THE PROGRESS OF NATIONS 1999

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The day will come
when nations will be judged
not by their military or economic strength,
nor by the splendour of their capital
cities and public buildings,
but by the well-being of their peoples:
by their levels of health, nutrition and education;
by their opportunities to earn a fair reward for their
labours; by their ability to participate in the
decisions that affect their lives; by the respect that is
shown for their civil and political liberties;
by the provision that is made for those who are
vulnerable and disadvantaged;
and by the protection that is afforded to the
growing minds and bodies of their children.
The Progress of Nations, published annually
by the United Nations Children's Fund, is
a contribution towards that day.

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Foreword

Nearly a decade ago, leaders and representatives from more than 150 countries, gathered at the World Summit for Children, set out a number of ambitious global goals for children and development for the 1990s. It would have been all too easy for these goals to have remained an eloquent statement of good intentions. They became, instead, a practical blueprint for action and, together with the Convention on the Rights of the Child, they have placed children at the centre of the world's development and human rights concerns.

Many countries can point to significant gains made during this decade towards achieving the World Summit goals and upholding children's rights: young lives saved by improved health and nutrition, children protected from hazardous and exploitative labour, futures transformed by the opportunity to attend school. In other cases, however, conflicts, debt, economic crises and mistaken priorities have taken a terrible toll on children, who always pay a high price for the failures of adults.

The Progress of Nations plays an essential role in monitoring global advances towards the goals set in 1990 as well as in recording the setbacks. This year's edition documents the devastating impact of HIV/AIDS on children, while celebrating the enormous strides that have brought the world so close to the eradication of polio. In 1999, the world will welcome the 6 billionth member of our human family. *The Progress of Nations* uses the occasion of this landmark birth as a lens through which to examine the widely divergent prospects that await this child – and indeed all children – on the eve of the millennium. The report's final commentary spotlights the need to lift the catastrophic burden that debt imposes on children and families in some of the poorest countries on earth.

The Progress of Nations 1999 not only provides new and valuable data on vital issues affecting children, but it also helps governments, international organizations and non-governmental organizations focus their priorities more effectively towards attaining the World Summit goals and upholding all children's rights.

Kofi A. Annan
Secretary-General
United Nations

THE ROLL OF THE DICE

COMMENTARY: THE 6 BILLIONTH BABY

UNICEF/Zambia/Pirozzi

The roll of the dice

By Carol Bellamy

During this final year of the 20th century, a child will be born, bringing the world's population to 6 billion. What lies ahead for this 6 billionth baby, no one can say. But for the majority of babies, the risks are high and the odds daunting. Half the world's poor are children. Early death from preventable disease, illiteracy or traumatic conflict often awaits them. For the 6 billionth child and for all children, the odds can and should be better.

Somewhere on the planet this year, a mother will give birth to a very special child.

All babies are special, of course – and in that sense, the child will be no different from the 130 million other new lives that start in 1999, on the very doorstep of the millennium. But this baby's birth will mark the instant that the world's human population reaches 6 billion.

No one knows when or where the baby will arrive. It could be a girl or a boy, the child of a millionaire or – far more likely – the child of a family living on less than a dollar a day. But regardless of where the infant draws its first breath, it will be endowed with the same fundamental human rights as any other child – to life, to protection, to education, to health care, to an adequate standard of living and more.

There is a catch, however. The child's chances of enjoying these birthrights, and of fulfilling his or her potential, will depend on where this baby is born and to whom – and whether it is a girl or a boy.

The odds are not in the child's favour.

Facing the odds

In fact, the 6 billionth baby has less than 1 chance in 10 of being born into relative prosperity, as a member of the majority in an industrialized country or of the wealthy minority in a developing one. On the other hand, the child has 3 chances in 10 of being born into extreme poverty – and 4 in 10 of being only marginally better off.

Half the world's poor are children, and more babies are being born into poverty now than ever before. Never in history have we seen such numbers.

Far less likely, the roll of the dice will bring the baby into a universe almost unimaginably rich in resources. Her horizons will stretch as wide as the world itself. At the flick of a switch, energy accumulated over eons in the earth's crust will provide the child with an extraordinary array of services and conveniences.

With the tap of a computer key, the accumulated knowledge of the world's libraries can be at her fingertips. At a very young age, she will be able to exchange messages, play games and make friends with children thousands of miles away.

Meanwhile, advances in medical science are rapidly increasing the prospects for human longevity. If present trends continue, it is estimated that some 70,000 children who are born in the United States in the first year of the 21st century will be around to see the dawning of the 22nd.

But along with technological advances and material prosperity, it is possible that social isolation and emotional insecurity may lie in her future. Divorce rates are increasing, overwork blights family life, human contact shrinks and the young, increasingly alienated, are treated more as consumers than as children.

At least this 6 billionth child, if born in the developing world, will probably not be isolated or lack human contact. In the village or shanty town most likely to be home, there will be plenty of children to play with, and plenty of relatives and neighbours to take an interest. The child will also, in most cases, be brought up in a religion that will provide spiritual strength.

Yet, while this life may be rich in people, it will be desperately poor in material resources. Energy is likely to be scarce – and if the 6 billionth child is a girl, she will most likely have to trudge miles a day to collect fuel.

And if the child gets and retains a place in class, her school may lack sufficient pencils, let alone books, for her to use.

With half the children of Africa already suffering from illness caused by unsafe drinking water, poor sanitation and a degraded environment, it is almost certain that constant bouts of preventable diseases will sap the child's overall health. His physical and mental development are likely to be stunted by malnutrition, making it unlikely that the 6 billionth child will ever reach his full potential – in fact he may have a shorter lifespan ahead of him than 1999 global standards suggest. A baby born in Malawi or Uganda, for example, is likely to live only half as long as one born in Singapore or Sweden. And reaching her fifth birthday is far from a certainty: One child in three born in countries such as Niger or Sierra Leone, for example, perishes before that milestone.

Carol Bellamy is Executive Director of UNICEF.

COMMENTARY: THE 6 BILLIONTH BABY

The 6 billionth child will also find himself in a world where the gap between rich and poor has never been so wide. The richest one fifth of humanity has 82 times the income of the poorest fifth – and consumes 86 per cent of the world's resources.

The material gap

These gaps do not just exist among nations, but also within them: The disparities cleave countries, even cities. A child born in an urban shanty town in Bangladesh is twice as likely to die before his first birthday as is an infant born elsewhere in the city. In many developing countries, the children of the relatively well-off benefit from publicly supported secondary and university education, while the poor lack even primary schools.

And huge disparities exist within industrialized countries as well. In Australia and the United Kingdom, for example, the richest one fifth have 10 times the wealth of the poorest.

Despite such inequities, if this child were assured of attaining her rights, she might be ready to take her chances regardless of where she was born. Unfortunately, there is no such guarantee, especially for most poor children. The vital statistics of the destitution they face are no less appalling for all their familiarity.

Every year, nearly 12 million children under the age of five die needlessly, mainly from a handful of easily preventable childhood diseases.

More than half of all South Asian children of this age are severely or moderately underweight, while nearly half of all under-ones in sub-Saharan Africa are not immunized against common killer diseases.

Worldwide, 130 million children of primary school age – mostly girls – are not in the classroom, and thus denied the chance of a better future, while millions attend schools where little learning actually takes place.

One quarter of children in developing countries who start school cannot stay long enough to ensure lasting literacy. And 250 million are being robbed of their childhood because they are trapped in child labour.

The 6 billionth child will be particularly disadvantaged if she is born into a minority ethnic group – a category that includes two thirds of the poorest children in the United States, for example. In Peru, indigenous people are one-and-a-half times more likely to be poor and almost three times more likely to be *extremely* poor than non-indigenous people.

The gender gap

If the baby is a girl, she will also be worse off than a boy born almost anywhere.

She may receive less than her brother when food is scarce, and she will be less likely to start school. If she is put in school, she will have a greater chance than her brother of being taken out, either to save her family the cost of schooling or because she is needed to work at home.

Like 2 million other girls each year, the 6 billionth child may suffer the pain and humiliation of genital mutilation. Or, as in some cultures, she will be brought up to believe that she does not belong at home but to the family of some as yet unknown husband. Married off in her early teens, she will probably be pregnant before her body is fully ready to carry a child, becoming a mother before she is a woman.

If the baby is a girl, she will be worse off than a boy born almost anywhere.

The results can be devastating. More than half of all women in Africa and about a third in Latin America give birth in their teens, and they are twice as likely as adults to die in childbirth – and their children are more likely to be born underweight.

From mother to child

In fact, the 6 billionth baby's future may well be written in his mother's and grandmother's pasts, for the consequences of deprivation are handed down through the generations like a hereditary disease.

Low birthweight is a clear example, a sensitive indicator of the health of both mother and baby, and one of the prime signs of a troubled life ahead for a child. About one in every five babies in developing countries starts life at less than 2.5 kg, mainly because of the mother's poor nutritional status. A low-birthweight baby is more likely to die in infancy or early childhood. If the infant survives, he is likely to suffer more illnesses, to be malnourished, to fail to reach his physical and intellectual potential and to have long-term disabilities. Increasing evidence

UNICEF/95-0040/Maass

Only about 10 per cent of today's children – those among the majority in industrialized countries or wealthy minorities in developing countries – have a chance to grow up with computers at their fingertips. Two boys view a computer at the World Summit for Social Development, held in Copenhagen.

shows that a low-birthweight child will be prone to diabetes, hypertension and heart disease in adulthood.

Nearly 4 in every 10 children under the age of five in developing countries are stunted, their stature a symbol of their diminished potential. Because their capacity for learning is also reduced, they do less well at school, and later in life their productivity and earnings are generally lower than those of their better-nourished peers. And, like all malnourished children, they are more susceptible to disease.

Anything that improves the prospects for children's well-being improves the prospects for the world.

Malnutrition makes children more likely to fall ill, and illness deepens their malnutrition; hunger and disease feed off each other in a constant downward spiral. The wreckage of ruined lives and wasted bodies represents a denial of human rights as abhorrent as torture – and a devastating handicap for a country's economic development.

Still another unexpected assault may await the 6 billionth baby: She may well lose her mother at birth. Every minute, a woman somewhere dies from pregnancy-related causes or in childbirth – almost 600,000 a year. Nearly all of these deaths occur in developing countries. More than 1 million children are orphaned in this way each year, and they are more likely to die within a few years than those whose mothers survive.

As with all children, much of the 6 billionth baby's future will be decided by the time he is two years old, the age by which his physical and mental development will have been largely set in accordance with a range of factors, including the quality of food, health care and stimulation he receives.

Much will depend on whether the child is breastfed, because exclusive breastfeeding for the first six months greatly enhances a child's prospects of surviving and thriving, and speeds cognitive development.

The 6 billionth baby's future will also be much brighter if her mother has received some education. The child will be less likely to die in infancy, will grow up healthier and better fed and will be more likely to start and to stay in school. Indeed, increased schooling for girls sends benefits cascading through societies and economies. As more girls are educated, and for longer periods, their confidence and empowerment will rise, and infant mortality and population growth will fall – all of this a boon to life expectancy and overall economic growth.

In short, anything that improves the prospects for children's well-being improves the prospects for the world.

Child rights are better recognized today than ever before, as evidenced by the nearly universal embrace of the Convention on the Rights of the Child, which has been ratified by every country in the world save two. And child rights and concerns are now higher on many public agendas than ever before.

By acting now, as a matter of urgency, to secure these rights, we can all help improve the odds for the 6 billionth baby – and *all* the rest of the world's children.

But the clock is ticking. Before we know it, some 12 years from now, the dice will roll again for the 7 billionth baby. ■

UNICEF/93-0627/Isaac

Half the world's poor are children, and more babies are being born into poverty than ever before. In Cambodia, where the GNP per capita is less than $1 a day, a girl carries her baby sibling.

LEAGUE TABLE: THE CHILD RISK MEASURE

This child risk measure is a new, and admittedly unfinished, idea, sparked by some of the issues presented in the essay on the birth of the world's 6 billionth child. The measure's merits and failings were scrutinized and debated during its preparation. It does not, for instance, incorporate a number of important risks that children face in industrialized countries – such as latchkey loneliness or alienation – because indicators do not exist for them. But despite its weaknesses, UNICEF puts this measure forward in order to launch an idea and a discussion. The world could well benefit from an improved approach to measuring children's welfare, one that reflects new knowledge about how children develop and that captures some of the most important new hazards children face. This attempt is offered as a step in that direction.

Measuring children's risks

For all children, entering this world entails risks, with the chance of full and healthful development dependent on a range of factors and sometimes, it seems, fate. The child risk measure (CRM) at right is an attempt to capture in numbers some of the risks a child faces until the age of 18. In this index, higher numbers represent greater risk. Using this gauge, a child faces the highest risk, an average of 61, in sub-Saharan Africa. A child in Europe faces the lowest, at 6.

The CRM, still a work in progress, was designed as a composite of five factors which have great impact on a child's well-being. The three developmental factors are under-five mortality, moderate or severe underweight and primary schooling. The other two are the likelihood of risk from armed conflict and from HIV/AIDS, increasingly important influences on a child's rights and well-being.

Conflict affects children of all ages directly, putting them in immediate danger, and indirectly, by depriving them of health care, education or even food. Where adult HIV/AIDS prevalence rates are high, children are at risk not just of acquiring the infection from their mothers, but also of suffering the loss of one or both parents, depriving that child of protection and support.

A number of factors that adversely affect adolescent development, such as child labour, sexual exploitation and lack of family support, do not form a part of this composite. This is due to a lack of data in many countries on these issues.

SUB-SAHARAN AFRICA

Angola	96
Sierra Leone	95
Somalia	92
Ethiopia	85
Guinea-Bissau	80
Niger	80
Congo, Dem. Rep.	76
Burundi	74
Eritrea	74
Liberia	74
Rwanda	70
Guinea	69
Chad	67
Mali	64
Mozambique	63
Central African Rep.	62
▶ *Regional average*	*61*
Burkina Faso	60
Nigeria	59
Zambia	58
Uganda	57
Malawi	55
Tanzania	53
Congo	51
Côte d'Ivoire	51
Madagascar	49
Zimbabwe	48
Cameroon	47
Kenya	46
Lesotho	46
Togo	46
Benin	45
Mauritania	45
Botswana	42
Namibia	42
Senegal	38
Ghana	36
Gambia	35
Gabon	32
South Africa	25
Mauritius	11

MIDDLE EAST AND NORTH AFRICA

Sudan	59
Yemen	49
Iraq	39
Algeria	26
▶ *Regional average*	*24*
Kuwait	24
Saudi Arabia	24
Egypt	21
Morocco	21
Lebanon	18
Iran	17
Oman	17
U. Arab Emirates	16
Turkey	15
Syria	13
Jordan	11
Tunisia	8
Libya	6
Israel	No data

The child risk measure (CRM) is based on the following five indicators:

U5MR – under-five mortality rate in 1997;

UNDWT – per cent of children moderately or severely underweight (period 1987–98);

NAPSCH – per cent of primary school age children not attending school (period 1987–97);

CONFLICT – security rating derived for 1998 from UNICEF Security Advisory;

HIVAIDS – HIV/AIDS prevalence rate for 15- to 49-year-olds, in 1997.

CENTRAL ASIA

Afghanistan	94
▶ *Regional average*	*41*
Georgia	27
Azerbaijan	24
Uzbekistan	23
Turkmenistan	21
Kyrgyzstan	13
Kazakhstan	12
Armenia	No data
Tajikistan	No data

EAST/SOUTH ASIA AND PACIFIC

Cambodia	60
Papua New Guinea	55
Korea, Dem.	50
Pakistan	49
Bangladesh	47
Bhutan	46
India	45
Myanmar	44
Nepal	44
Lao PDR	42
Sri Lanka	39
Indonesia	34
▶ *Regional average*	*31*
Viet Nam	31
Mongolia	25
Philippines	24
Thailand	22
Malaysia	14
China	13
Korea, Rep.	5
Australia	<5
Japan	<5
New Zealand	<5
Singapore	<5

Note: < = less than.

AMERICAS

Haiti	47
Guatemala	33
El Salvador	22
Nicaragua	22
Bolivia	21
Peru	19
Honduras	18
Colombia	16
Dominican Rep.	16
Venezuela	16
Ecuador	13
Mexico	11
▶ *Regional average*	*10*
Trinidad/Tobago	10
Panama	9
Brazil	8
Chile	8
Jamaica	8
Paraguay	8
Cuba	6
Uruguay	6
Argentina	5
Canada	<5
Costa Rica	<5
United States	<5

EUROPE

Yugoslavia	29
Albania	17
Belarus	11
Russian Fed.	11
TFYR Macedonia*	11
Croatia	10
Estonia	10
Czech Rep.	8
Latvia	8
Bulgaria	7
▶ *Regional average*	*6*
Greece	6
Romania	6
Austria	<5
Belgium	<5
Denmark	<5
Finland	<5
France	<5
Germany	<5
Hungary	<5
Ireland	<5
Italy	<5
Netherlands	<5
Norway	<5
Poland	<5
Portugal	<5
Slovenia	<5
Spain	<5
Sweden	<5
Switzerland	<5
United Kingdom	<5
Bosnia/Herzegovina	No data
Lithuania	No data
Moldova, Rep.	No data
Slovakia	No data
Ukraine	No data

* The former Yugoslav Republic of Macedonia, subsequently referred to as TFYR Macedonia.

Source: UNICEF.

The child risk measure

Indicators are transformed to a 0 to 100 scale before calculation of the CRM according to the following equation:

CRM = (U5MR + UNDWT + NAPSCH)/3 + CONFLICT/4 + HIVAIDS/4

The CRM is limited by availability of data. But it is also affected by the quality and timeliness of data. Taking the Congo as an example, its U5MR is a projection based on 1974 census data. If its current under-five mortality were in actuality the same as its neighbour, the Democratic Republic of the Congo, its CRM would change from 51 to 65.

The measure's composition is an important – and perhaps controversial – factor. If, for example, child mortality had been given twice the weight of the other two development indicators, the largest changes in the CRM would be found in the Democratic People's Republic of Korea (from 50 to 36), Sierra Leone (95 to 103) and Sri Lanka (39 to 31). All other countries would change by 6 points or less, with most countries changing by only 1 point or less.

Differences of 5 points or less between countries' risk measures are not considered significant. For this reason, countries with CRM values of less than 5 have been noted as '<5' in the league table.

Child mortality, underweight and primary schooling indicators, measured in the recent past, are strongly related to their values now and in the near future, provided that violent upheavals – such as armed conflict and the AIDS epidemic – do not occur. With the inclusion of the last two factors, the CRM more fully reflects child risk both now and over the next few years.

Rural/urban nutrition gaps identified

The prevalence of stunting or low height for age is consistently higher in rural areas than urban areas, according to data from 68 developing countries. Rates of stunting among rural children in these countries are, on average, more than 1.5 times higher than among urban children. In 36 countries, rural rates are from 1.5 to 4.3 times more than urban rates.

The rural/urban gap is greatest in China, followed by Viet Nam, Kazakhstan and Peru; 6 of the 12 countries with the highest rural/urban stunting disparities are in Latin America and the Caribbean.

These findings spotlight the urgent need to address these disparities and to ensure that all children's and women's right to adequate nutrition is fulfilled.

Stunting is a critical indicator of child malnutrition, and malnutrition plays a major role in more than half of all child deaths in developing countries.

Stunting often begins in the womb as a result of maternal malnutrition, which also leads to low-weight births. Low-birthweight babies are much more likely to die in the first month of life than babies of normal weight, and those who survive are likely to be stunted for the rest of their lives.

Long-term reduction in dietary intake and repeated episodes of illness cause stunting, and these are most damaging during the first two years of life. Since the brain is the most rapidly growing organ at this time, children who are stunted may also suffer reduced cognitive development and learning ability. In the Philippines, for example, children stunted before six months of age scored significantly lower on intelligence tests at 8 and 11 years of age than children who were not stunted. Stunting is also associated with diminished work capacity and increased risk of degenerative diseases in adulthood.

UNICEF/97-0518/Vauclair

Stunting's impact: Two 12-year-olds in Bangladesh. The line on the wall shows the normal height for that age.

Women who are stunted are more likely to experience obstructed labour and face a greater risk of dying in childbirth. If they live, they will more likely give birth to low-birthweight infants, continuing the impact of stunting over generations.

The rural/urban disparities are of particular concern because, overall, rates of stunting in the developing world have declined.

Nearly half of under-fives in developing countries were moderately or severely stunted during the 1980s; during the 1990s, the rate has declined to 38%, although seven countries have national rates of 50% or more: Afghanistan, Angola, Bangladesh, Cambodia, Guatemala, India and Pakistan.

While there is no single formula for improving nutrition, certain elements are essential. Eliminating discrimination against women and girls is vital, including ensuring access to education for girls. Sustained national economic growth is associated with improved nutrition, though not a necessary condition for it.

In countries such as Oman and Tanzania, the 'triple A' approach has helped rural communities *assess* nutritional problems, *analyse* their causes and initiate *actions* to improve nutrition. Targeted investment in basic social services can also help reduce disparities.

Differences in stunting

	Percentage of children under five who are stunted		
	Rural %	Urban %	Rural/urban ratio
China	39	9	**4.3**
Viet Nam	47	15	**3.1**
Kazakhstan	22	8	**2.8**
Peru	40	16	**2.5**
Brazil	19	8	**2.4**
Morocco	28	13	**2.2**
Paraguay	22	10	**2.2**
Tunisia	33	15	**2.2**
Dominican Rep.	15	7	**2.1**
Iran	25	12	**2.1**
Nicaragua	33	16	**2.1**
Bolivia	38	19	**2.0**
Congo, Dem. Rep.	52	28	**1.9**
Côte d'Ivoire	29	15	**1.9**
Ghana	30	16	**1.9**
Cameroon	30	17	**1.8**
Azerbaijan	29	17	**1.7**
Guinea	33	20	**1.7**
South Africa	27	16	**1.7**
Sri Lanka	19	11	**1.7**
Sudan	39	23	**1.7**
Turkey	27	16	**1.7**
Uganda	40	23	**1.7**
Botswana	34	21	**1.6**
Burkina Faso	31	19	**1.6**
El Salvador	28	17	**1.6**
Guatemala	57	35	**1.6**
Niger	42	27	**1.6**
Colombia	19	13	**1.5**
Haiti	35	24	**1.5**
Honduras	46	30	**1.5**
Malawi	50	34	**1.5**
Mali	33	22	**1.5**
Senegal	26	17	**1.5**
Yemen	44	29	**1.5**
Zambia	49	33	**1.5**

Sources: DHS, MICS and other national surveys, 1990–98.

Fertility rates falling worldwide

Fertility rates – the average number of live births per woman during her childbearing years – have been falling steeply around the world, a trend promising improved well-being among women and children.

A global review shows that in 33 countries, rates have been at least halved since 1970. In China, the Democratic People's Republic of Korea, Kuwait, Mongolia, Thailand and Tunisia, rates have declined by 60% or more. In Thailand, where the decline was the greatest, a woman had, on average, 5.6 children in 1970, but only 1.8 children in 1997.

Among industrialized countries, Ireland's fall in fertility was the largest, to 1.9 children in 1997, down from 3.9 in 1970. Italy and Spain have the lowest rates in the world, each with 1.2 children in 1997.

In this decade alone, fertility rates in 12 countries have fallen by an average of one or more children per woman. The biggest drop has been in Iran, where women now have 2 fewer children, on average, than in 1990. Fertility remains high, however, in 19 countries where women have, on average, 6 or more children; in Somalia, Uganda and Yemen, the average is more than 7 children.

Declines in the '90s

	Average number of births per woman 1990	Average number of births per woman 1997	Decrease by one child or more 1990–97
Iran	4.9	2.9	–2.0
Syria	5.7	4.1	–1.6
Kenya	6.1	4.6	–1.5
Mongolia	4.1	2.7	–1.4
Bangladesh	4.3	3.1	–1.2
Côte d'Ivoire	6.3	5.2	–1.1
Libya	4.9	3.8	–1.1
Oman	7.0	5.9	–1.1
Viet Nam	3.8	2.7	–1.1
Zimbabwe	5.0	3.9	–1.1
Haiti	5.4	4.4	–1.0
Tunisia	3.6	2.6	–1.0

Source: UN Population Division, *World Population Prospects: The 1998 Revision*, New York, 1998.

Exclusive breastfeeding gains*

More infants are gaining the irreplaceable benefits of exclusive breastfeeding during their first four months, according to data from 35 developing countries. Rates have increased in the 21 countries listed. Iran achieved the highest average annual increase in breastfeeding, 6 percentage points, followed by Brazil and Zambia. Breastfeeding rates have declined in Colombia, Jordan, Kenya, Kyrgyzstan, Morocco and Tunisia.

Breastfeeding gains stem from initiatives to publicize the benefits to both mother and child and to prohibit the advertising and promotion of breastmilk substitutes, feeding bottles and teats. Information activities, the training of health professionals and promotion of government policies on breastfeeding benefits have all played a role. In many countries, the Baby-Friendly Hospital Initiative – which aims to bring maternity ward practices into line with the 'Ten Steps to Successful Breastfeeding' drawn up by UNICEF and WHO – has proved effective. The number of hospitals worldwide implementing the initiative has risen from 900 in 1994 to nearly 15,000 today.

UNICEF and WHO emphasize that most babies do not need anything but breastmilk for the first six months. Breastmilk is the ideal nourishment, and breastfeeding saves the lives of 1.5 million infants each year, preventing commonly fatal diarrhoeal dehydration, respiratory infections and other ailments.

Women urgently need voluntary and confidential testing and counselling services to help deal with the cruel dilemma of HIV/AIDS as it relates to breastfeeding. Baby-Friendly Hospitals are an appropriate place, particularly in sub-Saharan Africa, to offer this support.

*Please refer to box on 'HIV and infant feeding', page 25.

UNICEF/93-1057/Toutounji

A Lebanese mother breastfeeds her newborn.

Breastfeeding on the rise

	Survey dates	% exclusively* breastfed at most recent survey	Percentage pt. increase per year
Iran	'95 & '97	66	6
Brazil	'86 & '96	42	4
Zambia	'92 & '96	27	4
Burkina Faso	'93 & '96	12	3
Egypt	'91 & '96	53	3
Madagascar	'92 & '97	61	3
Malawi	'92 & '95	11	3
Nicaragua	'92 & '98	30	3
Peru	'86 & '96	63	3
Philippines	'93 & '98	47	3
Ghana	'88 & '95	19	2
Sri Lanka	'87 & '93	24	2
Tanzania	'92 & '96	41	2
Yemen	'92 & '97	25	2
Cameroon	'91 & '98	15	1
Dominican Rep.	'86 & '96	25	1
Indonesia	'87 & '97	53	1
Mali	'87 & '96	13	1
Senegal	'86 & '97	16	1
Togo	'88 & '98	15	1
Zimbabwe	'89 & '94	16	1

*Babies up to 4 months.

Sources: DHS, MICS and other national surveys.

No place for children

Some 300,000 children and young people are estimated to be involved in wars at present, killing and dying for causes that they may barely understand. The actual numbers and age range of these children are unknown since such data is either not kept or not disclosed by the governments or armed groups in conflict situations. What is clear is that, despite the large and growing body of opinion that combat is no place for children of any age, children continue to be sacrificed in this way.

Official minimums

Ages of child recruitment into state forces

Age 15
Iraq
Japan*
Lao PDR**

Age 16
Bangladesh
Belgium
Bhutan
Burundi
Canada
Chile
Colombia
Cuba**
Dominican Rep.*
El Salvador
Germany***
Iran****
Mauritania
Mexico
Peru
United Kingdom

Age 17
Australia
Austria
Bolivia*
Brazil
Croatia
Estonia**
Finland
France
Germany
Honduras
India
Indonesia
Ireland
Israel
Italy
Jordan
Korea, Rep.
Libya
Luxembourg
Netherlands
New Zealand
Nicaragua
Norway
Portugal
Qatar
Rwanda
United States
Yugoslavia

Unofficial minimums

Ages at which children have been reliably reported as serving in state or pro-state forces

Age 8
Sierra Leone*****

Age 12
Chad
Liberia*****

Age 13
Uganda

Age 14
Angola**
Burundi
Somalia

Age 15
Congo*****
Congo, Dem. Rep.
Paraguay
Rwanda

Age 16
Ethiopia

Age 17
Algeria*****
Sudan*****
Togo
Zambia

Note: In both lists, children are volunteers unless otherwise indicated. Lists are not comprehensive.

* Military school.
** Conscripts.
*** Border guards.
**** Youth organization.
***** Paramilitary.

Sources: Coalition to Stop the Use of Child Soldiers, May 1999; UNICEF, unpublished data, December 1998.

Some data do exist on a far less horrific but nevertheless disturbing phenomenon related to youth involvement in the military. Surveys show that young volunteers below the age of 18 are accepted into the state armed forces or paramilitary groups in at least 62 countries. The data, even though limited, show that some form of military training or service for children is quite widely accepted.

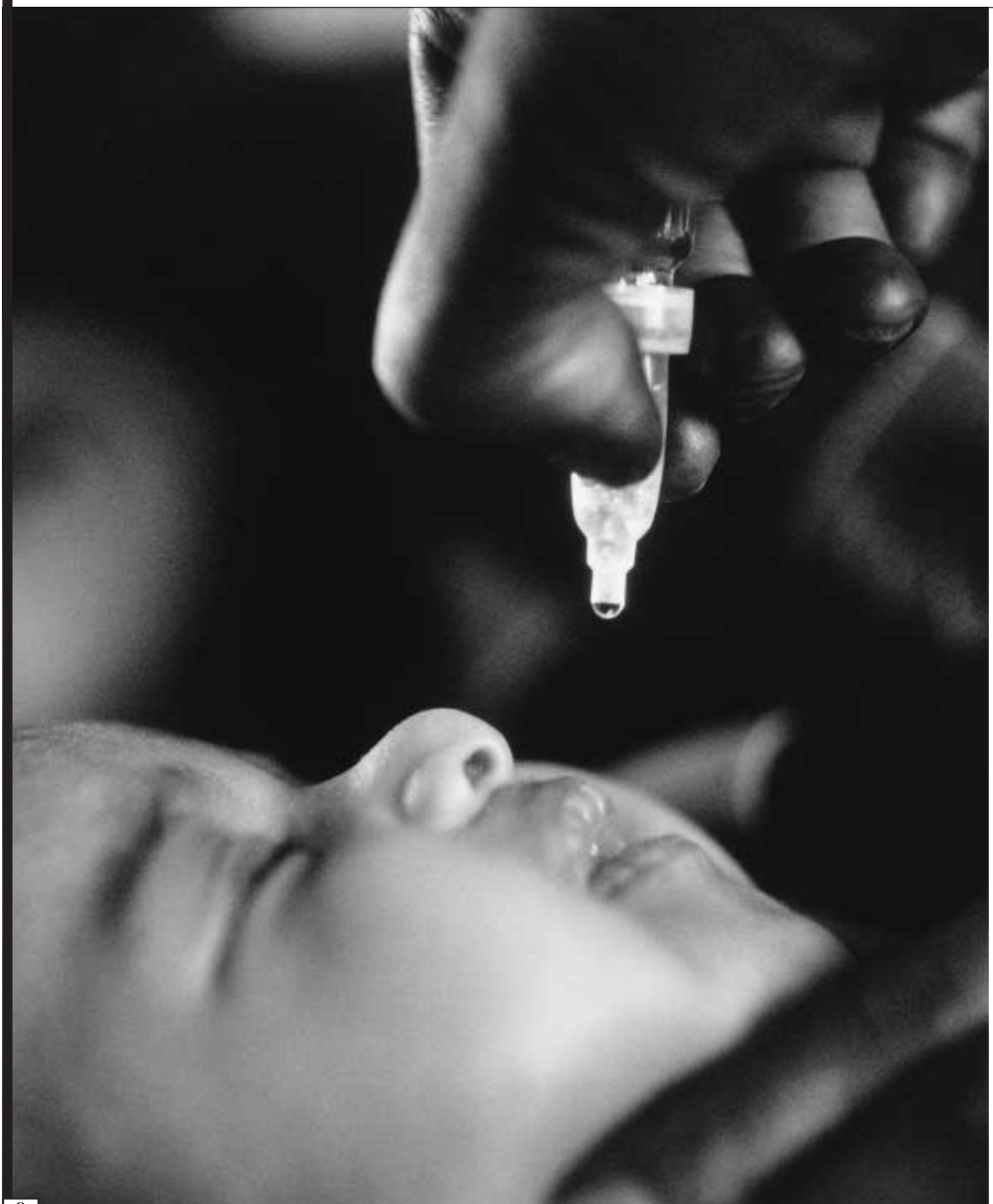
The Convention on the Rights of the Child, which defines a child as a person below the age of 18, makes an exception for military service, citing 15 as the minimum permissible age. However, the Convention goes on to recommend that those States that do permit children below 18 to serve should make it a priority to recruit those closer to 18.

Now, an Optional Protocol to the Convention on the Rights of the Child, proposed by the Committee on the Rights of the Child, is being drafted to raise the minimum age of military service from 15 to 18 years.

Having 15 as the minimum age of recruitment not only exposes children to the horrors of war but also jeopardizes those younger than 15, particularly in countries where birth registration – and thus official proof of age – is not universal.

A PRICELESS LEGACY

COMMENTARY: POLIO/VITAMIN A



UNICEF/91-0918/Lemoyne

A priceless legacy

By Sheikh Hasina

The global campaign to eradicate polio and eliminate vitamin A deficiency is a remarkable story of vision and commitment and an endeavour that is tantalizingly close to complete success.

It is 3:30 in the morning, in a village in Monirumpur in the western part of my country – Bangladesh. The first call to prayer is yet to break the sombre silence of the night. Outside, it is pitch-black and there is no electricity. But on this special day, health workers and volunteers are already in the health complex, hard at work by the light of candles and lanterns.

They rapidly pack carrier boxes with vials and load them onto rickshaw vans; as day breaks, dozens of them pedal off, ringing their bells. They are headed for designated vaccination sites in villages, offices, public squares, bus stops and ferry ports, where mothers are already gathering with their children.

The scene set and actors in place, an amazing public health drama plays out throughout the day, time after time and child after child: Volunteers methodically administer two drops of liquid and squeeze the contents of a capsule into a small mouth.

The liquid is oral polio vaccine, and the capsule contains vitamin A. When the activities in Monirumpur and in thousands of other communities throughout Bangladesh ended, nearly 90 per cent of all under-fives in the country had been immunized against polio *and* protected from vitamin A deficiency. It was another extraordinary – and routine – National Immunization Day (NID).

These Days have galvanized the nation, drawing people from virtually every stratum of society. Volunteers are the backbone: 600,000 volunteers made our last NID possible, and many of them had participated in previous NIDs over the years, for the sake of the country's children.

Each Day is meticulously arranged and requires determination and hard work. Advocacy and planning meetings are held at all levels, from the national to the local, where volunteers are mobilized and people motivated to have their children vaccinated. Radio and television networks broadcast discussions and interviews. Newspapers put out special supplements with messages from political and social leaders in our country, such as the President and myself. Posters, leaflets, stickers, billboard messages and banners are distributed – and local folk singers are particularly effective in letting people know where and when to bring their children for vaccination.

NIDs and other health interventions are credited with saving the lives of more than 120,000 children every year in Bangladesh. Before we started holding NIDs in 1995, there were more than 2,000 estimated cases of polio a year in our country. Last year, according to WHO, we had 282 cases.*

The global campaign

NIDs are not unique to Bangladesh, but are part of a global effort that has brought the world remarkably close to its goal of eradicating polio by the year 2000, a priceless gift from the 20th to the 21st century.

In 1998, NIDs protected 450 million children – more than two thirds of all the world's under-fives – against polio. In 1997/98, 36 countries in Africa held NIDs and most immunized more than 80 per cent of under-fives. Some 32 million children were vaccinated in the Middle East, the Russian Federation, the Caucasus and the Central Asian republics during March through May 1999. By early 1999, virtually all countries where polio is endemic had held NIDs.

In a number of instances, exceptional efforts were made. In Tanzania and Zambia, boats and planes were used to reach villages on islands and in the mountains. In an area of Sudan the size of the United Kingdom, but with just 40 km of paved roads, bicycles were flown in for delivering vaccines. In China – where two thirds of the country's terrain is either mountain, highland or plateau – health workers carried vaccines on horseback to remote settlements.

But perhaps most remarkable and moving has been the agreement of warring parties to silence their guns – in Afghanistan, Cambodia, the Philippines and Sri Lanka – in order to allow children to be immunized.

Regionally, we in Bangladesh and our neighbours in Bhutan, India, Myanmar and Nepal have worked together to hold NIDs on the same day, for maximum impact. In India, where WHO reported 70 per cent of the world's polio cases in 1998, 127 million children were vaccinated on a single day in January 1997 and even more – 134 million – in 1998, in the largest and most spectacular health events ever organized by any country.

I would like to take this opportunity to say a few words about my country. Bangladesh is a young nation in all senses of the term, except in our tradition and heritage, which are centuries old. Bangladesh came into being as a sovereign, independent State only a little over 25 years ago.

Nearly half of our people are under the age of 18, a demographic reality that helps explain our concern for and firm com-

Her Excellency Sheikh Hasina is the Prime Minister of the People's Republic of Bangladesh.

*Only five of these were confirmed as caused by wild polio virus, which is responsible for all person-to-person transmission of the disease.

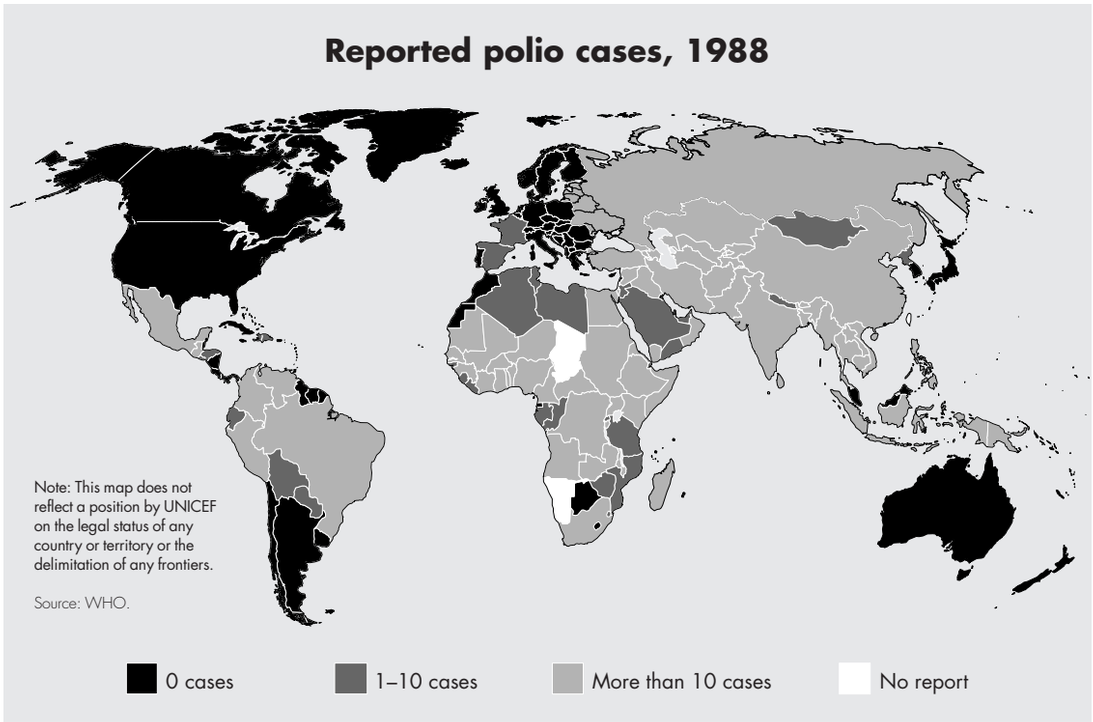
mitment to the welfare of our children, adolescents and youth, expressed at the World Summit for Children in 1990 and later reflected in our National Plan of Action. We were also among the first 20 countries to ratify the Convention on the Rights of the Child, thereby bringing it into force.

In our country, 370,000 children under the age of five still die each year, primarily from diarrhoea, acute respiratory infections, measles, neonatal tetanus and other vaccine preventable diseases. To reduce this loss, we have worked through the Expanded Programme of Immunization (EPI) to achieve a near-miraculous increase of immunization coverage for our children. Spurred by EPI, we have set up a delivery system that reaches every corner of our country, with 108,000 EPI outreach sites now being used for immunizations and for other life-saving interventions, including health education and counselling, information on oral rehydration therapy (ORT), and micronutrient supplementation.

Thus, we are working to eradicate polio and eliminate vitamin A deficiency, our two most important public health concerns. We are also waging an offensive against major childhood diseases, malnutrition – affecting more than half of our children virtually from their very first year – and micronutrient deficiency. Victory is still a long way off. But we are determined to win.

The fight against polio is global, led by WHO, in partnership with UNICEF, Rotary International, the US Centers for Disease Control and Prevention and literally thousands of groups around the world. The mass vaccination campaigns are the latest breakthrough against this elusive and ancient disease.

Polio has been known for at least 3,000 years – its immobilizing power was depicted on an ancient Egyptian engraving. It paralysed or killed about half a million people every year at its peak, before the development of a vaccine in 1955.



The disease can, thankfully, be completely eradicated, and NIDs are crucial in attaining this goal. By vaccinating all of a country's children at the same time with the oral polio vaccine, NIDs ensure that the wild virus is driven out of this large pool of hosts. This leads to its extinction, since it has no animal or insect reservoir in which to hide and can survive only briefly in the environment. It will follow smallpox, the first disease ever eradicated (in 1979, after a 12-year global campaign), into the annals of history.

But polio is a more elusive enemy than smallpox. Although it is highly infectious, polio rarely causes distinctive symptoms. Paralysis occurs in fewer than 1 per cent of cases; about 90 per cent produce virtually no symptoms at all. Some 200 people can be infected before a paralytic case finally signals an outbreak.

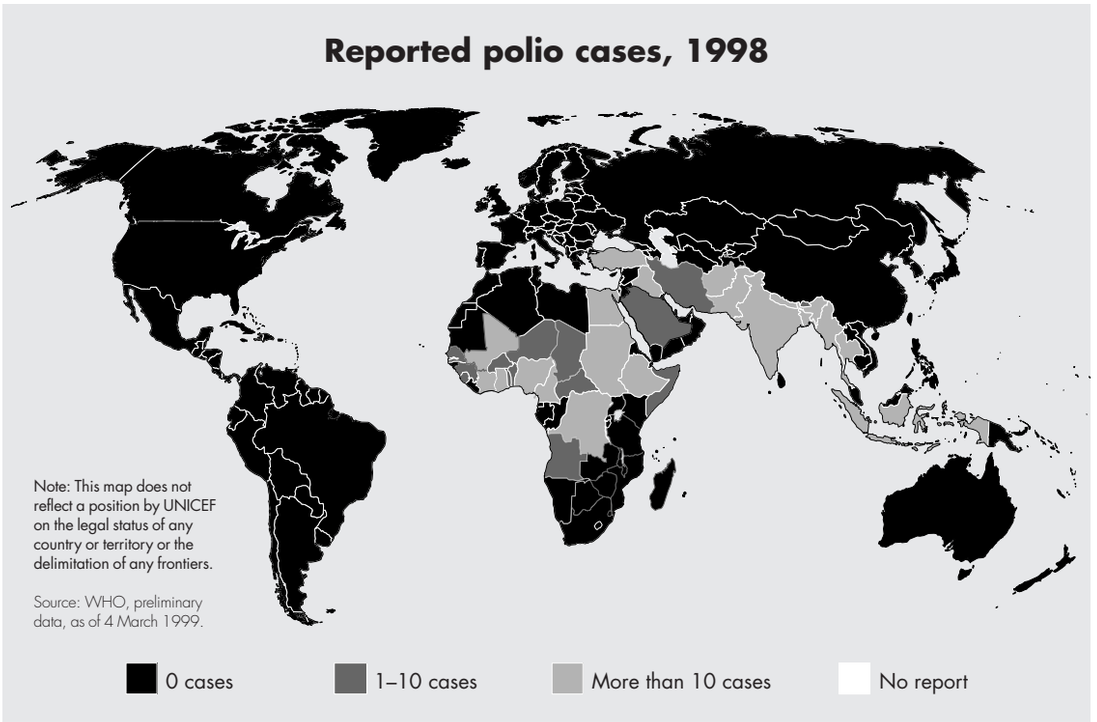
Another complicating factor is that the polio vaccine needs to be administered several times to attain adequate immunity – unlike the smallpox vaccine, which had to be given only once.

Despite these obstacles, a four-stage strategy against polio is working well. First, as many infants as possible are routinely immunized four times in their first year of life, as part of a series of vaccinations against the six major childhood diseases. Next, through NIDs, all children under five receive an additional two doses of polio vaccine, spaced about a month apart. Third, a surveillance system is set up to ensure that no polio case goes unidentified. Teams then go house-to-house to immunize every last child in areas where the virus is known or suspected to be circulating.

Routine immunization, the first stage of the strategy, has been widely embraced. By 1990, 4 out of every 5 infants worldwide were routinely immunized – up from just 1 in every 20 in the 1970s. But the proportion of the world's under-ones who are routinely vaccinated has fallen slightly in this decade (though the actual numbers have risen along with population increases), and the coverage rates in a number of countries and in specific areas remain far lower than the average. NIDs, by supplementing routine immunization, are vital in breaking this impasse.

The results speak for themselves. The number of polio cases worldwide has been cut dramatically in a decade. In 1988, according to WHO, there were an estimated 350,000, of which only 10 per cent were reported. In 1998, with improved surveillance, just over 5,000 cases were reported. North and South America have been officially certified polio-free, and in Europe, only Turkey has reported cases in the last year. Polio is rapidly disappearing from North, Southern and Eastern Africa and the Arabian Peninsula; in East Asia and the Pacific, the last case was reported in Cambodia in March 1997. Less than a decade ago, 10,000 children were paralysed in an epidemic in China; now, after a series of NIDs, no cases are reported there at all.

Polio has retreated to a few final strongholds – Afghanistan, Bangladesh, India, Nepal and



Pakistan in Asia, and Somalia, Sudan and parts of West and Central Africa. But even there, the world is winning.

We must maintain the momentum for eradication for the sake of our children. The gains have already been enormous. In all, 2 million to 3 million children worldwide are able to run, jump and play normally who – but for the campaign – would have been paralysed by polio.

As long as polio exists, the world has to spend $1.5 billion total each year to stop its spread. In the Americas, for example, more is spent to remain polio-free than is needed to eradicate the disease permanently throughout the world. We can all imagine how such resources could be better used.

Another dividend that is already benefiting children is the experience gained from NIDs in reaching children with other vital health interventions. In our case, as I have described, vitamin A is given along with the polio vaccine.

Vitamin A deficiency, which affects about 100 million children under five, impairs a child's resistance to disease and contributes to nearly a quarter of all deaths among those under five. It is also the leading cause of blindness in children in developing countries. And there is growing evidence that inadequate vitamin A in women greatly increases their risk of death in pregnancy and childbirth.

NIDs have proven to be true 'life-savers' in getting vitamin A to children in Bangladesh: Before we started having NIDs we were unable, despite our best efforts, to reach more than 55 per cent of our children. Now, over 90 per cent receive vitamin A as they are immunized.

The protection is powerful and inexpensive: A capsule costing just two US cents protects a child for up to six months.

Ending vitamin A deficiency is considered as effective in saving lives as two of the great success stories of recent years – immunization against the six major diseases and the use of ORT in treating diarrhoeal dehydration.

For much of the world, progress towards the goal of eliminating vitamin A deficiency, set at the 1990 World Summit for Children, has been good. By 1996, more than half of all young children in countries where deficiency is a public health problem were receiving vitamin A supplements, up from a third just two years before. Now, 35 countries are 'on track' to meet the goal.

Still, there is a gap that must be closed: In some countries rates of vitamin A supplementation are significantly lower than rates of polio immunization. Using NIDs to deliver both, as is done in Bangladesh and another 42 countries, is just the type of strategic advance needed now.

Indeed, both UNICEF and WHO have recommended that all countries with high under-five mortality and where vitamin A deficiency is a public health problem should combine the interventions. Supply is not an issue, since the Government of Canada is generously providing the vitamin A required.

NIDs, originally conceived as a short-term measure to finish off polio, have demonstrated an unsuspected long-term benefit. Studies show they improve cooperation between sectors of government, and that, in conducting NIDs, community organizations gain more central roles in health matters, leading to better communication with health services staff. These developments have already benefited other health programmes. And the 'culture of immunization' that NIDs helped create may also raise levels of vaccination against diseases other than polio.

All these gains can be preserved and actually extended by turning NIDs into broader Child Health Days. Such Days would be used to give vaccinations other than polio and to distribute vital micronutrients and antiworm medicines, as well as to promote mosquito nets treated with insecticide in areas where malaria is a threat. During Child Health Days, activities could be organized to promote breastfeeding, hygiene and the control of diarrhoea, and mothers and other caregivers could be informed about supplementary feeding and the psychosocial stimulation through play and interaction with adults that are vital for a child's healthy development.

The battle against polio has fired the imagination of governments worldwide and mobilized their will as few other causes have done, producing one of the greatest mass efforts in history. During its dramatic course it has also helped to pinpoint, and fill, gaps and weaknesses in existing health services; it has led to better management capacities and communications systems; it has strengthened surveillance systems for diseases; and it has inspired new ways of transporting vaccines while keeping them cool. In these ways, the polio campaign has given governments the confidence, will and capacity to tackle other major health concerns.

These victories, it is clear, need to be the beginning not the end of the story – the opening of a new chapter in ensuring the health of children all over the globe. ■

LEAGUE TABLE: VITAMIN A SUPPLEMENTATION

For want of two capsules of high-dose vitamin A – at the cost of two cents a capsule – a child might die this year from complications of measles or diarrhoea, among the most common childhood diseases. In fact, millions of young lives may be lost in the next 12 months because of vitamin A deficiency, and each death could be easily prevented.

Two potent capsules

The impact of vitamin A supplementation on reducing child mortality is comparable to – if not greater than – that of any single immunization against a childhood disease. Long known as a cause of blindness, vitamin A deficiency (VAD) has increasingly been recognized over the past decade as significantly heightening children's risk of dying from such common diseases as measles and diarrhoea. In fact, in countries where VAD is a problem, ensuring that children receive adequate vitamin A can reduce mortality by 23%.

Yet, while vitamin A supplementation ranks alongside immunization in protecting children's health, progress to ensure that children receive its benefits remains uneven, as this league table shows. One way of tackling the problem is to ensure that children with vitamin A deficiency receive a high-dose supplement twice a year.

Currently, there are 35 countries where over 80% of young children routinely receive at least one dose of vitamin A, and many of these nations are likely to reach the goal of eliminating VAD by the year 2000. But present coverage is inadequate in 44 other countries. Of these, only 29 have plans to add vitamin A supplementation to National Immunization Days (NIDs) and special campaigns in 1999.

Immunization is protecting 80% or more of children in many countries, a remarkable public health success. The challenge now is to get vitamin A – through supplementation or food fortification – to the more than 55 million children in countries around the globe who are suffering from vitamin A deficiency and who have not received any supplements.

One proven way of doing this is to build on measures and initiatives already in place. WHO and UNICEF recommend that vitamin A supplementation be included in routine immunization activities and such events as NIDs in all countries where the under-five mortality rate is greater than or equal to 70 per 1,000.

The progress made on vitamin A distribution, especially though NIDs, over the past year has been striking. It is a success story that leads us to believe that, with political will and public action, the goal set at the 1990 World Summit for Children can be reached, if not by the year 2000, soon after.

SUB-SAHARAN AFRICA	
Benin	1
Burkina Faso	1
Cameroon	1
Congo	1
Eritrea	1
Ethiopia	1
Ghana	1
Guinea	1
Liberia	1
Madagascar	1
Malawi	1
Mali	1
Mauritania	1
Namibia	1
Niger	1
Somalia	1
Tanzania	1
Togo	1
Uganda	1
Zambia	1
Angola	2
Burundi	2
Central African Rep.	2
Chad	2
Congo, Dem. Rep.	2
Côte d'Ivoire	2
Guinea-Bissau	2
Kenya	2
Lesotho	2
Mozambique	2
Nigeria	2
Rwanda	2
Sierra Leone	2
Botswana	3
Gabon	3
Gambia	3
Mauritius	3
Senegal	3
South Africa	3
Zimbabwe	3

MIDDLE EAST AND NORTH AFRICA	
Iraq	1
Oman	1
Sudan	1
Yemen	1
Iran	2
Morocco	2
Egypt	3
Algeria	4
Israel	4
Jordan	4
Kuwait	4
Lebanon	4
Libya	4
Saudi Arabia	4
Syria	4
Tunisia	4
Turkey	4
U. Arab Emirates	4

What the rankings mean

1 Good coverage achieved. Vitamin A deficiency is a public health problem and/or high under-five mortality exists. Countries have achieved high vitamin A supplementation coverage (over 80%) and are on track towards achieving the year 2000 goal of eliminating vitamin A deficiency as a public health problem.

2 Need to fulfil commitments. Vitamin A deficiency is a public health problem and/or high under-five mortality exists. Present coverage is inadequate, but these countries have made plans to add vitamin A to NIDs and special campaigns in 1999. However, unless these countries follow through on these commitments, supplementation coverage would **not** be expected to improve and the World Summit goal will not be achieved.

CENTRAL ASIA		EAST/SOUTH ASIA AND PACIFIC		AMERICAS		EUROPE	
Afghanistan	2	Bangladesh	1	Mexico	1	Albania	4
Tajikistan	3	Bhutan	1	Bolivia	2	Austria	4
Turkmenistan	3	Cambodia	1	Brazil	2	Belarus	4
Armenia	4	Lao PDR	1	Dominican Rep.	2	Belgium	4
Azerbaijan	4	Mongolia	1	Ecuador	2	Bosnia/Herzegovina	4
Georgia	4	Myanmar	1	El Salvador	2	Bulgaria	4
Kazakhstan	4	Nepal	1	Guatemala	2	Croatia	4
Kyrgyzstan	4	Philippines	1	Haiti	2	Czech Rep.	4
Uzbekistan	4	Thailand	1	Honduras	2	Denmark	4
		Viet Nam	1	Nicaragua	2	Estonia	4
		China	2	Peru	2	Finland	4
		India	2	Colombia	3	France	4
		Pakistan	2	Costa Rica	3	Germany	4
		Indonesia	3	Argentina	4	Greece	4
		Papua New Guinea	3	Canada	4	Hungary	4
		Sri Lanka	3	Chile	4	Ireland	4
		Australia	4	Cuba	4	Italy	4
		Japan	4	Jamaica	4	Latvia	4
		Korea, Dem.	4	Panama	4	Lithuania	4
		Korea, Rep.	4	Paraguay	4	Moldova, Rep.	4
		Malaysia	4	Trinidad/Tobago	4	Netherlands	4
		New Zealand	4	United States	4	Norway	4
		Singapore	4	Uruguay	4	Poland	4
				Venezuela	4	Portugal	4
						Romania	4
						Russian Fed.	4
						Slovakia	4
						Slovenia	4
						Spain	4
						Sweden	4
						Switzerland	4
						TFYR Macedonia	4
						Ukraine	4
						United Kingdom	4
						Yugoslavia	4

Source: UNICEF, 1999.

WHAT THE TABLE RANKS

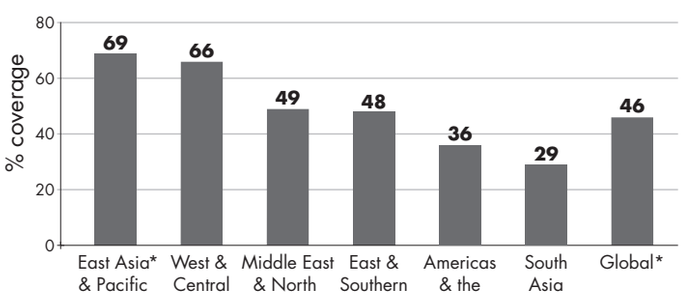
Progress in eliminating vitamin A deficiency

3 Major push needed. Vitamin A deficiency is a public health problem and/or high under-five mortality exists. Present coverage is inadequate through routine systems. Vitamin A supplementation is not added to NIDs or other campaigns, nor have any plans been made to do so. It is unlikely that the World Summit goal will be met in the near future in these countries.

4 No problem or no data. Vitamin A deficiency is either not a public health problem or no data exist to show it is a problem. Furthermore, under-five mortality rate is low (less than 70 per 1,000). No large-scale action is being taken.

Vitamin A: How regions are doing

In 1998, almost half of all children in the world who were at risk of vitamin A deficiency received at least one high dose of vitamin A. The challenge will be to ensure that children in marginalized situations are adequately covered.



*Excluding China.

Source: UNICEF, 1999.

Polio eradication in sight

If current progress continues and efforts are accelerated, early in the new millennium the world will be able to breathe a collective sigh of relief. The net is closing in on polio, case by case and country by country, and full eradication of this disabling disease is now in sight.

In both 1997 and 1998, 450 million children were immunized against polio each year, as part of the enormous effort under way in virtually every country of the world to eradicate the disease by 2000. Since 1988, the number of cases globally has fallen by 86%, a testament to immunization programmes and surveillance efforts, led by WHO, UNICEF, Rotary International, US Centers for Disease Control and Prevention and countless groups and individuals around the world.

As a result, in 1998, 5,108 cases of polio were reported; 1,564 were caused by the wild virus, which is responsible for all transmission of the disease. Only 33 countries reported polio at the end of 1998, 14 fewer than in 1997.

UNICEF/99-0037/Galbe

Village women welcome a vaccination team during southern Sudan's 1999 National Immunization Day.

In countries with inadequate polio surveillance, the number of reported cases can only be an estimate – the actual number of cases may be higher. In other countries (such as Indonesia, Myanmar and Thailand), where surveillance is good and the number of wild cases is low to none, cases of paralysis that physicians suspect might be polio are registered as such unless actually disproved by a lab test. This ensures that polio cases are not under-reported and that the public health system remains aware that the wild polio virus might still exist.

Reported polio cases, 1998

Country	Confirmed cases*		Country	Confirmed cases*	
Afghanistan	49	(24)	Iran	4	(4)
Angola	7	(3)	Iraq	30	(1)
Bangladesh	282	(5)	Mali	14	(2)
Benin	7	(2)	Myanmar	31	(0)
Bhutan	2	(0)	Nepal	29	(0)
Burkina Faso	8	(4)	Niger	8	(4)
Cameroon	14	(0)	Nigeria	312	(9)
Central African Rep.	9	(2)	Pakistan	286	(140)
Chad	6	(4)	Saudi Arabia	1	(1)
Congo, Dem. Rep.	19	(0)	Senegal	10	(2)
Côte d'Ivoire	37	(11)	Sierra Leone	3	(0)
Egypt	12	(12)	Somalia	10	(0)
Ethiopia	58	(0)	Sudan	42	(8)
Ghana	112	(18)	Thailand	26	(0)
Guinea	2	(0)	Togo	5	(1)
India	3,556	(1,281)	Turkey	26	(26)
Indonesia	91	(0)			

*The numbers listed in parentheses are paralytic cases of polio caused by wild polio virus, which is responsible for all transmission of the disease. A country with a good polio surveillance system that records no polio cases caused by the wild virus is deemed to be close to eliminating the disease. When a country has had no cases of polio caused by the wild virus for three consecutive years, it is considered polio-free.

Source: WHO, as of 4 March 1999.

Knowing the enemy: Polio surveillance systems

Between 1988 and 1998, the number of confirmed polio cases fell from 35,251 to 5,108, bringing the world close to eradicating a communicable disease for only the second time in history. But 50 countries still lack functional polio surveillance systems and, as of the end of 1998, only 7 countries in Africa had surveillance systems that could be considered fully adequate.

Surveillance around the world

Weakest		Improving
Angola	Korea, Dem.	Afghanistan
Bangladesh	Liberia	Benin
Bhutan	Madagascar	Cameroon
Burkina Faso	Maldives	Chad
Burundi	Mauritania	Côte d'Ivoire
Cape Verde	Mauritius	Kenya
Comoros	Mozambique	Lesotho
Congo	Nepal	Malawi
Congo, Dem. Rep.	Niger	Malaysia
Djibouti	Rwanda	Mali
Equatorial Guinea	Sao Tome/Principe	Morocco
Eritrea	Senegal	Nigeria
Ethiopia	Seychelles	Philippines
Gabon	Sierra Leone	Somalia
Gambia	Sudan	Thailand
Guinea	Togo	Tanzania
Guinea-Bissau	Yemen	Zambia

Source: WHO.

Significantly, however, India, which alone accounts for 70% of the confirmed polio cases in the world, achieved a functioning surveillance system in 1998.

Adequate polio surveillance systems are a world goal for the year 2000, and to help reach it, the international community's attention will be focused on 13 countries where polio still spreads freely. These 13 countries, which represent the biggest reservoir of polio in the world, account for 92% of all confirmed cases reported in 1998.

Surveillance systems are essential to eradicate polio, as every case of infection-related paralysis must be identified and then investigated in a laboratory. When polio is suspected, stool samples should be collected within 48 hours of the onset of symptoms and then transported to the nearest lab in time to allow testing for the live virus. If polio is found, follow-up tests are done by regional laboratories. The patient receives a complete follow-up exam within 60 days of onset to test for residual paralysis.

If the cause of the paralysis is in fact polio, it must be determined whether it is a wild (indigenous or imported) or a mutated vaccine strain of the virus. Knowing the strain is important, because a country can be considered polio-free only when it has had no cases of wild-virus polio for three consecutive years.

Also, when health officials know the origin of the strain they can respond appropriately, with either a new immunization programme or a door-to-door 'mop up' vaccination campaign.

There are 134 laboratories around the world that test all suspected polio cases. As of this writing, 107 of them have been assessed and 89 of them have been fully accredited.

Lack of obstetric care: Mothers and babies at risk

Caesarean sections are but one of a range of maternal health care interventions needed to save the lives of women and their babies and ensure that women's right to health care is fulfilled. Necessary measures include regular pre- and post-natal health care, skilled care during labour and delivery, adequate nutrition and rest, and care and support within the family, as well as emergency obstetric services. Every year, approximately 600,000 women die and another 15 million endure painful, debilitating, often permanent injuries resulting from pregnancy and childbirth.

C-section rates are one of the few indicators for measuring women's access to obstetric care for which data are widely available. But access to C-sections for women who need them represents only a fraction of women's total need for obstetric care.

Based on research and analysis, WHO has determined that the rate of C-sections in a given population should be no less than 5% and no more than 15% of all pregnancies if the lives of women and infants are to be protected.

Rates below 5% are clear and grave warnings that many women and babies are dying because of inadequate access to the whole spectrum of obstetric services. Rates above 15% indicate an unnecessarily high reliance on a major surgical procedure with numerous risks. It is essential that C-sections be performed only when necessary and in facilities that are adequately equipped and staffed to ensure safety.

Among the 33 countries listed, C-section rates in rural areas fall into the danger zone of less than 5%. In 15 of these countries, rates in urban areas are also below this percentage. In Chad and Madagascar, the level of obstetric care is critically low, with C-section rates of nearly zero in rural areas and only 1% and 2% respectively in urban areas.

Initiatives in several countries are helping to improve access to obstetric services. In Viet Nam, community networks help women with obstetric complications reach medical services quickly. Similarly, communities are sharing costs to improve referral systems for complications in Benin, Ghana, Mali, Nigeria, Senegal and Tanzania. Efforts such as these are essential for progress towards the goal of halving maternal mortality rates between 1990 and 2000.

At the same time, some countries with high C-section rates, such as Brazil (with 42% in urban areas) and the United States (21% nationally), have flagged the high rates as a problem to be addressed.

Where fewer than 5% of rural babies are delivered by C-section

	C-sections as % of births	
	Urban	Rural
Chad	1	0
Madagascar	2	0
Benin	4	1
Burkina Faso	4	1
Côte d'Ivoire	3	1
Haiti	4	1
Mali	2	1
Morocco	4	1
Mozambique	7	1
Nepal	5	1
Niger	2	1
Pakistan	6	1
Zambia	3	1
Cameroon	4	2
Central African Rep.	2	2
India	6	2
Nigeria	3	2
Rwanda	5	2
Senegal	4	2
Tanzania	4	2
Uganda	7	2
Uzbekistan	5	2
Ghana	9	3
Kazakhstan	7	3
Peru	13	3
Comoros	9	4
Egypt	11	4
Guatemala	16	4
Honduras	10	4
Indonesia	6	4
Jordan	6	4
Kenya	11	4
Philippines	8	4

Note: Table based on data from 47 countries; figures have been rounded.

Sources: DHS surveys and Reproductive Health Surveys (supported by the US Centers for Disease Control and Prevention), 1990–97.

Hepatitis B: Menace for the poor

Protection against hepatitis B, which claims approximately 1 million lives each year, is severely limited for children in many countries. WHO and UNICEF have recommended that the hepatitis B vaccine be included in every country's childhood immunization programme, and over 100 countries have done so. But 41 poor countries (with per capita incomes below $785) where hepatitis B is highly endemic* have been unable to afford the vaccine but have received no donor help. Of the 8 poor countries that have added the vaccine to their immunization programmes, 7 (Albania, Armenia, Gambia, Kyrgyzstan, Mongolia, the Republic of Moldova and Viet Nam) face uncertain funding for the vaccine in the future.

In public sector programmes in developing countries, the cost to fully immunize a child against hepatitis B is $1.50, about twice that of immunizing against the six childhood diseases combined, but still highly cost-effective.

Missing vaccine

Low-income countries where hepatitis B is highly endemic* that have not added the vaccine to their childhood immunization programmes

Angola	Congo, Dem. Rep.	Liberia	Sao Tome/Principe
Azerbaijan	Côte d'Ivoire	Madagascar	Senegal
Benin	Ethiopia	Malawi	Sierra Leone
Burkina Faso	Ghana	Mali	Somalia
Burundi	Guinea	Mauritania	Sudan
Cambodia	Guinea-Bissau	Mozambique	Tajikistan
Cameroon	Haiti	Myanmar	Tanzania
Central African Rep.	Kenya	Niger	Togo
Chad	Lao PDR	Nigeria	Turkmenistan
Comoros	Lesotho	Rwanda	Uganda
			Zambia

*A prevalence rate of 5% or more.

Source: WHO.

Rural children lag in DPT

Disparities in immunization coverage reveal weak spots where countries need to target initiatives to ensure that the right of all children to health care is fulfilled. In rural areas of Niger, for example, only 15% of children have been immunized against DPT (diphtheria, pertussis and tetanus), in contrast with 72% of those in urban areas, a difference of 57 percentage points. This is the greatest disparity among the 17 countries with urban/rural DPT coverage gaps of more than 20 percentage points. The Democratic Republic of the Congo and Eritrea have the next highest gaps, both with 49 percentage points. Of the 17 high-gap countries, 14 are in Africa.

From 1980 to 1990, many developing countries achieved great immunization gains, boosting DPT rates from about 30% to an average of 80%. The goal for the year 2000 is at least 90% immunization coverage for children in every country. Various strategies can overcome coverage disparities: China, for example, set district-level coverage targets.

Where the gap is widest: DPT3 coverage*

	% of under-ones immunized		Percentage pt. difference
	Urban	Rural	
Niger	72	15	57
Congo, Dem. Rep.	64	15	49
Eritrea	87	38	49
Mozambique	94	50	44
Yemen	71	30	41
Burkina Faso	70	30	40
Central African Rep.	68	32	36
Papua New Guinea	76	41	35
Mali	70	39	31
Côte d'Ivoire	66	37	29
Chad	42	14	28
Togo	62	36	26
Nepal	77	52	25
Cameroon	68	44	24
Guinea	71	47	24
Angola	35	14	21
Ghana	86	65	21

*Three doses of combined diphtheria, pertussis (whooping cough) and tetanus vaccine.

Sources: DHS, MICS and other nationwide surveys, 1995–98.

COMMENTARY: THE TOLL ON WOMEN AND CHILDREN

UNICEF/93-1229/Andrew

The AIDS emergency

By Janat Mukwaya

The advance of antiretroviral drugs in industrialized countries has left some with the illusion that the worst of the AIDS epidemic has passed. Nothing could be further from reality in the developing world where the silent, voracious epidemic is wiping out the historic gains of the public health and economic development efforts of the last 20 years.

Two decades have passed – a generation for us – since the first rumours drifted out of the remote villages along Lake Victoria, telling of a bewildering illness that sapped its victims to the bone.

Since then, like a vast thresher, AIDS has churned through our fertile land with ruthless force, cutting down the young, the educated, so many of our people in the prime of their productive life: 1.8 million Ugandans have died, 1.7 million children have lost their mother or both parents to AIDS over the course of the epidemic. Today, Uganda has the heartbreaking distinction of having the largest population of such orphans in the world.

Our story has been repeated across our continent. Of the 14 million people worldwide who have died of AIDS, more than 11 million have been Africans. A quarter of them have been children. Last year alone, 2 million men, women and children in Africa perished. We mourned our loved ones at nearly 5,500 funerals a day.

No one among us could have imagined the far-reaching devastation of the human immunodeficiency virus (HIV), but some facts are now clear. Young people – notably women – are the leading victims of this epidemic. More than 7,000 young men and women around the world are infected every day, as are an additional 1,600 children under the age of 15.

A deadly silence

The silence and stigma surrounding this terrible illness are fuelling its spread and stoking a lethal intolerance we must resist with all our might. Last December, Gugu Dlamini, a volunteer for an AIDS organization in South Africa, announced that she was HIV positive at a rally in Johannesburg, hoping to dispel some of the prejudice against people with the virus. Eleven days later Gugu was beaten to death by neighbours who claimed she had brought shame on the community.

The mob violence against this courageous woman was a brutal act of prejudice and intolerance. It was also an ominous reminder of the most vulnerable citizens in our developing countries – the women and children – who are routinely denied their rights to education, economic opportunity and proper health care. They are silenced by ignorance and fear, and doomed by their powerlessness to resist the dangers they face.

Consider our women, for example, who raise our children and produce our food. Their social and economic dependence on their husbands is so complete that they cannot refuse their husbands' demands, even when they fear that the men have contracted HIV from other sexual partners.

Women also avoid seeking vital medical services and counselling, and rarely do they dare to take the test for HIV, so great is their dread that their husbands will beat them and throw them out into a community where they will be even further ostracized.

If grown women are hobbled by their low social status and self-esteem, how can their adolescent daughters resist the sexual advances of older men and the pressures from their communities to marry, despite the potential exposure to HIV? Adolescent girls in sub-Saharan Africa are six times more likely to be infected than boys of the same age. There is a common and appalling myth in several African nations that a man infected with HIV can cure himself by having sexual relations with a virgin, thus increasing the toll on young girls.

Childhood lost

Tragically, it is children who shoulder the greatest burden of the epidemic. Worldwide, more than 8 million children have had to grow up without their mothers. Over 90% of those orphaned by AIDS live in sub-Saharan Africa.

To lose one or both parents to AIDS is to face a childhood of pain and peril. The suffering starts with the grief and horror of watching their parent waste away. Soon they suffer prejudice and neglect at the hands of their guardians and community. Every tenet of the Convention on the Rights of the Child is violated, from their right to education, health and development, to protection from exploitation and harm.

Our experience tells us that orphans have alarmingly higher rates of malnutrition, stunting and illiteracy. Often their community shuns them, presuming that they, too, harbour the fatal virus. Relatives who take them in often seize their paltry inheritance, and local laws offer little recourse to these lonely children.

Worse still, as surveys here in Uganda have shown, children whose parents have died often must shoulder heavier workloads and are treated more harshly than the foster family's own children. They are less likely to go to school

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COMMENTARY: THE TOLL ON WOMEN AND CHILDREN

and more likely to be depressed. One of our current district development plans reports that "orphan children [are] being defiled, married, neglected and…subjected to many forms of abuse."

Throughout the continent, young girls are especially vulnerable, and a reported rapid rise in sexual abuse in Zimbabwe, for example, has prompted the Government to set up a special hospital clinic to deal with the victims of this unconscionable behaviour.

Tens of thousands of orphans are simply abandoned to fend for themselves, like the 90,000 in Zambia living on the streets. Tens of thousands more are struggling in households headed by the eldest child. Newspaper reports chronicled the fate of little girls like Kugu Sengane, in Kwazulu Natal (South Africa), who was only 11 years old when she had to nurse both of her parents through the torment of their dying days. As they languished in pain, Kugu was barely able to keep them washed and fed, while having to care for her toddler brother. This is no life for a child.

Nearly half of those caring for orphans in some regions of Africa are elderly grandparents like Ennie Gambushe, who lives up the road from little Kugu Sengane. At age 64, Ennie aches so badly from her chronic arthritis that she has difficulty merely standing up. Yet after both of her daughters died from AIDS, she was left to look after 15 grandchildren, none of them older than 12.

From South Africa up through central and eastern Africa, such scenes highlight the catastrophic impact AIDS has had on our families and communities, leaving our aging grandparents with an exhausting responsibility. "Young girls – our children, our grandchildren, they are dying before we die," says 79-year-old Elizabeth Chipepa from Zambia, who inherited three small great-grandchildren when her granddaughter succumbed to AIDS. "You can hear others my age saying things like, 'I've lost my three children; the first one has left three children, the second has left six….'"

In my own country, a 60-year-old woman named Honodinta Nakayima is looking after 42 grandchildren, ranging from age 13 down to a few months, after seven of her children died.

The web of generations

For a long time it was typical to describe the AIDS epidemic in Africa as 'mysterious' and 'invisible', but that could hardly be further from reality. We have all shared the suffering of dying brothers, sisters and childhood schoolmates. There are empty seats at all of our tables, empty desks in our offices. But the loss of a friend or a relative is only the first rupture in the web of family generations that once protected our society.

When AIDS strikes the family breadwinner, his or her income dries up and the rest of the family slips deeper into poverty as they devote their meagre resources to nurse an ailing kin. Our studies show that when a father dies, his widow and eldest children must work two to four hours longer every day. Girls, in particular, may be forced to leave school to help at home and to work in the fields.

Moreover, the deadly virus rarely stops at one family member. Husbands infect their wives; about a third of newborns in turn acquire the infection from their mothers. Again, trapped by the silence and inhibited by the stigma surrounding the disease, women without symptoms of AIDS often discover their infection only after their infant is diagnosed with HIV.

Consider the wrenching experience of a woman I shall call Assumpta Mboya, who lives across the Great Rift Valley, in Nairobi. One of her 22-month-old twin daughters fell ill, and the doctor found that the baby tested positive for HIV. Soon afterwards, her baby died, followed by her husband. Then Assumpta had herself tested and confirmed her darkest fear. She still resists testing the surviving twin daughter who is now eight years old, even though she worries constantly about whether this girl is infected, too, and anguishes over what will become of her daughter if she herself dies first. Families like this are disintegrating across our continent, threatening the very foundation of our society.

A call for prevention

Our continent's human tragedy, caused by HIV/AIDS, is desperately compounded by a social welfare crisis. So many go without treatment for AIDS and its complications because antiretroviral drugs – that have kept patients in industrialized nations alive and healthy – cost thousands of dollars a year, making them only a dream for most in Africa. Massive resources are urgently needed to help us treat those infected, look after those

UNICEF/96-0635/Satmoko

The popular puppeteer Suyadi entertains children at a UNICEF-sponsored workshop in Indonesia. The workshop explored ways of using puppets to convey messages to children on AIDS as well as on gender issues, peace and sexual exploitation.

orphaned and prevent further spread of this disease.

Prevention efforts need the world's help also, not only to stave off the torrent that has swept southward into Malawi, Zambia, Zimbabwe, Botswana and South Africa, but also to brake its advance into Asia, where 7 million people are already infected. India is home to 4 million people with HIV, and the patterns of transmission indicate that we have no time to lose.

In the Indian city of Chennai (formerly Madras), the HIV-infection rate among truck drivers quadrupled from 1995 to 1996, a haunting echo of the AIDS explosion among the African lorry drivers who travelled the highways from Nairobi to Lusaka. Also in India, studies of pregnant women in the coastal town of Pondicherry reveal 4 per cent to be infected with HIV. Roughly a third of their infants will acquire the virus.

UNICEF/Zambia/Pirozzi

More than 7 million children in sub-Saharan Africa have been orphaned by AIDS, their mother or both parents having succumbed to the disease. Many of these children, like this boy in Zambia, are cared for by elderly grandparents. But tens of thousands of Zambian children are fending for themselves, many of them living on the streets.

We have learned that the crucial factor in successful prevention campaigns is the open, unwavering political commitment by each government to confront the epidemic forthrightly, to shatter the silence surrounding the virus and to prohibit discrimination of any kind. Behind the shield of silence, the stigma and shame associated with AIDS only enable this epidemic to further flourish. Nine out of 10 people in Africa with HIV do not know they are infected, and those who do know rarely tell their relatives, let alone their sex partners. Many African newspapers make no mention of AIDS in the bulging death notices.

Here in Uganda, when President Yoweri Museveni took office in 1986 he recognized the seriousness of this disease and its long-term consequences. He quickly established a national committee for AIDS prevention, which launched an intensive public education campaign based on catchy messages to attract our young people. Among other things, it encouraged condom distribution, voluntary HIV testing, counselling and support services. And even more important, it encouraged frank, public debate.

With its slogan 'Faithfulness, abstinence, condoms', our AIDS-prevention campaign has made remarkable progress. Many Ugandans are now postponing their first sexual experiences, taking fewer partners and using condoms more often. We have seen the rate of new infections among our people drop dramatically since the dark year of 1987, when we had 239,000 new cases of HIV/AIDS. By 1997, this figure had declined by more than three quarters, to 57,000. We are especially encouraged by the 40 per cent drop in HIV prevalence among pregnant women in urban areas – an important indicator for tracking the spread of the disease.

But we are not alone. Worlds away in South-East Asia, government officials and community advocates in Thailand have likewise been successful with their aggressive campaign to prevent the spread of AIDS. Warned by the catastrophic losses in Africa, Thai officials attacked their HIV epidemic at an earlier stage and particularly targeted their young population with their messages. As a result, in northern Thailand, the number of 21-year-old men who visited commercial sex workers dropped by half during the course of four years. Condom use increased by nearly 50 per cent, and only one third as many HIV infections were reported during that time.

A third country, Senegal, has also managed to stem the spread of the virus through a vigorous education programme aimed at young people. Among women and men under the age of 25, the use of condoms with 'non-regular' partners rose dramatically from only 5 per cent in 1990 to as high as 60 per cent in 1997.

These programmes may be only the first step, but they prove the point made by Dr. Peter Piot, the Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS), that prevention efforts "[do] not require new breakthroughs in technology, but rather new breakthroughs in political will."

These efforts must be targeted at the most vulnerable – young people, women and children. And they must firmly guarantee people their rights to education, health, economic livelihood – to life itself – so that, armed with knowledge and independence, our people can avoid HIV infection in the first place.

Years from now, when our great-grandchildren look back on the twilight of this century, will they learn that the leaders of the world shirked their duty to fight the leading killer of young people?

We cannot let that happen. Instead, let us show that we boldly reached out to the women and children most threatened by the pandemic and empowered them to defeat this terrible disease. ■

LEAGUE TABLE: CHILDREN ORPHANED BY AIDS

The devastating impact of the AIDS crisis on children in the developing world has yet to be fully understood. The number of orphans, particularly in Africa, constitutes nothing less than an emergency, requiring an emergency response. As already impoverished societies struggle with this massive blow, their hard-won gains in social development – including improvements in child health, nutrition and education – are being wiped out.

Magnitude of the orphan crisis

Loss is an inevitable corollary of disease and death, but the wrenching toll taken by AIDS is unique: So far the disease has left 8.2 million children without a mother or both parents, the vast majority of them in sub-Saharan Africa. And the total continues to grow, expected to reach 13 million by the year 2000, of whom 10.4 million will still be under the age of 15.

The children's personal tragedies are enormous. So, too, are the social crises occurring as the worst affected communities and nations – among the poorest in the world – struggle to care for the ill as well as a generation of orphans, on a scale unprecedented in human history.

In most parts of the industrialized world, usually no more than 1% of the child population is orphaned. Before the onset of the AIDS epidemic, societies in the developing world absorbed orphans into extended families and communities at a rate just over 2% of the child population. In contrast, a staggering 11% of children in Uganda are now orphans because of AIDS. In Zambia, 9% are orphans; in Zimbabwe, 7%; and in Malawi, 6%. Where prevalence rates among women are high, so are the numbers of children left behind.

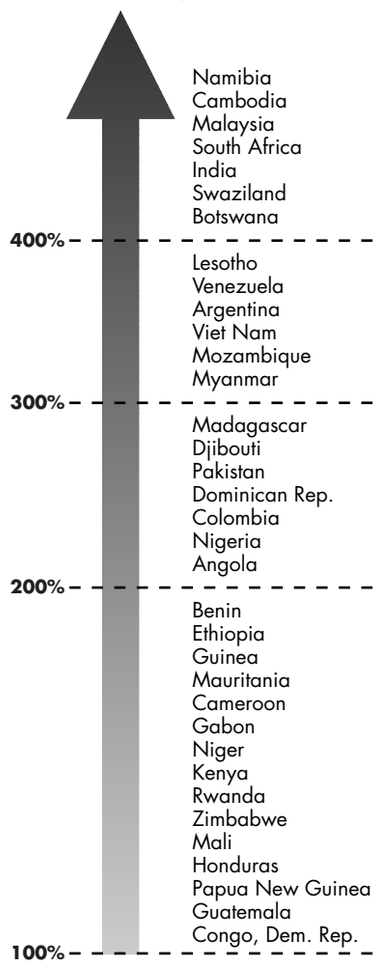
Nor are these losses abating: In 35 countries, the rate at which children have been orphaned has doubled, tripled or even quadrupled in just three years, from 1994 to 1997. Fears are that, because of AIDS, Asia will see its orphan population triple by the year 2000. And at this moment, according to UNAIDS, the number of children living with an HIV-positive parent is far greater than the number of children already orphaned, a disturbing prospect for the future.

Children who have lost their mother or both parents are society's most vulnerable members. Socially isolated because of the stigma of AIDS, they are less likely to be immunized, more likely to be malnourished and illiterate, and more vulnerable to abuse and exploitation.

Finding the resources needed to help stabilize the crisis and protect children is a priority that requires urgent action from the international community.

Mounting toll

Where the number of children orphaned by AIDS has increased sharply over three years*



*Countries are listed in descending order of percentage rate of increase over the three-year period, 1994–97. Here, orphans are defined as children under the age of 15 who have lost their mother or both parents to AIDS.

Source: UNAIDS/WHO.

SUB-SAHARAN AFRICA

Uganda	1,100
Zambia	890
Zimbabwe	700
Malawi	580
Togo	400
Botswana	390
Burundi	380
Côte d'Ivoire	380
Congo	360
Tanzania	360
Rwanda	350
Central African Rep.	340
Burkina Faso	290
Kenya	280
Ethiopia	250
Mozambique	180
Sierra Leone	170
Liberia	150
Congo, Dem. Rep.	140
Chad	130
Gambia	120
Ghana	110
Namibia	110
South Africa	110
Cameroon	100
Lesotho	100
Gabon	90
Senegal	90
Nigeria	60
Mali	50
Guinea	40
Angola	30
Benin	30
Niger	30
Guinea-Bissau	20
Mauritania	10
Madagascar	2
Eritrea	No data
Mauritius	No data
Somalia	No data

MIDDLE EAST AND NORTH AFRICA

Egypt	<1
Iran	<1
Iraq	<1
Israel	<1
Jordan	<1
Kuwait	<1
Lebanon	<1
Libya	<1
Oman	<1
Saudi Arabia	<1
Syria	<1
Tunisia	<1
Turkey	<1
Yemen	<1
Algeria	No data
Morocco	No data
Sudan	No data
U. Arab Emirates	No data

Note: < = less than.

CENTRAL ASIA

Afghanistan	<1
Armenia	<1
Azerbaijan	<1
Georgia	<1
Kazakhstan	<1
Kyrgyzstan	<1
Tajikistan	<1
Turkmenistan	<1
Uzbekistan	<1

EAST/SOUTH ASIA AND PACIFIC

Thailand	30
Cambodia	20
Myanmar	8
Papua New Guinea	6
India	3
Malaysia	2
Lao PDR	1
Nepal	1
New Zealand	1
Pakistan	1
Sri Lanka	1
Viet Nam	1
Australia	<1
Bangladesh	<1
Bhutan	<1
China	<1
Indonesia	<1
Japan	<1
Korea, Dem.	<1
Korea, Rep.	<1
Mongolia	<1
Philippines	<1
Singapore	<1

AMERICAS

Haiti	100
Honduras	20
Jamaica	20
Trinidad/Tobago	20
Dominican Rep.	10
United States	10
Panama	9
El Salvador	8
Costa Rica	6
Guatemala	6
Uruguay	4
Argentina	2
Ecuador	2
Mexico	2
Chile	1
Colombia	1
Nicaragua	1
Paraguay	1
Peru	1
Venezuela	1
Bolivia	<1
Canada	<1
Cuba	<1
Brazil	No data

WHAT THE TABLE SHOWS

The number of under-15s per 10,000 who have lost their mother or both parents to AIDS

Note: These estimations do not include those children who have lost only their father.

Comparable data on the number of children orphaned by AIDS are not available for many of the developed countries or those in transition, so these countries have been excluded from the league table.

Source: UNAIDS/WHO; data as at end-1997.

Where the numbers are highest*

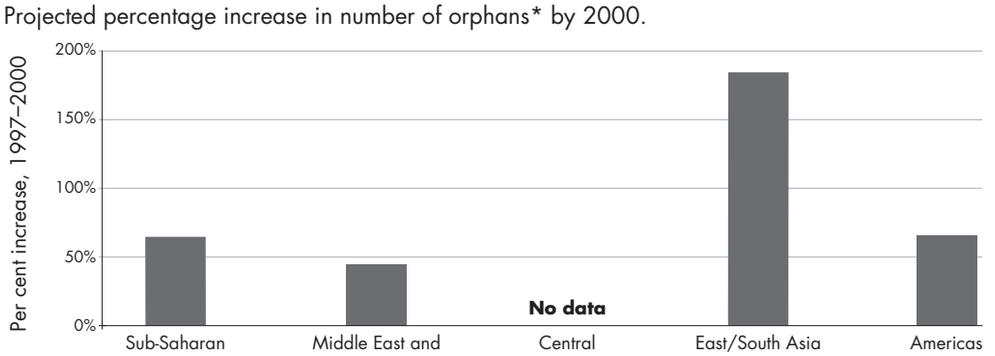
Uganda	1,100,000
Ethiopia	700,000
Tanzania	520,000
Zambia	360,000
Zimbabwe	360,000
Kenya	350,000
Nigeria	350,000
Congo, Dem. Rep.	310,000
Malawi	270,000
Côte d'Ivoire	240,000
South Africa	180,000
Burkina Faso	150,000
Mozambique	150,000
Burundi	110,000
India	110,000

*Children under the age of 15 who have lost their mother or both parents to AIDS, as at end-1997.

Source: UNAIDS/WHO.

Regional view: 2000

Projected percentage increase in number of orphans* by 2000.



Source: UNAIDS/WHO.

*Children under the age of 15 who have lost their mother or both parents to AIDS.

AIDS' impact on children's lives

In one of its most devastating and least visible consequences, HIV/AIDS is eroding precious and hard-won infant and child survival gains in a number of countries in Africa.

In Botswana, for example, AIDS will be responsible for 64% of deaths of children under five by the year 2000, offsetting much of the country's impressive child health progress. In South Africa and Zimbabwe, AIDS is projected to account for a 100% increase in child mortality. Some experts predict even more dramatic increases are to come. The US Census Bureau projects that by the year 2010, the mortality rate among children under five in Zimbabwe will be three-and-a-half times as high as it would have been without AIDS, and infant mortality may double. In some African countries, hospitals report that three out of four paediatric beds are taken up by children with AIDS.

The impact on children extends beyond those infected, as millions in the hardest-hit countries suffer the loss of parents and caregivers, and thus incur much greater risks to their health, nutrition and education. Mounting effects are already being seen on the nutrition of children living in households affected by AIDS. A study in Kagera (Tanzania) found that food consumption in poorer families dropped by 15% at the time of an adult's death from AIDS. Such a decline can have a significant impact on a child's development. Furthermore, children orphaned by AIDS run a higher-than-average risk of stunting; according to the World Bank, stunting among orphans is around 50%.

A fall in literacy rates in many countries is expected since children in AIDS-stricken households are taken out of school when families can no longer afford fees or when children are needed to help out at home or to earn an income. Orphans living in extended families are also generally the first to be denied an education. A study in Zambia indicated that in urban areas, 32% of orphans were not enrolled in school, compared with 25% of non-orphans. In rural areas, 68% of orphans were not in school, compared with 48% of non-orphans.

Much of the disease's economic impact remains difficult to measure; but there is no question that increased health care expenditures and loss of family income are straining resources, burdening women in particular and putting surviving children at greater risk of malnutrition, illiteracy and disease. AIDS is also decimating the ranks of the skilled and educated during their prime years, with potentially tragic implications for future development. A recent survey in Malawi, for example, found the rate of infection among schoolteachers to be higher than 30%.

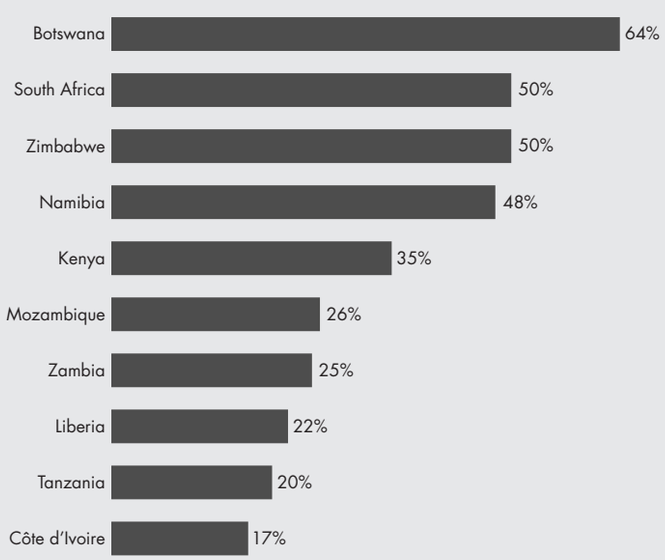
The burden is also great on already inadequate health care systems. In Zimbabwe, government projections are that HIV/AIDS will consume 60% of the health budget by the year 2005. In most developing countries, the disease is increasing the price of health care and reducing its availability, which will have the greatest impact on the poor. In many communities, healthy children whose parents have died from AIDS are at greater risk of dying of preventable diseases, because their illnesses tend to be attributed to AIDS and thus to go untreated. Evidence also indicates that orphans are less likely than other children to be immunized and to have their health care needs adequately met.

UNICEF/99-0286/Pirozzi

In some African countries hit hard by AIDS, it is no longer unusual to see children under 15 heading households. This Ugandan girl, who lost her parents to AIDS, cares for a blind grandmother and younger siblings.

AIDS and child mortality

The percentage of under-five child mortality due to AIDS, projected for the years 2000–2005

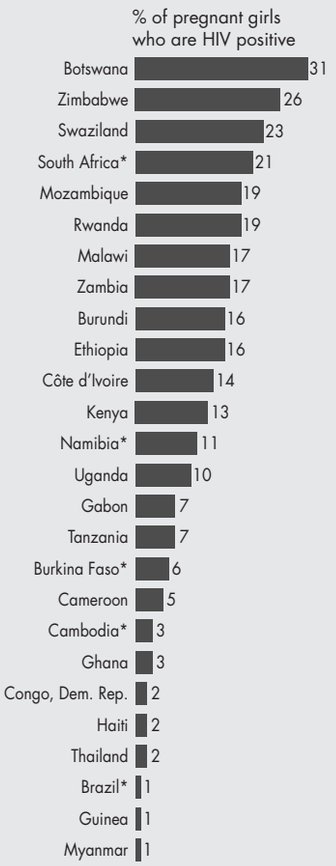


Source: United Nations Population Division, 1999.

At highest risk today: Teenage girls

In many countries, evidence points to a much higher prevalence of HIV among teenage girls than teenage boys.

The most vulnerable
HIV rates among pregnant girls (age 15 to 19) attending antenatal clinics in major urban areas



*Also includes girls outside major urban areas.

Sources: UNAIDS/WHO, US Bureau of Census, national AIDS programmes. Data: 1995–98.

In a recent study in western Kenya, 25% of girls between the ages of 15 and 19 were found to be HIV positive, compared to 4% of boys in the same age group. In Botswana's major urban areas, more than 30% of all pregnant adolescent women are infected, and in South Africa, Swaziland and Zimbabwe the infection rate is over 20% (see chart). Surveys in Zambia showed that the rate among all teenage girls (12%) is nearly three times that of teenage boys.

Higher prevalence rates among girls reflect their biological vulnerability to infection, their social and physical vulnerability in sexual relations and the impact of gender discrimination. The rates make it clear that much more needs to be done urgently to protect the rights of girls and women. Discrepancies in HIV rates between girls and boys also indicate that girls are more likely to be infected by older men than by boys their own age.

The rate of HIV infection among teenage girls in Asia is low compared to those in Africa, although rates in Asia are on the rise: In India, a Mumbai antenatal clinic is reporting 5% of pregnant teenagers who are HIV positive, twice as many as in 1994. Teenage girls in high-risk groups show alarming prevalence rates: In 19 provinces in Cambodia, more than 40% of sex workers under the age of 19 are HIV positive. In urban areas in Myanmar, the rate among teenage sex workers is 25%. However, in Thailand, early intervention proved successful in reducing prevalence among all high-risk groups, including teenage sex workers.

Epidemiologists find that, since infections are likely to be relatively recent among young people, a rising rate of infection in this group signals a growth in the spread of the disease. It is also an ominous sign that education and prevention programmes are not in place or not working.

In both industrialized and developing countries, interventions aimed at the young have proven to be the most effective and cost-efficient method for addressing the crisis in the long term. In the most comprehensive review of sexual health education undertaken to date and involving 68 countries, UNAIDS found that good education *does* help delay first intercourse and protect sexually active young people from HIV, other sexually transmitted diseases and pregnancy. It does not, as some fear, lead to earlier or increased sexual activity.

The benefits of education have been proven most explicitly in Uganda, the first African country with a staggering AIDS burden to respond to the crisis. There, the biggest decrease in prevalence has been among 15- to 19-year-olds, dropping from 38% in 1991 to 7.3% in some areas in 1996.

HIV infections rising among adolescents in North America and Europe

Worldwide, greater and greater numbers of teenagers are being infected with HIV; fully half of 1998's 5.8 million new infections occurred in the 15-to-24 age group.

Teenagers in developing countries are most affected, but the risk is growing for those in industrialized countries and countries in transition, as a new pattern of infection emerges. For example, young people age 13 to 21 now account for one quarter of new infections in the United States; in Canada, too, HIV is spreading at an increasing rate among teenagers. More and more of those infected are young women.

In Eastern Europe and Central Asia, a proliferating use of intravenous drugs has caused an explosion in infections: Some 270,000 people are now living with HIV/AIDS, with a significant number of new infections among adolescents. The epidemic is most advanced in Ukraine, which alone accounts for 18,000 cases of adolescent HIV infection. Until 1995, there were fewer than 30,000 cases of HIV/AIDS in both adults and children in the entire region.

Because intravenous drug use is a major factor in the disease's spread, the Russian Federation – with as many as several million drug users – could see a dramatic rise in infections. Many are likely to be among the young: In St. Petersburg, for example, up to 20% of drug users are teenagers, some as young as 12 years.

The disease is poised for even wider spread. Socio-economic upheavals have been paralleled not only by increasing drug use but also by dramatic changes in sexual behaviour among young people and a sharp increase in the spread of sexually transmitted diseases. In the Russian Federation, over the last few years the number of under-18 sexually active females has increased fourfold, a pattern also occurring elsewhere in the region. In striking contrast to Western Europe, where 60% of newly sexually active teenagers use condoms, lack of awareness has resulted in extensive high-risk behaviour; in the Republic of Moldova, for example, the rate is about 8%.

To date, HIV/AIDS prevention programmes have been implemented on a small scale in some countries. UNICEF has supported successful needle-exchange programmes including one in Odessa since 1997.

Teens at risk
Adolescents (age 15-19) living with HIV/AIDS

Western Europe	
Spain	5,400
Portugal	3,300
France	2,600
Italy	2,200
Germany	1,000
United Kingdom	600
Belgium	400
Greece	400
Switzerland	300
Netherlands	100
Subtotal	***16,300***
Eastern Europe	
Ukraine	18,000
Russian Fed.	2,300
Poland	1,100
Subtotal	***21,400***
Total 13 European countries	***37,700***
North America	
United States	17,000

Sources: Hamers and Downs at the European Centre for the Epidemiological Monitoring of AIDS (CESES), 1999; the United States Centers for Disease Control and Prevention. Data as at end-1997.

Born with HIV

HIV/AIDS is cutting a deadly swath through Africa's young: Of the 590,000 children who were infected with HIV globally in 1998 (the highest figure of any year so far), 530,000 were in sub-Saharan Africa. Most of them became infected prior to or during birth or through breastfeeding. In startling contrast, fewer than 1,000 infants were infected that year in the whole of North America and Western Europe.

Poverty and the resulting lack of health services, education and AIDS treatment play a part in this cruel discrepancy. But perhaps the biggest factor is women's lack of control in their sexual relationships and hence over many aspects of their health. Also endangering them is the heavy veil of shame and silence that still hangs over those with the disease in most of Africa. Because of shame or the fear of even appearing to have the disease, many women are further hindered in protecting themselves and their children. Young women are particularly vulnerable physically and socially to the pressures and forces at play (*see 'At highest risk today: Teenage girls', page 23*).

HIV-positive women in industrialized countries who become pregnant receive the antiretroviral drug zidovudine (ZDV, better known as AZT) from at least the 14th week of pregnancy, and the drug is administered to infants for 6 weeks after birth – an expensive regimen. Access to Caesarean section delivery (*see 'Lack of obstetric care: Mothers and babies at risk', page 15*) and to safe artificial feeding also reduces the risk of mother-to-child transmission. Such regimens account for the 5% or lower transmission rate in both France and the United States. In the developing world, by contrast, between 25% and 35% of children born to HIV-positive mothers acquire the infection during pregnancy, childbirth or through breastfeeding.

UNICEF/97-0066/Horner

Children at the UNICEF-assisted Vienpeng Home for Babies in Chiang Mai (Thailand). The centre cares for HIV-positive children as well as those who have lost their parents to AIDS.

Ominous leaps from 1994 to 1997

Countries where the number of children living with HIV/AIDS ...

... has quadrupled

	Number of children (age 0–14) infected
China	1,400
Namibia	5,000
Viet Nam	1,100

... has tripled

	Number of children (age 0–14) infected
Cambodia	5,400
Dominican Rep.	1,400
India	48,000
Malaysia	1,400
Myanmar	7,100
South Africa	80,000
Swaziland	2,800

... has doubled

	Number of children (age 0–14) infected
Angola	5,200
Benin	2,400
Botswana	7,300
Djibouti	1,300
Lesotho	3,100
Mozambique	54,000
Nigeria	99,000
Pakistan	1,800

Source: UNAIDS/WHO.

Note: The figures above are end-1997 estimates. In many countries, end-1999 estimates could be considerably higher.

Antiretroviral trials

Now there is some hope for reducing mother-to-child transmission in the developing world, as well. Last year, trials in Thailand of a short course of AZT (from the 36th week of pregnancy through labour) given to pregnant women with HIV proved successful in reducing transmission by about 50%. A more recent study found that a much shorter regimen – involving AZT and lamivudine (3TC) given during delivery and for one week after to both mother and child – reduced the chances of transmission by 37%. Following the Thai study, UNAIDS, and its co-sponsors UNICEF and WHO, announced a two-year pilot project aimed at reducing mother-to-child transmission, which will reach 30,000 women in 11 countries. Work is under way to establish facilities and expertise in all 11 countries, while treatment of HIV-positive mothers in Côte d'Ivoire and Thailand has already begun.

But even more important in halting the virus's spread is access to facilities where women can learn their HIV status in confidential surroundings and be counselled about their fertility options and the feeding of their babies. Most, of course, do not have access to such voluntary and confidential testing and counselling, and many who are seropositive face discrimination or even violence. Also, many of the mothers who know they are HIV positive have no access to appropriate and safe breastmilk substitutes (*see 'HIV and infant feeding', facing page*).

Alarm for Asia

The crisis Africa has faced for over a decade now appears poised to erupt on a wider scale. Higher prevalence among children is one indication of the rapid spread of the virus, and HIV prevalence among children is beginning to increase in a number of countries that, until recently, have seen a relatively low incidence. In India, for example, 48,000 children were infected with HIV at the end of 1997, triple the number of those infected in 1994. In three countries that had maintained low rates of seroprevalence – China, Namibia and Viet Nam – the rate of infection among children quadrupled between 1994 and 1997.

Counting AIDS' toll on children

Countries with the highest numbers of children living with HIV/AIDS

	Number of children (age 0–14) infected
Ethiopia	140,000
Nigeria	99,000
South Africa	80,000
Tanzania	68,000
Uganda	67,000
Kenya	66,000
Zimbabwe	57,000
Mozambique	54,000
Congo, Dem. Rep.	49,000
India	48,000

Source: UNAIDS/WHO; data as at end-1997.

Despite progress, TB treatment reaches too few

About one third of those ill with AIDS actually die from tuberculosis – their weakened immune systems making them easy prey for this disease. Driven in large part by the AIDS epidemic, TB is on the rise, now killing an estimated 2 million people each year.

But while life-prolonging drugs for AIDS remain a distant reality in the developing world, a highly effective and inexpensive treatment is available for TB. A strategy called DOTS, which stands for Directly Observed Treatment, Short Course, recommended by WHO, can cure up to 95% of TB cases and stem the spread of drug-resistant TB, while at the same time improving the quality of life for those who already have AIDS. As its name conveys, the treatment involves, in particular, the observation of patients swallowing appropriate dosages of anti-TB medicines for the full course of treatment, critical for the prevention of the multi-drug resistant strains of TB which have emerged in recent years.

Yet, only 16% of TB patients are receiving the recommended treatment. In 12 of the 22 countries where 80% of the world's TB cases occur, the DOTS strategy reaches fewer than half of those affected. Only five countries are making good progress: Cambodia, Kenya, Peru, Tanzania and Viet Nam have implemented DOTS programmes countrywide, with high success rates in detection and treatment.

In Peru, which once had one quarter of South America's TB cases, DOTS is successful in treating 85% of cases.

Brazil, however, which currently has the highest number of cases in South America, lacks a national DOTS strategy. Nigeria, the Russian Federation and Uganda are reaching less than 10% of cases. India, with an estimated 1.8 million TB cases – 23% of the world's total – has made some progress in recent years, reaching four times as many people in 1998 as in 1997. And China, with more than 1 million cases, has built an effective DOTS-based programme, but it only reaches half the country.

UNICEF/93-1750/Lemoyne

Children await registration for immunizations at one of the many UNICEF-assisted health clinics in China.

TB treatment scorecard for most-affected countries*

Good progress: Where more than half of TB cases are being treated in the DOTS** programme, with a greater than 70% success rate.

Cambodia
Kenya
Peru
Tanzania
Viet Nam

Some progress: Where between 10% and 50% of TB cases are being treated in the DOTS programme, with a greater than 70% success rate.

Bangladesh
China
Ethiopia
India
Indonesia
Myanmar
Philippines
South Africa
Thailand

Slow progress: Where the DOTS programme is either not used or is used to treat less than 10% of TB cases.

Afghanistan***
Brazil
Congo, Dem. Rep.***
Nigeria
Pakistan***
Russian Fed.
Uganda
Zimbabwe***

* Where 80% of the world's TB cases occur.

** Directly Observed Treatment, Short Course.

***Implementing DOTS but data not available.

Source: WHO.

HIV and infant feeding

A child whose mother is HIV positive runs a risk, presently estimated to be at least 1 in 7, of acquiring the virus through breastfeeding. About 500 to 700 infants are infected this way every day, but the exact mechanism of transmission is still not fully understood.

Before the terrible spectre of HIV/AIDS emerged, breastfeeding was recognized as the best way to feed infants in virtually all circumstances. Now, given the possibility of transmitting HIV through breastfeeding, joint WHO/UNICEF/UNAIDS guidelines on infant feeding have been issued to assist policy makers and health workers in addressing that risk and helping to safeguard the rights of mothers and their children. Central to these guidelines is the right of mothers to make decisions, on the basis of full and clear information, on what is best for them and their infants and to be supported in carrying out those decisions.

The guidelines warn of the potential harm in mixing breastfeeding and artificial feeding. Indeed, recent findings suggest that this combination may be particularly dangerous to infants. A new study of babies up to three months of age born to infected mothers suggests that those who are exclusively breastfed may face a significantly lower risk than was previously thought.

The study posits that feeding other solids or fluids in addition to mother's milk in the first months of life may be what injures the baby's gut and allows the deadly HIV virus to enter body tissues. Additional research is urgently needed to further pursue these important early findings.

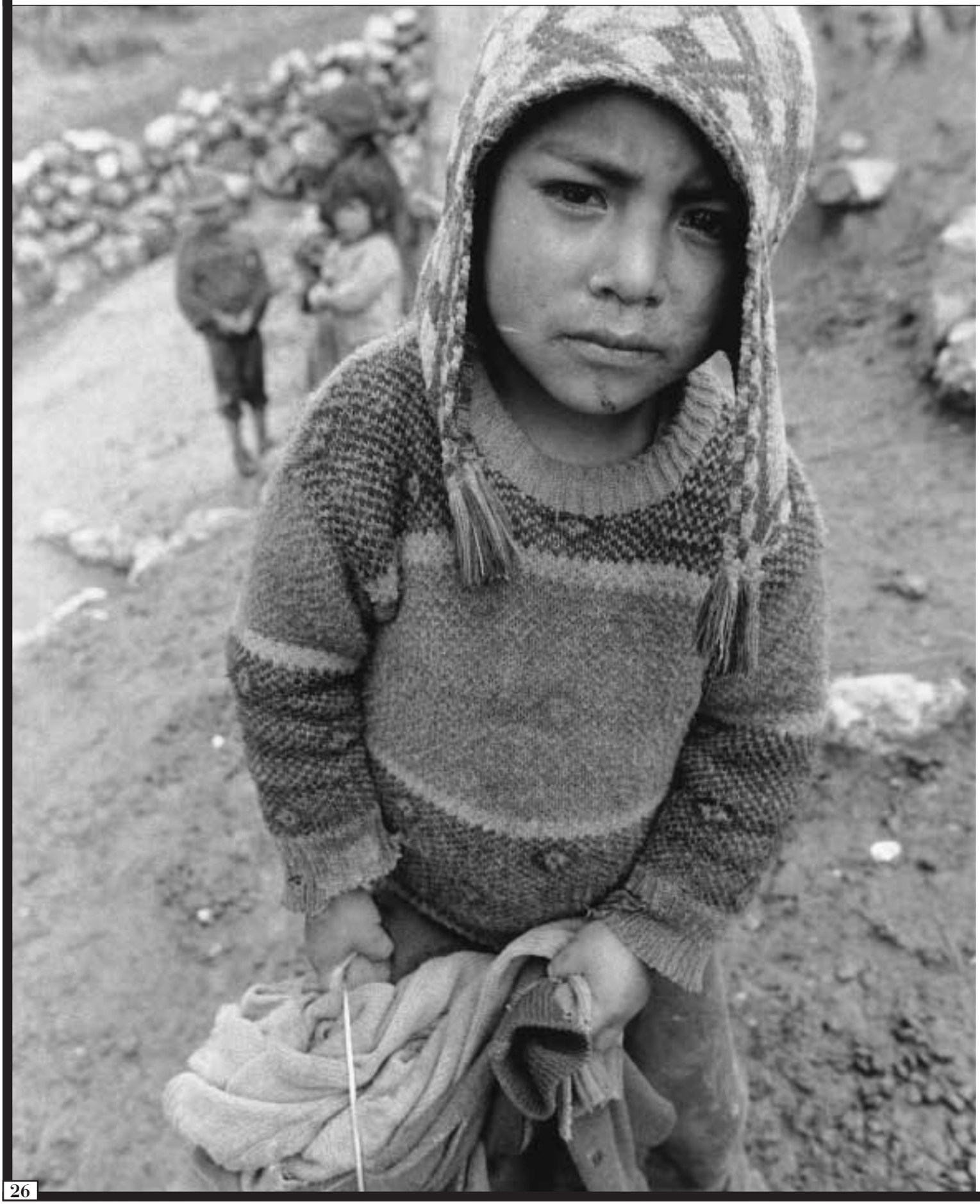
In the meantime, it remains critical to prevent 'spill-over' of artificial feeding to women who can safely breastfeed. This is best done through continued efforts by governments to implement the International Code of Marketing of Breastmilk Substitutes.

The guidelines also call for access to voluntary and confidential HIV counselling and testing for women and men. Women who are aware of their HIV status should be counselled on the risk of HIV transmission to their babies, and on the benefits and risks of all the various infant feeding options.

Women who are HIV negative, or who do not know their status, should be informed of the benefits of breastfeeding and of the particular importance of avoiding infection in the future.

DEBT HAS A CHILD'S FACE

COMMENTARY: DEBT RELIEF ESSENTIAL



UNICEF/96-0473/Balagtas

Debt has a child's face

By Shridath Ramphal

For nearly two decades, the debt crisis has had a crippling impact on some of the world's poorest countries, hobbling economic growth and draining scarce resources from health, education and other vital services. Can the campaign for debt relief be translated into effective action, ensuring that children of the new millennium are freed from the chains of debt and poverty?

Inscribed on the pinnacle of the Sun Yat-sen Memorial, in the Purple-Gold Mountains overlooking Nanjing in eastern China, are the words: "Tien xia wei gong" (What is under heaven is for all). Sun Yat-sen took these words from an ancient Chinese text as the guiding principle for the movement that liberated his country from feudalism.

Feudalism – part of the history of most nations, East and West, North and South – held people in permanent dependence, dividing them into powerful and powerless, haves and have-nots, those who made rules and those who had to obey them. To human society's great credit, we have moved to systems less unequal and unjust, in which the earth's bounty and the fruits of human toil are shared somewhat more fairly. But if the concepts of sharing and of fairness have evolved, they have done so only within States, and hardly among them.

The words on the memorial still have meaning for the world, especially for our modern global society: What is under heaven has *not* been, and *still is not*, for all on earth.

The debt bondage that ensnares hundreds of millions of the world's poorest people, particularly in Africa, provides clear evidence. As though bound to feudal lords, their lives and labour have been mortgaged to rich country banks and governments, often by leaders they did not choose, to finance projects that did not benefit them. Debt, like an oppressive political system, strips them of their rights. And its tyranny is particularly painful now, with sub-Saharan Africa in the grip of an unprecedented calamity as AIDS spreads remorselessly.

In the cool corridors of financial power, the plight of the debt-ridden may be spoken of in terms of capital flows, debt-service ratios and credit ratings. In the heat and dust of real life, however, debt is about lives, people's lives and – above all – children's lives.

Children pay the price

Debt has a child's face. Debt's burden falls most heavily on the minds and bodies of children, killing some, and stunting others so that they will never fully develop. It leaves children without immunization against fatal, but easily preventable, diseases. It condemns them to a life without education or – if they go to school – to classrooms without roofs, desks, chairs, blackboards, books, even pencils. And it orphans them, as hundreds of thousands of mothers die in childbirth each year, die as a result of inadequacies in health care and other services that poverty perpetuates.

Certainly, developing country governments that favour their own elites over their poor also bear much responsibility. But debt's demands make it hard for many governments to restructure their budgets towards more child-centred priorities even when they want to, and make it well-nigh impossible to succeed even if they do. Sub-Saharan Africa, for example, spends more on servicing its $200 billion debt than on the health and education of its 306 million children. The pattern is economically senseless and morally indefensible.

Each baby in Mauritania begins life encumbered with a debt of $997, in Nicaragua with $1,213, in the Congo with $1,872. The average for developing countries as a whole is $417. Yet in 1990 – nearly a decade ago – 71 Heads of State and Government, meeting at the World Summit for Children, committed themselves to "measures for debt relief" as part of a "global attack on poverty." They said that it is essential "to continue to give urgent attention to an early, broad and durable solution to the external debt problems facing developing debtor countries."

These world leaders endorsed the Convention on the Rights of the Child, adopted by the United Nations General Assembly the previous year, and now ratified by all but two nations, and they committed themselves to a series of goals by the end of the year 2000. These included halving malnutrition among under-fives and cutting their death rates by a third, halving maternal mortality rates, enabling every child to attend primary school and immunizing 90 per cent of the world's infants.

Debt gravely imperils these goals. Solving the debt crisis will not, of itself, mean that these targets are met: National policies are absolutely vital. But without a solution of the debt problem, there is no chance that the right national policies can be implemented or that goals can be reached by the year 2000, or any time in the predictable future.

Debt is not intrinsically bad: Indeed, money lent, borrowed

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COMMENTARY: DEBT RELIEF ESSENTIAL

and spent wisely spurs growth and improves people's lives. Nor is there anything new about debt crises: Ancient Greek city states defaulted after borrowing from the temple of Delos.

The current crisis, however, because it affects many of the world's poorest countries, makes their debt levels especially crippling.

The seeds of crisis were sown in the early 1970s, when OPEC countries dramatically raised oil prices – and deposited their increased earnings in Western banks. With interest to pay on these deposits, banks quickly embarked on a search for borrowers in developing countries. They found that the developing world wanted cash to invest in infrastructure and industry, and to pay for oil at its higher price.

So in a world seemingly awash with money, private loans – often unwise – were touted around developing countries; rich countries and international financial institutions, like the World Bank and the International Monetary Fund (IMF), also extended loans to less credit-worthy low-income countries.

Developing countries were tempted, also unwisely, by low interest rates, often below the rate of inflation. Confident that their commodities would continue to fetch high prices and that interest rates would remain low, they gambled that repayment would be easy. Much of the borrowed money went to inappropriate projects, to buy arms, or even into private overseas bank accounts. The poor, women and children, saw little of it.

Commodity prices instead fell sharply, interest rates increased and, in 1979, oil prices rose again. As the cost of servicing their debts escalated and their revenue plummeted, developing countries frantically borrowed more to try to meet their obligations and stave off ruin. But every percentage point increase in interest rates in the 1980s added more than $5 billion to what debtor countries had to pay each year. Killing arrears accumulated.

In a mathematical construct that only lenders could embrace and find just, between 1983 and 1990, indebted developing countries repaid the staggering amount of $1,000 billion. Astoundingly, despite this enormous transfer of wealth, their debt burden, which was some $800 billion in 1983, reached $1,500 billion by 1990 and nearly $2,000 billion by 1997 because of debt service arrears and new borrowing.

The crisis has been global, but it is gravest in sub-Saharan Africa, which owed $84 billion in 1980 and now owes $200 billion, an impossible drain on its fragile economies.

Africa overwhelmed

Africa has repaid its initial debt many times over in cash terms, losing precious social gains in the process and strapping its economies to the breaking point. Between a quarter and a third of national budgets in sub-Saharan countries (and 40 per cent in the most heavily indebted poor countries) go to service debt. For the countries enduring the calamitous impact of AIDS, such senseless misdirection of scarce resources is especially cruel.

This massive resource shift costs children dearly. In the United Republic of Tanzania, four times more goes to repay debt than to primary education and nine times more than to basic health. Mozambique pays wealthy creditors more than it spends on basic education and health combined. So, too, does Zambia, which currently owes $7.2 billion in debt, five to six times its export earnings.

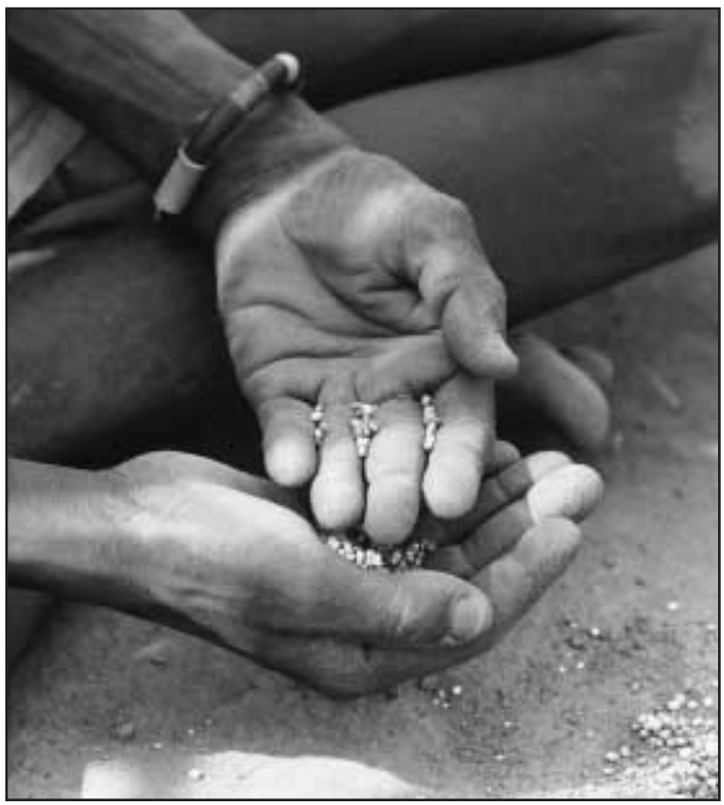
To further deepen the crisis, official development assistance (ODA) is plumbing record lows. The proportion of gross national product (GNP) that industrialized nations devote to assistance now stands at 0.22 per cent, less than a third of the UN target of 0.7 per cent. If it had remained at just 0.33 per cent, its level as recently as 1992, developing countries would be receiving $24 billion more each year.

And of the bilateral aid reaching poor countries, about one quarter boomerangs back to donors as debt repayments. In Tanzania, one in every three aid dollars, and in Nicaragua and Zambia, as much as one in every two, is spent in this pointless way, instead of relieving poverty or laying the foundations for future growth.

Debt increases dependence on aid, slows growth, inhibits foreign investment, creates instability and soaks up money that could be spent on health, education and other vital services. The debt crisis also cost creditor nations an estimated 6 million jobs in the 1980s, because money that debtor countries could have spent buying products went instead to service debt.

A mélange of capitals and countries have given their names to initiatives intended to relieve this debt slavery: London, Lyons, Mauritius, Naples, Toronto, Trinidad. But as far as the poor are concerned, they might all have been launched in never-never land, so meagre have been their results.

The approach now being followed is the Heavily Indebted



UNICEF/98-0254/Chalasani

More than a third of children in the heavily indebted poor countries have not been immunized, and about half the people in those countries are illiterate.

Poor Countries (HIPC) Initiative, designed to help 41 poor countries, 33 of them in Africa. Their child mortality rates are one-third higher – and their maternal mortality rates nearly three times greater – than the average for developing countries. More than a third of their children have not been immunized, and about a half of their people are illiterate.

The HIPC Initiative is the best hope yet to reduce all debt to what are supposed to be sustainable levels. But how slowly and grudgingly does it confer its benefits! Only two countries have received relief at the time of writing, despite the extreme urgency of their plight.

Countries must pass tough, often inappropriate, criteria to be eligible for the HIPC Initiative, undergoing, for instance, three to six years of harsh structural adjustment programmes that often deepen poverty or widen inequality while failing to promote growth. The Initiative set the debt service to export earnings ratio at 20–25 per cent, although the countries could ill afford the 16 per cent they were paying in 1996. They will thus be no more – and probably less – able to meet the goals set for children than they were before.

Little money has actually been provided for this Initiative, which is expected to cost about $12.5 billion, placing the appearance of financial rectitude above any real relief to the poor. How unlikely it is that the funding will materialize might be gauged from the experience of Honduras. Although Honduras was devastated at the end of 1998 by Hurricane Mitch, it has received only a fraction of the help promised by donors to meet $200 million in debt service due this year. In contrast, of course, was the speed with which donors mobilized *$100 billion* in just a few months to bail out East Asia, where insolvency threatened Western economies!

There has been a strong campaign to persuade rich country governments to make the HIPC scheme less rigid and to offer relief more quickly. This year, Canada, Germany, the United Kingdom and the United States called for reforms to speed the pace, calling also for debt cancellation for some severely stressed countries.

OXFAM similarly has proposed reforms, most notably to give earlier and much deeper relief to debtor countries that wish to devote 85–100 per cent of the savings to programmes to reduce poverty. These would, of course, have to be worked out through collaboration between lenders and borrowers. And a commitment on the part of both borrowers and lenders to protect an indebted country's capacity to deliver basic social services to its people – before any debt repayments are made – is another reform being proposed.

Uganda, the first country to get relief, is already educating another 2 million children; Bolivia, the second, is to help fund a national programme to reduce rural poverty. OXFAM calculates that such relief would enable Tanzania to enrol almost all of its children in primary school, Mozambique to double health expenditure and rehabilitate schools and health centres, and Nicaragua to achieve a wide range of objectives, including universal free primary education, improved primary health care for 1.2 million people, and safe water for 600,000 more of its citizens.

Push to cancel debt

Immensely valuable as such reforms could be, however, they are not enough. Unpayable debt exacerbates poverty, so some or all of the debt must be cancelled for the poorest countries at least. The Jubilee 2000 campaign, which calls for a one-off cancellation of unpayable debt at the millennium, has won both wide popular support and been endorsed by many political and religious leaders. The precise date may be a matter for debate, but the need for significant cancellation is now unquestionable.

It is said that cancellation would set a precedent and make it less likely that debtor countries would be lent money in the future. But, as we have seen, there have been defaults in the past, and the poorest debtors attract little investment anyway. Cancellation, it is also claimed, would create a 'moral hazard' by rewarding irresponsibility.

But reckless lending helped cause the crisis, so the responsibility is a joint one. Besides, the debtors have already repaid what they owe in actual cash terms; clearly, a greater moral hazard is created by continuing to insist on extreme financial stringency at the expense of children's lives.

Cancellation is an opportunity for both creditors and debtors to launch a war on poverty and direct resources to the most needy, especially children, by concentrating on human development. It would be consistent with the 20/20 Initiative – a plan for financing basic social services from national resources and donor funds agreed upon by all governments at the World Summit for Social Development in 1995 – and it is long overdue.

The time for a joint assault on debt and destitution is not now – it was yesterday. For millions of children, tomorrow will be too late. ■

UNICEF/97-0397/Balaguer

Debt's burden falls most heavily on the minds and bodies of children.

LEAGUE TABLE: EXTERNAL DEBT AS PERCENTAGE OF GNP

How to measure the levels of debt that can be sustained is intensely debated. Some argue that many definitions of what constitutes 'sustainable debt' put the thresholds so high that unacceptable sacrifices of basic social services, with great human costs, have to be made so that debt service can be paid. This league table of external debt-to-GNP ratios does not include such economic or social sustainability factors, but it does provide a useful perspective for examining and comparing countries' debt levels.

Gauging debt's burden

Borrowing is essential for financing development and is a fundamental aspect of the global economic system. Ideally, a country borrows to boost long-term productivity and economic output and to advance in human development, with gains from economic growth and exports going to further stimulate the economy and repay lenders the principal and interest owed.

However, when a country's debt becomes disproportionately large compared to its gross national product (GNP) and export earnings, then instead of stimulating growth and helping to advance human development, debt begins to sap economic vitality and drain resources from social sectors. To repay such high levels of debt (so as not to default or add arrears to the total debt), a country must divert already scarce resources. Too often the poor, especially children, pay the highest price, deprived of basic health care, nutrition and education because a significant proportion of government resources goes to servicing debt.

The table lists countries by region in order of the magnitude of their debt burden – calculated as the ratio of total external or foreign debt to GNP. The most debt-distressed countries top the regional lists. But their debt burdens are not equal. Guinea-Bissau, where debt is 366% of its GNP, has a far greater burden than Turkmenistan, where debt is 63% of GNP.

Averages often mask serious disparities. In sub-Saharan Africa, the most seriously affected region, the average is 69%. But this average includes South Africa, where the GNP is more than 40% of the combined GNP of the entire region and where the external debt-to-GNP ratio is low. As the chart on the facing page shows, when South African data is excluded, the region's ratio jumps to 108%.

The external debt-to-GNP ratio is only one measure used to gauge debt. The ratio of debt service to exports also determines whether poor countries' debts are 'sustainable', as do the terms on which debt is incurred. Guinea-Bissau, for example, borrowed nearly three quarters of its debt on concessional terms (at low interest rates for long terms, with repayment deferred), while Turkmenistan borrowed less than 5% on such terms. But Guinea-Bissau's very high debt-to-GNP ratio nonetheless indicates severe economic and social stress.

SUB-SAHARAN AFRICA	
Guinea-Bissau	366
Somalia	307
Congo	278
Mozambique	249
Mauritania	235
Angola	232
Congo, Dem. Rep.	232
Liberia	189
Zambia	185
Côte d'Ivoire	165
Ethiopia	159
Sierra Leone	141
Madagascar	119
Mali	119
Burundi	113
Cameroon	109
Gambia	108
Tanzania	97
Gabon	96
Guinea	95
Togo	93
Ghana	89
Malawi	89
Central African Rep.	88
Niger	86
Nigeria	85
Senegal	83
Benin	77
▶ *Regional average*	*69*
Chad	65
Kenya	65
Rwanda	60
Zimbabwe	58
Mauritius	57
Uganda	56
Burkina Faso	54
Lesotho	52
South Africa	20
Botswana	11
Eritrea	9
Namibia	2

MIDDLE EAST AND NORTH AFRICA	
Sudan	182
Syria	126
Jordan	117
Yemen	77
Algeria	69
Tunisia	63
Morocco	59
Turkey	47
Egypt	39
▶ *Regional average*	*37*
Oman	34
Lebanon	33
Kuwait	28
U. Arab Emirates	28
Israel	25
Saudi Arabia	15
Iran	10
Iraq	No data
Libya	No data

DEVELOPING WORLD AVERAGE

35%

CENTRAL ASIA

Turkmenistan	63
Tajikistan	45
Kyrgyzstan	43
Armenia	38
Georgia	28
▶ *Regional average*	*20*
Kazakhstan	19
Azerbaijan	12
Uzbekistan	11
Afghanistan	No data

EAST/SOUTH ASIA AND PACIFIC

Lao PDR	132
Viet Nam	89
Mongolia	73
Cambodia	70
Indonesia	65
Thailand	63
Papua New Guinea	56
Philippines	53
Malaysia	51
Sri Lanka	51
Nepal	49
Pakistan	47
Bangladesh	35
New Zealand	34*
Korea, Rep.	33
Bhutan	27
India	27
China	17
▶ *Regional average*	*11*
Australia	9*
Japan	0*
Singapore	0*
Korea, Dem.	No data
Myanmar	No data

AMERICAS

Nicaragua	306
Honduras	103
Jamaica	98
Ecuador	87
Panama	75
Bolivia	68
Peru	50
Chile	42
Venezuela	42
Argentina	39
Trinidad/Tobago	39
Costa Rica	38
Haiti	38
Mexico	38
Colombia	35
Uruguay	33
Dominican Rep.	29
El Salvador	29
Brazil	24
Guatemala	23
Paraguay	21
▶ *Regional average*	*19*
United States	16*
Canada	10*
Cuba	No data

EUROPE

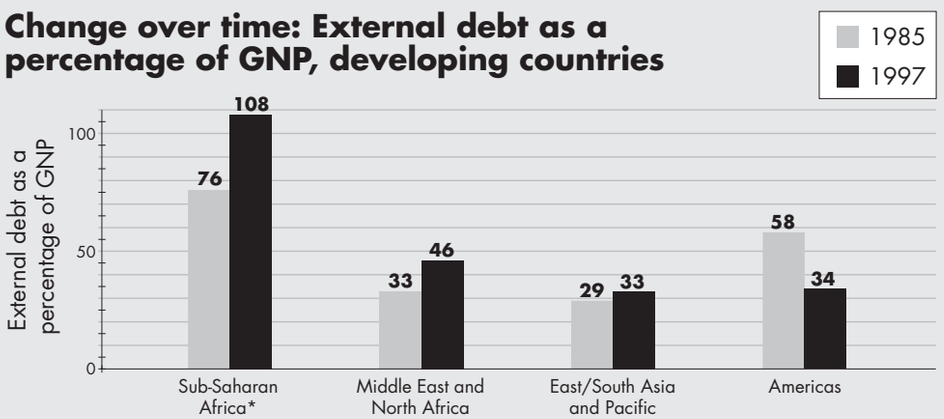
Bulgaria	101
TFYR Macedonia	71
Hungary	55
Moldova, Rep.	52
Slovakia	52
Czech Rep.	42
Bosnia/Herzegovina	41
Sweden	37*
Finland	36*
Croatia	35
Romania	33
Poland	29
Albania	28
Denmark	26
Russian Fed.	26
Greece	25*
Germany	19*
Ukraine	18
Lithuania	16
▶ *Regional average*	*15*
Estonia	14
Netherlands	13*
Austria	12*
Slovenia	12
Spain	12*
Latvia	9
Norway	6*
United Kingdom	6*
Belarus	5
Italy	5*
Belgium	0*
Switzerland	0*
France	No data
Ireland	No data
Portugal	No data
Yugoslavia	No data

WHAT THE TABLE RANKS

Total external debt as a percentage of gross national product (GNP)

*Central government external debt only.

Change over time: External debt as a percentage of GNP, developing countries



*Excluding South Africa.

Sources for league table and accompanying graph: World Bank, *Global Development Finance 1999* and *World Bank Atlas 1999*; and IMF, *Government Finance Statistics Yearbook*, 1998.

Debt takes heavy toll on children's rights

Out of 27 developing countries surveyed, only 9 manage to spend more on basic social services than on debt servicing, according to a recent study by UNICEF and UNDP. Six of the 12 African countries in the survey spend more than twice as much on debt as on basic social services. Such social services – including primary and reproductive health care, nutrition, safe water, adequate sanitation and basic education – are essential in safeguarding children's right to survival and development and in overcoming entrenched poverty.

In nine of the countries, debt payments absorb more than 30% of the national budget, and in Kenya, Malawi, Tanzania (excluding Zanzibar) and Zambia, debt drains 40% or more of budgets. In comparison, basic social services receive, on average, only 13% of national budgets, and less than 10% in seven of the countries – Brazil, Cameroon, Dominican Republic, Malawi, Nicaragua, Philippines and Zambia.

These findings indicate that world leaders need to renew the commitments made at the 1990 World Summit for Children to work for debt relief.

The findings also demonstrate why debt reduction is vital for the 20/20 Initiative, supported by UNICEF and other international agencies, which urges that developing countries allocate 20% of their budgets for the basics and that donor countries also earmark 20% of their official development assistance for the basics.

Where the money goes

	Year(s)	% of central government expenditure on: Basic social services	Debt service
Africa			
Tanzania*	1994–95	15	46
Kenya	1995	13	40
Malawi	1997	8	40
Zambia	1997	7	40
Cameroon	1996–97	4	36
Côte d'Ivoire	1994–96	11	35
Niger	1995	20	33
Benin	1997	10	11
Burkina Faso	1997	20	10
Uganda	1994–95	21	9
South Africa	1996–97	14	8
Namibia	1996–97	19	3
Asia			
Philippines	1992	8	31**
Sri Lanka	1996	13	22
Nepal	1997	14	15
Thailand	1997	15	1**
Latin America and Caribbean			
Jamaica	1996	10	31
El Salvador	1996	13	27
Honduras	1992	13	21
Brazil	1995	9	20
Nicaragua	1996	9	14**
Costa Rica	1996	13	13
Bolivia	1997	17	10**
Dominican Rep.	1997	9	10
Colombia	1997	17	8**
Belize	1996	20	6**
Chile	1996	11	3

*Excluding Zanzibar.

**International Monetary Fund, *Government Finance Statistics Yearbook*, 1996, data for the same or latest available year.

Sources: UNICEF and UNDP, *Country Experiences in Assessing the Adequacy, Equity and Efficiency of Public Spending on Basic Social Services*, October 1998, and unpublished documents.

How little has changed

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

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

"And when the impact becomes visible in rising death rates among children, rising percentages of low-birthweight babies, falling figures for the average weight-for-height of the under-fives, and lower school enrolment ratios among 6- to 11-year-olds, then it is essential to strip away the niceties of economic parlance and say that what has happened is simply an outrage against a large section of humanity…. Allowing world economic problems to be taken out on the growing minds and bodies of young children is the antithesis of all civilized behaviour. Nothing can justify it. And it shames and diminishes us all."

These words are taken from UNICEF's *The State of the World's Children 1989* report, but they could have been written yesterday. For years now, the consequences of the global debt crisis have fallen most heavily on the young, particularly on children in the 38 countries listed, which are poor, highly indebted and have been in desperate need of relief since the crisis began in 1982.

HIPC countries*

Angola	Equatorial Guinea	Madagascar	Sierra Leone
Bolivia	Ethiopia	Mali	Somalia
Burkina Faso	Ghana	Mauritania	Sudan
Burundi	Guinea	Mozambique	Tanzania
Cameroon	Guinea-Bissau	Myanmar	Togo
Central African Rep.	Guyana	Nicaragua	Uganda
Chad	Honduras	Niger	Viet Nam
Congo	Kenya	Rwanda	Yemen
Congo, Dem. Rep.	Lao PDR	Sao Tome and Principe	Zambia
Côte d'Ivoire	Liberia		

*The list of HIPC countries is evolving as countries' debt burdens are evaluated against three criteria. To qualify for assistance under the HIPC Initiative, a country must be poor, have an unsustainable debt (defined as more than 200–250% of the value of their annual exports with debt service greater than 20–25% of their annual income from exports) and have implemented reforms.

Note: Initially, the HIPC list contained 41 countries that appeared to fit the criteria. Since the programme began in 1996, Benin, Nigeria and Senegal have been found not to meet the criteria. Other countries are expected to be dropped and more to be added during the review process.

Source: World Bank.

The Highly Indebted Poor Country Initiative, or HIPC, was launched under the leadership of the World Bank and IMF at the end of 1996, with the goal of returning to solvency such severely impoverished countries with unsustainable debt burdens. Progress, however, has been slow and painful: So far, only two countries – Uganda and Bolivia – have received relief, and commitments for HIPC support have been made to only five additional countries.

As this publication goes to press, leaders of some of the wealthiest creditor countries are preparing to meet to discuss, among other issues, reforming and speeding the HIPC process. This is a hopeful sign. But proposals have been made before, and optimism is difficult to muster given the experience of the last 10 years, with outcomes so dwarfed by the overwhelming needs. And the costs to children, meanwhile, continue to mount.

Poor hit hardest as aid plummets

The gulf between rich and poor has widened dramatically during the 1990s – while aid to developing countries has plummeted. In the world's poorest countries, the average GNP slipped from $240 per person in 1990 to $232 in 1996. This contrasts with an average GNP surge from $20,900 to $27,000 per person in donor countries during the same period.

Despite this growth in donor wealth, official development assistance (ODA) dropped to $48.3 billion in 1997. In real terms, this was 21% lower than in 1992. For the Group of 7 – the leading industrial countries – the decline was almost 30%.

UNICEF/93-0695/Horner

Debt drains resources from vital services. Many countries allocate less than 10% of their national budgets to basic social services. A poor neighbourhood in Peru.

Cuts in ODA have hit hardest in poor countries where child mortality is high and access to primary education and safe drinking water is low, and which are also bypassed by private capital flows.

Aid as a proportion of donor countries' GNPs – a measure of their ability to provide aid – fell to an average of 0.22% in 1997, the lowest point since 1970, when the world agreed on the aid target of 0.7% of donors' GNP. Only four countries – Denmark, Netherlands, Norway and Sweden – consistently reach or exceed the target. Denmark earmarked 0.97% of its GNP for aid in 1997, the highest proportion among donor countries in the Organisation for Economic Co-operation and Development (OECD). The United States gave the lowest proportion, 0.09%.

Denmark also led donors on the basis of aid per person, giving $311 per capita; Italy was the lowest per capita donor, giving $22. Japan was the highest aid donor in dollar terms, allocating $9.4 billion, followed by the United States with $6.9 billion, and France with $6.3 billion.

If all donor countries had met the aid target of 0.7% of GNP, total aid would have been more than $100 billion above the 1997 total. Maintained for 10 years, this amount would be more than enough to ensure access to basic social services – basic education and primary health care, adequate nutrition and safe water and sanitation – for all communities.

Aid on the decline

Amounts*

	ODA as % of donor nations' GNP % 1997	% 1990	Total aid ($ billions) 1997	Aid per person ($) 1997	Change per person ($) since 1990
Denmark	0.97	0.94	1.6	311	67
Norway	0.86	1.17	1.3	297	7
Netherlands	0.81	0.92	2.9	189	6
Sweden	0.79	0.91	1.7	195	-25
Luxembourg	0.55	0.21	0.1	228	156
France	0.45	0.60	6.3	108	-27
Canada	0.34	0.44	2.0	68	-16
Switzerland	0.34	0.32	0.9	126	5
Finland	0.33	–	0.4	74	-67
Belgium	0.31	0.46	0.8	75	-24
Ireland	0.31	0.16	0.2	51	34
Australia	0.28	0.34	1.1	58	-12
Germany	0.28	0.42	5.9	71	-19
Austria	0.26	0.25	0.5	65	7
New Zealand	0.26	0.23	0.2	41	5
United Kingdom	0.26	0.27	3.4	59	5
Portugal	0.25	0.25	0.3	25	7
Spain	0.23	0.20	1.2	31	8
Japan	0.22	0.31	9.4	74	-18
Italy	0.11	0.31	1.3	22	-36
United States	0.09	0.21	6.9	25	-29
Average/total	**0.22**	**0.33**	**48.3**	**59**	**-18**

*In 1997 dollars. As of 1997, aid to Israel is no longer counted as ODA.

Sources: OECD, *Development Co-operation* (1996 and 1998 reports); UN Population Division, *World Population Prospects*, 1998 revision.

Focusing aid on the basics

During the 1990s, a broad understanding has developed that access for all to basic social services is vital for reducing poverty. These essentials comprise basic health care, including reproductive health, basic education, nutrition programmes and safe water supply and sanitation. Yet millions of children are deprived of their right to these building blocks for a brighter future, destined instead to live and die in poverty.

Development assistance is one key element in improving access to basic social services in poor countries and forms a linchpin of the 20/20 Initiative, which urges governments of both donor and developing countries to allocate 20% of their official development assistance and national budgets, respectively, to basic social services. However, it has been difficult to pinpoint what proportion of aid goes to the basics.

Now studies of 16 countries, conducted by UNICEF and UNDP, throw new light on this question. They found, for example, that in 7 of the 16 countries reviewed, 10% or less of aid goes to fund basic social services. In Kenya, Mali and Namibia, on the other hand, the levels are 20% or more. Another finding is that levels of aid to the basics can vary widely over time (shifts that are not indicated in the table). In Niger, for example, the share rose from 6% in 1992 to 18% in 1995, while in Peru it dropped from 22% in 1994 to 5% in 1996. These studies are helping reveal areas where greater resources should be focused, and further research will broaden this knowledge base.

Aid to basic social services

	Year	% of total aid spent on basic social services
Sub-Saharan Africa		
Namibia	1996	30
Mali	1996	23
Kenya	1995	20
Benin	1996	18
Burkina Faso	1996	18
Niger	1995	18
Uganda	1996	16
Zambia	1996	13
Tanzania	1996	10
Côte d'Ivoire	1994	9
Cameroon	1996	8
Latin America		
Nicaragua	1996	15
Bolivia	1996	8
Peru	1996	5
Asia		
Sri Lanka	1996	5
Viet Nam	1996	5

Sources: UNICEF and UNDP, *Country Experiences in Assessing the Adequacy, Equity and Efficiency of Public Spending on Basic Social Services*, October 1998, and unpublished documents.

Target 2000

A summary of the year 2000 goals agreed to by almost all nations at the 1990 World Summit for Children.

1. Reduction of infant and under-5 child mortality rates by one third of the 1990 levels, or to 50 and 70 per 1,000 live births respectively, whichever is less.

2. Reduction of the 1990 maternal mortality rates by half.

3. Reduction of severe and moderate malnutrition among under-5 children by half of the 1990 levels.

4. Universal access to safe drinking water and to sanitary means of excreta disposal.

5. Universal access to basic education and completion of primary education by at least 80% of primary school age children.

6. Reduction of the adult illiteracy rate (the appropriate age group to be determined in each country) to no more than half its 1990 level, with emphasis on female literacy.

7. Improved protection of children in especially difficult circumstances.

	Total population (millions) 1997	Population under 18 (millions) 1997	Annual no. of births (thousands) 1997	Annual no. of under-5 deaths (thousands) 1997	Under-5 mortality rate 1997	GNP per capita ($) 1997	% of under-5 children underweight 1987–98	Net primary school enrolment/ attendance [a/] (%) 1987–97	Total fertility rate 1997	Maternal mortality ratio [b/] 1980–97 Reported	Adjusted
SUB-SAHARAN AFRICA											
Angola	11.7	6.3	570	166	292	340	42	–	6.8	–	–
Benin	5.6	3.0	234	39	167	380	29	62	5.9	500	–
Botswana	1.5	0.8	52	3	49	3260	17	84	4.4	330	–
Burkina Faso	11.0	6.0	508	86	169	240	30	33 y	6.6	–	–
Burundi	6.4	3.4	270	48	176	180	37	52	6.3	–	–
Cameroon	13.9	7.0	550	80	145	650	14	65 y	5.3	–	–
Central African Rep.	3.4	1.7	129	22	173	320	27	63 y	4.9	1100	–
Chad	7.1	3.7	313	62	198	240	39	52	6.1	830	–
Congo	2.7	1.4	119	13	108	660	17	–	6.1	–	–
Congo, Dem. Rep.	48.0	25.9	2228	461	207	110	34	56 y	6.5	–	–
Côte d'Ivoire	14.1	7.2	525	79	150	690	24	55	5.2	600	–
Eritrea	3.4	1.7	141	16	116	210	44	31	5.7	1000	–
Ethiopia	58.2	30.4	2606	456	175	110	48	24	6.3	–	–
Gabon	1.1	0.5	43	6	145	4230	–	86 y	5.4	–	–
Gambia	1.2	0.6	48	4	87	350	26	65	5.2	–	–
Ghana	18.7	9.5	700	75	107	370	27	70 y	5.2	210	–
Guinea	7.3	3.8	305	61	201	570	–	33 y	5.6	670	–
Guinea-Bissau	1.1	0.6	47	10	220	240	–	47 y	5.8	910	910
Kenya	28.4	14.9	981	85	87	330	23	84 y	4.5	370	–
Lesotho	2.0	0.9	71	10	137	670	16	63	4.8	–	–
Liberia	2.4	1.4	109	26	235	490	–	56 y	6.4	–	–
Madagascar	14.6	7.3	598	94	158	250	40	59 y	5.5	490	–
Malawi	10.1	5.4	486	104	215	220	30	83 y	6.8	620	–
Mali	10.4	5.6	492	118	239	260	40	41 y	6.7	580	–
Mauritania	2.5	1.2	100	18	183	450	23	54 y	5.5	550	–
Mauritius	1.1	0.4	18	0	23	3800	16	98	1.9	30	–
Mozambique	18.4	9.4	803	168	209	90	26	50 y	6.3	1100	–
Namibia	1.6	0.8	58	4	75	2220	26	91	4.9	230	–
Niger	9.8	5.4	479	137	285	200	43	24	6.9	590	–
Nigeria	103.9	52.7	4056	758	187	260	36	59 y	5.2	–	–
Rwanda	6.0	3.2	274	47	170	210	27	61 y	6.2	–	–
Senegal	8.8	4.5	353	44	124	550	22	59	5.6	560	–
Sierra Leone	4.4	2.2	208	66	316	200	29	–	6.1	–	–
Somalia	8.8	4.8	469	99	211	110	–	17 y	7.3	–	–
South Africa	38.8	16.3	1056	87	82	3400	9	94	3.3	–	–
Tanzania	31.4	16.5	1295	185	143	210	27	48	5.5	530	–
Togo	4.3	2.3	179	22	125	330	19	81	6.1	–	–
Uganda	20.0	11.3	1026	141	137	320	26	64 y	7.1	510	–
Zambia	8.6	4.7	366	74	202	380	24	74 y	5.6	650	–
Zimbabwe	11.2	5.6	354	28	80	750	16	91 y	3.9	400	–
MIDDLE EAST AND NORTH AFRICA											
Algeria	29.4	13.3	866	34	39	1490	13	94	3.9	220	–
Egypt	64.7	28.3	1725	126	73	1180	15	80	3.4	170	170
Iran	64.6	30.6	1422	50	35	1780	16	97 y	2.9	37	–
Iraq	21.2	10.3	781	95	122	**	23	83 y	5.3	–	–
Israel	5.9	2.0	116	1	6	15810	–	–	2.7	5	–
Jordan	6.1	3.0	213	5	24	1570	9	89	4.9	41	41
Kuwait	1.7	0.8	40	1	13	22110	–	65	2.9	5	–
Lebanon	3.1	1.2	75	3	37	3350	3	76	2.7	100	–
Libya	5.2	2.5	152	4	25	5540	5	97	3.8	75	–
Morocco	26.9	11.0	699	50	72	1250	9	72	3.1	230	–
Oman	2.3	1.2	81	1	18	4950	23	90 y	5.9	21	–
Saudi Arabia	19.5	9.3	664	19	28	6790	–	61	5.9	–	–
Sudan	27.7	13.3	922	106	115	280	34	55 y	4.6	550	–
Syria	14.9	7.6	456	15	33	1150	13	91	4.1	110	–

	Total population (millions) 1997	Population under 18 (millions) 1997	Annual no. of births (thousands) 1997	Annual no. of under-5 deaths (thousands) 1997	Under-5 mortality rate 1997	GNP per capita ($) 1997	% of under-5 children underweight 1987–98	Net primary school enrolment/ attendance [a] (%) 1987–97	Total fertility rate 1997	Maternal mortality ratio [b] 1980–97	
										Reported	Adjusted
Tunisia	9.2	3.6	190	6	33	2090	9	96	2.6	70	70
Turkey	63.4	23.0	1419	64	45	3130	10	96	2.5	130	–
U. Arab Emirates	2.3	0.8	42	0	10	17360	14	78	3.5	3	–
Yemen	16.3	8.8	785	79	100	270	39	57 y	7.6	–	–
CENTRAL ASIA											
Afghanistan	20.9	9.9	1076	277	257	250	48	24 y	6.9	–	–
Armenia	3.6	1.2	46	1	30	530	–	–	1.7	35	–
Azerbaijan	7.6	2.8	128	6	46	510	10	–	2.1	37	–
Georgia	5.1	1.4	71	2	23	840	–	83	1.9	60	–
Kazakhstan	16.4	5.7	303	13	44	1340	8	–	2.3	70	–
Kyrgyzstan	4.6	2.0	118	8	68	440	11	97	3.2	65	–
Tajikistan	5.9	2.8	190	14	76	330	–	–	4.2	85	–
Turkmenistan	4.2	1.9	122	10	78	630	–	80 y	3.6	110	–
Uzbekistan	23.2	10.5	654	38	58	1010	19	–	3.5	21	–
EAST/SOUTH ASIA AND PACIFIC											
Australia	18.3	4.7	248	1	6	20540	–	97	1.8	–	–
Bangladesh	122.7	55.9	3403	371	109	270	56	76 y	3.1	440	–
Bhutan	1.9	1.0	74	9	121	400	38	–	5.5	380	–
Cambodia	10.5	5.0	365	61	167	300	52	97	4.6	470	–
China	1244.0	380.0	20410	959	47	860	16	100	1.8	60	60
India	966.2	392.7	24871	2686	108	390	53	79 y	3.2	440	–
Indonesia	203.4	77.8	4688	281	60	1110	34	94 y	2.6	450	–
Japan	126.0	24.0	1249	7	6	37850	–	100	1.4	8	–
Korea, Dem.	23.0	7.3	491	15	30	970	60	–	2.1	110	–
Korea, Rep.	45.7	12.6	685	4	6	10550	–	92	1.7	20	20
Lao PDR	5.0	2.5	200	24	122	400	40	71	5.8	650	–
Malaysia	21.0	8.7	530	6	11	4680	19	91	3.2	39	39
Mongolia	2.5	1.1	58	9	150	390	10	82	2.7	150	–
Myanmar	43.9	16.1	939	107	114	220	43	85 y	2.4	230	–
Nepal	22.3	10.9	775	81	104	210	47	70 y	4.5	540	–
New Zealand	3.8	1.0	57	0	7	16480	–	100	2.0	15	15
Pakistan	144.0	70.2	5263	716	136	490	38	66 y	5.1	–	–
Papua New Guinea	4.5	2.1	144	16	112	940	–	32 y	4.6	370	–
Philippines	71.4	31.6	2061	95	46	1220	28	100	3.7	210	–
Singapore	3.4	0.9	51	0	4	32940	–	94	1.7	6	–
Sri Lanka	18.3	6.3	326	6	19	800	34	–	2.1	60	60
Thailand	59.7	19.5	1001	38	38	2800	19	–	1.8	44	44
Viet Nam	76.4	32.1	1729	74	43	320	41	81 y	2.7	160	160
AMERICAS											
Argentina	35.7	12.2	712	17	24	8570	–	95	2.6	44	85
Bolivia	7.8	3.6	260	25	96	950	16	89 y	4.4	390	–
Brazil	163.7	60.5	3341	147	44	4720	6	94 y	2.3	160	–
Canada	30.3	7.2	350	2	7	19290	–	95	1.6	–	–
Chile	14.6	5.0	293	4	13	5020	1	88	2.5	23	–
Colombia	40.0	16.0	990	30	30	2280	8	89	2.8	80	80
Costa Rica	3.7	1.5	87	1	14	2640	2	94	2.8	29	35
Cuba	11.1	2.9	146	1	8	1170	9	100	1.6	24	24
Dominican Rep.	8.1	3.3	197	10	53	1670	6	81	2.8	230	–
Ecuador	11.9	5.0	309	12	39	1590	17	97	3.1	160	–
El Salvador	5.9	2.6	165	6	36	1810	11	79	3.2	160	–
Guatemala	10.5	5.4	388	21	55	1500	27	58 y	5.0	190	–
Haiti	7.8	3.9	250	33	132	330	28	68 y	4.4	–	–

These statistical profiles portray in sharp detail the development challenges the world faces at the start of the 21st century.

Among these 192 countries, per capita GNP ranges from $90 to $45,330 a year.

The under-five mortality rate varies from 4 to 316 deaths per 1,000 live births.

The percentage of underweight children ranges from 1% to 60%.

The primary school enrolment rate varies from 24% to 100% of children.

***The Progress of Nations* seeks to put an end to these intolerable inequalities by exposing them to the conscience of the world community.**

	Total population (millions) 1997	Population under 18 (millions) 1997	Annual no. of births (thousands) 1997	Annual no. of under-5 deaths (thousands) 1997	Under-5 mortality rate 1997	GNP per capita ($) 1997	% of under-5 children under-weight 1987–98	Net primary school enrolment/ attendance a/ (%) 1987–97	Total fertility rate 1997	Maternal mortality ratio b/ 1980–97	
										Reported	Adjusted
Honduras	6.0	3.0	202	9	45	700	18	90	4.4	220	220
Jamaica	2.5	1.0	55	1	11	1560	10	100	2.5	120	120
Mexico	94.3	38.7	2345	82	35	3680	14	100	2.8	48	85
Nicaragua	4.7	2.4	170	10	57	410	12	83	4.5	160	–
Panama	2.7	1.0	61	1	20	3080	7	91	2.7	85	–
Paraguay	5.1	2.4	160	5	33	2010	4	91	4.2	190	–
Peru	24.4	10.1	613	34	56	2460	8	87 y	3.0	270	–
Trinidad/Tobago	1.3	0.4	18	0	17	4230	7	88	1.7	–	–
United States	271.8	70.9	3835	31	8	28740	1	94	2.0	8	12
Uruguay	3.3	1.0	57	1	21	6020	5	96	2.4	21	–
Venezuela	22.8	9.5	571	14	25	3450	5	84	3.0	65	–
EUROPE											
Albania	3.1	1.1	65	3	40	750	–	96	2.5	–	–
Austria	8.1	1.7	84	0	5	27980	–	100	1.4	–	–
Belarus	10.4	2.6	100	3	27	2150	–	86	1.4	22	–
Belgium	10.1	2.1	108	1	7	26420	–	98	1.6	–	–
Bosnia/Herzegovina	3.5	0.9	37	1	19	*	–	–	1.4	10	–
Bulgaria	8.4	1.8	73	1	19	1140	–	92	1.3	15	–
Croatia	4.5	1.0	47	0	9	4610	1	82	1.6	12	–
Czech Rep.	10.3	2.3	91	1	7	5200	1	87	1.2	9	–
Denmark	5.3	1.1	64	0	6	32500	–	97	1.7	10	–
Estonia	1.4	0.3	12	0	23	3330	–	87	1.3	50	–
Finland	5.1	1.2	58	0	4	24080	–	99	1.7	6	6
France	58.5	13.5	716	4	5	26050	–	100	1.7	10	20
Germany	82.1	15.9	761	4	5	28260	–	100	1.3	8	–
Greece	10.6	2.1	98	1	8	12010	–	91	1.3	1	–
Hungary	10.2	2.2	100	1	11	4430	2	97	1.4	15	–
Ireland	3.7	1.0	51	0	7	18280	–	100	1.9	6	–
Italy	57.4	10.2	519	3	6	20120	–	98	1.2	7	–
Latvia	2.5	0.6	21	0	22	2430	–	90	1.3	45	–
Lithuania	3.7	0.9	38	1	24	2230	–	–	1.5	18	–
Moldova, Rep.	4.4	1.3	58	2	35	540	–	–	1.8	42	–
Netherlands	15.6	3.4	183	1	6	25820	–	99	1.5	7	10
Norway	4.4	1.0	58	0	4	36090	–	99	1.9	6	–
Poland	38.7	10.3	426	5	11	3590	–	95	1.6	8	–
Portugal	9.9	2.1	104	1	8	10450	–	100	1.4	8	–
Romania	22.5	5.4	207	5	26	1420	6	96	1.2	41	–
Russian Fed.	147.7	36.4	1411	31	22	2740	3	93	1.4	49	–
Slovakia	5.4	1.4	57	1	11	3700	–	–	1.4	9	–
Slovenia	2.0	0.4	18	0	6	9680	–	100	1.3	11	–
Spain	39.6	7.8	363	2	5	14510	–	100	1.2	6	–
Sweden	8.9	1.9	90	0	4	26220	–	100	1.6	5	–
Switzerland	7.3	1.5	81	0	5	44320	–	100	1.5	5	–
TFYR Macedonia	2.0	0.6	31	1	23	1090	–	85	2.1	11	–
Ukraine	51.1	12.1	496	11	23	1040	–	–	1.4	30	–
United Kingdom	58.5	13.4	701	5	7	20710	–	100	1.7	7	10
Yugoslavia	10.6	2.7	136	3	21	**	2	69	1.9	10	–

a/ Enrolment/attendance is derived from net primary school enrolment rates as reported by UNESCO and from national household survey reports of attendance at primary school.

b/ Since maternal deaths are often misclassified or underreported and data collection methods vary considerably, maternal mortality estimates are being adjusted to improve comparability and to better reflect the true levels of maternal mortality. As the "adjusted" column in this table shows, only partial data are currently available. A full set of the adjusted estimates will be available later in the year.

y/ School attendance data derived from household surveys.

* GNP per capita estimated range $785 or less.

**GNP per capita estimated range $786 to $3125.

LESS POPULOUS COUNTRIES

The countries listed below are those with populations of less than 1 million.

	League tables†												
	Child risk measure	Total external debt as % of GNP 1997	Total population (thousands) 1997	Population under 18 (thousands) 1997	Annual no. of births (thousands) 1997	Annual no. of under-5 deaths (thousands) 1997	Under-5 mortality rate 1997	GNP per capita ($) 1997	% of under-5 children under-weight 1988–97	Net primary school enrolment/ attendance a/ (%) 1987–97	Total fertility rate 1997	Maternal mortality ratio b/ 1980–97 Reported	Adjusted
Andorra	–	–	70	14	1	0.0	6	***	–	–	–	–	–
Antigua/Barbuda	–	–	66	24	1	0.0	21	7380	–	–	1.7	150	–
Bahamas	8	–	291	106	6	0.1	21	11830	–	95	2.6	–	–
Bahrain	8	–	583	210	12	0.3	22	7820	9	98	3	46	–
Barbados	15	38	267	72	3	0.0	12	6590	–	78	1.5	0	–
Belize	10	62	224	108	7	0.3	43	2740	6	99	3.7	140	140
Brunei Darussalam	6	–	308	121	6	0.1	10	25090	–	91	2.8	0	–
Cape Verde	15	52	399	191	12	0.9	73	1090	14	100	3.6	55	–
Comoros	43	102	640	327	23	2.1	93	400	26	53	4.9	500	–
Cook Islands	–	–	19	8	0	0.0	30	1550	–	–	–	–	–
Cyprus	3	–	763	224	10	0.1	9	14930	–	96	2.1	0	–
Djibouti	61	57	617	294	22	3.4	156	*	18	32	5.4	–	–
Dominica	–	71	71	26	1	0.0	20	3120	–	–	2.3	65	–
Equatorial Guinea	–	58	420	208	17	2.9	172	1050	–	–	5.6	–	–
Fiji	7	10	786	319	17	0.4	24	2470	8	99	2.8	38	–
Grenada	–	37	93	33	2	0.1	29	3000	–	–	–	0	–
Guyana	25	236	843	314	18	1.5	82	800	12	87	2.3	180	–
Iceland	2	–	274	78	4	0.0	5	27580	–	98	2.1	–	–
Kiribati	–	–	80	37	3	0.2	75	910	–	–	4.4	–	–
Liechtenstein	–	–	32	7	0	0.0	7	***	–	–	–	–	–
Luxembourg	11	–	417	89	5	0.0	7	45330	–	81	1.7	0	–
Maldives	43	52	263	136	9	0.7	74	1150	43	–	5.5	350	390
Malta	2	31	381	99	4	0.0	10	8630	–	100	1.9	–	–
Marshall Islands	–	–	58	27	2	0.2	92	1770	–	–	–	–	–
Micronesia (Fed. States of)	–	–	112	51	4	0.1	24	1980	–	–	4.1	–	–
Monaco	–	–	33	8	0	0.0	5	***	–	–	–	–	–
Nauru	–	–	11	5	0	0.0	30	–	–	–	–	–	–
Niue	–	–	2	1	0	–	–	–	–	–	–	–	–
Palau	–	–	18	8	1	0.0	34	**	–	–	–	–	–
Qatar	12	–	569	178	10	0.2	20	11570	6	80	3.8	10	–
Saint Kitts and Nevis	–	24	39	14	1	0.0	37	6160	–	–	2.4	130	–
Saint Lucia	–	26	148	53	3	0.1	29	3620	–	–	2.6	30	–
Saint Vincent/Grenadines	–	89	112	40	2	0.0	21	2500	–	–	2.2	43	–
Samoa	5	80	172	79	4	0.1	27	1150	–	97	4.2	–	–
San Marino	–	–	26	5	0	0.0	6	–	–	–	–	–	–
Sao Tome/Principe	18	672	138	73	6	0.5	78	270	16	93 y	4.7	–	–
Seychelles	7	28	75	39	3	0.1	18	6880	6	–	2.4	–	–
Solomon Islands	20	37	404	205	14	0.4	28	900	21	–	4.9	550	–
Suriname	–	–	412	164	8	0.3	36	1240	–	–	2.2	110	110
Swaziland	32	25	925	466	35	3.3	94	1440	–	95	4.7	230	–
Tonga	–	32	98	42	2	0.0	23	1830	–	–	4	–	–
Tuvalu	–	–	11	5	0	0.0	56	650	–	–	–	–	–
Vanuatu	20	21	177	88	5	0.3	50	1310	–	74	4.3	–	–

†See appropriate chapter for full description.

a/, b/ and y/ See statistical profiles for definitions.

* GNP per capita estimated range $786 to $3125.

** GNP per capita estimated range $3126 to $9655.

***GNP per capita estimated range $9656 or more.

Age of data

The table below gives the average age of the latest internationally available data for three key indicators: the under-5 mortality rate, the net primary school enrolment/attendance rate and the percentage of under-5s who are underweight.

The more up-to-date statistics used by most governments and international organizations are often interpolated and/or extrapolated from past surveys. The table shows the number of years that have elapsed, on average, between the last national on-the-ground surveys and the year 1998.

In some cases, governments may have more recent statistics that have not been made available to the United Nations.

Average age of data (in years) on the three social indicators

SUB-SAHARAN AFRICA

Madagascar	1.7	Congo, Dem. Rep.	3.7	South Africa	5.7
Mozambique	1.7	Uganda	3.7	Lesotho	6.0
Chad	2.0	Côte d'Ivoire	4.0	Burundi	6.7
Mauritius	2.0	Gambia	4.0	Ethiopia	6.7
Senegal	2.3	Botswana	4.3	Guinea	8.3
Benin	2.7	Burkina Faso	4.7	Angola	10.7
Tanzania	2.7	Ghana	4.7	Gabon	10.7
Mali	3.0	Zimbabwe	4.7	Guinea-Bissau	10.7
Mauritania	3.0	Rwanda	5.0	Somalia	10.7
Zambia	3.0	Cameroon	5.3	Liberia	11.0
Eritrea	3.3	Kenya	5.3	Sierra Leone	12.7
Malawi	3.3	Togo	5.3	Congo	13.7
Niger	3.3	Namibia	5.7		
Central African Rep.	3.7	Nigeria	5.7		

MIDDLE EAST and NORTH AFRICA

Egypt	3.0	Iran	4.3	Sudan	5.0
Algeria	3.3	Morocco	4.3	Syria	5.0
U. Arab Emirates	3.3	Yemen	4.3	Kuwait	6.7
Iraq	3.7	Lebanon	4.7	Jordan	7.7
Oman	3.7	Turkey	4.7	Saudi Arabia	10.0
Tunisia	3.7	Libya	5.0	Israel	10.7

CENTRAL ASIA

Kyrgyzstan	2.3	Georgia	6.3	Turkmenistan	9.0
Afghanistan	5.7	Kazakhstan	6.7	Armenia	10.7
Azerbaijan	6.0	Uzbekistan	7.0	Tajikistan	11.3

EAST/SOUTH ASIA and PACIFIC

Australia	1.5*	Viet Nam	3.0	Korea, Rep.	6.7
New Zealand	1.5*	India	3.3	Papua New Guinea	6.7
Bangladesh	2.0	Japan	3.5*	Singapore	6.7
Indonesia	2.3	Myanmar	3.7	Sri Lanka	6.7
Malaysia	2.3	Lao PDR	4.0	Korea, Dem.	8.7
Philippines	2.3	China	4.3	Bhutan	10.0
Mongolia	3.0	Pakistan	5.3	Thailand	10.3
Nepal	3.0	Cambodia	6.3		

AMERICAS

Chile	1.7	Colombia	3.3	Ecuador	5.0
Cuba	1.7	Dominican Rep.	3.3	El Salvador	5.0
Uruguay	2.3	Canada	3.5 *	Mexico	5.0
Brazil	2.7	Guatemala	3.7	Panama	5.0
Costa Rica	2.7	Haiti	4.3	Nicaragua	5.3
Peru	2.7	Honduras	4.3	Paraguay	6.0
Venezuela	2.7	Jamaica	4.3	Argentina	8.0
United States	3.0	Bolivia	4.7	Trinidad/Tobago	9.0

EUROPE

Austria	2.0 *	Estonia	2.5 *	Romania	3.3
Bulgaria	2.0 *	Finland	2.5 *	Russian Fed.	3.3
Ireland	2.0 *	France	2.5 *	Czech Rep.	3.7
Italy	2.0 *	Germany	2.5 *	Yugoslavia	3.7
Latvia	2.0 *	Greece	2.5 *	Hungary	4.7
Netherlands	2.0 *	Norway	2.5 *	Albania	5.0 *
Poland	2.0 *	Spain	2.5 *	Lithuania	8.0 *
Slovenia	2.0 *	Sweden	2.5 *	Ukraine	8.0 *
TFYR Macedonia	2.0 *	United Kingdom	2.5 *	Moldova, Rep.	8.5 *
Belarus	2.5 *	Croatia	2.7	Slovakia	8.5 *
Belgium	2.5 *	Portugal	3.0 *	Bosnia/Herzegovina	11.0 *
Denmark	2.5 *	Switzerland	3.0 *		

*Underweight not included.

Abbreviations

AIDS	acquired immune deficiency syndrome
CDC	Centers for Disease Control and Prevention (United States)
CESES	European Centre for the Epidemiological Monitoring of AIDS
DHS	Demographic and Health Surveys
DOTS	Directly Observed Treatment, Short Course
DPT	combined diphtheria/pertussis (whooping cough)/tetanus vaccine
GDP	gross domestic product
GNP	gross national product
HIPC	Heavily Indebted Poor Countries
HIV	human immunodeficiency virus
IMF	International Monetary Fund
MICS	multiple indicator cluster surveys
NGO	non-governmental organization
NID	National Immunization Day
ODA	official development assistance
OECD	Organisation for Economic Co-operation and Development
OPEC	Organization of Petroleum Exporting Countries
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
VAD	vitamin A deficiency
WHO	World Health Organization

Throughout *The Progress of Nations*, a dash (–) signifies no data were available.

Note: All dollars are US dollars.

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