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THE LEAST DEVELOPED COUNTRIES REPORT 2004

Part One: Chapter 2

SELECTED RECENT SOCIAL TRENDS:
POPULATION GROWTH, HUMAN DEVELOPMENT GOALS, THE HIV/AIDS EPIDEMIC

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Selected Recent Social Trends:

Population Growth, Human Development Goals, the HIV/AIDS Epidemic

Chapter 2

A. Population growth, age structure and urbanization

In 2003, the total population of the least developed countries was 718 million people, of whom some 428 million lived in African and Caribbean LDCs, 287.3 million in Asian LDCs and 2.7 million in island LDCs.

In comparison with other developing countries, population growth rates are high in the LDCs. They were actually increasing in the 1980s, and although they are now declining, the decrease is slow. It is estimated that the population growth rate has declined from 2.7 per cent per year in 1990–1995 to 2.4 per cent per year in 2000–2005. Although projections are difficult because of the progress of HIV/AIDS, the total population of the current group of LDCs is expected to reach 1.04 billion by 2020 and to double between 2001 and 2035. Chart 3 and chart 4 show the difference between trends in the LDCs and in other developing countries.

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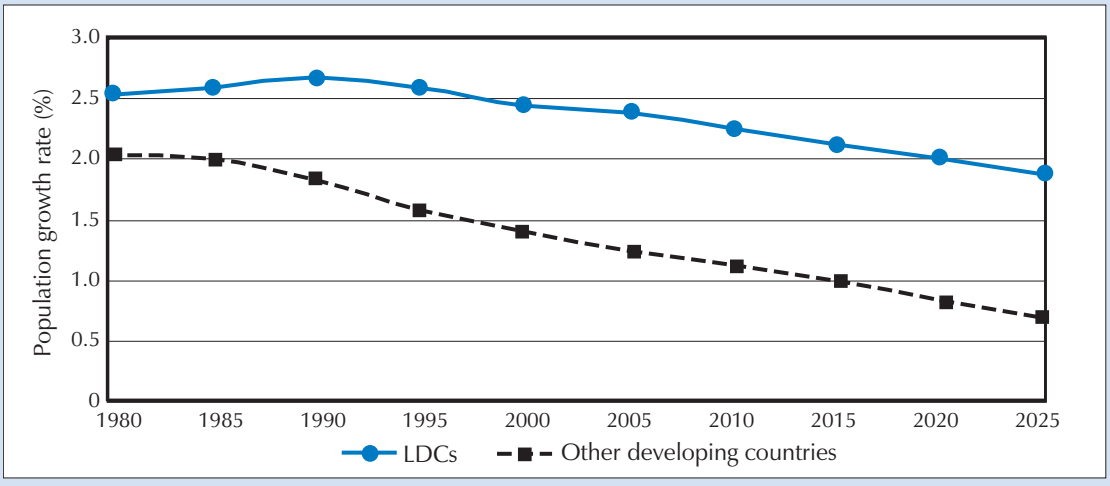
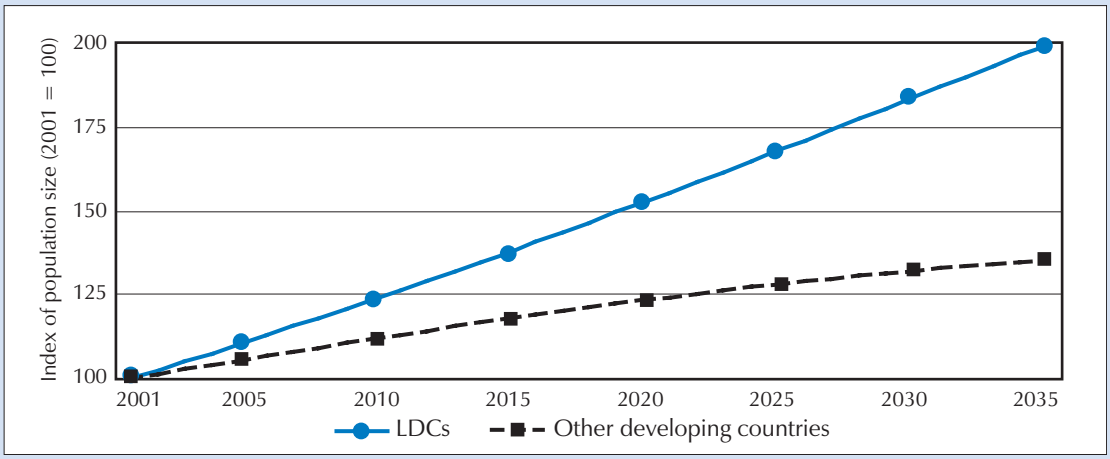
The high rates of population growth are due to the fact that the LDCs are at a much earlier stage of demographic transition than other developing countries.[1] The crude birth rate in 2000–2005 is estimated at 38.9 live births per 1,000 people in the LDCs as compared with 21.3 in other developing countries. The crude death rate in the same period was 15.1 per 1,000 people in the LDCs as compared with 7.8 per 1,000 in other developing countries (table 17).

CHART 3. ESTIMATED AND PROJECTED POPULATION GROWTH RATES IN THE LDCS AND IN OTHER DEVELOPING COUNTRIES, 1980–2025



Source: United Nations (2003a).

CHART 4. INDICES OF THE POPULATION SIZE OF THE LDCS AND OF OTHER DEVELOPING COUNTRIES, 2001–2035
(Index, 2001 = 100)



Source: UNCTAD secretariat estimates based on United Nations (2003a).

TABLE 17. CRUDE BIRTH RATE, CRUDE DEATH RATE AND TOTAL FERTILITY IN THE LDCS AND IN OTHER DEVELOPING COUNTRIES, 1995–2000 AND 2000–2005 AVERAGES

	Crude birth rate (per 1,000 population)		**Crude death rate** (per 1,000 population)		**Total fertility** (children per woman)	
	1995–2000	*2000–2005*	*1995–2000*	*2000–2005*	*1995–2000*	*2000–2005*
Least developed countries	40.7	38.9	15.9	15.1	5.46	5.13
Other developing countries	23.2	21.3	7.8	7.8	2.79	2.60

Source: United Nations (2003a).

The LDCs are at a much earlier stage of demographic transition than other developing countries.

Underlying the high birth rates in LDCs are very high fertility rates. During the period 2000–2005, it is estimated that every woman in the LDCs will give birth to 5.1 children. This is much higher than in other developing countries, where the fertility rate is 2.6. Within the LDC group, the fertility rate is higher in African LDCs (6.0 children per woman in 2000–2005) than in Asian LDCs (4.9). There are 16 LDCs where the fertility rate is over 6 children per woman — Afghanistan, Angola, Burkina Faso, Burundi, Chad, the Democratic Republic of the Congo, Ethiopia, Guinea-Bissau, Liberia, Malawi, Mali, Niger, Sierra Leone, Somalia, Uganda and Yemen. Most of these countries have very high population growth rates, as shown in table 18.

It is worth noting that amongst the LDCs, island LDCs and landlocked LDCs are at opposite ends of the spectrum in terms of birth rates and death rates. During the period 2000–2005, the average crude death rate in island LDCs, which stood at 5.9 per 1,000 population, was much lower than the rate in landlocked LDCs, which stood at 18.8 per 1,000. Similarly, although the difference was somewhat less, the average crude birth rate, which stood at 32.3 per 1,000 in the island LDCs during 2000–2005, was lower than the rate in the landlocked LDCs, which stood at 43 per 1,000. In general, island LDCs have better social indicators than other LDCs, and landlocked LDCs have worse ones. Life expectancy at birth provides an overall indicator that summarizes the pattern. Within the landlocked LDCs life expectancy is estimated as being only 45.9 years in 2000–2005, whilst in the island LDCs it is estimated at 53.6 years (based on United Nations, 2003a).

TABLE 18. POPULATION GROWTH RATES AND AGE STRUCTURE IN THE LDCs, 2000–2010

	Population Average annual growth rate (%) 2000–2005	2005–2010	% of population under 15 2000	% of population under 25 2000	Dependency ratio 2000
LDCs in which population growth rate is above the 2000–2005 LDC average					
Somalia	4.2	3.7	47.9	67.2	1.01
Liberia	4.1	2.7	46.6	66.6	0.95
Afghanistan	3.9	3.7	43.5	62.8	0.86
Sierra Leone	3.8	1.9	44.2	63.4	0.88
Eritrea	3.7	3.3	43.9	63.2	0.92
Niger	3.6	3.6	49.9	69.3	1.08
Yemen	3.5	3.6	50.1	68.2	1.06
Uganda	3.2	3.6	49.2	69.3	1.10
Angola	3.2	3.0	48.2	67.1	1.00
Burundi	3.1	3.3	47.6	68.0	1.04
Mali	3.0	3.2	46.1	65.8	1.06
Maldives	3.0	2.9	43.6	64.3	0.90
Mauritania	3.0	2.8	44.1	63.8	0.87
Chad	3.0	2.9	46.5	65.6	0.99
Bhutan	3.0	2.5	42.7	62.3	0.89
Burkina Faso	3.0	3.0	48.7	69.5	1.07
Guinea-Bissau	3.0	2.9	43.5	62.1	1.00
Solomon Islands	2.9	2.6	44.7	64.9	0.86
Democratic Republic of the Congo	2.9	2.9	48.8	67.7	0.98
Madagascar	2.8	2.7	44.7	64.0	0.91
Comoros	2.8	2.6	42.9	64.4	0.84
Gambia	2.7	2.3	40.3	58.2	0.81
Equatorial Guinea	2.7	2.5	43.8	62.1	0.91
Benin	2.7	2.6	46.3	66.6	0.96
Sao Tome and Principe	2.5	2.4	41.2	65.0	0.84
Ethiopia	2.5	2.4	45.2	64.3	0.95
Vanuatu	2.4	2.2	42.0	61.3	0.83
LDCs in which population growth rate is below the 2000-2005 LDC average					
Cambodia	2.4	2.3	43.9	62.5	0.86
Senegal	2.4	2.3	44.3	64.3	0.87
Togo	2.3	2.2	44.2	64.5	0.90
Lao People's Democratic Republic	2.3	2.2	42.7	62.1	0.86
Nepal	2.2	2.1	41.0	60.2	0.80
Sudan	2.2	1.8	40.1	59.9	0.77
Rwanda	2.2	2.1	44.3	66.5	0.92
Bangladesh	2.0	1.8	38.7	59.1	0.73
Cape Verde	2.0	1.9	39.3	61.1	0.85
Malawi	2.0	1.9	46.3	66.3	0.96
United Republic of Tanzania	1.9	1.8	45.0	65.6	0.93
Mozambique	1.8	1.5	43.9	63.6	0.90
Guinea	1.6	2.6	44.1	64.2	0.90
Djibouti	1.6	1.4	43.2	62.3	0.86
Haiti	1.3	1.3	40.6	62.2	0.80
Central African Republic	1.3	1.5	43.0	62.8	0.89
Myanmar	1.3	1.0	33.1	53.1	0.61
Zambia	1.2	1.3	46.5	67.3	0.97
Samoa	1.0	1.1	40.6	62.2	0.82
Lesotho	0.1	-0.5	39.3	59.1	0.82
LDCs	**2.4**	**2.3**	**43.2**	**63.2**	**0.86**

Source: UNCTAD secretariat estimates, based on United Nations (2003a).

Note: No data were available for Kiribati and Tuvalu.

An important consequence of the relatively high rate of population growth within LDCs generally is a relatively youthful age structure of the population. It is estimated that in 2000 43.2 per cent of the population were children less than 15 years old, and fully 63.2 per cent of the total population were under 25. The median age of the population in the LDCs, namely the age at which 50 per cent of the population is younger than and 50 per cent of the population is older than that age, was 18.1 years in 2000, compared with 17.5 years in 1980. The median age is projected to be 20.3 years in 2020.

63.2 per cent of total LDCs' population were under 25 in 2000.

Inevitably, there is a high dependency ratio, which is measured as the ratio of the dependent population (persons aged between 0 and 14 years, and 65 and over) to the working-age population (those aged between 15 and 64 years). For LDCs as a group, it is estimated that in 2000 the dependency ratio was 0.862. This compares with 0.582 in other developing countries. However, there are significant differences amongst the LDCs between the African and the Asian LDCs. In the African LDCs, the number of dependants is almost the same as the number of people of working age. There has been no change in this situation over the last 20 years, with the dependency ratio in 2000 standing at 0.936, the same level as it was in 1980. In Asian LDCs, in contrast, the dependency ratio is lower and has fallen slightly over the same period — from 0.857 to 0.832.[2]

For LDCs as a group, it is estimated that in 2000 the dependency ratio was 0.862. This compares with 0.582 in other developing countries.

The age structure puts considerable pressure on the provision of social services of all types and also implies that a high rate of employment creation is necessary in order to ensure that the population is fully employed. It is estimated that in 2000, 30.4 per cent of the population was of school age (6–17 years old). This figure is estimated to decrease only slightly — to 29.6 in 2010. ILO projections for the period 2000–2010 suggest that the total population of working age (15–64 years old) in LDCs as a group will increase by 29 per cent between 2000 and 2010. The annual increase in the population of working age will exceed 100,000 in 25 out of 44 LDCs for which data are available (table 19). Generating sustainable livelihoods, with remuneration above poverty lines, is a daunting challenge.

Finally, it is worth emphasizing that the majority of the population in LDCs, some 74 per cent, are located in rural areas. Urbanization is accelerating, however. The urban population share increased from 19 per cent in 1985 to 20.8 per cent in 1990, but it is estimated that in 2005 it will reach 28.4 per cent. A number of major metropolises are emerging. It is estimated that Dhaka in Bangladesh had a population of 12.5 million in 2000, and Kinshasa in the Democratic Republic of the Congo a population of 5 million. There were 17 other LDCs that had a city with a population of over 1 million in 2000. The total number of cities with over one million people is projected to increase from 22 in 2000 to 27 in 2015 in LDCs (based on United Nations, 2002).

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B. Progress towards selected human development goals[3]

The LDCs are identified as the poorest countries not just in terms of per capita income but also in terms of their low level of human assets and human development. The current gap between the LDCs as a group and developing countries as a whole and high-income OECD countries may be gauged from the following statistics:

- In 2001, life expectancy at birth in the LDCs was 50.4 years as against 64.4 years in developing countries as a whole and 78.1 years in high-income OECD countries.

Table 19. Trends in the working-age population[a] of the LDCs, 1990–2010

	Working-age population (Thousands)			Average yearly change in working-age population[b] (Thousands)				Change[c] (%)
	1990–1995	*1996–2000*	*2001*	*1990–1995*	*1996–2000*	*2000–2001*	*2000–2010*	*2000–2010*
Afghanistan	10 538	13 197	14 600	458	507	350	421	42.7
Angola	5 192	6 142	6 715	162	183	196	190	32.0
Bangladesh	63 886	73 223	79 585	1 405	1 963	2 319	2 124	27.5
Benin	2 488	2 987	3 306	81	100	113	110	34.9
Bhutan	343	400	438	8	13	12	34	30.4
Burkina Faso	4 548	5 310	5 792	111	164	144	181	29.7
Burundi	2 959	3 320	3 565	55	75	92	154	41.4
Cambodia	5 070	5 963	6 617	104	215	208	242	34.0
Cape Verde	191	218	236	6	4	10	7	35.1
Central African Republic	1 655	1 909	2 048	44	48	40	34	17.3
Chad	3 170	3 508	3 748	93	34	172	134	33.3
Comoros	237	282	310	8	8	11	13	35.3
Dem. Rep. of the Congo	20 186	23 937	26 059	698	668	749	859	37.4
Djibouti	281	325	346	9	7	7	..	..
Equatorial Guinea	200	228	247	4	6	7	6	30.2
Eritrea	1 784	2 036	2 192	45	47	60	84	41.5
Ethiopia	28 297	31 510	33 643	534	630	847	763	24.7
Gambia	568	691	753	23	22	16	19	26.2
Guinea	3 203	3 720	4 018	97	91	111	99	22.0
Guinea-Bissau	542	610	649	13	11	16	15	24.8
Haiti	3 588	4 181	4 564	92	122	131	84	21.5
Kiribati	..	54	55	..	..	1	..	..
Lao People's Dem. Rep.	2 311	2 682	2 921	58	76	83	91	31.0
Lesotho	987	1 101	1 152	23	18	14	5	5.2
Liberia	1 180	1 477	1 692	25	81	45	57	43.9
Madagascar	6 498	7 595	8 322	176	220	274	281	33.2
Malawi	4 464	5 076	5 468	75	143	98	135	22.2
Maldives	115	138	154	3	5	6	5	39.8
Mali	4 558	5 166	5 526	111	110	135	179	29.0
Mauritania	1 110	1 316	1 446	31	43	42	41	31.0
Mozambique	7 931	8 997	9 647	185	203	233	190	17.8
Myanmar	25 197	28 532	30 301	619	596	551	494	17.3
Nepal	10 647	12 130	13 077	245	292	349	320	26.5
Niger	4 034	4 902	5 431	139	176	164	222	39.9
Rwanda	3 388	3 754	4 256	- 45	164	158	113	24.5
Samoa	89	97	103	0	2	1	..	..
Sao Tome and Principe	..	80	82	..	..	2	..	..
Senegal	4 059	4 731	5 152	112	132	150	140	30.2
Sierra Leone	2 270	2 544	2 711	55	45	75	74	40.9
Solomon Islands	177	209	228	6	6	6	9	35.4
Somalia	3 606	4 074	4 504	25	138	145	183	43.9
Sudan	14 553	16 729	18 004	390	401	453	429	31.6
Togo	1 900	2 237	2 447	52	69	67	67	31.4
Uganda	8 715	10 272	11 186	266	299	299	450	35.6
United Rep. of Tanzania	14 135	16 648	18 006	465	450	433	556	27.6
Vanuatu	83	101	113	2	4	3	..	..
Yemen	6 615	8 284	9 201	346	264	371	304	49.6
Zambia	4 286	5 010	5 399	121	141	98	127	25.9
African LDCs	166 333	192 042	207 991	4 270	5 040	5 581	5 980	29.9
Asian LDCs	124 606	144 410	156 741	3 243	3 925	4 244	4 028	27.8
Island LDCs	894	1 179	1 281	25	30	40	34	36.0
LDCs	**291 833**	**337 631**	**366 013**	**7 538**	**8 995**	**9 865**	**10 042**	**29.0**

Source: UNCTAD secretariat estimates, based on World Bank, *World Development Indicators 2003*, CD-ROM; and ILO, LABORSTA database.

Note: No data were available for Tuvalu.

a The working-age population is the number of people between the ages of 15 and 64.

b The average yearly increase in working-age population was calculated as the average of the year-to-year changes in the given period.

c Percentage increase in working-age population between 2000 and 2010.

- During 1998–2000, 38 per cent of the population was undernourished as against 18 per cent in developing countries as a whole.
- In 2001, 33.7 per cent of the 15–24-year-old population was illiterate as against 15.2 per cent in developing countries as a whole.
- In 2001 the infant mortality rate was 101 per 1,000 live births in the LDCs as against 62 in developing countries as a whole and 5 in high-income OECD countries.
- In 2001, 16 out of every 100 children born alive in the LDCs died before their fifth birthday as against 9 out of every 100 in developing countries as a whole and less than 1 in every 100 in high-income OECD countries.
- In 1995–2001 only 31 per cent of births were attended by skilled health personnel in the LDCs as against 56 per cent in developing countries as a whole and 99 per cent in high-income OECD countries.
- In 1995, the maternal mortality rate was 1,000 per 100,000 live births in the LDCs as against 463 per 100,000 in developing countries as a whole and 12 per 100,000 in high-income OECD countries.
- In 2000, only 55 per cent of the rural population had sustainable access to an improved water source in rural areas of LDCs as against 69 per cent in developing countries as a whole (UNDP, 2003).

In 2001 the infant mortality rate was 101 per 1,000 live births in the LDCs as against 62 in developing countries as a whole and 5 in high-income OECD countries.

Progress is, nevertheless, being made in a number of LDCs. Table 20, based on the more detailed information in annex 1 to this chapter, sets out the trends since 1990 regarding a number of human development indicators which are used to measure progress towards achievement of the Millennium Development Goals (MDGs). Those targets are as follows:

(i) Halve, between 1990 and 2015, the proportion of people who suffer from hunger;

(ii) Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling;

(iii) Eliminate gender disparity in primary and secondary education, preferably by 2005 and at all levels of education no later than 2015;

(iv) Reduce by two thirds, between 1990 and 2015, the under-5 mortality rate;

(v) Halve, by 2015, the proportion of people without sustainable access to safe drinking water.

The lack of data is making it difficult to formulate any generalizations about progress by the LDCs as a group towards achievement of either the Millennium Development Goals or the POA targets.

These targets are also contained in the Programme of Action for the Least Developed Countries for the Decade 2001–2010 (POA), although there are differences between the goals of the POA and the MDGs (see box 1). For example, in the POA, as it was negotiated, the first target is actually more stringent, namely to halve the number of people suffering from hunger rather than the proportion of such people.

From the table and annex a number of points stand out.

First, there is a serious lack of data to monitor progress. Data coverage exceeds two thirds of the LDCs for only two of the five indicators. This problem was emphasized by UNCTAD soon after the POA was agreed (UNCTAD, 2001). There is an urgent need to improve national statistical capacity in the LDCs to monitor progress and provide data for informed policy-making on all fronts, including human development (see also UNDP, 2003: box 2.1). The lack of data is making it difficult to formulate any generalizations about progress by the LDCs

TABLE 20. PROGRESS TOWARDS ACHIEVEMENT OF SELECTED HUMAN DEVELOPMENT TARGETS[a] IN THE LDCS, 1990–2000

	Data availability	Achieved	Achievable by 2015	Low progress	Reversal/stagnation[b]
Hunger	34 LDCs		11 Chad Myanmar Malawi Sudan Benin Haiti Mozambique Guinea Mali Angola Togo	8 Lao People's Dem. Rep. Cambodia Mauritania Niger Central African Republic Uganda Yemen Lesotho	15 Afghanistan Burundi Dem. Rep. of the Congo Liberia Madagascar Rwanda Senegal Sierra Leone Somalia United. Rep. of Tanzania Zambia Bangladesh Burkina Faso Gambia Nepal
Primary education	25 LDCs	7 Cambodia Cape Verde Malawi Maldives Samoa Uganda Vanuatu	5 Rwanda Togo Bangladesh Lao People's Dem. Rep. Benin	10 Gambia Mali Senegal Eritrea Lesotho Mozambique Burkina Faso Niger Burundi Central African Republic	3 Dem. Rep. of the Congo United. Rep. of Tanzania Djibouti
Gender equality in education	29 LDCs	9 Bangladesh Lesotho Madagascar Maldives Rwanda Samoa Sudan Vanuatu Zambia	9 Mauritania Malawi United. Rep. of Tanzania Nepal Djibouti Myanmar Gambia Senegal Dem. Rep. of the Congo	8 Guinea Lao People's Dem. Rep. Niger Sierra Leone Togo Mali Burkina Faso Mozambique	3 Burundi Eritrea Ethiopia
Child mortality	48 LDCs		11 Bangladesh Bhutan Samoa Vanuatu Lao People's Dem. Rep. Nepal Cape Verde Comoros Solomon Islands Maldives Guinea	23 Eritrea Equatorial Guinea Uganda Yemen Malawi Kiribati Madagascar Djibouti Gambia Haiti Sao Tome and Principe Niger Guinea-Bissau Mozambique Myanmar Benin Sudan Ethiopia Lesotho Mali Togo Senegal Burkina Faso	14 Cambodia Rwanda United. Rep. of Tanzania Zambia Afghanistan Angola Burundi Central African Republic Chad Dem. Rep. of the Congo Liberia Mauritania Sierra Leone Somalia
Access to safe water	22 LDCs	7 Bangladesh Comoros Djibouti Maldives Nepal Samoa United. Rep. of Tanzania	6 Central African Republic Burundi Zambia Sudan Mali Senegal	6 Malawi Niger Uganda Togo Guinea Madagascar	3 Ethiopia Haiti Mauritania

Source: UNCTAD secretariat estimates, based on UNDP Human Development Report Office: direct communication. For details, see annex 1, table 1 of this chapter.

a The quantitative variables used to monitor the targets on hunger, primary education, gender equality in education, child mortality and access to safe water are under-nourished people as percentage of total population, net primary school enrolment ratio, ratio of girls-to-boys in primary and secondary school, under-five child mortality rate (per 1,000 live births) and percentage of people with sustainable access to improved water sources, respectively.

b Reversal or stagnation concerns cases in which the selected human development indicator either worsened or stagnated between 1990 and 2000.

Box 1. The need to reconcile the MDGs and quantifiable targets of the Programme of Action for the Least Developed Countries for the Decade 2001–2010.

An important feature of the Programme of Action for the Least Developed Countries for the Decade 2001–2010, which was agreed at the Third United Nations Conference on the Least Developed Countries held in Brussels in May 2001 (United Nations, 2001), was the inclusion of quantifiable development targets. These are similar to the targets associated with the MDGs, but they are not identical.

There are differences regarding the level of improvement that is expected, the indicators that are used and the time frame that is applied. One MDG target, for example, is a 75 per cent reduction of the maternal mortality rate between the base year 1990 and the target year 2015, while the corresponding POA target is a 75 per cent reduction of the maternal mortality rate between the base year 2001 and the target year 2015. Inconsistencies can be observed with respect to development targets on poverty, nutrition, health, education, gender equality and infrastructure.

There are not only overlaps between MDG targets and POA targets, but also several overlaps between different types of POA targets themselves. Furthermore, a good number of development targets in the Programme of Action are formulated in a manner that does not allow for measurement and monitoring of progress. This is because many of the targets have no base years (where necessary), no target years or no indicators associated with them.

In order to promote progress towards the monitoring of international development goals for the least developed countries it is necessary that the different targets be made measurable and the data situation improved, but it is also highly desirable that inconsistencies between different sets of international development goals be resolved. The failure to harmonize the two sets of targets until now has effectively led to a focus on the MDG targets and a widespread neglect of POA targets. This does not matter for those POA targets that are similar to those of the MDGs, but it does for those that are different. In sum, it is essential that the POA and MDG targets be harmonized and that the inconsistencies amongst the POA targets themselves be resolved.

Source: Herrmann (2003).

as a group towards achievement of either the Millennium Development Goals or the POA targets.

Secondly, with regard to the only indicator for which data coverage is more or less complete (under-5 mortality), only 11 out of the 48 LDCs for which data are available are likely to achieve the target. Six of these are island LDCs which start with relatively low levels of under-5 mortality.

Thirdly, for each individual target there are some countries where significant progress has been made. Notable cases include the following:

For each individual target there are some countries where significant progress has been made.

- The proportion of the population that is undernourished has fallen sharply from very high levels during the 1990s in Chad, Haiti, Malawi and Mozambique. In these four countries, the proportion undernourished during 1990–1992 was 58 per cent, 64 per cent, 49 per cent and 69 per cent respectively. During 1998–2000, the proportion had fallen to 32 per cent, 50 per cent, 33 per cent and 55 per cent respectively.
- Net primary school enrolment rates increased substantially from 1990 to 2000 in Bangladesh (from 64 per cent to 89 per cent), Benin (from 49 per cent to 70 per cent), Eritrea (from 24 per cent to 41 per cent), Gambia (from 51 per cent to 69 per cent), the Lao People's Democratic Republic (from 61 per cent to 81 per cent), Malawi (from 50 per cent to 100 per cent), Mali (from 21 per cent to 43 per cent), Rwanda (from 66 per cent to 97 per cent), Senegal (from 48 per cent to 63 per cent) and Togo (from 75 per cent to 92 per cent).
- The ratio of girls to boys in primary and secondary school rose impressively from 1990 to 2000 in Bangladesh (from 72 per cent to 103 per cent), Gambia (from 64 per cent to 85 per cent), Mauritania (from 67 per cent to 93 per cent), Nepal (from 53 per cent to 82 per cent) and Sudan (from 75 per cent to 102 per cent).

- The under-5 mortality rate fell sharply between 1990 and 2001 in Bangladesh (from 144 per 1,000 live births to 77), Bhutan (from 166 to 95), Comoros (from 120 to 79), Guinea (from 240 to 169), the Lao People's Democratic Republic (from 163 to 100), Maldives (from 115 to 77) and Nepal (from 145 to 91).
- The proportion of the population with sustainable access to improved water sources has risen particularly sharply in the United Republic of Tanzania. It is estimated that in 1990 only 38 per cent had such access, while in 2000 the proportion was 68 per cent.

Fourthly, no country is on course to meet all five of these human development targets by 2015. However, three countries — Bangladesh, Maldives and Samoa — are on course to meet four of them.

More progress is being made in human development dimensions that are directly affected by the quantity and quality of public services than with regard to those that are the outcome of both public services and levels of household income.

Fifthly, more progress is being made in human development dimensions that are directly affected by the quantity and quality of public services (primary education, gender equity in education and access to water) than with regard to those that are the outcome of both public services and levels of household income (hunger and child mortality). Progress is most promising in the area of gender equity: 9 out of the 29 LDCs for which data are available have already achieved the target, and a further 9 will achieve it by 2015 if current rates of progress continue.

C. The HIV/AIDS epidemic[4]

1. The gravity of the problem in LDCs

The HIV/AIDS epidemic is an important problem for LDCs and in some, particularly in Africa, it is turning into a development crisis which is threatening growth prospects and the achievement of human development goals. The advance of the epidemic in LDCs is a matter of acute concern because of their limited domestic resources to limit the spread of the virus and cope with its effects.

The HIV/AIDS epidemic is an important problem for LDCs and in some, particularly in Africa, it is turning into a development crisis which is threatening growth prospects and the achievement of human development goals.

There are major data difficulties in tracking the progress of the epidemic. But according to data in UNAIDS (2002), in 2001, when the LDCs comprised 11 per cent of the global population:

- 25.5 per cent of all men living with HIV in the world lived in LDCs (4.7 million out of 18.6 million);
- 35 per cent of all women living with HIV in the world lived in LDCs (6.5 million out of 18.5 million);
- 46 per cent of all children living with HIV in the world lived in LDCs (1.4 million out of 3 million);
- 37 per cent of all deaths from HIV/AIDS in the world occurred in LDCs (1.1 million out of 3 million);
- almost 50 per cent of all child deaths from HIV/AIDS in the world occurred in LDCs (about 280,000 out of 580,000);
- 48.5 per cent of children orphaned by HIV/AIDS live in LDCs (6.8 million out of 14 million) (UNAIDS, 2002).

Out of the 54 countries in which infection rates were above 1 per cent of the adult population in 2001, 28 were LDCs (see table 21). Most of these are located in Africa. For LDCs as a whole the adult HIV prevalence rate in 2001 was 4.1 per cent. But it was much higher (6.6 per cent) in African LDCs than in

TABLE 21. HIV PREVALENCE RATES IN ADULTS (AGED BETWEEN 15 AND 49) IN THE LDCs, 2001

Less than 3 per cent		Between 3 and 6 per cent		Between 6 and 13 per cent		Above 13 per cent	
Bangladesh	<0.1	Equatorial Guinea	3.4	Haiti	6.1	Malawi	15.0
Bhutan	<0.1	Benin	3.6	Ethiopia	6.4	Zambia	21.5
Lao People's Dem. Rep	<0.1	Chad	3.6	Burkina Faso	6.5	Lesotho	31.0
Maldives	0.1	Dem. Republic of the Congo	4.9	Sierra Leone	7.0		
Yemen	0.1	Uganda	5.0	United Rep. of Tanzania	7.8		
Madagascar	0.3	Angola	5.5	Burundi	8.3		
Senegal	0.5	Togo	6.0	Rwanda	8.9		
Nepal	0.5			Djibouti[a]	11.8		
Somalia	1.0			Central African Republic	12.9		
Gambia	1.6			Mozambique	13.0		
Mali	1.7						
Myanmar[a]	2.0						
Sudan	2.6						
Cambodia	2.7						
Eritrea	2.8						
Guinea-Bissau	2.8						
Liberia[a]	2.8						

Source: UNCTAD secretariat classification based on UNAIDS (2002).

Note: Data on HIV/AIDS prevalence rate were not available for the following LDCs: Afghanistan, Cape Verde, Comoros, Guinea, Kiribati, Mauritania, Niger, Samoa, Sao Tome and Principe, Solomon Islands, Tuvalu and Vanuatu.

a 1999 data.

Asian LDCs (0.2 per cent). There are 15 LDCs in Africa where the adult HIV prevalence rate exceeds 5 per cent. Infection rates are also high in Haiti and, within Asia, it exceeds 2 per cent in Cambodia and Myanmar. Overall deaths due to AIDS in 2001 were 2 per 1,000 persons in LDCs, as compared with 0.5 in the world as a whole.

A very disturbing feature of the epidemic is that the infection rates are high amongst young women. For LDCs as a group, 4.9 per cent of women aged between 15 and 24 live with HIV, as compared with 1.4 per cent for the world as a whole. Within African LDCs, 7.2 per cent of young women live with HIV, and there are at least 5 African LDCs in which one in ten of women aged between 15 and 24 live with HIV.

The intensity of HIV/AIDS within LDCs as a group at the present time reflects the current epicentre of the global epidemic in Africa and the weight of African countries within the LDC group.

The intensity of HIV/AIDS within LDCs as a group at the present time reflects the current epicentre of the global epidemic in Africa and the weight of African countries within the LDC group. Within Sub-Saharan Africa, there does not appear to be an overconcentration of people living with and dying from HIV/AIDS in LDCs. Within Sub-Saharan Africa, LDCs constituted over 50 per cent of the population in 2001, and accounted for 39 per cent of the men, 40 per cent of the women and 51 per cent of the children living with HIV/AIDS in the region. Similarly, 47 per cent of the adult and child deaths from HIV/AIDS in Sub-Saharan Africa occurred in LDCs.

There is some evidence that the epidemic has declined in Uganda and Zambia.

Perhaps the only positive feature of the current situation is that there is some evidence that the epidemic has declined in Uganda and Zambia. In Uganda, HIV prevalence rates among pregnant women in Kampala fell, according to UNAIDS (2002: 24), for eight consecutive years — from 29.5 per cent in 1992 to 11.3 per cent in 2001, a fact which suggests that the HIV/AIDS epidemic is being brought under control. More Ugandans are receiving antiretroviral drugs, but the rate of new infections remains high. It is hoped that Zambia is now

becoming the second African country to reverse the epidemiological crisis. HIV prevalence, though still high in Zambia, has significantly decreased among 15–29-year-old urban women from 28.3 per cent in 1996 to 24.1 per cent in 1999. For rural women aged between 15 and 24, HIV prevalence rates fell from 16.1 per cent to 12.2 per cent over the same period (UNAIDS, 2002: 26).

2. The economic and social impact of the epidemic

Increasing evidence suggests that the effects of the HIV/AIDs epidemic are particularly severe in the agricultural sector.

The HIV/AIDS epidemic is having, and will have, major detrimental consequences for economic activity as well as for the achievement of human development goals. This negative impact lags behind the spread of the HIV infection because it takes approximately seven to eight years before HIV-infected people become seriously ill and die.

There are various estimates of the macroeconomic impact (see McPherson, 2003). UNDP (2001) estimates that in the 1990s AIDS reduced Africa's per capita annual growth by 0.8 per cent. Other calculations suggest that the rate of economic growth has declined by 2–4 per cent in sub-Saharan Africa as result of AIDS (UNAIDS, 2002). It is also suggested that in the worst affected countries one to two percentage points will be pared off per capita growth in the coming years. If this happens, a number of economies will, after two decades, be about 20–40 per cent smaller than they would have been in the absence of AIDS (UNDP, 2001). According to UNAIDS (2002), for those countries with national HIV/AIDS prevalence rates of 20 per cent, annual GDP growth may fall by an average of 2.6 percentage points. Moreover, there is an adverse fiscal impact. Public revenues could drop by an expected 20 per cent by 2010 — as in Botswana — in AIDS-affected LDCs as a result of the economic impact of the HIV/AIDS epidemic (UNDP, 2002: 3).

Owing to labour bottlenecks, the problems of rural women, and especially female-headed households, can be particularly severe.

Increasing evidence suggests that the effects of the HIV/AIDS epidemic are particularly severe in the agricultural sector. This is going to have important negative consequences in countries such as the LDCs, in which the majority of the population live in rural areas and earn their living from agriculture. The reason for the severity of the impact is that the human resource losses associated with the epidemic are much less easily absorbed given the structure of agriculture, especially smallholder agriculture. The illness of productive members of the household leads to a double loss — the productive individual works less and there is a major demand for care for the sick person. About 20 per cent of rural families in Burkina Faso, for example, have reduced the amount of agricultural work done or abandoned their farms because of HIV/AIDS. In Ethiopia AIDS-affected households spent 11.6 to 16.4 hours per week performing agricultural work as compared with an average of 33.6 hours for non-AIDS-affected households (UNAIDS, 2002: 49). In Malawi, Mozambique and Zambia, there has been a progressive increase in cassava production (less labour-intensive) as a shift from staple-food maize production to compensate for lost labour (De Waal and Tumushabe, 2003). As labour bottlenecks tighten, malnutrition increases and traditional community-level support mechanisms are subjected to strain. The problems of rural women, and especially female-headed households, can be particularly severe. Food security worsens owing to reduced food availability caused by falling production with disruptions of the farming cycle, as well as owing to reduced food access due to declining income for food purchases.

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The HIV/AIDS epidemic is also affecting non-agricultural enterprises. In Zambia, for example, it is estimated that nearly two thirds of deaths among

managers are related to AIDS (UNAIDS, 2002: 58). Studies in southern Africa suggest that direct and indirect expenses incurred by firms on account of AIDS could cut profits by 6 to 8 per cent (ibid.: 54).

The public sector has also been suffering the costs of AIDS as service delivery has faltered, with experienced State employees falling sick and dying. This is affecting school teachers and health workers. In the Central African Republic, 85 per cent of teachers who died between 1996 and 1998 were HIV-positive, and they died on average 10 years before they were due to retire. Malawi has reportedly been losing at least one teacher a day (UNFPA, 2002). According to UNAIDS (2002), in Malawi and Zambia there has been a five- or sixfold increase in illness and death rates among health workers. To compensate for this, expenditure on the training of doctors and nurses to replace dying medical personnel would have to increase by 25–40 per cent in southern Africa in 2001–2010.

In sub-Saharan Africa, the annual direct medical costs of AIDS, excluding antiretroviral therapy, have been estimated at $30 per capita, although overall public health spending is less than $10 per capita for most African countries.

The epidemic is also adversely affecting school attendance. Children, especially girls, are removed from school, and kept at home to care for parents and family members, or to do housework to free older women for nursing, thus damaging growth prospects for the next generation. Children may become the household's only breadwinners, as working-age adults start falling victim to AIDS, and with other household members too old or too young to work. Carrying the burden of AIDS, the household may become unable to afford school fees and other expenses, and this could have serious intergenerational implications for future income, savings, productivity and growth, creating a vicious downward spiral. Spending on education is often redirected to the AIDS patient if he or she is a household member. Moreover, AIDS-infected children may not survive through the years of schooling.

Among the LDCs, in the Central African Republic school enrolment is reported to have fallen by 20 to 36 per cent, with girls being most affected (UNAIDS, 2002: 52). It is also notable that orphan school attendance in African LDCs is estimated to be 79 per cent of non-orphan school attendance.

For LDCs as a group child mortality rates in 2015–2020 are expected to be 14 per cent higher with the HIV/AIDS epidemic than they would have been without it.

Finally, the epidemic is overwhelming the capacity of health budgets and systems. In sub-Saharan Africa, the annual direct medical costs of AIDS, excluding antiretroviral therapy, have been estimated at $30 per capita, although overall public health spending is less than $10 per capita for most African countries (UNDP, 2001: 8). It is in this context that access to cheap retroviral drugs is so important. The quality of care is being adversely affected for all diseases owing to the high patient load and the inadequate number of hospital beds in AIDS-affected countries.

Some evidence of the expected social impact of the epidemic in LDCs is shown in table 22. For LDCs as a group child mortality rates in 2015–2020 are expected to be 14 per cent higher with the HIV/AIDS epidemic than they would have been without it. Life expectancy at birth in LDCs in 2010–2015 is expected to be 46.1 years rather than 58.7 years, which would have been attained without the HIV/AIDS epidemic. Life expectancy at birth in the LDCs with the highest rates of adult HIV prevalence now — Lesotho, Malawi and Zambia — is expected to be as low as 32.2, 39.7 and 35.3 years respectively during 2010–2015. Without the HIV/AIDS epidemic they would have been 63, 59.2 and 57.4 years respectively.

TABLE 22. ESTIMATED AND PROJECTED IMPACT OF AIDS ON UNDER-5 MORTALITY RATE AND LIFE EXPECTANCY AT BIRTH IN THE LDCs, GROUPED BY ADULT HIV PREVALENCE RATE RANGES,[a] 1995–2000, 2000–2005, 2015–2020 AND 2010–2015

(Annual average)

	Under-5 mortality rate (per 1,000 live births)						Life expectancy at birth (years)					
	With AIDS	Without AIDS	% diff.	With AIDS	Without AIDS	% diff.	With AIDS	Without AIDS	% diff.	With AIDS	Without AIDS	% diff.
	1995–2000			2015–2020			2000–2005			2010–2015		
Adult HIV prevalence rates above 13%												
Lesotho	159	121	32	132	67	98	35.1	59.0	-68.1	32.2	63.0	-95.7
Malawi	238	207	15	159	132	20	37.5	55.2	-47.2	39.7	59.2	-49.1
Zambia	167	122	38	84	68	24	32.4	53.4	-64.8	35.3	57.4	-62.6
Adult HIV prevalence rates between 6 and 13%												
Burkina Faso	170	153	11	87	82	7	45.7	54.2	-18.6	50.2	58.2	-15.9
Burundi	211	185	14	145	122	19	40.9	51.5	-25.9	44.3	55.4	-25.1
Central African Republic	170	145	17	103	85	20	39.2	53.4	-36.2	41.5	56.4	-35.9
Djibouti	199	178	11	158	116	37	45.7	52.3	-14.4	46.2	56.3	-21.9
Ethiopia	197	177	12	122	100	22	45.5	52.5	-15.4	48.2	56.5	-17.2
Haiti	115	109	5	75	71	5	49.5	59.2	-19.6	53.4	63.3	-18.5
Mozambique	235	210	12	164	141	17	38.1	48.5	-27.3	39.3	52.5	-33.6
Rwanda	220	191	15	134	120	12	39.3	50.7	-29.0	44.7	54.9	-22.8
Sierra Leone	287	281	2	195	190	2	34.2	37.9	-10.8	35.1	41.9	-19.4
United Rep. of Tanzania	129	113	14	72	62	15	43.3	52.1	-20.3	46.5	54.1	-16.3
Adult HIV prevalence rates between 3 and 6%												
Angola	218	213	3	151	144	5	40.1	44.1	-10.0	41.5	48.1	-15.9
Benin	145	140	3	93	83	12	50.6	53.8	-6.3	52.9	57.9	-9.5
Chad	212	207	3	137	133	3	44.7	48.8	-9.2	48.5	52.8	-8.9
Dem. Rep. of the Congo	151	141	7	84	77	9	41.8	48.0	-14.8	45.4	51.0	-12.3
Equatorial Guinea	..	..	..	..	..	..	49.1	52.0	-5.9	50.1	56.0	-11.8
Togo	139	125	11	78	70	13	49.7	57.0	-14.7	52.3	61.0	-16.6
Uganda	186	165	13	107	102	5	46.2	55.5	-20.1	55.0	59.5	-8.2
Adult HIV prevalence rates less than 3%												
Cambodia	119	116	3	58	53	9	57.4	59.9	-4.4	59.2	63.9	-7.9
Eritrea	156	150	4	89	80	12	52.7	55.2	-4.7	54.9	59.3	-8.0
Gambia	214	210	2	144	141	2	54.1	56.5	-4.4	58.1	60.5	-4.1
Guinea	..	..	..	..	..	..	49.1	51.5	-4.9	53.1	55.5	-4.5
Guinea-Bissau	225	220	2	154	150	3	45.3	47.8	-5.5	47.9	51.8	-8.1
Liberia	172	164	5	64	61	7	41.4	46.0	-11.1	42.9	50.0	-16.6
Mali	261	257	2	181	158	14	48.6	50.6	-4.1	52.3	54.4	-4.0
Myanmar	142	139	2	81	79	3	57.3	59.2	-3.3	58.8	63.2	-7.5
Sudan	..	..	..	..	..	..	55.6	57.5	-3.4	57.0	61.5	-7.9
LDCs, average	**186**	**171**	**9**	**117**	**103**	**14**	**44.6**	**54.9**	**-23.1**	**46.1**	**58.7**	**-27.4**
African LDCs, average	**188**	**172**	**10**	**121**	**106**	**14**	**44.1**	**51.7**	**-17.4**	**46.7**	**55.6**	**-18.9**
Memo:												
Africa, average	164	146	12	101	86	17	45.2	52.5	-16.3	47.8	56.4	-18.0
World average	121	114	6	77	69	12	50.6	58.9	-16.2	52.1	62.4	-19.8

Source: UNCTAD secretariat estimates, based on United Nations (2002).

a Refers to the countries' 2001 adult HIV prevalence rates, except for Djibouti, Liberia and Myanmar for which 1999 was the latest year available.

3. THE NEXUS BETWEEN POVERTY AND HIV/AIDS

There is a close, two-way relationship between poverty and HIV/AIDS. As UNFPA (2002: Overview of Chapter 6) has put it, "HIV/AIDS accompanies poverty, is spread by poverty and produces poverty in its turn". Poverty is one of the factors that create situations that cause people to engage in high-risk behaviour that makes them more vulnerable to HIV. For survival in conditions of extreme poverty, people, especially women and young girls, trade sex, often

unprotected under the threat of competition, for food, money, school fees or other essentials for themselves or their families, thus exposing themselves to HIV infections. This is contributing to the high incidence of HIV amongst young women noted earlier. Migration, some of which is associated with economic stress and the search for work, is also associated with the spread of the disease.

"HIV/AIDS accompanies poverty, is spread by poverty and produces poverty in its turn."

Extreme income poverty is associated with a lower nutritional status and a poorer general state of health. This can result in a less robust immune system, which lowers resistance to HIV exposure, and makes those already infected more susceptible to related infections. The poor may also have less access to sexual health and HIV education programmes, and less access to public health facilities, including treatment for sexually transmitted infections.

HIV/AIDS also exacerbates poverty. The very limited resources of households are drained as sick wage earners lose their jobs, and household assets are used for medicines and health care for sick family members. Savings and capital, which are so important for recovery and rebuilding, are drawn upon, and available resources are utilized for survival consumption instead of investment. According to one case study on the United Republic of Tanzania cited by UNAIDS (2002: 48), in households where one person was ill because of AIDS, as much as 29 per cent of savings was redirected in order to cope with the illness, with families thus being driven to the brink of economic ruin. The financial burden of funerals is high, for example in the United Republic of Tanzania, where households are reported to spend up to 50 per cent more on funerals than on medical care (UNDP, 2001). The vicious spiral is even more evident when AIDS strikes one family member and the family disposes of its assets, and other family members with bleak prospects for decent work are forced into high-risk activities to help cope with the costs of the disease.

In Southern Africa, the negative effects of the combination of food insecurity and AIDS have been further reinforced owing to a weakened capacity for governance following the death from AIDS of key personnel in government institutions.

The great danger is that this process will reach such a scale that communities break down and economic regress occurs at the national level. It has been argued that parts of Africa, including a number of LDCs, are now facing, or will soon face, a "new variant famine" (De Waal and Tumushabe, 2003). This is a type of famine that is closely associated with the undermining of productive capacities in agriculture and the breakdown of community support systems as an increasing proportion of the local population succumbs to AIDS. The situation in parts of southern Africa in 2002 is said to exemplify this phenomenon. There too the negative effects of the combination of food insecurity and AIDS have been further reinforced owing to a weakened capacity for governance following the death from AIDS of key personnel in government institutions.

To sum up, the nexus between poverty and HIV/AIDS is a particularly vicious link in the various domestic vicious circles that make it so difficult for poor countries and poor people to escape from poverty. It may also lead to economic regress which will intensify poverty and threaten human development achievements. Dealing with this will be a key challenge in the coming years not only for the LDCs where the epidemic is already raging, but also in the Asian LDCs.

D. Conclusions

A defining characteristic of the LDCs is that they have low levels of life expectancy, widespread hunger, disease and illiteracy, and high rates of infant, child and maternal mortality. The data in this chapter show that a few of them made significant progress in the 1990s towards the achievement of some of the human development targets set following the Millennium Declaration and

contained in the Programme of Action for the Least Developed Countries for the Decade 2001–2010. These successes suggest what may be possible. But overall the picture is one in which urgent action will be needed in most LDCs to achieve agreed goals. With regard to under-5 mortality, the only indicator where data coverage is almost complete, only 11 out of 48 LDCs can be expected to meet the goal of reducing child mortality by two thirds between 1990 and 2015 if the trends of the 1990s continue.

The task that the LDCs face is difficult because of the very low starting level in relation to most social indicators. But in addition, population growth rates in the LDCs are higher than in other countries and the age structure is much younger. It is estimated that in 2000 30 per cent of the population of LDCs was of school age (6–17 years old) and 43 per cent were under 15 years old. The dependency ratio was 0.862 in that year. Thus, each person aged between 15 and 64 had to support almost one "dependant" (under 15 or 65 years and over). By 2020 the median age of the LDC population, the age at which half the population is younger than and half the population is older than that age, is projected to be 20.3 years, up from 18.1 years in 2000. The pressure on education and health services from the very youthful population is thus going to continue for the next 20 years.

The LDC working-age population will increase by 29 per cent between 2000 and 2010. Reducing poverty will depend on creating remunerative employment for these new entrants to the workforce, as well as on improving the incomes of the existing workforce.

It is expected that the population of the LDCs, some 718 million in 2003, will increase to over 1 billion in 2020. The working-age population will increase by 29 per cent between 2000 and 2010. Reducing poverty will depend on creating remunerative employment for these new entrants to the workforce, as well as on improving the incomes of the existing workforce. The latter task is a major challenge, given that in 2001 34 per cent of the population aged between 15 and 24 in LDCs was illiterate.

The social and human challenges facing LDCs are all the more difficult because in some, particularly in Africa, the HIV/AIDS epidemic has reached a level where it is threatening growth prospects and further reducing the likelihood of achieving human development targets. At the present time the LDCs are disproportionately affected by the epidemic. This is perhaps best exemplified by the fact that whilst the LDCs constituted 11 per cent of the world population in 2001, they were the location for 46 per cent of the children recorded as living with HIV, 50 per cent of recorded child deaths from AIDS and 48.5 per cent of children orphaned by HIV/AIDS.

The HIV/AIDS epidemic threatens to become a particularly vicious link in a cycle of pervasive poverty, economic stagnation and low levels of human development. The seriously affected LDCs have very limited resources to cope with the problem, and urgently need external assistance to reverse current trends.

The HIV/AIDS epidemic threatens to become a particularly vicious link in a cycle of pervasive poverty, economic stagnation and low levels of human development. The seriously affected LDCs have very limited resources to cope with the problem, and urgently need external assistance to reverse current trends. Unless trends improve, as they have done in Uganda, not simply the achievement of the MDG and POA targets for reducing HIV infection rates, but also the achievement of all other poverty and human development targets will be put in jeopardy. Those LDCs that currently have low rates of infection need to ensure that the epidemic does not spread further among the population.

Finally, the need for better, more and more timely information on economic and social trends in the LDCs needs to be reiterated. As noted in the 2002 LDC Report, the data that are internationally available for measuring progress towards achievement of the MDGs and also the POA targets are "woefully inadequate in terms of their coverage of LDCs, their quality and their timeliness" (UNCTAD, 2002: 32). There is an urgent need for increased investment in national statistical systems. Better policies, at the national and international levels, ultimately depend on better information.

Annex 1: Progress towards achievement of selected Millennium Development Goals in LDCs

This annex, based on data provided by the UNDP Human Development Report Office, sets out the trends since 1990 regarding a number of human development indicators which are used to measure progress towards achievement of the Millennium Development Goals. These targets are:

(i) Halve, between 1990 and 2015, the proportion of people who suffer from hunger;

(ii) Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling;

(iii) Eliminate gender disparity in primary and secondary education, preferably by 2005 and at all levels of education no later than 2015;

(iv) Reduce by two thirds, between 1990 and 2015, the under-5 mortality rate;

(v) Halve, by 2015, the proportion of people without sustainable access to safe drinking water.

ANNEX TABLE 1. PROGRESS TOWARDS SELECTED HUMAN DEVELOPMENT TARGETS IN LDCS

	Target[a]	1990 level	2000 level	2015 target	Required 2000 level	Expected date of achievement[b]
Afghanistan	Hunger	63.0	70.0	31.5	52.5	Reversal
	Primary education	..	..	100.0	..	..
	Gender equality in education	50.0[c]	..	100.0	..	..
	Child mortality	260.0	257.0	86.7	183.7	Stagnation
	Access to safe water	..	13.0	..	..	..
Angola	Hunger	61.0	50.0	30.5	50.8	2015
	Primary education	..	36.9	100.0	..	..
	Gender equality in education	..	84.1[d]	100.0	..	..
	Child mortality	260.0	260.0	86.7	183.7	Stagnation
	Access to safe water	..	38.0	..	..	..
Bangladesh	Hunger	35.0	35.0	17.5	29.2	Stagnation
	Primary education	64.0	88.9	100.0	78.4	2004
	Gender equality in education	72.5	102.8	100.0	Achieved	Achieved
	Child mortality	144.0	77.0	48.0	101.8	2006
	Access to safe water	94.0	97.0	97.0	Achieved	Achieved
Benin	Hunger	19.0	13.0	9.5	15.8	2004
	Primary education	48.8[c]	70.3[d]	100.0	65.2	2010
	Gender equality in education	..	62.2[d]	100.0	..	..
	Child mortality	185.0	158.0	61.7	130.7	2040
	Access to safe water	..	63.0	..	..	..
Bhutan	Hunger	..	..	..	..	..
	Primary education	..	..	100.0	..	..
	Gender equality in education	..	..	100.0	..	..
	Child mortality	166.0	95.0	55.3	117.3	2007
	Access to safe water	..	62.0	..	..	..
Burkina Faso	Hunger	23.0	23.0	11.5	19.2	Stagnation
	Primary education	26.9	35.5	100.0	56.1	After 2040
	Gender equality in education	60.6	69.6	100.0	76.4	2034
	Child mortality	210.0	197.0	70.0	148.4	After 2040
	Access to safe water	..	42.0	..	..	..
Burundi	Hunger	49.0	69.0	24.5	40.8	Reversal
	Primary education	52.0[e]	53.7	100.0	67.4	After 2040
	Gender equality in education	82.0	79.4	100.0	89.2	Reversal
	Child mortality	190.0	190.0	63.3	134.3	Stagnation
	Access to safe water	69.0	78.0	84.5	75.2	2006
Cambodia	Hunger	43.0	36.0	21.5	35.8	2018
	Primary education	..	95.4	100.0	Achieved	Achieved
	Gender equality in education	..	83.2	100.0	..	..
	Child mortality	115.0	138.0	38.3	81.3	Reversal
	Access to safe water	..	30.0	..	..	..
Cape Verde	Hunger	..	..	..	..	..
	Primary education	..	98.8[f]	100.0	Achieved	Achieved
	Gender equality in education	..	..	100.0	..	..
	Child mortality	60.0	38.0	20.0	42.4	2010
	Access to safe water	..	74.0	..	..	..

Annex table 1 (contd.)

	Target[a]	1990 level	2000 level	2015 target	Required 2000 level	Expected date of achievement[b]
Central African Rep.	Hunger	49.0	44.0	24.5	40.8	2034
	Primary education	53.1	54.7	100.0	71.9	After 2040
	Gender equality in education	61.4	..	100.0	..	..
	Child mortality	180.0	180.0	60.0	127.2	Stagnation
	Access to safe water	48.0	70.0	74.0	58.4	2001
Chad	Hunger	58.0	32.0	29.0	48.3	2000
	Primary education	..	58.2	100.0	..	..
	Gender equality in education	..	55.5[d]	100.0	..	..
	Child mortality	203.0	200.0	67.7	143.5	Stagnation
	Access to safe water	..	27.0	..	..	..
Comoros	Hunger	..	..	..	..	..
	Primary education	..	56.2	100.0	..	..
	Gender equality in education	..	83.3[d]	100.0	..	..
	Child mortality	120.0	79.0	40.0	84.8	2011
	Access to safe water	88.0	96.0	94.0	Achieved	Achieved
Dem. Rep. of the Congo	Hunger	32.0	73.0	16.0	26.7	Reversal
	Primary education	54.3	32.6[f]	100.0	68.9	Reversal
	Gender equality in education	69.4[c]	79.8[f]	100.0	78.0	2012
	Child mortality	205.0	205.0	68.3	144.9	Stagnation
	Access to safe water	..	45.0	..	..	..
Djibouti	Hunger	..	..	..	..	..
	Primary education	31.6	32.6	100.0	59.0	Stagnation
	Gender equality in education	70.4[c]	85.3[d]	100.0	79.9	2007
	Child mortality	175.0	143.0	58.3	123.7	2030
	Access to safe water	..	100.0	..	Achieved	Achieved
Equatorial Guinea	Hunger	..	..	..	..	..
	Primary education	..	71.7	100.0	..	..
	Gender equality in education	..	71.5[d]	100.0	..	..
	Child mortality	206.0	153.0	68.7	145.6	2019
	Access to safe water	..	44.0	..	..	..
Eritrea	Hunger	..	58.0	..	..	..
	Primary education	24.1[c]	41.0	100.0	51.5	2032
	Gender equality in education	81.6[e]	76.7	100.0	87.5	Reversal
	Child mortality	155.0	111.0	51.7	109.5	2016
	Access to safe water	..	46.0	..	..	..
Ethiopia	Hunger	..	44.0	..	..	..
	Primary education	..	46.7	100.0	..	..
	Gender equality in education	68.3	68.0	100.0	81.0	Reversal
	Child mortality	193.0	172.0	64.3	136.4	After 2040
	Access to safe water	25.0	24.0	62.5	40.0	Reversal
Gambia	Hunger	21.0	21.0	10.5	17.5	Stagnation
	Primary education	50.9[c]	68.7	100.0	68.5	2016
	Gender equality in education	64.3	84.6	100.0	78.6	2008
	Child mortality	154.0	126.0	51.3	108.8	2030
	Access to safe water	..	62.0	..	..	..
Guinea	Hunger	40.0	32.0	20.0	33.3	2013
	Primary education	..	47.0	100.0	..	..
	Gender equality in education	43.1	57.3[f]	100.0	61.3	2022
	Child mortality	240.0	169.0	80.0	169.6	2015
	Access to safe water	45.0	48.0	72.5	56.0	After 2040
Guinea-Bissau	Hunger	..	..	..	..	..
	Primary education	..	53.5[d]	100.0	..	..
	Gender equality in education	..	64.9[d]	100.0	..	..
	Child mortality	253.0	211.0	84.3	178.8	2034
	Access to safe water	..	56.0	..	..	..
Haiti	Hunger	64.0	50.0	32.0	53.3	2011
	Primary education	22.1	..	100.0	..	..
	Gender equality in education	..	..	100.0	..	..
	Child mortality	150.0	123.0	50.0	106.0	2031
	Access to safe water	53.0	46.0	76.5	62.4	Reversal
Kiribati	Hunger	..	..	..	..	..
	Primary education	..	..	100.0	..	..
	Gender equality in education	97.9	..	100.0	..	..
	Child mortality	88.0	69.0	29.3	62.2	2024
	Access to safe water	..	48.0	..	..	..
Lao People's Dem. Rep.	Hunger	29.0	24.0	14.5	24.2	2016
	Primary education	61.4[c]	81.4	100.0	75.3	2008
	Gender equality in education	74.8[c]	82.0	100.0	83.8	2023
	Child mortality	163.0	100.0	54.3	115.2	2009
	Access to safe water	..	37.0	..	..	..

Annex table 1 (contd.)

	Target[a]	1990 level	2000 level	2015 target	Required 2000 level	Expected date of achievement[b]
Lesotho	Hunger	27.0	26.0	13.5	22.5	2112
	Primary education	72.8	78.4	100.0	83.7	2039
	Gender equality in education	123.8	106.8	100.0	104.6	Achieved
	Child mortality	148.0	132.0	49.3	126.3	After 2040
	Access to safe water	..	78.0	..	..	..
Liberia	Hunger	33.0	39.0	16.5	27.5	Reversal
	Primary education	..	83.4[d]	100.0	..	..
	Gender equality in education	..	69.7[d]	100.0	..	..
	Child mortality	235.0	235.0	78.3	166.1	Stagnation
	Access to safe water	..	..	..	..	..
Madagascar	Hunger	35.0	40.0	17.5	29.2	Reversal
	Primary education	..	67.7	100.0	..	..
	Gender equality in education	..	96.6	100.0[f]	Achieved	Achieved
	Child mortality	168.0	136.0	56.0	118.7	2029
	Access to safe water	44.0	47.0	72.0	55.2	After 2040
Malawi	Hunger	49.0	33.0	24.5	40.8	2004
	Primary education	49.7	100.6	100.0	Achieved	Achieved
	Gender equality in education	78.9	93.9	100.0	87.4	2004
	Child mortality	241.0	183.0	80.3	170.3	2020
	Access to safe water	49.0	57.0	74.5	59.2	2019
Maldives	Hunger	..	..	..	..	..
	Primary education	..	99.0	100.0	Achieved	Achieved
	Gender equality in education	..	101.0	100.0	Achieved	Achieved
	Child mortality	115.0	77.0	38.3	81.3	2012
	Access to safe water	..	100.0	..	Achieved	Achieved
Mali	Hunger	25.0	20.0	12.5	20.8	2013
	Primary education	21.3	43.3[f]	100.0	46.5	2019
	Gender equality in education	57.0	66.3[f]	100.0	70.8	2027
	Child mortality	254.0	231.0	84.7	179.5	After 2040
	Access to safe water	55.0	65.0	77.5	64.0	2010
Mauritania	Hunger	14.0	12.0	7.0	11.7	2022
	Primary education	..	64.0	100.0	..	..
	Gender equality in education	67.5	92.5	100.0	80.5	2003
	Child mortality	183.0	183.0	61.0	129.3	Stagnation
	Access to safe water	37.0	37.0	68.5	49.6	Stagnation
Mozambique	Hunger	69.0	55.0	34.5	57.5	2012
	Primary education	46.8	54.4	100.0	68.1	After 2040
	Gender equality in education	73.4	74.6	100.0	84.1	After 2040
	Child mortality	235.0	197.0	78.3	166.1	2035
	Access to safe water	..	57.0	..	..	..
Myanmar	Hunger	10.0	6.0	5.0	8.3	2001
	Primary education	..	83.2	100.0	..	..
	Gender equality in education	94.7	97.8	100.0	96.8	2007
	Child mortality	130.0	109.0	43.3	91.9	2035
	Access to safe water	..	72.0	..	..	..
Nepal	Hunger	19.0	19.0	9.5	15.8	Stagnation
	Primary education	..	72.4	100.0	..	..
	Gender equality in education	52.8	82.1	100.0	71.7	2006
	Child mortality	145.0	91.0	48.3	102.5	2010
	Access to safe water	67.0	88.0	83.5	Achieved	Achieved
Niger	Hunger	42.0	36.0	21.0	35.0	2022
	Primary education	24.9	30.4	100.0	55.0	After 2040
	Gender equality in education	53.8	67.3	100.0	72.3	2024
	Child mortality	320.0	265.0	106.7	226.1	2033
	Access to safe water	53.0	59.0	76.5	62.4	2025
Rwanda	Hunger	34.0	40.0	17.0	28.3	Reversal
	Primary education	65.9	97.3[d]	100.0	78.2	2000
	Gender equality in education	97.6	97.1[d]	100.0	Achieved	Achieved
	Child mortality	178.0	183.0	59.3	125.8	Reversal
	Access to safe water	..	41.0	..	..	..
Samoa	Hunger	..	..	..	..	..
	Primary education	..	96.9	100.0	Achieved	Achieved
	Gender equality in education	99.7	102.0	100.0	Achieved	Achieved
	Child mortality	42.0	25.0	14.0	29.7	2008
	Access to safe water	..	99.0	..	Achieved	Achieved
Sao Tome and Principe	Hunger	..	..	..	..	..
	Primary education	..	..	100.0	..	..
	Gender equality in education	..	..	100.0	..	..
	Child mortality	90.0	74.0	30.0	63.6	2031
	Access to safe water	..	..	..	..	..

Annex table 1 (concluded)

	Target[a]	1990 level	2000 level	2015 target	Required 2000 level	Expected date of achievement[b]
Senegal	Hunger	23.0	25.0	11.5	19.2	Reversal
	Primary education	48.1[c]	63.1	100.0	66.8	2022
	Gender equality in education	68.7[c]	83.9	100.0	80.0	2010
	Child mortality	148.0	138.0	49.3	104.6	After 2040
	Access to safe water	72.0	78.0	86.0	77.6	2011
Sierra Leone	Hunger	46.0	47.0	23.0	38.3	Reversal
	Primary education	..	..	100.0	..	..
	Gender equality in education	67.4	76.5	100.0	80.4	2026
	Child mortality	323.0	316.0	107.7	228.3	Stagnation
	Access to safe water	..	57.0	..	..	..
Solomon Islands	Hunger	..	..	..	..	..
	Primary education	..	..	100.0	..	..
	Gender equality in education	77.1	..	100.0	..	..
	Child mortality	36.0	24.0	12.0	25.4	2012
	Access to safe water	..	71.0	..	..	..
Somalia	Hunger	67.0	71.0	33.5	55.8	Reversal
	Primary education	..	..	100.0	..	..
	Gender equality in education	..	..	100.0	..	..
	Child mortality	225.0	225.0	75.0	159.0	Stagnation
	Access to safe water	..	..	..	..	..
Sudan	Hunger	31.0	21.0	15.5	25.8	2004
	Primary education	..	46.3[d]	100.0	..	..
	Gender equality in education	75.1	102.4[d]	100.0	Achieved	Achieved
	Child mortality	123.0	107.0	41.0	86.9	After 2040
	Access to safe water	67.0	75.0	83.5	73.6	2009
United Rep. of Tanzania	Hunger	36.0	47.0	18.0	30.0	Reversal
	Primary education	51.4	46.7	100.0	70.9	Reversal
	Gender equality in education	96.8	98.9	100.0	98.1	2005
	Child mortality	163.0	165.0	54.3	115.2	Reversal
	Access to safe water	38.0	68.0	69.0	Achieved	Achieved
Togo	Hunger	28.0	23.0	14.0	23.3	2015
	Primary education	74.7	92.3	100.0	84.8	2004
	Gender equality in education	59.2	70.4	100.0	75.5	2027
	Child mortality	152.0	141.0	50.7	107.4	After 2040
	Access to safe water	51.0	54.0	75.5	60.8	After 2040
Tuvalu	Hunger	..	..	..	..	..
	Primary education	..	..	100.0	..	..
	Gender equality in education	..	..	100.0	..	..
	Child mortality	..	..	..	..	..
	Access to safe water	..	..	..	..	..
Uganda	Hunger	23.0	21.0	11.5	19.2	After 2040
	Primary education	..	109.5	100.0	Achieved	Achieved
	Gender equality in education	..	88.9	100.0	..	..
	Child mortality	165.0	124.0	55.0	116.6	2020
	Access to safe water	45.0	52.0	72.5	56.0	2025
Vanuatu	Hunger	..	..	..	..	..
	Primary education	..	95.9	100.0	Achieved	Achieved
	Gender equality in education	85.7[c]	101.9	100.0	Achieved	Achieved
	Child mortality	70.0	42.0	23.3	49.5	2008
	Access to safe water	..	88.0	..	..	..
Yemen	Hunger	36.0	33.0	18.0	30.0	After 2040
	Primary education	..	67.1	100.0	..	..
	Gender equality in education	..	49.9[f]	100.0	..	..
	Child mortality	142.0	107.0	47.3	100.3	2020
	Access to safe water	..	69.0	..	..	..
Zambia	Hunger	45.0	50.0	22.5	37.5	Reversal
	Primary education	..	65.5	100.0	..	..
	Gender equality in education	..	92.4	100.0	Achieved	Achieved
	Child mortality	192.0	202.0	64.0	135.7	Reversal
	Access to safe water	52.0	64.0	76.0	61.6	2008

Source: UNCTAD secretariat compilation, based on UNDP Human Development Report Office: direct communication.

Notes: *a* The quantitative variables used to monitor the targets on hunger, primary education, gender equality in education, child mortality and access to safe water are under-nourished people as percentage of total population, net primary school enrolment ratio, ratio of girls-to-boys in primary and secondary school, under-five child mortality rate (per 1,000 live births) and percentage of people with sustainable access to improved water sources, respectively.

b This corresponds to the year in which the selected target will be achieved if the current rate of progress continues.

c Refers to the 1991 level. *d* Refers to the 1999 level. *e* Refers to the 1992 level. *f* Refers to the 1998 level.

Annex 2: Progress towards graduation from LDC status

An important indicator of economic and social development in the LDCs is progress made towards graduation from the LDC category. Useful information on trends in this respect is provided by the Committee for Development Policy (CDP) of the United Nations Economic and Social Council (ECOSOC). One role of the CDP is to assist in identifying the countries to be included in, or graduated from, the LDC category. Table 1 summarizes data which the CDP has provided in this respect, on the basis of the latest (revised) criteria which it suggested as criteria for identifying LDCs in its latest triennial review of the list of least developed countries conducted in 2003.

Countries are eligible for inclusion in the list of LDCs if they have a population of less than 75 million and meet the following criteria and thresholds: gross national income (GNI) per capita less than $750;[5] Human Assets Index (HAI), based on indicators of nutrition, health and education, less than 55; and Economic Vulnerability Index (EVI), based on indicators of merchandise export concentration, instability of export earnings, instability of agricultural production, share of manufacturing and modern services in GDP and population size, greater than 37. A country must meet all the criteria. Thresholds for graduation from the list are: per capita GNI greater than $900; HAI greater than 61; and EVI greater than 33. A country must meet at least two criteria to be eligible for graduation. The Committee also proposed a modified EVI, which included a sixth component, that is data on population displaced by natural disasters. The threshold for inclusion with the modified EVI is greater than 38 and the threshold for graduation less than 34.

The CDP recalled the importance of a smooth transition for countries graduating from LDC status. Two LDCs — Cape Verde and Maldives — have met the GNI and HAI graduation thresholds in two consecutive reviews and have accordingly been recommended by the CDP for graduation. The decision itself is the responsibility of the ECOSOC and ultimately the General Assembly. Three other small island LDCs — Kiribati, Samoa and Tuvalu — also met the GNI and HAI graduation thresholds under the 2003 review, and the CDP has noted that Samoa might qualify for graduation in the 2006 review if the country continues to meet two of the three graduation criteria.

According to the 2003 review, the only other low-income country eligible for addition to the list was Timor-Leste, which joined the group of LDCs on 4 December 2003.

ANNEX TABLE 2. INDICATORS USED IN DETERMINING ELIGIBILITY FOR LEAST DEVELOPED COUNTRY STATUS: GRADUATION FROM, AND INCLUSION IN, THE LDC LIST

		Population *2002 (millions)*	Per capita *GNI ($)*	HAI[a]	EVI[b]	EVI *(modified)*[c]
A. Low-income developing countries						
LDC	Afghanistan	23.3	523	11.6	50.1	49.0
LDC	Angola	13.9	447	25.6	48.5	46.8
LDC	Bangladesh	143.4	363	45.3	22.9	29.5
LDC	Benin	6.6	367	40.2	57.0	56.4
LDC	Bhutan	2.2	600	40.4	40.6	41.0
LDC	Burkina Faso	12.2	217	26.5	49.3	47.0
LDC	Burundi	6.7	110	19.7	53.8	49.6
LDC	Cambodia	13.8	263	44.5	49.7	48.1
	Cameroon	15.5	583	43.8	31.9	31.2
LDC	Cape Verde	0.4	**1 323**	**72.0**	55.5	56.7
LDC	Central African Republic	3.8	277	29.9	43.1	42.0
LDC	Chad	8.4	203	26.1	59.2	56.6
LDC	Comoros	0.7	387	38.1	59.1	58.7
	Congo	3.2	610	55.2	50.3	46.8
	Côte d'Ivoire	16.7	687	43.0	25.4	25.9
	Dem. People's Rep. of Korea	22.6	440	62.9	32.8	29.5
LDC	Dem. Rep. of the Congo	54.3	100	34.3	40.8	42.3
LDC	Djibouti	0.7	873	30.2	48.6	49.5
LDC	Equatorial Guinea	0.5	743	47.2	64.4	55.8
LDC	Eritrea	4.0	190	32.8	51.7	50.2
LDC	Ethiopia	66.0	100	25.2	42.0	40.7
LDC	Gambia	1.4	340	34.0	60.8	56.5
	Ghana	20.2	337	57.9	40.9	41.9

Annex Table 2 (contd.)

		Population *2002 (millions)*	Per capita *GNI ($)*	HAI[a]	EVI[b]	EVI *(modified)*[c]
LDC	Guinea	8.4	447	30.3	42.1	40.0
LDC	Guinea-Bissau	1.3	170	31.2	64.6	60.7
LDC	Haiti	8.4	493	35.3	41.7	43.5
	India	1 041.1	450	55.7	13.5	19.6
	Indonesia	217.5	610	73.6	18.1	21.9
	Kenya	31.9	350	49.3	28.4	29.0
LDC	Kiribati	0.1	**923**	**67.5**	64.8	60.4
LDC	Lao People's Dem. Republic	5.5	297	46.4	43.9	43.4
LDC	Lesotho	2.1	573	45.4	44.2	44.5
LDC	Liberia	3.3	285	38.7	63.1	58.3
LDC	Madagascar	16.9	253	37.9	21.6	27.0
LDC	Malawi	11.8	177	39.0	49.0	49.4
LDC	Maldives	0.3	**1 983**	**65.2**	33.6	37.5
LDC	Mali	12.0	230	19.9	47.5	45.4
LDC	Mauritania	2.8	377	38.2	38.9	37.7
	Mongolia	2.6	393	63.3	50.0	48.9
LDC	Mozambique	19.0	220	20.0	35.6	39.2
LDC	Myanmar	49.0	282	60.0	45.4	45.6
LDC	Nepal	24.2	240	47.1	**29.5**	**31.0**
	Nicaragua	5.3	395	60.8	39.4	42.5
LDC	Niger	11.6	180	14.2	54.1	53.1
	Nigeria	120.0	267	52.3	52.8	51.1
	Pakistan	148.7	437	45.5	20.2	26.1
	Papua New Guinea	5.0	673	46.2	36.1	38.6
LDC	Rwanda	8.1	230	34.1	63.3	59.6
LDC	Samoa	0.2	**1 447**	**88.8**	40.9	50.8
LDC	Sao Tome and Principe	0.1	280	55.8	41.8	37.0
LDC	Senegal	9.9	490	38.1	38.4	38.8
LDC	Sierra Leone	4.8	130	21.7	45.7	43.3
LDC	Solomon Islands	0.5	657	47.3	46.7	49.1
LDC	Somalia	9.6	177	8.5	55.4	53.1
LDC	Sudan	32.6	333	46.4	45.2	46.5
	Timor-Leste	0.8	478	36.4	..	..
LDC	Togo	4.8	293	48.6	41.5	42.8
LDC	Tuvalu	0.01	**1 383**	**63.7**	70.3	67.3
LDC	Uganda	24.8	297	39.8	43.2	41.6
LDC	United Republic of Tanzania	36.8	263	41.1	**28.3**	**30.2**
LDC	Vanuatu	0.2	**1 083**	57.4	44.5	46.4
	Viet Nam	80.2	390	72.7	37.1	39.4
LDC	Yemen	19.9	423	46.8	49.1	49.0
LDC	Zambia	10.9	317	43.4	49.3	47.6
	Zimbabwe	13.1	463	56.5	33.7	30.3
B. Economies in transition						
	Armenia	3.8	523	79.4	30.7	34.0
	Azerbaijan	8.1	607	72.8	38.9	40.6
	Georgia	5.2	647	76.2	47.6	48.2
	Kyrgyzstan	5.0	287	77.6	38.2	39.9
	Republic of Moldova	4.3	397	81.1	39.6	39.1
	Tajikistan	6.2	173	69.5	37.7	39.1
	Turkmenistan	4.9	780	84.5	60.9	53.8
	Ukraine	48.7	723	86.3	23.8	26.1
	Uzbekistan	25.6	607	81.3	40.3	36.3

Source: United Nations (2003b).

Notes: Figures in boldface type indicate a graduation criterion that has been met by a current LDC.

a The Human Asset Index (HAI) reflects the following: (a) nutrition, measured by the average calorie consumption per capita as a percentage of the minimum requirement; (b) health, measured by the under-5 child mortality rate; and (c) education, measured by: (i) the adult literacy rate and (ii) the gross secondary school enrolment ratio.

b The Economic Vulnerability Index (EVI) is an average of five indicators: (a) merchandise export concentration; (b) instability of export earnings; (c) instability of agricultural production; (d) share of manufacturing and modern services in GDP; and (e) population size.

c EVI with a sixth component, i.e. percentage of population displaced by natural disasters, to supplement data on the instability of agricultural production.

Notes

1. The demographic transition is the process of change whereby a country's previously high birth and death rates shift to lower values. In general, the fall in death rates, which occurs with rising living standards, advances in public health and better nutrition, occurs before the fall in birth rates, and thus during the transition period there is a high rate of population growth.
2. All the LDC regional averages in this section are simple, not weighted averages.
3. This section is based on data kindly provided by the UN Human Development Report Office.
4. This section is based on Gonsalves (2003).
5. For countries classified by the World Bank as low-income in at least one year between 1999 and 2001.

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