CHAPTER 1

The state of human development

"We have a collective responsibility to uphold the principles of human dignity, equality and equity at the global level. As leaders we have a duty therefore to all the world's people, especially the most vulnerable and, in particular, the children of the world, to whom the future belongs."

Millennium Declaration, 2000[2]

Sixty years ago the UN Charter pledged to free future generations from the scourge of war, to protect fundamental human rights and "to promote social progress and better standards of life in larger freedom". At the start of the new millennium the world's governments renewed that pledge. The Millennium Declaration, adopted in 2000, sets out a bold vision for "larger freedom" in the twenty-first century. That vision holds out the promise of a new pattern of global integration built on the foundations of greater equity, social justice and respect for human rights. The Millennium Development Goals (MDGs), a set of time-bound and quantified targets for reducing extreme poverty and extending universal rights by 2015, provide the benchmarks for measuring progress. More fundamentally, they reflect the shared aspirations of the global human community in a period of sweeping change.

This year marks the start of the 10-year countdown to the 2015 target date for achieving the MDGs. Today, the world has the financial, technological and human resources to make a decisive breakthrough in human development. But if current trends continue, the MDGs will be missed by a wide margin. Instead of seizing the moment, the world's governments are stumbling towards a heavily sign-posted and easily avoidable human development failure—a failure with profound implications not just for the world's poor but for global peace, prosperity and security.

Fifteen years after the launch of the first *Human Development Report,* this year's Report starts by looking at the state of human development. Writing in that first report, Mahbub ul Haq looked forward to a decade of rapid advance: "The 1990s", he wrote, "are shaping up as the decade for human development, for rarely has there been such a consensus on the real objectives of development strategies."[3] Since those words were written a great deal has been achieved. Much of the developing world has experienced rapid social progress and rising living standards. Millions have benefited from globalization. Yet the human development advances fall short of those anticipated in *Human Development Report 1990*—and far short of what was possible.

Viewed from the perspective of 2015, there is a growing danger that the next 10 years—like the past 10—will go down in history not as a decade of accelerated human development, but as a decade of lost opportunity, half-hearted endeavour and failed international cooperation. This year marks a crossroads. The international community can either allow the world to continue on its current human development path, or it can change direction and put in place the policies needed to turn the promise of the Millennium Declaration into practical outcomes.

The consequences of continuing down the current path should not be underestimated. Using country-level trend data, we estimate the human cost gaps in 2015 between MDG targets and predicted outcomes if current trends continue. Among the headlines:

The MDG target for reducing child mortality will be missed, with the margin equivalent to more than 4.4 million avoidable deaths in 2015

- The MDG target for reducing child mortality will be missed, with the margin equivalent to more than 4.4 million avoidable deaths in 2015. Over the next 10 years the cumulative gap between the target and the current trend adds more than 41 million children who will die before their fifth birthday from the most readily curable of all diseases—poverty. This is an outcome that is difficult to square with the Millennium Declaration's pledge to protect the world's children.
- The gap between the MDG target for halving poverty and projected outcomes is equivalent to an additional 380 million people in developing countries living on less than $1 a day by 2015.
- The MDG target of universal primary education will be missed on current trends, with 47 million children in developing countries still out of school in 2015.

Statistics such as these should be treated with caution. Projections based on past trends provide insights into one set of possible outcomes. They do not define the inevitable. As the financial market dictum puts it, past performance is not a guide to future outcomes. In the case of the MDGs, that is unambiguously good news. There is still time to get back on track—but time is running out. As the UN Secretary-General has said: "The MDGs can be met by 2015—but only if all involved break with business as usual and dramatically accelerate and scale up action now."[4]

The first section of this chapter is a brief overview of the progress and setbacks in human development over the past decade and a half. It highlights the great reversal in human development inflicted on many countries by HIV/AIDS, and the slowdown in progress on child mortality. Uneven progress across countries and regions has been accompanied by a divergence in human development in some key areas, with inequalities widening. The second section of the chapter turns to the MDGs. The limited—and slowing—advances in human development achieved over the past decade have a direct bearing on prospects for achieving the MDGs. Average incomes in developing countries have been growing far more strongly since 1990. Yet this income growth has not put the world on track for the MDGs—most of which will be missed in most countries. Part of the problem is that growth has been unequally distributed between and within countries. The deeper problem is that increased wealth is not being converted into human development at the rate required to bring the MDGs within reach. Our country-level data projections set out one possible set of outcomes that will follow if the world remains on the business-as-usual trajectory that the UN Secretary-General has warned against.

Progress and setbacks in human development

Human development is about freedom. It is about building human capabilities—the range of things that people can do, and what they can be. Individual freedoms and rights matter a great deal, but people are restricted in what they can do with that freedom if they are poor, ill, illiterate, discriminated against, threatened by violent conflict or denied a political voice. That is why the "larger freedom" proclaimed in the UN Charter is at the heart of human development. And that is why progress towards the MDGs provides a litmus test for progress in human development. There is more to human development than the MDGs themselves—and many of the MDG targets reflect a modest level of ambition. But failure on the MDGs would represent a grave setback.

The most basic capabilities for human development are leading a long and healthy life, being educated and having adequate resources

for a decent standard of living. Other capabilities include social and political participation in society. In this section we look at the record of human development over the past decade—a period of deepening global integration.

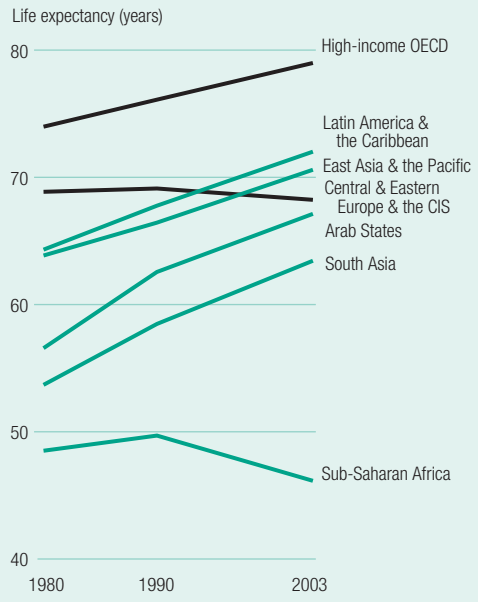
The era of globalization has been marked by dramatic advances in technology, trade and investment—and an impressive increase in prosperity. Gains in human development have been less impressive. Large parts of the developing world are being left behind. Human development gaps between rich and poor countries, already large, are widening. Meanwhile, some of the countries most widely cited as examples of globalization "success stories" are finding it harder to convert rising prosperity into human development. Progress in reducing child mortality, one of the most basic of human development indicators, is slowing, and the child death gap between rich and poor countries is widening. For all of the highly visible achievements, the reach of globalization and scientific advance falls far short of ending the unnecessary suffering, debilitating diseases and death from preventable illness that blight the lives of the world's poor people.

Advances in human development—a global snapshot

Looking back over the past decade the long-run trend towards progress in human development has continued. On average, people born in a developing country today can anticipate being wealthier, healthier and better educated than their parents' generation. They are also more likely to live in a multiparty democracy and less likely to be affected by conflict.

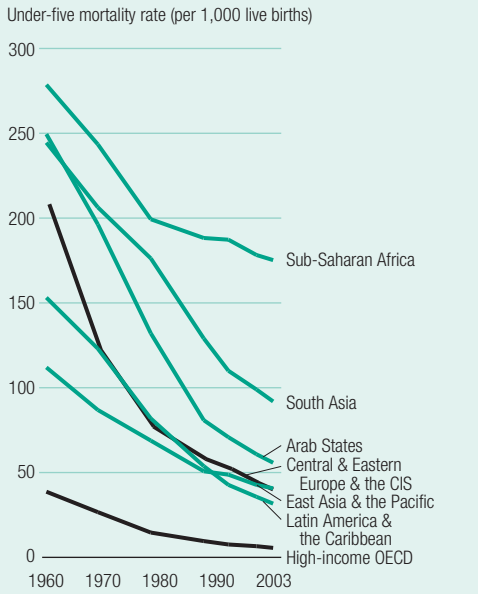
In a little more than a decade average life expectancy in developing countries has increased by two years. On this indicator human development is converging: poor countries are catching up with rich ones (figure 1.1). Increased life expectancy is partly a product of falling child death rates (figure 1.2). Today, there are 2 million fewer child deaths than in 1990, and the chance of a child reaching age 5 has increased by about 15%. Improvements in access to water and sanitation have contributed by reducing the threat of infectious disease. Another 1.2 billion people have gained access to clean water over the past decade. The rapid scale-up in global immunization since 2001 through the Global Alliance for Vaccines and Immunization has also brought down the death toll, saving an estimated half a million lives.

Figure 1.1 Life expectancy improving in most regions



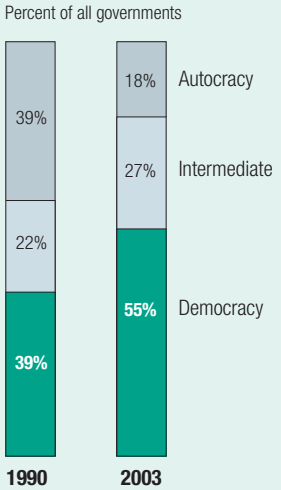
Source: UN 2005d.

Figure 1.2 Child death rates and trends improving



Source: UNICEF 2005c.

Figure 1.3 **Democracy gains ground**



Source: Calculated on the basis of data on population from UN 2005d and Polity scores from CIDCM 2005.

Advances in education have been equally impressive. There are still 800 million people in the world lacking basic literacy skills. Women account disproportionately for two-thirds of the total. Even so, literacy levels in developing countries have increased from 70% to 76% over the past decade, and the gender gap is narrowing.[5] Illiteracy today reflects past deficits in access to education. These deficits are shrinking. Compared with the position in 1990, there are 30 million fewer primary school–age children out of school, and the average number of years in school has climbed by half a year. The gender gaps in primary school enrolment, admittedly a limited indicator for gender equity, have narrowed, though girls still account for more than half of children out of school.

Extreme income poverty has been falling. Legitimate concerns have been raised about the use of the $1 a day poverty line to chart cross-country trends—and extreme caution is merited in using this indicator.[6] Measurement problems aside, poverty is a dynamic process that can only be partially captured by static indicators. But the trend points in a positive direction. Extreme poverty fell from 28% in 1990 to 21% today—a reduction in absolute numbers of about 130 million people.[7] Economic growth is one of the obvious requirements for accelerated income poverty reduction and sustained human development. Here, too, the headline news story is encouraging. Average per capita income growth in developing countries in the 1990s was 1.5%, almost three times the rate in the 1980s.[8] Since 2000, average per capita income growth in developing countries has increased to 3.4%—double the average for high-income countries. After two decades of declining average income, Sub-Saharan Africa has posted an increase of 1.2% a year since 2000. It is too early to treat this recovery as a turning point, but there are encouraging signs that growth may be taking root in a growing number of countries in the region.

Conflict is a less obvious good news story. Since 1990 the world has witnessed genocide in Rwanda, violent civil wars in the heart of Europe, wars in Afghanistan and Iraq and setbacks in the Middle East. The conflict in the Democratic Republic of the Congo has claimed almost 4 million lives—the greatest death toll since the Second World War. In Sudan a peace settlement in one of Africa's longest running civil wars served as a prelude to a new humanitarian crisis in Darfur, with more than 1 million people displaced. New threats to collective security have emerged. Yet despite the challenges posed for human development by violent conflict, there is some positive news. The number of conflicts has fallen since 1990. The last 15 years have seen many civil wars ended through negotiation under UN auspices. From Timor-Leste to Afghanistan, El Salvador and Sierra Leone peace has brought new opportunities for human development and democracy. Violent conflict poses one of the greatest barriers to accelerated human development. But the barrier can be lowered.

Progress towards democracy also has been mixed. Democracy is a fundamental aspect of human development. It is both intrinsically valuable, and therefore a human development indicator in its own right, and a means towards wider human development goals. Measuring progress is inherently difficult. Multiparty elections—now the world's preferred form of governance—are one condition. An independent judiciary, constraints on executive power, freedom of the press and respect for human rights give substance to the form of electoral choice. By the Polity indicator of democracy, a composite benchmark, the share of the world's countries with multiparty electoral systems that meet wider criteria for democracy has risen since 1990 from 39% to 55% (figure 1.3). This represents an increase of 1.4 billion people living under multiparty democracy.[9] More than two-thirds of Africans now live in countries with democratic multiparty election systems—and African governments themselves took the lead in opposing an anti-democratic coup in Togo.

However, multiparty elections are not a sufficient condition for democracy—and even on this measure the glass is almost half empty. Multiparty elections are largely absent from the Middle East, though countries such as Egypt and Jordan are increasing the democratic space for electoral politics. Of the world's two most populous countries, India is a thriving democracy,

but in China political reforms have lagged behind economic reforms. Many countries with multiparty elections, notably some countries of the former Soviet Union, are democracies in name and electoral autocracies in practice, with political leaders seen by their people as corrupt, tyrannical and predatory. Multiparty elections can provide a smokescreen that obscures overbearing executive power, limitations on press freedom and human rights abuses that strip democracy of its meaning. In some countries public protest has been a powerful antidote to such practices. During 2004 and 2005 long-serving presidents were driven from power in Georgia, Ukraine and Kyrgyzstan by public protest over perceived abuses of democratic process.

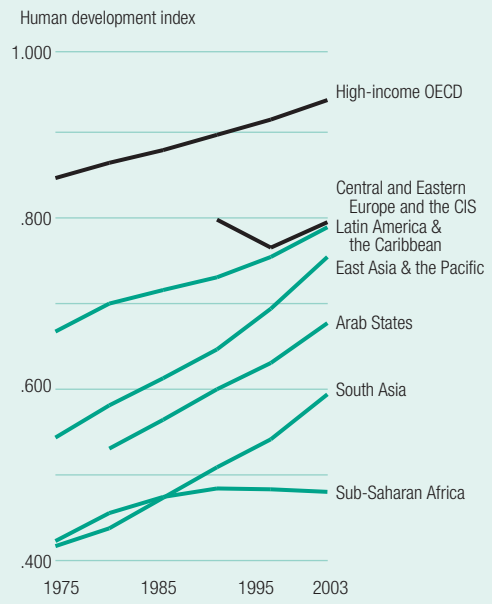
The scale of the human development gains registered over the past decade should not be underestimated—nor should it be exaggerated. Part of the problem with global snapshots is that they obscure large variations across and within regions. They also hide differences across dimensions of human development. Progress towards human development has been uneven across and within regions and across different dimensions.

Progress viewed through the human development index

The human development index (HDI) is a composite indicator. It covers three dimensions of human welfare: income, education and health. Its purpose is not to give a complete picture of human development but to provide a measure that goes beyond income. The HDI is a barometer for changes in human well-being and for comparing progress in different regions.

Over the last decade the HDI has been rising across all developing regions, though at variable rates and with the obvious exception of Sub-Saharan Africa (figure 1.4). Amid the overall progress, however, many countries suffered unprecedented reversals. Eighteen countries with a combined population of 460 million people registered lower scores on the HDI in 2003 than in 1990 (table 1.1). (Only six countries suffered such reversals in the 1980s.) The reversals have been heavily concentrated in two regions. Twelve of the countries with reversals are in Sub-Saharan Africa. Just over one-third of Sub-Saharan Africa's population—240 million people—live in countries that have suffered an HDI reversal. The former Soviet Union accounts for the other six countries in which the HDI slid backwards.

Figure 1.4 Human development improving in most regions



Source: Calculated on the basis of data underlying indicator table 2.

Table 1.1 Countries experiencing HDI reversal

1980–90	1990–2003
Congo, Dem. Rep. of the	Botswana
Guyana	Cameroon
Haiti	Central African Republic
Niger	Congo
Rwanda	Congo, Dem. Rep. of the
Zambia	Côte d'Ivoire
	Kazakhstan [a]
	Kenya
	Lesotho
	Moldova, Rep. of [a]
	Russian Federation [a]
	South Africa
	Swaziland
	Tajikistan [a]
	Tanzania, U. Rep. of [a]
	Ukraine [a]
	Zambia
	Zimbabwe

a. Country does not have HDI data for 1980–90, so drop may have begun before 1990.

Source: Indicator table 2.

HDI reversals are reflected in the relative standing of countries. In Sub-Saharan Africa the lethal interaction of economic stagnation, slow progress in education and the spread of HIV/AIDS has produced a free fall in HDI ranking (box 1.1). Southern Africa accounts for some of the steepest declines—a fall of 35 places for South Africa, 23 places for Zimbabwe and 21 places for Botswana. Of the countries of the former Soviet Union the biggest declines were in Tajikistan, which fell 21 places; Ukraine, 17 places; and the Russian Federation, 15 places. The economic disruption that followed the disintegration of the Soviet Union has been one of the two drivers for decline in HDI ranking. The other is a catastrophic drop in life expectancy. Russia fell 48 places in world life expectancy ranking from 1990 to 2003 (box 1.2).

Box 1.1 HIV/AIDS generates multiple human development reversals

Falling life expectancy is one indicator capturing the impact of HIV/AIDS. But the epidemic is generating multiple human development reversals, extending beyond health into food security, education and other areas.

HIV-affected households are trapped in a financial pincer as health costs rise and incomes fall. Costs can amount to more than one-third of household income, crowding out spending in other areas. In Namibia and Uganda studies have found households resorting to distress sales of food and livestock to cover medical costs, increasing their vulnerability. Meanwhile, HIV/AIDS erodes their most valuable asset: their labour. In Swaziland maize production falls on average by more than 50% following an adult death from HIV/AIDS.

Beyond the household, HIV/AIDS is eroding the social and economic infrastructure. Health systems are suffering from a lethal interaction of two effects: attrition among workers and rising demand. Already overstretched health infrastructures are being pushed to the brink of collapse. For example, in Côte d'Ivoire and Uganda patients with HIV-related conditions occupy more than half of all hospital beds.

HIV/AIDS is eroding human capacity on a broad front. Zambia now loses two-thirds of its trained teachers to HIV/AIDS, and in 2000 two in three agricultural extension workers in the country reported having lost a co-worker in the past year.

The spread of AIDS is a consequence as well as a cause of vulnerability. HIV/AIDS suppresses the body's immune system and leads to malnutrition. At the same time, nutritional deficiencies hasten the onset of AIDS and its progression. Women with HIV/AIDS suffer a loss of status. At the same time, gender inequality and the subservient status of women are at the heart of power inequalities that increase the risk of contracting the disease. Violence against women, especially forced or coercive sex, is a major cause of vulnerability. Another is women's weak negotiating position on the use of condoms.

Source: Gillespie and Kadiyala 2005; Yamano and Jayne 2004; Carr-Hill 2004; Swaziland, Ministry of Agriculture and Co-operatives and Business 2002.

The relationship between wealth ranking and HDI ranking varies across countries. Bangladesh and China are two of the fastest climbers in the HDI ranking. Since 1990 Bangladesh has risen 14 places in the HDI ranking but just 10 places in the global wealth ranking. What this suggests is that social progress in Bangladesh has outstripped economic advance relative to the performance of other countries. Conversely, China has continued its impressive ascent of the HDI ranking, but economic advance has outpaced social advance. The country has climbed 20 places in the HDI ranking and 32 places in the wealth ranking.

Simple decomposition of the HDI provides some insight into the underlying drivers of change. From very different starting points Bangladesh, China and Uganda have all increased their HDI score by about 20% since 1990. In China economic growth has been the biggest component in the change. In Bangladesh income growth was important, though far less so than in China: average income increased at about one-quarter of the rate for China. However, Bangladesh achieved balanced advances across the three dimensions of the HDI, registering stronger gains in life expectancy and education than China did. In Uganda minimal gains were achieved in life expectancy, with the bulk of the HDI gain coming from progress in school enrolment and, to a lesser extent, income. The decomposition exercise is explained in more detail in box 2 of *Note on statistics*.

Decomposition exercises raise important issues for policy-makers. Progress in human development requires advances across a broad front: losses in human welfare linked to life expectancy, for example, cannot be compensated for by gains in other areas such as income or education. Moreover, gains in any one area are difficult to sustain in the absence of overall progress. For example, poor health can constrain economic growth and performance in education, and slow growth reduces the resources available for social investment. The HDI decomposition exercises highlight the challenges facing different groups of countries. For China the challenge is to ensure that surging income growth is converted into sustained progress in non-income

Box 1.2 Mortality crisis in the Russian Federation: 7 million "missing" men

Life expectancy at birth in the Russian Federation is among the lowest for industrial countries: 65 years compared with 79 years in Western Europe. Since the early 1990s there has been a marked increase in male mortality over and above the historical trend. The number of additional deaths during 1992–2001 is estimated at 2.5–3 million. In the absence of war, famines or health epidemics there is no recent historical precedent for the scale of the loss.

Mortality is higher among men than women, especially among single and less educated men. In 2003 life expectancy was 59 years for Russian men and 72 years for women, one of the widest gender gaps in the world. If normal mortality ratios prevailed, 7 million more men would be alive in Russia. Put differently, gender inequality reduces the overall population by about 5%.[1]

Looking at the immediate causes of death provides part of the explanation. Russia suffers from a high incidence of cardiovascular disease, reflecting dietary and lifestyle factors. Alongside this "First World" epidemic, the Russian Federation is increasingly marked by infectious disease problems, with tuberculosis and HIV/AIDS growing threats. Homicide and suicide rates are high by industrial country standards and increased in the 1990s, with both indicators closely associated with overconsumption of alcohol.

Labour market restructuring, the deep and protracted economic recession of the 1990s and the collapse of social provision may have increased the levels of psychosocial stress experienced by the population. This was reflected in an increase in alcohol consumption and alcohol-related illness. At the same time, there was an increase in violent crime linked to a breakdown in state institutions dealing with law, order and security. Informal economic activity and contract enforcement through violence contributed to the decline in life expectancy: male homicide rates doubled in the first half of the 1990s.

Beyond violent crime and psychosocial stress the spread of preventable infectious diseases—tuberculosis, acute intestinal infections and diphtheria, in particular—points to flaws in the healthcare system. Public healthcare expenditure declined from 3.5% of GDP in 1997/98 to an average of 2.9% during 1999–2001. Wealthier households made increasing recourse to new private health services, but for many poorer families widespread demands for bribes and other informal payments put "free" public healthcare out of reach.

Russian mortality trends pose one of the gravest human development challenges of the early twenty-first century. Such an acute upsurge in mortality highlights the need for better research to identify the causes of excess male mortality and proactive public policies to identify and protect vulnerable populations during periods of rapid socio-economic transition. Particularly important is the development of institutions perceived as legitimate by the population and capable of overseeing a complex process of economic reform. Other transition economies—Poland, for instance—have managed to reverse negative mortality trends and to increase life expectancy.

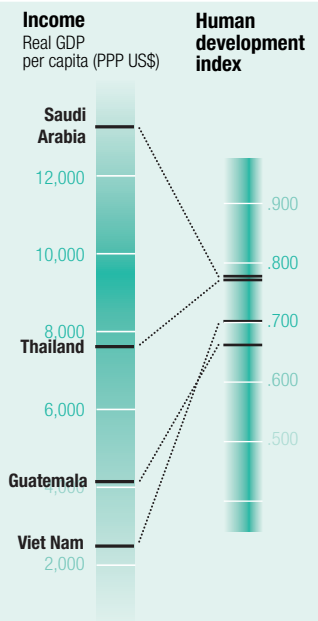
1. "Missing women" is a term more often encountered in the literature. It has been used to illustrate the female mortality differentials in some parts of Sub-Saharan Africa and South Asia (Sen 1999). The number of missing women or men is calculated by comparing the current ratio of women to men to the ratio considered normal in the absence of significant gender bias.

Source: Shkolnikov and Cornia 2000; World Bank 2005e; Men and others 2003; Malyutina and others 2002.

dimensions of human development. Income, after all, is a means to human development, not an end. In Uganda the challenge is to build on the achievements in education while identifying the reasons that advances in this area and in income are not extended to health. Bangladesh demonstrates that it is possible to sustain strong human development progress across a broad front even at relatively modest levels of income growth. Maintaining this progress, while accelerating economic growth and income poverty reduction, is critical for future development.

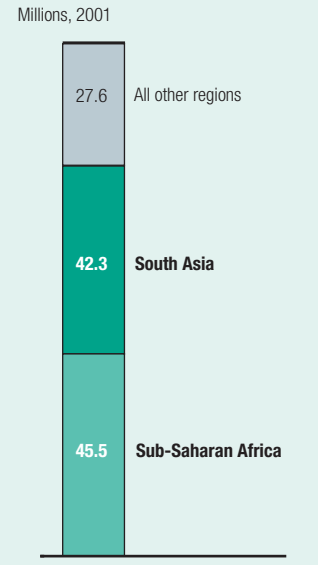
Some countries are far better than others at converting wealth into human development, as measured by the HDI. Saudi Arabia has a far higher average income than Thailand but a similar HDI ranking (figure 1.5). Guatemala has almost double the average income of Viet Nam but a lower HDI ranking. Large gaps between wealth and HDI rankings are usually

Figure 1.5 **Different income, similar HDI**



Source: Indicator table 1.

Figure 1.6 **Children not in school—mostly in Africa and South Asia**



Source: UNICEF 2005d.

an indicator of deep structural inequalities that block the transmission from wealth creation to human development. They also point to shortcomings in public policy, with governments failing to put in place strategies for extending opportunities among poor, marginalized or disadvantaged groups. As chapter 2 shows, structural inequalities have a major bearing on the rate of progress towards the MDGs.

Beyond the HDI, very large deficits in human capability remain. Metaphors about the human development glass being half empty or half full distract attention from one overwhelming fact: the extraordinary level of avoidable deprivation that prevails in the midst of an increasingly prosperous world.

The limits to human development

There is no more powerful—or disturbing—indicator of capability deprivation than child mortality. More than 10 million children die each year before their fifth birthday.[10] Sub-Saharan Africa's share of child mortality is growing. The region accounts for 20% of births but 44% of child deaths. Almost all childhood deaths are preventable. Every two minutes four people die from malaria alone, three of them children. Most of these deaths could be prevented by simple, low-cost interventions. Vaccine-preventable illnesses—like measles, diphtheria and tetanus—account for another 2–3 million childhood deaths.[11] For every child who dies, millions more will fall sick or miss school, trapped in a vicious circle that links poor health in childhood to poverty in adulthood. Like the 500,000 women who die each year of pregnancy-related causes, more than 98% of children who die each year live in poor countries. They die because of where they are born.

Progress in reducing poverty has been partial. One in five people in the world—more than 1 billion people—still survive on less than $1 a day, a level of poverty so abject that it threatens survival. Another 1.5 billion people live on $1–$2 a day. More than 40% of the world's population constitute, in effect, a global underclass, faced daily with the reality or the threat of extreme poverty.

Income poverty is closely linked to hunger. In a world of plenty, millions of people go hungry every day. More than 850 million people, including one in three preschool children, are still trapped in a vicious cycle of malnutrition and its effects.[12] Malnutrition weakens the immune system, increasing the risk of ill health, which in turn aggravates malnutrition. Around half of the deaths of preschool children are directly attributable to interactions between malnutrition and infectious disease.[13] Children who are moderately under weight are more than four times more likely to die from infectious disease than are well nourished children.

In turn, vulnerability to infectious disease is exacerbated by inadequate access to clean water and sanitation. More than 1 billion people lack access to safe water and 2.6 billion lack access to improved sanitation. Diseases transmitted through water or human waste are the second leading cause of death among children worldwide, after respiratory tract infection. The overall death toll: an estimated 3,900 children every day.[14]

Gaps in opportunities for education remain large. In an increasingly knowledge-based global economy about 115 million children are denied even the most basic primary education.[15] Most of the children who are not enrolled in school are in Sub-Saharan Africa and South Asia (figure 1.6). On average, a child born in Mozambique today can anticipate four years of formal education. One born in France will receive 15 years at vastly higher levels of provision. Average schooling in South Asia, at eight years, is half the level in high-income countries. Moreover, while the primary school enrolment gap may be closing, the gap between rich and poor countries measured in terms of average years of education is widening (figure 1.7). This is before taking into account differences in education quality: less than one-quarter of Zambian children emerge from primary school able to pass basic literacy tests.[16] Meanwhile, access to higher education remains a privilege available mainly to citizens of high-income countries. These education inequalities of today are the global social and economic inequalities of tomorrow.

Gender inequalities continue to limit girls' education. Even with the narrowing of gender

gaps, on average girls can expect to receive one year less of education than boys in African and Arab States and two years less in South Asia. In 14 African countries girls represent less than 45% of the primary school population. In Pakistan they represent just 41%—gender parity would put another 2 million girls in the country in school. In the developing world as a whole primary school completion rates are 75% for girls but rise to 85% for boys. Gender disparities are even wider at the secondary and tertiary levels. These deep gender disparities represent not just a violation of the universal right to education but also a threat to future human development prospects: girls' education is one of the most powerful catalysts for social progress across a wide range of indicators.

The end of convergence?

For most of the past 40 years human capabilities have been gradually converging. From a low base, developing countries as a group have been catching up with rich countries in such areas as life expectancy, child mortality and literacy. A worrying aspect of human development today is that the overall rate of convergence is slowing—and for a large group of countries divergence is becoming the order of the day.

In a world of already extreme inequalities human development gaps between rich and poor countries are in some cases widening and in others narrowing very slowly. The process is uneven, with large variations across regions and countries. We may live in a world where universal rights proclaim that all people are of equal worth—but where you are born in the world dictates your life chances. The following sections look at three areas in which inequalities between countries both reflect and reinforce unequal opportunities for human development: divergences in life expectancy, the slowdown in progress on child mortality and slowing reductions in income poverty and inequality.

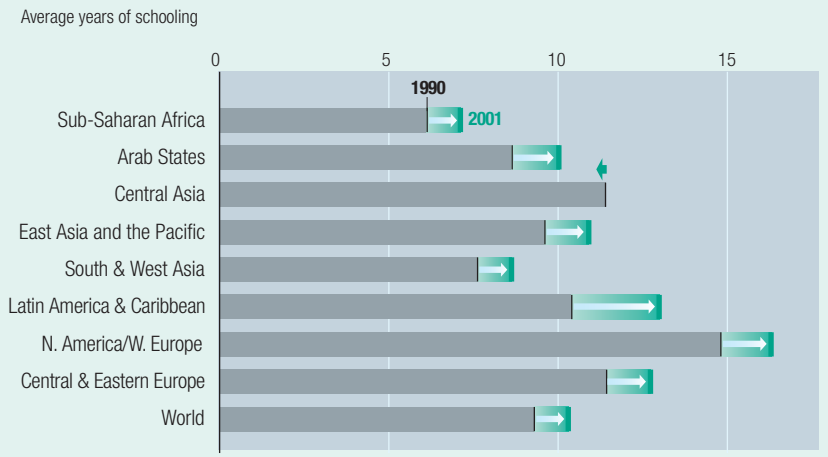
Life expectancy—the great reversal

Leading a long and healthy life is a basic indicator for human capabilities. Inequalities in this area have the most fundamental bearing on well-being and opportunities. Since the early 1990s a long-run trend towards convergence in life expectancy between rich and poor has been slowed by divergence between regions linked to HIV/AIDS and other setbacks.

Viewed at a global level, the life expectancy gap is still closing. Between 1960 and today life expectancy increased by 16 years in developing countries and by 6 years in developed countries.[17] Since 1980 the gap has closed by two years. However, convergence has to be put in context. All but three months of the two years' convergence since 1980 happened before 1990. Since then, convergence has ground to a halt, and the gaps remain very large. The average life expectancy gap between a low-income country and a high-income country is still 19 years. Somebody born in Burkina Faso can expect to live 35 fewer years than somebody born in Japan, and somebody born in India can expect to live 14 fewer years than somebody born in the United States.

Life expectancy is also an indicator of how healthy you can expect to be. One way of measuring risk is to assess the level of avoidable mortality—the excess risk of dying before a specified age in comparison with a population group in another country. With the high-income country average as a point of comparison, over half of mortality in developing countries is avoidable. Adults ages 15–59

Figure 1.7 Years in school—the gaps remain



Note: Data refer to school life expectancy.
Source: UNESCO 2005, p. 107.

On current indicators a child born in Zambia today has less chance of surviving past age 30 than a child born in 1840 in England

account for just under one-third of all deaths in developing countries but only one-fifth in developed countries.[18] The large health inequalities behind these figures draw attention to what has been described as the "law of inverse care"—the availability of medical care is inversely related to need. Health financing inequalities are central to this law. Per capita spending on health ranges from an average of more than $3,000 in high-income OECD countries with the lowest health risks to $78 in low-income countries with the highest risks and to far less in many of the poorest countries.[19]

Gains in life expectancy have been unequally shared. Latin America, the Middle East and Asia have been converging with rich countries. In South Asia life expectancy has increased by a decade in the past 20 years. By contrast, the countries of the former Soviet Union and Sub-Saharan Africa have been falling further behind.

In the countries of the former Soviet Union life expectancy has dropped dramatically, especially for males. In the Russian Federation life expectancy for males has dropped from 70 years in the mid-1980s to 59 years today—lower than in India. Economic collapse, the erosion of welfare provision and high rates of alcoholism and disease have all contributed (see box 1.2). Noncommunicable ailments—such as cardiovascular disease and injuries—account for the greatest share of the rise in deaths, though infectious diseases are also resurgent. If the death rate remains constant, about 40% of 15-year-old Russian males today will be dead before they reach age 60.[20]

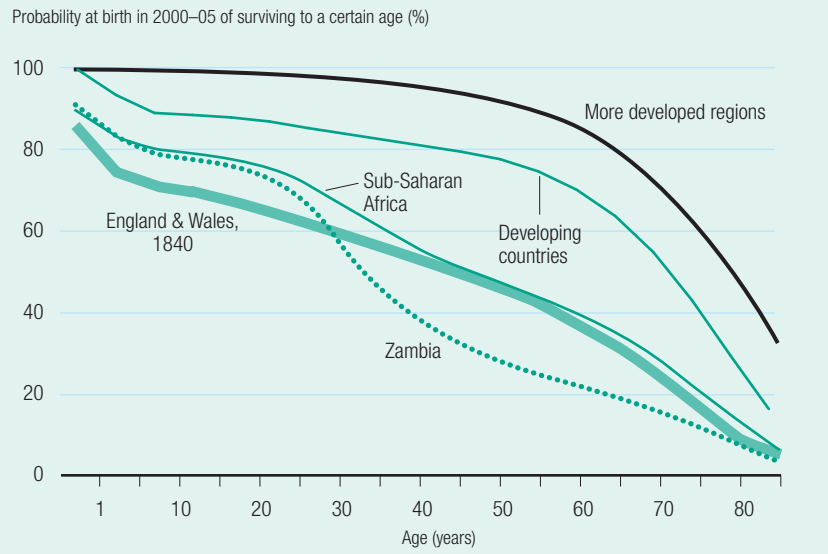
Sub-Saharan Africa is the region that explains the slowdown in progress towards greater global equality in life expectancy. Twenty years ago somebody born in Sub-Saharan Africa could expect to live 24 fewer years than a person born in a rich country, and the gap was shrinking. Today, the gap is 33 years and growing. HIV/AIDS is at the heart of the reversal. In 2004 an estimated 3 million people died from the virus, and another 5 million became infected. Almost all of these deaths were in the developing world, with 70% of them in Africa. Some 38 million people are now infected with HIV—25 million of them in Sub-Saharan Africa (see box 1.1).[21]

Statistics alone cannot capture the full scale of suffering associated with HIV/AIDS. But they can provide an insight into the scale of the demographic shock inflicted on the worst affected countries. On current indicators a child born in Zambia today has less chance of surviving past age 30 than a child born in 1840 in England (figure 1.8). For Sub-Saharan Africa as a whole a child born today has less chance of surviving beyond age 45.

Stark as they are, such statistics understate the human impact of HIV/AIDS. In Europe the greatest single demographic shock since the Black Death was experienced by France between 1913 and 1918, when the combined effects of the First World War and the 1918 influenza outbreak reduced life expectancy by about 16 years. Traumatic as that episode was, it pales against losses in life expectancy of 31 years in countries like Botswana (figure 1.9). In Zambia life expectancy has fallen by 14 years since the mid-1980s. And the projected rate of recovery is far slower than it was in France.

Looking to the future, Africa faces the gravest HIV/AIDS-related risks to human development. But new threats are emerging. Serious epidemics have emerged in several Indian states. In

Figure 1.8 Chances of survival in Sub-Saharan Africa are not much better than in 1840s England



Source: UN 2005d and University of California, Berkeley and Max Planck Institute for Demographic Research 2005.

Tamil Nadu HIV prevalence rates higher than 50% have been found among female sex workers, while both Andhra Pradesh and Maharashtra have passed the 1% prevalence mark.[22]

The incidence of HIV/AIDS is also growing in the countries of the former Soviet Union. Ukraine now has one of the fastest growing rates of HIV infection in the world, while the Russian Federation, with the second fastest growth rate (and 1 million infected), is home to the largest epidemic in the region.[23] The vast majority of people living with HIV are young, with intravenous drug use being the main accelerator. As in other parts of Eastern Europe the epidemic is in its early stages—which means that timely intervention can halt and reverse it. If neglected, there is considerable scope for the epidemic to expand as it reaches the general population.

The international response to HIV/AIDS has been profoundly inadequate. In an age of science, technology and economic affluence nothing demonstrates more powerfully the failure of rich countries to tackle the diseases that ravage a large section of humanity. Awareness of the AIDS virus emerged in the early 1980s. When the first *Human Development Report* was published in 1990, only 133,000 cases were reported to the World Health Organization (WHO), more than two-thirds of them in North America. The Report concluded: "AIDS is likely to reverse many of the successes in... raising life expectancy." Yet only now—some 20 million deaths later—is a credible international effort emerging. Just a small fraction of those in need have access to prevention and treatment services. Fewer than 8% of pregnant women have access to treatment for preventing mother-to-child transmission. In Africa fewer than 4% of people in need of antiretroviral treatment are receiving drugs.[24] There are some islands of success. Countries such as Senegal and Uganda have contained and started to reverse the crisis. Brazil and Thailand have saved lives with vigorous public health policies that improve access to medicines. These success stories demonstrate that the goal of treating 3 million people by the end of 2005, a first step towards rolling back the epidemic, is achievable.

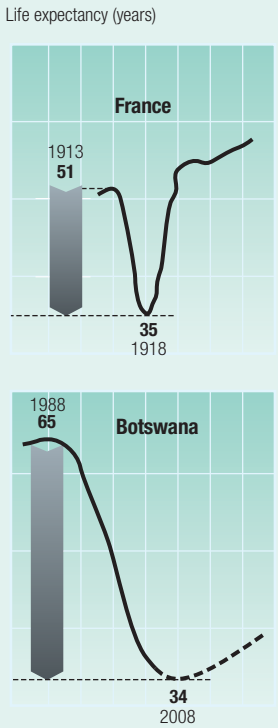
The slow and limited international response to the HIV/AIDS crisis has contributed directly to the deepening of global health inequalities. It also demonstrates the costs of delayed action. In 2004 the world spent an estimated $6 billion combating the virus through the Global Fund to Fight AIDS, Tuberculosis and Malaria.[25] Had resources been mobilized on this scale 20 years ago, the epidemic could have been reversed. Today, that amount is insufficient even to contain the crisis, let alone to meet the MDG target to "have halted by 2015 and begun to reverse the spread of HIV/AIDS". The international community's response to a global public health threat has been plainly inadequate. At the same time many governments in the worst affected countries have responded to the unprecedented challenge of HIV/AIDS with denial, stereotyping and neglect, exposing their citizens to grave risks.

Women and children last

Child survival is one of the most sensitive indicators of human welfare, the comparative health of nations and the effectiveness of public policy. Against this backdrop child death trends are fast approaching the point that merits declaration of an international health emergency. Of the 57 million deaths worldwide in 2002 one in five was a child less than five years old—roughly one child died every three seconds. An estimated 4 million of these deaths happened in the first month of life, the neonatal period.[26] Almost all child deaths happen in developing countries, while most of the spending to prevent child deaths happens in rich ones.

The interventions that could prevent or effectively treat the conditions that kill children and women of reproductive age are well known. Most are low cost—and highly cost-effective. Two in every three child deaths could be averted through provision of the most basic health services. Yet a health catastrophe that inflicts a human toll more deadly than the HIV/AIDS pandemic is allowed to continue. Nothing more powerfully underlines the gap between what we are able to do to overcome avoidable suffering and what we choose to do with the wealth and technologies at our disposal.

Figure 1.9 The demographic shock of AIDS exceeds that of the First World War



Source: UN 2005d and University of California, Berkeley and Max Planck Institute for Demographic Research 2005.

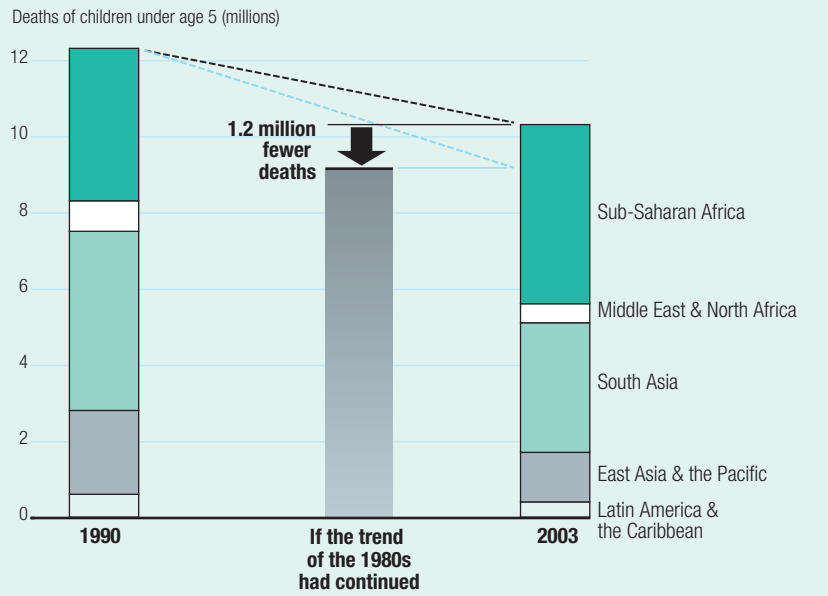
While the decline in child mortality has continued over the past decade, the rate of decline appears to be slowing over time. During 1990–2003 child deaths rates in developing countries fell at a pace one-third slower than during the 1980s (figure 1.10).[27] The slowdown has cost lives. Had the progress of the 1980s been sustained during the 1990s and the current decade, more than 1 million fewer children would have died in 2003.[28] Neonatal mortality has been falling far more slowly than child mortality, with the result that a rising share of child deaths occurs in the first month.[29] Of the 4 million deaths in this period, three-quarters occur in the first week of life.

The child survival story of the past decade is also one of divergence. The gap between rich and poor countries is widening, most spectacularly between rich countries and countries in Africa but also for other regions (figure 1.11). In 1980 child death rates in Sub-Saharan Africa were 13 times higher than in rich countries. They are now 29 times higher. The child mortality challenge extends beyond Sub-Saharan Africa. Even countries that are performing more strongly on economic growth are experiencing slowing progress in reducing child mortality. There is no single cause for the slowdown. Much of the decline in mortality since 1970 can be traced to rising living standards and fewer deaths from diarrhoeal disease and vaccine-preventable conditions. Other major killers linked directly to poverty—such as malnutrition and acute respiratory infection—have been declining more slowly. And deaths from malaria have been increasing.

Child mortality rates underline one of the central lessons of human development: the links between income and social progress are not automatic. On average, mortality rates fall as incomes rise. However, countries at similar levels of income display large variations (figure 1.12). For example, Honduras and Viet Nam have far lower levels of neonatal mortality than India and Pakistan. As such facts suggest, economic growth is not a guaranteed route to faster progress in cutting child deaths.

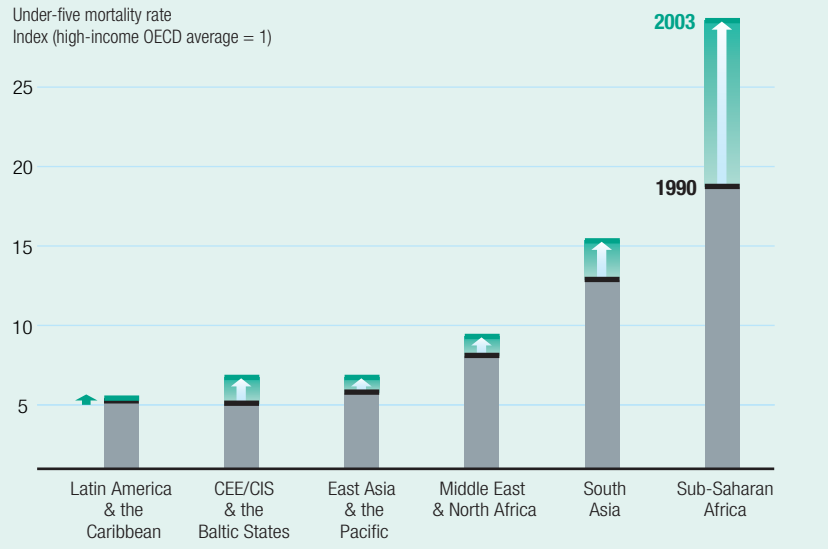
That conclusion is supported by the record of the past decade. Some of the most visible success stories in economic growth and globalization have been less successful in reducing child mortality. China and, to a more modest degree, India are in the front rank of high-growth, globalizing countries. Yet the annual progress in cutting child deaths has slowed in both countries since 1990, even as economic growth has increased (figure 1.13). The case of China demonstrates that even the most spectacular

Figure 1.10 Fewer children are dying—but progress is slowing



Source: Calculated on the basis of data from UNICEF 2005b.

Figure 1.11 Child mortality—gaps between rich and poor are widening



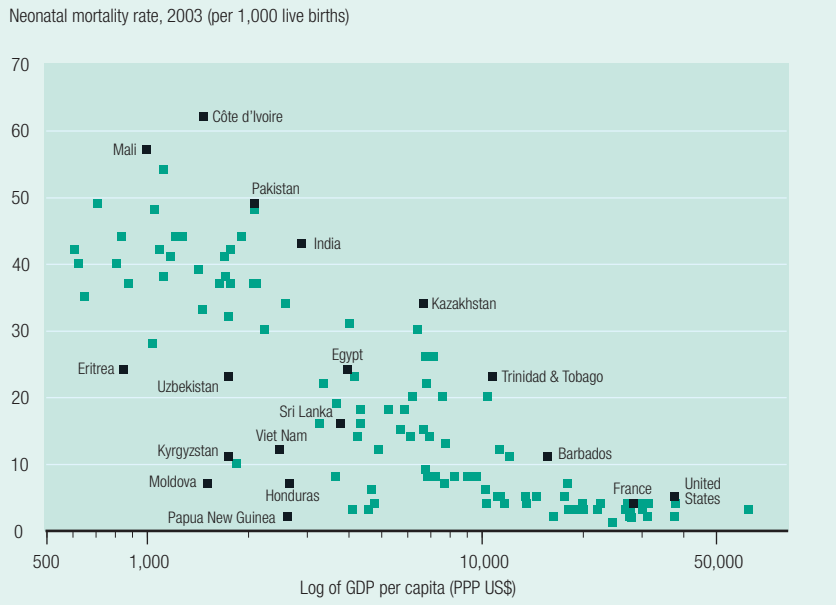
Source: UNICEF 2005c.

economic growth rates and rising living standards do not translate automatically into more rapid declines in the child mortality rate. Per capita income growth increased from 8.1% in the 1980s to 8.5% in 1990–2003, maintaining a spectacular advance in poverty reduction. Indeed, China has already achieved the MDG target of halving income poverty from 1990 levels. However, based on UN data, the annual rate of decline in the incidence of child mortality fell from 2.3% in the 1980s to 1.9% in 1990–2003.[30] There are variations within this trend—and shifting the reference years would produce different outcomes. But the slowdown has prompted questions about whether China, despite a strong track record in a wide range of human development indicators, will meet the MDG target of reducing child mortality by two-thirds by 2015.[31]

At a far higher level of child mortality than China, India seems to be headed in a similar direction. More rapid growth may have put the country on track for the MDG target of halving poverty, but India is widely off track for the child mortality target. The annual rate of decline in child mortality fell from 2.9% in the 1980s to 2.3% since 1990—a slowdown of almost one-fifth. As in China, the slowdown has occurred during a period of accelerating economic growth. Developments in India and China have global implications. India alone accounts for 2.5 million child deaths annually, one in five of the world total. China accounts for another 730,000—more than any other country except India.

Why has the rate of progress slowed? One view is that a slowdown in the rate of decline in child mortality is inevitable. Expanding public health provision through immunization programmes and other services can yield big public health gains, especially in reductions from high levels of mortality. Once these "low hanging fruits" have been collected, so the argument runs, the problem becomes more concentrated in populations that are harder to reach, more vulnerable and less accessible to public policy interventions, driving up the marginal costs of saving lives and dampening progress.

Figure 1.12 Income does not determine neonatal mortality



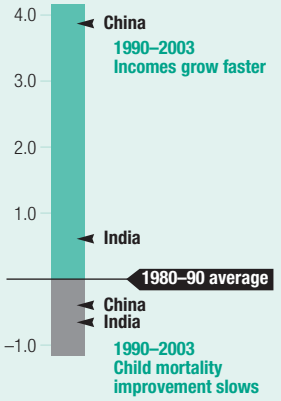
Source: WHO 2004b and World Bank 2005f.

Applied in the current context, the low hanging fruit argument lacks credibility. Some countries—Malaysia is an example—have accelerated the rate of reduction in child mortality from already relatively low levels. Others have sustained rapid progress over time, even during periods of low growth. In 1980 Egypt had a higher child mortality rate than Ethiopia does today. At its current rate of progress it will reach Sweden's level by 2010. Egypt has already achieved the MDG target.

Low income is not a barrier to progress. Viet Nam and Bangladesh have both accelerated the pace of child mortality rate reduction. Indeed, at a lower level of income and a comparable rate of economic growth, Viet Nam has now overtaken China on improvement in child mortality. Similarly, at a lower level of income and with far lower growth, Bangladesh has overtaken India (figure 1.14). These differences matter. Had India matched Bangladesh's rate of reduction in child mortality over the past decade, 732,000 fewer children would die this year. Had China matched Viet Nam's, 276,000 lives could be saved. Clearly, there is still a huge scope for rapid reductions in child death in India and China.

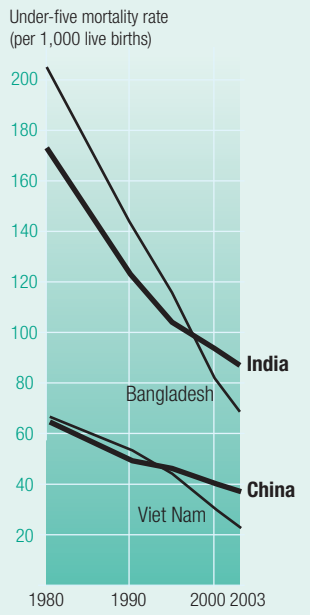
For both countries child mortality trends raise wider questions for public health and the distribution within developing countries of the

Figure 1.13 Income growth and child mortality improvement diverge in India and China



Source: Calculated on the basis of data on child mortality from UNICEF 2005e and data on GDP per capita (2000 US$) from World Bank 2005f.

Figure 1.14 **China and India fall behind in child mortality**



Source: UN 2005b.

benefits from globalization. Integration into global markets has manifestly enhanced wealth creation, generated economic dynamism and raised living standards for many millions of people in India and China. At the same time the human development benefits of economic success have been slow to trickle down to large sections of the population—and the trickle appears to be slowing in some key areas of public health.

Changing this picture will require public policies that address deep-rooted inequalities between rich and poor people, between men and women and between more prosperous and less prosperous regions. These inequalities are rooted in power differences—and they are perpetuated by public policy choices. Were India to show the same level of dynamism and innovation in tackling basic health inequalities as it has displayed in global technology markets, it could rapidly get on track for achieving the MDG targets. There are encouraging signs that public policy may now be moving in the right direction. During 2005 the announcement of ambitious new programmes aimed at overhauling the health system and extending services in poor areas appeared to mark a new direction in policy. Economic success has expanded the financial resources available for these programmes—and some states have shown that rapid progress can be achieved. The challenge is to ensure that effective reform takes root in the states and areas that account for the bulk of India's human development deficit (box 1.3).

Child mortality is intimately linked to maternal mortality. More than 15 years after the world's governments launched a Safe Motherhood Initiative, an estimated 530,000 women die each year in pregnancy or childbirth. These deaths are the tip of an iceberg. At least 8 million women a year suffer severe complications in pregnancy or childbirth, with grave risks to their

Box 1.3 **India—a globalization success story with a mixed record on human development**

"The slow improvement in the health status of our people has been a matter of great concern. We have paid inadequate attention to public health."

Dr. Manmohan Singh, Prime Minister of India, April 2005[1]

India has been widely heralded as a success story for globalization. Over the past two decades the country has moved into the premier league of world economic growth; high-technology exports are booming and India's emerging middle-class consumers have become a magnet for foreign investors. As the Indian Prime Minister has candidly acknowledged, the record on human development has been less impressive than the record on global integration.

The incidence of income poverty has fallen from about 36% in the early 1990s to somewhere between 25% and 30% today. Precise figures are widely disputed because of problems with survey data. But overall the evidence suggests that the pick-up in growth has not translated into a commensurate decline in poverty. More worrying, improvements in child and infant mortality are slowing—and India is now off track for these MDG targets. Some of India's southern cities may be in the midst of a technology boom, but 1 in every 11 Indian children dies in the first five years of life for lack of low-technology, low-cost interventions. Malnutrition, which has barely improved over the past decade, affects half the country's children. About 1 in 4 girls and more than 1 in 10 boys do not attend primary school.

Why has accelerated income growth not moved India onto a faster poverty reduction path? Extreme poverty is concentrated in rural areas of the northern poverty-belt states, including Bihar, Madhya Pradesh, Uttar Pradesh and West Bengal, while income growth has been most dynamic in other states, urban areas and the service sectors. While rural poverty has fallen rapidly in some states, such as Gujarat and Tamil Nadu, less progress has been achieved in the

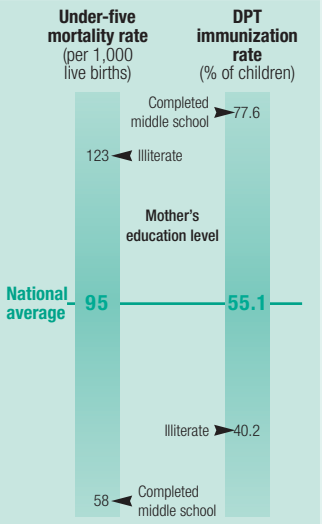
Differences among states in India

Indicator	India	Kerala	Bihar	Rajasthan	Uttar Pradesh
Female share of population (%)	48	52	49	48	48
Under-five mortality rate (per 1,000 live births)	95	19	105	115	123
Total fertility rate (births per woman)	2.9	2.0	3.5	3.8	4.0
Birth attended by health professional (%)	42	94	23	36	22
Children receiving all vaccinations (%)	42	80	11	17	21

Source: IIPS and ORC Macro 2000.

Box 1.3 **India—a globalization success story with a mixed record on human development** (continued)

Education inequalities put a brake on progress



Source: IIPS and ORC Macro 2000.

northern states. At a national level, rural unemployment is rising, agricultural output is increasing at less than 2% a year, agricultural wages are stagnating, and growth is virtually "jobless". Every 1% of national income growth generated three times as many jobs in the 1980s as in the 1990s.

The deeper problem facing India is its human development legacy. In particular, pervasive gender inequalities, interacting with rural poverty and inequalities between states, is undermining the potential for converting growth into human development.

Perhaps the starkest gender inequality is revealed by this simple fact: girls ages 1–5 are 50% more likely to die than boys. This fact translates into 130,000 "missing" girls. Female mortality rates remain higher than male mortality rates through age 30, reversing the typical demographic pattern. These gender differences reflect a widespread preference for sons, particularly in northern states. Girls, less valued than their brothers, are often brought to health facilities in more advanced stages of illness, taken to less qualified doctors and have less money spent on their healthcare. The low status and educational disadvantage suffered by women have a direct bearing on their health and their children's. About one-third of India's children are under weight at birth, reflecting poor maternal health.

Inadequate public health provision exacerbates vulnerability. Fifteen years after universal childhood immunization was introduced, national health surveys suggest that only 42% of children are fully immunized. Coverage is lowest in the states with the highest child death rates, and less than 20% in Bihar and Uttar Pradesh. India may be a world leader in computer software services, but when it comes to basic immunization services for children in poor rural areas, the record is less impressive.

Gender inequality is one of the most powerful brakes on human development. Women's education matters in its own right, but it is also closely associated with child mortality. The under-five mortality rate is more than twice as high for children of illiterate mothers as for children whose mothers have completed middle school (see figure). Apart from being less prone to undernutrition, better educated mothers are more likely to use basic health services, have fewer children at an older age and are more likely to space the births—all factors positively associated with child survival. As well as depriving girls of a basic right, education inequalities in India translate into more child deaths.

State inequalities interact with gender- and income-based inequalities (see table). Four states account for more than half of child deaths: Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh (see figure). These states also are marked by some of the deepest gender inequalities in India. Contrasts with Kerala are striking. Girls born in Kerala are five times more likely to reach their fifth birthday, are twice as likely to become literate and are likely to live 20 years longer than girls born in Uttar Pradesh. The differences are linked to the chronic underprovision of health services in high-mortality northern states, which is in turn linked to unaccountable state-level governance structures.

Translating economic success into human development advances will require public policies aimed explicitly at broadening the distribution of benefits from growth and global integration, increased public investment in rural areas and services and—above all—political leadership to end poor governance and address the underlying causes of gender inequality.

There are encouraging signs that this leadership may be starting to emerge. In 2005 the government of India launched a $1.5 billion National Rural Health Mission, a programme targeting some 300,000 villages, with an initial focus on the poorest states in the north and north-east. Commitments have been made to raise public health spending from 0.9% of national income to 2.3%. Spending on education has also been increased. In an effort to create the conditions for accelerated rural growth and poverty reduction, ambitious public investment programmes have been put in place to expand rural infrastructure, including the provision of drinking water and roads.

Translating increased financial commitment into improved outcomes will require a stronger focus on effective delivery and measures to improve the quality of public services. There is no shortage of innovative models to draw upon. States such Himachal Pradesh and Tamil Nadu have sustained rapid progress in education, not just by increasing budget provision but by increasing the accountability of service providers and creating incentives—such as free school meals, scholarships and free textbooks—aimed at increasing the participation of poor households.

Overcoming the legacy of decades of underinvestment in human development and deep-rooted gender inequalities poses immense challenges. Political leadership of a high order will be needed to address these challenges. Failure to provide it and to extend health and education opportunities for all, regardless of wealth and gender, will ultimately act as a constraint on India's future prospects in the global economy.

1. BBC News 2005a.

Source: BBC News 2005a; Cassen, Visaria and Dyson 2004; Kijima and Lanjouw 2003; Joshi 2004; Dev 2002; Drèze and Murthi 2001.

The risk of dying from pregnancy-related causes ranges from 1 in 18 in Nigeria to 1 in 8,700 in Canada

health. As with child mortality, the vast majority of these deaths occur in developing countries, with South Asia (where the maternal mortality ratio is 540 deaths per 100,000 live births) and Sub-Saharan Africa (where the ratio is 920 per 100,000 live births) accounting for 75% of the total. The risk of dying from pregnancy-related causes ranges from 1 in 18 in Nigeria to 1 in 8,700 in Canada. And as with child mortality, most deaths are avoidable: around three-quarters could be prevented through low-cost interventions. Despite this, overall levels of maternal mortality appear to have changed little over the past decade, especially in the majority of countries that account for the bulk of deaths. Underreporting and misreporting of maternal death make cross-country comparisons and precise trend analysis difficult (see box 5 of *Note on statistics*). However, proxy indicators—such as fertility rates and attendance by skilled health workers—indicate that the annual decline in mortality is slowing.[32]

Child health and maternal health are barometers for other areas of human development: the state of public health, the state of nutrition and the empowerment of women, among others. Failures in public health provision are reflected in the fact that the lives of about 6 million children's lives a year could be saved through simple, low-cost interventions (box 1.4). Measles causes more than half a million deaths a year. Diphtheria, pertussis (whooping cough) and tetanus (DPT) claim another half a million lives. Almost all of these deaths could be averted through immunization.[33] Yet 37 million children worldwide are not immunized with the DPT vaccine, and progress in immunization coverage has stalled across much of the developing world, notably among the poor. Immunization coverage is less than 50% for children living in households with incomes below the $1 a day international poverty line.[34] Three children die every two minutes as a result of malaria in Africa alone.[35] Many of these deaths happen for want of a simple insecticide-treated bednet. Fewer than 2% of children living in malaria-infected zones sleep under bednets that protect them from mosquitoes.[36] At an average cost of $3 per bednet this would appear to be a small investment in the prevention of a disease that claims more than 1 million lives a year and accounts for one in four of all child deaths in Africa. Yet it is an investment that the international community and national governments have been loath to make. Spending on malaria by the Global Fund to Fight AIDS, Tuberculosis and Malaria is just $450 million a year.[37]

Factors beyond the health sector are equally important. Louis Pasteur wrote that "the microbe is nothing, the terrain everything."[38] Poverty and inequalities in power, and a failure to reduce them, define the terrain for child and maternal death. Malnourishment among mothers is a major contributor to neonatal deaths. And malnutrition is implicated in half of all deaths in children under age 5. Poor and malnourished children are more likely to become sick and less able to resist childhood diseases. It is estimated that about 3,900 children die each day because of diseases transmitted through dirty water or poor hygiene.[39] These poverty-related impediments to progress are intimately linked to gender inequality and the low status of women. In much of the developing world—especially South Asia—women lack the power to claim entitlements to nutrition and health resources, exposing them and their children to increased risk of mortality.[40]

While child death is the most extreme indicator for inequality in life chances, the disparities between rich and poor draw attention to a wider problem. The vast majority of people who live in rich countries have access to the financial resources, technologies and services that prevent or, for diseases like AIDS, at least postpone death. Conversely, the vast majority of people in poor countries—especially if they happen to be poor—do not. It is this continued inequality in health outcomes that raises fundamental questions about the failure of governments in wealthy countries to develop a pattern of globalization that incorporates redistributive mechanisms to correct fundamental imbalances in life chances.[41]

Income poverty—slowing progress in an unequal world

"The tide of poverty and inequality that has previously engulfed the world is starting to turn", declares one influential report on globalization.[42] The sentiment reflects a widespread belief that,

Box 1.4 Saving 6 million lives—achievable and affordable

Most child deaths are avoidable. While faster economic growth would reduce mortality rates, mortality rates are higher than they need to be because of the indefensible underuse of effective, low-cost, low-technology interventions—and because of a failure to address the structural causes of poverty and inequality.

Cross-country research published in *The Lancet* in 2003 identified 23 interventions having the strongest impact on child mortality. These interventions—15 of them preventive and 8 curative—ranged from the provision of oral rehydration therapy to drugs and insecticide-treated bednets for preventing malaria and antenatal and obstetric care. Most of the interventions can be provided on a low-cost basis through trained health workers and local communities. Using 2000 data and assuming 100% coverage for these interventions, the authors of the study concluded that around two in every three child deaths—6 million in total—could have been avoided.

The findings highlight the huge potential for tackling one of the gravest human development problems facing the international community. Communicable diseases and systemic infections, such as pneumonia, septicaemia, diarrhoea and tetanus, cause two in every three child deaths—nearly all of them preventable. The 2.5 million deaths from diarrhoea and pneumonia could be dramatically reduced through community-level interventions supported by government agencies. The precise intervention priorities vary by country, and there is no single solution. But the common problem is one of low coverage of services, high levels of inequality linked to poverty and neglect of neonatal mortality in public health policy.

Several myths reinforce the idea that the MDG target of reducing child mortality by two-thirds may be unattainable. The following are among the most common:

- *Myth 1. Achieving rapid decline is unaffordable.* Not true. Some countries do face major financial constraints—hence the need for increased aid. But child mortality is an area in which small investments yield high returns. Recent cross-country research on neonatal mortality identifies a set of interventions that, with 90% coverage in 75 high-mortality countries, could reduce death rates by 59%, saving 2.3 million lives. The $4 billion cost represents two days' worth of military spending in developed countries.
- *Myth 2. High-technology interventions such as intensive care units hold the key to success.* Not true. Sweden at the end of the nineteenth century and the United Kingdom after 1945 achieved rapid declines in neonatal mortality with the introduction of free antenatal care, skilled attendance at childbirth and increased availability of antibiotics. Developing countries such as Malaysia and Sri Lanka have similarly achieved steep declines in neonatal deaths through simple, home-based, district-level interventions supported through training for health workers and midwives and publicly financed provision.
- *Myth 3. Poor countries lack the institutional capacity to scale up.* Not true. Institutions matter, but many poor countries have achieved rapid advances by using institutional structures creatively. Egypt has sustained one of the fastest declines in child mortality rates in the world since 1980. Bangladesh, Honduras, Nicaragua and Viet Nam have also achieved rapid progress. In each case decentralized district-level programmes have integrated child health and maternal health programmes—including immunization, diarrhoea treatment and antenatal care—into health service delivery. They also invested in training health workers and midwives and in targeting vulnerable populations. Even poor-performing countries do not lack evidence of the potential for scaling up. In the Indian state of Maharashtra a three-year pilot project covering 39 villages extended basic antenatal care programmes through home-based care provision and simple clinical interventions costing $5 per person covered. The infant mortality rate fell from 75 deaths per 1,000 live births in the baseline period (1993–95) to 39 three years later. The mortality rate in an adjacent district declined only from 77 deaths per 1,000 live births to 75 over the same period.

The potential for rapid progress reflects the large deficit in current provision. In Sub-Saharan Africa less than 40% of women deliver with skilled care and in South Asia less than 30% do. More than 60 million women each year deliver without skilled care. Inequality in service use—a theme taken up in chapter 2—adds to vulnerability. The poorest women are more likely to be malnourished and less likely to take advantage of services because they are unavailable, unaffordable or of inadequate quality. Beyond service provision, deeper gender inequalities exacerbate the problem. Estimates suggest that birth spacing could reduce death rates by 20% in India and 10% in Nigeria, the countries with the highest neonatal mortality rates. Lack of control over fertility, which is linked to imbalance in power within the household and beyond, is central to the problem.

The real barriers to progress in reducing child deaths are not institutional or financial, though there are constraints in both areas. Poor quality service provision and chronic financing shortfalls have to be addressed. At the same time, poverty reduction strategies need to focus more on the structural causes of high mortality linked to the low status of women, inequalities in access to healthcare and a failure to prioritize child and maternal health.

Source: Cousens, Lawn and Zupan 2005; Mills and Shilcutt 2004; Wagstaff and Claeson 2004.

when it comes to income, global integration has ushered in a new era of convergence. At best, the sentiment is weakly supported by the evidence. Poverty is falling, but slowly since the mid-1990s. Meanwhile, global inequality remains at extraordinarily high levels.

In the aggregate the past two decades have witnessed one of the most rapid reductions in

At the other end of the spectrum, Sub-Saharan Africa had almost 100 million more people living in poverty in 2001 than in 1990

poverty in world history. However, any assessment of trends in income poverty has to take into account large variations across regions. Global poverty reduction has been driven largely by the extraordinary success of East Asia, particularly China. At the other end of the spectrum, Sub-Saharan Africa had almost 100 million more people living on less than $1 a day in 2001 than in 1990. South Asia reduced the incidence of poverty, though not the absolute number of poor people. Latin America and the Middle East registered no progress, while Central and Eastern Europe and the CIS experienced a dramatic increase in poverty. The number of people living on less than $2 a day in Central and Eastern Europe and the CIS rose from 23 million in 1990 to 93 million in 2001, or from 5% to 20%.

In a military metaphor, the war against poverty has witnessed advances on the eastern front, massive reversals in Sub-Saharan Africa and stagnation across a broad front between these poles. The worrying trend for the future is that overall progress is slowing. Much of the success in pushing back poverty over the past two decades was achieved in the 1980s and the first half of the 1990s (table 1.2). Since the mid-1990s $1 a day poverty has been falling at one-fifth the 1980–96 rate. This is despite the fact that average growth for developing countries picked up in the 1990s, increasing at more than double the per capita rate of the previous decade. In China the rate at which growth is converted into poverty reduction has fallen sharply. Between 1990 and 2001 the incidence of $1 a day poverty declined by 50%, with 130 million fewer people living below the international poverty line. However, more than 90% of the decline took place between 1990 and 1996.

The rate of progress in income poverty reduction is a function of two factors: economic growth and the share of any increment in growth captured by the poor. No country has successfully sustained progress in reducing income poverty with a stagnating economy. In East Asia high growth has been central to the reduction of income poverty. More recently, economic take-off in India has created the potential for accelerated poverty reduction. At the 4% annual per capita growth rate achieved since 1980, incomes double every 17 years. With the 1% per capita growth rate India experienced in the two decades before 1980 it took 66 years for incomes to double.

In other regions the growth picture has been less encouraging. Average incomes in Sub-Saharan Africa are lower today than in 1990. Recent years have witnessed signs of recovery in several countries, including Burkina Faso, Ethiopia, Ghana, Mozambique and Tanzania. However, recovery has to be put in context. It will take Sub-Saharan Africa until 2012 just to restore average incomes to their 1980 levels at the 1.2% per capita annual growth experienced since 2000. In the countries of the former Soviet Union transition brought with it one of the deepest recessions since the Great Depression of the 1930s—and in many cases despite positive growth over the last few years, incomes are still lower than they were 15 years ago. Since

Table 1.2 Decline in income poverty, 1981–2001

Share of people living on less than $1 (PPP US$) a day (%)

Region	1981	1984	1987	1990	1993	1996	1999	2001
East Asia & Pacific	56.7	38.8	28.0	29.5	24.9	15.9	15.3	14.3
Europe & Central Asia	0.8	0.6	0.4	0.5	3.7	4.4	6.3	3.5
Latin America & Caribbean	10.1	12.2	11.3	11.6	11.8	9.4	10.5	9.9
Middle East & North Africa	5.1	3.8	3.2	2.3	1.6	2.0	2.7	2.4
South Asia	51.5	46.8	45.0	41.3	40.1	36.7	32.8	31.9
Sub-Saharan Africa	41.6	46.3	46.9	44.5	44.1	46.1	45.7	46.4
World	40.4	33.0	28.5	27.9	26.3	22.3	21.5	20.7

Source: World Bank 2005d.

1990 real per capita incomes have fallen by more than 10% in Kyrgyzstan, Russia and Ukraine and by 40% or more in Georgia, Moldova and Tajikistan. In Russia 10% of the population live on less than $2 a day, and 25% live below the national subsistence poverty line. Most countries of the Middle East and Latin America have seen only a marginal increase in average income.

These figures underscore the mixed experience of countries with regard to economic growth. While global integration has been associated with accelerated growth for some countries, current growth patterns remain incompatible with achieving the MDGs. On average, countries have to grow at 1%–2% per capita a year to halve poverty over a 25-year period, as envisaged under the MDGs. In 1990–2003 more than 1 billion people were living in countries growing at less than this rate—about half of them in Sub-Saharan Africa (table 1.3). Fifteen countries in Central and Eastern Europe also posted growth rates of less than 1% per capita during this period. However, recent years have been more encouraging, with a robust economic recovery driving a reduction in poverty. Russia and Ukraine have averaged growth rates of 6%–9% since 2000, rising to 9%–13% for Armenia, Azerbaijan and Tajikistan. In Russia poverty levels were halved between 1999 and 2002, with about 30 million people escaping poverty.

Economic stagnation has been a widespread feature of the globalization era: during the 1990s, 25 countries in Sub-Saharan Africa and 10 in Latin America experienced a sustained period of economic stagnation.[43] Volatility linked to crises in capital markets has been another recurrent problem under globalization—and one with a major bearing on poverty. In the two years after Russia was engulfed by a financial crisis in 1998, 30 million people were forced below the poverty line.[44] In Argentina the population living below the extreme poverty line

Table 1.3 Income growth bands

Annual GDP per capita growth rate, 1990–2003 (%)

Region	Negative	0%–1%	1%–2%	More than 2%
Arab States				
Countries	5	4	2	5
Population (millions)	34	70	19	139
East Asia & Pacific				
Countries	4	1	3	13
Population (millions)	3	6	81	1,814
Latin America & Caribbean				
Countries	4	8	9	12
Population (millions)	43	74	345	79
South Asia				
Countries	0	0	1	7
Population (millions)	0	0	152	1,324
Sub-Saharan Africa				
Countries	18	8	8	11
Population (millions)	319	108	171	76
Central & Eastern Europe & the CIS				
Countries	10	5	1	11
Population (millions)	253	58	10	85
High-income OECD [a]				
Countries	0	2	6	15
Population (millions)	0	135	224	510
World				
Countries	41	28	32	76
Population (millions)	653	450	1,081	4,030

a. Excludes the Republic of Korea, which is included in East Asia and Pacific.
Source: Indicator tables 5 and 14.

Box 1.5 The champagne glass effect—the global distribution of income

Building a global income distribution model from national household expenditure surveys reveals just how unequal the world is. It also helps to identify the global underclass living on less than $2 a day and to compare their position with that of people at the top end of the global income distribution.

If the world were a country, it would have had an average purchasing power parity income of $5,533 and a median income of $1,700 in 2000. The gap between median and average income points to a concentration of income at the top end of the distribution: 80% of the world's population had an income less than the average. Meanwhile, the average income of the top 20% of the world's population is about 50 times the average income of the bottom 20%.

Global income distribution resembles a champagne glass (see figure 1.16 in text). At the top, where the glass is widest, the richest 20% of the population hold three-quarters of world income. At the bottom of the stem, where the glass is narrowest, the poorest 40% hold 5% of world income and the poorest 20% hold just 1.5%. The poorest 40% roughly corresponds to the 2 billion people living on less than $2 a day.

How has the regional composition of the poorest 20% changed over time? The share of South Asia has fallen sharply, from one half in 1980 to one third today. Reflecting two decades of declining average incomes, Sub-Saharan Africa accounts for a rising share of the poorest 20%. Since 1980 that share has more than doubled from 15% to 36%, and it is still rising. One in every two people in Sub-Saharan Africa is now located in the poorest 20% of world income distribution, compared with one in every five people in East Asia and one in every four people in South Asia.

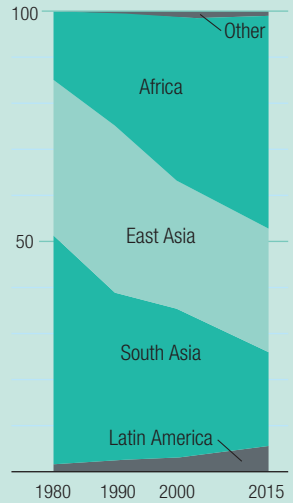
Unsurprisingly, rich countries dominate the top 20%. Nine of every 10 of their citizens are among the richest 20%. And Organisation for Economic Co-operation and Development countries account for 85% of income in the richest decile.

The global income distribution also highlights the extraordinarily high degree of inequality in Latin America. One-quarter of the region's population enjoys an income that puts it in the richest 20%, while more than 8% are in the poorest 20% of the global distribution.

Source: Dikhanov 2005.

Shifting shares of the world's poorest

Regional distribution of the poorest 20% in income (%)



Source: Dikhanov 2005.

more than tripled from 2000 to 2003, underlining yet again a lesson delivered by the 1997 East Asian financial crisis: integration into global capital markets comes with high human development risks attached.[45]

Inequality and poor countries' share of increased global wealth

Globalization has given rise to a protracted and sometimes heated debate over trends in global income distribution, their links with poverty and whether integration into global markets is leading to a convergence or a divergence of income between rich and poor countries. The trends matter because the share of increases in global wealth captured by poor countries has a bearing on average income and so on prospects for poverty reduction.

The answer to the question of whether poor countries are capturing a larger or smaller share of global increases in wealth depends partly on how it is asked.[46] For most of the world's poorest countries the past decade has continued a disheartening trend: not only have they failed to reduce poverty, but they are falling further behind rich countries. Measured at the extremes, the gap between the average citizen in

the richest and in the poorest countries is wide and getting wider. In 1990 the average American was 38 times richer than the average Tanzanian. Today the average American is 61 times richer. Purchasing power parity income in low-income countries as a group is one-thirteenth that in high-income countries.

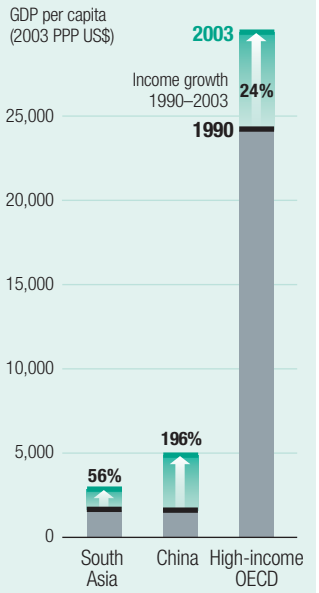
Weighting for population changes the picture. Because incomes have been growing more rapidly in China and (less spectacularly) in India than in high-income countries over the past two decades, the average gap has been closing in relative terms. This reverses a trend towards increased global inequality that started in the 1820s and continued until 1992.[47] Even here, though, the idea of convergence has to be put in context. High growth in India has been one of the most powerful forces for convergence. But on 2000–05 growth trends it will still take India until 2106 to catch up with high-income countries. For other countries and regions convergence prospects are even more limited. Were high-income countries to stop growing today and Latin America and Sub-Saharan Africa to continue on their current growth trajectories, it would take Latin America until 2177 and Africa until 2236 to catch up.

Most developing regions are falling behind, not catching up with, rich countries. Moreover, convergence is a relative concept. Absolute income inequalities between rich and poor countries are increasing even when developing countries have higher growth rates—precisely because the initial income gaps are so large (figure 1.15). If average incomes grow by 3% in Sub-Saharan Africa and in high-income Europe, for example, the absolute change will be an extra $51 per person in Africa and an extra $854 per person in Europe.

Part of the problem with the debate over global inequality is that it misses an important point. Income inequality is exceptionally high however it is measured and regardless of whether it is rising or falling. On the (conservative) assumption that the world's 500 richest people listed by *Forbes* magazine have an income equivalent to no more than 5% of their assets, their income exceeds that of the poorest 416 million people.[48]

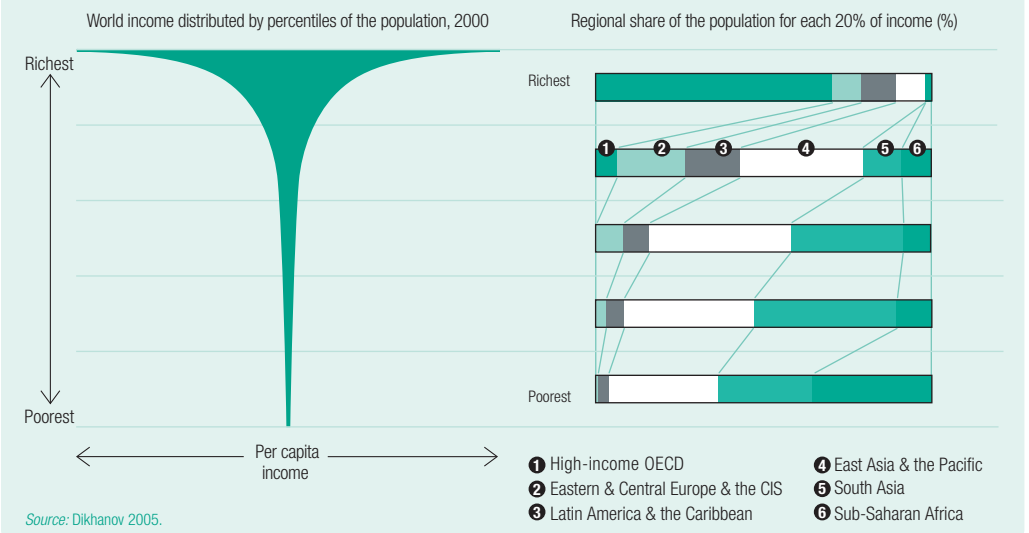
The scale of global inequality is best captured by global income distribution models. These models use national household survey data to create a unified global income distribution, placing everybody in the world in a unified ranking regardless of where they live (box 1.5). Presented in graphic form, global income distribution resembles a champagne glass, with a large concentration of income at the top and a thin stem at the bottom (figure 1.16).[49] The gap between top and bottom is very large—far greater than that found in even the most unequal countries. In Brazil the ratio of the income

Figure 1.15 **Growth convergence—and absolute income convergence**



Source: Calculated on the basis of data on GDP per capita from World Bank 2005f.

Figure 1.16 **Where the money is**



Source: Dikhanov 2005.

Championing globalization while turning a blind eye to global equity concerns is increasingly anachronistic

of the poorest 10% of the population to the richest 10% is 1 to 94. For the world as a whole it is 1 to 103. Measured more systematically by the Gini coefficient, the most widely used yardstick for inequality, the overall pattern of distribution for the world is more unequal than for any country except Namibia. On a scale where 0 is perfect equality and 100 is total inequality, the Gini coefficient for the world is 67.

Income inequalities between countries account for the bulk of global income inequality. About two-thirds of overall inequality can be traced to this source. Inequality within countries accounts for the balance. Reproduced at a national level, the gap between rich and poor countries would be regarded as socially indefensible, politically unsustainable and economically inefficient even in high-inequality regions such as Latin America. Global inequalities are less visible, but no less damaging to public interest, than inequalities within countries (explained in more detail in chapter 2). A world economy in which 40% of the population live on incomes so low as to preclude fully participating in wealth creation is hardly good for shared prosperity and growth.

Beyond the dysfunctional outcomes the extreme concentration of wealth at the top end of the global income distribution has one important consequence. Even small transfers relative to the income of the wealthy could generate very large increases in the incomes of the poor. Using the global income distribution model, we have estimated the overall financing that would be required to take everybody living below the $1 a day poverty line above the line. The calculation thus takes into account the depth of poverty, or the distance between household income and the income poverty line. Measured in 2000 purchasing power parity terms, the cost of ending extreme poverty—the amount needed to lift 1 billion people above the $1 a day poverty line—is $300 billion. Expressed in absolute terms, this sounds like a large amount. But it is equivalent to less than 2% of the income of the richest 10% of the world's population.

This is an illustrative exercise only. It is designed to draw attention to the modest financial resources, measured in global terms, needed to overcome extreme poverty. Achieving lasting redistributive outcomes, rather than describing their potential benefits, raises more complex challenges. Shares of global income reflect past and present growth trends. More fundamentally, as in any national economy global inequalities reflect disparities in technology, human capital and investment resources, as well as in factors linked to geography, history and—crucially—political and economic power. Redressing unequal outcomes requires measures to reduce these deeper structural inequalities that they reflect.

Some people claim that policy-makers have no need to consider inequalities beyond national boundaries. The distribution of income and opportunity between countries, so the argument runs, is not an issue for public policy. Writing in this vein, one commentator claims that "cross-country comparisons, no matter what measure is deployed, are just so much irrelevant data-mongering".[50] In an increasingly interconnected and interdependent world such views are at variance with both public perceptions and political realities. If we are part of a global human community, moral concern over unacceptable inequalities cannot be confined to national borders. This is especially the case when the policies adopted in one country have repercussions in another. As the growth of global social justice coalitions on issues such as aid, trade and debt amply demonstrates, international distribution does matter to a large constituency in rich and poor countries alike. Championing globalization while turning a blind eye to global equity concerns is an increasingly anachronistic approach to the challenges facing the international community.

It is sometimes argued that, even if global inequality matters, governments lack the capacity to influence distributional outcomes. That view too is flawed. In a national economy governments seeking greater equity in distributional outcomes can use a range of policy instruments. Fiscal transfers, public spending to enhance the assets of the poor and measures to extend market opportunities would all figure in. Public investment would play a critical role not just in overcoming immediate disadvantage

but also in equipping people with the capacities they need to work their way out of poverty and increase their self-reliance. There are analogies at a global level. International aid is the equivalent of a redistributive fiscal transfer mechanism with a potential to effect dynamic change, for instance, through investments in health, education and infrastructure. Similarly, international trade practices can open—or close—opportunities for poor countries and their citizens to capture a bigger share of the economic pie. The problem, as we show in chapters 3 and 4, is that these redistributive mechanisms are heavily underdeveloped.

Scenario 2015—prospects for the Millennium Development Goals

Forty-two years ago, on the steps of the Lincoln Memorial in Washington, DC, Martin Luther King, Jr. delivered the speech that defined the civil rights movement. Describing the US constitution as a "promissory note" guaranteeing freedom and social justice for all, he charged successive governments with giving African Americans "a bad check which has come back marked 'insufficient funds'". He went on: "But we refuse to believe that the bank of justice is bankrupt. We refuse to believe that there are insufficient funds in the great vaults of opportunity of this nation."[51]

The MDGs can also be thought of as a promissory note. Written by 189 governments to the world's poor people, that note falls due in 10 years time. Without an investment of political will and financial capital today, it too will come back marked "insufficient funds". Beyond the immediate human costs, a default on the scale in prospect will have implications for the credibility of the governments that made the pledge and on the future of international cooperation to resolve global problems.

There is more to human development than the MDGs. But progress towards the MDGs reflects progress towards human development. The MDGs represent the most comprehensive and most detailed set of human development goals ever adopted (box 1.6). They embody basic indicators for human development in its many dimensions, including income poverty, education, gender equity, progress in combating infectious disease and access to clean water and sanitation. The MDGs are also basic human rights. While measures such as global gross national income (GNI), the value of trade and the scale of foreign

Box 1.6 The Millennium Development Goals

In September 2005 the UN General Assembly will review achievements since the Millennium Declaration of 2000, including progress towards the eight Millennium Development Goals. These goals provide tangible benchmarks for measuring progress in eight areas, with a target date for most of them of 2015:

Goal 1 Eradicate extreme hunger and poverty. Halving the proportion of people living on less than $1 a day and halving malnutrition.

Goal 2 Achieve universal primary education. Ensuring that all children are able to complete primary education.

Goal 3 Promote gender equality and empower women. Eliminating gender disparity in primary and secondary schooling, preferably by 2005 and no later than 2015.

Goal 4 Reduce child mortality. Cutting the under-five death rate by two-thirds.

Goal 5 Improve maternal health. Reducing the maternal mortality rate by three-quarters.

Goal 6 Combat HIV/AIDS, malaria and other diseases. Halting and beginning to reverse HIV/AIDS and other diseases.

Goal 7 Ensure environmental stability. Cutting by half the proportion of people without sustainable access to safe drinking water and sanitation.

Goal 8 Develop a global partnership for development. Reforming aid and trade with special treatment for the poorest countries.

If solemn promises, ambitious pledges, earnest commitments and high-level conferences lifted people out of poverty, the MDGs would have been achieved long ago

investment say something about the world's success in creating wealth, the MDGs provide a marker for something more fundamental: the moral and ethical underpinnings of our interactions as a global community. That is why, as the report of the UN Millennium Project puts it, "The MDGs are too important to fail."[52]

But fail they will unless there is a change of gear in human development. Continuation of the trends described earlier in this chapter will have fatal consequences for the MDGs. Almost all of the goals will be missed by most countries, some of them by epic margins. In this section we use country by country projections to estimate the size of these margins. These projections highlight the potential costs of continuing on a business-as-usual basis between now and 2015.

This is not the first time that the international community has embraced ambitious goals. If solemn promises, ambitious pledges, earnest commitments and high-level conferences lifted people out of poverty, put children in school and cut child deaths, the MDGs would have been achieved long ago. The currency of pledges from the international community is by now so severely debased by non-delivery that it is widely perceived as worthless. Restoring that currency is vital not just to the success of the MDGs but also to the creation of confidence in multilateralism and international cooperation—the twin foundations for strengthened international peace and security.

Scenario 2015—projections not predictions

"Stocks have reached what looks like a permanently high plateau", declared Irving Fischer, a professor of economics at Yale University, on the eve of the Great Depression in October 1929. As events a few days later were to demonstrate, predicting the future is a hazardous affair. Future outcomes are seldom a continuation of past trends.

Our projections for 2015 are not predictions. Using trend analysis for 1990–2003, we look at where the world would be in 2015 on key MDGs if current trends continue. The trend projections are based on national data rather than regional averages, giving a more precise picture of the direction of current trends.[53] However, trends do not lead to inevitable outcomes. Trends can be improved—or worsened—through public policy choices, as well as by external factors over which governments have limited influence. But projecting the past into the future can help to focus public attention by providing one possible version of the future.

Several caveats have to be attached to our trends analysis. Good quality data are not available for many countries and several goals. Time-series data on education are lacking for 46 countries, for example. There are also problems with reviewing trends on a goal-by-goal basis. Progress in any one area is heavily conditioned by progress in other areas, with strong multiplier effects operating across the goals—for example, from health to education. Finally, some of the forces that might affect MDG progress are difficult to anticipate, including what might be thought of as systemic threats. As the International Monetary Fund (IMF) has warned, current imbalances in the global economy have the potential to result in slower growth—an outcome that would hurt poverty reduction efforts in developing countries. Beyond the global economy there are potentially grave threats to public health. For example, if the widely predicted outbreak of avian flu were to materialize, it would have devastating implications for the MDGs as well as for public health across all countries. Similarly, the full consequences of global warming and other ecological pressures on food systems could dramatically change the scenario for reducing malnutrition.

We make no attempt to factor in systemic risk, and so our results may err on the side of optimism. Even so, the results point unambiguously to a large gap between MDG targets and outcomes on current trends. The overall country by country progress report for child mortality and school enrolment is summarized in figure 1.17. This shows how many countries would achieve each MDG target by 2015 if current trends continue. It also shows how many countries will not meet the target until 2035 or later. As illustrated in map 1.1, Sub-Saharan Africa is not the only region off track for the MDG target of reducing child mortality by two-thirds.

Looking more broadly at progress towards five of the MDGs—child mortality, school enrolment, gender parity in education and access to water and sanitation—produces a similarly bleak prognosis. Among the summary findings to emerge from our trend analysis:

- Fifty countries with a combined population of almost 900 million people are going backwards on at least one MDG. Twenty-four of these countries are in Sub-Saharan Africa.
- Another 65 countries with a combined population of 1.2 billion will fail to meet at least one MDG until after 2040. In other words, they will miss the target by an entire generation.

Below, we briefly outline the 2015 projections behind these trends.

Child health and maternal health—millions more children will die

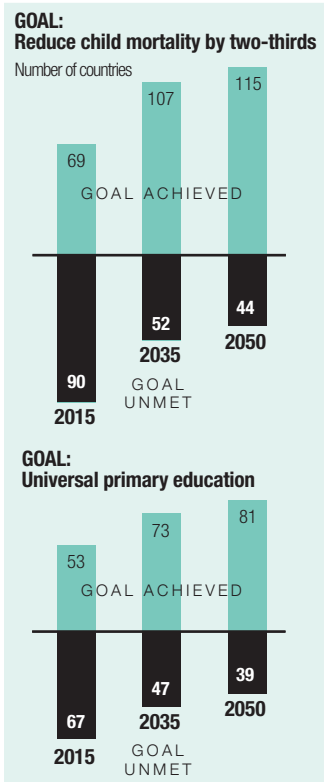
No indicator more powerfully demonstrates the scale of the challenge facing the international community than child mortality. The slowdown in progress since 1990 has set the world on course for comprehensive failure in meeting the MDG.

On current trends the world will achieve the two-thirds reduction in child deaths targeted by the MDGs in 2045—31 years late. Achieving the MDG target implies an average annual reduction of about 2.7% in the incidence of child mortality. This is more than double the observed rate for 1990–2002. Less than one-fifth of the developing world's population live in countries that are on track to meet the target. Not one Sub-Saharan African country with a significant population is on track to meet the target. Neither are China and India.

The projected gap between the 2015 target and the outcome that would take place if current trends continued represents a huge loss of life. It translates into an additional 4.4 million child deaths in 2015 above those that would occur if the MDG target were achieved (figure 1.18). Charting a linear trend from the cumulative cost of additional child deaths for 2003–15 provides an indicator for the annualized gap between target and outcome. The cumulative cost of that gap represents more than 41 million additional child deaths between now and 2015—almost all of them in developing countries (figure 1.19). These are lives that would be saved if the targets were met.

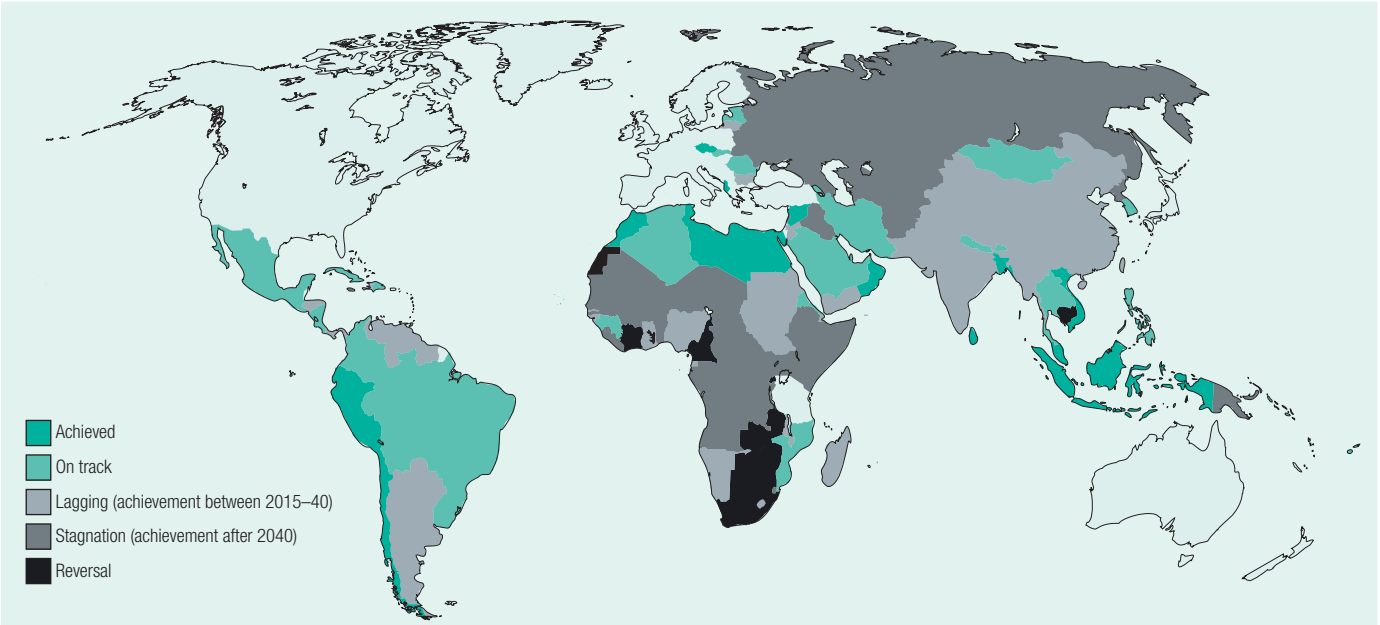
The following are among the main findings from the trend projection:

Figure 1.17 Missing the targets for children



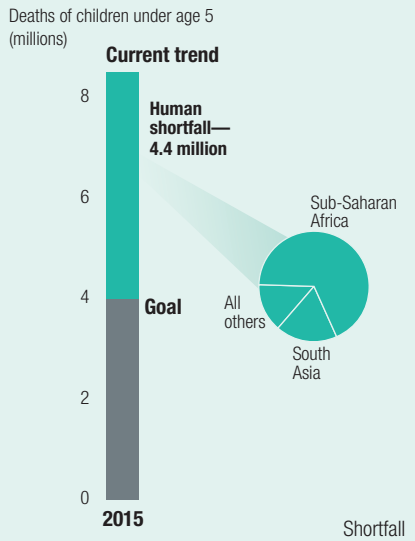
Source: Calculated on the basis of data on child mortality and primary enrolment from UN 2005b; for details see *Technical note 3.*

Map 1.1 The geography of child mortality—progress towards the 2015 MDG target



Note: This map is stylized and is not to scale. It does not reflect a position on the legal status of any country or territory or the delimitation of any frontiers.
Source: Calculated on the basis of data on child mortality and primary enrolment from UN 2005b; for details see *Technical note 3.*

Figure 1.18 **Child mortality—the human cost**



	Shortfall
Sub-Saharan Africa	3.0
Arab States	0.3
East Asia & the Pacific	0.3
South Asia	0.8
Latin America & Caribbean	0.0
All developing countries	**4.4**

Source: Calculated on the basis of data on under-five mortality from UN 2005b and births from UN 2005d; for details see *Technical note 3*.

- More than 45% of child deaths—4.9 million in all—occur in 52 countries that are going backwards or making little progress in reducing the death toll. Children born in these countries today who survive to adulthood will see barely improved prospects of survival for their own children.
- On current trends it will take Sub-Saharan Africa until 2115 to achieve the MDG target, putting it off track by a century. The two largest centres of child deaths in Sub-Saharan Africa are the Democratic Republic of the Congo, where conditions are deteriorating, and Nigeria. The child mortality rate in Nigeria has fallen from 235 per 1,000 live births to 198 since 1990. At this rate it will take Nigeria another 40 years to achieve the MDG target.
- Two-thirds of all child deaths occur in 13 countries. Of these, only two—Bangladesh and Indonesia—are on track for the MDG target. Another four—China, India, Niger and Pakistan—will achieve the goal between 2015 and 2040. The remainder—a group that includes Afghanistan, Angola, the Democratic Republic of the Congo, Ethiopia, Nigeria, Tanzania and Uganda—are either more than a generation off track or going backwards.

Data limitations make it impossible to track trends in maternal mortality with any accuracy. Best estimates for trends are derived from models that use proxy indicators, such as fertility rate and attendance at delivery by skilled medical personnel. The most widely used of these models suggests that the world is off track and that the rate of progress is slowing. For the developing world as a whole, the population-weighted rate of decline needed to achieve the MDG target is just over 3%. Sub-Saharan Africa is reducing maternal mortality at less than half that rate.[54]

Water and sanitation—more than a billion unserved

Progress in access to water and sanitation will have an important bearing on child death rates. Our trend analysis suggests that the target of halving the number of people without sustainable access to improved water sources will be missed by about 210 million people (figure 1.20). Another 2 billion people will also lack access to an improved sanitation source in 2015. Sub-Saharan Africa will account for the bulk of the deficit.

Halving extreme poverty and malnutrition depends on growth and distribution

Prospects for halving extreme poverty will be shaped by two factors: growth and distribution. Poverty will fall faster the higher the rate of growth for poor countries and the bigger the share of any increment to growth captured by poor people. Projections to 2015 indicate that if the current pattern of growth and distribution continues, the aggregate global target will be met, largely because of high growth in China and India. However, most countries will miss the target.

Our estimates indicate that there will be about 800 million people living on less than $1 a day and another 1.7 billion people living on less than $2 a day in 2015. The incidence of global $1 a day poverty will fall from 21% today to 14% in

2015. The regional composition of poverty will also change. Sub-Saharan Africa's share of $1 a day poverty will rise sharply, from 24% today to 41% in 2015. How does this picture compare with one in which each country meets the target of halving poverty? On our estimates there would be around 380 million fewer people living in $1 a day poverty if all countries achieved the target (figure 1.21). More than half of these people would be in Sub-Saharan Africa.

Sub-Saharan Africa's rising share of global poverty to 2015 reflects its weak growth record since 1990, exacerbated by highly unequal income distribution. The region would need to attain an implausibly high annual per capita growth rate of around 5% over the next decade to achieve the 2015 target. A mix of accelerated growth and improved distribution offers a better hope of getting on track.

Prospects for reaching the MDG target on malnutrition are even less promising. The incidence of malnutrition has fallen since 1990, from 20% to 17%. However, population growth has left the number of malnourished people unchanged. The pace of progress will have to double to reach the 2015 target. On the current trajectory there will still be around 670 million people suffering from malnutrition in 2015, 230 million more people than if the target were achieved. Sub-Saharan Africa accounts for almost 60% of the deficit.

Regional projections show a different pattern for malnutrition than for $1 a day poverty. While South Asia is projected to make strong progress on income poverty, it will still account for 40% of malnutrition in 2015. This is consistent with the current pattern in which South Asian countries record levels of malnutrition comparable to those in Sub-Saharan Africa, despite higher average incomes—an outcome that highlights the central role of gender inequalities in blocking advances in nutrition.

Education—missing the universal enrolment target

Education is a crucial human development goal in its own right and a key to progress in other areas. The promise to get every child into school and to close gender gaps in education powerfully symbolizes the hope that the transmission of poverty across generations can be broken.

That hope will remain unfulfilled if current trends continue. While the world is moving in the right direction, progress is too slow to achieve the 2015 target (figure 1.22). If current trends continue:

- The target of achieving universal primary education by 2015 will be missed by at least a decade. There will be 47 million children out of school in 2015, 19 million of them in Sub-Saharan Africa.
- Forty-six countries are going backwards or will not meet the target until after 2040. These countries account for 23 million of the 110 million children currently out of school in developing countries.

Gender parity and empowerment—one target already missed

One set of targets has already been missed. The MDG targets for gender parity in primary and secondary enrolment were supposed to be met

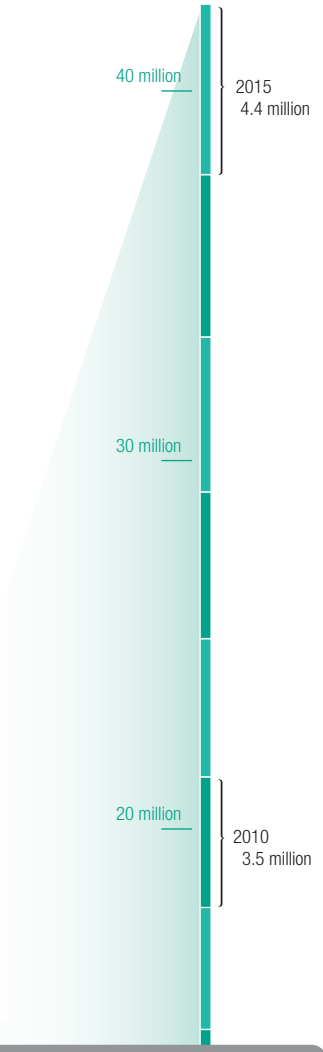
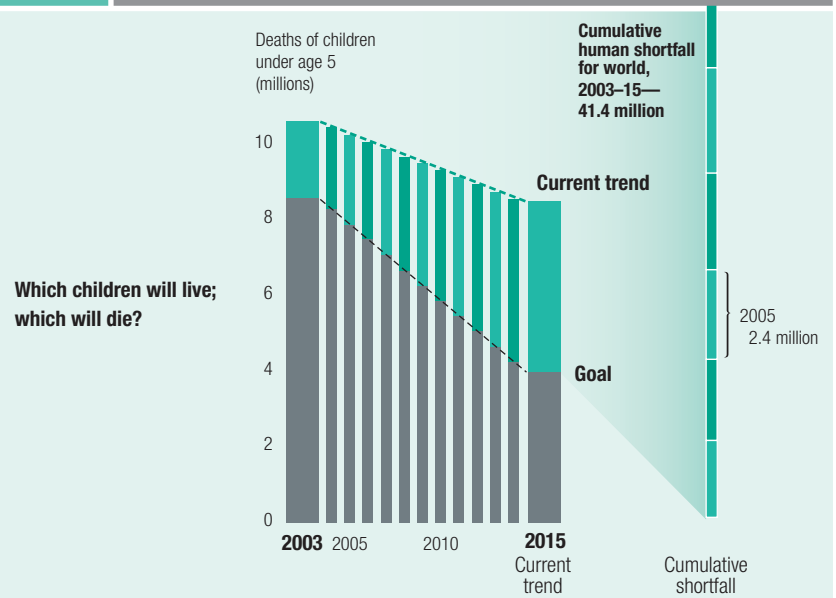


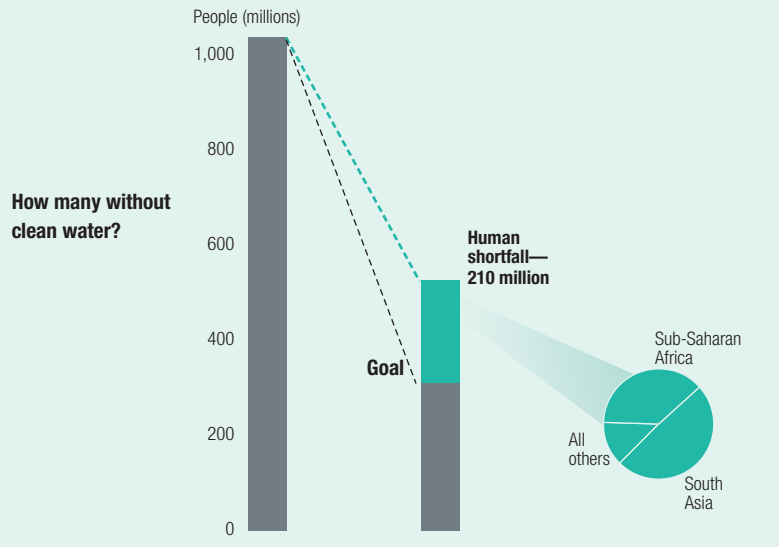
Figure 1.19 **Child mortality—the cumulative cost of missed targets**



	2003	2015 Current trend	Cumulative shortfall
Sub-Saharan Africa	4.8	5.1	28.1
Arab States	0.6	0.5	3.0
East Asia & the Pacific	1.2	0.7	2.9
South Asia	3.5	2.2	7.2
Latin America & Caribbean	0.4	0.1	0.2
All developing countries	**10.5**	**8.6**	**41.4**

Source: Calculated on the basis of data on under-five mortality from UN 2005b and births from UN 2005d. For details see *Technical note 3.*

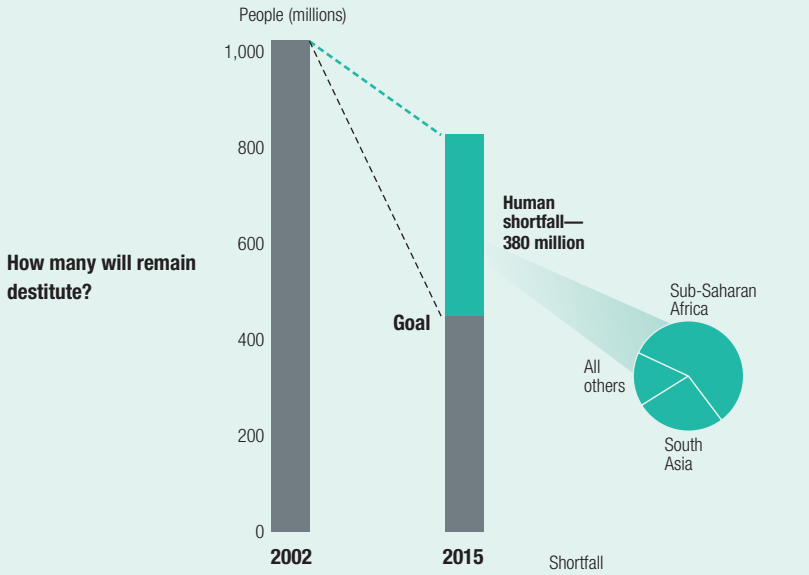
Figure 1.20 **No access to clean water—the human cost**



	2002	2015	Shortfall
Sub-Saharan Africa	278.2	198.6	80.1
Arab States	46.7	19.0	6.7
East Asia & the Pacific	419.0	190.7	14.6
South Asia	232.6	108.9	103.6
Latin America & Caribbean	55.0	8.1	4.9
All developing countries	**1,036.6**	**525.2**	**209.9**

Source: Calculated on the basis of data on people with access to improved water sources from UN 2005b and data on population from UN 2005d; for details see *Technical note 3.*

Figure 1.21 **Income poverty—the human cost**



	2002	2015	Shortfall
Sub-Saharan Africa	313.0	352.7	218.7
Arab States	7.0	9.8	7.5
East Asia and the Pacific	271.0	17.2	7.5
South Asia	431.0	395.0	101.4
Latin America & Caribbean	50.0	51.0	44.4
All developing countries	**1,072.0**	**826.7**	**379.9**

Source: Calculated on the basis of data on people living on less than $1 a day (PPP US$) from World Bank 2005d and data on population from UN 2005d; for details see *Technical note 3.*

by 2005. Had that target been achieved, there would be 14 million more girls in primary school today, 6 million of them in India and Pakistan and another 4 million in Sub-Saharan Africa. Trend projections are not encouraging. By 2015 the shortfall from the gender parity target will be equivalent to 6 million girls out of school, the majority of them in Sub-Saharan Africa (figure 1.23). In 41 countries accounting for 20 million of the girls currently out of school the gender gap is either widening or closing so slowly that parity will not be achieved until after 2040. Of course, there is more to gender parity than attendance in school. Research from many countries highlights wider aspects of gender disadvantage rooted in attitudes and cultural practices that diminish the value of girls' education. Progress in these areas is inherently more difficult to track on a comparative basis, though it is equally fundamental.

Beyond parity in education the MDGs include female representation in parliaments as an indicator of progress towards the empowerment of women. The gender empowerment measure (GEM) developed by the *Human Development Report* includes this indicator in a broader composite indicator that tracks female representation in legislative bodies, governments and the private sector, along with a range of income indicators.

Decomposing the GEM to provide a snapshot of women's current position highlights the limited progress towards gender empowerment. Globally, women hold only about 15% of legislative assembly seats. In only 43 countries is the ratio of female to male parliamentarians more than 1 to 5, and in only two—Rwanda and Sweden—is the ratio even close to parity. In most countries politics remains an overwhelmingly male domain.

Nigeria is one of 57 countries in which women account for less than 10% of legislative presence. Women account for 6% of Nigeria's House of Representatives, less than 4% of the Senate and no state governors. In Saudi Arabia and the United Arab Emirates there is no female representation, in some cases reflecting the use of laws to exclude women from voting or holding office. In countries where gender inequality

is a major barrier to progress in health, education and income poverty, such underrepresentation of women points to a worrying continuation of gender inequality and obstacles to social and income progress.

The GEM demolishes two widely held myths about gender empowerment. First, there is no evidence that Islam necessarily represents an obstacle to female empowerment, as measured by political representation. Malaysia, a Muslim country, has a GEM far higher than Saudi Arabia's and comparable to that of Greece. Second, there is no clear evidence that gender inequalities automatically diminish at higher levels of income (figure 1.24). Two members of the Group of Seven (G-7) industrial countries are poor performers on the GEM. Both Italy (ranked 36) and Japan (ranked 42) occupy a lower position than Costa Rica and Argentina. Similarly, both Japan and Sweden are democracies at comparable levels of human development as measured by the HDI, but Sweden's GEM score is almost double that of Japan. The conclusion: social norms, political culture and public attitudes matter as much as economic wealth and overall human development in defining opportunities for women.

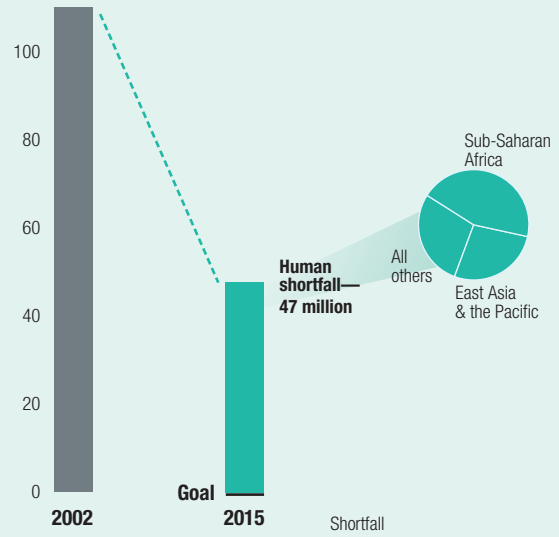
Changing course and getting on track

Trend projections identify one set of possible outcomes for the MDGs. Actual outcomes will reflect policy choices made by governments and the international community over the next decade. What emerges from the projections set out here is a clear warning. The gap between trend projections and MDG targets represents a huge loss of human life and human potential. The good news is that the gap can be closed.

Some countries have registered an extraordinary rate of advance towards the MDGs, often from very low levels of income. Viet Nam is one.[55] Income poverty has already been cut in half, falling from 60% in 1990 to 32% in 2000. Child mortality rates have fallen from 58 per 1,000 live births (a far lower rate than income would predict) to 42 over the same period. Rapid, broad-based economic growth has

Figure 1.22 Children not enrolled in school—the human cost

Primary-school age children out of school (millions)

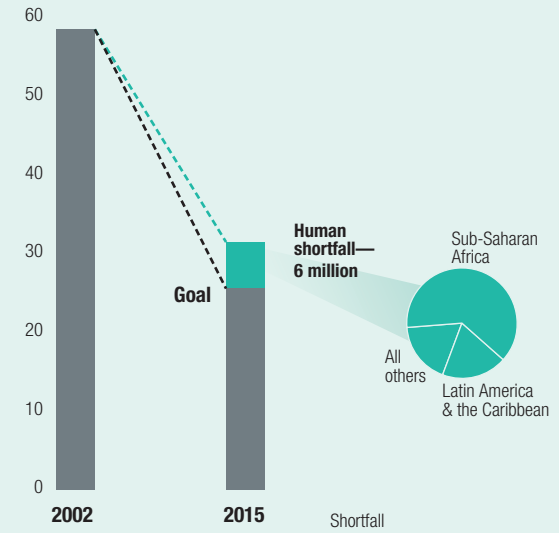


	2002	2015	Shortfall
Sub-Saharan Africa	45.5	18.7	18.7
Arab States	8.8	5.7	5.7
East Asia & the Pacific	10.0	15.8	11.3
South Asia	42.3	4.0	4.0
Latin America & Caribbean	3.3	0.9	0.9
All developing countries	**109.9**	**46.7**	**46.7**

Source: Calculated on the basis of data on children attending school from UNESCO 2005, data on children out of school from UNICEF 2005d and data on population from UN 2005d; for details see *Technical note 3.*

Figure 1.23 Girls not enrolled in school—the human cost

Primary-school age girls out of school (millions)

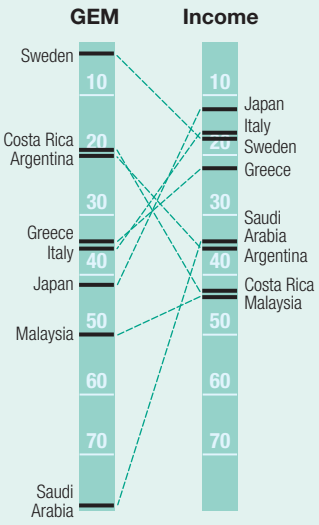


	2002	2015	Shortfall
Sub-Saharan Africa	23.8	9.6	3.8
Arab States	5.0	3.5	0.5
East Asia & the Pacific	4.9	7.1	0.7
South Asia	23.6	9.6	0.0
Latin America & Caribbean	1.5	1.1	1.1
All developing countries	**58.8**	**30.9**	**6.0**

Source: Caclulated on the basis of data on girls attending school from UNESCO 2005 and population growth rates from UN 2005d. For details see *Technical note 3.*

Figure 1.24 **Income does not predict gender empowerment**

Ranking among the 78 countries with a gender empowerment measure



Source: Indicator tables 14 and 26.

Box 1.7 Bangladesh—moderate growth, rapid human development

At the start of the 1990s pessimism about development prospects for Bangladesh was as deeply ingrained as pessimism is about Sub-Saharan Africa today. Slow economic growth, rapid population growth, limited progress on social indicators and acute vulnerability to natural disasters provoked descriptions of Bangladesh as "a landscape of disaster". That landscape has changed dramatically.

Since 1990 Bangladesh has recorded some of the developing world's most rapid advances in basic human development indicators. Child and infant mortality rates have been falling at more than 5% a year, the fertility rate has fallen sharply, and malnutrition among mothers has fallen from 52% in 1996 to 42% in 2002. Primary school enrolment rates have reached more than 90%, up from 72% in 1990, with close to gender parity, and enrolment in secondary education has been rising.

How did Bangladesh achieve this transformation of the human development landscape? Not by economic growth alone. True, the 1990s saw more rapid growth, with average incomes rising at just under 3% a year. However, Bangladesh is still a desperately poor country—average income is $1,770—and income poverty has been falling relatively slowly, by 10% between 1990 and 2002.

Four strategies have contributed to Bangladesh's human development take-off:

- *Active partnerships with civil society.* Non-governmental organizations (NGOs) have played a critical role in improving access to basic services through innovative programmes. For example, the Bangladesh Rural Advancement Committee (BRAC) has pioneered programmes to recruit and train local female teachers, develop relevant curriculum material and support parental involvement in school management. More than 2 million children go to school outside the formal government system. But NGO schools act as feeders for government middle schools.
- *Targeted transfers.* Wide-ranging social programmes have targeted improved nutrition while also creating wider incentives for human development. The Food for Schooling programme offers free rations to poor households if their children attend primary school. About 7% of government spending on education is allocated through this programme, reaching 2.1 million children and providing a stipend of $3 a month. Participating schools have achieved higher rates of girls' participation and lower drop-out rates, demonstrating how incentives can counteract the economic pressures and cultural prejudices that keep girls out of school.
- *Extended health programmes.* Immunization coverage against six major childhood diseases increased from 2% in the mid-1980s to 52% in 2001. Immunization programmes have been implemented through partnerships with international agencies and national NGOs.
- *Virtuous cycles and female agency.* Improved access to health and education for women, allied with expanded opportunities for employment and access to microcredit, has expanded choice and empowered women. While gender disparities still exist, women have become increasingly powerful catalysts for development, demanding greater control over fertility and birth spacing, education for their daughters and access to services.

Bangladesh achieved this remarkable progress at low levels of income and starting from a position of low literacy, high malnutrition and weak institutions. Its successes demonstrate what can be achieved through stronger state action and civic activism.

Rapid progress in a low-income country

Indicator	1990	2000
Income poverty (%)	59	50
Gini coefficient	25	30
Children under age 5 under weight for age (%)	72	51
Under-five mortality rate (per 1,000 live births)	144	69 [a]
Ratio of girls to boys in primary school (girls per 100 boys)	87	104 [b]

a. Data refer to 2003.
b. Data refer to 2002.

Source: Ahluwalia and Hussain 2004; Drèze 2004; Yunus 2004; Ahmed and del Ninno 2001; Sen, Mujeri and Quazi 2005.

contributed to Viet Nam's success. So have investments in human development during the 1980s. The challenge for Viet Nam is to sustain the rate of advance by reaching some of the country's most marginalized regions and groups.[56]

Viet Nam is an example—Chile is another—of a country that has converted high growth into rapid human development. Other countries have shown that rapid advance towards the MDGs is possible even at lower levels of growth. In Bangladesh public policies and interventions by civil society have expanded access to basic services and opportunities, propelling Bangladesh into a higher human development trajectory (box 1.7). As a region Sub-Saharan Africa has been slipping down in the human development rankings. However, some countries have registered marked advances. Ghana reduced income poverty from 51% in 1991 to 40% at the end of the 1990s.[57] Uganda has combined economic reform with an improved record in income poverty and education, though progress has been uneven (box 1.8).

Conflict remains a potent barrier to human development. Peace creates opportunities to

Box 1.8 Uganda—impressive progress, but uneven

Over the past decade Uganda has experienced sustained economic growth and made important advances in human development. Poverty reduction has been a national priority reflected in planning and budgeting. However, progress has been uneven—and the gains remain fragile:

- *Income poverty.* In the first half of the 1990s government policies focused on stabilization and growth. Average incomes grew 5% a year from 1990 to 2000. Income poverty fell rapidly in the 1990s, from 56% to 34%, putting the country on track for the 2015 MDG target. However, since 2000 income growth has slowed and the incidence of poverty has risen. Poverty is concentrated in rural areas, especially in the north and east, and is far higher among producers growing only food staples.
- *Education.* In the second half of the 1990s poverty reduction priorities shifted to education. Free primary education was introduced and public spending increased. Primary school enrolment rose from 5.3 million to 7.6 million between 1997 and 2003. Enrolment rates are the same for the poorest 20% of the population as for the richest 20%, and the gender parity gap has been closed at the primary level. Universal enrolment is now within reach, but drop-out rates make achieving universal completion by 2015 unlikely.
- *Health.* Outcome indicators for health, including infant, child and maternal mortality have either stagnated or deteriorated, with under-five mortality rising since 1995. One of the strongest MDG performers in Africa, Uganda is now off track for all of the major health goals. Recognizing that failure to reduce child and maternal mortality threatens to undermine social and economic progress, the government has convened a cross-ministry task force under the auspices of the Ministry of Finance to identify solutions.

These diverse trends draw attention to the challenges facing Uganda. Some challenges are driven by external forces, notably the price of coffee. Until 1997 producers of coffee, the main cash crop for smallholders, benefited from rising domestic prices and favourable terms of trade. The collapse in coffee prices since then has reversed these gains, partly accounting for the reversal in income poverty.

Another problem is that falling growth has coincided with rising inequality. The Gini coefficient has increased from 34 to 42 since 1997, suggesting that Uganda may be in transition from a low-inequality to a high-inequality country. Correcting this trend will require action to broaden the base of economic growth around smallholder farmers in rural areas, alongside a focus on more capital-intensive export agriculture.

Progress in the health sector has been hampered by deep structural problems. Malnutrition is implicated in two-thirds of childhood deaths, less than one-third of women give birth under the supervision of trained staff, and there has been no decrease in major childhood killers, such as malaria and measles. High fertility rates and inadequate birth spacing are another problem. Uganda has the third highest fertility rate in the world.

The contrast between progress in education and stagnation in health partly reflects public spending priorities. Not until the late 1990s was health identified as a major public spending priority, though the health sector budget has tripled in the past four years. Poor quality service provision is another barrier.

Mixed performance on human development

Indicator	1992	2002
Income poverty (%)	56	38
Gini coefficient	36	42
Children under age 5 under weight for age (%)	62	86
Under-five mortality rate (per 1,000 live births)	167 [a]	152
Maternal mortality ratio (per 100,000 live births)	523	505

a. Data are for 1990.

Source: Uganda, Ministry of Finance, Planning and Economic Development 2003; Ssewanyana and others 2004.

Changing course and getting the world on track for the MDGs will require new partnerships in development

remove that barrier. In Afghanistan there are encouraging early signs that improved human security is leading to opportunities for a rapid recovery from the human development free fall it experienced during two decades of conflict. Under a "back to education" plan adopted in 2001 the government aimed to increase school enrolments by 1.5 million. More than twice this number of children enrolled in primary school, with the figure rising to 4 million in 2003. An ambitious basic health programme has been adopted that aims at extending services across the country. Meanwhile, economic recovery is taking root. Seizing these opportunities depends critically on aid donors signing up for the long haul. The danger: the international community will lose interest as the strategic focus shifts elsewhere.

Attempts have been made to isolate the costs and benefits of investments in specific MDGs. Such exercises are unhelpful. Progress in any one area is heavily conditioned by progress across the MDGs—and beyond. Getting children into well equipped schools staffed by motivated teachers is a vital requirement for achieving the MDG target of education for all. But the full value of investments in education will not be realized if children are sick because their families lack access to clean water and affordable medicine. The multiplier effects that operate across the MDGs are especially strong for women's education. The education and empowerment of women are a human development goal in their own right: they are ends in themselves. Gender empowerment is also an accelerator towards the MDGs and wider human development goals. Educated women are better able to control their fertility and demand basic health services, less likely to contract HIV/AIDS and more likely to educate their daughters (see box 1.3).

Changing course and getting the world on track for the MDGs will require new partnerships in development. Many of the countries that are falling far short of achieving the MDGs, especially in Africa but also in other low-income regions, lack the financial resources for the public investments needed to create a virtuous circle of increased investment in human development and faster growth. The UN Millennium Project report of 2005 sets out an ambitious but practical framework for a new partnership based on two building blocks. First, each developing country needs to set out clear national strategies for reaching the MDGs, including the financing gaps that have to be covered. Second, rich countries, as part of their MDG commitment, need to mobilize the development assistance resources to cover these gaps—an issue that we look in more detail in chapter 3.

Beyond the question of financing is another fundamental requirement for getting the world back on track: a renewed focus on inequality and distributional equity. As we show in the next chapter, deep structural inequalities in human capabilities, opportunities and income act as a powerful brake on the MDGs. Releasing that brake by putting strategies for greater equality at the centre of national strategies for achieving the MDGs would dramatically enhance chances of success.