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POVERTY AND HEALTH PROBLEMS IN THE LEAST DEVELOPED AND LOW-INCOME OIC MEMBER COUNTRIES

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Many of the OIC least developed and low-income countries (OIC-LDLICs) are victims of the various dimensions of poverty, hence many of the OIC countries have poverty estimates, plans and targets. In fact, poverty is a complex multi-dimensional phenomenon, which consists of inadequate income or human development. However, the great progress in 20th century in reducing poverty and improving well being observed in many areas extending from education to health in many OIC-LDLICs. In this context, this paper attempts to investigate and assess the status and determinants of poverty in OIC-LDLICs. It evaluates the incidence of poverty in the OIC-LDLICs through examining the available statistical trends in poverty. In addition to this, it devotes a section to the poverty and health linkages since poverty is both a cause and consequence of ill health.

1. INTRODUCTION

Despite the tremendous advance in our understanding of economic and human development in the past three decades, eradicating, or at least reducing, poverty lies at the heart of the developing countries' problems. In fact, poverty is the world's greatest challenge. Th remarkable and unprecedented progress achieved over the 20th century in reducing poverty has been uneven and marred by setbacks. Thus, poverty persists. Moreover, non-income measures of poverty, low achievement in education, health and nutrition and other areas of human development have been the basic points both in the definition of poverty and in the poverty-reduction strategies.

Poverty is the result of economic, political and social processes that interact with each other and frequently reinforce each other in ways that exaggerate the deprivation of the poor. As technology progresses and the general standard of living rises, the poverty profile changes with new

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consumption items. Thus, the definition of poverty expanded and new dimensions have been introduced. The degree of interaction among elements has also increased because each element contributes to well being in a broad sense, but also contributes to the achievement of other elements. The broader definitions allow a better characterisation of poverty and, therefore, increase our understanding of poverty. This deeper understanding will often be critical to the design and implementation of specific programs and projects to help people escape poverty by expanding the set of policies that are relevant to the reduction of poverty.

Faced with this picture of global poverty and inequality, the international community has set itself several goals for the opening years of the century, based on discussions at various UN conferences in the 1990s. Following the commitments at the World Social Summit for Social Development in 1995, countries produce their own estimates of income poverty, set their own targets and elaborate their own plans. "Thus, more than three-quarters of countries have poverty estimates, and more than two-thirds have plans for reducing poverty, but fewer than a third have set targets for eradicating extreme poverty or substantially reducing overall poverty--the Social Summit commitments"(UNDP, Poverty Report 2000). Of the 140 countries surveyed, 43 OIC countries have national poverty plans, estimates and targets. Furthermore, 19 OIC countries have poverty plans in national planning and 20 have explicit poverty plans. But of the 43 OIC countries, only 13 have targets for eradicating extreme poverty or substantially reducing overall poverty (or both). Nearly half of the Sub-Saharan African countries have targets (Table A.1. in the Annex). The lack of targets is a serious shortcoming for all countries to address at the General Assembly's 5-year review. Until countries set realistic targets to measure progress, it is difficult to believe that they are mounting a concerted campaign to address poverty (UNDP, Poverty Report 2000).

Different dimensions of poverty interact in important ways in different parts of the world--and there are large variations among regions, with some seeing advances, and others setbacks, both in crucial income and non-income measures of poverty. Furthermore, poverty has spread far and wide in many OIC countries including the malnutrition, illiteracy, disease and low level and quality of consumption of hundreds of millions of people, particularly in the OIC Least Developed and Low Income Countries (OIC-LDLICs). Within the complexity originating both from the definition of poverty and the socio-economic structure of

these countries, identifying the essential causes of poverty is a precondition for formulating an effective anti-poverty strategy.

If the OIC-LDLICs wish to win the fight against poverty, it will be essential for them to understand the multi-dimensional nature of poverty before designing and implementing programs and projects aimed at helping people eradicate poverty. To evaluate the determinants of poverty in all its dimensions, it helps to think in terms of people's assets, the returns on these assets, and the volatility of returns, such as, human assets--the capacity for basic labour, skills and good health; natural assets--land; physical assets--access to infrastructure; financial assets--savings, access to credit and social assets. The returns on these assets not only depend on access to markets but also on the performance of institutions of the state and society.

This paper attempts to investigate and to assess the status and determinants of poverty, and evaluates the trends in poverty over time in the OIC-LDLICs. However, given the scarcity of complete data on poverty in these countries, the paper relies partly on UNDP's Human Development Report and World Bank's World Development Indicators reflecting the multi-dimensional nature of poverty. Since poverty is both a consequence and a cause of ill health, the paper devotes a section to discuss this issue as a special topic. The second section presents a broad overview of the OIC-LDLICs. The third provides some brief information about understanding poverty in the OIC-LDLICs and presents an evaluation of poverty in these countries. The fourth evaluates the trends in poverty and the fifth points out the health and poverty linkages. In the last section, the paper proposes a wide range of general policy recommendations for poverty alleviation based on a consensus on poverty reduction strategies.

2. OIC-LDLICs: OVERVIEW

The group of the OIC Least Developed Countries (OIC-LDCs) is made up of those member countries of the OIC (22 countries--see Table A.2 in the Annex) which are designated as least developed by the United Nations. These countries represent 45 per cent of the total number of LDCs in the world (49 countries). On the other hand, the group of OIC Low-Income Countries (OIC-LICs) is made up of those member countries of the OIC which are classified as low-income countries according to their 1999 GNP

per capita, at $755 level or less. With the exception of Djibouti and Maldives, this group includes all the OIC-LDCs and another 10 countries, namely Azerbaijan, Cameroon, Côte d'Ivoire, Kyrgyz Republic, Indonesia, Nigeria, Pakistan, Tajikistan, Turkmenistan and Uzbekistan. Together, these countries represent the OIC-LDLICs (32 countries out of the current 57 OIC member countries) and account for about 68% of the total population of the OIC member countries.

The OIC region is geographically vast. The current 57 OIC member countries are dispersed over a large area on four continents. And as the geographic distribution of the OIC-LDLICs presented in Table A.2 indicates, the majority of these countries (21 countries) are in Sub-Saharan Africa while 11 countries are in Asia. Each member country is endowed with potential economic resources in different fields and sectors such as agriculture, energy and mining, human resources and so on. Since different economic and social endowments lead to different levels of economic and human development, they do not make up a homogeneous group. However, in terms of economic structure and human development and poverty alleviation, the OIC-LDCs (22 countries) can be considered as homogeneous, while in the case of the other 10 OIC-LICs the situation is mixed due to different sizes and structures of the economy and different stages of development. Since most of the OIC-LDCs (18 countries) constitute a substantial part of Sub-Saharan Africa, it is possible, in general, to assume that what applies to this region, as a whole, also applies to the OIC-LDCs as a group.

The least developed countries, most of which being in Sub-Saharan Africa, will face the biggest challenges in eradicating poverty in the next decades. In these countries, human poverty is deepening faster than in the other regions in the world. Yet, Sub-Saharan Africa has some examples of success in different dimensions of poverty. Thus, with sustained support, the progress could be accelerated.

World regions, countries and even provinces within countries have grown at very different rates. Understanding why countries and regions have had disparate growth experiences and how this growth reaches poor people is essential for poverty reduction strategies. Wide divergences in growth among countries can be attributed to many interdependent factors such as differences in human and physical capital, productivity and different initial conditions, institutions, policy

choices. Moreover, openness to international trade, sound monetary and fiscal policies (reflected in moderate deficits and the absence of inflation), and a well developed financial system are conducive to growth. In addition to the role of aid, domestic and external shocks matter as well. Furthermore, culture, natural resources, geography and climate play an important role in different growth performances. For example, a remote or landlocked location acts as a drag on growth, and yet, 8 of the OIC-LDLICs are landlocked countries. Thus, this section presents the developments in some economic indicators, including structure of output, trade and debt.

TABLE 1: STRUCTURE OF OUTPUT
(Value added as % of GDP, average 1995-99)

	Agriculture	Industry	Of which Manufacture	Services
OIC-LDC	30.3	22.0	11.6	50.0
OIC-LIC	30.7	32.9	16.1	36.4
OIC-LDLIC	30.5	27.4	13.9	43.2

Source: Table A.3 in the Annex.

The economic structure of almost all the OIC-LDLICs has hardly changed over the past two decades. Table 1 above displays the averages of the sectoral shares in GDP for the OIC-LDLICs. With the highest share in GDP (43.2 per cent), the services sector plays a major role and constitutes an important source of income in almost all the OIC-LDLICs. The share of services amounts to 50 per cent in the OIC-LDCs and 36.4 per cent in the OIC-LICs. In contrast, the low share of the manufacturing sector with 13.9 per cent indicates the weak performance of this sector in most of the OIC-LDLICs. Agriculture is widely believed to be the primary economic activity and is assumed to play the major role in the economies of most developing countries. While agriculture has the second highest share in the OIC-LDCs group with 30.3 per cent of GDP, industry has the second highest share in GDP for the OIC-LICs with 32.9 per cent.

In general, agriculture and oil production are the two main economic activities that contribute the highest shares to the output of more than half of the OIC countries. Indeed, according to the recent IMF classification of economies by main sources of export earnings (see Table A.2), 13 OIC-LDLICs are classified as non-oil primary commodities, 5 of them are service exporting countries and 2 of the

countries are classified as manufactures exporting countries. On the other hand, only 6 OIC-LDLICs have diversified their sources of export earnings. It is then clear that almost half of the OIC-LDLICs countries are primary commodity dependent economies. There is no doubt that the exports of these commodities play a critical role in the prospects of growth and development in these countries. However, the primary commodity exports with exogenously determined prices constitute an important source of macroeconomic instability in these countries since international prices of primary commodities tend to fluctuate sharply. Consequently, they have faced highly unstable terms of trade at various times over the past decades. Coupled with a relatively large share of exports and imports in domestic activity, such fluctuations constitute an important source of macroeconomic volatility. Therefore, many OIC countries, particularly the LDCs, need to diversify their economies to have sustained levels of economic performance and to decrease their vulnerability to external shocks.

Trade is vital for growth, poverty reduction and long-term external debt stability but over the past two decades, many of the products exported by the LDLICs have been most affected by limits on market access in developed countries. Furthermore, the trade performance of the OIC-LDLICs in terms of export growth was weaker than that of the all LDCs group in the 1990s (Table A.3).

With small economies and high population growth rates, the 22 OIC-LDCs have a very low share in the total OIC income, even less than the national income of some individual OIC member countries such as Indonesia, Turkey and Saudi Arabia. Although the OIC-LDC group (22 countries) constitutes 26.3 per cent of the total OIC population in 1999, they produce (19 of them) only about 7.1 per cent of the total OIC income. On the other hand, the 10 OIC-LICs make up 42 per cent of the OIC population and produce 20 per cent of the total OIC income (SESRTCIC, Annual Economic Report on the OIC Countries: 2001). While GNP per capita in the OIC-LDCs was $359 in 2000, it was $523 in other OIC-LICs. Moreover, Table A.3 indicates that the average per capita income in the OIC-LDLICs as a group amounted to $441 in 2000, which is higher than the $420 of all LDCs in 2000.

In the 1990s, the OIC-LDLICs managed in general to realise a good level of growth in their production. The growth levels of GDP and per

capita GNP in most of these countries were comparable to the levels of the world's LDLICs as a group, but the high population growth rates may undermine the fragile economies of these countries. In the last decade, the OIC-LDLICs, as a group, were not able to grow at the same rate as that of their average population growth. However, a typical economy must be able to grow at least by the same rate to maintain the same level of per capita income.

Table (2) presents the flows of aid and private capital. The most important financing of development comes from domestic resources and foreign direct investment, which are important sources of capital, employment and trade opportunities for the LDLICs. The negative sign in 1999 in the private flows indicates that the capital flowing out of the country exceeds that which is flowing in. On average, net foreign direct investment in the OIC-LDLICs decreased in the last decade. In addition, it was lower than the developing countries' and all LDCs' average in 1999. This outflow was largely experienced by Indonesia. Furthermore, Official Development Assistance (ODA) has a critical role to play in support of LDLICs development. In the last decade, ODA, as percentage of GDP, declined in the majority of the OIC-LDLICs. Moreover, this percentage is still lower than the rate recorded by the all LDCs group. In the 1990s, a similar pattern in the aid and capital flows was also observed in the all LDCs group.

TABLE 2: FLOWS OF AID AND PRIVATE CAPITAL

	Official Development Assistance (as % of GDP)		Net Foreign Direct Investment (as % of GDP)		Other Private Flows (as % of GDP)	
	1990	1999	1990	1999	1990	1999
OIC-LDLICs	3.9	2.5	0.9	-0.5	1.4	-3.1
DCs	1.4	0.6	0.9	2.9	0.4	0.4
All LDCs	11.6	7.0		3.0	0.5	-0.1
S-Sah.Africa			0.3	2.4	0.2	0.8

Source: Table 13 in the Annex.

Moreover, foreign debt continues to be one of the most troublesome problems facing the majority of the OIC-LDLICs. Among the 32 OIC-LDLICs, 18 are severely indebted and 9 are moderately indebted. Therefore, debt relief plays a central role both for human development and poverty eradication. Indeed, the benefits of debt relief could be channelled to support education, health care and other basic needs.

3. UNDERSTANDING POVERTY IN THE OIC-LDLICs

Poverty is hunger, lack of shelter, being sick and not being able to visit a doctor. Poverty is losing a child to illness brought about by unclean water; poverty is not being able to go to school and not knowing how to read--not having a job and fear for the future, being vulnerable to adverse events. Poverty has many faces. Hence, the definition of poverty will be different at different times and in different places. But it is a situation that people want to escape. As poverty has many dimensions, it has to be looked at through a variety of indicators--both in income and non-income measures of poverty. This broader approach to deprivation provides a better characterisation of poverty and increases our understanding of its causes. Moreover, the different aspects of poverty interact and reinforce one another in important ways. For example, improving health not only improves well being but also increases income earning potential; and increasing poor people's job opportunities and participation in health and education leads to a better targeting of health and education services to their needs. Thus, this deeper understanding will be critical to the design and implementation of several programs, and it naturally expands the set of relevant poverty reduction strategies.

Poverty never results from the lack of one thing but from many interlocking factors that cluster in poor people's experiences. Thus, one route for investigating the causes of poverty is to examine the dimensions of poverty highlighted by the poor people. Poor people rarely speak about income, but they speak extensively about assets that are important to them. Poor people manage a diverse set of assets, such as human assets--the capacity for basic labour, skills and good health, natural assets--land, and physical assets--access to infrastructure. Thus, effective policy formation requires a meaningful understanding of the assets available to the population and the circumstances under which these assets are mobilised.

Defining poverty as a multi-dimensional phenomenon raises the question of how to measure overall poverty and how to compare achievements in different dimensions. One dimension may move in a different direction than another. Human poverty may improve while income worsens or vice versa. An alternative way is to define as poor anybody who is poor in anyone of the dimensions without attempting to estimate trade-offs among the dimensions. The World Bank focuses on

deprivation in different dimensions and on the multiple deprivations experienced by the poor, while UNDP's human development and poverty indices are attempts to capture the multi-dimensional nature of poverty.

The United Nations Development Program (UNDP) has played the leading role in defining poverty in terms of human development and has introduced measures including the Human Poverty Index (HPI) and Human Development Index (HDI). The former index, HPI, concentrated on 3 aspects of human deprivation. A long and healthy life, which is measured by the probability at birth of not surviving to age 40. Knowledge, which is measured by the adult literacy rate. And a decent standard of living, which is measured by the percentage of children under five who are underweight. The latter index, HDI, is a summary measure of human development. It measures the average achievements in a country in 3 basic dimensions of human development. A long and healthy life, measured by life expectancy at birth. Knowledge, measured by the adult literacy rate and the combined primary, secondary and tertiary gross enrolment ratio. And a decent standard of living, measured by GDP per capita (PPP US$). Because of revisions in the data and methodology over time, the HDI values are not comparable across editions of the UNDP Human Development Report. In addition to this, because of a lack of reliable data, the 2001 edition of the Report provides HDI for a total of 162 countries.

Based on the above discussion, poverty must be addressed in all its dimensions, not income alone. According to the Human Poverty Index (HPI) of the UNDP's Human Development Report 2001 (see Table A.4. in the Annex), an average of 43.8 per cent of the people in 17 OIC-LDCs (121 million) suffer from human poverty. This percentage reached 30.8 per cent (152.1 million) of the total population of 5 OIC-LICs. Thus, an average of 35.4 per cent of the people in 22 OIC-LDLICs (273.5 million) suffer from human poverty. Moreover, the HPI value in 4 OIC-LDLICs is almost equal to or exceeds fifty percent, indicating that an average of at least half the people in these countries suffer from human poverty. In terms of the global HPI ranks, 8 OIC-LDLICs were ranked within the lowest 10 global ranks. Furthermore, 19 OIC-LDCs and 9 OIC-LICs have poverty plans, estimates and targets (see Table A.1 in the Annex).

Moreover, the figures in Table A.4 indicate that poverty is not confined to the OIC-LDLICs only. The impact of human poverty is also

being increasingly felt in many OIC Middle Income Countries (MIC) and even in some oil exporting countries (OEC). An average of 21 per cent (almost 70 million) of the total population of 13 OIC countries (8 of them are middle income countries and the other 5 are oil exporting countries) are also suffering from human poverty. In fact, 12 OIC-MICs and OIC-OECs have poverty plans, estimates and targets as it is presented in Table A.1. In total, an average of 31.1 per cent of the total population of the OIC countries (342.5 million) suffer from human poverty.

In this respect, Table A.5 provides elements of HPI in the OIC-LDLICs. One major indicator of human poverty is a short life. Dying before the age of 40 represents a severe deprivation. In developing countries, 14.3 percent of the people were not expected to survive to this age and in Sub-Saharan Africa nearly 35% of the people were expected to die before reaching the age of 40 in 1998. Probability at birth of not surviving to the age of 40 reached nearly fifty per cent for some OIC-LDCs. In the period 1995-2000, the majority of the OIC-LDLICs was associated with a higher probability of dying before the age of 40 than the developing countries' average. The figures also show that nearly half of the population in the OIC-LDLICs is still without access to basic social and human needs such as education, health care, and improved water resources. In 1999, in 11 of the 20 OIC-LDCs, for which the data is available, the percentage of population using adequate sanitation facilities was less than fifty per cent. In 1999, in 22 out of the 27 OIC-LDLICs for which the data is available, the percentage of population using improved water resources was over fifty percent. In addition to this, in the same period, 18 out of 30 OIC-LDLICs had populations with low access to essential drugs. The World Health Organisation (WHO) defined low access as 50-79%. Furthermore, the average adult literacy rate in the OIC-LDLICs reached 58 per cent, which was lower than the average of developing countries of 72.9 per cent, but greater than the all LDCs average of 51.6 per cent in 1999.

The figures in Table A.6 (Elements of HDI in OIC-LDLICs) reflect the weak performance of the human development Index (HDI) and poverty alleviation in terms of HDI in the majority of the OIC-LDLICs countries as compared with their income growth performance in terms of GDP per capita. The negative sign in the last column (adjusted HDI; i.e., GDP per capita rank minus HDI rank) indicates that the GDP per capita rank is better than the HDI rank. As a result, nearly half of the

30 OIC-LDLICs is associated with a negative sign, indicating that the HDI rank is worse than the GDP per capita (PPP$) rank. While the adjusted HDI is negative in most of the OIC-LDCs indicating the unusual growth performances in the 1990s, it is positive in many OIC-LICs showing the remarkable human development performance of these countries. Thus, poverty in the OIC-LDLICs is not just low growth performances, it is also low human development, and hence, low income-earning capacity.

Table A.6 in the Annex provides the Elements of HDI in the OIC-LDLICs and reports their global ranks according to the values of this index in a set of 162 countries. In developing countries life expectancy at birth was 64.5 years, which is approximately 15 years greater than it was in 1999 in Sub-Saharan Africa, 48.8 years. In only 7 out of the 30 OIC-LDLICs for which the data is available, life expectancy is above the developing countries' average. Adult literacy rates are very low in most of the OIC-LDCs. Moreover, 16 out of the 30 OIC-LDLICs' adult literacy rates are less than fifty per cent. In contrast, in some OIC-LICs adult literacy rates are higher than the average of 72.9 per cent in developing countries and even reach the world average of 78.8 per cent. As a result, it is clear that these countries have relatively better values and ranks of HDI than the other OIC-LDLICs. Furthermore, in terms of the global HDI ranks among 162 countries, 7 OIC-LDLICs were ranked within the lowest 10 global ranks. Also, the countries at the bottom of the HDI ranking also rank near the bottom in the HPI. In these countries, the overall progress in human development has been too low to raise the majority of their people from poverty.

Education indicators in Table A.7 reveal the poor performances of education services. In 17 out of the 24 OIC-LDLICs for which the data is available, public expenditure on education as percentage of GNP in 1995-97 is lower than the average of developing countries and the world average. Moreover, in 13 of these countries, this percentage is found to be lower or at most equal to that in 1990. This indicates that no significant improvements have occurred in the education services in the 1990s. This has been reflected in the primary and secondary enrolment ratios and in the high percentages of children not reaching grade 5 in most of these countries.

The figures in Table A.8 reflect a low level of health services in almost all the OIC-LDLICs, especially those in Sub-Saharan Africa.

Although, in some health indicators the OIC-LDLICs performed better than the average of the world LDCs group, most of these countries still suffer from diseases such as malaria, tuberculosis and HIV/AIDS. Poverty and health linkages will be discussed in section 5.

The examination of both HDI and HPI elements has revealed the weak performance of the OIC-LDLICs on various fronts. One dimension may move in a direction different from another. For example, in some OIC-LDCs, GDP per capita (PPP$) has been rising since 1990, but elements of HDI--life expectancy at birth, adult literacy rate and gross enrolment ratio-- are still below the all LDCs average. However, GDP per capita has declined in some OIC-LDCs between 1997 and 1999, but life expectancy at birth and gross enrolment ratio are above the all LDCs average. Moreover, in some OIC-LDCs, not only GDP per capita has been declining, but also all elements of HDI were below the average of all LDCs (see Table A.6). Thus, poverty exists in all dimensions in OIC-LDLICs.

4. TRENDS IN POVERTY IN THE OIC-LDLICs

The 20th century saw great progress in reducing poverty and improving well being. In the past three decades, life expectancy in the OIC-LDLICs increased by 12 years on average and the infant mortality rate fell by 40%, and in the past two decades, net primary enrolment in the OIC-LDLICs increased by 16%. The proportion of the developing world's population living in extreme economic poverty has declined from 28 per cent in 1987 to 23 percent in 1998 (see Table A.10 and Table A.9). Substantial improvements in social indicators have accompanied growth in average incomes. In general, the developing world today is healthier, wealthier, better fed, and better educated. However, progress in eradicating poverty has been far from even. Thus, the rest of this section describes global trends in the income, education and health dimensions of poverty and shows the large diversity of outcomes for OIC-LDLICs. The differences in performance reflect differences in growth, in the distribution of assets, in the quality and responsiveness of state institutions and vulnerability to the external shocks. Highlighting the diversity in outcomes is important because it allows the identification of successes and failures in poverty reduction, enhancing thereby the understanding of what causes poverty and how best to reduce it.

It is well accepted that to obtain a fuller picture of the nature and structure of poverty it is necessary to have information on a broad range of factors including both income and non-income measures. This section presents, first, trends in income poverty, and then, it provides poverty trends for social indicators.

4.1. Income Poverty

Those who viewed poverty as a lack of income or commodities turned their attention to the expansion of per capita income and economic growth as a potential strategy to reduce poverty. However, economic growth can be powerful in alleviating poverty if the resources generated by growth were intensively channelled into human development, especially into improving health and education. Having no economic growth is almost entirely bad for poor people. Without economic growth, it is almost impossible to reduce income poverty. Furthermore, other aspects of human poverty such as illiteracy or child mortality cannot be sustained without economic growth. For instance, income poverty runs deep in Sub-Saharan Africa and is a serious threat to economic and social stability.

The poverty estimates in Table A.9 are based on a poverty line that reflects what it means to be poor in the world's poorest countries. When measuring poverty at the global level, the World Bank uses reference lines set at $1 per day in 1993 Purchasing Power Parity (PPP). However, the most commonly used way to measure poverty at the country level is based on the GDP per capita scale. While these numbers provide a sense of broad trends, they should be treated with caution in light of the shortcomings of the data mentioned in Table A.9.

Extreme poverty, defined as living on less than $1 a day, declined only slowly in developing countries during the 1990s: the share of the population in the world living on less than $1 a day fell from 28 percent in 1987 to 23 percent in 1998 (see Table A.9). This decline is below the rate needed to meet the International Development Goal (IDG)[1] of reducing extreme income poverty by half by 2015. Furthermore, there are large regional variations in the performance of extreme poverty. East

[1] The goals come from the agreements and resolutions of the world conferences organised by the United Nations in the first half of the 1990s.

Asia and the Middle East share of population living on less than $1 a day decreased. But in all other regions this percentage has risen or has not changed much. In Europe and Central Asia the share of people in poverty increased. In Sub-Saharan Africa the share of population living on less than $1 a day slightly decreased from an already high percentage of 46.6 per cent to 46.3 per cent over the same period, leaving almost half of the continent poor. In 1998, South Asia and Sub-Saharan Africa accounted for around 80 percent of the population living on less than $1 a day, up 5 percentage points from 1987.

For the OIC countries for which the data is available extreme poverty presents different performances within the regions and groups. In 5 out of the 8 OIC-LICs, the share of people in extreme poverty declined or remained below the regional average in the last decade. However, in three of them, extreme poverty exceeded the corresponding regional average. In fact, 2 countries within this group were faced with rising extreme poverty. In the last decade, in half of the 12 OIC-LDCs for which the data is available, the share of people in extreme poverty was below the corresponding regional average. In fact, in some OIC-LDCs in Sub-Saharan Africa, more than half of the population is living on extreme poverty. In total, nearly half of the 28 OIC countries have suffered from extreme poverty at a rate higher than the corresponding regional average, during the last decade. In a further 8 countries out of the 11 OIC countries surveyed, the share of people in extreme poverty declined. As a result, income poverty fell slightly in some OIC countries, but the amount of decline is not enough to reach International Development Goals. Anyway, it raises the hopes for reducing poverty with a more complete country based poverty reduction strategies.

In general, progress in social indicators and rapid growth accompanied the decline in poverty. Moreover, poverty increased in countries that experienced stagnation or contraction. Therefore, the overall decline in extreme poverty during the 1990s was driven by high rates of growth. Nevertheless, the decline in poverty in rapidly growing countries was slowed by increases in inequality in a number of countries with a large number of poor (World Development Report 2000/01).

For economic well being, the proportion of people living in extreme poverty should be reduced by half (no later than 2015). Since income poverty is a function of growth, to reduce income poverty, incomes of

the poor must grow as an economy expands. Thus, the achievability of this goal depends on prospects for growth and for the distribution of income, and on the developments in basic social indicators.

4.2. Social Indicators

Some social indicators have generally been improving over the last decades. Data on malnutrition, life expectancy, infant and child mortality, adult literacy and enrolment rates in the developing world, including the OIC-LDLICs, indicate continued progress in the 1990s. However, living conditions have deteriorated substantially over the last decade for many Africans, particularly in Sub-Saharan Africa. AIDS is causing declines in life expectancy and increases in infant and child mortality rates in the countries hit by the epidemic. Sub-Saharan Africa also experienced declines in enrolment rates between 1980 and 1994.

Malnutrition is another dimension of poverty measured by the proportion of children under 5 who are underweight. Table 3 below indicates that the percentage of underweight children in the OIC-LDLICs decreased in the last decade. Although the average decline in underweight children was 14 per cent in the OIC-LDLICs, the decline in all LDCs was only 2 per cent. Hence, the OIC-LDLICs average was lower than the all LDCs average, 41 per cent, but higher than the average of developing countries, 27 per cent.

TABLE 3: TRENDS IN SOCIAL INDICATORS

	Underweight Children under age 5 (%)		Life Expectancy at birth (years)			Infant mortality rate (per 1000 live births)			Under 5 Mortality Rate (per 1000 live births)		
	1990	1995-2000	1970	1993	1999	1970	1990	1999	1970	1990	1999
OIC-LDLICs	41	35	45.6	56.5	57.5	128	100	77	211	157	118
DCs	35	27	54.5	61.5	64.5	109	74	61	167	112	89
All LDCs	40	41	43.4	51.0	51.7	149	115	100	243	189	159
S-Sah.Africa	31	30	44.1	50.9	48.8	138	106	107	226	175	172
World		24	59.1	63.0	66.7	96	67	56	147	101	80

Source: Table A.10 and Table A.6 in the Annex.

On average, the life expectancy of people living in the OIC-LDLICs increased 12 years; but it still lags behind that of developing countries as it is indicated in Table 3. Furthermore, 15 OIC-LDLICs have seen life expectancy decline since 1993, most of them were affected by the AIDS epidemic.

Data on infant and child mortality indicates progress between 1990 and 1999 in all OIC-LDLICs. These rates in the OIC-LDLICs are declining too slowly to attain the IDGs. In the case of infant and child mortality rates, the average of the OIC-LDLICs has been lower than the average of all LDCs during the last three decades. In addition to this, between 1970 and 1999, infant mortality differences between world and OIC-LDLICs declined in absolute terms (from 32 in 1970 to 20.7 in 1999). Moreover, infant and child mortality rates in the OIC-LDLICs are still higher than the average of developing countries and world average. Thus, children born into poor countries have a higher chance of dying before their 1st and 5th birthdays than children born into better-off countries.

Furthermore, the OIC-LDCs shared the same experiences with the all LDCs group in many social indicators. Although, the life expectancy, infant and child mortality rates in some OIC-LDCs have been lower than the averages of all LDCs over the last 30 years, the gap between the OIC-LDCs and the all LDCs group has been decreasing since 1970.

TABLE 4: TRENDS IN KNOWLEDGE INDICATORS

	Adult Literacy Rate (%)		Gross Primary Enrolment Rates (% of relevant age group)				Net Primary Enrolment Rates (% of relevant age group)		
	1990	1999	1970	1980	1990	1997	1980	1990	1997
OIC-LDLICs	50.0	58.0	56	92	75	93	69	76	80
DCs	64.0	72.9							
All LDCs	45.0	51.6		94		97	74		86
S-Sah.Africa	51.0	59.6	46	81	68	78		46	

Source: Table A.12 and Table A.5 in the Annex.

The incidence of adult literacy in the OIC-LDLICs has risen since 1990, but it was still less than the average of developing countries and the world average. In the last decade, adult literacy rates rose 16 per cent in the OIC-LDLICs, but the rise in adult literacy in the all LDCs group was limited to only 14 per cent. Moreover, gross primary school enrolment data, presented in Table 4, show an improvement over the last 30 years. In spite of the enormous progress in some countries, regional trends diverged markedly with Sub-Saharan countries experiencing a slight decline in enrolment rates between the early 1980s and the mid-1990s, that is, 81% to 68%. The same is valid for the OIC-LDLICs; gross primary enrolment rates fell from 92% to 75% over the same period. Between 1980 and 1997, net enrolment rates have improved

almost in all the OIC-LDLICs. However, net enrolment rates are still lower than the rate recorded by the other low-income countries.

On current trends, none of the International Development Goals on social and knowledge indicators are likely to be achieved: two thirds decline in infant and child mortality rate, universal primary education (all by 2015). Thus, for social well being, reaching these targets will not be easy. But sufficient and necessary improvements in health programs, and income growth could make infant mortality and education targets achievable. Further, it is important to note that those efforts to improve health and education services have to concentrate on the most needy, namely the poor.

In addition to the various aspects of human development associated with social indicators, there are important linkages between human development and income earning capacity since income is a major determinant and outcome of human development. The specific way in which the poor participate in growth tends to be through increased or more productive use of their most abundant asset, labour. But the intrinsic characteristics of poverty--lack of education, poor nutrition and health--affect adversely their capacity to work. For example, a well-nourished and well-educated and healthy person can produce more, thereby earning more, ensuring future nourishment and work capacity. Further, in some OIC-LDLICs human poverty and extreme poverty accompanied each other. Without basic building blocks, such as education and health, the poor are unable to take advantage of income-earning opportunities that come with growth, therefore, the provision of basic social services, besides being important in its own right, constitutes an important element in the growth of a society.

Attaining the International Development Goals will require actions to spur economic growth since economic growth is the most powerful weapon in the fight against poverty--both for economic and social well being. Moreover, faster growth requires policies that encourage macroeconomic stability, shifting resources to the more efficient sectors and integrating with the global economy to share the benefits of technological progress. To achieve the goals for health and education, reducing infant and child mortality rates by two-thirds depends on halting the spread of HIV/AIDS, and increasing the capacity of developing countries' health systems to deliver more health services.

Although social indicators should benefit from improvements in economic growth, there should be targeted policy interventions that appear to have a large impact on health and educational outcomes. Second, international agencies must work with developing countries to strengthen country capacity to monitor progress on outcomes. Third, measuring the progress to action is crucial in the fight for higher living standards. Further, special attention must be given to the social structures and institutions that affect development. Therefore, we need a broader and more comprehensive strategy to fight poverty.

5. HEALTH AND POVERTY

Health, along with education, is seen as one of the fundamental goals of development. Indeed, health is seen as a dimension of poverty alleviation in its own right. This is reflected in the fact that four of the seven international development goals are related with health. Hence, this section is devoted to health and poverty linkages. Moreover, the concept of health is a broad one--a life cycle. It embraces health status, nutritional status, morbidity, disability, and mortality.

Health and sustainable development are closely connected. Safe water supply and sanitation, proper nutrition and a safe food supply, the control of disease, and access to health services all contribute to healthy populations. Conversely, poverty, lack of education and information, natural and human-induced disasters can all exacerbate health problems. As a consequence, poor health is associated with decreased productivity, particularly in the labour intensive agricultural sector, which is the sector that has the greatest share in GDP in many OIC-LDLICs.

Poverty is both a consequence and a cause of ill health. Malnutrition and ill health are often reasons why households end up in poverty or why they are already poor. In short, poor people are caught in a vicious circle, their poverty breeds ill health; this, in turn, conspires to keep them poor.

The cycle of health and poverty could be constituted by three items:

- **Characteristics of the poor**-- inadequate service utilisation, unhealthy sanitary, dietary practices, etc. which are caused by lack of income and knowledge; weak institutions and infrastructure, bad environment; poor health provision, that is, inaccessible, irrelevant services, low quality and inadequate stock of basic medicines and

poorly trained staff; exclusion from the health finance system, that is, limited insurance;

- **lead to poor health outcomes** such as ill health, malnutrition and finally
- **They end up with diminished income** such as loss of wages, costs of health care and greater vulnerability to catastrophic illness; hence, they again turn to the characteristics of poverty.

5.1. Malnutrition

The core indicators for health are presented in Table A.8 for the OIC-LDLICs. The first sign of ill health is reflected in the characteristics of the poor such as malnutrition. Between 1996 and 1998, as expected, the percentage of the under-nourished population in almost all the OIC-LDCLICs was lower than that in the other LDCs. One of the indicators of malnutrition is the percentage of children under 5 who are under-weight. This percentage has showed a quite good progress during the last decade. In addition to this, in more than half of the OIC-LDLICs the proportion of underweight children was lower than the all LDCs average in the last five years. The tragedy of malnutrition may be reduced by mothers' education and adequate health care.

5.2. Health services

Deprivation in health starts with lack of access to health care and other services. Of the 28 OIC-LDLICs for which data is available (see Table A.8), 20 had their average public expenditure on health as percentage of GDP lower than the average of developing countries in 1996-98. Moreover, public expenditure on health showed no remarkable progress in the last decade. In fact, health expenditures, as % of GDP, have, on average, declined in some OIC-LICs. Consequently, most of them suffer from insufficient levels of health service provision.

Moreover, safe water and sanitation are recognised as the principal tools to tackle communicable diseases such as malaria, cholera and HIV/AIDS. Lack of clean water and sanitation is the main reason for transmission of dangerous diseases. Although access to improved water sources and sanitation facilities have slightly increased since 1990, in 2000 about half of the population of the low income countries still lacked adequate sanitation. Almost all OIC-LDLICs have shown improvements in access to water sources and sanitation facilities in the

last decade, but in the majority of OIC-LDLICs the percentage of population having access to improved water sources is still below other low income countries.

Health services, in the case of births attended by a medically trained person, improved slightly during the last decade. Of the 14 OIC-LDLICs, for which the data is available, 8 experienced a rise in the births attended by skilled health staff. Furthermore, the OIC-LDCs lag behind the improvements in the health services: Births attended by skilled health staff declined in some OIC-LDCs in the 1990s. In five out of the 11 OIC-LDCs, for which the data is available, the number of births attended by skilled health staff declined. In addition, the OIC-LDCs did not experience recognisable improvements in their access to improved water sources and improved sanitation facilities.

5.3. Illness: the problems of AIDS and Malaria

Illness creates a devastating and lasting drain on household resources since it removes individuals from the labour pool and then can push a household into poverty; thus, the illness of one person within the family can affect the economic stability of the entire household.

AIDS is a disease of poverty in the sense that most people with AIDS are poor. It deepens and spreads poverty. And AIDS affects poor households more adversely--especially if the breadwinner is affected by illness because it is very hard to cope with medical expenses and the loss of income and services that an adult breadwinner typically provides. Furthermore, the rapid rise in adult deaths is leaving an unprecedented number of orphans. Hence, AIDS is also likely to increase poverty through the rise in the number of children who lose one or both parents. Evidence shows that orphans have significantly lower enrolment rates and are more likely to be malnourished than non-orphans are. Lack of schooling and inadequate nutrition will make it more difficult for orphans to escape poverty.

Furthermore, AIDS is the greatest challenge for OIC-LDLICs. Between 1995 and 1997, AIDS cases rose five times in Sub-Saharan Africa and in all LDCs. In 1997, in 8 out of the 26 OIC-LDLICs, AIDS cases were higher than the average of all LDCs. Unfortunately, infection rates are rising in most of the OIC-LDLICs. As a result, the disease

struck very hard in poor countries. In addition to this, more women and children are the victims of AIDS in some of the OIC-LDLICs. In 1999, the number of children under 14 living with AIDS in Sub-Saharan Africa reached approximately a million (see Table A.8).

Although they are curable, Malaria and Tuberculosis still affect some OIC-LDLICs. In 7 out of 10 OIC-LDLICs, Malaria cases decreased from their 1995 level. Moreover, in 15 out of the 30 OIC-LDLICs tuberculosis cases are lower than the world average, indicating a hope for the fight against the illness.

5.4. Infant, child and maternal mortality

The death rate is the best instrument for measuring the variations in the physical well being of people. Mortality could be used as an indicator both of income poverty and of ill being in a broader sense. Infant mortality rates are found to be very high (higher than the world average and the average of developing countries) in many OIC-LDLICs for which the data is available. In some countries, these rates have significantly lagged behind those realised in the all LDCs group. Also, more than half of the OIC-LDLICs experienced child mortality rates higher than those realised in the world. Infant and child mortality rates are also greater in the countries that are affected by the AIDS epidemic.

Most OIC-LDLICs have seen their infant and child mortality rates decline sharply as did those in the developing countries, which is discussed in the previous section. But some OIC-LDLICs have lost ground over the 1990s. Moreover, OIC-LDLICs achieved progress in life expectancy, but improvements in this indicator as in the case of infant and child mortality rates melted down by rising HIV/AIDS infections.

Since the World Summit, some progress has been made in improving human health. Most countries have experienced declining infant mortality rates and an increase in life expectancy. Nevertheless, progress has been slow and inadequate to meet many of the goals established by the international community.

Consequently, data on health indicators revealed the poverty-health puzzle in the OIC-LDLICs. Deprivation in health starts with lack of access to health care and other services and is fuelled by under-

nourishment, then lack of knowledge and income accompany this circle. Although, the health indicators have slightly advanced in the past decades, the OIC-LDLICs still cope with nutrition and illness problems rooted in lack of knowledge and of adequate health services. Hence, the_most abundant asset of the poor--labour--is disturbed by ill health and the consequent loss of income will be greater, especially if he is the breadwinner. Moreover, large households with many children or other economically dependent members create an additional puzzle for the poor. Whenever one of their members is faced with a health problem, they find themselves unable to decide whether to spend the limited income to cure the ill member or to meet the basic needs of the other members.

As a result, development cannot be achieved or sustained when poor health and inadequate access to health care facilities affect a large proportion of the population. Economic growth and development can contribute to improved health and better health care facilities in the poorest countries. Unsustainable economic growth can also cause environmental degradation, which, together with inappropriate consumption, can adversely influence human health. To protect and promote human health, to break the poverty and health cycle, we have to focus on meeting primary health care needs both in rural and urban areas, protecting vulnerable groups, children, women and the aged, controlling communicable diseases; and reducing health risks from environmental pollution and hazards.

Furthermore, economic growth is the strongest tool to fight against ill health, but growth by itself does not necessarily translate into improvements in health status; nor does improved health necessarily lead to a rise in income. Thus, we need to use the fruits of economic growth effectively and we need complementary investments to reap more benefits for the poor. For example, if policies and programs to improve health and expand education are combined with government action designed to promote investment and broad-based growth, the benefits to the poor will be that much greater.

6. CONCLUSION AND POLICY RECOMMENDATIONS

Poverty in the OIC-LDLICs is a complex multi-dimensional problem in spite of their vast resource endowments. Poverty includes lack of income and basic social needs; hunger and malnutrition; ill health,

limited or lack of access to education; increased morbidity and mortality from illness; homelessness and inadequate housing; unsafe environments. It is also characterised by lack of participation in decision-making and in social and cultural life. People living in poverty are particularly vulnerable to the consequences of disasters and conflicts. Thus, the source of poverty in the OIC-LDLICs is not just lack of income; it is also low human development, which, in turn, decreases their income earning capacity. Malnutrition, illness, and lack of knowledge destroy income-earning capacity. On the other hand, with a limited income, the OIC-LDLICs have low access to basic needs, such as education and health services. Understanding poverty with all of its dimensions is essential for designing and implementing programs and projects that help people alleviate poverty. A framework for action is needed to effectively reduce poverty in all its dimensions. National economic development is central to success in poverty reduction.

Despite the great progress achieved in the 20th century in reducing poverty and improving well being, poverty remains a global problem of huge proportions in the light of both income and human poverty indicators. Life expectancy, literacy and primary education and access to basic health care services have increased in the majority of the OIC-LDLICs and average mortality has been reduced. However, all these gains from increased life expectancy and reduced mortality are overshadowed by the rising incidence of HIV/AIDS in some countries in Sub-Saharan Africa. In addition to the low human development in the OIC-LDLICs, the poverty puzzle may be understood on various fronts: the OIC-LDLICs are weighed down by external debt, starved of private capital and technology, blocked from access to rich-country markets and faced with declining ODA.

Furthermore, there is no simple, universal blueprint for implementing poverty reduction strategies. Thus, the approach for reducing poverty has evolved over the past 50 years parallel to additional understanding of poverty within the complexity of the development. However, poverty with all its dimensions is full of vicious circles so it is hard to bring out the causes and consequences of poverty. Furthermore, gathering the data and information for a poverty reduction strategy is very hard and costly, but for the poor lasting benefits will outweigh the immediate costs.

What we learned from previous experiences is crucial to the development of poverty reduction strategies. Unfortunately,

experiences in the 1990s show that market reforms may fail to deliver growth and poverty reduction in the absence of necessary domestic institutions. Furthermore, there is evidence that technological progress in the past decade was increasingly biased toward skill in contrast to what was expected in the pattern of developing growth, unskilled labour intensive growth. Secondly, although public investment in health and education has been rising, it has been less effective than expected, in part because of serious problems in quality and in responsiveness to poor people's needs. Poverty work must underline the importance of the vulnerability to economic, health and personal shocks--for example, the financial crisis of the 1990s and the sequence of devastating natural disasters. Private capital flows now dominate the official flows in the world. Although long-term direct investment leads to a faster transfer of knowledge, short-term capital flows may particularly raise the volatility.

Eradication of poverty and improving the lives of poor people in low-income countries and strengthening poor people's abilities to build a better future for themselves is the common objective of the world. Since the lives of the poor are ringed with a tangle of vicious circles, different elements of human development are essential determinants to each other; countries may wonder where to begin and how to find the best way to reduce poverty. In this respect, a wide range of policy recommendations can be proposed for a multi-dimensional vision of poverty alleviation strategies as follows:

(1) Sustained economic growth and development should be based on national and people-centred poverty reduction strategies:

- A people-centred strategy should start by building the assets of the poor that make them less vulnerable. In addition to this, action is needed to reduce vulnerability to economic shocks, natural disasters, health and violence.

- Poverty programs need to be multi-sectoral and comprehensive since poverty is a multi-dimensional problem.

- Poverty reduction programs must set "time-bound goals and targets" for the eradication of poverty. Hence, it must be result-oriented and focused on outcomes that would benefit the poor.

- Poverty programs must be country driven; thus, the primary responsibility for developing the LDLICs rests with the LDLICs themselves. But also actions by the international community and development cooperation will continue to be essential.

(2) Accelerating economic growth with macroeconomic stability is the strongest weapon in the fight against poverty. Sustainable poverty reduction and growth must start with and build upon effective institutions. Moreover, rapid growth will depend on building a strong human resources base, which requires strengthening the support for education and health and, hence, access to basic social services.

(3) Economic growth contributes most to poverty reduction when it expands the employment, productivity and the wages of the poor people. For instance, it creates an environment for small-scale agriculture, micro-enterprises and the informal sector since these are the sectors on which most poor people depend for their livelihoods. Moreover, these sectors also contribute to growth by generating income and employment at low costs with fewer imported inputs and low management requirements.

(4) In order to benefit from the world economic activity and not to leave behind the advances in technology and in scientific and medical research, at least the fruits of these developments must be shared with the poor. To take full advantage of the opportunities presented by globalisation, the markets of rich countries must be opened to the products of poor countries and aid and debt relief must be increased to help poor people.

- To benefit from globalisation stronger regional cooperation and integration are indispensable to increase the competitiveness of the LDLICs economies.

- Effective, development-oriented, and durable solutions to external debt problems are urgently needed to reduce the current burden of debt since external debt affects most OIC- LDLICs and remains a main obstacle to their development.

- The Official Development Assistance (ODA) has a critical role to play in support of LDLICs development in order to reverse the declining trends of ODA and improve aid effectiveness.

(5) In order to mobilise both domestic and foreign financial resources, we need an enabling environment for savings and investment, which includes strong and reliable financial, legal and administrative institutions, sound macro-economic policies and the transparent and effective management of public resources.

(6) There must be a special focus to improve national public expenditure management systems so that domestic resources, external assistance and budgetary savings from debt relief must be effectively used for poverty-related purposes.

(7) Harmonisation of operational policies and procedures is needed to increase efficiency and to move more rapidly in enhancing development effectiveness, and to reduce burdens and costs on related groups.

(8) A people-centred process is also crucial in provision of good health. Governments, as financiers and providers of health services, have a key role to play, but the question is more than pumping money into health services. Services need to be accessible, affordable and relevant to poor people. Broadly speaking:

- The role of country's budget is crucial where the major concern is the amount of resources allocated to health; and possible reallocations of budgets to reach poor people better and the next focus will be on service delivery, that is, how to implement specific activities to reach poor people.

- To improve the health of poor people and reduce the impoverishing effects of ill health, non-income disadvantages faced by poor people should be reduced. For example, avoiding the large out-of-pocket payments of the poor when they fall ill, and providing an income support to households where the breadwinner is ill or unable to work.

- We have to inform the poor where they can obtain essential services and drugs and at what cost and how to prevent communicable diseases at household level since lack of knowledge leaves the poor unaware of opportunities.

(9) The rapid growth of the AIDS epidemic represents a great threat to the world especially to Sub-Saharan Africa and we need a strong measure to

combat HIV/AIDS epidemic and other communicable disease, particularly, tuberculosis and malaria. Parallel to this, action is needed to raise the access to safe water, sanitation and essential drugs and improvement in the health services is crucial to fight against communicable diseases. The prevention, treatment and control of these diseases must be given the highest priority since in many cases their incidence hinders social development and often causes poverty and social exclusion.

(10) The international community, the United Nations, the multilateral financial institutions, all regional organisations and local authorities, and all actors of civil society need to positively contribute their own share and resources in order to win the fight against poverty.

(11) The widespread poverty in the OIC-LDLICs is inconsistent with the aim of the OIC action since the ultimate goal of this cooperation is to improve the well being of the people in member countries. Hence, special efforts must be made to evolve poverty reduction strategies for the OIC-LDLICs. Further measures should be taken by the OIC member states for the implementation and realisation of poverty reduction strategies by creating an environment conducive to the provision of social development services and expanding OIC co-operation in the education and health sectors.

Poverty is a multi-dimensional concept without boundaries; yet, it is expanding on various fronts composed of many vicious cycles. Ill health reduces living standards and leads to poverty, but poverty is also a cause of ill health. Actually, ill health stems from the low income and inadequate knowledge of the poor. To break the cycle of poverty, we have to create a more powerful cycle aimed at poverty reduction. Thus, all the recommended actions are interrelated and mutually reinforcing each other. Consequently, to achieve sustainable development, we need effective allocation of resources; investment in health, education and social infrastructure; and strengthening of productive capacities and institution building. These are all essential to realise the vast and untapped human and economic potential in the OIC-LDLICs.

REFERENCES

Chen S. and M. Ravallion (2000), “How Did the World’s Poorest Fare in the 1990s?” Policy Research Working Paper, World Bank, Washington, D.C.

Claeson M., Griffin C., Johnston T., McLachlan M., Soucat A., Wagstaff A. and Yazbeck A. (2001), "Health, Nutrition and Population", World Development Report Background Papers, World Bank, Washington, D.C.

IMF (2000), World Economic Outlook, May 2000, IMF, Washington, D.C.

SESRTCIC (2001), Annual Economic Report on the OIC Countries: 2001, Ankara Centre, October 2001.

UN (2001), Third United Nations Conference on the Least Developed Countries, Brussels, Belgium, 14-20 May 2001.

UNDP (1997), Human Development Report 1997, Oxford University Press, New York, 1997.

UNDP (2000), Poverty Report 2000, Oxford University Press, New York, 2000.

UNDP (2001), Human Development Report 2001, Oxford University Press, New York, 2001.

Word Bank (2001), Global Development Finance 2001, The World Bank, Washington, D.C., 2000.

World Bank (2001), World Development Report 2000/01 "Attacking Poverty", The World Bank, Washington, D.C., 2000.
http://www.worldbank.org/poverty

World Bank and IMF (2000), The 2nd Africa Forum on Poverty Reduction Strategies, Dakar, Senegal, 10-13 September 2001.

Table A.1. National Poverty Plans, Estimates and Targets in OIC Countries

	Approach to national Anti-poverty Planning	Estimate of Extreme or Overall Poverty(%)	Target for Extreme or Overall poverty rate (%)
Arab States			
Algeria	Poverty in national planning	Extreme: 6 1995 Overall: 14 1995	
Bahrain	Poverty in national planning		
Djibouti		Extreme: 10 1996 Overall: 45 1996	
Egypt	Explicit poverty plan	Extreme: 7 1996 Overall: 23 1996	
Jordan	Explicit poverty plan	Extreme: 7 1993 Overall: 21 1993	
Lebanon	Poverty in national planning	Overall: 35 1996	
Morocco	Explicit poverty plan	Extreme: 7 1991 Overall: 13 1991	
Sudan	Poverty in national planning	Overall: 85 1992	
Tunisia	Poverty in national planning	Extreme: 6 1997	Extreme: 0 2002
Yemen	Explicit poverty plan	Extreme: 16 1998 Overall: 30 1998	
Asia and the Pacific			
Bangladesh	Poverty in national planning	Extreme: 36 1996 Overall: 53 1996	Extreme: 0 2002
Indonesia	Poverty in national planning	Overall: 18 1999	
Iran, Islamic Rep. Of	Poverty in national planning	Extreme: 6 1998 Overall: 15 1998	
Malaysia	Explicit poverty plan	Extreme: 1 1997 Overall: 7 1997	Extreme: 0 2020 Overall 0 2020
Maldives	Poverty in national planning	Overall: 13 1998	
Pakistan	Poverty in national planning	Extreme: 27 1998 Overall: 46 1998	Extreme: 13 2010 Overall: 15 2010
Europe and the CIS			
Albania	Poverty in national planning	Extreme: 10 1997	
Azerbaijan	Poverty in national planning	Extreme: 20 1996 Overall: 60 1996	
Kazakhstan	Extreme poverty plan	Extreme: 35 1996	
Kyrgyz Republic		Overall: 51 1996	Overall: 10 2015
Tajikistan	Poverty in national planning	Extreme: 37 1998 Overall: 47 1998	
Turkey	Poverty in national planning		
Uzbekistan	Poverty in national planning		
Latin America and the Caribbean			
Guyana	Poverty in national planning	Extreme: 29 1993 Overall: 43 1993	
Suriname		Extreme: 20 1997 Overall 48 1997	

Sub-Saharan Africa					
Benin	Poverty in national planning	Overall: 34	1996		
Burkina Faso	Poverty in national planning	Extreme: 30 Overall: 45	1994 1994		
Cameroon	Extreme poverty plan	Overall: 50	1997	Overall: 15	2010
Chad	Poverty in national planning	Overall: 54	1996		
Comoros	Extreme poverty plan	Extreme: 30 Overall: 51	1995 1995		
Côte d'Ivoire	Extreme poverty plan	Extreme: 10 Overall: 34	1998 1998	Extreme: 5 Overall: 25	2002 2002
Gambia	Extreme poverty plan	Extreme: 37 Overall: 55	1998 1999	Overall: 30	2025
Guinea	Extreme poverty plan	Extreme: 13 Overall: 40	1995 1995		
Guinea-Bissau	Extreme poverty plan	Overall: 49	1997		
Mali	Extreme poverty plan	Overall: 68	1998	Overall: 60	2002
Mauritania	Extreme poverty plan	Extreme: 33 Overall: 51	1996 1996	Overall: 42	2001
Mozambique	Extreme poverty plan	Extreme: 53 Overall 69	1997 1997	Extreme: 26 Overall: 48	2004 2004
Niger	Extreme poverty plan	Extreme: 34 Overall: 63	1993 1993		
Nigeria	Extreme poverty plan	Extreme: 29 Overall: 66	1996 1996	Overall: 20	2010
Senegal	Extreme poverty plan				
Togo	Extreme poverty plan	Extreme: 57 Overall: 72	1995 1995		
Uganda	Extreme poverty plan	Overall: 46	1996	Overall:<10	2017

Source: UNDP Poverty Report 2000.
Note: The status of poverty plans, estimates and targets is as of December 1999. Extreme (Absolute) poverty means that a person cannot buy enough food to meet basic nutritional needs. Overall (Relative) poverty means that a person cannot buy enough food and non-food items to satisfy essential needs, as for nutrition, clothing, energy and housing.

Table A.2. OIC Least Developed and Low Income Countries (OIC-LDLICs)

Africa		Asia	
OIC Least Developed Countries (OIC-LDCs)			
Comoros (9) (1) (5)	Benin (3) (1)	Afghanistan (4) (1) (8)	Maldives (9) (5)
Mozambique (2) (5)	Burkina Faso (3) (8) (2)	Bangladesh (6) (2)	Yemen (4) (2)
Somalia (3) (1)	Chad (3) (8) (2)		
Sudan (3) (1)	Gambia (3) (2)		
Uganda (8) (1) (5)	Guinea (3) (1)		
Djibouti (5)	Guinea-Bissau (3) (1)		
Senegal (2) (4)	Mali (3) (8) (1)		
Togo (3) (2)	Mauritania (3) (1)		
Sierra Leone (1) (4)	Niger (3) (8) (1)		
OIC Low-Income Countries (OIC-LICs)*			
Cameroon (1) (4)		Azerbaijan	Pakistan (6) (1)
Côte d'Ivoire (1) (3)		Kyrgyz Republic (1)(8)	Indonesia (4) (1)
Nigeria (7) (1)		Tajikistan (8)	Uzbekistan
		Turkmenistan (2)	

Sources: World Bank, Global Development and Finance 2001, Vol.1, pp.150-53. IMF, World Economic Outlook, May 2000, p.194.

Notes:

(*) Include also all the above OIC-LDCs, except Djibouti and Maldives, which are classified as Lower Middle income countries.

(1) Severely indebted (18 countries).

(2) Moderately indebted (9 countries).

(3) Non-oil primary products exporting countries (13 countries).

(4) Diversified source of exporting earnings (6 countries).

(5) Services exporting countries (5 countries).

(6) Manufactures exporting countries (2 countries).

(7) Oil exporting country (1 country).

(8) Land-locked countries (8 countries).

(9) Island Countries (2 countries).

Table A.3. Economic Indicators

	Size of the economy					Economic growth		Structure of the Economy			
	Population		GNP per capita		GDP	Exports	GDI (1)	(Value added as % of GDP, average 1995-99)			
	2000 (m)	1990-00 (%)	2000($)	1998-99 (%)	(1990-00) (%)	(1990-99) (%)	(1990-99) (%)	Agriculture	Industry	Of which Manufacture	Services
Afghanistan	22.68	4.1									
Bangladesh	129.44	1.6	380	3.3	4.8	13.2	7	26.0	22.5	13.5	52.0
Benin	6.30	2.8	380	2.2	4.7	1.9	5.3	36.0	13.0	7.5	50.5
Burkina Faso	12.29	2.4	230	2.7	4.1	0.4	4.8	33.0	27.0	21.0	40.0
Chad	7.47	2.9	200	-4.1	2.2	5	4.4	41.0	18.0	13.5	41.5
Comoros	0.57	2.6	380	-3.8	0,8 (*)	-21,4(+)	-5,9(*)	39.0	14.0	4.0	47.0
Djibouti	0.67	2.4	840	1.3		5,9(+)		3.0	20.0	4.0	77.0
Gambia	1.31	3.3	330	2.2	2.8(**)	-7.8(+)	3(*)	27.4	14.8	7.0	58.8
Guinea	9.14	2.5	450	0.9	4.3	4.7	2.4	23.5	25.0	9.0	51.5
Guinea-Bissau	1.20	2.2	180	2.8	0,3(**)	1,4(+)	-6,6(*)	52.5	15.4	6.3	32.4
Maldives	0.29	2.6	1460	3.3	6,7(*)			22.0	16.0	6.0	61.6
Mali	11.14	2.5	240	2.7	3.8	9.6	-0.8	46.5	17.0	5.0	37.0
Mauritania	3.02	2.8	370	2	4.2	1.6	6.8	26.0	29.5	11.5	44.5
Mozambique	17.69	2.2	210	6.6	6.4	13.4	13.1	32.5	18.0	13.0	49.5
Niger	10.84	3.4	180	-1.1	2.6	1.7	5.4	39.5	17.5	6.0	43.5
Senegal	9.66	2.6	500	2.3	3.6	2.6	3.1				
Sierra Leone	4.80	2.5	130	-9.8	-4.5	-12.2	-10.3	43.0	25.5	5.0	31.5
Somalia	9.67	2.2					2,6(*)				
Sudan	27.78	2.1	320	3.6	8,2(**)			39.0	18.0	9.0	43.0
Togo	4.80	2.8	300	-0.3	2.6	1.5	11.6	40.5	21.0	9.0	38.5
Uganda	21.84	3.0	310	4.8	7.1	16.3	9.9	47.0	16.0	7.5	37.0
Yemen	21.18	3.9	380	-3.9	3.5	10.2	7.7	19.5	38.0	12.5	42.5
OIC-LDCs	**333.78**		**359**					**30.3**	**22.0**	**11.6**	**50.0**
Azerbaijan	7.83	1.2	610	6	-5.3	12.6	14.7	23.0	37.5	6.0	39.5
Cameroon	15.33	2.7	570	2.2	1.7	2.7	0	41.5	21.5	10.5	37.0
Côte d'Ivoire	16.97	3.0	660	1.1	3.5	4.7	17.6	24.0	24.0	20.0	52.0
Indonesia	212.11	2.7	570	0.3	4.2	9.2	5.1	18.5	43.5	24.5	38.0
Kyrgyz Republic	4.90	1.2	270	1.7	-4.1	6.7	12.6	44.0	23.0	19.0	33.5
Nigeria	128.06	2.8	260	0.5	2.4	2.5	5.8	34.5	56.0	5.0	9.0
Pakistan	138.18	2.5	470	1.2	3.7	2.7	2.1	26.0	24.5	17.0	49.5
Tajikistan	6.29	1.8	170	2	-1.7			33.0	35.0		32.0
Turkmenistan	4.01	2.8	840	13.5	-4.8			32.0	31.0	27.0	37.0
Uzbekistan	24.14	1.8	610	1.5	-0.5			32	30.5	15.5	38
Other OIC-LICs	**533.68**		**523**					**30.7**	**32.9**	**16.1**	**36.4**
OIC-LDLICs	**867.46**	**2.5**	**441**					**30.5**	**27.4**	**13.9**	**43.2**
All LDCs	**2459.00**	**2.0**	**420**	**2.5**	**3.4**	**5.3**	**-1.4**				

Source: World Development Report 2001 and 2002, (*) 1990-1998; (**) 1990-99; (+) 1997-98.

(1) GDI: Gross Domestic Investment.

Table A.4. Human Poverty in OIC Countries

	HPI 1999 (1)		Population (1999, million)	
	Rank (2)	Value	Total	Suffering from human poverty
OIC-LDCs				
Maldives	25	15.8	0.28	0.04
Comoros	47	29.9	0.55	0.16
Djibouti	57	34.7	0.67	0.23
Sudan	58	34.8	27.35	9.52
Togo	63	38.3	4.66	1.78
Uganda	69	41	22.19	9.10
Yemen	70	42.5	20.45	8.69
Bangladesh	73	43.3	134.49	58.23
Benin	79	45.8	6.12	2.80
Senegal	80	45.9	9.48	4.35
Mauritania	82	47.2	2.85	1.35
Mali	83	47.8	10.88	5.20
Mozambique	84	48.3	17.28	8.35
Gambia	85	49.6	1.27	0.63
Guinea-Bissau	86	49.6	1.17	0.58
Chad	87	53.1	6.98	3.71
Niger	90	63.6	10.51	6.68
Total OIC-LDCs			**277.18**	**121.41**
As % of total OIC-LDCs				**43.80**
OIC-LICs				
Indonesia	38	21.3	208.28	44.36
Cameroon	49	31.1	14.91	4.64
Nigeria	59	36.1	124.66	45.00
Pakistan	65	39.2	132.17	51.81
Côte d'Ivoire	72	42.9	14.7	6.31
Total OIC-LICs			**494.72**	**152.12**
As % of total OIC-LICs				**30.75**
Total OIC-LDLICs			**771.9**	**273.53**
As % of total OIC-LDLICs				**35.44**
Other-OICs				
Jordan	7	8.5	5.14	0.44
Lebanon	11	10.2	3.36	0.34
Malaysia	13	10.9	21.67	2.36
Guyana	15	11.4	0.78	0.09
Turkey	19	12.9	66.11	8.53
Libya	27	16.7	6.97	1.16
Saudi Arabia	29	17	21.1	3.59
Iran	30	17.3	65.28	11.29
Syria	34	19.8	15.79	3.13
Algeria	40	23.5	27.08	6.36
Egypt	50	31.7	64.07	20.31
Oman	52	32.2	2.57	0.83
Morocco	62	36.4	28.86	10.51
Total other OIC			**328.78**	**68.94**
As % of total other OIC				**20.97**
Total OIC countries			**1100.68**	**342.47**
As % of total OIC countries				**31.11**

Source: UNDP, Human Development Report 2001.

Notes: (1) The HPI is a composite index that attempts to bring together the different dimensions of deprivation in three essential elements of human life which are already reflected in the HDI-- longevity, knowledge and a decent living standard. (2) HPI 1999 ranks have been calculated for the universe of 90 developing countries.

Table A.5. Elements of Human Poverty Index in OIC-LDLICs

	Probability at birth of not surviving to age 40 (%)	Adult literacy rate (%)		Population with access to:			Underweight children under age 5 (%)	
				Adequate sanitation facilities (%)	Improved water resources (%)	Essential drugs** (%)		
	(1995-2000)	1990	1999	1999	1999	1999	1990	1995-2000
OIC-LDCs								
Bangladesh	21.4	35.0	40.8	53	97	65	66	56
Benin	29.7	23.0	39.0	23	63	77	24	29
Burkina Faso	43.0	18.0	23.0	29		60	27	36
Chad	41.0	30.0	41.0	29	27	46	31	39
Comoros	20.6	52.0	59.2	98	96	90		26
Djibouti	42.3		63.4	91	100	80		18
Gambia	40.5	27.0	35.7	37	62	90	17	26
Guinea	38.3	24.0	35.0	58	48	93	24	
Guinea-Bissau	42.2	37.0	37.7	47	49	44	23	23
Maldives	12.5		96.2	56	100	50		43
Mali	38.5	32.0	39.8	69	65	60	22	40
Mauritania	33.1	34.0	41.6	33	37	66	16	23
Mozambique	49.2	33.0	43.2	43	60	50	47	26
Niger	41.4	28.0	15.3	20	59	66	44	50
Senegal	28.5	38.0	36.4	70	78	66	20	22
Sierra Leone	51.6	21.0	32.0	28	28	44	26	29
Sudan	27.3	27.0	56.9	62	75	15	34	34
Togo	34.1	43.0	56.3	34	54	70	18	25
Uganda	48.4	48.0	66.1	75	50	70	26	26
Yemen	20.0	39.0	45.2	45	69	50	27	46
Other OIC-LICs								
Azerbaijan			97.0			66		
Cameroon	36.2	54.0	74.8	92	62	66	17	22
Côte d'Ivoire	40.2	54.0	45.7		77	80	26	24
Indonesia	12.8	82.0	86.3	66	76	80	38	34
Kyrgyz Republic			97.0	100	77	66		
Nigeria	33.7	51.0	62.6	63	57	10	35	31

Table A.5. Elements of Human Poverty Index in OIC-LDLICs (continued)

	Probability at birth of not surviving to age 40 (%)	Adult literacy rate (%)		Population with access to:			Underweight children under age 5 (%)	
				Adequate sanitation facilities (%)	Improved water resources (%)	Essential drugs** (%)		
	(1995-2000)	1990	1999	1999	1999	1999	1990	1995-2000
Pakistan	20.1	35.0	45.0	61	88	65	42	26
Tajikistan			99.1			44		
Turkmenistan			98.0	100	58	66		
Uzbekistan		93.0	88.5	100	85	66		27
OIC-LDLICs		**50.0**	**58.0**				**41**	**35**
DCs	**14.3***	**64.0**	**72.9**				**35**	**27**
All LDCs	**30.3***	**45.0**	**51.6**				**40**	**41**
S-Sah.Africa	**34.6***	**51.0**	**59.6**				**31**	**30**

Source: UNDP Human Development Report 1995,2001.

(*) Stands for 1998 values.

(**) The data represented by World Health Organisation (WHO) Department of Essential Drugs and Medicines.

Policy assigns 4 groupings: very low access (0-49%), low access (50-79%), medium access (80-94%) and good access (95% and more).

Table A.6. Elements of Human Development Index in OIC-LDLICs

	Life expectancy at birth (years) 1999	Adult literacy rate (%), 1999	Gross enrolment ratio (%), 1999	GDP per capita (PPP US$), 1990	GDP per capita (PPP US$), 1997	GDP per capita (PPP US$), 1999	HDI value,1999	HDI rank (*)	Adjusted HDI (**)
OIC-LDCs									
Bangladesh	58.9	40.8	37	872	1382	1483	0.470	132	-4
Benin	53.6	39.0	45	1043	1800	933	0.420	147	-4
Burkina Faso	46.1	23.0	23	618	784	965	0.320	159	-17
Chad	45.5	41.0	31	559	1172	850	0.359	155	-7
Comoros	59.4	59.2	36	721	1317	1429	0.510	124	7
Djibouti	44.0	63.4	22	1000	1300	2377	0.447	137	-28
Gambia	45.9	35.7	45	913	948	1580	0.398	149	-23
Guinea	47.1	35.0	28	501	1139	1934	0.397	150	-32
Guinea-Bissau	44.5	37.7	37	841	811	678	0.339	156	0
Maldives	66.1	96.2	77	1200	3540	4423	0.739	77	7
Mali	51.2	39.8	28	572	565	753	0.378	153	0
Mauritania	51.1	41.6	41	1057	1622	1609	0.437	139	-14
Mozambique	39.8	43.2	23	1072	959	861	0.323	157	-11
Niger	44.8	15.3	16	645	765	753	0.274	161	-7
Senegal	52.9	36.4	36	1248	1815	1419	0.423	145	-13
Sierra Leone	38.3	32.0	27	1086	625	448	0.258	162	0
Sudan	55.6	56.9	34	949	1110	664	0.439	138	19
Togo	51.6	56.3	62	734	1167	1410	0.489	128	5
Uganda	43.2	66.1	45	524	1483	1167	0.435	141	-4
Yemen	60.1	45.2	51	1562	856	806	0.468	133	16
Other OIC-LICs									
Azerbaijan	71.3	97.0	71	3977	1463	2850	0.738	79	27
Cameroon	50.0	74.8	43	1646	2355	1573	0.506	125	2
Côte d'Ivoire	47.8	45.7	38	1324	1731	1654	0.426	144	-20
Indonesia	65.8	86.3	65	2181	3971	2857	0.677	102	3
Kyrgyz Republic	67.4	97.0	68	3114	1927	2573	0.707	92	15
Nigeria	51.5	62.6	45	1215	1270	853	0.455	136	11
Pakistan	59.6	45.0	40	1862	2209	1834	0.498	127	-5
Tajikistan	67.4	99.1	67	2558	943	1.031	0.660	103	36

Table A.6. Elements of Human Development Index in OIC-LDLICs (continued)

	Life expectancy at birth (years) 1999	Adult literacy rate (%), 1999	Gross enrolment ratio (%), 1999	GDP per capita (PPP US$), 1990	GDP per capita (PPP US$), 1997	GDP per capita (PPP US$), 1999	HDI value,1999	HDI rank (*)	Adjusted HDI (**)
Turkmenistan	65.9	98.0	81	4230	2345	3347	0.730	83	16
Uzbekistan	68.7	88.5	76	3115	2529	2251	0.698	99	15
DCs	**64.5**	**72.9**	**61**	**2170**	**3068**	**3530**	**0.647**		
All LDCs	**51.7**	**51.6**	**38**	**740**	**1008**	**1170**	**0.442**		
S-Sah.Africa	**48.8**	**59.6**	**42**	**1200**		**1640**	**0.467**		
World	**66.7**	**78,8(+)**	**65**	**4890**	**5990**	**6980**	**0.716**		

Source: UNDP, Human Development Report 2001.

Notes: (*) HDI ranks have been calculated for the universe of 162 countries.

(**) Adjusted HDI (GDP per capita PPP$ rank minus HDI rank) in which a positive figure indicates that the HDI rank is better than the GDP per capita rank (PPP$), a negative the opposite.

(+) Indicates the year 1998.

Table A.7. Education Indicators

		Net enrolment ratio (*)				
		Primary	Secondary			
	Adult literacy rate (%)	(as % of relevant age group)	(as % of relevant age group)	Children not reaching grade 5 (%)	Public expenditure on education (as % of GNP)	
	1999	1997	1997	1995-97	1990	1995-97
OIC-LDCs						
Bangladesh	40.8	75.1	21.6		1.5	2.2
Benin	39.0	67.6	28.2	39*		3.2
Burkina Faso	23.0	32.3	12.8	21*	2.7	3.6
Chad	41.0	47.9	17.9	41	1.7	1.7
Comoros	59.2	50.1	35.7	21*	4.1	
Djibouti	63.4	31.9	19.6	21	2.7	
Gambia	35.7	65.9	33.3	20*	4.1	4.9
Guinea	35.0	45.6	14.6	46*	2.1	1.9
Guinea-Bissau	37.7	52.3	24.1		3.2	
Maldives	96.2				6.3	6.4
Mali	39.8	38.1	17.9	16	4.1	2.2
Mauritania	41.6	62.9		36		5.1
Mozambique	43.2	39.6	22.4	54*	4.2	
Niger	15.3	24.4	9.4	27	3.2	2.3
Senegal	36.4	59.5	19.8	13	4.1	3.7
Sierra Leone	32.0	44.0			1.9	
Sudan	56.9					1.4
Togo	56.3	82.3	58.3	29*	5.6	4.5
Uganda	66.1				1.5	2.6
Yemen	45.2					7.0
Other OIC-LICs						
Azerbaijan	97.0				7.0	3.0
Cameroon	74.8	61.7			3.4	2.9
Côte d'Ivoire	45.7	58.3	34.1	25		5.0
Indonesia	86.3	99.2	56.1	12	1.0	1.4
Kyrgyz Republic	97.0	99.5	77.8		8.3	5.3
Nigeria	62.6				1.0	0.7
Pakistan	45.0				2.7	2.7
Tajikistan	99.1				9.7	2.2
Turkmenistan	98.0				4.3	
Uzbekistan	88.5				9.5	7.7
DCs	**73.1**	**85.7**	**60.4**	**22**	**3.5**	**3.8**
All LDCs	**51.9**	**60.4**	**31.2**		**2.7**	
World		**87.6**	**65.4**		**4.9**	**4.8**

Source: UNDP, Human Development Report 2001.
(*) UNDP Human Development Report 2000.

Table A.8. Health Indicators

					People living with HIV/AIDS						
	Under nourished people (%)	Under weight children under age 5 (%)	Births attended by skilled health staff (%)	Physicians (per 100000)	Adults (age 15-49) (%)	Women (age 15-49) (thousand)	Children (age 0-14) (thousand)	Malaria cases (per 100000 people)	Tuberculosis cases (per 100000 people)	Public expenditure on health (as % of GDP)	
	1996/1998	1995-2000	1995-1999	1990-1999	1999	1999	1999	1997	1998	1990	1996-1998
OIC-LDCs											
Bangladesh	38	56	14	20	0.02	0.0019	0.13	56	58	0.8	1.6
Benin	14	29	60	6	2.45	37	3	11918	41	0.5	1.6
Burkina Faso	32	36	27	3	6.44	180	20		18	1.2	1.2
Chad	38	39	11	3	2.69	49	4	4843	38	0.5	2.4
Comoros		26	52	7	0.12			2422	23		3.1
Djibouti		18		14	11.75	19	1.5	700	597		
Gambia	16	26		4	1.95	6.6	0.52	27369	114		1.4
Guinea	29		35	13	1.54	29	2.7	10951	65	1.2	1.2
Guinea-Bissau		23		17	2.5	7.3	0.56		156	1.1	1.1
Maldives		43		40	0.05			4	65	4.9	5.1
Mali	32	40	24	5	2.03	53	0.5	3688	39	1.6	2
Mauritania	13	23	58	14	0.52	3.5	0.26		154	0.5	1.8
Mozambique	58	26	44		13.22	630	52		104	3.6	2.1
Niger	46	50	18	4	1.35	34	3.3	10026	34	1.3	1.9
Senegal	23	22		8	1.77	40	3.3		94	2.8	2.6
Sierra Leone	43	29		7	2.99	36	3.3		72		1.7
Sudan	18	34		9	0.99			5283	80	1	
Togo	18	25	51	8	5.98	66	6.3		28	1.3	1.1
Uganda	30	26	38		8.3	420	53		142	0.7	1.8
Yemen	35	46	22	23	0.01			8560	73	1.2	2.1

Table A.8. Health Indicators (continued)

					People living with HIV/AIDS						
	Under nourished people (%)	Under weight children under age 5 (%)	Births attended by skilled health staff (%)	Physicians (per 100000)	Adults (age 15-49) (%)	Women (age 15-49) (thousand)	Children (age 0-14) (thousand)	Malaria cases (per 100000 people)	Tuberculosis cases (per 100000 people)	Public expenditure on health (as % of GDP)	
	1996/1998	1995-2000	1995-1999	1990-1999	1999	1999	1999	1997	1998	1990	1996-1998
Other OIC-LICs											
Azerbaijan	32	10	99	360	<0,01	<100	<100	130	61	2.6	1.2
Cameroon	29	22	55	7	7.73	290	22	4613	35	0.9	1
Côte d'Ivoire	14	24	47	9	10.76	400	32	6990	104	1.5	1.2
Indonesia	6	34	47	16	0.05	13	0.68	79	20	0.6	0.6
Kyrgyz Republic	17	11	98	301	<0,01	<100	<100		123	4.2	2.7
Nigeria	8	31		19	5.06	1400	120	593	19	1	0.2
Pakistan	20	26		57	0.1	15	1.6	54	60	0.8	0.8
Tajikistan	32			201	<0,01	<100	<100	507	41	4.3	6.6
Turkmenistan	10			300	<0,01	<100	<100		89	3.9	3.5
Uzbekistan	11	19	98	309	<0,01	<100	<100		62	4.6	3.3
DCs	**18**	**27**			**1.3**	**15362T**	**1252T**		**71**	**1.9**	**2.2**
All LDCs	**38**	**41**			**4.3**	**6389T**	**590T**		**97**		**1.6**
S-Sah.Africa	**34**	**30**			**8.7**	**12909T**	**1008T**		**121**	**0.7**	**2.4**
World		**24**			**1.1**	**15778T**	**1281T**		**63**	**4.7**	**5.6**

Source: UNDP, Human Development Report 2001.
T: Total.

Table A.9. Income Poverty

	Share of population living on less than $1 a day (%)				
	1987	**1990**	**1993**	**1996**	**1998**
East Asia & Pacific	**26.6**	**27.6**	**25.2**	**14.9**	**15.3**
Excluding China	**23.9**	**18.5**	**15.9**	**10**	**11.3**
Indonesia			14.3	11.8	7.7
Malaysia				4.3	
South Asia	**44.9**	**44**	**42.4**	**42.3**	**40**
Bangladesh				29.1	
Pakistan		11.6		31	
Sub-Saharan Africa	**46.6**	**47.7**	**49.7**	**48.5**	**46.3**
Burkina Faso			61.2		
Côte d'Ivoire	17.7				12.3
Guinea		26.3			
Guinea-Bissau		88.2			
Mali			72.8		
Mauritania				28.6	
Mozambique				37.9	
Niger		61.5		61.4	
Nigeria			31.1		70.2
Senegal		54		26.3	
Sierra Leone	57				
Uganda	50		36.7		
Middle East & North Africa	**4.3**	**2.4**	**1.9**	**1.8**	**1.9**
Algeria				<2	
Egypt		7.6			
Jordan		2.5			<2
Morocco		<2			
Tunisia		3.9		<2	
Yemen					15.7
Eastern Europe & Central Asia	**0.2**	**1.6**	**4**	**5.1**	**5.1**
Azerbaijan				<2	
Kazakhstan			<2	1.5	
Kyrgyz Republic			18.9		
Turkey			2.4		
Turkmenistan			20.9		
Uzbekistan			3.3		
World	**28.3**	**29**			**23.4**

Source: World Development Indicators 2001 and various years.

Notes: The poverty line is $1.08 a day at 1993 PPP. Poverty estimates are based on income or consumption data from the countries in each region for which at least one survey was available during 1985-1998. Where survey years do not coincide with the years in the table, the estimates were adjusted using the assumption that the sample of countries covered by surveys is representative of the region as a whole, and the number of poor people was then estimated by the region. For further details on data and methodology, see Chen and Ravallion (2000).

Table A.10. Mortality and Life Expectancy Trends in OIC-LDLICs

	Infant mortality rate (per 1000 live births)			Under five mortality rate (per 1000 live births)			Life expectancy at birth (years)		
	1970	**1990**	**1999**	**1970**	**1990**	**1999**	**1970**	**1993**	**1999**
OIC-LDCs									
Bangladesh	145	114	58	239	180	89	44.2	55.9	58.9
Benin	149	88	99	252	147	156	42.5	47.8	53.6
Burkina Faso	163	133	106	290	228	199	39.3	47.5	46.1
Chad	149	127	118	252	216	198	38	47.7	45.5
Comoros	159	94	64	215	151	86	47.8	56.2	59.4
Djibouti	160	117	104	241	164	149	40	48.4	44
Gambia	183	138	61	319	238	75	36	45.2	45.9
Guinea	197	140	115	345	237	181	36.5	44.7	47.1
Guinea-Bissau	186	146	128	316	246	200	36	43.7	44.5
Maldives	157	61	60	255	85	83	49.9	62.4	66.1
Mali	221	164	143	391	284	235	41.9	46.2	51.2
Mauritania	150	122	120	250	214	183	42.5	51.7	51.1
Mozambique	163	173	127	278	297	203	41.9	46.4	39.8
Niger	197	130	162	330	221	275	38.3	46.7	44.8
Senegal	164	84	68	279	185	118	40.6	49.5	52.9
Sierra Leone	206	149	182	363	257	316	34.4	39.2	38.3
Sudan	104	104	67	172	172	109	42.6	53.2	55.6
Togo	128	90	80	216	147	143	44.2	55.2	51.6
Uganda	110	99	83	185	164	131	46.3	44.7	43.2
Yemen	194	114	86	303	187	119	40.9	50.4	60.1
Other OIC-LICs									
Azerbaijan	41		35	53		45	68.4	70.7	71.3
Cameroon	127	90	95	215	148	154	44.3	56.3	50
Côte d'Ivoire	158	92	102	239	136	171	44.2	50.9	47.8
Indonesia	104	71	38	172	97	52	47.6	63	65.8
Kyrgyz Republic	111		55	146		65	62.4	69.2	67.4
Nigeria	120	101	112	201	167	187	42.7	50.6	51.5
Pakistan	117	104	84	181	158	112	49.2	61.8	59.6
Tajikistan	78		54	111		74	62.7	70.4	67.4
Turkmenistan	82		52	120		71	60	65.1	65.9
Uzbekistan	66		45	90		58	63.5	69.1	68.7
OIC-LDLICs	**128**	**100**	**77**	**211**	**157**	**118**	**45.6**	**56.5**	**57.5**
DCs	**109**	**74**	**61**	**167**	**112**	**89**	**54.5**	**61.5**	**64.5**
All LDCs	**149**	**115**	**100**	**243**	**189**	**159**	**43.4**	**51**	**51.7**
S-Sah.Africa	**138**	**106**	**107**	**226**	**175**	**172**	**44.1**	**50.9**	**48.8**
World	**96**	**67**	**56**	**147**	**101**	**80**	**59.1**	**63**	**66.7**

Source: UNDP, Human Development Report 2001 and various years.

Table A.11. Trends in Health Indicators for OIC-LDLICs

	AIDS cases (per 100000 people)	AIDS cases (per 100000 people)	Malaria cases (per 100000 people)	Malaria cases (per 100000 people)	Births attended by skilled health staff (%)	Births attended by skilled health staff (%)	Access an improved water source (% of population)		Access to improved sanitation facilities (% of population)	
	1995	1997	1995	1997	1988-90	1995-1999	1990	2000	1990	2000
OIC-LDCs										
Bangladesh	(.)		126.6	56	7	14	91	97	97	53
Benin	4	39.8	10570.4	11918	51	60		63	20	23
Burkina Faso	16.3	91,2	4680.5		33	27	53		24	29
Chad	9.3	109.7		4843	21	11		27	18	29
Comoros	0.3	2.8	30030.2	2422	24	52				
Djibouti	40.2	263.7	550.7	700	79					
Gambia	5.6	43.1		27369	65			62		37
Guinea	9.1	44	7048.7	10951	76	35	45	48	55	58
Guinea-Bissau	7.4	74			39			49		47
Maldives	(.)	1.8	6.6	4						
Mali	4.2	35.1		3688	14	24	55	65	70	69
Mauritania	1.5	6.7			20	58	37	37	30	33
Mozambique	7.4	33.5			29	44		60		43
Niger	6.8	30,7	8697.7	10026	21	18	53	59	15	20
Senegal	4.8	22,6	37.4		40		72	78	57	70
Sierra Leone	0.6	4,6						28		28
Sudan	0.9	5.9	854.9	5283	60		67	75	58	62
Togo	41.3	185.2			56	51	51	54	37	34
Uganda	10.3	249				38	44	50	84	75
Yemen	0.1	0.5		8560		22	66	69	39	45
Turkmenistan										

Table A.11. Trends in Health Indicators for OIC-LDLICs (continued)

	AIDS cases (per 100000 people)	AIDS cases (per 100000 people)	Malaria cases (per 100000 people)	Malaria cases (per 100000 people)	Births attended by skilled health staff (%)	Births attended by skilled health staff (%)	Access an improved water source (% of population)		Access to improved sanitation facilities (% of population)	
	1995	**1997**	**1995**	**1997**	**1988-90**	**1995-1999**	**1990**	**2000**	**1990**	**2000**
Other OIC-LICs										
Azerbaijan		0.1		130		99				
Cameroon	20.9	69.1	1631.2	4613	25	55	52	62	87	92
Côte d'Ivoire	47.2	265,5	32.7	6990	50	47	65	77	49	
Indonesia	(.)		728.8	79	44	47	69	76	54	66
Kyrgyz Republic		0				98		77		100
Nigeria		14.4		593	45		49	57	60	63
Pakistan	(.)	0.1	79.9	54	70		84	88	34	61
Tajikistan		0	105.3	507						
Uzbekistan						98		85		100
DCs	**4.8**	**28.9**	**883.1**		**63**					
All LDCs	**13.5**	**69.1**	**3220.7**		**29**		**70**	**76**	**40**	**46**
S-Sah.Africa	**22.2**	**111.1**			**39**		**49**	**55**	**55**	**55**
World	**5**	**39.7**			**69**					

Source: UNDP 1999,97,95 and World Development Indicators 2000.
Notes: (.) less than half the unit shown.

Table A.12. Trends in Education Indicators

	Gross primary enrolment rates (% of relevant age group)				Net primary enrolment rates (% of relevant age group)		
	1970	**1980**	**1990**	**1997**	**1980**	**1990**	**1997**
OIC-LDCs							
Bangladesh	54	61	73		60	65	75
Benin	36	67	61	78	53	52	68
Burkina Faso	13	18	36	40	15	29	32
Chad	35		57	58	26		48
Gambia		53		77	53		66
Guinea	33	36	37	54	30	26	46
Guinea-Bissau	39	68	59	62	47		52
Mali	22	26	24	49	20	19	38
Mauritania	14	37	51	79			57
Mozambique	47	99	58	60	35	41	40
Niger	14	25	29	29	22	25	24
Senegal	41	46	58	71	37	48	60
Sierra Leone	34	52	48				
Sudan	38	50	49	51			
Togo	71	118	103	120	79	72	82
Uganda	38	50	76	74			
Yemen	22			70			
Other OIC-LICs							
Azerbaijan		115		106			
Cameroon	89	98	101	85	71	75	62
Côte d'Ivoire	58	75		71	55		58
Indonesia	80	107	117	113	89	98	99
Kyrgyz Republic		116		104	100		100
Nigeria	37	109	27	98			
Pakistan	40	40	37				
Tajikistan				95			
Uzbekistan		81		78			
OIC-LDLICs	**56**	**92**	**75**	**93**	**69**	**76**	**80**
Low Income		**94**		**97**	**74**		**86**
S-Sah.Africa	**46**	**81**	**68**	**78**		**46**	

Source: World Development Indicators 1999, 2001 and various years.

Table A.13. Flows of Aid and Foreign Capital

	Official development assistance (as % of GDP)		Net foreign direct investment (as % of GDP)		Other private flows (as % of GDP)	
	1990	**1999**	**1990**	**1999**	**1990**	**1999**
OIC-LDCs						
Bangladesh	7.0	2.6		0.4	0.2	
Benin	14.5	8.9	0.1	1.3		0.0
Burkina Faso	12.0	15.0	0.0	0.4		0.0
Chad	19.0	12.3	0.0	1.0		-0.1
Comoros	18.1	11.1	-0.4	0.5	0.0	0.0
Djibouti	45.6		0.0	1,2*	-0.1	0*
Gambia	31.3	8.4	0.0	3.6	-2.4	0.0
Guinea	10.4	6.8	0.6	1.8	-0.7	
Guinea-Bissau	52.7	24.0	0.8	1.4		0.0
Maldives	14.5		4.1	3,1*	0.8	2.9
Mali	19.9	13.8	-0.3	0.7		0.0
Mauritania	23.3	22.8	0.7	0.2	-0.1	-0.2
Mozambique	39.9	3.0	0.4	9.7	1.0	-0.3
Niger	16.0	9.3		0.7	0.4	-1.1
Senegal	14.4	11.2	1.0	1.3	-0.3	-0.1
Sierra Leone	6.8	11.0	3.6	0.1	0.4	0.0
Sudan	6.2	2.5	0.0	3.8	0.0	0.0
Togo	16.0	5.1	0.0	2.1		0.0
Uganda	15.5	9.2	0.0	3.5	0.4	
Yemen	8.7	6.7	-2.8	-2.2	3.5	0.0
Other OIC-LICs						
Azerbaijan		4.0	0.0	12.7		2.1
Cameroon	4.0	4.7	-1.0	0.4	-0.1	-0.6
Côte d'Ivoire	6.4	4.0	0.4	3.1	0.1	-2.5
Indonesia	1.5	1.5	1.0	-1.9	1.9	-4.0
Kyrgyz Republic		21.3		2.8		-4.1
Nigeria	0.9	0.4	2.1	2.9	-0.4	-0.4
Tajikistan		6.5		1.3		-0.8
Turkmenistan		0.7		2.5		-4.2
Uzbekistan		0.8		0.6		3.1
OIC-LDLICs	**3.9**	**2.5**	**0.9**	**-0.5**	**1.4**	**-3.1**
DCs	**1.4**	**0.6**	**0.9**	**2.9**	**0.4**	**0.4**
All LDCs	**11.6**	**7.0**		**3.0**	**0.5**	**-0.1**
S-Sah.Africa			**0.3**	**2.4**	**0.2**	**0.8**

Source: UNDP 2001

(*) Indicates the year 1998.

Notes: The negative sign in the private flows indicates that the capital flowing out of the country exceeds that flowing in.