).

The spread of birth spacing has already been referred to as one of the great social advances of recent years. And it remains one of the greatest opportunities for obvious low-cost action in the years ahead. On maternal and child health grounds alone, the promotion of the knowledge to

Fig. 14 Safe motherhood

Every year, approximately 500,000 women die from causes related to giving birth. Having too many babies too close together, and having babies at too young or too old an age, is a major cause of many of those deaths. The chart below shows, for selected countries, the percentage of maternal deaths which could be prevented by family spacing.

* Married women who want no more children but are not using an effective family spacing method.

Source: Barbara Herz and Anthony R Measham, 'The safe motherhood initiative: proposals for action', Washington D.C., World Bank, 1987, based on data provided by Deborah Maine, Columbia University.

control the number and the timing of births would claim an automatic place among the priorities of real development.

The fact that birth spacing also helps to lower rates of population growth, through people themselves choosing to have fewer children, is an enormous dividend for the development effort. But the fundamental case for making birth spacing available to all couples over the next five years is that it gives people significantly more control over their own lives – and that is what real development is all about.

Primary health care

Particular health interventions are clearly of limited usefulness without a system for making them available to the majority. To meet this overarching need, the experience of recent decades has also yielded a major breakthrough of a different kind.

The primary health care (PHC) approach, arising from practical experience in all regions of the world in recent decades, has now been developed to the point where it offers a detailed and practicable strategy for achieving the World Health Organization's goal of 'Health for All by the Year 2000'. It is a strategy for the health dimension of *real development*. And it offers a significant improvement in the ratio between resources and results.

The PHC concept is not complicated and should not be allowed to become so.

It recognizes, first of all, that health is not just the absence of disease but a wider sense of well-being depending not just on health services but on employment and incomes, education and culture, rights and freedoms.

Second, primary health care recognizes that families and communities are health's first line of defence. If communities are well informed and well organized to define and articulate their needs, and if they are well supported by basic amenities such as clean water and safe sanitation, then people themselves can take the major responsibility for protecting their own health.

Maternal deaths: statistics of shame

This year's *State of the World's Children* report brings together new statistics on the well-being of the world's women (Table 7, page 106). Showing female life expectancies, literacy, school enrolment, contraceptive use, immunization levels, percentage of births attended by trained personnel, and maternal mortality rates for each country, the table shows the 'double disadvantage' of being born poor and female.

Most tragic of all are the statistics of maternal mortality. For every social indicator – be it literacy rate, life expectancy, or infant mortality – there is a wide gap between industrialized and developing worlds: but nowhere is that gap as wide as in maternal deaths. Overall, the risk of dying of causes related to pregnancy and childbirth is at least forty times higher in the developing world. And in the poorest countries, the risk rises to 150 times higher. In Africa there are almost 700 maternal deaths for every 100,000 live births. In South Asia there are over 500. In the industrialized world, the average is under ten.

Such statistics mean that approximately half a million women die of 'maternal causes' every year, leaving behind over one million motherless children. An estimated 200,000 die from illegal abortions – reflecting women's unmet need for family planning. Many more die painfully in childbirth because referral services are not available when something goes wrong.

With today's knowledge, most of those deaths, and most of this suffering, could be avoided – and at relatively little cost. And if perceptions about what is and what is not acceptable in today's world were to stay in step with today's capacity, then maternal deaths on this scale would now be a matter of international outrage.

First, there is a great deal that the family itself can do – *if* today's information about safe motherhood is made available. Families should know, for example, that the risks of pregnancy and childbirth can be drastically reduced by:

- Regular check-ups during pregnancy
- Making sure a trained person is present at the birth
- Making sure a pregnant woman gets more food and rest
- Spacing births at least two years apart and avoiding pregnancies under the age of 18 and over the age of 35 this alone could reduce maternal deaths by as much as 25%
- Making sure that female children are as well nourished as males, and that girls are well-fed during adolescence
- Knowing the warning signs during pregnancy, such as previous low birth weight; mother-to-be weighing less than 38 kg before pregnancy or failing to put on weight during pregnancy; any unusual swelling of legs, arms or face; bleeding; severe headaches or vomiting; or high fever.

Family knowledge is not enough. Government action is also essential – in providing pre-natal care, training birth attendants, and providing referral services so that more qualified people can deal with more complex problems.

The International Safe Motherhood Conference held in Nairobi, Kenya, in 1987 concluded that it should be possible to reduce maternal mortality rates by at least half by the end of the century.

For the kind of development which puts the most disadvantaged first, reductions in the maternal mortality rate would be one of the chief aims and measures of progress. As Dr. Attiya Inayatullah, Pakistan's Population Minister, concluded at the Nairobi conference: "It is intolerable that so many thousands of women are dying painful, lonely deaths in the process of giving life and we are doing so little to stop it. There is no greater indictment of development efforts than the high rates of maternal death that prevail in much of the world".

The second line of defence, in the primary health care strategy, is a community health worker (CHW) who is knowledgeable about, accepted by, and responsible to, the community which he or she serves. With a few months' basic training, plus regular supervision and refresher courses, a CHW can help to prevent and cope with the most common health problems of the community. In a typical neighbourhood, for example, the responsibilities of the community health worker might include advising on birth spacing, pre-natal care, safe delivery, breast-feeding, disease prevention, immunization services, oral rehydration therapy, diarrhoeal disease, home hygiene, adequate feeding, child growth monitoring, respiratory infections, malaria, and the distribution of essential drugs and supplies including vitamin A capsules or iron and iodine supplements.

In other words, the most common and obvious health needs of a community can usually be met by a CHW rather than a fully qualified doctor. The cost of training a CHW varies between $100 and $500. The cost of training a fully qualified doctor, who may in any case not wish to work for very long in a poor community, is rarely less than $60,000 and often very much more. It is this most basic and obvious efficiency which gives primary health care the power to bring about very significant improvements in the health of mankind at an affordable cost.

But if the primary health care approach were to stop at this point it would be a travesty of both its principles and its potential. It would be, at best, a second-class service for the poor.

In a genuine primary health care system, a community health worker – under whatever name – would also be trained to recognize more difficult health problems and empowered to call upon the third line in the defence of health – the more qualified personnel of district, provincial, and national health and development services. More qualified medical staff would also play the key role in the training and supervising of CHWs.

The referral system is therefore the litmus test of real primary health care. It is this which links means with needs in an efficient way and on a basis of need, allocating the right level of expertise to each health problem and so making maximum use of available resources. Efficiency and equity are therefore the twin principles standing at the centre of the primary health care approach. It is not, even in its curative dimension, a strategy only for providing low-cost treatment for common ailments. It is also a system which, fully implemented, would make the most sophisticated surgery in the most advanced urban hospital available to the poorest person in the most remote rural area.

No country, rich or poor, can claim to have a fully functioning primary health care system at present. But many tens of thousands of CHWs have been trained in the last decade and many governments have already achieved significant improvements in national health – and therefore in national capacity – by beginning down the primary health care road.

In many other nations, particularly in Africa, PHC is struggling to establish itself as a permanent presence in poor and rural communities. In part, the stumbling-block is money, and in particular, the money to meet the recurring costs of health workers' salaries, routine running expenses, minimum equipment, and essential drugs. But against this problem also, a strategic breakthrough may now have been made.

Just over one year ago, in September 1987, a new PHC initiative was announced by African Health Ministers, meeting with the Director-General of WHO and the Executive Director of UNICEF, at Bamako, Mali. The 'Bamako Initiative' (panel 10) plans to increase significantly the resources available for maternal and child health (MCH) services by a new way of mobilizing local resources and outside finance. The plan hinges around community participation in managing and financing primary health care services. The 30 to 35 most essential drugs could, if bought in bulk at low cost, be sold at prices considerably lower than people are already accustomed to paying, but sufficiently high to finance not only the replenishment of the drugs themselves but also the basic running costs of local MCH services. As experiences in Benin, Kenya and Tanzania have shown,

the 30 to 35 most essential drugs, including sachets of oral rehydration salts, vitamin A capsules, and vaccines, can be made available at a cost of approximately 50 cents per person per year. Throughout Africa, as in much of the developing world, it is not uncommon for families to spend up to 10% of their limited incomes on medicines of doubtful quality and uncertain availability. For a smaller proportion of their income, well-informed and well-served communities could purchase all their essential drugs and medicines at a price which would also subsidize the building of PHC in their own communities. Given development assistance for the foreign exchange necessary to purchase the drugs in bulk and get such schemes started, the ultimate aim of the Bamako Initiative is to make locally managed and sustained maternal and child health services available to at least 80% of villages and urban neighbourhoods throughout sub-Saharan Africa by the mid-1990s.

A breakthrough of a different kind may also have been made this year (1988) at the World Conference on Medical Education held in Edinburgh, Scotland. After four years of consultations in all regions of the world, the Conference issued the Edinburgh Declaration calling for very substantial changes in medical education world-wide. The overall aim is to try to make the training of doctors and other health personnel more relevant to the needs of the majority in their own societies. "*It is no longer enough only to treat some of the sick,*" says the Declaration, "*Thousands suffer and die every day from diseases which are preventable, curable, or self-inflicted, and millions have no ready access to health care of any kind.*" Stressing curriculum reform and the importance of communication, the Declaration calls upon medical institutions the world over to respond to the great needs and great opportunities for health improvement in the 1990s and to begin closing the gap between what science knows and what people need.

Food and nutrition

Adequate nutrition for all is also among the most obvious priorities of real development. And here too, the advances of the last two decades have made it possible to think about reaching that great human goal within the next few years.

Advances in food *production* have been truly revolutionary. Indonesia now exports rice. Pakistan exports wheat. In India, a 30-million-ton wheat reserve from local production has enabled the nation to cope, over the last two years, with its worst drought of the century (which in earlier times would certainly have precipitated mass famine). In sum, high-yielding varieties of maize, wheat, rice, and, more recently, sorghum, millet, cassava, and beans, have produced food surpluses in every region of the developing world save one. Africa, where food production per head has declined by an average of 1% a year for the past three decades, is still awaiting its major breakthrough.

Over the last ten years, much of the knowledge required to double food production from the small farms of Africa has become available. What is required to make the breakthrough is not, principally, more technical advances, important as they could be, but a dissemination of existing knowledge and a reorientation of *policy* towards the rural areas and the smaller farmers.

In Zimbabwe, for example, the 1980s have seen a new priority given to the country's smallholders – the three quarters of a million black farmers neglected during the long years of colonial rule. Land reform laws have redistributed a relatively modest amount of land; loans to small farmers have been increased 25-fold (using the eventual crop as collateral); research and investment have gone into packages of inputs, principally new seeds, fertilizers and pesticides, especially designed for the small farmer. An indigenous agricultural research capacity has focused on the needs of the small landowners; an efficiently organized but not very large number of agricultural extension workers have been made available to inform and support farmers in using new production methods; and targets have been set according to the yields already being achieved by the most productive 10% of farmers in each particular region. Since independence, maize prices have been increased by 129% to provide incentives to farming families; and a well-

organized National Farmers' Association has represented poorer farmers in negotiations with government.

As a result, despite war and drought and recession, Zimbabwe has quadrupled its food production in the last decade.

There are signs in other African countries of a similar reversal of the neglect of agricultural and rural life. Without doubt, Africa's climate and soils, its rainfall patterns and its poverty, its small markets and large distances, conspire to make the task more difficult than that of other continents. But new knowledge – and the best of traditional knowledge – is now waiting to be widely applied. New varieties of African maize, cowpea, and cassava are at hand. Techniques of inter-cropping and agro-forestry, soil and water conservation, mulching and nitrogen fixation, have been developed and tested. If the focus of policy is shifted to the rural poor – through credit schemes, input packages, extension networks, price incentives, and research which relates to the realities of small farmers in particular areas – then the production breakthrough can be achieved in Africa as well.

But just as health interventions need a delivery and support system, so too does new knowledge in agriculture. Nation-wide systems of agricultural extension workers – bringing new knowledge and techniques to farmers and taking the farmers' own knowledge and reactions back to the research institutes – are what will decide the future of African agriculture. As a recent study sponsored by the United Nations Environment Programme, USAID and UNICEF has concluded:

"*With such national networks in place, Africa's green revolution could begin to make a real impact on a wide scale during the 1990s. In the first half of the decade new varieties of cassava, upland rice and maize will have spread to a large enough acreage to make inroads into the massive food deficits of the more humid parts of Africa. It will not be until 1995 or later that the revolution spreads widely in the Sahel, first with new varieties of cowpea and sorghum and then millet. In countries that do not have effective extension, credit and supply systems, and pricing policies that give farmers an incentive to produce more food, the process will take far longer.*"

Food and employment

As important as advances in food production, is the realization that production is only half the problem. Over 50 million children in South Asia are undernourished today, despite the region's food surplus. And some 25 million children in Latin America are inadequately fed even though their region has become, after the United States, the world's major food exporter.

The problem is not simply one of distribution. It is a problem of what Amartya Sen has called *entitlement* – of not having the income to buy food, or the means to grow it, or the goods to exchange for it. Land reform, employment creation, and income levels are therefore as much a part of improving nutrition as high-yielding varieties of seed. No degree of technical advance, for example, can solve the problem that 80% of Latin America's land is owned by less than 10% of its people, or that 50% of the farm land in many parts of Asia is in the hands of less than 10% of farmers.

There is no low-cost or short-term answer to this problem. But at its core is the question of productive and remunerative employment of the kind which global growth, in combination with real development, could help to generate. The reversal of today's financial flows in favour of the developing world – via debt reduction, trade agreements, and increased aid – would stimulate demand and create jobs. If that renewed development effort included a conscious focus on the poor majority, and especially on improvements in subsistence agriculture (as it did in such diverse regions as China, the Republic of Korea, Sri Lanka, Taiwan, Thailand, and the Indian state of Kerala during the 1950s and 1960s), then rising farm prosperity would also lead to both better rural diets and rising demand for essential industrial goods. That demand would in turn help to generate more employment and improved diets in urban areas. As the Chairman of the OECD Development Assistance Committee has said in 1988:

"*Our interest in development as an enabling process and our concern for reaching the poor combine into a new look at agriculture. While agriculture has always been important among aid priorities, this*

importance has been mostly on farmers as producers. But, today, there is an increasing recognition that an agriculture-led strategy in most developing countries is also a strategy which reaches a large portion of the people who are poor. It is a strategy which, by increasing rural incomes, also improves nutrition. And it is a strategy which catalyzes other parts of the economy by enhancing demand for goods."

Nutrition

Once seen mainly as a problem of production, then as a problem of distribution, then as a problem of 'entitlement', it is time to add one further layer to the understanding of the nutrition problem and its potential solutions.

Both in scale and in severity, it is the child who is most affected by malnutrition. By the age of five, most of the growth of the child's brain and body is complete. There is no second chance. And if enhancing human capacity is the aim and the measure of real development, then there is no greater priority than maintaining the nutritional health of children in these vital years.

But it has become clear in the last decade that lack of food in the home is not usually the main cause of child malnutrition.

Paradoxical as this may seem to a public accustomed to the idea that food shortages, hunger, and malnutrition are virtually synonymous, the fact is that a combination of other factors have an even greater influence on nutritional status. In particular, illness is known to depress the appetite, reduce the absorption of food, drain away nutrients in diarrhoea, and burn up calories in fever. And the sheer frequency of nutritionally debilitating illnesses among children in poor communities is one of the major causes of poor growth.

Of possibly equal importance is the fact that most parents have not been empowered with today's knowledge about the special nutritional needs of the very young child – knowledge about the importance of breast-feeding, about the need to begin adding other foods at the age of 4 to 6 months, about the need to feed a small child twice as often as an adult, about the need to enrich the family's ordinary food with a little oil or fat, about the need to give a child small amounts of green vegetables each day, about the need to continue giving food and fluids during illness, about the need to pay special attention to feeding in the week after an illness so that the child can 'catch up' on the growth lost, and about the need to regularly check that a child is gaining weight from one month to the next.

In addition to all of these factors, poor nutritional health in pregnancy can lead not only to low birth weight but also to the malnutrition of the child in its early years. Maternal health, and the spacing of births at least two years apart, are therefore also major factors in child nutrition. "*In the past*", says Edgar Mohs, a former Director of the National Children's Hospital and present Minister of Health in Costa Rica, "*we believed that the lack of food was a major cause of illness and malnutrition. We have now started to accept that family spacing, breast-feeding, and the control of infectious disease are the keys to eradication.*"

Absolute shortage of money and food remains, for many millions of families, a problem which only economic growth and social justice can resolve. But the majority of families in the developing world today can afford an adequate diet for their children. And an indispensable part of the solution to the food problem is the mobilizing of all possible resources to inform and support parents in the use of today's nutritional knowledge (panel 13).

In particular, the technique of *growth monitoring* could become the means of achieving this. Regular monthly weight gain is the single most important indicator of a child's normal development. And growth monitoring – by monthly weighing – makes it possible for parents to acquire new knowledge in the dynamic and immediate context of their own child's actual progress. Entering the results of each monthly weighing on a growth chart can make the child's normal growth, or the lack of it, visible to the parents on whom that growth depends. If the chart shows that a child has not gained weight, then parents and health worker can together run through a check-list of possible causes amounting to a

catechism of today's nutritional knowledge – Is the child being breast-fed? Is powdered milk being overdiluted, or mixed with impure water, or fed from an unclean bottle? Is the child being weaned too early or late? Is feeding too infrequent? Is food too bulky and low in energy? Is the child fully immunized? Does the child have frequent illnesses? Is food withheld when the child has diarrhoea? Does the child have a fever? Does the child have greens mashed into its food? Does the mother know about 'catch-up' feeding?

In the last ten years, very few nations have taken advantage of the growth monitoring technique on a national level. Yet where it has been seriously attempted, as in Indonesia, it has proved its particular usefulness in the struggle for nutritional health. A large-scale, World Bank-assisted project in Tamil Nadu, India, for example, has used growth monitoring by village health workers as part of a programme which has reduced child malnutrition by 50% in 9,000 villages at a cost of approximately $10 per child per year. Similar results have been reported from Indonesia and from other major studies in recent years.

In practice, growth monitoring is inseparable from the strategy of primary health care briefly summarized earlier in this report. It contributes to PHC because it promotes knowledge and empowers communities to protect their own health. But it is also a method of extending PHC into the community, establishing regular contact between parents and health services, detecting the early signs of disability, and opening up the channels for more qualified help to be called upon.

Finally, growth monitoring could provide the right context for the food subsidies and nutrition programmes which have so fallen from favour in recent years. The currently widespread notion that 'nutrition programmes don't work' is largely the result of programmes which attempted the technically difficult and expensive task of rehabilitating the already malnourished child – often to see that child return to the clinic a few months later because malnutrition's causes had not been adequately addressed. Growth monitoring programmes, by contrast, seek to empower parents to *prevent* malnutrition by improved feeding practices and the prevention of illness. If, in this attempt to deal with causes, it is suspected that lack of money or food is the bedrock of the problem, then food subsidies or supplementary feeding programmes can be used in the most efficient way. Growth monitoring could therefore be a way of gearing available food to improvements in nutrition and targeting supplementary feeding programmes to those most in need.

In sum, increased food production, and even improved distribution or enhanced 'entitlement' to food, are not usually sufficient to solve the malnutrition problem. It is every bit as essential to empower families with the knowledge to take the wider range of actions necessary to convert available food into nutritional health.

Water and sanitation

Along with health care and nutrition, clean water and safe sanitation are basic to human well-being and therefore to real development. And it was to accelerate progress on this front that the United Nations established the International Drinking Water Supply and Sanitation Decade (1981–1990).

Now drawing to an end, the decade has been a co-operative effort between United Nations agencies and governments throughout the developing world.* And it has achieved a great deal. Since 1980, clean water has been made available to an additional 700 million people and sanitation to another 480 million. In particular, tremendous gains have been made against daunting logistical and management problems in nations such as China, India, and Pakistan.

Despite this progress, the overall aim of 'safe water for all' will not be achieved by the target

* International action for the Decade is co-ordinated by a steering committee chaired by the United Nations Development Programme (UNDP). The committee includes eleven United Nations agencies of which five are responsible for the major inputs – the United Nations Department for Technical Co-operation for Development (UNDTCD), WHO, the World Bank, UNDP, and UNICEF.

date of 1990. In the rural areas of the developing world, 60% of families are still without safe water and 85% are without adequate sanitation. In towns and cities, the position is predictably better: 23% do not have access to safe water supplies and 42% are without safe sanitation.

The original target was, it should be admitted, never a realistic one. By contrast, there are much more solid reasons for asserting that 'water for all' can be achieved in the decade ahead.

The main brake on progress has been high per capita cost. But technical advances from PVC pipes to improved gravity-fed systems, from lighter and cheaper drilling rigs to more reliable hand-pumps, have now reduced those costs more than it was thought possible. In comparatively recent times, for example, a deep well in a hard rock area could take a year to install; today, a $50,000 drilling rig can go through hard rock to water in a single day. In the mid-1970s, the failure rate for hand-pumps in India was 70%; today, it is less than 10%. A decade or so ago, there was very little international literature on the comparative costs and benefits of different water supply systems; today, the World Bank has published the results of field tests on 2,700 hand-pumps of 70 different kinds in 20 different countries.

As a result, improved technique alone has brought down the per capita cost of clean water supply to perhaps one thirtieth of its 1970s level.

Equally important, experience has also been gained of more efficient strategies. Twenty years ago, for example, it was widely believed that a well installed by a team of visiting experts was enough; today, it is known that success depends on the community's being involved in the planning, siting, constructing, installing, and maintaining of its own water supply. In the past, it was thought that clean water supplies would automatically reduce the 80% of diseases which are water-borne; today, it is known that clean water has very little impact on health unless communities are also well informed about basic hygiene and disease prevention. In the 1960s, many nations believed that nothing less than piping water to taps in each home was worth striving for; today, most governments are agreed that piping water to conveniently located standpipes in each community is the strategy which stands the most chance of making clean water available to all. Ten years ago, there was no adequate network for sharing technologies and experience in water and sanitation; today, co-operation between the five United Nations agencies involved is a model of international service to national governments in the sharing of experience and the efficient provision of technical advice.

The overall impact of these gains in both technique and strategy, according to a report presented to UNICEF's Executive Board this year, is that "*the feasibility of nation-wide coverage has increased dramatically*". In Asia the cost of clean water supply has been reduced to about $1 or $2 per person per year. In Africa and Latin America, per capita cost is slightly higher, at about $5 per person. Nigeria, for example, is now attempting a total programme to provide clean water supply and hygiene education at a cost which works out, including all operating and maintenance costs, at approximately $5 per person per year.

All in all, the real costs of achieving 'water for all' have been reduced to about *one third* of the amount estimated ten years ago. There is therefore every chance that one of the most basic of human needs could be met within the next ten years. But the money to do it will have to come not only through increased aid for water and sanitation but also through a re-allocation of the resources already available. Approximately 80% of the $12 billion a year currently being invested in water and sanitation, for example, is devoted to installing services for the better-off at an average per capita cost of $600.

Clean water and safe sanitation for all is an obvious priority for real development. Properly used, they can benefit health, boost productivity, save the time and labour of women, and improve the quality of everyday life. It is therefore now time to increase the resources available and put new knowledge to work on a scale commensurate with need. Inadequate technologies and strategies, leading to high per capita costs, were perhaps legitimate reasons for the failure to meet

the water and sanitation targets of the last ten years. There can be no such excuse for the next ten.

Housing

Decent housing ranks alongside health care, nutrition, water, and sanitation in the priority needs of all communities. The poor are just as concerned as anybody else about housing which is safe and convenient, and about homes which are comfortable to live in and aesthetically appealing. The majority, in all countries, aspire to a house which is not just somewhere to shelter in but somewhere to take pride in.

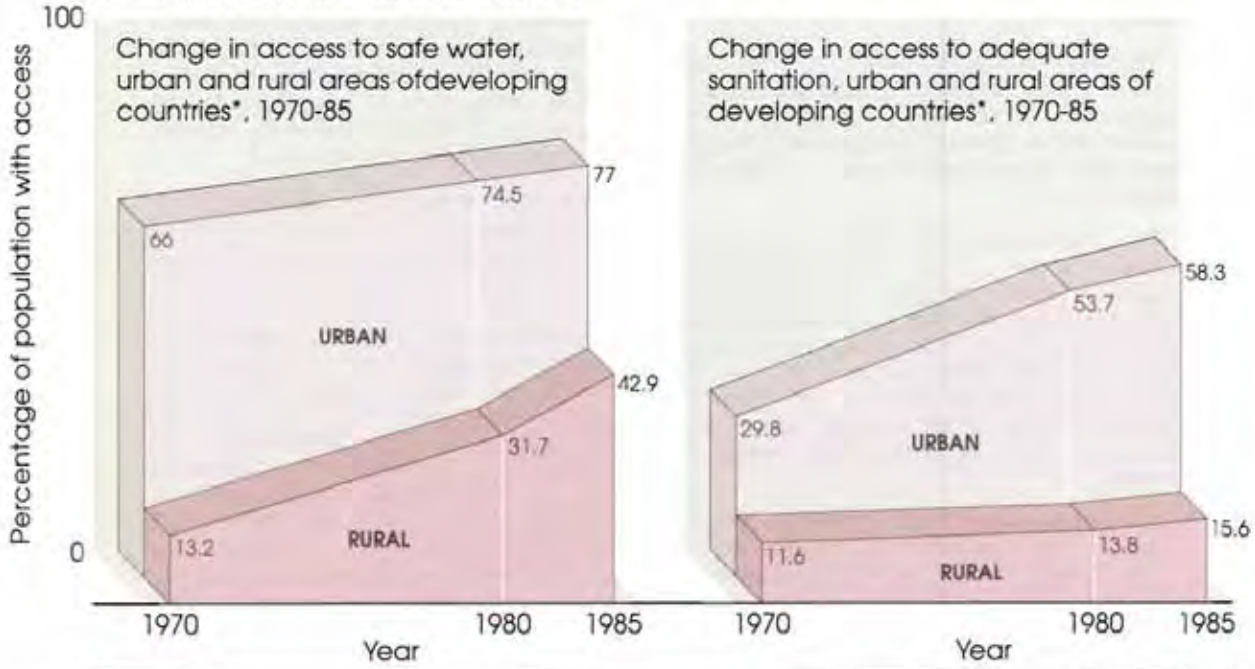
It is difficult to take pride in many of the overcrowded dwellings which today house the poorest 25% of the developing world's people. Often illegally erected and occupied, they may thereby be denied even the basic municipal services. In such conditions, a daily struggle is waged to maintain not only family health but basic human dignity and self-respect.

Only productive jobs and rising incomes can allow the poorest 25% to fulfil their aspirations for a decent home. Yet the lessons of the last ten or fifteen years have shown that there are ways of making far greater use of whatever government and municipal resources might be available.

Ten or fifteen years ago, the bulldozer was a favourite solution to the problem of settlements which to the better-off were slums and which to the poor were homes. As a strategy, it failed for the basic reason that the poor had nowhere else to

Fig. 15 Improvements in water supply and sanitation

Real progress has been made since 1970 in providing safe water and adequate sanitation. In rural areas the percentage of people with safe water supply has trebled. In urban areas, access to adequate sanitation has doubled. Rural sanitation lags far behind.



Source: 'International Drinking Water Supply and Sanitation Decade: mid-decade progress review', World Health Organization, Sept. 1988 update.

*Excluding China

Africa: The Bamako Initiative

More than 20 nations in sub-Saharan Africa are now drawing up plans for the Bamako Initiative, a major new international effort to make primary health care universally accessible to mothers and children by the mid 1990s.

The mainspring of the Bamako Initiative is the idea of decentralized, self-sustaining primary health care. Communities share in the financing and management of local primary health services, which are maintained by the proceeds from selling essential drugs.

Adopted by African Health Ministers in Bamako, Mali, in September 1987, the plan was strongly supported at the May 1988 Addis Ababa summit meeting of African Heads of State. UNICEF and WHO have drawn up guidelines for the initiative which have been endorsed by Africa's Ministers of Health.

Recently, virtually all African countries have expanded their networks of health centres and health posts. Large numbers of village health workers (VHWs) have also been trained to provide basic health services and information to their own communities.

But in today's economic climate, many governments are unable to provide the essential drugs, medical supplies, transport, fuel and money needed by these 'front line' health services. As a result, many village health posts are no longer functioning. Many VHWs also drop out because their communities are unable to pay them or because they lack drugs, supplies, support and supervision from the district health centre or hospital.

But experience has shown that most people are willing to pay for medicines. Most already pay far too much for drugs which are either inappropriate or of poor quality. The Bamako Initiative therefore aims to provide a steady supply of essential drugs which can be sold by village health workers at prices high enough to replenish the drugs and produce a cash surplus for the community to spend on health.

Success depends partly on decentralization of management and partly on governments implementing an essential drugs policy. But the aim is more than essential drug supply: it is to strengthen and extend maternal and child health care and to promote community involvement in decisions about local health priorities.

The Pahou pilot project in Benin illustrates the general principle. Here, VHWs selected by the community purchase 16 basic drugs from the district health centre, where they replenish their supplies each month. The VHWs sell their drugs to patients at a mark-up which the community retains for purposes such as paying the VHW's salary, providing free or subsidized drugs to the poorest, maintaining the village health post, or funding small health projects. Supervisors check the VHWs' drug inventories, petty cash and account books. Responsibility for deciding how the money is spent rests with the village health committee.

During the initial years of the Bamako Initiative, money generated from the sale of drugs (which have been provided free by aid donors) will be used to expand maternal and child health services, maintain universal immunization, and establish revolving drug funds at district and national levels. On current estimates for the first three years, the cost of providing essential drugs (including vaccines and syringes) to 130–200 million people will be about $0.50 to $0.75 per person per year. The total external aid required for this initial period amounts to $180 million, and the scheme is expected to require external financing of $100 million a year until the late 1990s. Discussions are currently underway with several major donor nations who see the Bamako Initiative as a practical means of investing in the long-term future of Africa's mothers and children.

go and therefore kept coming back to rebuild new homes amid the ruins of the old. In some places, public housing schemes were also attempted; but survey after survey showed that public building schemes and high-rise apartments rapidly also became high-cost and high-rent. They therefore rarely benefited the poorest 30% of urban populations and did little to halt the spread of illegal and inadequate housing.

More recently, new and better methods have been pioneered. And although solutions obviously differ from country to country, the United Nations Centre for Human Settlements has drawn two main lessons from housing improvement efforts in the developing world over the last decade.

The first is that the greatest resource for improvement in the quality of housing for the poor is the resourcefulness of the poor themselves. The solution does not therefore lie in destroying that resourcefulness by bulldozing homes; or in taking away all incentive by refusing to provide basic services; or in attempting to resettle communities many miles away from their only realistic sources of employment; or in strangling all initiatives in the red tape of building regulations often dating from colonial times. The solution lies instead in liberating that energy and motivation by making settlements legal; conferring security of tenure; allocating unused urban lands to the poor; abolishing the worst aspects of landlordism; tearing up building regulations which make the best the enemy of better; and providing credit and training and cheap building materials through the organized communities of the poor themselves.

The second and related lesson is that municipal resources are best used not for limited attempts to build new homes but for large scale upgrading and 'site and services' schemes catering to the majority. Working with community organizations to create a basic infrastructure of services – roads, sewers, water supplies, electricity lines – existing communities can be transformed and new communities can be established through the energy and the ingenuity of the people who are to live in them. External resources are therefore best concentrated on schemes which make it worth while for the poor to improve their own homes and their own environments by their own efforts.

These lessons, arising from experience in many developing nations, are beginning to be put into practice. In Hyderabad, India, to take one of the better-known examples, the neighbourhoods which are home to the poorest 25% of the city's families have been transformed, in the last ten years, into clean, well-lit settlements of modest brick houses with piped water and an efficient sewage system. With the participation of the community, a basic infrastructure of asphalt roads, electricity lines, tap water, and underground drainage was brought in by the Urban Community Development Department. Families were given the deeds to their own plot of land, plus a 1,000 rupee ($78) subsidy and a 7,000 rupee ($546) low-interest loan. With a further 2,000 rupees ($156) of their own capital, families could then construct their own home, normally consisting of two rooms and a separate toilet. In short, the lessons of recent experience have been creatively applied in order to improve the ratio of resources to results. Life in the new communities is not perfect; it is not where the middle classes would choose to live; and the poor themselves may legitimately aspire to something better. But it is nonetheless a very significant improvement on what was. And it has been brought about at a cost which makes it feasible to think of comparable improvements for the poorest communities everywhere.

Basic education

Lastly, in this brief overview of what progress might be made in real development over the next ten years, we turn to primary education and literacy.

The boost which the experience of the last ten years has given to the prospects for universal primary education lies not so much in new and cheaper techniques but in the growing realization that education enhances the investments made in almost every other aspect of the development effort. In other words, the cost-benefit ratio has changed, but through an increase in perceived benefit rather than a reduction in per capita cost.

There is also an intangible human dimension to those benefits in a world where, increasingly, to be illiterate is to be excluded. If the enhancement of peoples' capacity to improve their own lives is the main aim and measure of development, then nothing could contribute more directly to its achievement than education and literacy.

Today, the tangible symptoms of that process are also becoming clearer as research correlates education ever more closely with social advance. Agricultural production among poor farmers has been found to be up to 25% higher among those with even four years of schooling; smaller family size has also been correlated with educational levels even when income differences have been allowed for; and the incidence of child death and child malnutrition has been shown to be very significantly lower in the families of women who have completed primary education.

For many years, it was assumed that maternal education was simply an indicator of a family's socio-economic level, and that it was this, rather than the education itself, which explained the strong correlation with child health. But in recent years many studies have shown that, far from being just a proxy for income levels, maternal education is one of the most powerful levers – in its own right – for raising levels of family well-being. "*The evidence on the significance of the relationship is unequivocal,*" concludes the World Bank in its review of such studies, "*maternal education is closely related to child health whether measured by nutritional status or infant and child mortality.*"

Whether it be a farmer improving his or her output, or a mother protecting the normal development of her child, or a couple deciding to postpone the next pregnancy, or a community participating in a water supply and sanitation scheme, education catalyzes the process by replacing resignation with a degree of confidence, acceptance with an awareness of choice.

The value of that process is beyond purely economic calculation. But overall, the World Bank's researches on this subject have led to the conclusion that investment in education yields a return which is normally higher than the investment in physical capital. "*World-wide experience over the two past decades,*" concludes the Bank, "*demonstrates that education is a prudent economic investment, one that consistently earns high rates of return. Research also shows that returns are particularly high for educational investment in the poorest countries.*"

On any and all of these grounds, a minimum of four or five years in school for every boy and girl is therefore another obvious priority of real development.

In 1986, the percentage of 6-to-11 year old boys and girls in primary schools is approximately 100% and 99% respectively in Latin America, 69% and 45% in South Asia, and 80% and 65% in Africa. In other words, the proportion of children in school has doubled, despite a doubling in the absolute numbers of children over the last forty years. Such enrolment figures represent one of the developing world's greatest achievements. But the percentage of those enrolled who *complete* four years of education is very much lower in all regions – especially for girls. And it now appears that drop-out rates are rising, sometimes to as high as 50%, and that enrolment rates are falling as a direct result of adjustment to recession. On present trends, it therefore seems likely that the children of the poorest 15–20% of families are going to be excluded from literacy for decades to come.

It would be a tragedy if that were allowed to happen – if the spread of education were to stop short after coming so far. One of the greatest challenges for development in the next twenty years is going to be the challenge of reaching the very poorest groups and creating the conditions in which they can improve their own lives. Without education, that challenge will be many times more difficult.

But with limited public funds, and fierce competition among different government ministries, education is today struggling even to hold its own in a majority of the developing nations. In half of those nations, spending per pupil has actually declined in the 1980s (fig. 9). And if the great gains of the 1960s and 1970s are not to be lost, then more government resources, and more aid, will have to be allocated to schools.

At the same time, the experience of recent years must be gleaned for the ways and means of improving the cost-effectiveness of the educational effort. And from the important body of research on this subject, it is clear that the one great opportunity for increasing efficiency and restoring the momentum of primary education lies in the reshaping of educational spending.

At the moment, the pyramid of educational spending, like the pyramid of health spending, stands firmly on its apex. In the developing world as a whole, over 50% of government spending on education is devoted to secondary schools and higher education, catering for about 30% of the population. As the 30% who attend secondary schools and colleges are usually, if not exclusively, from the higher-income groups, such a pattern of spending means that public funds, including aid, are largely being devoted to the already better-off sections of society. Foreign aid for education helps to reinforce that distinction, with only 1% of all aid going to primary schools.

This bias towards the few rather than the many inevitably affects the quality as well as the quantity of education. In most cases, primary education is designed to prepare and select the 20% to 30% who will go on to secondary school. It therefore is designed to fail 70% or 80% of its intake, who then leave with an education relevant to crushed hopes rather than present realities.

In other words, education needs its own equivalent of the primary health care strategy, bringing the same twin principles of efficiency and equity to the allocation of educational resources. It is to discuss this need that UNESCO, the World Bank and UNICEF have convened a conference, for the fall of 1989, on the theme of 'basic education for all'. The hope is that this meeting will distil the experience of many nations and help to point the way forward in education in the same way that the Alma Ata conference of ten years ago lit the path towards primary health care.

Such a reshaping of priorities in education would not only allow progress to be maintained towards the point where all children were able to complete a very minimum of four years at primary school, it would also increase the *efficiency* of education as a tool for real development. As another World Bank study has concluded:

"*Current financing arrangements result in the misallocation of public spending on education. There is evidence, deriving from the effect of schooling on earnings and productivity, that in many countries the average dollar invested in primary education returns twice as much as one invested in higher education. Yet governments in these countries heavily subsidize higher education at the expense of primary education.*"

Reinforcing this case are the practical examples set by the Republic of Korea and Taiwan, whose economies have pulled so strongly in the last decade and whose investments in primary education in the 1960s were among the highest. In both cases, and in contrast to what was happening in much of the rest of the world, charges were instituted for secondary and tertiary education, while primary schooling was made freely available to all.

Once again, the political difficulties involved might be eased by a real development pact which significantly increased the amount of aid available for *primary* education.

Literacy

There are techniques and strategies which can boost education and literacy at low cost. A strong political commitment to the task has enabled Tanzania, for example, to achieve a remarkable 90% literacy rate, from a base of only 30% in 1971, by mobilizing university students and secondary school leavers, retired teachers and specially trained itinerant tutors, in an adult literacy programme which has shown what can be done even in the face of the most severe economic difficulties. To maintain high literacy levels, a shift system has been introduced into some primary schools, doubling their capacity. Parents have been mobilized to build classrooms, and out-of-college training programmes have rapidly increased the number of primary school teachers. Burma too is approaching universal literacy after a campaign which, starting in 1965, has mobilized workers, peasants' associations, youth move-

ments, the mass media, and thousands of university students and volunteer teachers with only two weeks training. Other countries have promoted literacy by enlisting the support of monastic and Koranic schools, and by mobilizing the literate population in 'each one teach one' campaigns. At a cost of between $20 and $30 per person reached, adult education programmes are a way of short-circuiting progress towards universal literacy and, incidentally, helping to overcome some of the problems associated with educating the children of illiterate parents.

But if high literacy rates are to be maintained, then there is ultimately no substitute for universal formal education. The costs are relatively high and the opportunities for reducing them are few. Some countries have tried double-shift systems to expand the places available. Others have tried to increase resources through reducing the salaries of teachers, increasing pupil-teacher ratios, recruiting less-qualified teachers, and experimenting with the community financing of schools. In the process, a great deal has also been learned about what kinds of spending *within schools* have the most effect on performance. Reviewing over 70 studies on this topic, the World Bank has concluded that textbooks, writing materials, and teacher quality have consistently more impact on achievement then class size or teachers' salaries.

Such knowledge can be a valuable aid to increasing efficiency. But there are strict limits to how much per capita costs can be reduced before the loss of quality begins to undermine both the effect of, and the demand for, primary schooling.

There are few short cuts in education. And it will never be cheap. But there is a great opportunity in the years ahead to increase both the resources available and the efficiency with which they are used. That opportunity lies in the restructuring of the educational pyramid, assisted by more external aid, in order to achieve the real development objective of at least four or five years in school for every child.

Synergisms

Despite very great difficulties, a real development pact could enable the developing world to make quite dramatic progress in meeting basic needs, and enhancing human capacity, through competent health care, adequate nutrition, safe water, and primary education, between now and the year 2000.

The greatest of all efficiencies would then begin to make its presence felt as these basic elements of social progress began to multiply each other's effectiveness.

In broad terms, improvements in water supply and nutrition, health care and education would help the poorest to come closer to their potential, improve their incomes, and contribute more productively to the kind of economic growth which could sustain social advance into the future. At a more detailed level, a thousand smaller synergisms would reverberate between the basic elements of real development: female literacy would help birth spacing programmes; fewer pregnancies would improve maternal and child health; better health would improve both school attendance and performance; improved schooling would lead to increased agricultural productivity and higher incomes; improved incomes would in turn benefit diets, child health, and survival rates; fewer child deaths would help to lower birth rates; smaller families would mean healthier mothers and children.

All of the basic elements of social and economic development are therefore linked together in a mutually retarding or mutually reinforcing relationship which can either minimize or multiply the investment in any one sector. And the quantum leap in the ratio of resources to results will only come when all of the basic elements of human development discussed in this chapter begin to add up to a whole which is very much greater than the sum of its parts.

Seven sins

As the previous chapter has tried to show, international development efforts of recent years have yielded a range of techniques and strategies which could accelerate real development even in the difficult decade which lies ahead. But those years, and the reflections and experience of many of the people and organizations most closely involved, have also yielded some vitally important principles which have often been found to make the difference between success and failure.

The principles themselves are well-known to most of those who have been engaged in the development efforts of recent times, but in surveying the main means of accelerating social progress for children and their families, it would be a travesty to omit those hard-won 'guiding principles', forged from the failures as well as the successes of the past. And at the risk of being too harsh on such efforts, those principles may be briefly summarized under the heading of development's 'seven deadly sins':

1. *Development without infrastructure*: Most of the cost-effective techniques now available, from immunization to oral rehydration therapy, new seed varieties to new hand-pumps, are of little value without a reliable delivery mechanism for informing and supporting the majority in using them.

In this context, the words of Dr Halfdan Mahler, on his retirement after fifteen years of successful leadership as the Director-General of the World Health Organization, are as relevant to every other aspect of development as they are to health:

"To strengthen their self-reliance, countries have to build up their own health infrastructure....The backbone of that kind of infrastructure is made up of properly trained staff and informed people."

As we have seen in many countries in the 1980s, 'delivery' can depend as much on demand as on supply. The promotion of specific improvements such as immunization or new varieties of seed therefore also has a role in building and strengthening delivery mechanisms.

2. *Development without participation*: Sustained development ultimately depends on enhancing people's own capacities to improve their own lives and to take more control over their own destinies. External assistance, whether from capital city or foreign country, cannot long be the star of the show, and must learn the skills of the supporting role. Whether in agriculture or industry, water supply or housing scheme, development experience to date has shown that there is an absolutely crucial distinction between the kind of assistance which enables and involves and the kind which alienates and disenfranchises. The success or failure of any development effort will usually depend on which side of that sometimes subtle line such assistance falls.

3. *Development without women*: The women of the developing world are responsible for producing and marketing most of its crops; they also carry the main responsibility for food preparation and home-making, for water and fuel, for nutrition and health care, for hygiene and for the education of the young. Not least, they are almost entirely responsible for the physical and mental development of the next generation. Yet in development assistance efforts to date, most of the education and training, the technology and the inputs, the investments and the loans, have gone to men.

That imbalance is difficult to correct because it is part of a landscape of fundamental social inequities in all countries. But the inefficiency involved in this bias, not to mention its injustice, costs the development effort dear. The effects of female education on family size, child health, and the use of available government services have already been mentioned. But the possibilities for increased productivity and incomes through credit, training, and technology for women have hardly begun to be explored. Similarly, investments in safe motherhood (see pages 40 to 41) and in labour-saving devices of particular relevance to women (such as more fuel-efficient methods of cooking and less labour-intensive ways of procuring the family's water and fuel and preparing its food) are among the most productive but the most ignored of all investments in social and economic development.

4. *Development without environment*: Fifteen years ago, it was widely thought that the environment was an industrialized world problem, a

Polio: the end in sight

In May 1988, representatives of 166 nations, meeting at the World Health Assembly in Geneva, took the historic decision to attempt to eliminate poliomyelitis from the planet by the year 2000.

In the industrialized world, the disease is almost eradicated (as recently as the 1950s, tens of thousands of cases of paralytic polio still occurred annually in Europe and North America). But in the developing world, polio still paralyses over 250,000 children a year and kills another 23,000.

Today, vaccines* are also beginning to lift the burden of polio from Africa, Asia, and Latin America. In the last twelve months, immunization has prevented approximately 220,000 cases of paralytic polio in the developing world.

The World Health Organization's Expanded Programme on Immunization (see panel 1), targets polio as one of the six major vaccine-preventable diseases. Only ten years ago, fewer than 5% of infants in developing countries were being immunized. Today, 55% of the infants born each year in the developing world receive three doses of oral polio vaccine by the age of 12 months. In countries such as Botswana, Brazil, China, Cuba, Egypt, Nicaragua, Republic of Korea, Saudi Arabia and Tunisia, 80%–90% of infants are already fully vaccinated against polio. Algeria, the Dominican Republic, India, Indonesia, Iran, Iraq, Kenya, Mexico, Pakistan, Tanzania and Turkey are among those confidently expected to reach the 80% mark by the year 1990.

In many countries, coverage has doubled or trebled in a six-month period through national vaccination days involving tens of thousands of volunteers. Others have taken a more gradual approach, building up routine vaccination services through the primary health care system.

One dark cloud on the horizon is the recent rise in drop-out rates in Africa south of the Sahara. Polio immunization normally requires three doses of the vaccine, and the drop-out rate is the percentage of those given the first dose who fail to turn up for the second or third doses. Going against the worldwide trend, which has seen a 25% fall in drop-out rates since 1984, the rate in sub-Saharan Africa has actually risen slightly from 36% in 1984 to 37% in 1987 (but against a much higher level of initial coverage). In some dozen countries the drop-out rate exceeds 50%.

The global elimination of polio, like that of smallpox, is technically feasible since the virus is transmitted by infected persons for only a few weeks and neither multiplies outside the human body nor transmits itself via animals. As with smallpox, a vaccine which is safe, effective, cheap, and simple to administer is already available. But unlike smallpox – which was controlled mainly by immunizing the close contacts of those infected – the eradication of polio will require maintaining high coverage levels (of the order of 90%) among children under the age of one year for some years even after no further polio cases are reported.

For all vaccines, a key to high and sustained levels of coverage – and low drop-out rates – is the involvement of political leaders, the media, community leaders, educators, and private voluntary organizations. In the fight against polio, in particular, Rotary International has made an outstanding contribution, raising the staggering sum of $240 million in voluntary contributions through its worldwide 'PolioPlus' programme. Just as important, thousands of Rotarians – often leaders in their communities – have become personally committed to the polio programme and brought influence, know-how and resources to the task.

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* There are two polio vaccines. Inactivated polio vaccine (IPV), given by injection in at least two doses, was first introduced in 1955. In 1961 an orally administered, live polio vaccine (OPV) was introduced and is now the most widely used. Three doses of OPV are required for immunity.

function of affluence, and of little relevance to the developing world. Today, the deforestation of lands, the erosion of soils, the silting of lakes and rivers, the new propensity to drought and flood, and industrial disasters such as the Bhopal tragedy, have shown that the environment is also a third world problem. At the same time, rising concern over the depletion of the ozone layer, the possible warming of the earth's atmosphere, and the unknown consequences of the destruction of the world's tropical forests, should have made it clear to all that the environment is *everyone's* problem. The Brundtland Report, 'Our Common Future', bringing together the experience of the last decade, argues that in every development initiative the environment ought to be a part of the forethought not the afterthought:

"*There has been a growing realization in national governments and multilateral institutions that it is impossible to separate economic development issues from environment issues; many forms of development erode the environmental resources upon which they must be based, and environmental degradation can undermine economic development. Poverty is a major cause and effect of global environmental problems. It is therefore futile to attempt to deal with environmental problems without a broader perspective that encompasses the factors underlying world poverty and international inequality.*"

5. *Development without the poor*: Development has for too long been confined to showcase examples and pilot projects. Such demonstration projects have shown what can be done; the emphasis must now shift towards *doing it*. In the 1990s, the great need is to apply the knowledge we already have on a scale commensurate with need.

'Going to scale' in this way means reaching not just 50% or 60% but almost all families. Whether we are talking of immunization services or primary schools or agricultural training, there is a tendency to assume that reaching half or two thirds of a given population is enough. The fact is that the problems of malnutrition, poor growth, frequent ill-health, child deaths, maternal mortality, illiteracy, and low productivity are concentrated among the *poorest* third of the developing world's families.

This challenge of reaching the very poorest is the greatest challenge in social development. Over the last ten years, almost every initiative – large or small – has come up against the same problem of reaching the unreached. Even the most serious and politically difficult attempts at shifting priorities in favour of the poor – via primary schools or adult literacy campaigns, rural clinics or supplementary feeding programmes – have often failed to reach substantial numbers among the very poorest groups.

There is no one answer to this problem. Just as the impact on the environment must now be borne in mind at every stage of every development initiative, so the pressure must be maintained at every stage to keep the focus on the poorest communities. In particular, the pressure must be kept up for the increasing representation of the poor in decision-taking and for the inversion of spending pyramids so that the majority of resources available for development are devoted to action which benefits the poorest.

6. *Development without the doable*: Experts in the various disciplines of development, who must take much of the credit for the knowledge base now available, must also take some of the blame for the failure to implement that knowledge on a significant scale.

Partly because research and development has focused on small-scale and pilot projects, where the ratio of real resources to problems is often artificially high, the plans put forward for development initiatives have often been more appropriate for meetings of development experts than for meetings of cabinet ministers. Often, everything that needs doing has been listed without priorities or politically attractive strategies for doable step-by-step implementation. That is one reason why so many well-informed plans, and so much of the knowledge of recent years, has remained on the shelf of potential. Failure to implement has then been impotently lamented as a lack of political will.

The task facing development experts across all disciplines over the next ten years must be a different one. It is the task of shaping today's knowledge into plans which are capable of attracting what political will is available; politi-

cians must be handed not the blunt instrument of undifferentiated knowledge but the sharp axe of the 'doable'.

Analysing why the dream of universal immunization (fig. 16) is becoming a reality, for example, the Director of WHO's Expanded Programme on Immunization (EPI) comments that "*EPI has been successful because it is inexpensive, easily implemented and easily understood, and because it brings immediate, highly visible benefits. It is good public health, and good politics.*" For all the same reasons, immunization has been well supported by the industrialized nations.

The argument that immunization is different, a special case, has some validity. But the point at issue here is that every effort must somehow be made to endow other aspects of the development process with this same political attraction. It is no use pretending that we live in an ideal world where obvious priorities are automatically implemented. There is fierce competition for resources in every country. And if the development experts are to maximize their contribution to real development in the decade ahead, then the challenge is not the increasing refinement and sophistication of paper plans and existing concepts but the shaping of available knowledge into achievable, large-scale, low-cost, high-impact, and politically attractive plans.

7. *Development without mobilization*: The task of development in the decade ahead is, in large part, the task of putting today's knowledge at the disposal of the majority. In many cases, that task is as important as the creation of infrastructure and services. Immunization facilities will not be sufficiently used, for example, if parents do not know where and when and why their children are to be vaccinated. Clean water supplies will not improve the lives of families who do not have the knowledge to convert that physical facility into better health. Diarrhoeal dehydration and acute respiratory infections will not be defeated unless parents know how to cope and when to get help.

For too long, that task of putting essential development knowledge – and especially knowledge about improving the health and the nutrition of children – has been left to health services which have neither the time nor the training nor the outreach to do that job well. Meanwhile, a communications revolution has given the developing world an unprecedented capacity to put new knowledge at the disposal of the majority.

The time has now come to fully exploit that new capacity. School systems today reach three quarters of the developing world's population. Radio reaches into a majority of its homes, television and newspapers into a majority of its communities. Religious leaders and institutions regularly reach out to, and are heeded by, a majority of parents in most nations. Tens of thousands of non-governmental organizations are now at work in some of the very poorest communities. Government employees, from water and sanitation officials to agricultural extension workers, now reach with varying degrees of effectiveness into most communities. And the hundreds of thousands of CHWs trained in this last decade have brought the health services into contact with a greater proportion of national populations than ever before.*

In the industrialized world, the struggle against the major threats to life and health, such as cancer, heart disease, and AIDS, is increasingly being waged by all the communications resources at society's disposal – its postal services and its billboards, its schools and its health services, its television and radio stations, its newspapers and magazines, its church leaders and its voluntary organizations. The time has come for the developing world to also tackle the major threats to the life and health of its people – including vaccine-preventable diseases, diarrhoeal dehydration, acute respiratory infections, low birth-weight, and maternal mortality (as well as cancer, heart disease, and AIDS) – by mobilizing its social capacity even more effectively in that cause.

In the last decade, nations such as Syria and Turkey, Egypt and Senegal, and many countries

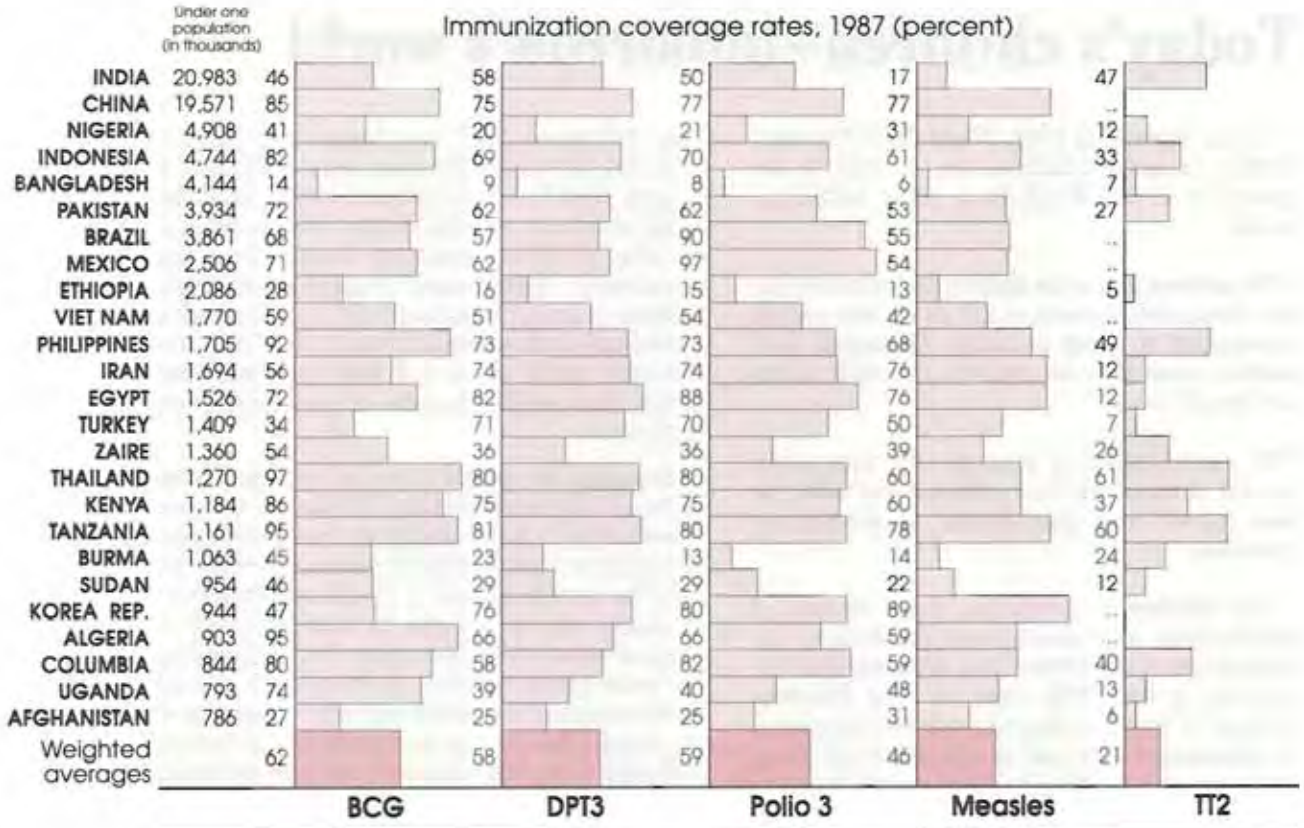
* A forthcoming UNICEF publication – *All for Health* – documents the increasing involvement of all sections of society in the promotion of health knowledge during the 1980s. Intended as a companion booklet to *Facts for Life* (see footnote on page 10), the publication is available by writing to Facts for Life Unit, UNICEF DIPA H-9F, UNICEF House, 3 UN Plaza, New York, NY 10017, USA.

in Latin America have shown what can be achieved by mobilizing this new capacity to inform and support parents in protecting their children by immunization. In the next decade, a broader mobilization of social resources could advance the cause of real development by putting a wide range of vital knowledge at the disposal of all families.

It is no exaggeration to say that the avoidance of these 'seven sins', or, more positively, the observance of these hard-won principles, could more than double the cost-effectiveness of the development effort in the 1990s and beyond. The subject of development, as a conscious discipline, is only 40 years old. For most of those years, progress has been pushing through the sand-

Fig. 16 Immunization coverage, 1987

Eighty-four percent of the developing world's infants live in the 25 countries listed below. The chart shows the percentage of one year-old children in those countries who were immunized against the main vaccine-preventable diseases in 1987. The column for DPT3 shows the percentage of one year-olds who have received the necessary three doses of vaccine against diphtheria, pertussis and tetanus. The column for polio3 shows the percentage with the necessary three vaccinations against polio. The column for TT2 shows the percentage of pregnant women who have received the necessary two injections of tetanus toxoid which protect both mother and new-born baby against tetanus.



For Ethiopia and Columbia, TT2 are 1986 figures. For Nigeria, Tanzania, and Korea Rep., all figures are for 1986.

Source: UNICEF, May 1988.

dunes of often naïve assumptions about the nature of the process. Today, development stands on firmer ground. And it is this base of hard-won knowledge and technique, strategies and guiding principles, which brings significant real development achievements within reach over the decade ahead.

What the priorities should be, within the range of what is now achievable, is a matter for the governments of developing nations. They and their regional organizations will set their own goals according to their own lights. Ultimately, if development is to be an enabling process, people themselves will decide on, and work towards, the fulfilment of their own priorities. This report has so far attempted to illustrate the considerable progress which *could* be achieved, over the next ten years, by means of a *real development pact* between the industrialized and developing nations.

Of particular concern to UNICEF, in this context, is the extraordinary progress which is now possible in the field of maternal and child health in the 1990s. And it is to this specific issue that the concluding chapter of this report now turns.

Today's children – tomorrow's world

In late September 1988, World Bank President Barber Conable concluded his address to the governors of the World Bank group with these words:

"The stubborn fact of the Eighties is that growth has been inadequate, poverty is still on the rise and the environment is poorly protected. Unchanged, these realities would deny our children a peaceful, decent and livable world."

"We cannot afford to give up. We must build, instead, on what has been achieved and what has been learned over four decades of development experience."

For children in particular, those decades of development experience, and particularly the experiences of the 1980s, have demonstrated that progress in the 1990s could be truly dramatic. Because of this, it is time to assert the fundamental importance – for real development – of doing what can now be done to improve the lives and the development of the rising generation.

At this moment, many millions of children are growing up in circumstances which mean that they will never fulfil the mental and physical potential with which they were born. And that is a human tragedy which contains within itself the seeds of its own renewal. Those children will not be able to derive maximum benefit from the educational opportunities available, and their abilities to work productively and to be rewarded accordingly will be similarly restricted. They are therefore likely to be less able to protect the health and normal growth of generations yet unborn.

Breaking this self-perpetuating cycle is central to the development process. Without it, all other investments in water supply or food production, education or basic community services will be less effective simply because a significant proportion of people will not be able to contribute fully to them or benefit fully from them. In the context of all other progress, there is therefore a special need to protect *the mental and physical growth of all young children.* The real possibility of largely achieving this great goal, over the next ten years, is a subject worthy of the notice of the political leaders of all nations. And there are now signs that high-level political attention is beginning to turn in this direction.

In the final communiqué of the May 1988 Moscow Summit, General Secretary Gorbachev and President Reagan "*offered their support for the WHO/UNICEF goal of reducing the scale of preventable childhood deaths through the most effective methods of saving children*" and urged "*other countries and the international community to intensify efforts to achieve this goal*". Similarly, the heads of State of most nations in Africa, Asia and Latin America have, in the last five years, expressed a new commitment to making the breakthrough in the health and development of the world's children (panel 5).

The time may therefore be right to consider a meeting of heads of State – or perhaps a Special Session of the United Nations General Assembly such as was held to consider the crisis in Africa – in order to discuss and prepare for action on the great opportunities now available for protecting today's children – and tomorrow's world.

In addition to its specific agenda, such a meeting might also help to bring the subject of *children* to the centre of political and economic concern. In how we bring up our children are sown the seeds of peace and prosperity or of violence and degradation. And it is time that this obvious premise was acted upon more consistently in both industrialized and developing worlds.* It is time, also, to begin attending to the needs and rights of children not as a mere by-product of progress but as an end and a means of progress itself. The true test of a civilization is how well it protects its vulnerable and how well it safeguards its future: children are both its vulnerable and its future. Investing in their development today – by meeting their most obvious needs and attending with all the wisdom and resources at our command to their physical, mental, and emotional development – is the only level of action which both meets pressing human needs today and leads to the pre-emption and solution of what may otherwise become the almost insoluble problems of tomorrow.

Such a *summit for children* might also help to bring political leaders together not confrontationally across the table of today's problems but co-operatively and facing in the common direction of our common future. Specifically, the overall theme of *'Today's Children – Tomorrow's World'* might provide a lens to focus attention on the convergence of sectoral problems in their human impact and offer also the ten, twenty, or thirty year depth of field which the great issues of environment and poverty so insistently demand.

In the needs of children are combined all of the core issues of development. And there is no natural limit to the breadth of issues which world leaders might discuss in relation to improving the lives of children. But however deep such a conference might slice into its potential agenda, its first priority should be to address the major *specific opportunities* for bringing about the great advance which is now possible in protecting the lives and the mental and physical development of the vast majority of the world's young children.

This report therefore concludes with a summary of the specific achievements which now beckon – and which an international *summit for children* might now help to achieve.

The bubble of protection

The need for special protection for the growing minds and bodies of children under the age of five has been perceived by a great many people and organizations in recent years. Some have described it as a need for a 'protective plastic bubble' over the early years of life. Others have expressed the same thought as a need to artificially raise the socio-economic level of the very young child by focusing resources on those elements in the environment of poverty – poor

* It is also clear, at this time, that a new concern for children is arising in the industrialized world. In the United States today, for example, there is an increasing awareness that 20% of the nation's children live below the official poverty line. And in the Soviet Union, Health Minister Chazov noted at the landmark Communist Party Conference in June of 1988 that "*we are proud of our health care system, but we keep silent about the fact that we are ranked 50th in the world, behind Mauritius and Barbados, in infant mortality.*" An international meeting to focus on children might therefore have its counterparts in individual nations, just as the *International Year of the Child* launched countless national initiatives for improving the lives of children in both developing and industrialized countries.

hygiene, poor health care, poor food, poor feeding practices – which most threaten normal growth and development. Still others have talked, more dramatically, of constructing a 'bridge over the valley of death', referring to the need to use today's knowledge to construct a safe means of crossing the dangerous period from about the sixth month of life to about the age of two – the period when most of the damage to health and growth is done.

However that need is expressed, the key to the meeting of it is the empowerment of parents.

From the moment of conception to the end of the first six months of life, the environment of the child *is* the mother. In that period, the decisive factor in the child's survival and growth is the mother's nutritional health. From the age of six months onwards, the environment of the child is increasingly the home and the community. If that environment is characterized by poverty and poor services, then it poses a multitude of new threats. And in this period, the decisive factor for the safety of the child is the parents' and especially the mother's *ability to protect*.

Creating a barrier around a child's most vulnerable years therefore comes down to improving first the health of mothers and then the capacity of parents.

The agenda of any new international commitment to children must therefore look first to the major advances which are both necessary and possible for *women*.

This need coincides with another of the obvious priorities of real development. For the sake of women as women, and not just as mothers, urgent action is necessary to reduce the terrible toll now being taken on women's lives and health by the processes of pregnancy and childbirth. By making knowledge about birth-spacing universally available, by enrolling all pregnant women for basic pre-natal care (including tetanus injections and supplementary feeding where necessary), by ensuring that a trained person is present at every birth, and by organizing referral services for emergency obstetric cases, primary health care could reduce by *more than half* the developing world's appalling maternal death rates.

The knowledge exists to achieve a reduction on that scale at a cost which every developing nation can afford to begin implementing and every industrialized nation can afford to support. This is not a question of possibilities. It is a question of priorities. And if the world's media could find any way of bringing to the world's attention the often agonizing and lonely 'maternal deaths' of half a million women every year, in the same way that the sufferings of drought or famine are brought before the conscience of the world, then it would surely not be long before the world would demand that something be done.

Such a reduction in the quantity of women's deaths would also be some measure of improvement in the quality of women's lives. And for many millions of children, that improvement in their mothers' health would also mean a healthier infancy, including better nutrition before birth and less vulnerability to infection and poor growth in the first few months of life.

One important consequence would be a fall in the incidence of low birth-weights. At the moment, approximately 20% of the world's babies are born weighing less than 2,500 grammes*. Those infants are approximately twice as likely to become malnourished and twice as likely to die in childhood as babies of normal weight at birth.

Reducing the prevalence of low birth-weight to less than 10% by the year 2000 might therefore be one of the first goals of *real development* which an international conference on children could consider adopting. It is a goal which, if reached, could protect the lives and the health of many

* The problem is particularly acute in South Asia, where almost one third of all babies are born with low birth-weights. Such a figure reflects the very poor health and nutritional standing of pregnant women (not only during their pregnancies but in their own childhood and adolescence) and the fact that 65% of pregnant women in the region suffer from nutritional anaemia. Poor maternal health is associated with the poor nutritional health of children and so perpetuates itself into the next generation. Improving the nutrition of girls, and providing pre-natal care, therefore suggests itself as one of the most vital leverage points for real development in much of South Asia.

millions of children; and it could only be achieved by protecting the lives and the health of many millions of women.

Parental capacity

The second means of creating a protective dome around the early years of childhood is the enhancement of parents' capacity to cope with the threats to life and growth which come thick and fast – and in direct proportion to the poverty of the family's circumstances – when the child reaches the age of about six months and begins to come into contact with new foods and a new environment.

Today, the means are at hand to significantly enhance that protective ability. By mobilizing all means of communication and support, parents everywhere can be empowered with knowledge about the importance of breast-feeding and immunization; the special nutritional needs of the young child; the need to monitor child growth; the methods of preventing and coping with diarrhoeal disease, respiratory infections, and malaria; the facts about domestic hygiene and protection against common disease.

If parents can be empowered by these means to achieve what all parents desire – the normal healthy growth of their children – *then it should be possible over the next ten years to defeat almost all of the major specific causes of frequent illness, poor mental and physical development, and early death among children under five.*

It is behind this cause that a *summit meeting for children* could rally both the political will and the financial and social resources. With that support, some historic achievements are waiting to be accomplished within a very few years from now. Universal immunization could virtually eliminate deaths and poor growth caused by measles, whooping cough, and tetanus. Polio could be eradicated. Iodine deficiency disorders (including the foetal brain damage which affects tens of thousands of new-borns) and vitamin A deficiency (which blinds at least 250,000 children each year) can be overcome by salt iodation, iodinated oil injections, and vitamin A capsules administered alongside immunization programmes in those areas of the world where they are needed.

Similarly, all parents could be informed about ORT and the ways and means of preventing and coping with the diarrhoeal diseases and respiratory infections which are major causes of death and poor development in children of all developing nations. If that knowledge were backed up by community health workers who could treat or refer the small percentage of cases which are beyond the competence of the well-informed parent, then almost all of the six million children a year who now die from those two causes could be saved.

These few common illnesses cause many more children to die every year, and many more families to go through unimaginable suffering, than all the droughts or famines or floods of the last 25 years. And they probably cause more malnutrition and poor growth than the lack of food itself. Yet no tragedy in today's world is more unnecessary. And it would surely not be allowed to continue if the world were made aware of it in the same way as we are increasingly made aware of the more unusual and more visual tragedies of our times.

There is therefore no question that high-level political commitment to these tasks, including international support, could soon result in the saving of many millions of children's lives each year and the protection of the normal mental and physical growth of many millions more.

This great goal is achievable and affordable in the next decade (fig. 5). The bubble of protection can be created. The bridge across the valley of death can be built. The knife of poverty can be blunted when it comes near to the life of a child. Today, the needs of children can be met, and the capacities of tomorrow's adults can be protected, by empowering parents with present knowledge and supporting them in putting it into practice.

The costs

Special protection for the years from pregnancy to the child reaching the age of five is a

Talloires declaration: protecting children

'Protecting the world's children – an agenda for the 1990s' was the main subject under discussion at the latest meeting of the Task Force for Child Survival held in Talloires, France, in March 1988. The Task Force, established in March 1984 by the World Bank, the United Nations Development Programme, the World Health Organization, the Rockefeller Foundation and UNICEF, periodically brings together health ministers from developing nations and leaders of bilateral aid organizations to discuss progress in implementing today's low-cost, high-impact strategies for protecting the life and health of children. To make public the essence of the three days of discussion in France, the Task Force has issued the 'Declaration of Talloires'. The main points:

○ "Remarkable health progress has been achieved during the past decade. Global recognition that healthy children and healthy families are essential for human and national development is steadily increasing... The international community has become engaged in partnership with national governments in the creation of successful global programmes, ensuring the availability of financial support and appropriate technologies. These include:

○ immunization programmes, which now protect more than 50% of infants in developing countries with polio or DPT vaccines, preventing some 200,000 children from becoming paralysed with polio and over a million children from dying each year from measles, whooping cough, or tetanus;

○ diarrhoeal diseases control programmes which now make life-saving fluids (particularly oral rehydration salts) available for 60% of the developing world's population, the use of which may be preventing as many as one million deaths annually from diarrhoea;

○ initiatives to control respiratory infections which hold promise in the years ahead of averting many of the three million childhood deaths from acute respiratory infections each year in developing countries not prevented currently by immunization;

○ safe motherhood and family planning programmes which are so important in protecting the well-being of families".

The meeting also suggested that the following be considered by national and international bodies as targets to be achieved by the year 2000:

○ the global eradication of polio;

○ the virtual elimination of neonatal tetanus deaths;

○ a 90% reduction of measles cases and a 95% reduction in measles deaths compared to pre-immunization levels;

○ a 70% reduction in the 7.4 million annual deaths due to diarrhoea in children under the age of 5 years which would occur in the year 2000 in the absence of oral rehydration therapy, and a 25% reduction in the diarrhoea incidence rate;

○ a 25% reduction in case fatality rates associated with acute respiratory infection in children under 5 years;

○ a reduction of infant and under-five child mortality rates in all countries by at least half (1980–2000), or to 50 and 70 respectively per 1,000 live births, whichever achieves the greater reduction;

○ a 50% reduction in current maternal mortality rates.

The meeting concluded that: "achievement of these targets would result in the avoidance of tens of millions of child deaths and disabilities by the year 2000, as well as a balanced population growth as parents become more confident their children will survive and develop. The eradication of poliomyelitis would, with the eradication of smallpox, represent a fitting gift from the 20th to the 21st centuries."

Finally, the Talloires Declaration sought to draw world attention to the potential for additional low-cost, effective initiatives to "improve the quality and coverage of educational services to obtain universal primary education and 80% female literacy" and to achieve the "virtual elimination of severe malnutrition of under-five children while also significantly reducing moderate and mild malnutrition in each country".

subject worthy of the attention of political leaders at this time both because of the fundamental breakthrough for development which it would represent and because a high-level political commitment is what is needed if this opportunity is to be seized in the 1990s.

But a *summit for children* might also wish to progress to the broader vision of what could now be done.

This report has tried to show that many of the greatest and most obvious problems affecting children and their families, problems of water and food, health and nutrition, housing and education, are susceptible to low-cost and obvious solutions. To draw attention to these glaring opportunities, the world has held a great many special years and special decades and special conferences in recent years. And such events have played an enormous part in building the knowledge which could today be the base for a new advance. But most of the necessary actions and strategies are now tried and tested, available and affordable. And what is needed in the next ten years is not the advancement of knowledge in narrow confines or the pursuit of development in fragmented pieces but the *mass application of existing knowledge and strategy on all fronts.*

In other words, a *summit for children* might also wish to consider the wider task of making the 1990s into a *Decade of Doing the Obvious.*

That task would obviously have to include considering the scale of resources which would be needed to take advantage of the low-cost opportunities, outlined in chapter IV of this report, for overcoming the worst aspects of poverty by the end of this century. As we have seen, relatively inexpensive methods are available for meeting essential needs in health and nutrition, water and sanitation, education and literacy. But would the *absolute* costs be higher than the ceiling of realism?

There are dangers in reducing such costs to dollars, not least because political commitment and managerial competence are at least as important as financial resources. But in very broad terms, the additional cost of meeting the most essential of human needs would be in the region of $30 to $50 billion per year throughout the 1990s. And in equally broad terms, this cost would need to be met in part by community participation, in part by the bending of government priorities in favour of the poor, and in part by increased international aid for real development.

Strategies and costs would obviously vary a great deal from rural to urban areas and from one country to another (depending especially on the existing level of infrastructure and outreach services). But the development experience of the last 10 to 15 years suggests that national scale action at reasonable cost is now possible in all the main areas of basic human needs.

Experience in low-income developing countries indicates, for example, that primary health care, including essential maternal and child health services, can be made available at a per capita cost of approximately $5 per person per year. Similar experience in education suggest that the cost of primary school for all 6-to-11 year olds works out to an average cost in the region of $25 per child per year. Successful adult literacy programmes have also been managed for a cost of approximately $20–$30 per person who becomes literate. Finally, as we have already seen, piped water supply and basic sanitation can be made available for an annualized cost of approximately $6 per person.

World-wide, the 'absolute poor' now total over 1 billion men, women, and children. But it is clearly impossible to focus the development effort *exclusively* on the very poorest. Water supply or nutrition programmes, for example, have to be put at the disposal of whole villages or urban neighbourhoods if they are to be made available to the very poorest – whose lives are inseparable from the complex social and economic realities of their communities. It is therefore necessary to think in terms of ensuring that essential needs are reliably met not just for the one billion or more who are the absolute poor of the world in the 1980s and 90s, but for the 1.5 to 2 billion people who will constitute the poorest third of the developing world's population.

Applying such costs to such needs suggests that the total sum required would be in the region of

Tanzania: success at Iringa

In December 1983, huge crowds packed the Samora Machel stadium in Tanzania for the launch of a programme to improve the health and nutrition of the nation's children. Over 100,000 people, including musicians, singers, dancers, cultural troupes, sporting teams, the Prime Minister of Tanzania, and the Executive Director of UNICEF took part in the event.

Five years later, the programme is being evaluated. In the 168 villages of Iringa Region, where the programme started, severe malnutrition has been reduced by 60% and young child deaths have been brought down by about 30%.

Programmes consciously designed to improve the nutritional health of children are notorious, among experienced field workers, for their disappointing results. Iringa is an important exception. What lies behind its measurable successes?

The process started, not with the inauguration ceremony, but one and a half years earlier, when development planners began meeting with villagers, government administrators and political leaders in the Iringa Region to ask what they thought of the proposed Nutrition Programme. In the meetings that followed, villagers themselves put forward some of the most radical suggestions. It was at a village meeting, for example, that a community leader first proposed training village people to run the child-weighing programme.

Social mobilization was therefore built in from the outset, and the communities began to feel responsible for the programme.

In the first six months after the launch, mobile teams visited the 168 selected villages. In every village a health committee was formed or strengthened and two village health workers trained. Parents began bringing their children to regular Village Health Days, where they were weighed, vaccinated, and treated for common ailments, and health workers gave parents practical advice.

No new organizations or institutions have been created for the Iringa programme. Tanzania already has an administrative infrastructure extending from central government through to the village. The Iringa Programme has systematically mobilized this infrastructure, with government officers taking responsibility for it as part of their normal duties. At community level, village chairmen and party cadres help extension staff and village health workers to organize activities such as Health Days, latrine construction, income-generating activities for women, the building or renovation of new health facilities, and the cultivation of new drought-resistant crops.

Central to the social mobilization process is the village meeting, the focus of assessment and action. Here, the results of the child-weighing programme are discussed. Among the most common problems are child care and feeding, since most mothers are overworked and do not have time to give their children more than two meals a day. To tackle this problem, a total of 236 child day care centres have been set up, usually in a school classroom or under a shady tree, catering in total for 15,000 children. In most villages an attendant is paid to feed and take care of the children, often using funds from the local government tax returned to the village to support development activities.

The programme makes effective use of all available communication media. Films have proved popular as a means of informing and motivating communities, and health information is also broadcast by radio. A quarterly newsletter, using articles from village correspondents, keeps community leaders in touch with progress in other villages. The child growth chart itself has been useful for involving parents in studying their own children's growth and development. Musicians and cultural troupes also help to communicate health messages at Health Days and special events.

During the past 18 months the programme has expanded to cover all 620 villages in the region. The Iringa approach is now being applied in selected districts of six other regions, and nationwide extension is being costed and considered.

$30–$50 billion per year throughout the 1990s. This sum is considerably less than one half of one percent of the world's $13 trillion world economy and a minuscule amount in relation to the great human and economic advances it could help achieve. But it is a large amount in the context of the resources now available for the poorest and the least powerful classes of society.

It is possible that as much as 25% of that total cost could be born by communities themselves. The Bamako Initiative (panel 10), for example, aims to make available essential maternal and child health services for a cost which will be less than many families are already paying for drugs and medicines. And at an annualized cost of approximately $5 per person per year, piped water supply and basic sanitation could be provided to urban areas for less than many families and communities are now paying to commercial water vendors. In meeting these and most other needs, there are today major new opportunities for *self-help* if governments can provide an enabling environment in which peoples' own efforts are well informed and well-supported.

But the majority of the $30–$50 billion required each year needs to be made available from a carefully thought-out combination of a shift in budget priorities by the governments of the developing countries and an increase in, and re-allocation of, aid from the industrialized countries.

In every area of human need, it is now possible to make significant progress by *relatively modest* shifts of resources from high per capita cost approaches, serving mostly the better-off, to low per capita cost strategies serving mainly the poorest strata of society. In health, the hospitals and doctors and medical technologies which reach perhaps 15% of a population often claim 60% to 80% of the health budget. In education, more than half of total government spending is often allocated to the 10% or 20% of students, mainly from higher-income groups, who go on to secondary schools and colleges. In water and sanitation, 80% of the $12 billion now being spent each year is devoted to providing services for better-off urban groups, at an average capital cost of $600 per person served, and only 20% is allocated to providing services for the poorest, at an average capital cost of $20–$30 per person.

There is therefore very considerable scope for meeting essential needs through the re-allocation of *existing* resources. Certainly it would be possible to release another 25% of the total resources required each year by a shift in the priorities – and in government spending – towards what might be called 'development with a human face'.

But in practice no government, whatever its ideology, can ignore political realities and devote all of its resources to the poor, the whole poor, and nothing but the poor. Nor can anti-poverty programmes be entirely financed by 'taking from the rich' in countries where doubling the taxes of the top 10% would mean doubling the taxes of every factory worker, schoolteacher and low-paid government official. How, then, is a significant reallocation of resources to be achieved?

In the past, fundamental shifts of resources in favour of the poor have usually occurred in the special circumstances of political revolutions (usually with civil war and high human costs) or following the defeat and withdrawal of an occupying power (as in the Republic of Korea in the 1940s) or where there has been a long and vigorous tradition of truly competitive democracy (as in Sri Lanka or the Indian state of Kerala). But for the majority of developing countries, a way must be found to make progress in less exceptional contexts.

In facing that challenge, today's low-cost strategies for meeting essential needs are a vital practical factor. They effectively lower the amount of political will required (and the level of political risk involved) in accelerating progress for the poorest. But, at a total cost which may be estimated at around $30–$50 billion a year, it will still not be easy to finance such programmes solely by the re-allocation of existing resources. And it is here that foreign aid could make its most crucial contribution.

For obvious reasons, it is politically easier to allocate a greater proportion of national resources to primary health care, or to basic education for

all, or to low-cost water and sanitation systems, if the *total* resources available for health and education are *expanding*. This would be especially true if some significant part of those increasing resources were, at first, made available exclusively for the purpose of assisting governments to overcome the worst aspects of absolute poverty.

External aid could therefore be used to address the fundamental task of reducing the political resistances and making it easier for developing country governments to bend priorities towards the poorest sections of their societies. That is why it is now the *combination* of increased aid and shifting priorities which offers the most feasible and least turbulent way forward towards the eradication of the worst aspects of absolute poverty.

Specifically, if the aid-giving nations were to reduce by half the gap between present aid levels (averaging 0.34% of the donor nations' GNPs) and the long-agreed aid target of 0.7% of GNP, then this alone would make available more than half the sum required to meet basic human needs by the end of this century.

It is, of course, unrealistic to assume that all aid, or even all increases in aid, could be devoted exclusively to this purpose. The financing of roads and other aspects of physical and human infrastructure can also be an important part of the development process and, in any case, the priorities of aid budgets, like the priorities of internal government spending, are more easily altered if overall aid budgets are expanding. It would therefore be important to ensure that a very significant proportion of the *increase* in aid were devoted to the direct attack on poverty.

It would, for example, be reasonable to think of increasing aid from today's level of $50 billion to approximately $75 billion within five years while at the same time co-operating with the governments of developing countries to ensure that at least *one third* of that total aid figure was allocated, in the first instance, to the meeting of the most essential needs of the poorest groups.

It would also be possible to design such an approach so that it contributed significantly to the other major purpose of foreign aid – the stimulation of economic growth. Most of the costs of a direct attack on poverty would obviously be local costs incurred in local currencies. If they were largely financed by the industrialized nations under the terms of a *real development pact*, then this would also allow developing countries to 'earn' significant amounts of foreign exchange (in much the same way as tourism brings in foreign currencies which are in large part spent in local currencies and therefore generate foreign exchange earnings). Foreign aid would therefore help committed governments in the developing world to bend priorities towards the poor while at the same time contributing towards renewed economic growth by increasing the availability of desperately needed foreign exchange.

Initially, a substantial proportion of increases in aid could be allocated in this way, with the specific aim of measurably improving the lives and enhancing the capacities of the poorest. The aid component would gradually be taken over by developing country governments as their economies moved towards sustained economic growth the effort to eradicate the worst consequences of poverty could also, therefore, be an efficient way of using resources to promote economic advance.

Internationally and within nations, it would be important to see such an overall strategy principally as an 'enabling' process. The industrialized world could, through its trade and aid and financial policies, create the kind of economic environment which would enable the developing world to earn a higher standard of living for its people. Similarly, within developing nations, governments could help to create the kind of environment – through improved health, nutrition, and education – which would better *enable* families to meet their own needs through their own efforts.

In the longer-term, of course, the meeting of human needs would make an even more fundamental contribution to sustained economic progress. As World Bank President Barber Conable said in September 1988:

"Poverty on today's scale prevents a billion people from having even minimally acceptable standards of living. To allow every fifth human being on our

planet to suffer such an existence is a moral outrage. It is more: it is bad economics, a terrible waste of precious development resources."

If this great goal of meeting the basic needs of all mankind is to be met by the end of this century, then the plans for achieving it – both for increasing external aid and adjusting internal priorities – need to be made in time for the beginning of the fourth and final UN Development Decade of this century (1991–2000). In that time, aid programmes could be publicly re-examined – in both East and West – with a view to identifying what proportion of aid is currently allocated to meeting essential human needs and attempting to increase that proportion to approximately one third over the next three years. Similarly, developing country governments could also begin analysing and publishing reviews of their own resource allocations and of the major opportunities for shifting some of the emphasis to low-cost methods of meeting the needs of their poorest peoples. Finally, international organizations, including United Nations agencies, should also participate fully in this exercise, reviewing the allocation of their own resources and bringing their accumulated international experience to bear on helping countries to identify and refine low-cost methods for enabling the poorest groups to meet their own and their children's needs.

Conclusion

In summary, the main argument of this report has been that the derailment of the development effort in recent years now presents an opportunity to re-examine the direction of that effort and to make a new commitment to the kind of progress which meets the needs and enhances the capacities of the poorest quarter of mankind. In the coming restructuring of economic relationships, a global approach which takes into account the needs and the contribution of the developing world would be in the interests of both North and South. But it would require a reversal of today's financial flows through action on debt reduction, the stabilization of commodity prices, a lowering of protectionist barriers, and an increase in aid and investment. Such a transfer of resources should now form part of a *real development pact* to abolish the worst aspects of absolute poverty in the next decade. But after the publication of the Brundtland Report, it is clear that any development pact should in effect be an *environment and development pact*, including practical and financial assistance for developing countries to make the difficult decisions necessary for long-term environmental protection. If that dimension could be added to real development, then it may also be possible to begin applying the brakes to the environmental deterioration which will otherwise become an ever-greater problem for an ever-greater proportion of mankind as this century draws to a close.

Finally, if the first hints of light perceived in the 1988 Intermediate-range Nuclear Forces treaty, and in the lessening of regional tensions between the superpowers, were to become a full dawn of arms control, then not only would the threat of war recede but the resources available for a new pact for real development and the protection of the environment could conceivably be increased. Several times in this report, the comparison has been made between the costs of social progress and the costs of armaments. But so overwhelming are the resources now directed to the military that some degree of demilitarization has become almost a pre-condition – in the great majority of countries – for the meeting of all other human needs. To put that claim in perspective, the transfer of only 5% of today's total military spending of over $1 trillion a year, by developing and industrialized countries, could release the $50 billion a year which would be enough to overcome the worst aspects of absolute poverty on the planet by the year 2000.

Ironically, the debt crisis may now be prying open the channels of a North-South dialogue which, for most of the 1980s, have been muddied by misunderstanding and silted by inaction. Creatively conducted, there is more than a faint possibility that discussions on the resolution of the debt crisis could lead in the direction of realism and reform on both sides. It is therefore not too much to hope for a thaw in North-South relations, coinciding with the thaw in East-West relations which now appears to be beginning.

AIDS: the threat to children

In a growing number of developing countries, AIDS is now a serious threat to the child survival gains of the 1980s.

The World Health Organization estimates that at least 200,000 cases of AIDS have occurred worldwide, and that 5 to 10 million persons are already infected with the AIDS virus (human immunodeficiency virus, or HIV). Data on AIDS in children is still weak, but several recent reports indicate that, in some African countries, as many as one third of all cases occur in the very young. In some parts of Africa, 25% of urban women of reproductive age are infected with HIV – meaning that approximately one in every ten urban children is being born with the AIDS virus.

Infected babies face a short life, during which they will be acutely ill most of the time. Nearly all will die before reaching two years of age. There will therefore be a dramatic rise in child death rates in countries where AIDS is a widespread problem.

Most child victims of AIDs were infected before they were even born. Recent studies show that approximately half of all HIV-infected women will pass the virus to their babies while still in the womb or during childbirth. Usually, these women are unaware of their infection when they become pregnant.

Smaller numbers of older children are also infected, mainly through contaminated blood received in transfusions or through other skin-piercing procedures. Adolescents are affected in small but growing numbers, usually through sexual intercourse.

Breast-feeding is not a significant means of transmitting AIDS. Although there have been a few reports of infants possibly being infected through breast-milk, the many life-protecting advantages of breast-feeding greatly outweigh the small risk that AIDS may be transmitted in this way. WHO and UNICEF strongly recommend breast-feeding, even where the AIDS virus is prevalent.

The use of unsterile needles and syringes in child immunization programmes has also been accused of spreading the virus. But there are no known cases of this having happened, and WHO and UNICEF have concluded that "the potential for the spread of HIV infection in childhood immunization sessions is low even where sterilization practices are below standard".

There is at present no effective treatment or cure for AIDS, and it is unlikely that a vaccine will be developed before the end of the century. All parents and young people therefore need to know what they can do to protect themselves, their partners, and their unborn children against the AIDS virus.

In many countries, maternal and child health workers are now being trained to respond to this challenge. But the war against AIDS cannot be waged effectively by the health services alone. What is required – and what is now beginning to happen under the leadership of the World Health Organization – is a massive social mobilization effort, involving all available means of education and communication.

In the struggle against AIDS, developing countries are now beginning to employ some of the social mobilization techniques which have been so effectively used to promote child survival programmes – especially immunization and diarrhoeal disease control – during the 1980s. In Tanzania, for example, the AIDS control programme will involve the radio and newspapers, folk media and community leaders, voluntary organizations and schools. In Uganda, the prevention of AIDS is already taught in all primary and secondary schools.

The restructuring of economic relationships between the major economies of the North is both inevitable and already under way. A wider vision would see the resolution of the debt crisis and the restoration of growth to the developing world as an inseparable part of this process, serving the interests of global growth by liberating the demand of the South for the products of the North.

A wider vision still would see in the complexity of such negotiations the possibility of pursuing such a new economic relationship with the South as part of a real development pact by which the developing nations would not only return to economic growth but to the kind of development which meets the needs and enhances the capacities of the poorest half of their populations.

It cannot be stressed too much that it is the international community as a whole, and every individual citizen within it, which stands to gain, tangibly, from the realization of such a vision. The persistence of poverty on this planet is ultimately inseparable from the issues of violence, instability, and environmental deterioration which affect us all and will affect us increasingly as we move towards the opening of a new millenium.

It is therefore neither too great an abstraction nor too distant a consideration to urge political leaders, in the closing years of the 1980s, to examine the structural links between the resolution of pressing economic problems and the possibility of international co-operation to overcome absolute poverty in our times. It may be that years of political inertia lie ahead, years in which problems of poverty, violence, and the degradation of the environment impinge ever more frequently and painfully on the lives of ever more people, before political leadership addresses itself to more than piecemeal or short-term solutions. Or it may be that the time has now come when the political vision and leadership will emerge to address the unity of these problems rather than the fragments of their consequences.

UNICEF's experience commits it irrevocably to the belief that international co-operation to meet the essential needs of all children – and their families – is the greatest investment which it is possible for the human race to make in its future economic prosperity, political stability, and environmental integrity.

No one could overestimate the complexity of such a task or the political creativity and commitment which will be required to address it. But if the vision and leadership were now to emerge, and if relatively modest resources were to made available, then this report has attempted to show that past experience and past technique now stand ready to convert that vision and those resources into the greatest human achievements of this or any other century.

II
MEASURING REAL DEVELOPMENT

A supplementary
chapter to
The State of the World's
Children 1989

Measuring real development

One of the principal arguments of the 1989 *State of the World's Children* report is that the debt crisis is an opportunity to redirect the international development effort so that it becomes a movement which unequivocally puts the poor first in good times and in bad. More specifically, it should be, and be seen to be, a movement which has as its first priority the meeting of the needs of all human beings for adequate nutrition, clean water, safe sanitation, primary health care, adequate housing and basic education.

To accompany such a reorientation, there is clearly a need for methods of measuring and comparing levels of achievement and rates of progress in relation to these aims. From UNICEF's point of view, in particular, there is a need for an agreed method of measuring levels of, and changes in, the well-being of children. This additional note to the 1989 report therefore presents the case for the use of national under-five mortality and illiteracy rates as the principal indicators of progress for children. The average annual reduction rate for under-five mortality and illiteracy is proposed as the corresponding 'speedometer' of the rate of progress.

As an introduction to the importance of, and the search for, social indicators, this supplementary chapter first summarizes the limitations of the conventional yardstick of development – per capita GNP – as an indicator of human well-being.

The limitations of GNP

The conventional measure of a country's level and pace of development is of course per capita Gross National Product (GNP) and its annual growth rate. Although obviously useful for many purposes, the limitations of per capita GNP as a development indicator have long been acknowledged.

First of all, GNP is principally concerned with production which is traded or monetarized; it does not adequately reflect such factors as the growing of food for family consumption, or the unpaid labour of women, or the do-it-yourself building of homes, or the local collection and consumption of water or firewood. All of these and many more unmeasured activities are clearly fundamental to development for many millions of people, particularly in rural areas. Usually also, average income statistics fail to reflect real levels of 'social income' provided by such government-financed services as health and education.

When used as a method of comparing levels of development in different countries, per capita GNP also suffers from serious distortions. Since a large proportion of GNP does not enter into world trade, official exchange rates cannot reflect domestic purchasing power. The price of a pair of sandals or a bus journey, for example, may be five or fifteen times higher in Paris than in Dakar, but this is not taken into account when one says that the per capita GNP of France is 25 times higher than that of Senegal.(Some attempts to allow for this factor have suggested that per capita GNP in most developing countries would have to be adjusted by a factor of as much as three or more.) An additional weakness is that comparisons between countries on the basis of per capita GNP cannot, of course, take into account such realities as the need to spend more on clothes or fuel in colder climates, or on irrigation or fertilizer in regions where rainfall is less or soils more impoverished.

A further serious drawback to per capita GNP, as a development indicator, is the fact that it is an *average* figure. It is arrived at by taking the total value of a nation's annual product and dividing it equally among its total population, a notion which is often at considerable variance with what happens in practice. And as disparities in the share of national wealth enjoyed by different sections of the population may in some cases be extreme, so per capita GNP may conceal more than it reveals about the condition of the poor which, it is argued, should be development's first concern. Kenya, Brazil and Peru, for example, have per capita GNPs which are approximately double those of, respectively, Bangladesh, Thailand, and Sri Lanka; but were we to compare these three pairs of countries using only the per capita GNP enjoyed by the poorest 40% of their populations, then we would find that the poor are as well off in Bangladesh as in Kenya, in Thailand as in Brazil, in Sri Lanka as in Peru (Panel 15).

A new focus: the poorest 40%

A hypothetical country with a population of ten people in which five people receive an income of $100 per year and the other five receive $10,000 a year would have an average annual income of over $5,000 a year. Per capita GNP – the conventional indicator of a country's economic development – may therefore say very little about the standard of living of the poor. If, as this year's *State of the World's Children* report argues, the development effort should be refocused on the poorest groups, then better indicators of their economic well-being are needed to guide and measure that effort.

From this point of view, the GNP per capita of the poorest 40% of a country's population would clearly be a more meaningful figure. Unfortunately, such a statistic does not exist for the majority of countries.

The following table uses the best available information on the current per capita GNP *of the poorest 40%* in 46 nations (24 developing, 22 industrialized). Column 1 shows the country's overall average GNP per capita, column 2 shows GNP per capita of the poorest 40%, and column 3 shows what proportion of total GNP accrues to the poorest 40% of households.

As an indicator of economic development focused on the poor, the table quickly shows its value:

- It shows, for example, that although the overall GNP per capita of Kenya is double that of Bangladesh, there is no difference between the two countries when we look at the per capita GNP of their poorest 40%.
- Similarly, Brazil has an overall GNP per capita which is twice that of Thailand, but the per capita GNP of Thailand's poorest 40% is actually *higher* than that of Brazil.
- Peru's overall GNP per capita is two-and-a-half times as high as Sri Lanka's – but the per capita GNP of the poorest 40% of the two countries is about the same.
- Côte d'Ivoire and the Philippines also have about the same level of overall GNP per capita, but the per capita GNP of the poorest 40% in the Philippines is about two thirds higher than that of Côte d'Ivoire.
- Mexico's overall GNP per capita is a little higher than that of Hungary, but the per capita GNP of Mexico's poorest 40% is only about half that of Hungary.

	Country	GNP per capita in US $ 1985		% of total GNP accruing to poorest 40% of households
		Total	Poorest 40%	
1	Netherlands	9180	5141	22.4
2	Japan	11330	6203	21.9
3	Belgium	8450	4563	21.6
4	Sweden	11890	6094	20.5
5	Hungary	1940	994	20.5
6	Germany, F.R.	10940	5579	20.4
7	Ireland	4840	2456	20.3
8	Switzerland	16380	8231	20.0
9	Spain	4360	2115	19.4
10	Norway	13890	6563	18.9
11	Yugoslavia	2070	968	18.7
12	UK	8390	3880	18.5
13	Finland	10870	5000	18.4
14	Israel	4920	2214	18.0
15	Italy	6520	2853	17.4
16	Denmark	11240	4889	17.4
17	USA	16400	7052	17.2
18	Canada	13670	5844	17.1
19	Bangladesh	150	64	17.3
20	Korea (Rep. of)	2180	921	16.9
21	Egypt	680	281	16.5
22	France	9550	3916	17.0
23	Hong Kong	6220	2519	16.2
24	India	250	101	16.2
25	New Zealand	7310	2906	15.9
26	Sri Lanka	370	147	15.9
27	El Salvador	710	275	15.5
28	Australia	10840	4173	15.4
29	Portugal	1970	749	15.2
30	Thailand	830	315	15.2
31	Indonesia	530	191	14.4
32	Philippines	600	213	14.1
33	Argentina	2130	751	14.1
34	Trinidad & T	6010	1998	13.3
35	Costa Rica	1290	387	12.0
36	Mauritius	1070	308	11.5
37	Turkey	1130	325	11.5
38	Malaysia	2050	574	11.2
39	Zambia	400	108	10.8
40	Venezuela	3110	801	10.3
41	Mexico	2080	515	9.9
42	Kenya	290	65	8.9
43	Côte d'Ivoire	620	132	8.6
44	Panama	2020	364	7.2
45	Peru	960	168	7.0
46	Brazil	1640	287	7.0

A second and related problem is revealed in Table A, which shows the unreliability of per capita GNP as a means of predicting the level of well-being in a population as directly measured by its illiteracy rate or its under-five mortality rate (U5MR). Either because of more favourable historical or natural conditions, or through the pursuit of different policies and priorities over a sufficient period of time, some countries have clearly managed to achieve higher levels of health and education for the majority of their population than other countries with the same or even greater economic resources at their disposal. For example South Africa, with a per capita GNP of over $2,000, has an under-five mortality rate of over 100 – more than twice as high as in Sri Lanka, which has a per capita GNP of only $400 or one fifth as much.

Per capita GNP is a valuable indicator of a country's total economic production. And in its defence as a *social* indicator, it should be said that it remains a broadly useful if often fallible predictor of the likely well-being of a given population. Health is not always to the rich nor education to the well-off, but that is certainly the way to bet. And it should perhaps be noted also that one would not, in any case, expect per capita GNP to maintain a linear relationship with under-five mortality rates or literacy levels, as these variables operate on a scale which is conceptually or biologically determined, whereas per capita GNP operates under no such restrictions. It is obviously impossible, for example, to exceed 100% literacy, and yet the 100% goal can be, and in some cases has been, achieved by middle-income countries with a per capita GNP of less than $2,000. Further gains in per capita GNP, however significant, cannot therefore be correlated with equivalent gains in literacy. To a lesser extent, similar problems arise as life expectancy rises beyond 70 and under-five mortality rates fall below about 15. Comparisons of per capita GNP with various social indicators therefore tend to be more useful when comparing countries at broadly the same level of economic development. (This is one argument for using social indicators as a complement to, rather than a replacement for, per capita GNP.)

Table A GNP per capita, U5MR and illiteracy rates, 1986-87

	U5MR 1987	GNP per capita 1986	Illiteracy rate 1986
India	152	290	57
China	45	300	31
Zambia	130	300	24
Sri Lanka	45	400	13
Nigeria	177	640	57
Cameroon	156	910	38
Brazil	87	1,810	21
South Africa	101	2,010	
Yugoslavia	28	2,300	8
USSR (1980)	30	4,550	0
Spain	11	4,860	5
Oman	149	4,980	70
Trinidad	24	5,360	4
Libya (1985)	123	7,170	34
Singapore	12	7,410	14
Italy	12	8,550	3
UAE	33	14,680	47
USA	13	17,480	1

The search for alternatives

Despite these often-cited drawbacks, per capita GNP and its rate of change have remained the most widely used indicator of development. In part, this reflects the fact that there is a practical need for a single all-purpose measure. And in fulfilling that need, perhaps the greatest advantage of per capita GNP is simply the fact that *it is there.*

The concept of measuring the Gross National Product, on a world-wide scale, was first developed in the 1940s. Today, with varying degrees of regularity and reliability, the complex machinery exists in almost all countries for the generation and collection of the wide variety of economic information which is aggregated into the single statistic of GNP. Per capita GNP is therefore maintained on its throne as much by its

army of supporting statistics as by the divine right of its merits as a ruler. National accounting systems – the legacy of the many Western or Western-trained economists who brought Keynesian tools to the study of development economics during the 1950s – have made possible this enthronement of GNP and are still the envy of many of the social scientists who have tried, since the 1950s, to find and to promote other ways of measuring the development process.

Nonetheless, by the early 1970s disillusionment with GNP had become widespread. As experience of conscious development efforts accumulated, so the assumptions that propped up per capita GNP as its yardstick were increasingly called into question. In particular, it became untenable to assume that growth in GNP would automatically 'trickle down' to the poor or that, failing this, governments would intervene to ensure the distribution of the benefits of economic progress. Even the defence that inequality is necessary for the promotion of growth has worn increasingly thin as no correlation between inequality and increases in GNP has emerged to support such a theory. (Indeed in many countries it has become clear that gross inequalities are actually standing in the way of further economic progress.)

By the mid-1970s this disillusionment with development efforts directed primarily towards improvements in per capita GNP, plus a growing recognition of its theoretical weaknesses as an indicator of well-being, had opened the gates to the search for alternatives. In particular, a certain momentum began to gather behind the idea that there ought to be some more direct way of measuring development as a process leading to the eradication of absolute poverty and to the satisfaction of essential human needs. It proved, however, easier to agree on this broadly stated objective than on the specific methods of measurement required.

Some advocated the use of official poverty lines, expressing the level of development in terms of the percentage of the population falling below such a line. But this method too had its weaknesses. How was the line to be decided? How might it be standardized to enable comparisons between countries? And what would the statistic have to say about how far various sections of the population were below the line, or about what progress they were making towards it, or about what was happening to those who were barely above it? Others suggested that national employment levels would be a more useful indicator, but it was quickly realized that Western economic concepts of employment were often of little relevance to a developing world in which underemployment and low productivity were the real issues. Still others attempted to modify per capita GNP by complex calculations aimed at transforming it into a 'level of living indicator' or a 'social index' or a 'measure of economic welfare', but the results were further complexity and confusion rather than the emergence of a clear and easily available indicator of the level of human well-being and of changes within it over time.

Increasingly, as social statistics became more available, attention began to turn towards more direct yardsticks of basic needs satisfaction such as average life expectancy, infant and child mortality rates, literacy and school enrolment ratios, nutritional status, or the percentage of people with access to clean water. Gradually, from a combination of theoretical superiority and practical availability, the indicators which have emerged into most widespread use are the adult literacy rate, the under-five mortality rate (U5MR), and average life expectancy.

The first advantage of such indicators is that they measure 'end results' of the development process rather than inputs to it. It is this which gives them an edge not only over per capita GNP but also over many of the other available social indicators. 'End results' such as levels of literacy, average life expectancy, under-five mortality, and nutritional status are to be preferred, for the present purpose, to inputs such as the level of school enrolment or the availability of calories per head or of doctors per thousand population, all of which are 'means' of achieving end results. A few indicators such as literacy or, arguably, access to clean water, measure both means and ends of development.

Second, the results measured by these indicators seem to be the sum of a wide variety of inputs

which might be included in a common-sense list of basic needs – sufficient income, adequate nutrition, water supply, environmental safety, essential health knowledge, primary health care and basic education. A trade-off is involved here. On the one hand, an indicator of development needs to be as closely indicative as possible of the ultimate but necessarily diverse, ill-defined and immeasurable goal of a full and enjoyable life for all. On the other hand, it must have the practical attribute of measurability and availability (and preferably of being relatively easy to understand and communicate). As a compromise between these essentially conflicting criteria, indicators such as average life expectancy, adult literacy levels, under-five mortality rates, and nutritional levels, have the advantage of measuring things which stand as reasonably close proxies for what one is ultimately trying to measure while at the same time being relatively easy to measure and to communicate.

Third, these direct measures of well-being are less susceptible than per capita GNP to the fallacy of the average. This is because the natural scale does not allow the rich to live for one thousand times as long as the poor, or their children to be one thousand times as likely to survive, even if the man-made scale permits them to have one thousand times as much income. In other words, it is much more difficult for a wealthy minority to affect a nation's average life expectancy or its under-five mortality rate, and these indicators therefore present a more accurate, if far from perfect, picture of the health status of the majority. A significant fall in the under-five mortality rate or a significant rise in average life expectancy cannot be achieved without the major-

Chart 1a The narrowing gap

The gap between the industrialized and developing worlds is narrowing when measured by social indicators such as the under-five mortality rate.

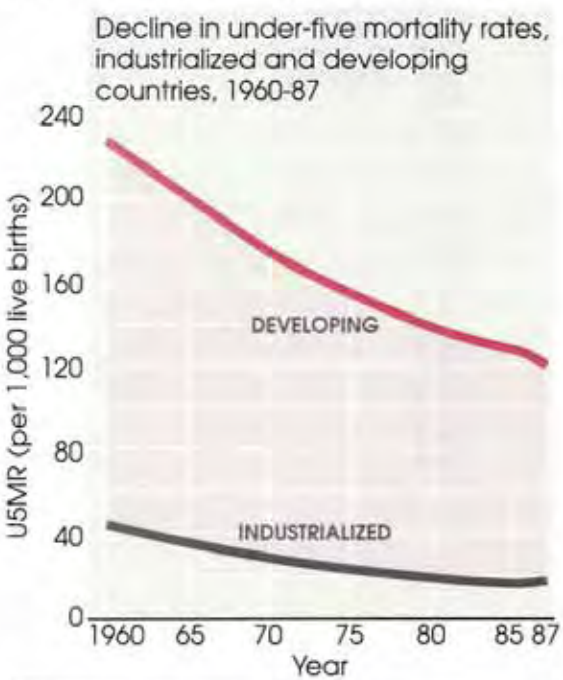
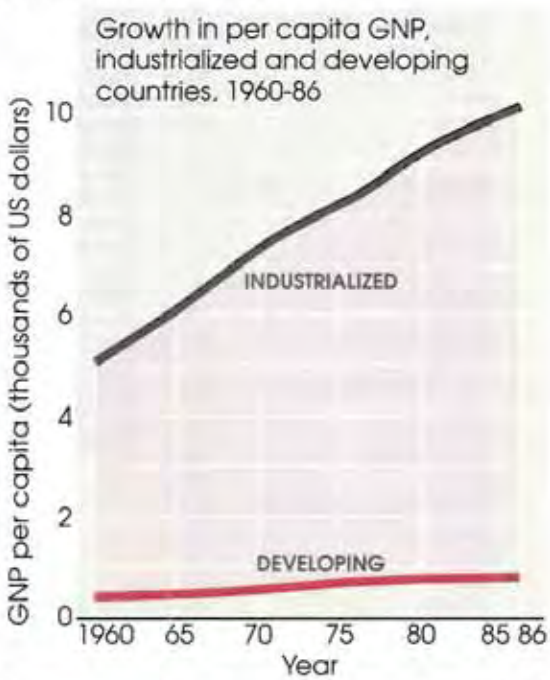


Chart 1b The widening gap

The gap between the industrialized and developing countries continues to widen when measured by growth in per capita GNP.



Child survival: a league table

The following 'league tables' list the nations of the developing world according to the percentage of their children born who survive to the age of five. This child survival rate is another way of expressing the under-five mortality rate (U5MR).

Americas	% children born who survive to age 5
Cuba	98·1
Costa Rica	97·7
Jamaica	97·7
Trinidad and Tobago	97·6
Chile	97·4
Uruguay	96·8
Panama	96·5
Argentina	96·2
Guyana	96·1
Venezuela	95·5
Paraguay	93·7
Colombia	93·1
Mexico	93·0
Dominican Rep.	91·6
El Salvador	91·3
Brazil	91·3
Ecuador	91·1
Nicaragua	90·1
Guatemala	89·7
Honduras	88·9
Peru	87·4
Haiti	82·6
Bolivia	82·4

Middle East and North Africa	% children born who survive to age 5
Kuwait	97·7
United Arab Emirates	96·7
Lebanon	94·7
Jordan	94·0
Syrian Arab Rep.	93·3
Tunisia	91·4
Iran, Islamic Rep. of	90·6
Iraq	90·4
Turkey	90·3
Saudi Arabia	89·8
Algeria	88·9
Libyan Arab Jamahiriya	87·7
Morocco	87·7
Egypt	87·1
Oman	85·1
Yemen	80·5
Yemen, Dem.	79·8

Africa South of the Sahara	% children born who survive to age 5
Mauritius	97·0
Botswana	90·5
Kenya	88·4
Zimbabwe	88·4
Congo	88·3
Zambia	87·0
Lesotho	86·1
Côte d'Ivoire	85·5
Ghana	85·1
Liberia	85·0
Cameroon	84·4
Togo	84·4
Zaire	83·6
Gabon	82·8
Uganda	82·8
Nigeria	82·3
Tanzania, U. Rep. of	82·1
Sudan	81·6
Madagascar	81·3
Benin	81·2
Burundi	80·8
Rwanda	79·1
Senegal	78·0
Mauritania	77·7
Somalia	77·5
Central African Rep.	77·4
Chad	77·3
Guinea-Bissau	77·3
Niger	76·8
Burkina Faso	76·3
Guinea	74·8
Ethiopia	73·9
Malawi	73·3
Sierra Leone	73·0
Angola	71·2
Mozambique	70·5
Mali	70·4

Asia	% children born who survive to age 5
Singapore	98·8
Malaysia	96·7
Korea, Dem. Rep. of	96·6
Korea, Rep. of	96·6
Sri Lanka	95·5
China	95·5
Thailand	94·9
Mongolia	93·9
Philippines	92·5
Papua New Guinea	91·5
Viet Nam	90·9
Burma	90·2
Indonesia	88·0
India	84·8
Lao People's Dem. Rep.	83·7
Pakistan	83·1
Bangladesh	80·9
Bhutan	80·0
Nepal	80·0
Kampuchea	79·2
Afghanistan	69·6

ity sharing, to some significant degree, in the advances which make such changes possible.

In this particular sense, the proportion of adults who are literate and the proportion of children who are adequately nourished, being percentages rather than averages, are even better indicators than mortality rates or average life expectancy. Like other indicators such as the availability of clean water, levels of literacy and nutrition measure directly what proportion of a given population is benefiting from a particular improvement. Furthermore, literacy rates have the advantage of measuring the spread of not only a desirable end result of development but also a key means of participating in, and benefiting from, all other aspects of the development process. Such advantages might have been enough to promote the national literacy level as the one candidate, among the various social indicators, to challenge for equal status with per capita GNP as the principal indicator of development. Unfortunately, literacy levels suffer from the disadvantage of being based on a relatively soft definition, and one which allows for very great qualitative inequality.

Finally, from the important point of view of international comparison, average life expectancy, under-five mortality rates, adult literacy levels and the nutritional status of young children, do not suffer from exchange rate distortion and domestic value difficulties which are such a serious drawback in inter-country comparisons of per capita GNP. By the same token, these social indicators are also relatively objective and impervious to the charge of ethnocentricity. A further important advantage, as Chart 1a shows, is that social indicators more truly measure and encourage the 'real development' effort by recording the fact that, when measured by these fundamental human criteria, the gap between the industrialized and developing countries *is closing*. Chart 1b shows that when measured by per capita GNP, the gap is continuing to widen, and this reflects the important point of continuing inequality of economic opportunity. But the widening GNP gap does not necessarily represent a widening gap in the quality of life as, above a certain point, rising incomes tend to be devoted to less and less fundamental improvements.

To set against these formidable advantages of life expectancy, under-five mortality rate, adult literacy levels, and the nutritional status of children as development indicators, there are two principal disadvantages. The first is the relative weakness, at this time, of their statistical bases. Apart from the question of the different definitions used in the collection of such statistics (particularly in the cases of literacy and nutritional status of children), there is also the problem of infrequent and unreliable data collection and the use of limited sample surveys, crude extrapolations, and other highly error-prone methods of compiling national social statistics. But serious as this problem is, it adds up to a case for improved data collection rather than a case against the indicators themselves. In most countries, it should be remembered, systematic collection and analysis of the underlying data for determining GNP began only in the 1950s.

The second problem is that there is no agreed theoretical basis for combining these various social indicators into any single overall indicator which could be elevated to the same status as per capita GNP (which is itself a composite figure, but with a well-established if very imperfect theoretical base) in the monitoring of the development process. Several attempts have been made to construct a composite social indicator, of which the most widely known is the Physical Quality of Life Index (PQLI), evolved in the mid-1970s by the Washington-based Overseas Development Council. The PQLI indexes a nation's average life expectancy at age one and its infant mortality rate on a scale of 0 to 100 by setting zero as the worst level recorded by any country in the year 1950 and one hundred as the best level expected to be achieved by any country by the year 2000. The adult literacy level – the third social indicator used in the PQLI – is expressed as a percentage and is therefore, of course, already scaled 0 to 100. The three scores for each of these indicators are then averaged to give the PQLI, on the scale of 0 to 100, for each country. The PQLI therefore brings together three of the most valuable of the available social indicators into one composite indicator of development which is relatively resistant to the inequality factor, reasonably free of ethnocentricity, reflective of many of the

elements which are close proxies for the desired goal, reasonably easy to calculate and communicate, and lends itself readily to inter-country comparison and analysis.

To set against these merits, the principal weakness of the PQLI is that there is no particular reason for giving equal weight to the three indicators which it combines. If, for a given country, the three scores for each indicator are very close then it would seem simpler and sounder to select one of them to stand as the single overall indicator of social development. If, on the other hand, the three scores are markedly different then it could argued that the PQLI, by arbitrarily giving each indicator an equal weighting, is making a concealed value judgement. A country with a high average life expectancy and a low level of literacy may produce the same PQLI as one with a high level of literacy and a low average life expectancy; the PQLI is saying that these two states represent equal levels of development, a conclusion which, by definition, is judgementally arrived at.

There are, however, worse crimes in development than making value judgements. And one suspects that a closely argued debate about the relative merits of these three key indicators – or rather about the relative weights which should be attached to them in measuring the quality of life – would produce a fairly even result. The fact that this reasonable value judgement has been made in order to combine these three elements into the PQLI is therefore perhaps a small price to pay for the many advantages of such a broad and easily understandable indicator of progress towards meeting essential human needs.

U5MR and illiteracy

Governments and international organizations will, of course, select their own indicators according to their own priorities. UNICEF's mandate, as an advocate for children, leads it to favour for its own purposes the use of the the under-five mortality rate (U5MR), supplemented by the illiteracy rate (and especially the female illiteracy rate).

Both of these indicators have all the advantages already listed in the discussion so far, and both have a direct bearing on the survival and development of children. In particular, the U5MR reflects the nutritional health and the health knowledge of mothers; the level of immunization and ORT use; the availability of maternal and child health services (including pre-natal care); income and food availability in the family; the availability of clean water and safe sanitation; and the overall safety of the child's environment. *The U5MR is therefore chosen by UNICEF as its single most important indicator of the state of a nation's children.*

In practice, it could also be argued that the U5MR is the best available *single indicator* of social development overall, as most of the factors which it distils are as indicative of the meeting of the essential needs of all human beings as they are of the particular well-being of children. It is as a reflection of this reasoning, as well as of UNICEF's special mandate, that the statistical tables published each year as an annex to the *State of the World's Children* report list the nations of the world not in ascending order of their per capita GNP but in descending order of their under-five mortality rates.

Measuring the rate of progress

Whatever social indicators are chosen, there remains the important problem of measuring not just the level achieved but also the rate of progress over time.

If the indicator used is per capita GNP, then the usual 'speedometer' is its annual rate of growth. This method is not without its flaws and suffers again from the inequality factor.

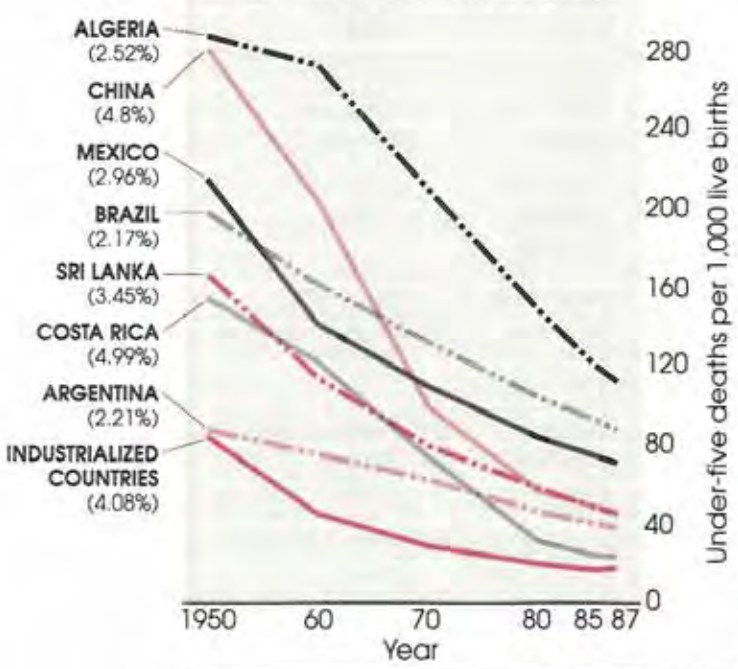
A 10% increase in the income of the richest 25% of the population, for example, would boost the annual rate of growth in per capita GNP by considerably more than a 10% rise in the incomes of the poorest 25%. This may mean that the rate of progress, so measured, has a tenuous connection with meeting the essential needs of the majority. Nonetheless, the annual percentage

growth rate in per capita GNP remains an available and useful indicator of the pace of economic development.

Similarly, the average annual reduction rate (AARR) in the levels of U5MR and illiteracy serves as a useful 'speedometer' for progress against these key social indicators.* Unlike the comparison of absolute changes, the AARR reflects the fact that the limits to U5MR or illiteracy reduction are approached only with increasing difficulty. As lower levels of under-five mortality and illiteracy are reached, for example, the same absolute reduction obviously represents a greater percentage reduction. The AARR therefore shows a higher *rate* of progress for, say, a five-point reduction if that reduction happens at a lower level of under-five mortality or illiteracy.

Chart 2 Falling child deaths

Declines in under-five mortality rates, 1950-87, selected countries



The figure in parentheses is the the average annual reduction rate between 1950 and 1987.

(A fall in U5MR of 10 points from 100 to 90 represents a reduction of 10%, whereas the same 10-point fall from 20 to 10 represents a reduction of 50%.)

Chart 2 shows the usefulness of the U5MR and its annual average reduction rate as a 'speedometer' for social progress, making it possible to compare rates of progress in different countries or at different times. Table B shows how the AARR can also be used to measure and compare rates of progress in different regions within the *same* country. When used in conjunction with GNP growth rates, the U5MR and its reduction rate can therefore give a picture of the progress being made by any country or region, and over any period of time, towards the satisfaction of some of the most essential of human needs.

Table C shows that just as there is no fixed ratio between a nation's GNP and its U5MR or literacy rate, so there is no fixed relationship between the annual reduction rate in U5MR or illiteracy and the annual rate of progress in per capita GNP. Such comparisons help to throw the emphasis on to the policies, priorities and other factors which determine the ratio between economic and social progress. Table D summarizes four decades of progress in reducing both births and child deaths in the world. Table E lists, for all countries, the annual reduction rate in U5MR and fertility from 1960 to 1987 and the annual growth rate in per capita GNP.

Strengthening the data base

Social indicators are attracting increasing attention as the opening of the fourth United Nations

* The average annual reduction rate (AARR) can be calculated according to the formula

$$100\left(1-\sqrt[t]{\frac{Qi}{Qo}}\right)=\text{AARR}$$

where Qo is the original level, Qi is the new level, and t is the time in years taken to move from Qo to Qi.

Child death rates: the historical record

Under-five death rates (U5MRs) are one of the prime measures of social development. The United nations has set a target U5MR of 70 deaths per 1,000 live births, or less, to be achieved in all nations by the year 2000 (or a halving of the 1980 rate, whichever is less). The following historical table shows when this U5MR target of 70 was reached by the countries which have already achieved it. It also lists the nations which are on course to reach the target by the year 2000. For all other countries, Table E on page 88 gives the annual U5MR reduction rate which will have to be achieved if the year 2000 target is to be met.

1930	New Zealand Iceland	Norway
1935	Australia Netherlands	Sweden Switzerland
1940	UK USA	
1945	Denmark Finland	
1950	Canada Ireland	Israel
1955	Austria Belgium Cyprus Czechoslovakia	France Germany, F.R. Japan Luxembourg
1960	Bulgaria Germany, D.R. Hong Kong Italy	Malta Singapore Spain
1965	Barbados Greece Hungary Jamaica	Poland Trinidad Uruguay
1970	Cuba Fiji Kuwait Lebanon	Malaysia Panama Romania
1975	Argentina Bahrain Costa Rica Korea, D. Rep. Korea, Rep. of Mauritius	Portugal Suriname UAE Venezuela Yugoslavia
1980	Albania Chile China Guyana	Paraguay Qatar Sri Lanka USSR
1985	Colombia Jordan Mexico	Mongolia Philippines Thailand
1990	El Salvador Guatemala Nicaragua	Syria Tunisia
1995	Cape Verde Honduras Iran Iraq	Papua N.G. Saudi Arabia Viet Nam
2000	Algeria Botswana Brazil Burma	Dominican Rep. Ecuador S. Africa

Development Decade draws near. Over 800 parliamentarians from five countries, for example, have recently signed a request to the President of the World Bank urging that increased use be made of social indicators and arguing that "*the conditions of the poor can best be measured by social indicators such as the mortality rate of children under 5; life expectancy; access to safe water; the adult literacy rate, particularly among women; and the proportion of children suffering from malnutrition*".

But the argument for greater emphasis on and use of social indicators must necessarily also be an argument for a very considerable strengthening of the data systems on which such indicators are based. Present knowledge of mortality and fertility rates, and especially of adult literacy rates and the nutritional status of children, is often desperately inadequate in quantity, reliability, and topicality.

As a consequence of this inadequacy, the major efforts of recent years to promote low-cost methods against the chief causes of under-five mortality – for example, by expanding immunization or oral rehydration therapy (ORT) – are often not yet reflected in national under-five mortality statistics. Usually, such statistics are computed from basic data which are two, three, or even more years out of date. To address this problem, UNICEF's regional office in Amman, Jordan, working with the London School of Hygiene and Tropical Medicine, has recently (1988) designed a new standard survey, based on the analytical techniques of Professor William Brass, for more closely tracking progress in reducing U5MR.

The new method evolved in Amman is designed to be a fast, accurate, simple, low-cost survey tool able to produce the kind of results which will pass the test of a careful technical review by the United Nations Population Division in New York. The aim is to provide a contemporary snapshot of under-five mortality for any given country. To date, the new method has been pioneered in one country – Jordan – where significant recent efforts have been made to improve child health and reduce under-five deaths (including a rapid expansion of immunization and widespread promotion of ORT). The results show that the infant mortality rate (deaths before the age of one per 1,000 live births) has fallen from 75 per 1,000 in 1980 to 35 per 1,000 in 1987 (an average annual reduction rate of 10%). This corresponds to an under-five mortality rate of 49 and contrasts markedly with the figure of 60 by which Jordan is represented in the standard, internationally comparable statistics.

Once the decision is taken to undertake such an enquiry, the survey can be underway within months and the results can then be available within weeks. Essential information on births can be gathered at the same time and the cost, for an up-to-date picture of a nations fertility and infant mortality rates, can be as little as $20,000. At the time of writing, Syria is completing a similar survey and Egypt, Oman, Sudan and Turkey are planning their own reviews.

Table B Infant mortality reduction, United States, 1950-84/87

The infant mortality rate (IMR) is the number of deaths before the age of one year per 1,000 live births.

Population group	Infant mortality rate		Average annual reduction rate
	1950	1984	1950-84
Total US population	29.2	10.8	2.88
White population	26.8	9.4	3.03
Black population	43.9	18.4	2.53
	1950	**1987**	**1950-87**
Washington D.C.	30	21	0.96
Puerto Rico	68	15	4.00

Nutritional surveillance

Finally, it is important that something be done to strengthen the information available on the nutritional status of children. No indicator could be more central to development than the percentage of a nation's children who are growing normally in mind and body; it is a measure not

only of the meeting of one of the most essential needs of today but also of one of the most vital of all investments in the future. Yet it is information which few, if any, countries have at their disposal.

To begin to fill this vacuum, three United Nations agencies – the Food and Agriculture Organization (FAO), the World Health Organization (WHO), and UNICEF – have launched an inter-agency Food and Nutrition Surveillance Programme to assist a large number of countries in establishing the criteria, definitions, and machinery for the regular collection of the appropriate data on the nutritional level of their young children. The ultimate aim of this programme – based on the three core indicators of birth weight, weight-for-age of children under five, and height-for-age of children entering primary school – is to generate the information necessary to guide policy in the direction of better nutritional levels for a nation's children. By providing such information regularly, the programme hopes to encourage "*policy makers to use surveillance data on changes in the human condition as frequently as they use indicators of economic change in making policy decisions*". The difficulties are formidable. But quarterly statistical reports on the nutritional health of the nation's children – and particularly of the children in the most vulnerable sections of society – would be no more difficult, in definition or collection, than the quarterly statistics which are regularly produced on the health of the nation's economy.

Conclusion

In sum, the 1990s will be a crucial decade in the struggle for 'real development'. And it is particularly important to establish, by the beginning of the decade, both an agreed means of measuring the level and rate of social advance and more timely and reliable data collection systems to make possible the monitoring of progress and the guidance of policy.

The present weakness in statistical knowledge about vital aspects of a nation's life and future is

Table C U5MR and illiteracy reduction rates, and per capita GNP growth rates

	U5MR			Illiteracy			GNP per capita
	1965	1986	Average annual reduction rate 1965-86	1970*	1985	Average annual reduction rate 1970-85	Average annual growth rate 1965-86
Argentina	71	39	2.8	7	5	2.2	0.2
Togo	261	159	2.3	83	59	2.2	0.2
Bangladesh	244	194	1.1	76	67	0.8	0.4
Zimbabwe	171	118	1.8	45	26	3.6	1.2
Burkina Faso	338	241	1.6	92	87	0.4	1.3
Costa Rica	106	24	6.8	13	6	5.0	1.6
India	258	156	2.4	66	57	1.0	1.8
Nigeria	299	180	2.4	75	58	1.7	1.9
Pakistan	255	173	1.8	80	70	0.9	2.4
Sri Lanka	102	46	3.7	23	13	3.7	2.9
Algeria	249	115	3.6	75	50	2.7	3.5
Thailand	130	53	4.2	21	9	5.5	4.0
Brazil	144	89	2.3	34	22	2.9	4.3
Yemen	347	200	2.6	95	85	0.7	4.7
Singapore	38	12	5.3	26	14	4.0	7.6

*Illiteracy rates not available before 1970

partly a result and partly a determinant of development's priorities. And it is this interactive relationship between the means of measurement and the aims of development wherein lies the true significance of social indicators.

Yardsticks such as average life expectancy, under-five mortality, literacy rates, and nutritional status, are of much more than academic importance. They are potentially important tools for the achievement of the kind of development which puts the poor first. Not only do they make possible the comparative analysis which can inform policy and make the most efficient use of human resources, they also help policy makers and the international community to keep the priorities of development more firmly in view, and perhaps to redress some of the biases which have entered into the development process through too exclusive an emphasis on per capita GNP. It was never consciously intended that growth in per capita GNP should become the ultimate aim of development, but there is an almost inevitable tendency for the measure to become the aim. Policies and programmes cannot, after all, be continuously set against some vague and unspecified ideal of development. Some more workaday yardstick is needed. But the exclusive use of per capita GNP for that purpose creates an incline in favour of increased priority – in research and analysis as well as in the allocation of resources – for those inputs and policies which yield the most satisfactory results against the chosen yardstick. In this way, the measure used can increasingly affect the priorities pursued. Were the measurement emphasis to shift towards a more direct recording of social progress in health, nutrition, and education, then it is likely that we would soon know more than we do today about the balance of inputs and the mix of policies which are most effective in accelerating progress in these fields. Wider use of selected social indicators, and wider public and political awareness of their importance, could therefore provide invaluable support for the attempt to redirect the development effort towards the enabling of all peoples to meet their own and their children's most essential needs.

Table D Total births, birth rates, U5MRs and their reduction rates, and total under-five deaths, by region, 1950, 1980, 1985, and 1987

	1950				1980					1985		1987				
	Births (millions)	Crude birth rate	U5MR	Total under-5 deaths (millions)	Births (millions)	Crude birth rate	U5MR	Average annual reduction rate in U5MR, 1950-1980	Total under-5 deaths (millions)	Average annual reduction rate in U5MR, 1980-1985	Total under-5 deaths (millions)	Births (millions)	Crude birth rate	U5MR	Average annual reduction rate in U5MR, 1980-1987	Total under-5 deaths (millions)
World total	98.3	39	251	24.8	124.9	28	123	2.35	15.5	1.62	15.0	136.5	27	108	1.84	14.7
Industrialized countries	19.5	23	84	1.6	17.5	15	20	4.67	0.3	3.30	0.3	17.4	15	18	1.49	0.3
Developing countries	78.8	47	295	23.2	107.4	32	138	2.50	15.2	1.68	14.7	119.1	31	120	1.98	14.4
Africa	11.4	51	332	3.8	22.2	46	191	1.83	4.2	1.42	4.4	26.5	46	172	1.49	4.5
West Asia	2.0	49	334	0.7	3.7	38	118	3.41	0.4	2.36	0.4	4.2	37	99	2.48	0.4
Southern Asia	22.6	47	344	7.7	35.8	38	200	1.79	7.0	3.43	6.5	39.8	36	158	3.31	6.1
East Asia	26.6	45	273	7.3	21.7	20	51	5.44	1.1	2.09	1.1	23.8	20	45	1.77	1.1
Southeast Asia	8.4	46	258	2.2	12.4	34	123	2.44	1.4	3.41	1.3	12.5	30	104	2.37	1.3
Central & South America	7.5	46	201	1.5	11.6	32	91	2.61	1.1	1.86	1.0	12.3	29	79	2.00	1.0

Source: Interpolation of UN Population Division and UN Statistical Office estimates.

U5MR = Under-five mortality rate

Table E U5MR reduction rates, GNP per capita growth rates, and fertility reduction rates, 1960-87

Country	Under 5 mortality rate						GNP per capita		Total fertility rate		
				Average annual rate of reduction			Average annual growth rate				
	1960	1980	1987	1960-80	1980-87	**required 1987-2000	1965-80	1980-86	1960	1987	Average annual reduction rate 1960-87
Afghanistan	380	321	304	0.84%	0.77%	10.68%	0.6		7.0	6.9	0.05%
Mali	370	323	296	0.68%	1.24%	10.50%	2.1	-0.5	6.5	6.7	-0.11%
Mozambique	330	258	295	1.22%	-1.93%	10.48%		-7.6	6.4	6.3	0.06%
Angola	346	272	288	1.20%	-0.82%	10.31%			6.4	6.4	0.00%
Sierra Leone	386	300	270	1.25%	1.49%	9.86%	0.7	-1.8	6.3	6.5	-0.12%
Malawi	364	300	267	0.96%	1.65%	9.79%	3.2	-0.7	6.9	7.0	-0.05%
Ethiopia	294	260	261	0.61%	-0.05%	9.63%	0.4	-2.1	6.7	6.2	0.29%
Guinea	346	280	252	1.04%	1.54%	9.38%	1.3	-0.7	6.4	6.1	0.18%
Burkina Faso	362	265	237	1.55%	1.58%	8.95%	1.7	-0.8	6.7	6.5	0.11%
Niger	320	258	232	1.07%	1.51%	8.81%	-2.5	-5.7	7.1	7.1	0.00%
Chad	326	253	227	1.26%	1.54%	8.65%	-1.9	2.9	6.0	5.8	0.13%
Guinea-Bissau	315	253	227	1.09%	1.54%	8.65%	-2.7	2.4	5.1	5.4	-0.21%
Central African Rep	308	244	226	1.16%	1.09%	8.62%	0.8	-0.8	5.7	5.8	-0.06%
Somalia	294	247	225	0.87%	1.32%	8.59%	-0.1	0.8	6.6	6.6	0.00%
Mauritania	320	249	223	1.25%	1.56%	8.53%	-0.1	-1.9	6.5	6.5	0.00%
Senegal	313	251	220	1.10%	1.87%	8.43%	-0.5	0.0	6.7	6.3	0.23%
Rwanda	248	231	209	0.35%	1.42%	8.07%	1.6	-1.6	7.7	8.2	-0.23%
Kampuchea	218	330	206	-2.09%	6.38%	8.04%			6.3	4.6	1.16%
Yemen, Dem.	378	236	202	2.33%	2.20%	7.83%		-5.5	7.0	6.6	0.22%
Bhutan	297	222	200	1.44%	1.48%	7.76%			5.9	5.5	0.26%
Nepal	297	222	200	1.44%	1.48%	7.76%	0.0	0.8	5.9	5.8	0.06%
Yemen	378	227	195	2.52%	2.15%	7.58%	6.5	5.1	7.0	6.9	0.05%
Burundi	258	215	192	0.91%	1.60%	7.47%	2.4	-0.5	5.7	6.2	-0.31%
Bangladesh	262	211	191	1.08%	1.41%	7.43%	-0.3	0.9	6.7	5.4	0.80%
Benin	310	211	188	1.91%	1.64%	7.32%	-0.3	0.0	6.8	7.0	-0.11%
Madagascar	364	216	187	2.58%	2.04%	7.28%	-0.4	-4.1	6.6	6.6	0.00%
Sudan	293	210	184	1.65%	1.87%	7.16%	0.8	-4.2	6.7	6.4	0.17%
Tanzania, U. Rep.	248	201	179	1.05%	1.64%	6.97%	0.8	-2.6	6.9	7.1	-0.11%
Nigeria	318	198	177	2.34%	1.59%	6.89%	4.2	-5.3	6.9	6.9	0.00%
Bolivia	282	207	176	1.53%	2.29%	6.85%	1.7	-5.9	6.6	6.0	0.35%
Haiti	294	197	174	1.98%	1.76%	6.76%	0.9	-2.3	6.2	4.6	1.10%
Gabon	288	194	172	1.96%	1.70%	6.68%	5.6	-1.7	4.1	5.1	-0.81%
Uganda	224	187	172	0.90%	1.19%	6.68%	-2.2	-1.8	6.9	6.9	0.00%
Pakistan	277	192	169	1.82%	1.81%	6.56%	1.8	3.4	7.0	6.3	0.39%
Zaire	251	186	164	1.49%	1.78%	6.34%	-1.3	-3.2	5.9	6.1	-0.12%
Lao PDR	232	189	163	1.02%	2.09%	6.30%			6.2	5.6	0.38%
Togo	305	176	156	2.71%	1.71%	5.98%	1.7	-4.5	6.2	6.0	0.12%
Cameroon	275	176	156	2.21%	1.71%	5.98%	2.4	3.5	5.8	5.8	0.00%
India	282	160	152	2.22%	2.39%	5.79%	1.5	2.9	5.8	4.2	1.19%
Liberia	258	173	150	1.98%	2.02%	5.69%	0.5	-5.5	6.3	6.5	-0.12%
Ghana	224	165	149	1.52%	1.45%	5.65%	-0.8	-2.8	6.9	6.3	0.34%
Oman	378	196	149	3.23%	3.84%	5.65%	9.0	9.8	7.2	7.1	0.05%
Cote d'Ivoire	264	166	145	2.29%	1.91%	5.45%	2.8	-3.1	7.3	7.4	-0.05%
Lesotho	208	161	139	1.27%	2.08%	5.14%	6.8	0.5	5.8	5.7	0.06%
Zambia	228	146	130	2.20%	1.64%	4.65%	-1.2	-5.3	6.6	7.1	-0.27%
Egypt	300	164	129	2.97%	3.37%	4.59%	2.8	2.6	7.1	4.6	1.59%
Peru	233	144	126	2.38%	1.89%	4.42%	0.8	-2.6	6.9	4.3	1.74%
Libya	268	150	123	2.86%	2.80%	4.24%			7.2	6.8	0.21%
Morocco	265	152	123	2.74%	2.98%	4.24%	2.7	0.4	7.2	4.6	1.65%
Indonesia	135	145	120	2.39%	2.67%	4.06%	5.2	2.0	5.4	3.1	2.03%
Congo	241	132	117	2.97%	1.71%	4.31%	2.7	2.2	5.9	5.9	0.00%
Kenya	208	133	116	2.21%	1.93%	4.13%	3.1	-1.4	8.1	7.9	0.09%
Zimbabwe	182	132	116	1.59%	1.83%	4.25%	1.7	-0.1	7.5	5.6	1.08%
Algeria	270	147	111	2.99%	3.93%	3.48%	4.2	1.4	7.4	5.7	0.96%
Honduras	232	140	111	2.49%	3.26%	3.48%	1.1	-2.3	7.4	5.3	1.23%
Guatemala	230	130	103	2.81%	3.27%	3.48%	3.0	-4.1	6.8	5.6	0.72%
Saudi Arabia	292	131	102	3.93%	3.51%	3.41%			7.3	7.1	0.10%
Nicaragua	210	132	99	2.29%	4.03%	3.07%	-0.7	-4.3	7.3	5.3	1.18%
Burma	229	118	98	3.26%	2.62%	3.83%	1.6	2.7	5.9	3.9	1.52%
South Africa	192	120	98	2.32%	2.85%	3.70%	3.2	2.8	6.5	4.4	1.53%
Turkey	258	133	97	3.26%	4.41%	2.92%	3.6	2.4	6.1	3.4	2.14%
Iraq	222	110	96	3.45%	1.93%	4.19%			7.2	6.2	0.55%
Botswana	174	110	95	2.27%	2.07%	4.12%	9.9	7.4	6.9	6.1	0.46%
Iran, Islamic Rep.	254	130	94	3.29%	4.53%	2.80%	2.9	3.6	7.3	5.6	0.98%
Viet Nam	233	116	91	3.43%	3.41%	3.41%			6.0	3.9	1.58%

** *The average annual reduction rate required, to achieve the U.N. target of reducing U5MR to 70 or less by the year 2000, or halving the 1980 rate, whichever is less.*

Country	Under 5 mortality rate						GNP per capita		Total fertility rate		
				Average annual rate of reduction			Average annual growth rate				
	1960	1980	1987	1960-80	1980-87	**required 1987-2000	1965-80	1980-86	1960	1987	Average annual reduction rate 1960-87
Ecuador	183	107	89	2.65%	2.60%	3.91%	5.4	−1.6	6.9	4.5	1.57%
Brazil	160	103	87	2.18%	2.38%	4.03%	6.3	0.3	6.2	3.3	2.31%
El Salvador	206	110	87	3.09%	3.30%	3.47%	1.5	−2.3	6.8	4.7	1.36%
Tunisia	255	113	86	3.99%	3.83%	3.11%	4.7	0.9	7.2	3.8	2.34%
Papua New Guinea	247	111	85	3.92%	3.74%	3.16%			6.3	5.5	0.50%
Dominican Rep.	200	102	84	3.31%	2.74%	3.77%	3.8	−1.8	7.3	3.6	2.58%
Philippines	135	86	75	2.23%	1.94%	4.19%	3.2	−4.0	6.6	4.2	1.66%
Mexico	140	83	70	2.58%	2.40%	3.85%	3.6	−2.0	6.7	3.4	2.53%
Colombia	148	78	69	3.15%	1.74%	4.29%	3.7	0.1	6.7	3.5	2.38%
Syrian Arab Rep.	218	87	67	4.49%	3.66%	3.18%	5.1	−0.9	7.5	6.6	0.47%
Paraguay	134	70	63	3.19%	1.49%	4.42%	4.1	−2.4	6.8	4.5	1.52%
Mongolia	158	77	61	3.53%	3.27%	3.38%			5.7	5.3	0.27%
Jordan	218	80	60	4.89%	4.03%	3.07%	5.8	−0.2	8.0	7.1	0.44%
Lebanon	92	62	53	1.95%	2.22%	4.04%			6.4	3.3	2.42%
Thailand	149	67	51	3.92%	3.82%	3.29%	4.4	2.8	6.4	2.4	3.57%
Albania	151	60	48	4.51%	3.14%	3.55%			5.8	2.9	2.53%
China	202	56	45	6.21%	3.08%	3.58%	4.1	9.2	5.9	2.3	3.43%
Sri Lanka	113	58	45	3.28%	3.56%	3.32%	2.8	2.5	5.2	2.6	2.53%
Venezuela	114	50	45	4.04%	1.49%	4.42%	2.3	−4.1	6.5	3.6	2.16%
Guyana	94	54	39	2.73%	4.54%	2.79%	0.7	−6.9	6.0	2.6	3.05%
Argentina	75	46	38	2.41%	2.69%	3.79%	1.7	−2.6	3.1	2.9	0.25%
Panama	105	43	35	4.37%	2.90%	3.51%	2.8	0.2	5.9	3.0	2.47%
Korea, Dem. Rep. of	120	43	34	5.00%	3.30%	3.29%		5.6	3.5		1.73%
Korea, Rep. of	120	43	34	5.00%	3.30%	3.29%	7.3	6.8	5.4	1.9	3.79%
Malaysia	106	42	33	4.52%	3.39%	3.42%	4.7	1.1	6.7	3.3	2.59%
United Arab Emirates	239	43	33	8.22%	3.71%	3.07%			6.9	4.6	1.49%
Uruguay	56	43	32	1.31%	4.13%	3.19%	2.5	−3.7	2.9	2.6	0.40%
USSR	53	34	30	2.20%	1.77%	4.28%			2.5	2.3	0.31%
Mauritius	104	42	30	4.43%	4.69%	2.71%	3.7	3.6	5.7	1.9	3.99%
Romania	82	36	28	4.03%	3.53%	3.34%		3.0	2.0	2.1	−0.18%
Yugoslavia	113	37	28	5.43%	3.90%	2.94%	5.2	0.0	2.7	1.9	1.29%
Chile	142	43	26	5.80%	6.93%	1.28%	0.0	−2.7	5.3	2.7	2.47%
Trinidad and Tobago	67	29	24	4.10%	2.67%	3.55%	3.1	−6.6	5.0	2.6	2.39%
Kuwait	128	34	23	6.41%	5.43%	2.30%			7.4	4.6	1.75%
Jamaica	88	29	23	5.40%	3.26%	3.23%	−0.1	−3.3	5.4	2.7	2.53%
Costa Rica	121	31	23	6.58%	4.17%	2.75%	3.3	−1.0	6.9	3.2	2.81%
Bulgaria	69	25	20	4.95%	3.14%	3.26%			2.2	1.9	0.54%
Poland	70	24	19	5.21%	3.28%	3.47%		1.3	2.6	2.2	0.62%
Cuba	87	27	19	5.68%	4.90%	2.32%			4.7	1.7	3.70%
Hungary	57	26	19	3.85%	4.38%	2.88%	5.1	1.5	1.8	1.7	0.00%
Portugal	112	30	19	6.37%	6.32%	1.80%	4.6	1.2	3.1	1.7	2.20%
Greece	64	23	17	4.99%	4.23%	2.64%	4.8	−0.1	2.2	1.7	0.95%
Czechoslovakia	32	20	17	2.32%	2.29%	4.00%			2.4	2.0	0.67%
Belgium	35	15	13	4.15%	2.02%	3.67%	3.6	0.9	2.7	1.6	1.92%
USA	30	15	13	3.41%	2.02%	3.67%	1.8	1.9	3.3	1.8	2.22%
New Zealand	27	16	13	2.58%	2.92%	3.67%	1.7	1.1	3.8	1.9	2.53%
Israel	40	18	13	3.91%	4.54%	2.79%	3.7	−0.1	3.9	2.8	1.22%
Austria	43	16	12	4.82%	4.03%	3.07%	4.0	1.8	2.8	1.5	2.29%
Singapore	50	15	12	5.84%	3.14%	3.07%	8.3	5.7	4.9	1.7	3.84%
Italy	50	17	12	5.25%	4.85%	2.19%	3.2	1.0	2.5	1.5	1.87%
German Dem. Rep.	44	15	12	5.24%	3.14%	3.07%			2.4	1.7	1.27%
United Kingdom	27	14	11	3.23%	3.39%	3.42%	2.0	2.3	2.8	1.8	1.62%
Ireland	36	15	11	4.28%	4.33%	2.42%	2.8	−1.9	4.0	2.4	1.87%
Germany, Fed. Rep.	40	16	11	4.48%	5.21%	2.42%	3.0	1.8	2.5	1.4	2.12%
Denmark	25	11	11	4.02%	0.00%	4.56%	2.2	2.5	2.6	1.5	2.02%
Spain	56	15	11	6.37%	4.33%	2.42%	4.1	1.2	2.9	1.7	1.96%
Australia	25	14	10	2.86%	4.69%	2.71%	2.2	1.4	3.3	1.8	2.22%
France	34	13	10	4.69%	3.68%	2.71%	3.7	0.6	2.9	1.8	1.75%
Hong Kong	65	14	10	7.39%	4.69%	2.71%	6.2	4.8	5.3	1.7	4.12%
Canada	33	13	9	4.55%	5.12%	1.91%	3.3	1.6	3.6	1.6	2.74%
Netherlands	22	11	9	3.41%	2.83%	3.07%	2.7	0.6	3.1	1.5	2.65%
Norway	23	11	8	3.62%	4.45%	2.19%	3.6	3.5	2.9	1.7	1.96%
Switzerland	27	11	8	4.39%	4.45%	2.19%	1.5	1.4	2.5	1.6	1.64%
Japan	40	13	8	5.46%	6.70%	1.02%	5.1	3.1	2.0	1.7	0.60%
Finland	28	9	7	5.52%	3.53%	2.56%	3.6	2.1	2.6	1.6	1.56%
Sweden	20	9	7	3.91%	3.53%	2.56%	2.0	1.7	2.3	1.6	1.11%

III
STATISTICS

Economic and social statistics on the nations of the world, with particular reference to children's well-being.

General note on the data

The data provided in these tables are accompanied by definitions, sources, explanations of signs and individual footnotes where the definition of the figure is different from the general definition being used. Tables derived from so many sources – nine major sources are listed in the explanatory material – will inevitably cover a wide range of reliability. Official government data received by the responsible United Nations agency have been used wherever possible. In the many cases where there are no reliable official figures, estimates made by the responsible United Nations agency have been used. Where such internationally standardized estimates do not exist, the tables draw on data received from the appropriate UNICEF field office. All data from UNICEF field office sources are marked with * or Y.

The figures for under five and infant mortality rates, life expectancy, crude birth and death rates, etc. are part of the regular work on estimates and projections undertaken by the United Nations Population Division. These and other international estimates are revised periodically which explains why some of the data will differ from those found in earlier UNICEF publications. In the case of GNP per capita and ODA, the data are the result of a continuous process of revising and updating by the World Bank and OECD respectively.

Where possible only comprehensive or representative sample national data have been used although, as in the table on "Wasting", there are certain exceptions. Where the figures refer to only a part of the country this is indicated in a footnote.

Signs and explanations

Unless otherwise stated, the summary measures for the four U5MR (under five mortality rate) groups of countries are the median values for each group. The median is the middle value of a data set arranged in order of magnitude. The median is the average commonly used where there are a large number of items of data with a great range, as is the case in these tables, and it has the advantage of not being distorted by the very small or the very large countries. In cases where the range of the data is not all that extensive, the most commonly used average is the mean, which is the sum of all the values divided by the number of the items. However, because we are dealing here with countries of very different sizes of population, we would immediately encounter the problem of weighting if we used the mean. Hence the choice of the median to give the reader some idea of the situation in a typical country of the appropriate U5MR group.

.. Data not available.

* UNICEF field office source.

(.) Less than half the unit shown.

T Total (as opposed to a median).

X See footnote at the end of the tables.

Y UNICEF field office source; see footnote at the end of the tables.

Most of the U5MR figures are interpolations based on five-year estimates prepared by the UN Population Division on an internationally comparable basis using various sources. In some cases, these interpolated estimates may differ from the latest national figures.

Index to countries

In the following tables, countries are ranked in descending order of their estimated 1987 under-five mortality rate which has then been rounded to the nearest whole number. The reference numbers indicating that rank are given in the alphabetical list of countries below.

TABLE 1: BASIC INDICATORS

		Under 5 mortality rate		Infant mortality rate (under 1)		Total population (millions)	Annual no. of births/infant and child deaths (0–4) (thousands)	GNP per capita (US $)	Life expectancy at birth (years)	% adults literate male/female	% of age group enrolled in primary school male/female	% share of household income 1975–1986	
		1960	1987	1960	1987	1987	1987	1986	1987	1985	1984–1986	lowest 40%	highest 20%
	Very high U5MR countries (over 170) Median	313	209	188	129	498T	24695T/5158T	265	48	43/22	68/43	. .	. .
1	Afghanistan	380	**304**	215	173	14.7	874/265	. .	42	39/8	23/12	. .	. .
2	Mali	370	**296**	210	170	8.6	461/136	180	45	23/11	27/16	. .	. .
3	Mozambique	330	**295**	190	170	14.5	690/204	210	47	55/22	92/73	. .	. .
4	Angola	346	**288**	208	169	9.2	467/134	470*	45	49/.	./.	. .	. .
5	Sierra Leone	386	**270**	219	155	3.8	197/53	310	42	38/21	68*/48*	. .	. .
6	Malawi	364	**267**	206	151	7.6	437/117	160	48	52/31	72/55	. .	. .
7	Ethiopia	294	**261**	175	155	43.8	2098/547	120	42	./.	44/28	. .	. .
8	Guinea	346	**252**	208	148	6.4	315/79	. .	43	40/17	40/17	. .	. .
9	Burkina Faso	362	**237**	205	139	8.3	419/99	150	48	21/6	45/26	. .	. .
10	Niger	320	**232**	191	136	6.5	357/83	260	45	19/9	37/20	. .	. .
11	Chad	326	**227**	195	133	5.3	247/56	80*	46	40/11	61/24	. .	. .
12	Guinea-Bissau	315	**227**	188	133	0.9	40/9	170	46	46/17	81/40	. .	. .
13	Central African Rep.	308	**226**	183	133	2.7	127/29	290	46	53/29	81/50	. .	. .
14	Somalia	294	**225**	175	133	6.9	363/81	280	46	18/6	26/13	. .	. .
15	Mauritania	320	**223**	191	128	1.9	92/21	420	47	./.	57/35	. .	. .
16	Senegal	313	**220**	180	129	6.8	331/73	420	47	37/19	66/45	. .	. .
17	Rwanda	248	**209**	146	123	6.5	361/75	290	49	61/33	68/66	. .	. .
18	Kampuchea	218	**208**	146	133	7.7	320/67	. .	49	85*/65*	./.	. .	. .
19	Yemen, Dem.	378	**202**	214	122	2.3	116/23	470	52	59/25	96/35	. .	. .
20	Bhutan	297	**200**	186	129	1.4	58/12	150	49	./.	29/17	. .	. .
21	Nepal	297	**200**	186	129	17.8	723/145	150	52	39/12	104/47	. .	. .
22	Yemen	378	**195**	214	117	7.3	378/74	550	52	27/3	125/31	. .	. .
23	Burundi	258	**192**	152	113	5.0	244/47	240	50	43*/26*	68/50	. .	. .
24	Bangladesh	262	**191**	156	120	106.7	4754/908	160	52	43/22	68/49	17	45
25	Benin	310	**188**	185	111	4.3	235/44	270	47	37/16	87/43	. .	. .
26	Madagascar	364	**187**	219	121	10.9	538/100	230	54	74/62	125/118	. .	. .
27	Sudan	293	**184**	170	109	23.1	1098/202	320	51	33*/14*	59/41	. .	. .
28	Tanzania, U. Rep. of	248	**179**	146	107	24.5	1356/243	250	54	93*/88*	70/69	. .	. .
29	Nigeria	318	**177**	190	106	101.9	5521/975	640	51	54/31	103/81	. .	. .
30	Bolivia	282	**176**	167	111	6.7	306/54	600	54	84/65	93/82	. .	. .
31	Haiti	294	**174**	197	118	6.1	218/38	330	55	40/35	83/72	. .	. .
32	Gabon	288	**172**	171	104	1.1	47/8	3080	52	70/53	127/125	. .	. .
33	Uganda	224	**172**	133	104	16.6	909/157	230	52	70/45	66*/50*	. .	. .
	High U5MR countries (95–170) Median	238	123	151	84	1499T	53573T/7584T	740	59	68/49	102/86	. .	. .
34	Pakistan	277	**169**	163	110	111.0	5398/911	350	58	40/19	55/32	. .	. .
35	Zaire	251	**164**	148	99	32.7	1611/265	160	53	79/45	112*/84*	. .	. .
36	Lao People's Dem. Rep.	232	**163**	155	111	3.8	161/26	. .	49	92/76	102/85	. .	. .
37	Togo	305	**156**	182	95	3.1	152/24	250	54	53/28	125/78	. .	. .
38	Cameroon	275	**156**	163	95	10.4	463/72	910	52	68/55	116/97	. .	. .
39	India	282	**152**	165	100	802.1	26783/4080	290	59	57/29	107/76	16	49
40	Liberia	258	**150**	153	88	2.3	113/17	460	55	47/23	82*/50*	. .	. .
41	Ghana	224	**149**	132	91	13.7	649/97	390	55	64/43	75/59	. .	. .
42	Oman	378		214		1.3	66/10	4980	57	47*/12*	101/86	. .	. .
43	Côte d'Ivoire	264	**145**	165	97	11.1	629/92	730	53	53/31	92/65	9	61
44	Lesotho	208	**139**	149	101	1.6	71/10	370	57	62/84	102/127	. .	. .
45	Zambia	228	**130**	135	81	7.6	420/54	300	54	84/67	112/101	11	61
46	Egypt	300	**129**	179	87	50.2	1805/233	760	62	59/30	96/77	17*	48*
47	Peru	233	**126**	142	89	20.7	729/92	1090	63	91/78	125/120	7*	61*
48	Libyan Arab Jamahiriya	268	**123**	160	84	4.1	197/24	. .	62	81/50	./.	. .	. .
49	Morocco	265	**123**	163	84	23.3	839/103	590	62	45/22	96/62	. .	. .
50	Indonesia	235	**120**	139	85	172.2	4751/570	490	57	83/65	121/116	14	49
51	Congo	241	**117**	143	74	1.8	87/10	990	49	71/55	./.	. .	. .
52	Kenya	208	**116**	124	73	22.1	1303/151	300	59	70/49	97/91	9	60
53	Zimbabwe	182	**116**	110	73	8.8	393/45	620	59	81/67	132/126	. .	. .
54	Algeria	270	**111**	168	75	23.1	965/107	2590	63	63/37	105/85	. .	. .
55	Honduras	232	**111**	144	70	4.7	196/22	740	65	61/58	103/102	. .	. .
56	Guatemala	230	**103**	125	60	8.4	363/37	930	63	63/47	82/70	. .	. .
57	Saudi Arabia	292	**102**	170	72	12.6	585/60	6950	64	71*/31*	78/65	. .	. .
58	Nicaragua	210	**99**	140	63	3.5	155/15	790	64	./.	93/103	. .	. .
59	Burma	229	**98**	153	71	39.1	1249/123	200	61	./.	./.	. .	. .
60	South Africa	192	**98**	135	73	33.0	1080/106	1850	61	./.	./.	. .	. .
61	Turkey	258	**97**	190	78	52.5	1521/148	1110	65	86*/62*	121/113	12*	57*
62	Iraq	222	**96**	139	70	17.1	779/75	3020*	65	90/87	107/91	. .	. .
63	Botswana	174	**95**	119	68	1.2	59/6	840	59	73/69	101/109	. .	. .

Note: nations are listed in descending order of their 1987 under-five mortality rates (shown in bold type)

		Under 5 mortality rate		Infant mortality rate (under 1)		Total population (millions)	Annual no. of births/infant and child deaths (0–4) (thousands)	GNP per capita (US $)	Life expectancy at birth (years)	% adults literate male/female	% of age group enrolled in primary school male/female	% share of household income 1975–1986	
		1960	1987	1960	1987	1987	1987	1986	1987	1985	1984–1986	lowest 40%	highest 20%
	Middle U5MR countries (31-94) Median	149	60	103	45	1782T	43781T/2552T	1230	67	87/80	107/103	14	53
64	Iran, Islamic Rep. of	254	**94**	169	65	51.3	2269/213	. .	66	62/39	127/107	. .	. .
65	Viet Nam	233	**91**	156	65	62.8	2080/190	. .	62	88*/80*	107/94	. .	. .
66	Ecuador	183	**89**	124	64	9.9	369/33	1160	66	85/80	117*/117*	. .	. .
67	Brazil	160	**87**	116	64	141.5	4101/358	1810	65	79/76	108*/99*	7*	67*
68	El Salvador	206	**87**	142	60	4.9	190/16	820	64	75/69	69/70	16	47
69	Tunisia	255	**86**	159	60	7.6	231/20	1140	66	68/41	127/108	. .	. .
70	Papua New Guinea	247	**85**	165	61	3.7	149/13	720	55	55/35	47*/37*	. .	. .
71	Dominican Rep.	200	**84**	125	66	6.7	213/18	710	67	78/77	131/135	. .	. .
72	Philippines	135	**75**	80	46	58.0	1975/147	560	64	86/85	107/106	14	53
73	Mexico	140	**70**	92	48	83.0	2457/172	1860	69	92/88	115/113	10	58
74	Colombia	148	**69**	93	46	29.9	887/61	1230	65	89/87	112/115	. .	. .
75	Syrian Arab Rep.	218	**67**	135	49	11.2	532/35	1570	66	76/43	117/105	. .	. .
76	Paraguay	134	**63**	86	42	3.9	144/9	1000	67	91/85	102/97	. .	. .
77	Mongolia	158	**61**	109	46	2.0	85/5	. .	64	93*/86*	100/103	. .	. .
78	Jordan	218	**60**	135	45	3.8	193/12	1540	67	87/63	98*/99*	. .	. .
79	Lebanon	92	**53**	68	41	2.8	83/4	. .	68	86/69	105/95	. .	. .
80	Thailand	149	**51**	103	40	53.3	1180/60	810	66	94/88	99/96	15	50
81	Albania	151	**48**	112	40	3.1	74/4	. .	72	./.	98/93	. .	. .
82	China	202	**45**	150	33	1088.6	22894/1041	300	70	82/56	137/120	. .	. .
83	Sri Lanka	113	**45**	70	34	16.6	371/17	400	71	91/83	104/102	16	50
84	Venezuela	114	**45**	81	36	18.3	578/26	2920	70	88/85	110/110	10*	54*
85	Guyana	94	**39**	69	31	1.0	24/1	500	70	97/95	101*/99*	. .	. .
86	Argentina	75	**38**	61	32	31.1	671/26	2350	71	96/95	109/109	14*	50*
87	Panama	105	**35**	69	23	2.3	62/2	2330	72	89/88	109/104	7*	62*
88	Korea, Dem. Rep. of	120	**34**	85	26	21.4	633/22	. .	70	./.	./.	. .	. .
89	Korea, Rep. of	120	**34**	85	26	42.1	775/26	2370	70	96*/88*	94/94	17	45
90	Malaysia	106	**33**	73	24	16.2	467/16	1830	70	81/66	101/101	11*	56*
91	United Arab Emirates	239	**33**	145	27	1.5	34/1	14680	71	58*/38*	99/101	. .	. .
92	Uruguay	56	**32**	50	27	3.1	58/2	1900	71	93*/94*	111/109	. .	. .
	Low U5MR countries (30 and under) Median	44	13	36	10	1227T	18083T/331T	7295	75	97/90	103/101	18	40
93	USSR	53	**30**	38	25	281.5	5082/153	4550*	70	./.	./.	. .	. .
94	Mauritius	104	**30**	70	24	1.1	20/1	1200	69	89/77	105/106	12	61
95	Romania	82	**28**	69	22	22.9	356/10	2560*	71	./.	98/97	. .	. .
96	Yugoslavia	113	**28**	92	25	23.4	347/10	2300	72	97/86	95/94	19	39
97	Chile	142	**26**	114	20	12.5	304/8	1320	72	97*/96*	110/109	. .	. .
98	Trinidad and Tobago	67	**24**	54	20	1.2	29/1	5360	71	97/95	93/96	13	50
99	Kuwait	128	**23**	89	19	1.9	62/1	13890	73	76/63	99/96	. .	. .
100	Jamaica	88	**23**	62	18	2.4	62/1	840	74	./.	106*/107*	. .	. .
101	Costa Rica	121	**23**	84	18	2.8	81/2	1480	75	94/93	103/101	12*	55*
102	Bulgaria	69	**20**	49	15	9.0	113/2	4150*	72	./.	103/102	. .	. .
103	Poland	70	**19**	62	18	37.7	600/12	2070	72	./.	101/101	. .	. .
104	Cuba	87	**19**	62	15	10.1	164/3	. .	74	96*/96*	108/101	. .	. .
105	Hungary	57	**19**	51	17	10.6	124/2	2020	71	./.	97/98	21	36
106	Portugal	112	**19**	81	16	10.2	138/3	2250	74	89/80	131/123	15*	49*
107	Greece	64	**17**	53	12	10.0	118/2	3680	76	97/88	106/106	. .	. .
108	Czechoslovakia	32	**17**	26	13	15.6	219/4	5820*	72	./.	97/98	. .	. .
109	Belgium	35	**13**	31	10	9.9	116/2	9230	75	./.	95/97	22	36
110	USA	30	**13**	26	10	243.4	3640/48	17480	76	./.	103/101	17	40
111	New Zealand	27	**13**	23	11	3.3	52/1	7460	75	./.	106/106	16	45
112	Israel	40	**13**	33	11	4.4	95/1	6210	76	97/93	98/100	18	40
113	Austria	43	**12**	37	10	7.5	86/1	9990	74	./.	100/100	. .	. .
114	Singapore	50	**12**	36	9	2.6	43/1	7410	73	93/79	118/113	. .	. .
115	Italy	50	**12**	44	10	57.2	635/8	8550	76	98/96	99/99	18	44
116	German Dem. Rep.	44	**12**	37	9	16.6	204/2	7180*	74	./.	104/103	. .	. .
117	United Kingdom	27	**11**	23	9	56.7	761/9	8870	76	./.	105/106	19	40
118	Ireland	36	**11**	31	9	3.6	67/1	5070	74	./.	100/100	20*	39*
119	Germany, Fed. Rep. of	40	**11**	33	9	60.8	643/7	12080	75	./.	97/97	20	40
120	Denmark	25	**11**	22	8	5.1	56/1	12600	76	./.	98/98	17	39
121	Spain	56	**11**	46	9	38.9	503/5	4860	77	97/92	104/103	19	40
122	Australia	25	**10**	21	9	16.2	244/3	11920	76	./.	106/105	15	47
123	France	34	**10**	29	8	55.6	774/8	10720	76	./.	113/111	17	42
124	Hong Kong	65	**10**	44	8	5.6	87/1	6910	76	95/81	106/104	16	47
125	Canada	33	**9**	28	8	25.9	358/3	14120	77	./.	106/104	17	40
126	Netherlands	22	**9**	18	8	14.5	174/2	10020	77	./.	113/115	22	36
127	Norway	23	**8**	19	7	4.2	52/0	15400	77	./.	97/97	19	38
128	Switzerland	27	**8**	22	7	6.5	75/1	17680	77	./.	./.	20	38
129	Japan	40	**8**	31	5	121.9	1445/12	12840	78	./.	101/102	22	38
130	Finland	28	**7**	22	6	4.9	61/0	12160	75	./.	104/104	18	38
131	Sweden	20	**7**	16	6	8.3	93/1	13160	77	./.	97/99	21	42

TABLE 2: NUTRITION

		% of infants with low birth-weight 1982-7	% of mothers breast-feeding 1980-86			% of children under five suffering from mild-moderate/severe malnutrition 1980-86	Prevalence of wasting (12-23 months)/ stunting (24-59 months) (% of age group) 1980-87	Average index of food production per capita (1979-81 = 100) 1986	Daily per capita calorie supply as % of requirements 1985	% of household income spent on all food/cereals 1980-85
			3 months	6 months	12 months					
	Very high U5MR countries (over 170) Median	15	96	92	75	30/6	8/46	97	92	53/18
1	Afghanistan	19*	. .	. .	. .	20*/. .	. /.	92	92	. /. .
2	Mali	17*	96*	. .	82*	. /. .	18/23*	103	69	57/22
3	Mozambique	15	. .	. .	. .	. /. .	. /.	85	68	. /.
4	Angola	17*	95*	. .	. .	. /. .	. /.	87	86	. /.
5	Sierra Leone	14	98*	94*	83*	24*/3*	26/46	101	85	47/18
6	Malawi	10	. .	. .	96*	. /. .	8/61	88	95	55/28
7	Ethiopia	. .	. .	97†	95†	. /. .	19/43	88	94	32/12
8	Guinea	18	100*	70*	40*	. /. .	. /.	94	85	. /.
9	Burkina Faso	18*	98*	98*	97*	33*/7*	17*/.	126	87	. /.
10	Niger	20	65*	30*	15*	17*/9*	26/32*	91	97	. /.
11	Chad	11	. .	. .	. .	. /. .	. /.	106	79	. /.
12	Guinea-Bissau	20*	100*	100*	98*	. /. .	. /.	131	105	. /.
13	Central African Rep.	15*	. .	. .	. .	24*/6*	. /.	94	92	. /.
14	Somalia	. .	92*	78*	54*	7*/1*	/27	91	91	. /.
15	Mauritania	10	. .	. .	. .	30/10	. /.	92	97	. /.
16	Senegal	10	94	94	82	29*/1*	8/27*	100	109	53/16
17	Rwanda	17	97*	97*	74*	29*/8*	23/45	87	87	29/10
18	Kampuchea	. .	100*	93*	72*	17*/3*	. /.	142	85	. /.
19	Yemen, Dem.	13	80*	60*	55*	32*/8*	/36	83	93	. /.
20	Nepal	. .	92*	92‡	82*	. /. .	27*/72*	97	88	. /.
21	Bhutan	. .	. .	. .	. .	33/6	. /.	102	. .	. /.
22	Yemen	9	80*	76‡	55*	. /. .	17/69	119	93	. /.
23	Burundi	14	. .	95*	90*	30/5	36/52*	97	99	. /.
24	Bangladesh	31	98*	97‡	89*	40/10	17/59	100	78	. /.
25	Benin	10	95	90	75	. /. .	14/.	116	94	37/12
26	Madagascar	10*	95	95	85	. /. .	. /.	96	111	58/22
27	Sudan	15	91*	86‡	72*	33*/8*	48/63	104	93	58/.
28	Tanzania, U. Rep. of	14	100*	90*	70*	42*/6*	17*/.	92	99	62/30
29	Nigeria	25	98*	80*	60*	24*/.	21*/.	105	92	52/18
30	Bolivia	15*	93‡	91‡	45*	. /. .	1/43*	89	88	33/.
31	Haiti	17‡	. .	98*	88*	. /5*	18*/52*	94	79	. /.
32	Gabon	16	. .	. .	. .	. /. .	/27*	97	124	. /.
33	Uganda	10	85*	70*	20*	15*/4*	3/27*	129	109	. /.
	High U5MR countries (95–170) Median	13	94	90	71	25/5	10/38	98	100	41/13
34	Pakistan	25*	78	73	67	. /10	14/1*	104	93	54/17
35	Zaire	. .	100*	99*	86*	15*/5*	11/40	98	96	55/15
36	Lao People's Dem. Rep.	39	. .	99	93	. /. .	20/44	129	96	. /.
37	Togo	20*	. .	99*	90*	20*/5*	9*/36*	84	97	. /.
38	Cameroon	13	92*	90‡	77‡	. /. .	2/43*	95	89	26/8
39	India	30	. .	. .	. .	33/5	37/.	111	94	52/.
40	Liberia	. .	96*	92*	70*	31*/4*	7*/38*	97	103	. /.
41	Ghana	17*	100*	70*	25*	23*/7*	28/31*	114	78	50/.
42	Oman	14	. .	. .	. .	. /. .	. /.	. .	. .	. /.
43	Côte d'Ivoire	14	93*	90*	50*	. /. .	21/.	98	102	38/10
44	Lesotho	10	. .	87*	. .	. /. .	7/23	79	100	. /.
45	Zambia	14	. .	. .	93*	. /. .	12/41*	96	85	50/13
46	Egypt	7	92	87	71	. /. .	3*/37*	104	127	36/7
47	Peru	9*	82*	71*	55*	. /. .	11/59	96	84	35/8
48	Libyan Arab Jamahiriya	5	. .	. .	. .	. /. .	. /.	141	152	. /.
49	Morocco	9	95*	61*	. .	19*/9*	6/12	118	108	48/14
50	Indonesia	14	98	97	83	27/3	17/.	119	109	48/21
51	Congo	12‡	98*	98*	95*	17*/5*	5*/27*	93	108	31/12
52	Kenya	13	89‡	84*	44*	30*/2*	10*/41*	93	87	42/18
53	Zimbabwe	15	98*	95*	84*	. /. .	. /.	100	84	43/9
54	Algeria	9*	. .	. .	. .	. /. .	. /.	104	121	. /.
55	Honduras	20*	48	28	24	15*/10*	. /.	90	95	39/.
56	Guatemala	10*	. .	84	74	40*/10	3*/69*	95	99	36/10
57	Saudi Arabia	6	. .	91*	52*	. /. .	9/.	202	132	. /.
58	Nicaragua	15*	. .	71*	. .	. /. .	(.)/22	74	105	. /.
59	Burma	16*	90*	. .	. .	. /. .	17/.	127	117	. /.
60	South Africa	12	. .	. .	. .	. /. .	. /.	86	118	. /.
61	Turkey	7	99*	91*	51*	. /. .	. /.	103	125	40/.
62	Iraq	9*	76	45	19	. /. .	2/14	119	118	. /.
63	Botswana	8	97	90	75	31/1	19/56	78	95	35/13

Note: nations are listed in descending order of their 1987 under-five mortality rates (see table 1)

		% of infants with low birth-weight 1982-7	% of mothers breast-feeding 1980-86			% of children under five suffering from mild-moderate/severe malnutrition 1980-86	Prevalence of wasting (12-23 months)/ stunting (24-59 months) (% of age group) 1980-87	Average index of food production per capita (1979-81 = 100) 1986	Daily per capita calorie supply as % of requirements 1985	% of household income spent on all food/cereals 1980-85
			3 months	6 months	12 months					
	Middle U5MR countries (31-94) Median	9	79	58	35	. ./. .	11/44	98	111	35/9
64	Iran, Islamic Rep. of	9*	. .	. .	. .	. ./. .	23*/60*	98	118	. ./. .
65	Viet Nam	18*	93*	88*	20*	40/10	7*/60*	119	97	. ./. .
66	Ecuador	10*	98	84	68	. ./. .	. /39	101	88	31/. .
67	Brazil	8*	59*	19*	5*	. ./. .	. ./. .	104	107	35/9
68	El Salvador	15*	31*	28*	. .	. /5*	2*/54*	84	91	33/12
69	Tunisia	7	95*	92*	71*	. ./. .	3/45	106	119	42/10
70	Papua New Guinea	25	. .	. .	. .	38*/. .	. /58*	98	79	. ./. .
71	Dominican Rep.	16*	86*	66*	45*	38*/2*	. ./. .	97	110	46/13
72	Philippines	18	68*	58*	28*	. ./. .	14*/42	95	101	47/. .
73	Mexico	15	62*	48*	27*	. ./. .	. ./. .	97	126	35/. .
74	Colombia	15*	80*	55*	36*	. ./. .	1/21	97	111	29/. .
75	Syrian Arab Rep.	9	88*	72*	41*	23*/2*	. /. .	99	129	. ./. .
76	Paraguay	6	80*	77*	49*	31*/1*	. ./. .	97	127	30/6
77	Mongolia	10	. .	. .	. .	. ./. .	. ./. .	96	117	. ./. .
78	Jordan	7	80*	70*	50*	. ./. .	9*/. .	102	117	36/. .
79	Lebanon	10	50*	40*	15*	. ./. .	. ./. .	127	101	. ./. .
80	Thailand	12	83	79	68	27/(.)	8/. .	105	102	34/. .
81	Albania	7	. .	. .	. .	. ./. .	. ./. .	95	118	. ./. .
82	China	6	. .	. .	. .	. ./. .	3*/10*	125	111	. ./. .
83	Sri Lanka	28	95	81	68	. ./. .	20/31*	91	114	48/21
84	Venezuela	9	50*	40*	30*	. ./. .	3/7	93	95	38/. .
85	Guyana	11	77	60	35	. /1	. ./. .	81	111	. ./. .
86	Argentina	6	66	36	14	. ./. .	. ./. .	99	122	35/4
87	Panama	8	62*	53*	. .	. ./. .	7/24	93	98	38/7
88	Korea, Dem. Rep. of	. .	. .	. .	. .	. ./. .	. ./. .	106	126	. ./. .
89	Korea, Rep. of	9	94*	93*	84*	. ./. .	. ./. .	107	117	35/. .
90	Malaysia	9	68*	. .	. .	. ./. .	12*/47*	113	110	30/. .
91	United Arab Emirates	. .	. .	. .	. .	6*/. .	. ./. .	. .	. .	. ./. .
92	Uruguay	8	54*	33*	12*	. ./. .	14*/. .	98	103	31/7
	Low U5MR countries (30 and under) Median	6	. .	. .	. .	. ./. .	. ./. .	105	128	19/2
93	USSR	6	. .	. .	. .	. ./. .	. ./. .	111	128	. ./. .
94	Mauritius	9*	59*	49*	39*	17/7	20*/. .	107	118	20/4
95	Romania	6	. .	. .	. .	. ./. .	. ./. .	121	127	. ./. .
96	Yugoslavia	7	. .	. .	. .	. ./. .	. ./. .	98	134	27/. .
97	Chile	7*	23*	18*	17*	. ./. .	1/10	106	102	29/7
98	Trinidad and Tobago	. .	68*	53*	25	* 48*/1*	10/5*	94	126	. ./. .
99	Kuwait	7	47*	32*	12*	. ./. .	2/14	. .	. .	. ./. .
100	Jamaica	8*	57*	40*	16*	39*/1*	14/9	99	112	38/. .
101	Costa Rica	9	61	38	20	. ./. .	3/8	93	118	33/8
102	Bulgaria	6	. .	. .	. .	. ./. .	. ./. .	104	146	. ./. .
103	Poland	8	42*	32*	. .	. ./. .	. ./. .	110	126	29/. .
104	Cuba	8	. .	. .	. .	. ./. .	. ./. .	108	127	. ./. .
105	Hungary	10	45*	21*	4*	. ./. .	. ./. .	110	135	25/. .
106	Portugal	8	. .	. .	. .	. ./. .	. ./. .	101	124	34/. .
107	Greece	6	. .	. .	. .	. ./. .	. ./. .	96	145	30/. .
108	Czechoslovakia	6	. .	. .	. .	. ./. .	. ./. .	117	143	. ./. .
109	Belgium	5	. .	. .	. .	. ./. .	. ./. .	104	139	15/2
110	USA	7	33	25	8	. ./. .	. ./. .	98	140	13/2
111	New Zealand	5	. .	. .	. .	. ./. .	. ./. .	105	131	12/. .
112	Israel	7	. .	. .	. .	. ./. .	. ./. .	103	119	26/. .
113	Austria	6	. .	. .	. .	. ./. .	. ./. .	104	130	16/2
114	Singapore	7*	. .	. .	. .	. ./. .	9/10	90	114	19/. .
115	Italy	7	. .	. .	. .	. ./. .	. /. .	100	143	19/2
116	German Dem. Rep.	6	. .	. .	. .	. ./. .	. ./. .	109	143	. ./. .
117	United Kingdom	7	. .	. .	. .	. ./. .	. ./. .	111	129	12/2
118	Ireland	4	. .	. .	. .	. ./. .	. ./. .	99	140	22/4
119	Germany, Fed. Rep. of	5	. .	. .	. .	. ./. .	. ./. .	116	133	12/2
120	Denmark	6	. .	. .	. .	. ./. .	. ./. .	126	129	13/2
121	Spain	. .	. .	. .	. .	. ./. .	. ./. .	101	130	24/3
122	Australia	6	. .	. .	. .	. ./. .	. ./. .	100	114	13/. .
123	France	5	. .	. .	. .	. ./. .	. ./. .	105	142	16/2
124	Hong Kong	4*	. .	. .	. .	. ./. .	. ./. .	143	119	19/3
125	Canada	6	26*	13*	. .	. ./. .	. ./. .	116	130	11/2
126	Netherlands	4	17*	. .	. .	. ./. .	. /. .	108	128	13/2
127	Norway	4	. .	. .	. .	. ./. .	. ./. .	103	114	5/2
128	Switzerland	5	. .	. .	. .	. ./. .	. ./. .	105	126	17/. .
129	Japan	5	. .	. .	. .	. ./. .	. ./. .	107	106	19/3
130	Finland	4	. .	. .	. .	. ./. .	. ./. .	108	111	16/3
131	Sweden	4	. .	. .	. .	. ./. .	. /. .	103	114	13/2

TABLE 3: HEALTH

		% of population with access to drinking water 1980–87	% of population with access to health services 1980–87	Percentage fully immunized 1981/1986–87					ORS per 100 episodes of diarrhoea (litres)	% of births attended by trained health personnel	Maternal mortality rate
				one-year-old children				pregnant women			
		Total/urban/rural	Total/urban/rural	TB	DPT	Polio	Measles	Tetanus	1986	1983–87	1980–87
	Very high U5MR countries (over 170) Median	32/ 61 /15	41/ 80 /30	26/46	14/27	7/28	19/33	5/11	21	23	420
1	Afghanistan	19*/ 56*/10*	29*/ 80*/17*	8/27	3/25	3/25	6/31	3/6	22	. .	640*
2	Mali	12*/ 23*/ 9*	15*/ . . /. .	19/29*	. . /8*	. . /8*	. . /11*	1/9*	3	27*	. .
3	Mozambique	13*/ 50*/ 7*	30*/ . . /. .	46/59*	56/51*	32/38*	32/46*	. . /59*	54	28	300[x]
4	Angola	32/ 90 /12	30*/ . . /. .	. . /29*	. . /10*	. . /16*	. . /55*	. . /52*	20	15	. .
5	Sierra Leone	22/ 61 / 6	. . / . . /. .	35/73	15/30	13/30	28/50	10/59	46	25	450
6	Malawi	51/ 66 /49	80*/ . . /. .	86/92	66/55	68/50	65/53	. . /20	39	59	250*
7	Ethiopia	6*/ . . /. .	46*/ . . /. .	10/28*	6/16*	7/15*	7/13*	. . /5	9	58	. .
8	Guinea	15/ 69 / 2	. . / . . /. .	4*/46*	. . /15*	. . /8*	15*/43*	5*/5*	4	. .	. .
9	Burkina Faso	20*/ 60*/15*	49*/ 51*/48*	16/67	2/34	2/34	23/68	11/26	37	. .	600*
10	Niger	34/ 41 /33	41*/ 99*/30*	28/28[y]	6/5	6/4[y]	19/27[y]	3/5	. .	47	420
11	Chad	26*/ . . /. .	. . / . . /. .	. . /40	. . /12	. . /12	. . /33	. . /9*	7	. .	700*
12	Guinea-Bissau	33/ 21 /37	. . / . . /. .	. . /82*	. . /47*	. . /48*	. . /60*	. . /23*	5	16*	400
13	Central African Rep.	16*/ . . /. .	45*/ . . /. .	26/53[x]	12/24[x]	12/24[x]	16/30[x]	13/20[y]	23	. .	600
14	Somalia	36/ 65 /21	27*/ 50*/15*	3/33	2/25	2/25	3/29	5/6	50	2	1100
15	Mauritania	. . / 80 /. .	30*/ . . /. .	57/91	18/32	18/61	45/69	1/. .	1	23	. .
16	Senegal	42/ 69 /27	. . / . . /. .	. . /92	. . /53	. . /53	. . /70	. . /8*	1	. .	530*
17	Rwanda	59/ 55 /60	27*/ 60*/25*	51/85*	17/78*	15/80*	42/63*	5/32*	. .	. .	210
18	Kampuchea	3*/ 10*/ 2*	53*/ 80*/50*	. . /54*	. . /37*	. . /35*	. . /54*	. . /3*	32	47*	. .
19	Yemen, Dem.	46*/ 85*/32*	30/ . . /. .	9/41*	5/25*	5/25*	6/35*	3/8	103	10	100
20	Bhutan	15/ 40 /14	19/ . . /. .	36/38	13/27	11/27	21/23	. . /10	20	3	. .
21	Nepal	34*/ 80*/32*	. . / . . /. .	32/78	16/46	1/40	2/22	4/15	23	10	850*
22	Yemen	31*/ 99*/21*	30*/ 75*/24*	15/28	25/14	25/14	40/15	. . /2*	25	12	. .
23	Burundi	39/ 94 /22	61*/ . . /. .	65/89	38/73	6/76	30/58	25*/59	12	12	. .
24	Bangladesh	41/ 29 /43	45*/ . . /. .	1/14	1/9	1/8	(.)/6	1/7	25	. .	600
25	Benin	18/ 26 /15	18*/ . . /. .	. . /67	. . /52	. . /52	. . /38	. . /9	7	34	1680*
26	Madagascar	18*/ . . /. .	56*/ . . /. .	25/42	40/30	. . /24	. . /10	. . /5	8	62	300*
27	Sudan	21*/ 60*/10*	51*/ 90*/40*	3/46	1/29	1/29	1/22	1/12	40	20	. .
28	Tanzania, U. Rep. of	50/ 88 /39	76*/ 99*/72*	78/95*	58/81*	49/80*	76/78*	36/60	42	74	370*
29	Nigeria	33/ 58 /25	40*/ 75*/30*	23/41	24/20	24/21	55/31	11/12	2	. .	1500
30	Bolivia	49*/ 84*/14*	63*/ 90*/36*	30/31	13/24	15/28	17*/33	. . /2	59	36*	480*
31	Haiti	35*/ 50*/25*	70*/ 80*/70*	60/45	14/20	3/28	. . /23	. . /56[y]	11	20	340*
32	Gabon	92*/ . . /. .	90*/ . . /. .	. . /79	. . /48	. . /48	. . /55	. . /32*	27	92*	120
33	Uganda	16*/ 90*/ 7*	61*/ 90*/57*	18/74	9/39	8/40	22/48	20/13	21	. .	300
	High U5MR countries (95–170) Median	47/ 73 /29	70/ 98 /45	55/72	36/66	30/62	24/55	10/30	22	51	140
34	Pakistan	53*/ 84*/40*	55/ 99 /35	11/72	3/62	3/62	2/53	1/27	80	24	600
35	Zaire	9*/ 15*/ 5*	26*/ 40*/17*	34/54*	18/36*	18/36*	23/39*	. . /26*	19	. .	800
36	Lao People's Dem. Rep	21/ 28 /20	. . / . . /. .	4/60[x]	7*/28[x]	7*/10[x]	7*/33[x]	2*/19[x]	72	. .	. .
37	Togo	35/ 68 /26	61*/ . . /. .	44*/66[x]	9*/41[x]	9*/40[x]	47*/48[x]	57*/64	23	15*	84[x]
38	Cameroon	26[y]/ . . /. .	41*/ 44*/39*	8/77*	5/45*	5/43*	16/44*	. . /26*	3	. .	140[x]
39	India	56/ 80 /47	. . / . . /. .	12/46	31/58	7/50	(.)/17	24/47	18	33	500
40	Liberia	20*/ . . /. .	39*/ 50*/30*	87/68*	39/28*	26/28*	99/55*	60/20*	. .	89	. .
41	Ghana	50/ 72 /39	60/ 92 /45	67/71	22/37	25/34	23/51	11/40	26	73	1070*
42	Oman	14*/ 70*/10*	91*/100*/90*	49/95	9/77	9/77	6/78	27/70	74	60	. .
43	Côte d'Ivoire	19*/ 30*/10*	30*/ 61*/11*	70*/53[y]	42*/71[y]	34*/71[y]	28/85[y]	25*/63*	17	20*	. .
44	Lesotho	14/ 37 /11	. . / . . /. .	81/84	56/77	54/77	49/79	0*/0*	25	28	. .
45	Zambia	47/ 65 /33	75*/ . . /. .	72*/92	44*/66	77/61*	21/58	. . /41	32	. .	110
46	Egypt	76/ 88 /64	. . / . . /. .	71/72*	82/82*	84/88*	65/76*	10/12*	24	24	80
47	Peru	55/ 73 /18	. . / . . /17	63/61	18/42	18/45	24*/35	4/6*	7	55*	310
48	Libyan Arab Jamahiriya	96/100 /90	. . / . . /. .	55/77[x]	55/62[x]	55/62[x]	57/50[x]	6/12[x]	49	76	80*
49	Morocco	27*/ 63*/ 2*	70*/100*/50*	. . /87	43/78	45/78	. . /76	. . /33	11	. .	330
50	Indonesia	36*/ 53*/30*	75*/ . . /. .	55/82	(.)/69	(.)/70	(.)/61	10/33	14	43	800
51	Congo	21/ 42 / 7	83*/ 97*/70*	92/86	42/71	42/71	49/69	. . /67	8	. .	. .
52	Kenya	28/ 61 /21	. . / . . /. .	. . /86	. . /75	. . /75	. . /60	. . /37	21	. .	170*
53	Zimbabwe	52*/ . . /. .	71*/100*/62*	64/86*	39/77*	38/77*	56/73*	. . /48	5	69	150*
54	Algeria	88*/100*/80*	88*/100*/80*	59/95	33/66	30/66	17/59	. . /. .	8	. .	130
55	Honduras	69/ 91 /55	73*/ 85*/65*	46/66	38/58	37/61	38[x]/57	11/25[y]	48	50	82*
56	Guatemala	52*/ 80*/27*	34*/ 47*/25*	29/34	42*/16*	42*/18*	8/24	1/2[y]	17	19*	110
57	Saudi Arabia	91/100 /68	97*/100*/88*	49/93	53/89	52/89	12/80	. . /50	97	78	. .
58	Nicaragua	56/ 91 /10	83*/100*/60*	65/93	23/43	52/85	20/44	. . /25*	202	. .	65*
59	Burma	29*/ 35*/27*	33*/100*/11*	15/45	5/23	. . /13	. . /14	6/24	12	97	140
60	South Africa	. . / . . /. .	. . / . . /. .	. . /. .	. . /. .	. . /. .	. . /. .	. . /. .	. .	. .	. .
61	Turkey	78*/ 95*/63*	. . / . . /. .	42/34	64/71	69/70	52/50	. . /7*	42	78*	210*
62	Iraq	89*/100*/46*	93*/ 97*/78*	76/99	13/76	16/76	33/69	4/53	26	50*	. .
63	Botswana	57/ 98 /47	88/100 /85	80/99	64/86	71/88	68/91	32/40	19	52*	300

Note: nations are listed in descending order of their 1987 under-five mortality rates (see table 1)

		% of population with access to drinking water 1980-87	% of population with access to health services 1980-87	Percentage fully immunized 1981/1986-87					ORS per 100 episodes of diarrhoea (litres) 1986	% of births attended by trained health personnel 1983-87	Maternal mortality rate 1980-87
				one-year-old children				pregnant women			
		Total/urban/rural	Total/urban/rural	TB	DPT	Polio	Measles	Tetanus			
	Middle U5MR countries (31-94) Median	69/ 88 /50	78/ 92 /60	57/75	47/70	46/74	40/59	12/27	21	74	91
64	Iran, Islamic Rep. of	75*/ 95*/55*	78*/ 95*/60*	6/56	29/74	47/74	48/76	2/12	25	82*	120*
65	Viet Nam	41/ 60 /32	80/100 /75	../59	../51	../54	../42	../..	14	99	110
66	Ecuador	47*/ 75*/16*	62*/ 90*/30*	82/85	26/51	19/51	31*/46	4/5*	34	27	220*
67	Brazil	77/ 86 /53	../..	62/68	47/57	99*/90	73*/55	../..	31	73	150
68	El Salvador	40*/ 71*/22*	56*/ 80*/40*	47/55	42/53	38*/57	44/48	20/19[g]	180	35	74
69	Tunisia	75*/100*/50*	90*/100*/80*	65/94	36/89	37/89	65/79	2/27	3	60	..
70	Papua New Guinea	16/ 55 /10	../..	64/70*	50*/41*	32/41*	../34*	../23*	8	34	1000
71	Dominican Rep.	62/ 85 /32	80*/ .. /..	34/51[x]	27/80	42/79	17*/71	26/87*	21	57*	56[x]
72	Philippines	66*/ 83*/54*	../..	61/92	51/73	44/73	../68	37/49	10	..	80
73	Mexico	75/ 91 /40	45*/ .. /..	41/71	41/62	85/97*	33*/54	../..	14	..	92
74	Colombia	70*/ 89*/28*	60*/ .. /..	57/80	20/58	22/82	26/59	6/40*	22	51	130
75	Syrian Arab Rep.	75/ 98 /54	75*/ 92*/60*	36/81*	14/70*	14/70*	14/73*	3/6	12	37	280
76	Paraguay	26/ 46 /10	61*/ 90*/38*	42/66	28/58	26/93[x]	16/56	6/58*	21	22	470
77	Mongolia	../.. /..	../.. /..	53/53	99/79	99/74	../61	../..	..	99	140[x]
78	Jordan	93*/100*/60*	97*/ 98*/95*	0/2*	81/89	87/89	40/87	2/28	23	75	..
79	Lebanon	92*/ 95*/85*	../.. /..	../..	../91	../91	/81	../..	15	45	..
80	Thailand	66/ 50 /70	70*/ .. /..	71/97*	52/80	22/80*	../60*	27/61*	26	33	270
81	Albania	../.. /..	../.. /..	93/92	94/96	92/94	90/96	../..	..	..	..
82	China	../ 85 /..	../.. /..	../85	../75	../77	/77	../..	..	..	44
83	Sri Lanka	36/ 76 /26	93*/ .. /..	58/61	45/61	49/62	../47	48/39	24	87	90
84	Venezuela	../.. /65	../.. /..	77/86	54/54	75/64	43/57	../..	73	82	65
85	Guyana	73/100 /60	89*/ .. /..	../69	45/67	37/77	../52	/57[y]	23	93	100*
86	Argentina	64/ 72 /17	71/ 80 /21	63/91	46/75	38/85	73/81	../..	12	..	85[x]
87	Panama	82*/100*/65*	80*/ 95*/64*	77/89	49/73	50/74	53/78	/27*	18	83	90
88	Korea, Dem. Rep. of	../.. /..	../.. /..	52/69	52/62	51/70	31/35	../..	..	99	41
89	Korea, Rep. of	../.. /60	93*/ 97*/86*	42/47	61/76	62/80	5*/89	../..	..	..	34
90	Malaysia	69*/ 93*/53*	../.. /..	91/99	54/59	61/62	/20	20/25	17	82	59
91	United Arab Emirates	93/ 95 /81	90/ .. /..	18/78	45/75	45/75	42/56	../..	35	96	..
92	Uruguay	80*/ 93*/13*	80*/ .. /..	76/98	57/70	58*/70	95*/99	18/13[y]	17	..	56*
	Low U5MR countries (30 and under) Median	../.. /..	../.. /..	../90	85/90	90/90	70/84	../..	..	99	11
93	USSR	../.. /..	../.. /..	../93[x]	95/85*	95/99*	95/95*	../..	..	100	..
94	Mauritius	95*/ 95*/95*	100*/100*/100*	87/87*	82/85*	82/85*	/68*	1/68*	18	90*	99*
95	Romania	../.. /..	../.. /..	../95	../90	/90	/90	../..	..	99	180
96	Yugoslavia	../.. /..	../.. /..	99/84	90/90	95/89	95/92	../..	..	..	27
97	Chile	94*/ 98*/71*	../.. /..	100/97	97/93	96/95	93/92	../..	..	97*	55
98	Trinidad and Tobago	99/100 /96	../.. /..	../..	52/79	55/80	/60	/60[y]	2	90	81*
99	Kuwait	100*/ .. /..	100*/ .. /..	0/4	54/94	76/94	66/95	30/2	23	99	18
100	Jamaica	86*/ .. /..	../.. /..	../92	39/81	37/82	../62	50*/50[y]	18	89	100
101	Costa Rica	91/100 /82	80*/100*/63*	81/81	83/91	85/89	71/43	../90*	49	93	26
102	Bulgaria	../.. /..	../.. /..	97/99	97/99	98/99	96/99	98/..	..	100	22
103	Poland	../.. /..	../.. /..	95/95	95/97	95/98	65/91	../..	..	..	12
104	Cuba	../.. /..	../.. /..	97/96	67/87	82/86*	49/99	../..	166	..	31
105	Hungary	../.. /..	../.. /..	99/99*	99/99	98/99	99/99	../..	..	99	28
106	Portugal	../.. /..	../.. /..	74/71	75/96	16/78	70/66	../..	..	..	15
107	Greece	../.. /..	../.. /..	95/..	95/82	95/97	../81	../..	..	..	12
108	Czechoslovakia	../.. /..	../.. /..	95/99	95/99	95/98	95/98	../..	..	100	8
109	Belgium	../.. /..	../.. /..	../90	95/95	99/99	50/90	../..	..	100	10
110	USA	../.. /..	../.. /..	../..	/37*	/24*	96*/82*	../..	..	100	9
111	New Zealand	../.. /..	../.. /..	../20[x]	72*/72*	../84*	../..	../..	..	99	20
112	Israel	../.. /..	../.. /..	70/..	84/92	91/93	69/88	../..	..	99	5
113	Austria	../.. /..	../.. /..	90/90	90/90	90/90	90/60	../..	..	..	11
114	Singapore	100/100 /..	100/100 /..	83/92	87/98	88/97	57*/94	../90[y]	..	100	11
115	Italy	../.. /..	../.. /..	../30	../88	../81	/21	../..	..	..	13
116	German Dem. Rep.	../.. /..	../.. /..	95/99	80/93	90/94	95/98	../..	..	..	17
117	United Kingdom	../.. /..	../.. /..	../96	44/67	71/85	52/71	../..	..	98	7
118	Ireland	../.. /..	../.. /..	../80	36/45*	76/90*	../63*	../..	..	..	7
119	Germany, Fed. Rep. of	../.. /..	../.. /..	40/30*	50/30*	80/80*	35/30	../..	..	..	11
120	Denmark	../.. /..	../.. /..	95/85*	85/89	97/94	../..	../..	..	..	4
121	Spain	../.. /..	../.. /..	../..	../88	../80	../83	../..	..	96	10
122	Australia	../.. /..	../.. /..	../..	../..	../..	../68*	../..	..	99	11
123	France	../.. /..	../.. /..	80/96	79/97	80/97	(.)/55	../..	..	..	13
124	Hong Kong	99*/ .. /..	../.. /..	99/99*	84/94	94/86	../85	../90	..	..	4*
125	Canada	../.. /..	../.. /..	../..	../..	../..	../..	../..	..	99	2
126	Netherlands	../.. /..	../.. /..	../..	97/95	97/95	93/96	../..	..	..	5
127	Norway	../.. /..	../.. /..	/90[x]	/85	/90	/87	../..	..	100	4
128	Switzerland	../.. /..	../.. /..	../..	/90	/95	/60	../..	..	..	5
129	Japan	../.. /..	../.. /..	85/85*	../83*	../95*	../73*	../..	..	..	15
130	Finland	../.. /..	../.. /..	90/90*	92/94*	90/78*	70/81*	../..	..	..	5
131	Sweden	../.. /..	../.. /..	../17	99*/99*	99/98	56/94	../..	..	100	4

TABLE 4: EDUCATION

		Adult literacy rate		No. of radio/ television sets per 1,000 population 1985	Primary-school enrolment ratio			% of grade 1 enrolment completing primary school 1980-1986	Secondary school enrolment ratio 1984-1986 (gross) male/female
		1970 male/female	1985 male/female		1960 (gross) male/female	1984-86 (gross) male/female	1984-86 (net) male/female		
	Very high U5MR countries (over 170) Median	25/8	43/22	58/4	30/14	68/43	52/39	39	18/6
1	Afghanistan	13/2	39/8	91/6	15/2	23/12	../..	54	9/4
2	Mali	11/4	23/11	16/(.)	14/6	27/16	../..	25*	9/4
3	Mozambique	29/14	55/22	32/(.)	60/36	92/73	52/44	26	9/5
4	Angola	16/7	49/..	26/5	../..	../..	71*/61*	24	../..
5	Sierra Leone	18/8	38/21	222/8	30/..	68*/48*	../..	48†	23*/11*
6	Malawi	42/18	52/31	245/..	../45	72/55	48/43	28	6/3
7	Ethiopia	8/1	../..	184/2	11/3	44/28	../..	41*	14/9
8	Guinea	21/7	40/17	30/1	44/16	40/17	30/14	37	14/5
9	Burkina Faso	13/3	21/6	21/5	12/5	45/26	38/22	75	8/4
10	Niger	6/2	19/9	49/2	7/3	37/20	../..	67†	9/3
11	Chad	20/2	40/11	219/..	29/4	61/24	../..	29‡	10/2
12	Guinea-Bissau	13/6	46/17	34/..	35/15	81/40	71/35	18	18/4
13	Central African Rep.	26/6	53/29	58/2	53/12	81/50	63/40	53	19/7
14	Somalia	5/1	18/6	43/(.)	13/13	26/13	19/10	33*	15/8
15	Mauritania	../..	../..	132/(.)	13/3	57/35	../..	80	21/8
16	Senegal	18/5	37/19	109/31	36/..	66/45	52/36	86	18/9
17	Rwanda	43/21	61/33	58/..	../..	68/66	65/63	47	4/2
18	Kampuchea	../23	85*/65*	110/7	../..	../..	../..	50*	45/20
19	Yemen, Dem.	31/9	59/25	70/18	20/5	96/35	../..	40*	26/11
20	Bhutan	../..	../..	14/..	5/..	29/17	../..	25‡	7/1
21	Nepal	23/3	39/12	30/1	19/1	104/47	76/35	27*	35/11
22	Yemen	9/1	27/3	22/4	14/..	125/31	../..	15*	26/3
23	Burundi	29/10	43*/26*	53/(.)	27/9	68/50	46/37	..	6/3
24	Bangladesh	36/12	43/22	40/3	66/26	68/49	61/44	20	24/11
25	Benin	23/8	37/16	74/4	38/15	87/43	68/34	15*	23/9
26	Madagascar	56/43	74/62	../5	58/45	125/118	../..	30*	43/30
27	Sudan	28/6	33†/14†	251/51	35/14	59/41	../..	61*	23/17
28	Tanzania, U. Rep. of	48/18	93†/88†	89/(.)	33/18	70/69	51/53	76	4/3
29	Nigeria	35/14	54/31	85/5	46/27	103/81	../..	31*	42*/14*
30	Bolivia	68/46	84/65	581/66	78/50	93/82	83/75	32*	40/34
31	Haiti	26/17	40/35	21/3	50/42	83/72	45/42	45†	19/17
32	Gabon	43/22	70/53	96/19	../..	127/125	../..	59	31/22
33	Uganda	52/30	70/45	22/6	../32	66*/50*	43*/38*	58†	11*/5*
	High U5MR countries (95-170) Median	50/20	68/49	132/39	66/39	102/86	86/77	65	39/27
34	Pakistan	30/11	40/19	90/13	46/13	55/32	../..	34*	25/10
35	Zaire	61/22	79/45	100/(.)	88/32	112*/84*	86*/65*	65†	81*/33*
36	Lao People's Dem. Rep.	37/28	92/76	104/..	34/16	102/85	../..	14*	23/16
37	Togo	27/7	53/28	206/5	63/24	125/78	88/58	43	32/10
38	Cameroon	47/19	68/55	95/..	87/43	116/97	../..	70*	29/18
39	India	47/20	57/29	66/5	80/40	107/76	../..	38*	45/24
40	Liberia	27/8	47/23	228/16	45/18	82*/50*	../..	..	33*/13*
41	Ghana	43/18	64/43	184/10	52/25	75/59	../..	75†	45/27
42	Oman	../..	47†/12†	644/725	../..	101/86	84/76	60†	45/25
43	Côte d'Ivoire	26/10	53/31	133/51	68/24	92/65	../..	89†	27/12
44	Lesotho	49/74	62/84	28/(.)	63/102	102/127	../..	27*	18/26
45	Zambia	66/37	84/67	30/14	51/34	112/101	../..	85	24/14
46	Egypt	50/20	59/30	256/82	80/52	96/77	../..	64	77/54
47	Peru	81/60	91/78	203/76	95/71	125/120	../..	51*	68/61
48	Libyan Arab Jamahiriya	60/13	81/50	222/65	92/24	../..	../..	82	../..
49	Morocco	34/10	45/22	175/52	67/27	96/62	75/50	70*	39/27
50	Indonesia	66/42	83/65	117/39	86/58	121/116	99/97	80*	45/34
51	Congo	50/19	71/55	115/3	103/53	../..	../..	74	../..
52	Kenya	44/19	70/49	78/5	64/30	97/91	../..	62	25/15
53	Zimbabwe	63/47	81/67	43/14	../..	132/126	../..	79*	55/37
54	Algeria	39/11	63/37	221/72	55/37	105/85	96/80	83*	62/45
55	Honduras	55/50	61/58	366/64	68/67	103/102	../..	27*	31/36
56	Guatemala	51/37	63/47	44/26	50/39	82/70	../..	38	../..
57	Saudi Arabia	15/2	71*/31*	321/269	22/..	78/65	64/48	79	52/35
58	Nicaragua	58/57	../..	244/58	65/66	93/103	72/77	27	27/57
59	Burma	85/57	../..	81/(.)	61/52	../..	../..	27*	../..
60	South Africa	../..	../..	309/93	94/85	../..	../..	..	../..
61	Turkey	69/35	86*/62*	130/148	90/58	121/113	../..	85*	56/33
62	Iraq	50/18	90/87	189/57	94/36	107/91	92/81	65*	65/39
63	Botswana	37/44	73/69	126/..	35/48	101/109	85/93	80*	29/33

Note: nations are listed in descending order of their 1987 under-five mortality rates (see table 1)

		Adult literacy rate		No. of radio/ television sets per 1,000 population 1985	Primary-school enrolment ratio			% of grade 1 enrolment completing primary school 1960–1986	Secondary-school enrolment ratio 1984–1986 (gross) male/female
		1970 male/female	1985 male/female		1960 (gross) male/female	1984–86 (gross) male/female	1984–86 (net) male/female		
	Middle U5MR countries (31-94) Median	79/69	87/80	219/76	98/88	107/103	91/90	67	56/56
64	Iran, Islamic Rep. of	40/17	62/39	224/56	56/27	127/107	99/90	70*	56/38
65	Viet Nam	. . / . .	88*/80*	100/33	. . / . .	107/94	. . / . .	50*	44/41
66	Ecuador	75/68	85/80	293/64	87/79	117*/117*	. . / . .	50*	51*/53*
67	Brazil	69/63	79/76	391/184	97/93	108*/99*	. . / . .	20*	. . / . .
68	El Salvador	61/53	75/69	342/63	. . / . .	69/70	61/62	68*	23/26
69	Tunisia	44/17	68/41	219/56	88/43	127/108	99/90	78	45/33
70	Papua New Guinea	39/24	55/35	63/.	59/7	47*/37*	. . / . .	67*	20*/15*
71	Dominican Rep.	69/65	78/77	160/80	99/98	131/135	80/78	88*	43/56
72	Philippines	83/80	86/85	65/28	98/93	107/106	95/94	64*	66/69
73	Mexico	78/69	92/88	190/108	82/77	115/113	. . / . .	66	56/54
74	Colombia	79/76	89/87	139/96	77/77	112/115	72/74	37*	55/56
75	Syrian Arab Rep.	60/20	76/43	238/57	89/39	117/105	99/95	67*	72/49
76	Paraguay	84/75	91/85	163/23	105/90	102/97	86/84	48*	30/29
77	Mongolia	87/74	93*/86*	131/31	79/78	100/103	. . / . .	95*	88/96
78	Jordan	64/29	87/63	225/68	94/59	98*/99*	88*/88*	97	80*/78*
79	Lebanon	79/58	86/69	787/300	105/99	105/95	. . / . .	66*	57/56
80	Thailand	86/72	94/88	175/97	88/79	99/96	. . / . .	64*	35/35*
81	Albania	. . / . .	. . / . .	162/76	102/86	98/93	. . / . .	. .	74/65
82	China	. . / . .	82/56	113/9	. . / . .	137/120	99/91	66*	48/35
83	Sri Lanka	85/69	91/83	. . /28	100/90	104/102	99/99	91	63/70
84	Venezuela	79/71	88/85	422/130	100/100	110/110	. . / . .	68*	41/50
85	Guyana	94/89	97/95	. . / . .	107/106	101*/99*	. . / . .	84	58*/62*
86	Argentina	94/92	96/95	654/213	98/99	109/109	. . / . .	66*	68/79
87	Panama	81/81	89/88	183/160	98/94	109/104	90/89	73	56/63
88	Korea, Dem. Rep. of	. . / . .	. . / . .	172/10	. . / . .	. . / . .	. . / . .	. .	. . / . .
89	Korea, Rep. of	94/81	96*/88*	936/187	99/89	94/94	92/92	94	97/92
90	Malaysia	71/48	81/66	424/101	108/83	101/101	. . / . .	97	59*/59*
91	United Arab Emirates	24/7	58*/38*	264/98	. . / . .	99/101	87/89	97	54/66
92	Uruguay	93/93	93*/94*	598/166	111/111	111/109	. . / . .	88	. . / . .
	Low U5MR countries (30 and under) Median	94/89	97/90	457/280	104/103	103/101	96/97	95	83/82
93	USSR	98/97	. . / . .	656/296	100/100	. . / . .	. . / . .	. .	. . / . .
94	Mauritius	77/59	89/77	238/102	103/93	105/106	91/92	. .	53/49
95	Romania	96/91	. . / . .	141/173	101/95	98/97	. . / . .	. .	74/76
96	Yugoslavia	92/76	97/86	193/175	113/108	95/94	. . / . .	98	84/80
97	Chile	90/88	97*/96*	332/145	111/107	110/109	. . / . .	. .	67/73
98	Trinidad and Tobago	95/89	97/95	321/270	89/87	93/96	89/92	78	74/79
99	Kuwait	65/42	76/63	274/235	131/102	99/96	81/80	98	84/79
100	Jamaica	96/97	. . / . .	385/92	92/93	106*/107*	93*/96*	80	56*/60*
101	Costa Rica	88/87	94/93	85/77	97/95	103/101	87/88	75	41/44
102	Bulgaria	94/89	. . / . .	222/187	94/92	103/102	. . / . .	87	99/100
103	Poland	98/97	. . / . .	271/255	110/107	101/101	. . / . .	94	78/81
104	Cuba	86/87	96*/96*	327/197	109/109	108/101	95/94	86	84/89
105	Hungary	98/98	. . / . .	574/397	103/100	97/98	95/97	93	70/71
106	Portugal	78/65	89/80	212/157	132/129	131/123	. . / . .	88*	47/56
107	Greece	93/76	97/88	405/174	104/101	106/106	91/92	93	89/80
108	Czechoslovakia	. . / . .	. . / . .	272/280	93/93	97/98	. . / . .	94	. . / . .
109	Belgium	99/99	. . / . .	457/300	111/108	95/97	94/96	75	95/97
110	USA	99/99	. . / . .	2101/798	. . / . .	103/101	97/97	. .	100/100
111	New Zealand	. . / . .	. . / . .	904/290	110/106	106/106	100/100	. .	83/86
112	Israel	93/83	97/93	470/259	99/97	98/100	. . / . .	. .	75/83
113	Austria	. . / . .	. . / . .	620/435	106/104	100/100	. . / . .	95	78/80
114	Singapore	92/55	93/79	281/195	121/113	118/113	100/100	90	70/73
115	Italy	95/93	98/96	259/253	112/109	99/99	97/98	99	74/74
116	German Dem. Rep.	. . / . .	. . / . .	596/363	111/113	104/103	. . / . .	. .	79/76
117	United Kingdom	. . / . .	. . / . .	1016/437	92/92	105/106	97/97	. .	83/87
118	Ireland	. . / . .	. . / . .	568/252	107/112	100/100	. . / . .	. .	91/101
119	Germany, Fed. Rep. of	. . / . .	. . / . .	430/373	. . / . .	97/97	. . / . .	96	71/74
120	Denmark	. . / . .	. . / . .	416/386	103/103	98/98	. . / . .	99	105/105
121	Spain	93/87	97/92	298/270	106/116	104/103	98/98	95	95/101
122	Australia	. . / . .	. . / . .	1274/446	103/103	106/105	97/98	. .	95/98
123	France	99/98	. . / . .	879/394	144/143	113/111	100/100	95	92/99
124	Hong Kong	90/64	95/81	586/236	93/79	106/104	95/95	98	66/72
125	Canada	. . / . .	. . / . .	863/516	108/105	106/104	97/96	. .	103/103
126	Netherlands	. . / . .	. . / . .	828/462	105/104	113/115	85/88	95	106/102
127	Norway	. . / . .	. . / . .	780/330	100/100	97/97	97/97	100	95/100
128	Switzerland	. . / . .	. . / . .	821/400	118/118	. . / . .	. . / . .	99	. . / . .
129	Japan	99/99	. . / . .	787/580	103/102	101/102	100/100	100	95/97
130	Finland	. . / . .	. . / . .	988/470	100/95	104/104	. . / . .	. .	95/110
131	Sweden	. . / . .	. . / . .	868/390	95/96	97/99	. . / . .	98	79/88

TABLE 5: DEMOGRAPHIC INDICATORS

		Population under 16/under 5 (millions) 1987	Population annual growth rate (%) 1965-80	1980-86	Crude death rate 1960	1987	Crude birth rate 1960	1987	Life expectancy 1960	1987	Total fertility rate 1987	% population urbanized 1987	Average annual growth rate of urban population (%) 1965-80	1980-85	Contraceptive prevalence (%) 1981-85
	Very high U5MR countries (over 170) Median	239T/92T	2.5	2.7	28	19	47	46	37	48	6.4	23	5.4	5.1	1
1	Afghanistan	6.8/2.6	2.4	. .	30	23	52	49	34	42	6.9	21	6.0	. .	2*
2	Mali	4.2/1.7	2.1	2.3	29	21	50	50	35	45	6.7	19	4.9	4.5	1
3	Mozambique	6.7/2.6	2.5	2.7	21	19	45	45	40	47	6.3	23	11.8	5.3	. .
4	Angola	4.3/1.7	2.8	2.6	31	20	50	47	33	45	6.4	26	6.4	5.8	1
5	Sierra Leone	1.8/0.7	2.0	2.4	35	24	48	48	30	42	6.5	30	4.3	5.1	4
6	Malawi	3.7/1.5	2.9	3.2	28	20	53	53	38	48	7.0	13	7.8	. .	1
7	Ethiopia	21.1/7.6	2.7	2.4	28	24	51	44	36	42	6.2	12	6.6	3.7	2
8	Guinea	2.9/1.1	1.9	2.4	33	22	48	47	33	43	6.1	24	6.6	4.3	1
9	Burkina Faso	3.8/1.5	2.0	2.5	31	19	50	47	35	48	6.5	8	3.4	5.3	1
10	Niger	3.2/1.3	2.7	3.0	31	21	46	51	35	45	7.1	18	6.9	7.0	1
11	Chad	2.4/0.9	2.0	2.3	30	20	46	44	35	46	5.8	30	9.2	3.9	1
12	Guinea-Bissau	0.4/0.1	. .	. .	28	20	41	41	36	46	5.4	29	. .	. .	1
13	Central African Rep.	1.2/0.5	1.8	2.5	30	20	44	44	37	46	5.8	44	4.8	3.9	. .
14	Somalia	3.3/1.4	2.7	2.9	28	20	47	51	36	46	6.6	34	6.1	5.4	. .
15	Mauritania	0.9/0.3	2.3	2.6	28	19	51	46	36	47	6.5	38	12.4	3.4	1
16	Senegal	3.2/1.2	2.5	2.9	27	19	48	46	37	47	6.3	37	4.1	4.0	4*
17	Rwanda	3.4/1.3	3.3	3.3	22	17	51	51	42	49	8.2	7	6.3	6.7	10
18	Kampuchea	2.7/1.3	0.3	. .	21	17	45	42	42	49	4.6	11	1.9	. .	. .
19	Yemen, Dem.	1.1/0.4	2.8	2.5	29	16	50	47	37	52	6.6	42	3.2	4.9	. .
20	Bhutan	0.6/0.2	1.6	2.0	25	17	43	38	38	49	5.5	5	3.7	5.2	. .
21	Nepal	7.9/3.0	2.4	2.6	26	15	46	40	38	52	5.8	9	5.1	5.6	15
22	Yemen	3.7/1.4	2.0	3.1	29	16	50	48	37	52	6.9	22	10.7	7.3	1*
23	Burundi	2.4/0.9	1.9	2.7	25	17	44	46	42	50	6.2	6	1.8	2.7	1
24	Bangladesh	50.6/18.3	2.7	2.6	22	16	47	42	40	52	5.4	13	8.0	7.9	25
25	Benin	2.1/0.8	2.7	3.2	33	19	47	50	35	47	7.0	38	10.2	4.4	20
26	Madagascar	5.1/2.0	2.5	3.3	23	14	44	46	41	54	6.6	23	5.7	5.3	. .
27	Sudan	11.0/4.2	3.0	2.8	25	16	47	45	39	51	6.4	21	5.1	4.8	5*
28	Tanzania, U. Rep. of	12.6/5.0	3.3	3.5	24	14	51	51	41	54	7.1	28	8.7	8.3	1
29	Nigeria	51.8/20.4	2.5	3.3	24	16	52	50	40	51	6.9	33	4.8	5.2	5
30	Bolivia	3.1/1.2	2.5	2.7	22	14	46	43	43	54	6.0	49	2.9	5.6	26
31	Haiti	2.6/0.9	2.0	1.8	23	13	45	34	42	55	4.6	29	4.0	4.1	7
32	Gabon	0.4/0.1	3.5	4.4	25	17	31	38	40	52	5.1	43	4.2	4.6	. .
33	Uganda	8.4/3.3	2.9	3.1	21	16	50	50	43	52	6.9	10	4.1	3.0	1
	High U5MR countries (95–170) Median	620T/223T	2.9	3.3	21	11	48	42	44	59	5.8	41	5.1	4.7	16
34	Pakistan	52.4/21.4	3.1	3.1	24	13	49	47	43	58	6.3	31	4.3	4.8	8
35	Zaire	15.9/6.1	2.8	3.1	22	14	47	46	42	53	6.1	38	7.2	8.4	1
36	Lao People's Dem. Rep.	1.7/0.6	1.4	2.0	19	17	42	42	44	49	5.6	17	4.8	5.6	. .
37	Togo	1.5/0.6	3.0	3.4	27	14	48	45	39	54	6.0	24	7.2	6.4	. .
38	Cameroon	4.7/1.8	2.7	3.2	24	16	44	42	40	52	5.8	46	8.1	7.0	3*
39	India	315.4/111.5	2.3	2.2	21	11	42	32	44	59	4.2	27	3.6	3.9	34
40	Liberia	1.1/0.4	3.0	3.3	24	13	46	45	40	55	6.5	42	6.2	4.3	1
41	Ghana	6.5/2.5	2.2	3.5	21	13	47	44	45	55	6.3	32	3.4	3.9	10
42	Oman	0.6/0.2	3.6	4.7	28	13	51	46	40	57	7.1	10	8.1	7.3	. .
43	Côte d'Ivoire	5.7/2.3	4.2	4.2	26	14	44	51	39	53	7.4	44	8.7	6.9	3
44	Lesotho	0.7/0.3	2.3	2.7	24	13	41	41	40	57	5.7	18	14.6	5.3	5
45	Zambia	3.9/1.6	3.1	3.5	23	14	50	51	42	54	7.1	52	7.1	5.5	1
46	Egypt	21.4/7.9	2.4	2.7	21	10	45	36	46	62	4.6	48	2.9	3.4	30
47	Peru	8.7/3.1	2.8	2.3	19	9	47	35	48	63	4.3	69	4.1	3.8	43
48	Libyan Arab Jamahiriya	2.0/0.6	4.6	3.9	19	10	49	44	47	62	6.8	67	9.7	6.7	. .
49	Morocco	10.2/3.6	2.5	2.5	21	10	50	36	47	62	4.6	46	4.2	4.2	27
50	Indonesia	67.9/21.7	2.3	2.2	23	11	44	28	41	57	3.1	27	4.7	2.3	40
51	Congo	0.8/0.3	2.7	3.3	25	17	45	44	38	49	5.9	41	3.5	3.6	. .
52	Kenya	12.0/4.9	3.6	4.1	24	12	57	54	42	59	7.9	22	9.0	6.3	17
53	Zimbabwe	4.3/1.6	3.1	3.7	19	10	47	42	45	59	5.6	26	7.5	5.0	40
54	Algeria	11.0/4.0	3.1	3.1	21	9	51	40	47	63	5.7	44	3.8	3.7	7
55	Honduras	2.2/0.8	3.2	3.6	19	8	51	40	47	65	5.3	41	5.5	5.2	35
56	Guatemala	4.1/1.5	2.8	2.9	20	9	49	41	46	63	5.6	41	3.6	4.2	25
57	Saudi Arabia	5.9/2.3	4.6	4.1	23	8	49	42	44	64	7.1	75	8.5	6.1	. .
58	Nicaragua	1.7/0.6	3.1	3.4	18	8	51	42	47	64	5.3	58	4.6	4.5	9
59	Burma	15.9/5.4	2.3	2.0	21	10	42	31	44	61	3.9	24	2.8	2.8	5
60	South Africa	13.1/4.6	2.4	2.2	21	10	41	32	44	61	4.4	57	2.6	3.3	48
61	Turkey	19.8/6.7	2.4	2.5	16	8	43	29	51	65	3.4	47	4.3	4.4	38*
62	Iraq	8.4/3.1	3.4	3.6	20	8	49	43	49	65	6.2	72	5.3	6.3	14*
63	Botswana	0.6/0.2	3.5	3.5	20	12	52	48	46	59	6.1	21	15.4	4.5	29

Note: nations are listed in descending order of their 1987 under-five mortality rates (see table 1)

		Population under 16/under 5 (millions) 1987	Population annual growth rate (%) 1965–80	1980–86	Crude death rate 1960	1987	Crude birth rate 1960	1987	Life expectancy 1960	1987	Total fertility rate 1987	% population urbanized 1987	Average annual growth rate of urban population (%) 1965–80	1980–85	Contraceptive prevalence (%) 1981–85
	Middle U5MR countries (31–94) Median	608T/193T	2.6	2.3	15	7	43	29	54	67	3.5	53	4.5	3.7	49
64	Iran, Islamic Rep. of	23.4/9.1	3.2	2.8	19	8	53	42	50	66	5.6	53	5.5	4.6	23
65	Viet Nam	26.6/9.2	..	2.6	23	10	41	32	44	62	3.9	21	4.1	3.4	20
66	Ecuador	4.3/1.5	3.1	2.9	15	8	46	36	53	66	4.5	54	5.1	3.7	40
67	Brazil	53.7/18.4	2.4	2.2	13	8	43	29	55	65	3.3	75	4.5	4.0	65
68	El Salvador	2.4/0.8	2.7	1.2	17	9	48	36	50	64	4.7	44	3.5	4.0	47
69	Tunisia	3.1/1.1	2.1	2.3	19	7	47	31	48	66	3.8	54	4.2	3.7	42
70	Papua New Guinea	1.6/0.6	2.3	2.1	23	12	44	39	41	55	5.5	15	8.4	4.9	4
71	Dominican Rep.	2.8/1.0	2.7	2.4	17	7	49	32	51	67	3.6	58	5.3	4.2	47
72	Philippines	24.9/8.8	2.9	2.5	15	8	46	33	46	64	4.2	41	4.0	3.2	33
73	Mexico	34.7/11.3	3.1	2.2	12	6	45	29	57	69	3.4	71	4.5	3.6	48
74	Colombia	11.7/4.0	2.2	1.9	13	7	45	29	55	65	3.5	69	3.5	2.8	51*
75	Syrian Arab Rep.	5.7/2.2	3.4	3.5	18	7	47	44	50	66	6.6	51	4.5	5.5	20*
76	Paraguay	1.7/0.6	2.8	3.2	13	7	43	35	56	67	4.5	46	3.2	3.7	39*
77	Mongolia	0.9/0.3	3.0	2.8	15	8	41	39	52	64	5.3	51	4.5	3.3	..
78	Jordan	1.9/0.7	2.6	3.7	20	7	47	46	47	67	7.1	66	5.3	4.0	26
79	Lebanon	1.1/0.4	1.6	..	14	8	43	29	60	68	3.3	83	4.6	..	53*
80	Thailand	19.8/6.1	2.7	2.0	15	7	39	23	52	66	2.4	21	4.6	3.2	65
81	Albania	1.1/0.4	2.5	2.1	11	6	41	24	62	72	2.9	35	3.4	3.3	..
82	China	333.0/99.3	2.2	1.2	19	7	37	20	47	70	2.3	21	2.6	3.3	74
83	Sri Lanka	5.9/1.9	1.8	1.5	9	6	36	23	62	71	2.6	21	2.3	8.4	57
84	Venezuela	7.5/2.6	3.5	2.9	10	5	45	31	60	70	3.6	89	4.5	3.5	49*
85	Guyana	0.4/0.1	..	..	10	5	42	25	60	70	2.6	33	..	..	35*
86	Argentina	10.0/3.2	1.6	1.6	9	9	24	22	65	71	2.9	85	2.2	1.9	74
87	Panama	0.9/0.3	2.6	2.2	10	5	41	27	61	72	3.0	53	3.4	2.6	59
88	Korea, Dem. Rep. of	8.6/2.9	2.7	2.5	13	5	41	29	54	70	3.5	65	4.6	3.8	..
89	Korea, Rep. of	12.9/3.8	1.9	1.4	14	6	43	19	54	70	1.9	68	5.7	2.5	70
90	Malaysia	6.4/2.2	2.5	2.7	24	6	44	29	54	70	3.3	40	4.5	4.0	51
91	United Arab Emirates	0.5/0.2	16.1	5.6	19	4	46	23	53	71	4.6	77	18.9	5.5	..
92	Uruguay	0.9/0.3	0.4	0.4	10	10	22	19	68	71	2.6	85	0.7	0.9	..
	Low U5MR countries (30 and under) Median	289T/90T	0.9	0.6	9	10	21	14	69	75	1.8	73	2.1	1.4	71
93	USSR	75.4/25.2	0.9	1.0	7	11	24	18	68	70	2.3	66	2.2	1.6	..
94	Mauritius	0.3/0.1	1.6	1.0	10	5	44	19	59	69	1.9	42	4.0	2.1	75
95	Romania	5.9/1.7	1.1	0.5	9	11	20	16	65	71	2.1	50	3.4	1.0	58*
96	Yugoslavia	5.9/1.8	0.9	0.7	10	9	23	15	63	72	1.9	48	3.0	2.5	55*
97	Chile	4.1/1.4	1.8	1.7	12	6	37	24	57	72	2.7	84	2.6	2.1	43
98	Trinidad and Tobago	0.4/0.1	1.3	1.5	8	7	38	24	64	71	2.6	66	5.0	3.3	55*
99	Kuwait	0.8/0.3	7.0	4.4	10	3	44	33	60	73	4.6	95	8.2	5.1	..
100	Jamaica	0.9/0.3	1.5	1.5	10	6	39	26	63	74	2.7	51	3.4	3.2	52
101	Costa Rica	1.1/0.4	2.6	2.4	10	4	47	28	62	75	3.2	51	3.7	3.8	68
102	Bulgaria	2.0/0.6	0.5	0.2	9	12	18	13	69	72	1.9	68	2.8	1.7	76*
103	Poland	10.1/3.3	0.8	0.9	8	10	24	17	67	72	2.2	62	1.8	1.6	75*
104	Cuba	2.6/0.7	1.5	0.9	9	7	32	16	64	74	1.7	73	2.7	0.8	60
105	Hungary	2.4/0.6	0.4	-0.1	10	13	16	12	68	71	1.8	58	1.8	1.3	74*
106	Portugal	2.5/0.7	0.6	0.5	7	10	24	14	63	74	1.7	32	2.0	3.3	70*
107	Greece	2.2/0.6	0.7	0.5	8	10	19	12	69	76	1.7	61	2.5	1.9	..
108	Czechoslovakia	4.0/1.1	0.5	0.3	10	12	17	14	70	72	2.0	67	1.9	1.4	..
109	Belgium	2.0/0.6	0.3	0.0	12	11	17	12	70	75	1.6	97	0.5	0.4	81
110	USA	56.1/18.2	1.0	1.0	9	9	24	15	70	76	1.8	74	1.2	2.3	68
111	New Zealand	0.8/0.3	1.3	0.9	9	8	26	16	71	75	1.9	84	1.5	0.9	..
112	Israel	1.5/0.5	2.8	1.7	6	7	27	22	69	76	2.8	91	3.5	2.4	..
113	Austria	1.5/0.4	0.3	0.0	12	12	18	12	69	74	1.5	57	0.1	0.7	71
114	Singapore	0.7/0.2	1.6	1.1	8	6	38	17	65	73	1.7	100	1.6	1.2	74
115	Italy	11.5/3.1	0.6	0.3	10	10	18	11	69	76	1.5	68	1.0	0.9	78*
116	German Dem. Rep.	3.4/1.1	-0.2	-0.1	13	13	17	13	70	74	1.7	77	0.1	0.6	..
117	United Kingdom	11.7/3.7	0.2	0.1	12	12	17	13	71	76	1.8	92	0.5	0.3	83
118	Ireland	1.1/0.3	1.2	0.8	12	9	21	18	70	74	2.4	58	2.2	2.7	60*
119	Germany, Fed. Rep. of	10.1/3.1	0.3	-0.2	11	12	17	10	70	75	1.4	86	0.8	0.1	..
120	Denmark	1.0/0.3	0.5	0.0	9	11	17	11	72	76	1.5	86	1.1	0.3	63*
121	Spain	9.2/2.5	1.0	0.6	9	9	21	13	69	77	1.7	77	2.4	1.6	51*
122	Australia	4.0/1.2	1.8	1.4	9	7	22	15	71	76	1.8	85	0.2	1.4	67*
123	France	12.4/3.8	0.7	0.5	12	10	18	14	70	76	1.8	74	2.7	1.0	79*
124	Hong Kong	1.4/0.4	2.1	1.2	7	6	35	16	65	76	1.7	93	2.3	1.3	73
125	Canada	5.9/1.9	1.3	1.1	8	7	27	14	71	77	1.7	76	1.5	1.7	73
126	Netherlands	3.0/0.9	0.9	0.5	8	9	21	12	73	77	1.5	89	1.5	0.9	78
127	Norway	0.9/0.3	0.6	0.3	9	11	18	12	73	77	1.7	73	5.0	0.9	71*
128	Switzerland	1.2/0.4	0.5	0.3	10	10	18	12	71	77	1.6	59	1.2	0.9	70*
129	Japan	26.6/7.2	1.2	0.7	7	7	18	12	68	78	1.7	77	2.1	1.8	57
130	Finland	1.0/0.3	0.3	0.5	9	10	19	13	68	75	1.7	65	2.5	2.9	80*
131	Sweden	1.5/0.4	0.5	0.1	10	12	14	11	73	77	1.7	84	1.0	1.2	78

TABLE 6: ECONOMIC INDICATORS

		GNP per capita (US $) 1986	GNP per capita average annual growth rate (%) 1965-80	GNP per capita average annual growth rate (%) 1980-86	Rate of inflation (%) 1980-1986	% of population below absolute poverty level 1977-86 urban/rural	% of central gov't expenditure allocated to health/education/defense 1986	ODA inflow in millions US $ (1986)/ as a % of recipient GNP (1986)	Debt service as a % of exports of goods and services 1970	Debt service as a % of exports of goods and services 1986
	Very high U5MR countries (over 170) Median	265	0.8	-1.6	10.5	50/68	5.0/12.1/9.7	201/11.7	3.9	18.3
1	Afghanistan	. .	0.6	. .	. .	. ./. .	. ./. . /. .	2/. .	. .	. .
2	Mali	180	2.1	-0.5	7.4	27*/48*	1.7/ 9.0/8.1	372/22.7	1.0	14.2
3	Mozambique	210	. .	-7.6	28.1	. ./. .	. ./. .	422/9.8	. .	. .
4	Angola	470*	. .	. .	. .	. ./. .	. ./. .	131/. .	. .	. .
5	Sierra Leone	310	0.7	-1.8	33.5	. . /65	5.8/12.8/3.4	87/7.0	10.7	8.2
6	Malawi	160	3.2	-0.7	12.4	25/85	6.9/11.0/6.0	203/17.5	7.8	40.1
7	Ethiopia	120	0.4	-2.1	3.4	60/65	. ./. . /. .	642/11.5	11.3	25.8
8	Guinea	. .	1.3	-0.7	. .	. ./. .	. ./. .	175/. .	. .	. .
9	Burkina Faso	150	1.7	-0.8	6.3	. ./. .	6.2/17.7/19.2	284/19.3	6.5	14.8
10	Niger	260	-2.5	-5.7	6.6	. . /35*	. ./. . /. .	308/15.2	4.0	27.9
11	Chad	80*	-1.9	2.9	. .	30*/56*	. ./. . /. .	165/. .	4.0	2.2
12	Guinea-Bissau	170	-2.7	2.4	30.4	. ./. .	. . /14.0/. .	. ./. .	. .	. .
13	Central African Rep.	290	0.8	-0.8	11.5	. . /91	. ./. . /. .	139/14.8	5.3	9.6
14	Somalia	280	-0.1	0.8	45.4	40/70	. ./. . /. .	523/27.8	1.8	62.1
15	Mauritania	420	-0.1	-1.9	9.9	. ./. .	. ./. . /. .	187/23.9	3.3	17.4
16	Senegal	420	-0.5	0.0	9.5	. ./. .	. ./. . /. .	567/16.0	2.9	19.9
17	Rwanda	290	1.6	-1.6	5.6	30*/90*	. ./. . /. .	211/11.5	1.2	7.6
18	Kampuchea	. .	. .	. .	. .	. ./. .	. ./. . /. .	13/. .	. .	. .
19	Yemen, Dem.	470	. .	-5.5	4.8	. . /20	. ./. . /. .	58/5.7	0.0	74.6
20	Bhutan	150	. .	. .	. .	. ./. .	. ./. . /. .	40/19.3	. .	. .
21	Nepal	150	0.0	0.8	8.8	55/61	5.0/12.1/6.2	301/11.7	3.1	9.4
22	Yemen	550	6.5	5.1	13.1	. ./. .	4.7/22.5/28.8	233/4.7	0.0	59.6
23	Burundi	240	2.4	-0.5	6.4	55/85	. ./. . /. .	187/15.7	2.3	19.0
24	Bangladesh	160	-0.3	0.9	11.2	86/86	5.3/ 9.9/11.2	1455/9.5	0.0	25.1
25	Benin	270	-0.3	0.0	8.6	. . /65	. ./. . /. .	138/10.0	2.2	28.8
26	Madagascar	230	-0.4	-4.1	17.8	50/50	. ./. . /. .	316/12.7	3.7	27.7
27	Sudan	320	0.8	-4.2	32.6	. . /85*	. ./. . /. .	940/12.8	10.7	7.7
28	Tanzania, U. Rep. of	250	0.8	-2.6	21.5	. ./. .	4.9/ 7.2/13.8	681/15.2	5.3	15.3
29	Nigeria	640	4.2	-5.3	10.5	. ./. .	. ./. . /. .	60/0.1	4.3	23.4
30	Bolivia	600	1.7	-5.9	683.7	. . /85*	1.4/11.6/5.8	322/7.2	11.3	23.7
31	Haiti	330	0.9	-2.3	7.7	65*/80*	. ./. . /. .	175/8.2	7.5	6.0
32	Gabon	3080	5.6	-1.7	4.8	. ./. .	. ./. . /. .	79/2.7	5.6	17.5
33	Uganda	230	-2.2	-1.8	74.9	. ./. .	2.4/15.0/26.3	198/5.7	2.9	6.5
	High U5MR countries (95–170) Median	740	2.6	0.5	8.9	32/44	5.0/14.3/9.7	225/4.2	7.1	21.3
34	Pakistan	350	1.8	3.4	7.5	32/29	1.0/ 3.2/33.9	952/2.9	23.6	26.8
35	Zaire	160	-1.3	-3.2	54.1	. . /80*	. ./. . /. .	448/8.0	4.4	18.2
36	Lao People's Dem. Rep.	. .	. .	. .	. .	. ./. .	. ./. . /. .	48/. .	. .	. .
37	Togo	250	1.7	-4.5	6.7	42/. .	3.6/11.7/6.9	174/18.5	3.0	32.5
38	Cameroon	910	2.4	3.5	11.0	15/40	5.1/14.4/8.8	225/2.1	3.2	11.2
39	India	290	1.5	2.9	7.8	40/51	2.1/ 2.1/18.4	2059/0.9	25.8	17.9
40	Liberia	460	0.5	-5.5	1.1	. . /23	5.7/14.2/7.7	97/9.6	8.1	6.4
41	Ghana	390	-0.8	-2.8	50.8	59*/37*	8.3/23.9/6.5	371/6.6	5.5	10.8
42	Oman	4980	9.0	9.8	3.6	. ./. .	5.0/10.1/41.9	84/1.3	. .	11.3
43	Côte d'Ivoire	730	2.8	-3.1	8.3	30*/26*	4.0/20.5/3.9	186/2.1	7.1	23.3
44	Lesotho	370	6.8	0.5	13.1	50/55	6.9/15.5/9.6	88/16.1	2.7	4.2
45	Zambia	300	-1.2	-5.3	23.3	25/. .	7.2/16.0/. .	464/31.2	6.4	16.8
46	Egypt	760	2.8	2.6	12.4	21/25	2.4/10.8/17.7	1667/4.1	38.0	21.3
47	Peru	1090	0.8	-2.6	100.1	49/. .	. ./. . /. .	272/1.1	11.6	14.4
48	Libyan Arab Jamahiriya	. .	. .	. .	. .	. ./. .	. ./. . /. .	11/. .	. .	. .
49	Morocco	590	2.7	0.4	7.7	28/45	2.8/16.6/16.4	336/2.4	8.7	40.4
50	Indonesia	490	5.2	2.0	8.9	26/44	1.9/ 8.5/9.3	711/1.0	7.0	27.8
51	Congo	990	2.7	2.2	7.5	. ./. .	. ./. . /. .	110/5.9	11.5	39.8
52	Kenya	300	3.1	-1.4	9.9	10/55	6.4/19.7/8.7	458/6.9	5.9	22.5
53	Zimbabwe	620	1.7	-0.1	13.0	. ./. .	6.2/20.9/15.2	225/4.2	2.3	22.3
54	Algeria	2590	4.2	1.4	6.1	20/. .	. ./. . /. .	165/0.3	3.9	54.8
55	Honduras	740	1.1	-2.3	5.2	14/55	. ./. . /. .	288/8.5	2.9	18.5
56	Guatemala	930	3.0	-4.1	11.3	66/74	. ./. . /. .	135/1.9	7.4	23.4
57	Saudi Arabia	6950	. .	. .	-1.3	. ./. .	. ./. . /. .	31/0.0	. .	. .
58	Nicaragua	790	-0.7	-4.3	56.5	21/19	. ./. . /. .	150/5.6	10.5	12.9
59	Burma	200	1.6	2.7	2.1	40/40	7.7/11.7/18.8	416/5.1	12.2	55.4
60	South Africa	1850	3.2	2.8	13.6	. ./. .	. ./. . /. .	. ./. .	. .	. .
61	Turkey	1110	3.6	2.4	37.3	. ./. .	2.2/11.9/13.5	346/0.6	22.0	31.3
62	Iraq	3020*	. .	. .	. .	. ./. .	. ./. . /. .	33/. .	. .	. .
63	Botswana	840	9.9	7.4	7.6	40/55	5.0/17.7/6.4	102/10.4	0.9	4.3

Note: nations are listed in descending order of their 1987 under-five mortality rates (see table 1)

		GNP per capita (US $) 1986	GNP per capita average annual growth rate (%) 1965–80	1980–86	Rate of inflation (%) 1980–1986	% of population below absolute poverty level 1977–86 urban/rural	% of central gov't expenditure allocated to health/education/defense 1986	ODA inflow in millions US $ (1986)/ as a % of recipient GNP (1986)	Debt service as a % of exports of goods and services 1970	1986
	Middle U5MR countries (31–94) Median	1230	3.8	–0.6	9.4	20/34	6.2/12.2/8.1	147/1.1	9.8	20.6
64	Iran, Islamic Rep. of		2.9	3.6*		../..	../../..	27/..	..	..
65	Viet Nam		..	..		../..	../../..	147/..	..	..
66	Ecuador	1160	5.4	–1.6	29.5	40/65	7.3/24.5/11.8	147/1.4	8.7	32.3
67	Brazil	1810	6.3	0.3	157.1	../..	6.4/ 3.0/3.1	178/0.1	12.5	33.2
68	El Salvador	820	1.5	–2.3	14.9	20/32	7.5/17.5/28.7	355/9.2	3.7	18.0
69	Tunisia	1140	4.7	0.9	8.9	20/15	6.5/14.3/7.9	199/2.3	19.7	28.5
70	Papua New Guinea	720	..	..	5.1	10/75	9.6/17.0/4.5	263/10.9	1.3	12.5
71	Dominican Rep.	710	3.8	–1.8	15.9	45/43	9.0/12.8/8.1	106/2.1	4.4	20.6
72	Philippines	560	3.2	–4.0	18.2	50*/64*	6.0/20.1/11.9	956/3.2	7.5	18.3
73	Mexico	1860	3.6	–2.0	63.7	../..	1.4/11.5/2.5	252/0.2	23.6	36.8
74	Colombia	1230	3.7	0.1	22.6	32*/..	../../..	63/0.2	11.7	27.6
75	Syrian Arab Rep.	1570	5.1	–0.9	6.2	../..	../../..	842/4.9	11.3	15.6
76	Paraguay	1000	4.1	–2.4	19.0	19/50	3.1/12.2/12.1	66/1.9	11.7	22.9
77	Mongolia	..	..	..	..	../..	../../..	../..	..	..
78	Jordan	1540	5.8	–0.2	3.2	14/17	3.8/12.2/26.7	537/12.0	3.6	28.7
79	Lebanon	..	..	..	..	../..	../../..	62/..	..	..
80	Thailand	810	4.4	2.8	3.0	15/34	5.7/19.5/20.2	496/1.2	3.3	16.1
81	Albania	..	..	..	..	../..	../../..	../..	..	..
82	China	300	4.1	9.2	3.8	../10*	../../..	1134/0.4	..	7.8
83	Sri Lanka	400	2.8	2.5	13.5	../..	4.0/ 8.4/8.0	571/8.9	10.9	17.5
84	Venezuela	2920	2.3	–4.1	8.7	../..	8.1/19.8/4.9	16/0.0	2.9	27.7
85	Guyana	500	0.7	–6.9	9.4	../..	2.0/ 3.0/..	../..	..	..
86	Argentina	2350	1.7	–2.6	326.2	../..	1.3/ 6.0/5.2	88/0.1	21.6	52.2
87	Panama	2330	2.8	0.2	3.3	21/30	15.8/16.0/..	52/1.0	7.7	7.6
88	Korea, Dem. Rep. of	..	..	..	..	../..	../../..	../..	..	..
89	Korea, Rep. of	2370	7.3	6.8	5.4	18/11	1.5/18.1/29.2	–18/0.0	19.5	16.7
90	Malaysia	1830	4.7	1.1	1.4	13/38	../../..	193/0.8	3.8	13.7
91	United Arab Emirates	14680	..	..	–1.4	../..	6.2/ 9.7/45.3	34/0.2	..	..
92	Uruguay	1900	2.5	–3.7	50.4	22*/..	4.8/ 7.1/10.2	27/0.4	21.7	20.9
	Low U5MR countries (30 and under) Median	7295	3.3	1.1	8.2	../..	9.9/8.9 /6.8	19/0.2	5.7	18.9
93	USSR	4550*	..	..	..	../..	../../..	../..	..	..
94	Mauritius	1200	3.7	3.6	8.1	12/12	7.7/13.4/0.8	56/4.2	3.2	7.3
95	Romania	2560*	..	3.0*	..	../..	0.8/ 1.8/4.7	../..	..	11.9
96	Yugoslavia	2300	5.2	0.0	51.8	../..	../../60.0	19/0.0	10.0	12.9
97	Chile	1320	0.0	–2.7	20.2	27*/..	6.0/12.5/10.7	–5/0.0	19.1	30.8
98	Trinidad and Tobago	5360	3.1	–6.6	8.6	../39	../../..	19/0.4	4.6	13.2
99	Kuwait	13890	..	..	..	../..	7.1/12.6/12.8	5/0.0	..	..
100	Jamaica	840	–0.1	–3.3	19.8	../80	../../..	177/8.5	2.8	31.7
101	Costa Rica	1480	3.3	–1.0	32.3	../..	19.3/16.2/2.2	196/4.9	10.0	26.3
102	Bulgaria	4150*	..	..	..	../..	../../..	../..	..	..
103	Poland	2070	..	1.3	31.2	../..	../../..	../..	..	18.5
104	Cuba	..	..	..	..	../..	../../..	18/..	..	..
105	Hungary	2020	5.1	1.5	5.4	../..	3.6/ 1.6/6.9	../..	..	35.9
106	Portugal	2250	4.6	1.2	22.0	../..	../../..	139/0.5	6.8	31.5
107	Greece	3680	4.8	–0.1	20.3	../..	../../..	19/0.0	9.3	27.5
108	Czechoslovakia	5820*	..	..	..	../..	../../..	../..	..	..
109	Belgium	9230	3.6	0.9	5.7	../..	1.7/13.0/5.3	../..	..	..
110	USA	17480	1.8	1.9	4.4	../..	11.6/ 1.7/25.8	../..	..	..
111	New Zealand	7460	1.7	1.1	11.0	../..	12.5/10.9/4.7	../..	..	..
112	Israel	6210	3.7	–0.1	182.9	../..	3.4/ 6.7/30.1	1937/6.8	2.8	18.9
113	Austria	9990	4.0	1.8	4.5	../..	12.0/ 9.7/3.1	../..	..	..
114	Singapore	7410	8.3	5.7	1.9	../..	6.5/21.6/22.5	30/0.2	0.6	1.4
115	Italy	8550	3.2	1.0	13.2	../..	9.9/ 7.2/3.2	../..	..	..
116	German Dem. Rep.	7180*	..	..	..	../..	../../..	../..	..	..
117	United Kingdom	8870	2.0	2.3	6.0	../..	12.6/ 2.1/13.3	../..	..	..
118	Ireland	5070	2.8	–1.9	10.7	../..	13.2/11.7/3.1	../..	..	..
119	Germany, Fed. Rep. of	12080	3.0	1.8	3.0	../..	17.9/ 0.6/8.8	../..	..	..
120	Denmark	12600	2.2	2.5	7.3	../..	1.0/ 9.2/5.2	../..	..	..
121	Spain	4860	4.1	1.2	11.3	../..	13.1/ 6.2/4.4	0/0.0	..	..
122	Australia	11920	2.2	1.4	8.2	../..	9.5/ 7.2/9.3	../..	..	..
123	France	10720	3.7	0.6	8.8	../..	../../..	../..	..	..
124	Hong Kong	6910	6.2	4.8	6.9	../..	../../..	18/0.0	..	..
125	Canada	14120	3.3	1.6	5.5	../..	6.1/ 3.4/7.6	../..	..	..
126	Netherlands	10020	2.7	0.6	3.1	../..	10.8/11.1/5.2	../..	..	..
127	Norway	15400	3.6	3.5	7.0	../..	10.5/ 8.7/8.3	../..	..	..
128	Switzerland	17680	1.5	1.4	4.2	../..	13.1/ 3.1/10.3	../..	..	..
129	Japan	12840	5.1	3.1	1.6	../..	../../..	../..	..	..
130	Finland	12160	3.6	2.1	8.1	../..	10.6/13.7/5.2	../..	..	..
131	Sweden	13160	2.0	1.7	8.2	../..	1.1/ 8.9/6.6	../..	..	..

TABLE 7: WOMEN

		Life expectancy females as a percentage of males 1987	Adult literacy rate females as a percentage of males 1985	Enrolment ratios females as a percentage of males 1984-86		Contraceptive prevalence (%) 1981-85	Pregnant women immunized against Tetanus (%) 1986-87	% of Births attended by trained health personnel 1983-87	Maternal mortality rate 1980-87
				Primary-school	Secondary-school				
	Very high U5MR countries (over 170) Median	106.9	47.8	66.4	45.6	1	11	23	420
1	Afghanistan	102.4	20.5	52.2	44.4	2*	6	. .	640*
2	Mali	107.4	47.8	59.3	44.4	1	9*	27*	. .
3	Mozambique	107.1	40.0	84.6	55.6	. .	59*	28	300*
4	Angola	107.2	. .	85.9	. .	1	52*	15	. .
5	Sierra Leone	107.9	55.3	70.6*	47.8*	4	59	25	450
6	Malawi	102.9	59.6	89.6	50.0	1	20	59	250*
7	Ethiopia	107.9	. .	63.6	64.3	2	5	58	. .
8	Guinea	107.7	42.5	46.7	35.7	1	5*	. .	. .
9	Burkina Faso	107.1	28.6	57.9	50.0	1	26	. .	600*
10	Niger	107.4	47.4	54.1	33.3	1	5	47	420
11	Chad	107.1	27.5	39.3	20.0	1	9*	. .	700*
12	Guinea-Bissau	107.3	37.0	49.3	22.2	1	23*	16*	400
13	Central African Rep.	107.1	54.7	63.5	36.8	. .	20[y]	. .	600
14	Somalia	107.2	33.3	52.6	53.3	. .	6	2	1100
15	Mauritania	107.2	. .	61.4	38.1	1	. .	23	. .
16	Senegal	107.2	51.4	69.2	50.0	4*	8*	. .	530*
17	Rwanda	107.0	54.1	96.9	50.0	10	32*	. .	210
18	Kampuchea	106.0	76.5	. .	44.4	. .	3*	47*	. .
19	Yemen, Dem.	105.9	42.4	36.5	42.3	. .	8	10	100
20	Bhutan	97.2	. .	58.6	14.3	. .	10	3	. .
21	Nepal	97.8	30.8	46.1	31.4	15	15	10	850*
22	Yemen	105.7	11.1	24.8	11.5	1*	2*	12	. .
23	Burundi	107.0	60.5*	80.4	50.0	1	59	12	. .
24	Bangladesh	98.7	51.2	72.1	45.8	25	7	. .	600
25	Benin	107.1	43.2	50.0	39.1	20	9	34	1680*
26	Madagascar	105.7	83.8	94.4	69.8	. .	5	62	300*
27	Sudan	104.9	42.4[y]	69.5	73.9	5*	12	20	. .
28	Tanzania, U. Rep. of	106.5	94.6[y]	103.9	75.0	1	60	74	370*
29	Nigeria	107.0	57.4	78.6	33.3	5	12	. .	1500
30	Bolivia	108.9	77.4	90.4	85.0	26	2*	36*	480[x]
31	Haiti	106.2	87.5	93.3	89.5	7	56[y]	20	340*
32	Gabon	106.6	75.7	98.4	71.0	. .	32*	92*	120
33	Uganda	106.6	64.3	88.4*	45.5*	1	13	. .	300
	High U5MR countries (95-170) Median	106.0	67.2	83.5	61.1	16	30	51	140
34	Pakistan	100.0	47.5	58.2	40.0	8	27	24	600
35	Zaire	106.6	57.0	75.6*	40.7*	1	26*	. .	800
36	Lao People's Dem. Rep.	106.3	82.6	83.3	69.6	. .	19*	. .	. .
37	Togo	106.8	52.8	65.9	31.3	. .	64	15*	84*
38	Cameroon	108.0	80.9	83.6	62.1	3*	26*	. .	140*
39	India	100.5	50.9	71.0	53.3	34	47	33	500
40	Liberia	105.6	48.9	60.0*	39.4*	1	20	89	. .
41	Ghana	106.8	67.2	78.7	60.0	10	40	73	1070*
42	Oman	104.8	25.5	90.5	55.6	. .	70	60	. .
43	Côte d'Ivoire	106.6	58.5	70.7	44.4	3	63*	20*	. .
44	Lesotho	117.1	135.5	124.5	144.4	5	0*	28	. .
45	Zambia	104.3	79.8	90.2	58.3	1	41	. .	110
46	Egypt	104.4	50.8	80.2	70.1	30	12*	24	80
47	Peru	106.3	85.7	96.0	89.7	43	6	55*	310
48	Libyan Arab Jamahiriya	105.7	61.7	. .	. .	. .	12	76	80*
49	Morocco	105.7	48.9	66.7	69.2	27	33	. .	330
50	Indonesia	105.0	78.3	98.0	75.6	40	33*	43	800
51	Congo	107.0	77.5	. .	. .	. .	67	. .	. .
52	Kenya	106.9	70.0	93.8	60.0	17	37	. .	170*
53	Zimbabwe	106.3	82.7	95.5	67.3	40	48*	69	150*
54	Algeria	105.2	58.7	83.3	72.6	7	. .	. .	130
55	Honduras	106.7	95.1	99.0	116.1	35	25[y]	50	82*
56	Guatemala	107.9	74.6	. .	. .	25	2[y]	19*	110
57	Saudi Arabia	105.6	43.7*	75.0	67.3	. .	50	78	. .
58	Nicaragua	104.3	. .	. .	. .	9	25*	. .	65*
59	Burma	105.9	. .	. .	. .	5	24	97	140
60	South Africa	110.2	. .	. .	. .	48	. .	. .	. .
61	Turkey	105.4	72.1*	93.4	58.9	38*	7*	78*	210*
62	Iraq	103.2	96.7	88.0	60.0	14*	53	50*	. .
63	Botswana	110.6	94.5	109.4	113.8	29	40	52*	300

Note: nations are listed in descending order of their 1987 under-five mortality rates (see table 1)

		Life expectancy females as a percentage of males 1987	Adult literacy rate females as a percentage of males 1985	Enrolment ratios females as a percentage of males 1964-86		Contraceptive prevalence (%) 1981-85	Pregnant women immunized against Tetanus (%) 1986-87	% of Births attended by trained health personnel 1983-87	Maternal mortality rate 1980-87
				Primary-school	Secondary-school				
	Middle U5MR countries (31-94) Median	106.6	91.7	98.2	100.0	49	27	60	90
64	Iran, Islamic Rep. of	101.2	62.9	90.9	67.9	23	12	82*	120*
65	Viet Nam	107.3	90.9*	87.9	93.2	20	. .	99	110
66	Ecuador	106.6	94.1	100.0*	103.9*	40	5*	27	220*
67	Brazil	108.6	. .	91.7*	. .	65	. .	73	150
68	El Salvador	111.7	92.0	. .	113.0	47	19y	35	74
69	Tunisia	102.5	60.3	90.9	73.3	42	27	60	. .
70	Papua New Guinea	103.1	63.6	78.7*	75.0	4	23*	34	1000
71	Dominican Rep.	106.6	98.7	. .	. .	47	87*	57*	56*
72	Philippines	106.1	96.8	98.9	104.5	33	49	. .	80
73	Mexico	110.0	95.7	98.3	96.4	48	. .	. .	92
74	Colombia	107.3	97.8	102.8	101.8	51*	40*	51	130
75	Syrian Arab Rep.	106.0	56.6	96.0	68.1	20*	6	37	280
76	Paraguay	106.6	93.4	97.7	96.7	39*	58*	22	470
77	Mongolia	106.6	92.5*	103.0	109.1	. .	. .	99	140*
78	Jordan	105.7	72.4	100.0*	97.5*	26	28	75	. .
79	Lebanon	105.9	80.2	90.5	98.2	53*	. .	45	. .
80	Thailand	106.4	. .	97.0	100.0	65	61*	33	270
81	Albania	107.2	. .	94.9	87.8	. .	. .	. .	. .
82	China	104.6	68.3	91.9	72.9	74	. .	. .	44
83	Sri Lanka	106.1	91.2	100.0	111.1	57	39	87	90
84	Venezuela	109.2	96.6	100.0	122.0	49*	. .	82	65
85	Guyana	107.4	97.9	. .	106.9*	35*	57y	93	100*
86	Argentina	110.0	99.0	100.0	116.2	74	. .	. .	85*
87	Panama	105.7	98.9	98.9	112.5	59	27*	83	90
88	Korea, Dem. Rep. of	109.6	. .	. .	. .	. .	. .	99	41
89	Korea, Rep. of	109.3	91.7*	100.0	94.8	70	. .	. .	34
90	Malaysia	106.1	81.5	100.0	100.0	51	25	82	59
91	United Arab Emirates	106.3	65.5*	102.3	122.2	. .	. .	96	. .
92	Uruguay	109.9	101.1*	98.2	. .	. .	13y	. .	56*
	Low U5MR countries (30 and under) Median	108.2	92.8	100.0	103.6	71	. .	99	11
93	USSR	113.7	. .	. .	. .	. .	. .	100	. .
94	Mauritius	107.7	86.5	101.1	92.5	75	68*	90*	99*
95	Romania	108.0	. .	99.0	102.7	58*	. .	99	180
96	Yugoslavia	108.4	88.7	98.9	95.2	55*	. .	. .	27
97	Chile	110.3	99.0*	99.1	109.0	43	. .	97*	55
98	Trinidad and Tobago	107.5	97.9	103.4	106.8	55*	60y	90	81*
99	Kuwait	106.0	82.9	98.8	94.0	. .	2	99	18
100	Jamaica	107.4	. .	103.2*	107.1*	52	50y	89	100
101	Costa Rica	106.4	98.9	101.1	107.3	68	90*	93	26
102	Bulgaria	108.2	. .	99.0	101.0	76*	. .	100	22
103	Poland	111.8	. .	100.0	103.8	75*	. .	. .	12
104	Cuba	105.1	100.0*	98.9	106.0	60	. .	. .	31
105	Hungary	111.1	. .	102.1	101.4	74*	. .	99	28
106	Portugal	109.6	89.9	93.9	119.1	70*	. .	. .	15
107	Greece	105.9	90.7	101.1	89.9	. .	. .	. .	12
108	Czechoslovakia	110.8	. .	101.0	. .	. .	. .	100	8
109	Belgium	109.1	. .	102.1	102.1	81	. .	100	10
110	USA	109.8	. .	100.0	100.0	68	. .	100	9
111	New Zealand	108.4	. .	100.0	103.6	. .	. .	99	20
112	Israel	104.9	95.9	102.0	110.7	. .	. .	99	5
113	Austria	110.0	. .	100.0	102.6	71	. .	. .	11
114	Singapore	107.9	84.9	100.0	104.3	74	90y	100	11
115	Italy	109.1	98.0	101.0	100.0	78*	. .	. .	13
116	German Dem. Rep.	108.1	. .	99.0	96.2	. .	. .	. .	17
117	United Kingdom	107.8	. .	100.0	104.8	83	. .	98	7
118	Ireland	107.5	. .	100.0	111.0	60*	. .	. .	7
119	Germany, Fed. Rep. of	108.9	. .	100.0	104.2	. .	. .	. .	11
120	Denmark	107.9	. .	100.0	100.0	63*	. .	. .	4
121	Spain	108.2	94.8	100.0	106.3	51*	. .	96	10
122	Australia	109.0	. .	101.0	103.2	67*	. .	99	11
123	France	111.1	. .	100.0	107.6	79*	. .	. .	13
124	Hong Kong	107.7	85.3	100.0	109.1	73	90	. .	4*
125	Canada	109.3	. .	99.0	100.0	73	. .	99	2
126	Netherlands	108.9	. .	103.5	96.2	78	. .	. .	5
127	Norway	109.0	. .	100.0	105.3	71*	. .	100	4
128	Switzerland	108.7	. .	. .	. .	70*	. .	. .	5
129	Japan	107.7	. .	100.0	102.1	57	. .	. .	15
130	Finland	110.7	. .	100.0	115.8	80*	. .	. .	5
131	Sweden	107.8	. .	102.1	111.4	78	. .	100	4

TABLE 8: BASIC INDICATORS ON LESS POPULOUS COUNTRIES

		Under 5 mortality rate		Infant mortality rate (under 1)		Total population (millions)	Annual no. of births/infant and child deaths (0-4) (thousands)	GNP per capita US $	Life expectancy at birth (years)	% adults literate	% of age group enrolled in primary school
		1960	1987	1960	1987	1987	1987	1986	1987	male/female 1985	male/female 1984-1986
1	Gambia	375	264	213	153	0.8	39/10	230	44	36/15	92/58
2	Equatorial Guinea	315	217	188	128	0.4	18/4	180[a]	47	./.	./.
3	Djibouti	. .	. .	. .	123	0.4	19/2	480[a]	48	15[a]/9[a]	./.
4	Swaziland	227	177	152	119	0.7	36/6	690	57	70/66	110/108
5	Vanuatu	. .	. .	. .	101[a]	0.2	./.	. .	. .	57[a]/48[a]	./.
6	Comoros	216	132	128	81	0.4	23/3	320	53	56[a]/40[a]	90/70
7	Cape Verde	213	94	143	67	0.3	15/1	460	62	61/39	112/105
8	Sao Tome and Principe	. .	91[y]	. .	74[y]	0.1	./.	340	. .	73[a]/42[a]	./.
9	Maldives	. .	91	. .	68[a]	0.2	./.	310	. .	83[a]/82[a]	./.
10	Solomon Islands	. .	. .	. .	44[a]	0.3	./.	530	. .	./.	./.
11	St. Christopher/Nevis	. .	. .	. .	41[a]	(.)	./.	1700	65[a]	./.	./.
12	Dominica	. .	. .	. .	40[a]	0.1	./.	1210	77[y]	./.	./.
13	Samoa	. .	. .	. .	33[a]	0.2	./.	680	. .	./.	./.
14	Saint Vincent	. .	. .	. .	33[a]	0.1	./.	960	. .	./.	./.
15	Qatar	239	43	145	32	0.3	11/(.)	13200	70	51[a]/51[a]	121/121
16	Suriname	96	40	70	32	0.4	10/(.)	2510	70	90/90	136/130
17	Fiji	98	33	71	27	0.7	19/1	1810	71	90/81	129/128
18	Bahrain	208	32	130	27	0.5	14/(.)	8510	71	79/64	111/110
19	Bahamas	. .	. .	. .	23[a]	0.2	./.	7190	. .	./.	./.
20	Belize	. .	. .	. .	23[a]	0.2	./.	1170	. .	./.	./.
21	Antigua and Barbuda	. .	. .	26[a]	21[a]	0.1	./.	2380	70[y]	./.	./.
22	Saint Lucia	. .	. .	. .	18[a]	0.1	./.	1320	73[y]	./.	./.
23	Seychelles	. .	21[a]	. .	17[a]	0.1	./.	. .	70[a]	56[a]/60[a]	103[y]/102[y]
24	Grenada	. .	. .	. .	14[a]	0.1	./.	1240	66[y]	./.	./.
25	Brunei Darussalam	. .	. .	. .	12	0.2	./.	15400	. .	85[a]/69[a]	./.
26	Barbados	66	15	54	11	0.3	5/(.)	5150	74	./.	113/108
27	Cyprus	36	14	30	12	0.7	13/(.)	4360	76	96[a]/83[a]	99/100
28	Luxembourg	41	12	33	9	0.4	4/(.)	15770	75	./.	101[a]/99[a]
29	Malta	42	9	37	7	0.3	7/(.)	3450	73	86/82	99/95
30	Iceland	22	5	17	4	0.2	4/(.)	13410	78	./.	98/100

Note: nations are listed in descending order of their 1987 under-five mortality rates (see table 1)

Footnotes to Tables

Table 1:
Basic Indicators

Angola	GNP per capita	1980
Sierra Leone	Primary enrolment	1982
Chad	GNP per capita	1982
Burundi	Adult literacy	1982
Sudan	Adult literacy	1986
Tanzania, U. Rep. of	Adult literacy	1986
Uganda	Primary enrolment	1982
Zaire	Primary enrolment	1983
Oman	Adult literacy	1982
Egypt	Household income	1974
Peru	Household income	1972
Saudi Arabia	Adult literacy	1982
Turkey	Adult literacy	1984
	Household income	1973
Iraq	GNP per capita	1980
Ecuador	Primary enrolment	1983
Brazil	Primary enrolment	1983
	Household income	1972
Mongolia	Adult literacy	1982
Jordan	Primary enrolment	1983
Venezuela	Household income	1970
Guyana	Primary enrolment	1980
Argentina	Household income	1970
Panama	Household income	1973
Korea, Rep. of	Adult literacy	1982
Malaysia	Household income	1973
United Arab Emirates	Adult literacy	1975
Uruguay	Adult literacy	1975
USSR	GNP per capita	1980
Romania	GNP per capita	1983
Chile	Adult literacy	1984
Jamaica	Primary enrolment	1983
Costa Rica	Household income	1971
Bulgaria	GNP per capita	1980
Cuba	Adult literacy	1981, age 10 +
Portugal	Household income	1973-4
Czechoslovakia	GNP per capita	1980
German Dem. Rep.	GNP per capita	1980
Ireland	Household income	1973

Table 2:
Nutrition

Mali	Breast-feeding	Urban only, 3-5 months & 9-11 months
	Stunting	12-23 months
Angola	Breast-feeding	1976, duration not stated
Ethiopia	Breast-feeding	1977
Burkina Faso	Wasting	1978
Niger	Stunting	12-23 months
Senegal	Stunting	12-23 months
Nepal	Breast-feeding	1976
	Wasting & Stunting	1975
Yemen	Breast-feeding	1979
Burundi	Stunting	1979, 12-23 months
Bangladesh	Breast-feeding	1976
Sudan	Breast-feeding	1979
Nigeria	Wasting	Aged 0-5 years
Bolivia	Breast-feeding	1977
	Stunting	0-59 months
Haiti	Low Birth Weight	1978
	Wasting & Stunting	1978
Gabon	Stunting	12-23 months
Uganda	Malnutrition	Between 70% and 80% standard weight for height
		Less than 70% standard weight for height
	Stunting	12-23 months
Pakistan	Stunting	Rural only
Togo	Breast-feeding	1977
	Wasting & Stunting	1977
Cameroon	Breast-feeding	1978
	Stunting	12-23 months
Liberia	Wasting & Stunting	1976
Ghana	Stunting	12-23 months
Zambia	Stunting	1970-74 Rural only
Egypt	Wasting & Stunting	1978
Congo	Low Birth Weight	Urban only
Kenya	Breast-feeding	1978
	Wasting & Stunting	Rural only
Viet Nam	Wasting & Stunting	Aged 0-5 years
El Salvador	Wasting & Stunting	Rural only
Papua New Guinea	Malnutrition	1978, age unspecified
	Stunting	Rural only
Dominican Rep.	Breast-feeding	Urban only
Philippines	Breast-feeding	1978
Mexico	Breast-feeding	1976
Syrian Arab Rep.	Breast-feeding	1978
Paraguay	Breast-feeding	1979

continued over

Jordan	Wasting	1975
China	Wasting & Stunting	5 provinces only
		Aged 0-6 years
Sri Lanka	Stunting	12-23 months
Venezuela	Breast-feeding	1977
Panama	Breast-feeding	1979
Korea, Rep. of	Breast-feeding	1974
Malaysia	Wasting & Stunting	Sabah State only
Mauritius	Breast-feeding	Up to 9 months
Chile	Breast-feeding	Urban only
Trinidad and Tobago	Breast-feeding	1977
	Stunting	12-23 months
Kuwait	Breast-feeding	1978-9
Jamaica	Breast-feeding	1976
Poland	Breast-feeding	1977
Hungary	Breast-feeding	1975-6
Canada	Breast-feeding	1978
Netherlands	Breast-feeding	1975

Table 3:
Health

Afghanistan	Maternal mortality	1978
Mozambique	Maternal mortality	Hospital data only
Malawi	Maternal mortality	1975
Niger	Tuberculosis, polio and measles	Aged 0-5 years
Chad	Drinking water	1975
Central African Rep.	Drinking water	1975
	Immunization	1985
Senegal	Tetanus	1985
	Maternal mortality	1975
Nepal	Maternal mortality	1979
Benin	Maternal mortality	Hospital data only
Madagascar	Maternal mortality	1979
Tanzania,U. Rep. of	Maternal mortality	Institutional deaths only
Bolivia	Measles	Aged 1-5 years
	Maternal mortality	1973-77
Haiti	Tetanus	1985
Gabon	Tetanus	1985
Laos	Immunization	1985
Togo	Immunization	Aged 0-3 years
	Maternal mortality	1977
Cameroon	Drinking water	1975
	Maternal mortality	1975, Hospital data only
Ghana	Maternal mortality	Hospital data only
Cote d'Ivoire	Tuberculosis, DPT, polio and measles	Aged 1-2 years
Peru	Measles	Age 1-5
Libyan Arab Jamahiriya	Immunization	1985
	Maternal mortality	1978
Kenya	Maternal mortality	1977
Zimbabwe	Maternal mortality	1979, Hospital data only
Honduras	Measles	Aged 1-5 years
	Tetanus	1985
	Maternal mortality	1979
Guatemala	DPT, polio	2 doses only
	Tetanus	1985
Nicaragua	Maternal mortality	1978
Turkey	Maternal mortality	1975-76
Ecuador	Measles	Aged 1-5 years
	Maternal mortality	1978
Brazil	Polio	2 doses only
	Measles	Aged 1-5 years
El Salvador	Polio	2 doses only
	Tetanus	1985
Papua New Guinea	DPT	2 doses only
Dominican Rep.	Tuberculosis	1985
	Measles	Aged 1-5 years
	Maternal mortality	1978
Mexico	Polio	2 doses only
	Measles	Aged 1-5 years
Paraguay	Polio	2 doses only
Mongolia	Maternal mortality	1978
Guyana	Tetanus	1984
	Maternal mortality	1977
Argentina	Maternal mortality	1979
Korea, Rep. of	Measles	Ages 1-5 years
Uruguay	Polio	2 doses only
	Measles	Aged 1-5 years
	Tetanus	1984
	Maternal mortality	1978
USSR	Immunization	1985
Trinidad and Tobago	Tetanus	1984
	Maternal mortality	1977
Jamaica	Drinking water	1975
	Tetanus	1985
Cuba	Polio	2 doses only
Hungary	Tuberculosis	1984
USA	DPT, polio	1983
	Measles	Aged 1-5 years

continued over

New Zealand	Immunization	1985
Singapore	Measles	Aged 1-5 years
	Tetanus	1985
Ireland	Immunization	1985
Germany, Fed. Rep. of	Tuberculosis, DPT & polio	1985
Denmark	Tuberculosis	1984
Australia	Measles	1985
Norway	Tuberculosis	1983
Japan	Tuberculosis	1984
	DPT	1985
	Polio	1985, 2 doses only
	Measles	1984, Aged 1-5 years
Finland	Immunization	1984
Sweden	DPT	DT only

Table 4:
Education

Angola	Primary enrolment	1982
Sierra Leone	Primary enrolment	1982
	Primary completion	1976
	Secondary enrolment	1982
Niger	Primary completion	1977
Chad	Primary completion	1975
Bhutan	Primary completion	1978
Burundi	Adult literacy	1982
Sudan	Adult literacy	1986
Tanzania, U. Rep. of	Adult literacy	1986
Nigeria	Secondary enrolment	1982
Bolivia	Primary completion	1976
Haiti	Primary completion	1978
Uganda	Primary enrolment	1982
	Primary completion	1978
	Secondary enrolment	1982
Zaire	Primary enrolment	1983
	Primary completion	1976
	Secondary enrolment	1983
India	Primary completion	1978
Liberia	Secondary enrolment	1980
Ghana	Primary completion	1977
Oman	Adult literacy	1982
	Primary completion	1977
Cote d'Ivoire	Primary completion	1978
Saudi Arabia	Adult literacy	1982
Turkey	Adult literacy	1984
Iran (Islamic Rep. of)	Primary completion	1969
Ecuador	Primary enrolment	1983
	Secondary enrolment	1983
Brazil	Primary enrolment	1983
Colombia	Primary completion	1973
Paraguay	Primary completion	1977
Mongolia	Adult literacy	1982
	Primary completion	1978
Jordan	Primary enrolment	1983
	Secondary enrolment	1983
Venezuela	Primary completion	1978
Guyana	Primary enrolment	1980
	Secondary enrolment	1980
Argentina	Primary completion	1975
Korea, Rep. of	Adult literacy	1982
United Arab Emirates	Adult literacy	1975
Uruguay	Adult literacy	1975
Chile	Adult literacy	1984
Jamaica	Primary enrolment	1983
Cuba	Adult literacy	1981, Age 10 +
Portugal	Primary completion	1974

Table 5:
Demographic Indicators

Afghanistan	Contraceptive prevalence	1971-2
Senegal	Contraceptive prevalence	1978
Yemen	Contraceptive prevalence	1979
Sudan	Contraceptive prevalence	1978-9, North only
Cameroon	Contraceptive prevalence	1978
Turkey	Contraceptive prevalence	1978
Iraq	Contraceptive prevalence	1974
Colombia	Contraceptive prevalence	1980
Syrian Arab Rep.	Contraceptive prevalence	1978
Paraguay	Contraceptive prevalence	1979
Lebanon	Contraceptive prevalence	1971
Venezuela	Contraceptive prevalence	1977
Guyana	Contraceptive prevalence	1975
Romania	Contraceptive prevalence	1978
Yugoslavia	Contraceptive prevalence	1976
Trinidad and Tobago	Contraceptive prevalence	1977
Bulgaria	Contraceptive prevalence	1976
Poland	Contraceptive prevalence	1977
Hungary	Contraceptive prevalence	1977
Portugal	Contraceptive prevalence	1979-80

continued over

	Italy	Contraceptive prevalence	1979
	Ireland	Contraceptive prevalence	1970
	Denmark	Contraceptive prevalence	1975
	Spain	Contraceptive prevalence	1977
	Australia	Contraceptive prevalence	1970
	France	Contraceptive prevalence	1978
	Norway	Contraceptive prevalence	1977-8
	Switzerland	Contraceptive prevalence	1980
	Finland	Contraceptive prevalence	1977
Table 6: Economic Indicators	Mali	Poverty level	1975
	Angola	GNP per capita	1980
	Niger	Poverty level	1975
	Chad	GNP per capita	1982
		Poverty level	1976
	Rwanda	Poverty level	1975
	Sudan	Poverty level	1975
	Bolivia	Poverty level	1975
	Zaire	Poverty level	1975
	Iraq	GNP per capita	1980
	Iran (Islamic rep. of)	GNP per capita growth rate	1980-5
	USSR	GNP per capita	1980
	Romania	GNP per capita	1983
		GNP per capita growth rate	1980-84
	Bulgaria	GNP per capita	1980
	Czechoslovakia	GNP per capita	1980
	German Dem. Rep.	GNP per capita	1980
Table 7: Women	Afghanistan	Contraceptive prevalence	1971-2
		Maternal mortality	1978
	Mozambique	Maternal mortality	Hospital data only
	Sierra Leone	Primary enrolment	1982
		Secondary enrolment	1982
	Malawi	Maternal mortality	1975
	Central African Rep.	Tetanus	1985
	Senegal	Contraceptive prevalence	1978
		Tetanus	1986
		Maternal mortality	1975
	Nepal	Maternal mortality	1979
	Yemen	Contraceptive prevalence	1979
	Burundi	Adult literacy	1982
	Benin	Maternal mortality	Hospital data only
	Madagascar	Maternal mortality	1979
	Sudan	Adult literacy	1986
		Contraceptive prevalence	1978-9, North only
	Tanzania, U. Rep. of	Adult literacy	1986
		Maternal mortality	Institutional deaths only
	Bolivia	Maternal mortality	1973-77
	Haiti	Tetanus	1985
	Gabon	Tetanus	1985
	Uganda	Primary enrolment	1982
		Secondary enrolment	1982
	Zaire	Primary enrolment	1983
		Secondary enrolment	1983
	Togo	Maternal mortality	1977
	Cameroon	Contraceptive prevalence	1978
		Maternal mortality	1975, Hospital data only
	Liberia	Secondary enrolment	1980
	Ghana	Maternal mortality	Hospital data only
	Libyan Arab Jamahiriya	Maternal mortality	1978
	Kenya	Maternal mortality	1977
	Zimbabwe	Maternal mortality	1979, Hospital data only
	Honduras	Maternal mortality	1979
		Tetanus	1985
	Guatemala	Tetanus	1985
	Saudi Arabia	Adult literacy	1982
	Nicaragua	Maternal mortality	1978
	Turkey	Adult literacy	1984
		Contraceptive prevalence	1978
		Maternal mortality	1975-76
	Iraq	Contraceptive prevalence	1974
	Ecuador	Secondary enrolment	1983
		Maternal mortality	1978
	Brazil	Primary enrolment	1983
	El Salvador	Tetanus	1985
	Dominican Rep.	Maternal mortality	1978
	Colombia	Contraceptive prevalence	1980
	Syrian Arab Rep.	Contraceptive prevalence	1978
	Paraguay	Contraceptive prevalence	1979
	Mongolia	Adult literacy	1982
		Maternal mortality	1978
	Jordan	Primary enrolment	1983
		Secondary enrolment	1983
	Lebanon	Contraceptive prevalence	1971

continued over

Venezuela	Contraceptive prevalence	1977
Guyana	Secondary enrolment	1980
	Contraceptive prevalence	1975
	Tetanus	1984
	Maternal mortality	1977
Argentina	Maternal mortality	1979
Korea, Rep. of	Adult literacy	1982
United Arab Emirates	Adult literacy	1975
Uruguay	Adult literacy	1975
	Tetanus	1984
	Maternal mortality	1978
Romania	Contraceptive prevalence	1978
Yugoslavia	Contraceptive prevalence	1976
Chile	Adult literacy	1984
Trinidad and Tobago	Contraceptive prevalence	1977
	Tetanus	1984
	Maternal mortality	1977
Jamaica	Primary enrolment	1983
	Secondary enrolment	1983
	Tetanus	1985
Bulgaria	Contraceptive prevalence	1976
Poland	Contraceptive prevalence	1977
Cuba	Adult literacy	1981, Age 10+
Hungary	Contraceptive prevalence	1977
Portugal	Contraceptive prevalence	1979-80
Singapore	Tetanus	1985
Italy	Contraceptive prevalence	1979
Ireland	Contraceptive prevalence	1970
Denmark	Contraceptive prevalence	1975
Spain	Contraceptive prevalence	1977
Australia	Contraceptive prevalence	1970
France	Contraceptive prevalence	1978
Norway	Contraceptive prevalence	1977-8
Switzerland	Contraceptive prevalence	1980
Finland	Contraceptive prevalence	1977

Table 8:

Basic Indicators on less populous countries

Equatorial Guinea	GNP per capita	1981
Djibouti	GNP per capita	1981
Vanuatu	Adult literacy	1979
Comoros	Adult literacy	1980
Sao Tome and Principe	Under 5 mortality	1985
	Infant mortality	1985
	Adult literacy	1980
Maldives	Adult literacy	1977
Dominica	Life expectancy	1984
Qatar	Adult literacy	1981
Antigua and Barbuda	Life expectancy	1984
Saint Lucia	Life expectancy	1984
Seychelles	Adult literacy	1971
	Primary enrolment	1982
Grenada	Life expectancy	1984
Brunei Darussalam	Adult literacy	1982
Cyprus	Adult literacy	1976
Luxembourg	Primary enrolment	1983

Definitions

Under five mortality rate: annual number of deaths of children under 5 years of age per 1,000 live births.

Infant mortality rate: annual number of deaths of infants under one year of age per 1,000 live births.

GNP: gross national product. Annual GNPs per capita are expressed in current United States dollars. GNP per capita growth rates are annual average growth rates that have been computed by fitting trend lines to the logarithmic values of GNP per capita at constant market prices for each year of the time period.

Life expectancy at birth: the number of years new-born children would live if subject to the mortality risks prevailing for the cross-section of population at the time of their birth.

Adult literacy rate: percentage of persons aged 15 and over who can read and write.

Primary and secondary enrolment ratios: The *gross* enrolment ratio is the total number of children enrolled in a schooling level – whether or not they belong in the relevant age group for that level – expressed as a percentage of the total number of children in the relevant age group for that level. The *net* enrolment ratio is the total number of children enrolled in a schooling level who belong in the relevant age group, expressed as a percentage of the total number of children in that age group.

Income share: the percentage of private income received by the highest 20% and lowest 40% of households.

Low birth-weight: 2,500 grammes or less.

Breast-feeding: either wholly or partly breast-feeding.

Child malnutrition: *mild or moderate:* between 60% and 80% of the desirable weight-for-age; *severe:* less than 60% of the desirable weight-for-age.

Maternal mortality rate: annual number of deaths of women from pregnancy related causes per 100,000 live births.

Prevalence of wasting (acute malnutrition) and stunting (chronic malnutrition): the percentage of children with greater than minus two standard deviations from the 50th percentile of the weight-for-height reference population (wasting) or the height-for-age reference population (stunting). Wasting/stunting therefore means less than 77% (approximately) of the median weight-for-height (wasting) or height-for-age (stunting) of the reference population of the United States National Center for Health Statistics.

Access to health services: percentage of the population that can reach appropriate local health services by the usual local means of transport in no more than one hour.

DPT: diphtheria, pertussis (whooping cough) and tetanus.

ORS: oral rehydration salts.

Maternal mortality rate: annual number of deaths of women from pregnancy related causes per 100,000 live births.

Children completing primary school: percentage of the children entering the first grade of primary school who successfully complete that level in due course.

Crude death rate: annual number of deaths per 1,000 population.

Crude birth rate: annual number of births per 1,000 population.

Total fertility rate: the number of children that would be born per woman, if she were to live to the end of her child-bearing years and bear children at each age in accordance with prevailing age-specific fertility rates.

Urban population: the percentage of population living in urban areas as defined according to the national definition used in the most recent population census.

Contraception prevalence ratio: percentage of married women age 15–44 currently using contraception.

Absolute poverty level: that income level below which a minimum nutritionally adequate diet plus essential non-food requirements is not affordable.

ODA: official development assistance.

Debt service: the sum of interest payments and repayments of principal on external public and publicly guaranteed debts.

Main sources

Under five and infant mortality:	United Nations Population Division and United Nations Statistical Office
Total population:	United Nations Statistical Office and United Nations Population Division
Child population:	United Nations Population Division
Births:	United Nations Population Division
Infant and child deaths:	United Nations Population Division and UNICEF
GNP per capita:	World Bank
Life expectancy:	United Nations Population Division
Adult literacy:	United Nations Educational, Scientific and Cultural Organization (UNESCO)
School enrolment and completion:	United Nations Educational, Scientific and Cultural Organization (UNESCO)
Household income:	World Bank
Low birth-weight:	World Health Organization (WHO)
Breast-feeding:	World Health Organization (WHO)
Child malnutrition:	World Health Organization (WHO) and UNICEF Field Offices
wasting (acute malnutrition) and stunting (chronic malnutrition):	World Health Organization (WHO)
Food production and calorie intake:	Food and Agriculture Organization of the United Nations (FAO) and World Bank
Access to drinking water:	World Health Organization (WHO)
Access to health services:	World Health Organization (WHO)
Immunization:	World Health Organization (WHO) and UNICEF field offices
ORS:	World Health Organization (WHO)
Births attended:	World Health Organization (WHO)
Maternal mortality:	World Health Organization (WHO)
Radio and television:	United Nations Educational, Scientific and Cultural Organization (UNESCO)
Crude death and birth rates:	United Nations Population Division
Fertility:	United Nations Population Division
Urban population:	United Nations Population Division
Contraceptive prevalence:	United Nations Fund for Population Activities (UNFPA)
Inflation:	World Bank
Absolute poverty level:	World Bank
Expenditure on health, education, food and defence:	World Bank
Official development assistance:	Organisation for Economic Co-operation and Development (OECD)
Debt service:	World Bank

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THE STATE OF THE WORLD'S CHILDREN 1989

The 1989 *State of the World's Children* report looks at some of the major child health achievements of the 1980s–achievements which are now saving the lives of at least two and a half million young children each year. But this rate of progress, says the report, is now threatened by rising debts and the reversal of economic development in large areas of the third world. In many nations, spending on health and education has fallen steeply in the 1980s. And in many of the poorest countries, rates of child malnutrition appear to be rising again after 40 years of steady progress.

The heaviest burden of the debt crisis is therefore being passed on to the children of the world's poor. It is the young child whose growing mind and body is susceptible to permanent damage from even temporary deprivation. It is the young child whose individual development today and whose social contribution tomorrow is being shaped by the economics of now.

Calling for action on debt reduction, trade, and aid to restore the momentum to development–and to help the industrialized world itself return to more stable economic growth–the report argues that the derailment of the development effort also offers an opportunity to re-examine its direction. Development should put the poor first–in good times and in bad. It should be–and be seen to be–a movement which has as its first priority the meeting of the essential needs of all human beings for adequate nutrition, clean water, safe sanitation, primary health care, adequate housing, and basic education. This is the kind of development which corresponds to the broad priorities of the great majority in the developing world. And this is the kind of development which could enlist the broad support of the majority in the industrialized world.

What is needed in the decade ahead, says UNICEF, is a *real development pact*, between industrialized and developing nations, to attempt to meet the needs and enhance the capacities of the poorest third of mankind. With such a commitment, the report concludes, the knowledge and experience gained over the last few decades could convert relatively small increases in resources into the achievement of one of the greatest of all goals–the eradication of the worst aspects of absolute poverty by the end of the present century.

OXFORD UNIVERSITY PRESS

£3.25 net in UK $6.25 USA

ISBN 0–19–261827–X