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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Commentaries represent the personal views of the authors and do not necessarily reflect UNICEF policy.

Photo credits of children on the league tables: (left to right) UNICEF/4404Z/90/Murray-Lee; UNICEF/91-821/Taylor; UNICEF/96-0187/Hartley; UNICEF/5912-92/Lemoyne; UNICEF/4087/Bregnard; UNICEF/5568-92/Hartley.

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Foreword

The Progress of Nations charts the advances made since the 1990 World Summit for Children, at which governments pledged to take specific steps to improve the lives of their children.

Each year, the report challenges—even provokes—countries to fulfil those promises, and the 1997 edition is no exception. It assesses such fundamental areas as the quality of basic education, people's access to hygienic sanitation and the effect of AIDS on child death rates. It also highlights issues that have been less visible on the development agenda, such as violence against women and girls, how justice systems handle young offenders and the protection of breastfeeding from unethical practices to market infant formula.

In detailing a broad range of both achievements made and challenges remaining, the report calls on every country not just to fulfil the pledges explicit in the goals established at the Summit, but to maintain children at the very top of their national agenda.

I am proud to commend *The Progress of Nations 1997* to you.

Kofi A. Annan
Secretary-General
United Nations

Introduction
Charting progress for children

The Progress of Nations, an annual scorecard of the social health of nations, records achievements in the form of statistics that measure fulfilment of minimum human needs. The knowledge it unearths is fundamental to solving problems, because information is the first ingredient needed by those with the will and the means to make change.

The Progress of Nations 1997 tells both good news and bad, and some news that is both. For example, mortality rates among children under 5 have declined impressively over the past 15 years—but HIV/AIDS is undermining that success in about 30 countries. A code is in place to protect breastfeeding from unethical infant formula marketing practices—but enforcement of the code is spotty. Safe water supplies have expanded dramatically in recent years—but access to sanitation is falling.

This year's edition takes a broad view, assessing not only basic social conditions but also progress and disparity in areas that are more difficult to measure. Many of these have a profound impact on children's lives. No statistic can capture the impact of violence that is directed against girls and women simply because they are female, yet that violence thwarts their development as well as that of their nations.

And as for children who come into conflict with the law, few nations keep track of how many young people are in custody, for how long and why. Though some countries in both the developing and the industrialized worlds are reforming their juvenile justice systems, too many young people still suffer harsh treatment and enjoy fewer legal protections than do adults.

UNICEF/Pirozzi

Recognition of the importance of such topics has grown as the concept of child rights has taken hold in the world community. With all but three nations having ratified the Convention on the Rights of the Child, the idea is gaining ground that bettering children's lives is not a matter of government largesse but a fundamental legal requirement.

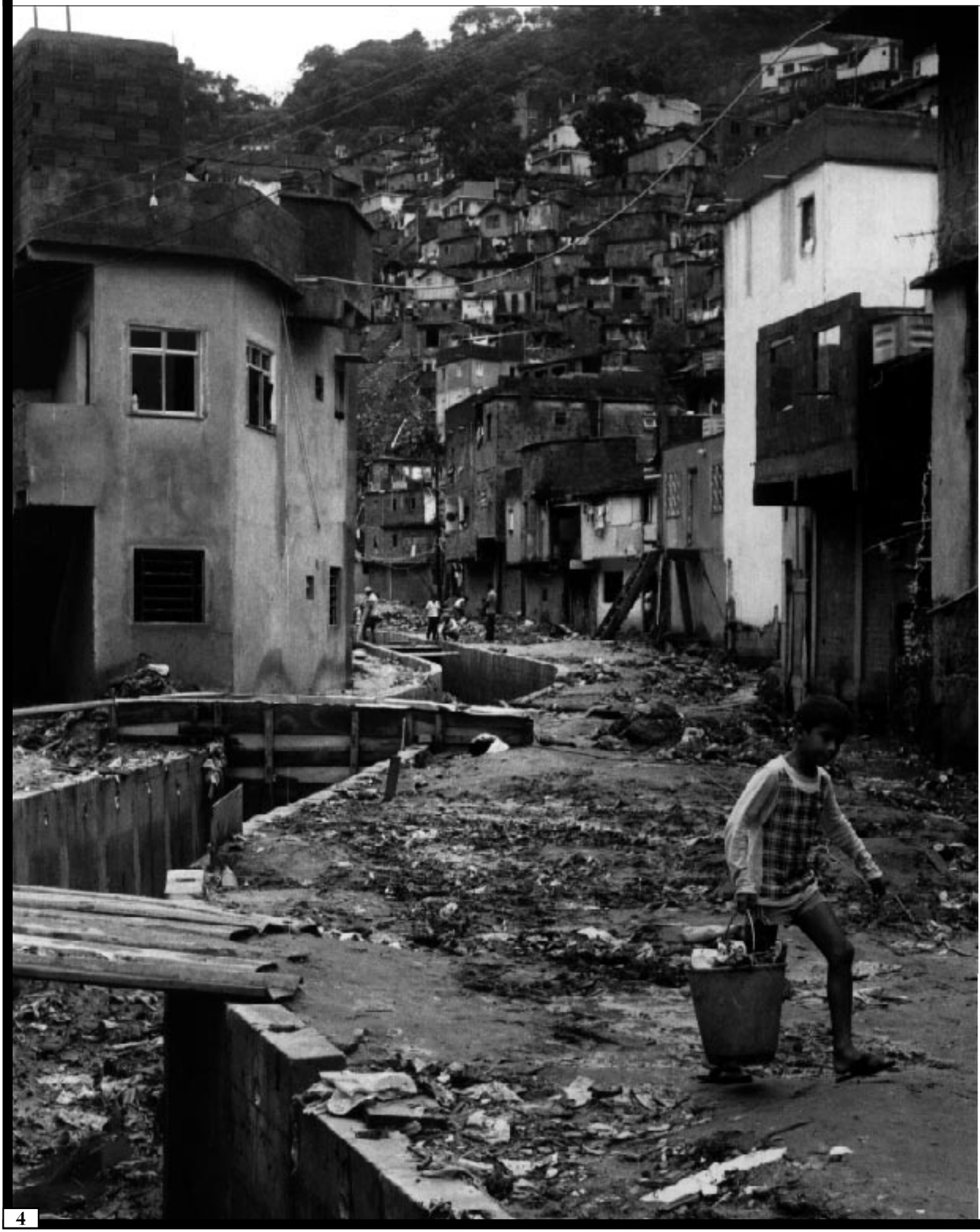
UNICEF/95-0962/Paul

Legislation upholding the rights pledged in the Convention is being enacted at all levels of government, and children throughout the world are learning to claim their rights. For some young people, implementation of the Convention will guarantee a birth certificate or a seat in the classroom. For others, including those in industrialized countries where 'over' development brings its own problems, the Convention will back efforts to improve the physical and social environment.

This year's *Progress of Nations*, the fifth, presents another indicator of development: improved statistics. When we conceived the publication, we hoped that the report in itself would inspire governments to sharpen their statistical self-knowledge. That has proved correct. *The Progress of Nations 1997* is filled with evidence of improvements in both the quality and the quantity of the data, revealing both the advances and the declines in children's well-being.

It is clear that, buoyed by knowledge, committed governments have a far better opportunity to achieve the goals agreed to at the 1990 World Summit for Children. Fulfilment of these goals will ensure that all children, especially the least advantaged, have a real chance to survive, grow up healthy and well-nourished, go to school and achieve their full potential.

Carol Bellamy
Executive Director
UNICEF



UNICEF/098-83/Hetzer

The sanitation gap: Development's deadly menace

Akhtar Hameed Khan

Adequate sanitation is the foundation of development—but a decent toilet or latrine is an unknown luxury to half the people on earth. The percentage of those with access to hygienic sanitation facilities has declined slightly over the 1990s, as construction has fallen behind population growth. The main result can be summed up in one deadly word: diarrhoea. It kills 2.2 million children a year and consumes precious funds in health care costs, preventing families and nations from climbing the ladder of development.

On the brink of the 21st century, half the world's people are enduring a medieval level of sanitation. Almost 3 billion individuals do not have access to a decent toilet, and many of them are forced to defecate on the bare ground or queue up to pay for the use of a filthy latrine. This unconscionable degradation continues despite a fundamental truth: Access to safe water and adequate sanitation is the foundation of development. For when you have a medieval level of sanitation, you have a medieval level of disease, and no country can advance without a healthy population.

In many developing countries, the plagues of old are revisiting, taking their strength from teeming urban squatter settlements and shanty towns, from streets and waterways awash in excrement and garbage. The recent cholera epidemic in Peru and outbreaks of bubonic and pneumonic plague in India are but three examples.

Plagues make headlines, but in human terms, the price of neglecting sanitation is both more prosaic and more profound. It can be summed up in one word: diarrhoea. It thrives in the absence of hygienic conditions and is tied with pneumonia as the biggest child-killer on earth, taking the lives of 2.2 million children each year. Diarrhoeal episodes leave millions more children underweight, mentally and physically stunted, easy prey for deadly diseases and so drained of energy that they are ill equipped for the primary task of childhood: learning.

How can any nation hope to advance if its people—its main resource—are so diminished from the beginning of their lives? How can leaders ignore the fact that their citizens are diminished not by an implacable enemy or an incurable disease but by something as mundane and easily preventable as diarrhoea? And how can a civilized world tolerate the status quo when it could be fixed with an investment equal to 1 per cent of yearly world military expenditures?

To deny people basic sanitation is not just inhumane—it also kicks the first step out from a country's ladder of development. History has taught that a safe means to dispose of bodily wastes is not a luxury that can wait for better economic times but a key element in creating them.

In the late 19th century, life expectancy in the industrial city of Liverpool (UK) was about 35, lower than in any developing country today. A key reason for the abbreviation of those lives was the lack of safe water and sanitation, and providing these services was a decisive turning point in reducing infant death rates. Epidemiologists studying historical records realize that there has been a tendency to underestimate the impact of water and sanitation on people's health.

Considering the state of the infrastructure in the developing world, it is no surprise that diarrhoea still holds sway in the 1990s. As population has increased, so too has the number of people lacking access to sanitation. Just since 1990, an additional 300 million individuals are making do without decent sanitation, an ominous indication that the world community is failing in its efforts to provide services where they are most needed.

Many large cities are still without central sewage systems for their millions of residents. In New Delhi, for example, less than 40 per cent of households are connected to sewers. In Ibadan (Nigeria), a city of more than 1 million people, less than 1 per

Akhtar Hameed Khan has been involved in development work for more than 40 years. Since 1980, he has been Director of the Orangi Pilot Project in Karachi (Pakistan), which has brought modern sanitation to a squatter community of 1 million people. Previously he organized farmers' cooperatives and rural training centres and served as an adviser to various development projects in Pakistan. He has been a research fellow and visiting professor at Michigan State University (US), Director of the Pakistan Academy of Rural Development and Principal of Victoria College (Bangladesh).

cent of households have sewer connections.

Though latrines are available to some city dwellers in developing countries, more than a third lack adequate sanitation. In such conditions, many of these residents, particularly the very poor, are forced to defecate in open spaces or to dispose of their waste in nearby gullies and streams. Have we become so inured to the disparity between rich and poor that we fail to notice the dreadful irony of people defecating in vacant lots in the shadows of high-tech office buildings?

Such de facto latrines become breeding grounds for bacteria, ripe to contaminate the children who play in these open spaces and the families who wash and fetch drinking water from streams near them. These sites also encourage the growth of virulent strains of typhoid, typhus and dysentery and infestation by disease-ridden carriers such as insects and vermin. The water that collects in urban detritus, such as discarded vehicle tyres, nurtures mosquitoes, which spread deadly malaria, yellow fever and dengue fever—the latter a relatively modern disease. Rats, coexisting with people in this fragile environment, thrive on the mountains of waste that accumulate around squatter settlements and are the principal carriers of bubonic and pneumonic plague.

Since 1990, an additional 300 million people are making do without decent sanitation.

UNICEF/96-0437/Hernandez-Claire

Disease carriers such as insects and vermin thrive on the mountains of waste surrounding squatter settlements. Nearby residents seek salvageable items in a garbage mound outside Guadalajara (Mexico).

Declining access

Even where sanitation facilities are available, they are often woefully inadequate. In Kampala in the 1980s, for example, as many as 40 people were using each city latrine. Given the volume of use, inevitably such public latrines are filthy, attracting swarms of disease-bearing insects and frequently overflowing, particularly during storms.

I try to take comfort from what good news there is, and the success in expanding access to safe water stands in stark contrast to the shameful failure in sanitation. By 1994, three quarters of the world's people had access to safe water, up from 61 per cent just four years earlier. This is crucial, as safe water is a key part of the sanitation equation. But during the same period, the proportion of people who had a sanitary means of excreta disposal declined from 36 to 34 per cent.

This decline should set off an alarm. It tells me that the world community is far off track and, just three years before the millennium, has no hope of achieving its goal of providing adequate sanitation to everyone on earth by the year 2000. Access rates are low partly because some countries have tightened their definitions of what constitutes adequate sanitation. While it is good news that standards are being raised, the fact that the minimum standard is now a notch higher does not excuse governments for their failure to provide such a fundamental human necessity to all their people at the end of the 20th century.

Hopes for increasing access to sanitation began to erode in the 1980s, years that many have called the 'lost decade' of development, when many poor countries found their budgets stretched thin from making payments on enormous international loans.

In Africa, for example, 22 per cent of the total value of exports in 1990 went to debt repayment. In addition, many economies underwent the shock therapy of structural adjustment programmes called for by the Bretton Woods institutions and donor nations. Public expenditures, and often basic services, were cut.

The numbers show what happened. In Nairobi, capital expenditures for water and sewerage fell by a factor of 10, from $27.78 per capita in 1981 to $2.47 in 1987, and per capita maintenance expenditures declined by two thirds. In Zimbabwe, close to one quarter of village water pumps fell into disrepair when the Government slashed maintenance funds from $12 per water site in 1988 to $5.30 in 1990. The incidence of cholera and dysentery surged in Kinshasa for several months in 1995 when funds for water chlorination ran out.

Growing cities

In terms of simple numbers, the need for sanitation is greatest in rural areas. United Nations statistics show that only 18 per cent of rural residents in developing countries have access, compared with 63 per cent in urban communities. However, the urban figures in some cases do not include squatter communities, home to 30 to 60

per cent of a city's population in many developing countries.

Whatever the numbers, though, lack of sanitation is far more worrisome in urban areas than in rural regions, mainly because of population density. Simply put, the more people in a given space, the greater the potential for contact with human waste.

And the world is on a relentless path towards increasing urbanization. Almost half the people on earth will live in urban areas by the year 2000, growing to 61 per cent by 2025. The population of my country, Pakistan, is about 70 per cent rural now, but within 30 years that will shrink to less than 45 per cent.

Public authorities are not helping to find homes for urban migrants, so they take matters into their own hands: After the rich build their homes and offices and shops, the enterprising poor improvise their own communities on what is left over—the most undesirable and marginal land, adjacent to garbage dumps, on hillsides, in gullies and ravines, on soil that is either too rocky or too sandy or lies in a flood plain.

These crowded 'informal' settlements remain largely unserved by public utilities, mostly because of governments' unwillingness to acknowledge that they even exist. It is no surprise, then, that these communities are places of poor hygiene and rampant disease. In some cases, the urban poor suffer infant death rates 1.5 to 3 times higher than people who are better off, partly due to lack of safe water and sanitation.

The price of poverty

The poor also pay a high 'tax' for their poverty, and entrepreneurs always seem to find a creative way to extort it—such as by charging exorbitant prices for use of public latrines.

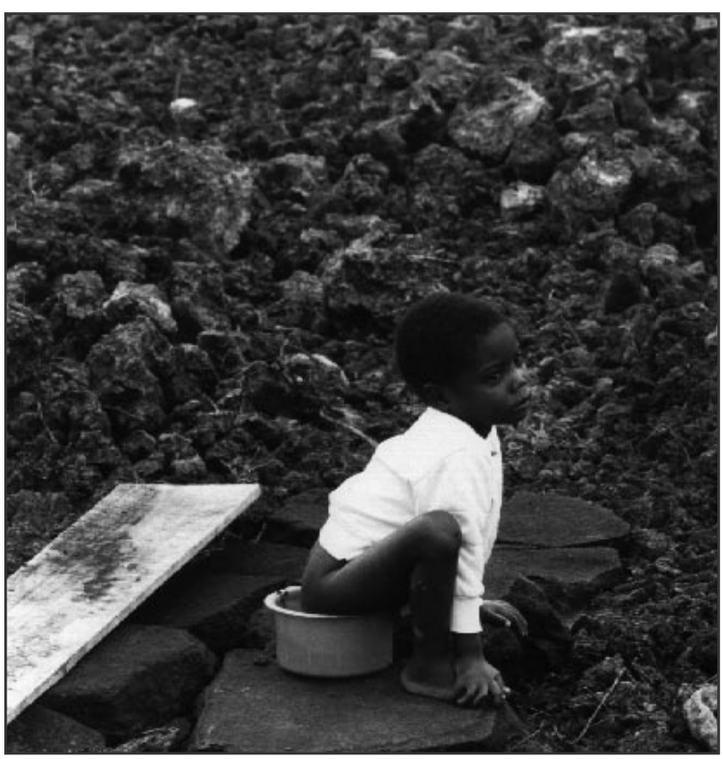
In Kumasi (Ghana), for example, where the poorest pay for each visit to the neighbourhood latrine, they spend more on sanitation services each year than do residents with toilet facilities in their homes. Residents of some impoverished communities spend 20 per cent or more of their income for small quantities of water of questionable purity, while their neighbours in wealthier, established neighbourhoods receive government-subsidized piped water.

And then there is the health 'tax'. In a study in Karachi, we found that people living in areas without sanitation or hygiene education spend 6 times more on medical bills than do people in areas with sanitation and hygiene knowledge.

These are staggering, and unnecessary, expenses. Think what it would mean for a family if that money were available to spend on other essentials: healthier food and more of it, school books and pencils, investment in business.

But such outlays do reveal a critical fact: Poor people are prepared to pay for access to safe water and hygienic sanitation. In one Brazilian city, residents were asked how much they were willing to pay for installation and maintenance of water and sewage services. The figures they cited were 4 times above the actual cost for water and more than 2 times for sewage.

Providing sanitation systems is a daunting and expensive task, but it is not impossible. It requires political will and a clear-headed understanding of the implications of failing to act. So far in this decade, governments in Africa, Asia and Latin America have invested roughly $2.1 billion a year in water and sanitation services for rural and underserved urban areas—and still they fell behind. The cost of achieving universal coverage would be an additional $4.7 billion a year (in 1994 dollars) for a decade, or a total of $6.8 billion per year.



UNICEF/94-0576/Murray-Lee

Children's health suffers in the absence of hygienic sanitation. The problem is exaggerated in refugee camps, such as this one near Goma (Democratic Republic of Congo), during the Rwanda emergency.

The figure also includes $300 million a year for hygiene education programmes, which are just as important as latrines, given that they teach people the importance of such basic activities as washing their hands after defecating. Operating and maintaining sanitation systems would add another 5-20 per cent to the bill.

Informal settlements remain largely unserved by public utilities, mainly because of governments' unwillingness to acknowledge their existence.

A bill of $68 billion over 10 years may sound high. But it is only about 1 per cent of what the world will spend on military expenditures in this decade. Given the cost to human health of failing to provide sanitation, it is hard to understand how a humane society can say no. Given the payback in terms of development, I cannot think of a more lucrative investment.

The cost would be less if governments mounted an attack on waste within existing water and sanitation systems. High costs, low efficiency and unreliability—these are the characteristics of many public utilities in developing countries. Maintenance does not make for good photo opportunities.

Water systems are notoriously leaky in developing countries, where 30 to 60 per cent of the water treated and pumped never makes it to the consumer at the end of the pipe because of leaks and illegal tapping. Such losses cost Latin Americans between $1 billion and $1.5 billion each

year—the amount needed annually to provide water and sanitation services to all the region's currently unserved citizens by the year 2000.

Most government sanitation funds subsidize services to the middle class and the rich.

Using the right technology for the job is another affordable way to provide modern sanitation—and I am not suggesting second-rate systems for the poor. Designers and engineers, wedded to traditional construction methods and often caught in a tangle of questionable bidding practices, insist on using large-width piping and installing it deep in the ground. These are costly procedures appropriate for intensively developed areas with heavy vehicular traffic. But in communities where structures are small and most traffic is on foot, narrow pipes laid just under the surface of lots, fields and footpaths usually suffice, at a small fraction of the price.

With a very small customer base, most sanitation utilities remain largely unaccountable to the community at large, and often they make little effort to go after customers who fail to pay their bills. Most government sanitation funds end up subsidizing services to the middle class and the rich in established neighbourhoods, ignoring those who can least afford it. This is unjust and, given the price it extracts from the country's development, foolish.

But I do not expect any sudden shifts in public policy. One thing I have learned during many years of working both inside and outside government is that the authorities do not act until forced by the people.

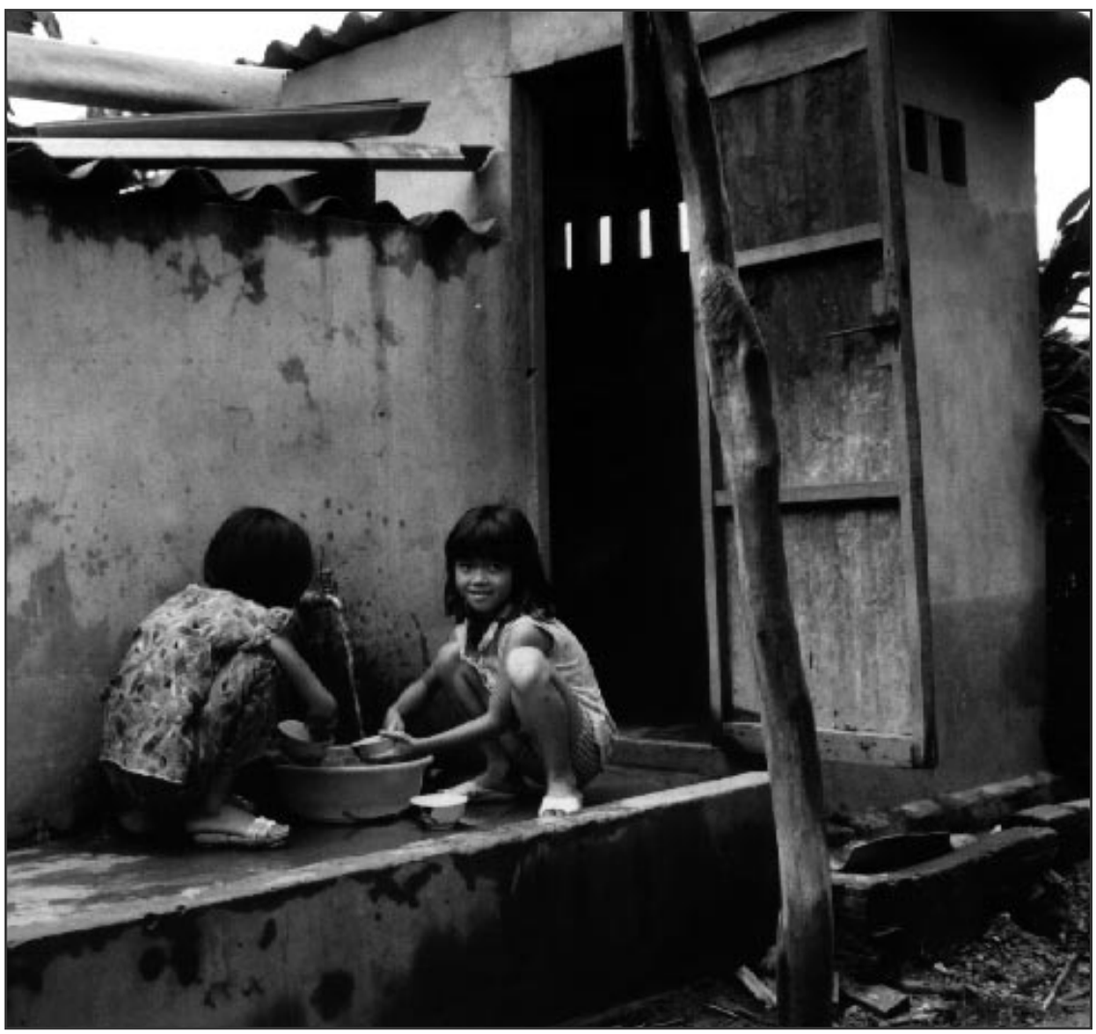
Marginalized communities are invisible to bureaucrats, who often do not view the poor as part of their constituency. Unrepresented communities must organize themselves to demand the attention they deserve. And they will organize, once they understand what is needed and how to go about it. But they will need help.

When the people lead

Experience shows how much change can be generated by a little help. In the Dharavi slum of Bombay, pavement dwellers were forced to use wretched public toilets, each of which served as many as 800 people. Working with local and international NGOs, female construction workers living in the slum were taught how to build latrines. The project had a dual benefit: They learned skills that more than doubled their income, and they got modern latrines. Construction costs were only 40 per cent of those charged by private contractors. The pavement dwellers each pay 2 to 5 rupees (less than 15 cents) per month for cleaning and maintaining the new facilities. The Bombay Municipal Corporation recently pledged to support construction of 2,000 latrine blocks, each with five latrines.

The residents of Lemba, a poor neighbourhood of Kinshasa, endured huge mounds of rotting garbage that blocked sewage canals and drew armies of rats—until they had the idea to hold a cleanliness contest. Now they cart the waste to a central dump where it is separated. Glass, plastic and paper are sold; organic waste is composted, to be sold later as fertilizer. Revenue from the operation supports community improvement efforts.

The city I know best is Karachi. Like many cities in developing countries, about 40 per cent of Karachi's population lives in squatter communities, called *katchi abadis*. These are not decaying slums in the urban centre but dynamic new neighbourhoods developed on the edge of the city over the past 25 years by enterprising migrants from rural areas. For rich people living in estab-



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A water tap, a sanitary latrine and children who understand the importance of hygiene: This home in Viet Nam has all the basics of sanitation.

lished neighbourhoods, Karachi has modern sanitation, with flush latrines in the homes and underground sewers. But most of the poor living in the *katchi abadis* had only bucket latrines and open sewers.

Virtually every home in Orangi has a toilet connected to an underground sewage line, all paid for by the residents.

In the 1970s, the municipal government made a major shift in policy: The authorities accepted the fact that the *katchi abadis* were here to stay. This was a key step, because it enabled people to buy title to their homesites, giving them a sense of permanency and the incentive to invest in improvements. The city dug water lines to the *katchi abadis*, but they still lacked sewage service. The streets were filled with excrement and other waste. People, especially children, paid with their health. This in turn meant that families were spending an enormous percentage of their income on medical bills.

In 1980, we formed an organization called Orangi Pilot Project to work with one of these communities. Orangi is home to about 1 million working-class people—skilled labourers, clerks, shopkeepers—with family incomes averaging about 1,000 rupees ($30) per month. The residents had formed numerous community associations that relentlessly pressed their demands with the authorities, but they were getting nowhere. Sanitation was their most urgent need, above health care, schools and jobs. They wanted the government to install a modern sewage system. This seemed unlikely to happen. Orangi Pilot Project set about helping them to develop it on their own.

Seventeen years later, virtually every home in Orangi has a pour-flush toilet connected to an underground sewage line, all paid for by the residents. Orangi Pilot Project provided technical advice and plans for a simplified design, which reduced the cost by almost a factor of 10, but the organization did not contribute one rupee for construction. Each family invested about a month's income to buy materials and hire labour. We avoided government contractors, who often pad costs and include kickbacks for officials.

The city has plans to build a treatment plant, but for now, as in the rest of Karachi, Orangi's sewage lines empty into creeks.

From an initial desire for better sanitation, these stalwart people have gone on to develop a whole series of services to improve their lives and futures. They have organized mothers' classes on disease prevention and hygiene—for which the women pay—as well as group discussions about family planning. Now, more than half of Orangi women plan the births of their children, compared to 7 per cent in other communities.

The children fill the rooms of over 500 private schools. Parents are willing to pay the extra fees for the private schools because they are better than the government schools. There is also a revolving loan fund for small businesses, which are thriving in every lane of Orangi. It is a community transformed. The people have been strengthened by their role in solving their most fundamental problem, and their pride is visible.

The Orangi experience reinforces an essential lesson: Adequate sanitation is fundamental to improving living standards. In its absence, diarrhoea and other illnesses prevail, leading to high death rates and forcing families to spend their scarce savings on medical care. No matter how hard they work, the poor are then left with little hope of accumulating the means to start up the ladder of development. But when this fundamental problem is solved, especially when the people play a leading role in solving it, they are strengthened, and the stage is set for advance.

The experience teaches another lesson as well. Through their massive collective effort, the people of Orangi pushed aside the roadblocks the bureaucrats had erected in their path. However, the roadblocks should not be there in the first place. It is inhumane to expect the many to endure medieval sanitation while the few enjoy modern facilities. As government policy—or lack of policy—it is economically suicidal. With enough pressure from their citizens as well as the international community, governments will learn that they cannot remain indifferent to the most fundamental of human needs. ■

UNICEF/5388/Isaac

When local residents participate in the solutions to their water and sanitation problems, bureaucratic roadblocks can be overcome and living standards improved. Young women fetch water from a handpump in their village near Peshawar (Pakistan).

SANITATION LEAGUE TABLE

ACCESS TO SANITATION

Sanitation is fundamental to development. Public health officials have long known that epidemics of communicable diseases cannot be stopped without safe water and sanitation and widespread public health measures. But the percentage of people with access to sanitation has actually fallen in the developing world since 1990, as funding has declined and population has increased.

SUB-SAHARAN AFRICA

Sanitation access: Data dilemmas

What type of facility is sanitary? What is 'convenient access'? Each country has its own definition, or more than one—often different for urban and rural areas.

The sanitation league table does not provide exact rates of access to sanitation, nor does it rank countries on this basis. Rather, the table groups countries in broad categories by percentage of people with access to sanitation according to the national definition. These definitions vary both in type of toilet facility and in its distance from the home. Because of these differences in definitions and also in data reporting methods and the quality of data, direct comparisons of countries' achievements are difficult.

Definitions may reflect countries' level of economic development, urbanization and resources available for sanitation. Rapid urbanization increases population densities and puts greater demands on sanitation facilities.

Some countries count ordinary pit latrines as adequate sanitation, while others count only ventilated improved pit (VIP) latrines and/or flush toilets connected to a septic tank or a sewerage system. In Uganda, for example, pit latrines are counted as sanitary, and the latest Demographic and Health Survey (DHS) shows 80% of households with access. But if pit latrines are not counted, the level of access shrinks to a mere 3%. Because of this discrepancy, the table uses data from Uganda's sanitation surveillance system, which reported access of 57%.

Differences behind the data must be explained to understand why, for example, Tanzania, one of the least developed countries, has a rate of access to adequate sanitation above 75%, while Brazil, far wealthier and more developed, has an access rate below 50%.

Pit latrines may be adequate for rural communities but may not be appropriate for urban areas. Therefore, more urbanized countries, such as Argentina and Brazil, record only flush toilets as adequate and report lower rates of access than poorer countries, such as Kenya and Tanzania.

Discrepancies can also arise depending on whether data are gathered by routine government reporting or by surveys—both of which were used in preparing the table. The rate of access to adequate sanitation is usually determined by dividing the number of sanitation facilities in a community by the number of inhabitants. Routine reporting may, however, rely on outdated census data or fail to take into account squatter communities or public sanitation facilities that fall into disrepair. It may also not include privately built latrines.

Household surveys, on the other hand, can provide data on actual availability of sanitation facilities—rather than simply on what facilities have been provided—and have the advantage of providing direct, timely information from the field. Surveys can therefore point to problems in data obtained from routine reporting. They are, however, much more expensive than routine government reporting, may use different definitions and are subject to sampling errors and distortions.

The WHO/UNICEF Joint Monitoring Programme was established in 1990 to help countries strengthen water and sanitation data collection and evaluation. Generally, countries' definitions have since become more restrictive and realistic, resulting in reports of lower rates of access. Just as many countries need to step up efforts to improve access to sanitation, greater standardization of definitions is needed to allow for more accurate global comparisons of progress.

	LEVEL OF ACCESS
Kenya	1
Mauritius	1
Tanzania	1
Botswana	2
Burundi	2
Cameroon	2
Central African Rep.	2
Congo	2
Ghana	2
Guinea	2
Mozambique	2
Nigeria	2
Rwanda	2
South Africa	2
Uganda	2
Zambia	2
Zimbabwe	2
Burkina Faso	3
Côte d'Ivoire	3
Gambia	3
Guinea-Bissau	3
Lesotho	3
Madagascar	3
Mali	3
Mauritania	3
Namibia	3
Senegal	3
Togo	3
Angola	4
Benin	4
Chad	4
Congo, Dem. Rep.	4
Ethiopia	4
Liberia	4
Malawi	4
Niger	4
Sierra Leone	4
Somalia	4
Eritrea	No data
Gabon	No data

MIDDLE EAST AND NORTH AFRICA

	LEVEL OF ACCESS
Algeria	1
Iran	1
Jordan	1
Libya	1
Oman	1
Saudi Arabia	1
Tunisia	1
U. Arab Emirates	1
Iraq	2
Lebanon	2
Morocco	2
Syria	2
Turkey	2
Egypt	3
Sudan	4
Yemen	4
Israel	No data
Kuwait	No data

CENTRAL ASIA

	LEVEL OF ACCESS
Kazakstan	1
Kyrgyzstan	1
Turkmenistan	1
Afghanistan	4
Armenia	No data
Azerbaijan	No data
Georgia	No data
Tajikistan	No data
Uzbekistan	No data

EAST/SOUTH ASIA AND PACIFIC

	LEVEL OF ACCESS
Australia	1
Korea, Rep.	1
Malaysia	1
Philippines	1
Singapore	1
Thailand	1
Bhutan	2
Indonesia	2
Mongolia	2
Sri Lanka	2
Bangladesh	3
India	3
Lao Rep.	3
Myanmar	3
Pakistan	3
Cambodia	4
China	4
Nepal	4
Papua New Guinea	4
Viet Nam	4
Japan	No data
Korea, Dem.	No data
New Zealand	No data

AMERICAS

	LEVEL OF ACCESS
Costa Rica	1
Dominican Rep.	1
El Salvador	1
Guatemala	1
Honduras	1
Jamaica	1
Panama	1
Trinidad/Tobago	1
Argentina	2
Bolivia	2
Colombia	2
Cuba	2
Ecuador	2
Mexico	2
Uruguay	2
Venezuela	2
Brazil	3
Nicaragua	3
Paraguay	3
Peru	3
Haiti	4
Canada	No data
Chile	No data
United States	No data

WHAT THE TABLE RANKS

Percentage of population with access to a sanitary means of excreta disposal

To deny people basic sanitation is not just inhumane–it also kicks the first step out from a country's ladder of development.

Sources: WHO, Water Supply and Sanitation Collaborative Council and UNICEF, *Water Supply and Sanitation Sector Monitoring Report: 1996*; other government reports; MICS and DHS.

WHAT THE RANKINGS MEAN

1 75-100% ACCESS

2 50-74% ACCESS

3 25-49% ACCESS

4 0-24% ACCESS

The definition of access varies by country and refers to a means of sanitation either in the dwelling or at a convenient distance. (*See* '*Sanitation access: Data dilemmas*'.)

Note: Comparable sanitation data do not exist for Europe.

UNICEF/1569/Wilkin

Basic hygiene: Learning early to wash hands in Bolivia.

UNICEF/5021/Horner

A strong commitment to sanitation is essential to reducing the incidence of diarrhoea, a leading killer of children under 5.

Water/sanitation gap widening

An estimated 2.9 billion people lack access to adequate sanitation, up from 2.6 billion in 1990. But access to safe water is improving. Today, almost 800 million more people can count on safe water supplies than could in 1990. The number with access increased from 2.5 billion to 3.3 billion.

Most governments and communities have placed a higher priority on safe water, but that in itself is not a panacea for all ills. Without a stronger commitment to sanitation, it will be difficult to reduce the incidence of diarrhoea, a leading child killer, and other diseases that flourish in unsanitary conditions. Among steps to combat disease and malnutrition, the Convention on the Rights of the Child calls on countries to ensure provision of clean drinking water and sanitation (article 24).

The table shows the percentage of people with access to safe drinking water and sanitation in the 15 developing countries with the largest under-5 populations, along with the percentage point gap between the two. In Bangladesh, China, Egypt and India, the gap is greater than 40 percentage points, with Egypt having the widest—54 percentage points. Only in Nigeria is the gap reversed, with 58% of the population having access to sanitation and 51% with access to safe drinking water.

A small gap is not necessarily a sign of success. Ethiopia, for example, has a small gap, but also the lowest combined access rate among these countries: 25% for safe water and 19% for sanitation.

Water and sanitation: Coverage disparities

Coverage gaps in developing countries with the highest under-5 population

	% access to safe water	% access to sanitation	% pt. gap
Egypt	83	29	54
India	81	29	52
Bangladesh	97	48	49
China	67	24	43
Brazil	72	44	28
Pakistan	74	47	27
Congo, D. Rep.	42	18	24
Viet Nam	43	22	21
Myanmar	60	43	17
Mexico	83	72	11
Iran	90	81	9
Philippines	86	77	9
Indonesia	61	53	8
Ethiopia	25	19	6
Nigeria	51	58	–7

Data from 1993 to 1995, except Brazil and Ethiopia (1991).

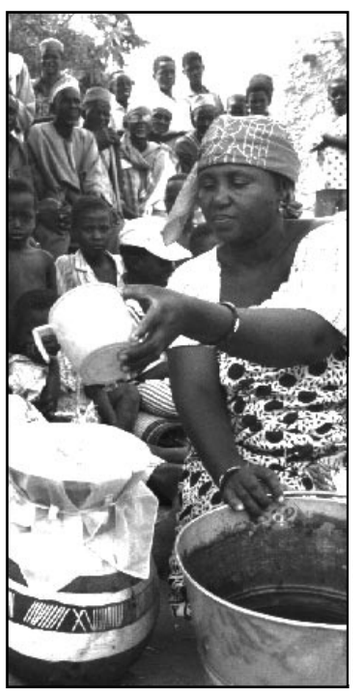
Sources: WHO, Water Supply and Sanitation Collaborative Council and UNICEF, *Water Supply and Sanitation Sector Monitoring Report: 1996;* other government reports; MICS and DHS.

78% of all guinea worm cases occurring in Sudan

Conflict in southern Sudan has cast a shadow over remarkable global progress towards the World Summit for Children goal of elimination of guinea worm disease (dracunculiasis) by the year 2000. In 1996, Sudan accounted for 78% of all guinea worm cases worldwide, up from 32% just two years before. This reflects both a decline in incidence in other countries and better reporting of cases in Sudan.

Guinea worm disease is caused by drinking water contaminated with a parasite that grows 20 to 30 inches in a patient's body, bringing debilitating pain, ulcers, fever and joint deformities. Only 10 years ago, it afflicted millions of people in Africa and Asia. But today, only 10 countries report more than 1,000 guinea worm cases, and all except Sudan have shown a decline in cases in the past three years, nearly conquering the 'fiery serpent', as the parasite is known. Pakistan, which has had no reported cases since 1994, was certified in January as having eliminated the disease, and Kenya had no reported cases in 1996. India reported nine cases but verified that the spread of the disease was contained, thereby increasing the possibility of achieving elimination in 1997.

In Sudan, armed conflict continues to hamper prevention efforts, although there is now greater access for health workers and equipment to southern Sudan where most guinea worm cases occur. Population upheaval because of the civil war could retard much of the progress in eradication. Unlike immunization, which can be accomplished during a few 'days of tranquillity' agreed to by forces in conflict, eliminating guinea worm disease takes continuous work for a year or more. Community water supplies must be improved, cloth water strainers distributed to families, and health education and surveillance programmes set up.



UNICEF/93-1965/Pirozzi

Niger: A health worker demonstrates filtering water, part of the fight to eradicate guinea worm.

War against guinea worm

Occurrence of guinea worm disease

	Guinea worm cases, 1996	% of total cases*
Sudan	114,772	78
Nigeria	10,729	7
Ghana	4,877	3
Burkina Faso	3,199	2
Niger	2,978	2
Côte d'Ivoire	2,785	2
Mali	2,249	2
Togo	1,583	1
Uganda	1,455	1
Benin	1,204	1
Mauritania	464	0
Ethiopia	372	0
Chad	117	0
Yemen	62	0
Senegal	20	0
Cameroon	13	0
India	9	0
Kenya	0	0
Pakistan	0	0

*Percentages do not add up to 100 due to rounding.

Source: US Centers for Disease Control and Prevention, *Guinea Worm Wrap Up*, issue number 64, 7 February 1997.

Grading school sanitation: Few high marks

How sanitary can conditions be when 90 young children in a school are sharing one toilet? Or when 54% of the toilets are not functioning?

Primary schools in some of the poorest countries have inadequate sanitation facilities, according to a pilot survey of 14 countries in 1995. The worst findings were in rural schools in Bangladesh, Maldives and Nepal, where more than 90 pupils on average are sharing one toilet. By comparison, rural schools in Burkina Faso, Madagascar and Togo have fewer than 50 students per toilet. In urban areas, though, these three countries are among those with the worst record, with more than 50 pupils per toilet on average. Six countries have fewer than 50 students per toilet in city schools.

UNICEF/93-2006/Pirozzi

Inadequate sanitation at schools hinders students' health and hygiene and can drive down attendance, especially for girls. These children in Benin are benefiting from a newly installed latrine at their primary school.

None of the 14 countries has increased the number of school toilets by more than 8% since 1990, suggesting that they are barely managing to keep up with the rise in student populations.

The record on toilet conditions is equally dismal. In Bangladesh, Maldives and Nepal, around half the school toilets are unusable, meaning they are either unclean (flush toilets) or in need of a new hole (latrines). Cape Verde rates best in cleanliness, with 91% of toilets being cleaned daily. In Bangladesh, 40% of schools reported that toilets are cleaned not even once a week.

The 14 countries do somewhat better in providing safe water in schools. All of them except Ethiopia and Togo provide water to at least half the primary schools. In Cape Verde all schools have safe water. Bhutan provides water to 95% of schools and Maldives to 90% of schools.

Inadequate sanitation and water in schools jeopardize not only students' health but also their attendance. Girls in particular are likely to be kept out of school if there are no sanitation facilities.

Student access to toilets

	Pupils per toilet		% toilets non-usable
	rural	urban	
Nepal	92	9	54
Bangladesh	91	9	48
Maldives	95	–	48
Madagascar	45	55	36
Benin	–	67	34
Bhutan	85	15	32
Burkina Faso	36	64	31
Tanzania	68	32	29
Cape Verde	–	90	24
Uganda	80	20	24
Togo	46	54	14
Ethiopia	77	23	12
Zambia	85	–	6
Equatorial Guinea	–	80	–

Source: A. Schleicher, M. Siniscalco and N. Postlethwaite, *The Conditions of Primary Schools: A Pilot Study in the Least Developed Countries; A Report to UNESCO and UNICEF,* September 1995.

Making ORT a household habit

Diarrhoeal dehydration is a leading child killer in developing countries, largely because of inadequate sanitation. It claimed the lives of an estimated 2.2 million children under age 5 in 1995 alone. As many as 90% of these deaths could have been prevented with ORT (oral rehydration therapy).

ORT—defined by WHO in 1993 as an increased volume of fluids, either oral rehydration salts (ORS) or other recommended home fluids, along with continued feeding—addresses the dehydration promptly, by replacing body fluids lost by diarrhoea at the first sign of the disease.

Children in the 15 developing countries listed come down with diarrhoea from 2 to 6 times each year. In 10 of these countries, more than 80% of children are given ORT; in Bangladesh, Ethiopia, Indonesia and Pakistan, virtually every child is treated with ORT.

Yet, while significant progress has been made in recent years, it is difficult to accurately measure the gains. A previous definition of ORT simply called for giving the child ORS or home fluids, without specifying the importance of the volume of fluids or of continued feeding. Since the definition was modified only in 1993, most survey data, including those in this table, are still based on the earlier definition. About three quarters of the households in developing countries now use ORT as defined before 1993, up from 38% in 1994. But only about one third of homes now use ORT following the new definition, a more effective treatment for diarrhoeal dehydration.

Progress in oral rehydration

ORS/RHF* use in countries with the most diarrhoeal episodes among under-5s per year

	Estimated annual diarrhoeal episodes (millions)	% of diarrhoeal episodes treated by ORS/RHF
China	360	85
India	310	67
Nigeria	110	86
Pakistan	90	97
Bangladesh	70	96
Brazil	50	83
Ethiopia	50	95
Congo, Dem. Rep.	50	90
Indonesia	40	99
Mexico	30	81
Philippines	30	63
Sudan**	30	35
Tanzania	30	90
Iran**	20	37
Kenya	20	76

* Oral rehydration salts/recommended home fluids.
** Excludes RHF.
Note: Estimated diarrhoeal episodes are best estimates from a variety of sources.
Sources: National household surveys including DHS and MICS reports, 1993–1996.

UNICEF/92-0058/Lemoyne

In China, 85% of diarrhoeal episodes are treated with ORT.

UNICEF/95-0133/Charton

Putting babies before business

The Right Reverend Simon Barrington-Ward

For babies everywhere, the benefits of breastfeeding are undisputed. But for babies in developing nations, breastfeeding is imperative: Their very survival depends on the immune-boosting properties of mother's milk. For them, infant formula is not just inferior; it can cause disease or even death. Poor families often over-dilute costly formula with unclean water and mix it in unclean bottles, adding to the risk. Yet, despite international pleas and a marketing code agreed to 16 years ago, manufacturers still market infant formula and other substitutes unethically around the world. It is time for them to stop.

Not all miracles stand up to scientific scrutiny, but breastmilk is one that does. It is without doubt one of the world's greatest life-savers. The most sophisticated science has taken a long time to recognize and prove what mothers and midwives always knew—breastfeeding is best for babies and there is no substitute of equal value.

Breastmilk is a 'live' and incredibly complex substance, containing all the nutrients vital for nourishment, as well as growth factors believed to help in tissue development and antibodies to fend off infections. It is always at the right temperature, requires no mixing, sterilization or equipment, and is safe regardless of the quality and availability of water. Its composition changes from feeding to feeding, and even within feedings, and the amount is triggered by the mother's hormonal response to the needs of the baby. Breastfeeding encourages bonding between mother and baby and discourages conception.

The World Health Organization and UNICEF recommend that babies be fed breastmilk only—nothing else, not even water—for about the first six months of life. Worldwide, reduction of formula feeding and improved breastfeeding practices could save an estimated 1.5 million children a year.

So why are only an estimated 44 per cent of infants in the developing world (even less in the industrialized countries) exclusively breastfed? One factor has to be the relentless promotion of breastmilk substitutes. It is no accident that breastfeeding levels are high in countries like Burundi and Rwanda, where there is little marketing.

I am now firmly persuaded that the promotion regularly practised by the infant formula companies is unethical and that it flouts the International Code of Marketing of Breast-milk Substitutes, to which they signed on. In fact, they helped draft the Code, which seeks to protect breastfeeding as "an unequalled way of providing ideal food for the healthy growth and development of infants."

The World Health Assembly adopted the Code in 1981 as a recommendation to its member States. They in turn are urged to translate it into national legislation ensuring that breastmilk substitutes are not marketed or distributed in such a way as to interfere with the protection, promotion and support of breastfeeding.

All along, the industry has insisted that it was 'self-monitoring' to ensure that its members followed the Code. The International Baby Food Action Network (IBFAN), a non-governmental organization, suspected otherwise, and it doggedly set about to collect evidence. Enough violations of the Code accumulated to justify a consumer boycott of infant formula manufacturers.

Based on IBFAN's findings and showing good-faith efforts to be fair, the groups that imposed the boycott have lifted and then reinstated it over the years. Currently, church and consumer groups, businesses and trade unions in 17 countries are active in the boycott in response to findings by IBFAN.

But rather than redressing the marketing wrongs, the infant formula manufacturers' lobby has wilfully misinterpreted the Code: Despite the word 'International' in its title, the manufacturers insist that the Code applies only to developing countries. They have also hammered away to discredit IBFAN's findings, particularly with governments and United Nations agencies.

Cracking the Code

In 1994, the Church of England called for a hiatus in the slanging match between the manufacturers and IBFAN. The Church suspended its support for the boycott while it sought unbiased, independent research into baby formula marketing practices.

To obtain that information, we joined in creating the Interagency Group on Breastfeeding Monitoring (IGBM), formed with 27 organizations including Christian Aid, OXFAM, Save the Children and the UK Committee for UNICEF. Now we have stark new evidence in the form of a report, *Cracking the Code*, which proves that 32 companies, including

The Right Reverend Simon Barrington-Ward, Bishop of Coventry, was until recently chair of the International and Development Affairs Committee of the Church of England's General Synod. He represented the Church on the Interagency Group on Breastfeeding Monitoring. Bishop Simon is a member of the House of Lords and has served as General Secretary of the Church Mission Society. This commentary was written in his personal capacity.

Gerber, Mead Johnson, Nestlé, Nutricia and Wyeth, have been routinely ignoring the Code.

Cracking the Code reports on a study undertaken between August and October 1996 in Bangladesh, Poland, South Africa and Thailand. In each country, the study involved interviews with 800 pregnant women and new mothers and 120 health workers in 40 facilities. The results showed that, among other violations of the Code, the formula companies have been distributing marketing literature promoting formula over breastmilk and giving away formula to maternity hospitals and mothers—from 1 in 12 mothers surveyed in Poland to 1 in 4 in Thailand.

Free samples, especially those handed out by health professionals, are a particularly insidious form of promotion. A mother can easily switch from breast to bottle, but from bottle to breast is another story. After being fed with free samples of formula even for just a few days, the baby, used to an artificial teat, is fussy about accepting the breast. While the baby has been drinking formula, the mother's milk production has declined.

Now the worried mother has a cranky and hungry baby on her hands, and she is convinced she must give up the breast and use formula for the duration. Rarely are such problems—and their solutions—explained to women when 'gifts' of baby formula are thrust into their hands. And when a doctor or nurse is providing the 'gift', it carries the health profession's implicit stamp of approval.

The industry has complained that the IGBM study is biased and unscientific. This is rubbish. Independent coordinators supervised the study in each country, and the many organizations that sponsored it would not have gone through this exercise without firm assurances that rigorous research protocols would be observed.

The Church of England suspended its support of the boycott as an act of good faith while the study was undertaken. The industry's criticism of the study adds up to this: The multinationals simply are not about to acknowledge their own unethical practices in countries that offer promising market potential.

It is now clear to me that the only way to end these practices is by threatening the commercial interests that drive them.

To concentrate its effectiveness, the consumer boycott has targeted one company: Nestlé. But that is not to suggest that the others are pure in their motives and actions—quite the contrary. They go about the same business, obscured in the shadows, while the light is shined on Nestlé. And if the IGBM had the resources to survey more countries, I have no doubt that we would find many more companies violating the Code.

These violations are not innocent; they are wilful. The companies have a moral obligation to abide by the Code, but instead they have treated it like something they can ignore with impunity until they are caught. They bank on the fact that developing countries do not have the resources to police the companies. *Cracking the Code* was our response to this implied challenge, and I hope it puts the manufacturers on notice that those countries have allies in the effort to put babies before business.

The body as a machine

The companies' aggressive efforts to replace something safe and naturally perfect with a manufactured commodity is a continuation of a long campaign that began during the Industrial Revolution. It has its roots in the mechanistic philosophy that viewed the human body as a machine that could be rationally managed.

The first breastmilk substitute was sold in the mid-1860s, and Henri Nestlé, a chemist working in Frankfurt, brought his product to market soon after. Mixing meal and cow's milk in "correct scientific proportion," he said in 1867, results in "a food which is all that could be desired." But he was wrong, along with any number of others who promoted supposedly 'scientific' techniques, such as bloodletting.

In the four countries surveyed, 32 companies have been routinely ignoring the Code.

The move towards infant formula became epidemic in the industrialized countries after the Second World War and is spreading in rapidly urbanizing parts of the developing world. Despite their claims, though, industry has never developed a product on a par with breastmilk. In fact, the best that science has done in this area is to prove that women's bodies know better than any manufacturer what to feed their babies, and when.

Of course, the impact of inappropriate infant feeding is immeasurably greater in developing countries. Lack of safe water for mixing the formula and contamination of feeding bottles are the main reasons why formula-fed babies die; another is that families cannot afford adequate supplies of formula, so they dilute it too much.

Compared to babies who are exclusively breastfed, those who are fed formula have 10 times the risk of incurring bacterial infections requiring hospitalization, 4 times the risk of meningitis and 3 to 4 times the risk of developing middle ear infections and gastroenteritis.

The risk, though, is not just in the developing world. In terms of lifelong chronic illness in industrialized countries, formula-fed babies have increased levels of asthma, allergies, eczema, diabetes and ulcerative colitis—and 5 to 8 times the risk of childhood lymphomas. Children who are not breastfed have lower scores on mental development tests and their vision is not as sharp. It is all noted in the scientific literature.

No one wants to impose breastfeeding on mothers. When women have the resources to afford adequate supplies of formula, safe water and fuel to sterilize bottles and synthetic nipples, formula may be an appropriate alternative for those who do not wish to breastfeed.

Formula is not the optimal choice, however, and women should be told that. Quite frankly, I question how much true 'choice' is involved when doctors, mothers and all the rest of society have been inundated with messages that disparage breastfeeding, in ways both subtle and blatant.

Some few mothers are unable to lactate, but there would be far fewer if all mothers were helped to begin breastfeeding immediately following delivery, rather than having a bottle thrust right into the baby's mouth.

The industry, along with many women's groups, says infant formula frees women who work outside the home from the tether of breastfeeding. That, they argue, is why bottle-feeding spreads in tandem with urbanization.

But is bottle-feeding really more convenient than breastfeeding? Is it easier to buy, prepare, tote, refrigerate and heat bottles of formula? The perceived inconvenience of breastfeeding should also be weighed against the later inconvenience of having to stay at home from work to care for formula-fed children, who, statistics tell us, are more sickly than breastfed children.

Employers undoubtedly need to do more to accommodate breastfeeding mothers, and they should be encouraged by

supportive government policies. Adequate, paid maternity leave, high-quality infant care at or near the workplace and facilities to express and store breastmilk would go far to encourage working mothers to begin breastfeeding and continue it after returning to work. Given its benefits for babies' health, it is in employers' interest to support the practice—to reduce absenteeism.

People in poor countries are often persuaded by advertisements that bottle-feeding is the modern thing to do. Having lived in Nigeria and travelled through much of Africa and Asia, I can report that formula manufacturers regularly use images of white doctors surrounded by black or Asian babies to promote their products as being the modern, healthy, 'first world' way to bring up a baby. It is a very potent and persuasive message, trading on images of modernization.

The true costs of formula

The price of bottle-feeding is an issue for finance ministers as well as families. From China to Zambia, when developing countries import breastmilk substitutes, they are exporting scarce foreign exchange that is desperately needed for other vital priorities. On top of that, precious health care funds are spent on illnesses wrought by artificial feeding.

If the 51 per cent of Indian mothers who exclusively breastfeed were to stop, replacing all their breastmilk with formula would cost about $2.3 billion. In Indonesia, a study in the 1980s calculated that mothers produced over 1 billion litres of breastmilk annually; equivalent supplies of commercial milk would cost $400 million. Savings in health costs and reduced fertility rates related to breastfeeding were estimated to be another $120 million. In Haiti, where just 3 per cent of infants are exclusively breastfed, infant formula costs $10 a week, or more than twice a typical income.

That is why it is so devastating when free samples end and the mother finds that her milk has diminished. For those who cannot afford adequate supplies of formula, the temptation to overdilute it is enormous.

Compare the cost of formula with the cost of feeding a mother so that she can properly breastfeed. Ideally, she needs an additional 500 calories a day above her normal diet, something easily achieved at far less than the cost of formula. In India, for example, five days' worth of that extra food costs less than 15 rupees (45 cents). By comparison, a five-day supply of formula costs about 130 rupees ($3.70). In the Philippines, Jose Fabella Hospital saved more than $100,000, an astounding 8 per cent of its annual budget, within one year of becoming a baby-friendly hospital, promoting and supporting exclusive breastfeeding of infants.

The Baby-Friendly Hospital Initiative is one approach to improving breastfeeding rates. A hospital is designated 'baby-friendly' when staff have agreed not to distribute or otherwise promote artificial baby milk and to implement specific steps to support breastfeeding.

This is an excellent initiative, but it does not protect women after they go home from the hospital, nor does it protect the many women in developing countries who give birth at home. There, messages promoting formula reach them via the media, formula company sales representatives and the commercial influence of health care workers through so-called professional education.

To rein in the multinationals, we need rigorous laws to enforce the International Code of Marketing of Breast-milk Substitutes in all countries. Such laws are crucial both to redress practices that have undermined breastfeeding and to prevent such practices in countries where commercial pressures have yet to gain a foothold. Compliance with the Code must be enforced by committed governments.

UNICEF/93-1821/Andrew

Exclusive breastfeeding for the first six months of life promotes healthy growth and a strong immune system.

Such national laws are not easily enacted. The industry grows more powerful every day, thanks to economic globalization. Yet 16 countries have managed to achieve full compliance with the Code, meaning that they have adopted appropriate laws. (*See league table.*) Of course, whether those laws are adhered to completely is another question.

Challenging laws

Not surprisingly, the industry has challenged some of these new laws in national courts. Their arguments can verge on the ludicrous: In India, Nestlé argued that it could not meet the law's requirement that a notice about the superiority of breastmilk appear in a panel at the centre of formula tins—because one cannot pinpoint the centre on a cylindrical tin!

Legal measures are only a beginning. We also need advocacy programmes to dispel the myths about breastfeeding. In the United States, social attitudes are such that mothers who breastfeed in public places frequently face harassment, sometimes even by police officers unaware that it is legal to breastfeed in public. More countries should offer the kind of explicit support provided by the Canadian province of Quebec, where women on public assistance who breastfeed receive an extra $50 per month.

Finally, the industry should ask itself why it continues its stubborn pursuit of this market, given the cost to its image. The multinationals seem to believe they can wear down the opposition, but I have yet to hear IBFAN—or anyone else who knows the facts—cry 'uncle' in this battle to save 1.5 million infant lives each year. Surely profits from synthetic baby milk cannot be so great that these multinational companies are willing to endanger their income on other products by doggedly pursuing unethical marketing strategies for formula.

Artificial baby milk should not be advertised in any way, and that must be final. Although there is a place for synthetic baby formula, that place is behind the chemist's counter. Women should have to think consciously about their decision to use formula rather than breastmilk. They are free to decide to use formula, but that choice must be informed by the truth about what bottle-feeding will cost them and their babies. ■

NUTRITION LEAGUE TABLE

PROTECTING BREASTFEEDING FROM UNETHICAL MARKETING

The first step on the road towards healthy nutrition is protecting, supporting and promoting breast-feeding. A key vehicle for that effort is the International Code of Marketing of Breast-milk Substitutes. Adopted by the World Health Assembly in 1981, it calls on all countries to regulate marketing of breastmilk substitutes to prevent breast-feeding from being undermined.

How countries enforce the Code

The International Code of Marketing of Breast-milk Substitutes aims to promote infant nutrition by protecting breastfeeding from inappropriate marketing of infant formula and other breastmilk substitutes. It is a minimum standard, enforceable through "national legislation, regulations or other suitable measures." Only countries that have adopted legally enforceable measures implementing the Code in its entirety are listed in **category 1**. Just 16 countries fall into this category—a disappointing showing considering that the Code is a minimum standard.

Countries in **category 2** have enacted only some of the Code's provisions. For example, the member States of the European Union, based on an EU Directive, have adopted legislation that is weaker than the Code. It provided that legislation only apply to infant formulas (and not to the wider category of breastmilk substitutes, bottles and teats) and that advertising be allowed in baby care and scientific publications.

Category 3 includes countries that have developed voluntary agreements with manufacturers providing no means of enforcement. In Australia this approach has proved reasonably successful. But the widespread violations reported in South Africa and Thailand (*see Commentary*) show the shakiness of such arrangements. Also in **category 3** are countries that have drafted measures or are still examining how best to implement the Code. Many are from Central and Eastern Europe and the Commonwealth of Independent States, where the distribution of breastmilk substitutes was formerly centrally controlled.

SUB-SAHARAN AFRICA

	LEVEL OF COMPLIANCE
Burkina Faso	1
Cameroon	1
Madagascar	1
Tanzania	1
Benin	2
Congo, Dem. Rep.	2
Ethiopia	2
Guinea	2
Guinea-Bissau	2
Mozambique	2
Nigeria	2
Senegal	2
Angola	3
Botswana	3
Burundi	3
Congo	3
Côte d'Ivoire	3
Eritrea	3
Gabon	3
Gambia	3
Ghana	3
Kenya	3
Lesotho	3
Malawi	3
Mali	3
Mauritania	3
Mauritius	3
Namibia	3
Niger	3
Rwanda	3
Sierra Leone	3
South Africa	3
Togo	3
Uganda	3
Zambia	3
Zimbabwe	3
Central African Rep.	4
Chad	4
Somalia	4
Liberia	No data

MIDDLE EAST AND NORTH AFRICA

	LEVEL OF COMPLIANCE
Iran	1
Lebanon	1
Algeria	2
Israel	2
Saudi Arabia	2
Tunisia	2
Turkey	2
U. Arab Emirates	2
Yemen	2
Egypt	3
Iraq	3
Jordan	3
Kuwait	3
Libya	3
Morocco	3
Oman	3
Sudan	3
Syria	3

Only 16 countries have achieved full compliance with the Code, meaning that they have adopted appropriate laws aimed at enforcing it.

CENTRAL ASIA

	LEVEL OF COMPLIANCE
Armenia	3
Georgia	3
Kazakstan	4
Afghanistan	No data
Azerbaijan	No data
Kyrgyzstan	No data
Tajikistan	No data
Turkmenistan	No data
Uzbekistan	No data

EAST/SOUTH ASIA AND PACIFIC

	LEVEL OF COMPLIANCE
India	1
Nepal	1
Philippines	1
Sri Lanka	1
Bangladesh	2
China	2
Indonesia	2
Japan	2
Lao Rep.	2
Mongolia	2
Papua New Guinea	2
Viet Nam	2
Australia	3
Bhutan	3
Cambodia	3
Korea, Rep.	3
Malaysia	3
Myanmar	3
New Zealand	3
Pakistan	3
Singapore	3
Thailand	3
Korea, Dem.	No data

AMERICAS

	LEVEL OF COMPLIANCE
Brazil	1
Costa Rica	1
Dominican Rep.	1
Guatemala	1
Panama	1
Peru	1
Canada	2
Chile	2
Colombia	2
Cuba	2
Mexico	2
Argentina	3
Bolivia	3
Ecuador	3
El Salvador	3
Haiti	3
Honduras	3
Jamaica	3
Nicaragua	3
Paraguay	3
Trinidad/Tobago	3
Uruguay	3
Venezuela	3
United States	4

EUROPE

	LEVEL OF COMPLIANCE
Austria	2
Belgium	2
Denmark	2
Finland	2
France	2
Germany	2
Greece	2
Hungary	2
Ireland	2
Italy	2
Netherlands	2
Norway	2
Portugal	2
Spain	2
United Kingdom	2
Albania	3
Belarus	3
Czech Rep.	3
Latvia	3
Lithuania	3
Poland	3
Russian Fed.	3
Slovakia	3
Sweden	3
Switzerland	3
TFYR Macedonia*	3
Croatia	4
Estonia	4
Moldova, Rep. of	4
Romania	4
Bosnia/Herzegovina	No data
Bulgaria	No data
Slovenia	No data
Ukraine	No data
Yugoslavia, Fed. Rep.	No data

WHAT THE TABLE RANKS

Level of compliance with the International Code of Marketing of Breast-milk Substitutes

WHAT THE RANKINGS MEAN

1 **FULL COMPLIANCE:** Countries that have enacted legislation or other legally enforceable measures that implement the International Code of Marketing of Breast-milk Substitutes in its entirety, as called upon by the World Health Assembly.

2 **PARTIAL COMPLIANCE:** Countries that have enacted legislation or other legally enforceable measures encompassing some of the Code's provisions. These measures therefore do not adhere to the Code as a "minimum standard" as stressed by the World Health Assembly.

3 **SOME ACTION:** Countries that have not enacted legislation or other legally enforceable measures implementing the Code but are in the process or have taken other measures. Examples include voluntary agreements with industry that regulate all or some of the marketing practices covered by the Code, drafting of measures to fully or partially implement it, or establishment of a working group to study how best to implement it.

4 **NO ACTION:** Countries that have taken no steps to implement the Code.

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

Sources: International Code Documentation Centre, forthcoming *Code Handbook*, and information from UNICEF field offices, 1994–1996.

UNICEF/87-0006/Tolmie

The 'kangaroo' technique, used in the absence of incubators, keeps premature babies, like this one in Colombia, warm and in constant contact with their mothers.

Exclusive breastfeeding: A chance for survival

The lives of almost 1.5 million infants could be saved every year if for the first six months of life they were exclusively breastfed. That means nothing but breastmilk—no solids, no other liquids, not even water.

Data from 69 developing countries, including new estimates from 40 countries since last year's report, show that half of them have exclusive breastfeeding rates below 25%, with 14 countries at 10% or less. In only 15 countries are 50% or more of the infants exclusively breastfed.

The good news is that the number of countries gathering data has more than doubled since 1993, when only 32 developing countries had data on breastfeeding.

For optimal nutrition and protection against disease, exclusive breastfeeding is recommended. After the first six months of life, to ensure their healthy development and survival, babies should be given nutritious food together with breastmilk. They also need good care and access to health services.

10% and under

Developing countries with exclusive breastfeeding rates of 10% or less

	%
Niger	1
Nigeria	2
Angola	3
Côte d'Ivoire	3
Haiti	3
Central African Rep.	4
Thailand	4
Cameroon	7
Paraguay	7
Maldives	8
Senegal	9
Dominican Rep.	10
Togo	10
Trinidad/Tobago	10

50% and over

Developing countries with exclusive breastfeeding rates of 50% or more

	%
Rwanda	90
Burundi	89
Ethiopia	74
Tanzania	73
Uganda	70
Egypt	68
Eritrea	65
China	64
Mauritania	60
Bangladesh	54
Turkmenistan	54
Bolivia	53
Iran	53
India	51
Guatemala	50

Data refer to infants under four months of age.

Sources: DHS, MICS and other nationwide surveys, 1987–1996.

One in five babies too small at birth

One in five babies born in developing countries weighs less than the standard for a healthy-sized baby: 2.5 kg (about 5.5 pounds). The four countries with the highest rates of underweight births—Bangladesh, India, Pakistan and Sri Lanka—are all in South Asia. It is also the region with the highest rates of child malnutrition, underscoring the fact that low-birthweight babies are more susceptible to disease and tend to grow up malnourished.

Low birthweight is a major factor in the global total of more than 5 million yearly neonatal deaths. In developing countries, low birthweight usually results from maternal malnutrition.

Some developing countries—including Argentina, Chile, Costa Rica, Ghana, Jordan, Kuwait, Mongolia, Paraguay, Saudi Arabia, Singapore, Turkmenistan and the United Arab Emirates—have reduced low-weight births to levels equal to or lower than those of industrialized countries.

From age 1 to 3, children born underweight face increased risk of seizures, blindness and deafness, cerebral palsy and mental retardation. Low birthweight is also linked to a small impairment in cognitive development.

Most data on underweight births come from hospital records, leaving out the many babies born at home. How this factor skews the data is uncertain. A hospital birth may indicate higher income and therefore better nutrition, or it could indicate a higher-risk birth, possibly skewing the data towards lower birthweight.

15% or more

Developing countries with 15% or more low-birthweight babies, and their rate of institutional births

	% institutional births	% low-birthweight babies
Bangladesh	5	50
India	26	33
Pakistan	13	25
Sri Lanka	94	25
Papua New Guinea	–	23
Burkina Faso	43	21
Guinea	25	21
Afghanistan	5	20
Guinea-Bissau	–	20
Malawi	55	20
Mozambique	27	20
Togo	8	20
Angola	16	19
Yemen	12	19
Lao Rep.	7	18
Madagascar	45	17
Mali	24	17
Rwanda	25	17
Viet Nam	70	17
Congo	–	16
Ethiopia	10	16
Kenya	44	16
Myanmar	–	16
Namibia	67	16
Nigeria	31	16
Somalia	2	16
Central African Rep.	50	15
Congo, Dem. Rep.	–	15
Haiti	20	15
Iraq	49	15
Nicaragua	59	15
Niger	16	15
Philippines	28	15
Sudan	18	15

Less than 10%

Developing countries with less than 10% low-birthweight babies, and their rate of institutional births

	% institutional births	% low-birthweight babies
Chile	98	5
Paraguay	55	5
Turkmenistan	90	5
Costa Rica	98	6
Mongolia	97	6
U. Arab Emirates	95	6
Argentina	90	7
Ghana	42	7
Jordan	78	7
Kuwait	97	7
Saudi Arabia	86	7
Singapore	99	7
Botswana	66	8
Malaysia	90	8
Mexico	63	8
Oman	82	8
Tunisia	86	8
Turkey	60	8
Uruguay	96	8
Algeria	76	9
China	51	9
Cuba	99	9
Honduras	45	9
Iran	65	9
Korea, Rep.	99	9
Morocco	37	9
Panama	84	9
Venezuela	97	9

Sources: WHO and updates from UNICEF field offices, 1990–1994 (low birthweight).

Stunting: A scar and a wound

Stunting (low height for age) in children under age 5 is an indicator of long-term or chronic malnutrition, reflected by inadequate growth of the long bones in a child's body. Stunting is caused by insufficient or poor quality food, poor feeding patterns, inadequate care of children and women, frequent infection and poverty. Malnutrition, mostly in mild or moderate forms, contributes to more than half of all child deaths and to diminished capacities for those who survive. Low birthweight may be a result of the mother's stunting (because of her poor nutrition) and is a significant precursor to childhood stunting.

In 35 countries (44% of the 80 countries that have data), at least one in every three children under 5 is stunted. In 10 of those countries, half or more of the children are stunted.

Stunting weakens immunity, impairs learning capacity and work performance and affects overall quality of life. For girls, it presents an additional risk: It is associated not only with low adult height but also with smaller pelvic size, increasing the risk of obstructed labour and thereby of maternal mortality.

Stunting can be either the 'scar'—reflecting an early period of growth failure—or the 'wound'—an indication of ongoing deficient growth. Height variations resulting from ethnic differences do not affect stunting data, as such variations do not tend to show up until adolescence.

Children of stunted parents tend to suffer the same fate—adults who began life stunted but whose diets later improved still tend to give birth to stunted children.

One third or more

Developing countries where 33% or more of under-5s are stunted

	%
Eritrea	66
Ethiopia	64
Bangladesh	63
Bhutan	56
Mozambique	55
Zambia	53
India	52
Guatemala	50
Madagascar	50
Pakistan	50
Lao Rep.	48
Malawi	48
Rwanda	48
Nepal	47
Tanzania	47
Viet Nam	47
Congo, Dem. Rep.	45
Myanmar	45
Botswana	44
Mauritania	44
Burundi	43
Nigeria	43
Honduras	40
Yemen	39
Cambodia	38
Uganda	38
Peru	37
Sierra Leone	35
Central African Rep.	34
Ecuador	34
Kenya	34
Sudan	34
Togo	34
Lesotho	33
Philippines	33

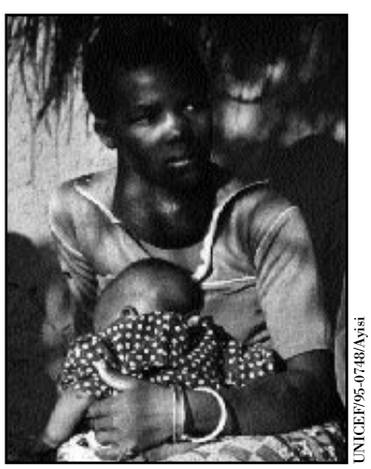
One tenth or less

Developing countries where 10% or less of under-5s are stunted

	%
Chile	3
Trinidad/Tobago	5
Jamaica	6
Venezuela	6
Costa Rica	8
Panama	9
Mauritius	10

Sources: DHS, MICS and other nationwide surveys, 1987–1996.

Slow starters catching up in salt iodization



UNICEF/95-0748/Ayisi

Mozambique – now iodizing 62 per cent of its salt to combat iodine deficiency disorders, including goitre and mental retardation.

Three years ago, 48 developing countries were reported in *The Progress of Nations* as having no active salt iodization programmes. Today, most of them have begun to iodize their salt or import iodized salt. Progress in 14 of them has been dramatic, with salt iodization levels crossing the 50% mark. Topping the chart are Tunisia (98%), Lebanon (92%) and Zambia (90%). Ten of the countries with no data are either known to be producing iodized salt, have enacted legislation to do so or have installed the iodizing equipment.

It was estimated that up until 1990, about 40 million infants—one third of all babies born each year in the world—were at some risk of mental impairment due to iodine deficiency in their mothers' diets. This year, because of the worldwide increase in the use of iodized salt, 12 million children are expected to be spared that risk. And the number of babies born cretins (suffering from severe and irreversible mental and physical damage) is expected to have dropped by more than half, from around 120,000 in 1990 to under 55,000 worldwide.

Progress in salt iodization*

	% salt iodized
Tunisia	98
Lebanon	92
Zambia	90
Indonesia	85
Iran	82
Burundi	80
Jordan	75
Sierra Leone	75
Uganda	69
Paraguay	64
Mozambique	62
Viet Nam	59
Malawi	58
Iraq	50
Cuba	45
Mongolia	42
Philippines	40
South Africa	40
Benin	35
Chad	31
Central African Rep.	28
Burkina Faso	22
Yemen	21
Mali	20
Turkey	18
Myanmar	14
Congo, Dem. Rep.	12
Angola	10
Ghana	10
Haiti	10
Senegal	9
Niger	7
Korea, Dem.	5
Togo	1
Afghanistan	–
Cambodia**	–
Congo**	–
Côte d'Ivoire**	–
Egypt**	–
Guinea**	–
Guinea-Bissau**	–
Lesotho	–
Liberia	–
Malaysia**	–
Morocco**	–
Papua New Guinea**	–
Somalia	–
Sudan**	–

*Progress among the 48 developing countries that had no salt iodization programmes in 1994.

**Some salt is iodized and efforts to increase availability of iodized salt are under way.

Sources: UNICEF field offices, DHS, MICS, 1993–1996.

UNICEF/93-1223/Cindy Andrew

Fighting AIDS together

Peter Piot

The world's children are benefiting from several decades of unprecedented health progress. Child-killing diseases are succumbing to vaccination campaigns and low-cost remedies, reducing death rates and improving the quality of young lives. But in about 30 developing countries, HIV/AIDS is threatening and even reversing these strides. Meanwhile, in the industrialized countries, AIDS is starting to be called a 'manageable' disease, as costly miracle drugs seemingly pull its victims back from the brink of death. Now the fight against AIDS faces new dangers: complacency in the industrialized countries and divisiveness between them and the developing nations.

In the early days of my involvement in the global effort against AIDS, I visited the women's medical unit of the giant Mama Yemo Hospital in Kinshasa. There, women in their late teens and early twenties, many of whom had supported themselves as sex workers, were wasting away from AIDS-related infections. As I passed bed after bed of young women resigned to death, I realized that similar scenes were playing out in clinics all over sub-Saharan Africa. I wondered how we could ever hope to gain any ground against AIDS in developing countries with primitive medical tools and scattershot, underfunded prevention programmes. And I wondered what the explosion of AIDS cases would do to all the hard-won gains in child survival and development.

That was 14 years ago, and the world community has since woken up to the crisis and begun to mount a credible response. But I still hold onto that mental image from Mama Yemo Hospital and I still hold many of the same concerns: Despite expenditures of about $18 billion a year (as of 1993), despite emerging miracle drugs, despite the talk of AIDS as a 'manageable' disease, not enough has changed in those countries that are home to 90 per cent of the epidemic, and there are growing indications of division between those countries and the wealthier ones where people with AIDS are far fewer and resources far greater.

Every day, 1,000 children around the world die from AIDS. In 1996 alone, the disease took the lives of 1.5 million people. About 90 per cent of the 23 million people currently infected with HIV live in developing countries. Experts estimate that 30 million to 40 million people will be HIV-positive by the year 2000, about the same number as the entire population of Argentina or Spain.

In about 30 countries, mostly in sub-Saharan Africa, AIDS is stalling and even reversing the best efforts to improve the health of children and adults, women and men, the poor and the rich. And only 8 per cent (approximately $1.5 billion) of the $18 billion a year is being spent on prevention, care and research in the developing countries.

Even more ominous is the fact that the majority of newly infected adults are under 25 years old, with all too obvious implications for the future. Women, mostly in their childbearing years, now account for nearly half of new infections.

And the worst may be yet to come. According to some forecasts, rates of infection will not peak until the year 2010 in 19 of the hardest-hit countries, most of which are in sub-Saharan Africa. While the deaths attributable to AIDS represent a small percentage of total deaths, they are enough to reverse some improvements in life expectancy. Fifteen sub-Saharan African countries may experience a decline of up to 11 years of life expectancy by the year 2000 compared to projections of deaths without AIDS.

Still to face the brunt of the epidemic is Asia, home to over half the world's population. Despite the fact that AIDS has only recently begun to take hold in the region, the number of new infections each day is already comparable to the number in sub-Saharan Africa. Unless major advances are made in preventing and treating the disease, projections are grim for high-population countries like India, where clinic data show that HIV is beginning to work its way into the middle class.

And it is not just those who become infected who suffer. AIDS is a disease with strong ripple effects, primarily because it strikes so relentlessly at people in the prime of life. When a mother becomes debilitated by AIDS-related illness, often the first thing to happen is that her children's care suffers. Those children may miss vaccinations, eat

Dr. Peter Piot, Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS), has been working on the international fight against HIV/AIDS for 14 years. Before UNAIDS was formed in 1996, he was responsible for AIDS research and development activities at WHO. Formerly, at the Institute of Tropical Medicine in Antwerp (Belgium), Dr. Piot established a group devoted to research, training and technical cooperation on the disease and on reproductive health. He was among the first to document a number of important aspects of the epidemic in developing countries and co-launched Projet SIDA in Kinshasa (Democratic Republic of Congo), the first international HIV/AIDS project in the developing world. He was also a co-discoverer of the Ebola virus in 1976.

fewer and less nutritious meals, suffer more bouts of illness. Then a child (or more than one) is likely to be pulled out of school to work in the market, cultivate the family plot or care for the baby.

When the mother dies, she may follow several other extended family members to the grave, so the likelihood of an aunt or uncle being able to take in her newly orphaned children is slim. In regions that formerly were noted for the unbreakable links of extended family networks, we now have the shocking reality of households headed by aged grandparents or children—12-year-olds responsible for providing food and shelter for a family of even younger siblings.

The AIDS 'tilt'

With this devastation so overwhelmingly affecting the developing world, the effort to fight AIDS is tilted just as overwhelmingly in the other direction, to the industrialized world. The most obvious example of this tilt is the new combination therapies, widely available in industrialized countries. The cost of these drugs—up to $15,000 a year per patient—is inconceivable to most people in the hard-hit nations. For the lucky few who could afford them, these therapies can be found only in middle-income countries like Brazil and Thailand; they are virtually unavailable in Africa.

But other examples of the tilt abound. Of the $2.6 billion spent on HIV prevention efforts worldwide each year, only 14 per cent is spent in developing countries. These countries account for an even smaller proportion—6 per cent—of the $11.6 billion spent for care. Research on development of a vaccine, especially crucial in the hard-hit countries, gets less than 5 per cent of the $4.2 billion spent annually on HIV/AIDS research worldwide, according to most recent estimates.

The historical lack of funding for vaccine development is scandalous and irrational, given what is at stake. However, there is encouraging news from the AIDS Research Evaluation Task Force of the US National Institutes of Health (NIH).

AIDS is a development challenge, intermingling issues of poverty, inequality, culture and sexuality in complex ways.

The Task Force, overseen and prodded by distinguished independent scientists, has called for a revitalization of the vaccine quest. NIH is now considerably increasing its vaccine efforts. In addition, a consortium of organizations has founded the International AIDS Vaccine Initiative to stimulate vaccine research. In particular, the initiative will support research targeted at HIV subtypes found in areas of the world where the disease is spreading most rapidly. Governments must also develop incentives to encourage serious investment on the part of drug companies in reaching this goal.

Funding aside, the concentration of research in the industrialized world has other worrying implications. For instance, research on preventing mother-to-child transmission of HIV and on treating HIV-related conditions in children has been very limited, undoubtedly because these are largely problems of the developing world. Developing countries also need to be supported in building their own capacity to make AIDS medications available to their citizens who need them. It is imperative that the resources, the knowledge and the effort in fighting AIDS be spread more evenly around the globe.

At the same time, more must be done to bring comfort to the lives of people sick from HIV-related illnesses. Painkillers, antidiarrhoeals, medicines to treat fungal infections—even these basic medicines are not affordable to people in the poorest countries.

Achievements at risk

Hanging in the balance are achievements made by the world community over several decades in reducing infant mortality and improving child health and nutrition. Mortality rates for those under age 5 have been cut in half over the past 30 years. About 8 of every 10 children worldwide are now immunized against six major childhood diseases: measles, polio, diphtheria, pertussis, tetanus and tuberculosis. Polio is on the verge of eradication, and measles and neonatal tetanus are on the same path. Deaths of children from diarrhoea—which, along with pneumonia, is the number one killer of children in poor countries—are also in retreat because of cost-effective treatments like oral rehydration therapy (ORT).

UNICEF/HQ92-1229/Sprague

Not only those who are infected with HIV suffer from the disease. As a mother sickens, care for her children often suffers. Her daughter clinging to her, a young mother speaks with an AIDS counsellor in a poor neighbourhood of São Paulo (Brazil).

Since 1985, 2.5 million young lives have been saved each year through low-cost health programmes.

Numbers are faceless, though, and I am fortunate to have spent enough time in developing countries to have seen the faces behind the numbers. In 20 years of working in these countries, I have watched the achievements evolve and met the people whose lives have been changed as a result. Today when I travel to Latin America, I see old people crippled by polio, but not children, because polio has been eliminated from the western hemisphere. When I travel to countries like Bangladesh and Kenya, I see packets of oral rehydration salts for sale in corner kiosks, and I know that many fewer children are dying from diarrhoea. In Africa, in Asia, in many places that I travel, I see volunteers going door to door to make sure that every child turns up for the next vaccination day, or to support new mothers in breastfeeding, or to explain how to use ORT.

These achievements are real, and the groundwork is in place for them to continue. But whenever we start to celebrate them, they are quickly overshadowed by the bad news about AIDS. The explanation for its relentless sweep through communities and countries is rooted in its fundamental nature. AIDS has succeeded so far in defeating efforts to stop it because it is not just another disease. Rather, it is fundamentally a development challenge, intermingling issues of poverty, inequality, culture and sexuality in complex ways.

Worldwide, HIV infection most often results from heterosexual intercourse. Beyond that biological reality, some people are especially vulnerable to HIV infection because of their social, cultural or economic situation. One such cause of vulnerability is the social inequality between women and men. Women, especially young women, have little power to dictate the terms of sexual relationships and are therefore much more vulnerable to infection. The 'sugar daddy' phenomenon is not new, but in the age of AIDS, older men are pursuing ever younger women and girls in the belief that they are less likely to be infected. Thus, a key to stopping the epidemic is action that enhances the ability of women and young people to control their lives, including their sexual relationships.

UNICEF/97-0074/Horner

The impact of AIDS crosses generations. As parents succumb to the illness, other relatives must fill crucial child-care roles. This grandmother in Thailand is raising her grandchildren, whose parents died of AIDS.

Dangers of division

As real strides are made in the industrialized countries, people are beginning to talk about AIDS as a 'manageable' disease. A magazine article in the US last December even wondered if we are in 'the twilight of AIDS'. This sort of talk brings the potential of dangerous complacency and of even greater division between the 'have' and the 'have-not' nations.

That is a profound mistake on two counts. On an ethical plane, it is immoral to describe as 'manageable' a disease that is only 'manageable' for a fraction of the wealthiest 10 per cent of its victims. On a practical plane, it would be foolhardy for one simple reason: Like all infectious diseases, AIDS will not be defeated anywhere until it is defeated everywhere—miracle drugs or no.

This is why it is so important that we avoid the temptation to view AIDS as two different diseases, one that is manageable in the wealthier countries and one that is a death sentence in the poorer countries. We are all in this boat together, and if we slip into an 'us vs. them' view of the world, we are sunk.

As former Zambian President Kenneth Kaunda said in a recent speech invoking the memory of his son, dead from AIDS in 1986, "Every one of us ignores AIDS in the house of their neighbour at their own peril." If we can stick together, if governments and NGOs and committed individuals in every community in every country are willing to learn from the painfully earned wisdom of their neighbours around the world, we can slow down and even reverse this epidemic. We do not have to watch these grim numbers continue their march across the world map.

To stop that march, we need accessible, affordable ways to prevent transmission between sexual partners and from mothers to children. This includes access to affordable and high-quality condoms, and increasingly to the recently developed condom for women. In 1994, US trials of a new drug, zidovudine (ZDV), to help HIV-positive mothers give birth to healthy babies had striking results: a two-thirds decrease in HIV transmission. But it is beyond the reach of poor women. UNAIDS, the US Centers for Disease Control and Prevention, and other organizations are now collaborating with researchers in Africa and Asia to find economical ways to make ZDV available where it is most needed. Other low-cost drugs to prevent mother-to-baby transmission during pregnancy and childbirth are under development and look promising.

One of the problems facing families and health workers in developing countries is the potential for HIV infection through breastfeeding. While the factors determining transmission of the virus from mother to baby are not yet fully understood, studies suggest that breastfeeding confers a 1-in-7 risk of infecting the baby with HIV.

The lack of funding for an AIDS vaccine is scandalous and irrational.

An HIV-positive mother now faces a quandary. If she is affluent, she probably lives in a setting that makes the use of breastmilk substitutes a reasonable option. In all likelihood, she has easy access to safe water (or fuel to boil the water) for mixing the formula and cleaning the cups or bottles. She can afford as much formula as her baby needs. Attentive health services are available to treat the additional infant illnesses that may accompany use of breastmilk substitutes. Although in a perfect world breastfeeding is always the

best option, for a well-to-do woman infected with HIV, using formula might be a good choice.

But mothers at the bottom of the economic ladder face a cruel dilemma: They can either breastfeed, with the risk of passing along HIV, or they can use breastmilk substitutes, with the risk of exposing their babies to potentially lethal diseases and to malnutrition from formula that is overdiluted.

If we know that some babies are becoming infected through breastmilk, we have a moral obligation to do everything we can to prevent those infections. First, we must make sure that every woman has access to affordable, confidential HIV testing. If she takes the test and it turns out positive, she must be supported in making the agonizing infant-feeding decision. She needs to be informed in a respectful way about the relative risks so that she can make a choice based on accurate facts.

Where safe water is accessible close by, and where breastmilk substitutes are available at reasonable cost, an HIV-infected mother might choose to feed formula to her child. However, she herself is powerless to ensure a reliable water supply or quality health services, nor can she influence the price of formula. These are matters of public health, and that is the responsibility of governments.

When leaders lead

A few heroic leaders understand AIDS for the profound development challenge it is, and they have approached it with an unprecedented call to action. When that becomes part of the national consciousness, the worst effects of the epidemic can be avoided.

Ugandan President Yoweri Museveni, for example, rarely delivers a speech in which he does not mention AIDS, and the trickling down of that rhetoric is at least partly responsible for the levelling off of infection rates in urban areas of Uganda. Some surveys in antenatal clinics there have found that between 1990-1993 and 1994-1995, HIV prevalence among women aged 15-24 declined by 35 per cent.

In South Africa, President Nelson Mandela has called for a national struggle to vanquish AIDS on a scale similar to that mobilized to bring down apartheid. Zimbabwe responded to high HIV prevalence rates with a mandatory weekly lesson in life skills for all students aged 9 to 19. The course, begun in 1993, addresses HIV/AIDS in the context of coping with emotions and expectations, gender roles and plans for the future, and students role-play to develop strategies for responding to peer pressure.

Similar bright spots of leadership are occurring in Asia. Only a few years ago, Thailand was viewed by complacent neighbours as the only country in the region likely to have a significant problem with AIDS. The virus had gained a foothold in 1988, and the availability of commercial sex in the country of 59 million people allowed it to flourish. As a result, about 45,000 Thais died from HIV infection in 1995.

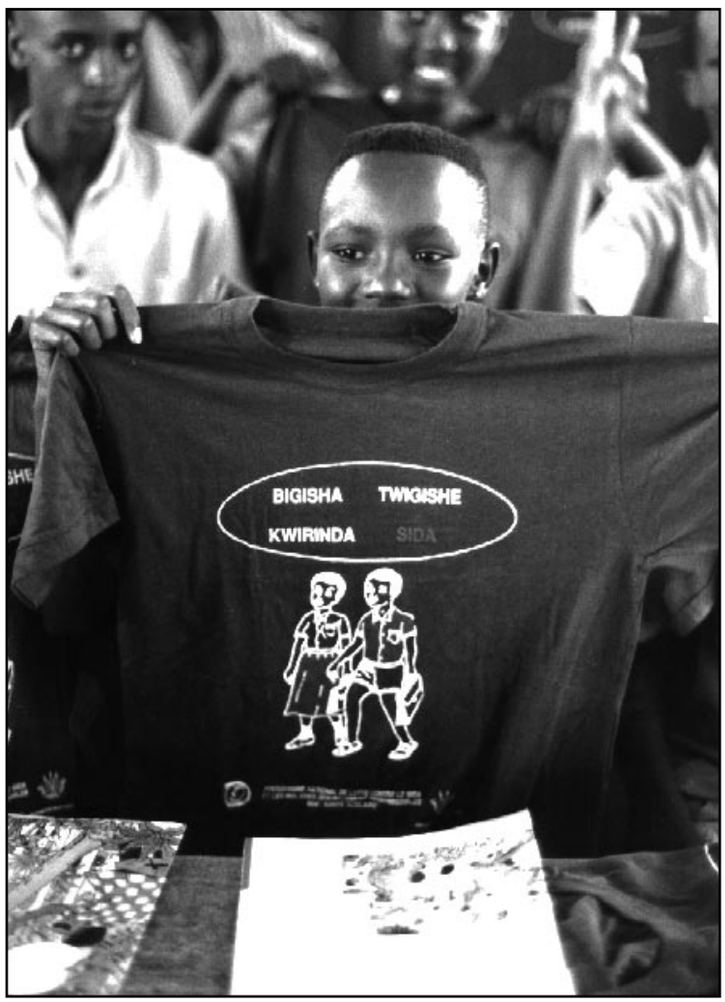
But Anand Panyarachun, who was Prime Minister in 1991 and 1992, instituted a far-reaching AIDS education programme that has put Thailand in much better shape than some of its neighbours. Mr. Anand required every government minister to include a budget line for AIDS. The centrepiece of a public education programme was a series of explicit AIDS prevention messages aired on radio stations at least once every hour. Condoms were widely distributed to brothels. Sex businesses that refused to require condom use were shut down. Calls for abstinence from casual sex were partnered with the condom campaign, promoted tirelessly by the Prime Minister's dynamic AIDS adviser, Mechai Viravaidya.

As a result, there was an 80 per cent decrease in sexually transmitted diseases in Thailand from 1989 to 1994. The number of new HIV infections in Thailand each year has more than halved since 1990. Success stories like these should be the most powerful argument against complacency.

These successes demonstrate that if we focus our efforts on those most vulnerable, if we expand use of the communication tools that work and commit ourselves to developing a vaccine and affordable drugs, we can stop this plague. We already proved we can muster global will and resources with the campaign that raised vaccination rates worldwide from 40 per cent to 80 per cent in just five years.

The worst that can happen for our prospects of wiping this virus from the earth is to allow complacency and divisiveness between the haves and have-nots to prevent us from developing responses that work in the countries where they are most needed. We can defeat HIV/AIDS—if we all acknowledge our ownership of it.

President Mandela said it best: "As the freedom of each nation is interdependent with that of others, so too is the health and well-being of their peoples. Nowhere is this more true than in the case of AIDS. The challenge of AIDS can be overcome if we work together as a global community." ■



UNICEF/95-0521/Davies

Educating people about how AIDS is transmitted is essential in combating the disease. A girl participating in an AIDS awareness workshop in Bujumbura (Burundi) holds a T-shirt that says, "We are taught and we teach AIDS awareness" in the Kirundi language.

Gauging AIDS' terrible toll

How many infants will die of AIDS in the year 2010? Anywhere between 83,000 and 357,000 in just 19 of the high-risk countries. The more conservative estimates come from the UN Population Division, which believes that, with 75,000 infants (under 1 year of age) dying of AIDS in 1995, the pandemic essentially levelled off. But the estimates by the United States Bureau of the Census are more pessimistic: AIDS took 105,000 infant lives in 1995 in the 19 countries, and the toll will surge to more than 3 times that number in 2010— more than 10 times the number of infant deaths from all causes in Europe (except Eastern Europe).

The main reason for the difference between the two estimates is their assumptions as to the timing of the peak of the epidemic in these countries: The Census Bureau believes that the peak will come in 2010, while the UN believes it peaked in 1995. In the 19 countries, the Census Bureau attributes 26% of infant mortality to AIDS in 2010, whereas the UN estimate is 8%.

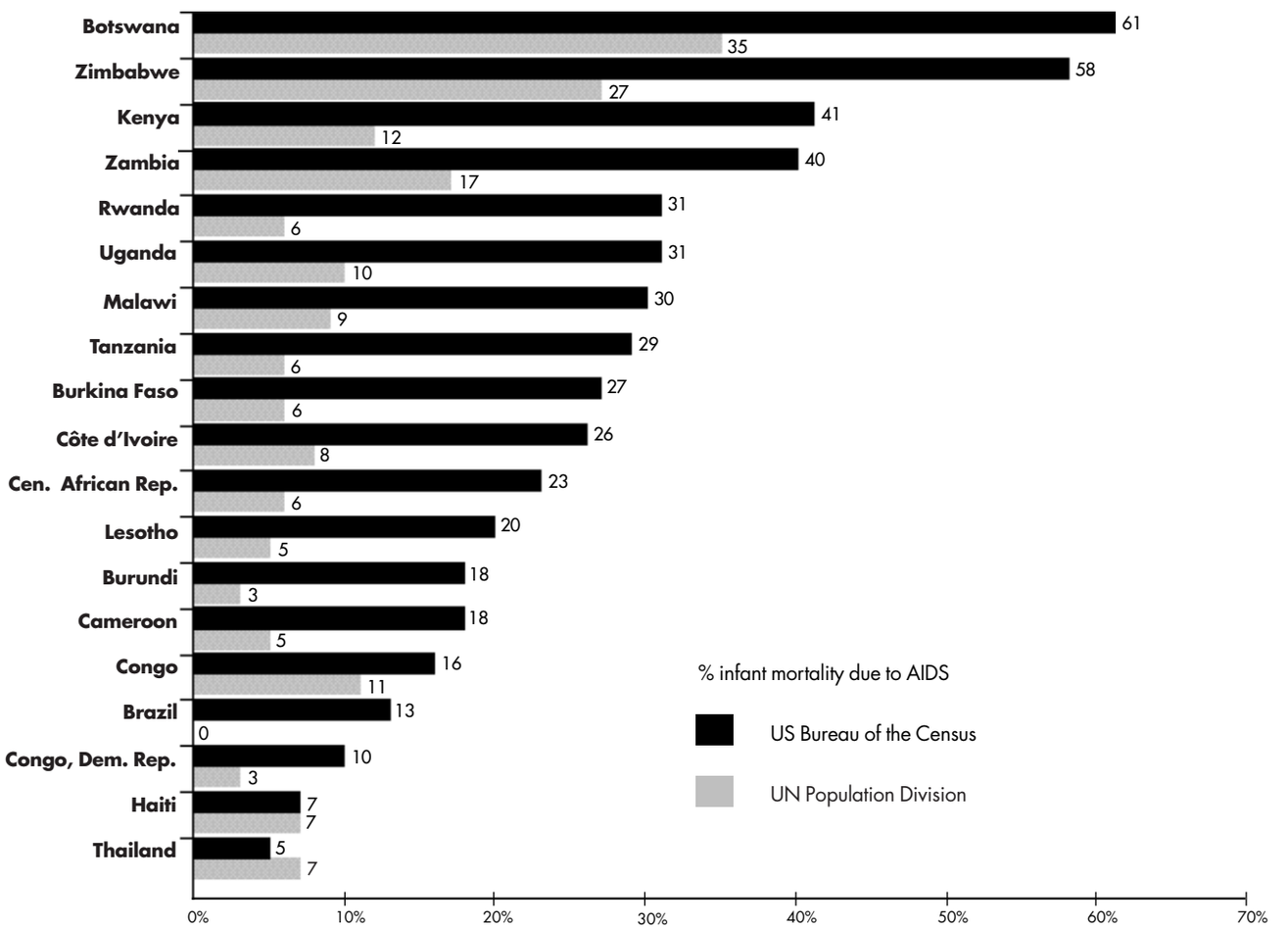
As to the impact on individual countries, the Census Bureau projects that in Kenya, AIDS will claim 51,000 infants in 2010, 41% of all infant deaths in the country. The comparable UN estimate is 12% or 12,200 infants. In Zimbabwe, according to the Census Bureau's calculations, 36,300 infants will die of AIDS in 2010, 58% of the total; the UN estimate is 11,500 deaths or 27% of all babies dying in the country. But Botswana is projected to be the biggest casualty of the scourge in 2010—61% or 4,500 of 7,500 total infant deaths (according to the Census Bureau) and 35% or 1,600 of 4,500 infant deaths (according to UN figures).

The projections cover 19 of the 32 hardest hit countries where HIV/AIDS now rages. But the epidemic is only beginning to grow in Asia, for example, and new countries could appear on this chart if prevention and control efforts do not take hold.

Worldwide, the percentage of infant deaths attributable to HIV/AIDS is still small. That is because at this time AIDS is not a significant cause of infant or child death in the countries with the biggest percentage of the world's children, especially China and India.

It is important to remember that the impact of HIV/AIDS on children is not only measured in statistics on their health but also in the health of their parents and communities. A young child whose parents are sick or dead is at heightened risk of death from preventable diseases and malnutrition, while older children (girls especially) must often leave school to care for sick parents, mind younger siblings or go to work. In all of these ways, the effect of HIV/AIDS on development is potentially enormous—and as yet unmeasured.

Per cent of infant deaths due to AIDS
Projections for the year 2010



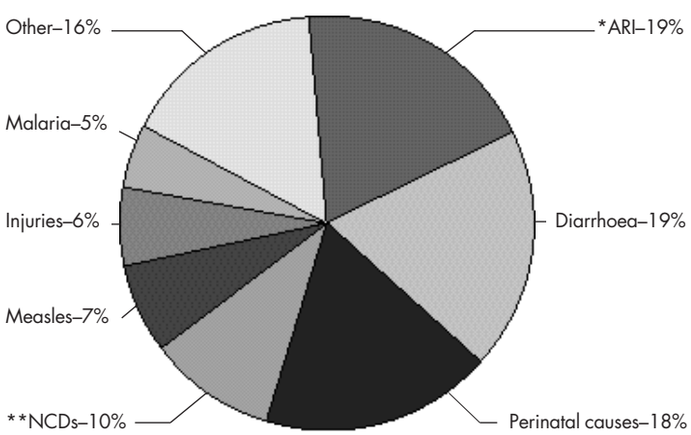
Sources: US Bureau of the Census, *The Demographic Impacts of HIV/AIDS: Perspectives from the World Population Profile*, 1996; UN Population Division, *World Population Prospects: The 1996 Revision*, 1997.

HEALTH LEAGUE TABLE

CHILD DEATH RATES

The proportion of children who reach their fifth birthday is one of the most fundamental indicators of a country's concern for its people. Child survival statistics are a poignant indicator of the priority given to the services that help a child to flourish: adequate supplies of nutritious food, the availability of high-quality health care and easy access to safe water and sanitation facilities, as well as the family's overall economic condition and the health and status of women in the community.

Re-slicing the cause-of-death pie



Determining the cause of death for children under 5 has always been a more difficult task than estimating the number of child deaths. Better estimates of the cause of child death have resulted from a new global study by WHO, the World Bank and Harvard University, reflected in the pie chart.

The chart revises earlier estimates of the proportion of deaths attributable to each cause. It also provides information on two categories—injuries and non-communicable diseases—not previously included in cause-of-death estimates.

Although the new pie chart attributes a smaller percentage of deaths to diarrhoea and acute respiratory infections, it confirms them as the leading causes of child death. Malnutrition alone accounts for just 3% of under-5 deaths, but it plays a contributing role in more than half of all child deaths in developing countries.

* Acute respiratory infections.
** Non-communicable diseases.

Sources: Adapted from *Global Burden of Disease*, WHO, World Bank and Harvard University, 1996.

SUB-SAHARAN AFRICA

		%
1	Gambia (110)	56
2	Botswana (52)	45
2	Mauritius (23)	45
4	Zimbabwe (74)	41
5	Senegal (130)	40
6	Cameroon (106)	39
7	Rwanda (139)	37
8	Burkina Faso (164)	33
9	Namibia (78)	32
10	Togo (128)	27
11	Chad (152)	26
11	South Africa (67)	26
13	Eritrea (195)	25
13	Ethiopia (195)	25
13	Mali (225)	25
16	Gabon (148)	24
16	Madagascar (164)	24
16	Malawi (219)	24
19	Guinea-Bissau (227)	22
19	Mauritania (195)	22
21	Guinea (219)	21
21	Mozambique (220)	21
23	Kenya (90)	20
24	Benin (142)	19
24	Uganda (145)	19
26	Lesotho (140)	17
27	Ghana (130)	16
▶	*Regional average (174)*	*14*
28	Congo (108)	14
28	Somalia (211)	14
30	Côte d'Ivoire (150)	12
31	Tanzania (160)	11
32	Burundi (176)	9
33	Central African Rep. (165)	8
33	Liberia (216)	8
35	Sierra Leone (284)	6
36	Nigeria (191)	3
37	Congo, Dem. Rep. (207)	1
38	Niger (320)	0
39	Angola (292)	-12
40	Zambia (203)	-27

MIDDLE EAST AND NORTH AFRICA

		%
1	Oman (25)	74
2	Egypt (51)	72
3	Algeria (40)	71
4	U. Arab Emirates (19)	70
5	Iran (40)	68
6	Turkey (50)	65
7	Tunisia (37)	64
8	Jordan (25)	62
8	Saudi Arabia (34)	62
10	Kuwait (14)	60
▶	*Regional average (57)*	*59*
11	Israel (9)	53
12	Morocco (75)	51
12	Syria (36)	51
14	Yemen (110)	48
15	Libya (63)	47
16	Sudan (115)	43
17	Iraq (71)	14
18	Lebanon (40)	0

WORLD AVERAGE

89

Under-5 deaths per 1,000 births, 1995

Since 1985, 2.5 million young lives have been saved each year through low-cost health programmes.

CENTRAL ASIA

		%
1	Kyrgyzstan (54)	40
2	Tajikistan (79)	37
2	Uzbekistan (62)	37
4	Georgia (26)	35
5	Kazakstan (47)	34
6	Turkmenistan (85)	33
7	Azerbaijan (50)	15
▶	*Regional average (132)*	*12*
8	Armenia (31)	9
9	Afghanistan (257)	8

EAST/SOUTH ASIA AND PACIFIC

		%
1	Malaysia (13)	69
2	Sri Lanka (19)	63
3	Viet Nam (45)	57
4	Singapore (6)	54
5	Korea, Rep. (9)	50
6	Thailand (32)	48
7	Cambodia (174)	47
8	Bangladesh (115)	45
8	Japan (6)	45
10	New Zealand (9)	44
11	Indonesia (75)	41
12	Australia (8)	38
13	Nepal (114)	37
14	India (115)	35
15	Mongolia (74)	34
▶	*Regional average (85)*	*31*
16	Korea, Dem. (30)	30
17	Lao Rep. (134)	29
18	China (47)	28
19	Bhutan (189)	24
19	Philippines (53)	24
21	Pakistan (137)	9
22	Papua New Guinea (95)	0
23	Myanmar (150)	-3

AMERICAS

		%
1	El Salvador (40)	67
1	Jamaica (13)	67
3	Mexico (32)	63
4	Cuba (10)	62
4	Honduras (38)	62
6	Ecuador (40)	60
7	Nicaragua (60)	58
7	Peru (55)	58
9	Chile (15)	57
9	Guatemala (60)	57
11	Trinidad/Tobago (18)	55
12	Dominican Rep. (44)	53
▶	*Regional average (34)*	*51*
13	Uruguay (21)	50
14	Colombia (32)	45
14	Costa Rica (16)	45
16	Paraguay (34)	44
17	Venezuela (24)	43
18	Brazil (53)	42
19	Bolivia (105)	38
19	Canada (8)	38
21	Haiti (124)	36
22	Panama (20)	35
23	Argentina (27)	34
24	United States (10)	33

EUROPE

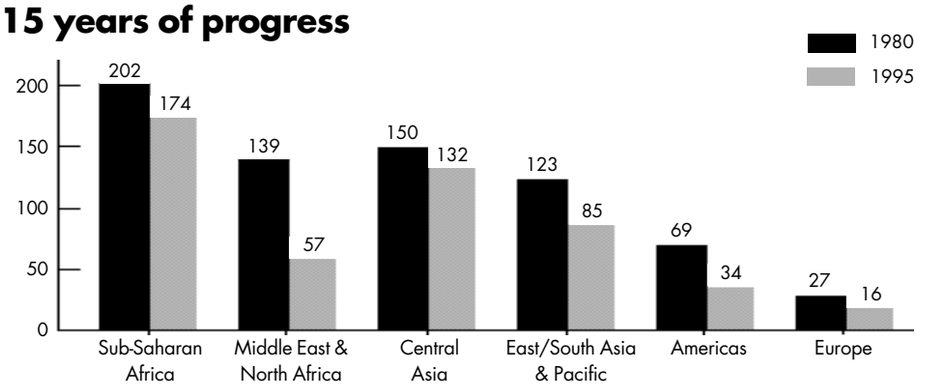
		%
1	Portugal (11)	65
2	Austria (7)	59
3	Greece (10)	57
4	Germany (7)	56
4	Slovenia (8)	56
6	Bosnia/Herzegovina (17)	55
6	TFYR Macedonia (31)	55
8	Italy (8)	53
9	Czech Rep. (10)	50
9	Ireland (7)	50
9	United Kingdom (7)	50
12	Yugoslavia, Fed. Rep. (23)	48
13	Hungary (14)	46
14	Finland (5)	44
14	Spain (9)	44
14	Sweden (5)	44
▶	*Regional average (16)*	*41*
17	Croatia (14)	39
18	Belarus (20)	38
19	Switzerland (7)	36
20	Slovakia (15)	35
21	Belgium (10)	33
21	Poland (16)	33
23	Lithuania (19)	32
24	France (9)	31
24	Moldova, Rep. of (34)	31
26	Albania (40)	30
26	Denmark (7)	30
26	Russian Fed. (30)	30
29	Latvia (26)	28
30	Estonia (22)	27
30	Netherlands (8)	27
30	Norway (8)	27
33	Bulgaria (19)	24
34	Ukraine (24)	23
35	Romania (29)	19

Source: UNICEF.

WHAT THE TABLE RANKS

Percentage reduction in under-5 mortality rates from 1980 to 1995. The 1995 rate per 1,000 births is in parentheses.

15 years of progress



Under-5 mortality rate (deaths per 1,000 live births)

Source: UNICEF.

Pneumonia: Little progress on a big killer

Acute respiratory infections (ARI), mainly pneumonia, kill more than 2 million children each year. Yet many countries are only beginning to take steps to reduce the devastating but largely preventable toll. Many ARI deaths could be averted if families knew pneumonia's danger signs, if health workers were trained to diagnose and treat pneumonia, and if clinics stocked life-saving antibiotics. Since 1992, however, only 16 countries have undertaken surveys of clinics to determine health workers' training and the availability of basic antibiotics. And only 23 countries have completed household surveys to gauge families' awareness of danger signs.

In 10 of the countries that surveyed clinics, fewer than half of health workers are trained in pneumonia case management. In several countries, such as Colombia, the Dominican Republic, Indonesia, Malaysia, Thailand and Zimbabwe, a high percentage of clinics stocked antibiotics, but a much lower percentage of health workers were trained to treat pneumonia. Pakistan and Papua New Guinea had low rates for both antibiotics and training. Among countries with household surveys, only in Egypt do more than half of caretakers know when to seek treatment.

But there is good news from the world's two most populous countries: China has trained 88% of health workers in standard case management of ARI, and India is a close second at 87%. Nearly all clinics surveyed in both countries stock necessary antibiotics.

At the beginning of this decade, few countries had programmes to reduce mortality from pneumonia. Of 88 countries where pneumonia is thought to be common, 59 have now started control programmes, and household surveys are being carried out in 60 countries.

First steps in taming a killer

Countries with clinic surveys of ARI* management

	% health workers trained in case management	% clinics with basic antibiotics
China	88	99
India	87	94
Philippines	83	52
Bangladesh	66	94
Viet Nam	65	-
Sudan	64	68
Morocco	47	79
Paraguay	46	60
Thailand	44	87
Colombia	36	67
Papua New Guinea	33	27
Pakistan	29	38
Dominican Rep.	26	82
Zimbabwe	25	97
Malaysia	23	100
Indonesia	18	63

Countries with household surveys of ARI home management

	% caretakers knowing when to seek care
Egypt	57
Sudan	48
Swaziland	48
Philippines	44
Uganda	41
Viet Nam	40
Mongolia	36
Côte d'Ivoire	35
India	35
Somalia	35
Sri Lanka	35
Tanzania	33
Nigeria	32
Myanmar	26
Turkmenistan	26
Kyrgyzstan	25
Ghana	24
Congo, Dem. Rep.	22
Pakistan	20
Ethiopia	19
Lao Rep.	18
Papua New Guinea	15
Yemen	7

* Acute respiratory infections.

Sources: WHO, Division of Diarrhoeal and Acute Respiratory Disease Control, *1994-1995 Report;* UNICEF, unpublished data, 1992-1995.

52 countries falling short on immunization goal for DPT

Reaching the year 2000 goal of 90% immunization levels is a major challenge for many countries. At least 52 countries with populations of more than 1 million are unlikely to meet the goal of immunizing all children under the age of 1 against DPT (diphtheria, pertussis and tetanus). From 1980 to 1990, developing countries accomplished extraordinary gains for child health by raising immunization rates for DPT, as well as measles, polio and tuberculosis, from about 30% to an average of 80%.

Sub-Saharan Africa faces the greatest difficulties, with 31 countries projected to fall short of the DPT immunization goal. Angola, Central African Republic and Chad could have DPT immunization rates of less than 20% in the year 2000 unless they are able to reverse current trends. Countries in other regions with low projected rates include Haiti, Nepal, Pakistan, Papua New Guinea and Yemen. Immunization data are a basic child health indicator, but seven industrialized countries have inadequate data: Australia, Austria, France, Ireland, Japan, New Zealand and Switzerland. Most of the other industrialized countries are projected to attain DPT (or DT only) immunization levels of at least 85%.

Despite concern that commitment to immunization might waver after the 1990 achievement, 90 countries are on track towards the year 2000 goal, based on their 1990 to 1995 performance. Current levels of DPT immunization save the lives of more than 1 million children each year.

UNICEF/2307/Demmers

Rwanda: Projected to achieve 39% immunization rate by the year 2000.

Immunizing for the year 2000

Countries unlikely to meet the goal of 90% coverage of DPT by the year 2000

Projected immunization rate by the year 2000

Sub-Saharan Africa			
Zimbabwe	82	Lesotho	44
South Africa	80	Gabon	40
Kenya	79	Rwanda	39
Botswana	71	Uganda	39
Zambia	66	Cameroon	38
Malawi	65	Somalia	38
Liberia	64	Congo	32
Senegal	62	Nigeria	31
Ethiopia	59	Niger	28
Côte d'Ivoire	56	Burkina Faso	27
Ghana	53	Sierra Leone	22
Togo	50	Congo, D. Rep.	21
Mali	48	Angola	19
Burundi	46	C. African Rep.	18
Eritrea	46	Chad	14
Mozambique	46		

Middle East and North Africa			
Sudan	81	Yemen	15

Central Asia			
Turkmenistan	81	Afghanistan	67
Kyrgyzstan	68	Georgia	49

East/South Asia and Pacific			
Philippines	81	Nepal	47
Myanmar	75	PNG*	36
Bangladesh	62	Pakistan	13

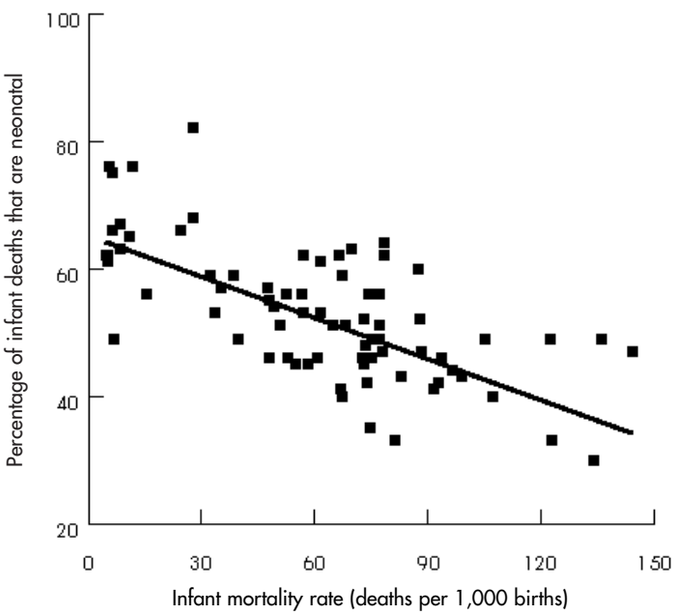
Americas			
Uruguay	84	Costa Rica	76
Brazil	81	Venezuela	72
Paraguay	80	Haiti	28

Europe	
TFYR Macedonia	82
Bosnia/Herzegovina	78
Latvia	50

* Papua New Guinea.

Sources: WHO and UNICEF, unpublished data for 1990 and 1995.

Proportion of infant mortality that is neonatal



As a country's rate of infant mortality (deaths in the first year of life) declines, the percentage of neonatal deaths (those in the first 28 days) grows.

Source: DHS and government reports, 1986–96.

Neonatal deaths: 5 million each year

Of the annual 8 million infant deaths worldwide occurring during the first year of life, 5 million are neonatal deaths—those taking place during a baby's first four weeks. A total of 98% of all neonatal deaths are in developing countries.

The graph demonstrates a global trend: As a country's infant mortality rate falls, the proportion of neonatal deaths tends to rise. This is true both in developing countries (most are in the middle of the graph) and in the industrialized countries (clustered on the left).

A baby is at greater risk during delivery and the first month of life than at any other point during childhood. And 85% of all neonatal deaths are due to birth asphyxia and trauma, tetanus, premature birth and infections. But there is an erroneous belief that these most common causes of death in developing countries are not responsive to public health measures.

Cost-effective interventions can, in fact, significantly reduce neonatal (as well as maternal) mortality. These include vaccinating women of childbearing age against tetanus; promoting good maternal nutrition; ensuring prenatal care and deliveries by skilled birth attendants; and upgrading health facilities with equipment, drugs and staff training needed to treat obstetric and neonatal emergencies. Newborns need immediate breastfeeding, warmth, cleanliness, hygienic care and resuscitation when necessary. Some will also need special attention for the early detection and treatment of illnesses.

In the industrialized countries, where infant deaths are much more rare, neonatal deaths constitute an even higher proportion of the infant mortality rate. Most neonatal deaths in these countries result from congenital abnormalities and premature birth.

Malaria's death toll: A child every 30 seconds

Alone or in conjunction with other illnesses, malaria kills over 1 million children under age 5 every year—a child every 30 seconds. Children experience over half of all malaria episodes.

Four species of the malaria parasite, transmitted by the *Anopheles* mosquito, affect humans, but the most dangerous species, causing nearly all malaria-related deaths, is *Plasmodium falciparum*, which predominates in sub-Saharan Africa and parts of South-East Asia, Oceania and South America. Over 40% of the world's population lives in malaria-endemic areas, but 90% of the estimated annual 300 million to 500 million malaria cases afflict people in sub-Saharan Africa.

Prevention efforts against malaria have had mixed results. Although water-drainage and insecticide-spray programmes have been effective in some parts of the world, they have not proven to be practical or sustainable in the more severely affected regions. Additionally, no vaccine against malaria is likely to be available for routine use in the near future. However, another preventive measure, insecticide-impregnated bednets or curtains, has proven to reduce deaths among children in Africa. Initiatives are under way to promote the widespread use of these materials, though the initial cost of buying them and the added expense of subsequent treatments with insecticide are beyond the reach of many poor families.

As prevention is so difficult, the ability to provide effective treatment for malaria is of great importance. But treatment has also been made more difficult because nearly everywhere that *falciparum* is prevalent, it is at least partially resistant to chloroquine, the cheapest and most widely available medication. The problem of *falciparum* drug resistance is most acute and severe in parts of South-East Asia and Brazil where malaria may also be resistant to the readily available second-line medications.

The challenge of drug resistance demands that health workers be trained to recognize and provide proper treatment for the problem and that health systems have appropriate drugs available.

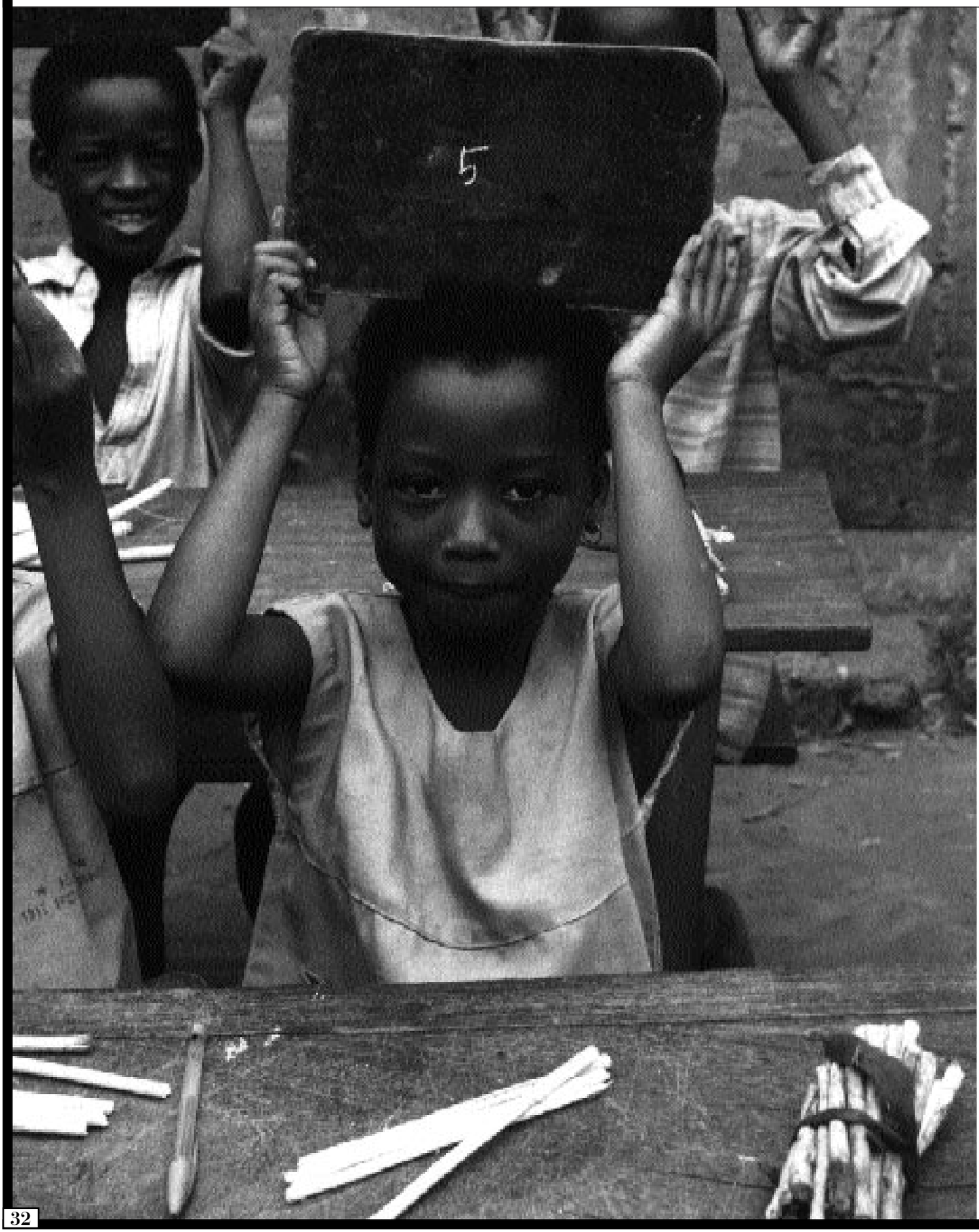
Where *P. falciparum* is chloroquine-resistant

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

Middle East and North Africa	
Iran	Sudan
Oman	Yemen
Central Asia	
Afghanistan	
East/South Asia and Pacific	
Bangladesh	Nepal
Cambodia*	Pakistan
China	Papua New Guinea
India	Philippines
Indonesia	Sri Lanka
Lao Rep.	Thailand*
Malaysia	Viet Nam
Myanmar*	
Americas	
Bolivia	Panama
Brazil*	Paraguay
Colombia	Peru
Ecuador	Venezuela

* *P. falciparum* has widespread resistance to more than one drug.

Source: WHO, *International Travel and Health, Vaccination Requirements and Health Advice, 1997.*



UNICEF/93-1992/Pirozzi

Quality education: One answer for many questions

Harry Sawyerr

Three years before the millennium, 140 million children are still not in school, despite government pledges to achieve universal access to basic education by the year 2000. Many of the youngsters who are in school find themselves squeezed onto crowded benches in dilapidated classrooms, lacking even a slate, while a teacher drills lessons by rote. Over the past 20 years, while countries rushed to increase the numbers of schools and teachers, quality and relevance of education often took a back seat. But quantity is not an acceptable trade-off for quality, and it is time to put more attention into what takes place in the classroom.

How can we instil an understanding of fundamental human rights? Achieve sustainable social and economic development? Resolve ethnic conflict? Stop gender disparity? Put an end to child labour? Eliminate the sexual exploitation of children? Give hope to a new generation of children growing up in an ever more complex world?

The answer is education—quality, relevant education that prepares our young people to participate meaningfully in their own development, both in their immediate communities and in the larger world. Education is a fundamental human right—pledged by the Convention on the Rights of the Child. Without it, few if any of these problems can be solved.

Not only do good schools instil basic skills in children, they also educate them about their rights—and shield them from violations of those rights. The International Labour Organization has said that the single most effective way to stem the flow of children into abusive forms of employment is to extend and improve schooling so that it will attract and retain them.

It is no secret that most countries are falling far short of fulfilling the promise made at the World Summit for Children in 1990: universal access to basic education by the year 2000. About 140 million young people are currently not in school, and almost 1 billion adults, two thirds of them women, are illiterate.

The obstacles to education are the same ones that have undermined economic and social advancement: widespread poverty, lack of skilled personnel, top-down bureaucracies, the inferior treatment of women, rapid population growth, skewed distribution of education funds, bloated military spending and onerous foreign debt burdens. But in the end, all the reasons add up to one: insufficient will.

Education requires a greater commitment than any other development activity because it is not a one-time injection but a continuous, labour-intensive process. It requires skilled, highly trained staff to dedicate year after year of patient toil. It requires quality curricula and plenty of books, slates and chalk. It requires buildings and benches. To provide these tools, countries—and parents—must make the decision that educating a child is worth sacrificing other priorities. Education simply cannot be sold short.

If the will can be found, so can the funds. In sub-Saharan Africa, for example, just an extra $2.5 billion (about 20 per cent of the $10 billion to $13 billion annual cost of servicing the over $200 billion foreign debt) would provide a seat in a classroom for every child. Reallocating one third of the region's military spending would do the same. Worldwide, if just $3 billion to $6 billion of the estimated $680 billion currently spent on the military per year could be diverted to education, most experts believe that every child would have a place in a decent school.

This is not happening. In Africa, average per capita education spending declined from $41 in 1980 to $26 in 1985, and in 1995, it stood at only $28. These figures actually underestimate the decline in spending because they are not adjusted for inflation. The portion of international aid dedicated to education declined steadily from 17 per cent in 1975 to 9.8 per cent in 1990, increasing slightly to 10.7 per cent in 1994.

After the 1990 World Conference on Education for All (Jomtien,

Harry Sawyerr recently retired as Minister for Education of Ghana, a position he had held since 1993. He spearheaded the development of the strategic plan for the country's major education reform, the Free, Compulsory and Universal Basic Education programme, kicked off in 1996. In 1995, Mr. Sawyerr was elected President of the Caucus of African Ministers of Education and Chairman of the Bureau of African Ministers. His career in public service spanned almost 30 years.

Thailand), countries around the globe made the push to get all their children in school. The emphasis was on quantity—numbers of schools, numbers of teachers, numbers of children enrolled. Those efforts are not lost, but they are not enough. Parents can recognize poor schools and they do not send their children to them; youngsters quickly lose interest when the curriculum and teaching style do not suit their needs. Insufficient quantity—of schools and teachers—is certainly the main explanation for the failure so far to achieve universal access to basic education. But another important reason is insufficient quality and relevance, for they lead to disenchanted families and wasted resources.

If parents are persuaded that education is more valuable in the long term than their children's contribution from an unskilled job or domestic duties, they will do whatever it takes to send their children to school. In some cases, economic necessity keeps children at home. Some youngsters begin school but drop out because they are inadequately prepared: They are malnourished and cannot pay attention, or they did not have the physical and emotional attention in early childhood that is essential to the development of young minds and bodies. These problems are well known, and if we are not addressing them, the quality of our schooling is surely lacking.

Teachers are key

The classroom needs to be a stimulating place for children—and that depends on quality teachers. According to some projections, low-income countries (not even including China and India, the highest population countries) need about 4.5 million more teachers to achieve universal primary education by the year 2000—1.8 million more than will exist if current trends continue. There is simply not enough time to build all the training colleges needed if we are to achieve the goal of education for all by the year 2000. To do so, we must find alternative ways to train teachers, such as on the job, through regular sessions and seminars.

Good schools not only instil basic skills, they also educate children about their rights.

One model for improving teacher training is India's Teacher Empowerment Project. Begun in 1994, it is now in place in two of India's poorest states, Madhya Pradesh and Uttar Pradesh. The project, also known as *Shikshak Samakhya Pariyojana*, or 'equal say', is based on the idea that local control improves teachers' self-respect and builds trust and cooperation between teachers and communities. The project emphasizes teacher-to-teacher skills training and makes use of resource centres where teachers can exchange ideas. It encourages individual attention to students and includes singing, dancing and art in the curriculum.

In Zimbabwe, education was revamped after independence in 1980. Now, training combines full-time study with on-the-job learning in the classroom. Teacher salaries rise with each successfully completed year of study, leading to full qualification and pay. Antiquated pay scales based on race and gender have been abolished. For the first two years, there was a shortage of qualified candidates, but the success of the programme soon brought an influx of skilled teachers into the country's classrooms.

Regular, high-quality in-service sessions are part of the reason why the *Escuela Nueva* approach has been so successful in raising enrolment in rural Colombia. Workshops provide teachers the opportunity to share ideas and methods, especially important in areas where they may be isolated from their peers. The benefit of ongoing training lies not just in the specific techniques the teachers learn but also in the underlying message that their professional skills are valued.

Escuela Nueva schools also succeed because they are relevant to the students' lives and lifestyles. The learning process is dynamic, with extensive student participation, and flexible, allowing students to proceed at their own pace and to take time off when necessary, such as during the harvest. The curriculum is practical, covering such topics as farming and local customs.

The cost of teachers

Preparing an *Escuela Nueva* teacher costs only about $500 more than regular teacher training, and it has been a worthwhile investment. In just 15 years, 2,000 schools blossomed into 20,000. Drop-out rates have fallen and scores on achievement tests have improved.

UNICEF/95-0248/Davies

A good teacher makes the classroom a stimulating place, but low-income countries need about 4.5 million more instructors to reach the goal of universal primary education. A teacher works with her students at a primary school in Burundi's capital, Bujumbura.

Teacher pay is another key issue for improving the quality of primary schooling. Salaries are the major share of education budgets—50-60 per cent for education as a whole and even more at the primary level.

In just 15 years, 2,000 Escuela Nueva schools blossomed into 20,000.

Nonetheless, teachers are widely underpaid and in many countries make poverty-level wages. In Uganda, for example, teachers' salaries are below the poverty line and lower than the pay of other skilled professionals. As a result, headmasters often provide supplements with funds collected by Parent-Teacher Associations, which means that teacher incomes depend on the ability of parents to bear extra costs. Thus, wages vary widely from region to region.

After major declines in pay in Africa and Latin America during the 1980s, there is growing recognition that low salaries have hindered attempts to attract and retain qualified professionals. Incentives can help make up the difference. In Indonesia, for example, teachers in rural or other 'less desirable' areas receive a 50 per cent salary bonus. Many African countries require villages to house rural teachers. In Tanzania, the lack of accommodation for teachers in rural areas became so severe that in 1991 a presidential fund was established to help resolve the shortage.

Another way to control expenditures while improving quality is to use lower cost teaching assistants recruited from the local community. Assistants spare teachers from routine tasks and allow them to spend more time working with students. And, through ongoing training, paraprofessionals can gradually work their way into the professional ranks.

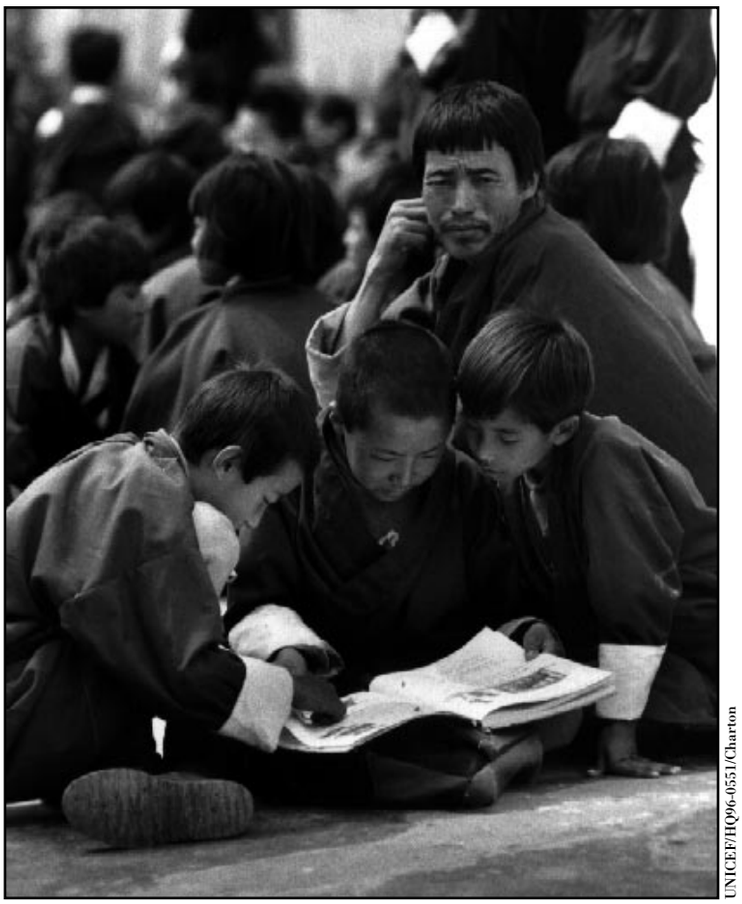
These are all innovative strategies to squeeze every last bit from the funds available, an activity that becomes even more important when demand for schools is expanding. But efforts to stretch budgets must not be allowed to undermine the quality of education. While Myanmar has undergone rapid expansion of primary schooling, in 1993-1994 two thirds of its teachers had no training and only 4 per cent had access to in-service training.

Tanzania illustrates what can happen if funds are cut when spending is already at a minimum. In response to repeated calls by international donors to reduce per-pupil expenditures, the country cut education expenditures dramatically. A 1990 survey found that half of all primary school teachers were depending on other sources of income and a quarter of secondary school teachers were holding down additional jobs, sometimes cutting class hours short to do so. Dilapidated schools lacked chairs and were jammed with an average of 60 students in every classroom. Books and materials were almost non-existent.

The dearth of supplies is a serious impediment almost everywhere in the developing world. A 1995 study in 14 of the world's least developed countries found that in 9, fewer than half the classrooms had a usable chalkboard. Children need to read daily to solidify their skills, but in 13 of the 14 countries, at least 70 per cent of pupils had no books at home. In most African countries, pupils must provide their own notebooks, pens and slates. Since books are often imported and therefore very expensive, few children have any books at all. In 1990 in Tanzania, an average of 12 students were sharing each book.

In these situations, parents and communities are asked to fill the gap. In Viet Nam, communities have been reasonably successful at providing school buildings at low cost through voluntary labour and contributions. In Uganda, construction of primary schools has been left entirely to parents and communities, resulting in great discrepancies from one community to another. Fewer than half the country's classrooms are permanent structures, and in some regions, almost half the classes are held outdoors for lack of classrooms. Currently, 1 million children (one third of those aged 6-10) are not enrolled in primary school.

When communities and parents are simply asked to pay the bill, they may view education as a burden. But if they are given a meaningful role, they usually contribute willingly. In Guinea, for example, parents take part in resolving issues such as quality of teaching. Committees of parents and community members have also been formed in Zimbabwe to encourage participation in planning and managing education.



UNICEF/HQ96-0551/Charton

Despite the obstacles of mountainous terrain and isolated villages, Bhutan is making efforts to expand education access. Three boys share a book in the yard of a school.

Curricula for today

Once they arrive in the classroom, primary school teachers often find a curriculum that is out of date and irrelevant to the lives of the students. But revising it is primarily a question of political will, as Zimbabwe found soon after its independence in 1980. Over a period of about two years, panels of teachers, university educators and government officials at national and local levels collaborated in the effort. The new curriculum highlights the country's history and culture, the environment and national unity. Care was

UNICEF/96-0248/Toutounji

The lack of books, slates and other school supplies is a serious problem almost everywhere in the developing world. These Egyptian girls are reading books borrowed from a mobile library in a suburb of Cairo.

taken to include people of different ethnic groups in illustrations and examples.

Once consensus on content was achieved, attention turned to textbooks. Commercial publishers were encouraged to develop their own books, as long as they matched the curriculum. Meanwhile, the Ministry of Education printed inexpensive booklets on newsprint and distributed them free of charge so that every school would have a basic supply. For the first 11 years, the Ministry required that textbooks be published in the country. Along with getting learning materials into the hands of its students, Zimbabwe's policy turned publishing into one of the most vibrant industries in the country.

The curriculum used in the schools of the Bangladesh Rural Advancement Committee, or BRAC, aims to teach basic literacy, numeracy and social awareness, while also developing the child's creative and social skills through poetry, crafts and singing and dancing.

BRAC is probably best known for its success in placing girls in quality schools. In its 30,000 schools, which aim to serve the poorest families, two thirds of the seats are filled by girls. BRAC succeeds in part by building its facilities in rural villages close to children's homes and giving preference in hiring to women, who make up about three quarters of the teachers.

The success of the programme demonstrates that the goal of universal primary education cannot be achieved unless efforts are made to make schooling equally accessible to girls. In the developing world, 20 per cent of girls are not enrolled. Just one in four of Burkina Faso's school-age girls attends school, and in Yemen, 39 per cent of girls are enrolled—compared with 73 per cent of boys.

Girls' lower rates of school attendance result from a complicated set of issues stemming from poverty and cultural practices: their domestic duties, teachers' preferential treatment of boys, the lack of female teachers, fear of sexual harassment and rape, distance from schools, lack of sanitation and traditions that put greater value in educating boys than girls.

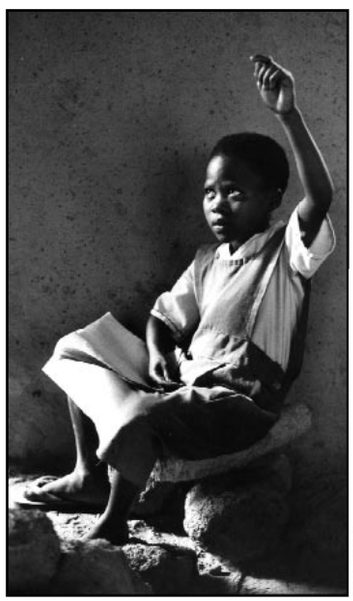
These obstacles are hard to overcome, but political will and demonstrated support for girls have already made a big difference in many cases. Schools in countries including Kenya, Nepal, Pakistan and Senegal adapt to accommodate girls' domestic and other responsibilities. Throughout the developing world, new cadres of female teachers are easing parents' concerns about sending their daughters to school.

Localizing education

Here in Ghana, a quarter or more of all girls are not enrolled in primary school. Getting them into the classroom is one of the goals of our current programme to improve education quality. This activity has paralleled efforts to recover from the devastating economic decline of the 1970s and early 1980s.

In 1980/1981, just before the reform began, education's share of the national recurrent budget was 17 per cent, but by 1994 it had reached a peak of 41 per cent, with a budget of 187 billion Cedis ($100 million). Although it dropped to 35 per cent in 1997, the share of the education budget devoted to primary schooling climbed to 66 per cent this year, from 44 per cent in 1984.

After a decade of reform, we are working to improve the quality of instruction, strengthen and decentralize management and make sure more children have a seat in the schoolroom. In 1996, we initiated a plan for Free, Compulsory and Universal Basic Education, or FCUBE, aimed at expanding access, improving teaching quality and increasing efficiency in administration.



UNICEF/Pirozzi

One of the goals of Ghana's education reform programme is to get more girls in the classroom. In the rural town of Tamale in northern Ghana, a girl in primary school uses a stone for a seat.

One of our main objectives is to localize education. District Education Oversight Committees and local School Management Committees have been established nationwide to participate in teacher recruitment and school upkeep. FCUBE also provides scholarships for girls. The quality of teaching is receiving a big boost with teacher colleges earmarked for renovations and new training programmes.

A new curriculum is being developed, and our policy requiring that children be taught in their mother tongue for the first three years of primary school will be more vigorously pursued. The curriculum will continue to address new challenges and trends, such as teen pregnancy, drug abuse, HIV/AIDS, safe motherhood and the environment. Science resource centres are being established in all 110 districts, building know-how in science and computer literacy to prepare our children for the future—and the present.

The challenges faced by all countries in fulfilling people's human rights are substantial. Education is not only a fundamental right, it is also the best tool governments have for guaranteeing that their citizens have the ability to claim their other rights.

In the early 1990s, more than one quarter of the 94 million children who enrolled in school in developing countries each year did not reach the fifth grade. More than 25 million girls and boys walked through the classroom door full of excitement and anticipation—only to have their hopes thwarted. That is a human tragedy. If we can find the will, we can create schools that fulfil their hopes and dreams. ■

Doing more with less

UNICEF/94-0731/Booker

Despite per capita income of only $240 a year, 88% of Viet Nam's children, like this girl in Ho Chi Minh City, are in school.

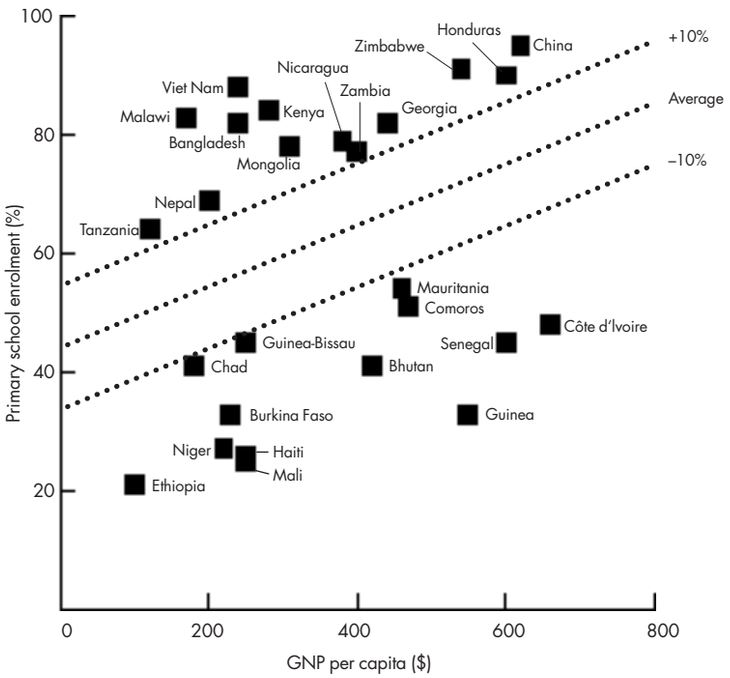
When it comes to getting young people into the schoolroom, some countries are doing far better than others with comparable or higher incomes. Thirteen countries have primary school enrolment rates 10 or more percentage points above the average rates for their per capita GNPs. In contrast, 13 other countries have rates 10 percentage points or more below average for their income.

Among the poorest countries, with per capita GNPs below $300, Bangladesh, Kenya, Malawi and Viet Nam have enviable enrolment rates of over 80%, about 20 percentage points above what could be expected at their income level. But in a similar income bracket, Ethiopia, Haiti, Mali and Niger enrol less than 30% of their primary school age children. Malawi's rate compares well even with that of Saudi Arabia (not on the chart), which at 63% is 20 points lower than Malawi's, although its per capita GNP ($7,040) is 40 times higher than Malawi's.

Zimbabwe (per capita GNP of $540) has a remarkable 90% rate; Guinea, at the same economic level, comes in under 35%. China's rate of 95% is an impressive 20 percentage points above the average rate for its income; in the same income category, Côte d'Ivoire and Senegal have rates nearly 30 percentage points below average.

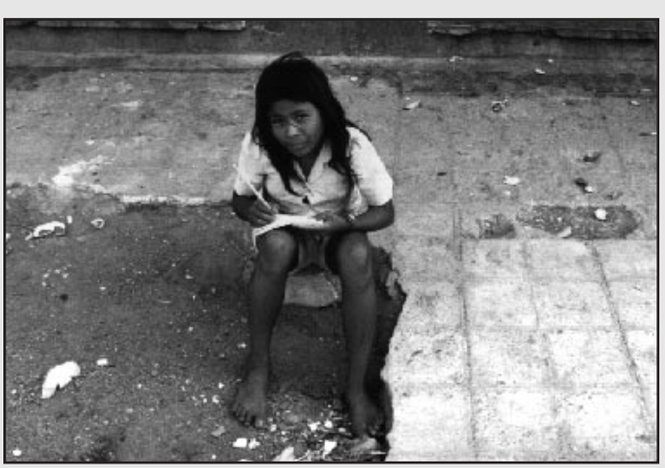
The Convention on the Rights of the Child mandates that countries make primary education free and compulsory, and the World Summit for Children goal for the year 2000 is universal access to basic education and completion of primary school by at least 80% of primary school age children.

Enrolment and GNP per capita



Note: Graph includes only those countries that have annual GNP per capita below $800, school enrolment rates 10% or more above or below the average and data from 1990 or later. Enrolment figures are for children aged 6 to 10 years except Burkina Faso (7–13) and Niger (7–12).
Sources: Demographic and Health Surveys and other national surveys, various years, 1990–1995.

Girls' education: Commitment or neglect?



UNICEF/93-1170/Horner

Nicaragua is one country where a higher percentage of girls are enrolled in school than boys. This girl in Managua does her homework outside a building damaged during the country's civil war.

Twelve countries with annual per capita GNPs below $500 show little or no disparity between girls' and boys' primary school enrolment rates. However, in 8 countries with incomes in the same range, girls' enrolment lags 15 percentage points or more behind boys' rates.

Girls' enrolment: A primary problem in 8 countries

Primary school enrolment in countries with per capita GNP below $500

Gender gaps 3 percentage points and under	% point gap	Gender gaps 15 percentage points and over	% point gap
Nicaragua	*–3	Benin	36
Haiti	*–1	Yemen	34
Bangladesh	0	Chad	28
Malawi	0	Guinea-Bissau	26
Rwanda	0	Togo	22
Zambia	0	Nepal	20
Georgia	1	Gambia	18
Ghana	1	Niger	15
Madagascar	1		
Kenya	2		
Mauritania	2		
Nigeria	2		

*A negative gender gap indicates a higher enrolment rate of girls.

Sources: UNESCO and UNICEF.

Maths and science: Some developing countries score high

UNICEF/91-4029/Sprague

Slovakia achieved the fourth-highest math score among countries with per capita GNP below 5,000.

In the largest-ever international education survey, 13-year-olds from Singapore outscored those from 40 other countries and areas in mathematics and science tests. Students from the Republic of Korea placed second in maths, and those from the Czech Republic stood second in science.

In addition, Thailand achieved higher scores in maths than wealthier countries such as Denmark, Germany, Spain and the United States, and performed almost as well in science. Iran, with relatively low scores, is close to Denmark in science. Six of the top 15 places in both maths and science went to students from Eastern European countries, while some wealthier industrialized countries, including France, Germany and the United States, were not in the top 20.

The tests were given to the students as part of the Third International Mathematics and Science Study. Comparisons of factors such as class size, spending per pupil and class time spent on subjects indicate that none of these alone determines how well students perform.

National wealth clearly does not always predict educational performance. Six countries with per capita GNPs of less than $5,000 had maths scores higher than other countries with per capita GNPs 5 times greater.

Educational success and wealth

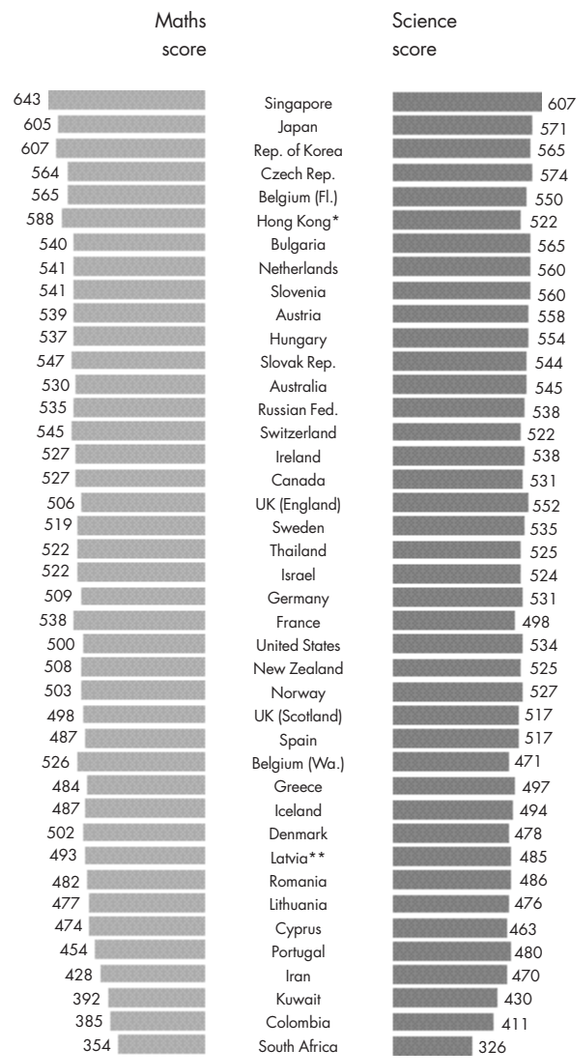
Per capita GNP less than $5,000	Maths score	Per capita GNP more than $25,000
	643	Singapore
	605	Japan
Czech Rep.	564	
Slovakia	547	
	545	Switzerland
Bulgaria	540	
	539	Austria
Hungary	537	
Russian Fed.	535	
Thailand	522	
	509	Germany
	503	Norway
	502	Denmark
Overall average	**500**	United States
Latvia*	493	
Romania	482	
Lithuania	477	
Iran	428	
Colombia	385	
South Africa	354	

*Latvian-speaking students.

Source: Reports from the Third International Mathematics and Science Study 1994–1995, November 1996.

Student achievement in maths and science

Eighth graders' scores on the Third International Mathematics and Science Study



Note: Countries are listed in order of combined maths and science scores. There are two UK entries, England and Scotland, and two entries for Belgium, Flanders and Wallonia.

*Study carried out prior to reunification with China.

**Latvian-speaking students.

Source: Reports from the Third International Mathematics and Science Study 1994–1995, November 1996.

UNICEF/93-1883/Zaman

A teacher reads to her students in an open-air classroom in Dhaka. More than 80% of Bangladesh's teachers have had teacher training.

Do teachers make the grade?

School enrolment ratios are a fundamental indicator of a country's commitment to education, but they tell nothing about the quality of teaching. A pilot survey of 857 primary schools in 14 least developed countries (with GNPs per person below $1,000) sponsored by UNESCO and UNICEF points to teacher education and absenteeism as two areas in dire need of improvement.

In 8 of the 14 countries, more than 50% of primary school teachers have only 8 to 11 years of schooling—or less. In Benin, Tanzania and Uganda the rate is above 90%. Benin and Tanzania have compensated for lack of education by training almost all their teachers, but only 50% of Uganda's teachers are trained. And in Burkina Faso, Cape Verde and Togo, more than 25% of teachers have no training.

In 9 out of the 14 countries, 10% or more of teachers were absent two or more days during the week before the survey, and in Tanzania, Uganda and Zambia 25% or more were absent. However, the survey counted attendance in training courses among the reasons for absenteeism. Other reasons include teachers' health, family sickness or other family matters.

Most of the countries surveyed face economic distress; however, investment in education, beginning with the basics, is one of the most important steps in promoting social progress and economic development.

Primary school instruction quality in least developed countries

	% teachers with a lower secondary education or less	% teachers without teacher training	% teachers absent at least 2 days in week before survey
Bangladesh	44	18	8
Benin	92	1	2
Bhutan	30	8	14
Burkina Faso	70	27	10
Cape Verde	87	35	10
Equatorial Guinea	77	8	8
Ethiopia	0	13	18
Madagascar	46	10	18
Maldives	89	22	8
Nepal	32	3	11
Tanzania	91	0	38
Togo	77	41	7
Uganda	91	50	30
Zambia	24	14	25

Source: A. Schleicher, M. Siniscalco and N. Postlethwaite, *The Conditions of Primary Schools: A Pilot Study in the Least Developed Countries: Report to UNESCO and UNICEF*, September 1995.

Rural kids short-changed

In Burkina Faso, 75% of primary school age children in urban areas attend school, but in rural areas only 26% do. The 49 percentage point gap is the greatest among 41 countries surveyed during the period 1990–1995; in Mali, Morocco, Niger and Senegal the gaps exceed 30 percentage points. Nearly two thirds of the countries surveyed have urban/rural gaps of at least 10 percentage points or more. In only 3 of the 41 countries—Bangladesh, Kenya and Namibia—are attendance rates in rural areas slightly higher than in urban areas.

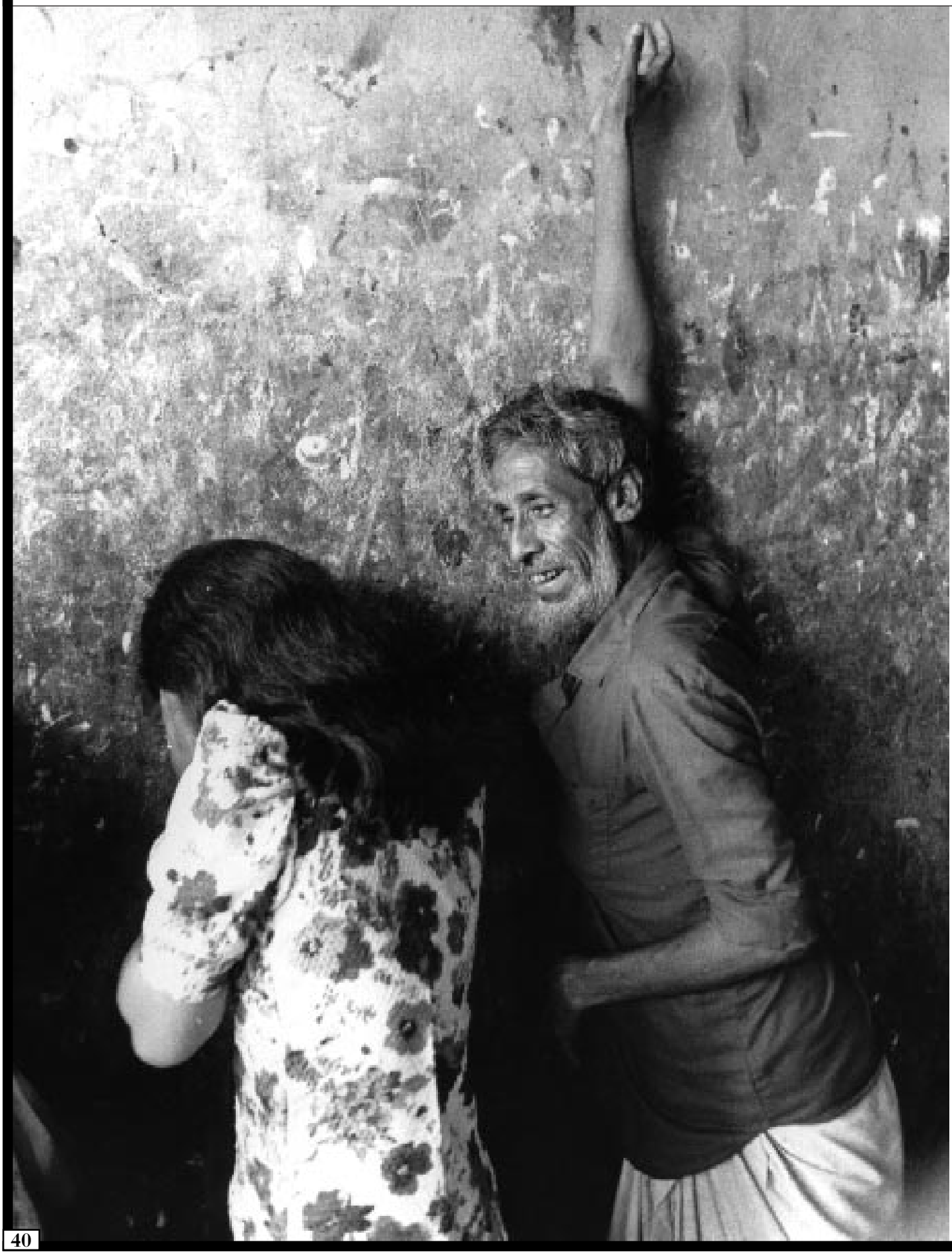
The surveys also measured disparities between boys' and girls' school attendance and found that these were not as great as those between urban and rural attendance. In only 2 of the 41 countries—Yemen and Nepal—were gender disparities greater than urban-rural differences. In Yemen, the attendance rate for girls is 34 percentage points lower than for boys. In Nepal, it is 20 percentage points lower.

Disparities between regions within countries are also often significant. In India, the rate of primary school attendance in Kerala is 95%, while in Bihar it is 51%. The rate in Lower Egypt is 89%, but drops to 69% in Upper Egypt.

Disparity in urban and rural attendance

	% urban	% rural	Percentage point difference
Burkina Faso	75	26	49
Niger	62	20	42
Morocco	73	35	38
Mali	50	16	34
Senegal	65	32	33
Madagascar	84	54	30
Nigeria	89	59	30
Zambia	79	50	29
Yemen	79	51	28
Congo, Dem. Rep.	76	48	28
Central African Rep.	70	44	26
Haiti	86	60	26
Guatemala	73	51	22
Côte d'Ivoire	64	43	21
Guinea	47	27	20
India	84	64	20
Ghana	82	63	19
Cameroon	76	59	17
Rwanda	64	47	17
Uganda	78	62	16
Egypt	93	78	15
Pakistan	75	60	15
Nepal	82	68	14
Mauritania	61	48	13
Dominican Rep.	88	76	12
Tanzania	74	62	12
Algeria	97	88	9
Colombia	94	85	9
Malawi	91	82	9
Zimbabwe	87	78	9
Indonesia	97	89	8
Myanmar	91	84	7
Paraguay	84	78	6
Peru	90	84	6
Philippines	81	75	6
Turkey	74	70	4
Bolivia	90	87	3
Jordan	98	96	2
Kenya	83	84	1
Bangladesh	72	74	2
Namibia	75	77	2

Sources: Demographic and Health Surveys and other national surveys, 1990–1995.



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The intolerable status quo: Violence against women and girls

Charlotte Bunch

Violence against women and girls is the most pervasive violation of human rights in the world today. Its forms are both subtle and blatant and its impact on development profound. But it is so deeply embedded in cultures around the world that it is almost invisible. Yet this brutality is not inevitable. Once recognized for what it is—a construct of power and a means of maintaining the status quo—it can be dismantled.

Imagine a people routinely subjected to assault, rape, sexual slavery, arbitrary imprisonment, torture, verbal abuse, mutilation, even murder—all because they were born into a particular group. Imagine further that their sufferings were compounded by systematic discrimination and humiliation in the home and workplace, in classrooms and courtrooms, at worship and at play. Few would deny that this group had been singled out for gross violations of human rights.

Such a group exists. Its members comprise half of humanity. Yet it is rarely acknowledged that violence against women and girls, many of whom are brutalized from cradle to grave simply because of their gender, is the most pervasive human rights violation in the world today.

Gender violence is also a major health and development issue, with powerful implications for coming generations as well as society in general. Eliminating this violence is essential to constructing the paradigm of human security—and by that I mean peace, peace at home and peace at large. Without it, the notion of human progress is merely a fantasy.

However, opening the door on the subject of violence against the world's females is like standing at the threshold of an immense dark chamber vibrating with collective anguish, but with the sounds of protest throttled back to a murmur. Where there should be outrage aimed at an intolerable status quo there is instead denial, and the largely passive acceptance of 'the way things are'.

Consider a few facts from this dark chamber—facts that leave no doubt that gender violence merits a prominent place on the human rights agenda:

◆ Roughly 60 million women who should be alive today are 'missing' because of gender discrimination, predominantly in South and West Asia, China and North Africa.

◆ In the United States, where overall violent crime against women has been growing for the past two decades, a woman is physically abused by her intimate partner every nine seconds.

◆ In India, more than 5,000 women are killed each year because their in-laws consider their dowries inadequate. A tiny percentage of the murderers are brought to justice.

◆ In some countries of the Middle East and Latin America, husbands are often exonerated from killing an unfaithful, disobedient or wilful wife on the grounds of 'honour'.

◆ Rape as a weapon of war has been documented in seven countries in recent years, though its use has been widespread for centuries.

◆ Throwing acid to disfigure a woman's face is so common in Bangladesh that it warrants its own section of the penal code.

◆ About 2 million girls each year (6,000 every day) are genitally mutilated—the female equivalent of what would be amputation of all or part of the male penis.

◆ More than 1 million children, overwhelmingly female, are forced into prostitution every year, the majority in Asia. In the wake of the AIDS epidemic, younger and younger children are being sought in the belief that they are less likely to be infected.

At first glance, this brutal litany of statistics might seem wildly exaggerated. Yet while it is true that gender violence is a new field of research and studies are often limited in size, it is nonetheless clear that these crimes are, in the main, vastly under-reported. As social scientists are now discovering, the sheer scope and universality of violent acts against women and girls defy even the most educated perceptions.

Equally shocking is the fact that most gender violence not only goes unpunished but is tolerated in silence—the silence of society as well as that of its victims. Fear of reprisal, censorship of sexual issues, the shame and blame of

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Liz Gilbert/Sygma

In Sillakoro (Côte d'Ivoire), female genital mutilation is practised as part of an initiation rite that takes place in a forest. Three months after they were excised, these adolescent girls take part in a ritual ceremony, walking single file into the village from the forest.

those violated, unquestioning acceptance of tradition and the stranglehold of male dominion all play their part. In many countries, so does the active or passive complicity of the State and other institutions of moral authority.

In addition, while gender violence is as old as humanity, it is only in the past decade that it has been publicly recognized, systematically studied and legislated against to any significant degree. In the 1990s, such violence finally gained currency on the international level with its recognition as a human rights issue. That is welcome news, and most of the credit goes to women's groups that have struggled against enormous odds to bring the issue to light. But this is no reason for complacency.

As the second millennium draws to a close, there have been reprisals against the progress in the field—rightly regarded as a challenge to male primacy. Some studies even suggest that certain forms of violence against women and girls are on the rise. For gender violence, in all of its varied manifestations, is not random and it is not about sex. It serves a deliberate social function: asserting control over women's lives and keeping them second-class citizens. Constant vigilance is needed to protect the fragile gains made thus far, to continue along the road to equality—and to bring an end to the torrent of daily violence that degrades not only women but humankind in its entirety.

The intimate enemy

For tens of millions of women today, home is a locus of terror. It is not the assault of strangers that women need fear the most, but everyday brutality at the hands of relatives, friends and lovers. Battering at home constitutes by far the most universal form of violence against women and is a significant cause of injury for women of reproductive age. Yet it is not the sort of act that commands headlines because it happens behind closed doors and because victims fear speaking out. Even in a comparatively open society like the US, research shows that only 1 in 100 battered women ever reports the abuse she suffers. Crime statistics reveal that most women who are raped know their attackers, as do 40 per cent of female murder victims.

Indeed, domestic violence is tragically commonplace. It occurs across education, class, income and ethnic boundaries. A World Bank analysis of 35 recent studies from industrialized and developing countries shows that one quarter to one half of all women have suffered physical abuse by an intimate partner. And while there are not yet enough data to make accurate country-by-country comparisons, the prevalence and pattern of domestic violence are remarkably consistent from one culture to the next. Statistics on rape from industrialized and developing countries show strikingly similar patterns: Between one in five and one in seven women will be victims of rape in their lifetime.

One might assume that the spreading emancipation of women would have diminished the reach of violence. Yet violence in the home has been stubbornly resistant to advances in women's rights. In many Western countries, domestic violence is targeted by law and the media, but it has not summoned the sort of insistent public campaigns as have issues such as driving while intoxicated or smoking.

Further, in most countries today, domestic abuse is officially regarded as a private family matter. While sexual and physical assault are broadly accepted as crimes outside the home, the law in most countries is mute when it comes to attacks within the family nest. Laws that stop at the doorstep of the family are a form of moral hypocrisy. And there are other equally compelling reasons why the issue cries out for urgent and fervent public attention.

First, domestic violence reaches menacingly into the next generation. Children of violent fathers are often physically abused alongside their mothers. In addition, studies show that children of violent parents are more apt not only to repeat that behaviour with their own offspring but to commit violent acts in the larger society. This dangerous cycle must be broken.

Second, there are clear parallels between behaviour within and outside the home. If the systematic oppression of women and girls is tolerated widely at the family level, society at large will be shaped accordingly. Studies strongly indicate that domestic violence is a key component of social problems, including street children, child labour and prostitution.

Third, it is a matter of public health. Violence debilitates women and girls physically, psychologically and socially, sometimes with lifelong results.

Fourth, family violence affects the healthy development and productivity of all societies. Women are now widely accepted as the

cornerstone of sustainable development; protecting their rights and raising their status is essential to endeavours ranging from family planning to food production. Women's aspirations and achievements are powerfully inhibited, not just by the injuries of physical attacks but by the implicit threat of male violence.

This is a lesson learned early, when the shadow of violence begins to restrain a girl's imagination of what she can do and be. The lesson is never forgotten. Where is the woman who has not felt a whisper of fear in the face of male aggression—and limited her activities accordingly?

Harmful traditions

In all societies, poverty, discrimination, ignorance and social unrest are common predictors of violence against women. Yet the most enduring enemies of a woman's dignity and security are cultural forces aimed at preserving male dominance and female subjugation—often defended in the name of venerable tradition.

In industrialized societies like the US, where institutions formally frown on gender violence, behaviour belies official pronouncements: rap music insulting women as 'whores'; a popular men's magazine that celebrates gang rape and depicts female bodies being fed into meat grinders; sexual harassment of women trying to integrate into the armed forces; and societal pressures that induce young women to starve themselves or use technology to create 'ideal' bodies, often destroying their health in the process.

In developing countries, violent practices against women are often recognized and defended as strands of the cultural weave. Wife-beating, for example, is considered part of the natural order in many countries—a masculine prerogative celebrated in songs, proverbs and wedding ceremonies.

At their most extreme, expressions of gender violence include 'honour' killings, female genital mutilation and dowry deaths, as well as a deep-seated, even murderous, preference for male children.

In courts of law, the 'honour defence' is institutionalized in some Middle Eastern and Latin American countries, allowing fathers or husbands to walk away from murder. In 12 Latin American countries, a rapist can be exonerated if he offers to marry the victim and she accepts. In one country, Costa Rica, he can be exonerated even if she refuses his offer. The family of the victim frequently pressures her to marry the rapist, which they believe restores the family's honour.

The concept of male honour—and fear of female empowerment—also underlies the practice of female genital mutilation (FGM). This excruciating procedure removes part or all of a girl's external genitalia and causes lifelong health problems for some women. It is aimed at preserving female chastity and marriage prospects and achieves its purpose at the expense of a woman's sexual pleasure and bodily integrity. Up to 130 million women and girls today in at least 28 countries, mostly in Africa, have had their genitals excised to some degree.

Defenders of the rite, who include many women, call FGM a traditional cultural practice of no business to outsiders. This is an old song. Throughout history, 'culture' has been invoked to justify abhorrent practices ranging from slavery to binding women's feet. FGM must be eradicated because it is a grave human rights violation and a public health menace that transcends any and all cultural boundaries.

Traditions also feed the practice of 'dowry death', in which a woman is killed because she is unable to meet her in-laws' demands for dowry. In India, over a dozen women a day die as a result of such disputes, mostly in kitchen fires designed to look like accidents.

'Son preference' is another insidious force directed against women, particularly in Asia. Genetic testing for sex selection, though officially outlawed, has become a booming business in China, India and the Republic of Korea. Anecdotal evidence suggests that outright infanticide, usually of newborn girls, takes place in some communities in Asia, while discrimination in health care also cuts short the lives of unwanted girl children in some regions.

In 12 Latin American countries, a rapist can be exonerated if his victim agrees to marry him.

In countries where people have adequate health care and food, 105 boys are born on average for every 100 girls, but fewer male babies survive the first year of life, reflecting the female's inherent biological advantage. In some nations, mostly in Asia, the sex-ratio drops dramatically. All told, violent discriminatory practices directed at girls and women have driven an estimated 60 million females off the face of the earth. Yet, instead of an international uproar over these disappearances, the plight of the so-called 'missing women' is usually noted briefly in the women's section of development reports.

As war becomes less a battle between countries and more a struggle for supremacy between ethnic groups, women and girls increasingly face rape and forced pregnancy in times of conflict. Well over 20,000 Muslim women were known to be raped in Bosnia and Herzegovina during the Balkan war, and more than 15,000 women were raped in one year in Rwanda. Just in recent years, mass rape has also been reported as a weapon of war in Cambodia, Liberia, Peru, Somalia and Uganda.

These are but a few of the ways

UNICEF/93-1169/Horner

A repatriated refugee waits with her child in a resettlement camp in Nicaragua. Despite international conventions designed to protect them, women are particularly vulnerable during times of political or ethnic conflict.

that society drives home the message that a woman's life and dignity—her human rights—are worth less than a man's. From the day of their birth, girls are devalued and degraded, trapped in what the late UNICEF Executive Director James P. Grant poignantly termed 'the apartheid of gender'. Long after slavery was abolished in most of the world, many societies still treat women like chattel: Their shackles are poor education, economic dependence, limited political power, limited access to fertility control, harsh social conventions and inequality in the eyes of law. Violence is a key instrument used to keep these shackles on.

UNICEF/95-0484/Linton

Participants in a tailoring programme in the Upper Nile region of Sudan make garments for their community. Skills training programmes help women gain a degree of economic independence, crucial in areas where many women have lost their husbands in armed conflicts.

Changing the status quo

There is nothing immutable about the violent oppression of women and girls. It is a construct of power, as was apartheid, and one that can be changed. But because it has been so deeply ingrained, for so long, in virtually every culture remaining on earth, the effort to dismantle the societal structures that tolerate it, or patently refuse even to see it, will require creativity, patience and action on many fronts.

Stopping violence against women and girls is not just a matter of punishing individual acts. The issue is changing the perception—so deep-seated it is often unconscious—that women are fundamentally of less value than men. It is only when women and girls gain their place as strong and equal members of society that violence against them will be viewed as a shocking aberration rather than an invisible norm.

The old saying that the longest journey begins with a single step applies here. All over the world, many people have begun to take small steps towards establishing full citizenship for women and girls in a just society. They include the husband and wife who refuse to subject their daughter to FGM; the judge who metes out the maximum penalty to a rapist; the young man who participates in a 'take back the night' rally; and the parliamentarians who reform their countries' laws in fulfilment of women's and girls' human rights.

Globally, that first step must be implementation of the Convention on the Rights of the Child (ratified by 190 countries as of May 1997) and the Convention on the Elimination of All Forms of Discrimination against Women, or CEDAW (ratified by 160 countries). Although beliefs and practices do not change magically with the ratification of treaties, they are a vital first step because they lay the groundwork for ongoing social and legal reform.

The Convention on the Rights of the Child is critical because of the broad overlay between women's and children's rights. Gender violence becomes a feature of a girl's life long before adulthood, whether in the home or as part of a broader social pattern of abuse. The Convention obliges ratifying States to take all appropriate measures to protect children from "all forms of physical or mental violence." Specific injunctions target harmful traditional practices, sexual abuse and trafficking in children.

Now that the Convention has been ratified by all but three countries on earth, actions are under way in many nations to make it a real force in children's lives. For example, juvenile justice systems are being reformed in about half the countries in Latin America, and a number of countries, most notably the Philippines, have strengthened laws protecting children against sexual exploitation.

Similar efforts are under way to bring CEDAW to life. In Botswana and Zimbabwe, judges have used CEDAW to prevent discrimination against women in citizenship laws. Brazil has drafted a new Constitution reflecting CEDAW's goals, and Tanzania has reversed a discriminatory customary law relating to clan land. Several Latin American countries and Sweden have established ombudswomen to address women's concerns. At least six countries have set up police stations just for women, and Mexico has appointed a special prosecutor for sex crimes. Cameroon and China recently opened their first shelters for domestic abuse victims. These institutions not only protect women but serve as a constant reminder to all of society that women's rights are an issue of state concern.

These are important steps for women's rights in general and for stopping violence in particular, but so far there are too few steps taking place in too few countries. The majority of countries that have ratified CEDAW have yet to incorporate its principles into domestic law and practice. CEDAW faces deep resistance, as indicated by the fact that it has more substantive reservations entered against it than does any other international treaty. *(See accompanying news story.)*

Implementing these rights must start with the education of girls. Their unequal access to education is one of the most fundamental abridgements of human rights and one that perpetuates their weakened position, making them vulnerable to oppression and ultimately to violence. In addition to the obvious benefits of literacy and numeracy, education gives girls the confidence to make the most of their abilities. The educational system also provides a forum for challenging attitudes about violence—for both boys and girls. In addition, having girls in the classroom sends a potent message to boys about equality.

Girls' education is the assured route to women's economic empowerment. Earning money elevates a woman's self-esteem and her standing in her home and community. It can also propel a woman out of a destructive relationship or encourage her to change its terms.

Building on the famous example of Bangladesh's Grameen Bank, schemes that establish revolving funds to give women small business loans are springing up in all regions. More than 20 countries have begun microcredit programmes that often link loans to social and health services, helping women to care for themselves and their children. The credit is used for such projects as livestock raising, opening small shops and paying school fees. More than 15,000 Cambodian women have obtained small loans, for example, and Viet Nam has seen a dramatic

increase in school enrolment among daughters of borrowers.

Efforts are also under way to end traditional practices that violate women and girls. A number of groups are beginning to have some success in persuading both men and women that FGM claims too high a price. Some clerics have begun to speak out against it, and efforts are under way in the Gambia and Kenya to develop a coming-of-age ritual that does not involve any cutting. Another hopeful sign is recent action by Canada and the US to grant political asylum to some women threatened by FGM in their home countries, thereby defining the practice as a legitimate criterion for refugee status.

Political power is also crucial to women's empowerment. Although a female Head of State does not guarantee equal rights for her sex, women in positions of authority throughout political systems clearly have a beneficial effect, not least by the example they set. But there is far, far to go. And while women have the right to vote everywhere except in six Middle Eastern countries and Brunei Darussalem in South-East Asia, worldwide they hold just 7 per cent of high-level elected and appointed offices in government. *(See league table.)*

Women's climb into the halls of power challenges the existing power structure, and replacing that structure will require the collective efforts not just of women but also of supportive men. The State and other institutions of authority can be indispensable allies.

The 1990s have been a decade of unprecedented achievement in women's human rights. But international recognition of violence against women as a human rights issue did not happen without a struggle. Women had to organize in a global campaign to demonstrate the extent of violence and its impact on their ability to exercise their human rights. The international community was called to witness its own failure to protect women's fundamental right to personal security.

The defining moment of this campaign—the Global Tribunal on Violations of Women's Human Rights—came during the 1993 World Conference on Human Rights in Vienna, where participants sounded a call to eliminate "violence against women in public and private life" and declared that the rights of girls and women are "an inalienable, integral and indivisible part of universal human rights." For an entire day in Vienna, many delegates and others at the Conference listened as 33 women gave riveting personal testimony to the abuses they had suffered.

On the scale of what takes place every day in every community of the world, it was a miniscule but emblematic summary of the anguish long faced by women. But it was apparent, looking around the room, that facts and figures had been transformed into flesh and blood, and the rapt audience was profoundly changed by the experience. The Tribunal marked an official end to the centuries-old cover-up of these atrocities, and it awakened many women and men to the international community's responsibility to protect women from such abuse.

Later that year, in response to the momentum generated in Vienna, the United Nations General Assembly adopted the Declaration on the Elimination of Violence against Women, considered a formal elaboration of CEDAW, which did not itself specifically address gender violence when it was drafted in 1979. This Declaration was a landmark document in three ways: It framed violence against women within the dialogue on human rights; it identified being female as the primary risk factor for violence; and it broadened the definition of gender violence to include all aspects of women's and girls' lives. Another milestone was the 1994 appointment of a UN Special Rapporteur on Violence against Women.

A systematic effort to raise the profile of violence against women must involve every sector of every society—the judicial system, the media, educators, health care authorities, governmental and non-governmental agencies, politicians, religious leaders and, of course, individual women and men. For the most part, it is women's movements with their many non-governmental organizations working across national, cultural, religious and class lines that have initiated and energized the effort.

Few social movements have registered as great an impact in as short a time—and with such remarkably peaceful methods. And yet, these small, determined groups continue to work largely alone. How many government officials have staked their careers on resolving the problem of gender-based violence?

It is time for them to do so. ■

UNICEF/93-1278/Murray-Lee

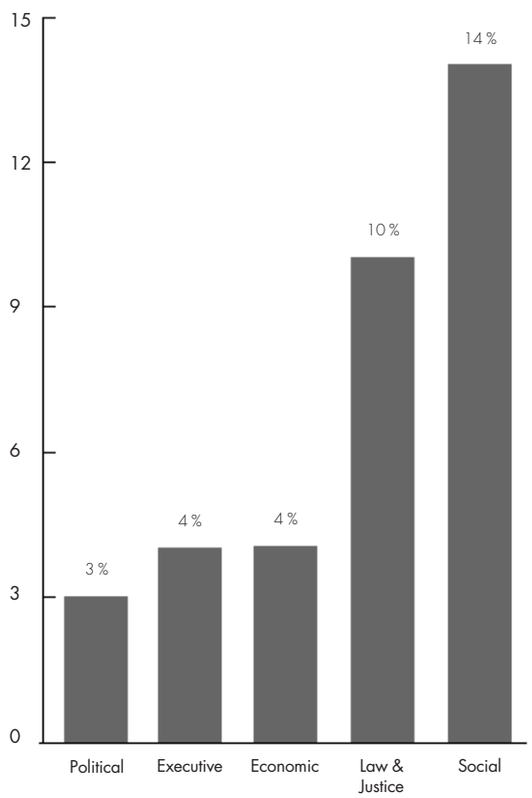
A journalist in training interviews women near Kathmandu. Education for girls and women is a reliable route to economic empowerment and long-term change in the status quo.

WOMEN'S LEAGUE TABLE

WOMEN AT TOP LEVELS OF GOVERNMENT

Bureaucracy has traditionally been a male preserve, and while women are slowly inching their way into government positions, the number of women at senior decision-making levels remains pathetically low. But numbers, though powerful indicators, are not an absolute barometer of inequality. Discrimination against women can end only when there is a sea change in attitudes, when women's inferior status at all levels of society—economic, social and political—is recognized as a travesty and not the norm.

Women at top levels of government worldwide by sector



Women make up only 7% of ministerial positions, globally. Even within this small percentage, they remain heavily concentrated in the areas of social affairs, including education, health and family. The total number of women ministers worldwide in the social category is 14%, whereas the total for political ministerial positions is only 3%, and for executive posts, 4%. Within the economic category, women hold 4% of ministerial positions. They fare slightly better in the areas of law and justice, with 10% of posts.

Source: Derived from data provided by the UN Division for the Advancement of Women, based on January 1996 information from *World Wide Government Directory, Inc.*

SUB-SAHARAN AFRICA

1	Benin	19
1	Eritrea	19
1	Gambia	19
4	Guinea	15
5	Niger	14
6	Angola	11
6	Tanzania	11
6	Uganda	11
9	Burundi	10
9	Ghana	10
9	Mali	10
12	Burkina Faso	9
12	Chad	9
12	Namibia	9
15	Botswana	8
15	Central African Rep.	8
15	Congo, Dem. Rep.	8
15	Côte d'Ivoire	8
15	Guinea-Bissau	8
15	Nigeria	8
15	Rwanda	8
15	Zambia	8
15	Zimbabwe	8
▶	*Regional average*	7
24	Congo	7
24	Ethiopia	7
24	Senegal	7
27	South Africa	6
28	Liberia	4
28	Malawi	4
28	Mauritania	4
28	Mozambique	4
28	Sierra Leone	4
28	Togo	4
34	Cameroon	3
34	Gabon	3
34	Kenya	3
37	Lesotho	0
37	Madagascar	0
37	Mauritius	0
37	Somalia	0

MIDDLE EAST AND NORTH AFRICA

1	Israel	13
1	Syria	7
3	Jordan	6
4	Libya	5
5	Egypt	3
5	Tunisia	3
5	Turkey	3
▶	*Regional average*	2
8	Sudan	2
9	Algeria	0
9	Iran	0
9	Iraq	0
9	Kuwait	0
9	Lebanon	0
9	Morocco	0
9	Oman	0
9	Saudi Arabia	0
9	U. Arab Emirates	0
9	Yemen	0

WORLD AVERAGE

7%

Percentage of women ministers

CENTRAL ASIA

1	Kyrgyzstan	11
2	Azerbaijan	8
3	Tajikistan	4
▶	*Regional average*	*3*
4	Kazakstan	3
4	Turkmenistan	3
4	Uzbekistan	3
7	Afghanistan	0
7	Armenia	0
7	Georgia	0

WHAT THE TABLE RANKS

Percentage of ministerial-level posts, both elected and appointed, held by women.

Women's climb into the halls of power challenges the existing power structure, and replacing it will require the efforts of both women and men.

EAST/SOUTH ASIA AND PACIFIC

1	Australia	15
2	Bhutan	13
2	Sri Lanka	13
4	New Zealand	9
5	Bangladesh	8
6	Viet Nam	7
7	China	6
7	Japan	6
7	Malaysia	6
10	Philippines	5
▶	*Regional average*	*4*
11	Indonesia	4
11	Pakistan	4
13	India	3
13	Korea, Rep.	3
15	Korea, Dem.	1
16	Cambodia	0
16	Lao Rep.	0
16	Mongolia	0
16	Myanmar	0
16	Nepal	0
16	Papua New Guinea	0
16	Singapore	0
16	Thailand	0

Selma Achipala, Counsellor of Namibia's Permanent Mission to the UN.

UNICEF/93-BOU0957/Toutounji

AMERICAS

1	Haiti	29
2	Canada	19
3	Panama	17
4	Mexico	16
4	Nicaragua	16
4	Trinidad/Tobago	16
7	Chile	14
7	United States	14
9	Colombia	13
9	Guatemala	13
11	Costa Rica	11
11	Venezuela	11
▶	*Regional average*	*10*
13	Honduras	10
14	Paraguay	7
14	Uruguay	7
16	Ecuador	6
16	El Salvador	6
16	Jamaica	6
16	Peru	6
20	Brazil	4
20	Dominican Rep.	4
22	Cuba	3
23	Argentina	0
23	Bolivia	0

EUROPE

1	Sweden	38
2	Finland	36
3	Denmark	29
3	Norway	29
5	Austria	24
5	Netherlands	24
7	Ireland	21
8	Spain	17
9	France	15
9	Slovakia	15
9	Switzerland	15
12	Croatia	12
12	Portugal	12
14	Belgium	11
14	Germany	11
14	Latvia	11
▶	*Regional average*	*10*
17	Slovenia	9
17	TFYR Macedonia	9
19	Poland	8
19	United Kingdom	8
21	Hungary	6
21	Yugoslavia, Fed. Rep.	6
23	Albania	5
23	Belarus	5
23	Bulgaria	5
26	Italy	4
27	Russian Fed.	2
28	Bosnia/Herzegovina	0
28	Czech Rep.	0
28	Estonia	0
28	Greece	0
28	Lithuania	0
28	Moldova, Rep. of	0
28	Romania	0
28	Ukraine	0

Source: Derived from data provided by the UN Division for the Advancement of Women, based on January 1996 information from *World Wide Government Directory, Inc.*

Outlawing violence against women: A first step

Legislation against domestic violence has been enacted in 44 countries around the world; 17 have made marital rape a criminal offence; 27 have passed sexual harassment laws; and just 12 countries have laws against FGM.

The few laws that do exist vary significantly in strength and enforceability from one legal system to another. In countries that have not enacted specific laws, it may be possible to prosecute offenders under more general criminal statutes.

Some governments have introduced accessible and well-integrated legal provisions, such as Ecuador's 1995 law against domestic violence—a clear-cut prohibition of physical and mental assaults. Current and former cohabitants and parties in non-marital intimate relationships are included in the legislation, and psychological violence is explicitly defined.

Other laws are more vague: New Zealand has enacted family violence legislation without specific reference to women or girls; in Malawi, a constitutional provision makes a general commitment to implementing policy on domestic violence.

In recent years, sexual harassment has been publicly acknowledged as harmful to women, and countries are taking the first steps by adopting legislation prohibiting it. In the last two years, legislation that directly addresses sexual harassment has been passed in Belgium, Belize, Costa Rica, Finland, France, Ireland, Paraguay, the Philippines and Switzerland. Similar legislation has been proposed in Chile, Italy, Jamaica and South Africa.

Laws that criminalize gender-based violence are positive steps but they offer no guarantees. Worldwide, even where laws are in place, prosecution of perpetrators is rare, and successful prosecutions uncommon.

Countries that have enacted legislation against:

Domestic violence

Argentina
Australia
Bahamas
Bangladesh
Barbados
Belize
Bolivia
Brazil
Canada
Chile
China
Colombia
Costa Rica
Cyprus
Czech Rep.
Denmark
Ecuador
El Salvador
Finland
France
Guatemala
Guyana
Honduras
Ireland
Israel
Italy
Jamaica
Malawi
Malaysia
Mexico
New Zealand
Panama
Paraguay
Peru
Portugal
St. Lucia
St. Vincent/ Grenadines
South Africa
Spain
Trinidad/Tobago
Tunisia
United Kingdom
United States*
Uruguay

Marital rape

Australia
Austria
Barbados
Canada
Denmark
France
Germany
Ireland
New Zealand
Norway
Poland
South Africa
Spain
Sweden
Trinidad/Tobago
United Kingdom
United States*

Sexual harassment

Argentina
Australia
Austria
Bahamas
Belgium
Belize
Canada
Costa Rica
Finland
France
Germany
Guinea
Ireland
Israel
Lesotho
Malawi
Namibia
Netherlands
New Zealand
Panama
Paraguay
Philippines
Spain
Sweden
Switzerland
United Kingdom
United States

Female genital mutilation

Australia
Burkina Faso
Canada
Egypt**
France***
Ghana
New Zealand
Norway
Sudan****
Sweden
United Kingdom
United States

* Legislation enacted by state law.
** No criminal law, but a ministerial decree forbids the practice.
*** By court decision, not specific legislation.
**** 1946 law only prohibits infibulation.

Compiled from various sources, January–May 1997, including R. Boland (editor, *Annual Review of Population Law*, Harvard University); N. Toubia (Director of Research, Action & Information Network for Bodily Integrity of Women); J. Aeberhard-Hodges (International Labour Organization); and *State Responses to Domestic Violence*, Women, Law & Development International, Washington, DC, 1996.

UNICEF/5387-92/Lemoyne

The risk of death in childbirth increases where women lack access to emergency obstetric care. Mother and baby recover from childbirth in a Cambodian hospital.

Risk of death in childbirth can be as high as 1 in 7

Pregnancy and childbirth complications are the leading cause of death and disability for women of reproductive age in developing countries. In Afghanistan, Guinea, Sierra Leone and Somalia, a woman faces a 1-in-7 lifetime risk of dying due to pregnancy or childbirth. But in Spain, Switzerland, Canada and Norway, the risk is 1 in 7,300 or less.

In 17 countries, women face at least a 1-in-10 chance of dying from pregnancy-related causes sometime during their lives. But in 16 countries the lifetime risk is 1 in 4,000 or less. Complications from pregnancy and childbirth kill about 585,000 women each year. A woman faces that danger each time she becomes pregnant, so the more pregnancies she has, the greater the total risk. Lifetime risk of maternal mortality is based on both the risk of dying from maternal causes and the average number of births. No public health problem shows greater disparity between rich and poor countries than maternal mortality.

Most obstetric deaths are linked to five causes: haemorrhage, sepsis (blood poisoning), eclampsia (convulsions leading to coma), unsafe abortion and obstructed labour. A number of interventions—improved emergency obstetric care to deal with serious complications, deliveries performed by skilled birth attendants, family planning, iron folate supplements, a rich and varied diet throughout pregnancy and prompt initiation of breast-feeding—vastly improve the odds.

Lifetime risk of maternal death

Highest risk			
Afghanistan	1 in 7	Ethiopia	1 in 9
Guinea	1 in 7	Mozambique	1 in 9
Sierra Leone	1 in 7	Niger	1 in 9
Somalia	1 in 7	Rwanda	1 in 9
Angola	1 in 8	Eritrea	1 in 10
Yemen	1 in 8	Mali	1 in 10
Bhutan	1 in 9	Nepal	1 in 10
Burundi	1 in 9	Uganda	1 in 10
Chad	1 in 9		

Lowest risk			
Spain	1 in 9,200	Italy	1 in 5,300
Switz.	1 in 8,700	Belgium	1 in 5,200
Canada	1 in 7,700	UK	1 in 5,100
Norway	1 in 7,300	Austral.	1 in 4,900
Sweden	1 in 6,000	Sing.	1 in 4,900
Denmark	1 in 5,800	Nether.	1 in 4,300
Austria	1 in 5,600	Finland	1 in 4,200
Greece	1 in 5,600	Slovenia	1 in 4,000

Regional risk	
Sub-Saharan Africa	1 in 13
Central Asia*	1 in 35
Middle East & N. Africa	1 in 60
East/South Asia & Pacific	1 in 70
Americas	1 in 215
Europe	1 in 1,400
Developing countries	1 in 50
World	1 in 60

* Figure influenced by high rates of fertility and maternal mortality in Afghanistan. If Afghanistan is excluded, lifetime risk of maternal death in Central Asia is 1 in 330.

Source: WHO and UNICEF. *Revised 1990 Estimates of Maternal Mortality, A New Approach by WHO and UNICEF*, April 1996.

A bill of rights for women, but with reservations

Few international treaties have been as widely accepted as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). As of May 1997, 160 countries had ratified, acceded or succeeded to CEDAW. Three—Afghanistan, Sao Tome and Principe and the United States—had signed, indicating their intention to ratify. Thirty States had neither signed nor ratified.

But CEDAW, like its companion treaty on the rights of the child, has provoked scores of reservations—indicating widespread and deep-rooted resistance to the concept of full equality for women. Nearly one third of States parties have lodged substantive reservations or declarations, signalling they will not be bound by certain CEDAW provisions—ranging from equality in nationality and citizenship and in sharing family property to women's participation in the military and the clergy. A few nations, including Malaysia, Maldives, Morocco, Pakistan and Tunisia, have gone much further, filing general reservations to any portion of the Convention that conflicts with existing national, customary or religious law.

Many of these reservations appear to violate the 1969 Vienna Convention on the Law of Treaties, which prohibits reservations that are incompatible with the object and purpose of a treaty. Particularly disturbing are reservations from 24 nations against article 16, a core provision that guarantees equality between women and men in marriage and family life.

Such reservations strike at the heart of CEDAW. They reject the extension of human rights protection into the private domain and entrench the inferior role of women. Similarly undermining the purpose of CEDAW are most of the dozen reservations to article 2, which outlines legal steps to eliminate gender discrimination.

Although reservations come from every corner of the globe, a few generalizations can be drawn. The five Nordic countries comprise the only region to accept CEDAW without reservation. The Caribbean countries have lodged fewer reservations than countries in other regions.

Most of the 12 ratifying States in the Middle East and North Africa cited conflict with religious or customary law as a reason for not giving CEDAW unconditional approval. Most of the region's nations defer to Islamic Sharia law on matters pertaining to family or the status of women. However, the CEDAW review committee has been able, through constructive dialogue, to address reservations with individual States parties.

It is encouraging that some nations have modified or withdrawn their reservations, often as a result of this constructive relationship. For example, Malawi withdrew, in 1991, its general reservation against provisions of CEDAW that required immediate eradication of certain traditional customs and practices and, in 1994, Brazil withdrew its reservations to key provisions of article 16.

Lagging on CEDAW

Signed but not ratified

Afghanistan
Sao Tome/Principe
United States

Not signed, not ratified

Bahrain
Brunei Darussalam
Cook Islands*
Djibouti
Holy See
Iran
Kazakstan
Kiribati
Korea, Dem.
Marshall Islands
Mauritania
Micronesia, Fed. States of
Monaco
Myanmar
Nauru
Niger
Niue*
Oman
Palau
Qatar
San Marino
Saudi Arabia
Solomon Islands
Somalia
Sudan
Swaziland
Syria
Tonga
Tuvalu
U. Arab Emirates

*CEDAW extends to these countries through New Zealand's ratification.
Source: UN Office of Legal Affairs, May 1997.

Help wanted: Skilled birth attendants

Barely half the mothers in developing countries deliver their babies under the supervision of a physician, nurse or other professional with midwifery skills, a key factor in ensuring survival of both babies and mothers.

Countries with the lowest rates of professionally attended births also share some of the world's worst maternal mortality rates. Of the 38 countries listed, nearly two thirds have rates of at least 900 maternal deaths per 100,000 live births. Somalia, the country with the lowest percentage of professionally attended births (2%), has a maternal mortality rate of 1,600 per 100,000 births. Next on the chart are Afghanistan and Nepal, both with 9% of births attended by a skilled professional and with maternal death rates of 1,700 and 1,500, respectively.

UNICEF/5889-92/Lemoyne

The use of skilled birth attendants (doctors, nurses and midwives) helps reduce the risk of death from pregnancy and childbirth complications.

Many of these countries suffer from the common burdens of poverty and war. Despite poverty, though, some countries are making progress. Thirteen nations with per capita GNP of less than $500 have managed to achieve rates of 50% or more of births attended by skilled professionals.

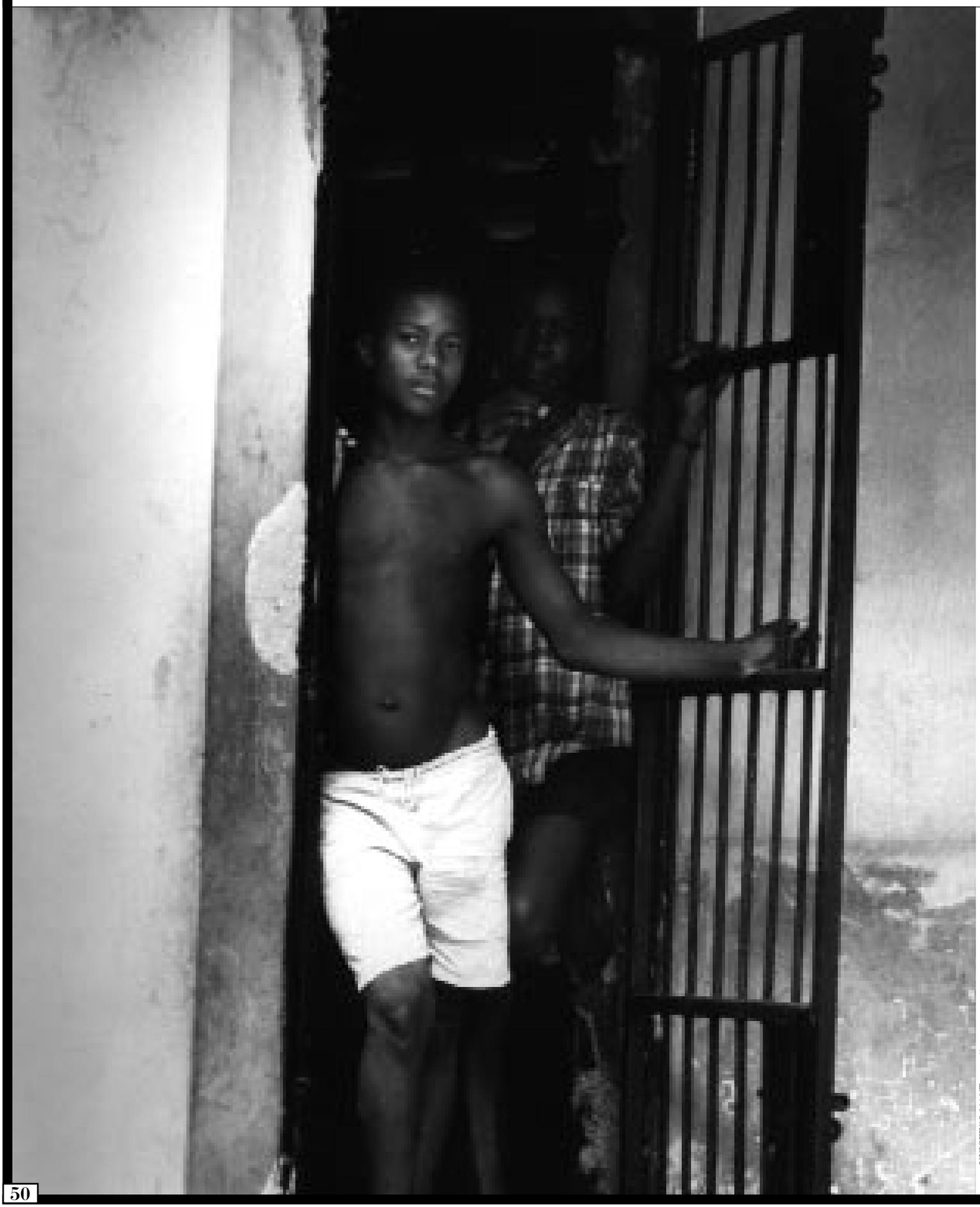
History has shown that the presence of skilled birth attendants is a key factor in bringing down the number of maternal deaths. Of the 46 countries in which trained professionals attend 90% or more of births, only 5 have maternal death rates above 100 per 100,000 live births. In the industrialized countries, 99% of births are professionally attended.

Risky childbirth

Countries with less than 50% of births attended by skilled birth attendant

	%		%
Somalia	2	Guinea	31
Afghanistan	9	Nigeria	31
Nepal	9	India	34
Bangladesh	14	Guatemala	35
Ethiopia	14	Indonesia	36
Bhutan	15	Uganda	38
Chad	15	Lesotho	40
Niger	15	Mauritania	40
Yemen	16	Morocco	40
Burundi	19	Burkina Faso	42
Pakistan	19	Gambia	44
Papua N.G.	20	Ghana	44
Eritrea	21	Benin	45
Haiti	21	Côte d'Ivoire	45
Mali	24	Kenya	45
Mozambique	25	C. African Rep.	46
Rwanda	26	Egypt	46
Guinea-Bissau	27	Senegal	46
Cape Verde	30	Bolivia	47

Source: WHO, Maternal and Newborn Health and Safe Motherhood Programme (1986–1996 data), *Coverage of Maternity Care*, 1997.



UNICEF/95-1008/Toutounji

No age of innocence: Justice for children

Lisbet Palme

Whether due to government paternalism or to simple disregard for their rights, juveniles who come into conflict with the law often face justice systems that treat them capriciously and offer fewer protections than they offer adults. Children in many countries face the wrath of the law for the 'crimes' of being poor, neglected or abused. Regardless of the reasons for their offences, young people are entitled to fair treatment at the hands of juvenile justice systems that are designed to aid youngsters' return to productive society as quickly as possible.

No one can question the notion that children are entitled to the fundamental necessities of life: love and nurturance, food and shelter, health care and education. But the understanding and acceptance of another fundamental entitlement—due process of law—is harder to come by. Few countries take seriously a young person's right to fair treatment at the hands of the justice system; few adults even realize that juveniles have this right. When young people come into conflict with the law, instead of finding compassion and help, they often face harsh punishment, and without the legal protections that adults have.

Sometimes young offenders are penalized just as if they were adults, with the maturity and experience to distinguish between right and wrong on a grown-up level. Sometimes they face even worse: Adults must be accused of breaking the law before they can be legally detained, but in many countries a judge can put children in jail simply because of 'irregular conduct'—they are dirty or are sleeping on the street or have lost their identity papers.

Sometimes the authorities put a benevolent face on the punishment, incarcerating children 'for their own protection'. In India, for example, police can apprehend young people if they are "likely to be abused or exploited for immoral or illegal purposes or wrongful gains"—in other words, any child who is poor is liable to be victimized by the criminal system in the name of altruism.

And sometimes juveniles in detention are abused physically and sexually, in some cases even tortured, by those who are supposed to guard them.

This treatment is inhumane, and it is inconsistent with the Convention on the Rights of the Child, which was adopted by the United Nations General Assembly in 1989 and has been ratified by all but three countries on earth (Cook Islands, Somalia and the United States). When young people come into conflict with the law, they need help, not retribution.

I was only 20 years old when I started to work for and with children in detention. My experience over the years has only strengthened my conviction that we must develop juvenile justice systems that are compassionate and rational. Our children are entitled to fair treatment, and society as a whole will benefit when they receive it.

Injustice to juveniles

Let us be clear about this: Juveniles are being subjected to grave injustices at every moment in countries around the globe. In Jamaica, children as young as 10 are held for indeterminate periods of time, often with adults, in dank detention cells. In Egypt, children who work as prostitutes are not only sexually exploited for commercial purposes but are criminalized and also face harsher penalties than adult sex workers. In Rwanda, youngsters below the country's age of criminal responsibility (14) are imprisoned in connection with the nation's recent genocide.

In Australia, aboriginal children are incarcerated at 18 times the rate of non-aboriginals. In Sudan, children are subject to punishments that include flogging, amputation and execution. In Kenya, up to 120 children a week find themselves in Nairobi's juvenile court for the 'crime' of being homeless. The majority of children in the West Bank who are sentenced according to Israeli security laws have no legal right to a lawyer.

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COMMENTARY

In just the past 15 years, nine countries are known to have put offenders to death for crimes they committed as juveniles. In the US, 137 juveniles have been sentenced to death since 1973, and nine of them have been executed for crimes committed when they were under 18. While China has outlawed capital punishment for children under 18, in practice 16-year-olds can be sentenced to death—although the sentence is suspended until they reach 18.

Young people accused of heinous crimes comprise a tiny percentage of the juveniles who come into contact with the criminal justice system. The tragedy is that the great majority of juvenile offenders have committed minor crimes or are guilty of nothing at all. Many of those held in custody have not even been convicted—they are simply awaiting trial, sometimes for extremely long periods of time. In Lebanon, for instance, 90 per cent of incarcerated children are waiting to be tried, some for as long as two years.

The percentage of children who are in custody is one indication of how effectively countries are dealing with young offenders. In Italy, with a population of 57 million, about 650 juveniles are being detained on a typical day. But in the US, with a population just 5 times greater than Italy's, 150 times more children are detained—almost 100,000 young people. This wholesale locking away of young people cannot be justified on any terms.

Most countries take a passive attitude towards juvenile justice, as evident from the lack of accountability. Very few governments even keep track of how many children are involved with the criminal justice system. Any country's national statistics office can tell you the percentage of children who were born underweight, have been immunized, are enrolled in school. But ask what percentage of children are incarcerated and in most cases you will receive no precise answer. How can we possibly be caring properly for our children if we lack such fundamental information?

Governments around the world have agreed to track statistics on child health and development as a way to support their children's progress. Governments must develop similar indicators about how their young people fare in the justice system. At a minimum, every country should know how many children are being held, for how long and why.

The roots of conflict

I believe fervently that youthful offenders are made, not born, and that the vast majority would not be made if troubled young people had the benefit of loving nurturance from supportive parents, schools (including pre-schools) and communities. When that support is wanting, they should come under the care of youth guidance authorities. Most children fall into conflict with the law because such assistance is simply not available or does not operate properly.

Impoverished young people experience society's linkage between poverty and crime from an early age. Many of them become involved with the police and the justice system simply because they appear poor or socially undesirable, or because they 'look' dangerous—not because they have broken any law.

You don't have to probe very far into the backgrounds of children who wind up in police stations and courtrooms to find a common denominator: poverty. In developing countries, poverty often forces children out of the house when they are as young as 10, sometimes even younger. They may never have had the opportunity to go to school, or may have attended irregularly or been 'pushed' out, their performance hindered by hunger or distance from the school. Civil unrest may have forced them to flee their rural home for the city, where they arrived without papers and became separated from family members or friends.

At any rate, these young people are probably living on the street, where destitution may lead them to steal from a shop, pick someone's pocket or barter the only thing they own—their bodies—for survival.

In the industrialized countries, many young people are surrounded by wealth but live in deprivation, taunted by the unattainable riches of a consumer society. Growing up in neighbourhoods where every corner has its drug dealer, and lacking the role model of grown-ups who go to legitimate jobs every morning, some find it impossible to resist the temptation of the drug trade's easy money. Eventually the police catch up with them. That is often the start of a life in which they know their probation officers better than their teachers.

These children have been discarded by their families and their societies, and they hear that message loud and clear. With the gap between the rich and the poor continuing to grow, we can expect to see even more 'discarded' children in the coming years.

The US, with just 5 times the population of Italy, has 150 times more children in detention.

A decision by a police officer or a judge to detain a child on the basis of some vague infraction like vagrancy or suspicion of misconduct can expose him or her to callous injustice or to a system that is overloaded, uncaring and often designed for adults. When poor children are accused of more serious crimes, they typically receive the inferior services of overworked lawyers—if they get any legal representation at all. Once stigmatized by a criminal record, these juveniles become scapegoats for the complex problems that adult society has been unable to solve.

On the other hand, some young people who should be handled by the justice system escape it altogether. In most societies, well-to-do parents can often make use of social connections to 'take care of' any charges brought against their children when they come into conflict with the law, even when the accusations are serious.

The first step towards ensuring fair justice for all juveniles is identifying the 'many'—those in need of social services—and separating them from the criminal justice system so it can function for the 'few'—the serious offenders. The involvement in the justice system of children whose only 'crime' is poverty also pads the juvenile crime statistics, which in turn inflame media accounts of marauding young offenders.

When responsibility begins

All countries have an age at which people become adults in the legal sense of the word—they can vote, sign legal contracts, marry. But the Convention on the Rights of the Child calls for countries to establish a minimum age below which young people "shall be presumed not to have the capacity to infringe the penal law"—in other words, an age below which they are too young to be responsible for their actions and therefore too young to face criminal sanctions.

But this age varies widely, and in many cases it is far too young: The age of criminal responsibility is 7 years in, for example, Bangladesh, India, Ireland, Jordan, Liechtenstein, Myanmar, Nigeria, Pakistan, South Africa, Sudan, Switzerland, Tanzania and Thailand. Under

common law, the age is also 7 in most US states. A child barely old enough to go to school cannot possibly have the maturity to understand the consequences of his or her behaviour. *(See accompanying news story.)*

Given that such young children can be subject to the penal code, it is all the more important that each country establish a humane and constructive juvenile justice system. Such a system is designed to deal with young offenders until they reach the age of adulthood. In an ideal world it serves as a safety net, catching children who commit petty offences and, instead of locking them away, helping them learn a sense of responsibility for their actions. The system should be based on knowledge of child development. At the same time, the juvenile justice system must protect society from potentially dangerous criminals.

In many countries, a few brutal, highly publicized crimes by young people have led to public demands to lower the age at which children are held criminally responsible. Government leaders must resist the temptation to reduce the juvenile justice system to a structure for retribution designed for the rare hardened child criminal. Glib slogans like 'Adult time for adult crime' betray the very people that society has failed and encourage 'warehousing' of juveniles—in prisons that in reality serve as training grounds for criminals.

The Convention on the Rights of the Child requires that children who are deprived of their liberty, or incarcerated, be treated with humanity and respect for their dignity. This young boy is in a children's detention centre in Moscow.

Preventing juvenile crime

There is no question that preventing crime is preferable to punishing it. Never is that more true than in the case of juvenile delinquency, so often a cry for help from a troubled youngster.

The UN Guidelines for the Prevention of Juvenile Delinquency, known as the 'Riyadh Guidelines', recognize the importance of preventing young people from being stigmatized by the justice system. The Guidelines call for the development of measures that "avoid criminalizing and penalizing a child for behaviour that does not cause serious damage to the development of the child or harm to others." This statement sends a profound message: Preventing juvenile delinquency or crime is not just a matter of protecting society—its aim is to help children overcome their misdeeds and fulfil their potential. It is also less costly and more efficient for society to prevent young people from starting on criminal careers than to pay for the outcome of criminal behaviour.

Many programmes have been established to help young people. In the Canadian province of Ontario, a Reasoning and Rehabilitation Project run by probation officers helps juveniles to modify impulsive behaviour and learn alternative responses to interpersonal problems. Recidivism has fallen dramatically among the participants. In the Netherlands, Project HALT requires vandals to personally compensate their victims but in such a way that avoids stigmatizing them with the label of 'criminal'.

In Morocco, children's clubs in four cities offer recreational and cultural activities for urban children aged 7 to 12. The clubs also offer moral support and guidance to help young people remain in school.

The Philippines has a programme, begun in 1986, that focuses on substance abuse, sexual exploitation and children in conflict with the law. Active in 32 cities, it includes a range of activities to support street children and prevent juvenile delinquency. Belgium, Israel and the Netherlands all have a Children's Rights Shop where young people can find help for problems relating to the law and their rights.

Young people who commit offences should bear the responsibility for their actions—but they must be held accountable in a manner appropriate to their level of maturity. Treating the few serious offenders fairly but firmly will take the heat off the many who are unfairly labelled as delinquents or worse.

Those who are found guilty need help to reintegrate into society, to develop opportunities leading to a meaningful life. They also need the best professional help that society can provide. The countries with the best juvenile justice records are those that keep contact between youth and the police, courts and jails to a minimum.

Many countries have far to go. For example, England sometimes incarcerates its young offenders for indeterminate periods. The Russian Federation has no juvenile courts, judges, prosecutors or lawyers. In Yemen, the law allows

In a German detention facility, a young man marks off the time remaining in his sentence.

for the arbitrary detention of children.

Societies may differ as to how they interpret fundamental human values, but in all societies the expectation of responsible behaviour increases as a child grows. We cannot legitimately expect a seasoned, mature understanding of the subtleties of right and wrong from adolescents, especially those who have suffered from abuse or neglect. Article 39 of the Convention specifically calls for countries to take measures to promote the recovery and social reintegration of such child victims. We are dealing with human beings who are still developing. Our goal must be to help mend what has gone wrong and prepare them for later success—not simply to punish them.

Real justice for juveniles

Fortunately, we have a useful tool for developing our juvenile justice systems: the Convention on the Rights of the Child. It establishes broad rights for children, and ratifying countries pledge to reform their laws to fulfil those rights. Among its many benefits, the Convention has served as a wake-up call to countries that have not adequately addressed the issue of juvenile justice.

The Convention, which defines children as people below the age of 18, lays out specific guidelines for the treatment of any child who runs afoul of the law. Among its provisions, children are presumed innocent until proved guilty and are entitled to appropriate legal counsel and fair resolution without delay. It stipulates that children accused of infringing the penal code must be treated in a way that promotes their sense of dignity and takes into account the desirability of assuming a constructive role in society. It prohibits cruel, inhuman or degrading punishment, including capital punishment or life imprisonment without possibility of release. It stresses that detention should only be a measure of last resort and only for the shortest period of time.

The underlying message is clear: The best interests of the child must be at the heart of any juvenile justice process. For those young people found guilty of criminal behaviour, the emphasis should be on reintegration, not retribution.

Along with the Convention and the Riyadh Guidelines (adopted in 1990), we have guidance from the UN Rules for the Protection of Juveniles Deprived of their Liberty (1990) and the Standard Minimum Rules for the Administration of Juvenile Justice (1985), also known as the 'Beijing Rules'. The Beijing Rules provide guidance to member States in developing measures to protect the human rights of children in conflict with the law. Underscoring once again the importance of placing the child's best interests at centre stage, the first of the Fundamental Perspectives of these rules is: "Member States shall seek, in conformity with their respective general interests, to further the well-being of the juvenile and her or his family."

Reasoned responses

Prodded by the Convention, many countries are beginning the process of making their laws responsive to the needs of juvenile offenders. In Latin America, a remarkable reform of juvenile justice has been under way since 1990, paralleling the region's dramatic democratization process. Brazil led the way with its Statute for Children and Adolescents, adopted following a fervent outcry provoked by widely publicized violence against children who were living on the streets.

The Statute sets out strict guidelines to ensure the rights and freedoms of juveniles in conflict with the law, including a specification that detention be used as a last resort and only for the shortest appropriate period of time. Bolivia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Guatemala and Peru have also enacted such measures, and reform is under consideration in Chile, Colombia, Nicaragua and Paraguay.

Young people must be held accountable for their offences in a manner appropriate to their level of maturity.

In a first step towards more progressive laws, Chile passed a measure in 1994 that prohibits incarceration of juveniles in adult prisons. By 1996, the number of juveniles held in adult institutions had fallen by more than half, to less than 2,000. In Costa Rica, about 140 juveniles were deprived of their liberty before passage of reform legislation in 1996. After its passage, the number dropped to 40. This is the result of rationalizing the system so that those accused of minor offences receive the help they need for successful reintegration into society, leaving only serious offenders in detention.

One example of a reasoned approach to juvenile justice is New Zealand's The Children, Young Persons and Their Families Act of 1989. The legislation aims to separate welfare issues from justice issues and to mete out justice through consensus, rather than heavy-handed government intervention. The measure recognizes the special needs of young people by involving family members in the justice process and bringing in outside agencies that can offer real rehabilitation alternatives. The majority of youth are diverted from criminal courts and confinement institutions.

In addition, New Zealand's process underscores the value of partnerships. By involving non-governmental organizations (NGOs), outside legal counsel and young people and their families, the juvenile justice system remains open. This openness reinforces something that young people need to know: The door into that system swings both ways—it does not lock forever behind them.

A unique opportunity for reform arose in South Africa with the swift ratification of the Convention on the Rights of the Child in 1995 and President Nelson Mandela's enthusiastic endorsement of the Convention. The process combined the framework of international instruments with traditional African methods of conflict resolution. Based on the spirit of *ubuntu*, or community approach, these strategies encourage the participation of the child, family and community.

Likewise in Namibia, independence and the ratification of the Convention provided an opportunity to further juvenile justice reform. Efforts began after a 1993 study found that 90 per cent of children had been sentenced

without legal representation, and those sentenced to serve time were being sent to adult prisons. Now, a screening process has been established to divert juveniles in the capital, Windhoek, away from the justice system where possible. The condition is that they complete a life-skills course, which teaches responsible decision-making. Young people are increasingly being held separately from adults in Namibia, and a police training manual has been prepared to assist in developing the skills of law enforcement officials in dealing with juveniles.

With the adoption of a Child Protection Code in 1996, Tunisia embarked on an effort to create a culture of child rights throughout the country. The Code requires that children in conflict with the law be consulted and that their cases be heard in juvenile courts presided over by specially trained judges.

In Scotland, offenders under age 16 appear before a 'children's hearing', which is not considered a court of law and has no punitive options. In the West Bank, lawyers from Defense for Children International (DCI-Israel and DCI-Palestine) have worked together to represent minors in Israeli and Palestinian courts. Although there is not yet a juvenile justice system in Gaza, a cooperative training project of DCI-Israel and Palestinian Lawyers for Human Rights has provided training to build such a system.

For the most part, I am proud of the attention my country, Sweden, has given to juvenile justice. The system emphasizes care by social service agencies for anyone under 21. Children under 15 may not be sentenced under the penal code, and only in rare cases is imprisonment allowed for a child under 18. A prison sentence is allowed for young people between 18 and 21 only if the crime is especially serious, and life imprisonment is not permitted for a crime committed by anyone younger than 21. However, in recent years we have seen a number of heinous crimes committed by young people in Sweden. In these cases the courts have seen no alternative to a prison sentence. A recent government report has proposed new alternatives for these offenders, such as special youth homes.

Some countries have so far faltered in their attempts to reform their juvenile justice systems. India's Juvenile Justice Act of 1986, designed to promote uniform treatment on the basis of minimum UN standards, has faced spotty implementation. The Act supports separate systems for handling destitute children and delinquent children, promotes humane and non-institutional services and emphasizes NGO participation. But in action it has not proved to be very child-friendly. Officials who deal with children have not been adequately trained, and while the State is empowered to take charge, it is not obligated to care and protect.

In at least 15 countries, 7-year-old children can be held responsible for criminal actions.

The Lao People's Democratic Republic has not developed a system of juvenile justice. Eritrea incarcerates children from age 12 together with adults. Fiji's Juvenile Act of 1974 establishes separate courts and detention centres for children. But the reform undermined some of the compassionate aspects of the traditional courts, and efforts are under way to re-establish them.

The Committee on the Rights of the Child, to which countries report on their efforts to implement the Convention, has expressed concern about juvenile justice procedures in a number of countries. Based on a review of reports from 51 countries, the Committee explicitly suggested legal reform in 37 countries. Obviously there is much to be done, but I am encouraged by the fact that juvenile justice is finally on the world's agenda.

The path to adulthood is uncharted. As young people travel it, they must negotiate around more obstacles than ever before. Sometimes they stumble. When they come into conflict with the law, they have the right to fair treatment by a justice system designed for rehabilitation, not retribution. The creation of that system is a responsibility that we all must carry on our shoulders. If we do not, who will? ■

When young people come into conflict with the law, they need to know that the door into the justice system swings both ways—it does not lock forever behind them. In Cleveland (US), a teenager is held in a juvenile detention centre.

Old enough to be a criminal?

Children below a certain age are too young to be held responsible for breaking the law. That concept is spelled out in the Convention on the Rights of the Child, which calls for nations to establish a minimum age "below which children shall be presumed not to have the capacity to infringe the penal law." But the Convention does not set a specific age, and it varies greatly.

International standards, such as the Beijing Rules for juvenile justice, recommend that the age of criminal responsibility be based on emotional, mental and intellectual maturity and that it not be fixed too low.

The Committee on the Rights of the Child, which monitors countries' implementation of the Convention, has recommended that the age be guided by the best interests of the child.

In the US, the age of criminal responsibility is established by state law. Only 13 states have set minimum ages, which range from 6 to 12 years old. Most states rely on common law, which holds that from age 7 to age 14, children cannot be presumed to bear responsibility but can be held responsible.

In Japan, offenders below age 20 are tried in a family court, rather than in the criminal court system. In all Scandinavian countries, the age of criminal responsibility is 15, and adolescents under 18 are subject to a system of justice that is geared mostly towards social services, with incarceration as the last resort. As of April 1997, only 15 juveniles were serving a prison sentence in Sweden.

In China, children from age 14 to 18 are dealt with by the juvenile justice system and may be sentenced to life imprisonment for particularly serious crimes.

In most countries of Latin America, the reform of juvenile justice legislation is under way. As a result, the age of adult criminal responsibility has been raised to 18 in Brazil, Colombia and Peru. Children from age 12 to 18 are held responsible under a system of juvenile justice.

The wide variation in age of criminal responsibility reflects a lack of international consensus, and the number of countries with low ages indicates that many juvenile justice systems do not adequately consider the child's best interests.

Age of criminal responsibility is just one variable influencing how juveniles are treated by justice systems. Other variables include whether there is a separate juvenile law based on child rights; whether a young person is subject to punitive sanctions or only to socio-educational measures; and whether the country has separate court systems and jails for young people. A juvenile justice system provides legal protections and an objective standard for treatment. In its absence, young people may be handled by the adult criminal justice system or be held in 'protective' custody, where they have no legal protections and may face arbitrary or harsh treatment.

Age of criminal responsibility

Minimum age at which children are subject to penal law in countries with 10 million or more children under 18 years old

Mexico	*6–12	Indonesia	8	Korea, Rep.	12	Russian Fed.	14
Bangladesh	7	Kenya	8	Morocco	12	Viet Nam	14
India	7	UK (Scotland)	8	Uganda	12	Egypt	15
Myanmar	7	Ethiopia	9	Algeria	13	Argentina	16
Nigeria	7	Iran	***9	France	13	Brazil	****18
Pakistan	7	Philippines	9	Poland	13	Colombia	****18
South Africa	7	Nepal	10	Uzbekistan	13	Peru	****18
Sudan	7	UK (England)	10	China	14	Congo, D. Rep.	–
Tanzania	7	UK (Wales)	10	Germany	14		
Thailand	7	Ukraine	10	Italy	14		
United States	**7	Turkey	11	Japan	14		

* Most states 11 or 12 years; age 11 for federal crimes.
** Age determined by state; minimum age is 7 in most states under common law.
*** Age 9 for girls, 15 for boys.
**** Official age of criminal responsibility; from age 12 children's actions are subject to juvenile legal proceedings.
Sources: CRC Country Reports (1992–1996); *Juvenile Justice and Juvenile Delinquency in Central and Eastern Europe*, 1995; United Nations, *Implementation of UN Mandates on Juvenile Justice in ESCAP*, 1994; Geert Cappelaere, Children's Rights Centre, University of Gent, Belgium.

Over 7 million children are refugees

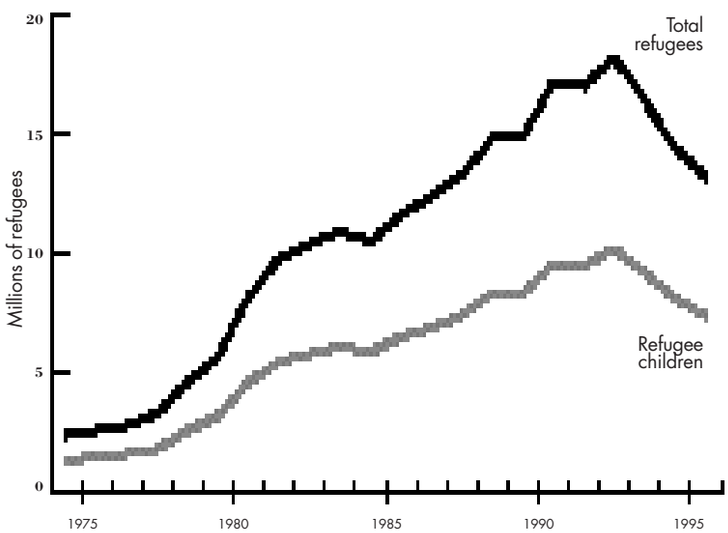
More than half the world's refugees are children under 18 years of age, according to estimates based on a survey by the Office of the UN High Commissioner for Refugees (UNHCR). Although the number of child refugees worldwide has declined from a record 10.2 million in 1993, at 7.4 million it is still greater than the entire population of Switzerland.

Of a total 13.2 million refugees, the greatest number, 2.7 million, have fled Afghanistan. Bosnia and Herzegovina is the home country of the second highest number, 1 million.

Iran is sheltering the largest number of refugees, with 2 million people from Afghanistan and Iraq. Pakistan, the second-ranking country of asylum, currently has 1.2 million refugees from Afghanistan.

Refugees—those crossing national borders to seek safety—represent about one third of the total number of people uprooted by conflicts or persecution. UNHCR estimates that the remaining two thirds, more than 30 million people, are displaced within their own countries. If the proportion of children among the internally displaced is similar to that among refugees, then the combined total of uprooted children worldwide is over 20 million. The internally displaced face many of the same hardships as refugees but are often cut off from assistance from relief organizations.

Global refugee population, 1975–1996



Note: Children (aged 0-17 years) comprise 56% of total refugee population, extrapolated from demographic data on sample of 4 million refugees.
Source: UNHCR, *UNHCR at a Glance*, February 1997; and UNHCR, *The State of the World's Refugees: 1995*.

Hidden killers

In more than 60 countries around the world, over 115 million anti-personnel landmines threaten lives and limbs. Approximately 2.5 million new mines are laid each year.

Egypt has the largest number of mines, an estimated 23 million—a legacy of World War II and subsequent Arab-Israeli wars. Iran has 16 million mines, the second highest number, followed by Angola with 15 million. Bosnia and Herzegovina is the most heavily mined country, with 152 mines per square mile. Together, Afghanistan, Angola and Cambodia have suffered 85% of the world's landmine casualties.

Mine clearance is dangerous and costly: An anti-personnel landmine costs as little as $3 to manufacture, but as much as $300 to $1,000 to remove. The pace of de-mining lags far behind that of new mines still being placed. Only about 15.6 million mines have been cleared (most of these in Egypt), just 13% of the number in place. The cost of removing all the active mines worldwide is estimated at $33 billion.

A landmine kills or maims a person every 20 minutes—more than 25,000 people a year. Of these victims, 5,000 to 6,000 are children. Angola has about 70,000 amputees, including 8,000 children—one amputee for every 154 persons. Most casualties are civilians killed or injured after hostilities have ended.

Hope for curbing this deadly plague centres around 'the Ottawa process'. This initiative was launched with a global NGO coalition calling for action at a conference last October, when Canada invited every country to return to Ottawa in December 1997 to sign a treaty forbidding the production, use, stockpiling or export of anti-personnel landmines. About 60 countries support this total ban, while others have indicated partial support.

Existing and cleared landmines (estimated)

	Mines remaining	Mines cleared
Egypt	23,000,000	11,000,000
Iran	16,000,000	200,000
Angola	15,000,000	80,000
Afghanistan	10,000,000	363,000
Cambodia	10,000,000	62,000
China	10,000,000	280,000
Iraq	10,000,000	21,000
Bosnia/Herz.	6,000,000	–
Viet Nam	3,500,000	59,000
Croatia	3,000,000	250,000
Mozambique	3,000,000	17,000
Other countries	6,214,000	3,228,000
Total	**115,714,000**	**15,560,000**

Source: UN Department of Humanitarian Affairs, January 1997.

The cost of war: Billions for development diverted to emergencies

Wars are doubly destructive, shattering lives and societies and also forcing reallocation of resources that could be used for longer-term development. Sorely needed development aid has been increasingly shifted to emergency assistance during the past decade—and even resources for emergency aid have fallen short of people's needs.

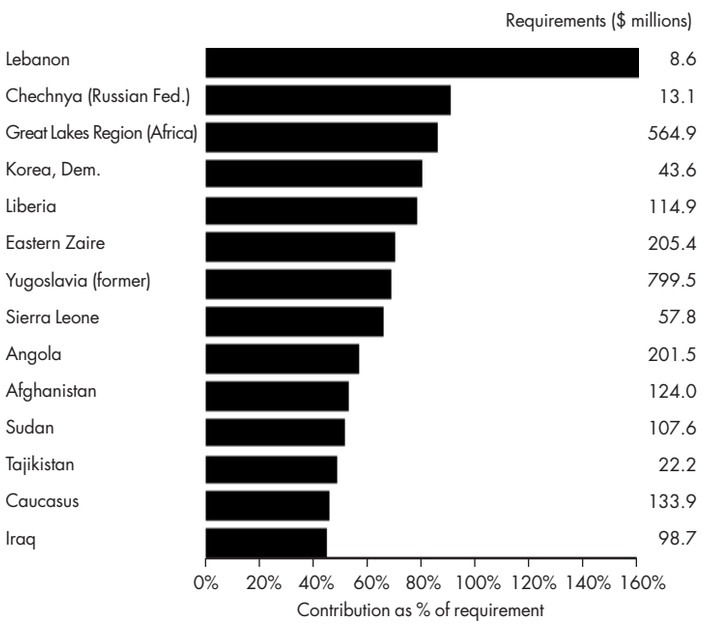
Government allocations for peace-keeping and contributions for emergency humanitarian assistance (most of it due to war rather than natural disasters) increased fivefold, from less than $2 billion in 1985 to nearly $10 billion in 1994, reflecting an upsurge in conflicts that have had a devastating impact on civilians, especially children.

Despite this dramatic increase, contributions to UN agencies for emergency aid have consistently fallen short of the amounts requested. During 1992–1996, donors' response to UN emergency appeals fell short by an average of 28%. Of the appeals for 14 countries in 1996 and early 1997, contributions for 13 countries fell short of the amounts required. The request for aid to Iraq had the greatest shortfall, almost 60%.

UNICEF and other agencies strive to integrate emergency programmes into longer-term development efforts, providing immunizations, for example, and 'school-in-a-box' kits so that children can continue learning. Despite these efforts, however, conflicts undermine development.

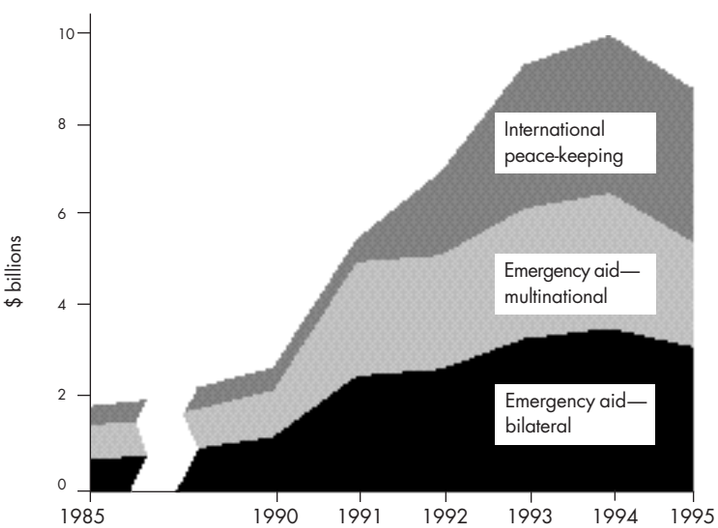
In 1985, allocations for emergency aid and peace-keeping were equivalent to 5% of total development aid from industrialized countries. By 1994, these allocations had reached over 16% of their total aid. This means that tens of billions of dollars that could have been available for long-term development have been shifted to help alleviate the human costs of war.

UN humanitarian assistance appeals



Note: Refers to appeals with end dates in 1996 or early 1997.
Source: UN Department of Humanitarian Affairs Web site at http:www.reliefweb.int, April 1997.

Emergency aid and peace-keeping expenditures



Source: OECD, *Development Co-operation* (1994 and 1996 reports).

Healthy cities, healthy children

Leonard Duhl and Trevor Hancock

Economic development has brought comfort and convenience to many people in the industrialized world, but in its wake are pollution, new health problems, blighted urban landscapes and social isolation. Growing numbers of the dispossessed are also being left on the sidelines as the disparity between rich and poor grows. In an effort to remedy these ills, people from disparate backgrounds in thousands of communities are joining together with government agencies under the Healthy Cities/Healthy Communities banner to improve the quality of life in their towns and cities.

Life is vastly easier in the industrialized world than it was 150 years ago. Most people live longer, eat more and work less. Many live in private homes and drive to work alone in their own cars. Office workers communicate instantaneously across continents through telephone, fax and e-mail. Industries crank out new goods faster than people can buy them in ever-bigger shopping malls.

But the advantages of modern life are not available to everyone, nor do they come without a price: new kinds of health problems, many caused by our own bad habits or by the dirty air and water left behind by industries; the loss of parkland as highways devour open space; declining literacy as television beats teachers in the competition for children's attention; cadres of unemployed and homeless people overlooked by the free market system; and sprawling, desolate suburbs where neighbours are strangers and fear of crime isolates people behind locked doors.

Added to these is the disinvestment in services and physical infrastructure over the past 15 years, which has hit urban dwellers—especially poor urban dwellers—the hardest. The cuts in government spending for social programmes are all the more stark when viewed in the context of a world with a widening gap between rich and poor. The fraying of social safety nets, most severe in the United States, has increased the percentage of children under 6 living in poverty from 20 per cent of US children in 1980 to 24 per cent in 1995. Without addressing these fundamental inequalities, programmes developed to mend worsening urban conditions will be unable to secure long-lasting solutions.

Even when government agencies and private organizations have the economic means and political will to address these ills, the typical approach is fragmented and specialized: A programme is created to fix a problem. A clinic is opened to treat disease, ignoring the fact that good health is much more than the absence of illness. Schools are upgraded, but the curriculum ignores lessons learned on the streets and in the media, which set the patterns for children's beliefs and perceptions.

There is a better way. It is rooted in the simple but revolutionary idea that health is less about medical care than about equitable access to such basic prerequisites of health as food, shelter, transportation, clean air and water, education, physical safety and meaningful jobs paying sufficient wages. This way of thinking expands on the idea that no person or family is an island; everyone's life is bound up in the whole community.

Quality of life

Ask people to imagine their ideal community and what they describe is a modern version of a 19th century European market town: a place that is built to human scale; small and compact yet technologically and ecologically sophisticated; where all the activities of daily life are located within walking distance; where the absence of cars means that children can play safely and people can greet their neighbours while strolling on the sidewalk; and where trees and grass and flowers are plentiful.

The message is obvious: What people want is quality of life. They want their children to be healthy and happy and safe, they want to work close to home at meaningful jobs for which they are fairly compensated, they want to have time for recreation and learning. Most of all, they want

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Dr. Hancock is a public health physician and health promotion consultant, in recent years emphasizing healthy cities/communities. He works for local communities, provincial and national governments, health care organizations and the World Health Organization. He has been consulted on healthy city/community projects in several countries, notably Sweden and the US, as well as throughout Canada. Dr. Hancock was a family physician prior to becoming an Associate Medical Officer of Health for the City of Toronto, where he helped initiate the Healthy Cities movement.

human connections. What people are describing when they talk about their ideal town or city is a healthy community. Not very many exist—yet. But for more than 10 years now, a movement called 'Healthy Cities/Healthy Communities' has been helping communities to cure their ills—or better yet, to prevent them.

The movement emerged from the concerns of people in diverse countries about the deterioration of their communities. It was sparked in 1984 by a one-day workshop—Healthy Toronto 2000—organized in conjunction with a conference on healthy public policy. There, staff from the World Health Organization (WHO) recognized an opportunity to put health promotion concepts into practice in Europe. Two years later, Healthy Cities projects were initiated in 11 European cities.

Oakland passed a measure requiring that 2.5% of the city budget go to children's needs.

Municipalities in at least 50 countries were participating by 1996, when WHO chose Healthy Cities as the theme for its annual World Health Day. To date, participating communities number in the thousands worldwide.

Given current trends, nothing could be more important than an initiative aimed at improving the quality of life and health in cities. By the year 2000, almost half the world's population will live in and around urban areas. In the industrialized countries, growth is increasingly taking place in suburban areas, which puts even more demands on transportation, housing and other services because of the suburbs' dispersion and low population density. For children, especially in neighbourhoods left behind by economic progress, Healthy Cities/Healthy Communities is a tool for fulfilling the rights pledged in the Convention on the Rights of the Child—among them, the right to health care, to education and to housing, as well as the right to play and to participate in society.

Creating a healthy city

A healthy city is not a finished product created at one point in time; it is a dynamic place where citizens and government have established relationships and processes that allow them to collaborate in tackling any problems that arise. The healthy city approach calls for collective action, in which all the sectors—local government as well as community, religious and other groups and individual citizens—work together for a common purpose. A healthy city is also sensitive to gender, working to eliminate the discrimination that women face in access to housing, services and jobs.

The role of local government is too often overlooked. Yet in analysing health improvements in the city of Oxford (UK) in the past 200 years, public health physician Jessie Parfitt wrote: "Many would be surprised to learn that the greatest contribution to the health of the nation over the past 150 years was made not by doctors or hospitals but by local government."

Municipal governments are involved in making decisions about urban planning, public works, housing, fire and police protection, education, public health, transportation and a whole host of other issues that have, cumulatively, far more impact on the well-being of their citizens than do health care services. Ensuring that local officials take health into account in making decisions is an important part of the process of creating healthier cities and communities.

People tend to view needs as endless and resources as few. But resources are greater than anyone at first imagines, and discovering that fact makes people realize how much power they have to address their most pressing problems. Every community has individuals who are ready and willing to contribute their untapped, if not professional, skills—entrepreneurial, political and managerial.

While no city can claim to have achieved the ideal, Horsens (Denmark), one of the first cities in the WHO Europe project, comes close. With initial leadership from local government staff and politicians, this community of 70,000 people has made the healthy city approach integral to its way of working and to municipal decision-making. Representatives from all municipal departments make up a Healthy City Group chaired by a full-time coordinator. At a Healthy City Shop, people come together to work on myriad problems ranging from environmental clean-ups to closer integration of immigrants into the life of the city. So successful is the approach that a joint public/private sector partnership has established a consulting group to advise others on how to create healthier cities.

The Healthy Communities banner is guiding similar efforts in many other cities. In 1990, the City Council and the residents of Parksville (Canada) developed a process to involve all parts of the community in defining a set of shared values and writing a plan based on them. The values statement developed by the citizens of Parksville, a rapidly growing community of 10,000 people in British Columbia, emphasizes environmental quality, maintenance of a small-town atmosphere, economic vitality, equal access to a range of human services and amenities, affordable public transportation and an ongoing forum for citizens to express opinions on local issues. These values have been integrated into a decision-making checklist that is applied to new construction.

The Healthy Community process has now also been used as the framework for developing a strategic plan for Parksville. This effort resulted in the creation of a 'Healthy Community Advisory Commission' and a new organizational design for local government. Five committees, staffed by over 100 volunteers, are working in areas such as economic development, environment, housing, transportation and access for people with disabilities.

Children's role

Children are a crucial part of a healthy city's life and growth. Without their participation, the community is not fully represented. Too often, lip-service is given to children's needs, but in a healthy city, young people are part of civic life. They express opinions and take part in neighbourhood projects.

In Rouyn-Noranda, a city of 30,000 in Quebec (Canada), 5,000 young people were asked in 1987 to describe what their town would be like in the future if it were more healthy. Their ideas formed the basis of a youth agenda, presented to the City Council, which has helped to shape the city's activities for a number of years.

Among the agenda's initiatives were a programme of activities to highlight accomplishments by young people and steps to reduce emissions of acids and heavy metals from the smelter that is the economic lifeblood of the region. During a community forum in June 1996, a second round of projects was adopted, including plans for neighbourhood justice circles for youth and a strategy to reduce poverty.

Healthy Cities has been active in Oakland, California (US) since 1993. Even before that, the city

worked in partnership with the county administration to promote the health and well-being of its residents. In several Oakland neighbourhoods, the infant death rate used to be as high as in some developing countries—more than 20 deaths per 1,000 live births. Public health officials had undertaken the usual measures: more prenatal care, nutrition programmes, counselling of mothers. But these actions had negligible effect. Community members formed a coalition to work on the problem.

That effort led to the establishment in the early 1990s of a series of coalitions of diverse people addressing issues of education, housing, economic development, security and law enforcement. At one meeting, when the discussion turned to infant mortality, representatives of some coalitions started to leave, because they felt their mandate was unrelated. Persuaded to stay, they began to see that the infant death rate is an issue not just of health but also of poverty, adolescence, education, housing and transportation.

Four years later, the rate in the neighbourhoods had dropped by half, the first decline in 25 years—because people began to address infant deaths not only as a medical problem but also as a community problem. Collaboration between agencies improved and the city won a federal grant aimed at reducing infant mortality. In addition, through the coalition process, the word spread about services that had been available all along, so more pregnant women began to take advantage of them.

Healthy Cities raised awareness among Oakland's residents of the importance of investing in children's well-being. In 1996, Oakland passed a 12-year budget bill appropriating 2.5 per cent of the city's budget to children's needs. Children were a major force in getting this legislation passed, and they are participating in deciding how to allocate funds.

In Milan (Italy), an Urban Child Project began in 1989, with UNICEF backing, to work on improving the quality of life for children, with an emphasis on their right to participation. A well-to-do city, Milan nonetheless suffers from the range of modern social ills, including poverty, crime and unequal access to community services. Research undertaken when the project began found little coordination among the many institutions dealing with children's issues. Information about young people's needs was disjointed, and there was no systematic monitoring of conditions.

In 1994, Milan established a Council for Child Well-being to oversee plans for children's programmes, monitor fulfilment of child rights and assist in coordinating municipal resources. Two pilot projects were begun in 1995 to help social workers access services more efficiently, renew urban areas and encourage the participation of children and local communities.

Many benefits have resulted. Resources for services were surveyed, resulting in development of a map, called 'Friendly spaces for us', which was widely distributed. Children, assisted by facilitators, surveyed their neighbourhoods and prepared plans for improving them, complete with designs and models. They have carried out projects to improve parks and courtyards with the help of local artisans and municipal technicians.

More than 3,000 children have participated in Milan's healthy cities' activities, and the project is expanding to three additional neighbourhoods. The total population now benefiting is about 300,000.

Children in Seattle, Washington (US), similarly got involved in improving their environment through Kid's Place. It was initiated in 1983 by a retired paediatrician so that young people would have somewhere to go for recreation other than shopping malls.

The first activity, developed by children with some adult help, was a simple questionnaire asking children about places in their community—the cleanest place, the happiest place, the most unsafe, the most stimulating.

With this survey, the children identified dangerous intersections, polluted areas, good schools and safe areas—all without an expensive study. They pointed out that public transport did not take them where they wanted to go because it was developed to carry adults to and from work. The Mayor, impressed by their effort, asked them to suggest changes in the bus routes. The routes were changed, the children's needs were met and the buses made more money. Seattle has now developed a city-wide policy for children and youth.

Kid's Place and similar programmes are now active in many cities in Europe, Japan and North America. The results have included new parks and play areas, pedestrian bridges, neighbourhood centres and clinics for adolescents. Young people have won approval for midnight basketball games and have persuaded principals to keep schools open late so they can be used for recreation.

These efforts have in common the participation of citizens in deciding the community's priorities and working to achieve them. A healthy community is dynamic. It has the capacity to change with the times and with the needs of its citizens. But they cannot do it alone. Only when governments join with residents in willing partnership can urban areas become responsive to the needs and rights of all their inhabitants, young and old, poor and rich. These efforts require political will and new forms of democratic and participatory governance reoriented towards social needs.

As we enter the urban millennium, when the majority of the world's children will be born and raised in cities, the health and well-being of young people and of future generations will depend upon our ability to create healthier cities and communities. The progress of nations will thus be closely tied to the progress of cities. ■

Philip Wolmuth/Panos Pictures

The urban infrastructure of the industrialized countries, particularly in poor areas, is crumbling after 15 years of disinvestment. A neighbourhood full of boarded-up buildings, such as this one in London, is no place for a child.

Youth unemployment rate highest in Spain, lowest in Austria and Switzerland

In Spain, more than 40% of young people age 24 and under who are looking for work fail to find it. At the other end of the scale, in Austria and Switzerland, the youth unemployment rate is only 6%.

More than a quarter of the 22 industrialized countries providing information have youth unemployment rates above 20%. In 10 of the countries, female unemployment rates are higher than those of males, while in 8 countries, young men have a harder time finding jobs than young women.

The data include only those young people of a specified age, usually 15 through 24, who are looking for work. A country's youth unemployment rate is the number of youth seeking employment as a percentage of the total number of working and work-seeking youth. In every country, the youth unemployment rate is higher than the total unemployment rate.

The Convention on the Rights of the Child calls for countries to set minimum ages for employment, regulate conditions of work and protect children from work that threatens their health, education or development (article 32). The International Labour Organization's general minimum age of 15 years (provided this is not less than the age of completion of compulsory schooling) is the most widely used standard.

Youth unemployment results in social and economic trauma at a personal, community and national level. For young people, work is more than earning an income: It is a critical phase in the transition from dependent childhood to independent adulthood and a source of emotional and social well-being. Although the links between youth employment and crime are tenuous, research affirms the association between unemployment and a decline in psychological health.

While the phenomenon is disturbing, it is not new: 10 years ago, youth unemployment rates varied from 5% to 48% in industrialized countries; today, they vary from 6% to 43%. By seeking solutions to the problem—such as promoting ways to combine education and work—countries can address labour markets' ever increasing demand for higher skills and the best interests of young people.

Youth unemployment rates
Unemployed youth age 24 and below

	% unemployed male	female	total		male	female	total
Spain	37	51	43	New Zealand	16	14	15
Finland	32	36	34	United Kingdom	16	11	14
Italy	29	39	34	United States	13	11	12
France	26	32	29	Germany	11	9	10
Greece	20	37	28	Netherlands	9	11	10
Belgium	19	27	22	Norway	11	9	10
Sweden	22	22	22	Luxembourg	8	8	8
Ireland	18	16	17	Denmark	6	9	7
Australia	17	16	16	Japan	7	7	7
Canada	19	14	16	Austria	4	7	6
Portugal	13	20	16	Switzerland	6	6	6

Source: Eurostat news release no. 3/97, 1997; OECD, *OECD in Figures*, 1996.

Teens at risk: Drinking and bullying

Millions of adolescents in some of the wealthiest countries in the world are seriously affected by alcohol abuse and bullying—behaviours that compromise their health and limit their chances to become successful adults. Both alcohol abuse and bullying, found at high levels in a number of industrialized countries, according to a WHO youth health survey, are associated with alienation from school and home, as well as low academic achievement. Boys are at higher risk than girls.

In the countries surveyed, the highest levels of alcohol abuse among both boys and girls are found in Denmark. Danish girls have the highest levels of all: 67%. Denmark is the only country where girls have a higher rate of alcohol abuse than boys. In 14 countries or regions within countries where 15-year-olds were asked about their experience with alcohol, more than one third of boys reported being drunk two or more times.

Teens who misuse alcohol are more likely to develop health problems and die prematurely. While the increased risk is partly the result of the direct effects of excessive alcohol consumption—liver disease, depression, road accidents—it is also due to the link between drinking and other high-risk behaviours, such as smoking and violence.

Bullying—which includes physical contact or verbal abuse—is also associated with such high-risk behaviours as drinking to excess and smoking. The variation in the amount of bullying occurring among 15-year-olds is striking. Germany has the highest rates: 86% of boys and 72% of girls reported bullying others at least once in the past school term. In Wales, the rates dropped to 28% of boys and 13% of girls.

More than half of boys and girls in Austria, Belgium (Wallonia), Denmark and Lithuania reported engaging in bullying. The behaviour, however, is considerably less frequent among girls than boys.

Alcohol abuse
Percentage of 15-year-old students who had 2 or more episodes of drunkenness

	% male	% female
Denmark	65	67
UK (Wales)	61	59
UK (Scotland)	53	51
Finland	52	50
Austria	46	30
Denmark (Greenland)	46	46
Slovakia	46	20
UK (N. Ireland)	44	36
Canada	39	38
Hungary	37	20
Czech Rep.	36	19
Latvia	35	21
Germany*	34	26
Poland	34	18
Belgium (Flanders)	31	16
Norway	30	29
Belgium (Wallonia)	27	20
Lithuania	27	17
Sweden	27	22
Estonia	26	10
France*	24	13
Spain	23	19
Switzerland	22	13
Russian Fed.*	21	12
Israel	8	6

Bullying
Percentage of 15-year-old students who took part in bullying others at least once in the previous school term

	% male	% female
Germany*	86	72
Austria	78	59
Denmark	75	53
Lithuania	73	53
Belgium (Wallonia)	70	56
Denmark (Greenland)	64	40
Estonia	64	32
Belgium (Flanders)	62	34
Israel	57	25
Finland	56	26
Norway	56	19
Latvia	54	36
France*	49	39
Russian Fed.*	46	35
Canada	42	23
Switzerland	42	13
Hungary	40	18
Czech Rep.	39	23
Slovakia	35	16
UK (Scotland)	34	16
Poland	32	14
Sweden	32	12
UK (N. Ireland)	29	10
UK (Wales)	28	13

* France, Germany and the Russian Fed. are represented only by areas.
Source: A. King, B. Wold, C. Tudor-Smith, and Y. Harel, *The Health of Youth: A Cross-National Survey*, WHO Regional Publications, European Series No. 69, 1996. (Surveys undertaken 1993/94.)

Sharing the wealth? Aid at lowest level in 45 years

UNICEF/93-1994/Pirozzi

Development aid goes far when used to develop skills of local staff. A health worker, her training supported by aid funds, weighs a baby in Benin.

Official development assistance (ODA) from the industrialized countries is in the doldrums, slumping to an average of just 0.27% of their combined GNP, the lowest level since aid statistics were first collected in 1950. The US gave the lowest portion of its GNP for aid: 0.10% in 1995, the latest year for which figures are available. In contrast, Denmark, the Netherlands, Norway and Sweden all allocated more than 0.7% of their GNP for development assistance, the international target agreed upon in 1969. Denmark tops the list, earmarking 1.04%.

In absolute dollars, Japan gave the most aid ($14.5 billion), almost double that of the US ($7.4 billion). The US dropped to fourth place from first place in 1990, when it gave $11.4 billion in aid. However, together with France and Germany, these four countries accounted for more than three fifths of the total $59 billion in aid provided by 21 Organisation for Economic Co-operation and Development (OECD) donors in 1995.

On the amount of aid per person, however, Denmark heads the list, giving $311 per capita. Three countries—Italy, Portugal and the US—gave $28, the lowest amount per capita.

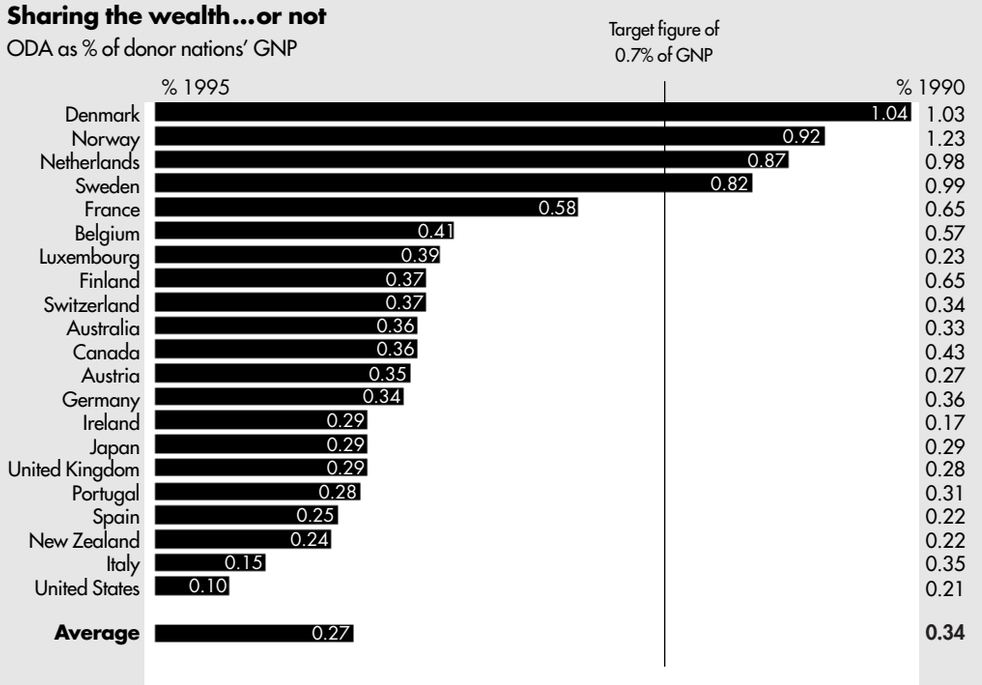
Though private investments and loans flowing to developing countries have surged, tripling from $52 billion in 1990 to $159 billion in 1995, most have gone to a dozen or so emerging economies, including China, Mexico and the Republic of Korea. The poorest countries, particularly in sub-Saharan Africa, have received hardly any private loans or investment. Aid is crucial for these countries in combating poverty, repaying debt, supporting investment and financing social services.

A glimmer of hope in the disquieting aid picture is the evidence of a shift in aid allocations towards social sectors. This trend gains further impetus from the 20/20 initiative, supported by UNDP, UNESCO, UNFPA, UNICEF and WHO.

The initiative calls for allocating 20% of aid and 20% of developing countries' budgets for basic social services—primary health care, including reproductive health and family planning, nutrition, basic education and safe drinking water supply and sanitation. These services are the foundation for sustainable human development.

Sharing the wealth...or not

ODA as % of donor nations' GNP



Source: OECD, *Development Co-operation* (1996 Report), 1997.

Amounts

	Total aid ($ billions) 1995	Aid per person ($) 1995	Change per person ($) since 1992*
Japan	14.5	116	-5
France	8.4	145	-15
Germany	7.5	92	-9
United States	7.4	28	-18
Netherlands	3.2	208	-2
UK	3.2	54	1
Canada	2.1	70	-14
Sweden	1.7	194	-59
Denmark	1.6	311	8
Italy	1.6	28	-33
Spain	1.3	34	-2
Australia	1.2	67	6
Norway	1.2	287	-8
Switzerland	1.1	151	-59
Belgium	1.0	102	2
Austria	0.8	95	15
Finland	0.4	76	-68
Portugal	0.3	28	-6
Ireland	0.2	43	30
Luxembourg	0.1	160	58
New Zealand	0.1	35	-1
Total	**$58.9**	**Avg. $72**	**-$13**

*Changes are based on constant prices and exchange rates.

SOCIAL INDICATORS

LESS POPULOUS COUNTRIES

The indicators used to construct the league tables in *The Progress of Nations 1997* include: access to sanitation; per cent reduction in under-5 mortality, 1980-1995; and women at top levels of government. Using the same indicators, the following table shows the progress of those countries with populations of less than 1 million. The regional standing of these less populous countries can be assessed by comparing the figures given here with the relevant league tables. In addition, basic social indicators, also provided in this table, can be compared with the Statistical Profiles on the following pages.

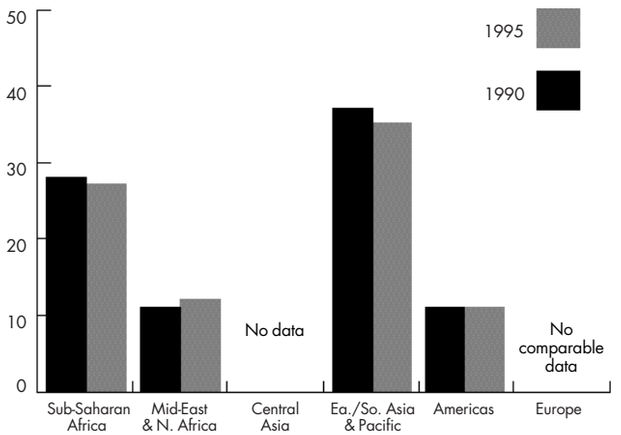
	League tables												
	Access to sanitation	% reduction in under-5 mortality rate 1980–1995	Women at top levels of government %1996	Total population (thousands) 1995	Population under 18 (thousands) 1995	Annual no. of births (thousands) 1995	Annual no. of under-5 deaths (thousands) 1995	Under-5 mortality rate 1995	GNP per capita ($) 1995	% of under-5 children underweight 1981–94	Primary school enrolment (%) a/ 1984–94	Maternal mortality rate b/ 1990	Total fertility rate 1995
Antigua and Barbuda	96	–	0	66	24	2	0.0	22	6770	10	–	–	1.7
Bahamas	85	20	19	279	96	5	0.1	28	11940	–	94	100	2.0
Bahrain	100	52	0	557	203	12	0.2	20	7840	–	100	60	3.2
Barbados	100	65	31	261	73	3	0.0	10	6560	5	78	43	1.7
Belize	57	29	0	213	105	7	0.3	40	2630	–	97	–	3.9
British Virgin Islands	100	–	–	19	7	0	0.0	28	8500	–	–	–	–
Brunei Darussalam	99	56	0	293	116	6	0.1	10	14240	–	90	60	2.9
Cape Verde	24	23	13	386	187	12	0.9	73	960	19	100	–	3.7
Comoros	99	39	6	612	327	25	2.5	100	470	–	51	950	5.8
Cook Islands	100	18	–	19	8	1	0.0	28	1550	–	–	–	–
Cyprus	98	50	8	745	224	12	0.1	10	10380	–	96	5	2.3
Djibouti	90	21	0	601	285	23	3.6	158	780	23	32	570	5.6
Dominica	99	–	18	71	25	2	0.0	21	2990	5	–	–	2.4
Equatorial Guinea	34	28	5	400	197	16	2.8	175	380	–	–	820	5.7
Fiji	100	40	5	784	327	18	0.5	25	2440	–	99	90	2.9
Grenada	–	–	21	92	33	2	0.1	33	2980	–	–	–	2.8
Guyana	81	33	6	830	315	19	1.1	59	590	18	–	–	2.4
Iceland	–	41	15	269	78	4	0.0	5	24950	–	–	0	2.2
Kiribati	100	–	–	78	36	2	0.2	77	920	–	99	–	3.7
Luxembourg	–	43	29	407	86	5	0.0	9	41210	–	85	0	1.7
Maldives	66	37	6	254	135	10	0.8	77	990	39	60	–	6.8
Malta	98	32	0	367	98	5	0.1	12	7970	–	99	0	2.1
Marshall Islands	–	–	8	55	26	2	0.2	92	1680	–	100	–	–
Micronesia (Fed. States of)	100	–	0	123	57	4	0.1	28	1890	–	85	–	4.7
Montserrat	84	–	–	11	4	0	0.0	14	3330	–	100	–	2.3
Palau	96	10	10	17	8	1	0.0	35	790	–	100	–	–
Qatar	99	58	0	548	172	10	0.2	23	11600	–	81	–	3.9
Saint Kitts and Nevis	100	–	0	41	15	1	0.0	40	5170	–	–	–	2.5
Saint Lucia	–	–	9	142	51	3	0.1	22	3370	–	90	–	3.1
Saint Vincent/Grenadines	98	–	20	112	40	3	0.1	23	2280	–	–	–	2.4
Samoa	94	–	8	165	75	4	0.2	54	1120	–	–	35	4.0
Sao Tome/Principe	11	–	0	133	70	6	0.5	81	350	17	–	–	4.8
Seychelles	54	–	33	73	39	3	0.1	20	6620	6	–	–	2.6
Solomon Islands	14	45	0	378	194	13	0.4	31	910	–	–	–	5.2
Suriname	54	39	0	427	172	10	0.3	32	880	–	–	–	2.5
Swaziland	70	29	0	857	430	32	3.4	107	1170	10	95	560	4.7
Tonga	99	–	–	98	42	2	0.0	24	1630	–	–	–	3.5
Turks and Caicos Islands	–	–	–	14	5	0	0.0	31	780	–	–	–	–
Tuvalu	87	27	–	10	4	0	0.0	56	650	–	98	–	–
Vanuatu	43	47	0	169	84	5	0.3	58	1200	20	74	280	4.5

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

b/ Several of the maternal mortality rates vary substantially from government estimates. A review of these data will be part of a forthcoming revision of maternal mortality estimates.

Regional progress towards the year 2000 goals

The graphs below present regional summaries of progress towards six of the key year 2000 goals agreed to by countries at the 1990 World Summit for Children.

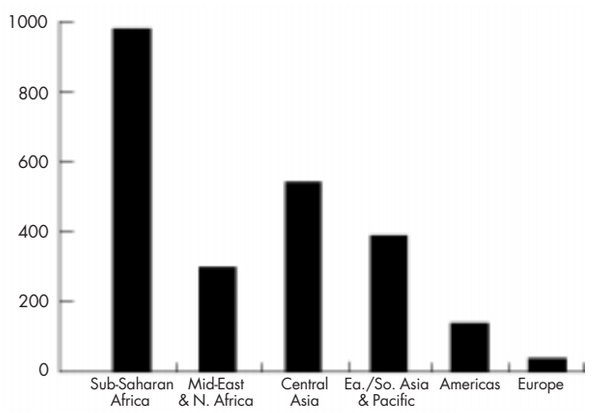


Child malnutrition

Percentage of under-5 children underweight

GOAL

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

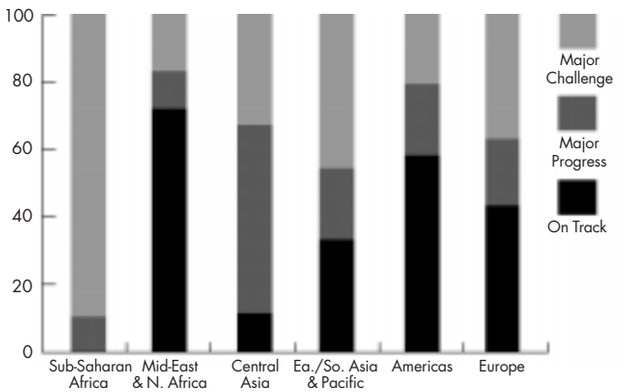


GOAL

Reduction by half of the 1990 maternal mortality ratio.

Maternal mortality

Maternal deaths per 100,000 births (1990)

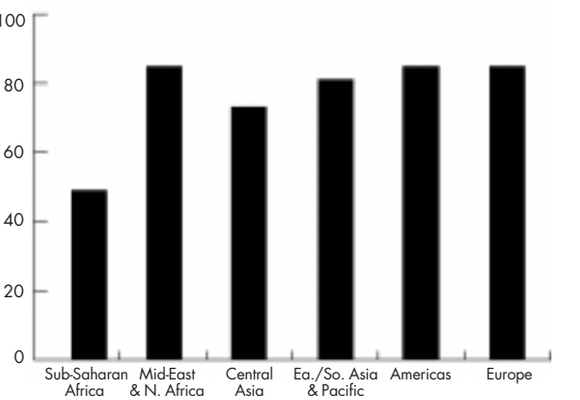


Under-5 mortality

Percentage of countries in each region by level of progress towards the year 2000 goal (1995)

GOAL

Reduction of under-5 mortality rate by one third or 70 per 1,000 live births, whichever is less.

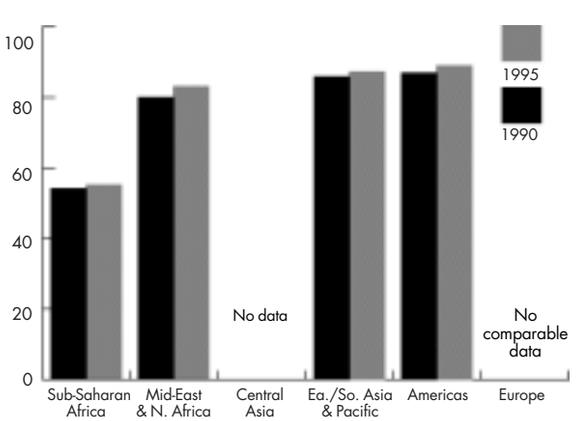


GOAL

Maintenance of a high level of immunization coverage (at least 90%).

DPT3 immunization

Percentage of children receiving three immunizations against diphtheria, pertussis and tetanus (DPT3) by age 1 (1995)



Net student enrolment

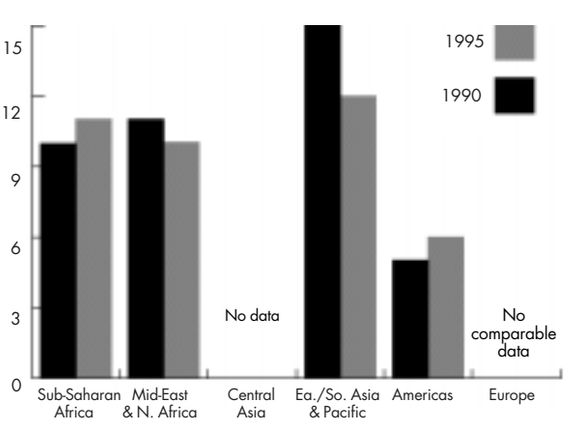
Percentage of children of primary school age who are enrolled in primary school

GOAL

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

GOAL

Universal access to primary education with special emphasis on reducing disparities between girls and boys.



Gender disparity in net student enrolment

The disparity is expressed as the number of percentage points by which boys' enrolment rates exceed girls' rates

These statistical profiles put into stark relief the development challenge the world faces.

Among these 149 countries, per capita GNP ranges from $80 a year to $40,630 a year.

The under-5 mortality rate varies from 5 deaths per 1,000 live births to 320; the maternal death rate ranges from 6 deaths per 100,000 live births to 1,800.

The primary school enrolment rate varies from 17% of young people to 100%.

By exposing these intolerable disparities, *The Progress of Nations* is a contribution to ending them.

	Total population (millions) 1995	Population under 18 (millions) 1995	Annual no. of births (thousands) 1995	Annual no. of under-5 deaths (thousands) 1995	Under-5 mortality rate 1995	GNP per capita ($) 1995	% of under-5 children under-weight	Primary school enrolment a/ (%)	Total fertility rate 1995	Maternal mortality rate b/ 1990
SUB-SAHARAN AFRICA										
Angola	10.8	5.8	536	162	292	410	–	–	6.9	1500
Benin	5.4	3.0	234	37	142	370	–	53	6.1	990
Botswana	1.5	0.7	52	3	52	3020	15	96	4.7	250
Burkina Faso	10.5	5.7	491	77	164	230	30	33	6.8	930
Burundi	6.1	3.2	271	50	176	160	37	51	6.5	1300
Cameroon	13.2	6.7	527	56	106	650	14	68	5.5	550
Central African Rep.	3.3	1.6	125	22	165	340	27	55	5.1	700
Chad	6.3	3.2	271	42	152	180	–	41	5.7	1500
Congo	2.6	1.4	113	12	108	680	24	–	6.1	890
Congo, Dem. Rep.	45.5	24.3	2104	421	207	120	34	56	6.5	870
Côte d'Ivoire	13.7	7.1	512	105	150	660	24	48	5.4	810
Eritrea	3.2	1.6	134	29	195	100	41	27	5.6	1400
Ethiopia	56.4	29.5	2768	506	195	100	48	21	7.0	1400
Gabon	1.1	0.5	39	8	148	3490	–	86	5.2	500
Gambia	1.1	0.5	45	5	110	320	–	55	5.4	1100
Ghana	17.3	8.9	679	92	130	390	27	70	5.5	740
Guinea	7.3	3.9	352	73	219	550	26	33	6.8	1600
Guinea-Bissau	1.1	0.5	44	10	227	250	23	45	5.6	910
Kenya	27.2	14.5	996	111	90	280	23	84	5.1	650
Lesotho	2.0	1.0	73	10	140	770	21	75	5.0	610
Liberia	2.1	1.0	119	30	216	450	–	56	6.6	560
Madagascar	14.9	7.9	630	103	164	230	34	62	5.9	490
Malawi	9.7	5.2	488	118	219	170	30	83	6.9	560
Mali	10.8	5.8	532	120	225	250	31	25	6.9	1200
Mauritania	2.3	1.1	88	17	195	460	23	54	5.2	930
Mauritius	1.1	0.4	22	1	23	3380	16	94	2.3	120
Mozambique	17.3	8.8	748	156	220	80	27	52	6.3	1500
Namibia	1.5	0.8	56	4	78	2000	26	77	5.1	370
Niger	9.2	5.0	471	151	320	220	36	27	7.3	1200
Nigeria	111.7	58.0	4915	939	191	260	36	59	6.2	1000
Rwanda	5.2	2.8	262	48	139	180	29	61	6.3	1300
Senegal	8.3	4.3	350	46	130	600	22	45	5.8	1200
Sierra Leone	4.2	2.1	205	61	284	180	29	48	6.3	1800
Somalia	9.5	5.1	488	97	211	120	–	17	7.0	1600
South Africa	41.5	18.1	1264	84	67	3160	9	96	4.0	230
Tanzania	30.0	15.8	1258	200	160	120	29	64	5.7	770
Togo	4.1	2.1	177	23	128	310	19	69	6.3	640
Uganda	19.7	10.9	1006	155	145	240	26	–	7.1	1200
Zambia	8.1	4.5	350	83	203	400	28	77	5.7	940
Zimbabwe	11.2	5.7	436	31	74	540	16	91	4.9	570
MIDDLE EAST AND NORTH AFRICA										
Algeria	28.1	13.0	844	31	40	1600	13	93	4.1	160
Egypt	62.1	27.5	1682	89	51	790	12	84	3.6	170
Iran	68.4	35.0	2439	90	40	1033	16	96	5.0	120
Iraq	20.1	9.9	759	54	71	1036	12	79	5.5	310
Israel	5.5	1.9	114	1	9	15920	–	–	2.8	7
Jordan	5.4	2.7	204	5	25	1510	9	97	5.4	150
Kuwait	1.7	0.8	41	1	14	17390	6	64	2.9	29
Lebanon	3.0	1.2	76	3	40	2660	–	–	2.9	300
Libya	5.4	2.8	221	14	63	5310	5	97	6.2	220
Morocco	26.5	11.5	720	56	75	1110	9	69	3.4	610
Oman	2.2	1.2	97	2	25	4820	12	93	7.2	190
Saudi Arabia	18.3	8.8	641	22	34	7040	–	63	6.1	130
Sudan	26.7	12.9	914	126	115	480	34	–	4.8	660
Syria	14.2	7.4	442	21	36	1120	12	93	4.4	180
Tunisia	9.0	3.7	221	8	37	1820	9	99	3.1	170
Turkey	60.8	23.1	1345	81	50	2780	10	73	2.6	180
U. Arab Emirates	2.2	0.8	42	1	19	17400	–	100	3.6	26
Yemen	15.0	8.1	723	76	110	260	39	57	7.6	1400
CENTRAL ASIA										
Afghanistan	19.7	9.2	1039	268	257	280	–	29	6.9	1700
Armenia	3.6	1.2	53	2	31	730	–	–	1.9	50
Azerbaijan	7.5	2.8	159	8	50	480	–	–	2.5	22
Georgia	5.5	1.5	79	2	26	440	–	82	2.0	33
Kazakstan	16.8	6.0	315	15	47	1330	–	–	2.4	80
Kyrgyzstan	4.5	1.9	119	7	54	700	–	86	3.4	110
Tajikistan	5.8	2.8	183	17	79	340	–	–	4.1	130
Turkmenistan	4.1	1.9	122	11	85	920	–	–	3.8	55
Uzbekistan	22.8	10.5	673	42	62	970	–	95	3.7	55
EAST/SOUTH ASIA AND PACIFIC										
Australia	17.9	4.6	261	2	8	18720	–	98	1.9	9
Bangladesh	118.2	57.2	3079	477	115	240	67	82	3.3	850
Bhutan	1.8	0.9	74	12	189	420	38	41	5.9	1600
Cambodia	10.0	4.7	358	72	174	270	40	–	4.7	900
China	1220.2	378.1	20858	1021	47	620	16	95	1.9	95
India	929.0	379.8	24343	3002	115	340	53	68	3.2	570
Indonesia	197.5	77.7	4695	354	75	980	35	91	2.8	650
Japan	125.1	25.2	1260	8	6	39640	–	100	1.5	18
Korea, Dem.	22.1	6.9	487	17	30	970	–	–	2.1	70

	Total population (millions) 1995	Population under 18 (millions) 1995	Annual no. of births (thousands) 1995	Annual no. of under-5 deaths (thousands) 1995	Under-5 mortality rate 1995	GNP per capita ($) 1995	% of under-5 children under-weight	Primary school enrolment a/ (%)	Total fertility rate 1995	Maternal mortality rate b/ 1990
Korea, Rep.	44.9	12.8	686	7	9	9700	–	93	1.7	130
Lao Rep.	4.9	2.5	221	28	134	350	40	68	6.7	650
Malaysia	20.1	8.8	542	7	13	3890	23	–	3.4	80
Mongolia	2.5	1.1	69	5	74	310	12	78	3.4	65
Myanmar	45.1	18.9	1264	220	150	220	43	85	3.5	580
Nepal	21.5	10.6	819	95	114	200	46	69	5.2	1500
New Zealand	3.6	1.0	57	1	9	14340	–	99	2.1	25
Pakistan	136.3	66.7	5163	755	137	460	38	66	5.3	340
Papua New Guinea	4.3	2.0	142	13	95	1160	35	73	4.9	930
Philippines	67.8	30.5	2029	105	53	1050	30	90	3.8	280
Singapore	3.3	0.9	57	0	6	26730	–	100	1.8	10
Sri Lanka	17.9	6.4	322	7	19	700	38	–	2.2	140
Thailand	58.2	19.8	994	36	32	2740	26	–	1.8	200
Viet Nam	73.8	32.1	1996	99	45	240	45	88	3.2	160
AMERICAS										
Argentina	34.8	12.1	707	19	27	8030	–	95	2.7	100
Bolivia	7.4	3.5	256	27	105	800	16	89	4.6	650
Brazil	159.0	60.5	3228	203	53	3640	6	91	2.3	220
Canada	29.4	7.2	383	3	8	19380	–	97	1.7	6
Chile	14.2	4.9	296	5	15	4160	1	86	2.5	65
Colombia	35.8	14.5	883	26	32	1910	8	91	2.8	100
Costa Rica	3.4	1.4	85	1	16	2610	2	87	3.0	55
Cuba	11.0	2.9	152	2	10	1170	–	100	1.6	95
Dominican Rep.	7.8	3.2	199	9	44	1460	10	81	2.9	110
Ecuador	11.5	4.9	308	12	40	1390	17	94	3.3	150
El Salvador	5.7	2.6	164	8	40	1610	11	70	3.3	300
Guatemala	10.6	5.4	399	24	60	1340	27	70	5.1	200
Haiti	7.1	3.3	247	31	124	250	28	26	4.7	1000
Honduras	5.7	2.9	200	8	38	600	18	90	4.6	220
Jamaica	2.5	0.9	57	1	13	1510	10	100	2.5	120
Mexico	91.1	38.6	2356	79	32	3320	14	98	2.9	110
Nicaragua	4.1	2.1	143	10	60	380	12	79	4.1	160
Panama	2.6	1.0	62	1	20	2750	7	91	2.8	55
Paraguay	4.8	2.3	157	5	34	1690	4	90	4.4	160
Peru	23.5	10.0	617	35	55	2310	11	88	3.2	280
Trinidad/Tobago	1.3	0.5	21	1	18	3770	7	88	2.2	90
United States	267.1	69.9	3911	40	10	26980	–	100	2.0	12
Uruguay	3.2	0.9	53	1	21	5170	7	94	2.3	85
Venezuela	21.8	9.3	569	14	24	3020	6	88	3.1	120
EUROPE										
Albania	3.4	1.3	76	3	40	670	–	–	2.7	65
Austria	8.0	1.7	88	1	7	26890	–	100	1.4	10
Belarus	10.4	2.7	111	2	20	2070	–	97	1.5	37
Belgium	10.1	2.2	117	1	10	24710	–	96	1.6	10
Bosnia/Herzegovina	3.6	0.9	44	1	17	*	–	–	1.5	–
Bulgaria	8.5	1.9	86	2	19	1330	–	83	1.5	27
Croatia	4.5	1.1	49	1	14	3250	–	82	1.6	–
Czech Rep.	10.3	2.5	115	1	10	3870	–	–	1.5	15
Denmark	5.2	1.1	68	0	7	29890	–	99	1.8	9
Estonia	1.5	0.4	14	0	22	2860	–	90	1.4	41
Finland	5.1	1.2	64	0	5	20580	–	–	1.8	11
France	58.1	13.6	701	7	9	24990	–	99	1.7	15
Germany	81.6	15.8	777	5	7	27510	–	97	1.3	22
Greece	10.5	2.2	103	1	10	8210	–	91	1.4	10
Hungary	10.1	2.3	108	2	14	4120	–	93	1.5	30
Ireland	3.5	1.1	47	0	7	14710	–	100	1.9	10
Italy	57.2	10.7	532	4	8	19020	–	–	1.2	12
Latvia	2.5	0.6	26	1	26	2270	–	81	1.5	40
Lithuania	3.7	1.0	43	1	19	1900	–	–	1.6	36
Moldova, Rep. of	4.4	1.4	63	2	34	920	–	–	2.0	60
Netherlands	15.5	3.4	192	2	8	24000	–	93	1.6	12
Norway	4.3	1.0	59	1	8	31250	–	99	1.9	6
Poland	38.6	10.8	473	8	16	2790	–	97	1.8	19
Portugal	9.8	2.2	110	1	11	9740	–	100	1.5	15
Romania	22.7	5.8	245	7	29	1480	–	94	1.5	130
Russian Fed.	148.5	37.9	1439	46	30	2240	–	94	1.4	75
Slovakia	5.3	1.5	66	1	15	2950	–	–	1.7	–
Slovenia	1.9	0.4	18	0	8	8200	–	96	1.3	13
Spain	39.6	8.4	387	4	9	13580	–	100	1.2	7
Sweden	8.8	1.9	112	1	5	23750	–	99	1.9	7
Switzerland	7.2	1.5	82	1	7	40630	–	100	1.5	6
TFYR Macedonia	2.2	0.6	32	1	31	860	–	87	2.0	–
Ukraine	51.8	12.6	532	14	24	1630	–	–	1.5	50
United Kingdom	58.1	13.3	721	6	7	18700	–	100	1.8	9
Yugoslavia, Fed. Rep. of	10.3	2.7	132	4	23	**	–	69	1.9	–

a/ Enrolment is derived from net primary school enrolment rates as reported by UNESCO, and national household survey reports of attendance at primary school.
b/ Several of the maternal mortality rates vary substantially from government estimates. A review of these data will be part of a forthcoming revision of maternal mortality estimates.
* GNP per capita estimated range $765 or less.
** GNP per capita estimated range $766 to $3035.






Age of data

The table below gives the average age of the latest internationally available data for three key indicators: the under-5 mortality rate, the net enrolment rate (proportion of children of primary school age who are enrolled in primary school) 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 1996.

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

A small number of countries have no known data at all for certain indicators. Published data for such countries usually represent estimates based on neighbouring countries at similar levels of GNP per capita.

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

SUB-SAHARAN AFRICA					
Senegal	1.0	Kenya	3.0	Guinea	6.7
Malawi	1.3	Niger	3.3	Botswana	7.3
Uganda	1.3	Mali	4.0	Sierra Leone	7.7
Congo, Dem. Rep.	1.7	Zambia	4.0	Chad	8.0
Madagascar	1.7	Eritrea	4.3	Liberia	9.7
Mauritius	1.7	South Africa	4.3	Gabon	10.0
Mozambique	1.7	Togo	4.3	Somalia	10.0
Central African Rep.	2.0	Burundi	4.7	Gambia	11.3
Côte d'Ivoire	2.7	Cameroon	4.7	Benin	12.3
Mauritania	2.7	Lesotho	4.7	Congo	13.0
Tanzania	2.7	Rwanda	4.7	Guinea-Bissau	13.0
Zimbabwe	2.7	Ethiopia	5.0	Angola	14.7
Burkina Faso	3.0	Namibia	5.0		
Ghana	3.0	Nigeria	5.0		
MIDDLE EAST and NORTH AFRICA					
Algeria	1.7	Oman	3.7	Libya	6.7
Yemen	2.0	Tunisia	4.0	Sudan	8.7
Egypt	2.3	Syria	4.3	U. Arab Emirates	8.7
Morocco	3.0	Iraq	4.7	Saudi Arabia	9.7
Turkey	3.0	Kuwait	5.3	Israel	11.0
Iran	3.3	Jordan	6.3	Lebanon	12.7
CENTRAL ASIA					
Kyrgyzstan	1.5 *	Armenia	–	Kazakstan	–
Uzbekistan	2.0 *	Azerbaijan	–	Tajikistan	–
Afghanistan	9.0 *	Georgia	–	Turkmenistan	–
EAST/SOUTH ASIA and PACIFIC					
Nepal	1.0	Myanmar	3.3	Bhutan	8.3
New Zealand	1.5 *	Pakistan	3.3	Korea, Rep.	8.7
Japan	2.0 *	India	3.7	Malaysia	9.7
Indonesia	2.3	Philippines	3.7	Thailand	10.3
Viet Nam	2.3	Mongolia	4.3	Cambodia	10.7
Australia	2.5 *	Lao Rep.	5.3	Papua New Guinea	11.3
China	2.7	Sri Lanka	7.0	Korea, Dem.	13.0
Bangladesh	3.0	Singapore	7.7		
AMERICAS					
Brazil	1.3	Haiti	3.7	Venezuela	5.0
Colombia	1.7	Nicaragua	3.7	Jamaica	5.3
Chile	2.0	El Salvador	4.0	Paraguay	5.3
Guatemala	2.3	Honduras	4.0	Panama	6.0
Canada	2.5 *	Peru	4.3	Cuba	6.7
United States	2.5 *	Dominican Rep.	4.7	Ecuador	7.0
Bolivia	2.7	Uruguay	4.7	Trinidad/Tobago	8.0
Costa Rica	3.0	Mexico	5.0	Argentina	8.7
EUROPE					
Hungary	1.5 *	France	2.0 *	Belgium	3.5 *
Latvia	1.5 *	Greece	2.0 *	Yugoslavia, Fed. Rep.	3.5 *
Poland	1.5 *	Ireland	2.0 *	Finland	8.5 *
Romania	1.5 *	Russian Fed.	2.0 *	Italy	8.5 *
Slovenia	1.5 *	Sweden	2.0 *	Albania	10.0 *
TFYR Macedonia	1.5 *	Germany	2.5 *	Bosnia/Herzegovina	–
Austria	2.0 *	Netherlands	2.5 *	Czech Rep.	–
Belarus	2.0 *	Spain	2.5 *	Lithuania	–
Bulgaria	2.0 *	Switzerland	2.5 *	Moldova, Rep.	–
Croatia	2.0 *	United Kingdom	2.5 *	Slovakia	–
Denmark	2.0 *	Norway	3.0 *	Ukraine	–
Estonia	2.0 *	Portugal	3.0 *		

New nations are excluded from this list when most of the available statistics pre-date independence.
* Underweight not included.

Abbreviations

AIDS	acquired immune deficiency syndrome
ARI	acute respiratory infections
BRAC	Bangladesh Rural Advancement Committee
CDC	US Centers for Disease Control and Prevention
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CRC	Committee on the Rights of the Child
DCI	Defense for Children International
DHS	Demographic and Health Surveys
DPT	combined diphtheria/pertussis (whooping cough)/tetanus vaccine
DT	combined diphtheria/tetanus vaccine
EU	European Union
FCUBE	Free, Compulsory and Universal Basic Education
FGM	female genital mutilation
GNP	gross national product
HIV	human immunodeficiency virus
IBFAN	International Baby Food Action Network
IGBM	Interagency Group on Breastfeeding Monitoring
ILO	International Labour Organization
IMR	infant mortality rate
MICS	Multiple Indicator Cluster Surveys
NCD	non-communicable diseases
NIH	US National Institutes of Health
NGO	non-governmental organization
ODA	official development assistance
OECD	Organisation for Economic Co-operation and Development
ORS/ORT	oral rehydration salts/oral rehydration therapy
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	Office of the United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
U5MR	under-five mortality rate
WHO	World Health Organization

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