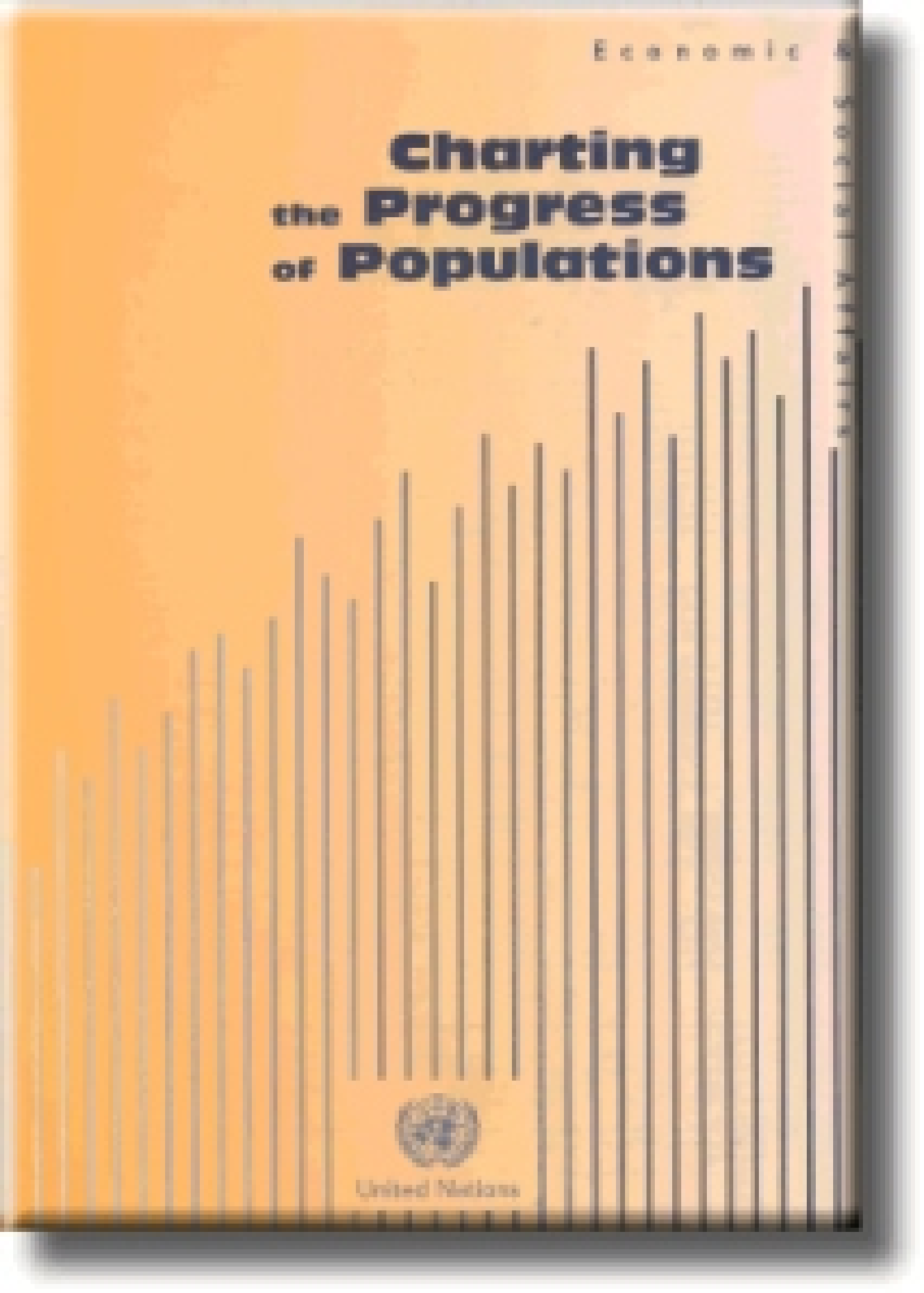
Economic

Charting the Progress of Populations



United Nations

PREFACE

In the 1990s the United Nations held a series of global conferences addressing a number of economic and social issues of international concern. Besides identifying targets to measure progress in particular fields, these conferences succeeded in forging a consensus on the development issues confronting the international community. The United Nations is now engaged in the review and appraisal of progress in achieving the goals and objectives of those conferences.

The present publication grew out of the participation of the Population Division, Department of Economic and Social Affairs, in activities aimed at ensuring a coordinated and system-wide implementation of the goals and commitments adopted by the conferences. In 1997, the Population Division issued a *Wall Chart on Basic Social Services for All*, as a contribution to the work of the system-wide ACC Task Force on Basic Social Services for All. The chart brought together key statistical indicators relevant to the goals adopted at the recent conferences. However, that format precluded an analytic summary of the information or background information about the data sources, coverage and quality. While further information about each indicator is available from the responsible United Nations agencies, this information is scattered among a variety of sources. Recognizing the desirability of an accessible and concise and updated analytic summary of these key indicators, the Population Division has issued the present report.

The report provides information on 12 key socio-economic indicators related to the goals of the conferences. Goals are explicitly identified in documents adopted at the above-mentioned global conferences, particularly, the International Conference on Population and Development, the World Summit for Social Development, the Fourth World Conference on Women and the Second United Nations Conference on Human Settlements (HABITAT II). The indicators are: total population, access to health services, contraceptive prevalence, underweight prevalence among preschool children, maternal mortality, infant and child mortality, life expectancy at birth, school enrolment, adult illiteracy, access to safe water, access to sanitation, and floor area per person. The data are the latest available as of September 1999.

Acknowledgements are due to the various United Nations offices and specialized agencies that assisted in the preparation of the publication. Particular thanks are due to the following organizations which provided data and valuable comments on earlier drafts: the United Nations Children's Fund (UNICEF) (chap. II, IV, V, X and XI); the United Nations Educational, Scientific and Cultural Organization (UNESCO) (chap. VIII and IX); the United Nations Centre for Human Settlements (UNCHS) (chap. XII); the United Nations Population Fund (UNFPA); and the World Health Organization (WHO) (chap. IV, V, X, and XI). Acknowledgement is also due to the Trust Fund for the Follow-up to the World Summit for Social Development, which provided partial support for the printing of this publication.

Charting the Progress of Populations, as well as other population information, may also be accessed on the Population Division POPIN world wide web site at *www.popin.org*.

Comments or questions about this report are welcome. Readers may contact the Director, Population Division, Department of Economic and Social Affairs, United Nations, New York, NY 10017, United States of America, at fax 1-212-963-2147, or e-mail to *population@un.org*.. For further information regarding specific indicators, contact the offices or agencies cited in the source notes.

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Explanatory notes

Symbols of United Nations documents are composed of capital letters combined with figures.

Details and percentages in tables do not necessarily add to totals because of rounding.

The term "billion" signifies a thousand million.

More developed regions comprise Northern America, Japan, Europe, Australia and New Zealand.

Less developed regions comprise all regions of Africa, Latin America and the Caribbean, Asia (excluding Japan), Melanesia, Micronesia and Polynesia.

The least developed countries with a population of 150,000 or more, classified as such by the United Nations General Assembly in 1998, are:

> Afghanistan, Angola, Bangladesh, Benin, Bhutan, Burkina Faso, Burundi, Cambodia, Cape Verde, Central African Republic, Chad, Comoros, Democratic Republic of the Congo, Djibouti, Equatorial Guinea, Eritrea, Ethiopia, Gambia, Guinea, Guinea-Bissau, Haiti, Lao People's Democratic Republic, Lesotho, Liberia, Madagascar, Malawi, Maldives, Mali, Mauritania, Mozambique, Myanmar, Nepal, Niger, Rwanda, Samoa, Sierra Leone, Solomon Islands, Somalia, Sudan, Togo, Uganda, United Republic of Tanzania, Vanuatu, Yemen and Zambia.

The following abbreviations are used in the present report:

DHS	Demographic and Health Surveys
FWCW	Fourth World Conference on Women
HABITAT	United Nations Conference on Human Settlements (Habitat)
ICPD	International Conference on Population and Development
IDWSSD	International Drinking Water Supply and Sanitation Decade
LSMS	Living Standards Measurement Study
MICS	Multiple Indicator Cluster Surveys
MMR	Maternal mortality ratio
PAPCHILD	Pan-Arab Project for Child Development
RAMOS	Reproductive Age Mortality Surveys
SDA	Social dimensions of adjustment
UNCHS	United Nations Centre for Human Settlements
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WSSD	World Summit for Social Development

INTRODUCTION AND OVERVIEW

Recognizing that development remains the great challenge of our time, the United Nations launched a series of global conferences during the 1990s. Addressing such critical issues as education (Jomtien, 1990), children (New York, 1990), the environment (Rio de Janeiro, 1992), human rights (Vienna, 1993), population (Cairo, 1994), poverty (Copenhagen, 1995), status of women (Beijing, 1995), urban habitat (Istanbul, 1996) and food security (Rome, 1996), these global conferences succeeded in consciousness-raising and in setting the international agenda. Through them the international community has come to agree on numerically defined goals which are expected to give policy makers and planners better guidance in making and evaluating social policies in the years to come.

The present report was prepared as the United Nations was engaged in the first series of systematic quinquennial reviews of progress towards achieving the goals and objectives of those conferences, culminating in a series of special sessions of the General Assembly to assess progress and identify priorities for further implementation of the conference goals and objectives.

Charting the Progress of Populations was prepared by the Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat in support of follow-up activities to the global conferences. It provides basic statistical information and sources for 12 key indicators relevant to goals agreed upon by Governments. A particular effort was made to show where countries currently stand and how close they are to the agreed goals.

The indicators were selected for their relevance to six of the main themes of the various global conferences: population, with special emphasis on reproductive health and family planning services; primary health care; nutrition; basic education; drinking water and sanitation; and shelter. The 12 indicators are:

(a) Total population;
(b) Access to health services;
(c) Contraceptive prevalence;
(d) Underweight prevalence among preschool children;
(e) Maternal mortality;
(f) Infant and child mortality;
(g) Life expectancy at birth;
(h) School enrolment;
(i) Adult illiteracy;
(j) Access to safe water;
(k) Access to sanitation;
(l) Floor area per person.

All the recent international conferences and summits have recognized that accurate and timely data are essential for monitoring progress in achieving the conference goals. In order to assess progress for broad regions and for the world, it is necessary for key indicators to be measured in a manner that permits comparison. For most of the indicators included in the present report, comparable and recent national estimates are available. However, the quality of the underlying data varies, and for some indicators further work is needed to improve comparability across countries. For instance, under the auspices of the WHO/UNICEF Joint Monitoring Programme, considerable progress has been made in improving coverage and timeliness of information on access to safe water and sanitation. Still, the estimates are not fully comparable across countries. In the case of access to health services, there remain important questions—about the features of facilities, staff and services available—that must be present for coverage to be considered adequate.

For indicators that provide a high degree of international comparability, achieving that comparability often means adjusting the data in order to give a better estimate of the underlying concept. For instance, for certain countries, all the mortality estimates shown here have been adjusted or indirectly estimated. However, the degree of adjustment is not the same for all the indicators. In the case of mortality indicators in the present report, the underlying data are relatively more complete for infant and child mortality, followed by life expectancy, while the estimates of maternal mortality are substantially more dependent on indirect methods.

Although in most cases, the more developed countries tend to have data that are of better quality and more up-to-date than the developing countries, there are some indicators for which this is not the case. In more developed regions data for five of the 12 indicators are either not available or are available for only a few countries. These indicators are child malnutrition, adult illiteracy and access to health services, to safe water and to sanitation. For some indicators, such as adult illiteracy, this is because the problem has been largely overcome in the more developed countries, and national data gathering has turned to other indicators of educational attainment. In other cases, such as child malnutrition, a concerted effort has been made to obtain timely and comparable data in developing countries, while in most developed countries data either are lacking at the national level or have not been tabulated in a comparable manner. As compared with the other themes, national data on shelter are limited in both developed and developing countries, as shown in chapter XII. Standard definitions and standardized estimates, which make it possible to compare data across countries, are available for some indicators, but not for others. The majority of data used in this report refer to the 1990s, but some data are for earlier times.

In most of the areas covered by the 12 indicators, significant progress has been made in many regions in recent decades. The growth rate of the world's population is estimated to have peaked in the 1960s and has declined significantly since then. Important advances have been made in making accessible the means to combat the most common diseases of childhood, and an increasing number of children are routinely immunized against major diseases. Improvements in life expectancy at birth in the past half century, for both developing and developed countries, represent a remarkable social and demographic achievement. In the area of education, the absolute number of illiterate adults in the world has, since the early 1990s, begun to decline (UNESCO,1995). WHO and UNICEF also report that access to safe water and sanitation facilities significantly increased during the 1980s.

At the same time, progress has been quite uneven across the world's regions. The 12 indicators show substantial variations between regions and countries in their past achievements (see fig. A). Some countries have already surpassed most of the conference goals, while others have yet to make significant progress. Some countries or regions perform very well in one area but poorly in others.

Organization of chapters

Chapters are organized by indicator in the order listed below. Each chapter begins with excerpts of relevant goals adopted at the global conferences and summary information concerning other international conferences and agreements. (Conferences are listed at the end of this introduction.) A definition of the indicator and a summary of the recent situation in reference to the conference goals follow. Each chapter also includes information on data sources, coverage and quality, and references which provide further information. A statistical table is also included.

Total population

The ICPD Programme of Action notes that early stabilization of the world population would make a crucial contribution to achieving sustainable development. During 1999, world population reached 6 billion persons. During the mid-1990s, world population was still growing at a rate of 1.3 per cent per year, with an average annual addition of 78 million persons. As of 1999, countries with 100 million or more population included China, India, the United States of America, Indonesia, Brazil, Pakistan, the Russian Federation, Bangladesh, Japan and Nigeria. According to the medium variant of the United Nations population estimates and projections, world population will reach 7.2 billion by the year 2015, which is the reference date for achieving many of the Conference goals. Ninety-eight per cent of the global increase in population between 1999 and 2015 will take place in the less developed regions. Africa will experience, by far, the most rapid rate of growth.

Access to health services

In three fourths of the 92 countries with data, the majority of the population is estimated to have access to health services. In about one third of the 92 countries, access is close to universal, or above 90 per cent. Access to health services tends to be limited in Africa, where nearly 40 per cent of the countries have estimated levels of access below 50 per cent. By contrast, in Asia and Oceania, and Latin America and the Caribbean, only 10 per cent of the countries with data have access levels of 50 per cent or less. It should be noted, however, that estimates are available for only about one half of the Asian and Oceanic countries with populations over 150,000 and for only approximately two thirds of the Latin American and Caribbean countries.

Contraceptive prevalence

In general, in countries and regions where the level of contraceptive use is low, many women say they want to stop childbearing or delay the next child, yet are not using contraception. Data on contraceptive prevalence reveal that the majority of married couples use some form of contraception in about half of the countries with data available. Within the less developed regions, there are substantial differences between Africa and the other two regions. In Africa more than one half of the countries (55 per cent) have prevalence rates less than 20 per cent. In Asia and Oceania,18 per cent of the countries have prevalence rates below 20 per cent, and in Latin America and the Caribbean, only 4 per cent have such rates.

Underweight prevalence among preschool children

Malnutrition usually results from a combination of inadequate dietary intake and infection. The percentage underweight is the most widely cited indicator to assess the nutritional status of young children. Underweight prevalence among children is one are in which the worst cases of deprivation are seen in Asia and Oceania rather than in Africa; in several countries over half of pre-school children are under weight. Only one quarter of countries in the less developed regions have achieved a low prevalence (under 10 per cent) of underweight among children.

Maternal mortality

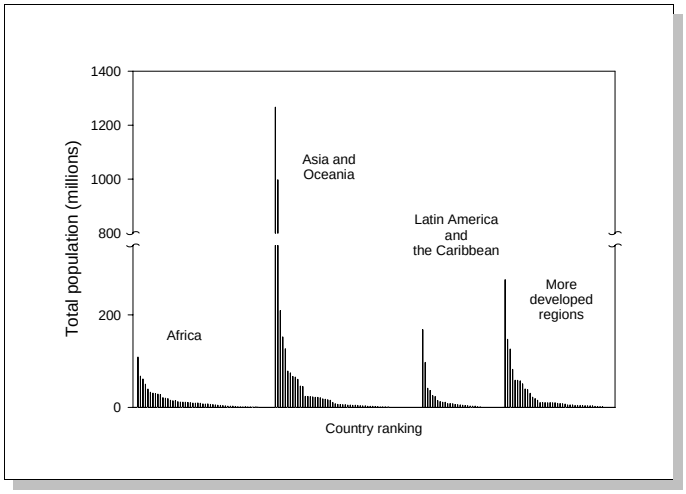
Maternal mortality shows a wide disparity among countries, with ratios under 10 deaths per l00,000 births in some countries and substantially over 1,000 deaths in other countries. The range of values is greater, in proportional terms, than for any other health and development indicator included in this report. As of 1990, one fifth of the countries had maternal mortality ratios estimated at less than 30 maternal deaths per 100,000 births. By region, about 70 per cent of countries in the more developed regions fall into that category, whereas only 6 per cent in the less developed regions do so. The countries from the less developed regions with maternal mortality less than 30 were all in Asia and Oceania. In the case of Africa, no country had a ratio less than 100, and more than four fifths of African countries had a maternal mortality ratio of 500 or more. The majority of African countries will need to make significant progress to achieve the year 2005 goal for countries with the highest levels of mortality—namely, a maternal mortality ratio below 125. It should be noted that the estimates should be taken as indicating orders of magnitude; the standard errors associated with the estimated ratios are very large.

Infant mortality and under-5 mortality

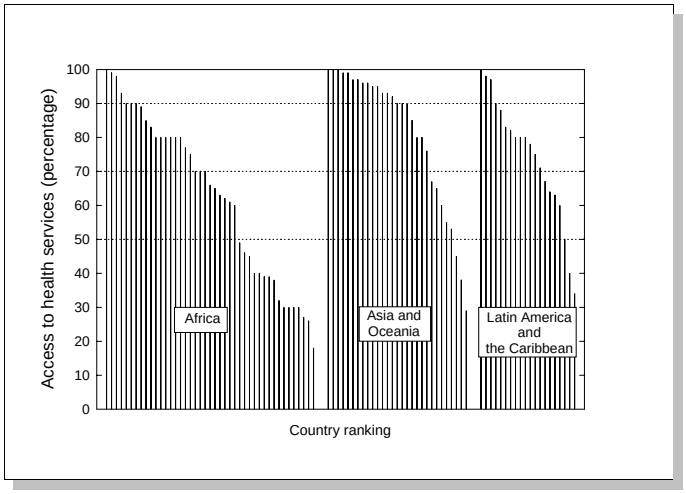
At the global level, approximately half of the countries are estimated to have infant and child mortality rates below the goals set for the year 2015. However, this is the result of very disparate levels in the more developed regions, on the one hand, and the less developed regions, on the other. For example, in Africa, only 4 out of 53 countries have attained the goals for

Figure A. 12 indicators, by country ranking and region

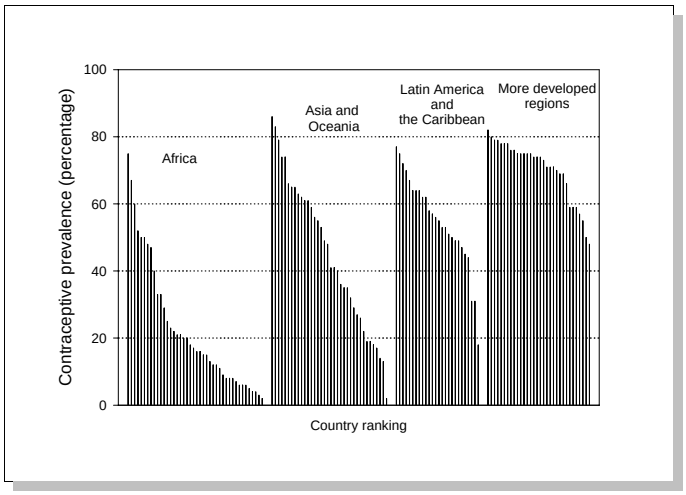
Total population



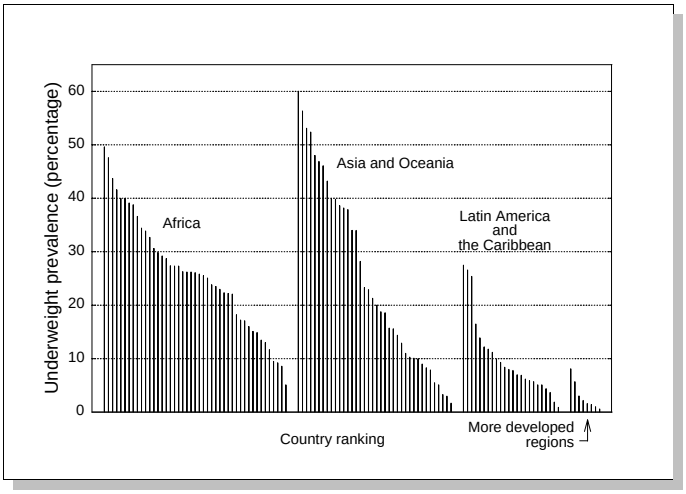
Access to health services



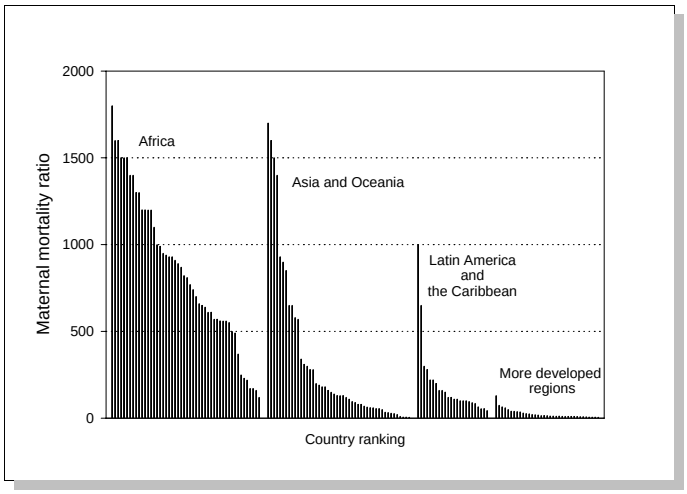
Contraceptive prevalence



Underweight prevalence among preschool children



Maternal mortality ratio



Infant mortality rate and under-5 mortality rate

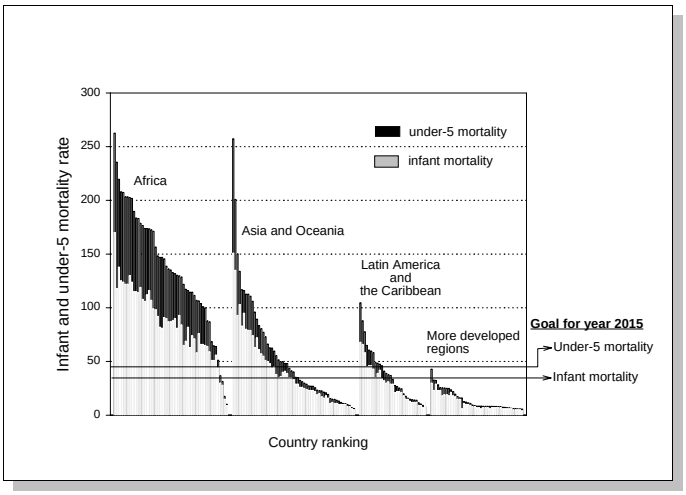
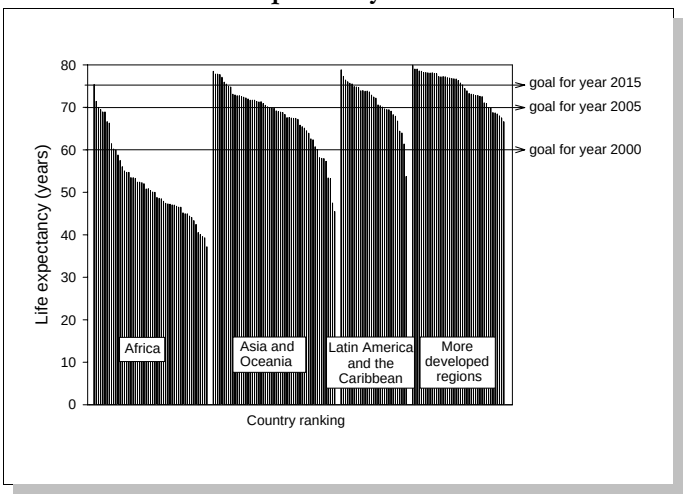
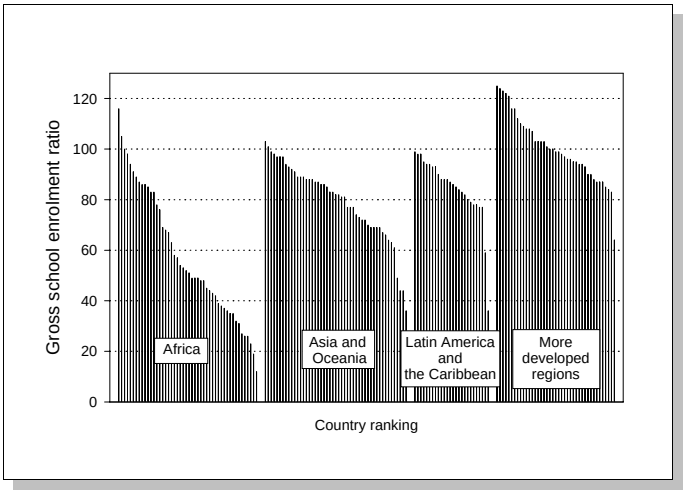


Figure A *(continued)*

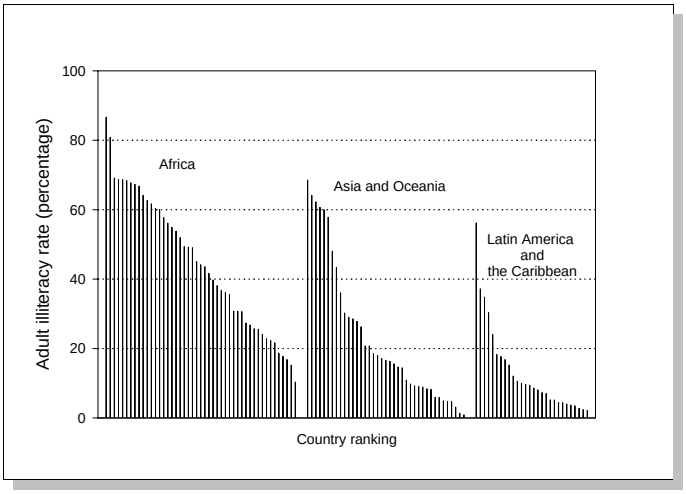
Life expectancy at birth



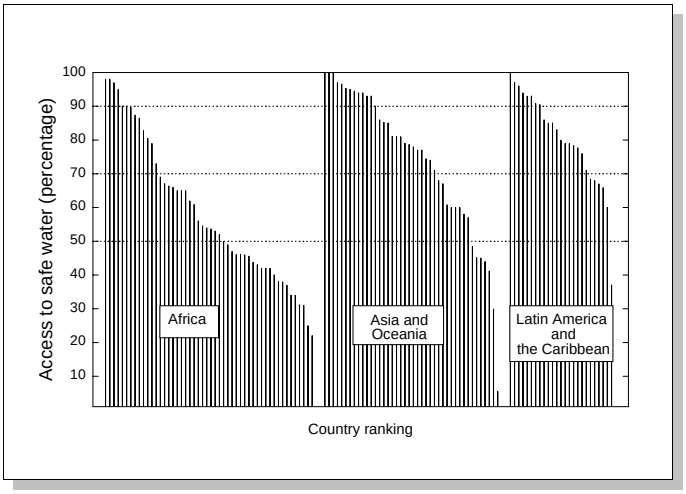
Gross school enrolment ratio for primary and secondary school combined



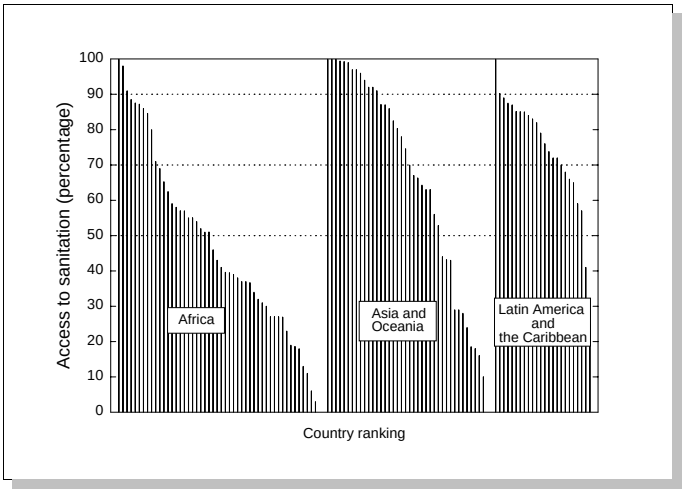
Adult illiteracy rate



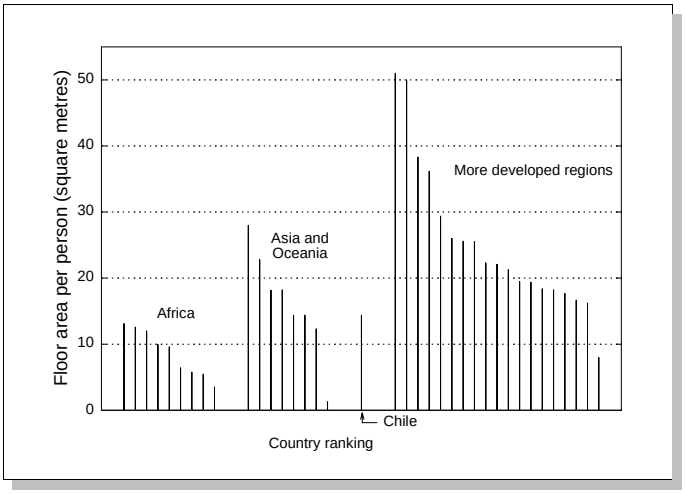
Access to safe water



Access to sanitation



Floor area per person



2015. In reference to the more immediate goal of reducing the infant mortality rate to 50 and the under-5 mortality rate to 70 by the year 2000, more than 90 per cent of African countries still fall short. All of the countries in the more developed regions have infant mortality rates below 35 and under-5 mortality rates below 45.

Life expectancy at birth

As of 1995-2000, about 70 per cent of all countries have achieved the year 2000 goal of a life expectancy at birth of 60 years or more. Over two fifths have already attained the year 2005 goal of 70 years or more, and about one fifth of countries have already achieved the year 2015 goal of at least 75 years. Of the roughly 30 per cent of all countries that have not yet reached the goal for the year 2000, most are African. All countries in the more developed regions have achieved the life expectancy goal of at least 60 years by year 2000, and over half have achieved the 2015 goal. Yet, one fifth of the developed countries have still to reach the goal for 2005, and about one quarter, the goal for 2015. These countries are concentrated in Eastern Europe, including the Russian Federation.

Gross enrolment for primary and secondary school combined

Education is now clearly recognized as a key component of policies aimed at achieving socio-economic development. Of the 164 countries with data available, one third have an enrolment ratio close to the conference goal of universal access to education. On the other hand, nearly one fifth of those countries—most of them in Africa—still have enrolment ratios less than 50. Since low enrolment ratios indicate a need for more school places to respond to unsatisfied educational needs and for measures to encourage increase in enrolment, the majority of African countries will need to make substantial investments in education in the years to come just to meet the needs of the current population. The school-age population is also growing more rapidly in Africa than in any other region. In most countries, boys have higher enrolment ratios than girls, and the differences are substantial in many countries, particularly where levels of enrolment are low overall. In nearly half of the developing countries, the enrolment ratio for boys exceeds that for girls by 5 points or more. However, in Latin America and the Caribbean, the gender gap in school enrolment is narrower than in the other less developed regions. In a substantial fraction of the countries of that region enrolment ratios for girls are higher than for boys.

Adult illiteracy

In the less developed regions, the majority of the adult population is illiterate in nearly one quarter of the countries, although a similar number of countries report that less than 10 per cent of their adult population is illiterate. It should be particularly noted that more than half of the least developed countries report that over half of their adults are illiterate. There is a wide gender gap in literacy in Africa and parts of Asia. More than half of the countries in Africa and about one third of those in Asia and Oceania have female illiteracy rates that are higher than male rates by 20 percentage points or more. In contrast, in Latin America and the Caribbean, no country has such a wide gender gap.

Access to safe water

During the International Drinking Water Supply and Sanitation Decade (1981-1990), significant progress was made in providing access to safe water supplies and sanitation facilities. A large proportion of the population in the developing world, however, still lives without access to safe water and sanitation, on which the health and productive capacity of people depend. Of 117 countries with data available in the less developed regions, the majority of the population lack access to safe water in 25 per cent of the countries. A similar percentage of countries have achieved or are close to achieving the goal of universal access.

Access to sanitation

In all regions, access to sanitation is more limited than access to safe water. In about one third of the 112 countries with data available in the less developed regions, the majority of the population do not have access to sanitation. When the two indicators—access to safe water and access to sanitation—are weighted by population size, about one quarter of the population of the less developed regions lacks access to safe water, but more than half have no access to sanitation.

Floor area per person

Floor area per person is one of the 10 key housing indicators selected by the Commission on Human Settlements to measure progress in meeting the objectives of the Global Strategy for Shelter to the Year 2000, adopted by the General Assembly in 1988. Data availability at the national level is extremely limited for this indicator, as compared with the other indicators included in the present report. Many indicators of crowding and other aspects of housing have been compiled mainly for cities rather than nation-wide. At the national level, out of 37 countries with data available, two thirds report floor area per person of less than 20 square metres. Housing tends to be more crowded in African countries than in other regions. More developed regions have relatively more floor space per person.

In general, most African countries are currently far from reaching the goals identified at the recent United Nations conferences. Asian and Oceanic countries fare better but tend to have larger intra-regional variations than other major regions. Also, in Asia and Oceania, progress is not consistent across different indicators. Progress in some areas, such as access to health services, has been substantial but is lagging in others, especially child malnutrition. In the less developed regions, the countries of Latin America and the Caribbean are the closest to achieving the conference goals for most of the 12 indicators. Their achievements in the field of education are particularly noteworthy.

Conference reports

The relevant conferences and the titles of the policy documents adopted are listed below, by theme:

(a) Primary health: The International Conference on Primary Health Care (Alma-Ata, USSR, 6-12 September 1978) adopted the **Declaration of Alma Ata**;

(b) Global health for all: The World Health Assembly, in resolution WHA.34.36 (1980), adopted the **Global Strategy for Health for All by the Year 2000**;

(c) Maternal health: The International Conference on Safe Motherhood (Nairobi, 10-13 February 1987) adopted the **Safe Motherhood Initiative: A Call to Action**;

(d) Education: The World Conference on Education for All: Meeting Basic Learning Needs (Jomtien, Thailand, 5-9 March 1990) adopted the **World Declaration on Education for All**;

(e) Children: The World Summit for Children (New York, 29-30 September 1990) adopted the **World Declaration on the Survival, Protection and Development of Children in the 1990s** and the **Plan of Action for Implementing the World Declaration**;

(f) Nutrition: The International Conference on Nutrition (Rome, 5-11 December 1992) adopted the **World Declaration on Nutrition** and **Plan of Action for Nutrition**;

(g) Environment: The United Nations Conference on Environment and Development (Rio de Janeiro, 3-14 June 1992) adopted the **Rio Declaration on Environment and Development** and **Agenda 21**;

(h) Small islands: The Global Conference on the Sustainable Development of Small Island Developing States (Bridgetown, Barbados, 26 April-6 May 1994) adopted the **Declaration of Barbados** and the **Programme of Action for the Sustainable Development of Small Island Developing States**;

(i) Human rights: The World Conference on Human Rights (Vienna, 14-25 June 1993) adopted the **Vienna Declaration** and **Programme of Action**;

(j) Population: The International Conference on Population and Development (Cairo, 5-13 September 1994) adopted the **Programme of Action of the ICPD**;

(k) Social development: The World Summit for Social Development (Copenhagen, 6-12 March 1995) adopted the **Copenhagen Declaration on Social Development** and the **Programme of Action of the World Summit for Social Development**;

(l) Women: The Fourth World Conference on Women (Beijing, 4-15 September 1995) adopted the **Beijing Declaration** and **Platform for Action**;

(m) Human settlements: The United Nations Conference on Human Settlements (Habitat II) (Istanbul, 3-14 June 1996) adopted the **Istanbul Declaration on Human Settlements** and the **Habitat Agenda**;

(n) Food security: The World Food Summit (Rome, 13-17 November 1996) adopted the **Declaration on World Food Security** and the **World Food Summit Plan of Action**.

I. Total Population

International objective

Recognizing that the ultimate goal is the improvement of the quality of life of present and future generations, the objective is to facilitate the demographic transition as soon as possible in countries where there is an imbalance between demographic rates and social, economic and environmental goals, while fully respecting human rights. This process will contribute to the stabilization of the world population, and, together with changes in unsustainable patterns of production and consumption, to sustainable development and economic growth (para.6.3 of ICPD Programme of Action).

Definition

Total population refers to the mid-year population.

Recent situation

Population size is relevant to the goals of recent United Nations conferences as a background indicator that approximates a country's demand or need for basic social services.

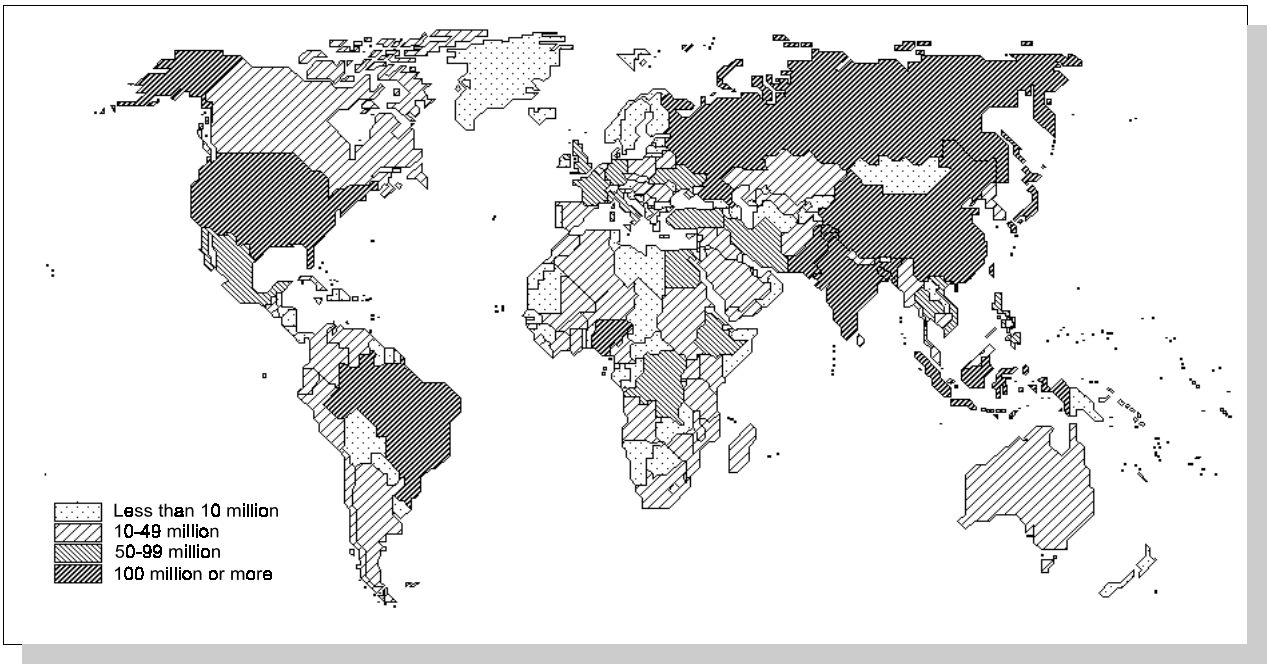
Although there are no Conference goals for population size, the ICPD Programme of Action notes that early stabilization of the world population would make a crucial contribution to the achievement of sustainable development (paras. 1.11, 3.14, 6.3). In addition, it is expected that implementation of the goals and objectives contained in the Programme of Action—which address many of the fundamental population, health, education and development challenges facing the human community—would result in world population growth at levels below the United Nations "medium" projection (para. 1.4).

During October 1999, world population reached 6 billion persons, doubling in size in under 40 years. World population is still growing at a rate of 1.3 per cent per year, with an average annual addition of 78 million persons during 1995-2000.

As of 1999, countries with a population of 100 million or more are China, India, United States of America, Indonesia, Brazil, Pakistan, Russian Federation, Bangladesh, Japan and Nigeria (fig. I.1).

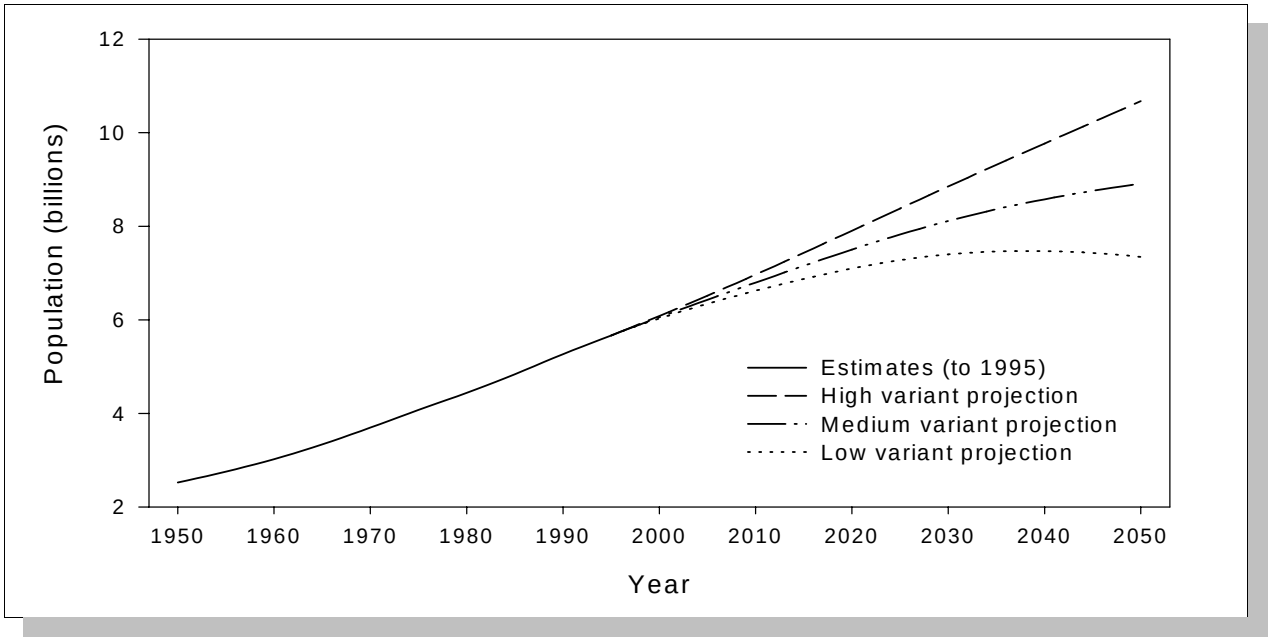
Both the annual growth rate and the annual addition to numbers are projected to decline in the coming years, but the pace of future change is uncertain. According to the medium variant of the United Nations population estimates and projections (United Nations, 1999), world population will reach 7.2 billion by the year 2015, which is the reference date for achieving many of the Conference goals (fig. I.2). Population will still be growing by about 50 million persons per year during 2010-2015, according to the medium-variant projections. By the year 2050, population is projected to reach 8.9 billion. However, according to the high and low variant projections, which are considered to be plausible alternatives, population size could be as high as 10.7 billion in 2050 or as low as 7.3 billion.

Figure I.1. Total population, 1999



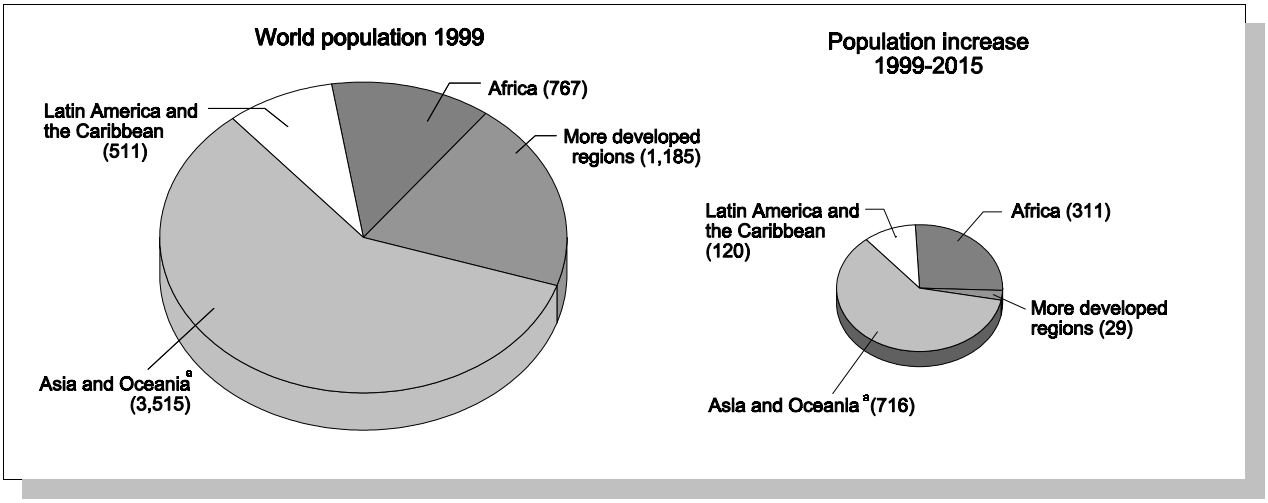
Source: World Population Prospects: The 1998 Revision, Volume I: Comprehensive Tables (United Nations publication, Sales No. E.99.XIII.9).

Figure I.2. Estimated and projected growth of the world population, 1950-2050



Source: *World Population Prospects: The 1998 Revision, Volume I: Comprehensive Tables* (United Nations publication, Sales No. E.99.XIII.9).

Figure I.3. Distribution of world population, 1999, and the increase in population, 1999-2015
(Millions)



Source: World Population Prospects: The 1998 Revision, Volume I: Comprehensive Tables (United Nations publication, Sales No. E.99.XIII.9).

[a] Excluding Japan, Australia and New Zealand, which are included in the more developed regions.

Roughly one fifth of the world population currently lives in the more developed regions, including Australia/New Zealand, Europe, Japan and North America (fig. I.3). The remaining 80 per cent live in the developing countries of Africa (13 per cent), Asia and Oceania (58 per cent) and Latin America and the Caribbean (8 per cent). The less developed regions are projected to absorb 98 per cent of the population growth occurring between 1999 and 2015.

SOURCES OF DATA, COVERAGE AND QUALITY

Estimates of total population are calculated and biennially updated by the Population Division of the United Nations Secretariat, within the framework of the official United Nations world population estimates and projections prepared by the Population Division.

Data underlying the population estimates are national and subnational census data and data on births, deaths and migrants that are available from national sources and publications, as well as from special country questionnaires sent to national statistical offices by the Statistics Division of the Department of Economic and Social Affairs of the United Nations Secretariat. For all countries, census and registration data are evaluated and, if necessary, adjusted for incompleteness by the Population Division as part of its preparations of the official United Nations population estimates and projections.

The Population Division updates and publishes estimates of total population in its *World Population Prospects* series. The most recent publication is *World Population Prospects: the 1998 Revision* (United Nations, 1999). Data are available for all countries and areas of the world. Estimates are presented for 5-year periods from 1950 through 1995. Projected total populations are given through 2050.

FOR FURTHER INFORMATION

Director, Population Division
Department of Economic and Social Affairs
United Nations
New York, NY 10017
United States of America
Facsimile: 1-212-963-2147
Internet: http://www.undp.org/popin/wdtrends/wdtrends.htm

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II. Access to Health Services

International goals

All countries should ... seek to make primary health care, including reproductive health care, available universally by the end of the current decade (para. 8.5 of ICPD Programme of Action)

[The goals include,] by the year 2000, attainment by all peoples of the world of a level of health that will permit them to lead a socially and economically productive life, and to this end, ensuring primary health care for all (para. 36(g) of WSSD Programme of Action).

Governments should promote full access to preventive and curative health care to improve the quality of life, especially by the vulnerable and disadvantaged groups, in particular women and children (para. 74 (g) of WSSD Programme of Action).

Provide more accessible, available and affordable primary health-care services of high quality, including sexual and reproductive health care ... (para. 106 (e) of FWCW Platform for Action).

The Declaration of Alma Ata endorsed the goal of Health for All by the Year 2000. The global strategy of Health for All by the Year 2000, adopted by the WHO World Health Assembly in 1977, aims to achieve a level of health for all peoples in all countries which would permit them to work productively and participate actively in the social life of their community.

Agenda 21 and the World Food Summit Plan of Action also include paragraphs on access to health services.

Definition

Access to health services is defined as being able to reach appropriate local health services by local means of transport in no more than one hour, and is measured as a percentage of the population.

Recent situation

Since its adoption at the World Health Assembly in 1977, the "Health for All" strategies have provided a blueprint for the formulation of health policies at both the national and international levels. They have been adopted by virtually all countries in the world and have also been instrumental in putting health at the centre of the development agenda. In keeping with that approach, the ICPD Programme of Action reaffirmed that increasing access to primary health care is crucial for reducing mortality and morbidity.

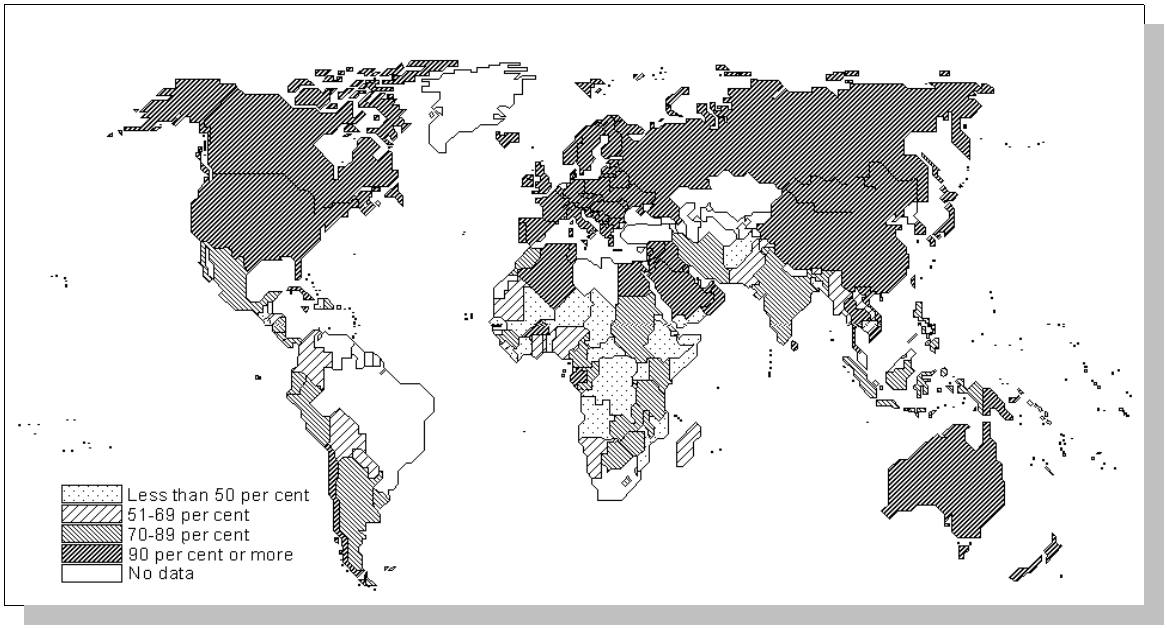
During the past decade, many of the less developed countries have managed to provide populations with greater access to health services. In three fourths of the 92 countries with data available, the majority of the population is estimated to have access to health services. In about one third of the 92 countries, access is close to universal, above 90 per cent (table II.1).

Regional disparities, however, are significant, particularly between Africa and the other less developed regions (fig. II.1 and II.2). Access to health services tends to be limited in Africa, where nearly 40 per cent of the countries have estimated levels of access below 50 per cent. Within Africa, countries that have access of less than 50 per cent are largely concentrated in the sub-Saharan region (fig. II.1).

By contrast, in the case of both Asia and Oceania and of Latin America and the Caribbean, only 10 per cent of the countries with data have access levels of 50 per cent or less. Universal or close to universal access has been achieved in about 60 per cent of Asian and Oceanic countries. In Latin America and the Caribbean, two thirds of the countries have access levels between 51 and 90 per cent. It should be noted, though, that estimates are available for only about half of the Asian and Oceanic countries with population over 150,000 and for approximately two thirds of the Latin American and Caribbean countries.

The least developed countries are lagging substantially behind the rest of the world, as measured by this indicator. For them, universal access to health services remains a remote goal. Almost half of the least developed countries fail to provide the majority of population with access to health services, and only 2 of the 35 have access estimated at 90 per cent or better.

Figure II.1. Percentage of population with access to health services, 1985-1995



Source: UNICEF, *The State of the World's Children, 1996* (New York, Oxford University Press, 1996).

NOTE: Estimates are not presented for countries or areas with populations under 150,000. Countries from the more developed regions are assumed to have access to health services of over 90 per cent.

Table II.1. Distribution of countries according to access to health services, 1985-1995

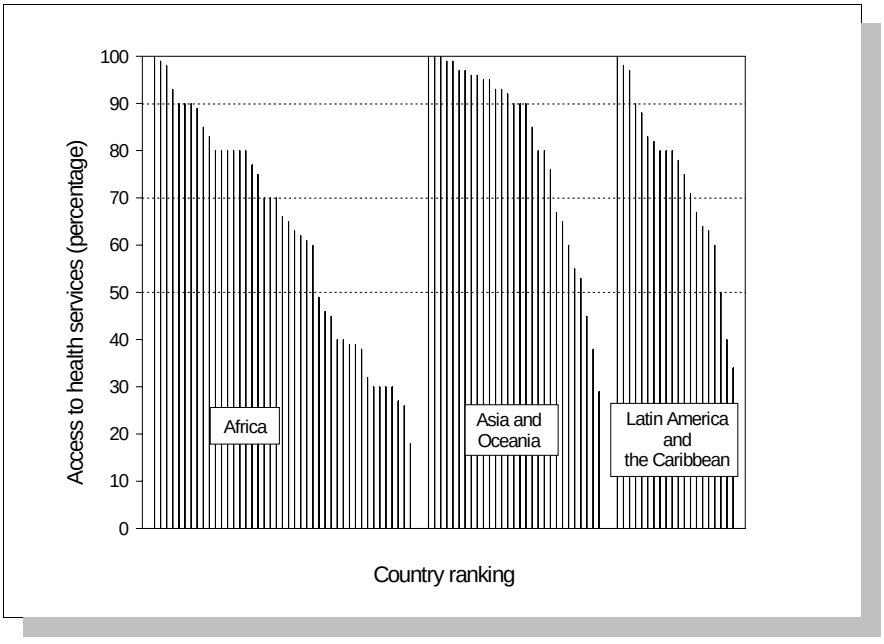
	Percentage of countries with access to health services				Number of countries	
	90 per cent or more	50-89 per cent	Less than 50 per cent	Total	With data available	Total
Less developed regions	30	46	24	100	92	141
Least developed countries	6	46	49	100	35	45
Africa	16	47	37	100	43	53
Asia and Oceania[a]	59	31	10	100	29	57
Latin America and the Caribbean	20	70	10	100	20	31

Source: UNICEF, *The State of the World's Children, 1996* (New York, Oxford University Press, 1996).

NOTE: Excludes countries and areas with populations under 150,000. Due to rounding, the sum of the subcategories may not be equal to 100 per cent.

[a] Excluding Japan, Australia and New Zealand, which are included in the more developed regions.

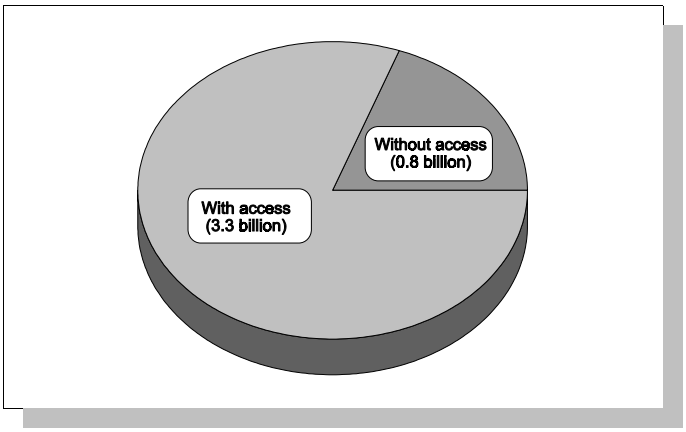
Figure II.2. Access to health services, 1985-1995, by country ranking and region



Source: UNICEF, *The State of the World's Children, 1996* (New York, Oxford University Press).

NOTE: Bars show level of access to health services for individual countries.

Figure II. 3. Distribution of population in the less developed regions, by access to health services, 1985-1995



Source: UNICEF, *State of the World's Children, 1996* (New York, Oxford University Press).

NOTE: Excluding the population in countries without information about access.

Figure II.3 shows access to health services weighted by population size. Overall, four fifths of the population living in less developed regions already have access to basic health services.

"Access to health services" has many dimensions which cannot be captured adequately in a single statistic. Access to quality reproductive health care was a particular focus of certain United Nations global conference documents, including the ICPD Programme of Action. Even though available data are insufficient to give a comprehensive overview of such access, there is information bearing upon certain aspects of it.

Data on maternal health care that have been compiled by WHO show vast discrepancies in coverage of care between the developing and the developed world, between rural and urban areas and between different socio-economic groups. As table II.2 shows, nearly all women in the more developed regions receive prenatal care and the assistance of a skilled attendant at delivery, but in every developing region substantial proportions of women do not receive such care. Access to maternal health care is more limited in Africa than in Asia, and more limited in Asia than in Latin America and the Caribbean.

Africa, particularly sub-Saharan Africa, also lags behind other developing regions in providing access to family planning services. For instance, an obvious precondition for adequate access is that potential clients should know of a place to obtain services. In over 60 per cent of the African countries, one third of the Asian countries and one fourth of the Latin American countries surveyed in the early 1990s or late 1980s, under 80 per cent of the women knew where to obtain family planning services (United Nations, 1998). Estimates for 1994 indicate that in only about 40 per cent of the developing countries was any type of modern contraception readily and easily available to at least 80 per cent of the population. Many fewer countries than this had achieved good access to the full range of safe and effective contraceptive methods (United Nations, 1998). Despite undoubted progress during the past decade, the goal of making good-quality family-planning services universally available (ICPD, para. 7.16) is far from being met.

Table II.2. Global and regional estimates of prenatal care and deliveries attended by skilled personnel, around 1996

	Estimated percentage of women	
	Receiving prenatal care	With skilled attendant at delivery
World	68	57
More developed regions	97	99
Less developed regions	65	53
Africa	63	42
Asia and Oceania[a]	65	53
Latin America and the Caribbean	73	75

Source: *World Population Monitoring, 1998* (United Nations publication, forthcoming). Based on data from WHO.

[a] Excluding Japan, Australia and New Zealand, which are included in the more developed regions.

SOURCES OF DATA, COVERAGE AND QUALITY

Information on access to health services is provided by UNICEF field offices and published in its *State of the World's Children* series. Data are available for 92 countries or areas with populations of 150,000 or more in 1995 and for the years between 1985 and 1995, depending on the country. None is from more developed regions. For some countries, data refer to years before 1985, differ from the standard definition, or refer to only part of the country. It should also be kept in mind that health care facilities tend to be concentrated in urban areas, and in some cases, rural areas may have a much lower level of access. The data sources give separate estimates for rural and urban areas.

It should be noted that this indicator is particularly problematic, both conceptually and in adequacy of measurement. For instance, there is risk of giving an over-optimistic assessment of access when attention focuses only on the proximity of health facilities or on facilities that have appropriate staff present, for medicines and vaccines may be absent. The availability of facilities does not always translate into their utilization, either, and services may be priced beyond the reach of the poor. Work is ongoing under the auspices of WHO and UNICEF to improve indicators of access to basic health services.

It is also useful to be able to examine access to specific aspects of basic health care, and some statistics related to reproductive health are highlighted above. WHO has been collecting data on the use of maternal health care services since 1985 and has built up a database on coverage of maternal health care and the barriers to appropriate utilization of services. The available data are derived from a wide variety of sources: routine health service reports, special

surveys and government estimates. The information about women's knowledge of where to obtain family planning services and actual use of contraception (see chap. III) comes from representative national surveys. However, fewer surveys have inquired about knowledge of family planning services than about actual use of family planning (see United Nations, 1998). The estimates of availability of modern contraceptive methods are based on the most recent of several comparable surveys conducted by Mauldin, Ross and others (cited in United Nations, 1998), of informed observers familiar with individual country programmes. Ratings of method availability from this source should be regarded as approximate. The surveys of knowledgeable respondents do, however, have the advantage of providing estimates covering nearly the entire population of the developing world, measured comparably at different times and across countries.

FOR FURTHER INFORMATION

Director
Division of Evaluation, Policy and Planning
United Nations Children's Fund
633 Third Avenue
New York, NY 10016
United States of America
Facsimile: 1-212-824-6491/6492/6990

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III. Contraceptive Prevalence

International goals

All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so. (Principle 8 of ICPD Programme of Action; also in para. 95 of FWCW Platform for Action).

All countries should take steps to meet the family-planning needs of their populations as soon as possible and should, in all cases by the year 2015, seek to provide universal access to a full range of safe and reliable family-planning methods and to related reproductive health services which are not against the law. (para. 7.16 of ICPD Programme of Action).

It should be the goal of public, private and non-governmental family-planning organizations to remove all programme-related barriers to family-planning use by the year 2005 through the redesign or expansion of information and services and other ways to increase the ability of couples and individuals to make free and informed decisions about the number, spacing and timing of births and protect themselves from sexually transmitted diseases.(para. 7.19 of ICPD Programme of Action).

[The goals include] making accessible through the primary health-care system reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015 ... (para. 36(h) of WSSD Programme of Action).

... right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice ... (para. 94 of FWCW Platform for Action).

Develop and implement programmes to ensure universal access for women throughout their life-span to a full range of affordable health-care services, including those related to reproductive health care, which includes family planning and sexual health ... (para. 136(f) of the Habitat Agenda).

Agenda 21, the Vienna Programme of Action and the World Food Summit Plan of Action also contain paragraphs on family planning and reproductive health.

Definition

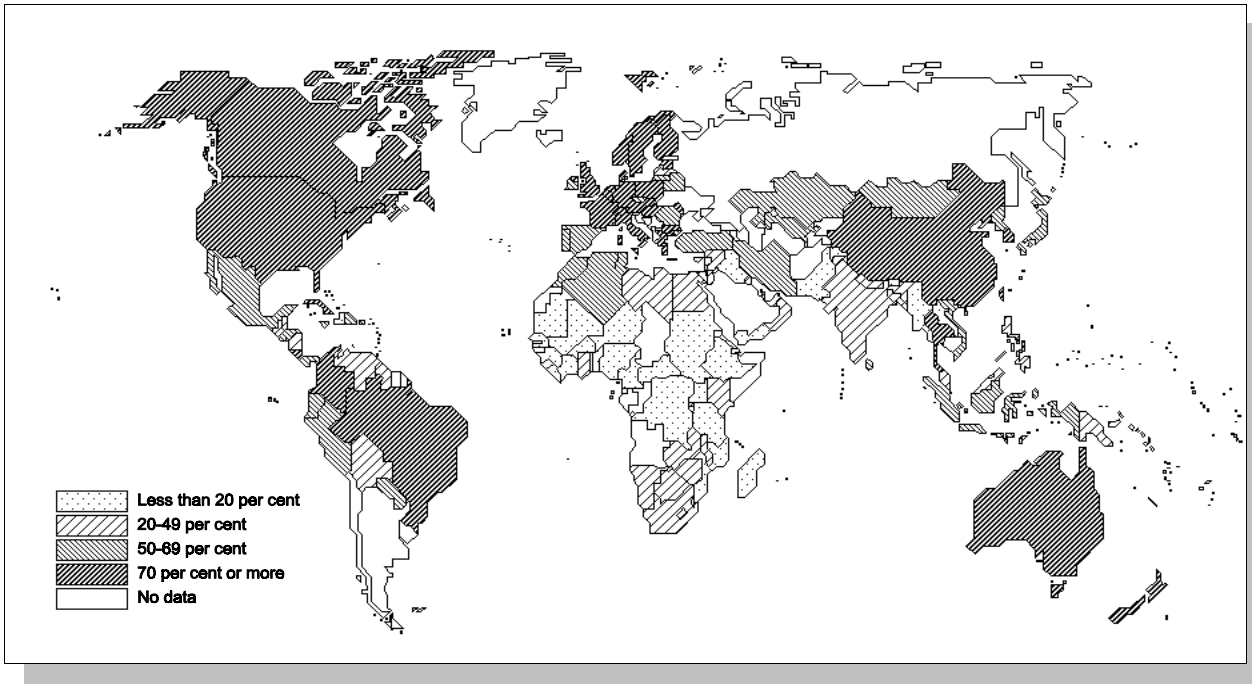
Contraceptive prevalence refers to the percentage currently using contraception, either traditional or modern methods, among currently married women of reproductive age, including, where possible, those in consensual unions. Users of contraception are defined as women who are practicing, or whose male partners are practicing, any form of contraception, including female or male sterilization, injectable or oral contraceptives, intrauterine devices, diaphragms, spermicides, condoms, rhythm, withdrawal or abstinence.

RECENT SITUATION

International agreements do not establish specific national or global targets for contraceptive prevalence. However, contraceptive prevalence can be regarded as an indirect indicator of progress in providing access to reproductive health services, including family planning, one of the eight elements of primary health care. Contraceptive practice depends not only on people's fertility desires but also on availability and quality of family planning services, social traditions that affect the acceptability of contraceptive use and other factors such as marriage patterns and traditional birth-spacing practices that independently influence the supply of children.

The immediate hindrances to increased contraceptive practice in developing countries are usually the difficulties of providing adequate services rather than governmental policies aimed at restricting contraceptive availability. Governments have increasingly come to view family planning as part of the basic health services that should be available to their populations. Over time, organized family planning programmes have greatly increased the availability of contraceptives in developing countries. However, access to modern methods is still very limited in Africa and in parts of other regions (United Nations, 1998).

Figure III.1. Contraceptive prevalence



Sources: World Contraceptive Use 1998 (United Nations publication, Sales No. E.99.XIII.4) and files maintained by the Population Division of the United Nations Secretariat.

NOTE: Based on the most recent available survey data, with an average date of 1991. Estimates are not presented for countries or areas with populations under 150,000.

Table III.1. Distribution of countries according to contraceptive prevalence

	Percentage of countries with contraceptive prevalence of:					Number of countries	
	70 per cent or more	50-69 per cent	20-49 per cent	Less than 20 per cent	Total	With data available	Total
World	24	28	25	23	100	132	184
More developed regions	71	26	3	0	100	31	43
Less developed regions	10	29	32	30	100	101	141
Least developed countries	0	0	22	78	100	32	45
Africa	2	12	31	55	100	42	53
Asia and Oceania[a]	15	30	36	18	100	33	57
Latin America and the Caribbean	15	54	27	4	100	26	31

[a]Excluding Japan, Australia and New Zealand, which are included in the more developed regions.

Sources: World Contraceptive Use 1998 (United Nations publication, Sales No. E.99.XIII.4) and files maintained by the Population Division of the United Nations Secretariat.

NOTE: Based on the most recent available survey data, with an average date of 1991. Excludes countries and areas with populations under 150,000. Due to rounding, the sum of the subcategories may not be equal to 100 per cent .

Statistics on contraceptive prevalence show that the majority of married couples use some form of contraception in about half of the countries with data available (table III.1). One quarter of countries or areas have levels of use of 70 per cent or more, and roughly another quarter have levels in the range of 50-69 per cent. There are, however, significant regional differences between the more developed regions and the less developed regions as well as between the less developed regions as a whole and the least developed countries only. In the more developed regions, all countries except one report prevalence rates of 50 per cent or higher; in the less developed regions, only 40 per cent of the countries do so. Further, none of the least developed countries report prevalence higher than 50 per cent, and in approximately 80 per cent of them, prevalence is lower than 20 per cent.

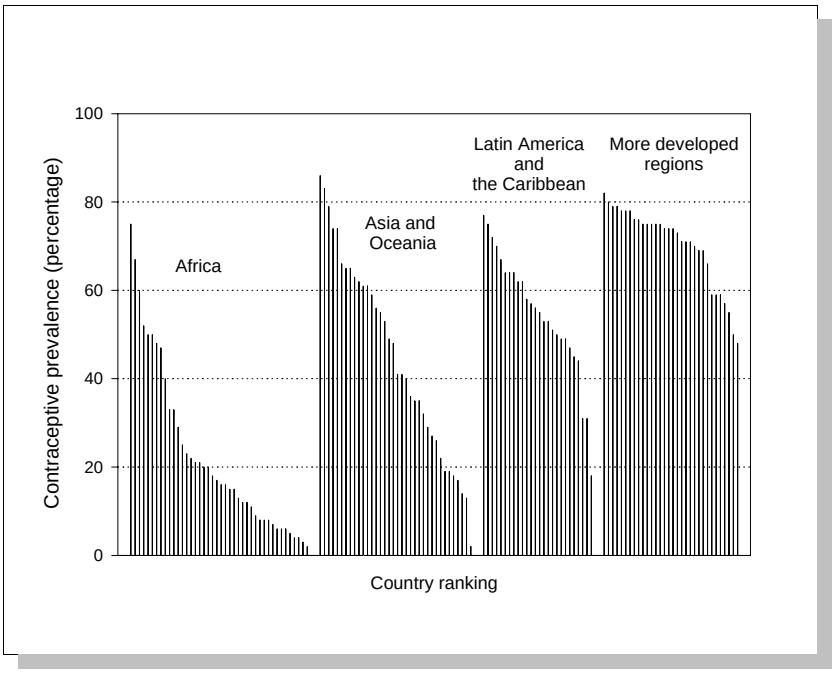
Within the less developed regions, there are substantial differences between Africa and the other two regions (also see fig. III.1 and III.2). Only 14 per cent of African countries fall in the category of 50 per cent or more, while 45 per cent of Asian and Oceanic countries and 69 per cent of Latin American and the Caribbean countries do so. Over half of the African countries have prevalence rates less than 20 per cent. In Asia and Oceania, it is 18 per cent, and in Latin America and the Caribbean, only 4 per cent.

Figure III.3 is produced by applying a country's prevalence rate to the number of married women of reproductive age. The percentage practicing contraception is 58 per cent.

In general, in countries and regions where the level of contraceptive use is low, many women say they want to stop childbearing or delay the next child, yet are not using contraception. The level of such "unmet need" for contraception tends to be especially high in sub-Saharan Africa: in 20 sub-Saharan countries surveyed in the late 1980s and early 1990s, an average of 29 per cent of married women of childbearing age currently wanted to stop childbearing or delay the next birth, yet were not using contraception (United Nations, 1998). Even though women and men in most sub-Saharan countries tend to want larger families than do couples in other regions, desired family size has been declining in all developing regions, and particularly large numbers of African women would like to delay the next birth.

It should be noted that most of what is known about contraceptive practice is derived from surveys of women. With the recent increasing inclusion of men in surveys, however, it has become possible to some extent to investigate men's reproductive behaviour and also to compare differences and similarities between men and women. In Asia, Europe and Latin America, married men's and women's reports of the level of current contraceptive use are usually similar, but in most sub-Saharan African countries men report substantially more use of contraception. Also, when men report more use of contraception, the difference in male and female reports is often due mainly to greater use by men of condoms and, sometimes, the rhythm method (periodic abstinence). Even where the overall level of use is similar from men's and women's reports, men usually report greater use of these methods. Methods for which women often report more use include intrauterine devices (IUDs), female sterilization and injectables (United Nations, 1998).

Figure III.2. Contraceptive prevalence, by country ranking and region



Source: World Contraceptive Use 1998 (United Nations publication, Sales No. E.99.XIII.4) and files maintained by the Population Division of the United Nations Secretariat.

NOTE: Bars show level of contraceptive prevalence for individual countries.

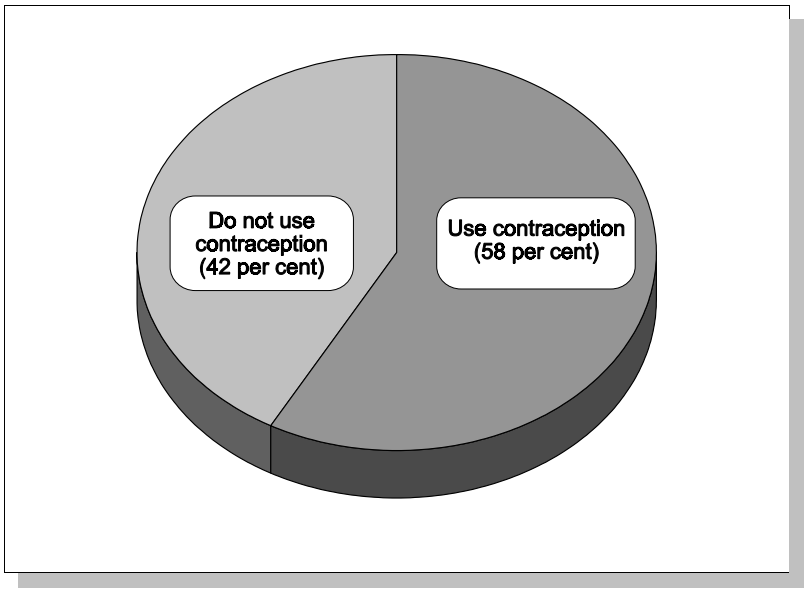


Figure III.3. Distribution of married women of reproductive age, by contraceptive prevalence

Source: World Contraceptive Use 1998 (United Nations publication, Sales No. E.99.XIII.4) and files maintained by the Population Division of the United Nations Secretariat.

NOTE: Reproductive age is 15-49 years.

SOURCES OF DATA, COVERAGE AND QUALITY

The Population Division maintains files on contraceptive prevalence. The most recent publication with updated data is the wall chart: *World Contraceptive Use 1998* (United Nations, 1999). In addition, beginning with *World Population Monitoring, 1996* (United Nations, 1998), updates of recent levels and trends in contraceptive use have been presented annually in the annex tables of the monitoring reports.

Information about contraceptive use comes almost entirely from representative sample surveys of women or—less commonly—men of reproductive age. Executing agencies for such surveys vary, depending on the country. National statistical offices and ministries of health are the most common source, but other governmental offices or non-governmental voluntary or commercial organizations are frequently involved. Many surveys are conducted in collaboration with international survey programmes.

Most surveys use a similar set of questions to inquire about contraceptive use, including reference to a list of specific contraceptive methods. However, under-reporting can occur when specific methods are not mentioned by the interviewer. This can be the case with the use of traditional methods such as rhythm and withdrawal, and the use of contraceptive surgical sterilization. "Current" use is often specified in surveys to mean "within the past month", but sometimes the time reference is left vague, and occasionally longer reference periods are specified. Despite such problems the data are still sufficiently consistent to permit meaningful comparison. Available data refer to a range of dates, depending on the frequency of relevant surveys (see the annex table and the data sources cited below).

The base population of married or in-union couples provides a good basis for cross-country comparison of levels of contraceptive practice within the main population group likely to need such services, although in some societies, a focus on married women omits a substantial fraction of contraceptive use and of sexually active persons in need of family planning services. Information about contraceptive practice is less widely available for persons who are not in a union, and there is often no information available about how many of the unmarried population are sexually active, which makes it more difficult to make meaningful comparisons across countries for the entire population of reproductive age.

For further information

Director, Population Division
Department of Economic and Social Affairs
United Nations
New York, NY 10017
United States of America
Facsimile: 1-212-963-2147
Internet: http://www.undp.org/popin/wdtrends/wdtrends.htm

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IV. Underweight Prevalence among Preschool Children

International goals

Countries ... should make every effort to eliminate the adverse effects of poverty on children and youth, including malnutrition and preventable diseases. (para. 6.8 of ICPD Programme of Action).

... by the year 2000, a reduction of severe and moderate malnutrition among children under 5 years of age by half of the 1990 level (para. 36(f) of WSSD Programme of Action).

... promote and ensure household and national food security, ... including a reduction worldwide of severe and moderate malnutrition among children under the age of 5 by one half of 1990 levels by the year 2000, giving special attention to the gender gap in nutrition (para. 106(w) of FWCW Platform for Action).

The World Health Organization's Global Strategy of Health for All by the Year 2000 established the following goal: at least 90 per cent of the children within a population should have a weight-for-age which corresponds to the reference values by the year 2000. The World Declaration and Plan of Action for Nutrition, adopted at the International Conference on Nutrition (Rome, 1992), the Declaration adopted at the World Summit for Children (1990), and WHO's Ninth General Programme of Work for 1996-2001 also include the goal of reducing severe and moderate malnutrition among children under 5 by half between 1990 and 2000.

Definition

Underweight prevalence among preschool children refers to the percentage of children under 5 years of age who have a weight that is more than two standard deviations below the median weight-for-age of the standard reference population of the United Sates National Center for Health Statistics (NCHS). The standard reference population is commonly referred to as the NCHS/WHO international reference population.

Recent situation

Malnutrition is usually the result of a combination of inadequate dietary intake and infection. Malnourished children are more likely to die as a result of common childhood diseases, to have lifetime disabilities and weakened immune systems, and to lack a full capacity for learning. UNICEF estimates that malnutrition contributes to more than half of the nearly 12 million under-5 deaths in developing countries each year (UNICEF, 1997).

Percentage *underweight*, or low weight-for-age, is the most widely cited of three interrelated indicators commonly used to assess the nutritional status of young children. Low height-for-age, which is termed *stunting*, reflects chronic undernutrition, while low weight-for-height, or *wasting*, reflects acute nutritional problems. The percentage underweight is a composite of the latter two aspects of undernutrition; a child with low weight-for-age may be either short or thin.

National data on underweight prevalence are available for 116 countries. As shown in figure IV.1 and table IV.1, around 30 per cent of countries have underweight prevalence of less than 10 per cent, whereas one fourth have rates of 30 per cent and higher. Two thirds of the countries in Latin America and the Caribbean have low underweight prevalence (less than 10 per cent) as do the few countries in more developed regions with available data. Comparing regional data, Asia and Oceania have the highest prevalence rates with almost 40 per cent of the countries in that region falling in the highest prevalence category. About one third of the African countries have a prevalence rate of 30 per cent or higher and 40 per cent have a rate of between 20 and 29 per cent. In none of the least developed countries is the prevalence rate below 10 per cent.

Underweight among children is one area where the worst cases of deprivation are seen in Asia and Oceania rather than in Africa (fig. IV.2). UNICEF (1997) has explored several causal factors of child malnutrition, which include poverty, disease and inadequate dietary intake, discrimination and violence against women, and a lack of access to good education. Although it is clear that the high prevalence rates among populous countries such as Bangladesh, India and Pakistan contribute to the poorer performance of the Asian and Oceanic region, it remains unclear which causal factors are most responsible for the high prevalence in those countries.

In terms of population, about one third of the under-5 population in less developed regions is estimated to be underweight (fig. IV.3).

Figure IV.1. Underweight prevalence among preschool children, 1990-1998

Sources: World Health Organization, *WHO Global Database on Child Growth and Malnutrition* (Geneva, 1997) and updates from the database; UNICEF, *The State of the World's Children, 2000* (New York, Oxford University Press, 2000).

NOTE: Estimates are not presented for countries or areas with populations under 150,000. Countries from the more developed regions are assumed to have underweight prevalence among children of less than 10 per cent.

Table IV.1. Distribution of countries according to underweight prevalence among preschool children, 1990-1998

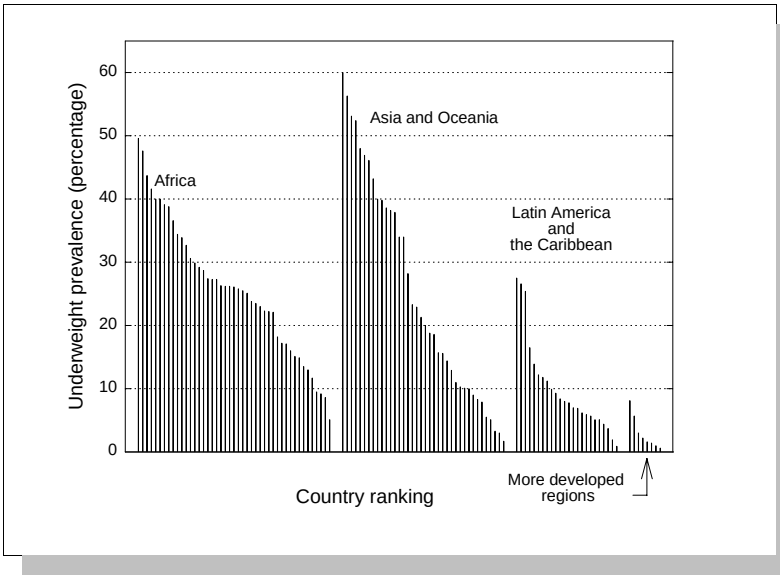
	Percentage of countries with underweight prevalence of:					Number of countries	
	Less than 10 per cent	10-19 per cent	20-29 per cent	30 per cent or more	Total	With data available	Total
World	30	22	22	25	100	116	184
More developed regions	100	0	0	0	100	9	43
Less developed regions	24	24	24	27	100	107	141
Least developed countries	0	8	36	56	100	39	45
Africa	7	22	40	31	100	45	53
Asia and Oceania[a]	21	26	13	39	100	38	57
Latin America and the Caribbean	63	25	13	0	100	24	31

Sources: World Health Organization, *WHO Global Database on Child Growth and Malnutrition* (Geneva, 1997) and updates from the database; UNICEF, *The State of the World's Children, 2000* (New York, Oxford University Press, 2000).

NOTE: Excludes countries and areas with populations under 150,000. Includes 7 countries with data earlier than 1990. Due to rounding, the sum of the subcategories may not be equal to 100 per cent.

[a] Excluding Japan, Australia and New Zealand, which are included in the more developed regions.

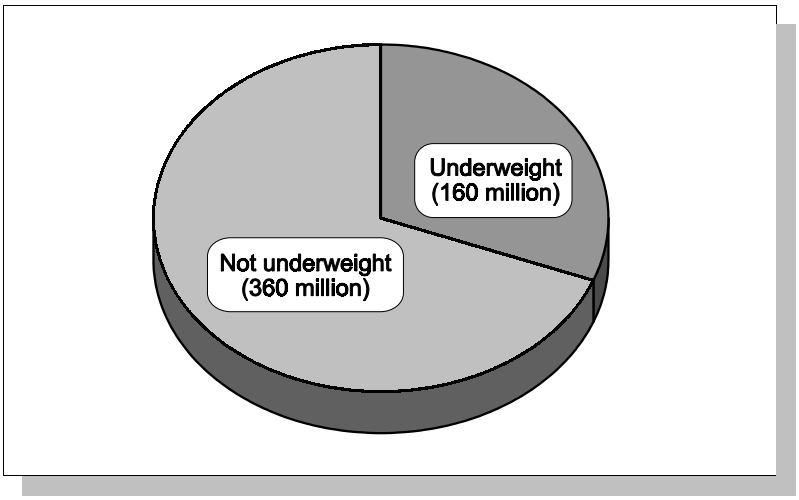
Figure IV.2. Underweight prevalence among preschool children, 1990-1998, by country ranking and region



Sources: World Health Organization, *WHO Global Database on Child Growth and Malnutrition* (Geneva, 1997) and updates from the database; UNICEF, *The State of the World's Children, 2000* (New York, Oxford University Press, 2000).

NOTE: Bars show level of underweight prevalence for individual countries. Includes 7 countries with data earlier than 1990.

Figure IV.3. Distribution of population under-5 in the less developed regions, by underweight prevalence, 1990-1998



Sources: World Health Organization, *WHO Global Database on Child Growth and Malnutrition* (Geneva, 1997) and updates from the database; UNICEF, *The State of the World's Children, 2000* (New York, Oxford University Press, 2000).

NOTE: For countries with data on underweight prevalence, representing 97 per cent of the under-5 population of the less developed regions.

SOURCES OF DATA, COVERAGE AND QUALITY

Most of the representative national data on children's nutritional status are derived from sample surveys, which are often carried out in collaboration with one of several international survey programmes, including the Demographic and Health Surveys (DHS), funded by USAID; the UNICEF-supported Multiple Indicator Cluster Surveys (MICS); the PAPCHILD Surveys sponsored by the Pan-Arab League and UNFPA; and the World Bank-sponsored LSMS and SDA surveys in sub-Saharan Africa. These special data collection efforts are largely responsible for the availability of recent data for a large number of developing countries. Recent data are available for 116 countries (63 per cent of the countries included in the present report, representing about 90 per cent of the under-5 population). About 70 per cent of the observations pertain to 1995 or later; only 6 per cent are for dates earlier than 1990. In most of the more developed countries, data on children's nutritional status have not been presented with reference to the NCHS/WHO standard and/or have not been compiled at the national level. Thus, comparable data are available only for a few countries. Data availability is best for Africa with a country coverage of 85 per cent. Data are available for 67 per cent of countries in Asia and Oceania and for 77 per cent of those in Latin America and the Caribbean.

In order to calculate this indicator, a national or international reference population may be used. A WHO working group has recommended that the best available data for the reference population have been established by NCHS. This standard may be used for children up to 5 years of age, since the influence of ethnic or genetic factors on height and weight of young children is considered insignificant.

The age ranges of children covered by the statistics vary by country. For example, although most often the data are for children aged under 5 years, for some countries the figures are for children 3 or 4 years of age and younger. In some countries, the age of children is difficult to determine precisely. In addition, a few of the surveys included here did not cover all regions of the country. However, such differences in geographic and age coverage are not likely to affect seriously the comparability of the statistics presented here.

Data are compiled by the WHO and UNICEF, and published in the *WHO Global Database on Child Growth and Malnutrition* and *The State of the World's Children.*

FOR FURTHER INFORMATION

Director
Division of Evaluation, Policy and Planning
United Nations Children's Fund
633 Third Avenue
New York, NY 10016
United States of America
Facsimile: 1-212-824-6497/6491/6490
Internet: http://www.unicef.org/statis/

Department of Nutrition for Health and Development
World Health Organization
CH-1211 Geneva 27
Switzerland
Facsimile: (41-22) 7914158
Internet: http://www.who.int/nutgrowthdb

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V. Maternal Mortality

International goals

Countries should strive to effect significant reductions in maternal mortality by the year 2015: a reduction in maternal mortality by one half of the 1990 levels by the year 2000 and a further one half by 2015 .... Countries with intermediate levels of mortality should aim to achieve by the year 2005 a maternal mortality rate below 100 per 100,000 live births and by the year 2015 a maternal mortality rate below 60 per 100,000 live births. Countries with the highest levels of mortality should aim to achieve by 2005 a maternal mortality rate below 125 per 100,000 live births and by 2015 a maternal mortality rate below 75 per 100,000 live births (para. 8.21 of ICPD Programme of Action).

By the year 2000, a reduction in maternal mortality by one half of the 1990 level; by the year 2015, a further reduction by one half (para. 36(d) of WSSD Programme of Action).

... reduce ill health and maternal morbidity and achieve world wide the agreed-upon goal of reducing maternal mortality by at least 50 per cent of the 1990 levels by the year 2000 and a further one half by the year 2015 ... (para. 106(i) of FWCW Platform for Action).

The same goal of reducing the maternal mortality ratio by half between 1990 and 2000 has been established by several conferences, including the Nairobi Safe Motherhood Conference (1987) and the World Summit for Children (1990), and by WHO's Ninth General Programme of Work (1996 -2001).

Definition

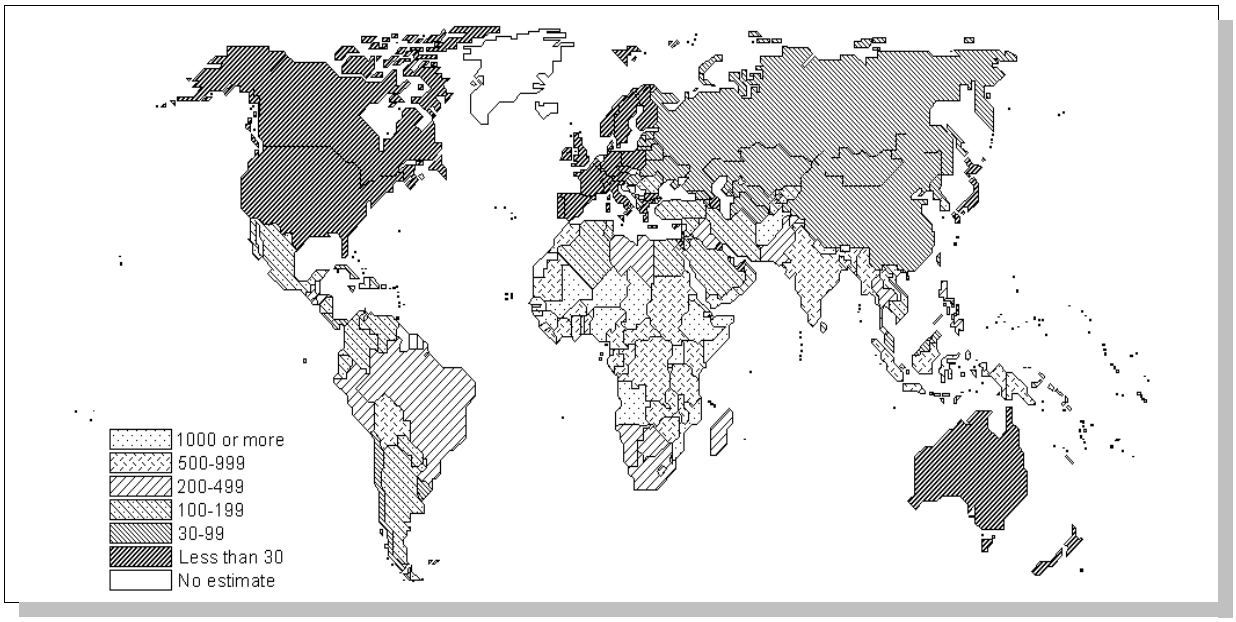
A maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. The maternal mortality ratio is the number of maternal deaths over a year per 100,000 live births in that year.

Recent situation

Maternal mortality shows a wide disparity among countries, with ratios under 10 deaths per 100,000 births in some cases and substantially exceeding 1,000 in others. The range of values is greater, in proportional terms, than for any of the other health and development indicators included in this report.

As of 1990, one fifth of the countries had maternal mortality ratios estimated at less than 30 maternal deaths per 100,000 births (table V.1). By region, about 70 per cent of the countries in the more developed regions fall in this category, whereas only 6 per cent in the less

Figure V.1. Maternal mortality ratio, 1990



Source: WHO/UNICEF, *Revised 1990 Estimates of Maternal Mortality: A New Approach* (Geneva, WHO, 1996).
NOTE: Estimates are not presented for countries or areas with populations under 150,000.

Table V.1. Distribution of countries according to estimated maternal mortality ratio, 1990

	Percentage of countries with a maternal mortality ratio of:							Number of countries	
	Less than 30	30-99	100-199	200-499	500-999	1,000 or more	Total	With estimates available	Total
World	20	18	17	10	21	13	100	157	184
More developed regions	71	26	3	0	0	0	100	35	43
Less developed regions	6	16	20	13	27	17	100	122	141
Least developed countries	0	2	0	5	48	45	100	42	45
Africa	0	0	8	10	50	32	100	50	53
Asia and Oceania[a]	15	27	23	13	15	8	100	48	57
Latin America and the Caribbean	0	29	42	21	4	4	100	24	31

Source: WHO/UNICEF, *Revised 1990 Estimates of Maternal Mortality: A New Approach* (Geneva, WHO, 1996).
NOTE: Excludes countries and areas with population under 150,000. Due to rounding, the sum of the subcategories may not be equal to 100 per cent.
[a] Excluding Japan, Australia and New Zealand, which are included in the more developed regions.

developed regions do so. None of the lest developed countries belongs to this category. Nearly half of the least developed countries have maternal mortality ratios in the highest category, more than 1,000, and nearly half have ratios between 500 and 999.

Those countries from the less developed regions with maternal mortality of less than 30 are all in Asia and Oceania. In the case of Africa, no country has a ratio less than 100, and more than four fifths of the African countries have a maternal mortality ratio of 500 or more. In Eastern and Western Africa, maternal mortality is particularly high (figs. V.1 and V.2). The majority of African countries will need to make significant progress to achieve the year 2005 goal for countries with the highest levels of mortality—namely, below 125.

In contrast to Asia and Oceania, where countries are spread across the entire range of levels of maternal mortality, the range of values is more limited in Latin America and the Caribbean. The majority of Latin American and the Caribbean countries have mortality ratios less than 200.

Figure V.3 shows the percentage shares of 15-to-49-year-old women living in countries with different levels of maternal mortality. Nearly half of the women of reproductive age live in countries with a maternal mortality ratio less than 100. Yet, about 25 per cent of women live in countries with maternal mortality ratios between 500 and 999, and another 5 per cent, in countries with maternal mortality ratios 1,000 and above.

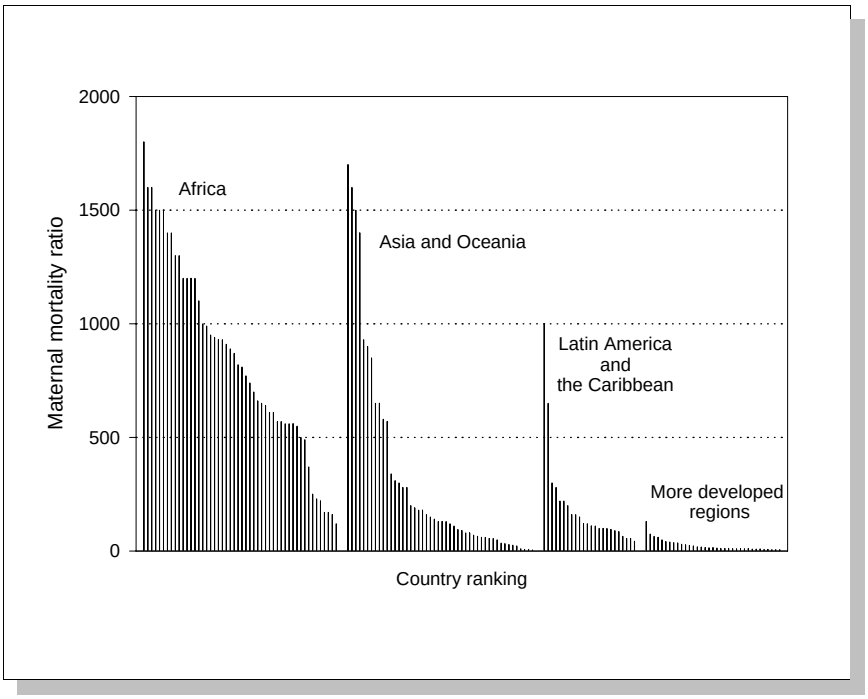
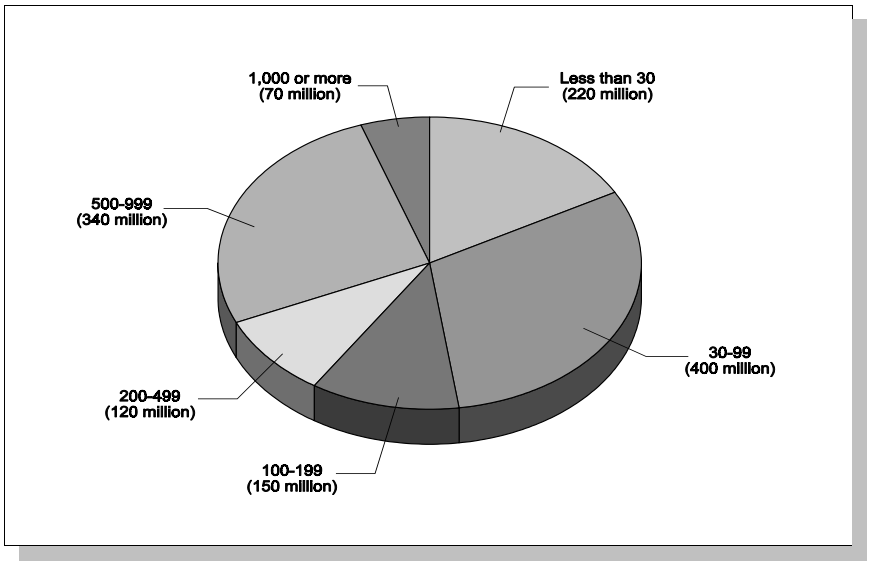


Figure V.2. Maternal mortality ratio, 1990, by country ranking and region

Source: WHO/UNICEF, *Revised 1990 Estimates of Maternal Mortality: A New Approach* (Geneva, WHO, 1996).

NOTE: Bars show level of maternal mortality ratio for individual countries.

Figure V.3. Distribution of female population of reproductive age, by maternal mortality ratio, 1990



Source: WHO/UNICEF, *Revised 1990 Estimates of Maternal Mortality: A New Approach* (Geneva, WHO, 1996).

NOTE: For countries with data, representing 99 per cent of women of reproductive age.

SOURCES OF DATA, COVERAGE AND QUALITY

The maternal mortality ratios shown here were estimated by the World Health Organization and United Nations Children's Fund. The estimates are for 1990 and available for 157 countries. They are published in *Revised 1990 Estimates of Maternal Mortality: A New Approach* (WHO/UNICEF, 1996).

The direct computation of the Maternal Mortality Ratio (MMR) requires a well-developed registration system of births and deaths, as well as causes of death. Yet few countries have complete counts of births and deaths; even fewer register the cause of death, and fewer still systematically note pregnancy status on the death form. Where vital registration systems are absent or inadequate, it is possible to estimate maternal mortality using techniques such as reproductive-age mortality surveys (RAMOS). Household surveys using direct estimation have a number of disadvantages, including cost, since sample sizes need to be very large. The results inevitably have wide margins of error. Some indirect survey techniques (sisterhood methods) are more efficient in terms of sample size but do not produce a current estimate and have large margins of error. In general, countries with high maternal mortality have neither adequate systems of vital registration nor the resources to rely on surveys. Because of the absence of data for some 80 countries of the world and the lack of comparability of figures from different sources, WHO and UNICEF have used a combination of adjustment factors and modelling techniques to develop estimates for all countries for 1990. The development of these 1990 estimates of maternal mortality has been followed by increased efforts on the part of the countries to measure maternal mortality. In order to take these new data into account, work is now under way to develop a new set of global, regional and national estimates.

WHO and UNICEF note that their estimates of MMR are primarily intended to be used in countries with no estimates of maternal mortality or where there is concern about the adequacy of officially reported estimates. The intention is to draw attention to the existence and likely dimensions of the problem of maternal mortality. The estimates should be taken as indicating orders of magnitude rather than precise estimates and may be used to monitor changes over the decade rather than to monitor trends on a year-to-year basis, since the standard errors associated with the estimated MMR are very large.

In estimating MMR, WHO and UNICEF made the following adjustments:

(a) For developed countries with complete vital registration systems and relatively good attribution of cause of death: MMR is the reported number, adjusted by a factor of 1.5 to account for the problem of misclassification of maternal death;

(*b*) For developing countries with good health registration but poor or non-existent attribution of cause of death: a model was used to predict the proportion of deaths of women of reproductive age which are maternal. The proportion was then applied to the deaths of women of reproductive age actually registered;

(c) For countries with RAMOS type of estimates of maternal mortality: the MMR derived from the RAMOS study was used directly, without any adjustments;

(*d*) For countries with sisterhood estimates of maternal mortality: the reported proportion of all deaths of women of reproductive age which are maternal was applied to the total number of deaths of women of reproductive age taken from the United Nations Population Division's population estimates and projections for the year 1990;

(*e*) For countries with no estimates of maternal mortality: a model was used to predict the proportion maternal of all deaths of women of reproductive age. The proportion was then applied to the adult female deaths generated by the United Nations Population Division's population estimates and projections.

FOR FURTHER INFORMATION

Director, Division of Reproductive Health
World Health Organization
CH-1211 Geneva 27
Switzerland
Facsimile: 41-22-791-4158

Director
United Nations Children's Fund
633 Third Avenue
New York, N.Y. 10016
United States of America
Facsimile: 1-212-824-7758
Internet: http://www.unicef.org/statis/

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VI. Infant and Under-5 Mortality

International goals

Countries should strive to reduce their infant and under-5 mortality rates by one third, or to 50 and 70 per 1,000 live births, respectively, whichever is less, by the year 2000 .... By 2005, countries with intermediate mortality levels should aim to achieve an infant mortality rate below 50 deaths per 1,000 and an under-5 mortality rate below 60 deaths per 1,000 births. By 2015, all countries should aim to achieve an infant mortality rate below 35 per 1,000 live births and an under-5 mortality rate below 45 per 1,000 (para. 8.16 of ICPD Programme of Action; also para. 36(c) of WSSD Programme of Action and para.106(l) of FWCW Platform for Action).

The Programme of Action adopted at the 1990 World Summit for Children set the same target of reducing the infant mortality and the under-five mortality rates by one third, or to 50 and 70 per 1,000 live births, respectively, whichever is less, by the year 2000 (appendix I(a)). The goal was also adopted by the WHO's Ninth General Programme of Work (1996-2001).

The Vienna Declaration and Programme of Action, adopted at the 1993 World Conference on Human Rights, includes a clause on reducing infant mortality rates (chap. II, para. 47).

Definition

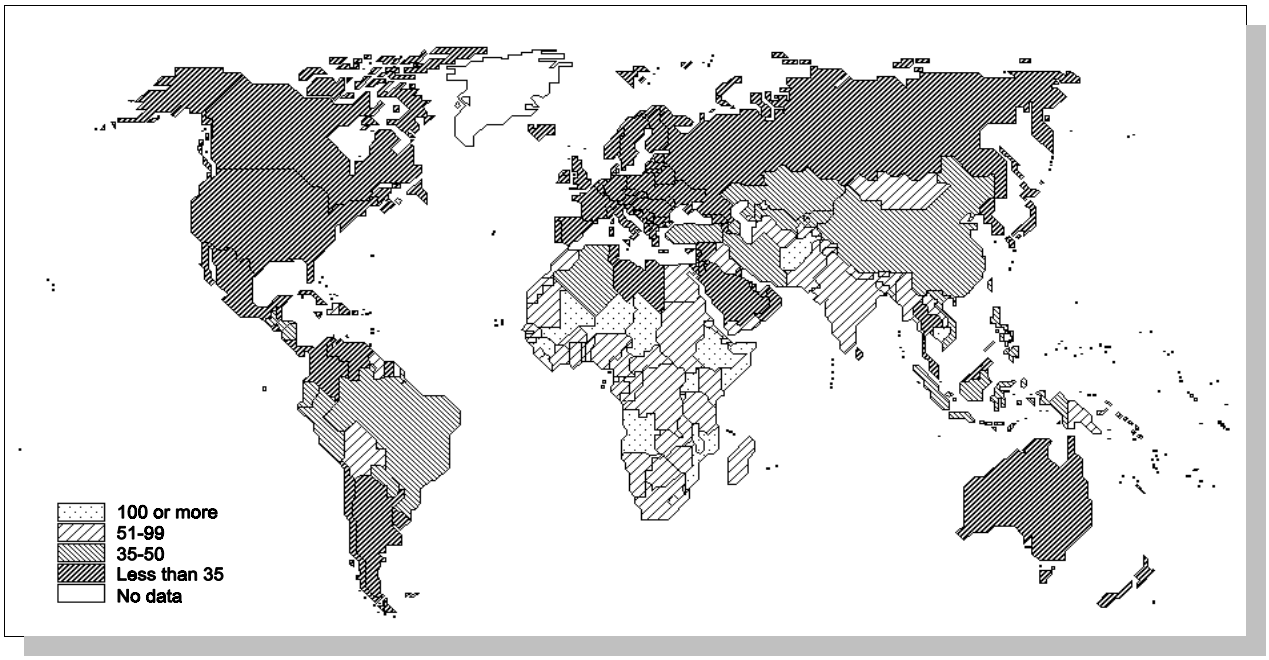
Infant mortality refers to the probability of dying before age 1 per 1,000 newborns. Under-5 mortality means the probability of dying before age 5 per 1,000 newborns.

Recent situation

The promotion of child survival and health has long been an important aim of the wide range of policies adopted to improve the overall health status of a population. Important advances have been made in making accessible the means to combat the most common diseases of childhood, and an increasing number of children are routinely immunized against diseases that in the past were major killers or causes of lifetime disability, such as measles and polio. Low-cost interventions have made major inroads in reducing suffering and death from diarrhoeal diseases. Nevertheless, many countries still experience unacceptably high levels of infant and child mortality (fig. VI.1 and VI.2). There are large interregional disparities as well.

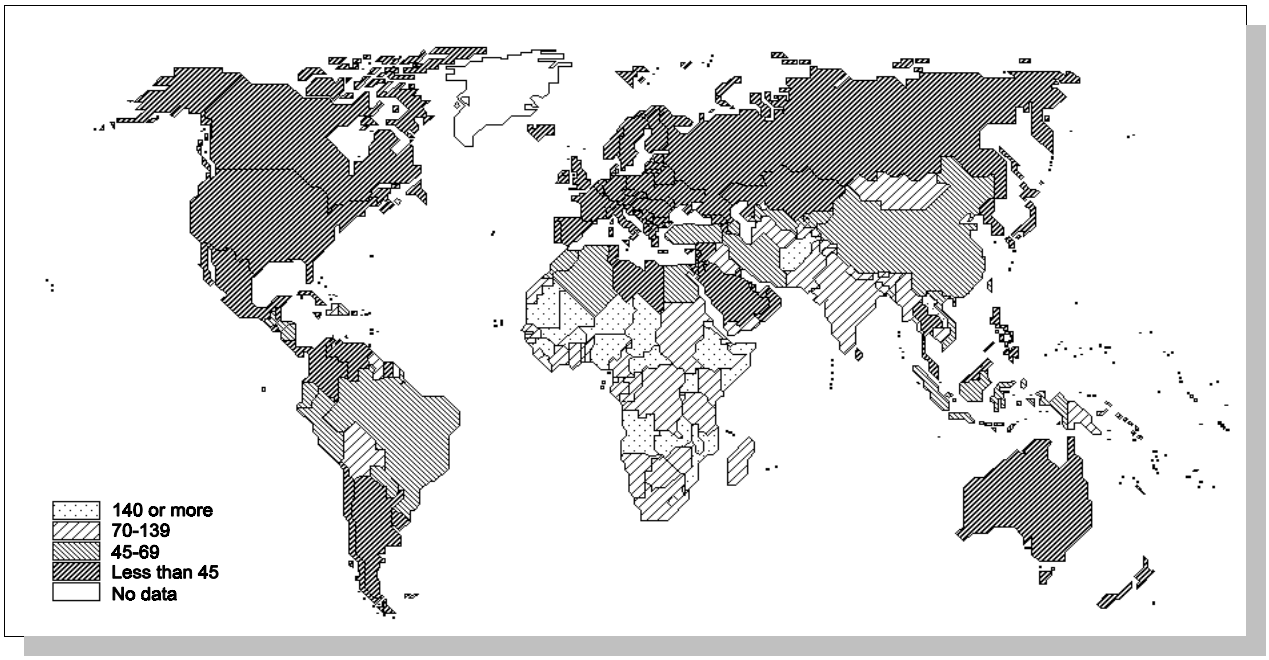
At the global level, slightly over half of the countries are estimated to have infant and child mortality rates lower than the goals set for the year 2015—below 35 and 45, respectively (tables VI.1 and VI.2). However, this is the result of very disparate levels experienced by the more developed regions, on the one hand, and the less developed regions, on the other. All countries from the more developed regions have infant and under-5 mortality rates below 35 and 45. In contrast, only about 40 per cent of the countries from the less developed regions have infant and under-5 mortality rates below the goals for 2015. Among the least developed countries, only two (4 per cent) have infant and under-5 mortality rates below the goals for 2015.

Figure VI.1. Infant mortality rate, 1995-2000



Source: World Population Prospects: The 1998 Revision, Volume I: Comprehensive Tables (United Nations publication, Sales No. E.99.XIII.9).
NOTE: Estimates are not presented for countries or areas with populations under 150,000.

Figure VI.2. Under-5 mortality rate, 1995-2000



Source: World Population Prospects: The 1998 Revision, Volume I: Comprehensive Tables (United Nations publication, Sales No. E.99.XIII.9).
NOTE: Estimates are not presented for countries or areas with populations under 150,000.

Table VI.1. Distribution of countries according to infant mortality rate, 1995-2000

	Percentage of countries with infant mortality rate of:					Number of countries
	Less than 35	35-49	50-99	100 or more	Total	
World	53	10	26	11	100	184
More developed regions	100	0	0	0	100	43
Less developed regions	38	13	33	15	100	141
Least developed countries	4	2	49	44	100	45
Africa	8	2	57	34	100	53
Asia and Oceania[a]	51	19	25	5	100	57
Latin America and the Caribbean	68	23	10	0	100	31

Source: *World Population Prospects: The 1998 Revision, Volume I: Comprehensive Tables* (United Nations publication, Sales No. E.99.XIII.9).
NOTE: Excludes countries and areas with populations under 150,000. Due to rounding, the sum of the subcategories may not be equal to 100 per cent.

[a] Excluding Japan, Australia and New Zealand, which are included in the more developed regions.

Table VI.2. Distribution of countries according to under-5 mortality rate, 1995-2000

	Percentage of countries with under-5 mortality rate of:					Number of countries
	Less than 45	45-69	70-139	140 or more	Total	
World	53	12	20	15	100	184
More developed regions	100	0	0	0	100	43
Less developed regions	39	16	26	19	100	141
Least developed countries	4	7	33	56	100	45
Africa	8	8	40	45	100	53
Asia and Oceania[a]	54	18	23	5	100	57
Latin America and the Caribbean	65	26	10	0	100	31

Source: *World Population Prospects: The 1998 Revision, Volume I: Comprehensive Tables* (United Nations publication, Sales No. E.99.XIII.9).
NOTE: Excludes countries and areas with populations under 150,000. Due to rounding, the sum of the subcategories may not be equal to 100 per cent.

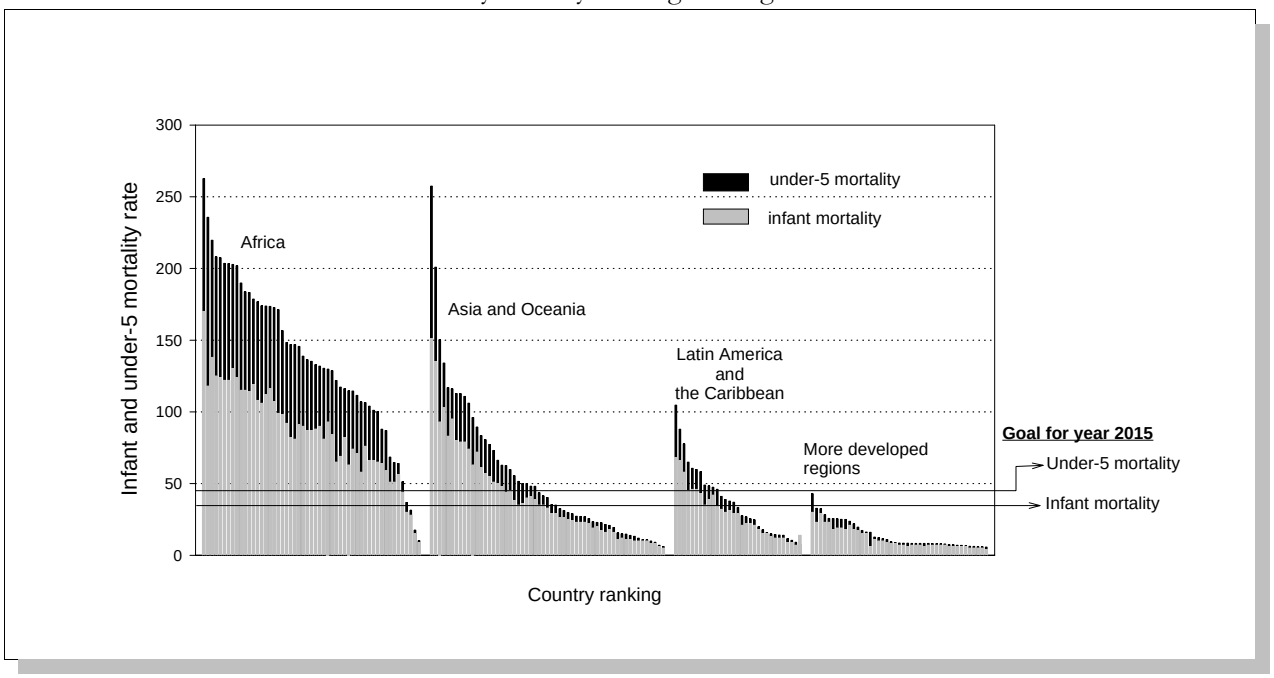
[a] Excluding Japan, Australia and New Zealand, which are included in the more developed regions.

In order to reach the goals set for the year 2000—50 for the infant mortality rate and 70 for the under-5 mortality rate—nearly half of the countries in the less developed regions still need to reduce both mortality rates. A large majority of the least developed countries have infant and child mortality rates above the goals, with many remaining far above the goals.

There are large regional differences among major less developed areas. Latin American and Caribbean countries tend to have the lowest mortality—nearly 70 per cent of the countries in the region have already surpassed the year 2015 goals for both infant and under-5 mortality. In Africa, only four out of 53 countries (8 per cent) have attained the goals for 2015. In reference to the more immediate goal of reducing the infant mortality rate to 50 and under-5 mortality rate to 70 by the year 2000, about 90 per cent of the African countries still fall short, whereas only 10 per cent of the Latin American and Caribbean countries do so. Within Africa, it is particularly Eastern Africa, Western Africa and Middle Africa which have high infant and under-5 mortality rates (figs. VI.1 and VI.2).

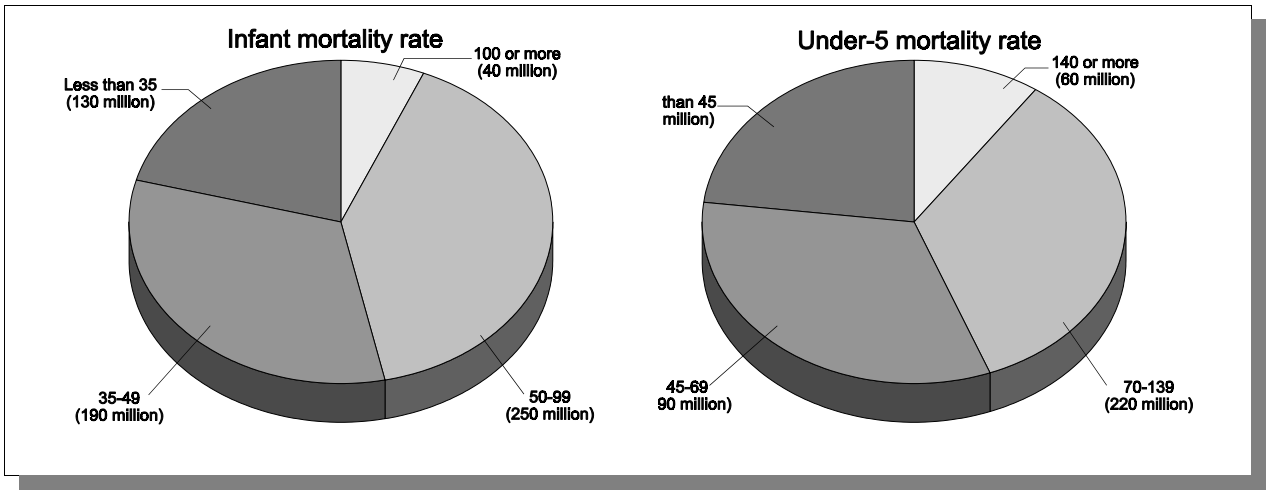
Under-5 mortality is more sensitive than infant mortality as an indicator of the underlying social, environmental and behavioural factors that determine mortality in childhood (United Nations, 2000). Regional differences for child mortality are indeed larger than for infant mortality. Figure VI.3 shows that most African countries not only have high mortality but that differences between the infant mortality rate and the under-5 mortality rate are much larger in African countries than in other regions.

Figure VI.3. Infant and under-5 mortality rates, 1995-2000, by country ranking and region



Source: *World Population Prospects: The 1998 Revision, Volume I: Comprehensive Tables* (United Nations publication, Sales No. E.99.XIII.9).
NOTE: Bars show level of infant and under-5 mortality rates for individual countries.

Figure VI.4. Distribution of child population by infant and under-5 mortality rates, 1995-2000



Source: *World Population Prospects: The 1998 Revision, Volume I: Comprehensive Tables* (United Nations publication, Sales No. E.99.XII.9).

At the global level, about one fifth of the child population lives in countries with low mortality—below the goals for the year 2015 (fig. VI.4). However, nearly half of the child population is in countries with infant and under-5 mortality rates still higher than the goals for the year 2000—50 and 70, respectively. About 10 per cent of young children live in countries where under-5 mortality rates remain extremely high.

SOURCES OF DATA, COVERAGE AND QUALITY

Estimates of infant and child mortality rates are calculated and biennially updated by the Population Division of the United Nations Secretariat, within the framework of the official United Nations world population estimates and projections prepared by the Population Division.

Original data sources include vital registration, sample registration systems, surveillance systems, censuses and demographic surveys. For all countries, available data are evaluated and, if necessary, adjusted for incompleteness by the Population Division.

In many less developed countries, routine data collection in the health services omits many infant or child deaths. However, adjustments can sometimes be made for incomplete registration and age misstatement, and in many developing countries maternity-history data gathered in nationally representative sample surveys provide a sound basis for estimating levels and trends of infant and child mortality. Where direct estimates are unavailable or require adjustment, infant and child mortality rates can be estimated through indirect or modeling methods based on special questions asked in censuses or demographic surveys. Sample surveys have been more successful at obtaining estimates of infant and child mortality than of adult mortality, and because of this, information about levels and trends of mortality of young children is currently substantially more complete and more timely than is information about the mortality of adults.

The Population Division updates and publishes estimates of infant and child mortality rates within its *World Population Prospects* series. The most recent publication is *World Population Prospects: the 1998 Revision* (United Nations, 1999). Data on infant and child mortality are available for all countries and areas of the world with populations of 150,000 persons or more. Estimates of infant mortality are presented for 5-year periods from 1950-1995. Projected infant and child mortality rates are also given through 2050.

FOR FURTHER INFORMATION

Director
Population Division
Department of Economic and Social Affairs
United Nations, New York, NY 10017
United States of America
Facsimile: 1-212-963-2147
Internet: http://www.undp.org/popin/wdtrends/wdtrends.htm

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VII. Life Expectancy at Birth

International goals

Countries should aim to achieve by 2005 a life expectancy at birth greater than 70 years and by 2015 a life expectancy at birth greater than 75 years. In addition, countries with the highest levels of mortality should aim to achieve by 2005 a life expectancy at birth greater than 65 years and by 2015 a life expectancy at birth greater than 70 years (ICPD Programme of Action, para. 8.5).

... By the year 2000, a life expectancy of not less than 60 years in any country (WSSD Programme of Action, para.3(b)).

The Declaration of Alma Ata endorsed the goal of health for all by the year 2000. The global strategy of Health for All by the Year 2000, adopted by the WHO World Health Assembly in 1980, aims to achieve a level of health for all peoples in all countries which would permit them to work productively and participate actively in the social life of their community.

Definition

Life expectancy at birth is defined as the average number of years that a newborn could expect to live if he or she were to pass through life subject to the age-specific mortality rates of a given period.

Recent situation

The past half century of improvement in life expectancy at birth, both for developing and developed countries, has been a remarkable demographic and social achievement. Life expectancy at birth is 65 years (63 years for males and 68 for females). Average life expectancy at birth has increased by nearly 20 years since 1950, with every region of the world benefiting. However, as recently exhibited by a number of countries, mortality declines are not irreversible. In parts of Eastern Europe and the former USSR, adult mortality, particularly for men, rose during the 1980s and early 1990s. New infectious diseases, including HIV/AIDS, have emerged while others have re-emerged and quickly spread in a mobile world. Civil strife continues to cost lives in all regions.

As of 1995-2000, slightly over 70 per cent of all countries have achieved the year-2000 goal of a life expectancy at birth of 60 years or more (table VII.1). In fact, 45 per cent have already attained the year-2005 goal of 70 years, and about one fifth have achieved the year-2015 goal of 75 years. Of the nearly 30 per cent of all countries that have not yet reached the goal for the year 2000, most are African.

Figure VII.1. Life expectancy at birth, 1995-2000 (both sexes)

Source: *World Population Prospects: The 1998 Revision, Volume I: Comprehensive Tables* (United Nations publication, Sales No. E.99.XIII.9).
NOTE: Estimates are not presented for countries or areas with populations under 150,000.

All countries in the more developed regions have achieved the life expectancy goal of 60 years by year 2000, and over half have achieved the 2015 goal. Yet, one fifth of the countries (8 countries) have still to reach the goal for 2005, and about one quarter (11 countries), the goal for 2015. These countries are concentrated in Eastern Europe, including Russia. In sharp contrast to the more developed regions, nearly two fifths of the countries in less developed regions have not achieved the 2000 goal. A large majority of the least developed countries have not achieved the 2000 goal, and only 2 countries (4 per cent) have reached the 2005 goal. Four fifths of African countries and over one tenth of the developing Asian and Oceanic countries have not achieved the 2000 goals; however, nearly all countries in Latin America and the Caribbean have. Only one African country has achieved the goal for 2015. About one fifth of Latin American and Caribbean countries and about one tenth of Asian and Oceanic countries have already reached the 2015 goal.

Figure VII.2 shows life expectancy for individual countries by country ranking and region. The distribution for the more developed regions is more rectangular, indicating smaller intraregional disparities. Differences in life expectancy at birth among countries within Africa are larger than in the other regions.

Nearly two thirds of the world population live in countries where life expectancy at birth is between 60 and 70 years (fig. VII.3). About 15 per cent of the population (800 million people) live in countries where life expectancy at birth is less than 60 years, and a similar percentage live in countries where life expectancy at birth is more than 75 years.

Table VII.1. Distribution of countries according to life expectancy at birth, 1995-2000

	Percentage of countries with life expectancy at birth of:					
	More than 75 years	70-75 years	60-70 years	Less than 60 years	Total	Number of countries
World	21	24	27	28	100	184
More developed regions	56	26	19	0	100	43
Less developed regions	10	24	30	36	100	141
Least developed countries	0	4	11	84	100	45
Africa	2	2	17	79	100	53
Asia and Oceania[a]	12	33	40	14	100	57
Latin America and the Caribbean	19	45	32	3	100	31

Source: *World Population Prospects: The 1998 Revision, Volume I: Comprehensive Tables* (United Nations publication, Sales No. E.99.XII.9).

NOTE: Excludes countries and areas with populations under 150,000. Due to rounding, the sum of the subcategories may not be equal to 100 per cent.

[a] Excluding Japan, Australia and New Zealand, which are included in the more developed regions.

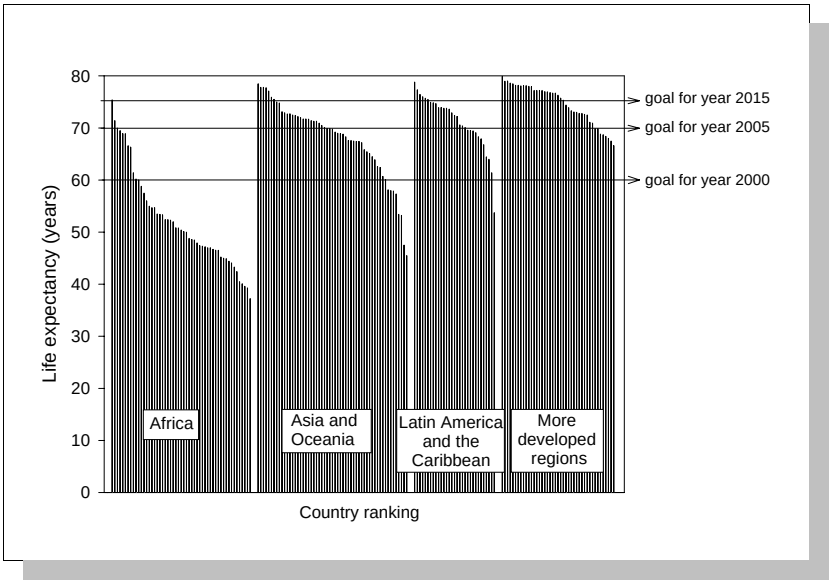
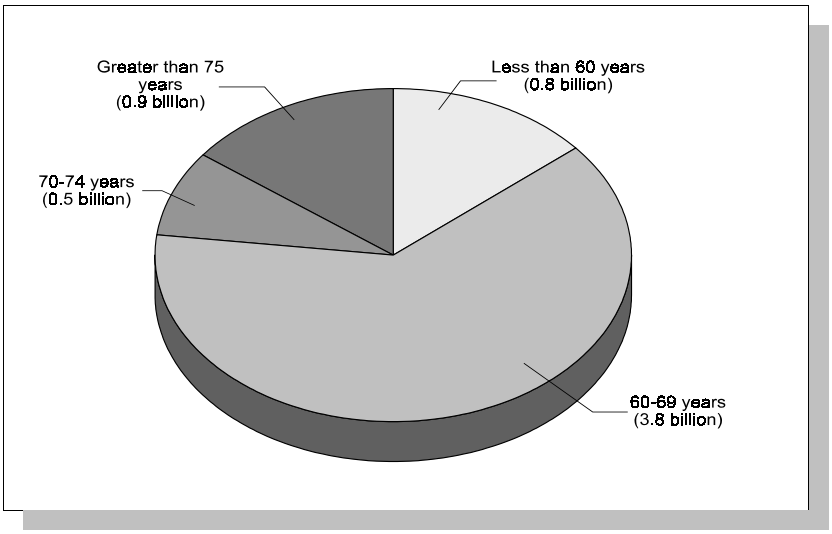


Figure VII.2. Life expectancy at birth, 1995-2000, by country ranking and region

Source: World Population Prospects: The 1998 Revision, Volume I: Comprehensive Tables (United Nations publication, Sales No. E.99.XIII.9).

NOTE: Bars show level of life expectancy at birth for individual countries.

Figure VII.3. Distribution of world population by life expectancy at birth, 1995-2000



Source: World Population Prospects: The 1998 Revision, Volume I: Comprehensive Tables (United Nations publication, Sales No. E.99.XIII.9).

SOURCES OF DATA, COVERAGE AND QUALITY

Estimates of life expectancy at birth are calculated and biennially updated by the Population Division of the United Nations Secretariat, within the framework of the official United Nations world population estimates and projections prepared by the Population Division.

Original data sources include vital registration, sample registration systems, surveillance systems, censuses and demographic surveys. Such information is compiled by the United Nations on a regular basis from national sources and publications and from special country questionnaires sent to national statistical offices by the Statistics Division of the United Nations Secretariat.

For all countries, available data are evaluated and, if necessary, adjusted for incompleteness by the Population Division. Where data on deaths by age are of good quality or where adjustments for age misstatement and incompleteness can be made, the life expectancy at birth can be calculated directly from registered deaths and population counts, which are usually based on census enumerations. When data on deaths by age are unavailable from registration systems or sample surveys, life expectancies at birth are derived through indirect methods based on special questions asked in censuses or demographic surveys and the use of model life-tables.

Life expectancy at birth is based on age-specific mortality rates for a given year or period of years. Rates are commonly available and tabulated for ages under 1 year, 1-4 years and for 5-year age intervals thereafter, up to a final category, such as 80 years and above (depending on the country). Some data sources yield estimates for only some age groups, so that it may be necessary to employ separate adjustments to data from different sources in order to arrive at a complete and consistent set of rates for a given period of time (also see the discussion of the infant and child mortality rates above, chap. VI).

The Population Division updates and publishes estimates of national life expectancy at birth, by sex, in its *World Population Prospects* series. The most recent publication is *World Population Prospects: The 1998 Revision* (United Nations, 1999). Data on life expectancy at birth are available for all countries and areas of the world with populations of 150,000 persons or more. Estimates are presented for 5-year periods from 1950-1955 through 1990-1995. Projected life expectancies are also given through 2050.

FOR FURTHER INFORMATION

Director
Population Division
Department of Economic and Social Affairs
United Nations
New York, NY 10017
United States of America
Facsimile: 1-212-963-2147

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VIII. Gross Enrolment for Primary and Secondary School Combined

International goals

All countries should further strive to ensure the complete access to primary school or an equivalent level of education by both girls and boys as quickly as possible, and in any case before the year 2015 .... Countries that have achieved the goal of universal primary education are urged to extend education and training to, and facilitate access to and completion of education at secondary school and higher levels (para. 11.6 of ICPD Programme of Action).

... By the year 2000, universal access to basic education and completion of primary education by at least 80 per cent of primary school-age children; closing the gender gap in primary and secondary school education by the year 2005; universal primary education in all countries before the year 2015 (para. 36(a) of WSSD Programme of Action, and (similarly stated in) para. 80(b) of FWCW Platform for Action).

The World Declaration on Education for All, adopted at the World Conference on Education for All, set a goal of universal access to primary education by the year 2000 (para. 8) and includes paragraphs emphasizing gender equality in access to education (e.g., article 3.3).

The World Declaration and Plan of Action on the Survival, Protection and Development of Children, adopted at the World Summit for Children, has a paragraph on universal access to primary education, with special emphasis on girls (appendix II(iv)).

Agenda 21, adopted at the United Nations Conference on Environment and Development, includes several paragraphs on primary and secondary education (e.g., paras.25.5, 25.14(d) and 36.4).

The Habitat Agenda refers to universal access to education and gender equality in education (paras. 32, 36, 45(l) and 119(h)).

Definition

The gross enrolment ratio for primary and secondary school combined refers to the total enrolment, regardless of age, in primary and secondary education per 100 persons of the population of primary- and secondary-school age, according to national regulations.

Recent situation

Education is now clearly recognized as one of the key components of policies aimed at solving issues of international concern. Without educational policies, policies aimed at alleviating poverty, reducing infant mortality and improving public health, protecting the

environment, strengthening human rights, improving international understanding, and seeking to gain or regain competitiveness in advanced technology are essentially incomplete (UNESCO, 1990).

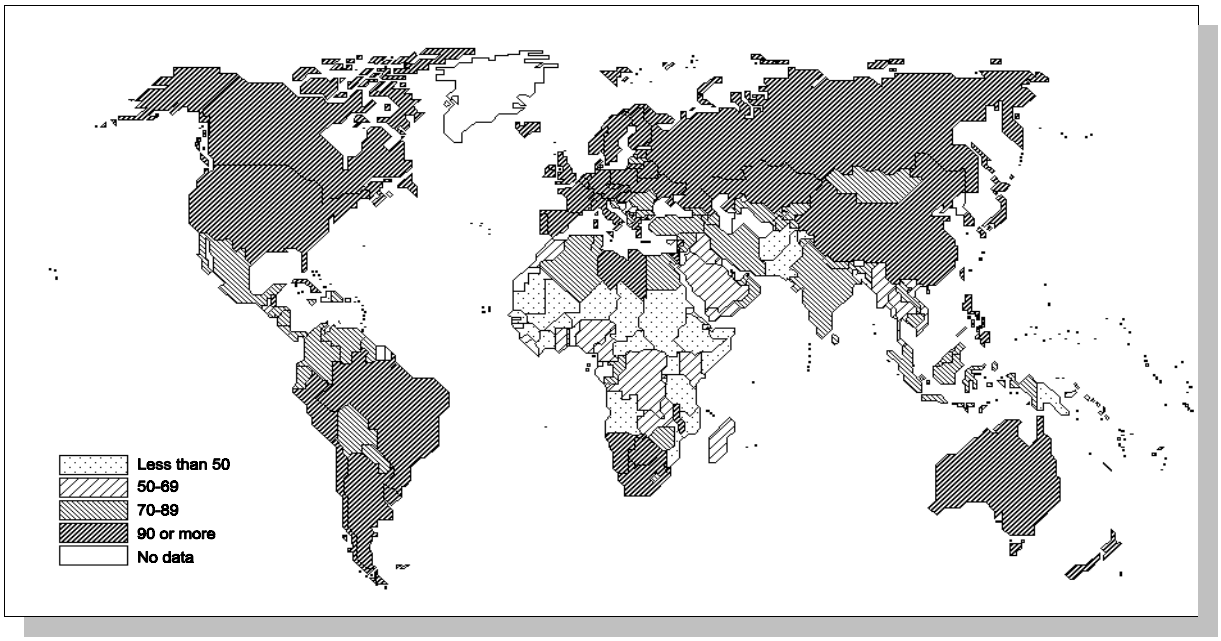
While progress has been made towards the goal of education for all over the past few decades, wide disparities remain.

Of the 164 countries with data available, about one third (59 countries) have an enrolment ratio of 90 or more, approaching the conference goal of universal access to education, and another third have an enrolment ratio in the 70-89 range (table VIII.1 and figs. VIII.1 and VIII.2). On the other hand, nearly one fifth of the countries (28 countries) still have enrolment ratios of less than 50. Most of those countries are in Eastern, Western and Middle Africa.

In the more developed regions, 80 per cent of the countries are found in the highest category and nearly one fifth in the second highest (70-89). Only one country, Yugoslavia, falls in the category of enrolment ratios of 50-69, and none is in the lowest group. In the less developed regions, the largest group (40 per cent) have enrolment ratios of 70-89. One fifth of the countries are in the highest category (90 or more) and nearly one quarter are in the lowest category (less than 50).

There are striking differences in enrolment between Africa and the other two less developed regions in table VIII.1. Nearly half of African countries have enrolment ratios below 50, while in the other regions under 10 per cent of countries have such low ratios (including Haiti in Latin America and the Caribbean and Afghanistan, Bangladesh, Pakistan and Papua New Guinea in Asia and Oceania). The highest enrolment ratios are found in Latin America

Figure VIII.1. Gross enrolment ratio for primary and secondary school combined, 1990-1996 (both sexes)



Source: UNESCO Statistical Yearbook1999 (Paris, UNESCO Publishing and Bernan Press, 1999).
NOTE: Estimates are not presented for countries or areas with populations under 150,000.

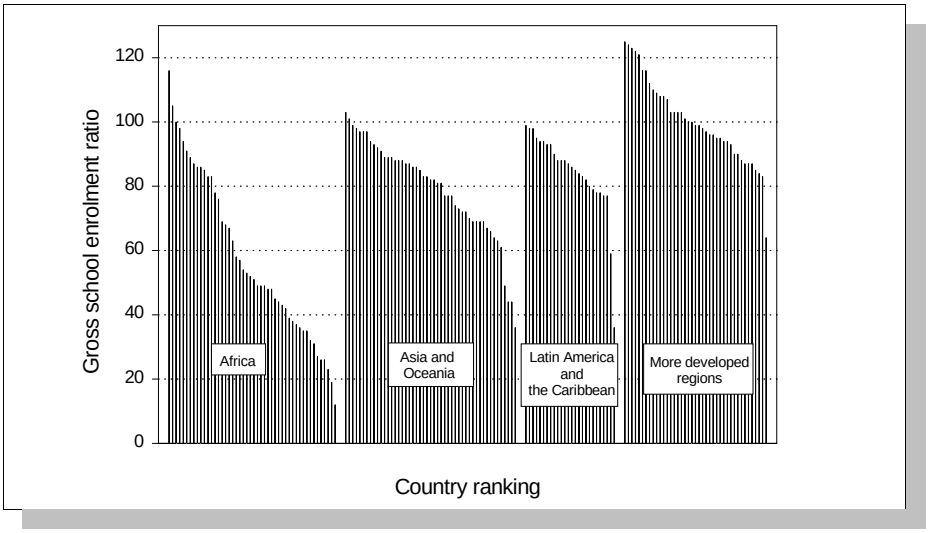


Figure VIII.2. School enrolment ratio, 1990-1996, by country ranking and region

Source:. *UNESCO Statistical Yearbook 1999* (Paris, UNESCO Publishing and Bernan Press, 1999).

NOTE: Bars show level of gross enrolment ratio for individual countries. Includes 5 countries with data earlier than 1990.

Table VIII.1. Distribution of countries according to gross enrolment ratio for primary and secondary school combined, 1990-1996

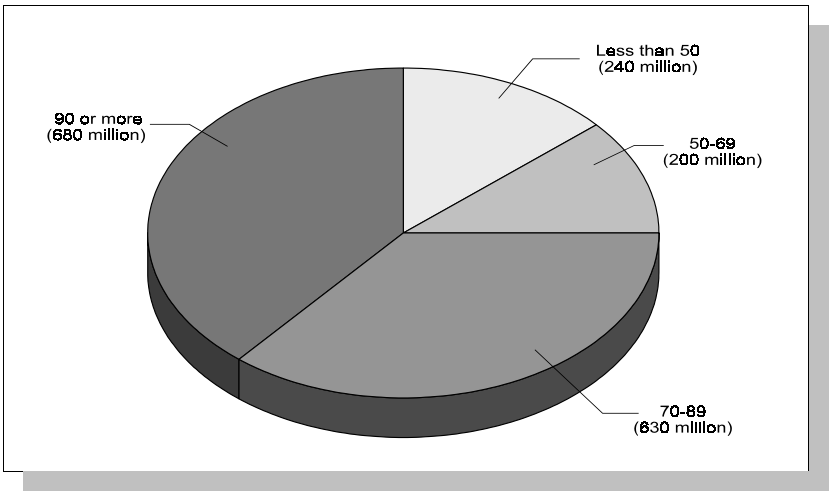
	Percentage of countries with gross enrolment ratio of:					Number of countries	
	90 or more	70-89	50-69	Less than 50	Total	With data available	Total
World	36	34	13	17	100	164	184
More developed regions	80	17	2	0	100	41	43
Less developed regions	21	40	16	23	100	123	141
Least developed countries	2	19	21	57	100	42	45
Africa	13	19	21	48	100	48	53
Asia and Oceania[a]	22	51	18	8	100	49	57
Latin America and the Caribbean	35	58	4	4	100	26	31

Source: UNESCO Statistical Yearbook 1999 (Paris, UNESCO Publishing and Bernan Press, 1999).

NOTE: Excludes countries and areas with populations under 150,000. Includes 5 countries with data earlier than 1990. Due to rounding, the sum of the subcategories may not be equal to 100 per cent.

[a] Excluding Japan, Australia and New Zealand, which are included in the more developed regions.

Figure VIII.3. Distribution of under-15 population by school enrolment ratio, 1990-1996 (both sexes)



Source: UNESCO Statistical Yearbook 1999 (Paris, UNESCO Publishing and Bernan Press, 1999).

NOTE: For countries with enrolment data, representing 99 per cent of the under-15 population. Includes 5 countries with data earlier than 1990.

and the Caribbean, where one third of the countries have ratios of 90 or more. In Asia and Oceania, about one fifth of countries have enrolment ratios that high. Most of the least developed countries have enrolment ratios under 50, and only one country (Malawi) has a ratio of 90 or more.

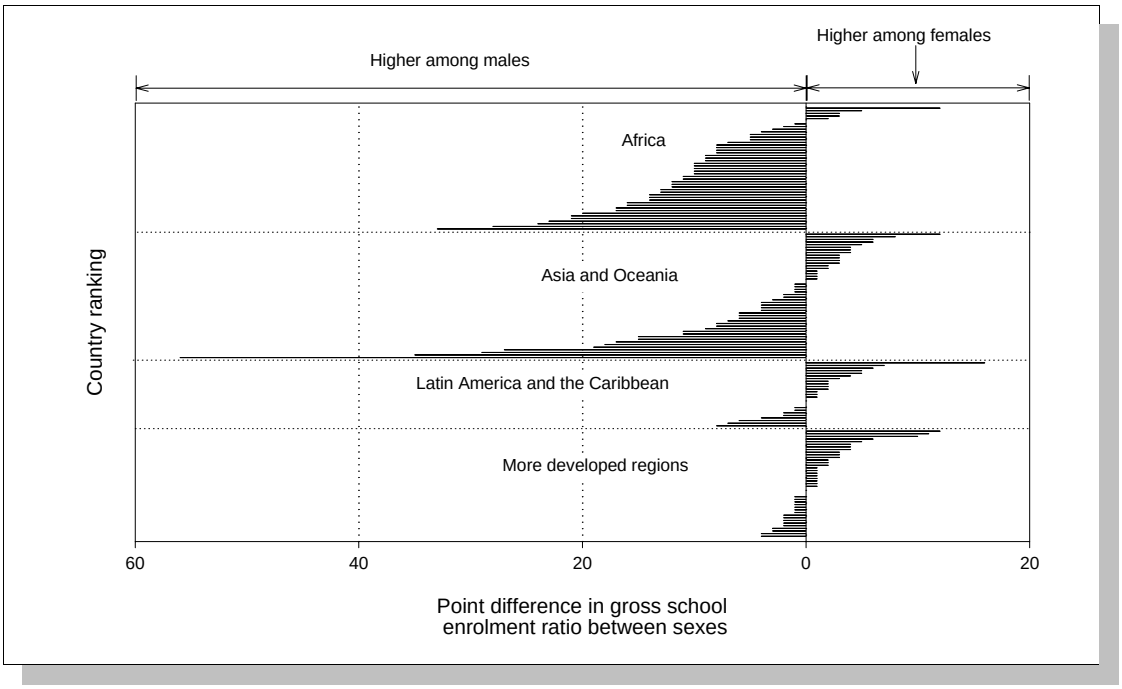
Nearly 40 per cent of world population under age 15 live in countries with enrolment ratios of 90 or more, and a roughly equal number live in countries with enrolment ratios of 70-89 (fig. VIII.3). However, around 240 million children (13 per cent) live in countries with enrolment ratios under 50, indicating very limited access to education.

Table VIII.2 and figure VIII.4 show gender gaps in school enrolment ratios. In most countries, boys have higher enrolment ratios than girls, and the differences are substantial in many countries, particularly where levels of enrolment are low overall.

At the global level, in more than one third of countries, school enrolment ratios are higher for boys than for girls by 5 points or more. In about half of the countries, gender gaps are within 5 points. The differences between the more developed regions and the less developed regions appear significant. In the more developed regions, the large majority of countries (88 per cent) have gender gaps of less than 5 points, whereas in the less developed regions nearly half of the countries have substantially higher enrolment ratios for boys than for girls. The gender gap is particularly large in the countries classified as the least developed. Within the latter group are the countries with the largest gender differences of all, in Yemen (56 points), Nepal (35 points) and Togo (33 points).

Over three quarters of the African countries have enrolment ratios for boys exceeding those for girls by more than 5 points, as do over one third of the countries in Asia and Oceania. At the same time, half the Asian and Oceanic countries have small gender gaps in enrolment (i.e., within 5 points). In Latin America and the Caribbean, the gender gap in school enrolment is much more limited than in the other less developed regions. In one fifth of the countries enrolment ratios for girls are higher than for boys by 5 or more points. In other less developed regions, substantial gender gaps favouring girls are less common.

Figure VIII.4. Sex difference in school enrolment ratio, 1990-1996, by country ranking and region



Source: UNESCO Statistical Yearbook 1999 (Paris, UNESCO Publishing and Bernan Press, 1999).

Table VIII.2. Distribution of countries according to difference in school enrolment ratio between sexes, 1990-1996

	Percentage of countries with enrolment ratio of:				Number of countries	
	Male higher than female: 5 points or more	Difference less than 5 points	Female higher than male: 5 points or more	Total	With data available	Total
World	36	54	10	100	162	184
More developed regions	0	88	12	100	41	43
Less developed regions	48	42	10	100	121	14
Least developed countries	83	15	3	100	41	45
Africa	79	17	4	100	47	53
Asia and Oceania	37	53	10	100	49	57
Latin America and the Caribbean	12	68	20	100	25	31

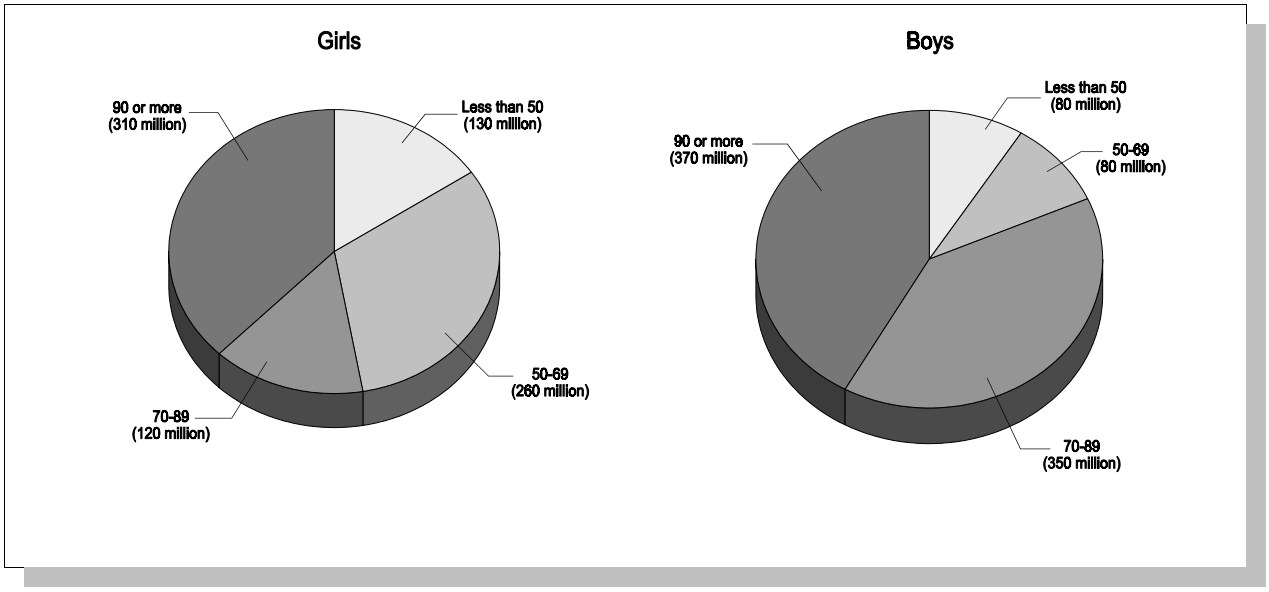
Source: UNESCO Statistical Yearbook 1999 (Paris, UNESCO Publishing and Bernan Press, 1999).
NOTE: Excludes countries and areas with populations under 150,000. Includes 5 countries with data earlier than 1990.
Due to rounding, the sum of the subcategories may not be equal to 100 per cent.
[a] Excluding Japan, Australia and New Zealand, which are included in the more developed regions.

Over 80 per cent of boys under age 15 live in countries with male enrolment ratios of at least 70, and around 40 per cent in countries with ratios of 90 or more (fig. VIII.5). About 10 per cent live in countries with male enrolment ratios below 50. Thus, the large majority of boys live in settings where it is usual for boys to attend school, even if attendance cannot be taken for granted. By contrast, only about half of girls live in countries with female enrolment ratios of 70 or more. The percentage of girls living in countries with near-universal female enrolment is only a few points lower than the corresponding percentage for boys, but many fewer girls are found in settings with enrolment ratios of 70-89. Around one third of girls live in countries with enrolment ratios for girls of 50-69, and around 15 per cent in countries with ratios of under 50.

SOURCES OF DATA, COVERAGE AND QUALITY

International statistics on school enrolment are compiled by UNESCO and published in its *Statistical Yearbook* series and on the Internet. Data are available for 162 countries by sex and for 164 countries for both sexes combined, or approximately 90 per cent of the countries included in the present report. This wide country coverage is one of the advantages of using the gross enrolment ratio, as compared with the net enrolment ratio, which includes in its numerator only those students of primary- and secondary-school age. The data pertain to the latest available year between 1990 and 1996, depending on the country; several exceptions are noted in the annex. Since the school year, in a number of countries, does not coincide with the academic year, the year is the one in which the school or academic year starts.

Figure VIII.5. Distribution of under-15 girls and boys by school enrolment ratio, 1990-1996



Source: UNESCO Statistical Yearbook 1999 (Paris, UNESCO Publishing and Bernan Press, 1999).

Data on total enrolment are normally available for most countries on an annual basis, collected through national school censuses. The data included here were gathered mainly from official replies to UNESCO questionnaires and surveys but also from official reports and publications, supplemented by information available to the United Nations from other national and international sources.

The ratios have been calculated taking into account the different national systems of education and the duration of schooling at the first and second levels. The age groups used to calculate enrolment ratios for the primary and secondary levels have been determined by UNESCO according to the following rules:

(*a*) For countries that have a single school system at each level, the age group is defined in conformity with the normal entrance age and normal duration of general schooling at the first and second levels;

(*b*) In the case of countries with several systems of different duration, the system followed by the majority of the pupils is used;

(*c*) The durations used are those that are operative in the year considered.

The age group for the combined ratio for the first and the second levels is defined by taking the range covering the two age groups defined for the first and second levels. Although school-age ranges vary by country, they are typically 6-11 years for primary school and 12-17 years for secondary school.

Enrolment ratios for the second level are based on the total enrolment, including general education, teacher-training and technical and vocational education.

It should be noted that the gross enrolment ratios at the first and the second levels include all pupils, whatever their ages, whereas the population is limited to the range of official school ages. Therefore, for some countries, the gross enrolment ratio can exceed 100. In many less developed regions, the official entry age may not be adhered to by large sectors of the population because of lack of funds. Furthermore, in the majority of countries, secondary education is disaggregated into two stages, with the first stage coinciding with compulsory education and the second stage including technical and vocational training. This indicator may not capture the qualitative changes taking place in secondary education in many countries, particularly with respect to vocational education and second-chance programmes.

FOR FURTHER INFORMATION

Director
UNESCO Institute for Statistics
United Nations Educational, Scientific and Cultural Organization
7, place de Fontenoy
75352 Paris 07-SP
France
Telephone: 33-1-45-68-55-20
Internet: http://unescostat.unesco.org

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IX. Adult Illiteracy

International goals

[The goals include] reducing the adult illiteracy rate ... to at least half its 1990 level, with an emphasis on female literacy ... (para. 36(k) of WSSD Programme of Action).

Eradicate illiteracy among women (Strategic objective B.2 of FWCW Platform for Action).

Eliminate the gender gap in basic and functional literacy, as recommended in the World Declaration on Education for All (para. 81(c) of FWCW Platform for Action).

The World Declaration on Education for All, adopted at the World Conference on Education for All, set the goal of reduction of the adult illiteracy rate to half of its 1990 level by the year 2000, with sufficient emphasis on female literacy to significantly reduce the current disparity between male and female illiteracy rates (para. 8). The year 1990 was International Literacy Year.

The World Summit for Children and the United Nations Conference on Environment and Development also endorsed the goal of reducing the adult illiteracy rate to half of its 1990 level.

Definition

Adult illiteracy refers to the proportion of the adult population who cannot, with understanding, both read and write a short simple statement on everyday life. Here, the literacy rate is expressed as a percentage of the population aged 15 years or above.

Recent situation

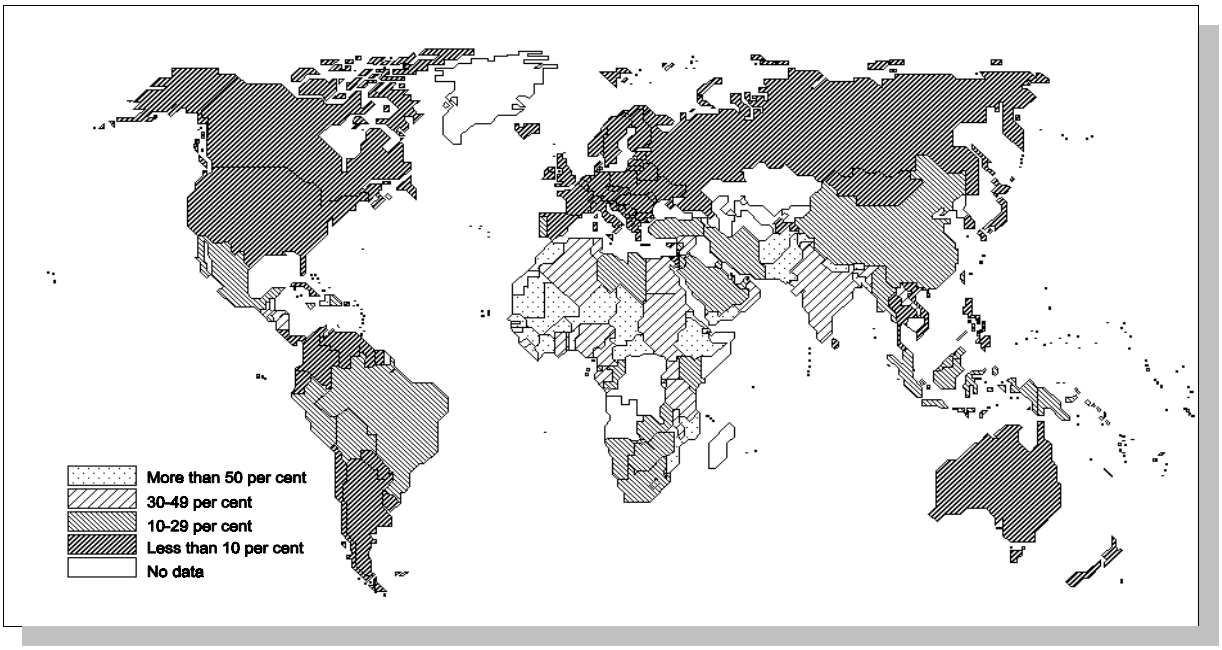
The adult illiteracy rate has been steadily declining in all countries, particularly during the past few decades. It is estimated that the overall illiteracy rate in the world had fallen to 23 per cent in 1995, and is projected to reach 21 per cent at the beginning of the twenty-first century. In addition, the absolute number of illiterate adults in the world reached its peak in the early 1990s and has begun to decline (UNESCO, 1999). Nevertheless, just as the school enrolment ratio shows that there are still a large number of young people who do not have access to education (see chap. VIII), the adult illiteracy rate demonstrates that even larger numbers of illiterate adults in the developing world today continue to be deprived of the educational advantages they were denied as children (UNESCO, 1990). Regional and gender disparities remain wide as well.

In the less developed regions, the majority of the adult population is illiterate in nearly one quarter of the countries, although a similar number of countries report that less than 10 per cent of their adult population is illiterate (table IX.1 and fig. IX.1 and IX.2). It should be particularly noted that more than half of the least developed countries report that the majority of their adults are illiterate. Considering the importance of literacy in individual well-being as well as in a country's social and economic development, low literacy levels among the least developed countries pose a serious challenge to those countries.

Among the major regions, illiteracy rates are relatively low in Latin America and the Caribbean, where Haiti is the only country with an adult illiteracy rate greater than 50 per cent. Six countries in Asia and Oceania (Afghanistan, Bangladesh, Bhutan, Nepal, Pakistan and Yemen) also have illiteracy rates higher than 50 per cent. The situation is far worse for Africa, where 40 per cent of countries with data available have illiteracy rates higher than 50 per cent. No country in Africa reports a rate lower than 10 per cent, but around 60 per cent of the countries in Latin America and the Caribbean do so. In Asia and Oceania, nearly 40 per cent of the countries have illiteracy rates between 10 and 30 per cent, and over one third have illiteracy rates of less than 10 per cent.

In less developed regions, there are still close to 900 million adults who are illiterate (fig. IX.3). About 2 billion are literate.

Figure IX.1. Adult illiteracy rate, 1995 (both sexes)



Source: Data furnished by UNESCO, providing results of the 1998 UNESCO literacy estimates and projections.

NOTE: Estimates are not presented for countries or areas with populations under 150,000. Countries from the more developed regions are assumed to have illiteracy rates below 10 per cent.

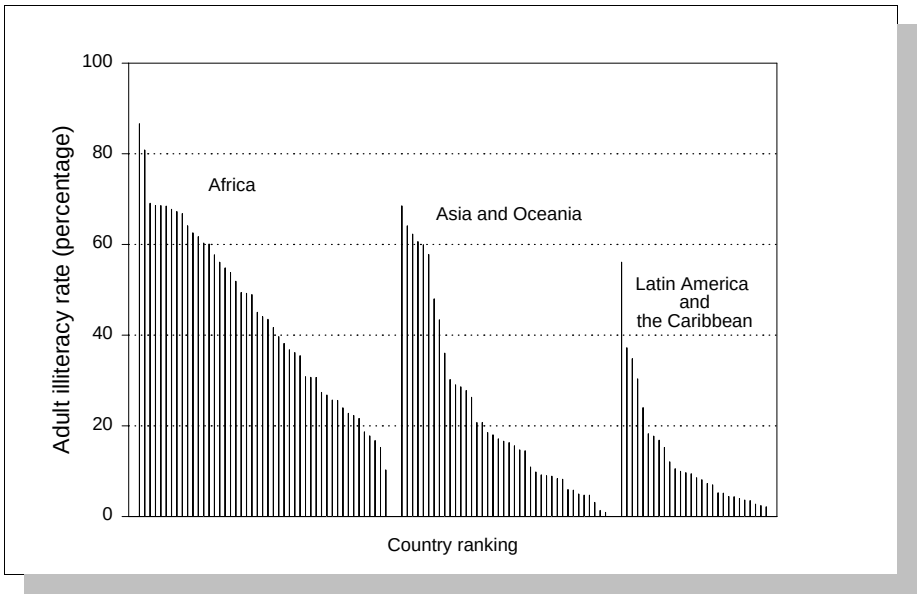


Figure IX.2. Adult illiteracy rate, 1995, by country ranking and region

Source: Data furnished by UNESCO, providing results of the 1998 UNESCO literacy estimates and projections.

NOTE: Bars show level of illiteracy rate for individual countries.

Table IX.1. Distribution of countries in the less developed regions according to adult illiteracy rate, 1995

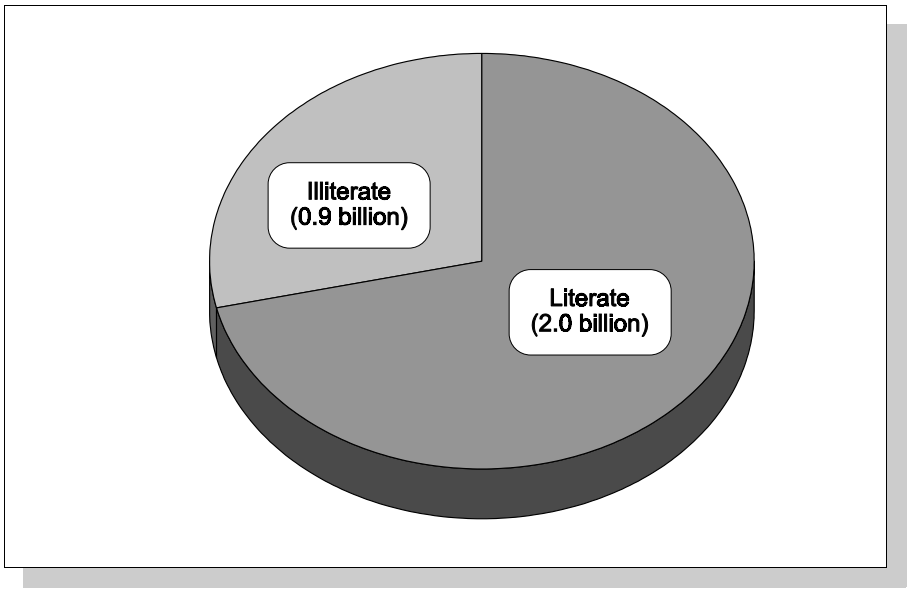
	Percentage of countries with adult illiteracy rate of:					Number of countries	
	Less than 10 per cent	10-29 per cent	30-49 per cent	50 per cent or more	Total	With data available	Total
Less developed regions	27	31	19	23	100	114	141
Least developed countries	3	11	25	61	100	36	45
Africa	0	28	32	40	100	47	53
Asia and Oceania [a]	36	38	10	15	100	39	57
Latin America and the Caribbean	61	25	11	4	100	28	31

Source: Data furnished by UNESCO, providing results of the 1998 UNESCO literacy estimates and projections.

NOTE: Excludes countries and areas with populations under 150,000. Due to rounding, the sum of the subcategories may not be equal to 100 per cent.

[a] Excluding Japan, Australia and New Zealand, which are included in the more developed regions.

Figure IX.3. Distribution of adult population in the less developed regions, by adult illiteracy rate, 1995



Source: *UNESCO Statistical Yearbook 1999* (Paris, UNESCO Publishing and Bernan Press, 1999).

Table IX.2. Distribution of countries in the less developed regions according to percentage point difference in adult illiteracy between sexes, 1995

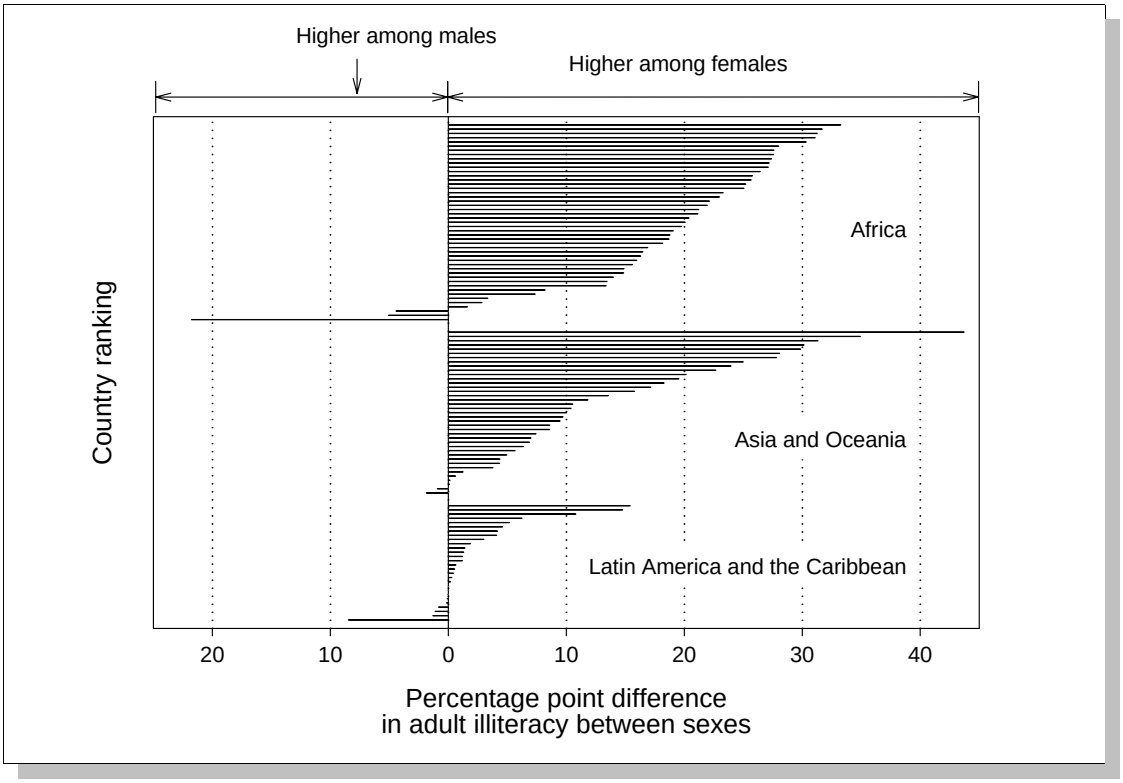
	Percentage of countries with adult illiteracy rate of:					Number of countries	
	Female higher than male: 20 points or more	Female higher than male: 5-19 points	Difference less than 5 points	Male higher than female: 5 points or more	Total	With data available	Total
Less developed regions	32	34	30	4	100	114	141
Least developed countries	64	31	3	3	100	36	45
Africa	53	34	6	6	100	47	53
Asia and Oceania [a]	31	44	26	0	100	39	57
Latin America and the Caribbean	0	21	75	4	100	28	31

Source: Data furnished by UNESCO, providing results of the 1998 UNESCO literacy estimates and projections

NOTE: Excludes countries and areas with populations under 150,000.

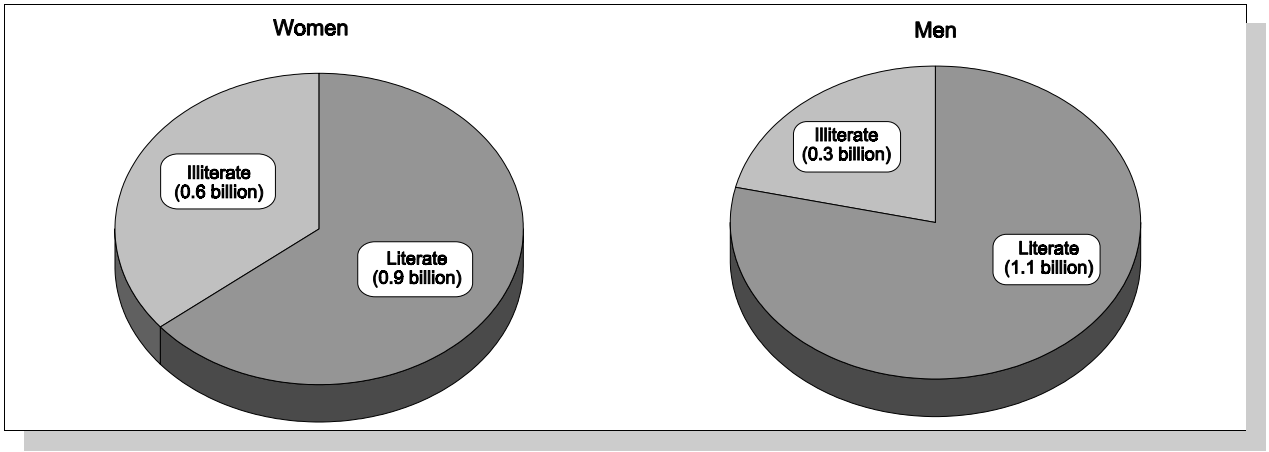
[a] Excluding Japan, Australia and New Zealand, which are included in the more developed regions.

Figure IX.4. Sex difference in adult illiteracy rate, 1995, by country ranking and region



Source: Data furnished by UNESCO, providing results of the 1998 UNESCO literacy estimates and projections.
NOTE: Bars show point difference in adult illiteracy rate between sexes for individual countries.

Figure IX.5. Distribution of the female and male adult populations in the less developed regions, by literacy status, 1995



Source: *UNESCO Statistical Yearbook 1999* (Paris, UNESCO Publishing and Bernan Press, 1999).

Comparing male and female illiteracy rates (table IX.2 and fig. IX.4), wide gaps are most common in Africa, where more than half of the countries have female illiteracy rates at least 20 points higher than male rates. However, in one country (Lesotho) the illiteracy rate for men exceeds that for women by over 20 points. In Asia and Oceania about one third of countries have gender differences in illiteracy rates of 20 points or more. In contrast, in Latin America and the Caribbean, no country has such a wide gender gap. Nearly all of the least developed countries have a substantial gap in illiteracy rates, and in two thirds of the least developed countries illiteracy is higher among women by 20 percentage points or more.

Compared with the school enrolment ratio, discussed in chapter VIII above, the adult illiteracy rate indicates a more serious gender gap in education, at least among the adult population. (Although the school enrolment ratio tends to be lower for girls than for boys, there are quite a few countries with enrolment ratios higher for girls than for boys.)

The majority of illiterates in the less developed regions are women (fig. IX.5). About 0.6 billion women living in those regions are illiterate, compared to about 0.3 billion men. The illiteracy rate among women is about 38 per cent, and that among men 21 per cent, or a percentage point gap of 17 points.

SOURCE OF DATA, COVERAGE AND QUALITY

The most recent estimates come from the 1998 UNESCO literacy estimates and projections (UNESCO, 1999). Data are available for 114 countries in the less developed regions (about four fifths of the countries). The limited data for countries in the more developed regions are included in the annex table. No recent data are available for most countries in the more developed regions because many developed countries, where high levels of literacy have been attained, no longer collect literacy statistics during national population censuses. UNESCO estimates that illiteracy averaged around 1 per cent in those countries in 1995.

Statistics on adult illiteracy are primarily collected during national population censuses and demographic surveys, including household surveys, labour-force surveys and literacy surveys, supplemented by additional data from national publications and reports as well as special ad hoc surveys.

Literacy ideally should be determined by the measurement of reading, writing and numeracy abilities of each person within a social context. It may however be too time-consuming, costly and operationally complex to organize such measurements during national population censuses. Literacy status is therefore usually based on self-declaration or declaration by the head of household, which sometimes gives rise to concerns about data reliability and consequently comparability, especially for women in many developing countries. According to UNESCO, most countries follow the standard definitions, while the criteria and practices used during actual data collection to determine whether a person is literate or not can vary from country to country.

According to UNESCO, the reliability of the literacy estimates and projections varies from country to country. Reliability is relatively high for the 78 countries that have provided the latest literacy statistics from the 1990 population census round. The use of statistics gathered during the 1980 round of population census has produced literacy estimates and projections of acceptable quality for 30 countries. These are supplemented by estimates of lesser quality obtained either through the use of literacy statistics collected prior to 1980 or by means of sample surveys or derived using a method based on data other than literacy rates.

For further information

Director
UNESCO Institute for Statistics
United Nations Educational, Scientific and Cultural Organization
7, place de Fontenoy
75352 Paris 07-SP
France
Facsimile: 33-1-45-68-55-20
Internet: http://unescostat.unesco.org

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X. Access to Safe Water

International goals

All countries should give priority to measures that improve the quality of life and health by ensuring a safe and sanitary living environment for all population groups through measures aimed at ..., ensuring access to clean water ... (para. 8.10 of ICPD Programme of Action).

... Providing ... access to safe drinking water in sufficient quantities ... for all (para. 36(l) of WSSD Programme of Action).

... Ensure the availability of and universal access to safe drinking water ... as soon as possible (para. 106(x) of FWCW Platform for Action).

... Promoting access for all people to safe drinking water ... and other basic services, facilities and amenities, especially for people living in poverty, women and those belonging to vulnerable and disadvantaged groups (para. 40(c) of the Habitat Agenda).

In addition to the conference goals above, international targets for this indicator have been established under the auspices of the World Health Organization. The Global Strategy of Health for All by the Year 2000 set a target of 100 per cent by the year 2000. The more recent Ninth General Programme of Work for 1996-2001 establishes a target of 85 per cent by the year 2001.

The International Drinking Water Supply and Sanitation Decade,1981-1990, was proclaimed by the General Assembly in 1980. It was also a component of the WHO Global Strategy of Health for All by the Year 2000.

The World Summit for Children and the United Nations Conference on Environment and Development also adopted goals on universal access to safe water.

Definition

Access to safe water is measured by the proportion of population with *access* to an *adequate amount* of *safe* drinking water located within a *convenient distance* from the user's dwelling. Under the WHO/UNICEF Joint Monitoring Programme, the words in italics were defined at the country level. "Access" is interpreted as actual use by the population.

Recent situation

The International Drinking Water Supply and Sanitation Decade (1981-1990) envisaged as its primary goal the attainment of full access to water supply and to sanitation by all inhabitants in the developing countries by the year 1990. Initiatives taken during the Decade succeeded in providing access for an additional 1 billion people to safe water supplies (WHO/UNICEF, 1990). The significant progress made during the 1980s is considered to be

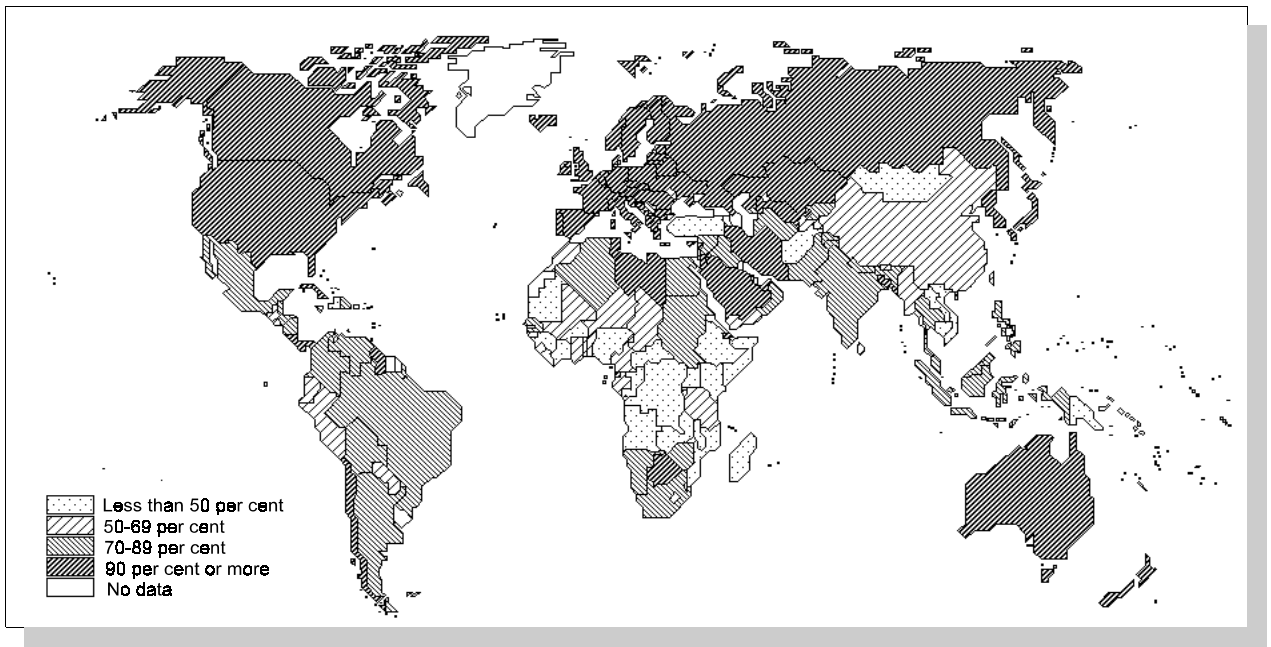
due to the rediscovery and improvement of various simple and low-cost water and sanitation technologies and the promotion of community participation. Yet, a large proportion of the world's population still live without access to safe water, on which health and productive capacity depend (see fig. X.1.)

Of 117 countries with data available in the less developed regions, the majority of the population lack access to safe water in 25 per cent (table X.1 and fig. X.2). A similar percentage of countries have achieved or are close to achieving the goal of universal access. The situation in the least developed countries is much more serious. In half of the least developed countries, the majority of population live without access to safe water.

In contrast to the other less developed regions, in Latin America and the Caribbean only one country (Haiti) has access below 50 per cent and around three quarters of the countries have access of 70 per cent or more. In around 40 per cent of the African countries, however, the majority of the population lacks access to safe water. In Asia and Oceania less than one fifth of the countries have such limited access.

Figure X.3 shows the percentage share of population with and without access to safe water. The base population includes only those in the less developed regions and with data available. About 30 per cent of the population in the countries included do not have access to safe water, which amounts to about 1.3 billion people. The other 70 per cent—3.2 billion people—are estimated to have access to safe water.

Figure X.1. Percentage of population with access to safe water, 1990-1998



Source: UNICEF, *The State of the World's Children, 2000* (New York, Oxford University Press, 2000).

NOTE: Estimates are not presented for countries or areas with populations under 150,000. Countries in the more developed regions are assumed to have access to safe water at more than 90 per cent.

Table X.1. Distribution of countries according to percentage of population with access to safe water, 1990-1998

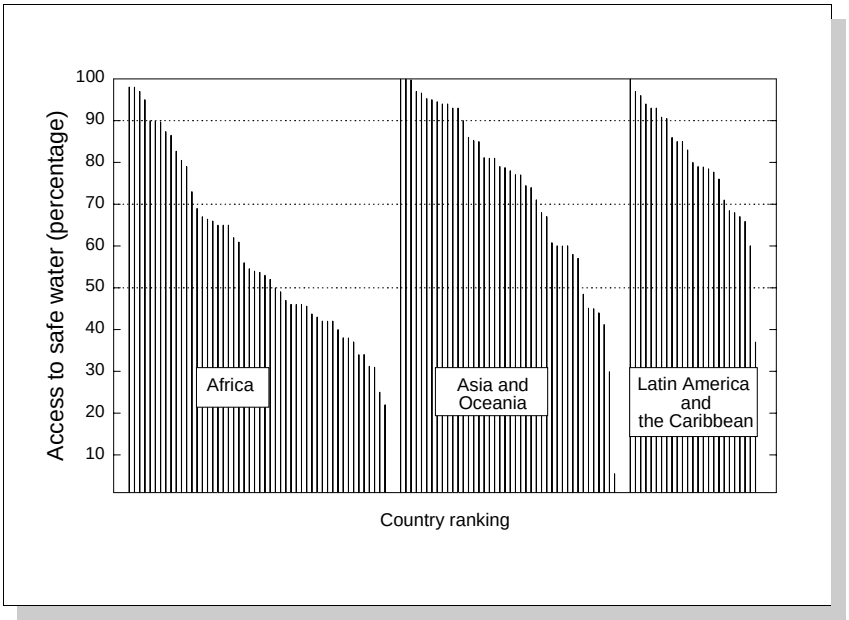
	Percentage of countries with access to safe water					Number of countries	
	90 per cent or more	70-89 per cent	50-69 per cent	Less than 50 per cent	Total	With data available	Total
Less developed regions	24	26	25	25	100	117	141
Least developed countries	7	7	37	49	100	41	45
Africa	14	12	32	42	100	50	53
Asia and Oceania[a]	31	33	19	17	100	42	57
Latin America and the Caribbean	32	44	20	4	100	25	31

Source: UNICEF, *The State of the World's Children, 2000* (New York, Oxford University Press, 2000).

NOTE: Excludes countries and areas with populations under 150,000. Due to rounding, the sum of the subcategories may not be equal to 100 per cent.

[a] Excluding Japan, Australia and New Zealand, which are included in the more developed regions.

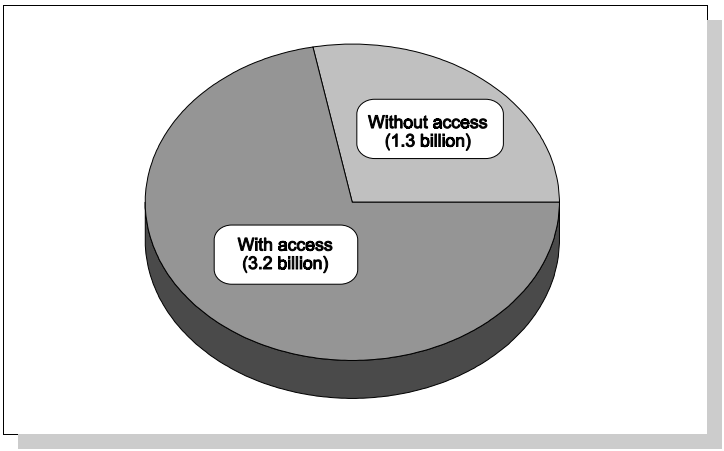
Figure X.2. Percentage of population with access to safe water, 1990-1998, by country ranking and region



Source: UNICEF, *The State of the World's Children, 2000* (New York, Oxford University Press, 2000).

NOTE: Bars show level of access to safe water for individual countries.

Figure X.3. Distribution of population in the less developed regions, by access to safe water, 1990-1998



Source: UNICEF, *The State of the World's Children, 2000* (New York, Oxford University Press, 2000).

NOTE: For countries with data on access to safe water, representing 96 per cent of the population of the less developed regions.

SOURCES OF DATA, COVERAGE AND QUALITY

Data are collected by the World Health Organization and the United Nations Children's Fund under their Joint Monitoring Programme and are published in the *Water Supply and Sanitation Sector Monitoring Report* series; an updated review will be released in 2000. The most recent data currently available appear in *The State of the World's Children, 2000* (UNICEF, 2000). Data are available for 1990-1998, depending on the country, and for 117 countries or areas (83 per cent of the countries in the less developed regions). Data for several countries in the more developed regions are included in the annex.

Most countries have a variety of data sources from which to estimate water indicators, such as administrative records, population censuses and household surveys. However, a review by WHO/UNICEF of the water data indicates considerable variation in national estimates over a short period of two years or less, suggesting that the estimates are sometimes based on uncertain data (WHO/UNICEF, 1993).

The critical elements of the water indicator are "adequate", "safe" and "convenient distance", since how they are determined will affect the estimates of coverage. A common approach of censuses is to determine the source of water, but not always specifically for drinking water. While the type of source is often used to assess whether the supply is "safe", it is rare to find questions which provide information on "adequate amount" and "convenient distance", which are distinct in the sense that there may be access to water but it is not necessarily convenient to fetch it owing to distance.

Household surveys generally have more flexibility to include additional questions. But this flexibility frequently leads to survey questions which differ across surveys, resulting in different estimates of water coverage, even for the same geographical area and time period. For the current indicator, definitions of the critical concepts are determined at the country level. When no definition is available at the country level, the following definitions from WHO (1996b) may be used:

(a) Access to water: In urban areas a distance of not more than 200 metres from a home to a public standpost may be considered reasonable access. In rural areas, reasonable access implies that a person does not have to spend a disproportionate part of the day fetching water for the family's needs;

(b) Adequate amount of water: 20 litres of safe water per person per day;

(c) Safe water: Water that does not contain biological or chemical agents directly detrimental to health. It includes treated surface water and untreated but uncontaminated water from protected springs, bore-holes, sanitary wells, etc.;

(d) Convenient distance: In urban areas, to fetch 20 litres of safe water per person per day, 200 metres would be a reasonable distance from the home.

FOR FURTHER INFORMATION

Chief
Water and Environmental Sanitation Section
United Nations Children's Fund
633 Third Avenue
New York, NY10016
United States of America
Facsimile: 1-212-824-6480/6482
Internet: http://www.unicef.org/statis/

Director
Department for Protection of the Human Environment/
Water, Sanitation and Health
World Health Organization
CH-1211 Geneva 27
Switzerland
Facsimile: 41-22-791-4159
Internet: http://www.who.int/water_sanitation_health

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XI. Access to Sanitation

International goals

All countries should give priority to measures that improve the quality of life and health by ensuring a safe and sanitary living environment for all population groups through measures aimed at ..., ensuring access to ... sanitation, ... (para. 8.10 of ICPD Programme of Action).

... Providing ... proper sanitation for all (para. 36(l) of WSSD Programme of Action).

... Ensure the availability of and universal access to ... sanitation (para. 106(x) of FWCW Platform for Action).

... Promoting access for all people to ... sanitation and other basic services, facilities and amenities, especially for people living in poverty, women and those belonging to vulnerable and disadvantaged groups (para. 40(c) of the Habitat Agenda).

The Global Strategy for Health for All by the Year 2000 set an international target for this indicator of 100 per cent by the year 2000. The more recent Ninth General Programme of Work for 1996-2001 established a target of 75 per cent by the year 2001.

The International Drinking Water Supply and Sanitation Decade, 1981-1990, was proclaimed by the United Nations General Assembly in 1980. It was also a component of the WHO Global Strategy for Health for All by the Year 2000.

The World Summit for Children and the United Nations Conference on Environment and Development also adopted goals on universal access to sanitation.

Definition

Access to sanitation is measured by the percentage of population with access to *a sanitary facility* for disposal of human excreta in the user's dwelling or located within *a convenient distance* of the user's dwelling. Under the WHO/UNICEF Joint Monitoring Programme, the words in italics were defined at the country level. "Access" is interpreted as actual use by the population.

Recent situation

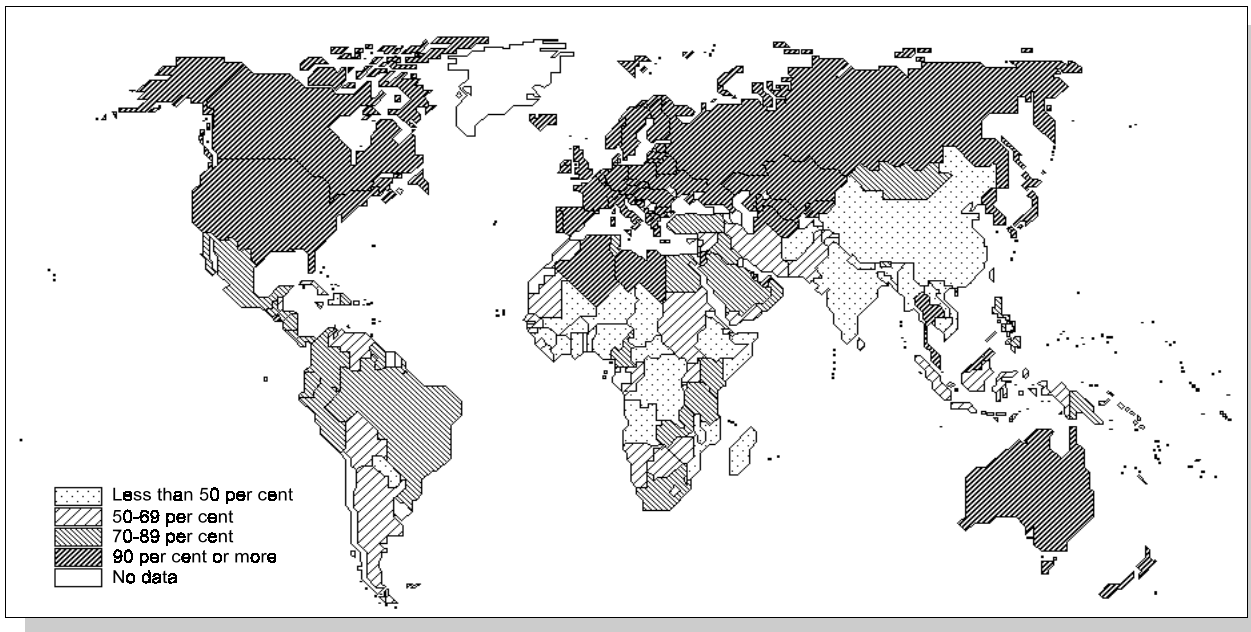
Data on access to sanitation has almost the same country coverage as the previous indicator, access to safe water. However, access to sanitation is generally found to be more limited. When compared with figure X.1 on safe water, figure XI.1 shows much wider areas with a dot pattern, indicating access to sanitation less than 50 per cent. For example, countries such as Bangladesh, India and Nepal, which have more than 70 per cent access to safe water, have less than 50 per cent access to sanitation.

In more than one third of the countries (39 out of the 112 with data available), the majority of the population do not have access to sanitation (table XI.1). As compared with access to safe water, this is 10 percentage points higher. In 76 per cent of the least developed countries, most people lack access to sanitation. Thus, substantial investment in sanitation facilities is needed in order to achieve the goal of universal access to sanitation, especially in the poorest countries.

In over half of the African countries and more than one quarter of the Asian and Oceanic countries, the majority of the population lacks access to sanitation. Figure XI.2 shows that there are still a number of countries where less than one fourth of the population has access to sanitation. In Latin America and the Caribbean the situation is much better, with only two countries (Haiti and Paraguay) in the lowest category (less than 50 per cent) and over two thirds of the countries having at least 70 per cent access. Although many Asian and Oceanic countries have low or moderate levels of access, around one third of the region's countries have near-universal (90 per cent or more) access to sanitation, a higher proportion than in the other less developed regions.

In all regions, access to sanitation is more limited than access to safe water. When access to sanitation is weighted by population (fig. XI.3), the result is strikingly different from that on access to safe water (fig. X.3): about one quarter of the population of the less developed regions lack access to safe water, but more than half have no access to sanitation.

Figure XI.1. Percentage of population with access to sanitation, 1990-1998



Source: UNICEF, *The State of the World's Children, 2000* (New York, Oxford University Press, 2000).

NOTE: Estimates are not presented for countries or areas with populations under 150,000. Countries from the more developed regions are assumed to have access to sanitation at more than 90 per cent.

Table XI.1. Distribution of countries according to percentage of population with access to sanitation, 1990-1998

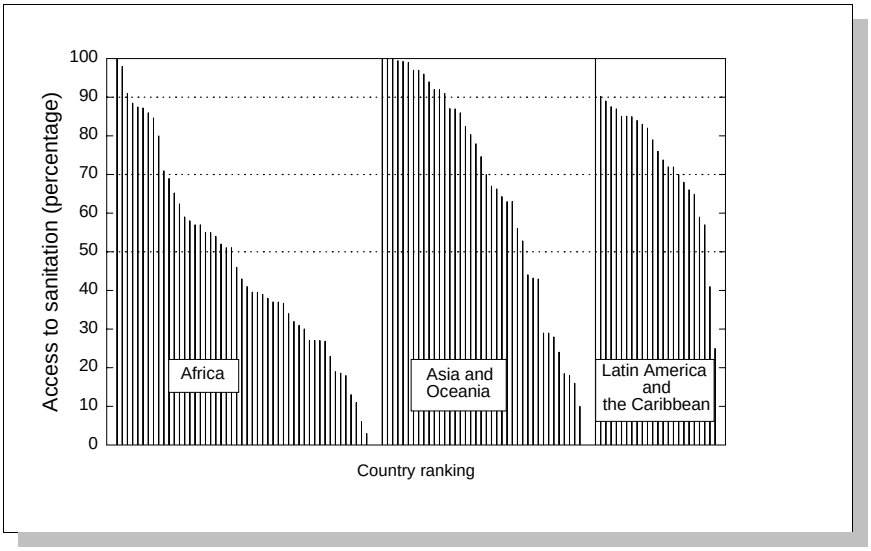
	Percentage of countries with access to sanitation of:					Number of countries	
	90 per cent or more	70-89 per cent	50-69 per cent	Less than 50 per cent	Total	With data available	Total
Less developed regions	16	27	22	35	100	112	141
Least developed countries	0	7	17	76	100	42	45
Africa	6	14	27	53	100	49	53
Asia and Oceania[a]	33	21	18	28	100	39	57
Latin America and the Caribbean	8	63	21	8	100	24	31

Source: UNICEF, *The State of the World's Children, 2000* (New York, Oxford University Press, 2000).

NOTE: Excludes countries and areas with populations under 150,000. Due to rounding, the sum of the subcategories may not be equal to 100 per cent.

[a] Excluding Japan, Australia and New Zealand, which are included in the more developed regions.

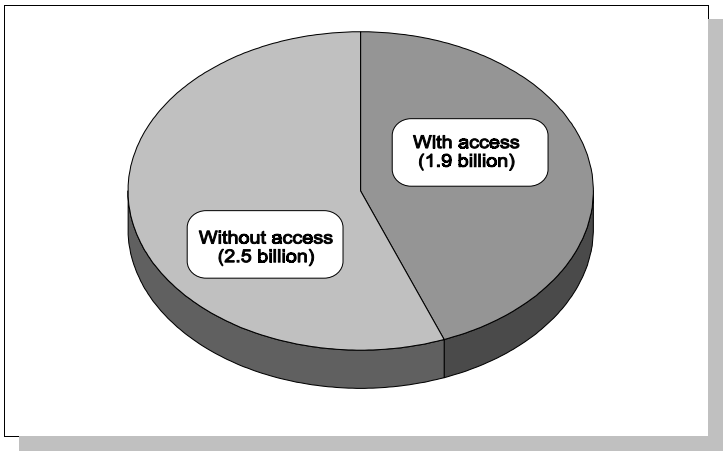
Figure XI.2. Percentage of population with access to sanitation, 1990-1998, by country ranking and region



Source: UNICEF, *The State of the World's Children, 2000* (New York, Oxford University Press, 2000).

NOTE: Bars show level of access to sanitation for individual countries.

Figure XI.3. Distribution of population in the less developed regions, by access to sanitation, 1990-1998



Source: UNICEF, *The State of the World's Children, 2000* (New York, Oxford University Press, 2000).

NOTE: For countries with data on access to sanitation, representing approximately 96 per cent of the population of the less developed regions.

SOURCES OF DATA, COVERAGE AND QUALITY

Data are collected by the World Health Organization and the United Nations Children's Fund under the Joint Monitoring Programme and are published in the *Water Supply and Sanitation Sector Monitoring Report* series; an updated review will be released in 2000. The most recent data currently available appear in *The State of the World's Children, 2000* (UNICEF, 2000). Data are available for 1990-1998, depending on the country, and for 112 countries or areas in the less developed regions. Data for a few countries in the more developed regions are included in the annex.

Most countries have a variety of data sources from which to estimate sanitation indicators, such as administrative records, population censuses and household surveys. However, a review by WHO/UNICEF of the sanitation data indicates considerable variation in national estimates over a short period of two years or less, suggesting that the estimates are sometimes based on uncertain data (WHO/UNICEF, 1993).

The critical elements of the indicator are "sanitary facility" and "convenient distance". Censuses have been used to determine the type of facility used by a household, but rarely the distance to it. For household surveys the situation is similar to that for water, where added flexibility in survey questions increases the number of different classifications of sanitary facilities. For the current indicator, definitions of these two concepts are determined at the country level.

When no definition is available at the country level, the following definitions from WHO (1996b) may be used:

(a) Sanitary facility: A unit for disposal of human excreta which isolates faeces from contact with people, animals, crops and water sources. Suitable facilities range from simple but protected pit latrines to flush toilets with sewerage. All facilities, to be effective, must be correctly constructed and properly maintained;

(b) Convenient distance: A maximum of 50 metres from the dwelling.

For further information

Chief
Water and Environmental Sanitation Section
United Nations Children's Fund
633 Third Avenue
New York, NY 10016
United States of America
Facsimile: 1-212-824-6480/6482
Internet: http://www.unicef.org/statis/

Manager
Community Water Supply and Sanitation
EHE/CWS
World Health Organization
CH-1211 Geneva 27
Switzerland
Facsimile: 41-22-788-4226
Internet: http://www.who.int/water_sanitation_health

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_____ (1993). *Water Supply and Sanitation Sector Monitoring Report 1993*. Geneva.

XII. Floor Area per Person

International goals

All countries should give priority to measures that improve the quality of life and health by ensuring a safe and sanitary living environment for all population groups through measures aimed at avoiding crowded housing conditions ... (para. 8.10 of ICPD Programme of Action).

... Improving the availability of affordable and adequate shelter for all ... (para. 36(m) of WSSD Programme of Action)

Adequate shelter means more than a roof over one's head. It also means adequate privacy; adequate space; physical accessibility; adequate security, including security of tenure; structural stability and durability; adequate lighting, heating and ventilation; adequate basic infrastructure, such as water-supply, sanitation and water-management facilities ... (para. 60 of the Habitat Agenda).

Agenda 21, adopted at the United Nations Conference on Environment and Development, and the Vienna Programme of Action, adopted at the World Conference on Human Rights, also adopted goals on housing.

Definition

Floor area per person is defined as the median floor area (in square metres) of a housing unit divided by the average household size. This indicator measures the adequacy of living space in dwellings. A low value for the indicator is a sign of overcrowding.

Recent situation

Floor area per person is one of the 10 key housing indicators approved by the Commission on Human Settlements (UNCHS) to measure progress towards meeting the objectives of the Global Strategy for Shelter to the Year 2000, adopted by the General Assembly in 1988 and by the Commission in 1995.

Human settlement conditions in many parts of the world are deteriorating, mainly as a result of low levels of investment. Floor area per person is to a considerable degree the outcome of market forces, which are, in turn, shaped by a variety of housing policies. Housing policies, particularly in urban areas, greatly affect the living conditions of people. In low-income settlements, reduced space per person can be associated with certain health risks (United Nations, 1996).

Table XII.1 shows the distribution of countries according to floor area per person. Since data availability is very limited for this indicator at the country level (results have been collected mostly at the city level in 188 cities), observations based on current national data should be interpreted with caution.

At the global level, out of 37 countries with data available, two thirds report floor area per person of less than 20 square metres. This global average is an outcome of two disparate housing situations in the more developed regions, on the one hand, and in the less developed regions, on the other. In the more developed regions, about 60 per cent of the countries with data report floor area per person of 20 square metres or larger. In the case of the less developed regions, only 10 per cent of the countries do so.

Floor area per person is less than 20 square metres for all of the African countries, and for three quarters of the Asian and the Pacific countries. Two countries in Asia and the Pacific—Israel and the Philippines—report floor area per person of 20 square metres or more. Chile, the only country in Latin America and the Caribbean which has data for this indicator, reports floor area per person of less than 20 square metres.

Figure XII.1 graphically shows the differences in floor area per person among the major regions. Based on the limited data, African countries tend to have less floor area per person than those in other regions. The more developed regions tend to have relatively more floor space per person than the other regions, while Asia and Oceania lies between Africa and the more developed regions.

Table XII.1. Distribution of countries according to floor area per person, 1990-1995

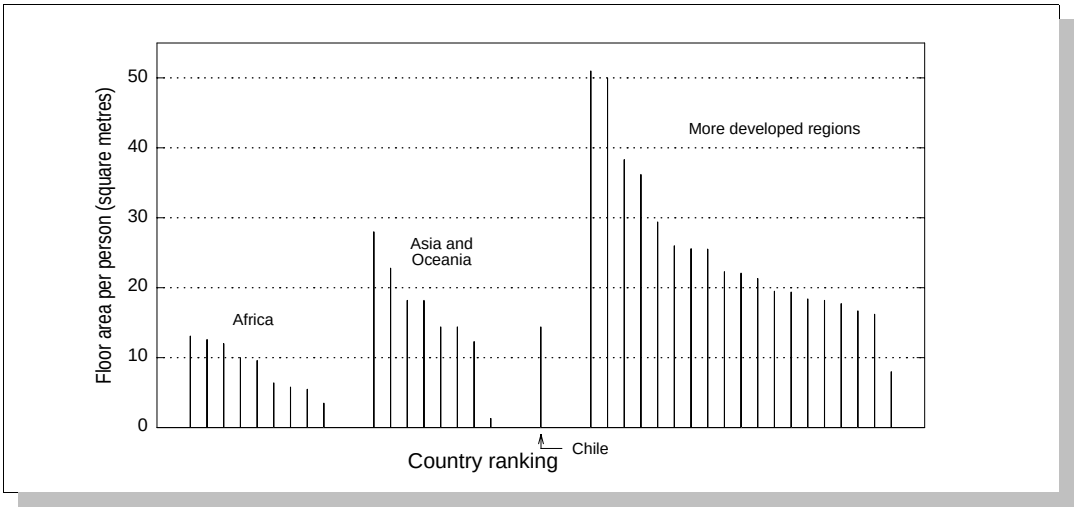
	Percentage of countries with floor area per person of:			Number of countries	
	20 square metres or more	Less than 20 square metres	Total	With data available	Total
World	35	65	100	37	184
More developed regions	58	42	100	19	43
Less developed regions	11	89	100	18	141
Least developed countries	0	100	100	4	45
Africa	0	100	100	9	53
Asia and Oceania[a]	25	75	100	8	57
Latin America and the Caribbean	0	100	100	1	31

Source: Urban Indicators Programme, UNCHS.

NOTE: Excludes countries and areas with populations under 150,000.

[a] Excluding Japan, Australia and New Zealand, which are included in the more developed regions.

Figure XII.1. Floor area per person, 1990-1995, by country ranking and region



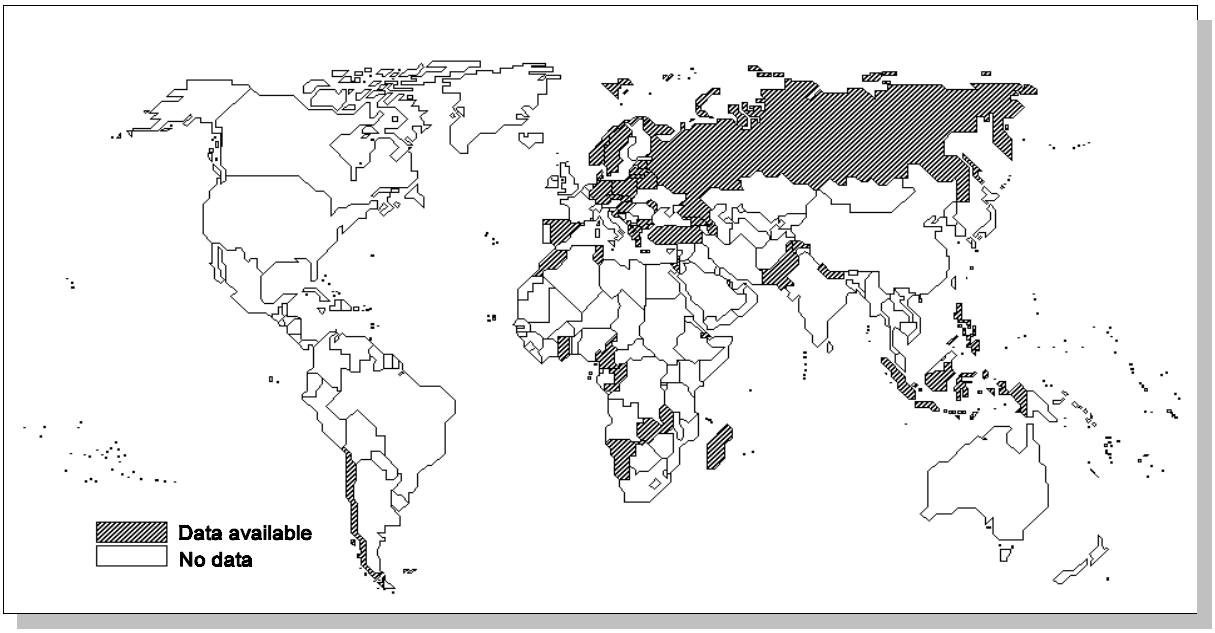
Source: Urban Indicators Programme, UNCHS, 1997.
NOTE: Bars show floor area per person for individual countries with data available.

Table XII.2. Distribution of cities according to floor area per person, 1990-1995

	Percentage of cities with floor area per person (in square metres) in the range:						Number of cities	
	20 or more	15-19	10-14	5-9	Less than 5	Total	With data available	Total[a]
World	18	18	24	28	13	100	188	237
More developed regions	56	37	5	2	0	100	41	62
Less developed regions	7	12	29	35	17	100	147	175
Least developed countries	4	4	23	37	33	100	52	63
Africa	5	1	33	40	21	100	80	94
Asia and Oceania[b]	5	15	32	32	17	100	41	49
Latin America and the Caribbean	15	42	15	23	4	100	26	32

Source: Urban Indicators Programme, UNCHS, 1997.
[a] Number of cities in the Urban Indicators database.
[b] Excluding cities in Japan, Australia and New Zealand, which are included in the more developed regions.

Figure XII.2. Data availability of floor area per person at the national level, 1990-1995



Source: Urban Indicators Programme, UNCHS, 1997.

Findings in table XII.2, which is based on city-level data, reinforce those from table XII.1. In more than half of the cities in the more developed regions, floor area per person is 20 square metres or more. In the less developed regions, only 7 per cent of the cities fall in this category, while over half have average floor area under 10 square metres per person. Urban housing in Latin America and the Caribbean is significantly more crowded than in the more developed regions, but it tends to be significantly less crowded than in either Africa or Asia/Oceania. In nearly 60 per cent of Latin American and Caribbean cities, the average floor area is at least 15 square metres per person, while this is the case in only 6 per cent of African cities and 20 per cent of the cities in Asia and Oceania. There are also significant variations within intraregional groups, with, for example, substantially more spacious living arrangements in high-income than in transitional economies within the more developed regions (not shown).

SOURCES OF DATA, COVERAGE AND QUALITY

Data are compiled by the United Nations Centre for Human Settlements under its Urban Indicators Programme. Primary data sources include censuses and household surveys. Data are available from 1987 to 1995, depending on the country.

Data availability at the national level is extremely limited for this indicator, as compared with the other indicators included in this report. This indicator has been collected at the city level by the UNCHS Urban Indicators Programme. While city data are available for 188 cities, only 37 countries have provided national data (20 per cent of the 184 countries with populations of 150,000 or more). Of those 37 countries, about half are from the more developed regions, primarily from Europe (see fig. XII.2). The country coverage for the less developed regions is only 13 per cent.

"Floor area" includes all living space, along with bathrooms, internal corridors and closets. Covered semi-private spaces such as corridors, inner courtyards or verandas should be included in the calculation, if used by the household for cooking, eating, sleeping, or other domestic activities. "Floor area" refers to a housing unit, defined as a separate and independent place of abode intended for habitation by one household at the time of the census or other inquiry.

Various levels of data collection are necessary to provide a full picture of this aspect of housing. Floor area per person does not by itself give a complete picture of living conditions. Cultural values affect sensitivity to crowding as well. According to UNCHS, however, this indicator is more precise and policy-sensitive than related indicators, such as persons per room or households per dwelling unit.

For further information

Coordinator
Urban Indicators Programme
United Nations Centre for Human Settlements
P.O. Box 30030
Nairobi, Kenya
Facsimile: 254-2-624263/4
Internet: www.unhabitat.org/guo/uip.htm

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Annex Table

ANNEX TABLE: DATA FOR 12 INDICATORS, BY COUNTRY

Country or area	Total population, 1999 (thousands) (1)	Access to health services, 1985-1995 (percentage) (2)	Contraceptive prevalence[a] (percentage) (3)	Underweight prevalence under 5, 1990-1998 (percentage) (4)	Maternal mortality ratio, 1990 (per 100,000 live births) (5)	Mortality rate: infant and under 5, 1995-2000 (per 1,000 live births) (6)
AFRICA						
Algeria	30,774	98	52 A	13	160	44 / 51
Angola	12,479	30	..	42	1,500	125 / 208
Benin	5,937	18	16 A	29	990	88 / 133
Botswana	1,597	89	33 B	17	250	58 / 107
Burkina Faso	11,616	90	8 A	33	930	99 / 171
Burundi	6,565	80	9 B	37	1,300	119 / 179
Cameroon	14,693	70	16 A	22	550	74 / 115
Cape Verde	418	..	..	14	..	56 / 64
Central African Republic	3,550	45	15 A	27	700	98 / 157
Chad	7,458	30	..	39	1,500	112 / 174
Comoros	676	..	21 A	26	950	76 / 106
Congo	2,864	83	..	*17*	890	90 / 132
Côte d'Ivoire	14,526	30	11 A	24	810	87 / 136
Dem. Republic of the Congo	50,335	26	8 A	34	870	90 / 139
Djibouti	629	..	..	18	570	106 / 174
Egypt	67,226	99	47 A	12	170	51 / 65
Equatorial Guinea	442	..	..	..	820	108 / 177
Eritrea	3,719	..	5 A	44	1,400	91 / 146
Ethiopia	61,095	46	4 A	48	1,400	115 / 184
Gabon	1,197	90	..	..	500	87 / 135
Gambia	1,268	93	12 A	26	1,100	122 / 203
Ghana	19,678	60	20 A	27	740	66 / 101
Guinea	7,360	80	2 A	26	1,600	124 / 207
Guinea-Bissau	1,187	40	..	..	910	130 / 203
Kenya	29,549	77	33 A	22	650	66 / 104
Lesotho	2,108	80	23 A	16	610	93 / 130
Liberia	2,930	39	6 B	..	560	116 / 174
Libyan Arab Jamahiriya	5,471	..	40 A	5	220	28 / 32
Madagascar	15,497	65	17 A	40	490	82 / 116
Malawi	10,640	80	22 A	30	560	138 / 220
Mali	10,960	30	7 A	40	1,200	118 / 236
Mauritania	2,598	63	3 A	23	930	92 / 148
Mauritius[b]	1,150	100	75 A	15	120	15 / 18
Morocco	27,867	70	50 A	9	610	51 / 69
Mozambique	19,286	39	6 A	26	1,500	114 / 183
Namibia	1,695	62	29 A	26	370	65 / 122
Niger	10,400	32	4 A	50	1,200	115 / 190
Nigeria	108,945	66	6 A	39	1,000	81 / 147
Réunion	691	..	67 A	..	..	9 / 10
Rwanda	7,235	80	21 A	27	1,300	124 / 202
Senegal	9,240	40	13 A	22	1,200	63 / 115
Sierra Leone	4,717	38	..	29	1,800	170 / 263
Somalia	9,672	27	..	..	1,600	122 / 204

ANNEX TABLE *(continued)*

Life expectancy, female/male, 1995-2000 (years) (7)	School enrolment ratio (primary & secondary) female/male, 1990-1996 (percentage) (8)	Adult lliteracy rate, female/male, 1995 (percentage) (9)	Population with access to Safe water, 1990-1998 (percentage) (10)	Population with access to Sanitation, 1990-1998 (percentage) (11)	Floor area per person, 1990-1995 (sq.metres) (12)	Country or area
						AFRICA
70 / 68	82 / 90	55 / 29	90	91	..	Algeria
48 / 45	—45—	.. / ..	31	40	..	Angola
55 / 52	35 / 63	81 / 55	56	27	..	Benin
48 / 46	93 / 90	25 / 30	90	55	..	Botswana
45 / 44	18 / 28	90 / 71	42	37	..	Burkina Faso
44 / 41	34 / 44	67 / 48	52	51	..	Burundi
56 / 53	53 / 63	38 / 23	54	89	9.6	Cameroon
71 / 66	80 / 85	39 / 19	65	27	..	Cape Verde
47 / 43	26 / 43	73 / 46	38	27	..	Central African Republic
49 / 46	23 / 47	65 / 38	54	27	..	Chad
60 / 57	44 / 54	52 / 38	53	23	..	Comoros
51 / 46	78 / 92	33 / 17	34	69	12.6	Congo
47 / 46	38 / 58	69 / 51	42	39	..	Côte d'Ivoire
52 / 49	41 / 62	.. / ..	42	18	..	Dem. Republic of the Congo
52 / 49	22 / 31	67 / 40	90	55	13.1	Djibouti
68 / 65	81 / 93	62 / 37	87	88	..	Egypt
52 / 48	.. / ..	33 / 11	95	54	..	Equatorial Guinea
52 / 49	33 / 41	.. / ..	22	13	..	Eritrea
44 / 42	20 / 33	74 / 60	25	19	..	Ethiopia
54 / 51	.. / ..	47 / 26	67	..	..	Gabon
49 / 45	46 / 62	76 / 62	69	37	..	Gambia
62 / 58	50 / 64	47 / 25	65	32	5.5	Ghana
47 / 46	20 / 41	78 / 50	46	31	..	Guinea
46 / 44	*27 / 50*	84 / 53	43	46	..	Guinea-Bissau
53 / 51	66 / 68	31 / 14	44	85	..	Kenya
57 / 55	84 / 72	8 / 30	62	38	..	Lesotho
49 / 46	.. / ..	72 / 38	46	30	..	Liberia
72 / 68	*94 / 102*	40 / 13	97	98	..	Libyan Arab Jamahiriya
59 / 56	51 / 51	.. / ..	40	40	5.8	Madagascar
40 / 39	94 / 106	59 / 28	47	3	..	Malawi
55 / 52	20 / 33	75 / 60	66	6	..	Mali
55 / 52	42 / 54	73 / 51	37	57	..	Mauritania
75 / 68	84 / 82	22 / 14	98	100	..	Mauritius
69 / 65	54 / 71	70 / 42	65	58	10.0	Morocco
47 / 44	27 / 38	77 / 45	46	34	..	Mozambique
53 / 52	108 / 103	23 / 20	83	62	3.5	Namibia
50 / 47	14 / 23	93 / 79	61	19	..	Niger
52 / 49	61 / 77	53 / 34	49	41	..	Nigeria
80 / 71	.. / ..	13 / 18	..	..	..	Réunion
42 / 39	52 / 55	48 / 31	..	..	..	Rwanda
54 / 51	37 / 48	77 / 57	81	65	..	Senegal
39 / 36	*29 / 43*	82 / 55	34	11	..	Sierra Leone
49 / 45	*8 / 16*	.. / ..	31	43	..	Somalia

Country or area	Total population, 1999 (thousands) (1)	Access to health services, 1985-1995 (percentage) (2)	Contraceptive prevalence[a] (percentage) (3)	Underweight prevalence under 5, 1990-1998 (percentage) (4)	Maternal mortality ratio, 1990 (per 100,000 live births) (5)	Mortality rate: infant and under 5, 1995-2000 (per 1,000 live births) (6)
South Africa	39,900	..	50 B	9	230	59 / 87
Sudan	28,883	70	8 A	34	660	71 / 112
Swaziland	980	..	20 B	..	560	65 / 100
Togo	4,512	61	12 B	25	640	84 / 129
Tunisia	9,460	90	60 A	9	170	30 / 37
Uganda	21,143	49	15 A	26	1,200	107 / 173
United Rep. of Tanzania	32,793	80	18 A	31	770	81 / 130
Western Sahara	284	..	..	..	..	64 / 88
Zambia	8,976	75	25 A	24	940	82 / 147
Zimbabwe	11,529	85	48 A	15	570	69 / 117
ASIA						
Afghanistan	21,923	29	..	48	1,700	151 / 257
Armenia	3,525	..	..	3	50	26 / 33
Azerbaijan	7,697	..	..	10	22	36 / 50
Bahrain	606	..	61 A	9	60	16 / 22
Bangladesh	126,947	45	49 A	56	850	79 / 111
Bhutan	2,064	65	19 A	*38*	1,600	63 / 96
Brunei Darussalam	322	..	..	..	60	10 / 11
Cambodia	10,945	53	..	52	900	103 / 134
China [c]	1,266,838	92	83 A	16	95	41 / 48
China, Hong Kong SAR [d]	6,801	99	86 A	..	7	6 / 7
Cyprus	778	..	..	..	5	8 / 9
Dem. People's Rep. of Korea	23,702	..	62 A	60	70	22 / 26
East Timor	871	..	..	..	..	135 / 201
Gaza Strip	1,077	..	..	..	..	24 / 29
Georgia	5,006	..	..	..	33	19 / 23
India	998,056	85	41 A	53	570	72 / 89
Indonesia	209,255	80	55 A	34	650	48 / 63
Iran (Islamic Republic of)	66,796	80	65 A	16	120	35 / 52
Iraq	22,450	93	14 B	23	310	95 / 116
Israel	6,101	..	..	..	7	8 / 10
Japan	126,505	..	59 A	..	18	4 / 6
Jordan	6,482	97	35 A	5	150	26 / 31
Kazakhstan	16,269	..	59 A	8	80	35 / 41
Kuwait	1,897	100	35 B	2	29	12 / 15
Kyrgyzstan	4,669	..	..	11	110	40 / 50
Lao People's Dem. Rep.	5,297	67	19 A	40	650	93 / 150
Lebanon	3,236	95	..	3	300	29 / 35
Macau	467	..	..	..	..	10 / 11
Malaysia	21,830	..	48 B	20	80	11 / 15
Maldives	278	..	..	43	..	50 / 66
Mongolia	2,621	95	61 A	10	65	51 / 73
Myanmar	45,059	60	17 A	39	580	79 / 113

Life expectancy, female/male, 1995-2000 (years) (7)	School enrolment ratio (primary & secondary) female/male, 1990-1996 (percentage) (8)	Adult llliteracy rate, female/male, 1995 (percentage) (9)	Population with access to Safe water, 1990-1998 (percentage) (10)	Population with access to Sanitation, 1990-1998 (percentage) (11)	Floor area per person, 1990-1995 (sq.metres) (12)	Country or area
58 / 52	118 / 115	18 / 16	87	87	..	South Africa
56 / 54	40 / 47	62 / 37	73	51	..	Sudan
63 / 58	92 / 96	25 / 22	50	59	..	Swaziland
50 / 48	59 / 92	65 / 34	55	37	..	Togo
71 / 68	86 / 91	47 / 24	98	80	12.0	Tunisia
40 / 39	44 / 54	50 / 26	46	57	..	Uganda
49 / 47	41 / 42	41 / 20	66	86	..	United Rep. of Tanzania
63 / 60	.. / ..	.. / ..	..	..	..	Western Sahara
41 / 40	63 / 72	35 / 18	38	71	6.4	Zambia
45 / 44	84 / 89	14 / 7	79	52	..	Zimbabwe
						ASIA
46 / 45	22 / 49	84 / 54	6	10	..	Afghanistan
74 / 67	91 / 86	.. / ..	..	..	..	Armenia
74 / 66	90 / 87	.. / ..	..	..	12.3	Azerbaijan
75 / 71	105 / 101	21 / 11	94	97	..	Bahrain
58 / 58	*38 / 49*	74 / 51	95	43	..	Bangladesh
62 / 60	.. / ..	72 / 44	58	70	..	Bhutan
78 / 73	93 / 90	15 / 7	..	..	..	Brunei Darussalam
55 / 52	68 / 86	.. / ..	30	19	..	Cambodia
72 / 68	95 / 98	27 / 10	67	24	..	China
81 / 76	84 / 80	13 / 4	..	..	..	China, Hong Kong SAR
80 / 76	.. / ..	7 / 2	100	..	..	Cyprus
75 / 69	.. / ..	.. / ..	100	99	..	Dem. People's Rep. of Korea
48 / 47	.. / ..	.. / ..	..	..	..	East Timor
73 / 69	.. / ..	.. / ..	..	..	..	Gaza Strip
77 / 69	80 / 82	.. / ..	..	..	18.2	Georgia
63 / 62	62 / 81	62 / 35	81	29	..	India
67 / 63	79 / 85	22 / 10	74	53	14.4	Indonesia
70 / 69	83 / 90	37 / 21	95	64	..	Iran (Islamic Republic of)
64 / 61	58 / 73	.. / ..	81	75	..	Iraq
80 / 76	94 / 92	7 / 3	..	..	28.0	Israel
83 / 77	103 / 103	.. / ..	97	..	..	Japan
72 / 69	.. / ..	20 / 10	97	99	..	Jordan
72 / 63	94 / 88	.. / ..	93	99	..	Kazakhstan
78 / 74	68 / 69	24 / 18	..	..	..	Kuwait
72 / 63	91 / 87	.. / ..	79	100	..	Kyrgyzstan
55 / 52	63 / 80	56 / 31	44	18	..	Lao People's Dem. Rep.
72 / 68	95 / 93	23 / 10	94	63	..	Lebanon
80 / 75	89 / 86	12 / 4	..	..	..	Macau
74 / 70	84 / 78	21 / 11	78	94	..	Malaysia
63 / 66	89 / 90	5 / 5	60	44	..	Maldives
67 / 64	76 / 64	1 / 1	45	87	..	Mongolia
62 / 59	68 / 70	22 / 12	60	43	..	Myanmar

Country or area	Total population, 1999 (thousands) (1)	Access to health services, 1985-1995 (percentage) (2)	Contraceptive prevalence[a] (percentage) (3)	Underweight prevalence under 5, 1990-1998 (percentage) (4)	Maternal mortality ratio, 1990 (per 100,000 live births) (5)	Mortality rate: infant and under 5, 1995-2000 (per 1,000 live births) (6)
Nepal	23,385	..	29 A	47	1,500	83 / 117
Oman	2,460	96	22 A	23	190	25 / 30
Pakistan	152,331	55	18 A	38	340	74 / 106
Philippines	74,454	76	40 A	28	280	35 / 44
Qatar	589	..	32 B	6	..	17 / 23
Republic of Korea	46,480	100	79 A	..	130	10 / 13
Saudi Arabia	20,899	97	..	..	130	23 / 27
Singapore	3,522	100	74 C	..	10	5 / 6
Sri Lanka	18,639	93	66 A	34	140	18 / 21
Syrian Arab Republic	15,725	90	36 A	13	180	33 / 40
Tajikistan	6,104	..	..	..	130	57 / 81
Thailand	60,856	90	74 A	19	200	29 / 35
Turkey	65,546	..	63 A	10	180	45 / 60
Turkmenistan	4,384	..	..	..	55	55 / 77
United Arab Emirates	2,398	99	27 A	14	26	16 / 19
Uzbekistan	23,942	..	56 A	19	55	44 / 63
Viet Nam	78,705	..	65 A	40	160	38 / 56
Yemen	17,488	38	13 A	46	1,400	80 / 113
EUROPE						
Albania	3,113	..	..	8	65	30 / 43
Austria	8,177	..	71 C	..	10	6 / 7
Belarus	10,274	..	50 A	..	37	23 / 28
Belgium	10,152	..	79 A	..	10	7 / 8
Bosnia and Herzegovina	3,839	..	..	..	..	15 / 17
Bulgaria	8,279	..	76 C	..	27	17 / 20
Croatia	4,477	..	..	1	..	10 / 12
Czech Republic	10,262	..	69 A	1	15	6 / 8
Denmark	5,282	..	78 B	..	9	7 / 9
Estonia	1,412	..	70 A	..	41	19 / 25
Finland	5,165	..	80 C	..	11	6 / 7
France	58,886	..	75 A	..	15	6 / 8
Germany	82,178	..	75 A	..	22	5 / 6
Greece	10,626	..	..	..	10	8 / 9
Hungary	10,076	..	73 A	*2*	30	10 / 12
Iceland	279	..	..	..	..	5 / 6
Ireland	3,705	..	69 A	..	10	7 / 8
Italy	57,343	..	78 C	..	12	7 / 8
Latvia	2,389	..	48 A	..	40	18 / 25
Lithuania	3,682	..	59 A	..	36	21 / 24
Luxembourg	426	..	..	..	..	7 / 8
Malta	386	..	..	..	..	8 / 9
Netherlands	15,735	..	79 A	..	12	6 / 8
Norway	4,442	..	74 B	..	6	5 / 6

Life expectancy, female/male, 1995-2000 (years) (7)	School enrolment ratio (primary & secondary) female/male, 1990-1996 (percentage) (8)	Adult lliteracy rate, female/male, 1995 (percentage) (9)	Population with access to Safe water, 1990-1998 (percentage) (10)	Population with access to Sanitation, 1990-1998 (percentage) (11)	Floor area per person, 1990-1995 (sq.metres) (12)	Country or area
57 / 58	59 / 94	81 / 46	71	16	14.4	Nepal
73 / 69	71 / 75	49 / 25	85	78	..	Oman
65 / 63	29 / 58	76 / 46	79	56	1.3	Pakistan
70 / 67	97 / 97	6 / 6	85	87	22.8	Philippines
75 / 70	83 / 84	20 / 21	..	97	..	Qatar
76 / 69	99 / 98	5 / 1	93	100	..	Republic of Korea
73 / 70	67 / 71	41 / 20	95	86	..	Saudi Arabia
79 / 75	81 / 85	14 / 4	100	..	..	Singapore
75 / 71	90 / 87	13 / 6	57	63	..	Sri Lanka
71 / 67	70 / 78	46 / 15	86	67	..	Syrian Arab Republic
70 / 64	82 / 88	2 / 1	60	..	..	Tajikistan
72 / 66	66 / 67	8 / 4	81	96	..	Thailand
72 / 67	69 / 84	28 / 8	49	80	*18.2*	Turkey
69 / 62	.. / ..	.. / ..	74	91	..	Turkmenistan
77 / 74	89 / 88	25 / 27	97	92	..	United Arab Emirates
71 / 64	83 / 91	.. / ..	90	100	..	Uzbekistan
70 / 65	*67 / 71*	12 / 5	45	29	..	Viet Nam
58 / 57	34 / 90	82 / 38	61	66	..	Yemen
						EUROPE
76 / 70	86 / 85	.. / ..	..	..	8.0	Albania
80 / 74	102 / 104	.. / ..	..	..	..	Austria
74 / 62	95 / 94	2 / 0	..	..	19.5	Belarus
81 / 74	127 / 122	.. / ..	..	..	..	Belgium
76 / 71	.. / ..	.. / ..	..	..	..	Bosnia and Herzegovina
75 / 68	83 / 84	3 / 1	..	..	16.7	Bulgaria
77 / 69	84 / 83	4 / 1	..	..	22.1	Croatia
77 / 70	101 / 99	.. / ..	..	..	25.5	Czech Republic
78 / 73	112 / 111	.. / ..	..	..	51.0	Denmark
75 / 63	99 / 97	.. / ..	..	..	21.3	Estonia
81 / 73	113 / 103	.. / ..	..	..	..	Finland
82 / 74	108 / 110	.. / ..	..	..	..	France
80 / 74	102 / 104	.. / ..	..	..	36.2	Germany
81 / 76	95 / 95	6 / 2	..	..	*26.0*	Greece
75 / 67	100 / 99	1 / 1	..	..	29.4	Hungary
81 / 77	100 / 102	.. / ..	..	..	..	Iceland
79 / 74	112 / 108	.. / ..	..	..	..	Ireland
81 / 75	96 / 97	2 / 1	..	..	..	Italy
74 / 62	88 / 88	1 / 0	..	..	19.4	Latvia
76 / 64	91 / 90	1 / 0	..	..	16.2	Lithuania
80 / 73	.. / ..	.. / ..	..	..	..	Luxembourg
79 / 75	92 / 96	9 / 10	..	..	..	Malta
81 / 75	120 / 124	.. / ..	..	..	..	Netherlands
81 / 75	106 / 109	.. / ..	..	..	38.3	Norway

Country or area	Total population, 1999 (thousands) (1)	Access to health services, 1985-1995 (percentage) (2)	Contraceptive prevalence[a] (percentage) (3)	Underweight prevalence under 5, 1990-1998 (percentage) (4)	Maternal mortality ratio, 1990 (per 100,000 live births) (5)	Mortality rate: infant and under 5, 1995-2000 (per 1,000 live births) (6)
Poland	38,740	..	75 C	..	19	15 / 16
Portugal	9,873	..	66 C	..	15	9 / 11
Republic of Moldova	4,380	..	74 A	..	60	29 / 32
Romania	22,402	..	57 A	6	130	23 / 33
Russian Federation	147,196	..	..	3	75	18 / 22
Slovakia	5,382	..	74 A	..	..	11 / 13
Slovenia	1,989	..	..	..	13	7 / 8
Spain	39,634	..	59 B	..	7	7 / 8
Sweden	8,892	..	78 C	..	7	5 / 6
Switzerland	7,344	..	71 C	..	6	6 / 9
The Former Yugoslav Republic of Macedonia	2,011	..	..	..	..	23 / 26
Ukraine	50,658	..	..	..	50	19 / 25
United Kingdom	58,744	..	82 A	..	9	7 / 8
Yugoslavia	10,637	..	..	2	..	18 / 26
		..				
LATIN AMERICA AND THE CARIBBEAN						
Argentina	36,577	71	..	2	100	22 / 25
Bahamas	301	..	62 B	..	100	15 / 18
Barbados	269	..	55 B	..	43	12 / 14
Belize	235	..	47 A	6	..	29 / 37
Bolivia	8,142	67	45 A	8	650	66 / 88
Brazil	167,988	..	77 A	6	220	42 / 48
Chile	15,019	97	..	1	65	13 / 15
Colombia	41,564	60	72 A	8	100	30 / 39
Costa Rica	3,933	80	75 A	5	55	12 / 15
Cuba	11,160	98	70 B	9	95	9 / 12
Dominican Republic	8,364	80	64 A	6	110	34 / 46
Ecuador	12,411	88	57 A	*17*	150	46 / 60
El Salvador	6,154	40	53 A	11	300	32 / 41
Guadeloupe	450	..	44 C	..	..	9 / 11
Guatemala	11,090	34	31 A	27	200	46 / 61
Guyana	855	..	31 C	12	..	58 / 78
Haiti	8,087	50	18 A	28	1,000	68 / 105
Honduras	6,316	64	50 A	25	220	35 / 49
Jamaica	2,560	90	62 A	10	120	22 / 27
Martinique	392	..	51 C	..	..	7 / 9
Mexico	97,365	78	67 B	*14*	110	31 / 38
Netherlands Antilles	215	..	..	..	..	14 / 16
Nicaragua	4,938	83	49 A	12	160	43 / 58
Panama	2,812	80	58 C	7	55	21 / 28
Paraguay	5,358	63	56 A	4	160	39 / 48
Peru	25,230	75	64 A	8	280	45 / 65
Puerto Rico	3,839	..	64 C	..	..	12 / 14

Life expectancy, female/male, 1995-2000 (years) (7)	School enrolment ratio (primary & secondary) female/male, 1990-1996 (percentage) (8)	Adult lliteracy rate, female/male, 1995 (percentage) (9)	Population with access to Safe water, 1990-1998 (percentage) (10)	Population with access to Sanitation, 1990-1998 (percentage) (11)	Floor area per person, 1990-1995 (sq.metres) (12)	Country or area
77 / 68	96 / 97	0 / 0	..	..	18.2	Poland
79 / 72	117 / 115	13 / 7	..	..	..	Portugal
72 / 64	87 / 86	3 / 1	55	50	18.4	Republic of Moldova
74 / 66	86 / 87	4 / 1	..	..	..	Romania
73 / 61	95 / 91	1 / 0	..	..	17.7	Russian Federation
77 / 69	98 / 95	.. / ..	..	..	22.3	Slovakia
78 / 71	94 / 93	0 / 0	..	..	..	Slovenia
82 / 75	120 / 114	4 / 2	..	..	25.6	Spain
81 / 76	126 / 115	.. / ..	..	..	50.0	Sweden
82 / 75	97 / 100	.. / ..	..	..	..	Switzerland
75 / 71	86 / 88	.. / ..	..	..	..	The Former Yugoslav Republic of Macedonia
74 / 64	92 / 88	.. / ..	..	..	..	Ukraine
80 / 75	131 / 119	.. / ..	..	..	..	United Kingdom
76 / 70	66 / 63	.. / ..	76	69	..	Yugoslavia
						LATIN AMERICA AND THE CARIBBEAN
77 / 70	99 / 97	4 / 4	71	68	..	Argentina
77 / 71	101 / 85	4 / 5	94	82	..	Bahamas
79 / 74	*87 / 93*	.. / ..	100	100	..	Barbados
76 / 73	97 / 99	.. / ..	83	57	..	Belize
63 / 60	*73 / 81*	24 / 10	80	65	..	Bolivia
71 / 63	—94—	17 / 17	76	70	..	Brazil
78 / 72	93 / 93	5 / 5	91	..	14.4	Chile
74 / 67	89 / 87	10 / 9	85	85	..	Colombia
79 / 74	80 / 78	5 / 5	96	84	..	Costa Rica
78 / 74	96 / 93	4 / 4	93	66	..	Cuba
73 / 69	86 / 81	19 / 18	79	85	..	Dominican Republic
73 / 67	87 / 86	12 / 8	68	76	..	Ecuador
73 / 67	78 / 78	27 / 21	66	90	..	El Salvador
81 / 74	.. / ..	.. / ..	..		..	Guadeloupe
67 / 61	56 / 63	42 / 27	68	87	..	Guatemala
68 / 61	87 / 85	3 / 1	91	88	..	Guyana
56 / 51	*35 / 37*	59 / 53	37	25	..	Haiti
72 / 68	80 / 74	31 / 30	78	74	..	Honduras
77 / 73	83 / 82	11 / 20	86	89	..	Jamaica
82 / 76	.. / ..	3 / 4	..		..	Martinique
76 / 70	88 / 89	13 / 8	85	72	..	Mexico
78 / 73	.. / ..	4 / 4			..	Netherlands Antilles
71 / 66	80 / 76	37 / 37	78	85	..	Nicaragua
76 / 72	*85 / 85*	10 / 9	93	83	..	Panama
72 / 68	80 / 81	10 / 7	60	41	..	Paraguay
71 / 66	97 101	17 / 7	67	72	..	Peru
79 / 69	.. / ..	7 / 7	..	..	..	Puerto Rico

ANNEX TABLE *(continued)*

Country or area	Total population, 1999 (thousands) (1)	Access to health services, 1985-1995 (percentage) (2)	Contraceptive prevalence[a] (percentage) (3)	Underweight prevalence under 5, 1990-1998 (percentage) (4)	Maternal mortality ratio, 1990 (per 100,000 live births) (5)	Mortality rate: infant and under 5, 1995-2000 (per 1,000 live births) (6)
Suriname	415	..	..	..	..	29 / 33
Trinidad and Tobago	1,289	100	53 B	*7*	90	15 / 16
Uruguay	3,313	82	..	4	85	18 / 20
Venezuela	23,706	..	49 C	5	120	21 / 25
NORTHERN AMERICA						
Canada	30,857	..	75 A	..	6	6 / 7
United States of America	276,218	..	71 A	1	12	7 / 9
OCEANIA						
Australia [e]	18,705	..	76 B	0	9	6 / 7
Fiji	806	..	..	8	90	20 / 23
French Polynesia	231	..	..		..	11 / 14
Guam	164	..	..		..	10 / 12
New Caledonia	210	..	..	..	..	11 / 16
New Zealand	3,828	..	70 C	..	25	7 / 8
Papua New Guinea	4,702	96	26 A	..	930	61 / 84
Samoa	177	..	..	..	35	23 / 27
Solomon Islands	430	..	..	*21*	..	23 / 27
Vanuatu	186	..	..	..	280	39 / 48

Sources: See the preceding chapters for data sources for each indicator.

NOTES: Data are shown only for countries or areas with populations of 150,000 or more in 1995, as estimated by the Population Division, Department of Economic and Social Affairs. Two dots (..) indicate that data are not available. An em dash (–) indicates the amount is nil or negligible. Numbers in italics indicate the value pertains to a year in the range of 1985-1990.

[a] Letters next to the numbers for contraceptive prevalence indicate reference years. A refers to 1990 or later; B, 1985-1989; C, 1975-1984.

[b] Including Agalega, Rodrigues and Saint Brandon.

[c] For statistical purposes, the data for China do not include Hong Kong Special Administrative Region (Hong Kong SAR).

[d] As of 1 July 1997, Hong Kong became a Special Administrative Region (SAR) of China.

[e] Including Christmas Island, Cocos (Keeling) Islands and Norfolk Island.

Life expectancy, female/male, 1995-2000 (years) (7)	School enrolment ratio (primary & secondary) female/male, 1990-1996 (percentage) (8)	Adult llliteracy rate, female/male, 1995 (percentage) (9)	Population with access to Safe water, 1990-1998 (percentage) (10)	Population with access to Sanitation, 1990-1998 (percentage) (11)	Floor area per person, 1990-1995 (sq.metres) (12)	Country or area
73 / 68	.. / ..	9 / 5	..	..	..	Suriname
76 / 72	88 / 87	3 / 1	97	79	..	Trinidad and Tobago
78 / 70	99 / 92	2 / 3	..		..	Uruguay
76 / 70	85 / 80	9 / 8	79	59	..	Venezuela
						NORTHERN AMERICA
82 / 76	103 / 104	.. / ..	..	..	..	Canada
80 / 73	99 / 100	.. / ..	..	..	..	United States of America
						OCEANIA
81 / 76	122 / 123	.. / ..	..	..	..	Australia
75 / 71	98 / 97	11 / 7	77	92	..	Fiji
75 / 69	103 / 95	/	..	..	..	French Polynesia
77 / 73	/ ..	/		..	..	Guam
76 / 69	102 / 99	.. / ..		..	..	New Caledonia
80 / 74	108 / 105	.. / ..	97	..	..	New Zealand
59 / 57	45 / 54	37 / 19	41	83	..	Papua New Guinea
74 / 69	87 / 86	.. / ..	68	..	..	Samoa
74 / 70	58 / 69	.. / ..	..	..	..	Solomon Islands
70 / 66	58 / 64	.. / ..	77	28	..	Vanuatu