THE PROGRESS OF NATIONS 2000

THE PROGRESS OF NATIONS

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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Contents

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Foreword

Over the past eight years, *The Progress of Nations* has diligently recorded the world's progress towards giving all children the chance to live a decent life – a life of dignity and opportunity. The benchmarks have been the goals set at the 1990 World Summit for Children and the rights enshrined in the Convention on the Rights of the Child, which virtually all nations have ratified.

This publication describes what becomes possible when nations invest in children's well-being and protect their rights. Millions of children are now less likely to be left mentally impaired because of iodine deficiency. Millions more are enjoying better health, thanks to improved access to clean water. More children are enrolled in school now than was the case 10 years ago. Breastfeeding rates are up in many countries, and birth registration records have vastly improved. Polio is on the verge of eradication. Immunization has worked miracles in countless villages and remote locations in developing countries, turning despair into hope and uncertainty into promise. *The Progress of Nations* also captures the slow but steady progress girls and women are making as they overcome inequality and discrimination and regain their right to live to their full potential. Child labour and sexual exploitation are being tackled with great vigour.

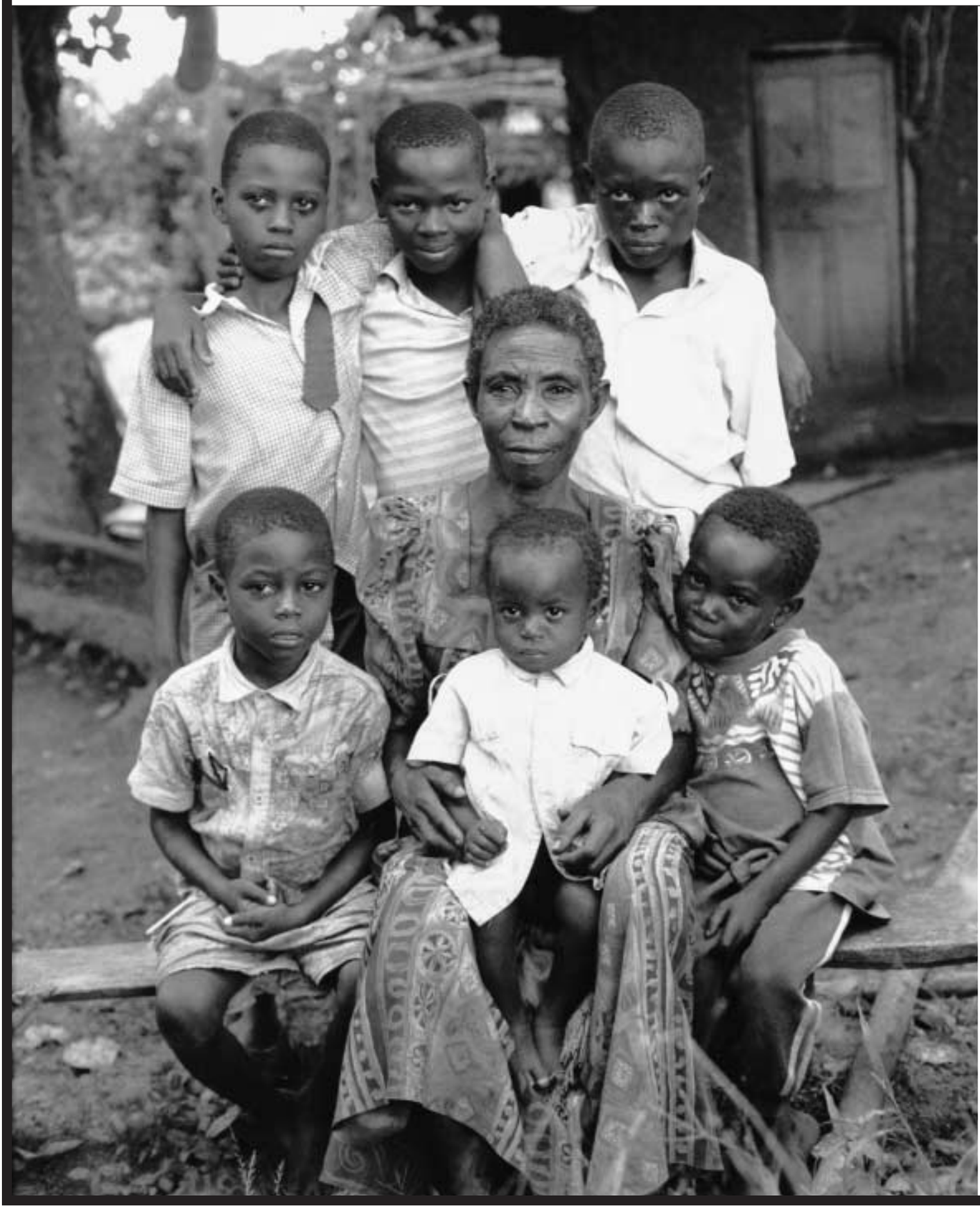
But this publication also recounts the great distances the world must still travel. Goals remain unmet and rights unrealized because of poverty, gender discrimination, debt, wars, inadequate commitment or unequal social development. *The Progress of Nations* records the devastating speed with which HIV/AIDS has, in less than a generation, become the greatest catastrophe facing the continent of Africa and is now spreading in Asia and parts of Central Europe and Latin America. So malevolent is the threat that the economic prospects and social stability of entire regions are at risk. It is fitting, therefore, that HIV/AIDS is the central topic of this issue of *The Progress of Nations*. The figures on infection rates among youth are horrifying. Efforts to educate and inform people, especially youth, about HIV/AIDS must be pursued with far greater energy.

This issue also celebrates the power of immunization and sets out a new agenda for vaccines. In the chapter on early childhood care it makes the case for early investment in children as a key to reducing poverty. And it concludes with a painful reminder that, on every continent, in brothels, slums, factories and war-torn areas, children lost among the living are hoping to touch the moral radar of a world that seems to have forgotten them. The principle of 'all children, all rights' is still much too far from being a reality.

Kofi A. Annan
Secretary-General
United Nations

MY SONG AGAINST AIDS

COMMENTARY: SPEAKING OUT ON AIDS



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My song against AIDS

By Femi Anikulapo-Kuti

Nigerian star Fela Anikulapo-Kuti had the gift of music and a personal courage that made him a larger-than-life figure. He had millions of fans around the world and was a political activist who spoke up for the rights of his people and never hesitated to criticize corrupt leaders. Many powerful people in politics and the military wanted him silenced, but nothing, not even jail and torture, could break his spirit or quiet his voice. What silenced him where nothing else could was AIDS. Fela died from the disease in 1997, at the age of 58.

The day after he died, his family decided to announce the cause of his death to the world. The news shocked and affected the lives of many millions. His son, Femi Anikulapo-Kuti, tells the story of how, in revealing the cause of his father's death, he and his family hoped to lift the veil on the killer epidemic, and of Femi's own personal crusade to break the silence surrounding AIDS, the greatest catastrophe facing Africa.

In Nigeria and many other countries in the developing world, an unacceptable silence continues to hamper efforts to check the fast and deadly spread of AIDS. Governments, families and individuals have all played into the hands of the disease by remaining silent or not speaking out loudly and repeatedly enough for the message to sink in.

After my father's death, his brother Olikoye Ransome-Kuti and I spoke up because we felt a personal need to break the silence about AIDS. We felt it would be criminal to continue in the conspiracy of silence, which only encourages ignorance, stokes denial and perpetuates misinformation during this monumental catastrophe.

The moment we went public was also the start of my personal commitment to give a voice to the shocking reality of AIDS.

In my concerts, I speak about AIDS, and I often have banners on stage promoting AIDS awareness. I also try to build this awareness through other forums and I challenge others lucky enough to be in my position to do the same.

AIDS is real and it is here, indiscriminately cutting down those we know and love – brothers, sisters, fathers and mothers.

Africa and its friends need to confront AIDS with the same determination and unity as they would any enemy seeking to annihilate them. Although battle hardened, Africa has never confronted such a ruthless foe: Of the 2.8 million people who died of AIDS last year, 79 per cent were Africans. By the end of this year, 10.4 million children under the age of 15, the majority in Africa, will have lost their mother or both parents to AIDS.

AIDS is our continent's greatest social and human catastrophe in history and its profoundly grave implications on economic and political stability are already evident: Families are devastated, communities are decimated, hospitals are overwhelmed. Schools have lost teachers to the disease and pupils are being forced to drop out for lack of funds. Businesses have suffered personnel and productivity losses that are difficult to absorb. Africa's hard-won gains in recent years – in health, education and industry – are evaporating.

We are grateful that the United Nations Security Council this year discussed for the first time ever a health issue and put AIDS in Africa on its agenda, asking donor nations to commit more resources to fighting it.

With such help, however, must come national obligations as well. One of the most important actions for governments and all those in positions of influence, knowledge and power is to raise the alarm loudly and clearly. Information is a powerful tool in the struggle to tame the rampant spread of AIDS. In Africa, it is one of the few tools we have.

We have not used it very well. In some parts of Nigeria, only about 1 person in 10 even knows what AIDS is, much less how to avoid it. And we are paying dearly for this ignorance: There are 2.7 million people now infected with HIV in our country.

This lack of information exists not only here in Nigeria. Such levels of misinformation are to be found all over the continent.

Failing to educate people about the disease is like signing their death sentence. Political leaders, artists, performers and teachers, therefore, need to seize every opportunity to educate people

Femi Anikulapo-Kuti is a world-renowned ambassador of Afro-Beat music and a celebrity advocate in the fight against AIDS. He has developed television spots and messages in Nigeria that reach millions of his young fans and call for urgent action against practices that lead to the death of young and old alike.

about how to protect themselves from HIV infection.

There is so much that needs to be said.

We must speak about the high risks our mothers and sisters face of contracting this disease; their risks are higher than men's and boys'. Girls and women are extremely vulnerable. Physiologically, they become infected more easily than men, and social pressures, cultural practices, violence, repression and prevailing values and behaviours make it difficult or even impossible for them to protect themselves. We cannot, with clear consciences, keep quiet about this. We must help women understand their rights and risks, and we need to support them when they exercise their right to take control of their sexuality and their bodies.

As individuals, we must speak of the need to change behaviour. It is suicidal to have numerous sexual partners. The message must be repeated again and again in as many ways as necessary that the surest protection against HIV infection is either abstinence or practising safe sex and limiting one's sexual exposure. All those who are sexually active must take full responsibility for their actions and health and use condoms to protect themselves and others.

Equally, we must dispel the negative myths surrounding life with AIDS. As with many HIV-positive people, Fela was ill for several years, and he was lucky to have a family that loved and cared for him through the difficult times of his sickness. But many people who are HIV positive are ostracized and treated as outcasts, or worse, by their own communities. Far more often than we would like to admit, chil-

My voice counts too

By Hortense Bla Me

HIV/AIDS now outranks every other disease as the top killer in Africa. The continent has lost nearly 15 million people to AIDS since the early 1980s, and its children are the majority of the 10.4 million children below the age of 15 who will be orphans by the end of 2000 because of AIDS.

It is a dreadful toll, and the worst is yet to come as infection rates double and triple in other parts of the world. The figures make a compelling case for more resources, clear high-level commitments, fresh and innovative approaches, and shared expertise in dealing with this gargantuan and complex challenge. In Africa, using peer education to reach adolescents and youth is one strategy with unlimited potential. As this young AIDS campaigner from Côte d'Ivoire says, youths can be the most effective communicators for behavioural change, especially when they are involved in creating and disseminating the messages.

I speak for those children and adolescents whose tremendous potential to influence society has not been fully harnessed, with tragic results. If recognized, this potential can turn the tide against the relentless death march of HIV/AIDS.

The disease has infected more than 34.3 million people in the world to date, about a third of whom are youths between the ages of 15 and 24. Every minute, six young people below the age of 25 become infected with HIV. In my country, Côte d'Ivoire, we are told that approximately 11 per cent of the population is seropositive. This infection rate has a direct and immediate impact on children: 320,000 children in Côte d'Ivoire will have lost their mother or both parents to AIDS by the end of 2000.

I believe that to overcome the crisis of AIDS everybody must be involved, particularly the youth. In Côte d'Ivoire, we are trying through youth organizations such as the Parlement des Enfants (Children's Parliament) to bring a youth perspective to solving the problems facing the country. At the same time, we are changing the perception that youth are a source of these problems.

On the contrary, we are part of the solution. We have many talents and skills. We have a keen sense of the problems in our societies. More significantly, we can communicate effectively with others our age.

Those of us in the Children's Parliament have found that young

Hortense Bla Me, age 19, is the President of the 100-member Children's Parliament in Côte d'Ivoire, which she joined at age 13. She is an active promoter of the rights of children and young people and especially of youth involvement in HIV/AIDS prevention campaigns.

dren and other sick people are abandoned in hospitals or other institutions. Such ignorance and intolerance must be stamped out. Those living with AIDS can be helped to live full and secure lives and in turn help others avoid the disease.

In families where AIDS has struck, truth must be spoken about the cause of death. Using popular euphemisms such as 'after a brief illness' or attributing death to supernatural causes or other substitutes makes it easy to ignore the real cause and thus incur the further loss of life.

Let all of us who are losing loved ones to AIDS make it known that the disease is here and it is indiscriminate in its attack. By accepting this, it will be easier for more people to participate in information campaigns to enable those who have so far escaped AIDS to avoid contracting it.

But behavioural change is only part of the solution. When people are poor and unemployed, they feel hopeless. Many 'area boys and girls' – the street children of Lagos – have told me that they engage in risky sexual behaviour out of the boredom and the lack of security and direction that comes with living on the streets.

The message is clear: To fight AIDS, we must fight poverty, with greater energy and more resources than ever before.

Until there is a cure, let us raise our voices against HIV/AIDS in a song heard around the world. It is a song of defiance and struggle.

But most of all, it is a song of hope – the hope that when we sing forcefully together, the silence and stigma that nourish this epidemic can be broken, and life can triumph over death. ■

people are hungry for information on AIDS. We have seen their behaviour change once they learn the facts. In 1993, for instance, only about 5 per cent of sexually active Ivorian boys and girls between the ages of 15 and 19 used condoms. By 1998, one third of sexually active teenagers in that age group reported always using condoms. This was after AIDS education messages reached them.

Youth engage in risky behaviour in part because of a knowledge gap. Many, particularly those from poor backgrounds, lack ways to get accurate information about AIDS. The 59 per cent of Ivorian boys and 46 per cent of girls who attend primary school do not receive reliable information on HIV/AIDS there.

Parents, who are often uneducated and uninformed themselves, cannot help. More than half of adult men and over two thirds of adult women are illiterate and largely cut off from knowledge about AIDS. Cultural obstacles are another factor. It is still taboo in many families in my country to discuss sex or sexually transmitted infections. Girls in particular are often reluctant or unable to enquire about sex for fear of being considered morally 'loose'.

The result is that too many children – especially the most marginalized – are ignorant about how the disease spreads. In a recent survey of attitudes about AIDS in Côte d'Ivoire, sponsored by UNICEF, more than half of all youths considered it the responsibility of their parents to provide sex education. However, 9 out of 10 young people said that they learned about sex from the media or on "the street."

The lack of accurate information from a parent or another close family member is a tragedy. We can, however, turn this into an opportunity. Because young people can and do speak honestly to one another about their concerns when they have the information and the confidence to impart it.

Peer education is one of the most powerful but underused tools we have to confront HIV/AIDS.

I have experience working with young prostitutes in Bouaké, the second largest city in Côte d'Ivoire. One of them, 13-year-old Dominique (a pseudonym), said she became a prostitute when she was 11.

Dominique is from a poor family; she has nine siblings, her father had lost his job and her mother was busy caring for a newborn. Dominique followed a friend into prostitution, earning up to $10 a night, a large sum of money for a girl from a poor family.

Soon, Dominique heard that she could get sick from having unprotected sex but she did not know that an infected person could look normal and healthy; that HIV is spread by having unprotected sex with an infected person; that there is no cure; and that everyone is vulnerable.

I took her to Renaissance Santé Bouaké (RSB), a non-governmental organization (NGO) that works on AIDS issues with the support of UNICEF. There she saw shocking pictures of how AIDS destroys the body. She learned that at that time one fourth of all pregnant women in the city were HIV positive.

The information was life changing. She soon brought two other young prostitutes to RSB to learn more about the disease. Now all three girls have quit prostitution and are in a school run by the Catholic Church where they acquire practical life skills. Dominique is attending school and learning to be a seamstress.

But just knowing about HIV/AIDS is not sufficient to change the way we behave. There is another factor: power. AIDS preys most on those who lack power, and girls are the most vulnerable. They are often pressured or forced into having sex, or are denied information they need to help them make informed decisions. Girls frequently lack the skills to negotiate with boys or men and the confidence to challenge them; girls fear that being too assertive will make them unpopular. Even when a girl makes an informed decision to have sex, she may be unable to negotiate safe sex.

So it is not enough just to teach skills. The Children's Parliament of Côte d'Ivoire has made it a priority to talk about HIV/AIDS in the context of children's rights. We explain the Convention on the Rights of the Child and tell young people that they have a right to be educated and a right to participate in decisions about their bodies and their lives.

For a young person, challenging cultural and sexual stereotypes is a tall task. The community must stand behind young people as they assert themselves. RSB is recruiting parents, teachers and children into the effort. Project Miwa (My Child) is helping educate young and old alike about HIV/AIDS and children's rights.

Young people, especially adolescent girls, have been reassured to see that they are not alone in tackling this frightening disease. Project Miwa does more than promote health: It makes AIDS education a way of empowering healthy children.

AIDS is challenging us to find new solutions to our problems. Together, we really can save the world. ■

LEAGUE TABLE: ESTIMATED PROPORTIONS (%) OF 15- TO

AIDS is decimating the developing world – nowhere more savagely than in sub-Saharan Africa – and great numbers of young people are now falling under the fury of its unrelenting attack. This league table documents the toll of the epidemic.

A bitter legacy

In Botswana, 1 in 3 young women and 1 in 7 young men aged 15 to 24 are infected with HIV, as are 1 in 4 young women and 1 in 10 young men in Lesotho, South Africa and Zimbabwe. In nine other countries in sub-Saharan Africa, more than 1 in 10 young women and 1 in 20 young men are infected.

The signs are evident in too many countries. In Cambodia, for example, 1 in 33 young women and 1 in 50 young men are infected, and in Haiti, 1 in 33 young women and 1 in 20 young men are HIV positive.

How did these rates come to be so disastrously high, now, more than 15 years into the withering curse of the AIDS epidemic?

How, with the enormous losses already endured – the millions of dead and dying, the children orphaned, the human, economic and social blight this epidemic has caused – have we come no further than to this bitter place?

How is it that, after 15 years of such painful acquaintance with AIDS, we have bequeathed such a deadly legacy to 10.3 million of our young?

The HIV-infection rates among young people are a searing indictment, documenting failures of vision, commitment and action of almost unimaginable proportions. They tell the story of leadership unworthy of the name and the virtual abandonment of sub-Saharan Africa, at a time of dire need, to a disaster that may soon engulf other regions as well. And they speak of devastation waiting to emerge elsewhere, under a similar cover of silence, apathy and neglect.

Although AIDS cannot be cured, it can be prevented. Current infection rates should never have reached such catastrophic levels. Now that they have, leaders at all levels and in all countries, both industrialized and developing, must immediately commit the resources, time and energy to prevent further such tragedies. A strong international response to this grave emergency is long overdue and young people now at the epicentre of the epidemic need to be involved.

The world has averted its gaze for too long, in the process aiding and abetting in this most unpardonable of crimes – the preventable deaths of millions of young people.

SUB-SAHARAN AFRICA

	Female	Male
Botswana	34	16
Lesotho	26	12
South Africa	25	11
Zimbabwe	25	11
Namibia	20	9.1
Zambia	18	8.2
Malawi	15	7.0
Mozambique	15	6.7
C. African Rep.	14	6.9
Kenya	13	6.4
Ethiopia	12	7.5
Burundi	12	5.7
Rwanda	11	5.2
Côte d'Ivoire	9.5	3.8
Tanzania	8.1	4.0
Cameroon	7.8	3.8
Uganda	7.8	3.8
Congo	6.5	3.2
Burkina Faso	5.8	2.3
Togo	5.5	2.2
Congo, Dem. Rep.	5.1	2.5
Nigeria	5.1	2.5
Gabon	4.7	2.3
Ghana	3.4	1.4
Chad	3.0	1.9
Sierra Leone	2.9	1.2
Angola	2.7	1.3
Guinea-Bissau	2.5	1.0
Benin	2.2	0.9
Gambia	2.2	0.9
Liberia	2.2	0.9
Mali	2.1	1.3
Senegal	1.6	0.7
Niger	1.5	1.0
Guinea	1.4	0.6
Mauritania	0.6	0.4
Madagascar	0.1	0.04
Mauritius	0.04	0.04
Eritrea	ND	ND
Somalia	ND	ND

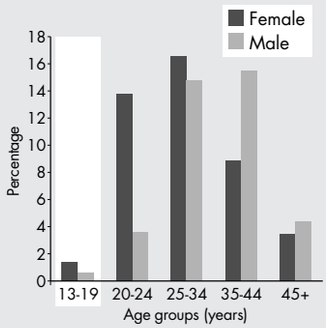
MIDDLE EAST AND NORTH AFRICA*

	Female	Male
Algeria	<0.01	<0.01
Egypt	<0.01	<0.01
Iran	<0.01	<0.01
Iraq	<0.01	<0.01
Israel	<0.01	<0.01
Jordan	<0.01	<0.01
Kuwait	<0.01	<0.01
Lebanon	<0.01	<0.01
Libya	<0.01	<0.01
Morocco	<0.01	<0.01
Oman	<0.01	<0.01
Saudi Arabia	<0.01	<0.01
Sudan	<0.01	<0.01
Syria	<0.01	<0.01
Tunisia	<0.01	<0.01
Turkey	<0.01	<0.01
U. Arab Emirates	<0.01	<0.01
Yemen	<0.01	<0.01

*1997 estimates.

Adolescence: Window of opportunity

Studies in countries with generalized AIDS epidemics show that women become infected at younger ages than men, usually by older men. Men's infections tend to occur at later ages. To change behaviour and prevent infections, therefore, intervention programmes should focus mostly on adolescents.



Source: Masaka District Annual Survey (Uganda), 1997.

24-YEAR-OLDS LIVING WITH HIV/AIDS

CENTRAL ASIA

	Female	Male
Kazakhstan	<0.01	0.07
Afghanistan	<0.01	<0.01
Armenia	<0.01	<0.01
Azerbaijan	<0.01	<0.01
Georgia	<0.01	<0.01
Kyrgyzstan	<0.01	<0.01
Tajikistan	<0.01	<0.01
Turkmenistan	<0.01	<0.01
Uzbekistan	<0.01	<0.01

EAST/SOUTH ASIA AND PACIFIC

	Female	Male
Cambodia	3.5	2.4
Thailand	2.3	1.2
Myanmar	1.7	1.0
India	0.6	0.4
Papua New Guinea	0.3	0.1
Singapore	0.2	0.2
Nepal	0.2	0.1
Malaysia	0.1	0.6
Viet Nam	0.1	0.3
Philippines	0.06	0.03
Lao PDR	0.05	0.04
Sri Lanka	0.05	0.04
Pakistan	0.04	0.06
Indonesia	0.03	0.03
Australia	0.02	0.1
China	0.02	0.1
New Zealand	0.02	0.05
Japan	0.01	0.03
Bangladesh	0.01	0.01
Korea, Rep.	<0.01	0.02
Bhutan	<0.01	<0.01
Korea, Dem.	<0.01	<0.01
Mongolia	<0.01	<0.01

AMERICAS

	Female	Male
Haiti	2.9	4.9
Dominican Rep.	2.8	2.6
Honduras	1.7	1.4
Panama	1.4	1.7
Guatemala	0.9	1.2
Trinidad/Tobago	0.6	0.8
Jamaica	0.4	0.6
Argentina	0.3	0.9
Brazil	0.3	0.7
Costa Rica	0.3	0.7
El Salvador	0.3	0.7
Venezuela	0.2	0.7
United States	0.2	0.5
Peru	0.2	0.4
Uruguay	0.2	0.4
Colombia	0.1	0.4
Ecuador	0.08	0.4
Chile	0.08	0.3
Canada	0.07	0.3
Mexico	0.06	0.4
Nicaragua	0.06	0.2
Paraguay	0.04	0.13
Bolivia	0.03	0.13
Cuba	0.02	0.06

EUROPE

	Female	Male
Ukraine	0.8	1.3
Portugal	0.3	0.6
Switzerland	0.3	0.4
Spain	0.2	0.5
Belarus	0.2	0.4
France	0.2	0.3
Italy	0.2	0.3
Moldova, Rep.	0.1	0.3
Russian Fed.	0.1	0.3
Austria	0.1	0.2
Belgium	0.1	0.1
Denmark	0.08	0.2
Netherlands	0.08	0.2
Latvia	0.06	0.2
Greece	0.05	0.1
United Kingdom	0.05	0.1
Ireland	0.05	0.06
Germany	0.04	0.1
Sweden	0.04	0.06
Czech Rep.	0.03	0.06
Norway	0.03	0.01
Hungary	0.02	0.08
Finland	0.02	0.03
Romania	0.02	0.02
Slovenia	0.01	0.03
Croatia	0.01	0.02
Slovakia	0.01	0.02
Albania	<0.01	<0.01
Estonia	<0.01	<0.01
Lithuania	<0.01	<0.01
TFYR Macedonia*	<0.01	<0.01
Bosnia/Herzegovina	ND	ND
Bulgaria	ND	ND
Poland	ND	ND
Yugoslavia	ND	ND

ND = No data.

< = less than.

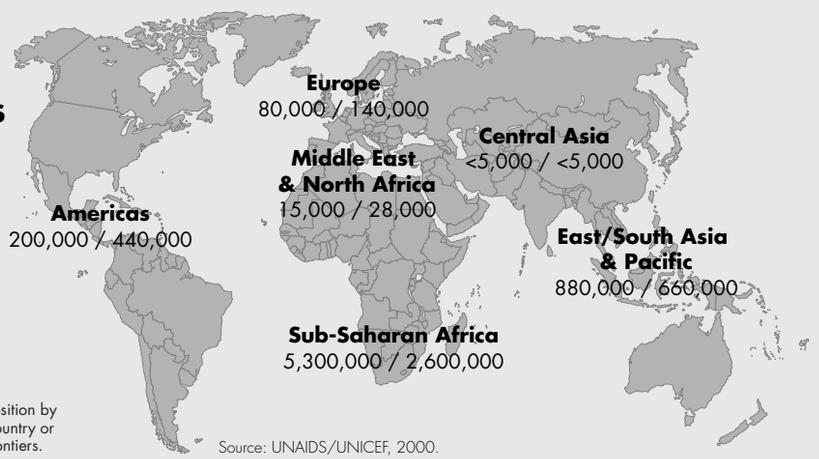
* The former Yugoslav Republic of Macedonia, subsequently referred to as TFYR Macedonia.

Source: UNAIDS/UNICEF.

WHAT THE TABLE RANKS

Estimated HIV/AIDS rates in youths at end-1999

Young women and men (aged 15-24) estimated to be living with HIV/AIDS as of end-1999



Global total: 10.3 million young people
(6.4 million young women/ 3.9 million young men)

Note: This map does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers.

Source: UNAIDS/UNICEF, 2000.

Surveys show what youths don't know could

AIDS is the gravest catastrophe ever to face the African continent and it threatens to erase all the hard-won progress achieved in economic, political and social spheres. Young people are the most vulnerable, and an analysis of surveys conducted among this age group over the past six years is presented here. The findings have serious policy implications for the donor community, national governments and advocacy groups. The overwhelming message from these surveys is that information about AIDS and its deadly danger is not getting out or is not being absorbed. As this selection of stories shows, overcoming the information deficit among boys and girls about their own vulnerability is a matter of extreme urgency, especially at a time when prevalence levels among 15- to 24-year-olds in some countries are soaring as high as 20-25%.

The results of recent surveys in 17 countries show a dangerous lack of knowledge among young people about how they can protect themselves from AIDS. In all 17 countries, girls know less than boys do. This knowledge gap is one important element in understanding the higher HIV-infection rates among girls in many countries and in improving prevention efforts.

In Mozambique, where HIV prevalence is a high 13%, 74% of girls between the ages of 15 and 19 were unable to name a single way to protect themselves from the infection. For boys, the figure was a lower but still disturbing 62%. In the United Republic of Tanzania, where 8% of the population is believed to be infected, 51% of girls surveyed could not name a single method to avoid infection, nor could 35% of boys. In Zambia, 23% of girls and 10% of boys, in Côte d'Ivoire, 22% of girls and 8% of boys and in Zimbabwe, 17% of girls and 8% of boys were unable to name even one way to avoid infection.

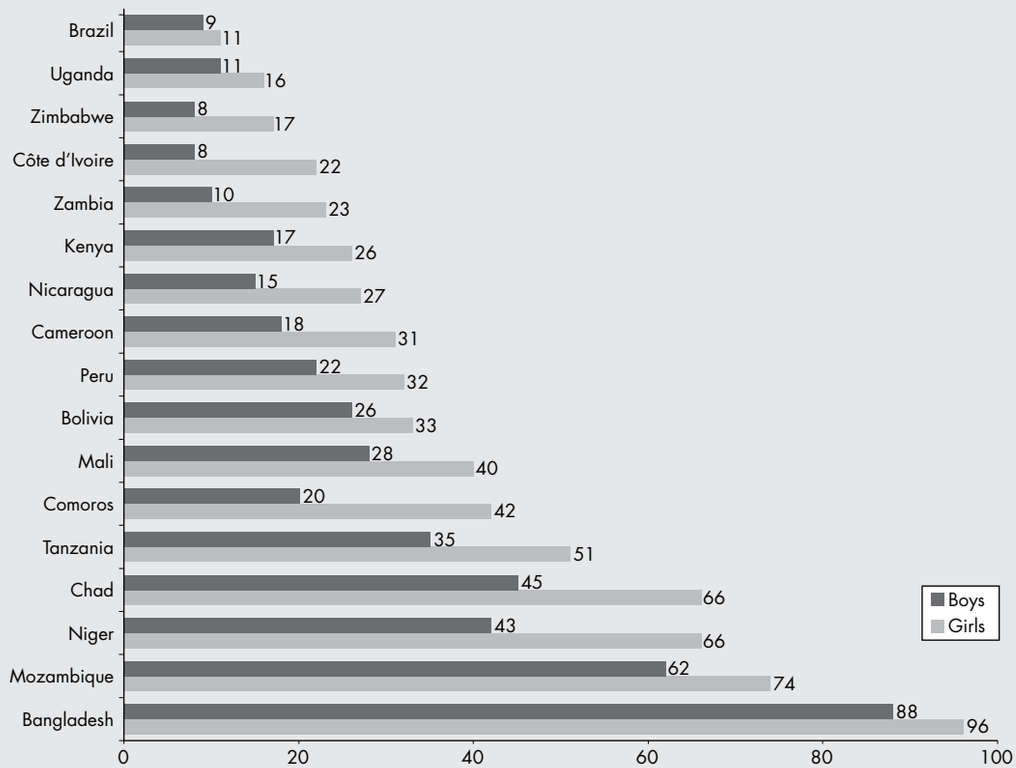
In countries with fairly low prevalence rates of HIV/AIDS, there are exceedingly high percentages of young people unaware of protective measures – in Bangladesh, 96% of girls and 88% of boys; and in Chad, 66% of girls and 45% of boys.

The data stress the need for much greater emphasis on reaching all youths and especially girls and women, whose rights to information are all too often frustrated by poverty, local customs, violence and social or religious bias. Also, as survey data from Zambia and Zimbabwe show, even where awareness of how to protect oneself is relatively high, sexually active girls did not see themselves at risk (*see story 'Seeing no risk in sex', facing page*).

This reveals that basic knowledge about HIV/AIDS does not always lead to less risky behaviour. Experience shows that the chances for behavioural change improve when information campaigns address underlying attitudes, values and skills needed to protect oneself, and when those at whom the messages are aimed – in this case young people – actively participate in designing such campaigns.

Information gap

Percentage of boys and girls (aged 15-19) who do not know any way to protect themselves against HIV/AIDS



Sources: Demographic and Health Surveys (DHS), 1994-1999.

kill them

Seeing no risk in sex

In eight countries in which HIV/AIDS has reached epidemic levels, with 5% or more of the population infected, a significant proportion of sexually active girls (aged 15-19) think they face no risk of contracting the disease, according to results of recent surveys.

In three countries – Haiti, Zambia and Zimbabwe – the misperception of risk was shared by 63%, 52% and 50% of girls, respectively, and by more than 40% of girls in three other countries surveyed.

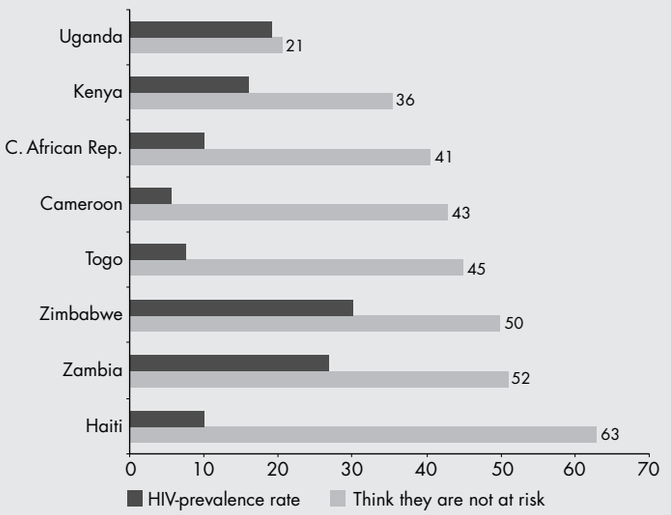
These surveys are helping uncover a number of critical challenges in communicating essential information needed to combat the epidemic, particularly to girls in this age group.

One such challenge is how to help young people convert the information they have about HIV/AIDS into personal awareness of risk. This is illustrated by the situation in both Zambia and Zimbabwe, where HIV prevalence is very high (19% and 25%, respectively) and relatively high proportions of girls can name ways to protect themselves (*see story on facing page*). Nevertheless, more than 50% of sexually active girls in both countries still do not consider themselves at any risk of getting AIDS.

One gleam of hope comes from Uganda, where prevalence rates at the time of the survey were higher than they are now. The percentage of girls who responded that they were unaware of any risk to themselves was lowest there (21%), partly as a result of an aggressive and effective government-sponsored AIDS awareness campaign.

A blind date with AIDS

Percentage of sexually active girls (aged 15-19) who do not see themselves at risk of AIDS, compared with HIV prevalence*



*At the time of survey as measured among pregnant women (in surveillance studies, 1994-1999).

Source: DHS, 1994-1999.

Deceived by appearances, girls face disaster

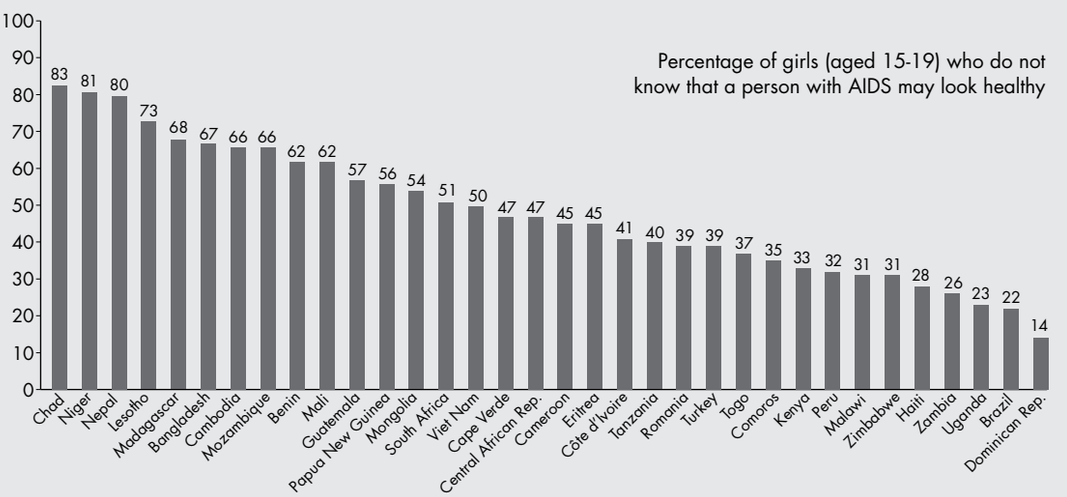
Recent surveys conducted in 34 countries are revealing how little young people, particularly girls, know and understand about HIV/AIDS. In 15 of the countries, 50% or more of girls aged 15 to 19 do not know that someone who looks healthy can be infected with HIV and transmit it to others. In Côte d'Ivoire, 41% of girls are deceived by appearances, in Cameroon, 45% and in South Africa, 51%. In Mozambique, the level is 66%.

Girls' vulnerability to HIV infection, already higher than that of boys the same age for a number of physical, social and cultural reasons, is further heightened by this information deficit. Stronger campaigns and activities are urgently needed to debunk myths about the disease and provide youths, girls in particular, with the details they need to protect themselves.

Because the number of HIV infections is increasing most rapidly among 15- to 24-year-olds, education about the disease needs to be a continual process, reaching children before they move into this high-risk age group. Early interventions will enable children to master the information in stages and build on that knowledge year after year. The goal of saving lives by changing young people's behaviour clearly hinges on how well they come to understand and internalize the risks of the epidemic.

Countries in which very high percentages of girls think that a person who appears to be healthy cannot be infected include Chad (83%), Niger (81%) and Nepal (80%). These countries also have generally low prevalence levels, but experience from programmes in the field shows that it is never too early to start the education and information campaigns vital to controlling the epidemic.

Looks can kill



Source: DHS and other nationwide surveys, 1994-1999.

Another face of AIDS: 860,000 children without teachers

An estimated 860,000 children in sub-Saharan Africa lost their teachers to AIDS in 1999. Children in Kenya, Nigeria and South Africa are most seriously affected by these losses.

For reasons that are not entirely clear, HIV seroprevalence is very high among teachers and school administrators. Zambia, for example, recorded 1,300 teacher deaths in the first 10 months of 1998, more than twice the number of deaths in 1997 and two thirds the number of new teachers trained annually. In the Central African Republic, between 1996 and 1998 almost as many teachers died as retired.

Although HIV/AIDS affects all sectors, its most profound effects are concentrated in education. Now, all over sub-Saharan Africa, hard-won gains in school enrolment – and the returns on investments countries have made to improve education – are being eroded. Schooling is disrupted when teachers are absent from class due to illness, death or the need to care for ill family members, or when a decreasing number of teachers have to take on larger classes. HIV-positive teachers are leaving schools in remote areas that lack health care facilities and requesting postings in locations near hospitals.

Teacherless children

Primary schoolchildren who lost a teacher to AIDS, 1999

South Africa	100,000
Kenya	95,000
Zimbabwe	86,000
Nigeria	85,000
Uganda	81,000
Zambia	56,000
Malawi	52,000
Ethiopia	51,000
Tanzania	49,000
Congo, Dem. Rep.	27,000

Source: UNAIDS, UNICEF.

HIV/AIDS also affects children who drop out of school when their families can no longer afford their school costs because the breadwinner is ill and is no longer working, or where AIDS treatments eat up a larger share of the household budget. In some countries, parents are keeping their daughters, in particular, out of school for fear they might become infected.

In a number of countries, public spending is being shifted away from education to cope with other aspects of the AIDS crisis, which means less funding is available to hire and train teachers to replace those who have died. Educational quality also suffers when fewer resources are available for classrooms and materials. Discriminatory attitudes and practices towards AIDS-affected individuals interfere with the learning process, and high rates of teacher turnover and fluctuating numbers of students constrain educational planning.

However, education must be safeguarded in the face of the AIDS crisis, as schools are key to reducing the impact of the disease. Countries' efforts to develop school-based programmes to control HIV/AIDS have been dealt a mortal blow, and assistance from the international community is urgently needed.

Low rates must not stall action

If the AIDS epidemic has taught the world anything, it is that any HIV-prevalence rate needs to be regarded as a clear and present danger. The list (*at right*) highlights how prevalence percentages do not need to be high to be disastrous. In India, the rates of 0.6% among 15- to 24-year-old women and 0.4% among men of the same age translate into 570,000 women and 340,000 men infected, the second highest number of infections after South Africa. Similarly, in the Russian Federation, rates of 0.1% among women and 0.3% among men mean 14,000 women and 29,000 men carry the virus.

Not so long ago, current high-prevalence countries probably had rates comparable to these but failed to take the containment steps needed.

No priority can be greater than to stem the spread of AIDS through well-conceived and generously funded prevention and management programmes.

Number of young people living with HIV/AIDS in selected countries

	Female (15-24)		Male (15-24)	
Country	%HIV+	Number HIV+	%HIV+	Number HIV+
Bangladesh	0.01%	840	0.01%	1,600
Japan	0.01%	510	0.03%	2,300
China	0.02%	23,000	0.1%	120,000
Hungary	0.02%	120	0.08%	600
Romania	0.02%	350	0.02%	340
Bolivia	0.03%	250	0.1%	1,000
Germany	0.04%	1,900	0.1%	4,100
Pakistan	0.04%	6,400	0.06%	8,700
United Kingdom	0.05%	1,700	0.1%	3,300
Mexico	0.06%	6,300	0.4%	40,000
Netherlands	0.08%	750	0.2%	1,700
Russian Fed.	0.1%	14,000	0.3%	29,000
France	0.2%	8,800	0.3%	13,000
Jamaica	0.4%	970	0.6%	1,400
India	0.6%	570,000	0.4%	340,000
Haiti	2.9%	25,000	4.9%	42,000

Source: UNAIDS/UNICEF, 2000.

Asia strives to control epidemic

India is now swamped with the second largest number of HIV-infected people, and the disease is menacing populations in Cambodia, Myanmar, Thailand and other Asian countries.

UNICEF, other UN agencies, national governments and NGOs have initiated several programmes to combat this epidemic.

• In Cambodia, efforts are being made to build capacity among regional and local organizations with access to high-risk populations to develop and maintain prevention and care programmes targeted at primary, secondary and vocational school students, out of school youth, women of reproductive age, women and children living with HIV/AIDS and to the media.

• In Thailand, which has one of Asia's most mature epidemics with close to 755,000 people living with HIV/AIDS, child-friendly community schools have been created to promote health, psychosocial development and resilience for children and youth affected by HIV/AIDS.

• Myanmar is considered to have one of the fastest growing HIV/AIDS epidemics in Asia, with an estimated 530,000 people infected. A programme called SHAPE (school-based healthy living and HIV/ AIDS prevention education project) is under way to address this grave problem.

A project on the social marketing of condoms, run by Population Services International, is helping expand knowledge on HIV prevention and the availability of condoms throughout the country. But its outreach is still very limited. Inadequate support from donors and the Myanmar government's own ambivalent attitude regarding the seriousness of the HIV/AIDS epidemic are leading to efforts that are not commensurate with the magnitude of the problem.

Mother-to-child transmission risk better known

More than 70% of women aged 15 to 49 in 11 HIV-endemic countries including the Central African Republic, Haiti, Kenya, Tanzania, Uganda, Zambia and Zimbabwe (*see list*) know that a mother infected with HIV can transmit the virus to her child.

Survey data from 17 countries show that awareness of transmission risk is highest in countries with high HIV-prevalence rates and much lower in countries with relatively low HIV-prevalence rates, such as Chad, Madagascar, Mali and Niger.

In 1999, 1.3 million children under the age of 15 were infected with HIV. In many of these cases, the virus was passed from mother to child during late pregnancy, labour, childbirth or breastfeeding.

These figures suggest, therefore, that awareness of risk and knowledge of how to avoid transmitting the virus are still not sufficient to stem its spread.

Voluntary testing and counselling must be available in antenatal clinics to provide information on what women can do if they are HIV positive and, given their situation, what acceptable alternatives to breastfeeding exist.

Also, even in countries where HIV is most prevalent, the majority of mothers are not HIV positive, and it is important that testing and counselling services are available to help them avoid infection.

In northern Thailand, rates of mother-to-child transmission among women participating in such programmes have dropped from 25% to 7.5%.

These programmes also offer uninfected women and their partners information on how to avoid infection and assist those who are infected in making informed decisions about sexual practices, childbearing and infant feeding.

Mothers' knowledge

Percentage of women (aged 15-49) who know that the AIDS virus can be transmitted from a mother to her child

Dominican Rep.	96	Central African Rep.	70
Zimbabwe	92	Côte d'Ivoire	66
Zambia	88	Cameroon	65
Kenya	85	Benin	62
Uganda	85	Madagascar	58
South Africa	84	Mali	41
Peru	79	Chad	36
Haiti	74	Niger	26
Tanzania	73		

Sources: DHS and other nationwide surveys, 1994-1999.

Aid for AIDS unequal to the challenge

The battle against AIDS in the developing world entails enormous costs befitting an international emergency on the grandest scale. Just last year, the Joint United Nations Programme on HIV/AIDS (UNAIDS) released figures estimating that $2 billion to $3 billion annually would be needed to combat the disease. The greatest need is in sub-Saharan Africa, home to 70% of all people living with HIV/AIDS.

In the face of this emergency, however, aid from industrialized countries for HIV/AIDS-related activities in developing countries (home to 95% of people living with the disease) totalled only $302 million in 1998.

The United States was the largest donor, giving $147 million (1.7% of its total aid), followed by the United Kingdom, which gave $26 million, and the Netherlands, which gave $22 million. The United States has announced that in the year 2000 its aid to developing countries for HIV/AIDS prevention programmes will reach $270 million.

Assistance for AIDS-related activities from most donor countries amounted to less than 1% of their total aid disbursement in 1998, a discouraging statistic as total aid from industrialized to developing countries plummeted by 21% between 1992 and 1998.

Aid for HIV/AIDS-related activities has increased more than fivefold from $59 million in 1987, but funding per person has actually dwindled as the epidemic has escalated. In 1988, aid funding totalled $21 per person living with HIV/AIDS; in 1998, funding worked out to be less than $9 per person.

In Africa, HIV/AIDS kills 10 times as many people as do wars on the continent and has done great damage to social structures and services. The international community needs to boost its resources to fight this deadly enemy.

Lending a hand

	Aid for HIV/AIDS, 1998 ($ millions)	Aid as % of total donor aid, 1998
United States	147	1.7
United Kingdom	26	0.7
Netherlands	22	0.7
Canada	15	0.9
Germany	15	0.3
Norway	15	1.1
Sweden	15	1.0
Japan	14	0.1
Australia	12	1.3
Denmark	8	0.5
Belgium	5	0.6
Luxembourg	2	1.8
Switzerland	2	0.2
Finland	1	0.4

Source: UNAIDS.

UNICEF/00-0110/Lewnes

Indian men discuss a campaign on preventing sexually transmitted infections, including HIV/AIDS. India now has close to 4 million people infected and faces a devastating epidemic.

THE TIME TO SOW

COMMENTARY: EARLY CHILDHOOD CARE

UNICEF/93-0711/Horner

The time to sow

By Carol Bellamy

Poverty continues to enslave huge populations, denying 1.2 billion people – 600 million of them children aged one to five years – good health and productive lives. To change this painful situation, the world needs to begin with children, assuring every one of the 130 million born each year the best possible start in life.

We are finally understanding how enormous our children's promise is from the moment of birth, how well-prepared infants are to survive, thrive and learn.

They depend on us adults; they beguile, charm and demand that we give them the time, nurturing and attention they seem to know that they need. When they receive the essentials, they reward us all along the way, from their very first smile into the next generation.

The building blocks are fairly modest: Children need health care, sound nutrition (with an emphasis on breastfeeding), a safe and hygienic environment and playful and loving interaction. This is the minimum; it is neither extravagant nor exorbitant. Yet from this simple foundation, they go on to astound us with their achievements, mastering language, arts, sciences and the complexities of life.

Only recently have we learned, however, how wasteful of their talents we can be.

An exciting and expanding body of knowledge shows how the early years of life are absolutely vital, laying the ground for the child's survival, growth, health and later accomplishments. During this time, the neural network in the brain develops, depending largely on the stimulation and care the child receives. Before a healthy child reaches the age of two and a half, millions of neural links have been forged, connections upon which physical, mental and cognitive development largely depend.

Heart of development

We squander our children's innate capacities and stint their care in those critical early years at grave expense. In violating children's rights by denying them the essentials they need and deserve, we harm them and ourselves, permitting and encouraging the seeds of poverty, alienation, hatred and despair to take root.

Effective early care for children lies at the very heart of human development. For those most persuaded by economic arguments, investments in services and support for children in the early years have an estimated return as high as 7 to 1. With 130 million infants born each year, this presents an enormous opportunity for social development that few leaders would want to ignore and an investment that few can afford to miss. Especially since it holds out the best promise we have for relieving poverty, which is now coiled so much more tightly around so many, and for changing the long-entrenched patterns of gender discrimination that violate girls' and women's rights and choke social progress.

Both poverty and gender discrimination replicate themselves from generation to generation. By ensuring children good early care, based on gender equity, we take vital and giant steps in breaking these cycles of discrimination and deprivation and unleashing new creative powers.

What does effective early childhood care entail for the vast majority of the world's estimated 1 billion children between the ages of zero and eight years? It recognizes the interaction among health, nutrition and the emotional well-being of children and their primary caregivers. To care for a child by necessity means being concerned about the conditions a woman faces at home and in society at large. For in countries and cultures where women's voices are muffled and poverty and discrimination limit their access to resources and services, where they have rare respite from wearying rounds of work, minimal legal protection and low status, optimal child development is impossible. Where men have little or no role in bringing up small children, yet lack respect for the women who are the caregivers, the stage is set for underachievement by all but a handful of children.

Effective early care means homes and an environment where children are protected against disease, where there is access to clean drinking water and adequate nourishment; where women can start exclusively breastfeeding their children. It also means that there is time and space for infants to grow and learn through play and exploration and to develop language through interaction with others.

For all these reasons, effective early care has to reach beyond the home into the environment and culture surrounding the immediate family.

As members of an extended family with a vital stake in human development, community and religious leaders, health and nutrition workers, teachers, employers and entire nations have an interest in and a responsibility for the

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care that the children in their communities and nations receive.

When children's rights are realized, both the immediate and longer-term rewards in human development are great. Supported from the moment of birth and before, children are likely to survive and to be healthier and happier, to be better able to learn throughout life and to become productive citizens.

The results are also visible on spreadsheets, in lower costs for remedial education and curative health expenditures. And in a delayed reaction well worth waiting for, effective care leads to better grounded, better nourished, healthier and more stable and productive societies.

All over the world, millions upon millions of families do provide excellent care for their children. Many millions of others, however, are unable to do so, usually because they are among the 1.2 billion people in developing countries who live below the poverty line of $1 per day.

They wage a vast but largely unnoticed struggle against disease, unsafe water, poor sanitation, ignorance, malnutrition, gender discrimination and often war and violence. How can we continue to be surprised that 11 million children below age five die each year in this unequal contest and that millions more lose physical and intellectual potential?

It is difficult to grasp the physical and cognitive effects of malnutrition alone: Half the children of South Asia and one third of those in sub-Saharan Africa are malnourished, their motivation, attention, curiosity and cognitive abilities dulled. Malnutrition and the repeated infections that accompany it produce a lethal lethargy that can prevent a young child from enjoying the care he or she deserves. Implicated in nearly half of all child deaths and countless failures to thrive, malnutrition has been estimated to cost the world – in one year alone – the equivalent of 46 million years of productive, disability-free life.

During a child's early years, low birthweight, recurrent illnesses, a lack of psychosocial stimulation, poor nutrition and the stresses of poverty can lead to poor health and a general lowering of intellectual, behavioural and social abilities.

Creating and revitalizing basic social services and building strong partnerships with poor communities are crucial aspects of ensuring a good start to life for children.

These are preventable losses, for which the solutions are known, available, fairly inexpensive and highly cost effective. The answer is to invest in children – time, energy, care and resources – and to do this from the earliest possible time, from birth and even before, when the investments will have the greatest impact on later human development. Creating and revitalizing basic social services and building strong partnerships with poor communities are crucial aspects of ensuring a good start to life for children.

Investing in children

A child whose mother has access to the care and services she needs during pregnancy and childbirth, a child born into a community with a competently staffed and adequately stocked primary health care centre, where information about nutrition and help for common ailments and infections are available, is a child off to a good start. When there is time for the stimulation and early learning that lead to better formal school achievement later, where there is access to clean water and adequate sanitation systems and 'child-friendly' primary schools – these too are vital factors in a good start in life.

An additional global expenditure of approximately $70 billion to $80 billion each year would help extend basic services that provide this kind of vital foundation to all. This is by no means an exorbitant amount, particularly in light of the benefits that would accrue, but it is one that developing countries on their own could not muster.

However, if developing countries devoted about 20 per cent of national budgets and donor nations a similar proportion of official development assistance (ODA) to basic social services, then the resources, for the most part, would be available. Such allocations are the basis of the 20/20 Initiative, advocated by UNICEF and other partners and endorsed by many nations at the World Summit for Social Development in 1995.

There are many reasons why countries do not honour the most basic rights of children. In some, war has destroyed infrastructure, economies and communities; AIDS is rampant, particularly in Africa, and it is very dangerously eroding already fragile social structures and the abilities of communities and nations to respond. Corruption drains the coffers in many others. And in far too many, the spiral of increasing and self-perpetuating debt strains already threadbare budgets and translates into disaster for children.

It is an enormous blot on the conscience of the world that in the 41 heavily indebted poor countries (HIPCs) – where human development indicators are the worst in the world – debt service consumes three to five times the amount of resources spent on basic services. In almost half of those same countries, nearly 50 per cent of people lack access to adequate sanitation and clean drinking water; 26 of the 31 countries with the highest numbers of child deaths in the world are in the HIPC group.

Not only is debt relief still stymied, but development assistance has also fallen from an average of 0.33 per cent of gross national product (GNP) in 1990 to an average of 0.24 per cent in 1998. This is happening in the context of a global economy that has grown to more than $30 trillion today and in donor countries where average GNP per person increased from $20,900 to $27,000 over the course of the last decade.

There is no question that the resources exist, but too little money is allotted for children's survival, growth and development, and too few people understand the implications for all societies of missed opportunities in early childhood.

When care in early childhood is made a priority, much can be achieved. The accomplishments of the past 10 years are significant. Immunization alone saves the lives of 2.5 million children each year. The conditions for unleashing these children's full human potential, however, remain largely unchanged in poor communities.

Simple transforming steps

We no longer have the excuse of ignorance. We know of good working examples of the integrated approach that ensures children's survival and brings out their potential. Programmes in India, Jamaica, Kenya, Peru and Turkey, for example, offer important lessons and hold out promise for similar gains elsewhere.

So too does an evolving integrated early childhood care and development approach in the

UNICEF/98-1117/Pirozzi

A child is weighed on a sling scale in a rural health post in Kenya. Low birthweight is a major factor in the deaths each year of 4 million infants worldwide in their first month of life.

Philippines, which demonstrates the success communities have had in weaving together health, nutrition, psychosocial care and early education services for young children. This programme aims to cut infant and child mortality, malnutrition and elementary school drop-out rates by half. These are crucial objectives in a country where nearly one third of children are underweight or stunted, and the under-five mortality rate is 44 deaths per 1,000 live births.

Around the country children in child-care centres, like the ones in the Philippine village of Capagao, play with well-worn toys and with musical instruments improvised from discarded bottles and bamboo slats, leaf through books and learn from brightly coloured posters about animals, the alphabet and hygienic hand-washing practices. Health and nutrition workers in the village are trained to counsel parents on better early childhood care, including exclusive breastfeeding and oral rehydration therapy (ORT). Children receive their routine immunizations at the health station. Health workers maintain a map of all houses in the community in which is recorded every child's growth, access to iodized salt and other micronutrients and the availability of clean water and sanitation.

These are simple steps; they are also life-saving and life-transforming ones. More importantly, the services are accessible within communities and are locally run. They include health care, day care, primary education and parent-effectiveness training. In typical villages, day-care workers, midwives, health workers and child development workers focus on multiple areas, so that health and nutrition workers now understand how children best begin to learn, and day-care workers are now aware of health issues.

UNICEF is supporting these efforts with local governments in 20 provinces and five cities by bolstering basic social services in rural communities through the establishment of community health and nutrition posts. In Capiz Province alone, 200 such posts are to be in place by the end of 2000. These health and nutrition posts provide mothers with a venue to meet, discuss health, nutrition and psychosocial needs of their babies, to be counselled by the village health worker and to have access to basic services such as vitamin A and iron supplements.

In the tiny island province of Guimaras, where child poverty rates exceed 70 per cent, a child-minding centre exists for poor families, allowing both parents to work. Day-care centres are being built village by village. Nationwide, the number of accredited new centres increased by 11 per cent in 1998, to more than 20,000.

UNICEF is helping improve the health of mothers and the capacity of parents and other caregivers to provide a loving and stimulating home environment for young children. Through a community-based parent-effectiveness service programme, organized parent groups learn about child health, psychosocial care, nutrition protection and even gender relations. UNICEF also supports training of day-care and local health workers and distributes parent-counselling cards and other information materials to grass-roots service providers.

In three regions in the Philippines, an integrated early childhood care and development project is being funded by the World Bank and the Asian Development Bank, with support from UNICEF and in partnership with local and national governments.

Efforts such as these are vitally needed all over the world, and a broad and vocal alliance – a truly global movement – is needed to support them, to help give voice and visibility to what is being done. The efforts of governments, all sectors of civil society, religious and grass-roots organizations, the media and international organizations are crucial in helping make children's rights the priority.

Putting children first

There can never be a single model of early childhood care, nor is one desirable. Experience shows that there are about as many effective approaches as there are needs.

We do know, however, that the best programmes are those concerned with the overlapping physical, intellectual and emotional needs of children. They approach child development as a holistic process and the child's needs as interrelated. We also know that each community has to have the freedom and the resources to create, refine and improve its own best practices, because policies and practices that relate to the way people live their lives are the ones children and parents need.

The world can take great pride in the succession of extraordinary steps made over the past decade in adopting the Convention on the Rights of the Child – now ratified virtually universally – and working to achieve the goals agreed upon at the 1990 World Summit for Children.

Now, as we look ahead to the UN General Assembly's Special Session on Children next year on those goals, it seems a very good time to rededicate ourselves to keeping up the momentum. We must continue arguing for, negotiating for and creating the best for children. Their needs should be given priority in the allocation of resources. Nations should commit themselves in principle, in policies, in law and in budgeting.

What is good for children is and must be a human development priority for everyone. Making it such a priority is the surest proof that a society is committed to ensuring the well-being of its people and stemming the tide of poverty, suffering and death that threatens to engulf us all. ■

LEAGUE TABLE: STUNTING IN CHILDREN UNDER AGE 5

The success the world has had in protecting children's rights and realizing human potential is captured far more eloquently in flesh and bone than in concrete or steel, far more tellingly in the height of children than in that of skyscrapers.

This league table presents stunting rates among children under five, which are unconscionably high. In six countries of East and South Asia, at least half of the children are stunted, as are 40% of children in sub-Saharan Africa.

Stunting does not come easy. It happens over time, and means that a child has endured painful and debilitating cycles of illness, depressed appetite, insufficient food and inadequate care. Many children do not survive such rigours, many of those who do survive carry long-term deficits in mental capacity along with losses in stature.

Short-changing children

Low weight at birth, insufficient feeding, inadequate care and nutrient depletions caused by repeated bouts of illness culminate over time in a child whose height is less than that of other children of the same age. Such stunting is a standard marker of a failure in early growth.

Deprivations in feeding and care that impair growth in the critical first years may also reduce a child's cognitive development and learning ability, often leading to poor school performance and dropping out.

Some 39% of children under five in the developing world are stunted – around 209 million children. Stunting rates are highest in Asia and sub-Saharan Africa.

Inadequate feeding and repeated illness are the immediate causes of stunting in the young child. This vicious cycle is itself a result of poverty and the consequent inability of families to adequately care for their children. A lack of clean water supply in a poor community, or a long distance between home and health clinic, for example, affects the level of care that can be given.

Stunting also occurs when babies are born underweight because the mother was poorly nourished or because she was herself stunted.

Once established, stunting and its effects typically become permanent. Stunted children may never regain the height lost and most will never gain the corresponding weight. And when the window of early childhood is closed, the associated cognitive damage is often irreversible.

SUB-SAHARAN AFRICA	
Ethiopia	64
Angola	53
Madagascar	48
Malawi	48
Congo, Dem. Rep.	45
Lesotho	44
Mauritania	44
Burundi	43
Nigeria	43
Rwanda	42
Tanzania	42
Zambia	42
Niger	41
▶ *Regional average*	*40*
Chad	40
Eritrea	38
Uganda	38
Mozambique	36
Sierra Leone	35
Central African Rep.	34
Kenya	33
Zimbabwe	32
Gambia	30
Mali	30
Botswana	29
Burkina Faso	29
Cameroon	29
Guinea	29
Namibia	28
Ghana	26
Benin	25
Côte d'Ivoire	24
Senegal	23
South Africa	23
Togo	22
Somalia	14
Mauritius	10
Congo	No data
Gabon	No data
Guinea-Bissau	No data
Liberia	No data

MIDDLE EAST AND NORTH AFRICA	
Yemen	52
Sudan	33
Iraq	31
▶ *Regional average*	*25*
Egypt	25
Morocco	23
Oman	23
Tunisia	23
Syria	21
Turkey	21
Saudi Arabia	20
Iran	19
Algeria	18
U. Arab Emirates	17
Libya	15
Lebanon	12
Jordan	8
Israel	No data
Kuwait	No data

CENTRAL ASIA

Afghanistan	52
▶ *Regional average*	*37*
Uzbekistan	31
Kyrgyzstan	25
Azerbaijan	22
Kazakhstan	16
Armenia	No data
Georgia	No data
Tajikistan	No data
Turkmenistan	No data

EAST/SOUTH ASIA AND PACIFIC

Korea, Dem.	62
Cambodia	56
Bangladesh	55
Nepal	54
India	52
Pakistan	50
Lao PDR	47
Myanmar	45
▶ *Regional average*	*44*
Viet Nam	44
Indonesia	42
China	34
Philippines	30
Mongolia	22
Sri Lanka	18
Thailand	16
Australia	No data
Bhutan	No data
Japan	No data
Korea, Rep.	No data
Malaysia	No data
New Zealand	No data
Papua New Guinea	No data
Singapore	No data

AMERICAS

Guatemala	46
Honduras	40
Haiti	32
Bolivia	26
Peru	26
Nicaragua	25
El Salvador	23
Mexico	18
Paraguay	17
Colombia	15
Venezuela	13
▶ *Regional average*	*13*
Brazil	11
Dominican Rep.	11
Panama	9
Uruguay	8
Costa Rica	6
Jamaica	6
Chile	2
United States	2
Argentina	No data
Canada	No data
Cuba	No data
Ecuador	No data
Trinidad/Tobago	No data

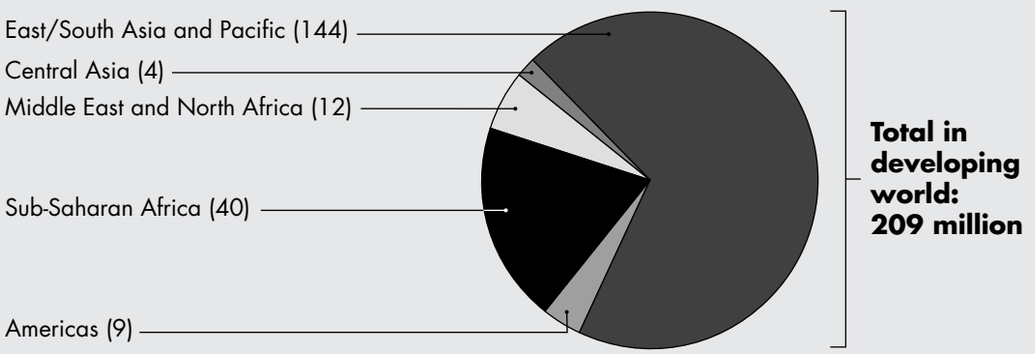
EUROPE

Russian Fed.	13
▶ *Regional average*	*11*
Romania	8
Yugoslavia	7
Czech Rep.	2
Croatia	1
Albania	No data
Austria	No data
Belarus	No data
Belgium	No data
Bosnia/Herzegovina	No data
Bulgaria	No data
Denmark	No data
Estonia	No data
Finland	No data
France	No data
Germany	No data
Greece	No data
Hungary	No data
Ireland	No data
Italy	No data
Latvia	No data
Lithuania	No data
Moldova, Rep.	No data
Netherlands	No data
Norway	No data
Poland	No data
Portugal	No data
Slovakia	No data
Slovenia	No data
Spain	No data
Sweden	No data
Switzerland	No data
TFYR Macedonia	No data
Ukraine	No data
United Kingdom	No data

WHAT THE TABLE RANKS

Percentage of children under five who are stunted

Number of stunted children under age five (in millions)



Source: DHS, multiple indicator cluster surveys (MICS), WHO and UNICEF, 1990-1998.

Victory possible against iodine deficiency

Just two short decades ago, iodine deficiency was a major global problem, impairing the growth and mental development of large numbers of children and retarding social and economic progress in developing and industrialized nations.

Now, because of salt iodization, some 70% of the world's population is protected from iodine deficiency. More than 90% of the population in 29 countries uses adequately iodized salt, and in another 36 countries at least half of the population is protected.

As a result, millions of people are spared iodine deficiency's more evident effects such as goitre and cretinism, and societies as a whole are spared the serious economic and social consequences, including an overall reduction in the mental capacities of their populations.

But while progress has been impressive, there are still 34 countries with a combined total of about 1 billion people where 50% or less of the population uses iodized salt. These include the majority of countries in Central and Eastern Europe, where progress has slipped in recent years, and Pakistan, the Philippines and Turkey, which have greater resources but poorer track records than many other countries. In 14 of the 34 countries, 10% or less of salt is iodized.

Salt iodization is simple and inexpensive. Making it happen calls for government commitments to put legislation and monitoring mechanisms in place and to build partnerships with local salt producers.

Creating public awareness of the problem of iodine deficiency, thereby building a constituency for iodized salt, is another key to reaching the target of universal salt iodization.

Low levels, high risk

	% of households consuming iodized salt		% of households consuming iodized salt
Cuba	0	Turkey	18
Ethiopia	0	Pakistan	19
Mauritius	0	Equatorial Guinea	20
Sudan	0	Tajikistan	20
Turkmenistan	0	Burkina Faso	23
Mauritania	3	Swaziland	26
Ukraine	4	Kyrgyzstan	27
Korea, Dem.	5	Ghana	28
Cambodia	7	Russian Fed.	30
Gambia	9	Fiji	31
Mali	9	Belarus	37
Senegal	9	Guinea	37
Angola	10	Yemen	39
Iraq	10	Syria	40
Dominican Rep.	13	Sri Lanka	47
Philippines	15	Guatemala	49
Uzbekistan	16	Thailand	50

Sources: UNICEF, DHS, MICS (1992-2000).

Weighing in for better child health

A baby's weight at birth is a good indicator of both the mother's health status and the infant's chances of survival and development. Infants who weigh less than 2.5 kg at birth face high immediate and long-term risks. But this key indicator is not well monitored as many of the 116 million children born each year in developing countries are not weighed at birth. Over 20 million – more than one in every five children – are low-birthweight babies.

Low birthweight (less than 2.5 kg, about 5.5 pounds) is a major factor in the deaths each year of 4 million infants before the age of one month and in illnesses affecting millions more. Evidence is mounting that low birthweight leads to a 50% greater risk of diabetes, heart disease and cancer later in life.

Data from 34 countries show that in 16 of them (*see list*), more than half of infants are not weighed at birth. In Chad, Egypt, Haiti, Niger and Pakistan, 80% or more of newborns are not weighed.

Nearly half of all births in developing countries are not attended by doctors, nurses or midwives. Traditional birth attendants, who assist deliveries in the absence of trained health personnel in their communities, can play useful roles by encouraging weight gain during pregnancy and weighing the babies they deliver.

The unweighed
% of infants not weighed at birth

Chad	89
Pakistan	88
Egypt	84
Haiti	82
Niger	80
Rwanda	74
Nigeria	73
Uganda	73
Mali	69
Madagascar	64
Comoros	55
Mozambique	55
Togo	55
Kenya	54
Zambia	53
Senegal	51

Sources: DHS (1990-1999) and additional analysis.

Antenatal care could save millions

Ten years ago, leaders attending the World Summit for Children pledged to ensure universal access by women to maternal health care by the year 2000. Yet 44 million women in the developing world still receive no antenatal care.

Insufficient maternal care during pregnancy and delivery is largely responsible each year for nearly 600,000 maternal deaths and an estimated 5 million infant deaths either just before or during delivery or in the first week of life.

Out of the 88 countries for which data are available, the situation is particularly desperate in 13 countries (*see list*). The lowest rates of maternal care were found in Bangladesh, Chad, Mali, Nepal and Pakistan.

The surveys also contained the good news that in 27 countries – including Kenya, Rwanda, Uganda and Zambia – more than 90% of women received skilled care at least once during their pregnancies.

Contact with a doctor, nurse or midwife facilitates maternal immunization and allows health personnel to manage the pregnancy, detect complications and promote good eating, hygiene and adequate rest.

Maternal care rates tend to be low and maternal mortality rates high in countries where women's status is low, a consequence of women having fewer economic and educational opportunities and little access to social services. Also, fewer people have access to routine health services, including skilled maternity care, in impoverished, remote geographical areas than in urban areas.

The national percentages do not reveal the entire picture, as they mask huge rural/urban disparities.

Where antenatal care is lowest
% of women (aged 15-49) attended by skilled health personnel at least once during pregnancy

Chad	23
Nepal	24
Mali	25
Bangladesh	26
Pakistan	26
Cambodia	34
Yemen	34
Niger	39
Morocco	42
Mauritania	48
Eritrea	49
India	49
Tanzania	50

Sources: DHS, WHO and UNICEF (1990-1999).

Health care vital in stopping ARI

Too few parents in the developing world seek professional health care when a child has an acute respiratory infection (ARI) – despite the high risks associated with ARI – according to data from recent surveys.

In eight countries – Bangladesh, Benin, Cameroon, Chad, Haiti, Mali, Niger and Togo – the situation is particularly worrisome. In those countries, only up to a third of children who had had ARI within two weeks of the survey had been seen by a doctor or other health care provider. Overall, in 18 of the 29 countries surveyed, fewer than half of the children with ARI were taken to a health care provider.

Where the lucky few are treated

% of children with ARI taken to a health care provider*

Chad	19	Madagascar	37	Nicaragua	58
Mali	22	Côte d'Ivoire	39	Uganda	61
Niger	26	Mozambique	39	Comoros	62
Togo	26	Central African Rep.	41	Egypt	62
Haiti	27	Bolivia	43	Indonesia	69
Benin	32	Malawi	46	Viet Nam	69
Bangladesh	33	Dominican Rep.	48	Tanzania	70
Cameroon	33	Colombia	49	Zambia	71
Eritrea	37	Zimbabwe	52	Jordan	76
Guatemala	37	Kenya	57		

*Within two weeks of the survey date.

Source: DHS (1994-1999).

The surveys showed that children in eastern and southern African countries were somewhat better off than those in West Africa, as more than half of those with ARI were taken to health care providers, compared with fewer than a third of children in West African countries.

ARI is a leading cause of mortality in young children, killing nearly 2 million children under the age of five in developing countries every year. Of crucial importance in preventing these deaths is the fact that when a child develops ARI, he or she needs to be seen by a health care provider. Whether or not this happens depends on a number of variables, including whether family members can recognize the signs of ARI – a cough accompanied by rapid breathing – and know to seek expert care. Other factors include whether good care and drugs are easily available and accessible and whether women's status prevents children from receiving the professional health care they need.

An analysis of survey results shows that educated mothers are more likely to seek professional health care when a child has ARI than are mothers with no education. In Cameroon, for example, children whose mothers are educated are three to four times more likely to be seen by a health provider than are children whose mothers are not educated.

UNICEF is working with the World Health Organization (WHO) and other partners to improve home and community health care for children as part of the Integrated Management of Childhood Illness (IMCI) strategy.

Teen mothers and their children at risk

When an adolescent becomes a mother, her health and that of her child are threatened. Early childbearing also means girls lose out on schooling and have few employment options, thus perpetuating circumstances that disadvantage girls. The risks associated with adolescent motherhood make it a clear violation of children's right to health and survival – for both the young mother and her child.

Children of adolescent mothers are more likely to be born underweight and to die within their first month of life compared to those whose mothers are older. If they survive the first month, these children are still more likely to die before their fifth birthdays.

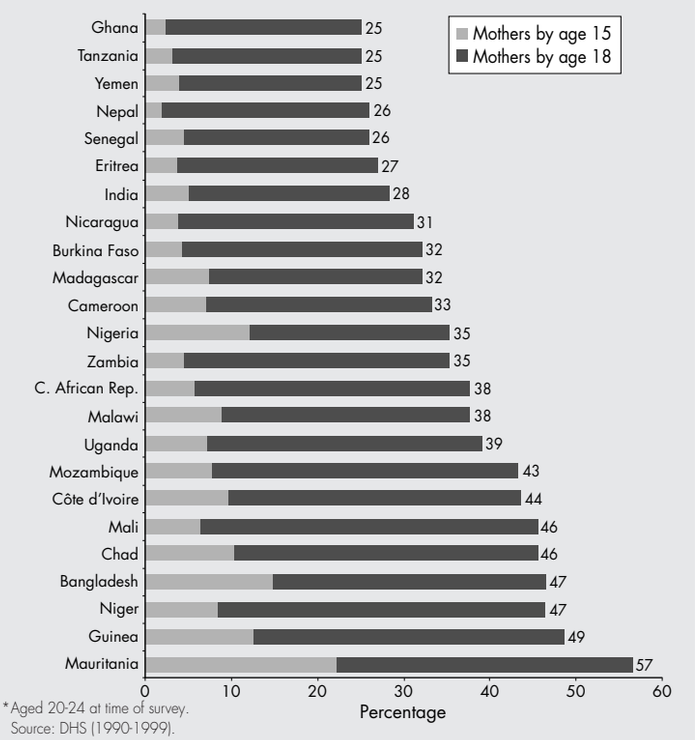
For the young mothers, the risk of dying during childbirth is heightened. Teenage girls over 15 years of age are twice as likely to die from childbirth as are women in their 20s, while girls under 15 are at five times greater risk. Early sexual activity also increases the risk of infection with HIV/AIDS.

Data from 54 countries show that in Bangladesh, Chad, Guinea, Mauritania and Nigeria more than 1 in every 10 women have their first child before age 15. In Mauritania, the rate is especially high: Nearly a quarter of women have their first child before the age of 15 and over half have their first child before age 18. In 20 other countries, more than one out of every four women give birth before age 18.

Women who begin bearing children during adolescence typically have more children over the course of their reproductive years.

In both Chad and Côte d'Ivoire, for example, where 10% or more of girls become mothers by the age of 15, the average woman will give birth to six children. That is twice the average fertility rate in the developing world.

% of women* who gave birth by age 15 or 18



*Aged 20-24 at time of survey.

Source: DHS (1990-1999).

THE POWER OF IMMUNIZATION

COMMENTARY: NEW AGENDA FOR VACCINES

UNICEF/99-1112/Lemoyne

The power of immunization

By Dr. William Foege

Immunization stands at a crossroads after an astounding 15 years of vigorous campaigns around the world. Through determined efforts of national governments, international agencies and hundreds of thousands of volunteers, 2.5 million children's lives are saved each year. But there are still 30 million infants not protected by routine vaccination in developing countries. They are among the 11 million children who die from preventable causes every year. How to reach these unreached children and extend the power of new or improved vaccines within poor countries are the twin challenges now facing the world.

I can think of no other human endeavour that has as dramatic, deep and positive a legacy as does immunization.

In countless tiny villages and dense urban centres, from Africa and Asia to Latin America and the former Soviet Union, more than 100 million babies a year are immunized, receiving vaccines to prevent diphtheria, tetanus, whooping cough, polio, measles and tuberculosis, saving millions from death and sparing millions more at minimal cost from paralysis, visual impairment and brain damage.

Generations of healthy adults owe their very lives to the fact that they were immunized as children and protected against life-threatening diseases. And the material and human progress so many societies have made rests heavily on public health improvements, of which immunization is a linchpin.

Yet immunization's success is a low-key, quiet and self-effacing story taken for granted by many, especially in the industrialized world, where it is still saving lives. It does not receive the attention and acclaim it deserves even in the developing world, where its contribution, particularly over the past 15 years, has been truly remarkable. Since the 1970s, global coverage has soared from less than 10 per cent to almost 75 per cent, saving the lives of 2.5 million children each year.

Not since the eradication of smallpox over 20 years ago has the power of immunization been so evident as in the stunning success of the 12-year campaign to eradicate polio. The world has watched and applauded as immunization efforts have pushed back the wave of disability, suffering and death brought on by polio. Polio cases, which reached an estimated 350,000 a year as recently as 1988, had dropped to about 7,000 by 1999.

In a global mobilization unmatched in peacetime, 470 million children under five years of age were immunized in 1999, an extraordinary achievement made possible by the selfless, committed and sustained efforts of Rotary International, UNICEF, WHO and more than 10 million volunteers in nearly 100 nations.

The efforts have been well rewarded. North and South America have officially been certified polio-free, and in Europe only Turkey reported a few cases in 1998. The disease is rapidly disappearing from most of eastern and southern Africa, North Africa and the Arabian Peninsula. In East Asia and the Pacific, the last indigenous case was reported in Cambodia in 1997. Polio has now retreated to outposts in Afghanistan, Bangladesh, India, Nepal and Pakistan in Asia, and Somalia, Sudan and parts of West and Central Africa, where it clings on partly because of wars, poverty and difficulties in reaching some areas. But the world is determined to prevail against polio.

A spotty scorecard

The experience with polio, while filling us with satisfaction, must also drive us to consolidate our accomplishments by turning the power of immunization on diseases that are still killing millions of children and impairing the abilities of countless others. We must aim for full coverage and complete effectiveness of immunization, not the spotty scorecard that proclaims success in scattered corners of the globe and neglect in many others.

- There are still 30 million infants in the developing world who are not immunized before their first birthday.
- More than 900,000 children under five still die each year from measles.
- Neonatal tetanus kills 200,000 each year.
- Annually, 370,000 under-fives die from whooping cough and 50,000 from tuberculosis.
- Diphtheria has re-emerged in parts of the former Soviet Union.
- Half of all pregnant women are not immunized against maternal tetanus, which kills 30,000 women every year.

The continuation of this suffering and loss of life contravenes the natural human instinct to

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COMMENTARY: NEW AGENDA FOR VACCINES

help in times of disaster. Imagine the horror of the world if a major earthquake were to occur and people stood by and watched without assisting the survivors! Yet every day, the equivalent of a major earthquake killing over 30,000 young children occurs to a disturbingly muted response. They die quietly in some of the poorest villages on earth, far removed from the scrutiny and the conscience of the world. Being meek and weak in life makes these dying multitudes even more invisible in death.

All children everywhere must be able to enjoy the benefits of science and experience developed around vaccines. All children everywhere, without discrimination, have and must be able to enjoy equal rights. The Convention on the Rights of the Child, ratified by all but two countries, binds the world in a compact to realize these rights. Distance and remoteness must therefore neither blind our vision, blunt our feelings, nor stall our response to this numbing, recurrent tragedy. It is our collective responsibility to see that these deaths are prevented.

And they are preventable. We can and must now go the distance and finish what so desperately remains to be done by unleashing the full power of immunization against the six traditional child-killer diseases.

Measles is still a severe threat, especially in South Asia and sub-Saharan Africa, and efforts are needed to stop the downward slide in measles coverage that occurred in Africa during the 1990s.

Half of the infants born in developing countries are unprotected against tetanus and 200,000 die from the disease each year because their mothers have not been immunized with tetanus toxoid. And as infants die, so too do women: In parts of Africa, fewer than 40 per cent of women are immunized against tetanus. In rural pockets of China and India, 10 per cent or less may be protected.

Whooping cough (pertussis) still afflicts 20 million to 40 million people every year, primarily in developing countries, although a pertussis vaccine has been available for more than 70 years.

Efforts to reach the unreached must go hand in hand with the improvement of immunization safety. Reuse of unsterilized needles, poor hygiene at the time of vaccination and inadequate waste disposal are the main culprits. Failures in the cold chain to maintain vaccines at the proper temperature are also a problem. Personnel must be trained and systems introduced to prevent these dangerous practices.

The Safe Injection Global Network – which links international organizations, NGOs and private sector entities – is promoting the use of syringes that function only for a single dose. It is also investigating the possibility of introducing vaccines that don't require needles for delivery, but can be given through other methods, including oral doses, jet ejectors, nasal sprays, skin creams and even genetically modified foods.

A clear priority now is to renew commitment at all levels to attain the immunization goals. The net must be cast wider to reach all those who have not been reached thus far – the poor, the displaced, people living in far-flung villages, children living on the streets, refugees and people living in areas of conflict. Extensive educational and outreach campaigns must be mounted in countries with high incidences of disease. Governments must renew their commitment and resolve problems caused by corruption, inadequate services and mismanagement.

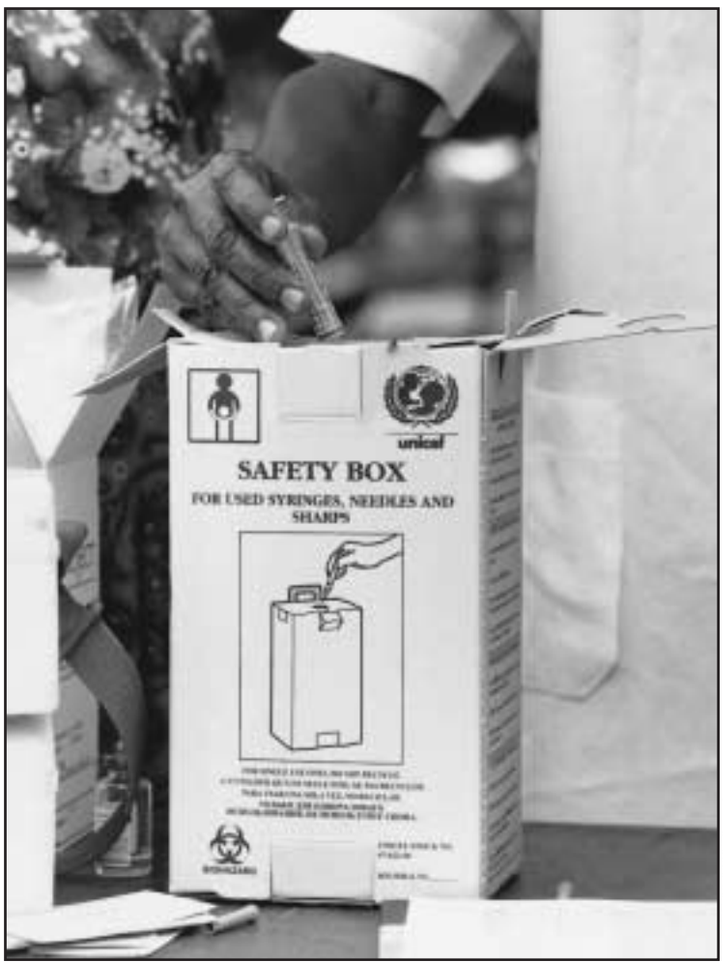
A revolution only for some

Vaccines have changed the course of history and human development, and they continue to do so. A veritable public health revolution is occurring, with relatively recent vaccines and vaccine-delivery technologies joining and strengthening the august ranks of older tried-and-true vaccines. The promise these developments hold is enormous; the unacceptable reality is that many in the developing world will continue to be excluded from their benefits.

A vaccine now offers protection from hepatitis B (which causes liver cancer later in life), for example, and over 60 countries have added it to their routine immunization programmes. But at a cost of $1.50 per child to administer the three necessary doses, the vaccine does not reach many of those who need the protection most. Approximately $20 million would make the vaccine available in sub-Saharan Africa.

Similarly, a new vaccine against Hib (*Haemophilus influenzae* type b, which causes bacterial pneumonia and meningitis) has been introduced in 24 developing countries. Now, $80 million stands between the vaccine and the lives of the millions of other children at risk in developing countries, where at least 400,000 die every year from the infections Hib causes.

The list does not end there, however. There are new vaccines on the horizon to combat the largest threats to children in developing countries, such as



UNICEF/00-0239/Pirozzi

Safety boxes, such as this one being used following a vaccination in Mozambique, are cost-effective ways to ensure immunization safety. Such measures help eliminate reuse of unsterile needles and prevent unsafe disposal practices.

acute respiratory infections (ARI), which kill approximately 2 million children each year. The first-ever vaccine against pneumococcal infection – responsible for more than half of pneumonia deaths – was licensed this year in the United States. Field tests have commenced in Africa on a vaccine variety better able to combat the strains of the disease that are common in developing countries. A vaccine against respiratory syncytial virus (RSV) – which causes many of the remaining deaths from ARI – is under development.

The promise these developments hold is enormous; the unacceptable reality is that many in the developing world will continue to be excluded from their benefits.

Poor countries also urgently need new vaccines against diarrhoeal diseases – so common where poor hygiene and sanitation, unsafe water and malnutrition occur. These diseases kill another 1.8 million children each year. Rotavirus causes one quarter of the deaths from severe dehydrating diarrhoea in young children in developing countries. While oral rehydration therapy (ORT) can be an effective treatment, prevention is essential and requires large-scale immunization along with improved sanitation and water systems.

Vaccines are also being developed for dysentery and *Escherichia coli*, each of which kills upwards of a half million children a year.

Malaria, endemic to much of Africa and parts of Brazil and India, causes up to half a billion illnesses and at least 1 million deaths each year, about 75 per cent of them among children under five, making a malaria vaccine especially urgent.

Other vaccines are being tested for parasitic diseases such as schistosomiasis and dengue, which infect hundreds of millions of children and adults. Until recently, these vaccines have received inadequate attention because developing countries – with very limited resources – were their only market.

And the story is the same for yellow fever, which kills far too many children and adults across large swaths of Africa and Latin America. A very effective vaccine has been available for 65 years, but cost keeps it out of many of the routine immunization programmes where it is needed most.

A clear and common enemy

The chasm between what we are capable of and what we actually do to protect all children everywhere needs to be bridged before it grows any wider.

It is, of course, very possible to extend the proven power of immunization to all the world's children, and the resources needed to do so can be found.

A commitment of $750 million over five years by the Bill and Melinda Gates Foundation led to the development of the Global Alliance for Vaccines and Immunization (GAVI). GAVI is an international partnership created to improve access to sustainable immunization services, expand vaccine production and use, accelerate vaccine development, improve the quality of vaccines and delivery mechanisms and make immunization an integral part of health systems and development efforts. It is an all-star line-up of the major organizations in the immunization field, among them members of the vaccine industry, foundations, national and local governments and NGOs, and organizations such as UNICEF, WHO and the World Bank. A major thrust of the Initiative is the Global Fund for Children's Vaccines made possible by the Gates grant, which will be used to buy hepatitis B, Hib and other under-utilized vaccines.

UNICEF, which has long been the main vaccine supplier for developing countries, has taken the lead in ensuring that vaccine financing is sustainable. The goal of the UNICEF-driven Vaccine Independence Initiative is to have countries that can afford vaccines pay for them so that funding is freed to purchase new and existing vaccines for very poor countries.

These efforts fully recognize the enormous benefits of vaccines, the power of immunization and the effectiveness of collaboration among governments, NGOs, private sector and international organizations. Taken together, they provide new hope that the world will overcome the impediments of war, poverty and mismanagement and make victory certain over the one clear and common enemy against which the entire world can and must unite – diseases that needlessly kill children. ■

UNICEF/98-1048/Pirozzi

A child in Yemen receives drops of the oral polio vaccine. The disease is being pushed to the brink of eradication: Globally, there were about 7,000 confirmed cases in 1999.

LEAGUE TABLE: THE DPT3 COVERAGE MEASURE

Immunization remains the single most feasible and cost-effective way of ensuring that all children enjoy their rights to survival and good health. In the developing world, immunization saves the lives of 2.5 million children every year. Because of its recognized power and efficacy, renewed efforts are being made globally to mobilize more resources for another push to ensure that all children are protected by immunization and that new vaccines for other common killer diseases are developed.

A mixed performance

The series of immunizations known as DPT can prevent diphtheria, pertussis (whooping cough) and tetanus, but these three diseases still kill 600,000 children and afflict millions of others every year in developing countries. To be fully protected, children must receive three doses of the vaccine, administered at the ages of one month, one month and a half and three months. The percentage of children receiving the final dose (DPT3) is therefore a revealing and vital gauge of how well countries are providing immunization coverage for their children.

This league table shows progress, or lack of it, towards the lofty goal of immunizing 90% of children in all countries by the end of 2000. As the table indicates, 40 developing countries – and many industrialized countries – have done extremely well, attaining or exceeding the 90% coverage goal set at the 1990 World Summit for Children. The high performers are found primarily in the Americas, Central Asia, Europe and the Middle East and North Africa, but in sub-Saharan Africa, a region beset by economic hardship, armed conflict and AIDS, three countries – Gambia, Malawi and Mauritius – also attained 90% coverage or above. On average, however, only about half of the children in sub-Saharan Africa are protected. Countries in East Asia and the Pacific generally have high coverage, while South Asia, with a regional average of 70%, remains well below the goal.

The world average is now 77%, the result of a massive immunization campaign in many countries during the 1980s. That kind of push needs to be extended to provide coverage for all children. The new Global Alliance for Vaccines and Immunization (GAVI) has been created to renew this effort. It aims to help poor countries that meet specific criteria (*see 'Plans to save more children with Hib vaccine', page 24*) overcome the great gaps they face in immunizing their children. GAVI aims by the year 2005 to have assisted these countries in attaining at least 80% DPT3 and measles coverage in all districts.

SUB-SAHARAN AFRICA

Gambia	96
Malawi	96
Mauritius	90
Botswana	82
Tanzania	82
Benin	81
Zimbabwe	81
Mozambique	77
Rwanda*	77
Kenya	76
South Africa	76
Namibia	74
Zambia*	70
Ghana	68
Madagascar	68
Senegal*	65
Guinea-Bissau*	63
Côte d'Ivoire	61
Eritrea	60
Ethiopia	58
Lesotho*	57
Sierra Leone	56
Gabon*	54
Mali	52
Burundi	50
▶ *Regional average*	*48*
Cameroon	46
Central African Rep.	46
Guinea	46
Uganda	46
Burkina Faso	37
Togo	37
Angola	36
Mauritania*	28
Chad	24
Somalia*	24
Congo*	23
Niger	22
Nigeria	21
Liberia	19
Congo, Dem. Rep.	10

MIDDLE EAST AND NORTH AFRICA

Iran	100
Oman	100
Lebanon	97
Libya	97
Syria	97
Iraq	96
Tunisia	96
Saudi Arabia	94
U. Arab Emirates	94
Israel	93
Kuwait	93
Morocco	93
Egypt	92
Jordan	91
▶ *Regional average*	*84*
Algeria	80
Sudan	72
Yemen	68
Turkey	56

Immunization drop-out rates signal flawed systems

The high BCG-DPT3 drop-out rates of 10% to 59% (*at right*) spell bad news for the health of young children and present a challenge for local health delivery systems. Health systems in countries where the drop-out rate is more than 10% are considered flawed by health experts.

The figures show that caregivers had been in contact with health care systems because their young children had received an anti-tuberculosis BCG

CENTRAL ASIA

Turkmenistan	99
Uzbekistan	99
Kazakhstan	98
Azerbaijan	97
Kyrgyzstan	97
Tajikistan	94
Georgia	86
Armenia	82
▶ *Regional average*	*74*
Afghanistan	34

EAST/SOUTH ASIA AND PACIFIC

Sri Lanka	100
China	98
Singapore	96
Viet Nam	96
Malaysia	95
Thailand*	95
Mongolia	94
Indonesia	90
Myanmar	87
Australia	86
Bhutan	86
▶ *Regional average*	*82*
New Zealand	81
Philippines	79
Nepal	76
Korea, Rep.	74
India	73
Japan*	70
Bangladesh	68
Cambodia	64
Pakistan	59
Papua New Guinea	58
Lao PDR	55
Korea, Dem.	37

AMERICAS

Peru	100
Cuba	98
Panama	98
Canada	97
Honduras	97
Mexico	96
Brazil	94
Chile	93
Uruguay	92
Trinidad/Tobago	91
United States	90
Jamaica	88
▶ *Regional average*	*86*
El Salvador	86
Costa Rica	85
Ecuador	85
Argentina	83
Paraguay	81
Dominican Rep.	74
Colombia	70
Guatemala	70
Nicaragua	69
Bolivia	41
Venezuela	38
Haiti	22

EUROPE

Hungary	100
Finland	99
Slovakia	99
Czech Rep.	98
Ukraine	98
Belarus	97
France*	97
Moldova, Rep.	97
Netherlands	97
Portugal	97
Romania*	97
Russian Fed.	97
TFYR Macedonia*	97
Albania	96
Bulgaria	96
Germany	95
▶ *Regional average*	*94*
Estonia	94
Latvia	94
Switzerland	94
Croatia	93
Lithuania	93
United Kingdom	93
Slovenia	91
Austria*	90
Bosnia/Herzegovina	89
Greece*	85
Italy	70
Belgium	No data
Denmark	No data
Ireland	No data
Norway	No data
Poland	No data
Spain	No data
Sweden	No data
Yugoslavia	No data

*1997 coverage data.

Source: UNICEF, 1999.

WHAT THE TABLE RANKS

Percentage of children who have received 3 doses of DPT

shot. They did not, however, return with their children to complete the three-dose series of diphtheria/pertussis/tetanus vaccine (DPT3). This suggests that caregivers either were dissatisfied with the services or were not even made aware that a course of DPT was needed.

These figures are important because they pinpoint deficiencies in the quality of immunization services being provided and can spark measures to correct the problems and improve DPT3 coverage within the current infrastructure at minimal additional cost.

Figures that spell trouble

BCG-DPT3 drop-out rates, 1999 (in descending order)

59% to 50% Mauritania, Somalia, Venezuela, Niger, Bolivia

49% to 40% Togo, Angola, Burkina Faso, Chad, Democratic People's Republic of Korea

39% to 30% Mali, Cameroon, Guinea, Turkey, Djibouti, Uganda, Liberia

29% to 20% Sierra Leone, Côte d'Ivoire, Samoa, Nicaragua, Bangladesh, Gabon, Guinea-Bissau, Democratic Republic of Congo, Guatemala, Mozambique, Nigeria, South Africa, Ethiopia, Haiti, Ghana, Congo

19% to 10% Kenya, Senegal, Equatorial Guinea, Argentina, Algeria, Cambodia, Eritrea, Madagascar, Colombia, Dominican Republic, Burundi, Armenia, Zambia, Ecuador, Central African Republic, Philippines, Namibia, Bosnia and Herzegovina, Benin, Tanzania, Yemen, Nepal, Sudan, Panama, Comoros, Pakistan, Swaziland, El Salvador

Source: UNICEF, 1999.

Polio: Eradication within sight

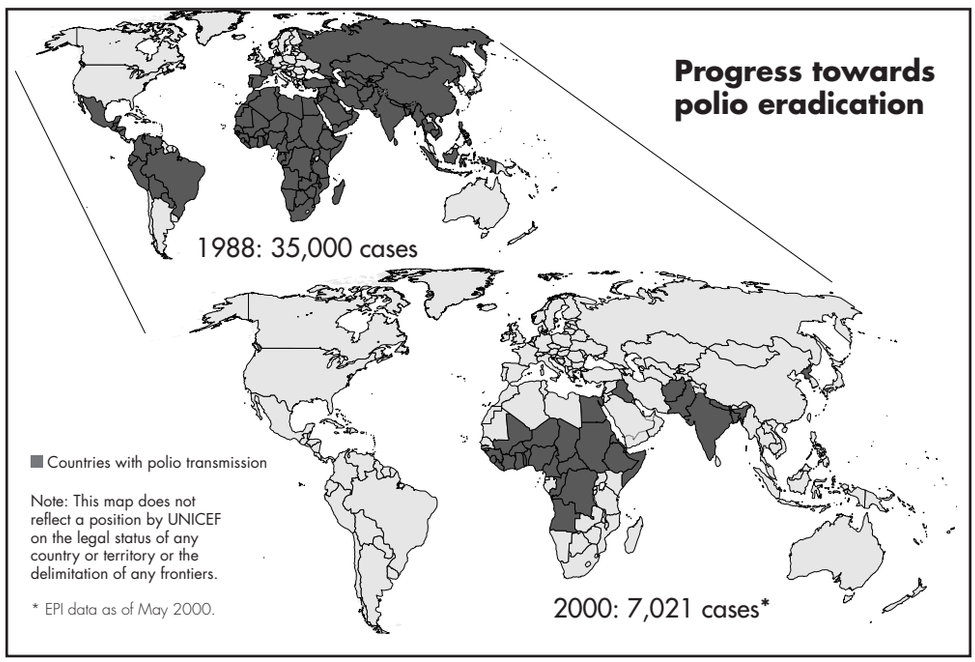
A comprehensive global campaign to reach the milestone of polio eradication by the year 2000 has pushed back the number of detected cases so far to about 7,000. The campaign has also narrowed the disease's reach: The number of countries reporting the presence of polio dropped from 50 to 30 between 1998 and 1999 alone. When the campaign began in 1988, there were 35,000 cases confirmed worldwide. It is estimated that these represented only one tenth of all cases occurring at that time in virtually all developing countries.

India now has the greatest number of polio cases, followed by Angola and Nigeria. Four large-scale National Immunization Days (NIDs) were held in India last year reaching as many as 147 million children in a single day; as a result, reported cases declined by approximately 40%.

The greatest efforts this year will be concentrated in the 14 countries with the highest risk for continued transmission of polio into the year 2001. These are Afghanistan, Angola, Bangladesh, Chad, Congo, the Democratic Republic of Congo, Ethiopia, India, Iraq, Niger, Nigeria, Pakistan, Somalia and Sudan.

Inadequate surveillance in several of these countries means that available figures could be inaccurate and the countries are not expected to achieve eradication by the end of the year 2000. Campaigns to end polio will therefore have to be maintained through 2003, with an intensification of activities such as house-to-house immunization and redoubling of efforts to reach the unreached.

The delay to achieve eradication is minor compared to the remarkable progress made to date.



Last year alone, through National and Sub-National Immunization Days, 470 million children in 83 countries were immunized. In 52 of these countries, vitamin A supplementation, which helps reduce childhood deaths from common infections, was included in the immunization activities.

Continuing conflicts in some countries in Africa and South Asia posed serious challenges to the polio eradication efforts, but effective interventions by the United Nations Secretary-General, UN agencies and other partners yielded truces during which warring factions silenced their guns for specified days to allow immunization teams to reach children in conflict areas. As a result of these 'days of tranquillity', 8.7 million children in the Democratic Republic of Congo, 4.4 million in Afghanistan and 3 million in Angola were immunized in 1999.

Similar interventions were carried out in war-torn Sierra Leone and southern Sudan, and more will be needed this year and the next to ensure that every child is reached if the world is to achieve the global certification of polio eradication in the year 2005.

Plans to save more children with Hib vaccine

Every year, a shocking 400,000 children die from pneumonia and meningitis because the 43 developing countries in which they live lack resources to add the life-saving Hib (*Haemophilus influenzae* type b) vaccine to routine immunization programmes.

A priority objective of the Global Alliance for Vaccines and Immunization (GAVI) – of which UNICEF is a member – is to have at least half of eligible Hib-endemic countries introduce the Hib vaccine by 2005.

First in line are 26 poor countries, selected on the basis of three criteria: per capita incomes under $1,000; DPT3 immunization coverage of 50% or more (indicating the capacity to deliver the vaccine); and populations under 150 million. Another 17 countries will become eligible if their DPT3 coverage improves.

Pneumonia and meningitis primarily affect children under five years old; the most vulnerable are those between 4 months and 18 months of age. Up to 20% of children who survive Hib meningitis are at risk of permanent neurological disability, including brain damage, hearing loss and mental retardation.

Hib vaccine (there are several types) was introduced in the early 1990s and is now a part of many industrialized and other countries' immunization programmes. The vaccine is among the safest of all vaccines and provides 95% protection for infants who are fully immunized.

Lining up for help

Hib-endemic countries eligible for vaccine aid*

Benin	Gambia	Malawi	Sudan
Burundi	Ghana	Mali	Tanzania
Comoros	Guinea-Bissau	Mozambique	Yemen
Côte d'Ivoire	Guyana	Rwanda	Zambia
Cuba	Kenya	Sao Tome/Principe	Zimbabwe
Eritrea	Lesotho	Senegal	
Ethiopia	Madagascar	Sierra Leone	

*Based on DPT3 coverage of 50% or more, per capita income under $1,000 and population under 150 million.

Source: UNICEF.

Poor countries pay for vaccines

Low-income countries – with GNPs per person ranging from $110 to $785 – are showing stronger commitment to the health of children, judging by the resources these governments are allocating for purchasing the necessary vaccines. Figures comparing 54 low-income countries indicate that 24 of them (*see list, top right*) are financing 25% or more of vaccine costs. Nine of the 24 pay 100% of the vaccine costs.

Some of these countries have benefited from the Vaccine Independence Initiative (VII) promoted and supported by UNICEF. The Initiative requires participating governments to plan and budget for vaccines. It then helps the countries procure vaccines at the best possible cost, accepts their currency for vaccine payment and offers flexible financial terms to support the process.

Even countries with very low GNP per capita are encouraged to meet between 10% and 25% of their vaccine costs. Twenty-nine low-income countries (*see list*) finance less than 25% of their vaccine costs. Six of these – Benin, Ethiopia, Madagascar, Sudan, Tanzania and Zambia – finance between 10% and 15%.

It is encouraging that although the majority of poor countries are struggling under heavy debt burdens and may be torn by conflicts and civil strife, many have shown such positive commitment to improving the health of their children.

The vaccines to protect a child against diphtheria, measles, pertussis, polio, tuberculosis and tetanus cost $1 in most developing countries when purchased through advantageous procurement systems such as UNICEF's. Other costs – including health workers' training and salaries, cold chain equipment and syringes and needles – bring the total to about $17.

Investing in health

Low-income countries financing 25% or more of routine EPI vaccines*

	% financed		% financed		% financed		% financed
Burkina Faso**	100	Nigeria	100	Togo	80	Gambia	30
Chad**	100	Pakistan	100	Viet Nam	73	Moldova, Rep.	29
Ghana	100	Senegal**	100	Nepal	53	Cameroon	27
Honduras	100	India	98	Uganda	50	Guinea	25
Mali**	100	Côte d'Ivoire**	95	Mongolia	40	Haiti	25
Nicaragua	100	Niger**	80	Turkmenistan	36	Lesotho	25

Bottom of the ladder

Low-income countries financing less than 25% of routine EPI vaccines*

	% financed		% financed		% financed		% financed
Benin	15	Kenya	3	Bosnia/Herzegovina	0	Mozambique	0
Ethiopia	15	Sierra Leone	3	Cambodia	0	Myanmar	0
Madagascar	10	Burundi	2	Congo	0	Rwanda	0
Sudan	10	Malawi	2	Eritrea	0	Somalia	0
Tanzania	10	Afghanistan	0	Guinea-Bissau	0	Tajikistan	0
Zambia	10	Angola	0	Lao PDR	0		
Armenia	7	Azerbaijan	0	Liberia	0		
Central African Rep.	4	Bhutan	0	Mauritania	0		

*The routine vaccines of the expanded programme on immunization (EPI) are diphtheria, measles, pertussis, polio, tuberculosis and tetanus. Yellow fever is part of EPI coverage in countries at risk in Africa and South America. Low-income country in this list represents GNP per capita of $785 or less.

**These countries have benefited from grants from the European Union.

Sources for both lists: Vaccine finance: UNICEF; income levels: World Bank.

Tetanus: Infants and mothers at high risk

Each year about 200,000 infants die in the first month of life from neonatal tetanus, an entirely preventable disease; 90% of these deaths occur in 27 developing countries.

India accounts for the highest number of deaths – more than 48,000 in 1999. Nigeria has the second highest toll, followed by Pakistan. Together these three countries account for more than half of the world's neonatal tetanus deaths.

Tetanus occurs in newborns as a result of unsanitary birth practices, such as when the umbilical cord is cut with an unclean blade.

In mothers, tetanus causes about 30,000 deaths annually, with an astonishing 100 million women at risk, despite the fact that it can be easily prevented through immunization.

Maternal and neonatal tetanus is a public health problem in 57 countries. It occurs where poverty, poor health care, low levels of immunization and unsanitary delivery conditions all converge.

Immunization of women of childbearing age with at least three doses of tetanus toxoid vaccine (TT) provides complete protection against both maternal and neonatal tetanus. A mother protected against tetanus will pass her immunity on to her newborn child for the first two or three months. To sustain immunity, a child must receive three doses of DPT (diphtheria/pertussis/tetanus) through routine immunization services.

As high as the neonatal tetanus toll is, it represents a marked decrease from the 800,000 newborn deaths in 1985, thanks to immunization of pregnant women and promotion of hygienic delivery practices. In 104 developing countries that have met the criteria to eliminate maternal and neonatal tetanus, rates have dropped to less than 1 neonatal tetanus case per 1,000 live births in each district of the country.

Work is now concentrated on administering three doses of tetanus toxoid to women of childbearing age in areas with no access to antenatal care or routine immunization services and on promoting clean delivery practices everywhere.

The tetanus toll

Estimated neonatal deaths*

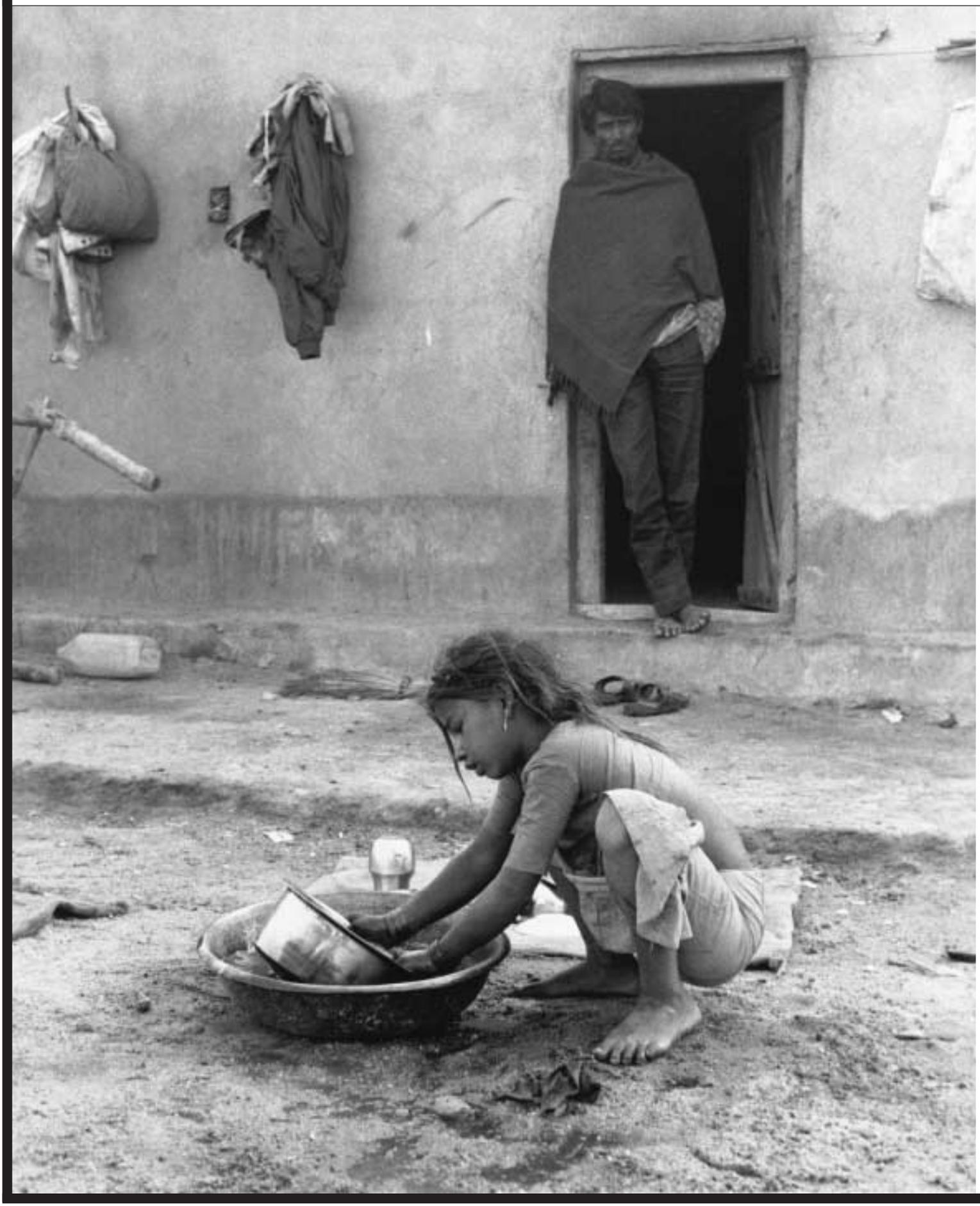
India	48,600
Nigeria	34,600
Pakistan	21,600
Ethiopia	13,400
Bangladesh	10,400
Congo, Dem. Rep.	10,000
Somalia	8,800
China	8,600
Afghanistan	4,200
Indonesia	4,100
Niger	3,600
Mozambique	3,000
Nepal	3,000
Angola	2,700
Chad	2,500
Mali	2,400
Senegal	2,300
Yemen	2,300
Sudan	2,200
Ghana	2,000
Burkina Faso	1,600
Cambodia	1,500
Cameroon	1,500
Côte d'Ivoire	1,100
Liberia	600
Mauritania	200
Guinea-Bissau	100
Total	**196,900**

*The numbers of deaths in the table are estimated, as most neonatal deaths occur at home, before the baby reaches two weeks of age, and neither the birth nor the death is reported.

Source: WHO, 1999 estimates.

THE LOST CHILDREN

COMMENTARY: REACHING THE UNREACHED



UNICEF/98-0768/Fournier

The lost children

By Juan Somavía

Barely heard and hardly seen, hundreds of millions of children endure grave and multiple violations of their rights. Among these children are the millions who labour on farms and in factories, who are trapped in commercial sexual exploitation, child soldiers, the millions not registered at birth, those lacking access to clean water and education, those not immunized and the millions living on the streets. The plight of all these children demands far more than the muted response it has so far evoked from the global community.

Breathtaking numbers of children are lost every day around the globe. Far too many – 30,500 each day, 11 million each year – die from largely preventable causes.

But as heartbreaking and senseless as those deaths are, it is not about them that I write. I am speaking of the millions upon millions of children who are lost among the living. Made virtually invisible by the deepest poverty, not registered at birth – and thus denied official acknowledgement of their name and nationality and the protection of their rights – they endure in profound obscurity.

The lost children are the most exploited, the poorest of the poor: child soldiers, girls in brothels, young bonded workers in the factories, sweatshops, fields and homes of our seemingly prosperous globe. They are robbed of their health, their growth, their education – and often even their lives.

Of the estimated 250 million children between the ages of 5 and 14 who are economically active, some 50 million to 60 million between the ages of 5 and 11 are engaged in such intolerable forms of labour.

To grasp the scale of the numbers, imagine a country as populous as the United States, in which the entire population is made up of child labourers. Then imagine further, within that population, an underclass of children more numerous than the citizens of France or the United Kingdom, working in conditions that cripple their bodies and minds, stunt their growth and shorten their lives.

No one would tolerate such an abomination if it were visible and concentrated in one place. Yet we continue to tolerate it in a hidden and dispersed form, to our collective peril and shame.

Reckless endangerment

The lives of these lost children are endangered from birth, by malnutrition, frequent disease and unhygienic environments. All are children of the poor; they number some 600 million and subsist on less than $1 a day.

They can be found in many of the overlapping populations known through numbing statistics: the more than 200 million children whose growth has been stunted, the nearly 170 million who are underweight. They are counted among the 40 per cent to 50 per cent of iron deficient children under five in developing countries. They are there amidst the 31 million refugees and internally displaced in camps around the world, and amidst the nearly 1 billion people who entered this new century unable to read and write.

The lost children may well be those from ethnic minorities who lack fluency in a national language and whose traditions are not part of a country's dominant culture. Excluded in this way, they may also be denied their rights to citizenship and education, and thus are more vulnerable to exploitation.

They are often children who are isolated geographically, living in areas with few schools and other basic services.

Their lives are circumscribed by work. Children as young as five can be found in rural areas toiling on their parents' farms or alongside adults in the fields of commercial agriculture in both industrialized and developing countries. In some cases, children under 10 years of age account for one fifth of the child labour force in rural areas.

Gruelling agricultural work, with its extremes of heat and cold, long hours, repetitive motions and lifting, strains young bodies. Exposure to chemicals and pesticides is common: In rural areas, more child workers in agriculture, for example, are estimated to die from pesticide poisoning than from all of the most common childhood diseases put together. The work is so onerous that those lucky enough to attend school after a day in the field are often too exhausted to learn.

Many of the lost children are girls. Gender discrimination combines with poverty to crush girls' sense of autonomy and self, as well as their potential. In many poor families, for instance, when choices are made about whether to send a daughter or a son to school, it is gender that tips the scale against the girl.

As a result, millions are shunted away from education onto the well-worn path of domestic work, labouring at home for their own families or outside their home

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COMMENTARY: REACHING THE UNREACHED

for others. They are among the least visible of all children exploited in this manner, because the domestic tasks performed by girls and women are often not even dignified with the label of 'work'. The obscurity and low status of their toil put girls at further risk: Many are both physically and sexually abused.

Then, in one of the most brutal extremes befalling these lost children, millions – primarily girls – are forced into the netherworld of commercial sexual trafficking and exploitation. Because of the clandestine and criminal nature of these activities, statistics are imprecise. But it is estimated that trafficking in children and women for commercial sexual purposes in Asia and the Pacific alone has victimized over 30 million people during the last three decades.

In Nepal, between 5,000 and 7,000 girls are believed to be trafficked every year across the border to neighbouring countries. The abuse these children endure has long-term, life-threatening consequences, including psychological trauma, the risk of early pregnancy and its attendant dangers, and HIV/AIDS and other sexually transmitted infections.

Education is every child's right; nothing can compare or compete with it, and when it is of good quality and relevant to children's lives, it truly can fight poverty.

Another heinous form of exploitation that children are subjected to is conscription or coercion into armed conflict. An estimated 300,000 children under the age of 18 have been reported as serving in government or opposition forces during the 1990s in myriad countries.

In Liberia, where a vicious seven-year-long civil war raged until 1997, the conflict drove 750,000 Liberians from their country, left more than 1 million internally displaced and killed more than 150,000 people. As many as 15,000 children, some as young as six, served as soldiers. Many of these boys were considered 'hard-core combatants' – youths who had been forced to commit atrocities against their own families or villages as a show of loyalty to their commanders. Another brutal side of the conflict saw thousands of girls forced into sexual slavery by the warring factions.

Actions, not words

Many gains have been made in the decade since the World Summit for Children and the adoption of the Convention on the Rights of the Child. To bring this progress to its full fruition, the world must now force itself to confront and change the miserable fates of those children who have gained the least, or nothing at all.

A crucial step is to make the time-bound eradication of the worst forms of child labour and exploitation a cause for all of us, not in words, but in action; not in speeches, but in policies and resources. It is a global cause we all share across regions, cultures, spiritual traditions and development levels. A cause to which we all want to contribute in practical terms.

During the last eight years, some 90 countries have made progress on this important front, uniting behind the International Labour Organization's (ILO) International Programme on the Elimination of Child Labour (IPEC) to form a strong alliance that has turned this issue into a global cause. From just one donor country and six participating States in 1992, IPEC now has nearly 25 donors and more than 65 participating countries. In those countries, projects are helping prevent children from becoming involved in child labour, remove them from such situations through rehabilitation and education and provide improved livelihoods for their families through decent work.

In addition, the unanimous adoption in June 1999 of a new Convention (No. 182) on the Elimination of the Worst Forms of Child Labour by the International Labour Conference of the ILO offers enormous leverage in ending the worst forms of child labour. These include such practices as child slavery, the forced recruitment of child soldiers, forced labour, trafficking, debt bondage, serfdom, prostitution, pornography and various forms of hazardous and exploitative work.

Convention 182 requires ratifying nations to take immediate

UNICEF/00-0099/Pirozzi

A boy sleeps on a pavement in South Africa. Poverty has consigned millions of children globally to a life of suffering on the streets, in bonded labour, in brothels, factories and fields.

action to protect children from abusive labour and to provide those removed from these horrors with rehabilitation and education.

A dozen countries have already ratified this new human rights instrument and many more report that they will do so in the next few months. Within IPEC, we are intent on winning rapid ratification on a country-by-country basis through a wide range of activities – from private lobbying to public rallies, from on-line information to wall posters.

But we are committed to going beyond universal ratification to ensure that the principles of this Convention are integrated within national legal structures and implemented in ways that give realistic hope of rapidly eradicating these worst forms of child labour.

UNICEF/93-1272/Murray-Lee

A girl in Nepal earns money through scavenging. Around 600 million children in developing countries are subsisting on less than $1 a day.

Education, the key

"Education," said the late Julius Nyerere, a former schoolteacher and much loved first President of the United Republic of Tanzania, "is not a way of escaping the country's poverty. It is a way of fighting it."

We know that more than 110 million children of school age in the developing world are not in school and that most of them are labouring. We also know that every year that a child attends school dramatically reduces the chance that he or she will end up in economic servitude.

Education is every child's right; nothing can compare or compete with it, and when it is of good quality and relevant to children's lives, it truly can fight poverty. Education empowers by opening new possibilities and opportunities for children to participate and contribute, to the fullest of their abilities, unhampered by their class or gender.

The Convention on the Elimination of the Worst Forms of Child Labour fully recognizes the power of education, noting that the long-term solution to child exploitation "lies in sustained economic growth leading to social progress, in particular poverty alleviation and universal education."

We can set a new standard for humanity by consigning the enslavement of children in these worst forms of child labour and exploitation to the scrap heap of history.

The link between education and poverty alleviation is especially important because the economic abyss between the rich and the poor has widened over the past decade. Now, despite unprecedented global economic expansion, more and more people are being isolated in ever deeper poverty. The assets of the world's three richest billionaires, for example, are more than the combined gross national product of all of the 48 least developed countries and their 600 million people. In contrast, the poorest one fifth of the world's population shares only 1 per cent of the world's GNP.

In the fight against child labour and the exploitation of children, education must go hand in hand with global measures to buffer poor nations through steps such as fairer trade, more aid, deeper debt relief, better investment policies and more stable commodity prices.

Global moral imperative

A strategic combination of such measures would give all of us a rare chance to end the vicious cycle of poverty and reclaim lost lives.

We know where to find the lost children. They are in the tents and barracks of Africa. In the brothels of Asia, the slums of Europe and North America, the sweatshops of Latin America. Seeing their faces, even if only for a fleeting moment, how can we allow ourselves to forget them?

Will we simply write off their lives and futures? Or will we go the final mile to protect the rights of these youngest and most vulnerable members of the human family?

We can set a new standard for humanity by consigning the enslavement of children in these worst forms of child labour and exploitation to the scrap heap of history.

Let us extend the gains now enjoyed by so many other children to this last, most isolated group. Let us be the ones who stand firm until all children lost in such dangerous obscurity emerge into a brighter future. ■

City to countryside: A long way to go in schooling

The gap between the number of children attending primary school in urban areas and those in rural areas is large and proving hard to bridge, according to surveys in 54 countries conducted between 1990 and 1999. In 34 countries (*see graph*) there is at least a 10 percentage point urban/rural gap.

The urban/rural divide is greatest in Eritrea, where 79% of children in urban areas attend school, while only 24% attend in the countryside – a 55 percentage point difference. In 24 countries the gaps are 20 percentage points or more.

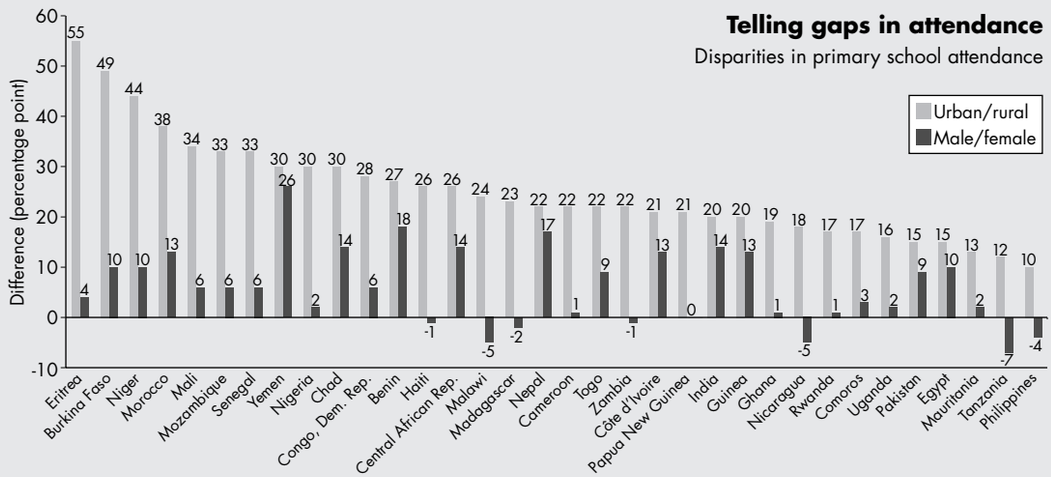
Urban and rural disparities above 30 or more percentage points were found in 10 countries. Burkina Faso, Eritrea and Niger showed disparities of 40 or more percentage points.

Girls in rural areas are at a double disadvantage. Not only are many of them not in school, as in urban areas, but they must also contend with more severe challenges such as fewer schools, longer distances from home to school and stronger cultural constraints, as well as deeper poverty and discrimination.

Research shows, however, that efforts to get and keep girls in school, regardless of whether they work, are over age for the appropriate grade level or live in rural areas, benefit boys as well – sometimes even more than girls.

To date, the most successful methods of reducing the attendance gap between city and countryside have also been those designed to increase girls' attendance.

Telling gaps in attendance
Disparities in primary school attendance



Note: The bars on the chart represent the percentage point difference between urban and rural school attendance and between male and female school attendance. Bars below zero on the chart represent greater female school attendance than male school attendance.

Sources: DHS, MICS and other national surveys, 1992-1999.

Out of school: The orphan's dilemma

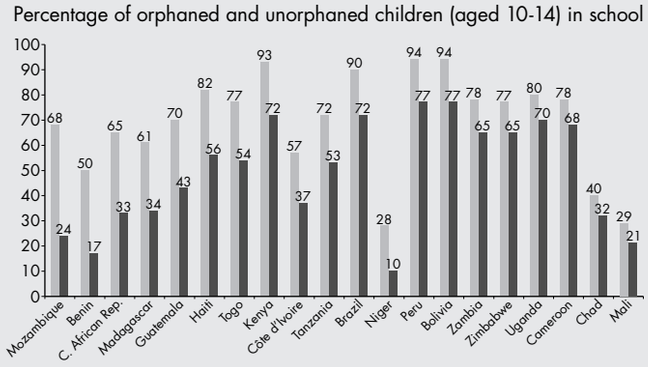
Studies in 20 countries, most of them in Africa, confirm what has long been suspected: Children whose parents have died are less likely to attend school than those who have not lost a parent and who are living with at least one parent.

Benin, the Central African Republic and Mozambique have the greatest gaps in school attendance between children who are orphaned and those who are not. In Benin, for example, only 17% of children whose parents have died attend school, compared to 50% of those with both parents still living. In most of the countries surveyed, the average difference is 19 percentage points. Only Chad and Mali have gaps of less than 10 percentage points.

Many children have both parents alive and well but are still denied their right to education. In Mali and Niger, for example, rates of school attendance for children with both parents alive are 29% and 28%, respectively – the lowest in these surveys and lower than the rates of attendance for orphaned children in many countries.

These figures challenge countries to ensure that the great loss children suffer when parents die does not compromise children's right to an education. Countries that have managed to narrow the attendance gap have valuable lessons to share.

Who is in school?
Percentage of orphaned and unorphaned children (aged 10-14) in school



Note: Countries are shown in decreasing order of disparity between children whose parent(s) are living and orphaned children.

Sources: DHS, UNICEF, 1994-1999.

UNICEF/98-0104/Pirozzi

Rwandan orphans tackle a school assignment. Orphans have less access to services such as health and education than do children with one or both parents living.

Battles won, but FGM war still rages

Thousands of residents of Kouroussa in eastern Guinea last December witnessed a dozen or so excisers turn in their knives and reject the practice of female genital mutilation (FGM). In Senegal, 148 villages have issued public declarations that they will end the procedure. These are significant victories for grass-roots organizations, NGOs and international agencies working to end the painful practice.

In Africa, efforts to eliminate FGM range from laws criminalizing the procedure to education and outreach programmes. Nine countries have banned the procedure; prosecutions have occurred in three; and three countries have proposed laws against FGM. Twenty countries conduct or support education and outreach programmes. Penalties for those convicted vary from monetary fines to lifelong incarceration.

Legislation specifically prohibiting FGM has also been passed in seven industrialized countries that have significant populations from countries where it is practised. France has relied on existing legislation banning violent acts resulting in mutilation to prosecute those who perform FGM or parents who approve the practice for their daughters. Belgium has proposed laws against the procedure, 11 industrialized countries have supported education and outreach programmes and 2 have issued statements condemning FGM.

WHO estimates that 130 million women and girls ranging in age from infants to mature adults have undergone FGM, which involves the partial or complete removal of female genitals. FGM is practised in nearly 30 African countries and among a few minority groups in Asia. In Africa, the prevalence rate ranges from around 5% in the Democratic Republic of Congo and Uganda to 98% in Djibouti and Somalia. About 75% of all cases are found in Egypt, Ethiopia, Kenya, Nigeria, Somalia and Sudan.

Though perceived as a ritual that upholds the value of chastity and improves a girl's prospects for marriage, FGM violates the human rights of girls and women because it involves the removal of healthy sexual organs without medical necessity and has detrimental – sometimes dire or even fatal – long-term physical effects and very serious psychological consequences. The procedure also breaches the human right to health and bodily integrity.

The fight continues

	African countries	Industrialized countries
Legislation/decree against FGM* (year enacted)	Burkina Faso (1996) Central African Rep. (1966) Côte d'Ivoire (1998) Djibouti (1994) Ghana (1994) Guinea (1965) Senegal (1999) Tanzania (1998) Togo (1998) Egypt (Ministerial decree, 1996) Nigeria (Edo state only, 1999)	Australia (state laws, 1994-97) Canada (1997) New Zealand (1995) Norway (1995) Sweden (1982, 1998) United Kingdom (1985) United States (federal law, 1996; state laws, 1994-98)
Prosecutions in FGM cases	Burkina Faso Egypt Ghana	France
Proposed laws against FGM	Benin Nigeria Uganda	Belgium
Education and outreach programme by or funded by government**	Benin Burkina Faso Cameroon Central African Rep. Côte d'Ivoire Djibouti Egypt Eritrea Ethiopia Gambia Ghana Guinea Kenya Mali Niger Senegal Sudan Tanzania Togo Uganda	Australia Belgium Canada Denmark France Netherlands New Zealand Norway Sweden United Kingdom United States

*Female genital mutilation.
**According to latest information available to the Center for Reproductive Law and Policy (CRLP).

Source: CRLP, March 2000.

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Oblivious to health risks, a teenager smokes in Rotherham, United Kingdom. There are more teenage smokers in industrialized countries now than in 1994, and the increase is higher among girls than boys.

More teens smoking in industrialized countries

Increasing numbers of 15-year-olds are risking their lives in Europe and North America, where the average percentage of teenagers who smoke every day increased from 12% in 1994 to 16% in 1998 in 20 countries surveyed. Smoking among girls increased in all but one country. Rates more than doubled in Estonia, Lithuania, the Russian Federation and Slovakia. Girls are now smoking at higher rates than boys in almost half of the countries surveyed. Four years ago, this was the case in only five of these countries.

The surveys show that Hungary has the highest teen smoking rates, with a steep 29% of boys and 20% of girls smoking daily. Germany and Austria were the second and third highest, with 23.5% and 23%, respectively, of all teens smoking. In Israel, the percentage of all teens smoking daily more than doubled in four years, increasing from 5.5% in 1994 to 12% in 1998. The percentage of boys alone nearly tripled, from 6% to 17%.

Finland, which reported the largest number of teens smoking daily in 1994, was the only country with an overall decrease four years later. Declining rates among boys were reported in Austria and Northern Ireland.

Who's lighting up?

% of 15-year-olds who report smoking daily

	Boys		Girls	
	1998	(1994)	1998	(1994)
Austria	20	(21)	26	(21)
Belgium	21	(19)	20	(14)
Canada	17	(16)	21	(21)
Czech Rep.	16	(11)	11	(6)
Denmark	15	(10)	21	(17)
Estonia	17	(16)	8	(3)
Finland	19	(25)	20	(19)
France	20	(18)	25	(18)
Germany	22	(16)	25	(19)
Hungary	29	(19)	20	(13)
Israel	17	(6)	7	(5)
Latvia	27	(22)	12	(8)
Lithuania	15	(9)	6	(2)
Norway	18	(16)	21	(15)
Poland	22	(17)	14	(8)
Russian Fed.	20	(13)	14	(5)
Slovakia	20	(13)	10	(3)
Sweden	10	(10)	16	(13)
United Kingdom				
N. Ireland	16	(20)	24	(20)
Scotland	19	(17)	24	(21)
United States	13	(10)	12	(10)

Source: WHO Regional Office for Europe, 'Health and Health Behaviour among Young People' surveys, 1993-1994 and 1997-1998.

Billions still lack clean water and sanitation

Despite the fact that every year nearly 2 million children die from diarrhoeal and other water-related diseases, the world remains unable to get clean water and adequate sanitation to those who most desperately need them. Some slight improvements have been made over the past decade: Globally, water supply coverage is up from 78% in 1990 to 82% in 1999. More than 800 million people gained access to clean water. And sanitation coverage is up from 54% in 1990 to 59% in 1999.

However, in absolute terms, the increases have not kept pace with the need: More than 1 billion people lack access to clean drinking water and approximately 2.5 billion people – more than one third of the world's population – have no sanitary means of excreta disposal.

In the 16 most populous developing countries – representing 80% of all the world's people – sanitation coverage remains a greater challenge than access to water. In China, the Democratic Republic of Congo, Ethiopia and India alike, less than half of the population has access to adequate sanitation facilities. Even when coverage rises, as it has in Bangladesh (from 37% in 1990 to 53% in 1999) and Pakistan (from 34% to 59% over the same period), large numbers of people remain at risk from the lack of safe excreta disposal.

Of the nearly 2 million children who die from diarrhoeal and other water-related diseases, almost all are under the age of five.

Millions also suffer from parasitic worm infections that stem from the presence of human excreta and solid wastes in the environment and cause anaemia, malnutrition and sometimes death.

Along with disease and fatalities, there are other, more subtle hardships, including the squalor of life in communities that lack clean water and adequate sanitation facilities and the time burden, which falls disproportionately on girls at the expense of their schooling and on women at the expense of their own health and child-care tasks.

Access to clean water is generally improving around the world, but some countries still lag: In the Democratic Republic of Congo, Ethiopia, Nigeria and Viet Nam, for instance, access levels are all below 60%.

And in some countries, such as Bangladesh, arsenic contamination is rendering the available water presumed to be clean and safe dangerously unsafe.

Reaching people in rural areas is still the greatest challenge. More than a quarter (29%) of the world's rural population lacks access to clean water and nearly two thirds (64%) lacks access to sanitation facilities.

Water and sanitation: Now and then

% of population covered, in the 16 largest developing countries

	Clean water sources* 1999	(1990)		Sanitation facilities** 1999	(1990)
Bangladesh	97	(91)	Thailand	96	(86)
Egypt	95	(94)	Egypt	94	(87)
Iran	95	(86)	Turkey	92	(88)
India	88	(78)	Philippines	83	(74)
Pakistan	88	(84)	Iran	81	(81)
Philippines	87	(87)	Mexico	73	(69)
Mexico	86	(83)	Viet Nam	73	(No data)
Brazil	83	(83)	Brazil	72	(63)
Turkey	82	(78)	Indonesia	65	(54)
Thailand	80	(71)	Nigeria	63	(60)
Indonesia	76	(69)	Pakistan	59	(34)
China	75	(71)	Bangladesh	53	(37)
Nigeria	57	(49)	China	38	(29)
Viet Nam	56	(No data)	India	31	(21)
Congo, Dem. Rep.	45	(No data)	Congo, Dem. Rep.	20	(No data)
Ethiopia	24	(22)	Ethiopia	15	(13)

Total population covered, world (in millions)

Clean water sources* 1999	(1990)	Change	Sanitation facilities** 1999	(1990)	Change
4,932	(4,110)	+821	3,599	(2,826)	+772

*These include house connections, public standpipes, boreholes with handpumps, protected dug wells, protected springs, rainwater collection. Tanker trucks and bottled water are not included. The data do not imply that the level of services or quality of water is adequate or safe. No discounting was made to allow for intermittance of services or quality of the water supply.

**These include connection to a sewer or septic system, pour-flush latrine, simple pit or ventilated improved pit latrine and other facilities as long as they are private or shared (but not public). Types not considered safe are bucket latrine, overhang latrine, open latrine, uncovered pit latrine or open field, 'bush' sanitation.

Source: UNICEF/WHO estimates, March 2000, for the forthcoming *Year 2000 Global Assessment of the Water Supply and Sanitation Sector,* by UNICEF/WHO/Water Supply and Sanitation Collaborative Council (expected publication date: October 2000).

And in urban areas, high population growth rates are outpacing increases in both water and sanitation coverage.

The world will not meet the 1990 World Summit goal of universal access to safe water and sanitation by the year 2000, but that task, vastly compounded by burgeoning urban populations, remains as urgent today as it was a decade ago.

UNICEF/99-0594/Pirozzi

Residents of a village in northern Iraq fetch water from a UNICEF-installed pump. More than 1 billion people still lack access to clean drinking water globally and 2.5 billion lack adequate sanitation.

Halt in overall aid decline, but no sustained increase seen

Official development assistance (ODA) ended its five-year plummet in 1998, when total aid given increased to $51.9 billion, from $48.3 billion in 1997 – a jump of 9.6% in real terms. Increased donations by 15 of the 21 industrialized countries that give ODA contributed to this turn of events, due in part to short-term support in the aftermath of the Asian financial crisis and the decisions by several countries to re-emphasize or rebuild aid programmes after cutbacks in the 1990s.

The good news of 1998 is tempered, however, by the overall downward trend of ODA since 1990. From 1990 to 1998, average total ODA as a percentage of a donor's gross national product (GNP) dropped from 0.33% to 0.24%, and aid per person dropped from $75 to $63.

In 1998, Denmark, the Netherlands, Norway and Sweden, the most consistent and generous donors, remained the only four countries to exceed the ODA target of 0.7% of a donor country's GNP, agreed upon by the world in 1970. Denmark contributed at the highest rate (0.99%), and the United States at the lowest (0.10%).

Denmark also gave the most per person at $323, with Norway and Luxembourg close behind at $299 and $265, respectively. Since 1990, Luxembourg has had the sharpest increase in ODA per person, by $194, and Finland the steepest decline, by $64.

As in 1997, the top three donor countries in dollar terms were Japan ($10.6 billion), the United States ($8.8 billion) and France ($5.7 billion). Overall, the seven most industrialized countries (the G7) gave an average of 0.20% of their GNP to ODA, less than half that given by non-G7 countries (0.45%).

Decline in donor aid flattens out

	ODA as % of donor nations' GNP		Total aid ($ billions)	Aid per person ($)	Change per person ($)
	%1998	%1990	1998	1998	since 1990
Denmark	0.99	0.94	1.7	323	83
Norway	0.91	1.17	1.3	299	29
Netherlands	0.80	0.92	3.0	194	11
Sweden	0.72	0.91	1.6	177	-36
Luxembourg	0.65	0.21	0.1	265	194
France	0.40	0.60	5.7	98	-36
Belgium	0.35	0.46	0.9	87	-13
Finland	0.32	0.65	0.4	77	-64
Switzerland	0.32	0.32	0.9	123	1
Ireland	0.30	0.16	0.2	54	37
Canada	0.29	0.44	1.7	55	-22
Japan	0.28	0.31	10.6	84	0
Australia	0.27	0.34	1.0	52	0
New Zealand	0.27	0.23	0.1	34	5
United Kingdom	0.27	0.27	3.9	66	11
Germany	0.26	0.42	5.6	68	-22
Portugal	0.24	0.25	0.3	26	7
Spain	0.24	0.20	1.4	35	11
Austria	0.22	0.25	0.5	56	-1
Italy	0.20	0.31	2.3	40	-19
United States	0.10	0.21	8.8	32	-22
Average/total	**0.24**	**0.33**	**51.9**	**63**	**-12**

Note: Amounts in 1998 dollars.

Sources: OECD, *Development Co-operation* (1995 and 1999 reports); UN Population Division, *World Population Prospects*, 1998 revision.

Rich countries: Where 47 million children are poor

One child out of six – or 47 million children – in OECD countries lives in poverty, says a new UNICEF report. (OECD countries include industrialized as well as industrializing countries that meet certain criteria; *see note below chart*.)

Mexico and the United States now top the list of OECD countries where children live in 'relative' poverty: More than one in four children in Mexico (26.2%) and more than one in five in the United States (22.4%) are poor. The report defines relative poverty as living in a household where income is less than half of the national median.

The next most severe child poverty rates are found in Italy (20.5%), the United Kingdom (19.8%) and Turkey (19.7%).

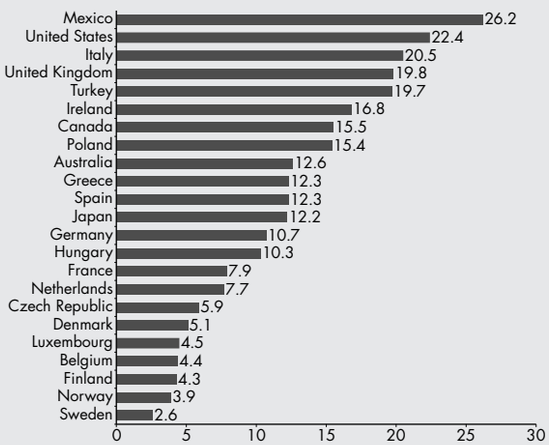
At the other end of the scale are Belgium, Denmark, Finland, Luxembourg, Norway and Sweden, where child poverty levels range from as low as 1 in 38 in Sweden (2.6%) to 1 in 20 in Denmark (5.1%). In the Nordic countries, the low levels of child poverty reflect the high levels of investment in family policies.

Besides having the lowest levels of child poverty in the industrialized world, the Nordic countries are also the most generous donors. The two donor countries with the highest levels of child poverty, Italy and the United States, contribute the least aid when considered as a percentage of GNP (*see story 'Halt in overall aid decline, but no sustained increase seen', at left*).

The high rates of child poverty in rich countries underscore the need for all nations – not just poor ones – to identify the pockets of poverty in their countries and to take measures to protect the children who are affected.

Deep pockets, persistent poverty

Percentage of children living in relative poverty in OECD-member countries



Note: All countries listed are members of OECD. Criteria for membership include an open market economy, democratic pluralism and respect for human rights.

Source: UNICEF, 'A league table of child poverty in rich nations', *Innocenti Report Card No. 1*, UNICEF Innocenti Research Centre, Florence, 2000.

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) 1998	Population under 18 (millions) 1998	Annual no. of births (thousands) 1998	Annual no. of under-5 deaths (thousands) 1998	Under-5 mortality rate 1998	GNP per capita ($) 1998	% of under-5 children underweight 1990-99	Net primary school enrolment/ attendance [a/] (%) 1990-99	Total fertility rate 1998	Maternal mortality ratio [b/] reported 1980-98
SUB-SAHARAN AFRICA										
Angola	12.1	6.5	583	170	292	380	42	–	6.7	–
Benin	5.8	3.1	238	39	165	380	29	63	5.8	500
Botswana	1.6	0.8	52	3	48	3070	17	98	4.3	330
Burkina Faso	11.3	6.1	519	86	165	240	30	34	6.5	–
Burundi	6.5	3.4	271	48	176	140	37	37	6.2	–
Cameroon	14.3	7.2	562	86	153	610	22	71 y	5.3	430
Central African Rep.	3.5	1.7	130	22	173	300	27	42	4.9	1100
Chad	7.3	3.8	318	63	198	230	39	52	6.0	830
Congo	2.8	1.5	121	13	108	680	–	–	6.0	–
Congo, Dem. Rep.	49.1	26.7	2264	469	207	110	34	59	6.4	–
Côte d'Ivoire	14.3	7.3	533	80	150	700	24	55	5.0	600
Eritrea	3.6	1.8	144	16	112	200	44	37	5.7	1000
Ethiopia	59.6	31.3	2652	459	173	100	48	36	6.3	–
Gabon	1.2	0.5	43	6	144	4170	–	83	5.4	600
Gambia	1.2	0.6	49	4	82	340	26	60	5.2	–
Ghana	19.2	9.7	711	75	105	390	27	70 y	5.1	210
Guinea	7.3	3.8	309	61	197	530	26	39	5.5	670
Guinea-Bissau	1.2	0.6	48	10	205	160	–	47 y	5.7	910
Kenya	29.0	15.0	987	115	117	350	22	85 y	4.4	590
Lesotho	2.1	1.0	72	10	136	570	16	60	4.7	–
Liberia	2.7	1.5	117	28	235	490	–	34	6.3	–
Madagascar	15.1	7.6	600	94	157	260	40	68	5.4	490
Malawi	10.3	5.6	489	104	213	210	30	83 y	6.7	620
Mali	10.7	5.7	499	118	237	250	40	40	6.5	580
Mauritania	2.5	1.3	102	19	183	410	23	63	5.5	550
Mauritius	1.1	0.4	17	0	23	3730	16	98	1.9	50
Mozambique	18.9	9.7	817	168	206	210	26	44	6.2	1100
Namibia	1.7	0.8	59	4	74	1940	26	86	4.9	230
Niger	10.1	5.5	488	137	280	200	50	27	6.8	590
Nigeria	106.4	53.8	4114	769	187	300	36	36	5.1	–
Rwanda	6.6	3.5	282	48	170	230	27	67	6.1	–
Senegal	9.0	4.6	358	43	121	520	22	60	5.5	560
Sierra Leone	4.6	2.3	211	67	316	140	29	–	6.0	–
Somalia	9.2	5.0	484	102	211	110	26	–	7.2	–
South Africa	39.4	16.4	1056	88	83	3310	9	87	3.2	–
Tanzania	32.1	16.9	1314	187	142	220	27	57	5.4	530
Togo	4.4	2.3	181	26	144	330	25	73	6.0	480
Uganda	20.6	11.7	1054	141	134	310	26	87	7.1	510
Zambia	8.8	4.8	372	75	202	330	24	85	5.5	650
Zimbabwe	11.4	5.6	353	31	89	620	15	87	3.8	400
MIDDLE EAST AND NORTH AFRICA										
Algeria	30.1	13.4	875	35	40	1550	13	94	3.8	220
Egypt	66.0	28.6	1726	119	69	1290	12	92	3.3	170
Iran	65.8	30.4	1389	46	33	1650	16	96	2.8	37
Iraq	21.8	10.6	792	99	125	**	23	90	5.2	–
Israel	6.0	2.0	117	1	6	16180	–	–	2.7	5
Jordan	6.3	3.1	218	8	36	1150	5	86	4.8	41
Kuwait	1.8	0.8	39	1	13	20190	–	87	2.9	5
Lebanon	3.2	1.2	74	3	35	3560	3	91	2.7	100
Libya	5.3	2.5	156	4	24	5540	5	96	3.8	75
Morocco	27.4	11.0	706	49	70	1240	9	70	3.0	230
Oman	2.4	1.2	83	1	18	4940	23	86	5.8	19
Saudi Arabia	20.2	9.6	680	18	26	6910	14	76	5.7	–
Sudan	28.3	13.5	932	107	115	290	34	40	4.6	550
Syria	15.3	7.7	464	15	32	1020	13	94	4.0	110

	Total population (millions) 1998	Population under 18 (millions) 1998	Annual no. of births (thousands) 1998	Annual no. of under-5 deaths (thousands) 1998	Under-5 mortality rate 1998	GNP per capita ($) 1998	% of under-5 children under-weight 1990-99	Net primary school enrolment/ attendance [a] (%) 1990-99	Total fertility rate 1998	Maternal mortality ratio [b] reported 1980-98
Tunisia	9.3	3.6	189	6	32	2060	9	96	2.5	70
Turkey	64.5	23.0	1425	60	42	3160	10	88	2.5	130
United Arab Emirates	2.4	0.8	43	0	10	17870	14	98	3.4	3
Yemen	16.9	9.2	807	98	121	280	46	58 y	7.5	350
CENTRAL ASIA										
Afghanistan	21.4	10.3	1113	286	257	250	48	24 y	6.8	–
Armenia	3.5	1.1	45	1	30	460	–	–	1.7	35
Azerbaijan	7.7	2.8	122	6	46	480	10	90	2.0	37
Georgia	5.1	1.4	69	2	23	970	–	95	1.9	70
Kazakhstan	16.3	5.6	298	13	43	1340	8	100	2.3	70
Kyrgyzstan	4.6	2.0	117	8	66	380	11	97	3.2	65
Tajikistan	6.0	2.9	190	14	74	370	–	87	4.1	65
Turkmenistan	4.3	1.9	121	9	72	640	–	80 y	3.6	110
Uzbekistan	23.6	10.6	652	38	58	950	19	88	3.4	21
EAST/SOUTH ASIA AND PACIFIC										
Australia	18.5	4.7	246	1	5	20640	–	95	1.8	–
Bangladesh	124.8	55.9	3468	368	106	350	56	81	3.1	440
Bhutan	2.0	1.0	75	9	116	470	–	53	5.5	380
Cambodia	10.7	5.1	364	59	163	260	52	78	4.6	470
China	1255.7	380.5	20134	946	47	750	16	99	1.8	65
India	982.2	395.8	24671	2590	105	440	53	71	3.1	410
Indonesia	206.3	77.8	4662	261	56	640	34	94	2.5	450
Japan	126.3	23.7	1261	5	4	32350	–	100	1.4	8
Korea, Dem.	23.3	7.4	485	15	30	*	60	–	2.0	110
Korea, Rep.	46.1	12.5	682	3	5	8600	–	97	1.7	20
Lao PDR	5.2	2.6	202	23	116	320	40	76	5.7	650
Malaysia	21.4	8.8	525	5	10	3670	19	94	3.1	39
Mongolia	2.6	1.1	58	9	82	380	10	94	2.6	150
Myanmar	44.5	16.0	943	107	113	220	39	85 y	2.4	230
Nepal	22.8	11.1	779	78	100	210	47	70	4.4	540
New Zealand	3.8	1.0	57	0	6	14600	–	100	2.0	15
Pakistan	148.2	72.0	5306	722	136	470	38	72	5.0	–
Papua New Guinea	4.6	2.1	146	16	112	890	–	32 y	4.6	370
Philippines	72.9	32.0	2064	91	44	1050	28	96	3.6	170
Singapore	3.5	0.9	50	0	5	30170	–	93	1.7	6
Sri Lanka	18.5	6.2	327	6	19	810	34	90	2.1	60
Thailand	60.3	19.3	1000	37	37	2160	19	80	1.7	44
Viet Nam	77.6	32.1	1681	71	42	350	39	95	2.6	160
AMERICAS										
Argentina	36.1	12.2	715	16	22	8030	–	95	2.6	38
Bolivia	8.0	3.7	262	22	85	1010	10	62	4.3	390
Brazil	165.9	60.2	3340	140	42	4630	6	95	2.3	160
Canada	30.6	7.2	344	2	6	19170	–	95	1.6	–
Chile	14.8	5.0	291	3	12	4990	1	88	2.4	23
Colombia	40.8	16.1	988	30	30	2470	8	79	2.8	80
Costa Rica	3.8	1.5	89	1	16	2770	5	93	2.8	29
Cuba	11.1	2.9	143	1	8	1170	9	94	1.6	27
Dominican Rep.	8.2	3.3	196	10	51	1770	6	84	2.8	230
Ecuador	12.2	5.0	309	12	39	1520	–	90	3.1	160
El Salvador	6.0	2.6	166	6	34	1850	11	78	3.1	160
Guatemala	10.8	5.5	393	20	52	1640	24	78	4.9	190
Haiti	8.0	3.9	253	33	130	410	28	66	4.3	–

STATISTICAL PROFILES

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 $100 to $45,100 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 total fertility rate ranges from 7.5 children born per woman to 1.1.

The maternal mortality rate varies from 1,100 to 0.

***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) 1998	Population under 18 (millions) 1998	Annual no. of births (thousands) 1998	Annual no. of under-5 deaths (thousands) 1998	Under-5 mortality rate 1998	GNP per capita ($) 1998	% of under-5 children underweight 1990-99	Net primary school enrolment/ attendance a/ (%) 1990-99	Total fertility rate 1998	Maternal mortality ratio b/ reported 1980-98
Honduras	6.1	3.0	203	9	44	740	18	86	4.2	220
Jamaica	2.5	1.0	54	1	11	1740	10	88	2.5	120
Mexico	95.8	38.8	2335	79	34	3840	8	97	2.7	47
Nicaragua	4.8	2.4	172	8	48	370	12	73	4.4	150
Panama	2.8	1.1	61	1	20	2990	7	94	2.6	85
Paraguay	5.2	2.5	162	5	33	1760	4	91	4.1	190
Peru	24.8	10.1	611	33	54	2440	8	100	2.9	270
Trinidad/Tobago	1.3	0.4	17	0	18	4520	–	88	1.6	–
United States	274.0	71.2	3788	30	8	29240	1	95	2.0	8
Uruguay	3.3	1.0	57	1	19	6070	5	93	2.4	21
Venezuela	23.2	9.6	572	14	25	3530	5	84	3.0	65
EUROPE										
Albania	3.1	1.1	63	2	37	810	–	100	2.5	–
Austria	8.1	1.7	82	0	5	26830	–	91	1.4	–
Belarus	10.3	2.5	98	3	27	2180	–	85	1.4	22
Belgium	10.1	2.1	106	1	6	25380	–	98	1.6	–
Bosnia/Herzegovina	3.7	0.9	37	1	19	**	–	100	1.4	10
Bulgaria	8.3	1.8	71	1	17	1220	–	98	1.2	15
Croatia	4.5	1.0	47	0	9	4620	1	95	1.6	12
Czech Rep.	10.3	2.2	88	1	6	5150	1	87	1.2	9
Denmark	5.3	1.1	63	0	5	33040	–	99	1.7	10
Estonia	1.4	0.3	12	0	22	3360	–	87	1.3	50
Finland	5.2	1.2	57	0	5	24280	–	98	1.7	6
France	58.7	13.5	713	4	5	24210	–	100	1.7	10
Germany	82.1	15.8	749	4	5	26570	–	86	1.3	8
Greece	10.6	2.1	97	1	7	11740	–	90	1.3	1
Hungary	10.1	2.2	97	1	11	4510	–	97	1.4	15
Ireland	3.7	1.0	52	0	7	18710	–	100	1.9	6
Italy	57.4	10.1	512	3	6	20090	–	100	1.2	7
Latvia	2.4	0.6	20	0	22	2420	–	93	1.3	45
Lithuania	3.7	0.9	36	1	23	2540	–	–	1.4	18
Moldova, Rep.	4.4	1.3	56	2	35	380	–	–	1.7	42
Netherlands	15.7	3.4	179	1	5	24780	–	99	1.5	7
Norway	4.4	1.0	57	0	4	34310	–	100	1.9	6
Poland	38.7	10.1	418	5	11	3910	–	97	1.5	8
Portugal	9.9	2.1	103	1	9	10670	–	100	1.4	8
Romania	22.5	5.3	202	5	24	1360	6	92	1.2	41
Russian Federation	147.4	35.6	1420	36	25	2260	3	93	1.3	50
Slovakia	5.4	1.4	56	1	10	3700	–	–	1.4	9
Slovenia	2.0	0.4	18	0	5	9780	–	95	1.3	11
Spain	39.6	7.5	360	2	6	14100	–	100	1.1	6
Sweden	8.9	1.9	86	0	4	25580	–	100	1.6	5
Switzerland	7.3	1.5	80	0	5	39980	–	96	1.5	5
TFYR Macedonia	2.0	0.6	31	1	27	1290	–	96	2.1	11
Ukraine	50.9	11.8	486	11	22	980	–	–	1.4	25
United Kingdom	58.6	13.4	689	4	6	21410	–	98	1.7	7
Yugoslavia	10.6	2.7	136	3	21	**	2	69	1.8	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/ The maternal mortality data provided in this table are those reported by national authorities. They have not been adjusted for the well-documented problems of under-reporting and misclassification.

y/ School attendance data derived from household surveys.

*GNP per capita estimated range $760 or less.

**GNP per capita estimated range $761 to $3030.

LESS POPULOUS COUNTRIES

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

	League tables†													
	Stunting 1990-97	DPT3 1998	HIV/AIDS prevalence (15-24 years) (%) 1999 Female	HIV/AIDS prevalence (15-24 years) (%) 1999 Male	Total population (thousands) 1998	Population under 18 (thousands) 1998	Annual no. of births (thousands) 1998	Annual no. of under-5 deaths (thousands) 1998	Under-5 mortality rate 1998	GNP per capita ($) 1998	% of under-5 children underweight 1990-97	Net primary school enrolment/ attendance a/ (%) 1994-99	Total fertility rate 1998	Maternal mortality ratio b/ reported 1980-98
Andorra	–	90	–	–	72	14	1	0	6	****	–	–	–	–
Antigua/Barbuda	–	100	–	–	67	24	1	0	20	8450	–	98	1.7	150
Bahamas	–	89	2.7	3.9	296	107	6	0	21	11830	–	99	2.6	–
Bahrain	12	98	<0.01	<0.01	595	212	11	0	20	7640	9	97	2.8	46
Barbados	–	93	0.8	1.2	268	71	3	0	15	7890	–	100	1.5	0
Belize	–	87	0.9	2.2	230	109	7	0	43	2660	6	88	3.6	140
Brunei Darussalam	–	97	<0.01	<0.01	315	122	6	0	9	25160	–	91	2.8	0
Cape Verde	16	80	–	–	408	193	13	1	73	1200	14	99	3.5	55
Comoros	34	75	–	–	658	332	23	2	90	370	26	60	4.8	500
Cook Islands	–	95	–	–	19	8	0	0	30	–	–	98	–	–
Cyprus	–	98	0.07	0.1	771	223	10	0	9	11920	–	96	2.0	0
Djibouti	26	23	13.9	8.8	623	298	23	4	156	**	18	33	5.3	–
Dominica	–	99	–	–	71	25	1	0	20	3150	–	89	1.9	65
Equatorial Guinea	–	81	0.6	0.3	431	213	17	3	171	1110	–	89	5.5	–
Fiji	3	86	–	–	796	317	17	0	23	2210	8	99	2.7	38
Grenada	–	97	–	–	93	33	2	0	28	3250	–	98	3.6	0
Guyana	10	90	2.3	3.9	850	313	18	1	79	780	12	87	2.3	190
Iceland	–	98	0.06	0.1	276	78	4	0	5	27830	–	98	2.1	–
Kiribati	–	88	–	–	81	37	3	0	74	1170	–	71	4.5	–
Liechtenstein	–	–	–	–	32	7	0	0	11	***	–	–	–	–
Luxembourg	–	94	–	–	422	90	5	0	5	45100	–	–	1.7	0
Maldives	27	97	–	–	271	138	9	1	87	1130	43	93	5.3	350
Malta	–	92	–	–	384	98	4	0	7	10100	–	100	1.9	–
Marshall Islands	–	86	–	–	60	27	2	0	92	1540	–	100	–	–
Micronesia (Fed. States of)	–	80	–	–	114	52	4	0	24	1800	–	–	4.0	–
Monaco	–	99	–	–	33	7	0	0	5	****	–	–	–	–
Nauru	–	50	–	–	11	–	0	0	30	–	–	98	–	–
Niue	–	100	–	–	2	1	0	–	–	–	–	100	–	–
Palau	–	74	–	–	19	9	1	0	34	***	–	–	–	–
Qatar	8	94	<0.01	<0.01	579	180	10	0	18	****	6	94	3.7	10
Saint Kitts and Nevis	–	98	–	–	39	14	1	0	37	6190	–	89	2.4	130
Saint Lucia	–	88	–	–	150	54	3	0	21	3660	–	–	2.4	30
Saint Vincent/Grenadines	–	99	–	–	112	40	2	0	23	2560	–	84	2.2	43
Samoa	–	100	–	–	174	80	4	0	27	1070	–	93	4.1	–
San Marino	–	98	–	–	26	5	0	0	6	–	–	–	–	–
Sao Tome/Principe	26	73	–	–	141	75	6	0	77	270	16	93 y	4.7	–
Seychelles	–	99	–	–	76	40	3	0	18	6420	–	100	2.1	–
Solomon Islands	–	69	–	–	417	210	14	0	26	760	–	–	4.8	550
Suriname	–	90	0.8	1.3	414	162	8	0	35	1660	–	–	2.2	110
Swaziland	–	76	28	13	952	477	36	3	90	1400	–	91	4.7	230
Tonga	–	97	–	–	98	41	2	0	23	1750	–	95	3.6	–
Tuvalu	–	94	–	–	11	5	0	0	56	–	–	100	–	–
Vanuatu	–	93	–	–	182	89	5	0	49	1260	–	90	4.3	–

† See appropriate chapter for full description.

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

**GNP per capita estimated range $761 to $3030.

***GNP per capita estimated range $3031 to $9360.

****GNP per capita estimated range $9361 or more.

Age of data

The table below gives the average age of the latest internationally available data for the 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 1999.

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

Cameroon	1.7	Mauritania	3.3	Namibia	6.0
Kenya	1.7	Eritrea	3.7	Nigeria	6.3
Niger	1.7	Congo, Dem. Rep.	4.0	South Africa	6.3
Mozambique	2.0	Gambia	4.0	Ethiopia	6.7
Togo	2.0	Uganda	4.0	Lesotho	6.7
Mauritius	2.3	Central African Rep.	4.3	Liberia	10.0
Zimbabwe	2.3	Malawi	4.3	Gabon	10.3
Chad	2.7	Rwanda	4.3	Angola	11.0
Madagascar	2.7	Botswana	5.0	Guinea-Bissau	11.0
Senegal	3.0	Côte d'Ivoire	5.0	Sierra Leone	13.0
Tanzania	3.0	Burkina Faso	5.3	Congo	14.0
Zambia	3.0	Guinea	5.3	Somalia	14.7
Benin	3.3	Burundi	5.7		
Mali	3.3	Ghana	5.7		

MIDDLE EAST and NORTH AFRICA

Iraq	2.0	U. Arab Emirates	3.7	Iran	5.0
Algeria	2.3	Oman	4.0	Sudan	5.0
Jordan	2.7	Libya	4.3	Lebanon	5.3
Yemen	2.7	Tunisia	4.3	Syria	5.3
Egypt	3.0	Turkey	4.3	Kuwait	6.7
Saudi Arabia	3.3	Morocco	4.7	Israel	10.3

CENTRAL ASIA

Azerbaijan	2.0	Uzbekistan	3.0	Tajikistan	7.0
Kyrgyzstan	2.3	Afghanistan	6.3	Turkmenistan	9.7
Kazakhstan	2.7	Georgia	6.3	Armenia	11.0

EAST/SOUTH ASIA and PACIFIC

Australia	1.5*	Indonesia	3.0	Bhutan	6.0
New Zealand	1.5*	Viet Nam	3.0	Cambodia	6.3
Malaysia	2.0	Japan	3.5*	Thailand	6.3
Mongolia	2.0	India	3.7	Korea, Rep.	6.7
Philippines	2.3	Myanmar	3.7	Singapore	6.7
Bangladesh	2.7	China	4.7	Papua New Guinea	7.3
Nepal	2.7	Lao PDR	4.7	Korea, Dem.	9.3
Sri Lanka	2.7	Pakistan	5.7		

AMERICAS

Guatemala	1.3	Brazil	3.0	Colombia	4.0
Bolivia	1.7	Peru	3.0	Jamaica	4.0
Chile	1.7	Dominican Rep.	3.3	El Salvador	4.3
Mexico	1.7	Honduras	3.3	Haiti	4.3
Nicaragua	1.7	Panama	3.3	Ecuador	5.0
Costa Rica	2.0	Canada	3.5*	Trinidad/Tobago	6.0
Cuba	2.3	United States	3.7	Paraguay	6.7
Uruguay	2.7	Venezuela	3.7	Argentina	8.3

EUROPE

Bulgaria	1.0*	United Kingdom	2.0*	Estonia	3.5*
Poland	1.0*	Belgium	2.5*	Spain	3.5*
Austria	1.5*	Denmark	2.5*	Bosnia/Herzegovina	4.0*
Portugal	1.5*	Germany	2.5*	Czech Rep.	4.3
Croatia	2.0	Italy	2.5*	Yugoslavia	4.7
Finland	2.0*	Norway	2.5*	Hungary	5.3
France	2.0*	Sweden	2.5*	Albania	6.0*
Greece	2.0*	TFYR Macedonia	2.5*	Slovakia	8.0*
Ireland	2.0*	Slovenia	3.0*	Lithuania	8.5*
Latvia	2.0*	Romania	3.3	Ukraine	8.5*
Netherlands	2.0*	Russian Fed.	3.3	Moldova, Rep.	9.0*
Switzerland	2.0*	Belarus	3.5*		

*Underweight not included.

Abbreviations

AIDS	acquired immune deficiency syndrome
ARI	acute respiratory infection
BCG	anti-tuberculosis vaccine
DAC	Development Assistance Committee (OECD)
DHS	Demographic and Health Surveys
DPT	diphtheria/pertussis/tetanus vaccine
EPI	expanded programme on immunization
FGM	female genital mutilation
GAVI	Global Alliance for Vaccines and Immunization
GNP	gross national product
Hib	*Haemophilus influenzae* type b
HIPC	heavily indebted poor countries
HIV	human immunodeficiency virus
IDD	iodine deficiency disorders
ILO	International Labour Organization
IMCI	Integrated Management of Childhood Illness (initiative)
IPEC	International Programme on the Elimination of Child Labour (ILO)
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
ORT	oral rehydration therapy
RSV	respiratory syncytial virus
TT	tetanus toxoid vaccine
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
VII	Vaccine Independence Initiative
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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